Department of Health Care Access and Information
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NOTICE OF PUBLIC MEETING:
HEALTH CARE PAYMENTS DATA PROGRAM (HPD) ADVISORY COMMITTEE

July 23, 2026
APPROVED MEETING MINUTES

Members Attending: Ken Stuart, California Health Care Coalition; Charles Bacchi, California Association of Health Plans; Kiran Savage-Sangwan, California Pan-Ethnic Health Network (CPEHN); William Barcellona, America's Physician Groups; Emma Hoo, Purchaser Business Group on Health; Cheryl Damberg, RAND Corporation; Amber Ott, California Hospital Association; Joan Allen, Service Employees International Union-United Healthcare Workers West; Janice Rocco, California Medical Association; Steffanie Watkins, Association of California Life and Health Insurance Companies

Members Attending Virtually: Barrie Cheung, PerformRx

Members Not in Attendance: John Kabateck, National Federation of Independent Business

HPD Advisory Committee Ex-Officio Members Attending: Michael Valle, Department of Health Care Access and Information (HCAI); Dr. Linette Scott, California Department of Health Care Services (DHCS); Isaac Menashe, Covered California

Presenters: Scott Christman, Chief Deputy Director, HCAI; Michael Valle, Assistant Director, HCAI; Christopher Krawczyk, Chief Analytics Officer, HCAI; Dionne Evans-Dean, Chief Data Programs Officer, HCAI; Anthony Tapney, MBA, Assistant Branch Chief, HCAI; Anna Dito, Cost Transparency Section Manager, HCAI; Anna Kriuchkova, MSc, Research Data Specialist II, HCAI; David Winston, MSc, Research Data Specialist II, HCAI; Jasmine Neeley, Supervisor I, HCAI; Rodney Garcia, Supervisor I, HCAI

Public Attendance: 53

Agenda Item # 1: Welcome and Meeting Minutes
Morgan Clair, Facilitator

Welcome and review of meeting ground rules and procedures. Review and approval of April 23, 2026, meeting minutes.

The committee voted and approved the April 23, 2026, meeting minutes with Cheryl Damberg making a motion and Janice Rocco seconding. The minutes were approved by 10 committee members.

No Questions or Comments from the Committee.

No Public Comments.

Agenda Item # 2: Department Updates
Scott Christman, Chief Deputy Director, HCAI

Presentation on department and program updates.

HCAI reported that the 2026–27 budget includes major investments for distressed hospitals; noting a shift from a loan to a small grant program, establishes a Health Care Access Stability Unit, and provides continued support for reproductive health, gender affirming care, behavioral health workforce funding, and CalRx initiatives. HCAI also highlighted federal support for the Rural Health Transformation Program, outlining efforts in transformative care delivery, rural workforce development, and health IT infrastructure. Additional updates included the transfer of the Data Exchange Framework and the Office of the Patient Advocate to HCAI, new authority under Senate Bill 660, and confirmation of long-term sustained funding for the HPD Program.

Questions or Comments from the Committee:
The committee asked whether the number of distressed hospitals has been increasing and where they might find information on underlying drivers. HCAI explained that application numbers vary by eligibility, noting loan and small grant programs with limited awards and persistent structural challenges intensified by federal funding shortfalls. The committee also asked whether any hospitals had converted to rural emergency hospital status and whether distress was concentrated in rural areas. HCAI indicated it was unaware of any conversions and noted that distressed hospitals exist in both rural and urban settings.

No Public Comments.

Agenda Item # 3: Deputy Director Updates
Michael Valle, MPA, Assistant Director, HCAI

Presentation on division policy and program activities of interest.

HCAI outlined the meeting agenda, noting planned discussions on demographic data, provider data, Employee Retirement Income Security Act (ERISA) data completion and quality, and the integration of Dental, Non-Claims Payments (NCP), and Pharmacy Benefit Managers (PBM) data into the HPD. HCAI thanked California health plans and all HCAI data submitters for their continued support and collaboration. HCAI also noted that at the April 23, 2026, meeting, there was a request for an update from the Office of Health Care Affordability on their hospital spending measurement methodology and the use of HPD data; written materials were provided and made available on the HCAI website.

Questions or Comments from the Committee:
The committee congratulated HCAI on the progress made to the project roadmap.

No Public Comments.

