OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Board Meeting

November 18, 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 Items**

a) Vote to Approve June, 2026, Meeting Minutes
Vishaal Pegany

b) Vote to Approve October 29, 2026, Meeting Minutes
Vishaal Pegany

Item #4 **Informational Items**

a) Overview of Progressive Enforcement Regulations, Including Board Follow Up and Public Comment
Vishaal Pegany; CJ Howard, Assistant Deputy Director; Megan Brubaker, Engagement, Governance and Policy Group Manager

b) Spending Target Discussion: Statewide Spending Target and High-Cost Hospital Target Adjustment Methodology
Vishaal Pegany; CJ Howard; Andrew Feher, Research and Analysis Group Manager

c) Update on Behavioral Health Spending Analysis and Investment Benchmark
Margareta Brandt, Assistant Deputy Director; Debbie Lindes, Health Care Delivery System Group Manager

Item #5 **General Public Comment**

Item #6 **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

Findings from California Health Care Foundations "Worried Sick"

- In September 2026, California Health Care Foundation (CHCF) released a compilation of studies on the opinions, experiences, and perspectives of close to 4,000 Californians about the costs of health care.
- CHCF also conducted focused interviews with 24 Californians across race, region, languages, insurance types, and income levels. All reported problems affording health care.

Common themes include:

1. Difficult tradeoffs families make to afford care
2. Anxiety, fear and stress due to rising health care costs
3. Delaying or skipping care because of costs
4. Distrust of the system and deep skepticism that change is possible

Source: California Health Care Foundation, Worried Sick: Californians on a Health Care System They Can't Afford, September 28, 2026. https://www.chcf.org/resource/2026/09/28/listening-california-health-care-costs/

Consumer Voices on the Impact of Unaffordable Health Care

Tradeoffs

"We're struggling to even eat, and the wages don't add up with inflation, and then we have medical care to worry about... I'm worried crazy about my daughter and her medications."

BLACK WOMAN, COVERED CALIFORNIA

Anxiety/Fear

"My biggest concern is, our insurance premiums have gone up almost double in five years... and then I have to wait four months, or five months, or six months just to be seen."

ANHPI MAN, EMPLOYER INSURANCE

Distrust

"Companies make big earnings. They make huge profits. When medicine was invented, it was meant to cure people. But now, later, it all got spoiled. They take advantage of people when they are vulnerable."

LATINO MAN, MEDI-CAL

Source: California Health Care Foundation, Worried Sick: Californians on a Health Care System They Can't Afford, September 28, 2026. https://www.chcf.org/resource/2026/09/28/listening-california-health-care-costs/

Findings from California Health Care Foundation Interviews

CHCF also asked interviewees question about “where they place the blame for the high cost of care.” Common themes include:

1. Corporate greed and corruption
2. Unfair and unpredictable prices
3. Administrative waste and complexity
4. No one is regulating costs
5. Complicated rules to deny treatment

Source: California Health Care Foundation, Worried Sick: Californians on a Health Care System They Can’t Afford, September 28, 2026. https://www.chcf.org/resource/2026/09/28/listening-california-health-care-costs/

Where Californians Place Blame for Health Care Affordability Challenges

Corporate Greed/Corruption

"Politicians are more interested in keeping their power and friends happy, because those friends are paying to help them stay in power, rather than actually solve the issues that are concerning us, the patients."

ANHPI MAN, EMPLOYER PLAN

Industry Leverage

"Companies are so big. They own so many different things that they have so much leverage... If there's just two or three of them, they can dictate price."

WHITE MAN, EMPLOYER PLAN

Errors and Administrative Waste

"They're asking me for an X-ray on my right leg when the problem was on my left. Or I'm at the doctor's office and they say we didn't get the fax."

LATINA WOMAN, MEDICARE

Rules to Deny Treatment

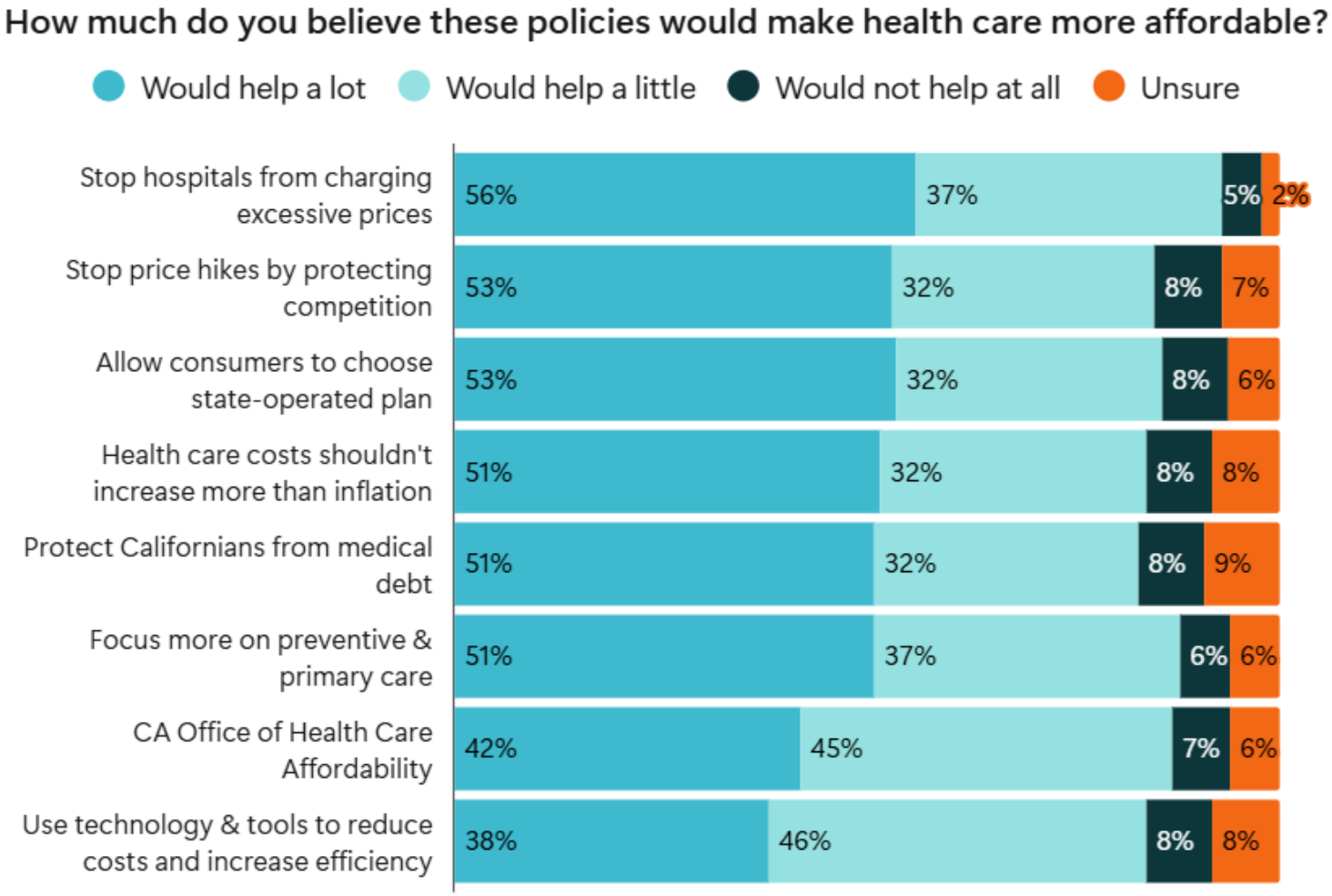
"Because everything is money for corporations, for shareholders. You can always see that they deny, deny, deny. People have died because they denied transplants or attention for cancer."

LATINA WOMAN, EMPLOYER PLAN, SPEAKING SPANISH

Source: California Health Care Foundation, Worried Sick: Californians on a Health Care System They Can't Afford, September 28, 2026. https://www.chcf.org/resource/2026/09/28/listening-california-health-care-costs/

Findings from California Health Care Foundation Focus Groups and Survey

Field surveys that reached more than 3,700 Californians and focus groups of 169 Californians asked which policies would improve health care affordability.



Source: California Health Care Foundation, Worried Sick: Californians on a Health Care System They Can't Afford, September 28, 2026. https://www.chcf.org/resource/2026/09/28/listening-california-health-care-costs/

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 Items: Vote to Approve June 24, 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

Action Consent Items: Vote to Approve October 29, 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

Overview of Progressive Enforcement Regulations, Including Board Follow Up and Public Comment

Vishaal Pegany - Deputy Director;
C.J. Howard - Assistant Deputy Director;
Megan Brubaker - Engagement, Governance, and Policy Manager

HCAI

Department of Health Care Access and Information

Progressive Enforcement Regulations – Informal Public Comment Period

- OHCA posted draft regulations on the OHCA website on October 8, 2026, and received 27 public comment letters during the informal public comment period from October 8 – 30, 2026.
- Comment letters came from unions, consumer advocacy groups, individual hospitals, health plans, and specialty care and hospital associations, among others.
- The summary slides that follow group the comments into these categories:
  - Hospital Spending Measurement
  - Physician Organization Spending Measurement
  - Health Plan Spending Measurement
  - Enforcement considerations
  - Technical Assistance (TA) and Public Testimony (PT)
  - Performance Improvement Plans (PIPs)
  - Financial Penalties
  - Transparency and Confidentiality
  - Other Comments

Note: This summary is not inclusive of all comments received. Please refer to the full set of public comment letters here: https://hcai.ca.gov/document/spending-target-enforcement-regulations-public-comment/

Hospital Spending Measurement

Comment	Response
Measurement must be clearly understood by entities.	OHCA has described its hospital measurement methodology in public materials that are available on its website, met with hospitals and hospital associations to answer questions, held workshops, and responded to email inquiries from entities. The regulations include a Measurement Manual that includes the complete methodology for measuring entity performance and calculating penalties.
Make changes to hospital measurement methodology before taking enforcement actions.	OHCA has worked on the hospital measurement methodology since April 2024 and this work included engaging a workgroup with hospital representatives and other industry experts to provide input through 2025. OHCA finalized its measurement approach at its December 2025 Board meeting. At the September 2026 board meeting, OHCA accommodated a request from hospitals requesting that OHCA combine the inpatient and outpatient spending measures into a single measure. While OHCA is not making additional changes now, OHCA remains open to enhancing hospital measurement in the future through additional updates and consideration of alternative data sources.
Basing spending target compliance on multiple years of data/spending growth/trend provides a more stable and accurate assessment of long-term spending trends.	The spending targets established under OHCA's enabling statute apply to individual performance years, and OHCA thus evaluates each year of performance separately. Entities may explain excess spending using multiple years of data during the 45-day period. This enables entities to share information about spending variation and volatility across multiple years. Additionally, "historical spending growth" is an enforcement consideration, which the office may use when determining whether an entity is subject to enforcement actions.
Retain combining inpatient and outpatient spending into a single weighted measure.	OHCA acknowledges and appreciates this comment.

Hospital Spending Measurement

Comment	Response
Only find that a hospital has exceeded the target when growth is larger than normal year-to-year variation.	Entities can explain abnormal year-over-year swings during the 45-day period after they have been notified that they've exceeded the target.
Exclude any self-financed amounts for Medi-Cal because public hospitals fund the nonfederal share. Including self-financing overstates hospitals' net reimbursement.	Currently, there is no single data source for self-financed amounts. HCAI is exploring changes to hospital data collection that would enable hospitals to report self-financed amounts.
Establish minimum utilization volumes for both reporting and enforcement.	In the September 2026 board meeting, OHCA indicated adopting minimum volume thresholds (e.g., payer-specific discharges or visits in the bottom percentile) in OHCA's reporting of hospital spending measures could address volatility for smaller hospitals or those with small patient volumes in a particular payer category. OHCA has not yet established minimum volume thresholds and is exploring them for its reporting of 2023-24 hospital spending.
Clarify in the measurement manual that inpatient/outpatient measures offset and across markets and change "average excess spending" to "spending difference from target."	At the September 2026 board meeting, OHCA described the combined growth measure, which weights inpatient and outpatient growth based on each service line's share of net patient revenue in the base measurement year. OHCA also provided examples of different growth rates for inpatient and outpatient measures and different shares of net patient revenue. The combined growth formula in the Measurement Manual is consistent with prior discussion. OHCA will not accept the naming change for average excess spending at this time.

Hospital Spending Measurement

Comment	Response
Retain volume and service-intensity adjustments so hospitals are not penalized for serving more or higher-acuity patients or providing resource-intensive care.	OHCA acknowledges and appreciates this comment.
Adjust for inpatient intensity based on a case mix index calculated using All Patient Refined Diagnosis Related Groups APR-DRGs instead.	OHCA will not accept this change. OHCA explored this proprietary tool previously but decided not to use it because we would not be allowed to publicly disclose the weights for each APC code. We use the Medicare APC weights because they are publicly available.
Test if HPD visits are representative for each hospital and payer and publish results.	At the December 2025 board meeting, OHCA shared analyses showing that all-payer and commercial intensity measures are strongly positively correlated for both inpatient (where the full census of utilization can be used) and outpatient care (which relies on a large sample that excludes a portion private self-insured ERISA plans and small plans that are not required to report data to the HPD).
Specify treatment of unweighted services, hospitals and payers that fail tests or have no Average Visit Intensity (AVI).	In instances where a hospital reports no revenue or utilization for inpatient or outpatient services in a market (or if AVI cannot be derived), as a function of the formula, combined growth will be equal to the growth in the service line with non-zero inputs.
Give each hospital its HPD visit counts, APC weight sums, and counts retained at each step of calculation.	OHCA will explore releasing additional hospital-level variables derived using HPD, to the extent they comply with the HPD's data release process and the California Health and Human Services Data De-Identification Guidelines (DDG).

Hospital Spending Measurement

Comment	Response
Base determination of compliance for hospitals reporting on non-calendar year basis on the higher of 1) the calendar year target that would otherwise apply or 2) the average of the calendar year spending targets weighted by the number of months that fall in each calendar year.	OHCA will not accept this change at this time. OHCA is charged with reducing administrative reporting burden on health care entities. OHCA can explore what additional data collection or existing data sources could allow for calendar year measurement based on service rendered dates.
Incorporate by reference OHCA's previously posted methodology to calculate inpatient and outpatient revenue from April 2026.	The Measurement Manual includes all data sources required to measure spending performance and calculate penalties. Incorporating the April 2026 technical document into the regulations is not necessary.
Base enforcement on all-payer measurement due to cross-subsidization; Only enforce against entities that exceed both its all-payer and commercial targets.	Measuring and enforcing by market allow for the identification of cost drivers specific to certain markets because health care spending, covered persons, health care product benefit designs, and payment arrangements differ among markets. Measuring and enforcing at the market level prevents spending performance in one market from obscuring spending growth in another market and allow health care entities to implement cost reducing strategies tailored to each market.

Hospital Spending Measurement

Comment	Response
Fix issues in the Measurement Manual: 1) Align descriptions of hospital spending in Sections 2, 3, and 4 with the formulas in Section 5. 2) Define “IP NPR Payer-Specific Share” and “OP NPR Payer-Specific Share.” 3) Add a payer subscript to every hospital formula and define each hospital market by the AFDR columns it draws from. 4) “Allowed amount basis” has no defined basis in the Annual Financial Disclosure Report.	• OHCA has aligned the formulas and definitions for “at target” variables. • OHCA has replaced the phrase “payer type” with “market” in Section 97445 (ii). • The Manual sufficiently articulates that year-over-year growth is weighted by inpatient and outpatient share of services at t – 1 (the base year). • OHCA did not include additional subscripts to the Manual since sections already note that growth is “calculated by market.” • OHCA has removed the phrase “on an allowed amount basis” from the definition of inpatient and outpatient NPR.

Physician Organization Spending Measurement

Comment	Response
Current attribution methodology holds physician organizations accountable for members who are not actual patients. Improve mechanisms to identify and correct attribution errors, such as using data collected from physician organizations directly.	OHCA will explore updates and alternative data sources for physician organization measurement and, to the extent OHCA adopts a different approach, OHCA will incorporate updates into future rulemaking.
The physician organization measure needs to account for varying degrees of delegated financial risk and operational responsibility in each contract. OHCA should establish an adjustment process with consistent criteria and documentation requirements.	OHCA will explore updates and alternative data sources for physician organization measurement and, to the extent OHCA adopts a different approach, OHCA will incorporate updates into future rulemaking.
OHCA should be required to review applicable Division of Financial Responsibility, plan and foundation agreements, and evidence of operational authority before enforcement actions.	Recognizing that delegated arrangements for physician organizations vary, OHCA has added “extent of delegated clinical and financial risk,” to our enforcement considerations listed in regulations. Note the enforcement considerations are not an exclusive list. Physician organizations may provide additional data or information about their delegated arrangements to OHCA during the 45-day period.

Physician Organization Spending Measurement

Comment	Response
OHCA must establish a risk and equity adjustment methodology for the reporting of data, per 127502(f) and (g). Health and socioeconomic status of patient populations can materially impact the cost of care in ways beyond providers' control. Proposed enforcement considerations are not enough.	In September 2023, after discussion with the Board and Advisory Committee, OHCA determined that it would measure and report age/sex adjusted spending for health plans and physician organizations. In May 2026, OHCA determined that it would revisit an equity adjustment methodology in two years. The draft regulations do allow entities to demonstrate the impact of relevant factors that contributed to excess spending growth including "the impact of unique population characteristics or changes in the distribution of social risk of the entity's population." Social risk includes the socioeconomic status of the entity's population. Per Health and Safety Code section 1270502.5(g), OHCA will continue to evaluate if equity adjustments are necessary and reliable.
Establish a workgroup focused on an attribution methodology that holds physician organizations accountable for costs within their control.	As mentioned in today's executive update, OHCA will begin to have meetings with physician organization stakeholders and convene ad-hoc workgroup meetings in 2027 as needed.
OHCA should reconcile eligibility periods, panel status, contract effective dates, and relationships among plans, foundations, and medical groups before drawing conclusions about spending growth.	This proposal is a departure from the physician organization measurement approach that OHCA presented in the August 2023 board meeting, with input from the Board and Advisory Committee. As mentioned earlier, OHCA is exploring updates and alternative data sources for physician organization measurement. To the extent OHCA adopts a different approach, OHCA will propose such updates at a future Board meeting for discussion and incorporate any updates into future rulemaking.

Health Plan Spending Measurement

Comment	Response
Provide clarity on enforcing against TME and TNME separately.	Statute requires OHCA to set separate administrative cost and profit targets for payers and FIDS. (Health and Safety Code section 127502 (h)). The purpose of the separate target is to deter growth in administrative costs and profits. Separate targets are individually enforceable.
OHCA should explain how required expenses, external cost drivers, and affordability investments will be treated.	OHCA will assess enforcement considerations by entity and, through the 45-day period, evaluate whether excess spending was within the entity's control.
OHCA should continue technical engagement with plans and actuaries before finalizing the payer methodology to further analyze volatility, market differences, required administrative costs, and possible disincentives to affordability investments.	OHCA remains open to enhancing health plan measurement in the future through stakeholder engagement, additional updates and consideration of alternative data sources.

Enforcement Considerations

Comment	Response
Expand enforcement considerations to include HR1 cuts, non-organized labor costs, macroeconomic trends, entity financial distress, revenue volatility, risk adjustment, equity adjustment, etc.	The list of enforcement considerations in draft regulations is non-exhaustive and covers these instances. For example: HR1 cuts would fall under changes in state and federal law. Entities may explain all or a portion of excess spending based on a variety of factors listed and not listed in regulations.
OHCA must give written justification and standardize the process for determinations on enforcement considerations and excess spend.	OHCA will update the regulations to include a summary of the basis for the final determination in the notice sent to entities who exceed the target.
Replace “clear and convincing evidence” standard for showing OHCA’s calculations are incorrect with “preponderance of evidence” standard.	OHCA will accept this change to the regulation text.
Allow additional extensions and accept requests for extensions up until the deadline for 45-day period.	OHCA will not accept this change. To ensure an effective progressive enforcement process, OHCA must timely analyze information received during the 45-day period and make prompt decisions regarding additional enforcement.
45-day letters should specify NPR, discharges, CMI, AFDR visits, HPD visit counts, APC weight sums, and AVI.	OHCA will update 45-day letter requirements to include descriptions of the calculations used to determine an entity’s performance.

Enforcement Considerations

Comment	Response
When posting list of entities that exceeded target, OHCA should include amount of growth that was justified and unjustified.	OHCA will not accept this change. OHCA's current measurement methodology does not calculate justified and unjustified growth. Entities will have an opportunity to explain excess spending during the 45-day period.
Per statute, regulations must include consideration of uncontrollable spending as a mandatory step.	OHCA has updated regulatory text in § 97452 from "may" to "shall" to clarify that the Director shall consider factors such as the amount of the entity's excess spending growth when determining whether the entity is subject to additional enforcement.
45-day letter should go to hospital's CEO and CFO and include SIERA contact.	OHCA will not accept this change at this time. Regulations currently requires the letter to be sent to the primary contact person designated by hospitals for SIERA data submissions or to the entity's agent for service of process. Currently, hospitals do not provide OHCA with updated CEO and CFO contacts to enable their inclusion. OHCA will continue to explore other sources for appropriate contacts for the 45-day letter and may change this in the future.
Change "non-supervisory organized labor costs" to "non-supervisory labor costs."	OHCA will not accept this change. The list of enforcement considerations in draft regulations is non-exhaustive. Entities may explain all or a portion of excess spending based on a variety of factors listed and not listed in regulations.
Retrospective NOLA-like process must be anticipated and acknowledged in the final enforcement regulations.	OHCA has already included non-supervisory organized labor costs as an enforcement consideration.
Labor unions of a health care entity must be able to request a retrospective NOLA and status updates throughout the enforcement process.	OHCA does not accept this change at this time. OHCA has already included non-supervisory organized labor costs as an enforcement consideration. As OHCA validates actual non-supervisory organized labor costs during the enforcement process, it may need to consult with labor unions.

Enforcement Considerations

Comment	Response
Explain how payer mix, service mix, patient acuity, and other operational differences are incorporated into compliance decisions.	The list of enforcement considerations in draft regulations is non-exhaustive. Entities may explain all or a portion of excess spending based on a variety of factors listed and not listed in regulations.
Consider whether high-cost patient outliers are covered by high-cost drugs.	OHCA will not combine these enforcement considerations at this time. While some high-cost patient outliers' costs may be covered by the high-cost drug consideration, this may not be the case in every circumstance. Entities can provide information regarding their high-cost patient outliers during the 45-day period for OHCA's consideration.
Consider broadening extension criteria beyond extraordinary events.	The list of acceptable reasons for an extension beyond the 45-day deadline is non-exhaustive. Entities can request an extensions based on other extraordinary events that directly impacts the submission of a response.
OHCA must establish a waiver process.	The waiver is permissive, not required, under the statute: Health and Safety Code section 127502.5 (i) states that the office may establish requirements for health care entities to file for a waiver of enforcement actions. Many of the example factors listed in the statute's waiver framework overlap with those factors listed in OHCA's enforcement considerations. For that reason, OHCA has declined to pursue a waiver process at this time. OHCA may revisit this determination in future years after gaining experience with the enforcement process and a better understanding of reasonable factors, anticipated costs, and extraordinary circumstances that may warrant a waiver of enforcement.
Establish an exemption for hospitals with patient volumes at or below 25% of the statewide average	OHCA is not accepting this change. OHCA can consider low patient volumes in the enforcement considerations under "the entity's impact on consumer access and affordability."

