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

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HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Monday, October 14, 2024
10:00 am

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

Members Absent: Dr. David Carlisle

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

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

Agenda Item # 1: Welcome, Call to Order and Roll Call
Vice Chair, Dr. Sandra Hernández

Vice Chair Hernández opened the October meeting of California's Health Care Affordability Board, advising that she will be chairing today's meeting due to the departure of the Chair, Dr. Mark Ghaly. It is anticipated that a new Chair will be elected at the next Board meeting. Roll call was taken, and a quorum was established. Vice Chair Hernández welcomed Secretary Kim Johnson, on behalf of the Board.

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

Director Landsberg provided an overview of the agenda and advised that, following the vote to approve the August meeting minutes, Margareta Brandt will open Informational Item 5a by providing an Update on the Draft Primary Care Definition and Investment Benchmark. This will be followed by Action Item 4a, which is a Vote to Approve the Primary Care Investment Benchmark.

Director Landsberg read HCAI's Land Acknowledgement statement in consideration of it being Indigenous Peoples' Day, Director Landsberg provided the following Executive Updates:

- Acknowledgement of Secretary Dr. Mark Ghaly's recent departure on September 31st as head of the California Health and Human Services Agency (CalHHS), as well as a member and chair of this Board. .
- The Governor appointed Kim Johnson as the new Secretary of CalHHS and the newest member of the board.
- Updates on legislation impacting HCAI that Governor Newsom recently signed into law:
    - AB 2297 expands protections to patients who need financial assistance for hospital bills. The new law will improve access to hospitals' financial assistance programs by prohibiting eligibility time limits, clarifying what can be included in a patient's costs to be waived or reduced, and prohibiting liens on any real property, including homes, to collect unpaid hospital debts.
    - SB 1061 prohibits reporting medical debt to credit reporting agencies and prohibits these agencies from including medical debt on their reports.
    - SB 1447 impacts Children's Hospital Los Angeles and AB 869 impacts small, rural, critical access, and district hospitals, as well as hospital recipients of the Distressed Hospital Loan Program. Both bills allow these hospitals to seek approval from HCAI for a delay of up to three years beyond the 2030 seismic safety compliance deadline if certain criteria are met and HCAI grants approval.
- Governor Newsom vetoed:
    - Legislation giving broad extensions on seismic safety standards to all hospitals.
    - AB 3129 which would have required private equity groups and hedge funds to obtain the Attorney General's written consent at least 90 days prior to acquisitions or changes of control of certain health care facilities, provider groups, and other providers. In his veto message, Governor Newsom noted that OHCA was established to review mergers, acquisitions, and corporate affiliations involving health care entities and to analyze health care consolidation. The message also acknowledges that HCAI can refer transactions to the AG.
    - SB 966 which would have required Pharmacy Benefit Managers (PBMs) to be licensed by the Department of Insurance. PBMs in California must register with DMHC. HCAI and DMHC are reviewing approaches to collect information on PBMs.
- Updates following the August Board Meeting in Monterey:
    - Director Landsberg has directed OHCA staff to commence an investigative study of hospital market competition in Monterey County. The focus of this study is to assess market competition, consolidation, presence of a market failure, and any anti-competitive effects on cost, access and affordability for health care services in the region. OHCA may refer its detailed findings to the Attorney General, who may take further action. OHCA will complete the investigative study by working with economic experts and will publish a report on its findings. OHCA will provide status updates but will not disclose specific information about the study until the report is published.

- HCAI Program Updates:
  - HCAI's Workforce Development Program recently launched a Behavioral Health Transformation webpage, accessible through the HCAI website under "Workforce Initiatives." Behavioral Health Transformation is the effort that will implement the March 2024 ballot initiative known as Proposition 1 and will complement and build on California's other major behavioral health initiatives. HCAI will administer at minimum 3 percent (estimated at $100 million annually) in Prop 1 bond funding for the first-ever sustained and coordinated statewide workforce initiatives to expand a culturally competent and well-trained behavioral health workforce.
  - HCAI staff are currently reviewing the public comments provided for the Healthcare Payments Data Program (HPD) non-claims payment data collection regulations that will govern file specifications for non-fee-for-service payment data, as well as specify other details for data collection. The OHCA team and HPD team are working together to develop a framework for non-claims payment. In addition, at its upcoming HPD Advisory Committee meeting on October 24, staff will share progress and solicit input on HPD's public reporting priorities and share its most recent data reports.

