OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Board Meeting

January 28, 2026

HCAI

Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Welcome, Call to Order, and Roll Call

HCAI

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 December 16, 2025 Meeting Minutes
Vishaal Pegany

Item #4 **Action Item**
Vote to Appoint Advisory Committee Member
Megan Brubaker, Engagement and Governance Group Manager

Item #5 **Informational Items**

a) Cost-Reducing Strategies – Los Angeles General Medical Center Safer@Home Program
Margareta Brandt, Assistant Deputy Director; Dr. Brad Spellberg, Chief Medical Officer; Dr. Josh Banerjee, Associate Medical Director of Transitions of Care; Dr. Christopher Lynch, Medical Director, Safer@Home Program

b) Hospital Sector Target Adjustments Methodology – Considering Resubmissions of Hospital Data
Vishaal Pegany; CJ Howard, Assistant Deputy Director

c) Update on Total Health Care Expenditures Data Submission Regulations (DSG 3.0)
Vishaal Pegany

d) Exploring Drivers of Health Care Spending Across Commercial Payers
Andrew Feher, Research and Analysis Group Manager

e) Spending Target Enforcement – Performance Improvement Plan Follow-up
Vishaal Pegany; CJ Howard

Item #6 **General Public Comment**

Item #7 **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

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Rural Health Transformation Program

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
  - California received an intent to award $233,639,308 for the first year

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 45 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

Quarterly Work Plan*

		Total Health Care Expenditures & Spending Targets	Cost and Market Impact Review (CMIR)	Promoting High Value
JAN	Board	• Update on Total Health Care Expenditures Data Submission Regulations (DSG 3.0) • Exploring Drivers of Health Care Spending Across Commercial Payers • Spending Target Enforcement – Performance Improvement Plan Follow-up • Hospital Sector Target Adjustments Methodology – Considering Resubmissions of Hospital Data		• Cost-Reducing Strategy – Los Angeles General Medical Center's Safer@Home Program
	AC	• Update on Behavioral Health Out-of-Plan Spending • Introduction to Total Health Care Expenditures Data Submission Regulations (DSG 3.0) • Spending Target Enforcement – Technical Assistance, Public Testimony, Waiver of Enforcement, and Performance Improvement Plans	• CMIR Update	• Introduction to HCAI Health of Primary Care in California Snapshot
FEB	Board	**No Meeting**		
	AC	**No Meeting**		
MAR	Board	• Spending Target Enforcement -- Performance Improvement Plans • Spending Target Data Submission Enforcement – Introducing Regulatory Text • Total Health Care Expenditures Data Submission Regulations (DSG 3.0) – Discussing Comments on Regulatory Text	• CMIR Update • CMIR Regulations – Introducing Regulatory Text	
	AC	**No Meeting**		
APR	Board	• Spending Target Penalties • Spending Target Data Submission Enforcement – Discussing Comments on Regulatory Text • Hospital Measurement Update • Total Health Care Expenditures Data Submission Regulations (DSG 3.0) – Status Update for Regulatory Text	• CMIR Regulations – Discussing Comments on Regulatory Text	
	AC	• Spending Target Enforcement -- Performance Improvement Plans • Spending Target Penalties • Hospital Measurement Update	• CMIR Regulations – Discussing Regulatory Text	

* Work plan is subject to change.

Future Topics Beyond April 2026*

THCE & Spending Target

- Spending Target Data Submission Enforcement – Status Update for Regulatory Text
- Spending Target Enforcement – Penalties, Board Vote, Regulations
- Interim Report on Health Care Spending

Promoting High Value

- Behavioral Health Investment Benchmark
- HCAI Primary Care Snapshot Updates
- Introduce Equity and Quality Adjustment

Assessing Market Consolidation

- Update on Material Change Notices Received, Transactions Receiving Waiver or Warranting a CMIR, and Timing of Reviews for Notices and CMIRs
- CMIR Regulations – Status Update for Regulatory Text

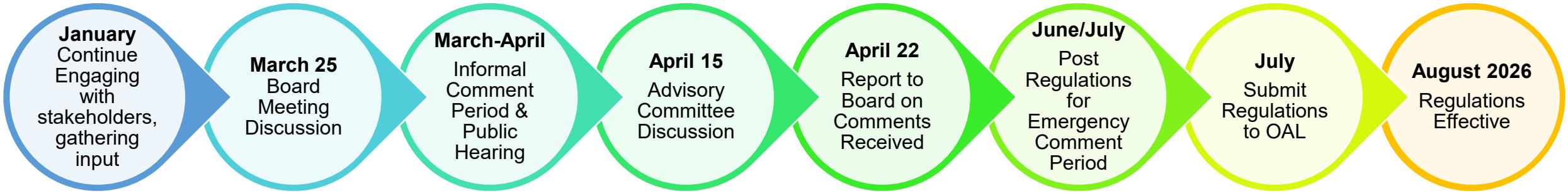
* Subject to change.

2026 Reporting Roadmap*

	Total Health Care Expenditures & Spending Targets	Promoting High Value
Q1	• Cost Driver Issue Brief #1: Population aging, utilization, and chronic condition prevalence	• HCAI Primary Care Snapshot Brief
Q2	• OHCA Facility-level National Provider Identifier (NPI) Crosswalk • OHCA Facility-level Inpatient and Outpatient Spending Dataset • Interim Health Care Spending Report • Cost Driver Issue Brief #2: Intensity of services	• HPD Behavioral Health Spending Analysis
Q3		• Health System Performance Baseline Report • HCAI Primary Care Snapshot (static version) • HPD Behavioral Health Spending Analysis
Q4	• Cost Driver Issue Brief #3: Regional price variation in shoppable services	

* Subject to change.
Note: Cost Driver Issue Briefs #2 and #3 may publish in either Q2 or Q4 of 2026.

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.

National Health Expenditures (NHE) 2024 Growth Rates

- Health care spending reached $5.3 trillion in 2024, averaging $15,474 per person. The per capita growth rate was 6.1%, down from 6.5% in 2023.
- Among the major coverage sources, Medicaid spending per enrollee grew fastest at 16.6% ($11,050 per enrollee), up from 6.5% in 2023. The authors attribute this accelerated spending growth to changes in enrollment composition and rising provider payment rates.
- Medicare spending per enrollee grew 5.4% ($16,779 per enrollee), down from 6.7% in 2023.
- Private health insurance spending per enrollee grew 5.2% ($7,676 per enrollee), down from 9.6% in 2023. Private health insurers' nonmedical spending grew 4.4%, down from 10.5% in 2023.

