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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

CALIFORNIA HOSPITAL ASSOCIATION,

Petitioner,

vs.

OFFICE OF HEALTH CARE AFFORDABILITY; CALIFORNIA DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION; ELIZABETH LANDSBERG, in her official capacity as Director of the OFFICE OF HEALTH CARE AFFORDABILITY and Director of the CALIFORNIA DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION; and THE HEALTH CARE AFFORDABILITY BOARD,

Respondents.

Case No. CPF-25-519370

FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]

REDACTED

Action Filed: October 15, 2025

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Petitioner CALIFORNIA HOSPITAL ASSOCIATION respectfully petitions this Court for a Writ of Mandate pursuant to Code of Civil Procedure section 1085 and Declaratory Relief pursuant to Code of Civil Procedure section 1060, and by through this First Amended Verified Petition and First Amended Complaint, alleges as follows:

INTRODUCTION

1. California's hospitals are dedicated to the provision of high-quality and affordable health care services to all Californians. Our state's hospitals are the backbone of the health care delivery system, and in particular, the health care safety net. Unfortunately, the actions taken by the Office of Health Care Affordability ("OHCA") and its Board implement arbitrary and irresponsible cost targets that single out hospitals and will severely disrupt our hospitals' ability to provide comprehensive, high-quality services by starving them of the resources they need to perform their critical roles. By the California Hospital Association's ("CHA") estimates, OHCA's onerous and ill-informed actions would result in more than 75% of all California hospitals operating at a loss, forcing deep layoffs and cuts in hospital services. In fact, CHA projects that OHCA's cost targets will result in the loss of roughly 40,000 jobs for nurses and other hospital workers, and the elimination of vital health care services at hospitals all over the state including labor and delivery, mental health care, cancer care, and emergency and trauma care. CHA anticipates that patients will be forced to travel farther for care, face longer wait times, experience more overcrowding in the ER, and lose access to critical services like maternity care, cancer care, mental health, and surgery services.

2. California's hospitals enthusiastically support the Legislature's goal of promoting the affordability of health care services. Our hospitals work hard every day to control their costs, and specifically the amounts patients pay out-of-pocket. For example, despite California's high cost of living, statewide per capita health care spending ranks the 23rd highest nationally. (See Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, *National health expenditure data: Health expenditures by state of resident, 1991-2020* (2020) <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence> [as of Oct. 3, 2025].) Due in large part to hospitals'

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longstanding cost containment efforts, integrated primary care, and care coordination efforts, hospital-specific spending is even lower, ranking 34th nationally. (*Ibid.*) Each hospital in the State maintains a charity and discounted care policy ensuring that patient out-of-pocket costs for lower-income patients do not exceed Medicare rates, and in many cases completely forgives any amount that the patient might owe. The state's hospitals provided $1.1 billion of charity care during 2023, an average of $2.6 million per hospital. (See Cal. Health and Human Svcs, *Hospital Annual Financial Data 2023 Pivot Table – Hospital Annual Selected File* (April 2025 Extract) (Oct. 9, 2024) <https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables/resource/879f1a0c-c476-4248-bdae-0c883d02e5a0> [as of Oct. 3, 2025].)

3. Our hospitals are also at the forefront nationally of developing new and innovative approaches to delivering care more efficiently and effectively. Just by way of example, California hospitals are implementing street medicine programs (sending out medical professionals to meet and provide critical services to unhoused patients on the street where they live), bringing substance use disorder counselors into emergency rooms, and innovating traditionally inpatient services, such as CAR-T immunotherapy technology for cancer treatment, into care that can be provided to outpatients. California hospitals also launched Hospital-at-Home hybrid care programs during the COVID-19 pandemic that merged in-home visits from nurses or paramedics with virtual check-ins with providers, remote monitoring, and laboratory and pharmacy services. These innovations not only ensure underserved people have access to services, improving health and outcomes, but reduce costs and inefficiencies as individuals can avoid frequent and expensive visits to the emergency room and inpatient hospitalizations.

4. CHA, on its own behalf as well as on behalf of the roughly 400 hospitals it represents, brings this First Amended Verified Petition and First Amended Complaint to challenge actions taken by Respondents that impose strict cost targets on California's hospitals. These cost targets effectively limit the annual increase in the reimbursement hospitals may receive, including from commercial health plans, which have historically been based on market-driven, arms-length contract negotiations between the payer and the hospitals. Under OHCA's cost targets, however, the market will no longer control. While the statute requires that the OHCA Director enforce cost

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targets in ways that maintain access, quality, equity, and workforce stability, discussions of OHCA's Board and staff have at times indicated that hospitals are at risk of having significant sanctions imposed if the revenue they receive exceeds the applicable target, regardless of the reasons the hospital may justifiably require increased revenue at a rate in excess of the cost target. And for those hospitals that OHCA has designated as high-cost (the "high-cost hospitals") the cost targets are even stricter. The enforcement period for OHCA's cost targets began on January 1, 2026, and thus hospitals will need to act rapidly to avoid noncompliance, although precisely *how* to ensure compliance remains unknown.

5. More specifically, as of January 2026, OHCA requires that California hospitals limit their revenue largely by way of limiting the reimbursement they receive for providing care, such that their revenue does not increase annually by more than 3.5% for most hospitals, and 1.8% for seven high-cost hospitals. California hospitals that do not do so in 2026 and subsequent years are subject to ill-defined enforcement sanctions, including potentially substantial monetary penalties. California hospitals are charged with complying with these targets, and face sanctions for noncompliance, even though OHCA has not adopted rules as to how it will determine whether a hospital has exceeded the applicable target; that is, there has not yet been adopted a measurement methodology so that hospitals will have no way of knowing if they are exceeding the targets even though they are now enforceable as of January 1, 2026.

6. CHA of course acknowledges that the Legislature has charged OHCA with the responsibility to establish cost targets. However, the Legislature carefully circumscribed OHCA's authority by identifying critical factors that OHCA must consider, and by requiring that the cost targets be evidence-based. For example, when adopting cost targets, OHCA is required by statute to consider and maintain access to quality and equitable care and promote the stability of the health care workforce. (See, e.g., Health & Saf. Code § 127502(b)(3), (c)(5), (c)(6).)[1] Antithetically, OHCA has adopted cost targets applicable to hospitals that will compromise the availability of health care services, necessarily impacting the delivery of quality and equitable

[1] Unless otherwise stated, all further statutory references herein are to the Cal. Health & Safety Code.

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care, and that are wholly inconsistent with the evidence before OHCA concerning labor cost increases, increases in the cost of treating emerging diseases and health care technologies (including the extraordinary cost of certain life-saving drugs), the cost of capital improvements required to comply with California's seismic safety law, and other policy changes affecting provider reimbursement and coverage under government sponsored health programs.

7. For example, the evidence before OHCA shows that the rate of labor costs for hospitals in the western region of the country has grown in recent years at 6% annually. (CHA, public comment to OHCA Board, Mar. 20, 2025, p. 4.; CHA, public comment to OHCA Board, Apr. 11, 2025, p. 9 [both citing Kaufman Hall, *National Hospital Flash Report* (Dec. 2024) <https://www.kaufmanhall.com/sites/default/files/2025-02/KH-NHFR_Report-December-2024-Metrics.pdf> (as of Oct. 3, 2025)].) Yet OHCA adopted a cost target for most hospitals of 3.5% declining over time to 3.0%, and for some hospitals of 1.8% declining over time to 1.6%. In so doing, OHCA never explained how hospitals are to manage something like a 6% increase in the cost of labor while limiting the increases in revenue to from 1.6% to 3.5%, particularly since labor costs comprise about one-half of hospital costs. (Nearly 55% of hospital spending goes directly to employees—nurses, medical assistants, nurse practitioners and other health care workers.[2]) OHCA actions will therefore result in massive layoffs of health care workers, leaving hospitals understaffed and jeopardizing quality of care for patients.

8. Similarly, throughout OHCA's formulation of cost targets, hospitals explained to OHCA that federal legislation was on the horizon that would significantly reduce payments to hospitals under the Medicaid program (known as "Medi-Cal" in California). That legislation was enacted in the "One Big Beautiful Bill Act," ("OBBBA") which CHA estimates will reduce California hospital payments under Medicare and Medi-Cal by at least $66 billion to $128 billion over the next ten years. In addition to these reimbursement reductions, the OBBBA is also projected to significantly increase uncompensated care costs for hospitals due to health care

[2] See California Health and Human Services, *Hospital Annual Financial Data 2023 Pivot Table – Hospital Annual Selected File (April 2025 Extract)* (Oct. 9, 2024) <https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables/resource/879f1a0c-c476-4248-bdae-0c883d02e5a0> (as of Oct. 3, 2025).

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coverage losses in government sponsored programs. In California, it is estimated that 1.6 million individuals will become uninsured by 2034 due to OBBBA. (Burns et al., *How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State?: Allocating CBO's Estimates of Additional Uninsured People Across the States* (Aug. 20, 2025) Kaiser Family Foundation.) Without the ability to negotiate for increased payments from non-governmental payers to offset at least some of this reduced reimbursement and increased uncompensated care costs—and indeed, some commercial payers are already limiting payment rates for California hospitals, citing the cost targets[3]—California hospitals will be facing severe funding losses that will undoubtedly result in the diminution of services, including the likely closure of emergency rooms and potentially entire hospitals, as well as the elimination of jobs. The OHCA Board did not in any way revise or delay their actions to consider the impacts of these severe funding losses and cuts to patients' health care coverage.

9. It is therefore no surprise that members of the California Legislature, from both parties, have stated their concern that OHCA's actions are not aligned with the ultimate goal of its enabling statute. In a May 2025 meeting of the Senate Budget Subcommittee that oversees OHCA, Committee Chair Senator Akilah Weber Pierson, M.D. (D-San Diego) commented: "The ultimate goal of OHCA, which is to reduce the cost of health care for individuals, will not be met. . . . I don't know, I think we're living in a fantasy world. If [providers have] this spending limit but they have to put this money out for these things that have been mandated [by existing law and regulation], then at the end of the day, something has to give. So either they won't make [compliance with the cost targets] and will be penalized, or they have to cut services. And either way, the people who will pay are the patients." (Statements of Sen. Akilah Weber Pierson, Hearing of the California Senate Budget and Fiscal Review Subcommittee 3 on Health and Human Services (May 1, 2025), 1:12:19–1:13:25.) As Senator Pierson concluded, "access is an issue. We have an issue with access in the state, but it is already being negatively impacted by

[3] See, e.g., Scripps Health, public comment to OHCA Board, Jan. 28, 2025 ("many insurance companies are erroneously claiming they can only increase compensation to providers by 3% based on OHCA requirements…demanding Scripps accept financial concessions that do not consider our increasing costs.").

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these targets." (*Ibid.*) Senator Shannon Grove (R-Bakersfield) further stated "It's hard for me to understand from a business perspective that this body passes out policies . . . that increase costs for all of our providers— hospitals, medical providers, doctors, everybody has a higher cost. . . . I don't see how you can cap a cost and not hurt the providers that will eventually hurt the people seeking medical care? . . . . My big issue is that capping . . . is just going to devastate hospitals . . . ." (Statements of Sen. Shannon Grove, Hearing of the California Senate Budget Subcommittee 3 on Health and Human Services (May 1, 2025), 1:01:38–1:02:58.)

10. CHA has hoped to foster a collaborative relationship with OHCA and its Board, and work with OHCA to assist it with accomplishing its mission and improving the health care delivery system for all Californians. CHA and its member hospitals actively participated in the public process that ultimately resulted in the cost targets. CHA recognized early on the importance of the Legislature's charge to OHCA to establish cost targets that would promote affordability while maintaining access, equity, and quality, and the challenges that OHCA would face to accomplish the Legislature's objectives. CHA understood that it would be critical that OHCA would have access to the best and most timely and accurate information so that its decisions would be fully informed and evidence-based. Accordingly, CHA and its members submitted detailed and voluminous comments to OHCA, both in writing and in person at the various public meetings of the OHCA Board.

11. Unfortunately, as detailed below, the input from CHA, California's hospitals, and other provider groups and members of the public went unheard. OHCA only focused on capping hospital spending, without ensuring its cost targets would not harm patients or the availability of hospital services. OHCA barged ahead, adopting a 5-year statewide cost target, a hospital specific sector and hospital sector target, a criteria to deem particular hospitals as "high-cost", and a separate cost target for those high-cost hospitals, all of which are wholly at odds with the information provided to OHCA and the statutory framework guiding its work. Either OHCA did not consider this information or chose to ignore it and move forward based on preconceived notions that were flatly repudiated by the material presented to OHCA. As a result, rather than promoting access to high quality health care services and the equitable availability and provision

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of health care services statewide, OHCA's actions threaten the viability of the entire health care delivery system. If hospitals are starved for the funds they require to operate, they will be forced to cut back on services to remain viable, including emergency room services, obstetrical services, behavioral health services, and many others. As some hospitals close or reduce services, there will undoubtedly be a snowball effect, as the remaining hospitals will be overwhelmed, unable to adequately serve the presenting patients, and have to themselves reduce services or close their doors. The comments from CHA and its members tried to inform OHCA and its Board of these very real concerns but OHCA's actions belie any indication that this input was seriously considered.

12. A significant reason that OHCA ended up adopting cost targets that are arbitrary and unsupported by the material before OHCA is that OHCA made decisions prematurely and based on data recognized as faulty and incomplete. OHCA was not required to establish initial individual health care sectors (used to create specific cost targets by sector) until October 1, 2027, and was not required to establish sector cost targets until June 1, 2028. (§§ 127502(*l*)(2)(A) and (B).) The Legislature intentionally gave OHCA sufficient time to gather and comprehensively analyze the data necessary to make reasonable decisions that would be in the best interest of the people in California. For instance, the Legislature wished to ensure that the cost targets would not be based on data from the period of the public health emergency arising from the COVID-19 pandemic, as it was widely recognized that this time period was aberrational. (See § 127502(d)(3) [the methodology used to set cost targets "shall provide differential treatment of the 2020 and 2021 calendar years due to the impacts of COVID-19 on health care spending and health care entities."].)

13. Yet, OHCA and its Board "rushed to judgement," establishing a hospital sector more than two years before required, and a hospital sector cost target more than three years before required by law. (As discussed in paragraphs 49 and 205 *infra*, the cost target applied to hospitals does not in fact provide differential treatment of COVID-19 years.) Then, OHCA's Board acted to establish cost targets for hospitals it deemed to be high-cost *before* establishing a method for measuring hospital spending or correcting recognized deficiencies in the data used to establish the

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criteria to assess hospitals as high-cost and the high-cost targets. And as discussed above, OHCA refused to slow down for any consideration of watershed events impacting health care, such as the enactment of unprecedented cuts to federal funding. These precipitous OHCA actions deprived hospitals and communities at large of the meaningful deliberation required to access and analyze the voluminous and complex information needed to promulgate rational cost targets that would be in furtherance of the Legislature's goals.

14. Accordingly, CHA challenges herein five actions that have been taken by Respondents, including:

a. The promulgation of a 3.5% statewide cost target for 2025, declining to 3.0% by 2029;

b. The adoption of a hospital sector;

c. The adoption of a hospital sector cost target equal to the statewide cost target;

d. The adoption of criteria for identifying supposed high-cost hospitals; and

e. The adoption of reduced cost targets for the high-cost hospitals, starting at 1.8% for 2026 and declining to 1.6% by 2029.

15. As discussed in greater detail below, these actions are invalid because they are (a) inconsistent with the Legislature's mandates, (b) are arbitrary and capricious, and therefore a prejudicial abuse of discretion in that Respondents failed to properly consider the relevant factors as reflected in the enabling legislation and took actions that are not supported by the relevant record, (c) violated the takings and due process clauses of the United States and California Constitutions in that they will result in payments to hospitals that are confiscatory and subject hospitals to enforcement without a cogent articulation of how to comply with the cost targets, and (d) in the case of the adoption of the criteria for identifying high-cost hospitals, were not adopted in conformance with the California Administrative Procedure Act.

JURISDICTION AND VENUE

16. The Court has jurisdiction over this action pursuant to Code of Civil Procedure section 1085, subdivision (a) and section 1060.

17. Relief in mandamus is authorized by Code of Civil Procedure section 1085 in order

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to compel the performance of a clear, present, and mandatory and ministerial duty where the petitioner has a beneficial interest in the performance of that duty.

18. Specifically here, relief in mandamus is authorized in order to compel Respondents to act in conformance with mandatory state laws obligating them to promote access, equity, and quality of health care and workforce stability in the enactment of health care cost targets and health care sectors and to create or adjust cost targets following particular methodological and data requirements. (See, e.g., §§ 127500.5(a)(7)–(8), (c), (d), (e), (g), (h), (o)(1); 127502(b)(3), (c)(2), (c)(5)–(7), (d), (e); 127505(a); 127506.) Relief in mandamus is also authorized in order to compel Respondents to act in conformance with the federal and state constitutions and statutes, in particular, to prohibit Respondents from enacting cost targets that facially violate the Takings and Substantive Due Process clauses and that are so vague that they violate the procedural due process rights of CHA members, and from employing their unlawfully promulgated methodology to designate hospitals as "high-cost" hospitals.

19. Trial courts may also issue a writ to correct an agency's abuse of discretion. (See *People for the Ethical Operation of Prosecutors & Law Enforcement v. Spitzer* (2020) 53 Cal.App.5th 391, 407 [a writ of mandate "will lie to correct abuses of discretion."] [citing *Cal. Public Records Research, Inc. v. Cnty. of Stanislaus* (2016) 246 Cal.App.4th 1432, 1443].) Insofar as Respondents have any discretion with regards to the duties outlined in the OHCA enabling statute, a writ of mandamus should nonetheless lie to correct Respondents' abuses of this discretion, in particular, in failing to appropriately consider or demonstrate a rational connection between their actions, the factors they are required by law to consider, and the input they received from public commenters and the OHCA Advisory Committee. (See §§ 127501.11(a); 127501.12(d) [obligations to consider input from Advisory Committee and Public Comments].)

20. Declaratory relief is authorized under Code Civ. Proc. section 1060 in order that any person "who desires a declaration of his or her rights or duties with respect to another . . . may, in cases of actual controversy relating to the legal rights and duties of the respective parties, bring an original action or cross-complaint in the superior court for a declaration of his or her

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rights and duties in the premises, including a determination of any question of construction or validity arising under the instrument or contract." (Code Civ. Proc., § 1060.)

21. Declaratory relief is appropriate here establishing that OHCA's (1) establishment of the statewide cost target, (2) creation of a hospital sector, (3) establishment of a hospital sector cost target, (4) adopted methodology to determine high-cost hospital criteria, and (5) establishment of a high-cost hospital cost target are improper, arbitrary and capricious, and contradict the mandates set out in OHCA's enabling statute and the federal and California Takings and Due Process Clauses.

22. Venue is proper in the Superior Court for the County of San Francisco. CHA member hospitals including, among others, the University of California San Francisco Medical Center, Kaiser Permanente Medical Center San Francisco, Zuckerberg San Francisco General Hospital, and CPMC Hospital, are located and do business in the City and County of San Francisco. These hospitals are affected by the actions of Respondents being challenged herein, in that they are subject to the cost targets adopted by Respondents. (Code Civ. Proc., § 393(b).) In addition, the California Attorney General has an office in the City and County of San Francisco. (Code Civ. Proc., § 401.)

THE PARTIES

23. Respondent THE CALIFORNIA OFFICE OF HEALTH CARE AFFORDABILITY is, and at all times mentioned herein was, a California governmental agency within the Department of Health Care Access and Information. OHCA's headquarters are located in Sacramento, California. OHCA and its Board are responsible for carrying out various duties set forth in the California Health Quality and Affordability Act (the "Act"), Health & Safety Code sections 127500 through 127507.6, including the promulgation of cost targets and health care sectors. OHCA and its Board have taken the actions being challenged in this Petition and Complaint.[4]

[4] Throughout this Petition and Complaint, Respondents are collectively referred to as "OHCA" or "Respondents."

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24. Respondent THE CALIFORNIA HEALTH CARE AFFORDABILITY BOARD ("Board"), as defined by Health & Safety Code section 127501.10, is, and at all times mentioned herein was, a board within OHCA, with members appointed pursuant to the Act. The Board, with recommendations from the OHCA Office, is responsible for taking various actions as set forth in the Act, including, among other items, establishing and/or approving a statewide cost target, health care sectors, and sector cost targets. The Health Care Affordability Board is situated within OHCA, whose headquarters are located in Sacramento, California.

25. Respondent THE CALIFORNIA DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION ("HCAI") is, and at all times mentioned herein was, a California governmental agency. OHCA is established within HCAI. (§ 127501.) HCAI's headquarters are located in Sacramento, California.

26. Respondent ELIZABETH LANDSBERG is the Director of HCAI ("Director") and the Director of OHCA. (§ 127501(a) [the Director of HCAI serves as the director of OHCA].) The Director is the senior-most official responsible for the implementation of the obligations of HCAI and OHCA as set forth in state legislation, including the obligations of OHCA with respect to the promulgation and implementation of cost targets. The Director is sued in her official capacities. The Director's office is located in Sacramento, California.

27. Petitioner CALIFORNIA HOSPITAL ASSOCIATION ("CHA" or "Petitioner") is a trade association representing the interests of hospitals in the State of California. CHA is incorporated in the State of California with its principal office in Sacramento, California. CHA's member hospitals provide both inpatient and outpatient hospital services. CHA represents roughly 400 hospitals and health systems throughout California, including general acute care hospitals, children's hospitals, small and rural hospitals, psychiatric hospitals, academic medical centers, public hospitals, not-for-profit hospitals, investor-owned hospitals, and multi-hospital health systems. These hospitals furnish vital health care services to millions of our state's citizens. CHA's mission is to represent and serve these hospitals and health systems and maintain a financial and regulatory environment within which these hospitals can continue to provide equitable access to affordable, safe, high-quality, and comprehensive health services to patients

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and their communities.

28. CHA brings this action on its own behalf and in its representative capacity on behalf of its members, all of which will be directly and adversely affected by the actions of the Respondents challenged in this case. The CHA Board has approved and authorized the filing and conduct of this litigation. Specifically, CHA is interested in its members' abilities to carry out their central missions of providing high quality, accessible, and equitable health care to their communities, which includes supporting its members in efforts to secure the financial resources necessary to furnish such care. CHA is further interested in its members' abilities to properly support their workforce, including retaining necessary highly trained personnel, providing reasonable compensation, assisting with professional education, and providing opportunities for career advancement. As discussed in this Petition and Complaint, OHCA's actions will impede, and likely entirely eliminate in certain instances, CHA's members' ability to provide accessible, quality, and equitable care and maintain the stability of their workforces.

29. The remainder of this Petition is organized as follows:

a. Factual Background (paragraphs 30–83). In this section, CHA first provides the factual background pertaining to the five challenged OHCA actions.

b. Relevant Statutory and Regulatory Background (paragraphs 85–96). In this section, CHA discusses the relevant statutory and regulatory provisions addressing OHCA's actions.

c. Legal Background (paragraphs 97–109). This section presents legal background relating to the arbitrary and capricious standard of review for agency actions, the Takings and Due Process clauses, and the rulemaking provisions of the California Administrative Procedure Act.

d. Standing (paragraphs 110-144). This section reviews why CHA has standing to bring this action, both on its own behalf and on behalf of its members.

e. The Dispute (paragraphs 145–303). This section discusses the reasons why OHCA's actions pertaining to the cost targets are inimical to its statutory mandates and unsupported and contradicted by the record before OHCA when it made the decisions

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challenged in this Petition and Complaint. This section also addresses why the cost targets violate the Takings and Due Process clauses of the United States and California Constitutions, and why the establishment of high-cost hospital criteria resulted in an underground regulation in violation of the California Administrative Procedure Act. The evidentiary record is discussed in detail in this section.

f. First Cause of Action (paragraphs 304–315). This section sets forth CHA's first cause of action, incorporating and relying on the previous paragraphs of this Petition and Complaint, which is a claim for a writ of mandate under section 1085 of the Code of Civil Procedure.

g. Second Cause of Action (paragraphs 316–326). This section sets forth CHA's second cause of action, which is a claim for declaratory relief under section 1060 of the Code of Civil Procedure. As with the First Cause of Action, this section incorporates and relies on the previous paragraphs of this Petition and Complaint.

FACTUAL BACKGROUND

A. California's Office of Health Care Affordability

30. In 2022, the California Legislature established OHCA within the Legislature's 2022-2023 state budget package. (Sen. Bill No. 184, approved by Governor, June 30, 2022 (2021–2022 Reg. Sess.) ch. 47, § 19.) Broadly, OHCA is charged with collecting, analyzing, and reporting data on total health care expenditures, developing policies for lowering health care costs for consumers and purchasers, and enforcing cost targets to control the cost of health care so that all Californians receive accessible, affordable, equitable, and high-quality care.

31. As discussed further below, OHCA's authorities and obligations are in Health & Safety Code chapter 2.6, sections 127500 et seq. Throughout OHCA's enabling statute, the Legislature makes clear its intent that the goal of promoting health care affordability for consumers should not come at the cost of health care quality, efficiency, access, and workforce stability. (See, e.g., § 127500.5(b), (c), (g), (o)(1).)

32. OHCA is housed within HCAI and is overseen by an eight-member board with input from an advisory committee. (§ 127501.10 [establishing the Health Care Affordability

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Board]; § 127501.12 [establishing the Health Care Affordability Advisory Committee].)

33. By statute, some responsibilities fall specifically to the Board, while others can be carried out by the Director or OHCA designee.

34. OHCA has three main goals: slowing health care spending growth through setting and enforcing cost targets, promoting high value care through a variety of projects, including investments in primary care and behavioral health and work to advance health care workforce stability, and assessing market consolidation. This case challenges OHCA's actions with regard to the setting of cost targets.

B. OHCA Cost Targets

35. The California Legislature authorized OHCA to set health care cost targets, which it defined as "the target percentage for the maximum annual increase in per capita total health care expenditures." (§ 127500.2(j).) In other words, to comply with the cost targets, from one year to the next, a health care entity in California's per capita health care expenditures may not rise more than the target percentage for that year. The OHCA Director is empowered to enforce cost targets, including through administrative penalties. (§ 127502.5(a)(4).) As implemented by OHCA, for hospitals, the cost targets are not limits on their expenditures but are expected to be limits on the annual increase in their net revenues, that is, how much they collect from payers and patients.

36. The OHCA Office has the obligation to develop a transparent methodology to set health care cost targets, which is to be approved by the Board. (§ 127502(d)(1).) The methodology must include a review of historical trends and projections for economic indicators and population-based measures (§ 127502(d)(2)), a review of historical trends in costs for Medi-Cal, Medicare, and commercial health care coverage, providing differential treatment of 2020 and 2021 due to the impacts of COVID-19 on health care spending and health care entities (§ 127502(d)(3)), and a review of potential relevant factors to adjust future cost targets, including labor costs, trends in the price of health care technologies, provider payer mix, and state or local mandates such as required capital improvement projects (§ 127502(d)(4)).

37. Using this methodology, OHCA's Board has authority to set statewide cost targets, as well as cost targets for payers, providers, and fully-integrated delivery systems. (See

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§127502(a) ["The board shall establish a statewide health care cost target"]; § 127502(b)(1) ["The board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities . . ."]; § 127500.2(k) [defining "health care entity" as including "a payer, provider, or fully integrated delivery system"].) As these categories are defined in OHCA's enabling statute, OHCA is able to set cost targets for a variety of health care entities, including private health insurers, third party administrators of health plans, public health care payers, including Medicare and Medi-Cal, Medi-Cal managed care plans, physician organizations, hospitals, skilled nursing facilities, clinics, ambulatory surgical centers, clinical laboratories, imaging facilities, and other provider types. (E.g., § 127500.2(h), (o), (p), (q).)

38. OHCA's Board further has authority to establish specific targets by health care sector, and to define these health care sectors, "which may include geographic regions and individual health care entities," excluding fully integrated delivery systems. (§§ 127501.11(a)(2), 127502(b)(1).) OHCA's Office is obligated to promulgate regulations in accordance with the Board's definition of health care sectors. (§ 127502(b)(1).)

39. The OHCA Board may adjust cost targets by health care sector "when warranted to account for the baseline costs in comparison to other health care entities in the health care sector and geographic region." (§ 127502(b)(2).)

