OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Board Meeting

May 27, 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 April 22, 2026 Meeting Minutes
Vishaal Pegany

Item #4 **Action Item**
Vote to Approve Advisory Committee Members
Megan Brubaker, Engagement, Governance, and Policy Group Manager

Item #5 **Informational Items**

a) Cost-Reducing Strategy Presentation: Providence
Margareta Brandt, Assistant Deputy Director; Laureen Driscoll, MBA, MSN, RN, Chief Executive, Providence California; Daniel Kelly, MBA, BSN, RN, Chief Nursing Officer, Providence California

b) Spending Target Data Submission Enforcement – Status Update and Comments on Regulatory Text
CJ Howard, Assistant Deputy Director; Heather Hoganson, Assistant Chief Counsel

c) Introduction to Equity Adjustment and Quality Adjustment to Spending Targets
Margareta Brandt; Maggie Heidmann, Health Equity and Quality Performance Group Manager

d) Spending Target Enforcement – Continued Spending Target Penalty Discussion
Vishaal Pegany; CJ Howard

e) Cost and Market Impact Review Regulations – Introduction to Regulatory Text
Heather Hoganson

Item #6 **General Public Comment**

Item #7 **Adjournment**

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

Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

HCAI
Department of Health Care Access and Information

With Appreciation

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

Descriptive Statistics for Comparable Hospitals, FY 2019-2023

During the April 2026 Board meeting, OHCA provided an overview of hospital financials from FY 2022 and 2023. Several Board members asked to see a longer time-series, which can be seen below

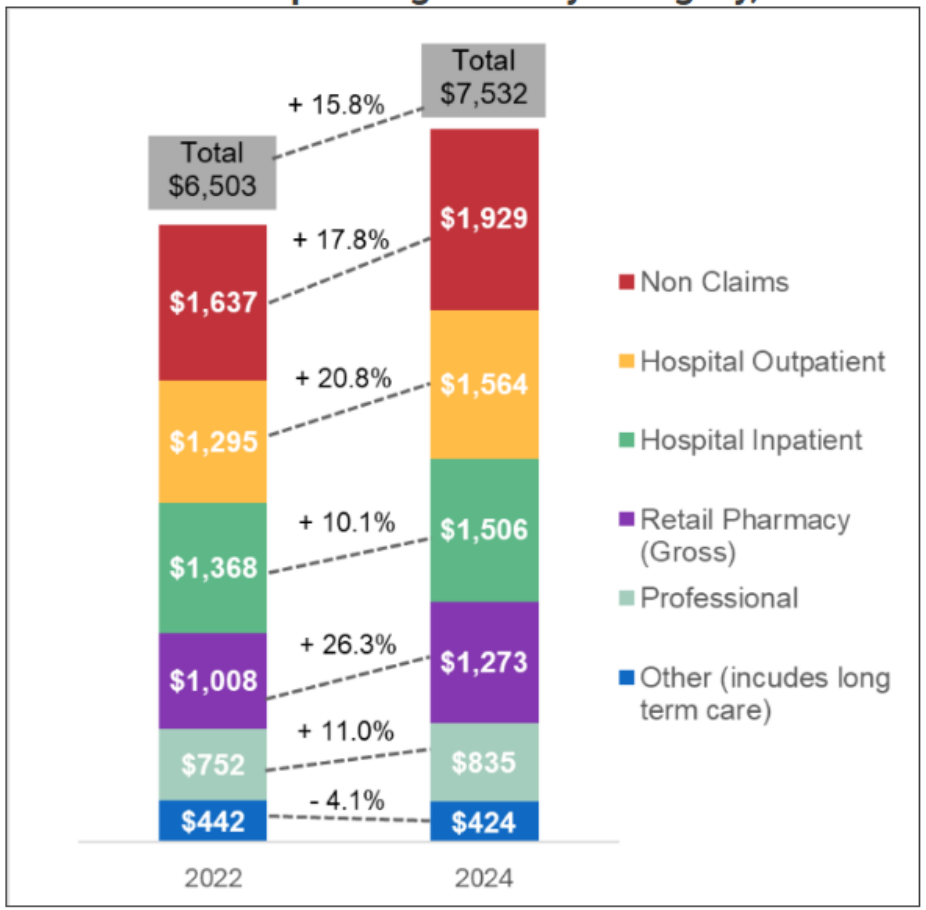
	Formula	2019	2020	2021	2022	2023
Number of comparable hospitals		365	362	366	368	366
Operations						
Total operating revenue, billions $	A	$117.6B	$119.9B	$127.5B	$135.5B	$145.7B
Total operating expenses, billions $	B	$112.7B	$118.8B	$124.2B	$134.1B	$145.7B
Net from operations, billions $	C=A-B	$4.8B	$1.1B	$3.3B	$1.41B	$0.015B
Operating margin, %	C / A	4.1%	0.9%	2.6%	1.0%	0.1%
Net non-operating revenue and expenses, billions $	D	$3.7B	$5.9B	$9.1B	$0.5B	$7.5B
Profit (Net Income), billions $	E=C+D-taxes – extraordinary items	$8.5B	$6.9B	$12.3B	$1.8B	$7.4B
Total margin, %	E/A	7.2%	5.8%	9.6%	1.3%	5.1%

Data from Hospital Financials (HAFDR). Comparable hospitals only – that is, those hospitals that are statutorily required to submit all HAFDR pages.

California's Spending Growth Target Initiative: Insights From Commercial Total Medical Expense Reporting

- A recent Health Affairs Forefront article highlights how OHCA's commercial TME can identify where spending growth is concentrated and how those trends connect to state affordability strategies.
- From 2022 to 2024, commercial TME PMPY increased 15.8%, with growth concentrated in capitation, hospital outpatient services, and gross retail pharmacy, which together accounted for 80% of the increase.

Exhibit 2: California commercial market per-member-per-year total medical expense growth by category, 2022–24



Downer, K., Feher, A., Pegany, V. (2026, May 13). *California's Spending Growth Target Initiative: Insights From Commercial Total Medical Expense Reporting.* Health Affairs Forefront. https://www.healthaffairs.org/do/10.1377/forefront.20260506.540

California's Spending Growth Target Initiative: Insights From Commercial Total Medical Expense Reporting

- The article connects these spending trends to three areas of policy focus within HCAI/OHCA:
  - Encouraging population-based payments linked to quality;
  - Adjusted targets for a subset of high-cost hospitals; and
  - Supporting prescription drug affordability efforts through initiatives like CalRx.
- By linking measured cost drivers to specific policy levers, OHCA's spending data can help identify where targeted interventions are most likely to improve value and manage costs in the commercial market.

Downer, K., Feher, A., Pegany, V. (2026, May 13). *California's Spending Growth Target Initiative: Insights From Commercial Total Medical Expense Reporting.* Health Affairs Forefront. https://www.healthaffairs.org/do/10.1377/forefront.20260506.540

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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

Public Comment

HCAI
Department of Health Care Access and Information

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

Action Consent Item: Vote to Approve April 22, 2026 Meeting Minutes

HCAI
Department of Health Care Access and Information

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

Public Comment

HCAI
Department of Health Care Access and Information

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

Informational Items

HCAI
Department of Health Care Access and Information

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

Cost-Reducing Strategy: Providence

Margareta Brandt, Assistant Deputy Director
Laureen Driscoll, MBA, MSN, RN, Chief Executive, Providence California
Daniel Kelly, MBA, BSN, RN, Chief Nursing Officer, Providence California

HCAI
Department of Health Care Access and Information

Providence

Transforming Our Culture

Laureen Driscoll, Chief Executive, Providence California

Dan Kelly, Chief Nursing Officer, Providence California

May 27, 2026

Providence Leaders

Laureen Driscoll, MBA, MSN, RN

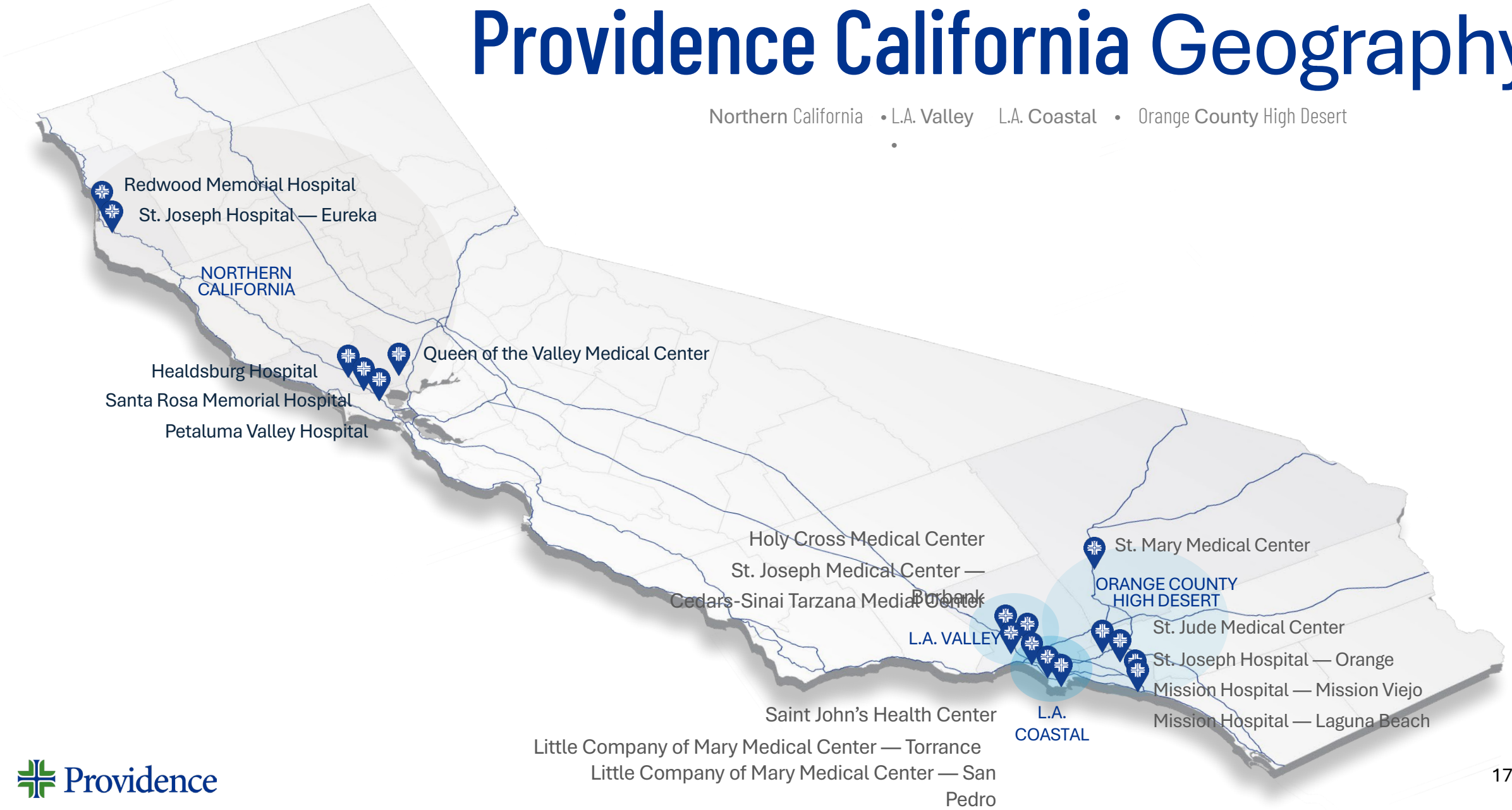
Chief Executive, Providence California

Daniel Kelly, MBA, BSN, RN

Chief Nursing Officer, Providence California

Providence California Geography

Northern California • L.A. Valley • L.A. Coastal • Orange County High Desert



Providence

Providence | California

17 Acute Hospital Campuses

246 Clinics

18 Ambulatory Surgery Centers

20 Urgent Cares

25k Caregivers

10,544 Medical Staff

2830 TOTAL AFFILIATE PROVIDERS

514 Affiliate Primary Care

2,316 Affiliate Specialists

2188 TOTAL MEDICAL GROUP PROVIDERS

528 Medical Group Primary Care

1,660 Medical Group Specialists

5018 TOTAL AFFILIATE AND MEDICAL GROUP PROVIDERS

2.85M Medical Group In-house Visits

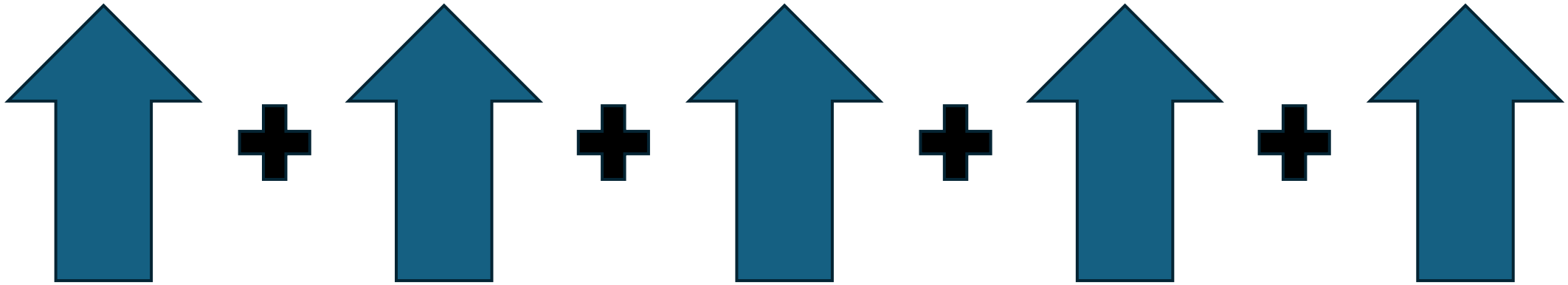
413K Medical Group Virtual Visits

695K Value Based Care Members

105K Surgeries (IP/OP)

Cost Drivers External to Our Control

Costs associated with payor behavior, labor, pharmaceutical costs, and fees result in an incremental cost of $300m per year



73% increase underpayments and denials

43% increase touches per claim (manual intervention)

33% increase claims >90 days old

38% increase pharmaceutical spending in the US over the last five years

10% annual increase cost of professional fees

Additionally, with current seismic regulations included, Providence needs to reinvest ~$7 billion into capital over the next 5 years

Cost Control Measures

Core business operational Improvements

- $220m reduction in agency labor spend over 2 years
- 2024 length of stay improvements saved 14,740 patient days, and ~$18M
- Medical supply inflation held at 5.5% over prior 2 years vs national benchmark trend of 7.6%

Programmatic Improvements

- Growth in high acuity services
- Changes in payment models, funding sources
- Strategic realignment of care to meet community needs

