



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

Health Care Affordability Advisory Committee Meeting

October 14, 2026



Department of Health Care
Access and Information



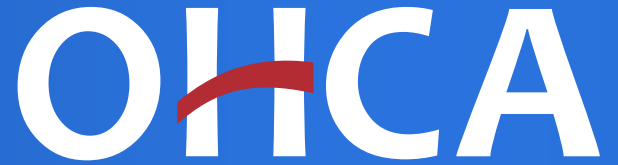
Office of Health Care Affordability
Department of Health Care Access and Information

Welcome and Call to Order



Agenda

1. **Welcome and Call to Order**
2. **Executive Updates**
Michael Valle, Assistant Director; Vishaal Pegany, Deputy Director
3. **Review Report on Promoting High Value Health Care in California, 2023-2024**
Margareta Brandt, Assistant Deputy Director; Debbie Lindes, Health Care Delivery System Group Manager
4. **Payer Strategies for Primary Care Investment in California**
Margareta Brandt; Jill Yegian, Ph.D., Yegian Health Insights
5. **Health Plan of San Mateo Primary Care Investment Strategies**
Margareta Brandt; Miriam Sheinbein, M.D., IBCLC, Medical Director, Health Plan of San Mateo; Luarnie Bermudo, Director of Provider Services, Health Plan of San Mateo
6. **OHCA Equity and Quality Measure Set Update**
Margareta Brandt
7. **Spending Target Enforcement – PIP Implementation and Enforcement Regulations**
Vishaal Pegany; CJ Howard, Assistant Deputy Director; Megan Brubaker, Engagement, Governance, and Policy Group Manager
8. **Overview of Progressive Enforcement Regulations, Including Spending Target Performance Measurement**
Vishaal Pegany; CJ Howard; Megan Brubaker
9. **General Public Comment**
10. **Adjournment**



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

Executive Updates

Michael Valle, Assistant Director
Vishaal Pegany, Deputy Director



2027 Public Meeting Calendar

<table><tr><th colspan="7">January</th></tr><tr><td>S</td><td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td>1</td><td>2</td></tr><tr><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr><tr><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td></tr><tr><td>17</td><td>18</td><td>19</td><td>20</td><td>21</td><td>22</td><td>23</td></tr><tr><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td><td>29</td><td>30</td></tr><tr><td>31</td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>	January							S	M	T	W	T	F	S						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31							<table><tr><th colspan="7">February</th></tr><tr><td>S</td><td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td></tr><tr><td></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td></tr><tr><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td></tr><tr><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td>20</td></tr><tr><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td></tr><tr><td>28</td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>	February							S	M	T	W	T	F	S		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28							<table><tr><th colspan="7">March</th></tr><tr><td>S</td><td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td></tr><tr><td></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td></tr><tr><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td></tr><tr><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td>20</td></tr><tr><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td></tr><tr><td>28</td><td>29</td><td>30</td><td>31</td><td></td><td></td><td></td></tr></table>	March							S	M	T	W	T	F	S		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31				<table><tr><th colspan="7">April</th></tr><tr><td>S</td><td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td></tr><tr><td></td><td></td><td></td><td></td><td>1</td><td>2</td><td>3</td></tr><tr><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td></tr><tr><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td></tr><tr><td>18</td><td>19</td><td>20</td><td>21</td><td>22</td><td>23</td><td>24</td></tr><tr><td>25</td><td>26</td><td>27</td><td>28</td><td>29</td><td>30</td><td></td></tr></table>	April							S	M	T	W	T	F	S					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
January																																																																																																																																																																																																														
S	M	T	W	T	F	S																																																																																																																																																																																																								
					1	2																																																																																																																																																																																																								
3	4	5	6	7	8	9																																																																																																																																																																																																								
10	11	12	13	14	15	16																																																																																																																																																																																																								
17	18	19	20	21	22	23																																																																																																																																																																																																								
24	25	26	27	28	29	30																																																																																																																																																																																																								
31																																																																																																																																																																																																														
February																																																																																																																																																																																																														
S	M	T	W	T	F	S																																																																																																																																																																																																								
	1	2	3	4	5	6																																																																																																																																																																																																								
7	8	9	10	11	12	13																																																																																																																																																																																																								
14	15	16	17	18	19	20																																																																																																																																																																																																								
21	22	23	24	25	26	27																																																																																																																																																																																																								
28																																																																																																																																																																																																														
March																																																																																																																																																																																																														
S	M	T	W	T	F	S																																																																																																																																																																																																								
	1	2	3	4	5	6																																																																																																																																																																																																								
7	8	9	10	11	12	13																																																																																																																																																																																																								
14	15	16	17	18	19	20																																																																																																																																																																																																								
21	22	23	24	25	26	27																																																																																																																																																																																																								
28	29	30	31																																																																																																																																																																																																											
April																																																																																																																																																																																																														
S	M	T	W	T	F	S																																																																																																																																																																																																								
				1	2	3																																																																																																																																																																																																								
4	5	6	7	8	9	10																																																																																																																																																																																																								
11	12	13	14	15	16	17																																																																																																																																																																																																								
18	19	20	21	22	23	24																																																																																																																																																																																																								
25	26	27	28	29	30																																																																																																																																																																																																									
<table><tr><th colspan="7">May</th></tr><tr><td>S</td><td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td>1</td><td></td></tr><tr><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td></tr><tr><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td></tr><tr><td>16</td><td>17</td><td>18</td><td>19</td><td>20</td><td>21</td><td>22</td></tr><tr><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td><td>29</td></tr><tr><td>30</td><td>31</td><td></td><td></td><td></td><td></td><td></td></tr></table>	May							S	M	T	W	T	F	S						1		2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31						<table><tr><th colspan="7">June</th></tr><tr><td>S</td><td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td></tr><tr><td></td><td></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr><tr><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td></tr><tr><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td></tr><tr><td>20</td><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td></tr><tr><td>27</td><td>28</td><td>29</td><td>30</td><td></td><td></td><td></td></tr></table>	June							S	M	T	W	T	F	S			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30				<table><tr><th colspan="7">July</th></tr><tr><td>S</td><td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td></tr><tr><td></td><td></td><td></td><td></td><td>1</td><td>2</td><td>3</td></tr><tr><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td></tr><tr><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td></tr><tr><td>18</td><td>19</td><td>20</td><td>21</td><td>22</td><td>23</td><td>24</td></tr><tr><td>25</td><td>26</td><td>27</td><td>28</td><td>29</td><td>30</td><td>31</td></tr></table>	July							S	M	T	W	T	F	S					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	<table><tr><th colspan="7">August</th></tr><tr><td>S</td><td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td></tr><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td></tr><tr><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td></tr><tr><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td>20</td><td>21</td></tr><tr><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td></tr><tr><td>29</td><td>30</td><td>31</td><td></td><td></td><td></td><td></td></tr></table>	August							S	M	T	W	T	F	S	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31				
May																																																																																																																																																																																																														
S	M	T	W	T	F	S																																																																																																																																																																																																								
					1																																																																																																																																																																																																									
2	3	4	5	6	7	8																																																																																																																																																																																																								
9	10	11	12	13	14	15																																																																																																																																																																																																								
16	17	18	19	20	21	22																																																																																																																																																																																																								
23	24	25	26	27	28	29																																																																																																																																																																																																								
30	31																																																																																																																																																																																																													
June																																																																																																																																																																																																														
S	M	T	W	T	F	S																																																																																																																																																																																																								
		1	2	3	4	5																																																																																																																																																																																																								
6	7	8	9	10	11	12																																																																																																																																																																																																								
13	14	15	16	17	18	19																																																																																																																																																																																																								
20	21	22	23	24	25	26																																																																																																																																																																																																								
27	28	29	30																																																																																																																																																																																																											
July																																																																																																																																																																																																														
S	M	T	W	T	F	S																																																																																																																																																																																																								
				1	2	3																																																																																																																																																																																																								
4	5	6	7	8	9	10																																																																																																																																																																																																								
11	12	13	14	15	16	17																																																																																																																																																																																																								
18	19	20	21	22	23	24																																																																																																																																																																																																								
25	26	27	28	29	30	31																																																																																																																																																																																																								
August																																																																																																																																																																																																														
S	M	T	W	T	F	S																																																																																																																																																																																																								
1	2	3	4	5	6	7																																																																																																																																																																																																								
8	9	10	11	12	13	14																																																																																																																																																																																																								
15	16	17	18	19	20	21																																																																																																																																																																																																								
22	23	24	25	26	27	28																																																																																																																																																																																																								
29	30	31																																																																																																																																																																																																												
<table><tr><th colspan="7">September</th></tr><tr><td>S</td><td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td></tr><tr><td></td><td></td><td></td><td>1</td><td>2</td><td>3</td><td>4</td></tr><tr><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td></tr><tr><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td></tr><tr><td>19</td><td>20</td><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td></tr><tr><td>26</td><td>27</td><td>28</td><td>29</td><td>30</td><td></td><td></td></tr></table>	September							S	M	T	W	T	F	S				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30			<table><tr><th colspan="7">October</th></tr><tr><td>S</td><td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td></tr><tr><td></td><td></td><td></td><td></td><td>1</td><td>2</td><td></td></tr><tr><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr><tr><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td></tr><tr><td>17</td><td>18</td><td>19</td><td>20</td><td>21</td><td>22</td><td>23</td></tr><tr><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td><td>29</td><td>30</td></tr><tr><td>31</td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>	October							S	M	T	W	T	F	S					1	2		3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31							<table><tr><th colspan="7">November</th></tr><tr><td>S</td><td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td></tr><tr><td></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td></tr><tr><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td></tr><tr><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td>20</td></tr><tr><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td></tr><tr><td>28</td><td>29</td><td>30</td><td></td><td></td><td></td><td></td></tr></table>	November							S	M	T	W	T	F	S		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30					<table><tr><th colspan="7">December</th></tr><tr><td>S</td><td>M</td><td>T</td><td>W</td><td>T</td><td>F</td><td>S</td></tr><tr><td></td><td></td><td></td><td>1</td><td>2</td><td>3</td><td>4</td></tr><tr><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td></tr><tr><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td></tr><tr><td>19</td><td>20</td><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td></tr><tr><td>26</td><td>27</td><td>28</td><td>29</td><td>30</td><td>31</td><td></td></tr></table>	December							S	M	T	W	T	F	S				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
September																																																																																																																																																																																																														
S	M	T	W	T	F	S																																																																																																																																																																																																								
			1	2	3	4																																																																																																																																																																																																								
5	6	7	8	9	10	11																																																																																																																																																																																																								
12	13	14	15	16	17	18																																																																																																																																																																																																								
19	20	21	22	23	24	25																																																																																																																																																																																																								
26	27	28	29	30																																																																																																																																																																																																										
October																																																																																																																																																																																																														
S	M	T	W	T	F	S																																																																																																																																																																																																								
				1	2																																																																																																																																																																																																									
3	4	5	6	7	8	9																																																																																																																																																																																																								
10	11	12	13	14	15	16																																																																																																																																																																																																								
17	18	19	20	21	22	23																																																																																																																																																																																																								
24	25	26	27	28	29	30																																																																																																																																																																																																								
31																																																																																																																																																																																																														
November																																																																																																																																																																																																														
S	M	T	W	T	F	S																																																																																																																																																																																																								
	1	2	3	4	5	6																																																																																																																																																																																																								
7	8	9	10	11	12	13																																																																																																																																																																																																								
14	15	16	17	18	19	20																																																																																																																																																																																																								
21	22	23	24	25	26	27																																																																																																																																																																																																								
28	29	30																																																																																																																																																																																																												
December																																																																																																																																																																																																														
S	M	T	W	T	F	S																																																																																																																																																																																																								
			1	2	3	4																																																																																																																																																																																																								
5	6	7	8	9	10	11																																																																																																																																																																																																								
12	13	14	15	16	17	18																																																																																																																																																																																																								
19	20	21	22	23	24	25																																																																																																																																																																																																								
26	27	28	29	30	31																																																																																																																																																																																																									

Health Care Affordability Board Meetings

Wednesday, January 27

Wednesday, February 24

Wednesday, March 24

Wednesday, April 28

Wednesday, May 26

Wednesday, June 23

Wednesday, July 28

Wednesday, August 25

Wednesday, September 22

Wednesday, October 27

Wednesday, November 17

Wednesday, December 15

Health Care Affordability Advisory Committee Meetings

Wednesday, January 13

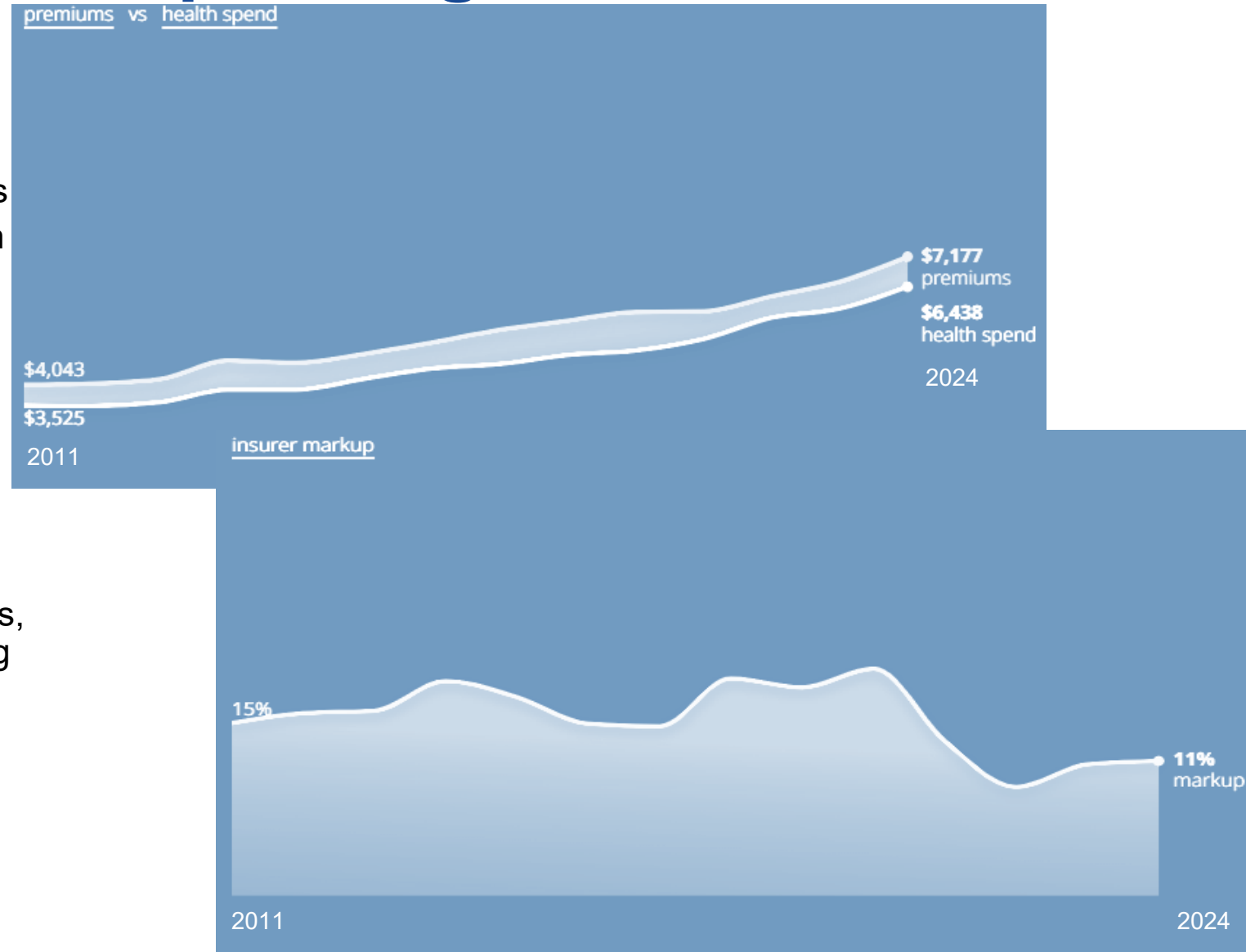
Wednesday, April 14

Wednesday, July 14

Wednesday, October 13

Commercial Health Care Spending and Premiums, 2011-2024

- A recently published JAMA Health Forum article examined the extent to which growth in fully-insured commercial health care spending explains growth in fully-insured commercial premiums from 2011 to 2024.
- Using CCIIO MLR reports, the authors found that, across all states, average premiums grew \$3,143 (78.4%), health spending grew \$2,844 (84.2%), and insurer markups as a share of premium revenue decreased from 18.6% in 2011 to 14.9% in 2024.
- Overall, the growth in health spending accounted for 91% of the overall growth in average premiums, suggesting that policymakers interested in slowing the growth in premiums should focus on slowing the growth in health care spending.
- In California, as the adjacent figures show, average premiums increased 77.5%, health spending grew 82.6% and insurer markups as a share of premium revenue decreased 4 percentage points (26.7%).



OHCA Fall 2026 Publications

- In late September, OHCA posted on its website a preliminary [facility-level crosswalk for Fiscal Years 2023 and 2024](#) and emailed hospitals with a request to review and verify that OHCA correctly assigned National Provider Identifiers (NPI) to the hospital's license number.
- In addition, OHCA posted a cost driver [issue brief](#) using Health Care Payments Database data to examine commercial price variation in shoppable services.
- On October 7th, OHCA posted two additional reports on its website:
 1. The [Report on Promoting High Value Health Care in California, 2023-2024](#) which presents baseline information on alternative payment model (APM) adoption and primary care spending for 2023 and 2024 prior to implementation of APM adoption goals and primary care investment benchmarks; and
 2. The [Interim Report: Health Care Spending Trends in California, 2023-2024](#). This provides a second assessment of health care spending in California prior to the statewide spending target taking effect for performance year 2025.

The Payment Model That's Holding Back California's Health Care System

- Last month, the California Health Care Foundation published a perspective piece which argued that a sustainable path to affordability requires public programs, commercial health plans, and providers to shift away from the traditional fee-for-service (FFS) payment model and adopt alternative payment models (APMs) that pay providers for keeping patients healthy rather than for the volume of services they deliver.
- The author uses the Health Care Payment Learning and Action Network (HCP-LAN) framework to describe APM arrangements, how the arrangements influence quality and cost, and MemorialCare's experience under APM arrangements.
 - Tiers 1 and 2 of the HCP-LAN APM framework remain mostly fee-for-service. Tier 3 adds quality and budget goals, while Tier 4 uses a population-based payment, often a fixed payment per patient, and places providers at greater financial risk.
 - Patients cared for by organizations in Tier 3 and Tier 4 arrangements receive higher-quality services, more consistent preventive care, and better chronic disease management. When providers share responsibility for costs, total spending can be lower than spending under FFS models and pharmacy spending may also decline.
 - Most of MemorialCare's APMs have been in Tier 3 or Tier 4 since 2016 leading to operational priorities of shifting care to lower-cost settings, integrating care, and expanding virtual services.
 - Tiers 3 and 4 of the HCP-LAN framework are OHCA's preferred APM categories.

The Payment Model That's Holding Back California's Health Care System

- With less than one-third of U.S. health care payments currently using the more advanced APM tiers, the author argued that change is happening but too slowly. A possible solution could be for federal policymakers to make it easier for providers to take on financial risk by allowing participants in the Center for Medicare and Medicaid Innovation (CMMI) pilot programs to keep a share of the money they save for the first few years of participation before requiring them to cover overruns.
- Related to the work of OHCA, the author recommended that, in addition to the current APM requirements and spending targets, OHCA should also publish payer performance data and penalize plans that fall short of APM enrollment targets.
- The author emphasized that delivery systems should build the capacities they will soon need to comply with California's health care spending policies because wider use of APMs could lead to more personalized, streamlined care, lower costs, and better coordination among clinicians.

California Health Care Foundation- The 25% Problem

Around 25 cents of every health care dollar does not help patients become healthier or get better care. In 2020, it was estimated that this added up to as much as \$73 billion dollars a year in California's health care system.

WHERE DOES THE 25% GO?



Administrative waste:
Red tape and
paperwork



Excessive profits:
Unfair pricing without
competition



Preventable illness:
Conditions caught
too late

California Health Care Foundation- The 25% Solution

According to CHCF, there are 10 actions to start to solve the 25% problem:

1. Support OHCA's authority to slow the growth of health care spending (top priority).
2. Cap payments to hospitals under state health care contracts.
3. Don't allow extra fees or different prices for the same service, just because of where it is delivered.
4. Prohibit contract terms that unfairly limit competition and patients' choices.
5. Give the Department of Managed Health Care the power to reject unreasonable premium increases.
6. Prevent medical debt by strengthening existing statewide hospital financial assistance programs.
7. Expand financial assistance programs to other providers and settings.
8. Require and support all California providers and health plans to adopt electronic prior authorization practices.
9. Require standardized claims and billing system rules across all health plans and health systems.
10. Shift health care spending into primary care.

A Combined Affordability Strategy

CHCF's research points to a broad approach to achieving health care affordability rather than a single policy. Californians want reforms that:

- 1. Lower prices that are already too high**
Directly address hospital prices, facility fees, and market power
- 2. Prevent unjustified future increases**
Set enforceable limits and require savings to reach consumers
- 3. Reduce barriers that keep people from care**
Improve coverage choices, primary care access, and debt protections
- 4. Hold the health care system accountable**
Use transparent enforcement and measure whether households save money

Cost and Market Impact Review – Emergency Regulations

The Office of Health Care Affordability (OHCA) updated its Cost and Market Impact Review (CMIR) regulations (California Code of Regulations (CCR) at Title 22, Division 7, Article 1, sections 97431 *et seq.*) through emergency rulemaking. The regulations were approved by the Office of Administrative Law on October 2, 2026, and will be effective November 2, 2026.

The regulatory documents are available on HCAI's webpage.

You may:

- Read the [approved emergency regulation text](#);
- Read the [Finding of Emergency](#);
- Read the [Addendum to the Finding of Emergency](#).

Issues Around Hospital-Reported Net Patient Revenue (NPR)

- In response to hospital stakeholder comments about volatility in inpatient and outpatient growth rates, at the [September Board meeting](#), OHCA addressed this topic in detail.
- OHCA noted that contractual adjustments can induce volatility in hospital-reported NPR, and importantly, this volatility exists in hospitals' data prior to OHCA applying any volume or intensity adjustments.
- A second source of volatility in growth rates stems from low utilization volume; 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.
- For more information, please refer to the September Board slides linked above.

Slide Formatting



Indicates items that the Advisory Committee provides input or recommendations on based on statute and other areas as requested by the Board or OHCA.



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

Public Comment





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

Informational Items





Review Report on Promoting High Value Health Care in California, 2023-2024

Margareta Brandt, Assistant Deputy Director

Debbie Lindes, Health Care Delivery System Group Manager



Report Overview

- Presents data on alternative payment model (APM) adoption and primary care spending in California for calendar years 2023 and 2024.
 - Markets included: Commercial, Medicare Advantage, Medi-Cal Managed Care
 - Data presented at statewide level and where applicable, by market and by payer
- Serves as a baseline assessment of APM adoption and primary care spending prior to the implementation of primary care annual improvement benchmarks (2025) and APM adoption goals (2026).
- Includes brief updates on additional work to promote high value system performance.
- Appendices identify data exclusions, data validation processes, APM and primary care methodologies, and context for Medi-Cal data.
- Complements the *Interim Report: Health Care Spending Trends in California, 2023-2024*, which reports on the rate of growth of total health care spending from 2023 to 2024.

