



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, July 8, 2026
10:00 AM

Members Attending: Joan Allen; Barry Arbuckle; Kati Bassler; Hector Flores*; Iftikhar Hussain; David Joyner; Sean Kim; Tam Ma; Kassie Maroney*; Katina Murray*; Carolyn Nava; Nancy Netherland; Janice O'Malley; Mike Rabourn; Sumana Reddy; Cristina Rodriguez*; Kiran Savage-Sangwan; Andrew See; Stephen Shortell; Sarah Soroken; Ken Stuart; Suzanne Usaj; Michael Weiss

Members Absent: Stephanie Cline; Magdalena Pruitt; Travis Lakey; Amanda McAllister-Wallner; Mike Odeh; Manan Shah

Health Care Affordability Board Member Attending: Richard Kronick*

*Attended virtually

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; 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, Los Angeles General Medical Center; CJ Howard, Assistant Deputy Director, HCAI; Heather Hoganson, Assistant Chief Counsel, HCAI

Facilitators: Jane Harrington, Leading Resources Inc.

Meeting Materials: <https://hcai.ca.gov/public-meetings/june-health-care-affordability-advisory-committee-meeting-4/>

Agenda Item # 1: Welcome and Call to Order

Elizabeth Landsberg, Director, HCAI

Director Landsberg opened the July meeting of the Health Care Affordability Advisory Committee. Four new committee members were sworn in. Roll call was taken.

Director Landsberg then presented an overview of the meeting agenda and invited the new committee members to introduce themselves.

Agenda Item # 2: Executive Updates

Elizabeth Landsberg, Director, HCAI

Vishaal Pegany, Deputy Director, HCAI

Director Landsberg provided Executive Updates, including the following:

- The Behavioral Health Services Act (BHSA) Workforce Education and Training (WET) Plan was approved last month. The behavioral health work force will receive specialized training to serve individuals with the highest acuity behavioral health needs, including those experiencing homelessness, recent incarceration, or substance use disorder.
- Mathematica recently published a report on California's \$4.7 billion Children and Youth Behavioral Health Initiative (CYBHI). HCAI's Certified Wellness Coach program now has almost 5,000 wellness coaches providing support to children and youth in schools and community organizations. Statistics show lower suicide ideation and improved outcomes for children and youth.
- The Health Care Payments Data (HPD) program released two new data briefs:
 - The first brief, GLP-1 Prescriptions for Weight Loss over Time, 2018-2023, presents prescriptions and costs for GLP-1 use for weight loss by drug product in the commercial and Medi-Cal markets.
 - The second brief, Insulin and Metformin Geographic Access and Mail-Order Use, presents miles traveled to pharmacies with mail-order use by county.
- With the budget that started on July 1, 2026, HCAI has new components of interest:
 - Funding to support gender affirming care including strengthening the provider network, establishing a stabilization program, and covering uncompensated care.
 - \$90 million for grants for hospitals in financial distress.
 - HCAI will set up a new unit to evaluate hospitals' strategic importance to their communities, assist in planning for maintaining critical services in the event of a hospital's financial distress, and provide technical assistance to financially distressed hospitals.
 - There's also additional funding for HCAI's CalRx program to support the development of lower cost epinephrine pens and tuberculosis drugs. HCAI hopes to distribute the epinephrine pens to schools statewide as it has done with albuterol and will identify a supply partner to setup an ordering system for the tuberculosis drugs.
- HCAI released Requests for Applications (RFAs) for California's Rural Health Transformation Program (CalRHT), specifically for accelerator partnerships. For each RFA, there will be a grant guide, a webinar, and an FAQ. Anyone who is interested in tracking the information can sign up for RHT alerts.

Deputy Director Pegany provided Executive Updates, including the following:

- An overview of a June 2026 Health Affairs article which assessed the effects of private equity acquisitions of primary care practices on primary care, physician practice patterns, and patient care in the traditional Medicare market.
- An overview of a May 2026 JAMA article which proposes a state administered primary care common fund as a way to address fragmentation and underinvestment in primary care.

