OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Advisory Committee Meeting

September 22, 2025

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Welcome and Call to Order

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Agenda

1. **Welcome and Call to Order**

2. **Executive Updates**
   Vishaal Pegany, Deputy Director

3. **Discussion of Data Submission Enforcement**
   Vishaal Pegany; CJ Howard, Assistant Deputy Director

4. **Introduction to Spending Target Enforcement; Timeline and Enforcement Considerations**
   Vishaal Pegany; CJ Howard

5. **Update on Behavioral Health Spending Definition and Measurement Methodology, Including Summary of Public Comments**
   Margareta Brandt, Assistant Deputy Director; Debbie Lindes, Health Care Delivery System Group Manager

6. **General Public Comment**

7. **Adjournment**

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Executive Updates

Vishaal Pegany, Deputy Director

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What is the Rural Transformation Program?

The Rural Health Transformation Program (RHTP) is a strategic effort to improve health care in rural areas, where access, workforce, and infrastructure gaps create unique challenges. The RHTP is an investment of $50 billion over five years to transform rural health access.

This program was designed to:

Improve rural health care access and sustainability	Improve Health Outcomes

Funding

Federal Funding Distribution: $50 billion will be disbursed for five years (FFY 2026 – FFY 2030).

$25B will be distributed equally among approved states	Additional $25B funding as determined by factors identified by CMS

State Funding Distribution

A baseline of $100M per year will be distributed to approved states	Additional funding may be available based on application scores.

CMS must have all applications approved by December 31, 2025.

Spending Deadline: States have two years to spend each year's funding allotment.

Rural Health Transformation Goals

Make Rural America Healthy Again	• Support rural health innovations and new access points to promote preventative health and address root causes of diseases.
Sustainable Access	• Help rural providers become long-term access points for care by improving efficiency and sustainability.
Workforce Development	• Attract and retain a high-skilled health care workforce by strengthening recruitment and retention of healthcare providers in rural communities.
Innovative Care	• Spark the growth of innovative care models to improve health outcomes, coordinate care, and promote flexible care arrangements.
Tech Innovation	• Foster use of innovative technologies that promote efficient care delivery, data security, and access to digital health tools by rural facilities, providers, and patients.

Rural Health Transformation Activities

States must identify at least 3 of the following activities within their proposals:

Promoting evidence-based interventions to improve prevention/chronic disease management.
Payments to providers
Promoting technology driven solutions for prevention and management.
Training/TA for developing and adopting technology-enabled solutions that improve care delivery in rural hospitals
Recruiting and retaining clinical staff to rural areas with a 5-year service obligation
Fostering Collaboration: local and regional partnerships between rural facilities and providers
Provide TA, software, hardware for significant tech advances to improve efficiency, cybersecurity, patient outcomes
Right sizing health care delivery by identifying needed services, facilities, etc.
Supporting access to OUD/SUD treatment
Projects that support value-based care
Capital expenditures and infrastructure: to ensure long-term costs align with patient volume

Stakeholder Engagement

HCAI will be reaching out to stakeholders to conduct stakeholder engagement sessions via webinars, surveys, and listening sessions before the application deadline.

RHT Stakeholder Engagement Schedule	
September 4	Kickoff Webinar (completed)
September 5 – September 16	Stakeholder Survey (completed)
September 15	NOFO Released from CMS
September 15 – September 26	Stakeholder Engagement
September 16 – September 26	HCAI Drafting of Priorities
September 29 – October 6	Stakeholder Listening Sessions
October 6 – November 5	Application finalization, Review, and Submission

Stakeholder Engagement

We welcome additional feedback and input!

Contact: State Office of Rural Health:

CalSORH@hcai.ca.gov

Sign Up for our Rural Health Mailing List:

https://hcai.ca.gov/mailing-list/

When subscribing, remember to select “Rural Health” under the *Healthcare Workforce* category to ensure you receive updates directly from SORH.

CalSORH website:

https://hcai.ca.gov/workforce/health-workforce/california-state-office-of-rural-health/

Cost and Market Impact Review: Covenant Care

- Covenant Care California LLC (“Covenant Care”) submitted a Material Change Transaction regarding the transfer of skilled nursing facilities and assisted living facilities (assets, operations, and leases), which was deemed complete on April 24, 2025.

- OHCA is proceeding to a Cost and Market Impact Review for three Covenant Care facilities that will be operated by entities affiliated with The Ensign Group, Inc. after the transaction closes:
  - Buena Vista Care Center in Santa Barbara County
  - Shoreline Care Center in Ventura County
  - Huntington Park Nursing Center in Los Angeles County

- OHCA will publish the Preliminary CMIR Report on its website and allow 10 business days for parties and the public to submit written comments in response to the findings.

Quarterly Work Plan*

		Total Healtare Expenditures & Spending Targets	Cost and Market Impact Review (CMIR)	Promoting High Value
AUG	Board	• Discussion of Data Submission Enforcement, Continued • Discussion of Spending Target Enforcement – Assessing Performance		
	AC	**No Meeting**		
SEPT	Board	**No Meeting**		
	AC	• Discussion of Data Submission Enforcement • Introduction to Spending Target Enforcement; Timeline and Enforcement Considerations		• Update on Behavioral Health Spending Definition and Measurement Methodology, Including Public Comments
OCT	Board	• Board Vote – Data Submission Scope and Range of Penalties (tentative) • Discussion of Spending Target Enforcement – Assessing Performance, Continued • Update -- Monterey Hospital Market Competition Study (tentative)	• CMIR Update	
	AC	**No Meeting**		
NOV	Board	• Board Vote – Data Submission Scope and Range of Penalties (tentative) • Discussion of Spending Target Enforcement – Technical Assistance and Public Testimony • Data Submission Guide 3.0 Regulations		• Update on Behavioral Health Spending Definition and Summary of Public and Advisory Committee Comments
DEC	Board	• Board Vote – Data Submission Scope and Range of Penalties (tentative) • Discussion of Spending Target Enforcement – Technical Assistance and Public Testimony, Continued • Update on Hospital Spending Measurement		
	AC	**No Meeting**		

* Work plan is subject to change.

Future Topics Beyond December 2025

THCE & Spending Target

- Data Submission Enforcement – Discuss Regulations (April Effective Date)
- Spending Target Enforcement – Discuss Public Testimony, Performance Improvement Plans, and Penalties
- Follow-up on High-Cost Hospitals and Factors Considered in Identification

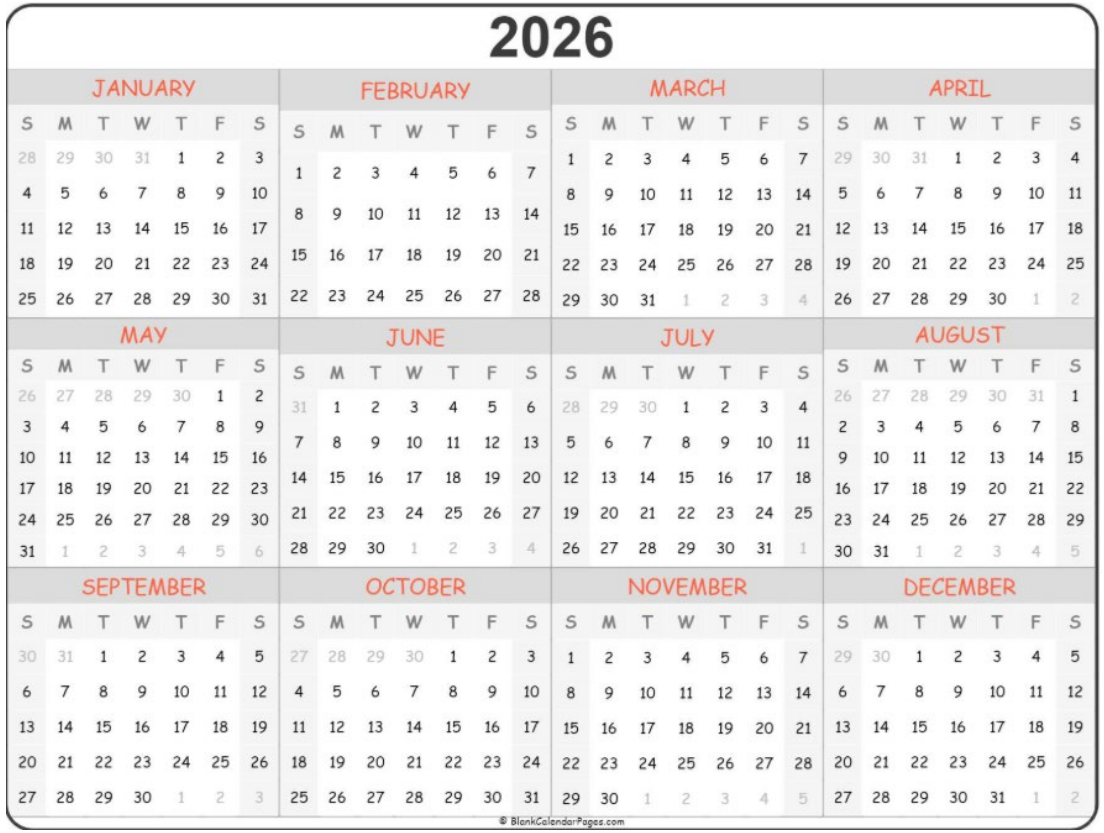
Promoting High Value

- Behavioral Health Investment Benchmark

Assessing Market Consolidation

- Update on Material Change Notices Received, Transactions Receiving Waiver or Warranting a CMIR, and Timing of Reviews for Notices and CMIRs

2026 Public Meeting Calendar



Health Care Affordability Board Meetings

Wednesday, January 28
Wednesday, February 25
Wednesday, March 25
Wednesday, April 22
Wednesday, May 27
Wednesday, June 24
Tuesday, July 21
Wednesday, August 26
Wednesday, September 23
Wednesday, October 28
Wednesday, November 18
Wednesday, December 16

Health Care Affordability Advisory Committee Meetings

Wednesday, January 14
Wednesday, April 15
Wednesday, June 17
Wednesday, September 16

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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Informational Items

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Data Submission Enforcement

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

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Statute

Board

Approve:
(b) The board shall approve all of the following:
(2) The scope and range of administrative penalties and the penalty justification factors for assessing penalties.

(c) The director shall present to the board for discussion all of the following:
(5) Review and input on administrative penalties to inform any adjustments to the scope and range of administrative penalties and the penalty justification for assessing penalties.

Office

(h) (1) The director may directly assess administrative penalties when a health care entity has failed to comply with this chapter by doing any of the following:
(A) Willfully failing to report complete and accurate data. …
(E) Knowingly failing to provide information required by this section to the office.
(F) Knowingly falsifying information required by this section.

(2) The director may call a public meeting to notify the public about the health care entity's violation and declare the entity as imperiling the state's ability to monitor and control health care cost growth.

Adopt regulations to implement the statute (HSC 127501 (c)(16), 127501.4 (k), and 127502 (b)(1))

Data Submissions

Data reported in 2024:

- OHCA received all files from the 17 required submitters.
- On average, plans resubmitted each file about 2 times before OHCA accepted all of a plan's files as complete and accurate. OHCA provided technical assistance to all entities.
- 13 plans had submitted all files by October 1, 16 plans by November 1, and all plans by December 18.

Data reported in 2025:

- OHCA requires two new files: Alternative Payment Models (APM) and Primary Care.
- Medi-Cal Managed Care Organizations will submit APM and Primary Care files and OHCA will continue to use total medical expense data from DHCS for MCO reporting.
- Combined with the addition of MCO submissions, plans will submit data by licensed entity, which will expand the number of submitters from 17 to 51. For 2024, submission was at the parent level of the organization.

Data reported in 2026:

- OHCA may add a Behavioral Health file to the data submission.
- Other requirements may be added, or existing requirements may be amended based on lessons learned from 2025 data submission.

Scope and Range of Penalties and Penalty Justification Factors

The Board will approve the Scope and Range of the penalties.

- Penalty amount(s)
- Penalty structure (e.g., per day fee, per member fee, mixed, etc.)

The Board will approve the Penalty Justification Factors.

- These guide OHCA in determining which board-approved penalty amount(s) are assessed.
- The following factors are outlined in statute 127502.5.(d)(6):
  - The nature, number, and gravity of the offenses.
  - The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity.
  - The market impact of the entity.
- Other factors can be considered, such as an entity's cooperation and active communication with the Office.

Data Submission Guide

- The Data Submission Guide defines standards for data completeness and defines data as acceptable when it has passed automated and manual data validation checks to ensure that data are in a valid file format and layout, free of illogical or missing/incomplete data values, and free of other technical deficiencies related to file submission, storage, or processing.
- The Data Submission Guide provides a 5-day period for entities to correct any issues identified by the Office after they are noticed. During this period, the Office could delay the assessment of a penalty.

Considerations for Penalty Structure

- The penalty needs to be reasonable, provide an incentive to submit data timely, and deter entities from not submitting or withholding data to evade spending target enforcement.
- OHCA is unable to measure THCE or enforce the target against entities that fail or refuse to submit data.
- If an entity fails to submit data, it may also impact reporting of spending for other health care entities, such as providers organizations that are measured based on attribution of total medical expenses.

In the following illustrative scenarios for discussion today, we focus on a penalty structure for submitters who (1) submit untimely data and (2) fail to submit data. Once data is submitted, submitters have 5 days upon notification to remediate errors with the office (under existing process). This penalty structure would also apply for the submission of inaccurate data.

