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

2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

HEALTH CARE AFFORDABILITY ADVISORY COMMITTEE

MEETING MINUTES
Monday, March 17, 2025
9:00 AM

Members Attending: Joan Allen; Barry Arbuckle; Aliza Arjoyan*; Kati Bassler; Cline* Adam Dougherty; Parker Duncan Diaz; Hector Flores*; Stacey Hrountas*; Travis Lakey; Carolyn Nava; Mike Odeh; Marielle Reataza*; Sumana Reddy; Cristina Rodriguez; Andrew See; Stephen Shortell; Sumana Reddy; Suzanne Usaj

*Attended virtually

Members Absent; Stephanie Cline; Carmen Comsti; David Joyner; Tam Ma; Janice O'Malley; Yolanda Richardson; Kiran Savage-Sangwan; Sarah Soroken, Ken Stuart, Rene Williams

Health Care Affordability Board Member Attending: Ian Lewis, Sandra Hernandez*

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 Systems Compliance Assistant Chief Counsel; Janna King, Health Equity and Quality Performance Manager; Debbie Lindes, Health Care Delivery System Group Manager; Jean-Paul Buchanan, OHCA Attorney

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 Systems Compliance Assistant Chief Counsel, HCAI; Janna King, Health Equity and Quality Performance Manager, HCAI; Debbie Lindes, Health Care Delivery System Group Manager, HCAI

Facilitators: Jane Harrington, Leading Resources Inc.

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

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

Director Landsberg opened the March meeting of California's Health Care Affordability Advisory Committee meeting. Roll call was taken for a record of attendance. Director Landsberg provided logistical information related to the new meeting site at Covered California, announced Abbie Yant's resignation from the Committee, and presented the meeting agenda.

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

Director Landsberg provided the following Executive Updates:

- Assembly Member Mia Bonta introduced Assembly Bill 1415. This bill, sponsored by Health Access California, would add health care systems as a new definition and allow data to be collected at the health system level. It would add Management Services Organizations (MSOs) to health care entities under the statute. It would also require private equity groups, hedge funds, and newly created business entities created for the purpose of the transaction to submit written notice to OHCA before a proposed merger acquisition goes into effect.
- The Health Care Payments Data (HPD) Program has been accepting applications for requests to access non-public HPD data. OHCA will soon publish its fifth public HPD report. The latest HPD visualization focuses on the types of health care services provided to Californians each year. This information is available on the OHCA website. At next week's OHCA Board meeting, the HPD team will provide an update to the board about the staff's utilization of the HPD.
- OHCA's investment of $31 million in the Song Brown Primary Care Residency Program continues to successfully certify many wellness coaches from its fifty-one training programs.

Deputy Director Pegany provided a summary of the Millbank Memorial Fund's February 2025 report outlining lessons learned from efforts by multiple states to slow and shift health care spending. He announced that representatives from Massachusetts and Oregon will be providing updates on their respective statewide spending target programs at the next OHCA board meeting. He also summarized an article published in the February 2025 JAMA Health Forum that examined fourteen key drivers of per capita health care spending across counties in the United States.

Discussion and comments from the Committee included:

- A member asked if a statewide Group Purchasing Organization (GPO) had been considered, stating that a reduction in the cost of supplies would help control overall costs.
- The Office responded that there are some efforts at Department of General Services (DGS) to work with counties regarding purchasing.
- A member congratulated OHCA for its work on alignment issues, citing a spillover effect on other initiatives such as the Integrated Healthcare Association (IHA) and three health plans in Purchaser Business Group on Health (PBGH) which are working on primary care with the California Quality Collaborative. They are working

with over one hundred practices in the state, many of which are small and rural. Pertaining to the Journal of American Medical Association (JAMA) Health Forum study, the member also pointed out that prices may get a lot of attention, but utilization can be a bigger factor in explaining cost differences across counties in the United States. The member concluded noting that spending is price times utilization and includes intensity as well.