Deputy Director Pegany provided the following Executive Updates:

- Updates on Total Health Care Expenditures (THCE) data collection efforts:
  - In August 2024, OHCA received aggregate Medicare fee-for-service (FFS) expenditure enrollment data from CMS for calendar years 2022 and 2023. This is for the purpose of the baseline report that is required by statute.
  - The Total Medical Expense (TME) data submission deadline for non-Medicaid Managed Care Organization (non-MCO) plans for calendar years 2022 and 2023 data was September 1.
  - As of October 8th, OHCA has received complete TME submissions from 15 submitters, and 2 other submitters have submissions in progress. They are currently conducting data quality assessments and beginning to schedule another round of one-on-one meetings with the payers to review their submissions.
  - In late February 2025, OHCA expects to receive TME files from the Department of Health Care Services (DHCS) for MCO plans.
- Deputy Director Pegany then highlighted an article from Health Affairs that analyzed spending data from Connecticut, Delaware, Massachusetts, Oregon, and Rhode Island.
- Deputy Director Pegany then reviewed the 2025 Board and Advisory Committee meeting dates, which are also available on HCAI's public meeting website.
- Reminder about slide formatting: a yellow arrow indicates that the office has decision-making authority over that item and a green arrow indicates that the board has ultimate decision-making authority over that item.

Discussion and comments from the Board included:

- A member expressed appreciation to the staff for launching the investigation into the issues raised in Monterey, specifically regarding the billing practices. The member asked if there is an estimated deadline for when a report will be ready to be provided to the attorney general.
    - The office advised that they do have a preliminary approach and timeframe, but much of that timeframe is going to be dependent upon the cooperation of the people that they want to speak to or entities from whom they will need documents. If all goes well, they expect the report to be ready in about six-to-nine months.
- A member briefly thanked Secretary Ghaly and welcomed Kim Johnson, specifically thanking Kim Johnson for her work on the implementation of the Asian and Pacific Islander (API) equity budget.
- A member acknowledged the variation in health care spending when looking at Rhode Island, Massachusetts and Connecticut, which are all adjacent to each other yet are smaller than California when combined. There may be lessons to learn from that as our own data is being reviewed. In thinking of future discussion on sector targets, a geographic breakdown might be particularly insightful.
    - The Office responded that OHCA has collected regional total medical expense files by Covered California rating regions. They will be able to review the variation and get into more granular types of analysis. They further stated that Rhode Island is different from the others, as they have an existing price cap on the hospital rate of growth. However, they will continue to look at those variations and are hoping to soon have a tailored approach for California.
- A member shared news that some of the Monterey hospitals made an announcement that they would be taking steps to lower their costs. They requested if the Board could obtain copies of the hospitals' plan for that.
    - The Office stated that the Community Hospital of the Monterey Peninsula (CHOMP) submitted a letter to the Board that outlined some of their steps. That letter is in the Board packet. They do not have any information regarding the other announcements. CHOMP did identify 50 million dollars in cost savings initiatives but stated that they would follow up with more details on the specifics later. The Office will work on obtaining specifics.
- A member expressed disappointment with the recent veto of AB 3129 that Assembly Member Wood had moved forward. They asked whether OHCA has the capacity to address those issues.
    - The Office replied that while all three of the Assistant Deputy Directors are continuing to fill their team, the Office is confident that they have the staff capacity to address those issues. The Office further stated that part of their existing workload includes looking at transactions that involve private equity; the recently revised regulations better capture such transactions.
- A member stated that they are looking forward to the conversation later today covering the sector's specific targets. They believe it is important to move towards those targets as quickly as possible, consistent with the many demands of the Office.

- A member expressed interest in a deeper dive with the folks from Massachusetts to understand the dramatic rate and spend that they experienced in 2022 beyond what is shared in the health affairs article.
    - The Office responded that they had invited some states to speak to the Board over a year ago, so they could reach out to request another conversation with them.

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

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

a) Approval of the August 28, 2024 Meeting Minutes

Deputy Director Pegany introduced the action item to approve the August meeting minutes.

Board member Ian Lewis motioned to approve, and Board member Richard Kronick seconded.

Public Comment was held on agenda item 3a. No public comment was made.

Voting members who were present voted to accept. There were 5 ayes, 1 absent and 1 abstained. The motion passed.

