OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Board Meeting

December 16, 2025

HCAI

Department of Health Care Access and Information

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Welcome, Call to Order, and Roll Call

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Department of Health Care Access and Information

Agenda

Item #1 **Welcome, Call to Order, and Roll Call**
Secretary Kim Johnson, Chair

Item #2 **Executive Updates**
Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director

Item #3 **Action Consent Item**
Vote to Approve November 19, 2025 Meeting Minutes
Vishaal Pegany

Item #4 **Informational Items**

a) Update on Behavioral Health Out-of-Plan Spending
CJ Howard, Assistant Deputy Director; Andrew Feher, Research and Analysis Group Manager

b) Spending Target Data Review
Vishaal Pegany; CJ Howard; Andrew Feher

c) Methodology for Measuring Inpatient and Outpatient Hospital Spending
Vishaal Pegany; Brian Briscombe, Senior Quantitative Analyst, RAND; Cheryl Damberg, Senior Economist, RAND

d) Spending Target Enforcement – Introduction to Performance Improvement Plans
Vishaal Pegany; CJ Howard

e) Introduction to HCAI Health of Primary Care in California Snapshot
Margareta Brandt, Assistant Deputy Director; Debbie Lindes, Health Care Delivery System Group Manager

Item #5 **General Public Comment**

Item #6 **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

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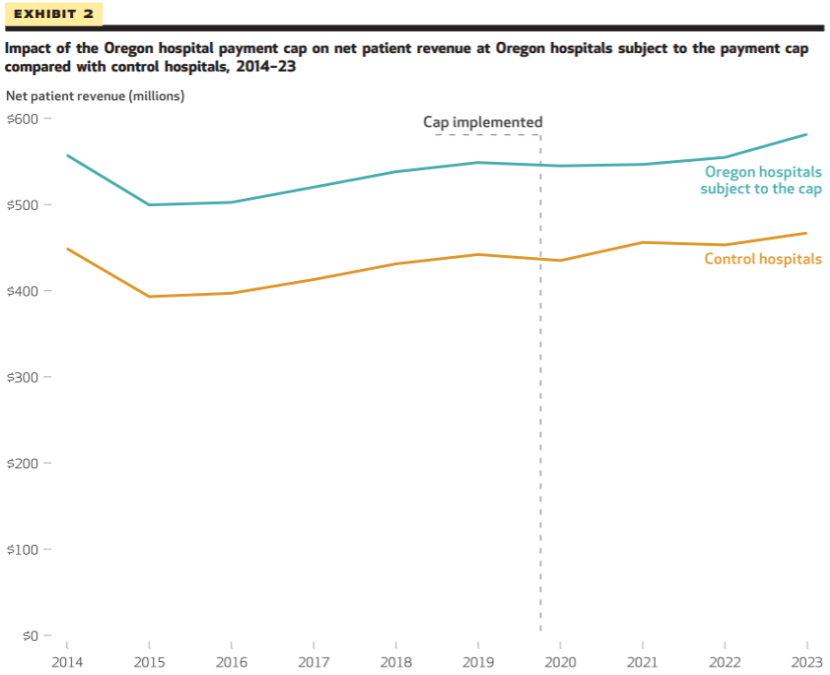
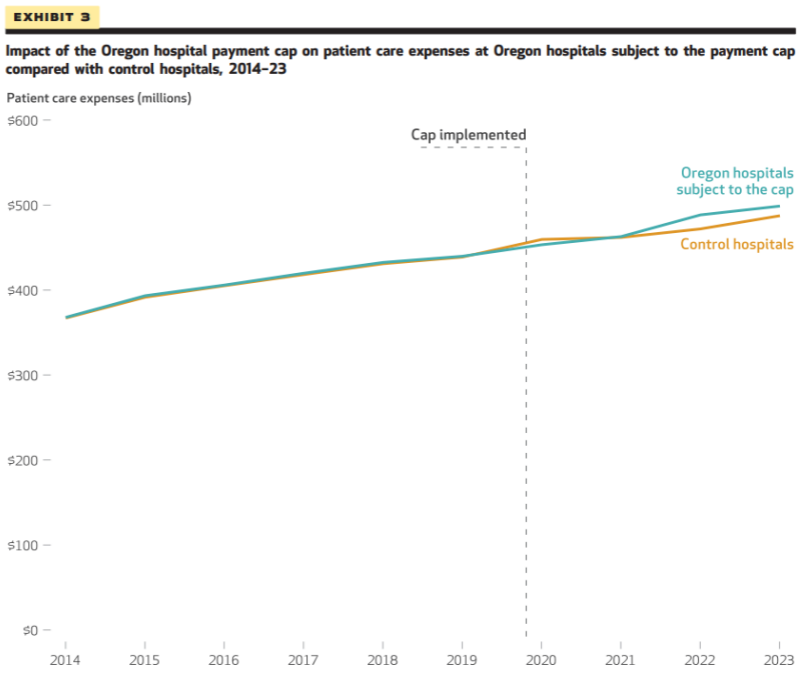
Hospital Finances, Operations and Patient Experience Remain Stable After Hospital Payment Cap in Oregon

- In October 2019, Oregon implemented a hospital payment cap, limiting hospital payments to 200 percent of Medicare payments for care provided to state employees.
- A December 2025 *Health Affairs* article examined the effects of Oregon's 2019 hospital payment cap on hospitals' finances, operations and care delivery. Using several data sources from 2014 to 2023 and a synthetic difference-in-differences, the authors found – compared to non-Oregon hospitals – no detectable changes in revenues, expenses, or operating margins in Oregon hospitals. In addition, the authors found small improvements in several measures of patient experience in Oregon hospitals compared to non-Oregon hospitals.

Exhibit 2 and 3 show changes over time in net patient revenue and patient care expenses for Oregon hospitals subject to the cap and a synthetic control group of hospitals.





Murray, R., Ryan, A., Whaley, C. (2025, December 2). *Hospital Finances, Operations, And Patient Experience Remain Stable After Oregon's Hospital Payment Cap Was Implemented.* Health Affairs. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00682

The Antitrust Antidote to Hospital and Nursing Home Corporatization — Promises and Pitfalls

The Corporatization of Health Care:

Hospitals: Since 2008, mergers and the consolidation of hospital ownership has resulted in more than 90% of U.S. metropolitan hospital markets classified as “highly concentrated” and increased hospital costs to patients and payers by as much as 65%.

Skilled Nursing Homes: Between 2016 and 2021 more than 3,200 of approximately 15,000 skilled nursing facilities changed ownership, with private equity owning roughly 5 percent. Studies show substantial hidden profits, as well as the generation of returns in less transparent ways (e.g., staffing cuts), and where harms may play out in terms of patient safety, not price.

Physician Employment: As of 2024, three in four physicians were employed by hospitals, health insurers, or investor-owned companies raising concerns not only about higher prices and reduced competition, but the erosion of professional autonomy, pressures to align clinical decisions with financial incentives, and the emergence of complex ownership structures involving management services organizations (MSO) that evade long-standing restrictions on the corporate practice of medicine.

Singh, Y. (2025, November 6). *The Antitrust Antidote to Hospital and Nursing Home Corporatization - Promises and Pitfalls.* New England Journal of Medicine. https://www.nejm.org/doi/full/10.1056/NEJMp2505020

The Antitrust Antidote to Hospital and Nursing Home Corporatization — Promises and Pitfalls

Corporatization of Health Care Remedies:

While antitrust enforcement is essential, it is insufficient to foster an affordable, accessible, and high-value health system. Because market concentration is not the sole source of harm, antitrust enforcement cannot be the only remedy. The author recommends a more expansive pro-competitive policy tool kit, including:

- Ownership transparency
- Real estate and financial transparency laws to track and limit related-party leaseback arrangements
- Minimum quality and staffing standards
- Support for independent providers through targeted subsidies and tax incentives
- Labor protections
- Reforms to Medicare and Medicaid reimbursement models that provide incentives for consolidation

Example: Massachusetts has effectively banned future sale–leaseback agreements with real estate investment trusts (REIT) and requires health care entities to disclose investor ownership. Other state and federal policymakers could follow their lead.

Singh, Y. (2025, November 6). *The Antitrust Antidote to Hospital and Nursing Home Corporatization - Promises and Pitfalls.* New England Journal of Medicine. https://www.nejm.org/doi/full/10.1056/NEJMp2505020

PBGH Data Demonstration Project: Creating a Usable Data Framework for Purchasers

Milliman

- Transparency data (TiC and HPT) through Turquoise Health
- Commercial Claims Database of 70M+ lives

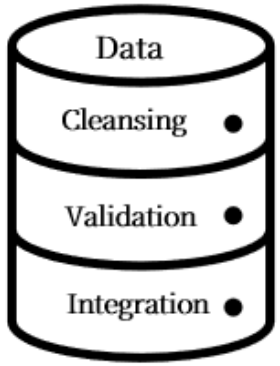
embold HEALTH

- Clinician level quality scores

THELEAPFROGGROUP

- Hospital Safety Grades

- Employer claims data
- Eligibility data



PBGH Purchaser Business Group on Health

- Product design and development
- Coordination of entities
- Ensuring analysis reflects employer priorities
- Advising employers with insights and recommended actions

A unique framework:

1. Dataset that combines cost and quality
2. Employer specific reports based on utilization
3. Custom actionable insights

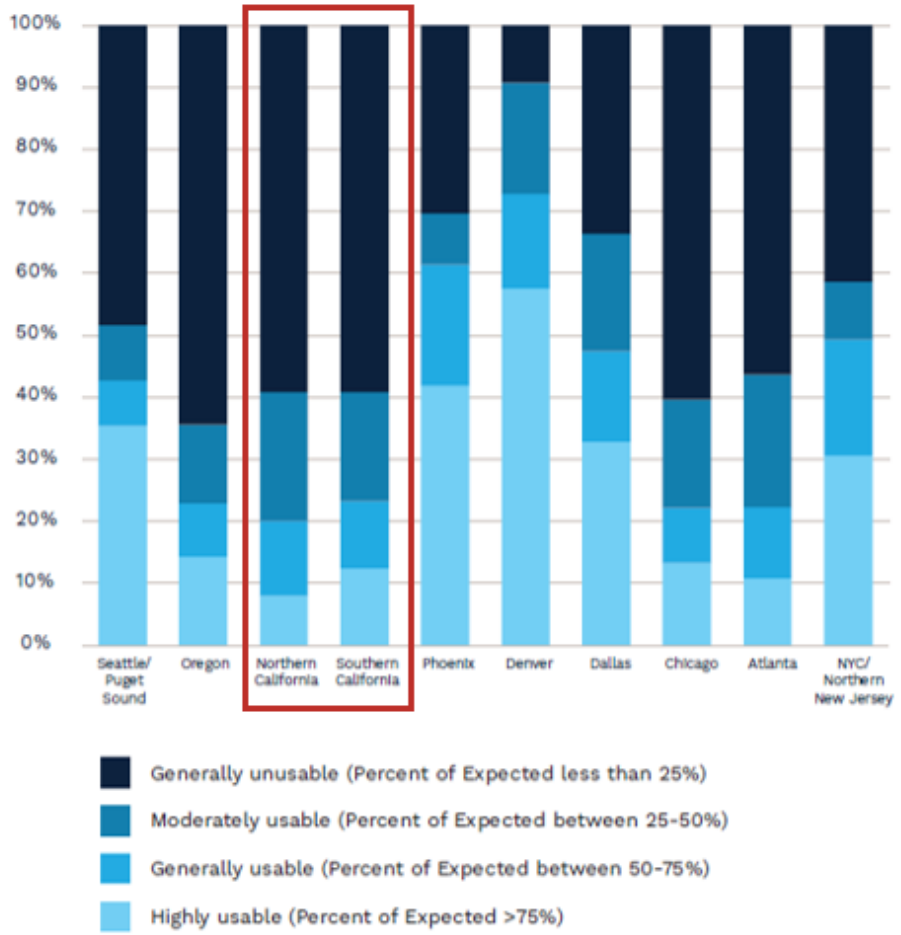
PBGH Data Project: Key Findings

Key findings:

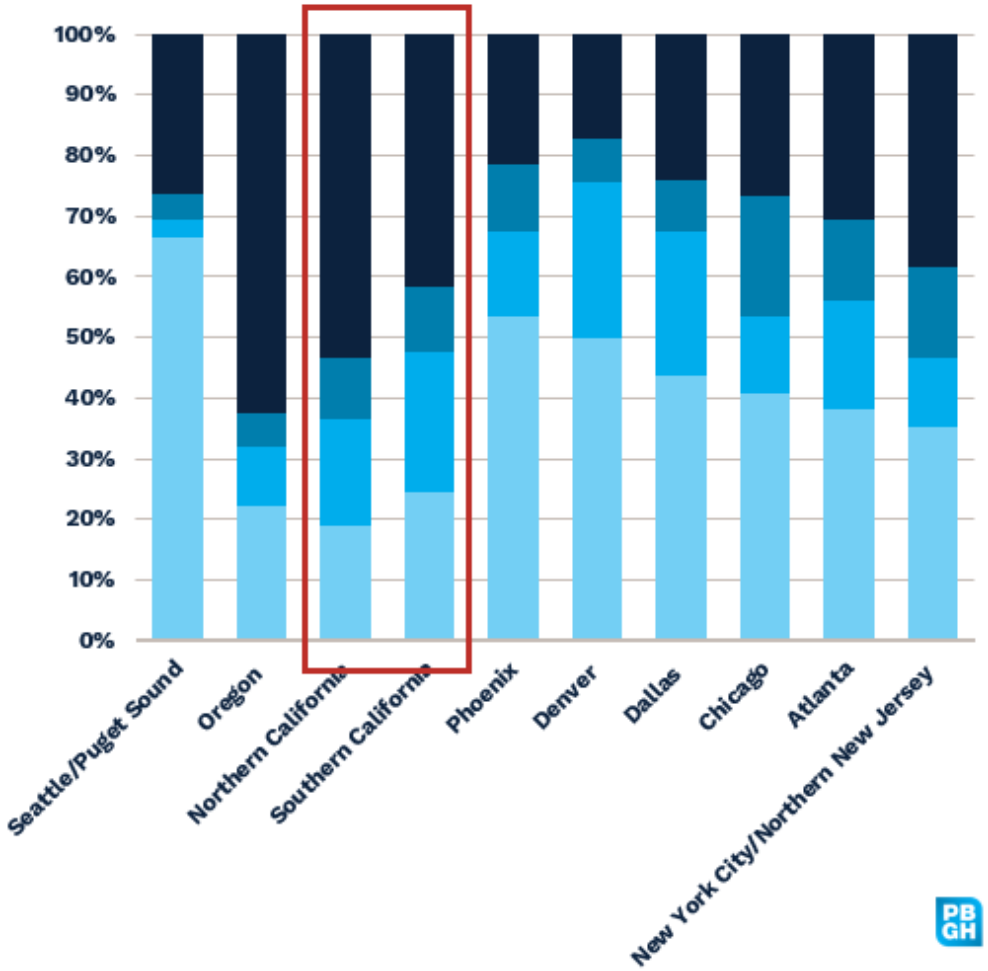
1. Quality of the data varies dramatically
2. **Price variation defies economic logic**
3. **Cost and quality show no correlation**
4. Site-of-service savings are market-specific
5. Health plan market share doesn't predict pricing power
6. Data access barriers persist
7. Sophisticated data and analytical infrastructure is essential
8. Meaningful cost comparisons are otherwise unavailable

Usability of Negotiated Rates, by Regional Market

Hospital Data



TiC Data



Purchaser Business Group on Health (2025, October 6). *Leveraging Health Care Price Transparency: Making Transparency Data Actionable for Employers and Public Purchasers.* https://www.pbgh.org/initiative/pbgh-health-care-data-demonstration-project/

California-Specific Examples

Figure 6. Payer Submitted TiC Files Show Higher Median Rates in Northern California for Vaginal Delivery without Complication (DRG 807)

Negotiated Facility Rates (25th-75th percentile) for Vaginal Delivery without Complication (DRG 807) by Regional Market

