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

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HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Tuesday, December 16, 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; Andrew Feher, Research and Analysis Group Manager, HCAI; Brian Briscombe, Senior Quantitative Analyst, RAND; Cheryl Damberg, Senior Economist, RAND; Margareta Brandt, Assistant Deputy Director, HCAI; Debbie Lindes, Health Care Delivery System Group Manager, HCAI; Sheila Tatayon, Assistant Deputy Director, HCAI; Heather Hoganson, Assistant Chief Counsel, HCAI

Meeting Materials: **https://hcai.ca.gov/public-meetings/december-health-care-affordability-board-meeting-2/**

Agenda Item # 1: Welcome and Call to Order
Secretary Kim Johnson

Chair Johnson opened the December meeting of California's Office of Health Care Affordability Board. Roll call was taken, and a quorum was established.

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

Director Landsberg provided an overview of the meeting agenda.

Director Landsberg provided Executive Updates, including the following:

- Updates on the Health Care Payments Data Program (HPD):
  - A new data brief was recently released that covers behavioral health spending in California's commercial market for the five-year period from 2018 to 2023.

- To date, HCAI has published eight public data reports which are available on the HCAI website.
- Pharmacy Benefit Managers (PBM) data is now being incorporated into the HPD. HCAI will be working on its PBM data collection regulations this coming summer.

Deputy Director Pegany provided Executive Updates, including the following:

- Beginning January 5, 2026, through March 31, 2026, OHCA will be accepting submissions of interest from individuals who would like to serve on the OHCA Advisory Committee.
    - A subcommittee has been formed to review the submissions. Newly appointed subcommittee members Dr. Sandra Hernandez and Ian Lewis will recommend a slate later this spring and will select the members who will serve on the Advisory Committee from July 1, 2026, to June 30, 2028. The subcommittee will also review the submissions to fill the Advisory Committee's payer vacancy and will present its recommendation to the Board next month.
    - Further information and a link to submit a Submission of Interest form will be available on the OHCA website beginning on January 5, 2026.
- A summary of the following three publications:
    - An article published in Health Affairs, titled "Hospital Finances, Operations, And Patient Experience Remain Stable After Oregon's Hospital Payment Cap Was Implemented."
    - An opinion piece in the New England Journal of Medicine's Perspective, titled " The Antitrust Antidote to Hospital and Nursing Home Corporatization — Promises and Pitfalls."
    - A report from the Purchaser Business Group on Health's (PBGH) Data Demonstration Project, titled "Leveraging Health Care Price Transparency: Making Transparency Data Actionable for Employers and Public Purchasers."
- An update on the Cost and Market Impact Review (CMIR) program.
- A reminder about slide formatting.

Discussion and comments from the Board included:

- A member asked for clarification, regarding the PBGH Demonstration Project, about the method utilized to assess data usability.
    - The Office explained that the data was assessed for usability and completeness. If the submitted data met the expectations for specific billing codes at specific hospitals (i.e., a reasonableness check) and met a 75% standard in terms of expected values or completion, it was considered highly usable.
- A member added that hospitals and health plans have not done what is required to make the data usable; submitted data was technically compliant but unusable. The federal schema was recently updated to address this issue, and enforcement will begin in February 2026.
- A member stated that California has laws that require plans to divulge to purchasers sufficient data to recalculate how pricing was derived and asked if there are any recommendations for how those laws would be better enforced or buttressed.

    - A member replied that their work is focused at the federal level but that federal changes will make a material difference that will apply to California as well. The member noted specifically that Kaiser's data was unusable and emphasized that the Consolidated Appropriations Act has required the submission of data since 2021 related to the obligation of self-insured employers to use claims data to make informed purchasing decisions. There is still work to be done to ensure basic transparency information is available.
- A member asked how this information impacts OHCA's all payer claims database (HPD) and OHCA's ability to analyze data and data quality.
    - The Office replied that it relies on different data sets to measure total spending but that the HPD could be used for cost driver analysis. The transparency data could dovetail with HPD data to analyze the price of, for example, hospital services or other professional services to compare the allowed amounts and paid amounts by health plans for alignments or discrepancies with what was reported. Additionally, the data hospitals report under federal law is different from the data in the HPD, which is from the health plans; they are different data sources.
- A member commented that given the poor data quality and that Kaiser comprises more than half of the commercial market in Sacramento, the non-usability of its data results in an inaccurate depiction of health care providers in the region.
    - A member responded that PBGH will rerun the data this year and hopes for more compliance with the new federal rules.
- A member asked for more information about the key finding that health plan market share does not predict pricing power.
    - A member responded that a comparison across health plans in the report can determine which plans had better rates and which facilities had better quality and safety. In some markets, small health plans had better rates and better quality and safety than the five largest health insurers (Blue Cross/Blue Shield, United Healthcare, Cigna, Aetna, Humana), which was an unexpected result.
- A member commented on the potential impacts stemming from the various research articles summarized and expressed concerns about potential unintended consequences that can result and harm patients. The member highlighted ensuring that health care spending is focused on care and not administrative overhead.
- A member commented that PBGH will next compare claims to Transparency in Coverage (TIC) data to compare hospital rates to insurance payments in order to serve self-insured employers in making better purchasing decisions. The study enables entities to make better business decisions; for example, it verified that the direct contracts included in the study were of higher value and also noted network redesign based on quality and to some extent, costs.

