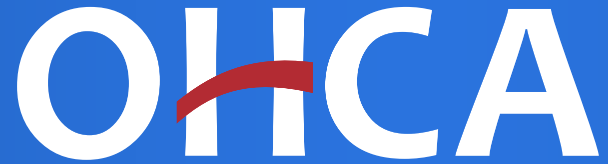
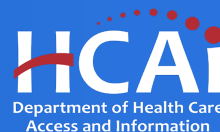
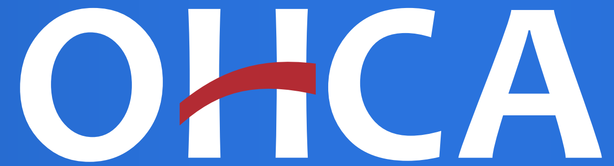


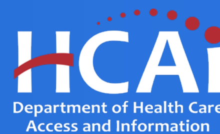
Health Care Affordability Board Meeting

March 25, 2026





Welcome, Call to Order, and Roll Call



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 January 28, 2026 Meeting Minutes
Vishaal Pegany

Item #4 **Informational Items**

a) Hospital Sector Target Adjustments Methodology – Follow-up on Resubmissions of Hospital Data
Vishaal Pegany; CJ Howard, Assistant Deputy Director

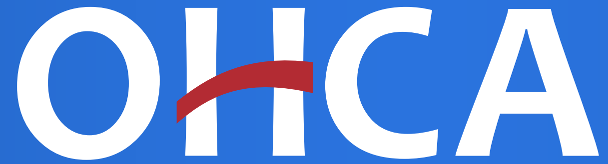
b) Non-Supervisory Organized Labor Adjustment and Assessment – Introductory Discussion
Vishaal Pegany; CJ Howard

c) Spending Target Enforcement – Continued Performance Improvement Plan Discussion
Vishaal Pegany; CJ Howard

d) Total Health Care Expenditures Data Submission Regulations (DSG 3.0) – Discussion of Comments on Regulatory Text
CJ Howard; Margareta Brandt, Assistant Deputy Director

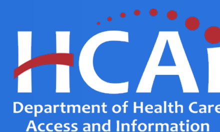
Item #5 **General Public Comment**

Item #6 **Adjournment**



Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director



Black Liberation Statement

At HCAI, we acknowledge the devasting and longstanding impacts racism, oppression, and white supremacy has had on Black and African American communities. We also believe it is critical to acknowledge that Black communities have been treated inhumanely by the U.S. government through enslavement, segregation, mass incarceration and exploitation through medical experimentation used to advance medicine resulting in longstanding inequities. To begin to rectify these wrongs, there must be an explicitly anti-racist approach to reduce racial disparities in health care and more broadly.

At HCAI, we envision a health care system where doctors listen to their Black patients, center their experiences, and take proactive steps to counter implicit bias resulting in quality care and improved patient outcomes. In solidarity and allyship with California's Black communities, HCAI centers and amplifies the voices of our Black partners, leaders, colleagues, and community members. We uplift Black resilience, education, and health. We fully commit to revisiting HCAI's programs, policies, and procedures to ensure state resources are distributed equitably in a manner that recognizes our responsibility to address disparities impacting Black communities.

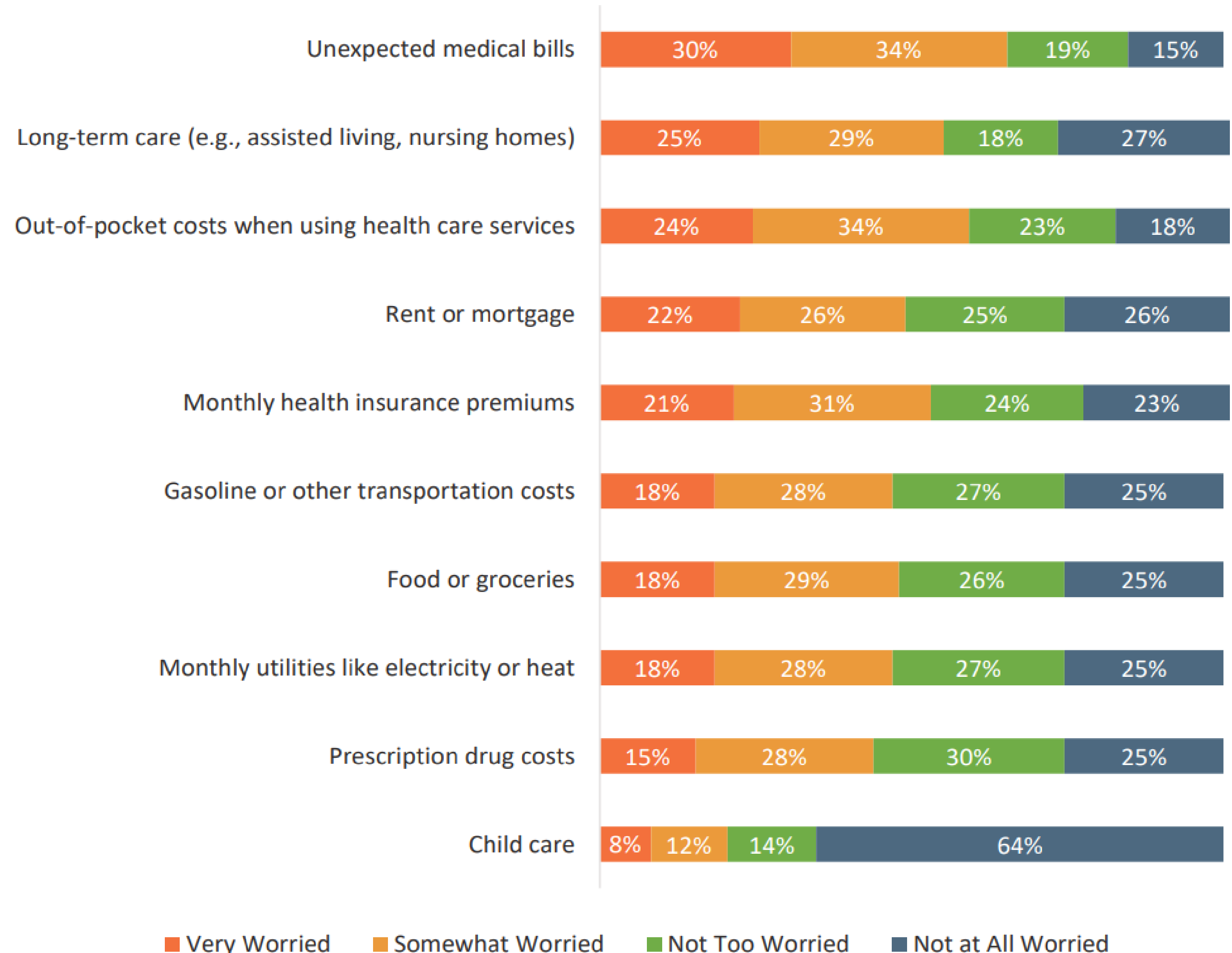
Spring Patient and Consumer Forum Debrief

- Staff engaged around 100 patients, patient advocates and consumer advocates.
- Multiple participants expressed support for OHCA's work and appreciation for the forum discussion, noting that they felt more comfortable voicing their opinions in this setting.
- Some participants representing patients with rare diseases shared their concern over possible incentives to deny health care services for patients with chronic conditions that require high levels of costly care.
  - These advocates suggested implementing carveouts for Specialized Treatment Centers/ Centers of Excellence to ensure no negative unintended consequences for these patients due to entity responses to the spending target.
  - Advocates expressed their interest and willingness to collaborate with OHCA and provide their input in future discussions to inform enforcement of spending targets.
- Labor union representatives and small business owners noted their struggles in negotiating benefits for employees without sacrificing wage increases.
- The meeting materials, including the presentation, can be accessed at the Patient and Consumer Forum webpage.

Health Care Costs Cause Economic Hardship

More Than 6 in 10 Californians Are Worried About Being Able to Afford Unexpected Medical Bills, Far Exceeding Worries About Rent, Gas, and Groceries (Figure 38)

Q: HOW WORRIED ARE YOU ABOUT BEING ABLE TO AFFORD THE FOLLOWING FOR YOU AND YOUR FAMILY?

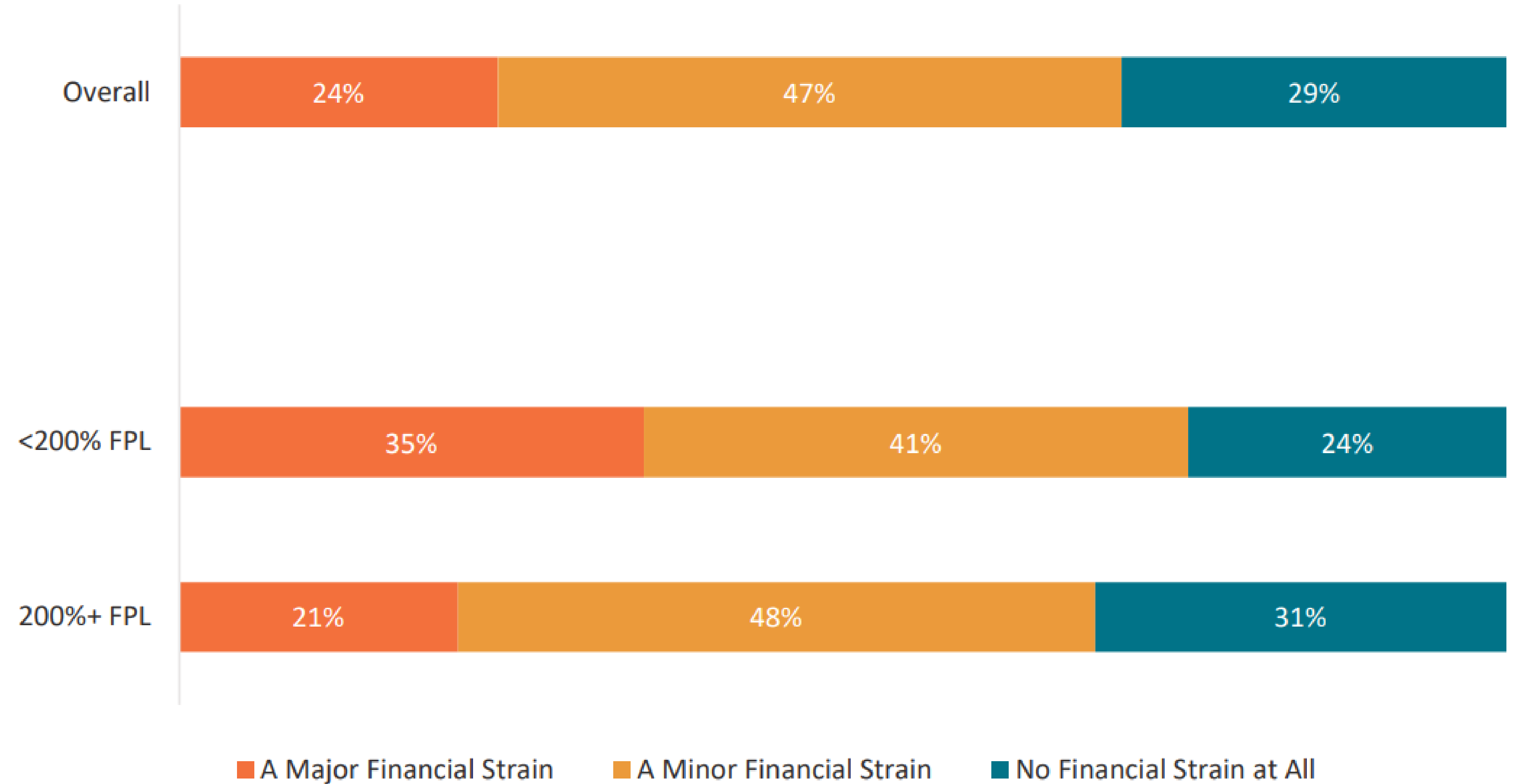


Joynt, J., Catterson, R. Alvarez, E. (2026, February). *The 2026 CHCF California Health Policy Survey*. California Health Care Foundation. https://www.chcf.org/resource/2026-california-health-policy-survey/

Health Care Costs Cause Economic Hardship

Seven in 10 Californians Feel That Health Care Expenses Place a Financial Strain on Their Household (Figure 33)

Q: HOW MUCH FINANCIAL STRAIN, IF ANY, DO YOU FEEL YOUR HEALTH CARE EXPENSES PLACE ON YOUR HOUSEHOLD?

