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 ADVISORY COMMITTEE

MEETING MINUTES
Wednesday, January 14, 2026
10:00 AM

Members Attending: Joan Allen; Barry Arbuckle; Kati Bassler; Carmen Comsti; Adam Dougherty; Hector Flores*; David Joyner; Travis Lakey; Janice O'Malley; Sumana Reddy; Cristina Rodriguez; Kiran Savage-Sangwan; Andrew See; Ken Stuart; Suzanne Usaj; Michael Weiss; Mike Odeh*; Carolyn Nava; Stephen Shortell; Sarah Soroken

Members Absent: Stephanie Cline; Stacey Hrountas; Tam Ma; Amanda McAllister-Wallner; Marielle Reataza; Manan Shah; Iftikhar Hussain

Health Care Affordability Board Member Attending: Ian Lewis

*Attended virtually

Presenters: Vishaal Pegany, Deputy Director, HCAI; CJ Howard, Assistant Deputy Director, HCAI; Andrew Feher, Research and Analysis Group Manager, HCAI; Margareta Brandt, Assistant Deputy Director, HCAI; Debbie Lindes, Health Care Delivery System Group Manager, HCAI; Sheila Tatayan, Assistant Deputy Director, HCAI; Brian Kearns, Assistant Chief Counsel, HCAI

Facilitators: Jane Harrington, Leading Resources Inc.

Meeting Materials: **https://hcai.ca.gov/public-meetings/january-health-care-affordability-advisory-committee-meeting/**

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

Director Landsberg opened the January meeting of the Health Care Affordability Advisory Committee. Roll call was taken, and a quorum was established. Director Landsberg then presented 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:

- 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 2026 to support a transformative care model that links larger hospitals with rural hospitals via eConsult and supportive services, alongside workforce development and technology upgrades.
    - Because the award exceeds the original $200 million budget, the budget will be revised and resubmitted to CMS by the end of January 2026, with CMS having 45 days to respond and approve the budget.
    - An acknowledgment that the award will not adequately account for the budget cuts included in the HR1 legislation that affect Medicaid, Medicare, SNAP, and other programs.
    - California ranked third in the amount of funding received, behind Alaska and Texas, but is among the lowest on a per capita basis due to the allocation formula.
    - In response to stakeholder feedback, the program prioritizes a transformative care model that supports existing hub-and-spoke models that connect rural hospitals to larger hospitals that provide more specialty care, expanding and supporting existing rural workforces, and technology and tools to modernize electronic health records and expand data exchange.

Deputy Director Pegany provided Executive Updates, including the following:

- A reminder that OHCA will be accepting submissions of interest forms for individuals who want to serve on the Advisory Committee from January 5 to March 31, 2026. The subcommittee reviewed the submission of interest forms related to the Payer vacancy and will present its recommendation to the Board this month. Including the Payer vacancy, there are 16 seats with terms that will end on June 30, 2026. All current Advisory Committee members may reapply if interested. The selected members will serve a two-year term from July 1, 2026, through June 30, 2028. The Advisory Committee meets four times a year to provide input on health care topics of interest to the Board. Further information and the link to apply is available on the OHCA website.
- A summary of the Monterey County Hospital Market Competition Study that was published on November 13, 2025. The key highlight from this report is that there was no evidence that higher operating costs, wages or quality explain the high prices, and evidence suggests that a lack of market competition is the reason for such prices.
- An update on the projected timeline for revising the Cost and Market Impact Review regulations due to the passage of assembly bill 1415.
- An overview of an October 2025 study from the California Health Care Foundation titled *The 25% Problem: Why Health Care is So Expensive (And What We Can Do About It*).

- An overview of a September 2025 Health Affairs article called *How Insurers That Own Providers Can Game the Medical Loss Ratio Rules.*
- An overview of a December 2025 Health Affairs article titled *Hospital Finances, Operations and Patient Exchange Remain Stable After Oregon's Hospital Payment Cap was Implemented.*
- A summary of a November 2025 opinion piece in the New England Journal of Medicine called *The Antitrust Antidote to Hospital and Nursing Home Corporatization – Promises and Pitfalls*.
- An overview of the approved data submission enforcement structure including next steps.
- An update on OHCA's methodology for measuring inpatient and outpatient hospital spending.
- Reminder about slide formatting.

