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

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HEALTH CARE AFFORDABILITY ADVISORY COMMITTEE

MEETING MINUTES
Tuesday, January 21, 2025
9:00 AM

Members Attending: Joan Allen; Barry Arbuckle; Adam Dougherty; Parker Duncan Diaz; Hector Flores*; Stacey Hrountas*; Marielle Reataza; Sumana Reddy; Cristina Rodriguez; Stephen Shortell; Ken Stuart; Suzanne Usaj; Abbie Yant*; Carolyn Nava; Tam Ma; David Joyner; Carmen Comsti; Aliza Arjoyan*; Stephanie Cline*; Kiran Savage-Sangwan; Travis Lakey; Sarah Soroken

*Attended virtually

Members Absent: Kati Bassler; Mike Odeh; Janice O'Malley; Yolanda Richardson; Andrew See; Rene Williams

Health Care Affordability Board Member Attending: Dr. Richard Pan

HCAI: Jean-Paul Buchanan; Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director; Margareta Brandt, Assistant Deputy Director; Andrew Feher, Research and Analysis Group Manager; Heather Hoganson, Health System Compliance Assistant Chief Counsel; Janna King, Health Equity and Quality Performance Manager; Debbie Lindes, Health Care Delivery System Group Manager

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; Margareta Brandt, Assistant Deputy Director, HCAI; Andrew Feher, Research and Analysis Group Manager, HCAI; Efrain Talamantes, MD, MBA, MSc, SVP & COO, Health Services, AltaMed; Heather Cline Hoganson, Health System Compliance Assistant Chief Counsel, HCAI; Janna King, Health Equity and Quality Performance Manager, HCAI; Debbie Lindes, Health Care Delivery System Group Manager, HCAI

Facilitators: Karin Bloomer, Leading Resources Inc.; 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 January meeting of California's Health Care Affordability Advisory Committee meeting.

Roll call was taken for a record of attendance, and a quorum was established.

Director Landsberg provided an overview of the meeting agenda and stated that, due to the fires in Los Angeles, Agenda Item 5: Cost-Reducing Strategies presentation by AltaMed will be rescheduled to take place at a future Advisory Committee meeting.

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

Director Landsberg opened with a statement recognizing the destruction and impact of the fires in Southern California and provided a brief overview of the State's response and support. She then provided Executive Updates on the Governor's 2025-26 proposed budget, and the various impacts it will have upon HCAI as a department.

Deputy Director Pegany provided additional Executive Updates on OHCA's 2025 quarterly workplan, the process for AC member application and/or reappointments process, and a few key findings the latest Center for Medicare and Medicaid Services (CMS) report on national health expenditures.

Discussion and comments from the Committee included:

- A member expressed appreciation for the report on the Los Angeles (LA) fires and the diaper initiative. The member also provided a resource for clinicians and their supporters to assist with providing clinical care in a disaster - https://www.familydocs.org/resources/disaster-crash-cart/
    - Another member stated that a lot of physicians and their practices were affected and shared the website for the LA County Medical Association's Physician Toolkit - https://www.lacmamembers.com/physician-toolkit
    - A member stated that there will be many people with new disabilities such as serious respiratory challenges and serious illnesses from burns because of the fires. They also provided the following resource - https://calsilc.ca.gov/
- A member commented that during the Coronavirus (COVID) pandemic, utilization did go down for a couple of years and then it shows back up, so it would be interesting to see a view of pre-COVID data and the trend in expense change as well as the supply shortages in terms of pharmaceutical costs, staffing costs and other aspects.
- A member shared that they would like to see data regarding low-value care spending in California. They stated that low-value care spending is estimated to be between $100-$700 billion in the United States, with Medicare comprising approximately 40 percent of that spending, Medicaid comprising approximately 15 percent, and commercial insurance comprising approximately 11 percent of that low-value care spending. The member recommended that the Board and OHCA staff