- An overview of an article in Health Affairs Forefront titled “States are Exceeding their Cost Growth Targets. What Does it Mean?” which emphasizes that while cost growth targets and transparency can reveal the sources of spending growth, complementary policies are necessary to meaningfully bend the cost curve.
- An overview of the key findings from the HCAI data brief regarding GLP-1 Prescriptions for Weight Loss over Time, 2018-2023.
- An update on the next steps for OHCA’s equity adjustment and a reminder that OHCA has elected to not apply an equity adjustment to payers’ performance against spending targets. For at least two years, OHCA will monitor data and re-assess the suitability of a payer-level equity adjustment to improve health equity.
- An update on OHCA’s quality adjustment recommendation which is to wait to apply a quality adjustment to the spending targets and monitor cost and quality data and reassess quality adjustment factors in at least two (2) years.
- An announcement that the HCAI Primary Care Snapshot initiative will report primary care data from both HCAI and external data sources to create a shared understanding of the health of California’s primary care sector and track its progress. The first snapshot will be released in fall 2026 as a static report. Starting in 2027, annual releases will include both a static report and an interactive dashboard.
- A reminder about slide formatting.

Discussion and comments from the Committee included:

- A member suggested that the Advisory Committee focus on innovations, such as the Primary Care Common Fund discussed in the JAMA article, to strengthen the long-term viability of primary care, particularly for patients with unstable insurance coverage. The member stated that a common approach to funding consistent primary care could improve quality of care and reduce costs across the state. The member also encouraged the committee to urge payers to recognize and support the delivery of high-quality health care.
- A member stated that spending growth targets are unlikely to change health care entities’ underlying business models or behavior and suggested that OHCA focus on fundamentally changing how health care organizations generate revenue by rewarding entities for moving away from fee-for-service and Diagnosis Related Group (DRG) payment models towards earning more of their revenue from risk adjusted prospective payments. The member also suggested using the HCAI data to know where the cut point could be to then use the spending target and the penalty structure as a forcing function to nudge the organization into desired behaviors, noting that OHCA could offer a reduced penalty or waiver if the entity has a certain percentage of its revenue or utilization under an accountable care organization (ACO) where the literature suggests that this would result in a lower rate of growth and costs.
- A member stated that, similar to primary care, specialty care has been affected by private equity ownership, noting that private equity-owned specialty practices tend to increase the number of procedures performed, patient visits, and the use of Advanced Practice Providers (APPs). The member also stated that many APPs are being supervised by physicians who are only available electronically rather than in person and expressed concern that this may affect the quality of care.

- A member suggested that OHCA collect data on the costs of injectable drugs administered in physician's offices or outpatient centers and expressed concern that the dramatic increase in the cost of injectable drugs may be obscured when bundled with other payments.
- A member stated that increased investment in primary care is needed to address the challenges facing the primary care system. The member added that hospital-employed primary care physicians receive compensation at approximately twice the rate of independent primary care physicians who do not have the same leverage to negotiate rates.
- A member encouraged OHCA to conduct studies on the Return on Investment (ROI) for the GLP-1 drugs specifically by cohort.
- A member referenced the Health Affairs article regarding states that exceeded spending targets and asked for additional information on if those states adjusted their cost targets. The member referenced another Health Affairs article that stated that there were workforce reductions in Rhode Island as a result.
- A member asked whether there is a plan to monitor the long-term effects and potential increase in costs associated with GLP-1 medications due to the ease of access, particularly for those patients who may not require them.
- A member reiterated a prior suggestion of looking at the idea of different financing models for primary care, and cited a recent Gallup poll indicating that, for the first time, a majority of Americans are unable to afford health care and emphasized the growing urgency of implementing the complementary strategies outlined in the article in addition to the cost growth targets to address spending growth.
- A member explained that Rhode Island had reduced its cost growth targets for two years by implementing price caps along with spending growth targets. The following year Rhode Island did achieve a cost reduction.
- A member expressed interest in better understanding the relationship between private equity ownership and rising costs for both payers and providers, noting that the health care system was built on a fee-for-service model.
- A member encouraged OHCA to distinguish between costs for GLP-1 medications that are dependent on pharmacy or hospital contracts, the beneficiaries, and Average Wholesale Price (AWP) versus Wholesale Acquisition Cost (WAC).
- A member asked whether HCAI's report on Monterey County was connected to the UCLA study and webinar on Pathways to Unified Health Care Financing with Primary Care.
 - The Office replied that HCAI is conducting a parallel effort with the California Health and Human Services Agency (CalHHS) to prepare the report required by Senate Bill 770, which examines various unified financing options.
- A member commented that a recent *JAMA* article states that the high costs of GLP-1 prescriptions are not offset by improvements in health outcomes or reductions in diabetes treatment costs. Noting that the recent article stated that a 60-90% reduction in the healthcare costs of GLP-1s was needed to see a net benefit.