Key Takeaways

- Statewide **APM adoption**, as measured by the percent of members attributed to capitation and full risk or shared savings and shared risk payment categories eligible for quality-linked payments, increased slightly from 70.5% in 2023 to 73.0% in 2024.
 - APM adoption increased in Medicare Advantage and Medi-Cal Managed Care markets, remained stable in Commercial HMO/POS** market, and declined in Commercial PPO/EPO** market.
- Statewide **primary care spending**, measured by spending on primary care services through claims and non-claims payments, increased slightly from 4.7% in 2023 to 4.8% in 2024 as a percent of total medical expense (TME).
 - Primary care spending growth was greatest in Medi-Cal Managed Care market,* with a slight increase in Medicare Advantage and slight decreases in Commercial HMO/POS and PPO/EPO markets.
- Statewide, although **over 85% of members** were attributed to a capitation payment arrangement, **nearly 70% of spending** was in fee-for-service in 2023 and 2024.

*Medi-Cal Managed Care covered benefits do not align with those in other markets, making cross-market comparisons unreliable (e.g. Medi-Cal Managed Care TME does not include retail pharmacy spending).

**HMO: Health Maintenance Organization; POS: Point of Service; PPO: Preferred Provider Organization; EPO: Exclusive Provider Organization

APM Adoption and Primary Care Spending Data Source

- Calendar year 2023 and 2024 data submitted by 33 payers with at least 40,000 members across Commercial, Medicare Advantage, and Medi-Cal Managed Care markets using the technical specifications outlined in OHCA's Total Health Care Expenditures Data Submission Guide (DSG) 2.0.
- **APM adoption** data includes:
 - Claims and non-claims payments, member attribution to payment arrangements with or without a link to quality, total member months of coverage, and total medical expense.
- **Primary care spending** data includes:
 - Claims and non-claims payments for primary care services, member months of coverage where a payment was made, and total medical expense.

Note: Due to rounding, numbers presented throughout this report may not add precisely to the totals provided.

APM and Primary Care Data Exclusions

- Several payers' data has been excluded from APM and/or primary care reporting due to data validation concerns which OHCA is working with these payers to resolve.*
- Other exclusions:
 - Exclusion of two payers' data from the commercial PPO/EPO market due to low member months, and
 - Exclusion of spending in the “Commercial – Other” market category because enrollment and spending in this category represented less than 1% of the commercial market.

*See Appendix for list of specific payers whose data has been excluded from reporting.

Context for Medi-Cal Data

- In collaboration with DHCS, OHCA instructed Medi-Cal Managed Care plans (MCPs) on how to report certain Medi-Cal payments in OHCA primary care and APM data submissions.*
 - These instructions were intended to support consistent and accurate reporting of Medi-Cal specific payments by identifying payment types to include or exclude from reporting.
 - The instructions aimed to exclude payments made by DHCS that MCPs do not control from MCP reporting.
- Categories of Medi-Cal specific payments addressed in the instructions include:
 - Minimum fee schedules (e.g., Adverse Childhood Experiences)
 - Pass-through payments
 - Uniform dollar or percent increases
 - Value-based payments
 - Other (e.g., Enhanced Care Management)

Note: OHCA will continue to work with DHCS to refine inclusions and exclusions of Medi-Cal specific payments for future reporting years.

*See Appendix for full list of Medi-Cal specific payments MCPs were encouraged to include or exclude from 2025 APM and primary care submissions.

APM Adoption Data, 2023-2024

OHCA APM Adoption Goals

APM Adoption Goals for Percent of Members Attributed to HCP-LAN Categories 3 and 4 by Payer Type				
	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	65%	25%	55%	55%
2028	75%	35%	60%	65%
2030	85%	45%	65%	75%
2032	90%	55%	70%	85%
2034	95%	60%	75%	95%

Performance on 2026 goal assessed on 2026 data collected in 2027, reported in 2028.

Defining APMs for Adoption Goals

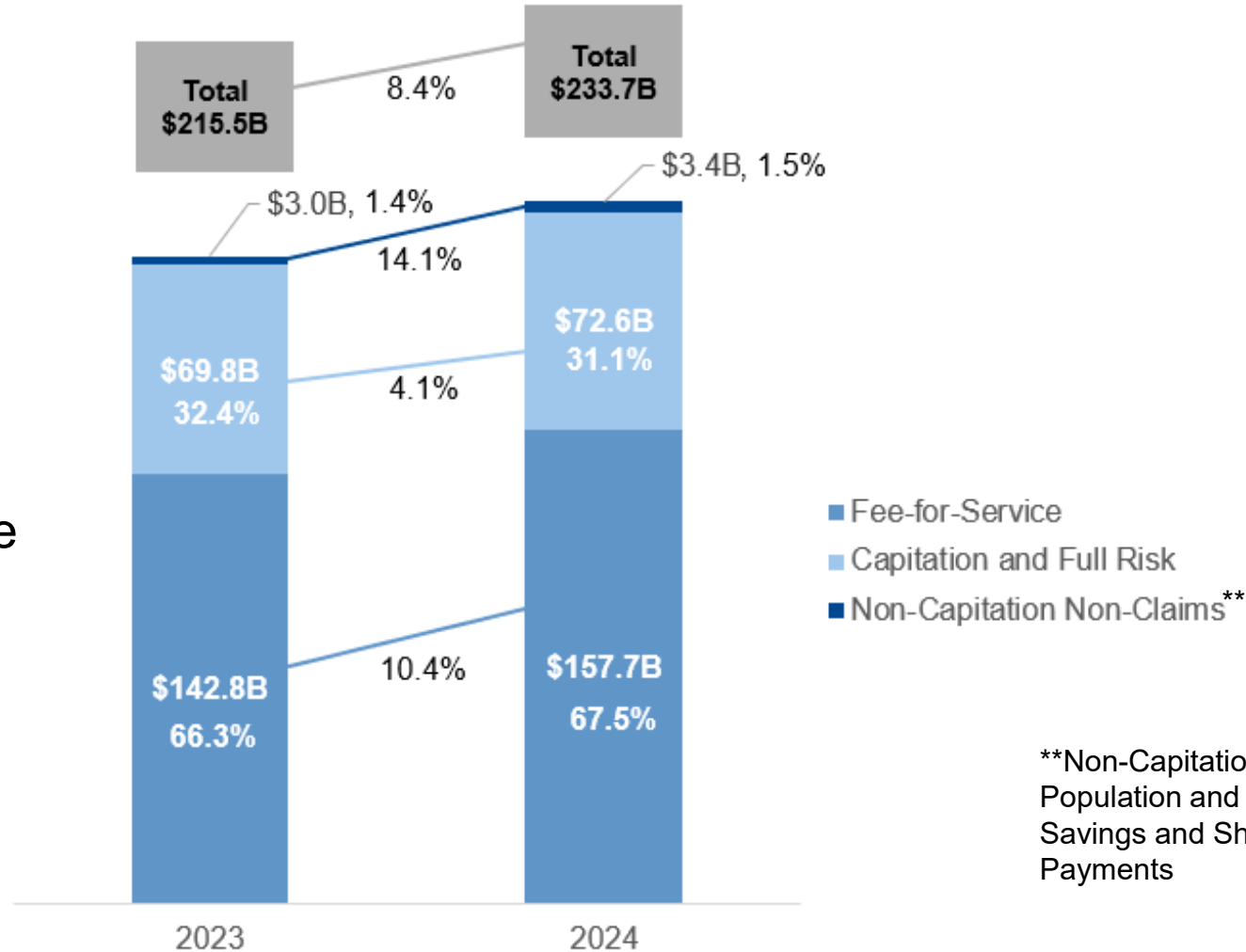
- OHCA uses the Health Care Payment Learning and Action Network (HCP-LAN) framework* to monitor progress towards the APM Adoption Goals. HCAI's Expanded Non-Claims Payments Framework, used for data collection, crosswalks to the HCP-LAN categories.
- Goals are based on the percent of members attributed to HCP-LAN Categories 3A, 3B, 4A, 4B, and 4C arrangements whose payments are linked to quality:
 - 3A: APMs with Shared Savings
 - 3B: APMs with Shared Savings and Downside Risk
 - 4A: Condition-Specific Population-Based Payment
 - 4B: Comprehensive Population-Based Payment
 - 4C: Integrated Finance and Delivery System

*See Appendix for more detail on the HCP-LAN framework.

Expanded Non-Claims Payment Framework: <https://hcai.ca.gov/affordability/ohca/expanded-non-claims-payments-framework/>

Statewide Total Medical Expense (TME) within each Payment Category by Dollars and Percent of Total*

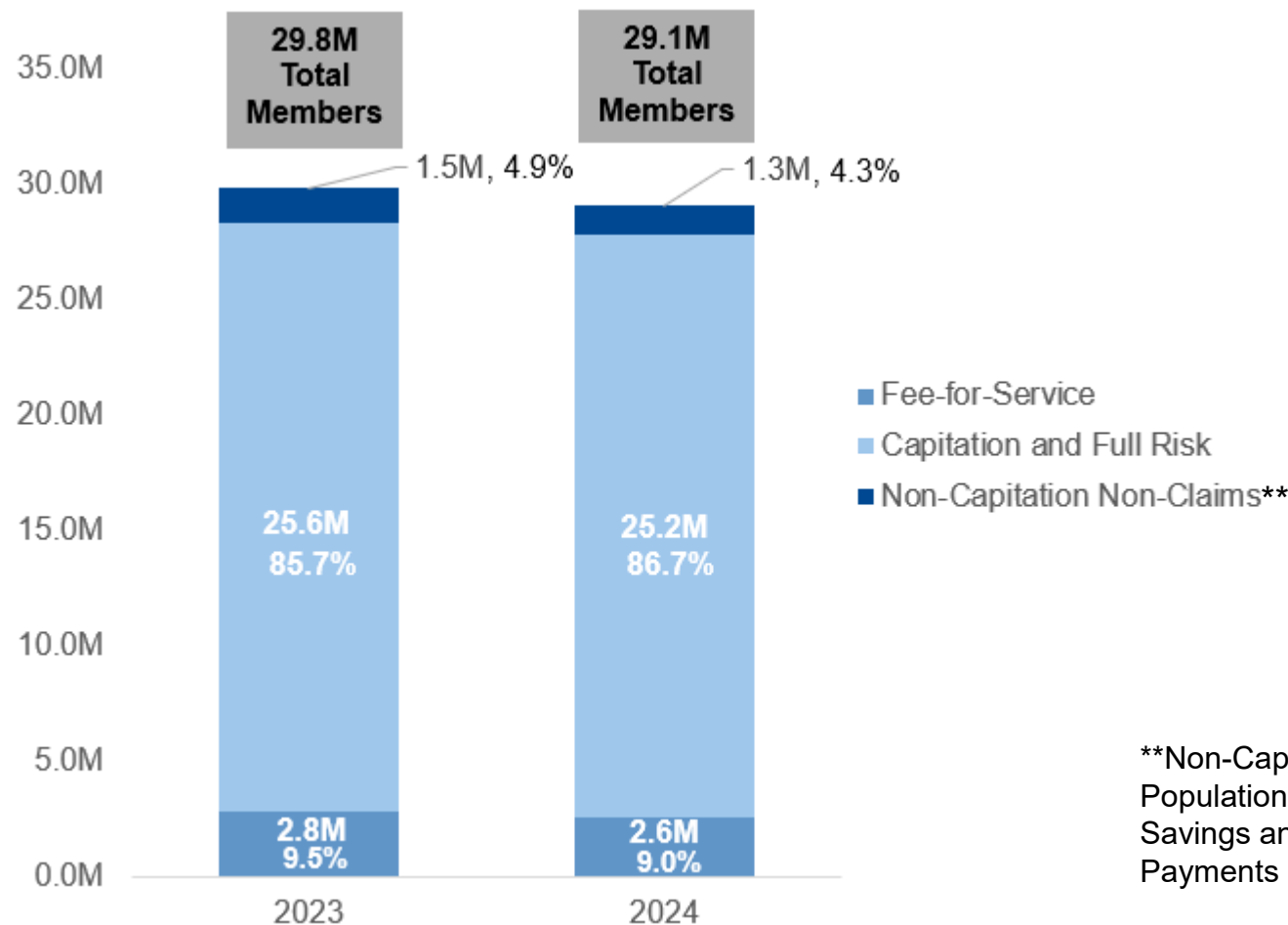
Year-over-year changes represent change in dollars spent



**Non-Capitation Non-Claims includes Performance Payments, Population and Practice Infrastructure Payments, Shared Savings and Shared Risk Payments, and Other Non-Claims Payments

*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to Appendix for more details on excluded payers.

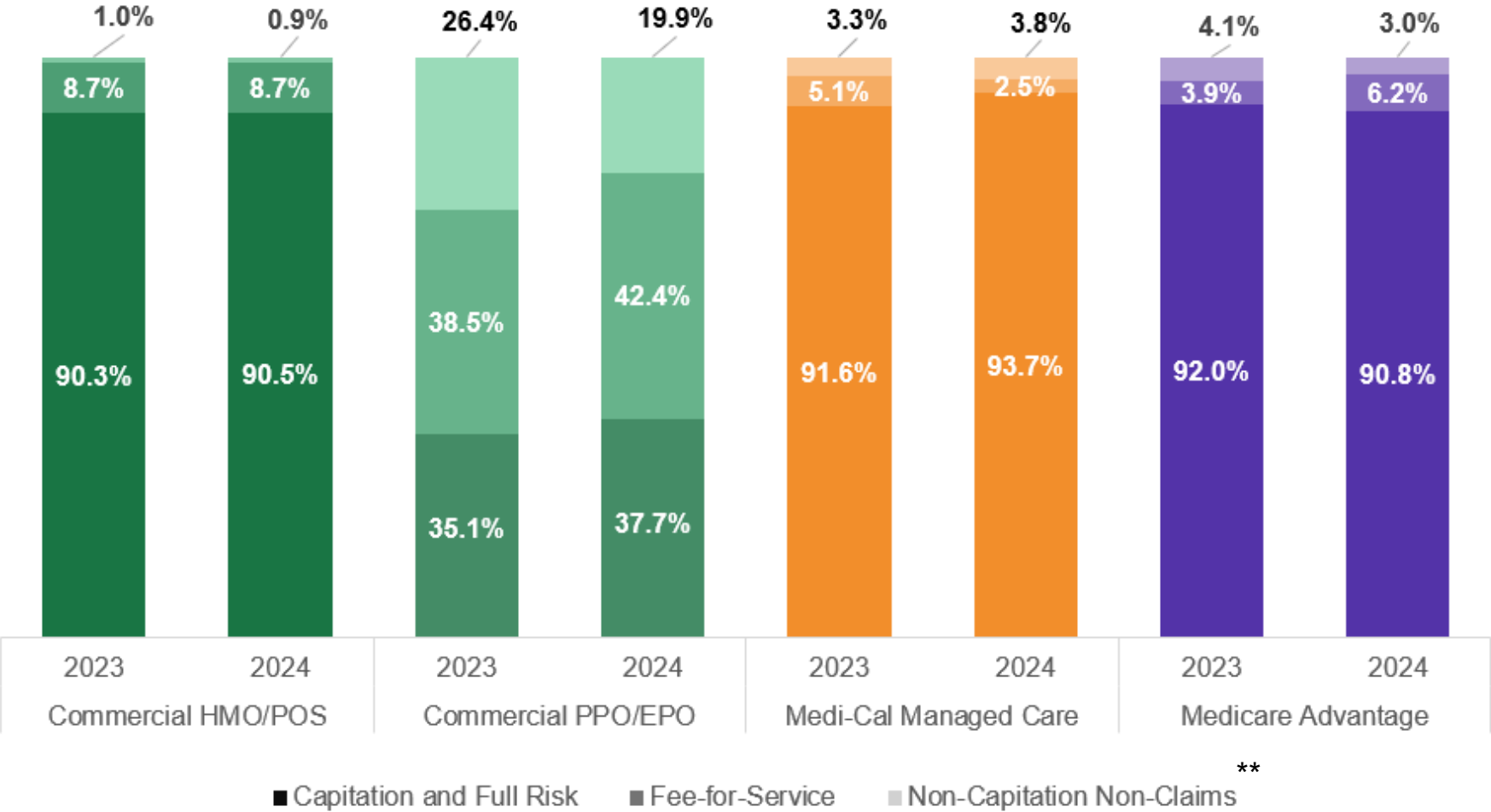
Count and Percent of Statewide Members by Attributed Payment Category*



**Non-Capitation Non-Claims includes Performance Payments, Population and Practice Infrastructure Payments, Shared Savings and Shared Risk Payments, and Other Non-Claims Payments

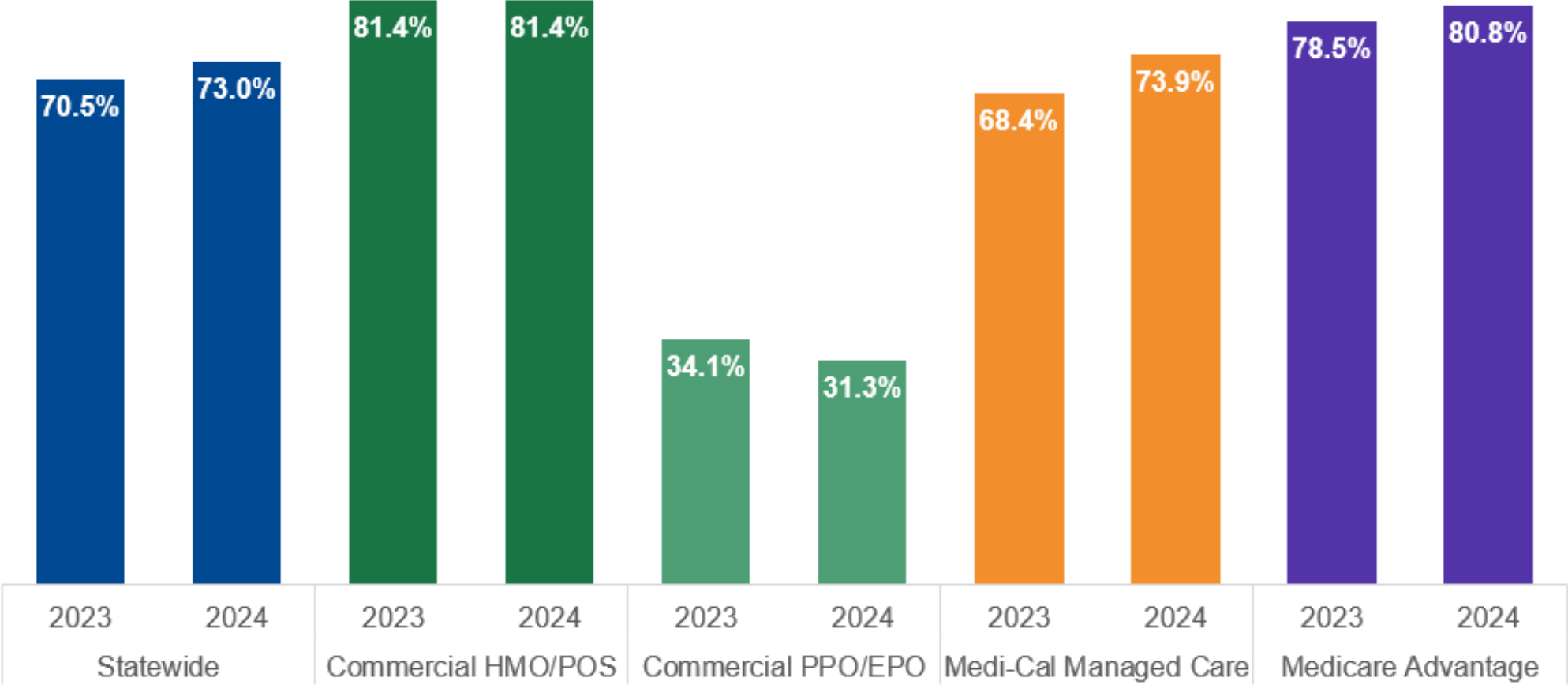
*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to Appendix for more details on excluded payers.

Percent of Members Attributed to Each Payment Category, by Market and Plan Type*



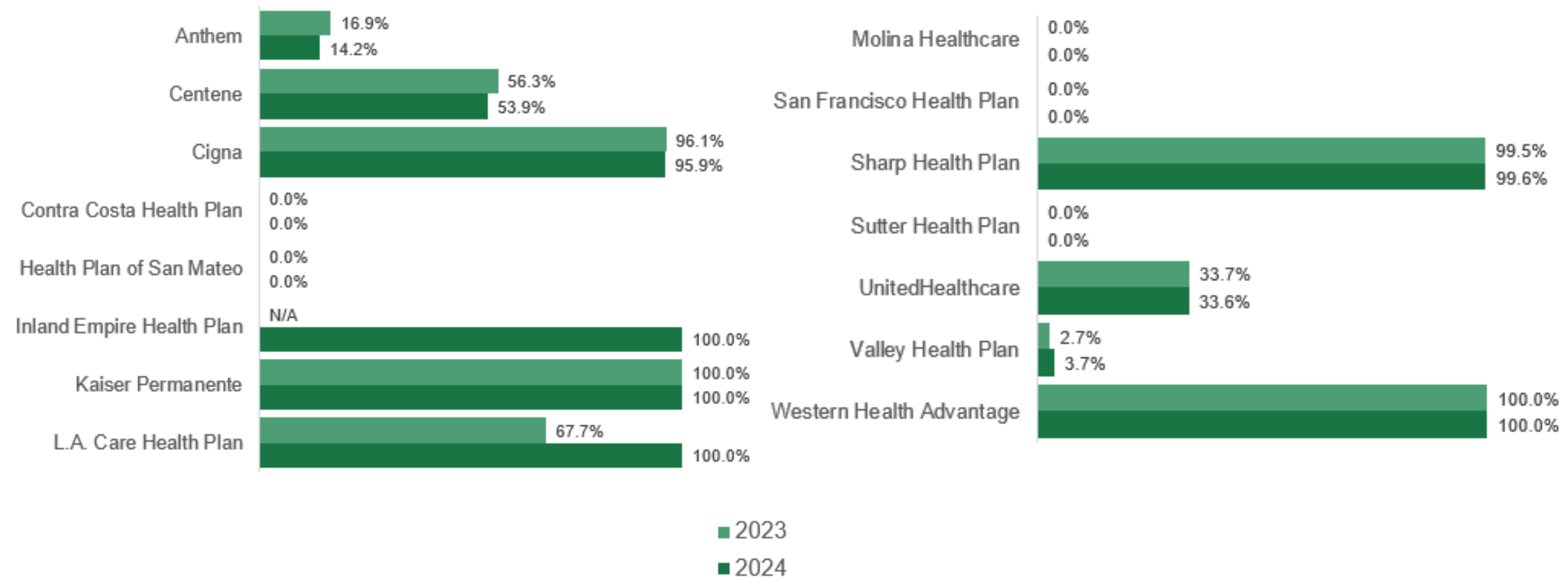
*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to Appendix for more details on excluded payers. **Non-Capitation Non-Claims includes Performance Payments, Population and Practice Infrastructure Payments, Shared Savings and Shared Risk Payments, and Other Non-Claims Payments.

