OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Board Meeting

November 19, 2025

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Department of Health Care Access and Information

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Welcome, Call to Order, and Roll Call

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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 October 28, 2025 Meeting Minutes
Vishaal Pegany

Item #4 **Action Items**

a) Vote to Establish a Subcommittee for the Selection of Advisory Committee Member
Megan Brubaker, Engagement and Governance Group Manager

b) Vote to Approve Data Submission Enforcement – Penalty Scope and Range
Vishaal Pegany

Item #5 **Closed Session to be held in Conference Room 1238**

California Hospital Association vs. Office of Health Care Affordability, et al
Petition for Writ of Mandate, San Francisco Superior Court Case #CPF 25519370, pursuant to Gov. Code, § 11126, subd. (e).

Item #6 **Informational Items**

a) Monterey Hospital Market Competition Study
Sheila Tatayon, Assistant Deputy Director; Arnold Analytics, LLC – Daniel R. Arnold, PhD; Paul B. Ginsburg, PhD; Katherine L. Gudiksen, PhD

b) Introduction to DSG 3.0 Regulations, Including Update on Behavioral Health Definition and Summary of Public Comments and Advisory Committee Feedback
CJ Howard, Assistant Deputy Director; Margareta Brandt, Assistant Deputy Director; Debbie Lindes, Health Care Delivery System Group Manager

c) Update on Cost and Market Impact Review Program
Sheila Tatayon

Item #7 **General Public Comment**

Item #8 **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

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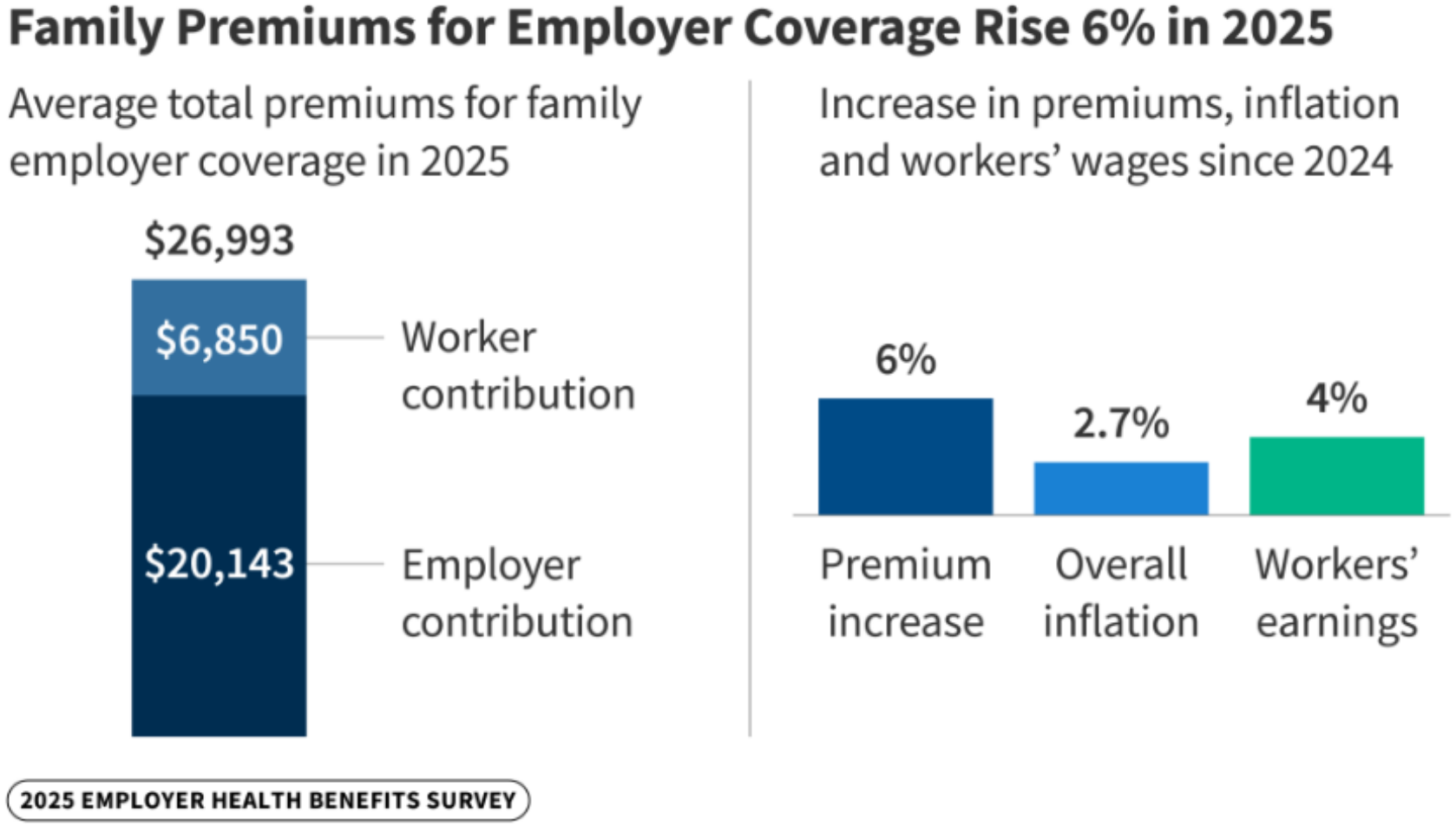
California's Rural Health Transformation Proposal

The CA-RHT program vision is a **connected, resilient rural health system** in which every rural and frontier Californian can access timely, person-centered primary, maternal, specialty, chronic condition, and behavioral health care close to home, **supported by a sustainable workforce, modern technology and data infrastructure**.

The program will develop regional coordination and partnerships, apply evidence-based care, deploy tools that work in low resource settings, and align sustainable payment to fund local readiness and health care services.

2025 Employer Health Benefits Survey

- Premiums for families with employer-sponsored health coverage reached an average of almost $27,000 in 2025.
- Over the last year, the average family premium increased by 6%. By comparison, wages grew 4 percent and overall inflation 2.7 percent.



Claxton, G., Rae, M., Winger, A., Wager, E. (2025, October 22). *2025 Employer Health Benefits Survey*. KFF. https://www.kff.org/health-costs/2025-employer-health-benefits-survey/

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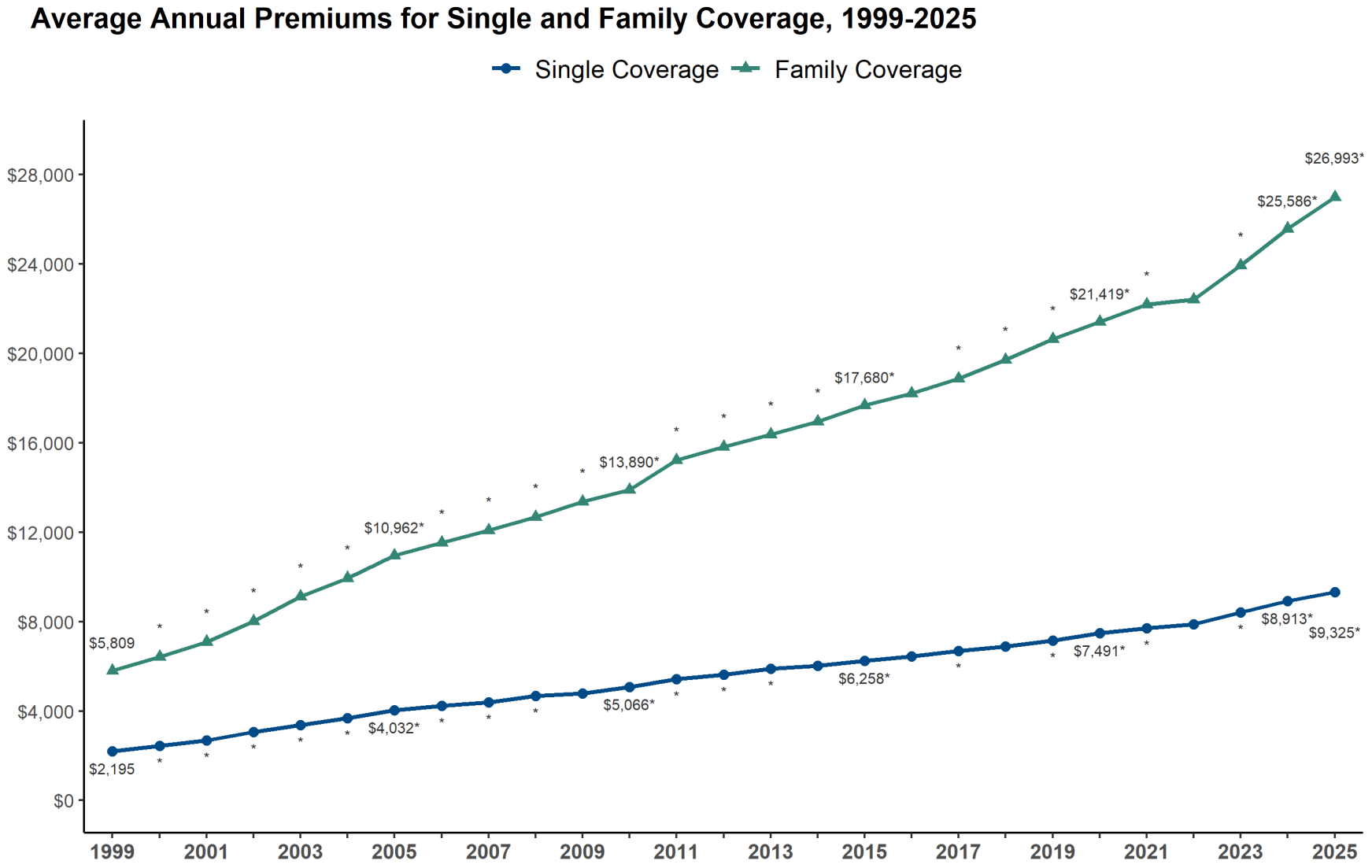
2025 Employer Health Benefits Survey

- Average annual premiums have increased over the past 26 years. Specific to the past five years:
  - Average single coverage increased 24%
  - Average family coverage increased 26%
  - Wages increased 28.6%
  - Inflation increased 23.5%



Claxton, G., Rae, M., Winger, A., Wager, E. (2025, October 22). *2025 Employer Health Benefits Survey*. KFF. https://www.kff.org/health-costs/2025-employer-health-benefits-survey/

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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Action Consent Item: Vote to Approve October 28, 2025 Meeting Minutes

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Action Item: Vote to Establish Subcommittee for Selection of Advisory Committee Members

Megan Brubaker, Engagement and Governance Group Manager

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Health Care Affordability Advisory Committee Solicitation

- OHCA recently reopened the Health Care Affordability Advisory Committee application submission process to fill one vacancy.

  Additional Information

  - Seeking individuals with a **health care payer perspective**.
  - Application deadline: November 30, 2025.
  - Term: January 1, 2026 – June 30, 2026. The selected member may apply for reappointment thereafter.

- The Office requests the Board to establish a standing subcommittee to provide recommendations on Advisory Committee selection for the next two years, including filling the current vacancy.

Advisory Committee Members – 28

Payers

Vacant

Manan Shah
Vice President & GM, Commercial Business, Elevance Health / Anthem Blue Cross of California

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

Hospitals

Barry Arbuckle
President & Chief Executive Officer, MemorialCare Health System

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

Travis Lakey
Chief Financial Officer, Mayers Memorial Hospital District

Medical Groups

Hector Flores
Medical Director, Family Care Specialists Medical Group

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

David S. 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 Director, Total Rewards, The Wonderful Company LLC

Iftikhar Hussain
Chief Financial Officer, San Francisco Health Service System

Health Care Workers

Stephanie Cline
Respiratory Therapist, Kaiser

Sarah Soroken
Mental Health Clinician, Solano County Mental Health

Cristina Rodriguez
Physician Assistant, Altura Centers for Health

Consumer Representatives & Advocates

Carolyn J 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

Motion – AC Selection Subcommittee

Motion to appoint two Board members to a standing subcommittee that will work with staff to provide recommendations on Advisory Committee selection for the next two years. This would include working with staff to fill vacancies and during the annual solicitation process for the next two years.

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Action Item: Vote to Approve Data Submission Enforcement - Penalty Scope and Range

Vishaal Pegany, Deputy Director

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Board Feedback

- Multiple board members raised concerns that the penalties are too low to incent compliance.
- A member recommended increasing the Failure to Submit Data penalty in the months following December 1, rather than waiting a full year. Another member suggested doubling the penalty amount every three months after December 1.
- A member noted the lack of compliance with federal transparency reporting requirements and that many entities did not respond until the penalty became so problematic that executives noticed. This serves as an example for OHCA.

Board Feedback

- A member commented that a consequential upfront penalty and then going before an administrative law judge would incentivize timely data submission.
- A member requested the Office double check the penalty amount as a percentage of a plan's annual net profit numbers.
  - The Office confirmed the data is correct and notes the $5 is per member, not per member per month.
- A member requested a better understanding of the Department of Managed Health Care's experience with administrative actions, including what it means in practice to enforce the law through an administrative law judge.

Advisory Committee Feedback

- Members expressed concern that the proposed penalty structure will not motivate health care entities to timely submit data and larger entities would potentially view the penalties as inconsequential and simply the “cost of doing business.”
- A member suggested that instead of the two $10K penalties for the untimely submission of data, increasing the penalty amount to $10k, $50k, $100k, or $250K based on a small, medium, or large entity size. This could encourage entities to submit their data closer to the deadline.
- A member appreciated that the fines multiplying each year makes it so expensive for submitters that they have to comply. This reduces the incentive for submitters to skip a certain bad year because the fines would continue to multiply.
- A member commented that having public testimony to explain the reasons for noncompliance is valuable.

Written Public Comment

- A commenter requested a corrective action plan process before imposing penalties, increasing the data resubmission window, and exercising penalty discretion when entities demonstrate good-faith efforts to comply.
- A commenter recommended having the penalty reflect the financial condition and size of the entity. In addition, a per member per year penalty for health plans and insurers, with similar scaling to size for other entities; escalating penalties month by month from December until July or August of the reporting period and then year by year until, in year 3, making the penalty commensurate with the incentive to avoid data submission.

Note: Written public comment submitted and summarized after the August Health Care Affordability Board meeting.

Verbal Public Comment

- A commenter stated the penalty proposal will not induce future data submission compliance, especially when a spending target enforcement penalty could be hundreds of millions of dollars in comparison to a small data submission penalty. They also recommended placing the penalty in the context of an entity's national revenues, which range from $100B to $300B, and stated that some large entities routinely ignore California law.
- A commenter expressed concern that the penalty proposal will not motivate entities to timely submit data and recommended proportionate and escalating penalties scaled to an entity's size to ensure the penalty is a legal obligation and not just a cost of doing business.
- A commenter shared that health plans have been compliant with data submission requirements before any penalties are in place. Industry takes the requirements seriously and approaches the process in good faith as a partner. They appreciated OHCA's recognition, as it finalizes the penalty framework, that data submission compliance has been consistent across the board.

Note: Public comment summarized from the October Health Care Affordability Board meeting.