Proposed Data Submission & Enforcement Process – Updated Based on Board Input

Data Due Date and Optional Extensions	
1.	Data due to the Office September 1.
2.	Optional extensions per request by the data submitter.
	Extension 1: A fifteen-day extension requested by the entity by the submission deadline that requires email status updates every 3 days including: • any issues or barriers the entity is experiencing • current projected submission date • progress toward completion • any need for technical assistance from the Office.
	Extension 2: An additional fifteen-day extension can be requested by the entity prior to the first extension ending, contingent upon the entity complying with the requirements of the first extension period. OHCA will require regular check-ins with the Office during this period with the same requirements as the first extension.

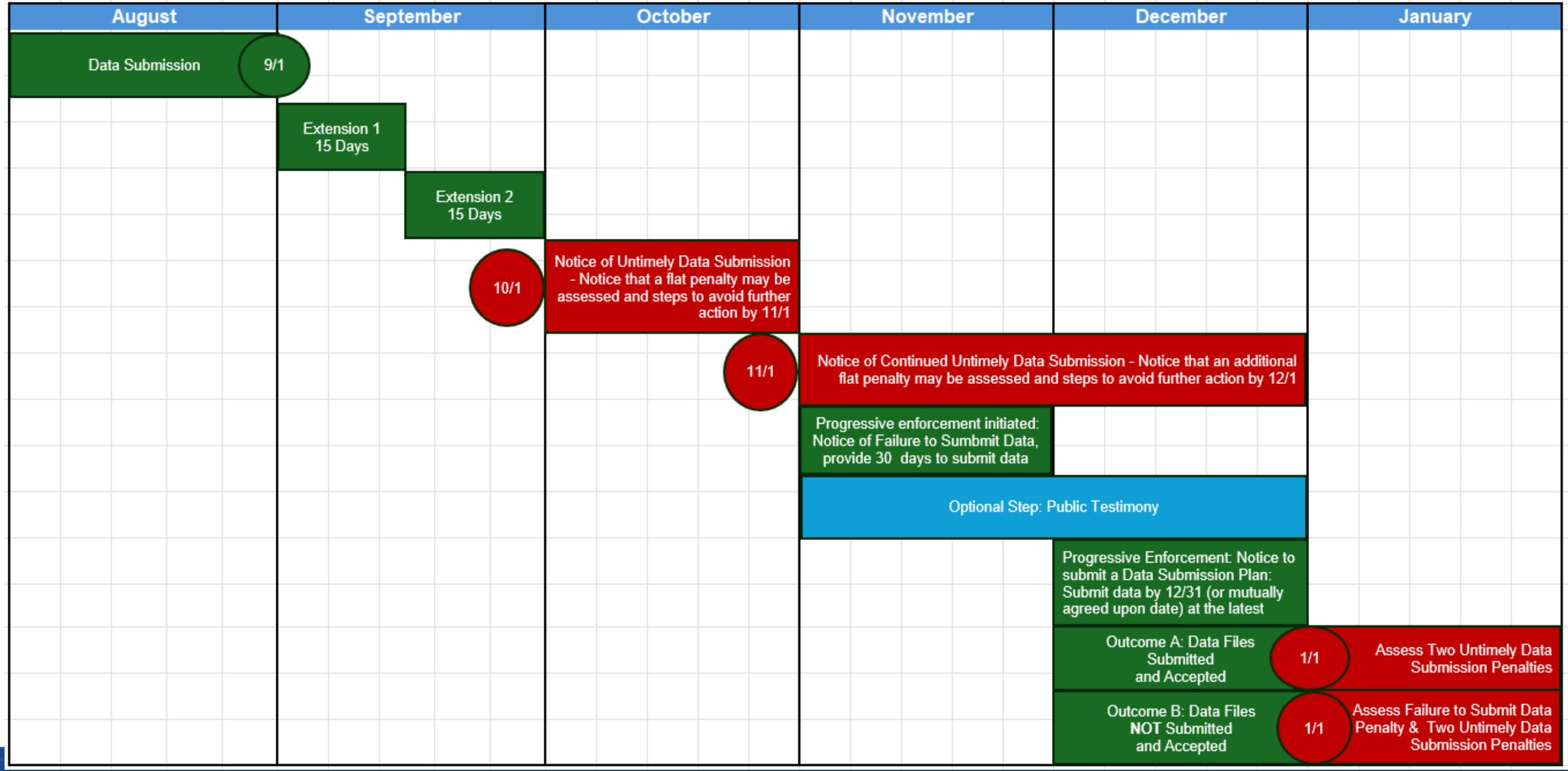
Proposed Data Submission & Enforcement Process – Updated Based on Board Input

Untimely Data Submission Penalties	
3.	If data has not been submitted by the submission deadline or end of one or both extension periods, submitters would be subject to an initial flat untimely data submission penalty of $10,000.
4.	If data are then not submitted by November 1, the submitter would be subject to an additional flat untimely data submission penalty of $10,000, and a progressive enforcement process which may result in a Failure to Submit Data Penalty.
Progressive Enforcement Process	
5.	If data is not submitted by November 1, progressive enforcement would begin on November 1 with a notice that the submitter has failed to submit data. The Office would provide technical assistance and allow up to 30 days for the submitter to submit data.
6.	Optional Step: The Office may compel public testimony.
7.	If data is not submitted at the end of the 30 days, the submitter would provide a data submission plan to the Office indicating the actions they will take to submit their data no later than December 31st or by a date agreed upon by the Office.

Proposed Data Submission & Enforcement Process – Updated Based on Board Input

Failure to Submit Data Penalty	
8.	If data is not submitted by December 31st or the agreed upon date, the entity would be subject to a per member failure to submit data penalty, in addition to the untimely data submission penalty.
9.	For data submitters that repeatedly fail to submit data, each year the failure to submit data penalty amount would double.($5/member year 1, $10/member year 2, $20/member year 3, etc.)
10.	OHCA will make public all penalties once formally assessed.
11.	OHCA could adjust the penalty amounts based on changes to an economic indicator, such as the California Consumer Price Index (CCPI).
Other Legal Remedies for failure to submit data	
12.	OHCA could continue to pursue other legal remedies in addition to penalties to acquire the submitter's data. The Office could take administrative action and could notify the licensing or regulatory agency of the entity's failure to comply with California law.

Scenario: Both Extensions



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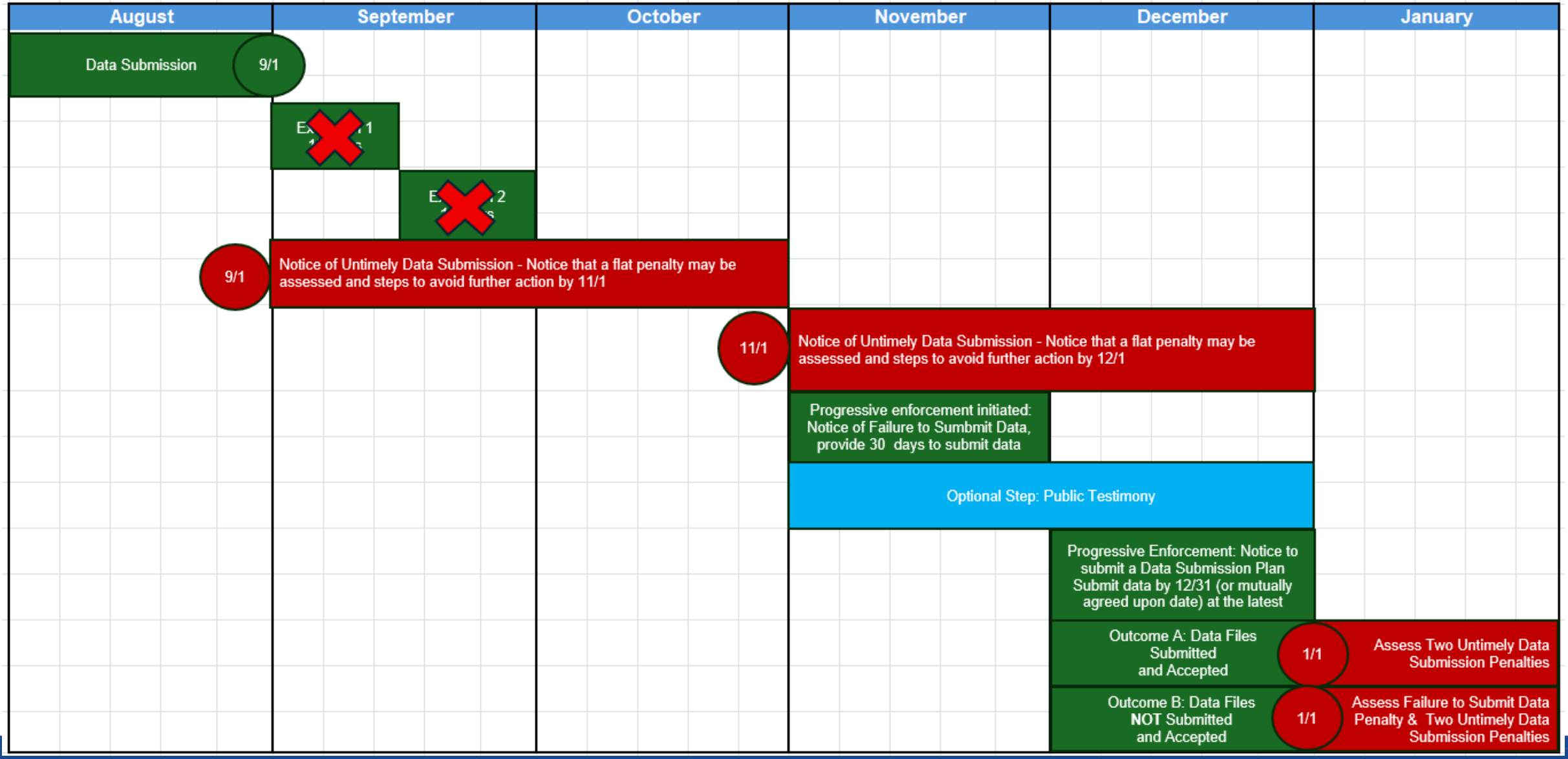
Scenario: No Extensions



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Examples of Penalty Amounts

Plan Info		Outcome A: Untimely Data Submission Penalties	Outcome B: Additional Untimely Data Submission Penalties	Outcome C: Failure to Submit Data Penalty			
Data Submitter	**Covered Lives (Includes all lines of business)**	**$10,000**	**$10,000 + $10,000**	**$0.50/member + $20,000**	**$2/member + $20,000**	**$5/member + $20,000**	**$10/member + $20,000**
Small	80,000	$10,000	$20,000	$40,000 + $20,000 = **$60,000**	$160,000 + $20,000 = **$180,000**	$410,00 + $20,000 = **$420,000**	$800,000 + $20,000 = **$820,000**
Medium	200,000	$10,000	$20,000	$100,000 + $20,000 = **$120,000**	$400,000 + $20,000 = **$420,000**	$1,000,000 + $20,000 = **$1,020,000**	$2,000,000 + $20,000 = **$2,020,000**
Large	2,500,000	$10,000	$20,000	$1,250,000 + $20,000 = **$1,270,000**	$5,000,000 + $20,000 = **$5,020,000**	$12,500,000 + $20,000 = **$12,520,000**	$25,000,000 + $20,000 = **$25,020,000**
Very Large	8,000,000	$10,000	$20,000	$4,000,000 + $20,000 = **$4,020,000**	$16,000,000 + $20,000 = **$16,020,000**	$40,000,000 + $20,000 = **$40,020,000**	$80,000,000 + $20,000 = **$80,020,000**

Note: This is an illustrative example meant to guide discussion and not a recommendation.

Discussion: Options for Penalty Structure and Amounts

Does the Advisory Committee have feedback on the Office's current proposal to:

- Establish two flat untimely data submission penalties ($10,000 each).
- Establish a $5 per member penalty for failure to submit data.
- Double the per member failure to submit data penalty in each subsequent non-compliant year.
- Adjust the penalty amounts based on changes to an economic indicator, such as the California Consumer Price Index (CCPI).

Discussion: Data Enforcement Steps and Process

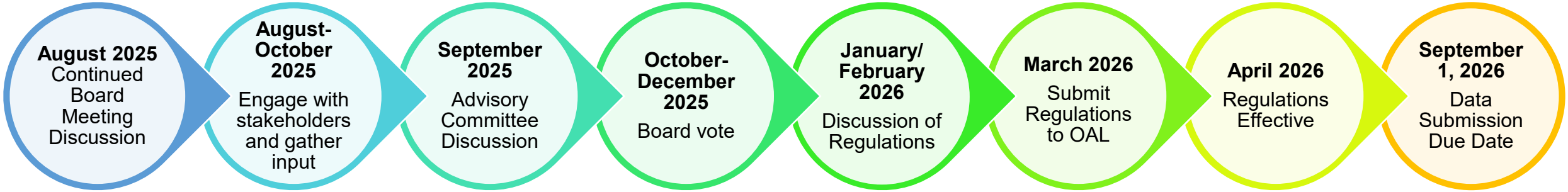
Does the Advisory Committee have feedback on the enforcement process? Specifically:

- The timing and duration of extensions
- The progressive enforcement steps (notice and technical assistance, optional public testimony, data submission plan, failure to submit data penalty)

Board Vote and Regulations Process

- The Board will vote on the scope and range of penalties (i.e., the penalty structure and amounts) October - December 2025.
- OHCA will draft regulations and begin the regulations process.
- If feedback received requires reconsideration on the scope and range of penalties, OHCA will return to the Board for more discussion and a potential vote.

Next Steps



Note: This timeline aligns with planned regulations for Data Submission Guide updates and other data submission regulations updates.

