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

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HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Wednesday, November 19, 2025
9:00 am

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

Members Absent: Dr. Richard Pan

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; Megan Brubaker, Engagement and Governance Group Manager, HCAI; Margareta Brandt, Assistant Deputy Director; Debbie Lindes, Health Care Delivery System Group Manager, HCAI; Sheila Tatayon, Assistant Deputy Director; Arnold Analytics, LLC – Daniel R. Arnold, PhD; Paul B. Ginsburg, PhD; Katherine L. Gudiksen, PhD

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

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

Director Landsberg provided an overview of the meeting agenda, noting that there would be a closed session for the Board members to discuss a lawsuit brought by the California Hospital Association against OHCA.

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

Director Landsberg provided an update about the Rural Health Transformation Program grant application that was submitted to the Centers for Medicare and Medicaid Services (CMS) on November 4, 2025, on behalf of California. CMS is required to respond by December 31, 2025.

Deputy Director Pegany provided:
- An update on OHCA's ongoing work on the hospital spending measurement.
- An overview of the results from the 2025 Employer Health Benefits Survey conducted by the Kaiser Family Foundation that focuses on the cost of employee health care premiums.

- A reminder about slide formatting.

Discussion and comments from the Board included:
- A member stated that the actual cost impact to employees for health care is actually higher than what was presented because it does not consider growing deductibles and increased out-of-pocket spending that have been a key feature of employer sponsored benefits over the last couple of decades. Health care is at the top of the affordability crisis in this country and in this state.

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

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

a) Vote to Approve the October 28, 2025, Meeting Minutes

Deputy Director Pegany introduced the action item to approve the October meeting minutes. Richard Kronick proposed a motion to approve. Dr. Sandra Hernandez 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 five ayes and two members were absent. The motion passed.

Agenda Item #4: Action Items
Megan Brubaker, Engagement and Governance Group Manager, HCAI
Vishaal Pegany, Deputy Director, HCAI

a) Vote to Establish a Subcommittee for the Selection of Advisory Committee Member

Megan Brubaker announced an opening on the Health Care Affordability Advisory Committee submission portal for an individual with the health care payer perspective to fill the vacancy created by Aliza Arjoyan's retirement last month. The application deadline is November 30, 2025. The term runs from January 1,2026 to June 30, 2026, with the opportunity for the selected member to apply for reappointment thereafter. She presented a motion to appoint two board members to a two-year subcommittee for the selection of Advisory Committee members, including filling the current vacancy. She also thanked Elizabeth Mitchell and Dr. Richard Pan for having served on the committee for the past three years and asked for nominations.
Richard Kronick nominated Ian Lewis and Dr. Sandra Hernandez. They each accepted the nomination.

Richard Kronick made a motion to appoint Ian Lewis and Dr. Sandra Hernandez to fill

the standing subcommittee vacancies. Elizabeth Mitchell seconded the motion.

Public comment was held on agenda item 4a. No members of the public provided comments.

Voting members who were present voted on agenda item 4a. There were three ayes, two members abstained, and one member was absent. The motion passed.

b) Vote to Approve Data Submission Enforcement – Penalty Scope and Range

Deputy Director Pegany provided a summary of the feedback provided by Board members at the October Board meeting and reviewed the Advisory Committee's feedback, as well as the written and verbal public comments that had been received.

Discussion and comments from the Board included:

- A member stated that shortening the data submission timeline requirement to something less than six months would result in a simpler, less administratively burdensome process.
    - The Office clarified that the proposed process would take four months. It begins with a September 1st deadline followed by a $5 per member penalty that would be imposed on December 1st and a $10 per member penalty that would be imposed on December 31st.
- A member expressed concern that having a submission process that lasts longer than three months could be burdensome for staff, given the number of plans, options, and graduating penalties.
    - The Office replied that it does not anticipate a significant need to impose penalties, noting that currently 48 of the 50 plans have submitted their data on time. The other two plans are reconciling a few issues. For these reasons, the Office stated that it does not believe this will be overly administratively burdensome. The Office will update the Board annually on the data submission progress.
- A member expressed concern that the penalties may not be substantial enough to be an effective deterrent if a plan determines that it is in its financial interest to be non-compliant.
- A member acknowledged that the plans have thus far been compliant in submitting data on time and suggested that significant financial incentives could be imposed in the future if non-compliance becomes an issue.

