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

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HEALTH CARE AFFORDABILITY BOARD

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

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

Members Absent: Dr. Sandra Hernández, Dr. Richard Pan

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

Meeting Materials: https://hcai.ca.gov/public-meetings/march-health-care-affordability-board-meeting-2/

Agenda Item # 1: Welcome and Call to Order
Chair Secretary Kim Johnson, HCAI
Elizabeth Landsberg, Director, HCAI

Director Landsberg opened the March meeting of California's Health Care Affordability Board. Roll call was taken, and a quorum was established.

Director Landsberg provided an overview of the meeting agenda.

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

Director Landsberg provided Executive Updates, including the following:

- HCAI's two new data reports from the Healthcare Payments Data program (HPD), one on trends in healthcare services performed in the state from 2018 to 2023, and another on out-of-pocket costs for chronic conditions. Both reports are available on the HCAI website. The HPD team will discuss these reports later in today's agenda.
- Resignation of Dr. David Carlisle from the Health Care Affordability Board, noting that this was his last meeting. Director Landsberg acknowledged and expressed appreciation for Dr. Carlisle's contributions to the Board.

Deputy Director Pegany provided updates on the following:

- Key points from the March 12, 2025, report by the Milbank Memorial Fund, which looked at efforts by five states to increase primary care spending.
- Proposed amendments to the Total Health Care Expenditures (THCE) Data Submission Regulations and Data Submission Guide. If approved, these would take effect by the end of April 2025.
- Call for members to serve on the Health Care Affordability Advisory Committee. The submission deadline is April 15, 2025. The application is on HCAI's website under "Affordability."
- Reminder about slide formatting.

Chair Johnson reiterated the invitation to join the Advisory Committee. There were no comments from the Board.

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

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

a) Approval of the February 25, 2025, Meeting Minutes

Deputy Director Pegany introduced the action item to approve the February meeting minutes. Dr. David Carlisle proposed a motion to approve, with a second from Ian Lewis.

Public comment was held on agenda item 3. No members of the public provided comments.

Voting members who were present voted on item 3. There were five ayes, and three members were absent. The motion passed.

Agenda Item #4: Information Items
Vishaal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI
Andrew Feher, Research Manager, HCAI
David Seltz, Executive Director, Massachusetts Health Policy Commission
Sarah Bartelmann, Cost Growth Target & Health Care Market Oversight Program Manager, Oregon Health Authority
Michael Valle, Deputy Director and Chief Information Officer, HCAI
Dionne Evans-Dean, Chief Data Officer, HCAI
Chris Krawczyk, Chief Analytics Officer, HCAI
Margareta Brandt, Assistant Deputy Director, HCAI

a) Follow up on Hospital Sector Target Methodology and Values including Advisory Committee Feedback

Deputy Director Pegany and Research Manager Andrew Feher presented follow-up responses to four Board member requests made in the February, as well as an overview of the feedback provided at the March Advisory Committee meeting.

Discussion and comments from the Board included:

- A member asked if any hospital feedback was new or different from the Office's context of review.
  - The Office replied they are reconsidering the 50th percentile discharge threshold and would like Board feedback to find a balance between not excluding too many hospitals from analysis but having consideration for smaller hospitals as well.
- A member suggested including more California hospitals located further south than Santa Barbara in the feedback group.
  - A member observed on slide 18 a disparity in how hospital systems are viewed. Some see a hospital's inclusion in a system as a method to spread out costs, while others see it as a way to portray the appearance of lower overall costs.
- A member expressed a concern about using a percentile-based discharge threshold because too many smaller hospitals would be eliminated; even an 80- or 100-bed hospital will have thousands of discharges which suggests we would have data confidence.
- A member expressed concern that potential cuts to public programs would shift costs to commercial purchasers and asked if there has been any thought given to innovative cost containment strategies to maintain affordability for the commercial sector if these cuts were to happen.
  - The Office replied that the general feedback from hospitals was that if these cuts were to materialize, there would be no other choice than to increase commercial reimbursements to make up for losses.
  - The member expressed hope for leadership around cutting costs as opposed to shifting costs and mentioned a federal reference pricing bill.
- A member expressed support, regarding the discharge question, for eliminating the data related to smaller hospitals (25-30 beds) but was unsure what the threshold should be.
- A member asked if any hospitals that had suggested using operating margins made strong arguments about why they should be used.
  - The Office replied that it heard varying perspectives on this such as how operating expenses could be allocated from a system to an individual hospital within the system, but also that it is not appropriate to look at hospitals on an individual basis due to other expenses outside of the hospital. In addition, the Office heard that hospitals can be high cost but with high expenses and therefore have a small margin but still be expensive, as well as efficient hospitals with lower margins over time but that it may not be fair to look at margins alone.
- A member expressed shared concern regarding the effects on access, quality and clinical expansion but believes the Board needs to move forward in addressing the affordability problem.

