

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

Health Care Affordability Board Meeting

September 23, 2026



Department of Health Care
Access and Information



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

Welcome, Call to Order, and Roll Call



Department of Health Care
Access and Information

Agenda

Item #1 **Welcome, Call to Order, and Roll Call**
Secretary Kim Johnson, Chair

Item #2 **Executive Updates**
Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director

Item #3 **Action Consent Item**
Vote to Approve August 26, 2026, Meeting Minutes
Vishaal Pegany

Item #4 **Informational Items**

a) Cost-Reducing Strategy Presentation: Rady Children's Health Orange County Pediatric Value-based Care **(Cancelled)**
Margareta Brandt, Dr. Michael Weiss, F.A.A.P., V.P. Population Health, Rady Children's Health Orange County

b) Spending Target Enforcement- Target Values for PIP Implementation, and Follow up on feedback from Enforcement Workshop
Vishaal Pegany; CJ Howard

c) Follow Up Request on Hospital Measurement – Combining Inpatient and Outpatient Spending Measures and Issues related to Volatility in Hospital-Reported Net Patient Revenue
Vishaal Pegany; Andrew Feher

d) Examining Regional Variation in Commercial Prices for Shoppable Services and Projected Savings from Reference Pricing
Andrew Feher

e) Cost and Market Impact Review: Quarterly Update
Brian Kearns, Assistant Deputy Director

Item #5 **General Public Comment**

Item #6 **Adjournment**

The agenda order is tentative and subject to change without prior notice.



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

Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director



2027 Public Meeting Calendar

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Health Care Affordability Board Meetings

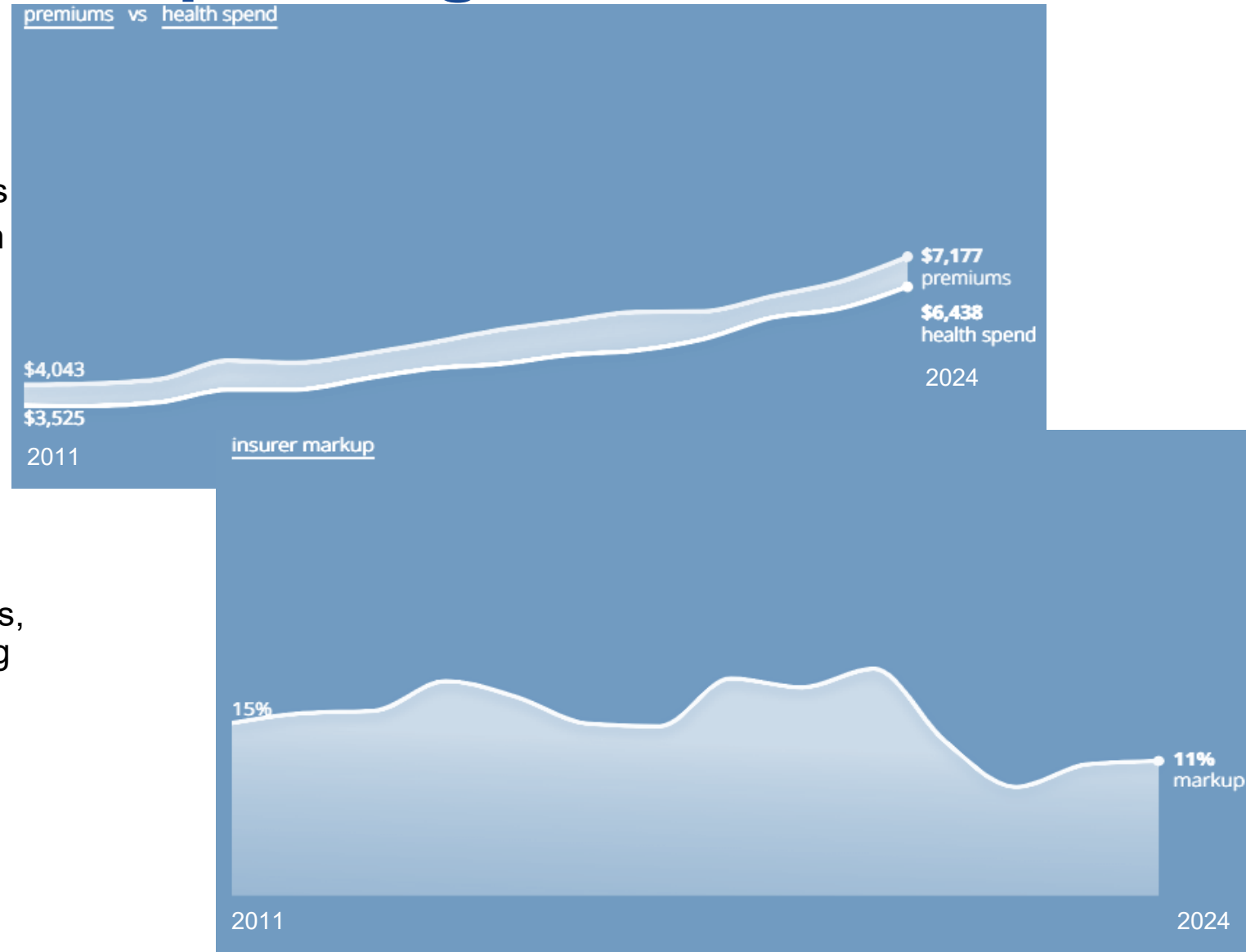
- Wednesday, January 27
- Wednesday, February 24
- Wednesday, March 24
- Wednesday, April 28
- Wednesday, May 26
- Wednesday, June 23
- Wednesday, July 28
- Wednesday, August 25
- Wednesday, September 22
- Wednesday, October 27
- Wednesday, November 17
- Wednesday, December 15

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 September 2026 Publications

- Earlier this month, 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. OHCA has requested feedback by October 9th, 2026.
- In addition, OHCA posted a cost driver [issue brief](#) using Health Care Payments Database data to examine commercial price variation in shoppable services.

Slide Formatting



Indicates informational items for the Board and decision items for OHCA



Indicates current or future action items for the Board



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

Action Consent Item: Vote to Approve August 26, 2026 Meeting Minutes





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



Department of Health Care
Access and Information



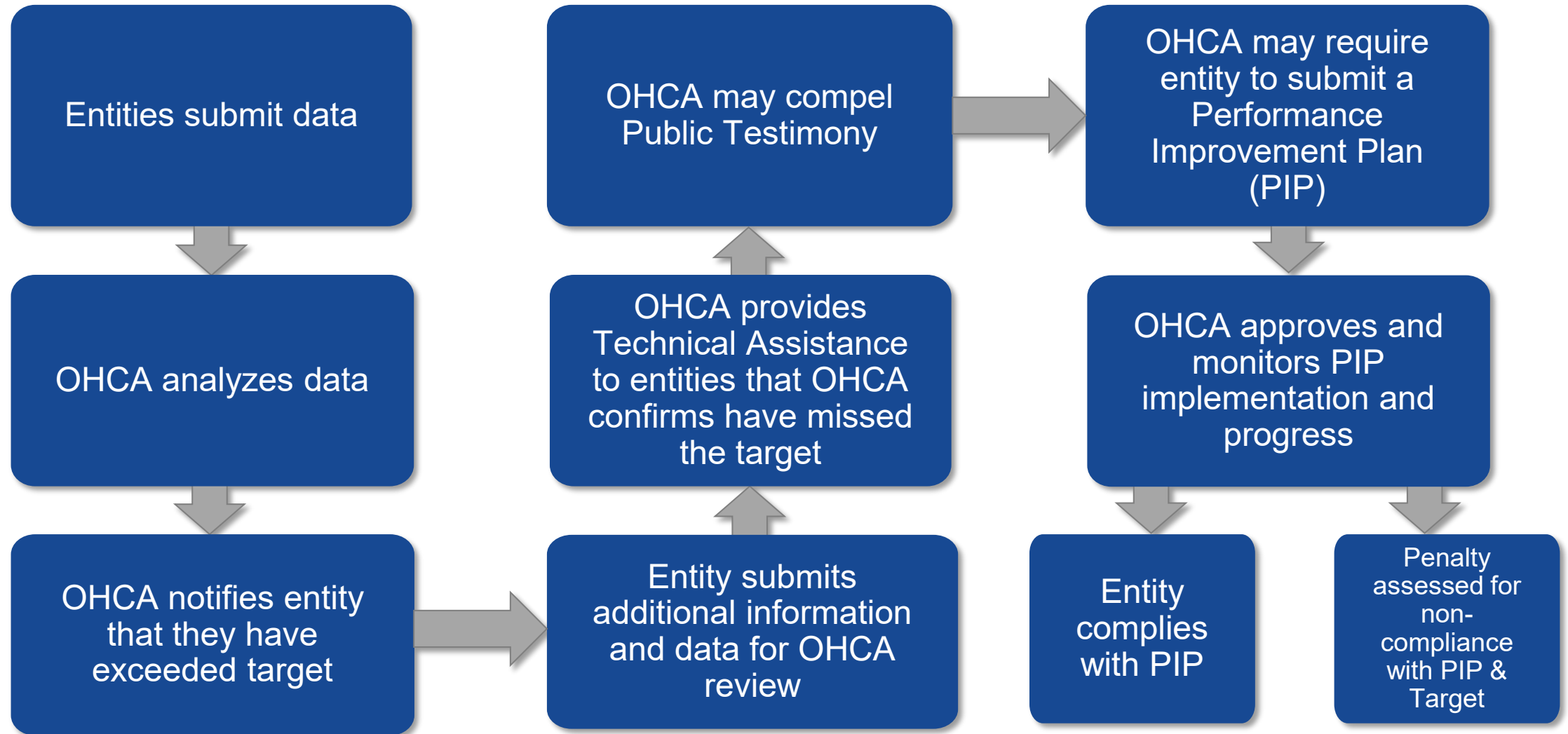
Office of Health Care Affordability
Department of Health Care Access and Information

Spending Target Enforcement - Target Values for PIP Implementation and Follow up on feedback from Enforcement Workshop

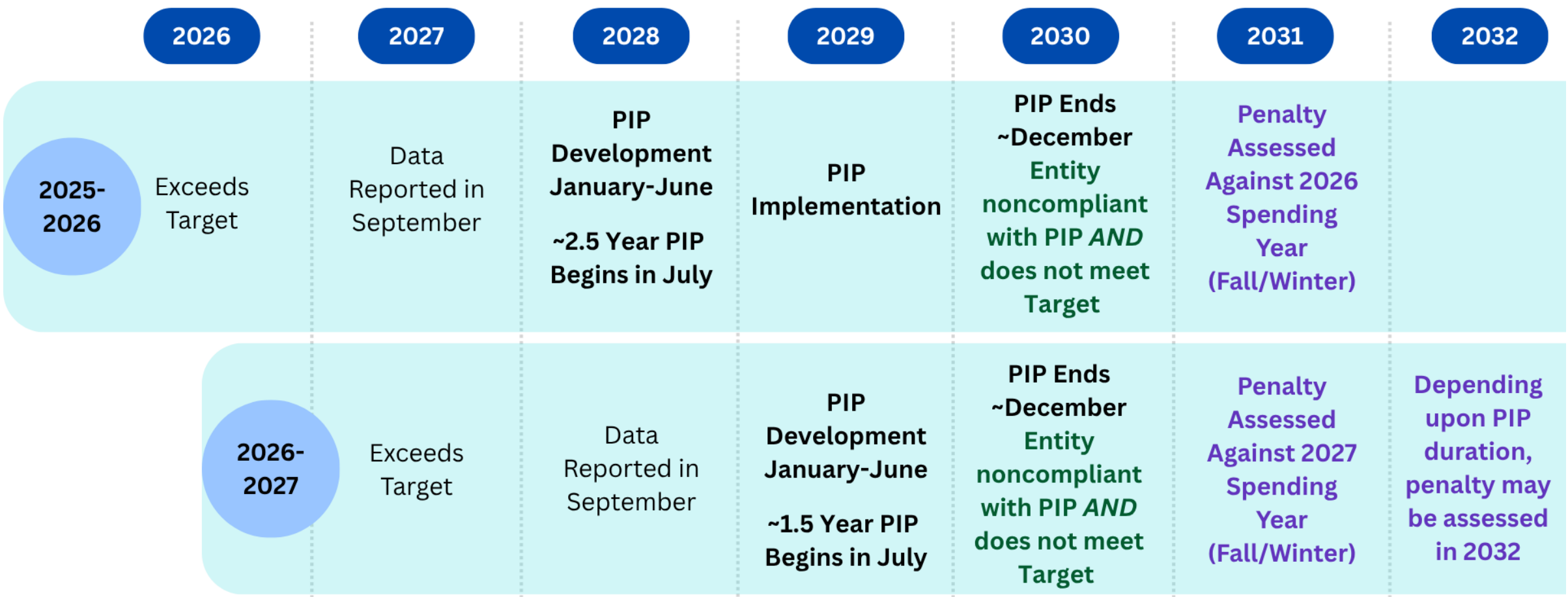
Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director



OHCA Progressive Enforcement Process



Potential Enforcement Timeline for Health Plans



Target Values for PIP 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?

Target Values for PIP 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.