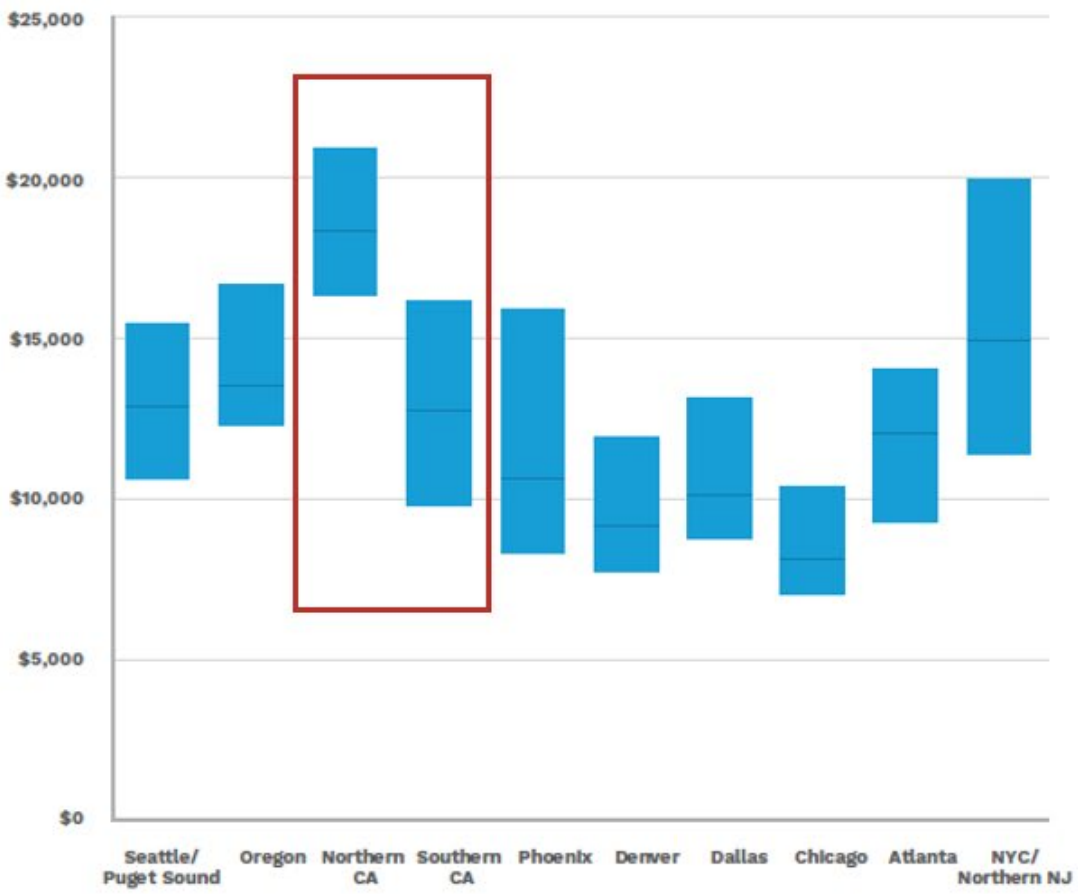
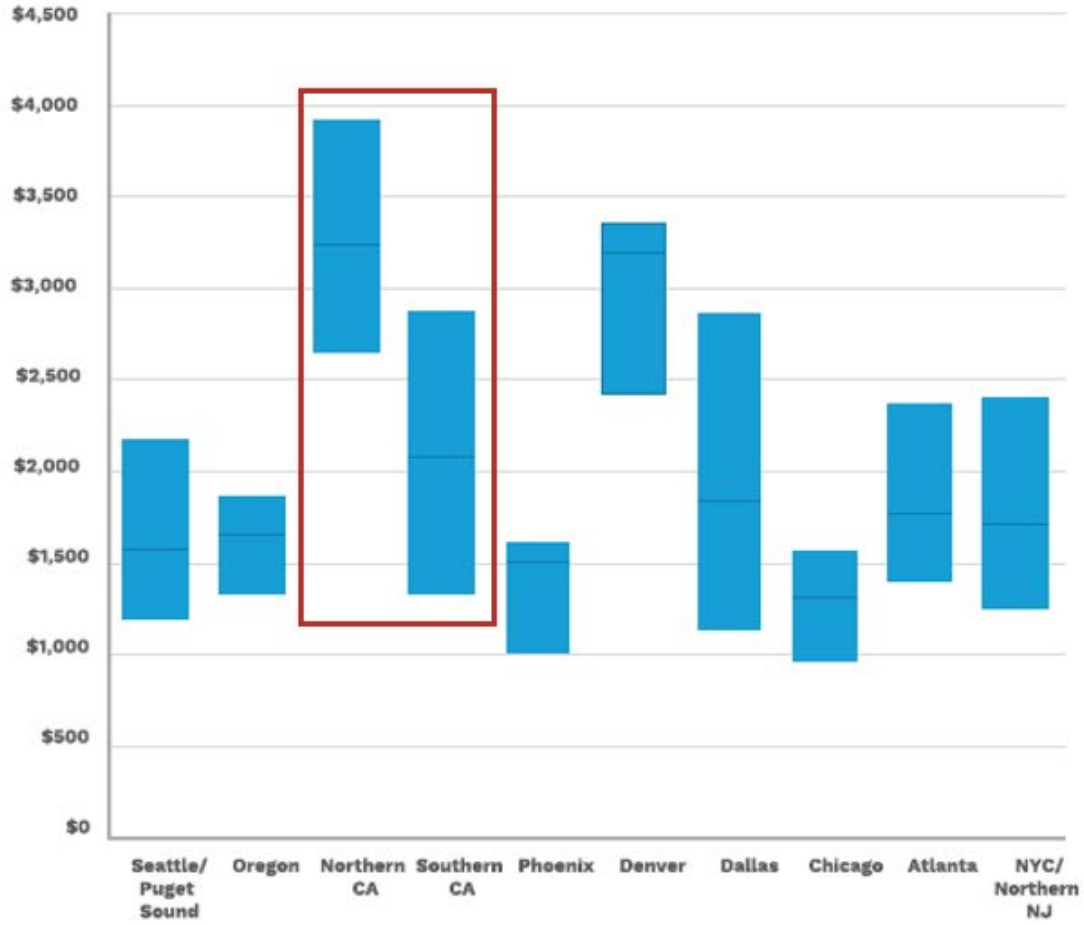
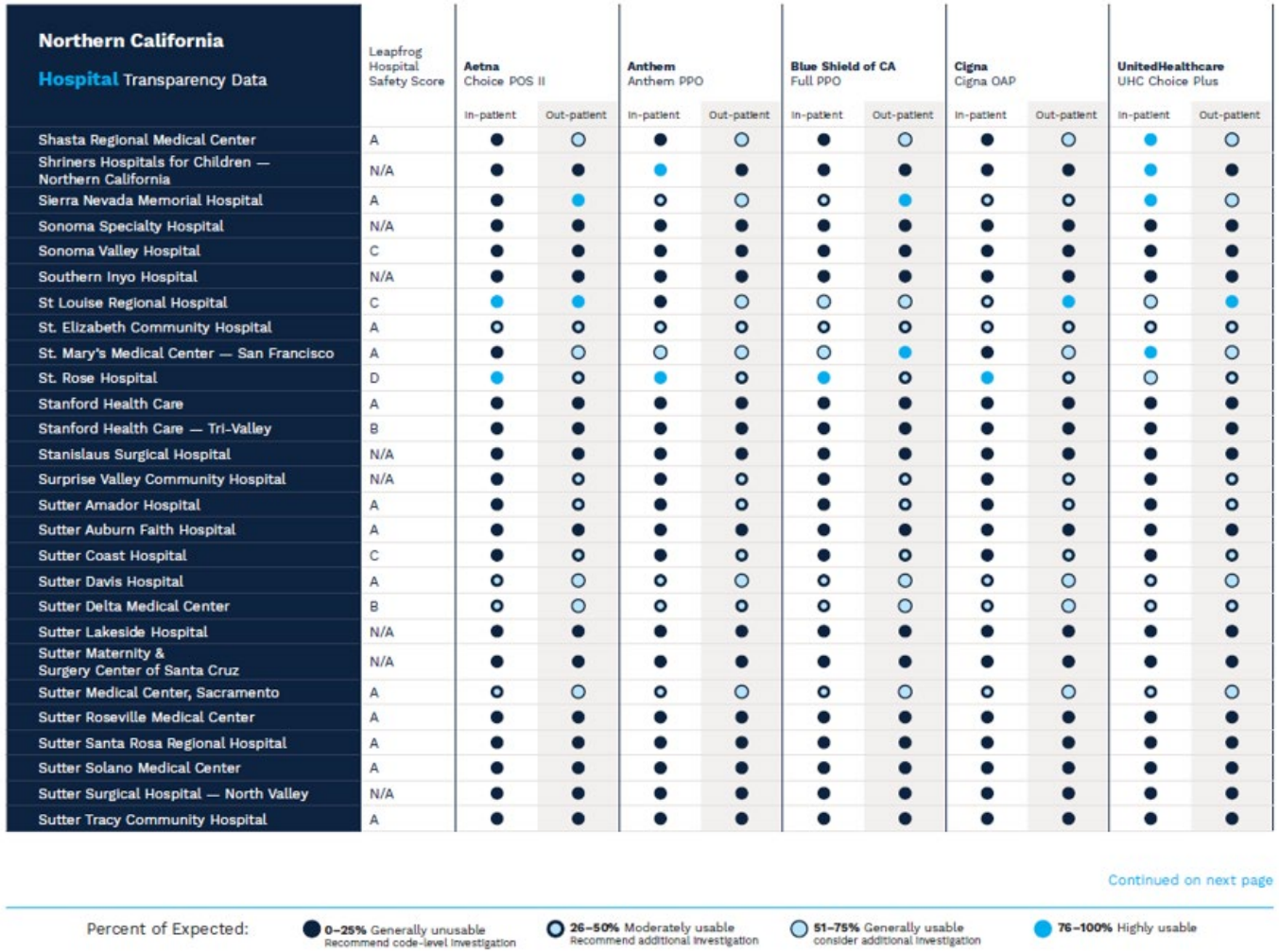


Figure 8. Payer Submitted TiC Files Show Higher Median Rates in Northern California and Denver for Emergency Room Visits (99284)

Negotiated Facility Rates (25th-75th percentile) for Emergency Room Visit (99284) by Regional Market



Usability of Transparency Data and Hospital Safety Grades



Northern California Hospital Transparency Data	Leapfrog Hospital Safety Score	Aetna Choice POS II		Anthem Anthem PPO		Blue Shield of CA Full PPO		Cigna Cigna OAP		UnitedHealthcare UHC Choice Plus	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Shasta Regional Medical Center	A	●	○	●	○	●	○	●	○	●	○
Shriners Hospitals for Children — Northern California	N/A	●	●	●	●	●	●	●	●	●	●
Sierra Nevada Memorial Hospital	A	●	●	○	○	○	●	○	○	●	○
Sonoma Specialty Hospital	N/A	●	●	●	●	●	●	●	●	●	●
Sonoma Valley Hospital	C	●	●	●	●	●	●	●	●	●	●
Southern Inyo Hospital	N/A	●	●	●	●	●	●	●	●	●	●
St Louise Regional Hospital	C	●	●	●	○	○	○	○	●	○	●
St. Elizabeth Community Hospital	A	○	○	○	○	○	○	○	○	○	○
St. Mary's Medical Center — San Francisco	A	●	○	○	○	○	●	●	○	●	○
St. Rose Hospital	D	●	○	●	○	●	○	●	○	○	○
Stanford Health Care	A	●	●	●	●	●	●	●	●	●	●
Stanford Health Care — Tri-Valley	B	●	●	●	●	●	●	●	●	●	●
Stanislaus Surgical Hospital	N/A	●	●	●	●	●	●	●	●	●	●
Surprise Valley Community Hospital	N/A	●	○	●	○	●	○	●	○	●	○
Sutter Amador Hospital	A	●	○	●	○	●	○	●	○	●	○
Sutter Auburn Faith Hospital	A	●	●	●	●	●	●	●	●	●	●
Sutter Coast Hospital	C	●	○	●	○	●	○	●	○	●	○
Sutter Davis Hospital	A	○	○	○	○	○	○	○	○	○	○
Sutter Delta Medical Center	B	○	○	○	○	○	○	○	○	○	○
Sutter Lakeside Hospital	N/A	●	●	●	●	●	●	●	●	●	●
Sutter Maternity & Surgery Center of Santa Cruz	N/A	●	●	●	●	●	●	●	●	●	●
Sutter Medical Center, Sacramento	A	○	○	○	○	○	○	○	○	○	○
Sutter Roseville Medical Center	A	●	●	●	●	●	●	●	●	●	●
Sutter Santa Rosa Regional Hospital	A	●	●	●	●	●	●	●	●	●	●
Sutter Solano Medical Center	A	●	●	●	●	●	●	●	●	●	●
Sutter Surgical Hospital — North Valley	N/A	●	●	●	●	●	●	●	●	●	●
Sutter Tracy Community Hospital	A	●	●	●	●	●	●	●	●	●	●

Continued on next page

Percent of Expected:
● **0–25%** Generally unusable — Recommend code-level investigation
○ **26–50%** Moderately usable — Recommend additional investigation
○ **51–75%** Generally usable — consider additional investigation
● **76–100%** Highly usable

Purchaser Business Group on Health (2025, October 6). *Leveraging Health Care Price Transparency: Making Transparency Data Actionable for Employers and Public Purchasers.* https://www.pbgh.org/initiative/pbgh-health-care-data-demonstration-project/

Price Variation for Inpatient Maternity Care in Northern California

Northern California

Figure 3a. *Comparison of Inpatient Maternity Rates*

Market Benchmarks - Inpatient Maternity Rates

		Payer Transparency Data					
MS-DRG	**Description**	**Record Count**	**Minimum**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**Maximum**
786	Cesarean section w/o sterilization w Mcc	165	$8,046	$37,516	$45,984	$51,313	$78,413
787	Cesarean section w/o sterilization w Cc	189	$8,046	$23,763	$43,632	$48,728	$59,249
788	Cesarean section w/o sterilization w/o Cc/Mcc	193	$8,046	$21,422	$27,199	$31,764	$58,688
806	Vaginal delivery w/o sterilization/d&c w Cc	189	$8,046	$17,603	$26,460	$31,062	$36,848
807	Vaginal delivery w/o sterilization/d&c w/o Cc/Mcc	193	$7,881	$16,352	$18,368	$20,903	$36,848

		Hospital Transparency Data					
MS-DRG	**Description**	**Record Count**	**Minimum**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**Maximum**
786	Cesarean section w/o sterilization w Mcc	43	$11,189	$22,447	$25,264	$43,074	$91,039
787	Cesarean section w/o sterilization w Cc	58	$11,189	$15,996	$18,934	$25,522	$87,987
788	Cesarean section w/o sterilization w/o Cc/Mcc	60	$10,850	$15,480	$18,789	$25,273	$74,399
806	Vaginal delivery w/o sterilization/d&c w Cc	58	$9,190	$11,726	$14,121	$20,926	$35,641
807	Vaginal delivery w/o sterilization/d&c w/o Cc/Mcc	61	$7,150	$11,076	$13,267	$18,683	$33,430

Purchaser Business Group on Health (2025, October 6). *Leveraging Health Care Price Transparency: Making Transparency Data Actionable for Employers and Public Purchasers.* https://www.pbgh.org/initiative/pbgh-health-care-data-demonstration-project/

PBGH Data Demonstration Project: Policy Implications

Government Action is Needed to Achieve Fair Commercial Prices for Patients

- Strengthen Transparency in Coverage (TiC) rule to improve the usability of data
  - Improve data standardization
  - Require real dollars, not estimates
  - Implement drug pricing data transparency
- Bring more transparency and increase accountability for hospitals and service providers (third party administrators, pharmacy benefit managers)
  - Increased penalties for service providers that block employer data access
  - Increased penalties for hospitals that do not meet transparency requirements
  - PBM reporting requirements and transparency
- Price data alone is not enough; employers must have access to quality data and the ability to process data

Cost and Market Impact Review Update

Res-Care, Inc. (“Res-Care”), submitted a Material Change Transaction to OHCA regarding the transfer of seven subsidiaries that operate intermediate care facilities providing home and community-based health services in California through community group homes (including 11 Medicaid waiver group homes) to individuals with intellectual and developmental disabilities and other conditions. The buyer is National Mentor Holdings, Inc. (dba “Sevita”), and the transfer is part of Sevita’s nationwide acquisition of Res-Care and other affiliates under the parent company BrightSpring Health Services, Inc.

OHCA deemed the submission complete on April 21, 2025, and the review was tolled pending reviews by other agencies, resuming on October 22, 2025. Upon finishing review of the Material Change Transaction, OHCA determined that it will proceed to a CMIR regarding Sevita’s acquisition of the seven Res-Care subsidiaries:

- Alternative Choices, Inc.
- J&J Care Centers, Inc.
- Normal Life of California, Inc.
- Res-Care California, Inc.
- Rockcreek, Inc.
- RSCR California, Inc.
- RSCR Inland, Inc

Full documents regarding the Transaction are available.

OHCA will publish the Preliminary CMIR Report on the page linked above and allow ten business days for the parties and public to submit written comments in response to the findings

If any member of the public wishes to make a comment regarding this transaction or its anticipated impacts as described above, please email CMIR@hcai.ca.gov. (Please add “Comment on CMIR for Transaction 1367- Res-Care” to the subject line.)

To view a list of notices of material change transactions submitted to OHCA, please visit here.