Proposed Data Submission & Enforcement Process – Updated Based on Board Input

Data Due Date and Optional Extensions	
1.	Data due to the Office September 1.
2.	Optional extensions per request by the data submitter.
	Extension 1: A fifteen-day extension requested by the entity by the submission deadline that requires email status updates every 3 days including: • any issues or barriers the entity is experiencing • current projected submission date • progress toward completion • any need for technical assistance from the Office.
	Extension 2: An additional fifteen-day extension, or another date agreed upon by the office, can be requested by the entity prior to the first extension ending, contingent upon the entity complying with the requirements of the first extension period. OHCA will require regular check-ins with the Office during this period with the same requirements as the first extension.

Proposed Data Submission & Enforcement Process – Updated Based on Board Input

Untimely Data Submission Penalties	
3.	**Level 1-** If data has not been submitted by the submission deadline or end of one or both extension periods, submitters would be subject to an initial flat untimely data submission penalty of $10,000.
4.	**Level 2-** If data are then not submitted by November 1, the submitter would be subject to an additional flat untimely data submission penalty of $50,000.
Progressive Enforcement Process	
5.	If data is not submitted by November 1, progressive enforcement would begin on November 1 with a notice that the submitter has failed to submit data. The Office would require entities to submit a data submission plan with detailed milestones for submitting the data before December 1. The Office would provide technical assistance as needed.
6.	Optional Step: The Office may hold a public meeting and request an entity to provide public testimony.

Proposed Data Submission & Enforcement Process – Updated Based on Board Input

Failure to Submit Data Penalty

7. If data is not submitted by December 1st or an agreed upon date that is no later than January 1, the entity would be subject to a $5 per member failure to submit data penalty, in addition to the untimely data submission penalties.

8. If data is not submitted by December 31st or the agreed upon date, the per member penalty would increase to $10, and would be assessed in addition to the untimely data submission penalties.

9. **Level 3-** The per member penalty amounts will double for each consecutive year that the Office assesses an entity a failure to submit data penalty.

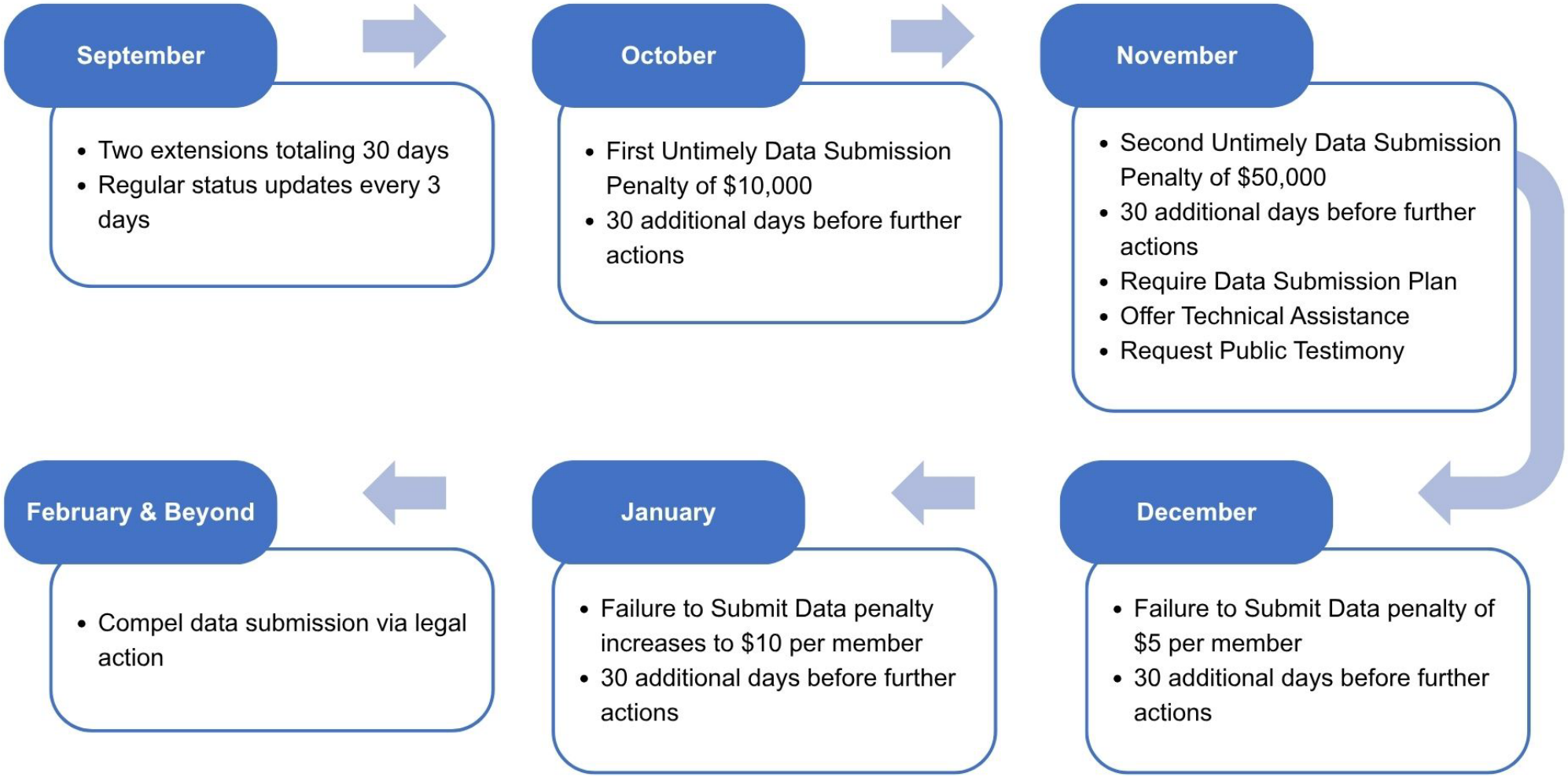
	1st Late Penalty	2nd Late Penalty	1st Failure to Submit (~Dec 1)	2nd Failure to Submit(~Dec 31)
Year 1	$10,000	$50,000	$5 Per Member	$10 Per Member
Year 2	$10,000	$50,000	$10 Per Member	$20 Per Member
Year 3	$10,000	$50,000	$20 Per Member	$40 Per Member
Year 4	$10,000	$50,000	$40 Per Member	$80 Per Member

Proposed Data Submission & Enforcement Process – Updated Based on Board Input

Other Remedies and Legal Action for failure to submit data	
10.	OHCA could continue to pursue other legal remedies in addition to penalties to acquire the submitter's data. The Office could take administrative action and could notify the licensing or regulatory agency of the entity's failure to comply with California law.
11.	OHCA will provide the Board updates on the compliance with data submission requirements starting at September Board meetings and will make public all penalties once formally assessed.

OHCA Data Submission Enforcement Actions

OHCA will take the following actions to obtain the data necessary for measuring California's health care spending growth and enforcing spending targets:



Draft Motion

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

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

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

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

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

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

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Informational Items

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Monterey Hospital Market Competition Study

Sheila Tatayon, Assistant Deputy Director
Arnold Analytics, LLC - Daniel R. Arnold, PhD, Paul B. Ginsburg, PhD, Katherline L. Gudiksen, PhD

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Background on Market Competition Study

- Concerns over hospital prices in Monterey County have been building for years. In August 2024, the Office of Health Care Affordability (OHCA) held a public meeting specific to these concerns. The full landscape of Monterey hospital prices, why they vary, and the impacts of prices has not been comprehensively analyzed.

- A core statutory mandate for OHCA is to "monitor cost trends, including conducting research and studies on the health care market, including, but not limited to, the impact of consolidation, market power, venture capital activity, profit margins, and other market failures on competition, prices, access, quality, and equity."

- On October 14, 2024, Director Landsberg directed OHCA to conduct an investigative study of hospital market competition in Monterey County.

Under Cal. Health & Saf. Code, §127507, subd. (a) and Cal. Gov. Code, § 11180, the Director is authorized to make investigations concerning "(a) All matters relating to the business activities and subjects under the jurisdiction of the department; . . . and (c)[s]uch other matters as may be provided by law."

Background on Market Competition Study

OHCA retained health care economic experts, Arnold Analytics, to assist OHCA in the investigative study and produce the report. The team includes:

- **Daniel R. Arnold, PhD**, Senior Research Scientist, Brown University School of Public Health, Affiliated Scholar, The Petris Center, University of California Berkeley
- **Paul B. Ginsburg, PhD**, Professor of the Practice of Health Policy and Management, Sol Price School of Public Policy, University of Southern California, and Senior Scholar, USC Schaeffer Institute
- **Katherine L. Gudiksen, PhD**, Executive Editor/Senior Health Policy Researcher, The Source on Healthcare Price and Competition, University of California College of the Law, San Francisco
- **Christopher M. Whaley, PhD**, Associate Professor, Department of Health Services, Policy and Practice, Brown University School of Public Health

Outline

- Background on Monterey County
- Analysis of hospital prices
- Impact of high hospital prices
- Analysis of costs, wages, and quality
- Cost-shifting
- Reasons for high prices
- Policy options
- Conclusion

Key Findings: Monterey Hospital Market Competition Study

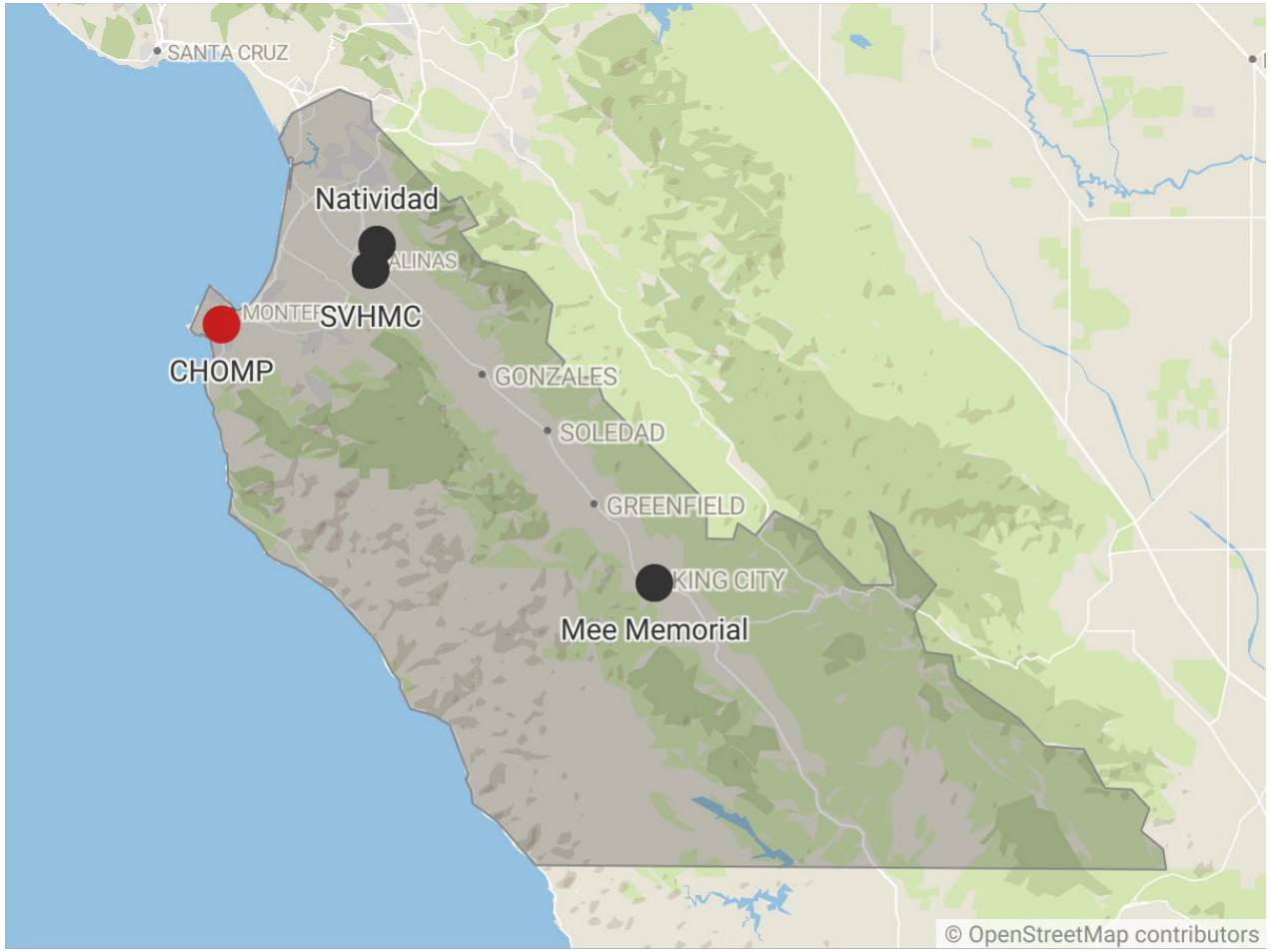
- New hospital price analyses show Monterey County to have the highest inpatient and 4th highest outpatient prices among California counties.
- There is no evidence that higher operating costs, wages, or quality explain the high prices.
- High percentages of Medicare and Medi-Cal patients and low margins on physicians and clinics may explain a small portion of the high hospital prices.
- Evidence suggests a lack of competition as the reason for high prices.

Background on Monterey County

- Population of 435,000
  - Mostly rural
  - Largest cities are Salinas (160k pop.), Seaside, and Monterey (both ~30k pop.)
- Population mostly in northern coastal areas and Salinas Valley
  - Remainder of county very sparsely populated
  - Lengthy drive between the two population centers
- Economy based on tourism, retirement living, and agriculture
  - Tourism and retirement concentrated in northern coastal areas
  - Agriculture concentrated in Salinas Valley
- Three hospitals*
  - Community Hospital of the Monterey Peninsula (CHOMP)
  - Natividad Medical Center
  - Salinas Valley Health Medical Center (SVHMC)

*Mee Memorial Hospital is a fourth smaller general acute care hospital located near the county's southern border as opposed to the northern border like the other three. The analysis revealed it has little to no competitive impact on the other three hospitals.

