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

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HEALTH CARE AFFORDABILITY ADVISORY COMMITTEE

MEETING MINUTES
Wednesday, October 30, 2024
10:00 am

Members Attending: Joan Allen; Barry Arbuckle; Aliza Arjoyan*; Stephanie Cline*; Carmen Comsti; Parker Duncan Diaz; Hector Flores*; David Joyner; Carolyn Nava; Mike Odeh; Janice O'Malley*; Sumana Reddy; Kiran Savage-Sangwan; Sarah Soroken; Abbie Yant*; Kati Bassler; Marielle Reataza; Cristina Rodriguez; Travis Lakey; Stephen Shortell; Ken Stuart; Stacey Hrountas

*Attended virtually

Members Absent: Adam Dougherty; Tam Ma; Yolanda Richardson; Andrew See

Health Care Affordability Board Member Attending: Rick Kronick

HCAI: Jean-Paul Buchanan; Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director; Sheila Tatayon, Assistant Deputy Director; Margareta Brandt, Assistant Deputy Director; Janna King, Health Equity and Quality Performance Manager; CJ Howard, Assistant Deputy Director; Debbie Lindes, Health Care Delivery System Group Manager

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; Sheila Tatayon, Assistant Deputy Director, HCAI; Margareta Brandt, Assistant Deputy Director, HCAI; Janna King, Health Equity and Quality Performance Manager, HCAI; CJ Howard, Assistant Deputy Director, HCAI; Debbie Lindes, Health Care Delivery System Group Manager, HCAI

Facilitators: Jane Harrington, Leading Resources Inc.

Meeting Materials: **https://hcai.ca.gov/public-meetings/january-health-care-affordability-advisory-committee/**

Agenda Item # 1: Welcome, Call to Order and Roll Call
Elizabeth Landsberg, Director, HCAI

Director Landsberg opened the October meeting of California's Health Care

Affordability Advisory Committee meeting. Roll call was taken, and a quorum was established. Director Landsberg provided an overview of the meeting agenda.

Agenda Item # 2: Executive Updates and New Member Introductions
Elizabeth Landsberg, Director, HCAI
Vishaal Pegany, Deputy Director, HCAI

Director Landsberg opened with a statement of HCAI's solidarity with Indigenous Peoples and a review of the Land Acknowledgement. She then provided Executive Updates on HCAI's Healthcare Payments Data program and the August board meeting that took place in Monterey, CA.

Deputy Director Pegany provided updates on OHCA's Total Health Care Expenditure (THCE) data collection efforts. Deputy Director Pegany also presented details from an article that was published on the Health Affairs website in August 2024 which analyzed spending data from Connecticut, Delaware, Massachusetts, Oregon, and Rhode Island.

Discussion and comments from the Committee included:

- A member asked for clarification regarding OHCA's statement related to the Community Hospital of the Monterey Peninsula (CHOMP) payer mix was not an issue. They would like to know if it is an issue but not enough to explain the full cost or is OHCA claiming that payer mix does not influence cost for commercial insurance.
- The Office responded that their staff presented data on the payer mix and CHOMP does not have more Medi-Cal patients than the statewide average. They compared each hospital to the statewide average, and while Salinas and Natividad do have more Medi-Cal patients than the statewide average, CHOMP does not. Staff also noted that Chris Whaley, a researcher from Brown University who presented at the August Board meeting, had also pushed back on the notion of cost shifting, finding no correlation between a high government mix higher prices. Staff also mentioned that Medi-Cal financing is extremely complicated given the many supplemental payments going to these hospitals and there should be a more nuanced look when saying Medi-Cal is insufficient.
- A member commented on the spending growth in 2022, stating their belief that it will be much worse in 2023 and moving into 2024 as well. Specialty pharmacy is not necessarily retail pharmacy depending on where the payer selects prescription drug benefit.
- A member requested clarification regarding the percent of Total Medical Expenses (TME) submissions and asked if OHCA has any information regarding the reason for the late submissions.
    - The Office responded that they had 18 submitters, although one of the submissions is still going through the data validation process.
- A member requested more detailed information regarding the Monterey hospitals, such as the frequency of procedures, the percentage of different specialties, and the severity of disease. They inquired whether this data was also collected and will be considered in the reporting.

- The Office replied that the data presented in Monterey was from HCAI annual financial data, which does include utilization metrics and expenditure data. However, the data was focused on publicly available data sets rather than required claims data that would contain the more granular information that the member is requesting.