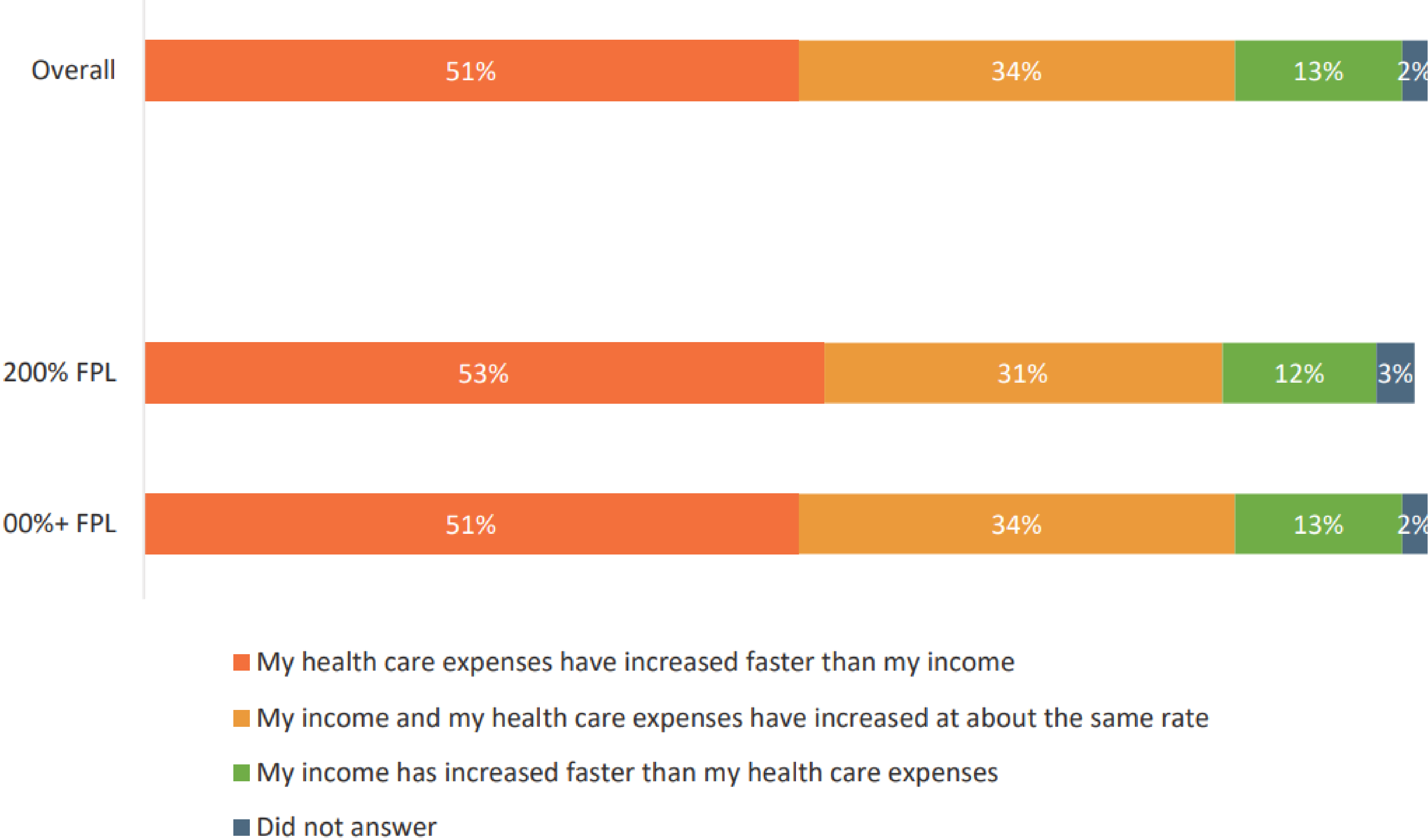


Joynt, J., Catterson, R. Alvarez, E. (2026, February). *The 2026 CHCF California Health Policy Survey*. California Health Care Foundation.
https://www.chcf.org/resource/2026-california-health-policy-survey/

Health Care Costs Cause Economic Hardship

Half of Californians Across Income Groups Say Their Health Care Expenses Have Increased Faster Than Their Income
(Figure 36)

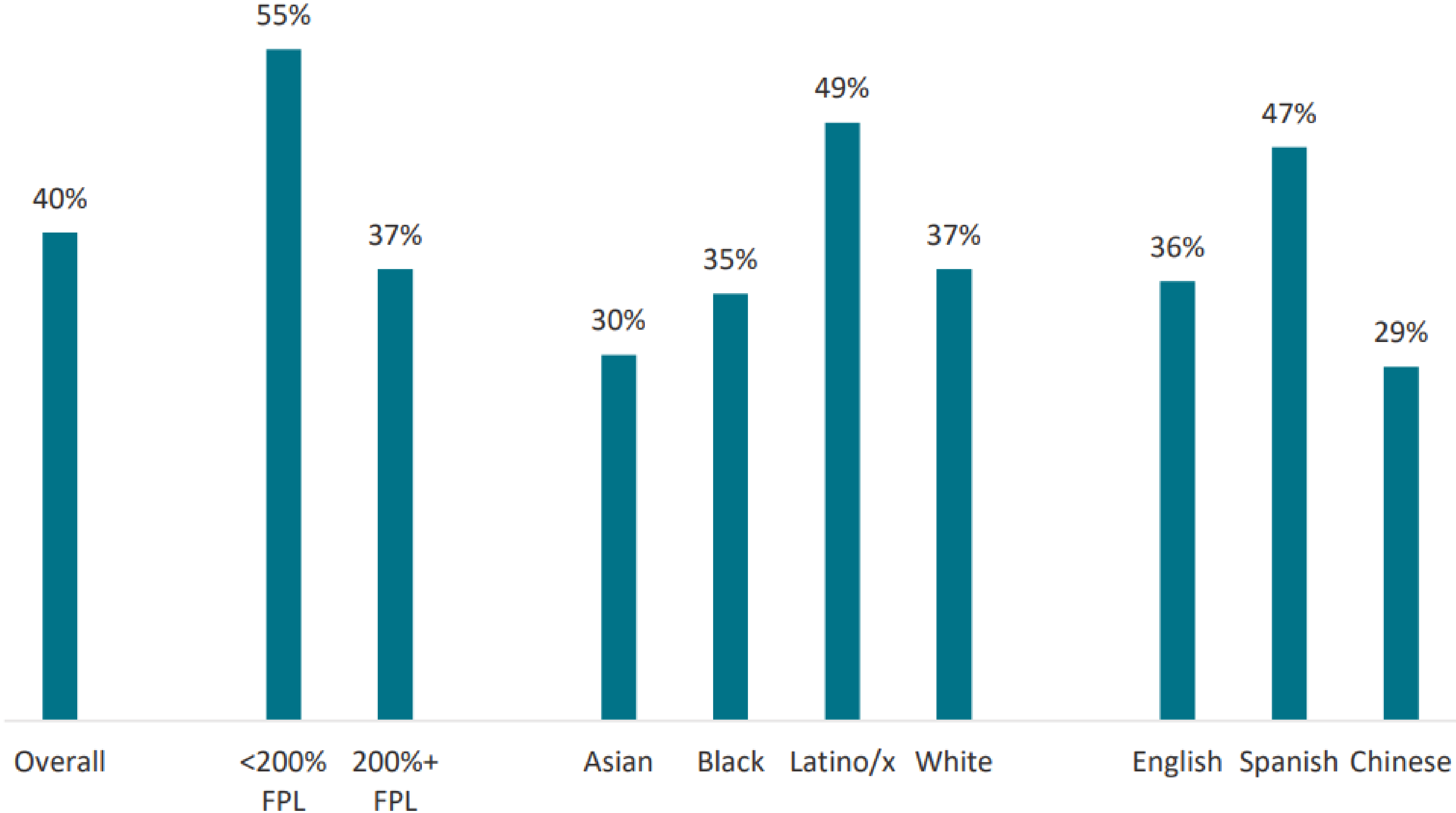
Q: WHICH OF THE FOLLOWING STATEMENTS COMES CLOSEST TO YOUR EXPERIENCE, EVEN IF NONE ARE EXACTLY RIGHT?



Health Care Costs Cause Economic Hardship

Four in 10 Californians and More Than Half of Californians with Low Incomes Have Medical Debt (Figure 43)