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

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

Vote to Approve the November 19, 2025, Meeting Minutes

Deputy Director Pegany introduced the action item to approve the November meeting minutes. Board member Lewis proposed a motion to approve. Board member Kronick seconded the motion.

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

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

Agenda Item #4: Informational Items

a) Update on Behavioral Health Out-of-Pocket/Out-of-Plan Spending
CJ Howard, Assistant Deputy Director, HCAI
Andrew Feher, Research and Analysis Group Manager, HCAI

Assistant Deputy Director Howard provided an update on the behavioral health out-of-plan spending analysis that OHCA has engaged in for the last several years. Research and Analysis Group Manager Andrew Feher provided an overview of the analysis, along with some of its limitations.

Discussion and comments from the Board included:

- A member expressed appreciation for HCAI's focus on acquiring better behavioral health care spending data, citing equitable access problems that result from behavioral health outpatient providers who limit the number of insurance-paid patients they accept because of their low reimbursement rate. The member hopes that better data sets become available through private partnerships or state action given the repercussions; the outpatient dollars avert higher cost inpatient interventions.
- A member commented that the results of this survey show that the magnitude of the problem is not so different from that of primary care commercial payments in general.
- A member noted that epidemiology data shows that generally about 20% of the population has a mental health condition at any time.
- A member asked about comparing behavioral health care access for patients who are enrolled in Health Maintenance Organizations (HMOs) to those enrolled in Preferred Provider Organizations (PPOs).
    - The Office replied that there is a plan to add a behavioral health file to the body of existing data in the Data Submission Guide 3.0 which would enable exploration of this question for in-plan services.

- A member commented that, to the extent it informs this work, there is a significant effort by many large employer plans to integrate behavioral health into primary care despite the challenges with appropriate reimbursement and coding.
    - The Office replied that there is a payment subcategory for integrated behavioral health that will allow measurement and tracking of its growth over time.
- A member expressed appreciation for HCAI's work and mentioned the overlay with the state's significant behavioral health investment during this time span and how that is changing behavioral health capacity overall, especially as it relates to workforce.

Public comment was held on agenda item 4a. One member of the public provided comments.

b) Spending Target Data Review
Vishal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI
Andrew Feher, Research and Analysis Group Manager, HCAI

Assistant Deputy Director Howard reviewed data relating to the setting of the statewide spending target and data related to adjusted hospital targets. Deputy Director Pegany provided an update that outpatient measures can be considered for inclusion in the potential list of factors for adjusting targets for high-cost hospitals in a subsequent year.

Discussion and comments from the Board included:

- A member noted that the per capita health care data presented ends in 2020 and is likely understated since costs for 2023, 2024, and projections for 2025 show the highest commercial increases in a decade. The member asked when newer data would be incorporated.
    - The Office replied that it uses the Centers for Medicare and Medicaid Services (CMS) State Health Expenditure Accounts (SHEA) data, which was last updated in 2023 with state-level data through 2020.
- A member expressed the need to acknowledge the major changes that were caused by the passage of the Affordable Care Act in 2010 and to consider how those changes affected the data variations between 10-year and 15-year averages.
- A member suggested that the implementation of a 10-year average would be more effective than the 20-year average that is being used now because it would be a better predictor of the expected growth rate of median household income over the next five years.
- A member stated a preference for setting a target that comes in below the predictive track of median household income so that health care costs can come back down within the range of affordability.
- A member commented that if the look-back period is shortened, more recent data is critical.

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

c) Methodology for Measuring Inpatient and Outpatient Hospital Spending
Vishaal Pegany, Deputy Director, HCAI
Brian Briscombe, Senior Quantitative Analyst, RAND
Cheryl Damberg, Senior Economist, RAND

Deputy Director Pegany, and Brian Briscombe from RAND, provided an overview of OHCA's methodology for measuring inpatient and outpatient hospital spending, summarized the Hospital Spending Workgroup's recent feedback, shared aggregate results from FY 2022, and outlined next steps.

