OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Board Meeting

February 25, 2025

HCAI

Department of Health Care Access and Information

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Welcome, Call to Order, and Roll Call

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Department of Health Care Access and Information

Agenda

Item #1 **Welcome, Call to Order, and Roll Call**

Secretary Kim Johnson, Chair

Item #2 **Executive Updates**

Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director

Item #3 **Action Consent Item**

Vishaal Pegany

a) Vote to Approve January 28, 2025 Meeting Minutes

Item #4 **Informational Items**

Vishaal Pegany; CJ Howard, Assistant Deputy Director; Andrew Feher, Research and Analysis Group Manager; Margareta Brandt, Assistant Deputy Director; Debbie Lindes, Health Care Delivery System Group Manager

a) OHCA's Recommendation for Hospital Sector Target Methodology and Values
b) Proposed Hospital Sector Definition Regulations
c) Baseline Report Content Preview
d) Proposed Total Health Care Expenditures Regulations, Summary of Public Comments
e) Behavioral Health Investment Benchmark including Advisory Committee Feedback

Item #5 **General Public Comment**

Item #6 **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

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Black Liberation Statement

At HCAI, we acknowledge the devasting and longstanding impacts racism, oppression, and white supremacy has had on Black and African American communities. We also believe it is critical to acknowledge that Black communities have been treated inhumanely by the U.S. government through enslavement, segregation, mass incarceration and exploitation through medical experimentation used to advance medicine resulting in longstanding inequities. To begin to rectify these wrongs, there must be an explicitly anti-racist approach to reduce racial disparities in health care and more broadly.

At HCAI, we envision a health care system where doctors listen to their Black patients, center their experiences, and take proactive steps to counter implicit bias resulting in quality care and improved patient outcomes. In solidarity and allyship with California's Black communities, HCAI centers and amplifies the voices of our Black partners, leaders, colleagues, and community members. We uplift Black resilience, education, and health. We fully commit to revisiting HCAI's programs, policies, and procedures to ensure state resources are distributed equitably in a manner that recognizes our responsibility to address disparities impacting Black communities.

Lessons Learned from State Efforts to Slow and Shift Health Care Spending

In its February 2025 publication, The Millbank Memorial Fund, in collaboration with Freedman HealthCare, published a report that describes the experiences of states that have designed and implemented policies to pursue multiple targets – i.e., a statewide cost growth benchmark, a primary care investment target, and/or the adoption of alternative payment models – and gathers lessons from their experiences to inform future policy development.

From this report, three major themes emerged:

1. Multi-stakeholder alignment requires a clear, shared vision and close collaboration. One way to achieve this is by creating a vehicle for public purchaser collaboration as a vanguard to drive the engagement of other payers and stakeholders.
2. This shared vision is needed to articulate goals holistically. Regulations can make the goals explicit and establish expectations.
3. Enforcement approaches blend creativity, fortitude, and patience to achieve accountability. Effective examples of this combination include an expansive data collection and monitoring approach and fostering accountability through contracting language and regulation.

Source: Seifert, R., Rourke, E., Condon, M. (2025). Lessons Learned from State Efforts to Slow and Shift Health Care Spending. *Millbank Memorial Fund*, https://www.milbank.org/publications/lessons-learned-from-state-efforts-to-slow-and-shift-health-care-spending/

Lessons Learned from State Efforts to Slow and Shift Health Care Spending

Table 1 depicts how different states are currently addressing the task of slowing growth in health care spending.

- Connecticut and Maryland have set both cost growth and primary care spending targets.
- California joins Delaware, Oregon, and Rhode Island in addressing all three areas of health care spending.

Table 1. States with Combinations of Cost Growth, Primary Care Spending, and Alternative Payment Model Targets

State	Cost Growth Target	Primary Care Spending Target	Alternative Payment Model Target
California	X[a]	X[b]	X[c]
Connecticut	X[d]	X[d]	0
Delaware	X[e]	X[f]	X[f]
Maryland	X[g]	X[h]	0
Massachusetts	X[i]	0	0
Oregon	X[j]	X[k,l]	X[k,l]
Rhode Island	X[m]	X[n]	X[n]
Washington	X[o]	0	X[o]

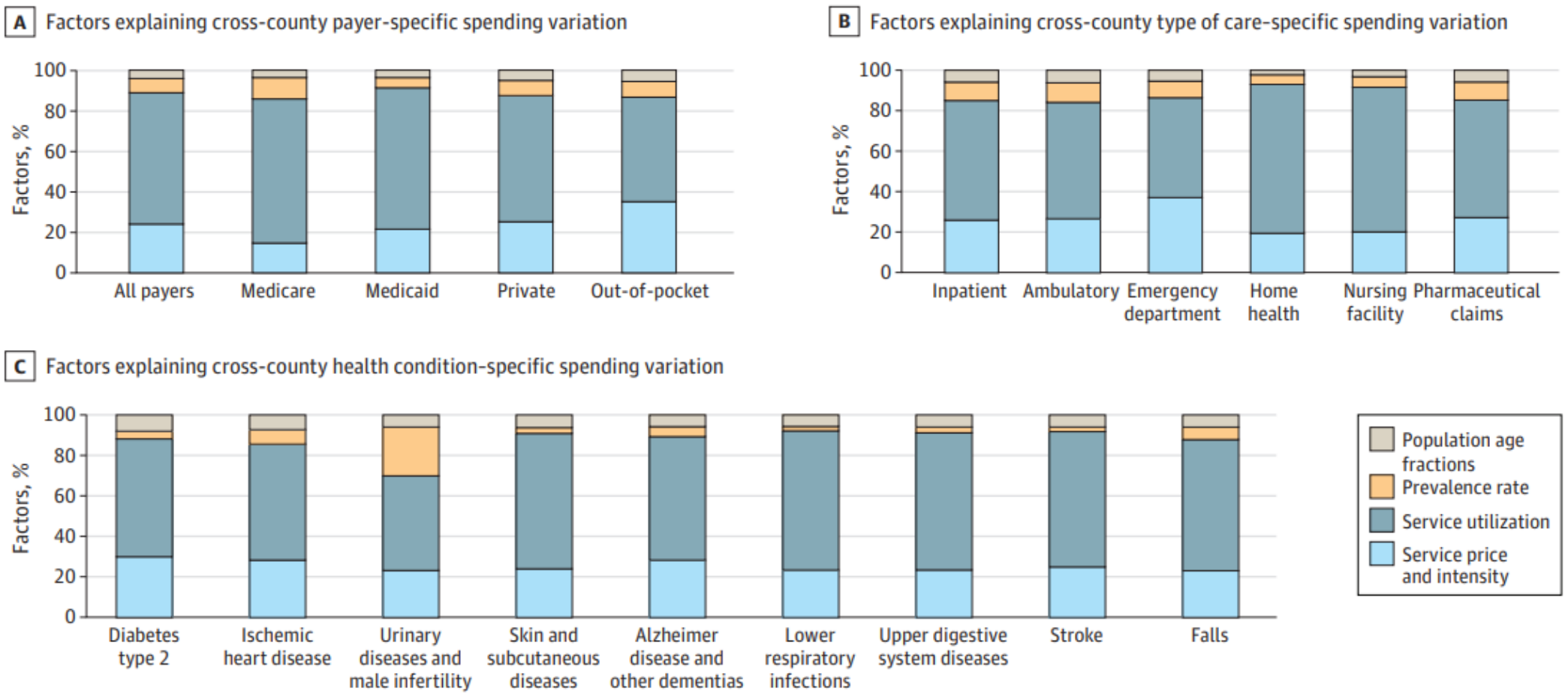
Source: Seifert, R., Rourke, E., Condon, M. (2025). Lessons Learned from State Efforts to Slow and Shift Health Care Spending. *Millbank Memorial Fund*, https://www.milbank.org/publications/lessons-learned-from-state-efforts-to-slow-and-shift-health-care-spending/

Service Utilization Key Driver of Health Care Spending

- A February 2025 article in *JAMA Health Forum* included findings from a study of drivers of variation in health care spending across U.S. counties.
- Data for 4 key drivers of per capita spending (age, disease prevalence, service utilization, and service price and intensity) were extracted for 3,110 US counties, 148 health conditions, 38 age-sex groups, 4 payers, and 7 types of care for 2019. Data sources included U.S. Disease Expenditure project, U.S. Health Disparities (USHD) project and Global Burden of Disease (GBD) study.
- Most cross-county spending variation was explained by service utilization (65%) followed by service price and intensity (24%), disease prevalence (7%) and aging (4%).
- Increases in median income were associated with more utilization, except for emergency department and hospital inpatient care, while the share of Medicare beneficiaries with Medicare Advantage was associated with less utilization. The share of physicians who specialize in primary care was associated with lower prices and intensity of care, while Medicare Advantage was associated with higher prices and intensity of care.
- For private insurance, more variation in spending was attributed to service price and intensity compared to other payers.

Source: Dieleman JL, Weil M, Beauchamp M, et al. (2025). Drivers of Variation in Health Care Spending Across US Counties. *JAMA Health Forum*, 6(2):e245220. doi:10.1001/jamahealthforum.2024.5220

Figure 2. Factors That Explain Cross-County Variation in Spending Per Capita



Factors explaining variation in total spending and by payer (A), type of care (B), and 9 highest-spending health conditions (C). Each bar shows the total variation explained by each factor. Because all variation was explained these percentages add up to 100%.

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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Public Comment

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Action Consent Item: Vote to Approve January 28, 2025 Meeting Minutes

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Informational Items

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OHCA's Recommendation for Hospital Sector Target Methodology and Values

Vishaal Pegany, Deputy Director

CJ Howard, Assistant Deputy Director

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Board Follow-Up Items

Board Follow-ups

1. One Board Member asked OHCA to meet with hospitals and collect feedback on the presented methodology for identifying high-cost hospitals.
2. One Board Member asked that OHCA project how many years it might take for high-cost hospitals to come in line with the 80th percentile.
3. One Board member asked that OHCA examine the distributions (not just percentiles) of the unit and relative price measures.
4. One Board member asked that OHCA compare CMS Hospital Price Transparency reporting and HCAI Annual Financial reporting.

1. Board Follow-up: Hospital Feedback

Question: Can OHCA meet with hospitals and collect feedback on the presented methodology for identifying high-cost hospitals?

Approach: OHCA met with the following 5 hospitals between the January 2025 Board meeting and the February 2025 Board meeting: Community Hospital of the Monterey Peninsula, Salinas Valley Health, Sharp HealthCare, Stanford Tri-Valley, and Stanford HealthCare.

Discussion included:

- Overview from the hospitals on their facilities and programs.
- Feedback on the proposed options for identifying disproportionately high-cost hospitals that may merit a lower spending target value.
- Suggestions for different measures OHCA could consider to identify disproportionately high-cost hospitals.

1. Board Follow-up: Hospital Feedback

Identification of High-Cost Hospitals:

- Consider the top quartile (>75th percentile) of all California hospitals, noting that only singling out 10 or so hospitals will not bend the overall cost curve.
- Consider excluding disproportionate share hospitals (DSH).
- Consider adjustments for Academic Medical Centers as they often have fundamentally different organization and staffing structures with many specialists.
- Do not use a methodology that preemptively excludes 50% of California hospitals (discharge threshold).
- Evaluate at a health system level rather than individual hospital; a hospital may have high margins, yet the hospital may incur costs outside of the hospital but within its system (e.g., clinics) that potentially have much lower margins.
- Use operating margins for health systems to identify outliers, not operating margins of individual facilities.

Unit Price Measure

- For unit price measure, use average net patient revenue per case mix adjusted discharge (instead of using commercial-only) to normalize for payer-mix.
- Case Mix Index (CMI) does measure intensity but doesn't adequately account for quaternary care in which patients stay longer than 30 days. CMI does not consider all costs of care (e.g., transportation cost for organ transplants).
- Unit price measure does not account for the costs some hospitals incur, e.g., for capital expansion. Existing reimbursement levels would make it difficult to justify investments for regulatory purposes and expansion.

1. Board Follow-up: Hospital Feedback

Relative Price Measure

- Avoid Commercial to Medicare ratios and use the average net patient revenue per case mix adjusted discharge (instead of using commercial-only).
- Revise calculation of relative price measure (Commercial to Medicare Payment to Cost Ratio) as follows: Only include Medicare FFS (Traditional) in the calculation as capitated rates for Medicare Advantage are not adjusted for area wage index or teaching status. There is also no standard methodology of how systems allocate capitation revenue to hospitals. These changes would account for those who are in more heavily capitated arrangements than those who are not.
- Use the Massachusetts method of creating a relative price measure with the Healthcare Payment Database to have a more accurate picture of actual payments, noting that this would take more time.

Repeat Outlier: One entity agreed that using 3 out of 5 years across two measures to identify high-cost hospitals was a good approach; another entity preferred the use of a pooled average across the five years.

Payer Mix Threshold: Some agreed that a threshold of 5% revenue for both commercial and Medicare was reasonable, while others indicated this is not a sufficient percentage but did not recommend an alternative.

1. Board Follow-up: Hospital Feedback

Other feedback and comments:

- Caution should be exercised when determining who is a high-cost facility.
- Delay the sector target to allow for the COVID-19 pandemic numbers to not be included in 5-year averages.
- Medicare reimbursement is going down and higher commercial are needed to support hospital operations.
- The relative under reimbursement of physicians in Medicare drives lower commercial reimbursement.
- Aggressive pricing caps will have unintended consequences affecting access to care.
- Do not rush to “do something.” Instead, be measured and deliberate.
- Consideration is needed for:
  - High-cost living areas resulting in increased compensation and benefits for employees of facilities.
  - Clinical innovation, investments, and expansion of services resulting in high up-front costs.
  - Research conducted by academic medical centers, which is much more advanced than the rest of the country and may be funded in whole in or in part by clinical revenue.
  - Efforts to coordinate care through increased use of Alternative Payment Models such as capitation payments.
  - The impact of federal actions, such as increased tariffs, proposed cuts by Congress that may impact Medi-Cal/Medicare funding and ultimately payments to hospitals.
  - Complexity of specialty pharmacy costs and passed through charges.
  - The need for hospitals to maintain positive operating margins.
  - Payer mix.

2. Board Follow-up: Projecting Cost Metrics

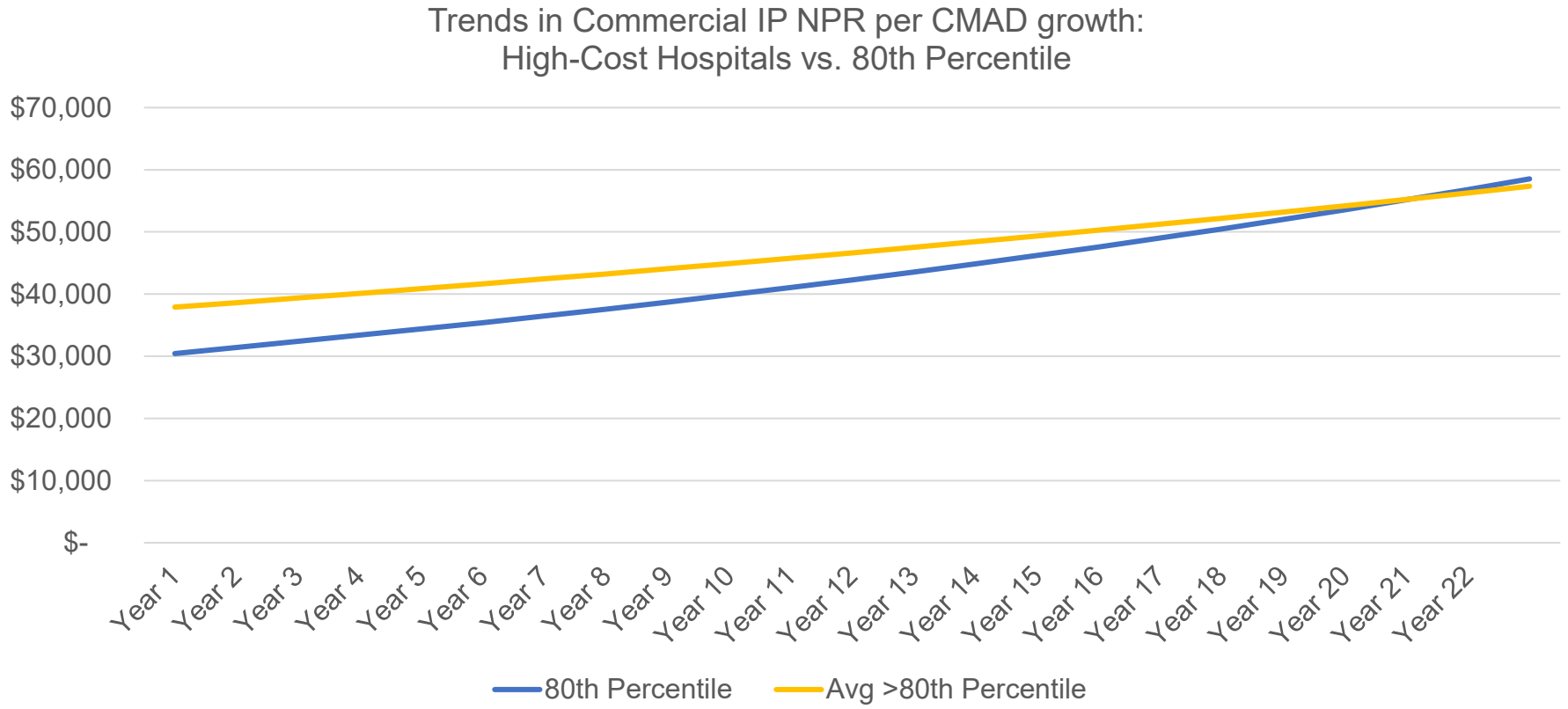
Question: To inform target setting, how many years might it take for high-cost hospitals to come in line with the 80th percentile if the cost relativity approach is used as the basis for target setting?