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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Action Consent Item: Vote to Approve November 19, 2025 Meeting Minutes

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Informational Items

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Update on Behavioral Health Out-of-Plan Spending

CJ Howard, Assistant Deputy Director
Andrew Feher, Research Scientist Manager

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Department of Health Care Access and Information

Background

- Recent research using commercial claims data from 2008-2016 found the share of spending out-of-network for behavioral health increased from 12.6% in 2008-2010 to 34.4% in 2014-2016.*
- The Board and Advisory Committee raised concerns that OHCA's Total Health Care Expenditures (THCE) data collection does not (and cannot) include out-of-plan spending.
- In an effort to remedy this limitation, OHCA contracted Mathematica to use the California-specific Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey Household Component (MEPS-HC) survey to estimate behavioral health out-of-plan spending for Californians.
- The analysis focused on behavioral health in light of research suggesting that a growing share of behavioral health providers do not accept insurance and that patients may struggle to find in-network behavioral health providers.

* Source: https://pmc.ncbi.nlm.nih.gov/articles/PMC7859128/

Data Source

- 2019-2022 Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey Household Component (MEPS-HC) survey
- MEPS-HC includes information from consumers on health insurance coverage and healthcare utilization and costs.
    - Spending in the MEPS-HC is defined for each medical event (e.g., office visit, inpatient stay, outpatient visit, etc.).
    - For each event, data show spending by private insurance, public programs, and self-pay (out-of-pocket).
    - Each event includes type of provider, diagnosis codes, and procedure codes.
- Event Files included in analysis:
    - Hospital Inpatient Stays
    - Emergency Room Visits
    - Office-Based Medical Provider Visits
    - Outpatient Visits
    - Home Health Visits

Defining Behavioral Health Spending and Out-of-Plan Spending

An event is considered behavioral health-related if it meets at least 1 of 4 criteria:

1) The event includes a diagnosis code or ICD-10 code within the code range for “Mental, Behavioral and Neurodevelopmental disorders,” or
2) The event includes a diagnosis code in the Clinical Classifications Software Refined (CCSR) category “Mental or Behavioral Health Disorder,” or
3) The type of care reported by the respondent is categorized as Psychotherapy/Mental Counseling for an emergency room, outpatient, or office-based event, or
4) The type of medical provider seen during an outpatient, office based, or home health event is categorized as a behavioral health medical provider.

MEPS-HC does not include an out-of-plan spending variable. To operationalize this concept, the Mathematica team defined an expense as out-of-plan if the expense was 100% paid out-of-pocket and met one of the following:

- Occurred after the deductible was met, or
- Occurred prior to meeting the deductible but there were other non-behavioral health expenses where insurance paid all or some of the expenses.

If neither condition is met, the expense is considered an in-plan, out-of-pocket expense.

Note: ICD-10 is a medical coding system used to classify diseases, symptoms, injuries and causes of death.

MEPS-HC Limitations

- MEPS-HC captures health care spending and utilization among the U.S. civilian population living in non-institutional community settings. Therefore, all health utilization in institutional settings (including mental health utilization) are excluded.*
- MEPS-HC data is voluntarily reported, and mental health services, especially inpatient mental health hospital visits, may not be reported due to stigma, confidentiality, or individuals not recalling these events.
- MEPS-HC has relatively small state-level sample sizes: 20,000-30,000 nationally but only 2,000-3,000 individual survey respondents in California.

* Individuals are not included in the survey if they are in institutional care. Institutional care includes inpatient rehabilitation facility, nursing home, residential mental health treatment center, residential eating disorder treatment center, residential drug and alcohol or addiction treatment, residential hospice care, and residential respite care

California MEPS-HC Sample, 2019-2022

- Member years corresponds to the number of months that a respondent was in the survey, divided by 12. Some members may not be in the survey for a whole calendar year if there is a birth, death, or move from the household.
- From 2019 to 2022, the number of member years who reported behavioral health expenses ranged from 217 to 323; the number of member years who reported out-of-plan behavioral health expenses ranged from 41 to 45. Per AHRQ guidance, published estimates should be based on an unweighted sample of at least 60 respondents. As such, one should interpret the out-of-plan estimates with caution.

Year	Member Years	Member Years with Behavioral Health Expenses	Member Years with Out-of-Plan Behavioral Health Expenses
2019	3,179	323	43
2020	3,229	294	41
2021	3,120	314	45
2022	2,199	217	41

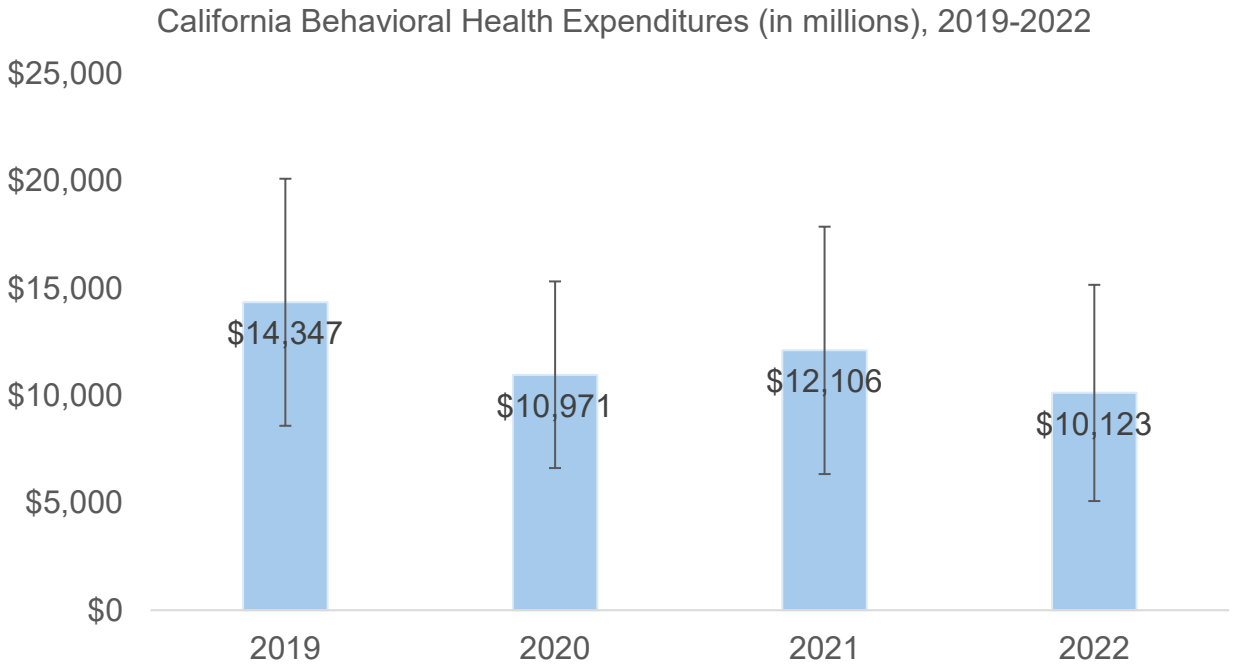
California Behavioral Health Expenditures, 2019-2022

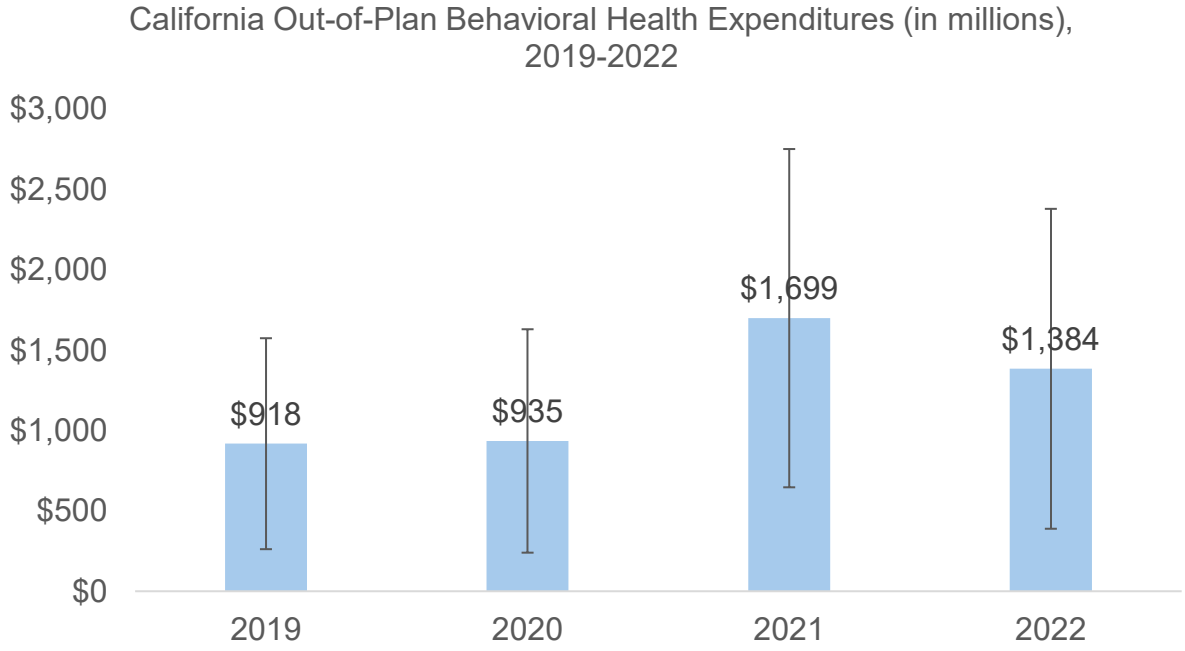
- From 2019 to 2022, MEPS-HC data suggest that behavioral health spending fluctuated between increases and decreases but over the 4-year period declined substantially; over that same period, the data suggest that out-of-plan behavioral health spending increased dramatically.
- From 2019 to 2022, out-of-plan spending as a share of total behavioral health spending ranged from 6% to 14% across years and 10% when pooled, well below the 30% data point cited at prior Board meetings.

Year	Behavioral Health Expenditures (in millions)	Out-of-Plan Behavioral Health Expenditures (in millions)	Out-of-Plan Behavioral Health Expenditures as a share of the total
2019	$14,347	$918	6%
2020	$10,971	$935	9%
2021	$12,106	$1,699	14%
2022	$10,123	$1,384	14%
Cumulative Total	$47,547	$4,936	10%

MEPS-HC Estimates of Behavioral Health Spending Are Marked by Considerable Sampling Variability

The relatively small number of survey respondents who report behavioral health and out-of-plan behavioral health spending results in large confidence intervals (i.e., the range of values that cannot be rejected is very wide), preventing analysts from being able to conclude whether behavioral health spending is increasing or decreasing from one year to the next.





Note: Vertical brackets denote 95 percent confidence intervals.

Comparing In-Plan Behavioral Health Spending in MEPS-HC and HPD

- As the previous slide showed, from 2019 to 2022, MEPS-HC data suggest that behavioral health spending in California fluctuated between increases and decreases but over the 4-year period declined substantially.
- By contrast, preliminary analysis of HPD data suggest behavioral health spending steadily increased from $9.1 billion in 2019 to $11.6 billion in 2022.

Year	In-Plan Behavioral Health Expenditures in Millions (MEPS-HC)	Preliminary Analysis: Behavioral Health Expenditures in Millions (HPD)
2019	$13,429	$9,161
2020	$10,036	$10,084
2021	$10,407	$11,131
2022	$8,739	$11,675
Cumulative Total	$42,611	$42,051

Note: Both the MEPS-HC and HPD behavioral health expenditures include the Commercial, Medicare and Medicaid markets. To identify and categorize behavioral health spending in the HPD, we used the Milbank-Freedman specifications, which rely on the primary diagnosis field on claims to identify a mental health or substance use disorder diagnosis.

Conclusion

- To be responsive to Board and Advisory Committee interest in out-of-plan behavioral health spending, OHCA engaged Mathematica to explore whether MEPS-HC survey data could be used to estimate changes in behavioral health spending in California.
- We found that MEPS-HC could not reliably estimate trends in aggregate behavioral health spending in California and showed trends at odds with administrative data from HPD.
- OHCA will work with other institutions and organizations to make further progress on understanding out of pocket and out of plan behavioral health spending.

OHCA

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Department of Health Care Access and Information

Spending Target Data Review

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director
Andrew Feher, Research Scientist Manager

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Key Economic Indicators in 2024 and Long-term Trends

At the Board's request, OHCA reviewed 2024 data on key economic indicators to assess whether recent trends in income and inflation materially change the conditions that informed the original 3.0% spending target, which was based on the 20-year average growth in median household income from 2002 to 2022.

- California median household income rose 11.9% in 2024, bringing the 20-year annual average (2004–2024) to 3.7% — a 0.7 percentage point increase over the 2002–2022 average.
- The Consumer Price Index (CPI-U) for California rose 3.1% in 2024, bringing the 20-year annual average (2004–2024) to 2.9% — a 0.1 percentage point increase over the 2002–2022 average.

Sources: U.S. Census Bureau, Median Household Income in California [MEHOINUSCAA646N], retrieved from FRED, Federal Reserve Bank of St. Louis. https://fred.stlouisfed.org/series/MEHOINUSCAA646N. California Department of Finance. *California Consumer Price Index – All Items (CPI)*. Retrieved from https://dof.ca.gov/wp-content/uploads/sites/352/Forecasting/Economics/Documents/CPI-All-Item-CY.xlsx
Centers for Medicare & Medicaid Services. *Market Basket Data: Medicare Economic Index (MEI)*. Retrieved from https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data

Health Care Spending Trends from OHCA's Baseline Report

OHCA's Baseline Report noted the following trends:

- Commercial TME and THCE PMPY grew by 5.0% and 6.4%, respectively
- Medicare TME and THCE PMPY grew by 6.1% and 5.4%, respectively
- Medi-Cal TME and THCE PMPY grew by 1.2% and 2.9%, respectively

Market	2022 -2023 TME PMPY Growth	2022 – 2023 THCE PMPY Growth
Commercial	5.0%	6.4%
Medicare	6.1%	5.4%
Medi-Cal	1.2%	2.9%

Source: https://hcai.ca.gov/wp-content/uploads/2025/06/Baseline-Report-Health-Care-Spending-Growth-Trends-in-California-3.pdf

Long-term Trends in California Health Care Spending & Economic Indicators

Indicator	Time Period	5 Year Average	10 Year Average	15 Year Average	20 Year Average
Per Capita Health Care	2002 -2020	5.2%	4.8%	4.8%	5.4%
Median Household Income	2004 - 2024	5.3%	5.3%	4.1%	3.7%
Consumer Price Index	2004 - 2024	4.0%	3.4%	2.9%	2.9%
Gross State Product Per Capita	2003 - 2023	6.1%	5.5%	4.3%	4.3%

High-Cost Hospital Adjustment

- In April 2025, after defining hospitals as a sector, the Board adjusted targets for hospitals that met the following criteria:
  - Above the 85th percentile for three out of five years from 2018-2022 on Commercial Inpatient Net Patient Revenue (NPR) per Case Mix Adjusted Discharge (CMAD) and Commercial to Medicare Payment to Cost Ratio (PTCR);
    - Excluding hospitals that have decreasing values for two consecutive years on both measures, which results in the hospital falling below the 85th percentile in 2022.
  - Above the 30th percentile in annual discharges;
  - Share of Medicare and Other Third Party revenue above 5%; and
  - Have comparable financial data in the HCAI Hospital Financial Reports.
- The hospitals that met these criteria were considered high cost compared with other hospitals within the hospital sector.
- The Office also committed to annually provide an updated list of hospitals that meet the above criteria and an updated list of factors for consideration to adjust targets for high-cost facilities within the hospital sector.

High-Cost Hospitals with New Financial Report Data

In September 2025, HCAI published an updated snapshot of Hospital Financial Reports for fiscal years ending between 07/01/2023 and 6/30/2024.

In the following slides, we provide an update on hospitals that meet the high cost criteria using the latest available data.

Key Takeaways:

1. No change in the list of the high-cost hospitals for data covering the five-year period from 2019-2023.
2. Unit price for high-cost hospitals is ~2 times higher than unit price for all other comparable hospitals.
3. Relative price for high-cost hospitals is ~1.5 times higher than the relative price for all other comparable hospitals.