Discussion and comments from the Board included:

- A member asked if there was any specific feedback that the Office would like to receive from the Board.
    - The Office replied that the workgroup members had some concern about the low proportion of commercial outpatient visits, but the correlation analysis supports moving forward with this measurement methodology. Next steps will confirm that OHCA has the correct National Provider Identifiers (NPIs) which will allow OHCA to provide regulated entities with a facility-level data set of these measures.
- A member requested an update on the timeline for the inclusion of data in the HPD for self-insured (Employment Retired Income Security Act) ERISA plans and for other smaller plans, as well as data for the capitated larger plans.
    - The Office replied that the HPD currently receives encounter data and will receive non-claims payments associated with those encounters in the future but they are not relying on the dollar amounts from the HPD; rather, they use the HPD for utilization to calculate intensity adjustments. Additionally, the Office receives HPD data monthly and it is not aware of any concerns with data submission by large health plans.
    - The member asked if the encounter records include Ambulatory Payment Classification (APC) weights or some data that can be converted into weights.
    - The Office explained that publicly available APC weights from CMS are added to claims and encounter data. The office remarked that not all commercial claims have APC weights, whereas there is higher APC representation among Medicare claims.
- A member expressed concern that the wide variability across hospitals in the percentage of visits reported in the financial disclosure reports found in the HPD may be due to the inconsistencies in the methods used by hospitals to report visits. The member suggested being wary of using the data to compare across hospitals in revenue per adjusted outpatient visit if hospitals are reporting differently. The member suggested that work be done to evaluate how hospitals count visits and to focus on ensuring standardized reporting methods.
    - The Office replied that some hospitals had asked if the lower proportion of commercial visits found in the HPD were representative. The Office will reconvene the work group in the spring to present correlation analyses and any additional analysis that has been done regarding the minimum viable sample of APC weights necessary to produce a reliable or consistent estimate. For any

outlier or edge cases, OHCA will contact the hospital for explanation of how it is counting visits.
  - The member expressed concern that the year-to-year differences in reporting are not limited to edge cases but are across the majority of hospitals; this may be due to the variability in the way that hospitals submit financial data.
  - The Office replied that HCAI has some next steps regarding improving the match up of data in the HPD but could offer additional guidance to hospitals on data reporting procedures.
- A member stated that many procedures are being moved from inpatient to outpatient and asked how these changes would be reflected over time, citing the need to look at inpatient and outpatient data at the same time to determine how increases in outpatient procedures affect Average Visit Intensity (AVI).
  - The Office explained that the Ambulatory Payment Classifications (APC) weight would pick up more intensive outpatient services and that the AVI is a multiplier that can help reflect those more intensive services. Changes in the Case Mix Index (CMI) can reveal what types of inpatient cases remain. OHCA and the work group are interested in exploring a combined measure.
  - The member expressed concern that having a separation between inpatient and outpatient may discourage a hospital from implementing measures that may reduce health care costs due to a fear of financial penalties.
  - The Office replied that financial penalties are not automatic. There is a 45-day response period for hospitals and payers to explain certain drivers of spending growth. The shift from inpatient to outpatient could be a one-time shift that would stabilize in outyears.
- A member commented that it is difficult to incorporate measures for both volume and price, and that the focus is currently on price-per-unit of service for inpatient and outpatient care while volume is being assessed as it relates to total health care expenditures.

Public comment was held on agenda item 4c. Two members of the public provided comments.

d) Spending Target Enforcement – Introduction to Performance Improvement Plans

Vishal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI
Sheila Tatayon, Assistant Deputy Director, HCAI

Deputy Director Pegany provided an overview of HCAI's ongoing discussion of spending target enforcement and introduced Performance Improvement Plans (PIPs). Assistant Deputy Director Howard reviewed the key points of the statute and provided an overview of OHCA's proposed enforcement process.

Discussion and comments from the Board included:

- A member asked for clarification on spending target enforcement policies in Massachusetts and Oregon, as well as California's administrative penalty.

- The Office replied that Massachusetts does not have stand-alone penalty authority but it can impose a $500,000 penalty for failure to file a PIP. Oregon has not required a PIP thus far. In California, the Board is responsible for approving the scope and range of financial penalties to be effectuated in a rulemaking package. Additionally, the statute describes penalties as being commensurate with how much the entity exceeds the target. The Office will come back to the Board with a proposed scope and range of penalties, along with factors that go along with that.