Technical Assistance (TA) and Public Testimony (PT)

Comment	Response
TA must be advisory – entities declining to implement cannot create a presumption of noncompliance.	OHCA will update regulatory text in § 97453 to include “as applicable” to clarify that an entity will consider reasonable efforts to implement technical assistance if applicable to the entity.
Update regulations to clarify that OHCA would provide TA to all entities that exceed target.	OHCA will update regulatory text in § 97453 to include “shall.”
Public Testimony (PT) should be done in stages/phases – first written and then in-person if an entity does not comply with written PT requirement.	OHCA will not accept this change at this time. In future years, OHCA may determine that phases for public testimony are appropriate.
Clarify in regulations that PT will be made public.	Draft regulations specify that oral public testimony be given at a public meeting. OHCA will update the regulation text to clarify that written testimony will be made public.

Performance Improvement Plans (PIPs)

Comment	Response
PIPs should be collaborative and provide meaningful opportunity to improve.	OHCA will engage with entities and partner agencies throughout the PIP development and approval process, providing multiple opportunities for input, collaboration, and revision.
More guidance on how to draft a successful PIP for public health systems	The PIP process will be collaborative. The PIP Submission Guidance may develop over time to include additional guidance for specific entity types.
PIPs should be action steps, not goals – per statute.	The SMART Goals include strategies, or action steps, that the entity must include in its stated goal. Health and Safety Code section 127502.5 (c)(1) requires that a PIP "includes, but is not limited to" specific strategies, adjustments and action steps.
*Assessment of PIP compliance must be separate from target compliance; PIPs should not be tied to achievement of spending target, per statute language.	As required by Health and Safety Code section 127502.5(d)(1), PIP compliance and target attainment will be separately treated for purposes of determining penalty assessment. Achievement of the spending target will not be included as a SMART goal to ensure alignment with Section 127502.5(d)(1). Draft regulations have been updated to clarify that both assessments remain separate.
Requirement of PIP should be based on established criteria, which include written findings about unjustified growth.	The enforcement considerations are a criteria that will be used to determine which entities proceed to a PIP. OHCA updated regulations to include in the PIP notice information about the enforcement considerations that informed OHCA's decision to require a PIP.

*This comment is also responsive to an earlier question from the Board.

Performance Improvement Plans (PIPs)

Comment	Response
Update regulations with objective approval criteria for PIPs – OHCA may not dictate PIP strategies.	OHCA will not accept this change. Health and Safety Code section 127502.5(a) charges OHCA with enforcing the targets in a manner that ensures compliance with the target. While entities will propose PIPs, Health and Safety Code section 127502.5(c)(1) prohibits OHCA from approving a PIP that proposes to meet targets in ways that are likely to erode access, quality, equity, or workforce stability. OHCA, necessarily, will need to evaluate and approve PIP strategies.
Update text to read “OHCA shall not approve, require, or direct, including through approval or a request for revisions, any PIP, strategy, or action upon a showing by a health care entity that the action is likely to erode access, quality, equity, or workforce stability.”	OHCA will not accept this change. Draft regulation text states that OHCA will evaluate PIP proposals by considering factors including: “the adequacy of measures to mitigate adverse impacts on access, quality, equity, and workforce stability.” Additionally, statute prohibits the approval of PIPs that propose to meet the target in ways that are likely to erode access, quality, equity, and workforce stability are adequate.
OHCA should identify which proposed PIP interventions create material risks to access, quality, etc.	Entities are well positioned to propose mitigation strategies as they are more readily familiar with how changes to operations can pose risks to access, quality, equity, affordability and workforce stability. OHCA will point out gaps in proposed PIPs and will have a collaborative process with the entity before approving PIPs.
PIP Guidance D.8 should include DMHC's access measures such as time-and-distance standards, timely access, and network adequacy and DHCS's network adequacy for Medi-Cal Managed Care.	OHCA accepts this addition and will update the PIP guide with this addition. The measures in the guide are not an exhaustive list nor are they specifically required. Entities may choose other measures.

Performance Improvement Plans (PIPs)

Comment	Response
Permit entities to select appropriate, entity-specific outcomes and measures.	Draft regulations and PIP Submission Guidance requires entities to draft their own proposed outcomes and measures.
Permit entities to report partial results, leading indicators, and implementation progress when outcomes require time.	The PIP Submission Guidance requires that entities report progress on achieving PIP goals, completing activities, and balancing measure performance at a minimum cadence of every 6 months. Final outcomes are not required to be reported until submission of the final progress report.
Establish evaluation criteria when the PIP is approved.	Draft regulations includes criteria for evaluating PIP proposals.
Require every proposed PIP to include a workforce stability and patient care impact analysis examining staffing levels, vacancies, turnover, layoffs, use of temporary staff, service reductions, and compliance with applicable staffing and labor standards. Labor unions must have an opportunity to review and respond to the analysis before PIP approval.	OHCA will not accept the change regarding the proposed analysis. This requirement may not be applicable or suitable for all PIPs. PIPs will be based on entity-specific drivers of health care spending, and some drivers may not necessitate this type of analysis. Section D.8 of the PIP Submission Guidance includes the requirement to develop balancing measures for each goal or strategy, which describe how entities will maintain or improve access, quality, equity, and workforce stability. Entities are required to include mitigation strategies and measures that entities will track and report on in progress reports and the final progress report. The PIP Submission Guidance includes optional existing measures to include for reference. Entities may choose to propose workforce stability analyses as part of this required section in the PIP. Lastly, draft regulations require OHCA to post PIP proposals and accept public comment for 10 business days prior to approval.

Performance Improvement Plans (PIPs)

Comment	Response
PIPs should reduce rate of growth in spending, not reduce spending.	OHCA will not accept this change. Health and Safety Code section 127502.5(c)(1) states OHCA may require a PIP that includes strategies “to improve spending performance.” Entities may need to meet the spending target by reducing excess spending in certain areas, which entities can identify through the cost driver analysis required as part of the PIP.
Give entities opportunity to fix PIPs after Board input.	Draft regulations currently provide a process for making required edits or producing additional information after OHCA completes its evaluation and/or consults with the Health Care Affordability Board and other state regulators.
Give entities authority to modify PIPs and create process for it.	OHCA will consider this change in a future update to regulations.
Explain decisions to require modifications (connection to PIP, material adverse effect, etc.).	Draft regulations require OHCA to notify entities when it has rejected a PIP proposal or when it requires additional information – identification of issues needing revisions will be shared at that time.
Add new section to PIP Guidance identifying applicable target entities need to meet to avoid penalty.	OHCA will accept this change.
Update regs/manual to clarify which year will be measured to assess compliance with target in conjunction with PIP.	As regulations are currently written, this will be dependent upon the timeline agreed upon by entities and OHCA.

Performance Improvement Plans (PIPs)

Comment	Response
Avoid overlapping PIPs	OHCA will work with entities to consolidate PIPs where appropriate and when authorized by the enabling statute. Each spending target year is enforceable. There may be circumstances where overlapping PIPs are deemed necessary by the office.
Extensions should be available when a hospital acting in good faith needs additional time for operational reasons.	Draft regulations provide for extensions for the submission of PIP proposals, requests for additional information or revised PIP proposals, PIP progress reports, modifications to PIPs, and PIP final progress reports.
Lengthen the initial PIP submission period from 45 to 60 days and increase the extension window from 30 to 45 days	OHCA will update regulations to increase the PIP extension from 30 days to 45 days.
Change PIP's attestation from "accurate and true" to "based on knowledge, information, and belief."	OHCA will not accept this change at this time. “Accurate and true” is the appropriate standard for an individual signing on behalf of the entity to confirm the accuracy of the information provided.
Revise regulations text to say that OHCA “may,” not “shall,” obtain Board input in closed session.	OHCA will update regulations to reflect that OHCA will obtain Board input on PIP before approving or rejecting a PIP and such input may occur during closed session.
Regulations should include that OHCA will regularly update public on PIP progress reports.	OHCA will not accept this change at this time. Statute requires that OHCA provide the Board with regular updates on entities’ compliance with PIPs. The PIP Submission Guidance includes sections F.1 and G.1 to meet this requirement to update the Board and the public through detailed summaries of PIP compliance. These updates may be publicly shared thru Board meetings, on the OHCA website, or in an annual report.

Financial Penalties

Comment	Response
Regulations should guarantee adjustments to penalty calculations for reasonable spending growth.	The Board-approved penalty justification factor for “nature, number, and gravity of offenses” can be considered when determining a final penalty amount.
Greater transparency on how Medi-Cal financing and nonfederal share contributions influence on penalties; Regulations should include consideration of Medi-Cal match.	The Board-approved penalty justification factors already include consideration of nonfederal share associated with Medi-Cal as required in statute (Health and Safety Code section 127502.5 (d)(3)). This will be a fact-specific inquiry for each entity subject to a penalty.
Include notice and cure protections to definition of "repeatedly fails to implement" in § 97456(a)(3)	OHCA will update the regulations to include a notice and cure opportunity for § 97456(a)(3).
Penalty justification factors should be further defined.	The regulations include the penalty justification factors as approved by the Board and do not require further definition at this time.
Conform to Board-approved language on scope and range of spending target penalty.	OHCA will update the regulations to incorporate language from the Board resolution.
Revisit penalty framework	In the future, OHCA and the Board may consider changes to the spending target penalty and procedural penalty frameworks. The Board would need to approve changes to the penalty scope, range, and justification factors.
Penalties should be phased in.	OHCA will not accept this change. Board-approved penalty justification factors cover various situations that OHCA may consider when determining a final penalty amount, including the nature, number, and gravity of the offenses, among others.

Financial Penalties

Comment	Response
Penalties should account for financial condition, investments in patient-centered care, the degree to which an entity's spending growth was attributable to factors outside of its control, including government mandates and broader economic conditions.	Board-approved penalty justification factors cover various situations that OHCA may consider when determining a final penalty amount, including the financial condition of the entity, among others.
Clarify that for public entities, §97457(a)(2) does not treat the general revenues or reserves of a county, the University of California, or another governmental parent as resources of the hospital.	OHCA will not accept this change as Health and Safety Code section 127502.5(d)(6)(B) requires the director to consider all of the following to determine the penalty: 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.
Further define procedural penalty triggers: what is an acceptable PIP; what is a reasonable opportunity to cure; how will cure efforts be evaluated.	The PIP Submission Guidance and draft regulations includes a list of factors that OHCA will consider when assessing whether to approve or reject a PIP, see § 97455(d)(6). Draft regulations and the PIP Submission Guidance also include information about submission and extension timelines that provide entities with the opportunity to submit required information and documents and request additional time if necessary.
How will procedural penalties and spending target penalties avoid being duplicative or disproportionate?	Procedural penalties and spending target penalties are calculated using different penalty calculation formulas and respond to different types of violations. Board-approved penalty justification factors allow for proportionate penalties.

Transparency and Confidentiality

Comment	Response
Extend PIPs' confidentiality protections to entire enforcement process.	OHCA accepts this request and will update the regulations to allow for requests for confidential treatment during other stages of the progressive enforcement process.
Clarify in regs that proprietary information will not be disclosed following a request to withdraw.	OHCA accepts this request and will update regulations to clarify that entities may withdraw documents not deemed to be confidential.
Expand per se confidential treatment documents list and clarify how it'll be different for these documents.	OHCA declines to expand the list of per se confidential documents at this time but may consider adding documents to the list over time.
Make public the list of entities that exceeded the target at the beginning of the 45-day period.	OHCA accepts this request and will update the regulations to include posting a public list of who receives an initial determination on exceeding targets.
Establish a public comment period before final enforcement determinations.	OHCA has updated the regulations to allow for a 10-day public comment period on health care entities that have exceeded the target.

Transparency and Confidentiality

Comment	Response
Make public decisions on enforcement with at least a summary of reasons.	OHCA partially accepts this change. OHCA will post a list of entities that exceeded the target and will identify the extent to which the target was exceeded. OHCA will post a list of entities required to implement a PIP, including the enforcement considerations used in making that determination.
Post explanation of whether growth is justified or not, and entities' response to OHCA, after 45-day period.	OHCA will not accept this change. OHCA will post a list of entities that exceeded the target and will identify the extent to which the target was exceeded.
Require OHCA to publicly explain its decisions to modify spending calculations, decline enforcement, or select a particular enforcement action	OHCA partially accepts this change. The regulations will be updated to require identification of the enforcement considerations used in making the determination to require an entity to move beyond technical assistance. OHCA will not modify spending calculations, except for instances where a spending calculation was made in error.
Make public TA and PT – rethink the "may" in "OHCA may post TA letters."	OHCA has accepted this change.
Add notice of penalty to list of what is a public record.	The regulations require OHCA to post the identities of entities subject to enforcement. OHCA may consider the timing of posting the final Director's Order in a future rulemaking.
Add requirement to post amounts of penalties and justification factors considered.	Per Health and Safety Code section 127501.6 (b)(2)(f) administrative penalties imposed and assessed will be included in annual reports. OHCA will not publicize the basis for its penalty justification determinations because this is part of OHCA's deliberative process.

Transparency and Confidentiality

Comment	Response
Notify any labor union representing workers at a health care entity when they have exceeded the target, and timely updates at every subsequent stage of the enforcement process.	OHCA will not accept this change at this time. OHCA has updated the regulations to allow for a 10-day public comment period on health care entities that have exceeded the target. The draft regulations also includes a 10-day public comment period on proposed performance improvement plans. OHCA will also periodically post a detailed summary of an accountable health care entity's compliance with an approved performance improvement plan.
Add requirement to post progress reports.	OHCA will not accept this change at this time. Statute requires that OHCA provide the Board with regular updates on entities' compliance with PIPs. The PIP Submission Guidance includes sections F.1 and G.1 to meet this requirement to update the Board and the public through detailed summaries of PIP compliance. These updates may be publicly shared thru Board meetings, on the OHCA website, or in an annual report.
Add when public postings for PIPs occur; Add in regulations that Board and public will receive notice of each "public record" (e.g. PIPs, PIP progress reports, etc.) in a timely manner.	OHCA will not accept this change. Timelines for PIPs and penalties will likely be different for each entity. Additionally, approval of PIPs, completion of progress reports, etc., are dependent upon a variety of factors including consultation with other state regulators and Health Care Affordability Board, availability of data, and more. OHCA is committed to posting information when it is available and appropriate for public dissemination.

Other Comments

Comment	Response
Update definition of “accountable health care entity,” to be consistent with statute.	The accountable health care entity definition will evolve over time to include more health care entities that are enumerated in the statute.
Replace "required submitter" with "accountable health care entity" in (§ 97456(b)(1) and § 97452(b)(3)(B)(iii)	OHCA will update the regulations in response to this feedback.
OHCA should consult with 340B experts on how 340B fits within the high-cost drugs enforcement consideration.	OHCA appreciates this feedback and will consider it for future enforcement activities.
Establish spending target adjustments and methodology for provider efficiency, Medi-Cal Utilization, and participation in APMs.	Thank you for this feedback. This comment is more appropriate for target setting.

Progressive Enforcement Regulations

Does the Board have any feedback on the draft regulations?

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 Discussion: Statewide Spending Target and High-Cost Hospital Target Adjustment Methodology

Vishaal Pegany, Deputy Director;
C.J. Howard, Assistant Deputy Director;
Andrew Feher, Research Scientist Manager

HCAI

Department of Health Care Access and Information

Spending Target Discussion

Today's discussion:

1. Potential Updates to the Statewide Spending Target
   - Update on median household income growth and select economic and health care measures
   - Potential revisions to previously established targets (2028 and 2029)
   - Consideration of setting targets for 2030 and beyond
2. High-Cost Hospital Adjustments
   - Update based on the most recent five-year period (FY 2020-2024)
   - Modification to the existing methodology by using data reflected in the SIERA system

Next meeting:

1. Continue today's discussion
2. Discuss Non-Supervisory Organized Labor Adjustment (NOLA)

Timeline and Process for Adopting the Spending Target

Statutory Language on Target Setting Timeline

127502.

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

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

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

(4) **The board shall adopt final targets on or before June 1, at a board meeting**. The board shall remain in session, and members shall not receive per diem under Section 127501.10, until the board adopts all required cost targets for the following calendar year.

Source: Health and Safety Code § 127502

Statewide Spending Target

Statewide Spending Target

In April 2024, the Board voted to establish a base spending target of 3% based on average historical growth in median household income from 2002 to 2022, signaling that health care spending should not grow faster peoples' incomes. The board added a half a percentage point to 2025, and 2026, and a fifth of a percentage point to 2027 and 2028, phasing down to 3% for 2029. In 2025 and 2026 the Board did not change the statewide spending target values.

Performance Year	Per Capita Spending Growth Target
2025	3.5%
2026	3.5%
2027	3.2%
2028	3.2%
2029	3.0%

Long-term Trends in California Health Care Spending & Economic Indicators

Market	Time Period	Average TME PMPY Growth
Commercial Total Medical Expense (TME)	2022–2025	6.5%
Medicare Advantage TME	2022–2025	5.3%

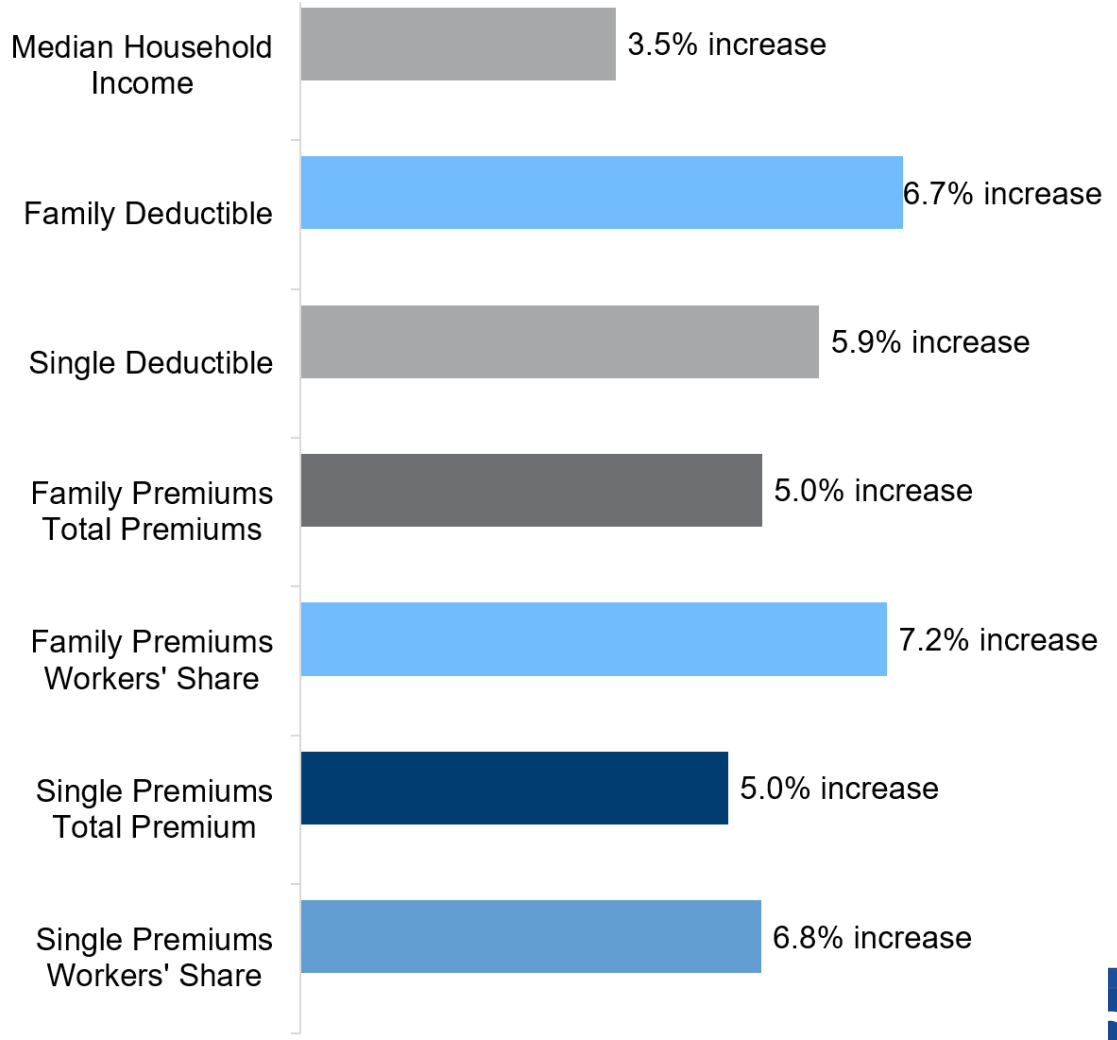
Indicator	Time Period	5 Year Average	10 Year Average	15 Year Average	20 Year Average
Median Household Income	2005 - 2025	5.4%	4.8%	4.3%	3.5%
Consumer Price Index	2005 - 2025	4.4%	3.5%	3.0%	2.8%
Gross State Product Per Capita	2005 - 2025	6.8%	5.4%	5.0%	4.2%

Note: 2025 TME is preliminary and subject to change.

Trends in Health Care Costs

- California's rising health care costs have placed a growing financial burden on workers and families.
- OHCA recommends that the Board continue to center the statewide spending target – a benchmark for consumer affordability – on a primary measure of consumer affordability and ability to pay (e.g., Median Household Income).

Average Annual Growth Rates for Premiums and Deductibles for Private Sector Workers and Median Household Income in California, 2005-2025



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

Potential Changes to the Statewide Spending Target

1. No action – Maintain 2028 and 2029 targets.
   - The Board does not need to act now. It will, however, need to set 2030 targets by June 1, 2029.
2. Modify existing targets based on more recent data.
   - Modify the target values for performance years 2028 and 2029.
3. Modify existing targets and extend the time-series of set targets.
   - Modify the target values for 2028 and 2029, and set targets for 2030, 2031, and/or 2032.
4. Maintain existing targets and extend the time-series of set targets.
   - Maintain the targets as set for 2028 and 2029, and set targets for 2030, 2031, and/or 2032.
5. Explore other alternatives to inform target setting.

Performance Year	Currently Set Per Capita Spending Growth Target
2025	3.5%
2026	3.5%
2027	3.2%
2028	3.2%
2029	3.0%
2030	-
2031	-
2032	-

Note: The Board may need to review other statutory considerations prior to adopting targets.

Potential Changes to the Statewide Spending Target

Performance Year	Maintain Existing Targets	Revise Future Targets Based on Recent Data	Revise Future Targets and Extend Target Setting	Maintain Existing Targets and Extend Target Setting
2025	3.5%	3.5%	3.5%	3.5%
2026	3.5%	3.5%	3.5%	3.5%
2027	3.2%	3.2%	3.2%	3.2%
2028	3.2%	3.5%	3.5%	3.2%
2029	3.0%	3.5%	3.5%	3.0%
2030			3.5%	3.5%
2031			3.5%	3.5%
2032			3.5%	3.5%

Statewide Spending Target Value

Does the Board have input on the following options related to the statewide spending target:

1. Leave spending target values as currently set for 2028-2029.
2. Update spending target values based on the more recent 20-year historical period.
3. Set targets for 2030, 2031, and or 2032 to provide industry with a predictable and sustainable rate of change.
4. Update the data or methodology for target setting.

