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

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HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Wednesday, January 28, 2026
10:00 am

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

Members Absent: Don Moulds
Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; Megan Brubaker, Engagement and Governance Group Manager, HCAI; Margareta Brandt, Assistant Deputy Director, HCAI; Brad Spellberg, Chief Medical Officer, Los Angeles General Medical Center; Dr. Josh Banerjee, Associate Medical Director of Transitions of Care, Los Angeles General Medical Center; Dr. Christopher Lynch, Medical Director, Safer@Home Program; CJ Howard, Assistant Deputy Director, HCAI; Andrew Feher, Research and Analysis Group Manager, HCAI; Sheila Tatayon, Assistant Deputy Director, HCAI

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

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

Chair Johnson opened the January 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 and noted that the February 2026 Board meeting has been canceled. The Board will reconvene in March.

Director Landsberg provided Executive Updates, including the following:

- In late December, California received a provisional $233.6 million award from the Centers for Medicare and Medicaid Services (CMS) for the Rural Health Transformation Project for the federal fiscal year that ends September 30, 2026.

CMS will provide funds for subsequent fiscal years at the completion of each budget period.

Deputy Director Pegany provided Executive Updates, including the following:

- A quarterly work plan update, highlighting topics that will be discussed at the March and April Board meetings.
- A list of future topics beyond April 2026.
- An overview of expected reports by OHCA in 2026.
- The projected timeline for revising the Cost and Market Impact Review (CMIR) regulations due to AB 1415.
- A summary of a Health Affairs report on CMS' 2024 National Health Expenditures.
- A reminder that OHCA emailed hospitals and posted a preliminary facility level crosswalk to support implementation of its hospital spending work stream. OHCA also posted a Cost Driver Issue Brief that utilizes Healthcare Payments Data (HPD) to build upon findings from the baseline report.
- A notification that OHCA is establishing a Patient and Consumer Forum that will convene two to four times a year to work with patients, consumers, and advocacy groups to understand their concerns and lived experiences. The inaugural meeting will be held on March 10, 2026 as a hybrid meeting to ensure accessibility.
- A reminder about slide formatting.

Discussion and comments from the Board included:

- A member observed that the National Health Expenditures data excluded administrative costs for the commercial sector and suggested that this data be looked at even if it is not a primary cost driver.
- A member asked, regarding primary care work and the Rural Health Transformation Program, if the Office is partnering with local initiatives that are already doing work, such as on primary care payment reform.
    - The Office replied that it is currently collaborating with relevant groups in rural areas, working to identify and help support accelerator programs and learn best practices to incubate similar collaborations in areas that do not already have them. The Office highlighted the work being done using the transformative care model to facilitate primary care and chronic disease management in rural communities.
- A member asked if the authors of the National Health Expenditure Data report discussed the causes of increased use and intensity that do not seem to be related to price.
    - The Office replied that it would look into this.
- A member expressed concern that some spoken or written public comments may not be accurate and asked how these statements could be assessed for accuracy, and how the Board and the public could be informed about any errors that have been presented as facts. Some analysis of the comments would be helpful.
    - The Office replied that it would take this matter into consideration.

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

Agenda Item #3: Action Consent Item
Vote to Approve December 16, 2025 Meeting Minutes
Vishaal Pegany, Deputy Director, HCAI

Deputy Director Pegany introduced the action item to approve the December meeting minutes. Rick Kronick proposed a motion to approve. Ian Lewis 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 one member abstained. The motion passed.

Agenda Item #5: Informational Items (out of order)
a) Cost-Reducing Strategies – Los Angeles General Medical Center Safer@Home Program
Margareta Brandt, Assistant Deputy Director, HCAI
Dr. Brad Spellberg, Chief Medical Officer, Los Angeles General Medical Center
Dr. Josh Banerjee, Associate Medical Director of Transitions of Care, Los Angeles General Medical Center
Dr. Christopher Lynch, Medical Director, Safer@Home Program

Dr. Spellberg presented an overview of the Safer@Home Program at Los Angeles General Medical Center to shift the treatment of patients from hospital care to virtual care at the patient's home if the patient meets specific criteria. Dr. Spellberg developed the program with Dr. Banerjee and day-to-day operations are overseen by Dr. Lynch.

