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, January 28, 2025
10:00 am

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

Members Absent: Dr. David Carlisle

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; Megan Brubaker, Engagement and Governance Group Manager, HCAI; CJ Howard, Assistant Deputy Director, HCAI; Andrew Feher, Research Manager, HCAI; Margareta Brandt, Assistant Deputy Director, HCAI; Sheila Tatayon, Assistant Deputy Director, HCAI; Heather Cline Hoganson, Assistant Chief Counsel, HCAI

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

Agenda Item # 1: Welcome and Call to Order
Vice Chair, Sandra Hernández
Elizabeth Landsberg, Director, HCAI

Vice Chair Hernandez opened the January meeting of California's Health Care Affordability Board. Roll call was taken and a quorum was established.

Director Landsberg welcomed attendees to the May Lee State Office Complex, HCAI's new office headquarters beginning summer 2025, and provided an overview of the meeting agenda.

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

Director Landsberg provided Executive updates, including the following information:

- Update on California's emergency response to those affected by the devastating fires in Southern California, including providing services that meet the immediate needs of survivors, as well as accelerating and expediting recovery processes in communities, and improving emergency preparedness and response systems.

- Update on the $322 billion 2025-26 proposed state budget.
  - The state has eliminated 6,500 positions and implemented operational cuts of nearly 8 percent, which will impact OHCA and HCAI along with most other departments. There are also uncertainties with the new federal administration.
- Update on the Healthcare Payments Data Program (HPD) and its milestone of accepting applications for requests to access non-public HPD data from researchers, state agencies, and others. HCAI's OHCA and HPD teams plan to co-present to the Board about how staff are using the HPD in March 2025.

Deputy Director Pegany provided an overview of OHCA's Quarterly Work Plan, key findings from a 2024 Centers for Medicare and Medicaid (CMS) report on national health expenditures, and a reminder about slide formatting.

Discussion and comments from the Board included:
- A member stated that regarding the CMS report, the insured population is at a record high and that most of the growth in services is driven by the increased number and intensity of the services. The member expressed concern that emphasizing efforts to restrain costs may result in denying needed patient care. The member also requested clarification regarding the growth rates for cost of care, whether it is a an overall percentage increase or a per capita increase.
  - The Office clarified that the figures presented were growth rates on a per capita basis by respective program.

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

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

a) Approval of the December 16, 2024, Meeting Minutes

Board Member Hernández introduced the action consent item to approve the December meeting minutes.

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

Agenda Item #4: Action Item
Megan Brubaker, Engagement and Governance Group Manager, HCAI
a) Vote to Establish a Subcommittee for the Selection of Advisory Committee Members

Megan Brubaker presented an overview of the solicitation and selection process to establish a subcommittee for the selection of Advisory Committee Members.

Discussion and comments from the Board included:

- A member commented that the questions were effective and the process for solicitation evolved appropriately, which resulted in a balanced and representative set of committees.
- A member nominated Ian Lewis.

Board Member Hernández proposed a motion to approve reappointing last year's subcommittee members, Elizabeth Mitchell and Dr. Richard Pan. Board Member Lewis seconded the motion.

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

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

Agenda Item #5: Information Items (out-of-order)
Andrew Feher, Research Manager, HCAI
Vishaal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI
Margareta Brandt, Assistant Deputy Director, HCAI

a) Hospital Sector Data Analysis, Including Advisory Committee Feedback

Andrew Feher provided an overview of the Hospital Sector Data Analysis, focusing on county-level analysis and urban versus rural counties.

Deputy Director Pegany provided an overview of the Advisory Committee feedback.

Discussion and comments from the Board included:
- A member asked for more detail regarding the methodology used to obtain the commercial-to-Medicare payment-to-cost ratio.
  - The Office explained that they used a payment-to-charge ratio compares the amount a commercial payer pays for a medical service compared to what Medicare would pay for the same service, showing how much more or less the commercial pays relative to Medicare's standard rate for that service.
- A member asked whether OHCA is considering alternative measures or data sources, such as the newly available federal transparency) data from hospitals or the commercial total cost of care measure developed by Health Partners that teases out price and utilization.
  - The Office replied that they are aware of other data sets but, given the low compliance rate for reporting the federal transparency data by hospitals, OHCA is using HCAI data because it is more complete for the several hundred hospitals being studied.
  - The member responded they hope OHCA will consider other data sets, although incomplete, for insight and recommend a broad approach to get past the historic complaints about the metrics.

