OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Board Meeting

October 28, 2025

HCAI

Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

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Welcome, Call to Order, and Roll Call

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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, 2025 Meeting Minutes
Vishaal Pegany

Item #4 **Action Item**
Vote to Approve Data Submission Enforcement – Penalty Scope and Range

Item #5 **Informational Items**

a) Data Submission Enforcement, Continued, Including Advisory Committee Feedback
Vishaal Pegany; CJ Howard, Assistant Deputy Director

b) Spending Target Enforcement – Waiver of Enforcement, Technical Assistance, and Public Testimony
Vishaal Pegany; CJ Howard

Item #6 **General Public Comment**

Item #7 **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

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Land Acknowledgement

The Department of Health Care Access and Information (HCAI) acknowledges that its Sacramento and Los Angeles offices sit on land stolen from the Miwok (“mee-waak”), Nisenan (“nish-n-non”), Chumash (“choo-mash”) and Gabrielino-Tongva (“gab-ree-uh-lee-noh”- “to-VAA-ngar”) People. We believe it is essential to recognize the historical truths regarding the government-sanctioned forced displacement, enslavement and efforts at cultural genocide inflicted on these peoples. We acknowledge the resilience and fortitude of these and other native people who continue to survive as cultures and communities despite decades of mistreatment.

In solidarity and allyship with native peoples, HCAI commits to being positive catalysts for change by disseminating actionable information to expose the lingering impact of past actions against native peoples and underserved communities; by listening to tribal voices to guide us in eliminating barriers native people face in becoming part of the health workforce; and by revisiting HCAI’s programs, policies, and procedures to allocate state resources equitably in a manner that recognizes our responsibility to address disparities.

CalRx® Insulin Announcement

- On October 16, 2025, Gov. Newsom announced that CalRx Insulin Glargine in pen form will be available beginning **January 1, 2026.**
- The CalRx insulin glargine pens are interchangeable with Lantus®, ensuring seamless substitution for patients.
- This product will be available to California pharmacies for $45 and to consumers at a suggested retail price of no more than **$55 per 5-pack of 3 mL pens** (average cost of $11 per pen)—a substantial reduction from current retail market prices.
- “Today’s action marks a significant milestone in California’s ongoing efforts to reduce prescription drug costs,” **said California Health and Human Services Agency Secretary Kim Johnson.** “Lowering the cost of insulin moves us closer to a California where no one is forced to choose between their health and their financial stability.”

[Watch Gov. Newsom’s Announcement]

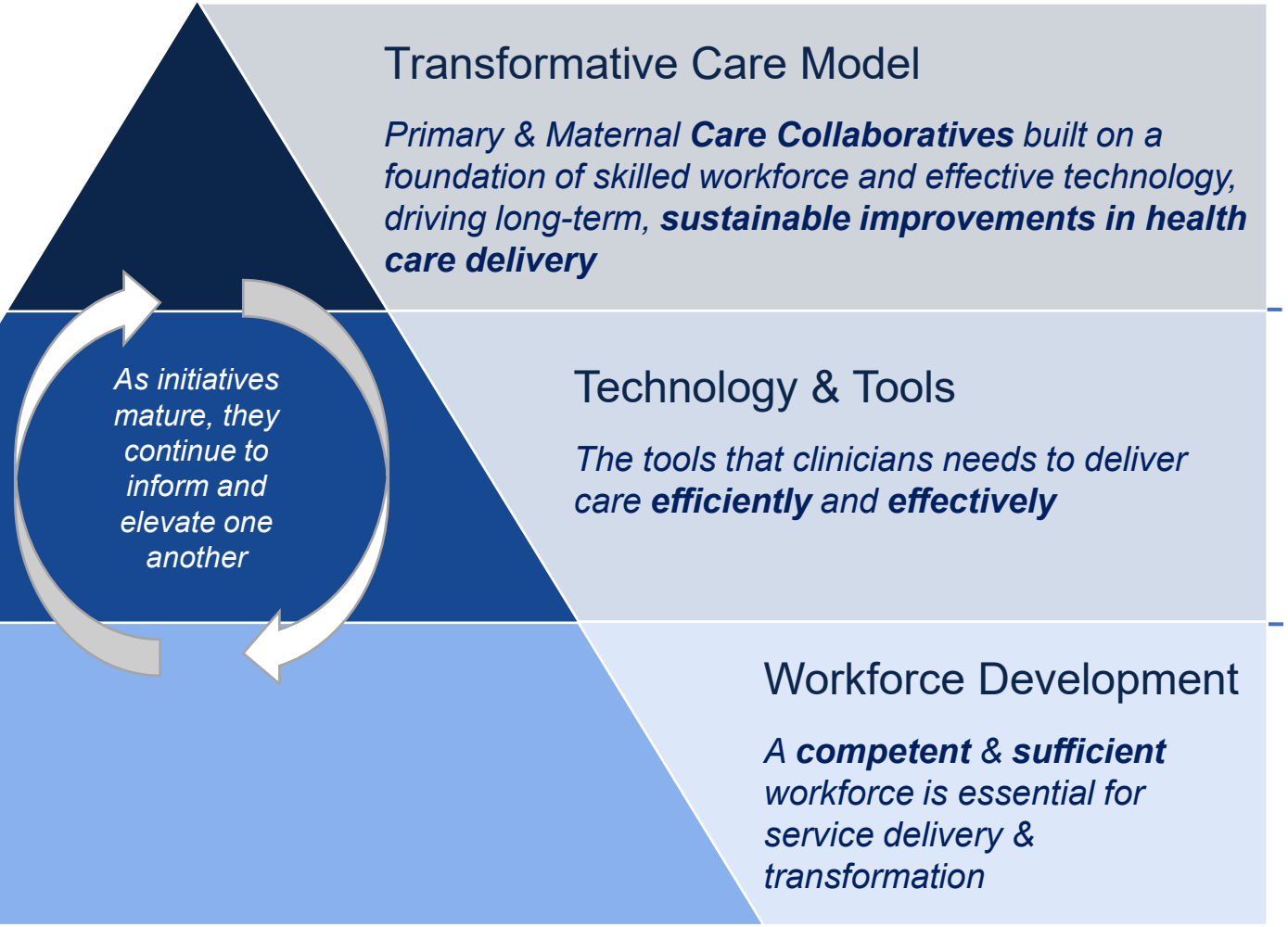
[Visit CalRx Biosimilar Insulin Initiative]

Legislative Update

Some of the recently signed legislation impacting HCAI and health care affordability includes:

- AB 1415 expands material change notice of transaction filing requirements to include private equity, hedge funds, and management services organizations (MSO) and authorizes OHCA to collect data from MSOs.
- SB 660 moves the Data Exchange Framework to HCAI, expands the Framework by adding entities required to participate, revises the stakeholder governance process, and requires a legislative report about governance and accountability approaches.
- AB 1312 requires hospitals to check if patients qualify for programs such as CalFresh or CalWORKs. If they do, hospitals must assume the patient qualifies for charity care or discount programs – a process called presumptive eligibility.
- SB 40 prohibits health plans and insurers from imposing cost sharing of more than $35 for a 30-day supply of insulin, as well as banning step-therapy for insulin coverage.
- SB 41 prohibits spread pricing, requires PBMs and group purchasing organizations to pass through 100% of manufacturer rebates to health plans, prohibits PBMs from marking up the prices of generic drugs, and bans PBMs from steering patients to their own pharmacies.

