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

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HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Tuesday, February 25, 2025
10:00 am

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

Members Absent: None

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; CJ Howard, Assistant Deputy Director, HCAI; Andrew Feher, Research Manager, HCAI; Margareta Brandt, Assistant Deputy Director, HCAI; Debbie Lindes, Health Care Delivery System Group Manager, HCAI

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

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

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

Director Landsberg 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:

- Recognition of February as Black History Month and HCAI's Black Liberation Statement developed by its Racial Equity Team. Working for health equity is at the core of HCAI's mission and a foundational step in furthering equity is to acknowledge the long history of intentional inequities – to name the violence and racism that has been perpetuated on Blacks and African Americans that underlies the health disparities that persist to this day. It is important to celebrate Black culture and the incredible

resilience of Black communities. OHCA is committed to furthering diversity, equity, and inclusion at HCAI and in the state of California.
- Introduction of Assembly Bill 1415, by Assembly Member Mia Bonta, Chair of the Health Committee, that would change OHCA's existing law by adding to the definition of a health care entity both management services organizations (MSOs) and health systems. If this bill becomes law, MSOs and health systems would be considered health care entities subject to data requirements and spending targets set by the Board. In addition, the bill would change current law regarding Cost and Market Impact Reviews. Currently, health care entities must provide OHCA with prior written notice of proposed transactions, including selling or transferring assets to one or more health care entities. AB 1415 would similarly require private equity groups, hedge funds, or newly created businesses created specifically for the purpose of entering into agreements or transactions with a health care entity, to also file a notice with the Office before a proposed transaction with a health care entity.

Deputy Director Pegany provided updates, including the following information:
- Findings from the Millbank Memorial Fund's February 2025 report on key lessons learned from multiple state efforts to slow and shift total health care spending.
- Findings from a JAMA Health Forum February 2025 article on the drivers of variation in health care spending across US counties.
- Reminder about slide formatting.

Discussion and comments from the Board included:
- A member asked if Assembly Bill 1415 is currently sponsored.
  - The Office replied that it is not currently sponsored.
- A member asked about possible causes to the pattern that shows Medicare Advantage users having lower utilization with higher intensity or cost.
  - The Office replied that the report mentioned lower utilization and differences in the types of services that Medicare Advantage enrollees use, with Medicare Advantage patients using more ambulatory services.
- A member noted that this may be a case where associative or correlative analyses do not imply causality. The pattern may be influenced by the population enrolling in Medicare Advantage.
- Another member noted it may have to do with areas in the country with higher Medicare Advantage penetration. They praised the study for its emphasis on variation in utilization, as well as prices.

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

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

a) Approval of the January 28, 2025, Meeting Minutes

Vice Chair Hernández introduced the action consent item to approve the January meeting Minutes. Board Member Pan proposed a motion to approve, with a second from Board Member Kronick.

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: Information Items
Andrew Feher, Research Manager, HCAI
Vishaal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI
Margareta Brandt, Assistant Deputy Director, HCAI
Debbie Lindes, Health Care Delivery System Group Manager, HCAI

a) OHCA's Recommendation for Hospital Sector Target Methodology and Values

Deputy Director Pegany, Assistant Deputy Director CJ Howard, and Research Manager Andrew Feher presented an overview of the Board actions taken in response to four specific Board member requests. They followed this with a presentation of OHCA's recommendation for hospital sector target methodology and values.

Discussion and comments from the Board included:

- A member asked if the hospital industry offered alternatives to the methodology or solutions for reducing commercial costs.
  - The Office replied that there was discussion from hospitals about the dynamics of cost-shifting. We did not get into the issue of reducing costs over time but specifically asked them for input on the methodology to identify high-cost hospitals.
- A member asked about the possibility of using Transparency in Coverage (TIC) data combined with employer data to show rates and variation across facilities.
  - The Office replied that input would be welcome when this topic is covered in an upcoming slide.
- A member asked for more information about the Massachusetts recommendation for creating a relative price measure.
  - The Office explained that Massachusetts uses their All Payer Claims Database to measure relative prices of hospitals that they index to a value of one and then report by types of hospitals and how the pricing is relative to each other. According to the 2022 to 2023 Massachusetts Cost Trends Report, they use 200% of Medicare's price as a conservative point of comparison for what constitutes acceptable prices. David Seltz from Massachusetts will be speaking at the March meeting and can elaborate further.
- A member asked how OHCA is examining the role that a hospital plays in the ecosystem so that communities do not experience reduced access and quality.
  - The Office responded that in terms of front-end review, the entities will be reviewed using the categories that they themselves have chosen and the way in which they report their hospital financial data.

    - The member questioned whether something can be done on the back end before corrective actions are imposed so that communities do not experience reduced access.
    - The Office responded that this area may need ongoing conversations as, for example, one hospital that had asked the Office to consider the expenses for their outpatient clinics.
- A member inquired whether teaching hospitals would have the indirect medical education adjustment included in determining the Medicare rates for the hospital.
    - Another member replied that the indirect medical education adjustment would be included in that calculation.
- A member asked, related to the question of measuring systems, if OHCA would look at the cost of other facilities, e.g. insist on site-neutral payments for outpatient practices or specialty once acquired, since after these kinds of acquisitions, prices increase. They want visibility into this if OHCA looks at systems.
    - The Office responded that if they were to pursue this task, they would have to acquire the legal authority to collect data by health system, set up the infrastructure, and develop regulations.
- A member asked, with regard to the relative price measure and in comparison, to the cost of delivering services, if Massachusetts or any other cost target state has attempted to create another relative cost measure or metric, getting at the question of what a fair price is.
    - The Office replied that it is not aware of any other state and that they use the Commercial to Medicare ratio because it is the best approach that they are aware of.
- A member inquired about the incongruity between the third and fourth bullets on slide 21: for a hospital, Medicare reimbursement is decreasing, causing higher commercial rates to be necessary to support hospital operations; but for physicians, Medicare reimbursement drives lower commercial rates.
    - The Office replied a hospital made the comment, but the thinking perhaps was the way that commercial tends to peg their reimbursement to a multiple of Medicare; if Medicare rates decline, then commercial will subsequently reduce prices for physicians.
- A member commented that given the newly introduced Assembly bill around systems, it would be helpful in the meetings with hospitals to have more knowledge about the varieties of hospital system designs that exist and how integrated they are, along with their funding models, to take the data into account in creating the methodology. The Member recommended at a future meeting to look at a few models to understand how they work financially and to better position us to think about methodology moving forward.
- A member stated that none of the various data sets being used are adequate on their own; for example, not knowing gross charges, payer rates, and cash prices is challenging. They suggested using TIC data which shows rates in combination with other data sets (claims, employer, hospital-reported and possibly quality and safety data) that are available to take full advantage of all the currently available data.

- A member asked the Office to explain what appears to be a two-headed distribution of the Commercial to Medicare Payment to Cost Ratio (PTCR) on slide 26, if there is something different about the hospitals in each head.
    - The Office responded that they could provide additional information on hospitals that tend to be below 200 percent versus above.
    - A member hypothesized that hospitals at the lower end could be public hospitals and those with high fractions of Medi-Cal.
- A member pointed out that some of the feedback received at the meetings with the hospitals was given in the context of overarching uncertainties, particularly relating to potential action at the federal level.
- A member noted, in reference to slide 40, that Northbay was not doing well in prior years but is now performing better than the state average and asked if a reduced target would apply.
    - The Office responded that they have reached out to Northbay to further discuss their data.
    - The member asked hypothetically, if the three-out-of-five years methodology is used but there is significant improvement in the last two years, how that would impact the application of the target.
    - The Office responded they would welcome Board suggestions.
    - The member thought it problematic to apply a reduced spending target on an entity that has seen significant spending decreases, especially as hospitals respond to the spending target; some will trend down more quickly than others and this improvement in more recent years should be considered.
- A member noted that when identifying high-cost hospitals, there is a cut-off/cliff in the formula; if a hospital is slightly over or under the cut-off it determines whether the year is considered.
- A member commented that if hospitals respond to the sector target by coming down from an outlier status the OHCA experiment should be considered a success.
- A member asked if the Office has the same authority and flexibility to adjust any enforcement action with the reduced spending target as with the statewide spending target and if so, suggested factoring in any reduced trend to enforcement decision-making.
    - The Office replied affirmatively and noted the point. Several members expressed a desire to move forward with this process, allowing the methodology to evolve.
- The Office noted that this discussion starts a 45-day public comment window that will end on April 11, 2025. The Board will then have until June 1st to set targets for 2026 with the option to set targets beyond 2026.