Agenda Item #5: Informational Items (out-of-order) and Agenda Item # 4: Action Items
Margareta Brandt, Assistant Deputy Director, HCAI

a) Update on Primary Care Definition and Investment Benchmark

Assistant Deputy Director Brandt provided an update on the proposed primary care definition and investment benchmark. She also introduced Mary Jo Condon from Freedman HealthCare who was present to assist with answering questions.

Discussion and comments from the Board included:
- A member stated that he is happy to see rather than spending an extra dollar in hospitals, some portion of spend will be invested into primary care. However, without a mechanism in place to direct that, the member is unsure how that is going to happen.
- A member asked if the Office knew whether Rhode Island had additional teeth to direct some of their investment in primary care. He also inquired whether there is evidence that additional investment in primary care has resulted in overall improvements in population health.

- Mary Jo Condon replied that Rhode Island did have a gradual 1% increase per year in primary care spending while also implementing price growth limits. Their price growth limits essentially say that hospital costs cannot increase more than the Consumer Price Index (CPI) plus one on an annual basis. That worked for a long time until CPI went up very high. Delaware also has that same requirement in place. One thing that is a bit unique about Delaware, Colorado, Rhode Island, and Oregon is that they all have a primary care investment requirement, so there is something in regulation and/or statute that gives them that little bit of extra teeth to push that forward. Rhode Island and Delaware have a defined offset, which is a specific policy mechanism in place to offset the increased investment of primary care. Colorado does not have that defined offset, and its insurance commissioner's regulatory authority may be used in ways that are not visible publicly. In Oregon, a lot of the cost pressure comes through contracts that they have with Medicaid Managed Care Organizations, in which those contracts are supposed to simultaneously increase this primary care investment while not increasing total costs. One thing that Rhode Island has in place that has been incredibly helpful is a strong statewide buy-in into the idea of increasing primary care investment and a lot of voluntary, multi-stakeholder collaboration that is convened by a non-governmental organization called the Care Transformation Collaborative. Many of the state purchasers here in California have come together to work together on similar initiatives.

- A member stated that while there is a desire to increase the overall percentage of primary care, consideration needs to be given to the sickest population's access to advanced primary care, as that will be where the greatest opportunities for cost savings are. While there is no specific enforcement mechanism at this time for these primary care benchmarks, there could be benchmarks created in a future corrective action plan. If someone were to exceed their cost target, would the Office look at that as a tool to try to push a plan or risk-bearing organization to increase their primary care spend?
  - The Office responded that there are two main tools for enforcement; the first tool is transparency, and the other is that if an entity exceeds their spending target and has not hit their primary care benchmark, then that may be included in their performance improvement plan.
- A member expressed concern regarding exclusion of OB/GYNs from the primary care provider definition. Although OB/GYNs are considered a primary care provider, they would not contribute to the primary care spend, which could lead to entities pushing people away from choosing an OB/GYN as their primary care provider if they are not meeting their target, because the care from OB/GYNs would not be counted as primary care spending. Policy makers have been debating whether OB/GYNs are considered primary care providers, but if we give an active disincentive to choose an OB/GYN as primary care providers that could have a disproportionate effect on women. If OHCA were to include OB/GYNs, would the over-count be large?
  - The Office advised that they had many questions about this as well, which led to very in-depth conversations. Part of the problem is the data challenge that

including OB/GYNs would present. They are committed to revisiting this issue in a year once they're able to conduct the Health Care Payments Database (HPD) analysis. This in no way undermines the value that the Office places on the work and services provided by OB/GYNs. This will be an important ongoing conversation. As they continue to focus on whole-person, coordinated, comprehensive care, many services provided by OB/GYNs do not meet that standard. If OB/GYNs were to be included, then all office visits and all evaluation and management codes billed by OB/GYNs would count towards the primary care investment spending, which could potentially lead to overcounting. Also, if entities were to push women away from choosing OB/GYNs as their primary care provider, that would be a very serious violation of the Knox Keene Act, which would not be tolerated.