Approach: Based on 2022 HCAI Hospital Annual Financial Disclosure data, using Commercial Inpatient NPR per CMAD, we did the following:

- Compute the 80th percentile, weighted by inpatient discharges, among Comparable hospitals and assume a growth rate between 3-3.5%, depending on the year.
- Compute the average, weighted by inpatient discharges, for the 15 hospitals that are above the 80th percentile on both the Inpatient NPR per CMAD and Commercial to Medicate PTCR for 3 out of 5 years, and assume a 1.9% growth rate.
- Assess when the lines between the two groups intersect.

2. Projecting Commercial IP NPR per CMAD

In a scenario where the average of the Inpatient NPR Per CMAD of hospitals above the 80th percentile grows at 1.9% and the 80th percentile grows at the statewide target*, it would be approximately 22 years before high-cost hospitals come in line with the 80th percentile.



*2026 at 3.5%, 2027 and 2028 at 3.2%, and 2029 and beyond at 3.0%

3. Board Follow-up: Unit and Relative Price Measure Distributions, 2018-2022

Board members expressed interest in not only percentiles but also in understanding the distribution of the unit and relative price measures.

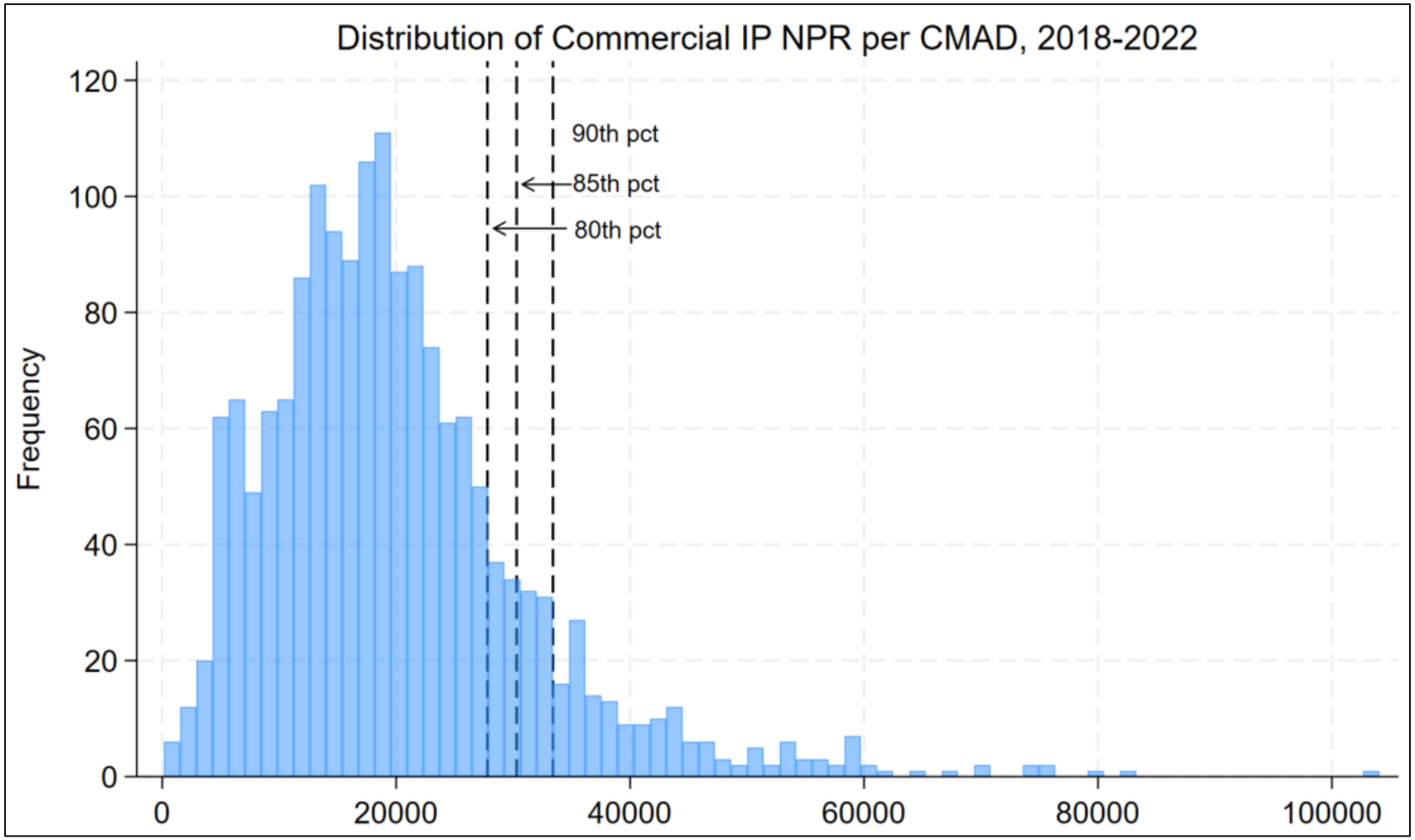
	Mean	80th percentile	85th percentile	90th percentile	Tukey Outlier (75th percentile + (.25 x IQR)*	One Standard Deviation Above the Mean	Two Standard Deviations Above the Mean
Commercial IP NPR per CMAD	$21.1K	$27.8K	$30.3K	$33.4K	$29.1K	$32.2K	$43.3K
Commercial to Medicare PTCR	205%	265%	279%	303%	281%	301%	398%

Note: Descriptive statistics weighted by the number of inpatient discharges.

*Sacarny, A., Barnett, M. L., Le, J., Tetkoski, F., Yokum, D., & Agrawal, S. (2018). Effect of peer comparison letters for high-volume primary care prescribers of quetiapine in older and disabled adults: A randomized clinical trial. *JAMA Psychiatry*, *75*(10), 1003. https://doi.org/10.1001/jamapsychiatry.2018.1867. The Tukey method is an approach for identifying outliers. To identify observations that are outliers on the right tail of a distribution, one uses the 75th percentile plus a multiplier factor of the interquartile range. Tukey JW. Exploratory Data Analysis. Addison-Wesley Publishing Company, 1977.

3. Distribution of Unit Price among Comparable Hospitals, 2018-2022

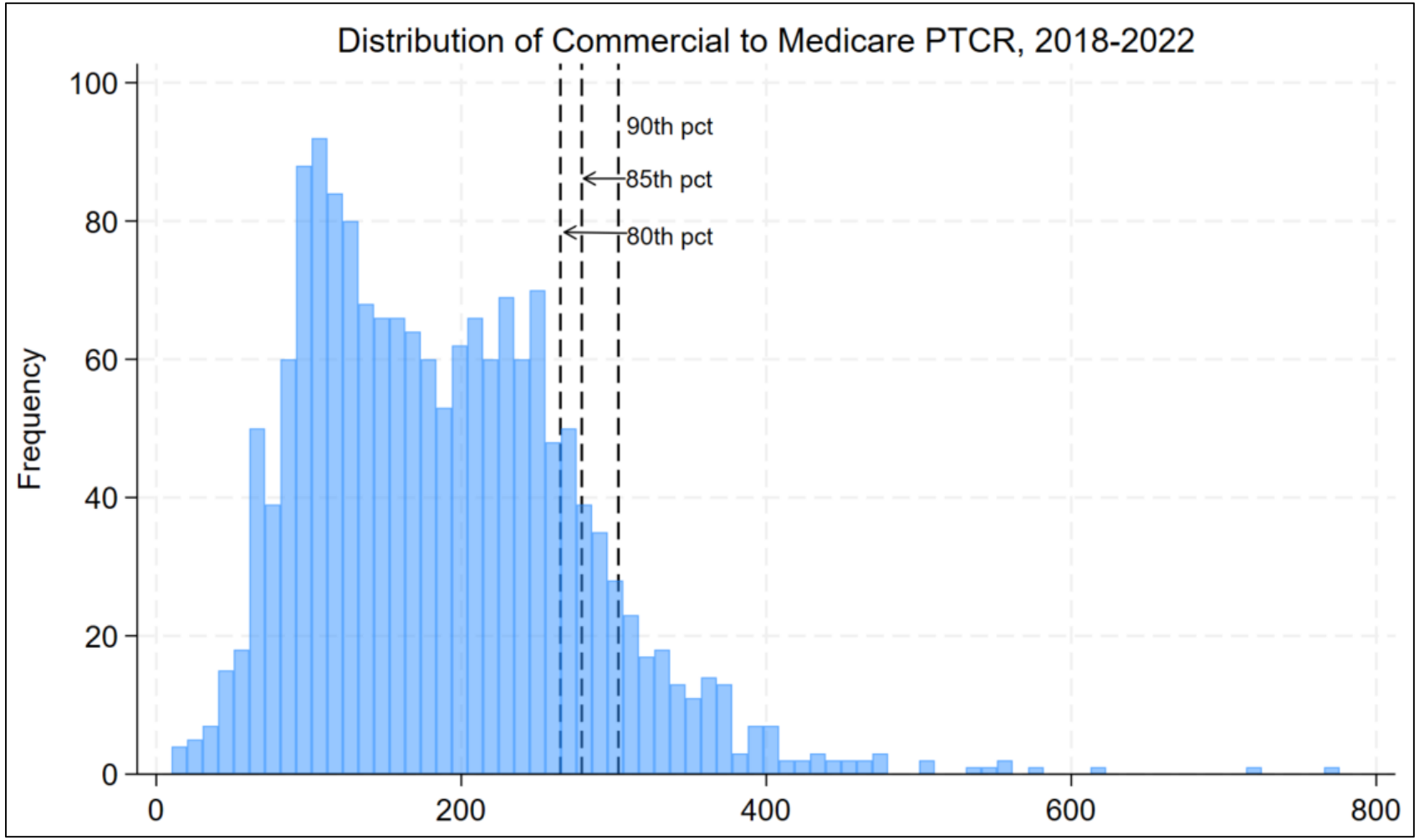
The histogram shows where the 80th ($27.8K), 85th ($30.3K) and 90th ($33.4K) percentiles array within the broader distribution of Commercial IP NPR per CMAD.



Figures include comparable hospitals with at least 5% of gross patient revenue from Medicare or Commercial payers.

3. Distribution of Relative Price among Comparable Hospitals, 2018-2022

The histogram shows where the 80th (265%), 85th (279%) and 90th (303%) percentiles array within the broader distribution of Commercial to Medicare PTCR.



Figures include comparable hospitals with at least 5% of gross patient revenue from Medicare or Commercial payers.

4. Hospital Reporting Comparison

Data Source	Description	Advantages	Limitations
CMS Hospital Price Transparency	Self-reported gross charges, payer-specific negotiated rates, and cash discount prices by service for all services posted on each hospital's website in a comprehensive machine-readable file. A display of self-reported gross charge, payer rate and cash prices for 300 shoppable services in a consumer-friendly format.	• Includes gross charges, payer rates and cash prices for all items and services. • Includes gross charges, payer rates and cash prices for 300 shoppable services in a consumer-friendly format.	• Not available prior to 2021. • May be difficult to locate on a hospital website. • Not all California hospitals may be in compliance.* • Variation in form, formats prior to July 2024 complicates usability and comparisons.** • Service volume is not reported, which limits calculation of total revenue or spend.
HCAI Hospital Annual Financial	Self-reported general hospital information, ownership, medical staff specialties, services inventory, number of beds, utilization data by payer, balance sheets, statements of changes in equity, income statements, cash flows, revenues by payer, expenses by natural classification, cost allocation, and labor hours and hourly rates.	• Publicly available from 2012-2023 on data.ca.gov. • Contains data on all California hospitals. • Standardized form and format aids comparisons.	• Does not contain gross charges, payer rates and cash prices for all items and services. • Does not have a display of gross charges, payer rates and cash prices paid for 300 shoppable services.

*Mulaney, B., et al. (2021) Compliance with Price Transparency Policy by California Hospitals (Working Paper). The Freeman Spogli Institute for International Studies, Stanford. https://healthpolicy.fsi.stanford.edu/publication/compliance-price-transparency-california-hospitals. ** Gordon, L., et al. (2024) Health Care Transparency: CMS Needs More Information on Hospital Pricing Data Completeness and Accuracy. United States Government Accountability Office. https://www.gao.gov/assets/gao-25-106995.pdf.

OHCA's Recommendation for Hospital Sector Target Methodology and Values

OHCA's Recommendation for Hospital Sector Target Setting

Today, OHCA will present its recommended methodology for identifying high-cost hospitals and a methodology for adjusting target values for those hospitals.

- Today's discussion starts a 45-day public comment window that will end on April 11, 2025.
- The Board will have until June 1st to set targets for 2026 and can set targets for beyond 2026 at this time.

To adjust target values, we must consider:

1. How to identify disproportionately high-cost hospitals that merit a lower target.
2. How to determine sector target values and adjust for disproportionately high-cost hospitals.

Recommendation to Identify Disproportionately High-Cost Hospitals

OHCA recommends selecting disproportionately high-cost hospitals that merit a lower target value by identifying hospitals that are above the 85th percentile for 3 out of 5 years on both the unit price measure of Commercial Inpatient Net Patient Revenue (NPR) per Case Mix Adjusted Discharge (CMAD) and relative price measure of Commercial to Medicare Payment to Cost Ratio (PTCR). Additionally, OHCA recommends excluding hospitals whose financial data is not available or comparable, and those that do not meet a payer-mix threshold of 5% gross patient revenue from Medicare or Commercial payers. Based on board input, OHCA did not apply or consider a discharge threshold in this analysis.

1. OHCA recommends identifying outliers as those that are above the 85th percentile. The 85th percentile approximates one standard deviation above the mean and the Tukey outlier method described previously.
2. OHCA recommends identifying repeat outliers as those that are above the 85th percentile for 3 out of 5 years (from 2018-2022) on both unit and relative price measures. Selecting hospitals that are outliers in 3 or more years identifies hospitals with systematically high costs.

Recommendation to Identify Disproportionately High-Cost Hospitals

3. OHCA recommends measuring unit price based on the measure, Commercial Inpatient NPR per CMAD, and relative price based on the measure, Commercial to Medicare PTCR. Using both measures identifies hospitals that have consistently high costs across multiple measures.
4. OHCA recommends a payer-mix threshold of 5%. A hospital's share of revenue needs to come from a broad payer mix for the Commercial to Medicare PTCR measure to be credible.
5. OHCA recommends excluding non-comparable hospitals from this analysis. Comparable financial data is not available for Kaiser Hospitals, Long Term Care Emphasis Hospitals, Psychiatric Health Facilities, Shriner's, and State Hospitals.

This approach identifies 11 hospitals as repeatedly disproportionately high-cost outliers.