Source: Hartman, M et al. (2026). *National Health Care Spending Increased 7.2 Percent In 2024 As Utilization Remained Elevated*. *Health Affairs*. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.01683

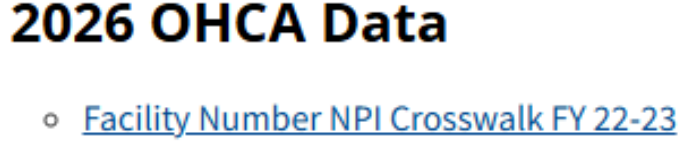
National Health Expenditures (NHE) 2024 Growth Drivers

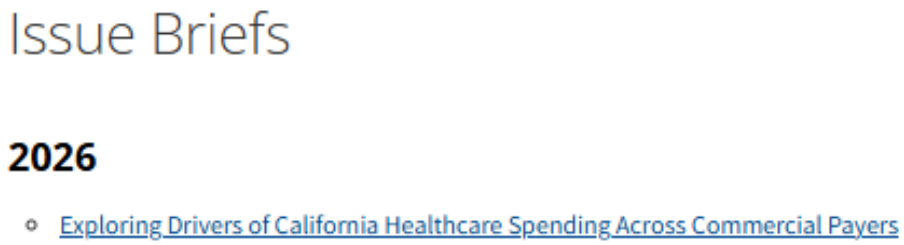
- The insured population decreased from an all-time high of 92.5% in 2023 down to 91.8% in 2024.
- Similar to 2023, the authors note that spending growth was driven primarily by nonprice factors such as the use and intensity of services, particularly for hospital care, physician and clinical services and retail prescription drugs.
- In 2024, medical price growth contributed 2.5 percentage points, while use and intensity accounted for a larger share at 3.6 percentage points of the 6.1% per capita increase.
- Three Largest Spending Categories:
  - **Hospital Care** (31% of total spending) increased 8.9%, down from 10.6% in 2023. Growth was highest for private health insurance (10.4%), followed by Medicaid (8.5%) and Medicare (6.9%). Growth in prices for hospital care was 3.4%, up from 2.7% in 2023 and the highest rate of increase since 2007.
  - **Physician and Clinical Services** (21% of total spending) increased 8.1%, up from 7.4% in 2023. Prices for this category rose by 1.8% compared with a .6% increase in 2023.
  - **Prescription Drugs** (9% of total spending) increased 7.9%, down from 10.8% in 2023. Prices for prescription drugs grew slower at 1.4% compared to 2.3% in 2023.

Source: Hartman, M et al. (2026). *National Health Care Spending Increased 7.2 Percent In 2024 As Utilization Remained Elevated*. *Health Affairs*. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.01683

OHCA January 2026 Publications

- Earlier this month, OHCA emailed hospitals and posted on its website a preliminary facility-level crosswalk to support implementation of its hospital spending workstream.
- In addition, OHCA posted its first cost driver issue brief using HPD data to build upon findings from its baseline report.





Patient and Consumer Forum on Health Care Affordability

OHCA is establishing a patient and consumer forum that would convene 2 to 4 times per year. The goals of this forum are:

- To actively engage patients, consumers, and advocacy groups in our work.
- To listen and understand their concerns and lived experiences.
- To inform these groups on the work of OHCA and the Board.

Inaugural Session: March 10, 2026, from 1:00-5:00 PM

- Date and time are tentative and will be confirmed.
- Meeting will be held in person, as well as virtually, to ensure accessibility.

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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Public Comment

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Action Consent Item: Vote to Approve December 16, 2025 Meeting Minutes

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Cost-Reducing Strategies: Los Angeles General Medical Center Safer@Home Program

Margareta Brandt, Assistant Deputy Director
Dr. Brad Spellberg, Chief Medical Officer
Dr. Josh Banerjee, Associate Medical Director of Transitions of Care
Dr. Christopher Lynch, Medical Director, Safer@Home Program

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Los Angeles General
Medical Center

An All-Virtual Acute, Home Care Model

Christopher Lynch, MD- *Medical Director of Safer@Home*

Josh Banerjee, MD- *Associate Medical Director of Transitions of Care*

Brad Spellberg, MD - *Chief Medical Officer*

SAFER @ OME

OVERVIEW

- **Virtual care, at home, for patients who would otherwise be in the hospital**
- **Patients monitored via remote pulse oximetry and thermometer**
- **Daily phone visit check-ins with video support**
- **All medications oral or inhaled in lieu of IV**
- **First implemented during COVID to enable home care for COVID pneumonia requiring oxygen**

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SAFER @HOME

ORIGIN

Los Angeles General Medical Center

- Ultimately, we cared for >4,000 patients with COVID pneumonia at home during the pandemic
- If not for Safer@Home, LA General would have reached the triage stage during winter of ‘20-’21
- Post COVID, LA General decided to expand the program to other common, acute illnesses

SAFER @ OME

ORIGIN

Los Angeles General Medical Center

- Historically “IV antibiotics” or “IV medications” has been a valid reason to admit people to hospital
- Similarly, new onset pneumonia severe enough to require oxygen
- But modern clinical trials have demonstrated that IV therapy is not more effective than oral
- And we found that oxygen up to 6 liters/hour could be safely given at home during COVID

WHY SAFER @ HOME

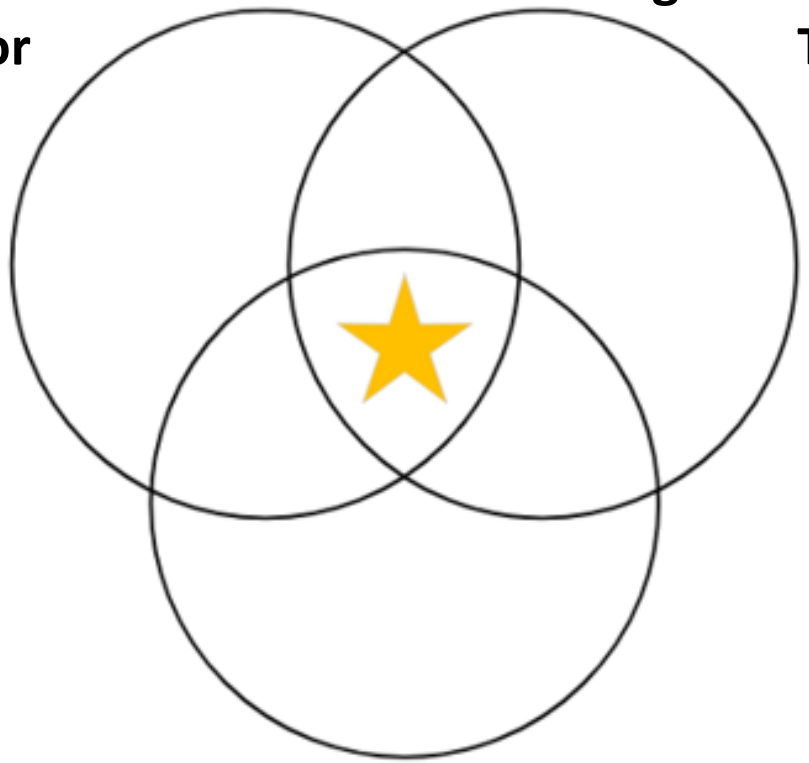
Los Angeles General Medical Center

- Hospitalizations can cause harm events and can be disruptive to patients' lives.
- Access to care is critical and hospital overcrowding can compromise quality of care.
- Recent innovations in care practices suggest we do not need to hospitalize patients for as many indications as previously thought.
- We should care for as many patients at home whenever it is safe to do.
- "Hospital at Home" models are not feasible due to expansive patient catchment area in LA County and limited staffing.
- LA General's community partners expressed a strong desire to expand patient-centered, out-of-hospital care

