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

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HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Tuesday, April 22, 2025
10:00 am

Members Attending: Secretary Kim Johnson, Richard Kronick, Ian Lewis, Elizabeth Mitchell, Dr. Richard Pan, Don Moulds

Members Absent: Dr. Sandra Hernández

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; CJ Howard, Assistant Deputy Director, HCAI; Sheila Tatayon, Assistant Deputy Director, Health Systems Compliance, HCAI Margareta Brandt, Assistant Deputy Director, HCAI; Janna King, Health Equity and Quality Performance Group Manager, HCAI

Meeting Materials: https://hcai.ca.gov/public-meetings/april-health-care-affordability-board-meeting-3/

Agenda Item # 1: Welcome and Call to Order
Chair Secretary Kim Johnson, HCAI
Elizabeth Landsberg, Director, HCAI

Chair Secretary Kim Johnson opened the April meeting of California's Health Care Affordability Board as a subcommittee. Roll call was taken following agenda item two, and a quorum was established.

Director Landsberg provided an overview of the meeting agenda.

Agenda Item # 2: Executive Updates
Elizabeth Landsberg, Director, HCAI
Vishaal Pegany, Deputy Director, HCAI
Deputy Director Pegany provided the following information:

- On April 17, 2025, the Office of Administrative Law (OAL) approved amendments to the Total Health Care Expenditures Data Collection regulations with an immediate effective date.

- On April 21, 2025, OAL approved a regulation defining all hospitals as a sector with an immediate effective date. The approved regulatory documents are posted on the HCAI website in the OHCA section of the Laws and Regulations page.
- OHCA has posted documentation to its website that explains how to use publicly available HCAI data to calculate the unit and relative price measures of Commercial Inpatient Net Patient Revenue per Case Mix Adjusted Discharge, and Commercial to Medicare Payment to Cost Ratio.
- An overview of facts about spending target.
- The Quarterly Work Plan for April through June and future topics beyond June 2025.
- A reminder about slide formatting.

Discussion and comments from the Board included:

- A member requested an update, such as the change in median household income and the medical and general inflation rates, from last year to now to understand trends relative to the cost target.
    - The Office replied that this topic could be considered at the May or June meeting when the Baseline Report is discussed using 2022 and 2023 data.

Public comment was held on agenda item 2. One member of the public provided comments.

Agenda Item # 3: Action Consent Item
Vishaal Pegany, Deputy Director, HCAI

a) Approval of the March 25, 2025 Meeting Minutes

Deputy Director Pegany introduced the action item to approve the March meeting minutes. Board Member Lewis proposed a motion to approve, with a second from Board Member Kronick.

Public comment was held on agenda item 3.

Voting members who were present voted on item 3. There were four ayes, one abstain and one member absent. The motion passed.

Agenda Item #5: Information Items
Vishaal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI
Shiela Tatayon, Assistant Deputy Director, HCAI
Margareta Brandt, Assistant Deputy Director, HCAI
Janna King, Manager, HCAI

a) Update on Measuring Hospital Outpatient Spending

Deputy Director Pegany provided an update on how OHCA is refining methods to measure outpatient hospital spending. Deputy Director Pegany stated that this work is key to ensuring that there is a standard approach to measuring hospital spending across both inpatient and outpatient settings.

Discussion and comments from the Board included:

- A member referred to the fact that Health Care Payments Data (HPD) captures approximately 80% of California's health care expenses. The member asked how different the remaining 20% would be from the 80%. The member also asked why Medi-Cal chose the proprietary system rather than an Ambulatory Payment Classifications (APC) and if there are advantages to aligning with Medi-Cal.
    - The Office replied that they will reach out to the Department of Health Care Services (DHCS) for more information regarding their reasoning. In general, HCAI prefers open source tools but the Office also recognizes there are some limitations associated with using Medicare weights and will do a full exploration of the Enhanced Ambulatory Patient Groups (EAPG) weights to see what the data show.
- A member suggested that the inclusion of Consolidated Appropriations Act of 2021 (CAA) data, which includes actual pricing, could be complementary to the claims data that HCAI already has.
    - The Office asked clarifying questions about the data source.
- A member referred to the missing 20% data in the HPD and reported anecdotally that many self-insured purchasers run their claims through third-party administrators who may be unaware of the existence of the HPD. The member suggested there could be more public education to motivate increased participation in the HPD.
- A member asked about the existence or prevalence of alternative payment method models (APM) in hospital outpatient settings and if they affect the ability to use Ambulatory Payment Classifications (APCs) or Ambulatory Patient Groups (APGs).
    - The Office replied that the focus would be on utilization data to calculate the weights but if a hospital is engaged in an APM, the claims and encounter data would still come to the HPD.
- A member asked if there had been a comparison between the number of visits reported in the HPD and the number of visits reported in the annual financial disclosure reports as part of validation. The member also suggested using HPD data to develop weights versus Medicare weights to see which is more appropriate.
    - The Office responded that it has begun validation work. Additionally, the attribution process of linking claims and encounter data to facilities is underway by leveraging hospital National Provider Identifiers (NPIs) and replicating linkages done by RAND for hospital price transparency work. Regarding utilization counts, OHCA's findings show that on aggregate, trends look similar in revenue and utilization for both the HPD and hospital financial data.
- A member suggested using the Health Care Cost Institute (HCCI) as an additional resource for validation work, citing that CalPERS used HCCI in 2019 and 2020 to

