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

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HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Wednesday, May 27, 2026
10:00 am

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

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; Margareta Brandt, Assistant Deputy Director, HCAI; Laureen Driscoll, MBA, BSN, RN, Chief Executive, Providence California; Daniel Kelly MBA, BSN, RN, Chief Nursing Officer, Providence California; Nicholas Burchell, Senior Government Affairs Officer, Providence California; CJ Howard, Assistant Deputy Director, HCAI; Heather Hoganson, Assistant Chief Counsel, HCAI; Maggie Heidmann, Health Equity and Quality Performance Group Manager, HCAI

Meeting Materials: https://hcai.ca.gov/public-meetings/may-health-care-affordability-board-meeting-4/

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

Chair Johnson opened the May meeting of the California Health Care Affordability Board. Roll call was taken, and a quorum was established.

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

Director Landsberg provided an overview of the meeting agenda.

Director Landsberg then provided Executive Updates, including the following:

- A new statewide program will be launched this summer to provide 400 diapers at no cost to families with newborns who are delivered at participating California hospitals.
- The May revision of the state budget is now balanced at $349 billion. Highlights of the revised budget include:
  - Sustainable ongoing funding for the Health Care Payments Database (HPD).

    - Support for distressed hospitals. HCAI is administering $25 million from a distressed hospital small grant provided by the passage of AB 108 for financially struggling small and rural hospitals. HCAI has received 11 applications and hopes to award funds within a few weeks. The budget proposes an additional $50 million for hospitals in acute financial distress.
    - Funding to implement Proposition 1's behavioral health system transformation along with the Departments of Health Care Services and Public Health. HCAI will receive three percent of funding to support its behavioral health workforce.
- Recognition and thanks were extended to board member Elizabeth Mitchell on her last day as a member of this board.

Deputy Director Pegany provided Executive Updates, including the following:

- An update on the hospital financials from fiscal years 2022 and 2023 that were presented at the April 2026 board meeting.
- An overview of a recently published article in Health Affairs Forefront written by OHCA staff that highlights how commercial Total Medical Expenditure data can help identify areas of concentrated spending growth, and how those trends relate to state affordability policies.

- An announcement that this year's interim report on health care spending covering 2023 and 2024 will be presented later this summer, not at next month's board meeting. The Health System Performance report, looking at 2023 and 2024 alternative payment model and primary care spending data, will be published and presented early this fall.

There were no comments or discussion from the Board.

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

Agenda Item #3: Action Consent Item
Vote to Approve April 22, 2026 Meeting Minutes
Vishaal Pegany, Deputy Director, HCAI

Deputy Director Pegany introduced the action item to approve the April 2026 meeting minutes. Board member Lewis proposed a motion to approve. Board member Hernández 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. All six voting members voted aye. The motion passed.

Agenda Item #5: Informational Items (out of order)
a) Cost Reducing Strategy Presentation: Providence
Margareta Brandt, Assistant Deputy Director, HCAI
Laureen Driscoll, MBA, BSN, RN, Chief Executive, Providence California
Daniel Kelly MBA, BSN, RN, Chief Nursing Officer, Providence California
Nicholas Burchell, Senior Government Affairs Officer, Providence California

Assistant Deputy Director Brandt introduced representatives from Providence California who provided an overview of the key strategies that Providence implemented to balance agency or contract labor costs with overall workforce stability, including strengthening retention and recruitment.

Discussion and comments from the Board included:

- A member asked how the $220 million in cost reduction for agency labor affected the organization's total revenue.
  - The presenter explained that the savings helped reduce the organization's negative operating margin and support its goal of breaking even this year.
- A member expressed concerns about the cost increases for Providence caused by the administrative burden related to underpayments and denials.
  - The presenter stated that the number of touches required for each claim to be processed is challenging and increases administrative burden. Providence California noted they are working to streamline payment processes and are considering introducing legislative solutions to reduce administrative burden.
- A member commented that this is a tremendous opportunity to improve the availability and quality of health care by reducing the administrative burden.
- A member noted that investment returns represent a significant portion of profits and asked what mechanisms are in place to ensure funds are directed toward patient care or returned to purchasers who bear the costs, rather than being used primarily to grow investment reserves.
  - The presenter replied that Providence California's commitment as a not-for-profit organization is to reinvest any funds that remain after all debts are paid from the divestiture into its California ministries. While some funds will be applied to meet seismic safety requirements for 2030, others will be used to serve the health and safety needs of patients in poorer communities that are not profitable.
- A member asked if these changes have resulted in measurable impacts on patient experience or on the quality of care.
  - The presenter reported strong performance in sepsis management, reduction in healthcare associated infections (HAIs), and reduction in readmissions rates, noting that six hospitals have achieved Magnet designation. The presenter stated that patient experience scores have improved, in part due to virtual nursing programs that support administrative functions.
- A member asked whether Providence California has sufficient flexibility from payers and whether they are paid through alternative payment models to align services with community needs.
  - The presenter explained that there are geographic differences. Northern California has a fee-for-service model with less capitation and value-based care.