Population and Key Principles for Enrollment

Patient Requires Admission or Continued Enrollment

High Probability of Treatment Response



Low Probability of Rapid Decompensation

SAFER @OME OVERVIEW

Current eligible diagnoses:

- Acute gallstones
- Alcohol withdrawal
- Asthma/COPD exacerbation
- Bone infections
- Cellulitis (skin infection)
- Complicated Urinary/Kidney Infections
- Diabetic foot infections
- Heart failure exacerbations
- Multiple sclerosis exacerbations
- Pneumonia (viral or bacterial)

- Other as needed

Los Angeles General Medical Center

Safer@Home **Process**

1

Care team calls the on-call Safer@Home Attending (12 hours per day coverage)

2

Reviews criteria for the program

3

If accepted, teaching and DME provided to the patient by Discharge Lounge nursing

4

Daily video visits with nurse using disease-specific script, with hospitalist back up

5

If face-to-face eval needed, Med Uber transportation provided to Urgent Care

Strategies to Address Barriers to Implementation

- Provider Adoption
  - Departmental, Chiefs/Chairs, and Resident Grand Rounds Presentations
  - ED Physician and Nurse Champions (part of S@H Leadership Team)
  - ED and Medical Unit Huddles
  - S@H Attending on-call 7a-7p
  - Job aids for residents and fellows

- Evolution of strategies based on provider feedback
  - Make enrollment process more efficient
  - Need for 24/7 (overnight) process for ED providers
  - Need for antibiotic decision support
  - Creation of more standardized pathways (e.g., Heart Failure Exacerbation)
  - Easy access to most current and more detailed program information

Enrollment Order Sets with Antibiotic Decision Support

	$	Component	Status	Dose ...	Details
Safer at Home - Diabetic Foot Infection (Planned Pending)					
		Safer at Home - Infected Diabetic Foot Ulcer (For questions, please contact Safer at Home Attending listed on Amion)			
		Referral Information:			
☑		Enroll into Safer at Home			T;N, DM Foot Ulcer Infection (cellulitis, OM)
☑		Communication Order (DO NOT USE FOR MEDICATIONS)			T;N >>If patient is currently in the ED or ED OBS, patient must be discharged AND transported to ED OBS. Discuss and coordinate with...
		DME Orders (All patients enrolled into Safer at Home to receive pulse oximeter and thermometer. Order additional DME as needed):			
☑		DME Respiratory Oximetry Device			Device for Home use, Not applicable for this Order, T;N, Safer at Home
☑		DME Miscellaneous Equipment			T;N, Safer at Home: DME Thermometer
☑		DME Phone for Safer at Home			T;N, Safer at Home
		Prescriptions:			
		RECOMMENDED EMPIRIC ORAL ANTIBIOTIC (for patients >18 years old) · If susceptibilities available, used targeted therapy (in consultation with ID if necessary). · Duration of therapy: - 5-6 days if exam is consistent with cellulitis. - 4 weeks if concern for osteomyelitis but further workup needed (i.e. MRI as outpatient; antibiotic treatment can be extended in outpatient setting if needed). - 6 weeks if findings consistent with osteomyelitis (i.e. XR findings consistent or able to probe to bone). · If renal dysfunction present, adjust dose and discuss with pharmacy as needed. >> If no abscess present, the patient has not previously grown MRSA or Pseudomonas from prior cultures, and the wound is not gangrenous: · Amoxicillin-clavulanic acid 875mg BID. If renal dysfunction, discuss with pharmacy regarding renal dosing. >> If an abscess is present (even if drained), or the patient has previously grown MRSA: · TMP-SMX 2 DS BID + metronidazole 500 mg BID (when using TMP-SMX, be mindful of need for renal dose adjustment. If renal dysfunction, consider alternative medication or discuss with pharmacy regarding renal dosing). · Clindamycin 600mg TID - be aware of GI side effects and compliance. · Doxycycline 100 mg BID + metronidazole 500 mg BID. >> If the patient has previously grown Pseudomonas (not resistant to ciprofloxacin/levofloxacin) or the wound is gangrenous: · Levofloxacin 750 mg daily + metronidazole 500 bid mg once daily. If renal dysfunction, discuss with pharmacy regarding renal dosing for levofloxacin.			
☐		amoxicillin-clavulanate (amoxicillin-clavulanate 875 ...			1 tabs, Oral, Q12H, # 56 tabs, Safer at Home Patient Dosing per ID recommendations.
☐		sulfamethoxazole-trimethoprim (sulfamethoxazole-tri...			2 tabs, Oral, BID, # 112 tabs, Safer at Home Patient Dosing per ID recommendations.
☐		metroNIDAZOLE (metroNIDAZOLE 500 mg oral tablet)			2 tabs, Oral, Q24H, # 28 tabs, Safer at Home Patient Dosing per ID recommendations.
☐		clindamycin (clindamycin 300 mg oral capsule)			2 caps, Oral, Q8H, # 168 caps, Safer at Home Patient Dosing per ID recommendations.
☐		doxycycline (doxycycline monohydrate 100 mg oral c...			= 1 caps, Oral, BID, # 56 caps, Safer at Home Patient Dosing per ID recommendations.
☐		levoFLOXacin (levoFLOXacin 750 mg oral tablet)			1 tabs, Oral, Q24H, # 28 tabs, Safer at Home Patient Dosing per ID recommendations.

Staff Facing Website

lacounty.sharepoint.com/sites/dhs-saferathome

Link can also be found on Home Page next to UpToDate under "Los Angeles General Quick Links"

SAFER@HOME

Safer@Home

Home
What is Safer@Home?
Inpatient Referring Provid...
ED/OBS Referring Provid...
Nursing (Primary RNs)
Referral Criteria
Home Monitoring Equip...
Site contents
Recycle bin
Edit

+ New | Page details | Preview | Analytics

Click the applicable tiles below for more information.