create a California benchmark in which to compare CalPERS data inside and outside of hospital settings.
    - The Office asked if CalPERS looked at aggregate trends or facility specific analyses.
    - The member explained that CalPERS had utilized county data, but their understanding is that more granular data is available, possibly even down to the facility level.

Public comment was held on agenda item 5a. Two members of the public provided comments.

b) Follow up - Sector Target Methodology and Values including Summary of Public Comment

Deputy Director Pegany provided feedback on the public comments received, as well as feedback received from one hospital at a hospital engagement meeting. CJ Howard reviewed the Board discussions regarding sector target methodology. Deputy Director Pegany followed up with broader considerations for the Board regarding hospital sector targets.

Discussion and comments from the Board included:

- A member commented that many social services are channeled through the health care system because there is generally more willingness to spend money on health care than on social services. When hospitals provide social services that could be funded by other community resources, it results in higher costs for individuals in commercial plans who end up subsidizing social services. The member suggested that other entities, such as local and state governments, support more funding for social services.
- A member observed that federal proposals further limit housing, social services and Medicaid coverage.
- A member expressed a desire for a more robust conversation about a sense of shared responsibility for the community, citing the disproportionally higher premiums paid by individual commercial payers, particularly those in employment-based plans.
- A member commented that there seems to be a lot of misunderstanding that providers are not yet under the 3.5% target, scaling down to 3%. We have a lot of work to do considering that it is now four months into the first non-enforceable year.
- A member stated that similar analysis on commercial spending showed that higher quality is not correlated with higher prices; in fact, higher quality outcomes tend to be associated with lower-cost facilities. The member also asked if any hospital or industry staff had recommended strategies for affordability.
    - The Office replied that the comment letters they received from hospitals stated that they applauded the goal of OHCA and are aligned with its mission to improve consumer affordability. However, the hospitals did not suggest any specific strategies.
- A member asked if any of the comments had been fact-checked.

    - The Office responded that the comments were not edited; they were reported as submitted.
- A member requested clarification about how the inclusion of outpatient data, which comprises 40% of hospital costs, would be incorporated into the target.
    - A member replied that their understanding is that the target would be evaluated on both inpatient and outpatient spending. The member asked the Office if this was correct.
    - The Office confirmed that is correct.
- A member commented that the hospital target is based on price, not volume, adding that for much of the last decade, a large portion of the overall affordability problem has been rapid increases in outpatient volume. This will continue to be a problem for consumers despite any target. The member encouraged further conversations in the future since hospital revenue can increase substantially through increases in volume even if prices are held to the target level.

Public comment was held on agenda item 5b. Forty-one members of the public provided comments.

Agenda Item# 4: Action Consent Item

a) Vote to Establish Hospital Sector Target – On or before June1, the Board will establish a target value(s)

Prior to taking action on Agenda Item #4, CJ Howard presented summary statistics and alternative options for the Board's consideration, followed by Deputy Director Pegany who presented three draft motions.

Discussion and comments from the Board included:

- A member asked for confirmation that the statute calls for the Board to periodically update spending targets to utilize new information to inform any potential actions that the Board could enact.
    - The Office confirmed that this is correct.
- A member commented that the Board has statutory options to respond to extraordinary circumstances that may occur outside of an entity's control, either through periodic target updates on the front end or the evaluation of factors during enforcement on the backend.

Secretary Johnson proposed a motion to advance Motion 2 as displayed on slide 96, with a second from Board Member Kronick.

Discussion and comments from the Board continued:

- A member asked if a hospital will be removed from the list if it falls below the criteria for two years in a row or if a hospital would be added to the list if it exceeds the criteria for three years in a row.