research the low-value care spending in California as a driver of cost and spending, and what might be done to try to mitigate that.
    - Another member stated that there have been studies that when there are a lot of specialists in a specific region, there tend to be a lot of unnecessary procedures performed.
- A member stated that, regarding the national health expenditures, the data is likely still reflecting the fallout of the pandemic which resulted in delays in care, delays in access, complicated comorbidities, and late diagnoses, and a lot of the subcategory increases are a direct result of that. People are getting sicker and there will be a continued erosion of specialty access in both public and private networks. They stated that, on the primary care side, the data will continue to reflect cost increases because many physicians no longer accept Medicare patients which leads patients to go to the emergency room for care.
- A member commented that they are seeing a phenomenon with physicians who are stepping out of residency training or fellowships into employed positions and are often being incentivized with Relative Value Units (RVU)-style compensation, which is inherently volume driven. They are starting to see some early evidence of the impact on low-value care. The physicians appear to tend to triage patients out to specialists or to naturally let them flow into the emergency rooms, in addition to the physicians not spending enough time with the patients.
- A member commented that there are graduates who are unprepared to tackle how complex primary care has become, which leads to them ordering things that may be unnecessary and drive-up costs.
- A member expressed concern regarding the respiratory distress for those near the fires and hopes that there will be added support in providing personal protection equipment (PPE). The member also stated that the community evacuation and resource centers do not seem to be communicating with each other.
- A member asked whether the AC would receive a more in-depth presentation regarding the budget allocations, specifically regarding the approximate $100 million cut from the only LGBTQ+ mental health youth program.
    - The Office replied that they cannot comment on another department's budget. However, there will be a very thorough, lengthy budget process with subcommittee hearings and lots of opportunity to engage.

Public Comment was held on agenda item 2. One member of the public provided comments.

Agenda Item # 3: Update on the THCE Data Submission Guide & Regulations
Margareta Brandt, Assistant Deputy Director, HCAI
Andrew Feher, Research and Analysis Group Manager, HCAI

Assistant Deputy Director Brandt provided a recap of HCAI's approach to collecting alternative payment model data and primary care spending data, which is now included in the Total Health Care Expenditures (THCE) Data Submission Guide that has been

released for public comment. Andrew Feher then provided an overview of the key dates in the timeline for the THCE Data Submission Guide and 2025 data collection.

Discussion and comments from the Committee included:

- A member asked how the office was getting data for Medi-Cal.
  - The Office provided that the context is that they are obtaining the existing data from the Department of Health Care Services (DHCS) through the Medi-Cal Loss Ratio (MLR) filings. That allows them to measure total medical expenditures for MCO plans through DHCS. There are separate files where they handle attributed provider organization spending. They give instructions on how to attribute spending to physician organizations, and they'd like to get that process right with the commercial and Medicare Advantage plans before they extend that requirement to Medi-Cal Managed Care Organizations (MCOs). That was the first round of data collection. Under the proposed data collection for 2025, they would require the MCOs to report Alternative Payment Model (APM) on primary care files. They will receive another extension on the Total Medical Expenditure (TME) file, but going into 2026, they will see where they're at with the commercial and Medicare Advantage physician organization files. If they are in a good place with those, then they will extend that requirement to Medi-Cal MCOs.

Public Comment was held on agenda item 3. No members of the public comment provided comments.

Agenda Item #4: Introduce Sector Target Definition and Discussion
Vishaal Pegany, Deputy Director, HCAI
Andrew Feher, Research and Analysis Group Manager

Andrew Feher provided an overview of the Sector Target Definition and then invited the Advisory Committee to share any input they may have on whether any of the facility attributes he presented would merit special consideration or exemption from a high-cost sector target.

Deputy Director Pegany provided an overview of the Sector Target Implementation process.

Andrew Feher then provided an overview of HCAI's hospital reporting requirements, followed by definitions and a review of the hospital data metrics.

Deputy Director Pegany then provided an overview of the Hospital Sector Options.

Discussion and comments from the Committee included:

- A member asked what the rationale would be for a hospital to merit an exemption from a high-cost sector definition.
  - The Office replied that all hospitals are subject to the statewide target of three and a half percent this year and then that percentage will decrease over time. The Office further explained that the Board is considering whether to define all

hospitals as a sector. This would allow for a target lower than three percent for high-cost hospitals.

