May 21, 2026

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

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

Dear Chair Johnson:

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

- How OHCA will measure performance against the spending targets **currently in effect** remains unclear.
- OHCA risks undercutting legislative protections that ensure entities have meaningful opportunities to improve their spending performance prior to the imposition of monetary penalties.
- Penalties at the astronomical levels recommended by OHCA would undermine hospital care and endanger patients' access to care — the exact opposite of OHCA's stated goals.

Further detail on each of these concerns is provided below.

Clarity Needed on How Performance Against the Spending Targets Will Be Measured

The first enforceable spending target is now in effect (in fact, it has already concluded for any hospital whose fiscal year ended on March 31).[1] For the more than 150 hospitals with fiscal years ending on June 30, the first enforceable spending target year will end in less than six weeks. And yet, hospitals still do not know how their spending growth will be assessed against the targets, nor do they have confidence that OHCA's methodologies will accurately reflect year-over-year changes in the components of spending that are within their control. While OHCA's approach has positive and essential features, it has yet to be validated. Many

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

outstanding questions must be addressed to assure hospitals that their efforts to comply with OHCA's spending limits will be successful; absent that clarity, hospitals making good faith efforts to comply may still find themselves caught in the enforcement process. **To firmly resolve these outstanding ambiguities, the enforcement regulations promulgated this year must clearly specify how OHCA will measure hospitals against the spending targets.**

Volume and Intensity Adjustments Are Essential

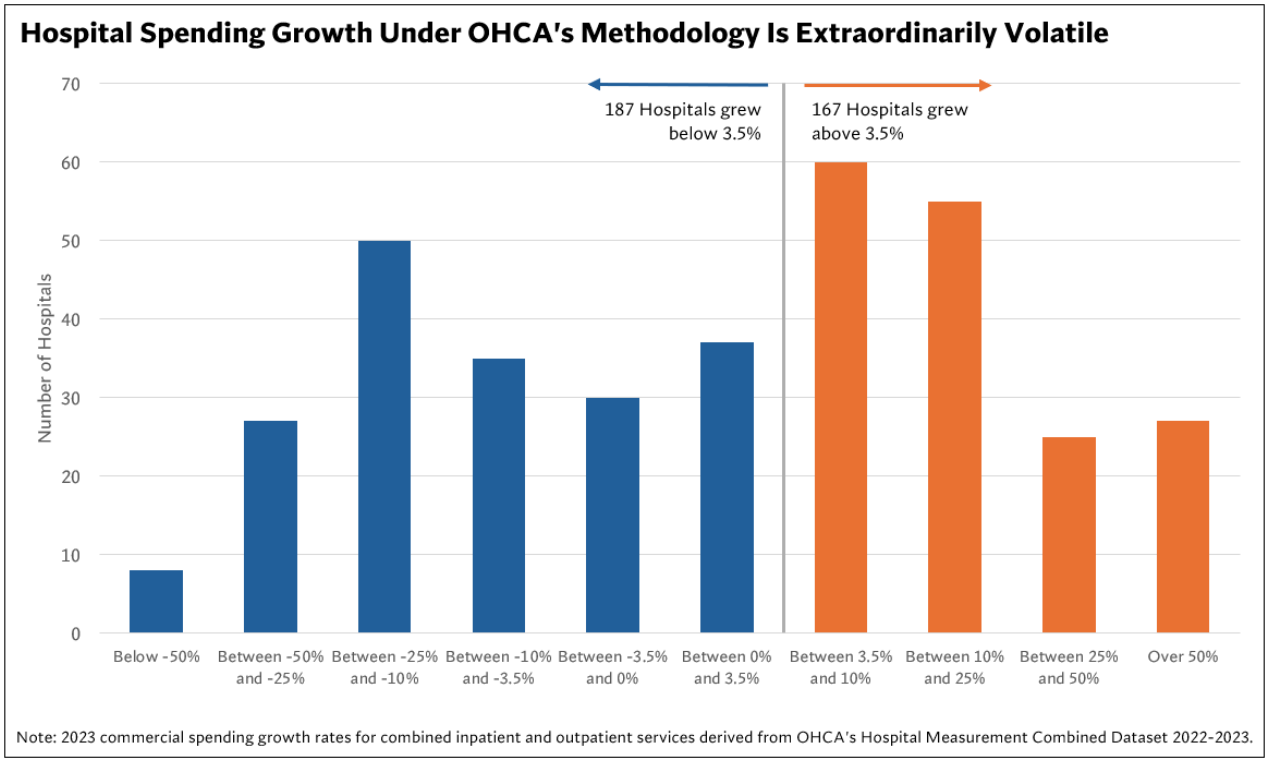
OHCA has spent more than a year developing its approach for measuring hospital spending growth with the help of a dedicated workgroup. The resulting methodology has essential features that aim to prevent fluctuations in volume and service intensity from biasing determinations of whether hospitals exceeded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