    - The Office replied that the Board would decide the cadence, whether the data is analyzed each year or every two years. If the data is analyzed next year, new hospitals could be added to the list and 2023 data would be included. Two years of an improving trend that puts the hospital below the 85th percentile could result in the hospital being removed from the list.
- A member suggested that this data be reviewed annually as it signals to the hospitals which direction they are headed. The member also expressed a belief that the use of hospital data for spending target purposes will result in better data submitted by hospitals and vendors, as well as better quality data in general.
- A member expressed concern about the fact that the California Hospital Association (CHA) testified that it could not replicate OHCA's calculations and results.
    - The Office explained that they had met with the CHA and the CHA staff stated that their latest calculations came close on the Payment to Cost Ratio. On April 9, 2025, OHCA provided a full data set, the step-by-step instructions, and the programming code to the CHA.
- A member asked for clarification regarding the methodology used to calculate the discharge threshold, stating that using 30% as the threshold may not consider that variation becomes too wide as to be usable, particularly as it relates to smaller hospitals.
    - The Office replied that it recognizes that smaller hospitals may be more volatile in terms of the number of patients they serve. OHCA has not conducted an analysis to determine a cutoff, but 30% has been given as the initial recommendation.
    - A member added that he does not have a quantitative answer to the question regarding the threshold and variability for small hospitals, but he believes that the variability is small enough to lead him to support 30% as a reasonable threshold.
    - A member expressed concern that using a percentile creates too big a variation. He suggested that analyzing the number of discharges would yield more accurate data which would better reflect the geographical differences between Southern California where there are more small hospitals and Northern California where larger hospitals are located. This percentile method would exclude many hospitals based on size and location.
- A member asked how outpatient data would be included in the analysis.
    - The Office replied that the Healthcare Payments Database could be a source for outpatient weights, as presented earlier. OHCA is calculating weighted averages for each facility and will convene a workgroup to get additional feedback. The goal is to have production data on outpatient measurements by the end of the year. For reporting on the performance year, it will be based on the same cadence that HCAI hospital finance data is released. HCAI is just getting 2023 data so there will always be a lag in terms of data availability. Essentially, Inpatient Net Patient Revenue (NPR) per Case Mix Adjusted Discharge would be added to Outpatient NPR per Adjusted Outpatient Visit to get a combined measure, although it is more meaningful to view the measures separately so that you could monitor inpatient and outpatient activity.

- A member suggested that the methods used to calculate inpatient and outpatient data be reviewed a year from now to improve the methodology for ranking hospitals so that the data reflects both inpatient and outpatient more accurately.
    - The Office replied that the identification of high-cost hospitals was based on those two measures, and that other measures could be added, including the outpatient component.
- A member expressed her support for Motion 2 and emphasized the importance of focusing on the Commercial to Medicare Payment to Cost Ratio because that is where the affordability crisis is most acute — in the commercial market. The member suggested a friendly amendment to Motion 2 that, due to hearing about challenges with the data, hospitals should be required to be 100% compliant with federal transparency requirements. The more transparency on cost, the easier to track progress.
- A member expressed concern about the modest effect that adopting Motion 2 would have, citing that only a dozen of the 430 hospitals in the state would be put on a 20-year track, not to come into line with the rest of the state, but only to make some improvements. The member additionally contemplated a hospital, for either data or behavioral reasons, going from the 87th percentile down to the 60th percentile, versus the concern of just dropping from 86 to 84, and the possibility where the current list of seven hospitals would be winnowed down to one or two.
- A member expressed support for Motion 2, adding that the discharge threshold, and the incentives for hospitals to have a positive trend, make sense. They expressed support for the idea that the Office would accept corrections to certified filing reports from hospitals, as well as an annual review of the methodology.
- A member also asked if the first sentence of the amendment which states “set the hospital sector spending target equal to the statewide spending target” would still be the case even if the motion is not adopted.
    - The Office replied that this is correct. The member stated that it is important to note that the adoption of this motion would only give special treatment to the seven hospitals which would have a different target than the statewide target that is applicable to all health care entities in the state, not just to hospitals.
- A member asked if an amendment could be added to the original amendment to include an annual revisiting of the methodology, including compliance with federal reporting.
- A member asked if the amendment would impose additional requirements on hospitals that exceed current federal requirements. A member explained that the requirement would mean actual compliance with federal law because currently there is not full compliance.
    - The Office asked how the state staff could determine federal compliance and how that would relate to meeting the target.
- A member replied that the hospital could attest full compliance with federal transparency requirements so that data is available on hospital costs and pricing.
    - The Office replied that it would not be able to enforce that attestation because a different regulator requires data submission to the federal government.

- A member expressed confusion about how adding the requirement for 100% compliance with federal law would be of benefit and added that it could create additional problems.
- A member asked if hospitals would be able to update or correct their data due to legitimate errors in interpretation or misclassification.
    - The Office stated that hospitals can resubmit data if they believe that errors were made.
- A member asked if calling out specific hospitals in the motion prevents these hospitals from submitting legitimately corrected financial statements.
    - The Board discussed that the motion that Secretary Johnson moved both identifies the individual hospitals as well as the methodology. A high-cost hospital that resubmitted financial reports that put it below the 85th percentile could be removed from the high-cost hospital list. The Board would need to amend its previous action with another action and the submission of new data would not automatically remove a hospital.