- A member asked which states have met their metrics, and whether there is any consideration for demographics, any trend in the homogeneity or heterogeneity of the demographics in these various states.
  - The Office stated that the spending data is not collected in such a way. The data reflects general statistics. The spending data itself reflects the spending on members for their covered benefits. OHCA would not be able to conduct a race ethnicity analysis based on that data. HCAI does have other data sources, including the Health Care Payments Data (HPD), and are working to ensure that the race ethnicity identification is well populated to allow for this type of analysis in the future.
- A member inquired whether it would be possible to receive an update on the Monterey Cost and Market Impact Report at the next Advisory Committee meeting. The member clarified that they are not requesting the contents of that report at the next meeting, but rather would like to be advised of the types of data that OHCA will be analyzing and the report status.
  - The Office clarified that this report will not be a Cost and Market Impact Review (CMIR) on a proposed transaction. This is an investigative study under OHCA's government code authority as a regulatory state agency to conduct investigations, which is why they will not be speaking about the preliminary findings until the final report is published.
- A member commented that, in reviewing the Health Affairs article slides, it would be useful to use some other data sources to review the quality metrics used by the states who have spending targets. That could be useful information as the committee discusses the quality and equity measures to be used in California.
  - The Office shared that Delaware and Massachusetts do have sections in their reports that focus on quality, and this is something that can be further researched in the future. OHCA's program will not only report on spending but will also report on quality.
- A member expressed concern that the rapid direction in which HCAI is going will dramatically expand the resources needed from the HPD or the scope of the data that has been collected. The member is also concerned about the fiscal constraints of the HPD.
  - The Office responded that Deputy Director Pegany's team is working closely with the HPD. The general fund appropriation for the HPD effectively runs out at the end of this year, so the Office will be looking to the legislature for ongoing sustainable funding.
- A member asked what the connection to the Attorney General's (AG) office is and what does the Office predict they may be looking at in terms of recommendations or referrals to the AG's office. The member also asked what are the goals aside from the study's report and what recommendations does the Office foresee in terms intervening in the market failures that may be identified.

- The Office replied that they are independent of the AG's office. OHCA's mission in conducing this investigative study is to provide public transparency. They will study consolidation in the marketplace, the competition, and practices that might be anti-competitive, as well as affordability and access. Other factors to consider, like those in a CMIR, may be to look at the potential effects on the labor market. They cannot predict what they will report to the AG, as they will not be able to make that determination until they are in the investigation. They will conduct the study, make their findings, publish a report, and it will be beyond what is reviewed in a traditional antitrust matter under California law or federal antitrust laws. If they do make a referral to the AG's office, it will be of their report, it will be comprehensive, and then the AG's office can decide whether to take further action. The AG's office will analyze it under unfair competition, state antitrust laws and federal antitrust laws.

Public Comment was held on agenda item 2. Two members of the public provided comments.

Agenda Item # 3: Update of Cost and Market Impact Review (CMIR) Program Including Revised Regulations
Sheila Tatayon, Assistant Deputy Director, HCAI

Assistant Deputy Director Tatayon provided an overview of the revisions to the Cost and Market Impact Review Program regulations that were made in August. She also provided an update on the notices of material changes that have been received to date.

Discussion and comments from the Committee included:

- A member requested confirmation that for all six of the notices received since April, all the CMIRs have been waived and the Office has not conducted any CMIRs on any transactions.
  - The Office confirmed that is correct. They also reminded the Committee of the process; Upon receipt of a notice of material change, the first step is to review if it is complete. They have not yet received a complete notice, and they typically must request more information. Once the transaction notice is complete, they start the clock of 45 days, which can be viewed within the electronic portal. The Office has completed processing ahead of the 45-day timeframe. If it is determined that the Office will conduct a CMIR, then they take 60 days to notify the parties as that is an appealable decision.
- A member asked whether the rationale behind the waiver is published when the decision is made to waive a CMIR.
  - The Office stated that they do not publish the waiver. The website will reveal whether a CMIR has been waived or not, as well as the start date for the 45-day time period. When a CMIR is ordered, all available information for the transaction will be publicly available. All supporting documents that are not determined to be confidential will be available on the HCAI website.
- A member inquired how the Office can be notified when an entity should've filed but failed to do so, even if the transaction has already been closed.