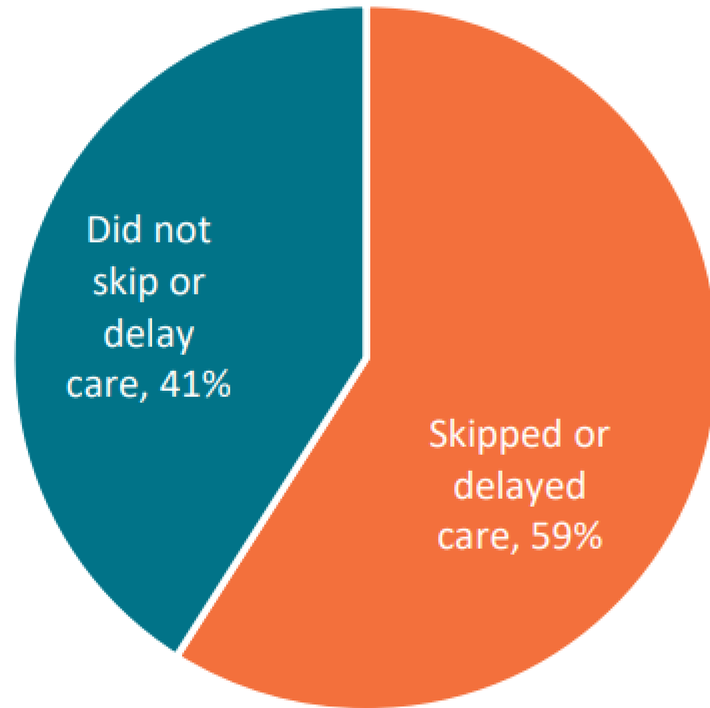
PERCENTAGE WHO SAY THEY HAVE ANY TYPE OF MEDICAL DEBT

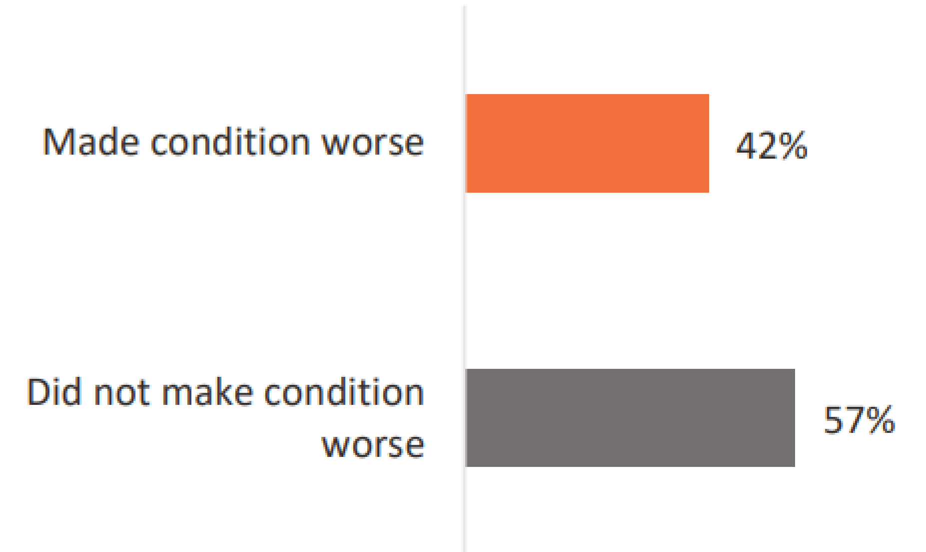


Joynt, J., Catterson, R. Alvarez, E. (2026, February). *The 2026 CHCF California Health Policy Survey*. California Health Care Foundation.
https://www.chcf.org/resource/2026-california-health-policy-survey/

Health Care Costs Cause Economic Hardship

Six in 10 Californians Report Skipping or Delaying Care Due to Cost; 4 in 10 of Those Say Skipping Care Made Their Condition Worse (Figure 21)



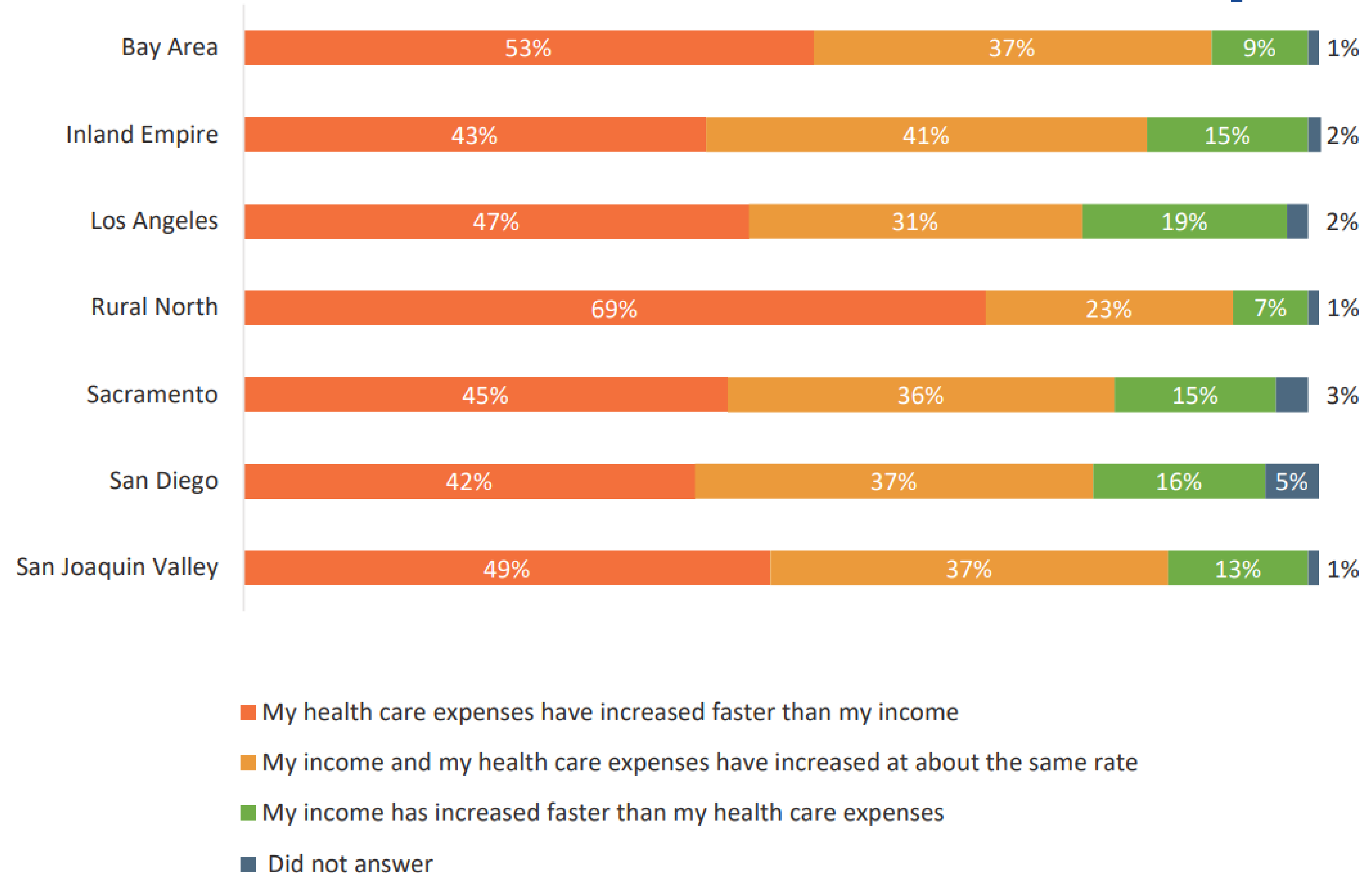


Joynt, J., Catterson, R. Alvarez, E. (2026, February). *The 2026 CHCF California Health Policy Survey*. California Health Care Foundation.
https://www.chcf.org/resource/2026-california-health-policy-survey/

Health Care Costs Cause Economic Hardship

Seven in 10 Rural North Respondents Say Their Health Care Expenses Have Increased Faster Than Their Income (Figure 37)

Q: WHICH OF THE FOLLOWING STATEMENTS COMES CLOSEST TO YOUR EXPERIENCE, EVEN IF NONE ARE EXACTLY RIGHT?

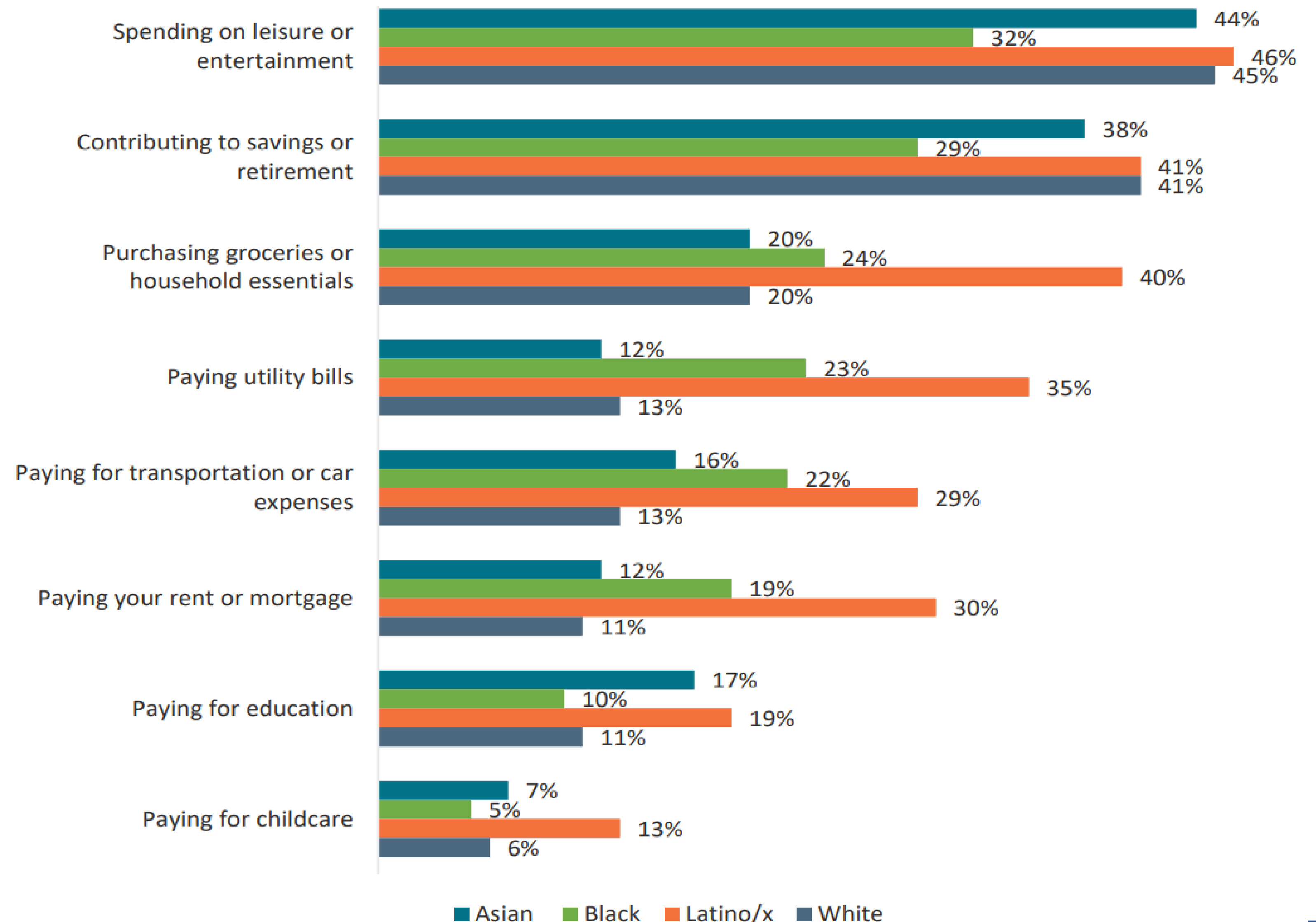


Joynt, J., Catterson, R. Alvarez, E. (2026, February). *The 2026 CHCF California Health Policy Survey*. California Health Care Foundation. https://www.chcf.org/resource/2026-california-health-policy-survey/

Health Care Costs Cause Economic Hardship

Many Latino/x Californians Report Reducing Spending on Many Things to Afford Health Care (Figure 30)

PERCENTAGE WHO SAY THEY OR A FAMILY MEMBER DELAYED, REDUCED, OR SKIPPED ANY OF THE FOLLOWING IN ORDER TO AFFORD HEALTH CARE EXPENSES IN THE PAST SEVERAL YEARS

