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

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# HEALTH CARE AFFORDABILITY ADVISORY COMMITTEE

MEETING MINUTES
Monday, September 22, 2025
10:00 AM

**Members Attending:** Joan Allen; Barry Arbuckle; Kati Bassler; Stephanie Cline; Carmen Comsti; Adam Dougherty*; Hector Flores*; Stacey Hrountas*; Iftikhar Hussain; David Joyner; Travis Lakey; Tam Ma; Amanda McAllister-Wallner; Carolyn Nava; Mike Odeh*; Marielle Reataza; Sumana Reddy; Cristina Rodriguez*; Kiran Savage-Sangwan; Andrew See; Manan Shah; Stephen Shortell; Sarah Soroken; Ken Stuart; Suzanne Usaj; Michael Weiss

**Members Absent:** Aliza Arjoyan; Janice O'Malley

**Health Care Affordability Board Member Attending:** Richard Pan*

*Attended virtually

**Presenters:** Vishaal Pegany, Deputy Director, HCAI; CJ Howard, Assistant Deputy Director, HCAI; Andrew Feher, Research and Analysis Group Manager, HCAI; Margareta Brandt, Assistant Deputy Director, HCAI; Debbie Lindes, Health Care Delivery System Group Manager, HCAI; Jean-Paul Buchanan, Legal, HCAI; Hovik Khosrovian, Senior Policy Advisor, HCAI

**Facilitators:** Jane Harrington, Leading Resources Inc.

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

**Agenda Item # 1: Welcome, Call to Order, and Roll Call**
*Vishaal Pegany, Deputy Director, HCAI*

Deputy Director Pegany opened the September meeting of California's Health Care Affordability Advisory Committee meeting. He introduced the four new members of the Advisory Committee. Roll call was taken for a record of attendance. Deputy Director Pegany then provided an overview of the meeting agenda.

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

Deputy Director Pegany provided an overview of the Rural Health Transformation Program and the following Executive Updates:

- On June 6, OHCA issued a determination to initiate its first Cost and Market Impact Review (CMIR) to examine portions of the material change notice submitted by Covenant Care California concerning the transfer of skilled nursing and assisted living facilities. After the transaction closes, OHCA will publish the preliminary CMIR report on their website and will allow 10 business days for parties and the public to submit written comments in response to the findings.
- A review of OHCA's quarterly work plan for the remainder of 2025 and an outline of plans for 2026.
- The passage of Assembly Bill 1415 by the Governor, which is legislation that includes new notice requirements for private equity groups, hedge funds, and management services organizations to submit notice of material changes with OHCA.
- Reminder about slide formatting.

Discussion and comments from the Committee included:

- A member reported that they have been closely monitoring the Rural Health Transformation Program at the federal level and cautioned that the full $50 billion allocation could potentially be expended without dedicating any portion to rural health care or rural residents. The member advised that HCAI exercise diligence in preparing the application to ensure that the funding appropriately benefits rural communities and their residents.
- A member stated that University of California, Berkeley has an online Master of Public Health (MPH) program and a cohort that specializes in rural health care called the Rural Health Leadership Initiative.
- A member emphasized the importance of recognizing that, although $50 billion is a substantial amount, H.R. 1 reduces funding by $1 trillion.
- A member asked when the committee can expect to review the draft application.
    - HCAI replied that, due to the condensed timeline for submission, they likely will not be able to share the draft application with the committee until after it is submitted. However, the listening sessions are intended to be the space where HCAI will discuss their priorities and potential activities. The listening sessions will be recorded and posted online, and anyone can attend. HCAI shared that they will be applying for the maximum amount of $200 million for each of the five years. Once the Centers for Medicaid and Medicare Services (CMS) approves the amount, OHCA will post it on their website with all the related information.
- A member asked when to expect CMS to tell the state how much it is eligible to receive.
    - HCAI responded that they will submit their application on November 5th and expect to receive notification from CMS regarding the amount to be awarded by late November as they must make their final decision by December 31st.
- A member asked whether the CMS review process will be similar to the past Notice of Funding Opportunity (NOFO) review process, and whether a review committee will be utilized.

- HCAI replied that CMS does have a review committee and the NOFO that was released outlines the number of points available in each category. HCAI further advised that CMS would reassess each state annually and may lower the amount awarded if a state does not meet their goals. If a state is not spending all their money, CMS may pull the unused funds and award it to other states.