Commercial Inpatient NPR per CMAD for Repeat Outlier Hospitals, 2018-2022

Key: above 85%

Hospital	2018	2019	2020	2021	2022	Pooled Avg 2018-22
All Other Comparable Hospitals	**$19.9K**	**$19.6K**	**$20.0K**	**$20.3K**	**$21.0K**	**$20.2K**
11 High-Cost Hospitals	**$37.8K**	**$40.8K**	**$41.0K**	**$40.2K**	**$41.5K**	**$40.2K**
Barton Memorial Hospital	$44,175	$37,411	$39,998	$33,344	$34,843	$38.4K
Community Hospital of The Monterey Peninsula	$32,729	$41,866	$42,292	$43,655	$38,891	$39.9K
Doctors Medical Center – Modesto	$27,288	$40,915	$35,947	$36,831	$39,679	$36.0K
Dominican Hospital	$37,237	$33,720	$33,201	$34,923	$33,291	$34.5K
Salinas Valley Memorial Hospital	$46,937	$43,061	$44,748	$50,400	$48,784	$46.7K
Stanford Health Care	$47,705	$47,374	$49,091	$53,366	$58,873	$51.5K
Goleta Valley Cottage Hospital	$29,669	$30,225	$31,738	$35,619	$34,842	$31.9K
Marshall Medical Center	$37,593	$37,125	$40,612	$31,305	$29,328	$35.5K
Northbay Medical Center	$56,414	$59,246	$53,057	$24,582	$22,062	$42.8K
Santa Barbara Cottage Hospital	$31,185	$30,325	$36,617	$32,636	$33,596	$32.8K
Washington Hospital – Fremont	$32,200	$33,404	$30,929	$33,082	$35,432	$32.9K

Commercial to Medicare Payment to Cost Ratio for Repeat Outlier Hospitals, 2018-2022

Key: above 85%

Hospital	2018	2019	2020	2021	2022	Pooled Avg 2018-22
All Other Comparable Hospitals	**202%**	**199%**	**200%**	**190%**	**197%**	**200%**
11 High-Cost Hospitals	**328%**	**365%**	**356%**	**344%**	**352%**	**350%**
Barton Memorial Hospital	409%	888%	981%	776%	942%	773%
Community Hospital of The Monterey Peninsula	239%	436%	352%	362%	369%	353%
Doctors Medical Center - Modesto	325%	371%	341%	324%	371%	347%
Dominican Hospital	355%	313%	336%	315%	333%	331%
Salinas Valley Memorial Hospital	405%	457%	461%	556%	501%	475%
Stanford Health Care	328%	336%	341%	351%	340%	340%
Goleta Valley Cottage Hospital	368%	391%	398%	370%	384%	383%
Marshall Medical Center	266%	302%	306%	297%	267%	288%
Northbay Medical Center	396%	290%	329%	174%	165%	269%
Santa Barbara Cottage Hospital	293%	300%	310%	310%	311%	305%
Washington Hospital - Fremont	349%	394%	353%	329%	364%	359%

Recommendation for Setting Sector Target Value

OHCA recommends setting the hospital sector target equal to the statewide target – to which they are already subject. Setting the hospital sector target equal to the statewide target clarifies that hospitals in the sector are subject to the statewide target unless and until the board modifies the spending target for the entire hospital sector or specific hospitals within the sector.

Performance Year	Per Capita Spending Growth Target
2026	3.5%
2027	3.2%
2028	3.2%
2029	3.0%

Recommendation for Adjusting the Sector Target for the Identified High-Cost Hospitals

OHCA recommends the following steps for setting a target value for identified high-cost hospitals that compares the identified group of hospitals that are repeat outliers on both unit and relative price measures with other hospitals in the sector:

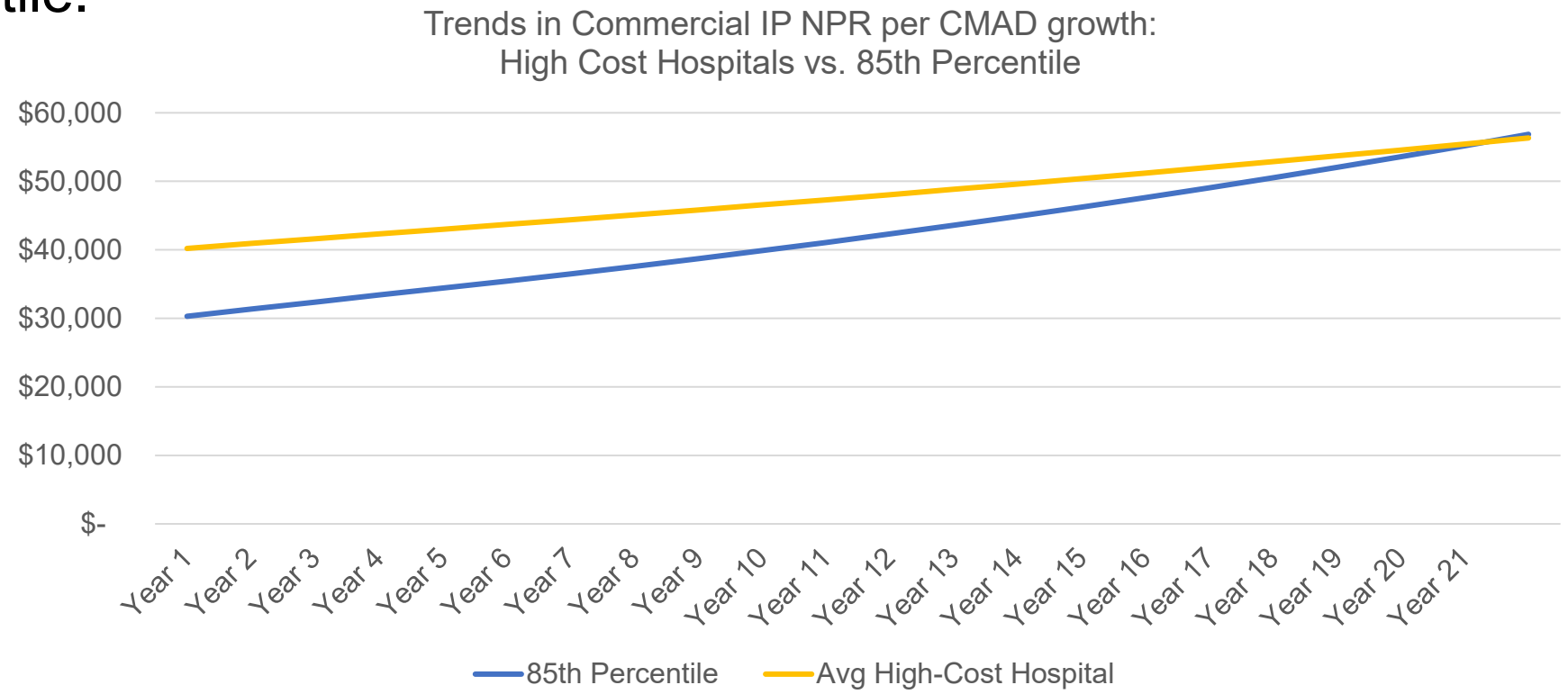
1. Divide the identified high-cost hospitals' average Commercial Inpatient NPR per CMAD weighted by the number of inpatient discharges for the five-year period 2018-2022, by the outcome of all other comparable hospitals' average Commercial Inpatient NPR per CMAD weighted by the number of inpatient discharges for the five-year period.
2. Divide the identified high-cost hospitals' average Commercial to Medicare Payment to Cost Ratio weighted by the number of inpatient discharges for the five-year period 2018-2022, by the outcome of all other comparable hospitals' average Commercial to Medicare Payment to Cost Ratio weighted by the number of inpatient discharges for the five-year period.
3. Average the outcomes from the calculations in step 1 and step 2.
4. Divide current statewide spending target by the average of the outcomes in step 3.

Recommendation for Adjusting the Sector Target for the Identified High-Cost Hospitals

Weighted Average Commercial Inpatient NPR per CMAD of High-Cost Hospitals (A)	Weighted Avg Commercial Inpatient NPR per CMAD All Other Hospitals (B)	Commercial Inpatient NPR Per CMAD Cost Relativity (C)=(A/B)	Combined Cost Relativity (G)=(C+F)/2	Statewide Spending Target for each performance year (H)		Recommended High-Cost Target Values by performance year (I)=(H/G)
$40,200	$20,200	2.0	1.9	2026	3.5%	1.8%
Weighted Average Commercial to Medicare Payment to Cost Ratio(PCTR) of High-Cost Hospitals (D)	Weighted Average Commercial to Medicare PTCR All Other Hospitals (E)	PTCR Cost Relativity (F)=(D/E)		2027 & 2028	3.2%	1.7%
350%	200%	1.8		2029	3.0%	1.6%

Projecting Commercial IP NPR per CMAD

In a scenario where high-cost hospitals grow at the proposed adjusted target values*, and the 85th percentile grows at the current statewide target values**, it would be approximately 20 years before high-cost hospitals come in line with the 85th percentile.



*2026 at 1.8%, 2027 and 2028 at 1.7%, and 2029 and beyond at 1.6%
**2026 at 3.5%, 2027 and 2028 at 3.2%, and 2029 and beyond at 3.0%

Recommendation for Adjusting the Sector Target for the Identified High-Cost Hospitals

- Under the status quo, the high-cost facilities would continue to grow no more than the statewide spending target but are doing so from a higher baseline level. Further limiting the rate of growth for these hospitals would bring the costs incurred by consumers for these hospitals more in line with the broader hospital sector, thereby reducing historical inequities between high-cost facilities and more efficient facilities.
- Lower costs from a slower rate of growth promotes more equitable access to more affordable care for Californians.
- Rooting the adjustment methodology in the statewide target underscores the principle of consumer affordability, as the statewide target is based on median household income growth, a key metric of consumer affordability.

Recommendation for Duration

OHCA recommends aligning the adjusted sector target values with the current statewide spending target schedule, 2026-2029:

- A multi-year target provides hospitals long-term predictability.
- Knowing the target value in advance encourages cooperation within the health care industry to meet the targets and allows the targets to influence negotiations for contracting and inform strategic planning and operations.

In the event of extraordinary circumstances, including highly significant changes in the economy or the health care system, the Board may consider changes to the target. OHCA recommends that the Board meet annually to consider any needed updates to the target, including adjustments for unforeseen circumstances.

OHCA Recommendation: Target Values for High-Cost Hospitals

	Hospital*	2026	2027	2028	2029
1	Barton Memorial	1.8%	1.7%	1.7%	1.6%
2	Community Hospital of the Monterey Peninsula	1.8%	1.7%	1.7%	1.6%
3	Doctors Medical Center - Modesto	1.8%	1.7%	1.7%	1.6%
4	Dominican Hospital	1.8%	1.7%	1.7%	1.6%
5	Salinas Valley Memorial Hospital	1.8%	1.7%	1.7%	1.6%
6	Stanford Health Care	1.8%	1.7%	1.7%	1.6%
7	Goleta Valley Cottage Hospital	1.8%	1.7%	1.7%	1.6%
8	Marshall Medical Center	1.8%	1.7%	1.7%	1.6%
9	Northbay Medical Center	1.8%	1.7%	1.7%	1.6%
10	Santa Barbara Cottage Hospital	1.8%	1.7%	1.7%	1.6%
11	Washington Hospital - Fremont	1.8%	1.7%	1.7%	1.6%

*All other hospitals in the sector and health care entities are subject to the statewide spending target.

Board Input

Does the Board have input on OHCA's recommendations for identifying high-cost hospitals, and setting and adjusting sector targets?

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Update on Proposed Hospital Sector Definition Regulations

Vishaal Pegany, Deputy Director

CJ Howard, Assistant Deputy Director

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Department of Health Care Access and Information

Hospital Sector Rulemaking Timeline for OHCA's Recommendation

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Department of Health Care Access and Information

Text of Proposed Regulations

California Code of Regulations
Title 22. Social Security
Division 7. Health Planning and Facility Construction
Chapter 11.5. Promotion of Competitive Health Care Markets; Health Care Affordability
Article 2. Health Care Spending Targets.

§ 97446. Health Care Sectors

Health care sectors, pursuant to Health and Safety Code section 127502, subdivisions (b)(1) and (l)(2)(A), are as follows:

(a) Hospital Sector. The hospital sector includes the following:
(1) General acute care hospital, as used in Health and Safety Code section 1250, subdivision (a),
(2) Acute psychiatric hospital, as used in Health and Safety Code section 1250, subdivision (b),
(3) Special hospital, as used in Health and Safety Code section 1250, subdivision (f),
(4) Chemical dependency recovery hospital, as used in Health and Safety Code section 1250.3, subdivision (a)(1), and
(5) Psychiatric health facility, as used in Health and Safety Code section 1250.2, subdivision (a)(1).

Note: Authority: Sections 127501, 127501.2, 127501.11, and 127502, Health and Safety Code.
Reference: Sections 127501, 127501.11, 127502, Health and Safety Code.

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Baseline Report Content Preview

Andrew Feher, Research and Analysis Group Manager

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Baseline Report

The Baseline Report will include the following health care spending analyses for calendar years 2022-2023:

- Statewide total health care expenditures (THCE).
- THCE by market category (e.g., Commercial, Medicare, Medi-Cal).
- Total medical expense (TME) by service category, region, and payer.

The Baseline Report must be published on or before June 1, 2025.

OHCA currently has all Commercial and Medicare data and is in the process of analyzing those data.

- OHCA has the 2022 Medi-Cal Managed Care Organization (MCO) data and is working with DHCS to obtain the 2023 MCO data.

Baseline Report

The Baseline Report will not include the following:

- Physician organization-level reporting.
- Performance against the target.
  - This will begin with the first Annual Report in 2027 for the 2025 performance year (comparing growth from 2024 to 2025).
- Alternative Payment Model and Primary Care analyses.
  - OHCA will begin data collection September 1, 2025 for calendar years 2023 and 2024.
- Behavioral Health Spending.

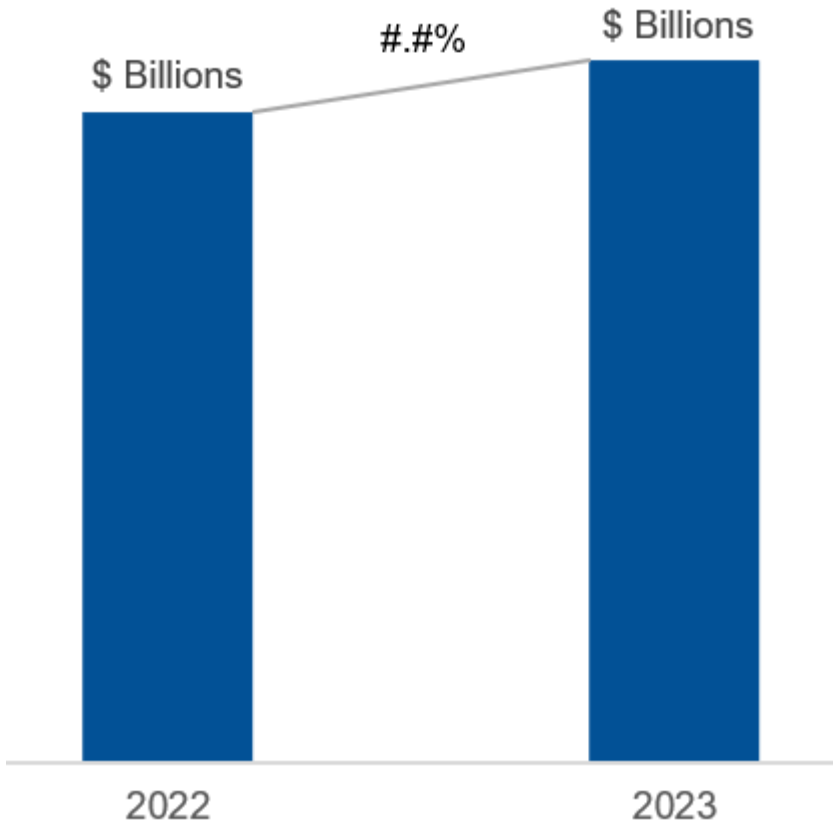
Baseline Report

The purpose of this presentation is to preview some of the analyses, show how the data will be presented, and obtain feedback.