40. The Legislature dictated that this be done in stages. The OHCA Board was obligated to establish the first statewide health care cost target in time for the 2025 calendar year, which would serve only as a reporting year and not be subject to enforcement. (§§ 127502(a); 127502(*l*)(1).) Enforcement of compliance began in the 2026 calendar year. (§ 127502(*l*)(1).)

41. The OHCA Board is not obligated to define initial health care sectors until October 1, 2027 (§ 127502(*l*)(2)(A)), and is not obligated to establish specific targets by health care sector until June 1, 2028, (§ 127502(*l*)(2)(B)).

42. The Act requires that OHCA's process for setting cost targets by health care sector be informed by considerations of access, quality, equity, and health care workforce stability. (§ 127502(b)(3).) Similarly, all cost targets must maintain quality and equitable care

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(§ 127502(c)(5)), promote the stability of the health care workforce (§ 127502(c)(6)), and be adjusted for a provider as appropriate upon a showing that nonsupervisory employee organized labor costs are projected to grow faster than the rate of cost targets (§ 127502(c)(7)).

43. The methodology the OHCA Office develops to set cost targets must also review historical trends and projections for economic indicators and population-based measures. (§ 127502(d)(2).) Sector targets must also be informed by historical cost data. (§ 127502(b)(3).)

44. Additionally, when establishing sector targets, the Act requires that OHCA set cost targets that encourage health care entities to service populations with greater health risks by taking into account patient mix and geographic costs, and that minimizes fragmentation and potential cost shifting. (§§ 127502(e), (*l*)(2)(C).)

45. When defining health care sectors themselves, the Act requires that the OHCA Board consider "factors such as delivery system characteristics." (§ 127502(*l*)(2)(A).)

46. In general, the Act requires that OHCA's actions maintain affordability, quality, equity, efficiency, access, and value of health care services (§§ 127500.5(b), (c), (o)(1); 127502.5(a)), with a particular focus on promoting primary care and behavioral health care (§§ 127500.5(a)(7)–(8), (e)), as well as that OHCA's cost targets not hinder workforce compensation or stability (§§ 127500.5(g), (h), (o)(1)).

C. <u>OHCA's Establishment of the Statewide Cost Target</u>

47. In December 2023, the OHCA staff presented preliminary recommendations to the Board regarding a statewide health care spending target value and the methodology to calculate the same. ("Spending target" is OHCA's preferred terminology and synonymous with "cost target," the terminology used in statute.)

48. The proposed cost target—an annual target of no more than 3% for 2025 to 2029—was calculated by taking a weighted average of the last 20 years (through 2021) of growth in the median household income in California. The OHCA staff chose to tie the target to median household income as a measure of consumer affordability. At this time, OHCA began discussing measuring health care entities' adherence with the cost target through a calculation of "total health care expenditures" ("THCE"). The OHCA staff recommended against any adjustments, such as to

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account for higher inflation, labor expenses, demographic changes (such as aging), health care technology cost growth, or to phase the target in over time.

49. When evaluating the preliminary proposal in December 2023, some Board members (as well as public commenters, as discussed in paragraph 205 *infra*) questioned components of the methodology, including the use of 20 years of historical median income data which included aberrational periods such as the 2008 Recession and the COVID-19 pandemic, and why factors like the increases in the cost of health care technologies and health care labor were not considered. (See Comments by Board Member Pan, *December 2023 OHCA Board Meeting Recording* (Dec. 19, 2023), 3:42:11–3:44:55 ["Why 20 years? Oh, because we have data on healthcare expenditures for 20 years? That, to me, is not exactly the best reason to pick that time—especially since you're including two very exceptional events, economically as well as healthcare-wise, in that period."]; see also *id.* at Comments by Board Member Kronick, 3:39:39–3:42:11 ["I mean, the 20 years seems like a pretty arbitrary period. And you know, we've got the 2008 recession in there. . . . I don't understand. Can you explain why you chose a 20-year period rather than, say, a 10-year period, which would have avoided including the last recession in it?"].)[5]

50. Another Board member noted that the value of the target reflects a somewhat arbitrary decision. (See Comments by Board Member Carlisle, *December 2023 OHCA Board Meeting Recording* at 3:44:55–3:48:28 ["Why did we pick the 3.0 number instead of [another value for the cost target]? That's a pretty arbitrary decision. . . . For a first time step or decision, there's a rationale for being more conservative, especially in the face of more recent data that might drive this number up higher based on the 2022 data that we have. . . It's kind of an arbitrary decision."].) Other Board members commented that more work was needed to have a sounder rationale for the chosen target, and time should be taken to get it right.

51. The Board discussed the statewide cost target over multiple months. In January 2024, OHCA revised its methodology to include more recent data in its calculation of the cost target, as recommended by CHA. (See CHA, public comment to OHCA Board, Dec. 13, 2023, p.

[5] Recordings of all OHCA Board meetings are available at HCAI's official YouTube channel: https://www.youtube.com/@ca_hcai.

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8.)[6] But, in so doing, OHCA removed the weighted component of the methodology, which had weighted the most recent years more heavily than older years, so that all twenty years would have an equal weight. Thus, OHCA effectively re-engineered its methodology to arrive at its previously recommended target of 3%. Had OHCA updated the data without changing the weights, the recommended target would have been higher than 3%.

52. Throughout discussions, some Board members continued to state concerns that the target was too low and did not include suitable adjustments. One Board member noted that "if we go forward with a target of 3%, and if my expectation is correct that a very large fraction of covered entitles will be above that target, then you'll be looking at a lot of requests for adjustments. We may end up with an inequitable and inefficient system. So trying to make this as uniform as possible would, I think, be very helpful." (*February 2024 OHCA Board Meeting Recording* (Feb. 28, 2024), 1:32:16–1:36:04.) Similarly, another Board member commented on the importance of clear policies regarding adjustments, as case-by-case assessments could introduce "arbitrariness in decision-making." (*Id.* at 1:27:06–1:28:51.) OHCA Staff acknowledged statutory provisions for adjustments to equity and quality, stating "it's kind of a question of whether you want to adjust performance or do you really need to adjust the target itself." (*Id.* at 1:36:04–1:37:42.)

53. However, at points throughout OHCA's process, other Board members, as well as Director Landsberg, supported low cost targets and strict enforcement, aiming to allow only narrow (if any) adjustments or justifications for higher spending growth above the target. Other Board Members argued that cost targets for some hospitals should be "as close to zero as legally possible." (See *October 2024 OHCA Board Meeting Recording* (Oct. 14, 2024), 2:27:00–2:29:54.) In July 2025, OHCA presented the statutorily delineated waiver process as being entirely optional, rather than mandatory. (*July 2025 OHCA Board Meeting Recording* (July 22, 2025), 3:07:24–3:08:30, 3:10:07–3:12:04, 3:17:38–3:20:00.)

54. Throughout discussions of the spending targets, the OHCA Board focused scant

[6] OHCA Board meeting public comments, presentations, and minutes are available on HCAI's website: https://hcai.ca.gov/public-meetings/.

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attention on its obligations to promote health care access, equity, and quality and workforce stability, even despite myriad public comments raising concerns about these (see paragraphs 149–193). In the March 2024 meeting, Director Landsberg presented the Board with statutory language regarding OHCA's "purpose." This slide and discussion selectively cited statutory language regarding affordability without noting language regarding OHCA's obligations on access, equity, quality, and workforce stability. (OHCA, *March 2024 Board Meeting Presentation*, slide 70 (Mar. 25, 2024).)

55. Further, in the April 2024 Board meeting, one Board Member asked, "we have an equity adjuster that's in the statute, right? That we haven't talked much about, but it's probably going to be more applicable when we start talking about sectors and other types of things, and also perhaps when we do enforcement as well." (*April 2024 OHCA Board Meeting Recording* (Apr. 24, 2024), 2:40:36–2:41:52.) It was not subsequently addressed in the hospital sector discussion. Later, in the November 2024 meeting, a Board member asked what would happen if hospitals met cost targets but equity measures worsened. The OHCA staff responded that OHCA does not have enforcement authority on equity measures, dismissing OHCA's responsibility to ensure that its cost targets do not have a detrimental effect on access. (OHCA, *November 2024 Board Meeting Minutes* (Nov. 20, 2024), p. 10.)

56. In April 2024, the OHCA Board approved a set of statewide cost targets to begin in 2025, at the following percentages.

Performance Year	Per Capita Spending Target
2025	3.5%
2026	3.5%
2027	3.2%
2028	3.2%
2029	3.0%

57. Unlike the OHCA staff's original proposal, these cost targets provide something of a "phase in," beginning at 3.5% and decreasing to 3% by 2029. However, the OHCA Board did not otherwise revise the proposal, despite significant concerns raised by public comments regarding possible impact of the cost targets, including on health care access, equity, and quality,

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and workforce stability (discussed in paragraphs 149 –192, *infra*).

58. In June 2024, OHCA filed an emergency regulation with the Office of Administrative Law to establish the statewide spending targets.

D. OHCA's Creation of a Hospital Sector

59. In November 2024, OHCA staff presented to the Board options for creating one or more hospital sectors, years before OHCA's statute required and before OHCA performed analyses on any other health care sector or assessed the performance of the statewide target.

60. OHCA appears to have prematurely focused on the hospital sector as a means to establish a hospital sector spending methodology—the practical piece used to enforce the statewide target against hospitals—and principally, to get at high-cost hospital spending. But, at the time of OHCA's November 2024 preliminary presentation, OHCA had not publicly presented data regarding hospital spending (that is, amounts spent on hospital services rather than expenditures by hospitals), OHCA had not finalized an approach for measuring hospital spending to determine compliance with cost targets, OHCA had not analyzed or reported on comprehensive total health care expenditures—its principal data source on spending trends (and which was designed to disaggregate spending for different major categories of expenditure, including hospital inpatient and outpatient spending), OHCA had not publicly analyzed or presented options for any other potential sector, and OHCA had not considered various other relevant issues. Indeed, in earlier meetings, Board members had expressed that "the problem is there's so much uncertainty still, that that is something that we should really think about not doing right off the outset. This is our first year trying to do this." (*March 2024 OHCA Board Meeting Recording* (Mar. 25, 2024), 1:32:47–1:35:02).

61. In December 2024, OHCA staff and Board members continued to consider the creation of a hospital sector, looking at initial data analysis of various approaches to identify high-cost hospitals. Staff and Board members recognized that there were no consistent patterns and trends in the data presented, rather, different groups of hospitals occupied the top 30 high-cost hospitals for different measures. One Board member also commented that a consideration of the hospital sector requires more consideration of outpatient costs, noting that "I'm afraid that if we're

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only looking at one piece of it, we may have unintended consequences, even on affordability." (See, e.g., *December 2024 OHCA Board Meeting Recording* (Dec. 16, 2024), 2:54:26–2:56:13.) (An approach for measuring outpatient hospital spending has still yet to be finalized.) Nonetheless, OHCA staff recommended, and the OHCA Board endorsed, defining a hospital sector at that time, rather than waiting until a later date. Similarly, while some Board members highlighted other options for specific health care sectors, including separating out sectors by geography and focusing on a health care sector specific to health plans, OHCA pressed on just with a hospital sector. (See, e.g., *id.* at 2:29:52–2:31:46 [Board members note urgency of considering health care sector for health plans].)

62. Prior to adopting the hospital sector in January 2025, it appears that the OHCA Board had a limited and incomplete understanding of hospital spending. For instance, witnesses the OHCA staff presented to the Board at the December 2024 meeting led one Board member to incorrectly state that there is no correlation between hospital costs and quality. See *December 2024 OHCA Board Meeting Recording* at 2:01:19–2:01:57 ("Did you look at quality in any way, shape, or form? . . . And is there any correlation? I know typically there is not. . .].) Further, the OHCA Board undertook a very abbreviated consideration of the hospital sector at the January 2025 meeting at which they approved the sector's establishment: the OHCA staff's presentation of the Advisory Committee's comments on the hospital sector took just longer than two minutes total. (*January 2025 OHCA Board Meeting Recording* (Jan. 28, 2025), 2:14:35–2:16:54.) These comments had included serious concerns about the pace of setting sector targets, especially given that hospital spending measurement and enforcement mechanisms of the statewide targets were not fully developed.

63. In January 2025, the OHCA Board voted 6-0 to establish a hospital health care sector to include hospitals defined in Health & Safety Code section 1250. Board members emphasized that defining a hospital sector was a necessary step to set spending targets for high-cost hospitals.

64. In March 2025, OHCA submitted an emergency regulation to establish the hospital sector, Cal. Code Regs., tit. 22, § 97446. In so doing, OHCA stated its belief that specific facts

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demonstrated the need for immediate action. In a notice "Finding of Emergency of Proposed Emergency Regulations," OHCA stated that it had "considered other potential sectors" but focused on hospitals because it had historical data on hospital spending, in contrast with other potential sectors. However, this is untrue. HCAI, OHCA's parent department, collects and publicly reports data similar to what it used to analyze historical hospital spending on long-term care facilities and primary care clinics, both of which are defined as health care entities under OHCA's statute. Additionally, the Department of Managed Health Care collects, and in the case of health plans, publishes comparable financial data for health plans and physician groups licensed as risk-bearing organizations. Despite being reminded of the availability of these data for other potential sectors, OHCA declined to conduct any further evaluation.

E. OHCA's Application of the 3.5% and Decreasing Cost Target to the Hospital Sector

65. In April 2025, the OHCA Board voted to apply the statewide cost target to the hospital sector, as follows:

Performance Year	Per Capita Spending Target
2026	3.5%
2027	3.2%
2028	3.2%
2029	3.0%

66. The OHCA Board adopted these target levels the same day as it reviewed public comment on the same issue. OHCA received 528 pages of public comments on its recommendation for the levels of the hospital sector spending targets (due April 11, 2025). The OHCA Board received a high-level summary of these comments at the April 22, 2025 Board meeting, and voted on the cost targets almost immediately after.

67. At this time, OHCA had not substantively engaged with issues of health equity or access or workforce stability within the context of discussing cost targets. At the March 2025 meeting, HCAI's Chief Analytics Officer provided a presentation to the Board, noting that the "foundational work" of conducting analysis on health equity was "underway, but the equity analyses have not yet commenced and so they will not be a focus of our presentation today." (Presentation by Chris Krawcyzk, HCAI Chief Analytics Officer, *March 2025 OHCA Board*

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Meeting Recording (Mar. 25, 2025), 4:09:58–4:10:30.) Similarly, at the same meeting, OHCA's staff acknowledged hospital workforce concerns, but workforce stability was not a part of the Board's conversation about the hospital sector target, despite significant public comment on the matter.

68. In adopting cost target levels, OHCA Board Members noted the acute uncertainty regarding federal health care funding, namely proposed cuts to Medicaid that were actualized in the federal OBBBA (signed by the President on July 4, 2025). But, OHCA Board Members reasoned that this only increases the importance of OHCA's work on affordability without consideration of how such cuts could impact accessibility to and equity of care in the state, especially in conjunction with proposed hospital cost targets. Indeed, after funding cuts were enacted into law in July 2025, Board members stated that the "fallout" of OBBBA "is all the more reason that we need to really ensure that the vision of OHCA and its target setting is made real and quickly." (Comments by Board Members Lewis and Kronick, *July 2025 OHCA Board Meeting Recording* at 2:04:35–2:07:14, 2:09:13–2:11:13.) Another Board member further stated that "to the extent that [OBBBA] is taking money out of the health care system, that makes it easier to hit 3.5%. It doesn't become an excuse to go above 3.5%." (*Ibid.*)

69. Board member comments at the April 2025 meeting indicate that at least certain Board members and the OHCA staff had not reviewed or seriously considered comments submitted by hospitals. At that meeting a Board member asked whether hospitals recommended strategies for affordability that they could focus on, to which an OHCA staff member stated, "there weren't any specific strategies suggested." (*April 2025 OHCA Board Meeting Recording* (Apr. 22, 2025), 1:55:09–1:58:40.) One Board member pushed back, stating "they were making suggestions—I think fairly concrete suggestions—about approaches to look at it. So I don't think it was entirely just like 'don't do anything.'" (*Ibid.*)[7]

[7] It is also simply untrue that hospitals did not recommend strategies for affordability. For example, CHA's October 9, 2024 letter provided several recommendations for "OHCA to explore to meaningfully improve affordability without sacrificing equitable access to high-quality care." (CHA, public comment to OHCA Board, Oct. 9, 2024, pp. 9-10.) And, CHA's July 17, 2025 Public Comment Letter asked OHCA to scrutinize health insurers' profits and administrative

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70. The cost targets applied to hospitals are meaningfully distinct from cost targets applied to other health care entities. To determine whether health care entities meet or exceed the statewide target, and any sector-specific, cost targets, OHCA had to devise an approach to collect and measure costs. Initially, for the statewide targets, OHCA determined that the agency could look to THCE for payers' expenditures and total medical expenditure (TME) for providers' revenues.

71. THCE, under the statute, means "all health care spending in the state by public and private sources, including all of the following:

> (1) All claims-based payments and encounters for covered health care benefits.
>
> (2) All non-claims-based payments for covered health care benefits, such as capitation, salary, global budget, other alternative payment methods, or supplemental provider payments pursuant to the Medi-Cal program.
>
> (3) All cost sharing for covered health care benefits paid by residents of this state, including, but not limited to, copayments, coinsurance, and deductibles.
>
> (4) Administrative costs and profits.
>
> (5) Pharmacy rebates and any inpatient or outpatient prescription drug costs not otherwise included in this subdivision."

(§ 127500.2.) And TME is the portion of THCE that is allocated to providers (and does not include payers' administrative costs and profits). OHCA proposed to allocate TME to providers by attributing health care expenditures on particular patients to their physician organizations.

72. OHCA determined that measuring TME would not reflect all hospital spending (as it would only reflect hospital spending by patients attributed to a particular physician organization). OHCA therefore proposed different methodologies for measuring spending on *hospital* inpatient and outpatient services. On the inpatient side, OHCA confirmed its approach in January 2025 to measure inpatient hospital spending by looking to *Inpatient Net Patient Revenue (NPR) per Case Mix Adjusted Discharge*.[8] Put more simply, OHCA plans to determine if

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costs, which OHCA's own baseline report showed were growing at exorbitant rates. (CHA, public comment to OHCA Board, July 17, 2024, pp. 9-10.)

[8] CHA's best understanding is that OHCA intends to apply cost targets by looking at commercial

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hospitals are exceeding cost targets by looking at *revenue* adjusted for service volume and patients' acuity levels and not the hospitals' costs associated with providing such care. OHCA has not yet adopted an expenditure measurement for hospital outpatient services, but continues to review feedback and has provisionally presented a similar methodology that looks at HCAI data to determine outpatient revenues and visits and then applies an outpatient intensity adjustment. It is important to note that both the inpatient and outpatient methodologies proposed by OHCA do not actually measure hospitals' *costs* (i.e., costs to provide care, employ a workforce, obtain new technologies, etc.) but measure payer and patient *spending* on hospital services instead.

F. OHCA's Adoption of High-Cost Hospital Criteria

73. In February 2025, the month after establishing a hospital health care sector, the Board began specifically discussing even stricter cost targets for hospitals it deemed "high-cost." This initial discussion by the Board revealed uncertainty in how best to address hospitals that are particular outliers in terms of costs.

74. The OHCA Office initially identified hospitals as high-cost if, in the last three out of five years among all hospitals for which comparable and complete data is available, they were above the 85th percentile in (1) commercial inpatient payments (that is, payments from nongovernmental payers such as private insurance companies and health plans), and (2) the commercial-to-Medicare payment-to-cost ratios. Initially, 11 hospitals met these criteria.

75. The Board continued to discuss the high-cost hospital criteria at the March 2025 Board meeting. Throughout these discussions, Board members expressed the need for additional information. For instance, one Board member asked to understand how sector targets would

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and non-governmental payer revenue, although OHCA has not been entirely clear on this point. In the event that OHCA applies the cost targets to governmental payers (such as Medicare or Medi-Cal) or includes revenue received by governmental payers in its measurements of compliance with the cost targets, the cost targets would be incompatible with federal law, and thus would be preempted to that extent and invalid under the Supremacy Clause of the United State Constitution. Similarly, CHA's best understanding is that OHCA intends not to apply cost targets to commercial plans governed by the federal Employee Retirement Income Security Act ("ERISA") but does intend to apply cost targets with respect to hospitals by including revenue received from ERISA plans in its measurements of compliance with cost targets. To the extent CHA's understanding is correct regarding the latter action, OHCA's actions here may also be preempted and invalid as incompatible with federal law.

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interact with proposed cuts to federal health care funding. However, other Board members opined that, rather than shifting unreimbursed costs of treating Medicare and Medi-Cal patients due to federal funding cuts, hospitals should look to cost containment strategies.[9] OHCA Office staff acknowledged that surveyed hospitals stated that if federal funding cuts were enacted (as they now have been), "they would have no choice but to increase their commercial reimbursements to make up for the losses." OHCA Office staff stated that they were "hoping there are other choices because that doesn't really achieve the goal of affordability," but provided no concrete solutions. (March 25, 2025 Board Meeting Video, 35:50–37:02.)

76. Again here, the Board appears to have had an incomplete understanding of the feedback provided, including that provided by its Advisory Committee. In the March 2025 Board Meeting, the OHCA staff's presentation of the Advisory Committee's comments on the high-cost hospital sector methodology took less than four minutes. (*March 2025 OHCA Board Meeting Recording* at 1:12:07–1:15:34.)

77. During OHCA's April 2025 Board Meeting, the Board unanimously voted to pass a motion to define a subset of hospitals "as high-cost hospitals" if they:

- Have comparable financial data in Annual Disclosure Reports which hospitals are required to submit to HCAI,
- Have a payer mix threshold of 5% (meaning that the hospital has at least 5% gross patient revenue from both Medicare and Commercial),
- Are in the top 15% in three out of five years from 2018-2022 on two financial measures: (1) Commercial Inpatient net patient revenue (NPR) per case mix adjusted discharge (CMAD) (reflecting commercial inpatient reimbursement, with risk adjustments) and Commercial to Medicare payment-to-cost ratio (PTCR) (reflecting the relative cost coverage between hospitals' commercial and Medicare payers);
- Are above the 30th percentile in annual discharges, and
- Do not have decreasing values on the two financial measures for two consecutive years that result in the hospital falling below the top 15% in 2022.

/ / /

[9] As discussed in paragraph 68, *supra*, OHCA Board Members continued to state the same after OBBBA's Medicaid cuts were passed into law.

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78. Following an original proposal that included the first three criteria above, OHCA altered its methodology to include consideration of both annual discharges and changes over time in the values on the financial measures. In particular, hospitals were to be excluded from this list if they had decreasing values for two consecutive years on the two financial measures, which resulted in the hospital falling below the 85th percentile in 2022. Similarly, hospitals were to be excluded from the list if they were below the 30th percentile in annual discharges. Notably, OHCA Office staff and Board members previously discussed that improving trends for one high-cost hospital may reflect issues with the hospitals' data, rather than their improved performance. (*March 2025 OHCA Board Meeting Recording* at 49:06–56:49.) The Board had similarly been made aware through public comment that one of the hospitals below the subsequently introduced discharge threshold had anomalous data. (Kelly Neiger, Barton Health, public comment to OHCA Board, Apr. 10, 2025.) A Board member also expressed concern regarding testimony from CHA that they had been unable to replicate OHCA's results and analyses. (See also paragraph 289, *infra*.)

79. The Board moved to apply this definition to any future hospitals meeting these criteria as identified in yearly assessments, without committing to modify the list of high-cost hospitals in accordance with the annual assessments.

G. <u>OHCA's Establishment of a High-Cost Hospital Cost Target</u>

80. In the February 2025 Board meeting, the OHCA staff recommended reduced cost targets for the 11 hospitals that initially met its high-cost hospital criteria. Specifically, for all hospitals to which this OHCA Board-created definition applied, the Board announced it would adjust the spending target value such that the cost target for high-cost hospitals fall from the 3.5% target applied to all other hospitals in the state to just 1.8%.

81. In the April 2025 meeting, the OHCA Board voted 6-0 to approve a modified version of this recommendation, applying only to seven of the originally identified 11 hospitals after applying the exclusions discussed in paragraph 78—excluding two hospitals that had decreasing values on the revenue and payment to cost ratio data for two consecutive years, and excluding another two hospitals for being below the 30% percentile in annual discharges. These

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further reduced cost targets are as follows:

Performance Year	Per Capita Spending Target
2026	1.8%
2027	1.7%
2028	1.7%
2029	1.6%

H. OHCA's Enforcement of Cost Targets

82. During recent public meetings, the OHCA Board and Director has signaled an interest in strict enforcement with automatic sanctions and monetary penalties and narrow opportunities for providers to obtain waivers from the enforcement process—which are provided for under the OHCA statute—even if they have justifications for increased cost growth.

83. In July 2025, the OHCA Board began to discuss enforcement in earnest. The OHCA staff discussed the statutory provision requiring an opportunity for health care entities to provide justification for exceeding cost targets, including information in support of a waiver from enforcement due to factors outside of their control. Unfortunately, however, the OHCA Board focused on their flawed interpretation that the waiver process was merely optional. Several Board members opined against waivers, stating waivers would undermine enforcement and favoring only very narrow exceptions. (*July 2025 OHCA Board Meeting Recording* at 3:07:24–3:08:30, 3:10:07–3:12:04, 3:18:14–3:20:00.) And an OHCA Board member noted that only "acts of god" should be acceptable justifications for exceeding cost targets, since the entire point of the cost targets is affordability, and that even federal changes such as Medicaid cuts, should not "undermin[e] enforcement." (*Id.* at 3:07:37 ["The only one right now that I would support on this list is the acts of God or catastrophic events—because we don't know yet that there are going to be."].)

84. The enforcement period has already begun as of January 1, 2026. (§ 127502, subd. (l)(1) ["The targets established for the 2026 calendar year, and each calendar year thereafter, shall be enforced for compliance . . . ."]; § 127502.5, subd. (a) ["The director shall enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets . . . ."].) These statutes make it clear that OHCA's obligation to enforce the cost

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targets is mandatory. To the extent OHCA may have discretion, that discretion concerns the manner in which enforcement will occur not whether enforcement will occur. Further, OHCA has failed to adopt any rules, standards or guidelines addressing enforcement, leaving hospitals to guess how enforcement will take place. Thus hospitals are placed in the untenable position of having to conduct their affairs beginning January 1, 2026 without knowing what the applicable enforcement regimen will look like. This is a formula for arbitrary agency decisions.

RELEVANT STATUTORY AND REGULATORY PROVISIONS

A. Health Care Affordability Statute

85. OHCA's enabling statute, Health Care Affordability, Health & Safety Code section 127500 *et seq.*, establishes OHCA, its Board, and its Advisory Committee, and sets out OHCA's responsibilities and authorities.

86. Multiple sections of the Act, including in the Legislature's Findings, Declarations, and Intent, section 127500.5, set out the following obligations for OHCA:

- OHCA must consider, maintain, and enhance health care quality, access, and equity when adopting cost targets. (See §§ 127500.5(c), (d), (o)(1); 127502(b)(3), (c)(5), (e)(2)(A)–(B); 127502.5(a).) These obligations apply throughout OHCA's process, including but not limited to the Board's establishment of all health care cost targets (§ 127502(c)), the Board's establishment of cost targets by health care sector (§ 127502(b)), the Board's methodology to set and adjust cost targets (§ 127502(d), (e)), and the Director's enforcement of cost targets (§ 127502.5(a).)

- OHCA must promote primary care and behavioral health care. (See §§ 127505(a), 127500.5(a)(7) –(8), (e).)

- OHCA must consider and promote workforce stability. (See §§ 127500.5(g), (h), (o)(1); 127502(b)(3), (c)(6)–(7), (e)(2)(C); 127502.5(a); 127506.) Again, these obligations apply throughout OHCA's process, including but not limited to the Board's establishment of health care cost targets, including health sector cost targets (see, e.g., § 127502(b), (c)), the Board's methodology to set and adjust cost targets (§ 127502(d), (e)), and the Director's enforcement of cost targets (§ 127502.5(a).)

- OHCA must make decisions informed by data, in particular, data regarding relevant health care economic factors. (See §§ 127500.5(b); 127501.6(a); 127502(b)(3), (c)(2)(A)–(B), (d)(2)–(7).)

- Similarly, when defining health care sectors, the Board must consider "factors such as delivery system characteristics." (§ 127502(l)(2)(A).)

