OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Advisory Committee Meeting

March 17, 2025

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Welcome, Call to Order, and Roll Call

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Agenda

1. **Welcome and Call to Order**

2. **Executive Updates**
   Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director

3. **Proposed Hospital Sector Definition Regulation**
   CJ Howard, Assistant Deputy Director

4. **OHCA's Recommendation for Hospital Sector Target Methodology and Values**
   Vishaal Pegany; CJ Howard; Andrew Feher, Research and Analysis Group Manager

5. **Cost Reducing Strategies – AltaMed**
   Efrain Talamantes, MD, MBA, MSc, SVP & COO, Health Services, AltaMed

6. **Update on Quality and Equity Performance Measurement, Including Public Comment Feedback**
   Margareta Brandt, Assistant Deputy Director; Janna King, Health Equity and Quality Performance Group Manager

7. **Update on Behavioral Health Definition and Investment Benchmark**
   Margareta Brandt; Debbie Lindes, Health Care Delivery System Group Manager

8. **General Public Comment**

9. **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director

Vishaal Pegany, Deputy Director

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

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

From this report, three major themes emerged:

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

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

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

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

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

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

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

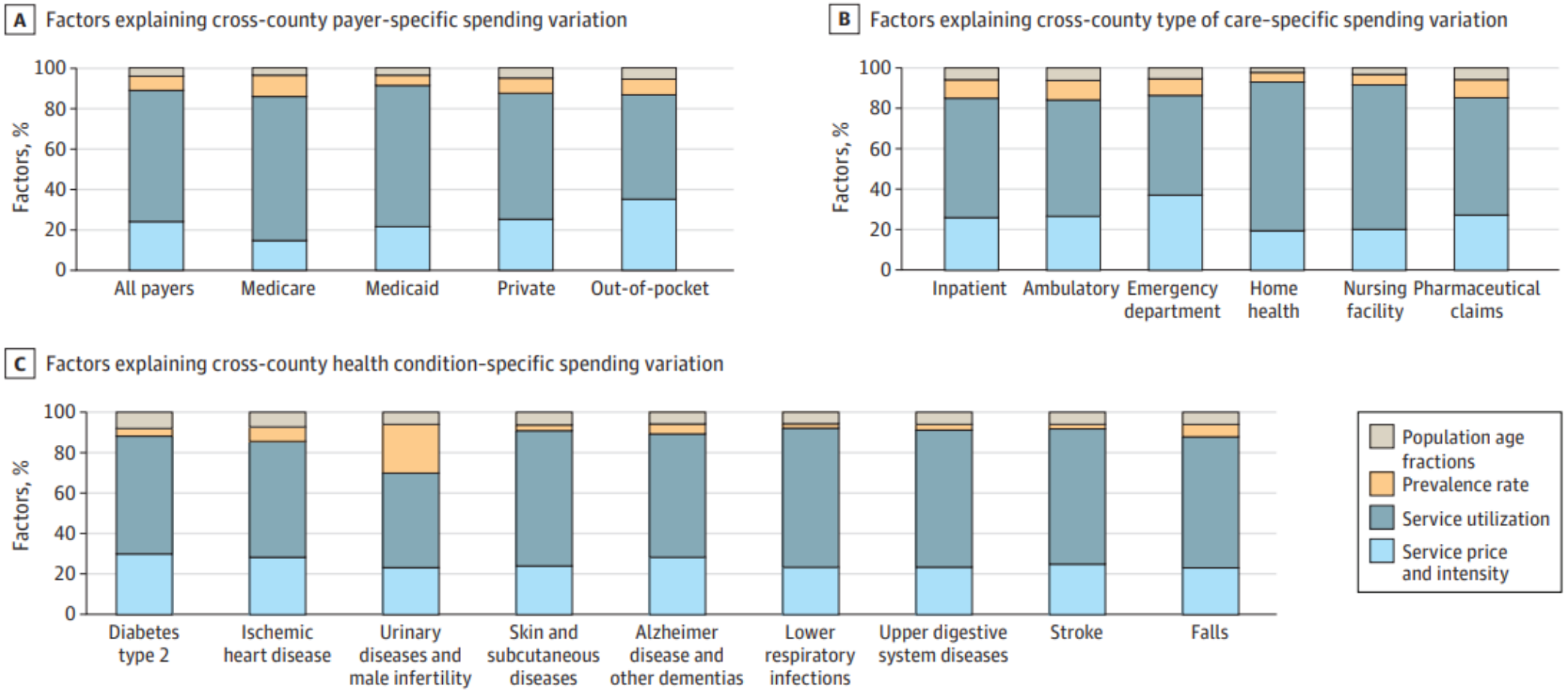
Source: Seifert, R., Rourke, E., Condon, M. (2025). Lessons Learned from State Efforts to Slow and Shift Health Care Spending. *Millbank Memorial Fund*, https://www.milbank.org/publications/lessons-learned-from-state-efforts-to-slow-and-shift-health-care-spending/

Service Utilization Key Driver of Health Care Spending

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

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

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



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

Slide Formatting

Indicates items that the Advisory Committee provides input or recommendations on based on statute and other areas as requested by the Board or OHCA.

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Public Comment

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Update on Proposed Hospital Sector Definition Regulations

Vishaal Pegany, Deputy Director

CJ Howard, Assistant Deputy Director

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Hospital Sector Rulemaking Timeline for OHCA's Recommendation

Text of Proposed Regulations

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

§ 97446. Health Care Sectors

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

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

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

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OHCA's Recommendation for Hospital Sector Target Methodology and Values

Vishaal Pegany, Deputy Director

CJ Howard, Assistant Deputy Director

Andrew Feher, Research and Analysis Group Manager

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OHCA's Recommendation for Hospital Sector Target Setting

On February 25, 2025, OHCA presented its recommended methodology for identifying high-cost hospitals and a methodology for adjusting target values for those hospitals to the Board members.

- The 45-day public comment window for OHCA's recommendation that began on January 28, 2025, will end on April 11, 2025.
- The Board will have until June 1st to set targets for 2026 and can set targets for beyond 2026 at this time.
- Today, OHCA will present the same recommended methodology to solicit feedback from the Advisory Committee members present in person, and online.

To adjust target values, the board must consider:

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

Recommendation to Identify Disproportionately High-Cost Hospitals

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

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

Recommendation to Identify Disproportionately High-Cost Hospitals

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

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

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

Key: above 85%

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

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

Key: above 85%

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

Recommendation for Setting Sector Target Value

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

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

Recommend a Formula-Based Approach to Adjust Targets for High-Cost Hospitals

- OHCA recommends that the target value for high-cost hospitals be based on the statewide spending target and adjusted according to the average cost relativity of the included hospitals.
- For example, the hospitals could be assigned a cost relativity tied to the California statewide mean for Commercial Inpatient NPR Per CMAD (or other measure, or combination of measures).
  - The statewide spending target for 2025 is 3.5%, and if a hospital is on average twice the statewide mean on Commercial Inpatient NPR per CMAD, they could be assigned a cost relativity of 2.0, then the hospital's target would be adjusted as follows:

[Statewide target] / [Hospital cost relativity] = [Hospital target]
3.5% / 2.0 = 1.75%

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

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

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

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

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

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

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

Recommendation for Duration

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

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

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

OHCA Recommendation: Target Values for High-Cost Hospitals

Hospital*	2026	2027	2028	2029
Barton Memorial	1.8%	1.7%	1.7%	1.6%
Community Hospital of the Monterey Peninsula	1.8%	1.7%	1.7%	1.6%
Doctors Medical Center - Modesto	1.8%	1.7%	1.7%	1.6%
Dominican Hospital	1.8%	1.7%	1.7%	1.6%
Goleta Valley Cottage Hospital	1.8%	1.7%	1.7%	1.6%
Marshall Medical Center	1.8%	1.7%	1.7%	1.6%
Northbay Medical Center	1.8%	1.7%	1.7%	1.6%
Salinas Valley Memorial Hospital	1.8%	1.7%	1.7%	1.6%
Santa Barbara Cottage Hospital	1.8%	1.7%	1.7%	1.6%
Stanford Health Care	1.8%	1.7%	1.7%	1.6%
Washington Hospital - Fremont	1.8%	1.7%	1.7%	1.6%

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

Advisory Committee Input

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

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Department of Health Care Access and Information

Cost-Reducing Strategies: AltaMed

Margareta Brandt, Assistant Deputy Director
Dr. Efrain Talamantes, Senior Vice President and
Chief Operating Officer of Health Services, AltaMed

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Seeking Additional Examples of Cost-Reducing Strategies

- OHCA is working with health plans, hospitals, and physician organizations to highlight examples of cost-reducing strategies – efforts to reduce cost while improving or maintaining quality – that have demonstrated results.

- OHCA is seeking additional examples of cost-reducing strategies. Examples might include a program that addresses a specific population, implementation of best practices for more efficient resource use, or an effort to increase care coordination, etc. Contact OHCA at ohca@hcai.ca.gov if you would like to propose a cost-reducing strategy for consideration.

Advancing High Value System Performance to Eliminate Disparities

Efrain Talamantes, MD, MBA, MSc,
SVP & COO, Health Services

Monday, March 17, 2025

AltaMed

OBJECTIVES

Overview

- History, Vision, Mission, Values & Strategy
- Our Services & Commitment to Health Equity

Our Journey to Value-Based Care: Progress & Lessons Learned

- AltaMed Viva Gold Senior Care & Enhanced Care Management (ECM)
- AltaMed Workforce & Pipelines

Next Steps

- Value-Based Care (VBC) Opportunities & Challenges
- Value-Based Care (VBC) Horizon

FOUNDED IN EAST LOS ANGELES IN 1969

From a volunteer-staffed storefront clinic…

…Today, We are the largest independent Federally Qualified Community Health Center in the U.S.

MISSION, VISION, VALUES, STRATEGY

Mission

To eliminate disparities in health care access and outcomes by providing superior quality health and human services through an integrated world-class service delivery system for Latino, multi-ethnic and underserved communities in Southern California.