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Public Comment

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Spending Target Enforcement

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

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Timeline for Advisory Committee(AC) Discussion and Input to Board and Office

**Timeline subject to change.*

Statute - Board Responsibilities

Board

Approve:

(b) The board shall approve all of the following:

(2) The scope and range of administrative penalties and the penalty justification factors for assessing penalties.

Discuss:

(c) The director shall present to the board for discussion all of the following:…

(4) Review and input on performance improvement plans prior to approval, including delivery of periodic updates about compliance with performance improvement plans to inform any adjustment to the standards for imposing those plans.

(5) Review and input on administrative penalties to inform any adjustments to the scope and range of administrative penalties and the penalty justification for assessing penalties.

Statute

Office

Enforcement Considerations and Progressive Enforcement Processes:
(a) The director shall enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets, allows each health care entity opportunities for remediation, and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access, quality, equity, or workforce stability. The director shall consider each entity's contribution to cost growth in excess of the applicable target and any actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target. The director shall review information and other relevant data from additional sources, as appropriate, including data from the Health Care Payments Data Program, to determine the appropriate health care entity that may be subject to enforcement actions under this section. Commensurate with the health care entity's offense or violation, the director may take the following progressive enforcement actions:

(1) Provide technical assistance to the entity to assist it to come into compliance.

(2) Require or compel public testimony by the health care entity regarding its failure to comply with the target.

(3) Require submission and implementation of performance improvement plans, including input from the board.

(4) Assess administrative penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

Statute

Office

Notification and Communication:
(b) Prior to taking any enforcement action, the office shall do all of the following:

(1) Notify the health care entity that it has exceeded the health care cost target.

(2) Give the health care entity not less than 45 days to respond and provide additional data, including information in support of a waiver described in subdivision (i).

(3) If the office determines that the additional data and information meets the burden established by the office to explain all or a portion of the entity's cost growth in excess of the applicable target, the office may modify its findings, as appropriate.

(4) The director shall consult with the Director of Managed Health Care, the Director of Health Care Services, or the Insurance Commissioner, as applicable, prior to taking any of the enforcement actions specified in this section with respect to a payer regulated by the respective department to ensure any technical assistance, performance improvement plans, or other measures authorized by this section are consistent with laws applicable to regulating health care service plans, health insurers, or a Medi-Cal managed care plan contracted with the State Department of Health Care Services.

Statute

Office

Technical Assistance and Performance Improvement Plans:
(c) (1) If a health care entity exceeds an applicable cost target, the office shall notify the health care entity of their status and provide technical assistance. The office shall make public the extent to which the health care entity exceeded the target. The office may require a health care entity to submit and implement a performance improvement plan that identifies the causes for spending growth and shall include, but not be limited to, specific strategies, adjustments, and action steps the health care entity proposes to implement to improve spending performance during a specified time period. The office shall request further information, as needed, in order to approve a proposed performance improvement plan. The director may approve a performance improvement plan consistent with those areas requiring specific performance or correction for up to three years. 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. The standards developed under Article 7 (commencing with Section 127506) may be considered in the approval of a performance improvement plan.

(2) The office shall monitor the health care entity for compliance with the performance improvement plan. The office shall publicly post the identity of a health care entity implementing a performance improvement plan and, at a minimum, a detailed summary of the entity's compliance with the requirements of the performance improvement plan while the plan remains in effect and shall transmit an approved performance improvement plan to appropriate state regulators for the entity.

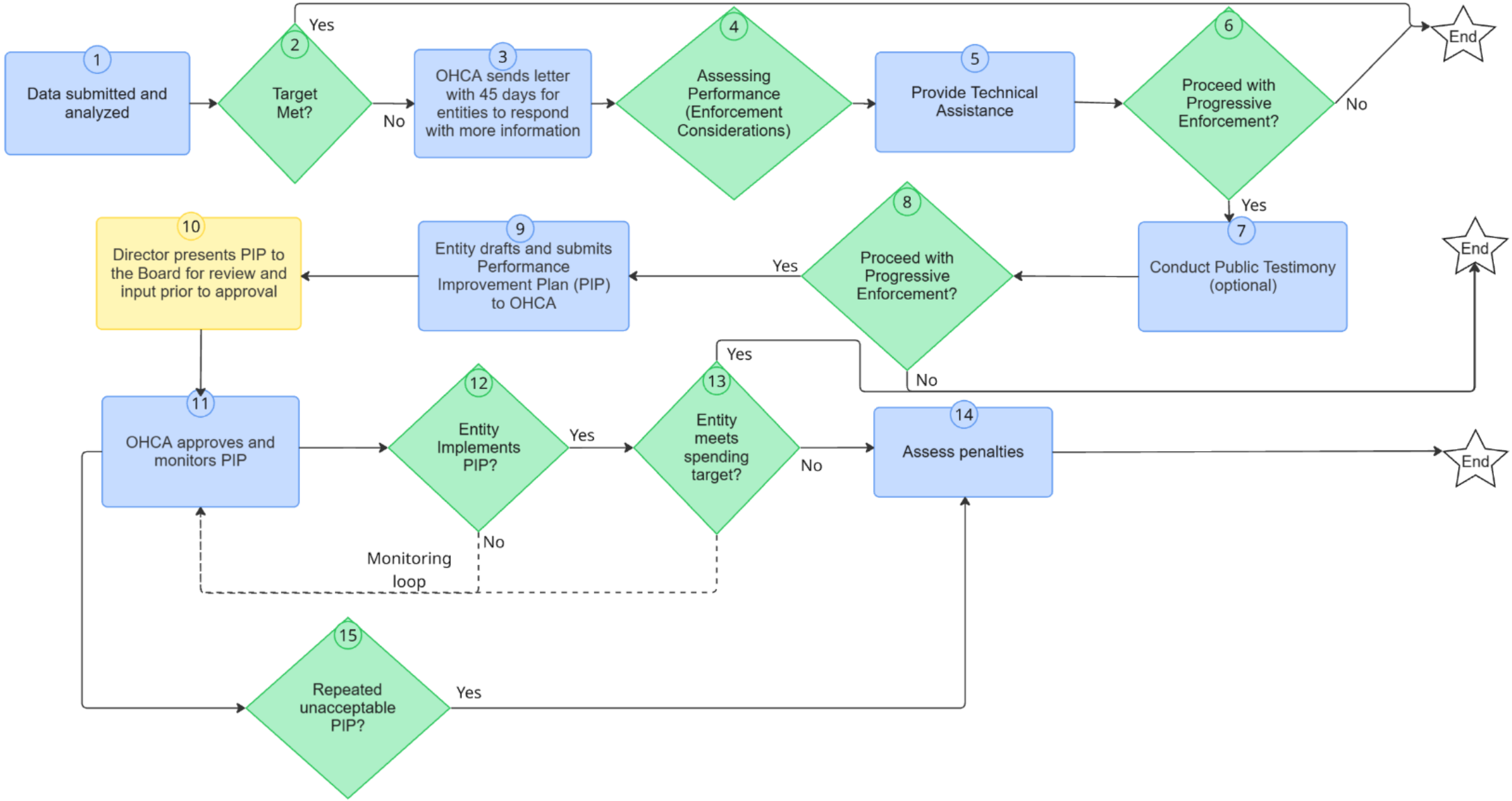
(3) A health care entity shall work to implement the performance improvement plan as submitted to, and approved by, the office. The office shall monitor the health care entity for compliance with the performance improvement plan.

Statute

Office

Optional Waiver of Enforcement:
(i) The office may establish requirements for health care entities to file for a waiver of enforcement actions due to reasonable factors outside the entity's control, such as changes in state or federal law or anticipated costs for investments and initiatives to minimize future costly care, such as increasing access to primary and preventive services, or under extraordinary circumstances, such as an act of God or catastrophic event. The entity shall submit documentation or supporting evidence of the reasonable factors, anticipated costs, or extraordinary circumstances. The office shall request further information, as needed, in order to approve or deny an application for a waiver.

Enforcement Process Flow



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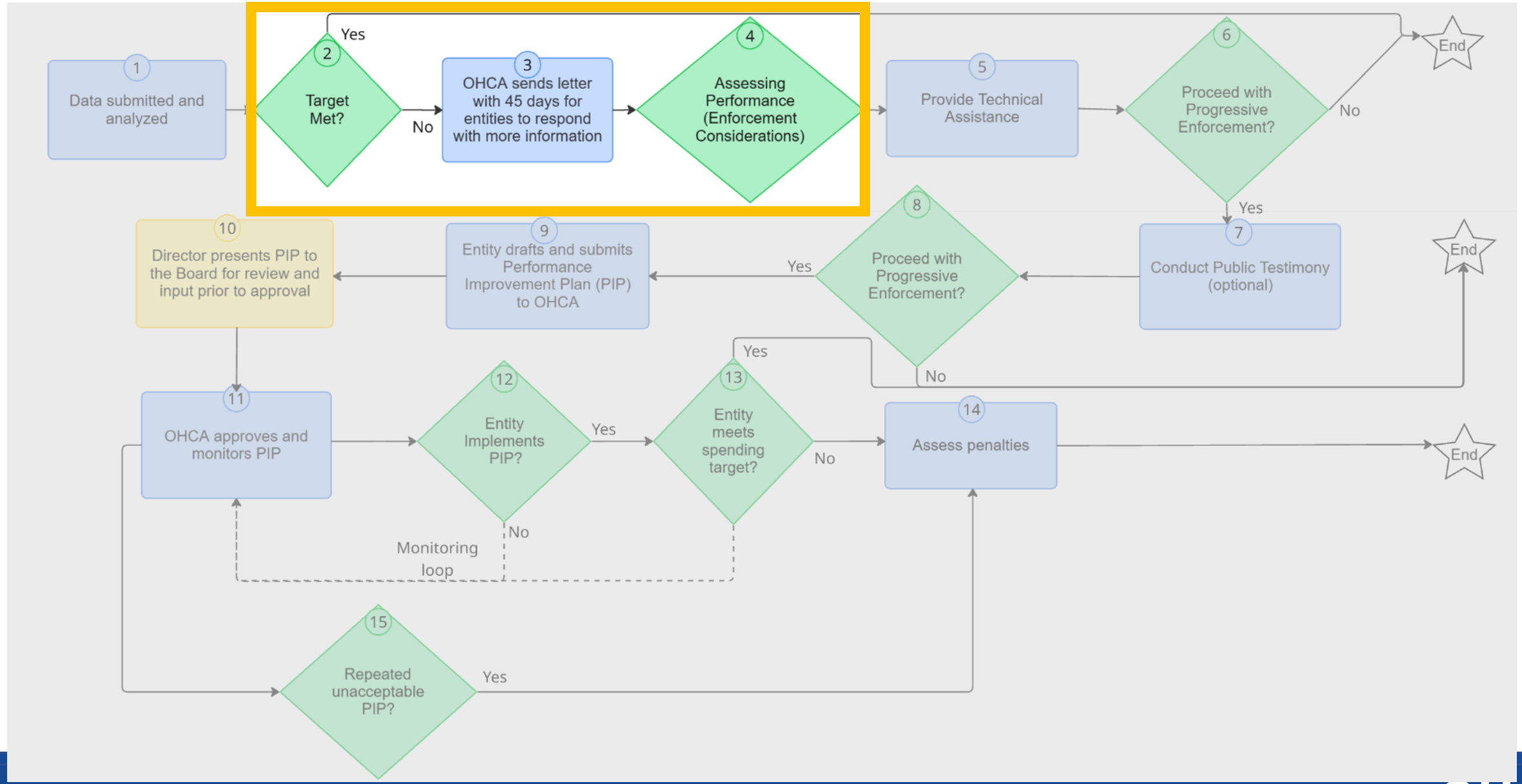
Enforcement Process Flow-Todays Discussion



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Overview: Enforcement Considerations

- OHCA will report entity-level spending growth to determine which entities exceeded the spending target.
- Per statute, if an entity exceeds a spending target, the Office will provide technical assistance to the entity.
- Enforcement Considerations are factors, characteristics, spending attributes, or other circumstances that OHCA could consider **when determining which entities would proceed beyond technical assistance** to public testimony, performance improvement plans, and/or financial penalties for a given year.
- These considerations will **NOT** change or modify an entity's reported performance or directly exempt or waive an entity from enforcement each year.
- These considerations will be explored for their validity with in-depth conversations with entities and supporting evidence provided by entities and evaluated by the Office.
- These considerations will likely not impact all entities uniformly, and in many cases cannot be forecasted and incorporated into the process and methodology to set spending targets.
- If the Office notices consistent effects across entities, the Office would present to the Board to inform prospective adjustments to spending targets.

Enforcement Considerations vs. Reasonable Factors

Enforcement Considerations	Reasonable Factors
Factors that OHCA can consider during progressive enforcement Under HSC Section 127502.5(a), the Director shall consider… • each entity's contribution to cost growth in excess of the applicable target and • any actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, • factors that contribute to spending in excess of the applicable target, and • the extent to which each entity has control over the applicable components of its cost target.	**Specific to a waiver of enforcement request** Under HSC Section 127501.5(i), the office **may** establish requirements for health care entities to file for a waiver of enforcement actions due to: • *reasonable factors* outside the entity's control, such as changes in state or federal law or • *anticipated costs* for investments and initiatives to minimize future costly care, such as increasing access to primary and preventive services or • under *extraordinary circumstances*, such as an act of God or catastrophic event. The entity shall submit documentation or supporting evidence of the reasonable factors, anticipated costs, or extraordinary circumstances. The office shall request further information, as needed, in order to approve or deny an application for a waiver.