Note: The Board may need to review other statutory considerations prior to adopting targets.

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

Public Comment

HCAI
Department of Health Care Access and Information

High-Cost Hospital Adjustment

Background: Adjusted Targets for High-Cost Hospitals

- In April 2025, after defining hospitals as a sector, the Board adjusted targets for hospitals that met the following criteria:
  - Above the 85th percentile for three out of five most recent years of data (2018-2022) on Commercial Inpatient Net Patient Revenue (NPR) per Case Mix Adjusted Discharge (CMAD) and Commercial to Medicare Payment to Cost Ratio (PTCR);
    - Excluding hospitals that have decreasing values for two consecutive years on both measures, which results in the hospital falling below the 85th percentile in the most recent data year (i.e., 2022).
  - Above the 30th percentile in total annual discharges;
  - Share of Medicare and Commercial revenue above 5%; and
  - Have comparable financial data in the HCAI Hospital Financial Reports.
- The hospitals that met these criteria were considered high-cost compared with other hospitals within the hospital sector.

Background: Adjusted Targets for High-Cost Hospitals

- The Office also committed to annually provide an updated list of hospitals that meet the aforementioned criteria and an updated list of factors for consideration to adjust targets for high-cost facilities within the hospital sector.
- In December 2025, OHCA presented an update to the list of hospitals that met the above criteria based on data from 2019-2023. The list of hospitals that met the criteria was unchanged from April 2025. Several hospitals came forward asking OHCA to consider resubmitted data.
- Since January 2026, OHCA and the Board have discussed how and whether to consider resubmitted data.
- In March 2026, OHCA indicated that it would return with options for identifying high-cost hospitals that include using revised data, originally submitted data, and alternative methodologies.

Hospital Annual Financial Disclosure Report Background

- Every fall, HCAI publishes the Hospital Annual Financial Disclosure Report (Hospital Financial Data) Complete Data Set on the Open Data Portal.
- The regulatory process allows hospitals to resubmit historical data at any time and for multiple years.
- When HCAI publishes the **Complete Data Set** each fall, files on the Open Data Portal are not modified or adjusted to reflect prior year resubmissions.
- The resubmissions are publicly available on HCAI's website via the **SIERA** system.

Summary of High-Cost Hospital Analysis

Objective: (1) compare what hospitals originally reported to HCAI prior to the adoption of high-cost hospital targets in April 2025 to what they reported to HCAI in resubmitted data after April 2025 when the Health Care Affordability Board finalized the criteria to identify high-cost hospitals; (2) compare hospital-reported data to Health Care Payments Data (HPD) and RAND Price Transparency data, both of which rely on claims and are not directly reported by hospitals.

Findings:

- Four high-cost hospitals – Community Hospital of the Monterey Peninsula (CHOMP), Salinas Valley, Santa Barbara Cottage and Washington Fremont – resubmitted 3 or more years of historical data. Using the resubmitted data, they would no longer meet the Board's high-cost criteria.
- Compared with their original submissions, those four high-cost hospitals reported an average decrease of $7,800 (25%) on commercial IP NPR per CMAD and an average decrease of 115 percentage points (45%) on the Commercial to Medicare PTCR.
- These large decreases in commercial IP NPR per CMAD and Commercial to Medicare PTCR for the four high-cost hospitals that resubmitted multiple years of data were the result of increases in commercial discharges, increases in Medicare NPR, increases in Medicare PTCR, decreases in commercial NPR and decreases in commercial PTCR, all of which were statistically significant.
- Two claims-based data sources – the Healthcare Payments Data (HPD) and RAND Price Transparency data – are generally consistent with the metrics in the hospitals' originally submitted data, indicating that these facilities have some of the highest commercial inpatient spending levels in California.

Implication: these results highlight the importance of comparing hospital-reported data to other data sources.

Update to High-Cost Hospital Analysis Complete Data Set 2020-2024

Commercial Inpatient NPR per CMAD for Repeat Outlier Hospitals

above 85%

Hospital	2020	2021	2022	2023	2024	Pooled Avg 2020-24
All Other Comparable Hospitals	**$20.3K**	**$20.5K**	**$21.2K**	**$21.9K**	**$21.8K**	**$21.1K**
6 High-Cost Hospitals	**$39.6K**	**$41.3K**	**$43.3K**	**$44.8K**	**$43.1K**	**$42.5K**
Community Hospital of The Monterey Peninsula	$42.3K	$43.7K	$38.9K	$42.6K	$36.8K	$40.8K
Doctors Medical Center – Modesto	$35.9K	$36.8K	$39.7K	$37.0K	$24.3K	$34.8K
Dominican Hospital	$33.2K	$34.9K	$33.3K	$36.1K	$34.9K	$34.5K
Santa Barbara Cottage Hospital	$36.6K	$32.6K	$33.6K	$35.5K	$31.0K	$33.8K
Stanford Health Care	$49.1K	$53.4K	$58.9K	$63.1K	$71.2K	$59.9K
Washington Hospital – Fremont	$30.9K	$33.1K	$35.4K	$31.7K	$28.1K	$31.8K

Salinas Valley Memorial Hospital, previously on the Complete Data Set (CDS) list, no longer meets the high-cost criteria due to decreasing values for two consecutive years on both measures, which results in the hospital falling below the 85th percentile in 2024.

Source: Complete Data Set 2020-2024 retrieved 10/01/2026. Hospital-wide case-mix index

Commercial to Medicare Payment to Cost Ratio for Repeat Outlier Hospitals

above 85%

Hospital	2020	2021	2022	2023	2024	Pooled Avg 2020-24
All Other Comparable Hospitals	**202%**	**192%**	**199%**	**206%**	**192%**	**198%**
6 High-Cost Hospitals	**338%**	**334%**	**348%**	**349%**	**311%**	**336%**
Community Hospital of The Monterey Peninsula	353%	363%	369%	380%	335%	360%
Doctors Medical Center - Modesto	343%	325%	372%	367%	337%	349%
Dominican Hospital	336%	316%	334%	352%	350%	338%
Santa Barbara Cottage Hospital	310%	310%	311%	322%	207%	290%
Stanford Health Care	339%	351%	340%	343%	331%	340%
Washington Hospital - Fremont	352%	328%	363%	330%	306%	336%

Salinas Valley Memorial Hospital, previously on the Complete Data Set (CDS) list, no longer meets the high-cost criteria due decreasing values for two consecutive years on both measures, which results in the hospital falling below the 85th percentile in 2024.

Source: Complete Data Set 2020-2024 retrieved 10/01/2026.

High-Cost Hospital Analysis With Resubmitted Data SIERA 2020-2024

Commercial Inpatient NPR per CMAD for Repeat Outlier Hospitals

above 85%

	2020	2021	2022	2023	2024	Pooled Avg 2020-24
All Other Comparable Hospitals	**$20.5K**	**$20.6K**	**$21.3K**	**$21.7K**	**$21.8K**	**$21.2K**
High-Cost Hospitals	**$37.4K**	**$39.0K**	**$46.6K**	**$45.8K**	**$47.6K**	**$43.5K**
Doctors Medical Center - Modesto	$35.9K	$36.8K	$39.7K	$31.4K	$24.3K	$33.6K
Dominican Hospital	$33.2K	$34.9K	$33.3K	$36.1K	$34.9K	$34.5K
John Muir Medical Center- Walnut Creek*	$23.4K	$21.1K	$41.6K	$38.9K	$39.4K	$33.2K
Stanford Health Care	$49.1K	$53.4K	$58.9K	$63.1K	$71.2K	$59.9K

*John Muir Medical Center resubmitted its FY 2022 data in September 2024, which resulted in higher commercial net patient revenue.

Source: SIERA 2020-2024 retrieved 10/02/2026.

Commercial to Medicare Payment to Cost Ratio for Repeat Outlier Hospitals

above 85%

	2020	2021	2022	2023	2024	Pooled Avg 2020-24
All Other Comparable Hospitals	**202%**	**193%**	**200%**	**205%**	**192%**	**198%**
High-Cost Hospitals	**286%**	**282%**	**346%**	**342%**	**335%**	**320%**
Doctors Medical Center - Modesto	343%	325%	372%	367%	337%	349%
Dominican Hospital	336%	316%	334%	352%	350%	338%
John Muir Medical Center- Walnut Creek	100%	103%	332%	306%	334%	240%
Stanford Health Care	339%	351%	340%	343%	331%	340%

*John Muir Medical Center resubmitted its FY 2022 data in September 2024, which resulted in higher commercial net patient revenue.

Source: SIERA 2020-2024 retrieved 10/02/2026.

Examining High-Cost Hospital Resubmissions

OHCA Methodology to Calculate Commercial Inpatient Net Patient Revenue per Case Mix Adjusted Discharge

Step 1

Multiply

Total commercial inpatient discharges

x

Case Mix Index (CMI)

=

Case Mix Adjusted Discharge (CMAD)

then

Step 2

Divide

Commercial Inpatient Net Patient Revenue (NPR)

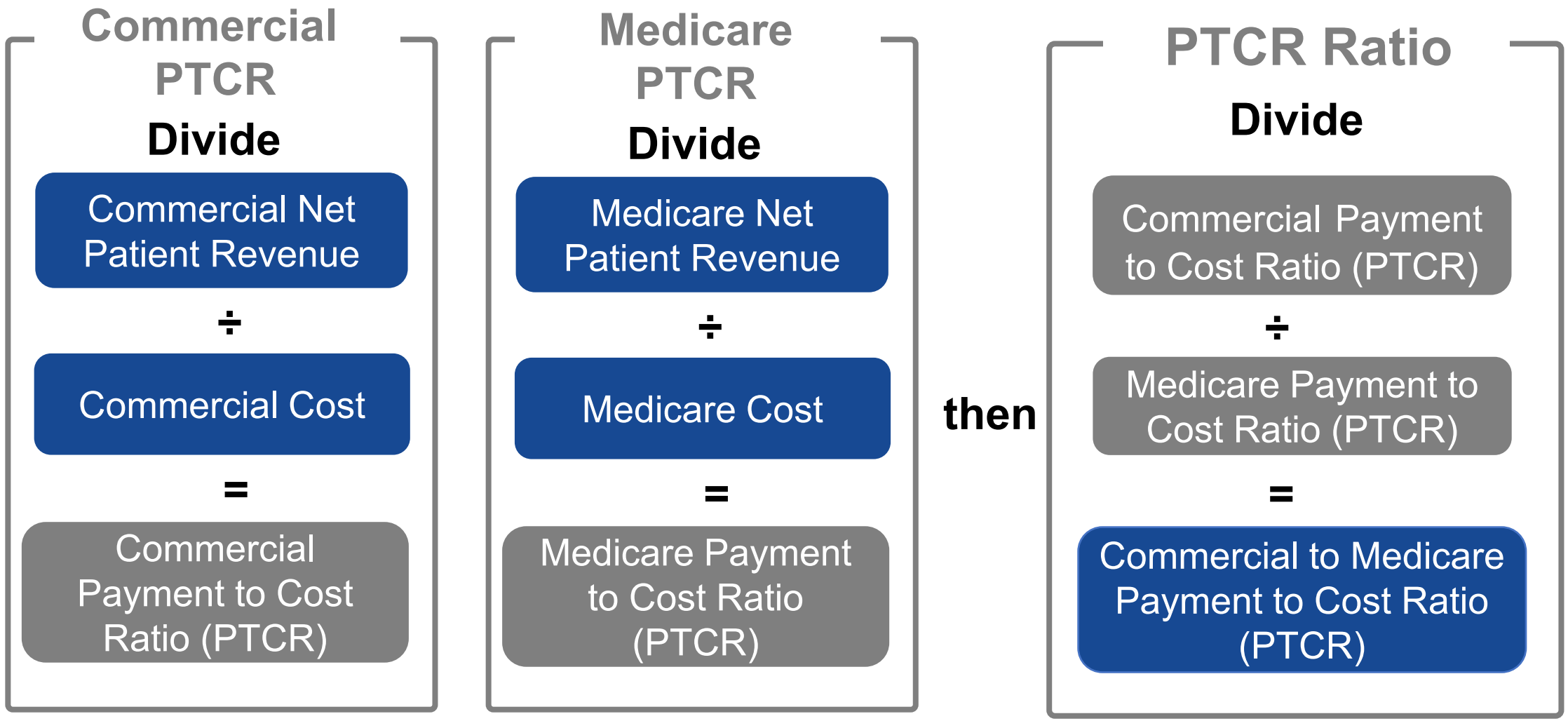
÷

Case Mix Adjusted Discharge (CMAD)

=

Commercial Inpatient NPR per CMAD

OHCA Methodology to Calculate Commercial to Medicare Payment to Cost Ratio (PTCR)



Changes That Reduced Commercial IP NPR per CMAD and Commercial to Medicare PTCR

OHCA observed hospitals made changes to 3 key variables that led to reductions in the Commercial IP NPR per CMAD and Commercial to Medicare PTCR.

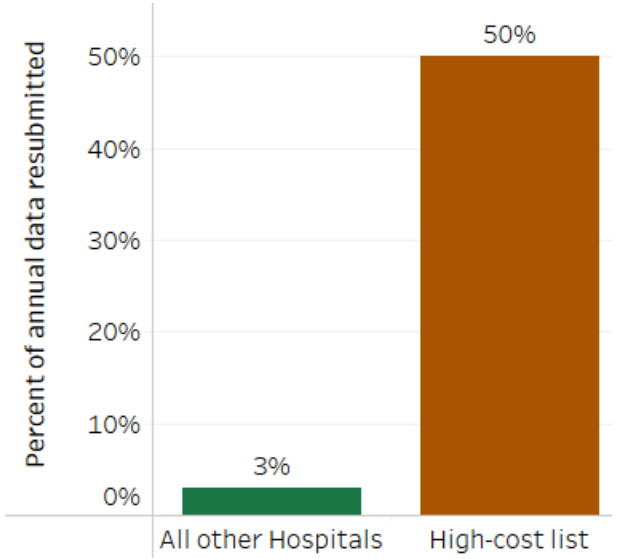
1. Revised commercial discharges upward (and reduced discharges in other payer categories), which increases the number of CMADs and thus lowers Commercial IP NPR per CMAD
2. Revised commercial net patient revenue downward (and increased revenue in other payer categories), which lowers both Commercial IP NPR per CMAD and Commercial to Medicare PTCR
3. Revised Medicare net patient revenue upward (and reduced revenue in other payer categories), which lowers Commercial to Medicare PTCR

Note: Among hospitals that resubmitted data since October 2025, in addition to the reallocation described above, there are changes in overall net patient revenue and overall discharges, compared to their original submission.

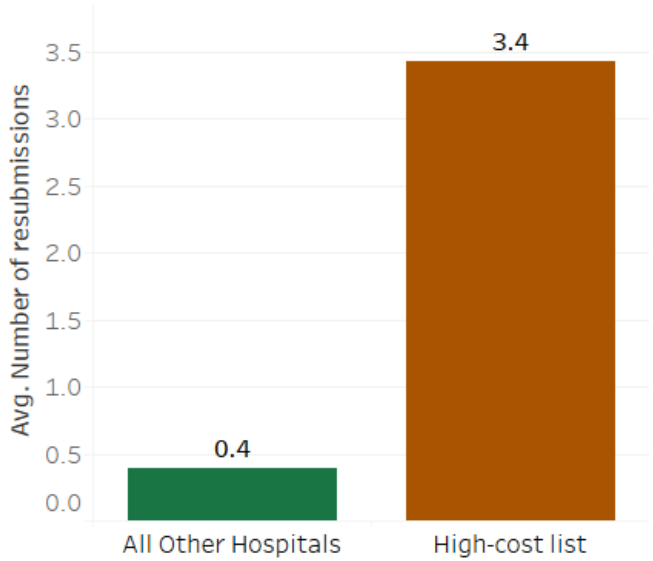
High-Cost Hospitals are More Likely to Resubmit Data for 2018-2023

- Since October 1, 2025, among high-cost hospitals, 50% of hospital-years included a resubmission for FY 2018-2023 compared to 3% for all other hospitals. The 47-percentage point difference (1,567%) is statistically significant (p-value = 0.00).
- On average, high-cost hospitals resubmitted 3.4 years of data, compared to 0.41 years of data for all other hospitals. The difference of 3 years (741%) is statistically significant (p-value = 0.00).
- CHOMP resubmitted 5 years of data; Salinas Valley and Santa Barbara Cottage each resubmitted 6 years; and Washington Fremont resubmitted 3 years.

Percent of hospital-year resubmissions since 10/1/2025 for FY 2018-2023



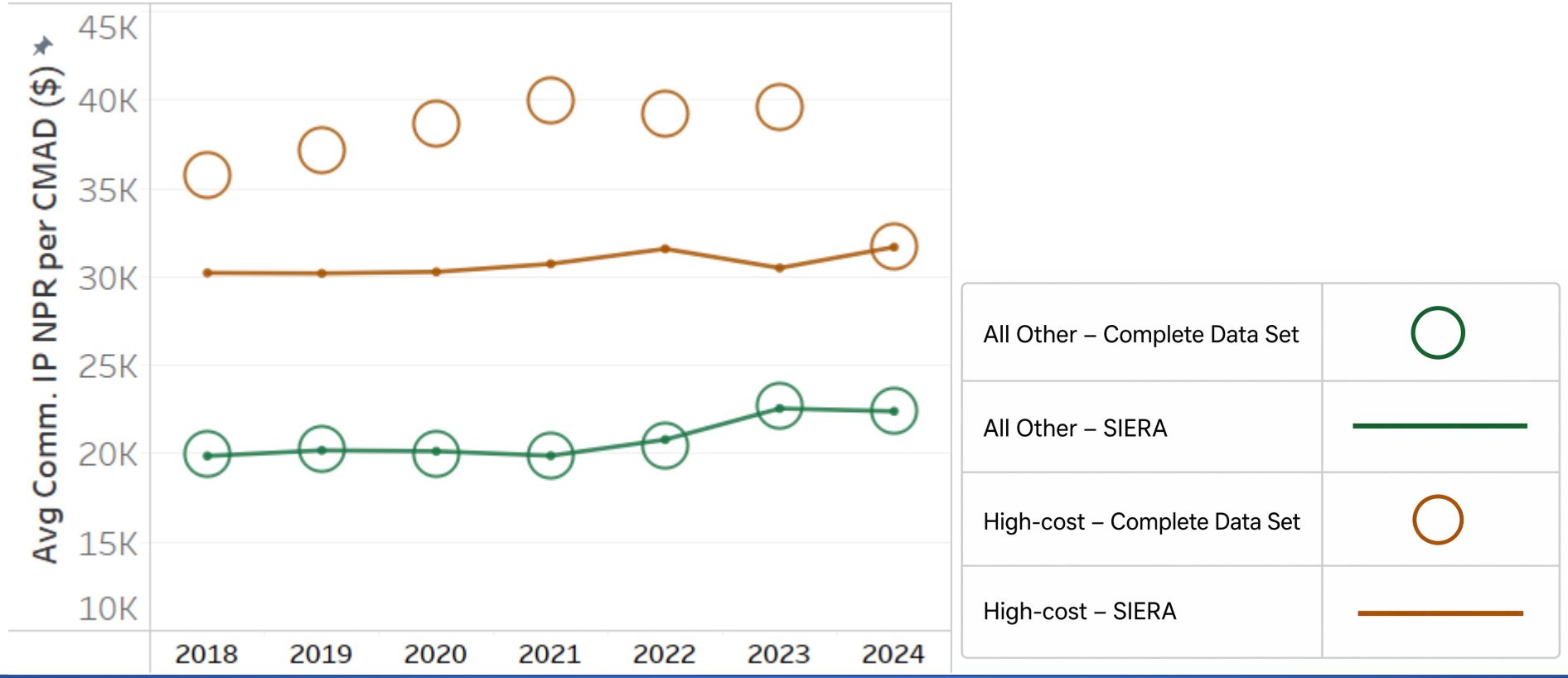
Average number of resubmissions since 10/01/2025 for FY 2018-2023



Note: Point estimates and p-values based on bivariate regressions.

Commercial Inpatient NPR per CMAD in Complete Data Set vs SIERA, 2018-2024

For FY 2018-2023, the four high-cost hospitals that resubmitted multiple years reported an average commercial IP NPR per CMAD that was ~$7,800 (25%) lower in their resubmissions compared with the CDS. For all other hospitals, there was no substantive difference between SIERA and CDS.



Commercial to Medicare PTCR in Complete Data Set vs SIERA, 2018-2024

For FY 2018-2023, the four high-cost hospitals that resubmitted multiple years reported an average commercial to Medicare PTCR that was 115 percentage points (45%) lower compared with the CDS. For all other hospitals, there was no substantive difference between SIERA and CDS.



Complete Data Set vs SIERA Resubmissions Deep Dive: Commercial Discharges

- Resubmissions from hospitals on the high-cost list resulted in an **increase in reported commercial discharges**, except for Washington Hospital – Fremont.
- Commercial discharges is the denominator for IP NPR per CMAD. **An increase in commercial discharges decreases commercial IP NPR per CMAD.**

Percent Change in Commercial Discharges*

increase in resubmission

decrease in resubmission

	2018	2019	2020	2021	2022	2023	2024
Community Hospital of The Monterey Peninsula	0%	29%	19%	19%	4%	4%	0%
Salinas Valley Memorial Hospital	23%	8%	8%	2%	2%	1%	0%
Santa Barbara Cottage Hospital	3%	0%	15%	2%	3%	2%	0%
Washington Hospital - Fremont	0%	0%	0%	0%	0%	0%	0%
*All other hospitals***	0%	0%	-1%	0%	0%	0%	0%

*All calculations are rounded to the nearest whole number.

**All other hospitals includes all comparable hospitals that were not the original seven high-cost hospitals.

Complete Data Set vs SIERA Resubmissions Deep Dive: Commercial Net Patient Revenue

- All resubmissions from hospitals on the high-cost list resulted in a **decrease in commercial net patient revenue.**
- Decreases in commercial NPR decreases the Commercial PTCR, which in turn decreases the Commercial to Medicare PTCR. Additionally, **decreasing commercial NPR lowers the Commercial IP NPR per CMAD.**

Percent Change in Commercial Net Patient Revenue*

increase in resubmission

decrease in resubmission

	2018	2019	2020	2021	2022	2023	2024
Community Hospital of The Monterey Peninsula	0%	-15%	-18%	-19%	-15%	-21%	0%
Salinas Valley Memorial Hospital	-10%	-18%	-24%	-29%	-30%	-38%	0%
Santa Barbara Cottage Hospital	-21%	-11%	-11%	-7%	-10%	-7%	0%
Washington Hospital - Fremont	0%	0%	0%	-8%	-5%	-11%	0%
*All other hospitals***	0%	1%	0%	0%	0%	0%	0%

*All calculations are rounded to the nearest whole number.