Further Testing of Hospital Spending Methodology Is Needed

While conceptually promising, more work is needed to validate OHCA's approach for measuring hospital spending, particularly with respect to how OHCA plans to estimate intensity for outpatient services. Its approach utilizes a new and incomplete data source — the Healthcare Payments Database — that only covers 20% of hospital-reported commercial outpatient visits statewide. For many hospitals, the coverage is likely even lower. Although OHCA has shown that there are strong correlations between a hospital's commercial and all-payer intensity scores, the deviations between these two values can be very large, regularly above 30%. Without a fix, OHCA will routinely mismeasure true spending growth and take enforcement action against hospitals based on these mismeasurements. Before this approach is used to hold hospitals accountable against the spending targets, further testing is needed. Even with improvements, the approach will not fully capture annual fluctuations in patient needs. OHCA will have to work closely with hospitals that exceed their target to determine whether unmeasured changes in service intensity are a driving factor that provides a reasonable basis for that excess growth. However, solidifying the measurement approach up front will save OHCA from having to engage dozens of hospitals within the enforcement process on justifiable reasons they exceeded their target.

Assess Hospital Compliance Against the Spending Targets on a Multiyear Basis

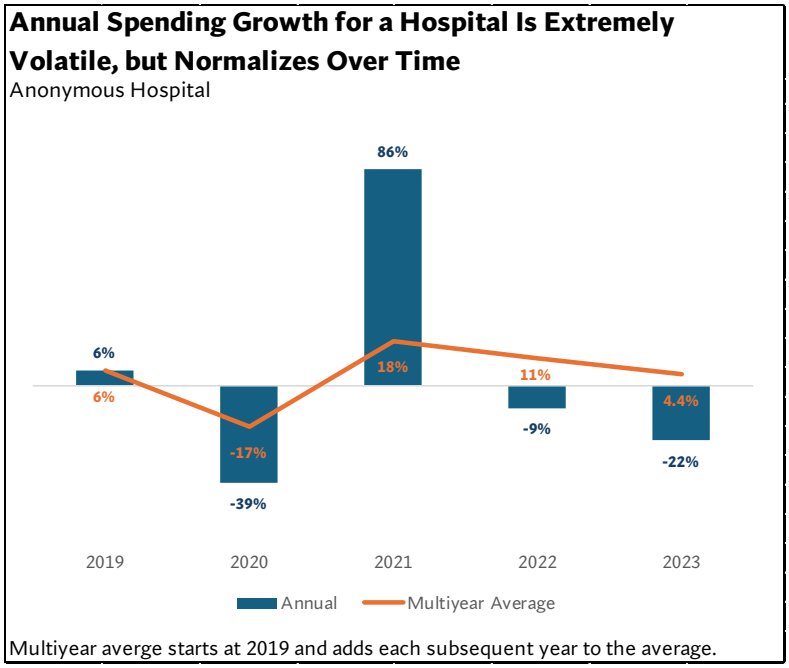
OHCA's 2022-23 hospital spending data reveal incredible volatility in individual hospitals' measured spending growth. As the first figure on the next page shows, 35 (nearly 10% of) hospitals saw annual commercial spending growth of greater than 50% or less than negative 50% between 2022 and 2023. A further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