Discussion and comments from the Committee included:

- A member asked for clarification regarding the completeness of the Health Care Payments Data (HPD) in terms of the ability to calculate intensity for both fully insured and self-funded plans. The member also asked if OHCA intends to measure hospital inpatient and outpatient spending separately.
    - The Office replied that it currently calculates the measures separately, but it may combine the measures in the future while maintaining the ability to continue to report the measures separately. While the HPD lacks complete data for private self-insured payers and for commercial claims regarding number of visits, when we examined the relationship between the all-payer average visit intensity and the commercial average visit intensity, we found that the two measures are strongly, positively correlated in 2022, despite there being different sample sizes by payer.
- A member asked for the definition of case mix index (CMI).
    - The Office explained that the CMI is calculated by taking the Diagnosis Related Groups (DRGs), applying a weight that is published by CMS, and then dividing that by the number of DRGs.
- A member asked if there is a way to capture the data related to high-cost drugs given in outpatient procedures.
    - The Office replied that the Ambulatory Payment Classification (APC) weights include the high-cost drugs and that new drugs that have not already been assigned APC weights can be calculated using a standard unit that corresponds to a dollar amount.
- A member asked how HCAI plans to allocate the additional $33 million in funds granted by CMS.
    - HCAI replied that it is still evaluating how to allocate the funds for the most effective immediate impact, with the current focus being on workforce and the transformative care model. HCAI added a caveat that the budget will have to be approved by CMS, noting that the Notice of Award contained unfriendly wording.
- A member suggested that the Office look at low-value care, possibly using the calculator developed by Dr. Mark Frederick at the University of Michigan. The member suggested looking at market concentration regarding vertical integration

and insurers to determine which markets are exploiting the loophole. The member also stated that the Oregon study yielded short-term results that should not be over interpreted.

- A member asked what type of DRG weights were being used on the inpatient side.
  - The Office replied that it used Medicare Severity – Diagnosis Related Group (MS-DRG) data.
- A member suggested that All Patient Refined Diagnosis Related Group (APR-DRG) data be used because it provides four levels of severity for each DRG and more robust pediatric and maternity weights.
  - The Office asked if this is a proprietary tool.
  - The member affirmed that it was a 3M proprietary tool. The tool tries to adjust the severity of the patient, as well as the mix of services.
  - The Office explained that there are tradeoffs between the two measuring tools, anyone could look up MS-DRG data to see how specific weights were applied, but that is not possible with the 3M data.
  - The member suggested that the Office revisit this question given that it is trying to measure a multi-billion-dollar industry. The member also expressed concern that the outpatient data could create erroneous conclusions based on lumping all outpatient services together, for example, outpatient surgery, outpatient lab, outpatient imaging, outpatient emergency room, etc. The member suggested that the comparisons be made by line, comparing services such as emergency room versus outpatient surgery.
  - The Office replied that it would take this suggestion into consideration.
- A member noted that there is a timeline for National Provider Identifier (NPI) mapping for hospitals and asked if there is a timeline in place for non-hospital entities, particularly rolling individual physicians into physician organizations.
  - The Office explained that physician organizations are not licensed in the State, so it is exploring other data submission collection efforts. The Office recognizes the need to systematically identify physician organizations in the future but a firm timeline for this has not yet been established.
- A member asked if there is an ongoing effort to define health care systems to be able to see vertical integration.
  - The Office replied that there is an existing resource called the Compendium of Health Systems, as well as other data sets that have specific definitions for health care systems. The Office is exploring the possibility of building on existing data sources to map these organizations in the future.
- A member emphasized the value of the vertical integration model because it allows for the application of Alternative Payment Models (APMs). The member suggested that having APMs for everyone could move the needle towards value and equity and could incentivize better data collection. The member also noted that a statewide strategy is needed to share the health care costs of those who are uninsured or who will become uninsured as a result of HR1.
- A member asked for more details regarding the three initiatives under the Rural Health Transformation Project grant.
  - HCAI replied that the Rural Health Grant application can be found on the HCAI website.