Vision

To be the leading community-based provider of quality health care and human services.

Core Values

- Patients always come first
- Employees are our most valuable asset.
- Encourage process excellence and innovation for quality outcomes.
- Promote wellness and advocate for strong and healthy communities.
- Integrity, honesty and respect in all of our endeavors.
- Commitment to teamwork.

Strategy

By 2030, AltaMed Health Services and its affiliates will reach the 90th percentile for all Medi-Cal priority HEDIS measures and achieve a 4.5-star rating in national Medicare benchmarks. AltaMed will grow to care for more than 500K full risk members and increase its geographic footprint in Southern California.

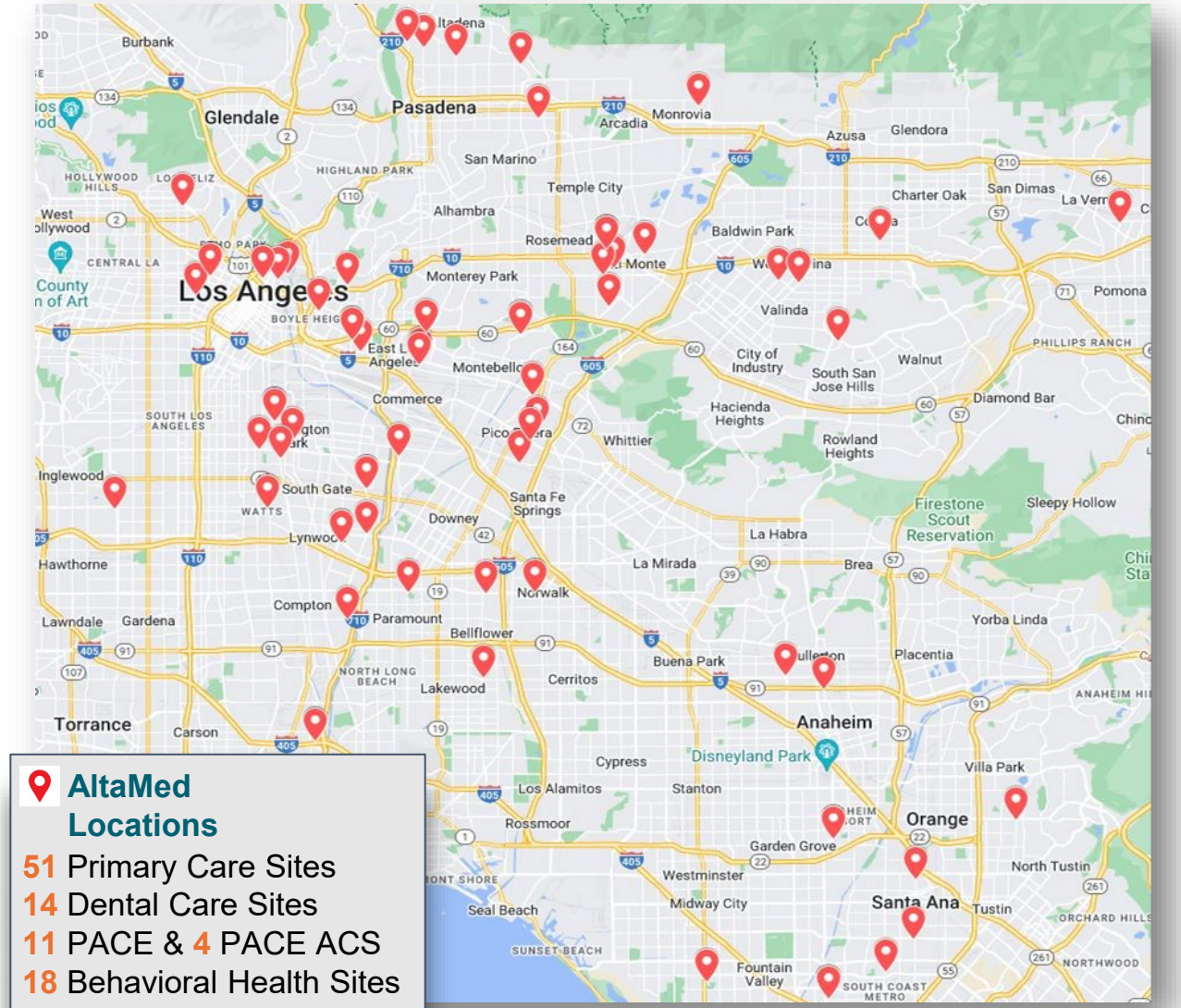
FAST FACTS: LARGEST INDEPENDENT FQHC IN THE U.S.

5,200 employees working across
67+ sites in Southern California
500K patients served annually
2.89M annual in-clinic & virtual visits

Our providers and employees reflect the communities we serve in both culture and language.

Who We Serve

84% Medi-Cal
74% Hispanic/Latinos
40% Language Other than English
62% Spanish Language Preference
50% Below Federal Poverty Level
0.937 Social Vulnerability Index
0.87 Housing Stability Score



OUR HEALTH SERVICES

Primary Care
- Urgent Care
- Senior Care
- Women's Health
- Pediatrics
- Family Medicine
- Radiology Services

Dental Care & Oral Health
- Preventive & Restorative Services
- Extractions
- Exams & X-Rays
- 5 Mobile vans
- 6 Oral Health Units

Mobile Health Clinics
- 4 Mobile Health
- 6 Mobile Dental

Hospitalist/Transitions of Care/ Clinician Home Visit Program
- Clinical teams serving more chronically ill patients in the hospital / home / street

Infectious Disease & HIV Services
- Hepatitis C Treatment
- HIV Prevention and Testing
- Mental Health, Case Management

Pharmacy Services
- Online refills and text reminders
- Same day delivery

Behavioral Health
- Individual Psychosocial Therapy

Onsite Specialty Care
- *Pediatric:* Neurology, Urology, Dermatology, Gastroenterology, Orthopedics, Ophthalmology, Allergy/Immunology, Cardiology
- *Adult:* Psychiatry, Podiatry, Dermatology, Sports Medicine, Cardiology, Maternal Fetal Medicine, Urogynecology, Palliative Care

Health Equity
- Research/Evaluation & Medical Education
- Pipeline & Workforce
- Youth Services Linkages to Care
- Adolescent Family Life Program
- Certified Parenting Classes/ Family Planning

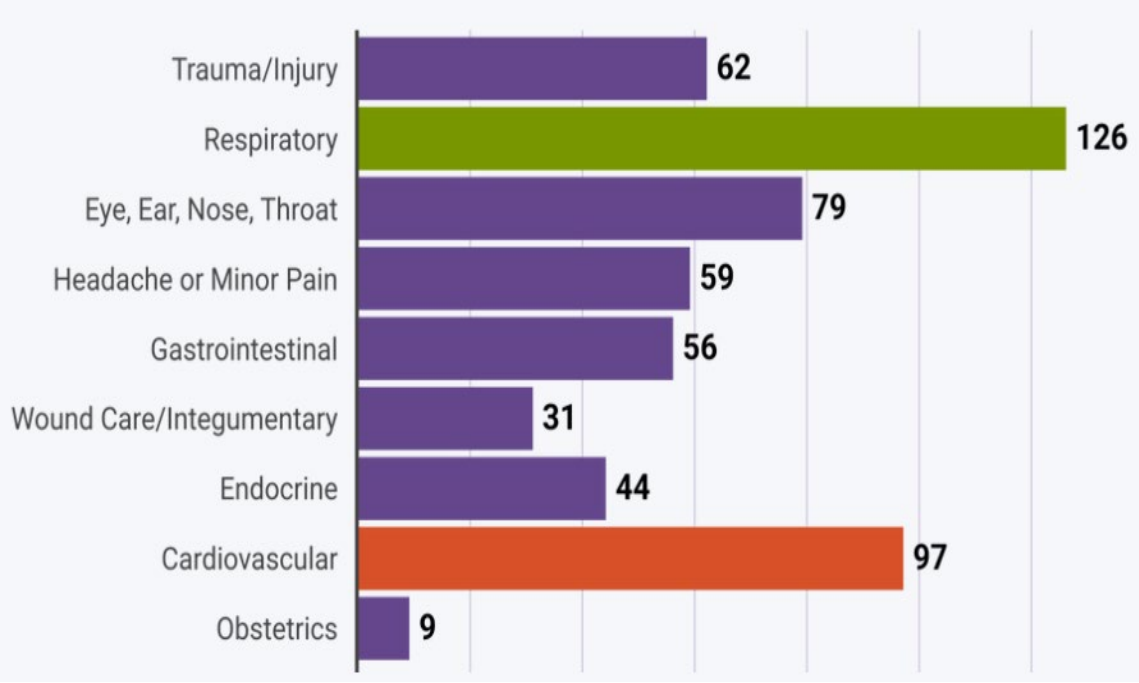
Program of All-Inclusive Care for the Elderly (PACE)
- Largest PACE provider in CA
- Full Service PACE Sites- 9
- Alternative Care Settings (ACS)- 4

ALTAMED FIRE EMERGENCY RESPONSE: A TRUSTED COMMUNITY PROVIDER

Ensure access to essential care in a time of need

- **230** AltaMed volunteers, including doctors, nursing staff, and support teams.
- **650+** clinical visits.
- **451** patients cared for at the Pasadena Convention Center.
- **20%** of patients required medication refills—primarily for cardiovascular or endocrine conditions—after losing their prescriptions in the fires.
- **100+** daily check-ins with evacuees
- **850** direct engagement touch points
- **297** showers provided
- **2,000** hygiene products distributed

Total number of visits per concern or diagnosis



➢ Connected patients impacted by the fire with daily essentials: medicine, showers, laundry services, food, temporary housing, emergency relief funds, mental health services.