- A member stated that while the level of integration leads to more efficiency, there is a tipping point where integration becomes monopolistic behavior. Larger medical practices that are more efficient and more integrated can destabilize the workforce by driving higher salaries, making it more difficult for smaller practices to recruit and retain physicians.
- A member asked for clarification about information in the article regarding increases in median income being associated with more utilization, except for emergency department and more inpatient care. The member mentioned that patients who do not meet a certain income level are likely to delay care until they need emergency care or hospitalization, which are the highest drivers of cost.
    - The Office acknowledged and appreciated the highlight that lower income consumers face more barriers to care and decreased amount of utilization outside of emergency department visits. The Office reiterated that the general theme of the article is that health care utilization rises as income increases.

Public Comment was held on agenda item 2. No member of the public provided comments.

Agenda Item # 3: Proposed Hospital Sector Definition Regulation
CJ Howard, Assistant Deputy Director, HCAI

Assistant Deputy Director Howard provided an update of the proposed hospital sector definition, including the proposed regulatory text.

Discussion and comments from the Committee included:

- A member asked why long-term care hospitals (LTCH) are not included under the Specialty Hospitals sector.
    - The Office explained that the term “special hospital” is included within the statute. All regulations must align with the statute, which is why that term has been included in the regulation. Although the term “special hospital” is not currently being used, it may be used in the future. If a long-term care hospital is part of a general acute care hospital, then they would meet the definition under Section 1250 of the Health and Safety Code.

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

Agenda Item #4: OHCA's Recommendation for Hospital Sector Target Methodology and Values
Vishaal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director

CJ Howard presented the recommended methodology for identifying high-cost hospitals and for adjusting target values for these hospitals. The same information was presented at the OHCA Board Meeting on February 25, 2025, which began the 45-day public comment period that ended on April 11, 2025. The board has until June 1, 2025, to set targets for 2026 and may set targets for beyond 2026 at that time.

Discussion and comments from the Committee included:

- A member asked for clarification of the five percent payment threshold.
  - The Office replied that the Commercial to Medicare Payment to Cost Ratio (PTCR) compares commercial revenues to commercial costs and Medicare revenues to Medicare costs. For the ratios to be valid, there needs to be substantial revenues from both; otherwise, the ratio could be skewed by limited data. Hence the need for a payment threshold.
- A member asked if the Office could elaborate on specific potential market variations they may be exploring.
  - The Office replied that they are investigating a drop off that was noticed at NorthBay. The results of that investigation will be reported to the Board shortly.
- A member noted that ten of the eleven hospitals included in the current list of high-cost hospitals are in Northern California. The member remarked that if OHCA intends to move from the 80th percentile to the 85th percentile, they recommend a geographic examination of Northern versus Southern California hospitals which may result in the addition of more high-cost outlier hospitals for both regions.
- A member expressed concern that the Commercial Inpatient Net Patient Revenue (NPR) per Case Mix Adjusted Discharge measure seems incomplete because commercial payments are not independent of Medicare/Medicaid costs in the long term. The member also stated that the exclusion of outpatient costs can also contribute to this data being incomplete considering that outpatient costs make up at least half of service volume, and inpatient services are being shifted to outpatient. In addition, the member expressed a preference for using a rolling three-year method as that would likely result in more current data. The member asked if the list will be updated yearly and if every health care entity will have the same target.
  - The Office replied that there are ongoing conversations with the Board to decide whether the list should be updated annually or at a different cadence, such as every two years. The Office mentioned that it highlighted the difference between the unit price measure and the relative price measure as well as the tradeoffs in a presentation at a recent Board meeting. It was noted that a benefit of the Payment-to-Cost-Raito (PTCR) is that it encompasses outpatient revenue.
- A member expressed concern about how capitation is being handled for both Medicare Advantage and commercial insurance. The member also asked for clarification regarding how the data is calculated when a system pays out-of-network claims and services that are not available at their hospital. For example, ambulatory