- A member asked, regarding the commercial to Medicare cost ratio, if infrequent services received by Medicare patients would be excluded from the data set.
    - The Office clarified that although different services may be used by different populations are being compared, the ratio compares the amount a commercial payer pays for a medical service compared to what Medicare would pay for the same service.
- A member requested clarification about the prohibition of including Kaiser data in the hospital sector.
    - The Office replied that while Kaiser cannot be included in the hospital sector, OHCA could still report on Kaiser hospitals using data collected by HCAI for individual Kaiser facilities.
- A couple of members requested OHCA report on Kaiser hospital data.
    - The Office replied they will review how it fits in with OHCA's public reporting.
- A member expressed an interest in which hospital systems may have capitation arrangements that may be a subset of their payments and how systems may shift services because of capitation arrangements. The member also mentioned a letter from Salinas Valley Health which details how the hospital's annual financial data that is reported to HCAI only reflects services under their hospital license but does not include services at their clinics which are operated by separate licenses.
    - The Office stated that many health care entities are part of larger health care systems that operate multiple types of health care entities. Individual health care entities that are part of larger health systems may be subject to different spending targets (i.e., a provider organization may have a different target than a hospital even if they are part of the same system). OHCA will measure spending for each health care entity based on how it is structured and licensed. If a health care entity exceeds the target, OHCA may consider the larger system in which the entity operates as part of its evaluation and any necessary performance improvement plans.
- A member expressed concern that while systems need to be held accountable, at the same time we must ensure artificial barriers are not created that impede efforts to improve quality and lower costs across the system.
    - The Office responded that data is evaluated based on how it was filed. There is no statutory definition of a health care system that allows OHCA to set a sector target for it. Establishing a definition is something that needs to be explored further.
    - A member expressed the importance of working toward defining health systems and measuring spending by health systems.
- A member mentioned that the important task of capturing atypical referral patterns or excessive referrals is difficult to do under the current guidelines; this should be addressed.
- A member expressed appreciation for the ongoing HPD funding that will provide data and a clearer understanding of how integrated delivery systems compare with the hospital sector.
- A member noted that to the extent hospitals say their costs are higher due to primary care or their other relationships, with data OHCA can begin to understand norms; for example, Salinas claims this drives their costs which are 476% of Medicare with an

18% operating margin. Is this the norm for a system or are there efficiencies that can be had?
- A member notes that understanding how dollars are allocated within the Kaiser system is not intended to undermine the integrated nature of what they are doing; intent matters as well as transparency.

Public Comment was held on agenda item 5a. Seventeen members of the public provided comments.

Agenda Item #4b: Vote to Establish Hospital Sector

Vishaal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI

Assistant Deputy Director Howard provided a recap of the hospital sector options that had been presented at the December 2024 meeting. Deputy Director Pegany provided an overview of the Advisory Committee feedback.

Discussion and comments from the Board included:

- A member mentioned that one theme in the Advisory Committee feedback is that the methodology is still a work in progress and needs to be refined, particularly in defining sectors, while another theme is the desire to act swiftly to begin this process. The challenge is in navigating these two desires.
- A member asked if any individuals on the Advisory Committee who wanted to move more slowly had any constructive alternative proposals.
- A member confirmed that the Advisory Committee did not provide any alternative proposals.
- A member asked whether hospitals would be subject to the statewide target if a decision was to be made to not define hospitals as a sector.
    - The Office replied affirmatively that all health care entities, of which hospitals are a subset, are subject to the statewide target.
- A member asked if defining a health care sector is what is needed to be able to define separate targets for the subsets of the sectors.
    - The Office explained that if the Board were to vote affirmatively today on the motion to define hospitals as a sector, staff would develop draft regulations and at the February Board meeting, would present a recommendation on the methodology to identify high-cost hospitals. After a 45-day public comment period, the Board would then have the option at the April or May board meeting to establish the target(s).
- A member asked if the Board would have the authority to choose the methodology that will be used in identifying the high-cost hospitals.
    - The Office responded in the affirmative.
- A member mentioned that that hospitals are an obvious sector. And while hospitals are a big part of health care delivery, the most important sector is health systems. The member expressed concern that identifying hospitals as a sector may divert attention away from health systems.

- A member urged staff to not disrupt systems that are working well when evaluating hospital performance against the target.
- A member mentioned the huge pace of growth in commercial employer-sponsored health coverage and expressed concern about the rising costs of which are passed on to the employees, negatively impacting their incomes. They recommended moving swiftly in this work to alleviate some of the rapidly rising health care costs built into some workers' contracts.
- A member stated that hospitals comprise 31 percent of health care costs nationwide and 40 percent in California, so with this outsize impact, hospitals should be defined as a sector.
- A member commented that higher health care costs also have an impact on manufacturers who must raise prices to cover these costs and agrees the pace is too slow.
- A member shared that this conversation is an opportunity to begin to understand how these hospitals work and why some hospitals may be outliers.

Member Hernández proposed a motion to define hospitals as a sector. Member Mitchell seconded the motion.