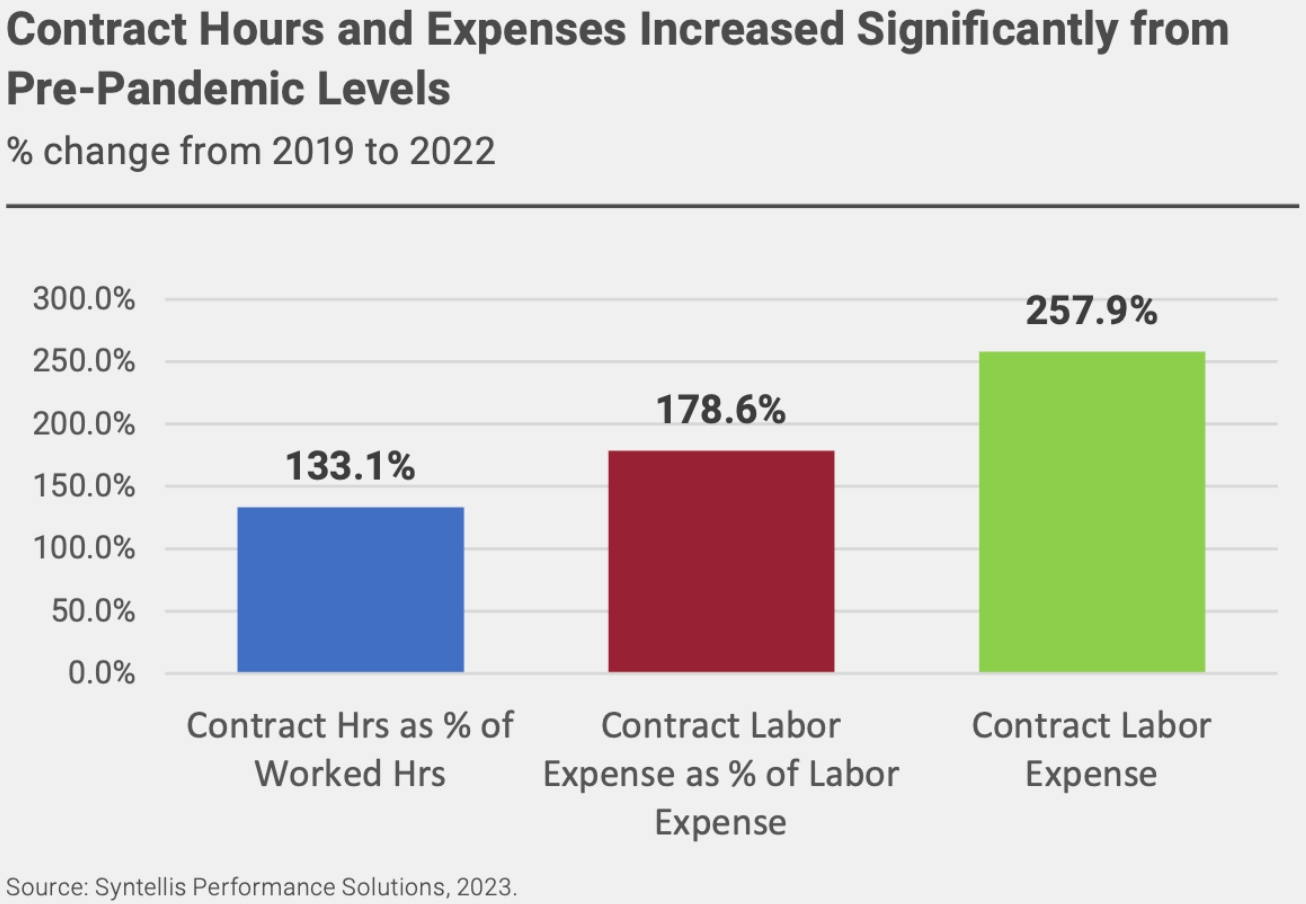
Reimagine & Partnership

- Queen of the Valley Medical Center (QVMC) Sale (Late 2026)
- Partnerships in post-acute and behavioral health
- Physical Asset Optimization

Sustainable payment

- Contract renegotiations
- Remediation of payment degradation

Agency Labor Cost: An Industry Challenge



- A severe nationwide shortage of qualified healthcare professionals has forced many hospitals to rely on expensive agency labor to fill patient care needs.
- The COVID-19 pandemic significantly impacted caregiver retention, increasing the need for agency labor.
- Agency labor is significantly more expensive than full-time caregivers, typically adding **50% or more** to a caregiver's hourly rate.[1]
- Compared to 2019, nationwide contract hours as a percent of worked hours rose 133.1% in 2022. Contract labor expense as a percent of total labor expense increased 178.6% and total contract labor expense skyrocketed 257.9% over the three-year period.[2]
- Reducing agency spend frees resources to reinvest in our employed workforce.

Cultural Transformation| California

Analyzed Caregiver Engagement Survey → Caregiver Engagement

- Analyzed Caregiver engagement surveys for themes at the end of 2022
  - Lack of Connection to Core Leader
  - Lack of Career Opportunity
  - Plan to leave organization in 1-2 years

Developed Stay Conversations → Workforce Hiring

- Trained 900 Core Leaders on conducting Stay Conversations
- New hires receive 2 stay conversations in 1st 6 months of employment
- All Caregivers receive a Stay Conversation annually

Strengthened the Workforce →Agency Utilization Reduction

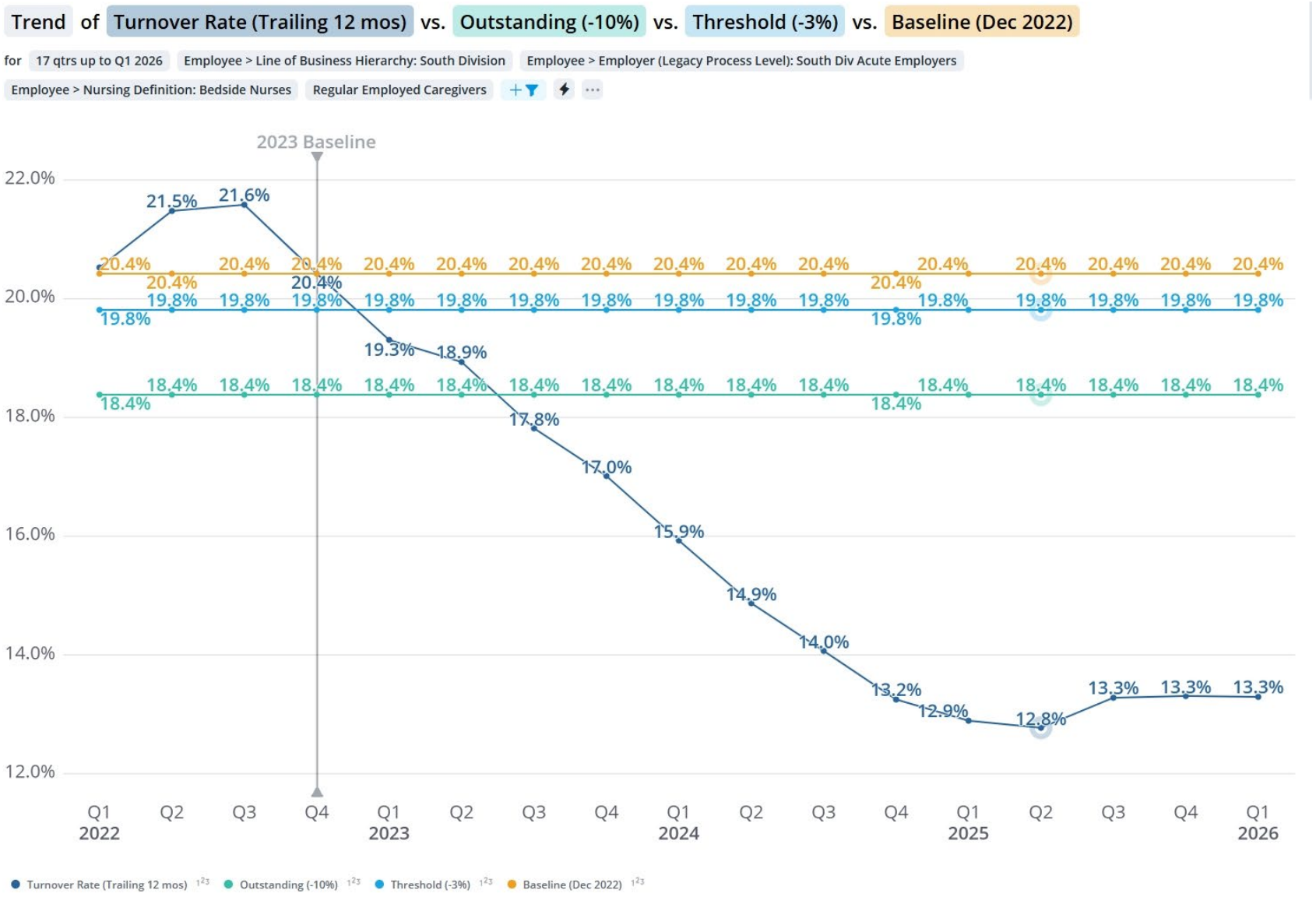
- Accelerated TIPs Hiring
- Developed Clinical Fellowship into Specialty Areas
- TIP Fellows / Residents Hired = **4550** since 2023
  - Fellows: 1603
  - Residents: 2947

Cultural Transformation| Strategic Focus

South Division Focus #1:

❖**Caregiver Engagement**

- Strengthen hiring and retention initiatives
- Ministry reviews of Position Controls
- Partnering with Human Resources / Talent Acquisition on hiring initiatives
- Stay conversations focused on First-Year Turnover

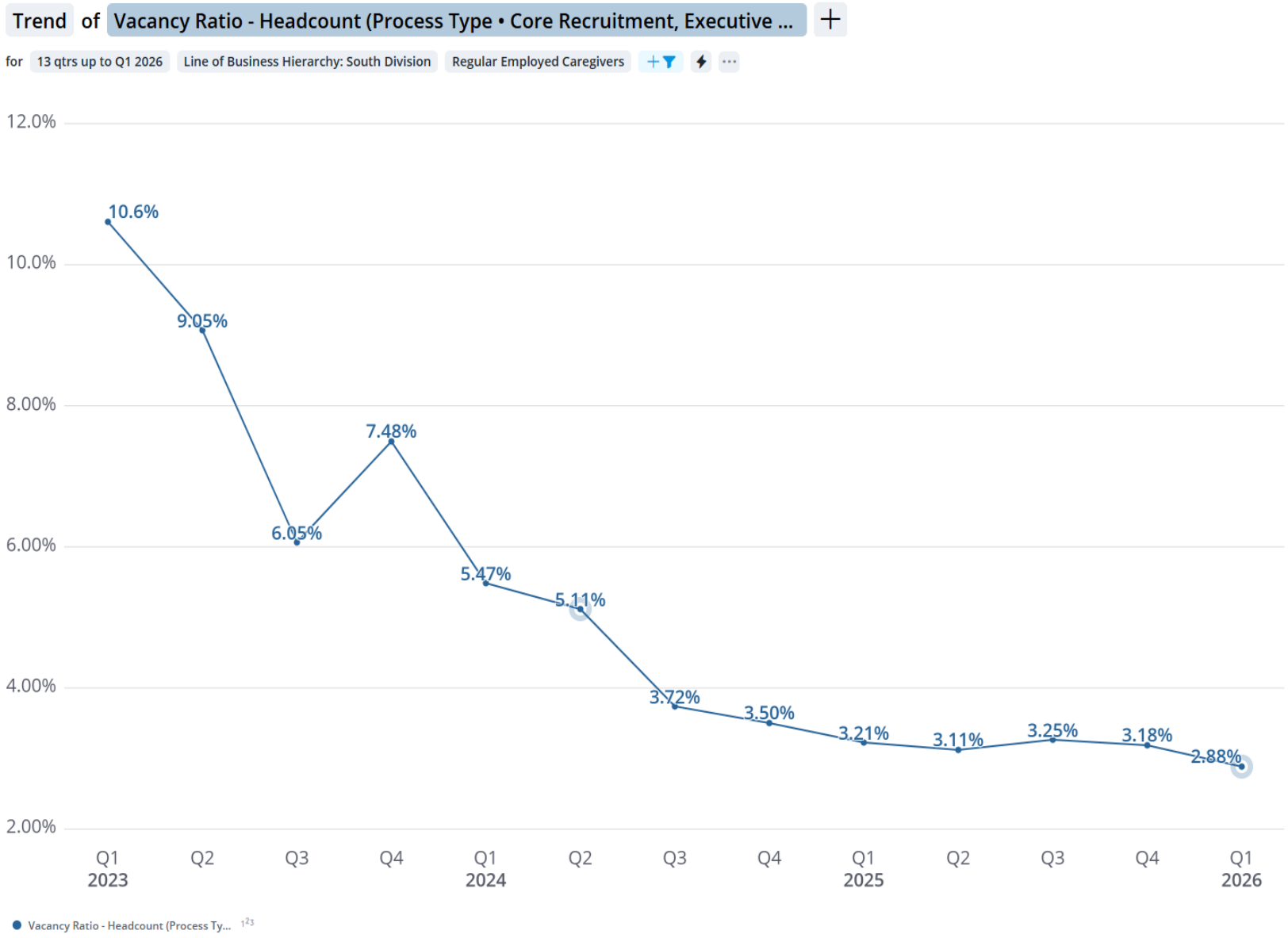


Cultural Transformation| Strategic Partnership

South Division Focus #2:

- ❖ **Workforce Hiring**

- ➢ Reduced open vacancies across Division
  - ✓ Increased TIP hiring (Fellows & Residents)
  - ✓ Improved Leave of Absence (LOA) Management
- ➢ Position Control Accountability
- ➢ Adjustments made to meet workforce needs and changes
  - ✓ Workforce Council focus on Talent Acquisition, Hiring practices, and LOAs
  - ✓ Focused Hiring Sessions
  - ✓ Flexible staffing and scheduling
  - ✓ Implementing innovation and technology at the bedside



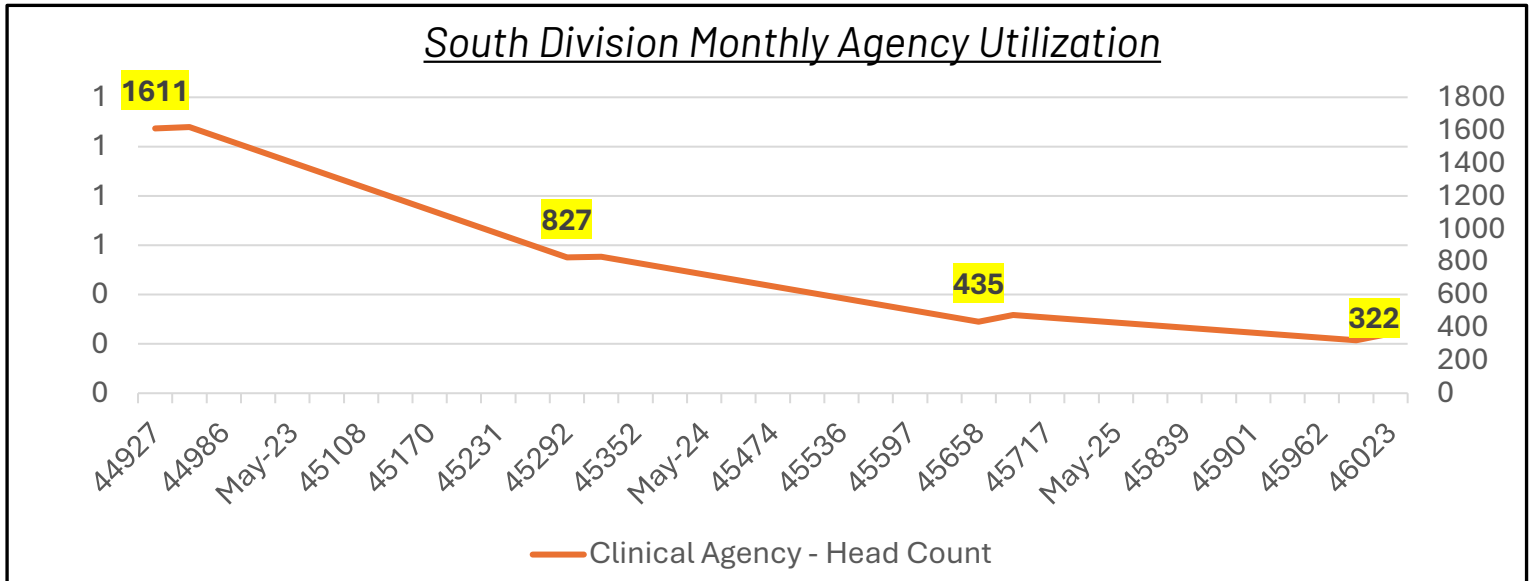
Providence

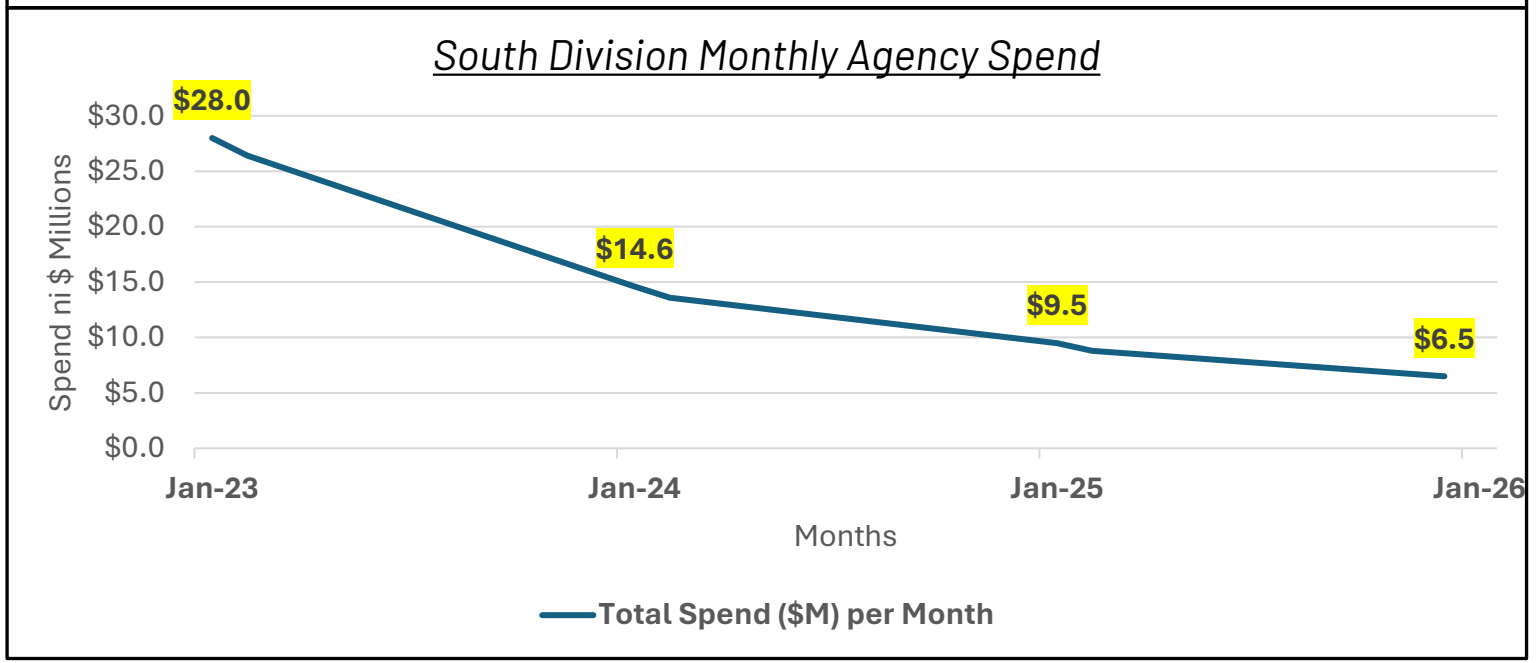
Cultural Transformation| Agency Reduction Plan

South Division Focus #3:

❖**Agency Utilization Reduction**

- Increased accountability for local position controls
- Focused recruitment for high priority / high cost / hard to fill positions
- Reduce contract labor by filling vacancies with TIPs (Fellows/Residents)
- Increased focus on Leave of Absence management
- Achieved a reduction in spend and utilization of agency labor of **$220+M** from 2023-2025. Today, monthly agency spend is **down 76%** compared to January 2023.