Other States Processes

Massachusetts (Regulatory Factors)	Oregon (Reasonableness Factors)
• Baseline spending and spending trends over time, including by service category • Pricing patterns and trends over time • Utilization patterns and trends over time • Population(s) served, payer mix, product lines, and services provided • Size and market share • Financial condition, including administrative spending and cost structure • Ongoing strategies or investments to improve efficiency or reduce spending growth over time • Factors leading to increased costs that are outside the CHIA-identified Entity's control • Any other factors the Commission considers relevant.	• Changes in federal or state law • Changes in mandated benefits • New pharmaceuticals or treatments • Changes in taxes (or other admin) • "Acts of God" • Investments to improve health/ health equity • High-cost outliers • Increased behavioral health spending after state raised Medicaid rates • Longer inpatient stays because hospitals were unable to discharge patients to other facilities • Patients with more than $1 million in annual costs, especially for pediatric practices • Increased Medicaid non-claims spending, likely quality payments and COVID-related payments • Increased frontline workforce costs • Service expansions to meet community needs

Potential Enforcement Considerations

Population Characteristics
High-Cost Patient Outliers
Historical Spending Growth
Impact on Consumer Access and Affordability
Investments in Primary and Preventive Care
Entity Baseline Costs
High-Cost Drugs
Changes in State and Federal Law
Acts of God or Catastrophic Events

Potential Enforcement Considerations

Population Characteristics

- OHCA collects age/sex demographic data that allow it to factor the degree to which changes in spending may be driven by underlying changes in the age/sex composition of an entity's population.
- OHCA could consider the extent to which an entity's population age/sex distribution has changed year to year and contributed to changes in spending.
- Adjusting for changes in the age/sex composition may not always show a lower percentage change in an entity's spending growth.
- OHCA would still determine if an entity met the spending target using unadjusted data, but could use age/sex adjusted spending change to determine to what degree spending growth is the result of age/sex demographic changes.

Commercial Market Age/Sex Adjusted Data for Spending Growth From 2022-2023

Submitter Name	Aetna	Anthem Blue Cross	Blue Shield of CA	Centene / Health Net	Cigna	Kaiser	LA Care	Molina	Sharp	Sutter	UnitedHealthcare	Valley Health Plan	Western Health Advantage
Unadjusted Growth Rate	5.1%	5.5%	5.2%	3.9%	4.4%	4.3%	-0.2%	19.8%	4.1%	7.3%	6.5%	13.4%	5.5%
Age-sex Adjusted Growth Rate	5.1%	5.5%	5.5%	4.0%	4.2%	4.2%	0.0%	19.6%	4.0%	7.2%	6.3%	13.6%	5.5%

Potential Enforcement Considerations

High-Cost Patient Outliers

- The emergence of high-cost outliers has the potential to drive fluctuations in an entity's spending growth.
- After determining that an entity exceeded the spending target OHCA could work with the entity to determine the extent to which emergence of high-cost outliers caused the entity to exceed the spending target.
- In some cases, emergence of high-cost outliers may be outside the entity's control. Including this factor would enable OHCA to consider random or unexpected events that drove volatility in an entity's spending in a particular year.

Historical Spending Growth

- OHCA could evaluate an entity's longer term historical growth (e.g., OHCA could evaluate the average growth over several years, and/or could evaluate the number of years an entity has or has not met the spending target).
- Evaluating historical growth could focus OHCA's enforcement capacity on entities that have a consistent pattern of overspending.

Potential Enforcement Considerations

Impact on Consumer Access and Affordability

- The degree to which spending has adversely impacted consumer access to affordable care. This can include statewide and regional market share and impact.

Investments in Primary and Preventive Care

- OHCA could evaluate the degree to which increased spending or investments in primary and preventive care caused an entity to exceed the spending target.

Entity Baseline Costs

- Not all entities will begin operating under the spending target from comparable baseline costs.
- In addition to measuring and comparing the entity's percentage growth, OHCA could prioritize enforcement actions with entities that have inexplicably high costs and absolute high growth.

High-Cost Drugs

- New therapies and new uses of existing drugs may lead to unusually high spending growth due to increases in demand, cost, or availability. OHCA would need to evaluate the extent of control and any excessive mark-up behavior by entities when evaluating high-cost drugs as an enforcement consideration.

Potential Enforcement Considerations

Changes in State and Federal Law

- Entities may be affected by changes in state or federal law.
- State benefit changes or mandates, mandated wage increases, or federal tariffs may increase an entity's spending significantly.
- OHCA could consider the extent to which these changes impacted an entity’s spending growth.
- Sudden and unexpected changes in federal trade and fiscal policy could also impact the cost care.
- If the office sees a systematic effect that applies uniformly across the health care system or to sectors of the health care system, that information would be presented and considered for future spending target setting.

Acts of God or Catastrophic Events

- Acts of God and catastrophic events are unforeseeable, often caused by forces of nature and beyond human control.
- OHCA could assess the extent to which the event was foreseeable, or if the entity failed to take reasonable precautions to mitigate damage.
- OHCA could take into account acts of God and catastrophic events as contributing factors to an entity’s excess spending.

Discussion: Enforcement Considerations

Are there other considerations the Office should evaluate when assessing an entity's performance and determining whether further enforcement actions are warranted?

Summary of OHCA Engagement on High-Cost Drugs

OHCA Engagement on High-Cost Drugs

- OHCA met with 8 stakeholders (health plans, physician organizations, hospitals, consumer advocates) between May and July; one meeting remains in late-July.
- Discussions focused on high-cost drugs as a mitigating factor for exceeding the spending target. OHCA is trying to understand:
  - the extent of control over drug costs.
  - trends in high-cost drugs.
  - relationships between various entities in the workflow of purchasing and administering drugs.
  - feedback from entities on how to operationalize a mitigating factor for high-cost drugs.
- Focused primarily on physician-administered drugs (vs. retail pharmacy).

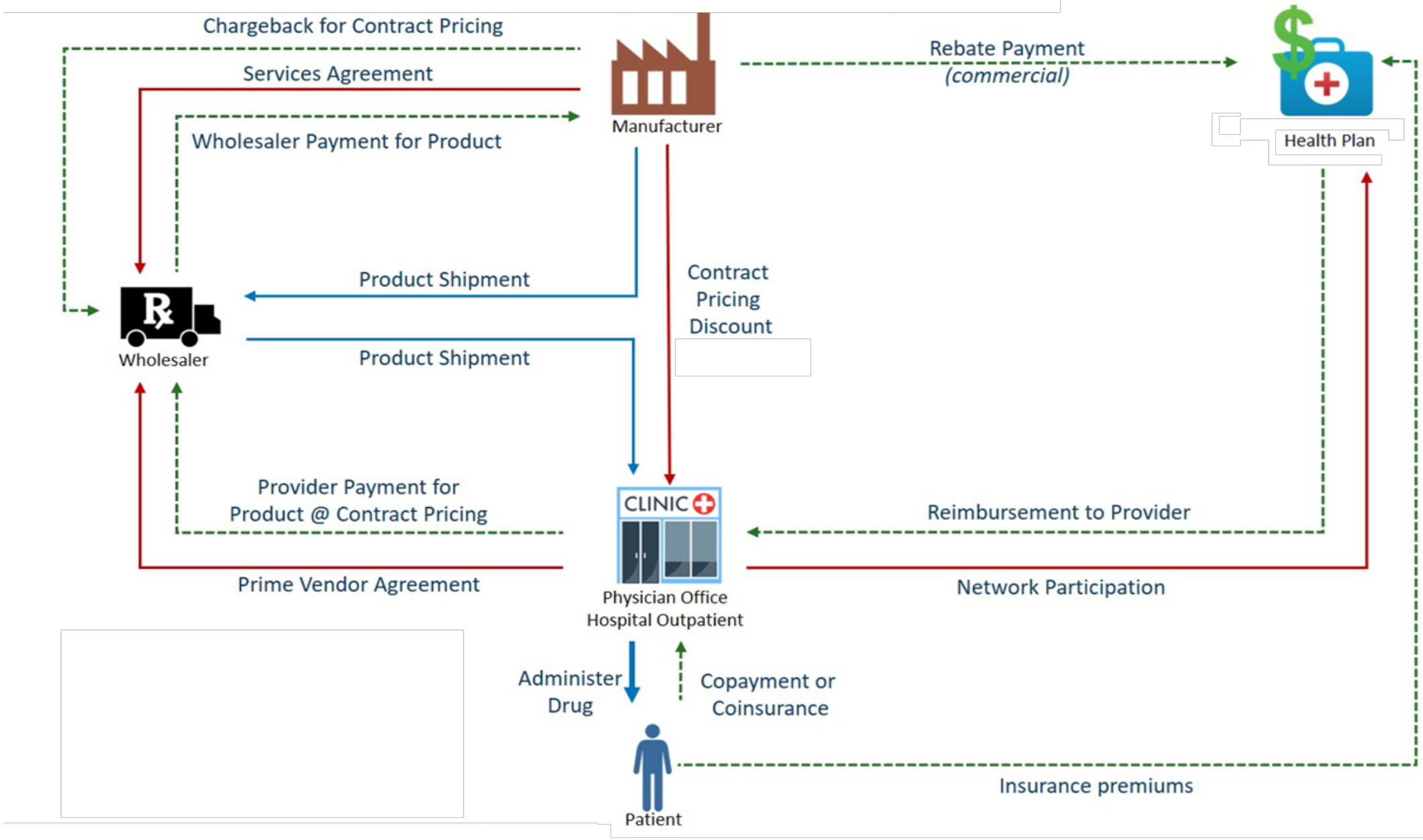
Retail vs Physician-Administered Drugs

There are significant price differences for the same drug depending on whether it is administered in a hospital outpatient department, inpatient department, physician's office, or purchased at a retail pharmacy.

Retail Drugs	Physician-Administered Drugs
• Purchased by patient at retail pharmacy. • Covered under pharmacy benefit of a health plan. • Includes oral medications, some injectables (like insulin), and other medications that can be self-administered.	• Usually purchased by physician's office or hospital and administered to patient. • Covered by the medical benefit of a health plan. • Includes infusions, injections, and medications administered in a clinical or hospital setting.

Stakeholder Roles

Health Plans	• Contract with Pharmacy Benefit Managers (PBMs) to manage drug benefits, including by categorizing drugs into tiers • Sometimes have choice in formulary design • Pay for drug costs and administration fees
Physician Organizations	• Prescribe medications and stay informed about new therapies • Administer physician-administered drugs • Monitor patient responses and manage potential drug interactions
Hospitals	• Obtain medications from licensed pharmaceutical wholesalers or group purchasing organizations • Manage inpatient and outpatient drug administration
Consumer Advocates	• Educate the public • Advocate for policy changes that make drugs more affordable and accessible • Support accountability for drug companies and health care entities



Fein, Adam J. (2021, October 26). Follow the Vial: The Buy-and-Bill System for Distributing and Reimbursing Provider-Administered Outpatient Drugs. https://www.drugchannels.net/2021/10/follow-vial-buy-and-bill-system-for.html

PBMs vs GPOs

Pharmacy Benefit Managers (PBMs)

- Emerged in the 1960s to manage prescription drug benefits for insurance companies, handling claims processing and reimbursement.

- **Current Trends**
  - **Formulary Management -** PBMs determine which drugs are covered by insurance plans and at what cost to the patient.
  - **Rebates and Pricing -** PBMs negotiate rebates with pharmaceutical companies, but the impact of these rebates on drug prices and patient costs is a subject of ongoing debate.
  - **Pharmacy Networks -** PBMs establish and manage networks of pharmacies that are covered under insurance plans, influencing patient access to medications.
  - **Vertical Integration -** Some PBMs have merged with or been acquired by insurance companies, pharmacies, or pharmaceutical companies, raising concerns about potential conflicts of interest and anticompetitive practices.
  - **Mail Order Drugs -** PBMs are increasingly involved in mail-order pharmacy operations, sometimes owning or partnering with mail-order pharmacies.

Group Purchasing Organizations (GPOs)

- Emerged in the early 20th century as a way for hospitals and other healthcare providers to pool their purchasing power to negotiate lower prices from suppliers.
- Leveraged buying power allows smaller entities to access the same discounts as larger organizations.

- **Current Trends**
  - GPOs have expanded their roles beyond just procurement, incorporating data analytics, logistics, and digital transformation strategies to improve supply chain efficiency.
  - GPOs have faced criticism for potentially limiting competition and choice, and for the complexity of their operations and financial structures.

Key Observations

- Health care entities all note limited ability to control drug costs.
- Anti-inflammatory, oncology, ophthalmic, diabetes and obesity drugs were identified as high-cost drugs driving spending.
- New therapies and new uses of existing high-cost drugs were also identified as key drivers of drug costs; however, the regular introduction of biosimilars and generics helps reduce cost growth.
- Changes in pharmacy benefit managers (PBM) and contracts are common and can result in changes to prices and formularies.
- The lack of transparency in pharmaceutical pricing means entities along the supply chain can increase costs and mark-ups.

Key Observations

- Suggestions to OHCA include:
  - Reference Oregon's model when developing OHCA's mitigating factor for high-cost drugs.
  - Reference data from the NASHP Hospital Cost Tool, like the cost-to-charge ratio
  - Use charge masters, encounter data, hospital pharmacy reports, high-cost drug carve outs from contracts, and 340B discount information to verify drug costs and trends.
  - Collect data on which drugs are highest cost and determine their impact on an entity's cost growth.
  - Evaluate the division of financial responsibility between a provider and a payer.
  - Examine any cost savings from PBMs.

Health Plans

Plans report that their influence over drug costs is limited and dependent upon contracts with pharmacy benefit managers (PBMs) and group purchasing organizations (GPOs).