Commercial Inpatient NPR per CMAD for Repeat Outlier Hospitals, 2019-2023

above 85%

Hospital	2019	2020	2021	2022	2023	Pooled Avg 2019-23
All Other Comparable Hospitals	**$19.7K**	**$20.4K**	**$20.4K**	**$21.4K**	**$21.9K**	**$20.7K**
7 High-Cost Hospitals	**$39.7K**	**$40.1K**	**$42.1K**	**$43.8K**	**$45.2K**	**$42.2K**
Community Hospital of The Monterey Peninsula	$41.8K	$42.4K	$43.8K	$38.9K	$42.5K	$41.9K
Doctors Medical Center – Modesto	$40.9K	$36.0K	$36.8K	$39.7K	$36.9K	$38.1K
Dominican Hospital	$33.7K	$33.2K	$34.9K	$33.3K	$36.1K	$34.2K
Salinas Valley Memorial Hospital	$43.1K	$44.7K	$50.4K	$48.6K	$48.4K	$47.0K
Santa Barbara Cottage Hospital	$30.3K	$36.6K	$32.6K	$33.5K	$35.5K	$33.7K
Stanford Health Care	$47.4K	$49.2K	$53.3K	$58.8K	$63.2K	$54.9K
Washington Hospital – Fremont	$33.3K	$30.9K	$33.2K	$35.5K	$31.8K	$32.9K

Commercial to Medicare Payment to Cost Ratio for Repeat Outlier Hospitals, 2019-2023

above 85%

Hospital	2019	2020	2021	2022	2023	Pooled Avg 2019-23
All Other Comparable Hospitals	**200%**	**199%**	**191%**	**200%**	**205%**	**199%**
7 High-Cost Hospitals	**365%**	**350%**	**355%**	**362%**	**361%**	**359%**
Community Hospital of The Monterey Peninsula	437%	353%	363%	369%	380%	381%
Doctors Medical Center - Modesto	372%	343%	325%	372%	367%	356%
Dominican Hospital	314%	336%	316%	334%	352%	330%
Salinas Valley Memorial Hospital	457%	461%	556%	501%	470%	487%
Santa Barbara Cottage Hospital	300%	310%	310%	311%	322%	311%
Stanford Health Care	335%	339%	351%	340%	343%	342%
Washington Hospital - Fremont	392%	352%	328%	363%	330%	355%

Discussion And Target Setting Considerations

OHCA suggests not re-setting spending target values.

- Year-over-year volatility in reported median household income is expected.
- Historical health care spending growth still outpaces growth in family incomes and consumers' ability to afford care; as outlined in statute and expressed by this board, the intent of the targets is to improve consumer affordability.
- Setting multi-year targets provides health care entities with predictability and consistency.
- OHCA will receive THCE data on the 2025 calendar year (a non-enforceable year) in September of 2026; to date OHCA has not reported the state's total health care spending growth relative to a spending target.

Does the Board have input on OHCA's recommendation?

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Methodology for Measuring Inpatient and Outpatient Hospital Spending

Vishaal Pegany, Deputy Director
Brian Briscombe, Senior Quantitative Analyst, RAND
Cheryl Damberg, Senior Economist, RAND

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Background

- From July through December 2025, OHCA convened the Hospital Spending Workgroup, soliciting input from key stakeholders on its approach to inpatient and outpatient measurement.

- Today we will begin by describing how OHCA will measure inpatient and outpatient spending, summarize the Workgroup's recent feedback, and share aggregate results from FY 2022 data and conclude with an outline of next steps.

Statutory Considerations: Data Sources for Hospital Measurement

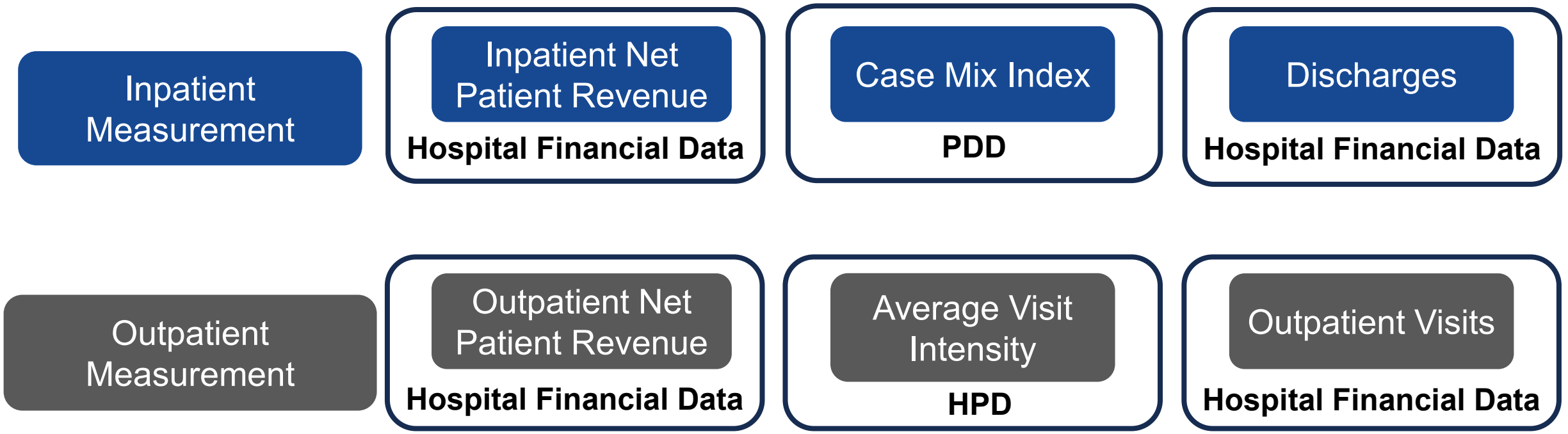
Statutory Requirements

"Notwithstanding any other state or local law, the office shall collect data and other information it determines necessary from health care entities, except exempted providers, to carry out the functions of the office. **To the extent consistent with federal law and to the greatest extent possible, the office may use existing and emerging public and private data sources to minimize administrative burdens and duplicative reporting, including data or information from federal agencies as well as state agencies...**"

Excerpt from Health and Safety Code Section 127501.4(a)

Measurement Data Sources

- For its inpatient measure, OHCA will use Hospital Financial Report data and Patient Discharge Data (PDD).
- For its outpatient measure, OHCA will use Hospital Financial Report data and the HPD.



Hospital Financial Report data refers to the Hospital Annual Financial Disclosure Report data.

OHCA Methodology to Measure Hospital Inpatient Spending

Step 1

Multiply

Total inpatient discharges

x

Case Mix Index (CMI)

=

Case Mix Adjusted Discharge (CMAD)

then

Step 2

Divide

Inpatient Net Patient Revenue (NPR)

÷

Case Mix Adjusted Discharge (CMAD)

=

Inpatient NPR per CMAD

Note: OHCA would report the metric by payer type (e.g., Commercial, Medicare and Medi-Cal).

OHCA Methodology to Measure Hospital Outpatient Spending

Step 1

Multiply

Total outpatient visits

x

Average Visit Intensity

=

Intensity Adjusted Outpatient Visits

then

Step 2

Divide

Outpatient Net Patient Revenue (NPR)

÷

Intensity Adjusted Outpatient Visits

=

Outpatient NPR per Intensity Adjusted Outpatient Visit

Note: OHCA would report the metric by payer type (e.g., Commercial, Medicare and Medi-Cal).

Feedback from December Workgroup Meeting

#	Feedback Theme	OHCA's Response
1	What will OHCA do when facilities have a small proportion (or number) of visits in the Health Care Payments Database (HPD)?	OHCA will explore characteristics of hospitals that have small proportions of visits in HPD and may reach out to certain facilities to learn more about how they report outpatient visits on their Hospital Financial Report filings.
2	If OHCA doesn't plan to use a combined measure for 2026, what happens if a hospital exceeds the target on the outpatient metric but not the inpatient metric, or vice versa?	OHCA is focused on finalizing its methodology for outpatient measurement. Both measures will be considered during enforcement and creating a combined measure is a separate topic that OHCA will explore.
3	Concern with relatively low proportion of Commercial outpatient visits found in the HPD. What steps will OHCA undertake to assess the extent to which HPD data for commercial outpatient measurement are representative?	OHCA has examined the correlation between measures of intensity for inpatient and outpatient care across payer types (e.g., all-payer compared to commercial). OHCA will explore potential analyses to determine how much the average visit intensity might vary given small sample sizes.
4	Can OHCA report a volume-only adjusted outpatient measure?	Yes, when OHCA releases a hospital-level data set with inpatient and outpatient data for FY 2022 and 2023, it will include both a volume-only adjusted outpatient measure as well as a volume- and intensity-adjusted outpatient measure.

Feedback from December Workgroup Meeting

#	Feedback Theme	OHCA's Response
5	Are high-cost drugs (muti-million-dollar doses) accounted for in OHCA's average visit intensity calculation?	If these high-cost drugs are administered in an outpatient setting, CMS' APC system has a payment rate in Addendum A that is converted in APC weight using the conversion factor and used in OHCA's visit intensity calculation. If these high-cost drugs are administered in an inpatient setting, the case mix index (CMI) adjustment will account for them.

Approach to Outpatient Measurement

Why Mapping Facilities Across Two Data Sources Is Needed

- As noted on prior slides, we calculate Average Visit Intensity (AVI) for outpatient visits using claims and encounters from the HPD.
- In HPD data, providers are identified by National Provider Identifier (NPI).
- Hospital Financial Reports are license-level annual reports with HCAI facility ID and CMS Certification Number (CCN).
- To align the HPD claims and encounters with entities that jointly submit on the Hospital Financial Reports, we match NPI to CCN (parent level).

Example: Mapping Facilities in the HPD

Hospital Financial Reports

Facility number (HCAI ID)	Facility name	CCN (CMS Certification Number)
106111111	Sample hospital 1	5-ZZZZ
107111111	Sample hospital 2	5-YYYY

MedPAR / CMS CCN-NPI Crosswalk

CCN (CMS Certification Number)	NPI (National Provider Identifier)
5-ZZZZ	11111111111
5-YYYY	2222222222
5-YYYY	3333333333

Facility crosswalk imported into HPD

Facility number (HCAI ID)	Facility name	CCN (CMS Certification Number)	NPI (National Provider Identifier)
106111111	Sample hospital 1	5-ZZZZ	11111111111
107111111	Sample hospital 2	5-YYYY	2222222222
107111111	Sample hospital 2	5-YYYY	3333333333

NPI is then used to identify facilities in HPD.

Counting Outpatient Visits in the HPD

Hospital Financial Reports include the universe of visit counts, as reported by hospitals.

Per Chapter 4000 of the Accounting and Reporting Manual for California Hospitals, the Hospital Financial Reports count visits to each cost center:

- If a patient visits more than one part of a hospital (i.e., two ambulatory cost centers), that may count as one visit for each ambulatory cost center.
- Ancillary services don't count as additional visits during the same day as the ambulatory visit, but they may count as a visit if no ambulatory visit occurred that day.

Calculating Average Visit Intensity

- OHCA will use Medicare's Ambulatory Payment Classifications (APCs) to estimate average intensity.
- APCs correspond to procedure codes (HCPCS codes) and APC weights are publicly available on the CMS website.*
- HPD claims are assigned an APC code and APC weight based on Addendum A for each facility.
- For each payer type, we calculate average visit intensity by dividing the sum of the APC weights by the number of visits found in HPD.
- For the aggregate 2022 results presented in subsequent slides, we begin by calculating payer-specific average visit intensity. Then, we calculate facility-wide average visit intensity as a weighted average of payer-specific average visit intensities.

*See more on Addendum A at Quarterly Addenda Updates | CMS

Considerations: Data Sources for Calculating Average Visit Intensity

Data Sources	Advantages	Drawbacks
Current approach: Use existing data in Hospital Financial Reports and the HPD	• Leverages existing resources and minimizes administrative burden for regulated entities • Allows reporting of both volume-only and volume + intensity-adjusted spending measures	• Requires two distinct data sources that increase OHCA's data analytic efforts and extend reporting preparation period • Requires hospitals to check and provide input on entity crosswalk between Hospital Financial Reports and HPD • A volume-only outpatient measure risks ignoring the complex care hospitals provide in that setting.

Considerations: Data Sources for Calculating Average Visit Intensity

Data Sources	Advantages	Drawbacks
Future Consideration: Collect new data from hospitals	• Offers opportunity to include all patients and would be most aligned with the financial data source • Potential to fold into hospital financial data reporting, which includes attestation to data's accuracy	• Longer timeframe for collection of outpatient encounter data (similar to the Patient Discharge Data) and reporting • Introduces additional burden to data submitters • OHCA administrative burden for collecting, validating, and compiling data for comparable hospitals (approximately 365* organizations) • Not all hospital organizations may have the ability to report desired details

*For the calendar year ending in Fiscal Year 2022, there are more than 360 comparable hospitals, but approximately 30 facilities do not report outpatient visits in Hospital Financial Report filings.

Applying the Methodology to Calculate 2022 Aggregate Results

Number of Facilities Identified in the HPD

For Fiscal Year 2022, not all Comparable hospitals reported outpatient visits. But among those that did, OHCA's crosswalk identified 327 of the 338 (97%) facilities.

	Number of Facilities	% of Comparable Hospitals in Hospital Financial Reports
Comparable hospitals in Hospital Financial Reports	368	
… with outpatient visits in Hospital Financial Reports	338	92%
… with outpatient visits in HPD	327	89%
… with outpatient visits with APC weights	322	88%

Note: A small number of facilities with visits in the Hospital Financial Reports were not found in HPD. Most were mental health facilities. In addition, there were three cases where two Hospital Financial Reports share the same CCN; for these cases, all the HPD claims we identified corresponded to the larger Hospital Financial Report reporting entity. We did not observe any HPD claims linked to the smaller entity.

Aggregate Results: Number of Outpatient Visits Found in the HPD

Of the 19.6 million outpatient visits found in HPD, 12.2 million (62.2%) have an APC weight to estimate an all-payer Average Visit Intensity (AVI). Within the Commercial market, 59% of outpatient visits in the HPD have an APC weight to estimate a Commercial AVI.

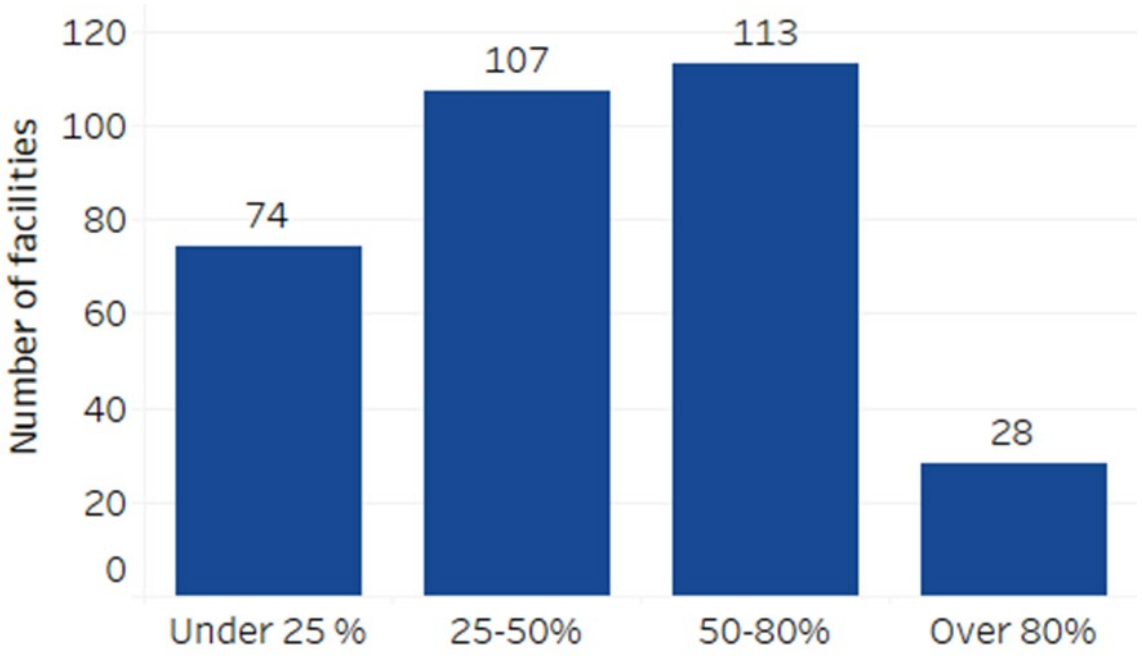
2022 Fiscal Year Comparable Hospitals	Total	Commercial	Medicare	Medi-Cal
Outpatient visits in Hospital Financial Reports	48.5 million	15.3 million	15.9 million	15.4 million
Outpatient visits in Hospital Financial Reports among hospitals found in HPD	48.1 million	15.1 million	15.8 million	15.3 million
Outpatient visits in HPD	19.6 million	2.9 million	9.9 million	6.7 million
% of Hospital Financial Reports reported visits	*40.7%*	*19.2%*	*63.0%*	*43.8%*
Outpatient visits with APC weights in HPD	12.2 million	1.7 million	6.7 million	3.8 million
% of Hospital Financial Reports reported visits	*25.5%*	*11.0%*	*42.7%*	*25.0%*