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- OHCA must consider input from Advisory Committee and Public Comments. (See §§ 127501.11(a); 127501.12(d).)

- OHCA must provide an opportunity for health care entities to provide additional information to justify exceeding a cost target, including to support waivers from enforcement. (See §§ 127502.5(b)(2), (i).)

87. The statute also sets out the following timeline:

- "The board shall establish a statewide health care cost target for the 2025 calendar year and for each calendar year thereafter. The 2025 baseline target shall be a reporting year only and shall not be subject to enforcement pursuant to Section 127502.5." (§ 127502(*l*)(1).)

- "The targets established for the 2026 calendar year, and each calendar year thereafter, shall be enforced for compliance pursuant to Section 127502.5." (§ 127502(*l*)(1).)

- "[T]he office shall prepare a report on baseline health care spending . . . on or before June 1, 2025." (§ 127501.6(a).)

- "On or before October 1, 2027, the board shall define initial health care sectors. . . . Sectors may be further defined over time." (§ 127502(*l*)(2)(A).) OHCA's office "shall promulgate regulations accordingly." (§ 127502(b)(1).)

- "Not later than June 1, 2028, the board shall establish specific targets by health care sector . . . ." (§ 127502(*l*)(2)(B).)

B. Statewide Spending Target Regulation

88. Cal. Code Regs., tit. 22, § 97447 sets out the Statewide Per Capita Spending Target as follows:

(a) For performance years 2025 and 2026, the target is 3.5%.

(b) For performance years 2027 and 2028, the target is 3.2%.

(c) For performance year 2029, the target is 3.0%.

89. OHCA cites Health & Safety Code sections 127501 and 127502 as authority for this emergency regulation.

C. Health Care Sectors Regulation

90. Cal. Code Regs, tit. 22, § 97446 defines "Health care sectors," pursuant to Health & Safety Code § 127502(b)(1) and § 127502(*l*)(2)(A) to include the "Hospital Sector," which includes:

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(1) General acute care hospitals, as defined in Health and Safety Code section 1250, subdivision (a),

(2) Acute psychiatric hospitals, as defined in Health and Safety Code section 1250, subdivision (b),

(3) Special hospitals, as defined in Health and Safety Code section 1250, subdivision (f),

(4) Chemical dependency recovery hospitals, as defined in Health and Safety Code section 1250.3, subdivision (a)(1), and

(5) Psychiatric health facilities, as defined in Health and Safety Code section 1250.2, subdivision (a)(1).

91. OHCA cites Health & Safety Code sections 127501, 127501.2, 127501.11 and 127502 as authority for this emergency regulation.

D. Legal Obligations for Hospitals

92. Federal and state laws also impose on California hospitals numerous unavoidable legal obligations that impose substantial and often unavoidable financial burdens, regardless of a facility's size, location, or patient demographics.

93. As an example at the federal level, under the Emergency Medical Treatment and Labor Act (EMTALA), hospitals must provide emergency care to all patients regardless of ability to pay or insurance status. EMTALA does not provide any separate funding stream, however.

94. The Medicare and Medicaid Acts also dictate hospital reimbursement, and in particular circumstances, require hospitals to take on additional financial burdens. For instance, given particularities of Medicare's reimbursement of graduate medical education, hospitals that wish to train additional resident providers above a Congressionally-set number of reimbursable slots may not receive additional compensation for the training of those residents. As discussed in paragraph 8, changes to federal law pursuant to the OBBBA are also expected to reduce California hospitals' Medicare and Medi-Cal payments and significantly increase uncompensated care costs.

95. At the state level, seismic safety standards require hospitals to remain fully operational after major earthquakes by 2030, a costly mandate that can threaten facility closures without additional support, particularly for small hospitals in rural or suburban areas. According to a 2019 study by the RAND Corporation, the seismic upgrades needed to bring all hospitals in

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compliance with the 2030 requirements may cost as much as $143 billion. (RAND, *Updating the Costs of Compliance for California's Hospital Seismic Safety Standards* (March 28, 2019) <https://www.rand.org/pubs/research_reports/RR3059.html> [as of Oct. 3, 2025].)

96. Meanwhile, new state laws (Lab. Code §§1182.14–1182.16) are phasing in substantial minimum wage increases for health care workers, adding further financial pressure.

LEGAL BACKGROUND

A. Arbitrary and Capricious Agency Action

97. "A court must ensure that an agency has adequately considered all relevant factors, and has demonstrated a rational connection between those factors, the choice made, and the purposes of the enabling statute." (*California Hotel & Motel Assn. v. Indus. Welfare Com.* (1979) 25 Cal.3d 200, 212.) An agency's failure to do so renders an agency's action unlawfully arbitrary and capricious.

98. To determine whether a regulation is arbitrary, capricious, or lacking in evidentiary support, courts must determine whether "an agency has adequately considered all relevant factors, and has demonstrated a rational connection between those factors, the choice made, and the purposes of the enabling statute." (*W. States Petroleum Assn. v. California Air Res. Bd.* (2025) 108 Cal.App.5th 938, 957–58 [internal quotations omitted].)

B. Takings Clause

99. The Takings Clauses of the California and United States Constitutions guarantee property owners "just compensation" when their property is "taken for public use." (Cal. Const., art. I, § 19; U.S. Const., 5th Amend.)

100. Even if property remains in its owner's hands, the United States Supreme Court has established that a regulation of property that "goes too far" may effect a taking of that property (i.e., a "regulatory taking"). (See *Pennsylvania Coal Co. v. Mahon* (1922) 260 U.S. 393, 415–16 ["The general rule at least is that while property may be regulated to a certain extent, if regulation goes too far it will be recognized as a taking."]; see also *Penn Central Transp. Co. v. City of New York* (1978) 438 U.S. 104.)

101. Price and rate regulations can constitute a regulatory taking where the rate-setting

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sets an unjust or unreasonable rate. "A rate is too low if it is so unjust as to destroy the value of the property for all the purposes for which it was acquired, and in so doing practically deprives the owner of property without due process of law." (*20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216, 295 [quotation modified].) A court may invalidate an ordinance on its face if its terms "preclude avoidance of confiscatory results." (*Fisher v. City of Berkeley* (1984) 37 Cal.3d 644, 683; see also *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805, 816–21 [holding that an insurance rate regulation provision was invalid where it limited rate adjustments to insurers substantially threatened with insolvency]; *Birkenfeld v. City of Berkeley* (1976) 17 Cal.3d 129, 169–71 [holding that a rent control measure was invalid where the Board had no power to adjust rent ceilings until it received a separate petition for that unit and considered the petition at an individualized adjustment hearing].)

C. Due Process Clause

102. The Due Process Clauses of the California and United States Constitutions guarantee property owners "due process of law" when the government "deprive[s] [them] of . . . property." (Cal. Const., art. I, §§ 7, 15; U.S. Const., 14th Amend., § 1.)

103. Procedural due process requires that punishments not be imposed without fair notice of what is prohibited or required. "[A] punishment violates 'due process if the statute or regulation under which it is imposed fails to provide a person of ordinary intelligence fair notice of what is prohibited . . ." or required. (*Kerman Telephone Co. v. Public Utilities Com* (2023) 94 Cal.App.5th 920, 931–32.) "In the administrative law context, the failure to give fair notice to a regulated entity of what is forbidden or required justifies vacating the imposed punishment resulting from the alleged violation of a regulation." (*Ibid.*) Once procedural due process protections are triggered, "to evaluate what procedural protections are due under the federal and state due process clauses, courts "consider the following factors: '(1) the private interest that will be affected by the official action, (2) the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards, (3) the dignitary interest in informing individuals of the nature, grounds and consequences of the action and in enabling them to present their side of the story before a

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responsible governmental official, and (4) the governmental interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.'" (*In re Bailey* (2022) 76 Cal.App.5th 837, 857.)

104. Derived from the concept of "fair notice," the void-for-vagueness doctrine similarly "bars the government from enforcing a provision that 'forbids or requires the doing of an act in terms so vague' that people of 'common intelligence must necessarily guess at its meaning and differ as to its application.' [Citations.]" (*Mae M. v. Komrosky* (2025) 111 Cal.App.5th 198, 214–15 [quoting *People v. Hall* (2017) 2 Cal.5th 494, 500].) "To survive a void-for-vagueness challenge, '(1) [t]he regulations must be sufficiently definite to provide fair notice of the conduct proscribed; and (2) the regulations must provide sufficiently definite standards of application to prevent arbitrary and discriminatory enforcement.'" (*Ibid.* [quoting *Snatchko v. Westfield LLC* (2010) 187 Cal.App.4th 469, 495].) A facial challenge requires showing that the regulation is invalid "in the generality or great majority of cases." (see *People v. Buenrostro* (2018) 6 Cal.5th 367, 388 [quoting *San Remo Hotel v. City and County of San Francisco* (2002) 27 Cal.4th 643, 673.].)

105. In addition, a price control provision violates due process (specifically, Substantive Due Process) if it "deprive[s] investors of a 'fair return' and thereby become[s] confiscatory." (*Galland v. City of Clovis* (2001) 24 Cal.4th 1003, 1021, as modified (Mar. 21, 2001); see also *Kavanau v. Santa Monica Rent Control Bd.* (1997) 16 Cal.4th 761, 771.) "[W]hen considering whether a price regulation violates due process, a 'court must determine whether the [regulation] may reasonably be expected to maintain financial integrity, attract necessary capital, and fairly compensate investors for the risks they have assumed, and yet provide appropriate protection for the relevant public interests, both existing and foreseeable.'" (*Kavanau, supra,* 16 Cal.4th at p. 772 [citing *Permian Basin Area Rate Cases* (1968) 390 U.S. 747, 792].**)**

106. California courts do not require the application of a specific formula for determining whether a regulation violates substantive due process requirements. (See *Kavanau, supra,* 16 Cal.4th at p.772 [citing *Fisher v. City of Berkeley* (1984) 37 Cal.3d 644, 681, *aff'd sub nom. Fisher v. City of Berkeley, Cal.* (1986) 475 U.S. 260.) Rather, "the essential inquiry in due

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process cases involving price controls is whether the regulatory scheme's *result* is just and reasonable." (*Kavanau, supra*, 16 Cal.4th at p. 778 [emphasis in original].) For example, in *Fisher v. City of Berkeley*, the court noted that while a rental ordinance may temporarily restrict landlords' profits, "it may not indefinitely *freeze* the dollar amount of those profits without eventually causing confiscatory results." (*Fisher, supra*, 37 Cal.3d at p. 683 [emphasis in original].)

D. Administrative Procedure Act

107. The California Administrative Procedure Act ("APA") requires that every regulation, as defined by the APA, be adopted according to specific procedures unless expressly exempted by statute.[10] (Gov't Code, § 11340.5, subds. (a), (b).) The APA defines "regulation" broadly to include "every rule, regulation, order, or standard of general application or the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure, except one that relates only to the internal management of the state agency." (Gov't. Code, § 11342.600.)

108. An "underground regulation" is one that has not been promulgated according to the APA and therefore, is invalid and cannot be enforced. (Gov't. Code, § 11340.5; Welf. & Inst. Code, § 14124.; *Naturist Action Com. v. Department of Parks & Recreation* (2009) 175 Cal.App.4th 1244, 1250 [holding that a regulation adopted without complying with requirements of the Administrative Procedure Act is an "underground regulation" and invalid].) Even if an agency interpretation is unwritten, if it applies generally and is an interpretation of the law, it is a "regulation" and is invalid if not adopted in compliance with the APA. (*Morning Star Co. v. State*

[10] These procedures include: public notice of the proposed regulatory action (Gov't Code, §§ 11346.4, 11346.5); issuing a complete text of the proposed regulation with a statement of the reasons for it (*id.*, § 11346.2, subds.(a), (b)); giving interested parties an opportunity to comment on the proposed regulation (*id.*, § 11346.8); responding in writing to public comments (*id.*, §§ 11346.8, subd. (a), 11346.9); and forwarding a file of all materials on which the agency relied in the regulatory process to the Office of Administrative Law (*id.*, § 11347.3, subd. (b)), which reviews the regulation for consistency with the law, clarity, and necessity (*id.*, §§ 11349.1, 11349.3).

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Bd. of Equalization (2006) 38 Cal.4th 324, 332-36.)

109. An agency policy is a regulation subject to the APA if it meets two conditions. "First, the agency must intend its rule to apply generally, rather than in a specific case. The rule need not, however, apply universally; a rule applies generally so long as it declares how a certain class of cases will be decided. [Citation.] Second, the rule must 'implement, interpret, or make specific the law enforced or administered by [the agency], or ... govern [the agency's] procedure.'" (*Tidewater Marine Western, Inc. v. Bradshaw* (1996) 14 Cal.4th 557, 571.)

STANDING

110. CHA has standing because it has a distinct interest, beyond that of the general public, in ensuring that OHCA complies with the Legislature's mandates to consider access, quality, and workforce stability when setting cost targets, developing the hospital sector, and designating high-cost hospitals. Further, as of January 1, 2026, CHA's member hospitals face concrete and imminent harm. Finally, CHA also has public-interest standing, as the implementation of the cost targets threatens the accessibility and quality of hospital care which are core concerns at the heart of the public interest.

111. This Court may apply essentially the same standing analysis to CHA's writ and declaratory relief causes of action. Although courts apply the beneficial interest test to writ claims (Code Civ. Proc., § 1086) and the interested person test to declaratory relief claims (*id.*, § 1060), courts have applied beneficial interest cases when analyzing standing to obtain a declaratory judgment. (See, e.g., *Monterey/Santa Cruz etc. Trades Council v. Cypress Marina Heights LP* (2011) 191 Cal.App.4th 1500, 1521.)

A. CHA Has Standing

1. CHA Is Beneficially Interested

112. In order to seek relief by way of a writ of mandate, a petitioner must establish a clear and present beneficial interest in the agency's performance of its mandatory or discretionary duty. (See *California Hospital Assn. v. Maxwell-Jolly* (2010) 188 Cal.App.4th 559, 568-569, as modified on denial of reh'g (Sept. 16, 2010); see also *Pich v. Lightbourne* (2013) 221 Cal.App.4th 480, 490-491.) CHA's mission is to represent and serve hospitals and health systems and maintain

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a financial and regulatory environment within which hospitals can continue to provide access to affordable, safe, high-quality patient care. There is therefore no question that CHA has a beneficial interest (both on its own behalf and in its representative capacity on behalf of its members), over and above the interest held in common with the public at large, in Respondents performing their functions in accordance with the law. (See *Maxwell-Jolly*, *supra*, 188 Cal.App.4th at p. 569 ["CHA is a beneficially interested party. It has an interest in challenging the amendments to the state plan and enforcing the Medicaid Act that is above the interest held by the public at large. CHA seeks the enforcement of public duties imposed on the Legislature and the Department by the Medicaid laws. Namely, CHA is interested in having its members compensated for the medical services they provide in accordance with the laws and rules established by Congress for the Medicaid program. These interests are sufficient to satisfy the beneficial interest prerequisite for obtaining writ relief."].) Here, CHA is interested in ensuring that the cost targets adopted by Respondents and the related actions of Respondents challenged in this petition and complaint are in accordance with State law and the United States and California Constitutions, that Respondents have adequately considered the relevant factors when taking the challenged actions, that the challenged actions are supported by the record before Respondents when they were taken, and that CHA's members are compensated for the services they provide in accordance with State law and the United States and California Constitutions.

2. CHA Is Suffering an Injury in Fact

113. Some courts have applied the federal injury in fact test when assessing whether a petitioner has a beneficial interest. This test "requires a party to prove by a preponderance of the evidence that it has suffered an invasion of a legally protected interest that is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical." (*Associated Builders and Contractors, Inc. v. San Francisco Airports Com.* (1999) 21 Cal.4th 352, 362 [quotation marks omitted].)

114. In addition to having an interest here that is over and above the interest of the public at large, CHA has suffered an injury in fact because it is "an organization that has expended staff time or other resources on responding to a new threat to its mission," thereby "diverting those

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resources from other projects." (*California Medical Assn. v. Aetna Health of California Inc.* (2023) 14 Cal.5th 1075, 1095; accord, *Animal Legal Defense Fund v. LT Napa Partners LLC* (2015) 234 Cal.App.4th 1270, 1280-1281 ["the plaintiff's claimed diversion of resources can constitute injury in fact"].) California courts have approved of a line of federal decisions across multiple circuits that applied the "diversion of resources" theory of organizational standing that was first articulated by the United States Supreme Court. (*Havens Realty Corp. v. Coleman* (1982) 455 U.S. 363, 379 ["there can be no question that the [petitioner] organization has suffered injury in fact" where the respondent's practices resulted in "concrete and demonstrable injury to the organization's activities—with the consequent drain on the organization's resources"]; *California Medical Assn. v. Aetna, supra,* 14 Cal.5th at pp. 1093–1095; 234 Cal.App.4th at p. 1281; see also e.g., *Fair Housing of Marin v. Combs* (9th Cir. 2002) 285 F.3d 899, 905; *Nnebe v. Daus* (2d Cir. 2011) 644 F.3d 147, 156–157.)

115. Since April 2024 when the statewide targets were adopted, CHA has had to devote significant resources to respond to Respondents' actions related to the establishment of cost targets, which threatened CHA's bona fide, preexisting mission. CHA has diverted substantial employee time and other resources to analyze cost target-related materials published by OHCA, submit detailed and voluminous public comments and participate in public hearings in an effort to persuade OHCA to adopt reasonable targets, engage with state legislators and the governor to reconsider OHCA's unlawful targets, and educate members on OHCA's establishment and enforcement of the cost targets. These efforts and expenditures were independent of the costs incurred in this instant litigation, which was filed in October of 2025, and include activities and related expenditures arising from the cost targets and other actions taken by Respondents that are challenged herein both before and after the cost targets and other actions were adopted by Respondents. The organization estimates that, since April 2024, CHA staff collectively devoted approximately 8,737 direct hours to OHCA-related work outside of litigation, with 6,603 of those hours dedicated to analysis and member education. The personnel expenditures (employee salaries and benefits) associated with these efforts represent a significant financial outlay, over a million dollars of personnel time, that would not have approached these magnitudes absent

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OHCA's contested actions.

116. CHA has also engaged outside consultants to assist on issues related to OHCA's challenged actions. In particular, in February 2025, CHA engaged Toyon Associates to perform quantitative analysis related to OHCA's methodology for identifying high-cost hospitals. CHA paid Toyon $8,990 for their services.

117. Following April 2025, when the OHCA Board adopted the last of the five challenged actions, CHA's activities and resource allocation intensified in response to the finalization of these measures. CHA continued to invest considerable time and money in activities such as further analysis of the finalized rules and ongoing member education. CHA has determined that the total compensation it incurred relating to these activities, exclusive of activities in connection with this litigation, totals $953,098, of which $375,279 pertain to analyzing the impact of the OHCA cost targets and $103,617 pertains to member education concerning the cost targets. These post-April 2025 efforts required the engagement of senior leadership, including the CEO, senior vice presidents, legal counsel, and other key personnel, who worked collaboratively to address the implications of OHCA's actions for CHA's members. All told, seventeen different CHA employees spent time in non-litigation activities related to the cost targets. By way of example, between April 22, 2025 and February 28, 2026, Ben Johnson (Group Vice President, Financial Policy) spent 693 hours in non-litigation activities pertaining to the OHCA cost targets, Victoria Valencia (Vice President, Data Analytics) spent 912 hours in non-litigation activities pertaining to the OHCA cost targets, and Jenny Nguyen (Vice President, Financial Policy) spent 863 hours in non-litigation activities pertaining to the cost targets. These activities and the associated costs represent resources that CHA was compelled to divert solely because of the actions of Respondents that are challenged by CHA in this Petition and Complaint as being unlawful; absent these actions, CHA would not have needed to incur these expenses or dedicate such substantial staff time to addressing the resulting challenges.

B. <u>CHA's Members Also Have Standing</u>

118. CHA's members have standing to sue in their own right as demonstrated by the harms articulated in this Petition, which confers associational standing on CHA. (See *California*

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Community Choice Assn. v. Public Utilities Com. (2024) 103 Cal.App.5th 845, 853 [the associational standing doctrine "requires that (a) the association's members would otherwise have standing to sue in their own right; (b) the interests the association seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." (internal quotation marks and brackets omitted)].)

1. CHA's Members Have a Beneficial Interest

119. In order to seek relief by way of a writ of mandate, a petitioner must establish a clear and present beneficial interest in the agency's performance of its mandatory or discretionary duty. (See *Maxwell-Jolly*, *supra*, 188 Cal.App.4th at 569 ["CHA is interested in having its members compensated for the medical services they provide in accordance with the laws and rules established by Congress for the Medicaid program"]; see also *Pich,* supra, 221 Cal.App.4th at p. 484 [Petitioners were recipients of public benefits that were incorrectly calculated or untimely paid as a result of a new computer system].) As objects of agency action, CHA's members have a beneficial interest because they are deprived of a legal interest and required to take actions they otherwise would not take. (Cal. Practice Guide: Administrative Law (The Rutter Group 2025) ch. 14-B, ¶ 14:30.)

120. Additionally, "[a] beneficial interest generally means plaintiffs have some special interest to be served or some particular right to be preserved or protected over and above the interest held in common with the public at large." (*Pich, supra*, 221 Cal.App.4th at pp. 490–91.) There can be no dispute that California hospitals have an "over and above" interest in OHCA establishing cost targets, a hospital sector, hospital cost targets, high-cost hospital designations, and high-cost hospital targets in a manner that complies with law, is not arbitrary and capricious, promotes the Legislature's goals of access, quality care, equity and workforce stability, is based on reliable data, and does not limit payments in a manner that is confiscatory in violation of the California and United States Constitutions. CHA's members—California's hospitals—are subject to OHCA's cost targets and will face enforcement actions for noncompliance, which will considerably impact (and in some cases could entirely eliminate) hospitals' abilities to carry out

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their missions of providing accessible, equitable, and high quality health care to their communities. The flawed cost targets and related OHCA actions challenged herein that OHCA promulgated threaten hospitals' abilities to deliver high quality care to all patients by forcing hospitals to forego revenue that will result in service, workforce, and access cutbacks.

2. CHA Member Hospitals Are Suffering an Injury in Fact

121. As noted above, the federal injury in fact test "requires a party to prove by a preponderance of the evidence that it has suffered an invasion of a legally protected interest that is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical." (*Associated Builders and Contractors, Inc*, *supra*, 21 Cal.4th at p. 362 [quotation marks omitted].)

122. The injury in fact test is met where "[g]overnment regulations [] require or forbid some action by the plaintiff." (*Food and Drug Administration v. Alliance for Hippocratic Medicine* (2024) 602 U.S. 367, 382.) That is exactly the case here. Hospitals are required to comply with the cost targets or face mandatory enforcement if they do not comply. (Health and Safety Code §§ 127502, subds. (c)(4), (l)(1), 127502.5.)

123. Additionally, compliance with the cost targets is causing CHA's members to suffer concrete, particularized, and imminent harms. Indeed, the cost targets are "directed at [CHA's members] in particular," and they "require[] them to make significant changes in their everyday practices." (*Abbott Laboratories v. Gardner* (1967) 387 U.S. 136, 154.)

3. Standing Is Available for Pre-Enforcement Challenges

124. Furthermore, if CHA's members "fail to observe the [agency's] rule, they are quite clearly exposed to the imposition of strong sanctions." (*Ibid*.)

125. The substantial risk of mandatory compliance with performance improvement plans, monetary penalties, reputational harm, and disruptions to patient care to CHA members that do not comply with the cost targets constitutes an injury in fact sufficient to confer standing. (*America's Health Ins. Plans v. Hudgens* (11th Cir. 2014) 742 F.3d 1319, 1327-28; *Coral Construction, Inc. v. City and County of San Francisco* (2004) 116 Cal.App.4th 6, 25 ["a realistic danger of sustaining a direct injury as a result of the statute's operation or enforcement" is sufficient to confer standing].)

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126. To emphasize, the risk of sanctions for noncompliance is concrete. OHCA is required to enforce the cost targets so that hospitals deemed noncompliant at the director's discretion will be forced to conform to a performance improvement plan and face the prospect of monetary penalties. This is true even though enforcement actions have not yet begun (though the enforcement period has begun). OHCA is statutorily required to take enforcement actions against noncompliant hospitals: the agency may force a hospital to comply with a performance improvement plan, "[a]ssess administrative penalties," "[r]equire or compel public testimony" by the hospital, or "call a public meeting to notify the public about the health care entity's violation." (Health & Saf. Code, § 127502.5, subds. (a), (h).) OHCA is also required to "make public the extent to which the health care entity exceeded the target." (*Id.*, § 127502.5, subd. (c)(1).)

4. CHA Member Hospital Impacts

127. Compliance with the cost targets is causing, and will continue to cause, CHA's members to suffer concrete, particularized, and imminent harms. Hospitals are experiencing these harms now. For example, some commercial payers are already limiting payment rates for California hospitals, citing the cost targets. Hospitals have also incorporated the anticipated effects of the cost targets into their budgeting processes and operational decisions, leading them to reevaluate investments in community projects. Waiting for a later enforcement process does not avert these harms. Enforcement will be based on actions hospitals are taking *today* in response to the cost targets, and those actions cannot be unwound or retroactively corrected once compliance is assessed.

