OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Advisory Committee Meeting

January 14, 2026

HCAI

Department of Health Care Access and Information

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Welcome and Call to Order

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Agenda

1. **Welcome and Call to Order**

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

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

4. **Introduction to DSG 3.0 Regulations, Including Update on Behavioral Health Definition and Summary of Board Feedback**
   Andrew Feher; Margareta Brandt, Assistant Deputy Director; Debbie Lindes, Health Care Delivery System Group Manager

5. **Update on Cost and Market Impact Review Program**
   Sheila Tatayon, Assistant Deputy Director; Brian Kearns, Assistant Chief Counsel

6. **Spending Target Enforcement: Waiver of Enforcement, Technical Assistance, Public Testimony, and Performance Improvement Plans**
   Vishaal Pegany; CJ Howard

7. **Introduction to the HCAI Health of Primary Care in California Snapshot**
   Margareta Brandt; Debbie Lindes

7. **General Public Comment**

9. **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

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Rural Health Transformation Updates

Recap to-date

- Grant Application Submitted November 4th
- Proposal focused on three key initiatives:
  - Transformative Care Model
  - Workforce Development
  - Technology & Tools
- The Centers for Medicare and Medicaid Services (CMS) announced awards on December 29th
  - HCAI received $233,639,308 for the first budget period

Next Steps

- HCAI will revise the grant budget to account for the increased funds
- Revisions due to CMS by Jan. 30
- CMS will review and approve the use of funds within 30 days of HCAI submission
- HCAI will share additional information as it becomes available through our stakeholder mailing list and website
- Contact us at the new Rural Health Transformation address: CalRHT@hcai.ca.gov

Submission of Interest Forms Open for the Advisory Committee

Advisory Committee Member Selection Timeline

January 5 - March 31
Submission of Interest Open

April – June
Analyzing submissions and Subcommittee Meetings

July - August
Present recommended slate to Board
Appoint AC members

September 16, 2026
First AC meeting for new appointees

Advisory Committee Members – 28

Payers

Vacant ★

Manan Shah
VP & General Manager, Commercial Business, Elevance Health / Anthem Blue Cross of California

Andrew See
Senior Vice President, Chief Actuary, Kaiser Foundation Health Plan

Hospitals

Barry Arbuckle ★
President & Chief Executive Officer, MemorialCare Health System

Tam Ma
Associate Vice President, Health Policy and Regulatory Affairs, University of California Health

Travis Lakey
Chief Financial Officer, Mayers Memorial Hospital District

Medical Groups

Hector Flores ★
Medical Director, Family Care Specialists Medical Group

Stacey Hrountas ★
Chief Executive Officer, Sharp Rees-Stealy Medical Centers

David Joyner
Chief Executive Officer, Hill Physicians Medical Group

Physicians

Adam Dougherty ★
Emergency Physician, Vituity

Michael Weiss
Vice President, Population Health, Children's Hospital of Orange County

Sumana Reddy
President, Acacia Family Medical Group

Purchasers

Ken Stuart ★
Chairman, California Health Care Coalition

Suzanne Usaj ★
Senior Principal, Health and Benefits
Mercer

Iftikhar Hussain
San Francisco Health Service System

Health Care Workers

Stephanie Cline ★
Respiratory Therapist, Kaiser

Sarah Soroken
Mental Health Clinician, Solano County Mental Health

Cristina Rodriguez ★
Physician Assistant, Altura Centers for Health

Consumer Representatives & Advocates

Carolyn Nava ★
Senior Systems Change, Disability Action Center

Mike Odeh ★
Senior Director of Health, Children Now

Kiran Savage-Sangwan
Executive Director, California Pan-Ethnic Health Network (CPEHN)

Amanda McAllister-Wallner
Executive Director, Health Access

Marielle A. Reataza ★
Executive Director, National Asian Pacific American Families Against Substance Abuse (NAPAFASA)

Organized Labor

Joan Allen
Government Relations Advocate, SEIU United Healthcare Workers West

Carmen Comsti ★
Lead Regulatory Policy Specialist, California Nurses Association/National Nurses United

Janice O'Malley ★
Legislative Advocate, American Federation of State, County and Municipal Employees

Kati Bassler ★
President, California Federation of Teachers, Salinas Valley

Academics/ Researchers

Stephen Shortell ★
Professor, UC Berkeley School of Public Health

★ Term ends on June 30, 2026

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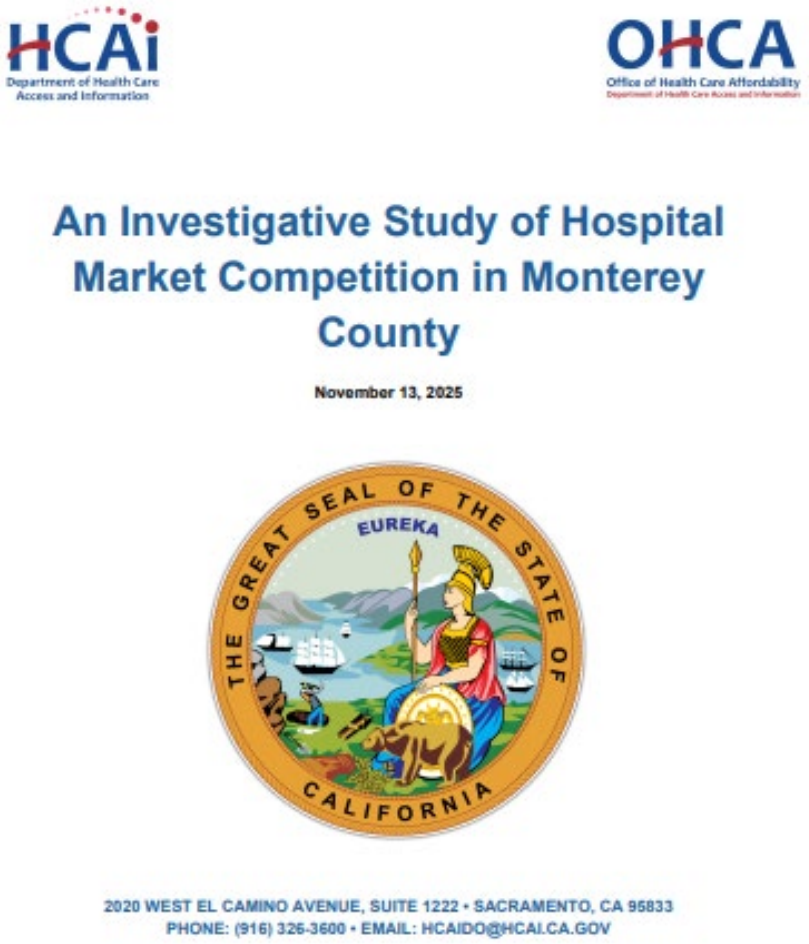
Monterey Hospital Market Competition Study Published on November 13, 2025

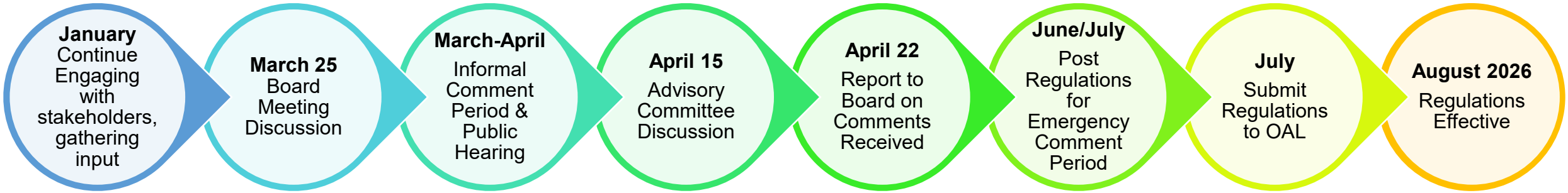
- Concerns over hospital prices in Monterey County have been building for years. In August 2024, the Office of Health Care Affordability (OHCA) held a public meeting specific to these concerns.
- On October 14, 2024, Director Landsberg directed OHCA to conduct an investigative study of hospital market competition in Monterey County.
- OHCA retained health care economic experts, Arnold Analytics, to assist OHCA in the investigative study and produce the report.



Key Findings: Monterey Hospital Market Competition Study

- New hospital price analyses show Monterey County to have the highest inpatient and 4th highest outpatient prices among California counties.
- There is no evidence that higher operating costs, wages, or quality explain the high prices.
- High percentages of Medicare and Medi-Cal patients and low margins on physicians and clinics may explain a small portion of the high hospital prices.
- Evidence suggests a lack of competition as the reason for high prices.
- The profound lack of competition means that market forces are unlikely to reduce hospital prices and the state may need to consider additional policy options that directly restrict the pricing power of the hospitals in Monterey County.

Projected Timeline for Revising CMIR Regulations Due to AB 1415



AB 1415 (Chapter 641, Statutes of 2025) was signed by the Governor on October 11, 2025.

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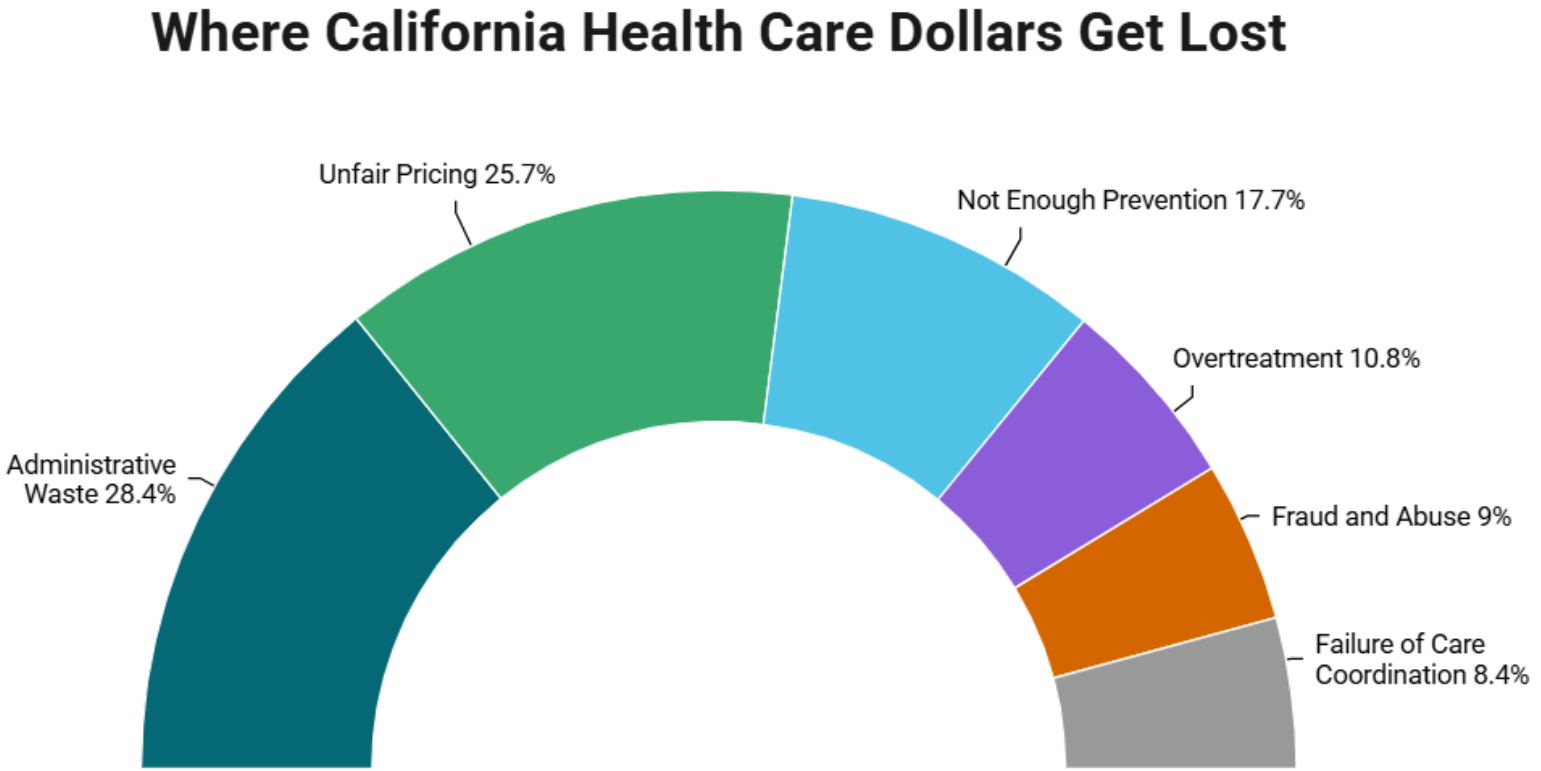
The 25% Problem: Why Health Care Is So Expensive (And What We Can Do About It)

Around 25% of every dollar spent in California's health care system does not contribute toward better care or patient health. This money instead goes toward:

1. Administrative waste
2. Unfair pricing and too few choices
3. Not enough prevention in health care

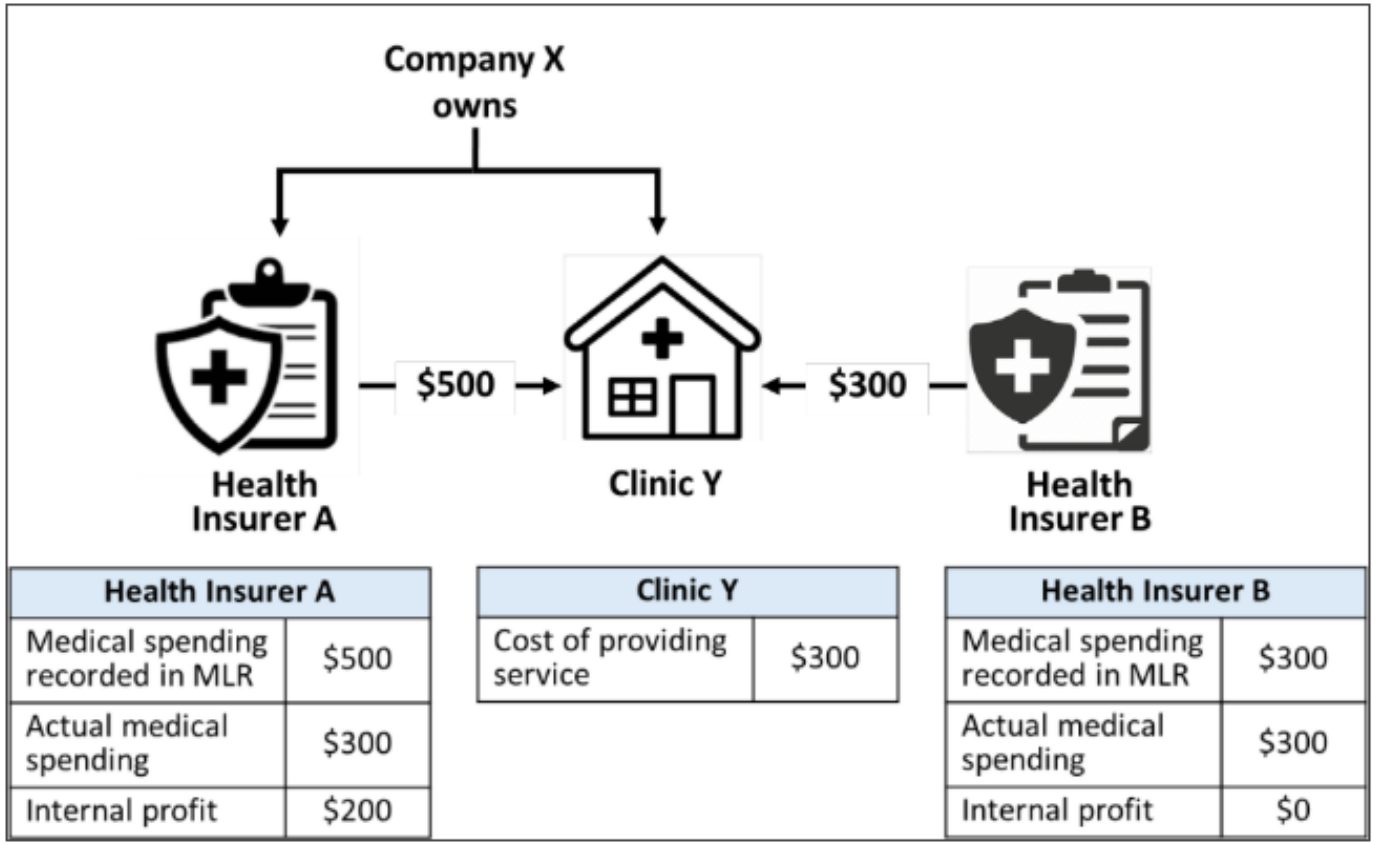


Source: Getting to Affordability: Spending Trends and Waste in California's Health Care System, 2020, CHCF. Data is from 2014 sources.

Stemikis, K., Teare, C. (2025, 13 October). *The 25% Problem: Why Health Care Is So Expensive (And What We Can Do About It)*. California Health Care Foundation. https://www.chcf.org/resource/why-health-care-is-so-expensive/

How Insurers That Own Providers Can Game The Medical Loss Ratio Rules

A recent Health Affairs Forefront article argues that a medical loss ratio (MLR) loophole creates an incentive for vertically-integrated insurers to direct spending to its affiliated providers, who may charge inflated prices, thus allowing the insurer to increase its reported MLR without delivering more care or improving quality.



Health Insurer A	
Medical spending recorded in MLR	$500
Actual medical spending	$300
Internal profit	$200

Clinic Y	
Cost of providing service	$300

Health Insurer B	
Medical spending recorded in MLR	$300
Actual medical spending	$300
Internal profit	$0

Angeles, J.; Bailit, M. (2025, 29 September). *How Insurers That Own Providers Can Game The Medical Loss Ratio Rules.* Health Affairs Forefront. https://www.healthaffairs.org/content/forefront/insurers-own-providers-can-game-medical-loss-ratio-rules

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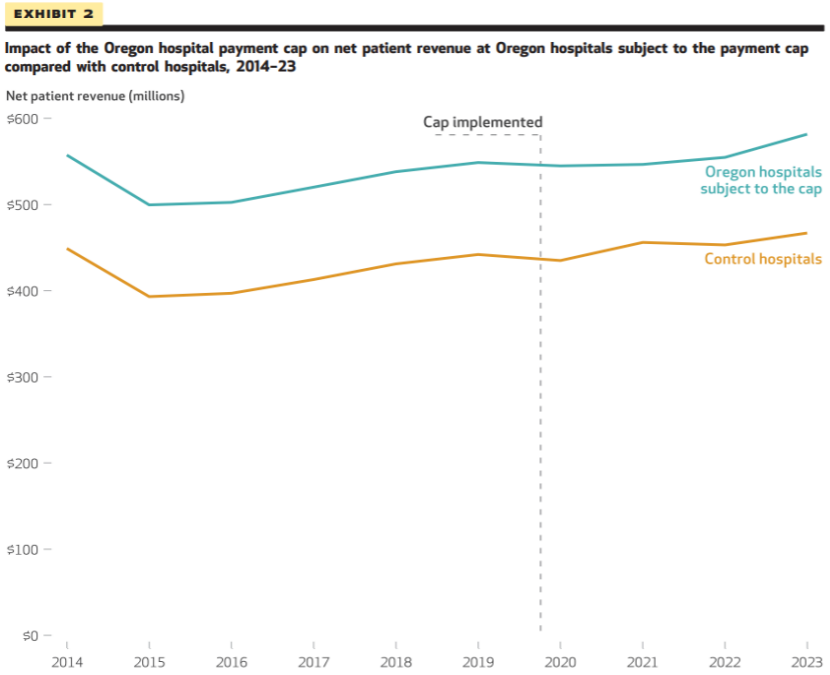
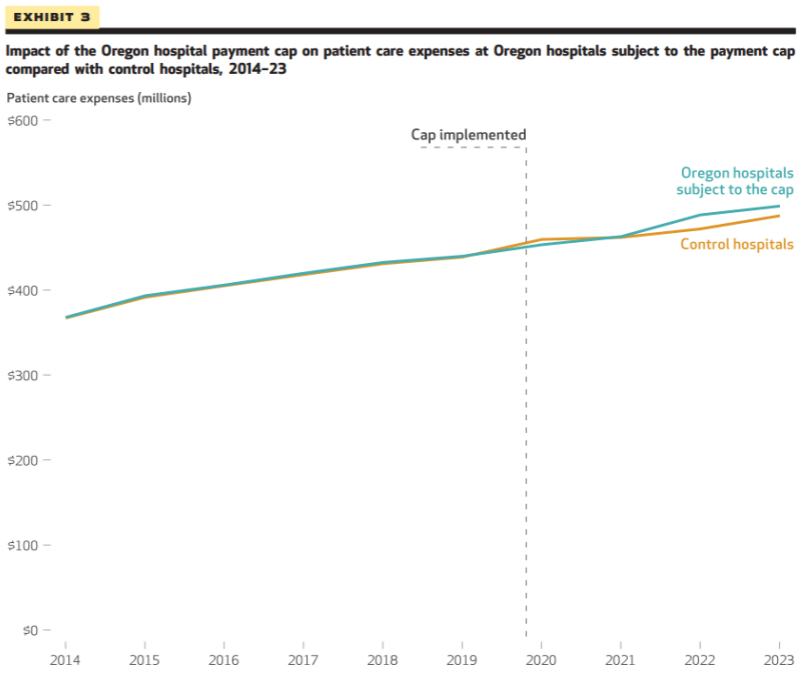
Hospital Finances, Operations and Patient Experience Remain Stable After Hospital Payment Cap in Oregon

- 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

Update on Data Submission Enforcement

- At the November Health Care Affordability board meeting, OHCA staff presented the Board members with its updated draft motion for the data submission penalty structure.
- The presentation included:
  - Previous feedback from the Board.
  - Feedback from the September Advisory Committee meeting.
  - A summary of verbal and written public comment received by OHCA.
- Board member Ian Lewis motioned for an approval, and Dr. Richard Kronick provided a second.
- After public comment, the draft motion was unanimously approved by the Board.

Approved Data Submission Enforcement Structure

The Scope and Range of Data Submission Enforcement Penalties shall be the following:

a) Level 1 – Administrative penalty of $10,000 for data not submitted by September 1st of the submission year or an agreed upon extension date.

b) Level 2 – An additional administrative penalty of $50,000 for data not submitted by November 1st of the submission year.

c) Level 3 – An additional administrative penalty up to a base amount of $5 per member if data is not submitted by December 1st of the submission year, and up to $10 per member if data is not submitted by December 31st .

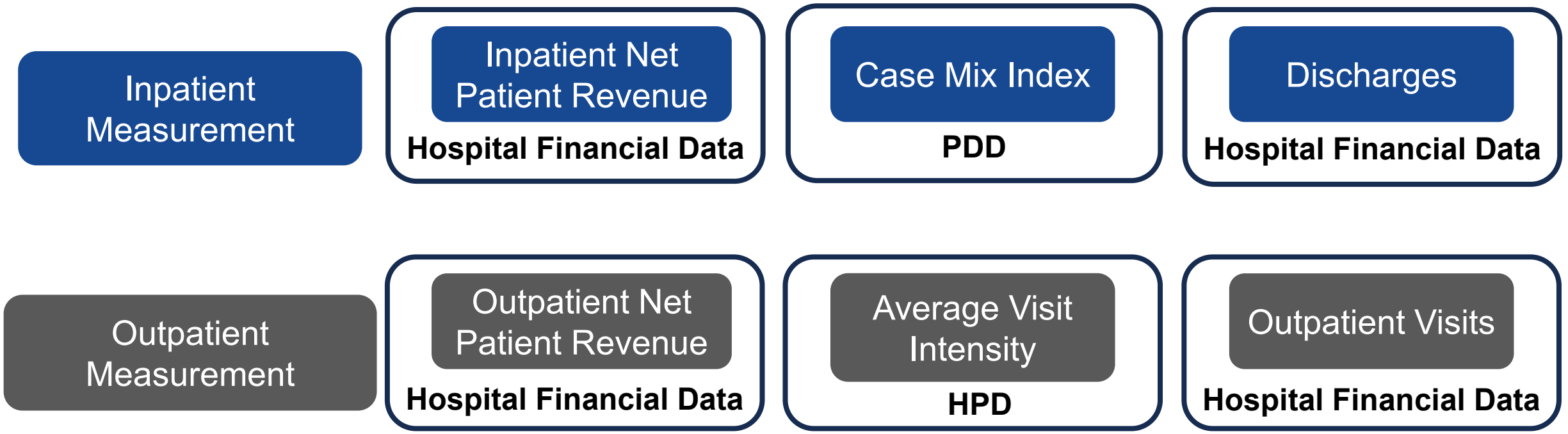
    1) The per member base penalty amounts will double for each consecutive year that the Office assesses an entity a level 3 administrative penalty.

Note: These administrative penalties do not limit the Office's ability to pursue other legal remedies.

Update on OHCA's Methodology for Measuring Inpatient and Outpatient Hospital Spending

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).

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.
- With this method, we can calculate payer-specific average visit intensity.

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

Next Steps

- Later this month, OHCA plans to post an “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.

Slide Formatting

Indicates items that the Advisory Committee provides input or recommendations on based on statute and other areas as requested by the Board or OHCA.

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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 and Analysis Group Manager

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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 or occurred after the deductible was met.

