



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, September 23, 2026
10:00 am

Members Attending: Secretary Kim Johnson, Dr. Sandra Hernández, Richard Kronick, Ian Lewis, David Chase, Dr. Mikah Owen, Dr. Richard Pan, Don Moulds

Members Absent: None

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; CJ Howard, Assistant Deputy Director, HCAI; Andrew Feher, Research Scientist Manager, HCAI; Ty Christensen, Health Program Audit Manager II, HCAI; Brian Kearns; Assistant Chief Counsel, HCAI

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

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

Secretary Kim Johnson, Chair

Chair Johnson opened the September 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 and announced that agenda item 4a, the presentation on Cost-Reducing Strategies by Rady Children's Health Orange County, had been postponed to a future meeting.

Director Landsberg provided Executive Updates, including the following:

- An overview of the Data Exchange Framework, which supports both high-value and lower-cost health care systems, aligning with the Health Care Affordability Board's goals.
 - HCAI is conducting statewide outreach to ensure that all organizations required to sign the data agreement comply with the requirements established by Senate Bill 660.

- By January 1, HCAI is required to publish a list identifying all entities required to sign the data agreement, including those that signed and those that did not.
- An advisory committee meets bi-monthly to develop recommendations for additional accountability measures and best practices mandated by the statute.
- The state allocated \$66 million in funding to support access to gender affirming care and reproductive health care . Funds included \$30 million for uncompensated reproductive and gender-affirming care, \$10 million for youth-specific services, and \$26 million to bolster the statewide provider network for gender affirming care
- HCAI recently released an RFI seeking partners to serve as third-party administrators for these grant programs.

Deputy Director Pegany provided Executive Updates, including the following:

- HCAI has posted its 2027 Health Care Affordability Board and Advisory Committee calendar of meeting dates on its webpage.
- An overview of a recent JAMA article that examined the extent to which growth in fully insured commercial health care spending contributed to growth in fully insured commercial premiums from 2011 to 2024.
- Earlier this month, OHCA posted a preliminary facility-level crosswalk for fiscal years 2023 and 2024 to support its hospital measurement work. Hospital contacts were asked to review and verify the assignment of National Provider Identifiers (NPIs) to hospital license numbers and provide feedback by October 9, 2026. More than 25 facilities have provided feedback to date.
- OHCA published a Cost Driver Issue Brief using the Health Care Payments Data (HPD) to examine commercial price variation for shoppable health care services.
- An update on payer annual data submissions indicated that 40 of the 52 submitters have completed their submissions. Of the twelve remaining submitters, seven have received approved extensions, and OHCA is working with the remaining five to resolve technical issues.
- A reminder about slide formatting.

Discussion and comments from the Board included:

- A member noted that, in addition to reducing costs, the data exchange network could ease the burden on patients of transferring information between providers, particularly for those with multiple chronic conditions.
 - The Office agreed, noting that the goal is to improve patient care, reduce unnecessary duplicate services, and help ensure that providers have access to the information needed to understand a patient's health care history.
- A member asked whether administrative costs borne by providers, such as staff time associated with prior authorization requirements, are included in health care spending or are separately identified in the data.
 - The Office replied that administrative costs incurred by providers are included in medical costs and are not reported separately.

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

Agenda Item #3: Action Consent Item

Vote to Approve August 26, 2026 Meeting Minutes

Vishaal Pegany, Deputy Director, HCAI

Deputy Director Pegany introduced the action item to approve the August meeting minutes. Board member Hernandez moved to approve. Board member Kronick seconded the motion.

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 seven ayes. The motion passed.

Agenda Item #4: Informational Items

b) Spending Target Enforcement – Target Values for PIP Implementation and Follow-up on Feedback from Enforcement Workshop

Vishaal Pegany, Deputy Director, HCAI

CJ Howard, Assistant Deputy Director, HCAI

Deputy Director Pegany and Assistant Deputy Director Howard provided an update on target values for Performance Improvement Plan (PIP) implementation and follow-up on feedback received during the Enforcement Workshop.

Discussion and comments from the Board included:

- A member sought clarification on the rationale for holding an entity to the 3.5% target used in the hypothetical scenario, particularly if the entity could satisfy the PIP without achieving the target. The member also questioned why a lower target could not be applied in a subsequent year.
 - The Office explained that the statute contemplates a progressive enforcement process intended to bring an entity into compliance with the spending target it originally exceeded. Applying a lower target through the PIP would therefore be inconsistent with the Office's interpretation of the statute.
- A member expressed concern that spending above the target becomes part of the entity's higher baseline in subsequent years and is not recovered for consumers.
 - The Office noted that spending target penalties could potentially address excess spending if an entity does not come into compliance. The Board could also consider adjusting an entity's target.
- A member asked whether a PIP could incorporate a target higher than the target the entity originally exceeded.
 - The Office explained that the original target represents the minimum target that can be incorporated into the PIP, but a higher target established by the Board could apply if circumstances warrant.
- A member expressed concern that the proposed framework could incentivize entities to repeatedly increase their spending baseline, resulting in higher spending being

incorporated into future targets. The member noted that such an approach could place greater importance on the use of penalties to promote compliance.