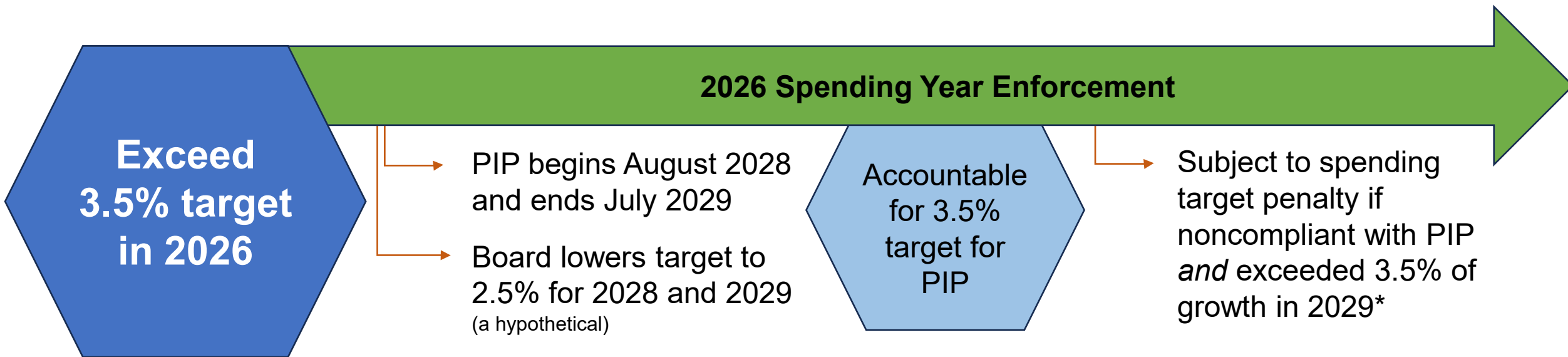
Target Values for PIP Implementation

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

Recommendation: 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 PIP Implementation

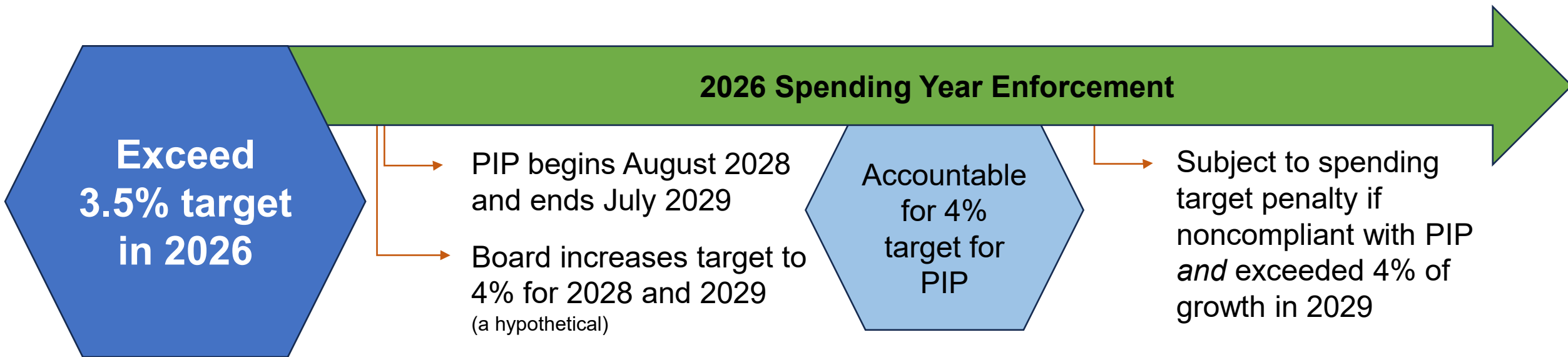
Example - Lower target value is established by the Board for a future year compared with the target that prompted enforcement.



***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 hypothetical target of 2.5% in 2029.

Target Values for PIP Implementation

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





Discussion: Target Values for PIP Implementation

Does the Board have any input on OHCA's recommendation on target values for PIP implementation?

Follow Up: Feedback from PIP Workshop

- OHCA hosted 4 workshops for health care entities on the spending target enforcement process, with a focus on obtaining feedback on performance improvement plans (PIPs) in June and July 2026.
- Feedback from entities shared during the workshops was presented at the August 2026 Board meeting.
- All letters received by a July 31 deadline to provide comment on the draft PIP Guidance and overall enforcement process were included in August Board meeting materials.
- The following slides provide a high-level summary of comments from the letters, organized by progressive enforcement step.

Follow Up: Feedback from PIP Workshop

Topic	Comment
Assessing Performance	• Commenters urged OHCA to promulgate regulations that standardize the process for explaining excess growth, explain how spending growth will be assessed against the target, and consider a multi-year assessment of spending. • Commenters shared concern that OHCA has not explained how growth will be assessed against the target. • A commenter asked that OHCA develop a process that accounts for the complexity of pediatric health care. • Commenters urged OHCA to be transparent about how OHCA applies enforcement considerations and selects entities for progressive enforcement. • Commenters urged OHCA to consider reasonable drivers of spending growth as enforcement considerations, such as: timely access and quality performance; factors outside of an entity's control; new legal mandates such as AB 2975's safety requirements; public hospital Medi-Cal financing; organized and nonorganized labor costs; and more. • A commenter urged OHCA to account for hospitals' Disproportionate Share Hospital (DSH) status, critical access hospital designation, total yearly uncompensated care burden, rural hospital status, and Health Professional Shortage Area (HPSA) designation.

Follow Up: Feedback from PIP Workshop

Topic	Comment
Waiver of Enforcement	• A commenter urged OHCA to establish a waiver process.
Technical Assistance (TA)	• Commenters asked that TA be a meaningful part of the enforcement process.
Public Testimony (PT)	• A commenter argued that PT should be reserved for entities acting in bad faith or for repeated violations.
Performance Improvement Plans (PIPs)	• Commenters urged that PIPs be collaborative and prioritized over penalties. • Commenters urged OHCA to protect confidential information submitted as part of a PIP with a standardized process. • A commenter urged OHCA to consolidate overlapping PIPs where appropriate. • Commenters stated that OHCA must provide a meaningful and realistic opportunity to improve via PIPs before imposing penalties.

Follow Up: Feedback from PIP Workshop

Topic	Comment
Performance Improvement Plans (PIPs)	• One commenter urged OHCA to give hospitals a minimum of 3 years to implement a PIP. • Commenters agreed that PIPs should be forward-looking. • Commenters asked that entities be given more time to submit a PIP. • A commenter argued that entities not face penalties for missed PIP milestones.
Spending Target Penalties	• A commenter argued that the initially commensurate amount should be reduced by costs explained during the enforcement considerations process. • Commenters suggested that OHCA consider factors when adjusting the penalty size, such as whether the entity is part of a larger system or independent; the entity's reserve amount; investments to reduce long-run spending; initiatives to improve access; good faith efforts to implement a PIP; and more. • A commenter asked that OHCA apply adjustment factors transparently and consistently. • Commenters argued that the proposed penalty structure would lead to large penalties that risk significant instability and the closure of services and facilities. • Commenters worried about the impact of penalties on specialized facilities like academic medical centers.

Follow Up: Feedback from PIP Workshop

Topic	Comment
Spending Target Penalties	• Commenters suggested alternative penalty approaches, such as a tiered approach with a more reasonable maximum penalty amount or a cap on penalties at the level of a hospital's patient care earnings.
General Enforcement	• Commenters urged OHCA to validate and test its measurement methodology and a commenter recommended that OHCA reconvene the Hospital Spending Workgroup. • Commenters urged OHCA to combine the inpatient and outpatient measures for hospitals. • Commenters shared concerns about the ability of the proposed enforcement process to balance affordability with access, quality, workforce stability, and equity. • Commenters shared concerns about the impact of the target on their ability to provide financial assistance to patients. • Commenters shared concerns about the multiple ways entities can exceed the target, across multiple lines of business. One commenter urged OHCA to refrain from simultaneous enforcement across multiple lines of business. • Commenters urged OHCA to ensure entities have meaningful opportunities to come into compliance with the target.

Follow Up: Feedback from PIP Workshop

Topic	Comment
General Enforcement	• Commenters shared that the target and enforcement will exacerbate measures already taken due to H.R.1 like workforce reductions and pauses on investments in areas like patient care improvements and equipment. • Commenters called the spending target a “one-size-fits-all” approach that does not fit all entity types, including specialized care facilities. • A commenter urged OHCA to clarify how it will coordinate with other regulators.

Clarifications on Enforcement

- Health and Safety Code section 127502.5(c)(1) does not permit OHCA to approve PIPs for an implementation period beyond 3 years.
- Prior to assessing penalties, OHCA would engage with entities through technical assistance, potentially public testimony, and performance improvement plans, which may be up to three years.
- Penalty justification factors would allow OHCA to consider factors like changes in state and federal policy, financial distress or large reserves, affiliated entities, and more, when determining the final penalty amount.
- OHCA has reported on health care spending using measures for health plans (June 2025), hospitals (April 2026), and physician organizations (June 2026).



Office of Health Care Affordability
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Public Comment





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Follow-Up Request on Hospital Measurement – Combining Inpatient and Outpatient Spending Measures and Issues related to Volatility in Hospital-Reported Net Patient Revenue

*Vishaal Pegany, Deputy Director
Andrew Feher, Research Scientist Manager*



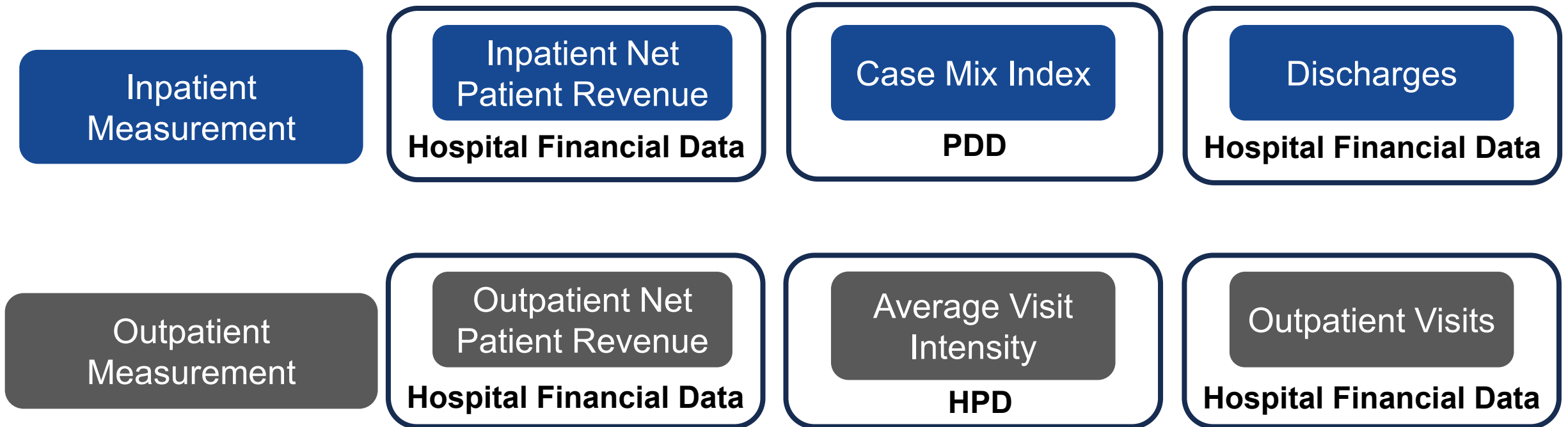
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Background on Development of Hospital Measurement

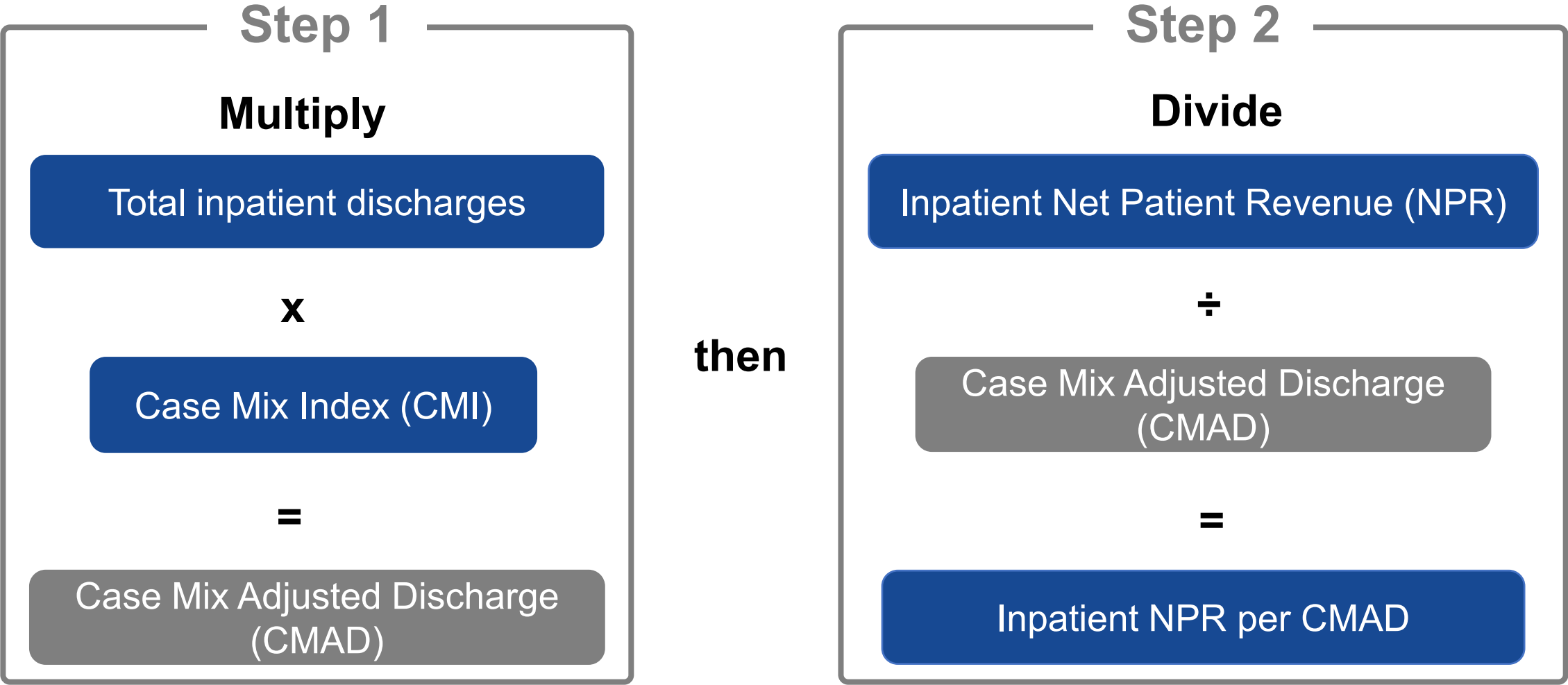
- From April 2024 to December 2025, OHCA convened a Hospital Workgroup, soliciting input from key stakeholders on its approach to inpatient and outpatient measurement.
- At the December 2025 Board meeting, OHCA presented its methodology for measuring inpatient and outpatient spending and indicated it would revisit a combined measure.
- Since then, hospital stakeholders--through the Progressive Enforcement Workshop and public comment--requested that OHCA implement an approach for combining inpatient and outpatient spending growth. As shown on the subsequent slides, a combined growth measure would result in hospitals having up to three spending growth measures for assessing performance (similar to payers and physician organizations):
 - Commercial spending growth
 - Medi-Cal spending growth
 - Medicare spending growth
- The update to the approach involves weighting inpatient and outpatient growth based on each service line's share of net patient revenue in the base measurement year.