- A member commented that it may make sense to have some exceptions. There may also be a need to make distinctions between types of hospitals, such as critical-access hospitals that are paid on a fundamentally different basis and state hospitals. They also stated that more data would be needed, such as detailed data about hospital utilization. The member inquired about information regarding hospital utilization.
- A member appreciated OHCA's specification of county and state hospitals as opposed to "designated public hospitals" and strongly discouraged the use of designated public hospitals due to that definition being significantly broader.
- A member advised to consider management of the whole of all the hospitals and incentives for the whole while deciding on exemptions.
    - The Office responded with a reminder that every entity will be subject to the statewide spending target unless and until there is a more specific sector target. If the Board sets a hospital sector target for some hospitals, those that aren't subject to that sector target will still be subject to the statewide spending target of 3.5 percent in 2026.
- A member commented that the list of hospital attributes presented is not mutually exclusive. For example, a hospital that is part of an integrated health system would fall into several of the categorical attributes listed. The member recommended that, rather than having integrated health systems as a separate category, have a market indicator that states whether the hospital is part of an integrated system.
- Another member stated that if the idea is to separate hospitals based on the attributes and potentially have different targets, then the Office will need to consider how to handle hospitals that would be classified under more than one of the categories listed.
    - OHCA acknowledged that there is a great extent of overlap for some of the hospitals and stated that the HCAI financial disclosure data will help "prune" some of the hospitals (non-comparable hospitals) for which OHCA simply won't have the underlying data to compute necessary metrics. At this moment, OHCA doesn't have agreed upon preferences or ideas on how to stratify the hospitals and is currently working with the Board to better understand the heterogeneity across the hospital landscape.
- A member stated that a few of the hospital attributes listed are some of the costliest hospital systems that the health plans work with. The member recommended that the Office review the data to ensure they are not unfairly or unnecessarily excluding hospitals that are materially impacting the cost of care.
- A member expressed a desire to dig into the definition of teaching hospitals, as the terms "teaching hospitals" and "academic medical centers" seem to be used interchangeably. However, while all academic medical centers are teaching hospitals, not all teaching hospitals are academic medical centers.
- A member commented that there are a lot of considerations to be made in terms of specific hospitals and expressed concern that if the length of stay would merit an exemption, then that could potentially cause hospitals to increase or decrease the length of stay to get in or out of an exemption. The member is also concerned about

the lack of workforce stability standards and what it could mean in terms of hospital staffing. Additionally, the member worried that this potential oversimplification of hospitals may overlook if the hospitals are meeting the primary care investment benchmarks as well.

- A member inquired what data attributes are missing from the OHCA analysis.
  - OHCA staff proceeded to cover these data elements later in the presentation.
- A member stated that the definition of specialty hospital needs to be more specific.
  - The Office replied that there is not a clean definition for specialty hospitals, they would be capturing each hospital that has attested to being a specialty hospital in the HCAI data.
- A member expressed concern with the lack of sufficient residency positions to complete and usher medical school graduates into a training program. This has been an issue for decades and will continue to get worse.
- A member commented that the metrics presented are only for inpatient services, so there is a lot of data missing regarding outpatient services.
  - The Office replied that HCAI financials do not have an easy way to gather the case weights for outpatient services in terms of the data that the hospitals report to HCAI, however they are looking into some options to enhance the HCAI financials. That won't be part of the data presented today, but the ultimate measurement approach would be inclusive of both inpatient and outpatient revenue.
- A member advised that there may be a potential conflict between an existing exclusion for sharing detailed information and the OHCA legislation which mandates submission of data. The member inquired which of those laws would take priority. They are concerned about Kaiser not being fully included or not included at a level of detail that is equal to that of other hospitals.
  - The Office responded that Kaiser is not exempt from the statewide target, but they do have a statutory definition in the OHCA enabling statute which defines them as a fully integrated delivery system. They will not look at Kaiser Health Plan, Kaiser Permanente Medical Group, and Kaiser Hospitals as individual entities. Kaiser will be measured as a system against the target. As part of this specific exercise focused on high-cost hospitals, Kaiser would not be part of the data analysis for sector target values. However, the Board could choose to set a fully integrated delivery system sector target for Kaiser that is different from the statewide spending target.
- The member clarified that there is a pre-existing exclusion, but now there is a new law under OHCA which has embedded requirements for health system providers and plans to submit information to OHCA. The member is asking which of these laws takes precedence, and whether the existing exemption would not apply as it would be overridden by the new OHCA law which would require more granular information to be submitted.
  - The Office replied that OHCA did begin to receive more granular financial and utilization details from Kaiser in 2020, so there will be more granularity available moving forward.
- A member asked if the administrative costs will be calculated in these metrics.

