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

2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Tuesday, August 26, 2025
10:00 am

Members Attending: Dr. Sandra Hernandez, Richard Kronick, Ian Lewis, Dr. Richard Pan

Members Absent: Secretary Kim Johnson, Elizabeth Mitchell, Don Moulds

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; CJ Howard, Assistant Deputy Director, HCAI

Meeting Materials:

Agenda Item # 1: Welcome and Call to Order
Elizabeth Landsberg, Director, HCAI

Director Landsberg opened the August 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 and a reminder that there will not be a Board meeting in September.

Agenda Item # 2: Executive Updates
Elizabeth Landsberg, Director, HCAI
Vishaal Pegany, Deputy Director, HCAI

Director Landsberg provided Executive Updates on the Rural Health Transformation Program (RHTP), part of the federal Budget Reconciliation bill (HR 1). The RHTP provides $50 billion over five years to strengthen health care access in rural areas. Of the $50 billion, $25 billion will be equally distributed among states with an approved application and $25 billion will be apportioned based on a state's application score.

- The federal government will be releasing a Notice of Federal Opportunity (NOFO). The law requires Centers for Medicare and Medicaid Services (CMS) to consider specific factors when distributing the funds and must approve or deny applications by December 31, 2025. To receive funding, states must submit a

Rural Health Transformation Proposal that addresses the required goals and activities. HCAI is awaiting final federal guidance for the official submission.
- HCAI's State Office of Rural Health will oversee California's proposal, guided by feedback from rural health leaders and broad stakeholder engagement. Stakeholder outreach will begin with a webinar on September 4th, a follow-up survey, and additional webinars and listening sessions at the end of September.

Deputy Director Pegany provided Executive Updates, including the following:
- A review of a National Bureau of Economic Research Working Paper which examined the effects of mergers between hospitals and physician practices on prices and quality for labor and delivery services.
- A review of a Health Affairs Scholar article which examined the total cost of coverage for Covered California households.
- An overview of the Quarterly Work Plan for the remainder of 2025 and plans for 2026.
- A reminder about slide formatting.

Discussion and comments from the Board included:
- A member asked how much funding California anticipates receiving from the Rural Health Transformation Program.
  - The Office replied that if every state were to get the same amount, California would receive $1 billion over five years but we will not know the specific factors until CMS releases the NOFO to describe how they define rural areas and how they will assign points.
- A member emphasized the need to provide hospitals with clarity as soon as possible regarding how spending will be measured given that they will be held to a target.
  - The Office replied that they understand the urgency and are working as fast as they can.
- A member recalled previous discussions regarding a regular review of the spending targets and requested the review process to be implemented into the work plan.
  - The Office stated that they would take the information back and noted they will have two years of data collection (2023 and 2024) on total health care expenditures at the payer level; these are pre-target year data but can be useful to understand what is happening with spending.
  - A member commented there will also be new information about median household income growth, as well as health care spending growth more generally, both nationally and in California.

Public comment was held on agenda item 2. Four members of the public provided comments.

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

a) Vote to Approve the July 22, 2025, Meeting Minutes

Deputy Director Pegany introduced the action item to approve the July meeting minutes. Ian Lewis proposed a motion to approve, with a second from Dr. Richard Pan.

Public comment was held on agenda item 3. No members of the public provided comments.

Voting members who were present voted on item 3. There were four ayes. The motion passed.

Agenda Item #4: Informational Items
Vishaal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI

a) Discussion of Data Submission Enforcement, Continued

Assistant Deputy Director CJ Howard provided an update on data submission enforcement, as well as answers to questions that the Board asked at the July meeting.