Ian Lewis proposed a motion to approve. Richard Kronick seconded the motion.

Public comment was held on agenda item 4b. Three members of the public provided comments.
Voting members who were present voted on agenda item 4b. There were five ayes and one member was absent. The motion passed.

Agenda Item #6c: Update on Cost and Market Impact Review Program (out of order)
Sheila Tatayon, Assistant Deputy Director, HCAI

Sheila Tatayon provided the Board with an update on the 26 material change notices (MCNs) OHCA has received this year, including the first cost and market impact review that OHCA is conducting on the acquisition of 22 skilled nursing facilities by Covenant Care California LLC. The cost and market impact review focuses on 3 of the 22 facilities being acquired. Assistant Deputy Director Tatayon also provided the Board with an overview of the recently passed Assembly Bill 1415 which amends the Health Care Quality and Affordability Act.

There were no comments or questions from the Board on this item.

Public comment was held on agenda item 6c. Two members of the public provided comments.

Agenda Item #6b: Introduction to DSG 3.0 Regulations, Including Update on Behavioral Health Definition and Summary of Public Comments and Advisory Committee Feedback (out of order)
Vishaal Pegany, Deputy Director, HCAI
Margareta Brandt, Assistant Deputy Director, HCAI
Debbie Lindes, Health Care Delivery System Group Manager, HCAI

Deputy Director Pegany provided an overview of the proposed changes for the Data Submission Guide 3.0 (DSG 3.0) which outlines the requirements for the submission of data for the 2024-2025 calendar years.

Assistant Deputy Director Brandt provided an overview of the proposed changes for the DSG 3.0 regarding the Alternative Payment Model (APM) file and the Primary Care file. She also provided an overview of the behavioral health definition.

Debbie Lindes presented a summary of the public comments on the behavioral health definition and the feedback provided by the Advisory Committee at its September meeting.

Discussion and comments from the Board included:

- A member asked for clarification regarding the delay associated with acquiring County specialty mental health data.
    - The Office replied that there is a mismatch between the way data is collected by OHCA and the way that data is collected by California Department of Health Care Services (DHCS), so it is working with DHCS to develop a structure that OHCA can implement to analyze County behavioral health spend data.
- A member stated that the data related to specialty mental health is of critical importance and urged the Office to continue to work with DHCS to develop the necessary methodology to obtain it.
- A member asked if there had been any progress in assessing out-of-pocket costs.
    - The Office replied that it presented an approach to measuring out-of-pocket, out-of-plan spending for behavioral health services using the Medical Expenditure Panel Survey (MEPS) data to the Board in the past, but that it has subsequently found that data source unsuitable to credibly estimate year-to-year changes in out-of-plan

behavioral health spending. The Office plans to update the Board in December on its findings.