Background on Monterey County



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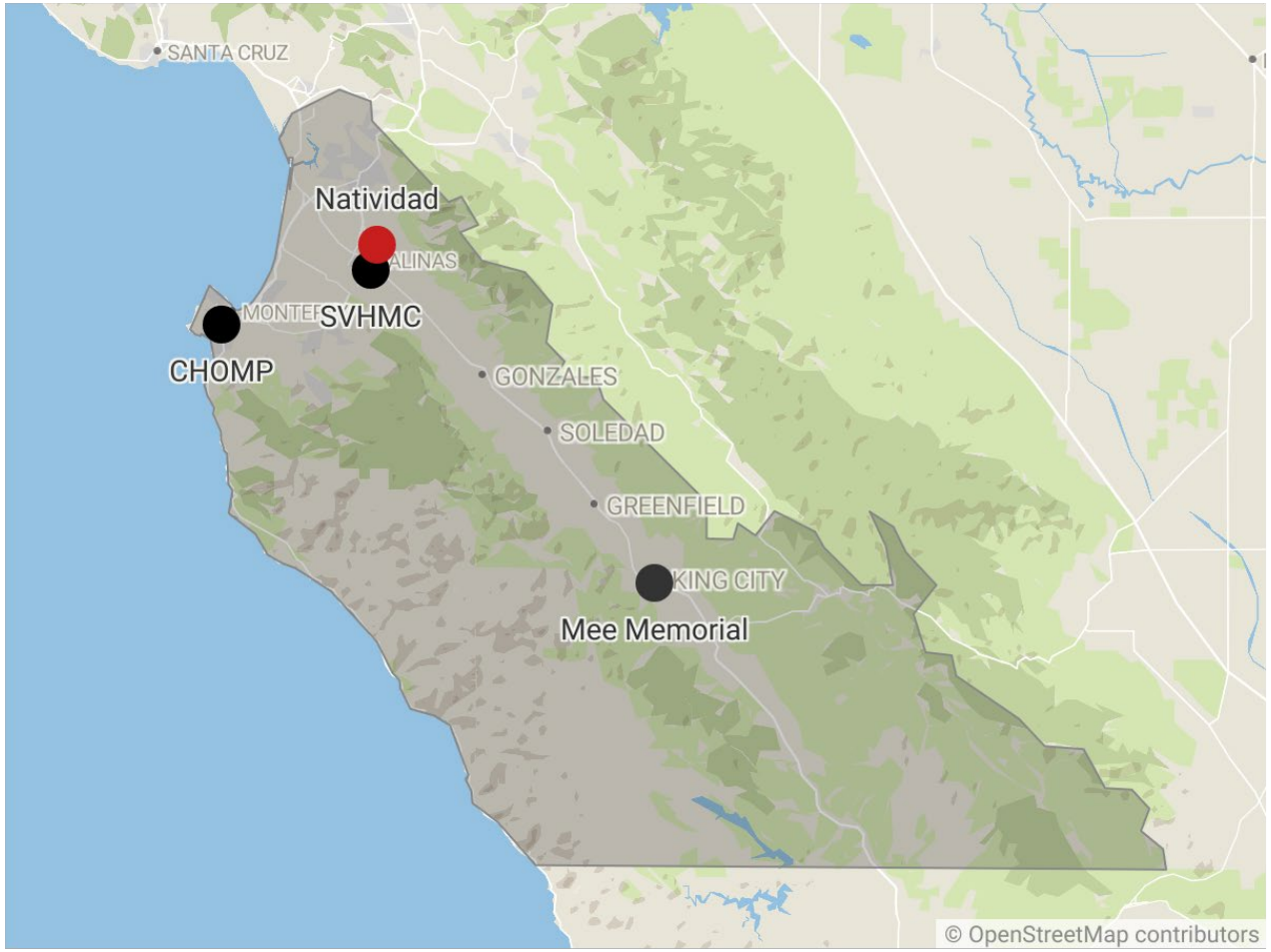
Community Hospital of the Monterey Peninsula (CHOMP)

- 258 beds
- Nonprofit
- Part of Montage Health:
  - Montage Medical Group
  - MoGo urgent care centers
  - ASPIRE Health (Medicare Advantage plan)
- Payer mix: 63% public payer (Medicare + Medi-Cal) in 2022
  - The statewide average was 62% in 2022.

Background on Monterey County



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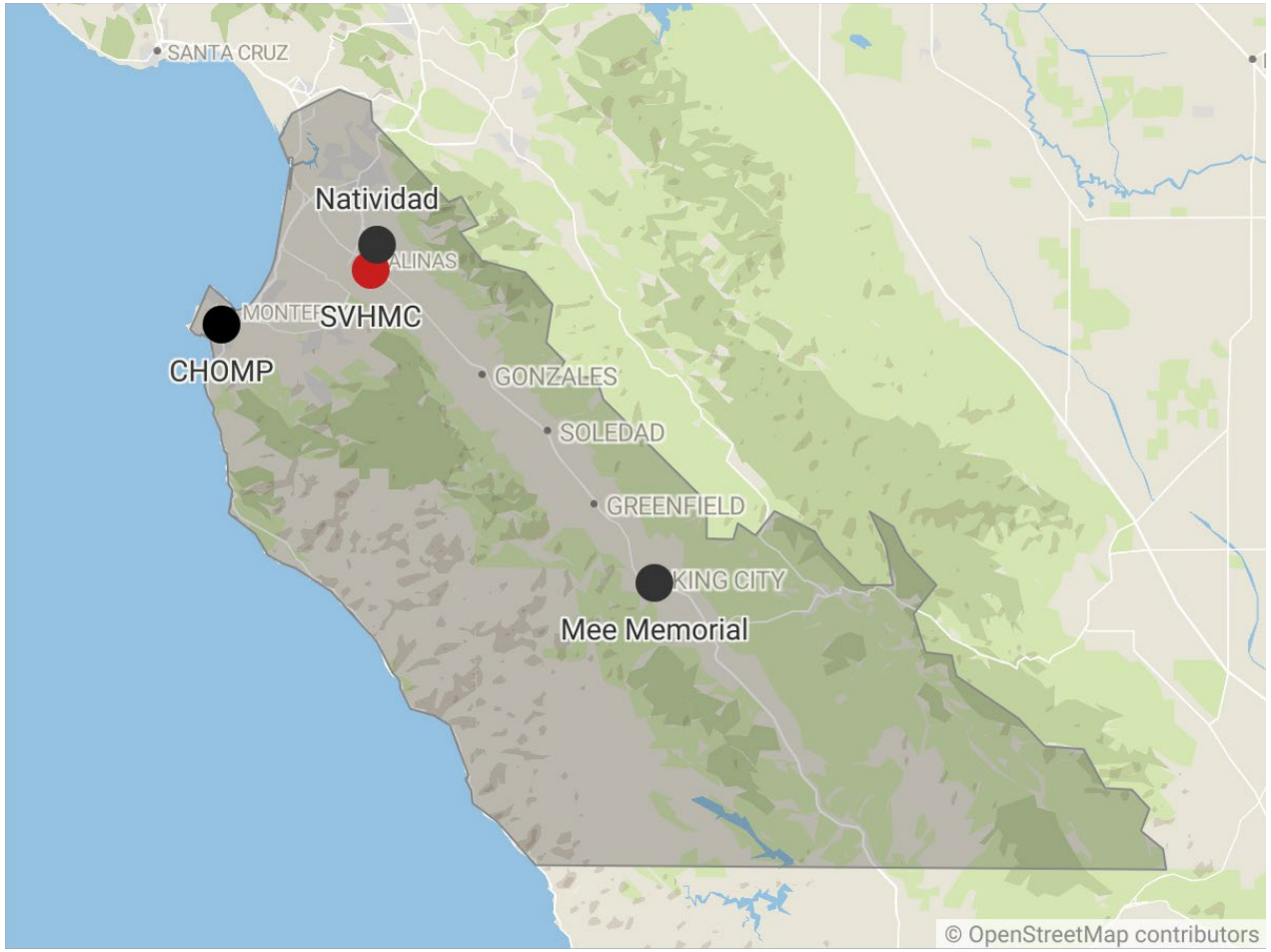
Natividad Medical Center

- 172 beds
- County hospital
  - Directly employs physicians
- Safety net hospital in the county
- Payer mix: 78% public payer (Medicare + Medi-Cal) in 2022
  - The statewide average was 62% in 2022

Background on Monterey County



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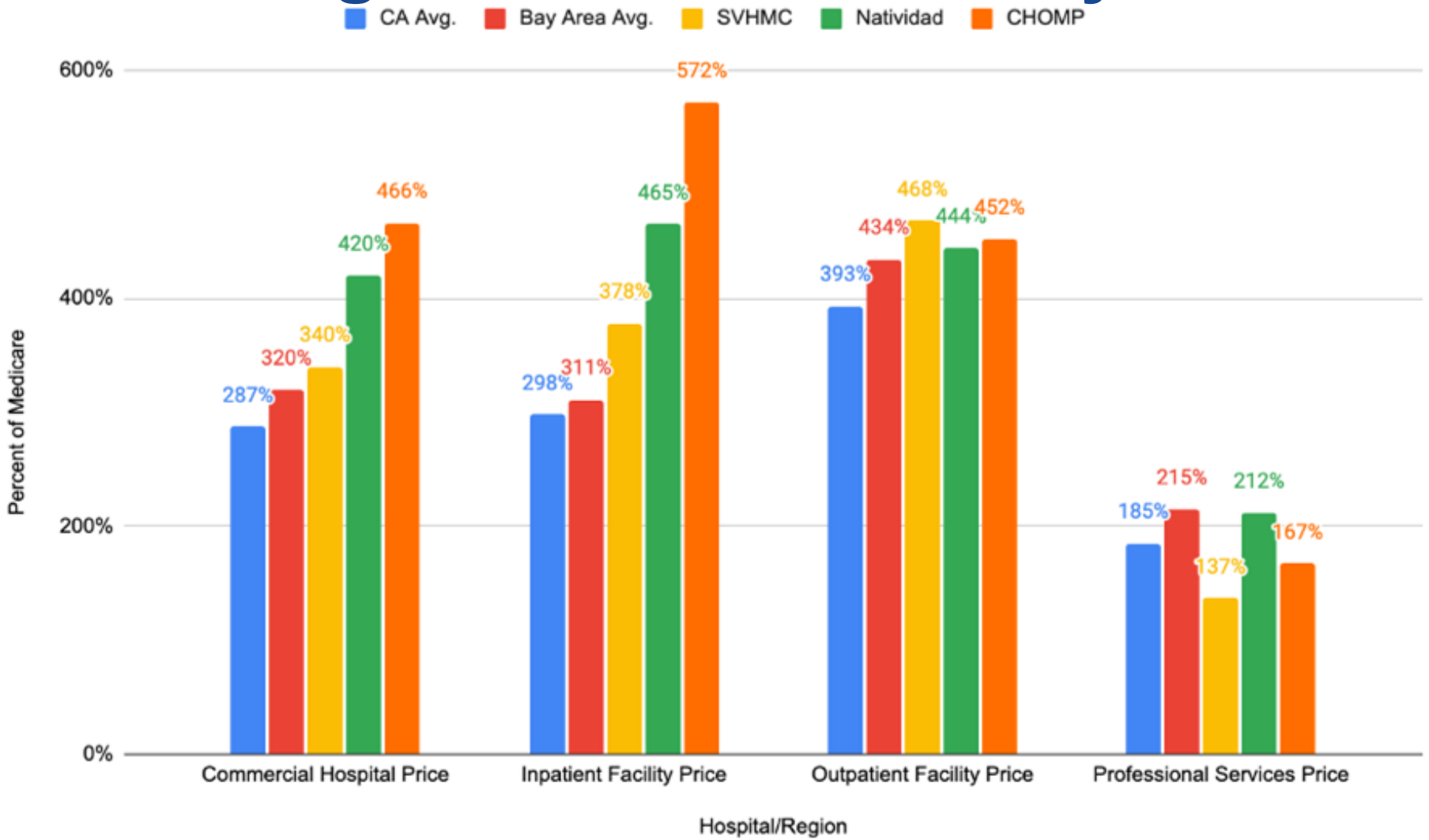
Salinas Valley Health Medical Center (SVHMC)

- 243 beds
- District hospital
- Part of Salinas Valley Health ("SVH")
  - Salinas Valley Health Clinics, including both primary care and specialty care
- Payer mix: 70% public payer (Medicare + Medi-Cal) in 2022
  - The statewide average was 62% in 2022

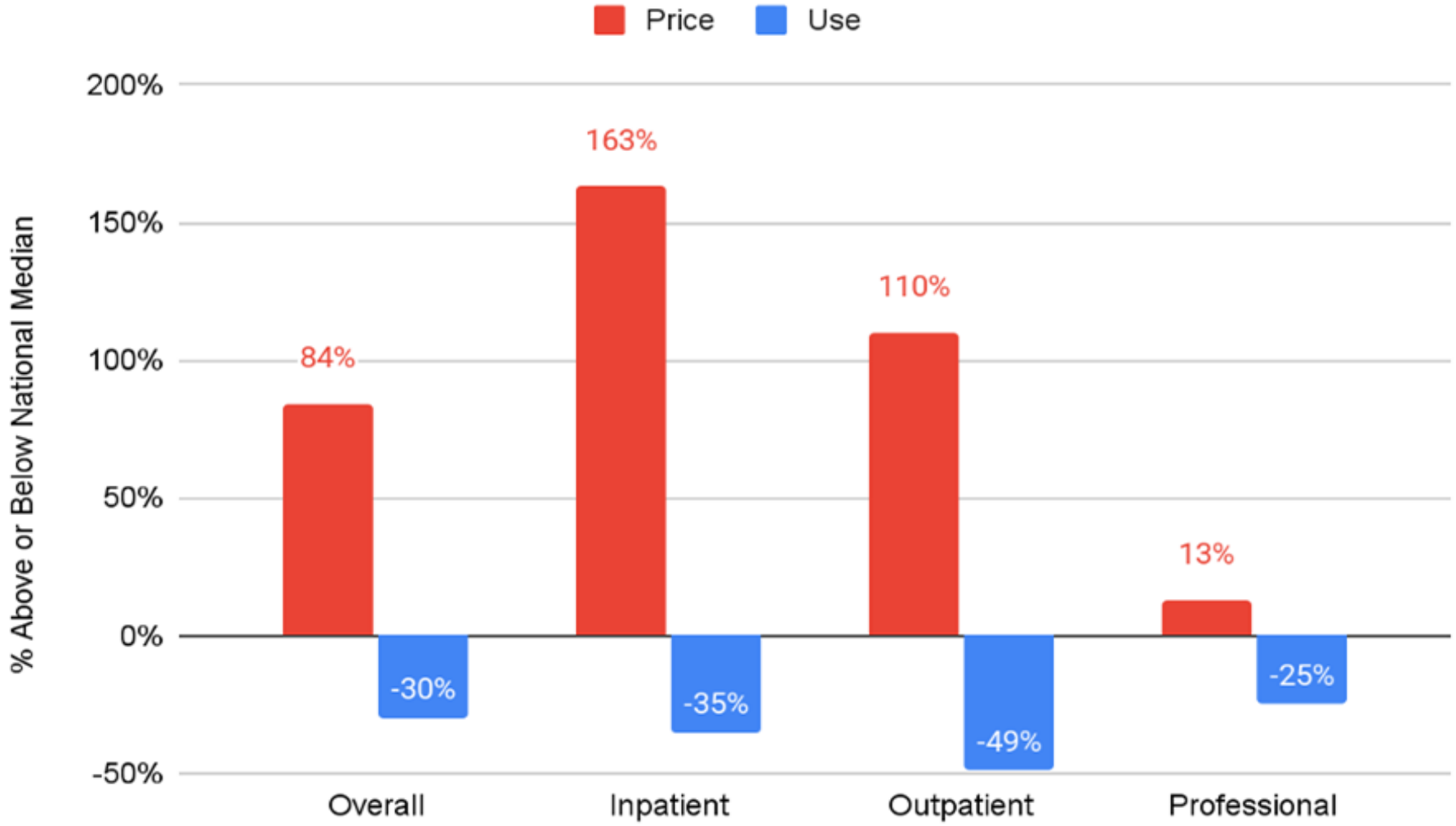
Previous Studies Have Found Monterey Hospital Prices Much Higher than CA and Bay Area Averages



Source: Slides 119-122 from California Department of Health Care Access and Information. (2024, August 28). *Health Care Affordability Board Meeting* [PowerPoint slides]. https://hcai.ca.gov/wp-content/uploads/2024/09/August-2024-OHCA-Board-Meeting-Presentation-1.pdf

Notes: Bay Area is defined here as the counties of Alameda, Contra Costa, Napa, San Francisco, San Jose, San Mateo, Santa Cruz, and Santa Rosa, which differs a bit from the CDPH definition (see page 3) of Bay Area that used in the rest of the report.