ALTAMED & AFFILIATED COMPANIES

Infrastructure to Support Value-Based Care

- Largest independent FQHC in the U.S, IPA, MSO, rKK, Foundation
- Full and shared risk value-based care across multiple businesses
- Diverse portfolio, including Medi-Cal, Medicare, Dual-Eligibles, Managed Care, Commercial, HIV, Behavioral Health, Dental, Pharmacy, and PACE

VALUE-BASED CARE: THROUGH THEIR EYES

Our Patients

Excellence in patient care, medical knowledge, diagnosis, outcomes throughout care continuum

Our Teams

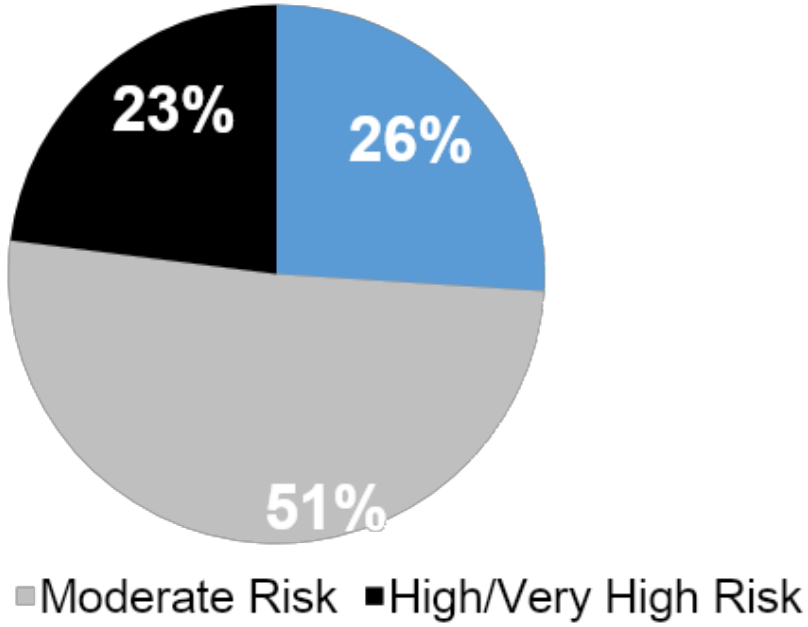
Strong relationship with leadership, peers, and multi-disciplinary teams to achieve maximum scope of practice

Our Physicians

Practice evidence-based high-quality care to improve health, making a greater impact

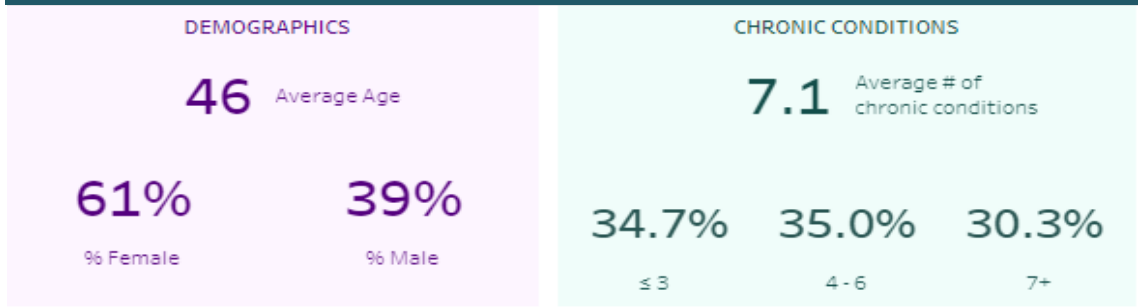
ALTAMED PATIENT RISK STRATIFICATION

Total Population 338,144



Utilization	Implications for VBC
• Emergency Department Utilization*	• 54.5% of all ED Visits are from High/Very High Risk

High/Very High Risk (N=77,774)



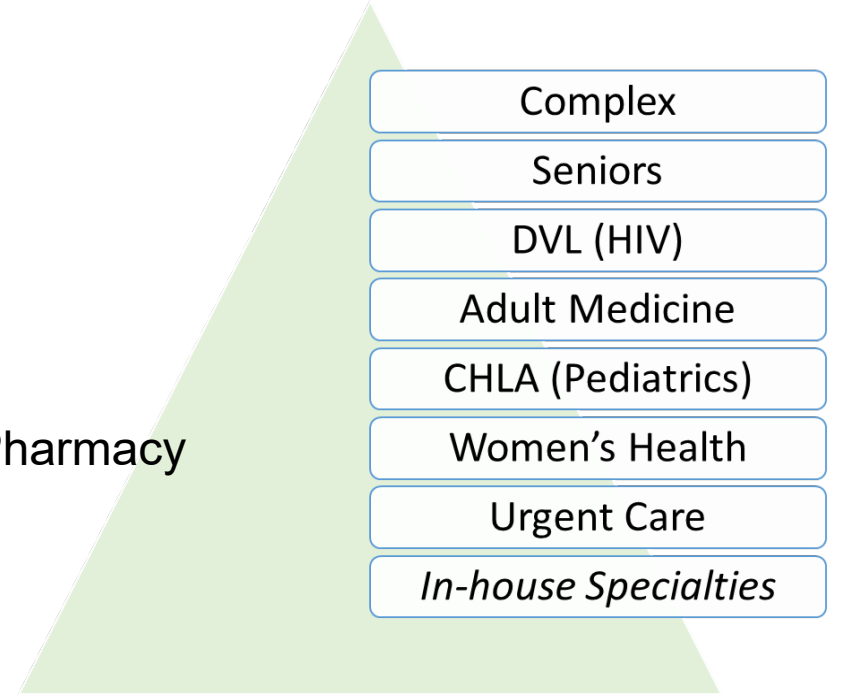
Top Diagnoses	Utilization	
	High	Very High
Chronic renal failure	2042	3496
Disorders of the immune system	2249	2332
Congestive heart failure	915	1941
Chronic ulcer of the skin	559	1335
Complications of mechanical devices	543	990
AIDS and or HIV complications	771	739
Cardiomyopathy	487	881
Spinal cord injury/disorders	551	785
Autoimmune / connective tissue diseases	756	553
Hepatitis C	298	593

Data Sources:
*ACG Dashboard

ALTAMED VALUE-BASED CARE CONTINUUM

Global Risk Patients and Complex Clinical & Social Care Needs

- Medical Management (Altura MSO/AHN)
- Hospitalists
- Transitions of Care
- Clinician Home Visitation Program
- Urgent Care / 24/7 Virtual Care Access
- Behavioral Health / Psychiatry
- Diabetes Chronic Disease Management Clinic / Clinical Pharmacy
- Complex Care / Enhanced Care Management
- In-house Specialties

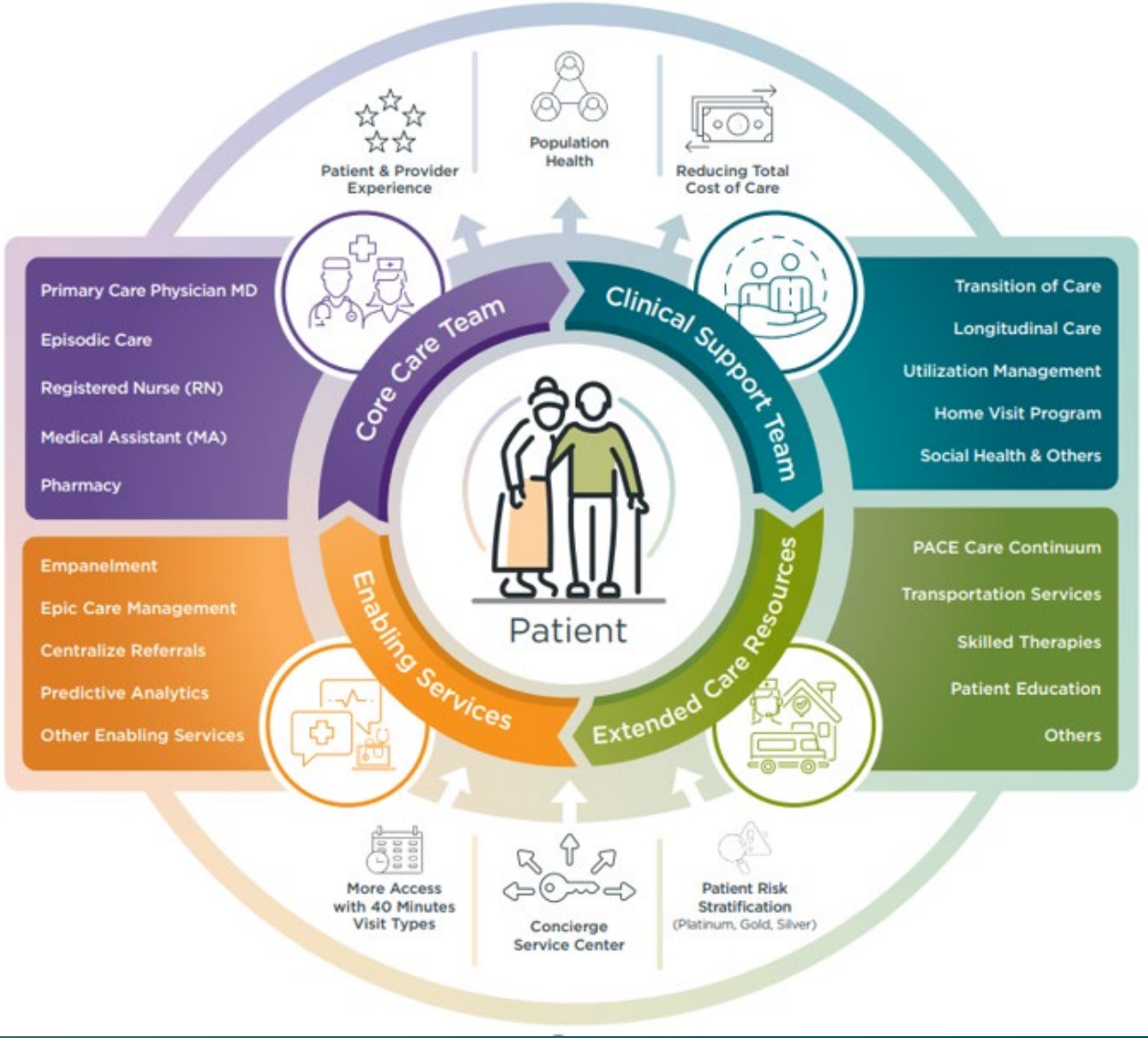


Enhanced Coordination of Care	Coordination & Referral to Community & Social Services	Comprehensive Transition Care	Health Promotion