Rural Health Transformation Proposed Initiatives



Transformative Care Model

*Primary & Maternal **Care Collaboratives** built on a foundation of skilled workforce and effective technology, driving long-term, **sustainable improvements in health care delivery***

Technology & Tools

*The tools that clinicians needs to deliver care **efficiently** and **effectively***

Workforce Development

*A **competent** & **sufficient** workforce is essential for service delivery & transformation*

Potential Levers

illustrative working draft not intended to be exhaustive or definitive

Care Collaboratives:
- ✓ *FQHC*
- ✓ *Rural Health Clinics*
- ✓ *Tribal Health Clinics*
- ✓ *Small physician practices*
- ✓ *Rural Hospitals*

Telehealth e-Consults

Maternity & Primary Care Model

Accelerator Partnerships

Data Exchange:
- ✓ *Health Information Exchange*
- ✓ *Health Information Interoperability*
- ✓ *Community Information Exchange*

Modernizing Digital & Physical Infrastructure:
- ✓ *Telehealth devices*
- ✓ *Remote monitoring devices*
- ✓ *Electronic medical records*

Target Workforces:
- ✓ *Allied Health Professionals*
- ✓ *Midwives*
- ✓ *Doulas*
- ✓ *Rural Residencies*
- ✓ *Family Medicine Obstetric Fellowships*
- ✓ *Medical Assistants*
- ✓ *Licensed Vocational Nurses*
- ✓ *Ultrasound Technicians*
- ✓ *Radiology Technicians*

Pipeline Programs:
- ✓ *High School*
- ✓ *Community College*

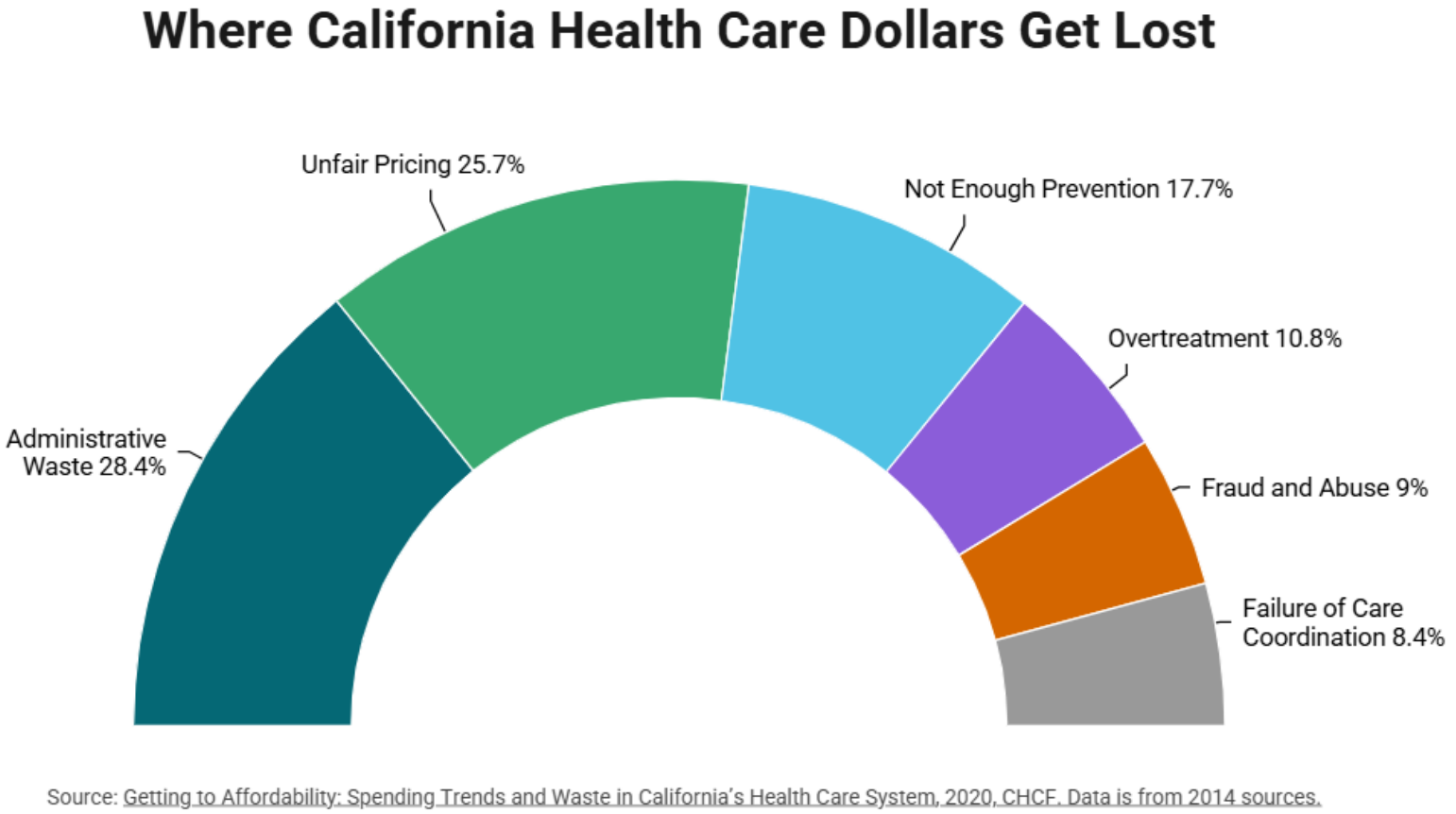
Retention & Recruitment Grants

Behavioral Health Training

The 25% Problem: Why Health Care Is So Expensive (And What We Can Do About It)

Around 25% of every dollar spent in California's health care system does not contribute toward better care or patient health. This money instead goes toward:

1. Administrative waste
2. Unfair pricing and too few choices
3. Not enough prevention in health care

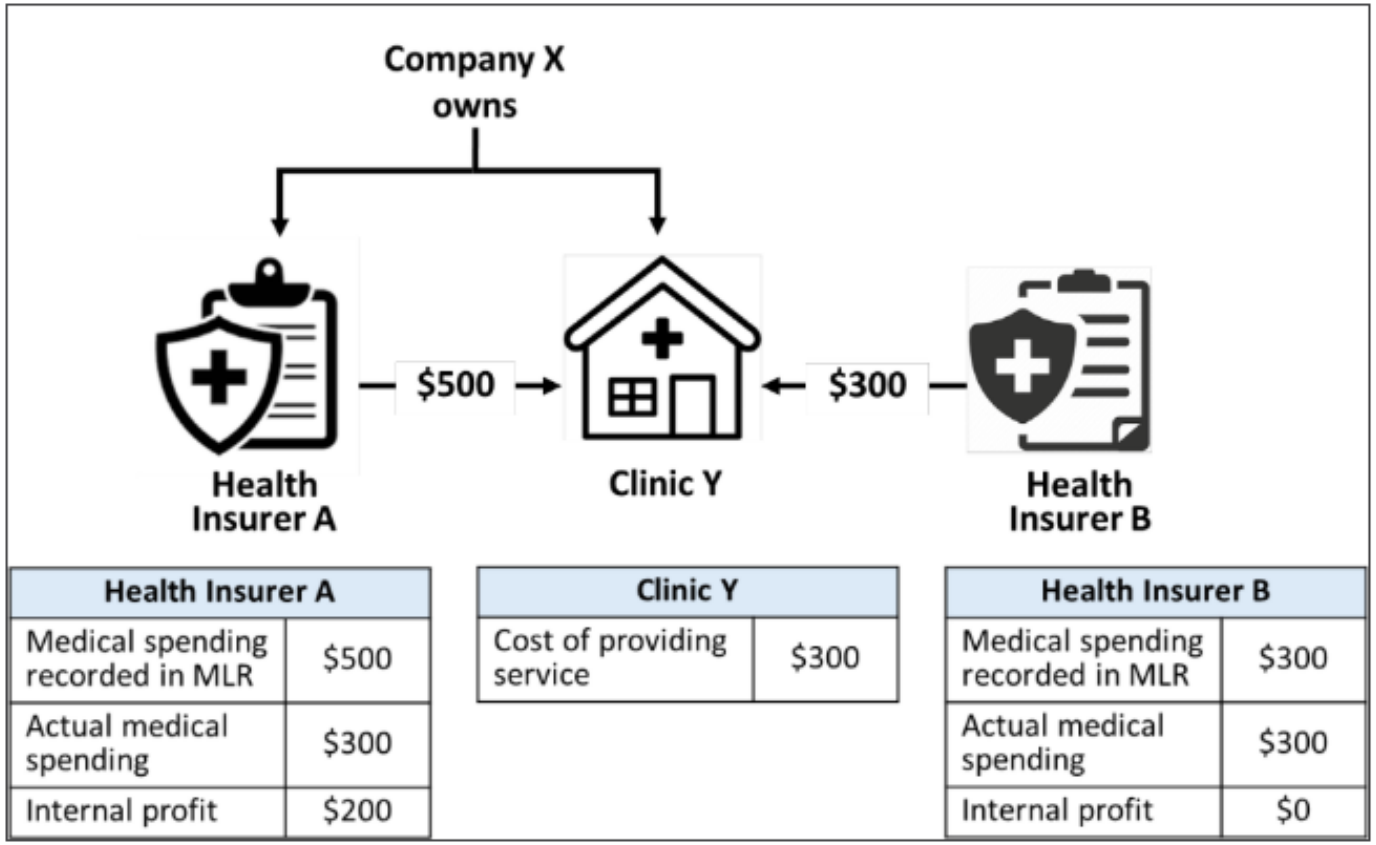


Source: Getting to Affordability: Spending Trends and Waste in California's Health Care System, 2020, CHCF. Data is from 2014 sources.