Monterey Hospital Prices are Higher than National Average, While Utilization is Lower



Source: Health Care Cost Institute. (2023). *Healthy Marketplace Index*. https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Price-and-Use

Price Analyses Conducted for this Study

County-level inpatient and outpatient facility prices were calculated using claims data from:

- CalPERS facility claims data for all their members located throughout California from 2013 to 2023.
- Covered California facility claims data for both individual and group products from 2018 to 2024.

Data enabled the following price analyses:

1. Wage-adjusted prices for the 10 most-common inpatient admissions and 23 common outpatient procedures.

2. Adjusted prices for a larger set of services to get one average hospital price per county.

Accounting for Wage Differences When Comparing Prices

- To allow for apples-to-apples comparison of prices across the state, a wage index is used to account for variations in counties, such as having higher input costs.
- For example, San Francisco County has the highest index at 1.62, reflecting the county's higher costs.

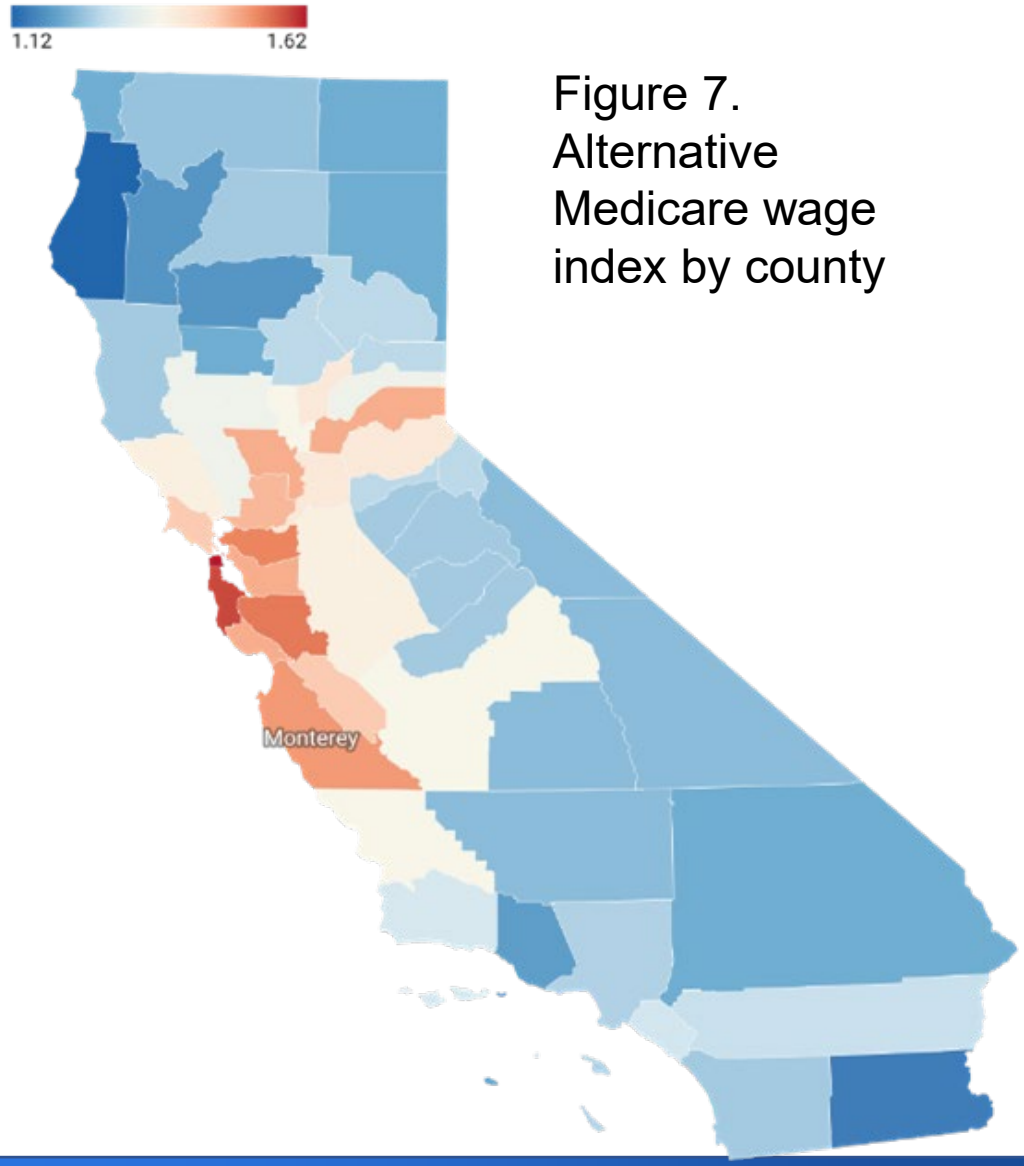
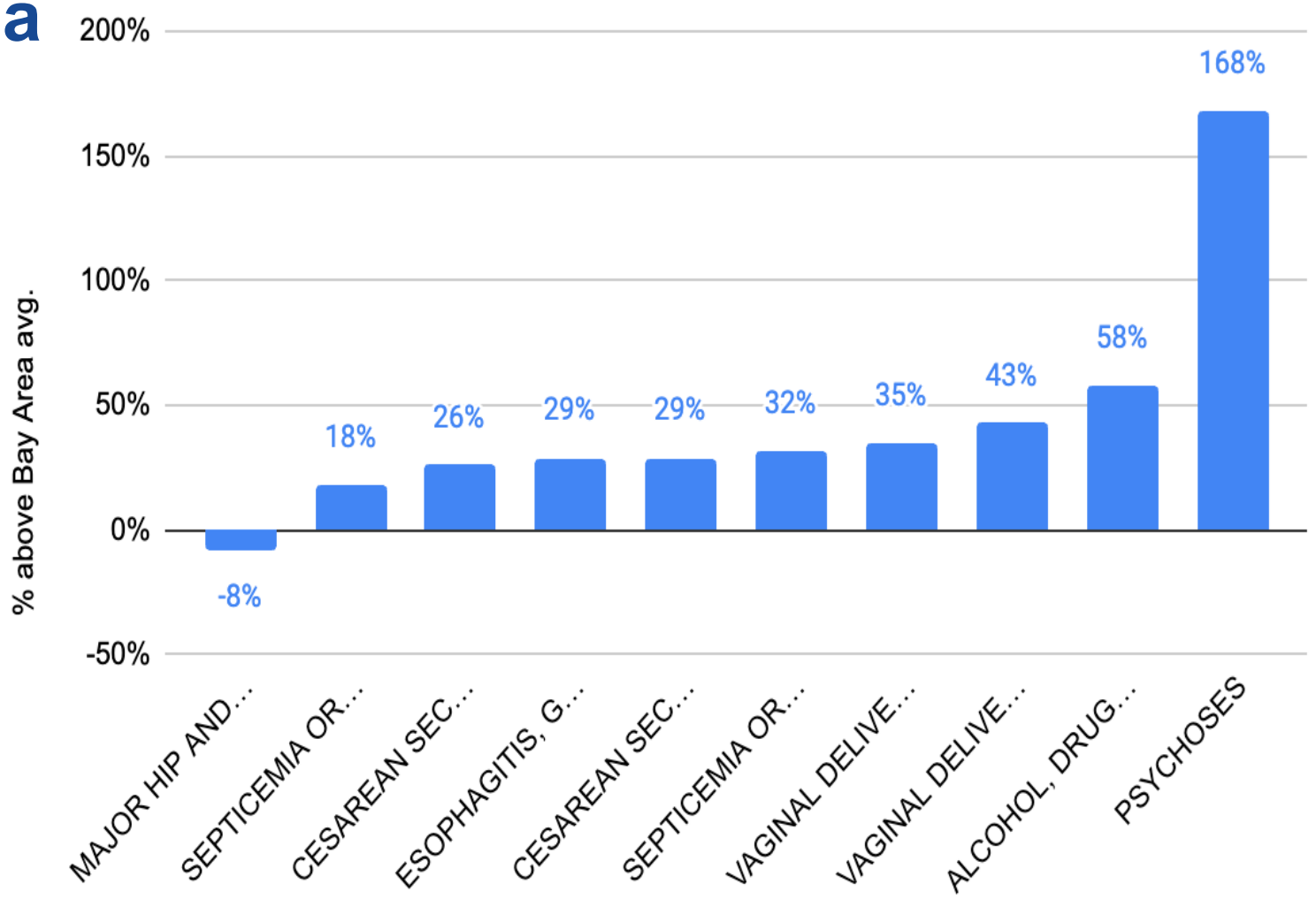


Figure 7. Alternative Medicare wage index by county

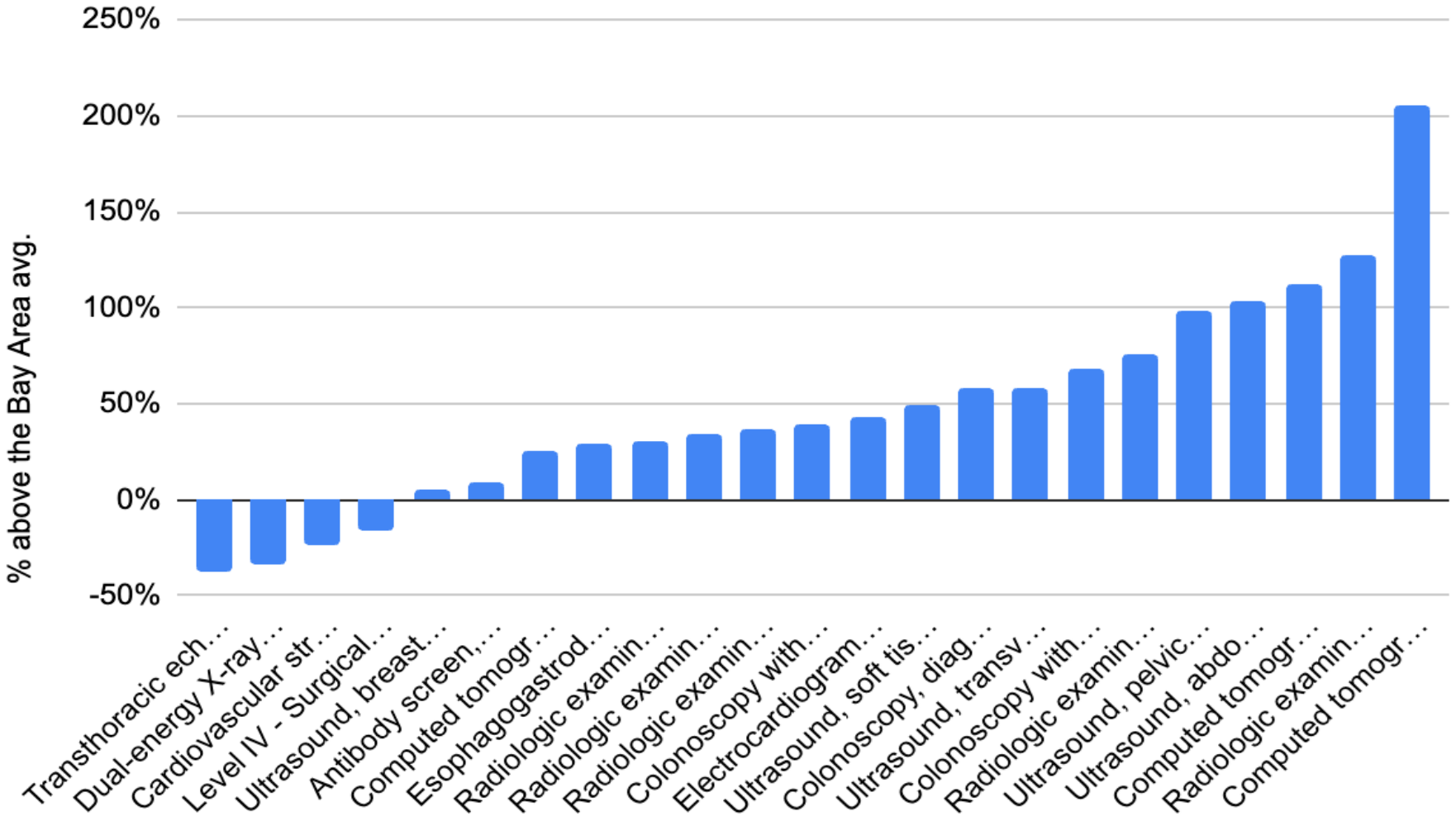
Source: MedPAC https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch9_MedPAC_Report_Online_Only_Appendix_Comparing_Wage_Indexes_SEC.pdf MedPAC. (2023). *Chapter 9 online-only appendix: Reforming Medicare's wage index systems–Comparing current (2022) CMS wage indexes with illustrative alternative wage indexes (June 2023 report)* [Data set]. MedPAC. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch9_MedPAC_Report_Online_Only_Appendix_Comparing_Wage_Indexes_SEC.pdf
Notes: Figure 7 in the report. An index of 1 corresponds to wages at the national average.

The Average of the Wage-Adjusted Prices for the 10 Most Common Inpatient Admissions is 32% Higher in Monterey Than the Bay Area



Note: The figure above corresponds to the information shown in Table 1 of the report. The full names of the 10 admissions are available in the Appendix of this presentation.

The Average of the Wage-Adjusted Prices for 23 Common Outpatient Procedures is 47% Higher in Monterey Than the Bay Area



Note: The figure above corresponds to the information shown in Table 2 of the report. The full names of the 23 procedures are available in the Appendix of this presentation.