Drug Cost Drivers	Cost Mitigation
• High-cost drugs like autoimmune, anti-inflammatory, rheumatoid arthritis, oncology, diabetes, and skin condition treatments • Increased utilization • New therapies	• Contracting with multiple PBMs • Developing creative group purchasing arrangements • Managing utilization via prior authorizations • Presenting cost information to prescriber and patient before prescription

Health Plans

- Plans noted they often carry financial risk for many injectable drugs due to requirements under Section 1375.8 of the Health and Safety Code (commonly referred to as Richman Bill). Under the Richman Bill, health plans cannot delegate risk for the following injectables unless there is negotiation with the capitated provider to assume that risk:
  - Injectable chemotherapeutic medications and injectable adjunct pharmaceutical therapies for side effects
  - Injectable medications or blood products used for hemophilia
  - Injectable medications related to transplant services
  - Adult vaccines
  - Self-injectable medications
  - Other injectable medication or medication in an implantable dosage form costing more than two hundred and fifty dollars ($250) per dose
- These negotiation results in varying configurations for financial risk between plans and providers, such as Full Richman carve out, chemotherapy risk only, or high-cost risk.

Health Plans

- Plans noted the following barriers to managing costs:
  - Changing PBMs for a better price can also lead to changes in formularies
  - Specialty drugs may have limited distribution channels through high-cost facilities
  - Manufacturer co-pay cards encourage patients to choose branded drugs
  - Allowing patient choice for drugs may lead to selection of high-cost brands
  - Hospital markups on drugs beyond the wholesale price
- Plans noted that Oregon's broad approach to high-cost drugs as a reasonable factor is a good model and suggested addition consideration of:
  - entry of new high-cost drugs
  - new uses or updated guidance about length of course or where they should be administered
  - increases in demand, cost, or availability

Physician Organizations

Physician organizations report that their influence over drug costs is limited and depends on negotiations with health plans for higher reimbursement payments.

Drug Cost Drivers	Cost Mitigation
• Oncology agents • Ophthalmic injections • New high-cost drugs • New uses of high-cost drugs • Tariffs on supplies and medications • Increased demand (new vaccines, aging baby boomers) • Lack of savings passed on to physicians from rebates • Inflation	• Negotiating with health plans to remove high-cost drugs from their division of financial responsibility • Utilizing health plans' drug protection plans • Internal cost-savings programs like encouraging the use of biosimilars, site-of-service redirection (from higher cost facilities to preferred sites) • Reference pricing (setting a maximum price for a group of similar drugs)

Physician Organizations

- **Retail benefit drugs:** Generally, physician organizations do not bear financial risk for retail drugs unless they are a part of a health system that has risk for some or all retail drugs.
- **Medical benefit drugs:** Financial risk for physician organizations can vary in their financial responsibility for office-based medications, vaccines, and outpatient medications delivered in outpatient facilities. Some have full risk for home infusion medications and inpatient medications.
- Many high-cost drugs are rolled into hospital claims that are billed under the medical benefit; these are not as easy to identify compared to retail pharmacy claims.
- A physician organization reported that when there is a material change in their drug costs (new market entrant, increase in utilization, other supply chain issues) that would result in a significant financial impact, they try to renegotiate their capitation rate to account for the change. An example is new vaccines. Others try to negotiate financial risk back to the health plan but may not be successful because of how plans treat/classify drugs.

Physician Organizations

- Physician organizations reported that a small number of high-cost drugs are responsible for outsized amounts of their cost growth and drug costs, matching trends seen elsewhere in the market.
    - For example, Keytruda has a cost of ~$200K per patient per year and has experienced a significant increase in usage as it had one second-line indication in 2024 and increased to 49 indications with multiple first-line indications and used in combo therapy with other high-cost medications. Usage is a among a small portion of members, but it represents an outsized share of total medical drug spend.
- Physician organizations suggested that OHCA exclude drugs from the cost target with new codes or a new first line treatment indication on claims, exclude a limited number of high-cost drugs with no cost-effective alternative, and potentially drill down to a subset of drug codes that could be compared year-over-year.

Hospitals

Hospitals report that their control over the cost of drugs is limited to what their GPO or PBM is able to negotiate for them, what they are reimbursed for by Medi-Cal and Medicare, and health plan formulary decisions.

Drug Cost Drivers	Cost Mitigation
• Oncology agents, specialty biologics (auto-immune, anti-inflammatory), cell and gene therapies (including CAR-T), as well as ophthalmic injections; expanded utilization (such as GLP1s being used for cardiovascular treatment)	• Switching GPOs to get better pricing but some noting that it is not easy • Negotiating to exclude high-cost drugs in contracts • Hospitals noted that some high-cost drugs mitigate overall spending -- curative medications like high-cost sickle cell disease drugs are one example.

Hospitals

- For critical access hospitals that bill by charges, they have to charge over 2x the average wholesale price of the drug to cover the cost of labor and supplies.
- One hospital noted that because they are paid per diem or capitation on the inpatient side, they don't get paid more for providing more services and/or drugs.
- A hospital noted that as an employer they looked at drug costs for their self-insured plan and noted savings opportunities, such as a dozen patients alone switching from Humira to biosimilars would save millions. To achieve broader savings, it would require prescriber and patient education and being able to obtain this data from their PBM.
- Some hospitals discourage/disallow white- or brown- bagging because they can provide all drug needs through their own pharmacies. This approach enables them to reduce delays for patients and minimize waste.

White-bagging: Drugs are shipped directly from specialty pharmacy to medical providers for administration.
Brown-bagging: Drugs are dispensed to patients, who then bring the drug to their medical provider for administration.

Hospitals

- One hospital noted that they are able to renegotiate their contracts with GPOs when there's been a material change – like new vaccines, new high-cost medications, etc.
- One hospital noted that treatments for some indications like cancer can change from year-to-year, impacting costs and potentially impacting performance against the targets.
- Hospitals suggested OHCA make cost adjustments for inflation, expensive and rare therapies, and whether hospitals opened any new services that are impacting drug spending. One hospital suggested that OHCA focus on the misuse of high-cost drugs rather than volume when considering high-cost drugs as a spending factor.
- Hospitals suggested the impact of high-cost drugs could be measured by: using drug revenue codes from claims to compare high-cost drugs year-over-year; evaluating evidence of changes in costs like a charge master or hospital pharmacy reports; and using encounter data submitted to health plans to tease out medical benefit pharmacy costs bundled in capitation payments.

Consumer Advocates

- Consumer advocates suggested that OHCA should look to the NASHP Hospital Cost Tool to reference what Medicare FFS reimburses for drugs and comparing how many times a hospital is charging over Medicare.
- Advocates noted that markups of drug costs are driving high spending. While some markup is understandable, they stated that markups 4-5 times of Medicare is unjustified. Markup behavior may be associated with the market power of the entity.
- Lastly, advocates said that health plans, especially those with a large national footprint, should have purchasing power to drive down drug costs.

Advisory Committee Discussion

Does the Advisory Committee have any initial feedback on inclusion of high-cost drugs as an enforcement consideration? Specifically:

- The size and impact of drugs on an entity exceeding the target. For example, some costly drugs are highly utilized (e.g., GLP-1s) while other drugs have relatively low utilization but have extraordinarily high launch prices (e.g., cell and gene therapies).
- Significant market changes: some changes increase costs such as new therapies while other changes lower costs, such as expiration of patents.
- Determining who to hold accountable in varying configurations of financial risk in HMO-based capitated, delegated arrangements.
- Excessive markup behavior by providers and purchasing power of payers.
- Data and information health care entities should submit to distinguish between controllable overspending and external cost pressures.

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Public Comment

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Department of Health Care Access and Information

Update on Behavioral Health Spending Definition and Measurement Methodology

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 and behavioral health.
- **Measure the percentage of total health care expenditures allocated to primary care and behavioral health** 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 primary care and behavioral health.
- Promote improved outcomes for primary care and behavioral health.

Update on Behavioral Health Investment Benchmark

- Board deferred setting benchmark this year.
- Will revisit in summer 2026, with additional data and experience to inform deliberations.
- Behavioral health spending data submitted to OHCA in September 2026 will be used only for measurement and reporting, not comparison to a benchmark, for at least one year.

Behavioral Health Spending Measurement

1. Schedule

- Payers will submit aggregate behavioral health spending data beginning in September 2026, covering the years 2024-2025.
- OHCA will release the first report on behavioral health spending, using this data, in the summer of 2027.

2. Data Submitters

- Payers and fully integrated delivery systems:
  - Commercial plans
  - Medicare Advantage plans
  - Medi-Cal managed care plans

Behavioral Health Spending Measurement

3. What Will Be Submitted

- Claims and non-claims payments for behavioral health care (as defined by OHCA).
  - Aggregated by performance year and market category.
  - Using the Expanded Non-Claims Payments Framework categories and subcategories for analysis and reporting.
- Detailed methodology will be included in the Data Submission Guide to be finalized spring 2026.

Mental Health and Substance Use Disorder Spending Analysis

Mental Health (MH) & Substance Use Disorder (SUD) Spending Analysis

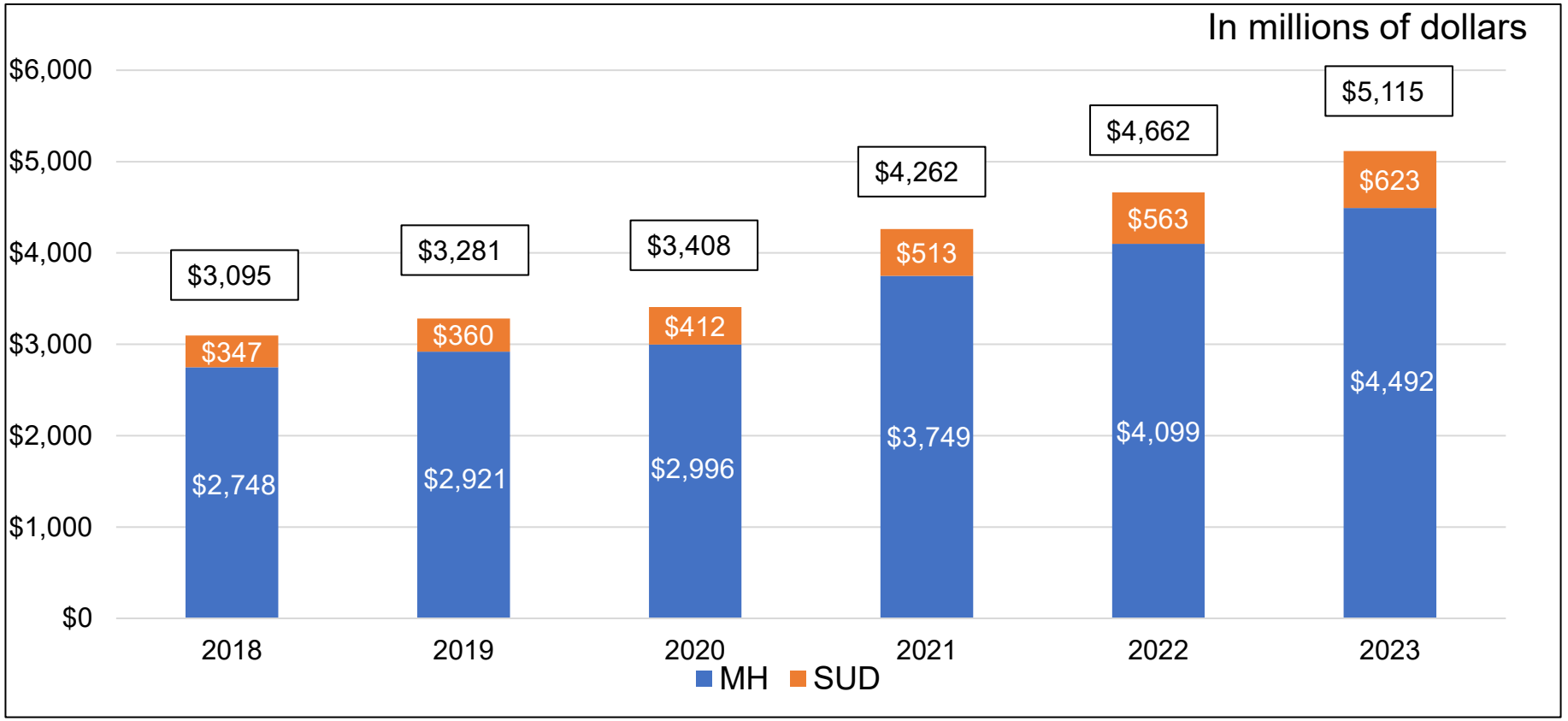
- **Purpose:** Compare mental health and substance use disorder spending for each service subcategory in commercial claims spending based on previous behavioral health spending analysis.
- **Background:** This analysis used data from the Health Care Payments Data Program (HPD) and applied the Milbank methodology for capturing behavioral health spend.
  - Claims are categorized as MH or SUD based on **primary** diagnosis code. Some claims may include both MH and SUD diagnosis codes.

Analysis of Commercial Behavioral Health Subcategories – Key Takeaways

- Commercial behavioral health spending increased about $2 billion (65 percent) from 2018 to 2023
- Spending for substance use disorder (SUD) services grew at a slightly faster rate than spending for mental health (MH) services
- MH services account for about 88% of commercial behavioral health spending, and 12% is for SUD services
- For mental health spending and commercial behavioral health spending overall, the outpatient professional (non-primary care), pharmacy, and inpatient facility subcategories account for the bulk of claims spending
- Most commercial spending for SUD services is in facilities: inpatient, residential, outpatient, and emergency departments

MH and SUD Components of Total Commercial BH Spend Change, 2018-2023

Total commercial behavioral health spend increased about 2 billion dollars from 2018 to 2023. MH spend increased ~63% and SUD spend increased ~80% from 2018 to 2023.