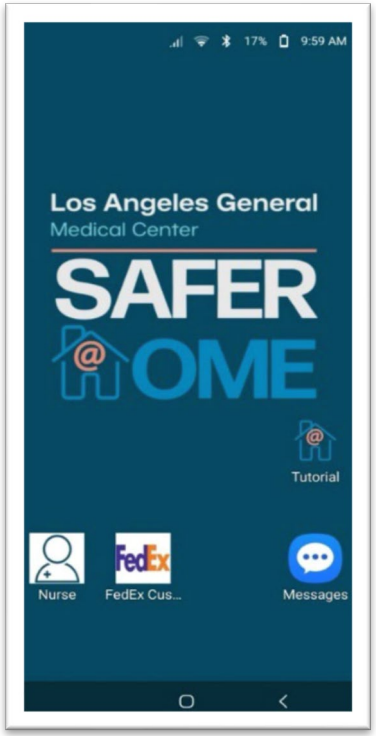
SAFER @ OME

Patient Barriers

There is a digital divide in our patient population that makes it difficult for them to fully take advantage of the S@H program. Lack of access to reliable technology perpetuates further disparity in healthcare.

Improve Access Via

Voice **Messaging** **Video**



SAFER @ OME

RESULTS

Year 1 of the Program

Patient Characteristic	Safer At Home Cohort	Comparison Cohort	P Value
Total	876	1590	
Care Setting at Discharge--no. (%)			
Hospital (Inpatient)	396 (45.2%)	1590 (100%)	
Emergency Department / Observation / Urgent Care (Outpatient)	480 (54.8%)	0 (0%)	
Patient Age--avg. (SD)	54.0 (14.5)	52.3 (19.6)	0.15
Patient Sex			0.14
Female	335 (38.2%)	688 (43.3%)	
Male	541 (61.8%)	901 (56.7%)	
Patient Race/Ethnicity--no.(%)			0.071
White	10 (2.6%)	59 (3.7%)	
Hispanic	326 (83.2%)	1235 (77.7%)	
Black	14 (3.6%)	108 (6.8%)	
Asian	19 (4.9%)	75 (4.7%)	
Other	26 (6.6%)	113 (7.1%)	
Patient Case Mix Index--avg.(SD)	1.27 (0.66)	1.26 (0.59)	0.72
Patient Expected Mortality--avg.(SD)	0.016 (0.47)	0.019 (0.059)	0.45

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Medical Center

RESULTS

Year 1 of the Program

Patient Outcome	Safer At Home Cohort	Comparison Cohort	P- Value
Hospital Length of Stay Days avg.(SD)	1.33 (2.00)	5.34 (10.44)	<0.0001
Number of 30-Day Urgent Care Visit Per Patient--avg. (SD)*	0.61 (0.96)	0.083 (0.51)	<0.0001
Number of 30-Day Emergency Department Visit Per Patient--avg. (SD)*	0.19 (0.50)	0.21 (0.85)	<0.0001
30-Day Hospital Readmission--no. (%)	174 (19.9%)	266 (16.9%)	0.062
30-Day Mortality--no. (%)	4 (0.5%)	16 (1.0%)	0.13

Los Angeles General
Medical Center

SAFER @OME

RESULTS

- In year 1, **876** patients enrolled = 2.3 pts/day
- In year 2, **1,171** patients enrolled = 3.2 pts/day
- In year 3, **1,230** patients in 11.5 mos = 3.5 pts/day
- Year 1 detailed financial analysis would generate an additional 50% of savings with higher enrollment now achieved

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Exceptional Care. Healthy Communities.

Safer@Home Analysis

Year 1 Financial Analysis

- LA General has a very high rate of Medicaid/uninsured
- $4 million revenue lost; mostly Medicare/Commercial
- $10 million costs avoided; mostly Medicaid; $0.7 million in fixed costs
- Net $5.6 million saved; Net savings for Medicaid/uninsured Net losses for Medicare/Commercial

Table 1. Net Hospital Financial Outcomes: Cost Avoidance vs. Lost Revenue and Fixed Costs

Total Inpatient Days Saved Insurance (N, %)	Total Inpatient Days Saved	Total Lost Revenue	Total Variable Costs Avoided	Total Fixed Costs of the Program*	Net Revenue Lost + Cost Saved	Net Revenue/ Cost Per Case
Base Case Analysis						
Medicare: 121 (13.8%)		-$1,876,585	$1,469,533	-$94,279	-$501,331	-$4,143
Medicaid: 676 (77.2%)		-$1,670,311	$7,861,619	-$526,714	$5,664,594	$8,380
Commercial: 11 (1.3%)		-$444,152	$166,734	-$8,571	-$285,989	-$25,999
Tricare/VA: 3 (0.3%)		-$34,256	$48,040	-$2,337	$11,447	$3,816
Uninsured: 65 (7.4%)		-	$761,348	-$50,646	$710,702	$10,934
Total	**-3504**	**-$4,025,305**	**$10,307,274**	**-$682,547**	**$5,599,422**	**$6,392**

Reimbursement at around 55–65% of normal DRG payment would be cost neutral to society/payors, while enabling cost savings at hospitals with normal payor mixes

Los Angeles General
Medical Center

Questions?

Thank You

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Department of Health Care Access and Information

Public Comment

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Action Item: Vote to Appoint Advisory Committee Member

Megan Brubaker, Engagement and Governance Group Manager

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Special Payer Recruitment Process

- October 29, 2025 – November 30, 2025, 13 submissions received.
- New AC Subcommittee appointed at the November Board meeting.
- Subcommittee met in December to discuss submissions and recommend a Payer for appointment.

Advisory Committee Members – 28

Payers

Kassie Maroney
Senior Vice President, Underwriting and Analytics, Chief Actuary, Blue Shield of California

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
Chief Financial Officer, 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 Advocate, 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

Highlight indicates Subcommittee recommendation

Draft Motion from the Subcommittee

- Approve Kassie Maroney to the Advisory Committee in the Payer category.
- This term ends on June 30, 2026.

General Recruitment Reminder

OHCA is currently accepting submissions of interest to serve on the Advisory Committee.

- Selected members will serve a two-year term from July 1, 2026 - June 30, 2028.
- Submission of interest form is due by March 31, 2026.

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
Chief Financial Officer, Salinas Valley Health

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Respiratory Therapist, Kaiser

Sarah Soroken
Mental Health Clinician, Solano County Mental Health

Cristina Rodriguez ★
Physician Assistant, Altura Centers for Health

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Mike Odeh ★
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Amanda McAllister-Wallner
Executive Director, Health Access

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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

Advisory Committee Member Selection Timeline

January 5 - March 31

Submission of Interest Open

April - May

Analyzing submissions and Subcommittee Meetings

June - July

Present recommended slate to Board

Appoint AC members

July 8 or October 14, 2026

First AC meeting for new appointees

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Informational Items

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Hospital Sector Target Adjustments Methodology: Considering Resubmissions of Hospital Data

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

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Hospital Annual Financial Disclosure Report Background

- Annually, every fall, HCAI publishes the Hospital Annual Financial Disclosure Report (HAFDR) Complete Data Set.
- The regulatory process allows hospitals to resubmit prior year data.
- When HCAI publishes the Complete Data Set each fall, prior years are not modified or adjusted to reflect prior year resubmissions.
- The resubmissions are made available on HCAI's website via the SIERA system.