- A member sought clarification on how compliance with a PIP would be determined, including whether compliance would be based solely on meeting the applicable spending target or could also consider process measures and an entity's implementation of the PIP.
 - The Office explained that it will be developing PIP guidance and accompanying regulations which are expected to be discussed at the next Board meeting. The Office added that an entity that meets the agreed-upon SMART goals would be compliant with the PIP, whether or not the entity meets the spending target.
- A member emphasized the importance of carefully developing and approving PIP SMART goals, noting that the goals are intended to serve as a means of achieving the spending target. The member added that an entity could satisfy all its SMART goals and successfully complete the PIP while still exceeding the spending target.
 - The Office acknowledged the concern, noting that the goals, structure, and components of PIPs will be critical to effectively implementing the statutory requirements.
- A member noted that SMART goals may help position an entity to meet future spending targets but do not necessarily ensure that the targets will be achieved. The member expressed concern that an entity could implement the initiatives required by its PIP and satisfy its SMART goals while still making financial decisions that result in spending above the target.
 - The Office replied that the entity would not meet its spending target in this case.
- A member asked whether meeting the applicable spending target could itself be included as a PIP goal, thereby linking compliance with the PIP to achievement of the spending target.
 - The Office noted that this could be duplicative of existing statutory requirements but agreed to further consider the issue.
- A member questioned why an entity's target could be increased during the course of a PIP if the Board raises the target, while the original target would remain in place if the Board lowers it. The member suggested that, for consistency, the target established at the beginning of a PIP should remain unchanged throughout the PIP.
 - The Office explained that applying a lower target to an entity through a PIP when the Board has established a higher target for all entities in the same year could create concerns about program consistency. The Office noted that the issue arises because spending targets vary by year and would not present the same concern if target values remain the same.
- A member sought clarification on whether an entity could be subject to a spending target different from the broader industry target during the PIP process.
 - The Office clarified that entity-specific targets would not be established through the PIP process but could be adopted by the Board through the target-setting process.
- A member questioned why the target applicable to a PIP would need to change from the original target the entity exceeded, suggesting that the original target remain in place for the duration of the PIP.

- The Office explained that the issue arises when the spending target in effect at the end of a PIP differs from the target the entity originally exceeded. Because the statute provides for penalties only when an entity fails to comply with both its PIP and the spending target, the Office must determine which target applies when evaluating compliance.
- A member reiterated the suggestion that the original spending target the entity exceeded remain the applicable target for purposes of evaluating compliance at the end of the PIP.
 - The Office acknowledged that retaining the original target is an option but noted that this could create inconsistencies if the Board subsequently establishes a higher spending target. The Office explained that it is seeking the Board's input on whether an entity should continue to be held to a lower target through its PIP when the target applicable to other entities has increased.
- A member sought clarification on how the annual enforcement process would interact with an ongoing PIP as the entity moves into subsequent performance years.
 - The Office confirmed that enforcement is evaluated separately for each performance year.
- A member sought clarification on whether a new PIP would be implemented within the three-year time frame or whether changes would be made to an existing PIP.
 - The Office replied that an entity could undergo a PIP process once and subsequently be required to implement another PIP for a different calendar year. The decision to prioritize the entity for another PIP would depend on the factors driving its spending, which could be the same as or different from those addressed in the prior PIP.
- Another member agreed that such changes can take time but reiterated that implementing structural changes alone may not be sufficient to control spending if an entity subsequently increases prices.
- A member recommended that each PIP include a quantification of the financial impact of spending above the target, in addition to the SMART goals. The member noted that when excess spending is incorporated into an entity's future baseline, understanding the ongoing dollar impact would help the Board and the public monitor its effects on the market and future target setting.
- A member sought clarification on how subsequent PIPs would relate to prior PIPs when an entity exceeds the spending target in multiple, nonconsecutive years. The member suggested that, because organizational change may take time, subsequent PIPs could build on the progress and changes made under earlier PIPs.
 - The Office confirmed that an entity could be required to implement a subsequent PIP for a different performance year. The Office explained that each year would be evaluated separately and that the decision to prioritize an entity for another PIP would depend on the factors driving its spending, which could be the same as or different from those addressed in the prior PIP.
- A member noted that an entity enters the PIP process because it exceeded the spending target in effect at that time, while subsequent changes to the statewide target reflect broader market conditions rather than the circumstances of an individual entity. The member suggested there may therefore be a rationale for

continuing to hold an entity to the original target if it does not comply with its PIP. The member also raised the question of whether the degree to which an entity exceeds the target should be considered in determining the appropriate enforcement response.

