OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Board Meeting

June 9, 2025

HCAI

Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Welcome, Call to Order, and Roll Call

HCAI

Department of Health Care Access and Information

Agenda

Item #1 **Welcome, Call to Order, and Roll Call**

Secretary Kim Johnson, Chair

Item #2 **Executive Updates**

Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director

Item #3 **Action Consent Item**

Vishaal Pegany

a) Vote to Approve April 22, 2025 Meeting Minutes

Item #4 **Informational Items**

a) Presentation of the Baseline Report
Vishaal Pegany; CJ Howard, Assistant Deputy Director; Andrew Feher, Research and Analysis Group Manager

b) Update on Measuring Hospital Spending
Vishaal Pegany; CJ Howard; Andrew Feher

c) Update on Behavioral Health Definition and Investment Benchmark
Margareta Brandt, Assistant Deputy Director; Debbie Lindes, Health Care Delivery System Group Manager

Item #5 **General Public Comment**

Item #6 **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

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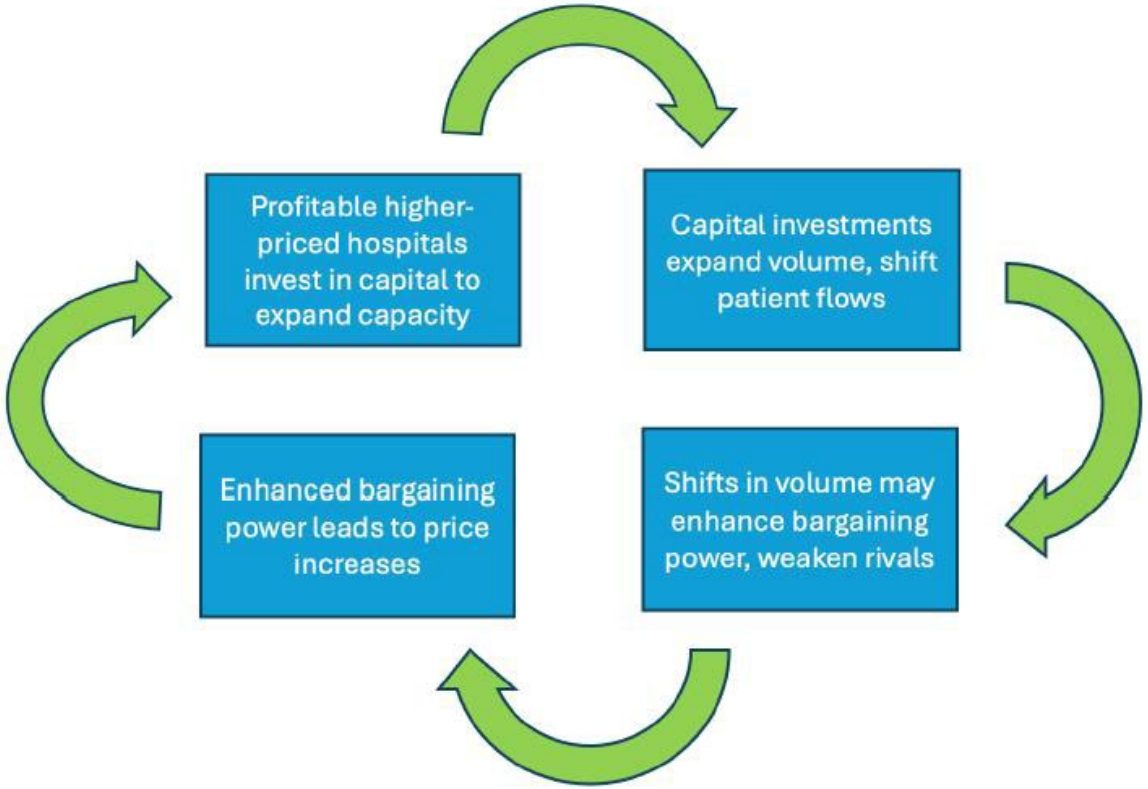
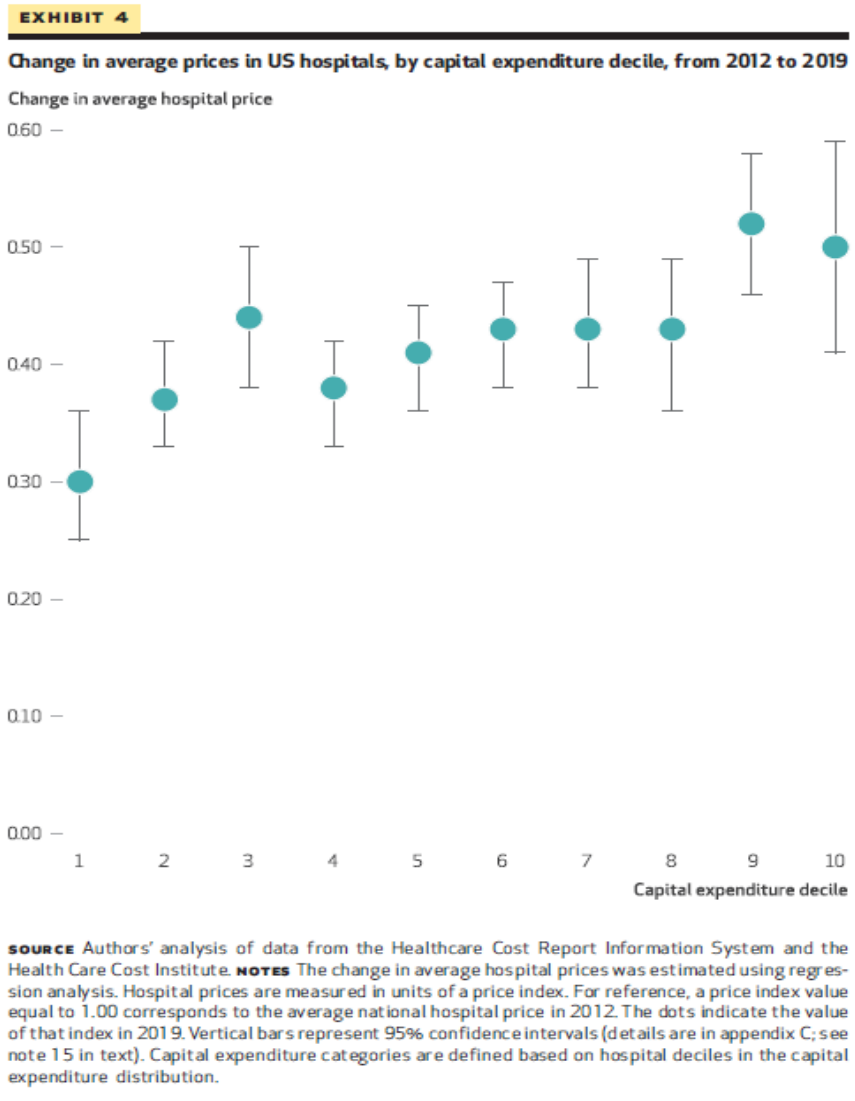
Health Affairs: Hospital Capital Expenditures