Orange County and Los Angeles are more mature markets with greater capitation, but there are increases in Medicare Advantage utilization costs that are difficult to manage. There is still much work to be done around these issues.

- A member asked about the payer mix for Providence California.
  - The presenter stated that approximately 73 percent of Providence California's payer mix is governmental and noted concerns about the impact of Department of Health Care Services' Quality Assurance Fee (QAF) funding changes.
- A member asked how Providence California is preparing for the potential impact of federal policy changes, including HR 1.
  - The presenter stated that Providence California is evaluating its service footprint while maintaining its commitment to serving Medi-Cal and other vulnerable populations. The presenter stated that Providence California is one of the largest providers of health care to the Medi-Cal population and emphasized its commitment to providing care to vulnerable communities.
- A member asked whether Providence California contracts directly with purchasers or primarily through commercial payers.
  - The presenter explained that their arrangements are primarily with commercial payers and Providence California also has a Restricted Knox-Keene license.
- A member asked whether payment models influence the pace of operational improvements and patient experience gains.
  - The presenter explained that markets with stronger alignment among hospitals, physicians, and medical groups tend to achieve improvements more quickly and it is easier to adopt alternative payment models like capitation.
- A member asked if Providence California has estimates of cost per case mix, adjusted admission, and per adjusted outpatient visits data from recent years and how those metrics are applied in their system.
  - The presenter replied that these metrics are incorporated into budgeting and noted that increasing patient acuity in hospitals due to the shift of lower acuity care to ambulatory settings has created market specific challenges.
- A member requested more examples of accelerated nurse training programs or other partnerships with higher education related to their retention strategy. The member also requested information about innovative technology solutions on the horizon and for tried and tested methods that were deemed effective.
  - The presenter replied that four of its hospitals will be piloting the use of the DAX platform, which is a voice-activated ambient technology that accurately documents data into the medical record. Another innovation being considered is the Bio Button, a device that is affixed to the patient to measure and document vital signs, eliminating the need to wake a patient during the night. Additionally, Providence California is working to reduce administrative burden for physicians and nurses. They are also exploring innovative strategies using virtual technology for pharmacy management. They also have partnerships with schools that teach imaging and other therapies. Providence California is working with schools to adapt the Licensed Vocational Nurse (LVN) curriculum to align with current hospital needs.

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

Agenda Item #4: Action Item (out of order)
Vote to Appoint Advisory Committee Members
CJ Howard, Assistant Deputy Director, HCAI

Assistant Deputy Director Howard presented the recommended slate of Advisory Committee members to the Board. The subcommittee recommends reappointing nine incumbents and appointing five new members.

Discussion and comments from the Board included:

- A member asked which incumbents reapplied and which did not.
  - The Office responded that it could follow up with the list of those who resubmitted applications.
  - A subcommittee member responded that one incumbent reapplied but was not recommended for reappointment due to the number and strength of applications in the physicians category, and the need to strike a balance and be open to other perspectives.
  - A subcommittee member noted the lack of a pharmacy voice on the Advisory Committee and the subcommittee's recommendation for a pharmacy category while not expanding the current number of Advisory Committee members.
- A subcommittee member noted that the purchaser category is currently vacant because the individual previously serving in that role has changed positions. They believe the Advisory Committee would benefit by giving extra time for that recruitment, especially given that the current purchaser representatives do not directly represent a purchaser at this time.
  - A subcommittee member noted they are open to Board feedback regarding situations in which individuals change Advisory Committee categories due to a job change since there is no precedent for this occurrence.
- A member stated that a hospital representative and consultant should not be in the purchaser category.
- A member asked what statute says regarding appointment to the Advisory Committee, including current or previous representation.
  - The Office responded that statute requires Advisory Committee members to be representatives of the category they serve; this implies current representation. The Office further noted that the Board may, by majority vote of its voting members, remove a member or reassign a member to a different category.
- A member requested that when individuals change categories, the recommended slate reflect them in their new categories for clarity. Another member requested also seeing the category in which they were originally appointed.
- A member asked that if an appointed member changes positions midterm, this information be presented to the Board so that it may determine whether to move the individual to a new category or conduct additional recruitment.