    - The Office responded that they work hard to monitor what is happening in the space of acquisitions and mergers. They do receive some emails in their CMIR inbox from individuals alerting the Office to a transaction either before or after it has happened. When the Office determines that the transaction should have been filed, they take steps to reach out to the parties to request information, to notify the parties that they should have filed and ask why they did not do so. The Office encouraged the members of the committee and anyone in the public to utilize the CMIR email address to contact them and stated that they generally provided responses within 48 hours.
- A member asked for clarification regarding requests for confidentiality: If a request for confidentiality is denied in part, could the party redact specific information or withdraw the entire CMIR request?
    - The Office replied that the party could choose to take either action – to redact specific information or withdraw the entire CMIR request.
- A member asked if OHCA will always publish the names of the party online while the CMIR process is ongoing.
    - The Office confirmed that the names of the party will be published as the names of the parties to the transaction must be identified in the notice which is published online.
    - A member expressed concern, stating that publishing the names of the parties could leave smaller entities vulnerable to acquisitions by larger entities.
    - The Office reiterated that the entity could request confidentiality, and if their request is denied, they could then choose to redact specific information or withdraw the entire transaction.
- A member asked if people could subscribe to a ListServ where an email blast would be triggered when a new submission is in process.
    - The Office stated that once a notice is deemed to be complete, the transaction is listed on the website, but ListServ notices are not sent to the public for each new transaction.
- A member asked whether there is a template or guidance provided to advise third-party entities, not involved in the transaction, about how to notify the Office of a transaction taking place.
    - The Office advised they do not have anything like that currently. However, they have received emails where some people may be requesting guidance and the Office responds to those emails with information and extends an invitation to meet if they require further discussion.
- A member asked for clarification of a business units' waiver process.
    - The Office stated they will look at a transaction once it has been noticed. Then the Office will look at every party to the transaction and what is happening in California, specifically the impact on provision of health care services in California. Just because a transaction is waived by the Office does not mean that the office will stop following the transaction. In regulations, once these business units enter into their transactions, they will then be subject to the Office's regulations, and this will be an ongoing review process.

Public Comment was held on agenda item 3. One member of the public provided

comments.

Agenda Item #4: Introduce Quality and Equity Measure Set Proposal
Margareta Brandt, Assistant Deputy Director, HCAI
Janna King, Health Equity and Quality Performance Group Manager, HCAI

Assistant Deputy Director Brandt and Janna King provided an overview of the Quality and Equity Measure Set proposal.

Discussion and comments from the Committee included:

- A member commented that this data is difficult to obtain. The member shared that, as part of their Equity and Practice Transformation (EPT) grant process, they requested race data from their Medi-Cal managed care provider. When they received the data, they realized it was deeply flawed. The member recommended having something in place to double check the data for accuracy. There are disparities in health care, and those disparities will grow when we have efficient technologies such as Artificial Intelligence (AI) methodologies.
- A member commented that, while working to incorporate more disaggregated data on race and ethnicity, the Asian categories is difficult to quantify. In Asian American and Pacific Islander (AAPI) spaces, there are over 50 ethnic groups and over 100 spoken and written languages. This data is necessary as there are some communities that are much larger in quantity than others, which also impacts the disparities in health.
- A member recommended a larger focus on clients who are lost to follow-up care and continuity of care.
- A member expressed concern that most people who would greatly benefit from and would qualify for behavioral health services do not actually seek them. The member asked whether there are better ways to find that data through community-based practices.
    - The Office replied that, on the payer side of health care access, the Department of Managed Health Care (DMHC) Health Equity and Quality Measure Set includes the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey measure of Getting Needed Care for Medi-Cal, commercial, and exchange plans to report on patient experience accessing care.
    - On the hospital side, the HCAI Hospital Equity Measures Reporting Program is going to start to look at language access by reporting on percentage of patients by preferred language spoken. The Office sees that as a key access point on the language side for hospitals.
    - There are gaps for physician organizations for patient experience and access measures that the Office will look to address over time. This is an area where the Office can conduct additional equity analyses to supplement the reporting on performance on the proposed OHCA Quality and Equity Measure Set.
- A member asked if there is a way to expand the measure set to include additional behavioral health measures or other behavioral health information. The member expressed concern that there are key data points to be gathered from behavioral