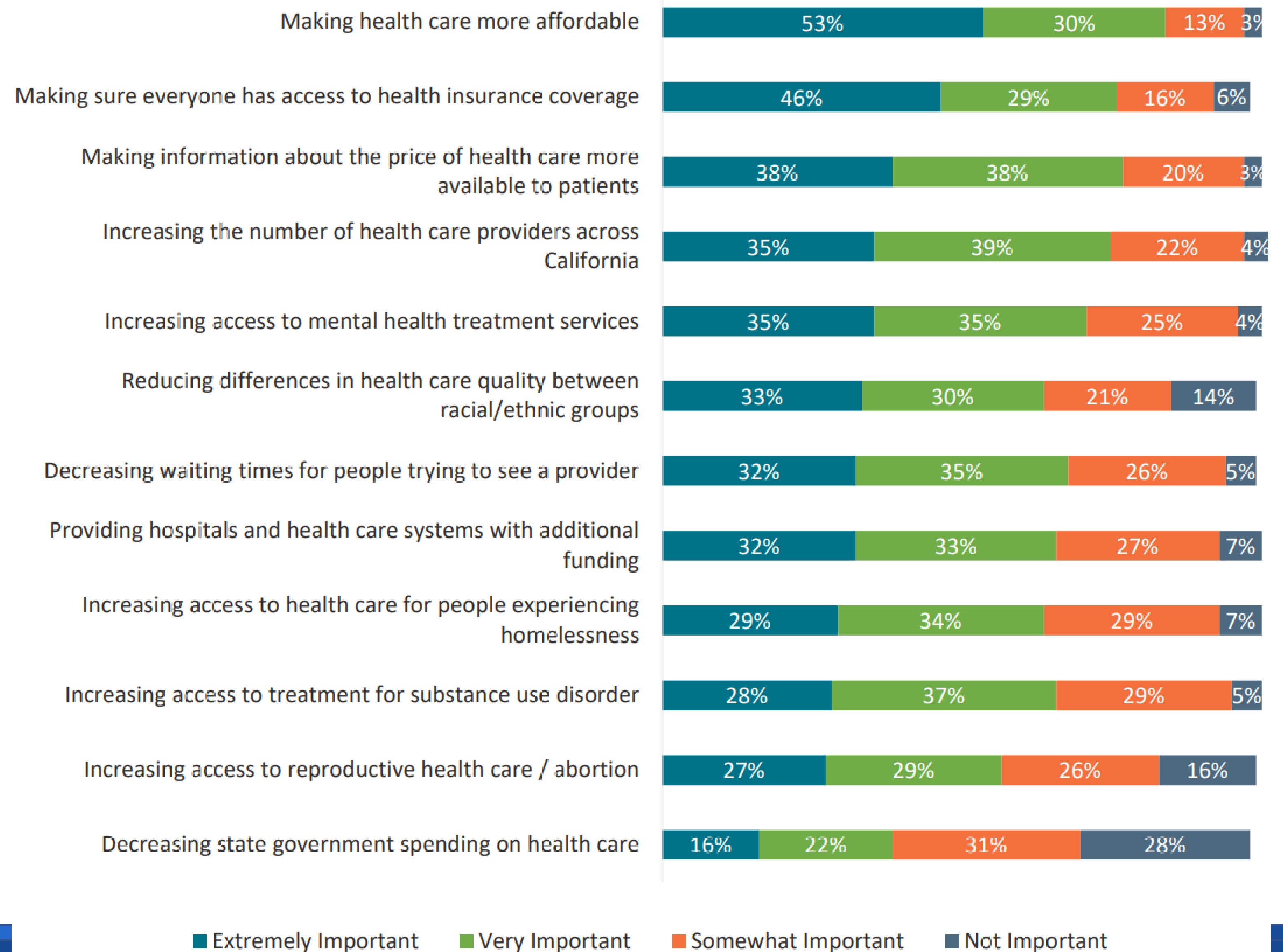


Joynt, J., Catterson, R. Alvarez, E. (2026, February). *The 2026 CHCF California Health Policy Survey*. California Health Care Foundation.
https://www.chcf.org/resource/2026-california-health-policy-survey/

Health Care Costs Cause Economic Hardship

About 8 in 10 Californians Say Making Health Care More Affordable Is an Important Priority for Policymakers in 2026 (Figure 7)

Q: HOW IMPORTANT DO YOU THINK IT IS FOR THE CALIFORNIA GOVERNOR AND LEGISLATURE TO WORK ON THE FOLLOWING THINGS IN 2026?



Joynt, J., Catterson, R. Alvarez, E. (2026, February). *The 2026 CHCF California Health Policy Survey*. California Health Care Foundation. https://www.chcf.org/resource/2026-california-health-policy-survey/

Administrative Spending and Profit Across Insurance Markets – *Health Affairs*

- An article in the March 2026 issue of Health Affairs examines administrative spending and profit across U.S. states for calendar year 2023 across health insurance markets – specifically fully insured commercial, Medicaid managed care, and self-funded employer plans – and finds substantial variation in this "non-medical spending," with particularly wide variation in profit levels.
- In the fully insured commercial market, median administrative spending is estimated at $599 per member per year (PMPY) and median profit at $63 PMPY.
- Across insurance markets, the spending is roughly $600 - $700 PMPY in the fully insured and Medicaid managed care markets, compared with about $285 PMPY in the self-insured employer market.
- Because these spending levels show wide variation, the authors suggest that moving higher spending states toward median levels could yield meaningful savings.

Source: Buxbaum, J. D., Arnold, D. R., Fuse Brown, E. C., & Whaley, C. (2026). *Substantial variation in administrative spending and profit across state insurance markets, 2023*. Health Affairs, 45(3). https://doi.org/10.1377/hlthaff.2025.00779

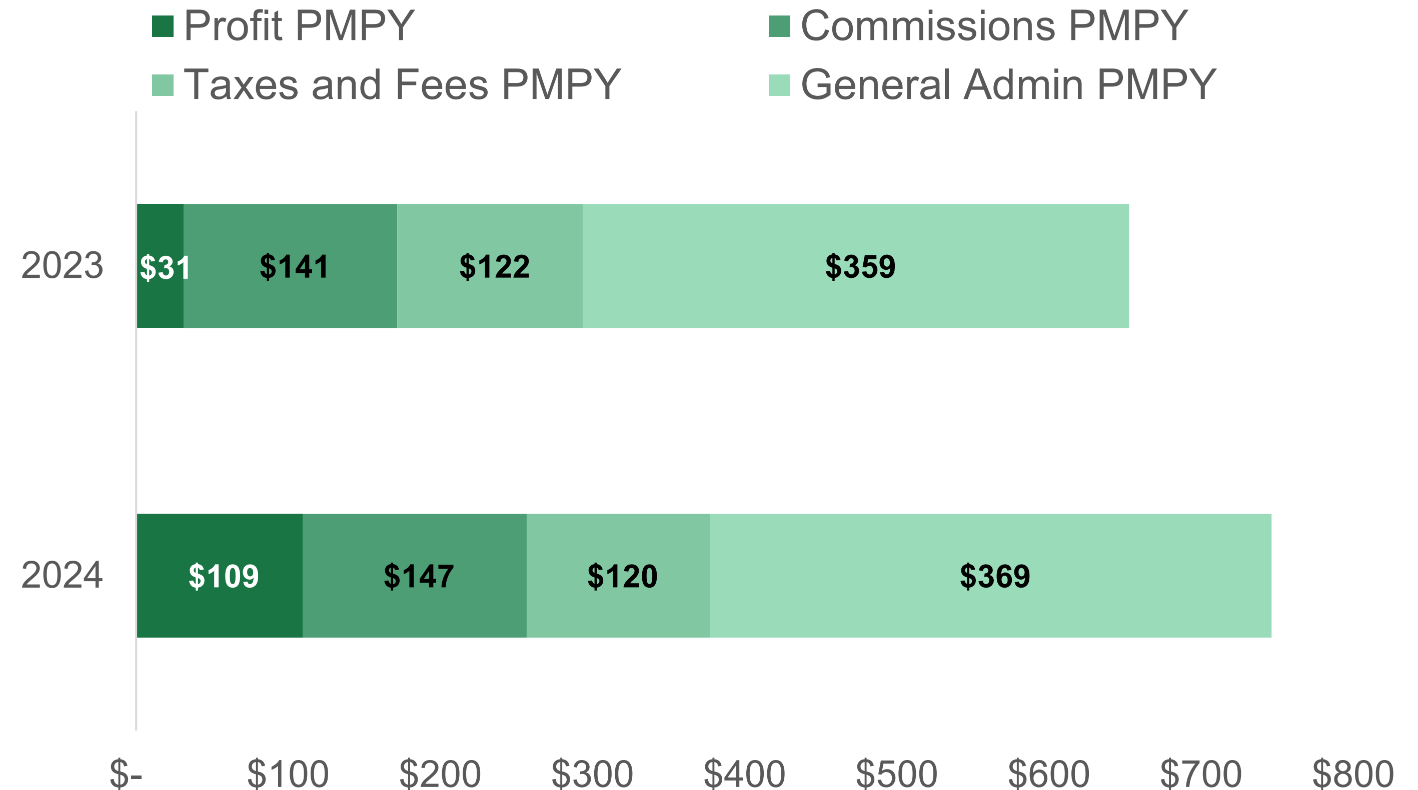
Potential Savings from Administrative Spending Reductions– *Health Affairs*

- The authors estimate that reducing above median states to the median level of non-medical spending could save approximately:
    - **$6 billion in the fully insured markets**
    - **$9 billion in Medicaid managed care**
    - **$4 billion in self-funded employer market**
- While the study highlights potential savings, it also notes that some non-medical spending supports necessary plan functions, including activities related to plan operations and oversight.
- At the same time, the authors note that a substantial share of the spending is not directly tied to improving care quality or reducing health care costs.
- The article highlights opportunities to reduce administrative costs in the health system including standardizing quality reporting requirements, simplifying contracting processes, and streamlining prior authorization.

Source: Buxbaum, J. D., Arnold, D. R., Fuse Brown, E. C., & Whaley, C. (2026). *Substantial variation in administrative spending and profit across state insurance markets, 2023*. Health Affairs, 45(3). https://doi.org/10.1377/hlthaff.2025.00779