    - The Office stated that the Net Patient Revenue (NPR) measure typically covers health care services delivered. HCAI financials do have other data elements related to administration, but they did not focus on administrative expenses in this presentation.
- The member further inquired whether there will be an effort to disaggregate or remove that type of data, as the administrative costs are a significant contributor to the high cost of healthcare. That is an important metric to review to address the high costs.
    - The Office advised that the administrative expenses are embedded in the payments for patient care, so it is reflected in the data. They will not disaggregate it. The purpose of the spending target is to set an overall target, and then the entities can decide how to meet that target. For example, they could reduce their administrative expenses or provide more care coordination. It will be up to the entity to determine what adjustments they want or need to make to meet the target.
- Another member commented that administrative costs and profits are part of what separates our nation's health care costs from other industrialized nations health care costs, so it would be very worthwhile to look at that data disaggregated to obtain a clear picture of how that data is playing a role in costs.
- A member asked if the inpatient revenues reflect the billed amounts or the allowed amounts, as the billed amounts are irrelevant regarding Medicare costs.
    - The Office replied that the numbers presented are the net amounts after all contractual deductions, so they reflect the allowed amounts.
- A member recommended adding Medicaid ratios to the commercial and Medicare ratios.
- A member commented that they are interested in looking at the biggest numbers and biggest impacts in the urban centers as opposed to the average or the rate.
- A member asked whether the operating margin includes inpatient and outpatient services, and if so, why are there no other metrics related to outpatient services such as NPR per emergency department visit or NPR per outpatient surgery.
    - The Office confirmed that the operating margin is inclusive of both inpatient and outpatient care. With the way that the HCAI financials come in, there is not a way for them to calculate the revenue for outpatient services as they require different levels of resource. The hospitals are not reporting case weights for lab tests, outpatient surgeries, or emergency department visits, so they're unable to calculate an equivalent case mix on the outpatient side. However, this is something HCAI is working on.
    - The member responded that unnecessary emergency room visits are a significant cause of excess cost and low-value care. For most hospitals, outpatient margins are much higher than inpatient margins.
- A member stated that none of the metrics listed involve outcomes and asked whether that is something that will be incorporated.
    - The Office responded that they do have a requirement for equity and quality measures, which will be further discussed this afternoon.
- A member asked if there is a way to divide the average commercial inpatient NPR per CMAD by average charge per day.