[redacted]

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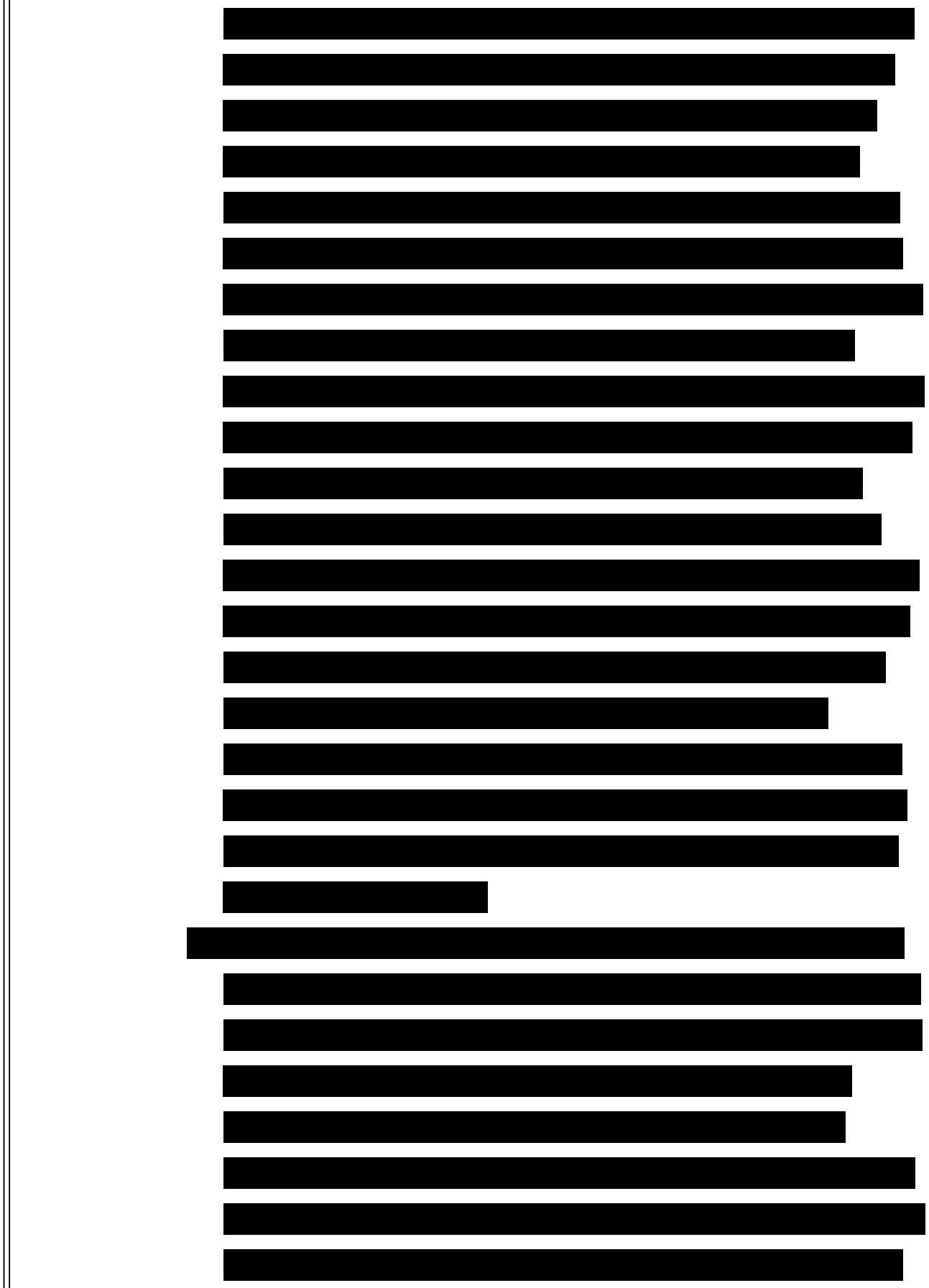

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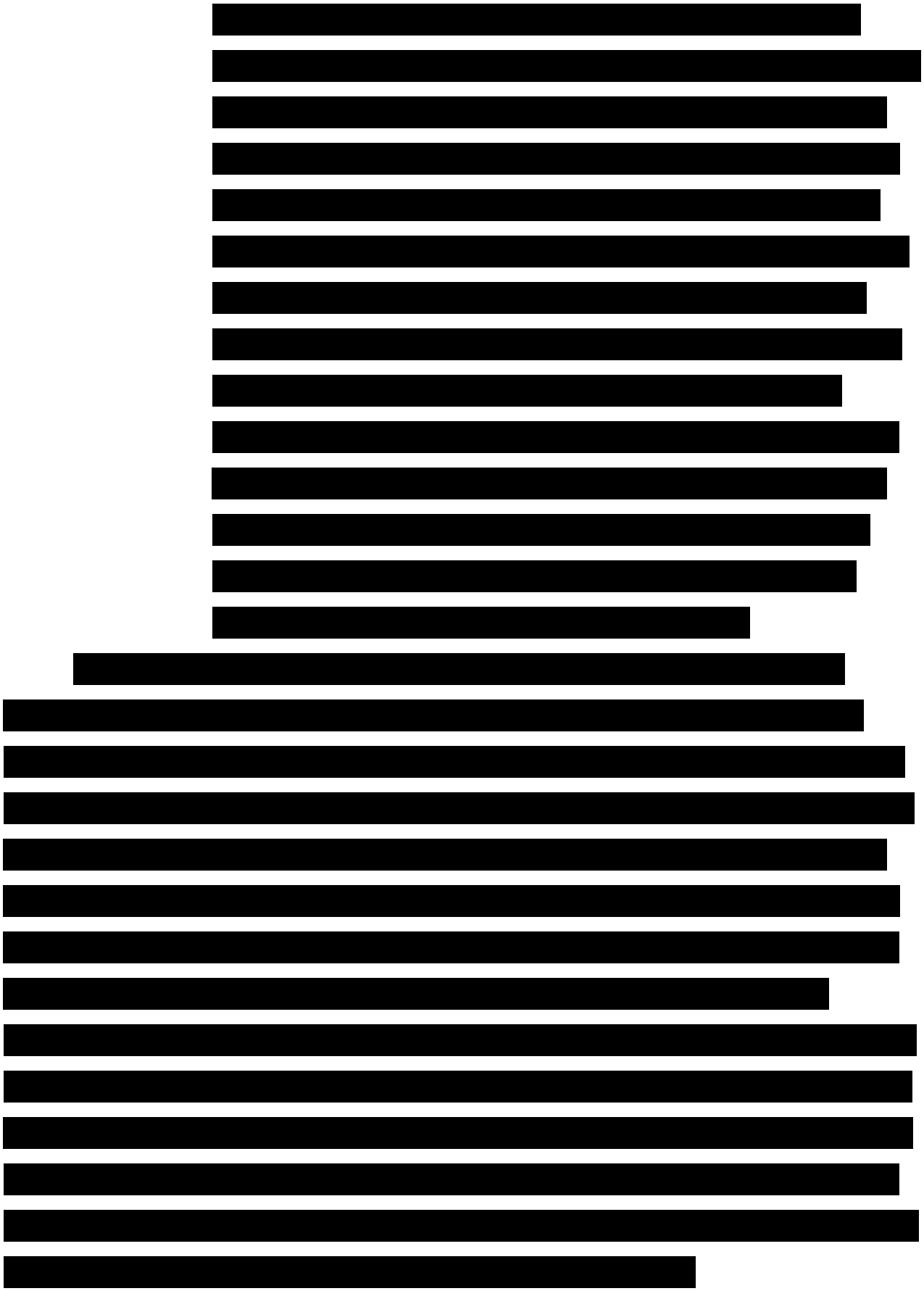

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136. This paragraph is intentionally omitted.

B. Public Interest Standing

137. Associations like CHA may assert public interest standing. (See *Rialto Citizens for Responsible Growth v. City of Rialto* (2012) 208 Cal.App.4th 899, 912–16.)

138. Public interest standing is an exception to the beneficial interest requirement that "has often been invoked by California courts" in cases "where the question is one of public right and the object of the mandamus is to procure the enforcement of a public duty." (*Green v. Obledo* (1981) 29 Cal.3d 126, 144.) In such cases, it is "sufficient" that the Petitioner "is interested as a citizen in having the laws executed and the duty in question enforced." (*Ibid*.) Public interest standing "promotes the policy of guaranteeing citizens the opportunity to ensure that no governmental body impairs or defeats the purpose of legislation establishing a public right." (*Ibid*.) Such is the case here where CHA seeks to compel OHCA's performance of its statutory duties to promote affordability while maintaining access, quality, equity, and workforce stability. (See *Diaz v. Quitoriano* (1969) 268 Cal.App.2d 807, 811 [department's performance of their "legislatively declared purpose" and "duty" was "a matter of public right"].)

139. Moreover, public interest standing applies, like here, when the agency's duties are "sharp" (i.e., clear and well-defined) and the public need for enforcement is "weighty." (*Citizens for Amending Proposition L v. City of Pomona* (2018) 28 Cal.App.5th 1159, 1174.)

a. The sharpness prong is met here. The enabling statute clearly defines OHCA's duties to promote health care affordability "while maintaining quality, access, and equity of care, as well as promoting workforce stability," "maintaining high-quality health care jobs," "recognizing the need to maintain and increase the supply of trained, culturally and linguistically competent health care workers," and ensuring that "cost containment does not constrain the health care workforce that California needs, including the competitive wages and benefits of frontline health care workers." (§ 127500.5, subds. (g), (o)(1); see also § 127506, subds. (b), (c).) Additionally, with respect to the establishment and enforcement of cost targets, OHCA must:

- "develop a methodology . . . to set health care cost targets" that is "available and transparent to the public" (§ 127502, subd. (d)(1)), and includes a review of

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"historical trends and projections for economic indicators and population-based measures" (§ 127502, subd. (d)(2)), "historical trends in costs for Medi-Cal, Medicare, and commercial health care coverage" (§ 127502, subd. (d)(3)), and "potential factors to adjust future cost targets," including labor costs, trends in the price of health care technologies, provider payer mix, and state or local mandates such as required capital improvement projects (§ 127502, subd. (d)(4));

- set targets that "maintain[] quality and equitable care" and "[p]romote the stability of the health care workforce, including the development of the future workforce" (§ 127502, subd. (c)(6));
- set sector cost targets that are "informed by historical cost data and other relevant supplemental data" and by "consideration of access, quality, equity, and health care workforce stability and quality jobs" (§ 127502, subd. (b)(3)); and
- adjust cost targets "as appropriate upon a showing that nonsupervisory employee organized labor costs are projected to grow faster than the rate of any applicable cost targets" (§ 127502, subd. (c)(7)).

b. The public need for enforcement of OHCA's statutory duties is also weighty. The cost targets, which OHCA enacted without adherence to its statutory mandate, threaten access to quality health care.

140. "[T]his mandate proceeding seeks relief that is unavailable on the administrative appeal," no matter what that process ultimately looks like. (See *Diaz, supra*, 268 Cal.App.2d at p. 812.) Rather, Respondents have not adopted an administrative appeal process regarding the challenged decisions, the enabling legislation does not provide for one, and Respondents have not indicated that an administrative appeal process will be adopted.

RIPENESS

141. A controversy is "ripe" for judicial resolution "when it has reached the point that the facts have sufficiently congealed to permit an intelligent and useful decision to be made." (*Vandermost v. Bowen* (2012) 53 Cal.4th 421, 452.) The ripeness requirement "should not prevent courts from resolving concrete disputes if the consequence of a deferred decision will be lingering

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uncertainty in the law, especially when there is widespread public interest in the answer to a particular legal question." (*Ibid*.)

142. A ripeness analysis evaluates "both the fitness of the issues for judicial decision and the hardship to the parties of withholding court consideration." (*Abbott, supra*, 387 U.S. at p. 149.)

143. The controversy in this case is undoubtedly ripe for judicial review. CHA challenges specific actions already taken by OHCA that have created a concrete dispute. The challenged agency actions are all final agency actions. The evidence on which these actions are to be adjudicated is set forth in a developed administrative record, and not some new *post-hoc* record to be established in this court, so the facts in this case have "sufficiently congealed" to permit judicial resolution. Indeed, agency actions "have the force of law before their sanctions are invoked as well as after." (*Id*. at p. 150.) Such actions "are appropriately the subject of attack" where, as here "expected conformity to them causes injury cognizable by a court." (*Ibid*.)

144. Judicial review at this juncture is not only appropriate but also necessary. The issue is fit for judicial decision since CHA and its members are already implementing comprehensive changes to their operations to comply with the cost targets for 2026, which OHCA is required to enforce long after irreversible decisions are made by hospitals. (See § 127502, subds. (c)(4), (l)(1); § 127502.5, subd. (a).) Forcing hospitals to sit with uncertainty for years, uncertainty that has and will continue to impact hospitals' revenue and in turn access and health care quality, before allowing this challenge to be heard will result in significant hardship to CHA members and CHA will face significant hardship without relief from this Court. Reversing those systemic changes, such as rehiring workers who were let go and have moved on to other positions or re-opening shuttered service lines, will be costly and arduous, if not impossible. And contractual concessions made to payers will be unable to be retroactively corrected. Moreover, there will be sufficient hardship to CHA members and CHA will face significant hardship without relief from this Court.

THE DISPUTE

145. In establishing OHCA, the California Legislature set out to address the significant

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challenge of health care affordability. And, in so doing, the Legislature was clear that OHCA's work to improve health care affordability must promote, rather than come at the expense of, health care access, equity, and quality, and the stability of the health care workforce.

146. OHCA has not struck this balance. OHCA has repeatedly acted—in its establishment of the statewide cost target, premature establishment of a hospital cost sector to particularly apply a 3.5% and decreasing cost target to hospitals, and application of an even stricter cost target for those hospitals deemed (by an arbitrary, OHCA-created methodology) to be high-cost—in ways that fail to protect, promote, or sufficiently consider health care access, equity, and quality, and workforce stability. Instead, OHCA has relied on incomplete and at times faulty data and designed narrow, improperly-focused, and unattainable cost targets, which neither consider the actual factors that impact hospital costs nor are constructed to actually ensure consumer affordability.

147. As myriad public commenters have told OHCA repeatedly, trying to comply with these improper cost targets would significantly harm hospitals and threaten the crucial (and statutorily-mandated) factors of access, equity, quality, and workforce stability.[12] Not only do OHCA's actions not demonstrate a sufficient consideration of these factors, the public record also reveals Respondents' disregard for maintaining access, equity, and quality.

148. Accordingly, Respondents have repeatedly acted in violation of OHCA's own enabling statute and the federal and California constitution, as well as arbitrary and capriciously.

A. <u>In Setting the 3.5% and Decreasing Cost Targets, Both Statewide and as Applied to Hospitals, OHCA Has Not Promoted, and Has Repeatedly Disregarded Concerns About, Health Care Access, Equity, and Quality and Workforce Stability.</u>

149. First and foremost, multiple of OHCA's actions—both setting a statewide target at 3.5% and decreasing that would apply to all health care entities including hospitals and payers, and specifically focusing on and applying targets to the hospital sector—are contrary to OHCA's

[12] The public comments cited in this Verified Petition and Complaint are those available through public webpages. Petitioner does not currently have access to the relevant Administrative Records here; Petitioner's counsel originally submitted a Public Records Act request for the relevant records on June 4, 2025, and to date has only received documents related to OHCA's rulemaking record for Cal. Code Regs., tit. 22, §§ 97447 and 97446.

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enabling statute and are arbitrary and capricious, as OHCA entirely failed to promote and repeatedly disregarded concerns about the statutorily mandated goals of health care access, equity, and quality and workforce stability.

150. The Act requires that OHCA's process for setting cost targets be informed by considerations of access, quality, and equity, (§ 127502(b)(3)), and the cost targets must maintain quality and equitable care (§ 127502(c)(5)). In general, as well, the OHCA statute requires that OHCA's actions promote and maintain affordability, quality, equity, efficiency, access, and value of health care services (see, e.g., §§ 127500.5(b), (c), (o)(1), 127502(c)(5), (6)), with a particular focus on promoting primary care and behavioral health care (§§ 127500.5(a)(7)–(8), (e)).

151. Nonetheless, the record of publicly available information regarding OHCA's actions is replete with evidence that both the statewide cost targets and the cost targets specifically applied to the hospital sector and payers will severely threaten the very factors that the Legislature obligated OHCA to protect. This includes concerns from some individual Board members themselves (as discussed in paragraphs 49–50 and 52, *supra*), as well as a significant quantity of public comments and comments from the Advisory Committee. As discussed in paragraphs 54–55, 67–69, *supra*, the extent to which the OHCA Board engaged with this feedback was insufficient, and fundamentally, their cost targets do not integrate it. Accordingly, even if OHCA considered these factors, which the public record does not attest to, OHCA's actions to adopt the statewide cost target as applied to hospitals and the hospital cost target are without support in the record before OHCA at the time these actions were taken.

152. The Act also requires that OHCA's process for setting cost targets be informed by considerations regarding health care workforce stability (§ 127502(b)(3)). Similarly, the cost targets must promote the stability of the health care workforce (§ 127502(c)(6)), and be adjusted for a provider as appropriate upon a showing that nonsupervisory employee organized labor costs are projected to grow faster than the rate of cost targets (§ 127502(c)(7)). In general, as well, the statute requires that OHCA's cost targets not hinder workforce compensation or stability (§§ 127500.5(g), (h), (o)(1)). The record before OHCA, however, demonstrates that the cost targets will compromise workforce stability and result in workforce reduction, and contains no

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support for the proposition that the cost targets would promote or be consistent with workforce stability. OHCA received significant comments that applying a 3.5% and decreasing cost target to hospitals would significantly destabilize the health care workforce to the tune of thousands of lost jobs statewide. Further, OHCA has not adopted a mechanism to adjust the cost target to reflect increases in nonsupervisory organized labor costs, despite the fact that the statute explicitly authorizes this adjustment to be prospective based on projected costs, rather than only a retroactive adjustment or a factor considered within the enforcement process. OHCA's cost target decisions are therefore completely without support from the record that was before it when it adopted the cost targets.

1. The Statewide Target Threatens Access, Equity, Quality, and Workforce Stability.

153. As the OHCA Board considered the statewide cost targets, health care providers and other entities and individuals submitted extensive public comments, both in writing and during public meetings.

154. These comments highlighted numerous problems that a 3.5% and decreasing cost target would pose for hospitals, payers, and other health care providers, in particular, that these targets were not consistent with the statute's requirement that the targets be designed to maintain accessible, equitable, and quality health care and promote the stability of the health care workforce. (§§ 127502(c)(5), (6) [the health care cost targets shall "[p]romote the goal of improved affordability for consumers and purchasers of health care, while maintaining quality and equitable care" and "promote the stability of the health care workforce".)

155. For instance, comments submitted during OHCA's process of setting the statewide target noted that the issues presented by the OHCA Office to the Board narrowly focused on affordability alone, while "neglecting to consider whether spending targets at the levels being contemplated would properly promote quality and equity, including for vulnerable populations." (See, e.g., CHA, public comment to OHCA Board, Dec. 13, 2023, pp. 4–5.)

156. In a public comment made in the February 2024 Board meeting, the California Children's Hospital Association noted that "without an upfront adjustment to the target to accommodate these new treatments, our members will have no guidance about how accelerated

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spending growth due to these drugs—and future ones—will be handled by OHCA staff." (Comments by Mira Morton, California Children's Hospital Association, *February 2024 OHCA Board Meeting Recording* at 2:01:22–2:03:40.) The Association further commented that the target would create uncertainty about "whether future investments in [hospitals'] residency programs will be approved by OHCA staff." (*Ibid.)* In summary, the Association commented: "OHCA staff's recommendation is to set an extremely low target—lower than the majority of hospitals, and especially children's hospitals, are likely to meet—and also to make no upfront adjustments to give providers a sense of the board's priorities and values about what care and other hospital services should be funded, even if doing so requires growth that exceeds 3%. Instead, it would have our children's hospital members ask for forgiveness two years after spending on life-saving care, pediatric residencies, and other critical services has already occurred—and hope that OHCA affirms their decisions about their necessity, rather than taking corrective action and instituting fines. Our children's hospitals are very mindful of the impact that rapid growth in health care spending has on families and payers, both public and private. They take their responsibility to constrain costs seriously and will continue to do their part to ensure California's sickest children receive the best care as efficiently as possible. But we would urge you to make adjustments to this proposal to make the target more realistic and provide clear guidance to providers about what spending you value and do not want to see cut. These changes will not eliminate the incentives you hope to create with the target, but they will ensure that the target does not inadvertently discourage or penalize critical health activities and services." (*Ibid.)*

157. In another public comment made in the February 28, 2024 Board Meeting, a representative from Scripps Health explained that "we cannot keep pace with the escalating costs and lack of reimbursement. Government reimbursement has not kept pace with the rising cost of labor, supplies, and drugs that we face today. Scripps Health, like many other providers in California, operated at a loss in 2023, and this year we are targeting a one-half of one percent operating margin. We work hard to control costs, but we incur many costs that simply cannot be contained to a 3% target—like, as you've heard already, pharmaceutical costs, rising labor costs, cybersecurity costs, increasing supply chain expenses, and state-initiated legislative mandates

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including health care minimum wage and seismic compliance. Yet we must have that margin to invest in the services that our community deserves. We need to have the ability to invest in programs that promote an equitable future—one that invests in partnerships and innovations, like you've heard already today, that will ultimately reduce these costs in the long run to ensure that we can continue to provide excellent care for the communities we serve for the next 100 years." (Comments by Amber Ter-Vrugt, *February 2024 OHCA Board Meeting Recording* at 2:03:52–2:05:56.)

158. Certain public comments to the OHCA Board particularly highlighted that the harms of cost targets will have a disparate impact on already vulnerable groups (despite statutory protections, including in § 127500.5(d)). In their March 2024 public comment, the California Association of Public Hospitals and Health Systems stated "DHCS [California Department of Health Care Services] has reported that many [Medi-Cal] members are lacking basic preventive and wellness services, which often results in more severe diseases when diagnosed, such as advanced cancers and uncontrollable diabetes. Medi-Cal members also experience higher rates of unnecessary emergency department visits and hospital readmissions. These outcomes could be exacerbated under the current proposal as providers may increasingly seek to care for a healthier patient population or reduce preventive services to try to quickly cut back on costs, and it may undermine efforts like CalAIM." (California Association of Public Hospitals and Health Systems, public comment to OHCA Board, Mar. 11, 2024.) In the April meeting, a representative for the same Association reiterated that "should an unattainable target be adopted, we anticipate there could be reductions in preventative and outpatient care and staffing in ambulatory care settings, overburdened emergency departments and inpatient settings from a lack of access in more appropriate care settings, increased wait times and acuity of patients, and an inability to make needed infrastructure investments to create a safe space for patients and workers." (Comments by Kelly Brooks, California Association of Public Hospitals and Health Systems, *April 2024 OHCA Board Meeting Recording* at 3:34:06–3:35:58.) (See also District Hospital Leadership, public comment to OHCA Board, Mar. 11, 2024 ["If the OHCA Board were to adopt the proposed staff recommendation of a 3% annual target over 2025–2029, underserved communities would

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experience reductions of essential health care services, potentially exacerbating health disparities and perpetuating inequality for low-income Californians."].)

159. Similarly, University of California Health's March 2024 comment stated: "While we support OHCA's goal of increasing investments in primary care, we must emphasize that Californians, particularly seniors, persons living with disabilities, and patients with complex health conditions will always require specialized care and a spending target must support quality and equitable access to that specialty care as well, particularly for those who are disproportionately impacted by health disparities." (University of California Health, public comment to OHCA Board, Mar. 11, 2024.) In their March 2024 public comment, Henry Mayo Newhall Hospital also noted that "a comprehensive focus on health equity has the potential to lead to long-term cost savings but requires significant up-front investments and reorganization of delivery models." (Henry Mayo Newhall Hospital, public comment to OHCA Board, Mar. 15, 2024.)

2. The Hospital Sector Target Threatens Access, Equity, and Quality of Care.

160. Public commenters continued to reinforce these concerns during OHCA's consideration of the cost targets to be applied specifically to the hospital sector.

161. Meaningfully, members of the California Legislature submitted comments expressing concern that OHCA is not adequately acknowledging and protecting providers who care for underserved Californians, specifically those who treat high volumes of uninsured, Medi-Cal, and Medicare patients. (Assemblyman Heath Flora, Assemblyman Juan Alanis, Assemblywoman Rhodesia Ransom, and Senator Maria Alvarado-Gill, public comment to OHCA Board, Apr. 10, 2025.)[13]

162. Hospitals that the OHCA Office surveyed stated that aggressive pricing caps would

[13] See also Statements of Sen. Shannon Grove, Hearing of the California Senate Budget Subcommittee 3 on Health and Human Services (May 1, 2025), 01:02:27–01:08:57 ("Medi-Cal reimbursement rates are the hugest issue we face. Anybody who serves Medi-Cal patients—and I have a lot of them in my district, I have one hospital that is a 90/10 ratio (90% Medi-Cal, 10% plan oriented/commercial pay)—I guess I should say that's a pathway to bankruptcy. . . . When you treat somebody it costs $200 and you get 0.50/0.60 on the dollar, it's a pathway to bankruptcy.")

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have unintended consequences affecting access to care (OHCA, *February 2025 Board Meeting Presentation*, slide 21 (Feb. 25, 2025).), explained that hospitals have negative operating margins and the cost targets could cause hospitals to close service lines (OHCA, *March 2025 Board Meeting Presentation*, slides 20–22 (Mar. 25, 2025).), stated OHCA needed to consider the costs of clinical innovation and the expansion of services (*id.*), and repeatedly explained that hospitals need to cover the costs from uninsured and charity care and that OHCA should consider the ways in which hospitals invest in expanding community care, access, and value beyond just evaluating their costs (*ibid.*; OHCA, *April 2025 Board Meeting Presentation*, slide 43 (Apr. 22, 2025).). Other hospitals also told OHCA that the proposed spending targets would threaten critical service lines (including L&D, oncology, and orthopedics), reduce access and clinical capacity, and could jeopardize medical equipment upgrades and technological advancements. (See, e.g., Sutter Health, public comment to OHCA Board, Mar. 11, 2025; Children's Hospital Los Angeles, public comment to OHCA Board, Jan. 23, 2024.)

163. Further, public comments on the hospital sector cost target repeatedly urged that OHCA needs more time to analyze the potential consequences on the hospital sector on access, quality, equity, or workforce stability, cautioned that singling out the hospital sector will destabilize equitable access to high-quality hospital care, and warned that hospitals will have to cut back on specialty services and cut or cap service lines (including L&D). (See, e.g., OHCA, *March 2025 Board Meeting Presentation*, slide 95; OHCA, *April 2025 Board Meeting Presentation*, slides 45–62; Antelope Valley Medical Center, public comment to OHCA Board, Apr. 3, 2025.)

164. Much like comments submitted during OHCA's consideration of the statewide target, certain public comments highlighted that the cost targets will have a harmful and disparate impact on already vulnerable groups. In a March 2025 public comment to the OHCA Board, a community member who serves as Executive Director of a local non-profit entity focused on the needs of low income individuals asked "when critical service lines are reduced or eliminated due to funding constraints imposed by OHCA's cap, what is the state's plan to ensure continuity of care for elderly patients—including transportation, capacity, and funding—for those forced to seek

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care elsewhere?" (Kari Rader, public comment to OHCA Board, Apr. 16, 2025.) Celina Perez, a community member who serves as Executive Director of the non-profit First Chance Vallejo, Juvenile Justice Commissioner for Solano County, and Chaplin for VFW Post 1123, presented similar comments with regards to care for Solano County veterans. (Celina Perez, public comment to OHCA Board, Apr. 17, 2025 ["If OHCA moves forward with limiting these critical resources for California residents, how will the Office address lack of accessible, high-quality care for Solano County veterans that may result[] from service line closures, especially at a time when the federal government is considering making significant cuts to such services?"]; see also Celina Perez, public comment to OHCA Board, Apr. 11, 2025 [noting NorthBay Health delivers high-quality care to veterans and families from Travis Air Force Base].) In an April 2025 Comment, Adventist Health noted that an aggressive cost growth target cap would disallow opportunities to increase services in underserved areas. (Adventist Health, public comment to OHCA Board, Apr. 11, 2025.)

165. In another April 2025 public comment, the Private Essential Access Community Hospital (PEACH) Association commented that "[t]he OHCA-proposed spending target would further reduce health care spending in the Medi-Cal program resulting in a disproportionate blow to the most vulnerable communities that already only receive a third of health care investments compared to those that are not financially challenged or economically depressed." (PEACH Association, public comment to OHCA Board, Apr. 11, 2025.)

166. Other comments provided empirical research demonstrating how cost targets will lead to low quality care. An April 2025 Public Comment from USC Schaeffer Center for Health Policy & Economics stated "Our research—and basic economic principles—demonstrate that when you cap revenues and impose price supports on labor costs, then net revenues fall. Ultimately, quality can suffer, access is likely to be harmed and, often, higher cost suppliers exit the market. This risks leaving consumers with low-cost but low-quality care as their only option. When facing these policy induced constraints, hospitals may also decrease the provision of certain services (such as emergency room care) that truly have value and benefit the public. Ultimately, we encourage the pursuit of high-value health care, rather than the current approach of dampening

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high spending without considering health benefits and value of care." (USC Schaeffer Center for Health Policy & Economics, public comment to OHCA Board, Apr. 2025.)

167. Relatedly, other comments critique the research on which OHCA relied in making its decision. CHA's June 2025 letter critiques OHCA's reliance on studies that claim no meaningful relationship between hospital prices and quality, highlighting that broader academic literature shows hospitals with stronger financial positions are more likely to deliver higher-quality care. The letter references a 2022 scoping review and a National Bureau of Economic Research working paper that found positive associations between financial performance and quality. It also criticizes OHCA's selective citations to research on this issue which OHCA used to refute the relationship between hospital prices and quality, while ignoring the broader research and literature that demonstrates a positive correlation between hospital revenue and quality. And, the letter argues that financial resources play an essential role in supporting quality care. (CHA, public comment to OHCA Board, June 4, 2025, pp. 3-4).

168. Also importantly, CHA specifically commented that OHCA was not appropriately addressing these themes. "While OHCA staff has prepared and presented analyses of the potential impacts of a 3% spending target on health care spending growth, it has avoided any fair discussion and analysis of the impacts of its proposal on access, quality, or equity." (CHA, public comment to OHCA Board, Mar. 8, 2024, p. 13.) "It is incumbent upon OHCA to do more to analyze where cost growth can be reduced to meet the spending target without harming patients. However, no such analysis has been done." (*Ibid.*) "OHCA has not presented an analysis of the potential impacts of its proposed target on health care quality." (*Id.* at 14.)

169. Specifically regarding primary care, in a March 2025 Public Comment to the OHCA Board, Edwin Okamura asked on behalf of NorthBay Health: "given that NorthBay Health has committed $250 million to close the primary care gap in our region over the next six years and plans to bring the first health care clinic to Rio Vista in more than a decade, how does OHCA plan to fill that investment void if hospital spending is artificially capped and this critical expansion plan is halted?" (NorthBay Health, public comment to OHCA Board, Apr. 16, 2025.)

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3. The Hospital Sector Target Threatens Workforce Stability.

170. Public comments regarding the hospital sector cost target also illustrated its negative impact on the current and future health care workforce.