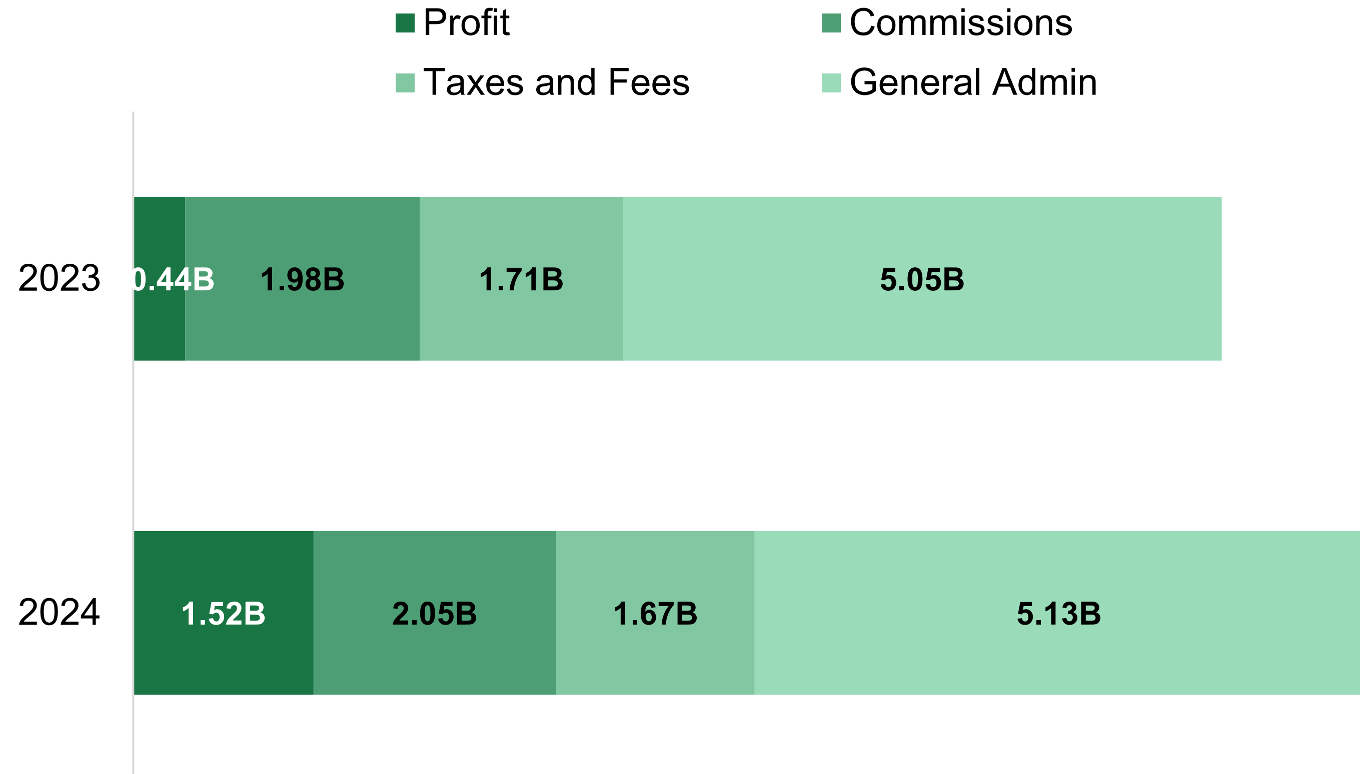
Non-Medical Spending in California's Fully Insured Commercial Market

- Using CCIIO medical loss ratio filings for the fully insured commercial market in California, administrative components – general administrative costs, taxes and fees and commissions – total $622 PMPY, slightly higher than the article's median of $599, while profit at $31 PMPY was below the national median of $63.
- From 2023 to 2024, administrative spending components grew 2.4% from $622 to $637, while profit grew 252% from $31 to $109.
- Consistent with OHCA statutory definitions, this analysis excludes quality improvement expenses, making this a conservative estimate of administrative spending.



Non-Medical Spending in California's Commercial Market

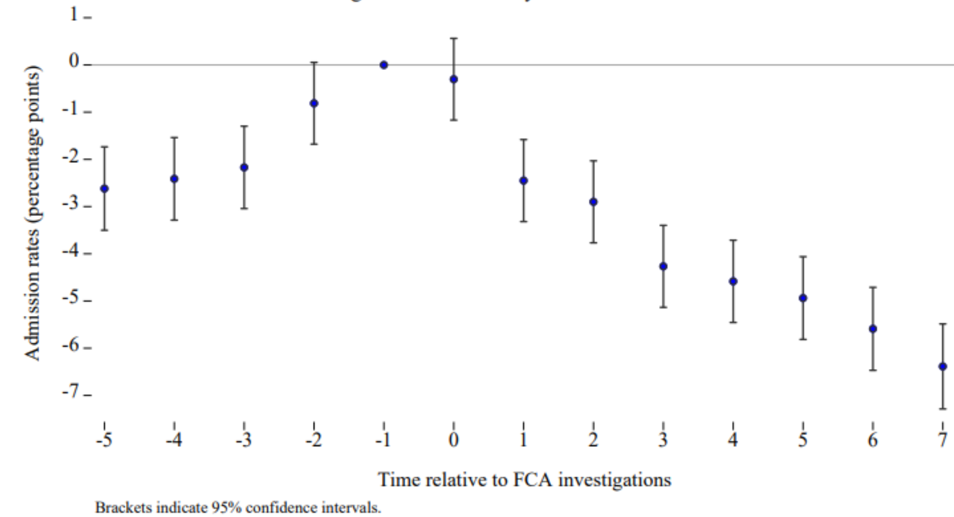
- When translated into aggregate dollars across the fully insured commercial market, administrative spending components grew 1.3% from $8.74 to $8.85 billion, while profit grew 247.5% from $0.44 to $1.52 billion.

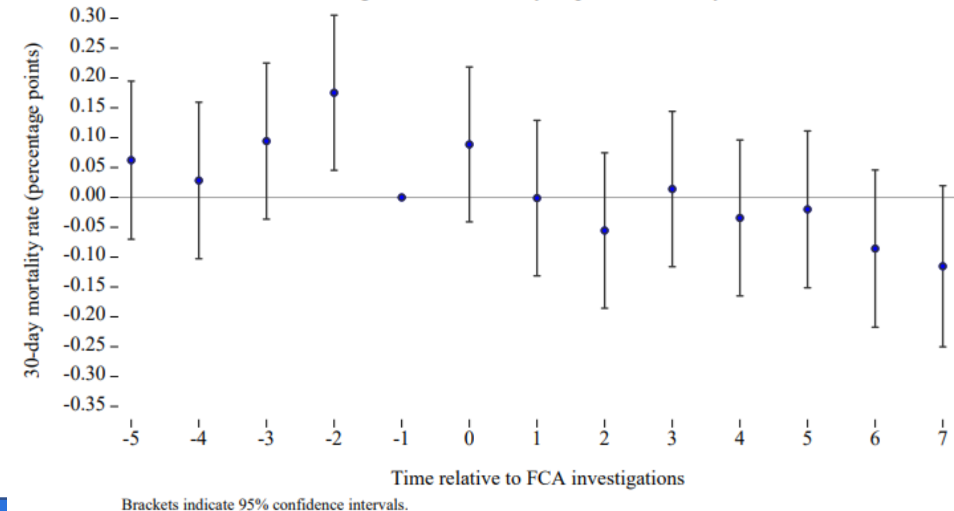


Source: CCIIO MLR Filings 2023 and 2024 among OHCA health plan submitters. Note: Consistent with OHCA statutory definitions used for MLR reporting, quality improvement expenses are excluded.

Reducing Waste through Anti-Fraud Enforcement

- A March 2026 National Bureau of Economic Research Working Paper examined the effects of anti-fraud enforcement on hospital admissions, Medicare spending and patient mortality.
- Using Medicare claims data from 2005-2019 and Department of Justice False Claims Act lawsuits where the federal government alleged hospital systems admitted patients unnecessarily, the authors found – compared to hospitals with no False Claims Act lawsuits – at hospitals subject to False Claims Act lawsuits, admissions decreased by 3.6 percentage points (9.7%), mortality rates decreased by 0.13 percentage points (2.3%), and spending decreased by $380 per patient (3.9%).
- This pattern of results suggests hospital administrators were encouraging inappropriate admissions, and the federal government's enforcement decisions resulted in reduced admissions (and thus lower spending) without harming patients.





Howard, D., Leder-Luis, D. (2026, March). *Reducing Waste through Anti-Fraud Enforcement: Evidence from Hospital Admission Cases*. National Bureau of Economic Research. https://www.nber.org/papers/w34938

OHCA March 2026 Publication

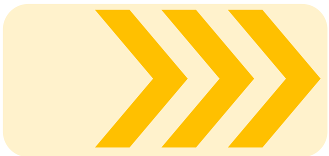
- In January, OHCA posted on its website a preliminary crosswalk to support implementation of its hospital spending workstream and asked hospitals to review the NPIs associated with it and to provide feedback by the end of February on whether any NPIs were missing or incorrectly assigned.
- OHCA received over 130 responses and incorporated comparable hospitals' feedback in March and posted an updated facility number-to-NPI crosswalk.

2026 OHCA Data

- Facility Number NPI Crosswalk FY 22-23

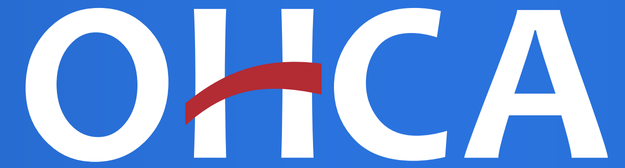
See updated crosswalk at: https://hcai.ca.gov/document/facility-number-npi-crosswalk-fy-22-23/

Slide Formatting

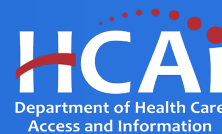


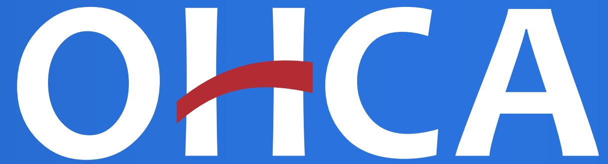
Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

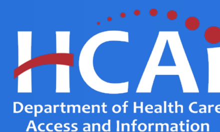


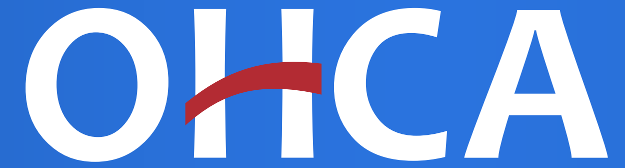
Public Comment



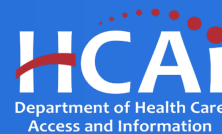


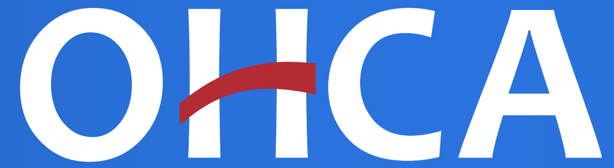
Action Consent Item: Vote to Approve January 25, 2026 Meeting Minutes



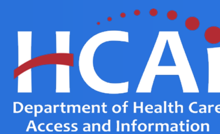


Public Comment



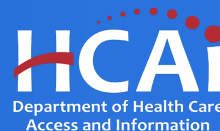


Informational Items



Hospital Sector Target Adjustments Methodology – Follow-up on Resubmissions of Hospital Data

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director



Hospital Annual Financial Disclosure Report Background

- State law requires hospitals to submit data to HCAI, which is analyzed by a team of eleven in the Hospital Financial Data Unit in the Office of Health Information (OHI).
- Every fall, HCAI's OHI publishes the Hospital Annual Financial Disclosure Report Complete Data Set. The report includes information about revenue, operating expenses, beds, discharges, lengths of stay, and more.
- The objective of this data is to maintain accurate, reliable, and timely information for use in making informed decisions, assessing effectiveness of healthcare systems, and supporting statewide health policy development and evaluation. Some uses of these reports include:
  - DHCS determination of disproportionate number of Medi-Cal and other low-income patients to establish eligibility to receive Medi-Cal disproportionate share payments and
  - DHCS establishing nurse to patient staffing ratios.
  - The Attorney's General Office determining the amount of uncompensated care services that must be provided when a hospital converts from one type of ownership to another.
  - Hospitals use this data to understand markets, performance improvement and strategic planning.

Health and Safety Code § 128675 - 128920

Hospital Annual Financial Disclosure Report Background

- OHI’s existing regulatory process for hospital financial reporting allows hospitals to revise prior year data.
- The Complete Data Set is published each fall and is not modified or adjusted to reflect prior year resubmissions. This is the data the Board used to adjust hospital sector targets.
- If a hospital resubmits data, those data 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.