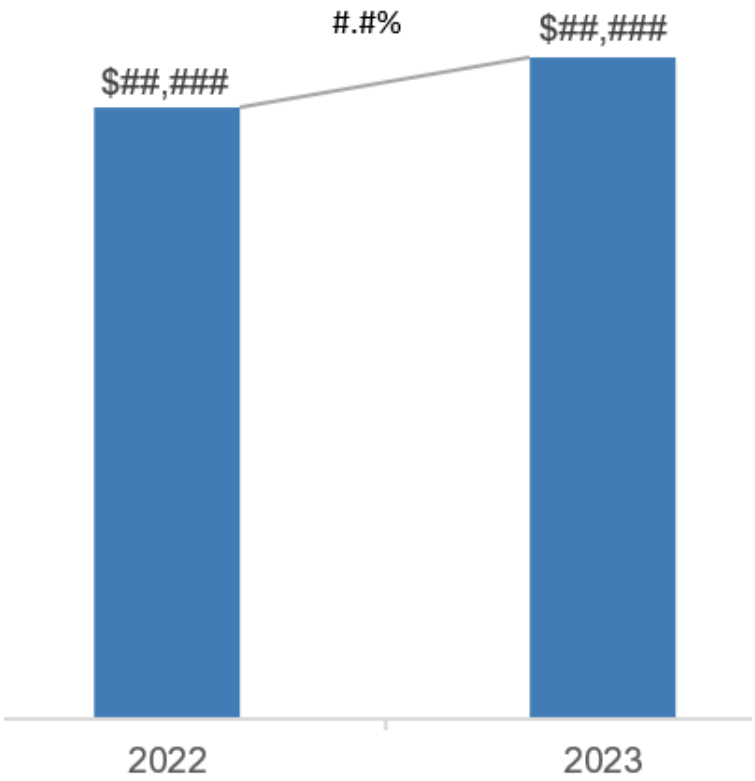
The exhibits on forthcoming slides **do not** contain actual data.

Statewide THCE

Statewide THCE and YoY Percentage Change

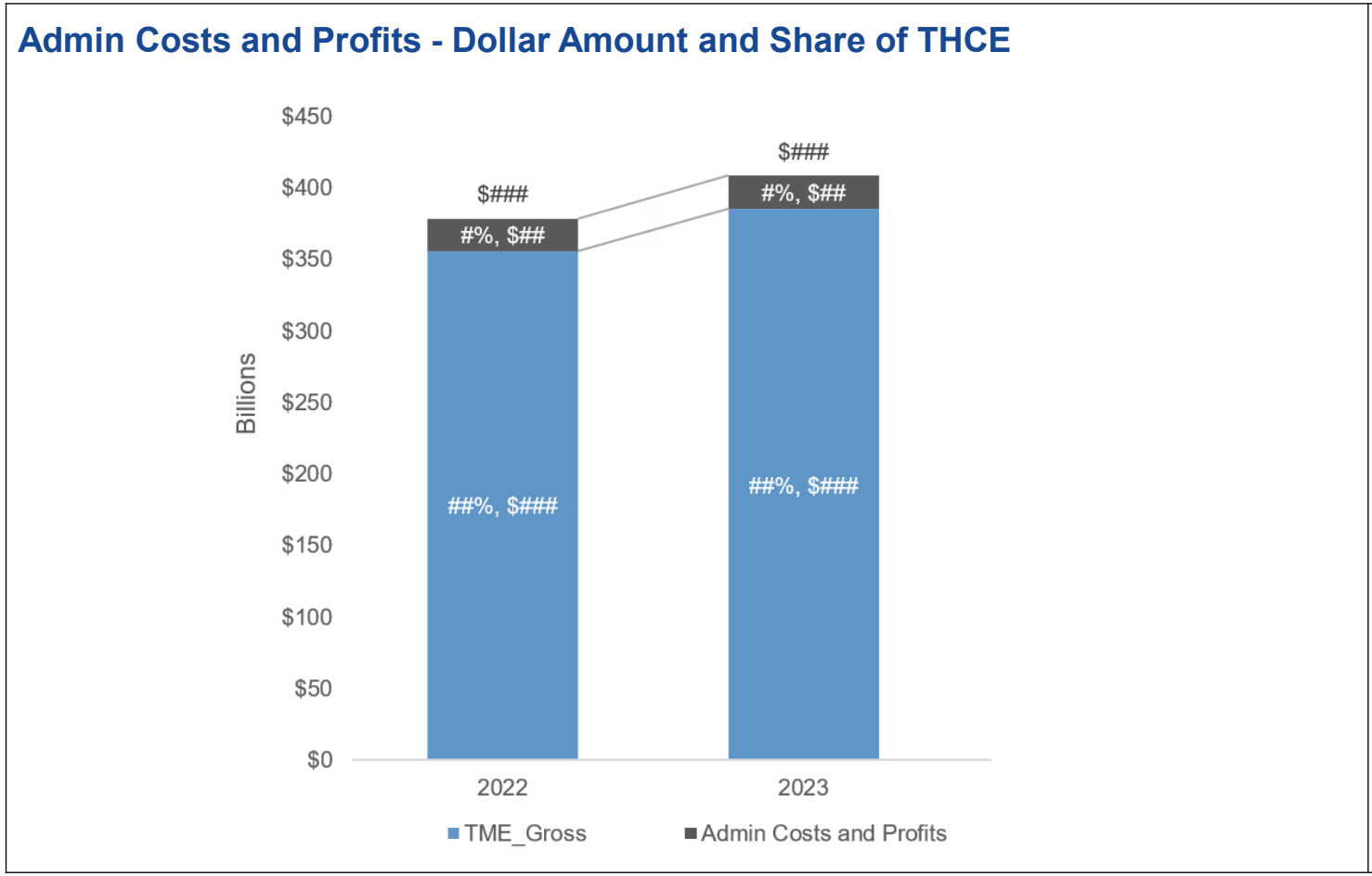


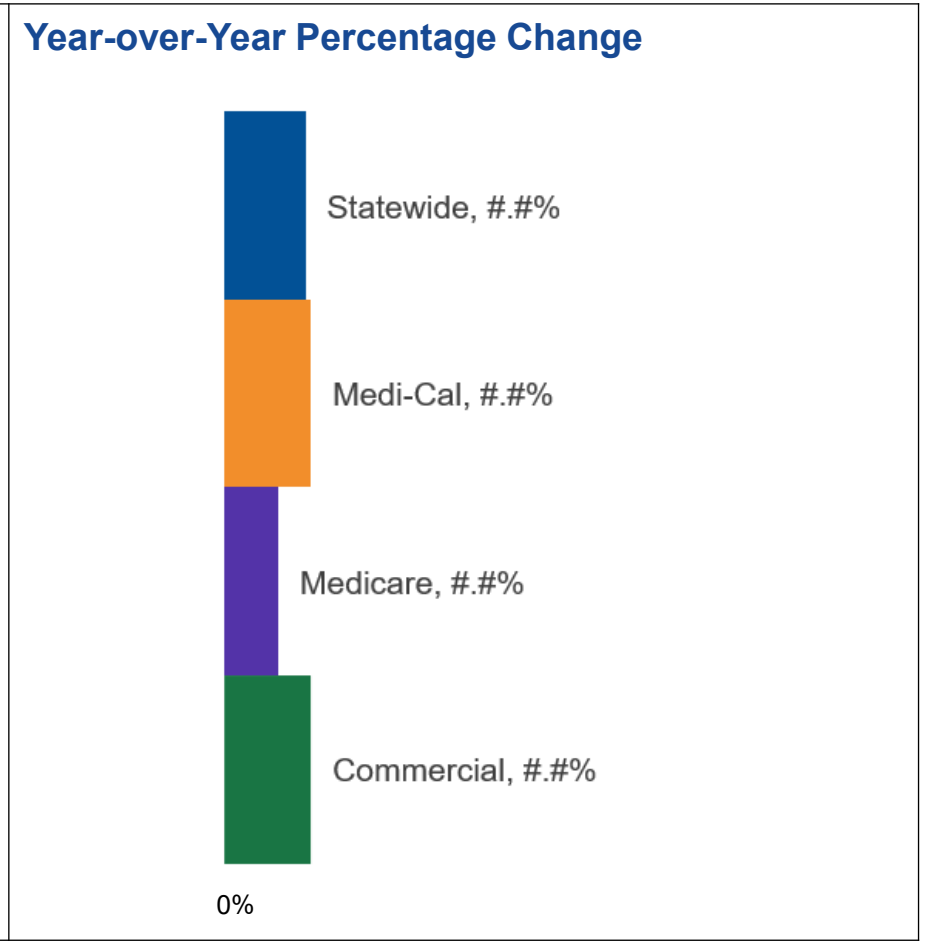
Statewide THCE Per Capita and YoY Percentage Change



Statewide total health care expenditures (THCE) overall, per capita, and their respective year-over-year (YOY) percentage change.

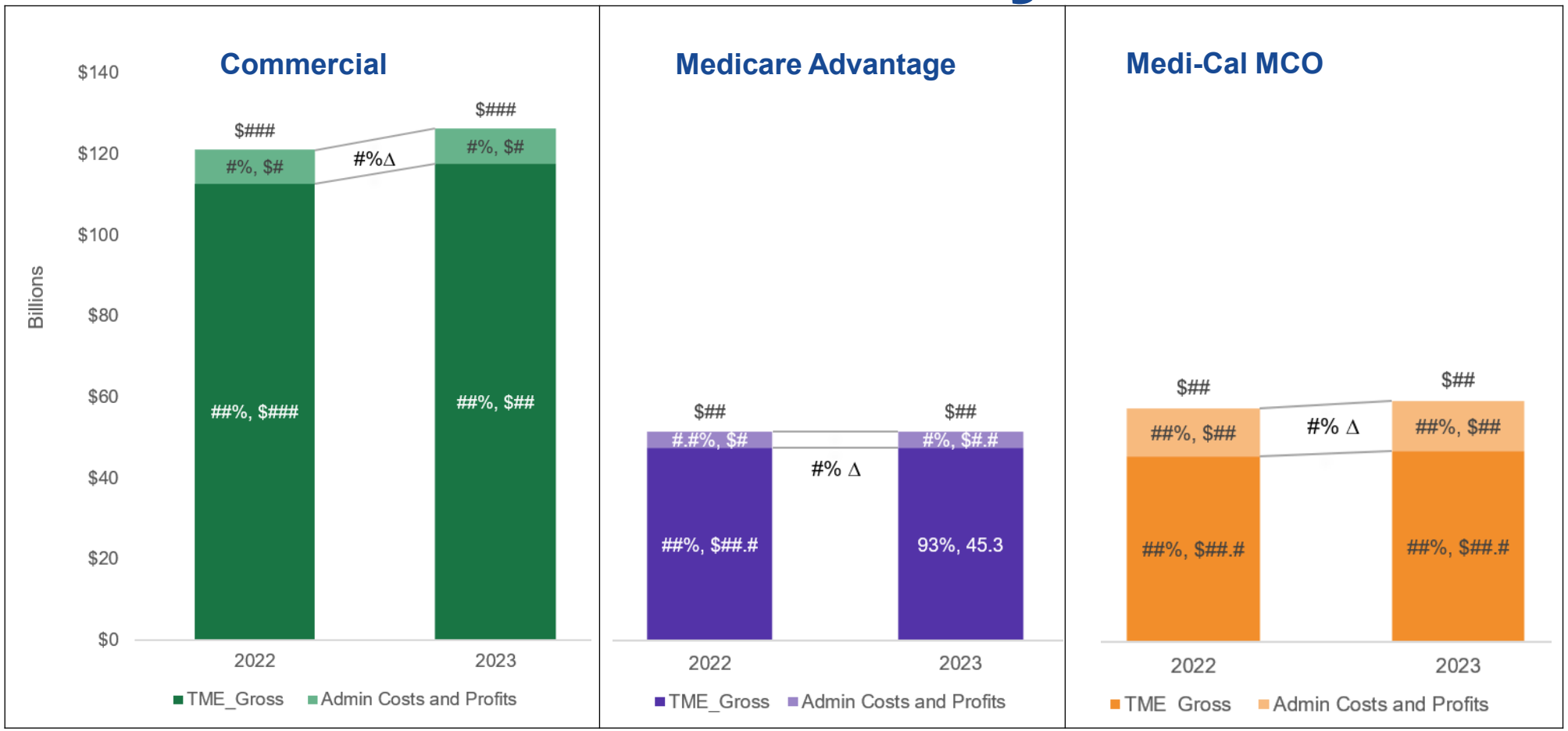
Statewide Administrative Costs and Profits





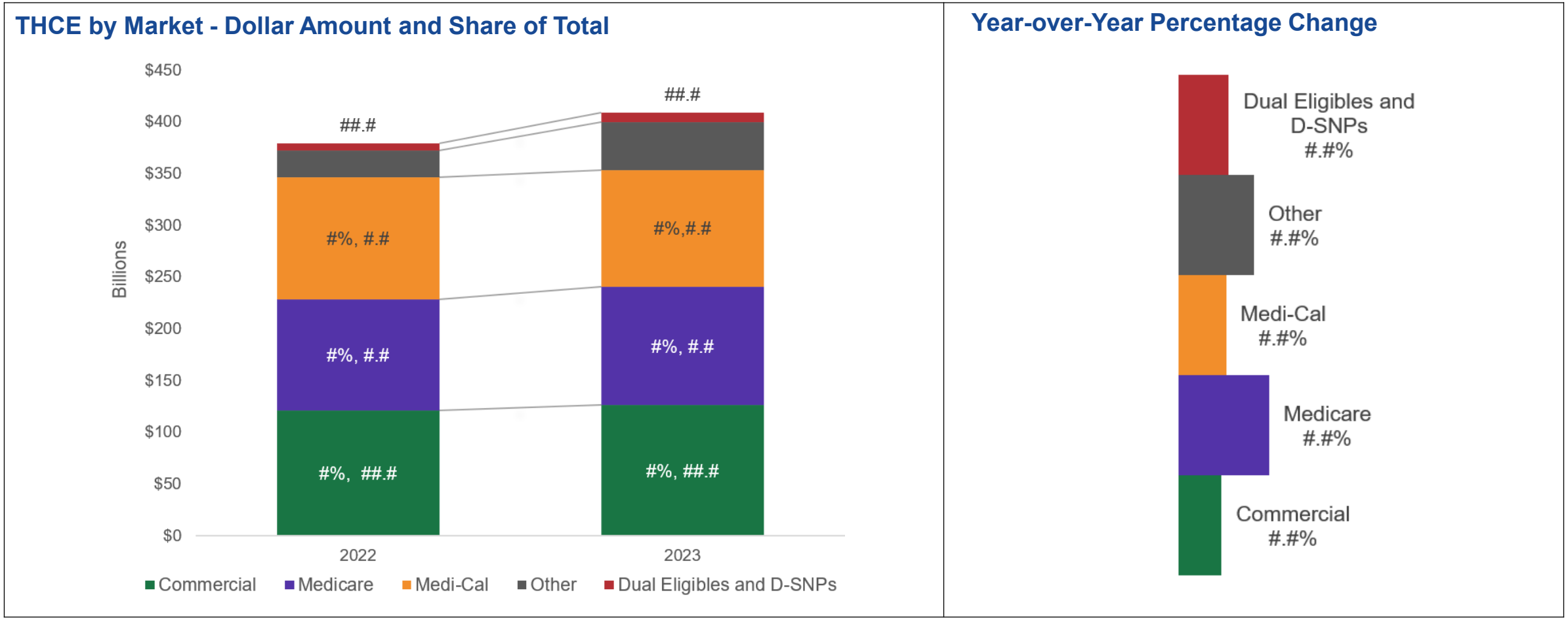
Statewide THCE disaggregated by TME and administrative costs and profits and as a share of total health care expenditures.

Admin Costs and Profits by Market



THCE disaggregated by TME and administrative costs and profits for the Commercial, Medicare Advantage, and Medi-Cal MCO markets.