services are included in capitation rates that are not hospital specific, and in other instances there out-of-network claims and services that are paid to other hospitals.
    - The Office explained that the NPR measurement encompasses all revenue for the hospitals, including capitated and PPO revenue. The Office replied that if the hospital cannot provide the service needed, HCAI financials requires them to report that under purchased services. That is more of an expense for the hospital rather than revenue. While they are responsible for providing the service, having to subcontract that service out leaves them with less than the capitation.
- A member expressed appreciation for the work that has been done and the progress that has been made. In supporting a historical look at the data, the member reflected on the development of a local (statewide) health care culture that's led to practices over decades that resulted in a geographic lack of competition among hospitals, the general inability to negotiate with them, and very little insight into the causes of such disparities in the delivery and cost of services. The member concluded by using the reasons above to underscore the importance of OHCA providing technical assistance to the entities subject to the new spending growth target.
- The Office appreciated the historical reflection and offered insight into the work HCAI has been doing to better understand the vast disparities within health care over the last few years. To better gain insight into the operational challenges that the most financially distressed hospitals encounter and assist these hospitals in remaining open, HCAI stood up the Distressed Hospital Loan Program. Now, the Office is setting spending growth and sector targets for high-cost hospitals. While the office agreed with the importance of providing technical assistance, it also wanted to temper the Committee's expectations by clarifying that the Office's charge is not prescriptive in nature and it does not have the authority to tell hospitals how to run themselves. The Office has had many important discussions with Board members and agree that these cost measures need to be achieved and that there are several ways of doing it (e.g., cost-reducing strategies and alternative payment models).
- A member inquired about the number of high-cost hospitals that would appear on the list if the Office calculated two (2) standard deviations opposed to one (1). The member also requested a future presentation on looking at the low-cost outliers – one or two standard deviations in the opposite direction to see what might be learned from these hospitals that have been consistently delivered at lower costs without compromising quality.
- The Office referred the member to the February Board presentation and the descriptive statistic slides that described what the unit and relative price measures would look like at one and two standard deviations, as well as what it may look like when taking the difference between the third and first quartile and multiplying it by a scalar factor of about 0.25 to obtain a range of different ways of thinking about the distribution.
- A member asked why Kaiser hospital information has not been included. The member mentioned having witnessed an effort at Kaiser to lower costs while having seen an emphasis on optimizing charges to Medicare and commercial insurers at private practices.
    - The Office responded that Kaiser hospitals are included in the sector, but they were not included in this analysis. The statute requires Kaiser to be treated as a

fully integrated delivery system. If the Board chooses to go in this direction, they could set a fully integrated delivery system sector. The Office will still be reporting on Kaiser hospitals individually as part of the HCAI financials. A recent change to state law requires Kaiser hospitals to report specific data with respect to each facility, so more of that granular data will be included in future reports.

- A member suggested that the Office could look at low-cost outliers using one or two standard deviations to discover ways to lower costs without compromising quality, while also looking at equity and quality measures.
- A member expressed support for creating a fully integrated delivery system sector to include Kaiser and to broaden the analysis of possible cost shifting within these systems, particularly for outpatient services. The member also stated the importance of offering technical assistance to hospitals in gathering data regarding workforce stability standards to ensure that reductions in cost do not create reductions in the workforce or impact workforce stability standards.
- A member asked if the inpatient case mix adjustment is sensitive enough to adjust for significant differences in the kinds of services the hospitals are providing.
    - The Office replied affirmatively and mentioned that this information was presented at the February Board meeting. The Office applied the Medicare Severity Diagnoss Related Group (MS-DRG) weights, a well-recognized way to adjust for inpatient intensity. This method may not be the best weighting to use for children's hospitals, so 3M All Payer Relative (APR) weights are being considered.
- A member mentioned that more and more patient services are moving from inpatient to outpatient, including procedures such as hip replacements. The member expressed a concern that the methodology may not fully account for outpatient services.
    - The Office replied that the methodology for high-cost hospitals does use two measures. The Office is working on including both inpatient and outpatient data in the year-over-year measurement so that it will be able to calculate an outpatient intensity adjustment and an outpatient spending per unit measurement.
- A member reacted to previous comments about the desire to achieve reduced health care costs without cutting labor costs. The member believes that this is an unrealistic idea and suggested that the Committee hold further discussion on this topic. The member also suggested that low-cost hospitals that have lower commercial inpatient net patient revenue be reviewed to determine if these hospitals appear on the list of hospitals that exceed the 3.5% target in order to survive. The member stated that given the current trend of shifting hospital inpatient to hospital outpatient care, and the probable elimination of the CMS inpatient only list, it is important to track these changes. Lastly, the member expressed a concern that the use of Medicare costs, which are reimbursed inconsistently, as a base for the calculations resulted in the elimination of several high-cost commercial hospitals, which seems inconsistent with the focus on reducing the commercial impact on employers and consumers.
- A member expressed a desire for a document that explains health care terms so that members would have a more cohesive understanding of the data being presented.