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

Agenda Item # 3: Cost-Reducing Strategy Presentation – 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, Los Angeles General Medical Center

Assistant Deputy Director Brandt introduced the leadership team from the Los Angeles General Medical Center who provided an overview of the Safer@Home Program as an example of a cost-reducing strategy. The program shifts care from the hospital to virtual care at home for patients who meet specific criteria.

Discussion and comments from the Committee included:

- A member asked if the Safer@Home program is presented to the patient as a choice or as a requirement.
- The presenter explained that participation is voluntary. Patients must have a stable home environment and be willing to participate in virtual care to be eligible for the program.
- A member asked about the cost to family members who must take time off from work to provide supportive care to a loved one.
- The presenter explained that patients who require a high level of support at home would not be eligible for the program.
- A member asked the proportion of patients who decline participation in the program or have an inadequate home environment.
- The presenter shared that approximately one out of five referrals to the program are not accepted.

A member asked how the Safer@Home program could be expanded to other health care systems.

- The presenter stated that the Vice President Provost of University of Southern California (USC) health system is interested in the program and explained that expanding the model to other systems can be challenging because it requires changing longstanding clinical practices. A member asked about primary care follow-up after patients are discharged from the Safer@Home program and if it helps reduce readmissions.
 - The presenter explained that appropriate primary care and specialty care is arranged before the patient is discharged from the program. Out-of-network patients receive support from Safer@Home's patient access center to coordinate follow-up with their health plan network.
 - A member stated that the sustainability of the model is based on cost aversion in a managed care setting and asked if this model has been tested with commercial payers outside the capitated or managed care environment. The presenter stated that LA General has not yet secured payment for Safer@Home services and hopes to explore this through future contract negotiations. A member asked how language barriers are addressed in a virtual setting and how medication

education and safety are handled. The presenter explained that communicating with patients in their preferred language is a foundational component of care at Los Angeles General. The hospital provides comprehensive interpretive services through both on-staff interpreters and a contracted interpretation service. Before discharge, patients enrolled in the program receive intensive education and participate in teach-back activities in their preferred language. The same interpretive services are available during virtual visits.

- A member asked how patients are educated before discharge on the proper use of prescribed medications and medical devices and whether care is coordinated with community pharmacies.
 - The presenter explained that, before discharge, patients receive education and hands-on instruction to ensure they understand how to use the self-monitoring equipment and prescribed medications. Patients leave the hospital with medications supplied by the hospital's pharmacy. When prescription adjustments are needed after discharge, the program coordinates closely with the patient's preferred community pharmacist to ensure that all relevant information is communicated to the pharmacist and to the patient.
- A member asked about the professional qualifications of care team members and the workload of the nurses conducting daily visits.
 - The presenter explained the care team includes physicians with backgrounds in urgent care, primary care, internal medicine, pediatrics, family medicine, as well as several specialists in infectious disease, cardiology, pulmonology, and neurology. The care team includes Advanced Practice Providers (APPs) experienced in emergency medicine and urgent care and nurses with urgent care clinical experience. The presenter also explained that two nurses typically support 20 to 40 patients per day, with additional nursing support available on busier days.

Public Comment was held on agenda item 3. One member of the public provided comments.

Agenda Item #4: Non-Supervisory Organized Labor Adjustment Data Collection Regulations

Vishaal Pegany, Deputy Director, HCAI

CJ Howard, Assistant Deputy Director, HCAI

Assistant Deputy Director Howard provided an update on the non-supervisory organized labor adjustment data collection and the data collection regulations.

Discussion and comments from the Committee included:

- A member asked how a non-unionized hospital that increases its hourly rate to match a competing unionized hospital's hourly rate could submit this cost escalation for adjustment to the spending target.
 - The Office replied that the statute explicitly calls for adjusting targets for non-supervisory organized labor costs and that statute does not provide a similar adjustment process for non-organized labor costs.