Discussion and comments from the Board included:
- A member asked about the ways in which payers are resisting the program and for recommendations for broader adoption in the industry.
  - The presenter stated that there is a need to create a commercial payment mechanism that pays hospitals 40 to 50% of Medicare Diagnosis Related Groups (DRGs) to make up for the loss of revenue that results from moving a patient from the hospital to virtual care at home. The presenter asked Board members for advice on how to achieve this aim.
- A member appreciated that the discussion is centered in the socio-demographic needs of the population, as well as the acknowledgement that this is not an attempt to shift skilled work into uncompensated care; it is a good example of the kind of pioneering work where the public sector can lead the private sector.
- A member asked for clarification about the safeguards in place to assess what type of care is appropriate for each family situation.
  - The presenter explained there are general criteria and disease-specific criteria assessed during the enrollment process. A key part of the general criteria is whether a patient can perform activities of daily living on their own. The patient must be able to answer the phone daily and take care of themselves. If the patient already has a caregiver, the caregiver must be present on site to participate in the

enrollment process so that they are fully oriented to the program and are able to answer questions. If either the patient or caregiver cannot demonstrate the ability to fulfill the requirements of the program after several attempts using the teach back method during enrollment, the Safer@Home Program attending physician and referring team are notified immediately to discuss next steps which could be hospitalization or admission to the emergency department. The presenter clarified that the term “caregiver” refers to a pre-existing caregiver; there is no expectation that family members would take on caregiver responsibilities if the patient did not previously have a caregiver at home.

- A member asked for clarification regarding how a Safer@Home patient affects revenue loss caused by the absence of the patient at the hospital.
  - The presenter explained that having another commercial or Medicare patient in the hospital bed does not create a loss while having a Medicaid or uninsured patient in the hospital bed would create a loss. The presenter also noted that value-based payment mechanisms could help address this issue by changing the payment structure and reducing the reliance on inpatient revenue.
- A member questioned how to change the incentive structure and work with payers and purchasers to take this innovative approach to scale, while also ensuring that the payment mechanisms are flexible enough to serve the patients who have the same diagnosis, but who do not meet the criteria for the Safer@Home program.
- A member mentioned that the program had an average daily census of 3.5 patients in year three and asked why there was a relatively small number of patients enrolled in this program.
  - The presenter replied that a better measurement would be the number of patients enrolled in the program as a percentage of annual discharges. Of about 30,000 discharges, about 5% are enrolled in the program. The 5% is because of the program criteria, not a resource problem, but the 5% margin of bed turnover helps patient flow in the emergency room and increases patient safety.
- A member asked if Medicare or commercial payers currently pay for this program.
  - The presenter replied that there is no Medicare payment for this program because the program does not meet Medicare criteria for hospital-at-home. There is also no Medicaid or Commercial payment for this program. There are plans to incorporate payment mechanisms into contracts when they are renegotiated that would include Medicare, Medicaid, and individual Commercial payers.
- A member asked if there were more clinical indications that could be eligible for this program in the future.
  - The presenter replied that the Safer@Home Program is looking at expanding treatment options for patients who have ophthalmological conditions as well as some interventional radiologic treatments.
- A member asked if technology was being used in ways to help scale the program.
  - The presenter replied that the program uses inexpensive, simple, effective technologies that respond to a specific need, like cellphones equipped with the preprogrammed app or remote pulse oximeters.
- A member asked how this program addresses alcohol withdrawal syndrome, given that alcoholism is a chronic condition.

- The presenter explained that the program focuses on acute withdrawal symptomatology with the understanding that this is a chronic condition and relapses do happen. The benefit of this program is that the patient has the support of the whole clinical team, particularly the nurses who monitor the patients for medication adherence. The program has had good outcomes with its protocols and criteria for both toxicology and addiction medicine.