Providence

Cultural Transformation| Highlights

- Achieved a reduction in spend and utilization of agency cost by **$220+M** from 2023-2025.

- The South Division team continues to sustain these significant reductions well into 2026 through collaboration with cross-functional teams and the implementation of cost-effective staffing models, along with continuous monitoring of agency labor utilization. Monthly agency spend **down 76%** compared to January 2023.

- Targeted measures implemented to optimize workforce management, in partnership with ministry leaders, Human Resource leaders, and Division leadership has resulted in
  - Nursing Turnover **down 40%**
  - Nursing Vacancies **down 86%**

- Strategic interventions aimed at enhancing workplace satisfaction and fostering a supportive environment, helped the South Division ministries exceed caregiver retention goals set by the organization and improve Caregiver engagement overall.
  - South Division Glint Caregiver Engagement score as of 2nd Quarter (April 2026) is **74**, exceeding system score of 73.

	2026 Q2 Apr
Engagement	74 (+1)
Response Rate	52% (11,853 of 22,948)
# comments	12,405
Top Strength	**Organization Potential** I am excited about this organization's future.
#2 Strength	**Growth** I have good opportunities to learn and grow at this organization.
#3 Strength	**Mission Connection Work** The work that I do at this organization is meaningful to me.

Providence

Co-Caring Pilot

Co-Caring, or Virtual Nursing, is a new model of care delivery including a team approach and collaborative partnership of bedside and virtual caregivers, each practicing at the top of their scope to delivery high quality care and an exceptional patient experience. This model of care incorporates virtual registered nurses (vRNs) into team-based nursing and aims to reduce administrative burden and improve patient care.

The virtual nurse assists with the following:

- Completes admission assessment
- Reviews diagnosis and reason for hospitalization
- Completes medication reconciliation for previous and new medications
- Begins discharge education and prepares patient for discharge

Co-Caring and Virtual Nursing have shown positive health and safety outcomes:

- A 50% reduction in patient falls with moderate to severe injury
- A 20% reduction in average patient discharge time
- A 5% reduction in hospital-acquired infections

Providence

Thank You

References

1: Pradhan, R., Beauvais, B., Ramamonjiarivelo, Z., Dolezel, D., Wood, D., & Shanmugam, R. (2024). Agency Staffing and Hospital Financial Performance: Insights and Implications. Journal of healthcare leadership, 16, 365–374. https://doi.org/10.2147/JHL.S470175

2: Syntellis Performance Solutions. Hospital Vitals: Financial and Operational Trends 2022. Available from: https://www.syntellis.com/sites/default/files/202303/AHA%20Q2_Feb%202023.pdf

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Public Comment

HCAI

Department of Health Care Access and Information

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

Action Item: Vote to Appoint Advisory Committee Members

Megan Brubaker, Engagement, Governance, and Policy Group Manager

HCAI
Department of Health Care Access and Information

Current Advisory Committee Members

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 ★
Executive Chairman of Health Systems, 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
CFO, Salinas Valley Health
San Francisco Health Service System (Previous Position)

Health Care Workers

Stephanie Cline ★
Respiratory Therapist, Kaiser

Sarah Soroken
Mental Health Clinician, Solano County Mental Health

Cristina Rodriguez ★
Physician Assistant, Altura Centers for Health

Consumer Representatives & Advocates

Carolyn Nava ★
Senior Systems Change, Disability Action Center

Mike Odeh ★
Senior Director of Health, Children Now

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

Amanda McAllister-Wallner
Executive Director, Health Access

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

Organized Labor

Joan Allen
Government Relations Advocate, SEIU United Healthcare Workers West

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

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

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

Academics/ Researchers

Stephen Shortell ★
Professor, UC Berkeley School of Public Health

★ Term ends on June 30, 2026

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

Applicant Pool

50 total submissions

- 13 incumbents
- 7 applicants pulled from special payer recruitment
- 30 new applicants

Recommended Slate

Payers

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

Manan Shah
Vice President & 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
Executive Chairman of Health Systems, 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

Magdalena Pruitt
Chief Medical Officer, Senior Vice President, AltaMed Health Services

David Joyner
Chief Executive Officer, Hill Physicians Medical Group

Physicians

Katina Murray
Associate CMO, USC Care; Vice Chair Clinical Affairs, Dept Family Medicine, Keck Medicine of USC

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

Vacant- Open for special recruitment

Health Care Workers

Stephanie Cline
Respiratory Therapist, Kaiser

Sarah Soroken
Mental Health Clinician, Solano County Mental Health

Cristina Rodriguez
Physician Assistant, Altura Centers for Health

Consumer Representatives & Advocates

Carolyn Nava
Senior Systems Change, Disability Action Center

Mike Odeh
Senior Director of Health, Children Now

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

Amanda McAllister-Wallner
Executive Director, Health Access

Nancy Netherland
Senior Specialist, Family Voices of America

Organized Labor

Joan Allen
Government Relations Advocate, SEIU United Healthcare Workers West

Mike Rabourn
Assistant Director of Research, 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

Others

Stephen Shortell
Professor, UC Berkeley School of Public Health

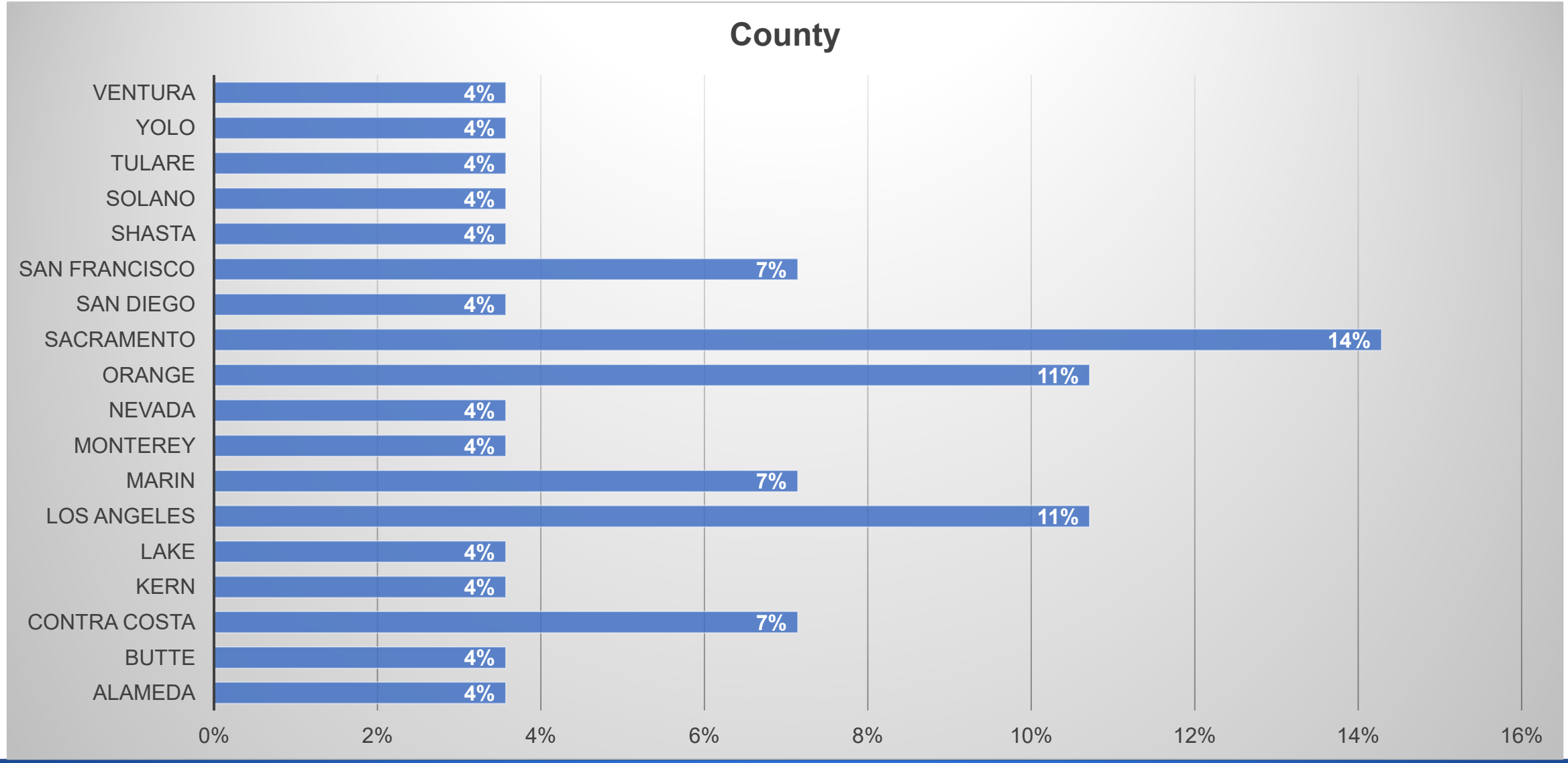
Sean Kim
Vice President Practice & Professional Development, California Pharmacist Association

= Reappointed Incumbents

= New Appointments

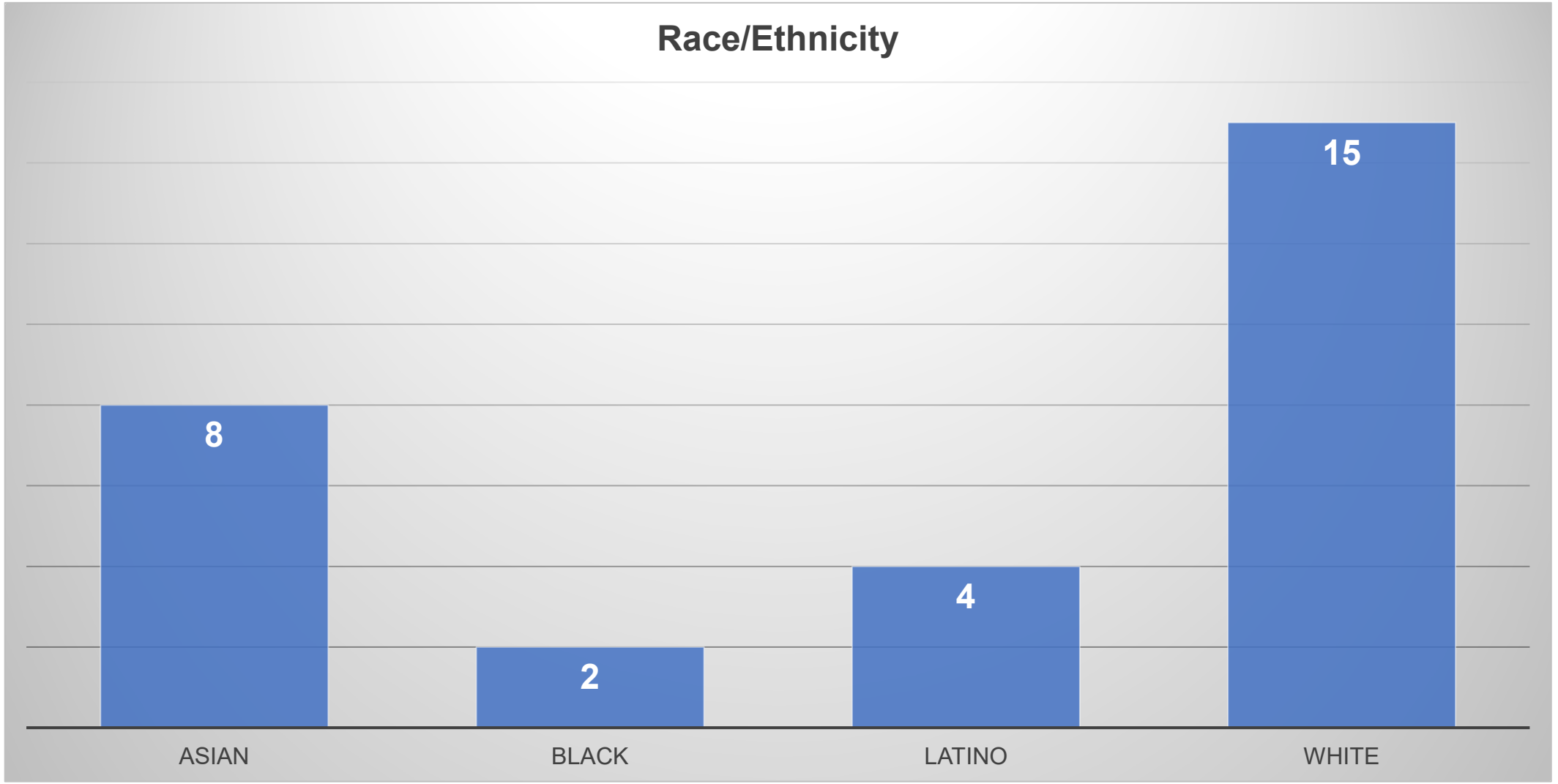
OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Demographics of Recommended Slate