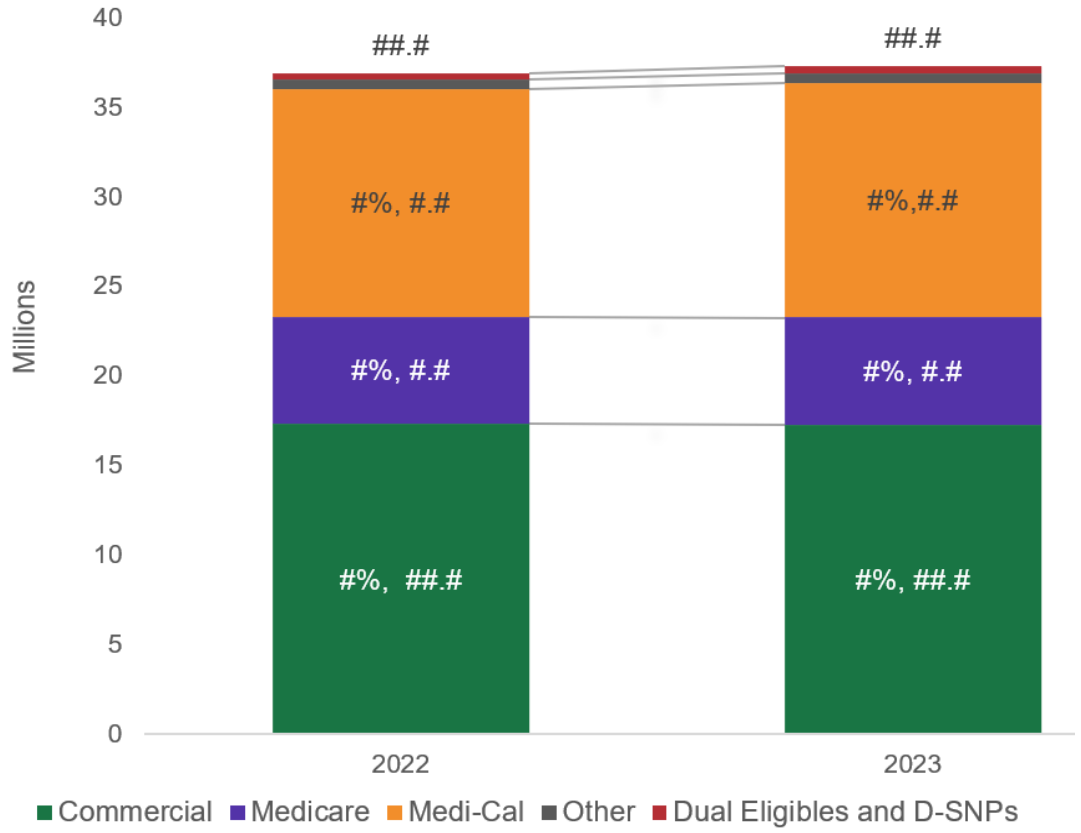
Statewide THCE by Market Category



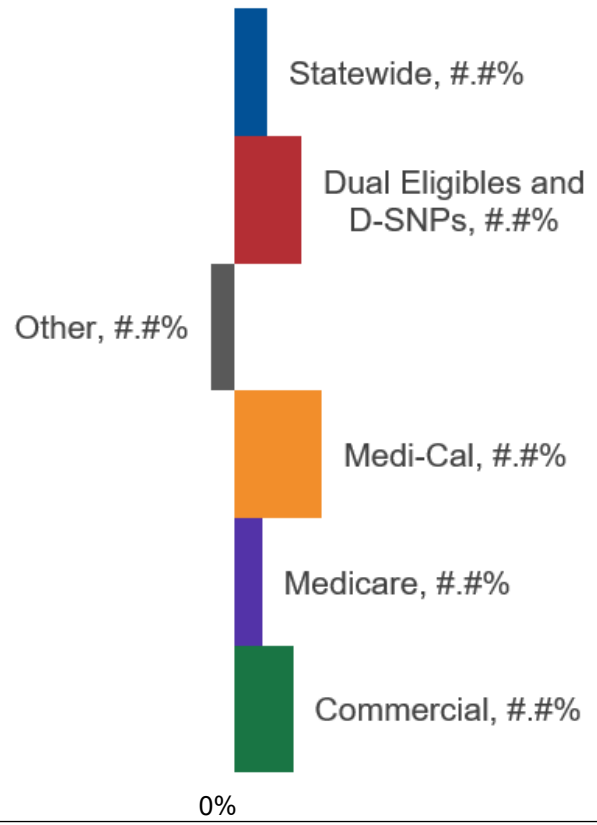
THCE by market and year-over-year percentage change.

Statewide Enrollment

Enrollment Count by Market and Market as Share of Statewide

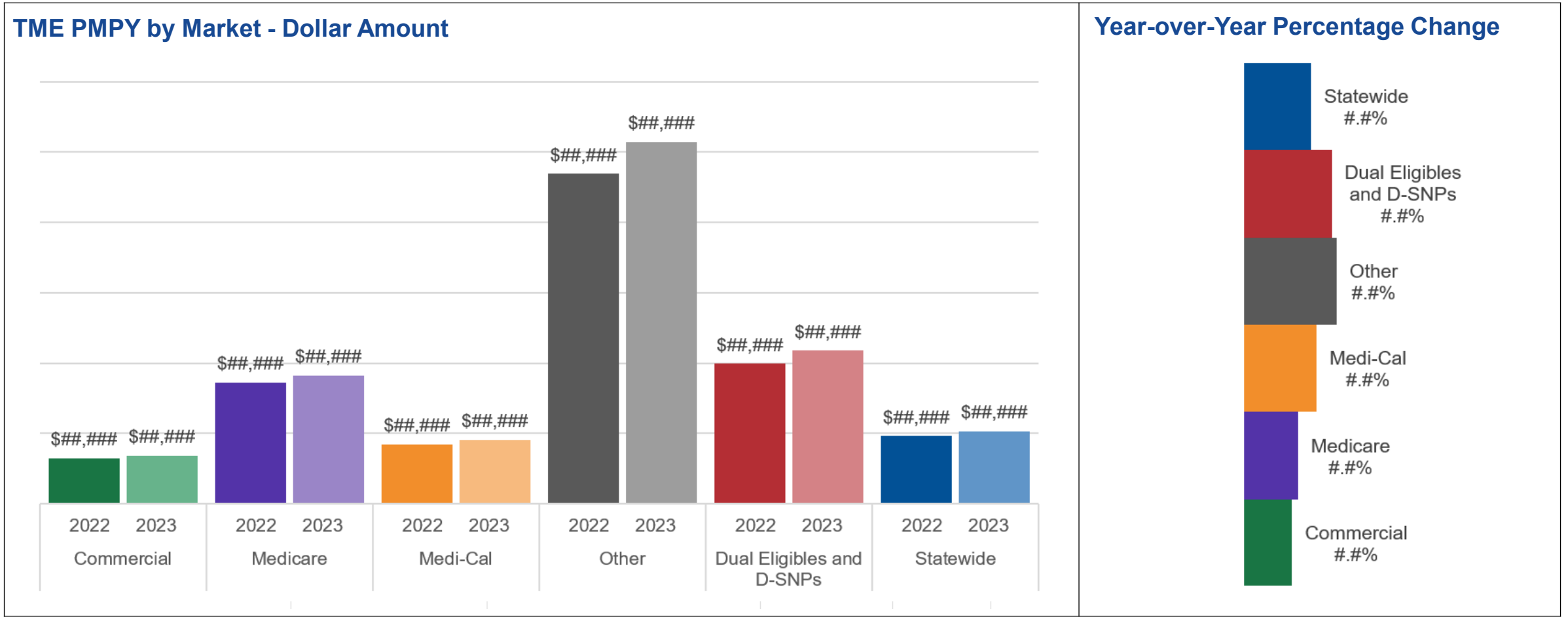


Year-over-Year Percentage Change



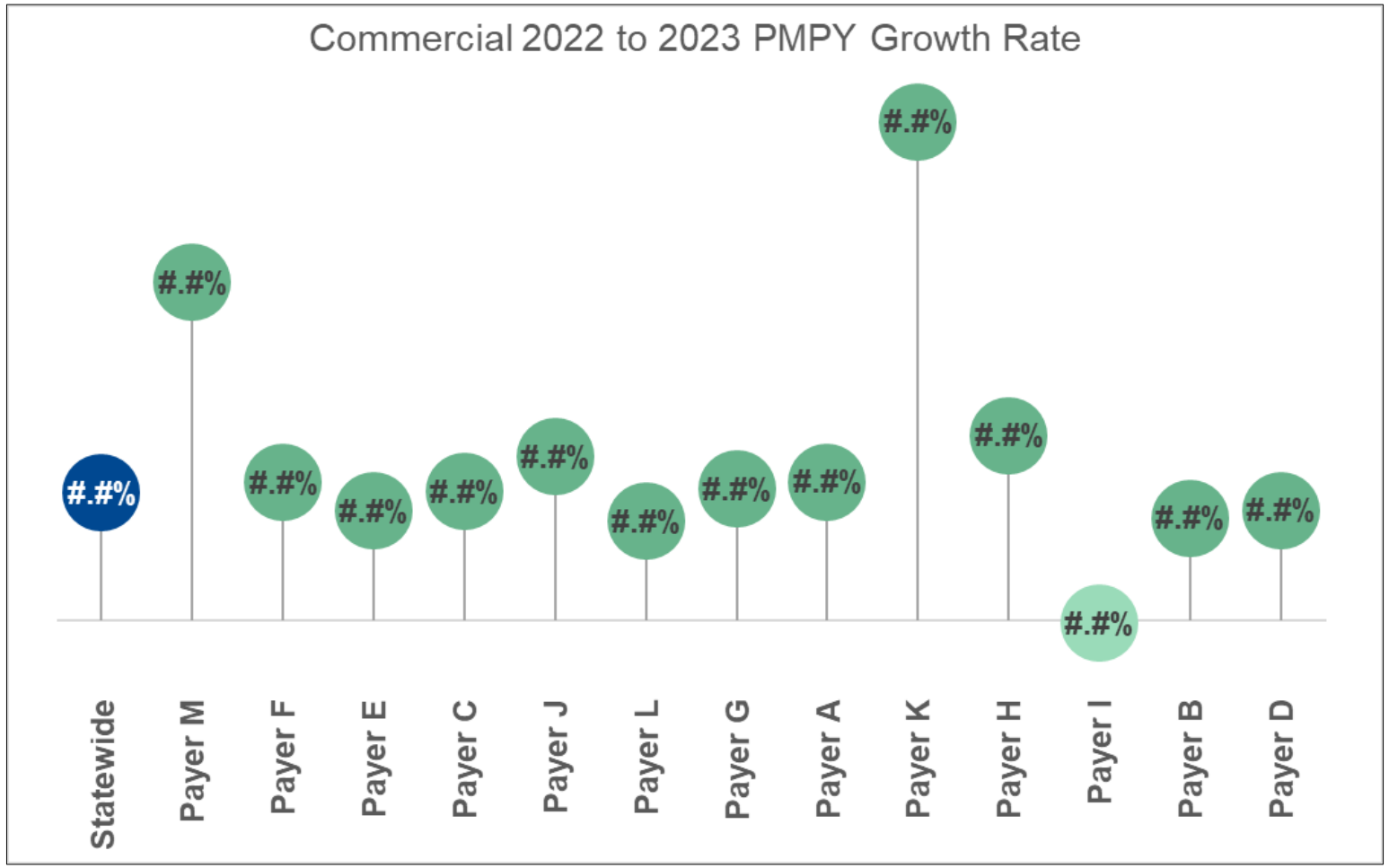
Enrollment by market

TME PMPY by Market



Total medical expenses per member per year (TME PMPY) amount by market and year-over-year percentage change.

TME PMPY Percent Growth by Payer



TME PMPY percentage growth from 2022 to 2023 by Commercial, Medicare Advantage and Medi-Cal MCO markets.

Commercial and Medicare Advantage Enrollment by Payer

Commercial Payers	2023 Market Share
Kaiser	##.#%
Blue Shield of California	##.#%
Elevance Health	##.#%
UnitedHealthcare	##.#%
Aetna	##.#%
Cigna Healthcare	##.#%
Centene / Health Net	##.#%
LA Care	##.#%
Sharp Health Plan	##.#%
Western Health Advantage	##.#%
Sutter Health Plan	##.#%
Molina Healthcare of California	##.#%
Valley Health Plan	##.#%
Total Members (N)	17,200,000

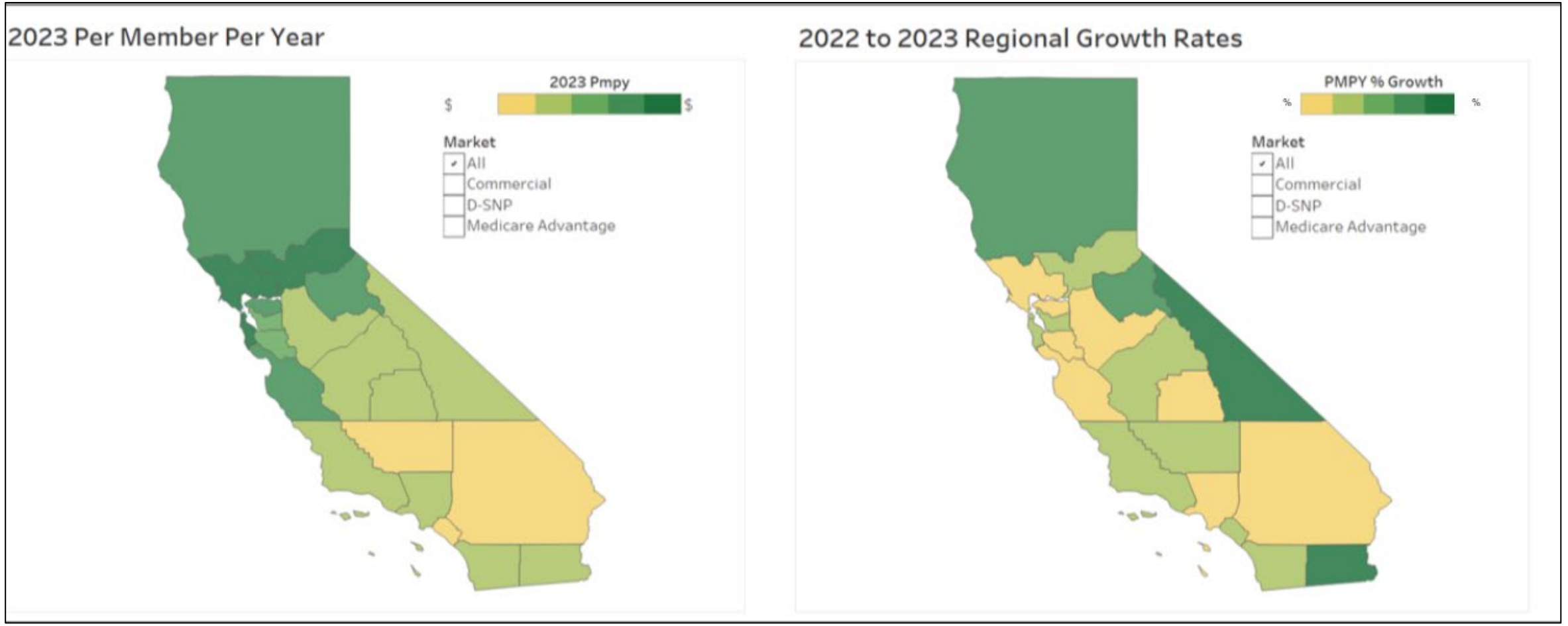
Medicare Advantage Payers	2023 Market Share
Kaiser Foundation Health Plans	##.#%
UnitedHealthcare	##.#%
SCAN Health Plan	##.#%
Blue Shield of California	##.#%
Centene / Health Net	##.#%
Elevance Health	##.#%
Aetna	##.#%
Alignment Health	##.#%
Universal Care Inc.	##.#%
Central Health Plan of California	##.#%
Sharp Health Plan	##.#%
Western Health Advantage	##.#%
Molina Healthcare of California	##.#%
Total Members (N)	2,600,000

Medi-Cal Enrollment by Managed Care Organization (MCO)

MCO Payers	2022 Market Share
Local Initiative Health Authority for Los Angeles	##.#%
Centene / Health Net	##.#%
Elevance Health	##.#%
Molina Healthcare of California	##.#%
Centene / Health Net	##.#%
Kaiser Foundation Health Plans	##.#%
Blue Shield of California	##.#%
Aetna	##.#%
UnitedHealthcare	##.#%
SCAN Health Plan	##.#%
Inland Empire Health Plan	##.#%
CalOptima	##.#%
Partnership Health Plan of California	##.#%
Health Plan of San Joaquin	##.#%
CalViva Health	##.#%
Central Coast Alliance for Health	##.#%
Kern Health Systems	##.#%
Community Health Group (CHG)	##.#%
Alameda Alliance for Health	##.#%
Santa Clara Family Health Plan	##.#%
Gold Coast	##.#%
Contra Costa Health Plan	##.#%
CenCal Health	##.#%
San Francisco Health Authority	##.#%
Health Plan of San Mateo	##.#%
Aids Healthcare Foundation	##.#%
Total Members (N)	12,700,000