Measurement Data Sources

- For its inpatient measure, OHCA uses Hospital Financial Report data and Patient Discharge Data (PDD).
- For its outpatient measure, OHCA uses Hospital Financial Report data and the Healthcare Payments Data (HPD).

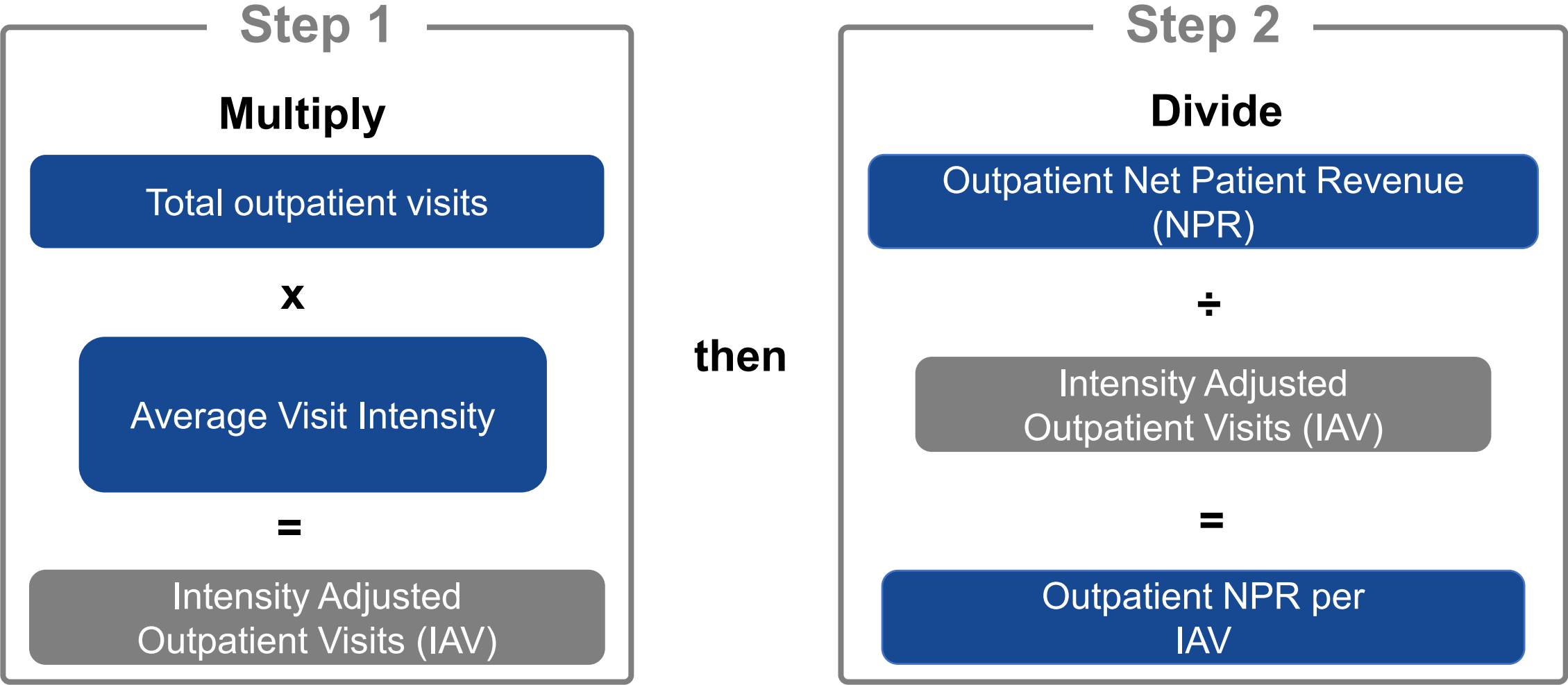


OHCA Methodology to Measure Hospital Inpatient Spending



Note: OHCA would report the metric by payer type (e.g., Commercial, Medicare and Medi-Cal).

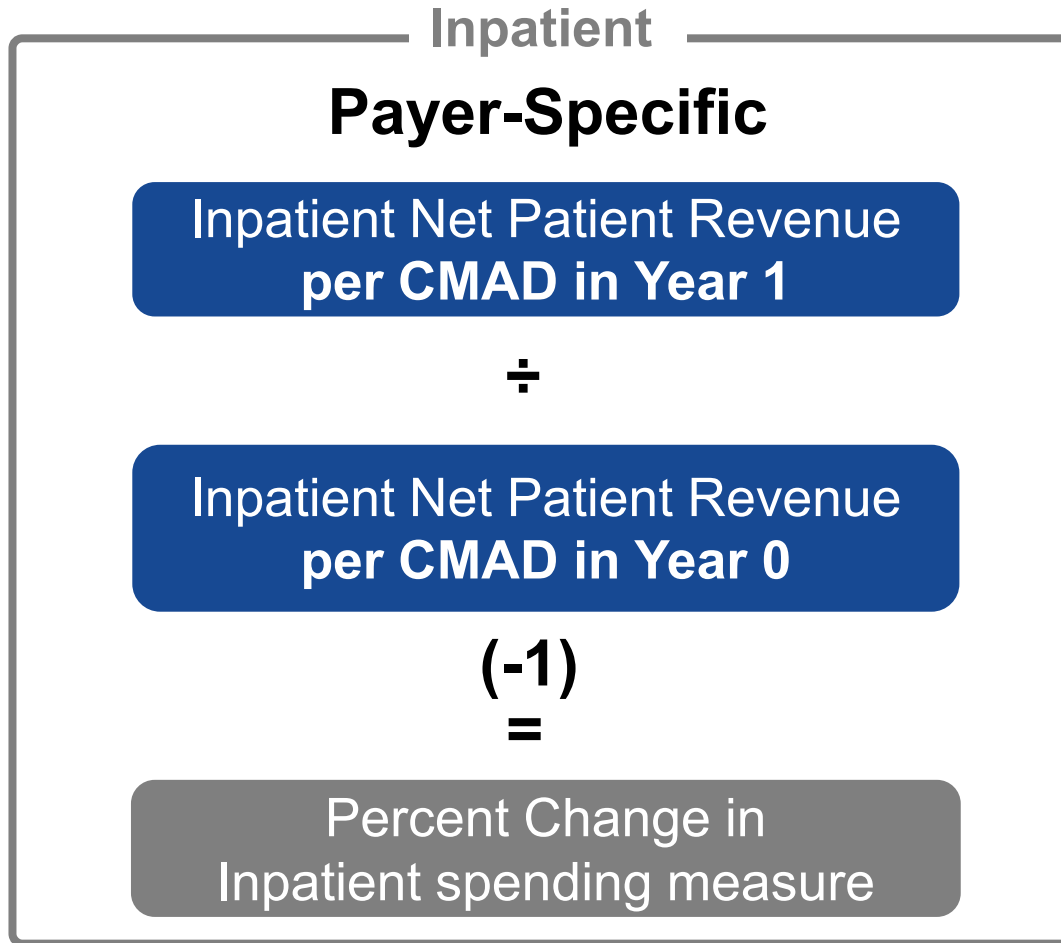
OHCA Methodology to Measure Hospital Outpatient Spending



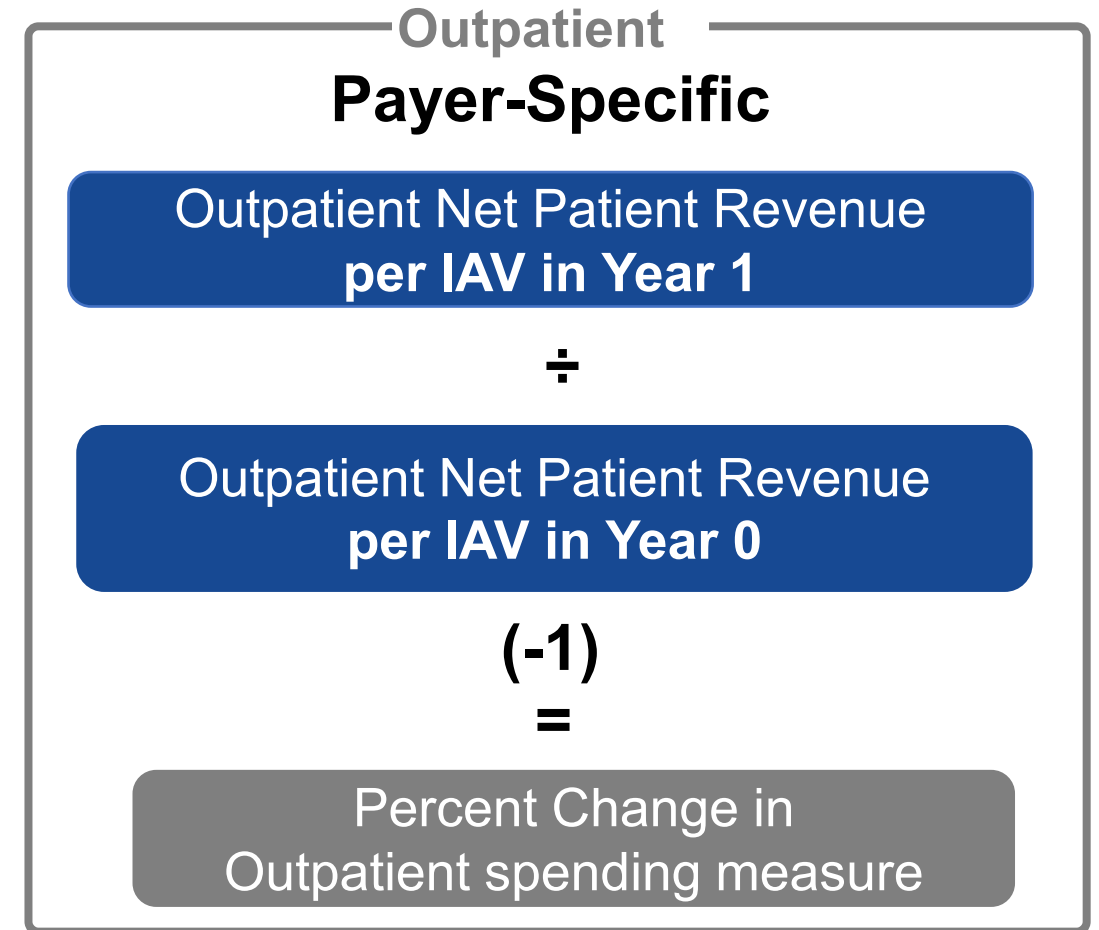
Note: OHCA would report the metric by payer type (e.g., Commercial, Medicare and Medi-Cal).

Methodology for Combined Growth Measure

First, we calculate spending measure (volume and intensity adjusted) percentage change between Year 1 and Year 0 for each payer, and for inpatient and outpatient separately.