- A member asked if training for the use of AI and robotic process automation is included in the budget for workforce development.
    - The Office replied that the focus is on primary care, maternity care professions, workforce retention, training, retraining and professional development. On the specialty side of things, the Office is mostly looking into E-consult. The Office is primarily focused on the human side of workforce development while also recognizing the need for retraining as AI increasingly replaces jobs.
- A member asked if a task force exists in the State that is focused on removing the large number of costly and burdensome outdated administrative regulations that are placed upon hospitals and providers, such as requirements stating that records be typewritten or legibly handwritten in ink.
    - The Office replied that it is committed to good governance, and it acknowledges the challenges caused by the addition of new regulations without the elimination of outdated regulations. The Office is not aware of a current initiative to update these regulations.
- A member asked if the author of the article regarding insurers gaming the Medical Loss Ratio (MLR) rules had looked at payers that owned Pharmacy Benefit Managers (PBMs) to determine if the PBMs were charging the highest drug costs to the health plan to increase the MLR.
    - The Office replied that it is also concerned about the costs that PBMs contribute to health care. There is some legislation included the Governor's budget about PBMs and the Office is excited about beginning to collect PBM data in the healthcare payments data program (HPD).
- A member stated that the Oregon study had used a percentage of Medicare DRG rates under the assumption that these rates are uniform and pointed out that using these rates might encourage some health care entities to manipulate the data to their advantage.
- A member shared an anecdote about a young woman who is in end-stage hospice care because her insurance company denied a claim that would have provided life-saving care and medication. The member emphasized the importance of remembering that there is a human being behind each data point.
    - The Office agreed that it is important to remember that these numbers represent human beings, our neighbors, and loved ones. The Office added that patients have the right to appeal any denial of coverage by health care plans.

Agenda Item # 3: Update on Behavioral Health Out-of-Plan Spending
CJ Howard, Assistant Deputy Director, HCAI
Andrew Feher, Research and Analysis Group Manager, HCAI

Assistant Deputy Director Howard and Andrew Feher provided updates on Behavioral Health Out-of-Plan spending.

Discussion and comments from the Committee included:

- A member stated that there has been a rise in the availability of online behavioral health services since the pandemic and that it might be useful to determine how many of these services are from self-referral or are not medically necessary.
- A member cautioned that there are fast-moving venture capital trends that may impact or impede the progress being made on OHCA's goal of providing high quality primary care with integrated behavioral health. The member cited the examples of local behavioral health clinicians being forced to join a larger aggregating behavioral health group and new companies that offer direct-to-consumer behavioral health care.
- A member suggested that more behavioral health data might be available from professional organizations such as the California Association of Marriage and Family Therapists and agencies like the Board of Behavioral Sciences, or from surveys done by unions that work with mental health professionals. While it may not speak directly to the out-of-plan spend, it may provide useful statistics to compare rates for similar kinds of care administered.
- A member suggested that a study be done to determine how health coverage, or the lack of it, affects the types of behavioral health services received by individuals.
- A member stated that not all online behavioral health services are self-referred. Many health care entities refer patients to these online services.
    - The Office expressed appreciation for the suggestions regarding additional data resources while acknowledging the difficulty of extrapolating self-payer data and stated that there may be other work groups who could take on this assignment.
- A member emphasized the importance of creating a system for collecting behavioral health data for children and adolescents, as they are a large and growing segment of behavioral health utilization.
- A member stated that independent therapists are losing the ability to remain independent because of the large national companies that are taking over as payers.
- A member asked for clarification about which telehealth visits can be counted.
    - The Office explained that telehealth visits that generate a claim can be counted and observed I the health payments data base. Although, a self-funded or self-referred visit through a carve out vendor usually would not be captured.

Public Comment was held on agenda items 2 and 3. One member of the public provided comments.

Agenda Item #4: Introduction to DSG 3.0 Regulations, Including Update on Behavioral Health Definition and Summary of Board Feedback
Andrew Feher, Research and Analysis Group Manager, HCAI
Margareta Brandt, Assistant Deputy Director, HCAI
Debbie Lindes, Health Care Delivery System Group Manager, HCAI

Andrew Feher introduced the topic of the DSG 3.0 Regulations. Assistant Deputy Director Brandt provided an overview of the changes made to the APM and primary care file instructions. Debbie Lindes summarized public comments and Board feedback regarding the behavioral health definition.