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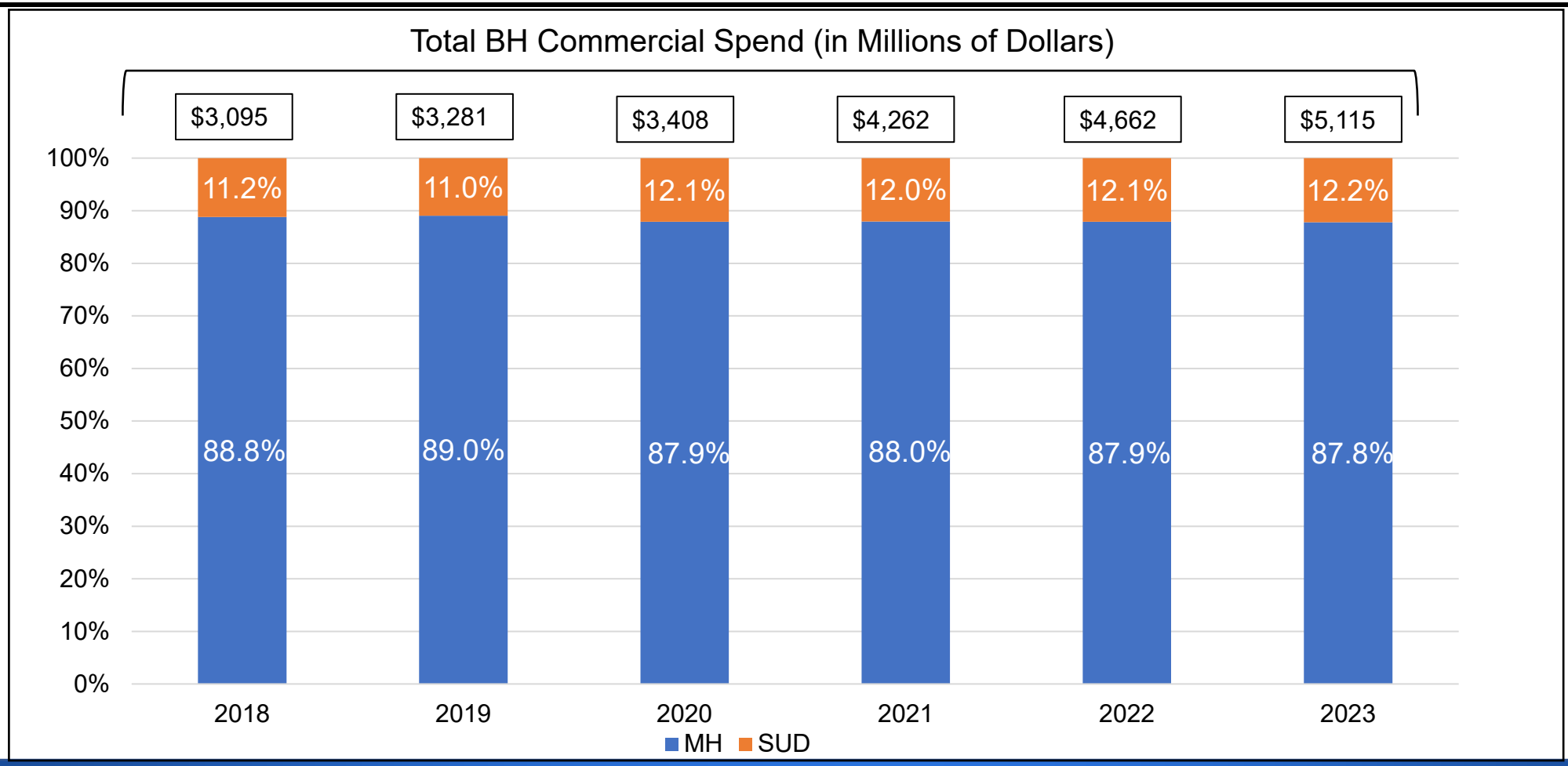
MH and SUD Percentage Distribution in the Commercial Market, 2018-2023

The MH and SUD shares of total commercial behavioral health spend remained fairly stable, with the SUD share of spending increasing by one percentage point from 2018 to 2023.



Percent MH Spend = Total MH Spend / Total Behavioral Health Spend
Percent SUD Spend = Total SUD Spend / Total Behavioral Health Spend

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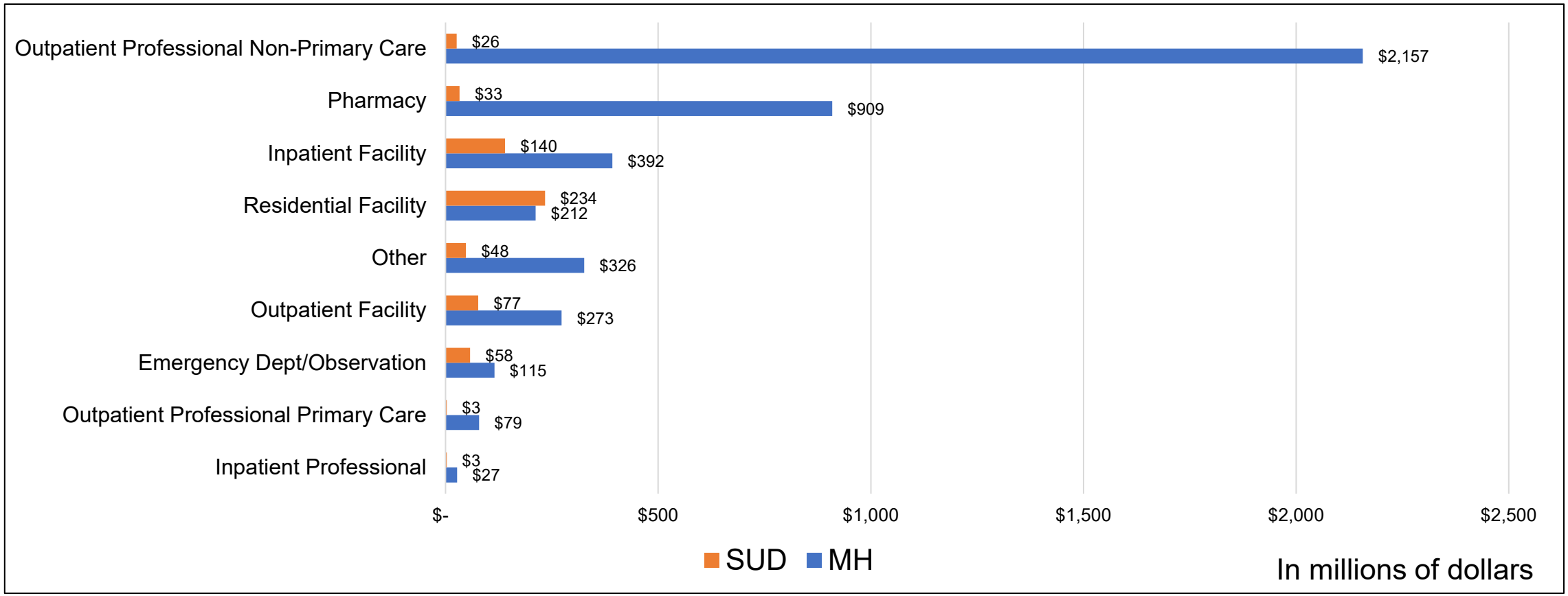
2023 MH and SUD Spend (in Millions of Dollars) in the Commercial Market by Service Subcategory

In 2023, the largest share of commercial MH spend was in Outpatient Professional Non-Primary Care and Pharmacy. The largest share of SUD spend was in Residential Facility.



Note: Subcategories do not sum to the total behavioral health figures in prior slides because the Mobile Services and Long-Term Care subcategories, for which spend was negligible in 2023, are excluded.

Proposed Behavioral Health Spending Definition and Measurement Methodology

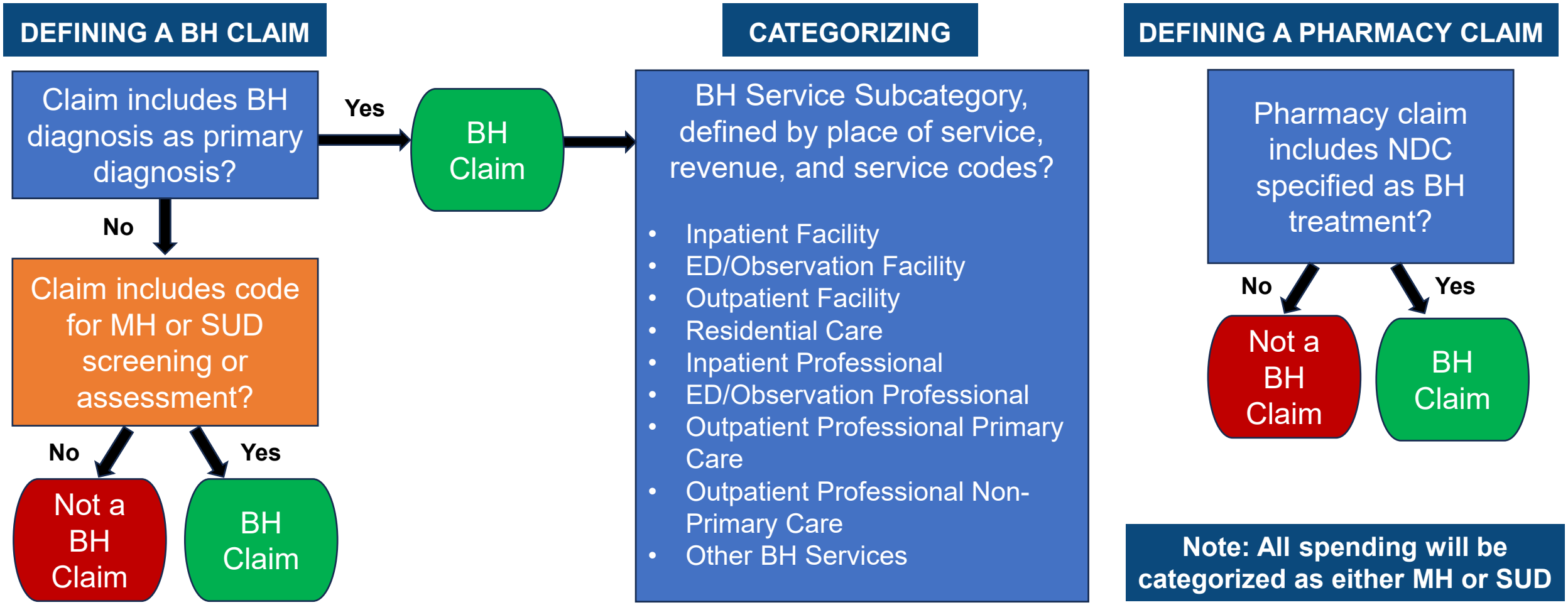
Three Recommended Modules for Behavioral Health Spending Measurement

OHCA proposes to use three modules to measure behavioral health spending, following the approach for measuring primary care spending. Behavioral health in primary care will be measured separately so it can be included in analyses of behavioral health or primary care 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.

Process Map for Identifying Behavioral Health (BH) Claims



Proposed Behavioral Health Reporting Categories

Reporting Categories	Service Subcategories
Outpatient/Community Based	Outpatient Professional Primary Care
	Outpatient Professional Non-Primary Care
	Outpatient Facility
Emergency Department	Emergency Department / Observation; Facility
	Emergency Department / Observation; Professional
Inpatient	Inpatient; Facility
	Inpatient; Professional
Residential	Residential Care
Other†	Other Behavioral Health Services
Pharmacy	Mental Health (MH) Prescription Drug Treatments Substance Use Disorder (SUD) Prescription Drug Treatments

†All spending for claims with a primary behavioral health diagnosis is included (i.e., spending not in other subcategories goes to "Other").

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.

Overview of Recommended Non-claims Behavioral Health Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Spending
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	Include payments to behavioral health providers and provider organizations for care management/coordination and for integration with primary care or social care.
A2	Primary care and behavioral health integration*	
A3	Social care integration	
A4	Practice transformation payments	Limit the portion of practice transformation and IT infrastructure payments allocated to behavioral health spending to the proportion of total claims and capitation payments going to behavioral health.
A5	EHR/HIT infrastructure and other data analytics payments	
B	**Performance Payments**	
B1	Retrospective/prospective incentive payments: pay-for-reporting	Include performance incentives in recognition of reporting, quality, and outcomes made to behavioral health providers.
B2	Retrospective/prospective incentive payments: pay-for-performance	

*May be paid to primary care or multi-specialty provider organizations for this purpose.

Overview of Recommended Non-claims Behavioral Health Care Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Care Spending
C	**Payments with Shared Savings and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	Not Applicable
C2	Procedure-related, episode-based payments with risk of recoupments	
C3	Condition-related, episode-based payments with shared savings	Include spending for service bundles for a behavioral health-related episode of care.
C4	Condition-related, episode-based payments with risk of recoupments	
C5	Risk for total cost of care (e.g., ACO) with shared savings	Not Applicable
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	

Overview of Recommended Non-claims Behavioral Health Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Care Spending
D	**Capitation and Full Risk Payments**	
D1	Primary Care capitation	Not Applicable
D2	Professional capitation	Calculate a fee-for-service equivalent based on a fee schedule for behavioral health services multiplied by the number of encounters.
D3	Facility capitation	Not Applicable
D4	Behavioral Health capitation	Allocate full behavioral health care capitation amount to behavioral health care spending.
D5	Global capitation	Calculate a fee-for-service equivalent based on a fee schedule for behavioral health services multiplied by the number of encounters.
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	
E	Other Non-Claims Payments	Limit the portion of other non-claims payments* allocated to behavioral health spending to the proportion of total claims and capitation payments going to behavioral health.
F	Pharmacy Rebates	Not Applicable

*May include retroactive denials, overpayments, payments made as the result of an audit, or other payments that cannot be categorized elsewhere.