Hospital market dynamics: positive feedback loop in hospital prices related to capital expenditures





Beaulieu, N., Hicks, A., Chernew, M. (2025, May 5), Hospital Capital Expenditures Associated With Prices And Hospital Expansion Or Withering, 2010-19. *Health Affairs*, VOL. 44, NO. 5, https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2024.01172

Health Affairs: Rhode Island Affordability Standards

In 2010, Rhode Island began limiting how much hospitals could increase prices. The state's affordability standards were associated with the following outcomes:

- Across the fully insured and self-insured markets, hospitals saw a 9.1% average price drop between 2010 and 2022 relative to comparison states.
- Average annual $449 relative reduction in fully insured premiums

The estimated aggregate impact included:

- Decrease of $87.7 million in annual premium and out-of-pocket spending for the fully insured market
- Increase of $30.7 million in annual spending for the self-insured market
- Decrease of $158.3 million in annual hospital commercial revenue

Affected groups	Aggregate impact per year, $ millions
Fully insured segment	
Employer premiums	−64.1
Member premiums	−20.8
Out-of-pocket spending	−2.9
Total	−87.7
Self-insured segment	
Employer premiums	27.2
Member premiums	8.8
Out-of-pocket spending	−5.3
Total	30.7
Statewide hospital commercial revenue	−158.3

SOURCE Authors' analysis of data from the Health Care Cost Institute, 2012–22; Healthcare Cost and Utilization Project, 2010–22 (accessible from the Agency for Healthcare Research and Quality's HCUPNet online data tool); National Association of Insurance Commissioners, 2010–22 (accessed from the Mark Farrah Associates Health Coverage Portal); and Medical Expenditure Panel Survey–Insurance Component, 2010–22. NOTES The impact statistics presented here are calculated from values of various parameters derived from the sources listed above. Appendix exhibit A14 matches sources to specific parameters; calculation methods are presented in the appendix section, "Calculations related to the impact of the affordability standards" (see note 9 in text).