Stemikis, K., Teare, C. (2025, 13 October). *The 25% Problem: Why Health Care Is So Expensive (And What We Can Do About It)*. California Health Care Foundation. https://www.chcf.org/resource/why-health-care-is-so-expensive/

How Insurers That Own Providers Can Game The Medical Loss Ratio Rules

A recent Health Affairs Forefront article argues that a medical loss ratio (MLR) loophole creates an incentive for vertically-integrated insurers to direct spending to its affiliated providers, who may charge inflated prices, thus allowing the insurer to increase its reported MLR without delivering more care or improving quality.



Health Insurer A	
Medical spending recorded in MLR	$500
Actual medical spending	$300
Internal profit	$200

Clinic Y	
Cost of providing service	$300

Health Insurer B	
Medical spending recorded in MLR	$300
Actual medical spending	$300
Internal profit	$0

Angeles, J.; Bailit, M. (2025, 29 September). *How Insurers That Own Providers Can Game The Medical Loss Ratio Rules.* Health Affairs Forefront. https://www.healthaffairs.org/content/forefront/insurers-own-providers-can-game-medical-loss-ratio-rules

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How States Are Using Hospital Price Caps To Save Money

Price Caps in State Employee Health Plans

- Oregon (2017)
- Washington (2025)
- Colorado, Nevada, and New Jersey have legislation pending

Price Caps in the Commercial Market

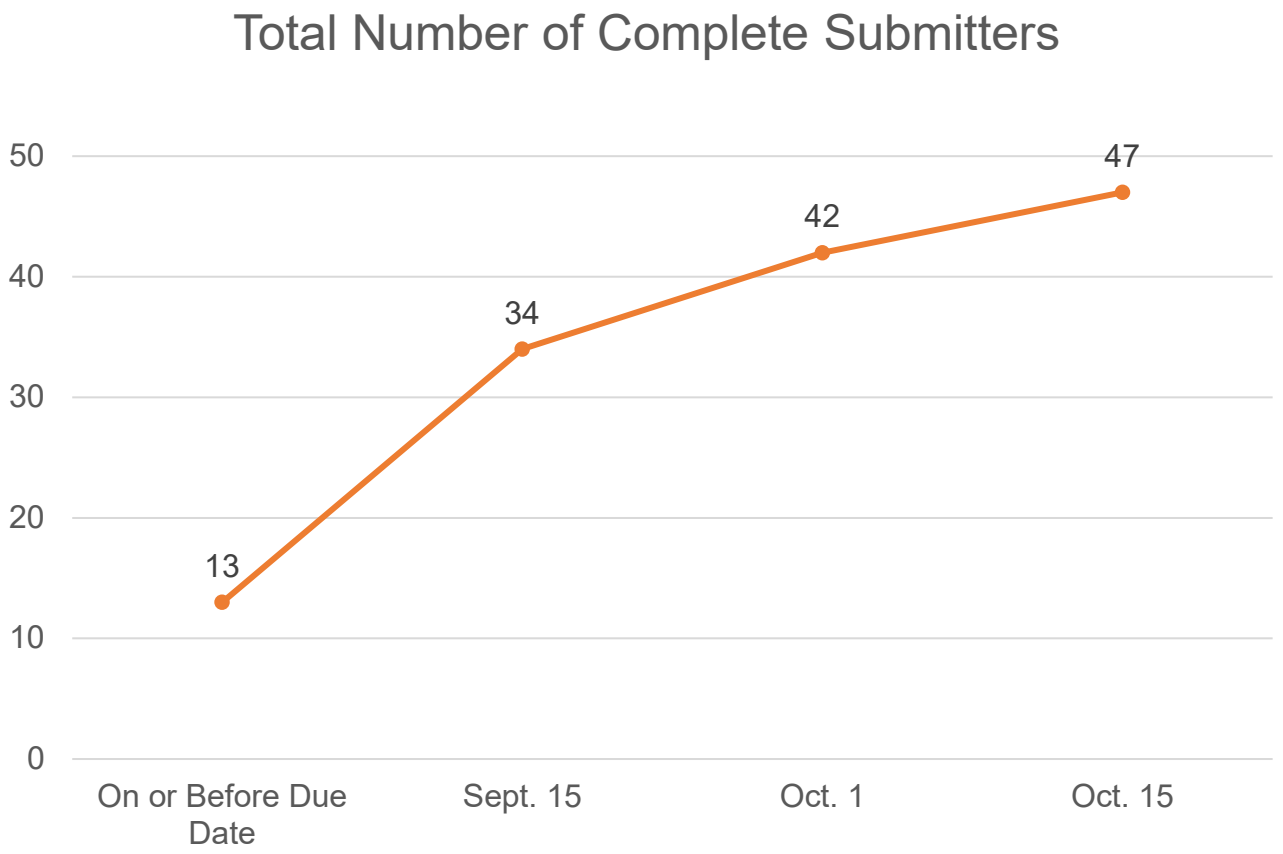
- Vermont (2025)
- Indiana (2025)
- Massachusetts, Montana, and Oklahoma have legislation pending

Hostert, N., Murray, R., Whaley, C., Fuse Brown, E. (2025, 9 October). *How States Are Using Hospital Price Caps To Save Money.* Health Affairs Forefront. https://www.healthaffairs.org/content/forefront/states-using-hospital-price-caps-save-money

2025 Data Collection Progress

As of October 15:

- Number of data submitters: 50
- Number of data submitters that have submitted one or more files: 50
- Submitters with all files submitted and passed automated validations: 47
- Submitters with one or more files outstanding: 3
- OHCA is in the process of completing manual validations and will follow up with submitters as needed to correct or reconcile any inconsistencies.



Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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Public Comment

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Action Consent Item: Vote to Approve August 26, 2025 Meeting Minutes

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Informational Items

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Data Submission Enforcement

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

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Data Submission Penalty Amounts: Context

The average $5 per member penalty for health plans would be $2.7M, ranging from $18,575 to $41M.[1]

The largest fines administered by the Department of Managed Health Care (DMHC) include the following:

Kaiser Foundation Health Plan, Inc.: $50 million penalty; $150 million investment over 5 years[2]

- Matter involved the plan's delivery of behavioral health care to enrollees, including timely access to care, oversight of the plan's providers and medical groups, network adequacy, conformity to mental health parity laws, and handling of member grievances and appeals

Local Initiative Health Authority for Los Angeles County (LA Care Health Plan) (2024): $13.5 million penalty; $21.5 million investment[3]

- Matter involved processing requests to authorize care, handling of member grievances and appeals, processing of provider disputes and claims payment, and oversight of contracted entities to ensure delivery of quality and timely care.

[1] This was calculated using 2024 revenue data from DHMC's Health Plan Dashboard, CDI's Market Share Reports, and 2023 enrollment data from CHCF's Enrollment Almanac
[2] Kaiser: https://www.dmhc.ca.gov/Resources/Newsroom/PressReleases/October12,2023.aspx
[3] LA Care: DMHC Settlement $35 million and DHCS Settlement $20 million: https://www.dmhc.ca.gov/Resources/Newsroom/PressReleases/October8,2024.aspx.

Data Submission Penalty Amounts: Context

Additional notable fines administered by DMHC since 2020:

2020: Blue Cross of California Partnership Plan: $1.2 million penalty

- Matter involved timely implementation of Independent Medical Review determinations to authorize coverage for medically necessary services

2022: Blue Cross of California (Anthem Blue Cross): $1.1 million penalty

- Matter involved application of office visit costs to enrollee deductibles impacting enrollees from 2015 through 2020, and failed to mail Explanation of Benefits (EOB) to enrollees in 2019

2022: Molina Healthcare of California: $1 million penalty

- Matter involved timely acknowledgment and resolution of provider disputes

2024: Blue Cross of California Partnership Plan, Inc. and Anthem Blue Cross: $8.5 million penalty

- Matter involved plan's processing of claims payment disputes in a timely manner from doctors, hospitals and other health care providers

2024: Anthem Blue Cross: $3.5 million penalty

- Matter involved plan's processing of health plan member complaints in a timely manner

2025: Kaiser Permanente: $819,500 penalty

- Matter involved plan's processing of health plan member complaints in a timely manner

[1] This was calculated using 2024 revenue data from DHMC's Health Plan Dashboard, CDI's Market Share Reports, and 2023 enrollment data from CHCF's Enrollment Almanac

Data Submission Penalty Amounts: Context

What is the proposed penalty as a percentage of a plan's annual revenue?