health that could benefit these analyses and better inform how to move forward.
    - The Office responded that they are hopeful that they can include more behavioral health measures over time. Regarding collecting additional data such as that involving domestic violence or changing the way data is reported, OHCA is collaborating with other state departments and public committees, as required by statute, as a part of developing its proposed measure set.
- A member asked if there is a way for any of the committee members to participate in discussing metrics for equity in any of these fields, whether it is hospital, payers, or physician groups.
    - The Office confirmed, stating that they are very interested in discussions on this topic and are open to following up with committee members. The Office further encouraged both written and verbal comments.
- A member inquired how quality measures work for hospitals who do not perform Obstetrics (OB) services or inpatient surgeries.
    - The Office responded that they are recommending adopting HCAI's HCAI Hospital Equity Measures Reporting Program. The key to that reporting program is requiring hospitals to publicly post these equity reports. HCAI will be providing technical assistance to hospitals to support reporting performance across these measures and stratified results. If there are specific technical assistance questions, the Office recommends reaching out to the HCAI Hospital Equity Measures Reporting Program. OHCA will not be administering the program but will be obtaining the data from the program. The Office noted that certain measures may be non-reportable for hospitals that do not offer specific services.
- A member commented some of the mental health and substance use behavioral health screening measures are too narrow to have a comprehensive idea of the quality and equity in the provision of mental health services. For example, some patients require out of network care to receive culturally and linguistically appropriate treatment, but there is no tracking of this type of care.
- A member recommended thinking about the data sets in buckets. For example, there could be a bucket for preventive care that would include colorectal screening, breast cancer screening, and pap smears. Pediatric preventive care could be another bucket, capturing data for child immunizations and well child check-ups. In adult medicine, you could put hypertension and diabetes into one bucket, which would be a result in a more productive measure. Behavioral health would be another bucket.
- A member emphasized that quality measures do not capture the core activities of providers or whether population health is improving. Data on whether patients can identify their primary care provider or continuity of care may be more informative.
- A member asked if there was any consideration of dental measures and whether OHCA consulted with the state Office of Oral Health.
    - The Office advised that dental measures have not been included yet. However, if that is of interest, they could consider that further.
- A member requested clarification regarding age stratification. While age stratification does appear in the hospital equity analysis, the member did not see that it was part of the physician equity analysis.
    - The Office confirmed that age stratification is not included in the payer measures

or the physician organization measures, but it is included in the HCAI Hospital Equity Measures reporting program stratification.

- A member stated that there are measures such as depression screening and follow-up and asthma medication ratio where they would want to see how the state is performing for kids and adolescents versus adults.
    - The Office replied that they are recommending adopting particular measures, such as depression screening for adolescents and adults, for payers and physician organizations. This will be built into the way that the measure is reported. There are two parts to this measure – the depression screening and then the follow-up on a positive screen. The Office will need to look into whether they can get a breakdown for adolescents versus adults.
- A member commented that researcher David Bautista from UCLA has been looking at California birth records for the last 20 years. The data shows that within the last couple of years over 40 percent of new moms are designating their babies under multiple racial and ethnic groups, which starts to blur the lines around what is intended with obtaining the race and ethnicity data.
- A member inquired how socioeconomic status is captured in the data. The member stated that there are a lot of folks who are a dollar too rich for Medi-Cal but are still poor. There should also be considerations for those who may have commercial insurance through work but are undocumented. Assumptions may be made that if an individual has commercial insurance, then they do not have a lot of the same disparities that others do, which could be incorrect.
- A member shared that, at Adventist Health White Memorial Hospital, they are starting to see hospitals around them closing their labor and delivery units, which causes patients to travel longer distances to get to White Memorial to deliver, which will skew the data in terms of outcomes and issues. The member also shared that there will likely be similar issues for pediatrics as the amount of pediatric independent practices are decreasing. Health deserts and rural health should also be a consideration.
- A member recommended that separate committees be created to focus on one or two measures each and focus on how to address those, rather than one committee reinventing the wheel for all measures.
- A member commented that when looking into quality and equity measures, there are disadvantaged facilities that don't have the ability to capture some metrics. For example, there are hospitals who are closing OB services and pediatric services for the purposes of reducing spending and costs. It is important to recognize that the value of looking at equity and quality measures is to understand where the gaps in access are, where there is inappropriate cherry picking or lemon dropping of high-cost patients. That is where the member sees the value in these measures rather than reinventing another value-based payment which incentivizes higher cost and uninsured people with certain types of payment plans being shoved out of the health care system. Some sort of regional analysis would be very important. It is important to understand the trends in terms of what is happening with health care closures, as well as with mergers and acquisitions, and how those will impact access to care and quality of care.
    - The Office replied that the goal of the proposed measure set is to monitor quality

and equity alongside performance against the spending targets to ensure that there are no negative impacts to the quality and equity measures.