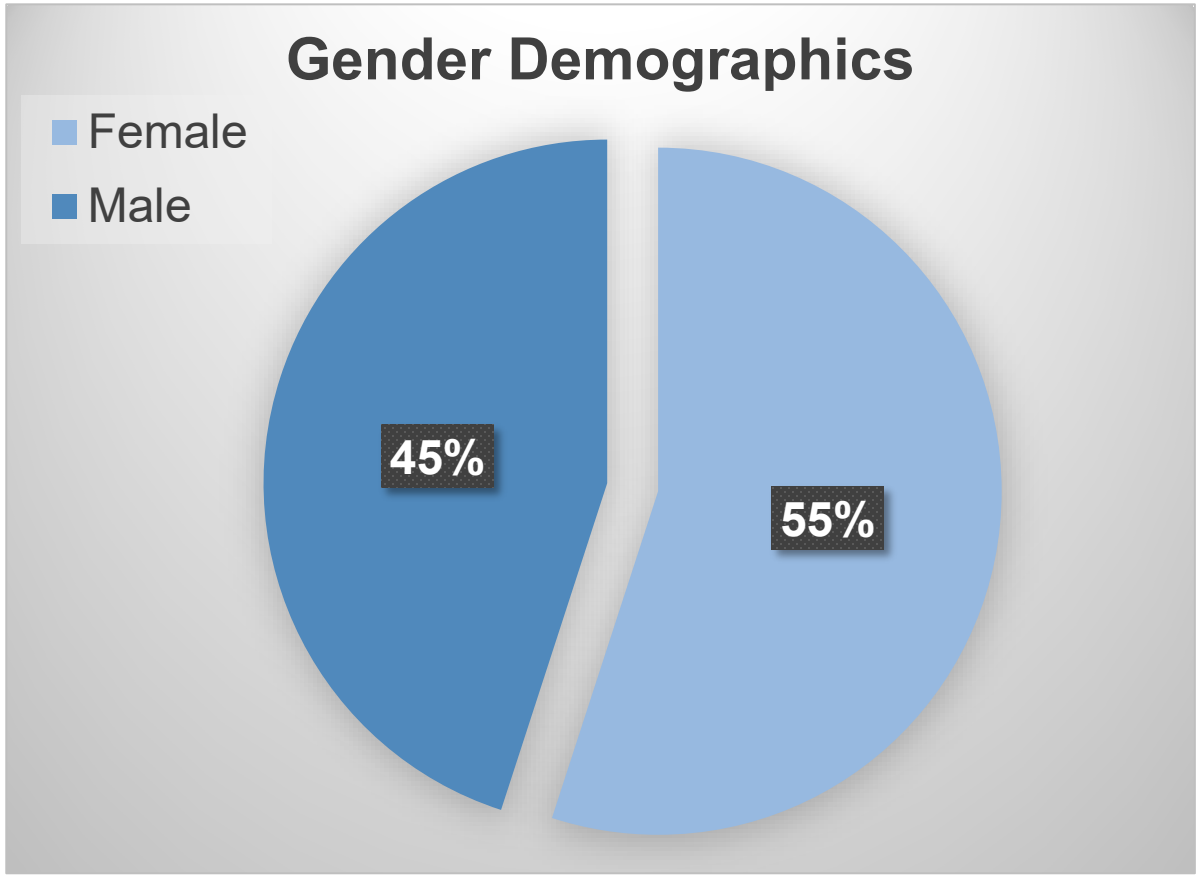


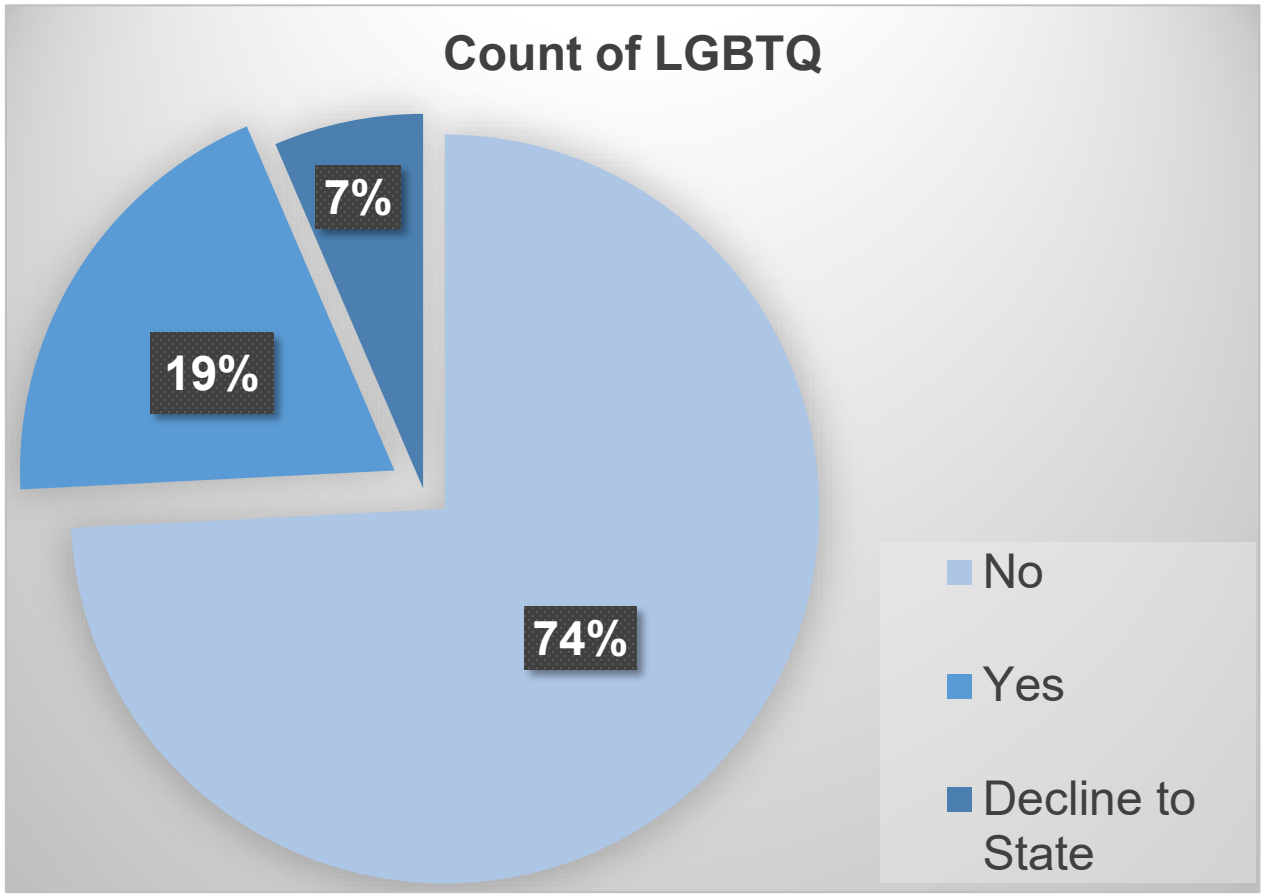
OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Demographics of Recommended Slate*



Demographics of Recommended Slate*





Draft Motion from the Subcommittee

- Approve the Recommended Advisory Committee Membership (29 members).
- Appoint the new and reappointed members for a 2-year term.

Next Steps

- OHCA will reach out to the approved Advisory Committee members and inform them of their appointment. The new members will attend their first Advisory Committee meeting on July 8, 2026.

- OHCA is currently holding a special recruitment period to fill the vacant purchaser perspective and the submission period will end on June 30, 2026.

- The subcommittee will meet in July to evaluate any new received submissions.

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

Public Comment

HCAI
Department of Health Care Access and Information

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

Spending Target Data Submission Enforcement: Status Update and Comments on Regulatory Text

Heather Hoganson, Assistant Chief Counsel
CJ Howard, Assistant Deputy Director

HCAI
Department of Health Care Access and Information

Public Comment Summary

- OHCA published draft Data Submission Enforcement regulations on April 20, 2026.
- Proposed regulations were discussed at the Health Care Affordability Board meeting in April 2026.
- Public comments were accepted from April 20 to May 11, 2026.
- OHCA received two comment letters.

Theme	Comment / Question Summary	OHCA Response
General	Comment that the proposed escalation of penalties—combined with earlier enforcement timelines—raises questions about proportionality, process fairness, and readiness. Concern that penalties could be imposed for issues stemming from evolving guidance, late-breaking clarifications, or requirements that were not fully defined at the time of submission. Urge prioritizing technical assistance and corrective action pathways before imposing significant monetary penalties, particularly where submission challenges are driven by process changes or unclear expectations.	OHCA recognizes the efforts of submitters to comply with reporting requirements. OHCA notes that the proposed regulations include multiple mechanisms intended to promote fairness and flexibility, including extension requests, a tiered escalating penalty structure, and appeal rights. The proposed regulations are intended to implement the statutory authority in a transparent, predictable, and consistent manner.
General	Recommend OHCA finalizes Data Submission Guide updates and related regulations prior to January of a given submission year as plans require time to make system and compliance procedure updates. As of now, plans have less than four months to adopt and comply with these regulation changes this year.	OHCA recognizes the operational planning necessary for submitters to implement changes to reporting requirements and data systems. OHCA notes that the enforcement framework was discussed publicly at multiple meetings of the Health Care Affordability Board and Health Care Affordability Advisory Committee prior to January 1, 2026. These meetings included discussion regarding enforcement concepts, timelines, extension procedures, and administrative penalties.

Theme	Comment / Question Summary	OHCA Response
General	§§ 97449 and 97451 Request procedures for when OHCA must make determinations and provide notices when a file is deemed to be submitted without the need for further changes. Recommend requiring OHCA to render determinations and responses within five (5) business days of the submission or re-submission of a file with a detailed explanation of why or why not a submission is in compliant under Health and Safety Code and California Code of Regulations.	OHCA declines to adopt the proposed changes. The review process may require iterative validation, quality assurance review, technical analysis, and follow-up communications with required submitters to evaluate whether the data is complete and accurate. The amount of time necessary to complete these activities may vary depending on the nature, scope, and complexity of the submission and any identified deficiencies.
General	§§ 97449 and 97451 Request clarification on the process to notify OHCA when payers need to send a corrected file due to system issues.	The process for communicating technical issues, correcting submitted files, and coordinating resubmissions is addressed in the Data Submission Guide (DSG). The DSG includes contact information for OHCA and OHCA's data management vendor. These contacts may be utilized for questions regarding information technology issues, submission procedures, file mapping, submission results, and reporting timelines.

Theme	Comment / Question Summary	OHCA Response
Extension Process	§ 97449(h)(3) When OHCA approves an extension, request providing ten business days in which to provide data submission progress updates, rather than five business days, unless the granted extension is for ten business days or less. This aligns with product management standards.	OHCA believes the updates every five business days are reasonable and necessary given the statutory timelines associated with data collection, validation, analysis, and enforcement activities for data submission. More frequent updates enable OHCA to monitor submission progress, identify potential barriers to timely completion, and coordinate technical assistance, if applicable. OHCA notes that extension requests are generally intended to address temporary or extraordinary circumstances, which require more frequent communications.
Extension Process	§ 97449 (h)(6) Recommend specifying that OHCA “must consider” circumstances preventing the timely submission of complete and accurate data files (e.g., natural disaster, unforeseen disruptions to business operations or information technology systems) when granting or denying requests for extensions of time.	In response to this comment, OHCA revised section 97449, subdivision (h)(6) from "may consider" to "shall consider."

Theme	Comment / Question Summary	OHCA Response
Extension Process	§ 97449 (h) - Recommend adding a section requiring OHCA to provide a written response, and within that response, clearly addressing and justifying the rationale for its decision in approving, denying, or requesting more information related to a submitter request for extension.	OHCA revised section 97449, subdivision (h)(1) to state that OHCA shall provide a written response when approving, denying, or requesting additional information related to a request for an extension of time. OHCA notes that Section 97449, subdivision (h)(6) identifies the circumstances OHCA considers when evaluating extension requests. Requiring additional detailed written justifications in every instance for every submitter could create an unnecessary administrative burden that may delay responses to extension requests during an active reporting period.
Extension Process	§ 97449(k)(2) - Consider extending the response window, from three business days to five business days, after OHCA's notification that a previously accepted file contains initially unidentified errors. This will help health plans ensure accurate and complete responses, particularly in situations where key personnel may be temporarily unavailable following the submission period.	In response to this comment, OHCA revised section 97449, subdivision (k)(2) to five business days.

Theme	Comment / Question Summary	OHCA Response
Public Reporting	Request that either the regulation or another procedure establish a formal process for public notification when an entity is approved for an extension, fails to submit data, or fails to submit corrected data.	OHCA acknowledges the importance of transparency. Public reporting is not an appropriate topic for this regulation package, as these regulations primarily focus on the enforcement framework for data non-submission. However, as we gain experience with how the eventual regulation framework affects submissions, we will evaluate how to best present the information.
Appreciation (Various)	Appreciation for requiring regular communication between the Office and the health plans during the extension process. Appreciation for proposing clearer definitions of what constitutes a “complete” and “timely” submission but stress that clear compliance timelines and procedures will be critical. Appreciation for defining the terms “accurate” and “complete.”	OHCA appreciates the feedback.

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

Public Comment

HCAI
Department of Health Care Access and Information

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

Introduction to Equity Adjustment and Quality Adjustment to Spending Targets

Margareta Brandt, Assistant Deputy Director
Maggie Heidmann, Health Equity and Quality Performance Group Manager

HCAI
Department of Health Care Access and Information

OHCA's Commitment to Advancing Health Equity and Quality

- California's health care system is large and complex, with a diverse mix of payers and health care delivery models that contribute to variation in spending, access to care, and health outcomes across the state.
- Despite growth in health care costs, higher levels of spending do not consistently translate into better outcomes, highlighting opportunities to improve efficiency, strengthen quality, reduce health disparities across the health care system, and better align care delivery and payment with value.
- OHCA is responsible for implementing several statutory requirements that aim to reorient the health care system toward greater value.
  - OHCA pursues work to advance health equity by implementing the spending targets to improve affordability, as well as through the OHCA Quality and Equity Measure Set, Workforce Stability Standards, Primary Care Investment Benchmark, Behavioral Health Investment Benchmark, and cost-reducing strategies.
- This work supports a shift toward a more value-driven health care system that prioritizes access to care, improved quality and equity, and affordability.

Key Terms and Definitions

- **Health equity:** is the absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g., sex, gender, ethnicity, disability, or sexual orientation). (WHO)
- **Social drivers of health (also known as social determinants of health):** the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2030).
- **Social risk:** refers to an individual's social and economic conditions shaped by underlying social drivers of health (SDOH) (UCSF SIREN).
- **Social Vulnerability Index (SVI):** a place-based SDOH index developed by the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) (Social Vulnerability Index).
- **Social Vulnerability Index (SVI) Quartiles:** the SVI ranks California census tracts to give a measure of relative social vulnerability ranging from 0 to 1. These scores have been categorized into quartiles, four equal groups, with higher SVI scores (SVI Quartile 4) indicating higher social risk.
- **SVI Quartile 4**: indicates members with the highest social risk as assessed through the SVI. For example, a member with higher social risk could be below 150% of the poverty level and aged 65 & older with a disability.

Equity Adjustment

Statutory Requirements

- In consultation with the board, the office **shall establish** equity adjustment methodologies to take into account social determinants of health and other factors related to health equity, **to the extent data is available and methodology has been developed and validated**.
- The methodology for setting a sector target for an individual health care entity shall be developed taking into account the following:
  - Allow for the setting of cost targets that **encourage an individual health care entity to serve populations with greater health care risks** by incorporating an equity adjustment **accounting for the social determinants of health and other factors related to health equity** for the entity's patient mix.

Health and Safety Code § 127502

Social determinants of health are also referred to as social drivers of health. This presentation uses social risk which refers to an individuals' social and economic conditions shaped by underlying social drivers of health (UCSF SIREN).

What is the Purpose of an Equity Adjustment?

Purpose

• Avoid potential unintended consequences of spending targets.
  • Do not want to discourage/penalize spending growth for services or populations where the level of care is insufficient.
  • Do not want health care entities to limit access or services for members with high social risk.
• Avoid undermining affordability by making health care more costly.
• Address social drivers of health and advance health equity.
• Encourage health care entities to address disparities in care for members with varying levels of social risk.
• Improve access, affordability, and equity of health care for all Californians.

OHCA would want an equity adjustment to meet one or more of these desired outcomes.

What an Equity Adjustment Is and Is Not

What the equity adjustment is	What the equity adjustment is not
• An adjustment to a health care entity's spending growth that does not change the spending targets. • For example, all health care entities would still have the 3.5% statewide spending target, but OHCA could use an equity adjustment based on social risk to adjust a health care entity's spending growth downward. • A method to identify health care entities serving a disproportionate share of members with high social risk by using available data, such as an SDOH index. • An allowance for higher spending growth for health care entities who are serving a disproportionate share of members with high social risk.	• A source of additional funding for health care entities to invest in efforts to address social risk. • A single solution to address health equity challenges in California. • A requirement for health care entities to spend more on initiatives to address social risk and reduce health disparities.

Equity Adjustment Development Process

Scope

- Assessed an equity adjustment for payers. Will separately assess for physician organizations and hospitals.

Process

- Since 2023, OHCA worked with health care experts, Mathematica, OnPoint Health Data, analysts, and researchers to review data analyses and discuss policy approaches to an equity adjustment.