- A member complimented the presentation and recommended that the Office annually publish primary care spending to reveal those who are moving at a faster pace than the minimum standard of 1% per year.
    - The Office responded that the intent is to annually publish primary care spending by payer, line of business, and product type and show those that are meeting the 0.5% to 1% annual investment benchmark. This includes both their primary spending level and whether they have met or exceeded it.
- A member asked if the Office will be looking at the implications of increased investment for primary care practices. It would be helpful to see what happens when practices get resources and technical assistance.
    - The Office stated that an evaluation of the impact of investment on primary care practices would need to be done in collaboration with purchasers, providers and payers, and the Office is happy to continue that discussion.
- A member asked for clarification about the data collection difficulties related to including OB/GYNs, stating that Oregon does include them in their definition of primary care. The member asked what the issues are with what Oregon has done and why would that not work here in California. Regarding the difficulties around non-claims payment, the member felt those are relatively minor. The member is not aware of the billing practices of OB/GYNs in California, but in other states all the billing for pregnancy related services is global billing. The member asked for a more detailed description of the problems and a clearer path forward. Many OB/GYNs do not provide primary care, but some do, and figuring out the path to measure that would be helpful moving forward.
    - The Office responded that among the states that measure primary care spending, many of the definitions do include OB/GYNs, some exclude them completely, and some count OB/GYNs as primary care but have a more limited set of services. This is what could cause data complexity. If they were to create one definition of primary care spending for all other designated primary care providers and then one definition of primary care spending for OB/GYNs that includes a more limit set of services, that would cause data complexity in terms of collecting spending in two definitions from payers.
    - A member followed up on this, asking what would be wrong with simply applying the current definition to OB/GYNs.

    - The Office clarified that doing so could potentially cause an overcounting of the primary care spend. More specialized care, office visits that are intended to treat more specialized OB/GYN conditions for women, would be over counted if OHCA were to include OB/GYNs in the current definition. For example, if an OB/GYN were to conduct a depression screening, a violence screening, a pap smear, those are all preventative services. However, if an OB/GYN is treating a patient with uterine fibroids, that would not fall under primary care. They would have to set up a different set of rules for what services count as primary care for OB/GYNs than they would for primary care providers.
- A member commented that the vision for primary care is to get patients who have complex chronic conditions more timely access to primary care. While there are OB/GYNs who do some comprehensive care, the majority do not. The member appreciated OHCA's plan to revisit this decision based on HPD data and supports OHCA staff's recommendation. The National Academy of Medicine has a full report on primary care that identifies primary care providers, and it does not include OB/GYN providers. This helps to inform the Office of how they're going to measure California against other states. The ultimate goal is for those with complex conditions to receive integrated, comprehensive, whole-person care, which is largely provided by the primary care providers that have been identified in the recommendation.
- A member suggested collecting data for a definition that includes OB/GYN and compare it to the definition without OB/GYN, to quantify the over-count or under-count.
    - The Office responded that currently the proposal is to collect primary care spending data from payers as a subset of their total health care spending data submissions using OHCA's proposed definition, which currently excludes OB/GYNs, and conduct a more detailed analysis of the types of care and services that OB/GYNs provide using the HPD. That analysis will reveal what portion of their services include comprehensive chronic condition management and related services. They will not be asking payers to provide two separate sets of data, as that would be burdensome both for the payers and the Office.
- A member clarified that the Office is proposing to differentiate the expectations by product line. If there is a lower primary care spend on the PPO side, the expectation is commensurate progress, starting with a lower benchmark. The member then suggested staggering the expectations to allow for more comparable data over time. For example, if OHCA expects a one-point improvement on the PPO side, then a quarter-point improvement should be expected in an integrated system or HMO, so that over time the PPO catches up and can be more comparable over time.
- Another member agreed that paying attention to the differences across product types for PPOs and HMOs makes sense both on level and rate of growth. The member further recommended paying attention to differences across population types. The primary care spending for children will likely always be larger than that for adults. On the Medi-Cal side, there is a much lower fraction of spending for

people with disabilities and they should not expect that to ever be equal. It is important to pay attention to those differences to understand them better and not expect everything to be equal.
    - A member stated that, as they look at the different populations, they must recognize that setting a percentage goal will not work globally. People with disabilities have a higher need for non-primary care services, and children have a larger fraction of spending on primary care than adults, so a more sophisticated approach for subpopulations may be more beneficial. The goal is to build a certain level of infrastructure for primary care to do care coordination for those with greater needs who will still need care from specialists.
- A member commented that purchasers are starting to think a lot about the difference between high-value and lower-value primary care and paying accordingly. There have been great strides made in this space with some terrific results. They are also thinking about what their expectations should be in terms of return and building that into contracts. As they continue down that road as payers, it is going to be important to have communication between the payers and OHCA.
    - The Office responded that a next step after the data analysis and publishing the report would be for the Office to meet with the payers who are performing well to find out what their primary care strategy is and what specific models they are implementing. The Office could then highlight those at a Board meeting, like the presentations on cost-reducing strategies.