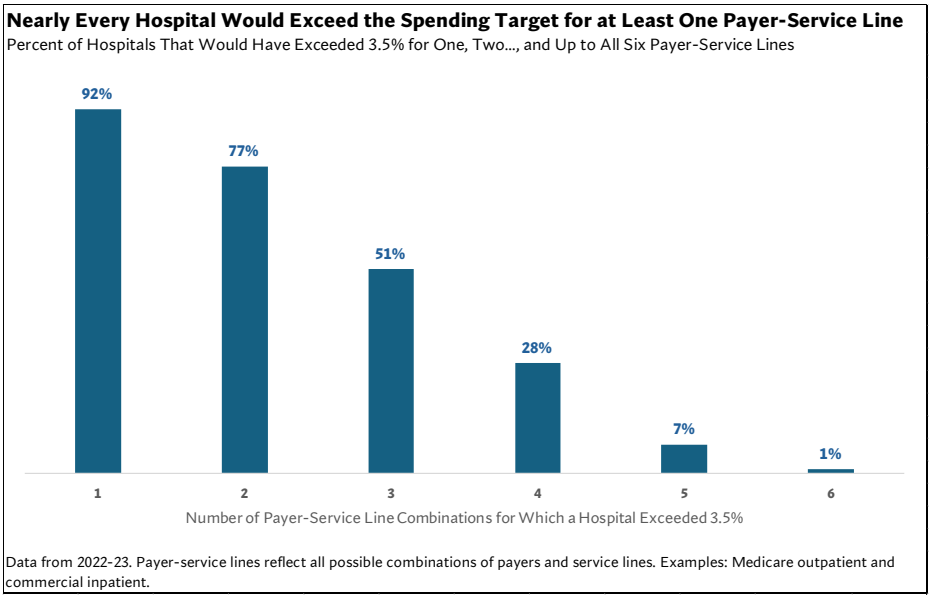
The figure below shows inpatient spending growth over a longer period for an individual hospital. It reveals that high growth rates over a single annual growth period are **not** indicative of a sustained trend of either explosive price growth or radical price cutting. Instead, the figure shows that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

Clarify What It Means to Be Accountable Against the Spending Targets

While there has been progress in developing the hospital spending measurement methodologies (despite more testing being needed), there remains a complete lack of clarity in what will actually constitute a violation of the spending target, given that OHCA has stated it will compare multiple spending growth trends against the targets to determine compliance. Relatedly, uncertainty remains around what it means to "contextualize" spending growth in Medicare and Medi-Cal, how self-financed spending growth (defined on page 5) will be treated, and how the



coming spike in uncompensated care due to the One Big Beautiful Bill Act (OBBBA) and related state policy changes will be considered.



OHCA has stated an intent to measure spending growth against the targets separately for each payer category (i.e., commercial, Medicare, and Medi-Cal) and, for hospitals, separately for each service category (i.e., inpatient and outpatient). Adopting this approach would yield six distinct ways for which a hospital could be found in violation of the spending targets. As the figure on the left shows, had the target been in place in 2023, almost no hospital would have been safe. OHCA would have had to commence enforcement actions against **326 (92%) of the 356 hospitals that reported data**. It would have had to issue technical assistance to and investigate the reasons why each of these 326 hospitals exceeded the target, and 326 hospitals would have had to supply extensive information justifying why, for example, their Medi-Cal inpatient spending grew above the target — even if their overall spending growth was within the state's limits.