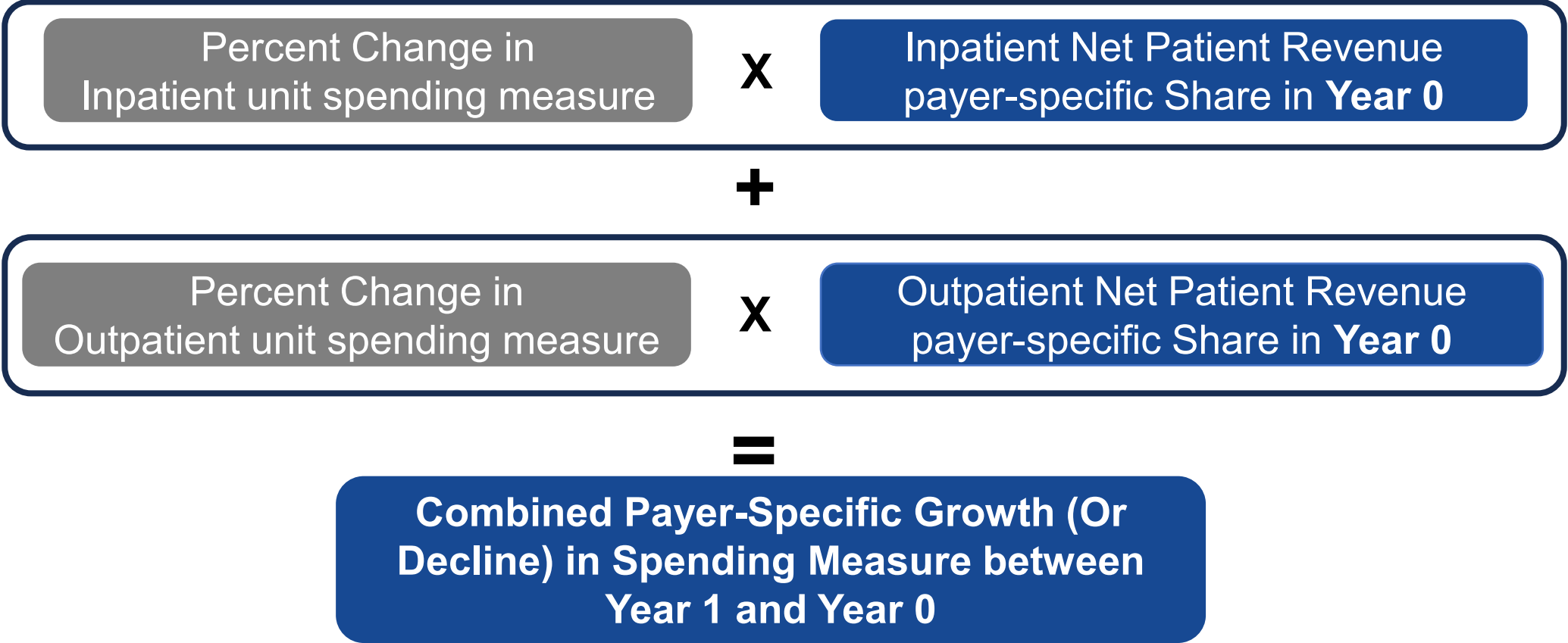
and



Note: OHCA reports the metric by payer type (e.g., Commercial, Medicare and Medi-Cal).
IP NPR per CMAD= Inpatient Net Patient Revenue per Case Mix Adjusted Discharge
OP NPR per IAV= Outpatient Net Patient Revenue per Intensity Adjusted Visit

Methodology for Combined Growth Measure

Then, using net patient revenue share for inpatient and outpatient in Year 0 as our weight, we calculate weighted combined growth for the facility for each payer type.



Note: OHCA reports the metric by payer type (e.g., Commercial, Medicare and Medi-Cal).

Example of the Combined Growth Measure Calculation

- In the example below, we calculate three payer-specific combined growth measures. For commercial, the facility has 4.5% growth for inpatient and 2.5% growth for outpatient. Using the net patient revenue share for inpatient and outpatient as our weight, we calculate combined commercial growth of 3.4%.
- For Medicare, the facility has -2% growth for inpatient and 0.6% growth for outpatient. The facility's combined growth is -1.4% since inpatient revenue in the base year represents 90% of Medicare NPR.
- For Medi-Cal, since outpatient net patient revenue is zero, then inpatient spending is given 100% weight. This means the combined growth is equal to inpatient spending change, which is 7.0%.

Payer	Measure	2022	2023	Change (%)	2022 Share of NPR by market	Weighted growth	Market Combined Growth Measure
		A	B	$C=100*(B/A)-1$	D	$E=C*D$	Sum of E by market
Commercial	Inpatient	22,000	23,000	4.5%	45%	2.0%	3.4%
	Outpatient	200	205	2.5%	55%	1.4%	
Medicare	Inpatient	9,000	8,800	-2.2%	90%	-1.98%	-1.4%
	Outpatient	50	53	6.0%	10%	0.6%	
Medi-Cal	Inpatient	14,200	15,200	7.0%	100%	7.0%	7.0%
	Outpatient	n/a	n/a	-	0	0	

Note: Hospital A values are hypothetical values for demonstration purposes. Inpatient indicator is IP NPR per CMAD = Inpatient Net Patient Revenue per Case Mix Adjusted Discharge, outpatient indicator is OP NPR per IAV= Outpatient Net Patient Revenue per Intensity Adjusted Visit

Combined Growth Measure: Descriptive Statistics

- Using the methodology described on the prior slides, we can calculate the combined growth measure for 334 comparable facilities for commercial, 339 for Medicare, and 334 for Medi-Cal.
- Calculations depend on Average Visit Intensity for Outpatient and Case Mix Index for Inpatient Measures. If a facility is missing one of these intensity measures but has non-zero revenue from the category, we are unable to calculate an accurate combined growth measure.

Combined Growth Measure, Number of Facilities with Calculated Measures, Unweighted

Indicator/Number of Facilities	Inpatient Growth (#)	Outpatient Growth (#)	Combined Growth Measure (#)
Commercial	352	309	334
Medicare	350	310	339
Medi-Cal	345	286	334

Commercial Combined Growth Measure 2022-23

- Out of 334 facilities, 177 facilities (53%) had commercial combined growth at or below 3.5% growth between 2022 and 2023.
- In comparison, 52.6% had commercial inpatient and 50% had commercial outpatient spending measure growth at or below 3.5%.

Commercial Inpatient, Outpatient and Combined Growth Measure Categories, Number of Facilities, 2022-23

	Inpatient		Outpatient		Combined	
Spending Measure Growth Rate	Number	% of Total	Number	% of Total	Number	% of Total
<=3.5%	185	53%	154	50%	177	53%
3.5-10%	58	16%	49	16%	55	17%
10-20%	36	10%	34	11%	48	14%
20-50%	40	11%	42	14%	30	9%
50%+	33	9%	30	10%	24	7%
Total Facilities with a Calculated Measure	352	100%	309	100%	334	100%

Note: All calculations are based on intensity and volume adjusted spending measures. For Inpatient this is IP NPR per CMAD= Inpatient Net Patient Revenue per Case Mix Adjusted Discharge and for Outpatient, this is OP NPR per IAV= Outpatient Net Patient Revenue per Intensity Adjusted Visit

Medicare Combined Growth Measure 2022-23

- Out of 339 facilities, 185 facilities (55%) had Medicare combined growth at or below 3.5% growth between 2022 and 2023.
- In comparison, 59% for inpatient measure growth and 50 percent for outpatient measure growth were below 3.5%.

Medicare Inpatient, Outpatient and Combined Growth Measure Categories, Number of Facilities, 2022-23

	Inpatient		Outpatient		Combined	
Spending Measure Growth Rate	Number	% of Total	Number	% of Total	Number	% of Total
<=3.5%	207	59%	156	50%	185	55%
3.5-10%	54	15%	34	11%	60	18%
10-20%	38	11%	42	14%	50	15%
20-50%	29	8%	42	14%	27	8%
50%+	22	6%	36	12%	17	5%
Total Facilities with a Calculated Measure	350	100%	310	100%	339	100%

Note: All calculations are based on intensity and volume adjusted spending measures. For Inpatient this is IP NPR per CMAD= Inpatient Net Patient Revenue per Case Mix Adjusted Discharge and for Outpatient, this is OP NPR per IAV= Outpatient Net Patient Revenue per Intensity Adjusted Visit

Medi-Cal Combined Growth Measure 2022-23

- Out of 334 facilities, 170 facilities (51%) had Medi-Cal combined growth at or below 3.5% growth between 2022 and 2023.
- In comparison, 54% for inpatient measure growth and 53% for outpatient measure growth were below 3.5%.

Medi-Cal Inpatient, Outpatient and Combined Growth Measure Categories, Number of Facilities, 2022-23

	Inpatient		Outpatient		Combined	
Spending Measure Growth Rate	Number	% of Total	Number	% of Total	Number	% of Total
<=3.5%	186	54%	151	53%	170	51%
3.5-10%	27	8%	24	8%	32	10%
10-20%	51	15%	36	13%	46	14%
20-50%	61	18%	45	16%	63	19%
50%+	20	6%	30	10%	23	7%
Total Facilities with a Calculated Measure	345	100%	286	100%	334	100%

Note: All calculations are based on intensity and volume adjusted spending measures. For Inpatient this is IP NPR per CMAD= Inpatient Net Patient Revenue per Case Mix Adjusted Discharge and for Outpatient, this is OP NPR per IAV= Outpatient Net Patient Revenue per Intensity Adjusted Visit

Combined Growth Measure: Descriptive Statistics

- The combined growth measure reduces dispersion in growth rates compared with the standalone inpatient and outpatient spending measures.
- But large positive and negative growth rates remain due to (1) volatility in hospital-reported net patient revenue from year to year and (2) low utilization volume.

Combined Growth Measure vs Inpatient and Outpatient Spending Measure Growth between 2022- 2023, Descriptive Statistics, Unweighted

Commercial	Min	1st p*	25th p	Median	Mean	75th p	99th p	Max
Combined	-78%	-53%	-8.6%	2.4%	8.8%	13.3%	193%	540%
IP	-96%	-72%	-12.0%	2.3%	39%	13.1%	473%	9210%
OP	-99%	-71%	-10.1%	3.8%	11.6%	15.9%	205%	444%

Medicare	Min	1st p*	25th p	Median	Mean	75th p	99th p	Max
Combined	-62%	-50%	-7.3%	2.2%	7.5%	12.1%	117%	864%
IP	-148%	-69%	-8.4%	0.8%	7.1%	10.3%	222%	864%
OP	-123%	-81%	-8.7%	3.2%	16.9%	20.4%	364%	885%

Medi-Cal	Min	1st p*	25th p	Median	Mean	75th p	99th p	Max
Combined	-91%	-61%	-9.6%	3.2%	7.3%	20.6%	120%	241%
IP	-93%	-61%	-11.9%	1.0%	6.7%	18.5%	144%	430%
OP	-94%	-74%	-13.6%	1.5%	8.2%	21.5%	177%	293%

Note: IP refers to Growth in Inpatient Net Patient Revenue per CMAD, and OP refers to Growth in Outpatient Net Patient Revenue per IAV

*p indicates percentile in all three tables



Discussion: Follow-Up Request on Hospital Measurement

Does the Board have any input on OHCA's approach to combining inpatient and outpatient spending growth to measure hospital performance against the target?

Issues in Volatility in Hospital-Reported Net Patient Revenue

- OHCA received questions regarding some hospitals showing significant year-over-year growth rates for inpatient and outpatient spending.
- Hospital financial data is submitted to HCAI following the [HCAI Accounting and Reporting Manual](#), which is informed by generally accepted accounting principles (GAAP). Both the inpatient and outpatient spending measure calculations depend on hospital-reported net patient revenue (NPR) values and allocation across payers. Often these allocations are based on projected or expected payment amount. If the realized amount and source of payment differs from the projected or expected, hospitals may adjust that in the next year's statements.
 - For example, if a hospital is projected to receive \$100 from commercial insurers in 2022, but only receive \$60, they will include \$40 as a contractual adjustment in the 2023 statement, reducing net revenue in 2023.
- When hospitals make these contractual adjustments or make changes to the methodology for applying contractual adjustments between years, this can cause substantial fluctuations in hospital-reported NPR, impacting year-over-year growth calculations.

Issues in Volatility in Hospital-Reported Net Patient Revenue

- Some hospitals have also noted that the volatility in year-over-year growth is also appearing in Medi-Cal and Medicare, markets where fee-for-service rates can be administratively set and managed care rates can be negotiated.
- Critical access hospitals that are reimbursed on a cost reporting basis by Medi-Cal and Medicare also note there may be swings in year-over-year growth due to changes in patient volumes or reimbursement levels.
- For some children's hospitals serving very few Medicare patients, there may also be volatility in year-over-year growth for that payer category.

Overview of Gross Patient Revenue to Net Patient Revenue Waterfall

Gross Patient Revenue

MINUS (-)

Deductions from revenue

(e.g., contractual adjustments, bad debt, charity and discounted care)

PLUS (+)

Credit balances

(e.g. teaching hospital clinical training)

PLUS (+)

Capitation Revenue

EQUALS (=)

Net Patient Revenue

Deductions from Revenue

Deductions from revenue include:

- Contractual adjustments to revenue from different payors including but not limited to Medicare, Medi-Cal and Commercial
- Quality incentive program (QIP)
- FFS and health plan supplemental payments associated with the Hospital Quality Assurance Fee (QAF) program
- County indigent programs
- Provisions for bad debt
- Charity and discounted care
- Policy discounts
- Teaching hospitals' teaching allowances
- Administrative adjustments

Examples of Hospital-Reported IP NPR Volatility

- As prior slides indicated, OHCA's measurement approach relies on hospital-reported net patient revenue (NPR).
- In many instances, hospital-reported NPR is the primary driver of year-over-year volatility in OHCA's measurement, inducing large swings in facility-level year-over-year growth rates prior to any application of volume or intensity adjustments.

Hospital A	Commercial Discharges	Commercial CMI	Commercial IP NPR	Commercial IP NPR per CMAD
2022	4,679	1.43	\$53,422,864	\$7,958
2023	4,875	1.40	\$169,207,296	\$24,849
YoY change	4.2%	2.1%	216.7%	212.3%

Hospital B	Medicare Discharges	Medicare CMI	Medicare IP NPR	Medicare IP NPR per CMAD
2022	7,836	1.89	\$317,587,392	21,390
2023	7,735	1.90	\$184,392,640	12,555
YoY change	-1.3%	0.5%	-41.9%	-41.3%

Note: Hospitals do not submit NPR for IP and OP services across all payers for managed care. Current HCAI methodology requires estimating inpatient NPR for managed care by multiplying NPR from managed care by a ratio of gross IP revenue from managed care to gross revenue from managed care. Outpatient revenue is then the residual.

Examples of Hospital-Reported OP NPR Volatility

- We see similarly large swings in aggregate OP NPR.
- When we reached out to hospitals with large swings in aggregate IP or OP NPR, those who got back to us noted (1) changes in consultants who may have had different methodologies for computing contractual adjustments and (2) errors in the allocation of contractual adjustments between IP and OP revenue.