Note: Commercial, Medicare and Medi-Cal visits are calculated as the sum of managed care and traditional subcategories. Not shown in the breakdown are County Indigents, Other Indigent and Other Payers

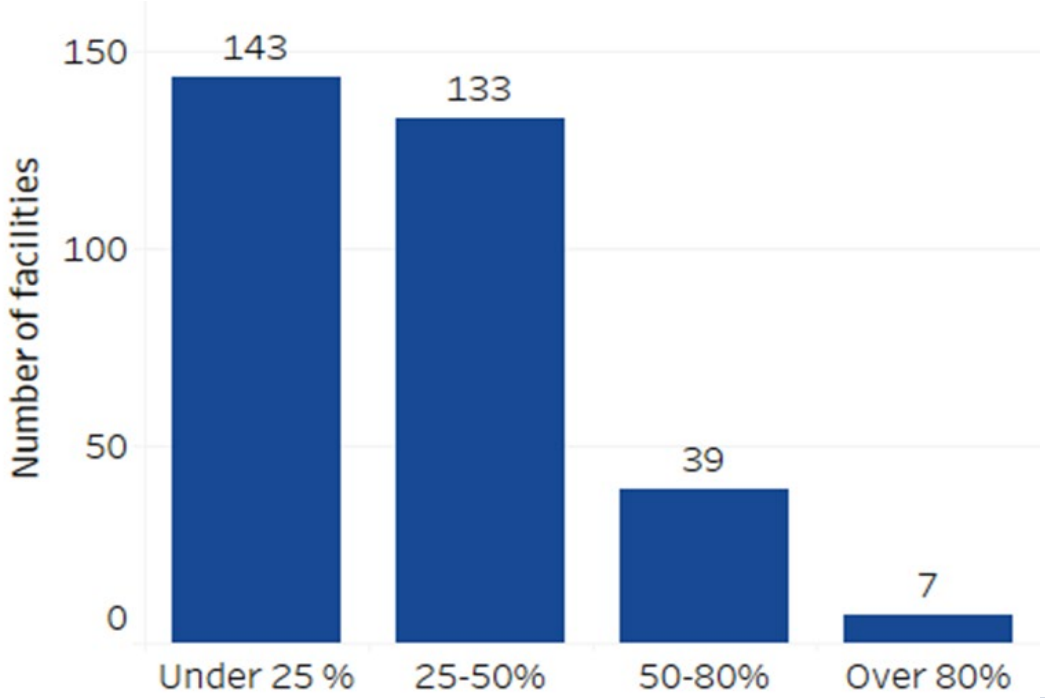
Proportion of Visits per Facility

- 2/3 of facilities have between 25-80% of Hospital Financial Report visits in the HPD.
- 1/2 of facilities have between 25-80% of Hospital Financial Report visits in the HPD with an APC weight.

HPD Visits/ Hospital Financial Reports Visits



HPD Visits with APC/ Hospital Financial Reports Visits



Charts include the 322 comparable facilities with outpatient visits found in HPD.

Comparing All-Payer and Commercial Average Visit Intensity (AVI) Measures

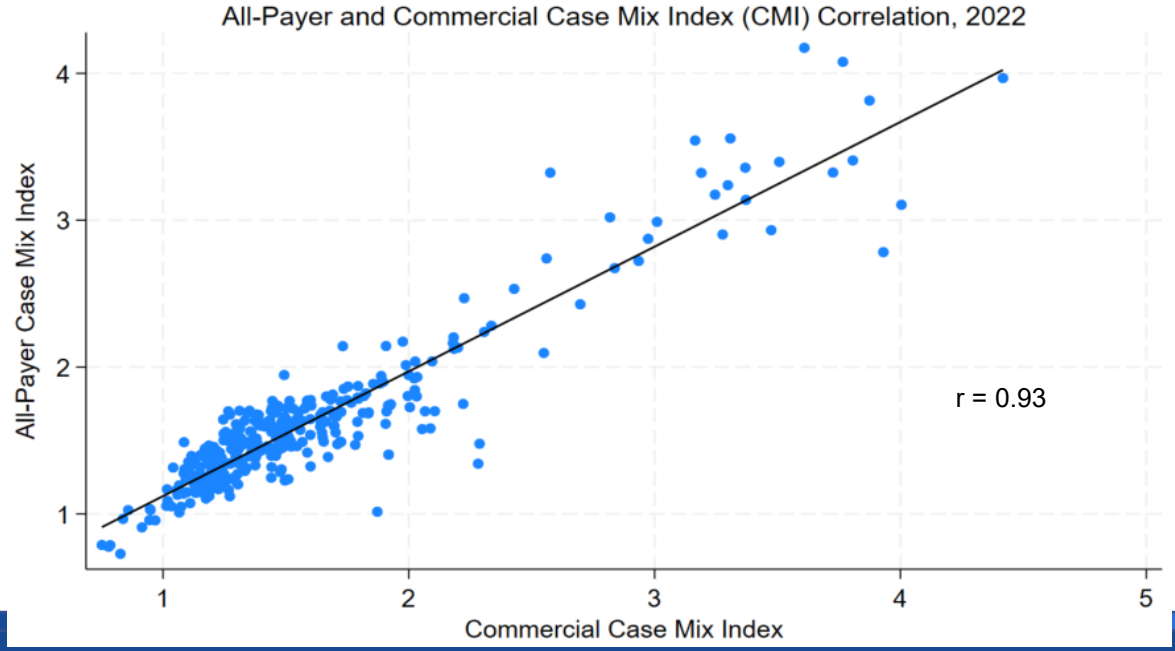
- Given the Workgroup's concerns about the relatively low proportion of Commercial outpatient visits found in the HPD, we examined the relationship between the All-Payer AVI and the Commercial AVI.

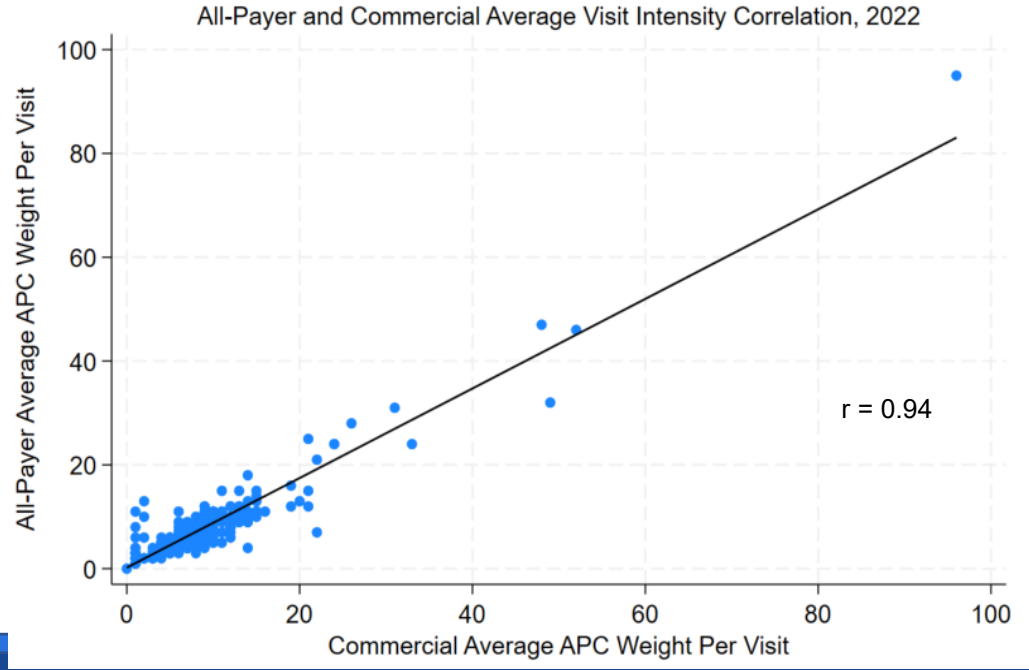
- We also examined the correlation between All-Payer Case Mix Index (CMI) and the Commercial CMI. Both of these inpatient intensity measures are calculated using the Patient Discharge Data (PDD).

- Note that while we use a sample of HPD outpatient visits to calculate AVI, we can use the full census of inpatient discharges from the PDD to calculate CMI.

Comparing All-Payer and Commercial Average Visit Intensity (AVI) Measures

- As the figures below show, the All-Payer and Commercial intensity measures are strongly, positively correlated for both inpatient (left figure) and outpatient care (right figure).
- These data support OHCA moving forward with payer-specific values for CMI and AVI when reporting inpatient NPR per CMAD and outpatient NPR per intensity-adjusted outpatient visit, respectively.





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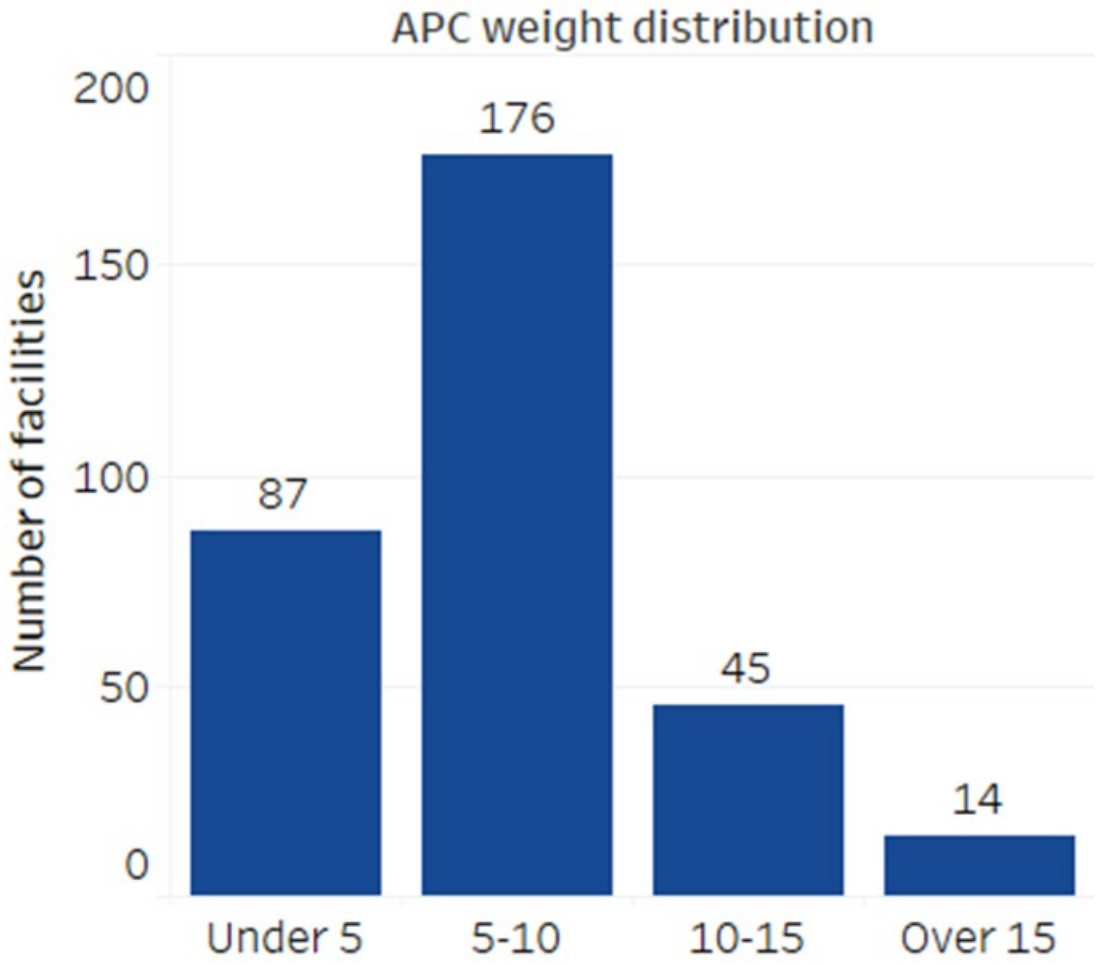
2022 Aggregate Results: Average Visit Intensity

- In 2022, the average visit intensity across comparable facilities was 7.9.
- As a check on the reasonableness of the estimates, we found that facilities with high average visit intensity tended to align with the type of facilities we would expect to have high visit intensity.
- Facilities with an APC weight of over 15 primarily include hospitals specializing in surgical care, cardiac treatment, spinal injury, and cancer care.



Charts include the 322 comparable facilities with outpatient visits found in HPD.

Potential Reasons for Differences Between Hospital Financial Reports and HPD Data Sources

- HPD data represents a large sample of medical services provided to Californians but does not represent 100% of the covered population.
  - Excludes some portion of the private self-insured ERISA plan population.
  - Excludes data from small plans (below 40K members) that are not required to report data to the HPD.
- Hospital NPIs could be missing from the OHCA Hospital Facility to NPI Crosswalk, but this wouldn't explain the substantial payer-level variation in outpatient visits found.
- Visit counts may be reported differently in the Hospital Financial Reports.

Next Steps

Applying the Methodology and Reporting Timelines

As shown below, hospital reporting is lagged compared to THCE reporting for payers. This means the results will be calculated for multiple years with this methodology. Note the first enforceable year's data is submitted in Fall 2029 and reported in Spring 2030.

Measurement Period	THCE Data Submitted	THCE Data Reported	Hospital Data Submitted	Hospital Data Reported
2022 to 2023	September 2024	June 2025	Fall 2025	Spring/Summer 2026
2023 to 2024	September 2025	June 2026	Fall 2026	Spring 2027
2024 to 2025	September 2026	June 2027	Fall 2027	Spring 2028
2025 to 2026*	September 2027	June 2028	Fall 2028	Spring 2029
2026 to 2027	September 2028	June 2029	Fall 2029	Spring 2030

Next Steps

- In January 2026, OHCA plans to post the OHCA Hospital Facility to NPI Crosswalk on its website with a request to hospitals to confirm the NPIs that map to their California license number.
- In March 2026, OHCA will update the crosswalk to reflect hospital feedback and apply the outpatient measurement methodology to FY 2022 and 2023 data.
- In April 2026, OHCA will post both a revised crosswalk and a facility level dataset that includes measures for payer-specific inpatient and outpatient spending for FY 2022 and 2023.

Timeline for Q1 2026 is dependent on timely feedback on the OHCA Hospital Facility to NPI crosswalk.

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Spending Target Enforcement: Introduction to Performance Improvement Plans

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

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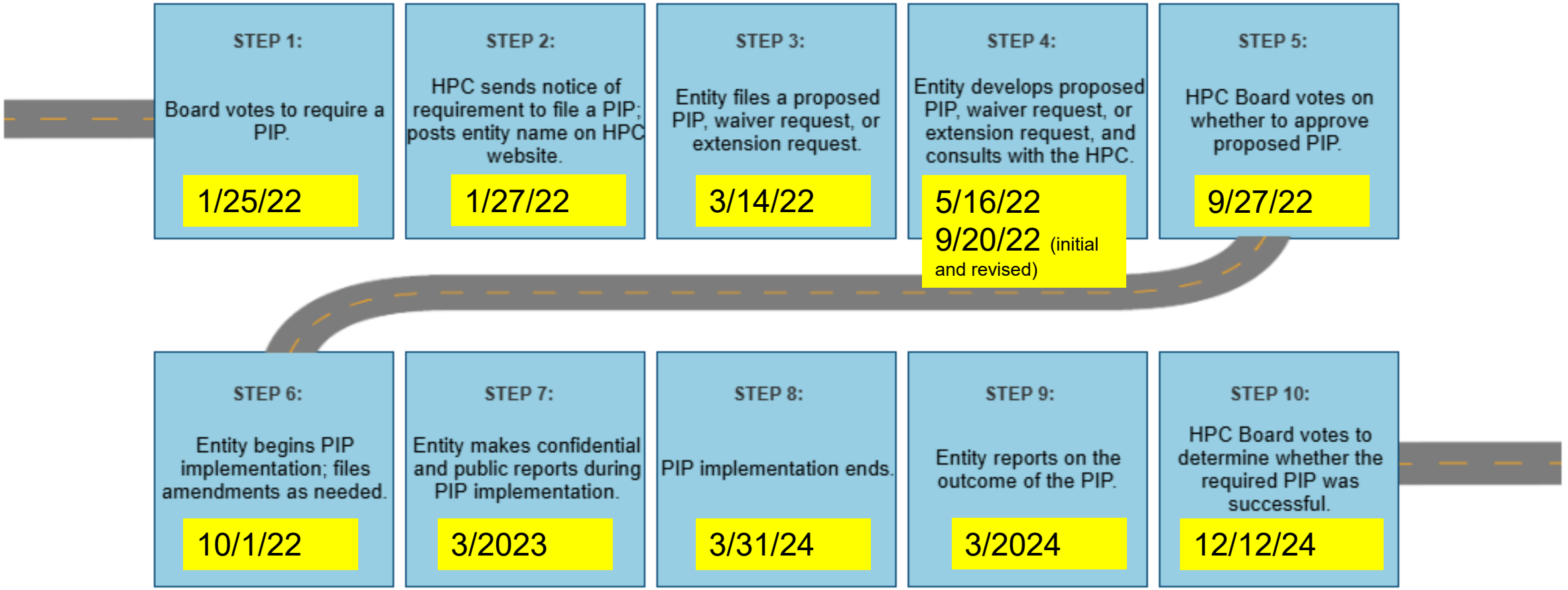
Massachusetts Performance Improvement Plan (PIP) Process

- The Health Policy Commission (HPC) may require PIP if an entity exceeds benchmark.
- Entities have 45 days to submit a PIP proposal and may request an extension. Requests of extensions greater than 45 days require an HPC board vote for approval.
- PIP implementation must conclude within 18 months.
- PIPs must:
  - Address drivers of excessive cost growth
  - Set and meet goals that address the performance year's excessive cost growth
  - Mitigate impact to care, services, access
  - Translate into savings for consumers
- HPC must monitor entities for compliance with PIP.
- HPC may require entities with unsuccessful PIPs to continue with existing PIP or submit a new PIP or they may delay or waive an additional PIP.
- HPC may assess penalty up to $500,000 if an entity willfully neglects to submit PIP, knowingly fails to provide required information, or does not implement PIP in good faith.
- HPC has required one PIP, which achieved $197.1M in savings.