Discussion and comments from the Committee included:

- A member asked why a primary care provider would move the behavioral health diagnosis to the first position. Why is the position on the claim so important for measurement? Complex primary care is deeply integrated, making it difficult to identify which diagnosis should be listed in the first position. The methodology is overly simplistic.
    - The Office replied that it is a limitation of the methodology. If a behavioral health diagnosis is counted regardless of where it occurs on a claim, it would result in overcounting care that is not behavioral health focused. The approach for the first round of data collection is to count behavioral health only if it is the primary reason for the visit. OHCA plans to study primary care claims with behavioral health diagnoses in other positions using HPD.
- A member expressed concern that 90% of the time, a behavioral health diagnosis will not be listed as the primary diagnosis, because patients often identify medical symptoms and clinicians recognize the role of behavioral health conditions in those symptoms, and suggested that more research be done to better measure behavioral health and primary care payment issues.
    - The Office expressed appreciation for this perspective and added that it is important to try to capture the critical behavioral health work that is being done by primary care providers. OHCA is not trying to influence primary care providers' coding practices.
- A member noted that an example of behavioral health care occurring in primary care is well-child visits, where conditions like attention deficit hyperactivity disorder (ADHD) may make up the majority of the visit, but it will be coded as a preventive visit.
- A member asked if dyadic care codes are included in the data.
    - The Office confirmed that dyadic care codes are included.
- A member noted that understanding how much spend for behavioral health is not captured using the primary diagnosis restriction, using HPD data, will be important.
- A member asked if autism related services are included in the code set.
    - The Office replied that autism related services that are provided by primary care providers in a primary care setting are included in the behavioral health in primary care code set. Autism services are also included in the behavioral health code set.
- A member expressed concern that an additional impediment to acquiring accurate behavioral health data, and to providing fully integrated behavioral health care, is the way behavioral health carveouts are structured. The member stated that most health plans will reject a claim that has a behavioral health condition as the primary diagnosis, instead routing it to the behavioral health carveout vendor. This makes it very difficult to capture the important behavioral health care being provided by primary care physicians.
- A member stated that although a behavioral health issue is contributing to a physical issue, the evaluation to rule out a major medical issue must be done first and insurers may not authorize the medical evaluation if they see that a behavioral health issue may be contributing.

- A member expressed concern that physicians are not being paid the targeted rate increases related to Prop 35, including for behavioral health services. It is important to ensure that the correct diagnosis is being submitted, which will hopefully result in correct payment. The way targeted rate increase data is being collected and paid for is unsatisfactory.
- A member expressed concern about the federally qualified health center (FQHC) and rural health center regulation that prohibits behavioral health providers from being paid for same day services when a primary care provider has also seen the patient. Under this system, safety net clinics are providing same day services but not getting paid.
- A member stated that clinicians know how to effectively treat behavioral health conditions, but insurance plans do not always pay for this type of care. In the context of current undercounting and underspending, if we set a benchmark that is appropriate to the need, this may lead to greater investment in appropriate behavioral health treatments.
- A member asked if there is data on integrated care, including integrated behavioral health care, within primary care.
    - The Office replied that its goal is to try to capture all types of integrated care in primary care settings, including integrated behavioral health, within the limitations of OHCA claims and non-claims data collection. OHCA will report distinctly on behavioral health in primary care spending, to understand how much spending is occurring in this area.
- A member expressed concern that primary care providers do not receive feedback or notes for patients who have been referred to a behavioral health provider with a third-party provider or behavioral health carveout vendor, resulting in less integrated care for patients. This differs from the level of communication that occurs with medical specialty referrals. The member stated that the “black box” of behavioral health referrals impacts the overall health outcomes and cost of care, especially for individuals with chronic medical conditions for whom total cost of care can be reduced by integrated behavioral health care. The member asked if the committee could try to influence this issue from a policy perspective.
- A member stated that access to behavioral health care is difficult because the system is fragmented, multi-layered and lacks clear communication channels. The member noted that in Medi-Cal, adults with a suspected behavioral health condition can have care for the assessment of that condition covered. The member noted that reimbursement for dyadic services is lower than for individual psychotherapy. The member asked if a behavioral health screening that occurs during a visit is counted even if a behavioral health diagnosis is not the first diagnosis.
    - The Office replied that screenings and assessments for behavioral health conditions count towards spending for both primary care and behavioral health without a diagnosis, and that these screenings are captured at the claim line level. The goals of the behavioral health in primary care work are to incentivize behavioral health integration into primary care and to increase investment in overall preventive behavioral health care.
- A member noted that policy signals sent by OHCA definitions and measurements are important. Because of how payers respond to benchmarks, the member is

concerned that workflows will be negatively impacted. The member offered an example of payer expectations to document and provide follow up within 30 days for positive behavioral health screenings, which add burden and may not be achievable due to limited access to behavioral health providers.