Otherwise, 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, or 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

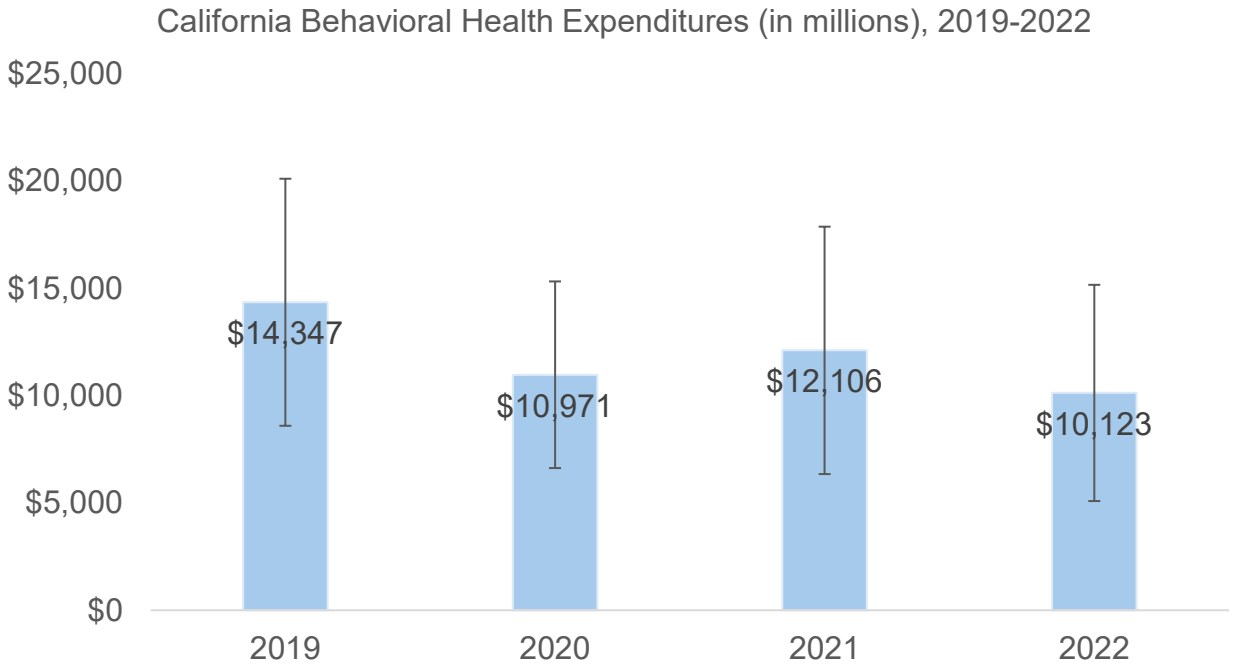
California Behavioral Health Expenditures, 2019-2022

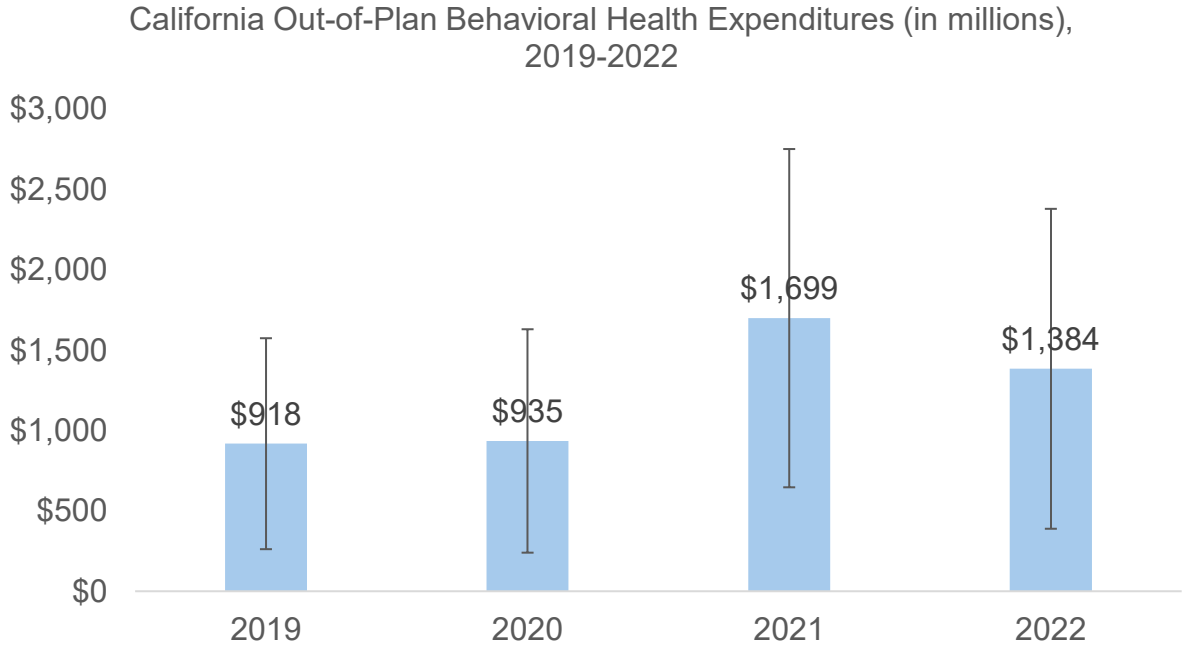
- From 2019 to 2022, MEPS-HC data suggest that behavioral health spending fluctuated between increases and decreases but over the 4-year period declined substantially; over that same period, the data suggest that out-of-plan behavioral health spending increased dramatically.
- From 2019 to 2022, out-of-plan 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.

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Introduction to DSG 3.0 Regulations, Including Update on Behavioral Health Definition and Summary of Board Feedback

Margareta Brandt, Assistant Deputy Director
Debbie Lindes, Health Care Delivery System Group Manager
Andrew Feher, Research and Analysis Group Manager

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Data Submission Guide (DSG) 3.0

- DSG 3.0 outlines requirements for submission of 2024-2025 data in 2026.
- Draft was released for public comment on proposed changes on January 5, 2026.
  - Public comments are due January 30, 2026.
- Annual registration due May 29, 2026.
- Data submission due September 1, 2026.

DSG 3.0 Proposed Changes

- New Behavioral Health file and payment allocation instructions.
- Medi-Cal Managed Care data will be required in all files.
- Separate reporting of self-insured member months and spending in Statewide Total Medical Expense (TME) file only.
- Copies of filed Medical Loss Ratio (MLR) reports emailed to OHCA with data submission.

DSG 3.0 Proposed Changes for APM and Primary Care Files

Alternative Payment Model (APM) File

- Provided additional guidance on how member months are attributed based on member coverage.
- Streamlined instructions by reorganizing into step-by-step process for easier use.
- Added a process map illustrating how member expenses are reported in the APM file.

Primary Care File

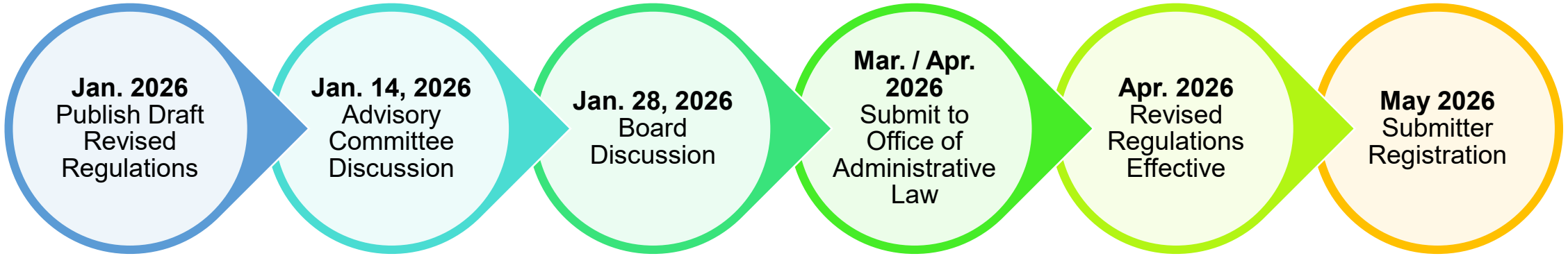
- Clarified primary care spending methodology for non-claims payment subcategories.
- Clarified primary care spend is reported based on the claim line level.
- Updates to primary care code set.
  - *e.g.*, added "363A00000X Physician Assistant" to the list of taxonomy codes; added new CMS Advanced Primary Care Management codes to the list of service codes.

DSG 3.0 Proposed Changes for APM and Primary Care Files

Medi-Cal Managed Care Plans only:

- Added reporting requirements clarifying which DHCS payments to include or exclude from measurement of primary care spending (numerator and denominator) and APM spending.
  - *e.g.*, exclusion of pass-through payments; inclusion of Vaccines For Children (VFC) Program vaccine administration fees.
- In the primary care file, revised the methodology for claims payments to instruct managed care plans to use 274 file submitted to DHCS in the Annual Network Certification to determine whether a provider on a claim is designated as a primary care provider (for physicians, nurse practitioners, and physician assistants).

DSG 3.0 Timeline



Update on Behavioral Health Definition and Summary Board Feedback

Primary Care & Behavioral Health Investments

Statutory Requirements

- Measure and promote a sustained systemwide investment in primary care and behavioral health.
- **Measure the percentage of total health care expenditures allocated to primary care and behavioral health** and set spending benchmarks that consider current and historic underfunding of primary care services.
- **Develop benchmarks** with the intent to build and sustain infrastructure and capacity and shift greater health care resources and investments away from specialty care and toward supporting and facilitating innovation and care improvement in primary care and behavioral health.
- Promote improved outcomes for primary care and behavioral health.

Measuring Behavioral Health Spending

Numerator

Claims-based payments for behavioral health + Non-claims-based payments for behavioral health = Total behavioral health spending

Denominator

Total claims-based payments + Total non-claims-based payments = Total medical expense

X 100% = Behavioral health spending as a % of total medical expense

Note: The numerator will include pharmacy spend for behavioral health medications and patient out-of-pocket responsibility for behavioral health services obtained through the plan, i.e., services for which a claim or encounter was generated. The denominator will include all pharmacy spending and all patient out-of-pocket responsibility for services obtained through the plan.

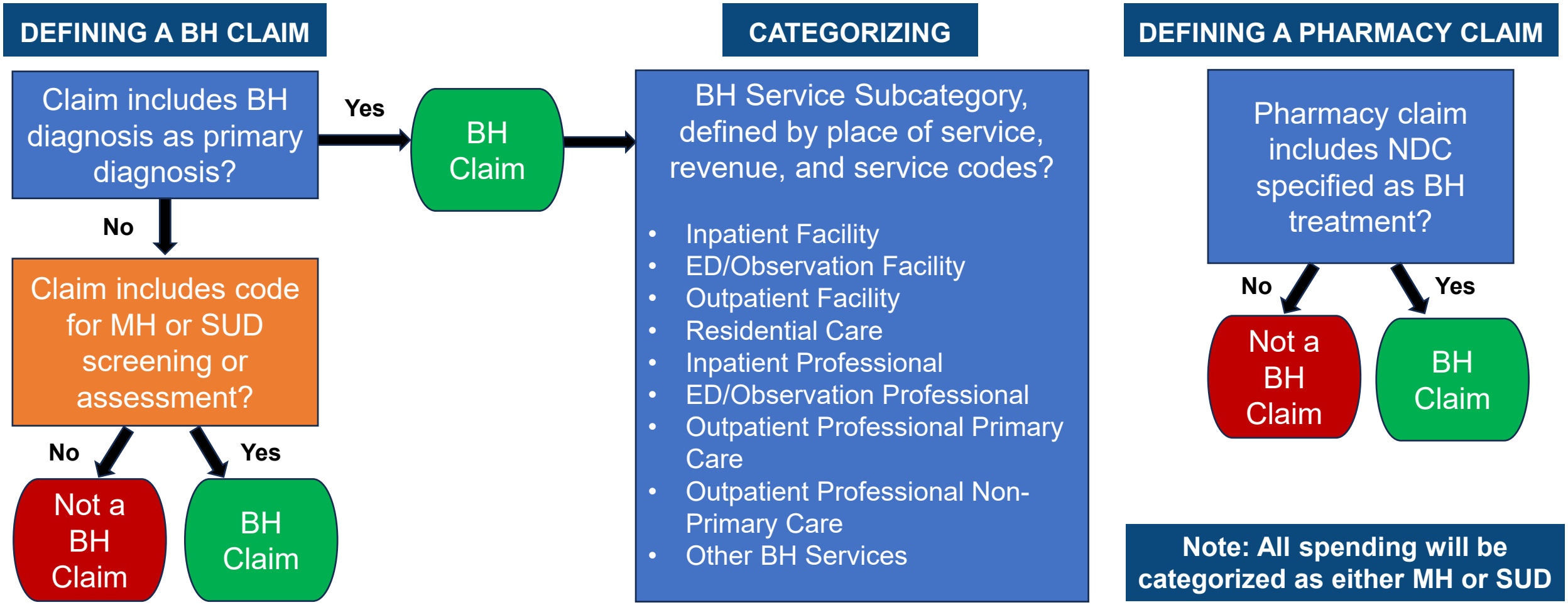
Three Recommended Modules for Behavioral Health Spending Measurement

OHCA proposes to use three modules to measure behavioral health spending, following the approach for measuring primary care spending. Behavioral health in primary care will be measured separately so it can be included in analyses of behavioral health or primary care spending.

Behavioral Health Claims Measurement Definition Principles

1. **Include all claims with a primary behavioral health diagnosis** in measurement.
   - Claims with service codes for mental health or substance use disorder screening or assessment also included, regardless of primary diagnosis code.
2. **Categorize claims** using place of service, revenue, and service codes.
   - "Other Behavioral Health Services" subcategory captures claims with a primary behavioral health diagnosis code that do not have a place of service, revenue, or service code associated with another subcategory.
3. **Include pharmacy claims** with a National Drug Code (NDC) specified by OHCA as a behavioral health treatment.
   - Measured separately, so can be included or excluded for analysis.
   - Categorized as mental health or substance use disorder claims.
   - Behavioral health diagnosis not required.

Process Map for Identifying Behavioral Health (BH) Claims



Proposed Behavioral Health Reporting Categories

Reporting Categories	Service Subcategories
Outpatient/Community Based	Outpatient Professional Primary Care
	Outpatient Professional Non-Primary Care
	Outpatient Facility
Emergency Department	Emergency Department / Observation; Facility
	Emergency Department / Observation; Professional
Inpatient	Inpatient; Facility
	Inpatient; Professional
Residential	Residential Care
Other†	Other Behavioral Health Services
Pharmacy	Mental Health (MH) Prescription Drug Treatments Substance Use Disorder (SUD) Prescription Drug Treatments

†All spending for claims with a primary behavioral health diagnosis is included (i.e., spending not in other subcategories goes to "Other").