171. The California Legislature understands that the state's health care workforce is both crucial and precarious. As an April 2025 Public Comment from USC Schaeffer Center for Health Policy & Economics stated: "Labor costs comprise a substantial portion (at least 46% according to KFF) of hospital operating costs, and hospitals are leading employers in many communities across the state. Legislators recognized the tension between efforts to curb rising hospital spending and labor market stability, including instruction in OHCA's enabling statute that spending target development should incorporate consideration of healthcare workforce stability and quality of jobs (§ 127506) and consider organized labor agreements (§ 127502(d)(7)). Additionally, recent statutes phase in increasing minimum wages for many employees of healthcare facilities (Sections 1182.14, 1182.15, and 1182.16 of the Labor Code), which counters the spending reduction objectives of OHCA." (USC Schaeffer Center for Health Policy & Economics, public comment to OHCA Board, Apr. 2025.)

172. Public commenters told OHCA the same. Hospitals that the OHCA Board surveyed cautioned that OHCA should consider that the health care workforce already has significant shortages, and that hospitals (especially those in high cost of living areas) need to be able to attract and retain clinicians to be able to provide specialty care, especially in geographically isolated areas. (OHCA, *March 2025 Board Meeting Presentation*, slides 20–22.) CHA notified OHCA that hospitals are already financially vulnerable, with "more than half operat[ing] in the red," and that OHCA's proposal could exacerbate this vulnerability. (CHA, public comment to OHCA Board, Mar. 20, 2025, p. 2.) CHA specifically explained that OHCA was not appropriately addressing workforce stability themes. "OHCA has not performed sufficient analysis of the trends in health care labor costs, the potential impacts of a 40% drop in health care spending growth on workforce stability, or the effects of negative real spending growth on access and quality." (CHA, public comment to OHCA Board, Mar. 8, 2024, p. 13.)

173. Further, hospitals specifically evidenced how cost targets would impact their

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workforces. In March 2025 public comments to the OHCA Board, Sutter Health stated that the proposed spending targets would stall their essential workforce development efforts. (Sutter Health, public comment to OHCA Board, Apr. 18, 2025.) In an April 2025 written public comment to the Board, Stanford Health Care (SHC) Tri-Valley stated that "[w]ith nearly half of our operating costs tied to labor, the mandated 3.5% spending growth rate annually would also mean forcing us to choose between cutting our lifesaving patient care and providing security and stability for our workforce and their families." (SHC Tri-Valley, public comment to OHCA Board, Apr. 18, 2025.) Adventist Health noted that labor costs have increased by 9.7% annually since 2021, alongside other escalating costs such as minimum wage increases, which are projected to cost an additional $73 million. (Adventist Health, public comment to OHCA Board, Apr. 11, 2025.) Surveyed hospitals further stated that the potential end result of the sector target is "nearly $5 billion diverted from patient care by 2029, more than 10,000 lost jobs, and 83% of hospitals operating in the red." (OHCA, *April 2025 Board Meeting Presentation*, slides 45–62.)

174. In its April 2025 comment, CHA further analyzed what impact the cost targets would have had if in place over the prior five years, explaining: "To balance their expenses with their lower revenues, by 2022, hospitals would have had to reduce their total expenses by 14%. Achieving this proportionate cut to their labor expenses would have required California's hospitals to reduce their full-time equivalent worker count by 58,000—14% of their workforce. Alternatively, hospitals would have had to suppress wages by an equivalent percentage amount, or rely on a combination of wage and force reductions." (CHA, public comment to OHCA Board, Apr. 11, 2025.)

175. Hospitals also told OHCA how its cost targets do not address issues with the future workforce, namely workforce training or graduate medical education, and would reduce funding for these critical programs. (OHCA, *April 2025 Board Meeting Presentation*, slides 45–62.) Hospitals explained that teaching hospitals have higher operating costs and could have to shrink training programs to meet the cost targets, negatively impacting workforce development. (*Id.*). In their April 2025 public comment, the PEACH Association commented that "[e]vidence indicates that physicians typically practice within 100 miles of their residency program. Most physicians

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serving low-income communities are affiliated with hospitals or teaching programs that bear the financial losses required to ensure doctors are available to provide necessary care to the residents. If hospitals are forced to cut costs to adhere to arbitrary and unstudied targets, they will face the possibility of saving money by reducing resident positions." (PEACH Association, public comment to OHCA Board, Apr. 11, 2025.)

176. Cuts to graduate medical education are particularly problematic because, as commenters shared, the state is facing a severe shortage of physicians. (See, e.g., Comments by Mira Morton, California Children's Hospital Association, *February 2024 OHCA Board Meeting Recording*, 2:01:22–2:03:40 [explaining California is facing "a severe shortage of pediatric specialists, and we cannot afford to leave children's hospitals wondering whether future investments in their residency programs will be approved by OHCA staff."].)

177. In part, these issues may be a result of the OHCA Board receiving incomplete information on this topic. As CHA described: "Since proposing the 3% target, OHCA staff received two requests from OHCA Board members to analyze the impacts of the target on the labor market. One request was to look at the effect of health care affordability challenges on general employment outcomes, while the other focused on the implications of the proposed 3% spending target for employment within the health care sector. OHCA staff promptly fulfilled the former request at the February board meeting, showing higher premiums are associated with lower wages and lower labor force participation. Meanwhile, OHCA declined to fulfill the latter request, ***betraying a consistent and troubling lack of balance in what information and questions receive analysis and presentation***.[18[sic]] The staff's rationale for answering one question but not the other was a lack of academic research specifically on the effect of spending targets on health care employment outcomes, a constraint that did not prevent them from relying on literature unrelated to spending target programs to discuss general employment impacts in response to the other question from the Board. Moreover, despite no published research to rely upon, OHCA has presented projections of the impacts of the spending target on total and per capita health care spending, with the purpose of showing affordability improvements they anticipate, again revealing a worrisome double standard." (CHA, public comment to OHCA Board, March 8, 2024

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[emphasis added].)

178. For all of these reasons, all of the cost targets applied to hospitals fall woefully short of their statutory obligations to maintain access, equity, quality, and workforce stability and do not demonstrate a sufficient consideration of these factors. For that reason, the cost targets are contrary to the intent and text of OHCA's enabling statute and are arbitrary and capricious.

B. OHCA's 1.8% and Decreasing High-Cost Hospital Cost Target Is Even More Antithetical to These Statutorily Mandated Considerations.

179. The more stringent cost targets OHCA applied to high-cost hospitals pose every concern discussed above to an even more problematic degree. The high-cost hospital targets are therefore also contrary to OHCA's enabling statute and arbitrary and capricious in that OHCA failed to adequately consider the factors it was required to consider under the Act or to demonstrate a reasonable connection between its decision concerning the high-cost hospital cost targets and these factors, and adopted high-cost hospital cost targets that are not supported by the record before OHCA.

180. Just as with the other cost targets, the Board received significant public comments and Advisory Committee feedback that the high-cost hospital cost targets would be detrimental to access, health care equity, quality of care, and workforce stability. But, while individual Board members were concerned about these issues, particularly as federal funding cuts came to fruition (see paragraphs 8, 94, *supra*), the OHCA staff and Board at large did not meaningfully engage with these comments and opted to exclusively focus on cost containment at the detriment of the statutorily mandated considerations of access, equity, quality, and workforce stability. Indeed, as discussed in paragraph 68 and footnote 9, *supra*, OHCA Board members stunningly suggested that OBBBA's cuts to insurance coverage would reduce health care access, and thus, reduce health care spending. One Board member reasoned: "the main thing about having more people uninsured is overall health spending goes down. I mean, the point of insurance is it improves access to care and it increases the use of health care services. . . . So, I mean, this is an abomination – but not, I think, a rationale for exceeding the 3.5% target." (Comment by Board Member Kronick, *July 2025 OHCA Board Meeting Recording* at 2:09:13–2:11:13.)

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181. As CHA has commented, the high-cost hospital cost target values are sub-inflationary and would "decimate hospitals' abilities to sustain services and their workforces." As CHA explained in its February 2025 public comment, as labor costs are growing at 6% for hospitals in the western United States, a 1.7% target is 70% to 80% lower than the recent cost growth for labor and other essential hospital costs. (CHA, public comment to OHCA Board, Feb. 21, 2025, p. 9.) Such a target would "pose[] deeply alarming consequences for patient care." (CHA, public comment to OHCA Board, April 11, 2025, p. 1.)

182. CHA specifically commented that the proposed high-cost hospital sector targets would necessitate "draconian cuts to the affected hospitals' workforces and service lines." (CHA, public comment to OHCA Board, Mar. 20, 2025, p. 4.) The March 2025 Comment also highlights that compounding federal funding threats with low sector targets would lead to hospital service cuts, worker layoffs, and curtailed access to care for millions of Californians. (*Id.* at 5; see also CHA, public comment to OHCA Board, June 4, 2025, pp. 1–5.)

183. Providers have commented similarly. Salinas Valley Health, a public district hospital designated as a high-cost hospital, told the OHCA Board in a March 19, 2025 letter that "[i]f implemented, the designation of SVH as a high-cost hospital—along with the associated limitations—will jeopardize our legacy and future as a safety-net healthcare system providing essential services to the vulnerable populations we serve." (Salinas Valley Health, public comment to OHCA Board, Mar. 19, 2025.) Salinas Valley explained that it had actively expanded low-cost access to care through an extensive clinic system and significant investments in non-hospital services, including non-hospital outpatient ambulatory surgery, endoscopy, radiation oncology, and imaging. As Salinas Valley commented, "[i]ronically, by intentionally shifting these services from outside our hospital license to lower-cost centers, our healthcare system—when viewed solely as a licensed hospital—has been mischaracterized as a high-cost outlier." (*Ibid.*) Salinas Valley noted that proposed federal cuts to Medicaid, ACA premium assistance, and key health programs were estimated to strip coverage from over 163,000 people in the hospital's district, including 50,000 children and 26,000 seniors, and "ignoring and exacerbating these impending changes will destabilize care delivery and restrict access to essential services,"

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especially for safety-net providers like SVH. (*Ibid.*) The hospital made clear that, even if data are later reassessed and SVH is no longer deemed a high-cost hospital, "imposing spending targets below the rate of inflation will immediately force difficult decisions regarding patient services and workforce reductions." (*Ibid.*) "Budget restrictions will force reductions in specialty services and safety-net programs, including oncology, cardiology, and mammography. It will also severely impact our ability to recruit much-needed primary care providers. Once lost, these services will be extremely difficult to restore." (*Ibid.*)

184. Washington Health, another public district hospital on the "high-cost" list, noted that it "shares the goals of OHCA to improve the affordability of the health care system and maintain access to high quality health care." (Washington Health, public comment to OHCA Board, June 4, 2025.) However, the hospital commented that it "do[es] not believe that subjecting [Washington Hospital] to the 1.8% growth target rate will achieve those goals, but instead will actually lead to higher health care costs as a result." (*Id.*) Fundamentally, the hospital commented "[w]e are gravely concerned that in order to meet this lower target rate, Washington Health will have no choice but to reduce or eliminate critical health services at a time when southern Alameda County residents are already facing serious health-care access challenges. We fear that the impact will be a reduction in timely access to non-emergent hospital services, forcing constituents to travel out of South County." (*Ibid.*)

185. Stanford Health Care, which "primarily serve[s] as tertiary and quaternary sites of care," described in its April 2025 public comment letter how the proposed high-cost targets are incompatible with the level of complex care it frequently provides, as well as the unique challenges posed by the high cost of living and employment in Silicon Valley. "The proposed sector rate would effectively hinder our ability to deliver essential specialized services—including but not limited to complex oncology care, critical organ transplantation procedures, highly advanced cardiothoracic surgeries, and level one trauma adult and pediatric services. . . . With nearly half of our operating costs tied to labor, a mandated 1.6% and 1.8% spending growth rate annually would also mean forcing us to choose between cutting our lifesaving patient care and providing security and stability for our workforce and their families." (Stanford Health Care,

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public comment to OHCA Board, Apr. 11, 2025.) Stanford also noted anticipated federal cuts to Medicaid and Medicare and foreseen reductions in federal biomedical research funding that will pose threats to health care and training of physician researchers. (*Ibid.*)

186. Dominican Hospital, another hospital on the "high-cost" list, told OHCA about its significant investments into expanding behavioral health services, developing permanent and transitional housing projects, and supporting safety-net clinics, all to respond to community health and access to care challenges. (Dignity Health Dominican Hospital, public comment to OHCA Board, Apr. 11, 2025.) As Dominican wrote "[a] reduction in Dominican Hospital's revenue growth to between 1.6 and 1.8 percent annually would have serious consequences for both the hospital and the broader community, including scaling back or eliminating community outreach programs . . . reducing on-call physician coverage, resulting in delays in patient care, increased transfers of patients outside the community, and greater strain on emergency services . . . staff reductions associated with the closure of community program . . . [and] an inability to introduce new services that benefit the community." (*Ibid.*)

187. PIH Health, which does not have a hospital designated as high-cost, commented regarding both the statewide target and OHCA's "consideration of an **even lower** target for arbitrarily defined 'high-cost' hospitals." (PIH Health, public comment to OHCA Board, Apr. 17, 2025 [emphasis in original].) As PIH wrote, "[t]hese targets do not even cover inflationary increases for critical supplies and pharmaceuticals—and our ability to continue our mission of providing high-quality patient care is in jeopardy." (*Ibid.*)

188. Sharp Healthcare, which also does not have a hospital designated as high-cost, commented that OHCA's proposal regarding high-cost hospitals "will undermine that success and inhibit the effective implementation of alternative payment models that OHCA was created to promote." (Sharp Healthcare, public comment to OHCA Board, Apr. 17, 2025 [citing Section 127504].)

189. These comments did not just come from hospitals themselves. The Health Plan of San Joaquin, a local Medi-Cal managed care plan, submitted a public letter to the OHCA Board requesting that OHCA "reevaluate the impact of its classification of Doctors Medical Center

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(DMC), Modesto as a "high-cost" hospital." (Health Plan of San Joaquin-Mountain Valley Health Plan, public comment to OHCA Board, Apr. 17, 2025.) "This designation would impose stringent spending reduction targets on DMC and could lead to service reductions that place significant strain on our region's Medi-Cal delivery system." (*Ibid.*) As the Health Plan stated, "[w]hile Health Plan supports the goal of advancing healthcare affordability, we strongly encourage OHCA to implement its statewide targets in close partnership with safety net hospitals and their community stakeholders, including Medi-Cal managed care plans. Doing so will help ensure that affordability efforts do not come at the expense of healthcare access, quality, or equity, particularly for Medi-Cal members." (*Ibid.*)

190. Sue Zwahlen, the Mayor of the City of Modesto and former nurse, similarly submitted a public comment urging the OHCA Board "to consider community impact resulting from lower annual hospital spending targets for [Doctors Hospital –Modesto ("DMC")] or any other safety net hospital." (Sue Zwahlen, Mayor of City of Modesto, public comment to OHCA Board, Apr. 17, 2025.) Mayor Zwahlen commented "I was informed by DMC that lowering the spending targets to less than 2% a year will result in diminished access to services, reduced staffing, and hinder their ability to invest in vital services that our residents depend on to survive." (*Ibid.*) As discussed in paragraph 281, *infra*, OHCA's methodology for determining high-cost hospitals does not account for payer mix. This is particularly harmful to providers like DMC, who receive the vast majority of reimbursement, at lower rates, from Medicare or Medi-Cal. (See also footnote 13 [California Senator discussing financial challenges of hospitals that receive a majority of their reimbursement from Medi-Cal and critiquing OHCA's cost targets accordingly].)

191. Some community health care entities further commented to note how the high-cost targets could hinder hospitals' ongoing support of population health and charity care programs. Santa Barbara Neighborhood Clinics (SBNC) submitted a comment concerning the high-cost target, including as it would be applied to Santa Barbara Cottage Hospital (which has been deemed high-cost) and Goleta Valley Cottage Hospital, which was included on the proposed list of 11 high-cost hospitals but ultimately not deemed to be high-cost. (SBNC, public comment to OHCA Board, Apr. 9, 2025.) The comment provides: "For many years, Santa Barbara Cottage Hospital

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(SBCH) has been an amazing partner to SBNC, providing $1.7 million in annual support to SBNC as part of its Population Health Program. SBCH and [Goleta Valley Cottage Hospital (GVCH)] provide charity care/free care to patients at or below 500% of the federal poverty limit and discounted care for patients at or up to 700% of FPL. This significant charity care program provides profound support to our community. OHCA's initiatives could lead to changes in the types of services offered at SBCH and GVCH, potentially impacting access to specialized care or certain treatments our patients rely on. We are deeply concerned about the unintended consequences on patient access to care as a result of the overall spending target that went into effect this year and will drop down to 3% by 2027. The even more restrictive cap being proposed for certain hospitals that have been deemed 'high cost,' including SBCH and GVCH, will have downstream effects on their ability to provide essential services to the families we serve in the county of Santa Barbara. We respectfully request that OHCA devote additional time for analysis and discussion before finalizing sectors or corresponding targets. We remain committed to achieving our shared goals of affordable, high-quality care, and we ask that you proceed with a keen eye toward ensuring care is not diminished in the pursuit of lower costs." (*Ibid.*)

192. Commenters also noted particular challenges for pediatric care. California Children's Hospital Association in an April 2025 noted for OHCA the unique challenges faced by children's hospitals, and the Children's Specialty Care Coalition noted that "a 1.8% cost target would make it extremely challenging, if not impossible" to sustain pediatric residency training programs (in contrast with the statutory requirement for OHCA to promote graduate medical education, § 127502(c)(6).) (Children's Specialty Care Coalition, public comment to OHCA Board, Apr. 9, 2025.)

193. As such, the high-cost hospital cost targets are antithetical to OHCA's statutory obligations to maintain access, equity, quality, and workforce stability and do not demonstrate sufficient consideration of these factors. For that reason, the high-cost hospital cost targets are contrary to OHCA's enabling statute and arbitrary and capricious.

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C. The Cost Targets Applied to Hospitals Are Improperly Narrow, Do Not Ensure Consumer Affordability, and Are Unattainable.

194. In addition to these significant concerns regarding health care access, equity, and quality and workforce stability, both sets of cost targets applied to hospitals (the 3.5% and decreasing target for most hospitals and the 1.8% and decreasing target for high-cost hospitals) are both insufficiently reasoned and methodologically flawed. This is an additional reason why the targets are contrary to statute and arbitrary and capricious.

195. OHCA's enabling statute requires that health care sector targets be informed by historical cost data (§ 127502(b)(3)), and all cost targets must include consideration of economic indicators or population-based measures (which may include established measures reflecting the broader economic, labor markets, and consumer cost trends and changes in the state's demographic factors that may influence demand for health care) (§ 127502(c)(2)). Moreover, the OHCA Office must develop a methodology (to be approved by the Board) that is used to set cost targets and that is transparent to the public (§ 127502(d)(1)). That methodology must include a consideration of historical trends in costs for Medi-Cal, Medicare, and commercial health care coverage, providing differential treatment of 2020 and 2021 due to the impacts of COVID-19 on health care spending and health care entities (§ 127502(d)(3)). The spending methodology must also review potential relevant factors to adjust future cost targets, including labor costs, trends in the price of health care technologies, provider payer mix, and state or local mandates such as required capital improvement projects (§ 127502(d)(4)).

196. As discussed below and the record demonstrates, OHCA's cost targets fall woefully short of these requirements. OHCA designed the cost targets to be too narrowly focused on historical growth in household income. The cost targets thus do not reasonably adjust for critical health economic considerations, like COVID-19, inflation, cost trends in labor, technology, and required capital investments (including seismic safety requirements), changes in federal funding (including the significant Medicaid changes passed by Congress in the OBBBA), state mandates (including minimum wage changes), and other factors outside hospitals' control. As a result, the cost targets do not meet any goal: they neither ensure consumer affordability nor

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are they attainable for hospitals when considering the multitude of factors contributing to hospital spending.

1. The Cost Targets Are Too Narrowly and Improperly Focused on Historical Median Income Growth, Ignoring Inflation and Other Key Factors for Hospital Costs and Spending.

197. OHCA received significant input that its cost targets are too narrowly focused on median household income growth and fail to account for multiple factors that impact health care spending. Specifically, commenters instructed that the target should consider and reflect inflation, demographic factors (such as aging), trends in labor and tech costs, impacts of COVID-19, costs of new pharmaceuticals, federal changes to Medicaid, state mandates such as minimum wage, seismic safety investments, and investments in Medi-Cal, and other upfront investments. (OHCA, *April 2025 Board Meeting Presentation*, slides 45–62.)[14]

198. As a result of these failings, the cost targets fail to consider economic indicators or population based measures, including "measures reflecting the broader economy, the labor markets, and consumer cost trends." (§ 127502(c)(2).) As Advisory Committee Member David Joyner stated, "setting a target that has nothing to do with medical cost inflation" is as though "we're going to set a target for how much gas should cost in this state and we're going to ignore refining capacity and production and supply and demand, we're just going to say household income and it can't go up by more than that. And yet the economic forces underneath the production of that product are nothing to do with that." (*March 2024 OHCA Advisory Committee Meeting* (Mar. 19, 2024), 2:56:36–2:57:00.) Mr. Joyner continued: "I worry that we haven't really thought through the unintended consequences, what happens when for example, Medi-Cal and

[14] See also Statements of Sen. Akilah Weber Pierson, Hearing of the California Senate Budget Subcommittee 3 on Health and Human Services (May 1, 2025), 1:12:30–1:13:26 ("It's interesting because if the goal is slow the rate of healthcare spending but there was no implementation about taking in the costs of SB 525 [minimum wage requirements], seismic [safety investments], inflation—like none of that was taken into consideration with these targets—whether it's for the high cost hospital or for every other hospital, then, I don't know, I think we're living in a fantasy world. If they've got this spending limit but they have to put this money out for these things that have been mandated, then at the end of the day, something has to give. So either they won't make it and will be penalized, or they have to cut services. And either way, the people who will pay are the patients.").

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Medicare don't keep up with the cost inflation and the providers have to somehow make the revenue add up to cover their costs. And you're seeing this with rural hospitals, I think is the canary in the coal mine for this situation. And we're meanwhile going to say 'well the commercial insurance can't go up by more than 3% because we've set this goal.' And I don't think we've thought through the implications of that completely." (*Id.* at 2:57:45–2:58:16)

199. A host of public commenters similarly noted the issues with cost targets that ignore measures reflecting the broader health care economy, including but not limited to inflation. CHA's October 2023 public comment noted that targets based solely on economic indicators such as growth in average income are "not reflective of the underlying drivers of health care cost growth" and "would result in severe underinvestment in California's health care system and seriously undermine access to quality care." (CHA, public comment to OHCA Board, Oct. 18, 2023, p. 1–2.) "It may not be possible to realize a high-performing health-care system under the constraints of a spending target equal to the economic indicators considered during the September discussions." (*Id.* at 4, see also *id.* at 5; CHA, public comment to OHCA Board, Dec. 13, 2023, p. 5 [describing that a target exclusively based on median family income would be unsustainably low.].)

200. Keck Medicine of USC in March 2024 similarly flagged factors outside of hospitals' control that the cost targets do not consider, including "escalation in costs imposed by pharmaceutical and biomedical companies, which derive substantial margins from the healthcare industry." (Keck Medicine of USC, public comment to OHCA Board, Mar. 8, 2024.)

201. In March 2024, Children's Specialty Care Coalition commented "[t]he OHCA recommendation does not take into consideration the inadequacy of Medi-Cal rates and the need to infuse more dollars into stabilizing this fragile network that has been underfunded for the last two decades." (Children's Specialty Care Coalition, public comment to OHCA Board, Mar. 11, 2024.) "While we applaud OCHA [sic] for focusing on making health care more affordable, we urge the Board to reject the 3% target, and for OHCA to reconsider its approach in terms of this ambitious target and carefully consider the needs of children with rare diseases and their families in the target-setting process." (*Ibid.*)

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202. CHA's October 9, 2024 public comment stated that the OHCA Board in its August 2024 Board meeting focused exclusively on market concentrations as driving variation in health care spending, while there are many drivers of hospital spending—regional differences in cost of living and labor costs, differences in population health needs and utilization levels, differing levels of investment in clinical training, and more. (CHA, public comment to OHCA Board, Oct. 9, 2024.)

203. In an April 2025 public comment, Adventist Health stated that "OHCA's proposed spending growth targets do not cover the rate of inflation and will negatively impact hospitals' ability to sustain vital patient services." (Adventist Health, public comment to OHCA Board, Apr. 11, 2025.) Adventist commented that "the proposed methodology fails to account for health system relationships and selectively ignores outpatient services. This results in an incomplete and misleading picture of financial performance." (*Ibid.*) And, it commented that "OHCA's creation of sector targets must take into account additional challenges from Medicare and Medi-Cal. In 2023, Adventist Health had a shortfall of over $685 million from Medicare and Medi-Cal. As the primary healthcare provider for many underserved areas, these shortfalls disproportionately impact our rural patients, who are often sicker due to limited access to preventative care." (*Ibid.*)

204. In another April 2025 public comment, the PEACH Association commented that "[b]ecoming and remaining a trauma center is expensive. Some components generate revenue, but other required components generate no revenue. These costs are generally not offset, and hospitals bear the cost for a trauma center to remain viable. Hospitals in low-income communities generally carry a greater financial burden for trauma because patients are often not commercially insured. Some studies arrived at a median annual cost of readiness in the tens of millions of dollars, although it was difficult to find a California-specific citation." (PEACH Association, public comment to OHCA Board, Apr. 11, 2025.) The comment asked "[h]as the OHCA Board studied the cost of trauma readiness? The data is lacking and is often estimated." (*Ibid.*)

205. Further, in line with concerns of particular Board members (see paragraph 49, *supra*), public commenters noted that the methodology used to calculate cost targets improperly used data, without differentiation, from years impacted by COVID-19. A comment by

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Washington Health in April 2025 specifically stated that "in our judgement, OHCA has exceeded its authority as outlined in the Health & Safety Code that addresses statewide health care cost targets. The code requires OHCA to . . . '[p]rovide differential treatment of the 2020 and 2021 calendar years due to the impacts of COVID-19 on health care spending and health care entities.' Nothing we see in the OHCA methodology takes into account the COVID-19 pandemic in the analysis." (Washington Health, public comment to OHCA Board, Apr. 11, 2025.) Marshall Medical Center also commented that "the years of 2018–2022 considered within the recommended methodology contain at least three years of financial impact from a global pandemic. The OHCA Board would be well-served by deferring their methodology adoption for a few months until the 2023 data can be included, which buys time to review and refine your methodology and will better reflect the "new normal" of delivering healthcare services in the post-pandemic era." (Marshall Medical Center, public comment to OHCA Board, Apr. 22, 2025.)[15]

206. Some public comments also discussed specific economic obligations already imposed on hospitals[16] that OHCA failed to consider. In its April 2025 public comment, the San Diego Regional Chamber of Commerce explained the impact of cost targets amidst seismic retrofitting costs, minimum wage, and Medicare and Medi-Cal funding: "Establishing a hospital sector-specific spending target first and identifying high-cost hospitals without a comprehensive analysis, including ignoring uncontrollable cost factors like the required 2030 seismic retrofitting, which will cost more than $100 billion statewide, or the new $25/hour minimum wage, risks destabilizing hospitals and reducing access to essential services. These uncontrollable cost factors, paired with significant underfunding from Medicare and Medi-Cal, are making it extremely

[15] Other commenters broadly took issue with OHCA's use of 20 years', versus 10 years', worth of data. (See, e.g., Kaiser Permanente, public comment to OHCA Board, Feb. 26, 2024, p. 1 ["Even if household income is the right measure, a 20-year lookback is inclusive of the years of the Great Recession, so the benchmark is skewed. A 10-year lookback more accurately represents normal past experience. The 20-year period behind us is a poor predictor of what is possible going forward."]; CHA, public comment to OHCA Board, Mar. 8, 2024, p. 3. ["OHCA explicitly rejected the use of projections, and instead based its spending target methodology on a 20-year historical period that includes the worst recession in a century since the Great Depression... OHCA has provided no clear rationale for using 20 years of data . . . ."].)

[16] See paragraphs 92–96, *supra*, for a discussion of these existing obligations.

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difficult for us to continue to provide care for our community." (San Diego Regional Chamber of Commerce, public comment to OHCA Board, Apr. 9, 2025.)