Agenda Item #4: Action Items

a) Vote to Approve Primary Care Investment Benchmark

Assistant Deputy Director Brandt introduced the action item to vote to approve the primary care investment benchmark. She clarified that this motion is specifically to approve the benchmark investment, which includes the change year over year and the 15% total by 2034.

Ian Lewis moved to approve the recommendation. Rick Kronick seconded.

- A member asked that the motion be divided into two parts: One for the benchmark percentage, and the other for the primary care definition.
    - The Office clarified that the definition is an Office decision, not a Board decision. The benchmark is the Board decision.

Public Comment was held on agenda item 4 and 5a. Eight members of the public provided comment.

Voting members who were present voted to approve. There were 5 ayes, 1 absent, and 1 abstained. The motion passed.

Agenda Item #5: Informational Items
Margareta Brandt, Assistant Deputy Director, HCAI
Sheila Tatayon, Assistant Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI
Vishaal Pegany, Deputy Director, HCAI

b) Update on Cost and Market Impact Review Program

Assistant Deputy Director Tatayon provided an update on the Cost and Market Impact Review (CMIR) Program and stated that the Office will provide an update on this item quarterly.

Discussion and comments from the Board included:

- A member asked for a reminder about the role and authority that the Attorney General (AG) has.
  - The Office replied that the AG monitors transactions of nonprofit health care entities. When the acquirer is a nonprofit entity, they must file with the AG's office rather than with OHCA. When transactions are filed with OHCA, OHCA can refer the transaction to the AG's office without having to wait until OHCA has completed their review of the transaction. The AG then has the discretion to act or not. The AG's office can act based on state antitrust laws, federal antitrust laws, and general unfair business practices. OHCA will update the Board when that occurs to the extent that they are able.
- A member asked if there are other transactions, aside from the Carelon CareMore transaction, which have not yet had a CMIR waived and are being considered.
  - The Office responded that they do have one where the notice from a skilled nursing facility is not complete yet because there is some outstanding information that is due.
- A member recalled a previous discussion about this process and an expectation that the Office would receive a larger number of transactions due to California's size and asked whether the Office is surprised by what seems to be a relatively small volume of transactions or if that number is what was expected.
  - The Office stated that they are not surprised by the number of transactions received because they know that there was a lot of merger and acquisition - activity in the first quarter of 2024. They know that there were some very large deals that were completed prior to April 1st because the statute went into effect on that date. Following that, they have seen a lull in merger activity. They are working with their sibling state departments to monitor some transactions, and they have reached out to entities that they believe should file with them. The Office expects to see an uptick in transactions, particularly due to the revision of their regulations. If an entity should have filed with

OHCA but did not, they would refer that to the AG as it would be a violation of OHCA's statute. Those may not go all the way to litigation and could be a matter of the AG sending a demand on OHCA's behalf that the entity does file.

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

c) Discussion of Office of Health Care Affordability's Statutory Authority to Address High Costs, Continued

Deputy Director Pegany introduced the discussion topic of OHCA's Authority to Address High Costs, which is a continuation of the discussion from the last meeting in Monterey.

Vice Chair Hernández facilitated the discussion. Discussion and comments from the Board included:

- A member commented that there is a case to be made to have a particular sector defined for at least three hospitals in Northern Monterey County. He suggested that they move forward with this in the short term as they shape a more comprehensive approach to what other sectors they may want to look at. Following the testimonies heard in Monterey, they do have some important benchmarks for what appropriate costs should be. As flawed as Medicare's reimbursement methodology may be, it is a benchmark. He does not recall hearing testimony that Medicare reimbursement was insufficient to cover reasonable costs for hospitals in this state, but there is a number at which that must be the case. He would welcome the opportunity to set a target as close to zero as possible as soon as the next meeting for the three hospitals in Monterey. He asked the Office to consider what an appropriate reimbursement threshold and appropriate spending threshold should be.
    - Another member responded that evidence has revealed that hospitals should be able to effectively manage costs at 160% of Medicare, as Medicare costs are supposed to reflect the cost of the service by law. Even if they set the threshold at 200%, that seems entirely reasonable.
- A member stated that one of the sectors that was discussed, and the Office, should perhaps lead with is geography, particularly the Covered California regions. The geography and economic diversity of the state is important to consider.
    - The Office responded that the definition of sector is broad in the statute. There are a few examples provided for geographic regions, fully integrated delivery systems, and individual health care entities. They have included some representative categories for provider organizations, which could be hospitals or physician organizations, categories of payer markets, which could be Medicare, Medi-Cal, or commercial, and individual health care entities.
- A member commented that health systems should be included in the statute as an entity in the long-term. That is an area where progress can and should be made.