Discussion and comments from the Board included:

- A member asked for clarification concerning how the California Consumer Price Impact (CCPI) adjustment would impact the penalty calculation.
  - The Office replied that purpose of the penalty adjustment based on changes to an economic indicator is to provide discretion to increase the amount of the penalty so that they remain relevant years from now without a need to update the penalty amounts in regulation.
- A member commented that the failure to submit data penalty equating to 0.06 percent of a plan's total revenue does not seem like much of a penalty if someone is intentionally not complying with the spending target. Additionally, the member asked what kind of penalties an Administrative Law Judge (ALJ) would be able to impose beyond what the Board is already imposing on the entity.
  - The Office responded that it is not the penalty that the ALJ would impose, but an order compelling the entity to submit the data. If the entity does not comply with the ALJ, the next step would be Superior Court and initiating a writ where the court mandates compliance with the ALJ order.
- A member commented that the procedure sounds onerous and expensive to the Office and may be time-consuming with an uncertain outcome. Entities could absorb the data submission penalty as a cost of doing business if they anticipate they will be well over the target. They may decide this is a good risk depending on what is decided on other penalty amounts. The member suggested increasing the $5 per member penalty substantially or perhaps $5 in January, another $5 in February, etc.; i.e., create something other than an annual penalty assessment.
- A member asked if the data continues to be useful after the $5 penalty date. The member also suggested imposing some form of a progressive penalty where every month the data is not submitted, the penalty increases.

    - The Office replied that the data would be important not just for the payer's performance, but also the physician organizations measured using attributed spending.
- A member requested clarification concerning the timing of the data in relation to when OHCA analyzes it and stated that an entity's failure to submit data impairs OHCA's ability to fulfill its statutory requirements.
- A member agreed with other commentors and stated that December should be the point at which penalties are accelerated monthly so that there is accountability for the lack of timeliness.
    - The Office replied that they need to receive the data in the fall for inclusion in THCE data; that is why they are imposing penalties starting January 1st.
- A member suggested the December penalty could be $10 per member and $5 a month for every additional month the data is not submitted.
- A member commented that the data is needed by the end of the year and questioned whether there is something more to leverage this outcome.
    - The Office responded that it will take back the Board's input and consider a progressive penalty structure, recognizing that this could be a first-year approach and could be updated in the second year depending on experience.
- A member shared that it is their understanding that the payer community has generally been cooperative. The member also commented it is important that OHCA sets the rules ahead of time so it does not look like they are tailoring penalties against any one particular entity but rather are pursuing a fair and justifiable process.

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

b) Discussion of Spending Target Enforcement – Assessing Performance

Deputy Director Pegany continued the discussion from last month's meeting along with Assistant Deputy Director CJ Howard focusing on spending target enforcement considerations. Deputy Director Pegany asked for feedback from the Board and the public concerning what factors should be considered when contextualizing spending and determining which entities receive enforcement steps.

Discussion and comments from the Board included:

- A member requested clarification regarding the timing of technical assistance.
    - The Office clarified that the statute requires them to provide technical assistance to any entity that exceeds the spending target, but entities are given an opportunity to provide additional information prior to the Office providing technical assistance.
- A member commented that it is useful to know if the entities' demographics changed in a way that would either give them an advantage or disadvantage in relation to the cost target.
- A member commented that if looking within sector (e.g., commercial, Medicare, or Medi-Cal), it is unlikely an age/sex adjustment matters materially. If looking at combined sectors, at the entity level, only consider an adjustment if the aging

population has changed considerably from the statewide average (since the statewide average in theory is built into the targets), such as if a service area is impacted by closures and the elderly go to a system that previously did not serve them.
    - Two other members agreed with the above comment.
- A member suggested keeping the adjustment simple and addressing acts of God and other considerations on a one-off basis through board discussion and public input.
- A member cautioned against creating a disincentive for a plan or other entity to take on patients for which they would not receive an adjustment if there is a shift in a market (such as an entity closure) but not impacting the entire state.
    - The Office replied that slide 41 shows a pre-spending target era with only one year of data, but it shows there are cases where a population adjustment could make a difference in whether an entity met the target. As an Office just starting with limited resources, maybe it is also a reason to instead pursue a performance improvement plan with other entities.
- A member asked if enforcement could be based on how far above the spending target an entity is.
    - The Office stated that this could be discussed during the consumer access and affordability portion of the presentation as it could depend on the entity's position in the market such as a large statewide plan that is dominant or a plan that is dominant in a region; one plan could have high cost growth but fewer people while another could be a large one that grew but not as much. The question is how to prioritize for enforcement.
- A member asked for clarity on whether this discussion covers potential enforcement of physician groups, hospitals, and other health care providers.
    - The Office confirmed that physician groups, hospitals, and other health care providers in addition to plans are a part of the discussion.
- A member stated that the Office should consider the size of the entity in terms of overall costs in the state and suggested not going after lots of little fish.
    - A member commented that if that little fish is the only player in the market it might be important to consumers and that there is variability in terms of the enforcement considerations.
- A member commented, regarding high-cost patient outliers, that from the previous hospital sector discussions and Monterey analysis the Board learned much of spending in what plans consider high-cost claims are actually the places where they often have the most control and referred to eyepopping numbers being charged to purchasers and payers, using an example of generic cancer treatment drugs as a control. This is the core purpose why providers are entrusted with patient care – to make these hard judgement calls.
- A member commented that there may be circumstances where high-cost treatment should be considered, for example, a new sickle cell therapy. There should be an opportunity for the entity to justify these high-cost patients, to not create a disincentive to making certain types of care available.
- A member stated that whatever is considered, it should be considered in comparison to the rest of the state. Every entity will have high-cost outliers. When an entity has

