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

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HEALTH CARE AFFORDABILITY ADVISORY COMMITTEE

MEETING MINUTES
Monday, June 16, 2025
10:00 AM

Members Attending: Joan Allen; Barry Arbuckle; Aliza Arjoyan*; Kati Bassler;Carmen Comsti; Adam Dougherty; Parker Duncan Diaz; Stacey Hrountas*; David Joyner; Travis Lakey; Tam Ma; Carolyn Nava; Mike Odeh; Janice O'Malley; Marielle Reataza*; Sumana Reddy; Andrew See; Suzanne Usaj; Cristina Rodriguez*

*Attended virtually

Members Absent; Stephanie Cline; Hector Flores; Stephen Shortell; Yolanda Richardson; Kiran Savage-Sangwan; Sarah Soroken; Ken Stuart, Rene Williams

Health Care Affordability Board Member Attending: Sandra Hernandez*

HCAI: Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director; Margareta Brandt, Assistant Deputy Director; Andrew Feher, Research and Analysis Group Manager; Debbie Lindes, Health Care Delivery System Group Manager; Brian Kearns, Assistant Chief Counsel

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; Andrew Feher, Research and Analysis Group Manager, Margareta Brandt, Assistant Deputy Director, HCAI; Debbie Lindes, Health Care Delivery System Group Manager, HCAI; Brian Kearns, Assistant Chief Counsel, HCAI

Facilitators: Jane Harrington, Leading Resources Inc.

Meeting Materials: **https://hcai.ca.gov/public-meetings/june-health-care-affordability-advisory-committee-meeting-3/**

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

Director Landsberg opened the June meeting of California's Health Care Affordability Advisory Committee meeting. Roll call was taken for a record of attendance. Director Landsberg announced that the Board reviewed the submissions for the open positions of the Advisory Committee and that it will present its recommendations for review and approval at the July 2025 Board meeting. Director Landsberg then provided an overview of the meeting agenda.

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

Director Landsberg provided the following Executive Updates:

- A recognition of June as Pride month, as well as HCAI's focus on diversity and equity.
- Acknowledged the team for its effort in preparing OHCA's Baseline Report and all that went into it – learning from other states, digging into the available data, devising the data submission guide, getting guidance from the Board and many stakeholders on what was important to capture, and working with the health plans submitting the data. She is very proud of the data team.
- Acknowledged the challenges in capturing data for dual eligibles, fully accounting for the complicated Medi-Cal spending streams and non-medical programs administered by DHCS.
- Announced that HCAI's plans to move its headquarters to the May Lee State Office Complex have been canceled. OHCA will remain at the 2020 West El Camino office in Sacramento where all ongoing Board and Advisory Board meetings will be held.
- Senate Bill 101 was passed on June 15, 2025, with a projected $12 billion deficit.
- There is $1.9 billion for HCAI to invest in the Behavioral Health workforce over the next five years.
- Two BH Connect programs will be launching soon – a loan repayment program and a graduate medical education program that supports psychiatric residencies.
- The revised budget requires that Pharmacy Benefit Managers (PBMs) be licensed by the Department of Managed Health Care (DMHC) and that they provide data to HCAI's Health Care Payments Data Program (HPD), California's All Payer Claims Database (APCD), to gain a better understanding of cost and to improve the affordability of drugs for all Californians.
- The May Revision expands the authority of the CalRx program to partner with brand name drug manufacturers; this change would give the state more tools to respond to supply chain disruption, market manipulation and other restrictions that can threaten access to essential medications. The program will have $5 million available to respond to emergent pharmaceutical health needs.

Deputy Director Pegany presented the following information:

- A review of two recent articles published in Health Affairs and OHCA's preliminary approach to pharmaceutical affordability.

