



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 BOARD

MEETING MINUTES

Wednesday, March 25, 2026

10:00 am

Members Attending: Richard Kronick, Ian Lewis, Elizabeth Mitchell, Dr. Richard Pan, Don Moulds

Members Absent: Secretary Kim Johnson, Dr. Sandra Hernández

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; CJ Howard, Assistant Deputy Director, HCAI; Margareta Brandt, Assistant Deputy Director, HCAI

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

Agenda Item #1: Welcome, Call to Order, and Roll Call

Elizabeth Landsberg, Director, HCAI

Director Landsberg opened the March meeting of California's Office of Health Care Affordability Board. Roll call was taken. Director Landsberg stated that the meeting would proceed as a subcommittee and that the vote to approve the January Board meeting minutes would be delayed until quorum is established upon the arrival of an additional Board member.

Agenda Item #2: Executive Updates

Elizabeth Landsberg, Director, HCAI

Vishaal Pegany, Deputy Director, HCAI

Director Landsberg provided an overview of the meeting agenda.

Director Landsberg then provided Executive Updates, including the following:

- Recognition of February's Black History Month and HCAI's Black Liberation Statement.
- The celebration of HCAI's Office of Workforce Development 4,000 certified wellness coaches statewide.

- Information about HCAI's five-year Workforce and Education and Training (WET) Plan, funded by 3 percent of the Behavioral Health Services Act's revenues. HCAI has developed an initial approach and will host a series of focus groups in April to gather further insights into the behavioral health needs of vulnerable populations and explore key workforce development topics as HCAI finalizes the WET plan that will be voted on later this year.
- A reminder that HCAI's Office of Health Information continues to release reports through the Healthcare Payments Data (HPD) Program.
- Information that Centers for Medicare and Medicaid (CMS) approved all but \$50 million of California's Rural Health Transformation Program's (RHTP) original award of \$233.6 million. HCAI is working to submit a revised application for this \$50 million, focusing on strengthening rural health care workforces and electronic infrastructure.
 - HCAI will convene a Rural Health Policy Council in June 2026 as a public forum for rural health stakeholders to discuss the implementation of the California RHTP implementation. HCAI also anticipates hosting a spring RHTP webinar and issue requests for applications for the program's initiatives in late spring/early summer.
- An acknowledgment of the Affordable Care Act's 16th anniversary signed into law on March 23, 2010.

Deputy Director Pegany provided Executive Updates, including the following:

- Information about OHCA's first Patient and Consumer Forum on March 10, 2026. Participants expressed support for OHCA's mission while raising concerns about potential incentives for entities to deny care for chronic conditions requiring high-cost services. Meeting materials and slides are available on OHCA's webpage.
- An overview of the latest findings from the California Health Care Foundation's 2026 Health Policy Survey.
- An overview of a March 2026 article published in Health Affairs which examined 2023 administrative spending across the fully insured, Medicaid managed care, and self-funded employer insurance markets.
- An overview of a March 2026 article published in the National Bureau of Economic Research that examines the effects of anti-fraud enforcement on hospital admissions, Medicare spending, and patient mortality.
- An update that OCHA recently posted a publication on its website regarding the National Provider Identifier (NPI) Crosswalk.
- A reminder that the 2026 OHCA Advisory Committee Submission of Interest Form closes March 30, 2026.
- A reminder about slide formatting.

Discussion and comments from the Board included:

- A member asked if the Rural Health Transformation work will align with OCHA's goal of increasing investment in primary care up to 14 percent.
 - HCAI replied in the affirmative and stated that key focus is on the primary care workforce, maternity care workforce, and hub hospitals that provide support for specialty care through e-consult.

- A member asked for clarification regarding the appointment process for the new Rural Health Policy Council.
 - HCAI replied that it is seeking representatives from rural hospitals and clinics, provider communities, physician and non-physician consumer advocacy groups, and tribal communities. Interested parties are encouraged to reach out.
- A member asked which health plan fees were included in the non-medical spending in California's fully insured commercial market (Slide 17).
 - The Office replied that it includes regulatory fees assessed by state insurance regulators. A member added that most of the fees included in non-medical spending are taxes.
- A member asked if the Health Affairs article identified any improvements in service or affordability related to the significant jump in profit or other reasons for the growth from year to year.
 - The Office replied that the article focused on the non-medical factors but based on the medical data it is aware of, total medical expenditures shows growth, not decreases. Additionally, as a function of 80/85% medical loss ratios, as health care costs increase so too do the administrative costs.
 - A member added that Medicare Advantage insurers earn a relatively low profit of about 1.5 percent per person.
- A member noted although many California health plans operate as non-profits they still generate substantial capital gains on their cash reserves; these reserves ostensibly exist for the public good. The member further observed that profit is captured at multiple levels within the health care system, including within spending categorized as medical costs. The member also thanked OHCA for highlighting the health care affordability crisis captured in the California Health Care Foundation's 2026 Health Policy Survey.
 - The Office noted that the legislature recently held hearings where the survey data was presented, followed by consumer and provider perspectives.