207. In their April 2025 written public comment, SHC Tri-Valley commented that "uncertainties concerning widely anticipated federal cuts to Medicaid and Medicare pose threats to health care in California. Additionally, the foreseen reductions in federal biomedical research funding would significantly hinder our mission to train and partner with physician researchers. Our focus to innovate clinical medical research that is translated into bedside care for complex cases is at the heart of our mission, and the proposed sector and sector rates will simply stifle future medical breakthroughs." (SHC Tri-Valley, public comment to OHCA Board, Apr. 18, 2025.) Further, they noted "[a]nother factor OHCA lacks in consideration are the increased state mandates on hospitals such as seismic compliance. As a result, California hospital construction costs continue to be the highest in the country by a significant margin. The costs that unavoidably result from the many levels of hospital regulation in California, both labor and non-labor related, must be considered." (*Ibid.*)

208. Salinas Valley Health also commented in February 2025 that OHCA should factor in potential federal policy changes when establishing hospital sector spending targets. (Salinas Valley Health, public comment to OHCA Board, Feb. 21, 2025.)

209. Board members' comments further reveal their lack of appreciation for hospitals' existing legal and economic obligations and responsibilities, including hospitals' EMTALA obligations. (See paragraph 93, *supra*.) For instance, in response to hospital feedback that OHCA should evaluate the value a hospital adds or provides to the community, one Board Member at the April 2025 meeting said: "what I hear is that the hospital is sort of picking up some of the slack in the community—at least that's what they believe they're doing." Based on the belief that commercially insured patients would be disproportionately supporting hospitals' work for communities, this member stated that it could be reasonable to tell hospitals "it's not your job to do that, and that community is going to have to figure out another way of doing it." (*April 2025 OHCA Board Meeting Recording* (Apr. 22, 2025), 1:09:06–1:13:32.) "We are challenging those communities to say guess what, your hospital, who you've normally turned to and may have done

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so for decades, is not going to do this anymore because we're going to make it much harder for them to do that. And therefore, you need to find some other way of essentially getting those resources." (*Ibid.*)

210. OHCA also reads some of their statutory obligations, namely looking to § 127502(d)(4), to only necessitate consideration of certain factors, like health care technology costs, in *future* adjustments of the cost targets. (See *December 2023 OHCA Board Meeting Recording* (Dec. 19, 2023), 2:49:28–2:51:20 ["Specifically, the statute says that the methodology for the spending target should review potential factors to adjust, including trends in the price of healthcare technologies. Now interestingly, it says 'for future targets,' which would suggest not for the initial target."].) This interpretation is incorrect: subdivision (d) is entirely forward looking, as it discusses the methodology needed to then *establish* cost targets, and thus should not be read to only apply to cost targets set after the initial round of cost targets.[17] And, in any event, other provisions also require that OHCA consider economic, labor, and consumer cost trends in forming all health care cost targets. (§ 127502(c)(2).) Yet, in using this overly narrow interpretation and by setting a five year target, OHCA has improperly asserted a right to bypass any considerations of these factors in the cost targets applying to 2026 through 2030, and indeed, has not sufficiently considered these factors in its existing work. As one Board member singularly worried "I guess my concern about this recommendation is . . . the lack of acknowledgment that perhaps—especially if we're going to talk about three, five years [for cost target ranges] . . . we shouldn't every year look at what has changed in the technological space. . . . The signal we're sending is we're discouraging people from providing coverage for [significant technological advancements]." (Statements of OHCA Board Member Pan, *December 2023 OHCA Board Meeting Recording*, 3:09:41—3:12:06.)

[17] Further, as discussed in footnote 23 and paragraph 297, OHCA enacted the high-cost hospital cost targets as "adjustments" to the hospital sector cost target, rather than as a separate health care sector cost target, as it did not articulate a separate high-cost hospital sector or promulgate an emergency regulation to establish one. Accordingly, even if § 127502(d)(4) only requires OHCA to consider the specific factors named in that subdivision for *adjustments* to cost targets following their initial establishment, at the very least, OHCA was required to consider these factors in their establishment of the high-cost hospital cost targets, and failed to do so.

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211. Finally, it is of note that other states with statewide cost targets are meaningfully distinct in what they consider. Recently, other states with cost targets (Connecticut and Rhode Island) have elected to adjust cost targets to consider inflation. Specifically, in Connecticut, the Office of Health Strategy is obligated by statute to consider the impact of inflation and determine whether a modification of the state's Healthcare Cost Growth Benchmark is indicated (Conn. Pub. Act 22-118); as a result of inflation, the cost target went up from 2.9% to 4.0% for 2024. (Conn. Office of Health Strategy, *Healthcare Benchmark Initiative* <https://portal.ct.gov/ohs/programs-and-initiatives/healthcare-benchmark-initiative?language=en_US> [as of Oct. 3, 2025].) Rhode Island also took into account inflation in establishing its cost targets, setting its cost target for 2023 at 6% "in anticipation of the lagged impact of the 2021-22 inflation spike in the U.S." (State of Rhode Island, Office of the Health Commissioner, *2023 Health Care Spending and Quality in Rhode Island* (2024) https://ohic.ri.gov/sites/g/files/xkgbur736/files/2025-05/2023%20CGT%20quality%20PHHE%20performance%202025%2005-12%20FINAL.pdf [as of Oct. 3, 2025].) As CHA's December 13, 2023 letter stated: "other states have set spending targets in excess of GDP Growth." (CHA, public comment to OHCA Board, Dec. 13, 2023, p. 6.) Thus, "California would be a major outlier if it set a target lower than recent years' GDP growth, which would be the case if it adopted an unadjusted target based on median family income growth." (*Ibid.*)

2. Cost Targets Do Not Ensure Consumer Affordability.

212. Egregiously, OHCA's approach to limiting hospital spending growth provides no assurance that cost targets will actually advance the statute's goal of consumer affordability. In other words, while OHCA wrongfully focused exclusively on cost containment to the detriment of other statutorily-required considerations, its cost targets do not necessarily even translate to affordability for consumers.

213. This is particularly because OHCA has not proposed a sufficient plan to ensure that savings from the imposed cost targets would be passed to consumers in the form of lower premiums and cost sharing, rather than simply being retained by payers as higher profits. (CHA, public comment to OHCA Board, Apr. 11, 2025, p. 11.)

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214. As CHA commented in February 2025, "[w]hile OHCA is singling out hospitals with unattainably low sector targets at far less than general inflation, health insurance companies are increasing consumer premiums by 10% or more annually. State agencies like the California Public Employees' Retirement System (CalPERS) recently offered one of the state's highest-cost health insurance companies a premium increase 40% higher than OHCA's statewide spending target, just as OHCA appears poised to impose spending targets on select hospitals that are roughly 50% lower than the statewide target. . . . No commensurate adjustments to payers' targets are being considered, leaving it unclear who will benefit from OHCA's targeting of a small set of providers. Before proceeding, OHCA should clearly state why it is not striving to ensure any strict targets on providers translate into savings for the California residents who pay billions of dollars in premiums to health insurance companies every year." (CHA, public comment to OHCA Board, Feb. 21, 2025, p. 10.)

215. This disconnect is even worse for the high-cost hospital target. "While payers contracting with the high-cost hospitals would benefit from limiting the growth of payments in 2026 to 1.8%, these payers' targets would remain at the statewide level generating a margin for payers to use as they see fit, including for administration and profits. A comprehensive approach to sector targets could take this into account and ensure that commensurate adjustments are applied to payer targets to ensure that Californians actually benefit from differentiated provider targets OHCA is imposing." (CHA, public comment to OHCA Board, Apr. 11, 2025, p. 11.)

3. <u>The Cost Targets Are Unattainable.</u>

216. As discussed further in paragraphs 241–249, *infra*, OHCA has yet to cogently articulate a complete methodology for how it will measure hospital spending to assess compliance with cost targets, but are nonetheless requiring hospitals to comply with cost targets in 2026 to avoid enforcement. (There is also a lack of clear direction from OHCA on how it will review and consider any hospital supplied justifications for exceeding cost targets, adding to the incoherence and arbitrariness of OHCA's actions.). Yet, as a result of OHCA's failures to consider or integrate into the cost target methodology key factors that drive hospital spending, it may simply not be possible for some hospitals to comply with these cost targets.

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217. Most critically, some hospitals have commented that the cost target could require them to close entirely. San Gorgonio Memorial Hospital (a safety-net hospital) stated in February 2024 (regarding 3% cost targets) that "if these limits would have been in place over the past 5 years, the Hospital's revenues would have been reduced by approximately $50M. In other words, the Hospital would have filed bankruptcy and closed 3 or 4 years into the program. Period!" (San Gorgonio Memorial Hospital, public comment to OHCA Board, Feb. 28, 2024.) The Hospital further commented that "[t]here are not enough cuts in services, staffing, or programs that could be made that would still allow the Hospital to remain operational in a manner that would meet the numerous California licensing, staffing, mandated benefits, seismic, reporting, and other HCAI capital and operational licensing requirements necessary to maintain a Hospital (not to mention Federal mandates such as EMTALA, price transparency, etc.)." (*Ibid.*)

218. Several hospitals further shared that meeting a 3% target, amidst their existing legal obligations that drive costs, would require "reevaluating the services we provide," limiting care expansions and other investments, "considering ways to reduce current staff by outsourcing all non-patient care services," and curtailing hiring of new staff." (See, e.g., Mountains Community Hospital, public comment to OHCA Board, Mar. 14, 2024.) And, meeting a 3% proposed target would create uncertainty about whether hospitals can meet state minimum wage and seismic retrofitting mandates.

219. The California Association of Public Hospitals & Health Systems commented in March 2024 that "applying the 3% target in Medi-Cal would be especially detrimental as it would assume Medi-Cal payments are adequate to begin with and it could lock in payment inequities in perpetuity." (California Association of Public Hospitals and Health Systems, public comment to OHCA Board, Mar. 11, 2024.)

220. The California Children's Hospital Association commented in March 2024 that "the recommended statewide cost growth target is unrealistically low, virtually ensuring that most providers will not meet it without providing guidance to those providers about what OHCA staff and the board might consider acceptable reasons for exceeding it." (California Children's Hospital Association, public comment to OHCA Board, Mar. 11, 2024.)

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221. El Centro Regional Medical Center commented in February 2024 that the cost targets would require them to delay infrastructure and technology updates, including updates to nurse call systems, MRI and CT machines, and computer systems needed to mitigate cyber threats. (El Centro Regional Medical Center, public comment to OHCA Board, Feb. 26, 2024.)

222. Hospitals expressed to the Board (in person and in writing) ways in which they have already significantly reduced costs under alternative payment models, and stated therefore that they cannot "squeeze out any more savings" and "it would be unlikely we could meet this 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, public comment to OHCA Board, Mar. 11, 2024; see also MemorialCare, public comment to OHCA Board, Feb. 28, 2024; PIH Health, public comment to OHCA Board, Mar. 7, 2024.)

223. PIH Health noted in March 2024 that "in the face of a thin nurse staffing environment, a 3% spending target would exacerbate our current challenges in hiring nurses and other healthcare professionals. A spending target of 3% would have removed $491 million from our budget over the past five years, potentially resulting in 320 jobs lost." (PIH Health, public comment to OHCA Board, Mar. 7, 2024.)

224. To be sure, these concerns continue to be true even with OHCA's revision to begin cost targets at 3.5%, lowering to 3% by 2029. CHA's June 21, 2024 letter noted new research that expects per capita health care spending to grow between 4.8% and 5.8% while California's statewide spending target is in place. (See also CHA, public comment to OHCA Board, June 21, 2024; see also CHA, public comment to OHCA Board, May 20, 2024, p. 1 [explaining that "meeting a 3.5% spending target in year one would require a sudden 30% drop in the growth of health care spending, which cannot be achieved without serious negative consequences for patient care."].)

225. A comment by California Medical Association in April 2025 stated that "[w]e continue to be concerned that the 3.5% health care spending target is too low for some health care entities to meet given inflation, the cost of providing care and increasing costs of labor, medical supplies, drugs, and those costs associated with new tariffs." (California Medical Association,

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public comment to OHCA Board, Apr. 11, 2025.)

226. Some comments specifically focused on the disparate harm that would occur from OHCA's failure to account for key factors. For instance, in an April 2025 letter, the Filipino American Chamber of Commerce of Solano County commented "[t]he 3.5% cap is below inflation and does not account for increased costs of staffing, supplies and medication. This cost control measure will discriminately impact hospitals like NorthBay that treat under-represented and under-resourced patients and will weaken the high-quality of care our communities receive. With one of the San Francisco Bay Area's largest Filipino American and Asian American populations we harbor serious concerns about what a shortage of healthcare services might mean particularly for our vulnerable seniors and marginal wage earners." (Filipino American Chamber of Commerce of Solano County, public comment to OHCA Board, Apr. 11, 2025.)

227. CHA's August 23, 2024 letter also provided several examples of the ways in which hospital spending and costs vary significantly across the state, such that the cost targets will have disparate impacts across the state. (CHA, public comment to OHCA Board, Aug. 23, 2024; see also Integrated Healthcare Association, public comment to OHCA Board, Apr. 2024 [suggesting that "it makes more sense to set different targets for different segments (e.g. regions) or [Lines of Business "LOBs"] depending on how that segment is performing currently vs. applying a target to everyone equally."].)

228. Finally, hospitals also explained how the cost targets are particularly challenging for hospitals given that their financial reserves were depleted by COVID-19. As the District Hospital Leadership Forum commented, "While it may appear that many hospitals/health systems have recovered from the COVID-19 pandemic . . . unfortunately, district hospitals are not in that same position. Simply put, most are experiencing significant workforce challenges, and their current financial state is not sustainable as evident by the high proportion needing DHLP loans." (District Hospital Leadership Forum, public comment to OHCA Board, Apr. 11, 2025.) Further, Tahoe Forest Hospital District ("TFHD") commented that "Prior to COVID, inflation escalation for TFHD would have been 83% of a 3.5% rate adjustment. It far exceeds that figure today. According to Becker's Hospital Review . . . 'Compared to 2022 year to date, drug expenses per

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calendar day grew 15%.' This is consistent with our experience here at TFHD and in particular in the Cancer Center. This is only one segment of our cost structure impacted by inflation and the fallout of the pandemic." (TFHD, public comment to OHCA Board, Apr. 10, 2025.) And Ridgecrest Regional Hospitals commented that they recently went through "10% layoffs as a result of [their] poor financial condition post COVID. Further cuts will only lead to more reductions. We are also having to delay replacing badly needed patient care and diagnostic equipment because cash reserves are so low." (Ridgecrest Regional Hospital, public comment to OHCA Board, Mar. 25, 2024.)

229. For all of these reasons, as well, OHCA's cost targets—the statewide target, the hospital sector target, and the high-cost hospital target—are contrary to statute and arbitrary and capricious.

D. <u>OHCA's Cost Targets Are Unconstitutionally Confiscatory.</u>

230. The impact of OHCA's cost targets are such that, in addition to violating OHCA's enabling statute, they are also unconstitutional.

231. As discussed above (see paragraphs 99–101) the Takings Clauses of the California and United States Constitutions guarantee property owners "just compensation" when their property is "taken for public use." (Cal. Const., art. I, § 19; U.S. Const., 5th Amend.) Regulations that control or cap total amounts paid to a party may constitute unconstitutional takings even if property remains in its owner's hands, where rate-setting sets an unjust or unreasonable rate. "A rate is too low if it is so unjust as to destroy the value of the property for all the purposes for which it was acquired, and in so doing practically deprives the owner of property without due process of law." (*20th Century Ins. Co. v. Garamendi* (1994) 8 Cal. 4th 216, 295 [quotation modified].) A court may invalidate an ordinance on its face if its terms "preclude avoidance of confiscatory results." (*Fisher v. City of Berkeley* (1984) 37 Cal. 3d 644, 683 [quotation modified]; see also *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal. 3d 805, 817–21 [holding that an insurance rate regulation provision was invalid where it limited rate adjustments to insurers substantially threatened with insolvency]; *Birkenfeld v. City of Berkeley* (1976) 17 Cal. 3d 129, 169–71 [holding that a rent control measure was invalid where the Board had no power to adjust

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rent ceilings until it received a separate petition for that unit and considered the petition at an individualized adjustment hearing].)

232. OHCA's cost targets will do just that, depriving hospitals so significantly of their ability to carry out their provision of health care so as to practically deprive the hospitals of their property without due process of law. In the same way, OHCA's cost target provisions also violate the substantive due process clause, which, in cases of price control provisions, requires that such provisions do not "deprive investors of a 'fair return' and thereby become confiscatory." (*Galland v. City of Clovis* (2001) 24 Cal.4th 1003, 1021, as modified (Mar. 21, 2001); see also *Kavanau v. Santa Monica Rent Control Bd.* (1997) 16 Cal.4th 761, 771.)

233. As already discussed, California hospitals consistently provided public comment to OHCA regarding the myriad ways in which the cost targets would fundamentally deprive hospitals of their ability to operate and provide care, and would result in limiting hospital revenue so that such revenue will not cover hospital costs or generate a fair return. Indeed, the record before OHCA, as discussed above (see paragraphs 194–228), strongly demonstrates that each of the challenged cost targets applied to hospitals will restrain revenue growth to substantially less than the rate of inflation, including the rate of increase in labor costs, will not allow for an increase in the costs shifted to commercial payers to offset reductions in payments from government programs, and will not take into account higher than inflation rate cost increases or expenditures such as hospital technology and pharmaceuticals, will not take into account revenue needed to comply with legal obligations such as the cost or required capital improvements to meet California's seismic safety mandates or are otherwise necessary to serve a hospital's community, and will not take into account any other necessary or unavoidable costs a hospital incurs in excess of the rate of growth allowed by the cost target, such as increases in prices resulting from the federal government's implementation of greatly enhanced tariffs.

234. As discussed above, some hospitals have commented that the cost target could require them to close entirely. (See San Gorgonio Memorial Hospital, public comment to OHCA Board, Feb. 28, 2024 ["if these limits would have been in place over the past 5 years, the Hospital's revenues would have been reduced by approximately $50M. In other words, the

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Hospital would have filed bankruptcy and closed 3 or 4 years into the program. Period!"].)

235. Hospitals have also told OHCA that they will be forced to cut service lines to comply with cost targets amidst other existing legal obligations and policy changes, including California's required minimum wage increases for health care workers (which will necessarily increase labor costs during the cost target enforcement years), California's seismic safety requirements, and the significant cuts to federal funding for government sponsored health coverage programs. Even if hospitals are not forced to close entirely, these cuts in service lines will be so significant as to fundamentally deprive hospitals of their ability to operate and provide care. As San Gorgonio explained, "[t]here are not enough cuts in services, staffing, or programs that could be made that would still allow the Hospital to remain operational in a manner that would meet the numerous California licensing, staffing, mandated benefits, seismic, reporting, and other HCAI capital and operational licensing requirements necessary to maintain a Hospital (not to mention Federal mandates such as EMTALA, price transparency, etc.)." (See San Gorgonio Memorial Hospital, public comment to OHCA Board, Feb. 28, 2024.)

236. Others commented similarly. Catherine Moy, the Mayor of the City of Fairfield, commented that "OHCA's hospital sector spending target of 3.5% will devastate NorthBay [Health] operationally and financially but also put in jeopardy the health of our community . . . NorthBay may be forced to cut critical services including their trauma care, labor and delivery, and behavioral health services, or delay their plans to open several much-needed primary and urgent care clinics throughout the region." (Catherine Moy, Mayor of the City of Fairfield, public comment to OHCA Board, Apr. 16, 2025.)

237. Scripps Health commented that "[u]nfortunately, the targets set by this body are not reducing the underlying costs. They are impeding our ability to return to financial stability, maintain access to care for our patients, and provide patient-centered care without needless bureaucratic barriers. . . Many insurance companies are erroneously claiming they can only increase compensation to providers by 3% based on OHCA requirements…demanding Scripps accept financial concessions that do not consider our increasing costs." (Scripps Health, public comment to OHCA Board, Jan. 28, 2025.)

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238. Sutter Health commented that "imposing spending targets that limit our health system's financial investment capacity will directly undermine our ability to grow and adapt to the needs of the population growth. . . . Expanding our access to care requires significant capital investment and spending targets would delay or even halt these critical improvements." (Sutter Health, public comment to OHCA Board, Mar. 11, 2025.)

239. Banner Lassen Medical Center explained to OHCA that "[l]owering the target even further, without a clear understanding of how spending will be measured, means that we would be forced to further reduce the care we provide. This could impact: Nuclear Medicine, Occupational Health, Urgent Care, Wound Care, and Expansion of Surgical Services." (Banner Lassen Medical Center, January 2025 Public Comment Letter.) El Centro Regional Medical Center similarly commented that the cost targets would require them to delay infrastructure and technology updates, including updates to nurse call systems, MRI and CT machines, and computer systems needed to mitigate cyber threats. (El Centro Regional Medical Center, public comment to OHCA Board, Feb. 26, 2024; see also California Children's Hospital Association, public comment to OHCA Board, Mar. 11, 2024 ["the recommended statewide cost growth target is unrealistically low, virtually ensuring that most providers will not meet it without providing guidance to those providers about what OHCA staff and the board might consider acceptable reasons for exceeding it."].)

240. As these comments illustrate, OHCA's cost targets will deprive hospitals so significantly of their ability to provide care so as to be confiscatory. OHCA's cost targets are thus unconstitutional.

E. <u>The Impending Enforcement of OHCA's Cost Targets Against Hospitals Without a Cogent Articulation of How Hospital Spending Is to Be Evaluated Is Unconstitutional.</u>

241. The impending enforcement of OHCA's cost targets is also unconstitutional. As discussed in paragraph 216, *supra*, OHCA's cost targets have entered their enforcement period starting in January 2026, so hospitals will need to act to comply with the cost targets to avoid enforcement. Yet, OHCA still has not provided hospitals with a sufficient indication of *how* they can comply with the cost targets, as OHCA has still not cogently articulated how it intends to

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measure hospital spending and evaluate hospitals' compliance with the cost targets. Moreover, there is a lack of clear direction from OHCA on how it will review and consider any hospital supplied justifications for exceeding cost targets, including information in support of a waiver for enforcement due to factors outside of their control. This uncertainty abridges hospitals' protected property interests by forcing them to operate without knowing what conduct will trigger enforcement, leaving them vulnerable to arbitrary penalties if they fail to correctly anticipate OHCA's eventual methodology or, by misfortune, fall outside its undefined parameters. This violates the procedural due process protections guaranteed by the Fourteenth Amendment to the United States Constitution, as well as by the California Constitution.

242. As the Children's Specialty Care Coalition commented in April 2025: "OHCA has not yet finalized its method for measuring hospital spending. OHCA has a legal prerogative to inform the creation of sector targets with historical cost data. However, the lack of a finalized methodology means the relevant historical cost data has not been reviewed and leaves hospitals in the dark as to how to comply with the target. Establishing hospital-specific sector(s) and corresponding spending targets is premature." (Children's Specialty Care Coalition, public comment to OHCA Board, Apr. 9, 2025.)

243. CHA similarly warned in its March 20, 2025 letter: "Because OHCA has not finalized a methodology for measuring hospital spending, neither hospitals nor the office itself know what the hospital sector targets mean for the affected organizations, workers, and patients." (CHA, public comment to OHCA Board, Mar. 20, 2025.)

244. Additionally, Stanford Health Care emphasized the same point in its March 20, 2025 letter: "With an existing statewide target of 3.5% (dropping down to 3% by 2029), and complete lack of clarity around how that target would be measured or enforced, the proposed action is premature." (Stanford Health Care, public comment to OHCA Board, Mar. 20, 2025.) Stanford continued: "OHCA has not yet finalized its method for measuring hospital spending. OHCA has a legal prerogative to inform the creation of sector targets with historical cost data. However, the lack of a finalized methodology means the relevant historical cost data has not been reviewed and leaves hospitals in the dark as to how to comply with the target." (*Ibid.*; see also

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Banner Lassen Medical Center, public comment to OHCA Board, Jan. 27, 2025.)

245. Montage Health commented in March 18, 2025: "OHCA is considering hospital sector-specific spending growth targets and the complete lack of clarity around how those targets would be measured or enforced. . . OHCA's approach to sector targets is both wildly premature and woefully inadequate." (Montage Health, public comment to OHCA Board, Mar. 18, 2025.)

246. Procedural due process under the United States Constitution protects only those interests that may be construed as liberty or property. Under California law, due process protections are broader and may extend to any statutorily conferred benefit, even if it does not qualify as a liberty or property interest under federal standards. (*People v. Ramirez* (1979) 25 Cal.3d 260, 263–64.) Hospitals have a property interest in operating without being subjected to arbitrary financial penalties. OHCA's enforcement scheme threatens to impose monetary sanctions without clear standards, depriving hospitals of funds without constitutionally adequate process.

247. Under the applicable framework, OHCA's process does not satisfy the minimum requirements of procedural due process. First, the property interest—continued hospital operations without arbitrary financial or other penalties—is substantial given the monetary sanctions, reputational harm, and disruption to patient care if a hospital is deemed noncompliant under unclear standards. Second, the risk of erroneous deprivation is high given the lack of finalized methodology, leaving hospitals to discover the applicable criteria only after sanctions are initiated. Third, the lack of clear, prospective standards forces hospitals to navigate enforcement without knowing the criteria by which they will be judged, undermining both the dignitary interest in being heard and the practical ability to conform conduct to regulatory expectations. Fourth, the administrative burden of providing basic procedural safeguards of OHCA articulating its standards prospectively is minimal compared to the consequences of its enforcement. Accordingly, OHCA's process does not satisfy the requirements of procedural due process under either the federal or California Constitution.

248. Additionally, requiring hospitals to act to avoid enforcement, particularly in ways that significantly alter their ability to carry out their work (see, e.g., paragraphs 230–240), without

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providing them fair notice of *how* to avoid enforcement, is unconstitutional. The void-for-vagueness doctrine prohibits enforcement of regulations that fail to provide fair notice of the conduct required and lack sufficiently definite standards to prevent arbitrary or discriminatory enforcement—standards that are violated when persons of "common intelligence must necessarily guess at [a regulation's] meaning and differ as to its application." (*Mae M. v. Komrosky* (2025) 111 Cal.App.5th 198, 214–15, quoting *People v. Hall* (2017) 2 Cal.5th 494, 500.) To survive a vagueness challenge, "(1) the regulations must be sufficiently definite to provide fair notice of the conduct proscribed; and (2) the regulations must provide sufficiently definite standards of application to prevent arbitrary and discriminatory enforcement." (*Ibid.*, quoting *Snatchko v. Westfield LLC* (2010) 187 Cal.App.4th 469, 495.) OHCA's cost target framework exemplifies this deficiency: hospitals are left to speculate whether compliance will be assessed based on inpatient revenue, outpatient adjustments, or other undefined metrics, and the plain text of OHCA's adopted methodology is itself ambiguous, lacking clear thresholds or guidance on how key provisions will be interpreted or applied. This uncertainty is not limited to isolated cases—it affects the regulated community broadly, leaving hospitals without meaningful guidance and exposing them to enforcement based on unclear or shifting criteria. Because OHCA has not finalized or disclosed a definitive methodology, hospitals must attempt to anticipate what criteria the agency will ultimately apply; those that guess incorrectly—or that, by misfortune, do not align with the chosen standard—will face enforcement actions, resulting in arbitrary penalties and reputational harm. The lack of clear, prospective standards invites arbitrary enforcement and renders the cost target scheme impermissibly vague and constitutionally unenforceable under both federal and California law.

249. For this reason, OHCA's actions are unconstitutional and OHCA should be prohibited from enforcing its cost targets against hospitals.

F. <u>OHCA's Creation of the Hospital Sector Was Premature, Not Data Driven, and Lacking in Evidence.</u>

250. Beyond the cost targets themselves, OHCA has otherwise acted unlawfully. First, OHCA's singling out of hospitals and creation of the hospital sector—which OHCA used as a

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mechanism to facilitate the creation of the hospital spending methodology to enforce cost targets against hospitals, particularly the high-cost hospitals— does not correctly follow the text and spirit of OHCA's enabling statute and is arbitrary and capricious.

251. As discussed above, the OHCA statute requires the OHCA Board to define *initial* health care sectors by 2027 and set sector-specific cost targets by 2028. (§ 127502(*l*)(2)(A), (B).)