Analyses

- Assessed programs by other states and CMS that apply social risk adjustments to the payments providers and health plans receive.
- Used the Social Vulnerability Index (SVI) and Health Care Payments Data (HPD) Program data to assess variation in social risk among members served by payers from 2018 to 2023.
  - Contracted with Mathematica to conduct an analysis.
  - Key findings:
    - Payers' distribution of members by SVI quartile is very stable and there is very little year-over-year change.
    - Even for members with the highest social risk (SVI Quartile 4), there is very little year-over-year change.

The SVI ranks California census tracts to give a measure of relative social vulnerability ranging from 0 to 1. These scores have been categorized into quartiles, four equal groups, with higher SVI scores (SVI Quartile 4) indicating higher social risk.

Assessment of Social Risk Distribution Among Payers

About the Analysis

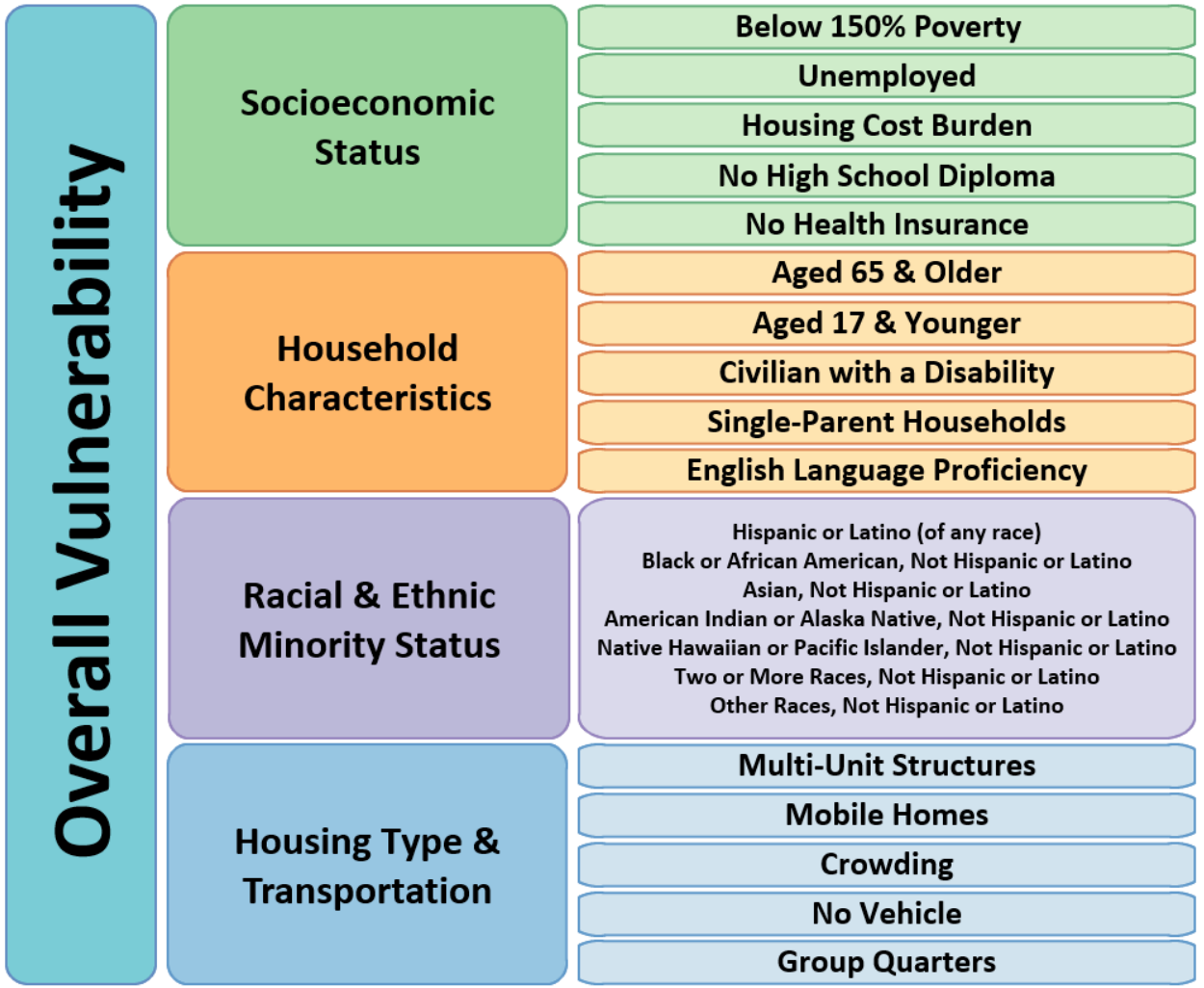
- To assess health equity, this analysis used an SDOH index focused on social risk.
- This analysis 1) examined social risk of California health insurance members and how social risk is distributed across payers to identify payers who take on members with disproportionate social risk within a market and 2) observed trends in payers' distribution of social risk over time.
- The Health Care Payments Data (HPD) Program data was used to assess variation in social risk among members served by California payers from 2018 to 2023.
  - Members' social risk was assessed by first applying a Social Vulnerability Index (SVI) score to each member based on address.
  - Members were then grouped based on their SVI quartile and variation across three key markets were assessed: Commercial, Medicare Advantage, and Medi-Cal Managed Care.
    - Both distribution by SVI quartile and volume of members in SVI Quartile 4, which indicates members with higher social risk, were considered.
- Social risk variation was analyzed at the payer-level; the analysis does not address social risk variation at the provider-level or hospital-level.

Data Notes and Limitations

- This analysis includes payers who submit data to the HPD. The HPD includes approximately 82% of Californians.
  - The HPD does not have complete self-funded commercial data or data on uninsured Californians.
- Data completeness in the HPD is between 99.2% - 100%[1] for required data elements such as: market category, payer, member zip code, etc.
  - Over 99% of member months were successfully linked to an SVI score for all 3 market categories.
- This analysis includes data for Medi-Cal Managed Care members. Medi-Cal fee-for-service data is not included.
  - Members without a Medi-Cal Managed Care Plan code, meaning a member could not be assigned to a Medi-Cal Managed Care payer, were excluded from the analysis.
- This analysis includes data for Medicare Advantage members. Medicare fee-for-service data is not included.
- The payers in this analysis differ slightly from the OHCA Baseline Report.
  - Two payers are in the OHCA Baseline Report but are not included in this analysis because they do not have data in the HPD.
  - One payer is included in this analysis but is not listed in the OHCA Baseline Report.

The Social Vulnerability Index (SVI)

- The Social Vulnerability Index (SVI) is a place-based index developed by the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR).
- This analysis uses the 2022 SVI, which equally weights 16 US Census variables from the American Community Survey (ACS) 2018-2022 (5 year) data and 2020 census tracts, to assign an SVI score.
- A higher SVI score indicates higher social risk.
  - SVI Quartile 4 indicates members with higher social risk.
  - For example, a member with higher social risk could be below 150% of the poverty level and aged 65 & older with a disability.
- SVI has a high correlation to the Healthy Places Index (HPI) and uses census tracts as the geographical unit.
- Very few California census tracts do not have an SVI score. Census tracts with no SVI score may have missing ACS data, therefore an SVI score could not be calculated.
  - Approximately 0.25% of the California population is missing an SVI score.

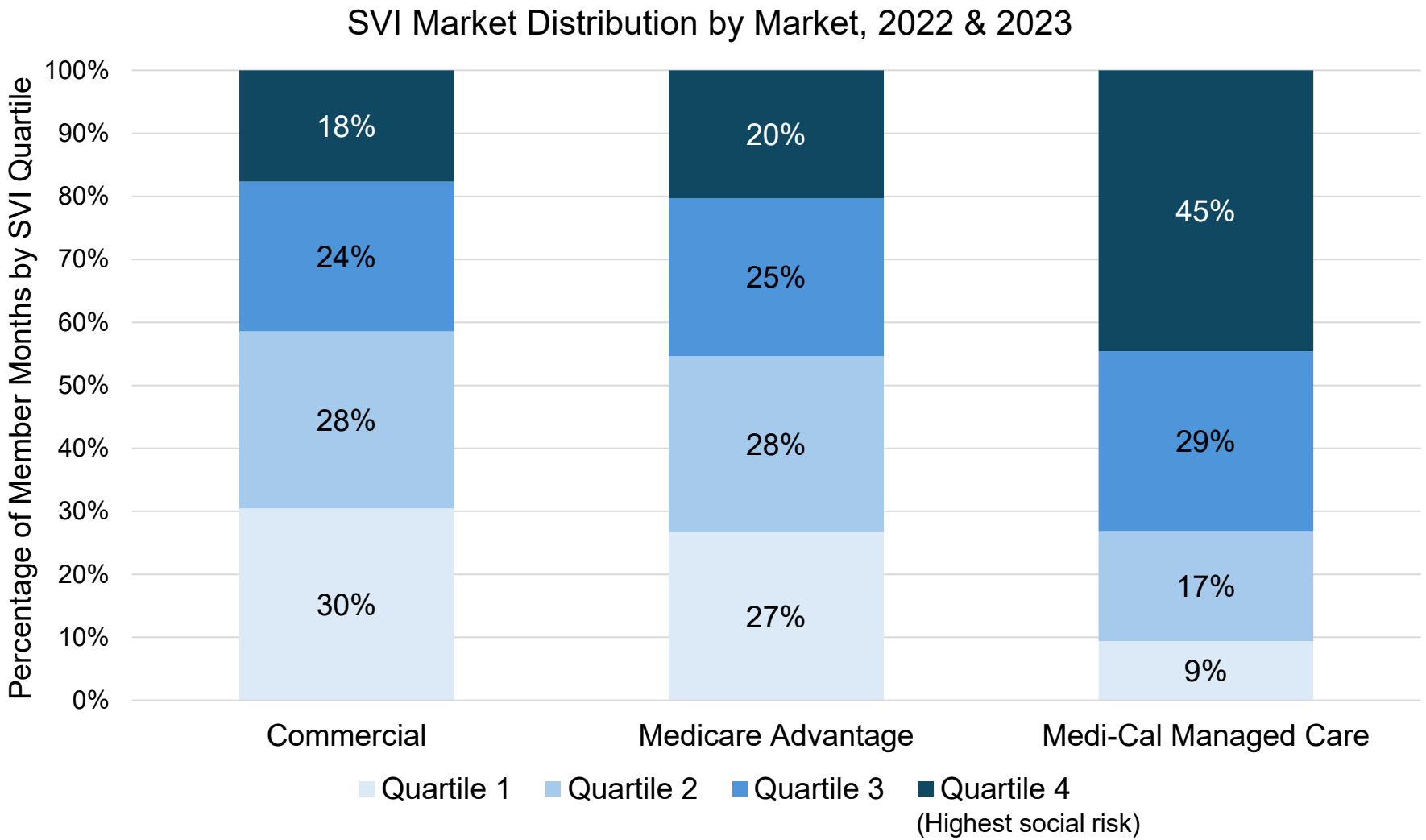


Place and Health- Geospatial Research, Analysis, and Services Program (GRASP), Social Vulnerability Index, https://www.atsdr.cdc.gov/place-health/php/svi/index.html

Key Findings

- Payers' distribution of members by Social Vulnerability Index (SVI) quartile is very stable and there is very little year over year change from 2018-2023.
  - The Commercial market has very little year-over-year variation in the percentage of members in SVI Quartile 4, whereas the Medicare Advantage and Medi-Cal Managed Care markets have slight year-over-year variation from 2018-2023.
- Commercial market members disproportionately have lower social risk than members in Medicare Advantage and Medi-Cal Managed Care markets.
- Medi-Cal Managed Care insures the largest percentage of members with higher social risk.
- In the Medicare Advantage market, members are almost evenly distributed across quartiles.

SVI Scores by Market



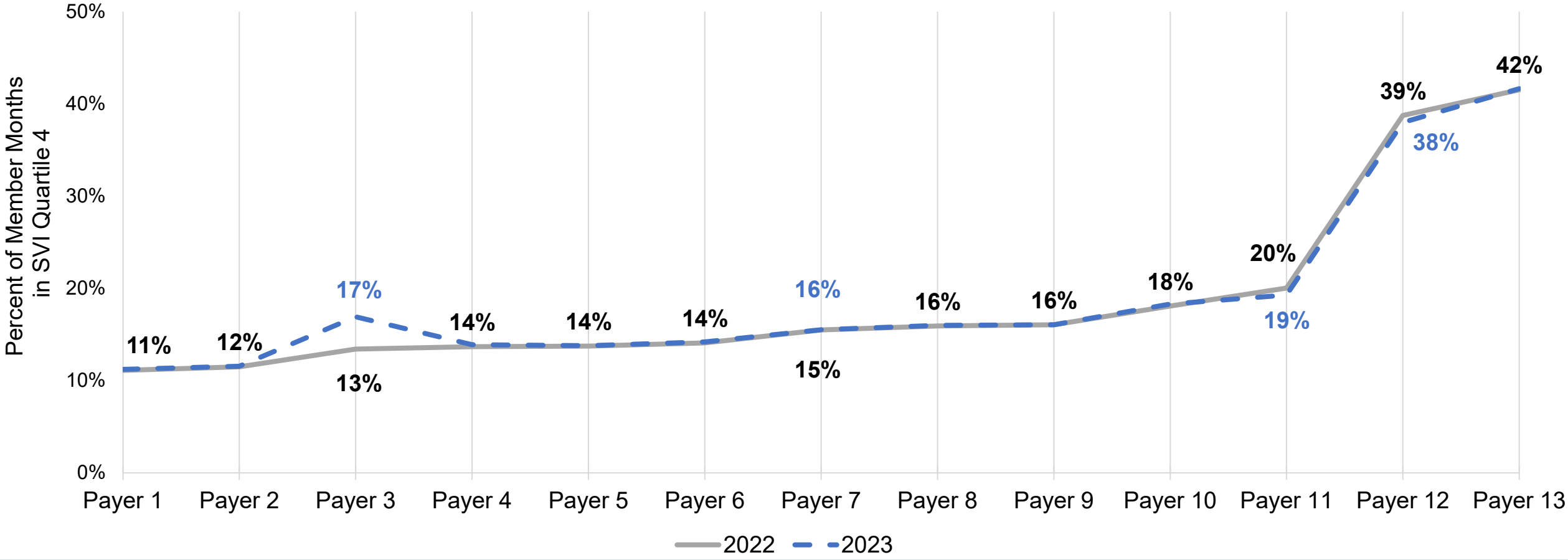
Note: Data from all 2022 and 2023 and all payers were combined to form the pooled dataset.

- Overall patterns within market categories are also observed at the individual payer-level.
- SVI score distribution remains relatively stable in all markets from 2018-2023.
- The Commercial market SVI score distribution skews towards lower social risk compared to other markets.
- The Medicare Advantage SVI scores are fairly evenly distributed across quartiles.
- The Medi-Cal Managed Care market enrolls members with higher social risk.

Note: SVI Quartile 4 represents members with the highest social risk.

Percentage of Commercial Members with the Highest Social Risk (SVI Quartile 4), 2022 and 2023

- Little variation for each payer's percentage of members with the highest social risk (SVI Quartile 4) from 2022-2023.
- Aside from two payers, the remaining 11 payers have only 11% to 20% of members with the highest social risk (SVI Quartile 4) in 2023.