**All other hospitals includes all comparable hospitals that were not the original seven high-cost hospitals.

Complete Data Set vs SIERA Resubmissions Deep Dive: Medicare Net Patient Revenue

- All resubmissions from hospitals on the high-cost list resulted in an **increase in Medicare net patient revenue.**
- Increasing Medicare NPR **increases the Medicare PTCR, which in turn decreases Commercial to Medicare PTCR.**

Percent Change in Medicare Net Patient Revenue*

increase in resubmission

decrease in resubmission

	2018	2019	2020	2021	2022	2023	2024
Community Hospital of The Monterey Peninsula	0%	23%	14%	9%	17%	27%	0%
Salinas Valley Memorial Hospital	16%	56%	58%	72%	59%	66%	0%
Santa Barbara Cottage Hospital	35%	29%	38%	25%	26%	25%	0%
Washington Hospital - Fremont	0%	0%	0%	8%	7%	10%	0%
*All other hospitals***	0%	0%	0%	0%	0%	0%	0%

*All calculations are rounded to the nearest whole number.

**All other hospitals includes all comparable hospitals that were not the original seven high-cost hospitals.

Complete Data Set vs SIERA Resubmissions Deep Dive: Commercial IP NPR per CMAD

All resubmissions from hospitals on the high-cost list resulted in a decrease in Commercial IP NPR per CMAD.

Percent Change in Inpatient Net Patient Revenue per Case Mix Adjusted Discharge*

increase in resubmission

decrease in resubmission

	2018	2019	2020	2021	2022	2023	2024
Community Hospital of The Monterey Peninsula	0%	-32%	-30%	-32%	-18%	-23%	0%
Salinas Valley Memorial Hospital	-32%	-25%	-28%	-30%	-30%	-36%	0%
Santa Barbara Cottage Hospital	-23%	-11%	-22%	-7%	-13%	-9%	0%
Washington Hospital - Fremont	0%	0%	0%	-16%	-12%	-18%	0%
*All other hospitals***	0%	3%	2%	0%	0%	0%	0%

*All calculations are rounded to the nearest whole number.

**All other hospitals includes all comparable hospitals that were not the original seven high-cost hospitals.

Complete Data Set vs SIERA Resubmissions Deep Dive: Commercial to Medicare PTCR

All resubmissions from hospitals on the high-cost list resulted in a **decrease in the Commercial to Medicare PTCR.**

Percent Change in Commercial to Medicare Payment to Cost Ratio*

increase in resubmission

decrease in resubmission

	2018	2019	2020	2021	2022	2023	2024
Community Hospital of The Monterey Peninsula	0%	-31%	-29%	-26%	-27%	-38%	0%
Salinas Valley Memorial Hospital	-24%	-47%	-50%	-59%	-55%	-62%	0%
Santa Barbara Cottage Hospital	-46%	-34%	-38%	-28%	-32%	-30%	0%
Washington Hospital - Fremont	0%	0%	0%	-12%	-9%	-15%	0%
*All other hospitals***	0%	2%	1%	0%	1%	0%	0%

*All calculations are rounded to the nearest whole number.

**All other hospitals includes all comparable hospitals that were not the original seven high-cost hospitals.

Summary of Changes: Community Hospital of the Monterey Peninsula (CHOMP)

Overview: CHOMP resubmitted five years of data: 2019 to 2023

Key changes between Original CDS Submission and Resubmissions in SIERA:

- Commercial inpatient NPR per CMAD was, on average, $11,455 lower (24.7% decrease).
  This change resulted from:
  - Commercial discharges increasing for each resubmission on average by 540 (14.4% increase)
  - Decreases in commercial NPR which was on average $80 million lower (17.9% decrease)

- Commercial to Medicare payment to cost ratio was, on average, 115 percentage points lower (30.2% decrease).
  This change resulted from:
  - Increases in Medicare NPR, which was on average $43 million higher (18.6% increase)
  - Decreases in Commercial NPR, which was on average $80 million lower (17.9% decrease)

**All calculations are done using Hospital Reported Financial data as outlined in the posted methodology Hospital Documentation- Updated June 2025.pdf

Summary of Changes: Salinas Valley Health Medical Center

Overview: Salinas resubmitted six years of data: 2018 to 2023

Key changes between Original CDS Submission and Resubmissions in SIERA:

- Commercial inpatient NPR per CMAD was, on average, $14,309 lower (30.3% decrease).
  This change resulted from:
    - Commercial discharges increasing for each resubmission on average by 178 (about 7% increase)
    - Reductions in commercial NPR of an average of $96 million (26% decrease)

- Commercial to Medicare payment to cost ratio was, on average, 240 percentage points lower (50.5% decrease).
  This change resulted from:
    - Increases in Medicare NPR, which was on average $70 million higher (55% increase)
    - Decreases in Commercial NPR, which was on average $96 million lower (26% decrease)

**All calculations are done using Hospital Reported Financial data and as outlined in the posted methodology Hospital Documentation-Updated June 2025.pdf

Summary of Changes: Santa Barbara Cottage Hospital

Overview: Santa Barbara Cottage resubmitted six years of data: 2018 to 2023

Key changes between Original CDS Submission and Resubmissions in SIERA:

- Commercial inpatient NPR per CMAD was, on average, $4,774 lower (14.3% decrease).
  This change resulted from:
  - Commercial discharges increasing for each resubmission on average by 202 (about 3.9% increase)
  - Reductions in Commercial NPR of an average of $46 million (10.8% decrease)

- Commercial to Medicare payment to cost ratio was, on average, 106 percentage points lower (34.4% decrease).
  This change resulted from:
  - Increases in Medicare NPR, which was on average, $68 million higher (29.4% increase)
  - Decreases in Commercial NPR, which was on average, $46 million lower (10.8% decrease)

**All calculations are done using Hospital Reported Financial data and as outlined in the posted methodology Hospital Documentation-Updated June 2025.pdf

Summary of Changes: Washington Hospital -- Fremont

Overview: Washington Fremont resubmitted three years of data: 2021 to 2023

Key changes between Original CDS Submission and Resubmissions in SIERA:

- Commercial inpatient NPR per CMAD was, on average, $5,008 lower (15.1% decrease). This change resulted from:
  - Decreases in Commercial NPR of an average of $23 million (8% decrease)
  - Commercial discharges, on average, stayed the same

- Commercial to Medicare PTCR Ratio on average decreased 39 percentage points (11.4% decrease).
  This change resulted from:
  - Increases in Medicare NPR, which was on average, $13 million higher (8.3% increase)
  - Decreases in Commercial NPR, which was on average, $23 million lower (8% decrease)

**All calculations are done using Hospital Reported Financial data and as outlined in the posted methodology Hospital Documentation-Updated June 2025.pdf

Explanations from High-Cost Hospitals That Resubmitted Multiple Years of Historical Data

OHCA reached out to the hospitals that resubmitted more than one year of financial data. OHCA sought to understand the underlying reasons or methodological changes that account for the changes in the reported data. OHCA received input from or met with two of the four facilities and has pending meetings with the other two.

The hospitals that OHCA was able to engage with reported:

- The revisions correctly match HCAI payor categories with the hospital's revenue and usage report from other internal systems (e.g. the clinical system). The general ledger system's insurance plan classifications used in the original submission did not align with HCAI payor categories as accurately as the revenue and usage report.
- Reviewing their net patient revenue against a zero-balance account report, which they report results in the net patient revenue better reflecting the percentage of gross charges compared with what they were paid from closed accounts.
- Revising patient census days (days, discharges, and statistics) to better align with insurance plan mappings to be consistent with insurance plan revisions to gross patient discharges.

Statistical Analysis of Observed Differences between High-Cost Hospitals and All Other Hospitals Across 8 Outcomes

Across eight financial and utilization outcomes, high-cost hospitals reported statistically significant changes in their resubmissions compared with all other hospitals. P-values less than 0.001 indicate the probability of observing differences as large as those reported in the table is ~0%, assuming no difference between high-cost and all other hospitals.

Outcome	Unit of Measure	DID Coefficient	P-value
Commercial Inpatient Net Patient Revenue per CMAD	$	-4602.9	0.000***
Commercial to Medicare PTCR	Percentage point	-66.0	0.000***
Commercial IP NPR (estimated)	$ millions	-17.7	0.000***
Commercial Discharges	count	133.2	0.000***
Commercial NPR	$ millions	-31.7	0.000***
Medicare NPR	$ millions	25.6	0.000***
Commercial PTCR	Percentage point	-19.1	0.000***
Medicare PTCR	Percentage point	9.7	0.000***

*** denotes statistical significance (P<0.001) based on difference-in-differences (DID) regressions for FY 2018-2023.

Comparing Hospital-Submitted Data to Other Data Sets

- Prior slides showed that, compared to their original submissions, in more recent resubmitted data, high-cost hospitals reported statistically significantly lower commercial IP NPR per CMAD and commercial to Medicare PTCR values.
- Comparing self-reported data and other administrative data can help inform the reliability of the observed differences in the self-reported data.
- In this instance, OHCA can compare hospital-reported CDS and SIERA data to the state's Health Care Payments Data (HPD) and RAND Price Transparency data. Both data sources rely on adjudicated claims that serve as the basis for hospital reimbursement.
- Using the HPD, OHCA derived hospitals' commercial inpatient spending per CMAD. For an additional source to validate hospital-reported data, OHCA used the standardized inpatient price variable available in the RAND Price Transparency data.

Comparing High-Cost Hospital-Reported Data to Payer-Submitted Claims Data

- For CHOMP, Salinas Valley and Santa Barbara Cottage, data from HPD and RAND are consistent with the hospitals' original CDS submission, suggesting that these facilities have some of the highest commercial inpatient spending levels in California.
- For Washington Hospital – Fremont, the evidence is mixed, as the RAND data suggests this facility is in the top decile while the HPD suggests it is in the top quartile.

IP NPR Per CMAD	Mean Percentile FY2022-2023 CDS	Mean Percentile FY2022-2023 HPD	Mean Standardized IP Price Percentile 2020-2022 RAND Round 5 Price Transparency	Mean Percentile FY2022-2023 SIERA
Case Study Hospitals				
Community Hospital of Monterey Peninsula	95	99	97	86
Salinas Valley Memorial Hospital	97	95	91	85
Santa Barbara Cottage	88	94	92	83
Washington Hospital - Fremont	88	75	97	79

Recap and Implications

- As part of its annual update to the high-cost hospital analysis, OHCA compared hospital data reported to HCAI prior to the adoption of high-cost hospital targets in April 2025 to resubmissions reported to HCAI after April 2025 when the Health Care Affordability Board finalized the criteria to identify high-cost hospitals.
- Four of the seven high-cost hospitals – Community Hospital of the Monterey Peninsula, Salinas Valley, Santa Barbara Cottage and Washington Fremont – resubmitted 3 or more years of historical data, and compared to all other comparable hospitals, were statistically significantly more likely to report increases in commercial discharges, increases in Medicare NPR, increases in Medicare PTCR, decreases in commercial NPR and decreases in commercial PTCR. The large reported changes in revenue and utilization in their resubmitted data would result in the four hospitals no longer meeting the board's high-cost hospital criteria.
- Additionally, the observed variance between the resubmitted data and other data sets highlights the need for the Board to carefully consider use of resubmitted data for updating the list of high-cost hospitals.

High-Cost Hospital Spending Target Adjustment

Does the Board have questions about the analysis or input on the use of CDS data, SIERA data, or other data sources, to inform determinations related to high-cost hospitals?

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

Update on Behavioral Health Spending Analysis and Investment Benchmark

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

HCAI

Department of Health Care Access and Information

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.

OHCA's Role in Improving Behavioral Health Outcomes

Systemwide Behavioral Health Goals

Behavioral health care that is:

- Accessible
- Comprehensive
- Coordinated
- Equitable
- High Quality

Motivate

California Stakeholder Actions

- Identify and support higher value care
- Build and sustain infrastructure and capacity
- Promote behavioral health integration with primary care and social and public health services
- Reduce disparities

Resulting In

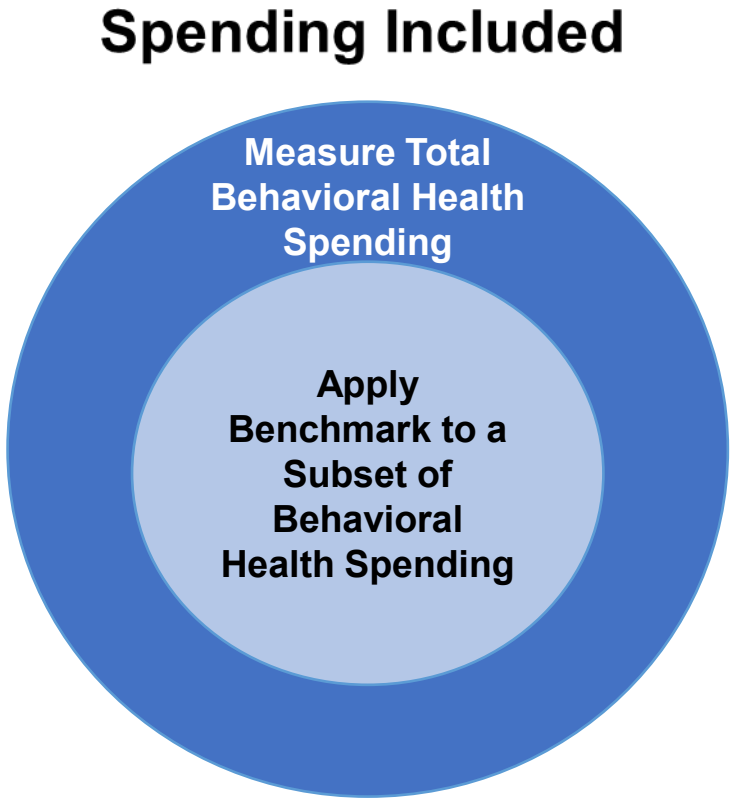
Supports

OHCA's Behavioral Health Workstream

- Promote sustained systemwide investment in behavioral health
- **Measure and report** the percentage of total medical expenditures allocated to behavioral health care
- Set focused **spending benchmarks** to support improved behavioral health outcomes
- Conduct analysis

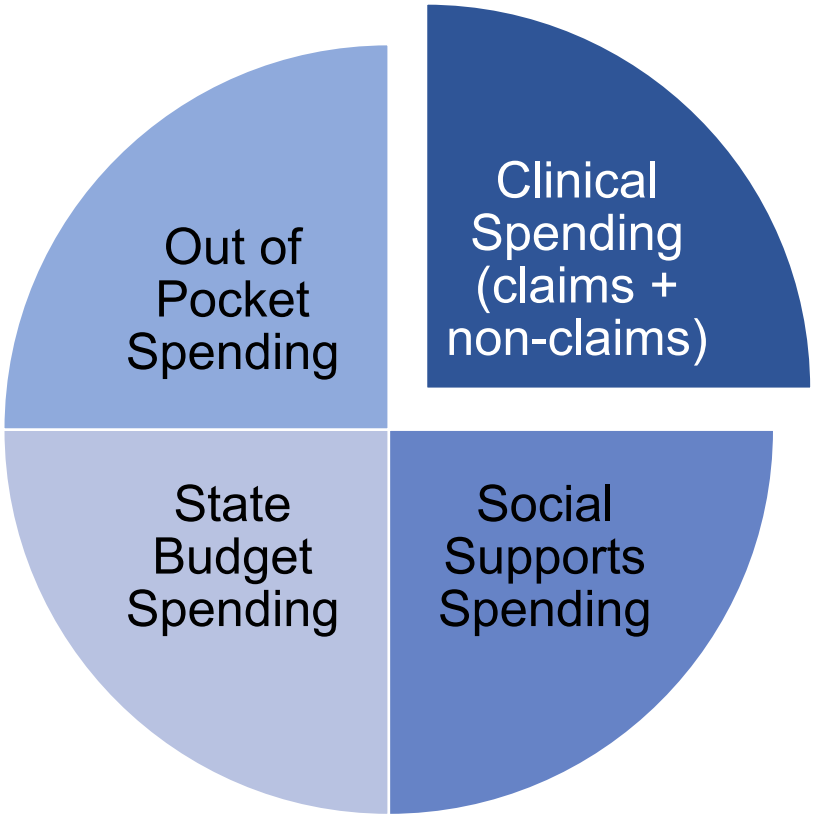
Broad Measurement, Focused Benchmark

- **Measurement:** OHCA has begun measuring **total** behavioral health spending as a percentage of total health care expenditures.
- **Benchmark:** OHCA continues to propose that the behavioral health investment benchmark should apply to a **subset** of behavioral health care spending.



Data Collection and Measurement Scope

Clinical services are services provided by medical and allied health professionals to prevent, treat, and manage illness, and to preserve well-being across the clinical care continuum, paid via claims and non-claims payments (e.g., outpatient therapy visit, day treatment programs).



- OHCA is measuring spending by payers on behavioral health clinical services.
- Data collected in September 2026 from Commercial, Medicare Advantage, and Medi-Cal Managed Care Plans on 2024 and 2025 behavioral health spending will be reported in 2027.
- OHCA and DHCS are developing a measurement approach for non-managed care plan Medi-Cal behavioral health spending for future reporting.

Adapted from Milbank Memorial Fund, April 2024. *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.* https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

Behavioral Health Spending Measurement

Payer data submissions:

- Include claims and non-claims payments for behavioral health care (as defined by OHCA).
- Are aggregated by year and market category (Commercial HMO/POS, Commercial PPO/EPO, Medicare Advantage, Medi-Cal Managed Care).
- Use the Expanded Non-Claims Payments Framework payment categories and subcategories for analysis and reporting.
- Capture integrated behavioral health spending in the Outpatient Professional Primary Care service subcategory and through primary care and behavioral health integration non-claims payments.

Detailed methodology included in OHCA's Data Submission Guide 3.0.

Principles for behavioral health claims and non-claims data collection previously reviewed in 2025 are included in the Appendix.

California Department of Health Care Access and Information, Office of Health Care Affordability. (2026, April). Total health care expenditures data submission guide (Version 3.0). https://hcai.ca.gov/wp-content/uploads/2026/06/THCE-Data-Submission-Guide-v3.0.pdf

Recap: 2025 Benchmark Proposal and Decision

2025 Benchmark Proposal

- In 2025, OHCA considered a benchmark that would require each payer to increase per-member, per-month spending on in-network outpatient and community-based behavioral health care by a set percentage relative to payer-specific baselines for the performance years (PY) 2026-2029.
- Informed by a 2029 assessment of 2027 data, OHCA would have updated the benchmark for the next five years (2030-2034).

2025 Benchmark Decision

- Delay benchmark until analyses provide a better understanding of behavioral health spending.
- Revisit readiness to set a benchmark in 2026.

Key Decisions for Setting a Behavioral Health Benchmark

Key Decisions for Benchmark Focus	Key Decisions for Benchmark Structure
1. Should the benchmark be the same across markets or tailored for each? 2. Should the benchmark focus only on certain behavioral health service subcategories (e.g., outpatient)? 3. Should the benchmark focus only on a specific diagnosis category (mental health or substance use disorder)? 4. Should the benchmark focus only on a specific population or age band (e.g., children/youth)? 5. Should the benchmark focus on in-network behavioral health spending?	1. Should the benchmark be a percentage of total medical expenses or a per member, per month amount? 2. Should the benchmark focus on incremental or long-term improvement, or some combination? 3. What should the timeline be for achieving the benchmark?

Healthcare Payments Data Program (HPD) Behavioral Health Analysis* Updates

Commercial and Medicare Advantage

- *Completed*:
  - Behavioral health spending as a share of total claims spending and by plan within markets
  - In- vs. out-of-network shares of behavioral health spending by market
  - Behavioral health spending by age band by market
  - Spending on Applied Behavior Analysis (ABA) services
  - Variation by geography
- *Ongoing*:
  - Spending on claims with a behavioral health diagnosis in a non-primary position

*HPD analysis uses the OHCA definition of behavioral health.

HPD Data Analysis – Approach and Limitations

- Analysis reflects spending from claims. Spending via capitation arrangements is not included.
- Analysis includes commercial and Medicare Advantage markets.
  - DHCS advised that Medi-Cal Managed Care Plan (MCP) spending data should be analyzed via OHCA payer submissions rather than HPD.
- Data was grouped by diagnosis category (i.e., mental health and substance use disorder) and service subcategory.*
- The HPD team continues to work with submitters to improve data quality. Health plans with known issues are excluded.
- Results presented today are preliminary.

*Service subcategories included on the next slide.

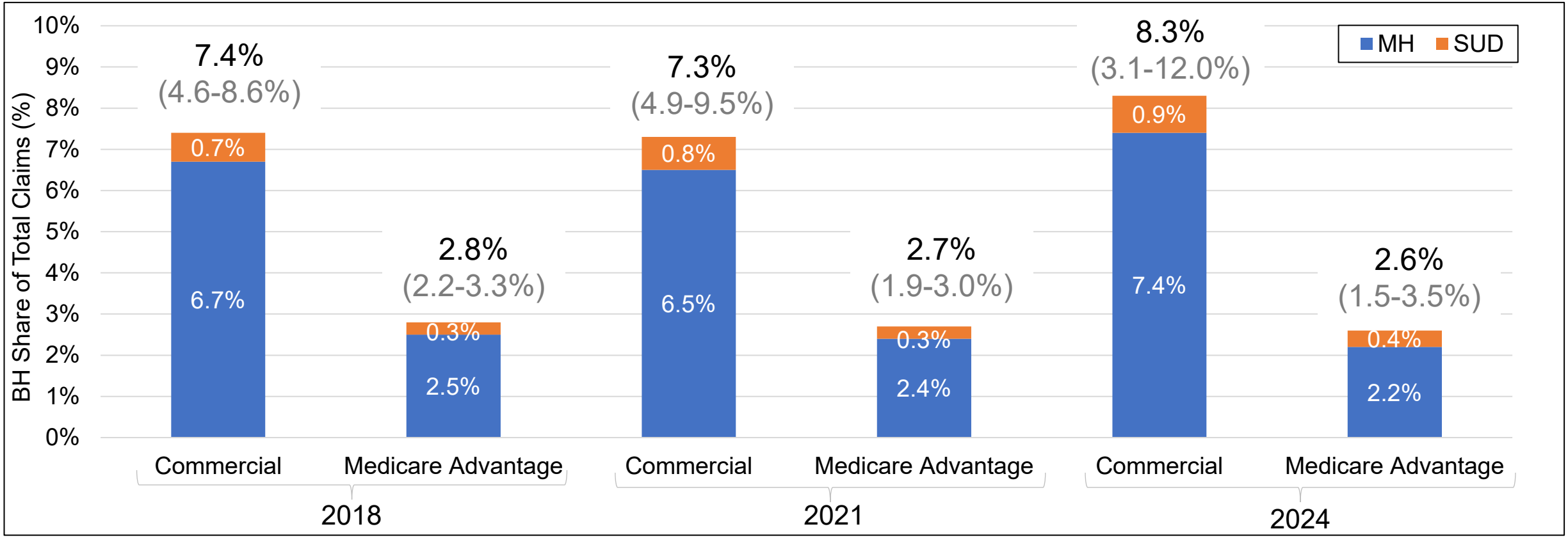
Behavioral Health Reporting Categories

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 Spending as a Share of Total Claims Spending Varies by Market

Commercial behavioral health spending as a percent of total claims spending is approximately 8% in 2024 compared to under 3% in the Medicare Advantage market.