    - The Office responded that this is an item they will discuss internally.
- A member inquired if the Office has analyzed the volatility for specific time periods and conducted a comparison.
    - The Office replied that they have been focusing on the five-year time period of 2018 to 2022 and will be updating that to include 2023 as available. They have not looked at data prior to 2018, but that is something they could do.
- A member asked whether the Office has considered that county hospitals primarily serve Medi-Cal and Medicare patients, so their costs are inflated for commercial patients.
    - The Office advised that they have held several meetings with the Board to discuss this topic and they understand the differences, which is why they began with the current frame.
- A member expressed concern that there are no hospitals listed North of Sacramento, yet there is still a population of 500,000 people who need care in that area.
    - The Office stated that the hospitals noted in the presentation are the top 30 hospitals in the state based on the metrics that were applied, and no regions were excluded from the data calculations.
- A member inquired whether OHCA could investigate the cause of the significant operating margins at psychiatric hospitals, especially considering the difficulty in accessing that care.
- Another member advised that over 50 percent of patients discharged from psychiatric hospitals to outpatient facilities do not show up at the outpatient facilities. Many psychiatric hospitals are staffed by psychiatric technicians or mental health workers who are not at master's or doctoral levels, so they get paid quite low.
- A member commented that an unstable economy where people do not have stability in their jobs or homes will cause an increase in mental health conditions and substance use disorders.
- A member expressed surprise with the low amount of Orange County facilities listed, specifically with the absence of UC Irvine Medical Center, which is the only academic center in Orange County.
- A member commented that the metrics presented are rooted in fee-for-service and there is an incentive to lower the unit price. However, the member does not see an incentive to lower utilization or case mix.
- A member stated that the average Commercial to Medicare Payment to Cost ratio may potentially be wildly misleading, as it implies that the Medicare payments are equitable across hospitals for the same type of procedure for the same type of patient. In reality, there is a 48 percent difference in the Medicare base rate between Cedars Sinai Hospital and UCLA.
- A member stated that for both county hospitals and the UCs, they provide a significant number of trauma services on the commercial side, which tend to be high-cost services. Also, the UC academic medical centers play a unique role within the health care delivery system across the state, as they see patients from 91 percent of California zip codes for the tertiary or quaternary care that's typically not available at local community hospitals or other hospitals in the region. Patients have to be referred to or travel to the UCs for very high-cost specialized services such as

trauma services and organ transplants. The UCs perform half of the organ transplants in the state of California, they provide care for very rare diseases, they operate the National Cancer Institute NCI-designated cancer treatment centers for hemophilia patients, T-cell therapy, Sickle-cell therapy treatment, and many other treatments that rely on high-cost drugs. Between the county hospitals and the UCs, these hospitals operate 8 out of 13 burn centers in the state of California, which is another highly specialized service that is high-cost and not available at a community hospital. This all plays a role in the performance metrics. The member urged OHCA to consider these factors as they continue to refine and think about these issues.

- A member recommended identifying sectors such as the top 15 academic medical centers, the top 15 psychiatric facilities, and the top 15 small community hospitals, as that would be more insightful data.
- A member asked how OHCA is handling maternity discharges in regard to the Commercial to Medicare Payment to Cost ratio, as the data may be skewed for hospitals with a large number of maternity discharges.
    - OHCA stated discharges is currently an established measure to compare rates, but the office is looking into potentially creating a threshold to increase credibility.
- A member recommended that OHCA continue to trend things such as local variation or uninsured patients and Medi-Cal patients. The member also recommended that OHCA look at payment parity, as well as the Managed Care Organization tax and how that might improve access to primary care or at least stabilize primary care practices. For instance, “does it improve access to care now that it is paying at Medi-Cal rates? Does it support the hospitals that are serving the Medi-Cal patients that are most often covered under Health Maintenance Organizations (HMO)?” Lastly, the member suggested that OHCA consider adjusting what governs the Medi-Cal program’s ability to pay non-contracted hospitals which is the Roger Amendment that establishes a base payment for Medi-Cal patients at a non-contracted hospital but doesn’t cover the total cost of providing care.
- A member commented that there will always be certain entities that need to be excluded, such as critical access hospitals and rural hospitals, because they are in sparsely populated areas and need to be subsidized for the work that they do.
- A member recommended that OHCA steer away from adjusting targets for specific hospitals and instead establish targets by sector.
- Several members expressed their support for Hospital Sector Option number 4 due to the flexibility that option would provide.
    - A member urged OHCA to move forward with Option 4 as it will address the hospitals in Monterey County in addition to providing flexibility.
- A member asked whether Kaiser hospitals would be included in the hospital sector.
- The Office responded that Kaiser hospitals would not be included in the hospital sector definition as they have their own definition under Fully Integrated Delivery Systems in the statute. If the Board wanted to apply a different target value to Kaiser, they could do it as a fully integrated delivery system sector target and then go through a process like what they are doing now with the hospital sectors.
- A member proposed a revision to Option 4, suggesting that an aggressive target is set, and those who don’t meet the target must provide justification.