Monterey had the Highest Adjusted Inpatient Price in the CalPERS Data

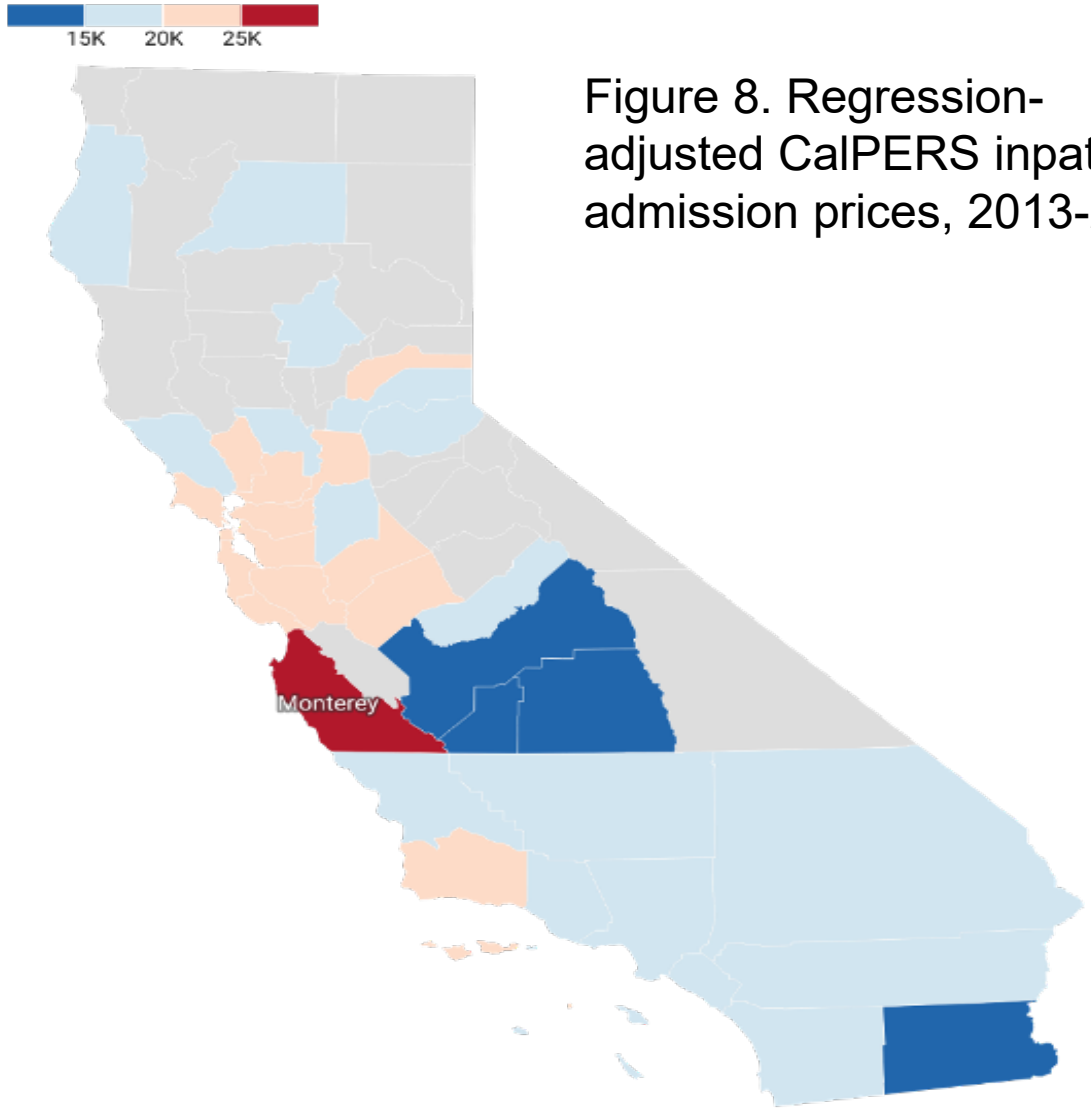


Figure 8. Regression-adjusted CalPERS inpatient admission prices, 2013-2023

In addition to wage adjustments, the prices shown also adjust for patient age and sex and severity (as captured by the admission's Diagnosis-Related Group).

Source: Authors' analysis of 2013-2023 inpatient facility claims from CalPERS. Notes: Legend above map denotes prices in dollar amounts. Only claims from CalPERS' "basic plan" enrollees are included (i.e., claims from Medicare supplement plan enrollees are excluded). Grayed out counties have populations of less than 100,000 and were excluded from the analysis due to small sample sizes.

Monterey had the 4th Highest Adjusted Outpatient Price in the CalPERS Data

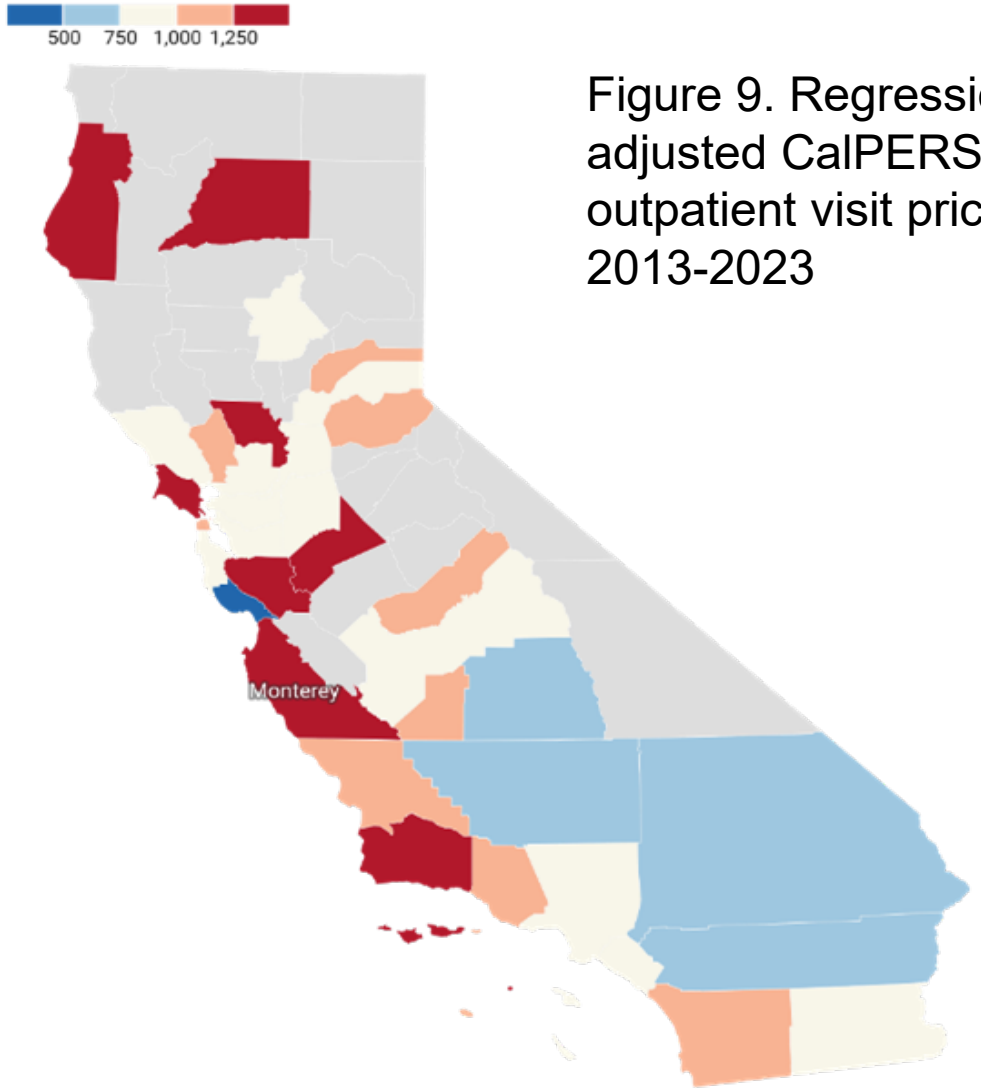


Figure 9. Regression-adjusted CalPERS outpatient visit prices, 2013-2023

In addition to wage adjustments, the prices shown also adjust for patient age and sex and intensity (as captured by Current Procedural Terminology codes).

Source: Authors' analysis of 2013-2023 outpatient facility claims from CalPERS. Notes: Legend above map denotes prices in dollar amounts. Only claims from CalPERS' "basic plan" enrollees are included (i.e., claims from Medicare supplement plan enrollees are excluded). Grayed out counties have populations of less than 100,000 and were excluded from the analysis due to small sample sizes.

Premiums in Monterey Are Higher and Rising Faster Than the State Average

Covered California

- From 2014 to 2025, the average annual increase in Region 9 was 10.9% while the statewide average was 7.6%.
- In 2024, the gross premium for an individual in Monterey ($884) was significantly higher than the statewide average ($655).

Note: Discussed in Section 3,a,i,1 of the report.

Impact of High Hospital Prices: Higher Premiums

Employer-sponsored insurance

- Increased difficulty affording coverage.
- Higher contributions by employers and employees
  - Higher employer contributions is shifted to employees
    - Smaller wage increases over time
    - Higher cost sharing
    - Particularly burdensome for low-wage employees
    - Impacts corroborated in interviews with union leaders
      - Encourage members to get some care outside of county

Note: Discussed in Section 4 of the report.

Impact of High Hospital Prices: Higher Premiums

Employer-sponsored insurance (Cont.)

- Increased incentive for employers to outsource low-wage work
  - Low-wage employers provide more limited coverage–or no coverage at all
- Burdens governments at federal, state, local level
  - Exclusion of employer/employee contributions from taxable income
    - Federal loss of revenue in FY 2026: $309.4 billion
    - Large State of California revenue loss as well
  - Higher costs for public employee health benefits
  - Higher spending to subsidize coverage for low-income people
    - Increased federal ACA subsidies
    - Some who lose employer coverage will enroll in Medi-Cal

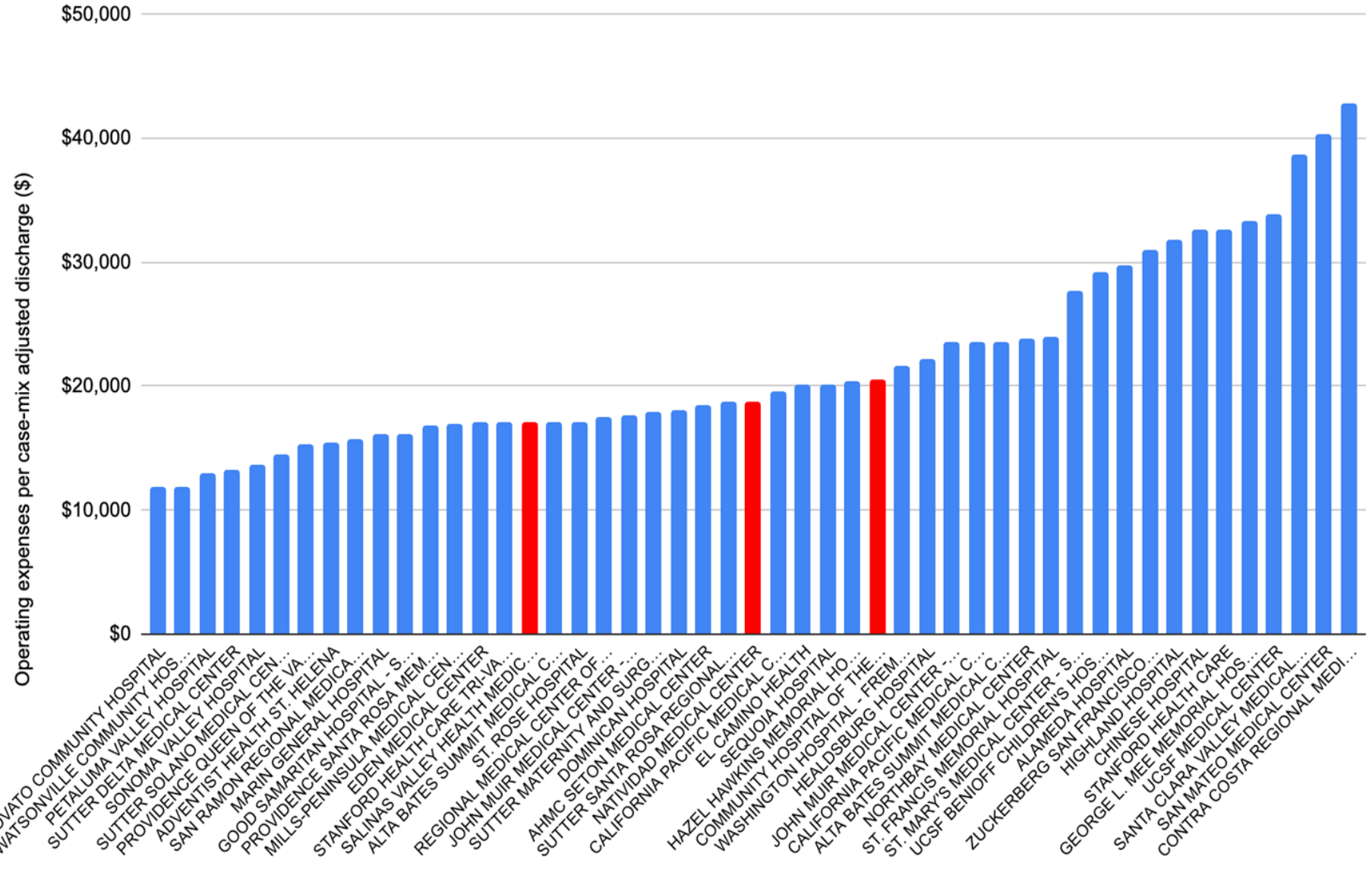
Note: Discussed in Section 4 of the report.

Why are Hospital Prices so High?

We looked at a variety of potential factors that may explain higher prices:

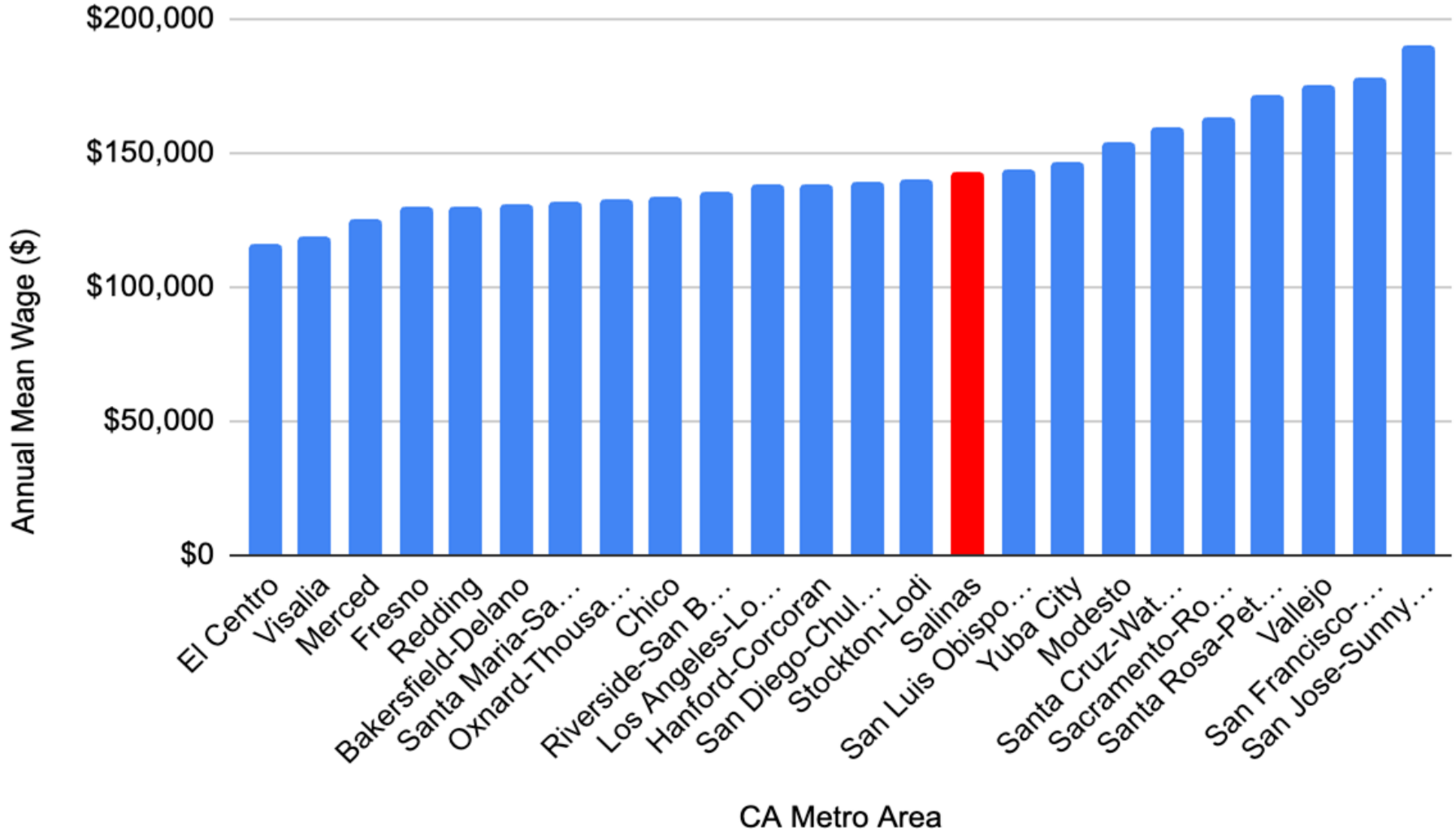
- Operating Costs
- Wages
- Quality
- Cost-shifting
- Lack of hospital competition

Higher Operating Costs Do Not Explain Higher Prices



Source: Authors' analysis of 2023 HCAI hospital annual financial data.
Note: Figure 12 in the report.