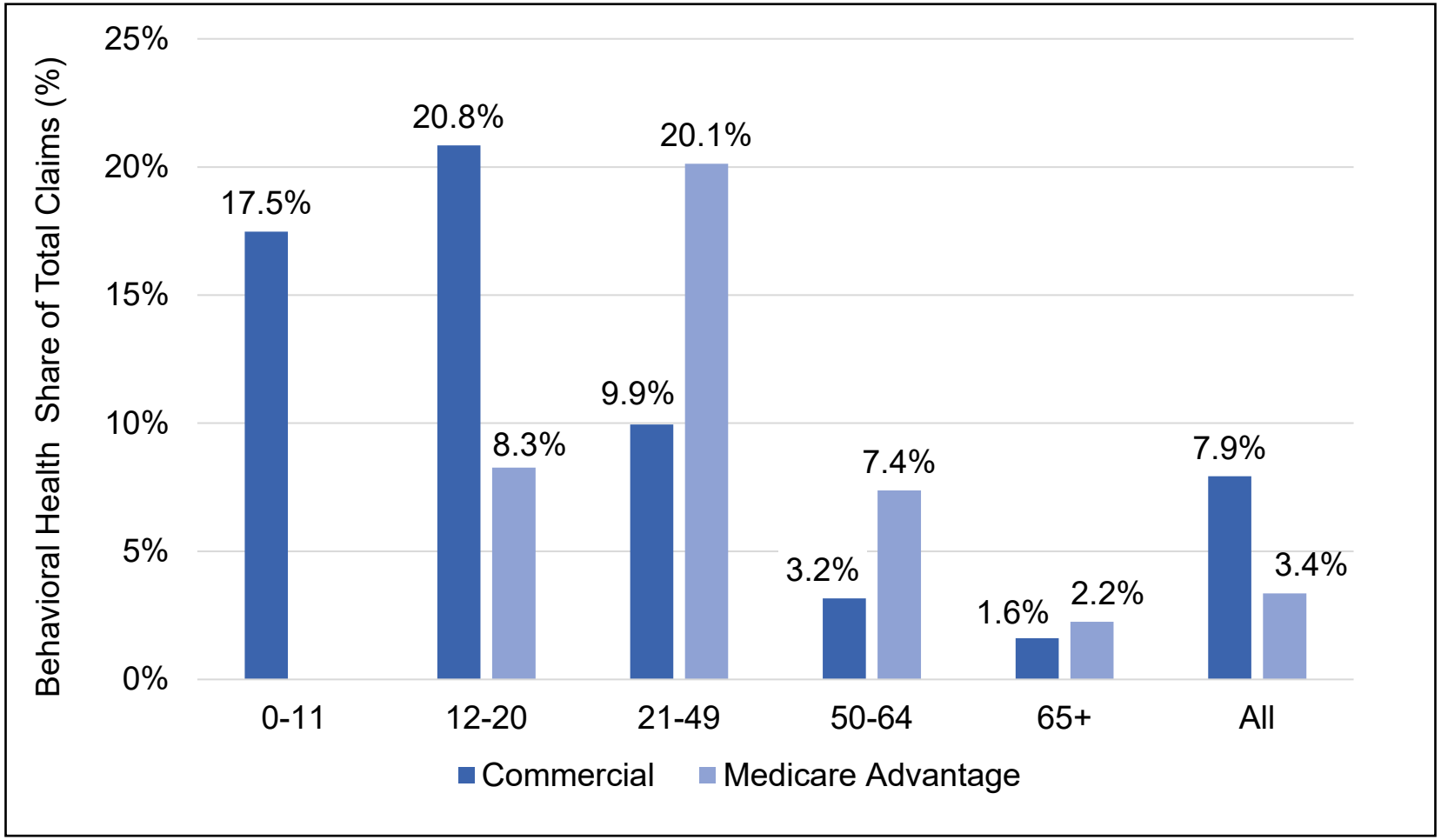


Key: Behavioral health as a share of total claims spending %
(Range of individual plan behavioral health as a share of total claims spending %)

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

2024 Behavioral Health Spending as a Share of Total Claims Spending by Age Band and Market

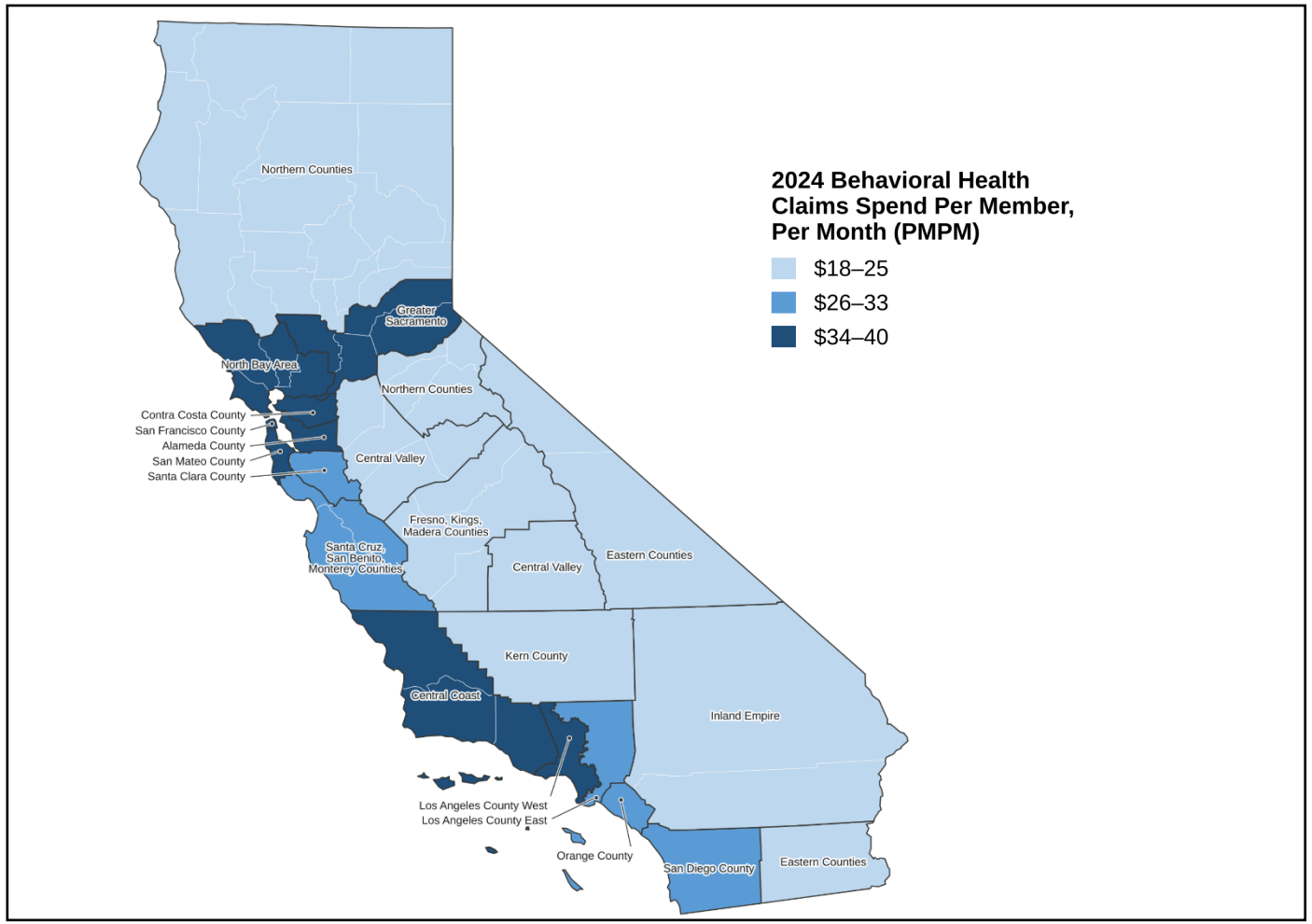
Behavioral health spending is a higher share of total claims spending for younger age bands, most likely due to higher total claims spending for the older age bands.



Note: 99.9% of 12-20, 91.2% of 21-49, 73.5% of 50-64, and 7.0% of 65+ age band's behavioral health spending included in this analysis was in the commercial market.

2024 Commercial Behavioral Health Claims Spending Per Member, Per Month (PMPM) by Covered CA Region

- Commercial behavioral health claims spending varies by Covered California region.
- Spending is higher in urban, coastal regions than in central valley, inland empire, and northern regions.
- Similar trends are seen for 2024 Medicare Advantage spending.*



*Medicare Advantage analysis included in the Appendix.

Benchmark Implications of Findings

Benchmark Key Decision	Analysis Implications
Should the benchmark be the same across markets or tailored for each?	Variation in behavioral health spending by market implies that OHCA should develop market-specific benchmarks.
Should the benchmark focus on incremental or long-term improvement, or some combination?	Variation in behavioral health spending by plans within the same market, and by geography, imply that OHCA should develop an incremental, relative benchmark.
Should the benchmark focus only on a specific population or age band (e.g., children/youth)?	Variation by age bands implies OHCA should not focus a benchmark on a specific age band.

Claims Spending in Behavioral Health Outpatient Service Subcategories Varies by Market and Plan

Outpatient Professional Non-Primary Care spending makes up between 14% and 57% of a plan's total behavioral health claims spending in the commercial market and between 2% and 29% of a plan's total behavioral health claims spending in the Medicare Advantage market.

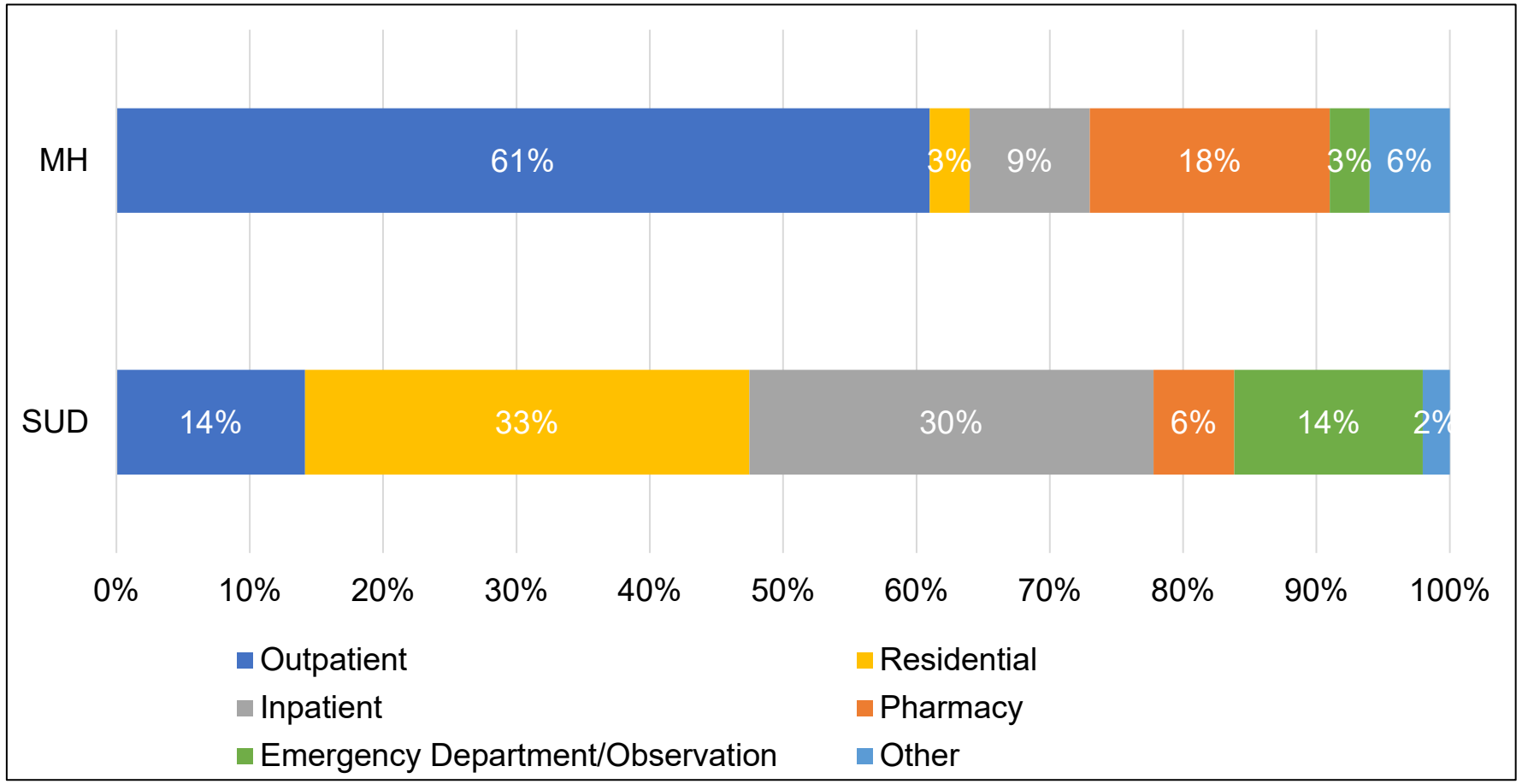
Outpatient Professional Non-Primary Care Share of Total Behavioral Health Claims Spending by Market
(Range of Individual Plan Shares)

Market	2018	2021	2024
Commercial	32% (14 - 37%)	39% (28 - 48%)	50% (26 - 57%)
Medicare Advantage	4% (4 - 12%)	8% (7 - 25%)	19% (2 - 29%)

Note: The Outpatient category includes care settings like offices, telehealth, home, partial hospitalization, and community mental health centers.

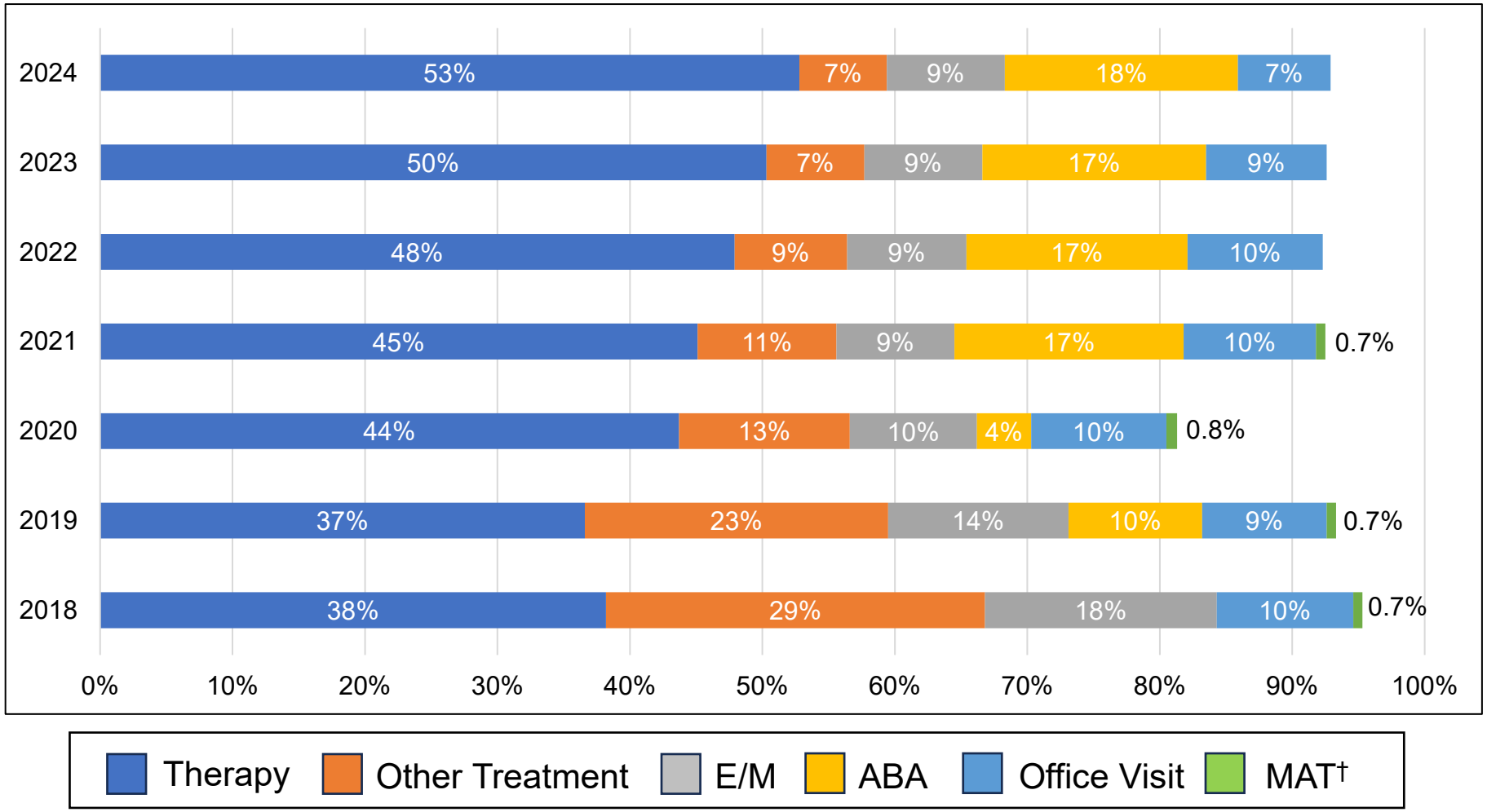
Distribution of Commercial MH vs. SUD Claims Spending by Subcategory, 2024

- For mental health (MH), the majority of claims spending was for outpatient services.
- For substance use disorders (SUD), the majority of claims spending was for residential and inpatient services.



Distribution of Commercial Outpatient Professional Non-Primary Care Spending*

- Psychotherapy and adaptive behavior analysis (ABA) treatment increased as a share of outpatient professional non-primary care spending from 2018 to 2024.
- Only ten service codes make up over 80% of outpatient professional primary care spending.

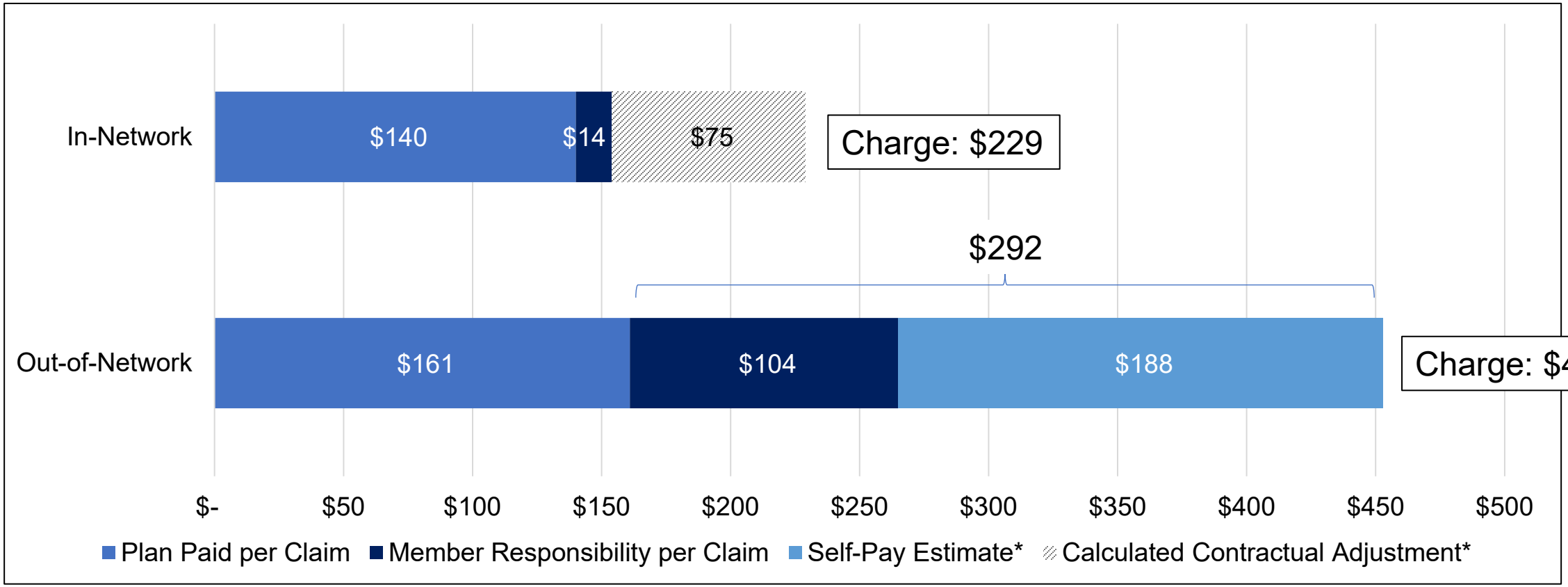


*Medicare Advantage analysis included in the Appendix. † Medication-assisted treatment (MAT).
Note: "Other Treatment" includes therapeutic repetitive transcranial magnetic stimulation (TMS) and therapeutic behavioral services and "E/M" includes psychiatric diagnostic evaluations, self-care/home management training, and mental health service plan development.

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

Estimated Member vs. Plan Payment Amounts for In- vs. Out-of-Network Commercial Psychotherapy Claims, 2024

On average, commercial members pay an estimated $292 for out-of-network psychotherapy compared to only $14 for in-network psychotherapy.



*Estimated value that is not a Healthcare Payments Database (HPD) field.
Note: Member responsibility includes co-insurance, co-pays, and deductible expenses. It does not include all self-pay by members when claims are not submitted and reimbursed.

Benchmark Implications of Findings

Benchmark Key Decision	Analysis Implications
Should the benchmark focus on incremental or long-term improvement, or some combination?	Variation in outpatient professional behavioral health spending by plans within a market implies OHCA should develop an incremental, relative benchmark.
Should the benchmark focus only on certain behavioral health service subcategories (e.g., outpatient)?	A benchmark focused on outpatient spending would be heavily influenced by psychotherapy and ABA spending.
Should the benchmark focus only on a specific diagnosis category (mental health or substance use disorder)?	Variation in behavioral health spending by diagnosis category implies OHCA could advance substance use disorder (SUD) outpatient investment and access via a SUD-focused benchmark.
Should the benchmark focus on in-network behavioral health spending?	Differences in consumer out-of-pocket spending for in-network vs. out-of-network psychotherapy implies OHCA could target these differences via an in-network-focused benchmark.

Investment & Payment Workgroup Feedback

- Workgroup members expressed support for OHCA's recommendation to delay setting benchmark.
- Members and OHCA agree that without self-pay and out-of-plan spending, there is a piece of behavioral health spend missing.
- Interest in exploring a benchmark focused on increasing substance use disorder (SUD) outpatient spend.
- Interest in focusing the benchmark discussion on the systemwide behavioral health goals and what an investment benchmark can and can't do.
- Interest in focusing the benchmark on spending that closely ties to improved outcomes.

Next Steps for Behavioral Health Investment Benchmark

OHCA proposes delaying setting a benchmark until OHCA's behavioral health data collection can provide additional information.

- OHCA will report on payer-submitted (Commercial, Medicare Advantage, and Medi-Cal Managed Care Plan) 2024 and 2025 behavioral health claims and non-claims spending in 2027.
- OHCA will continue conducting additional analyses on behavioral health claims spending using HPD (e.g., spending for claims with non-primary behavioral health diagnoses).
- OHCA will continue to work with DHCS to analyze and report non-managed care plan Medi-Cal behavioral health spending.