- A member stated that it would be helpful to understand how the Board is tracking the interactive effects if there are cuts at the federal level and this results in higher prices on the commercial side that net out below the spending growth target.
    - A member noted that when Medicare payments were reduced 10 years ago, hospitals made adjustments and costs went down. It is also possible that hospital prices to commercial payers will increase as well.
    - Another member commented that the predictions of cost shifting as a result of federal cuts reinforced why the target setting by market segment is so important and a reminder that the spending targets are not price targets. Tracking that information will help the Board to evaluate whether OHCA's emphasis on spending in isolation from prices is viable over time.
- A member asked about the ability of a hospital to manipulate data in its reporting.
    - The Office stated that when self-reported metrics are compared to non-self-reported metrics, there can be departures or deviations from performance improvements. The Office recognizes the need to have an out-of-sample validation source that does not rely on self-reported hospital generated financials to monitor changes in costs or spending.
- A member requested clarification on slide 26 regarding Northbay Hospital's change in their report preparer and whether the result was a change in the interpretation of their financial filings.
    - The Office responded that with the change in their 3rd party report preparer, it appears the way they approached categorizing net patient revenue from 2021 onward differed from prior years.
- A member asked, in regard to slide 23 and 24, if there is a significant difference in the Herfindahl-Hirschman Index between Northern California and Southern California, which seems to be a significant predictor of cost.
    - The Office replied that a 14-percentage point difference in operating a competitive market seems non-trivial and would be suggestive evidence that there is more competition and there tends to be lower relative prices in those five Southern California counties.
- A member asked if there had been any sub-regional analyses in places like San Bernardino to determine if there are cost reductions in less competitive areas.
    - The Office replied that it only compared the Northern California region to the Southern California region but can follow-up regarding the data for the San Bernardino analysis.
- A member mentioned the discrepancy in the older versus newer data related to Northbay, with the newer data being correct and causing Northbay to no longer be considered an outlier. The member asked for a suggestion for dealing with this situation given the method that had been previously discussed regarding identifying outliers.
    - The Office explained that the Northbay team intended to resubmit updated financials, and that the submission of updated financial information could be recalculated to determine where the hospital arrays in the distribution.
- A member asked about hospitals not being able to replicate OHCA's calculations.
    - The Office replied that some measures are easier to replicate than others. Commercial unit prices, as measured by Commercial Inpatient Net Patient Revenue per Case Mix Adjusted Discharge, are relatively straightforward to

calculate while the Commercial to Medicare Payment to Cost Ratio is more involved. The Office is producing step-by-step instructional documentation to assist hospitals in replicating the measures. A public version of this documentation will be available shortly.