- A member asked whether there's any clear data that shows ways that organized labor reduces overall costs in ways like reduced turnover and better working conditions that is the result of a workforce that is compensated fairly.
 - The Office replied that it is unaware of data related to beneficial impacts of a collective bargaining agreement. OHCA tracks turnover rates, and recruitment and retention rates as they relate to workforce stability standards.
- A member asked if the enforcement process will allow for an adjustment for organized and non-organized labor costs.
 - The Office explained that there would not be an adjustment, but the 45-day period allows entities to submit additional information to OHCA, such as non-unionized labor costs, which OHCA would evaluate when determining if the entity will be required to provide public testimony or implement a performance improvement plan.
- A member suggested that entities may not have finalized their contracts by the time information for the following year is due and may prefer to submit actual contract terms and rates once the contracts are finalized.
 - The Office explained that this approach may be appropriate for some entities because the timing does not align with the Board's schedule for adjusting targets.
- A member expressed appreciation for OHCA's timeline, which allows entities to submit data this year for performance year 2028. The member suggested that the first year of implementation will help identify changes that may be needed in subsequent years and encouraged a flexible approach. The member asked for clarification regarding the ability for a labor union to be the requesting organization on the specification document.
 - The Office explained that a labor union could initiate and submit a request, and that a completed request does require an attestation from the regulated entity regarding the accuracy of the submission.
- A member asked if a second party notification would be sent to a labor union if a regulated entity submits a request for a target adjustment.
 - The Office replied that the draft process is not currently structured to include a second-party notification to a labor union.
- A member commented that providing labor unions with notice when an entity submits its information would be beneficial, as the entity's assumptions may differ from those of the union. The member also suggested adding an "Other" requestor type to accommodate entities that do not fall within the hospital, physician organization, or Fully Integrated Delivery Systems (FIDS) categories.
- A member recommended adding checkboxes for specific occupational classifications to align with those used in the National Labor Relations Board's bargaining units.
- A member suggested that the specifications document request current costs rather than average costs, noting that current cost information is readily available and more accurate than the average hourly rate and current productive hours information that is currently being requested.
- A member suggested adding a linkage specification that would allow multiple entities covered by the same contract to be reported together.

- A member commented that calculating future changes in net patient revenue may be challenging when based on a negotiated contract that could change over time.
 - The Office replied that relying on projections is an imperfect approach that can be reconciled after the fact. An entity that seeks an upfront adjustment is still required to report whether projected higher organized labor costs actually materialized. Entities that do not seek an upfront adjustment will be able to report actual data after the fact, resulting in more accurate reporting.
- A member asked whether OHCA would consider increased labor costs when evaluating a health plan's performance.
 - The Office replied that the statute focuses on providers and FIDS so there isn't a similar process for health plans when requesting an upfront adjustment, but there are the enforcement considerations where the health plan will have the opportunity to explain spending growth attributable to impacts from other sectors.
- A member agreed that notifying the labor unions when an entity submits its organized labor cost projections would improve the accuracy of those projections. The member added that an organized health care workforce reduces turnover costs, helps address health care workforce shortages, and fosters an occupational culture that enhances patient care and professional development.
- A member suggested that OHCA collaborate with health care entities and organized labor to reduce the administrative burden associated with data submission.
- A member encouraged OHCA to include occupational classifications for pharmacists and pharmacy technicians in the union classifications.
- A member expressed concern about the potential for unintended consequences if a unionized hospital were to negotiate a significant wage increase to obtain a higher spending target adjustment, while a non-unionized hospital would not have the same opportunity.
- A member commented that much of the additional revenue received by unionized hospitals is retained by hospital systems rather than being directed to workers. The member also emphasized the need to prepare for potential adjustments to targets for both unionized and non-unionized hospitals because targets are based on projected rather than actual costs.
- A member commented that it would be more prudent to base spending growth targets on actual costs after the fact rather than on projected costs in advance.
- A member explained that the statutory language is intended to preserve workers' ability to organize and bargain for fair contracts, based on the premise that an organized workforce benefits the workers, the community, and patients.

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

Agenda Item #6: Cost and Market Impact Review Program – Status Update on Regulatory Text (out of order)

Heather Hoganson, Assistant Chief Counsel, HCAI

Assistant Chief Counsel Hoganson provided an overview of Cost and Market Impact Review (CMIR) updates and regulations.

Discussion and comments from the Committee included:

- A member expressed appreciation for the focus on Real Estate Investment Trusts (REITs) because REITs often act as managers of health care facilities, creating difficulties for patients and workers. The member also asked how the number of waived transactions compared with the Office's expectations and how that experience would inform the Office's expectations going forward.
 - The Office explained that it had initially reviewed data from Massachusetts, where one of the twelve transactions received (approximately 8%) was referred to CMIR, and that this served as the basis for the Office's expectations. The Office noted that it referred two of the forty-five transactions received to CMIR (approximately 4%) over the two years it has reviewed transactions but stated that this appeared reasonable given the proportionately higher number of transactions it had received compared to Massachusetts.
- A member asked if Pharmacy Benefit Managers (PBMs), Group Purchasing Organizations (GPOs), manufacturers and pharmacies are included in the list of health care entities. The member added that some pharmacies do provide clinical care services.
 - The Office explained that the statute has a specific list of health care entities that includes PBMs. A pharmacy that does not provide other medical services is not required to file under current law. Questions regarding the need for a pharmacy to file can be submitted to HCAI's CMIR inbox at CMIR@hcai.ca.gov.
- A member requested clarification regarding the process for incorporating public comments into the new version of the text before it is submitted to the Office of Administrative Law (OAL).
 - The Office explained that it will not hold another informal public comment period because updates to the portal based on the regulatory text are required so that individuals can continue submitting transactions. The updated regulatory text will be posted publicly for a minimum of five days before being submitted to OAL for review. Comments received during the first five calendar days after OAL submission may result in revisions to the text.
- A member expressed concern about research indicating that firms that effectively use upcoding can generate higher revenues and profits, potentially contributing to further market consolidation. The member added that artificial intelligence (AI) tools could make upcoding easier and referenced an ongoing investigation into alleged fraudulent laboratory submissions involving upcoding.

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

Director Landsberg opened the afternoon session by acknowledging Jean-Paul Buchanan's five years of service as Senior Attorney for HCAI. She expressed appreciation for his dedicated service and counsel at nearly every Board and Advisory

Committee meeting and wished him well on his future endeavors.

Agenda Item #5: Spending Target Enforcement – Continued Spending Target Penalty Discussion

Vishaal Pegany, Deputy Director, HCAI

CJ Howard, Assistant Deputy Director, HCAI

Deputy Director Pegany provided an overview of the Board discussions on the Spending Target Enforcement that have taken place since the April 2026 meeting. Assistant Deputy Director Howard provided an overview of procedural penalties.

Discussion and comments from the Committee included:

- A member suggested that the Office use the PIP process to encourage entities to adopt behaviors and payment models that reward prevention and reduce unnecessary hospitalizations. The member cited the Safer@Home program as one example of an innovation that promotes more affordable care.
- A member asked if the Office would respond differently in a hypothetical scenario in which 350 of 400 hospitals failed to meet the spending target than it would in a scenario in which only five hospitals failed to meet the target, particularly with respect to the potential effects on access to health care and OHCA's capacity to manage hundreds of PIPs.
 - The Office replied that it will need to develop a process prioritizing which entities are assigned to a PIP, given the large number of hospitals, health plans and medical groups. The Office noted that an entity will complete the PIP process before any penalties are imposed. It added that factors such as an entity's fiscal condition and impact on access will be considered when determining penalties.
- A member stated that the prospect of a penalty could have an immediate impact by increasing the likelihood that an entity would halt capital spending in anticipation of a possible penalty.
 - The Office replied that this possibility is present with any state of federal policy, and there would be many steps in the PIP process before any penalties could be assessed.
- A member asked how factors such as a 2.5% increase in costs caused by a state mandate and increased labor costs after the fact would be handled in regard to the 3.5% spending growth target.
 - The Office replied that those factors would be taken into account later as part of the enforcement process and the entity would be able to substantiate the drivers of excess spending.
- A member suggested matching the wording on the slides regarding an entity's fiscal condition so that both slides include the fiscal condition of the entire system.
- A member suggested that the wording regarding market impact of an entity could also reflect that the penalties are assessed by market segment.
- A member commented that cost growth increases caused by state mandates should not be counted as part of the cost growth penalty.
- A member suggested that it may be more effective to use a market average as a

basis for comparison because this average would include events like lifesaving cures that cause cost growth increases.