Behavioral Health Spending Definition and Measurement Methodology

Does the Board have any feedback on the proposed behavioral health investment benchmark approach?

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:
Wednesday, December 16, 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

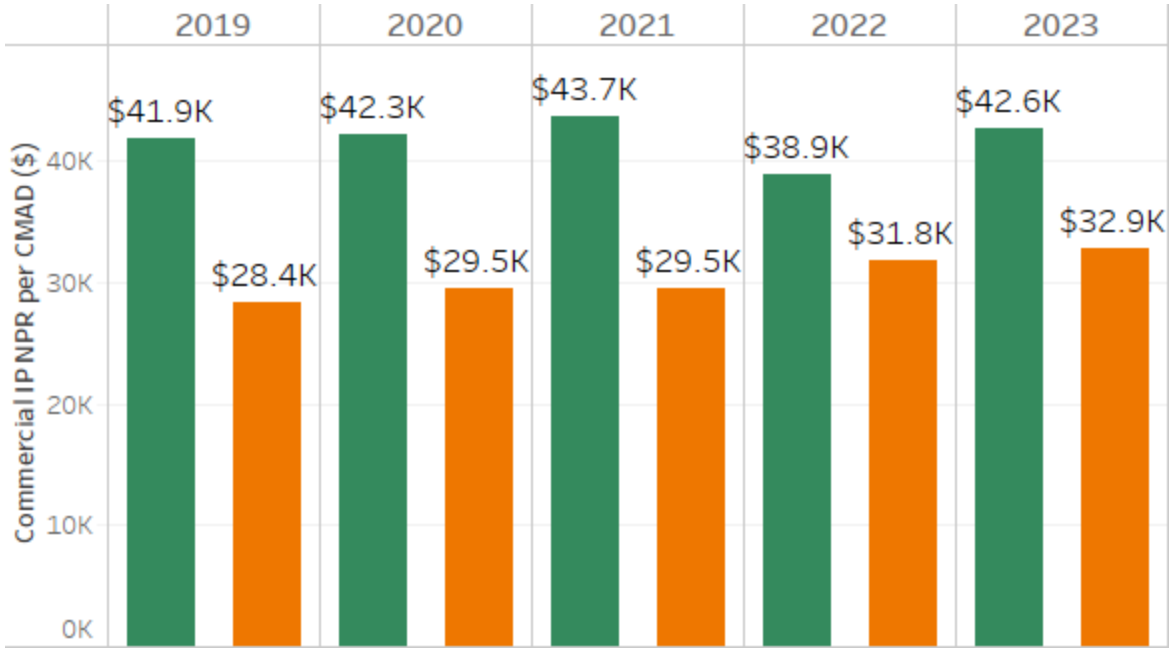
High-Cost Hospital Resubmissions by Facility

CDS compared with SIERA: Community Hospital of the Monterey Peninsula (CHOMP)

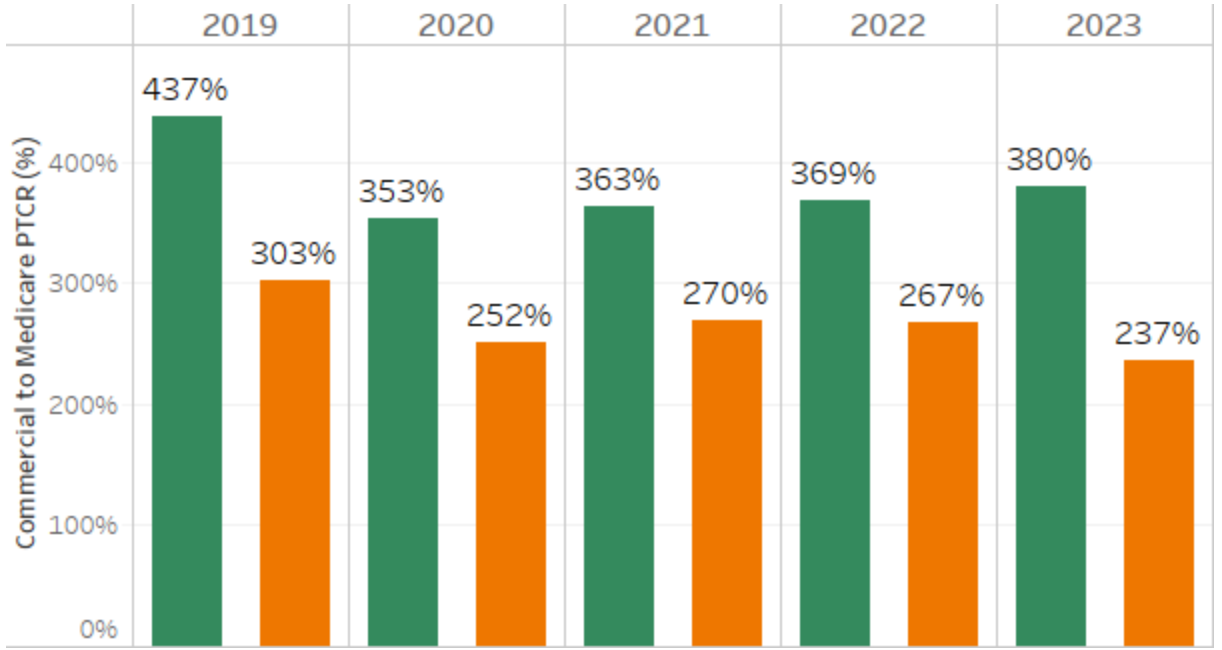
- Commercial inpatient NPR per CMAD was, on average, $11,455 lower (24.7% decrease).
- Commercial to Medicare payment to cost ratio was, on average, 115 percentage points lower (30.2% decrease).

Complete Data Set
SIERA

Commercial IP NPR per CMAD for CHOMP



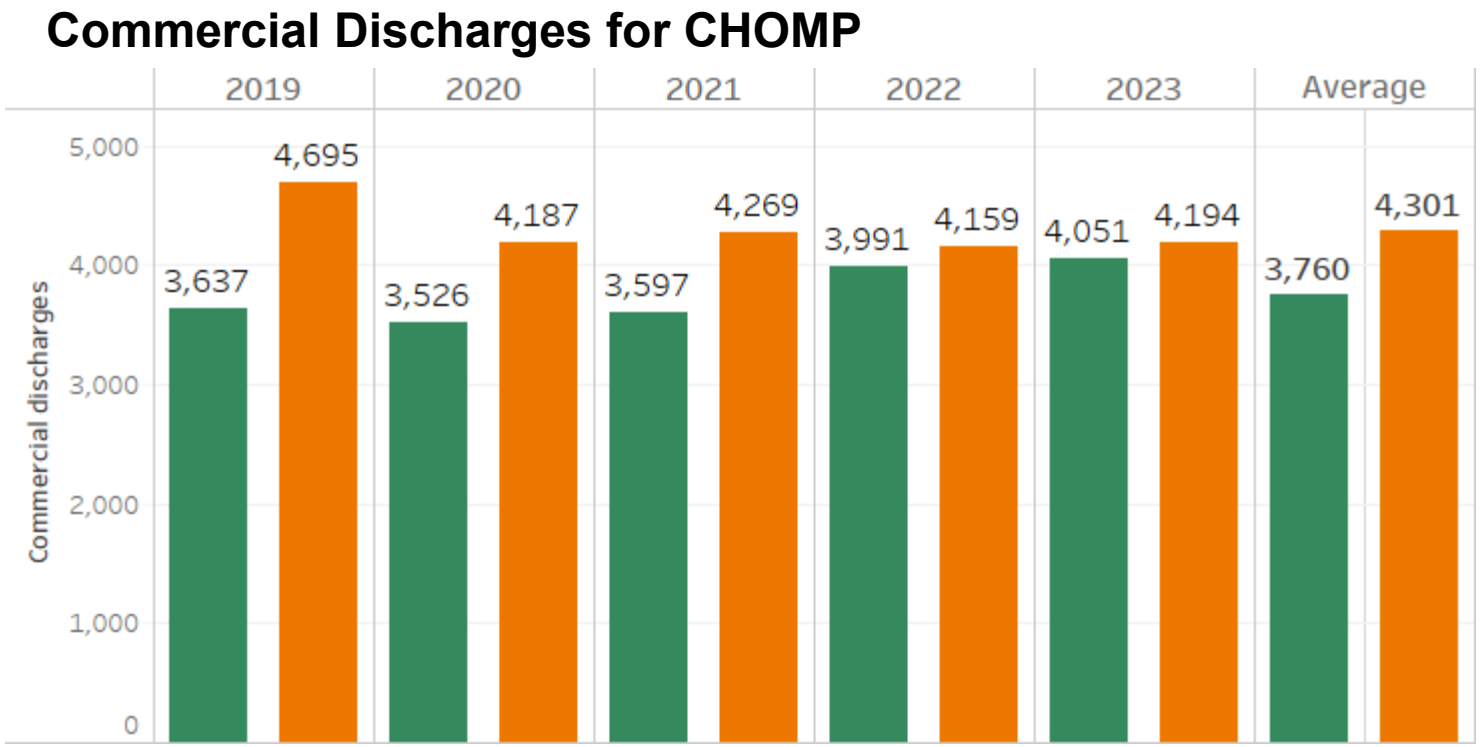
Commercial to Medicare PTCR for CHOMP



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

CDS compared with SIERA : Community Hospital of the Monterey Peninsula (CHOMP)

For CHOMP, Commercial discharges were, on average, 540 higher (14.4% increase), showing an increase for every resubmission.



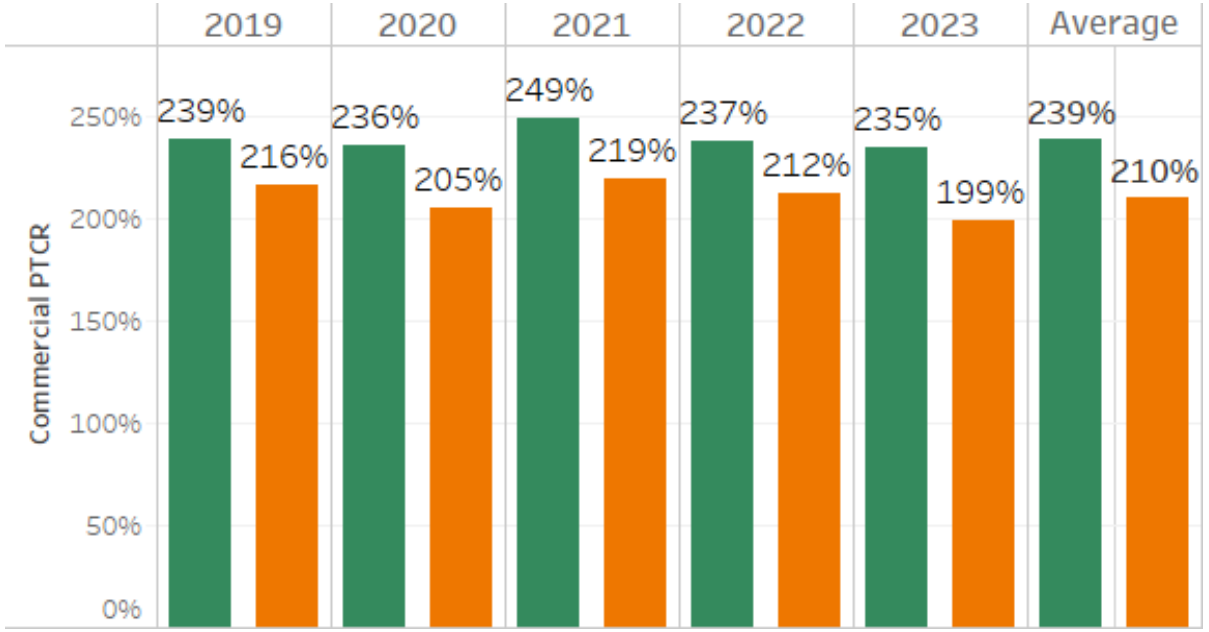
OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

CDS compared with SIERA : Community Hospital of the Monterey Peninsula (CHOMP)

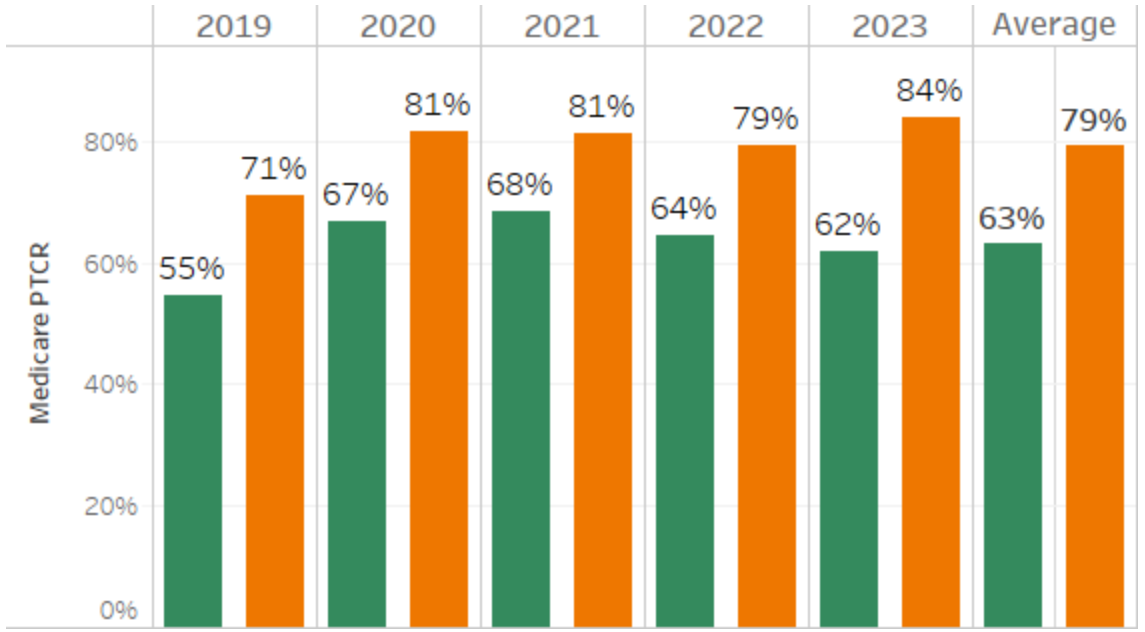
Commercial payment to cost ratio was, on average, 29 percentage points lower (12% decrease) while Medicare payment to cost ratio was, on average, 16 percentage points higher (25.7% increase).

Complete Data Set
SIERA

Commercial Payment to Cost Ratio for CHOMP



Medicare Payment to Cost Ratio for CHOMP



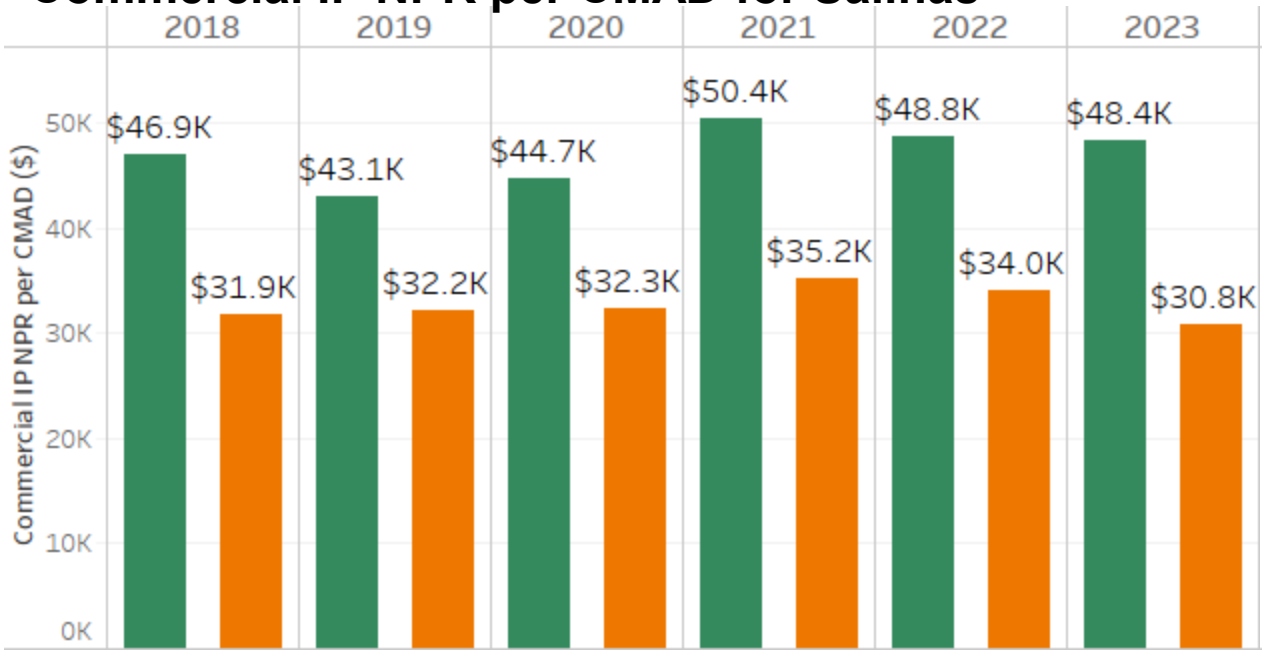
OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

CDS compared with SIERA : Salinas Valley Health Medical Center

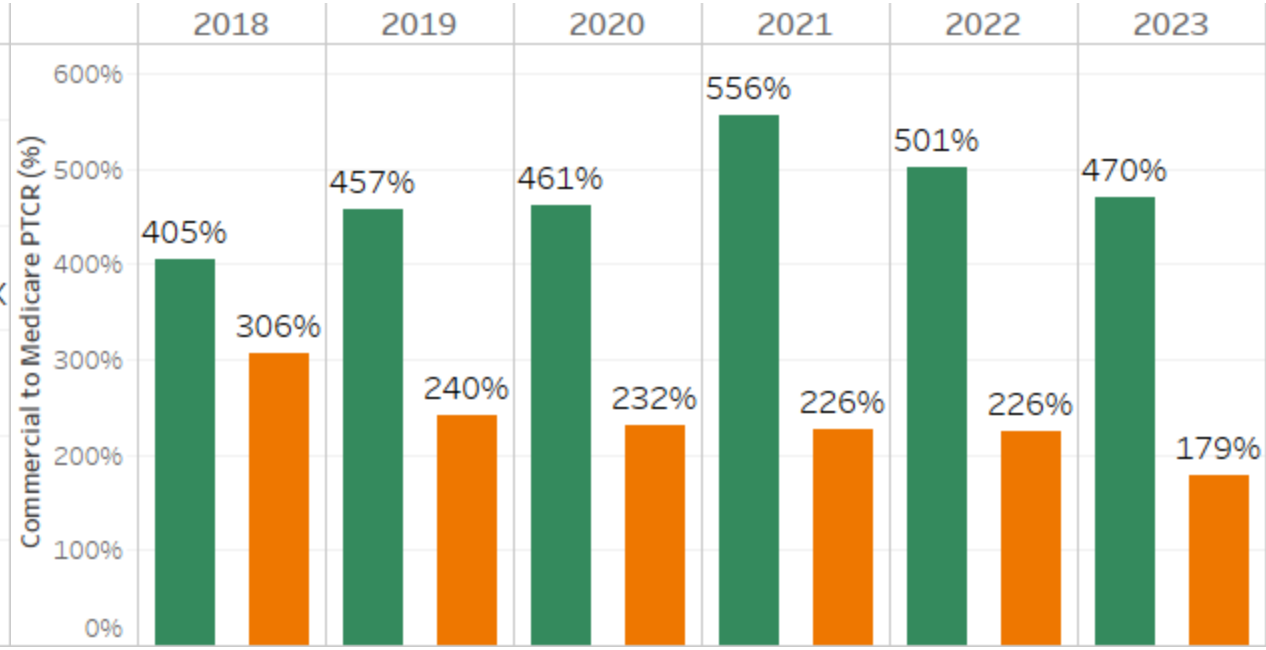
Commercial to Medicare payment to cost ratio was, on average, 240 percentage points lower (50.5% decrease). Commercial inpatient NPR per CMAD was, on average, $14,309 lower (30.3% decrease).

Complete Data Set
SIERA

Commercial IP NPR per CMAD for Salinas



Commercial to Medicare PTCR for Salinas



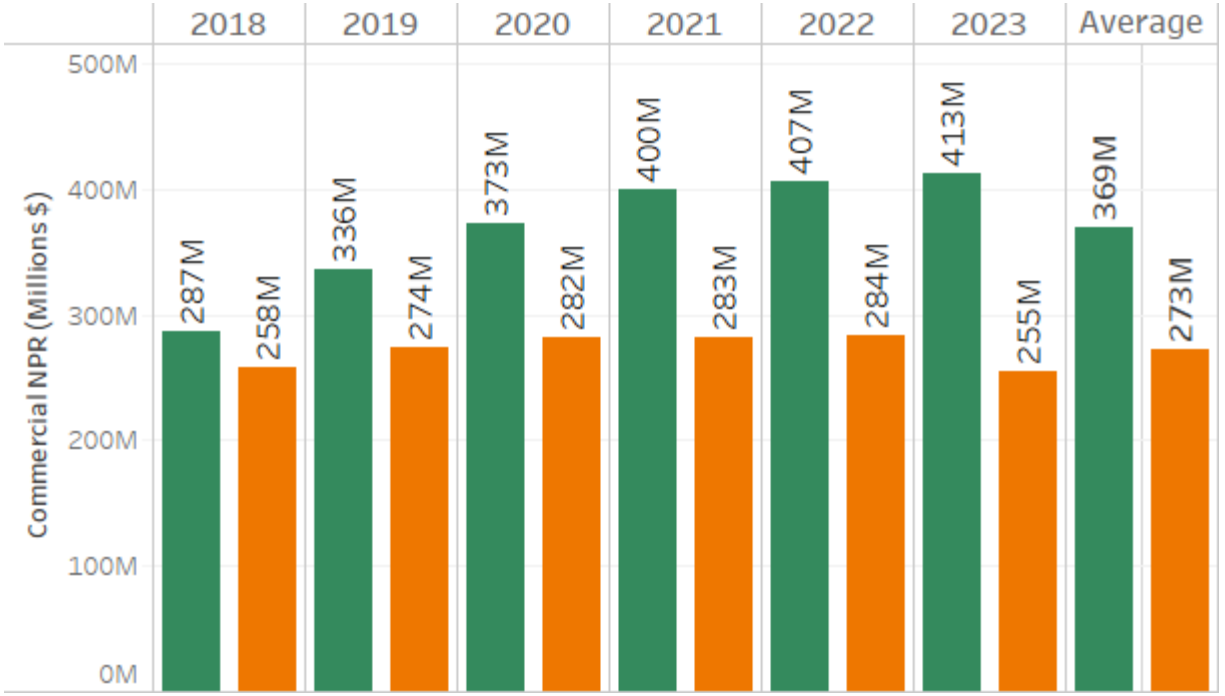
OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

CDS compared with SIERA : Salinas Valley Health Medical Center

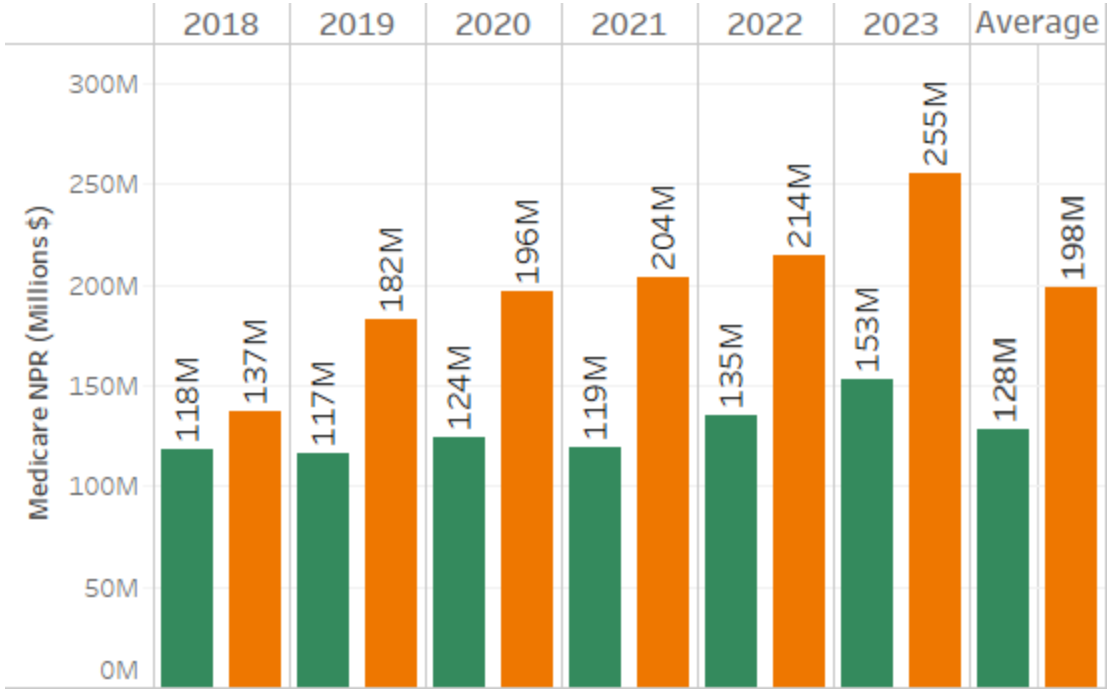
Commercial Net Patient Revenue decreased an average of $96 Million (about 26 percent) while Medicare Net Patient Revenue increased an average of $70 Million (about 55 percent).