ALTAMED VIVA GOLD SENIOR CARE MODEL

Expanded Care Team

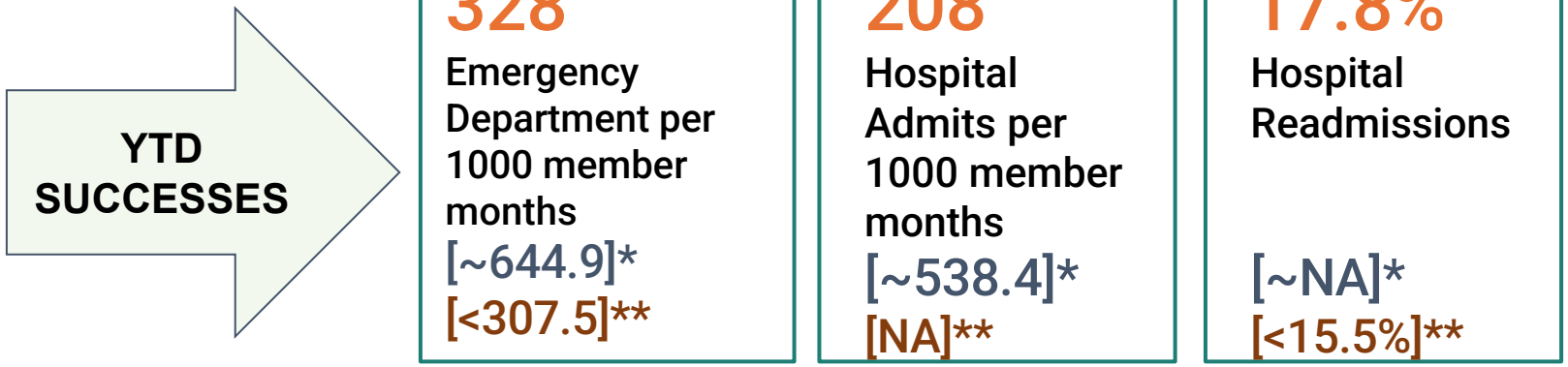
- Concierge Service
- Each Care Team cares for 900 patients
  - 1 Team Physician
  - 1 Advance Practice Provider
  - 2 Provider Partners (MA or LVN)
  - Care Manager RN



ALTAMED VIVA GOLD SENIOR CARE RESULTS

Performance

- As of 11/1/24: Total Members 2,074 out of 18,806 Medicare lives (>53% Duals)
- 74% of members completed their Medicare Health Assessment
- Recognition for Excellence in Dementia Care by the Healthy Brain LA Coalition



Lessons Learned & Scalability

- PCP – Patient bonding are difficult to overcome, but possible over time
- Hospital and Specialty Contracting require different approaches

*DHCS Managed Care Performance Monitoring Dashboard Data, April 2024, Data from Dual Members Jul 2023 – Jun 2024, 12 mo average rate in member months **National Medicare Benchmark for 2024

ENHANCED CARE MANAGEMENT RESULTS

Performance

- As of 11/1/24: 972 out of 1,092 enrolled members
- In 2023: 433 unique patients receiving enhanced care management
- ~3.8X PCP visits per year compared to 2.4X for non ECM eligible members
- Reduced ER visits in the first 3 months of enrollment

YTD SUCCESSES

40% DECREASE
Emergency Department Utilization

35% DECREASE
Hospital Admissions

28% DECREASE
Hospital Readmissions

5 out of 7
Quality HEDIS measures exceeded

Lessons Learned & Scalability

- Turnover due to Community Health Worker capacity, health plan pausing enrollment
- Opportunity for increased enrollment into ECM

WORKFORCE & PIPELINES TO ADDRESS PROVIDER SHORTAGE

AltaMed Institute for Health Equity

Established in 2017, the AltaMed Institute for Health Equity is our incubator for research & evaluation, medical and clinical education in underserved communities

Institute Initiatives

Undergrad, Graduate & Continuing Medical Education

- **Site Medical University**
- Nursing University
- AltaMed Family Medicine Residency Program
- Nurse Practitioner Fellowship
- Sports Medicine Fellowship
- Community Medicine Fellowship
- CHLA Pediatric Residency Rotations
- USC FM Residency Rotations
- White Memorial FM Residency Rotation
- AB 1045- Licensed Physicians from Mexico Program
- UCLA, UCI, USC, CDU
- National Medical Fellowships

School of Nursing Collaborative

- Certified Nursing Assistant (CNA) Program
- Licensed Vocational Nurse (LVN) Program
- LVN to Associates Degree Nursing (ADN) Program
- ADN to Bachelors Science Nursing (BSN) Program
- Bachelors Science Nursing (BSN) Leadership Program
- Phlebotomy Skills Training Program

Clinical Training Programs

- USC Pediatric Dentistry Fellowship
- Masters of Public Health (MPH) Field Study Program
- Masters of Social Work (MSW) Field Study Program
- Associate Clinical Social Worker (ACSW) Program

PHYSICIAN LEADERSHIP AND PROVIDER RETENTION

Training Our Own Leaders: Site Medical Director University Successes

See appendix for AltaMed provider demographics

Performance

- **Savings: $>1-1.5M per provider leader.** Savings based on projected loss of visits, recruitment fees, onboarding, and leadership development investments
- **Investment: $>5 per day per SMDU leader** based on associated costs of the program.
- **Retention/Leadership Growth: 100% retention and several have been promoted into key executive leadership roles.** SMDU survey shows SMDs plan to continue working at AltaMed for 3+ years in the future.
- **Access:** Supports retention and recruitment of culturally and linguistically concordant physician leaders

Lessons Learned & Scalability

- Retention rate for Medical Director leadership increased from 30% to 100% after 3 years of SMDU implementation.
- SMDU:
  - **Race Ethnicity:** 32% of Medical Directors identify as Latino, 23% Asian, 3% Black or AA, 3% Pacific Islander,10% White, and 29% did not respond or other.
  - **Gender**: 35% of Medical Directors identify as Female, versus 58% as Male, and 7% as other.
- Physicians' leadership development is critical to be successful in VBC transformation: clinical care, access, revenue, and VBC health outcomes.

VALUE-BASED CARE: OPPORTUNITIES & CHALLENGES

Risk

AltaMed is leveraging its successful track record in VBC; however, taking full risk across its entire patient population and a growing population poses greater challenges.

Opportunities

- Focus on VBC care models that are proactive about provider and patient engagement, this must include payment models that account for providers directly involved in community-based emergency response and preparedness efforts.
- Manage growing volume in more efficient and effective ways
- Medi-Cal Enrollment/ Membership Retention
- PCP Continuity of Care
- Support transitions of care between Hospital, Specialty, Primary Care, and Ancillary Services.
- Re-design care teams, existing roles, and develop roles that align with VBC goals
- Integrated Care Management
- Invest in provider leadership and address provider shortage

ALTAMED VALUE-BASED CARE HORIZON

Short Term (6 months)	Midterm (7-24 months)	Long Term (2026 +)

• VBC Leadership and Clinical Committee
• Population health analysis & segmentation with targeted interventions
• Integrate metrics and analysis for systems (PCP Continuity of Care, High-risk Programs, Specialty & Hospital)
• Re-design care teams: patient service-advocates, nursing, pre-visit planning/huddling
	• Leverage Physician, RNs and NPs – working at top of license – with focus on high risk patients, while achieving population health acute & chronic needs
	• Develop high-value specialist & hospital network using quality and affordability metrics
	• SDOH System & Workflow Integration
	  • CBO registry
	  • Predictive high-risk patient analysis
		• Adopt capitated APM model that further enhances VBC outcomes / affordability
		• Further align payment models to credit providers/clinics/regions for high-value quality outcomes
		• Scale VBC to new sites/regions

Questions

AltaMed

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Public Comment

HCAI

Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Update on Quality and Equity Performance Measurement, Including Public Comment Feedback

Margareta Brandt, Assistant Deputy Director

Janna King, Health Equity and Quality Performance Group Manager

HCAI

Department of Health Care Access and Information

OHCA's Quality and Equity Measure Set

Statutory Requirements

- **Adopt and track performance on a single set of standard measures for assessing health care quality and equity across payers, fully integrated delivery systems, hospitals, and physician organizations.**
- **Use recognized clinical quality, patient experience, patient safety, and utilization measures**.
- Consider available means for **reliable measurement of disparities in health care**, including race, ethnicity, sex, age, language, sexual orientation, gender identity, and disability status.
- **Reduce administrative burden** by selecting quality and equity measures that simplify reporting and align performance measurement with other payers, programs, and state agencies, including leveraging existing voluntary and required reporting to the greatest extent possible.
- **Coordinate with the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), Covered California, and CalPERS**, and consult with external quality improvement organizations and forums, payers, physicians, other providers, and consumer advocates or stakeholders.

These criteria are summarized from Article 2. Office of Health Care Affordability, Health and Safety Code § 127501-127501.12 and Article 4. Quality and Equity Performance, Health and Safety Code § 127503.

OHCA's Quality and Equity Measure Set

Statutory Requirements

- **Promote the goal of improved affordability** for consumers and purchasers of health care, **while maintaining quality and equitable care**.
- OHCA may require a health care entity to implement a performance improvement plan that identifies the causes for spending growth and shall include specific strategies, adjustments, and action steps the entity proposes to implement to improve spending performance during a specified time period. **The Director shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode access, quality, equity, or workforce stability.**

These criteria are summarized from Article 3. Office of Health Care Affordability, Health and Safety Code § § 127502(c)(5) and 127502.5.