- A member asked if there would be a standard approach for entities to provide progress reports or if an entity would propose its own method for reporting in its PIP.
  - The Office replied that it will be contemplating design decisions regarding the guidance and parameters for the submission of progress reports.
  - The member commented that a bias toward transparency would serve the overarching purpose well and suggested that there be a parallel map that clearly outlines the type of information that is made available to the public along with a timeline and the opportunity for public comment.
- A member asked why a PIP process would exist if it is optional and if it allows an entity to have a three-year extension for not meeting the target.
  - The Office explained that while the bill's enforcement steps were negotiated there was interest in including a progressive enforcement approach that gave OHCA an opportunity to actively engage with entities about how to meet the target. This is a requirement in the statute.
  - The member asked if there is an assumption that this will be a transparent and effective process, and if Massachusetts General had changed its procedures in response to a PIP.
  - The Office replied that it is attempting to think through all the steps of the process and obtain input from the Board and the public on how to ensure the PIP is as meaningful as possible to achieve real results. First and foremost, entities are expected to meet the target. Technical assistance is the next step but the PIP is the opportunity to actively engage with entities, require them to provide an assessment of why they exceeded the target, and engage about meaningful steps for reaching the target.
  - The member expressed that they believe PIPs will be a lot of work for staff with little result.
- A member asked to what extent entities have a right to a PIP.
  - The Office replied that the director of HCAI will determine whether OHCA will pursue a PIP with an entity. It will use the enforcement considerations to determine which entities go beyond technical assistance, adding that it is not a bad thing to be on a PIP; it is a tool that assists an entity to achieve compliance with the target.
  - The Office added that before a fine, OHCA must assess how an entity is complying with a PIP. It further explained that the statute requires a progressive enforcement process which means that the administrative penalty phase comes after the other steps. Statute additionally requires OHCA to monitor and report out on PIP performance.
- Several members asked for further clarification regarding PIPs and penalties.

  - The Office stated that a PIP is offered at the Director's discretion. If OHCA determined that an entity is non-compliant with a PIP or that the PIP needs to be modified, it may bring that information to the Board in a closed session where members can provide input on OHCA extending or modifying the PIP or assessing financial penalties. The Office added that the intent of the statute is to assist health care entities to come into compliance with cost targets through technical assistance and PIPs; these are generally required steps before assessing a financial penalty.
- A member asked what happens with entities that exceed the target but that OCHA does not place into a PIP.
  - The Office replied that it would annually review their data and could place them in a PIP the following year. The Office reiterated that it cannot penalize an entity without first having a PIP, except for egregious violations enumerated in statute. Additionally, the Office suggested that during conversations about the scope and range of penalties, the Board could provide input on factors, such as if an entity does not show improvement within the time period/interval specified in their PIP.
- A member stated that there is evidence that simply being on the list of entities that have missed the cost targets has moved entities to take action, either informally or more formally on a PIP. The member added that a possible challenge for the Board will be the need to make decisions about accepting an entity's proposed actions if these actions will reduce patient access.
- A member stated that including price reductions in a PIP should be a key way for entities to meet the targets.

Public comment was held on agenda item 4d. Two members of the public provided comments.

e) Introduction to HCAI Health of Primary Care in California Snapshot
Margareta Brandt, Assistant Deputy Director, HCAI
Debbie Lindes, Health Care Delivery System Group Manager, HCAI

Assistant Deputy Director Brandt introduced the Health of Primary Care in California Snapshot, a new initiative at HCAI facilitated by OHCA. Debbie Lindes provided an overview of the project team and deliverables.

Discussion and comments from the Board included:

- A member stated that progress on the five points presented in the Snapshot will lead to better health and lower costs and asked if part of the longer-term metrics will focus on connecting progress to each of those five points.
  - The Office replied that one intention of the Snapshot is to determine how work across the state is having an impact on primary care at a high-level. The Snapshot will include primary care investment data while a separate annual report will provide more detail and closely compare the entities that are meeting the primary care investment targets. The Office is considering ways to structure

    the release of the annual report to report data regarding the primary care investment benchmark as well as data regarding quality and equity performance, workforce stability, and alternative payment models.

- A member stated that an ongoing relationship with a primary care provider leads to positive outcomes, particularly for patients with chronic conditions. The member suggested that the Snapshot should contain a measure that captures the value of the coordination and continuity of having one primary care provider. The member hopes that this Snapshot effort will lead to better quality care and lower costs.
    - The Office replied that the HPD, along with Covered California and CalPERS, is exploring a measure of continuity of care that could be incorporated into the Snapshot in the future.
- A member suggested that indicators should also be evaluated on their ability to be reported by geographic region or individual population level to look at disparities for marginalized populations in the state. The member also suggested connecting with states like Massachusetts and Virginia to learn about how their dashboard is being used and what they might have done differently. The member added that there may be a way for the HPD data to provide metrics on Commercial to Medicare payment ratios in both primary care and specialties on a statewide and regional basis to make the data more actionable.
- A member suggested also considering barriers to improving primary care, such as why there is not more money going to primary care, given its demand from Californians and employers.

Public comment was held on agenda item 4e. One member of the public provided comments.

Agenda Item #5: General Public Comment

General Public comment was held. One member of the public provided comments.

Agenda Item #6: Adjournment

Chair Johnson adjourned the meeting.