- A member asked about language access for the non-English speakers enrolled in the program.
  - The presenter explained that 50% of the patients in the program do not speak English as a primary language. All the explanatory materials have been translated into dozens of different languages. The translated instructional videos are viewed by the patient and the family with a nurse in the discharge lounge during the enrollment process.
- A member asked if patients who have previously been treated in the hospital have the option of deciding not to participate in the Safer@Home Program.
  - The presenter replied that patients can say no to the program but that this has been rare, as most patients want to be home and that patient involvement is critical to successful outcomes. There is an additional pathway being developed that would allow a patient to avoid being admitted to the hospital from an emergency room visit if the patient meets the criteria for the program.

Public comment was held on agenda item 5a. Three members of the public provided comments.

Agenda Item #4: Action Item (out of order)
Vote to Appoint Advisory Committee Member
Megan Brubaker, Engagement and Governance Group Manager, HCAI

Megan Brubaker presented the draft motion from the subcommittee to appoint Casey Maroney, Senior Vice President of Underwriting and Analytics and Chief Actuary of Blue Shield, to the Health Care Affordability Advisory Committee in the payer category for a term that will end on June 30, 2026.

Discussion and comments from the Board included:

- A member stated that even though this is an individual appointment, there is also consideration about institutional representation on the Committee. The member encouraged candidates that had not been chosen for this spot to consider re-applying in a few months as more Committee positions become available.
- A member stated that this candidate would add significant input to the Advisory Committee.
- A member commented that in the past information was provided about how the candidate contributes to the geographic and other diversities of the committee.
  - The Office responded that they would include this information during the upcoming general selection process.

Chair Johnson introduced the action item to appoint Casey Maroney to the Advisory Committee. Dr. Sandra Hernández proposed a motion to approve. Ian Lewis seconded the motion.

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

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

Megan Brubaker reminded the Board and the public that from January 5 to March 31, 2026 OHCA is accepting submissions of interest to serve on the Advisory Committee. Selected members will serve from July 1, 2026 to June 30, 2028.

Agenda Item #5: Informational Items

b) Hospital Sector Target Adjustments Methodology: Considering Resubmissions of Hospital Data

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

Assistant Deputy Director Howard provided background information on the Hospital Annual Financial Disclosure Reports and led a discussion about considering resubmitted hospital data.

Discussion and comments from the Board included:

- A member asked if there is a timeline for the validation process.
  - The Office replied that the timeline is unique to each entity depending on the number of years of data that have been resubmitted or the nature of the changes.
- A member asked whether an entity is required to provide justification when resubmitting data that was previously certified as accurate.
  - The Office replied that the dialogue process for validation allows for discussion between HCAI and the facility to understand the nature of changes. The Office added that the hospitals self-report the data and that HCAI validates it for completeness and reporting compliance but does not perform a financial audit.
- A member expressed concern about creating a dynamic that could incentivize entities to game the system or put staff in the untenable position of having to validate the data on all submissions.
- A member suggested that a timeline be developed that allows for the resubmission of old data with a cut-off date so that each hospital is treated fairly, particularly those which have been designated as high-cost hospitals due to having submitted incorrect data. Going forward, the expectation is that hospitals will submit correct data and that the Board would not plan to recalculate high-cost outliers every year based on continually resubmitted data.
- A member expressed concern that the reason that some high-cost hospitals may resubmit data would be to remove themselves from the high-cost hospital list.