The Office explained that the staff drafted the motion to include naming the hospitals so that new hospitals would not be added as a result of revised financial statements.

- A member suggested that the vote be held in one month to give the members time to review the attestation portion of the motion.
- A member expressed support for transparency from hospitals as well as a concern about the federal/state interaction. The member suggested excluding that amendment from Motion 2.
- A member withdrew their amendment, stating that they will bring it up again because there is no excuse for hospitals to be noncompliant with transparency rules that have been in place for years.
- Secretary Johnson stated that one amendment had been withdrawn. An additional amendment had been proposed and it would be a new number 5 which would read, “Annually, the Office shall provide the Board with an updated list of hospitals who are high-cost and an updated list of factors to be considered in setting a hospital sector target.”
    - A member asked if the language could be changed from “high-cost” to “meet the criteria for high-cost.”
    - A member suggested changing the amendment to include “an updated list of factors to be considered in identifying high-cost hospitals” and to change the “hospitals who” to “hospitals which”.
- Secretary Johnson stated that the new number five is added to the original slide 97 to read, “Annually, the Office shall provide the Board with an updated list of hospitals which meet the above criteria as high-cost and an updated list of factors to be considered in identifying high-cost hospitals.”

Public comment was held on agenda item 4a. Twelve members of the public provided comments.

Secretary Johnson introduced the action item to approve the amended motion.

Voting members who were present voted on item 4a. There were five ayes, and one member absent. The motion passed.

Agenda Item #5: Informational Items

c) Update on Cost and Market Impact Review Program
Assistant Deputy Director Tatayon presented an update on the Cost and Market Impact Program.

Discussion and comments from the Board included:

- A member asked why Oregon, which is a much smaller state than California, has 51 filings while California only has 16 filings.
  - The Office explained that Oregon includes other types of health care entities in their jurisdiction, such as home health and hospice that are not under OHCA's jurisdiction.
- A member asked if Oregon exempts transactions from non-profit entities that are reviewed by another state agency.
  - The Office replied that Oregon works with its Attorney General, but they would have to verify whether transactions from non-profit entities are exempted.

Public Comment was held on agenda item 5c. One member of the public provided comments.

d) Update on Quality and Equity Performance Measurement, including Public Comment and Advisory Committee Feedback

Assistant Deputy Director Brandt and Janna King provided an update on quality and equity performance measurement, including public comment and advisory committee feedback. They announced that OHCA is adopting the OHCA Quality and Equity Measure Set, which is a combination of the Department of Managed Health Care (DMHC) Health Equity and Quality Measure Set, the Office of the Patient Advocate (OPA) Health Care Quality Report Card measures, and the HCAI Hospital Equity Measures Reporting Program measure set.

Discussion and comments from the Board included:

- A member asked if there was a reason why every pediatric medical visit is not being measured for quality and suggested aligning with DMHC and Medi-Cal.
  - The Office replied that it is adopting the child pediatric focus measures that are included in the DMHC and the OPA measure sets. OHCA can collaborate with DMHC and OPA to consider adding and adjusting measures as they change over time.
- A member asked if there was an effort to collect racial, ethnic, and sexual orientation data to assist in collecting more accurate data regarding equity.
  - The Office replied that it is working across sibling departments to collect this information, including language data, and notes that Covered California collects this data upon application but it is incomplete in the commercial and Medicare

Advantage markets. HCAI is pushing commercial payers in the HPD program for better data. Additionally, the HCAI Hospital Equity Measures Advisory Committee has shared best practices for collecting this data. Some sibling state departments have contract requirements to increase the reporting of member race, ethnicity, and other demographic factors which contribute to the collection of this data.

- A member stated that there is a need to create a culture among providers and patients that is non-threatening where everyone understands the benefit of collecting this data.
- A member expressed appreciation for the well-rounded approach, cited the importance of the alignment, and suggested that the administrative burden could be reduced by achieving consensus on a few key indicators.
- A member suggested it would be helpful and not an additional burden to add to the measure set those measures already being collected by the CDC (Centers for Disease Control and Prevention).
    - The Office replied that it had investigated the relationship between the CDC and the California Department of Public Health (CDPH) regarding hospital patient safety measures and that these findings would be part of its work moving forward, leading up to the fall.

Public Comment was held on agenda item 5d. One member of the public provided comments.

Secretary Johnson announced that Item #5e Update on Behavioral Health Definition and Investment Benchmark, including Advisory Committee Feedback, will be postponed until the May 2025 Board Meeting.

Agenda Item #6: Adjournment

Chair Johnson adjourned the meeting.