Behavioral Health Non-Claims Measurement Definition Principles

- Data collection via Expanded Non-Claims Payments Framework.
- Include all behavioral health non-claims subcategories.
- Allocate payments to behavioral health by various methods:
  - **Population health, behavioral health integration, and care management payments** only when paid to behavioral health providers.
  - **Practice transformation, IT infrastructure, and other analytics payments** not to exceed a set upper limit.
  - **Behavioral health capitation payments** included in full.
  - **Professional and global capitation payments** and **payments to integrated, comprehensive payment and delivery systems** allocated to behavioral health using a method similar to that for primary care.

Measuring Behavioral Health in Primary Care

To promote policy priorities, such as promoting integrated behavioral health and primary care and greater attention to preventive behavioral health care, OHCA proposes to measure behavioral health in primary care two ways:

1. Behavioral health spending data in OHCA's Total Health Care Expenditure (THCE) data collection.
2. Behavioral health data in the Health Care Payments Database (HPD).

Utilizing both data sources will allow OHCA to optimize its ability to understand this critical component of spending while minimizing data submitter burden.

Behavioral Health in Primary Care Module: Proposed Approach

1. **Short term** (2026 Data Collection): Capture a portion of behavioral health in primary care spending in OHCA's THCE data collection.
   - Claims: Outpatient Professional Primary Care subcategory of behavioral health spend measurement.
   - Non-claims: Primary Care and Behavioral Health Integration payments (subcategory A2).

2. **Longer term:** Analyze HPD data to measure integrated behavioral health provided by behavioral health clinicians with methodological nuance.
   - Refine methodology for future THCE data collection, perhaps in concert with benchmark development.

November Board Feedback

Feedback	OHCA Response
• Recommendation to prioritize incorporating Medi-Cal County behavioral health spending in measurement.	• OHCA continues to actively collaborate with DHCS, and with HPD, to establish a methodology for including County behavioral health spending in its measurement and reporting.
• Request to understand OHCA's approach to measuring out-of-pocket, out-of-plan spending for behavioral health services.	• OHCA explored using Medical Expenditure Panel Survey (MEPS) data to estimate out-of-plan spending; these estimates were unreliable. OHCA will work with other institutions to make further progress on this effort.
• Concern that measurement of screening and assessments may result in over-counting of behavioral health spend during preventive visits.	• When the primary diagnosis is not behavioral health, OHCA's methodology counts spending on claim lines for behavioral health screening and assessment services only, without counting spending from the entire claim.
• Question about OHCA's ability to attribute behavioral health spending to provider organizations.	• OHCA does not collect behavioral health spending attributed to provider organizations.

November Board Feedback

Feedback	OHCA Response
• Interest in understanding how commonly psychotherapy services are provided without a behavioral health diagnosis.	• OHCA can consider HPD analyses to evaluate how often common behavioral health services such as psychotherapy are provided without a behavioral health diagnosis.
• Question about whether OHCA's measurement will capture payments made to third party vendors.	• OHCA's methodology captures payments to providers made by health plans, whether claims-based or non-claims. This includes payments to third-party vendors, such as telehealth vendors. Payments made directly to vendors, for example by individuals or an Employee Assistance Program, would not be captured.

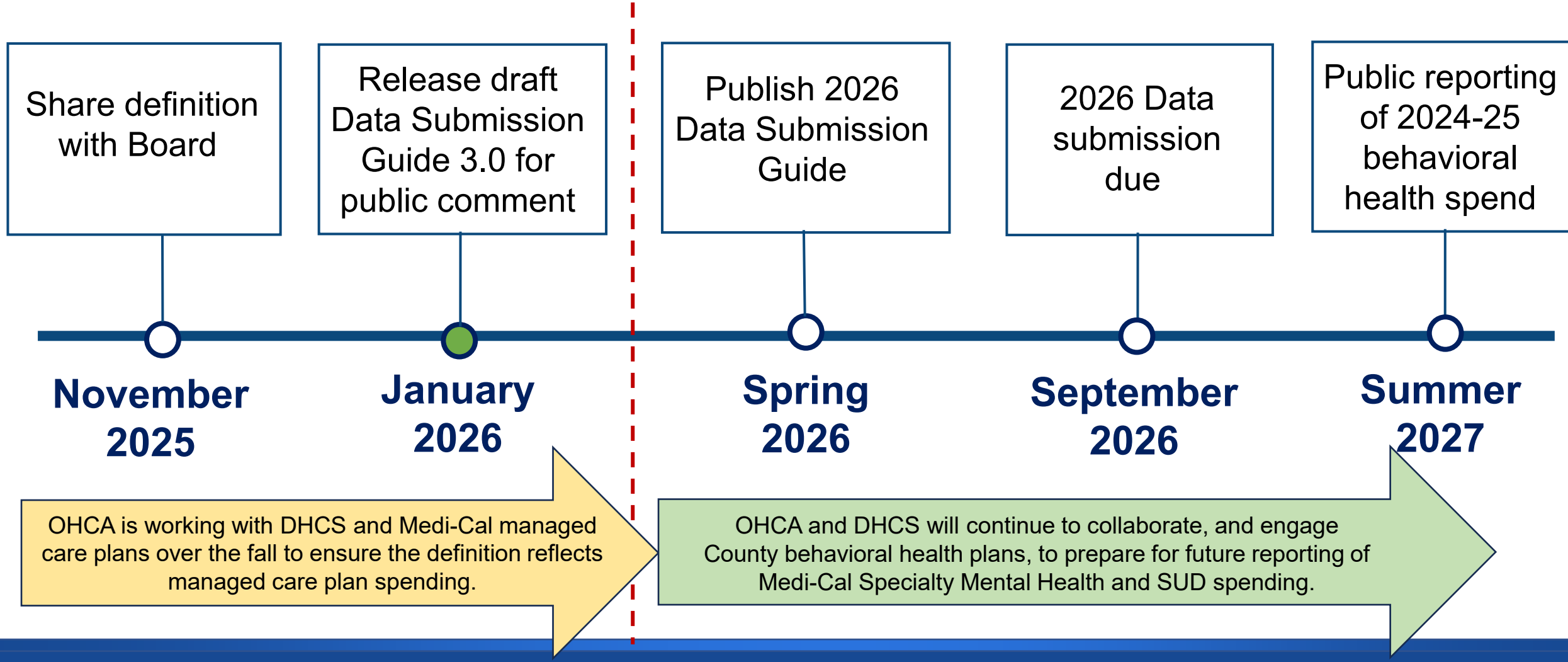
Recent Changes to the Behavioral Health Code Set and Methodology

- Updated the Outpatient Professional Primary Care subcategory
  - Removed codes from original Milbank list that do not align with OHCA's vision for and existing definition of primary care
- Incorporated new service (HCPCS/CPT) codes
  - New codes in CMS Physician Fee Schedule 2025 and 2026
    - *e.g.*, Care management services for behavioral health conditions (G0570)
- Added codes based on Department of Health Care Services (DHCS) feedback
- Updated screening and assessment codes based on review of DHCS manuals

Medi-Cal Considerations

- Added methodology to measure behavioral health spend for Medi-Cal members under age 21 to reflect that youth can receive behavioral health services without a behavioral health diagnosis
- Medi-Cal Managed Care Plans to submit behavioral health spending data in 2026
- OHCA continues to work with DHCS regarding measurement of county Specialty Mental Health and Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS) spending data

Timeline for Finalizing Behavioral Health Measurement Definition



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Data Submission Guide 3.0 Updates

Does the Advisory Committee have any additional feedback on Data Submission Guide 3.0 updates?

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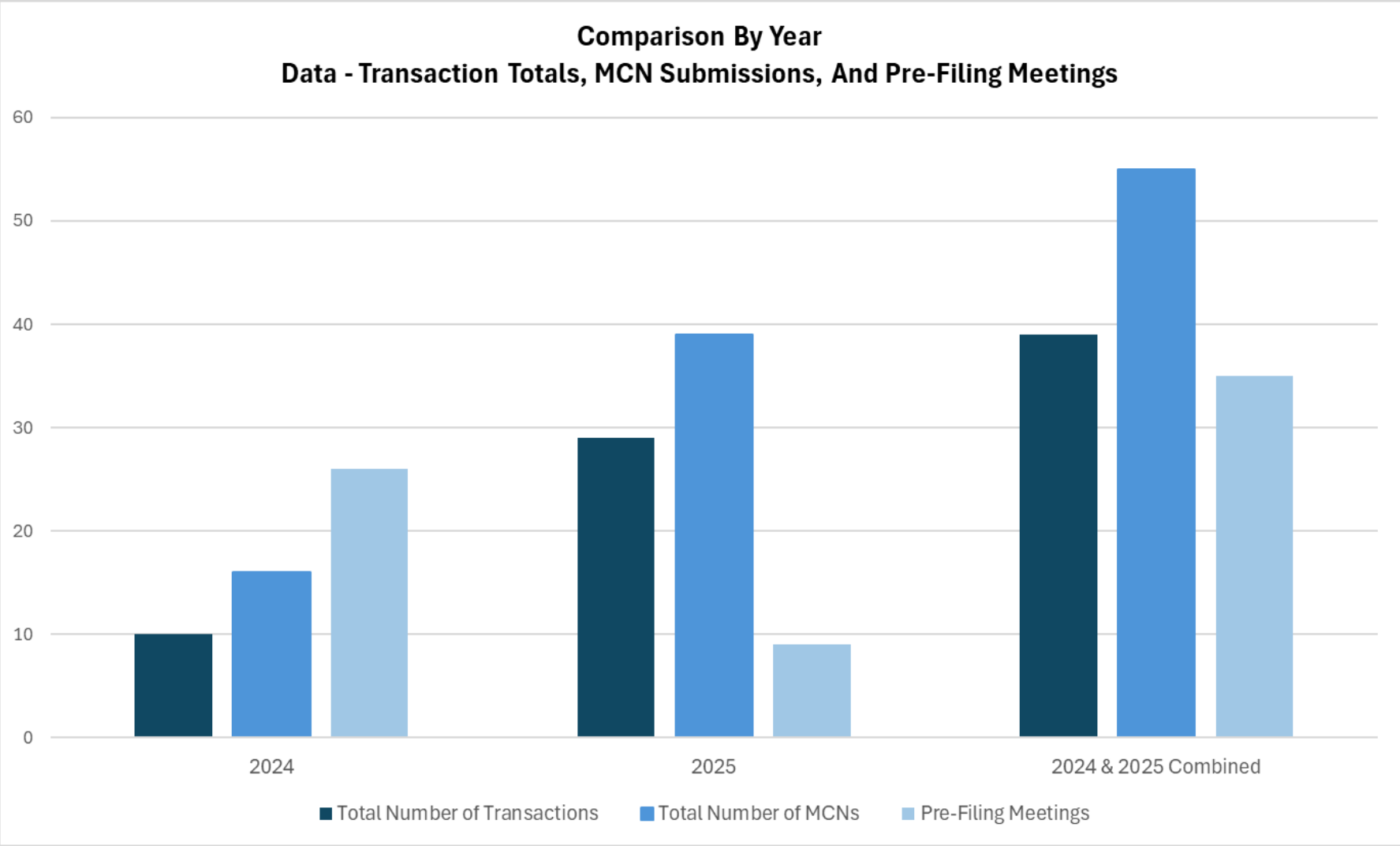
Update on Cost and Market Impact Review Program

Brian Kearns, Assistant Chief Counsel

HCAI
Department of Health Care Access and Information

CMIR Program April 2024 to December 2025



April 1- December 31, 2024

- 10 transactions
- 16 different MCN submissions (number of submitters per transaction varies)
- 26 Pre-Filing Meetings

January 1, 2025 – December 31, 2025

- 29 transactions
- 39 different MCN submissions
- 9 Pre-Filing Meetings

Total Transactions To Date

- 39 transactions

CMIR Program April 2024 to December 2025

Type of Transaction	Number	Percentage
Skilled Nursing Facilities (SNFs)	11	28%
Laboratories	5	13%
Physician Organizations	5	13%
Health Plans (HPs)/HPs plus Physician Organizations and/or Hospital	4	10%
Hospitals	2	5%
Ambulatory Surgery Centers	2	5%
Radiology Services	2	5%
Others	8	21%
Total	**39**	**100%**

Material Change Notices Currently in Review

MCN Submitters	Transaction Summary	Submission Complete	Status
Imperial Care LLC and El Centro Regional Medical Center	Imperial Care LLC is the licensee of El Centro Post-Acute Care, a skilled nursing facility located in El Centro, CA. The transaction will result in the transfer of the skilled nursing facility's operations to El Centro Regional Medical Center and sublease of the skilled nursing facility's real property to El Centro Regional Medical Center.	December 22, 2026	In Review

3 additional transactions are in review for completeness and will be posted to website once MCNs are deemed complete.