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

Conjoin Inpatient and Outpatient into A Single Measure

A hospital whose inpatient, outpatient, and total spending grows by 1%, 5%, and 3% respectively should not be determined to have violated a 3.5% spending target. OHCA must remedy this problem by either:

- **Averaging the inpatient and outpatient growth rates to estimate a single measurement of growth for each hospital.** (OHCA could weight the inpatient and outpatient growth rates by service line total patient revenues to account for hospitals' differing mixes of services.) Using 2023 data and considering only commercial spending growth, this would limit the scope of enforcement from 354 to 167 hospitals.
- **Only enforcing when hospitals exceed the targets for both their inpatient and outpatient service lines.** Again, using 2023 data and considering only commercial spending growth, this would limit the scope of enforcement from 354 to 90 hospitals.

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

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

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

Furthermore, shifts in coverage are coming because of OBBBA and other federal and state policy changes. Hundreds of thousands of people have already dropped their Covered California coverage due to the expiration of the enhanced subsidies, and millions are expected to fall off Medi-Cal coverage. These coverage losses will place further downward pressure on overall hospital reimbursement, increase uncompensated care, and leave hospitals with no good options for sustaining services and jobs. To protect access to hospital care in the face of OBBBA's cuts, OHCA can **and must** account for the law's impacts through its quantitative assessments of which hospitals exceeded their target. To achieve this, **OHCA should designate a hospital as exceeding its target only if it exceeds the target on both its all-payer and commercial lines.** Moreover, the all-payer line should account for all payments — not only those from commercial, Medicare, and Medi-Cal — to properly capture the effects on overall reimbursement from the increase in the ranks of uninsured patients and uncompensated care.

Account for Complexity of Medi-Cal Financing

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

Managed care is Medi-Cal's predominant delivery system that covers 94% of all Medi-Cal enrollees. In 2024, nearly half (48%) of total Medi-Cal managed care reimbursement for hospitals was self-financed — causing **total reimbursement in Medi-Cal managed care to be overstated by 20% that year**. Between 2022 and 2024, self-financed hospital reimbursement grew by more than $5 billion, while state-financed reimbursement grew by less than $1 billion. As a result, while payments in Medi-Cal managed care appear to have grown by 2.5% annually over this period, in truth, they grew by just 0.4% — far below the cost of caring for this population. To

meet its statutory obligations under provisions such as Health and Safety Code (HSC) § 127502(d)(5) and appropriately reflect the realities of Medi-Cal finance, OHCA must account for self-financing in its measurement of hospital spending growth against the targets.

Performance Improvement Plans Must Reflect a Meaningful Opportunity to Comply with Spending Targets

OHCA's April 2026 board meeting included extensive discussion of PIPs and how they relate to the monetary penalties that OHCA may impose as the final step in the progressive enforcement process. **As OHCA discusses, develops, and promulgates formal enforcement regulations, it must conform with and expound upon the protections and processes established in state law.**

Health Care Entities Must Have an Opportunity to Improve Spending Trends Under a PIP

The enforcement provisions of the California Health Care Quality and Affordability Act are unambiguous: Health care entities must have opportunities for remediation of their spending trends prior to the imposition of any monetary penalties. HSC § 127502.5(a)) mandates that the office "enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets, **allows each health care entity opportunities for remediation**, and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access, quality, equity, or workforce stability" (emphasis added).[2] State law further outlines a progressive enforcement process that starts with technical assistance, moves to (optional) public testimony, then mandatory performance improvement plans, and finally, as a last resort, monetary penalties.[3]

The Legislature did not intend the early steps of enforcement to be a check-the-box exercise. Rather, the process must include meaningful opportunities and adequate time for health care entities to implement cost-reducing strategies to meet the state's spending growth goals. First, this plainly requires that PIPs must be forward-looking; health care entities cannot go back in time to alter prior policies, practices, or service offerings. Therefore, PIPs should apply starting in the first annual measurement period following their approval. Second, entities must be given a reasonable amount of time to implement their PIPs. The returns on many cost-reducing strategies, like primary care investments, regularly lag the upfront investments. To balance the urgency of improving affordability and the time and work involved in system improvement, the Legislature thoughtfully established that PIPs may be imposed for a period up to three years.[4] Third, the PIPs must be self-directed. OHCA's role is to approve, not develop the PIPs. Health care entities must have a meaningful opportunity to develop and implement their own strategies, like investing in community-based care or adopting alternative payment methodologies, to comply with their target. OHCA's role is oversight to ensure the improvement plans' goals are reached and do not have negative unintended consequences.