- A member asked if the Office had received any input from providers on how to assign primary behavioral health codes, especially for screening and assessments, to avoid double counting behavioral health services during preventive visits.
    - The Office explained that one barrier it has identified to capturing behavioral health screening and assessments is that many providers may not bill for those types of codes despite performing the services, since they sometimes do not receive reimbursement for those services. If a behavioral health assessment is provided in a primary care setting, it will count as primary care and be included in behavioral health in primary care module. Behavioral health assessments will also count as behavioral health regardless of the setting in which they occur. The data included in the behavioral health in primary care module can be discretely included or subtracted from primary care or behavioral health spending to avoid double counting.
- A member stated that the Board's statutory charge is not only to reduce spending on acute and specialty care while reallocating that spending to earlier interventions, but to also facilitate system redesign. The member suggested that data be analyzed to determine what portion of the population is moving from diagnosis to in-plan treatment and the related timelines, as this information about access to care would be useful to policymakers and health plans going forward.
- A member stated that even though there is currently no way to compare County behavioral health data to behavioral health data in private health plans and managed care plans, it would be useful to include some totals to indicate how much money is being spent by the County on behavioral health. The member stated that there is some credible reporting that the out-of-pocket and out-of-plan spending is less than the amounts that were mentioned in today's discussion. The member also suggested that screenings for mental health or substance use disorder that are included in annual checkups or wellness visits be recorded by primary care providers and that it may make more sense to only count a portion of a wellness visit as being behavioral health. The member asked for clarification regarding the way psychotherapy visits are coded, whether OHCA knows if it is common or not to bill for psychotherapy without a primary behavioral health diagnosis.
    - The Office stated that it can incorporate measuring total behavioral health spending at the County level into its discussions with DHCS. The guidance for counting behavioral health screenings that occur in a primary care setting or another setting is at the claim line level, so OHCA would not count the spending for the entire primary care service claim, only the claim lines for behavioral health screening and assessment services.
    - Regarding counting psychotherapy services as behavioral health spending without a diagnosis, OHCA proposes to capture this spending by Medi-Cal managed care plans initially. OHCA can consider analyzing Health Care Payments Data (HPD) to gain an understanding of how often psychotherapy services occur without a primary behavioral health diagnosis.
- A member asked if payments are generally made for the whole claim and not by procedure code even if there is a procedure code for a screening.

    - The Office replied that procedure codes associated with a visit can be paid separately but frequently are not paid separately and that if spending on these claim lines is being counted, payers may be incentivized to pay for these procedures separately.
- A member asked about HCAI's ability to attribute spending to medical groups.
    - The Office explained that it receives a Total Medical Expenditures (TME) file from payers that attributes TME to provider organizations (PO) based on payer data. These data were not included in OHCA's 2025 baseline report. The Office plans to meet with large PO's to review the data before featuring any PO-level analysis in the second report that is expected to be issued around June 2026.
- A member asked if the data regarding the use of telehealth behavioral health services by third party vendors will be captured.
    - The Office replied that it can capture spending for behavioral health telehealth services that are submitted through a non-claims payment or through a claims payment. It does not currently have a process for capturing cash pay data for telehealth services.
- A member asked if there was a timeline for the development of a tool that could assess cash pay for behavioral health services.
    - The Office replied that a new data source is needed due to the setback with the MEPS data. It is likely that a survey would need to be conducted to gather data from consumers and behavioral health providers regarding visits and cash payments.

Public comment was held on agenda item 6b. Three members of the public provided comments.

Agenda Item #5: Closed Session to be held in Conference Room 1238
California Hospital Association vs Office of Health Care Affordability, et al
Petition for Writ of Mandate, San Francisco Superior Court Case #CPF 25519370, pursuant to Gov. Code, § 11126 subd. (e).

Public comment was held on agenda item 5. No members of the public provided comments.

Agenda Item #6a: Monterey Hospital Market Competition Study (out of order)
Sheila Tatayon, Assistant Deputy Director, HCAI
Daniel R. Arnold, PhD, Arnold Analytics, LLC
Paul B. Ginsburg, PhD
Katherine L. Gudiksen, PhD

Assistant Deputy Director Tatayon provided background information on the Monterey Hospital Market Competition Study. She then introduced economic experts Dan Arnold from Arnold Analytics, Paul Ginsburg, and Katherine Gudiksen who provided an overview of the study.