- The first article found that hospitals that invest more in capital infrastructure gained market share and access into adjacent geographic markets that led to shifts in patient flow toward the hospitals that invested heavily, thus resulting in raised prices. Hospitals that invest relatively less in capital lost market share and had fewer price increases. The pattern noted was that even in the absence of mergers and acquisitions, markets can consolidate as demand shifts to high price hospitals.
- The second article evaluated Rhode Island's strategy to curb hospital prices and its effect on enrollee premiums and hospital margins in the commercial market. Reduced premiums and out-of-pocket spending were observed in Rhode Island fully insured market, but this same reduction was not observed in Rhode Island's self-insured market. The authors suggested that greater transparency and oversight may be required for commercial rate regulations to benefit employers and members in the self-insured market.
- The Office provided a correction to the Commercial to Medicare Payment to Cost Raito (PTCR) Coding methodology specific to identifying high-cost hospitals. The original python coding consistently accounted for only 74 out of the 75 cost centers. In late May 2025 OHCA staff and consultants met to confirm the initial oversight and recalculate the PTCRs for comparable hospitals for the years 2018-2022. The findings concluded that the set of high-cost hospitals did not change nor did the new values impact the proposed sector target value for those identified as high-cost hospitals.
- An update on pharmaceuticals and affordability, providing background information and an overview of the factors impacting growth in drug spending.
- A reminder about slide formatting.

Discussion and comments from the Committee included:

- A member asked how the data related to capital expenditures and seismic projects will be handled regarding missed targets.
    - The Office explained that OHCA will be conducting a public process on reasonable factors for exceeding the target which will include the criteria included in the statute. The public discussion will not impact target setting, but it could be included in discussion to evaluate an entity's spending on the back end through enforcement.
- A member asked for clarification regarding the type of data that was used in the Rhode Island study which led to the conclusion that premiums and out-of-pocket spending had decreased as this is an important aspect of data collection that OHCA should be able to do as OHCA is implementing targets to evaluate how it impacts patients and consumers.
    - The Office replied that in this study, the Rhode Island researchers used data from the Medical Expenditure Panel Survey (MEPS). With the medical loss ratio requirement on plans, the intent is that if entities comply with the target, it should show a lower growth rate in medical spending. This should in turn result in a lower medical spending trend when they are reviewed by the Department of Managed Health Care (DMHC), which should result in lower premiums and out-of-pocket spending. OHCA will monitor this over time using publicly available rate data collected by DMHC as well as other data sets.

- A member suggested comparing the Rhode Island experience to the Massachusetts experience, noting that premiums in the latter have increased at twice the rate of inflation and at more than twice the rate of wage growth, which may mean that there is a gap between containing hospital prices and that translating into decreasing premiums.
- A member, referring to the Rhode Island presentation, asked about the factors that could account for the decrease in premiums for the fully insured and the increased premiums for the self-insured and if there was a way to monitor the cost shifting that could've been occurring during the period of data collection.
    - The Office provided several hypotheses for this occurrence. There is a difficulty in calculating the premium equivalent due to lack of data because self-insured employers are not required to report to the state regulator. Competitive forces in the self-insured plan market may cause the cost data for premiums to inaccurately reflect the costs of providing medical care. Fee increases caused by third-party administrators and administrative service only providers may increase premiums while also having limited transparency on those fees. The Rhode Island researchers did call for greater level of transparency and data reporting by self-insured plans, but there is limitations on what information states can require self-insured plans to provide.
- A member thanked OHCA for tracking pharmaceutical spending as a cost driver and noted that pharmaceutical spending within their hospital has increased 11% from last year and the hospital has no control over these expenses.
- A member suggested that OHCA look at pharmaceutical costs holistically, particularly for inpatient and clinically administered pharmaceuticals, citing cell and gene therapies which are cures that have high price tags and there are several adjunct services around these drugs like chemotherapy and longer hospital stays.
- A member stated that patients are being denied critical medications by Pharmacy Benefit Managers (PBMs) who deny approval of a medication because it is the wrong brand, requiring another prior authorization process without any guidance from the PBM as to what brands are acceptable. In addition, there are drug shortages that cause more access delays for patients to receive medications.
    - The Office suggested that the patients contact the DMHC Help Center for assistance in these matters.
- A member asked if the cost of advertising had been considered as a component of the Wholesale Acquisition Cost (WAC) or retail prices of pharmaceuticals. The member also asked if the submission of data by the PBMs to the Health Care Payments Data (HPD) would be subject to the Gobeille limitations.
    - The Office responded that PBM data submission will be impacted by Gobeille limitations, explaining that Gobeille refers to a Supreme Court case that states that self-insured plans are not required data submitters. Regarding marketing, there are limitations on what states can do about several components of prescription drug prices because of limits on interstate commerce. OHCA is exploring viable options.
- A member stated that SB 17 requires HCAI to be notified of the introduction of new drugs to the market and asked if the statute also requires notifying HCAI of a new clinical use of a drug which can wildly expand the use. The member cited the new