Massachusetts General Brigham (MGB) PIP Timeline – 3 Full Years



Massachusetts PIP Process Overview: https://masshpc.gov/sites/default/files/2023-06/pips-process-overview.pdf
Mass General Brigham PIP: https://masshpc.gov/cost-containment/pips/mgb

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Oregon PIP Process

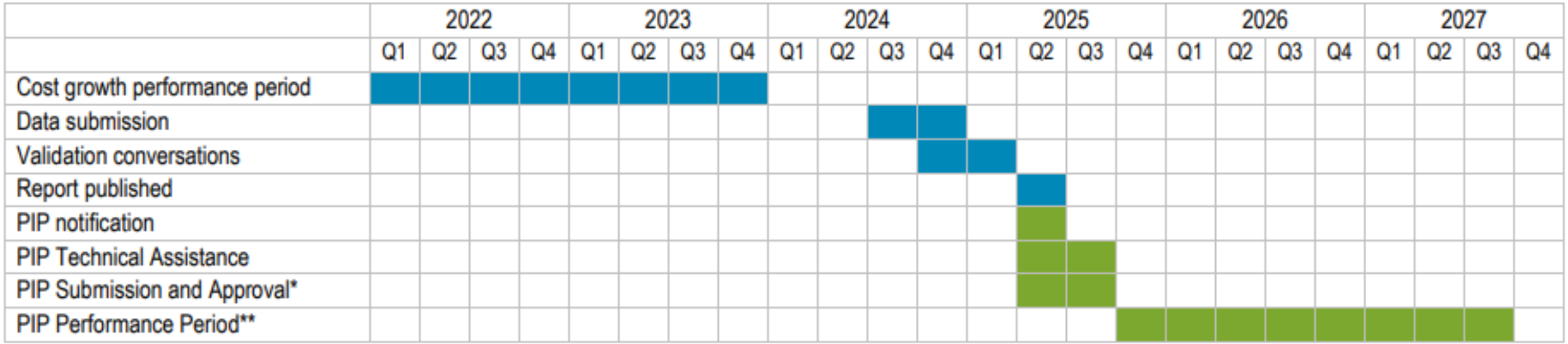
- Oregon Health Authority (OHA) must require a PIP for entities that exceed cost growth target without a reasonable cause.
- Entities have 90 calendar days to submit proposal and may request an extension of 45 calendar days or less. Requests must be made within 30 calendar days of original deadline.
- PIPs must conclude within 24 consecutive months from PIP approval date, unless extended by OHA.
- PIPs must:
  - Address entity's drivers of cost growth.
  - Generate savings for members, patients, payers, and purchasers.
  - Sustain savings beyond PIP performance period.
- Entities must submit progress reports every six months.
- OHA may require entities with unsuccessful PIPs to continue with existing PIP or submit a new PIP.
- OHA also has a financial penalty option for enforcement

OHA PIP Guidance: https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20Meeting%20Documents/CGT-6-PIP-Template-Guidance.pdf
OHA Statute: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=5882

Oregon PIP Process

Example Timeline

For this example, the entity exceeded the target with statistical confidence and without a reasonable cause for the 2022-2023 cost growth performance period. OHA notified the entity that a PIP was required and provided technical assistance for the PIP submission. OHA approved the submitted PIP with a 24-month performance period.



*If a PIP does not meet requirements, OHA may require entities to revise and resubmit the PIP.

**PIP performance periods may vary, based on the entity's cost growth drivers and strategies.

OHA PIP Guidance: https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20Meeting%20Documents/CGT-6-PIP-Template-Guidance.pdf

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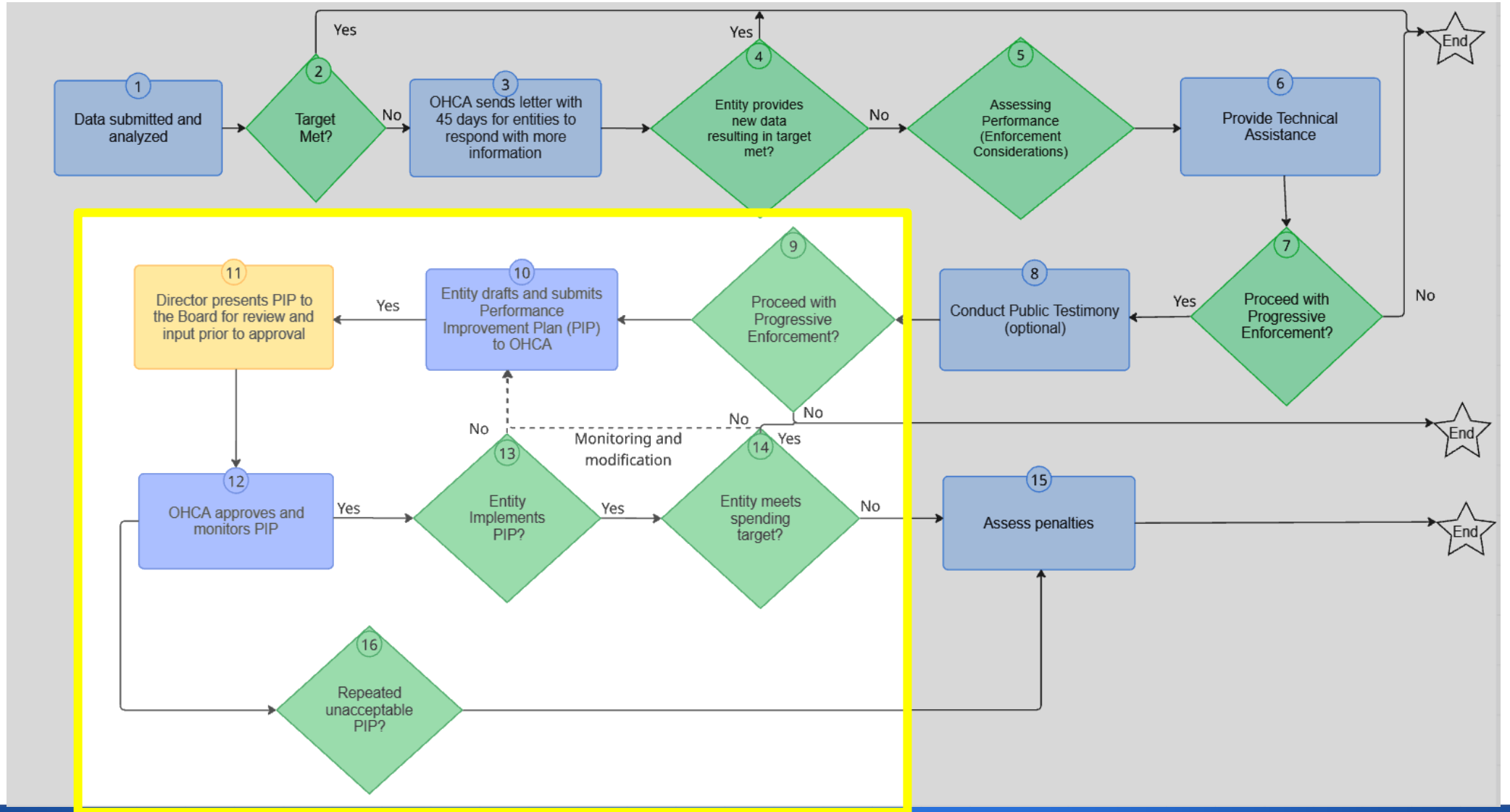
OHCA Enforcement Process Flow



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Statute

127502.5 (b)(4)
(b) Prior to taking any enforcement action, the office shall do all of the following: … **(4) The director shall consult with the Director of Managed Health Care, the Director of Health Care Services, or the Insurance Commissioner, as applicable**, prior to taking any of the enforcement actions specified in this section with respect to a payer regulated by the respective department **to ensure** any technical assistance, **performance improvement plans,** or other measures authorized by this section **are consistent with laws** applicable to regulating health care service plans, health insurers, or a Medi-Cal managed care plan contracted with the State Department of Health Care Services.

Statute

127502.5 (c)(1)-(3)
(1) "…**The office may require a health care entity to submit and implement a performance improvement plan** that identifies the causes for spending growth and shall include, but not be limited to, specific strategies, adjustments, and action steps the health care entity proposes to implement to improve spending performance during a specified time period. **The office shall request further information, as needed**, in order to approve a proposed performance improvement plan. The director may approve a performance improvement plan consistent with those areas requiring specific performance or correction for **up to three years**. The director shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode **access, quality, equity, or workforce stability**. The standards developed under Article 7 (commencing with Section 127506) may be considered in the approval of a performance improvement plan. **(2) The office shall monitor the health care entity for compliance** with the performance improvement plan. **The office shall publicly post the identity of a health care entity implementing a performance improvement plan** and, at a minimum, a detailed summary of the entity's compliance with the requirements of the performance improvement plan while the plan remains in effect and **shall transmit an approved performance improvement plan to appropriate state regulators** for the entity. **(3) A health care entity shall work to implement the performance improvement plan** as submitted to, and approved by, the office. The office shall monitor the health care entity for compliance with the performance improvement plan.

Statute

127502.5 (c)(4) and (5)
(4) The board, the members of the board, the office, the department, and employees, contractors, and advisors of the office and the department shall keep confidential all nonpublic information and documents obtained under this subdivision, and shall not disclose the confidential information or documents to any person, other than the Attorney General, without the consent of the source of the information or documents, except in an administrative penalty action, or a public meeting under this section if the office believes that disclosure should be made in the public interest after taking into account any privacy, trade secret, or anticompetitive considerations. Prior to disclosure in a public meeting, the office shall notify the relevant party and provide the source of nonpublic information an opportunity to specify facts documenting why release of the information is damaging or prejudicial to the source of the information and why the public interest is served in withholding the information. Information that is otherwise publicly available, or that has not been confidentially maintained by the source, shall not be considered nonpublic information. This paragraph does not limit the board's discussion of nonpublic information during closed sessions of board meetings. **(5)** Notwithstanding any other law, all nonpublic information and documents obtained under this subdivision shall not be required to be disclosed pursuant to the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records.

Statute

127502.5 (d)(1) and (5)

(1) 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, the director may assess administrative penalties commensurate with the failure of the health care entity to meet the target. **An entity that has fully complied with an approved performance improvement plan by the deadline established by the office shall not be assessed administrative penalties.** However, the director may require a modification to the performance improvement plan until the cost target is met.

(5) If, after the implementation of one or more performance improvement plans, the health care entity is repeatedly noncompliant with the performance improvement plan, the director may assess escalating administrative penalties that exceed the penalties imposed under paragraphs (1) and (2) of this subdivision and paragraph (4) of subdivision (a).

Statute

127502.5 (h)(1) and (2)

(1) The director may directly assess administrative penalties when a health care entity has failed to comply with this chapter by doing any of the following:

(A) Willfully failing to report complete and accurate data.

(B) Repeatedly neglecting to file a performance improvement plan with the office.

(C) Repeatedly failing to file an acceptable performance improvement plan with the office.

(D) Repeatedly failing to implement the performance improvement plan.

(E) Knowingly failing to provide information required by this section to the office.

(F) Knowingly falsifying information required by this section.

(2) The director may call a public meeting to notify the public about the health care entity's violation and declare the entity as imperiling the state's ability to monitor and control health care cost growth.

Statute

127501.6 (b)(2)
(b)(2) The **annual report shall include** all of the following: … **(F) Performance improvement plans required**, administrative penalties imposed and assessed, and the amount returned to consumers and purchasers, if any.

127501.11 (c)(4)
(c) The director shall present to the board for discussion all of the following: … **(4) Review and input on performance improvement plans prior to approval**, including delivery of periodic updates about compliance with performance improvement plans to inform any adjustment to the standards for imposing those plans.

127501.10 (e)(2)
(e)(2) The board shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code), except that **the board may hold closed sessions** when considering matters related to the office assessing administrative penalties, requiring performance improvement plans under Section 127502.5, and discussing nonpublic information and documents received by the office and board under this chapter.

What is a Performance Improvement Plan?

- PIPs are the action steps and strategies a health care entity agrees with the Office to implement to come into compliance with the spending growth target(s) during a specified time period.
- Entities will include in their PIPs the causes for spending growth, specific goals, strategies, adjustments, and action steps, and proposed measurements to track performance improvement.
- The success of a PIP will depend on entities' compliance with their approved PIP and their performance against spending growth targets.

- PIPs ***are not*** developed by OHCA staff – entities are responsible for developing a proposed PIP that will be evaluated and approved by OHCA.

OHCA's Proposed PIP Process

	Pre-Implementation
1.	OHCA determines if PIP is required
2.	OHCA consults with DMHC, DHCS, and CDI before taking action
2.	OHCA gives entity 45 days to submit a proposal; can request 1 extension of up to 30 days with weekly updates
3.	OHCA evaluates proposal, consults with regulatory agencies, obtains Board input, and discusses proposal with entity.
4.	OHCA makes decision to either approve PIP or require modifications and resubmission of a revised plan

	Implementation
5.	Entity begins implementing PIP – implementation period must end within 3 years
6.	Entity provides progress report(s) and meets with OHCA staff in accordance with approved PIP's timeline
7.	OHCA evaluates entity's progress and determines if entity is complying with PIP and/or if entity must modify PIP. Significant modifications may require consultation with regulators and input from Board

OHCA's Proposed PIP Process

	Post-Implementation
8.	After PIP's implementation period ends, entity has 45 days to submit final report
9.	OHCA evaluates final report and determines if PIP was successful

Discussion: Performance Improvement Plans

Does the Board have input on Performance Improvement Plans or how it fits into the enforcement process?

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Public Comment

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Introduction to HCAI Health of Primary Care in California Snapshot

Margareta Brandt, Assistant Deputy Director
Debbie Lindes, Health Care Delivery System Group Manager

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Department of Health Care Access and Information

Context

- The NASEM 2021 *Implementing High-Quality Primary Care* report proposed a US scorecard on the health of primary care to track implementation and progress towards high-quality primary care.
- National level and state level scorecards have been developed since then.
- California Health Care Foundation's (CHCF) Primary Care Investment Coordinating Group of California (PICG) recommended a primary care scorecard for California in 2022.