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

[3] See HSC § 127502.5(a) and (d)(1).

[4] See HSC § 127502.5(c).

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

California law states that, except in narrow circumstances specified in HSC § 127502.5(h)(1) for willful, egregious, or repeated noncompliance, a monetary penalty may only be imposed "if the director determines that a health care entity is not compliant with an approved performance improvement plan **and** does not meet the cost target" (emphasis added).[5] This provision, among others, establishes multiple protections that require clarification following the April board discussion and, ultimately, incorporation in the promulgated framework.

OHCA May Not Fine Entities Based on Midyear Compliance with a PIP

The spending target is a "target percentage for the maximum **annual** increase in per capita total health care expenditures" (emphasis added).[6] This means that that a monetary penalty may only be imposed after the office has determined that, in addition to being noncompliant with the PIP, the entity violated the corresponding year's spending target. **An entity cannot fail an annual target on sub-annual basis.** Accordingly, pursuant to OHCA's underlying regulatory framework, fining an entity for noncompliance with its target based on midyear benchmarks, monitoring, and deliverables is plainly impermissible. OHCA must give entities a year, at minimum, to comply with their PIP and associated spending target.

PIPs May Not Impose Cuts Beyond the Spending Targets

OHCA's authority to impose a PIP exclusively derives from its authority to enforce the spending targets; it does not have authority to enforce health care spending reduction goals that go beyond the spending targets OHCA establishes.[7] The Legislature's intent language (see in footnote 2) further affirms this limitation — PIPs may only be imposed to assist entities in coming into compliance with the spending targets. Imposing deeper cuts beyond the relevant spending target, as discussed at the April board meeting, would plainly violate the intent and letter of state law.

Additionally, PIPs may not be used to establish distinct spending targets. State law closely defines the process by which spending targets may be adopted and imposed;[8] nowhere does the law establish an opportunity to revise the spending targets via the PIP process. The target-setting process must include an initial recommendation from the office, discussion of the recommendation at a board meeting by March 1 of the year prior to the target taking effect, a 45-day public comment period, and adoption by the board by June 1 before the target takes effect. The PIP process is wholly distinct. Critically, the authority to make these decisions is partitioned — while the board sets spending targets, OHCA's director approves the PIPs. Clearly under the law, changes to an entity's spending target must occur through the formal spending target process, not through approval of a PIP that imposes cost reductions at any level beyond the spending targets that the director decides.

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

To avoid unintended consequences and reinforce a holistic approach to improving affordability, the Legislature tasked OHCA with ensuring that PIPs are not implemented "in ways that are likely to erode access, quality,

[5] See HSC § 127502.5(d)(1).
[6] See HSC § 127500.2(j).
[7] See HSC § 127502.5(a).
[8] See HSC § 127502(m).

equity, or workforce stability" (see HSC § 127502.5(a)). This important constraint ties the hands of both the office and entities in terms of what cost-reducing strategies may be employed. For hospitals, cutting revenues means cutting costs — costs that are concentrated in workforce recruitment and retention, facility upgrades (including those necessary to comply with state laws), and drugs and medical supplies used in patient care. Reducing hospital spending to the levels established by the spending targets may require service reductions that impair access to services, reduced ability to invest in quality-assurance activities, workforce reductions, and cuts to discretionary programs that address community needs. This is not what the Legislature envisioned. Flexibility will be needed for hospitals and other entities to implement cost-reducing strategies that avoid these negative impacts.