use for Wegovy, an obesity drug, for use as a cardiovascular drug. He expressed concern that the data that allows these new utilizations is not robust and stated that it might be worth looking into the impact of drug prices on the market from this perspective.
    - The Office replied that SB 17 does not require reporting an expanded use of a drug to market. There is robust reporting done by DMHC regarding drugs, which can be added to the PBM data to provide a good understanding of the situation and what needs to be done to address it.
- A member asked about how drug costs are affected if they are purchased directly from a manufacturer. The member also commented that drug costs may differ dramatically depending on how the end user is obtaining the medication, whether it is through a PBM on an insurance plan, or through the medical side, as is the case for J code and Q code drugs. The member suggested that this level of comparison may be of interest to OHCA.
    - The Office stated that costs are likely folded into outpatient billing for drugs. OHCA is meeting with health care entities, including hospitals, to learn about brown bagging and clear bagging, to better understand the general standards of practice, and what is considered reasonable markups, billing and reimbursement practices.
- A member asked when the rebate information will start to flow publicly.
    - The Office replied that the nonclaims data will be collected beginning in September 2025 and it is not yet known when it will be publicly available.
- A member asked if there had been any thought given to analyzing the total cost of a drug with its associated wraparound costs such as chemotherapy, a hospital stay and clinically administered medications.
    - The Office stated that this information may be retrieved from an ad hoc analysis on episodes of treatment and that this would require HPD data.
- A member asked if there was a system in place that allows for the tracking of prescriptions which have been denied by providers. The member also asked if there was any data that showed a correlation between generic drugs and adverse effects. The member expressed a desire for a publicly available summary of the information shared at the OHCA Advisory Board meetings that would be presented in plain language that everybody can understand.
    - The Office stated that HPD does not collect denied claims data so it cannot see which prescriptions have been denied. In a case such as this, OHCA would likely turn to literature to see what other researchers are doing to collect this information. The Office asked for clarification regarding the question about generic drugs and adverse effects.
- The member explained that manufacturers are allowed to create a generic version of a drug with some differences to the name brand drug on which it is based and that one of the differences could be different adverse effects. She asked if this data is being tracked or if this is something that OHCA could review.
    - The Office replied that it did not have the answer to that question but that it is aware of reporting to the Federal government about adverse drug related events. Regarding making OHCA's reports more easily digestible to the average

consumer, OHCA has been looking at creating infographics or other materials to share its findings with consumers.

- A member stated that clinicians need support for their time and for the value of the information that they provide. The member expressed concern that many patients who are using GLP-1 medications have adherence issues that cause a rapid regaining of the lost weight, citing the lack of care provided by the direct-to consumer companies who sell these drugs. They added that this is not cost-effective or care effective.
- A member expressed appreciation for the discussion, adding that it raises thematic, higher-level conversations about our culture and its desire for the instant gratification of a pill curing everything, a need to understand the comparative effectiveness of a drug while taking resource limitations into account, and the need to change the conversation around polypharmacy where more is not better. The member added that there is a need to use real time data rather than rely on Randomized Control Trials (RCTs) or biased research and development data that has been used in the past. Regarding prescription drug marketing to the public, the member stated that a lot of their research and development has been publicly financed.
- A member noted that there can be a dramatically different cost for the same drug depending on where it is infused. The member expressed concern that some physician organizations may choose not to have the high-cost drugs because the drugs will make it more difficult to meet the targets, causing higher costs for the drugs in hospital settings. The member stated that the location where the drug is administered can significantly influence the cost and is an issue which warrants further discussion.

Public comment was held on agenda item 2. No members of the public provided comments.

Agenda Item # 3: Update on Hospital Spending Measurement
Vishaal Pegany, Deputy Director, HCAI
Andrew Feher, Research and Analysis Group Manager, HCAI
CJ Howard, Assistant Deputy Director, HCAI

Deputy Director Pegany presented key updates on how OCHA will approach measuring hospital spending.