While the amount varies by plan (ranging from .01% to .14%), on average a $5 per member penalty equates to approximately 0.07% of a plan's annual revenue[1] and approximately 0.06% of the 2023 commercial market per member per year spend.

What is the proposed penalty amount as a percentage of a plan's annual net profit ?

- While the amount varies by plan (ranging from -3% to 3.84%), on average a $5 per member penalty equates to approximately 1.46% of a plan's annual net profit.[1]
- There are various measures for profit. The above information was calculated using DMHC's net profit/loss data.
- From 2022 to 2024, the range of plans with an annual negative net profit was 4 to 9.

What is the proposed penalty as a percentage of a plan's annual excess tangible net equity (ETNE)?

- While the amount varies by plan (ranging from -0.51% to 9.22%), on average a $5 per member penalty equates to approximately 1.1% of a plan's annual ETNE.[1]
- ETNE is the amount beyond the amount of tangible net equity (TNE) plans are required to maintain by DHMC. TNE encompasses a plan's "total assets minus total liabilities reduced by the value of intangible assets and unsecured obligations of officers, directors, owners, or affiliates outside of normal course of business."[2]

[1] This was calculated using 2024 revenue data from DHMC's Health Plan Dashboard, CDI's Market Share Reports, and 2023 enrollment data from CHCF's Enrollment Almanac
[2] DMHC TNE Slides and Definition: https://dmhc.ca.gov/Portals/0/AbouttheDMHC/FSSB/p7061516.pdf

Advisory Committee Feedback

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

Updated Proposal for Data Submission Enforcement

Considerations for Penalty Structure

- The penalty needs to be reasonable, provide an incentive to submit data timely, and deter entities from not submitting or withholding data to evade spending target enforcement.
- If an entity fails to submit data, OHCA is unable to measure THCE or enforce the target for payers and fully integrated delivery systems.
- If an entity fails to submit data, it may also impact reporting of spending for other health care entities, such as providers organizations that are measured based on attribution of total medical expenses.
- If entities do not submit data, the Office could take administrative action and request an administrative law judge to compel entities to comply with data submission requirements or pursue other legal actions. It could also notify licensing agencies of the entity's failure to comply with California law (disciplinary action at the licensing agency's discretion).

Statute

Office

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

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

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

(C) The market impact of the entity.

(e) Administrative penalties shall not constitute expenditures for the purpose of meeting cost targets. The imposition of administrative penalties shall not alter or otherwise relieve the health care entity of the obligation to meet a previously established cost target or a cost target for subsequent years.

Consultation with State Regulators of Health Plans:

b(4) The director shall consult with the Director of Managed Health Care, the Director of Health Care Services, or the Insurance Commissioner, as applicable, prior to taking any of the enforcement actions specified in this section with respect to a payer regulated by the respective department to ensure any technical assistance, performance improvement plans, or other measures authorized by this section are consistent with laws applicable to regulating health care service plans, health insurers, or a Medi-Cal managed care plan contracted with the State Department of Health Care Services.

To align with these requirements, the penalty amounts approved by the Board will denote “up to.”

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

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

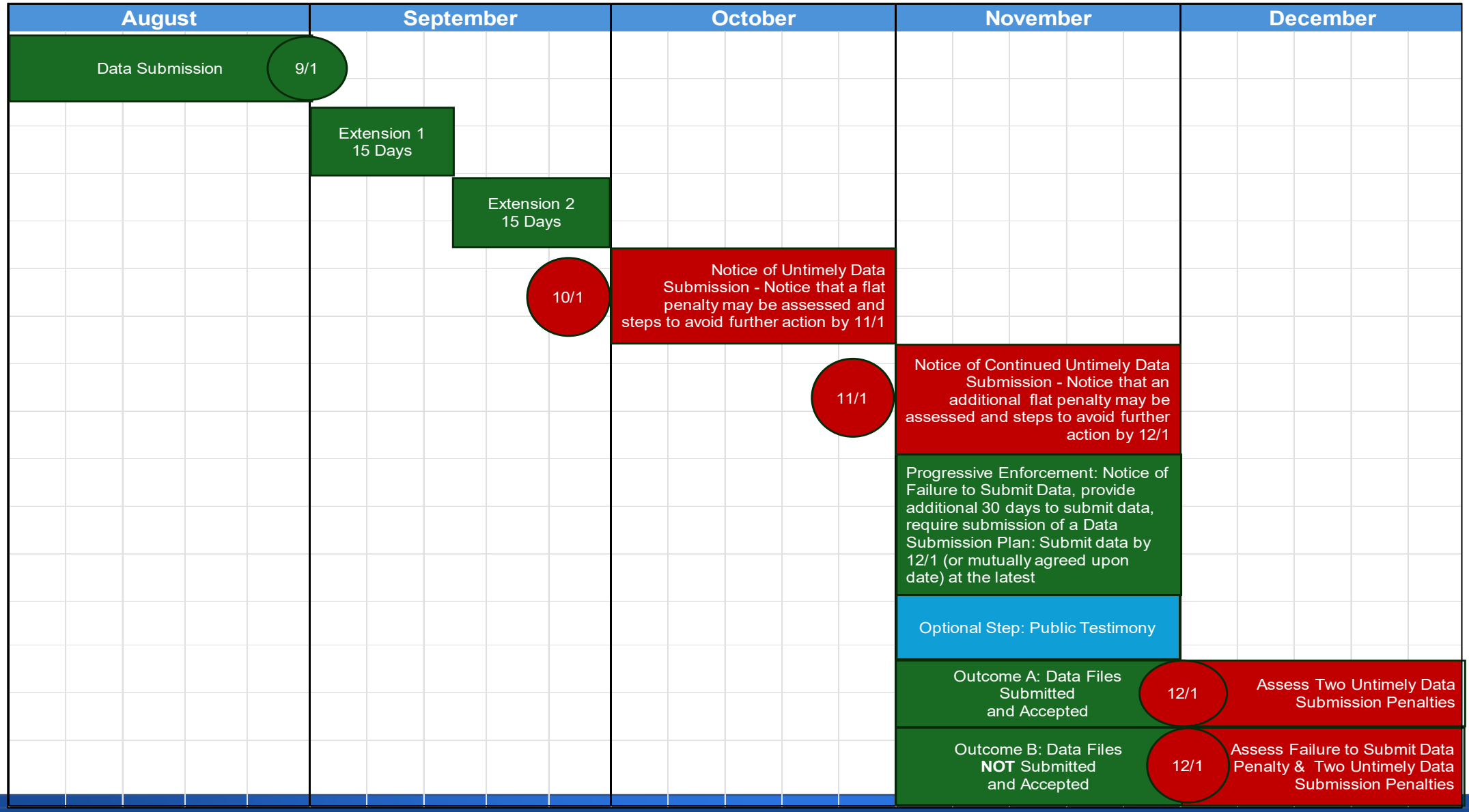
Proposed Data Submission & Enforcement Process – Updated Based on Board Input

Untimely Data Submission Penalties	
3.	If data has not been submitted by the submission deadline or end of one or both extension periods, submitters would be subject to an initial flat untimely data submission penalty of $10,000.
4.	If data are then not submitted by November 1, the submitter would be subject to an additional flat untimely data submission penalty of $50,000.
Progressive Enforcement Process	
5.	If data is not submitted by November 1, progressive enforcement would begin on November 1 with a notice that the submitter has failed to submit data. The Office may require a plan to submit data, provide technical assistance, and allow up to 30 days for the submitter to submit data.
6.	Optional Step: The Office may hold a public meeting and request public testimony.