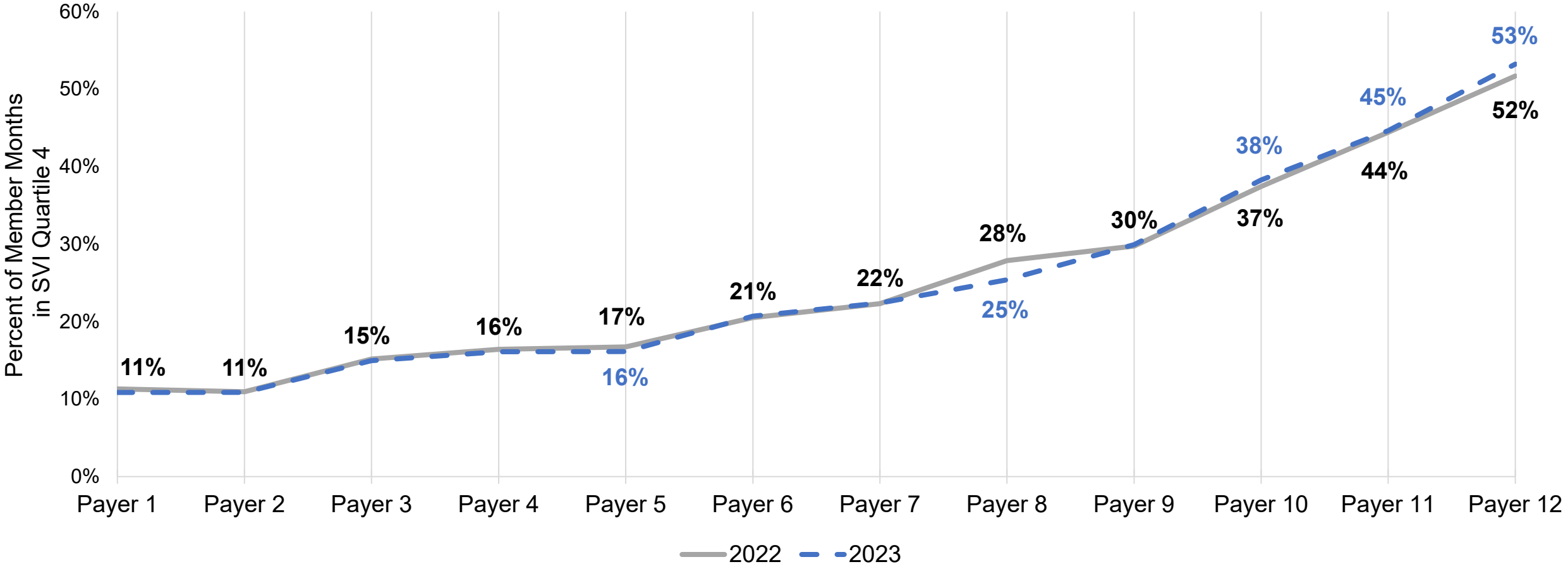


Additional years of data in Chart 1 in the Appendix

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

Percentage of Medicare Advantage Members with the Highest Social Risk (SVI Quartile 4), 2022 and 2023

- Little variation for each payer's percentage of members with the highest social risk (SVI Quartile 4) from 2022-2023.
- The percentage of payer's members with the highest social risk (SVI Quartile 4) range from 11% to 53% in 2023.

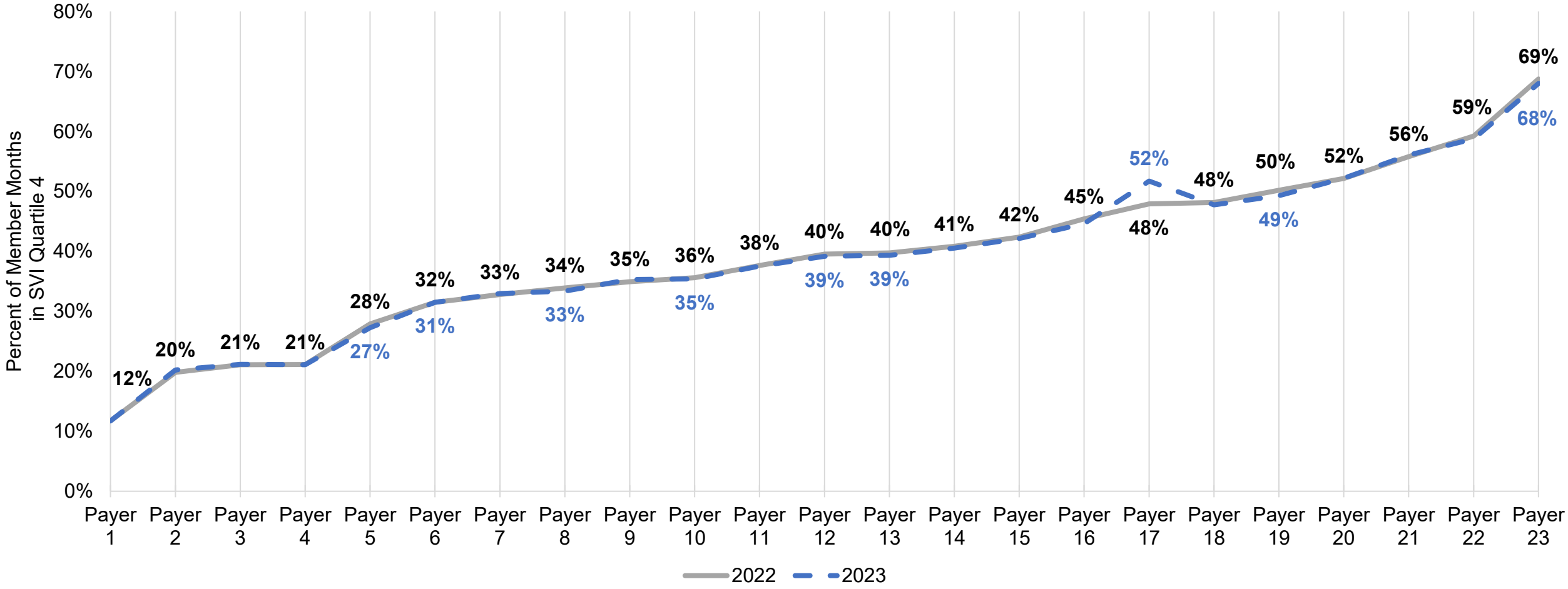


Additional years of data in Chart 2 in the Appendix

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

Percentage of Medi-Cal Managed Care Members with the Highest Social Risk (SVI Quartile 4), 2022 and 2023

- Little variation for each payer's percentage of members with the highest social risk (SVI Quartile 4) from 2022-2023.
- Greatest variation of payer's percentage of members with the highest social risk (SVI Quartile 4) in 2023.



Additional years of data in Chart 3 in the Appendix

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

Proposed Equity Adjustment Recommendation for Payers

Proposed Equity Adjustment Recommendation and Rationale

Our proposed recommendation is not applying an equity adjustment to payers' performance against spending targets.

Key rationale themes:

- OHCA's analysis of social risk does not indicate that payers are seeing year-over-year variation in social risk trends.
- The relationship between social risk and cost is inconclusive.
- Administrative burden and cost may outweigh the benefits and value of an equity adjustment.

Year-Over-Year Social Risk Trends are Stable

- Since the spending targets measure year-over-year Total Medical Expense (TME) per member, OHCA assessed year-over-year social risk trends using the Social Vulnerability Index (SVI) and Health Care Payments Data (HPD) Program data.
- This analysis showed that while social risk distribution varies between payers, there is little year-over-year change for each payer from 2018 to 2023.
  - Markets' and payers' social risk distribution remain very stable from year to year.
- The stability of payers' social risk mix suggests that changes in members' social risk profiles are not driving annual per capita spending increases, and therefore an equity adjustment might not be needed.
  - Given the stability of members' social risk, an equity adjustment based on member social risk may have minimal impact on the payer's performance against the spending targets.

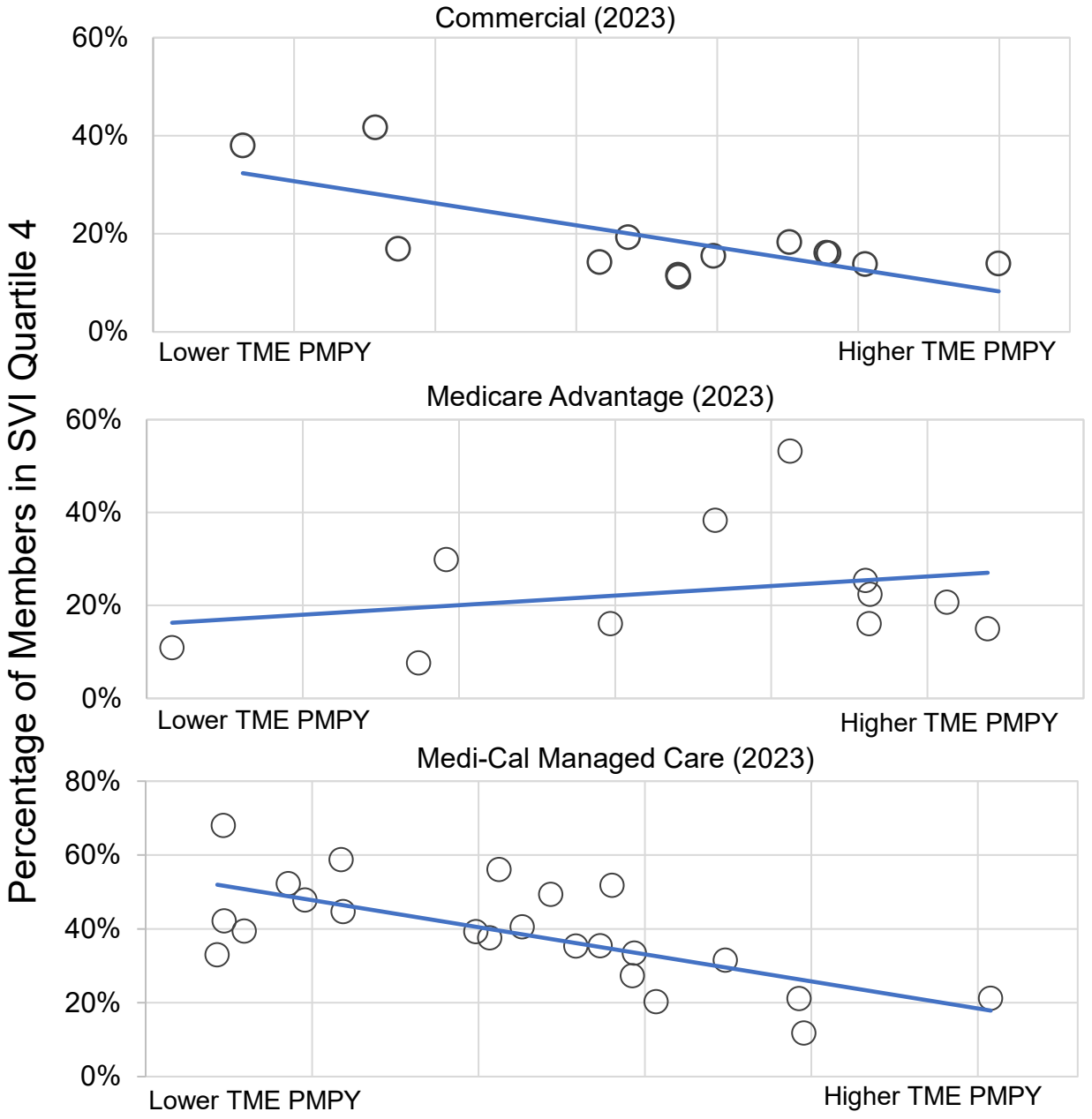
Relationship Between Social Risk and Cost is Inconclusive

- While there is social risk data available through the SVI and other sources, the relationship between social risk and cost is inconclusive.
  - A cohort study of members with complex medical comorbidity found that social risks were associated with higher odds of inpatient admissions, emergency department visits, and mental health visits during a 1-year period. This could indicate that members with social risks have greater health care spending.
  - Conversely, lower health care spending could be attributed to certain populations skipping needed care due to cost or access challenges. In 2025, 70% of Californians with low incomes (under 200% of the federal poverty level) reported skipping or delaying care due to cost.
  - Standardized social risk data collection at the clinical level remains limited, with gaps driven by insufficient training and support for providers to ensure data privacy, ethical use of data to avoid unintended consequences, and patient trust when collecting social risk information.
  - Research continues to emphasize the need to better understand the interaction between social risk and cost.
- OHCA's spending targets are centered on median household income and advance health equity by focusing on a metric that directly reflects what consumers can afford.
  - The impact of incentivizing additional spending, particularly for members with the highest social risk, is unknown.
- OHCA cannot guarantee that additional spending growth allowed through an equity adjustment would address social risk.

1. Tucher, E. L., Steele, A. L., Uratsu, C. S., McCloskey, J. K., & Grant, R. W. (2024). Social Risks and Health Care Use in Medically Complex Patients. *JAMA network open*, *7*(9), e2435199. https://doi.org/10.1001/jamanetworkopen.2024.35199 2. Flaherty, G., & Kanneganti, D. (2022, April 13). Ensuring Health Care Cost Growth Targets Promote Health Equity. *The Milbank Quarterly*. https://www.milbank.org/2022/04/ensuring-health-care-cost-growth-targets-promote-health-equity/#top. 3. The 2026 CHCF California Health Policy Survey. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2026/02/CHCFHealthPolicySurvey2026.pdf. 4. Chen, A.M. Barriers to health equity in the United States of America: can they be overcome?. Int J Equity Health 24, 39 (2025). https://doi.org/10.1186/s12939-025-02401-w 5. Dworkin, P., Boynton-Jarrett, R., & Garg, A. (2016). Avoiding the Unintended Consequences of Screening for Social Determinants of Health. JAMA, 316(8), 813–814. https://doi.org/10.1001/jama.2016.9282

Correlation Between Payer-Level Percentage of Members in SVI Quartile 4 and Total Medical Expense Per Member Per Year

Payer-level analysis shows a negative correlation between the percentage of members in SVI Quartile 4 and Total Medical Expense (TME) per member per year (PMPY) in Commercial (-0.72) and Medi-Cal Managed Care (-0.69) markets, while Medicare Advantage shows a positive correlation (0.26).



Analysis used an unweighted Pearson's correlations for 13 Commercial payers, 23 Medi-Cal Managed Care payers, and 11 Medicare Advantage payers.

Administrative Burden and Cost May Outweigh Benefits and Value

- The administrative burden and cost of implementing an equity adjustment for both payers and OHCA may outweigh the benefits and value.
- Administrative burden and cost of implementing an equity adjustment:
  - To implement an equity adjustment, payers may be required to submit additional data to assess the distribution of their members' social risk.

    For example, OHCA may need additional member address data from payers.
  - Payers would be required to engage with OHCA on additional data validation.
  - An equity adjustment would be resource intensive to ensure data completeness and accuracy and conduct detailed analysis.
- Benefits and value of implementing an equity adjustment:
  - The benefits to affordability are unclear. The effects of incentivizing additional spending, particularly for members with the highest social risk, is unknown.
  - In addition, the value is not compelling since social risk trends are stable and the relationship between social risk and cost is inconclusive.

Continue to Monitor Health Equity and Evaluate Social Risk in Enforcement

- In the absence of meaningful changes in social risk profiles and because the relationship between social risk and cost is inconclusive, implementing an equity adjustment for all payers may not be necessary at this time.
  - Continued monitoring may be more appropriate.
- OHCA would still assess if a payer met the spending target using unadjusted data but could consider evaluating changes in social risk when determining if a payer proceeds in the enforcement process.
- The enforcement process would give entities an opportunity to explain with supporting evidence how increases in members with the highest social risk and/or a disproportionate number of members with the highest social risk impacted excess spending growth.
- OHCA cannot validate the relationship between social risk and excess spending growth based on data we already collect. We may need to ask for more data during the enforcement process.
  - Changes in social risk may not appear in claims or non-claims data.

Recap of Advisory Committee and Public Comment Feedback

- Advisory Committee (AC) members expressed support for the recommendation.
- Some AC members discussed current social risk data limitations, including concerns about unintended consequences of demographic data collection, SDOH index biases, and the need to understand how SDOH, illness severity, and cost interact.
- Some AC members proposed additional analyses:
  - One AC member suggested conducting a pilot with one region to track changes in SDOH over time.
  - Some AC members recommended separating Covered California from the broader Commercial market to better understand population difference and variation in social risk.
- Some AC members cautioned against moving forward before completing analyses of social risk for physician organizations and hospitals.
- One AC member noted that stability in SVI quartiles does not mean community health needs are stable and that lack of change in the data should not be interpreted as lack of need for support.
- During public comment, one commenter supported the recommendation and encouraged unmasking payer names at future Board meetings, suggested including payer enrollment data, and proposed that assessing performance by markets could be the equity adjustment.

Summary of Proposed Equity Adjustment Recommendation

Our proposed recommendation is not applying an equity adjustment to payers' performance against spending targets.

Our proposed approach is to evaluate changes in social risk for payers through the enforcement considerations process.

Next Steps

- Over time, OHCA will continue to assess an equity adjustment's suitability for improving health equity.
  - We will monitor and assess new equity adjustment methodologies used by other programs.
  - OHCA will explore opportunities or emphasize the need for additional research into the inter-connected relationship between equity, quality, and cost.
- Assess whether and how to develop an equity adjustment for physician organizations and hospitals.
  - Based on the analysis of SVI and HPD data for payers, we hypothesize an analysis for hospitals and physician organizations will show similar results – that there is little year over year variation in the distribution of members by SVI quartile for hospitals and physician organizations.
  - OHCA will conduct more literature research and engage expert consultants about an equity adjustment for physician organizations and hospitals.