Material Change Notices Currently in Review

MCN Submitters	Transaction Summary	Submission Complete	Status
Euclid Endoscopy Center, L.P. and AmSurg Holdings, LLC	AmSurg Holdings, LLC, a subsidiary of Ambulatory TopCo, LLC (AmSurg), will acquire 51% of issued and outstanding membership interests in Euclid Endoscopy Center, L.P. (Euclid). Euclid will convert from a limited partnership to a limited liability company.	December 16, 2026	In Review
CareMeridian, LLC	CareMeridian, LLC, a rehabilitation services provider, will acquire all assets of Sierra Summit Head Injury Care Homes.	December 5, 2025	In Review
Physician Health Network Medical Corporation	Current shareholders are selling their equity interest in Physician Health Network Medical Corporation to David Ulick, M.D., and Eva L. Vargas, RN/BSN, through a Stock Purchase Agreement.	December 1, 2025	In Review

Material Change Notices Currently in Review

MCN Submitters	Transaction Summary	Submission Complete	Status
Covenant Care California, LLC; Covenant Care Mission, Inc.; Covenant Care Long Beach, Inc.; Covenant Care Morgan Hill, LLC; Covenant Care Capitola, LLC; Covenant Care Encinitas, LLC; Covenant Care La Jolla, LLC; Covenant Care Courtyard, LLC; and Covenant Care Lodi, LLC.	Submitters will transfer the assets and operations of its respective skilled nursing facilities to subsidiaries of International Equity Partners, Spyglass Heathcare, Links Healthcare Group, and The Ensign Group. OHCA is conducting a CMIR over three acquisitions by The Ensign Group.	April 24, 2025	In CMIR Review
Res-Care, Inc.	National Mentor Holdings, Inc. will acquire subsidiaries, equities, and assets from ResCare, an operator of intermediate care facilities for individuals with intellectual and developmental disabilities.	April 21, 2025	In CMIR Review

Transaction Reviews Completed Since May 2025

MCN Submitters	Transaction Summary	Submission Complete	Status
Rezolut Holdings, LLC	Envision Radiology, LLC will acquire 100% of the issued and outstanding equity interests of Rezolut Holdings, LLC from Rezolut, LLC pursuant to an Equity Purchase Agreement.	November 12, 2025	CMIR Waived *(December 24, 2025)*
MedImpact Healthcare Systems, Inc.	MedImpact Healthcare Systems, Inc. will acquire all of the membership interests of A&A Services, LLC d/b/a Sav-Rx. Both entities provide pharmacy benefit manager services nationwide.	November 7, 2025	CMIR Waived *(December 19, 2025)*
CCW La Jolla and Classic Residence Management Limited Partnership	The transaction is a merger by and among CC Living Holding Company, LLC, CC Merger Sub, LLC, CC-Development Group, Inc. (the target company, hereinafter “Vi Parent”) and representatives of Vi Parent’s stockholders. Following the proposed merger, an internal corporate restricting will result in changes to the indirect ownership of the skilled nursing facilities operated by CCW La Jolla, L.L.C. (“Vi at La Jolla Village) and Classic Residence Management Limited Partnership (“Vi at Palo Alto”).	October 31, 2025	CMIR Waived *(December 10, 2025)*

Transaction Reviews Completed Since May 2025

MCN Submitters	Transaction Summary	Submission Complete	Status
Evolent Health LLC	Evolent Health LLC is selling all shares of Evolent Care Partners Holding Company, Inc. (ECPHC) to Privia Management Company, LLC for a purchase price of $100 million. An Enhanced Track Accountable Care Organization operating a Medicare Shared Savings Program is included among ECPH's subsidiaries.	October 16, 2025	CMIR Waived *(November 21, 2025)*
El Centro Regional Medical Center, City of El Centro, and Imperial Valley Healthcare District	Pursuant to Assembly Bill 918 (2023), the newly established Imperial Valley Healthcare District will acquire El Centro Regional Medical Center, which includes its 161-bed general acute care hospital and outpatient centers in California.	October 8, 2025	CMIR Waived *(December 15, 2025)*
Ambulatory TopCo, LLC	Through an equity purchase agreement, Ascension Health Alliance, an out-of-state Catholic health system, will acquire Ambulatory TopCo, LLC's (AMSURG) ambulatory surgery centers (including 25 in California) for the purchase price of $3.9 billion.	October 1, 2025	CMIR Waived *(November 13, 2025)*

Transaction Reviews Completed Since May 2025

MCN Submitters	Transaction Summary	Submission Complete	Status
Alta Los Angeles Hospitals, Inc. and Southern California Hospital Systems, Inc.	NOR Healthcare Systems Corp. will acquire assets from Prospect Medical Holdings, Inc. as part of Chapter 11 bankruptcy proceedings. The transaction involves the sale of Southern California Hospital Systems, Inc. which operates Southern California Hospital at Hollywood, Southern California Hospital at Van Nuys, and Southern California Hospital at Culver City and Alta Los Angeles Hospitals, Inc. which operates Los Angeles Community Hospital, Los Angeles Community Hospital at Norwalk, and Los Angeles Community Hospital at Bellflower.	September 17, 2025	CMIR Waived *(October 30, 2025)*

Transaction Reviews Completed Since May 2025

MCN Submitters	Transaction Summary	Submission Complete	Status
Southern California Specialty Care, LLC	The transaction involves the sale of assets and real estate of three Kindred Hospitals including Southern California Specialty Care, LLC known as Kindred Hospital-La Mirada as well as hospitals in Louisiana and Arizona.	July 25, 2025	CMIR Waived *(August 27, 2025)*
John Muir Health (JMH), John Muir Medical Group (JMMG) and the University of California San Francisco Health (UCSF Health)	John Muir Health (JMH) and John Muir Medical Group (JMMG) are selling their equity interest in Bay Area Accountable Care Network, Inc., dba Canopy Health, to the University of California San Francisco Health (UCSF Health) through a Share Transfer and Sale Agreement.	July 16, 2025	CMIR Waived *(August 29, 2025)*

Transaction Reviews Completed Since May 2025

MCN Submitters	Transaction Summary	Submission Complete	Status
Mobile RadX Holdings, LLC dba Integrated Diagnostic Services	Mobile RadX, LLC dba Integrated Diagnostic Services will acquire Hemo Analytics, Inc.'s equity of its clinical laboratory and mobile radiology services through a Stock Purchase Agreement.	June 13, 2025	CMIR Waived *(July 24, 2025)*
Quest Diagnostics Incorporated and Fresenius Medical Care Holdings, Inc.	Quest Diagnostics Incorporated will acquire laboratory assets and services from two of Fresenius Medical Care Holdings, Inc.'s subsidiaries, Spectra East, Inc. and Spectra Laboratories, Inc.	May 28, 2025	CMIR Waived *(July 10, 2025)*

Transaction Reviews Completed Since May 2025

MCN Submitters	Transaction Summary	Submission Complete	Status
UCI Health and Premier Health Plan Services, Inc.	Pursuant to a Stock Purchase Agreement, The Regents, acting by and on behalf of UCI Health, propose to acquire 100% of the issued and outstanding shares of capital stock of Premier Health Plan Services, Inc.	May 22, 2025	CMIR Waived *(July 2, 2025)*
Cambridge Sierra Holdings, LLC	Cambridge Sierra Holdings, LLC is the operator of Reche Canyon Regional Rehab Center, a skilled nursing facility located in Colton, California. The transaction will result in the sale of the skilled nursing facility's real property from RC Real Estate Investments, Inc. to 1350 Reche Road, LLC and transfer of operations to Cape Cod Bay Holdings, LLC.	May 14, 2025	CMIR Waived *(July 3, 2025)*

Transaction Reviews Completed Since May 2025

MCN Submitters	Transaction Summary	Submission Complete	Status
Laboratory Corporation of America Holdings	Laboratory Corporation of America Holdings will acquire BioReference's laboratory testing businesses focused on oncology-related clinical testing services across the United States.	May 8, 2025	CMIR Waived *(June 23, 2025)*
Madera SNF Operations LLC	Madera SNF Operations LLC is the licensee of Golden Madera Care Center, a skilled nursing facility located in Madera, California. The transaction will result in the sale of the skilled nursing facility's real property to Kopion Healthcare Holdings, LLC and transfer of operations to Madera Post Acute, LLC.	May 1, 2025	CMIR Waived *(June 13, 2025)*

Transaction Reviews Completed Since May 2025

MCN Submitters	Transaction Summary	Submission Complete	Status
Crescent City Skilled Nursing, LLC	All real and personal property used in connection with the facility is being sold. Crescent City Skilled Nursing, LLC will transfer the operation of the facility to Crescent City Post Acute, LLC, and real estate ownership will transfer from The Roll Prop Co, LLC to 1280 Marshall LLC.	April 24, 2025	CMIR Waived *(May 27, 2025)*
California Cancer Associates for Research and Excellence, Inc.	cCare will agree to employ current clinical employees of California Urology, Inc. As part of the transaction, cCare MSO, Inc. will also employ certain non-clinical employees of California Urology, Inc.	April 18, 2025	CMIR Waived *(May 30, 2025)*

Transaction Reviews Completed Since May 2025

MCN Submitters	Transaction Summary	Submission Complete	Status
West Coast Hospitals, Inc.	Lazer Holdings LLC will acquire the operations of a skilled nursing facility in Santa Cruz County from West Coast Hospitals, Inc. The real estate will transfer from Coast Health Services, LLC to Freedom Propco LLC.	April 7, 2025	CMIR Waived *(June 13, 2025)*

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Spending Target Enforcement: Waiver of Enforcement, Technical Assistance, Public Testimony, and Performance Improvement Plans

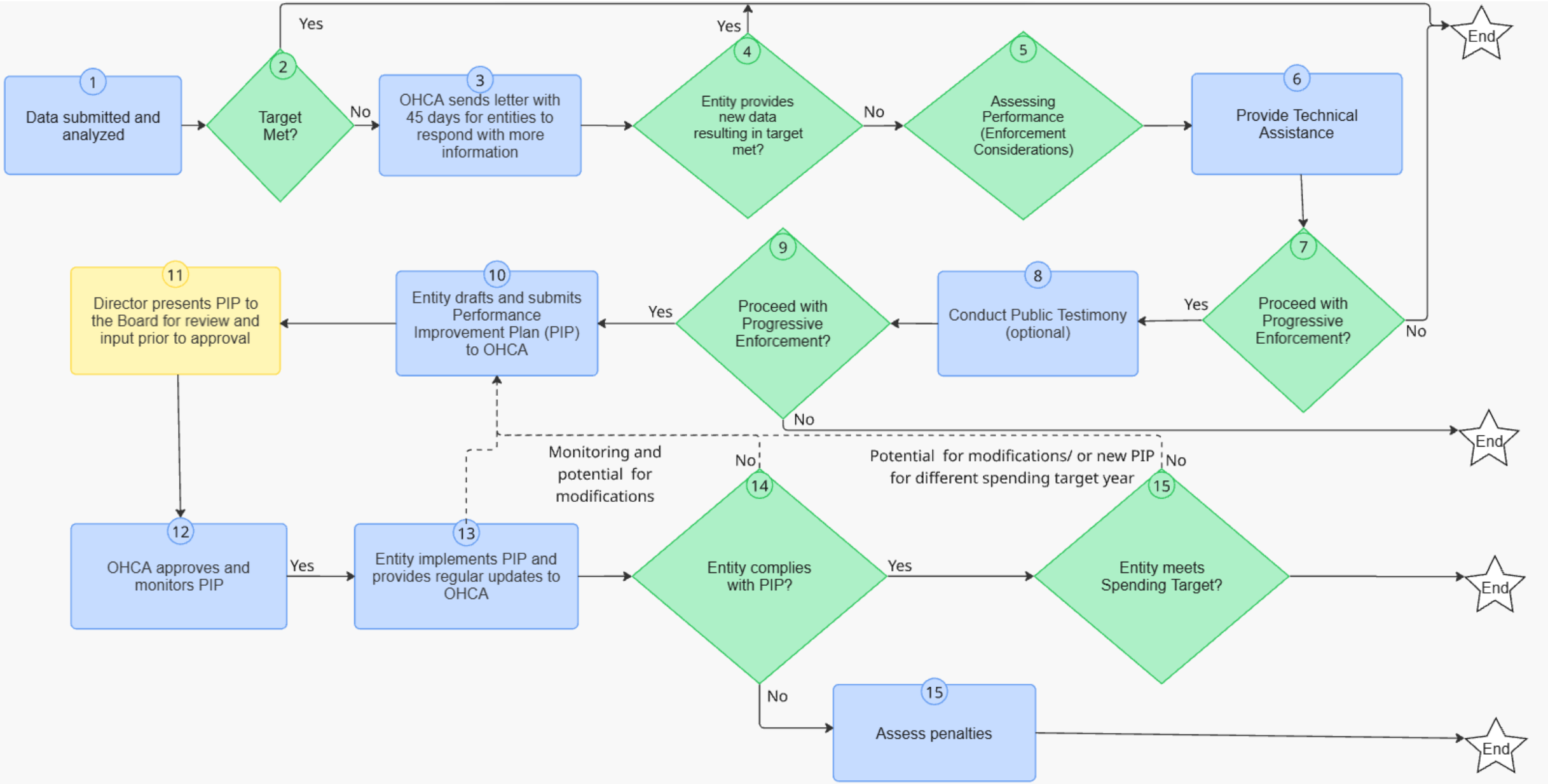
Vishaal Pegany, Deputy Director

CJ Howard, Assistant Deputy Director

HCAI

Department of Health Care Access and Information

Enforcement Process Flow



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Waiver of Enforcement

Statute

127502.5. (b)

(b) Prior to taking any enforcement action, the office shall do all of the following:
(1) Notify the health care entity that it has exceeded the health care cost target.
(2) Give the health care entity not less than 45 days to respond and **provide additional data, *including information in support of a waiver described in subdivision (i)*.**

127502.5. (i)

The **office may establish requirements for health care entities to file for a waiver of enforcement actions due to reasonable factors** outside the entity's control, such as changes in state or federal law or anticipated costs for investments and initiatives to minimize future costly care, such as increasing access to primary and preventive services, or under extraordinary circumstances, such as an act of God or catastrophic event. The entity shall submit documentation or supporting evidence of the reasonable factors, anticipated costs, or extraordinary circumstances. The office shall request further information, as needed, in order to approve or deny an application for a waiver.