    - The Office thanked the member for the suggestion and stated that there is an ongoing awareness on its part to include more explanations of health care terms and acronyms in the presentations. The Office encouraged members to make specific suggestions during the 45-day comment period which ends on April 11, 2025.
- A member expressed appreciation for the work and development of the Commercial to Medicare PTCR measure and suggested using this methodology to look specifically at hospitals that are just above 250% of Medicare to make adjustments that flatten the bell curve, allowing more equity. A hospital that starts out at a higher bar would be advised to get back to the regressive mean. The member also wanted to emphasize the Director's comment regarding the fact that OHCA's task is to create spending targets for the different sectors without offering methods to achieve these targets. Because of the differences in the appropriateness of care for lower-income individuals and higher-income individuals, the health care professionals' determination of best practices emphasizing quality over quantity may lower costs in the long-term.
- A member commented that the source of the cost of labor issue, which is a problem for hospitals and physician groups, is that California is such a high-cost state, and presents challenges to staff recruitment. The member suggested that OCHA look at ways to reduces costs that are manageable like solutions for workforce shortages of nurses and physicians. These shortages create the need to hire travel nurses, registry nurses and other vendors, all of which add to labor and the overall hospital operational costs. The member also suggested that OHCA look at regulatory relief for experiments that would remove state-specific regulations, allowing for the creation of lower-cost innovations available across the United States.
- A member expressed concern that there will be large Medicaid cuts coming soon that will reduce the level of care available to residents of California while also reducing revenues to medical providers.
    - The Office acknowledged the uncertainty and anxiety caused by these possible cuts to Medicaid and it recognizes the huge impact that these cuts would have on the Medi-Cal program and on the providers who rely on this revenue.
- A member commented on the nursing shortage, adding that there is also a shortage of nursing school positions. There is also a shortage of residency positions available for medical school graduates, creating an inability for some medical school graduates to be employable. There is a need for more access to training and the ability to complete training. The member also expressed the importance of there being scrutiny regarding the percentage of health care costs that are tied to the increasing profits earned by insurance companies and healthcare companies. It is important to understand how these rising salaries for the CEOs impact the cost of labor associated with health care costs. The member expressed concern that trust in the health care system is being eroded by the increasing pressures and higher costs caused by the insurance companies.

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

Agenda Item #7: Update on Behavioral Health Definition and Investment Benchmark (held out of order)
Margareta Brandt, Assistant Deputy Director, HCAI
Debbie Lindes, Health Care Delivery System Group Manager, HCAI

Assistant Deputy Director Brandt and Debbie Lindes provided an overview of the proposed methodology to identify behavioral health spending and an update on the work to define the behavioral health investment benchmark.

Discussion and comments from the Committee included:

- A member expressed a concern about spending that may be excluded when a behavioral health diagnosis is listed as secondary, specifically in the primary care setting, and concern that there may not be adequate workforce to meet need.
    - The Office replied that it is actively aiming to measure behavioral health occurring in a primary care setting through a behavioral health in primary care module while recognizing that including secondary diagnosis data could potentially capture spending that is not directly related to behavioral health. There is a possibility that using HPD or other data sources could clarify what data is missing when a secondary diagnosis is not considered.
    - The Office responded that it recognizes the need for improvements in infrastructure and workforce, citing the Behavioral Health Services Act and the passage of Prop 1. Barring unforeseen changes, significant Medicaid funds will be available for behavioral health workforce development.
- A member expressed concern about limiting the benchmark to only a portion of the care continuum, which could result in under-investment in care that is excluded from the benchmark.
- A member noted that OHCA's focus on spending may leave out consideration of quality.
- A member expressed a preference for the per member per month (PMPM) option as opposed to percentage because the costs of pharmaceuticals and cell and gene therapies will be huge drivers of increased costs.
- A member inquired about the length of time that Rhode Island has been tracking behavioral health.
    - The Office replied that they are unsure of the exact time frame they've been tracking, but that Rhode Island is comparing this year's spending with the 2022 baseline. The Office can provide an answer to that question as well as additional information regarding the development of the benchmark and its intent in a future meeting.
- A member expressed a concern that by focusing on clinical care for individuals who have hit rock bottom, there is a missed opportunity for early intervention for behavioral health problems which can be provided by community-based organizations. Many people who could benefit from behavioral health treatments do not seek clinical care. There is a need for belonging and connection which may not necessarily happen in a clinical or outpatient setting, and the concern is there will not be sufficient workforce or time to establish rapport and relationship with the patient needed to deliver high quality behavioral health care.

    - The Office replied that they recognize the limitations of capturing data related to prevention and early intervention work that happens outside of the clinical behavioral health space, given that their data source is data from health plans. They are open to suggestions about how to capture behavioral health spending more comprehensively.
- A member noted that non-claims payments will be difficult to measure.
- A member stated that as support for therapists grows through improved reimbursements, as more young people show interest in the field, and as more companies offer bulk credentialling, there will be an increase in the number of therapists, including bilingual therapists. Once patients receive integrated care with primary care that focuses on both physical and emotional care, there will be fewer emergency room visits and tremendous cost efficiencies.
- A member noted that due to behavioral health carveouts, when primary care physicians provide behavioral health care those claims are often denied by payers. Employee Assistance Program (EAP) services also may be missed in measurement.
- A member asked if the intent is to be measured at the health plan level, the payer level, or to roll it down to providers, and noted that attribution of members would be difficult. The member expressed concern that it might be difficult to measure per-member, per month spending especially for PPO plans who track subscribers. The member expressed agreement that OHCA should look at spending across the whole spectrum of behavioral health care.
    - The Office stated that the intent is to start with payers at the health plan level. There are also some requirements in the law about capturing alternative payment model and primary care data from restricted and limited Knox-Keene Act licensees. This could help to identify the types of data that could be collected from providers and then potentially allow direct collection of the data from providers, rather than having the payers attribute the payments.
- A member asked which spending categories would be assigned to the emerging technologies in behavioral health such as telemedicine, chat-based behavioral health, and the use of AI. The member expressed a concern that there is a chance that AI chat interactions could be counted as clinical visits and asked whether those should be considered in the same category as more traditional practices.
    - The Office stated that spending related to supporting or expanding IT infrastructure for providers, including behavioral health AI, would be captured in category A and its associated subcategories. Any spending that does not fit into these categories will be captured in the “other spending” category. The Office is proposing a limit to the amount of spending that can be allocated to behavioral health for both categories.
- A member noted that a very high percentage of primary care visits involve behavioral health, even when they are billed under a medical diagnosis. The member discussed warm hand-offs to behavioral health during primary care visits and stated that they are supportive of both increasing primary care spending and incentivizing behavioral health in primary care.
    - The Office stated that they are endeavoring to capture the behavioral health services provided in the primary care setting and are also endeavoring to incentivize that by measuring the behavioral health piece separately to enable

the calculation of the total spend between primary care and behavioral health without double-counting it.