Percent of Members Attributed to APMs with Quality-Linked Payments Statewide and by Market and Plan Type*



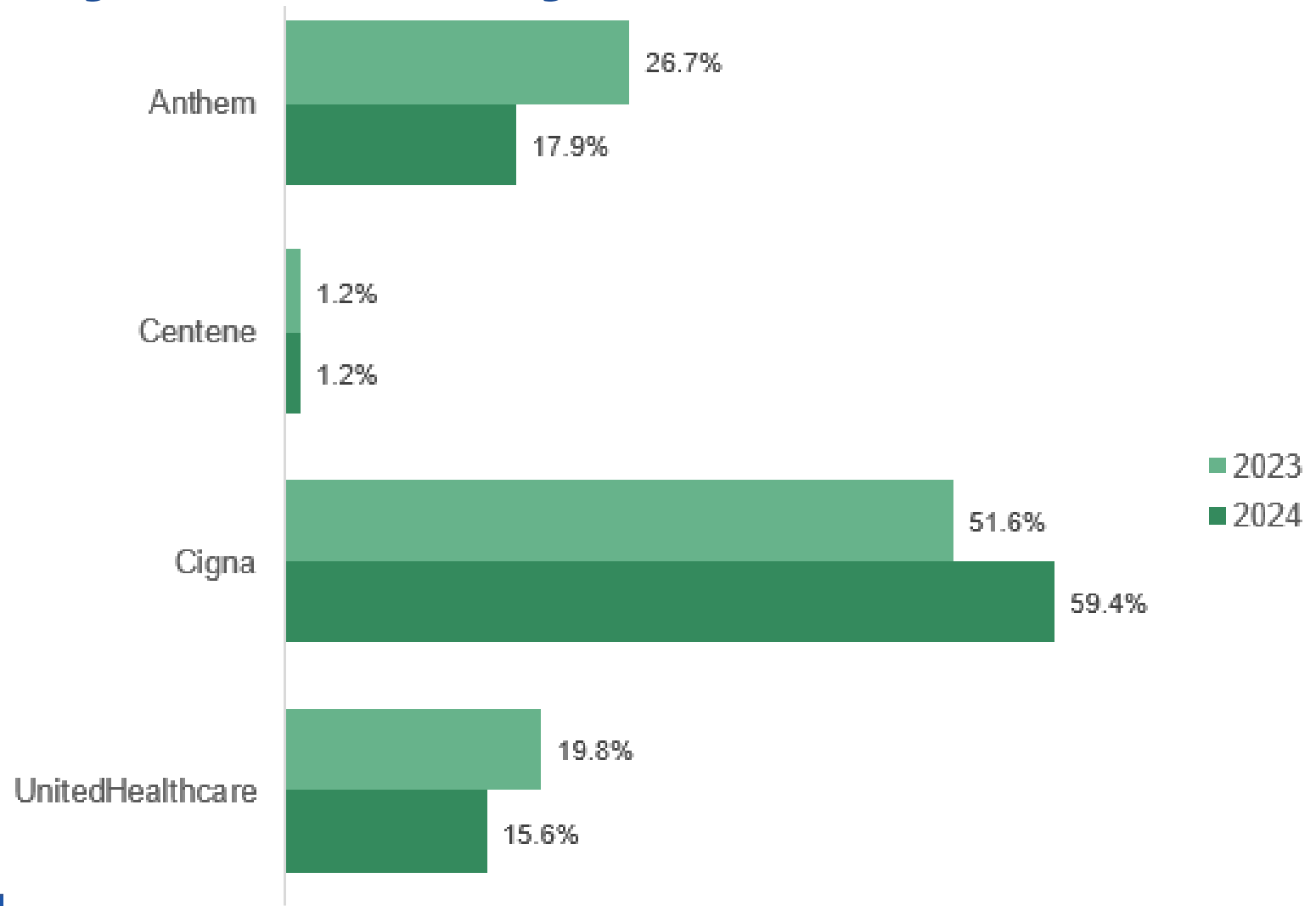
*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to Appendix for more details on excluded payers.

Commercial HMO/POS Members Attributed to APMs with Quality-Linked Payments*



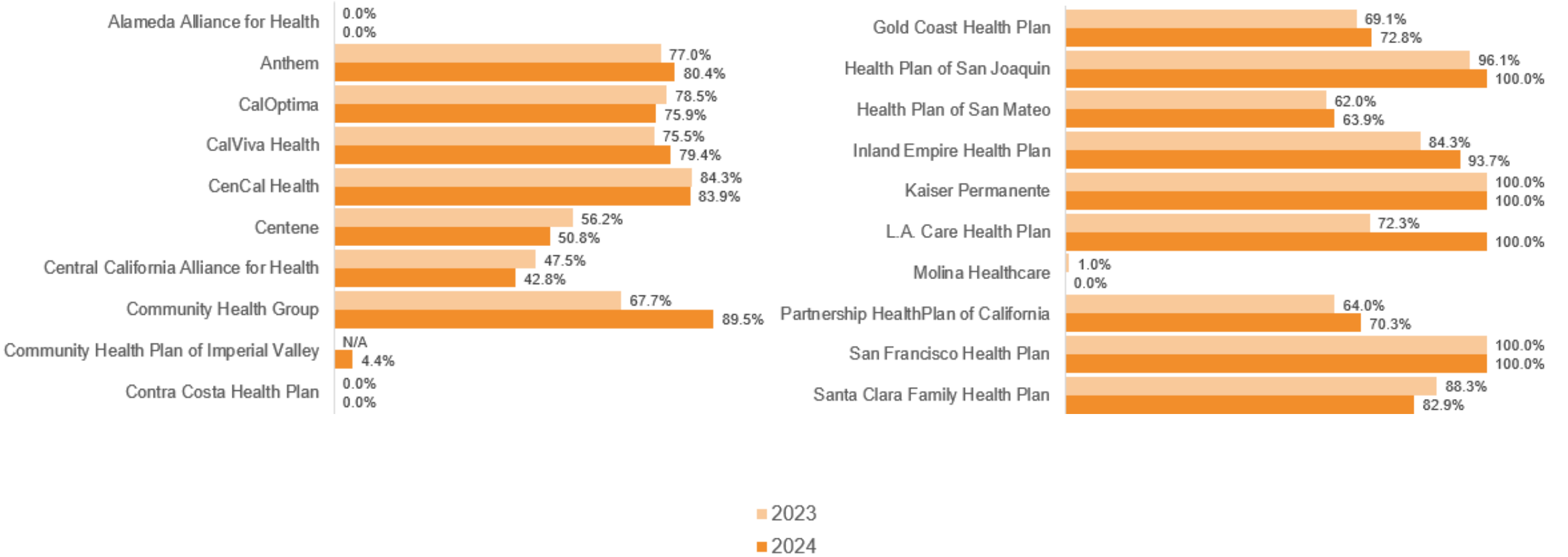
*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to the Exclusions slide for more details on excluded payers.

Commercial PPO/EPO Members Attributed to APMs with Quality-Linked Payments*



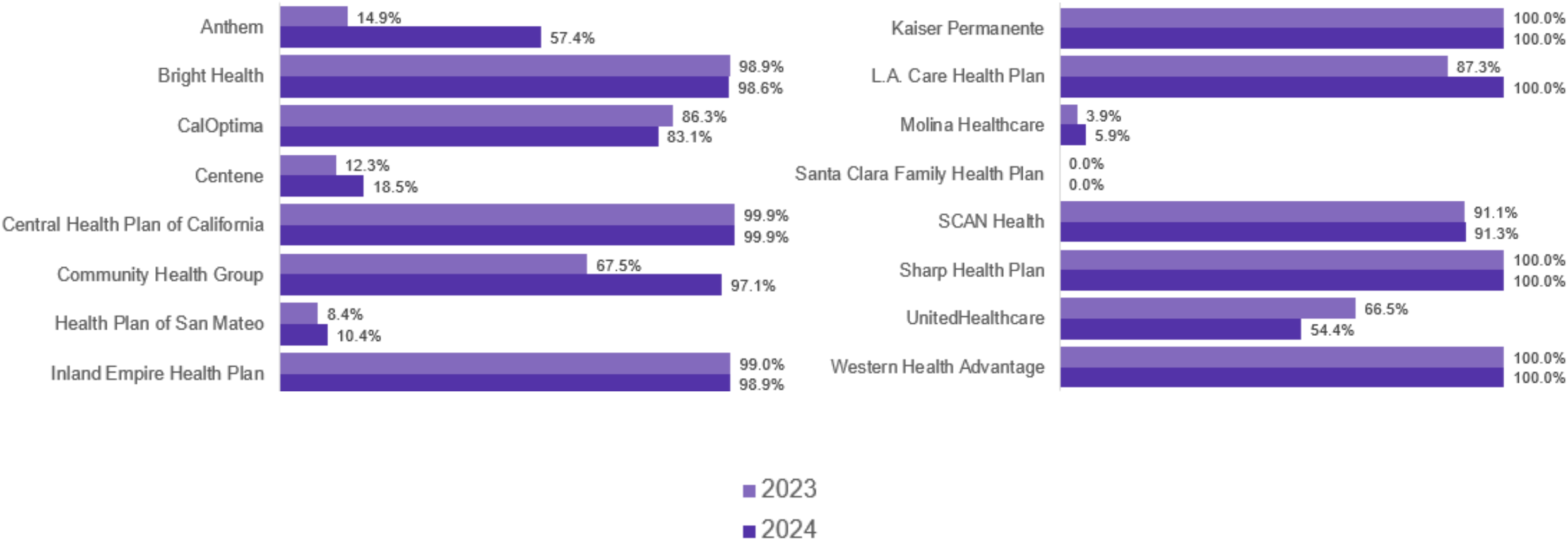
*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to the Exclusions slide for more details on excluded payers.

Medi-Cal Managed Care Members Attributed to APMs with Quality-Linked Payments*



*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to the Exclusions slide for more details on excluded payers.

Medicare Advantage Members Attributed to APMs with Quality-Linked Payments*



*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to the Exclusions slide for more details on excluded payers.

Measurement Limitations: APM

- Member attribution to payment arrangements is limited to the payment category highest on a continuum of clinical and financial risk, with capitation and full risk payment arrangements being the highest risk and fee-for-service (FFS) the lowest.
 - This data collection structure facilitates assessment against the APM adoption goals. However, it does not provide insight into how many payment arrangements a member is included in, or the proportion of their total spending in each of those arrangements.
- Differences in understanding of link to quality by payers.
 - OHCA received feedback that guidance on determining a member's link to quality was unclear in DSG 2.0, which may have resulted in understating the number of members attributed to APM arrangements that count toward OHCA APM adoption goals in this report.
 - DSG 3.0 instructions have been updated to clarify how to report a link to quality.

Primary Care Spending Data, 2023-2024

OHCA Primary Care Investment Benchmarks

Performance Years	Annual Improvement Benchmark
2025-2033	0.5 - 1% increase per year for each payer by line of business and product type
Performance Year	Investment Benchmark
2034	15% statewide across all payers, lines of business, and product types

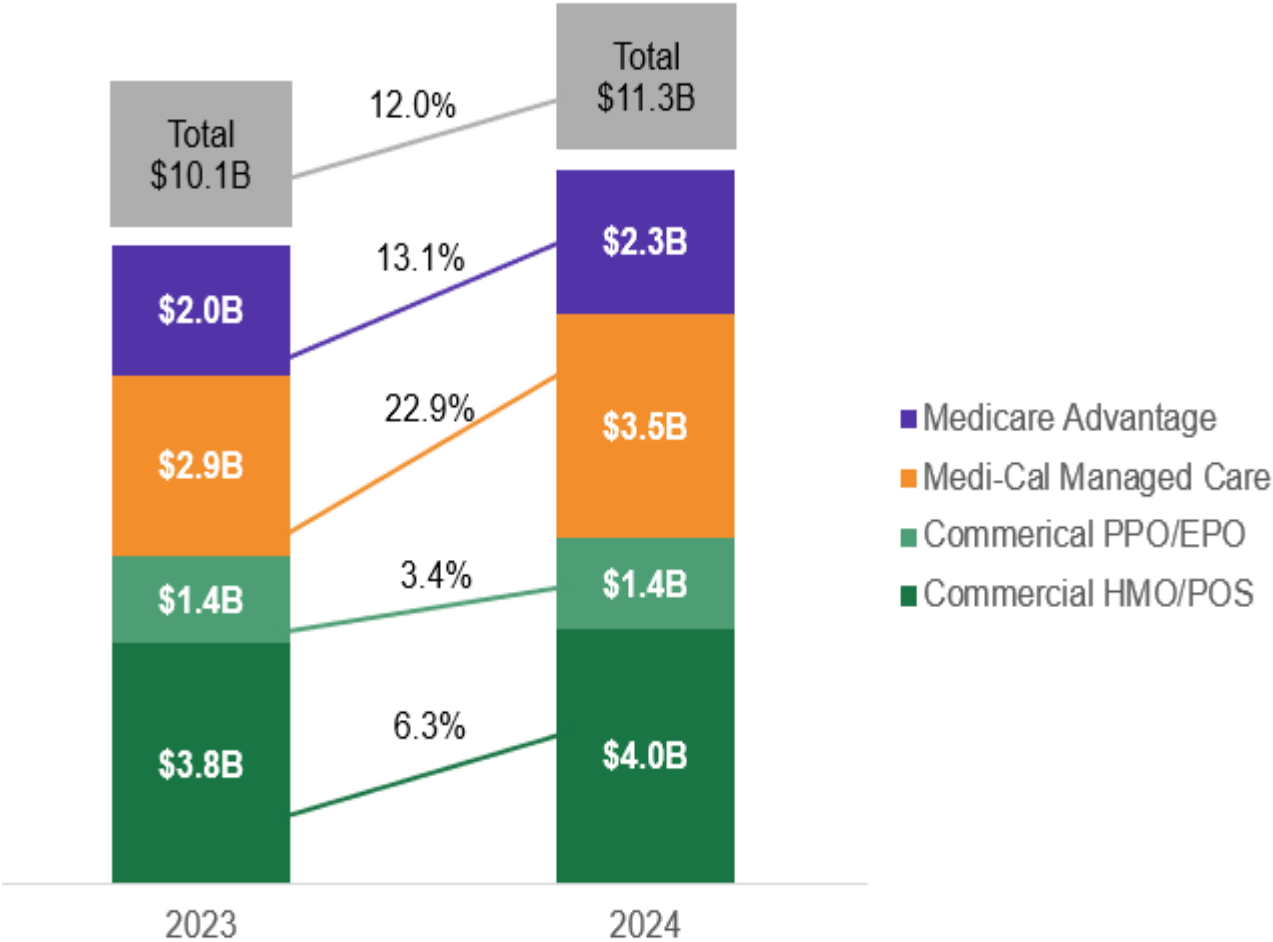
First Annual Improvement Benchmark assessed on 2025 data collected in 2026, reported in 2027.

OHCA Primary Care Spending Definition

- OHCA measures primary care spending as a percent of total medical expense and as a per-member, per-year amount.
 - Both claims and non-claims payments are included in the definition.
- OHCA defines primary care spending via claims based on a set of codes identifying primary care providers, primary care places of service, and primary care services.
- OHCA instructs submitters to use standardized methodologies to allocate portions of non-claims payments to primary care.

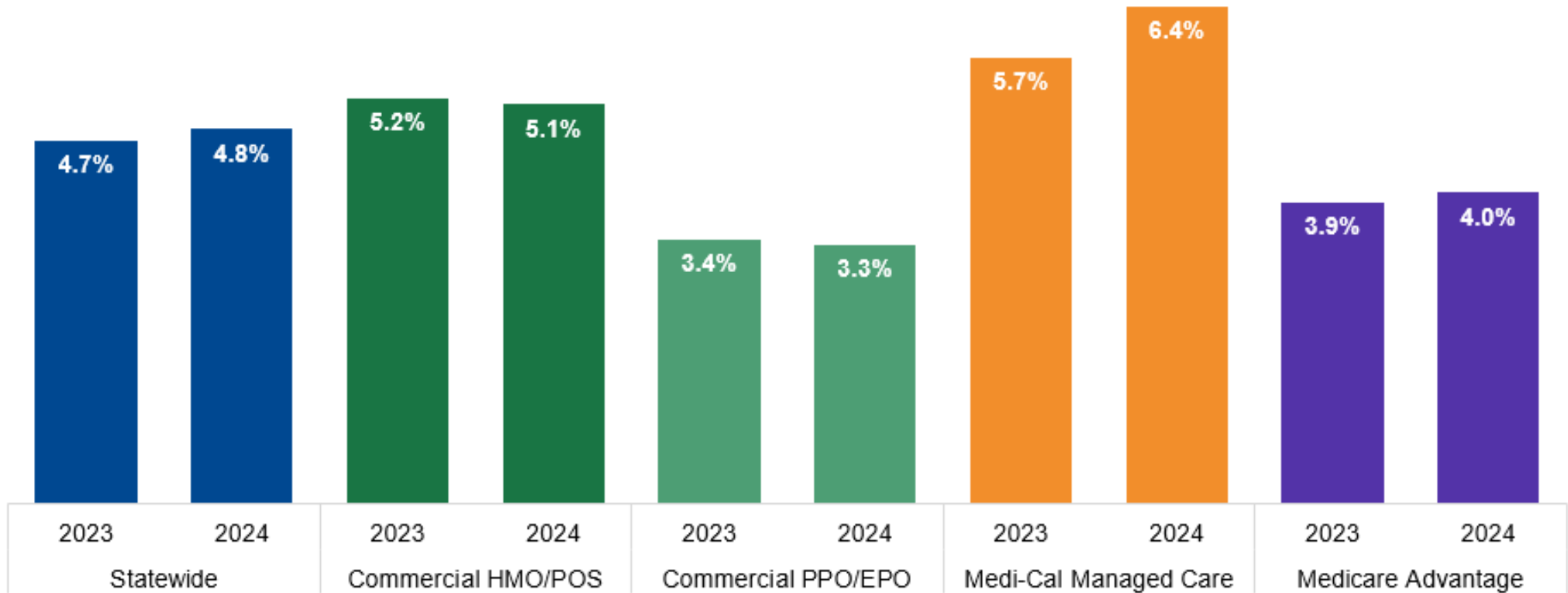
Total Primary Care Spending in Billions and Primary Care Spending Growth, Statewide and by Market and Plan Type*

Year-over-year changes represent change in dollars spent



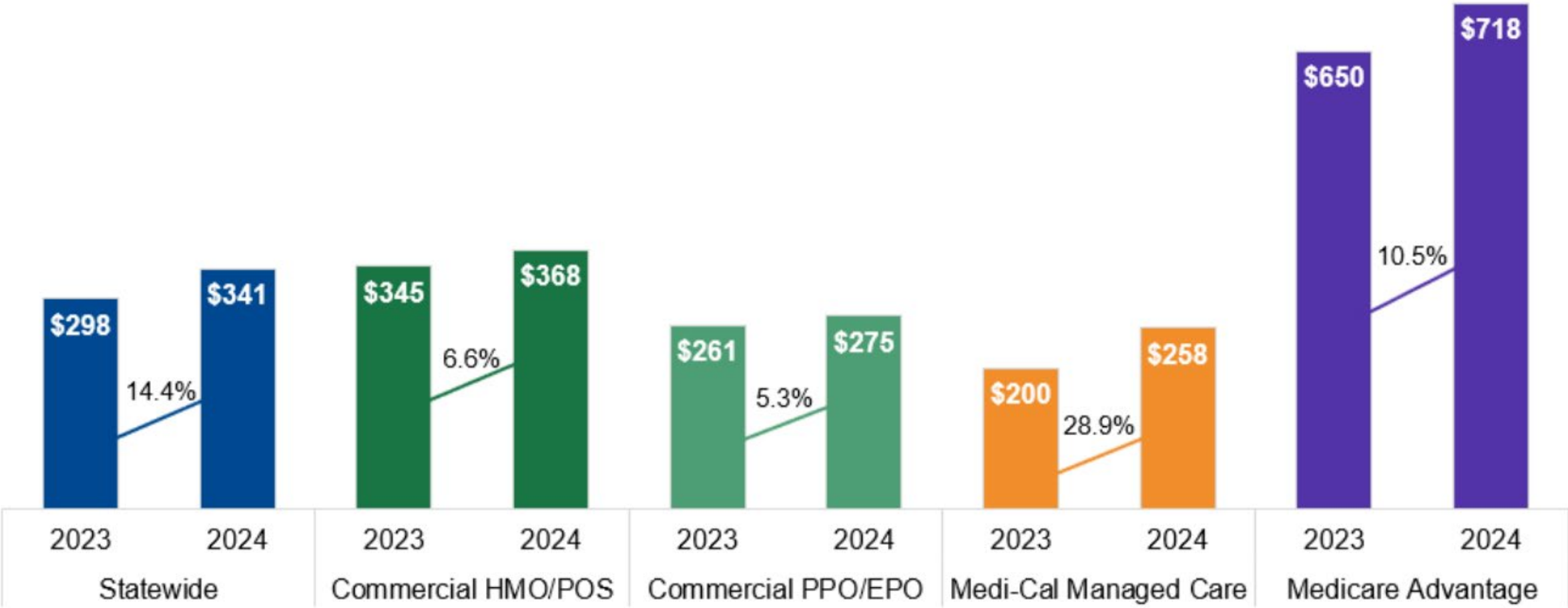
*Some payers' primary care spending data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to Appendix for more details on excluded payers.