Enforcement Considerations vs. Reasonable Factors

Enforcement Considerations	Reasonable Factors
Factors that OHCA can consider during progressive enforcement Under HSC Section 127502.5(a), the Director shall consider… • each entity's contribution to cost growth in excess of the applicable target and • any actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, • factors that contribute to spending in excess of the applicable target, and • the extent to which each entity has control over the applicable components of its cost target.	**Specific to a waiver of enforcement request** Under HSC Section 127501.5(i), the office **may** establish requirements for health care entities to file for a waiver of enforcement actions due to: • reasonable factors outside the entity's control, such as changes in state or federal law or • anticipated costs for investments and initiatives to minimize future costly care, such as increasing access to primary and preventive services or • under extraordinary circumstances, such as an act of God or catastrophic event. The entity shall submit documentation or supporting evidence of the reasonable factors, anticipated costs, or extraordinary circumstances. The office shall request further information, as needed, in order to approve or deny an application for a waiver.

Potential Enforcement Considerations

Population Characteristics
High-Cost Patient Outliers
Historical Spending Growth
Impact on Consumer Access and Affordability
Investments in Primary and Preventive Care
Entity Baseline Costs
High-Cost Drugs
Changes in State and Federal Law
Acts of God or Catastrophic Events

Waiver of Enforcement

OHCA will not implement a waiver of enforcement at this time for health care entities who fail to meet the health care spending target.

- The list of factors under the waiver are duplicative with the factors that OHCA can consider under enforcement considerations. As part of the process to assess an entity's performance against the target and determine which entities may proceed through the progressive enforcement process, OHCA can assess reasonable factors outside an entity's control, anticipated costs for investments and initiatives to minimize future costly care, and extraordinary circumstances.
- After the first several years of measuring, reporting, and enforcing spending targets, OHCA will learn if a waiver of a performance year is warranted for specific conditions and circumstances experienced by an entity.

Technical Assistance

Statute

Office

Enforcement Considerations and Progressive Enforcement Processes:
(a) The director shall 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. The director shall consider each entity's contribution to cost growth in excess of the applicable target and any actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target. The director shall review information and other relevant data from additional sources, as appropriate, including data from the Health Care Payments Data Program, to determine the appropriate health care entity that may be subject to enforcement actions under this section. Commensurate with the health care entity's offense or violation, **the director may take the following progressive enforcement actions:**

(1) Provide technical assistance to the entity to assist it to come into compliance.

(2) Require or compel public testimony by the health care entity regarding its failure to comply with the target.

(3) Require submission and implementation of performance improvement plans, including input from the board.

(4) Assess administrative penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

Statute

Office

Notification and Communication:
(b) Prior to taking any enforcement action, the office shall do all of the following:

(1) Notify the health care entity that it has exceeded the health care cost target.

(2) Give the health care entity not less than 45 days to respond and provide additional data, including information in support of a waiver described in subdivision (i).

(3) If the office determines that the additional data and information meets the burden established by the office to explain all or a portion of the entity's cost growth in excess of the applicable target, the office may modify its findings, as appropriate.

(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.

Technical Assistance:
(c) (1) If a health care entity exceeds an applicable cost target, the office shall notify the health care entity of their status and provide technical assistance. The office shall make public the extent to which the health care entity exceeded the target.

What is Technical Assistance?

- Technical assistance for the progressive enforcement of spending targets is information provided to health care entities to support their capacity to meet spending targets.

- This technical assistance will be a letter to the entity who exceeded the target, providing them with resources they could employ to assist them into coming into compliance with spending targets. These resources may include research studies, literature, information such as models for increasing primary care investment and APM adoption, and cost-reducing strategies presented to the Board. Letters may be tailored by health care entity and may decompose areas of excess spending.

- Technical assistance does not mean OHCA will direct an entity to implement specific changes to their operations.

Discussion: Technical Assistance Definition

Does the Advisory Committee have input on how OHCA is defining Technical Assistance or how it fits into the enforcement process?

Public Testimony

Statute

Office

Enforcement Considerations and Progressive Enforcement Processes:
(a) The director shall 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. The director shall consider each entity's contribution to cost growth in excess of the applicable target and any actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target. The director shall review information and other relevant data from additional sources, as appropriate, including data from the Health Care Payments Data Program, to determine the appropriate health care entity that may be subject to enforcement actions under this section. Commensurate with the health care entity's offense or violation, **the director may take the following progressive enforcement actions:**

(1) Provide technical assistance to the entity to assist it to come into compliance.

(2) Require or compel public testimony by the health care entity regarding its failure to comply with the target.

(3) Require submission and implementation of performance improvement plans, including input from the board.

(4) Assess administrative penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

What is Public Testimony?

- Public testimony is an optional step in progressive enforcement, at the discretion of the director.
- Public testimony is an opportunity to hear from health care entities that have exceeded the spending target. It can take various forms, including in-person or written testimony.
  - Entities may elaborate on why they went over the target.
- Public testimony for spending target enforcement is not:
  - An invitation for entities who are meeting the spending target to explain what they are doing. We can invite these entities to our meetings, but they are not required to comply.
  - Asking entities to explain how they plan to meet the target in the future.

Discussion: Public Testimony

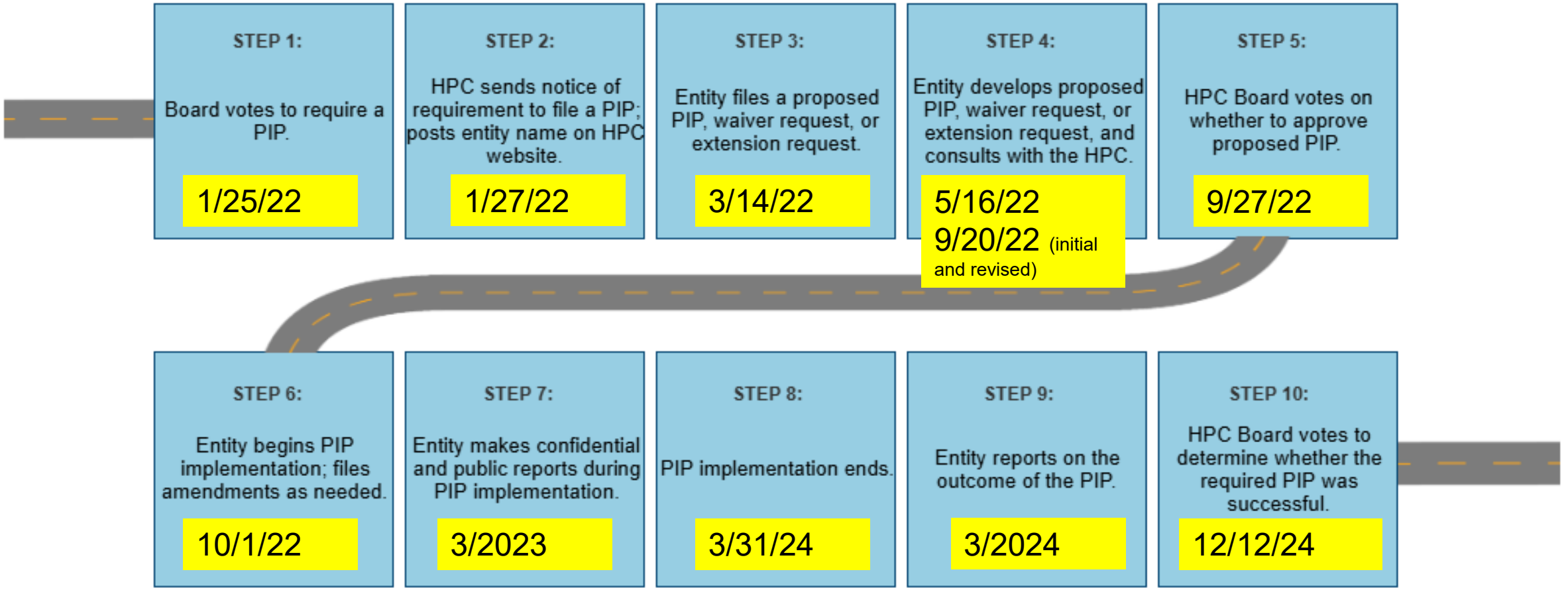
Under what circumstances, would the Advisory Committee want to hear from health care entities regarding exceeding the target?

Introduction to Performance Improvement Plans

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

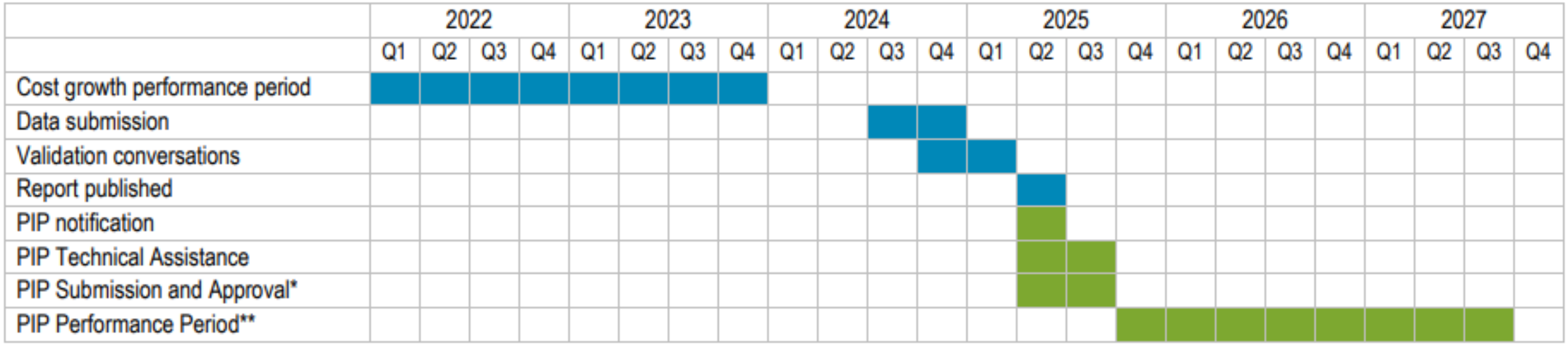
- Oregon Health Authority (OHA) must require a PIP for entities that exceed cost growth target without a reasonable cause.
- Entities have 90 calendar days to submit proposal and may request an extension of 45 calendar days or less. Requests must be made within 30 calendar days of original deadline.
- 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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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

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.

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

Timeline for Future Board Discussion

**Timeline subject to change.*

Discussion: Performance Improvement Plans

Does the Advisory Committee 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 the HCAI Health of Primary Care in California Snapshot

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

HCAI
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

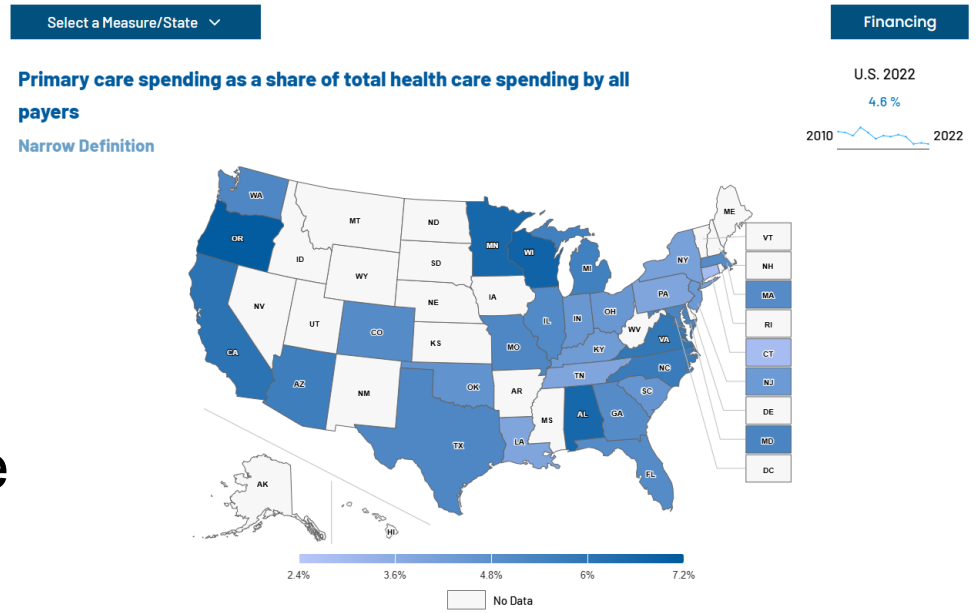
- Accessible
- Relationship-based
- Team-based
- Comprehensive

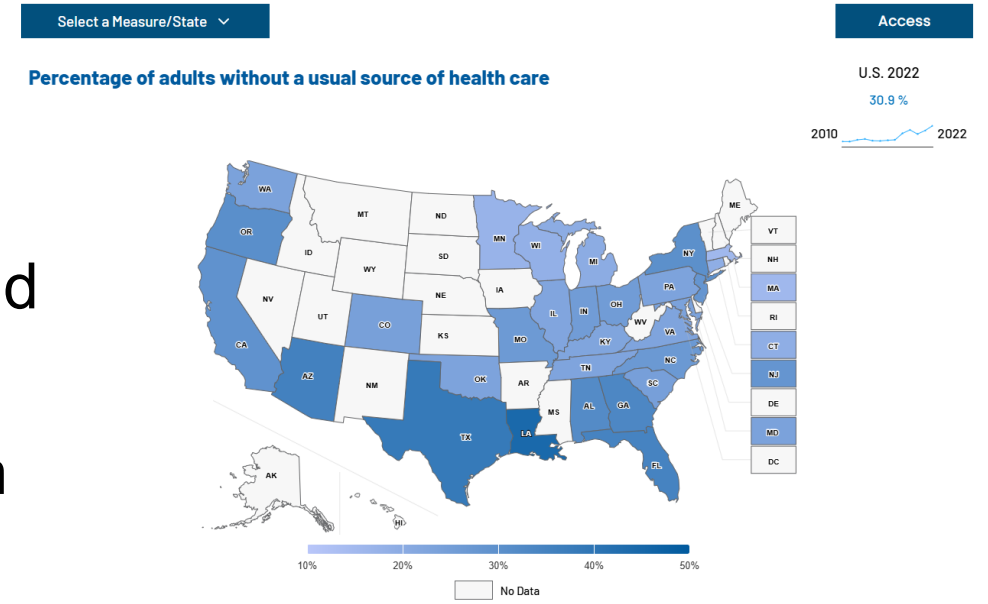
- Person- and family- centered
- Integrated
- Coordinated
- Equitable

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

Primary Care 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.