Discussion: Introduction to Equity Adjustment to Spending Targets

Does the Board have any questions about the assessment of social risk distribution among payers?

Does the Board have input on OHCA's proposed recommendation for the equity adjustment to the spending targets?

Proposed Quality Adjustment Recommendation

Quality Adjustment

Statutory Requirements

- The methodology for the spending target shall:
  - Allow the Board to **adjust targets downward**, when warranted, for health care entities that deliver **high-cost care that is not commensurate with improvements in quality.**
  - Allow the Board to **adjust targets upward**, when warranted, for health care entities that deliver **low-cost, high-quality care**.
- Data sources on cost and quality performance of health care entities may include, but are not limited to, all of the following:
  - Cost and quality performance data reported by or sourced from recognized quality improvement and transparency initiatives.
  - Any other relevant supplemental data, such as financial data on health care entities, submitted to state agencies, and data on costs, payments, and quality from the Health Care Payments Data Program.
  - Any relevant federal, state, or local data.

Proposed Quality Adjustment Recommendation and Rationale Themes

Our proposed recommendation is to wait to apply a quality adjustment to the spending targets.

- Our proposed recommendation applies to entities that deliver high-cost care not commensurate with improvements in quality and entities that deliver low-cost, high-quality care.
- OHCA will continue to monitor health care cost and quality data and reassess quality adjustment factors in at least 2 years.

Key rationale themes:

- Research, data, and analyses demonstrate that there is minimal to no link between health care cost and quality.
- Wait until OHCA has several years of experience analyzing total medical expense (TME) and quality performance data.
- Sibling departments are still implementing their quality performance programs.

Minimal to No Link Between Cost and Quality

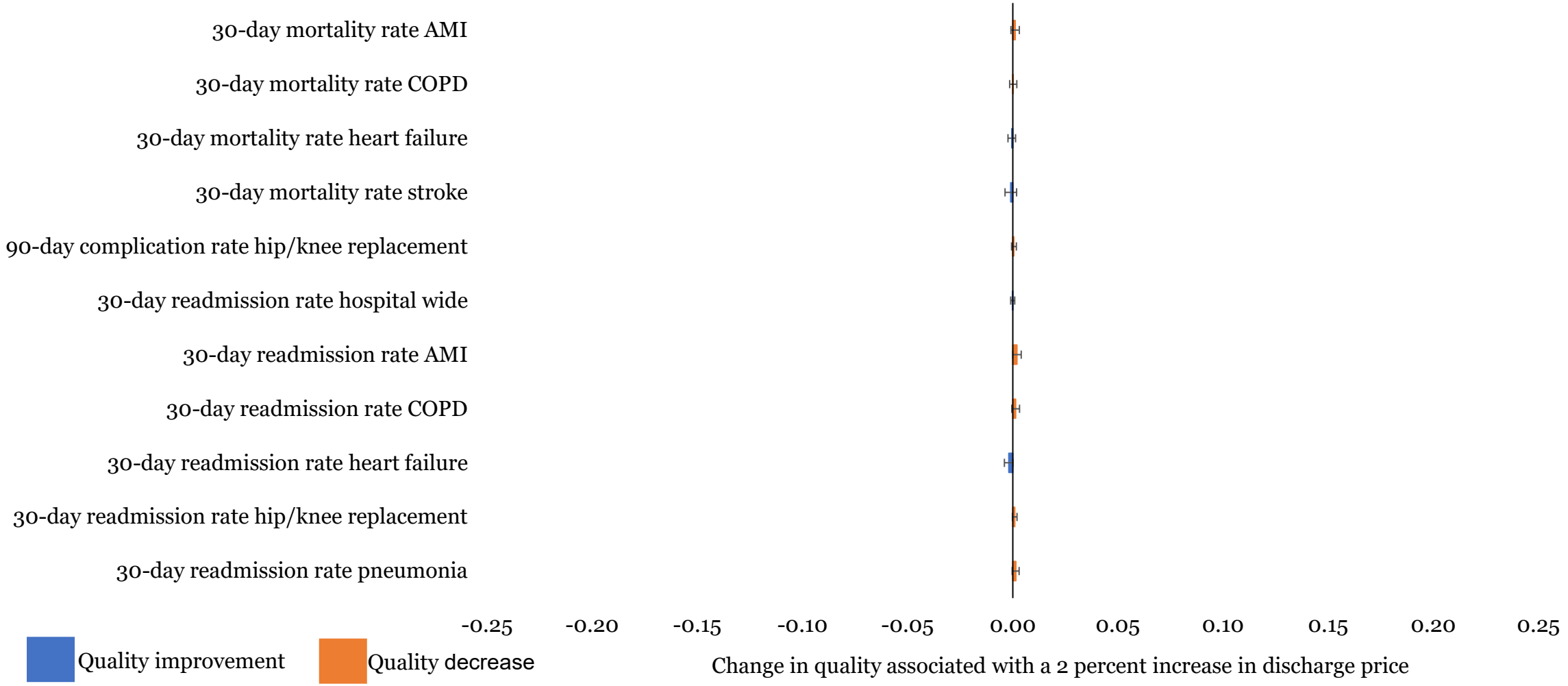
A systematic review of published literature, for studies that examined the association between quality and cost or spending measures, showed evidence that the direction of association between health care cost and quality is inconsistent. Most studies have found that the association between cost and quality is small to moderate, regardless of whether the direction is positive or negative. (Hussey et al., 2013)

Below is research showing there is minimal to no link between cost and quality for hospitals:

- For hospitals, cost might be associated with better outcomes in competitive markets but not in concentrated markets. Implying that prices might reflect market power and not superior quality. (Jamalabadi et al., 2020) (Cooper et al., 2022)
- In the August 2024 Board meeting, Christopher Whaley presented key findings from his examination of hospital prices. Two key findings are:
  - Hospital price increases don't lead to quality improvements.
  - Variation in California hospital prices is not linked to CMS quality stars.

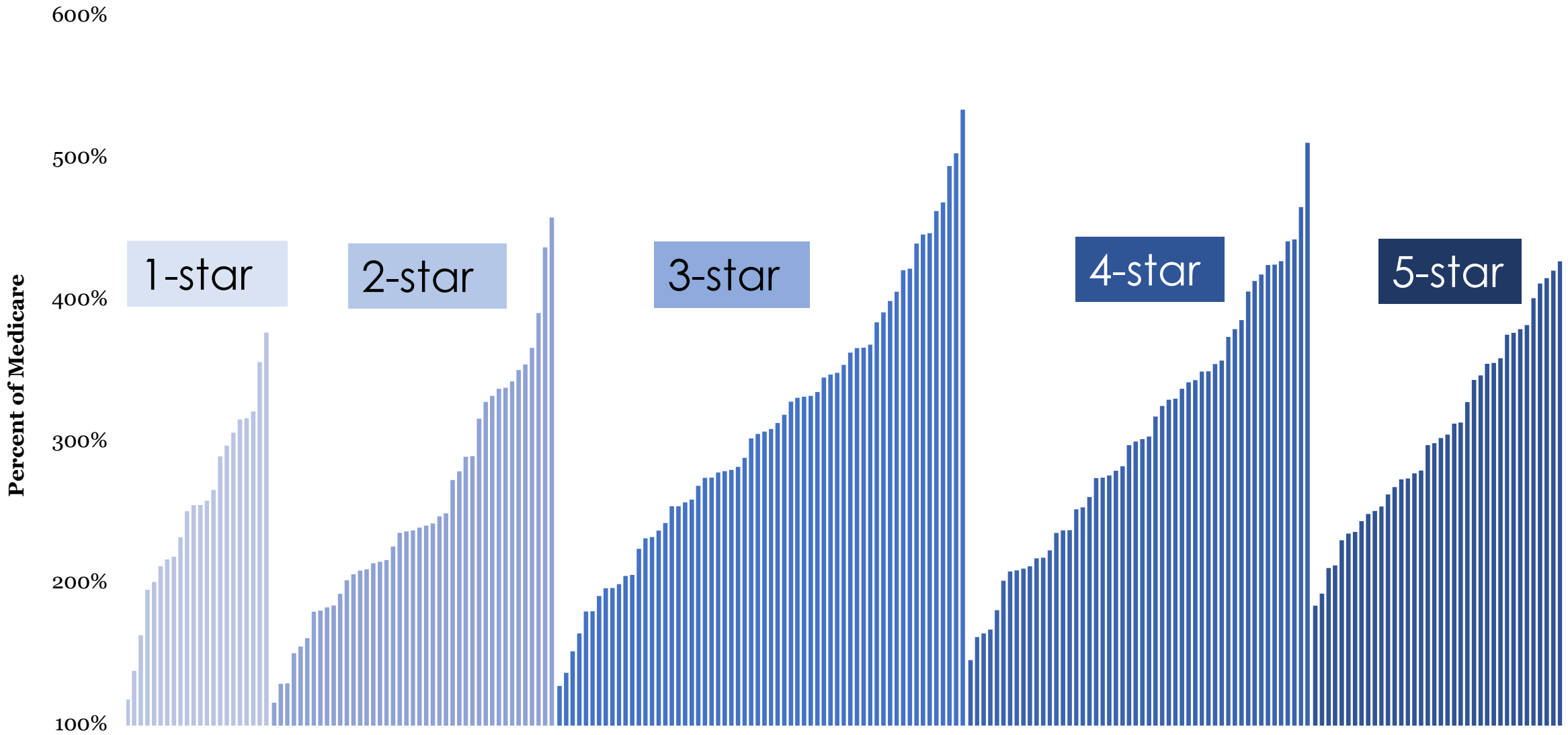
Hussey, P., Wertheimer, S., & Mehrotra, A. (2013). The association between health care quality and cost: a systematic review. *Annals of Internal Medicine*, 158(1), 27-34. https://doi.org/10.7326/0003-4819-158-1-201301010-00006; August 2024 Board Meeting Slides; Jamalabadi, S., Winter, V., & Schreyögg, J. (2020). A Systematic Review of the Association Between Hospital Cost/price and the Quality of Care. *Applied Health Economics and Health Policy*, 18(5):625-39. https://doi.org/10.1007/s40258-020-00577-6; Cooper, Z., Doyle J., Jr., Graves, J., & Gruber, J,. (2022). Do Higher-Priced Hospitals Deliver Higher-Quality Care?. Journal of Political Economy, NBER Working Paper 29809. https://doi.org/10.3386/w29809.

Hospital price increases don't lead to clinical quality improvements



Crespin and Whaley. 2022. "The Effect of Hospital Discharge Price Increases on Publicly Reported Measures of Quality." *Health Services Research*.

5x variation in California hospital prices is not linked to CMS quality stars



Analysis of Prices Paid to Hospitals by Private Health Plans data. Whaley et al. 2024

Minimal to No Link Between Cost and Quality

Quality and cost data and analyses indicate that there is minimal to no link between cost and quality for payers and physician organizations:

- Higher-cost care does not necessarily mean higher-quality care.
- The Integrated Healthcare Association's Cost & Quality Atlas showed variation in payer cost and quality, particularly by product type (HMO and PPO) and financial risk sharing.
  - Atlas analysis shows better quality and lower costs associated with HMOs and ACOs compared to PPOs.
- From the Office of the Patient Advocate Health Care Quality Report Cards, some physician organizations deliver high-quality, lower-cost care, while others deliver high-quality, higher-cost care.

Integrated Healthcare Association. (n.d.). Cost & Quality Atlas. https://www.iha.org/performance-measurement/cost-quality-atlas/; OPA. (2024). Health Care Quality Report Cards. https://www.cdii.ca.gov/consumer-reports/health-care-quality-report-cards/

OHCA TME and Quality Performance Data

- OHCA can consider a quality adjustment after several years of experience analyzing OHCA TME and quality performance data.
- It would be premature to use the OHCA TME and OHCA Quality and Equity Measure Set data to evaluate when a quality adjustment is warranted.
- OHCA TME data collection is in its 2nd year.
- OHCA will publish its first report with OHCA Quality and Equity Measure Set data in 2027.
  - It will take time to analyze the data and develop an approach to potentially use in a quality adjustment.

Sibling Departments Are Still Implementing Their Quality Performance Programs

- OHCA would like to align with sibling department programs for assessing and benchmarking quality performance.
- The Department of Managed Health Care (DMHC) plans to release its first report with Health Equity and Quality Measure Set (HEQMS) data in 2026.
  - The DMHC has until January 1, 2027, to promulgate regulations codifying the measures and benchmarks.
- HCAI released its first Hospital Equity Measures (HEM) reports in April 2026.
  - The current statute gives HCAI limited enforcement authority. The Health Equity Measures Advisory Committee is required to make recommendations to HCAI to revise the HEM reports and statute by September 2027.
  - HCAI is continuing to analyze the data in the HEM reports to identify and implement data collection improvements.

DMHC Licensing eFiling. (2023, December 27). *APL 23-029 – Health Equity and Quality Measure Set Benchmark*. https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL23-029-HealthEquityandQualityMeasureSetBenchmark(12.27.23).pdf; Health and Safety Code § § 127370-127376

Recap of Advisory Committee (AC) Meeting Feedback on the Quality Adjustment Proposed Recommendation

- The proposed recommendation was to **not apply** a quality adjustment to the spending targets.
- Several AC members expressed support for the prior recommendation.
- Some AC members requested that we recognize entities that are high-quality.
- An AC member recommended that quality performance be considered in the enforcement process.
- During public comment, an individual supported the recommendation and noted the statute language states that a quality adjustment may be done.

Summary of Proposed Quality Adjustment Recommendation

Our proposed recommendation to wait apply a quality adjustment to the spending targets.

- Our proposed recommendation applies to entities that deliver high-cost care not commensurate with improvements in quality and entities that deliver low-cost, high-quality care.

Next Steps:

- Continue to monitor cost and quality data and reassess quality adjustment factors in at least 2 years.
- Monitor how sibling departments are assessing and benchmarking quality performance.
- Provide an update to the Advisory Committee on this recommendation.

Discussion: Introduction to Quality Adjustment to Spending Targets

Does the Board have input on OHCA's proposed recommendation for the quality adjustment to the spending targets?

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

Public Comment

HCAi
Department of Health Care Access and Information

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

Spending Target Enforcement: Continued Spending Target Penalty Discussion

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

HCAI
Department of Health Care Access and Information

Review: Spending Target Penalties

- At the April 2026 Health Care Affordability Board meeting, OHCA began conversations on spending target penalties.
- At the August 2026 meeting, the Board may vote to approve the scope, range, and justification factors for penalties.
- Spending target penalties would be assessed when an entity fails to meet the spending target and has not complied with an approved performance improvement plan (PIP).
- The spending target penalty should:
  - Provide an incentive to implement the PIP and come into compliance with the target.
  - Per statute, be initially commensurate with an entity's failure to meet its applicable target and be adjusted after consideration of penalty justification factors.

Review: Spending Target Penalties

OHCA recommended the following approach to calculating spending target penalties.

Step 1: Initially Commensurate

- Calculate penalties that are initially commensurate with the degree to which the entity exceeded the spending target.
- "Initially Commensurate" is the difference between an entity's actual spending growth and what the growth would have been had the entity met the target.
- If 2023 were an enforceable year, "initially commensurate" penalties would have ranged from $4M - $350M.

Step 2: Penalty Justification Factors

- Consider a variety of penalty justification factors that could result in an increased or decreased final penalty amount.
- Penalty justification factors listed in statute include nature, number, and gravity of offenses, the fiscal condition and market impact of the entity.
- Other potential adjustment factors include input from other state agencies, other factors approved by the Board, and escalating amounts for repeated failure to meet targets.

Spending Target Penalties

Questions for today's discussion:

1. What year(s) would OHCA assess a penalty when an entity fails to implement their PIP and fails to come into compliance with their applicable spending target?
2. What should the penalty justification factors include?

Future Discussion Items

OHCA will return to the Board in June about the following questions:

1. What should be the range of spending target penalties? (i.e., the maximum and minimum)?
2. What should be the penalties for violations described under 127502.5(h)(1)?
3. Can OHCA assess penalties if an entity does not meet their mid-PIP milestones?
4. Summary of OHCA's recommendation for penalties' scope, range, and justification factors for Board discussion before August 2026 vote.

Spending Target Penalties

What year(s) would OHCA assess a penalty when an entity fails to implement their PIP and fails to come into compliance with their applicable spending target?