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

Agenda Item #4: Informational Items (out of order)

d) Total Health Care Expenditures Data Submission Regulations (DSG 3.0) – Discussion of Public Comments on Regulatory Text

CJ Howard, Assistant Deputy Director, HCAI

Margareta Brandt, Assistant Deputy Director, HCAI

Assistant Deputy Director Howard presented a summary of public comments received and OHCA's responses regarding the Total Health Care Expenditure Data Submission Guide (DSG 3.0). Assistant Deputy Director Brandt presented a summary of public comments received and OHCA's responses regarding the Alternative Payment Model, Primary Care, and Behavioral Health Data collection files, and the Medi-Cal Payments Addendum.

Discussion and comments from the Board included:

- A member referred to Slide 62 and asked for a sense of how often a provider's taxonomy code is missing on claim level data.
 - The Office advised that it would research this and will follow up.
- A member suggested using the National Plan and Provider Enumeration System (NPPES) data, which may not always be completely correct, when the taxonomy code is missing from the claim level data would be reasonable.
 - The Office stated that it would assess how frequently taxonomy codes are missing and continue discussions with the work group.

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

c) Spending Target Enforcement – Continued Performance Improvement Plan Discussion (out of order)

Vishaal Pegany, Deputy Director, HCAI

Deputy Director Pegany provided an overview of the continuing discussion regarding Performance Improvement Plans (PIPs) as a component of spending target enforcement.

Discussion and comments from the Board included:

- A member provided an example of a health care entity with a 6.5 percent cost growth (3 percent above the target) and asked whether a PIP would require reducing future cost growth to 3.5 percent or if the PIP would also address recovery of the extra 3 percent from the prior year(s).
 - The Office responded that the PIP would be about bringing the entity into compliance with the target, i.e., reducing future cost growth to 3.5%.
 - The member asked for confirmation that the extra 3% growth in the prior year(s) remains with the entity.
 - The Office confirmed and stated this is the reason the entity is subject to a PIP. A PIP is a function of the requirements in the law which requires the entity to have the opportunity to reduce its cost growth percentage to the target value or less via a PIP before OHCA can assess a financial penalty.
 - The member suggested there is a question of what the target is for that improvement: it could be coming down to 3.5% in the future, or it could be coming down to 3.5% in the future and giving back some of the extra money received in the past. Is it clear in the law what the target in the PIP needs to be?
 - The Office replied it would look into the question and continue the discussion at a future Board meeting.
- A member stated that to the degree that PIPs are alternatives to penalties, which are commensurate with the excess over the target, there needs to be a mechanism to bring the entity back below trend so that over the long run the entity is meeting the target and an incentive is not created so the entity gets a one-time pass every few years; e.g., you have a two-year PIP after the entity has

6.5% growth and then another 6.5% growth is baked into the future baseline. This could unravel the intent of the statute.

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

Agenda Item #3: Action Consent Item (out of order)

Vote to Approve January 28, 2026 Meeting Minutes

Vishaal Pegany, Deputy Director, HCAI

Deputy Director Pegany introduced the action item to approve the January 2026 meeting minutes. Board member Lewis proposed a motion to approve. Board member Kronick seconded the motion.

There were no comments or discussion from the Board.

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

Voting members who were present voted on agenda item 3. There were four ayes, and two members were absent. The motion passed.

Agenda Item #4: Informational Items

a) Hospital Sector Target Adjustments Methodology – Follow-up on Resubmissions of Hospital Data (out of order)

Vishaal Pegany, Deputy Director, HCAI

CJ Howard, Assistant Deputy Director, HCAI

Deputy Director Pegany presented background information regarding the Hospital Annual Financial Disclosure Report, an overview of the Board's actions to adjust the sector target for high-cost outlier hospitals, and an overview of hospital data resubmissions currently being reviewed by OHCA.

Discussion and comments from the Board included:

- A member asked how many data resubmissions are usually received by OHCA per year and the nature of those revisions.
 - The Office replied that there are 437 licensed general acute hospitals in California that report to HCAI and can resubmit data but that we are not in the position to set parameters about aspects of resubmission. In general, HCAI receives about 100 resubmissions annually. Two of the three hospitals referenced in the presentation are high-cost hospitals and one is not. They are in various stages of review and validation.
- A member asked for clarification from the January 2026 meeting about why revisions to 2027 spending targets are not possible.