- The Office and Board postponed the Advisory Committee vote until the June 2026 Board meeting so that the proposed slate can be clarified and allow for more time to recruit candidates for the purchaser category.

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

Agenda Item #5: Informational Items
b) Spending Target Data Submission Enforcement – Status Update and Comments on Regulatory Text
Heather Hoganson, Assistant Chief Counsel, HCAI

Assistant Chief Counsel Hoganson provided an overview of public comments that had been received during the public comment period between April 20, 2026 and May 11, 2026.

There were no comments or discussion from the Board.

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

c) Introduction to Equity Adjustment and Quality Adjustment to Spending Targets
Margareta Brandt, Assistant Deputy Director
Maggie Heidmann, Health, Equity, and Quality Performance Group Manager

Assistant Deputy Director Brandt and Health Equity and Quality Performance Group Manager Maggie Heidmann presented an introduction to equity adjustment and quality adjustment to the spending targets.

Discussion and comments from the Board included:
- A member acknowledged that equity work is challenging and recognized there are not established tools for addressing equity. The member suggested OHCA set a timeline for revisiting the equity adjustment question in one year or so. The member encouraged continued efforts to develop practical tools that could support incremental improvements in this area and incentivize payers to take on members with higher social risk.
- Several members agreed with Advisory Committee members that in the interest of transparency, OHCA should share the social risk analysis with the identified payers.
- A member suggested measuring the relationship between Social Vulnerability Index (SVI) and spending growth rather than focusing on year-to-year variation in SVI.
- A member suggested using existing quality measures to assess outcomes across racial and ethnic groups and creating incentives for payers and provider organizations that demonstrate progress in reducing disparities in patient outcomes.
    - The Office replied that the relationship between social risk and cost or spending is inconclusive.

- A member inquired about the rationale for applying the adjustment to performance instead of adjusting the targets themselves.
    - The Office explained that this approach is consistent with OHCA's existing risk adjustment methodology for age and sex, which applies adjustments to spending data rather than to the spending target.
- A member recommended that the Board consider allowing adjustment to spending performance for payers or providers that are serving disproportionate numbers of vulnerable people.
- A member asked how the dynamics would change if equity adjustments were applied to providers but not to payers.
    - The Office explained that a similar social risk distribution analysis could be conducted for physician organizations and hospitals based on the characteristics of the populations they serve. The Office noted that while such adjustments could allow for higher spending growth, challenges remain in determining whether the additional resources are ultimately used to address social risk factors.
- A member asked whether an entity serving a socially vulnerable population and subject to a Performance Improvement Plan (PIP) would have the opportunity to explain how social risk factors contribute to its spending growth.
    - The Office responded that entities are required to identify the drivers of spending growth as part of the PIP process and may propose strategies and investments designed to address social risk factors affecting the populations they serve.
- A member suggested that entities serving socially vulnerable populations may possess valuable data on the relationship between social risk factors and spending, which could help identify effective strategies for addressing social vulnerability.
- A member expressed concern that an equity adjustment could reduce accountability and stated support for an initial approach focused on transparency and accountability.
- A member suggested clearly communicating to payers that investments aimed at improving the health of vulnerable populations will be considered in the evaluation process.
- A member expressed concern that socially vulnerable populations often face barriers to accessing high-quality care and noted the importance of continuing to explore strategies that advance health equity. The member suggested revisiting the equity adjustment in a few years.
    - The Office responded that spending target adjustments may not be the most effective mechanism for addressing issues such as language access, access to care, or the needs of higher-risk populations, but emphasized its commitment to exploring other approaches that support health equity.
- A member agreed that, although the Office is not ready to implement equity adjustments at this time, it would be a mistake to abandon the task altogether given that there is a ten-year disparity in life expectancy between patients with assets and patients without assets.
- Several members expressed support for the recommendation from the Office to revisit the quality adjustment with several years of quality and cost data.
- Members discussed the relationship between health care quality and spending, suggesting that poor-quality care and adverse outcomes can contribute to higher

health care costs and may warrant further examination as part of future regulatory and policy efforts.
- Members called on researchers and other organizations to develop quality measures, data sets, and analyses that may help inform future efforts to address health disparities, quality improvement, and cost growth.