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

Agenda Item #5: Update on Cost and Market Impact Review Program
Brian Kearns, Assistant Chief Counsel, HCAI

Assistant Chief Counsel Kearns presented an update on the CMIR Program.

Discussion and comments from the Committee included:

- A member asked if the Office has published or plans to publish an explanation for the rationale behind a transaction that was waived.
  - The Office replied that it updates the website to show which transactions have been waived without including any additional information.
- A member suggested that providing an annual CMIR report that lists the transactions that were waived, along with the reasons why, would be a helpful tool for the industry to better understand which areas are causes for concern.
- A member asked if the after-transaction costs are being tracked.
  - The Office replied that the submitting entities do not have a continuous reporting obligation to explain how costs are changing, but the team is actively monitoring the market to see how costs are changing for both upcoming transactions and previously reviewed transactions.
- A member asked whether transactions are being monitored to determine if entities are becoming large enough to impact must-have status for health plans, which will drive up costs for consumers.
  - The Office replied that determining how an entity or transaction will impact a health care entity's bargaining leverage is a key factor that is considered during the pre-CMIR review, as well as after the CMIR occurs. Transparency is also provided by the filing requirement to provide a list of prior transactions and future intended transactions.
- A member asked if there would be enough data a year from now to determine where transactions are occurring, and what types of entities are buying and selling, to be able to report on how the transactions are changing the landscape of health care.
  - The Office replied that once sufficient data has been collected, the focus will be on informing the public on how these transactions are impacting health care costs in California.
- A member asked what percentage of transactions include private equity acquisitions.
  - The Office replied that there is private equity involvement in several transactions, but the percentage is not known. The AB 1415 regulations will require private equity companies, hedge funds, and MSOs to provide notices of involvement in transactions, and this information will provide a better picture of private equity involvement in these transactions.

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

Agenda Item #6: Spending Target Enforcement: Waiver of Enforcement, Technical Assistance, Public Testimony, and Performance Improvement Plans
Vishaal Pegany, Deputy Director; HCAI
CJ Howard, Assistant Deputy Director, HCAI

Deputy Director Pegany provided an overview of the Spending Target Enforcement, the Waiver of Enforcement, Technical Assistance, and the Performance Improvement Plans. Assistant Deputy Director Howard provided OHCA's definition of public testimony.

Discussion and comments from the Committee included:

- A member suggested that a list of well-known technical assistance organizations or consultants, and the names of quality improvement collaboratives could be provided to the entities which exceed the target.
- A member stated that artificial intelligence investment costs should be considered along with Electronic Medical Records (EMR), Health Information Exchange (HIE), remote patient monitoring and telehealth, as well as the costs incurred by an entity that engages a consultant for the assessment and implementation of a new strategy.
- A member expressed concern that there may be many organizations that require technical assistance and asked for a description of the types of technical assistance that the Office plans to offer.
    - The Office explained that the type of technical assistance it would offer to an entity would depend on the granularity of available data. Due to the availability of service category data for health care plans, technical assistance may include information about specific areas that may be causing the entity to exceed the target. The Office is assessing how it will respond to other organizations and provider types; however, the Office is not providing consulting services
- A member expressed concern that the disallowance of waivers at this time may negatively impact organizations, particularly safety-net organizations, due to the extreme volatility in the industry and uncertain federal funding.
    - The Office replied that simultaneously having a waiver process and enforcement considerations may cause confusion because some of the factors listed in statute as reasonableness factors for a waiver are present within the enforcement considerations, and the Office found that offering a waiver at this time may be duplicative. The Office may institute a waiver process in the future.
- A member asked if health systems would be evaluated as a whole or if individual hospitals would be assessed.
    - The Office replied that due to the way that the statute defines health care entities, each hospital and each facility is assessed separately. Health care plans are assessed by line of business such as commercial, Medicare, and Medi-Cal.
- A member asked about the timeline for progressive enforcement, specifically if there will be a time lag between steps or if they could occur simultaneously.
    - The Office explained that it would not wait for a year between enforcement steps. Some entities would only receive technical assistance for one year. Other entities

that receive technical assistance may also be compelled to provide public testimony or submit and implement a Performance Improvement Plan (PIP).