- A member asked how the Advisory Committee can be updated on what's learned through this process.
  - HCAI stated that they will provide periodic updates at these Advisory Committee meetings. They also encouraged subscriptions to the California State Office of Rural Health (CalSORH) mailing list that can be found on the HCAI website where updates will be posted.
- A member encouraged HCAI to direct as much of the funds as possible to go to rural hospitals.
- A member asked what the review committee makeup will consist of, whether the point system may change, and whether a state's stance on vaccines, gender affirming care, and reproductive services may be a factor.
  - HCAI shared that CMS has not announced who will sit on the review committee yet, and it's possible that they may not announce that. The scoring factors should not change, but the CMS administrator is able to make a judgement call in regard to assessing whether a state is utilizing their funds appropriately. HCAI expressed hope that CMS will follow the standard federal grant guidelines.
- A member asked how HCAI plans to approach potential federal statutory changes.
  - HCAI replied that the NOFO reveals that states will receive nearly 20% of the points if they make legislative changes within the five years in areas such as scope of practice, telehealth, and flexibility on upskilling providers to allow them to operate different types of practices. HCAI is working with the legislature to identify if there's any changes that they may be potentially interested in, but that's going to take many conversations, and it is not something that HCAI will specifically call out.
- A member encouraged HCAI to conduct a deep dive into the cuts and changes that are required to happen, and expressed concern that cuts to rural areas will result in loss of life if their hospitals are closed.
- A member commented that she was marked absent in the June Advisory Committee meeting minutes but was present, albeit a bit late.
  - The Office advised that the June minutes will be revised to reflect this change.
- A member asked for OHCA to elaborate on their plan to follow-up with high-cost hospitals and the factors considered in identification.
  - The Office responded that, when the Board passed its motion in April 2025 to adopt the sector targets in the resolution, it included language for OHCA to provide annual updates on the factors it uses to identify high-cost hospitals. The factors used were the unit prices and the relative prices to identify those outliers.
- A member recommended a review of the Covenant Care CMIR once it's been completed to determine what worked well in that process and how the process could be improved upon.

Public Comment was held on agenda item 2. Two members of the public provided comments.

**Agenda Item # 3: Discussion of Data Submission Enforcement**
*Vishaal Pegany, Deputy Director, HCAI*
*CJ Howard, Assistant Deputy Director, HCAI*

Assistant Deputy Director Howard facilitated the discussion on the data submission enforcement process.

Discussion and comments from the Committee included:

- A member asked what investment would be needed to fund regulatory staff to compile the data and suggested a penalty that would require the entity to fund a position housed within OHCA to collect the data.
  - The Office replied that this wouldn't be the best way to do it because the payers know their own systems and OHCA staff would not be able to accurately calculate an entity's total medical expenses. If there is a failure to comply, OHCA's legal team has the authority to take action for violating state law, although they would pursue other remedies first.
- A member asked to what extent other states have experienced issues with entities submitting timely data for meeting spending growth targets.
  - The Office advised that Oregon has imposed its first penalty for late data submission this year. OHCA has more enforcement authority than most other states with spending targets. They noted that, while some stakeholders may feel that these penalties seem large for data submission, ensuring data submission also ensures that OHCA has the means and mechanisms to enforce the spending targets. The Office also emphasized that, by December 2024, full compliance was obtained from all entities that were expected to submit data.
- A member requested OHCA to comment on the quality of the initial submissions.
  - The Office replied that on average, each plan had to resubmit their data twice. The Office stated they will expand on this more broadly at future Advisory Committee meetings. They also expect to have more insight to share following the 2025 submissions.
- A member asked how OHCA developed the penalty amounts in light of the potential for an entity who has exceeded the cost target not to submit the data and view the penalty as the cost of doing business. The member expressed concern that the penalty may be too small to achieve OHCA's desired results.
  - The Office advised that they are conducting additional analysis and will respond more broadly once that analysis is compiled.
- A member asked whether the data submitted by the health plans detail the amount of the expenses attributed to general administration and profit for the health plan.
  - The Office replied that they have conducted some analysis with the baseline report, but it will be interesting to compare the 2023 data to the 2024 data and to the 2025 data. They are evaluating the way that they are measuring administrative costs and profits more broadly.