Source: NASEM (2021) Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care | The National Academies Press, PICG Recommended Actions Recommended Actions - California Health Care Foundation

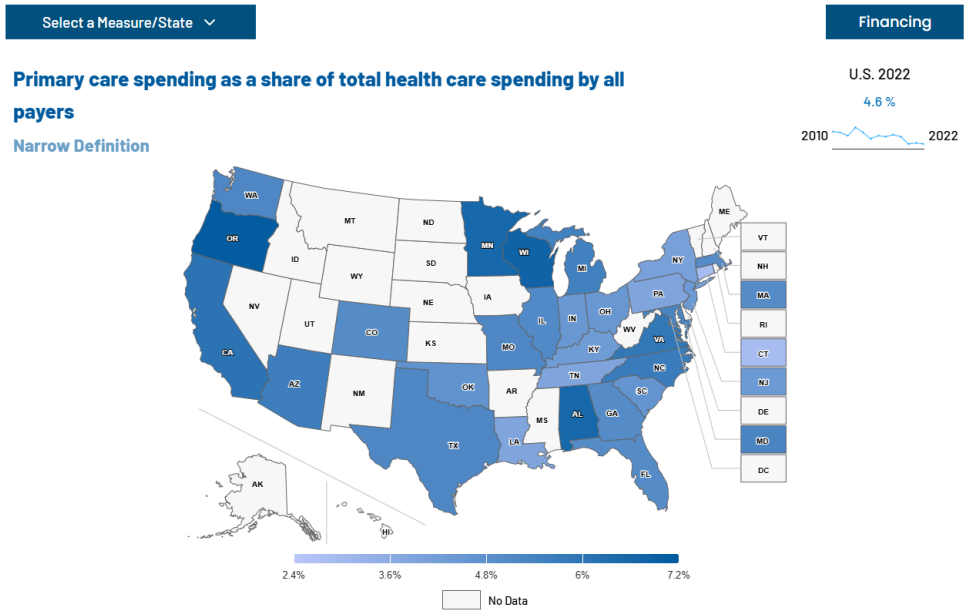
One Vision for Primary Care Delivery in CA

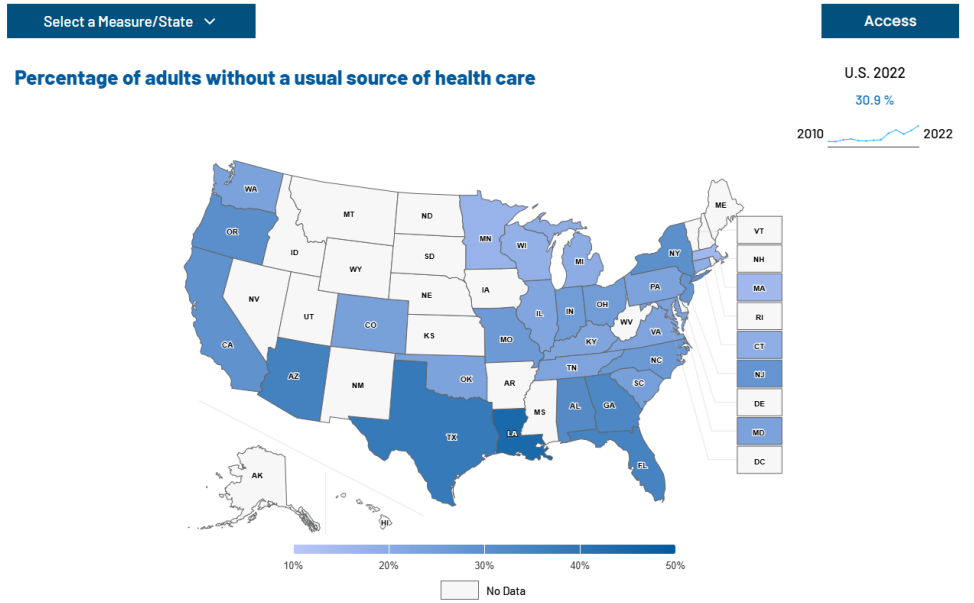
- Accessible
- Person- and family- centered
- Relationship-based
- Integrated
- Team-based
- Coordinated
- Comprehensive
- Equitable

California Quality Collaborative (CQC). (June 2020, revised April 2022). *Advanced Primary Care: Defining a Shared Standard*. Purchaser Business Group on Health (PBGH). https://www.pbgh.org/wp-content/uploads/2022/04/advanced-primary-care-shared-standard.pdf

Snapshot Purpose

- Create a **shared understanding** of the health of California's primary care sector, both statewide and for geographic regions within the state.
- **Track progress** toward equitable, high-quality, sustainable primary care for all Californians.
- Monitor performance on **key elements of the health of primary care**, including spending and outcomes.
- **Identify gaps and challenges** to inform action on access, workforce, and payment.





Source: Milbank Memorial Fund 2025 Primary Care Scorecard Data Dashboard. 2025 Primary Care Scorecard Data Dashboard | Milbank Memorial Fund

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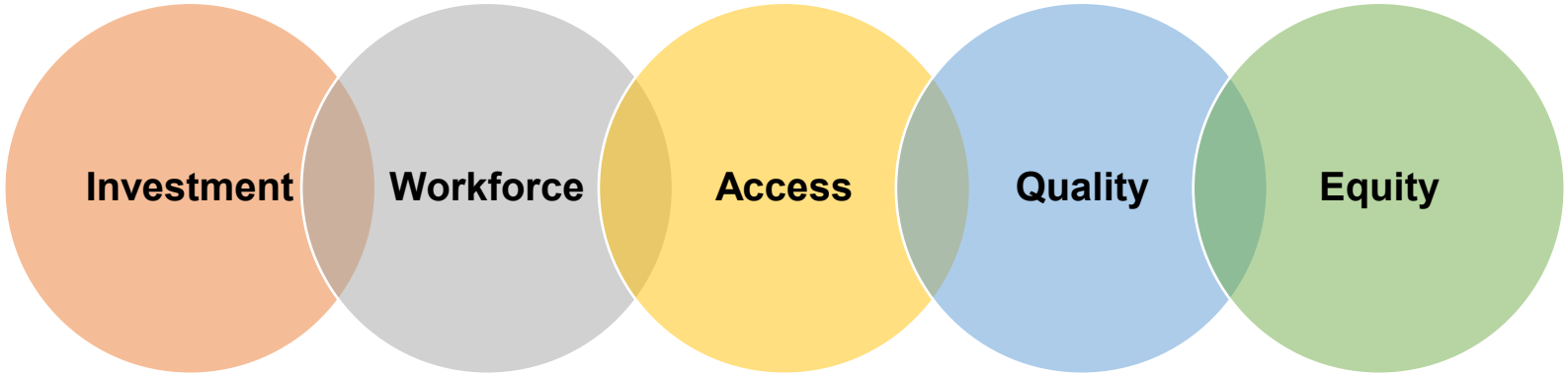
Snapshot Approach and Audiences

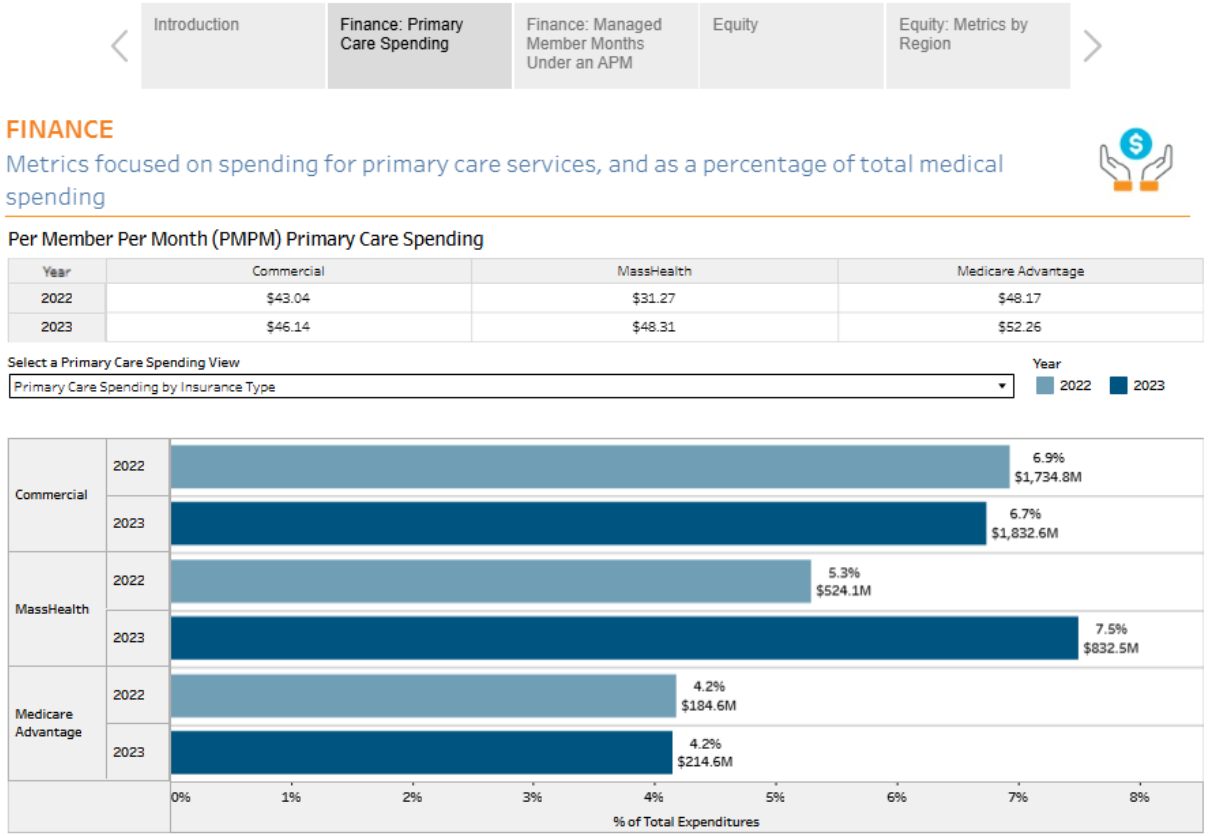
- **Compile data** from across HCAI and other sources to create a comprehensive picture of primary care in California, at the statewide level and regionally.
- Focus on **five key domains.**



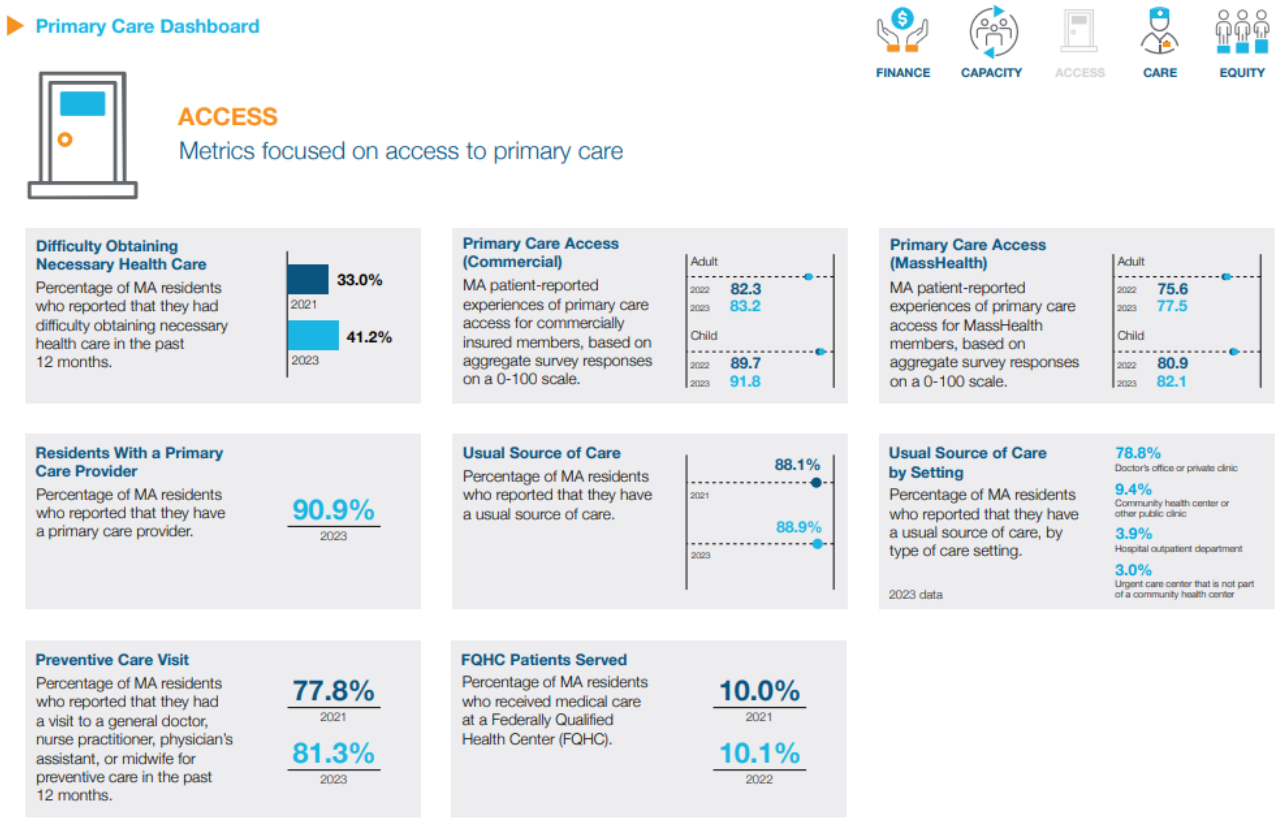
- Adopt a **phased approach** that begins with a static report on the key domains and adds indicators and interactive features over time.
- The primary audiences are **engaged stakeholders** (purchasers, payers, providers, state government, policymakers, consumer advocates, and researchers).

Example: Massachusetts Primary Care Dashboard

Interactive dashboard



Static dashboard



Source: https://www.chiamass.gov/massachusetts-primary-care-dashboard/#May-2024

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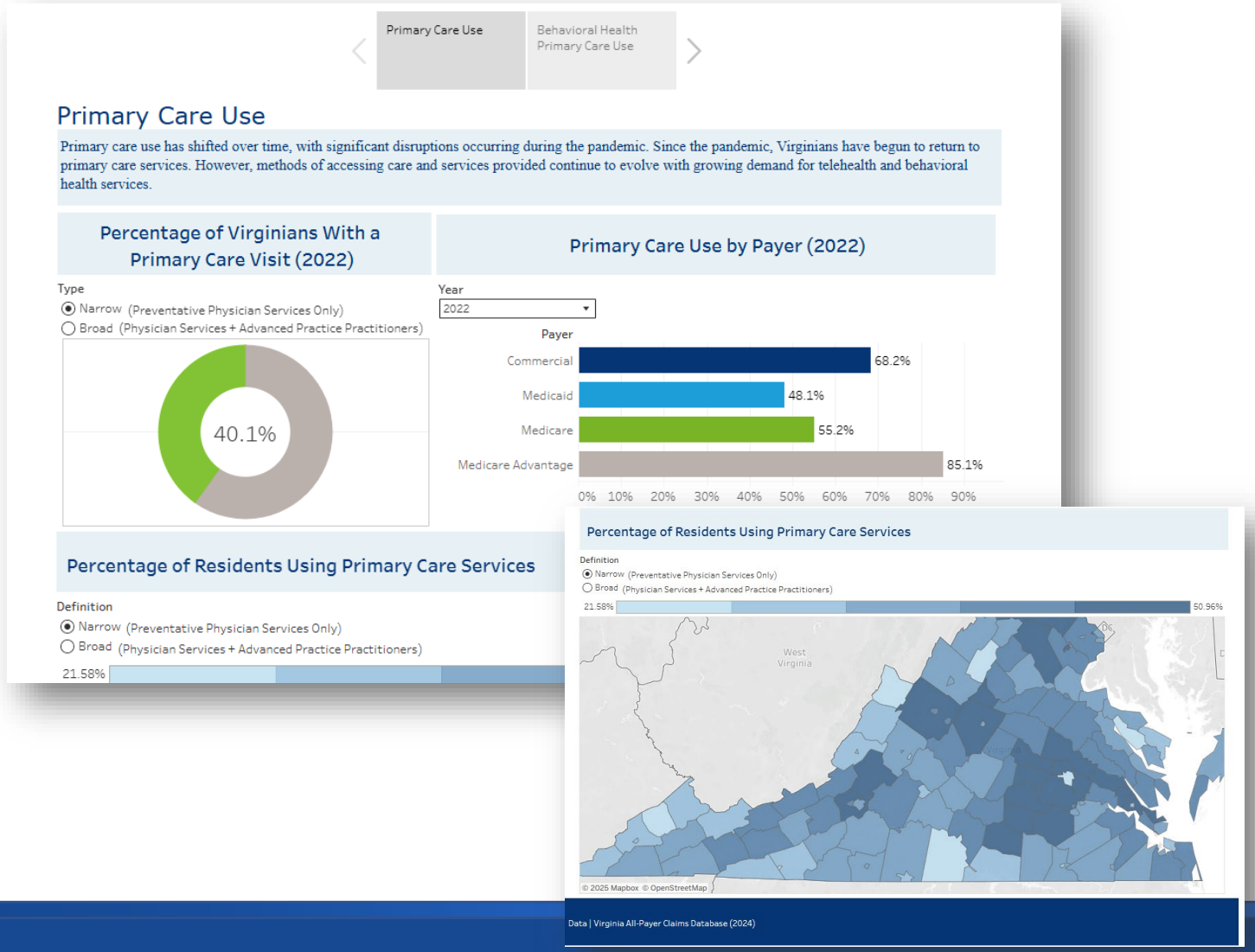
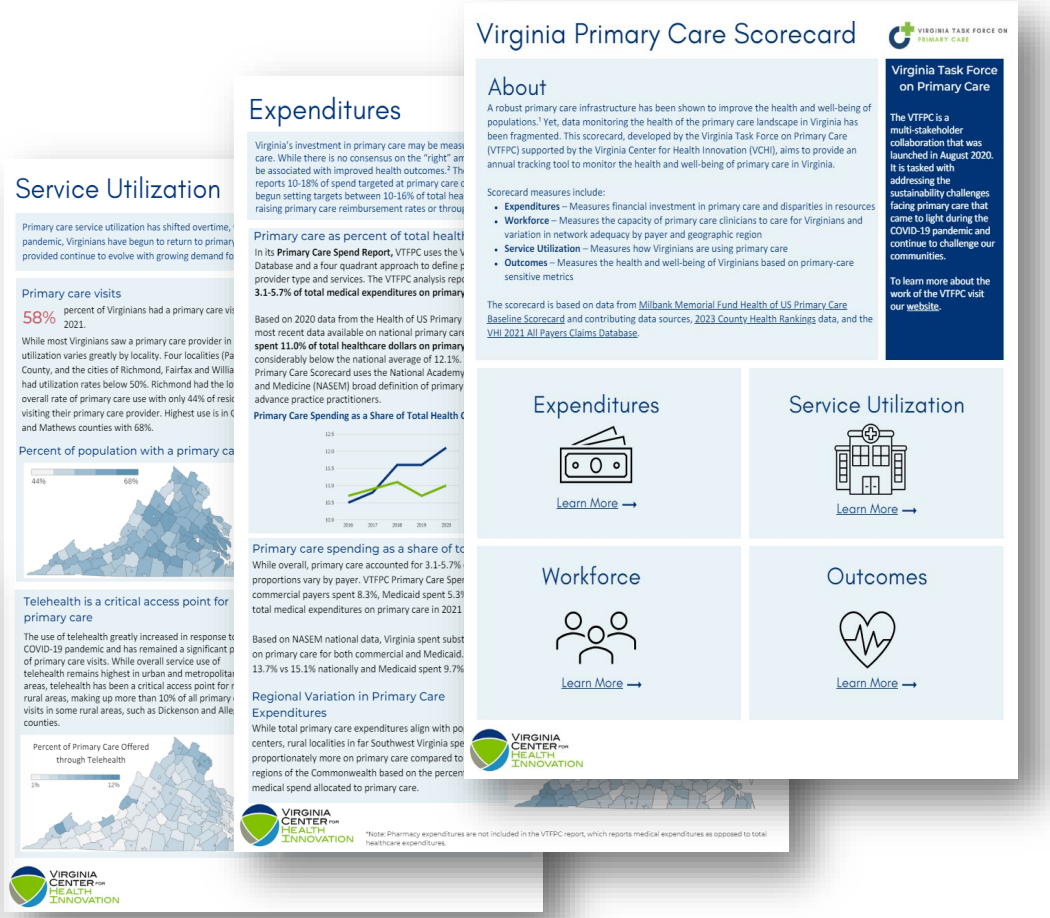
Example: Virginia Primary Care Scorecard