High-Cost Outlier Hospital Sector Target Adjustment Background

- The Board's April 2025 action to adjust the sector target for high-cost outlier hospitals relied on the HCAI Complete Data Sets from FY 2018-2022.
- The refreshed analysis (FY 2019-2023) that the Office presented to the Board in December 2025 added the FY 2023 Complete Data Set, which was published in September 2025.
- The methodology included hospitals above the 85th percentile on unit and relative prices. This relative cutoff could mean if one hospital drops below the 85th percentile, another could then come into the 85th percentile.

Current Hospital Data Resubmissions

- At the close of the December 2025 meeting, a hospital indicated that it had resubmitted prior year financial data and sought for the Board to consider the resubmitted data.
- After the December 2025 meeting, the hospital reached out to OHCA and indicated that it believes that were the Board to consider the resubmitted data from calendar years 2019-2022 that it would not meet the criteria that the Board used to adjust its target on the basis of it being a high-cost outlier within the hospital sector.
- OHCA has also learned of at least one other hospital with an adjusted sector target that has resubmitted their hospital annual financial disclosure reports for prior years.
- HCAI is still in the process of reviewing and validating these resubmitted data for one or more hospitals for one or more years.
- Given the pending status of the resubmitted data, OHCA has not re-run the target adjustment methodology and analysis based on these resubmitted data.

Considerations for Board Discussion

- The Board may wish to consider more recently submitted and revised data
- Whenever data are submitted, the entity attests that the data are accurate.
- If an entity discovers an error or makes modifications for a prior year, these changes will reflect in future submissions.
- OHCA could consider resubmitted data during the progressive enforcement process.
- Hospitals may continually resubmit prior year data in an effort to fall below the 85th percentile.

Considerations for Board Discussion

If the Board considers resubmitted data:

- The Office would need to determine and communicate to hospitals a date by which HCAI would need to receive resubmissions to ensure a fair and consistent process. Neither OHCA nor the Board have previously communicated guidance to hospitals regarding the process or timeframe by which the Board may consider resubmitted data.
- To date, HCAI has reviewed some facilities' resubmitted data, but other facilities' data are still pending validation. If the Board considered resubmitted data that HCAI has validated as of December 31, 2025, this may be perceived as unfair to a facility whose data is still pending validation.

Board Discussion: Considering Resubmitted Data

Does the Board desire to modify the methodology used to adjust targets to consider resubmitted data?

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Update on Total Health Care Expenditures Data Submission Regulations (DSG 3.0)

Vishaal Pegany, Deputy Director

HCAI
Department of Health Care Access and Information

2026 Data Collection Regulatory Timeline

- Draft updates to regulations and DSG 3.0 released for public comment on January 5
- Comments due to OHCA@HCAI.ca.gov by **January 30, 2026**
- Anticipated submission to Office of Administrative Law by April 2026.

- Drafts available for review on HCAI website: https://hcai.ca.gov/about/laws-regulations/

2026 Data Collection Timeline

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Exploring Drivers of Health Care Spending Across Commercial Payers

Andrew Feher, Research and Analysis Group Manager

HCAI
Department of Health Care Access and Information

Background

- OHCA is statutorily required to analyze drivers of health care spending. In early 2025, OHCA began using the Health Care Payments Database (HPD) for this purpose.
- At the April 2025 HPD Advisory Committee, OHCA shared that it planned to explore how different factors – for example, aging, chronic condition prevalence, and utilization – might affect spending growth, both overall and at the payer-level.
- In June 2025, OHCA published its baseline report on health care spending for calendar years 2022 and 2023 and is using the HPD for supplemental analyses.
- At the October 2025 HPD Advisory Committee, OHCA presented a version of the forthcoming slides that masked health plan names.
- In November and December, OHCA shared identified summary statistics with each commercial health plan and met with those who requested a meeting.

Key Distinctions

	Purpose	Granularity	Source	Cycle
OHCA	Report on spending growth	Aggregate	Financial / accounting systems	Collect two years of data annually
HPD	Examine cost trends and cost drivers	Detailed	Claims / encounters systems	Monthly rolling

Executive Summary

Background: OHCA's baseline report documented that, in the commercial market, total medical expenses per member per year (TME PMPY) increased by 5% from 2022 to 2023.

Objective: Use HPD data from 2022 and 2023 to examine commercial payer-level variation in (1) the average age of members, (2) the share of commercial members who used health care services and (3) the share of members with chronic conditions.

Findings: From 2022 to 2023, we find no meaningful change in the average age of members; we find that the utilization rate decreased for all payers; and chronic condition prevalence decreased for 4 out of 13 payers.

Implications: Since utilization decreased across all commercial payers, the observed increase in TME PMPY from OHCA's data collection is likely driven by other factors, such as higher prices or greater intensity of utilization, which we intend to explore in future analyses.

Empirical Approach

- For this analysis, we used HPD data – specifically, the eligibility, medical and reference tables as well as a crosswalk for chronic conditions diagnosis codes and a crosswalk of HPD to OHCA submitters.
- We created a member-year-payer-level dataset for 2022 and 2023 to align with OHCA's baseline report.
- We excluded less than 0.5% of distinct members in the HPD from the analysis due to conflicting or incomplete age or gender information. From OHCA's data, about 0.1% of member equivalents are submitted with unknown gender; these data are excluded when examining concordance across the HPD and OHCA data.
- Based on these exclusions, we found that approximately 85% of OHCA member months are represented in the HPD data. The count of member months in OHCA's data is higher due to submission of some private self-insured enrollment.

Key Metrics of Interest

- **Member Age:** The eligibility table reports an individual's age on a member-month basis. For this analysis, age was converted to one value per member per year. When a member's age increased by one year during the enrollment year, a midpoint age was assigned (e.g., 35.5 for individuals reported as 35 and 36 within the same year).

- **Utilization Rate:** Proportion of members who had at least one medical claim or encounter within a given calendar year, divided by the total number of members with coverage in the eligibility table during the same year.

- **Chronic Condition Rate:** Proportion of members who had at least one service incident in the medical table within a given calendar year containing a chronic condition diagnosis code, divided by the number of members with coverage in the eligibility table in that year.

- For the utilization and chronic condition measures, if an individual is covered by multiple health plans (Plan 1 and Plan 2) during the year and only accesses care with one of those plans (Plan 1), the individual will be counted as having utilization with Plan 1 but not Plan 2.