Agenda Item # 4: HPD Data Release and Program Reporting Updates
Chris Krawczyk, PhD, Chief Analytics Officer, HCAI

Presentation on progress and initiatives for data release and program reporting.

Questions and Comments from the Committee:
The committee asked why data requestor names are generic during review and withdrawal but specific once approved. HCAI stated that organizations are not named while requests are in process due to intellectual property concerns, but names become public upon approval. The committee also inquired about the process of working with current data users and whether HCAI would reach out to them regarding the 2024 data. HCAI explained that requestors initiate a supplemental request, and that an introduction will be provided on the application page for those adding 2024 data.

HCAI responded to committee questions about whether data requestors could link other state databases, such as birth or death records, to HPD data, and whether such linked data could eventually become a shared public asset. HCAI explained that it does not link external data assets to HPD data, though it hopes to expand that capacity over time. For now, any requestor wishing to link outside data must develop their own methodology and obtain necessary approvals from the stewards of the external data, such as California Department of Public Health for death records. Once approvals are secured, the requestor is responsible for bringing the data into the enclave and conducting the linkage themselves. HCAI added that there is not a current mechanism for making the linked data a public asset due to legal and contractual complications surrounding validation, liability, and intellectual property. The committee noted concerns about the cost implications of HCAI conducting data linkage work for other agencies, emphasizing that HCAI's limited budget could lead to higher costs for contributing groups if additional responsibilities were added.

No Public Comments.

Agenda Item # 5: HPD Data Collection Program Updates

Dionne Evans-Dean, MHA, Chief Data Programs Officer, HCAI;
Anthony Tapney, MBA, Assistant Branch Chief, HCAI;
Anna Dito, Cost Transparency Section Manager, HCAI;
Anna Kriuchkova, MSc, Research Data Specialist II, HCAI;
David Winston, MSc, Research Data Specialist II, HCAI;
Jasmine Neeley, Supervisor I, HCAI;
Rodney Garcia, Supervisor I, HCAI

Presentation on progress and initiatives, including:

a: Overview of data collection status.

b: Data quality efforts and engagement, including review of data completeness and quality.

c: Dental data collection.

d: Non-claims payment data collection.

e: Pharmacy benefit manager data collection.

Questions or Comments from the Committee on a: Overview of data collection status

The committee asked whether PBM data would include medical specialty drugs, and HCAI explained that data requirements will apply to PBMs licensed by the Department of Managed Health Care (DMHC), with specific elements still under development. Follow-up questions addressed specialty drugs distributed outside PBMs, and HCAI noted that specifics related to PBM data collection would be covered in a later presentation. The committee also asked whether the public would be able to comment on finalized PBM data elements, and HCAI confirmed that emergency regulations will provide a short public response window, with data specifications included in the package. Members further inquired about offering feedback earlier in the process, and HCAI stated that an inbox and website are available for submitting input while development continues.

Questions or Comments from the Committee on b: Data quality efforts and engagement, including review of data completeness and quality

The committee expressed appreciation for the improvements in data quality and encouraged continued efforts to strengthen ERISA data collection, recognizing the significant gap created by missing self-funded plan information. Members also raised questions about provider data, recommending that HCAI consider incorporating tax ID numbers through Medicare Data on Provider Practice and Specialty to support analyses focused on provider groups rather than individual clinicians. The committee emphasized that tax IDs are an important linking variable in many studies and urged HCAI to explore adding this field alongside existing National Provider Identifier (NPI) crosswalks. Additional discussion focused on race and ethnicity data, with members noting the importance of understanding how plans collect these fields – whether through self-report, imputation, or other methods – and asking whether this metadata will be visible to researchers in enclave datasets. HCAI explained that such detail is not currently

included but acknowledged the value of this information and noted that it may be considered as part of future enhancements. Members reiterated that self-report remains the gold standard for race and ethnicity data and that researchers need to know collection methods to accurately represent data quality in peer-reviewed publications. HCAI expressed appreciation for the feedback and indicated that it would continue exploring ways to integrate improvements and expand standard offerings within the enclave.