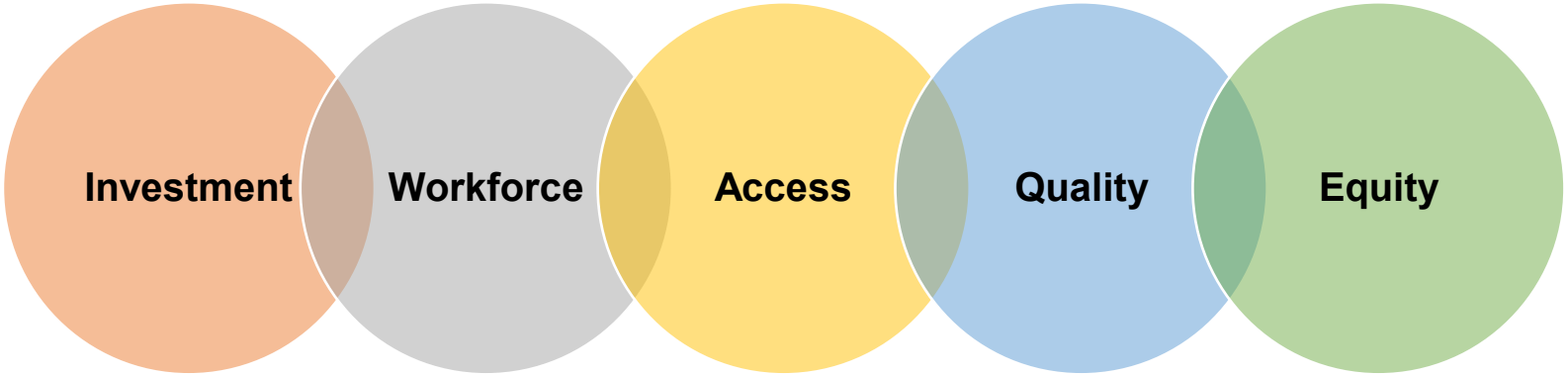




Source: Milbank Memorial Fund 2025 Primary Care Scorecard Data Dashboard. 2025 Primary Care Scorecard Data Dashboard | Milbank Memorial Fund

Primary Care Snapshot Approach and Audiences

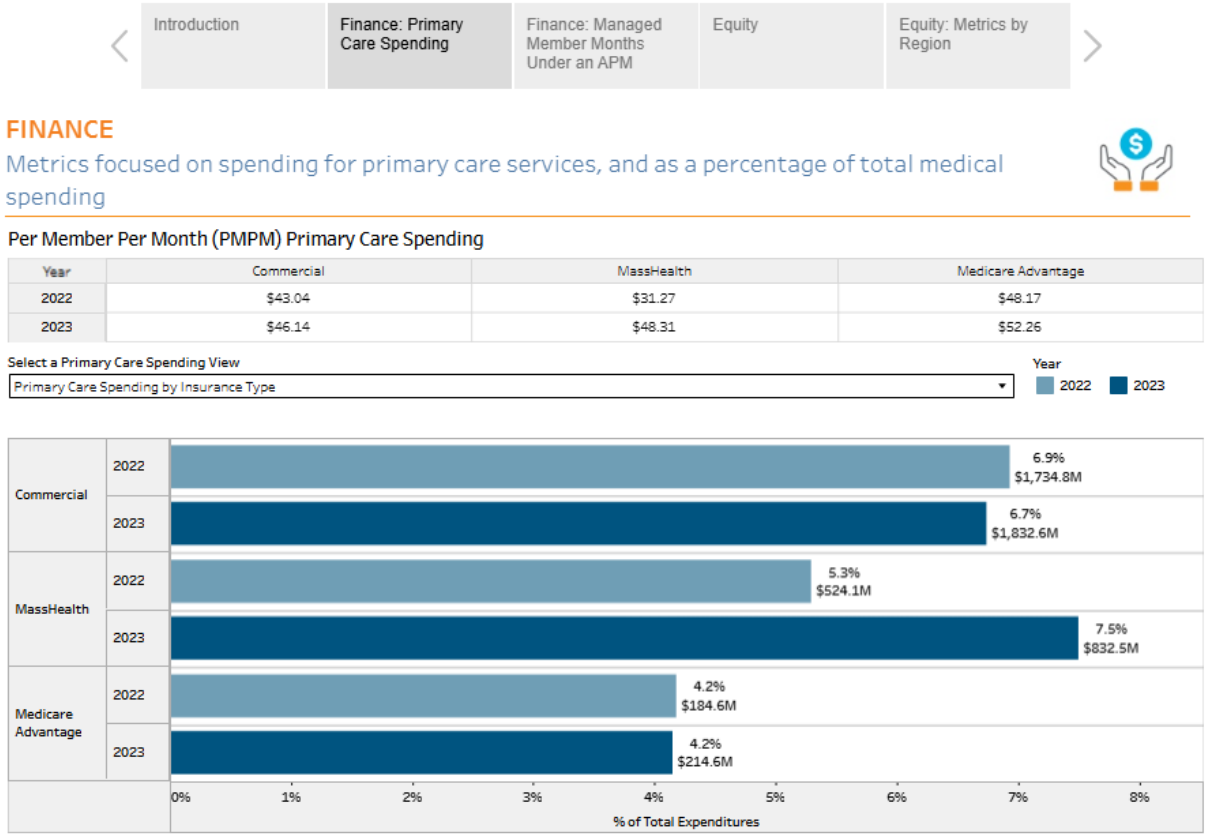
- **Compile and report on data** from across HCAI and other sources to create a comprehensive picture of primary care in California, at the statewide level and regionally.
- Focus on **five key domains.**



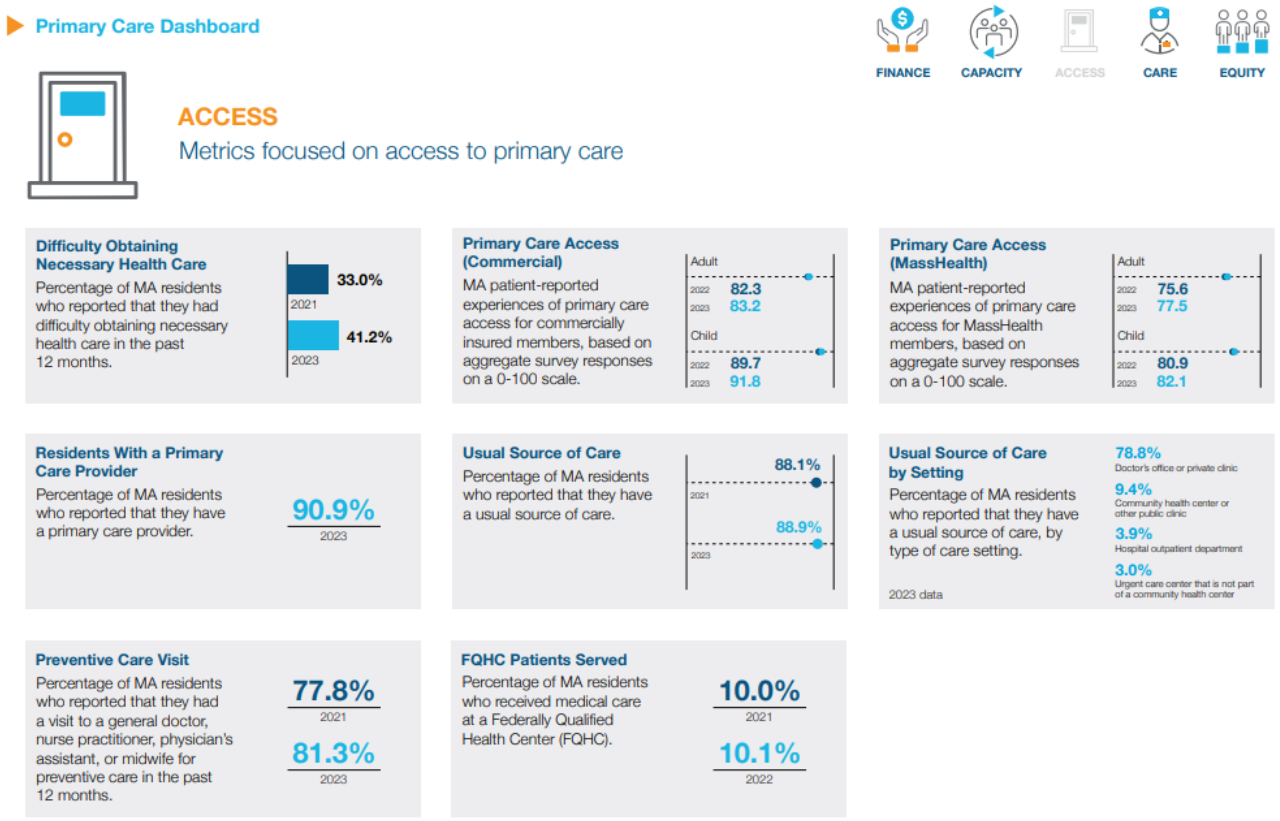
- Adopt a **phased approach** that begins with a static report on the key domains and adds indicators and interactive features over time.
- The primary audiences are **engaged stakeholders** (purchasers, payers, providers, state government, policymakers, consumer advocates, and researchers).