Primary Care Spending as Percent of Total Medical Expense (TME), Statewide and by Market and Plan Type*



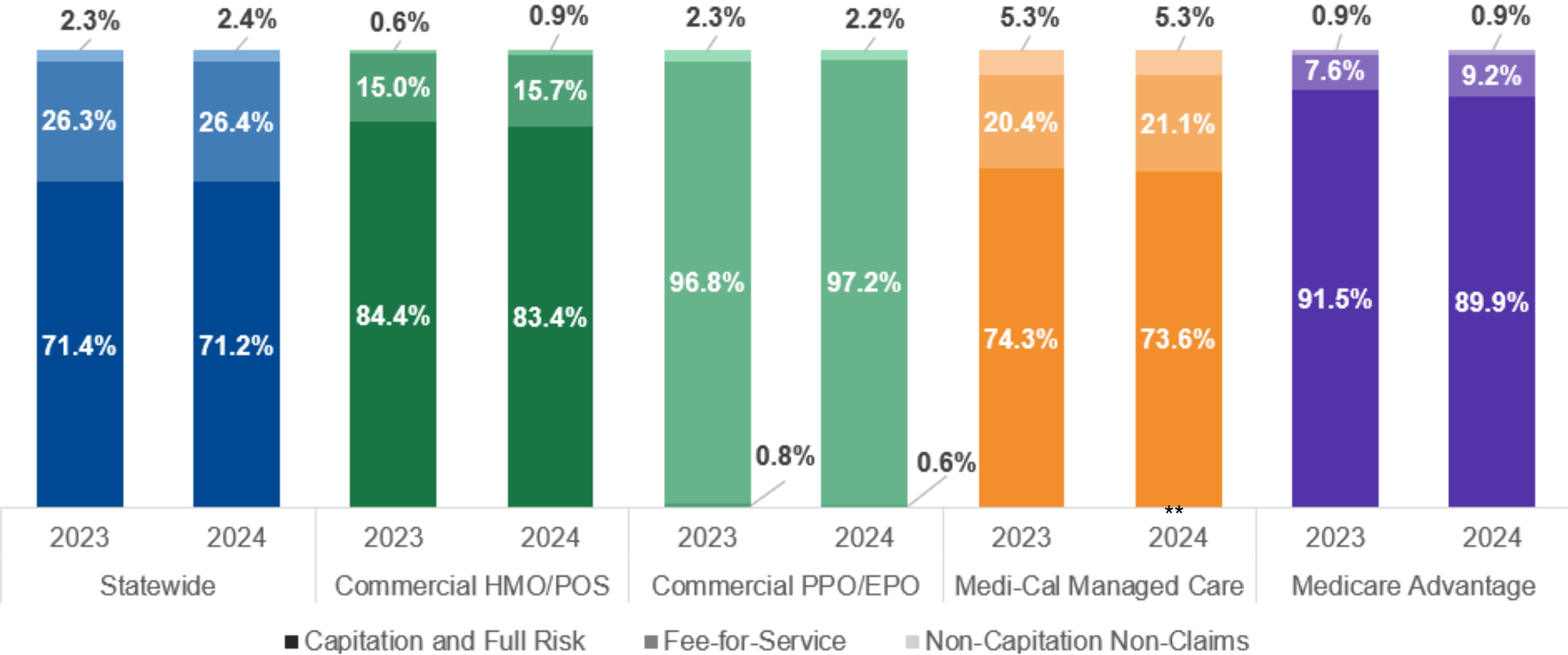
Note: Medi-Cal Managed Care covered benefits do not align with those in other markets, making cross-market comparisons unreliable (e.g., Medi-Cal Managed Care TME does not include retail pharmacy spending).

Primary Care Spending Per Member, Per Year, Statewide and by Market and Plan Type*



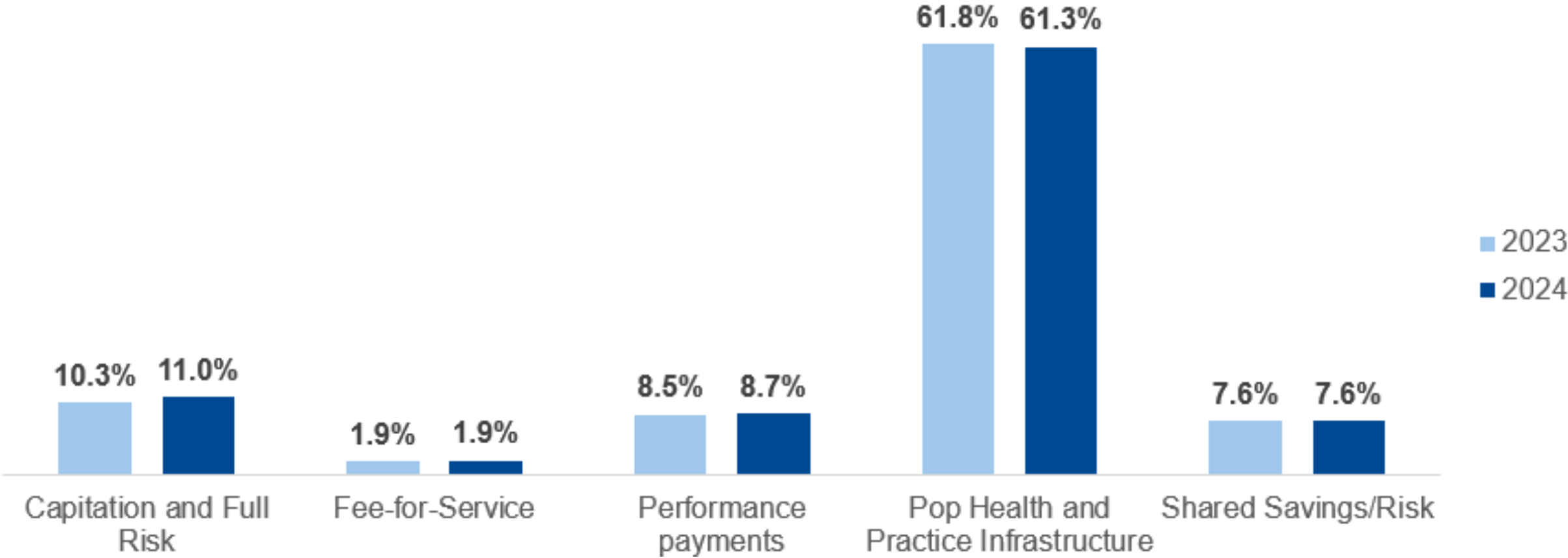
*Some payers' primary care spending data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to Appendix for more details on excluded payers.

Primary Care Spending by Payment Category, Statewide and by Market and Plan Type*



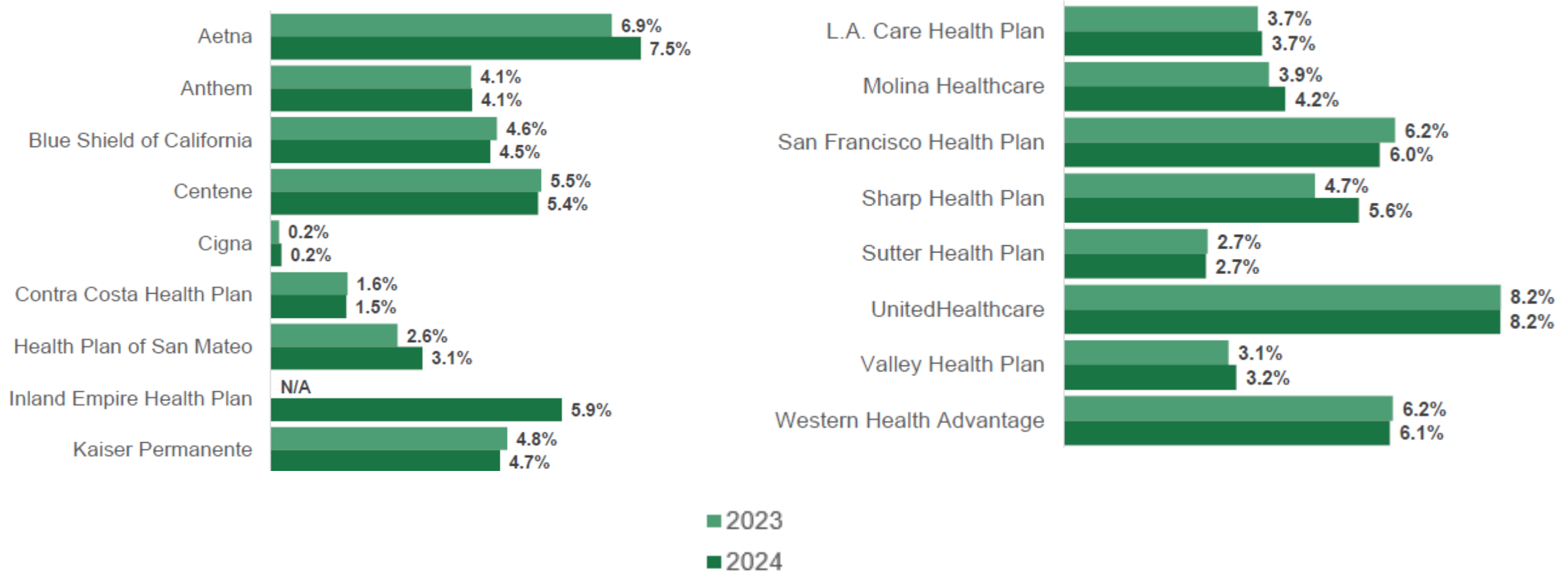
*Some payers' primary care data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to Appendix for more details on excluded payers. **Non-Capitation Non-Claims includes Performance Payments, Population and Practice Infrastructure Payments, Shared Savings and Shared Risk Payments, and Other Non-Claims Payments

Percent of Payment Category Allocated to Primary Care Statewide*

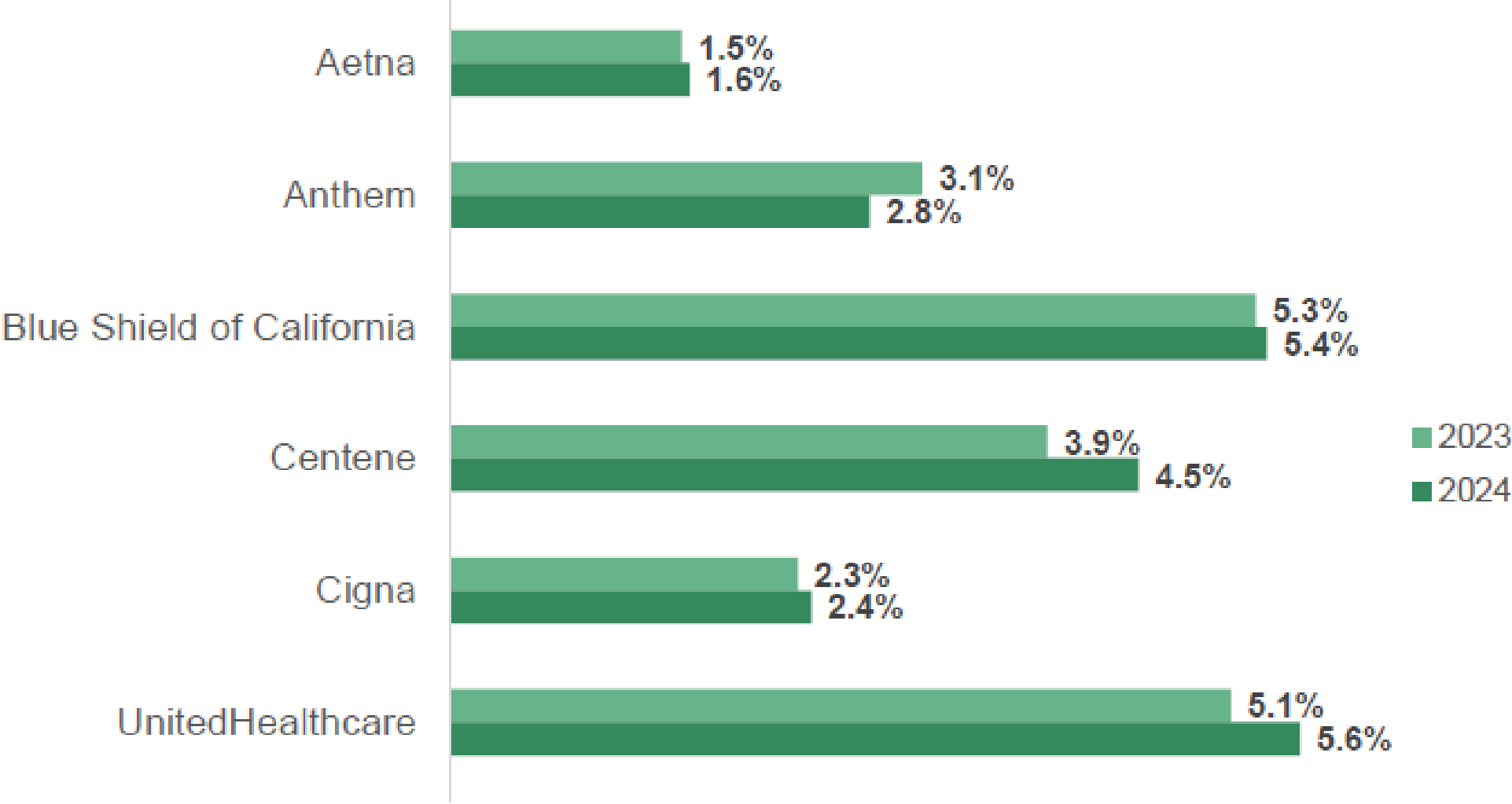


*Some payers' primary care data has been excluded due to data validation concerns which OHCA is working with them to resolve.

Commercial HMO/POS Primary Care Spending as a Percent of TME

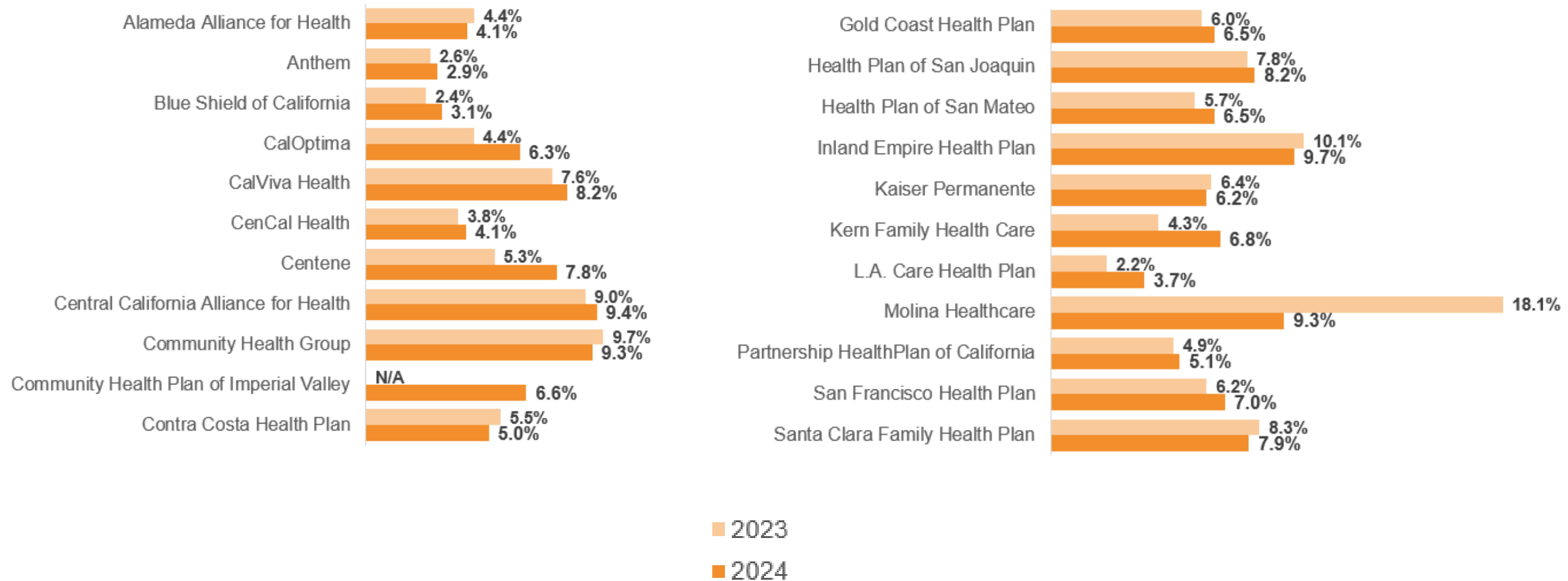


Commercial PPO/EPO Primary Care Spending as a Percent of TME*



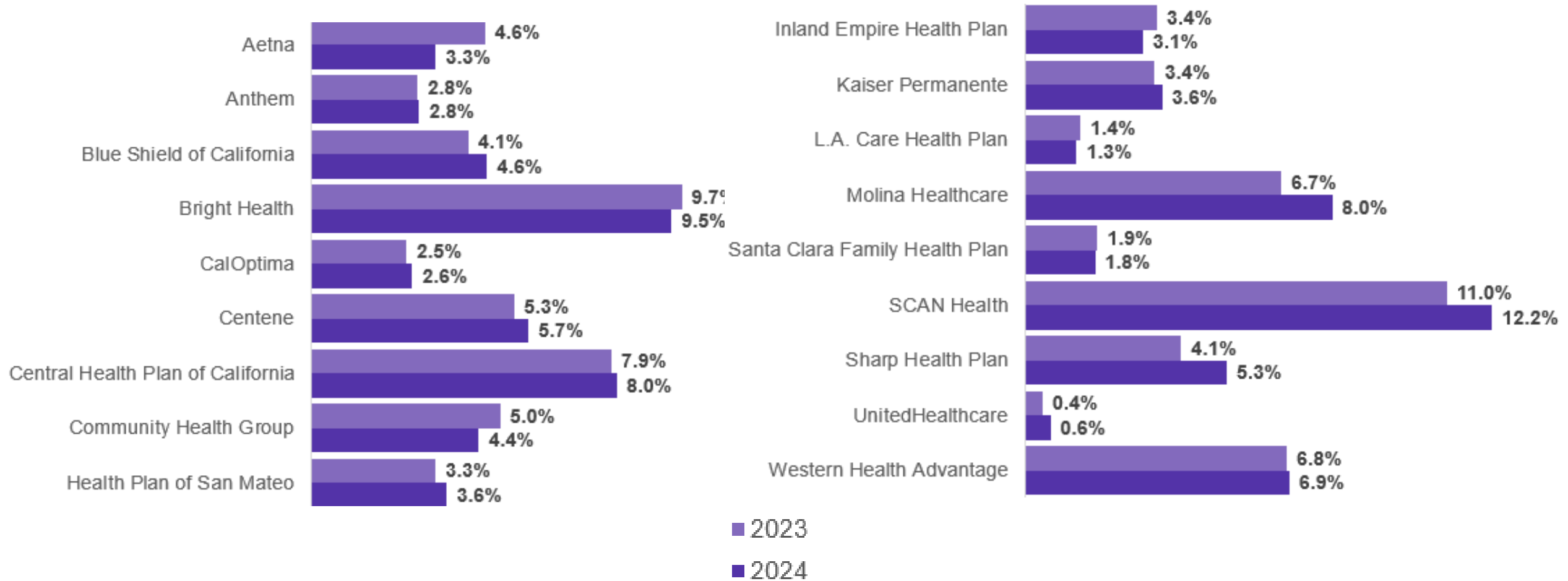
*Kaiser and Sharp Health Plan’s data has been excluded due to low member months in this market.

Medi-Cal Managed Care Primary Care Spending as a Percent of TME*



*Molina Healthcare reported an increase and change in membership population served, along with provider network composition changes which impacted the primary care spending as a percent of TME in the Medi-Cal Managed Care market between 2023 and 2024.

Medicare Advantage Primary Care Spending as a Percent of TME*



*Some payers' primary care data has been excluded due to data validation concerns which OHCA is working with them to resolve. Refer to the Exclusions slide for more details on excluded payers.

Measurement Limitations: Primary Care

- Non-claims primary care spending is estimated and may not fully capture actual resource allocation to primary care, particularly for capitation and full risk payments where encounter data are used as a proxy to determine the share of capitation attributable to primary care.
- Measurement of fee-for-service (FFS) spending on primary care relies on a structured definition of primary care.
 - While universal agreement on a primary care definition is elusive, OHCA continues to respond to stakeholder requests by adding providers, places of service, and service codes to the definition that align with its vision for primary care.
 - OHCA definition's reliance on a point-in-time network filing of credentialed primary care providers submitted to regulators may under-count services delivered by primary care providers who left the network prior to the time of filing.
- Measurement of FFS spending on primary care relies on claims completeness, such as rendering provider taxonomy field used to identify primary care providers.
- Downstream distribution of payments to frontline primary care providers is not visible.



Discussion: Report on Promoting High Value Health Care in California, 2023-2024

Does the Advisory Committee have any questions about the APM adoption and primary care spending data presented in the *Report on Promoting High Value Health Care in California, 2023-2024*?



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

Public Comment





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

Payer Strategies for Primary Care Investment in California

Margareta Brandt, Assistant Deputy Director
Jill Yegian, Ph.D., Yegian Health Insights





Payer Strategies for Primary Care Investment in California

Health Care Affordability Advisory
Committee

October 14, 2026

Jill Yegian, Ph.D., Yegian Health Insights

Increasing Momentum on Primary Care Investment

In 2022, the California Health Care Foundation released initial work on [commercial and Medi-Cal share of spending](#) on primary care in California.

In November 2025, CHCF sponsored a [statewide convening](#) on primary care investment implementation, bringing together 60+ leaders from health plans, provider organizations, purchasers, and national experts.

In 2024, the first [statewide primary care benchmark](#) was established by the Health Care Affordability Board based on the Office of Health Care Affordability's recommendation.

A set of 12 payer strategies was developed for consideration at the convening, and an [issue brief](#) highlights the key strategies and takeaways.

Primary Care Investment Strategy Sets

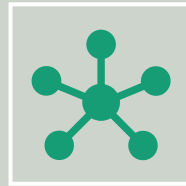
Cross-Cutting Features

- Net increase in resources to primary care practices
- Resources flow all the way to the frontline clinicians
- All types of practices able to participate
- Supports team-based care

Six of the 12 payer strategies were prioritized at the convening, noted with a star.



1: Contracting: Using contracts and payment models to drive primary care transformation



2: Networks: Cultivating networks that deliver advanced primary care



3: Practice Capabilities:
Collaborative investment in practice capabilities and infrastructure

Strategy Set 1: Contracting

Using contracts and payment models to drive primary care transformation

1.1 Enhance payment to primary care providers.

1.2 Implement payment models that support advanced primary care.

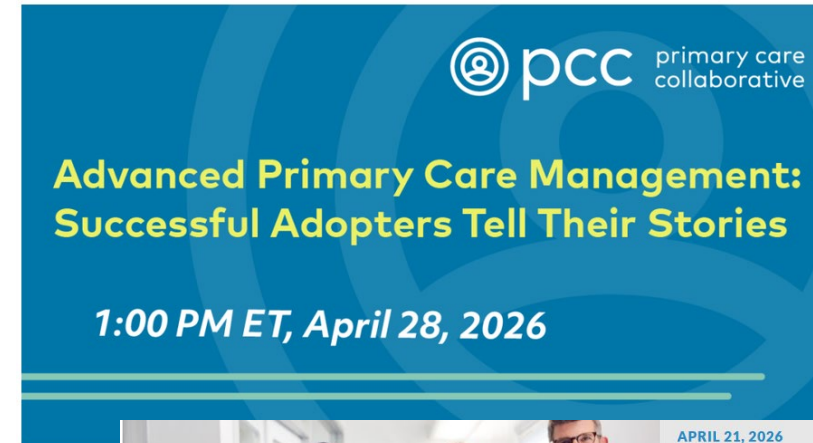
1.3 Make performance incentives sizable and timely.

1.4 Enable behavioral health integration.

1.1 Enhance payment to primary care providers.



- **Adopt CMS Advanced Primary Care Management Service codes** and pay at appropriate rates in all contracts.
- **Increase payment rates** for primary care services to ensure adequacy and review/update periodically



Resources

- Primary Care Collaborative webinar, [Advanced Primary Care Management: Successful Adopters Tell Their Stories](#), April 2026
- Miriam Sheinbein et al, [Revitalizing Primary Care: Health Plan of San Mateo's Investment Strategy](#). Milbank Memorial Fund, April 2026.