more high-cost outliers than statewide averages or trends, that puts burden on the Office to investigate the circumstances. The member also suggested that new technology should be considered in addition to high-cost drugs.
    - The Office asked if instead of a change in high-cost outliers or difference relative to a statewide comparison, it looked at a change in that entity's number or volume of high-cost outliers from the prior year, factored out the difference, and held them constant. This approach would likely only apply to smaller entities but could help in prioritization in terms of progressive enforcement.
    - The member replied that the approach seems plausible but that OHCA would still want a statewide view of change in high-cost outliers to compare against.
- A member commented that an entity could have fewer high-cost outliers but then pick up many more, for example, by bringing in a new service line for expensive conditions (e.g., a specialty transplant surgeon), they would be dinged on the change.
    - The Office asked in the example if it would be a one-time jump and then once they started serving that population there would be multi-year stability.
    - The member commented that if it is expensive enough to affect their overall cost growth and they can attribute most of the increase to the new service line, would OHCA understand; otherwise, it creates an incentive to not consider expanding new service lines.
- A member commented that these conversations are generic in nature and that in providing feedback to the Office on how to prioritize, the intent is not to deny access to care. When thinking about outliers, it should be a onetime look and revert to baseline when those outliers no longer exist. There will need to be significant judgement around how much time is spent trying to understand an outliers' impact on an entity's spending. It is very hard to pinpoint with precision how to assess the weight of these criteria. The member also agreed with looking to statewide figures as a measure by which we assess how much of an outlier there may be.
- A member commented, regarding the historical spending growth consideration, that they keep getting drawn to the consumer access and affordability piece and are having a hard time separating this from historical spending growth. The Board is teasing out two different things: 1) which entities to prioritize and 2) how progressive the enforcement will be. They suggest prioritizing and enforcing against entities starting at a higher baseline/cost point compared to others in the sector but question whether the Board needs to define a sector for every entity to make this approach possible. They also asked whether OHCA has the legal flexibility to be more patient with those starting from a lower baseline as compared to those who are starting from a higher baseline in the penalty amounts.
    - The Office replied that they put baseline spending forward as a potential option.
- A member commented that it makes sense to consider historical spending growth.
- A member suggested that the Board consider trends. If the entity is trending in the right direction and they are making efforts to improve, there might be room for latitude.
- A member asked for clarity concerning how OHCA would approach consumer access and affordability.