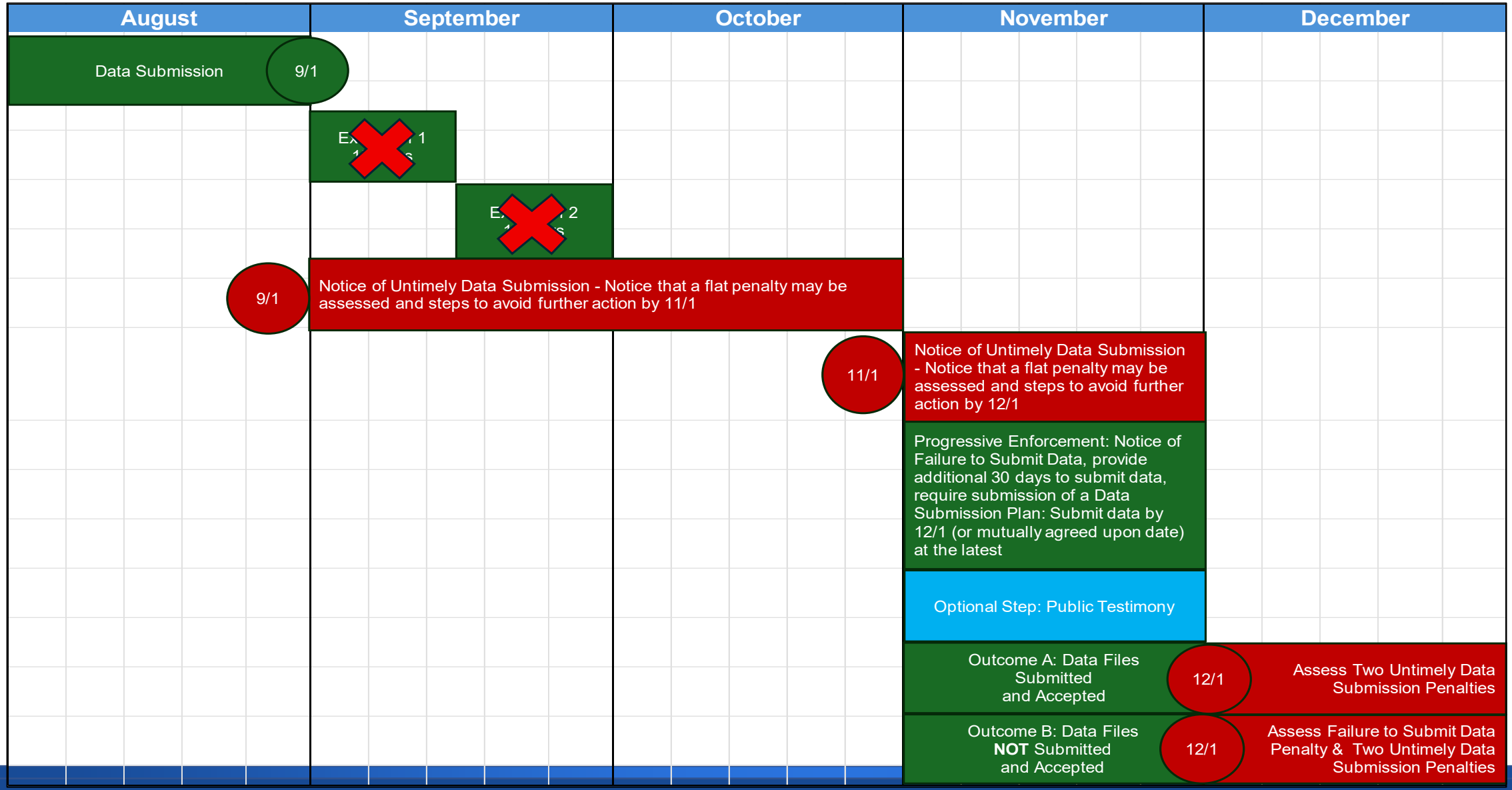
Proposed Data Submission & Enforcement Process – Updated Based on Board Input

Failure to Submit Data Penalty	
7.	If data is not submitted by December 1st or the agreed upon date, the entity would be subject to a per member failure to submit data penalty, in addition to the untimely data submission penalty.
8.	For data submitters that repeatedly fail to submit data, each year the failure to submit data penalty amount would double.($5/member year 1, $10/member year 2, $20/member year 3, etc.)
9.	OHCA will make public all penalties once formally assessed.
Other Legal Remedies for failure to submit data	
10.	OHCA could continue to pursue other legal remedies in addition to penalties to acquire the submitter's data. The Office could take administrative action and could notify the licensing or regulatory agency of the entity's failure to comply with California law.

Scenario: Both Extensions



Scenario: No Extensions



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Examples of Penalty Amounts

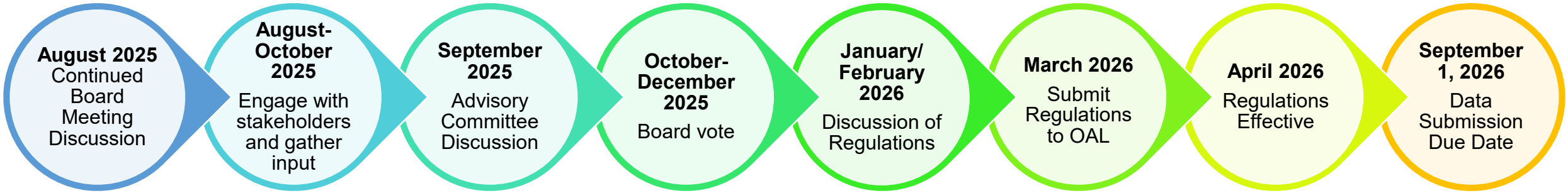
Plan Info		Outcome A: Untimely Data Submission Penalties	Outcome B: Additional Untimely Data Submission Penalties	Outcome C: Failure to Submit Data Penalty			
Data Submitter	**Covered Lives (Includes all lines of business)**	**$10,000**	**$10,000 + $50,000**	**$0.50/member + $60,000**	**$2/member + $60,000**	**$5/member + $60,000**	**$10/member + $60,000**
Small	80,000	$10,000	$60,000	$40,000 + $60,000 = **$100,000**	$160,000 + $60,000 = **$220,000**	$410,00 + $60,000 = **$470,000**	$800,000 + $60,000 = **$860,000**
Medium	200,000	$10,000	$60,000	$100,000 + $60,000 = **$160,000**	$400,000 + $60,000 = **$460,000**	$1,000,000 + $60,000 = **$1,060,000**	$2,000,000 + $60,000 = **$2,060,000**
Large	2,500,000	$10,000	$60,000	$1,250,000 + $60,000 = **$1,310,000**	$5,000,000 + $60,000 = **$5,060,000**	$12,500,000 + $60,000 = **$12,560,000**	$25,000,000 + $60,000 = **$25,060,000**
Very Large	8,000,000	$10,000	$60,000	$4,000,000 + $60,000 = **$4,060,000**	$16,000,000 + $60,000 = **$16,060,000**	$40,000,000 + $60,000 = **$40,060,000**	$80,000,000 + $60,000 = **$80,060,000**

Discussion: Options for Penalty Structure and Amounts

Does the Board have feedback on the Office's current proposal to:

- Establish two flat untimely data submission penalties ($10,000 and $50,000).
- Establish a $5 per member penalty for failure to submit data.
- Double the per member failure to submit data penalty in each subsequent non-compliant year.

Next Steps



Note: This timeline aligns with planned regulations for Data Submission Guide updates and other data submission regulations updates.

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Action Item: Vote to Approve Data Submission Enforcement Process

Vishaal Pegany, Deputy Director

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Draft Motion

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

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

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

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

   1) The per member base penalty amount will double for each consecutive year that data is submitted late or not submitted at all.

d) These administrative penalties are in addition to, and not in substitution for, other remedies provided by law.

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Public Comment

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Spending Target Enforcement: Assessing Performance, Technical Assistance, and Public Testimony

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

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Technical Assistance

Statute

Office

Enforcement Considerations and Progressive Enforcement Processes:
(a) The director shall enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets, allows each health care entity opportunities for remediation, and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access, quality, equity, or workforce stability. The director shall consider each entity's contribution to cost growth in excess of the applicable target and any actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target. The director shall review information and other relevant data from additional sources, as appropriate, including data from the Health Care Payments Data Program, to determine the appropriate health care entity that may be subject to enforcement actions under this section. Commensurate with the health care entity's offense or violation, **the director may take the following progressive enforcement actions:**

(1) Provide technical assistance to the entity to assist it to come into compliance.

(2) Require or compel public testimony by the health care entity regarding its failure to comply with the target.

(3) Require submission and implementation of performance improvement plans, including input from the board.

(4) Assess administrative penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

Statute

Office

Notification and Communication:
(b) Prior to taking any enforcement action, the office shall do all of the following:

(1) Notify the health care entity that it has exceeded the health care cost target.