- A member stated that in being part of the DMHC committee, an overarching takeaway was that they were not able to do what they needed to in terms of health equity which relied heavily on the National Committee for Quality Assurance (NCQA) accreditation to fill in the gaps. On the plan side, it would be important to look at the process and structural measures because these are missing from an equity standpoint. The member also noted for DMHC, there is no demographic stratification of the access measure, which is problematic.
- A member expressed concern that there is a lot of data missing from the physician organization measure set – there are a lot of populations missing and there is no stratification. The member asked whether that can be supplemented through the health plans. The member also stated that the older adults and people with disabilities populations are missing from these data sets, and those populations are vulnerable and at risk of being mistreated and underserved by the health care industry. This could be an area of opportunity for reducing costs through better quality community-based care.
- A member recommended that the Office note which of the quality measures are risk-adjusted and include patient safety in the measure set. The member suggested that OHCA conduct research on reliable data available, possibly through a California patient safety organization or entity that reports on issues such as sepsis, hospital acquired infections, falls, and other hospital-related safety issues.
- A member commented that they would like to find out how many physician organizations will be reporting to and the Office of the Patient Advocate (OPA), believing there is a mismatch, and this is a potential source of inequity. They stated that there is a challenge with behavioral health groups not contracting with Health Maintenance Organizations (HMO).
    - The Office replied that they will be cataloging the physician organizations that will be reporting to OPA compared to those reported through total health care expenditure (THCE) data collection.
    - The Office noted that attributing patients to a physician or a physician organization is difficult in Preferred Provider Organization (PPO) plans.
- A member asked if the hospital measures will be the only measures that OHCA will consider when evaluating whether a hospital meets a target and stated that some of the structural measures do not necessarily mean the hospital is improving equity.
    - The Office replied that the HCAI Hospital Equity Measure set is a starting point for looking at hospital quality and equity. There are other hospital measures that may be added to supplement this measure set.

Public Comment was held on agenda item 4. Two members of the public provided comments.

Agenda Item #5: Update on the THCE Data Submission Guide & Regulations
Margareta Brandt, Assistant Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI

Assistant Deputy Director Howard provided a brief overview of the proposed changes to the THCE Data Submission Guide 2.0 with a high-level implementation timeline.

Assistant Deputy Director Brandt provided an overview of the proposed approach to data collection for the Alternative Payment Model (APM) data as well as for the primary care spending data.

Discussion and comments from the Committee included:

- A member asked how the gap in capturing PPO self-funded data fits in with data extraction. The member stated that PPOs are Employee Retirement Income Security Act (ERISA) regulated, but not regulated by the DMHC.
    - The Office replied that there are not any exemptions for ERISA plans in their regulations. However, OHCA's regulations include language about submitting data consistent with federal law. A member explained that, with the HPD, they expect to aggregate 92 percent of all claims data with the absence of the ERISA self-funded plans. A former health plan in San Diego reported that they had an agreement with their health plan to put the data together to submit to HPD and that there would be no cost to do so but came back later requesting $45,000 to set that up.
- A member asked for clarification on the primary care annual improvement benchmark: 0.5 - 1% increase per year. Suppose an entity's 2024 baseline year is at 10%, would the goal be to increase from 10% to 11% or increase to 10.1%?
    - The Office replied that the annual improvement benchmark is to increase by 0.5 to 1 percentage points each year through 2033 so if the baseline was at 10%, then it would go up to between 10.5% or 11%, which is detailed in the formal adoption language.
- A member recommended that OHCA consider adding the TINs and the NPIs to the provider attribution addendum. The member stated that it is difficult for the plan, given the intensive work that they must undertake to match these various provider indices with the provider attribution addendum name. The member would like to figure out whether there is an opportunity to have this available at the onset to prevent the large amount of work that the payers would otherwise undertake.
    - The Office responded in agreement and clarified that they are working towards implementing this recommendation.
- A member asked which behavioral health services will be counted as primary care.
    - The Office responded that services such as depression screening and follow-up that occur in a primary care setting are included in the primary care definition. As the Office develops the behavioral health definition, it is aiming to measure behavioral health in a primary care setting as a discrete module of spending. For now, the overall primary care spending measurement includes these services such as a depression screening provided in a primary care setting by a primary

care provider.