- A member agreed with another member's earlier point of adopting a sector target at the next meeting and encourages the Board to move as quickly as possible in that direction. They suggested looking at what would happen if they were to adopt targets for the 10% of hospitals in the state that have the highest private to Medicare payment ratio. Perhaps the Board can adopt special targets for the three hospitals in Monterey.
- A member stated that in a lot of the places where they see high prices there is only one hospital that is in a more challenging circumstance than what they see in Monterey. They do agree that thinking of this in global terms is the right thing to do. Monterey is a primary focus after hearing testimony there from people whose lives were ruined because they went to a hospital. However, the Office needs to be looking more broadly because Monterey is not the only problem area in California. They mentioned that in Monterey there is an interrelation between the hospitals and medical groups that operate as sort of quasi systems. They noted that, in reviewing the CalPERS numbers in Monterey, the numbers were slightly below average on the professional services side and very high on the hospital side. However, the hospitals own or are affiliated with the major medical groups in that area. Referral patterns are likely to be a contributing factor in the high overall costs in places like Monterey. It is critical that the Office think about those dynamics when looking at areas.
- A member recommended that the Office consider whether to look at the situation in Monterey as a hospital sector in that geographic area, which uses two of the criterions, or to look at the county to understand these interactions. The member also stated that it would be interesting to see how primary care works there. The member encouraged the Office to use this statutory authority to bring the Board a recommendation about how to address this situation.
- A member suggested that the Office begin the approach by looking at the geographic sectors, and then focus on specific geographic sectors to further identify specific targets such as hospitals, entities, and provider groups.
- The Office advised that they will be taking all this feedback into account as they plan for future board meetings. They do still need to socialize a method for measuring hospital spending. Last January, Freedman HealthCare consultants provided a presentation to the Board about the limitations with spending attribution approaches. However, the Office needs to think beyond attribution for measuring hospital spending. They do have a provisional measurement approach that they've been working on with the hospital spending measurement workgroup, which is something that needs to be socialized with the Board and the public. That is an active work stream as they consider potential planning for sector targets. That workgroup is one that OHCA has convened to provide input and recommendations to the Office for developing a methodology. There cannot be a sector target on hospitals until there is a way to measure their spending.
- A member asked whether a fully integrated delivery system would be a subsector of the geographic sector or would it stand aside as its own sector.
    - The Office responded that a fully integrated delivery system has its own definition in the statute. However, they could do sector targets for fully integrated delivery systems. For example, there could be different values for

Kaiser North versus Kaiser South. However, fully integrated delivery systems can only be subject to one target at a time. The Office will circle back on this question.

- The Office reiterated the steps that need to be taken to set sector targets. The Board would need to provide the Office with direction on the sector targets. The Office would then define the sector through rulemaking. After defining sectors, the Board could then set the target in the spring.
  - A member asked for clarification regarding what the Board would need to clarify to get that regulation process started.
  - The Office presented a slide that explains the timeline for establishing a sector definition and targets.
- A member inquired about the administrative entities that contribute to cost. Would a qualified entity be a Pharmacy Benefit Manager or a health plan? Would those fall under a sector?
  - The Office replied that PBMs are not expressly defined as a health care entities in the statute. They can be considered under the payer definition, but that would need to be further explored in terms of what they would be held accountable to. The statute is focused on spending growth. A plan could be its own sector if they wanted to focus on items such as small group plans or individual market plans. OHCA will also be reporting on administrative costs and profits for plans as part of reporting on total health care spending.

Public Comment was held on agenda item 5c. Three members of the public provided comment.

Agenda Item #6: General Public Comment

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

Agenda Item #7: Adjournment

Vice Chair Hernández adjourned the meeting.