1.2 Implement payment models that support advanced primary care.

- Adopt a **hybrid or tiered payment model** that supports participation by all types of practices.
- Offer a **continuum of payment models** to enable broad participation by matching payment arrangement to readiness.
- Incorporate upfront lump-sum **payments to support practice transformation.**



Comprehensive Primary Care Plus (CPC+) Track 1 is a pathway for practices ready to **build the capabilities** to deliver comprehensive primary care.

CPC+ Track 2 is a pathway for practices poised to **increase the comprehensiveness** of primary care.

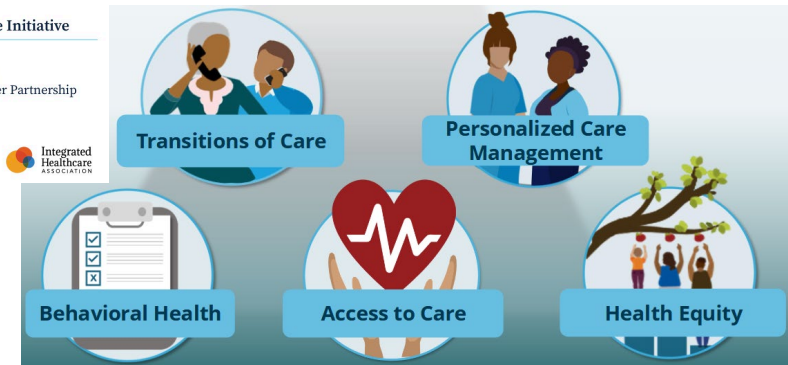
Primary Care First rewards **outcomes**, increases **transparency**, enhances care for **high need populations**, and reduces **administrative burden**.

California Advanced Primary Care Initiative

Memorandum of Understanding Among
California Payers in Support of Multi-payer Partnership

California Quality Collaborative

Integrated Healthcare Association



Resources:

- [California Advanced Primary Care Initiative \(CAPCI\)](#)
- [CMS Primary Care First model](#)

1.3 Make performance incentives sizable and timely.



- Incentives that provide a **meaningful share of revenue** garner attention from providers.
- **Pay providers on a quarterly basis** (or even monthly) to strengthen the connection between incentive payments and performance.
- **Offer a shared savings program** (generally for PPO and ACO) that rewards advanced primary care.



Primary Care Provider
Quality Incentive Program (PCP QIP)
Detailed Specifications
Published: March 2, 2026

2026

MEASUREMENT YEAR

Adult incentive measures

Defined as an individual member who is eighteen (18) years of age or older.

Type	Name	Min denominator	Max PMPM per attributed member
Resource utilization	Emergency room (ER) visits per 1,000 members	30 members	\$1.30
	Inpatient admits (IA) per 1,000 members	150 members	\$1.30
Clinical quality	Glycemic status assessment for patients with diabetes: Glycemic status >9.0%	1 member	\$0.8125
	Blood pressure control for patients with hypertension	1 member	\$0.8125
	Depression screening and follow-up (ages 18-64)	1 member	\$0.8125
	Colorectal cancer screening	1 member	\$0.8125
Patient experience	Patient experience survey	1 member	\$0.65
Maximum incentive per attributed member			\$6.50



Resources:

- Partnership HealthPlan of California (PHC) has a robust [performance incentive program](#)
- Blue Shield of California [Primary care pay-for-value hybrid payment model manual](#)

1.4 Enable behavioral health integration.

- Support provider adoption of **Collaborative Care Model or the Primary Care Behavioral Health** model.
- **Adopt Collaborative Care billing and other BHI codes**
- **Implement tools** such as BHI FAQs for internal use and network providers
- **Align/streamline processes** such as credentialing

Behavioral Health Integration into Primary Care

Provider Implementation Guide

Quick Links:

1. [What is behavioral health integration into primary care?](#)
2. [How does BHI enhance primary care?](#)
3. [Is BHI right for my practice?](#)
4. [What BHI services are reimbursed by \[PLAN NAME\]?](#)
5. [Where can I go if I have questions for \[PLAN NAME\] around BHI?](#)
6. [How can I get started to implement BHI?](#)
7. [BHI Primary Care Resources](#)
8. [Worksheet: BHI Financial Modeling](#)

1. What is behavioral health integration (BHI) into primary care?



of primary care and behavioral
es, using a systematic and
or a defined population.
e conditions, health behaviors
stressors and crises and
[Research and Quality](#)).
en improved when behavioral
eam ([American Psychological](#)



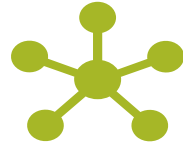
Advancing Behavioral Health Integration

Collaborative Strategies for Sustainable Change

Resources:

- California Quality Collaborative [Behavioral Health Integration Payer Workgroup](#)
- Blue Shield of California [Advancing Behavioral Health Integration](#)

Strategy Set 2: Networks



Cultivating
networks that
deliver advanced
primary care

2.1 Review vendor strategy and selection to ensure primary care linkage and maximize continuity.

2.2 Use utilization management as a learning tool.

2.3 Provide primary care practices with e-Consult.

2.4 Revise credentialing requirements.

2.1 Review vendor strategy and selection to ensure primary care linkage and maximize continuity.

- Telehealth and retail clinic **vendors should support** (not replace) PC providers.
- Consider contract clauses for telehealth vendors that **require coordination**
- **Require vendor data/encounters** flow into the PCP's records / EHR

CHECKLIST FOR PLANS IMPLEMENTING TELEHEALTH SERVICES

This checklist applies to Plans that wish to implement telehealth as part of their delivery of health care services in the commercial and/or Medi-Cal markets. Telehealth services may be delivered via web-based, smartphone or computer based applications and via telephone. The following are examples of telehealth modalities that a health plan may choose to use in the delivery of health care services¹:

- A **synchronous live visit** in which the provider delivers complete medical services via live, two-way video or audio between the enrollee and a remote provider;
- **Remote Patient Monitoring** in which the provider delivers services to an enrollee via remote monitoring of a enrollee with video and peripheral devices;
- An **asynchronous store and forward** consultation in which the provider delivers services to an enrollee via transmission of history and images between the enrollee and the provider for diagnosis and treatment; or,
- An **e-Consult** in which a consultation services an asynchronous communi

The Department of Managed Health Care (DMHC) has reviewed the telehealth in care delivery, and services are consistent with the amended.² The Department created telehealth services are integrated all-inclusive. The Department is under its review to make a finding un

Exhibit I-5: Standards of Accessibility

- ☐ Describe the full extent of telehealth services available to enrollees.
- ☐ Provide all policies and procedures that describe how the telehealth is accessed both by enrollees and providers.
- ☐ Include any access policies and procedures related to the telehealth program.
- ☐ Describe under what circumstances telehealth is used as a substitute for an in-person visit with a provider.
- ☐ Describe the Plan's appointment timeframes for accessing telehealth services.
- ☐ If the Plan is utilizing telehealth services to meet the timely access standards for an initial appointment, please describe how the Plan believes the use of telehealth meets the timely access standards for initial appointments. This information should also be filed in Exhibit J-13.

Resources:

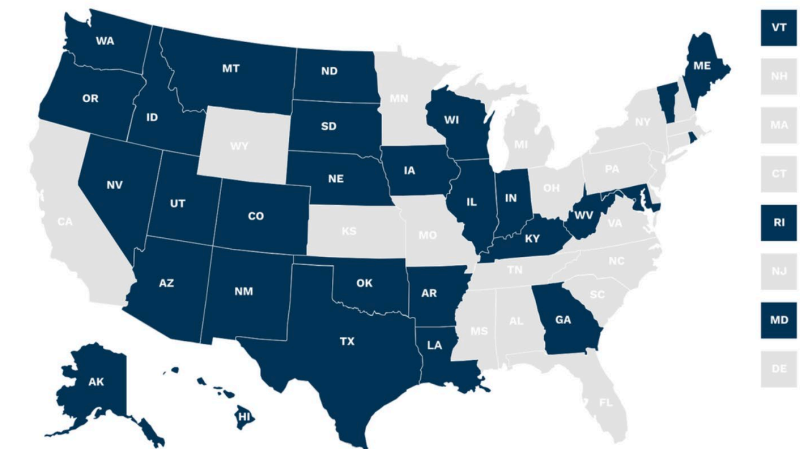
- Tillamook County (Oregon) community health center [Telehealth Services Agreement](#) includes telepsychiatry
- DMHC provides a [Managed Care Plan Contracting and Implementation Checklist](#)

2.2 Use utilization management (UM) as a learning tool.

- **Use UM** to improve specialty referrals, reduce denials and prior authorization requirements, and recognize high-performing practices
- **Pilot scorecards** that show PCPs their specialty referral patterns.
- Review PC services for frequent denials and **unnecessary prior authorization** requirements and revise payment policy.
- **Recognize practices** that deliver accessible, continuous, comprehensive, coordinated, accountable primary care.



Enacted Legislation Amending **Prior Authorization** in 2025



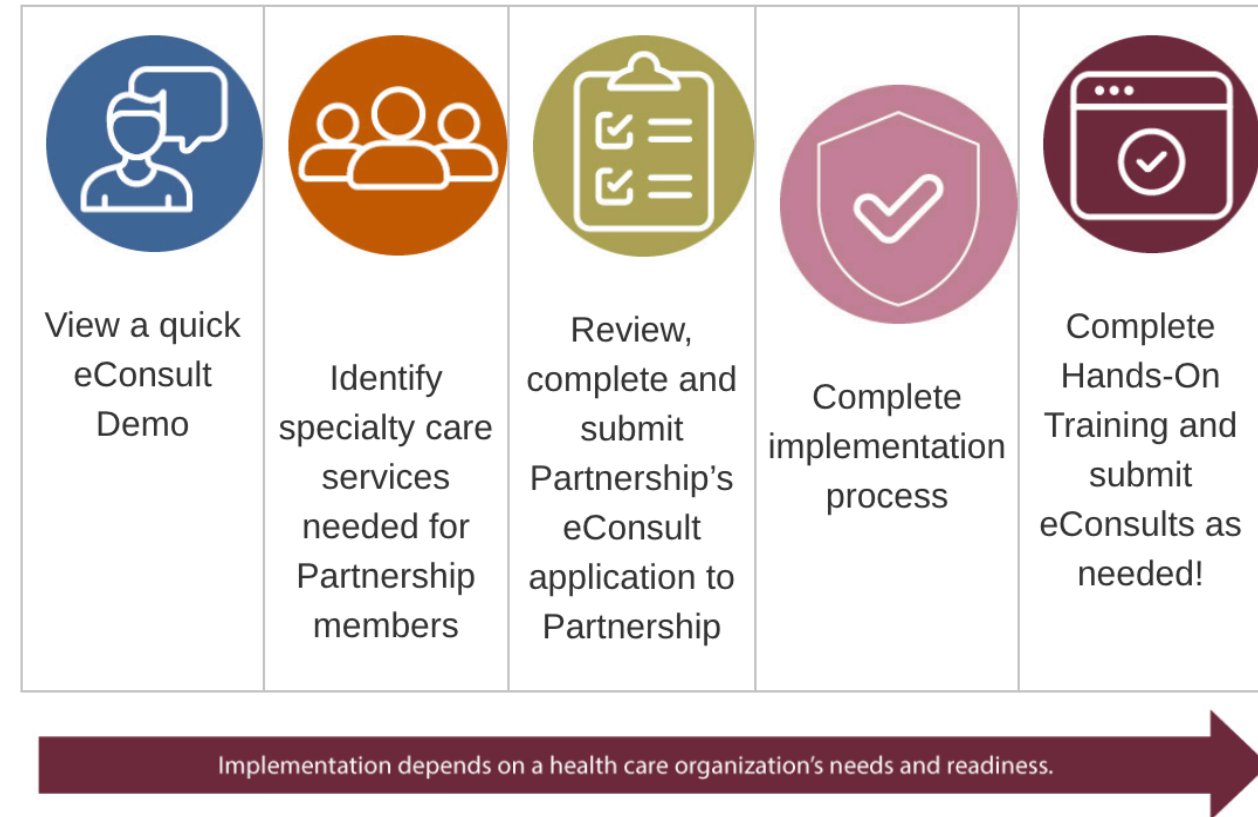
Resources:

- CHCF's [Reforming Prior Authorization in California](#)
- PBGH's [Care Excellence Program](#), adopted by Blue Shield of California

2.3 Provide primary care practices with access to specialty e-Consults.



- **Virtual clinician-to-clinician consultation** enables PCPs to manage more complex patients.
- eConsult can **reduce patient wait times** and improve continuity of care.



Resources:

- Partnership Health Plan [provides eConsult](#) services from external vendor ConferMED

2.4 Revise credentialing requirements.

- Ensure that network hospitals **allow family physicians privileges** if they meet training/procedure volume requirements.
- Ensure that the credentialing criteria **do not unintentionally exclude family physicians** from performing services they are trained for (e.g. colonoscopy, prenatal care).

10. MEDICAL CARE STANDARDS

A. Initial Preventive Physical Exam

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. Primary Care Providers (PCPs) are expected to schedule and provide an Initial Preventive Physical Exam (IPPE) for all IEHP DualChoice Members within 12 months of the Member's enrollment.^{1,2}

PROCEDURES:

A. An IPPE consists of the following components:³

1. Review of comprehensive medical and social history;
2. Review of risk factors for depression and other behavioral health conditions;
 - a. Use of validated, evidence-based screening instrument recognized by national professional medical organizations. Examples include the PHQ-9 for depression screening and the GAD-7 for anxiety disorder screening.
3. Review of functional ability and level of safety;
 - a. Use of validated, evidence-based screening instrument recognized by national professional medical organizations to assess for hearing impairment, activities of daily living, fall risk and home safety. Examples include an audiogram for hearing impairment, the "Timed Up and Go Test" for assessment of fall risk, the Katz ADL Index, the Lawton-Brody I-ADL Scale, and the Westmead Home Safety Assessment.
4. Examination - Obtain the following:
 - a. Height, weight, body mass index, and blood pressure;
 - b. Visual acuity screen; and
 - c. Other factors deemed appropriate based on the Member's medical and social history and current clinical standards.
5. End of life planning (upon agreement with the Member);
 - a. Verbal or written information provided to the Member about advanced directives.
6. Review current opioid prescriptions (if it applies);
7. Screen for potential substance abuse disorders (SUD);

Resources:

- [Inland Empire Health Plan's Provider Policy and Procedure Manual](#), provides standards for inclusion of primary care providers as Obstetrics Providers in the network

Strategy Set 3: Practice Capabilities



Collective, multi-payer investment in practice capabilities and infrastructure

3.1 Invest in practice transformation support.

3.2 Equip practices with accurate, actionable data.

3.3 Pay for specific roles.

3.4 Fund technology for practices.

3.1 Invest in practice transformation support for practices.



Common features of practice transformation support include:

- Assessment tool to identify gaps in competencies
- Common reporting platform
- Technical assistance
- Training for coaches

Equity and Practice Transformation (EPT) Provider Directed Payment Program

Application Instructions

EQuIP-LA Measure Set

Measures of Focus

Glycemic Status Assessment for Patients with Diabetes (>9%) (GSD)

Controlling High Blood Pressure (C)

Colorectal Cancer Screening (COL)

Measures align with MCAS MY24 and APC

Measure Type

Outcome

PhmCAT Overview



The PhmCAT provides an overview of your practice's baseline across key PHM domains, including to identify strengths and areas of opportunity.



This is the second annual PhmCAT submission. EPT practices will also complete the PhmCAT in 2026.



Practices and the Learning Center will use results to understand practice PHM capabilities, look at change in capabilities from 2024 - 2025, and inform EPT TA opportunities.

Resources:

- DHCS [Equity and Practice Transformation Program](#), managed by the Population Health Learning Center
- CQC [Equity and Quality at Independent Practices in LA County](#)

3.2 Equip practices with accurate, actionable data.



- **Practice-level data** is essential to inform population health management and enable delivery of advanced primary care.

Partnership Quality Dashboard (PQD)

This secure, online platform makes provider-site-level quality data available across quality improvement programs to help inform, prioritize, and evaluate quality improvement efforts. Specifically, PQD functionality includes:

<i>Measure-Specific Data</i>	PQD tracks provider performance on all Primary Care Provider Quality Improvement Program and HEDIS measures relevant to targets.
<i>Trended Data</i>	Providers can track their performance on the measures throughout the measurement periods (i.e. monthly rates).
<i>Comparative Data</i>	PQD allows providers to compare their performance to blinded data of peer providers, including local averages and national benchmarks

Resources:

- [Partnership HealthPlan of California's tools](#) include eReports and the Partnership Quality Dashboard
- The [California Advanced Primary Care Initiative](#) uses a common reporting platform (Cozeva) to measure and track advanced primary care results across participating practices and health plans.

3.3 Pay for specific roles.

- Support providers to **bridge to sustainability** under a new payment model.
- Support **team-based care** through training and credentialing to increase availability of primary care team members.



The screenshot shows the Health Plan of San Mateo website. The header includes the logo with the tagline "Healthy is for everyone" and navigation links for "Member Login", "Provider Login", and "Find a Provider". The main heading is "Primary Care Provider Grants". Below this, a paragraph explains that these grants are part of the "Primary Care Investment Strategy" to address the primary care crisis. To the right, a list of grant types is shown in a light blue box: "Primary Care Team Expansion Grant", "Core Team Stabilization Grant", "Provider Sabbatical Grant", and "Custom Pilot Grant". A second paragraph describes the challenges primary care teams face and how these grants aim to bolster them.

Health Plan
OF SAN MATEO
Healthy is for everyone

Member Login Provider Login Find a Provider

Primary Care Provider Grants

Our Primary Care Provider Grants are part of our larger [Primary Care Investment Strategy](#) to help our network tackle the primary care crisis and lay the groundwork for advanced primary care. HPSM's grants aim to stabilize, expand, and/or enhance the way primary care teams do their work.

- ⬇ Primary Care Team Expansion Grant
- ⬇ Core Team Stabilization Grant
- ⬇ Provider Sabbatical Grant
- ⬇ Custom Pilot Grant

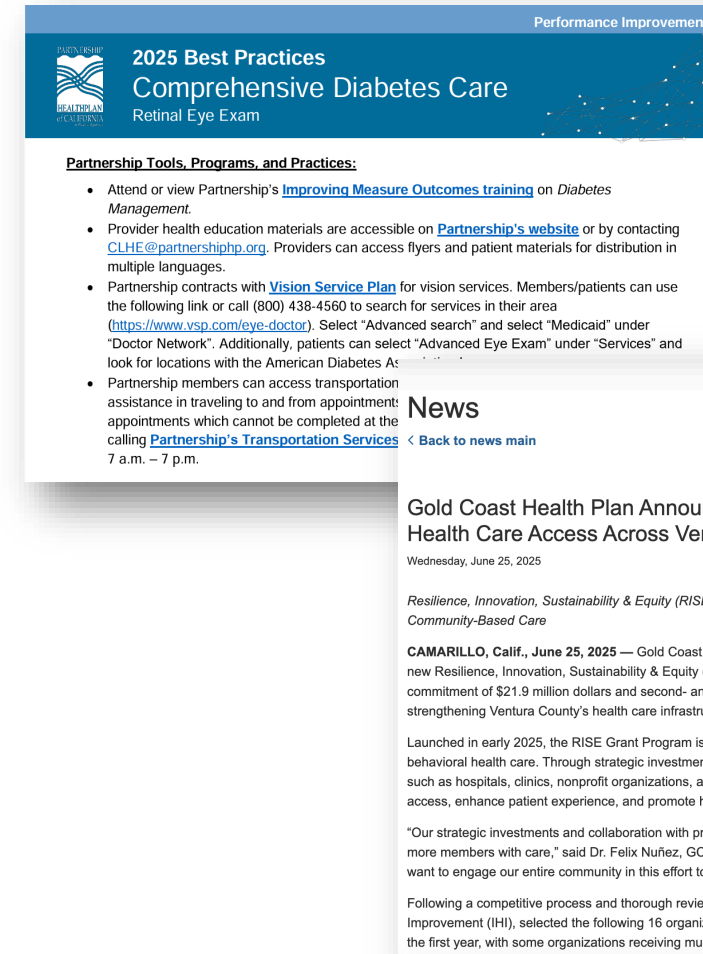
Primary care teams are the backbone of primary care, yet they are consistently understaffed. They face challenges balancing growing workloads and demand. This impacts individual and team well-being. Members of the primary care team stay because of the mission, the people and opportunities for growth. These grants aim to bolster the primary care team, so that they have the capacity, bandwidth and joy needed to deliver high quality primary care.

Resources:

- Health Plan of San Mateo launched a [Primary Care Provider Grants](#) program
- Inland Empire Health Plan has a [Provider Network Expansion Fund](#)
- [Growing Your Own Allied Health Workforce](#) initiative from Health Net and Futuro Health enables provider groups to cultivate local development of allied health workers

3.4 Fund technology for practices.

- **AI tools** for tasks including ambient scribe, chart abstraction, smart clinical decision support, inbox response
- **Equipment for installation in practices**, e.g. retinal cameras or blood monitors for diabetes



Resources:

- Partnership Health Plan launched a [small scale pilot](#) funding 10 retinal imaging cameras
- Gold Coast Health Plan [provided grants](#) for investments in infrastructure and equipment (e.g., mammography mobile unit, clinic expansion)

Considerations and Challenges

Variation in Provider Networks

Different primary care investment strategies will work better for some types of providers than for others. For independent practices, provide infrastructure support and avoid downside risk. For FQHCs, consider incentive programs and grants.

Sources of Investment in Primary Care

Options include health plans reserves and shifting resources away from low-value care.

Coverage Losses Create New Payer Pressures

Federal and state changes in subsidies, eligibility, and requirements for coverage programs have constrained resources.





Themes

1. Primary care investment must be multi-payer and multi-year to be effective.
2. Practices need predictable payment and practical infrastructure support, not one-time pilots.
3. Administrative burden and variation across plans undermine impact.
4. Access to timely, actionable data is as important as financial investment.
5. Alignment across contracting, network design, and practice capability strategies is essential.