Discussion and comments from the Committee included:

- A member expressed a preference for publicly available and transparent methodology over proprietary methods that may change unexpectedly. The member asked about combining inpatient and outpatient data to create a composite for the hospital.
    - The Office replied that it also prefers a public source, but it is exploring the proprietary tool and looking into some of its challenges. For better weights for children's hospitals there are alternatives OHCA is looking into. OHCA's goal is to create a combined measure of inpatient and outpatient data that can be disaggregated to see what is occurring by service category. As more services are

transitioning to outpatient, OCHA will have the ability to track those trends over time and will be able to report by payer type as well.

- A member suggested that hospitals be evaluated in the major categories of inpatient, emergency room, outpatient surgery, and infusions, and to look at variations within those categories rather than grouping everything together as outpatient, to determine how these categories drive costs and affect affordability.
    - The Office responded that having aggregate data for the outpatient category is necessary to have Total Medical Expenditures (TME). The TME measure of per capita spending (or per member spending) can also be reported on the payer side and the medical group side. Applying this methodology would not explain why outpatient per unit prices are increasing. That would require further conversations during enforcement or further analysis in the HPD of broader trends in health care.
- A member stated that more granularity on the outpatient side would be helpful particularly when comparing the Case Mix Index (CMI) of a psychiatric hospital or a long-term acute care hospital to a general acute care hospital because specialized and long-term care facilities have such high CMIs. The member also suggested that as OHCA decides between two different groupers, one which applies to the Medicare population and one that is used by Medi-Cal, using the currently available HPD data to run some validations. For example, Ambulatory Payment Classification (APC) data could be run against the Medi-Cal data and the proprietary 3M grouping could be run against the Medicare data.
    - The Office shared that it is more ahead on the Medicare APC weights and is starting early conversations about 3M, which it currently doesn't have access to.
- A member asked how Maryland and other states have handled this process.
    - The Office replied that while it had learned from other states, getting to a per unit measure of outpatient data has been tricky because there is not an analog similar to the inpatient side. HCAI will be creating something new to close the gap in how states are able to measure outpatient hospital spending.
- A member asked if nonclaims payments would be handled by using cost or payments as validators.
    - The Office explained that utilization data is more important for determining outpatient intensity adjustment. Payment validations will be conducted to verify that trends in revenue and the HCAI financials track to data in the HPD.
- A member asked who is currently using the 3M Enhanced Ambulatory Patient Grouping (EAPG) tool for reimbursement or risk adjustment and how DHCS uses it for Medi-Cal.
    - The Office stated that it believes that DHCS uses the 3M EAPG tool for hospital reimbursement, and that the Office will follow up on this to confirm. Some payers or providers use it for internal analytics. APCs are used more frequently, and even though they are Medicare weights, commercial plans are using them for their internal analytics.
- A member asked how different data types would be reconciled for identifying and adjusting outpatient visits as well as reconciling timing differences for reporting.
    - The Office replied that it will align the service dates for the outpatient visits to the way that the entity files its HCAI financials to keep the data consistent. The HPD

is being used as a broad sample that is consistent enough to calculate the intensity adjustment.

- A member stated that not having data for hospitals who are fully capitated or have a significant portion of capitation would be a handicap and highlighted the need to obtain this information.
    - The Office explained that the HPD includes encounter data and nonclaims payments associated with the encounters which will be used to look at utilization.

Public Comment was held on agenda item 3. Two members of the public provided comments.

Agenda Item #4: Update on Cost and Market Impact Review Program
Brian Kearns, Assistant Chief Counsel, HCAI

Brian Kearns presented an overview of the last year of the Cost and Market Impact Review Program which was launched on April 1, 2024.

There were no questions or comments from the Committee.

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

Agenda Item #5: Update on Behavioral Health Definition and Investment Benchmark
Margareta Brandt, Assistant Deputy Director, HCAI
Debbie Lindes, Health Care Delivery System Group Manager, HCAI

Margareta Brandt and Debbie Lindes provided an update on the behavioral health work stream, including insights from analysis of historical spending data, an overview of the previous behavioral health investment benchmark proposal, and a new recommendation to focus on data collection and measurement before setting a benchmark which was shared at the Board meeting in June.