TME by Region

Regional



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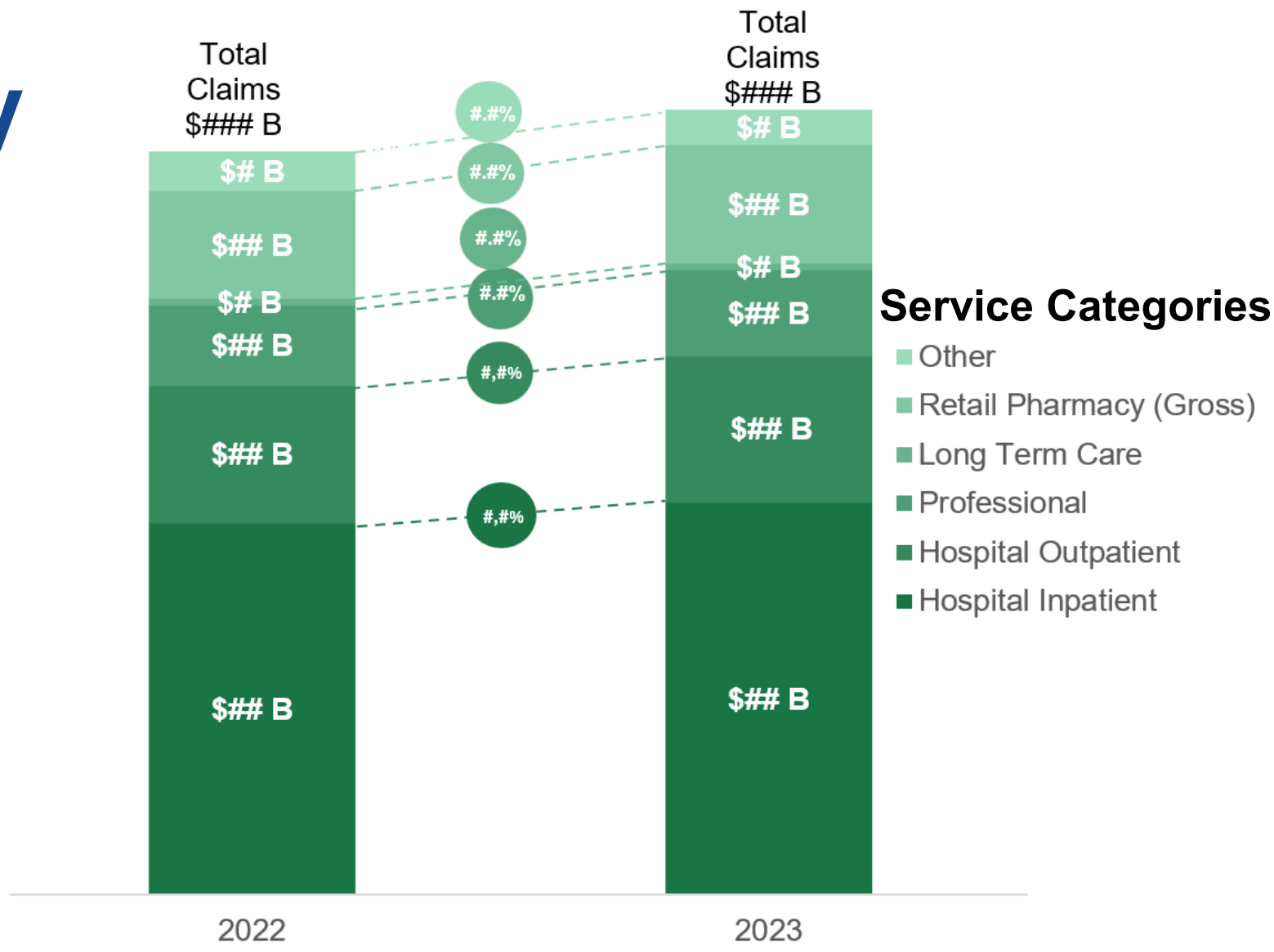
TME by Service Category



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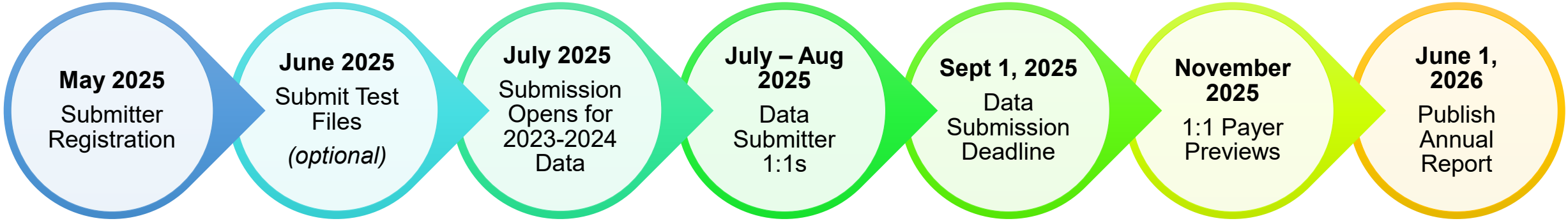
Proposed Total Health Care Expenditures Regulations: Summary of Public Comments

Margareta Brandt, Assistant Deputy Director,
CJ Howard, Assistant Deputy Director

HCAI

Department of Health Care Access and Information

2025 Data Collection Timeline



Theme	Comment/Question Summary	OHCA Response
Data Collection	Request to clarify scope of proposed definition of "affiliated" in 22 CCR 97445(a).	OHCA amends the term "affiliation" to "affiliated" for consistency with how the term is used in the regulations in 22 CCR 97449(d). OHCA also adds a cross-reference to the regulations where the term is used for clarity. The proposed changes are only for consistency and clarity and do not change the scope of the term in any way.
	Concern payments from the State for Medi-Cal providers (*i.e.*, directed payments) are not yet settled by the annual September 1 submission deadline.	OHCA acknowledges that for some claims, run-out may exceed the minimum 180-day claims run-out period. This is one of the reasons why Section 4.1 of the Data Submission Guide (DSG) requires data submission for the previous two calendar years (CY) with each annual data submission. Because the 180-day claims run-out period is calculated from December 31 of the most recent reporting year, updated CY data submitted to OHCA will reflect a claims run-out period of at least 540 days. OHCA intends to use the initial data submissions received in 2024 and 2025 to develop further insight into the impact of the 180-day minimum claims run-out period on overall data completeness.

Theme	Comment/Question Summary	OHCA Response
Data Collection	Concern proposed requirement for payers and FIDS to complete separate data submissions for each licensed health plan and/or health insurer will have significant implications for the data.	The existing “parent” registration is inconsistent with how many submitters operate their businesses in California. Because health plans and health insurers in California are separately licensed and regulated at the state-level by DMHC and CDI, respectively, most submitters are accustomed to reporting data for these license types separately, at the license-level. Additionally, OHCA’s existing “parent” registration is not aligned with the registration process for the Health Care Payments Data (HPD) program, which already requires annual registration at the license-level. The current lack of alignment impacts how entities’ data flows into each program and may make it more difficult for OHCA to utilize HPD program data for future analysis and reporting.
	Request to align how member responsibility amounts are reported across the Statewide TME, Attributed TME, and Regional TME files.	OHCA plans to restore the member responsibility data field in the Statewide TME file.

Theme	Comment/Question Summary	OHCA Response
Data Collection	Recommendation to revisit approach to how submitters report spending in the Commercial (Partial Benefits) market category.	The methodology for estimating expenses in the Commercial (Partial Benefits) market category has not changed from the existing, approved DSG. The proposed DSG includes new data fields in the Submission Questionnaire file to capture the type and amount of estimated expenses for more accurate analysis and reporting.
	Request to clarify whether/how MCO data would be categorized in Commercial (Partial Benefits) given carve-outs for many MH/SUD services and pharmacy.	MCO data would not be reported or otherwise categorized in the Commercial (Partial Benefits) market category because this market category only applies to the commercial market.
	Recommendation to adjust the data submission timeline or revise instructions so submitters can estimate Medicare shared savings amounts for the prior benefit year.	Section 4.1.2 of the DSG instructs submitters to “apply reasonable and appropriate estimations of non-claims liability for each provider (including payments expected to be made to providers not separately identified in the reporting) that are expected to be reconciled after the 180-day reconciliation period.”

Theme	Comment/Question Summary	OHCA Response
Data Exclusions	Request to clarify whether proposed exclusion of spending on “discounts and other member perks” in Section 4.3.1 of the DSG intends to exclude spending on mandatory supplemental benefits in Medicare Advantage plans.	OHCA plans to revise the DSG to clarify this exclusion. OHCA does not intend to exclude the cost of mandatory supplemental benefits in Medicare Advantage plans, as these are part of plan-required coverage beyond traditional Medicare.
	Request to clarify proposed exclusion of CMS reconciliation payments (such as Medicare sweep payments or Part D premiums).	OHCA plans to revise the DSG to clarify this exclusion. Since revenue is not reported in the THCE files, the exclusion of CMS reconciliation payments (such as Medicare sweep payments or Part D premiums) ensures that TME reflects the actual cost of care provided, without adjustments for post-reporting financial reconciliations.

Theme	Comment/Question Summary	OHCA Response
Attribution Addendum	Request to clarify why OHCA reduced the number of physician organizations listed in the Attribution Addendum.	OHCA developed the proposed version of the Attribution Addendum utilizing actual data from the Attributed TME files received from submitters during the September 2024 data submission. OHCA seeks to initially focus on larger entities, which based on analysis of reporting year 2023 data would be physician organizations with greater than 5,000 attributed members across the commercial and Medicare Advantage market categories. Combining the identified organizations' attributed members with the unattributed population (approximately 20 percent of covered lives in reporting year 2023) accounts for nearly ninety percent of covered lives across the commercial and Medicare Advantage market categories. The proposed version of the Attribution Addendum applies a 5,000 attributed member threshold and lists 145 physician organizations. This includes 122 physician organizations retained from the existing Attribution Addendum and 23 physician organizations newly identified through the September 2024 data submission. Within each annual data submission, submitters may identify organizations to which they can attribute at least 1,000 members, for potential addition to a future iteration of the Attribution Addendum. As OHCA refines its attribution approach, OHCA will revisit member thresholds.

Theme	Comment/Question Summary	OHCA Response
Data Accuracy	Recommendation to explore pathways to ensure that provider entity spending is accurately attributed, reported, and consistently aggregated across payers.	OHCA acknowledges that because there is no existing, comprehensive list of physician organizations operating in California with unique identifiers, many issues will need to be resolved with the continued involvement of stakeholders. OHCA notes that the Attribution Addendum will be periodically revised based on information received from submitters, with an ultimate objective of data completeness. All updates to the Attribution Addendum will be made in accordance with the regulatory process.
	Recommendation to allow for public input from payers on a report draft to ensure data is categorized and described accurately. For example, shifts in spending year-over-year may be due to membership changes, benefits mandates, and other factors.	OHCA conducted 1:1 sessions with each submitter in August 2024 prior to data submission, and again in November 2024 to preview total medical expenditure (TME) calculations. At the preview session, each submitter was given the opportunity to provide feedback and/or additional context for their data. OHCA also holds monthly Board meetings with multiple opportunities for public comment, including from payers.

Theme	Comment/Question Summary	OHCA Response
Miscellaneous	Recommendation OHCA and OHCA's vendor, Onpoint, explore additional methods to streamline the error-handling process during data submission.	OHCA and Onpoint are committed to continuously improving the data submitter experience. Webinars leading up to the submission deadline will include training on how to view automated validation errors on submission. Once files pass automated validation, there are additional manual validations that may require submitters to resolve discrepancies. OHCA and Onpoint are also available for technical assistance prior to and during the submission process.
	Recommendation to finalize updates to the DSG earlier than March of the submission year. Can OHCA provide more information on timing of future updates to the DSG?	Any updates to the DSG will be discussed at multiple Board meetings and proceed through a public comment process before submission to the Office of Administrative Law. Updates may occur annually as OHCA fully implements its program. For example, OHCA plans to update the DSG in 2026 to collect data necessary to report on progress towards a future behavioral health investment benchmark.

Theme	Comment/Question Summary	OHCA Response
Miscellaneous	OHCA should work with stakeholders to develop an appropriate risk adjustment methodology prior to any enforcement actions.	OHCA will not modify its risk adjustment methodology to consider clinical risk through these proposed regulations. OHCA currently collects data at the granularity needed to perform age/sex risk adjustment. OHCA will continue to assess the issue of whether clinical risk adjustment should be introduced in future reporting. OHCA remains open to other approaches to risk adjustment and will continue to assess options going forward.
	OHCA should work with DHCS to eliminate overlapping data collection efforts.	Starting Fall 2025, Medi-Cal Managed Care Plans (MCOs) will report primary care spending and APM data to OHCA, using OHCA's methodology, and DHCS will sunset its related reporting requirements. Data submitted to OHCA will be shared between the two departments. Additionally, to minimize reporting burdens for MCOs, the proposed regulations only require MCOs to report spending in the "Medi-Cal Managed Care" and "Dual-Eligibles (Medi-Cal Expenses Only)" market categories in the new APM and Primary Care files in 2025. For all other file types (Total Medical Expense files) OHCA will receive data directly from DHCS and the Centers for Medicare and Medicaid Services (CMS). However, MCOs may choose to voluntarily report spending in the "Medi-Cal Managed Care" and "Dual-Eligibles (Medi-Cal Expenses Only)" market categories to help prepare for full reporting in 2026.

Theme	Comment/Question Summary	OHCA Response
Alternative Payment Model (APM) and Primary Care Files	Request to change “Total Amount Paid/Allowed” to “allowed” amount in Section 4.8.1 of the DSG.	OHCA plans to revise the language in the DSG to “Total Amount Allowed” for consistency with the provided field description.
	Request to clarify how submitters should handle capitation based on risk-adjusted revenue.	Reported payments should match what the data submitter paid the provider organization without any subsequent risk adjustment. Capitation payments developed based on risk-adjusted revenue should be reported as developed and paid to the provider organization.
	Request to clarify why submitters are required to crosswalk primary care providers to the Annual Network Review file submitted to the DMHC.	OHCA proposes this requirement in response to stakeholder concerns that using only taxonomy to identify primary care providers (PCPs) would include some providers with a primary care taxonomy who may hold multiple certifications or subspecialties and do not practice primary care, therefore overinflating primary care spend measurement. OHCA’s Investment and Payment Workgroup suggested leveraging Annual Network Review submissions to accurately identify physicians, nurse practitioners, and physician assistants who practice as PCPs.

Theme	Comment/Question Summary	OHCA Response
Alternative Payment Model (APM) and Primary Care Files	Request to include retail pharmacy costs related to administration of vaccines in reported primary care spending.	During discussions at OHCA's Investment and Payment Workgroup, stakeholders had concerns that care provided at retail pharmacies did not align with the Workgroup's vision for whole-person, comprehensive, coordinated primary care. As a result, OHCA's measurement methodology excludes retail pharmacies as a primary care place of service. If the retail pharmacy place of service were added, all primary care services delivered in this setting would be included in spending measurement, which would not align with the vision for primary care. If only the administration of vaccines in retail pharmacies were added, it would require submitters to develop additional specialized logic to apply to retail pharmacies and would increase submitter administrative burden.
	Request to clarify why only administration of vaccines is considered a primary care service and not the full cost of the vaccine.	OHCA does not include the cost of the actual vaccine as part of primary care spend since this spending is not determined or controlled by primary care practices, nor does spending on the actual vaccine support primary care delivery or transformation. Additionally, the majority of states measuring primary care spending do not include the costs of the actual vaccines.

Theme	Comment/Question Summary	OHCA Response
Alternative Payment Model (APM) and Primary Care Files	Recommendation to allow submitters to estimate care coordination fee (CCF) payments in scenarios where a practice received capitation, but CCF payments are not distinguished as primary versus specialty care.	OHCA only intends to count CCF payments as part of primary care spending if they can specifically be tied to primary care programs. If the CCF payment is embedded within a capitation payment, the formula for allocating a portion of capitation payments to primary care spending (Figure 3 in Section 4.9.2 of the proposed DSG) would apply.
	Request to clarify how submitters should account for the fact that encounter data is incomplete from providers.	OHCA appreciates that incomplete encounter data may impact both the numerator and denominator of the ratio and therefore the impact on the spending allocated to primary care may vary based on completeness of encounter data. OHCA seeks to incentivize payers to work with providers to acquire more complete encounter data to support accurate allocation of these payments.
	Request to clarify hierarchy for payment categories in Section 4.8.1 of the DSG.	OHCA plans to revise the DSG to clarify the hierarchy. Provider clinical and financial risk increases moving across the categories of the Expanded Framework from A (Population Health and Practice Infrastructure Payments) to D (Capitation and Full Risk Payments), and as you move down subcategories within categories B through D.