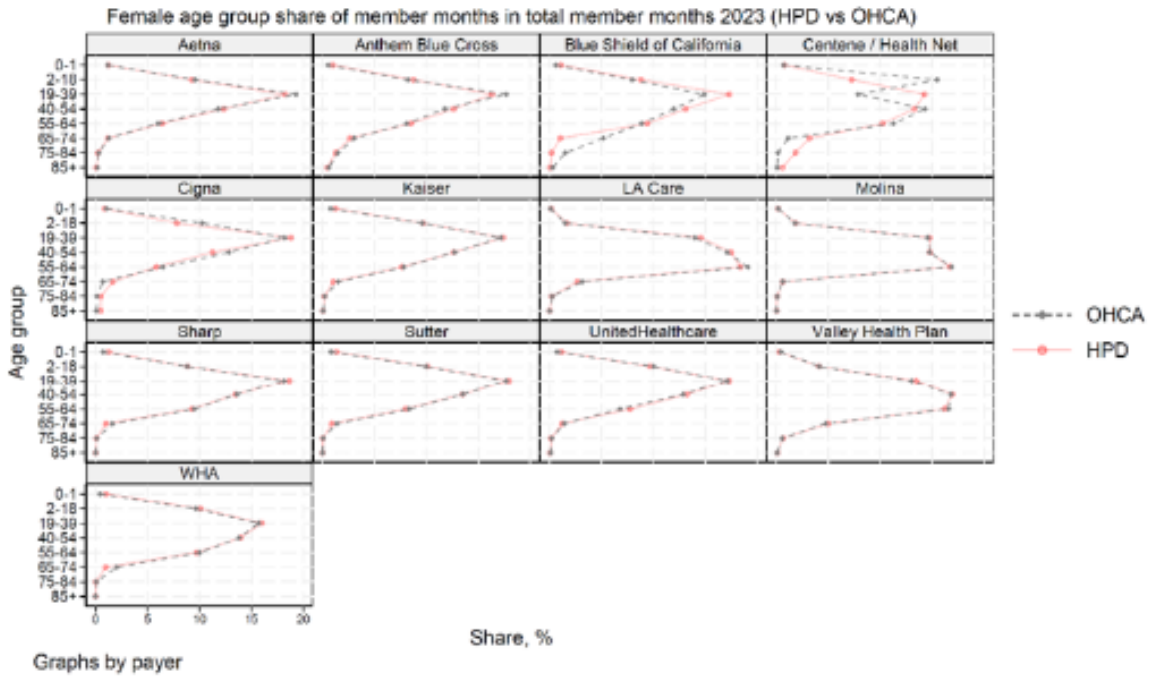
Note: The list of 30 chronic conditions and corresponding diagnosis codes are available at CMS's Chronic Condition warehouse.

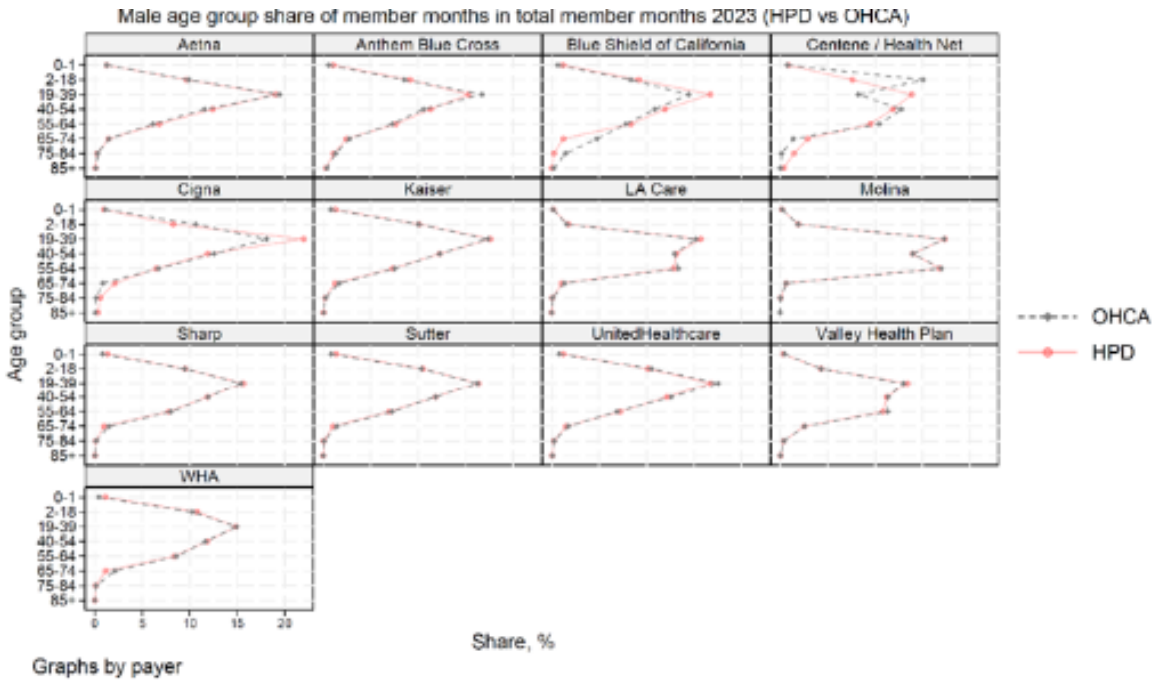
Limitations

- Utilization and chronic conditions are based on medical service records. Excluding pharmacy claims could result in understated utilization rates.
- Our analysis focused on how many members use their health insurance coverage (the extensive margin of utilization) but not how much care a member may have used (the intensive margin). In future analyses, we intend to explore the latter.
- For this analysis, we focus on the commercial market. In future analyses, we intend to incorporate the Medicare Advantage market category.

Gender Distribution Across HPD and OHCA Data Sources

To assess the extent to which we were able to effectively identify OHCA data submitters within the HPD, we began by comparing gender distributions across the HPD and OHCA data sources and found that they closely align for all but one payer.





Age Composition

- For 10 commercial payers, average age changed by less than 0.3 years (3.6 months) between 2022 and 2023.
- Overall, commercial payers saw an increase in average age from 36.1 to 36.2 years between 2022 and 2023.

Age, mean (SD)	2022	2023
Aetna	34.6 (18.2)	34.8 (18.2)
Anthem Blue Cross	37.6 (20.0)	37.9 (20.0)
Blue Shield of California	36.2 (18.6)	36.3 (18.6)
Centene / Health Net	41.0 (20.0)	41.1 (20.3)
Cigna	35.0 (18.0)	35.2 (17.8)
Kaiser	35.0 (18.6)	35.1 (18.5)
LA Care	45.4 (15.0)	43.5 (15.7)
Molina	44.1 (15.6)	43.5 (15.7)
Sharp	35.6 (18.3)	35.5 (18.6)
Sutter	34.3 (18.2)	34.4 (18.2)
UnitedHealthcare	34.8 (18.4)	35.0 (18.5)
Valley Health Plan	44.6 (17.3)	43.5 (17.8)
WHA	35.7 (18.7)	35.8 (18.7)
Market Average	**36.1 (18.9)**	**36.2 (18.8)**

Utilization Rate

- On average, payers saw a decrease in the share of members who used medical services from 76.7% in 2022 to 72.6% in 2023 (a 5.3% relative decrease).
- Kaiser had the highest share of members with utilization at 83.1% and 79.4% in 2022 and 2023.
- Cigna had the lowest share both in 2022 and 2023 at 41.0% and 36.9%, respectively.