- The Office explained that, to adjust targets for 2027, the office would have had to publish a recommendation and discuss it at a board meeting on or before March 1, 2026, followed by a 45-day comment period, and voted on by June 1, 2026. Because the initial March deadline has passed, 2028 is the soonest the Board could adjust targets. When targets are likely revisited next year, OHCA can show the status of resubmitted and non-resubmitted data so the Board can make an informed decision about potentially using revised data to adjust targets for 2028.
- A member asked if the inability to adjust the cost targets in 2027 was due to an issue with staff bandwidth or logistics.
 - The Office replied that it would have had to analyze the data in January or February in order to make the recommendation before March 1, 2026. However, the number of resubmissions still in the queue did not allow OHCA to rerun the methodology before the deadline.
 - The Office added that it would not be able to commit to completing the data resubmission analysis if many hospitals were to resubmit data.
- A member inquired whether HCAI has discretion to prioritize review of resubmitted data from select entities based on compelling circumstances.
 - The Office explained that it does not currently have defined criteria for prioritizing resubmissions.
- A member asked whether OHCA could develop a process to review resubmissions when compelling reasons exist.
 - The Office clarified that, while the process for hospitals to submit financial data has been in place for 50 years, this would represent a new use of the data.
- A member requested clarification on whether hospital-submitted data is assumed to be accurate at the time of submission.
 - HCAI staff explained that submissions are certified as true and accurate under penalty of perjury and noted that most revisions relate to disproportionate share hospital calculations and payer category designation errors. HCAI staff added that it conducts desk audits to identify potential issues and may require hospitals to submit revised data.
- A member asked whether OHCA can determine if reporting errors result in a hospital being incorrectly identified as exceeding the spending growth target.
 - The Office stated that it can assess whether errors lead to incorrect categorization.
- A member expressed appreciation for the Office's ability to correctly process a high volume of complex data and revised data.
- A member inquired about the frequency of intentional data misreporting by hospitals.
 - HCAI staff replied that it is not in the position to determine whether an error was made fraudulently but historically it has not observed intentional misreporting. Most revisions reflect updates to previously submitted information, for example, wage data.
- A member suggested that OHCA devise procedures on the front end that would prevent the incorrect categorization of a hospital due to subsequent submission

of revised data. The member expressed concern that the hospital and the community may be harmed in the time that it takes for OHCA to correct the error on the back end.

- A member suggested that OHCA consider, in reference to slide 33, the use of revised data as part of the 2028 target setting discussion that will be presented in late 2026.
 - The Office replied that it will include revised data as one of the options, along with information about when the data was pulled, and if there are any pending resubmissions from the entities. The Office noted uncertainty regarding the volume and processing time of resubmissions and stated that it will provide updates to the Board in the fall to enable the Board to make an informed decision regarding the treatment of revised data.
- A member asked whether revised data could be used to assess expected entity performance for the 2027 fiscal year.
 - The Office explained that this is not feasible, as resubmissions can affect hospital rankings and cause new entities to come within the 85th percentile threshold and some may fall out. The Office noted that in the fall it will present one set of data based on the complete data set and another one based on resubmitted data in which HCAI has completed validations.
- A member emphasized the importance of evaluating alternative thresholds, i.e., not a percentage in which entities can fall above or below, for identifying high-cost hospitals to mitigate potential harm from misclassification under the current 85th percentile approach.
- A member asked whether HCAI is considering changes to the existing data submission process.
- The Office replied that the topic before the Board is whether to change the methodology for high-cost hospitals based on resubmitted data. We are unable to do so for 2027 but are prepared to present options to the Board for 2028.

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

b) Non-Supervisory Organized Labor Adjustment and Assessment – Introductory Discussion (out of order)

Vishaal Pegany, Deputy Director, HCAI

CJ Howard, Assistant Deputy Director, HCAI

Assistant Deputy Director Howard presented an introductory discussion about the non-supervisory organized labor adjustment.

Discussion and comments from the Board included:

- A member noted the complexity of reporting organized labor cost data and appreciated OHCA's approach to capturing information upfront while preserving the ability to verify that the money was actually spent through a retrospective analysis. The member emphasized the importance of a shared understanding between employers and unions to support this process.

- A member noted that the statute was intended to ensure workers can negotiate fair contracts and emphasized the need to establish data submission processes that promote proactive and accurate reporting of organized labor cost adjustments to OHCA.
- A member asked, regarding slide 39, whether hiring more people in the nurses' union would increase the projected growth rate.
 - The Office replied that it would increase the projected growth rate for organized labor in that category.
- A member suggested counting the total organized labor cost rather than counting the cost of wages plus benefits for individual hourly employees.
- A member noted that focusing on the rate of compensation, rather than total spending, may better reflect actual outcomes given the uncertainty associated with projections made 15 months prior to the rate year.
 - The Office explained that the adjusted spending target is preliminary and would require a reconciliation process to confirm actual spending through spending target measurement and enforcement processes.
- A member suggested that the trend-setting discussion include a front end snapshot of likely wage growth or total labor costs so that the labor adjustment can be incorporated into the final trend adopted by the Board.
- A member expressed concern that restraining health care cost growth may also restrain the bargaining ability for health care workers seeking higher compensation.

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

Agenda Item #5: General Public Comment

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

Agenda Item #6: Adjournment

Director Landsberg adjourned the meeting.