- A member asked what areas would be covered in the regulations that the Office is planning to draft regarding potential enforcement considerations. The member also asked if suggestions and feedback would be taken into consideration.
    - The Office replied that the intent is for regulations to define technical assistance, explain the public testimony process, and enumerate enforcement considerations. The Office is open to receiving suggestions and feedback on additional considerations as part of this process.
- A member expressed support for taking a nuanced approach to enforcement considerations by reviewing the submissions on a case-by-case basis to determine if high costs are caused by factors that are outside of the entity's control.
- A member asked how external stakeholders and other members of the public would be brought into this process.
    - The Office replied that it will post the identities of the entities that exceed the target so that the members of the public, including groups that have relevant information, can make public comment or bring it to the attention of OHCA. The Office will continue to assess other methods for allowing public feedback.
- A member asked how increased costs due to a new union contract would figure into enforcement considerations.
    - The Office replied that organized labor adjustments will be covered in depth at a future Advisory Committee meeting.
- A member requested that The Office address the issue of inequity that results when a hospital is discriminated against because it does not have labor representation.
- A member asked that The Office provide information about the process for the submission of documentation for an entity that is requesting target adjustments due to organized labor adjustments as soon as possible.
- A member expressed concern that cost-reducing strategies will cut services and limit health care access and suggested that the strategies be collected and made public so the Advisory Committee could respond to the strategies based on accuracy and effectiveness.
- A member stated that the consideration of a recent union contract should not only apply to the unionized entities, but also to the non-unionized entities in the same area that are equally impacted by the salary increases.
- A member suggested that a study be done to determine what effect a unionized workforce has on the quality of care provided by a health care entity.
- A member asked for clarification about how interactive the enforcement process would be.
    - The Office replied that it is still working on the details, but there will be a systematic way of engaging with entities, which may be a portal, and that the process will include meetings where the Office will engage directly with entities.
- A member replied to the Office's question about which circumstances would merit hearing from a health care entity that has exceeded the target by stating that it would be worthwhile to hear from all entities that exceed the target at every step of the process.
- A member expressed concern that there will be a large number of potential entities

that exceed the target and that this will be burdensome for the Advisory Committee. The member suggested that the Office think through outlier criteria, at least in the beginning.

- A member stated that full transparency is important, and that having as much information as possible will allow the system to be adjusted. The member trusts that the staff will be able to develop a platform that will identify common factors that the Advisory Committee will be able to review.
- A member asked why the director of OHCA would choose not to have a public meeting.
    - The Office explained that the forum may not always produce meaningful dialogue and that the office could seek written testimony.
- A member suggested that a template be developed for entities that are giving public testimony. The template would list the topics that are to be included, as well as questions that the Advisory Committee would ask.
- A member asked how public testimony would be structured.
    - The Office replied that the Board would be engaging with the health care entity, and that members of the public would be allowed to make public comments afterwards.
- A member stated the need for the Advisory Committee to understand the causes of reduced access to health care and rising insurance costs, particularly in rural areas.
- A member asked if there would be a publicly available document that explains why an entity exceeded its target.
    - The Office replied that it will evaluate confidentiality and trade secret laws and will provide its findings at a future Advisory Committee meeting.
- A member encouraged the Office to create a version of the report that can be made public, emphasizing the public's right to, and interest in, transparency.
- A member suggested that a template be developed for entities that are subject to a PIP so that information that is submitted is easy to read and comparable. The member asked if Massachusetts or Oregon had created such a template.
    - The Office replied that it has a public facing version of the template that will be circulated and that it will look into creating a custom template.
- A member asked if members of the Advisory Committee would have the opportunity to make comments before the April 2026 Board meeting.
    - The Office replied that it would take that request into consideration. The Office added that feedback could be solicited through email or that another meeting could be scheduled.
- A member expressed concern that a large number of entities will miss the target and suggested that The Office wait until it has the first report of non-penalty metrics before it sets penalties. The member asked when the 2025 report will be available.
    - The Office explained that it will have the data for 2024 to 2025 in fall of 2026, and that there will always be a lag in data reporting.
- A member commented that the two-year timeline implemented in Massachusetts or Oregon seems like a very elongated time period for making adjustments when the entities had advance notice of the target.
- A member expressed concern about the lengthy PIP process and suggested that checkpoints and milestones be inserted into the process to build in transparency. The

