California Cardiovascular
Outcomes Reporting Program (CCORP)
Clinical Advisory Panel (CAP)
Draft Meeting Minutes for November 10, 2025

Meeting location (with a virtual option for the public):
Department of Health Care Access and Information
2020 West El Camino Avenue
Room 1237
Sacramento, CA 95833

Ronald Reagan UCLA Medical Center
200 UCLA Medical Plaza
Conference Room 647
Los Angeles, CA 90095

Philip R. Lee Institute of Health Policy Studies
480 16th Street
Conference Room 647
San Francisco, CA 94158

Clinical Advisory Panel Members present:

Ralph Brindis, M.D., M.P.H., F.A.C.C., Chair	Andrew Rassi, M.D.
Cheryl Damberg, Ph.D.	Maribeth Shannon, M.S.
Gordon L. Fung, M.D., M.P.H., Ph.D.	Richard J. Shemin, M.D.
Mamoo Nakamura, M.D., Ph.D.	Vincent DeFilippi, M.D.
Hon S. Lee, M.D.	Rita Redberg, M.D.

HCAI Staff and Health Analytics Branch (HAB) Staff present:

Scott Christman, M.A., HCAI Chief Deputy Director	Michael Valle, M.P.A., Deputy Director & Chief Information Officer
Lemeneh Tefera, M.D., M.Sc., Chief Medical Officer	Mark Kishiyama, Ph.D., Research Scientist III
Christopher Krawczyk, Ph.D., Chief Analytics Officer	Shannon Conroy, Ph.D., MPH, CCORP Manager

1 – 3. Call to Order, Welcome and Meeting Minutes – Ralph Brindis, M.D., M.P.H., F.A.C.C., CAP Chair

Ralph Brindis, M.D., Chairperson, welcomed everyone and called the meeting to order at 9:05 a.m. with roll call. A quorum was present to conduct business.

Action: The Clinical Advisory Panel unanimously approved the meeting minutes for the April 15th, 2025.

Action: The Subcommittee unanimously approved the meeting minutes for August 13th, 2025.

4. HCAI Director's Office Report – Scott Christman, Chief Deputy Director, Department of Health Care Access and Information

Chief Deputy Director Scott Christman presented department updates. Office of Health Care Affordability (OHCA), established by Governor Newsom, aims to lower healthcare costs and improve value through statewide spending targets. The California Hospital Association filed a lawsuit in San Francisco Superior Court last month against HCAI, OHCA, and the OHCA Board. The lawsuit challenges statewide spending targets, methods for identifying high-cost hospitals, and adjusted targets for high-cost hospitals. HCAI does not comment on pending litigation. Additional updates include the January 1, 2026 launch of the CalRx Biosimilar Insulin Initiative, administered by HCAI. This state-backed program offers CalRx biosimilar insulin pens at a reduced cost for individuals with diabetes, making California the first state to offer its own affordable insulin supply.

HCAI submitted a grant application to the Rural Health Transformation Program, administered by Centers for Medicare & Medicaid Services (CMS), as part of a 5-year federal initiative with a $50 billion budget to strengthen healthcare delivery in rural communities. HCAI surveyed a broad range of stakeholders, including healthcare providers representing rural hospitals, community clinics, rural health clinics, tribal clinics, and local behavioral health programs. Non-provider stakeholders included representatives from local governments, health departments, education and training programs, community-based organizations, and health plans. Based on stakeholder feedback, key focus areas are workforce development, chronic disease prevention, provider support, and optimizing healthcare delivery.

California strives to make healthcare and prescription drugs more transparent, accessible and affordable. Governor Newsom signed legislation specific to prescription drug affordability. Senate Bill (SB) 40 improves affordable access to insulin for individuals with diabetes and SB 41 standardizes pharmacy benefit managers operations in California.

Governor Newsom also signed several bills that impact HCAI directly:

- Assembly Bill (AB) 1415: Expands OHCA oversight to include private equity, hedge funds, and Management Service Organizations for material change notices.
- SB 660: Transfers California Health and Human Services Data Exchange Framework to HCAI, expands the entities required to participate in the Data Exchange Framework, and strengthens the program's stakeholder governance.
- AB 144: Establishes the Abortion Access Fund and authorizes HCAI to distribute funds to maintain Planned Parenthood services.