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

Prior to the second session, the Board was asked for further direction to be provided to staff regarding the recommendations for this hospital sector target.

Additional Comments from the Board included:

- A member expressed a need to ensure fairness in whatever methodology is enacted and to ensure that measures are in place to consider special circumstances for specific entities regarding targets and enforcement.
- Several members commended the work of staff and believe the recommendation strikes the right balance.
- A member inquired about the Office's process for notifying a hospital that it has been placed on the high-cost hospital list or if a status change occurs.
- A member mentioned the importance of data quality and allowing hospitals the opportunity to acknowledge that their audited, submitted data is wrong and determine how to respond to this. They also asked about the definition of systems and the data collection plan moving forward. They suggest starting with the definition AHRQ used in their compendium project.
- A member noted the complexity of the work and data challenges but also noted access to care and affordability problems now and welcomes continued conversations on how to drive down costs.

b) Proposed Hospital Sector Definition Regulations

Assistant Deputy Director CJ Howard provided an overview of the Hospital Sector Rulemaking Timeline and clarified which components of the Health and Safety Code 1250 are included in the hospital sector definition.

There were no discussions or comments from the Board.

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

c) Baseline Report Content Preview

Deputy Director Pegany and Andrew Feher presented a review of the proposed content for the baseline report.

Discussion and comments from the Board included:
- A member asked how the information on slide 54 reflects health plans, e.g., the administrative costs and profits of health plans or providers.
    - The Office replied that it is health plan administrative costs and profits information obtained from DMHC and the Center for Consumer Information and Insurance Oversight's (CCIIO) Medical Loss Ratio (MLR) reports.
- A member expressed a concern that administrative costs incurred by providers tend to be counted as health care. They wondered if there would be a way to separate administrative cost data from actual services for patients.
- A member wondered if the data for public health services that are provided by the government, but are not paid for by health plans, could be gathered at the county or city level to ensure that public health is adequately funded.
- A member inquired about the timing for behavioral health data to be included in this report.

    - The Office stated that behavioral health data would be collected beginning in September 2026, after the Board has approved the behavioral health investment benchmark, approved the definition of a behavioral health service and promulgated regulations for data collection.
- A member asked, in addition to plan administrative costs, which types of administrative cost data are most important for inclusion in this baseline report, and if there were any alternative ways of obtaining this data for medical groups and hospitals.
    - The Office replied that for hospitals, there is the hospital annual disclosure reports as a data source, although they will not report on specific hospitals in the baseline report. They are open to suggestions but there is no readily available data source for administrative costs and profits for physician organizations.
- A member commented that estimated administrative costs for medical groups could be obtained from the Medical Group Management Association (MGMA) and other sources.
    - The Office stated that it has the authority to collect audited financial statements for physician organizations that could be used in the future to derive administrative costs and profits but are currently focused on identifying the provider organizations before data collection begins.
    - A member commented that it is income for medical groups, not profit.
- A member commented that understanding the administrative costs on both the health plan side and the provider side is very important, especially if we start looking at systems.
- A couple of members noted, relative to behavioral health, that plans should know their spend (likely between 1.5 and 2.5 of total spend); it seems they could easily provide this number.
    - The Office responded that an agreed upon definition of behavioral health is needed.
- A member asked how much long-term care data is captured in reference to slide 62, total medical expense (TME) by service category.
    - The Office explained that this data is collected using the Data Submission Guide (DSG) for commercial, Medicare Advantage, DSNPs (dual-eligible special needs plans), and duals as part of year one. Medi-Cal managed care organization (MCO) plans were exempted this year, so OHCA is using existing reporting that MCOs supply to the Department of Health Care Services.
    - The member expressed appreciation for the inclusion of long-term care cost data and they suggested that there be an asterisk to acknowledge that long-term care is a significant budgetary issue which requires other sources of funding that are not represented in this report.
- A member appreciated the inclusion of consumer affordability data and asked for confirmation that an additional set of tables would be provided that show out-of-pocket spending in 2022 and 2023 as well as the changes in out-of-pocket spending in 2022 and 2023.
    - The Office stated that this can be accomplished by using TME data and will determine if they can report by region as well. It will also present information from the literature pertaining to consumer affordability in a narrative format.
- A member suggested using the Kaiser employer survey and the AHRQ-MEPS data on premium payments and suggested adding additional sections to the baseline report to