OHCA's Quality and Equity Measure Set

Purpose

- 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.
- Track progress towards OHCA's goals to improve access, affordability, and equity of health care for all Californians.

Proposed Quality and Equity Measure Set

- In April 2025, OHCA is proposing to adopt all or a subset of three publicly available measure sets and their respective stratification requirements to measure quality and equity across health care entities.
- In Fall 2025, after collaborating with sibling state departments, OHCA will present a recommendation for adding hospital patient safety measures.
- OHCA will continue to explore including additional equity analyses beyond the stratification requirements by demographic characteristics used by the measure set owners.

Payers	Physician Organizations	Hospitals
Fully Integrated Delivery Systems[1]		
Adopt the full Department of Managed Health Care (DMHC) Health Equity and Quality Measure Set and stratification requirements	Adopt a subset of the Center for Data Insights and Innovation Office of the Patient Advocate (OPA) Health Care Quality Report Card measures[2]	Adopt the full HCAI Hospital Equity Measures Reporting Program measure set and stratification requirements

[1] For fully integrated delivery systems, which include a payer, physician organization, and hospital component, OHCA will measure performance of each of these component entities.
[2] OPA does not report measures stratified by demographic characteristics.

Proposed OHCA Measures for Payers and Physician Organizations

Measure Name *(*Measures for payers only)*	Measure Category
Childhood Immunization Status	Process
Colorectal Cancer Screening	Process
Controlling High Blood Pressure	Outcome
Glycemic Status Assessment for Patients With Diabetes (<8.0% and/or >9.0%)	Outcome
All-Cause Readmissions	Outcome
Asthma Medication Ratio	Process
Breast Cancer Screening Rate	Process
Child and Adolescent Well-Care Visits	Process
Immunizations for Adolescents	Process
Depression Screening and Follow-Up for Adolescents and Adults (Depression Screening and Follow-Up on Positive Screen)*	Behavioral health, Process
CAHPS Health Plan Survey: Getting Needed Care (Adult and Child survey) or QHP Enrollee Experience Survey*	Access, Patient reported outcome or patient experience
Prenatal and Postpartum Care (Postpartum Care and Timeliness of Prenatal Care)*	Process
Well-Child Visits in the First 30 Months of Life (0 to 15 Months and 15 to 30 Months)*	Process

Sources: DMHC Licensing eFiling. (2024, June 28). APL 24-013 – Health Equity and Quality Program Policies and Requirements (6/28/2024). https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL24-013-HealthEquityandQualityProgramPoliciesandRequirements(6_28_2024).pdf?ver=9wJvJOJ61DNjXvVpRgHqeQ%3d%3d.; OPA. (2024). Health Care Quality Report Cards. https://www.iiii.ca.gov/consumer-reports/health-care-quality-report-cards/.; In the DMHC Health Equity and Quality Measure Set, CAHPS Child Survey is only for applicable Medicaid plans. CAHPS health plan survey does not apply to Exchange plans. Exchange plans will report to the DMHC on the QHP Enrollee Experience Survey in measurement year 2024.

Proposed OHCA Measures for Hospitals

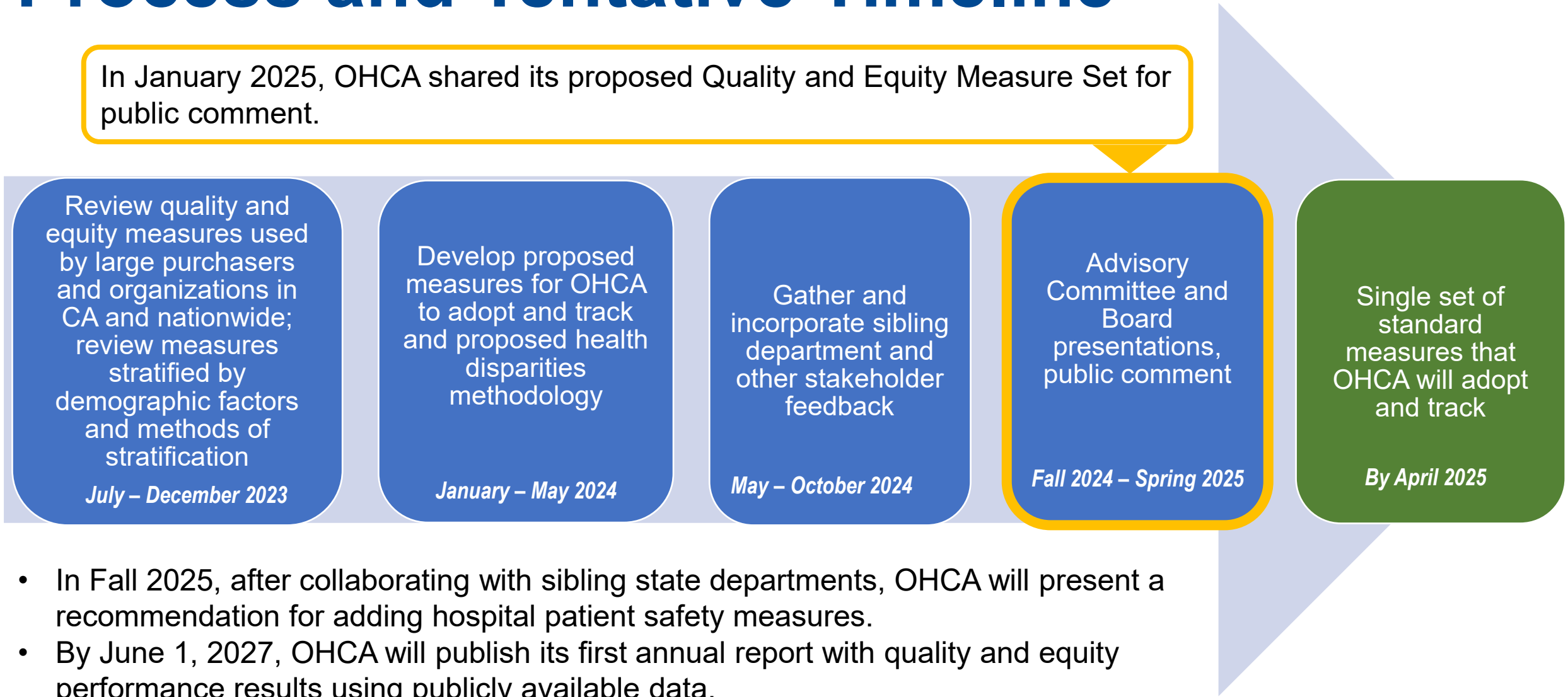
HCAI Hospital Equity Measures Reporting Program Measure Name	General Acute Hospital Measures	Acute Psychiatric Hospital Measures	Children's Hospital Measures	Measure Categories
Designate an individual to lead hospital health equity activities	X	X	X	Structural
Hospital Commitment to Health Equity Structural Measure	X	X	X	Structural
Provide documentation of policy prohibiting discrimination	X	X	X	Structural
Report percentage of patients by preferred language spoken	X	X	X	Structural
Screen Positive Rate for Social Drivers of Health	X	X	X	Structural
Screening for Social Drivers of Health	X	X	X	Structural
All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavior health diagnosis*	X	X		Outcome, Behavioral health
HCAHPS survey (Received information and education and would recommend hospital)	X	X		Patient reported outcome or patient experience
Pneumonia Mortality Rate*	X	X		Outcome
All-Cause Unplanned 30-Day Hospital Readmission Rate*	X		X	Outcome
Cesarean Birth Rate (NTSV)	X			Outcome
Death Rate among Surgical Inpatients with Serious Treatable Complications	X			Safety, Outcome
Exclusive Breast Milk Feeding	X			Process
Vaginal Birth After Cesarean Rate (VBAC)	X			Outcome
All-Cause Unplanned 30-Day Hospital Readmission Rate in an inpatient psychiatric facility*		X		Outcome, Behavioral health
Screening for metabolic disorders		X		Process
SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge		X		Behavioral health, Process
Pediatric experience survey with scores of willingness to recommend the hospital			X	Patient reported outcome or patient experience

*These measures promote overall patient safety but are not labeled as safety measures.

Source: HCAI. (n.d.). *Hospital Equity Measures Reporting Program*. https://hcai.ca.gov/data/healthcare-quality/hospital-equity-measures-reporting-program/.

Process and Tentative Timeline

In January 2025, OHCA shared its proposed Quality and Equity Measure Set for public comment.



- In Fall 2025, after collaborating with sibling state departments, OHCA will present a recommendation for adding hospital patient safety measures.
- By June 1, 2027, OHCA will publish its first annual report with quality and equity performance results using publicly available data.

Ongoing Work to Align Hospital Patient Safety Measures

- OHCA received feedback to consider adding Healthcare-Associated Infection (HAI) measures to the OHCA Quality and Equity Measure Set to improve its ability to monitor patient safety as hospitals work to meet spending targets.
- Sibling state departments, including CalPERS and Covered California, are currently working to develop a priority set of hospital patient safety measures, including consideration of HAI measures.
- OHCA will review this priority set of hospital patient safety measures from sibling state departments and will reconsider adding HAIs and potentially other hospital patient safety measures to the OHCA Quality and Equity Measure Set, with input from the Advisory Committee and Board in Fall 2025.

Background on Sibling Department Hospital Safety Measures

- Health and Safety Code 1288.55 and 1288.8 requires CDPH to oversee the prevention, surveillance, reporting, and response to HAIs in California's hospitals and other healthcare facilities. CDPH HAI measures include:
  - Central line-associated bloodstream infections (CLABSI)
  - Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections (BSI)
  - Vancomycin-resistant Enterococci (VRE) bloodstream infections (BSI)
  - Clostridioides difficile infections (CDI)
  - Surgical site infections (SSI) – 28 operative procedures including colon surgery, c-section, hip and knee prosthesis, and transplants.
- CDPH does not stratify HAI measure performance by demographic characteristics.
- The Covered California 2023-25 contract requires health plans to work with hospitals to improve performance on the same 5 HAIs as CDPH (CLABSI, MRSA, CDI, SSI Colon Surgery, and VRE) though Covered California has removed a specific hospital measure list in the 2026-2028 contract.
- The current CalPERS contract emphasizes improvement on 6 HAIs, 4 of which are tracked by CDPH (CLABSI, MRSA, CDI, SSI Colon Surgery, Catheter-Associated Urinary Tract Infection [CAUTI], and Sepsis Management) though these specific measures may be removed in future contracts.