Complete Data Set
SIERA

Commercial Net Patient Revenue for Salinas



Medicare Net Patient Revenue for Salinas



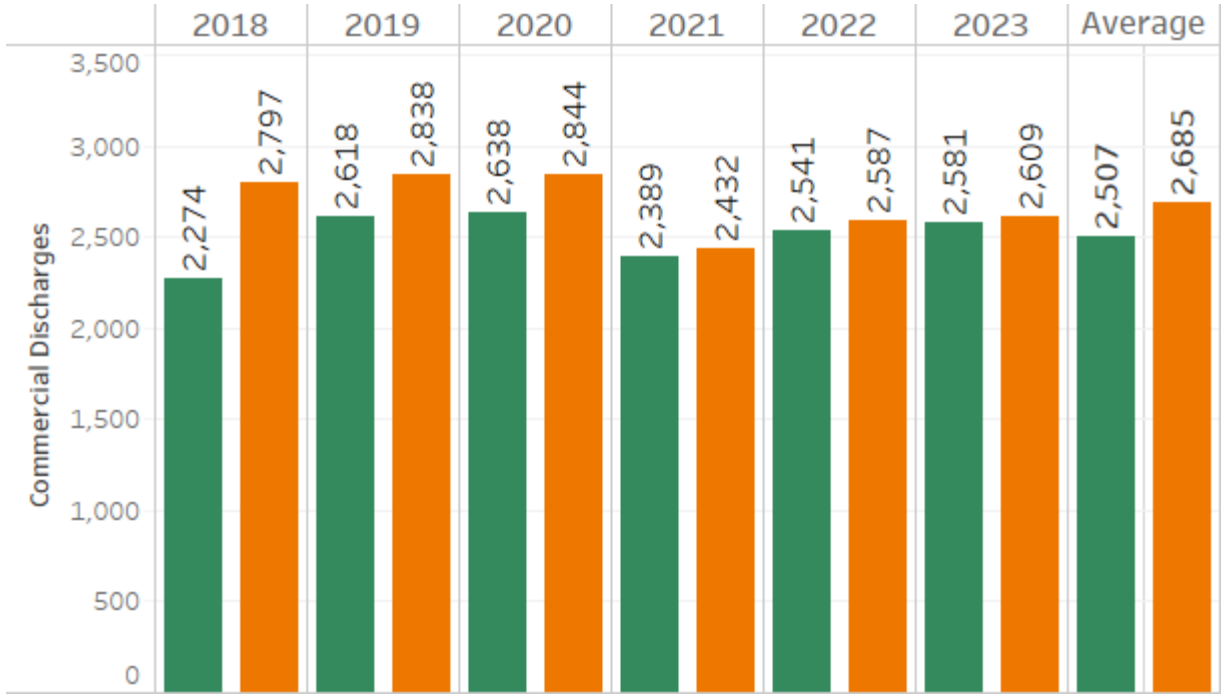
OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

CDS compared with SIERA : Salinas Valley Health Medical Center

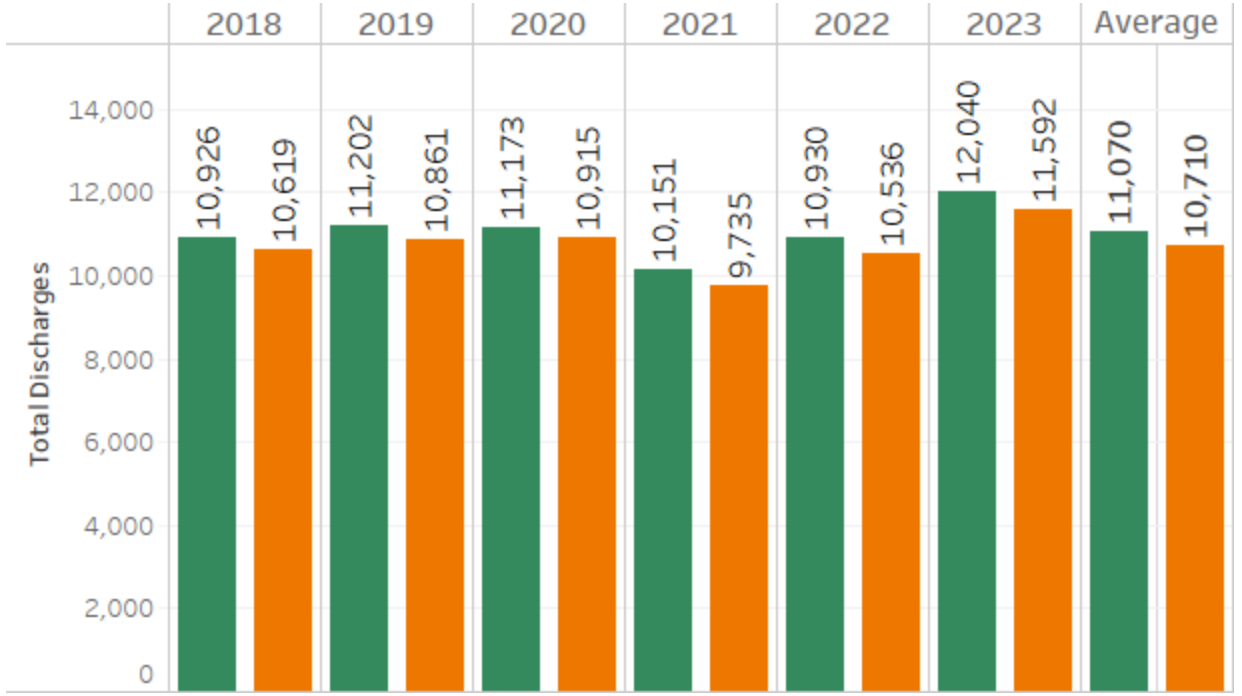
Commercial discharges increased for each resubmission, an average of 178 commercial discharges (about 7 percent increase).
In addition, for Salinas, Total Discharges decreased for each resubmission, an average of 360 total discharges (about 3 percent decrease).

Complete Data Set
SIERA

Commercial Discharges for Salinas



Total Discharges for Salinas



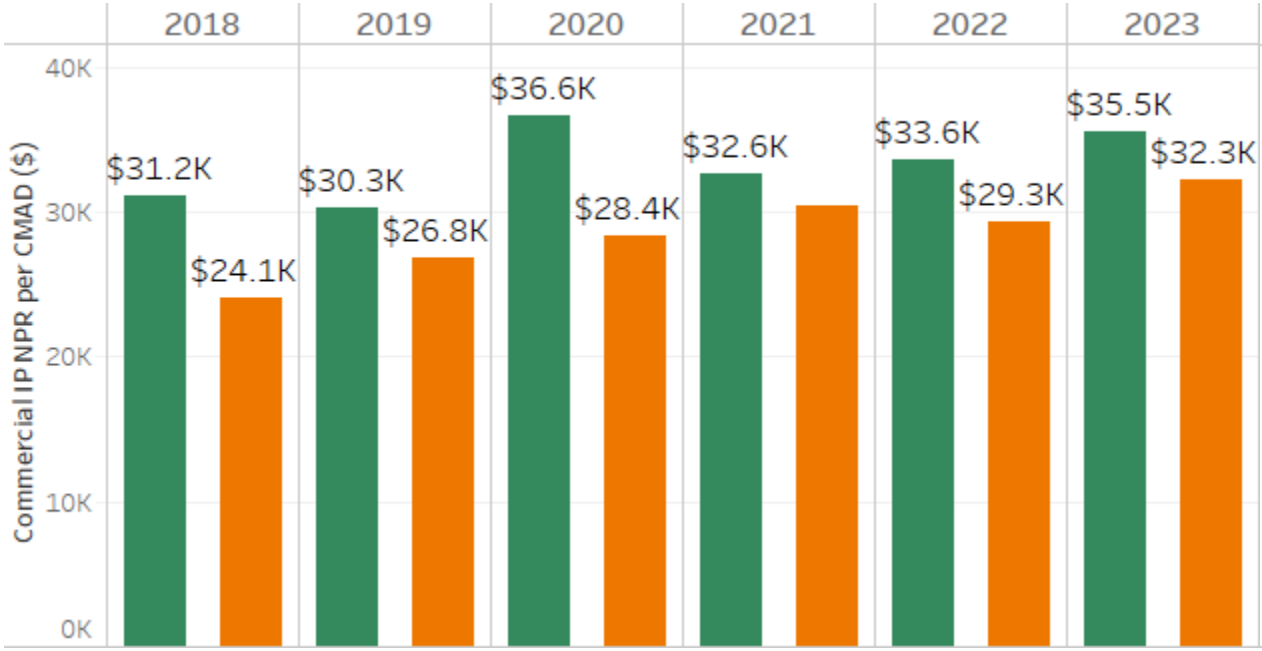
OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

CDS compared with SIERA : Santa Barbara Cottage Hospital

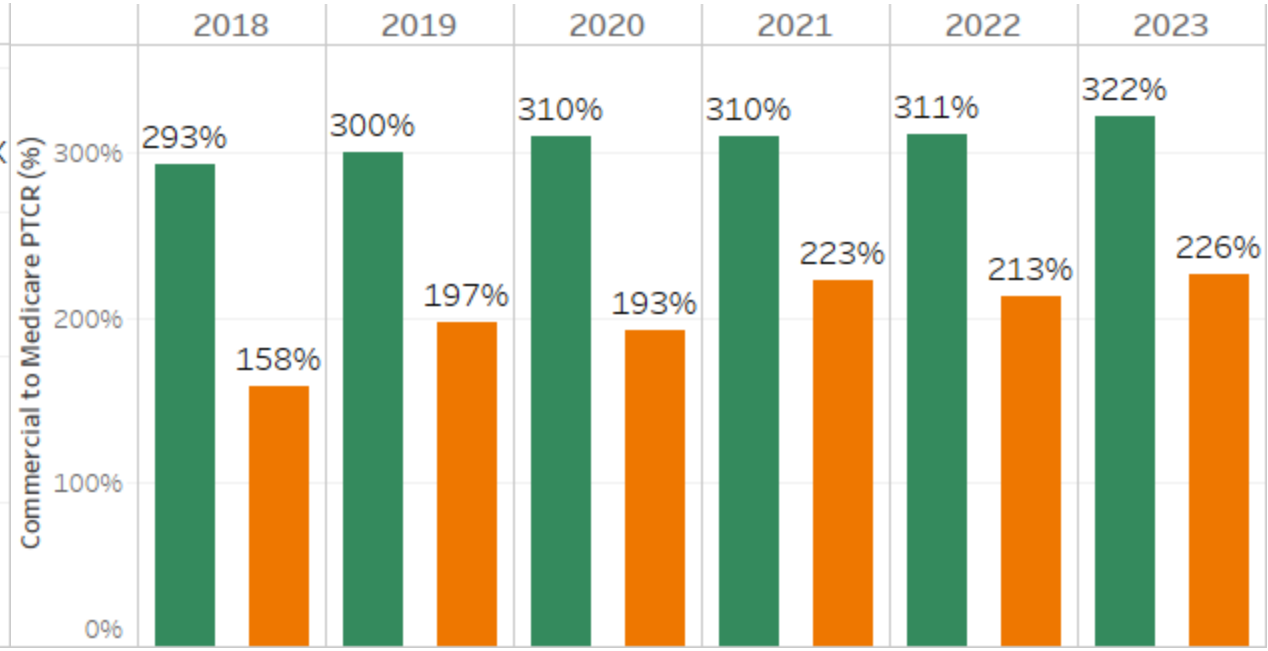
Commercial inpatient NPR per CMAD was, on average, $4,774 lower (14.3% decrease).
Commercial to Medicare payment to cost ratio was, on average, 106 percentage points lower (34.4% decrease).

Complete Data Set
SIERA

Commercial IP NPR per CMAD for SB Cottage



Commercial to Medicare PTCR for SB Cottage



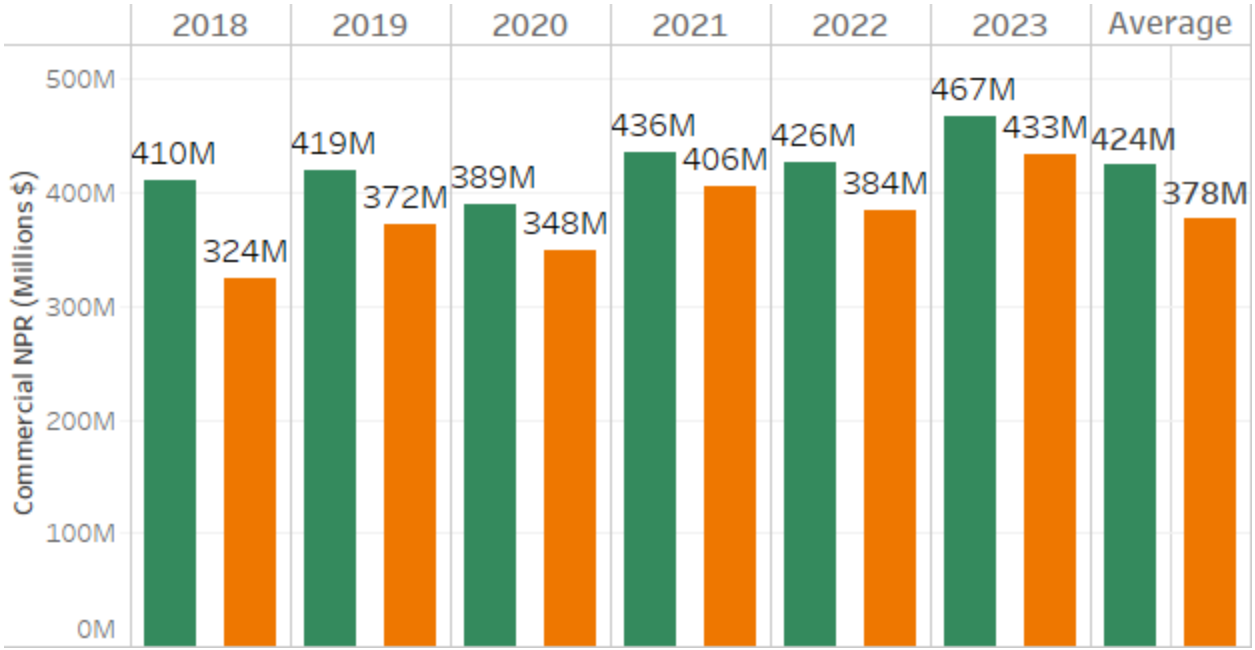
OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

CDS compared with SIERA : Santa Barbara Cottage Hospital

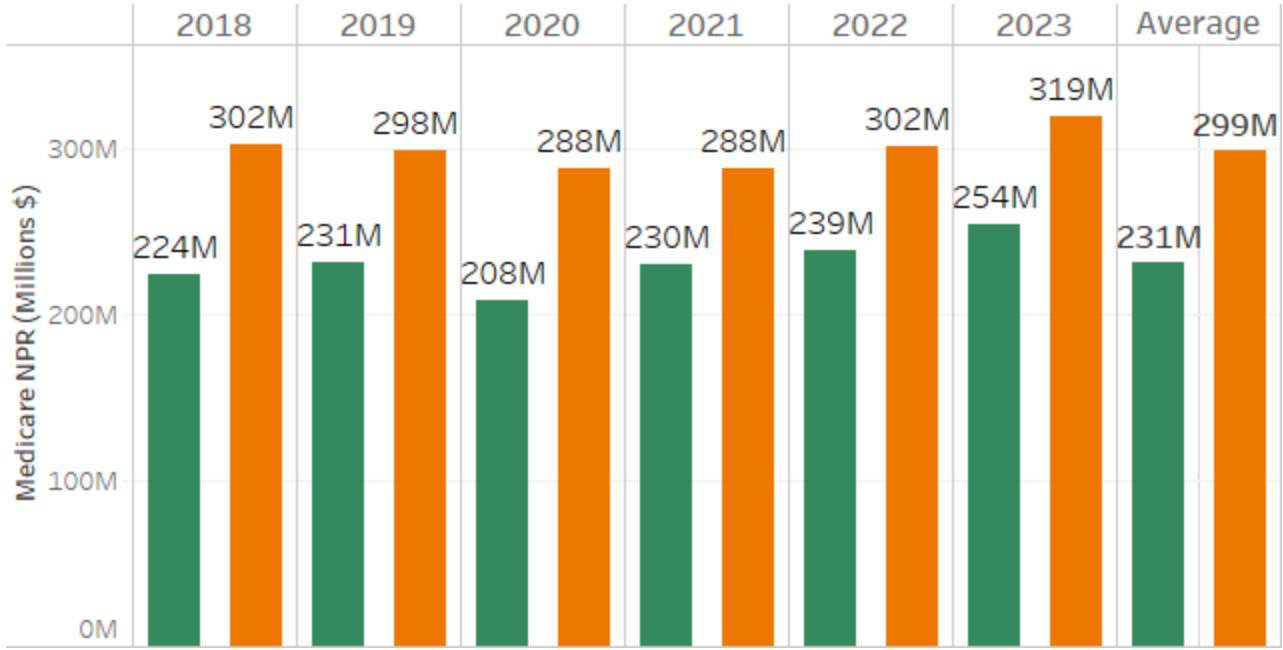
Reported Commercial Net Patient Revenue decreased an average of $46 Million (about 10.8 percent decrease) while Medicare Net Patient Revenue increased an average of $68 Million (about 29.4 percent).

Complete Data Set
SIERA

Commercial Net Patient Revenue for SB Cottage



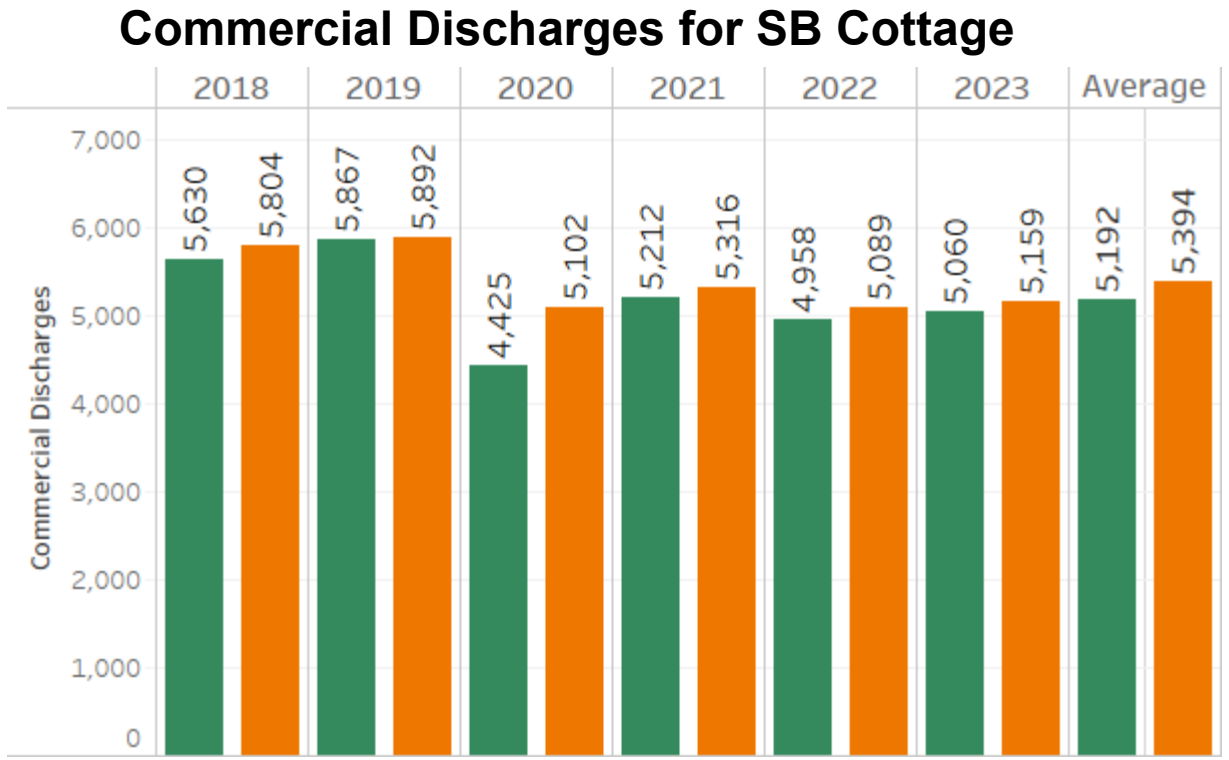
Medicare Net Patient Revenue for SB Cottage



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

CDS compared with SIERA : Santa Barbara Cottage Hospital

Commercial discharges increased for each resubmission, with an average of 202 discharges (about 3.9 percent increase).