compare with CMS's total health care spending in California, as well as hospital and physician spending. They also requested information from the hospital annual financial disclosure reports about changes in spending from 2022 to 2023 both in the aggregate and for specific hospitals.
    - The Office replied that these are helpful points and OHCA will do as much as it can.
- A member stated that an important piece of this report should be affordability, including the percentage of median household income that is spent on health care in the state, regional costs, and a breakdown of commercial costs by individual, small group, and large group markets. They indicated that this may not be achievable at this stage but could be considered for the future.
    - The Office replied that the data is currently being broken out by commercial, HMO, and PPO. Other market segments could be considered for inclusion in subsequent reports.
- A member suggested that the report keep a consumer perspective and focus on providing clear information that compares costs using a standard package as a basis for comparison for the average Californian.

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

d) Proposed Total Health Care Expenditures Regulations: Summary of Public Comments

Assistant Deputy Director Howard provided an update on the proposed Total Health Care Expenditures data submission guide.

Assistant Deputy Director Howard and Assistant Deputy Director Brandt then provided a summary of the public comments.

Discussion and comments from the Board included:
- A member asked for clarification about the availability of data regarding the largest physician organizations in the state and if it would be possible to include the data for the 20 largest physician organizations in the baseline report.
    - The Office replied that they are in the process of collecting this data and that it will be included in the report once the data is complete and reliable.
- A member asked which type of services provided at retail pharmacies are included in the fee-for-service payments data under primary care services.
    - The Office clarified that retail pharmacies are not included as a place of service in the primary care spend definition, rather fee-for-service payments at retail pharmacies are included in the total claims payments as part of total medical expense.

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

e) Behavioral Health Investment Benchmark including Advisory Committee

Assistant Deputy Director Brandt presented OHCA's proposed approach to a focus benchmark to behavioral health spending.

Debbie Lindes then provided an update on the work being done to develop a framework for the behavioral health investment benchmark along with a summary of feedback received from the work group.

Discussion and comments from the Board included:

- A member mentioned the importance of incorporating Medi-Cal and asked about the timeline and the challenges involved.
  - The Office replied that its goal is to incorporate Medi-Cal as soon as possible, alongside commercial and Medicare Advantage, including both data collection and spending measurement. The Office is actively working with DHCS to understand its spending streams and data sources. The challenge is in understanding the complexities and data sources of behavioral health spending in Medi-Cal and how to capture that spending.
- A member inquired about excluding inpatient psychiatric beds in the analysis.
  - The Office stated that there is a recognition that inpatient and residential behavioral health services are an important part of the behavioral health system; the Workgroup has identified supporting access to outpatient and community based behavioral health services and reducing out of pocket spending as priorities.
- A member suggested that there is a need for a longer conversation regarding the role of psychiatric beds within the continuum of care. Proposition 1, if used appropriately, should make available more beds which are badly needed in the continuum of care.
  - The Office replied that there are many parallel efforts going on within the California Health and Human Services Agency. The Office agreed with the need to have inpatient services available, is working on determining its specific role within the framework of overall state behavioral health transformation efforts and will continue to work with DHCS. HCAI is implementing the workforce components of the Behavioral Health Services Act.
- A member asked about the cause of the statistics on poor access to care embedded in the benchmark model rationale and why payers and purchasers are resistant to investment in behavioral health services given the demand post-Covid. The member suggested that OHCA may have more levers to influence payers, whereas other parts of HCAI may be more able to help with the supply side (provider shortages).
  - The Office replied that their initial research showed that some of the reasons are administrative complexity, the inability to provide needed care due to visit limits or prior authorization requirements, and the lack of payments that are comparable to payments received from self-pay clients. This research is ongoing, and an update could be presented to the Board at an upcoming meeting.