Panel Member Damberg asked if private equity transaction reporting data would be publicly available. Chief Deputy Director Christman confirmed that all notices of material change are posted online. Damberg requested making the data accessible in a simple database format, such as an Excel spreadsheet. Christman also responded to questions from the panel about the impact of the federal shutdown and Affordable Care Act enrollment trends. He confirmed there was no immediate impact from the shutdown.

5. HCAI Office of Information Services Report – Christopher Krawczyk, Ph.D., Chief Analytics Officer, HCAI

Chris Krawczyk, Ph.D., Chief Analytics Officer, provided a summary of key work in the Healthcare Analytics Branch (HAB). HAB completed its seventh year of stakeholder outreach and engagement, gathering feedback to inform the 2026 Analytic Strategic Plan. The 2024 patient-level confidential hospital data was released in the fall. Snapshot measures were refreshed and an updated prescription cost product will be released that includes Medi-Cal and Medicare Advantage. New data briefs were released on behavioral health spending and payment arrangements in the commercial markets.

The Health Care Payments Data (HPD) Program launched data request services this year and received over 30 requests. The first approved projects were granted access in October through the secure data enclave, a virtual environment that enables use of the data without downloading. The HPD Advisory Committee's October meeting focused on public reporting priorities and dental data quality. HPD will soon release a new product for hospital costs.

The Hospital Equity Measures Reporting Program (AB 1204) requires hospitals and hospital systems to submit an annual Hospital Equity Report to HCAI and post them publicly. These reports include core quality measures stratified by demographic factors, identification of the top ten disparities, and an Equity Plan. The first reports for the program were due on September 30, 2025.

The Panel requested additional information about HPD data requests. Dr. Krawczyk explained that requests come from a diverse set of users, including academic institutions, professional associations, and policy organizations. HCAI posts monthly updates on its website summarizing requester types and project descriptions. He also clarified that some requests include Medi-Cal data, which requires additional review by the Department of Health Care Services.

6. Nomination of CAP Chair – Christopher Krawczyk, Ph.D., Chief Analytics Officer, HCAI

Dr. Krawczyk facilitated Panel Chairperson nomination process. Nominations must be made verbally during the public meeting to avoid serial communications. Nominees must be current Panel members, and self-nominations are permitted. The appointment of the Panel Chairperson will be made at the discretion of the HCAI Director.

Nominees included Dr. Richard Shemin, Dr. Rita Redberg, and Dr. Andrew Rassi. Dr. Brindis declined nomination to continue as chair. Panel members and members of the public may submit letters of support for nominees and inform the Director's decision by Dec 2, 2025.

Additional points discussed were possible future term limits, which may align with those of other HCAI committees. Suggestions for term limits included 5-year term limits and adding a vice chair for smoother transitions. Governance structure and eligibility for future chairs may be revisited in upcoming meetings

7. California Cardiovascular Outcomes Reporting Program (CCORP) Updates – Shannon Conroy, Ph.D., M.P.H., CCORP Manager, HCAI

Shannon Conroy, PhD, MPH, presented CCORP updates. CCORP published the 2023 Coronary Artery Bypass Graft (CABG) Outcomes Report in September. The 2024 onsite CABG data audits are finished, and 118 hospitals will participate in 2025. The 2023 Percutaneous Coronary Intervention (PCI) Outcomes report was released over the summer, with the 2024 report underway. Dr. Conroy presented cardiovascular and valve procedure trends, highlighting the continued growth in Transcatheter Aortic Valve Replacement (TAVR) procedures.

Panel Member Shemin proposed bringing back a slide comparing procedure volumes in states like New York, Washington, and Pennsylvania, which Dr. Conroy and Panel Chairperson Brindis supported. The Panel noted that few states still mandate public reporting for cardiac procedures, with some early programs ending due to funding and priority changes. They recognized that national and voluntary reporting programs remain active, including the Society for Thoracic Surgeons (STS) and National Cardiovascular Data Registry (NCDR) registries, which continue to achieve strong participation.