252. These deadlines make good sense within the statutory context. The statute also requires (1) that the OHCA Board establish a reporting only statewide cost target for 2025 (to act as the comparison for the 2026 enforceable target) and (2) that the OHCA Office prepare a report on baseline health care spending by June 2025. The 2027 and 2028 deadlines for OHCA to establish initial sectors and targets therefore afford OHCA ample time to evaluate data it is only receiving in 2025, 2026, and 2027 to comprehensively understand California's health care spending and the impacts of the statewide cost target ***prior to*** determining which health care sectors should be initially defined and what specific targets to assign sectors.

253. Indeed, in the December 2024 Board Meeting, the OHCA Office noted that it had limited data to inform the establishment of potential sectors beyond hospitals. (OHCA, *December 2024 Board Meeting Presentation*, slide 65 (Dec. 16, 2024).) Even assuming that hospitals were the only sector for which OHCA had adequate data (a point that CHA contested in public comment, see also paragraph 64, *supra*), that does not mean it was correct to set the hospital sector at this initial point; instead, it strains OHCA's impartiality and credibility. The OHCA Office at this December meeting presented to the Board the option to "wait to establish sector targets for performance year 2027 or later." (OHCA, *December 2024 Board Meeting Presentation*, slide 67).

254. But, as noted above, the Board did not take this option, voting to establish a hospital health care sector to include hospitals defined in Health & Safety Code section 1250 *et seq*. All hospitals are subject to the statewide target unless and until the Board adjusts the target for all or a specified subset of hospitals within the sector.

255. This was premature. Significant evidence in the record indicates that OHCA's formation of a hospital sector lacked statutorily-mandated consideration of important factors. Further, OHCA formed the hospital sector prior to receiving and analyzing the kinds of data

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necessary to evaluate which sector(s), if any, should be established at this early stage.

256. The prematurity of OHCA's focus on sector targets and incompleteness of OHCA's data and methodologies for measuring hospital spending in particular have resulted in OHCA arbitrarily and improperly singling out hospitals. These actions have material consequences for hospitals, because OHCA's hospital spending methodology (which has not been finalized) is the mechanism by which OHCA has indicated it will determine compliance with, and thus enforce, cost targets against hospitals. As CHA has commented, moving to sector-specific targets without first evaluating the statewide target (or specific spending, of hospitals as well as other health care entities) could lead to arbitrary enforcement specifically against hospitals. (CHA, public comment to OHCA Board, Jan. 24, 2025, p. 3; CHA, public comment to OHCA Board, Apr. 17, 2025, p. 2.)

1. The Hospital Sector Is Premature.

257. First, OHCA created the hospital sector without sufficient consideration or analysis of the impact of a hospital sector-specific cost target on access, equity, quality, and workforce stability: the factors OHCA's enabling statute require it to consider.[18] As CHA commented multiple times, the hospital sector target creation was premature, as at the time the Board made the decision, OHCA had yet to analyze or report a single year of comprehensive spending data, evaluate available data for any other potential sector (as discussed above), had yet to determine how hospital spending will be measured, and had yet to assess the reasonableness of the statewide spending target before moving onto sector targets. (See, e.g., CHA, public comment to OHCA Board, Oct. 9, 2024, pp. 9–10; CHA, public comment to OHCA Board, Nov. 15, 2024, p. 4; CHA, public comment to OHCA Board, Dec. 12, 2024, p. 5; CHA, public comment to OHCA Board, Feb. 21, 2025, pp. 1–2.)

258. Indeed, CHA's October 9, 2024 comment described discussions at the August 2024 OHCA Board meeting that evidenced a lack of understanding about hospital spending and costs. "At the August board meeting, it was suggested that hospitals should be able to make do with

[18] As discussed above, see §§ 127500.5(c), (d), (g), (h), (o)(1); 127502(b)(3), (c)(5)–(7), (d)(2)–(7), (e). In particular, § 127502(b)(3) requires OHCA to, in "setting [] different targets by health care sector" be "informed by . . . consideration of access, quality, equity, and health care workforce stability . . . ."

commercial reimbursement no higher than 150% of what Medicare pays." (CHA, public comment to OHCA Board, Oct. 9, 2024, pp. 4–5.) However, as CHA responded in its comment letter, "reducing commercial reimbursement to 150% of Medicare would be catastrophic," noting that "[r]esources for patient care would drop by tens of billions of dollars, nearly four in five hospitals would operate in the red, and hospitals would be forced to reduce their workforces by as many as 59,000 jobs. The impact on patients would be devastating and would violate OHCA's charge to make care affordable while preserving access, equity, and quality." (*Ibid.*)

259. The OHCA Office surveyed hospitals and shared their findings in the February 2025 Board Meeting. Surveyed hospitals requested OHCA not "rush to do something, instead be measured and deliberate." (OHCA, *February 2025 Board Meeting Presentation*, slide 21.) Other public comments offered that it "may be premature to set hospital sector targets at this time," in particular because "OHCA has not yet finalized a methodology for measuring hospital spending," it "needs more time to analyze potential consequences of a hospital sector on access, quality, equity, or workforce stability," and "singling out [the hospital] sector will destabilize equitable access to high-quality hospital care." (OHCA, *March 2025 Board Meeting Presentation*, slide 95; OHCA, *April 2025 Board Meeting Presentation*, slides 45–62; see also Banner Lassen Medical Center, public comment to OHCA Board, Jan. 27, 2025; Scripps Health, public comment to OHCA Board, Feb. 29, 2025; Sharp, public comment to OHCA Board, Mar. 8, 2025; California Hospital Medical Center, public comment to OHCA Board, Apr. 11, 2025; PIH Health, public comment to OHCA Board, Apr. 17, 2025.)

260. Specifically, hospitals noted that creating a specific sector (and sector target) in 2025, rather than delaying as the statute expressly contemplates, would mean the sector specific target is skewed based on a 5 year period that includes costs from the COVID-19 pandemic. (OHCA, *February 2025 Board Meeting Presentation*, slide 21.)[19]

261. Hospitals also requested that OHCA delay the formation of specific sectors (and

[19] Section 127502(d)(3) requires that a methodology to set health care cost targets must "provide differential treatment of 2020 and 2021 calendar years due to the impacts of COVID-19 on health care spending and health care entities."

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targets) so that consideration could include "the impact of federal actions, such as increased tariffs, proposed cuts by Congress that may impact Medi-Cal / Medicare funding and ultimately payments to hospitals." (OHCA, *February 2025 Board Meeting Presentation*, slide 21, see also Salinas Valley Health, public comment to OHCA Board, Feb. 21, 2025 [strongly urging OHCA to assess the implications of imminent federal policy changes before imposing additional spending targets on specific hospitals].)

262. The District Hospital Leadership Forum's April 2025 letter compared the speed of OHCA's process with other states that enacted cost targets: "As leaders from Massachusetts and Oregon presented during the March OHCA Board meeting, both states were very intentional in their respective efforts to implement the health care spending targets. Prior to the 2012 Legislation, [Massachusetts] had more than 6-year period to review and analyze data, including issuing multiple reports, with actionable recommendations. In Oregon, they established their [All Payer Claims Database ("APCD")] in 2009 and had 10-years of experience with a landmark Medicaid waiver limiting Medicaid spending to 3.4% annual cost growth benchmark. In 2019, nearly 10 years after they began collecting and analyzing data, they moved forward with their Massachusetts-like program. Both states (who are model states for California) shared with the OHCA Board in March they did not rush to implement spending targets before any of the policy and analytical work had been completed. Their collaborative efforts and transparency led to high credibility and buy-in from industry." (District Hospital Leadership Forum, public comment to OHCA Board, Apr. 11, 2025.)

263. In January 2025, the Board received feedback from the Advisory Committee that its methodology required refinement, "particularly in defining sectors." (OHCA, *January 2025 Board Meeting Minutes*, (Jan. 28, 2025), p. 5.) Board members asked and were told that individuals on the Advisory Committee who wanted to move more slowly did not provide any alternative proposals. (*Ibid.*) But the Advisory Committee is not obligated to provide alternatives to a proposal deemed faulty; that Advisory Committee members did not themselves present an alternative did not absolve the Board of its obligation to consider the Committee's feedback and work with the OHCA Office to implement it.

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2. OHCA Formed the Hospital Sector Relying on Flawed, Incomplete Data.

264. Second, OHCA formed a hospital sector without sufficient relevant data. Again, the OHCA statute, § 127501.6(a), requires a baseline report on health care spending growth trends to be released on June 1, 2025 (the report was released on June 5, 2025).[20] (See also § 127502(b)(3) ["[t]he setting of different targets by health care sector . . . shall be informed by historical cost data and other relevant supplemental data,"]; § 127502(d)(2)–(7) [requiring the OHCA Office to develop and OHCA Board approve a methodology for setting cost targets that is based on historical trends and projections for economic indicators, provides differential treatment for 2020 and 2021 given COVID-19, considers labor costs, trends in health care technology pricing, payer mix, state mandates for capital improvement projects, and more].)[21]

265. Once it was released, the Baseline Report showed that hospital inpatient services grew at the lowest rate compared with other specified service categories. (OHCA, Baseline Report at 41.) The biggest drivers overall of increased health care costs were insurance companies and pharmaceutical companies: based on data from the Baseline Report, CHA estimates that insurance company administrative costs and profits ballooned more than 23% in 2023, while hospital spending grew less than 5% (inpatient hospital spending grew at an even lower rate, a mere 2.3%). (*Id.* at 26, 47.)

266. As discussed above, the Legislature provided sequential deadlines to allow OHCA to define initial health care sectors and set cost targets well after the release of the baseline report and relevant data analysis. But, by the time these data were released, OHCA had already established the hospital sector and voted on the hospital sector cost target. As a result, the hospital sector was created without the level of data analysis the Legislature mandated. As CHA has commented (see CHA, public comment to OHCA Board, Feb. 21, 2025, p. 2), OHCA should have first conducted this analysis before considering sector-specific targets.

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[20] Department of Health Care Access and Information, OHCA, *Baseline Report: Health Care Spending Trends in California, 2022–2023* (June 5, 2025) <https://hcai.ca.gov/wp-content/uploads/2025/06/Baseline-Report-Health-Care-Spending-Growth-Trends-in-California-3.pdf> [as of Oct. 3, 2025].

[21] See paragraph 210 and footnote 17 regarding OHCA's current obligations under § 127502(d)(4).

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267. Moreover, additional evidence in the record indicates the Board was aware of significant limitations and potential inaccuracies in the data available to OHCA at the time it established the hospital sector.

268. As discussed in paragraphs 61 and 62, *supra*, in the December 2024 and January 2025 Board meetings, multiple Board members explicitly acknowledged that the data used to inform sector definitions—particularly for hospitals—was incomplete, potentially flawed, and included outlier cases that "likely [were] bad data." (See *December 2024 OHCA Board Meeting Recording* at 2:28:59–2:29:11 [Board Member Pan asks about Covered California data, and OHCA staff respond that existing data is not comprehensive and express hope that future baseline reports will include geographic analysis]; *id.* at 2:27:01–2:28:52 [OHCA staff presentation outlines limited data availability for defining sectors beyond hospitals and acknowledges that additional data reporting is needed]; *id.* at 2:22:26–2:23:05 [Board Member Kronick remarks "likely that it is bad data," and Board Member Pan agrees, comparing it to a lab test that doesn't make sense and needs to be repeated]; *id.* at 2:23:25–2:24:09 [Sarah Lindberg of Freedman Healthcare confirms that outlier cases "likely do have something funky going on," possibly due to incorrect reporting or anomalies in the numerator/denominator]; *id.* at 2:18:06–2:20:27 [OHCA staff acknowledge that some hospitals may be losing money while others are far above the average]; *id.* at 2:24:27–2:26:02 [Board Member Kronick discusses how inpatient volume trends affect the interpretation of revenue growth and the feasibility of meeting statewide targets, noting that outpatient volume data is even more limited].) Despite these acknowledged data limitations, the Board proceeded to define hospital sector targets, citing statutory deadlines and stakeholder interest—a rationale wholly distinct from the quality or completeness of the underlying data.

269. Public comments also discuss these concerns. CHA's October 9, 2024 comment described discussions at the August 2024 OHCA Board meeting that evidenced flaws in data. "At the August board meeting, a witness presented data showing that California's hospitals, taken together, enjoyed a healthy operating margin of 11.1% in 2022 (with the national figure being even higher at 13%)." (CHA, public comment to OHCA Board, Oct. 9, 2024.) As CHA commented, alternative, credible sources "reveal that the data presented at the August board

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meeting are highly suspect and out of line with other analyses of the same and similar data." CHA cited a MedPAC analysis of the same data presented at the Board meeting for hospitals nationally, "finding that their all-payer operating margin averaged 2.7% in 2022, one-fifth of the 13% figure shared at the board meeting." (*Ibid.*) CHA also cited a Milliman analysis that corroborated the MedPAC estimate. And, CHA cited evidence that California hospitals reported an operating margin of 1.04% to HCAI in 2022, far below the 3% level that credit agencies deem necessary for hospitals to meet their financial obligations and sharply in contrast to the 11.1% margin for California hospitals cited at the Board meeting. (*Ibid.*)

3. OHCA Arbitrarily and Improperly Focused on the Hospital Sector.

270. Despite later finding that hospital spending, and in particular, hospital inpatient spending, grew at the lowest rate compared to other services in California, OHCA's myopic focus on hospitals and rush to judgment resulted in OHCA arbitrarily and improperly establishing a hospital sector before even considering any other sectors.

271. The statute authorizes the OHCA Board to "establish specific targets by health care sector, including…individual health care entities." (§ 127502(b)(1).) "Health care entities" are defined to include "a payer, provider, or a fully integrated delivery system." (§ 127500(j); see also § 127502(h)(1)–(3) [providing requirements for cost targets set for payers].) Accordingly, OHCA could have focused on other health care entities in lieu of or in tandem with hospitals, and was obligated at least to have given careful consideration to this approach. (See also *December 2024 OHCA Board Meeting Recording*, 2:30:37 [OHCA Office indicating OHCA's understanding that there could be a sector target for health plans].) And indeed, other states with cost targets (i.e. Massachusetts and Oregon) do not exclusively focus their cost targets on hospitals. (See OHCA, *March 2025 Board Meeting Presentation*, slides 42–43, 72–74.)

272. Even before the publication of OHCA's Baseline Report, OHCA was wrong to focus solely on hospitals. As discussed in paragraph 61, *supra*, during the December 2024 Board Meeting, multiple Board members stated explicitly that it was important to them that OHCA consider, fairly urgently, sector targets for other health care entities, including health plans, pharmacy benefit managers, and others, to which the Office responded that "the current focus is

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on hospital sector targets in response to stakeholder concerns raised and board interests." (See *December 2024 OHCA Board Meeting Recording* at 2:29:52–2:31:46.)

273. Similarly, CHA's January 2024 public comment stated that OHCA's misplaced focus on hospitals "occurs as health insurance companies—four of which effectively control the entire commercial market in California—are earning billions and engaging in practices that undermine access to patient-centered care." (CHA, public comment to OHCA Board, Feb. 22, 2024, p. 5.) CHA's February 2025 Public Comment specifically states that "[w]hile OHCA is singling out hospitals with unattainably low sector targets at far less than general inflation, health insurance companies are increasing consumer premiums by 10% or more annually. . . . Before proceeding, OHCA should clearly state why it is not striving to ensure any strict targets on providers translate into savings for the California residents who pay billions of dollars in premiums to health insurance companies every year." (CHA, public comment to OHCA Board, Feb. 21, 2025, p. 10.) Further, CHA's March 2025 letter argues that OHCA should wait for comprehensive data analysis before making sector decisions and criticizes the proposal for not considering the broader health care system. (CHA, public comment to OHCA Board, Mar. 20, 2025, pp. 1–2.)

274. City of Hope's April 2025 public comment stated: "Any sustainable policy must also acknowledge that hospitals are only one part of the healthcare cost equation. Overall affordability is also shaped by: [c]ommercial payer reimbursement practices, which influence provider behavior and access to care; [p]harmaceutical pricing, especially for specialty drugs that are essential in oncology and other high-acuity fields; [and] [a]dministrative burdens placed on providers, including complex billing systems, prior authorization requirements and delays, and claims denials, which add cost and divert resources away from patient care. We urge OHCA to pursue data-driven, equity-oriented policies that preserve access to advanced care while promoting shared accountability across the healthcare sector." (City of Hope, public comment to OHCA Board, Apr. 9, 2025.)

275. Despite the information provided to them, and the statutory flexibility to slow their process to obtain appropriate data, OHCA sped ahead, focusing solely on a hospital sector,

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without consideration of any other sectors, without sufficient consideration or evidence. Accordingly, OHCA's creation of the hospital sector is also contrary to statute and arbitrary and capricious.

G. <u>OHCA's Methodology for Determining High-Cost Hospitals Is Flawed.</u>

276. OHCA also erred in its creation of the methodology it used to determine which hospitals would be considered "high-cost." In general, OHCA's choice to determine certain hospitals as high-cost, and to assign even lower cost targets to those hospitals, creates an arbitrary, incoherent categorization of hospitals. The methodology OHCA employed to make these high-cost determinations only furthers that arbitrariness. If OHCA seeks to set or adjust a health care target for specific health care entities, it must develop a methodology that takes into account entities' ability to serve populations with greater health care risks. Specifically, the methodology must incorporate (1) risk factor adjustments reflecting the health status of the entity's patient mix (§ 127502(e)(2)(A)), (2) equity adjustments that account for the social determinants of health and other factors related to health equity for the entity's patient mix (§ 125502(e)(2)(B)), and (3) geographic cost adjustments reflecting the relative cost of doing business, including labor costs in the communities the entity operates (§ 12502(e)(2)(C)). Further, methodologies to set cost targets must be based on historical trends and projections for economic indicators, provide differential treatment for 2020 and 2021 given COVID-19, and consider labor costs, trends in health care technology pricing, payer mix, state mandates for capital improvement projects, and more. (§ 127502(d)(2)–(4).) As discussed in footnote 17, there can be no question that OHCA was obligated, in adjusting the hospital cost target downwards for high-cost hospitals, to consider the specific factors outlined in § 127502(d)(4)—"the health care employment cost index, labor costs, the consumer price index for urban wage earners and clerical workers, impacts due to known emerging diseases, trends in the price of health care technologies, provider payer mix, state or local mandates such as required capital improvement projects, and any relevant state and federal policy changes impacting covered benefits, provider reimbursement, and costs."

277. OHCA's methodology for determining high-cost hospitals fails to incorporate these statutorily-required adjustments and is otherwise arbitrary and capricious. As CHA and others

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have told OHCA throughout public comments (see, e.g., CHA, public comment to OHCA Board, Feb. 21, 2025, pp. 3–9), the methodologies selectively ignore basic factors regarding hospital finance, are economically flawed in several ways, and arbitrarily punish hospitals with particular economic circumstances, such as those with large Medicare shortfalls. Further, the data used to assess hospital costs raise serious and unaddressed quality concerns.

1. OHCA's Methodology to Identify High-Cost Hospitals Is Illogical and Incomplete.

278. Fundamentally, both of the methodologies OHCA has chosen to identify high-cost hospitals are flawed and do not account for factors outside of hospitals' control. And, combining the two flawed measures does not address their underlying infirmities.

279. The first measure (the "Commercial Reimbursement Measure") fails to account for underlying economic conditions that heavily influence the cost of providing patient care and thus drive what hospitals must charge commercial payers to remain financially sound. Specifically, this measure disproportionately identifies hospitals operating in particularly high-cost areas of California, wherein health care worker compensation is higher (as is necessary to maintain a strong, stable workforce). (See CHA, public comment to OHCA Board, Feb. 21, 2025, p. 2.)

280. Despite this flaw, the Commercial Reimbursement Measure remarkably does not include an adjustment to take into account differences in the cost of living in geographic areas throughout the State. A standard for identifying high-cost hospitals by comparing costs among hospitals statewide without taking this obvious factor into account is arbitrary on its face. As a result, six of the seven hospitals identified as high-cost are in some of the areas of the state with the highest cost of living and the highest labor costs, including Monterey, Palo Alto, Santa Cruz, Alameda County, and Santa Barbara. Hospitals in these areas necessarily incur higher costs than other hospitals. By way of example, the two major governmental payment programs in California, Medicare and Medi-Cal, adjust payment rates to reflect geographic differences in average wages throughout the state, which result in substantial payment difference depending on a hospital's location.

281. Equally remarkably, as previewed in paragraph 190, *supra*, this measure does not control for payer mix, that is, the relative percentages of sources of reimbursement for the

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hospital's patients. Thus, this measure masks enormous variability among hospitals related to the degree to which commercial payers cross-subsidize losses from government payers. This cross-subsidization is critical for hospitals' abilities to provide care. As CHA told OHCA, "[b]y looking only at hospitals' commercial reimbursement, the measure fails to control for the fact that some hospitals have more financially favorable payer mixes than others; hospitals without this distinct financial advantage need more revenue per commercial patient to cover their costs." (CHA, public comment to OHCA Board, Feb. 21, 2025, pp. 2–3.) Furthermore, "[b]y using this measure without any control for differences among hospitals in their payer mixes, OHCA risks penalizing hospitals for treating disproportionate shares of low-income Medi-Cal patients and elderly Medicare patients and making up their payment shortfalls the only way they can—through higher commercial payments." (*Id.* at 3.) It is irrational to compare net commercial revenue among hospitals for the purpose of identifying high-cost hospitals without taking this factor into account.

282. Hospitals told OHCA that its failure to account for payer mix in the Commercial Reimbursement Measure would create harm. As Marshall Medical Center commented, "we believe the proposed methodology is flawed and the likely outcome of using the proposed methods will be to reduce access to care. For example, your commercial reimbursement calculations do not consider the high cost of delivering care. As others in this meeting mentioned earlier, our expenses, including labor, materials, and supplies, have grown by double digits in the last five years, while our operating margin was a loss in that same period of time. . . . We are very concerned that there is no control in your commercial reimbursement measure methodology for payer mix. As a disproportionate share hospital, our payer mix is 50% Medicare, 25% Medi-Cal, and those payers reimburse us roughly 70 cents on the dollar of the actual cost of care." (Comment by Maya Scheider, Marshall Medical Center, *February 2025 OHCA Board Meeting Recording* (Feb. 25, 2025), 1:45:24–1:47:05.)

283. Third, this first measure ignores outpatient services, which similarly and improperly target hospitals that cross-subsidize relatively unprofitable outpatient services with relatively profitable inpatient services. (See CHA, public comment to OHCA Board, Feb. 21, 2025, pp. 3–4; see also CHA, public comment to OHCA Board, Apr. 11, 2025; California

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Association of Public Hospitals, public comment to OHCA Board, Jan. 24, 2025; California Association of Public Hospitals, public comment to OHCA Board, Feb. 20, 2025; California Children's Hospital Association, public comment to OHCA Board, Apr. 10, 2025; City of Hope, public comment to OHCA Board, Apr. 9, 2025; California Medical Association, public comment to OHCA Board, Apr. 2025; USC Schaeffer Center for Health Policy & Economics, public comment to OHCA Board, Apr. 2025; District Hospital Leadership Forum, public comment to OHCA Board, Apr. 11, 2025.)[22]

284. Accordingly, in contrast with statutory obligations to consider and adjust for various factors that impact costs, this measure penalizes hospitals for operating in high-cost areas and paying workers accordingly and myopically focuses on a small subset of patients and services. This error also ignores OHCA's statutory obligations to prioritize access, equity, quality, and workforce stability. As one commenter asked in an April 2025 public comment: "Please explain how the "high cost" measures account for key external factors affecting hospitals and data accuracy, as the County is concerned about enacting policies with sweeping consequences for local patients and healthcare workers." (Mitch Mashburn, public comment to OHCA Board, Apr. 18, 2025.)

285. While the second measure ostensibly controls for variations in hospitals' operating costs, the ratio penalizes hospitals with worse Medicare reimbursement. As a result, the validity of this model depends on the accuracy and appropriateness of Medicare payment policies, which is an unfounded assumption, as payment policies cause a significant portion of Medicare funding losses. (See CHA, public comment to OHCA Board, Feb. 21, 2025, p. 5; see also CHA, public comment to OHCA Board, Apr. 22, 2025.) Medicare payment methodologies are quite complex and idiosyncratic, with various adjustments that may result in greater Medicare shortfalls

[22] Should OHCA take the novel position that it defined a separate high cost hospital sector (despite not promulgating an emergency regulation for such a sector), OHCA's methodology would still be flawed. In addition to the obligations discussed throughout this petition that apply to both the setting and adjusting of cost targets, when defining health care sectors, the Board must consider "factors such as delivery system characteristics." (§ 127502(*l*)(2)(A).) By failing to account for the fact that the costs of some services cross-subsidize others, the OHCA Board wholly failed to consider factors such as delivery system characteristics.

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for some hospitals as compared to others for reasons that have nothing to do with a hospital's efficiency or quality. For instance, as CHA commented, distortions and idiosyncrasies in Medicare payment policies often occur "as a result of budget neutrality requirements in federal law that have the effect of redistributing funding from some hospitals to others." (CHA, public comment to OHCA Board, Feb. 21, 2025, p. 4.) Accordingly, this methodology punishes those hospitals with large Medicare shortfalls, as the ratio of such hospitals' net commercial patient revenue per case to the Medicare net revenue per case will be higher, just because the hospitals have suffered a greater Medicare shortfall, not because the hospital's revenue from commercial payers is unjustifiably high as compared to other hospitals. (*Id.* at 4–5.) And, even if a hospital that receives lower Medicare payments does have higher commercial payer revenue, this is an indication that the hospital is doing what it must to make up for a Medicare shortfall, not an indication that the hospital is a "high cost" hospital.

2. OHCA's Methodology to Discern High-Cost Hospitals Relies on Flawed Data.

286. Further, multiple comments raised concerns about the quality and appropriateness of the underlying data used to assess hospital costs and ultimately set cost targets. (See paragraph 268, *supra*.)

287. First, to discern hospital spending OHCA used hospital financial reports from 2018–2022, which contain extremely limited and unreliable data, including those altered by the peak of COVID-19. As discussed in paragraphs 49, 205, and 228, data from the COVID-19 years is aberrational, so much so that the Legislature determined such data should be provided differential treatment when used to calculate cost targets. (§ 127502(d)(3).)

288. Further, commenters have also noted that, as even HCAI staff and OHCA Board members have acknowledged, the data show a lack of clear and consistent patterns. (See, e.g., Montage Health, public comment to OHCA Board, Jan. 18, 2025.) Montage Health called the result of OHCA's analyses "a study in the power of creative statistics." (*Ibid.*)

289. Several comments also highlighted concerns about data quality, specifically introducing concerns that entities (such as CHA) have at times been unable to replicate OHCA's results (See Comments by Victoria Valencia, *April 2025 OHCA Board Meeting Recording*

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at3:48:33, see also CHA, public comment to OHCA Board, Apr. 11, 2025.). As discussed in paragraph 78, one OHCA Board member also expressed concerns about this data replication issue. (See Comments by Board Member Pan, *April 2025 Board Meeting Recording* at 3:02:47–3:03:29 ["One of the things that did come up which actually disturbed me a bit is the hospital association also testified that they can't seem to rerun the numbers and get the same results . . . That's the strength of the data and the transparency of the data that we're using. . . . I mean they testified they weren't able to duplicate it. So that's a little concerning."]

290. Further, as discussed in paragraph 78, OHCA made several methodological choices to exclude hospitals from the high-cost list if they had decreasing values for two consecutive years on the two financial measures or if hospitals were below the 30th percentile in annual discharges.

291. The OHCA Office itself acknowledged in the June 2025 Board meeting that it found a data coding error that was made in the methodology for identifying the high-cost hospitals. (See OHCA, *June 2025 Board Meeting Minutes* (June 9, 2025), p. 3.) While OHCA states this error did not impact the ultimate set of hospitals it deemed to be high-cost, this further emphasizes how OHCA's decisions were made too quickly, without sufficient data and measured deliberation.

292. Again, OHCA's action to incoherently distinguish between hospitals and apply a lower cost target to some hospitals is arbitrary and unlawful. For all of the reasons in this section, the methodology OHCA used to select which hospitals would be considered "high-cost" is, and compounds, the unlawfulness and arbitrariness of OHCA's actions.