RISE CA: Resourcing and Investing to Strengthen Equitable Primary Care in California

Align

- Establish Steering Committee to inform priorities

Activate

- Host Learning Community convenings to ideate and support implementation

Build

- Develop practical tools and resources responsive to needs

Learn

- Evaluate and synthesize project findings

Spread

- Accelerate adoption through communications and dissemination

- CHCF is launching a 2-year project that builds on prior work and convenings
- Objective is to move from conceptual alignment to coordinated implementation and accelerate statewide progress on strengthening primary care
- Mathematica (Dr. Diane Rittenhouse) is leading this effort

Additional Resources

- Jill Yegian and Melanie Ridley, [Payer Strategies for Primary Care Investment in California](#), CHCF issue brief, June 2026
- CHCF's [Primary Care Matters](#) resource collection, including an overview of [California Primary Care Initiatives](#)



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

Public Comment





Health Plan of San Mateo Primary Care Investment Strategies

Margareta Brandt, Assistant Deputy Director

Miriam Sheinbein, M.D., IBCLC, Medical Director, Health Plan of San Mateo;

Luarnie Bermudo, Director of Provider Services, Health Plan of San Mateo





Primary Care as a Common Good

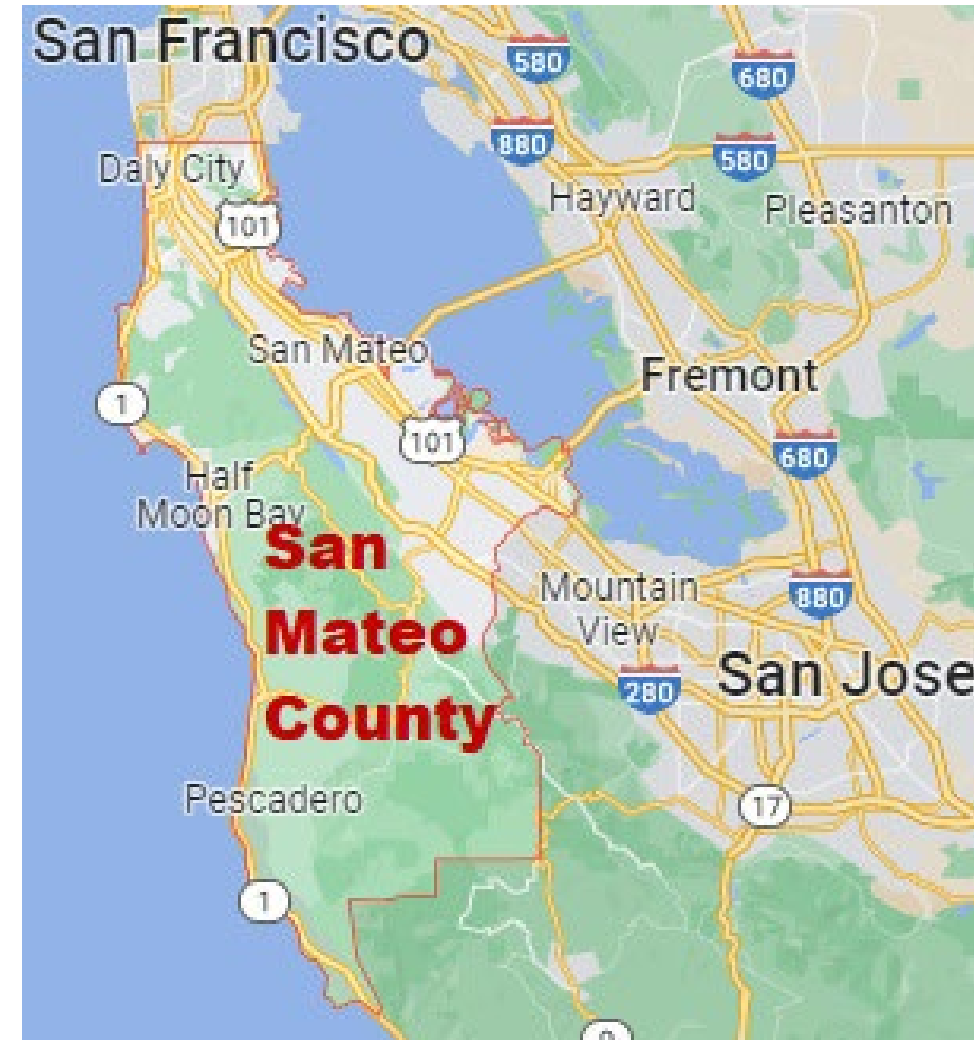
HPSM Primary Care Investment Strategy 2024-2028

Luarnie Bermudo, Director of Provider Services
Miriam Sheinbein, Medical Director

About Us



- Health Plan of San Mateo (HPSM) is a local, non-profit Medi-Cal/Medicare public health plan.
- For over 35 years, HPSM has been committed to fulfilling our vision that **Healthy is for Everyone.**
- With approximately 127,000 members, HPSM covers one in five San Mateo County, California, residents.



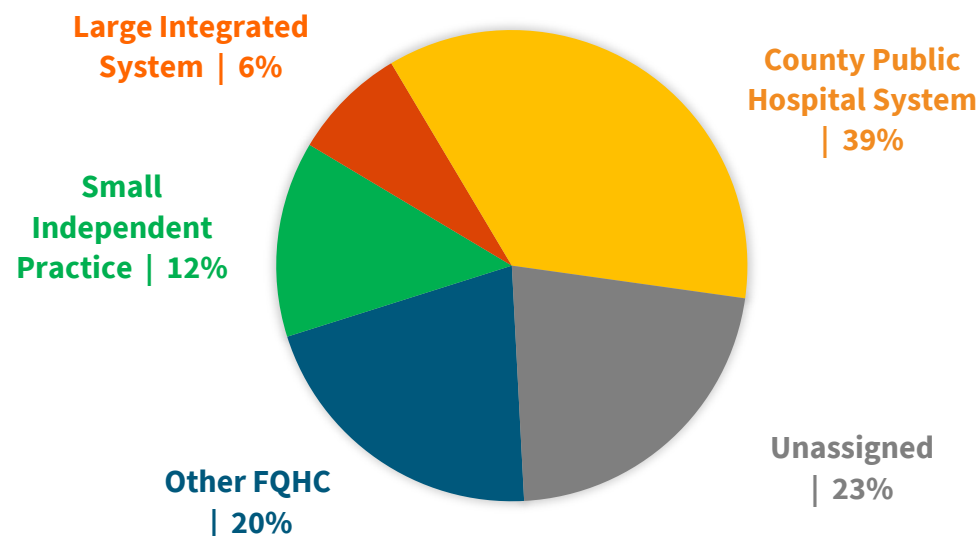
HPSM's 2026 NCQA Health Plan Rating



HPSM Primary Care Network at a Glance

1,700+ credentialed PCPs with 50 contracted provider groups
seeing members at 88 clinical sites

**HPSM TOTAL MEMBER ASSIGNMENT
BY CLINIC TYPE (9/2026)**



Top Five Provider Groups by Assigned Member Volume (9/2026):

Rank	Primary Care Group	Clinic Type	N Assigned Members	% All Assigned Members	LOB
1	SAN MATEO MEDICAL CENTER	County Public Hospital System	49,462	50.6%	MC, CA, HW, ACE
2	NORTH EAST MEDICAL SERVICES	Other FQHC	12,299	12.6%	MC, CA, ACE
3	RAVENSWOOD FAMILY HEALTH NETWORK	Other FQHC	9,887	10.1%	MC, CA, HW, ACE
4	PACIFIC FAMILY MEDICINE CLINIC	Small Independent Practice	3,976	4.1%	MC, CA, HW
5	PALO ALTO MEDICAL FOIUNDATION	Large Integrated System	3,667	3.8%	MC, CA, HW

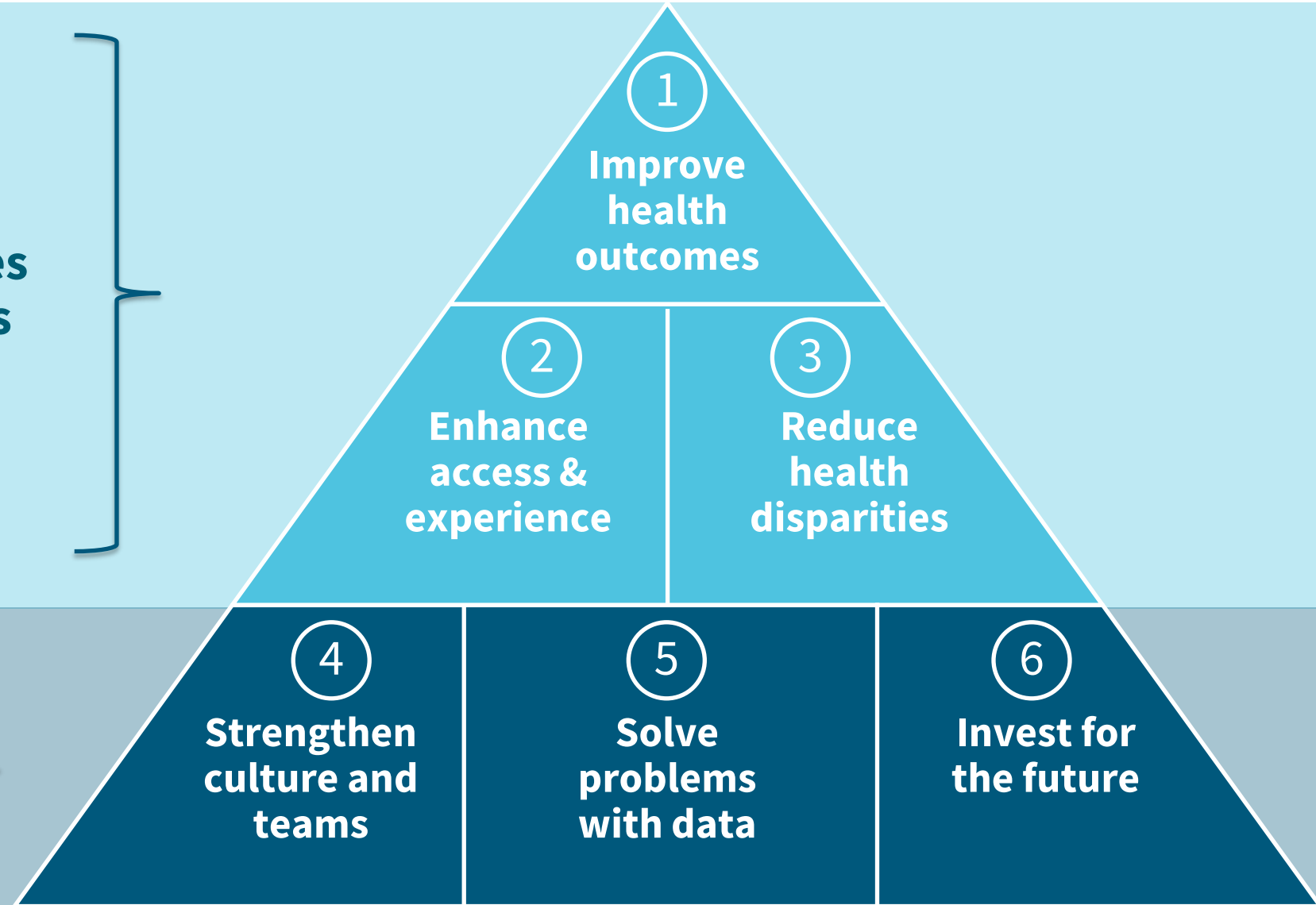
HPSM's 2024-2028 Strategic Plan

Area of Focus 1:

**Better Health Care Experiences
and Outcomes for all Members**

Area of Focus 2:

**Thriving Organizational
Capacity and Resilience**



Goal 6: Invest for the Future

We will ensure HPSM's long-term sustainability to advance our mission, by evaluating and pursuing opportunities to expand or invest differently.

6

**Future
Investment**



All investments of HPSM reserves were made applying our impact criteria.

“Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes.”

National Academies of Sciences, Engineering, and Medicine (NASEM)



PERSON & FAMILY
CENTERED



CONTINUOUS



COMPREHENSIVE
& EQUITABLE



TEAM BASED &
COLLABORATIVE

Shared Principles of Primary Care



COORDINATED
& INTEGRATED



ACCESSIBLE



HIGH VALUE

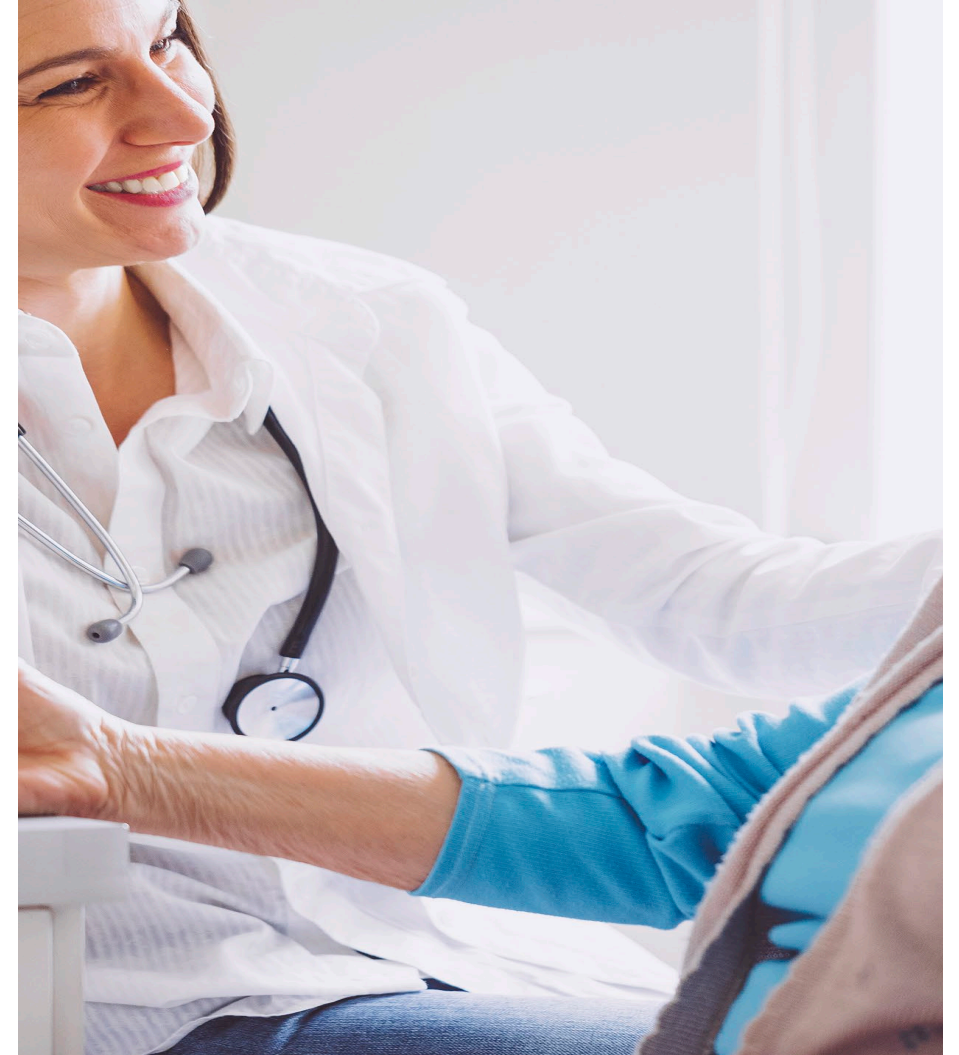
Challenges Facing Primary Care

Financial Neglect

Workforce Shortages, Bandwidth
and Burnout

Underdeveloped Population Health

Suboptimal Care Experience



Four Pillars of HPSM's Primary Care Investment Strategy



Better allocate resources

to address chronic underinvestment, support implementation of advanced primary care, and shift from a focus on volume to value



Promote a robust & thriving workforce

to fortify a diverse primary care workforce in San Mateo County that has capacity, bandwidth, and joy



Improve population health

by supporting our network to be more population-focused so that together we can achieve better and more equitable health outcomes for our members



Enhance the care experience

for members and families so that they are satisfied, engaged in their care and healthy

Quintuple Aim

Better Use of Resources

1. Measure/Report/Increase Primary Care Spend
2. Pay for Advanced Primary Care
3. Test Alternative Payment Models
4. Align with Other Payers
5. Offer Practice Supports

Better Work

1. Bolster the 3Rs: Recruitment, Retention, and Resilience
2. Promote Team-Based Care that Increases PCP Capacity
3. Enhance Staff Diversity, Inclusion, and Belonging
4. Invest in Workforce Development

Better Population Health

1. Increase Network Population Health Management Capabilities
2. Improve Data Transparency
3. Support Data Integration & Interoperability
4. Improve Performance & Reduce Disparities

Better Care Experience

1. Uplift member voices
2. Enhance Community Partnerships for more Coordinated, Integrated and Comprehensive Care
3. Improve Access
4. Increase Engagement

Primary Care Investment Goals

Goal	Primary Metric(s)
Better Use of Resources	Increase Primary Care Spend by 30% per capita
Better Work	Right-size primary care panels to 1200 members per primary care team.
Better Population Health	Show tiered improvement and reduction in disparities on prioritized HEDIS metrics*: WCV; BCS; DSF; GSD [†]
Better Care Experience	Increase members with a usual source of primary care .

*Tier 1: at or above 90th percentile: stay or exceed; Tier 2: between 50th and 90th percentile: greater than 25% gap closure to 90th percentile; Tier 3: below 50th percentile: exceed 50th percentile.

[†] Child and Adolescent Well-Care Visits (WCV); Breast Cancer Screening (BCS); Depression Screening and Follow Up (DSF); Glycemic Status Assessment for Patients with Diabetes (GSD)

Principles for Investing in Primary Care

Center our Customer

Not one size fits all

Flexibility > Prescriptiveness

Comprehensive and Synergistic

Storytelling

Provider Advisory Group (PAG)



Portfolio of Primary Care Investments

Goal	Investments
Better Use of Resources	Developed methodology for calculating, reporting and increasing Primary Care Spend
Better Work	Designed Primary Care Provider Grants program
Better Population Health	Launched Primary Care ACT (Assessments, Coaching and Technical Assistance)
Better Care Experience	Support access and engagement pilots.

Methodology for Calculating Primary Care Spend



A. Primary Care (PC) Spend:

Includes All Compensation: Capitation, FFS, Prop56, and Incentives

B. Total Cost of Care (TCOC):

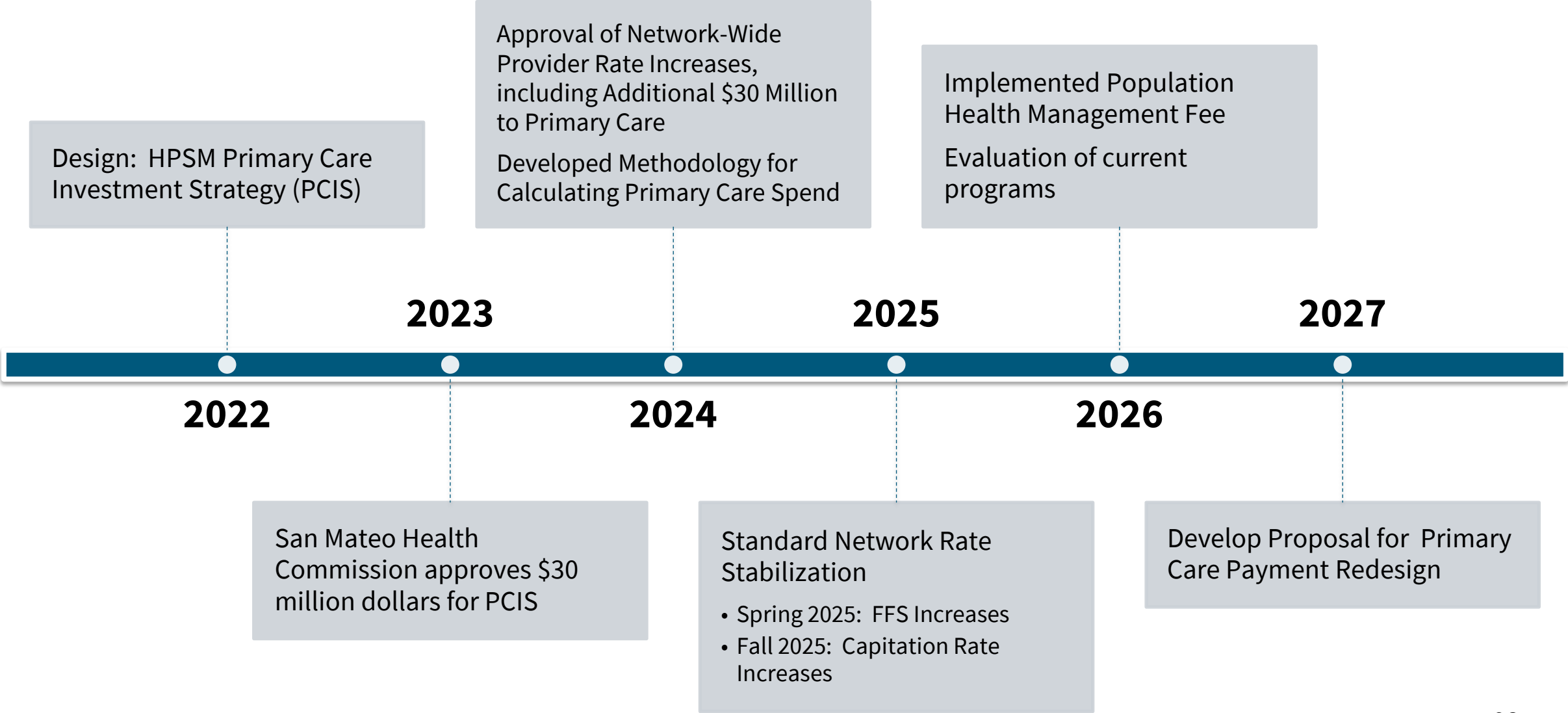
Includes:

All Common Benefits (IP, OP, SNF, Professional, Radiology, Lab, DME, PT/OT, Emergency Transport, etc.)

Excludes:

Pharmacy, UMQA and Medi-Cal only benefits (LTC Custodial, Hospital DP, NEMT/NMT, ECM/CS, CBAS, Dental)

Primary Care Payment Change Timeline



Primary Care Provider Grants

Grant type:

Purpose:

**Primary Care
Team Expansion**

Hire and integrate new interprofessional team members

**Core Team
Stabilization**

Recruit and retain Primary Care Providers and Medical Assistants

**Provider
Sabbatical**

Retain providers by enhancing resilience through sabbatical

**Custom Pilot
Program**

Design pilots and programs that improve primary care team capacity, bandwidth and joy

Primary Care ACT (**A**ssessments, **C**oaching and **T**echnical Assistance)



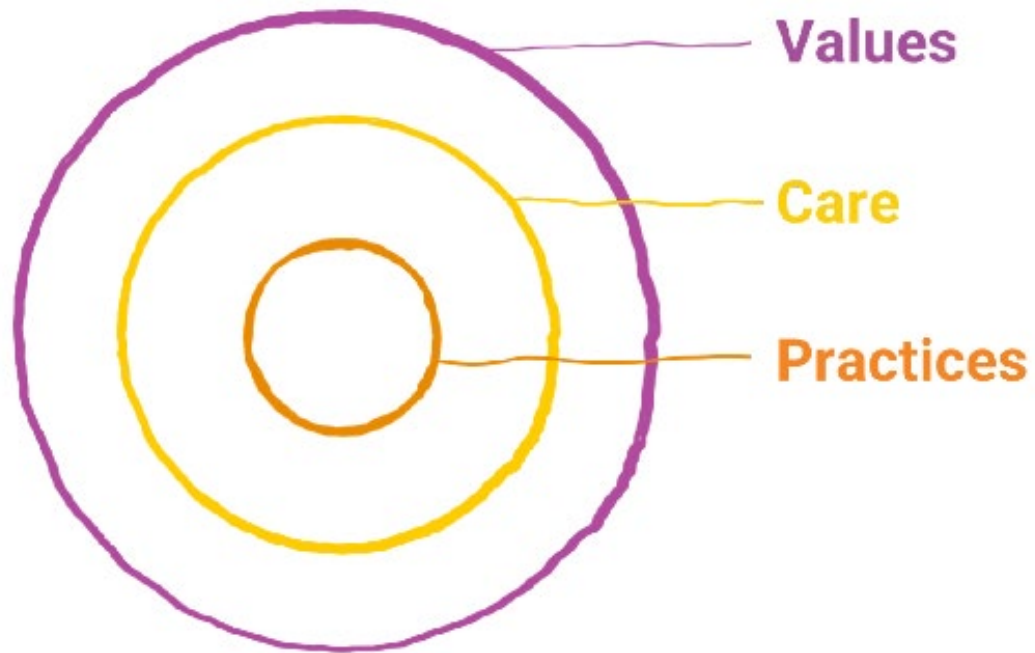
What is Primary Care ACT?