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Current Hospital Data Resubmissions

- At the close of the December 2025 Board meeting, a hospital indicated that it had resubmitted prior year 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 based on 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. Additionally, OHCA is aware of at least one other hospital that does not have an adjusted target that has resubmitted prior year data.
- 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 any resubmitted data.
- Based on statutory timelines, as noted at the close of the January 2026 meeting the Board is unable to adjust targets for 2027.

Considerations for Board Discussion

- At the January Board meeting several members expressed interest in exploring the feasibility of enabling the Board to consider revised hospital data for the 2028 target setting process.
- When 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 reporting changes would be reflected in future annual submissions.
- OHCA could consider resubmitted data during the progressive enforcement process.
- Were the Board to consider revised data it should be on a one-time instance to prevent entities from continually resubmitting data.

Considerations for Board Discussion

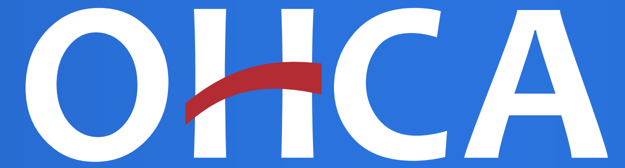
- To ensure a fair and consistent process, OHCA would need to communicate to hospitals a date by which they would need to submit revised data and determine a process by which OHCA would incorporate resubmitted data. Neither OHCA nor the Board have previously communicated guidance to hospitals regarding 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, for example, 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.
- HCAI has a limited number of staff that process annual and quarterly data submissions. The time needed to process resubmissions varies greatly based on the scope and complexity of the changes.

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

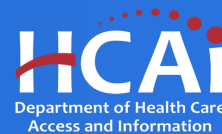
Board Discussion: Considering Resubmitted Data

OHCA staff's conclusion is that it is not operationally feasible for HCAI to commit to incorporate audited revised data for the 2028 target setting process.

- In late 2026, OHCA can present to the Board various options for their consideration as part of the 2028 target setting that include revised data; yet depending upon the number of revisions received, some revisions to prior year data may not be audited and available for Board review as part of the 2028 target setting process.
- The Board may also consider revising the hospital sector target adjustment methodology for 2028 target setting; such changes could include using different metrics or changing the lookback period.
- The time and level of effort to process each revision to prior year data vary. HCAI cannot guarantee that it will be able to review, validate and audit potentially hundreds of revisions to prior year data in time for them to be factored into 2028 target setting.
- During the enforcement process, OHCA will be able to evaluate revised data.

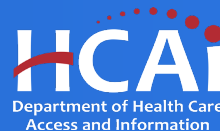


Public Comment



Non-Supervisory Organized Labor Adjustment and Assessment – Introductory Discussion

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director



Statute

127502 (c)(7)

The health care cost targets shall… Be adjusted for a provider or fully integrated delivery system's cost target, as appropriate upon a showing that **nonsupervisory employee organized labor costs are projected to grow faster than the rate of any applicable cost targets**.

127502 (d)(7)

The methodology shall **require the board to adjust cost targets** for a provider or a fully integrated delivery system as appropriate **to account for actual or projected nonsupervisory employee organized labor costs**, including increased expenditures related to compensation. For an adjustment to be effectuated, the provider, the fully integrated delivery system, or other associated party **shall submit a request with supporting documentation in a format prescribed by the office**. To validate the basis for the requested adjustment, the office may request or accept further information, such as any single labor agreement that is final and reflects the actual or projected increased nonsupervisory employee organized labor costs. *The office may audit the submitted data and supporting information as necessary.*

127502 (m)(1)-(4)

(1) The board shall hold a public meeting to discuss the development and adoption of recommendations for statewide cost targets, or specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities. The board shall deliberate and consider input, including recommendations from the office, the advisory committee, and public comment. Cost targets and other decisions of the board consistent with this section shall not be adopted, enforced, revised, or updated until presented at a subsequent public meeting. The meetings 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) consistent with paragraph (2) of subdivision (e) of Section 127501.10.

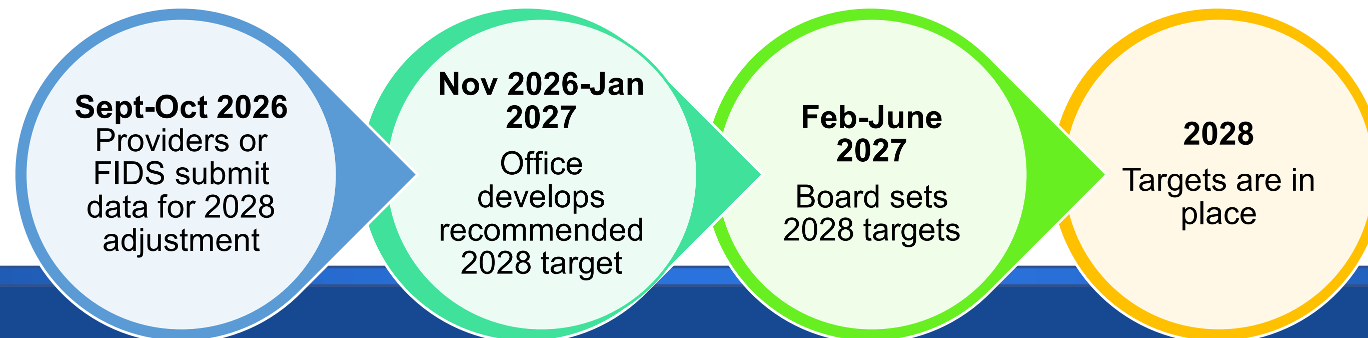
(2) The office shall publish on its internet website its recommendations for proposed cost targets for the board's review and consideration. **The board shall discuss recommendations** at a public meeting for proposed targets **on or before March 1 of the year prior to the applicable target year**.

(3) The board shall receive and consider public comments for 45 days after the board meeting.

(4) The **board shall adopt final targets on or before June 1**, at a board meeting.

Operational Implications

- The Board is the entity that sets and adjusts spending targets during the annual target setting process. The Office cannot adjust targets for entities.
- Timeline and Target Adjusting: Because the Board will need to approve any adjustments to the target, providers need to submit requests ahead of the annual target setting timeline.
- Example timeline for 2028 target setting:
  - September-October 2026: Providers or fully integrated delivery system (FIDS) submit request for a Non-supervisory Organized Labor (known hereafter as “organized labor costs”) adjustment.
  - On or before March 1, 2027: OHCA will publish recommendations for targets for 2028.
  - A 45-day public comment period commences after the Board discusses OHCA’s recommendations at a Board meeting. All organized labor cost adjustment requests would be made public with OHCA’s recommendation. OHCA may consult ahead of this date as needed with parties associated with the organized labor cost adjustment (i.e., providers or FIDS and affiliated labor unions)
  - On or before June 1, 2027: The Board approves targets for 2028.



Potential Conceptual Framework

1. OHCA will calculate, based on information provided by the entity, the cost of each organized labor contract as a percentage of the entity's total operating expenses for the baseline and performance years. This determines the relative weight of each contract compared to overall operating expenses. This will also yield the cost share of all other operating expenses (i.e., those not related to nonsupervisory employee organized labor costs).
2. OHCA will calculate the year-over-year change in the cost of each organized labor contract from a baseline to performance year to determine whether those total costs are projected to grow faster than the entity's spending growth target.
3. Using both the growth rate of each contract and the proportional cost share, OHCA will calculate a weighted average growth rate. In this weighted calculation, each organized labor contract grows at its negotiated rate, while all other operating costs grow at the entity's applicable calendar year spending target rate.

- The resulting value is a preliminary adjusted spending target for the performance year.
- OHCA would assess actual spending for organized labor during the enforcement process.

Potential Conceptual Framework

Scenario: Spending Target Year (performance year) is 2028

Total Entity Operating Expenses in 2028 was $100 million

Contract	2028 Projected Cost ($Millions)	Projected Growth Rate (2027-2028)	Cost Share of Total Operating Expenses	Weighted Growth
RN Union	22	5%	22%	0.011
MA Union	10	7%	10%	0.007
All Other Operating Expenses	68	3.5%	68%	0.024
		Entity's Adjusted Spending Target		**.042**

Calculation for Preliminary Adjusted Spending Target

(0.22 × 0.05) + (0.10 × 0.07) + (0.68 × 0.035) = 0.011 + 0.007 + 0.024 = (0.042)100 = **4.2%**

Methodological Implications

- The Board would adjust targets for a performance year before having access to data for the base year. The Board will adjust targets for 2028 in March-June of 2027. To determine the projected growth rate from 2027 to 2028, the office would need to rely upon projected entity spend and cost structures for 2027 and 2028.
- Data availability: Currently a data source does not exist to vet or validate that expenditures are related to organized labor costs. The Office may be able to determine if spending was for a particular type of labor (e.g., RNs) but is not able to delineate between organized and non-organized labor costs.
- If adjustments are made, entities would need to submit data to the Office demonstrating the actual growth in organized labor costs.

Policy Considerations

Should the Board adjust for one non-supervisory organized labor (organized labor) agreement at a time or the projected total change in all organized labor costs for a given provider?

- If the net effect of all organized labor cost increases are projected to be less than or equal to the target, then an organized labor adjustment may not be merited.
- If the Board adjusts for one organized labor agreement, where the projected increase exceeds the target, the Board could adjust the target upward.

What happens if the entity's organized labor costs do not grow as much as projected?

- The Board could approve adjustments to the target that are conditioned on the entity demonstrating during the enforcement process that their actual organized labor costs aligned with the projected values the Board used to approve the target adjustment.

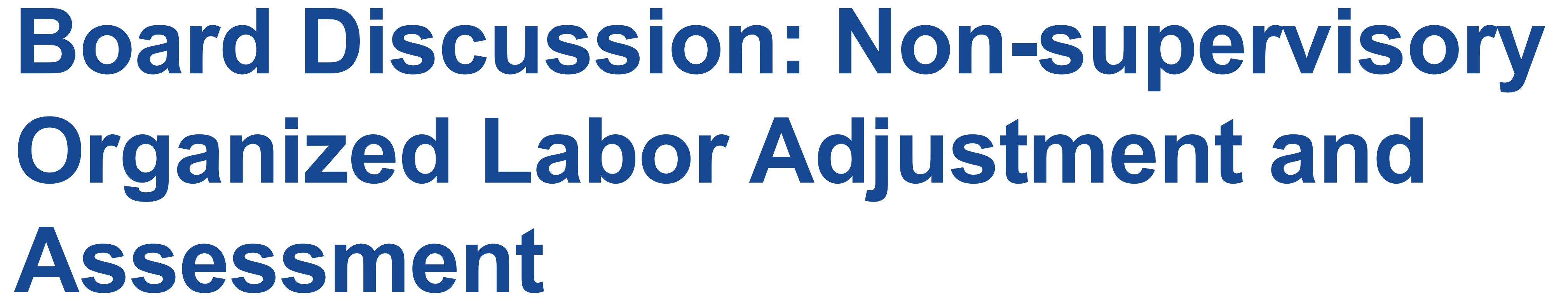
Policy Considerations

Should the Office evaluate organized labor costs as an enforcement consideration for entities that exceed the target?