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

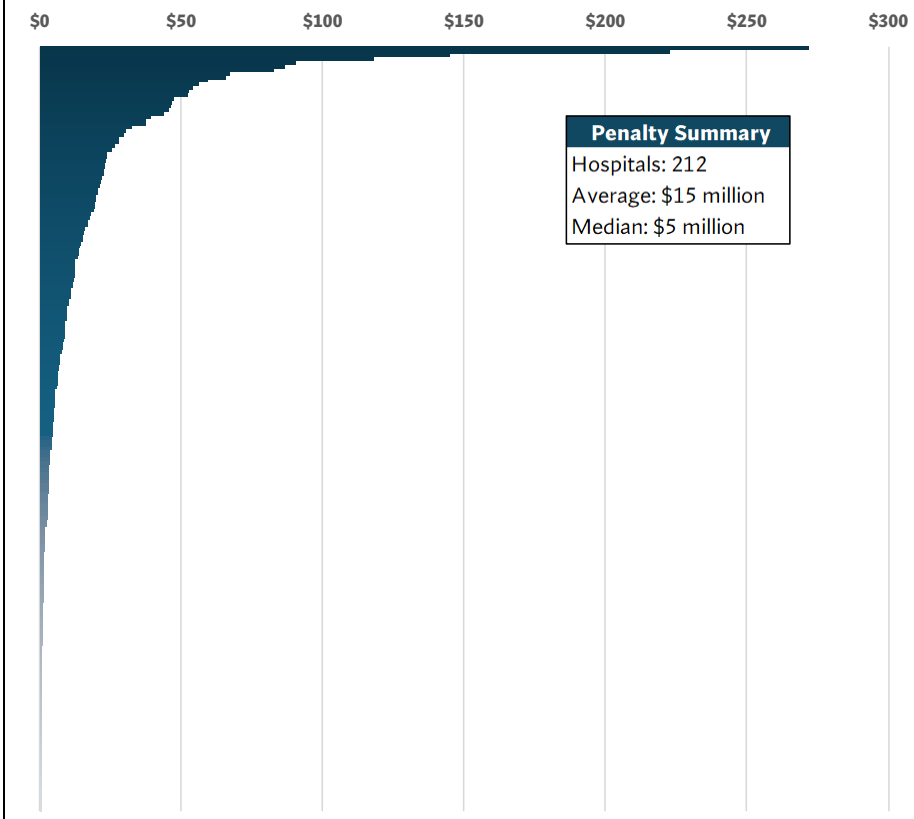
At the April board meeting, OHCA presented a two-step framework for determining the scope and range of monetary penalties for entities that failed their PIP and exceeded their spending target. First, the office would set an initial amount equal to the amount by which the entity exceeded its allowable growth under its target. Then, the office would adjust that amount to account for various factors, including the nature, number, and gravity of the offenses; the entity's fiscal condition; the entity's market impact; penalty justification factors; and input from other state agencies.

OHCA's Recommended Penalty Structure Could Result in Enormous Penalties

OHCA's charge is to promote affordability without jeopardizing access to high-quality, equitable care and the stability of jobs. Unfortunately, monetary penalties at the levels contemplated in OHCA's proposal would do just that and reflect the type of punitive approach to affordability the Legislature expressly disavowed. As the figure on the right shows, absent significant downward adjustments under step 2 of the framework, entities that

OHCA Penalty Structure Could Impose Penalties in the Hundreds of Millions of Dollars

Penalty Amount (in Millions) per Hospital Under Step 1 of Recommended Framework



Note: Penalties calculated based on difference between actual spending growth and allowable growth under a 3.5% target assumed applicable in 2023. Analysis only includes hospitals with fines over $1,000.