- A member expressed concern that the statute, as written, could result in health care providers and their associated health plans being subject to duplicative penalties.
- A member encouraged the Office to consider alternative approaches to establishing the initial penalty amount including using penalty ranges or graduated tiers based on the degree of non-compliance or establishing reasonable maximum penalties that align the penalty with its intended function to incentivize entities to meet the targets.
- A member asked for clarification about the public visibility of an entity's participation in the PIP process.
 - The Office explained that the statute requires it to publicly identify the entities that exceed the spending target, the amount by which they exceed the target, the entities placed on a PIP, and a detailed summary of each entity's progress under the PIP. The Office added that future Board meetings will include discussions regarding what information will be made public and what information will remain confidential.
- A member asked if all discussions regarding a PIP would be held publicly at Board meetings.
 - The Office replied that the statute provides the authority to conduct closed sessions to discuss a PIP.
- A member suggested that the public disclosure associated with the PIP process could motivate entities to modify their behavior to avoid negative publicity.
- A member encouraged the Office to examine an entity's relationship with its parent health system ownership to determine whether tax savings associated with its tax-exempt status are being invested to increase the entity's wealth rather than being used to reduce health care costs.
- A member encouraged the Office to be transparent about the requirement that a PIP not be approved if it would erode access, quality, equity, or workforce stability.
- A member stated that under accrual accounting, the likelihood of a penalty being imposed would have to be recorded, which may impose a debt service violation or may trigger other events.
- A member asked whether a PIP would include interim milestones and whether penalties could be imposed if these milestones were not met.
 - The Office replied that a PIP would include interim milestones that would be monitored to assess an entity's progress and compliance, but that the goal is to provide the entity with an opportunity to fully implement the PIP. The Office added that it could impose penalties for failing to meet milestones or for a lack of cooperation.
- A member stated that providers may need to reduce programs, expenditures, or labor costs in order to reduce spending growth, adding that such reductions would have tangible impacts.
- A member commented that determining when to impose the \$10,000-per-day penalty on an entity that repeatedly fails to implement a PIP may be challenging because an entity may make a good-faith effort to implement a PIP and still fail.

- A member recommended that OHCA include a rationale for increasing the penalty from \$500,000 to \$1,000,000, such as the entity's total revenue, the size of its reserves, the size of the health system, or its financial resources.
- A member suggested imposing the highest available penalty on entities that repeatedly fail to submit a PIP or submit unacceptable PIPs.
- A member recommended the establishment of a sliding scale for penalties based on factors such as the entity's reserves, to prevent entities from treating penalties as a cost of doing business rather than complying with the statute.
- A member stated that the proposed enforcement penalties are significantly lower than the potential penalties that may be imposed on an entity that exceeds the spending growth target and encouraged the Office to reconsider the proposed penalty amounts.
- A member asked whether there is an enforcement mechanism for unpaid penalties.
 - The Office replied that its attorneys would seek to collect unpaid penalties through the judicial system.
- A member commented that entities may choose to pay a fine rather than comply with regulations, particularly when doing so is more cost effective, and encouraged the Office to increase the penalties.
- A member asked if the \$10,000 per day fine would be assessed during discussions regarding the ways in which an entity plans to comply with the PIP.
 - The Office replied that the penalties apply to a lack of cooperation, not to ongoing discussions with the Office during the PIP approval process.
- A member commented that it would be surprising if an entity were to fail to comply with this process considering its visibility and encouraged OHCA to increase the penalties if the entity refuses to comply with the process.
- A member asked whether the PIP process allows the Office to provide guidance that helps entities improve patient outcomes while avoiding unintended consequences, such as workforce reductions.
 - The Office replied that the PIP guidance asks entities to identify factors that may hinder their ability to implement the PIP, monitor for unintended consequences affecting access, quality, and workforce stability, and include balancing measures to monitor those impacts. The Office added that ongoing discussions with entities would help ensure that their initiatives comply with the requirements of the statute.
- A member suggested increasing the penalties from \$10,000 per day to \$100,000 per day and increasing the flat penalty from \$500,000 to \$5,000,000 to create stronger deterrents.
- A member asked whether the Director would have the discretion to impose minimum and maximum penalties determined by intent.
 - The Office replied that it intends to apply a uniform approach at the outset of this process.
- A member asked for clarification regarding the transparency of the assessment of procedural penalties.
 - The Office replied that discussions are ongoing regarding what information related to the PIP process will be publicly disclosed and when it can be

shared.

- A member asked if the one-time penalty of up to \$500,000 would be assessed one or more times during a certain period of time.
 - The Office explained that the penalty would be assessed once per violation.
- A member asked whether an entity that elects to pay the \$500,000 penalty during the two-year PIP implementation period would be required to pay any applicable spending growth target penalties sooner.
 - The Office replied that procedural penalties could be assessed at the same time as the spending target penalty and initially be set at a commensurate amount. The Office added that the statute allows an entity to implement a PIP for up to three years.
- A member asked for clarification regarding which aspects of the PIP process would be made public throughout the duration of a PIP.
 - The Office replied that it is still developing its approach to determining which elements of the PIP process will be made public, adding that this will be an ongoing discussion.
- A member encouraged the Office to allow as much exposure and transparency for PIPs as possible because there's historically different level of compliance from entities when they are subject to public scrutiny.

Agenda Item #7: General Public Comment

Public Comment was held on agenda items 5 and 7. Two members of the public provided comments.

Agenda Item #9: Adjournment

Director Landsberg adjourned the meeting.