- Organized labor agreements can be executed at any time during a calendar year. An organized labor agreement can impact spending in more than one calendar year (or spending target measurement / performance year).
- For organized labor agreements executed after the annual target setting process, OHCA could factor organized labor cost increases that exceed the target through the enforcement process.

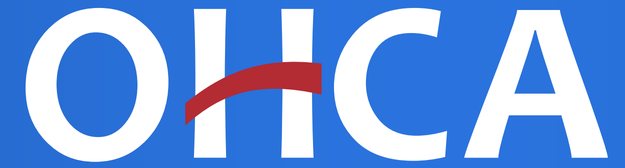
Stakeholder Engagement

- OHCA staff have had some initial meetings with labor and provider representatives and will continue engagement with stakeholders.
- Advisory Committee members and health care entities have expressed concern that increases to organized labor costs will lead to increases in non-organized labor costs because health care entities compete for the same workforce in a market. These commenters note this could impact their ability to meet the spending targets if the targets are not adjusted for non-organized labor costs as well.
- This topic will be agendized for the April Advisory Committee meeting for further discussion.

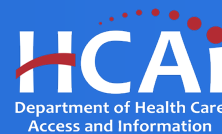


Board Discussion: Non-supervisory Organized Labor Adjustment and Assessment

Does the Board have input on the process for adjusting the targets for Non-supervisory Organized Labor costs?

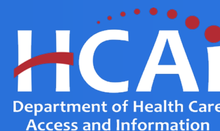


Public Comment



Spending Target Enforcement – Continued Performance Improvement Plan Discussion

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director



Review of Spending Target Enforcement

Performance Improvement Plans (PIPs)

- PIPs are the action plans, subject to final approval by OHCA, entities 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.
- OHCA will monitor entities for compliance with their approved PIP.
- 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.
- Decisions about which entities submit and implement a PIP are made at the discretion of the director.

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 explanation of need and regular 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

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

What is Included in a Performance Improvement Plan?

127502.5 (c)(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.

PIPs will likely include:

- Description of health care entity Cost driver analysis: Description and data-support analysis of the reasons for spending growth
- Summary of the PIP, including goals, strategies, and start and end dates, which will be included in public updates
- Specific, measurable, achievable, realistic, and time-bound (SMART) goals + specific strategies and rationale for each goal, evidence-base, and expected cost savings
- Assessment plan for each goal
- Description of PIP impact on consumer affordability
- Plan to sustain achieved goals and efficiencies
- Description of how cost reductions will maintain or improve access, quality, equity, and workforce stability
- Risk Mitigation Plan: Identification of potential barriers and mitigation approaches.
- PIP strategies that must be reported to other state regulators, as necessary
- Timeline for implementation, including deadlines, progress reports, meetings, etc.

How Will OHCA Monitor PIPs?

127502.5 (c)(2)
The office shall monitor the health care entity for compliance with the performance improvement plan.

OHCA will monitor entities' compliance with PIPs via:

Regular progress reports –

- Submitted on regular intervals
- Submission deadlines will be included in the PIP proposal's timeline
- Progress reports may include:
    - Summary of performance
    - Updates on progress toward SMART goals and related strategies
    - Timeline updates
    - Details on barriers or delays that impact PIP goals

Final progress report –

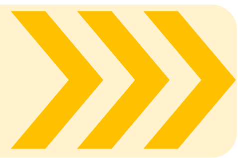
- Submitted within 45 days of the end of a PIP's implementation period
- Submission deadline will be included in the PIP proposal's timeline
- Final progress report may include:
    - Summary of performance
    - Outcomes of PIP goals and strategies
    - Information on lowered costs for consumers
    - Impact of cost reductions on access, quality, equity, or workforce stability
    - Steps taken to sustain achieved goals and efficiencies

How Will OHCA Evaluate PIPs?

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.

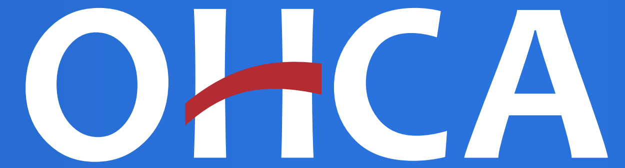
OHCA may assess the following factors when evaluating a PIP for compliance:

- Did the entity come into compliance with the spending target(s)?
- Did the entity achieve the PIP's goals?
- Did the entity implement the planned strategies?
- Did the entity mitigate negative consequences on access, quality, equity, and workforce stability?
- Did the entity take steps to ensure achieved goals or efficiencies will be sustained in future years to maintain compliance with the spending target(s)?
- Did the entity comply with the PIP's timeline?
- How do reported outcomes compare with relevant data recently submitted as part of OHCA's data collection to support the annual report and compliance with the spending target(s)?

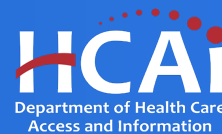


Discussion: Performance Improvement Plans

Does the Board have input on what is included in Performance Improvement Plans or how OHCA should evaluate them?



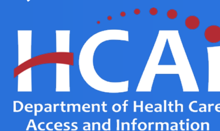
Public Comment



Total Health Care Expenditures Data Submission Regulations (DSG 3.0) – Discussion of Public Comments on Regulatory Text

CJ Howard, Assistant Deputy Director

Margareta Brandt, Assistant Deputy Director



Public Comment Summary

- OHCA published draft updates to data submission regulations and incorporated documents on January 5, 2026.
- Proposed revisions were discussed at the Advisory Committee and OHCA Board meetings in January.
- Public comments were accepted until January 30, 2026.
- OHCA received three comment letters.

Documents posted for comment included the following:

- Revisions to Regulation Text
- Revisions to Total Health Care Expenditures (THCE) Data Submission Guide (DSG Version 3.0)
- Revisions to OHCA Attribution Addendum
- New OHCA Behavioral Health Addendum
- New OHCA Medi-Cal Payments Addendum
- New OHCA Primary Care Addendum

Theme	Comment / Question Summary	OHCA Response
Submission Requirements	Multiple comments opposed to the requirement for plans to submit copies of filed Medical Loss Ratio (MLR) reports with OHCA data, and concerns that Medicare Advantage MLR due dates may not align with OHCA submission deadlines	OHCA plans to remove this proposed requirement. OHCA will continue to obtain MLR reports under data sharing agreements with Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) and from CMS.
	Request to clarify "optional supplemental benefits" to be included in Medicare Advantage data reporting	OHCA plans to add a reference to the federal definition of optional supplemental benefits in 42 CFR § 422.100(c) to the Data Submission Guide (DSG) for clarity.

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Theme	Comment / Question Summary	OHCA Response
Submission Requirements	OHCA's proposed "Attestation" field includes this language: By typing your name in this field, you certify under penalty of perjury under the laws of the State of California that the information provided in your organization's file submission is true and correct to the best of your knowledge. The commenter strongly recommends removing "under penalty of perjury under the laws of the State of California" from the above language.	OHCA does not plan to change this field. The language is necessary to ensure submitted files contain representations made in good faith. It is also consistent with existing requirements in data submission regulations for OHCA's CMIR program and HCAI's Hospital Annual Financial Data Reporting system. The commenter indicates the DMHC does not require any submissions under penalty of perjury. OHCA notes that all documents submitted by health plans to the DMHC's eFiling system, including all required health plan filings, exhibits, and attachments, are certified under penalty of perjury by a health plan representative under 28 CCR 1300.41.8(c)(2).

Theme	Comment / Question Summary	OHCA Response
Data Collection	Recommendation to separate self-insured spending data from fully-insured commercial plan spending.	This year, OHCA proposes to separate self-insured spending from fully-insured commercial HMO/PPO spending in the Statewide Total Medical Expense (TME) file to allow for more accurate calculation of payer-level THCE (TME plus administrative costs and profits). OHCA may continue to refine its approach in future years based on lessons learned from the 2026 data collection.
	Recommendation to remove existing requirement to provide an estimate of pharmacy rebate amounts when pharmacy spending is carved-out, and concern with providing proprietary information such as contract rates.	Providing estimated pharmacy spending and pharmacy rebate amounts when pharmacy benefits are carved-out is an existing requirement that has been clarified in an additional section of the DSG. If pharmacy benefits are carved out for members in the Commercial (Partial Benefits) market category, submitters are instructed to create a reasonable estimate of spending and rebates; proprietary contract information is not required.

Theme	Comment / Question Summary	OHCA Response
Data Collection	Request to clarify if a description of procedure and condition-specific episode-based payment arrangements is required when certain payment subcategories are reported in the Primary Care or Behavioral Health files.	The January draft of the DSG erroneously referenced this question in the Behavioral Health File specifications. Thank you for your comment identifying this error. The additional payment arrangement information is only required when payment subcategories C1 – C4 are reported in the Primary Care File. Payment subcategories C1 – C4 are procedure and condition-based payments with shared savings or shared risk.
Alternative Payment Model (APM) File	Request for clarification on whether "link to quality" is based on the contractual payment arrangement or on the payment of a quality incentive to a provider.	OHCA plans to revise the instructions in Section 4.8 of the DSG to clarify that "link to quality" is based on member attribution to a payment arrangement where the participating provider is eligible for an adjusted non-claims payment based on specific predefined goals for quality. The participating provider does not need to successfully earn an adjusted non-claims payment for the payment arrangement to have a "link to quality".

Theme	Comment / Question Summary	OHCA Response
Alternative Payment Model (APM) File	Raises concern that Behavioral Health Capitation non-claims payment subcategory (D4) with only a quality link could result in a member's total medical expense being attributed to value-based care, potentially overstating payment transformation.	OHCA will not modify its APM methodology in DSG 3.0. OHCA recognizes this limitation of its APM methodology. OHCA's APM adoption goals are based on the percent of members in qualifying arrangements that have payments linked to quality. OHCA will continue to evaluate this issue and consider adjustments in future revisions.
	Request to clarify whether fee-for-service (FFS) arrangements with quality-related incentives provided through increased fee schedule claims would be considered "linked to quality" and counted toward OHCA's APM Adoption Goals.	OHCA plans to revise the instructions in Section 4.8 of the DSG to clarify that FFS-only claims arrangements are never considered linked to quality, even in scenarios where FFS fee schedules are increased as a quality-related reward. In these arrangements, providers continue to be paid for each service delivered and the payment remains claims-driven. These arrangements shall be reported in the FFS-only category and do not count towards OHCA's APM Adoption Goals.

Theme	Comment / Question Summary	OHCA Response
Primary Care File	Request to remove Step 2 of methodology for identifying primary care providers paid via claims, which maps providers to DHCS and DMHC provider network filings because the filings are point-in-time snapshots that may exclude providers who were active during the reporting year, potentially resulting in underestimation of primary care spending. Request to clarify which month's DHCS 274 file should be used in Step 2.	OHCA acknowledges that DHCS 274 and DMHC annual provider network review filings are point-in-time snapshots. However, OHCA will not modify Step 2, which was developed with extensive stakeholder input, as this step helps distinguish PCPs from providers with identical taxonomy codes who do not practice primary care. The request to remove Step 2 and use taxonomy codes alone would include providers who do not practice primary care, potentially resulting in overestimation of primary care spending. OHCA added language to DSG 3.0 clarifying that Medi-Cal Managed Care plans should use the January 274 file to attribute primary care spending for the prior year (*e.g.*, January 2025 274 file applies to 2024 data submission).
	Recommendation to include vaccine administration spending for Vaccines for Children (VFC) claims in primary care spending across all lines of business.	Vaccine administration fees are already included as primary care spending across all markets. The costs of vaccine doses are not included.