Measuring Behavioral Health in Primary Care

To promote policy priorities, such as promoting integrated behavioral health and primary care and greater attention to preventive behavioral health care, OHCA proposes to measure behavioral health in primary care two ways:

1. Behavioral health data in OHCA's Total Health Care Expenditure (THCE) data collection
2. Behavioral health data in the Health Care Payments Database (HPD)

Utilizing both data sources will allow OHCA to optimize its ability to understand this critical component of spending while minimizing data submitter burden.

Behavioral Health in Primary Care Module: Proposed Approach

1. **Short term** (2026 Data Collection): Capture a portion of behavioral health in primary care spending in OHCA's THCE data collection

2. **Longer term:** Analyze HPD data to measure integrated behavioral health provided by behavioral health clinicians with methodological nuance
   - Expanded taxonomies, integrated psychotherapy and other services, etc.
   - Refine methodology for future THCE data collection, perhaps in concert with benchmark development

Calculating Behavioral Health and Primary Care Spend Without Double Counting

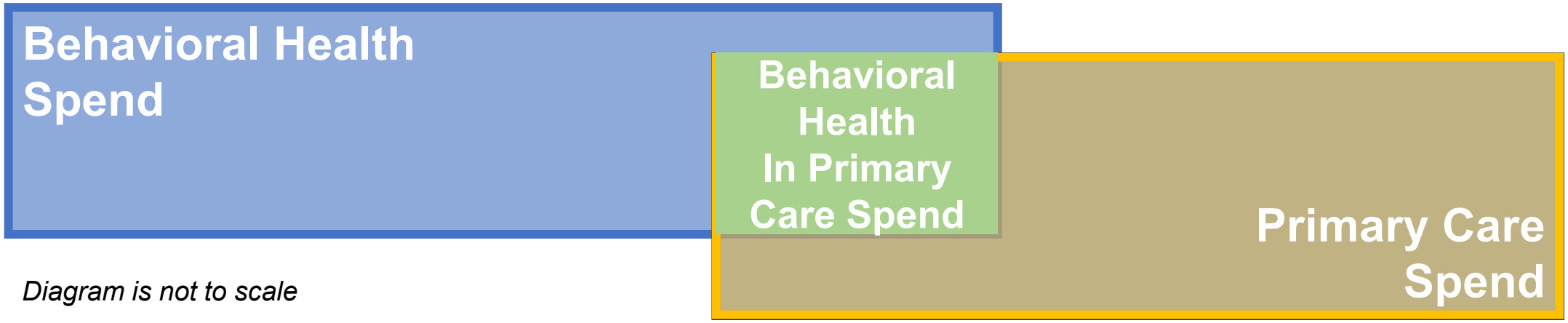


Diagram is not to scale

$$\text{Combined Primary Care and Behavioral Health Spend} = \left(\text{Primary Care Spend} + \text{Behavioral Health Spend}\right) - \text{Behavioral Health in Primary Care Spend}$$

Spending Included in the Behavioral Health in Primary Care Module

Payment Type	Spending Included
Claims	Outpatient Professional Primary Care subcategory • Existing set of primary care provider taxonomies, places of service • Service list includes screening and assessment, Collaborative Care Model and other integrated behavioral health codes
Non-Claims	Primary Care and Behavioral Health Integration payments (subcategory A2)

Behavioral Health Spending Definition and Measurement Methodology: Review of Public Comment

Sources of Public Comments

OHCA received comments on the proposed behavioral health spending definition, measurement methodology, and code set from several types of organizations:

- Consumer advocates and organizations representing specific population groups (5 organizations*)
- Provider organizations (3)
- Quality organization (1)
- Payer organization (1)
- Labor union (1)

*Five organizations submitted a joint comment letter

Measurement Methodology

Feedback (number of comments)	OHCA Response
Diagnoses • Support for using diagnosis codes rather than taxonomy to identify behavioral health claims (1) • The use of primary diagnosis is too restrictive and the definition should include claims with secondary behavioral health diagnoses or other ways to capture all behavioral health services (3) • Include G codes as well as F codes associated with Alzheimer's Disease and Dementia in code set (G codes are more likely to be used under capitation) (1)	• Including all spend on claims with a secondary behavioral health diagnosis would result in significant overcounting of medical spend • Including behavioral health spend for claims with a secondary diagnosis would also result in data submitter burden • OHCA will evaluate inclusion of G codes, including codes' overlap with the relevant HEDIS MY24 value sets
Services • Use specific procedure and service codes to identify a behavioral health claim in absence of primary diagnosis, in addition to screening and assessment (1)	• Expanding the list of services that do not require a primary behavioral health diagnosis will add data submitter burden and increase the risk of overcounting

Measurement Methodology

Feedback (number of comments)	OHCA Response
• Incorporate encounter data into methodology (1)	• Encounter data is used in the non-claims methodology to allocate portions of capitation payments to behavioral health.
• Include partial hospitalization, long-term care, intensive community treatment place of service codes (2)	• OHCA's definition does not limit measurement by place of service. Place of service codes for these facilities are included in service categorization.
• Include mobile clinic services as a subcategory, to encourage this type of care (1)	• OHCA will continue to monitor spending in this category using the Health Care Payments Database (HPD) and is open to including it in the future.
• Collect Medi-Cal data, including county behavioral health services claims, as soon as possible (2)	• OHCA is working with DHCS collect both Managed Care Plan and County behavioral health spending.
• Include paraprofessional providers included in Children and Youth Behavioral Health Initiative (CYBHI) fee schedule (1)	• Provider type is not part of OHCA's definition, so services meeting the diagnosis requirement will be included.

Behavioral Health in Primary Care Module

Feedback (number of comments)	OHCA Response
• General support for the module overall	
• Support for expanding the primary care provider taxonomy list to capture additional integrated behavioral health in primary care spend (1) • Oppose expansion of the list because of potential overcounting of non-integrated care and impact on primary care spend measurement (2)	• OHCA appreciates the potential impact of overcounting non-integrated spend and will use the Health Care Payments Database (HPD) to analyze options for an expanded module in the future • OHCA proposes keeping the module with the original (unexpanded) primary care taxonomies
• To avoid double-counting, count screening and referrals as primary care only and complex diagnoses and treatments as behavioral health (1)	• The module counts these services as both primary care and behavioral health; the modular format allows them to be included or excluded from each

Behavioral Health Investment Benchmark

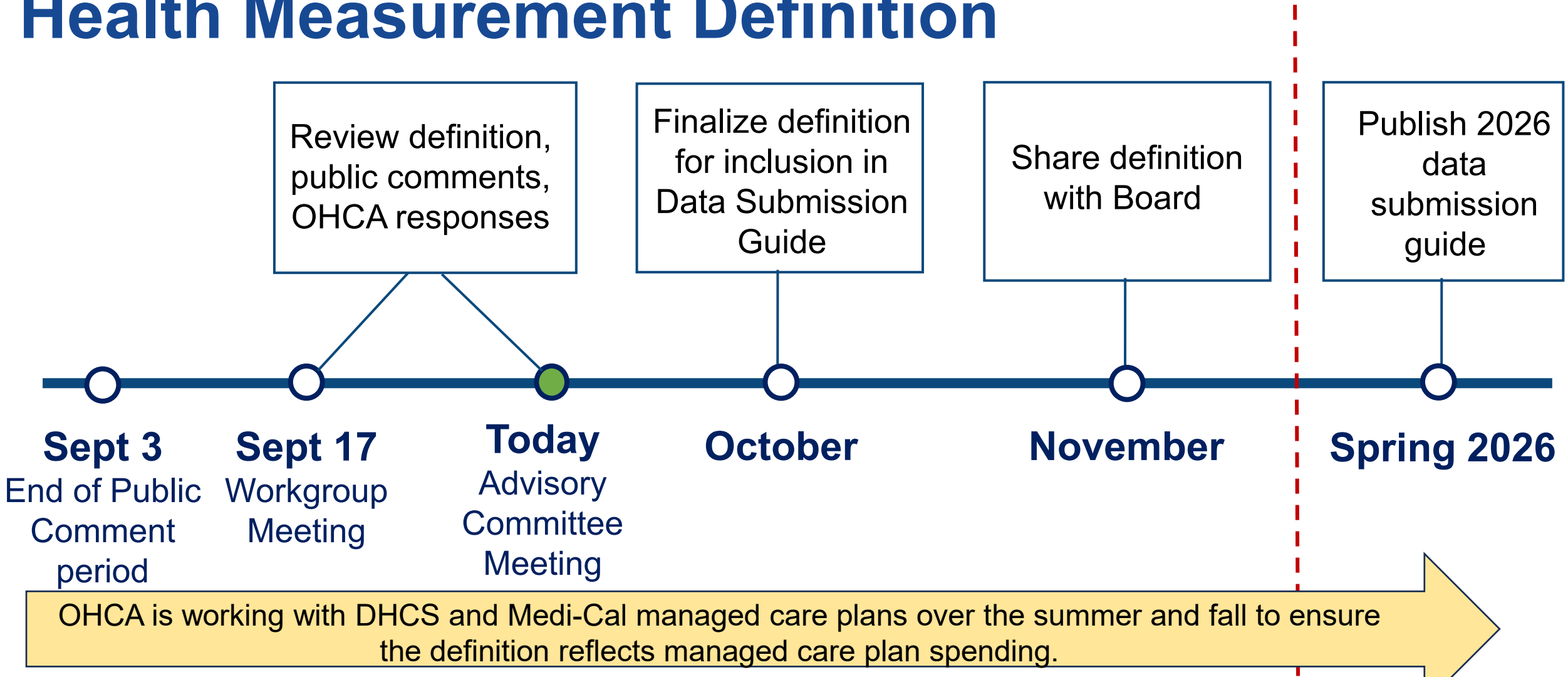
Feedback (number of comments)	OHCA Response
• Commenters support delay in setting a benchmark (2) • Urge timely action in filling data gaps to inform the benchmark (2)	• OHCA is planning extensive analysis over the next several months, with the intention to propose a benchmark to the Board in Summer 2026.
• Benchmark should encourage investment across the full continuum of care, rather than focus on outpatient and community-based care (1)	• Stakeholders strongly supported an outpatient-focused benchmark in 2025 • Once additional analyses are completed, OHCA will share findings to inform future discussions with stakeholders on the focus on the benchmark

Supplemental Analyses

Some comments went beyond the specifics of OHCA's proposed behavioral health definition and measurement methodology. These suggestions are more appropriately addressed as part of supplemental analyses or research studies. OHCA will evaluate these suggestions along with its other planned analyses of HPD data.

Feedback
• Quickly adopt a plan and timeline for an alternative approach to measuring out-of-plan, out-of-pocket spending for behavioral health care
• Assess spending and utilization using Z codes, including for social determinants of health
• Document preventive and treatment services in various settings to assess access
• Measure spending against unmet needs and desired outcomes
• Measure cost savings associated with modalities of care
• Evaluate payment rates for non-physician professionals

Detailed Timeline for Finalizing Behavioral Health Measurement Definition



Behavioral Health Spending Definition and Measurement Methodology

Does the Advisory Committee have any additional feedback on the behavioral health definition and measurement methodology?

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

General Public Comment

Written public comment can be emailed to:
ohca@hcai.ca.gov
To ensure that written public comment is included in the posted board materials, e-mail your comments at least 3 business days prior to the meeting.

HCAI
Department of Health Care Access and Information

Next Advisory Committee Meeting:

January 14, 2026

10am

Location:

2020 West El Camino Ave, Conference Room 900, Sacramento, CA 95833

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Adjournment

HCAI

Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Appendix

HCAI

Department of Health Care Access and Information

Additional Spending Target Enforcement Statutory Provisions

Statute

Office

Confidential Information:

(c)(4) The board, the members of the board, the office, the department, and employees, contractors, and advisors of the office and the department shall keep confidential all nonpublic information and documents obtained under this subdivision, and shall not disclose the confidential information or documents to any person, other than the Attorney General, without the consent of the source of the information or documents, except in an administrative penalty action, or a public meeting under this section if the office believes that disclosure should be made in the public interest after taking into account any privacy, trade secret, or anticompetitive considerations. Prior to disclosure in a public meeting, the office shall notify the relevant party and provide the source of nonpublic information an opportunity to specify facts documenting why release of the information is damaging or prejudicial to the source of the information and why the public interest is served in withholding the information. Information that is otherwise publicly available, or that has not been confidentially maintained by the source, shall not be considered nonpublic information. This paragraph does not limit the board's discussion of nonpublic information during closed sessions of board meetings.

(5) Notwithstanding any other law, all nonpublic information and documents obtained under this subdivision shall not be required to be disclosed pursuant to the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records.

Statute

Office

Administrative Penalties:
(d) (1) If the director determines that a health care entity is not compliant with an approved performance improvement plan and does not meet the cost target, the director may assess administrative penalties commensurate with the failure of the health care entity to meet the target. An entity that has fully complied with an approved performance improvement plan by the deadline established by the office shall not be assessed administrative penalties. However, the director may require a modification to the performance improvement plan until the cost target is met.