Discussion and comments from the Committee included:

- A member expressed concern that a significant category of behavioral health is not captured. The member noted that while many primary care physicians and pediatricians address behavioral health issues, they purposefully avoid putting a behavioral health diagnosis as the primary diagnosis on a claim because insurance companies will deny the claim or will refer the claim to carve-outs. The member suggested that behavioral health in primary care is much higher than reported.
    - The Office replied that it is aware of these limitations, such as different billing practices, in its data and thanked the member for pointing it out.
- A member asked how the methodology would address the overlap in primary care when a behavioral health diagnosis exists in a complex visit that involves multiple diagnoses, while also avoiding overcounting. Delivering this upstream care is key to controlling overall cost growth. The member expressed interest in seeing spending

data for traditional Medicare and Medi-Cal and asked about the methodology used to capture the out-of-pocket spend.
    - The Office responded that it will capture behavioral health delivered in primary care through the Behavioral Health in Primary Care module. However, the Office acknowledged that there are limitations to using a behavioral health primary diagnosis in this module, such as undercounting if claims with a secondary behavioral health diagnosis are excluded, or overcounting if every encounter with a behavioral health diagnosis is included. Additionally, the Office anticipates it could use the HPD claims data to further understand how much behavioral health spend in primary care settings is captured under secondary or tertiary diagnoses. The Office noted it does not have analysis of traditional Medicare spending to share at this time. The Office acknowledged challenges of capturing out-of-pocket, out-of-plan spend, but is working on developing a methodology to estimate that spend.
- A member acknowledged the complexity in categorizing behavioral health spend in primary care settings, such as FQHCs and Medi-Cal settings, where large portions of behavioral health are billed under primary care if a patient sees a primary care physician and therapist on the same day.
- A member commented that it is important to obtain the Medi-Cal data because it will provide inpatient data that is showing up less on the commercial side. The member asked if it would be possible to break down the spending for mental health and substance use disorder (SUD) separately.
    - The Office stated that it is possible that the spending data could be broken down by mental health and substance use disorder in future analyses.
- A member commented on the lack of access to behavioral health care and that the demand is a lot greater than the claims-based data shows. The claims-based data does not reflect the true demand or the out-of-pocket costs that people are paying for care.
- A member asked if or when there would be an effort to disaggregate the data OHCA presented by demographics, such as language data and geographic data. The member noted that some communities seek behavioral health services less due to stigma and language access and wanted to see how demographic data can be cross-referenced with spending data.
    - The Office replied that it would work with the HPD team to look into the feasibility of providing this data as part of its follow-up analysis.
- A member asked if supplemental data from schools would be included, particularly for new programs and apps from the Children and Youth Behavioral Health Initiative (CYBHI), and what impact artificial intelligence might have on the integrity of that data. The member expressed interest in capturing spending and utilization in the expanded array of service delivery models California is investing in, including mobile apps and peer-to-peer services. The member asked which specialties were included in the behavioral health in primary care module.
    - The Office replied that spending on Soluna and Bright Life Health would not be included in OHCA's data if it does not result in a claim paid by a health plan, but other services provided in schools and covered by Medi-Cal or commercial payers will be included. The Office noted that telehealth services will be captured

in its measurement and that it will categorize behavioral health spending based on the primary diagnosis on a claim. If care for a primary behavioral health diagnosis is delivered in a primary care setting, it will be captured under the behavioral health in primary care module.