	2022	2023	Percentage Change in share, %	Change in share, percentage points
Aetna	70.5%	66.7%	-5.5%	-3.8pp
Anthem Blue Cross	75.0%	71.7%	-4.4%	-3.3pp
Blue Shield of California	76.5%	71.3%	-6.9%	-5.2pp
Centene / Health Net	65.0%	62.5%	-3.7%	-2.4pp
Cigna	41.0%	36.9%	-9.9%	-4.1pp
Kaiser	83.1%	79.4%	-4.4%	-3.6pp
LA Care	59.7%	47.3%	-20.7%	-12.3pp
Molina	56.9%	47.4%	-16.7%	-9.5pp
Sharp	74.8%	72.8%	-2.7%	-2.0pp
Sutter	74.9%	72.8%	-2.8%	-2.1pp
UnitedHealthcare	70.2%	67.1%	-4.5%	-3.1pp
Valley Health Plan	66.4%	49.6%	-25.4%	-16.8pp
WHA	75.4%	73.6%	-2.3%	-1.8pp
Market Average	**76.7%**	**72.6%**	**-5.3%**	**-4.1pp**

Covered California Utilization Rate

To assess the reasonableness of our utilization rate analysis, we looked to Covered California, which has used its claims database to report on both overall and payer-specific trends in utilization and similarly found a decrease in the utilization rate from 2022 to 2023 (88% down to 83%).

HEI

QHP PERFORMANCE

No Utilization of Care Over Time

QHP Issuer	2019	2020	2021	2022	2023
All Population	**18%**	**18%**	**9%**	**12%**	**17%**
Anthem EPO	22%	20%	11%	15%	19%
Anthem HMO		21%	9%	14%	20%
Blue Shield HMO	17%	16%	9%	12%	16%
Blue Shield PPO	13%	12%	6%	9%	11%
Chinese Community HMO	29%	29%	15%	21%	28%
Health Net EPO	19%	17%	11%	13%	N/A
Health Net HMO	18%	20%	9%	11%	14%
Health Net PPO	33%	33%	21%	19%	24%
Kaiser HMO	17%	17%	8%	12%	16%
L.A. Care HMO	20%	21%	13%	16%	23%
Molina HMO	42%	31%	16%	23%	30%
Oscar EPO	26%	24%	10%	14%	18%
Sharp HMO	16%	16%	8%	13%	15%
Valley Health Plan HMO	29%	28%	14%	21%	28%
Western Health Advantage HMO	20%	18%	10%	13%	16%

COVERED CALIFORNIA

Values marked as high rate outliers (lower is better measure), based on z-scores or Interquartile Range, are identified with a red box. Lower rate outliers (lower is better) are identified with a blue circle.
Blank cells are suppressed data due to counts too low to report.
N/A indicates plan was not offered that year

90

Source: https://hbex.coveredca.com/data-research/plan-performance-reports/2024/Release%20Year%202024%20PPR%20-%20HEI%20Measures.pdf

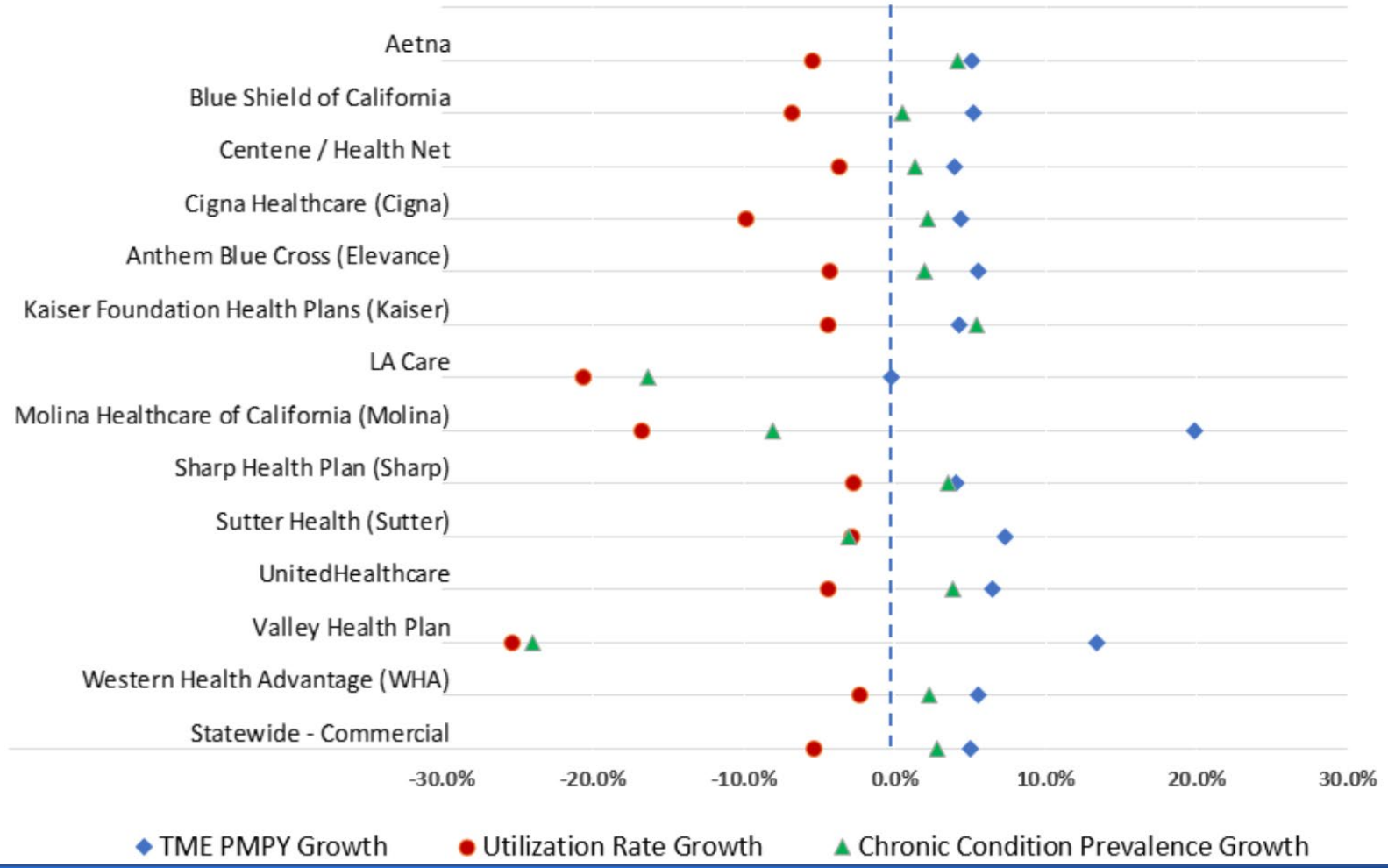
Chronic Condition Rate

- On average, the share of members with a chronic condition diagnosis was 31.5% in 2022 and 32.4% in 2023 (a 2.9% increase).
- Several payers saw an increase in the share of members with a chronic condition diagnosis – 5.4% for Kaiser, 4.1% for Aetna and 3.6% for Sharp – while other payers saw a decrease.
- The largest decreases in the share of members with chronic conditions were:
  - Valley Health Plan from 37.9% to 28.8% (a 24% decrease),
  - LA Care from 34% to 28.5% (a 16.3% decrease) and
  - Molina from 32.9% to 30.2% (an 8% decrease).