Theme	Comment/Question Summary	OHCA Response
Alternative Payment Model (APM) and Primary Care Files	Request to clarify whether the Payment Category “X = Fee-for-service” in the APM and Primary Care files includes retail pharmacy.	Within the APM and Primary Care files, payments reported under Payment Category X (“X = Fee-for-service”) must also be reported as Payment Subcategory X9 (“X9 = Claims: Total”). Subcategory X9, total claims payments, includes retail pharmacy.
	Request to clarify why Appendix B: Population Health and Infrastructure Payments does not include payer personnel and internal expenses.	The Population Health and Infrastructure Payments category is intended to capture only those non-claims payments that are made to providers or healthcare delivery organizations that support care delivery goals. Payer personnel and internal expenses are included in OHCA’s calculation of total health care expenditures as part of administrative costs and profits.
	Request to clarify whether care coordination fee (CCF) payments should be categorized furthest along the continuum of clinical and financial risk.	OHCA’s primary care payment allocation methodology asks that non-claims payments within a payment model are reported based on the intended use of the payment and in their distinct payment subcategory to support OHCA’s understanding of the intent of the non-claims payment. The primary care methodology does not require spending be allocated to the category furthest along the continuum. That allocation is only for the APM file.

Theme	Comment/Question Summary	OHCA Response
Alternative Payment Model (APM) and Primary Care Files	Request to update the primary care code set to remove some outdated codes.	OHCA plans to remove and correct several codes to reflect most current codes in use.
	Internal and DHCS review of new codes that align with existing codes in the primary care code set.	OHCA plans to add new codes for telehealth evaluation and management, COVID vaccine administration, and pharmacist subspecialties to align with existing code set.

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Update on Behavioral Health Investment Benchmark, including Advisory Committee Feedback

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Debbie Lindes, Health Care Delivery System Group Manager

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Department of Health Care Access and Information

Primary Care & Behavioral Health Investments

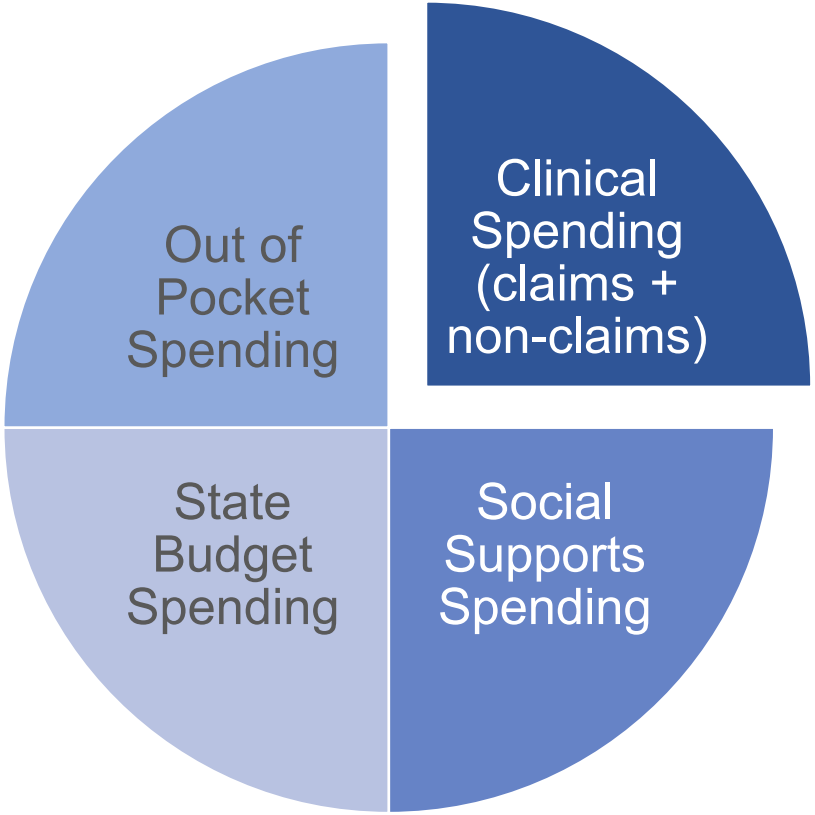
Statutory Requirements

- Measure and promote a sustained systemwide investment in primary care and behavioral health.
- **Measure the percentage of total health care expenditures allocated to Primary Care and Behavioral Health** and set spending benchmarks that consider current and historic underfunding of primary care services.
- **Develop benchmarks** with the intent to build and sustain infrastructure and capacity and shift greater health care resources and investments away from specialty care and toward supporting and facilitating innovation and care improvement in primary care and behavioral health.
- Promote improved outcomes for primary care and behavioral health.

Behavioral Health Spending Measurement

Data Collection and Measurement Scope

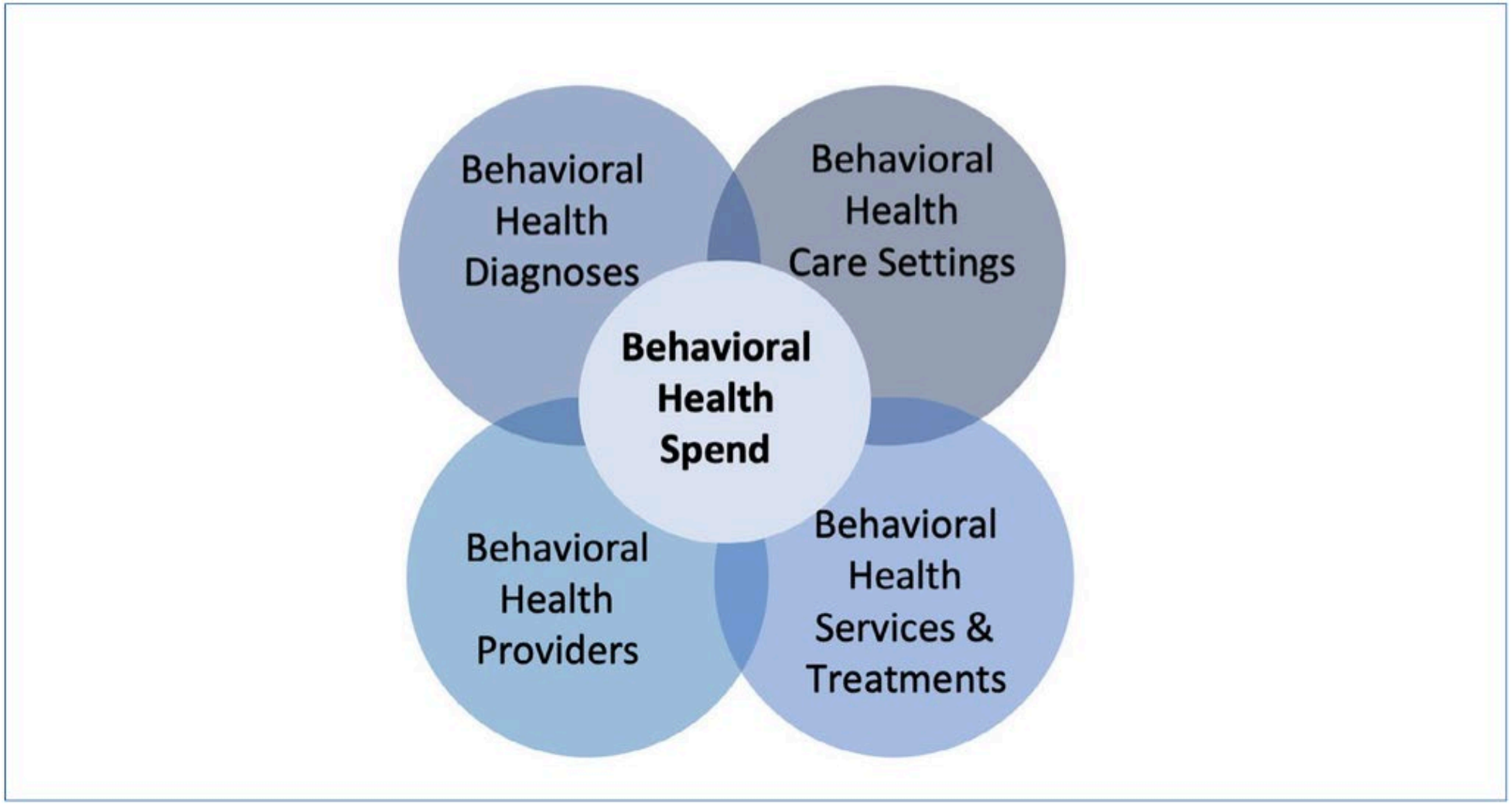
Clinical services are services provided by medical and allied health professionals to prevent, treat, and manage illness, and to preserve mental well-being across the clinical care continuum, paid via claims and non-claims payments (e.g., outpatient therapy visit, day treatment programs).



- Initial focus on clinical services and health care payers (e.g., commercial and Medicare Advantage).
- Possibility of using supplemental data sources to capture spending from other categories in the future.

Adapted from Milbank Memorial Fund, April 2024. *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.* https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

Defining Behavioral Health Spending



Measuring Behavioral Health Spending

Numerator

Claims-based payments for behavioral health + Non-claims-based payments for behavioral health = Total behavioral health spending

Denominator

Total claims-based payments + Total non-claims-based payments = Total medical expense

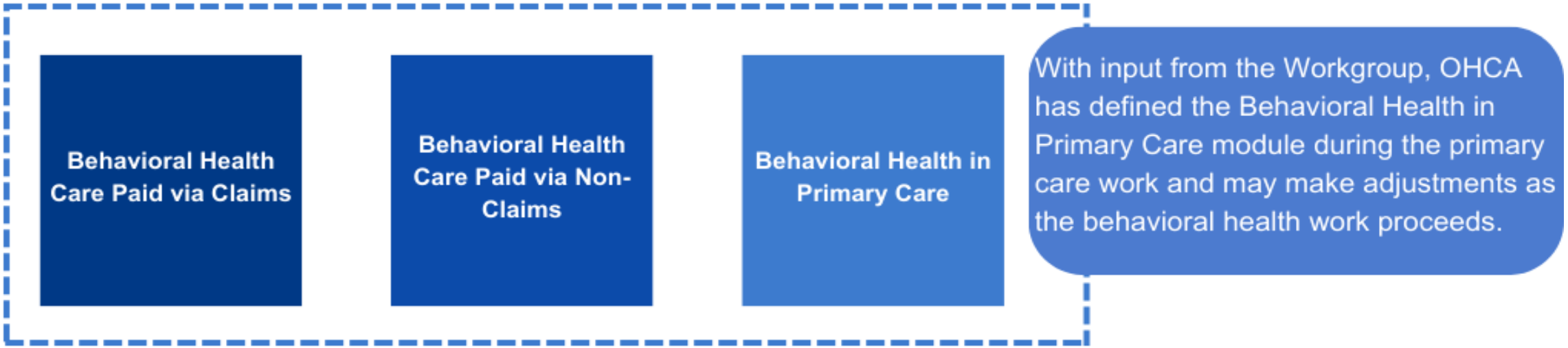
X 100% = Behavioral health spending as a % of total medical expense

Note: The numerator will include patient out-of-pocket responsibility for behavioral health services obtained through the plan i.e., services for which a claim or encounter was generated. The denominator will include pharmacy spending and all patient out-of-pocket responsibility for services obtained through the plan.

Source: Milbank Memorial Fund, April 2024. *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.* https://www.milbank.org/wp-content/uploads/2024/04/BH_SPENDING61824.pdf

Three Recommended Modules for Behavioral Health Spending Measurement

OHCA proposes to use three modules to measure behavioral health spending, following the approach for measuring primary care spending. Behavioral health in primary care will be measured separately so it can be included in analyses of behavioral health or primary care spending.

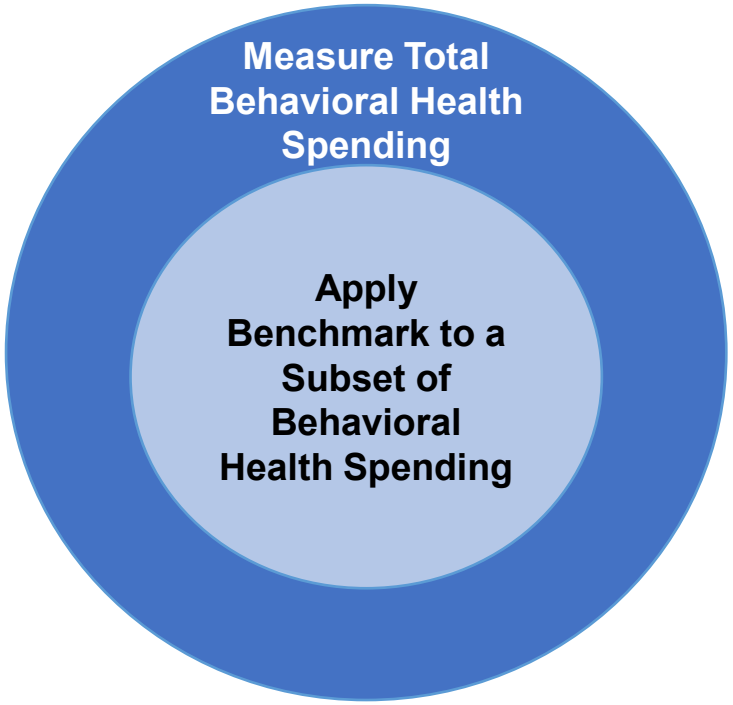


Behavioral Health Investment Benchmark Framework

Broad Measurement, Focused Benchmark

- **Measurement:** OHCA will be measuring **total** behavioral health spending as a percentage of total health care expenditures.
- **Benchmark**: OHCA proposes that the behavioral health investment benchmark applies to a **subset** of behavioral health care spend.

Spending Included

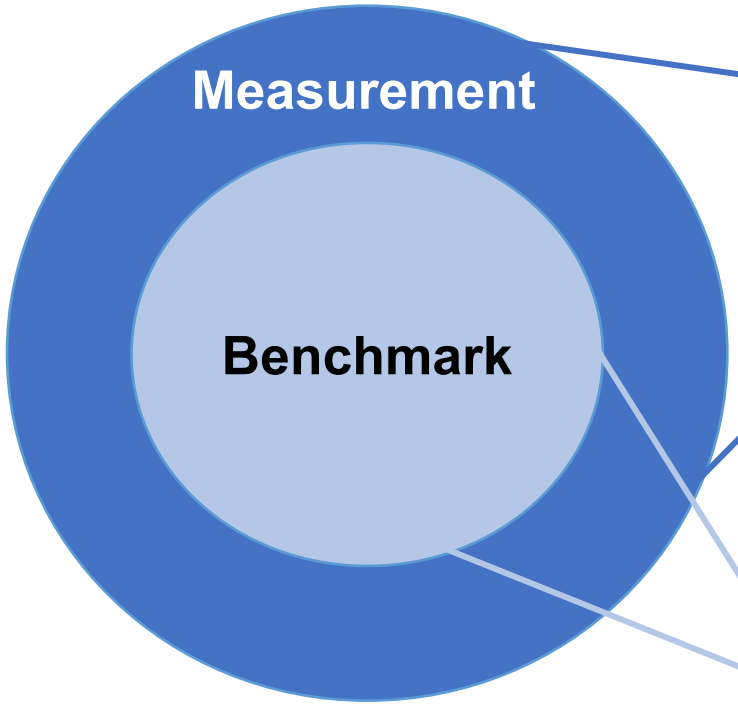


Benchmark Straw Model

Question	Working Straw Model
What should the increased behavioral health investment achieve?	Increased investment should help individuals in need of behavioral health care to receive more timely, high quality, and culturally-responsive care, in more appropriate settings, and with less out-of-pocket spending via improved access to outpatient and community-based services that are in-network.
How should OHCA structure the benchmark to achieve this aim?	Include in-network outpatient and community-based behavioral health services covered via commercial and Medicare Advantage* plans, excluding pharmaceutical spend.**

* OHCA would initially focus on commercial and Medicare Advantage and expand to Medi-Cal when data collection and methodology allow.
** Still under consideration.

Example: Measurement vs. Benchmark



Potential Service Categories for Total Spend Measurement:

- Long-term Care
- Residential
- Inpatient (including partial hospitalization)
- Emergency Department/Observation
- Outpatient Facility and Professional, including
  - Primary Care
  - Telehealth
  - Community-based services
- Community-based Mobile Clinic Services

Potential Service Categories for Benchmark:

- Outpatient Facility and Professional (including Primary Care, Telehealth, Community-based Services)
- Community-based Mobile Clinic Services

Benchmark Straw Model Rationale

Focus on outpatient and community-based care

- Emphasizes prevention and population health.
- Acknowledges that increased investment in upstream care can reduce demand for more resource-intensive services.
- Aligns with and complements other state policies focused on access, parity, and investments in expansion of facility infrastructure.