- The Office stated that they could obtain enrollment figures from the regulators for some of the statewide plans which could provide their market share. For the regional plans, they would need to look at the entity's position in the region, and for physician organizations, they would need to look at size.
- A member asked whether a rural hospital that is the only hospital in a large area would receive more or less latitude.
    - The Office replied that the enforcement considerations could cut both ways in terms of prioritizing more or less. A rural hospital would be more dominant in their market since they would be the only option but OHCA did not want to only look at market size or share since it would not account for situations like this; it would need to look at other factors as well, such as public payer mix.
- A member recommended prioritizing those who are aggressively driving prices, where price increases are the overwhelming factor resulting in them not meeting the target.
- A member cautioned that an investment in primary and preventive care could result in consolidation. If an entity bought all the primary care practices, they could frame that as an investment in primary care.
    - The Office stated that the statute calls for primary care investments and the goal is to shift spending away from unnecessary care or expensive specialty care. Some savings or cost avoidance would not materialize until later so the Office would look for that.
- A member expressed support for increasing investment in primary care. The member stated that, while costs will initially increase with the investment, the Board should expect costs to come down post the initial investment. There should not be a sustained increase in costs.
- A member stated they are cognizant of the fact that there are shortages in much of the state. Forty-five percent of CalPERS members live in a designated behavioral health or primary care shortage area. Most of these live not in rural California but in a big market. They suggested teasing out key strategies to differentiate between constructive and box checking approaches. They predict that there will be a high probability of box checking responses to this.
- A member commented that this consideration also talks about preventative services which do not often require a primary care physician to implement. We need to think about how we get better in systems and delivery capabilities around basic preventive and population-based care.
- A member commented that entity baseline costs as a potential enforcement consideration made sense to them.
- A member commented that if the Office will compare an entity's spending against statewide and then focus on those that exceed the target by more than many other entities, high-cost drugs (e.g., GLP-1s) will likely not matter much since most entities will be affected; the exception could be cell and gene therapies.
- A member suggested that if a hospital or health system decides to make an investment which will result in an increase in spending and could lead to improvement in health outcomes, the Office does not want to be in a position to say no.

- A member shared that the Institute for Clinical and Economic Review (ICER) analyzes the impact of new interventions, new treatments, new capabilities, so this is not a function that OHCA should take on. Should this situation arise, the Office could ask that entity to provide an analysis showing whether the potential outcome would justify the increase in spending.
- A member pointed out that there are high-cost drugs and technologies that are rapidly decreasing in price or coming off patent; this is a reason an entity should be well under the target. High-cost drugs and technology are something to think about for the statewide target but not at the individual entity level.
- A member commented that high-cost drugs from a pharmacy are likely uniform in impact across plans and systems versus those purchased by hospitals and used inpatient, these may be more heterogenous.
- A member asked if the Board is able to adjust the spending target after is set if there were widespread changes (e.g., tariffs) that would cause larger spending increases for all entities.
    - The Office stated that they would still need to follow the March and June timeframe so it is too late to change the current spending target but these enforcement considerations are a way to articulate how OHCA could handle these situations.
- A member recommended that the Board reassess this process annually given the changes at the federal level.
- A member agreed with the above comment and noted that it is also important to have a stake in the ground by which we are trying to hold entities accountable as the environment changes. As the Board looks at prospective spending targets, that would be the time to take the federal changes into account and not move the goal line in the middle of the reporting period.
- A member asked for an example of a foreseeable catastrophic event in which an entity did not take precautions to mitigate.
    - The Office replied that we will have big earthquakes in California and gave an example of seismic compliance, if a hospital has not sufficiently planned for and implemented seismic safety standards.
    - The member responded that if they are out of compliance with state law, that is a definitive standard but after that, how OHCA would assess reasonable precautions would be challenging.
- A member commented that perhaps another example would be gross negligence that resulted in a catastrophe that is perhaps proven in court.
- A member commented that if there is an earthquake, etc. and many people in a service area need health care, causing health care spending to go up, the Office should consider this.
- A member asked whether the statute has specific language regarding increases in negotiated labor rates.
    - The Office stated that this would not be an enforcement factor. The entity would submit data to OHCA to substantiate that a labor agreement resulted in costs growing faster than the target. This is a front-end adjustment.

- A member asked for clarification about technical assistance and what steps would be taken in the event that an entity has followed a corrective action plan but is still exceeding the spending target.
    - The Office replied that a performance improvement plan (PIP) would be time-limited and quantifiable, with significant milestones (i.e., measurable); it could also be updated. The Office also provided a timeline for future discussion, showing that in October OHCA will continue the discussion of assessing performance. In November and December, the Board will discuss technical assistance and public testimony. The order of these discussions could shift. PIPs will be discussed early next year, followed by a discussion on penalties in the spring.

Public comment was held on agenda item 4b. Six members of the public provided comments.

Agenda Item #5: General Public Comment

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

Agenda Item #6: Adjournment

Chair Johnson adjourned the meeting.