- The Office clarified that the enforcement process will be the same regardless of the target.
- A member recommended that OHCA focus on finalizing the hospital spending measurements, as it is challenging to consider hospital sector targets when they do not know how the spending will be measured.

Public Comment was held on agenda item 4. One member of the public provided comments.

Agenda Item #5: Cost-Reducing Strategies – AltaMed
Efrain Talamantes, MD, MBA, MSc, SVP & COO, Health Services, AltaMed

Per the opening remark by Director Landsberg, this presentation will take place at a future Advisory Committee meeting.

Agenda Item #6: Update on Cost and Market Impact Review Program
Heather Cline Hoganson, Assistant Chief Counsel, HCAI

Assistant Chief Counsel Hoganson provided an overview of the Cost and Market Impact Review (CMIR) Program updates.

Discussion and comments from the Committee included:
- A member commented that the 22-day period cited is impressive. However, CMIR has been waived for all submissions to date. The member asked what the process would have been had the CMIR not been waived.
  - The Office responded that, per the regulations, they have 45 days to determine whether the submission will be waived from undergoing a CMIR. If it is going to go to a CMIR, they have 60 days to notify the submitters of that happening. Then there is an appeal window. After that appeal window closes, the submission could go to a CMIR. They would engage economic experts, and there would be a more robust 90-day review. There could also be an extension to that, if needed.
- Another member inquired what the process would be if a transaction was not filed that should have gone through CMIR and closes.
  - The Office responded that they reach out to the parties who should have filed. It is possible that the entity did not know they should have filed the transaction. If an entity refuses to file, then OHCA would go to the Attorney General's (AG) office for assistance. The AG can take a number of court actions, including injunctive relief, or could also seek to unwind the transaction.
- A member asked whether the CMIR team has enough staff to accommodate the anticipated workload.
  - The Office replied that they have recently opened a number of positions but have not filled them yet. They may hire one or two attorneys, three or four classifications and some financial staff in the long run. However, they are handling their workload.

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

Agenda Item #7: Update on Quality and Equity Performance Measurement
Margareta Brandt, Assistant Deputy Director, HCAI
Janna King, Health Equity and Quality Performance Group Manager, HCAI

Assistant Deputy Director Brandt provided an introduction to the Quality and Equity Performance Measure Set updates.

Janna King provided an overview of OHCA's proposal for the Quality and Equity Performance Measure Set, as well as the feedback provided by the Board and Advisory Committee.

Discussion and comments from the Committee included:

- A member commented that collecting demographic data is challenging for physician organizations, as many historically marginalized groups prefer not to share this information.
- Another member asked how OHCA plans to foster trust among historically marginalized groups to ensure they are comfortable providing the demographic data.
    - The Office replied that most people will answer and provide self-identifying information when asked in a respectful manner. Trainings can be provided to inform providers of the best practices to request this information. If commercial health plans aren't doing as good of a job at collecting and reporting the data, then there needs to be transparency into that performance to promote improvement.
- The member further stated that a lot of community-based organizations collect this type of data more easily than government agencies and asked whether there are any initiatives to partner with these local agencies to standardize data collection practices.
    - The Office clarified that this data is not collected by any government entities aside from Medi-Cal, Covered California, and Medicare. On the commercial side, they are relying on the health care entities to collect and report that information.
- A member suggested using Level of Care Utilization System (LOCUS) or American Society of Addiction Medicine (ASAM) as a quality measure, as well as a timeliness measure similar to the timeliness data that DMHC and DHCS collect.
- A member asked what the Depression Screening and Follow-Up for Adolescents and Adults (Depression Screening and Follow-Up on Positive Screen) measures are.
- A member recommended that the Board consider utilizing the CMS Hospital Inpatient Quality Reporting Program, which has a number of hospital patient safety measures that are easily accessible. The member emphasized the need for hospital patient safety measures. The member also recommended that the Office consider utilizing Leapfrog, a private organization to which hospitals voluntarily submit patient safety data. Leapfrog currently includes nearly 3,000 hospitals across the United States. Of the nearly 400 hospitals in California that were presented earlier, nearly 70% of those hospitals participate in Leapfrog's patient safety grade program.
    - The Office replied that the CMS Hospital Inpatient Quality Reporting Program is one of a few organizations tracking and publicly reporting data on Healthcare-Associated Infection (HAI) measures, including the five HAI measures reported by California Department of Public Health. Considering this, the Office is determining whether there is a need for it to include HAI measures in its proposed quality and