Hospital C	Commercial Visits	Commercial AVI*	Commercial OP NPR	Commercial OP NPR per IAV
2022	37,098	10.5	34,616,820	\$89
2023	36,657	12.0	150,116,544	\$340
YoY change	-1.2%	14.3%	333.7%	282.0%

Hospital D	Commercial Visits	Commercial AVI	Commercial OP NPR	Commercial OP NPR per IAV
2022	2,379	7.2	5,492,234	\$322
2023	2,493	7.5	1,552,673	\$83
YoY change	4.8%	4.2%	-71.7%	-74.2%

Note: Hospitals do not submit NPR for IP and OP services across all payers for managed care. Current HCAI methodology requires estimating inpatient NPR for managed care by multiplying NPR from managed care by a ratio of gross IP revenue from managed care to gross revenue from managed care. Outpatient revenue is then the residual. *AVI= Average Visit Intensity for Outpatient Visits

Examples of Small Number of Observations

Low utilization volume is another driver of year-over-year volatility in OHCA's measurement. Hospitals with very few payer-specific discharges or visits can produce large year-over-year changes in case mix or visit intensity, which in turn produces large swings in unit price growth.

Hospital E	Medicare Discharges	Medicare CMI	Medicare IP NPR	Medicare IP NPR per CMAD
2022	10	1.56	\$286,445	\$18,299
2023	3	4.45	\$75,385	\$5,645
YoY change	-70%	185%	-74%	-69%

Hospital F	Commercial Visits	Commercial AVI	Commercial OP NPR	OP NPR per IAV
2022	246	26.3	\$355,609	\$55
2023	88	71.5	\$614,215	\$97.7
YoY change	-64%	172%	73%	78%

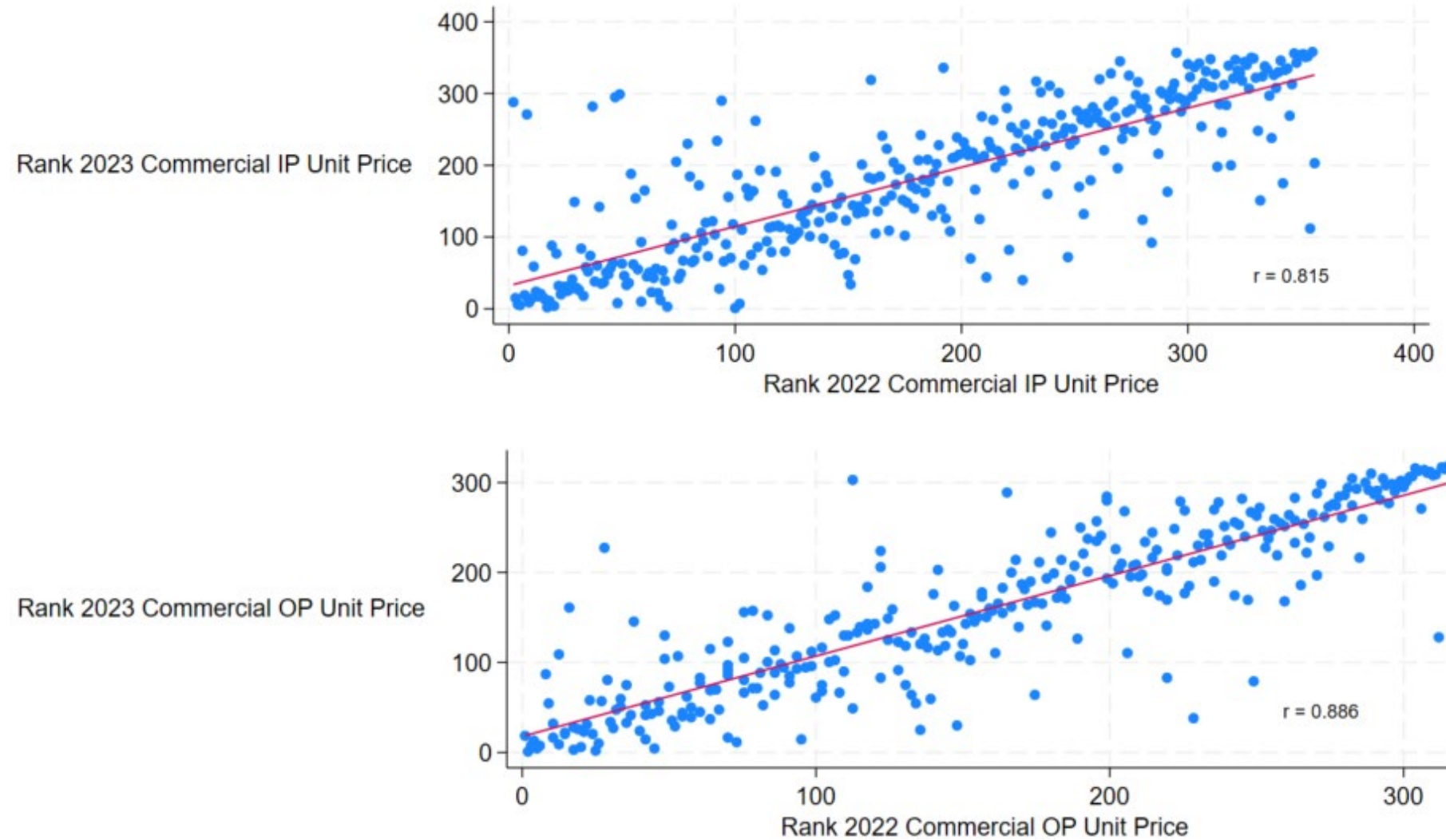
Note: Hospitals currently report net patient revenue by payer but not separately by place of setting, so analysts must estimate inpatient NPR for managed care by multiplying NPR from managed care by a ratio of gross IP revenue from managed care to gross revenue from managed care.

Examining Unit Price Levels Across Years

- Prior slides showed variation in growth rates from fiscal year 2022 to 2023. We can also examine inpatient and outpatient unit prices levels in 2022 and 2023 to understand whether there is similar variability or whether there is hospital-level persistence in price levels across the two years.
- To do so, we use Spearman rank correlations, which allow us to measure how strongly two variables move together in terms of their rank ordering. We sort hospitals by their inpatient and outpatient measures (from lowest to highest) for both years and for each market (Commercial, Medicare and Medi-Cal).
- If, for example, a set of hospitals has a high ranking in its commercial inpatient unit price in both 2022 and 2023, that would yield a strong correlation, indicating the measure is well-equipped to identify high-priced hospitals. By contrast, if a set of hospitals has high ranking in one year but a low ranking in the following year, that would yield a weak correlation, indicating noise in the unit price measure.

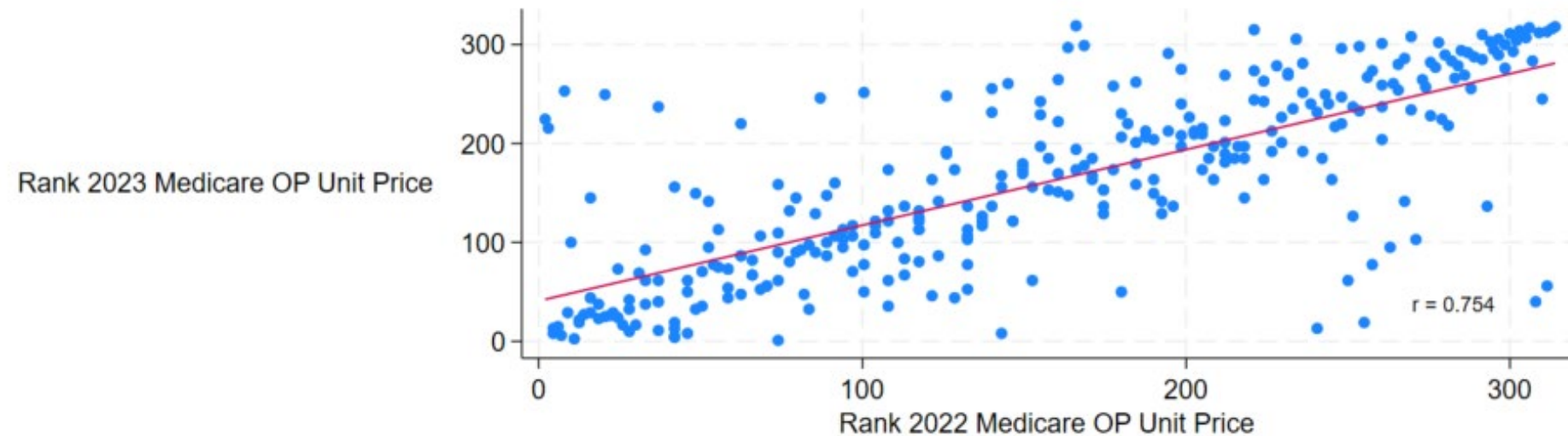
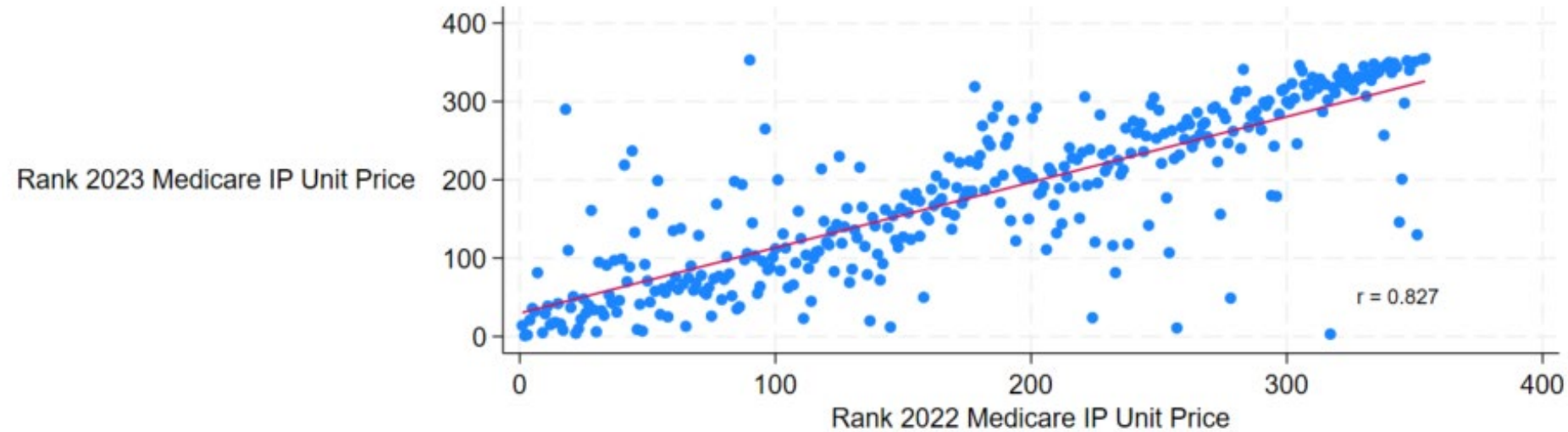
Commercial Inpatient and Outpatient Unit Price Rank Stability

In the commercial market, a hospital's price level compared to other hospitals is strongly, positively correlated from 2022 and 2023 with rank correlations of 0.815 for the IP measure and 0.886 for the OP measure.



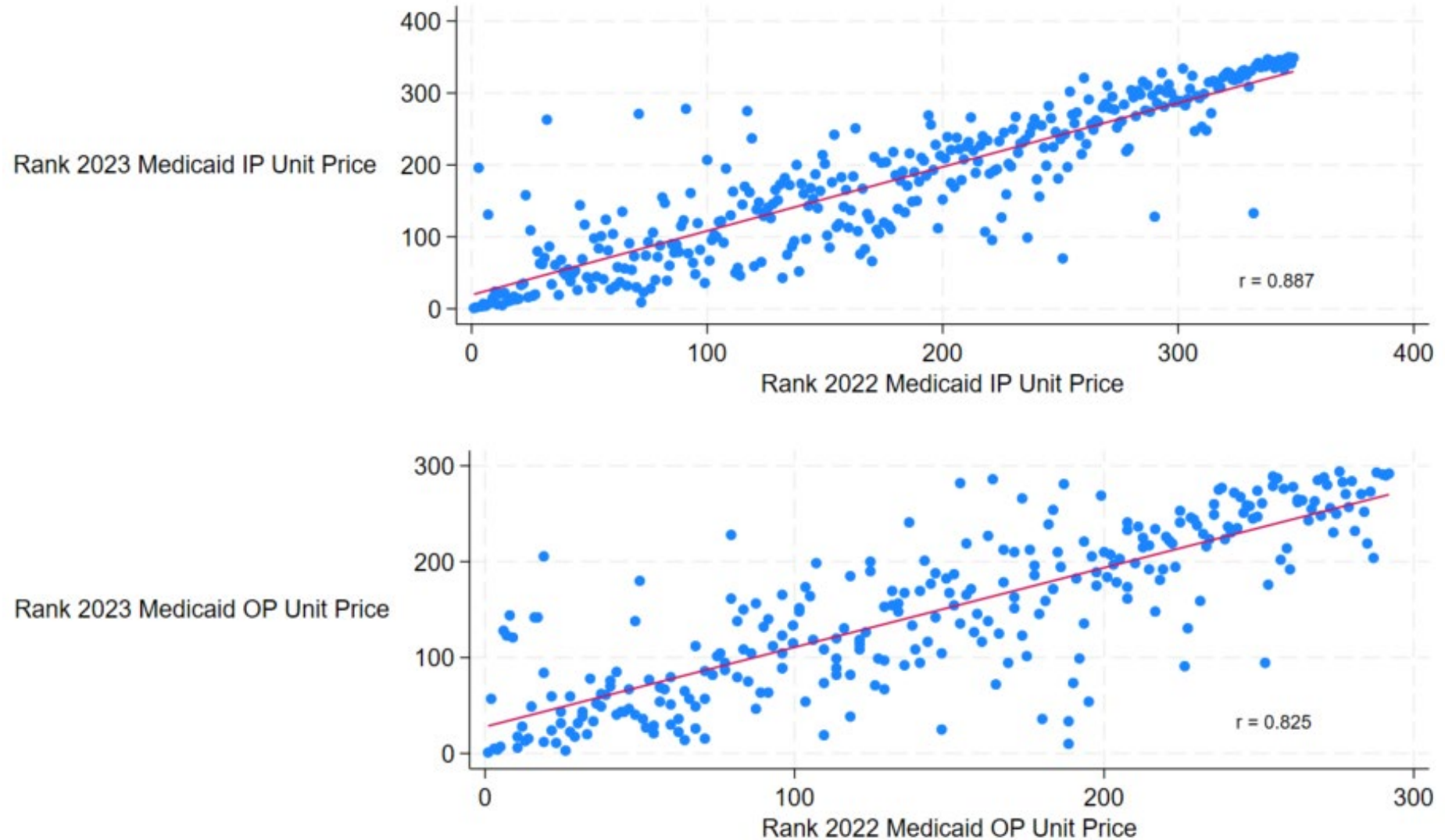
Medicare Inpatient and Outpatient Unit Price Rank Stability

In the Medicare market, a hospital's price level compared to other hospitals is strongly, positively correlated from 2022 and 2023 with rank correlations of 0.754 for the IP measure and 0.827 for the OP measure.