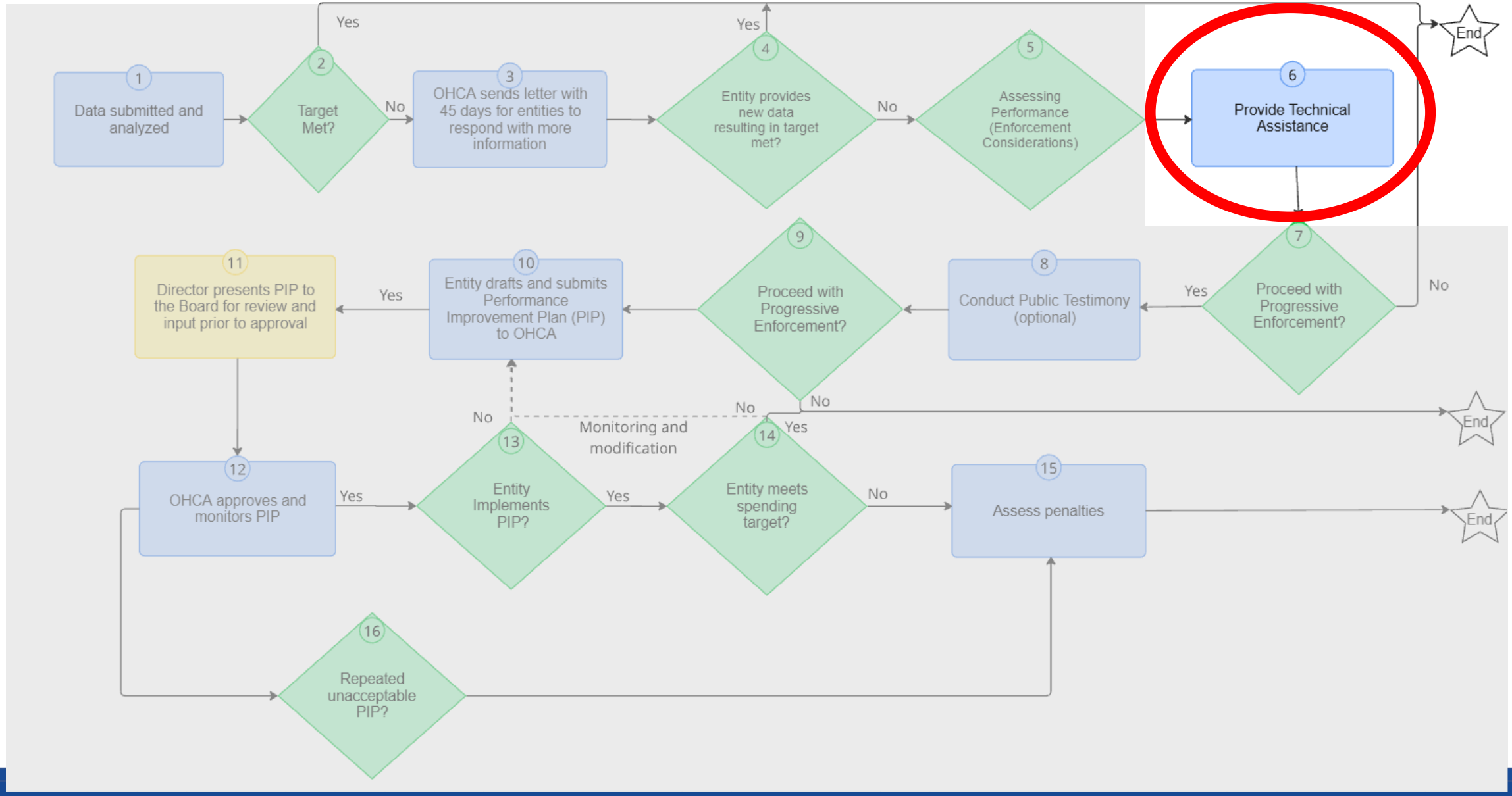
(2) Give the health care entity not less than 45 days to respond and provide additional data, including information in support of a waiver described in subdivision (i).

(3) If the office determines that the additional data and information meets the burden established by the office to explain all or a portion of the entity's cost growth in excess of the applicable target, the office may modify its findings, as appropriate.

(4) The director shall consult with the Director of Managed Health Care, the Director of Health Care Services, or the Insurance Commissioner, as applicable, prior to taking any of the enforcement actions specified in this section with respect to a payer regulated by the respective department to ensure any technical assistance, performance improvement plans, or other measures authorized by this section are consistent with laws applicable to regulating health care service plans, health insurers, or a Medi-Cal managed care plan contracted with the State Department of Health Care Services.

Technical Assistance:
(c) (1) If a health care entity exceeds an applicable cost target, the office shall notify the health care entity of their status and provide technical assistance. The office shall make public the extent to which the health care entity exceeded the target.

Enforcement Process Flow



What is Technical Assistance?

- Technical assistance for the progressive enforcement of spending targets is information provided to health care entities to support their capacity to meet spending targets.

- This technical assistance will be a letter to the entity who exceeded the target, providing them with resources they could employ to assist them into coming into compliance with spending targets. These resources may include research studies, literature, information such as models for increasing primary care investment and APM adoption, and cost-reducing strategies presented to the Board. Letters may be tailored by health care entity and may decompose areas of excess spending.

- Technical assistance does not mean OHCA will direct an entity to implement specific changes to their operations.

Discussion: Targeted Feedback (Technical Assistance) Definition

Does the Board have input on how OHCA is defining Technical Assistance or how it fits into the enforcement process?

Public Testimony

Statute

Office

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(2) Require or compel public testimony by the health care entity regarding its failure to comply with the target.

(3) Require submission and implementation of performance improvement plans, including input from the board.

(4) Assess administrative penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

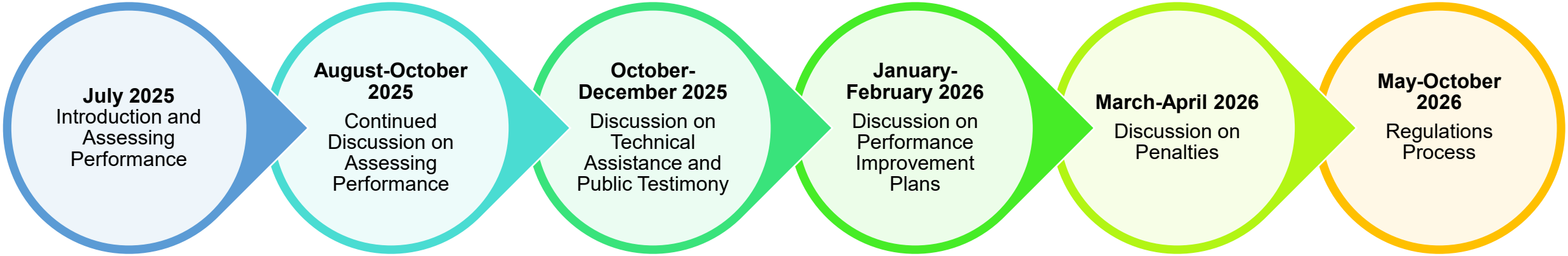
What is Public Testimony?

- Public testimony is an optional step in progressive enforcement, at the discretion of the director.
- Public testimony is an opportunity to hear from health care entities that have exceeded the spending target. It can take various forms, including in-person or written testimony.
  - Entities may elaborate on why they went over the target.
- Public testimony for spending target enforcement is not:
  - An invitation for entities who are meeting the spending target to explain what they are doing. We can invite these entities to our meetings, but they are not required to comply.
  - Asking entities to explain how they plan to meet the target in the future.

Discussion: Public Testimony

Under what circumstances, would the Board want to hear from health care entities regarding exceeding the target?

Timeline for Future Discussion



**Timeline subject to change.*

Waiver of Enforcement

Statute

127502.5. (b)

(b) Prior to taking any enforcement action, the office shall do all of the following:
(1) Notify the health care entity that it has exceeded the health care cost target.
(2) Give the health care entity not less than 45 days to respond and **provide additional data, *including information in support of a waiver described in subdivision (i)*.**

127502.5. (i)

The **office may establish requirements for health care entities to file for a waiver of enforcement actions due to reasonable factors** outside the entity's control, such as changes in state or federal law or anticipated costs for investments and initiatives to minimize future costly care, such as increasing access to primary and preventive services, or under extraordinary circumstances, such as an act of God or catastrophic event. The entity shall submit documentation or supporting evidence of the reasonable factors, anticipated costs, or extraordinary circumstances. The office shall request further information, as needed, in order to approve or deny an application for a waiver.