- A member asked that, given the multi-state health plans with money being fungible, have entities shifted their profits to another state where profits are not being measured?
    - The Office stated that they'd be unable to comment on plans that potentially shift profits to another state.
- A member asked whether OHCA will require health plans to submit all the Alternative Payment Models (APMs) that they offer or if they'll only require data regarding those that are Health Care Payment Learning and Action Network (HCP-LAN), categories three and four?
    - The Office responded that health plans must submit data regarding all APMs that they engage in, but the ones that count towards the APM adoption goal are categories three and four.
- A member expressed concern that the progressive fee schedule isn't sufficient to motivate some of the health plans who may have a large incentive to not submit timely.
- A member asked if the money that OHCA obtains through the penalties will be used to support OHCA operations or will be held in some type of escrow.
    - The Office stated that the funds would not be used for OHCA's operations. There is a Health Care Affordability fund established by statute where all penalty revenue will be deposited. That revenue is intended to defray the cost of care for consumers.
- A member asked for clarification on whether the fee structure for an entity that fails to submit for consecutive years would compound or stay at base level. For example, would OHCA have the ability to perform enforcement activities in the event that an entity fails to submit their data in 2027, faces their penalties, and then does submit their data in 2028.
    - The Office replied that it would be considered non-compliant for two years in a row. If there is a delay in data submission, OHCA will pursue all remedies. The Office also stated that this is a regulatory process which can be revisited if the enforcement actions aren't sufficient to achieve compliance.
- A member asked how the $5 per member penalty compares to a member on a Preferred Provider Organization (PPO) plan.
    - The Office clarified that the term "member" refers to the enrolled population as reported to the Department of Managed Health Care (DMHC) or California Department of Insurance (CDI).
- A member expressed support for enforcing public testimony for an entity to explain why they weren't compliant.
- A member recommended increasing the penalties for untimely data submission and suggested applying these penalties based on a small, medium, large, very large, scaled size of the entity.
- A member asked whether data submission is considered late if part of their enrollment data is submitted by the deadline.
    - The Office stated that it would be considered late if an entity does not submit complete data per the standards in the data submission guide.

- A member asked whether there are penalty tiers to create a significant deterrent to repeated untimely submission, citing one instance where a health plan was fined nearly $1 billion yet did not change their behavior.
- A member asked if there are any quality or safety data components to the required data submission.
    - The Office stated that most of this pertains to the spending data. They have a separate work stream on quality and equity measures and are leveraging the existing data submitted by the health plans to DMHC. Hospitals will be reporting the hospital equity quality measures to HCAI.
- A member asked if an entity's quality is a factor when evaluating the data submitted.
    - The Office replied that this is an ongoing discussion. As they are measuring spending performance, they also want to assess quality and equity performance to ensure that the quality of care provided is not decreasing at the expense of an entity's spending performance.
- A member suggested that having a more graded penalty for very large entities would make the penalty more meaningful. The member also asked if OHCA will be publishing a list of entities who fail to submit accurate or timely data.
    - The Office responded that publicizing the organizations who did not submit timely data is still under consideration.

Public Comment was held on agenda item 3. One member of the public provided comments.

**Agenda Item #4: Introduction to Spending Target Enforcement; Timeline and Enforcement Considerations**
*Vishaal Pegany, Deputy Director, HCAI*
*CJ Howard, Assistant Deputy Director, HCAI*

Assistant Deputy Director Howard and Deputy Director Pegany introduced the spending target enforcement timeline and enforcement considerations for discussion.

Discussion and comments from the Committee included:
- A member expressed appreciation for age and sex being factored in and inquired whether there will be any incentive or opportunity to include racial and ethnic demographic information.
    - The Office acknowledged the importance of including racial and ethnic demographic information and stated that they are exploring ways to incorporate that with quality measures. This data will reveal the spending or lack of spending for certain populations. OHCA has a work stream on equity adjustments and the law requires OHCA to develop an equity adjustment to the extent that there is a reliable, valid methodology. This analysis will take time and there is not a concrete date that the Office can share with committee at this moment.
- A member asked if age and sex adjustment data is available for those receiving Medi-Cal, and if there is any medical risk adjustment for those receiving Medi-Cal.
    - The Office shared that, for the first two years of their program, Medi-Cal Managed Care Organizations (MCOs) were not required to directly submit data

to OHCA. OHCA has been utilizing data that has been reported to DHCS, which is how they are able to calculate the total medical expenses using the medical loss ratio data. However, that data does not allow OHCA to conduct the age and sex adjustment for MCOs. Additionally, the Office had several discussions with the Board and Advisory Committee around risk adjustment in its first two years and opted to do an age/sex adjustment because of the ability to compare an entity to itself over time.