- A member asked for more information regarding how the primary care spend is evaluated where the health plan is not paying for primary care separately. Is primary care being evaluated by physician and advanced practitioners billed encounters compared to the total encounters or is in-basket messaging being taken into account?
    - The Office answered that the primary care spend definition includes a methodology to allocate a portion of capitation to primary care which is based on encounters and counting the encounters under a professional capitation, essentially calculating a ratio based on fee-for-service equivalents for primary care services to fee-for-service equivalents for all services under capitation and then multiplying that capitation payment by the ratio. This proposed methodology for allocating a portion of capitation to primary care spend has been previously published in collaboration with the Investment and Payment Workgroup. The data submission guide will cover this methodology in more detail.
- A member expressed concern regarding the amount of risk that may be forced upon the PPOs by OHCA.
    - The Office advised that they have aimed to address some of the challenges of increasing APM adoption in the PPO market through their APM Standards, but do recognize that there are both challenges and limitations to the amount of risk that can be delegated in a PPO plan.
- A member commented that OHCA is looking to move away from fee-for-service and towards APMs, as well as expanding or at least ensuring ample access. The member then stated if a payer and a provider have an ACO relationship in a given market, such as one of the Health Care Payment Learning and Action Network (HCP-LAN) category three, it is a full risk downside ACO which almost always have a narrower network. The member asked whether that narrower network would be considered a lack of access. For example, if they were to look at a ten-mile radius surrounding Anaheim Stadium, there would be 18 hospitals. If an ACO with a downside risk was entered, the consumer who chooses that would have fewer hospitals and fewer physicians. If there were eight hospitals rather than 18, would that be considered a lack of access? While moving towards an APM, they would also be reducing the number of physicians and hospitals that are available in the broader PPO plan or product.
    - The Office replied that payers must comply with DMHC regulations for delegation of risk as applicable. OHCA is measuring the members attributed to the APM model in its data collection. Additionally, plans must follow network adequacy rules. OHCA does not regulate timely access, but they do want to monitor access and review the timely access measures from other regulators such as DMHC.
- A member recalled that 85 percent of Medi-Cal patients are now in HMO plans and asked for clarification regarding why the APM presentation shows 55 percent instead when there is 85 percent in a capitated arrangement.
    - The Office responded that they developed the Medi-Cal APM adoption goals in collaboration with DHCS and worked with them based on their understanding of the data, how they are paying Medi-Cal managed care plans, and how the Medi-Cal managed care plans are then paying downstream providers such as provider

organizations, hospitals, and other health care entities.
    - OHCA believes that this number is reasonable based on their discussions with DHCS which revealed that there are several Medi-Cal managed care plans who are paying their downstream providers either fee-for-service or fee-for-service plus performance payments, and many of them are not paying capitation.
    - OHCA will revisit these goals based on two years of data collection. As they approach the 2026 adoption goal, that would be an opportunity for OHCA, the Board, and the Advisory Committee to revisit the goals and determine whether adjustments need to be made.
- A member commented that performance by the groups with capitation and how spending is allocated between primary care and specialty care would be an important thing to consider.
- A member stated that behavioral health should be strongly rooted in primary care, and that the spending goal for each should be 15 percent.
- A member asked how telehealth is incorporated.
    - The Office stated that they have included telehealth visits in their primary care definition if they are provided by a primary care provider for a primary care service.
- A member asked how episode-related payments are tracked.
    - The Office responded that in the episode-based payment category, the data is collected based on how the payer contracts with hospitals or provider organizations to provide a bundled payment, which can include visits or other services. The APM Adoption Goals are broadly based on categories of shared savings and shared risk and capitation-based payment models and increasing adoption of those models.
- A member expressed concern regarding depression screening, stating that many primary care providers who are treating patients in these marginalized communities are working in high volume clinics with higher clinician shortages who may not have adequate resources. There should be consideration for the delicacy of the situation, the likelihood that a patient may not be comfortable providing honest answers to depression screening questions, especially those in communities that experience stigma towards behavioral health such as the AAPI communities which are ranked as the least likely group to seek behavioral health services by the Substance Abuse and Mental Health Services Administration (SAMHSA).
- A member asked how the uninsured population fits into the data and access.
    - The Office replied that California has done a great job in expanding coverage as much as possible. However, the purpose and scope of OHCA, in terms of its data collection, will be on spending for covered services or covered benefits for the insured population. The annual reports are intended to be a bird’s eye view of the health care system and will report on metrics related to the uninsured rate in California and out-of-pocket spending. They are also working on some analysis related to the magnitude of that spending. Part of OHCA’s intention, for increased primary care investment, is to support increased use of behavioral health integration or the collaborative care model and for primary care practices to have more resources to provide more comprehensive, team-based care that may include a community health worker or a social worker.