Sources: CDPH. (2024, April 29). *Healthcare-Associated Infections (HAI) Program*. Healthcare-Associated Infections (HAI) Program. https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/HAI_LiaisonIP.aspx. Covered California. (2022, August 1). *Attachment 1 To Covered California 2023-2025 Individual Market QHP Issuer Contract: Advancing Equity, Quality, And Value*. Covered California 2023-2025 Individual Market Attachment 1. https://hbex.coveredca.com/stakeholders/plan-management/library/2023-2025_QHP_IND_Attachment_1_1-24-22_Clean.pdf. SSI Colon Surgery is a subset of the SSIs that CDPH tracks.

Summary of Advisory Committee Feedback and Public Comments

- Advisory Committee members encouraged adding Healthcare-Associated Infections measures, safety measures, and access measures.
- Advisory Committee members encouraged more stratification requirements while noting challenges in collecting demographic data.
- Public comments shared general support for alignment efforts.
- Public comments recommended additions, modifications, and removal of measures for the proposed OHCA Quality and Equity Measure Set.
- Public comments noted some limitations of the proposed OHCA Quality and Equity Measure Set.
- Public comments recommended changes to the stratification requirements of the proposed OHCA Quality and Equity Measure Set.
- Public comments requested that OHCA consider innovative ways to utilize data for reports and delay or change public reporting requirements for some measures.

Summary of January Advisory Committee Feedback

Measure Set Recommendations	
Feedback Theme	**OHCA's Response**
• Several Advisory Committee members encouraged OHCA to include the California Department of Public Health's Healthcare-Associated Infections (HAI) Program measures. • Several Advisory Committee members asked OHCA to consider adding more safety and access measures to the measure set.	• In Fall 2025, after collaborating with sibling state departments, OHCA will present a recommendation for adding hospital patient safety measures. • OHCA is required by statute to regularly review and update its measure set over time. The initial measure set is a starting point and can be updated over time. For example, including more measures as they become available for programmatic use.

Summary of January Advisory Committee Feedback

Stratification	
Feedback Theme	**OHCA's Response**
• An Advisory Committee member suggested OHCA require physician organizations to provide demographic data if they have it. • Advisory Committee members noted challenges with physician organizations collecting demographic data as many historically marginalized groups prefer not to share this information. • An Advisory Committee member encouraged OHCA to include disability in the stratification categories.	• OHCA will support and monitor statewide efforts to collect more complete demographic data and outcome measures, including stratifying measures by disability status. • OHCA plans to look at the overlap of physician organizations reported through payer THCE data submissions and those in the OPA Health Care Quality Report Cards. Depending on the results of this analysis, OHCA will collaborate with OPA and IHA to explore how to better align physician organizations included in the THCE data and OPA Health Care Quality Report Cards. OHCA will also work with OPA and IHA to explore options to stratify measures by demographic factors.

Summary of Public Comment

General Support	
Feedback Theme	**OHCA's Response**
• General support for alignment efforts and streamlining quality and equity performance measurement under a standard set. • Appreciation that OHCA included the Prenatal and Postpartum Care (Postpartum Care and Timeliness of Prenatal Care) measures in its proposal.	• OHCA appreciates this feedback.

Summary of Public Comment

Measure Set Recommendations	
Feedback Theme	**OHCA's Response**
Recommendation to add measures, including: • The California Department of Public Health's Healthcare-Associated Infections (HAI) Program measures. • A comprehensive plan for measuring access to care. • More outcome measures in the non-hospital measure sets. • Measures on post emergency department follow-up care for patients with substance use disorder. • More behavioral health measures.	• OHCA's statute requires that the OHCA Quality and Equity Measure Set use recognized measures and leverage existing voluntary and required reporting to the greatest extent possible. OHCA is uplifting measure sets developed through intensive multi-stakeholder processes and relying on existing measure sets with the aim to reduce administrative burden. • OHCA is required by statute to regularly review and update its measure set over time. The initial measure set is a starting point and can be updated over time.

Summary of Public Comment

Measure Set Recommendations	
Feedback Theme	**OHCA's Response**
Recommendation to remove/modify measures, including: • Consider reducing the payer measure set to 10-measures. • Remove the Immunizations for Adolescents measure to reduce unnecessary duplication with the Child and Adolescent Well-Care Visits measure. • Remove All-Cause Readmissions for payers. • Remove Screening and Positive Rate for Social Drivers of Health measures for hospitals. • Remove Death Rate Among Surgical Inpatients with Serious Treatable Complications measure for general acute care hospitals. • Remove Pneumonia Mortality Rate measure for acute psychiatric hospitals. • Remove the Glycemic Status Assessment for Patients with Diabetes < 8% measure and only keep the Glycemic Status Assessment for Patients with Diabetes > 9% measure. • Modify the Childhood Immunization Status Combo 10 measure to Combo 7.	• OHCA's statute requires that the OHCA Quality and Equity Measure Set use recognized measures and leverage existing voluntary and required reporting to the greatest extent possible. OHCA is uplifting measure sets developed through intensive multi-stakeholder processes and relying on existing measure sets with the aim to reduce administrative burden. • OHCA is required by statute to regularly review and update its measure set over time. The initial measure set is a starting point and can be updated over time.

Summary of Public Comment

Limitations	
Feedback Theme	**OHCA's Response**
• Request to comprehensively capture important trends in access, quality, and equity. • Concern that the CAHPS Health Plan Survey: Getting Needed Care does not accurately measure a member's ability to get needed care.	• Adopting the proposed quality and equity measure set is a starting point. OHCA will continue to work with sibling state departments and other partners to evolve these measure sets and collaboratively address the limitations we've highlighted.

Summary of Public Comment

Stratification	
Feedback Theme	**OHCA's Response**
• Request to clarify sexual orientation and disability stratification categories and to reduce stratification requirements for hospital-level reports to ensure these significant efforts produce meaningful results. • Recommendation to stratify physician organization measures by sexual orientation, gender identity, race, and ethnicity when such data becomes available from other agencies or sources. • Recommendation for OHCA to go beyond stratifying by race, ethnicity, sexual orientation, and gender identity. • Recommendation for OHCA to partner with research institutions to further support data analysis, particularly for health equity analyses and identifying health disparities. • Recommendation to take a more thorough look every five to seven years as quality and equity measurement and measure sets evolve and the ability to stratify data improves.	• Many state departments are working to encourage, require, and/or incentivize hospitals to have more complete demographic data, and we hope this will help improve the data available for health equity analyses. OHCA will collaborate across HCAI and with sibling state departments to reinforce and support these efforts. • OHCA will monitor efforts to improve demographic data and stratify more measures for physician organizations. OHCA will collaborate with OPA and IHA to explore opportunities to publicly report stratified measures. • OHCA will support and monitor efforts to advance health equity and reduce health disparities. • OHCA is required by statute to regularly review and update its measure set over time.

Summary of Public Comment

Reporting and Enforcement	
Feedback Theme	**OHCA's Response**
• Data reporting for hospitals has more stringent stratification requirements compared to reporting for payers and physician organizations and OHCA should consider stratification as an area of flexibility in reporting until these can be aligned. • Concern that the data collection and analysis for hospitals will be challenging and require additional resources. • Recommendation to delay publicly reporting the Well-Child Visits in the first 30 Months of Life (0-15 months and 15-30 months) measure until the enhancements to DHCS newborn enrollment can be realized. • Recommendation to regionally group data or incorporate multi-year datasets to find innovative ways to utilize existing data, particularly when sample sizes are small. • De-emphasize 2024 HCAHPS results since the survey is changing in 2025, making 2024 benchmarks invalid. • Monitor the Depression Screening and Follow-Up measure and do not publicly report performance due to data reporting challenges.	• OHCA is uplifting measure sets developed through intensive multi-stakeholder processes and relying on existing measure sets with the aim to reduce administrative burden. • OHCA does not have enforcement authority for performance on the measure set but will publicly report performance on the measure set and flag decreases in quality and equity in its annual reports, including for those entities that meet the spending targets. • OHCA will begin reporting on quality and equity performance in the June 2027 annual report. OHCA will coordinate with measure set owners and health care entities on measure changes that impact reporting.

Proposed Quality and Equity Measure Set

- In April 2025, OHCA is proposing to adopt all or a subset of three publicly available measure sets and their respective stratification requirements to measure quality and equity across health care entities.
- In Fall 2025, after collaborating with sibling state departments, OHCA will present a recommendation for adding hospital patient safety measures.
- OHCA will continue to explore including additional equity analyses beyond the stratification requirements by demographic characteristics used by the measure set owners.

Payers	Physician Organizations	Hospitals
Fully Integrated Delivery Systems[1]		
Adopt the full DMHC Health Equity and Quality Measure Set and stratification requirements	Adopt a subset of the OPA Health Care Quality Report Card measures[2]	Adopt the full HCAI Hospital Equity Measures Reporting Program measure set and stratification requirements

[1] For fully integrated delivery systems, which include a payer, physician organization, and hospital component, OHCA will measure performance of each of these component entities.
[2] OPA does not report measures stratified by demographic characteristics.