	2022	2023	Percentage Change in share, %	Change in share, percentage points
Aetna	28.5%	29.7%	4.1%	1.2pp
Anthem Blue Cross	35.5%	36.2%	2.0%	0.7pp
Blue Shield of California	34.9%	35.1%	0.5%	0.2pp
Centene / Health Net	34.4%	34.8%	1.3%	0.5pp
Cigna	15.4%	15.8%	2.2%	0.3pp
Kaiser	29.7%	31.3%	5.4%	1.6pp
LA Care	34.0%	28.5%	-16.3%	-5.5pp
Molina	32.9%	30.2%	-8.0%	-2.6pp
Sharp	32.0%	33.1%	3.6%	1.1pp
Sutter	32.4%	31.4%	-3.1%	-1.0pp
UnitedHealthcare	30.2%	31.4%	3.9%	1.2pp
Valley Health Plan	37.9%	28.8%	-24.0%	-9.1pp
WHA	38.1%	39.0%	2.3%	0.9pp
Market Average	**31.5%**	**32.4%**	**2.9%**	**0.9pp**

Change in Commercial Market TME PMPY, Utilization and Chronic Condition (2022 to 2023)

While TME PMPY increased across all but one commercial payer, utilization rates decreased, and the share of members with a chronic condition diagnosis increased for 9 out of 13 OHCA submitters.



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Takeaways and Next Steps

- In this analysis, OHCA used HPD data to build upon findings from its baseline report that featured aggregated total medical expense (TME) data.
- OHCA's baseline report documented that, from 2022 to 2023, total medical expense per member per year (TME PMPY) increased by 5.0% in the commercial market with variation across payers ranging from -0.2% to 19.8%.
- We explored three potential factors that may contribute to the spending growth and found that, from 2022 to 2023:
  - There was no meaningful change in the average age of members.
  - The share of members utilizing medical services decreased by 5.3% on average.
  - The share of members with chronic condition diagnosis increased by 2.9% on average.
- However, there was substantial variation in these metrics across payers.
- OHCA will continue use the HPD for cost driver analyses that build upon its statutorily required reports. In future analyses, we will explore price variation in shoppable services and intensity of utilization.

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Spending Target Enforcement: Performance Improvement Plan Follow-up

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

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Review of Board Discussion of Spending Target Enforcement Thus Far

- OHCA is collecting initial feedback form the Board, AC and the public to inform the development of spending target enforcement regulations in late 2026.
- Further opportunities for feedback will occur with the presentation of draft regulations, including a public workshop.
- So far, OHCA has had discussions of:
  - Assessing performance
  - Enforcement considerations
  - Technical assistance
  - Public testimony
  - Performance improvement plans

Review of Board Discussion of Spending Target Enforcement Thus Far

The below chart presented at the July Board meeting shows the initial planned timeline for discussion on various enforcement topics ahead of the regulations process later this year.

*Timeline from July 2025 Board Meeting (slide 75)

Updated Timeline

- OHCA is gathering feedback July 2025 – June 2026
- A discussion on spending target penalties is scheduled for spring 2026
- OHCA will develop regulations from summer – October 2026

Board Follow-Up Items

Do entities have to go through a Performance Improvement Plan (PIP) before being assessed a penalty?

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.

127502.5.(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.

127502.5.(h)(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.

Health & Safety Code § 127500.5 and Health & Safety Code § 127502.5

Board Follow-Up Items

Do entities have to go through a Performance Improvement Plan (PIP) before being assessed a penalty?

Yes, OHCA will first require a PIP before assessing a penalty, per statute's legislative intent that enforcement be progressive and that entities be assisted with coming into compliance via technical assistance and PIPs before being assessed a penalty.

PIPs also:

- Identify root causes of unaffordability by working with entities to make real lasting improvements.
- Create better understanding of how health care entities operate.
- Can identify meaningful interventions that may support other entities' PIPs and future state policy direction.

Health & Safety Code § 127500.5 and Health & Safety Code § 127502.5

Board Follow-Up Items

What is Oregon's cost target penalty?

The Oregon Health Authority's financial penalty for exceeding a cost target is based on a percentage of excess spending that increases annually for repeated offenses. More information will be shared about their penalty in a later presentation on spending target penalties.

Does OHCA have the resources to require and monitor PIPs for potentially hundreds of entities.

- OHCA is currently considering what resources are required for the PIP process.
- Ultimately, who proceeds to a PIP will depend on OHCA resources and the spending performance of entities year-to-year.

Board Follow-Up Items

Have entities in other states shown meaningful change due to a PIP?

- Massachusetts deemed Mass General Brigham's (MGB) PIP successful with a goal of $176.7M vs $197.1M in achieved savings in 18 months. The bulk of savings came from price reductions.
- MGB's strategies included:
  - **Price reductions** – reducing outpatient rates at multiple facilities, reducing rates to state-based marketplace coverage (ConnectorCare), and other insurance discounts - $142.9M in achieved savings.
  - **Reducing utilization** – Integrated Care Management Program, SNF utilization reduction, MGB health plan utilization management, and MRI and CT utilization - $48.1M in achieved savings.
  - **Shifting care to lower cost sites** – home hospital, virtual care - $6.3M in achieved savings.
- Oregon also has PIP authority, but they have not yet required one.

Board Follow-Up Items

Would OHCA need to accept a greater role in telling entities what to include or focus on in their PIP?

Only to the extent consistent with the law. OHCA has statutory responsibilities to ensure entities come into compliance with the targets and that PIP goals/strategies do not erode access, quality, equity, or workforce stability.

Statute
127502.5.(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.**

Health & Safety Code § 127502.5

Board Follow-Up Items

Do PIPs allow entities to get out of complying with the spending target while they are implementing a PIP?

No. When an entity misses a spending target while implementing a PIP, the statute provides OHCA with options to enforce the target, such as requiring modifications to the existing PIP, requiring a new PIP, or assessing penalties.

Statute
127502.5.(d)(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. **127502.5.(d)(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).

Health & Safety Code § 127502.5

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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:
March 25, 2026
10am

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

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Adjournment

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