8. 2024 Risk-Adjusted Mortality Outcome for Transcatheter Aortic Valve Replacement (TAVR) – Mark Kishiyama, Ph.D., Research Scientist, HCAI

Mark Kishiyama, Ph.D., Research Scientist, shared the methods and proposed risk models for the 2024 TAVR Outcomes Report. For 2024 the TVT Registry included TAVR data for 85 hospitals.

There was an increase in TAVR volume (10,024) and a decrease in 30-day mortality rate of 1.55% compared to 2% in 2023. 51 candidate risk factors were evaluated in the modeling process. The proposed risk model for in-hospital/30-day mortality included 12 risk factors of which 6 were significant and the c-statistic was 0.7607. Following the recommendation from the CAP last year, prior stroke was included as a risk factor to the model without negatively impacting the results.

The Panel reviewed the TAVR in-hospital/30-day mortality risk model. The discussion addressed model behavior regarding continuous variables and calibration, noted changes compared to previous years, considered acuity coding classifications (urgent, emergent, salvage), and evaluated data audit authorities. Panel Member Redberg made a motion to adopt the model with a revision to use continuous age rather than age group. Panel Members Shemin and Damberg seconded the motion.

Action: The Clinical Advisory Panel unanimously approved the mortality risk-model methods with revisions to use continuous age instead of age group.

9. 2024 Risk-Adjusted Stroke Outcome for TAVR – Mark Kishiyama, Ph.D., Research Scientist, HCAI

Dr. Kishiyama shared the risk-adjusted methods and proposed model for in-hospital/30-day stroke outcomes for TAVR. The statewide stroke rate for 2024 was 1.78%, a decrease from 2.02% in 2023. The proposed model included 9 risk factors with a c-statistic of 0.6371.

As part of their review the Panel members requested more detailed breakdowns of non-femoral TAVR access routes, highlighting the need to distinguish transcarotid access and its stroke risk from transfemoral access. Dr. Kishiyama explained that while the initial implementation of the model included such breakdowns, the categories were later consolidated for statistical purposes. He offered to adjust the model by changing age from a categorical to a continuous variable, which the panel supported.

Panel Member Redberg proposed a motion to accept the Stroke model with a revision to change age group to age as a continuous variable. Panel Member Fung seconded the motion.

Action: The Clinical Advisory Panel unanimously approved the stroke risk-model methods with revisions to use continuous age instead of age group.

10. TAVR Interventional Studies – Andrew Rassi, M.D., Interventional Cardiologist

Panel Member Rassi presented recent research and evolving trends for TAVR, highlighting its evolution from treating only high-risk aortic stenosis patients to approval for all surgical risk categories. Improved devices and healthier patient selection have led to better outcomes, including reduced mortality, stroke, bleeding rates, and shorter hospital stays. Long-term data from major durability trials including Evolut Low Risk, PARTNER 3, and NOTION show generally comparable performance of TAVR and

surgical valves, though limited follow-up beyond 10 years raises concerns for younger patients. The Early TAVR Trial suggested fewer urgent hospitalizations in asymptomatic severe aortic stenosis, but no mortality benefit and concerns about design bias.

Panel Member Rassi outlined emerging questions about long-term valve durability, strategies for young patients requiring repeat interventions, optimal timing of TAVR across disease severity, expanding use in bicuspid anatomy and aortic insufficiency, and best practices to reduce stroke. Discussion emphasized the need for extended follow-up beyond typical trial timelines, clarity in trial analysis methods, and awareness of the balance between scientific evidence and industry-driven expansion of indications.

11. TAVR Trials of Asymptomatic Patients – Rita F. Redberg, M.D., Cardiologist

Panel Member Redberg presented concerns about evidence supporting TAVR in asymptomatic patients. She noted that early trials, including the original PARTNER study, used inappropriate comparators and did not evaluate true medical management. Current ACC/AHA guidelines continue to recommend waiting for symptoms, and recent early-intervention trials showed no mortality or stroke benefit while raising issues related to study design and financial conflicts of interest.