(2) The administrative penalty shall be deposited into the Health Care Affordability Fund.

(3) Prior to assessing an administrative penalty against a health care entity, the director may consider related provision of nonfederal share, determined to be appropriate by the Director of Health Care Services, associated with Medi-Cal payments, such as expenditures by providers or provider-affiliated entities that serve as the nonfederal share associated with Medi-Cal reimbursement.

(4) To the extent that an administrative penalty is related to a Medi-Cal expenditure, including federal financial participation, the office shall coordinate with the State Department of Health Care Services to ensure appropriate treatment and return of any federal funds pursuant to Subpart F commencing with Section 433.300 of Part 433 of Title 42 of the Code of Federal Regulations.

(5) If, after the implementation of one or more performance improvement plans, the health care entity is repeatedly noncompliant with the performance improvement plan, the director may assess escalating administrative penalties that exceed the penalties imposed under paragraphs (1) and (2) of this subdivision and paragraph (4) of subdivision (a).

Statute

Office

Administrative Penalies:
(d)(6) The director shall consider all of the following to determine the penalty:

(A) The nature, number, and gravity of the offenses.

(B) The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity.

(C) The market impact of the entity.

(e) Administrative penalties shall not constitute expenditures for the purpose of meeting cost targets. The imposition of administrative penalties shall not alter or otherwise relieve the health care entity of the obligation to meet a previously established cost target or a cost target for subsequent years.

Statute

Office

Payers, Fully Integrated Delivery Systems, and Adverse Impacts:
(f) (1) For payers and fully integrated delivery systems, the director also shall enforce cost targets established by Section 127502 against the cost growth for administrative costs and profits.

(2) If a payer exceeds the target for per capita growth in total health care expenditures, but has met its target for administrative costs and profits, the payer shall submit relevant documentation or supporting evidence for the drivers of excess cost growth.

(3) This subdivision does not relieve a payer of its obligation to meet targets for per capita growth in total health care expenditures established by Section 127502, and does not limit enforcement actions for payers under this section.

(g) If data indicate adverse impacts on cost, access, quality, equity, or workforce stability from consolidation, market power, or other market failures, the director may, at any point, require that a cost and market impact review be performed on a health care entity, consistent with Section 127507.2.

Statute

Office

Directly Assessing Administrative Penalties:
(h) (1) The director may directly assess administrative penalties when a health care entity has failed to comply with this chapter by doing any of the following:

(A) Willfully failing to report complete and accurate data.

(B) Repeatedly neglecting to file a performance improvement plan with the office.

(C) Repeatedly failing to file an acceptable performance improvement plan with the office.

(D) Repeatedly failing to implement the performance improvement plan.

(E) Knowingly failing to provide information required by this section to the office.

(F) Knowingly falsifying information required by this section.

(2) The director may call a public meeting to notify the public about the health care entity's violation and declare the entity as imperiling the state's ability to monitor and control health care cost growth.

Statute

Office

Remedies and Rights:
(j) As applied to the administrative penalties for acts in violation of this chapter, the remedies provided by this section and by any other law are not exclusive and may be sought and employed in any combination to enforce this chapter.

(k) Following an administrative hearing, a health care entity adversely affected by a final order imposing an administrative penalty authorized by this chapter may seek independent judicial review by filing a petition for a writ of mandate in accordance with Section 1094.5 of the Code of Civil Procedure.

(l) After an order imposing an administrative penalty becomes final, and if a petition for a writ of mandate has not been filed within the time limits prescribed in Section 11523 of the Government Code, the office may apply to the clerk of the appropriate court for a judgment in the amount of the administrative penalty. The application, which shall include a certified copy of the final order of the administrative hearing officer, shall constitute a sufficient showing to warrant the issuance of the judgment. The court clerk shall enter the judgment immediately in conformity with the application. The judgment so entered has the same force and effect as, and is subject to all the provisions of law relating to, a judgment in a civil action, and may be enforced in the same manner as any other judgment of the court in which it is entered.

Statute- Health Care Affordability Fund

127501.8. (a) There is hereby established in the State Treasury the Health Care Affordability Fund for the purpose of receiving and expending revenues collected pursuant to this chapter. This fund is subject to appropriation by the Legislature.

(b) All moneys in the fund shall be expended in a manner that prioritizes the return of the moneys to consumers and purchasers.

(c) The office may identify any opportunities to leverage existing public and private financial resources to provide technical assistance to health care entities and support to the office. Any private or public moneys obtained may be placed in the Health Care Affordability Fund, for use by the office upon appropriation by the Legislature.

Statute

127502.5. (k) Following an administrative hearing, a health care entity adversely affected by a final order imposing an administrative penalty authorized by this chapter may seek independent judicial review by filing a petition for a writ of mandate in accordance with Section 1094.5 of the Code of Civil Procedure.

(l) After an order imposing an administrative penalty becomes final, and if a petition for a writ of mandate has not been filed within the time limits prescribed in Section 11523 of the Government Code, the office may apply to the clerk of the appropriate court for a judgment in the amount of the administrative penalty. The application, which shall include a certified copy of the final order of the administrative hearing officer, shall constitute a sufficient showing to warrant the issuance of the judgment. The court clerk shall enter the judgment immediately in conformity with the application. The judgment so entered has the same force and effect as, and is subject to all the provisions of law relating to, a judgment in a civil action, and may be enforced in the same manner as any other judgment of the court in which it is entered.

Behavioral Health Spending Measurement Methodology

Equation for Allocating Practice Transformation, EHR/HIT, and Other Non-Claims Payments to Behavioral Health

$$\text{Subcategory A4 Behavioral Health Spend*} = \Sigma \text{ Practice Transformation Payments} \times \frac{\text{Behavioral Health Claims + Behavioral Health Portion of Capitation Payments}}{\text{Claims: Total Claims + Capitation and Full Risk Payments}}$$

*This equation would also be used to allocate Category A5 EHR/HIT Infrastructure and Data Analytics and Category E Other Non-Claims Payments to behavioral health.

Apportioning Professional and Global Capitation to Behavioral Health

Example for a Professional Capitation arrangement:

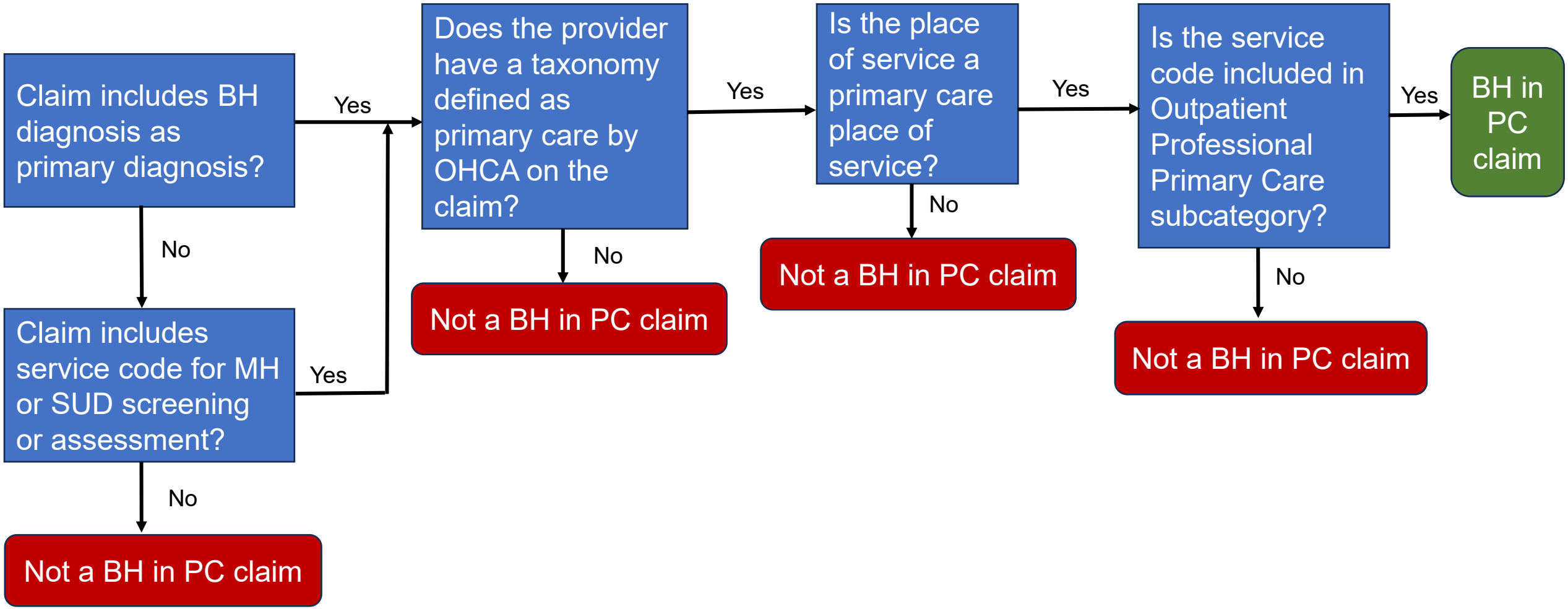
$$\frac{\Sigma\ (\#\ \text{of BH Encounters x FFS-equivalent Fee})_{segment}}{\Sigma\ (\#\ \text{of All Professional Encounters x FFS-equivalent Fee})_{segment}} = \text{Behavioral Health spend paid via professional capitation}$$

x Professional Capitation Payment

"Segment" means the combination of payer type (e.g., Medicaid, commercial), payer, year and region or other geography as appropriate.

Note: Methodology aligns with OHCA primary care approach.

Process Map for Identifying Behavioral Health in Primary Care Claims



Commercial Behavioral Health Spending

Behavioral Health Spending in the Commercial Market by Service Subcategory, 2018-2023

Service Subcategory	2018	2019	2020	2021	2022	2023
Outpatient Professional Non-Primary Care	33.0%	36.9%	39.3%	37.9%	38.3%	42.7%
Pharmacy	22.5%	20.7%	18.1%	20.9%	20.4%	18.4%
Inpatient Facility	16.4%	15.3%	14.6%	13.0%	11.9%	10.4%
Other	8.2%	6.1%	6.1%	6.6%	7.2%	7.3%
Outpatient Facility Non-Primary Care	7.4%	7.1%	7.3%	7.5%	7.2%	6.9%
Emergency Dept/Observation	5.3%	5.2%	4.5%	4.2%	3.9%	3.4%
Residential Facility	4.4%	5.8%	7.5%	7.5%	8.4%	8.7%
Outpatient Professional Primary Care	1.7%	1.8%	1.7%	1.7%	2.0%	1.6%
Inpatient Professional	1.0%	0.9%	0.9%	0.7%	0.7%	0.6%
Mobile Services	0.1%	0.1%	0.1%	<0.1%	<0.1%	<0.1%
Long-Term Care	<0.1%	<0.1%	<0.1%	<0.1%	<0.1%	*

*Data not included to comply with de-identification requirements.
Percent Subcategory Spend = Subcategory Spend/Total BH Spend

Mental Health Spending in the Commercial Market by Service Subcategory, 2018-2023

Service Subcategory	2018	2019	2020	2021	2022	2023
Outpatient Professional Non-Primary Care	36.5%	40.7%	44.0%	42.4%	43.0%	48.0%
Pharmacy	24.6%	22.7%	20.0%	23.0%	22.5%	20.2%
Inpatient Facility	14.2%	13.6%	12.8%	11.4%	10.3%	8.7%
Other Services	8.4%	6.1%	6.1%	6.2%	7.0%	7.3%
Outpatient Facility Non-Primary Care	6.5%	6.5%	6.6%	6.9%	6.6%	6.1%
Emergency Dep/Observation	4.1%	4.0%	3.5%	3.3%	3.0%	2.6%
Residential Facility	2.7%	3.5%	4.3%	4.2%	4.7%	4.7%
Outpatient Professional Primary Care	1.8%	2.0%	1.8%	1.9%	2.2%	1.8%
Inpatient Professional	1.0%	0.9%	0.9%	0.8%	0.7%	0.6%
Mobile Services	0.1%	0.1%	0.1%	<0.1%	<0.1%	<0.1%
Long-Term Care	*	<0.1%	*	<0.1%	*	*

*Data not included to comply with de-identification requirements.
Percent Subcategory Spend = Subcategory Spend/Total MH Spend

Substance Use Disorder Spending in the Commercial Market by Service Subcategory, 2018-2023

Service Subcategory	2018	2019	2020	2021	2022	2023
Inpatient Facility	33.0%	29.3%	27.9%	24.8%	23.2%	22.4%
Residential Facility	17.2%	24.7%	30.7%	31.6%	35.5%	37.6%
Emergency Dept/Obs	15.3%	15.5%	11.6%	11.1%	10.5%	9.3%
Outpatient Facility Non-Primary Care	15.1%	11.9%	12.3%	11.8%	11.0%	12.4%
Other	6.4%	6.3%	6.2%	9.3%	8.9%	7.7%
Pharmacy	6.0%	5.0%	4.4%	5.2%	5.3%	5.3%
Outpatient Professional Non-Primary Care	5.2%	5.6%	5.3%	4.6%	4.3%	4.3%
Outpatient Professional Primary Care	0.9%	0.8%	0.7%	0.7%	0.7%	0.5%
Inpatient Professional	0.9%	0.9%	0.8%	0.7%	0.6%	0.5%
Long-Term Care	<0.1%	<0.1%	<0.1%	<0.1%	<0.1%	*
Mobile Services	*	*	*	*	*	*

*Data not included to comply with de-identification requirements.
Percent Subcategory Spend = Subcategory Spend/Total SUD Spend