Example: Massachusetts Primary Care Dashboard

Interactive dashboard



Static dashboard



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

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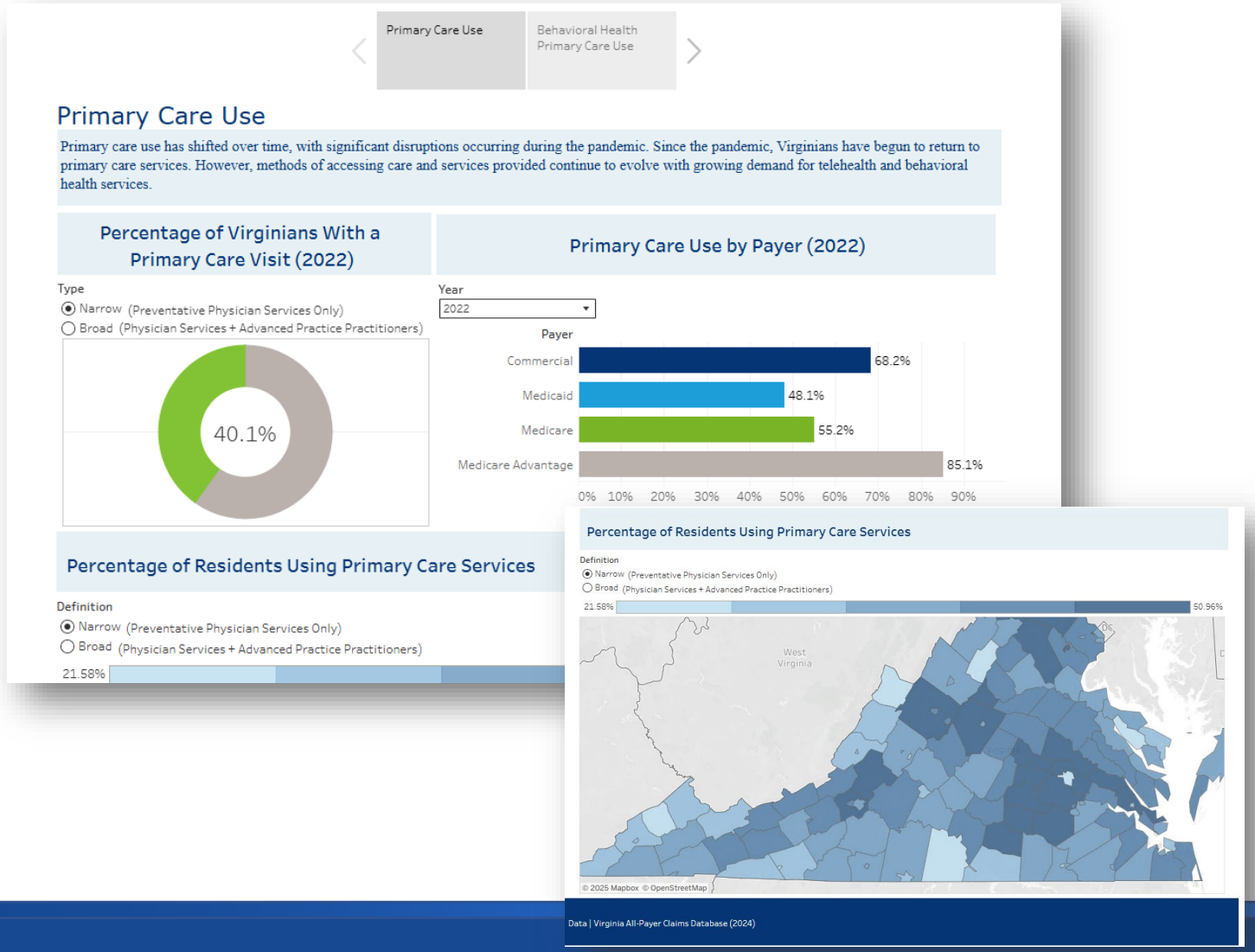
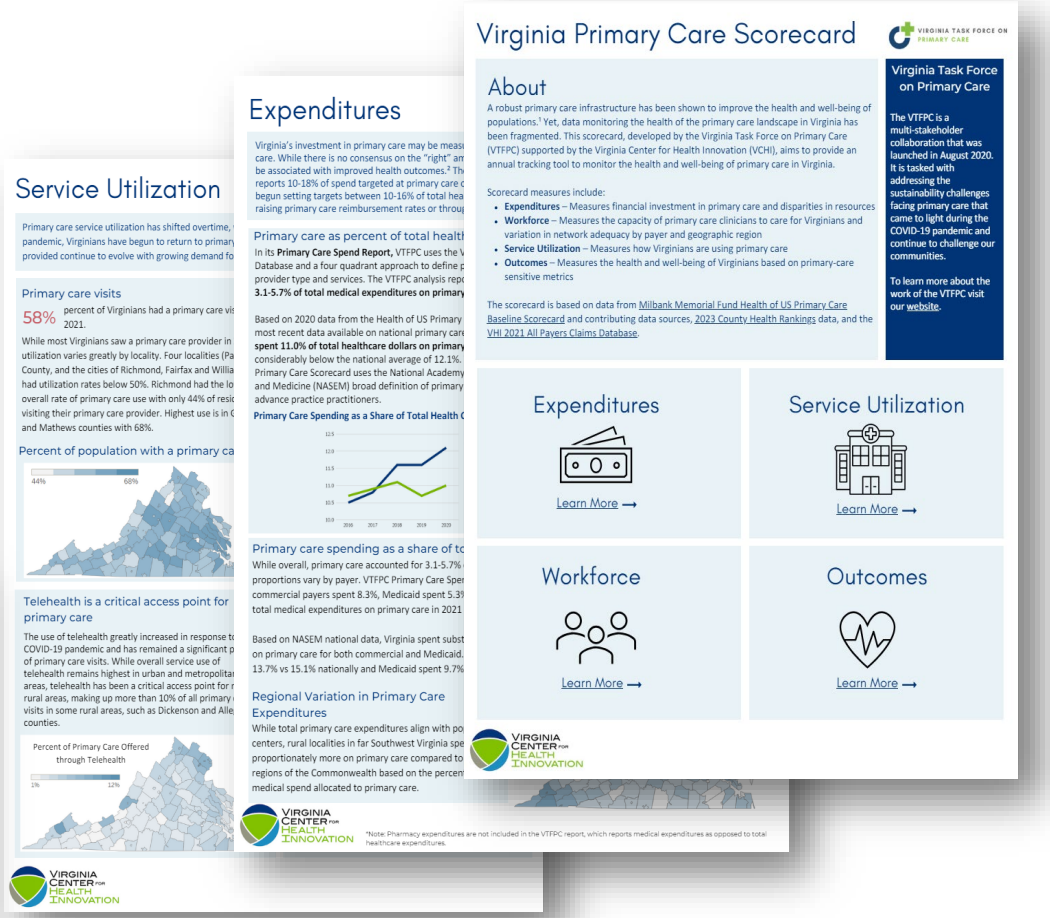
Example: Virginia Primary Care Scorecard

Interactive dashboard



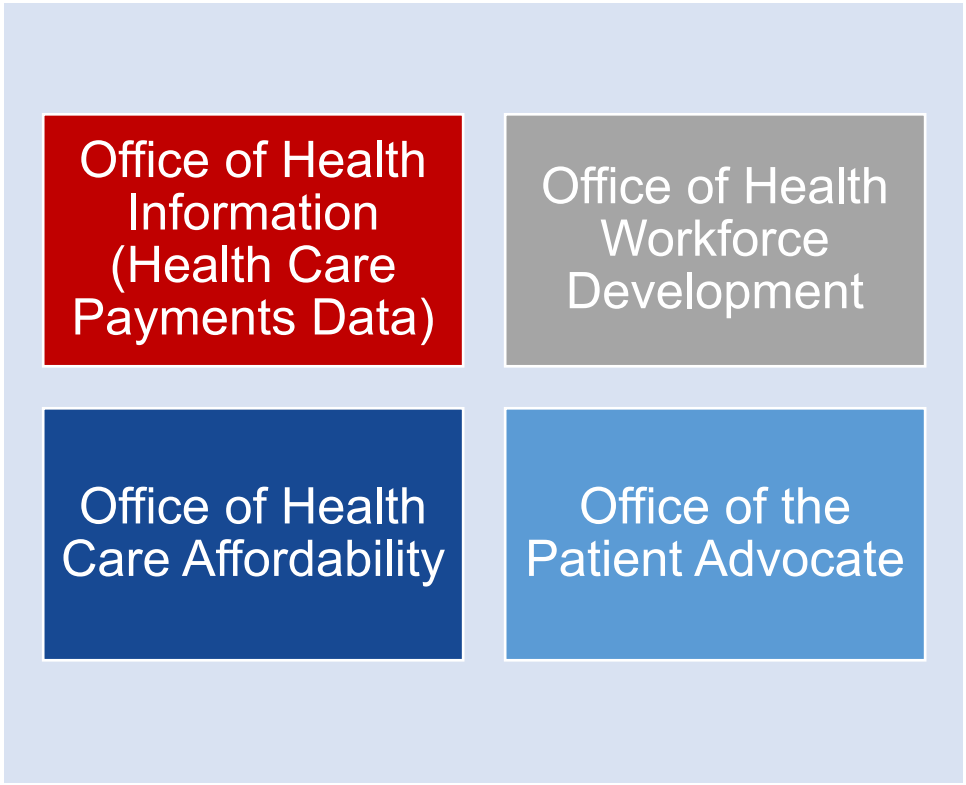
Static dashboard



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

HCAI Primary Care Snapshot Project Team

- The Primary Care 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 Primary Care 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

Office of Health Care Affordability

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

Primary Care Snapshot

Office of the Patient Advocate

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

Primary Care Snapshot Deliverables

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

- **Introduction to Primary Care Snapshot:** Timeline, approach to the static and interactive Primary Care Snapshots, stakeholder engagement.
- **Content Overview:** Current state of primary care in California, domains for future Primary Care 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 Primary Care Snapshot.
- **Update on Interactive Primary Care Snapshot:** Timeline and any other updates for development and release.

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

- **First Interactive Primary Care 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 Primary Care Snapshots

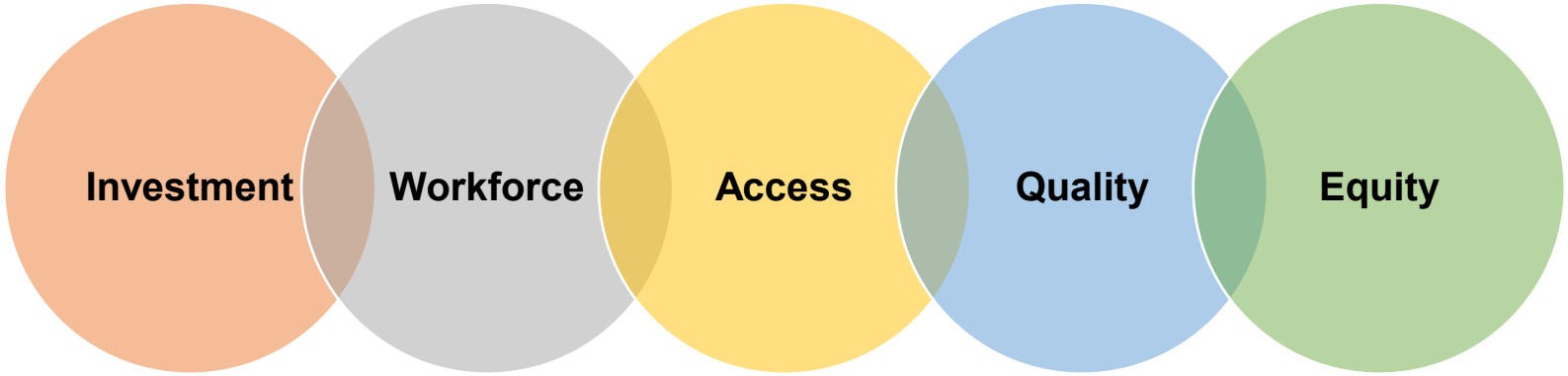
Note: Names of, and content within, deliverables are tentative and can be revised.

Primary Care Snapshot Indicator Development

Initial criteria for state and national indicators for the Primary Care Snapshot

- ✓ Is the indicator of interest to, and actionable for, California stakeholders?
- ✓ Is the indicator supported by existing, accessible California data sources or national data sources with California-specific data that can be tracked over time?
- ✓ Does the indicator directly measure the strength of the primary care sector?
- ✓ Does the indicator track change in the primary care sector, aligned with the five key domains?

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 Primary Care Snapshot development through at least year-end 2026.
- Report on Primary Care 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.

Primary Care 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 Primary Care 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 Primary Care Snapshot.

Primary Care 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)

Link: HCAI Primary Care Snapshot Workgroup – HCAI

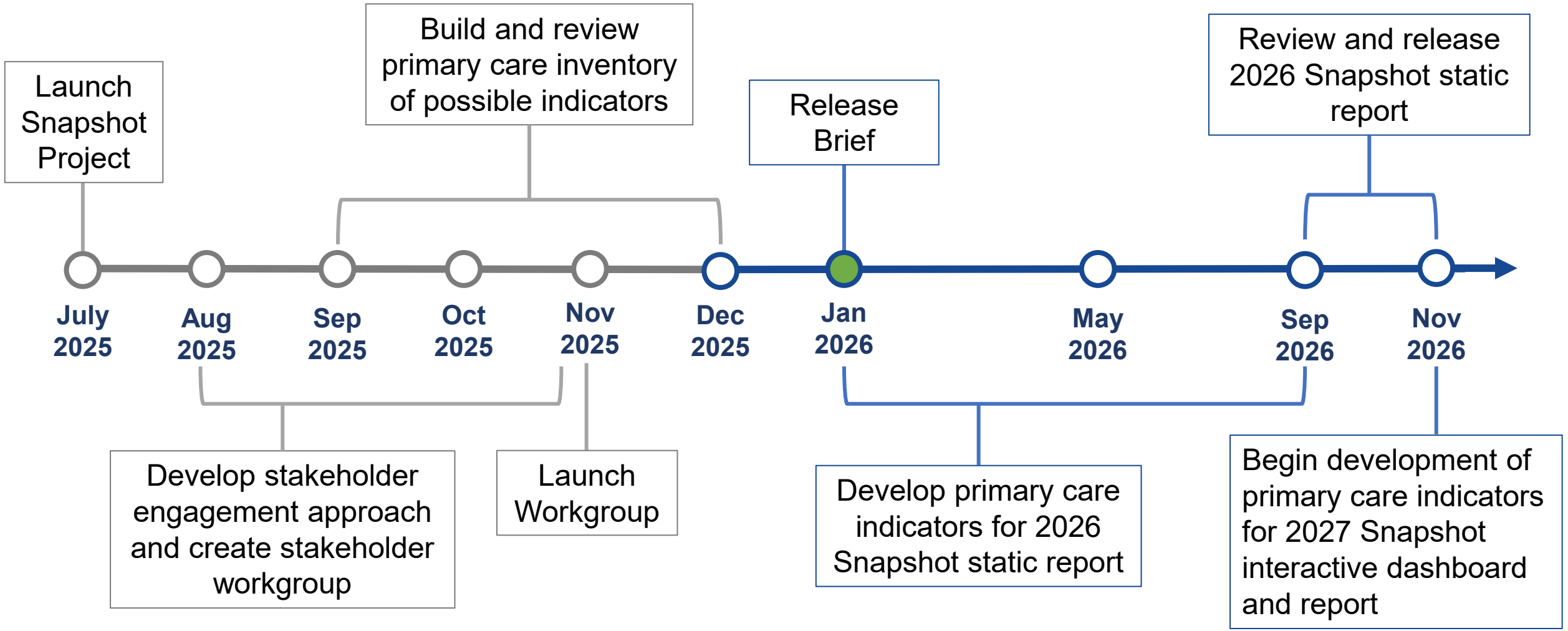
Upcoming: HCAI Brief on Primary Care in California

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

The brief will include:

- Purpose of the Primary Care 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 Primary Care Snapshot describing the phased approach and timeline for interactive Primary Care Snapshot development.

2025-2026 Primary Care 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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Department of Health Care Access and Information

Next Advisory Committee Meeting:

April 15, 2026
10:00 AM

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

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Adjournment

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