member requested that the Office incorporate ways to bring information about the process back to the Advisory Committee and the Board.
- A member suggested that the Advisory Committee be more proactive in recommending ways that the entities could be more transparent in how they spend taxpayer dollars and for the possible deregulation of arbitrary, expensive processes.

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

Agenda Item #7: Introduction to the HCAI Health of Primary Care in California Snapshot
Margareta Brandt, Assistant Deputy Director, HCAI
Debbie Lindes, Health Care Delivery System Group Manager, HCAI

Assistant Deputy Director Brandt provided an overview of the HCAI Health of Primary Care in California Snapshot. Debbie Lindes provided information about the project team, plan deliverables, and next steps.

Discussion and comments from the Committee included:
- A member stated that there are workforce replacement issues. As current primary care physicians age and retire from the workforce, there are less available to train incoming Advanced Practice Providers (APPs).
- A member suggested including measurements of physician-patient relationships, patient satisfaction, and clinician satisfaction with the system access in the Snapshot. The member also cautioned evaluating providers on a narrow definition of quality and noted how some payers treat different members of the care team, such as implementing differential copays for a physician versus a physician associate (PA), which may present a bigger challenge for small practices.
- A member suggested that the Office analyze the data for large health systems, independent physician-owned practices, and Federally Qualified Health Centers (FQHCs) separately to get a more accurate picture of the different economic challenges, health plan rates, and Federal support that each group has because of their very different dynamics and economics. The member also suggested looking at regional differences and comparing primary care in urban vs. rural areas.
- A member suggested that the data be reported by value-based payment (VBP) models, by payment source, and by FQHCs to assess whether those implementing VBP models perform better on primary care. The member advised the Office to choose measures that have sufficient sensitivity to determine how money is being spent for improvements in primary care. The member suggested incorporating other measures that may be more qualitative or proximate, like fewer missed appointments or workforce turnover, in addition to quality measures such as diabetes management. The member also suggested working with others on new primary data collection in the future, to fill in data gaps.
- A member asked if there had been any analysis of primary care investment by population, specifically children and youth populations versus older populations.

    - The Office replied that the primary care spending data collection does not break out spending by age group, but some of the other data that is being considered for the snapshot will be available by age group. There may be some primary care indicators measured using the HPD that can be broken out by age group or other population stratifications.
- A member advised considering how different payer types will impact reporting on indicators and recommended stratifying by payer types where possible. The member recommended stratifying by managed care versus fee-for-service models and separating Kaiser from the rest of the commercial market, as Kaiser is a completely different entity from other commercial payers.
    - The Office thanked the member for those flags and stated that it will look at these recommendations when evaluating data for the Snapshot.
- A member stated that it is important to understand differences in care delivery, quality, and access across different types of entities, such as private hospitals versus FQHCs and county public health departments.
- A member suggested that workforce issues, such as the impact of geography on access to training and education, be studied for providers like nurses. The member highlighted the importance of studying the workforce pipeline as upcoming retirements across providers will create a gap in the health care sector.
    - The Office replied that HCAI has a health workforce research data center that is working on workforce issues, including retirement age, and that this data is currently being published.
- A member encouraged HCAI to consider ways in which it could publicize its Snapshot reports more broadly, to highlight how improved primary care improves outcomes and supports cost growth containment.
    - The Office replied that it will review its communication strategy and looks forward to collaborating with members to promote the Snapshot.
- A member suggested that the Office compare by payment methodology, such as capitated models versus fee-for-service models, to determine if capitation causes more money to go to primary care.
- A member read a quote from Health Affairs regarding the increases in health care spending in the United States that primarily attributed the increases to hospital care, physicians in clinical services, and retail prescription drugs.

Agenda Item #8: General Public Comment

Public Comment was held on agenda items 7 and 8. No members of the public provided comments.

Agenda Item #9: Adjournment

Director Landsberg adjourned the meeting.