equity measure set. The Office further clarified that OHCA can look at other measures of quality and equity outside of the OHCA Quality and Equity Measure Set when approving or disapproving a performance improvement plan.

- Another member inquired what OHCA envisions in terms of potentially using these measures in performance improvement plans.
  - The Office replied that the guidance in the statue is that the director can consider other measures related to quality and equity when approving or disapproving a performance improvement plan. The director must also consider the impact on quality, equity, access, and workforce stability when approving or disapproving a performance improvement plan.
- A member stated that UC Davis got a D grade on Leapfrog and shows up in OHCA's data in the top 30 high-cost hospitals, which would indicate that is a hospital OHCA should focus on.
- A member stated that while the Office of the Patient Advocate (OPA) does not include demographic stratification, some of those measures are Healthcare Effectiveness Data and Information Set (HEDIS) measures for which the National Committee for Quality Assurance (NCQA) does have stratification. The member asked whether OHCA can require physician organizations to provide that data on demographics where they are already required to track it for those measures to avoid overlooking equity.
  - The Office responded that they will follow-up with OPA specifically about this and have had several discussions with them in terms of coordinating the adoption of their measure set within OHCA's measure set.
- A member expressed concern about disability measures being discarded considering the significant amount of discrimination that the people with disabilities face in health care.
  - The Office stated that part of the challenge they face with stratification is that not all these measures are collected in a standardized way or are collected at all. The statute required them to consider a wide range of demographic data factors for which they could stratify measures if they're available in a standardized way. They are currently working with and collaborating with other measure stewards and measure organizations who are conducting stratification, with the focus on race and ethnicity since that is currently the most available data. They are planning to propose expanding that as data becomes available and will continue to look for other avenues of stratification that are occurring in other measure sets.
- A member asked if there is a way that OHCA can help identify missing data.
- A member asked what OHCA plans to do with the data, as that will help inform which data to collect.
  - The Office replied that the long-term goal is to slow health care spending growth without lowering quality of care. The public reports will include both spending and quality performance, and they will eventually include APMs, primary care spending, and behavioral health spending.
- A member stated that discrimination and racial prejudice is rampant, and asked what action must be taken for this information to be brought forward for OHCA's consideration.
  - The Office advised that OHCA was created primarily to focus on costs, but they are

also focused on working to get a high-value system. The purpose of the OHCA Quality and Equity Measure Set is to promote high quality and more equitable health care for all Californians, monitor changes in quality and equity as health care entities work to meet spending targets, and track OHCA's goals to improve access, affordability, and equity of health care. They are very carefully considering all the public comments that are submitted to them.

Public Comment was held on agenda item 7. One member of the public provided comments.

Agenda Item #8: Update on Behavioral Health Benchmark
Margareta Brandt, Assistant Deputy Director, HCAI
Debbie Lindes, Health Care Delivery System Group Manager

Assistant Deputy Director Brandt provided an overview of the background of the Behavioral Health Benchmark.

Debbie Lindes provided an overview of the updates regarding the development of a framework for the Behavioral Health Investment Benchmark.