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

d) Spending Target Enforcement – Continued Spending Target Penalty Discussion
Vishaal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI

Assistant Deputy Director Howard and Deputy Director Pegany provided an overview of the proposed spending target penalties.

Discussion and comments from the Board included:
- A member requested clarification on how penalties would be assessed for a single year or across performance years.
  - The Office clarified that for each year an entity misses the target, provided they were required to implement a PIP, they can be held financially accountable. An entity subject to a two-and-a-half-year PIP that continues to exceed the spending target in consecutive years could still be subject to a corresponding penalty for each year, provided the entity did not successfully implement the PIP and failed to meet the spending target during those years.
- A member asked if there is a scenario in which the penalty would be higher than six years of exceeding the target, e.g., if an entity had six years of six percent growth, would a penalty ever exceed that amount.
  - The Office replied that the penalties follow a two-step process. The first step is commensurate dollar for dollar. The second step includes the adjustments required under the statute.
- A member asked if yearly milestones could be included in a two-and-a-half-year PIP, for example, so if the entity did not meet the milestones they would be out of compliance with the PIP; waiting until the end of the PIP would not be necessary.
  - The Office replied that this will be discussed at a future meeting but that there is value in allowing the PIP to unfold because the entity is still accountable for meeting each year's spending target.
- A member asked if an entity that is currently on a PIP but also misses the subsequent year's spending target would receive an amendment to the existing PIP or a new PIP.
  - The Office replied that operationally it may be optimal to have two discrete PIPs and treat each year individually. Each PIP would undergo a root cause analysis to determine the factors that led to excess spending which may result in differences contained within each PIP.
- A member stated that an entity that greatly exceeds the target (e.g.,12 percent) and complies with a PIP would not receive a penalty but asked if the PIP itself can require

the entity to have a lower-than-the-target rate of increase in the years of the PIP so that some money spent in excess of the target can be recovered.
    - The Office replied that the possibility of establishing different targets for entities who are on a PIP will be revisited at a later board meeting.
- A member asked for clarification that if an entity that had greatly exceeded the target, implemented a PIP, and still exceeded the target would not be penalized. The member commented that the purpose of the PIP is to come into compliance, not to comply per se with a PIP.
    - The Office explained that for a penalty to be assessed the entity must fail to comply with the PIP and also not come into compliance with the target. The Office added that these requirements underscore the importance of structuring meaningful PIPs. The Office does not have authority to assess penalties if the entity complies with its PIP.
- A member expressed concern that if the answer is no to the earlier question about whether a PIP can require a lower-than-the-target rate of increase, and with a five-year runway to get to the penalty stage, if OHCA only brings the entity back to that performance year's target, they could be multiple percentages ahead in spending compared to where they would have been if they had met the target each year. This incentivize entities to greatly exceed the targets in one year, successfully implement a PIP, and come back in line with the target. It would be different if OHCA could bring the entity back over the course of the PIP (e.g., 2.5 or 3 years) to where they would have been had they met the target each year.
    - The Office replied that for entities with excessive growth the Board may consider adjusting future targets in order to bring their growth back in line.
- A member suggested that the Board create some clear guidelines regarding the way that penalties are structured so that the penalties are seen to be based on objective criteria rather than personal feelings or relationships with entities.

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

e) Cost and Market Impact Review Regulations – Introduction to Regulatory Text
Heather Hoganson, Assistant Chief Counsel, HCAI
Assistant Chief Counsel Hoganson provided an overview of the changes to the Cost and Market Impact Review program related to the enactment of AB 1415.

There were no comments or discussion from the Board.

Agenda Item #6: General Public Comment

Public comment was held on agenda items 5e and 6 along with general public comment. Five members of the public provided comments.

Agenda Item #7: Adjournment

Chair Johnson adjourned the meeting.