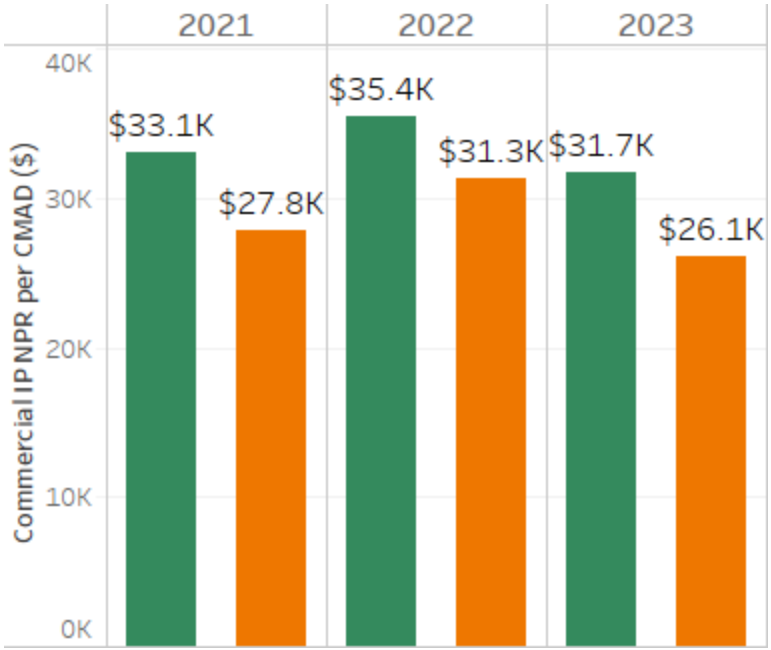


CDS compared with SIERA : Washington Hospital -- Fremont

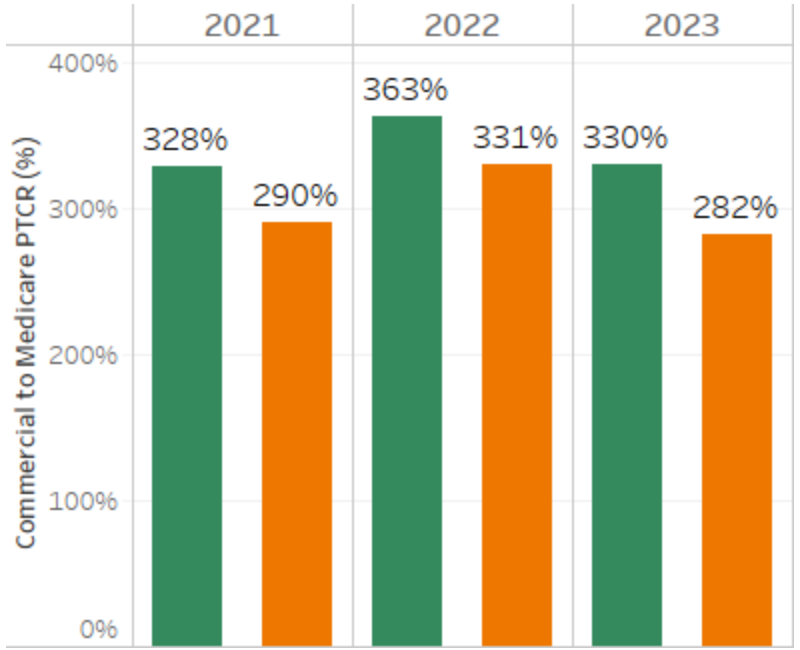
Commercial inpatient NPR per CMAD was, on average, $5,008 lower (15.1% decrease).
Commercial to Medicare PTCR Ratio on average decreased 39 percentage points (11.4% decrease).

Complete Data Set
SIERA

Commercial IP NPR per CMAD for Washington Hospital Fremont



Commercial to Medicare PTCR for Washington Hospital Fremont



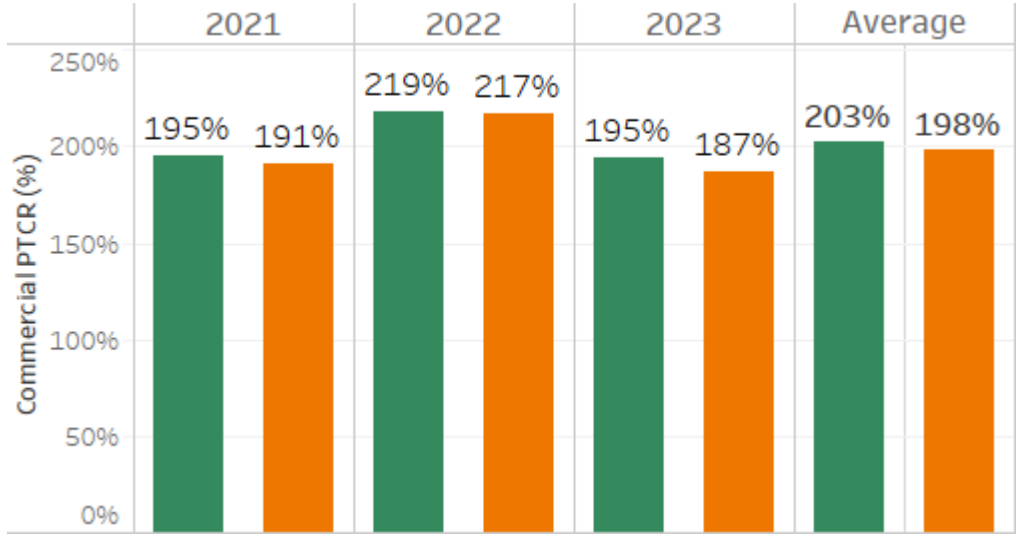
OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

CDS compared with SIERA : Washington Hospital -- Fremont

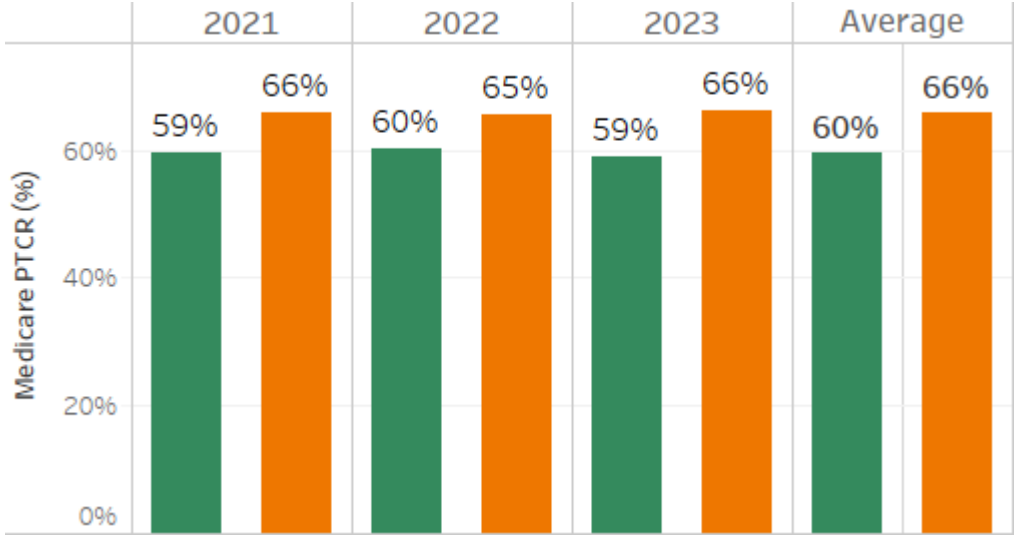
On average, Medicare PTCR increased 6 percentage points (10% increase), and commercial PTCR decreased 5 percentage points (3% decrease).

Complete Data Set
SIERA

Commercial Payment to Cost Ratio for Washington Hospital Fremont



Medicare Payment to Cost Ratio for Washington Hospital Fremont



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

Commercial Inpatient NPR per CMAD for Repeat Outlier Hospitals, 2019-2023

above 85%

Hospital	2019	2020	2021	2022	2023	Pooled Avg 2019-23
All Other Comparable Hospitals	**$19.7K**	**$20.4K**	**$20.4K**	**$21.4K**	**$21.9K**	**$20.7K**
7 High-Cost Hospitals	**$39.7K**	**$40.1K**	**$42.1K**	**$43.8K**	**$45.2K**	**$42.2K**
Community Hospital of The Monterey Peninsula	$41.8K	$42.4K	$43.8K	$38.9K	$42.5K	$41.9K
Doctors Medical Center – Modesto	$40.9K	$36.0K	$36.8K	$39.7K	$36.9K	$38.1K
Dominican Hospital	$33.7K	$33.2K	$34.9K	$33.3K	$36.1K	$34.2K
Salinas Valley Memorial Hospital	$43.1K	$44.7K	$50.4K	$48.6K	$48.4K	$47.0K
Santa Barbara Cottage Hospital	$30.3K	$36.6K	$32.6K	$33.5K	$35.5K	$33.7K
Stanford Health Care	$47.4K	$49.2K	$53.3K	$58.8K	$63.2K	$54.9K
Washington Hospital – Fremont	$33.3K	$30.9K	$33.2K	$35.5K	$31.8K	$32.9K

Note: This data was originally presented in December 2025.

Commercial to Medicare Payment to Cost Ratio for Repeat Outlier Hospitals, 2019-2023

above 85%

Hospital	2019	2020	2021	2022	2023	Pooled Avg 2019-23
All Other Comparable Hospitals	**200%**	**199%**	**191%**	**200%**	**205%**	**199%**
7 High-Cost Hospitals	**365%**	**350%**	**355%**	**362%**	**361%**	**359%**
Community Hospital of The Monterey Peninsula	437%	353%	363%	369%	380%	381%
Doctors Medical Center - Modesto	372%	343%	325%	372%	367%	356%
Dominican Hospital	314%	336%	316%	334%	352%	330%
Salinas Valley Memorial Hospital	457%	461%	556%	501%	470%	487%
Santa Barbara Cottage Hospital	300%	310%	310%	311%	322%	311%
Stanford Health Care	335%	339%	351%	340%	343%	342%
Washington Hospital - Fremont	392%	352%	328%	363%	330%	355%

Note: This data was originally presented in December 2025.

Appendix:
Behavioral Health 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" category 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.

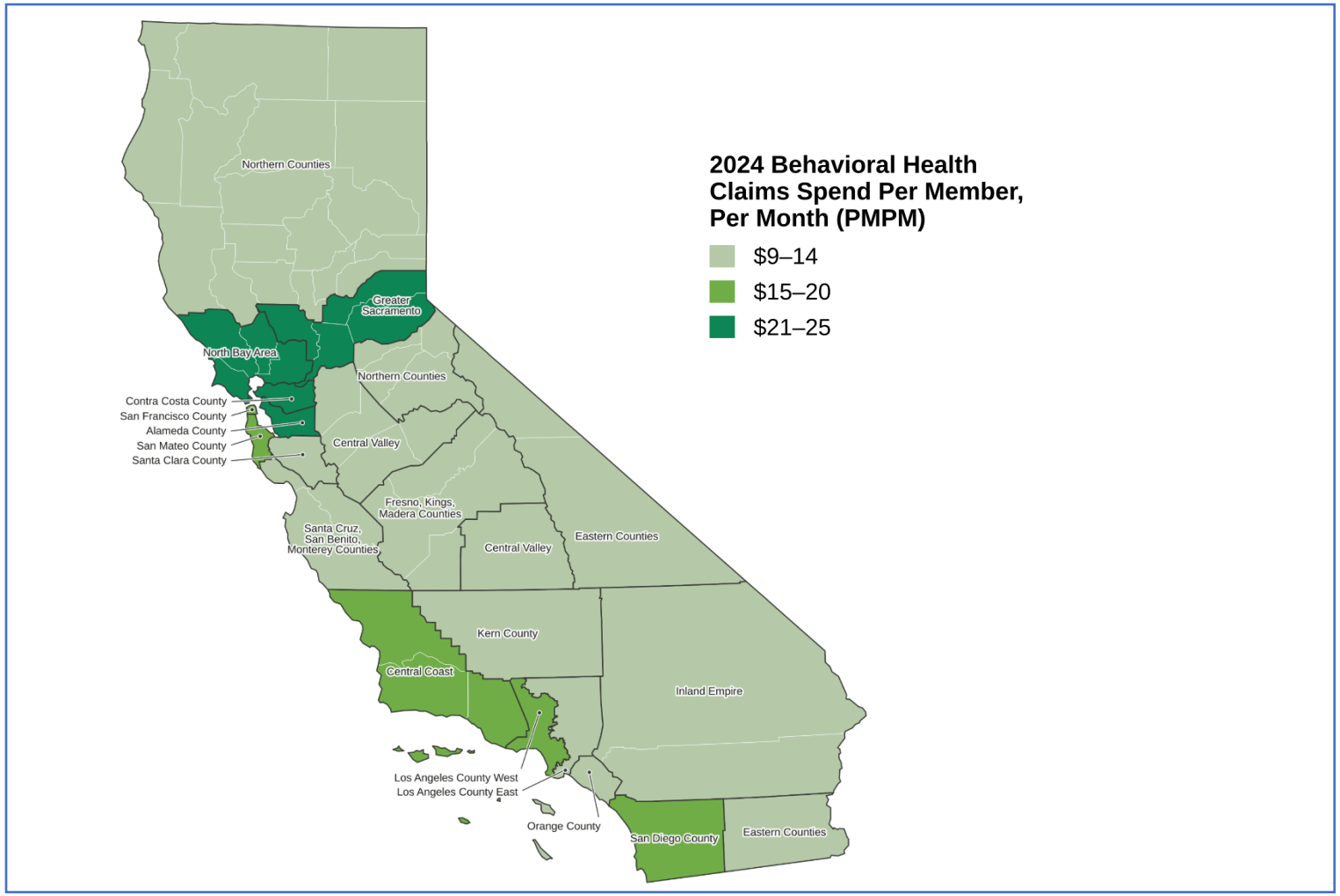
Note: OHCA's methodology also includes behavioral health screenings and assessments regardless of diagnosis and behavioral health services provided to Medi-Cal members under 21.

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.

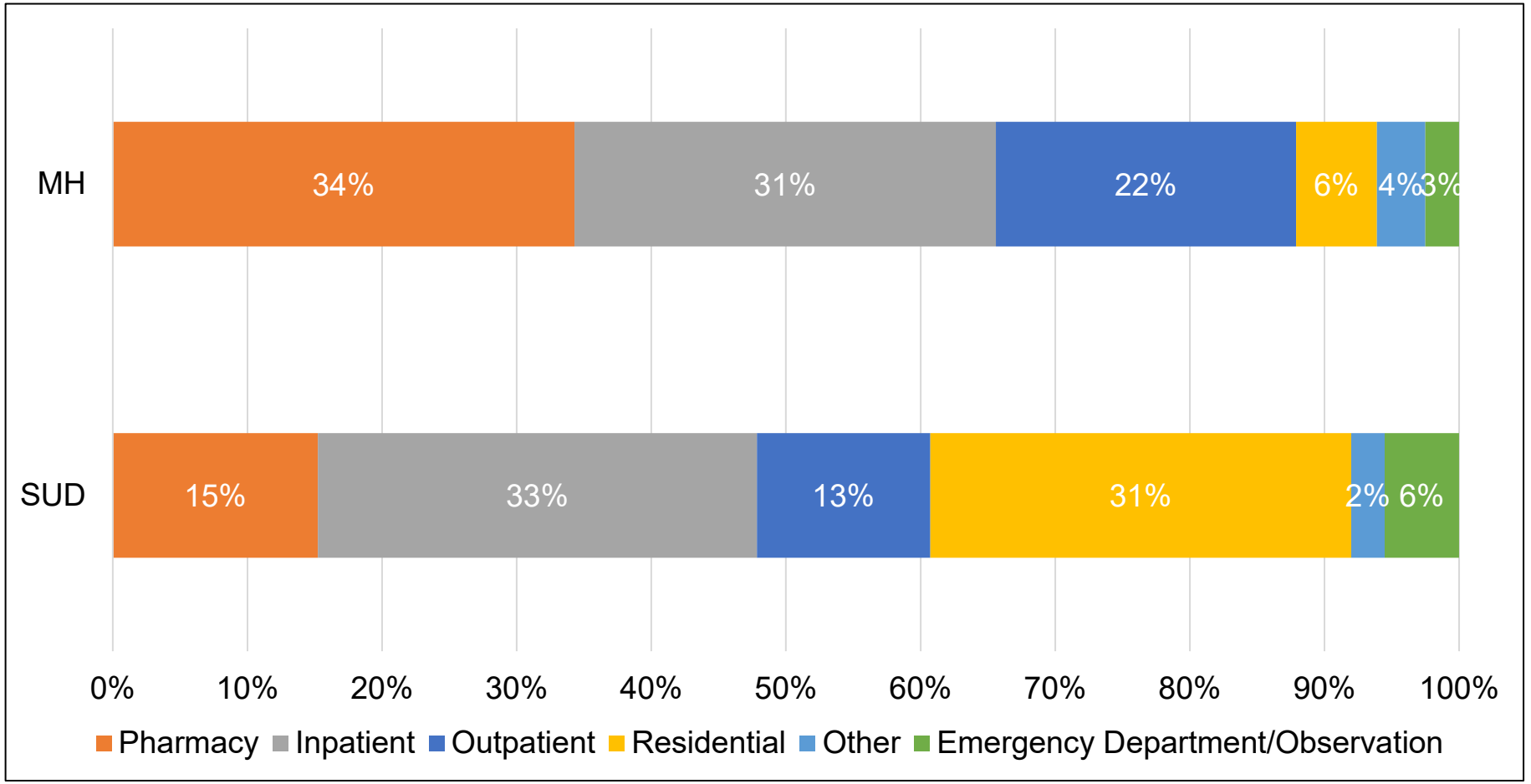
2024 Medicare Advantage Behavioral Health Claims Spending PMPM by Covered CA Region

- Medicare Advantage behavioral health claims spending varies by Covered California region.
- Regional spending patterns are similar to those in the commercial market.



Distribution of Medicare Advantage MH vs. SUD Claims Spending by Subcategory, 2024

- For mental health (MH), the majority of claims spending was for pharmacy and inpatient services.
- For substance use disorders (SUD), the majority of claims spending was for residential and inpatient services.

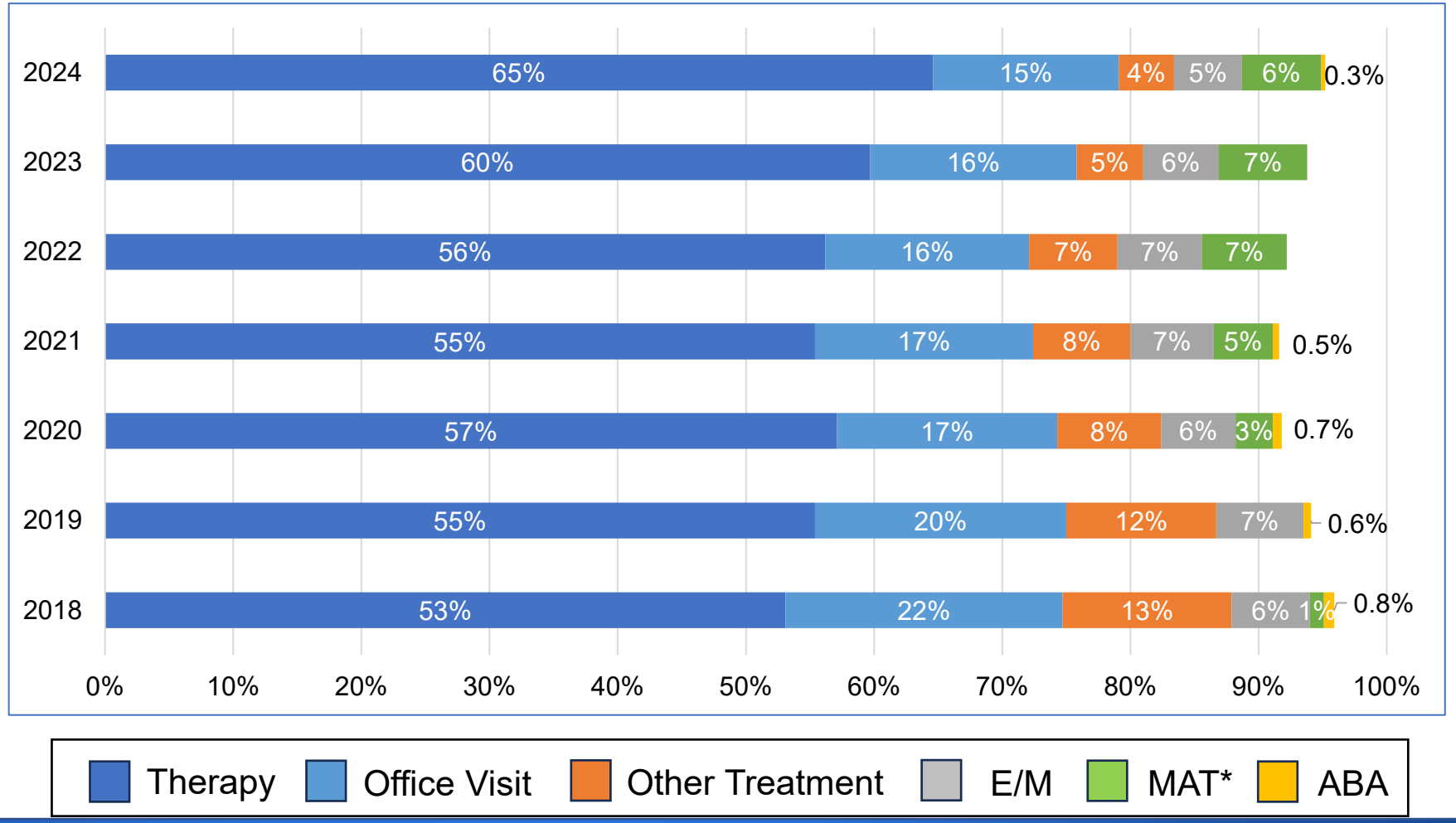


2024 Top 10 Service Codes Associated with the Most Commercial Outpatient Professional Non-PC Spend

Rank	Code	Description
1	90837	Psychotherapy, 60 minutes with patient
2	97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
3	90834	Psychotherapy, 45 minutes with patient
4	H2019	Therapeutic behavioral services, per 15 minutes
5	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
6	97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
7	90791	Psychiatric diagnostic evaluation
8	H0032	Mental health service plan development by non-physician
9	90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic
10	90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

Distribution of Medicare Advantage Outpatient Professional Non-Primary Care Spending

- Psychotherapy increased as a share of outpatient professional primary care spending from 2018 to 2024.



*Medication-assisted treatment (MAT)
Note: "Other Treatment" includes therapeutic repetitive transcranial magnetic stimulation (TMS) and therapeutic behavioral services and "E/M" includes psychiatric diagnostic evaluations, self-care/home management training, and mental health service plan development.

2024 Top 10 Service Codes Associated with the Most Medicare Advantage Outpatient Professional Non-PC Spend

Rank	Code	Description
1	90837	Psychotherapy, 60 minutes with patient
2	90834	Psychotherapy, 45 minutes with patient
3	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
4	G2067	Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled opioid treatment program)
5	90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, subsequent delivery and management, per session
6	90791	Psychiatric diagnostic evaluation
7	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
8	G2083	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes 2 hours post-administration observation
9	90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
10	H0020	Alcohol and/or drug services; methadone administration and/or service