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Theme	Comment / Question Summary	OHCA Response
Primary Care File	Request to add urgent care as a place-of-service (POS) to measurement of primary care spending.	OHCA will not add urgent care as a place-of-service (POS) in the primary care reporting specifications because care delivered in this setting does not align with OHCA's vision for coordinated, comprehensive, integrated primary care. OHCA's decisions about which places of service to include as primary care were informed by extensive stakeholder engagement.
	Recommendation that OHCA allow the use of a provider's primary taxonomy code associated with their National Provider Identifier (NPI) in National Plan and Provider Enumeration System (NPPES) when claim-level data is missing.	To ensure consistency and accuracy of provider classification, OHCA requires claim-level taxonomy codes to identify provider type and does not allow the use of NPIs to identify primary care providers. NPPES taxonomy derived from NPIs may not accurately reflect a provider's primary specialty and its use could misrepresent primary care providers and primary care spending.

Theme	Comment / Question Summary	OHCA Response
Behavioral Health File	Concern that OHCA's definition of behavioral health spending may capture only a portion of behavioral health services hospitals provide, due to its requirement that claims have a behavioral health diagnosis as the primary diagnosis.	OHCA will not modify its definition of behavioral health spending, which requires a primary behavioral health diagnosis. This definition was developed with stakeholder input, including extensive discussion with the Investment and Payment Workgroup. OHCA does not count claims with secondary behavioral health diagnoses because this could significantly overcount behavioral health spending and it would increase administrative burden on submitters.
Behavioral Health Addendum	Request to add eight behavioral health treatment codes that are billable for behavioral health treatment for Medi-Cal members under 21.	OHCA proposes to add four of the requested codes because the codes are consistent with other codes already included in the Addendum.* OHCA declines to add the other four requested codes because the codes are not specific to behavioral health treatment without a behavioral health diagnosis.** Including the codes would result in overcounting of non-behavioral health spending.

* Proposed codes added: 0362T: Dangerous behavior identification / supporting assessment related to ABA Therapy; 0373T: Exposure behavior treatment; H0046: Mental health service, NOS; S5108: Supervision related to ABA Therapy. ** Proposed codes not added: 99366: Medical team conference (face-to-face); 99368: Medical team conference (not face-to-face); S5110: Home care training, family; per 15 min session; S5111: Home care training, family; per session.

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Theme	Comment / Question Summary	OHCA Response
Medi-Cal Payments Addendum	Request for the rationale for exclusion of Medi-Cal supplemental payments in the Medi-Cal Payments Addendum. Recommendation to include all Medi-Cal payments in THCE reporting, noting exclusions such as Nonemergency Medical Transportation (NEMT), Non-Medical Transportation (NMT), Community Supports (CS), and Enhanced Care Management (ECM).	OHCA added the Medi-Cal Payments Addendum in response to questions from submitters about how to report certain Medi-Cal payment types during the 2025 data submission. The proposed Addendum ensures consistent and accurate reporting of specific Medi-Cal payments in the APM, Primary Care, and Behavioral Health files. OHCA already includes all Medi-Cal payments in the Statewide TME, Attributed TME, and Regional TME files. The NEMT and NMT payment exclusions in the Primary Care, Alternative Payment Model, and Behavioral Health files will be removed. OHCA plans to use THCE data submitted in 2026 to inform continued discussions with DHCS about future treatment of other Medi-Cal payments such as CS and ECM.

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Theme	Comment / Question Summary	OHCA Response
Data Validation and Resubmission	Request to extend the period for file remediation from five (5) business days to ten (10) business days and for OHCA to provide specificity when requesting file remediation.	OHCA will revise the timeframe for file remediation and resubmission to ten (10) business days. OHCA agrees that requests for resubmission of previously accepted files must notify a submitter how the file is deficient based on the specifications in the DSG.
	Request to automate cross-file validations and to provide documentation of automated and cross-file validation rules.	Because files may be submitted individually as they are ready, cross-file validations are a manual process performed only after all files have been received and passed automated validations. Automated field-level validations are documented in the file specifications in Section 5 of the DSG; cross-file validations are described in the proposed Appendix E: Cross-File Data Quality Checks.

Theme	Comment / Question Summary	OHCA Response
Miscellaneous	Request to publish DSG updates earlier and avoid mid-year changes to reduce submitter burden.	OHCA agrees with avoiding mid-year changes. All substantive changes to the DSG go through a public process and rulemaking. After the proposed addition of a Behavioral Health File this year, OHCA's file submission requirements will be more static going forward than in the first years of implementing the program.
	Recommendation to provide additional detail and context around proposed changes during THCE Data Submitter Workgroup meetings.	OHCA appreciates this feedback on how to improve THCE Data Submitter Workgroup meetings. OHCA will incorporate this feedback into the planning process for future THCE Data Submitter Workgroup meetings. Submitters are encouraged to contact OHCA at any time with feedback by email or during the meeting roundtable.

Theme	Comment / Question Summary	OHCA Response
Miscellaneous	Concerns around lack of standardization across payers when using payer-developed attribution methodology to attribute total medical expense (TME) to physician organizations (PO).	The proposed regulations do not make any changes to OHCA's existing attribution method. Submitters may use a payer-developed, rules-based approach to attribute TME only when members cannot otherwise be attributed based on capitated, delegated, or accountable care organization (ACO) arrangements. Payer-developed attribution was used for 9% of TME data reported for 2024. OHCA notes that this comment was not submitted by a PO. In PO previews, POs did not raise any concerns with spending attributed to their organizations by payer-developed methodologies.
	Concerns raised regarding the impact of updates to data submission regulations on data submission enforcement.	Commenters will have the opportunity to provide public comment on forthcoming data submission enforcement regulations once drafts are published.

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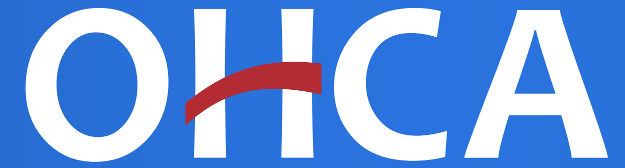
DHCS Feedback Incorporated

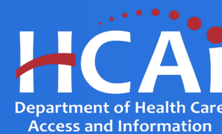
Theme	Feedback	OHCA Response
Behavioral Health Addendum	Request to reclassify certain poisoning codes as mental health or substance use disorder, to reflect intent of the poisoning event (e.g., intentional self-harm as mental health). Requests to include or exclude some codes that may not be considered mental health or services that may not be specific to behavioral health without a diagnosis.	OHCA updated the Behavioral Health Addendum to adopt the suggested reclassifications. OHCA reviewed and confirmed with DHCS which of the suggested codes to update in the Behavioral Health Addendum to align with OHCA's behavioral health definition and DHCS policies.
Primary Care Addendum	Request to add services that may be primary care and are commonly used in Medi-Cal at nursing and custodial care facilities. Request to add a column to the Primary Care Addendum to facilitate identification of codes that overlap with the Behavioral Health Addendum.	OHCA reviewed all suggested changes, and in consultation with DHCS made updates to the Primary Care Addendum when aligned with OHCA's primary care definition.

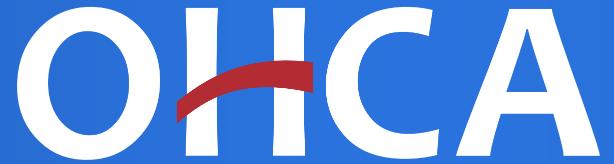
Next Steps

- Final drafts of proposed data submission regulations, including Data Submission Guide 3.0 and all addenda, will be posted to the HCAI website after the Board meeting.
- Submission to the Office of Administrative Law planned for early April 2026.
- Annual data submitter registration will begin in May 2026.



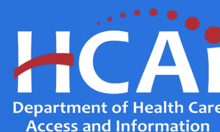
Public Comment





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 4 business days prior to the meeting.



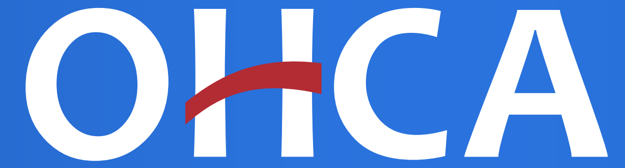
Next Board Meeting:

April 22, 2026

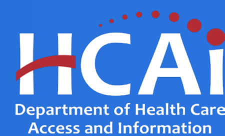
10am

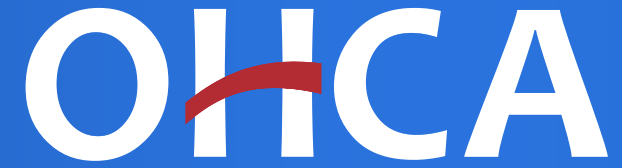
Location:

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

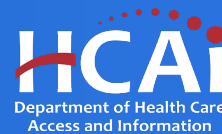


Adjournment

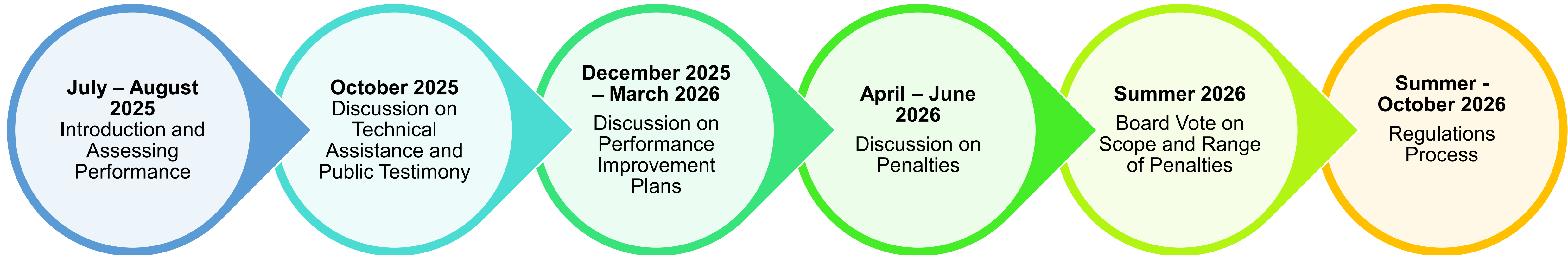




Appendix



Spending Target Enforcement 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

Review of Spending Target Enforcement

Assessing Performance

- Entities are noticed they exceeded the target and given 45 days to provide additional information
- The intent is to consider spending increases driven by factors outside the entity's control (e.g., high-cost patient outliers) and increases that could be potentially beneficial in improving the system long-term (e.g., investments in primary care).
- Enforcement Considerations are factors or circumstances that OHCA could consider when determining which entities would proceed beyond technical assistance to additional enforcement steps, like public testimony and performance improvement plans.
- These considerations will **NOT** change or modify an entity's reported performance or directly exempt or waive an entity from enforcement each year.

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

Review of Spending Target Enforcement

Technical Assistance

- Information provided to health care entities to provide resources and general guidance for compliance with spending targets.
- All entities that exceed the spending target will receive technical assistance.
- May include research studies, literature, cost-reducing strategies, etc.

Public Testimony

- An opportunity to hear from health care entities that have exceeded the spending target. This may take various forms, including in-person or written testimony.
- An optional step taken at the discretion of the director.