OHCA

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Department of Health Care Access and Information

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Office of Health Care Affordability

Department of Health Care Access and Information

Update on Behavioral Health Definition and Investment Benchmark

Margareta Brandt, Assistant Deputy Director

Debbie Lindes, Health Care Delivery System Group Manager

HCAI

Department of Health Care Access and Information

Primary Care & Behavioral Health Investments

Statutory Requirements

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

Investment and Payment Workgroup Members

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Chief Medical Officer, Covered California

Dan Southard
Chief Deputy Director, Department of Managed Health Care

February Board Meeting

Feedback

- Highlighted the importance of incorporating Medi-Cal into the definition and spending data collection in the future, given OHCA's proposed phased approach to start with commercial and Medicare Advantage
- Interest in understanding the rationale behind excluding inpatient spend in the proposed behavioral health investment benchmark
- Interest in tracking inpatient behavioral health spend, pharmacy costs, and payment rates for behavioral health services
- Interest in understanding the reasons for poor access and low network participation, from payer and provider perspectives
- Interest in capturing behavioral spend occurring in schools
- Discussion of how to broadly track behavioral health transformation across the state

Overview of Behavioral Health Spending Methodology and Definition

Measuring Behavioral Health Spending

Numerator

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

Denominator

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

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

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

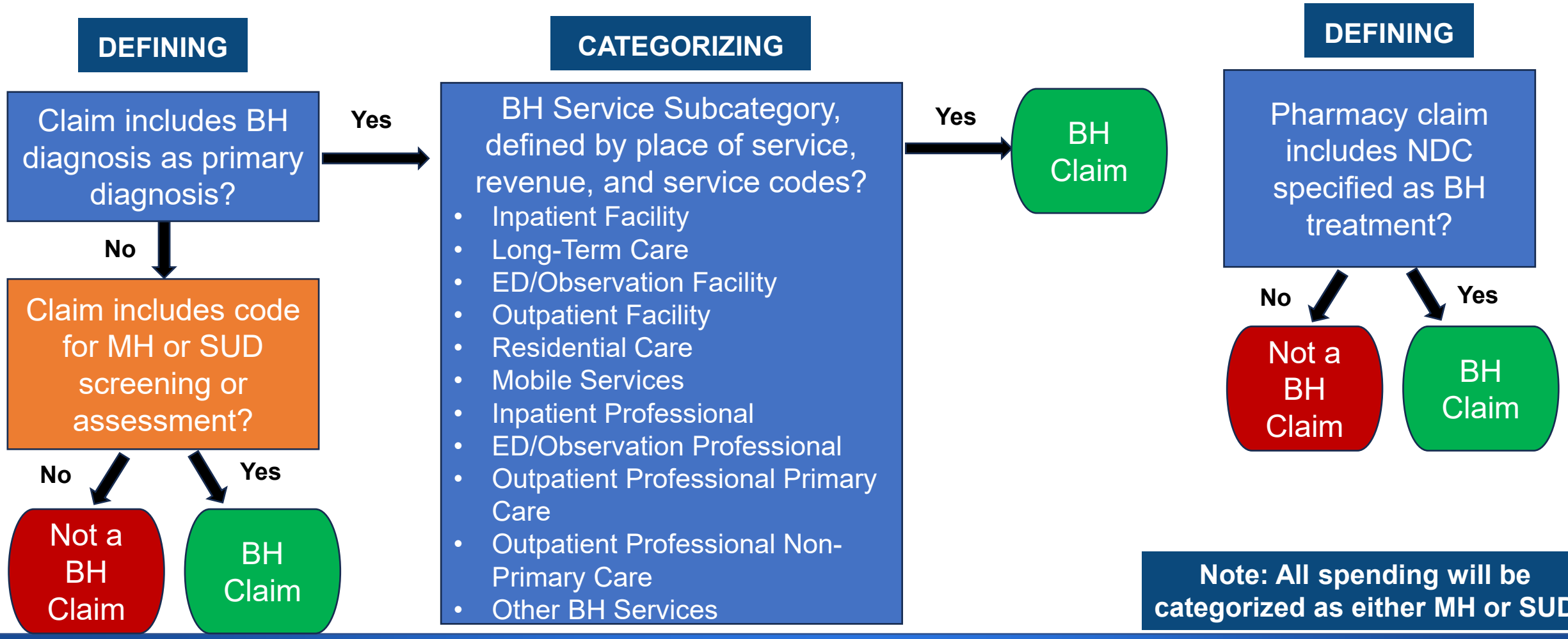
Milbank Memorial Fund, April 2024. *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.*

Behavioral Health Claims Measurement Definition Principles

1. **Include all claims* with a primary behavioral health diagnosis** in measurement.
   - Claims with service codes for mental health or substance use disorder screening or assessment also included, regardless of primary diagnosis code.
2. **Categorize claims** using place of service, revenue, and service codes.
   - “Other Behavioral Health Services” category captures claims with a primary behavioral health diagnosis code that do not have a place of service, revenue, or service* code associated with another subcategory.
3. **Include pharmacy claims** with a National Drug Code (NDC) specified by OHCA as a behavioral health treatment.
   - Measured separately, so can be included or excluded for analysis.
   - Categorized as mental health or substance use disorder claims.
   - Behavioral health diagnosis not required.

*OHCA is considering applying a service code filter to the "Other Behavioral Health Services" category.

Process Map for Identifying Behavioral Health (BH) Claims



Note: All spending will be categorized as either MH or SUD

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

Behavioral Health Non-Claims Measurement Definition Principles

- Data collection via Expanded Non-Claims Payments Framework.
- Include all behavioral health non-claims subcategories.
- Allocate payments to behavioral health by various methods:
  - **Population health, behavioral health integration, and care management payments** only when paid to behavioral health providers.
  - **Practice transformation, IT infrastructure, and other analytics payments** not to exceed a set upper limit.
  - **Behavioral health capitation payments** included in full.
  - **Professional and global capitation payments** and **payments to integrated, comprehensive payment and delivery systems** allocated to behavioral health using a method similar to that for primary care.

Expanded Framework, Categories A-C

Green = Include all of payment (if for BH)
Orange = Include portion of payment
Blue = Under discussion
White = Excluded or not applicable

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	2A
A2	Primary care and behavioral health integration	2A
A3	Social care integration	2A
A4	Practice transformation payments	2A
A5	EHR/HIT infrastructure and other data analytics payments	2A
B	**Performance Payments**	
B1	Pay-for-reporting payment	2B
B2	Pay-for-performance payment	2C
C	**Shared Savings Payments and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	3A
C2	Procedure-related, episode-based payments with risk of recoupments	3B
C3	Condition-related, episode-based payments with shared savings	3A
C4	Condition-related, episode-based payments with risk of recoupments	3B
C5	Risk for total cost of care (e.g., ACO) with shared savings	3A
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B

See HCAI Expanded Non-Claims Payments website: https://hcai.ca.gov/affordability/ohca/expanded-non-claims-payments-framework/

Expanded Framework, Categories D-F

Green = Include all of payment
Orange = Include portion of payment
Blue = Under discussion
White = Excluded or not applicable

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
D	**Capitation and Full Risk Payments**	
D1	Primary Care Capitation	4A
D2	Professional Capitation	4A
D3	Facility Capitation	4A
D4	Behavioral Health Capitation	4A
D5	Global Capitation	4B
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C
E	**Other Non-Claims Payments**	
F	**Pharmacy Rebates**	

See HCAI Expanded Non-Claims Payments website: https://hcai.ca.gov/affordability/ohca/expanded-non-claims-payments-framework/

Proposed Reporting Categories and Service Subcategories

Reporting Categories	Service Subcategories
Outpatient/Community-Based*	Community-Based Mobile Clinic Services
	Outpatient Professional Primary Care
	Outpatient Professional Non-Primary Care
	Outpatient Facility
Emergency Department	Emergency Department / Observation; Facility (no inpatient admission)
	Emergency Department / Observation; Professional (no inpatient admission)
Inpatient	Inpatient; Facility
	Inpatient; Professional
Long-Term Care and Residential	Long-term Care
	Residential Care
Other	Other Behavioral Health Services
Pharmacy	Mental Health (MH) Prescription Drug Treatments Substance Use Disorder (SUD) Prescription Drug Treatments

These categorizations may change as OHCA develops the final behavioral health investment benchmark and begins data collection.

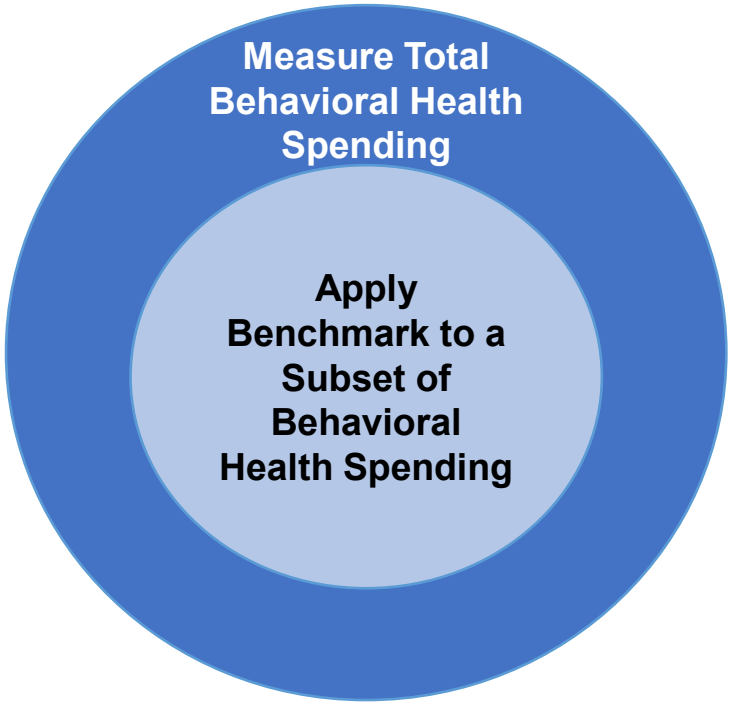
*Proposed behavioral health investment benchmark includes spend in this category.