Public Comment was held on agenda item 4b. Five members of the public provided comments.

Voting members who were present voted to define hospitals as a sector. There were six ayes and one member absent.

Agenda Item #5b: Sector Target Setting Methodology

Assistant Deputy Director Howard presented an overview of the methodology for setting sector targets and presented three options for identifying high-cost hospitals that may merit a sector target lower than the statewide spending target.

Discussion and comments from the Board included:

- A member requested information regarding the inpatient discharge threshold and how many hospitals are below that average inpatient discharges threshold.
    - The Office replied that on an above average discharge year, the low end would be 7500 inpatient discharges seen in 2021 and on the high-end around 8300 discharges in 2019, partly pivoting away from licensed beds which is invariant. Of the approximately 360 or so comparable hospitals, about 63% were omitted based on a discharge threshold above the average, which can change from one year to the next.
- A member commented that the options presented contain some overlap; however, option one lists more tertiary care centers than option two. The difference in hospital types within each list could be determined by a more or less insightful factor.
- A member asked if the 80th percentile can be explained as drawing a line if, for example, out of 100 hospitals, the top 80% would mean 20 hospitals or if the 80th

percentile was assessed as a bell-shaped curve with a standard deviation.
    - The Office confirmed that the first example would be correct in describing the 80th percentile used in the options presented.
- A member asked if it is possible to factor in extenuating circumstances when reviewing outliers or entities that don't meet sector targets. They are in favor of adding additional extenuating circumstances for the small group of hospitals that are in the highest range. They suggested contemplating possible criteria that could lead to a more thoughtful way of honing the list.
    - The Office replied that it would welcome suggestions from the Board regarding possible additional factors to be considered.
- A member commented on the distributions of data that may be of concern if they were tightly bunched, which could happen in the future if the averages get closer. Thresholds should surround credibility and volatility agreeing that it may be favorable to look at lower thresholds.
    - The Office added a note that they removed the volume factor to increase the number of hospitals on the individual measure, adding 50 or so more to option 1 and option 2, but it did not change the final result for option 3 in terms of overlap.
- Several members expressed a preference for option number three.
- A member commented that the Commercial to Medicare Payment to Cost Ratio placed focus on the commercial cost and puts the hospitals in control of whether they are outliers because they have control over the rates they are negotiating, leading the member to lean towards option 2.
- A member noted that some Advisory Committee members recommended not excluding psychiatric hospitals at this point.
- A member asked the Office to clarify if the exclusions would eliminate 340 of the 440 hospitals from the hospital sector target.
    - The Office confirmed that is correct, the high-cost hospitals the Board identifies would be held to a specific hospital sector target, whereas the remaining hospitals would still be subject to the original statewide spending target.
- A member commented that they noticed that the Monterey, Salinas, and Stanford hospitals come up regardless of the scenario, and asked whether the inclusion of Kaiser data would cause any changes to that.
    - The Office responded that they only have two years of Kaiser data that has been submitted to the department so far, which is for 2021 and 2022. As they receive more data, that could lead to more analysis which could inform a fully integrated delivery system target which may be different from the statewide target.
- A member asked if all the hospitals pull out the same two years of the five-year analysis or the variability in the five-year analysis of high costs.
    - The Office replied that for the most part, hospitals were meeting 4 or 5 out of 5 of the years analyzed. While some hospitals were subject to the challenges of the pandemic, the majority part of the costs are systemic five years plus two different metrics and exceeding those percentile thresholds consistently across the 10 opportunities.
- A member asked why the data presented excluded psychiatric hospitals?
    - The Office clarified that there was not a recommendation to exclude psychiatric hospitals. There were two lists of data presented: one with and without exclusions

and the advisory committee reacted to the first without exclusions where psychiatric hospitals were listed. They are excluded in the options presented by virtue of the data that is reported to HCAI.

Public Comment was held on the first section of agenda item 5b. Seven members of the public provided comments.

Assistant Deputy Director Howard presented the next section of agenda item 5b, a formula-based approach for adjusting the statewide sector spending target for the group of disproportionately high-cost hospitals.

Discussion and comments from the Board included:

- A member commented that setting a lower target value for high-cost hospitals above the 80th percentile would not bring them below where the 80th percentile is until 2065, which does not seem aggressive enough.
- A member asked whether the cost target would apply for hospitals with a small percentage of commercial patients.
  - The Office replied that the statewide target will be assessed by market and in previous discussions, they have noted some special considerations for Medi-Cal and other state and federal decisions that will affect spending patterns and trends.
- A member asked how the specific target for high-cost outliers impacts our calculation of the overall state target and if this sector target would that make it easier for other facilities to stay within the state spending target.
  - The Office clarified that the spending target impacts each entity individually.
- A member recommended that OHCA connect with one or two of the high-cost hospitals from the lists, regardless of methodology, to gain insight on each hospital's circumstances and surrounding variables for better understanding going into assessment methodology.
- A member asked whether the Board will take action on setting sector targets at next month's meeting.
  - The Office advised that OHCA has a March 1st deadline to propose a recommended target setting methodology and target value. The Office would then present that recommendation to the Board for discussion with a deadline of June 1st for targets to be effective for 2026. There will be time for further discussion at next month's meeting, and the Office encouraged the Board and public to suggest options or alternatives.