    - The Office clarified that the data team engages with a hospital to understand new data, but there is no requirement that justification for the resubmission be included and that we would not want to burden staff with the responsibility of deciding if the reasons for the resubmission are valid. Additionally, if the Board decides to recalculate the high-cost hospital list based on resubmitted data that is validated, it will reshuffle the list.
- A member suggested that a one-time correction for data that was submitted before 2022 be allowed because hospitals may have misunderstood how this data was going to be used, but that moving forward the expectation is that the data will be accurate, and that the data will be used to determine which hospitals will be designated high-cost hospitals.
- A member suggested that there be a deadline after which there will no longer be a recalculation to determine which hospitals fall into the percentage that is designated as high cost.
- A member expressed concern that although this data set has not been used to determine spending limits, it has been heavily relied upon by policymakers and the public, and questions how these unexpected data concerns could affect work being done at other state agencies.
    - The Office stated that this data is widely used by hospitals and health plans for benchmarking and for internal strategic planning.
- A member asked if the Office is asking the Board to modify the methodology to adjust targets or the data input used to adjust targets.
    - The Office confirmed that data input is part of the methodology.
- A member asked about the possibility of changing the deadlines for the resubmission of corrected data for previous years but establishing hard deadlines going forward.
    - The Office responded that several resubmissions are currently in progress and that, because no resubmission deadline has been communicated, establishing one this year would be unfair to hospitals that were not aware of it. To clearly communicate a timeline in advance, any deadline would need to apply starting next year, which could in turn affect the adjusted targets for 2028. The Office also noted that hospitals have already submitted data for two of the five years, with an understanding of how the data would be used, suggesting that the existing data could be used as-is.
- A member suggested that the Office create a timeline for data resubmission for data that had been submitted before a certain date and a different policy for any data that will be submitted after this date.
- A member asked how managing the data resubmission would work operationally.
    - The Office replied that it will consider the Board discussion regarding this topic and it will present potential options for procedures for handling data resubmission at a future meeting.
- A member emphasized the importance of creating a data resubmission procedure that is transparent and predictable for hospitals and the public.
- A member asked if resubmitted corrected data from prior years is automatically posted.

- The Office replied that the resubmissions are made available on HCAI's website via the SIERA System.

Public comment was held on agenda item 5b. Five members of the public provided comments.

c) Update on Total Health Care Expenditures Data Submission Regulations (DSG 3.0)
Vishal Pegany, Deputy Director, HCAI

Deputy Director Pegany shared updates on the Total Health Care Expenditures Data Submission Regulations.
There were no questions or comments from the Board.

Public comment was held on agenda item 5c. One member of the public provided comments.

d) Exploring Drivers of Health Care Spending Across Commercial Payers
Andrew Feher, Research and Analysis Group Manager, HCAI

Andrew Feher provided an overview of the drivers of health care spending across commercial payers.

Discussion and comments from the Board included:
- A member suggested that a term other than utilization be used to describe the measurement of the fraction of people who are using a service.
- A member expressed concern that the data regarding the decline in the number of people utilizing services in Slides 68 and 70 may be inaccurate.
  - The Office replied that some payers are undergoing data warehouse transformations that could account for some of the anomalies. There is ongoing work to ensure better data quality with each passing submission.
- A member asked if the data regarding the substantial changes in chronic condition frequency falls within the expected range of variation for large populations.
  - The Office replied that it did a general analysis of chronic conditions; the second iteration will include a more detailed analysis that will include the types of chronic conditions, comorbidities, and any selection effects that attract enrollees to certain plans based on product type or other characteristics.
- A member expressed concern that the data for chronic conditions that are well managed may not accurately reflect related costs.
  - The Office replied that utilization is tied to chronic conditions within the calendar year and to the plan in which the patient was enrolled; however, the issue brief's appendix provides an alternative operationalization with a retrospective look back into chronic condition prevalence.
- A member asked about a timeline for future analyses of items listed in the limitations section of the presentation.

    - The Office replied that two additional analyses would be available sometime during this calendar year.
- A member asked how Medicare Advantage data was handled.
    - The Office replied that the Medicare Advantage data was unreliable, so it was omitted. The hope is that there will be a version of this report where certain plans are omitted due to data quality or that their data quality improves sufficiently in the HPD so that it can be included.
- A member asked about the themes that had emerged in conversations with the health plans.
    - The Office replied that it had received feedback about which submitters should be included as part of the umbrella organization, a request for regional analyses that would allow the plans to compare their performance to their peers in the area, and information about methods for operationalizing utilization, chronic condition prevalence, pricing, and intensity.
- A member asked if the Office intends to talk with all commercial plans eventually.
    - The Office replied that speaking with all the commercial plans is the goal. One-third of plans that had been invited have participated in the meetings thus far.
- A member commented that more coding could be happening, such as risk adjusted payments, to there may not be a real change in chronic conditions but a more complete reporting of it.
- A member asked to what extent future reporting will be able to report directly on changes in price.
    - The Office replied that it is looking at price variation using the list of CMS shoppable services to compare prices, such as lab tests or lower limb MRI procedures to see how they vary both within and across regions. This is limited to what CMS generally thinks should not vary in quality. The Office would not look at an overarching price index, like the RAND price transparency data.
- A member asked why the Office is taking this approach.
    - The Office replied that it is focusing on goals that it believes it can accomplish in a reasonable amount of time but is open to feedback on its analytic roadmap. Additionally, the facility crosswalk to National Provider Identifier (NPI) that is out for public comment may become the basis for looking at hospital prices in the future.
- A member asked why the Transparency in Coverage data is not used since new rules were issued and there is increasing granularity on hospital pricing and negotiated rates that can supplement claims.
    - The Office replied that it is not opposed to whatever data sources are available, but the team wanted to start its work using HPD data immediately. It can also use non-HCAI data sources in the future.
- A member suggested that the team create an index of the most common and the most expensive DRGs across the state.