Medi-Cal Inpatient and Outpatient Unit Price Rank Stability

In the Medi-Cal market, a hospital's price level compared to other hospitals is strongly, positively correlated from 2022 and 2023 with rank correlations of 0.887 for the IP measure and 0.825 for the OP measure.



Next Steps on Volatility in Hospital-Reported Net Patient Revenue

- As previously noted, 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.
- In the near-term, hospitals can explain these large year-over-year swings during the 45-day period after they are notified by OHCA that they have exceeded the target.
- In the medium to long-term:
 - As previously mentioned, OHCA can consider additional information provided by the entity during the 45-day period. This can include changes in state and federal law impacting Medicare and Medi-Cal spending. Simultaneously, OHCA will be coordinating with DHCS to understand any state and federal decisions impacting Medi-Cal payments to hospitals.
 - HCAI is currently undergoing a stakeholder process to make changes to the way it collects hospital financial data. OHCA is exploring whether this process can be leveraged to make changes to have a better line of sight into contractual adjustments and reduce volatility in the long-term.
 - Additionally, 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.



Discussion: Follow-Up Request on Hospital Measurement

Does the Board have any input on volatility in hospital-reported NPR and other analyses OHCA shared?



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

Examining Regional Variation in Commercial Prices for Shoppable Services and Projected Savings from Reference Pricing

Andrew Feher



Executive Summary

Background: In prior cost driver analyses, we've examined how changes in utilization and patient characteristics contribute to spending growth, but have yet to explore the role of prices.

Objective: Use 2024 fully insured commercial market data from California's Health Care Payments Database (HPD) to examine regional price variation for 70 health care services the Centers for Medicare and Medicaid Services (CMS) has designated as shoppable – that is, services that can be scheduled in advance, are routinely provided in non-urgent settings, and where quality does not meaningfully vary – and then estimate potential savings under a reference pricing policy.

Findings:

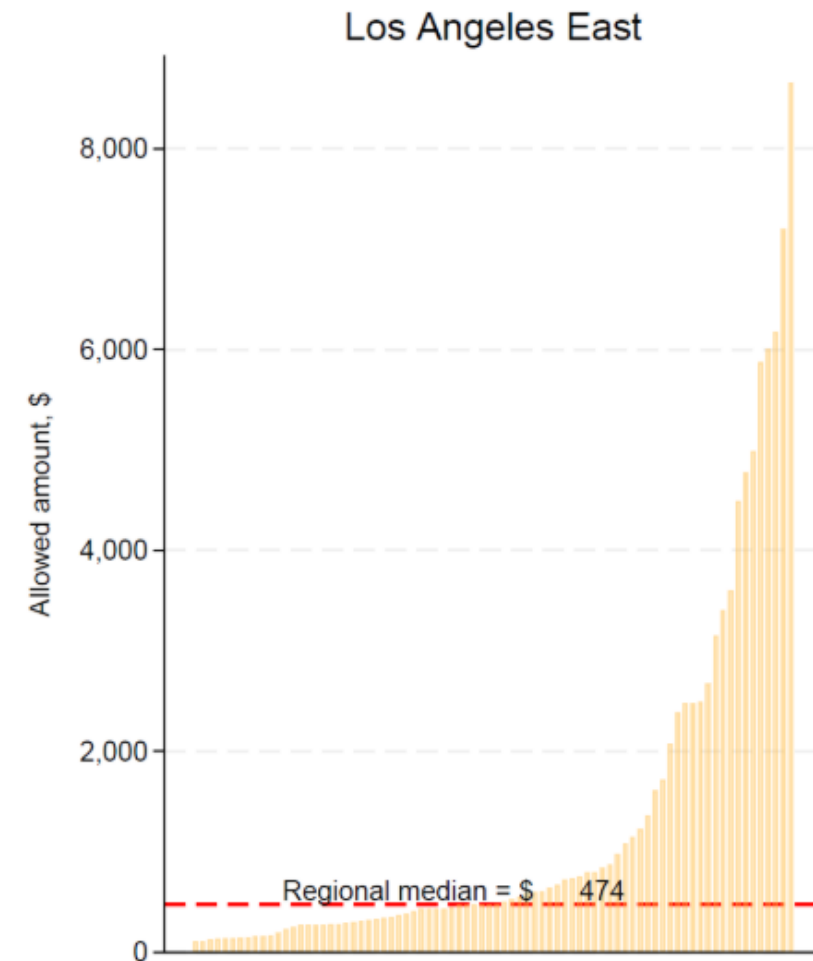
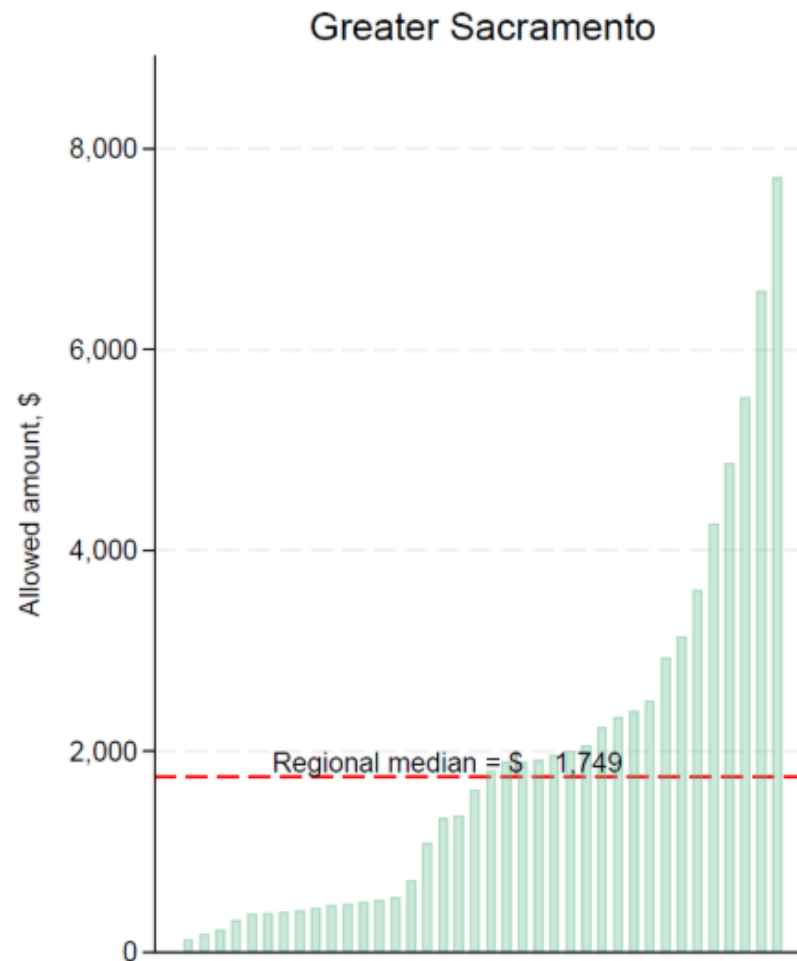
- In 2024, shoppable services represented almost \$4 billion in spending (approximately 9% of claims spending) in California's fully insured commercial market.
- For many of the most common shoppable services, we find that the difference in price between the 10th and the 90th percentile can vary by a factor of ten or more within the same region.
- If health plans, purchasers or policymakers adopted regional reference pricing for shoppable services, aggregate spending in the fully insured commercial market would decrease by \$1.3 billion (or 34.7% of current levels) in a single year.

Empirical Approach

- We used commercial market claims from California-based providers for 2024 from California's HPD.
- We applied the following exclusions:
 - Any encounters under capitation payment arrangements.
 - Any claims that are attributed to CalPERS members since CalPERS has reference pricing on some procedures.
 - If any shoppable services were administered in an emergency room or where patients were admitted in an emergency situation, we exclude these claims from the shoppable categories, but we keep those claims for the purposes of calculating statewide claims spending.
 - Services with negative or \$0 allowed amounts.
- To minimize the effect of outliers, we trimmed any claims that were below the 1st percentile and above the 99th percentile on shoppable procedures or DRG-level statewide.
- Finally, we constructed a service-region-year level dataset and calculated the median, 10th, 25th, 75th and 90th percentiles of allowed amounts within regions for each service. Region was defined based on the Covered California regions representing a county or group of counties in the state and based on rendering provider location.

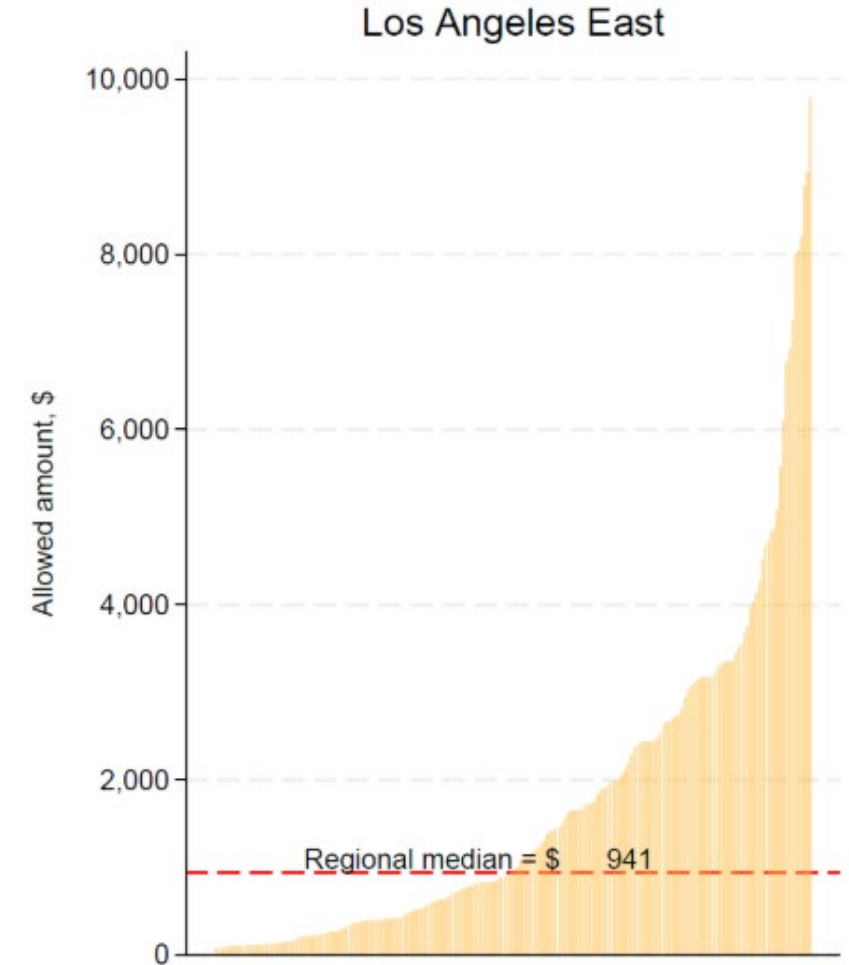
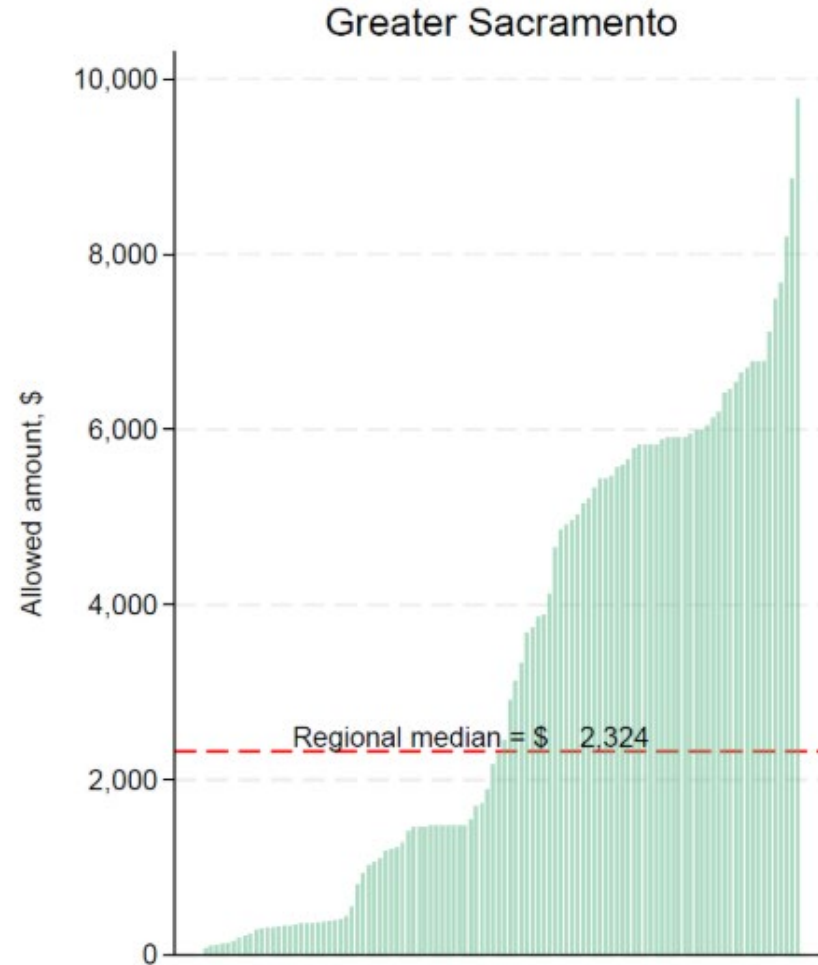
Price Variation Within and Across Regions: MRI

- For MRI, the Sacramento region median price was \$1,749, while in the LA East region, the median was \$474, or 3.7x variation.
- In both regions, prices ranged from \$100 and \$9,000.