OHCA would assess a penalty against the performance year that prompted enforcement.

- Entities could be required to implement a PIP for each year of noncompliance with the spending target. Entities could implement multiple PIPs simultaneously.
- This approach ensures that OHCA could assess penalties as part of progressive enforcement for each year an entity exceeds the target.
- At the end of a PIP, OHCA would determine whether the entity came into compliance with its applicable target.

OHCA will enforce each performance year individually

	2026	2027	2028	2029	2030	2031	2032
2025-2026	Exceeds Target	Data Reported in September	**PIP Development January-June** **~2.5 Year PIP Begins in July**	**PIP Implementation**	**PIP Ends ~December** **Entity noncompliant with PIP *AND* does not meet Target**	**Penalty Assessed Against 2026 Spending Year (Fall/Winter)**	
2026-2027	Exceeds Target	Data Reported in September	**PIP Development January-June** **~1.5 Year PIP Begins in July**	**PIP Ends ~December** **Entity noncompliant with PIP *AND* does not meet Target**	**Penalty Assessed Against 2027 Spending Year (Fall/Winter)**		
2027-2028	Exceeds Target	Data Reported in September	**PIP Development January-June** **~1.5 Year PIP Begins in July**	**PIP Ends ~December** **Entity noncompliant with PIP *AND* does not meet Target**	**Penalty Assessed Against 2028 Spending Year (Fall/Winter)**		

Penalty Justification Factors

What should the penalty justification factors include?

The statute describes the penalty justification factors outlined below.

OHCA does not recommend additional penalty justification factors at this time.

127502.5.(d)(6) The director shall consider all of the following to determine the penalty:

A. The nature, number, and gravity of the offenses.

B. The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity.

C. The market impact of the entity.

Penalty Justification Factors

Penalty Justification Factor	Non-exhaustive potential examples of what each factor could include on a case-by-case basis
The nature, number, and gravity of the offenses.	• Excess growth beyond the state average or that was an extreme outlier • Conduct that resulted in harm to public, patients, access to care, affordability, market competition, etc. • A history of exceeding the target • Excess growth due to investments in primary care
The fiscal condition of the health care entity…	• Bankruptcies or other legal proceedings • Whether the proposed penalty negatively impacts the entity's financial standing with other state and federal regulators • If the entity's revenue, profit, assets, etc. significantly increased, especially in comparison with other years, while exceeding the target
The market impact of the entity.	• If the entity's share of total covered lives statewide is significant or greater than the average • The entity's impact on spending in its county or Covered California region • If the entity plays a unique or essential role in providing care to underserved populations

Penalty Justification Factors

- Existing penalty justification factors listed in statute are broad enough to cover a wide variety of factors.
- Enforcement considerations are primarily used to determine whether an entity proceeds further in enforcement. In determining a penalty amount, “the nature, number, and gravity of the offenses” allows OHCA to consider relevant factors listed under enforcement considerations.
- The Board can add factors later, if the need arises.

Penalty Justification Factors

Should penalty justification factors be further defined?

OHCA recommends that the factors listed in statute do not require additional defining.

- OHCA should maintain broad language to avoid forcing a “one-size-fits-all” structure onto a diverse group of health care entities and diverse situations.
- Approaches to “market impact” were discussed at the April 2026 Board meeting. OHCA would consider various approaches to "market impact" that could increase or decrease a penalty amount, including but not limited to: an analysis of market power and comeptition, how the size of a penalty would positively impact a market by deterring future noncompliance, how the size of a penalty may negatively impact an entity’s participation in the market, and any spillover effects on the market.

Discussion: Penalty Years and Justification Factors

Does the Board have any initial feedback on:

Penalty justification factors would only be those listed in statute (§127502.5.(d)(6)) as listed below:

A. The nature, number, and gravity of the offenses.

B. The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity.

C. The market impact of the entity.

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Public Comment

HCAI

Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Cost and Market Impact Review: Introduction to Regulatory Text

Heather Hoganson, Assistant Chief Counsel

HCAI

Department of Health Care Access and Information

Revising CMIR Regulations Due to AB 1415

- Legislation added a new category of **Noticing Entities** required to submit material change notices (MCN) to OHCA for review:
    - Private Equity
    - Hedge Funds
    - Management Services Organizations
    - New entities created for the transaction
    - Entities that control a provider

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

Proposed CMIR Regulations

- **Defining noticing entities, MSOs, hedge funds, private equity**
- **Additions to Thresholds**
  - 22 CCR 97435 (b) describes the thresholds for health care entities, which currently reflect revenue and geographic parameters.
  - Adding noticing entity thresholds

- **Changes to OHCA's "(c) circumstances"**
  - 22 CCR 97435 (c) lists circumstances under which a transaction requires a filing.
  - Adding circumstances for private equity/hedge fund, MSOs, and real estate

Proposed CMIR Regulations

- **Updating Confidentiality Process**
  - Pulling out provisions from section 97438 into new 97437
  - Include CMIR process documents and third-party information

- **Revising Information for Public Notice**
  - Additional information for noticing entities
  - Adding quality assessments for current facilities
  - Adding post-transaction changes to real estate, collective bargaining

Proposed CMIR Regulations

- Adding a potential reason for Expedited Review (Urgent Situation)
- Adding financial risk due to real estate terms to a reason for CMIR
- Adding a remand procedure if new information might negate the reason to conduct a CMIR

Next Steps

- Informal Comment Period through Thursday, June 11, 2026
- Submission to OAL as an Emergency Regulation Package
- Update Submission Portal
- Update Website
  - Transaction Listing
  - FAQs

Updated 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.

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Public Comment

HCAI

Department of Health Care Access and Information

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

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.

HCAI
Department of Health Care Access and Information

Next Board Meeting:
June 24, 2026
10am

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

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Adjournment

HCAI

Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

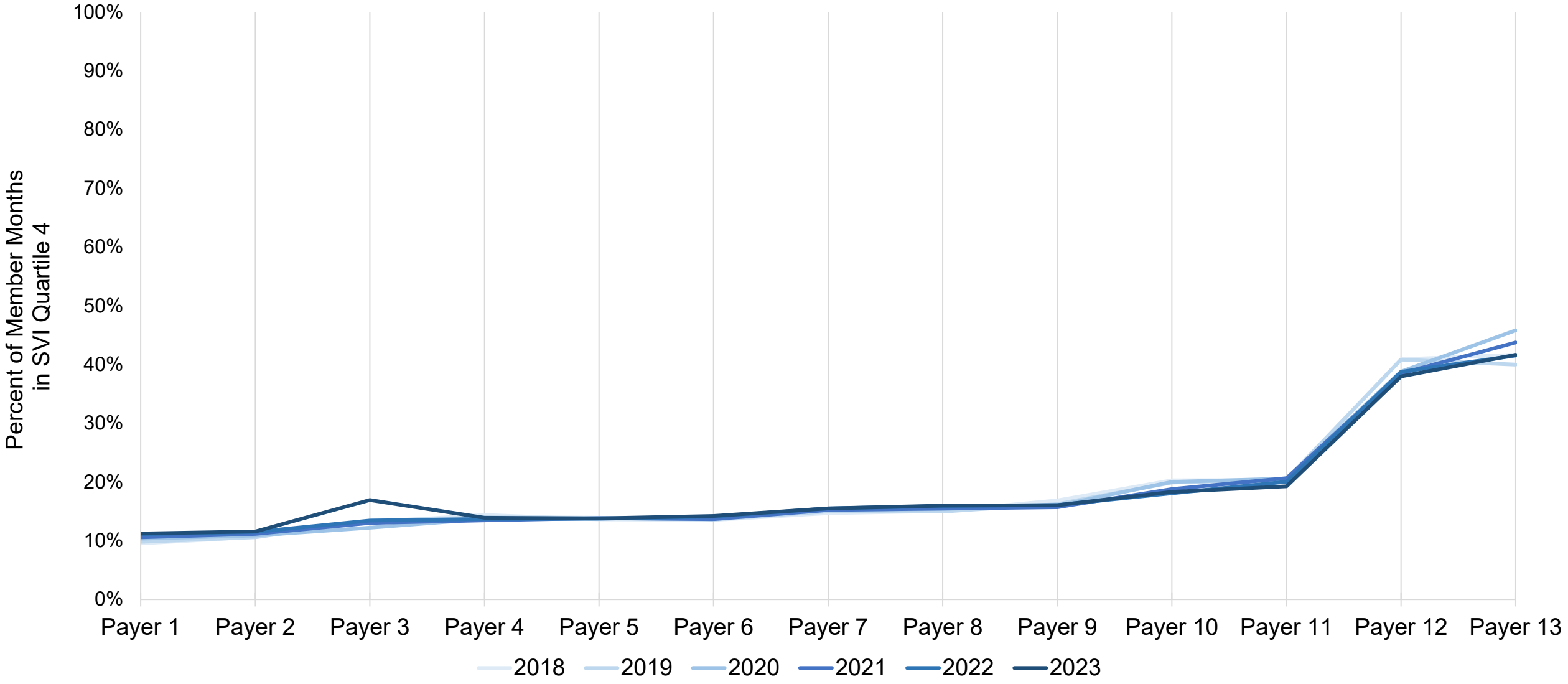
Appendix

HCAI

Department of Health Care Access and Information

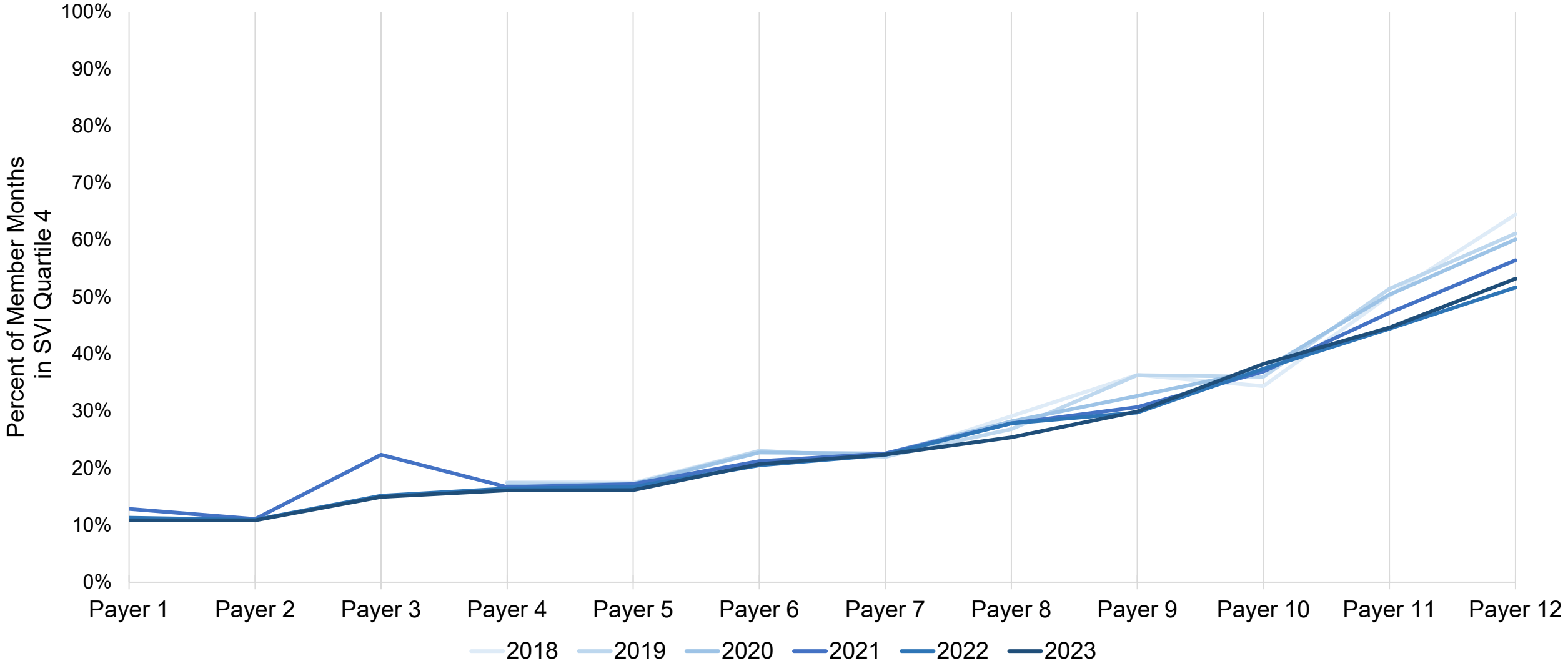
Assessment of Social Risk Distribution Among Payers

Chart 1: Percentage of Commercial Members with the Highest Social Risk (SVI Quartile 4), 2018-2023



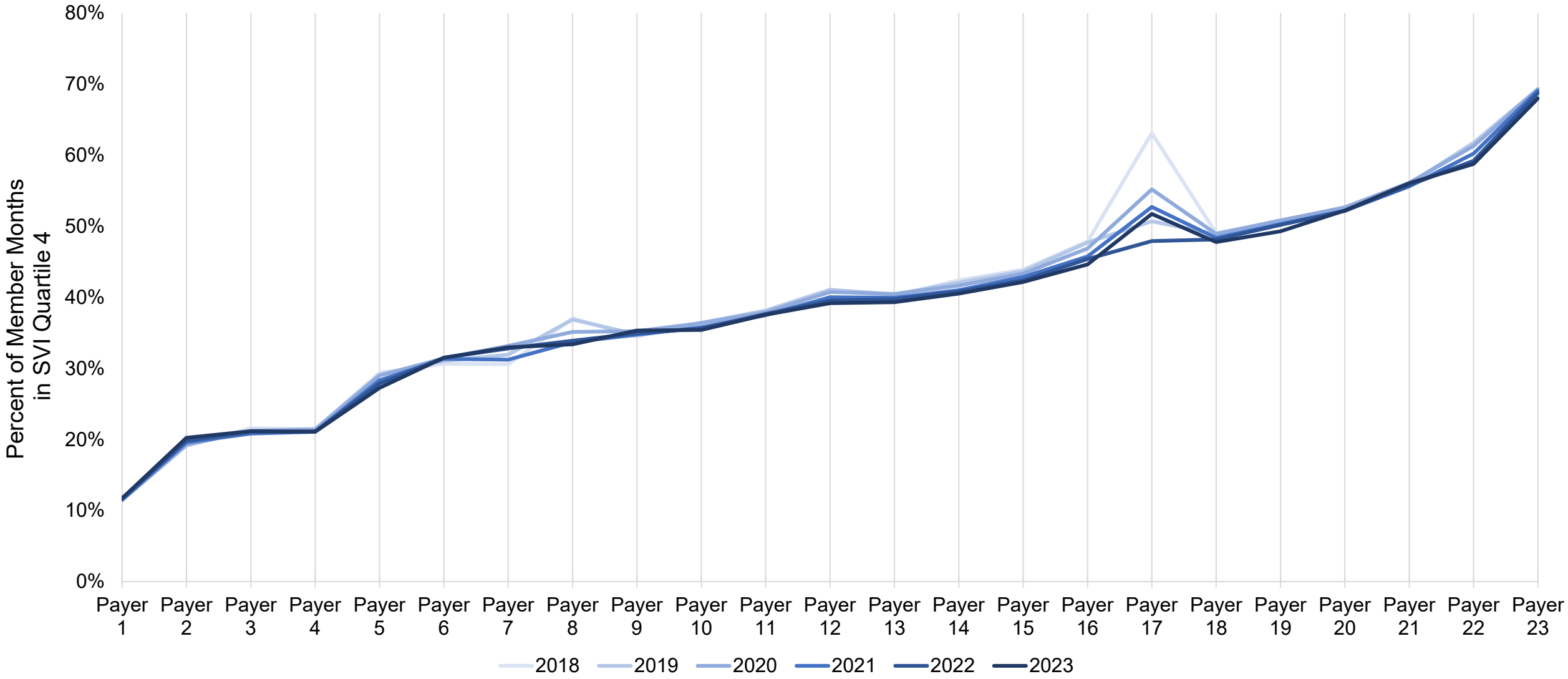
Only payers with data in the HPD for all 6 years are included.

Chart 2: Percentage of Medicare Advantage Members with the Highest Social Risk (SVI Quartile 4), 2018-2023



Some payers do not have data in the HPD for all 6 years.

Chart 3: Percentage of Medi-Cal Managed Care Members with the Highest Social Risk (SVI Quartile 4), 2018-2023



Only payers with data in the HPD for all 6 years are included.

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