Following the presentation, Panel members discussed both clinical and systemic factors influencing TAVR use. Panel Member Shemin emphasized the need for appropriateness criteria and shared decision-making, while Panel Member Rassi noted that some patients progress faster than guidelines predict and that rising TAVR volumes also reflects access for those who previously could not undergo surgery. Dr. Tefera highlighted broader systemic drivers, including financial incentives and practice norms.

Panel consensus centered on the need for data-driven standards and continued monitoring of California's rising TAVR volumes to determine whether trends reflect clinical need or external factors. Members agreed that evidence for TAVR in asymptomatic patients remains limited and that long-term outcomes, transparency, and guideline development are essential to ensuring appropriate, patient-centered care.

12. Expanding Cardiovascular Outcomes Reporting – Ralph Brindis, M.D., M.P.H., F.A.C.C., CAP Chair; Christopher Krawczyk, Ph.D., Chief Analytics Officer, HCAI

Panel Chairperson Brindis led a discussion for expanding cardiovascular procedures. He reviewed the CCORP mandate, which allows reporting on CABG, TAVR, and one additional cardiovascular procedure every three years based on CAP recommendation. The August 13 subcommittee meeting members who reflect, as much as possible, the broad constituency of the CAP explored potential expansions, focusing on feasibility, data burden, costs, data quality, procedure volume, evidence strength, equity, and timely reporting.

The subcommittee considered several options to expand reporting for all PCI, surgical aortic valve replacement (SAVR), atrial fibrillation (A-Fib) ablation, carotid

revascularization procedures (carotid endarterectomy and carotid artery stenting), peripheral vascular procedures, thoracic aortic procedures, electrophysiology procedures, implantable cardioverter defibrillators (ICDs), and assessing TAVR appropriateness. They discussed outcomes and issues including one-year mortality, trends over time, data gaming, growth in ambulatory centers, and statewide equity concerns. Dr. Krawczyk outlined HCAI's limits on data access and noted that expanding public reporting depends on data control, contractual access, or new agreements.

The Panel proceeded to review procedure volume trends, highlighting rapid growth in atrial fibrillation ablation, continued high TAVR volumes, and increases in carotid and peripheral vascular procedures, especially in ambulatory surgery centers. Additionally, they identified opportunities to enhance current TAVR reporting, conduct cost and equity analyses, examine evolving clinical indications, and assess feasibility of future work on AFib ablation, left atrial appendage occlusion devices, and SAVR as contextual information for TAVR.

Following the discussion, the panel agreed on three motions:

Action: The Clinical Advisory Panel unanimously approved not to add a new cardiovascular procedure this year.

Action: The Clinical Advisory Panel unanimously approved HCAI to further investigate AFib ablation and left atrial appendage for possible future reporting.

Action: The Clinical Advisory Panel unanimously approved HCAI to expand analyses and potential public reporting related to TAVR, including appropriateness and other patient demographics.

13. CCORP Public Reporting – Shannon Conroy, Ph.D., M.P.H., CCORP Manager, HCAI

Panel Member Shemin noted an increasing population of adult congenital heart disease (ACHD) patients undergoing complex surgeries that sometimes include concomitant CABG. These patients often have no coronary artery disease (CAD), but some may develop atherosclerosis and require bypass during congenital repair.

There is a concern that current exclusion criteria may not adequately address these cases, making risk adjustment difficult. A proposal was to add adult congenital heart disease with concomitant CABG to the list of exclusions from public reporting. Through further discussion the Panel agreed this was an oversight into the original criteria. Excluding these cases avoids skewed outcomes and gaming concerns.

Panel Member Shemin made a motion to exclude concomitant CABG performed during complex congenital heart disease procedures from public reporting. Panel Member Lee seconded the motion.

Action: The Clinical Advisory Panel unanimously approved the exclusion of complex congenital heart disease procedures from the public report.

14. Public Comment

There was no public comment.

15. Adjournment

Dr. Brindis thanked everyone and adjourned the meeting at 2:18 p.m.