Interactive dashboard



Static dashboard



Source: https://www.vahealthinnovation.org/primary-care-scorecard-dashboard/

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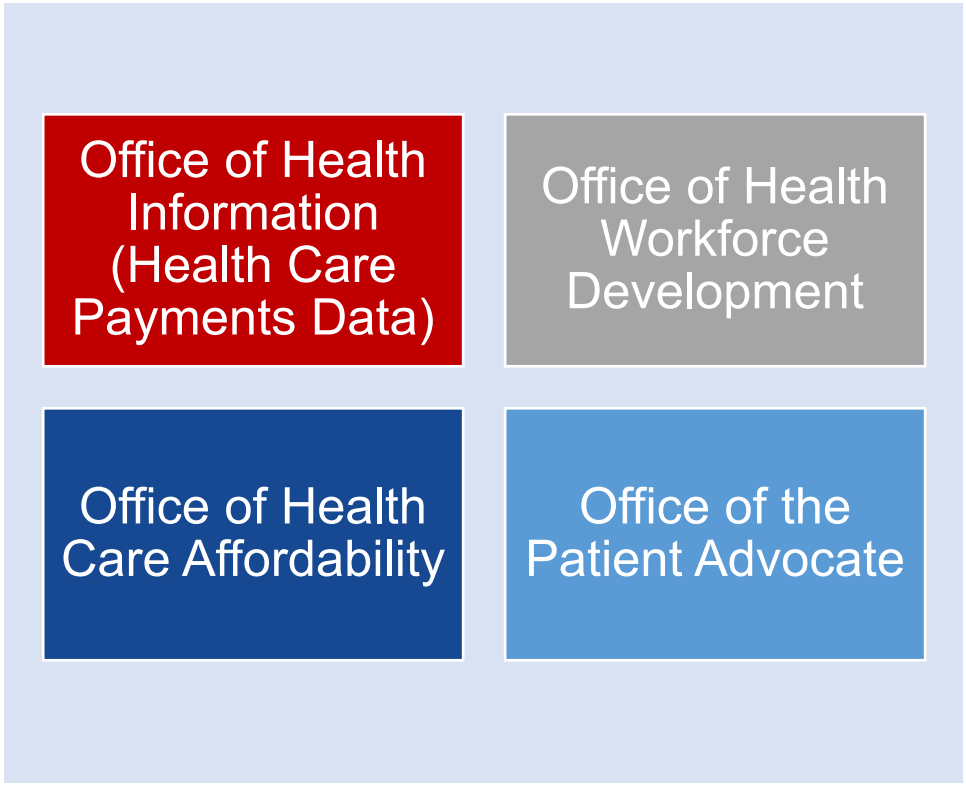
HCAI Snapshot Project Team

- The Snapshot is a collaborative HCAI project leveraging expertise in data, workforce, spending, equity, and quality.
- Contractor support from Freedman HealthCare and Diane Rittenhouse, Mathematica.
- Collaborating with CHCF on communications to support dissemination of the Snapshot.



HCAI Primary Care Reporting

Health workforce employment and educational data trends, with future reporting on primary care workforce supply and demand modeling

Office of Health Workforce Development

Healthcare Payments Data (HPD)

Primary care metrics such as primary care clinic utilization and avoidable emergency department visits

Plan-level performance toward annual improvement and statewide primary care investment benchmarks

Quality and patient experience rating reports for health plans and medical groups

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Snapshot Deliverables

Early 2026 — HCAI Brief on the Health of Primary Care in California

- **Introduction to Snapshot:** Timeline, approach to the static and interactive Snapshots, stakeholder engagement.
- **Content Overview:** Current state of primary care in California, domains for future snapshots.

Fall 2026 — Health of Primary Care in California Snapshot (static version)

- **First Static Report:** Baseline performance on key indicators for each domain to be included in interactive Snapshot.
- **Update on Interactive Snapshot:** Timeline and any other updates for development and release.

Fall 2027 — Health of Primary Care in California Snapshot (interactive)

- **First Interactive Snapshot:** Data dashboard featuring key indicators in each domain.
- **Accompanying Static Report:** Easily downloadable digest of performance on key indicators.

2028 and beyond — Annual updated Interactive and Static Snapshots

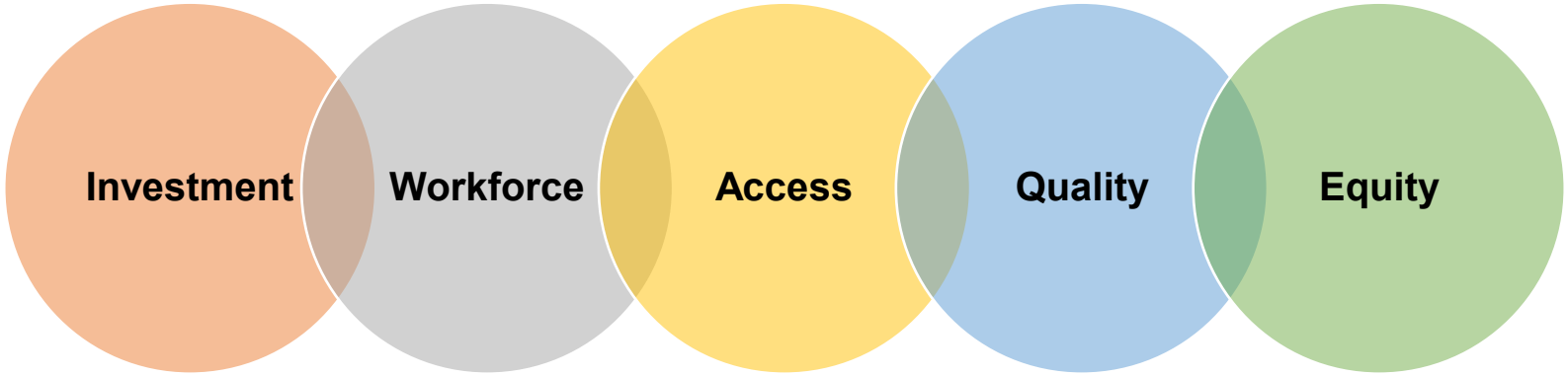
Note: Names of, and content within, deliverables are tentative and can be revised.

Snapshot Primary Care Indicator Development

Initial criteria for state and national indicators for the Snapshot

- ✓ Interest to California stakeholders.
- ✓ Concise set of indicators aligned with **five key domains** that will signal a positive change in California's primary care infrastructure.
- ✓ Supported by existing, accessible California data sources or national data sources with California-specific data.
- ✓ Are trackable over time, evidence-based, relevant, and actionable.

Example indicator: primary care investment by health plan and statewide



Stakeholder Engagement

Guiding Principles

- Engage a diverse set of stakeholders and seek their input to create a relevant slate of primary care indicators.
- Present stakeholders with a focused goal for the Primary Care Snapshot, based on current capabilities and an aligned vision for primary care.
- Convene a **new workgroup bi-monthly** for technical input, discussion among stakeholders, and Snapshot development through at least year-end 2026.
- Report on Snapshot progress to **existing HCAI stakeholder groups*** for feedback, quarterly or as needed.
- Conduct **individual meetings with stakeholders and experts**, as needed, to elicit candid feedback on indicator domains, preferences, and tradeoffs.

Stakeholder Groups

*Existing HCAI public stakeholder groups include OHCA Advisory Committee and Board, OHCA Investment and Payment Workgroup, HPD Advisory Committee, and Health Workforce and Education Training Council. The Snapshot team will also coordinate with sibling state departments (DMHC, DHCS, Covered CA, CalPERS) to solicit their input.

Snapshot Workgroup

Purpose: Provide primary care policy, data, and clinical expertise in the development and implementation of the HCAI Health of Primary Care in California Snapshot.

Workgroup Objectives

- Offer a transparent, public forum to understand stakeholders' priorities for the Snapshot.
- Engender thoughtful, comprehensive, and balanced stakeholder engagement to ensure strong buy-in and smooth implementation.
- Provide expert technical input on the availability and feasibility of primary care indicators for inclusion.

Workgroup activities will include:

- Reviewing best practices and lessons learned from other states, previous work in California, and literature on primary care measurement and reporting.
- Informing the development of primary care indicators for the HCAI Health of Primary Care in California Snapshot that promote equitable, high-quality, and cost-efficient care.
- Engaging stakeholders to gain the benefit of their knowledge and experience.
- Discussing strategies how to catalyze collective action towards high-quality, sustainable primary care in California through the Snapshot.

Snapshot Workgroup Members

Providers & Provider Organizations

Eric Ball, MD
Chair, Board of Directors, American Academy of Pediatrics in California (AAP-CA)

Rene Bravo, MD
President, California Medical Association (CMA)

Lisa Folberg, MPP
Chief Executive Officer, California Academy of Family Physicians (CAFP)

Susan Huang, MD
Chief Medical Officer, America's Physician Groups (APG)

Melissa Marshall, MD
Chief Medical Officer, California Primary Care Association (CPCA)

Jeremy Meis, PA-C, MPH
Immediate Past President, California Academy of Physician Associates (CAPA)

Aimee Paulson, DNP, MSN
President, California Association for Nurse Practitioners (CANP)

Health Plans

Edward Juhn, MD, MBA, MPH
Chief Medical Officer, Inland Empire Health Plan (IEHP)

Todd May, MD
VP Medical Director, Health Net

Consumer Reps & Advocates

Selene Betancourt, MPP
Senior Policy Manager, California Pan-Ethnic Health Network (CPEHN)

Diana Douglas, MA
Director of Policy and Legislative Advocacy, Health Access

Hospitals & Health Systems

Shunling Tsang, MD, MPH
Chair of Family Medicine, Riverside University Health System (RUHS)

Raul Ayala, MD, MHCM
Ambulatory Medical Officer, Adventist Health

Academic/SMEs

Kevin Grumbach, MD
Professor of Family and Community Medicine, UC San Francisco (UCSF)

Sunita Mutha, MD
Director, Healthforce Center at UCSF

Carlina Hansen, MHA
Senior Program Officer, California Health Care Foundation (CHCF)

Purchasers

Crystal Eubanks, MS-MHSc
VP of Care Transformation, Purchaser Business Group on Health (PBGH)

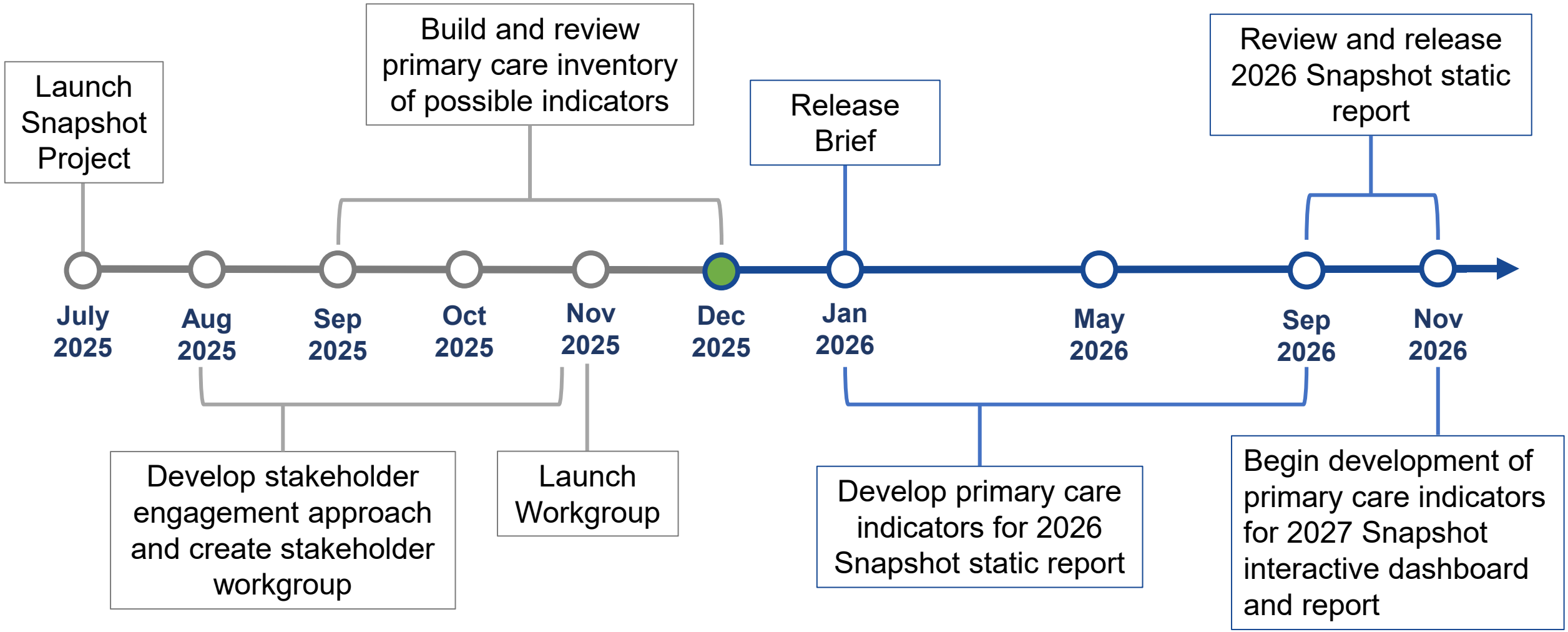
Upcoming: HCAI Brief on Primary Care in California

- Brief is scheduled for publication on the HCAI website early January 2026.
- Publication will be distributed via HCAI listserv and announced via social media (e.g., LinkedIn).

The brief will include:

- Purpose of the Snapshot initiative.
- Current state of primary care in California including baseline and contextual statistics from existing reporting in each of the five domains.
- Vision for Snapshot describing the phased approach and timeline for interactive Snapshot development.

2025-2026 Snapshot Timeline



Note: Stakeholder engagement occurring throughout the project lifecycle

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General Public Comment

Written public comment can be emailed to:
ohca@hcai.ca.gov
To ensure that written public comment is included in the posted board materials, e-mail your comments at least 3 business days prior to the meeting.

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Next Board Meeting:
January 28, 2026
10am

Location:
2020 West El Camino Ave, Conference Room 900, Sacramento, CA 95833

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Adjournment

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