- A member stated that the 15% benchmark for primary care supports the goal of investing in preventative care as opposed to only improving health care facilities. The member suggested that measuring increased outpatient care specific to behavioral health would be helpful along with increasing primary care and suggested moving from a percentage to a per member per month measurement approach.
- Another member supported a per member, per month measurement approach.
- A member disagreed with the idea that having more behavioral health providers would be the reason that more people will seek behavioral health care. The member pointed out that what prevents some individuals from seeking care is a cultural stigma and that worsening conditions will cause more individuals to seek care. The member would like to think beyond just the spending and utilization data to understand causation and would like to have further conversations about the topic.
    - The Office appreciates the conversation about the aspirational vision for our health care system and the assistance being offered about thinking through the details for developing the measurement methodology.
- A member asked if there were other ways to gauge these systems other than solely through data, stating a concern that this effort will not be sufficient for capturing an accurate picture and asked what else could be done to support this effort.
    - The Office replied that this is a parallel effort along with the work being done on the Children and Youth Behavioral Health Initiative, the many initiatives with Medi-Cal, and the work being done by DMHC with health plans.
- A member urged the Committee to focus on measurable impact, triaging the highest need, highest value, and biggest gaps while maintaining the aspirational vision by using the currently available data and the tools OHCA has.
- A member agreed with other members' discussions of how in many settings. Even if a behavioral health issue is the main thing bringing the patient to care, medical diagnoses are often prioritized in coding. The member also noted that when patients come to settings like the ED, that often means the system has failed and plans should be incentivized to cover care where it is most needed.
- A member asked for clarification regarding the allocation of payments for behavioral health services provided in a primary care setting.
    - The Office explained that OHCA is capturing all non-claims payments through its total health care expenditure data collection. It is implementing an allocation methodology for counting non-claims towards primary care and an allocation methodology for counting non-claims towards behavioral health so that they are each measured distinctly and do not overlap. The Office is proposing that a non-claims payment has to be made to a behavioral health provider or a behavioral health organization in order to count towards behavioral health spending. The Office also has a methodology to measure behavioral health spending in the primary care setting.
- A member agreed with another member's concerns that AI-driven behavioral health care is of unknown quality and untested AI should not be included.
- Another member asked if a definition for a behavioral health provider has been established.

    - The Office replied that they are working with the Investment and Payment Workgroup to define a set of providers who would count as behavioral health providers.
- Another member expressed support for the per member, per month measurement approach.
- A member encouraged engaging with Jeff Rideout of the Integrated Healthcare Association (IHA) about the Encounter Data Governance Entity (EDGE) program which will show how well the encounter data is capturing all the essential diagnoses even if there is a behavioral health component in addition to a primary care component.
- A member stated that behavioral health training is required in the family medicine residency, allowing primary care providers to provide behavioral health care. The member encouraged other medical specialties adopt the same requirement to increase the capability of the workforce to provide behavioral health care.
- A member suggested that the Committee invite Dr. Leo Lopez to talk about the successes and limitations of an open access to behavioral health model that was implemented in Long Beach. This model reduced costs by reducing emergency room visits but was unsustainable due to a workforce shortage compared to the needs of the population.

Public Comment was held on agenda item 7. Two members of the public provided comments.

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

Assistant Deputy Director Brandt issued a reminder that OHCA is seeking additional examples of cost-reducing strategies. Such examples might include a program that addresses a specific population, implementation of best practices for more efficient resource use, or an effort to increase coordination to improve and reduce costs while also improving quality. Anyone who is interested in proposing a cost-reducing strategy to OHCA can email a proposal to OHCA's general inbox and OHCA will follow-up to learn more. She then introduced Dr. Talamantes, the Senior Vice President and Chief Operating Officer of Health Services at AltaMed.

Dr. Talamantes provided an overview of AltaMed's history, vision, mission, and values as well as its strategies for creating value-based care outcomes. Strategies include patient risk stratification using John Hopkins Adjusted Clinical Group (ACG) model to redesign programs, Enhanced Care Management (ECM), and workforce initiatives to address the health care provider shortage.

Discussion and comments from the Committee included:
- A member asked how AltaMed deals with access and continuity, especially for those patients who are reluctant to change providers.
    - Dr. Talamantes replied that analysis of the data allows for identification of patients who are less engaged and provides the opportunity to find out why. If the