- A member noted that at FQHCs and in Medi-Cal, dyadic services are covered and can be provided on the same day as a medical service. The member provided examples of situations where provision of a behavioral health service might occur without having a primary behavioral health diagnosis on a claim, such as when a carve-out rejects a claim where a provider used z-codes, but a payer still pays for it. The member wondered if that kind of spend is captured or missed.
    - The Office expressed appreciation for committee members' comments that illustrate how complex the behavioral health system is in California. The Office explained that it is working with DHCS to capture behavioral health services provided by Medi-Cal managed care plans. Health plans are required to submit claims and encounters from their carve-outs to the HPD, so that data should be captured in HPD and in OHCA's future data collection as long as a primary behavioral health diagnosis is on the claim or encounter. The Office has received feedback relating to including Z codes in OHCA's behavioral health spending definition, and invited the member to share the specific Z codes the member is using to make sure they are included in the definition.
- A member requested an additional analysis that would include outcomes or quality measures alongside the spending trends. Behavioral health spending is increasing faster than anything other than pharmacy spending, so linking that spending to outcomes is important.
    - The Office replied that it welcomes feedback on process and outcome measures to consider tracking in addition to the behavioral health quality measures from OHCA's Quality and Equity Measure Set.
- A member commented that a substance use navigation program at the member's hospital can measure outcomes such as reductions in Emergency Department recidivism, medication compliance, and keeping primary care appointments as examples of measures that have demonstrable downstream effects.
- A member asked if the OHCA data includes behavioral health services that are administered at correctional health facilities at the County or State level.
    - The Office responded that this data does not include corrections data. The Total Health Care Expenditures (THCE) data includes spending on health care services at California Department of Corrections and Rehabilitation (CDCR), but it may not be broken out by the category of behavioral health.
- A member stated that a larger percentage of care in the behavioral health space is being delivered by entities that are not considered covered providers and suggested that it would be helpful to determine how much of the care is being provided by providers covered by the statute.
    - The Office stated that it could do a crosswalk of the statutory definition of providers and what exists in the data.
- A member commented that the steeper rise in behavioral health spending may be due to the State's passing of two mental health and substance use disorder treatment parity bills in 2020 and 2022 which increased the scope of covered

diagnoses from previously five diagnoses to currently the entire Diagnostic and Statistical Manual (DSM). The steeper rise in spending may reflect the historical under-provision of these services and the recent laws mandating increased provision of these services.

- A member stated that quality of care can be measured by Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS) assessment tools which plans are required by DMHC to use.
- A member commented that documenting behavioral health screenings can be onerous for providers. Treating a patient for behavioral health has a significant impact on every other diagnosis and effective primary care providers impact both medical and behavioral health conditions. Providing this type of care can reduce the need for emergency department care, and this impact can be measured if seasoned clinicians can determine which medical and behavioral health diagnoses should be paired together to document that impact.
- A member asked how it would be possible to capture all the behavioral health spending and utilization that may not be coded in claims. The member provided an example of a young person who does not want their parents to know they are getting behavioral health care. The member wants measurement to capture this type of care and spending that occur before patients get a behavioral health diagnosis, because this is a large amount of important care.
    - The Office replied that the scope of its data collection is through health plans but that it is looking at ways to capture behavioral health spending outside of that scope. Non-claims behavioral health spending is captured, but it is an ongoing challenge to capture behavioral health spending more broadly, including preventive care and services that are occurring upstream from what health plans cover.
- A member expressed concern that the current approach to behavioral health spending measurement will reinforce the existing lack of integration between behavioral health and primary care and is glad that the team is rethinking its approach to behavioral health in primary care integration. The member also expressed concern about health care systems being asked to increase spending above the current level for primary care and behavioral health without an adjustment to the overall spending target. Organizations may have to choose between meeting the overall spending growth target, which is set below medical cost inflation levels, and making the investments needed to meet the primary care and behavioral health investment benchmarks.
    - The Office explained that the primary care benchmarks have been chosen because research has shown this to be a cost-reducing strategy. Investment in prevention and early intervention will reduce overall costs. The Office intends for both the behavioral health benchmark and the primary care benchmark to incentivize behavioral health and primary care integration and will continue to develop ways to better capture and incentivize behavioral health in primary care spending.
- A member recommended that the benchmark be set as soon as possible while collecting more information. Many people are not getting care they need, so that spending needs to rise and the investments will have big impacts on health