- A member suggested that it might be helpful to have a benchmark on a cost-per-visit basis, to incent providers to take more patients through insurance.
- A member supported the benchmark recommendation, with its focus on outpatient, but hopes data is collected on both inpatient and outpatient spending. The member is concerned that if the benchmark included inpatient spending, that spending could overwhelm the outpatient spending.
- A member appreciated the inclusion of cultural effectiveness in the presentation and mentioned the importance of factoring in the expense of community outreach and interpretive services which are effective in delivering behavioral health services to non-English speakers.
- A member stated that the lack of access to behavioral health services is a huge problem, along with homelessness and substance use disorders. In terms of outpatient care, school-based behavior health services may be the only available care for young people. This data may be difficult to include because it does not involve health plan reimbursement.
- A member stated that California is transforming behavioral health care with investments in facilities with Proposition 1 and other investments, adding preventative and early intervention components, and focusing on severe mental illness and substance use disorder. Funds will be available to schools to receive Medicaid dollars for behavioral health services through the Children and Youth Behavioral Health Initiative. Capturing these point-in-time benchmarks with a foundational context in the long term could be both population-specific and could include targeted interventions being worked on across the state.
    - The Office replied that behavioral health includes substance use disorder services. In addition, there are now 1,200 certified wellness coaches working in schools under the Child and Youth Behavioral Health Initiatives. There is a state plan amendment that has been filed with the federal government to have wellness coaches be a Medi-Cal provider who are covered for children who are insured by Medi-Cal or by a commercial provider.
- A member stated that it would be useful to provide information about payment rates from the HPD for commercial insurers compared to Medicare and Medi-Cal. For self-pay, perhaps a survey or information gathering as part of licensure, gathering information about average per visit payment as well as payer mix could be helpful. There is a need for data related to out-of-pocket and out-of-plan costs that are not being captured.
- A member asked about the exclusion of pharmaceutical costs.
    - The Office replied that pharmaceutical spend is not included in primary care as it is not part of the primary care provider's core services; we are taking a similar approach with behavioral health in the workgroup. Additionally, pharmaceutical spend is a large percentage of overall behavioral health spend so including it could overshadow the desired changes in clinical care. It is also less often a barrier to access than getting, for example, psychotherapy.
- A member suggested tracking pharmaceutical costs in the larger measurement circle, even if they are not included in the benchmark.

    - The Office clarified that pharmaceutical costs will be included in the overall measurement of behavioral health costs, but not in the benchmark, as of the current proposal.
- A member asked if telehealth services will be included in the benchmark measurement.
    - The Office replied that the telehealth services paid by claims and delivered by traditional providers in a similar way to in-person care will be included.
- A member mentioned that chatbot services can facilitate access for some populations, communities, and languages and some people may prefer to use artificial intelligence (AI) over traditional care as it may be more neutral in many ways and may improve access. AI may become a major component of behavioral health services in five or ten years.
- The Office reminded the Board that there will be a presentation about the Health Care Payments Data Program at the March meeting.

Agenda Item #5: General Public Comment

Public Comment was held on agenda item 4e and item 5. Two members of the public provided comments.

Agenda Item #6: Adjournment

Chair Johnson adjourned the meeting.