- A member suggested focusing on the relatively small number of relatively large health care systems that account for a large fraction of the health care providers in California rather than becoming distracted by the complexity involved in these systems.
- A member asked who is held accountable at the system level if we measure systems, e.g., the CEO of the system or the various entities below.
    - The Office replied that, taking a hypothetical hospital-only system, individual hospitals could be measured on their own or net patient revenue could be aggregated on a unit basis to get a system-level measure, although this could mask variation within the system; OHCA would want to look at system and hospital level analysis. It depends on where control is exerted. If a system is influencing spending and negotiating rates, both the individual entity and the parent system would be involved in enforcement actions.
    - The member emphasized the importance of having visibility into how well the hospitals are meeting the floor for primary care investment, behavioral health, etc. even if the information is buried within a system.
- A member noted that OHCA has discretion regarding the assessment of hospitals and hospital systems that could trigger a deeper review, but hospitals could go in not knowing what matters to OHCA. Theoretically, OHCA could reflect on the fact that a hospital is in a system with lower cost components that could factor in to how OHCA assesses it. Similarly, a single hospital could be supporting multiple clinics in a community that make a difference in how OHCA views it. Overtime, clarity will come from OHCA's actions but currently there are no clear guidelines for the hospitals regarding the assessment criteria. In the future, it would be helpful for the providers to have this information.
- A member expressed a concern that some facilities in Monterey County are supporting outpatient settings and may be using them as loss leaders to allow the entity to drive up prices. The member believes the proper point of comparison is inpatient facility to other inpatient facilities, and outpatient to other outpatient, etc. While not in OHCA's mandate to influence how outpatient settings are financed, for example, they do not believe inpatient prices should be used to finance essential public goods such as outpatient clinics. They hope understanding these complexities and possibly informing the legislature to handle these health systems in geographies that are most out-of-line with the rest of the state.

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

b) Massachusetts and Oregon Cost Target Program Update Presentations

Deputy Director Pegany introduced David Seltz, Executive Director of the Massachusetts Health Policy Commission, and Sarah Bartelmann, Cost Growth Target

& Health Care Market Oversight Program Manager at the Oregon Health Authority. David Seltz and Sarah Bartelmann each presented their cost target program updates.

Discussion and comments from the Board included:

- A member asked David Seltz what proportion the $197 million savings represented in the Mass General Brigham (MGB) system's Performance Improvement Plan (PIP) in regard to the total cost of the facility.
  - David Seltz explained that the calculation was based on the spending that was above the benchmark for a few years. The total was approximately $300 million in commercial spending. It was then calculated to cover a period of eighteen months. He added that the commercial net patient service revenue for MGB is large. The current system measures spending for patients being attributed to primary care physicians within the MGB system. When patients attributed to another primary care physician end up at an MGB hospital, that would be revenue for the MGB hospital, however, the total spending for that patient would be attributed to their primary care provider that is part of a different system. This creates a gap in the regulatory process that shields some hospitals from further review. Recommendations have been made to the state legislature to amend the statute to address this issue.
- A member asked if there were any negative consequences of the program regarding access to health care or health services.
  - David Seltz replied that there had not been any negative implications for access quality and added that there had been initiatives that improved care, quality and access as well as improved financial performance from the first year of the PIP.
- A member asked if price reductions for an entity would translate into reduced spending, as they do in a system, when OHCA will be calculating growth spend.
  - The Office replied affirmatively, adding that the focus is on total spending, so changes can be made on the price side or the utilization side.
- A member asked if any Massachusetts or Oregon hospitals have closed based on these programs.
  - David Seltz stated that there has been no evidence linking the program to hospital closures in Massachusetts.
  - Sarah Bartelmann stated that while there have been closures in Oregon, mostly for specific lines of service, there is no evidence that these closures are related to the program. There is speculation that these closures are related to workforce shortages.
- A member noted that the Oregon program spent hundreds of hours speaking with providers and asked if an equivalent amount of time was spent speaking with employers and purchasers.
  - Sarah Bartelmann explained that while there had been many suggestions and requests by the employers, purchasers, and patients wanting the conversations pertaining to the process assessing reasonableness to be held publicly, it was ultimately decided to keep conversations between the state and payers or providers private to allow for the sharing of confidential or sensitive information. Public comment and public hearings regularly provide spaces for public input. There may be a need to modify this process in the future to allow more stakeholder engagement in the drafting of a performance improvement plan.