- A member stated that race, ethnicity, language, sexual orientation, gender identity, religion, and socioeconomic status will all be factors in advancing towards equity.
- A member expressed caution in including race, ethnicity, and other demographic data as some populations are historically under-utilizers.
- A member suggested that a measure of success would be access for the underserved populations and suggested including criteria that would ensure the underserved populations are not screened out.
- A member emphasized the importance of establishing targets that are viewed as legitimate by being reinforced with accurate data analysis. The member stated that, in earlier conversations, it was decided that it is not appropriate to adjust the spending target according to risk due to the limited fluctuations in risk from year to year. However, it is expected that there will be a 20-30% reduction in the Affordable Care Act (ACA) exchange membership as a result of H.R. 1, and it will primarily be younger, healthier members who will leave. This will lead to a higher average risk for the ACA population and a higher total cost of care. Considering this anticipated global increase in costs, the member recommends permitting an allowable adjustment to the spending target based on exposure to ACA exchange membership.
- A member stated that it is premature to adjust the spending target due to H.R. 1 as it is not yet known the exact impact it will have on spending.
- A member asked for clarification regarding the age adjustment in terms of enforcement.
    - The Office encouraged further discussion on this topic, noting that the age/sex adjustments are based off of payer specific data for the payer, and the Office is using the payer data to create a baseline for each payer to show how such changes could impact them. The Office's intention with the age/sex adjustments are that the level at which these grow will inform what type of enforcement action will be taken.
- A member asked for clarification regarding the information that will be publicized for those who miss the spending target, and whether that data will be publicized before or after any enforcement considerations have been applied.
    - The Office shared that the entity's name and the amount by which they missed the spending target will become public, and that its intention is to report unadjusted data as the Office has done in its Baseline Report. The Office reiterated that these discussions are enforcement considerations, but they are not necessarily deterministic.
- A member emphasized the importance of transparency about the enforcement considerations, as that data will provide guidance into how the process should be improved.

- A member cautioned OHCA to consider whether an enforcement consideration can be manipulated.
- A member asked whether Massachusetts or Oregon has imposed fines when an entity has exceeded the spending target due to reasonable factors.
    - The Office replied that Oregon has not required a performance improvement plan (PIP) from an entity yet. Massachusetts has required one PIP with Mass Brigham and OHCA will review that in a future Board or Advisory Committee meeting.
- A member advised OHCA to consider the size of the population an entity serves because smaller entities will have a lot more volatility. The member also noted the added layer of complexity with geographical price differences.
- A member expressed concern regarding high-cost patient outliers being used as reasons an entity may not meet the target, noting the potential gamification of the system. The member suggested using what the Diagnosis Related Group (DRG) would pay at the Medicare rate as a base for what could be considered a high-cost patient outlier.
    - The Office acknowledged the complexity present in this potential enforcement consideration because high-cost claims do occur every year. The Office stated that they would take a deeper look at how health care entities will determine what could be considered high-cost patient outliers.
- A member expressed concern for the rural hospitals, considering that they typically have a low volume of patients with a high Medi-Cal payer mix.
- A member asked OHCA to share their thoughts regarding the utilization and expenses anticipated in the coming years as a result of the federal changes.
    - The Office replied that, while they do expect the average cost for the ACA exchange population and the Medicaid population to increase as a result of H.R. 1, those changes likely will not affect the employer population, which makes it difficult to predict the changes to utilization and expenses.
- A member stated that, as people are forced out into less affordable plans, that will impact the outliers.
- A member cautioned OHCA against creating an inadvertent outcome where providers with fee-for-service payments are given an advantage in navigating enforcement over those plans who absorb costs with capitation.
- A member expressed a desire for more data regarding reinsurance thresholds in order to make an informed recommendation. The member believes that there is at least some macro level data for trends in high-risk patients currently available. The member also stated that if the intention is to determine the difference between fee-for-service and managed care, and if the costs are similar for a plan versus a rural hospital, then this seems like a data project. If the data is not available now, the member would lean toward excluding the high-cost patient outliers as an enforcement consideration at the onset, and would recommend addressing this as the program matures.
    - The Office responded that there may not be a systematic source for obtaining this data, but they could find out more through this enforcement process.
- A member stated that H.R. 1 will affect everyone. It may trigger sequestration, which will result in significant cuts to Medicare. That will lead to costs being shifted to

workers and their families through premium payments, through their salary, and through deductibles and copays.