A three-year practice transformation initiative, facilitated by our esteemed program partners, Population Health Learning Center and University of California San Francisco Center for Excellence in Primary Care. It offers:

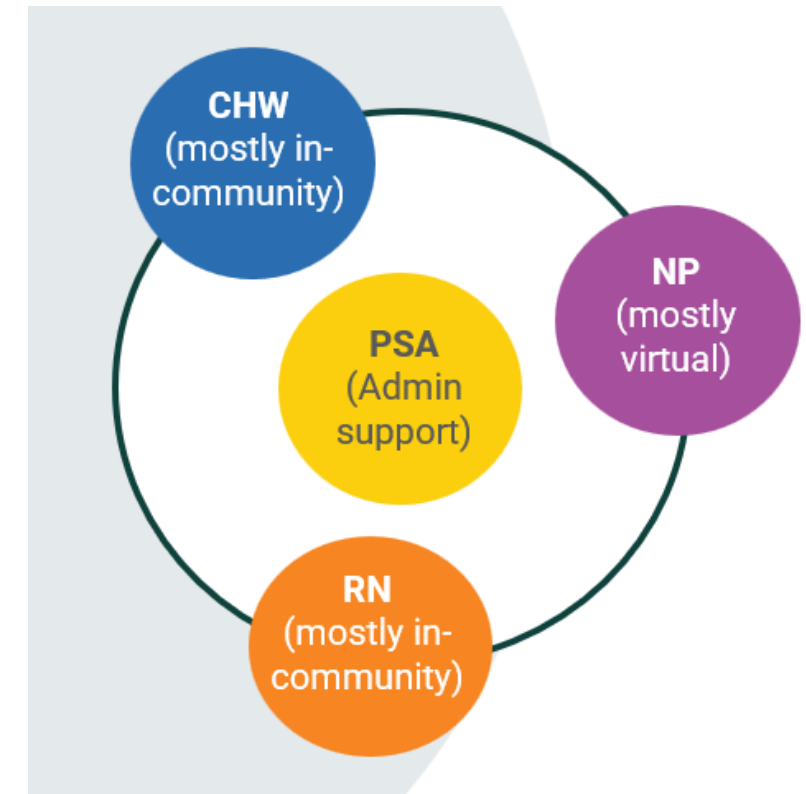
- Practice **Assessments** for the entire PCP provider network
- Targeted 1:1 **coaching** for select providers within the network
- Other forms of **technical assistance** to improve population health management capabilities, practice well-being, and clinical outcomes

Camino a la Salud Pilot*

Ethnographic Study: Understand the needs of
Health Plan of San Mateo Members,
Assigned but Unengaged in Primary Care



Camino Pilot:
A community-focused, virtual hybrid
primary care delivery model



Health Systems that invest more in primary care
have better and more equitable health outcomes.



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

Public Comment





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

OHCA Equity and Quality Measure Set Update: Proposal to Add Healthcare Associated Infection Measures for Hospitals

Margareta Brandt, Assistant Deputy Director



OHCA's Quality and Equity Measure Set

Statutory Requirements

- **Adopt and track performance on a single set of standard measures for assessing health care quality and equity across payers, fully integrated delivery systems, hospitals, and physician organizations.**
- **Use recognized clinical quality, patient experience, patient safety, and utilization measures.**
- Consider available means for **reliable measurement of disparities in health care**, including race, ethnicity, sex, age, language, sexual orientation, gender identity, and disability status.
- **Reduce administrative burden** by selecting quality and equity measures that simplify reporting and align performance measurement with other payers, programs, and state agencies, including leveraging existing voluntary and required reporting to the greatest extent possible.
- **Coordinate with the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), Covered California, and CalPERS**, and consult with external quality improvement organizations and forums, payers, physicians, other providers, and consumer advocates or stakeholders.

OHCA's Quality and Equity Measure Set

Statutory Requirements

- **Promote the goal of improved affordability** for consumers and purchasers of health care, **while maintaining quality and equitable care.**
- OHCA may require a health care entity to implement a performance improvement plan that identifies the causes for spending growth and shall include specific strategies, adjustments, and action steps the entity proposes to implement to improve spending performance during a specified time period. **The Director shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode access, quality, equity, or workforce stability.**

OHCA's Quality and Equity Measure Set

Purpose

- Promote high quality and more equitable health care for all Californians.
- Monitor changes in quality and equity as health care entities work to meet spending targets.
- Track progress towards OHCA's goals to improve access, affordability, and equity of health care for all Californians.

Background

- To develop the OHCA Quality and Equity Measure Set, OHCA analyzed over 300 quality measures used by health care organizations in California and nationally and met with stakeholders to gather feedback and to align with statewide efforts.
- OHCA received feedback on the proposed OHCA Quality and Equity Measure Set from the Health Care Affordability Advisory Committee and Board as well as public comment.
- The OHCA Quality and Equity Measure Set was adopted in April 2025.

Payers	Physician Organizations	Hospitals
Fully Integrated Delivery Systems ¹		
Adopt the full Department of Managed Health Care (DMHC) Health Equity and Quality Measure Set and stratification requirements	Adopt a subset of the Center for Data Insights and Innovation Office of the Patient Advocate (OPA) Health Care Quality Report Card measures ²	Adopt the full HCAI Hospital Equity Measures Reporting Program measure set and stratification requirements

¹ For fully integrated delivery systems, which include a payer, physician organization, and hospital component, OHCA will measure performance of each of these component entities.

² OPA does not report measures stratified by demographic characteristics.

Context

- Throughout its development process, stakeholders encouraged OHCA to expand the OHCA Quality and Equity Measure Set and address its limitations.
 - Stakeholders representing a range of perspectives encouraged OHCA to consider adding healthcare associated infection (HAI) measures and more hospital patient safety measures to the OHCA Quality and Equity Measure Set, citing the importance of monitoring patient safety as hospitals work to meet spending targets.
- When OHCA adopted the Quality and Equity Measure Set in April 2025, sibling state departments, including CalPERS and Covered California, were working to develop a priority set of hospital patient safety measures, including HAI measures.
- Now, to align with the emerging **California Alignment for Hospital Quality (Cal-HQ)** initiative and other statewide patient safety programs, OHCA is proposing to add HAI measures to the OHCA Quality and Equity Measure Set for hospitals.

Proposal to Add Healthcare Associated Infections (HAIs) Measures to the OHCA Quality and Equity Measure Set

- To align with statewide initiatives, OHCA proposes to adopt four HAI measures which are a subset of the California Department of Public Health (CDPH) HAI Program and the Center for Disease Control and Prevention (CDC) HAI measures and are the focus of the sibling state departments' priority set of hospital patient safety measures through Cal-HQ.
- The proposed four HAI measures are:
 1. Clostridioides difficile infections (CDI)
 2. Catheter-associated Urinary Tract Infection (CAUTI)
 3. Central line-associated Blood Stream Infection (CLABSI)
 4. Methicillin-resistant Staphylococcus aureus (MRSA)
- OHCA will rely on publicly reported data from CDPH or CDC to leverage existing reporting on these HAI measures.

Cal-HQ Background

- **California Alignment for Hospital Quality (Cal-HQ) mission:** Aligning statewide action for hospital quality
- **Initial Bold Goal:** Preventing 2,000 additional HAIs (beyond projected performance) statewide by December 2027 across 4 priority types (CAUTI, CLABSI, CDI and MSRA)
- **Leadership:** Covered California, CalPERS, and Cal Healthcare Compare
- **Collaboration & Oversight:** Multi-stakeholder steering committee (state agencies, quality improvement organizations, health plans, hospitals, patient advocates)



CDPH HAI Program Background

- Existing law (Health and Safety Code Sections 1288.55 and 1288.8) requires CDPH to oversee the prevention, surveillance, reporting, and response to HAIs in California's hospitals and other healthcare facilities.
- The CDPH HAI Program receives and publicly reports California hospital HAI data to inform the public and prompt healthcare providers to take action to prevent infections, conducts statewide surveillance of healthcare-associated reportable conditions, and provides infection prevention and control education, training, and consultation to healthcare providers.
- Hospitals subject to CDPH reporting on HAIs are all CDPH-licensed General Acute Care Hospitals, including long term acute care, critical access, and acute rehabilitation hospitals, regardless of size.
- OHCA will use CDPH data to report performance on 3 of the proposed HAIs:
 1. Clostridioides difficile Infection (CDI)
 2. Central Line-associated Bloodstream Infection (CLABSI)
 3. Methicillin-resistant Staphylococcus aureus (MRSA) Bloodstream Infection (BSI)

CDC HAI Program Background

- CDC's mission in healthcare safety includes tracking infections, responding to outbreaks, providing expertise and guidance, working with partners to implement infection prevention activities, spearheading research in infection prevention, and serving as the nation's gold standard microbiology laboratory for the pathogens most often implicated in HAIs.
- CDC's National Healthcare Safety Network (NHSN), the nation's most widely used HAI surveillance system, provides facilities, states, regions, and the nation with data to identify problem areas, measure progress of prevention efforts, and ultimately eliminate HAIs.
- More than 38,000 active hospitals, long-term care facilities, and other healthcare facilities provide data to NHSN, which in turn is used for national- and state-level analyses and for targeted prevention initiatives by healthcare facilities, states, regions, quality groups, and national public health agencies.
 - NHSN hospitals subject to CDC reporting are acute care hospitals (ACHs), critical access hospitals (CAHs), inpatient rehabilitation facilities (IRFs) and long-term acute care hospitals (LTACHs).
- OHCA will use CDC data to report performance on 1 proposed HAI:
 1. Catheter-associated Urinary Tract Infection (CAUTI)



Discussion: Proposal to Add HAI Measures to the OHCA Quality and Equity Measure Set

Does the Advisory Committee have input on OHCA's proposal to add these four HAIs to the OHCA Quality and Equity Measure Set to measure quality and safety performance of hospitals?



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

Public Comment





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

Spending Target Enforcement – Target Values for Performance Improvement Plan Implementation

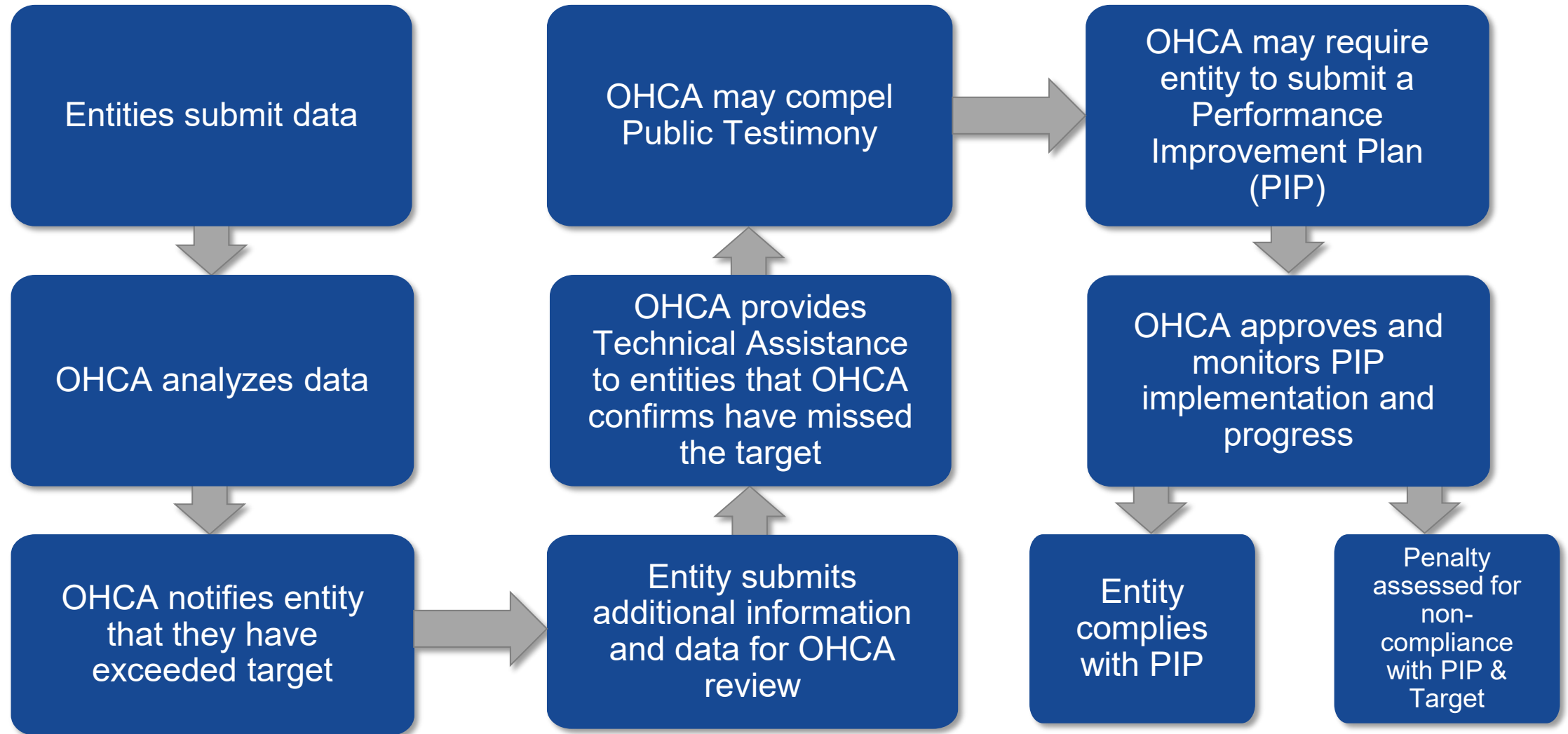
Vishaal Pegany, Deputy Director

CJ Howard, Assistant Deputy Director

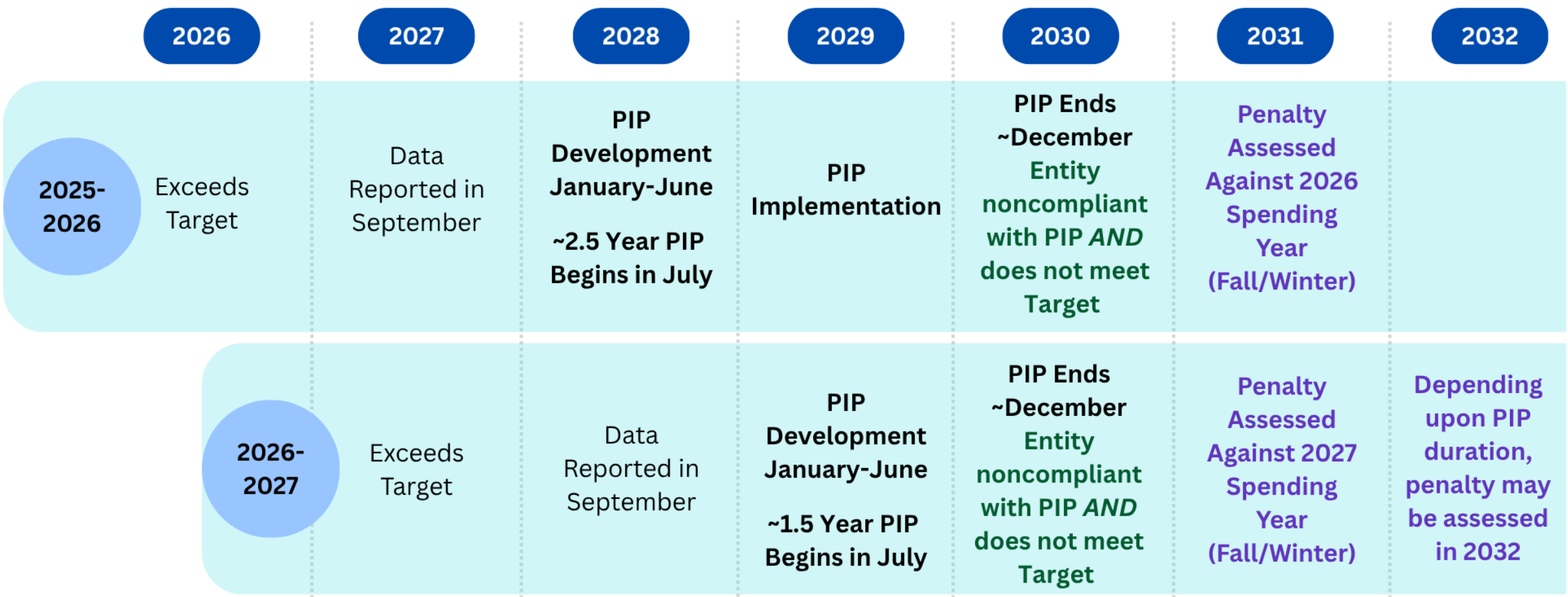
Megan Brubaker, Engagement, Governance and Policy Group Manager



OHCA Progressive Enforcement Process



Potential Enforcement Timeline for Health Plans



Target Values for Performance Improvement Plan Implementation

When an entity completes a Performance Improvement Plan (PIP), OHCA must determine:

1. If the entity complied with their PIP
- 2. If the entity came into compliance with the target**

Question: Which target will be used to determine if the entity came into compliance with the target?

Answer: The target value that prompted the enforcement action, or a target established by the board that is not less than the value that prompted enforcement.

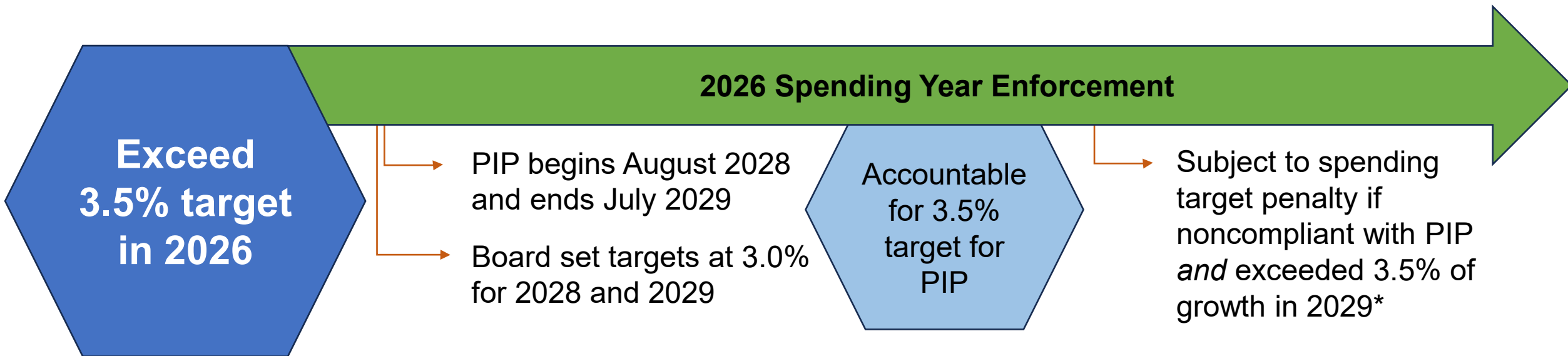
Target Values for Performance Improvement Plan Implementation

Considerations

- The target value at the end of a PIP could be different from the target value that prompted enforcement.
- PIPs are forward-looking.
- OHCA must be able to effectively operationalize the approach.
- The approach must align with statutory provisions.
- Target values will be specified in the approved PIP.
- As presented in previous board meetings, each target year is subject to enforcement. Even if an entity is subject to a different target value for purposes of a PIP, an entity could be subject to progressive enforcement for violating the applicable annual spending target.

Target Values for Performance Improvement Plan Implementation

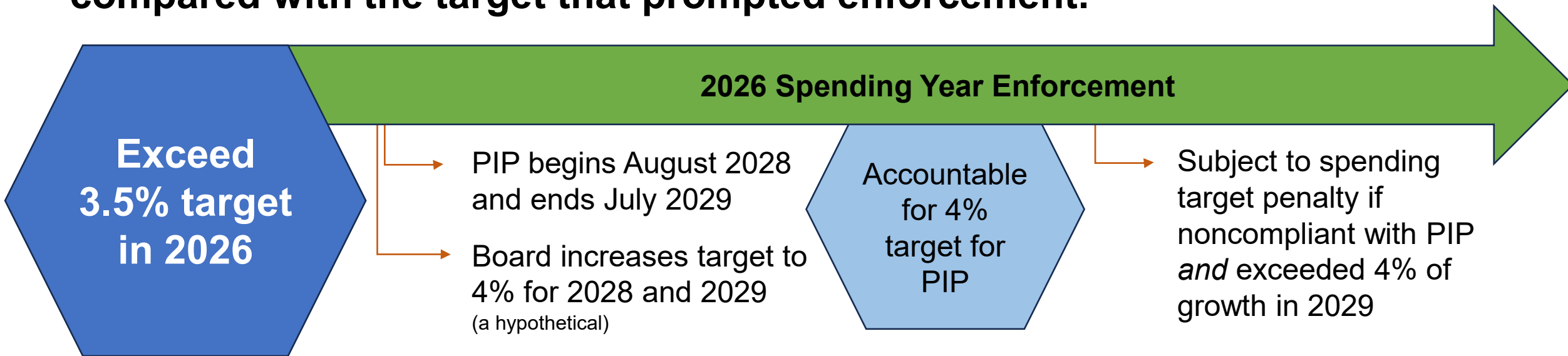
Example - Lower target value is established by the Board for a future year compared with the target that prompted enforcement.



***Reminder:** OHCA enforces each year individually/separately. The example above shows how OHCA would hold entities accountable for a PIP in response to 2026 spending performance. Entities would still be accountable for compliance with subsequent years' targets, including the board set target of 3.5% in 2029.

Target Values for Performance Improvement Plan Implementation

Example - Higher target is established by the Board for a future year compared with the target that prompted enforcement.



Alternative scenario: Instead of 4.0%, we held the entity accountable to the original 3.5% target. They had growth of 3.7% in 2029 and are potentially subject to penalties for not meeting a 3.5% target for the PIP in 2029. Because the entity was under 4%, they would not undergo progressive enforcement for performance year 2029.



Discussion: Target Values for Performance Improvement Plan Implementation

Does the Advisory Committee have any input on the target values for performance improvement plan implementation?