Public Comment was held on the second section of agenda item 5b. Two members of the public provided comments.

c) THCE Regulations and Data Submission Guide Updates, Including Advisory Committee Feedback

Assistant Deputy Director Brandt provided a recap of HCAI's approach to collecting both

alternative payment model data and primary care spending data. This information is now included in the THCE Data Submission Guide version 2.0 that has been released for public comment.

Andrew Feher, Research and Analysis Group Manager, presented the timeline for the Data Submission Guide public comment period as well as the 2025 Data Collection timeline.
Discussion and comments from the Board included:

- A member asked if OHCA will be collecting information on the quality metrics that are associated with the alternative payment model (APM) arrangements and whether the Board will see those.
    - The Office replied that they are not collecting data from each payer on the specific quality metrics that they use for each of their APM arrangements. In the Data Submission Guide (DSG), they are asking whether the payments are linked to quality. If payments are not linked to quality, then those payments will be reported separately and will not count towards OHCA's APM Adoption Goals.
- A member inquired whether OHCA has a list of approved quality metrics.
    - The Office confirmed that they do have a list of recommended quality metrics in their APM Standards for Payer-Provider Contracting (APM Standards).
- A member inquired whether the payers would report payments linked to quality based on the recommended quality metrics in the APM Standards.
    - The Office replied that payers are not required to report payments linked to these specific quality metrics currently, but that may be a future data collection consideration.

Public Comment was held on item 5c. No members of the public provided comments.

d) Update on Cost and Market Impact Review Program

Assistant Deputy Director Tatayon introduced Heather Cline Hoganson, one of HCAI's Assistant Chief Counsels, who then presented an overview of the Cost and Market Impact Review (CMIR) program updates.

Discussion and comments from the Board included:

- A member inquired how long a CMIR takes.
    - The Office replied that they have not sent any transactions for a CMIR yet. The transactions that have been submitted to them for review have taken 22 working days on average to conduct a preliminary review but were not submitted for a CMIR.
- A member asked if there are any private equity transactions that have been submitted for review.
    - The Office advised that a couple of transactions they have reviewed did seem to have some financing by private equity groups.
- A member expressed surprise at the small volume of transactions that have been submitted, specifically inquiring about Rady Children's Hospital which merged with

Children's Hospital of Orange County.
    - The Office stated that nonprofit entities may be reviewed by the Office of the Attorney General (AG) and would be exempt from being submitted to OHCA. They did revise their regulations in August 2024, which has resulted in a greater number of submissions.
- A member recalled an instance where a transaction was submitted to the Health Policy Commission (HPC) in Massachusetts where it was reviewed, a report was created and then sent to their Attorney General who denied the transaction based in part on the report from HPC. The member then asked for confirmation that OHCA's process is different.
    - The Office responded that OHCA's scope and jurisdiction does not include approving any transactions. If there were transactions that they felt would negatively impact access or competition after a CMIR was done, statutorily they can refer that to the AG who can take action if necessary. The Office further clarified that certain transactions are sent to the Department of Managed Health Care (DMHC), certain transactions are sent to the Department of Insurance, and certain transactions are sent to the AG. Those are exempt from OHCA's review unless one of those sibling departments refers it to them. A hospital is a health care entity and would be required to file with OHCA unless they are nonprofit.
- A member inquired whether there is communication between OHCA and their sibling departments.
    - The Office stated that they are in contact with their sibling departments on a frequent basis.
- A member asked whether they plan to compile a report with their sibling departments to provide a full picture of what is happening in California.
    - The Office replied that for transactions that have not come in through their office, they are not able to discuss the transactions publicly, but they have been exploring the idea. The first step would be to put links to DMHC and the AG's office on OHCA's website to allow the public to easily reference transactions. Then, OHCA has the statutory authority to conduct studies where there may be future opportunities to compile and conduct public studies. OHCA also mentioned that the California Health Care Foundation issues briefs on the state's activities to monitor and address market consolidation.

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

Agenda Item#6: General Public Comment

Public Comment was held on item 6. No member of the public provided comments.

Agenda Item #7: Adjournment

Vice Chair Hernández adjourned the meeting.