Higher Wages Do Not Explain Higher Prices - Registered Nurses



Source: Bureau of Labor Statistics (BLS) https://data.bls.gov/oes/#/home

Note: Figure 16 (a) in the report. The report also shows wages for licensed and practical vocational nurses, nursing assistants, healthcare support occupations, medical and health services manages, and surgical technologists. Salinas ranks similarly across these other occupations.

Higher Quality Does Not Explain Higher Prices

	CHOMP	SVHMC	Natividad	CA Avg.	National Avg.
Overall star rating (1-5, 5=best)	3	4	3	3	3
Patient survey rating (1-5, 5=best)	3	3	3	3	3
Timely & effective care					
Sepsis care					
Percentage of patients who received appropriate care for severe sepsis and/or septic shock (**higher** percentages are better)	50%	63%	57%	68%	63%
Colonoscopy follow-up					
Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy (**higher** percentages are better)	100%	100%	98%	91%	92%
Emergency department care					
Percentage of patients who left the emergency department before being seen (**lower** percentages are better)	1%	2%	1%	2%	2%
Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival (**higher** percentages are better)	75%	62%	27%	72%	70%

Source: CMS Hospital Compare https://www.medicare.gov/care-compare/?redirect=true&providerType=Hospital
Note: Table 3 in the report.

Higher Quality Does Not Explain Higher Prices

Green = statistically better than the national average
Red = statistically worse than the national average
Gray = not statistically different than the national average

	CHOMP	SVHMC	Natividad
Complications			
Rate of complications for hip/knee replacement patients		Not applicable	Not applicable
Serious complications	Worse		
Deaths among patients with serious treatable complications after surgery			
Infections			
Central line-associated bloodstream infections (CLABSI) in ICUs and select wards			
Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards			
Surgical site infections (SSI) from colon surgery			
Methicillin-resistant Staphylococcus Aureus (MRSA) blood infections			
Clostridium difficile (C.diff.) intestinal infections	Better	Better	Better

Source: CMS Hospital Compare https://www.medicare.gov/care-compare/?redirect=true&providerType=Hospital
Note: Table 4 in the report.

Higher Quality Does Not Explain Higher Prices

Green = statistically better than the national average
Red = statistically worse than the national average
Gray = not statistically different than the national average

	CHOMP	SVHMC	Natividad
Death rates			
Death rate for patients (hospital-wide)	Better		
Death rate for COPD patients			
Death rate for heart attack patients			
Death rate for heart failure patients	Better		
Death rate for pneumonia patients		Better	
Death rate for stroke patients			
Death rate for CABG surgery patients			
Unplanned hospital visits			
Rate of readmission after discharge from hospital (hospital-wide)			
Rate of readmission for chronic obstructive pulmonary disease (COPD) patients			
Rate of readmission for heart attack patients			Not applicable
Rate of readmission for heart failure patients			
Rate of readmission for pneumonia patients			

Source: CMS Hospital Compare https://www.medicare.gov/care-compare/?redirect=true&providerType=Hospital
Note: Table 4 in the report.

Cost-shifting

The term is used to describe a hospital's reaction to payment rates from public programs like Medicare and Medicaid not keeping pace with the cost of delivering care.

- Theory: Hospitals respond by raising prices paid by private insurers.
- This is distinct from the common practice of price discrimination, which is simply the act of charging different payers different prices for the same service.

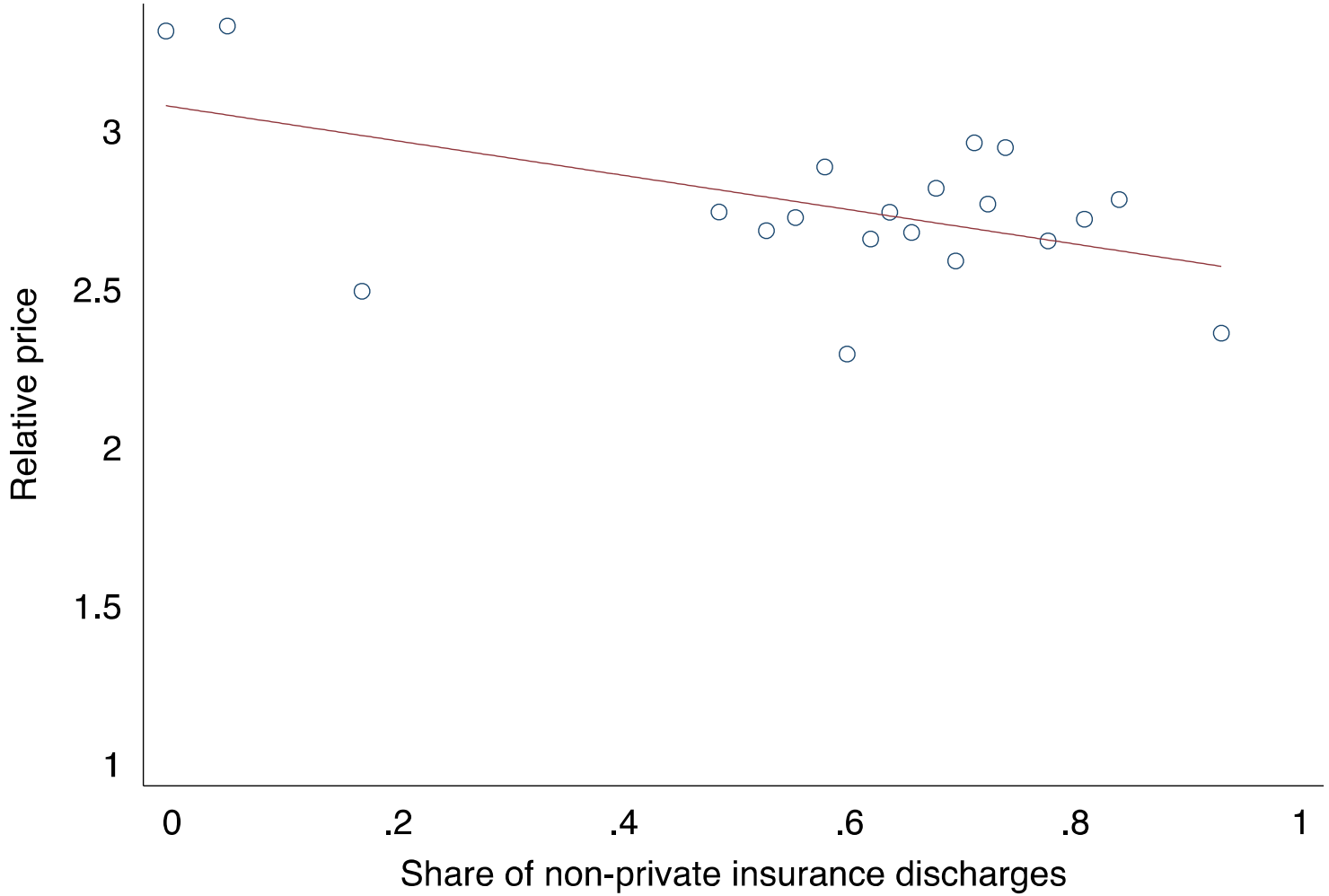
Cost-shifting is not supported by economic research.

- Theory: Most hospitals always negotiate as high a price as possible with private insurers.
- Empirical research: Most hospitals respond to lack of public payer rate increases by:
  - Increasing efforts to reduce costs.
  - Selectively *reducing* prices to increase services to privately insured patients.
  - Accepting lower margins.

Cost-shifting doesn't explain California hospital prices

Contrary to cost-shifting, ***CA hospitals with more publicly-insured patients have lower prices*** vs. hospitals with mainly private patients

10% point increase in non—private patients associated with statistically significant 5.4% point lower prices



MSA fixed effects included

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

Hospitals with “Must-Have” Status

Cost shifting can occur for hospitals with “must-have” status.

- Must-have hospitals are those that insurers need to construct a commercially viable network. Characteristics include:
  - Stellar reputation
  - Very large market share
  - The sole hospital in a rural area
  - In metropolitan areas, only a small minority of hospitals have this status
- Prices at must-have hospitals may be lower than what the market would support.

Interviews showed these three hospitals in Monterey County hold “must-have” status” and this might explain some higher prices for Natividad and SVHMC.

Voluntary, Confidential Interviews

- Physicians and physician organizations
- Health systems
- Insurers
- Labor unions offering coverage in Monterey County

Interview Results: Health Systems

- Described low or negative margins for professional services (e.g., medical groups affiliated with system) due to historical contracting practices.

- Analysis of commercial claims data shows professional service prices in Monterey near state averages.
  - Data was insufficient to analyze physician prices by medical group.

- Financial statements and tax filings show:
  - Low margins for Salinas Valley Health medical group.
  - Montage Medical Group has operated at a loss for 13 consecutive years, with an exception in 2020.

Interview Results: Health Systems

- Operating losses on physicians could explain a portion of the very high hospital facility prices, but not the bulk of it.
- Low physician prices could be a barrier to entry for new independent physician groups.
- If hospital revenues are constrained, health systems might substantially increase physician prices.

Interview Results: Payers

- Payers believe lack of competition is primary reason for high prices.
  - Monterey County functions like a rural area.
  - “Network adequacy is the biggest regulatory hurdle to having leverage with hospitals.”
  - “In that area, dropping any of the three hospitals would be very hard. In that area, 20 miles may as well be half a world away - it’s a commercial viability problem.”
- Payers, especially labor unions, encouraged members to obtain care outside the county and sometimes paid for travel expenses.
- Minimal managed care options are available in Monterey County.
  - Even Medicare Advantage enrollment is very low (15% in Monterey; 52% statewide average).
  - Must-have status allows hospitals to dictate terms on contracts (not just prices).

Interview Results: Physician Practices

- Consolidation of physicians with hospitals in Monterey County has increased over time.
  - Reflects changing physician practices nationwide
  - May not be active strategy by hospitals, but results are likely the same
- Some independent physician practices exist in the area, but all large medical groups are owned by a health system.
- Most physicians in private practice have admitting privileges at only one hospital.
  - Interviewees said that except for a few very highly specialized medical groups, physicians did not seek privileges at more than one hospital due to travel time and all requirements.

Physician Alignment with Health Systems

Peer-reviewed research shows that physician affiliation or ownership by a hospital leads to:

- Increase in Prices.
  - Primary care physicians affiliated with hospitals charged 10.7% higher prices for office visits compared to their independent counterparts.
  - Physician prices increased by 14% on average after an acquisition by a hospital system (e.g., primary care physicians increased by 15.1%; cardiologists increased by approximately 33.5%).
- Increase in referrals to higher-priced facilities like hospital outpatient department instead of lower-priced providers.

Vertical consolidation creates a formidable barrier to entry at all levels.

Competition is Ineffective at Restraining Prices of Hospitals in Monterey County

- Preponderance of evidence suggests that lack of competition is the reason for high prices.
- The highly consolidated and insulated market structure means regulatory actions, such as antitrust enforcement, or traditional market-based policy solutions, such as encouraging new hospital construction, are unlikely to succeed in constraining prices.

Policy Options to Constrain Prices: Spending Targets

The Health Care Affordability Board has already set a statewide target and a lower target for hospitals identified as having disproportionately high prices, including CHOMP and SVHMC. This approach requires entities to strategically manage growth in prices or volume or both.

Considerations:

- Does not require cutting prices.
- Incorporates existing price disparities because they are based on health care entity's existing payment rates.
- Are retroactive because measurement and reporting on excess spending occurs after the performance year ends.

Policy Options to Constrain Prices: Medicare-Based Price Caps

Limit commercial payments to a set percentage of Medicare rates (e.g., 250%).

Considerations:

- Focuses constraint on hospitals with the highest prices.
- Implementation can be complex, because payers often use different payment models than Medicare's diagnosis related group (DRG) reimbursement structure (e.g., capitation, case rates, bundled payments, etc.).
- Medicare rates are not always representative of costs to provide care to commercial population.

Policy Options to Constrain Prices: Hospital Global Budgets

The state could set annual revenue targets per hospital, adjusted for population, demographics, and quality. Budgets can be fixed (guaranteed annual revenue) or variable (adjusts with volume-related costs).

Considerations

- Allows hospitals to strategically restrain both costs and types of care delivered.
- Similar to spending targets, but done in a prospective manner.
- This is workable only if it is done for all hospitals in a region.

Conclusion

- Hospital commercial prices in Monterey far exceed both statewide and Bay Area benchmarks.
- Prices are not explained by:
  - operating costs
  - labor costs
  - quality of care
- High percentages of Medicare and Medi-Cal patients and low margins on physicians and clinics may explain a small portion of the high hospital prices.

Conclusion (Cont.)

- Hospital–physician integration, geographic dominance, and contracting practices channel patients to higher-priced hospitals, sustaining high prices.
- Selective contracting and patient steering do not work because all three hospitals are “must-haves.”
- Policies that foster competition, like antitrust enforcement, are unlikely to be effective.
- Policy options that directly restrain Monterey hospital prices should be considered.

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Public Comment

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Introduction to DSG 3.0 Regulations, Including Behavioral Health Definition Update and Summary of Public Comments and Advisory Committee Feedback

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

HCAI

Department of Health Care Access and Information

Data Submission Guide (DSG) 3.0

- DSG 3.0 outlines requirements for submission of 2024-2025 data in 2026.
- Draft will be shared for public comment on proposed changes in January 2026.
- Annual registration due May 29, 2026.
- Data submission due September 1, 2026.