- A member expressed concern regarding the publicizing of the names of entities who exceed the spending target and how that may affect their business.
    - The Office replied that there will be an education piece to this where they will frame it to help the public and interested parties to understand that some spending growth is reasonable and expected, and exceeding the statewide target does not necessarily deem an entity as high cost.
- A member commented on how valuable it is to have OHCA established at this time, to hold hospital systems and health care entities accountable for the ways they will respond to the changes in the California health care landscape as a result of H.R. 1.
- A member asked for clarification on how Oregon and Massachusetts approach the topic of evaluating historical spending growth.
    - The Office replied that Oregon's process is that an entity would miss the target for three out of five years prior to penalties, but this gets even further away from the Office's intent which is conceptualizing a way to conduct a year over year evaluation of an entity's spending growth.
- A member stated that an investment in preventative and primary care will lead to lower costs, which should be a factor for OHCA to consider regarding enforcement.
- A member encouraged OHCA to consider evaluating an entity's spending growth over a three-year out of five year period.
- A member recommended removing the word "spending" under the potential enforcement consideration for "Impact to Consumer Access and Affordability" so that it reads "The degree to which the entity has adversely impacted consumer access to affordable care." The member stated that there are several other actions an entity may take that would impact consumer access and affordability other than their spending.
- A member asked which metrics OHCA would use to measure the impact to consumer access and affordability.
    - The Office stated that the metrics could vary depending on the entity. For example, for health plans it could be measured by their enrollment; for hospitals it could be measured by their discharges; for physician organizations, it could be measured by membership.
- A member expressed concern with measuring spending for primary and preventative care, because if a hospital is shut down to lower spending, the impact will be a high-cost increase for that area as patients will have to receive care at their closest emergency room.
- A member recommended comparing the increased investment against data that shows an improvement to patient care or access, such as data DMHC or Department of Health Care Services (DHCS) has on timely access to appointments.
- A member asked if OHCA is looking at the investments at an individual hospital facility or to the health system overall.
    - The Office replied that their focus is on health care entities, which are defined in the statute as payers, providers and physician organizations. There is no definition of a health system in current state law, but they do recognize that many health care entities are part of systems. However, regardless of how an entity is

organized, OHCA must be able to measure, quantify, and evaluate how the spending is used to support expanded capacity at the health care entity level as defined under state law.

- A member commented that the HCAI report does not gather primary care investment data from hospitals, but this should not deter OHCA from looking at the various investments hospitals make into primary care.
    - The Office's replied that the primary care benchmark is a related effort, but the requirement is on payers to increase investments into primary care. Entities themselves could also be investing in primary care separate from what payers are doing. If this were to become a factor, the Office would need a way to measure and quantify it.
- A member commented that an entity should not be penalized for investing in their community and increasing access to care.
- A member recommended removing the word "inexplicably" from the potential enforcement consideration under "Entity Baseline Costs" as the reason for high costs may be inappropriate but it will often be explicable.
- A member stated that tariffs will increase drug costs across the industry for all providers, so an adjustment should be considered for that impact.
- A member asked if OHCA has a set definition for high-cost drugs.
    - The Office advised that they do not have a threshold for drug costs, but it could include physician administered drugs and specialty drugs.
- A member recommended that OHCA consider what is and is not in control of the specific entity.
- A member expressed concern that, if all of the suggested potential enforcement considerations become the enforcement considerations, it seems like an unworkable process for OHCA to manage. The member encouraged OHCA to prioritize its mission which is increasing consumer access and affordability. The member also suggested that the entities who have exceeded the cost targets in a manner that most impacts consumer access and affordability should be considered the highest priority for enforcement, and that OHCA should limit the number of potential enforcement considerations because it could hinder the effectiveness of the Office.
- A member advised of the In-Vitro Fertilization (IVF) mandate that was implemented into law this year which will result in an estimated 1-1.5% increase in health care costs. This will have a material impact on the 3.5% target. The member advised OHCA to adjust the target for known issues that are outside the control of the providers and have providers focus on explaining the issues that were in their control that contributed to missing the targets as this may better focus OHCA's efforts.
- Another member commented that, in many cases, these changes to state and federal law can be anticipated and accounted for, which would not justify an exemption as entities can plan for them.
- A member provided an example of a hospital that would likely be considered a high-cost outlier due to the fact that approximately 10% of their patients stay at the hospital for two or three days beyond the point at which they could be discharged because there are no post-acute facilities in that community to discharge patients to. In this situation, if this is the cause of the entity exceeding their target for two

consecutive years, then by the third year it would be reasonable to expect the entity to invest in a post-acute facility.