- A member asked whether there will be a reconsideration of what is or is not an APM, and whether there will be space to ensure that there aren't unintended consequences of shifting folks into specific types of payer models or plans.
    - The Office advised that they could look into ways to monitor for unintended consequences or negative actions based on the APM adoption goals and primary care investment benchmarks.
    - Regarding how OHCA is defining alternative payment models, they are using the Health Care Payments Learning and Action Network to define what payment models count towards the alternative payment model adoption goals. Payments that count towards the goals are shared savings and shared risk models, population-based payment models, global budgets, capitation and fully integrated delivery system payment models. Those are the types of alternative payment models that meet the APM adoption goals. They are collecting alternative payment model adoption data by the Expanded Framework categories and subcategories where they are asking payers to allocate how much spending is in each category and subcategory. They are collecting data on payments such as primary care and behavioral health integration, social care integration, and procedure-related episode-based payments with shared savings.
- A member shared that their practice has its own independent physician association (IPA), and primary care is delivered by medical groups. They trained at Kaiser, so they follow the Kaiser model of a single medical group providing all the primary care for the IPA. The premium is not the volume of visits, but rather what services are provided during the patient visit. For example, if a patient comes in with a sore throat but she's due for a pap smear, they will perform or offer to perform the pap smear during that visit. In a normal practice, doing so would put a doctor behind schedule because they took extra time with the patient. However, in their model, they schedule fewer appointments to allow the providers to make those interventions. If a patient is depressed, the provider is able to take the time necessary to counsel the patient. Spending extra time with the patient saves downstream dollars, so moving from volume to value is a critical piece to learn from this. The conundrum for safety net providers is that the federal government has onerous productivity and access requirements which are volume driven, and there are consequences for not meeting those volume demands. The member urged OHCA to consider how to advocate for the safety net to move from volume to value without the fear of facing negative financial consequences.

Public Comment was held on agenda item 5. No members of the public provided comments.

Agenda Item #6: Introduce Behavioral Health Definition and Investment Benchmark
Margareta Brandt, Assistant Deputy Director, HCAI
Debbie Lindes, Health Care Delivery System Group Manager, HCAI

Assistant Deputy Director Brandt along with Debbie Lindes provided an overview of the Behavioral Health Definition and Investment Benchmark.

Discussion and comments from the Committee included:

- A member asked whether there will be greater development in understanding what behavioral health care could look like outside of having a diagnosis and outside of a behavioral health clinic, as the process of getting diagnosed can be very difficult.
    - The Office replied that they have not developed a proposed definition yet, so that development work is ongoing. They have not yet decided whether diagnosis will be a key portion of the definition. There has been much discussion with a variety of opinions on this topic within the Investment and Payment Workgroup. Some folks have expressed that it seems critical to use diagnosis to track spending for behavioral health services, especially in a non-behavioral health setting such as a hospital. Others expressed that a diagnosis may not be as necessary when reviewing spending by behavioral health providers. They welcome feedback from the advisory committee in this ongoing discussion. The Office further advised that restricting by diagnoses could be accomplished in several ways. Some folks have looked at either primary diagnoses only or primary and secondary diagnoses on the claim. They could also approach the definition of applying that primary or secondary diagnosis plus a behavioral health service by a behavioral health provider. They could have a more strict or specific definition if that is of interest to the Board and the Advisory Committee. To capture behavioral health spending in a primary care setting or hospital, they must have a diagnosis to distinguish between behavioral health care and non-behavioral health related care.
- A member shared that under SB 855, the state determined what the standard of care is for medical necessity, which includes treatment for any diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM).
    - The Office replied that claims use the International Classification of Diseases, Tenth Revision (ICD-10) rather than the DSM, but agreed that the idea would be to be as broad as possible without including services that are unrelated to behavioral health.
- A member recalled a slide of the presentation which listed the Investment and Payment workgroup members, stating that they did not notice any representatives of clinical professional organizations or groups such as the California Psychological Association, individuals who are experts on what the standard of care is. The member expressed that this type of voice is essential for providing input on OHCA's behavioral health decisions. They also noticed the absence of a direct patient care behavioral health provider who is not in a managerial role, which is also an important perspective to consider.
    - The Office responded that they are happy to connect offline to discuss who should be added to the workgroup or meet with anyone outside of the workgroup who is interested in providing input.
- A member recommended that the Office's focus should be where the greatest access problems are, including individual and family therapy, group therapy, wrap-around services, residential, voluntary hospitalizations, and children's care.