DSG 3.0 Proposed Changes

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

DSG 3.0 Proposed Changes for APM and Primary Care Files

Alternative Payment Model (APM) File

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

Primary Care File

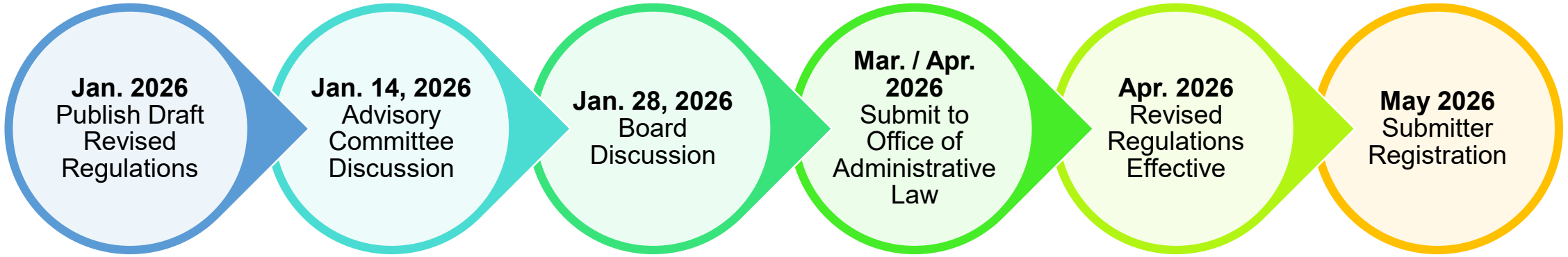
- Clarified primary care spending methodology for non-claims payment subcategories.
- Clarified primary care spend is reported based on the claim line level.
- Updates to primary care code set.
  - *e.g.*, added "363A00000X Physician Assistant" to the list of taxonomy codes; added new CMS Advanced Primary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

DSG 3.0 Proposed Changes for APM and Primary Care Files

Medi-Cal Managed Care Plans only:

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

DSG 3.0 Timeline



Update on Behavioral Health Definition and Summary of Public Comments and Advisory Committee Feedback

Primary Care & Behavioral Health Investments

Statutory Requirements

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

Measuring Behavioral Health Spending

Numerator

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

Denominator

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

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

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

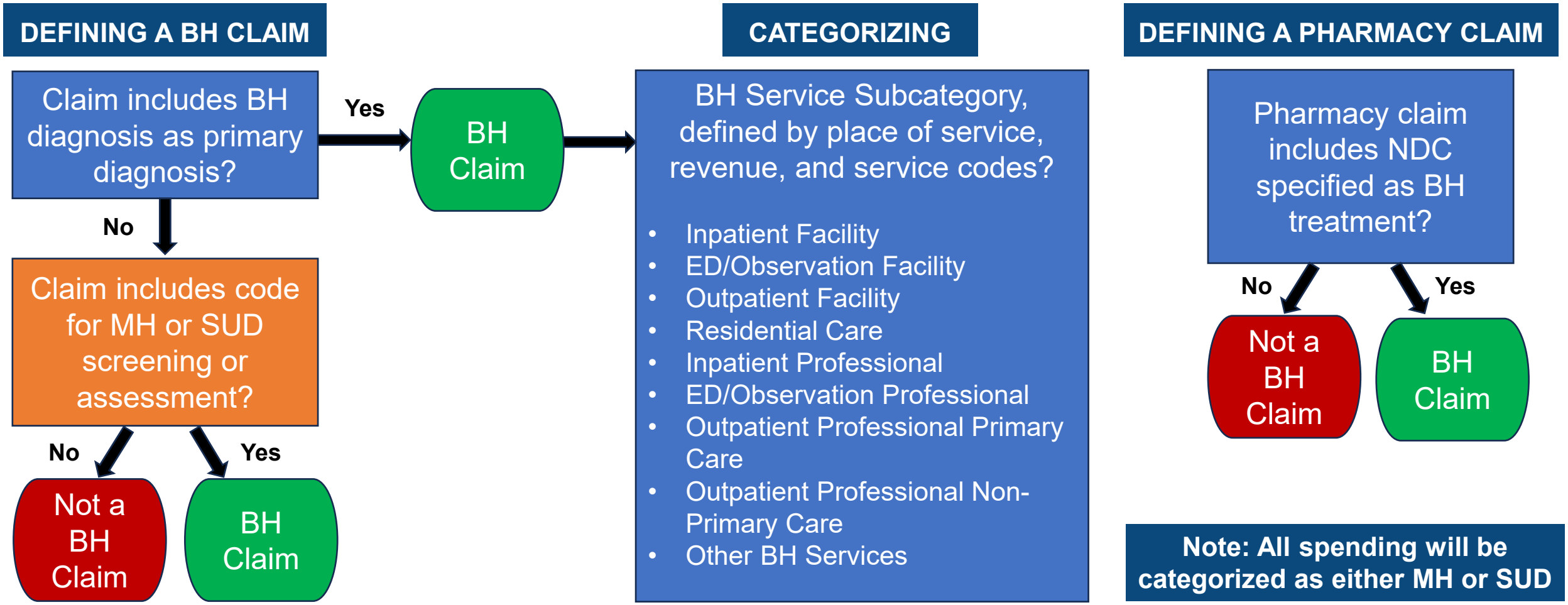
Three Recommended Modules for Behavioral Health Spending Measurement

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

Behavioral Health Claims Measurement Definition Principles

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

Process Map for Identifying Behavioral Health (BH) Claims



Note: All spending will be categorized as either MH or SUD

Proposed Behavioral Health Reporting Categories

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

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

Behavioral Health Non-Claims Measurement Definition Principles

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

Measuring Behavioral Health in Primary Care

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

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

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

Behavioral Health in Primary Care Module: Proposed Approach

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

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

Review of Public Comment and Advisory Committee Feedback

Sources of Public Comments

OHCA received comments on the proposed behavioral health spending definition, measurement methodology, and code set from several types of organizations:

- Consumer advocates and organizations representing specific population groups (5 organizations*)
- Provider organizations (3)
- Quality organization (1)
- Payer organization (1)
- Labor union (1)

*Five organizations submitted a joint comment letter

Measurement Methodology

Feedback (number of comments)	OHCA Response
Diagnoses • Support for using diagnosis codes rather than taxonomy to identify behavioral health claims (1). • The use of primary diagnosis is too restrictive and the definition should include claims with secondary behavioral health diagnoses or other ways to capture all behavioral health services (3). • Include G codes as well as F codes associated with Alzheimer's Disease and Dementia in code set (G codes are more likely to be used under capitation) (1).	• Including all spend on claims with a secondary behavioral health diagnosis would result in significant overcounting of medical spend. • Including behavioral health spend for claims with a secondary diagnosis would also result in data submitter burden. • OHCA will evaluate inclusion of G codes.
Services • Use specific procedure and service codes to identify a behavioral health claim in absence of primary diagnosis, in addition to screening and assessment (1).	• Expanding the list of services that do not require a primary behavioral health diagnosis will add data submitter burden and increase the risk of overcounting.

*The International Classification of Diseases, 10th Revision (ICD-10) categorizes codes related to dementia as either diseases of the nervous system (G codes) or mental, behavioral and neurodevelopmental disorders (F codes). G codes are not typically considered behavioral health diagnoses.

Measurement Methodology

Feedback (number of comments)	OHCA Response
• Incorporate encounter data into methodology (1).	• Encounter data is used in the non-claims methodology to allocate portions of capitation payments to behavioral health.
• Include partial hospitalization, long-term care, intensive community treatment place of service codes (2).	• Behavioral health care is included in measurement regardless of place of service. Place of service codes, revenue codes, and other codes are used to categorize spending.
• Include mobile clinic services as a subcategory, to encourage this type of care (1).	• OHCA will continue to monitor spending in this category using the Health Care Payments Database (HPD) and is open to including it in the future.
• Collect Medi-Cal data, including county behavioral health services claims, as soon as possible (2).	• OHCA will collect Managed Care Plan behavioral health spending in 2026. OHCA continues to work with DHCS to measure county behavioral health spending.
• Include paraprofessional providers included in Children and Youth Behavioral Health Initiative (CYBHI) fee schedule (1).	• Provider type is not part of OHCA's behavioral health definition. Services meeting the diagnosis requirement will be included, regardless of provider type.

Behavioral Health in Primary Care Module

Feedback (number of comments)	OHCA Response
• General support for the module.	
• Support for expanding the primary care provider taxonomy list to capture additional integrated behavioral health in primary care spend (1). • Oppose expansion of the list because of potential overcounting of non-integrated care and impact on primary care spend measurement (2).	• OHCA appreciates the potential impact of overcounting non-integrated spend and will use the Health Care Payments Database (HPD) to analyze options for an expanded module in the future. • OHCA proposes keeping the module with the original (unexpanded) primary care taxonomies.
• To avoid double-counting, count screening and referrals as primary care only and complex diagnoses and treatments as behavioral health (1).	• The module counts these services as both primary care and behavioral health; the modular format allows them to be included or excluded from each.

Behavioral Health Investment Benchmark

Feedback (number of comments)	OHCA Response
• Commenters support delay in setting a benchmark (2). • Urge timely action in filling data gaps to inform the benchmark (2).	• OHCA is planning extensive analysis over the next several months, with the intention to propose a benchmark to the Board in Summer 2026.
• Benchmark should encourage investment across the full continuum of care, rather than focus on outpatient and community-based care (1).	• Stakeholders strongly supported an outpatient-focused benchmark in 2025. • Once additional analyses using HPD are completed, OHCA will share findings to inform future discussions with stakeholders on the focus on the benchmark.

Supplemental Analyses

Some comments went beyond the specifics of OHCA's proposed behavioral health definition and measurement methodology. These suggestions are more appropriately addressed as part of supplemental analyses or research studies. OHCA will evaluate these suggestions and assess feasibility using available data sources.

Feedback
• Quickly adopt a plan and timeline for an alternative approach to measuring out-of-plan, out-of-pocket spending for behavioral health care.
• Assess spending and utilization using Z codes, including for social determinants of health.
• Document preventive and treatment services in various settings to assess access.
• Measure spending against unmet needs and desired outcomes.
• Measure cost savings associated with modalities of care.
• Evaluate payment rates for non-physician professionals.

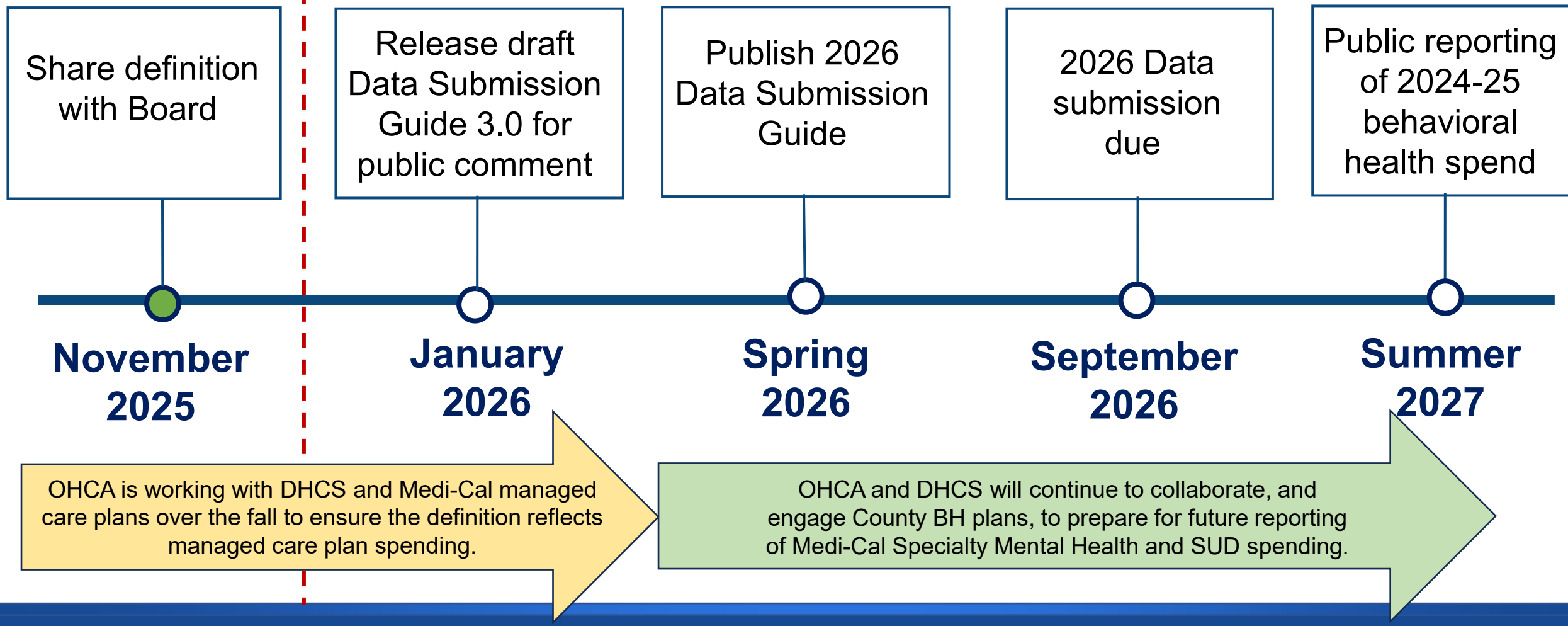
September Advisory Committee Feedback

Feedback	OHCA Response
• Support for measuring behavioral health occurring in primary care and incentivizing integration efforts.	• OHCA will continue to develop the behavioral health in primary care module, which aims to capture integrated behavioral health care and care provided by primary care providers, informed by HPD analysis.
• Request to analyze claims and spending for secondary behavioral health diagnoses.	• OHCA plans to conduct HPD analyses to identify spending associated with secondary diagnoses.
• Request to consider how to capture behavioral health spending for Medi-Cal members under 21 years old, for whom a diagnosis is not required to receive behavioral health services.	• OHCA's measurement methodology in DSG 3.0 will include spending on a defined set of behavioral health services for Medi-Cal members under 21 years, regardless of diagnosis. • OHCA will revisit the suggestion to include some core behavioral health services regardless of diagnosis, across markets, for DSG 4.0.

September Advisory Committee Feedback

Feedback	OHCA Response
• Recommendation to consider ways to measure out-of-pocket, out-of-plan spend.	• OHCA is exploring data sources and methodologies to analyze out-of-pocket, out-of-plan spending by consumers.
• Suggestion to analyze behavioral health quality of care.	• OHCA is researching behavioral health quality measures to monitor, in addition to those included in the OHCA Quality and Equity Measure Set.
• Appreciation for delayed benchmark; continued support for a spending benchmark focused on outpatient behavioral health care and in-network care.	• OHCA will conduct further analyses and plans to revisit benchmark setting with the Board in Summer 2026.
• Comments on impacts of immigration policy and funding for school-based care on access.	• OHCA acknowledges the impact of the recent policy changes on health care access for California's most vulnerable populations, including immigrants.
• Desire to better understand reasons for lower spend on substance use disorders and acknowledgement of frequent co-existence of mental health and substance use conditions.	• OHCA is beginning to conduct HPD analyses to identify drivers of spending for mental health and substance use disorder observed in prior analyses presented to the Board in June and July 2025.

Timeline for Finalizing Behavioral Health Measurement Definition



Behavioral Health Spending Definition and Measurement Methodology

Does the Board have any feedback on the behavioral health definition and measurement methodology?