patient wants to see the primary care provider more often, switching to AltaMed's Viva Gold program would allow the patient to do so. Patients can go back to their former primary care provider if they choose to do so.
    - Dr. Talamantes also shared that physicians also see the value of being part of a care team, allowing them to provide better care for patients with multiple chronic conditions and reducing the number of emergency department visits.
    - Dr. Talamantes said that continuity of care is a challenge due to the current financial model. Using full risk with Medicare allows AltaMed to decouple itself from fee-for-service and use full risk dollars. AltaMed is starting to develop this in a primary care setting for all Medi-Cal patients.
- Dr. Talamantes noted many physicians are interested in joining a team-based model that panels 900 patients per physician rather than the standard 2,000 patients per physician Physicians also want to take care of these patients who are higher risk and more complex.
- Dr. Talamantes shared that contracting with specialists has been a challenge, but they are moving a lot of their contracting with specialists to value-based models. This has resulted in positive outcomes thus far.
- A member asked about the data that is available for selecting relatively lower cost, higher quality specialists in hospitals and what could be done to improve that data.
    - Dr. Talamantes explained that because AltaMed has been under global risk for five years, there is more data available for analysis. Initially, information was gathered by rounding at hospitals. Hospitalists were then hired at two hospitals to gather and report information about patients' diagnoses and needs for ongoing care. At the other hospitals, data is collected and shared daily to discern the types of specialists involved and the different levels of quality of care being provided. There is reassurance in knowing that the discharged patient will receive appropriate follow-up care because AltaMed will set up the necessary appointments for the patient. There is a lack of real-time data to assess hospitalist and specialist quality.
- A member asked how low-value care is identified and avoided in the practice.
    - Dr. Talamantes stated that the medical education team provides updates about the latest evidence regarding appropriate care. AltaMed has its own set of ultimate clinical guidelines embedded in an electronic health record system which alerts clinicians if a procedure is inappropriate. This alert can be overridden but serves as a guideline. The medical directors provide feedback on the level of referrals and diagnoses. By including data that would not normally be assessed in primary care like emergency department visits, hospitalizations, readmissions, referrals, and imaging, clinicians stop ordering unnecessary labs and diagnostics.
- A member asked if AltaMed is considering the use of AI for clinical and administrative tasks to expand panel size, giving physicians more time with patients.
    - Dr. Talamantes stated that the use of AI is being considered. Currently many non-physicians (MAs, LVNs, RNs) are being leveraged behind the scenes using the data on the medical registry dashboards to contact patients. There may be ways to close gaps in patient care by having this group of non-physicians use their skill sets differently with the addition of AI.
- A member asked for more information on the home visit program and social health.

    - Dr. Talamantes explained that having hospitalists employed in two of the busiest hospitals led to the realization that some patients were too sick to leave home. A clinician home visitation program was developed about five years ago. The program spans five regions with two home teams per region. There is also a street medicine program. The challenge is that this is the most intense, highest-resource, and highest-cost program, and can only see about six patients a day in Los Angeles so it has to be focused on the right patients.
- A member noted that AltaMed has a restricted Knox-Keene license and asked if AltaMed foresees itself capitating hospitals so that they are more aligned.
    - Dr. Talamantes stated that capitation is a huge opportunity for evolving the specialty contracting approach, and an important way to better partner with hospitals.
- A member asked if AltaMed foresees utilizing hospital-at-home strategies.
    - Dr. Talamantes stated that while AltaMed has not yet looked at hospital-at-home strategies, it might be a way to partner with hospitals in addition to capitation. Currently there is some remote patient monitoring occurring, but it presents challenges. A hospital-at-home program may be a better way to support remote patient monitoring.
- A member cited the great strides that have been made by AltaMed's 2018 initiative to move from volume to value and asked how smaller FQHCs and safety net practices can find the capital necessary to make this transformation.
    - Dr. Talamantes explained that AltaMed leveraged shared risk pools to move into full risk over several years. AltaMed started out small with a multi-year plan, partnered with physician leadership to develop clinical practices, and adjusted frequency and intensity of patient care to match patient care needs. Implementing telehealth services and leveraging non-physicians to be support teams for providers allowed for positive outcomes in value-based care and quality patient experience.
- A member inquired about the level of clinician that sees the patient at home.
    - Dr. Talamantes explained that most of the clinicians who do home visits are nurse practitioners. Physicians assist the nurse practitioner if necessary.
- A member asked what pay for value looks like for specialists.
    - Dr. Talamantes stated this is an underdeveloped area. Currently they can assess and share costs in some specialty areas, but it is the exception, not the rule.
- A member asked if telehealth is provided by a vendor or by AltaMed's primary care providers.
    - Dr. Talamantes explained that AltaMed developed its own in-house telehealth service that operates 24 hours a day, seven days a week and is staffed by nurse practitioners with the supervision of a physician. The key to the success of this service is that it provides an entry point to care. Patients who call overnight are given an appointment to see a provider the next day. This has significantly reduced the number of emergency department visits. For telehealth to be successful, the program must have an entry point into the system with very close coordination of care.
- A member asked how AltaMed persuaded local Medi-Cal plans to shift to the value-based care model.