The committee also asked whether Administrative Services Only (ASO) applies only to health plans offering ASO services or also to third-party administrators of self-funded plans. HCAI explained that ASO includes both, since self-funded plans often rely on third parties for administration and data submission. Members noted challenges with opting self-funded clients into data submission, as contracts often do not compensate plans for providing these data, resulting in limited participation. Additional comments highlighted that Third-Party Administrator-processed claims may not appear in carrier data when labor trusts, rather than health plans, issue payments, meaning carriers may only transmit claims they directly pay.

The committee asked for clarification on a slide indicating that only 6.5% of covered ERISA lives were represented in the data. HCAI confirmed the figure and explained that the estimate reflects the absence of a data element distinguishing ERISA from non-ERISA entities, relying instead on known public organizations to approximate the percentage. Members requested the total covered ERISA population, and HCAI noted that 2024 covered lives total 4.6 million.

The committee then raised concerns about dental data completeness, citing increasing provider departures from dental networks and associated out-of-network spending. HCAI agreed to examine whether available files could identify providers leaving networks and assess the resulting gaps.

Additional discussion focused on demographic data, with members urging stronger efforts to collect language information and recommending that plans evaluate their communication practices, privacy messaging, and data collection methods to improve enrollee willingness to report demographic details. Members also suggested analyzing whether enrollees who do not report race or ethnicity receive fewer services, noting that low trust often coincides with both missing demographic data and reduced care utilization. HCAI indicated that such analyses may be feasible given current data availability and acknowledged that language data completeness appears higher than race and ethnicity, while still leaving room for improvement.

The committee asked about the completeness of provider data, specifically the capture of nurse practitioners and ancillary providers who may not be credentialed individually and instead bill under physician or organizational NPIs. HCAI acknowledged the concern and noted that available data points may help identify providers licensed in California but practicing out-of-state through telehealth, and that further delineation could improve accuracy. Additional feedback highlighted strong race and ethnicity

completeness in Medi-Cal enrollment data and suggested that similar performance should be achievable across other plans. Members also questioned why certain Medi-Cal managed care encounter fields were marked as not applicable, noting that charge and paid amounts are required for federal reporting. HCAI agreed to review the issue and coordinate with DHCS to determine whether these data should be included. Further discussion addressed provider types without NPIs or license numbers, particularly in-home supportive services providers – and how their inclusion affects linkage rates. HCAI expressed appreciation for the feedback and committed to following up on the identified data considerations.

The committee discussed low racial, ethnic, and language reporting in commercial and Medicare Advantage data, noting that large plans with long-term enrollees may have fewer opportunities to refresh demographic information. Members asked how HCAI is working with plans to improve these rates, emphasizing the need for multi-year engagement and trust building at both the provider and enrollee levels. HCAI described ongoing outreach led by its data intake and quality team, including preliminary discussions on collection practices and plans to identify actionable improvements over time. The committee also highlighted upcoming requirements under new federal Office of Management and Budget race and ethnicity standards, noting that future All-Payer Claims Database (APCD) data layouts will need to align. Additional questions addressed whether immigration-related concerns might reduce voluntary reporting, with HCAI acknowledging this possibility but noting that data lags may delay observable impacts. Members further raised technical questions about Medicare race variables and recommended deeper examination of how these fields are incorporated, particularly given imputation methods used in federal datasets. The committee also asked whether HCAI intends to add a field distinguishing ERISA from non-ERISA entities, and HCAI confirmed that this recommendation has been submitted for consideration in future APCD Common Data Layout. Finally, Covered California shared that it achieves over 80% self-reported race and ethnicity data and expressed willingness to collaborate on best practices, noting that demographic information may originate from multiple systems and that greater clarity about data sources and imputation could support improvement across plans.

Questions or Comments from the Committee on c: Dental data collection

The committee asked whether the Medicare Advantage counts in the breakout reflected supplemental benefits. HCAI explained that the categories shown represent the paired types pulled for Medicare Advantage and that they would need to verify whether those values specifically correspond to supplemental coverage. HCAI stated that they can check this and will follow up with clarification.

Questions or Comments from the Committee on d: Non-claims payment data collection
The committee asked which payer types are required to submit. HCAI responded that all commercial and Medicare Advantage plans are expected to submit, as long as they meet the minimum standards and have the data.