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Update on Cost and Market Impact Review Program

Sheila Tatayon, Assistant Deputy Director
OHCA Health System Compliance

HCAI
Department of Health Care Access and Information

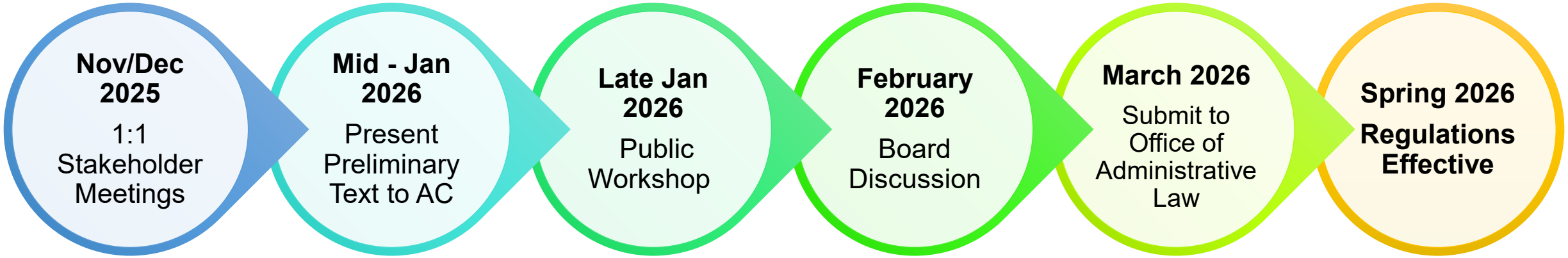
AB 1415 (Bonta, Chapter 641, Statutes of 2025) Amends the Health Care Quality & Affordability Act

- Expands Material Change Notice Requirements to additional entities:
  - Private Equity Groups and Hedge Funds.
  - Newly created business entities formed for the purpose of entering transactions with a health care entity.
  - Management Service Organizations (MSOs).
  - Entities that own, operate, or control a provider, regardless of whether provider is currently operating, providing health care services, or has a pending or suspended license.

- Defines Private Equity Groups, Hedge Funds & MSOs.

- Authorizes OHCA to collect data and information from MSOs.

AB 1415 Regulations Timeline (Projected)



Some dates are subject to change.

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Material Change Notices Currently in Review

MCN Submitters	Transaction Summary	Submission Complete	Status
MedImpact Healthcare Systems, Inc.	MedImpact Healthcare Systems, Inc. will acquire all of the membership interests of A&A Services, LLC d/b/a Sav-Rx. Both entities provide pharmacy benefit manager services nationwide.	November 7, 2025	In Review
CCW La Jolla and Classic Residence Management Limited Partnership	The transaction is a merger by and among CC Living Holding Company, LLC, CC Merger Sub, LLC, CC-Development Group, Inc. (the target company, hereinafter “Vi Parent”) and representatives of Vi Parent’s stockholders. Following the proposed merger, an internal corporate restructuring will result in changes to the indirect ownership of the skilled nursing facilities operated by CCW La Jolla, L.L.C. (“Vi at La Jolla Village) and Classic Residence Management Limited Partnership (“Vi at Palo Alto”).	October 31, 2025	In Review

4 additional transactions are in review for completeness and will be posted to website once material change notices are deemed complete.

Material Change Notices Currently in Review

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

Material Change Notices Currently in Review

MCN Submitters	Transaction Summary	Submission Complete	Status
Covenant Care California, LLC; Covenant Care Mission, Inc.; Covenant Care Long Beach, Inc.; Covenant Care Morgan Hill, LLC; Covenant Care Capitola, LLC; Covenant Care Encinitas, LLC; Covenant Care La Jolla, LLC; Covenant Care Courtyard, LLC; and Covenant Care Lodi, LLC.	Submitters will transfer the assets and operations of its respective facilities and assign rights and obligations under each facility's lease to a new operator or property owner.	April 24, 2025	In CMIR Review
Res-Care, Inc.	National Mentor Holdings, Inc. will acquire subsidiaries, equities, and assets from ResCare, an operator of intermediate care facilities for individuals with intellectual and developmental disabilities.	April 21, 2025	In Review

Transaction Reviews Completed Since May 2025

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

Transaction Reviews Completed Since May 2025

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

Transaction Reviews Completed Since May 2025

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

Transaction Reviews Completed Since May 2025

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

Transaction Reviews Completed Since May 2025

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

Transaction Reviews Completed Since May 2025

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

Transaction Reviews Completed Since May 2025

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

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 3 business days prior to the meeting.

HCAI
Department of Health Care Access and Information

Next Board Meeting:
December 16, 2025
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

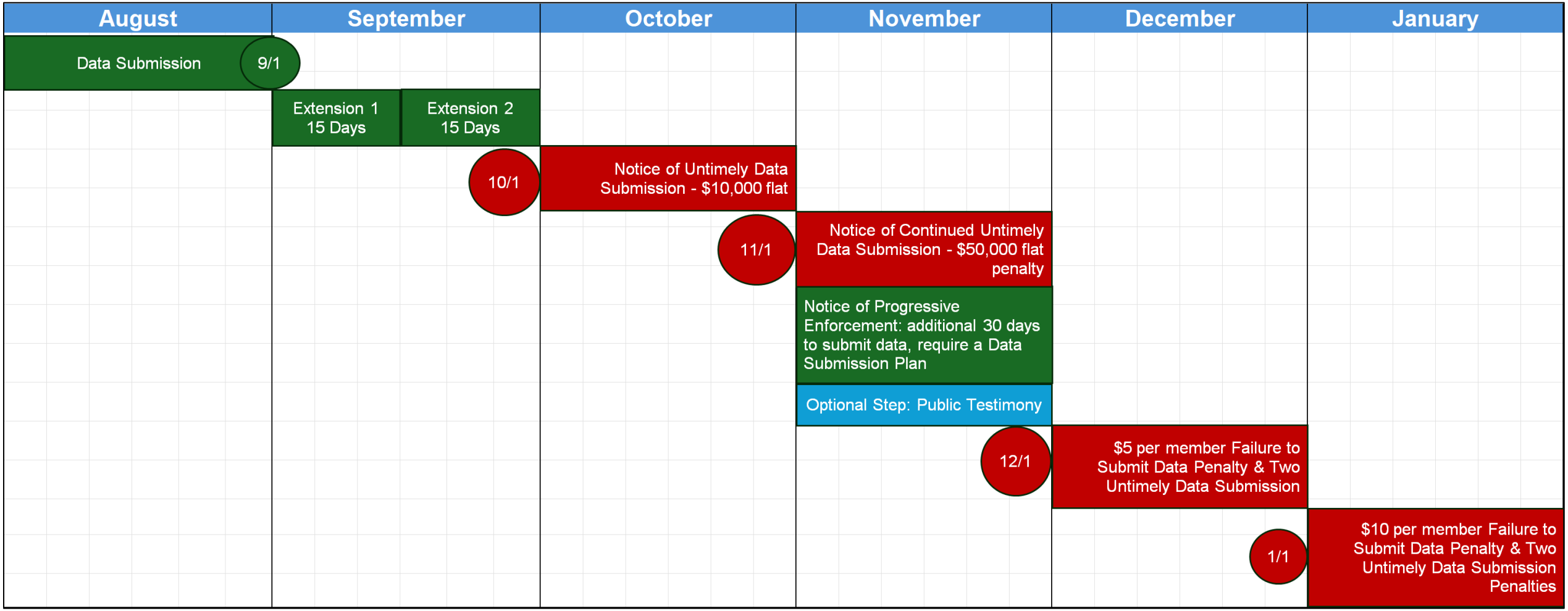
Appendix

HCAI

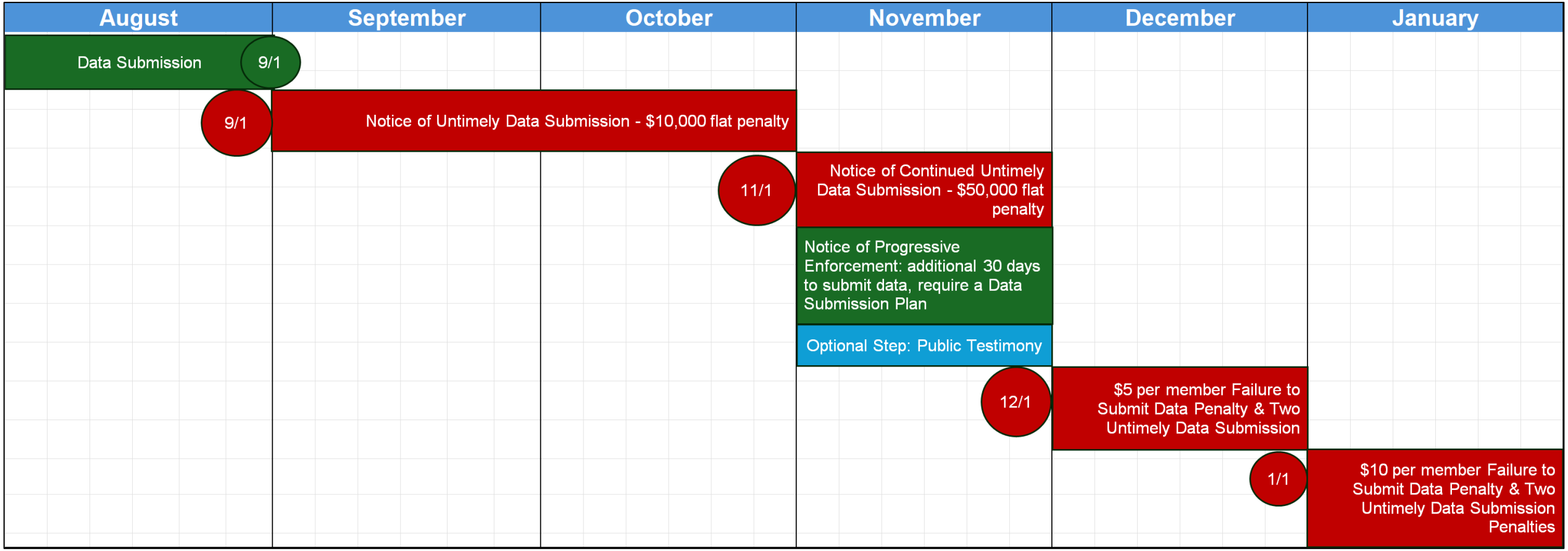
Department of Health Care Access and Information

Data Submission Enforcement Penalty Scope and Range

Scenario: Both Extensions



Scenario: No Extensions



Monterey Hospital Market Competition Study

Full Procedure Names of 10 Most Common Inpatient Admissions

MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITHOUT MCC
SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITHOUT MCC
CESAREAN SECTION WITHOUT STERILIZATION WITH CC
ESOPHAGITIS, GASTROENTERITIS AND MISCELLANEOUS DIGESTIVE DISORDERS WITHOUT MCC
CESAREAN SECTION WITHOUT STERILIZATION WITHOUT CC/MCC
SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC
VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITH CC
VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITHOUT CC/MCC
ALCOHOL, DRUG ABUSE OR DEPENDENCE WITHOUT REHABILITATION THERAPY WITHOUT MCC
PSYCHOSES

Full Names of 23 Common Outpatient Procedures

Transthoracic echocardiogram (TTE), complete.
Dual-energy X-ray absorptiometry (DXA), bone density study.
Cardiovascular stress test; tracing only, without interpretation.
Level IV - Surgical pathology, gross and microscopic examination.
Ultrasound, breast, unilateral, complete.
Antibody screen, RBC, each serum technique.
Computed tomography (CT), thorax; without contrast.
Esophagogastroduodenoscopy (EGD) with biopsy, single or multiple.
Radiologic examination, foot; complete, minimum 3 views.
Radiologic examination, spine, lumbosacral; 2 or 3 views.
Radiologic examination, shoulder; complete, minimum 2 views.
Colonoscopy with biopsy, single or multiple.
Electrocardiogram (ECG); tracing only, without interpretation.
Ultrasound, soft tissues of head and neck.
Colonoscopy, diagnostic.
Ultrasound, transvaginal.
Colonoscopy with removal of polyp(s) by snare technique.
Radiologic examination, chest; 2 views.
Ultrasound, pelvic (nonobstetric), complete.
Ultrasound, abdomen, complete.
Computed tomography (CT), abdomen and pelvis; with contrast.
Radiologic examination, hip, unilateral; complete, minimum 2 views.
Computed tomography (CT), thorax; with contrast.

Behavioral Health Spending Measurement Methodology

Overview of Recommended Non-claims Behavioral Health Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Spending
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	Include payments to behavioral health providers and provider organizations for care management/coordination and for integration with primary care or social care.
A2	Primary care and behavioral health integration*	
A3	Social care integration	
A4	Practice transformation payments	Limit the portion of practice transformation and IT infrastructure payments allocated to behavioral health spending to the proportion of total claims and capitation payments going to behavioral health.
A5	EHR/HIT infrastructure and other data analytics payments	
B	**Performance Payments**	
B1	Retrospective/prospective incentive payments: pay-for-reporting	Include performance incentives in recognition of reporting, quality, and outcomes made to behavioral health providers.
B2	Retrospective/prospective incentive payments: pay-for-performance	

*May be paid to primary care or multi-specialty provider organizations for this purpose.

Overview of Recommended Non-claims Behavioral Health Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Care Spending
C	**Payments with Shared Savings and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	Not Applicable
C2	Procedure-related, episode-based payments with risk of recoupments	
C3	Condition-related, episode-based payments with shared savings	Include spending for service bundles for a behavioral health-related episode of care.
C4	Condition-related, episode-based payments with risk of recoupments	
C5	Risk for total cost of care (e.g., ACO) with shared savings	Not Applicable
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	

Overview of Recommended Non-claims Behavioral Health Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Care Spending
D	**Capitation and Full Risk Payments**	
D1	Primary Care capitation	Not Applicable
D2	Professional capitation	Calculate a fee-for-service equivalent based on a fee schedule for behavioral health services multiplied by the number of encounters.
D3	Facility capitation	Not Applicable
D4	Behavioral Health capitation	Allocate full behavioral health care capitation amount to behavioral health care spending.
D5	Global capitation	Calculate a fee-for-service equivalent based on a fee schedule for behavioral health services multiplied by the number of encounters.
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	
E	Other Non-Claims Payments	Limit the portion of other non-claims payments* allocated to behavioral health spending to the proportion of total claims and capitation payments going to behavioral health.
F	Pharmacy Rebates	Not Applicable

*May include retroactive denials, overpayments, payments made as the result of an audit, or other payments that cannot be categorized elsewhere.

Equation for Allocating Practice Transformation, EHR/HIT, and Other Non-Claims Payments to Behavioral Health

$$\text{Subcategory A4 Behavioral Health Spend*} = \Sigma \text{ Practice Transformation Payments} \times \frac{\text{Behavioral Health Claims + Behavioral Health Portion of Capitation Payments}}{\text{Claims: Total Claims + Capitation and Full Risk Payments}}$$

*This equation would also be used to allocate Category A5 EHR/HIT Infrastructure and Data Analytics and Category E Other Non-Claims Payments to behavioral health.

Apportioning Professional and Global Capitation to Behavioral Health

Example for a Professional Capitation arrangement:

$$\frac{\Sigma\ (\#\ \text{of BH Encounters x FFS-equivalent Fee})_{segment}}{\Sigma\ (\#\ \text{of All Professional Encounters x FFS-equivalent Fee})_{segment}} = \text{Behavioral Health spend paid via professional capitation}$$

x Professional Capitation Payment

"Segment" means the combination of payer type (e.g., Medicaid, commercial), payer, year and region or other geography as appropriate.

Note: Methodology aligns with OHCA primary care approach.

Process Map for Identifying Behavioral Health in Primary Care Claims