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

Public Comment





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

Overview of Progressive Enforcement Regulations, Including Spending Target Performance Measurement

Vishaal Pegany, Deputy Director

CJ Howard, Assistant Deputy Director

Megan Brubaker, Engagement, Governance and Policy Group Manager



Proposed Progressive Enforcement Regulations

Sections of Proposed Regulations

- Definitions
- Total Health Care Expenditures Data Submission
- Spending Target Enforcement
- Technical Assistance
- Public Testimony
- Spending Target Performance Improvement Plan and Spending Target Penalties
- Procedural Penalties for Impeding or Impairing the Spending Target Enforcement
- Penalty Justification Factors
- Appeal of an Administrative Penalty

Proposed Progressive Enforcement Regulations

Sections of Proposed Regulations: Spending Target Enforcement

- The text covers processes for enforcement of an accountable health care entity.¹
- OHCA calculates an accountable health care entity's excess spending growth and makes a preliminary determination that the entity exceeded a spending target.
- This section covers enforcement considerations that may have contributed to the entity's spending growth, including but not limited to:
 - Population characteristics
 - Impact of high-cost patient outliers
 - Impact of high-cost drugs
 - Impact of investments in primary and preventative care
 - Impact of changes in state or federal law
 - Impact of acts of God or catastrophic events
 - Impact of non-supervisory organized labor costs
 - Entity's actions that impair or impede enforcement
 - Historical spending growth
 - Entity's impact on consumer access and affordability
 - Entity's baseline costs
 - Amount of entity's excess spending growth
- OHCA may request supplemental documentation, analysis, or data.
- OHCA may change its preliminary determination if the entity clearly and convincingly shows that OHCA's growth calculation is incorrect.

¹An "accountable health care entity" refers to a payer, a fully integrated delivery system, a physician organization, and a hospital health facility.

Proposed Progressive Enforcement Regulations

Sections of Proposed Regulations: Spending Target Performance Improvement Plan and Spending Target Penalties

- The text includes the process for submitting a performance improvement plan and gives entities 45-days to submit a proposal.
- Entities may request a 30-day extension and additional extensions may be granted.
- The text includes review process for proposals and progress reports.
- The text discusses confidentiality of nonpublic information and processes for requesting confidential treatment.
- An entity that is not compliant with an approved performance improvement plan and does not meet the spending target may be subject to an administrative penalty that is initially commensurate with excess spending.

Proposed Progressive Enforcement Regulations

Sections of Proposed Regulations: Penalty Justification Factors

The text includes the list of factors approved by the Board to determine the appropriate administrative penalty amount.

- 1) The nature, number, and gravity of the offenses.
- 2) 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.
- 3) The market impact of the entity.
- 4) The related provision of nonfederal share associated with Medi-Cal.

Proposed Progressive Enforcement Regulations

Two documents are incorporated into regulations by reference.

Spending Target Performance Measurement Manual

- This provides detailed information about how OHCA will measure spending performance by accountable health care entity type.
- This shows how OHCA calculates excess spending to determine the initially commensurate amount for an administrative penalty.
- This document is divided into 5 sections:
 1. Introduction
 2. Payer Calculations
 3. Hospital: Year-over-Year Growth in Inpatient and Outpatient Unit Spending
 4. Physician Organization (PO): Year-over-Year Growth in Attributed TME PMPY
 5. Initially Commensurate Calculations
- Per OHCA's presentation at the September 2026 Health Care Affordability Board meeting, the Manual describes a hospital spending growth measure that combines inpatient and outpatient spending into a single measure.¹

¹For more information about the combined spending growth measure for hospitals, see the slide deck presented at the [September 2026 Health Care Affordability Board meeting](#) (slides 30-54).

Proposed Progressive Enforcement Regulations

Performance Improvement Plan Submission Guidance

- This provides entities with detailed information about the performance improvement plan process, including how to submit a proposal and what to include in a proposal, progress report, and final progress report.
- The guidance is divided into nine sections (A-I) and includes one appendix (Appendix A):
 - Section A: Introduction
 - Section B: Submission Instructions
 - Section C: Extension Requests
 - **Section D: Content Requirements**
 - Section E: Evaluation of Proposal
 - Section F: Progress Reports
 - Section G: Final Progress Report
 - Section H: Evaluation of Final Progress Report
 - Section I: OHCA Contact Information
 - APPENDIX A: Attestation
- Section D: Performance Improvement Plan Content Requirements
 - D.1 Contacts
 - D.2 Organization Description
 - D.3 Brief Summary
 - D.4 Reasons for Spending Growth
 - D.5 Goals, Activities, and Milestones
 - D.6 Affordability for Consumers and Purchasers
 - D.7 Assessment Plan
 - D.8 Balancing Measures
 - D.9 Sustainability
 - D.10 Other State Agencies
 - D.11 Implementation Timeline
 - D.12 Attestation

Proposed Progressive Enforcement Regulations

Performance Improvement Plan Submission Guidance

D.5 Goals, Activities, and Milestones – Identify goals that are likely to reduce spending to bring the entity into compliance with the spending target. Goals should also consider how performance improvement plan intervention may positively impact equity, access, and workforce stability to ensure cost-reducing strategies do not negatively affect these areas. Each goal must have a rationale and follow the SMART Goal framework (see table below). Each goal must describe the specific activities necessary to meet the goals and include milestones to be reported on in each progress report.

S	Specific	The goal shall have a specific identified accomplishment. The desired accomplishment cannot be general or vague.
M	Measurable	The goal shall have identified measures or ways of tracking progress and accomplishment.
A	Achievable	The goal shall be attainable and realistic.
R	Relevant	The goal shall be related to your causes for spending growth and shall contribute to coming into compliance with the spending growth target.
T	Timebound	The goal shall have a specific timeframe and have an identified expected date of accomplishment.

EXAMPLE

SMART Goal – description of goal following the SMART Goal framework

1. Rationale for choosing this goal
2. Strategy 1 – strategy to meet the goal
 - a) Activity A – specific activity to implement strategy 1 by X deadline with milestones at X deadlines
 - b) Activity B - specific activity to implement strategy 1 by X deadline with milestones at X deadlines
3. Strategy 2 – strategy to meet the goal
 - a) Activity A – specific activity to implement strategy 2 by X deadline with milestones at X deadlines
 - b) Activity B - specific activity to implement strategy 2 by X deadline with milestones at X deadlines

Proposed Progressive Enforcement Regulations

Performance Improvement Plan Submission Guidance

- **D.6 Affordability for Consumers and Purchasers** – Describe in detail how each goal positively impacts affordability for consumers and purchasers. Lowered spending through implementing performance improvement plan strategies, whether through changes in utilization and/or pricing, should not solely reduce in-ternal operating expenses for the health care entity but positively impact affordability for consumers and purchasers. As relevant and applicable, disaggregate savings from performance improvement plan goals by payer market, line of business, and product type, and include specifics about the impact of performance improvement plan goals on unit costs. Note for Medi-Cal payer markets or lines of business where consumers may have mini-mal or zero cost-sharing, describe how each goal positively impacts affordability for the State of California as a purchaser.
- **D.7 Assessment Plan** – Describe in detail how progress will be measured for goals, activities, and milestones. The assessment plan must:
 - a. Include specific metrics and specific data sources to be used in progress reports and the final progress report.
 - b. Define key terms
 - c. Include measures to track progress towards SMART goals identified under Section D5 “Goals, Activities, and Milestones.”

Proposed Progressive Enforcement Regulations

Performance Improvement Plan Submission Guidance

- **D.8 Balancing Measures** – Describe in detail how the performance improvement plan proposal will maintain or improve access, quality, equity, and workforce stability. Include mitigation strategies and specific balancing measures that will be tracked internally. Performance on balancing measures must be provided to OHCA in progress reports and the final report. Balancing measures may include OHCA's Quality and Equity Measure Set, Workforce Stability Standards, etc.
- **D.9 Sustainability** – Describe in a detailed narrative response how achieved goals will be sustained in future years to comply with the spending target.
- **D.10 Other State Agencies** – If your performance improvement plan goals are related to, or otherwise impacted by, obligations or requirements monitored or enforced by other state regulators, clearly identify the relevant regulator(s) and describe the relationship or impact.
- **D.11 Implementation Timeline** – Develop a detailed timeline on performance improvement plan implementation that includes deadlines for goals, activities, and milestones. The performance improvement plan timeline must include progress reports, meetings with OHCA at a minimum cadence of every 6 months, and the final report. The proposed performance improvement plan implementation timeline must not exceed three years.

Proposed Progressive Enforcement Regulations

Performance Improvement Plan Submission Guidance

- **Proposal Deadline:**
 - Due within 45 calendar days of the date of OHCA's notice that a performance improvement plan is required and must be included in the proposal's timeline.
 - Extension requests of up to 30 calendar days must be submitted prior to the 45-day deadline.
 - Additional extensions may be granted dependent on an entity's unique situation.
- **Progress Report Deadlines:**
 - Must be submitted at a minimum cadence of every 6 months and deadlines must be included in proposal's timeline.
 - Extension requests must be received on or before the due date.
- **Final Progress Report Deadline:**
 - Due within 45 calendar days of the end of a performance improvement plan's implementation period and must be included in the proposal's timeline.
 - Extension requests must be received on or before the due date.

Enforcement Process Implementation Timeline





Discussion: Progressive Enforcement Regulations

Does the Advisory Committee have any input on progressive enforcement regulations?



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

Public Comment





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.



Next Advisory Committee Meeting:

January 13, 2027
10am

Location:

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



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

Adjournment





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

Appendix



Review Report on Promoting High Value Health Care in California, 2023-2024

Exclusions

- APM adoption data have been excluded due to ongoing data validation concerns for¹:
 - Aetna (Commercial HMO/POS, PPO/EPO, and Medicare Advantage)
 - Blue Shield of CA (Commercial HMO/POS, PPO/EPO, Medi-Cal Managed Care, and Medicare Advantage)
 - Kern Family Health (Medi-Cal Managed Care)
- APM adoption and primary care spending data have been excluded due to ongoing data validation concerns for¹:
 - Alignment Health (Medicare Advantage)
- Commercial PPO/EPO payer-level reporting excluded due to low enrollment in PPO plans for:
 - Kaiser Permanente and Sharp Health Plan
- OHCA's measurement of APM adoption and primary care spending reporting excludes a variety of payments and spending including but not limited to:
 - Medicare Fee-for-Service (FFS) and supplemental insurance payments, Medi-Cal FFS and Medi-Cal pharmacy spending, "Commercial – Other" market spending (enrollment and spending in this category represented less than 1% of the Commercial market), a portion of commercial self-insured spending, other state and federal program spending, spending from payers with fewer than 40,000 covered lives in any market, reinsurance recoveries.

¹OHCA is working with these payers to resolve ongoing data validation concerns.

Market Share by Plan: Commercial

Commercial HMO/POS	Market Share
Kaiser Permanente	63.2%
UnitedHealthcare	11.4%
Anthem	6.6%
Blue Shield of California	4.8%
Centene	3.8%
Aetna	2.5%
L.A. Care Health Plan	2.1%
Sharp Health Plan	1.2%
Western Health Advantage	1.1%
Sutter Health Plan	1.1%
Cigna	0.9%
Molina Healthcare	0.5%
Valley Health Plan	0.5%
Inland Empire Health Plan	0.2%
San Francisco Health Plan	0.1%
Contra Costa Health Plan	0.1%
Health Plan of San Mateo	< 0.1%
Total Members	10,992,519

Commercial PPO/EPO	Market Share
Anthem	33.2%
Blue Shield of California	24.8%
Cigna	19.1%
Aetna	18.6%
UnitedHealthcare	2.6%
Centene	1.7%
Kaiser Permanente	<0.1%
Sharp Health Plan	<0.1%
Total Members	5,127,254

Note: Enrollment used for market share calculations is determined by taking member months reported in the OHCA APM file divided by 12.

Market Share by Plan: Medi-Cal Managed Care

Medi-Cal Managed Care	Market Share
L.A. Care Health Plan	17.1%
Centene	11.4%
Inland Empire Health Plan	10.7%
Kaiser Permanente	7.5%
Partnership HealthPlan of California	6.6%
CalOptima	6.3%
Anthem	5.9%
Molina Healthcare	4.2%
Central California Alliance for Health	3.3%
CalViva Health	3.2%
Health Plan of San Joaquin	3.1%
Kern Family Health Care	3.0%
Alameda Alliance for Health	2.9%
Community Health Group	2.9%
Santa Clara Family Health Plan	2.1%
Contra Costa Health Plan	1.9%
Gold Coast Health Plan	1.8%
CenCal Health	1.8%
San Francisco Health Plan	1.3%
Blue Shield of California	1.3%
Health Plan of San Mateo	1.0%
Community Health Plan of Imperial Valley	0.7%
Total Members	13,667,037

Note: Enrollment used for market share calculations is determined by taking member months reported in the OHCA APM file divided by 12. Dual eligible members (those eligible for both Medicare and Medicaid) and Dual Eligible Special Needs Plans (D-SNPS) are captured in the Medicare Advantage totals. Dual eligible members when the payer is only administering Medi-Cal benefits are captured in the Medi-Cal totals.

Market Share by Plan: Medicare Advantage

Medicare Advantage	Market Share
Kaiser Permanente	41.9%
UnitedHealthcare	16.3%
Anthem	8.7%
SCAN Health	8.1%
Blue Shield of California	5.0%
Alignment Health	4.7%
Centene	4.4%
Aetna	4.0%
Bright Health	1.7%
Central Health Plan of California	1.2%
Inland Empire Health Plan	1.0%
L.A. Care Health Plan	0.6%
Molina Healthcare	0.5%
CalOptima	0.5%
Sharp Health Plan	0.4%
Santa Clara Family Health Plan	0.3%
Health Plan of San Mateo	0.2%
Community Health Group	0.2%
Western Health Advantage	0.1%
Total Members	3,364,121

Note: Enrollment used for market share calculations is determined by taking member months reported in the OHCA APM file divided by 12. Dual eligible members (those eligible for both Medicare and Medicaid) and Dual Eligible Special Needs Plans (D-SNPS) are captured in the Medicare Advantage totals. Dual eligible members when the payer is only administering Medi-Cal benefits are captured in the Medi-Cal totals.

HCP-LAN Framework

			
CATEGORY 1 FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	CATEGORY 2 FEE FOR SERVICE – LINK TO QUALITY & VALUE	CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION – BASED PAYMENT
	A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)	A APMs with Shared Savings (e.g., shared savings with upside risk only)	A Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	B APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	B Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)
	C Pay-for-Performance (e.g., bonuses for quality performance)		C Integrated Finance & Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

Highlighted categories are those that count toward OHCA APM adoption goals.

Claims and Non-claims Payment Categories

Category	Description
Claims Payments	
Fee-for-service (FFS)	Claims payments in which health care providers or organizations are paid for each service performed. Examples of services include tests and office visits.
Non-claims Payments	
Capitation and Full Risk Payments	
Capitation and Full Risk Payments	Per capita, non-claims payments paid to health care providers or organizations to provide a defined set of services to a designated population of patients over a defined period of time.
Non-capitation Non-claims Payments	
Population Health and Infrastructure Payments	Prospective, non-claims payments paid to health care providers or organizations to support specific care delivery goals; not tied to performance metrics. Does not include costs associated with payer personnel, payer information technology systems, or other internal payer expenses.
Performance Payments	Non-claims bonus payments paid to health care providers and organizations for reporting data or achieving specific predefined goals for quality, cost reduction, equity, or another performance achievement domain.
Shared Savings and Shared Risk Payments	Non-claims payments made to health care providers and organizations (or recouped from health care providers and organizations) based on performance relative to a defined spending target. Shared savings and shared risk payments can be associated with different types of budgets, including, but not limited to, episodes of care and total cost of care.
Other Non-Claims Payments	Any other payments to a health care provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit.

Medi-Cal Payment Inclusions/Exclusions

Arrangement Type	Program Name	Include/Exclude
Minimum Fee Schedule	Adverse Childhood Experiences (ACEs)	Include
Minimum Fee Schedule	Children and Youth Behavioral Health Initiative (CYBHI)	Include
Minimum Fee Schedule	Dental Managed Care Plans (DMC Plans) and Health Plan of San Mateo (HPSM) under the Dental Integration Pilot (DIP)	Include
Minimum-maximum Fee Schedule	Long-Term Care Fee-For-Service Equivalent Directed Payment	Include
Minimum-maximum Fee Schedule	Major Organ Transplant (MOT)	Include
Minimum Fee Schedule	Proposition 56 Abortion Services	Exclude
Minimum Fee Schedule	Targeted Rate Increases (excluding FQHC Parity)	Include
Other	California Children's Services (CCS)	Include
Other	Whole Child Model (WCM)	Include
Other	Community Supports (CS)	Exclude
Other	Community Reinvestment	Exclude
Other	Enhanced Care Management (ECM)	Exclude
Other	FQHC APM payments	Exclude
Other	FQHC Prospective Payment System (PPS) payments	Exclude
Other	Nonemergency medical transportation (NEMT)	Exclude
Other	Nonmedical transportation (NMT)	Exclude
Pass-Through Payment	Benioff Children's Hospital Oakland	Exclude
Pass-Through Payment	DMPH DP/NF	Exclude
Pass-Through Payment	DPH Distinct Part Nursing Facility (DP/NF)	Exclude
Pass-Through Payment	Hospital Quality Assurance Fee (HQAF)	Exclude

Arrangement Type	Program Name	Include/Exclude
Pass-Through Payment	Martin Luther King Jr. (MLK) Community Hospital	Exclude
Uniform Dollar Increase	Children's Hospital Supplemental Payment (CHSP)	Exclude
Uniform Dollar or Percent Increase	Designated Public Hospital Enhanced Payment Program (EPP)	Exclude
Uniform Dollar Increase	Developmental Screening Services	Exclude
Uniform Dollar Increase	District and Municipal Public Hospital Directed Payment (DHDP)	Exclude
Uniform Dollar Increase	Equity and Practice Transformation (EPT)	Exclude
Uniform Dollar Increase	Non-Hospital 340B Community Clinic Directed Payment (CCDP)	Exclude
Uniform Dollar Increase	Private Hospital Directed Payment (PHDP)	Exclude
Uniform Dollar or Percent Increase	Proposition 56 Dental	Exclude
Uniform Dollar Increase	Proposition 56 Family Planning	Exclude
Uniform Dollar Increase	Proposition 56 Physician Services	Exclude
Uniform Dollar Increase	Skilled Nursing Facility (SNF) Workforce & Quality Incentive Program (WQIP)	Exclude
Value-based Payment	Designated Public Hospital Quality Incentive Pool (DPH-QIP)	Exclude
Value-based Payment	District and Municipal Public Hospital Quality Incentive Pool (DMPH-QIP)	Exclude

The inclusion/exclusion instructions provided in writing to MCPs for 2025 data submissions were formalized in the 2026 Data Submission Guide: <https://hcai.ca.gov/wp-content/uploads/2026/06/OHCA-Medi-Cal-Payments-Addendum-April-2026.pdf>

Quality and Equity Performance Measure Set Update: Proposal to Add Healthcare Associated Infection Measures for Hospitals

Measures for Payers and Physician Organizations

Measure Name (*Measures for payers only)	Measure Category
Childhood Immunization Status	Process
Colorectal Cancer Screening	Process
Controlling High Blood Pressure	Outcome
Glycemic Status Assessment for Patients With Diabetes (<8.0% and/or >9.0%)	Outcome
All-Cause Readmissions	Outcome
Asthma Medication Ratio	Process
Breast Cancer Screening Rate	Process
Child and Adolescent Well-Care Visits	Process
Immunizations for Adolescents	Process
Depression Screening and Follow-Up for Adolescents and Adults (Depression Screening and Follow-Up on Positive Screen)*	Behavioral health, Process
CAHPS Health Plan Survey: Getting Needed Care (Adult and Child survey) or QHP Enrollee Experience Survey*	Access, Patient reported outcome or patient experience
Prenatal and Postpartum Care (Postpartum Care and Timeliness of Prenatal Care)*	Process
Well-Child Visits in the First 30 Months of Life (0 to 15 Months and 15 to 30 Months)*	Process

Sources: DMHC Licensing eFiling. (2024, June 28). APL 24-013 – Health Equity and Quality Program Policies and Requirements (6/28/2024). [https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL24-013-HealthEquityandQualityProgramPoliciesandRequirements\(6_28_2024\).pdf?ver=9wJvJOJ61DNjXvVpRgHqeQ%3d%3d](https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL24-013-HealthEquityandQualityProgramPoliciesandRequirements(6_28_2024).pdf?ver=9wJvJOJ61DNjXvVpRgHqeQ%3d%3d;); OPA. (2024). Health Care Quality Report Cards. <https://www.iii.ca.gov/consumer-reports/health-care-quality-report-cards/>; In the DMHC Health Equity and Quality Measure Set, 146 CAHPS Child Survey is only for applicable Medicaid plans. CAHPS health plan survey does not apply to Exchange plans. Exchange plans will report to the DMHC on the QHP Enrollee Experience Survey in measurement year 2024.

Measures for Hospitals

Measure Name	General Acute Hospital Measures	Acute Psychiatric Hospital Measures	Children's Hospital Measures	Measure Categories
Designate an individual to lead hospital health equity activities	X	X	X	Structural
Hospital Commitment to Health Equity Structural Measure	X	X	X	Structural
Provide documentation of policy prohibiting discrimination	X	X	X	Structural
Report percentage of patients by preferred language spoken	X	X	X	Structural
Screen Positive Rate for Social Drivers of Health	X	X	X	Structural
Screening for Social Drivers of Health	X	X	X	Structural
All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavior health diagnosis	X	X		Outcome, Behavioral health
HCAHPS survey (Received information and education and would recommend hospital)	X	X		Patient reported outcome or patient experience
Pneumonia Mortality Rate	X	X		Outcome
All-Cause Unplanned 30-Day Hospital Readmission Rate	X		X	Outcome
Cesarean Birth Rate (NTSV)	X			Outcome
Death Rate among Surgical Inpatients with Serious Treatable Complications	X			Safety, Outcome
Exclusive Breast Milk Feeding	X			Process
Vaginal Birth After Cesarean Rate (VBAC)	X			Outcome
All-Cause Unplanned 30-Day Hospital Readmission Rate in an inpatient psychiatric facility		X		Outcome, Behavioral health
Screening for metabolic disorders		X		Process
SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge		X		Behavioral health, Process
Pediatric experience survey with scores of willingness to recommend the hospital			X	Patient reported outcome or patient experience
Clostridioides difficile infections (CDI) – Proposed	X		X	Safety
Catheter-associated Urinary Tract Infection (CAUTI) – Proposed	X		X	Safety
Central line-associated Blood Stream Infection (CLABSI) – Proposed	X		X	Safety
Methicillin-resistant Staphylococcus aureus (MRSA) – Proposed	X		X	Safety

Sources: HCAI. (n.d.). *Hospital Equity Measures Reporting Program*. <https://hcai.ca.gov/data/healthcare-quality/hospital-equity-measures-reporting-program/>. CDPH (n.d.) *HAI Program*. <https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/HAIProgramHome.aspx>. CDC (n.d.) *HAIs*. <https://www.cdc.gov/healthcare-associated-infections/index.html>.