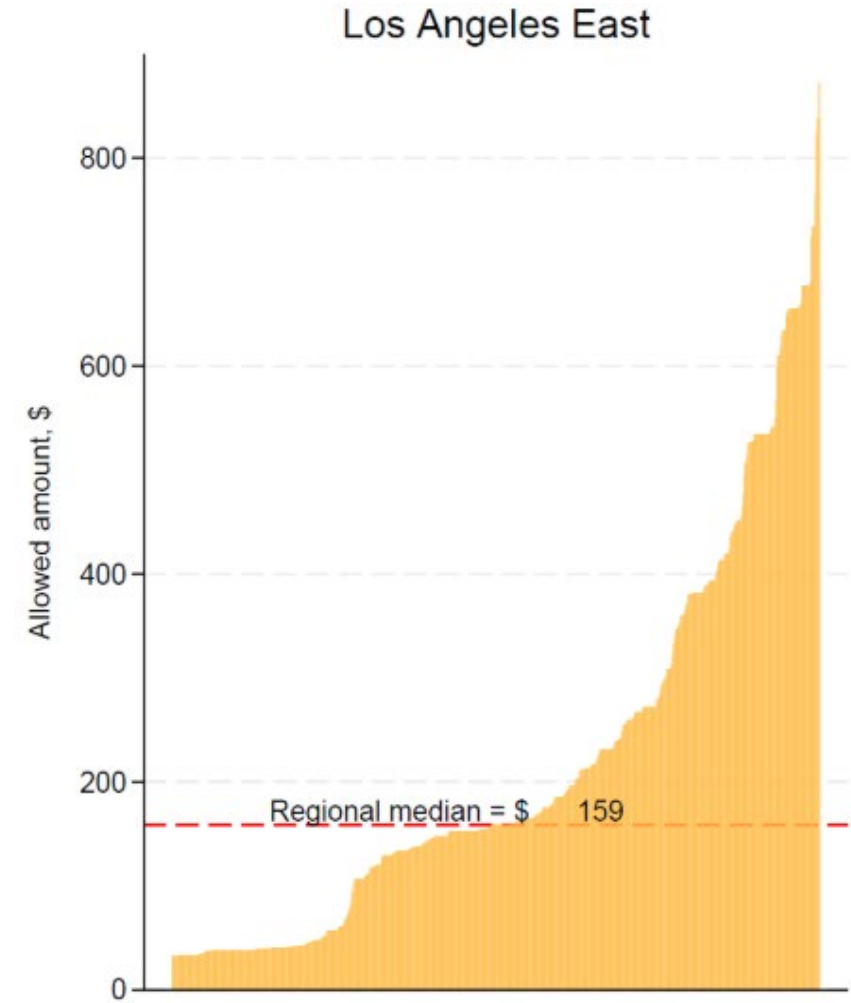
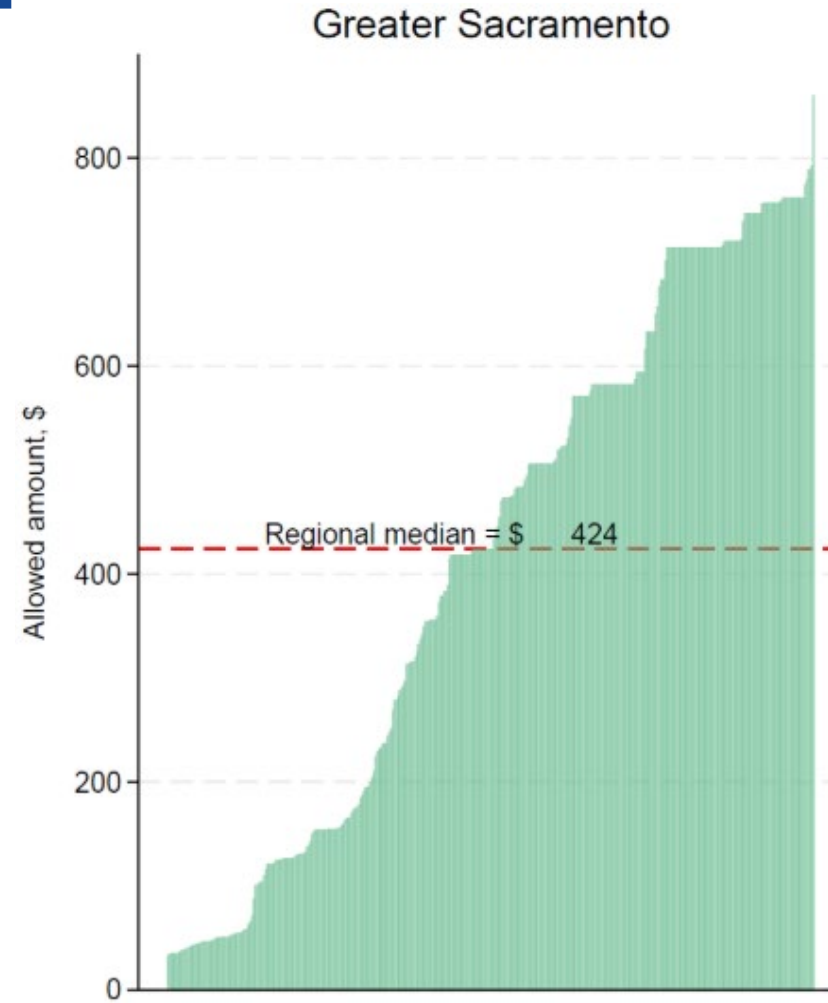
Price Variation Within and Across Regions: CT Scan

- For CT scan of abdomen and pelvis with contrast, the median price in the Sacramento region was \$2,324, while in the LA East region, the median was \$941, or 2.5x variation.
- In both regions, prices ranged from \$75 and \$10,000.



Price Variation Within and Across Regions: Mammogram

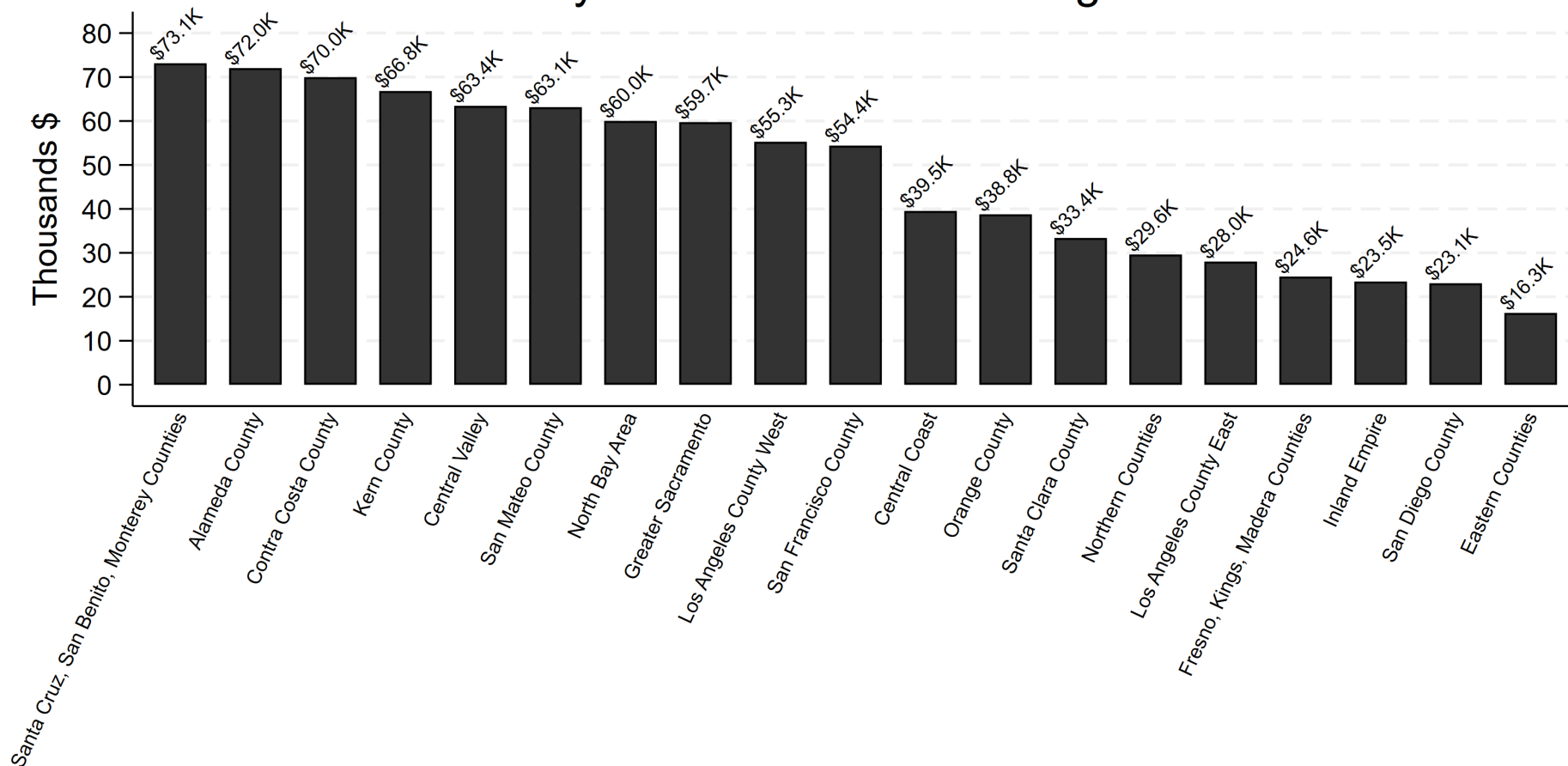
- For mammogram, the median price in the Sacramento region was \$424, while in the LA East region, the median was \$159, or 2.7x variation.
- In both regions, prices ranged from \$30 and \$900.



Price Variation Across all Covered California Regions: Hip/Knee Replacement

For hip/knee replacement without major complication, across Covered California regions, the median price ranged from a low of \$16,315 in the Eastern Counties to a high of \$73,119 in Santa Cruz, San Benito, Monterey Counties, or 4.5x variation.

Median Price for Hip/Knee Replacement without Major Complication by Covered California Region



Reference Pricing

- Reference pricing policies have been used across European countries and U.S. states to reduce price variation by steering consumers to lower-priced providers for elective services that vary in price but not in quality.
- Typically, an employer or insurer will set a reference price for a service or procedure (e.g., \$30,000 for an elective total knee replacement) and only provide reimbursement at or below that reference price. If a consumer seeks care at locations with services priced above the reference price, the consumer is responsible for the difference between the reference price and the provider's price, and that difference does not count toward the consumer's deductible or out-of-pocket maximum.
- Since 2011, CalPERS has implemented reference-based pricing for a limited set of procedures (e.g., total joint replacement, colonoscopy, arthroscopy, and cataract surgery). Evaluations have found reference pricing increased patients' use of low-price facilities, reduced use of high-price facilities, reduced prices at high-price inpatient hospitals without negative health outcomes and generated cost savings for employers.

Reference Pricing Savings

- To estimate potential savings from reference-based pricing of shoppable services, we first calculated total spending on the service within the region as is and then we calculated total spending but with the price capped at the regional median level.
- We defined savings from reference pricing as the difference between the two spending measures in dollars and also report it as a share of statewide total spending.
- Shoppable services represent 9.19% (approximately \$4 billion) of statewide commercial claims spending. If health plans or policymakers implemented regional reference pricing, 3.18% (approximately \$1.3 billion) could be saved, a 34.7% reduction in spending for shoppable services.