- A member asked if these private conversations with providers are having a positive impact on affordability.
    - Sarah Bartelmann explained that it may be too early to answer this question because this was their first time going through this process and that the results of the next round are still unknown. She offered to answer the question in six months.
    - David Seltz stated that even though these conversations are private, there is a sentinel effect. The payers and providers know that they are being monitored so they may offer a plan for reducing costs if they are questioned. There is an understanding of the need to focus on the collective effort to bring down costs and a desire to bring more transparency to the process.
    - Sarah Bartelmann added that she hopes to see the sentinel effect that David mentioned, but she is concerned that rather than offering cost reduction plans, the providers may offer justifications for higher costs. She has also seen the cost growth target used by health plans to justify the rejection of a proposed rate increase in the contract. Other provider organizations and health systems have been dropped from a network due to an inability to reach an agreement, citing the cost growth target.
- A member commented that by having private conversations between payers and providers, the missing element is that the people who are actually paying for care, self-insured purchasers or the patient, are being excluded.
    - A member asked how many multifactorial reviews resulted in not requiring a performance improvement plan.
    - David Seltz replied that there have been dozens of multifactorial reviews that did not result in requiring a performance improvement plan.
- A member asked for clarification about the multifactorial review process and what would result in requiring a performance improvement plan.
    - David Seltz explained that consideration is given to trends over time, to allow for anomalies in the data, with the understanding that the data will continue to be tracked. The one performance improvement plan that had been required was based on pre-pandemic data and experience that required a different level of nuance and understanding of the context of what organizations were dealing with at the time.
- A member asked about how real the price reductions were.
    - David Seltz replied that this was their first performance improvement plan and, as far as they know, the first in the country. Since completing the PIP, they have reflected on the process, results, and outcomes. A major factor in deeming that the performance improvement plan was successful was determining that the savings resulting from different strategies would be sustainable in the future.

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

c) Proposed Emergency Regulation on Hospital Sector Definition including Summary of Public Comment Feedback

Assistant Deputy Director CJ Howard presented the proposed Emergency Regulation on Hospital Sector Definition including a summary of the public comment feedback. Discussion and comments from the Board included:

- A member asked about the time frame for considering additional sectors.
  - The Office replied that a sector can be defined by the Board at any time but there is a constraint for setting a different target value. Adequate time needs to be allowed for a sector to be defined in regulation before initiating the target setting process.
- A member asked if hospitals would be subject to the statewide target regardless of whether the sector definition has been established.
  - The Office confirmed that hospitals will be subject to the statewide target regardless of whether the sector definition has been established, and the sector definition is independent of the target setting. Establishing a sector does enable different targets to potentially be established for some entities within a sector.

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

d) Healthcare Payments Data Program Update

Michael Valle, Deputy Director and Chief Information Officer in HCAI's Office of Information Services provided an introductory overview of the Healthcare Payments Data Program. Dionne Evans-Dean, HCAI's Chief Data Programs Officer, and Chris Krawczyk, HCAI's Chief Analytics Officer, co-presented this item with Michael Valle, discussing the Healthcare Payments Database (HPD) data collection, reporting, utilization, and data releases. Assistant Deputy Director Brandt then presented on OHCA's ongoing analysis of behavioral health spending using the Healthcare Payments Database (HPD).

Discussion and comments from the Board included:

- A member asked for information about requesting data on the website, the registration process, and how information related to these requests would be utilized in the future.
  - The Office explained that the idea is to crowdsource from the best and brightest academic minds in the state and nation to make best use of the data. In addition to the research potential for academics to use HPD data, there is an opportunity for collaborations with academic researchers and HCAI's team. Since the application process began in December, eight applications have been received with the expectation that requests will increase along with growing awareness of the program's existence.
- A member asked about the status of capitated arrangements in the HPD and if the data reflects capitation payments at the service level.
  - The Office replied that the database does not include payment information for non-claims encounters, including capitation payments. The Office is in the process of getting approval from the Office of Administrative Law to include non-

claims payment data collection. The non-claims data file layout resulted from a collaboration with the National Association for Health Data Organizations. It will include monthly capitation file data, annual non-claims payments data, and annual pharmacy rebate data. The hope is for plans to begin testing the data layout in the fall of 2025 and for plans to begin submitting production data in the fall of 2026.

- A member suggested that it would be helpful to have more detailed data regarding the access that Medi-Cal patients have to primary care providers while acknowledging that the questions regarding the data are quite broad.
    - The Office expressed appreciation for the suggestion and recognized the effort of its staff in compiling the data.

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

Agenda Item #5: General Public Comment

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

Agenda Item #6: Adjournment

Chair Johnson adjourned the meeting.