- A member suggested structuring PIP SMART goals as interim steps toward achieving the spending target, particularly for entities that may require significant operational changes before they can meet the target. The member noted that an entity could initially be required to implement structural changes, such as developing the capacity to participate in value-based payment arrangements, followed by achievement of the spending target in a subsequent year. The member emphasized that completing SMART goals without ultimately reducing spending growth could limit the effectiveness of the PIP.
- A member emphasized the importance of considering significant federal policy changes, including reductions in federal funding for the health care system, when evaluating potential penalties, particularly for entities serving Medi-Cal populations.
 - The Office noted that the impact of federal policy changes may vary by entity based on factors such as payer mix. An entity would need to provide specific data demonstrating the impact on its operations for the Office to evaluate whether those circumstances should be considered in enforcement. The Office also noted that revenue losses associated with public payer coverage do not necessarily justify offsetting those losses through higher commercial spending.

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

c) Follow-up Request on Hospital Measurement – Combining Inpatient and Outpatient Spending Measures and Issues Related to Volatility in Hospital-Reported Net Patient Revenue

Vishaal Pegany, Deputy Director, HCAI

CJ Howard, Assistant Deputy Director, HCAI

Andrew Feher, Research Scientist Manager, HCAI

Deputy Director Pegany, Assistant Deputy Director Howard, and Andrew Feher provided an overview of the proposed approach for combining inpatient and outpatient spending measures and issues related to volatility in hospital-reported net patient revenue.

Discussion and comments from the Board included:

- A member raised concerns about potential unintended consequences and incentives created by the methodology, including whether it could discourage efforts to improve efficiency by shifting care from inpatient to outpatient settings. The member also asked whether average visit intensity is a standardized, widely used measure and how it is calculated.
 - The Office explained that the HPD is used to calculate outpatient visit intensity because hospital financial data reports the number of outpatient visits but does not account for differences in the complexity or intensity of those visits. The

measure uses ambulatory classification weights to distinguish among different types of outpatient services. The Office is also seeking feedback from hospitals on National Provider Identifier (NPI) mapping to ensure that claims are accurately attributed to facilities. The Office noted that inpatient and outpatient growth would continue to be reported separately, even if they are combined for purposes of calculating facility-level market growth rates.

- A member cautioned that the methodology used to calculate average visit intensity could significantly affect the outpatient measure and should therefore be carefully evaluated, particularly because it is not a widely standardized measure. The member expressed support for developing a combined measure but emphasized the need to assess potential unintended consequences, including opportunities for variation or manipulation in how outpatient visit intensity is determined.
 - The Office clarified that the outpatient visit intensity calculation uses Centers for Medicare and Medicaid Services (CMS) weights for Ambulatory Payment Classification (APC) categories, providing a standardized approach to weighting outpatient services.
- A member requested clarification on which components of the analysis did not rely on the HPD.
 - The Office explained that five of the six measures rely exclusively on hospital-reported data, including all inpatient measures. For the outpatient measures, hospital-reported outpatient revenue and visit data are used, while the HPD is used to calculate average visit intensity.
- A member suggested considering minimum volume or percentage thresholds when applying measures by line of business, particularly when a line of business represents a very small portion of an entity's patient population.
- A member asked whether hospital revenue could be attributed to the period in which care was provided rather than when payment was received, noting that differences in the timing of care and payment could potentially contribute to fluctuations in reported financial data.
 - The Office explained that hospitals have some accounting discretion within Generally Accepted Accounting Principles (GAAP). It noted that changes in consultants or report preparers can result in different approaches to calculating contractual adjustments, which can produce significant year-to-year fluctuations in reported net patient revenue. The Office also identified reporting errors as another potential source of fluctuations in hospital revenue data and noted that the prevalence of such errors is unknown.
- A member noted a potential disconnect between standard financial reporting practices and OHCA's need to measure health care spending for affordability purposes. The member observed that differences in when services are provided and revenue is recognized may contribute to fluctuations in the data and emphasized the importance of considering these accounting factors when interpreting hospital financial information.
- A member requested additional information about HCAI's stakeholder engagement process, including any preliminary findings regarding potential changes to the measures being considered.