Behavioral Health Investment Benchmark Framework

Broad Measurement, Focused Benchmark

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

Spending Included



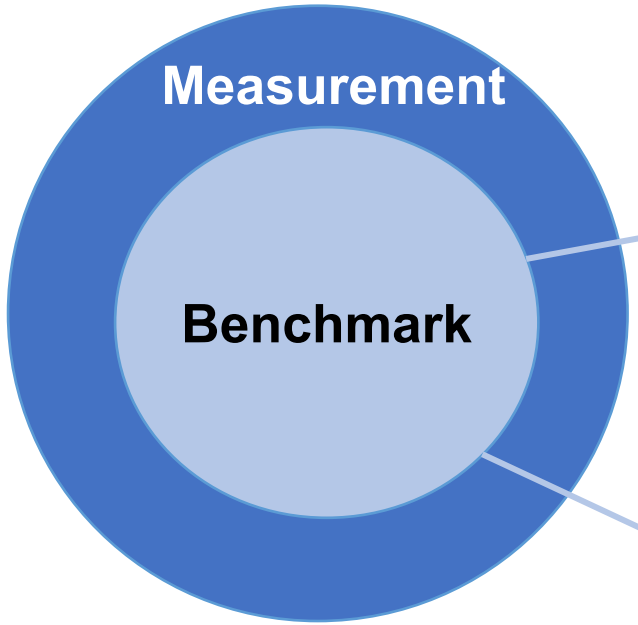
Example: Rhode Island Behavioral Health Investment Benchmark

The Rhode Island Office of the Health Insurance Commissioner (OHIC)'s **behavioral health spending obligation** focuses on community-based behavioral health care for commercial fully-insured children and adolescents, ages 0-18.

Spending obligation (benchmark):

- In 2025, carriers must increase per member, per month spending on community-based behavioral health care for target population to 200% of baseline (defined as calendar year 2022 spending).
- After 2025, carriers must have annual expenditures on community-based behavioral health care for the target population at the market average as determined by OHIC.
- Includes claims and non-claims spending for community-based behavioral health care.
- Applies to spending for residents of Rhode Island who receive care from providers located in Rhode Island.
- If carriers do not reach the benchmark, they will be subject to penalties determined by the Commissioner.

What is Included in the Proposed Benchmark?



Outpatient/Community-Based Service Claims Subcategories:

- Community-Based Mobile Clinic Services
- Outpatient Professional Primary Care
- Outpatient Professional Non-Primary Care
- Outpatient Facility

Non-claims payments in Expanded Framework categories:

A: Population Health and Practice Infrastructure Payments
B: Performance Payments
D: Capitation Payments (outpatient/community-based service subcategories only)

Key Decisions for Benchmark Setting

- Should the benchmark be a percentage of total medical expenses or a per member, per month amount?
- Should the benchmark focus on incremental or long-term improvement, or some combination?
- What should the timeline be for achieving the benchmark?

Set a benchmark based on the percent of total medical expense or a per member, per month amount?

Statute suggests a preference for using percent of total medical expense (TME) as a basis for benchmarking, which would be consistent with other approaches.

Reasons for Percent of TME

- Statute suggests preference for this approach.
- Communicates that increased spending on behavioral health care should reallocate rather than increase total spending.
- Consistent with the approach to the primary care investment benchmark.

Reasons for Per Member, Per Month (PMPM)

- Easier to reflect the cost of achieving behavioral health delivery goals.
- May guard against the benchmark becoming unnecessarily inflationary if total medical expense increases are higher than expected.
- More consistent with how payers typically measure health care costs.
- Consistent with the Rhode Island benchmark, the only other state behavioral health benchmark in the country.

Set an annual improvement or long-term investment benchmark? Or some combination?

An annual improvement benchmark meets each payer where they are today, and the long-term investment benchmark offers a vision for the future across all payers.

Reasons for Annual Improvement

- Consistent with statutory guidance to recognize differences across payers and patient populations.
- Acknowledges care delivery transformation takes time.
- Current spending level is unclear, so annual improvement gives more latitude to make adjustments.

Reasons for Long-Term Investment Goal

- Sets a vision for the future.
- Can reflect the potential budget needed to develop necessary behavioral health infrastructure.
- Can reflect current thinking on the “right” level of behavioral health care investment.

Reason for Combination

- Allows all to succeed at a reasonable pace.
- Aligns with the approach to the primary care investment benchmark.

How long should the time horizon be for the behavioral health investment benchmark?

Considerations

- Benchmark should be aggressive in pursuit of the policy goals underlying it.
- Benchmark should also reflect reasonable expectations of how long it will take to achieve.
- Align benchmark with other adopted OHCA benchmarks:
  - Spending growth (2029)
  - Primary care investment and alternative payment model adoption (2034)

Other OHCA Benchmarks

Health Care Spending Growth Target	• 3.5% in 2025 and 2026 • 3.2% in 2027 and 2028 • 3.0% in 2029 and beyond
APM Adoption	• Biannual improvement goals by payer type • By 2034: 95% for Commercial HMO and Medicare Advantage; 75% for Medi-Cal; 60% for Commercial PPO
Primary Care Investment	• For each payer, 0.5 to 1.0 percentage points per year as percent of TME • By 2034, 15% of TME for all payers

- Combine incremental and long-term goals.
- Acknowledge payers' different starting points and capacity for short-term improvement.
- Allow for adjustment as picture becomes clearer with more data.
- Set a long-term vision aligned with state policy goals.

Discussion

- Any feedback regarding the proposed reporting categories and subcategories for measuring behavioral health?
- Any feedback regarding the proposed methods for allocating non-claims payments to behavioral health measurement?
- Any recommendations on the key decisions for setting a behavioral health investment benchmark?

Tentative Timeline for Behavioral Health Work

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

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

X Provide Feedback ✓ Board Approval

OHCA

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Public Comment

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General Public Comment

Written public comment can be emailed to: ohca@hcai.ca.gov

HCAI

Department of Health Care Access and Information

Next Advisory Committee Meeting:

June 16, 2025
9:00 a.m.

Location:
1601 Exposition Blvd, Tahoe Auditorium,
Sacramento, CA 95815

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Office of Health Care Affordability

Department of Health Care Access and Information

Adjournment

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Appendix

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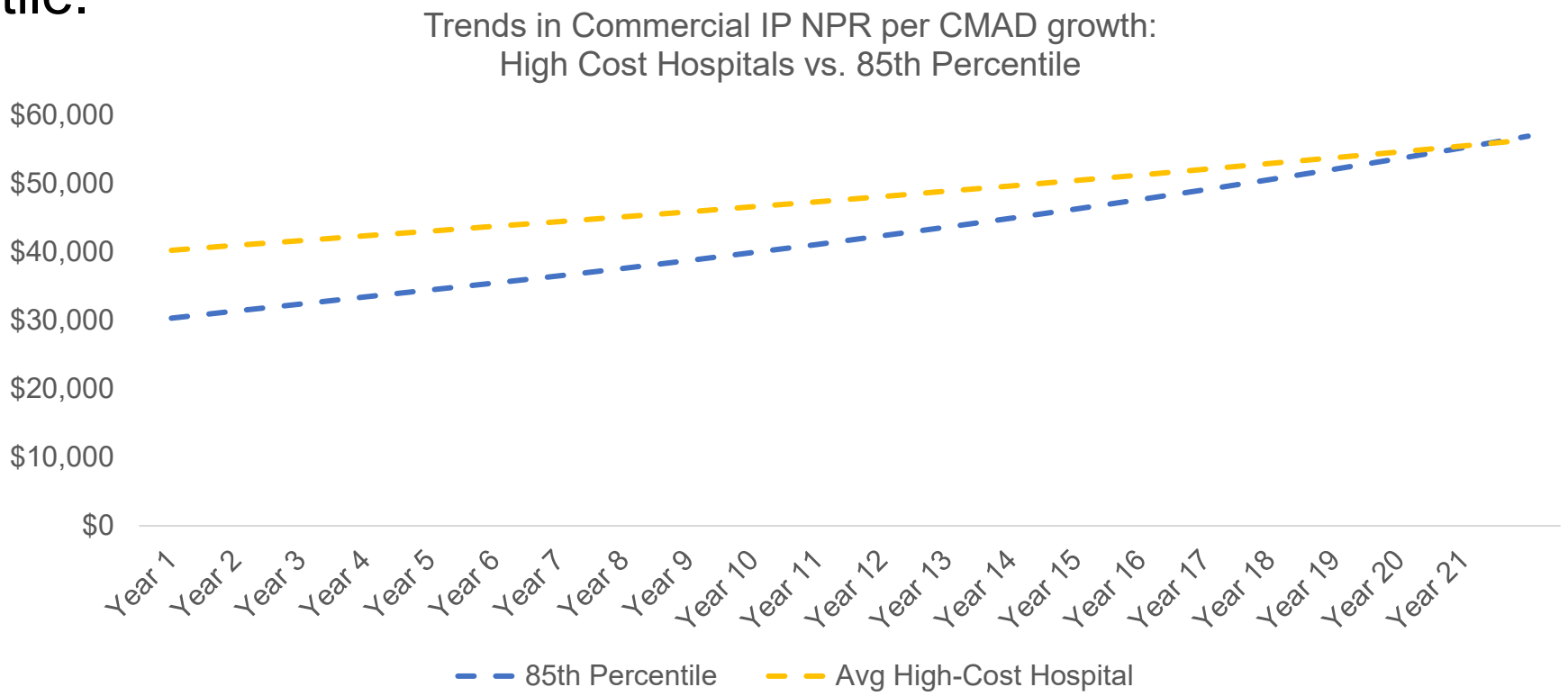
Projecting Commercial IP NPR per CMAD

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



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

Hospital Feedback

OHCA met with the following 5 hospitals between the January 2025 Board meeting and the February 2025 Board meeting: Community Hospital of the Monterey Peninsula, Salinas Valley Health, Sharp HealthCare, Stanford Tri-Valley, and Stanford HealthCare. OHCA is continuing to meet with hospitals this month, to gather feedback.

Discussion included:

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

Hospital Feedback

Identification of High-Cost Hospitals:

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

Unit Price Measure

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

Hospital Feedback

Relative Price Measure

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

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

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

Hospital Feedback

Other feedback and comments:

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