Shoppable category	2024 Statewide Claims spending by shoppable category, millions \$	2024 Statewide Claims spending capped at median regional allowed amounts by shop, millions \$	Savings, millions \$	Savings, % of category spending	Savings, % of statewide claim spending	Share in statewide spending, %
Evaluation and management services	\$1,644.9 M	\$1,350.5 M	\$294.5 M	17.90%	0.69%	3.83%
Laboratory and pathology services	\$299.7 M	\$119.9 M	\$179.7 M	59.97%	0.42%	0.70%
Medicine and surgery services	\$1,266.8 M	\$743.7 M	\$523.1 M	41.29%	1.22%	2.95%
Radiology services	\$720.8 M	\$354.9 M	\$365.9 M	50.76%	0.85%	1.68%
Total	\$3,932.2 M	\$2,569.0 M	\$1,363.2 M	34.7%	3.18%	9.19%

Limitations

- The reliability of our findings was constrained by limitations inherent in the data sources used. California's Department of Health Care Access and Information (HCAI) continues to work with submitters on improving data quality in the HPD. Potential errors in payer databases may introduce measurement error and contribute to the findings. Despite these concerns, HPD represents the best available source for examining claim-level healthcare costs and utilization in California.
- We analyze the fully insured commercial market only and exclude capitated services. With Kaiser representing more than 41% of California's commercial market enrollment, we exclude a significant proportion of the market from our analyses.
- Our calculation of the impact of capping services does not take into account potential actions by providers that have below-median allowed amounts who could respond by increasing their prices, negating some of the savings described here.
- We use the regional median allowed amount in 2024 as an option for the reference price. Setting reference prices in absolute values could require a complementary policy design feature to allow those caps to be adjusted annually for inflation.

Conclusion

- There is substantial variation in the prices for shoppable services within and across California regions.
- Shoppable services represent more than 9% of claims spending in California's commercial market.
- If California health plans through market-based mechanisms such as smart networks, or policymakers through regulatory reforms, adopted reference pricing for shoppable services in the fully insured commercial market, aggregate commercial spending would decrease by \$1.3 billion or 34.7% of current levels in a single year.
- Datasets with regional price variation and potential savings at the CPT code level are [available on the OHCA website](#).



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

Public Comment



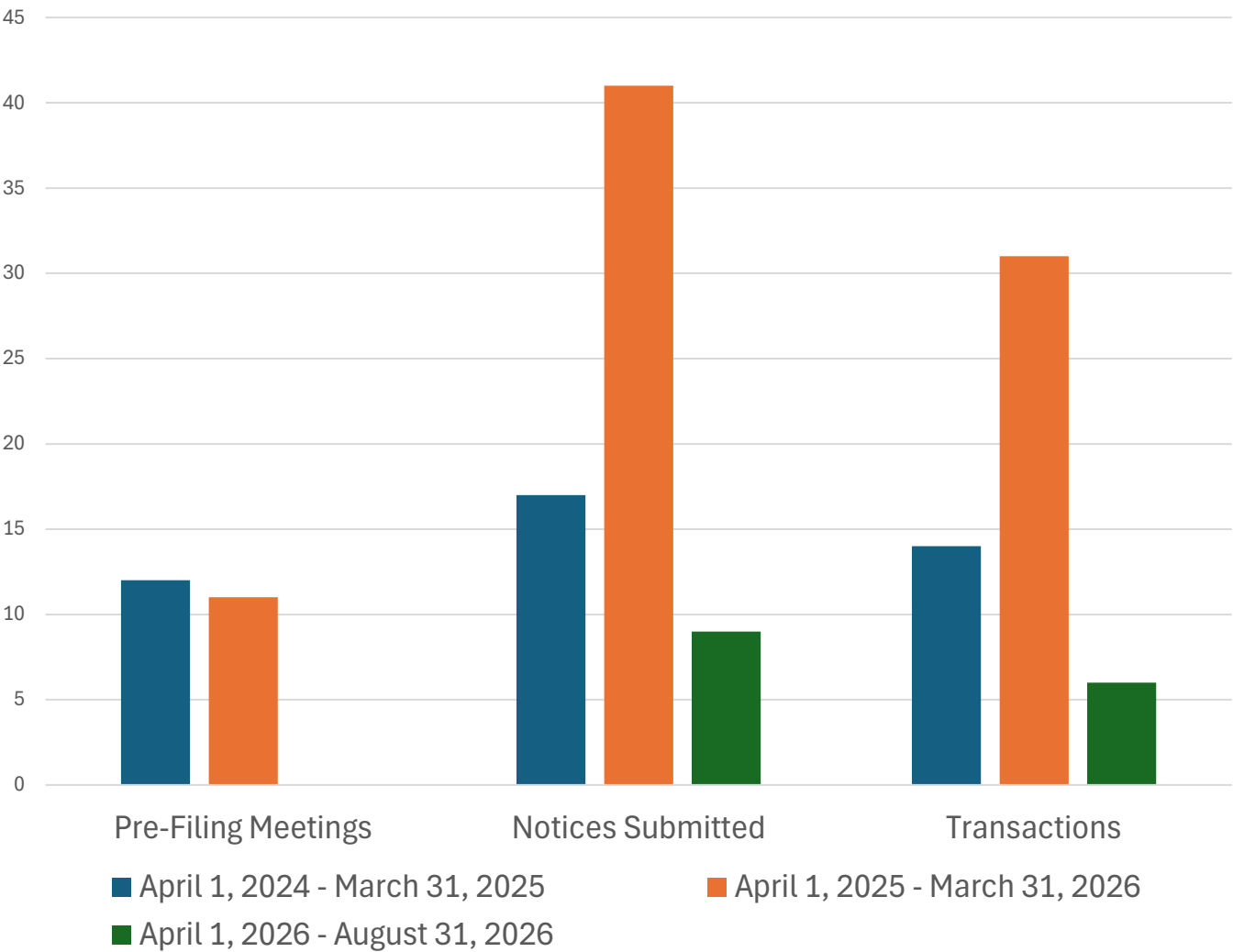


Update on Cost and Market Impact Review Program

Brian Kearns, Assistant Deputy Director



2 Years of the CMIR Program



April 1, 2024 – March 31, 2025

- 12 Pre-Filing Meetings
- 17 Distinct Notices Submitted
- 14 Transactions

April 1, 2025 – March 31, 2026

- 11 Pre-Filing Meetings
- 41 Distinct Notices Submitted
- 31 Transactions

April 1, 2026 – August 31, 2026

- 0 Pre-Filing Meetings
- 9 Distinct Notices Submitted
- 6 Transactions

51 Total Transactions Filed
April 1, 2024 – August 31, 2026

CMIR Program April 1, 2024 to August 31, 2026

Type of Transaction	Number	Percentage
Skilled Nursing Facilities (SNFs)	12	24%
Laboratories	8	16%
Physician Organizations	7	14%
Health Plans (HPs) / HPs plus Physician Organizations and/or Hospital	5	10%
Hospitals	4	8%
Ambulatory Surgery Centers	2	4%
Radiology Services	2	4%
Physician Specialty Group	2	4%
Others	9	18%
Total	51	100%

CMIR Program: April 2026 to Present

Since the last Board presentation:

- 6 Transaction Reviews Commenced
(9 Different Submissions)
- 5 Transaction Reviews Completed/Waived
- 1 CMIR Completed
- 0 Pre-Filing Meetings

Transaction Reviews Completed Since April 2026

Submitters	Transaction Summary	Submission Complete	Status
<u>Vitalant</u> and <u>San Diego Blood Bank</u>	Vitalant, an Arizona-based non-profit specializing in providing blood supplies to health systems and hospitals, will acquire San Diego Blood Bank, also a non-profit specializing in blood-related services, and will serve as its sole member.	February 13, 2026	CMIR Waived (April 3, 2026)
<u>Sharp HealthCare</u> and <u>Tri-City Healthcare District dba Tri-City Medical Center</u>	Tri-City Healthcare District plans to transfer substantially all of Tri-City Medical Center's assets and the District's liabilities to Sharp HealthCare and its wholly-controlled subsidiary Tri-City Medical Center Corporation. The transaction will be subject to voter approval in June 2026.	February 25, 2026	CMIR Waived (April 13, 2026)

Transaction Reviews Completed Since April 2026

Submitters	Transaction Summary	Submission Complete	Status
<u>Euclid Endoscopy Center, L.P.</u> and <u>AmSurg Holdings, LLC</u>	AmSurg Holdings, LLC, a subsidiary of Ambulatory TopCo, LLC (AmSurg), will acquire 51% of issued and outstanding membership interests in Euclid Endoscopy Center, L.P. (Euclid). Euclid will convert from a limited partnership to a limited liability company.	December 16, 2026	CMIR Waived (June 25, 2026)
<u>Centene Corporation</u> <u>("Centene"), Madison Health</u> <u>Group ("Madison"), Magellan</u> <u>Health Service of California, Inc.</u> <u>– Employer Services ("MHSC"),</u> <u>Magellan Federal, Inc.</u> <u>("Magellan Federal"), Magellan</u> <u>Healthcare Provider Group, Inc.</u> <u>("MHPG"), and Magellan Life</u> <u>Insurance Company ("Magellan</u> <u>Life")</u>	Centene will divest itself of several health care entity subsidiaries pursuant to a Stock Purchase Agreement with Madison. The transaction will ultimately result in MHSC, Magellan Federal, MHPG, and Magellan Life becoming wholly indirectly-owned subsidiaries of Madison.	March 19, 2026	CMIR Waived (May 4, 2026)

Transaction Reviews Completed Since April 2026

Submitters	Transaction Summary	Submission Complete	Status
<u>Vibra Hospital of San Diego, LLC</u> and <u>California Rehabilitation Institute, LLC</u>	Stallion Intermediate Corporation will acquire Select Medical Holdings Corporation which owns two hospitals and two management services organizations in California. Stallion Intermediate Corporation is wholly owned by Stallion Group Parent, LP and indirectly owned by WCAS Fund XIV, L.P., a fund affiliated with Welsh, Carson, Anderson & Stowe.	April 24, 2026	CMIR Waived (June 19, 2026)
<u>Genesis Healthcare Partners, P.C., Urology Partners of America Holdings, LLC, Urology Partners of America, LLC, Unio Health Partners, LLC, Genesis Healthcare Partners, P.C., Golden Gate Urology, Inc., GGU Physician Holdco, LLC, Kevin E. Sanders, M.D., Ira D. Sharlip, M.D., Wenwu Jin, M.D., Dr. Yan, Rodman S. Rogers, M.D., David G. Kornguth, M.D., Chi K. Lee, M.D., Andrew J. Pienkny, M.D., Allison M. Sih, M.D., Robert Q. Hoang, M.D., Daniel Oberlin, M.D., Gregory A. Barme, M.D. and Yevgeniy Veltman, M.D.</u>	Golden Gate Urology Inc. will transfer certain clinical assets to Genesis Healthcare Partners, P.C. and certain non-clinical assets to Unio Health Partners, LLC or one of its affiliates. Golden Gate's physicians will enter into employment agreements with Genesis, and its shareholder-physicians will acquire Genesis equity.	May 14, 2026	CMIR waived (June 26, 2026)

Transaction Reviews Completed Since April 2026

Submitters	Transaction Summary	Submission Complete	Status
<u>Long Beach NSC – Commons Clinic Medical Network, Commons Clinic MSO</u>	Commons Clinic MSO CA, LLC (CCMSO) and Commons Clinic Medical Network, PC (CCMN) will acquire the ambulatory surgery center, Long Beach NSC, LLC, from AmSurg Holdings, LLC.	May 18, 2026	CMIR Waived (June 16, 2026)
<u>NAHS Holding, Inc.(Submitter), MOJUMU, Inc., and Argent Trust Company solely as Trustee of the NAHS employee stock ownership plan trust</u>	MOJUMU, Inc., will acquire 100% equity ownership of NAHS Holding, Inc., from the NAHS employee stock ownership plan trust through a stock purchase agreement.	June 4, 2026	CMIR Waived (July 7, 2026) <u>(Post-Transaction Monitoring Advisory Letter)</u>

Transaction Reviews Completed Since April 2026

Submitters	Transaction Summary	Submission Complete	Status
<u>Hospital of Barstow, Inc.</u> <u>d/b/a Barstow Community</u> <u>Hospital</u>	Pursuant to an Agreement and Plan of Merger, not-for-profit QKA Health Corporation will acquire various health facilities owned and operated by Quorum Health Corporation and its subsidiaries, including the Hospital of Barstow, Inc., a general acute care hospital in Barstow, California and ten other hospitals outside of California.	July 16, 2026	CMIR Waived (August 31, 2026)

Material Change Notices Currently in Review

Submitters	Transaction Summary	Submission Complete	Status
<u>BayMark Health Services Inc.</u>	The Proposed Transaction will be implemented through a new-money recapitalization and a debt-for-equity exchange. BayMark operates a network of 25-communitied based treatment ceenters in California that offer opioid addiction treatment programs. Pursuant to transaction documentation, BayMark’s existing lenders will assume ownership of BayMark and its subsidiaries through the acquisition of a newly formed purchaser entity (“New BayMark Parent, LLC”). On the Proposed Transaction effective date, New BayMark Parent, LLC will acquire substantially all of the assets and/or equity interests of BayMark and issue new equity interests to BayMark’s creditors.	August 6, 2026	CMIR Waived (September 4, 2027)

CMIRs Currently in Review

Submitters	Transaction Summary	Submission Complete	Status
<u>Covenant Care California, LLC;</u> <u>Covenant Care Mission, Inc.;</u> <u>Covenant Care Long Beach, Inc.;</u> <u>Covenant Care Morgan Hill, LLC;</u> <u>Covenant Care Capitola, LLC;</u> <u>Covenant Care Encinitas, LLC;</u> <u>Covenant Care La Jolla, LLC;</u> <u>Covenant Care Courtyard, LLC;</u> <u>and Covenant Care Lodi, LLC.</u>	Submitters will transfer the assets and operations of its respective skilled nursing facilities to subsidiaries of International Equity Partners, Spyglass Healthcare, Links Healthcare Group, and The Ensign Group. OHCA is conducting a CMIR over three acquisitions by The Ensign Group.	April 24, 2025	In CMIR Review



General Public Comment

Written public comment can be emailed to: ohca@hcai.ca.gov
To ensure that written public comment is included in the posted board materials, e-mail your comments at least 4 business days prior to the meeting.



Next Board Meeting:
Thursday, October 29, 2026
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