Discussion and comments from the Board included:

- A member added context to slide 46, which compares Monterey to the benchmark Bay area, by explaining that the stated price for hip and knee procedures is a straight reference price which is a different mechanism from that which is used for other procedures. The member explained that this single price is why the wage-adjusted price for these procedures is so low compared to the rest of the procedures listed.
- A member asked why Natividad Hospital and Salinas Valley Hospital both have "must-have" status even though they are located within a few miles of each other.
    - The economic experts explained that one possibility for Natividad Hospital being assigned a must-have status may be because it is the only hospital of the three that has a trauma center, so all trauma patients in the area will go to Natividad. An insurer would want to have a contract with Natividad Hospital to keep costs down. Because Salinas Valley Hospital does not have a trauma center, it may have less of a must-have status than Natividad. Salinas Valley Hospital's prices are lower than Natividad Hospital's prices and much lower than Community Hospital of the Monterey Peninsula's (CHOMP) prices.
- A member asked if in the case of the existence of two hospitals located near each other, does the hospital obtain must-have status because it offers some necessary services or do those services give the hospital leverage for the rest of the contract?
    - The economic experts replied that offering necessary services gives the hospital leverage in negotiating its contracts.
- A member asked why CHOMP is also listed on the slide as having must-have status but its higher prices are not attributed to this status as are the higher prices at the other two hospitals.
    - The economic experts replied that CHOMP probably has the strongest of the "must-have" status, but the public payer percentage at CHOMP is virtually identical to the statewide percentage, so that does not explain why their prices are higher than rest of the state's prices.
- A member asked if an insurer could offer a viable product without Montage Medical Group and why Montage Medical Group's prices are lower than average.
- A member stated that 51% of Montage Medical Group is owned by CHOMP and 49% is owned by Salinas Valley.
    - The economic experts stated that many physicians in the area are aligned with the big health systems so it isn't possible to construct a network without physicians who are closely aligned with the hospitals.
- A member asked why the networks cannot get better prices.
    - The economic experts replied that historically the small number of physicians in the medical group who had been affiliated with the hospital did not mind taking a loss because it wasn't worth their time to negotiate. Over time, this has become a bigger factor and it is expected that prices will go up in the future as constraints are placed on hospital prices. Also, the physician groups set inpatient and outpatient facility prices at the level that brings in necessary revenue rather than battling with insurers over physician professional fees when they can raise facility prices themselves.
- A member cited research that shows that hospitals that manage to lower public rates are more efficient than commercial and asked if the survey team had asked the

hospitals how their leadership is trying to reduce prices through its managerial practices.
    - The economic experts replied that the question had been asked but the answer it had received would probably not satisfy the member.
- A member asked for clarification regarding a possible explanation for why hospital costs are higher even though operating costs per admission are not higher than the Bay Area average and profit margins are somewhat higher, but not high enough to explain the big differences in commercial to Medicare prices.
- A member asked if the reserves at these hospitals are significantly higher than those of other hospitals.
    - The economic experts replied that the reserve of cash on hand for these hospitals would last 400 to 500 days and that the nationwide median for cash on hand is around 200 days. The costs represented in the presentation were based on HCAI hospital cost reports. Health system cost reports were more difficult to assess because of the various reporting processes implemented by the health systems. A deep accounting would perhaps provide a different perspective.
- A member expressed appreciation for the OHCA staff and its partners, CalPERS and Covered California, for having taken this issue seriously and for taking such a deep dive. This report diagnoses the problem and gives policymakers a very helpful roadmap as to what happens when a market fails to take care of Californians' needs. There are lessons for all of California in this report.
- A member offered to share its organization's analysis of Hospital Price Transparency and Transparency in Coverage data that shows specifically where rates vary and how they align to quality.
- A member stated that CalPERS has had a hard time keeping insurance products in Monterey County and that starting January 1, 2026, Blue Shield Trio, which is a low-cost HMO product, will no longer be offered as an affordable option for members because it would raise statewide rates by 6%. It will be replaced with a significantly more expensive product. Monterey presents unique challenges and too much exposure to Monterey can be devastating for CalPERS' ability to offer an affordable product statewide.
- Public comment was held on agenda item 6a. Ten members of the public provided comments.

Agenda Item #7: General Public Comment

Public comment was held on agenda item 7. No members of the public provided comments.

Agenda Item #8: Adjournment

Chair Johnson adjourned the meeting.