- The Office explained that hospital financial reporting generally uses accrual accounting, which can create volatility in reported revenue. The Office is considering ways to increase transparency into deductions from revenue and separately identify certain payments, including supplemental payments, to reduce the impact of this volatility on the measures. HCAI is working to improve the clarity and transparency of its reporting guidance, including providing additional guidance on accounting practices and requiring hospitals to report inpatient and outpatient net patient revenue separately. HCAI is working with a national CPA firm to develop the guidance and will seek stakeholder input on identified reporting challenges.
- The Office further clarified the stakeholder process, explaining that HCAI plans to engage directly with hospital accounting professionals, including controllers and CFOs, to identify challenges with current reporting requirements and gather input on potential improvements. A national CPA firm will evaluate proposed changes for feasibility and compliance with GAAP.
- A member suggested examining hospital spending data over a five-year period to determine whether significant year-to-year fluctuations balance out over time and to provide additional context for interpreting the results. The member also recommended analyzing the HPD using allowed charges per CMAD and outpatient adjusted visits to assess whether those measures provide greater stability and reliability. As a longer-term consideration, the member suggested exploring California-specific or payer-specific weights as alternatives to Medicare-based weights for inpatient case mix and outpatient visit intensity.
 - The Office noted that a multi-year analysis would be more feasible for inpatient measures given available data, while extending the outpatient analysis further back could introduce measurement error due to challenges matching NPIs across fiscal years. The Office agreed to explore whether claims data from the HPD could be used to replicate certain measures and potentially provide more stable year-to-year results than hospital-reported financial data.

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

d) Examining Regional Variation in Commercial Prices for Shoppable Services and Projected Savings from Reference Pricing

Andrew Feher, Research Scientist Manager, HCAI

Andrew Feher provided an overview of regional variation in commercial prices for shoppable services and projected savings from reference pricing.

Discussion and comments from the Board included:

- A member presented three approaches to encouraging the use of lower-cost services:
 1. Under reference pricing, the payer establishes a maximum payment amount, which can encourage higher-cost providers to lower their prices with minimal impact on patients.

2. A site-of-service approach limits coverage based on where a service is performed, such as covering services at an ambulatory surgery center while requiring patients to pay the additional cost of receiving the service in a hospital setting.
3. An incentive-based approach reduces or eliminates patient cost sharing for using lower-cost providers and may be preferable for services that should not be discouraged.

The member noted that site-of-service approaches require monitoring and appropriate exceptions, while financial incentives can reduce overall savings. The member also raised potential limitations on patient steerage in the insured market under the Knox-Keene Act.

- A member asked whether reference pricing resulted in lower-cost providers increasing their prices toward the established reference price, in addition to higher-cost providers lowering their prices.
- A member commented that they were not aware of evidence that lower-cost providers had increased their prices in response to the reference price.
- A member asked whether the Office had examined the experiences of other states that have implemented similar reforms.
 - The Office explained that similar reforms have generally been implemented within state employee health plans, citing Oregon and CalPERS as examples. The Office noted that other states are exploring broader approaches, but that many are in earlier stages of implementation. The CalPERS experience provides a longer period of data for evaluating potential savings and patient outcomes.
- A member sought clarification on whether the estimate that shoppable services represent more than 9% of claims spending reflects the market after excluding Kaiser and CalPERS. The member noted that these exclusions represent a significant share of the commercial market in some regions and asked how similar reforms might apply to Kaiser given its capitated payment model.
 - The Office explained that it is unclear how reference pricing could be applied within Kaiser's closed system, where members generally receive care from Kaiser providers and do not have access to a broader network of providers with varying prices.
- A member expressed concern about relying on health plans to replicate the CalPERS approach through incentives or penalties that influence patient behavior. The member also raised concerns that such strategies could discourage needed care and noted challenges for patients in obtaining price information and understanding the relationship between price and quality. The member contrasted this approach with reference pricing models used in some European countries, where prices are negotiated and applied more broadly across payers.
- A member expressed greater optimism about the potential for reference pricing, noting that the initial CalPERS experience primarily resulted in higher-cost hospitals reducing their prices rather than patients paying more. The member suggested that similar effects could occur with broader implementation for certain services.

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

e) Cost and Market Impact Review – Quarterly Update

Brian Kearns, Assistant Chief Counsel, HCAI

Assistant Chief Counsel Kearns provided an overview of the Cost and Market Impact Review Quarterly Update.

The Board did not provide any comments or engage in discussion on this item.

Public comment was held on agenda item 4e. No members of the public provided comments.

Agenda Item #5: General Public Comment

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

Agenda Item #6: Adjournment

Secretary Kim Johnson, Chair

Chair Johnson adjourned the meeting.