- A member suggested adding demonstrated changes in cost as a result of changes to state and federal laws as an enforcement consideration. The member cautioned that not factoring this in could lead to providers refusing to provide care to certain patients or going out of business.
- A member cautioned against using changes to state and federal law as an enforcement consideration, citing a 2016 state law to ensure adequate provider networks that has not been followed.
- A member expressed concern for additional proposed rules that would impact safety-net financing and state-directed payments for public hospital systems as this would impact reimbursements and payments received from Medi-Cal and will likely increase uncompensated costs.
- A member expressed worry about progress when developing a specific list of changes to state and federal law, cautioning that putting forth any kind of specific list could have compounding negative impacts.
- A member stated that if a state department separate from OHCA passes laws which increase what is included in the Total Health Care Expenditure (THCE), then OHCA should adjust the target to reflect that increase.
- A member stated that, in regard to cost mitigation strategies, there are many strategies that have not been addressed, specifically strategies such as: clearly detailing effective alternatives to clinicians; ensuring that indications for medication side effects are clear; providing improved support once the decision is made to start a medication; and obtaining sufficient data to stop wasteful care. The member cited an example of skin substitutes, which companies initially charged Medicare $150 per square inch from a few reputable companies, and then the companies raised the price to hundreds of thousands of dollars per square inch. Obtaining this type of data would enable OHCA to recognize that kind of activity and control the costs. The member also cited a recent article published in the New York Times about a company who effectively treated two people with a very rare disease but has since gone out of business because the state was unwilling to pay for the treatment.
- A member commented that prescription drugs sometimes cost less when purchased out-of-pocket at a pharmacy than it would it a patient used their insurance. The member asked whether this type of data will be considered with this high-cost drug enforcement.
    - The Office replied that, if the cash price of a drug is lowered, state law requires pharmacists to offer that reduced price to the consumer. They clarified that OHCA does not have jurisdiction over drug manufacturers, so their focus will be on spending by plans, hospitals, and physician organizations.
- A member asked whether marketing techniques employed by pharmaceutical companies would be considered in the high-cost-drug enforcement.
    - The Office stated that pharmaceutical marketing falls under the domain of the federal government and is out of scope for state government. However, plans could perform utilization management to ensure that drugs are administered appropriately.

- A member commented that plans and hospitals could use their market power to reduce drug prices, and OHCA should expect these entities to take action to control pharmaceutical costs instead of simply passing the costs onto consumers. The member commented that the markup of drugs is a significant area for OHCA to review, specifically inpatient administered drugs which are completely within the control of the entity. The member also asked how OHCA plans to measure the cost of 340B drugs.
    - The Office clarified that enforcement considerations are not exemptions but are considerations to help prioritize which entities require enforcement and to provide direction for moving through the enforcement process. Regarding 340B drugs, hospitals are required to submit those financials to HCAI, but there is not a line-item breakout for those to provide visibility into the specifics of those amounts.
- A member stated that the cost of preventative medications and life-extending medications, even if they are more highly utilized, should not count against an entity. However, if a drug at a facility is above a certain threshold on the Medicare side, for instance an Average Sales Price (ASP) model, then the overage should not get excluded as an enforcement consideration.
- A member commented on the potential difficulty of defining a life extending drug.
- A member expressed concern that there is a substantial amount of profit hidden in Pharmacy Benefit Managers (PBM) complexity and asked if OHCA has the ability to obtain transparent information from the PBMs. The price for drugs and the markups would be insightful information from the PBMs.
    - The Office replied that under the recent budget act, there is PBM reform which will require PBMs to be licensed by DMHC and HCAI will require the PBMs to submit data to the Healthcare Payments Database (HPD), including data regarding cost information, rebates, and any rebate-like payments.
- A member cautioned that cost containment strategies may have unintended consequences. The member stated that “white bagging,” where medication is shipped directly to the provider’s office, can be a problem as it eliminates the utilization of the pharmacy. The member also expressed concern with “brown bagging,” where medication is shipped directly to the patient who then brings it to their provider’s office for treatment, as the provider cannot verify that it is the correct drug or has been stored properly.
- A member suggested that eliminating rebates on drugs would help reduce the drug costs, as rebates are unnecessary and provide direct profit to the PBM. The member also suggested that a proactive measure that could be taken to reduce drug costs would be for CMS to negotiate and establish uniformity in costs in the US that would match the costs of those same drugs in other countries.
- A member suggested that OHCA continue speaking with the health care entities to identify a few controllable factors, such as formulary management, group purchasing organizations (GPOs) or reference pricing and allow these to be the focus of OHCA’s enforcement considerations.
- A member recommended that OHCA utilize the full extent of its regulatory powers to gain transparency into the pathway of the cost of drugs from the pharmaceutical company to the patient to eliminate a lot of the gaming of the system. The member highlighted evidence-based guidelines for developing the formulary, followed by