outcomes. There is a real urgency to do everything possible to encourage insurance companies and health plans to invest more in behavioral health.
    - The Office responded that several Board members recommended that the Office revisit setting a benchmark in 2026 based on further HPD analysis.
- A member asked if it would be possible to determine how many health services are being provided to people who have recently moved to California from within the United States.
    - The Office shared that it did not have that data and could look into obtaining that.
- A member agreed with Board feedback about revisiting the benchmark sooner than 2028 and recommended that an analysis be done on mental health versus SUD and perhaps separate benchmarks set, given the low spending on SUD, how great the unmet need is, and how much non-evidence-based treatment there is.
- A member asked about what is needed to be able to incorporate county specialty mental health services.
    - The Office explained that it is collaborating with DHCS on a regular basis to look at that, learning about the Short Doyle system, and exploring ways to obtain data from a billing system that is completely different from other billing systems.
- A member commented that some of the difficulties with collecting information on specialty mental health services may be caused by Medi-Cal delaying its rollout of regulations (such as timely access), so the data may be incomplete or not reflective of the actual demand.
- A member agreed with prior comments that measuring behavioral health integration in primary care is important. The member commented that it might be worth thinking about the reasonableness of expecting further increases in behavioral health spending while phasing in spending targets and noted that state requirements contribute to increased behavioral health spending. It would be helpful to contextualize overall spending growth with information about state-mandated spending.
- A member commented that with CalAIM, there is an influx of moderate-severe patients into county mental health systems. Some psychiatrists and therapists will indicate in records that wait times longer than is allowed by timely access standards are appropriate. Data on access may need to be looked at in a detailed way because it may not always be what it seems.

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

Agenda Item #6: Baseline Report Briefing
Vishaal Pegany, Deputy Director, HCAI
Andrew Feher, Research and Analysis Group Manager, HCAI
CJ Howard, Assistant Deputy Director, HCAI

CJ Howard provided background on the data collection engagement for the 2022-2023 Baseline Report. Deputy Director Pegany presented a high-level overview of the report. Andrew Feher provided more detailed breakouts of Total Health Care Expenditure

(THCE) and Total Medical Expense (TME) data. These key highlights from the Baseline Report had been published a week earlier.

Discussion and comments from the Committee included:

- A member asked if OHCA had compared commercial Health Maintenance Organizations (HMOs) to commercial Preferred Provider Organizations (PPOs) and if the data showed that the cost of HMOs, which are mostly capitation, have grown at a slower rate than the cost of PPOs which are mostly fee-for-service.
    - The Office explained that it had made this comparison and that the data did show higher absolute levels and higher growth rates in the PPO space.
- A member asked for more information about conversations that were held with providers regarding administrative costs and profits.
    - The Office stated that there had been meetings with providers to review TME data that they had submitted to confirm its accuracy, but administrative costs and profits data were not reviewed or discussed because that data was collected from a different source. The Office is aware that administrative costs and profits vary year-to-year, and it hopes to engage the Health Plan Association to further learn about this year-to-year volatility.
- A member expressed concern that the increase in Medi-Cal spending is not going to patients.
    - The Office explained that it will have more conversations with DHCS to review its rate data which includes the administrative costs and profits component. New mandates placed on MCOs under California Advancing and Innovating Medi-Cal (CalAIM) and other initiatives may be driving the figure seen on the slide 97.
- A member would like further investigation into the disparity between the 7% commercial care and the 15% Medi-Cal managed care statistics to determine causation. The member questioned how OHCA will present its findings to the legislature, its constituents, and its stakeholders and asked if OHCA would be willing to share its highest recommendations and biggest points with the public.
- A member asked for more information about the 12% increase for Medicare fee-for-service.
    - The Office explained that the Medicare fee-for-service data it receives only shows summarized statewide enrollment or member months and some core service categories, so very little can be gleaned from it.
- A member asked for a disaggregation of administrative costs and profits to find out if marketing is a part of this and what the billing costs are within the administrative costs.
    - The Office replied that there are very strict rules about what is included in administrative costs and profits that it will share with the committee.
- A member explained that a physician would encourage other physicians to do 100-day renewals rather than 90 renewals to reduce the medication adherence failure points from five to four to comply with Medicare Advantage CMS measures on medication adherence.
- A member clarified that their previous comment about third-party vendors sending physicians messages about 100-day prescription renewals was a bad example. The

member's point was that the influx of messages from third-party vendors interferes with workflow, causes inefficiency, and probably increases costs.

Public Comment was held on agenda item 6. Two members of the public provided comments.

Agenda Item #7: General Public Comment

General Public Comment was held. No member of the public provided comments.

Agenda Item #8: Adjournment

The facilitator adjourned the meeting.