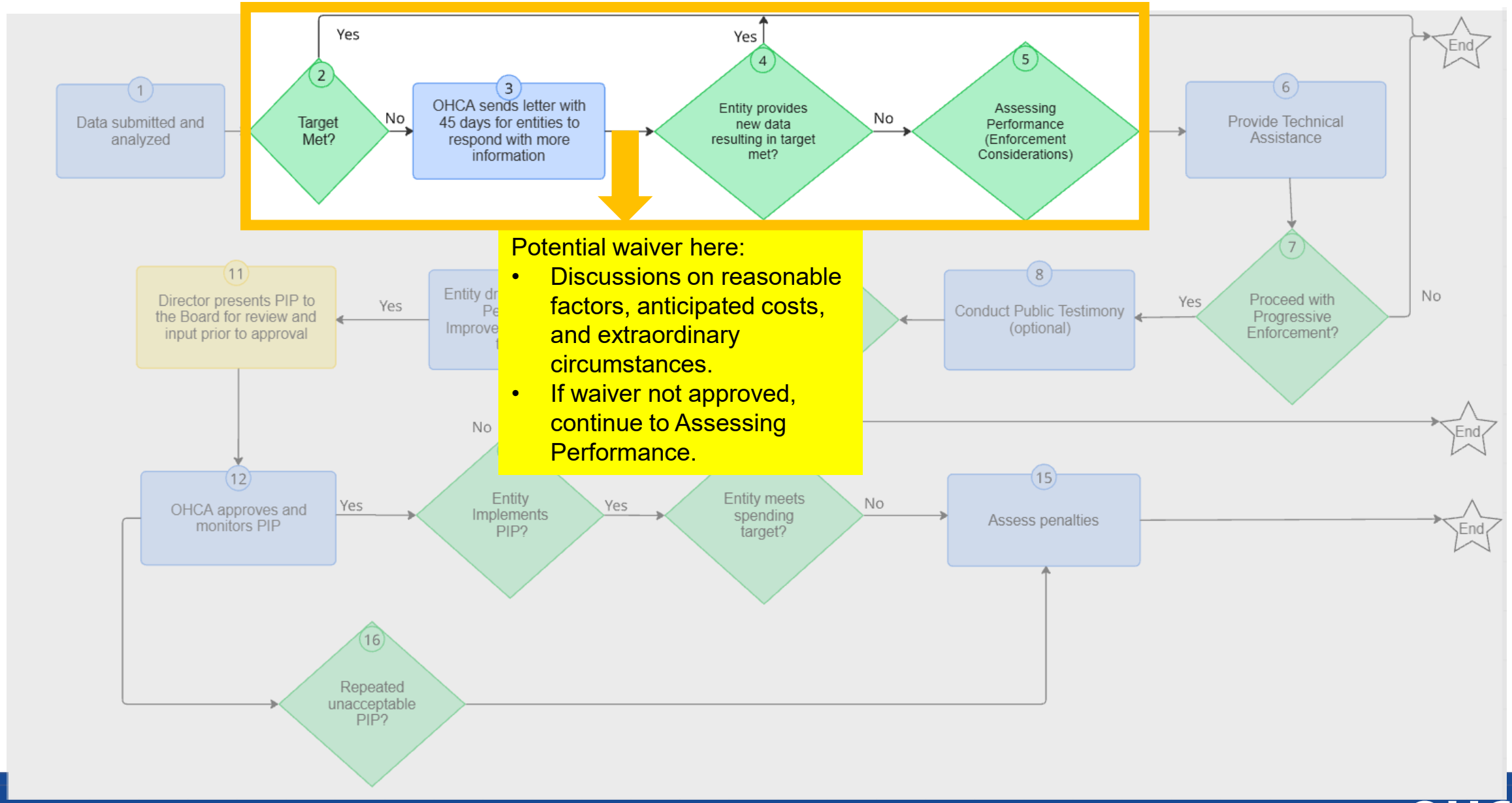
Enforcement Considerations vs. Reasonable Factors

Enforcement Considerations	Reasonable Factors
Factors that OHCA can consider during progressive enforcement Under HSC Section 127502.5(a), the Director shall consider… • each entity's contribution to cost growth in excess of the applicable target and • any actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, • factors that contribute to spending in excess of the applicable target, and • the extent to which each entity has control over the applicable components of its cost target.	**Specific to a waiver of enforcement request** Under HSC Section 127501.5(i), the office **may** establish requirements for health care entities to file for a waiver of enforcement actions due to: • reasonable factors outside the entity's control, such as changes in state or federal law or • anticipated costs for investments and initiatives to minimize future costly care, such as increasing access to primary and preventive services or • under extraordinary circumstances, such as an act of God or catastrophic event. The entity shall submit documentation or supporting evidence of the reasonable factors, anticipated costs, or extraordinary circumstances. The office shall request further information, as needed, in order to approve or deny an application for a waiver.

Potential Enforcement Considerations

Population Characteristics
High-Cost Patient Outliers
Historical Spending Growth
Impact on Consumer Access and Affordability
Investments in Primary and Preventive Care
Entity Baseline Costs
High-Cost Drugs
Changes in State and Federal Law
Acts of God or Catastrophic Events

Enforcement Process Flow



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

Waiver of Enforcement

OHCA will not implement a waiver of enforcement at this time for health care entities who fail to meet the health care spending target.

- The list of factors under the waiver are duplicative with the factors that OHCA can consider under enforcement considerations. As part of the process to assess an entity's performance against the target and determine which entities may proceed through the progressive enforcement process, OHCA can assess reasonable factors outside an entity's control, anticipated costs for investments and initiatives to minimize future costly care, and extraordinary circumstances.
- After the first several years of measuring, reporting, and enforcing spending targets, OHCA will learn if a waiver of a performance year is warranted for specific conditions and circumstances experienced by an entity.

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Public Comment

HCAI

Department of Health Care Access and Information

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

General Public Comment

Written public comment can be emailed to:
ohca@hcai.ca.gov
To ensure that written public comment is included in the posted board materials, e-mail your comments at least 3 business days prior to the meeting.

HCAI
Department of Health Care Access and Information

Next Board Meeting:
November 19, 2025
10am

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

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Adjournment

HCAI

Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Appendix

HCAI

Department of Health Care Access and Information

Additional Spending Target Enforcement Statutory Provisions

Statute

Office

Enforcement Considerations and Progressive Enforcement Processes:
(a) The director shall enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets, allows each health care entity opportunities for remediation, and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access, quality, equity, or workforce stability. The director shall consider each entity's contribution to cost growth in excess of the applicable target and any actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target. The director shall review information and other relevant data from additional sources, as appropriate, including data from the Health Care Payments Data Program, to determine the appropriate health care entity that may be subject to enforcement actions under this section. Commensurate with the health care entity's offense or violation, the director may take the following progressive enforcement actions:

(1) Provide technical assistance to the entity to assist it to come into compliance.

(2) Require or compel public testimony by the health care entity regarding its failure to comply with the target.

(3) Require submission and implementation of performance improvement plans, including input from the board.

(4) Assess administrative penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

Statute

Office

Notification and Communication:
(b) Prior to taking any enforcement action, the office shall do all of the following:

(1) Notify the health care entity that it has exceeded the health care cost target.

(2) Give the health care entity not less than 45 days to respond and provide additional data, including information in support of a waiver described in subdivision (i).

(3) If the office determines that the additional data and information meets the burden established by the office to explain all or a portion of the entity's cost growth in excess of the applicable target, the office may modify its findings, as appropriate.

(4) The director shall consult with the Director of Managed Health Care, the Director of Health Care Services, or the Insurance Commissioner, as applicable, prior to taking any of the enforcement actions specified in this section with respect to a payer regulated by the respective department to ensure any technical assistance, performance improvement plans, or other measures authorized by this section are consistent with laws applicable to regulating health care service plans, health insurers, or a Medi-Cal managed care plan contracted with the State Department of Health Care Services.

Statute

Office

Technical Assistance and Performance Improvement Plans:
(c) (1) If a health care entity exceeds an applicable cost target, the office shall notify the health care entity of their status and provide technical assistance. The office shall make public the extent to which the health care entity exceeded the target. The office may require a health care entity to submit and implement a performance improvement plan that identifies the causes for spending growth and shall include, but not be limited to, specific strategies, adjustments, and action steps the health care entity proposes to implement to improve spending performance during a specified time period. The office shall request further information, as needed, in order to approve a proposed performance improvement plan. The director may approve a performance improvement plan consistent with those areas requiring specific performance or correction for up to three years. 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. The standards developed under Article 7 (commencing with Section 127506) may be considered in the approval of a performance improvement plan.

(2) The office shall monitor the health care entity for compliance with the performance improvement plan. The office shall publicly post the identity of a health care entity implementing a performance improvement plan and, at a minimum, a detailed summary of the entity's compliance with the requirements of the performance improvement plan while the plan remains in effect and shall transmit an approved performance improvement plan to appropriate state regulators for the entity.