education for the physicians to ensure they are using evidence to guide patients to the best treatment for each individual patient. This approach could serve to place a greater focus on moving entities towards APMs which are the great equalizer.
- A member stated that approximately 50% of patients in California are under Medi-Cal Rx, which could provide valuable data that would reveal whether that program was successful in stabilizing drug costs. That data could also reveal best practices that OHCA could consider implementing.

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

**Agenda Item #5: Update on Behavioral Health Spending Definition and Measurement Methodology, Including Summary of Public Comments**
*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 key findings from the data analysis on behavioral health spending from the Health Care Payments Database (HPD), followed by a review of the proposed approach for measuring behavioral health spending. They also reviewed the public comments that OHCA received during the public comment period on the behavioral health spending measurement methodology which took place in August.

Discussion and comments from the Committee included:
- A member asked, of the $5.1 billion in total spending shown in the presentation, does OHCA know what the denominator is in terms of how many members that accounts for?
  - The Office replied that they would be happy to follow up to provide an answer to this question.
- A member expressed concern that only about 2% of behavioral health care is integrated in primary care, given that integrated primary care is important to primary care clinicians. As a primary care provider, this member has struggled to find integrated behavioral health providers who can get onto plan networks. The member encouraged commercial plans to step up and enroll therapists in integrated models. Additionally, the member encouraged OHCA to create incentives for health plans to adopt integrated models. The member noted that without major funding, there will be technical difficulty in using EHR to identify primary behavioral diagnoses, especially if screening and treatment are combined. The member noted that screening often turns into evaluation and treatment, especially in pediatrics, and for everyone screened during a regular office visit. The member also noted that behavioral health care should be provided alongside treatment for any chronic pain and chronic diseases such as diabetes. The member noted that addressing chronic illness together with behavioral health will decrease emergency room utilization, and that alternative payment models allow primary care providers to provide the necessary care for people who come in with mental health symptoms such as anxiety. The

member emphasized the need for behavioral health and primary care integration and incentivizing it.

- A member asked how all screening data for behavioral services can be captured, given that most people seek behavioral health care outside of primary care. The member noted that those who receive behavioral health care in primary care settings may not have a primary behavioral diagnosis. The member appreciated the delay in setting a behavioral health spending benchmark and expressed hope that further consideration will be given to not requiring a primary behavioral health diagnosis, especially when people often do not have a diagnosis and do not come in to primary care specifically for these services.
- A member asked if the Office can do some additional analysis of claims and spending for secondary behavioral health diagnoses, noting that it would be helpful context to have that information.
    - The Office stated that over the next year, they will conduct several analyses of the HPD to help clarify spending that is excluded when a secondary diagnosis is not provided.
- A member expressed continued support for a behavioral health spending benchmark focused on outpatient behavioral health spending to orient health care entities to invest more and improve access points for consumers. The member supported the delay in developing the benchmark given the complexity involved. The member requested clarification on whether behavioral health screening and assessment received in primary care will count only toward behavioral health spending and not toward primary care spending.
    - The Office replied that such screening would be counted toward both primary care and behavioral health. The methodology allows for breaking out spending so that spending counted in both could be subtracted out from the sum of primary care and behavioral health spend.
- A member noted how difficult it is in the current behavioral health system to ensure that people get access to the appropriate level of care, when they need it, and expressed appreciation for the consideration the Office has given in its behavioral health work to improve consumer access to upstream care. The member asked if the apparent increase in outpatient professional non-primary care spend observed in the presentation appendix is a reflection of increases in price or utilization.
    - The Office replied that to their recollection, these increases may have been driven mainly by increases in utilization; analysis has not been performed yet to show how much of that increase was an increase in telehealth utilization, and that the Office can follow up on that.
- A member asked if a behavioral health diagnosis coded by a primary care physician during an office visit counts as behavioral health spend.
    - The Office replied that such spending would be counted in the behavioral health in the primary care module.
- A member noted that a behavioral health diagnosis is not required for Medi-Cal members under the age of 21 to receive mental health services and asked if these services would be captured in either claims or non-claims payments. The member explained that this might be part of the changes related to CalAIM, although it's been common practice that F-code diagnoses are not required in order to receive