Access

- Nearly two thirds of adults with any mental illness did not receive mental health services; California ranks 49th among states on this measure.
- 63% of adolescents with symptoms of a major depressive episode did not receive treatment; California ranks 46th among states on this measure.
- 83% of adults with substance use disorder did not receive treatment; California ranks 50th among states on this measure.
- Among Californians who tried to make a mental health appointment in 2023, more than half (55%) waited longer than they thought reasonable.

Sources: California Health Care Foundation, Mental Health Care in California, July 2022. https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022.pdf; Commonwealth Fund, 2023 Scorecard on State Health System Performance. https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance; Mental Health America, The State of Mental Health in America, 2024. https://mhanational.org/sites/default/files/2024-State-of-Mental-Health-in-America-Report.pdf?eType=ActivityDefinitionInstance&eId=18ffe536-c4fd-4ab3-83b8-6b2a34118652; California Health Care Foundation, The 2024 CHCF California Health Policy Survey, January 2024. https://www.chcf.org/publication/2024-chcf-california-health-policy-survey/

Benchmark Straw Model Rationale

Network

- Among Californians who tried to make a mental health appointment in 2023, more than half (52%) reported difficulty finding a provider that takes their insurance.
- Californians used out-of-network psychiatrists and psychologists in 2021 more than 15 times as frequently as out-of-network medical/surgical specialist physicians, and any out-of-network BH clinician almost 6 times more frequently as medical/surgical physicians.

Cultural responsiveness

- Only about a third of Californians who are of Latinx or Asian, Native Hawaiian or Pacific Island ethnicities agree that their local communities have mental health workers that have knowledge about their ethnic groups' needs.

Sources: California Health Care Foundation, The 2024 CHCF California Health Policy Survey, January 2024. https://www.chcf.org/publication/2024-chcf-california-health-policy-survey/; Mark and Parish, Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue. RTI International, April 2024. https://www.rti.org/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue; NORC, The 2020-2021 California Communities Mental Health Services Survey, Sept. 2021. https://cultureishealth.org/wp-content/uploads/2022/11/CCMHSS-Final-Report.pdf

Alignment Opportunities: Prop 1 (2023)

Legislation	Element	OHCA Alignment
Proposition 1	Behavioral Health Services Act focus on community-based care.	Focused benchmark incentivizes payers to increase investment in community-based services.
	Behavioral Health Infrastructure Bond Act authorizes $6.4 billion in bonds to finance behavioral health treatment beds, supportive housing, community sites, and funding for housing veterans with behavioral health needs.	Focused benchmark on community-based services would complement Proposition 1 investments and direct investment to additional areas of need.

Alignment Opportunities: SB 855 (2020)

Legislation	Element	OHCA Alignment
SB 855	Requires insurers cover “medically necessary treatment” for all mental health and substance use disorders.	Includes a broad set of services to treat mental health and substance use disorders.
	Mandates in-network coverage for out-of-network providers when access is not available within geographic and timely access standards.	Incentivizes payers to increase investment in-network BH coverage.
	Prohibits plans from denying medically necessary services on the basis they should be or could be covered by a public entitlement program.	Benchmark focus on in-network care.

Alignment Opportunities: SB 221 (2021)

Legislation	Element	OHCA Alignment
SB 221	Ensures that appointments with nonphysician mental health and substance use disorder providers are subject to the timely access requirements.	Focused benchmark on community-based services provided in-network seeks to increase access. Potential HPD analyses that can leverage OHCA's behavioral health measurement definition: • Quality measures related to behavioral health care and follow-up • Number and distribution of providers and facilities billing for behavioral health services. • Licensed providers in payer networks as a percentage of total licensed providers in California.
	Ensures that an enrollee undergoing a course of treatment for an ongoing mental health or substance use disorder condition can get a follow-up appointment within 10 business days.	
	If a plan operates in an area with a shortage of providers and is not able to meet the geographic and timely access standards with an in-network provider, the bill requires the plan to arrange coverage outside its contracted network.	

Stakeholder Feedback

December Board Feedback

Feedback
• Support for a focused benchmark approach. • Interest in shaping the benchmark to support clearly-articulated statewide goals. • Highlighted importance of future incorporation of Medi-Cal. • Need for continued collaboration and information sharing with parallel efforts including those measuring out-of-plan spending. • Interest in alignment with other transformation efforts including legislation to strengthen behavioral health system and enhance access to school-based care.

January Advisory Committee Feedback

Feedback on Benchmark Framework

- Several members expressed support for proposed benchmark structure.
- A member supported including inpatient spending in the benchmark, to align with Proposition 1.
- Interest in linking benchmark performance to outcomes, and measuring continuity of care, to ensure goals are being met.
- Mixed feedback on telehealth: Recognition that telehealth is an important access point vs. challenges in ensuring high quality and equitable access.
- Suggestion to exclude artificial intelligence (chatbot care) from the benchmark.

Investment and Payment Workgroup Feedback

Feedback
• Overall strong Workgroup support for benchmark straw model, though a few members have raised questions or expressed concern that the straw model excludes inpatient, long-term care, and residential settings. • Appreciation for including spend for screening and assessments for behavioral health conditions regardless of outcome or diagnosis. • Interest in exploring alignment with the federal mental health parity law and final rule.

Tentative Timeline for Behavioral Health Work

Between meetings, OHCA will revise draft behavioral health definitions and investment benchmarks based on feedback.

	Jul-Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25
Workgroup	X	X	X	X	X	X	X	X	X	X	X
Advisory Committee		X			X		X			X	
Board				X		X		X		X	✓

X Provide Feedback ✓ Board Approval

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Public Comment

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General Public Comment

Written public comment can be emailed to:

ohca@hcai.ca.gov

To ensure that written public comment is included in the posted board materials, e-mail your comments at least 3 business days prior to the meeting.

HCAi

Department of Health Care Access and Information

Next Board Meeting:
March 25, 2025
9:00 a.m.

Location:
May Lee State Office Complex
651 Bannon St.
Auditorium, Room 300
Sacramento, CA 95811

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Office of Health Care Affordability

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Adjournment

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Appendix

HCAI

Department of Health Care Access and Information

Repeat Outlier on Unit Price – Commercial Inpatient NPR Per CMAD

- The following slide show hospitals that are repeat outliers on the unit price measure, commercial inpatient NPR per CMAD.
- For this analysis:
  - OHCA removed hospitals for which comparable financial data is not available (i.e., Kaiser hospitals, LTC Emphasis hospitals, Psychiatric Health Facilities, Shriner's Hospitals, and State hospitals).
  - OHCA identified 41 hospitals that met all the following criteria:

1. *Unit Price Repeat Outlier*: Commercial Inpatient NPR Per CMAD is above the inpatient discharge-weighted 85th percentile in 3 out of the past 5 years from 2018-2022.
2. *Payer Mix Threshold*: At least 5% gross patient revenue for Medicare or Commercial.

Repeat Outlier on Unit Price – Commercial Inpatient NPR per CMAD

Key: above 90 % above 85 %

List of Hospitals		
Alameda Hospital	Kindred Hospital - San Francisco Bay Area	Zuckerberg San Francisco General Hospital & Trauma Center
Barton Memorial Hospital	Kindred Hospital - South Bay	Adventist Health Clearlake
California Rehabilitation Institute	Kindred Hospital - Westminster	California Pacific Medical Center - Van Ness Campus
Chinese Hospital	Mark Twain Medical Center	Central Valley Specialty Hospital
Community Hospital of The Monterey Peninsula	Marshall Medical Center	Goleta Valley Cottage Hospital
Doctors Medical Center - Modesto	Northbay Medical Center	Kern Valley Hospital District
Dominican Hospital	Salinas Valley Memorial Hospital	Kindred Hospital - Riverside
Kentfield Hospital	Santa Clara Valley Medical Center	LAC/Rancho Los Amigos National Rehabilitation Center
Kindred Hospital - Brea	St. Francis Memorial Hospital	Mammoth Hospital
Kindred Hospital - La Mirada	Stanford Health Care	Regional Medical Center of San Jose
Kindred Hospital - Los Angeles	UCSF Medical Center	Ronald Reagan UCLA Medical Center
Kindred Hospital - Ontario	University of California Davis Medical Center	Santa Barbara Cottage Hospital
Kindred Hospital - Paramount	Vibra Hospital of Sacramento	Washington Hospital - Fremont
Kindred Hospital - San Diego	West Covina Medical Center	

Repeat Outlier on Relative Price - Commercial to Medicare Payment to Cost Ratio

- The following slide show hospitals that are repeat outliers on the relative price measure, Commercial to Medicare Payment to Cost Ratio.
- For this analysis:
  - OHCA removed hospitals for which comparable financial data is not available (i.e., Kaiser hospitals, LTC Emphasis hospitals, Psychiatric Health Facilities, Shriner's Hospitals, and State hospitals).
  - OHCA identified 35 hospitals that met all the following criteria:

1. *Relative Price Repeat Outlier*: Commercial to Medicare Payment to Cost Ratios above the inpatient discharge-weighted 85th percentile in 3 out of the past 5 years from 2018-2022.
2. *Payer Mix Threshold*: At least 5% gross patient revenue for Medicare or Commercial.

Repeat Outlier on Relative Price – Commercial to Medicare Payment to Cost Ratio

Key: above 90 % above 85 %

List of Hospitals		
Barstow Community Hospital	Monterey Park Hospital	Watsonville Community Hospital
Barton Memorial Hospital	Novato Community Hospital	Eden Medical Center
Community Hospital of The Monterey Peninsula	Oak Valley Hospital District	El Camino Health
Doctors Hospital of Manteca	Orange County Global Medical Center	French Hospital Medical Center - San Luis Obispo
Doctors Medical Center - Modesto	Petaluma Valley Hospital	Marshall Medical Center
Dominican Hospital	Salinas Valley Memorial Hospital	Mills-peninsula Medical Center
Emanuel Medical Center	Santa Barbara Cottage Hospital	Northbay Medical Center
Goleta Valley Cottage Hospital	Sharp Mcdonald Center	Seton Medical Center
Marin General Hospital	St. John's Pleasant Valley Hospital	Sierra Nevada Memorial Hospital
Memorial Hospital Modesto	Stanford Health Care	Sutter Amador Hospital
Mercy Hospital - Folsom	Sutter Tracy Community Hospital	Valleycare Medical Center
Mercy Medical Center - Merced	Washington Hospital - Fremont	

Repeat Outlier on Both Unit and Relative Price Measures

- The following slide show hospitals that are repeat outliers on the unit price measure, Inpatient NPR per CMAD and the relative price measure, Commercial to Medicare PTCR.
- For this analysis:
  - OHCA removed hospitals for which comparable financial data is not available (i.e., Kaiser hospitals, LTC Emphasis hospitals, Psychiatric Health Facilities, Shriner's Hospitals, and State hospitals).
  - OHCA identified 11 hospitals that met all the following criteria:

1. *Unit Price Repeat Outlier*: Commercial Inpatient NPR per CMAD is above the 85th percentile in 3 out of the past 5 years
2. *Relative Price Repeat Outlier*: Commercial to Medicare Payment to Cost Ratio is above the 85th percentile in 3 out of the past 5 years
3. *Payer Mix Threshold*: At least 5% gross patient revenue for Medicare or Commercial.

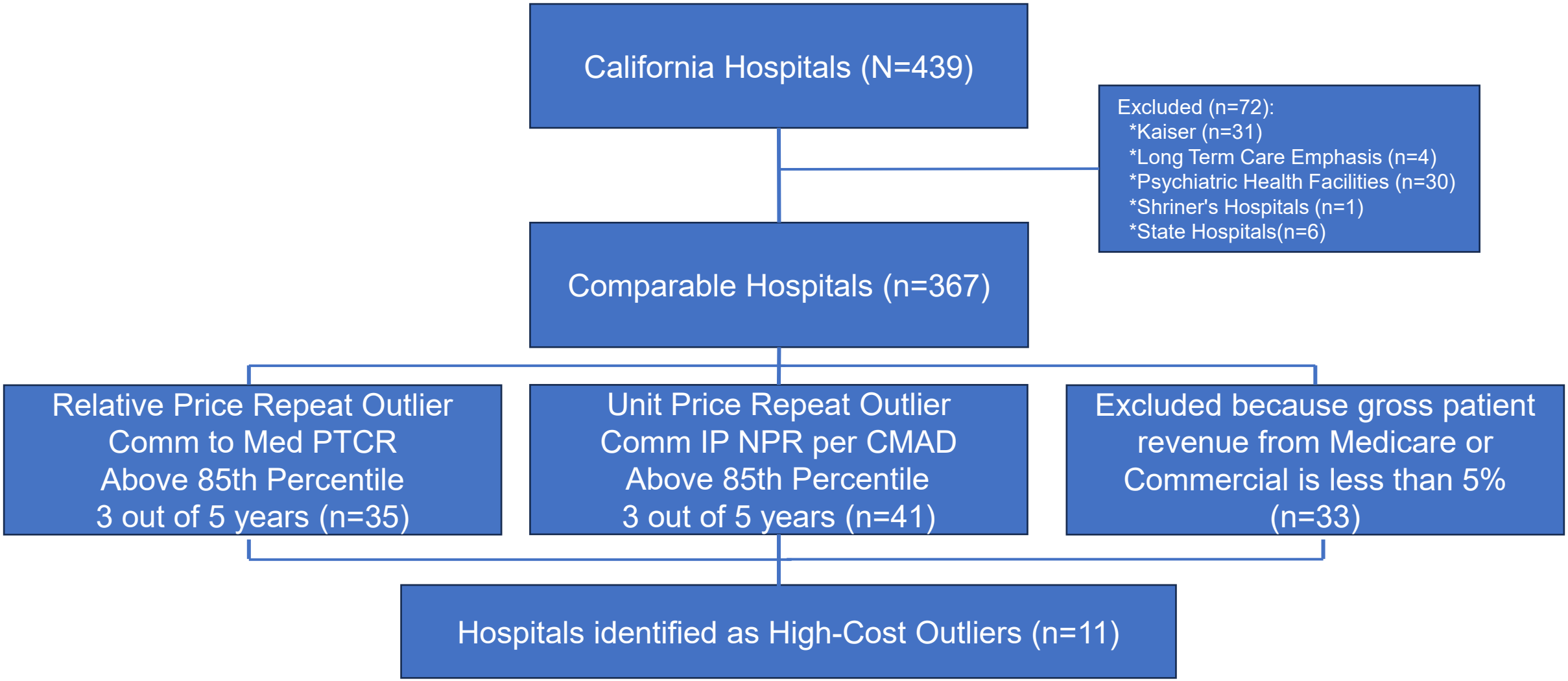
Repeat Outlier on Both Price Measures

Key: above 90 % above 85 %

Hospital	Pooled Average Commercial IP NPR per CMAD	Pooled Average Commercial to Medicare Payment to Cost Ratio	Pooled Average Number of Inpatient Discharges
Barton Memorial Hospital	$38.4K	773%	1.9K
Community Hospital of The Monterey Peninsula	$39.9K	353%	13.7K
Doctors Medical Center - Modesto	$36.0K	347%	24.4K
Dominican Hospital	$34.5K	331%	10.0K
Salinas Valley Memorial Hospital	$46.7K	475%	10.9K
Stanford Health Care	$51.5K	340%	28.3K
Goleta Valley Cottage Hospital	$31.9K	383%	1.5K
Marshall Medical Center	$35.5K	288%	5.0K
Northbay Medical Center	$42.8K	269%	9.7K
Santa Barbara Cottage Hospital	$32.8K	305%	17.5K
Washington Hospital - Fremont	$32.9K	359%	10.9K

Descriptive statistics for the cost metrics are weighted by the number of inpatient discharges.

Hospital Attributes



Additional Descriptive Statistics for Repeat Outlier Hospitals, 2018-2022

Hospital	Public Payer Mix	Case Mix Index (CMI)
All Other Comparable Hospitals	**72%**	**1.6**
11 High-Cost Hospitals	**71%**	**1.8**
Barton Memorial Hospital	57%	1.4
Community Hospital of The Monterey Peninsula	71%	1.6
Doctors Medical Center - Modesto	82%	1.6
Dominican Hospital	75%	1.7
Salinas Valley Memorial Hospital	72%	1.5
Stanford Health Care	56%	2.6
Goleta Valley Cottage Hospital	63%	1.9
Marshall Medical Center	79%	1.4
Northbay Medical Center	77%	1.6
Santa Barbara Cottage Hospital	71%	1.7
Washington Hospital - Fremont	72%	1.5

Descriptive statistics weighted by the number of inpatient discharges.