H. <u>OHCA's High-Cost Hospital Methodology Constitutes an Underground Regulation.</u>

293. OHCA's methodology for selecting high-cost hospitals is unlawful for a further reason.

294. In OHCA's enabling statute, the legislature exempted only "the adoption of cost targets under this section" from the APA. (§ 127502(n); see also Gov't Code § 11346.) And the statute says that the methodology for setting cost targets "for an individual health care entity" shall "[a]llow for the setting of cost targets based on the entity's status as a high-cost outlier," and "shall allow the board to adjust cost targets downward, when warranted, for health care entities

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that deliver high-cost care that is not commensurate with improvements in quality." (§ 127502(e)(1), (d)(6)(A).)

295. While the Legislature has exempted the adoption of cost targets from APA requirements, the Legislature did not exempt OHCA's action and methodology of defining "high-cost hospitals." This action is an underground regulation and thus invalid.[23]

296. Specifically, the OHCA Board's establishment of the categorical definition "high-cost hospitals" and application of a cost target to all hospitals meeting this definition is an underground regulation because (1) the Board has generally applied this definition to all hospitals falling within its self-created criteria, and (2) the Board's criteria are not based in statute but rather "interpret" or "make specific the law." (See *Tidewater Marine Western, Inc. v. Bradshaw* (1996) 14 Cal.4th 557, 571.)

297. Moreover, the Board has not established its definition for "high-cost hospitals" in accordance with APA requirements. The Board *did* follow APA emergency regulation requirements in establishing a definition for the "Hospital Sector," which it defined as including "general acute care hospitals," "acute psychiatric hospitals," "special hospitals," "chemical dependency recovery hospitals," and "psychiatric health facilities." (See Cal. Code Regs., tit. 22, § 97446; see also Office of Administrative Law, *File Number 2025-0411-01E, "Hospital Sector Definition"* (April 21, 2025).) The Board's actions therefore evidence that it understands the process required when establishing a categorical definition to which cost targets would be generally applied and heeded the Legislature's command under Section 127502(b)(1) that such sectors are defined through regulation. However, when defining "high-cost hospitals" for differential treatment the Board chose to not follow this mandatory process. Accordingly, the Board's action establishing this category and applying a 1.8% cost target to the category separate from the 3.5% cost target otherwise applied to all other hospitals in the same sector is an

[23] And, even if the Legislature did *not* exempt OHCA's actions described here (which CHA does not concede is the case), the statute also explicitly requires the definition of any "health sectors" to be issued through the regulatory process. (§ 127502(b)(1).) Thus, the Board was required either under the APA or the OHCA statute to promulgate regulations here in defining "high-cost hospitals."

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underground regulation and is void.

1. OHCA's High-Cost Hospital Target Category Is Generally Applied.

298. An agency rule which "declares how a certain class of cases will be decided" is a rule which applies generally and is subject to APA requirements. (*Tidewater Marine Western, Inc. v. Bradshaw* (1996) 14 Cal.4th 557, 571.) Agency "interpretations that arise in the course of case-specific adjudication are not regulations." (*Ibid.*)

299. OHCA here has created a rule which applies generally to a class of hospitals which meet the criteria listed in its April 22, 2025 Board Meeting slides. The generally applied rule is: if a hospital in California is (1) above the 85th percentile for three out of five years from 2018–2022 on Commercial Inpatient NPR per CMAD and Commercial to Medicare PTCR (but *do not* have decreasing values for two consecutive years which results in the hospital falling below the 85th percentile in 2022), (2) above the 30th percentile in annual discharges, (3) has a payer mix threshold of 5%, and (4) has comparable financial data in the HCAI Hospital Annual Disclosure Reports, this hospital will automatically be defined as a "high-cost hospital." OHCA is not considering the facts and circumstances of each individual hospital in deciding which cost target to apply—it is instead generally applying an automatic standard to govern its procedures and therefore meets the first prong of the underground regulation test.

2. OHCA's High-Cost Hospital Target "Interprets" or "Makes Specific" the Law.

300. An agency rule "must 'implement, interpret, or make specific the law enforced or administered by [the agency], or ... govern [the agency's] procedure.'" (*Tidewater Marine Western, Inc. v. Bradshaw* (1996) 14 Cal.4th 557, 571.) A regulation is not subject to APA requirements if it is "[a] regulation that embodies the only legally tenable interpretation of a provision of law." (Gov't. Code, § 11340.9(f).)

301. Here, OHCA's creation of a separate definition for high-cost hospitals and application of a separate cost target to this category is clearly not the only legally tenable interpretation of the OHCA statute and was adopted contrary to OHCA's statutory authority. Thus, in the absence of an applicable exemption beyond the adoption of cost targets, OHCA's actions here constitute rules that are subject to APA requirements. (See *Tidewater Marine*

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Western, Inc. v. Bradshaw (1996) 14 Cal.4th 557, 571; see also Gov't Code, § 11342.600.)

3. The High-Cost Hospital Criteria Was Not Promulgated in Accordance with the APA.

302. Finally, OHCA's actions are improper as they were not promulgated in accordance with APA requirements. Agencies are required to follow a series of procedural steps when promulgating a generally-applicable regulation. "[T]he APA establishes basic minimal procedural requirements for rulemaking in California. . . . 'Pursuant to those procedural requirements, agencies must, among other things, (1) give the public notice of the proposed regulatory action; (2) issue a complete text of the proposed regulation with a statement of reasons for it; (3) give interested parties an opportunity to comment on the proposed regulation; (4) respond in writing to public comments; and (5) maintain a file as the record for the rulemaking proceeding.'" (*John R. Lawson Rock & Oil, Inc. v. State Air Resources Bd.* (2018) 20 Cal.App.5th 77, 111; see also Gov't Code, § 11340 et seq.) In addition, state agencies are generally required to submit proposed regulations to the Office of Administrative Law (OAL), along with statutorily required information, as part of the overall rulemaking process. (See Gov't Code, §§ 11346.2, 11340 et seq.)

303. OHCA has failed to complete several of these procedural requirements, including providing a statement of reasons for its establishment of a "high-cost hospital" definition or responding in writing to public comments and filing any proposed regulations with OAL. OHCA's actions are thus an underground regulation, in violation of the APA, and are void as such. (*Tidewater Marine Western, Inc. v. Bradshaw* (1996) 14 Cal.4th 557, 561 ["We conclude that these interpretive policies do constitute regulations and therefore are void because they were not adopted in accordance with the APA."].

FIRST CAUSE OF ACTION

Writ of Mandamus – Code of Civil Procedure Section 1085

304. Petitioner refers to and incorporates all paragraphs above as though fully set forth herein at length.

305. Relief in mandamus is authorized by Code Civ. Proc. section 1085 in order to

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compel the performance of (1) a clear, present, and ministerial duty where (2) the petitioner has a beneficial interest in the performance of that duty. (*City of Dinuba v. County of Tulare* (2007) 41 Cal.4th 859, 868, citations omitted.) Although the issuance of a writ is often described as "discretionary," when these two requirements are met, the petitioner "is entitled as a matter of right to the writ, or, in other words, it would be an abuse of discretion to refuse it." (*May v. Board of Directors of El Camino Irr. Dist.* (1949) 34 Cal.2d 125, 133-34, citations omitted.)"

306. A "traditional" writ of mandate may be issued under Code of Civil Procedure § 1085 "to compel the performance of an act which the law specifically enjoins, as a duty resulting from an office, trust, or station, or to compel the admission of a party to the use and enjoyment of a right or office to which the party is entitled, and from which the party is unlawfully precluded by such inferior tribunal, corporation, board, or person." (Code Civ. Proc., § 1085.) It is fundamental that "mandamus will lie to compel a state official to perform a ministerial act." (8 Witkin, Cal. Proc., 5th (2020) Writs, § 85; see *Ellena v. Department of Ins.* (2014) 230 Cal.App.4th 198, 211 [reversing trial court's sustaining of demurrer to mandamus claims where insurance commissioner did not fulfil its ministerial duty to review a policy prior to approving it]; see also *Great Western Sav. & Loan Assn. v. City of Los Angeles* (1973) 31 Cal.App.3d 403, 414–15 [city council had ministerial duties related to approval of subdivision tract maps, and writ was properly issued to compel performance of the ministerial acts].)

307. In addition, under California law, mandamus can and should lie to correct an agency's abuse of discretion. "'Although traditional mandamus will not lie to compel the exercise of discretion in a particular manner, it is a proper remedy to challenge agency discretionary action as an abuse of discretion.'" (*Crestwood Behavioral Health, Inc. v. Baass* (2023) 91 Cal.App.5th 1, 16, *reh'g denied* (May 23, 2023) (quoting *CV Amalgamated LLC v. City of Chula Vista* (2022) 82 Cal.App.5th 265, 279.) An abuse of discretion in connection with an agency rulemaking will lie where the agency has failed to consider the relevant factors or has not "demonstrated a rational connection between those factors, the choice made, and the purposes of the enabling statute." (*California Hotel and Motel Ass'n v. Industrial Welfare Commission* (1970) 25 Cal.3d 200, 213 [en banc].)

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308. Here, a writ of mandamus should lie to correct OHCA's failure to follow its mandatory duties to promote access, equity, and quality of health care (including primary care and behavioral health care) and workforce stability in its enactment of each of (a) the statewide cost target (as applied to all healthcare entities, including hospitals and payers), (b) the hospital sector cost target, and (c) the high-cost hospital cost target. As discussed at length above, OHCA failed to promote and maintain these factors when adopting each of these cost targets, and the record reflects that each cost target, rather than promoting these factors, will be inimical to them in violation of OHCA's mandatory duties. (See §§ 127500.5(a)(7)–(8), (c), (d), (e), (g), (h), (o)(1); 127502(b)(3), (c)(5)–(7), (d)(2)–(7), (e); 127505(a), 127506.) Each cost target is therefore ultra vires and should be set aside.

309. Further, mandamus should lie because Respondents have acted arbitrarily and capriciously and abused their discretion in establishing each of the three cost targets at issue, for the following reasons:

a. Respondents have failed to adequately consider and promote access, equity, quality, and workforce stability in connection with the establishment of cost targets, as discussed in detail above.

b. Respondents have failed to demonstrate a reasonable connection between these factors and their decisions to promulgate each of the three cost targets at issue in that the record before Respondents when the cost targets were issued demonstrated that the targets will not promote access, quality, and workforce stability, but will be inimical with respect to these factors, as detailed above.

c. Each of the three cost targets at issue were not supported by the record before Respondents at the time each cost target was adopted, including public comments and comments from the Advisory Committee which Respondents are obligated by law to consider. (See §§ 127501.11(a);127501.12(d) [obligations to consider input from Advisory Committee and Public Comments].) Rather, the record demonstrates that each cost target will be adverse to considerations of access, equity, quality, and workforce stability, as detailed above.

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310. A writ of mandamus is also appropriate because Respondents, in creating the three cost targets at issue, failed to comply with their mandatory duties to create cost targets that are informed by historical cost data and economic indicators, and that are calculated using a methodology that provides differential treatment of 2020 and 2021 due to impacts of COVID-19 on health care spending, and that considers potential relevant factors, including but not limited to labor costs, health care technology costs, and state or local mandates, such as required capital improvement projects, and any relevant state and federal policy changes impacting covered benefits, provider reimbursement, and costs. (See §§ 127502(b)(3), (c)(2), (d)(3), (d)(4).)

311. A writ of mandate should also be issued to correct Respondents' abuses of its discretion in adopting the hospital sector. As discussed above, Respondents acted arbitrarily and capriciously and abused their discretion in adopting the regulations establishing a hospital sector. Respondents acted prematurely in establishing a hospital sector and a hospital sector target, well before the statutory deadline, and well before they had adequate information on which to base the establishment of this sector and the sector target. Accordingly, Respondents arbitrarily and irrationally singled out hospitals for the establishment of a sector, while ignoring payers and all other subject health care entities, without evidence to do so.

312. Further, a writ of mandamus should lie to correct Respondents' abuse of discretion and its failure to follow legally required processes in its designation of certain hospitals as "high-cost" and assignment of even lower cost targets to those hospitals. Respondents have adopted a methodology that is arbitrary and capricious in that it fails to take into account relevant factors and is reliant on flawed data. Respondents have not demonstrated a reasonable connection between the high-cost hospital criteria and the identification of hospitals with unjustifiably high commercial revenue so that revenue increases may reasonably be capped at rates much lower than other hospitals and that are much lower than the rate of inflation the hospitals will unavoidably face. As discussed above, the high-cost hospital methodology relies on two measures. The first measure, based on the relative NPR per CMAD among hospitals, fails to take into account critical factors, such as the difference among geographic areas in the cost of living and employee wages, as well as differences in governmental payer utilization among hospitals and the amount of

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governmental reimbursement shortfall a hospital must make up through commercial payer revenue. The second measure, based on the ratio of Medicare revenue cost coverage to commercial payer cost coverage, fails to take into account the various complexities of the Medicare reimbursement system, wherein hospitals may have a lower or higher Medicare cost coverage ratio for reasons that have nothing to do with hospital efficiency or quality, and arbitrarily penalizes hospitals where Medicare covers a low percentage of hospital costs requiring hospitals to make up the unreimbursed costs from commercial payers. Imposing a very low cost target on such hospitals exacerbates the problem created by low Medicare rates, as hospitals that have the largest need to shift unreimbursed Medicare costs to commercial payers will be the most restricted on their ability to do so, leaving them with no means of covering unreimbursed Medicare costs apart from substantial reductions to costs which would undoubtedly impact the hospital's ability to provide its current level of accessible high quality care in a manner that promotes health equity, and would create instability in the workforce as reduction in labor costs would be inevitable.

313. In addition, the high-cost hospital methodology is improper and unlawful because Respondents adopted it as an underground regulation without following the mandated process for adopting regulations set forth in the APA. "Whether an agency's practices amount to the enforcement of an underground regulation may be challenged through an action in mandamus pursuant to Code Civ. Proc. section 1085." (*Union of American Physicians & Dentists v. Kizer* (1990) 223 Cal.App.3d 490, 495.)

314. Finally, a writ of mandate should lie to correct OHCA's failure to follow the federal and California constitutions in creating cost targets that facially violate the Takings and Substantive Due Process clauses, as set forth in paragraphs 230–240 above. And, a writ of mandamus should lie to prohibit OHCA from enforcing its cost targets against hospitals without cogently articulating how it will assess compliance with the cost targets, which violates Procedural Due Process, as set forth in paragraphs 241–249. (See *People for Ethical Operation of Prosecutors etc. v. Spitzer* (2020) 53 Cal.App.5th 391, 410, as modified (Sept. 8, 2020) [concluding plaintiffs had standing to pursue their claims for a writ of mandate where the

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complaint described a program "in flagrant disregard of the government's constitutional duties and limitations."].)

315. CHA has no plain, speedy, or adequate remedy at law to resolve CHA's claims in this Petition and Complaint. There is no other process to seek a remedy for Respondents' actions. Neither the Act nor regulations promulgated by OHCA include an administrative appeal process or any other adequate process to challenge the cost targets, establishment of a hospital sector, and the high-cost hospital methodology adopted by Respondents.

SECOND CAUSE OF ACTION

Declaratory Relief -- Code of Civil Procedure Section 1060

316. Petitioner refers to and incorporates all paragraphs above as though fully set forth herein at length.

317. Declaratory relief is warranted in this matter.

318. Declaratory relief is authorized under Code Civ. Proc. section 1060 in order that any person "who desires a declaration of his or her rights or duties with respect to another . . . may, in cases of actual controversy relating to the legal rights and duties of the respective parties, bring an original action or cross-complaint in the superior court for a declaration of his or her rights and duties in the premises, including a determination of any question of construction or validity arising under the instrument or contract." (Code Civ. Proc., § 1060.)

319. "In an action for declaratory relief, a complaint is sufficient if it sets forth facts showing the existence of an actual controversy relating to the legal rights and duties of the respective parties and requests that the rights and duties be adjudged. (See *Tiburon v. Northwestern Pac. R. Co.* (1970) 4 Cal.App.3d 160, 170; see also *California Assn. of Health Facilities v. Department of Health Services* (1997) 16 Cal.4th 284, 290 [finding that a court "will not decide the correctness of an administrative agency's construction of a statute unless the party requesting relief has been cited or in some way concretely penalized by the agency based on that purportedly erroneous construction."].) Any doubts regarding the propriety of declaratory relief "generally are resolved in favor of granting relief." (*Osseous Technologies of America, Inc. v. DiscoveryOrtho Partners, LLC* (2010) 191 Cal.App.4th 357, 364.)"

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320. An actual controversy has arisen and now exists concerning the legality of OHCA, the OHCA Board, and other Respondents' conduct.

321. Respondents have acted illegally here because Respondents' (1) establishment of the statewide cost target (as applied to healthcare entities, including hospitals and payers), (2) creation of a hospital sector, (3) establishment of a hospital sector cost target, (4) adopted methodology to determine high-cost hospitals, and (5) establishment of a high-cost hospital cost target are contrary to law and arbitrary and capricious for all of the reasons set forth above.

322. Respondents have also acted illegally here because Respondents' confiscatory cost targets are unconstitutional.

323. Respondents have also acted illegally here because Respondents unlawfully promulgated a methodology to designate hospitals as "high-cost" hospitals without complying with the APA.

324. A declaration that OHCA's (1) establishment of the statewide cost target, (2) creation of a hospital sector, (3) establishment of a hospital sector cost target, (4) adopted methodology to determine high-cost hospital criteria, and (5) establishment of a high-cost hospital cost target are improper, arbitrary and capricious, and contradict the mandates set out in OHCA's enabling statute and the federal and California Takings and Due Process Clauses will avoid a multiplicity of actions.

325. For the reasons stated above, Petitioner has standing to seek the requested declaratory relief.

326. Accordingly, declaratory relief is not only appropriate to resolve this matter but is the *most appropriate and necessary* means to achieve resolution of this longstanding dispute. (See *Bess v. Park* (1955) 132 Cal.App.2d 49, 52–53 ["judicial economy strongly favors the use of declaratory relief to avoid a multiplicity of actions to challenge [an agency's] statutory interpretation or alleged policies."]; see also *Union of American Physicians and Dentists v. Kizer* (1990) 223 Cal.App.3d 490, 503.) In actions almost identical to the current matter declaratory relief has been established as the correct and most favored remedy to be sought. (See *Venice Town Council, Inc. v. City of Los Angeles* (1996) 47 Cal.App.4th 1547, 1566, as modified

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on denial of reh'g (Aug. 22, 1996) ["[A]ppellants' action has a more fundamental purpose. *They do not challenge any particular decision or order. . . .* Instead, appellants seek to resolve the City's fundamental misunderstanding of its responsibilities under the Mello Act *to avoid continued violations or nonenforcement in the future.* Declaratory relief has been held to be the proper remedy when it is alleged an agency has a policy of ignoring or violating applicable laws . . . *judicial economy strongly favors the use of declaratory relief to avoid a multiplicity of actions to challenge the City's statutory interpretation or alleged policies. As against the piecemeal review of similar issues by individual challenges to specific permit applications, the present action appears singularly economical.*"] [emphasis added] [citation modified].)

PRAYER

WHEREFORE, the Petitioner respectfully requests the Court to issue an Order:

1. Declaring improper and unlawful Respondents' establishment of the statewide cost target, creation of a hospital sector, establishment of a hospital sector cost target, adopted methodology to determine high-cost hospitals, and establishment of a high-cost hospital cost target;
2. Declaring unconstitutional Respondents' confiscatory cost targets;
3. Declaring unconstitutional Respondents' enforcement of cost targets without an articulation of how it will assess compliance;
4. Prohibiting Respondents from applying the statewide cost target to healthcare entities, including hospitals and payers;
5. Prohibiting Respondents from implementing a hospital sector;
6. Prohibiting Respondents from applying the hospital sector cost target to hospitals;
7. Prohibiting Respondents from employing their unlawfully promulgated methodology to designate hospitals as "high-cost" hospitals;
8. Declaring void and setting aside the Respondents' unlawfully promulgated methodology to designate hospitals as "high-cost" hospitals;
9. Prohibiting Respondents from applying the high-cost hospital cost target to any hospitals;

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10. Prohibiting Respondents from implementing unconstitutionally confiscatory cost targets to hospitals;

11. Prohibiting Respondents from unconstitutionally enforcing any cost targets without a cogent articulation of how it will assess compliance with cost targets;

12. For the costs of suit, including reasonable attorneys' fees pursuant to Code Civ. Proc., § 1021.5 or as otherwise appropriate; and

13. Such other and further relief as the Court deems appropriate.

DATED: April 2, 2026

HOOPER, LUNDY & BOOKMAN, P.C.

By: *s/ Lloyd A. Bookman*

LLOYD A. BOOKMAN
ALICIA W. MACKLIN
ERIN R. SCLAR
M.H. JOSHUA CHIU

Attorneys for California Hospital Association

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VERIFICATION

I am the [redacted] and am authorized to make this verification for and on its behalf. The facts alleged specific to [redacted] in the **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** are within my personal knowledge as [redacted] and are not known to the California Hospital Association ("CHA"). Therefore, I am better informed than CHA to make such verification here.

I have read the portions of the **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** related to [redacted], and know the contents. The matters stated in the following paragraph are true based on my own knowledge, except as to those matters stated on information and belief, and as to those matters I believe them to be true: paragraph 129.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on March 30, 2026, at [redacted], California.

[redacted]

Print Name of Signatory

[redacted]

Signature

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[redacted]

VERIFICATION

I am the [redacted] and am authorized to make this verification for and on its behalf. The facts alleged specific to [redacted] in the **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** are within my personal knowledge as [redacted] and are not known to the California Hospital Association ("CHA"). Therefore, I am better informed than CHA to make such verification here.

I have read the portions of the **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** related to [redacted], and know the contents. The matters stated in the following paragraph are true based on my own knowledge, except as to those matters stated on information and belief, and as to those matters I believe them to be true: paragraph 128.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on March 31, 2026, at [redacted], California.

[redacted] [redacted]

Print Name of Signatory Signature

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VERIFICATION

I am the [redacted] and am authorized to make this verification for and on its behalf. The facts alleged specific to [redacted] in the **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** are within my personal knowledge as [redacted] and are not known to the California Hospital Association ("CHA"). Therefore, I am better informed than CHA to make such verification here.

I have read the portions of the **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** related to [redacted] and know the contents. The matters stated in the following paragraph are true based on my own knowledge, except as to those matters stated on information and belief, and as to those matters I believe them to be true: paragraph 130.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on March 31, 2026, at [redacted], California.

[redacted]

Print Name of Signatory

[redacted]

Signature

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[redacted]

VERIFICATION

I am the [redacted] and am authorized to make this verification for and on its behalf. The facts alleged specific to [redacted] in the **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** are within my personal knowledge as [redacted] and are not known to the California Hospital Association ("CHA"). Therefore, I am better informed than CHA to make such verification here.

I have read the portions of the **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** related to [redacted] and know the contents. The matters stated in the following paragraph are true based on my own knowledge, except as to those matters stated on information and belief, and as to those matters I believe them to be true: paragraph 132.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on March 31, 2026, at [redacted], California.

[redacted]

Print Name of Signatory

[redacted]

Signature

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VERIFICATION

I am the [redacted] and am authorized to make this verification for and on its behalf. The facts alleged specific to [redacted] in the **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** are within my personal knowledge as [redacted] and are not known to the California Hospital Association ("CHA"). Therefore, I am better informed than CHA to make such verification here.

I have read the portions of the **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** related to [redacted], and know the contents. The matters stated in the following paragraph are true based on my own knowledge, except as to those matters stated on information and belief, and as to those matters I believe them to be true: paragraph 134.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on March 31, 2026, at [redacted], California.

[redacted]

Print Name of Signatory

[redacted]

Signature

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VERIFICATION

I am the [redacted] and am authorized to make this verification for and on its behalf. The facts alleged specific to [redacted] in the **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** are within my personal knowledge as [redacted] and are not known to the California Hospital Association ("CHA"). Therefore, I am better informed than CHA to make such verification here.

I have read the portions of the **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** related to [redacted] and know the contents. The matters stated in the following paragraph are true based on my own knowledge, except as to those matters stated on information and belief, and as to those matters I believe them to be true: paragraph 135.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on April 1, 2026, at [redacted], California.

[redacted]

[redacted]
Print Name of Signatory

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VERIFICATION

I am the [redacted] and am authorized to make this verification for and on its behalf. The facts alleged specific to [redacted] in the **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** are within my personal knowledge as [redacted] and are not known to the California Hospital Association ("CHA"). Therefore, I am better informed than CHA to make such verification here.

I have read the portions of the **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** related to [redacted], and know the contents. The matters stated in the following paragraph are true based on my own knowledge, except as to those matters stated on information and belief, and as to those matters I believe them to be true: paragraph 133.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on April 1, 2026, at [redacted], California.

[redacted]

Print Name of Signatory

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[redacted]

VERIFICATION

I am the [redacted] and am authorized to make this verification for and on its behalf. The facts alleged specific to [redacted] in the **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** are within my personal knowledge as [redacted] and are not known to the California Hospital Association ("CHA"). Therefore, I am better informed than CHA to make such verification here.

I have read the portions of the **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** related to [redacted], and know the contents. The matters stated in the following paragraph are true based on my own knowledge, except as to those matters stated on information and belief, and as to those matters I believe them to be true: paragraph 131.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on April 1, 2026, at [redacted], California.

[redacted] [redacted]

Print Name of Signatory Signature

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VERIFICATION

I am the Group Vice President, Financial Policy of California Hospital Association ("CHA") and am authorized to make this verification for and on its behalf. The facts alleged are within my personal knowledge as CHA's Group Vice President, Financial Policy, and I am therefore better informed than the organization itself and other CHA officers or employees. I am and have been at all relevant times responsible on behalf of CHA regarding the actions of the Office of Health Care Affordability ("OHCA") with respect to cost targets that are challenged in the foregoing **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]**. In that capacity, I have attended or reviewed materials from all OHCA Board meetings, have been principally responsible for CHA's public comments to OHCA regarding such actions, have reviewed publicly available OHCA material regarding the cost targets, and have reviewed public comments regarding the cost targets.

I have read the foregoing **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]**, and know the contents, except as to paragraphs 128 through 136. The matters stated in the foregoing document are true based on my own knowledge, except as to paragraphs 128 through 136, and those matters stated on information and belief including specifically the paragraphs and sentences listed below, and as to those matters I believe them to be true.

Matters stated in the following paragraphs and sentences are stated on information and belief: 54 (first sentence), 110 (second sentence), 115, 117, 118–120, 122-123, 127, 139(b), 144, 146–149 (with the exception of footnote 12), 152, 178–179, 193–194, 196, 198 (first sentence), 209 (first sentence), 212–213, 216, 229–230, 232, 240–241, 246–250, 253, 256, 257 (first sentence), 264 (first sentence), 266–267, 270, 275, 276–278, 279 (first sentence), 280 (second sentence), 281 (final sentence), 284 (first two sentences), 285 (final sentence), 287 (first sentence), 292–293, 295, 297, and 303–326.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on April 2, 2026, at Sacramento, California.

Benjamin Johnson
Print Name of Signatory

Signature

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PROOF OF SERVICE

CHA v. OHCA et al.
Case No. CPF-25-519370

STATE OF CALIFORNIA, COUNTY OF SAN DIEGO

At the time of service, I was over 18 years of age and not a party to this action. I am employed in the County of San Diego, State of California. My business address is 101 W. Broadway, Suite 1200, San Diego, CA 92101.

On April 2, 2026, I served true copies of the following document(s) described as **FIRST AMENDED VERIFIED PETITION FOR WRIT OF MANDATE [C.C.P. § 1085]; FIRST AMENDED COMPLAINT FOR DECLARATORY RELIEF [C.C.P. § 1060]** on the interested parties in this action as follows:

David Houska
Sophia T. Tonnu
Malinda Lee
Deputy Attorneys General
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Tel: (415) 510-3374
Fax: (415) 703-1107
E-mails:
David.Houska@doj.ca.gov
Sophia.TonNu@doj.ca.gov
Malinda.Lee@doj.ca.gov

BY E-MAIL OR ELECTRONIC TRANSMISSION: I caused a copy of the document(s) to be sent from e-mail address mhampshire@hooperlundy.com to the persons at the e-mail addresses listed in the Service List. I did not receive, within a reasonable time after the transmission, any electronic message or other indication that the transmission was unsuccessful.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on April 2, 2026, at San Diego, California.

/s/ Meghan A. Hampshire
Meghan A. Hampshire