(3) A health care entity shall work to implement the performance improvement plan as submitted to, and approved by, the office. The office shall monitor the health care entity for compliance with the performance improvement plan.

Statute

Office

Confidential Information:

(c)(4) The board, the members of the board, the office, the department, and employees, contractors, and advisors of the office and the department shall keep confidential all nonpublic information and documents obtained under this subdivision, and shall not disclose the confidential information or documents to any person, other than the Attorney General, without the consent of the source of the information or documents, except in an administrative penalty action, or a public meeting under this section if the office believes that disclosure should be made in the public interest after taking into account any privacy, trade secret, or anticompetitive considerations. Prior to disclosure in a public meeting, the office shall notify the relevant party and provide the source of nonpublic information an opportunity to specify facts documenting why release of the information is damaging or prejudicial to the source of the information and why the public interest is served in withholding the information. Information that is otherwise publicly available, or that has not been confidentially maintained by the source, shall not be considered nonpublic information. This paragraph does not limit the board's discussion of nonpublic information during closed sessions of board meetings.

(5) Notwithstanding any other law, all nonpublic information and documents obtained under this subdivision shall not be required to be disclosed pursuant to the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records.

Statute

Office

Administrative Penalties:
(d) (1) If the director determines that a health care entity is not compliant with an approved performance improvement plan and does not meet the cost target, the director may assess administrative penalties commensurate with the failure of the health care entity to meet the target. An entity that has fully complied with an approved performance improvement plan by the deadline established by the office shall not be assessed administrative penalties. However, the director may require a modification to the performance improvement plan until the cost target is met.

(2) The administrative penalty shall be deposited into the Health Care Affordability Fund.

(3) Prior to assessing an administrative penalty against a health care entity, the director may consider related provision of nonfederal share, determined to be appropriate by the Director of Health Care Services, associated with Medi-Cal payments, such as expenditures by providers or provider-affiliated entities that serve as the nonfederal share associated with Medi-Cal reimbursement.

(4) To the extent that an administrative penalty is related to a Medi-Cal expenditure, including federal financial participation, the office shall coordinate with the State Department of Health Care Services to ensure appropriate treatment and return of any federal funds pursuant to Subpart F commencing with Section 433.300 of Part 433 of Title 42 of the Code of Federal Regulations.

(5) If, after the implementation of one or more performance improvement plans, the health care entity is repeatedly noncompliant with the performance improvement plan, the director may assess escalating administrative penalties that exceed the penalties imposed under paragraphs (1) and (2) of this subdivision and paragraph (4) of subdivision (a).

Statute

Office

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

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

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

(C) The market impact of the entity.

(e) Administrative penalties shall not constitute expenditures for the purpose of meeting cost targets. The imposition of administrative penalties shall not alter or otherwise relieve the health care entity of the obligation to meet a previously established cost target or a cost target for subsequent years.

Statute

Office

Payers, Fully Integrated Delivery Systems:
(f) (1) For payers and fully integrated delivery systems, the director also shall enforce cost targets established by Section 127502 against the cost growth for administrative costs and profits.

(2) If a payer exceeds the target for per capita growth in total health care expenditures, but has met its target for administrative costs and profits, the payer shall submit relevant documentation or supporting evidence for the drivers of excess cost growth.

(3) This subdivision does not relieve a payer of its obligation to meet targets for per capita growth in total health care expenditures established by Section 127502, and does not limit enforcement actions for payers under this section.

Adverse Impacts:
(g) If data indicate adverse impacts on cost, access, quality, equity, or workforce stability from consolidation, market power, or other market failures, the director may, at any point, require that a cost and market impact review be performed on a health care entity, consistent with Section 127507.2.

Statute

Office

Directly Assessing Administrative Penalties:
(h) (1) The director may directly assess administrative penalties when a health care entity has failed to comply with this chapter by doing any of the following:

(A) Willfully failing to report complete and accurate data.

(B) Repeatedly neglecting to file a performance improvement plan with the office.

(C) Repeatedly failing to file an acceptable performance improvement plan with the office.

(D) Repeatedly failing to implement the performance improvement plan.

(E) Knowingly failing to provide information required by this section to the office.

(F) Knowingly falsifying information required by this section.

(2) The director may call a public meeting to notify the public about the health care entity's violation and declare the entity as imperiling the state's ability to monitor and control health care cost growth.

Statute

Office

Optional Waiver of Enforcement:
(i) The office may establish requirements for health care entities to file for a waiver of enforcement actions due to reasonable factors outside the entity's control, such as changes in state or federal law or anticipated costs for investments and initiatives to minimize future costly care, such as increasing access to primary and preventive services, or under extraordinary circumstances, such as an act of God or catastrophic event. The entity shall submit documentation or supporting evidence of the reasonable factors, anticipated costs, or extraordinary circumstances. The office shall request further information, as needed, in order to approve or deny an application for a waiver.

Statute

Office

Remedies and Rights:
(j) As applied to the administrative penalties for acts in violation of this chapter, the remedies provided by this section and by any other law are not exclusive and may be sought and employed in any combination to enforce this chapter.

(k) Following an administrative hearing, a health care entity adversely affected by a final order imposing an administrative penalty authorized by this chapter may seek independent judicial review by filing a petition for a writ of mandate in accordance with Section 1094.5 of the Code of Civil Procedure.

(l) After an order imposing an administrative penalty becomes final, and if a petition for a writ of mandate has not been filed within the time limits prescribed in Section 11523 of the Government Code, the office may apply to the clerk of the appropriate court for a judgment in the amount of the administrative penalty. The application, which shall include a certified copy of the final order of the administrative hearing officer, shall constitute a sufficient showing to warrant the issuance of the judgment. The court clerk shall enter the judgment immediately in conformity with the application. The judgment so entered has the same force and effect as, and is subject to all the provisions of law relating to, a judgment in a civil action, and may be enforced in the same manner as any other judgment of the court in which it is entered.

Statute - Health Care Affordability Fund

127501.8. (a) There is hereby established in the State Treasury the Health Care Affordability Fund for the purpose of receiving and expending revenues collected pursuant to this chapter. This fund is subject to appropriation by the Legislature.

(b) All moneys in the fund shall be expended in a manner that prioritizes the return of the moneys to consumers and purchasers.

(c) The office may identify any opportunities to leverage existing public and private financial resources to provide technical assistance to health care entities and support to the office. Any private or public moneys obtained may be placed in the Health Care Affordability Fund, for use by the office upon appropriation by the Legislature.

Statute

127502.5. (k) Following an administrative hearing, a health care entity adversely affected by a final order imposing an administrative penalty authorized by this chapter may seek independent judicial review by filing a petition for a writ of mandate in accordance with Section 1094.5 of the Code of Civil Procedure.

(l) After an order imposing an administrative penalty becomes final, and if a petition for a writ of mandate has not been filed within the time limits prescribed in Section 11523 of the Government Code, the office may apply to the clerk of the appropriate court for a judgment in the amount of the administrative penalty. The application, which shall include a certified copy of the final order of the administrative hearing officer, shall constitute a sufficient showing to warrant the issuance of the judgment. The court clerk shall enter the judgment immediately in conformity with the application. The judgment so entered has the same force and effect as, and is subject to all the provisions of law relating to, a judgment in a civil action, and may be enforced in the same manner as any other judgment of the court in which it is entered.

Enforcement Considerations in Other States

Massachusetts (Regulatory Factors)	Oregon (Reasonableness Factors)
• Baseline spending and spending trends over time, including by service category • Pricing patterns and trends over time • Utilization patterns and trends over time • Population(s) served, payer mix, product lines, and services provided • Size and market share • Financial condition, including administrative spending and cost structure • Ongoing strategies or investments to improve efficiency or reduce spending growth over time • Factors leading to increased costs that are outside the CHIA-identified Entity's control • Any other factors the Commission considers relevant.	• Changes in federal or state law • Changes in mandated benefits • New pharmaceuticals or treatments • Changes in taxes (or other admin) • "Acts of God" • Investments to improve health/ health equity • High-cost outliers • Increased behavioral health spending after state raised Medicaid rates • Longer inpatient stays because hospitals were unable to discharge patients to other facilities • Patients with more than $1 million in annual costs, especially for pediatric practices • Increased Medicaid non-claims spending, likely quality payments and COVID-related payments • Increased frontline workforce costs • Service expansions to meet community needs