Discussion and comments from the Committee included:

- A member recommended inclusion of inpatient care for part of the benchmark to be consistent with Proposition 1.
- A member expressed support for the OHCA behavioral work and noted that in her experience, insurers are sometimes refusing to bring a local bilingual bicultural therapist into their networks. This is one contributing factor to why the networks are so lacking.
    - Another member agreed, further commenting that it is very difficult for therapists in private practices to become accepted into insurance networks.
- A member commented that Proposition 1 focuses on the level of care when a person's rights are taken away. They want to do everything in their power to prevent that, to give people the treatment they need without getting to that point or meeting 5150 criteria. This is an equity issue, because those with money can access outpatient care, while those without money may have to access care via 5150 (involuntary admission). The member stated that people enrolled in Medi-Cal seeking behavioral health from their county can be on a wait list for almost a year for individual therapy, which is unacceptable. The member recommended that OHCA focus the benchmark on lower levels of care.
- A member agreed that the benchmark should focus on outpatient and community-based care, noting that it would be easy to spend a lot of money on inpatient care without getting much return in terms of outcomes.
- A member asked whether OHCA has considered how to determine whether the benchmark is meeting the overall goal of better, more accessible care. Quality measures for primary care are stronger than for behavioral health. OHCA could look at network participation by providers or out-of-pocket spend as measures of impact.
    - The Office replied that they are considering using the HPD data to perform

analyses that complement their work with the benchmark, as well as reviewing data from DMHC's behavioral health investigations.

- A member recommended utilizing the Level of Care Utilization System (LOCUS) and American Society of Addiction Medicine criteria (ASAM) to investigate whether people are receiving the level of behavioral health care needed. There should also be basic checks to compliance with network requirements, such as whether a health plan has a plan in place to provide out-of-network care when in-network care is not available.
    - The Office responded that they would follow up with the DMHC to inquire how they are implementing and assessing performance regarding accessing out-of-network care when in-network care is unavailable.
- A member commented that if there is not a way to enforce these laws in a timely manner or if corrective action plans take years to develop, then it is difficult to reap the benefits of these laws.
- A member recommended using assessments and standard of care measures, such as the Child and Adolescent Needs and Strengths (CANS) Assessment tool, to ensure people are receiving appropriate care.
    - The Office inquired how the standard of care measures are collected and reported. The member noted that these assessments are implemented by providers and that professional associations have standards of care for each behavioral health diagnosis.
- Another member recommended using Medi-Cal as a point of reference for how to use needs assessment tools and collect this data, as they are currently doing so.
- A member recommended that OHCA investigate the investments into telehealth and involuntary inpatient treatment to avoid incentivizing providers and plans from investing money into behavioral health care that does not provide quality care.
    - The Office replied that their Investment and Payment Workgroup has recognized telehealth as an important access component to outpatient behavioral health services, so they are proposing to potentially include it in the benchmark.
- A member suggested considering a distinction between telehealth that is delivered with a person's regular provider when in-person appointments are not feasible versus online-only, app-based telehealth platforms. The member expressed a view that if an individual wants in-person treatment they should have that option.
    - The Office stated that they would look into the data to see whether they can distinguish between telehealth services provided by an in-network provider versus via an app or via a telehealth vendor.
    - Another member added concern that because of how the apps are funded, there is danger that app-based care may become the only option.
- A member asked if there would be a way to track when people start with one provider and then go to another provider.
    - The Office responded that they would investigate whether there is a way to track continuity of care for behavioral health, possibly by tracking the number of therapy sessions with the same provider.
- A member expressed concern with Artificial Intelligence (AI) becoming incorporated into behavioral health care and a desire that this care not be counted in behavioral health measurement.
- A member noted that professional associations have ethical guidelines that

incorporate patient preferences and other considerations beyond standard clinical guidelines. AI might not be sensitive enough to respond to the subtle needs of the client.

- A member commented that sometimes clients need to be referred from one provider to another for their condition and this is difficult to track.
- A member noted that in terms of continuity, there can be repeated short episodes of care with different therapists instead of one longer course of treatment.

Agenda Item #9: General Public Comment

Public Comment was held on agenda items 8 and 9. No members of the public provided comments.

Agenda Item #10: Adjournment

The facilitator adjourned the meeting.