- A member asked for clarification regarding behavioral health care provided in a primary care setting, whether that would be a specialist who is situated in a primary care office providing those services side-by-side with the primary care provider or would that be a primary care provider who is well versed in psychotherapy or psychotropic medication management.
    - The Office advised that integrated behavioral health would include services such as depression screening and follow-up, as well as claim codes for integrated behavioral health such as using the collaborative care model and providing services in that manner. In their definition, they are not strict about specifying how that integration looks. They are trying to capture the claims that would include that type of care, and they would capture the non-claims spending on primary care and behavioral health integration through the non-claims data collection.
- A member commented that it will be interesting to see how the Mental Health Services Act (MHSA) hopefully boosts access to care. Voices of workers who can speak to what is like on the ground are needed to find the best ways to increase the behavioral health workforce because there is a huge need for additional licensed clinical social workers, psychologists, and Marriage and Family Therapists (MFTs).
- A member commented that creating an expectation within behavioral health does not mean everyone will be ready to deliver those kinds of services. For example, as a family physician leading a residency program, they have an obligated curriculum with significant behavioral health training; however, not all programs are set up this way. The member advised to approach with caution as the Office may end up creating expectations that cannot be met or verified, especially with a workforce shortage in behavioral health.
- A member commented that when primary care physicians are submitting a claim to the health plans where the primary diagnosis is a behavioral health diagnosis, it often gets rejected. Therefore, behavioral health is being provided by primary care physicians, but it is not directly tracked as a primary diagnosis for payment reasons.
- A member commented that it would be helpful for OHCA to speak with behavioral health specialty plans, since a large amount of overall behavioral health spending flows through these carve-out plans.
- A member commented in relation to hospital and emergency room visits, there is a question of what counts as behavioral health. For California Nurses Association nurses, they see patients coming in for an acute care reason; however, this is a trigger for a behavioral health condition. The member highlights need for training for all healthcare workers encountering patients, even in surgical settings, to understand behavioral health conditions and ensure people get the services they need.
- A member added that there is way more money being spent that we aren't tracking in private personal spending, such as acupuncture or vitamins. If we build an accessible and high-quality behavioral health system, where more care is covered, out-of-pocket spending should decrease.
- A member commented that claims for substance use disorder treatment (specifically medication-assisted treatment) may not capture the mental health diagnoses that were also treated during the same encounter, since substance use is the primary diagnosis.

- A member referenced a study by the Research Triangle Institute on the behavioral health workforce and high out-of-pocket spending, noting that behavioral health providers are paid less than other specialties. The member noted that high out-of-pocket spending has equity implications, and this spending needs to be brought into the system.
- A member commented that a few years ago, their health system began to embed behavioral health practitioners into the primary care practices. The member then asked how the Office will track the medical groups' capitated services when there is no claims payment or payment made?
    - The Office replied that this challenge is similar to primary care and it plans to address this issue using encounter data or other behavioral health service data to allocate a portion of capitation spending to behavioral health.
- A member commented that affordability is a very specific issue in behavioral health where individuals are more likely to spend money out-of-pocket on behavioral health, so a specific goal of this effort should be to get the health system to invest more in behavioral health care to allow individuals to spend less out-of-pocket for those services. Also, the member noted that behavioral health investment goals should focus on types of care that improve behavioral health outcomes.
- A member commented that affordability is key and that some of their most rewarding clinical encounters are when they can address the behavioral health underpinnings of a complex, high-utilizing patient.
- A member mentioned that in Monterey County a majority of educators in their group receive their behavioral health through telemedicine, as it is a desert for behavioral health providers in their region, and it is the only option folks have without paying out-of-pocket.
- A member mentioned that many patients with substance use disorder issues have unresolved trauma or mental health issues that have caused them to seek out and abuse substances, so providing the mental health care is necessary to resolve the substance use disorder issues and the related physical conditions that result from those issues. The member noted that providers tend to lean on medications instead of therapy and other supports. Providing a higher standard of care would be more effective and help prevent prolonged, worsening conditions that people with mental health issues tend to have. It would also help minimize involuntary treatment and institutionalizations.
- A member stated that the Emergency Medical Services (EMS) community and 988 crisis line community are increasingly tasked with responding to behavioral health emergencies, which leads to increased costs for the patient to be transported to a psychiatric facility or emergency room. A voice from the EMS community should also be included in this workgroup.
- A member recommended including those with lived behavioral health and substance use disorder experience in this workgroup, as they have a lot to contribute. They noted that there is a need for more peer support for people with substance use disorders.

Agenda Item #7: General Public Comment

Public Comment was held on agenda item 5 and item 6. One member of the public

provided comments.

Agenda Item #8: Adjournment

The facilitator adjourned the meeting.