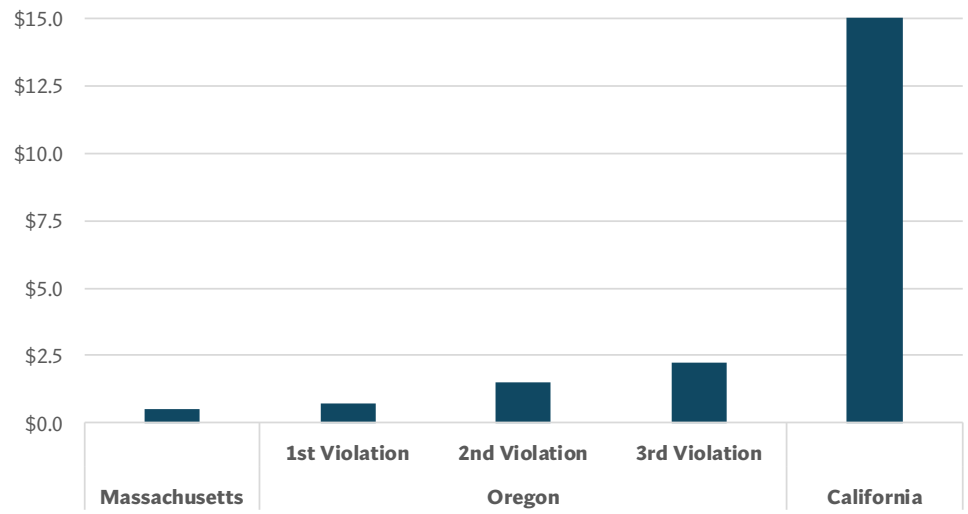
exceed their spending target for even a single year could potentially be subject to fines in the hundreds of millions of dollars. Had the 3.5% target been in place in 2023, 131 hospitals would have received penalties exceeding their entire operating earnings for the year. For 117 hospitals, the penalties would exceed their prior three-year cumulative total of operating earnings. Fines of these magnitudes would threaten the very viability of penalized hospitals, placing access to care and health care jobs at serious risk. Enormous downward adjustments would be needed to reduce the penalties to practicable levels, rendering the process unpredictable, inscrutable, and capricious.

Other States Provide a Model for a More Reasonable Penalty Structure

OHCA is closely modeled after spending target programs in Massachusetts and Oregon, both of which rely on PIPs and financial penalties as their principal means of enforcement. However, the monetary penalties in these other states vary significantly from OHCA's recommendation. In Massachusetts, the maximum financial penalty for failing to implement a PIP is $500,000. In Oregon, the financial penalty for failing to meet the state spending target starts at 5% of an entity's spending above the target (after the entity has been found to have exceeded the target with statistical significance and without good cause in three out of five years). The penalty then increases by 5 percentage points for every additional instance of an entity exceeding the target (using the same multiyear formula). The figure on the left shows what a true outlier OHCA's recommended penalty structure could be compared to its peers, with OHCA's penalties starting at 20 times those in Oregon. OHCA should align with its peer states' penalty structures and modify its recommended framework accordingly.

California's Recommended Penalty Structure Would Be a Major Outlier

Average Monetary Penalty (In Millions) Per Hospital Under Each State's Penalty Framework



Note: Penalties are applied to California and calculated based on the difference between actual spending growth and allowable growth for hospitals under a 3.5% target assumed applicable in 2023. Analysis only includes hospitals with fines over $1,000.

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

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

- Hospital financial status — To protect access to care, penalties must not undermine a hospital's ability to sustain services and remain viable. **OHCA should cap the penalty amount at a hospital's patient care earnings.**

- Factors beyond a hospital's control — New mandates that raise costs, inflationary pressures, and changes in patient needs all influence a hospital's spending, despite their best attempts to remain under the spending limit. **OHCA should deduct the costs associated with such factors from the penalty.**
- Efforts to improve access to high-quality, patient centered care — Investments in primary and behavioral health care, for example, cost more at the outset but result in long-term savings and better health for Californians. **OHCA should deduct the costs associated with such factors from the penalty.**
- Success in reducing spending trends up until the imposition of the penalty — **OHCA should credit an entity for any improvement in its spending performance.**

Without these adjustments, OHCA's penalties would be unduly punitive and ultimately undermine its statutory responsibility to improve affordability while maintaining equitable access to care.

Conclusion

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

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

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