Public comment was held on agenda item 5d. Three members of the public provided comments.

e) Spending Target Enforcement - Performance Improvement Plan Follow-up
Vishal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI
Sheila Tatayon, Assistant Deputy Director, HCAI

Deputy Director Pegany provided an overview of follow-up items from the December 2025 Board meeting discussion on Performance Improvement Plans (PIPs).

Discussion and comments from the Board included:

- A member asked if Oregon had imposed a cost target penalty.
  - The Office replied that Oregon had not yet imposed a cost target penalty, noting that their program is just ahead of California in terms of timing.
- A member asked if any states had imposed a cost target penalty.
  - The Office replied that California and Oregon are the only states that have financial penalty authority.
- A member asked if the statute states that an entity would have to both violate the cost target and be non-compliant with the PIP to receive an administrative penalty.
  - The Office affirmed that this is a correct interpretation of the statute.
- A member asked if an administrative penalty could be imposed on an entity that had complied with a PIP but failed to meet the cost target.
  - The Office explained that it is OHCA's statutory duty to assist an entity in coming into compliance with the spending target, so while no penalty would be imposed in this circumstance, OHCA could require a revised PIP to help them come into compliance.
- A member expressed concern that Technical Assistance and the PIP process could push out accountability indefinitely, adding that there needs to be a point at which the Office can clearly determine whether an entity has met its target.
  - The Office replied that the statute has steps that the Office must follow.
- A member asked for clarification about what the statute allows in terms of enforcement while a PIP is in place.
  - The Office explained that this is an iterative process that will evolve as OHCA assesses performance on the spending target. The statute allows the Director to go straight to penalties if there is evidence of willful misconduct, misreporting, etc. Otherwise, an entity that has complied with the PIP but misses the spending target cannot be assessed penalties.
  - Additionally, new data submitted each year can be assessed to determine if the entity should have a modified PIP or receive a new one; if they repeatedly fail to implement a PIP, that would trigger the administrative penalty.
- A member asked if Mass General Brigham's (MGB) PIP was the only example in Massachusetts.
  - The Office replied that it was the only example. A member added that the PIP probably accounted for a one percent reduction in MGB's spending.
- A member expressed concern that some entities may choose to reduce costs by adopting measures that limit quality access to care, such as laying off staff or shutting down an entire line of business.

- A member emphasized the fact that goal is to reduce spending rather than to assess penalties, adding that the PIPs need to be robust for them to be effective in achieving the real end goal.
- A member commented that ideally OHCA would not be in the PIP business and questions OHCA's ability to provide optimal PIP guidance. The focus should be on meeting the targets.
- A member stated that they envisioned the PIP process as being structured so that the entity would propose strategies for reaching the spending target and the Office would review the proposed PIP and give feedback, rather than having the Board propose strategies for reaching the cost target.
    - The Office stated that it would review the PIP, provide feedback, and ultimately approve the PIP. The Board would also provide input on the PIP.
- A member commented that strong enforcement of penalties has a powerful effect on compliance.

Public comment was held on agenda item 5e. Four members of the public provided comments.

Agenda Item #6: General Public Comment

Public comment was held on agenda item 6. One member of the public provided comments.

Agenda Item #7: Adjournment

Chair Johnson adjourned the meeting.