    - Dr. Talamantes stated that the health care plans are very motivated to collaborate in finding better arrangements for reducing costs, particularly for emergency room care or specialty care.
- A member asked how AltaMed motivates physicians to participate in a team-based model.
    - The adoption of EPIC, an electronic health record system, has enabled providers to see a full record of patient data, increasing trust across teams by allowing providers to work together. The utilization of this shared data can help all providers, even those who are incentivized by HEDIS, as well as those using quality-based measures. The scope and availability of the shared data allows team members to work more efficiently to provide better patient care.
- A member asked how often members of the Viva Gold Senior Care are allowed to see their providers and if they have any input about which provider they can see in the group.
    - Dr. Talamantes explained that the provider team is available every day and that same-day access is almost guaranteed except in the case of staff absence. If the team is inaccessible, the home visitation team will be activated for patients at home. If the patient is at the hospital, the discharge planners will go to the patient's bedside. AltaMed is developing a system that allows patients to choose a provider by investing in facility upgrades that are more senior-friendly and by doubling the number of sites by the end of 2026.

Public Comment was held on agenda item 5. One member of the public provided comments.

Agenda Item #6: Update on Quality and Equity Performance Measurement, Including Public Comment Feedback
Margareta Brandt, Assistant Deputy Director, HCAI
Janna King, Health Equity and Quality Performance Group Manager

Assistant Deputy Director Brandt and Janna King provided an update on the OHCA Quality and Equity Performance Measurement as well as a review of the feedback received via public comment and previous Advisory Committee discussions.

Discussion and comments from the Committee included:
- A member expressed appreciation for the move towards considering more meaningful surveys that look at continuity and relationships when trying to create value-based organizations.
- A member suggested further recognition or incentive for organizations working with underserved populations.
- A member stated that the landscape for immunization acceptance is changing dramatically, even in California.
- A member appreciated the fact that OHCA is aligning with existing metrics and not creating new ones. Each new metric creates more administrative burden, more complexity, and more costs.

- A member suggested that the current HEDIS childhood immunization metric be reviewed and adjusted to consider the limited availability of the flu vaccine in California between May and September, and the reluctance of extremely vaccine skeptical parents. The member suggested removing the flu vaccine from this metric and implementing a mechanism that would prevent a negative mark being recorded for a physician group when parents opt out of vaccinating their children.
    - Director Landsberg asked whether the concern about the flu vaccine had been raised with other organizations. To which the member responded yes, the issue had been raised to others. The member noted that they are interested in seeing the industry address this issue.
- A member stated that it is difficult to collect race and ethnicity data because many patients are afraid to reveal this information.
    - The Office expressed interest in hearing more about this.
- A member suggested that explaining to patients why race and ethnicity data collection is important and how it could benefit them can improve data collection.
- Another member appreciated the focused set of measures and suggested to keep that in mind over time in terms of administrative burden.
- A member commended OHCA on pursuing the hospital acquired infections data and emphasized the importance of having a set of relevant safety measures that are routinely collected and aligned with others. The member asked why CalPERS was not sure whether they would keep hospital acquired infections in their measurement set in the long run.
- A member commented that to the extent improvements are being made and they're holding constant, OHCA may consider the need to continue including that measure.
- Another member expressed support and appreciation for starting with existing measure sets.
- A member emphasized the importance of California's efforts to improve race and ethnicity data reporting and improve immunization data reporting. It is especially important for the State to replicate health care demographic data that was previously provided by the Federal government.

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

Agenda Item #8: General Public Comment

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

Agenda Item #9: Adjournment

The facilitator adjourned the meeting