behavioral health services. The member noted that a portion of behavioral health services, such as psychotherapy, is billed using Z-codes, which, if not captured under claims or non-claims spending, would miss capturing a significant portion of Medi-Cal children's behavioral health spend. Additionally, the member noted that Medi-Cal members of any age can receive behavioral services such as mental health assessment and treatment if they have a potential mental health condition not yet diagnosed and therefore, any services rendered before a diagnosis is identified, would not be captured.

- The member cited Research Triangle Institute's (RTI) 2024 study which showed much higher rates of out-of-network treatment for behavioral health compared to medical-surgical care, even for telehealth, and that provider shortages did not explain the disparities in out-of-network utilization or reimbursement. The study showed lower rates of reimbursement for in-network behavioral health office visits than for medical-surgical providers. The member noted that in their experience, many therapists do not participate in networks due to the administrative burden of seeking reimbursement from plans and the much lower reimbursement from plans than they can get from cash paying patients. The member supported incentivizing health plans to cover behavioral health in-network, within the insurance-based system. The member suggested conducting supplemental analyses to identify ways to incentivize health plans to recruit therapists to their networks, increase in-network care, and improve access.
- The member commented that while billing for dyadic services is relatively new in California, this is true preventive, early intervention care for children. Dyadic services include behavioral health support such as psychoeducation, assessment, screening and brief intervention given to a parent or caregiver for the benefit of the child, screening for adverse childhood experiences, linkage to resources, etc. The member noted that dyadic services should be incentivized and tracked.
- A member advised that many school districts have established robust behavioral health wellness centers with licensed social workers following the influx of money provided after COVID. The member stated however, that school-based facilities, which are likely the primary source of behavioral health care for school-aged children and adolescents, often do not bill Medi-Cal. The member noted that this is especially challenging for children who live in behavioral health deserts, where finding care outside of the school system is almost impossible. The member expressed concern for the continuity of care for these families as these wellness centers may close following the decrease in funds or when funds are cut in the future.
- A member recommended developing supplemental analyses to evaluate the quality of behavioral health care provided, compared to the standard of care. Is there a need for a deeper dive on the quality of the services being provided? Perhaps this is similar to the targeted investigations the DMHC conducts.
- The member emphasized the importance of analyzing out-of-pocket, private pay spending for medically necessary behavioral health services to identify barriers to in-network care. The member noted that the majority of out-of-pocket behavioral health spend is medically necessary care, and people just cannot get it through their insurance plans, or they cannot find culturally and linguistically appropriate providers

in network. The member recommended looking further into ways to measure out-of-pocket spend to inform decisions around what actual spend needs to look like within the insurance industry.

- A member wondered what utilization will look like for folks who may be afraid to use services because of their immigration status. The member expressed concern that immigrants who may have a greater need for behavioral health services may be too fearful to utilize the services available.
- The member noted that individuals with substance use disorders often have an underlying mental health condition that serves as the root cause of their substance use. The member added that the division between mental health and substance use disorder is artificial since people who have some kind of substance use disorder often times experience mental health issues. The member wondered what the behavioral health care landscape is going to look like as services continue to be cut.
- A member expressed surprise over the small amount of spending for substance use disorder as compared to spending for mental health. The member mentioned the two are comorbid and that the small amount of spending on substance use disorder treatment reflects the member's experience of having difficulty getting patients connected to substance use disorder treatment
    - The Office thanked the committee for their comments and noted that the Office is looking into how to potentially measure out-of-pocket, out-of-plan spend and hopes to bring an update back to the committee in the future. The Office appreciated the committee's feedback and noted it will use the information provided to inform the definition included in the Data Submission Guide that will be finalized next spring.

**Agenda Item #6: General Public Comment**

Public Comment was held on agenda item 5 and agenda item 6. Four members of the public provided comments.

**Agenda Item #7: Adjournment**

The facilitator provided a reminder of the next Advisory Committee meeting scheduled for January 14, 2026 and then adjourned the meeting.