DHCS clarified that they are working on sending HCAI data on capitated payments from DHCS to plans, and said Centers for Medicare and Medicaid Services is requesting non-claims data such as denied encounters, state directed payments, and Graduate Medical Education payments and can pass those on as they receive them. The committee discussed how directed payments would be reflected and determined that for now the extent of the work would be DHCS flowing the capitated payments from DHCS to the Medi-Cal managed care plans. The committee asked for examples of annual payments, and HCAI said they are any payments made outside of the typical claims, such as incentive payments and capitation, aggregated at the billing provider NPI for reporting.

The committee asked whether pharmacy rebates were at a summary level or drug level and whether they came from commercial plans, Medi-Cal, or Medicare, and HCAI said they come from the HPD commercial submitters and Medicare Advantage and are aggregated at the annual level per National Drug Code (NDC). Members noted workload issues for plans and thanked HCAI for collecting Medi-Cal claims and encounter data from DHCS for HPD rather than collecting it directly from the Medi-Cal plans. The committee asked to see the data fields in the capitated and non-claims payment file, and HCAI said they could send the layout and described the incorporation of the NCP layouts, the change to 11-digit NDC, and the request for unrounded capitated total amounts. The committee asked about Medicare fee-for-service and annual payment attribution, and HCAI said Medicare fee-for-service data that HCAI obtains for HPD does not include non-claims payments in the standard data set. For the commercial and Medicare Advantage non-claims payment submission, annual payments are aggregated at the NPI level, with pharmacy rebates aggregated at the NDC level and additional elements available in the files.

Questions or Comments from the Committee on e: Pharmacy benefit manager data collection
The committee asked whether the PBM work was under the purview of the group or if it was simply a report on the work being done. HCAI responded that the PBM data collection is directly under the purview of the HPD Advisory Committee, explaining that the Health Omnibus Trailer Bill added the PBM data collection to the HPD statute and added a PBM representative to the committee. HCAI stated that this will be something they routinely provide feedback on and bring to the committee.

The committee asked whether the data would capture what the pharmacy paid for the drug, noting that pharmacies can purchase the drug from a wholesaler and sometimes pay more than they are reimbursed. HCAI responded that one of the elements they have been asked to collect is the acquisition cost for affiliated pharmacies. HCAI explained that the PBM might have that information for pharmacies affiliated with the

PBM, but they would not be able to get it for non-affiliated pharmacies because that data is held by the pharmacy itself and would not be part of the data collection effort.

The committee asked whether PBMs had been responsive and cooperative. HCAI said they had a few interviews so far and that PBMs said the elements were not surprising, were consistent with what they report elsewhere, and were in line with what is coming in 2028 for the Consolidation Appropriations Act of 2026. HCAI added that PBMs have been appreciative of HCAI reaching out and giving them the opportunity to explain limitations. The committee asked whether PBMs had any pushback on the data points and the layout. HCAI said some PBMs might have some of the data but not all of it, depending on their organizational structure, and that the layout may not work for everyone. The committee noted that mid-size and larger PBMs should not have issues with the data points shown.

The committee asked if any analysis had been done comparing lives represented by PBM claims versus lives represented by health plans in the HPD, noting that self-funded employers may carve out the PBM piece. HCAI said it is early days and they have not gotten the data yet. HCAI said PBMs reported that data in the NCP files might be different and might not tie out completely. HCAI also said there are complicated relationships between rebate aggregators, claims adjudicators, and PBMs, and that a lot of analysis will be needed to see what is carved out and what is included.

The committee asked if HCAI was collecting information on the benefit design and whether formulary details and discounts would be included. HCAI said the formulary structure and rebates are being discussed and may be available through new reporting required by federal legislation, but it is not clear whether it is under their statute or appropriate to collect and may be more in DMHC's purview. HCAI said they are coordinating with DMHC to figure out where it lands. The committee encouraged continuing to push on benefit design data to understand patterns of utilization and spending.

No Public Comments.

Agenda Item # 6: Anticipated Next Meeting Topics
Morgan Clair, Facilitator

No Questions or Comments from the Committee.

No Public Comments.

Agenda Item # 7: Public Comment
Morgan Clair, Facilitator

No Questions or Comments from the Committee.

No Public Comments.

Agenda Item # 8: Adjournment
Morgan Clair, Facilitator

Morgan Clair thanked the committee and HCAI staff and adjourned the meeting at 11:58 am.

No Questions or Comments from the Committee.

No Public Comments.