Ryan, A., Whaley, C., Fuse Brown, E. Radhakrishnan, N., Murray, R. (2025, May 5), Rhode Island's Affordability Standards Led To Hospital Price Reductions And Lower Insurance Premiums. *Health Affairs*, VOL. 44, NO. 5 https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.01146

Key Economic Indicators in 2023 and Long-Term Trends

At the Board's request, OHCA reviewed 2023 data on key economic indicators to assess whether recent trends in income, inflation, and provider costs materially change the conditions that informed the original 3.0% spending target—based on the 20-year average growth in median household income from 2002 to 2022.

- California median household income rose 5.4% in 2023, bringing the 20-year annual average (2003–2023) to 3.1% — a 0.1 percentage point increase over the 2002–2022 average.
- The Consumer Price Index (CPI-W) for California rose 3.6% in 2023, bringing the 20-year annual average (2003–2023) to 2.8% — no change from the 2002–2022 average.
- The Medicare Economic Index (MEI), which measures inflation for physician practices, rose 3.8% in 2023, bringing the 20-year annual average (2003–2023) to 1.7% — a 0.1 percentage point increase over the 2002–2022 average.

Sources: U.S. Census Bureau, Median Household Income in California [MEHOINUSCAA646N], retrieved from FRED, Federal Reserve Bank of St. Louis. https://fred.stlouisfed.org/series/MEHOINUSCAA646N. California Department of Finance. *California Consumer Price Index – All Items (CPI)*. Retrieved from https://dof.ca.gov/wp-content/uploads/sites/352/Forecasting/Economics/Documents/CPI-All-Item-CY.xlsx. Centers for Medicare & Medicaid Services. *Market Basket Data: Medicare Economic Index (MEI)*. Retrieved from https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data

Payment to Cost Ratio (PTCR) Coding Correction

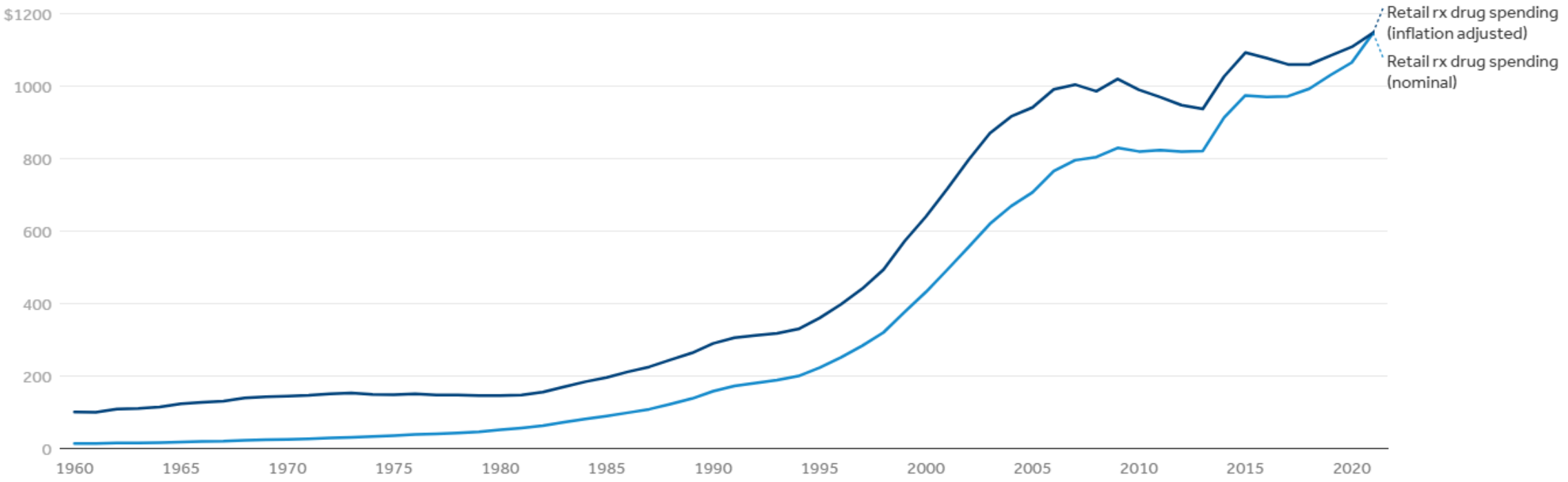
Specific to the methodology for identifying high-cost hospitals:

- PTCRs were originally calculated using Python code. In mid-May, OHCA staff created Stata code to calculate PTCRs and found that the resulting output differed from those that had previously been shared publicly.
- Upon further investigating the source of the discrepancy, OHCA noticed that, of the 75 hospital revenue centers referenced in HCAI's Hospital Annual Financial Disclosure Reports, one revenue center, Therapeutic Radiology, was inconsistently included in the original Python code.
- OHCA staff and consultants met in late May 2025 to confirm the initial oversight.
- Upon recalculating the PTCRs for Comparable hospitals for the years 2018-2022, including all 75 revenue centers, **OHCA found that the set of hospitals deemed high-cost did not change, nor did the proposed sector target value for those high-cost hospitals.**
- In addition, OHCA updated the publicly available hospital-level dataset on its website, which can be found on our Data and Reports page.
- Slides in the appendix summarize how previously reported PTCRs differ from the updated PTCRs based on a complete accounting of all hospital revenue centers.

Pharmaceuticals & Affordability

Pharmaceuticals are a cost driver

Nominal and inflation-adjusted per capita spending on retail prescription drugs, 1960-2021

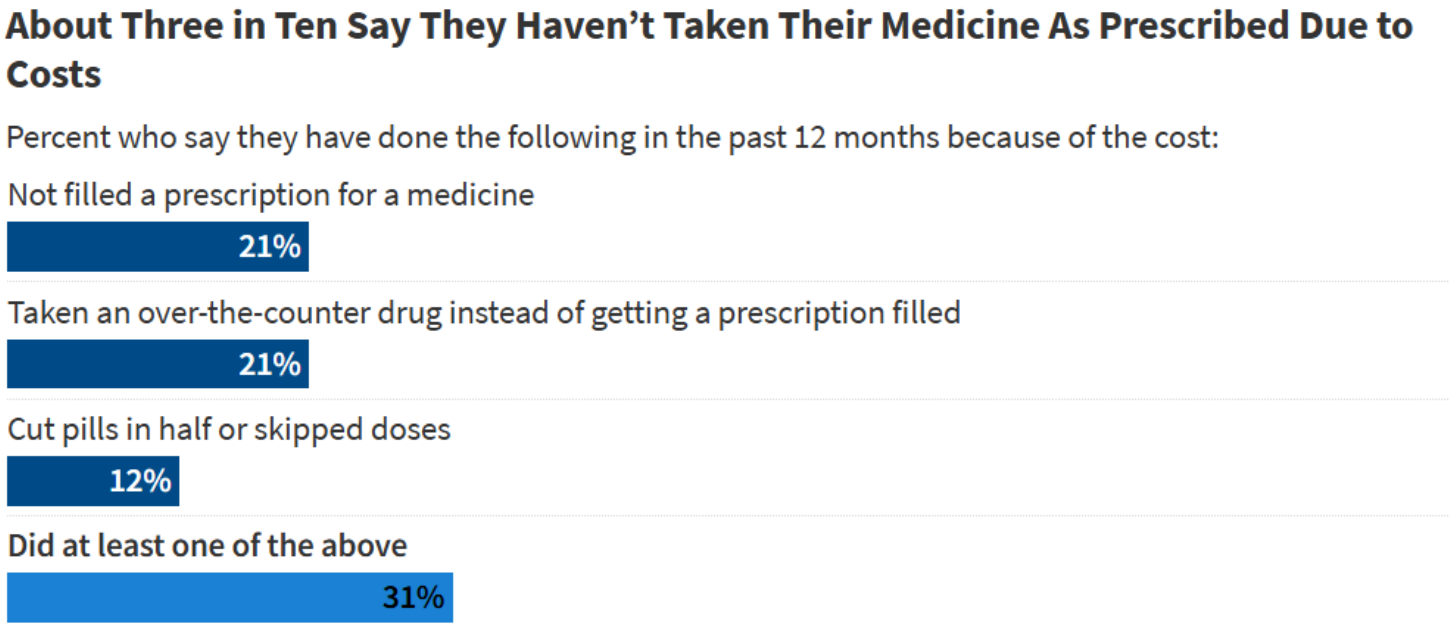


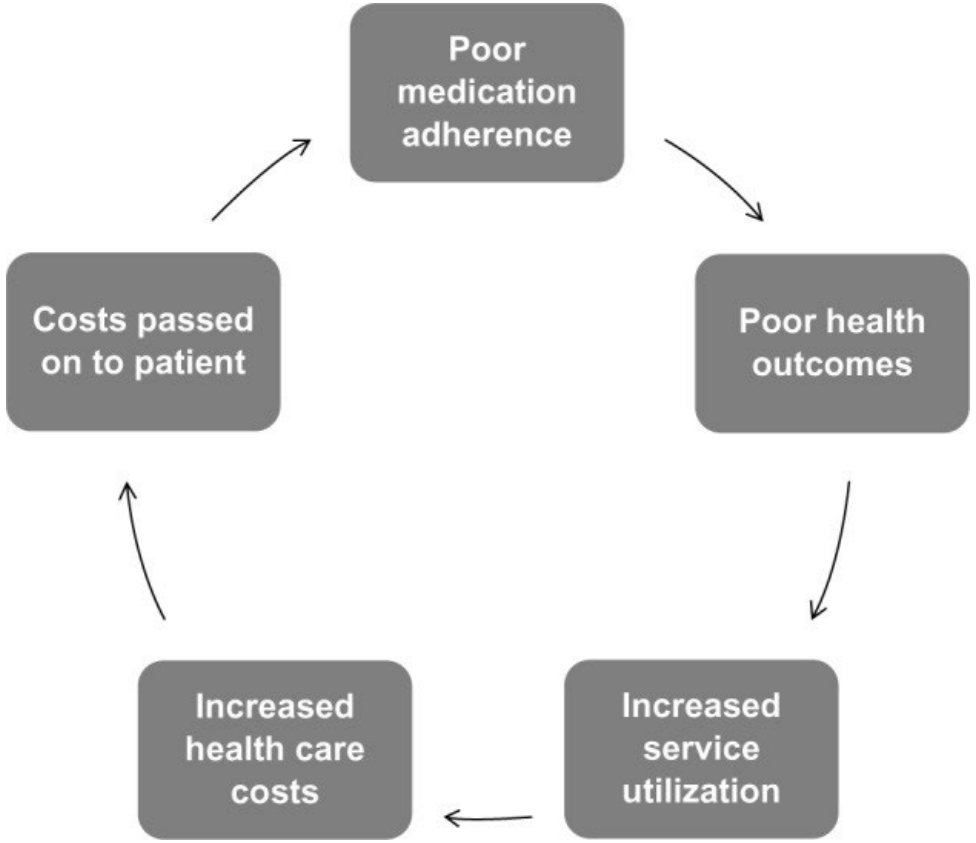
Source: KFF analysis of National Health Expenditures Accounts (NHEA) • Get the data • PNG

Peterson-KFF Health System Tracker

Source: Wagner, E., Telesford, I., Cox, C., & Amin , K. (2023, September 15). *What are the recent and forecasted trends in prescription drug spending?*. Health Systems Tracker. https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending

The High Cost of Drugs Poses a Barrier to Medication Adherence





Sources: Medication Adherence Rates Chart: Kirzinger, Ashley, et al. "Public Opinion on Prescription Drugs and Their Prices." *Kaiser Family Foundation*, 4 Oct. 2024, www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/. Patient Adherence Cycle: McGuire, M., & Iuga, A. (2014). Adherence and health care costs. *Risk Management and Healthcare Policy*, *7*, 35–44. https://doi.org/10.2147/rmhp.s19801

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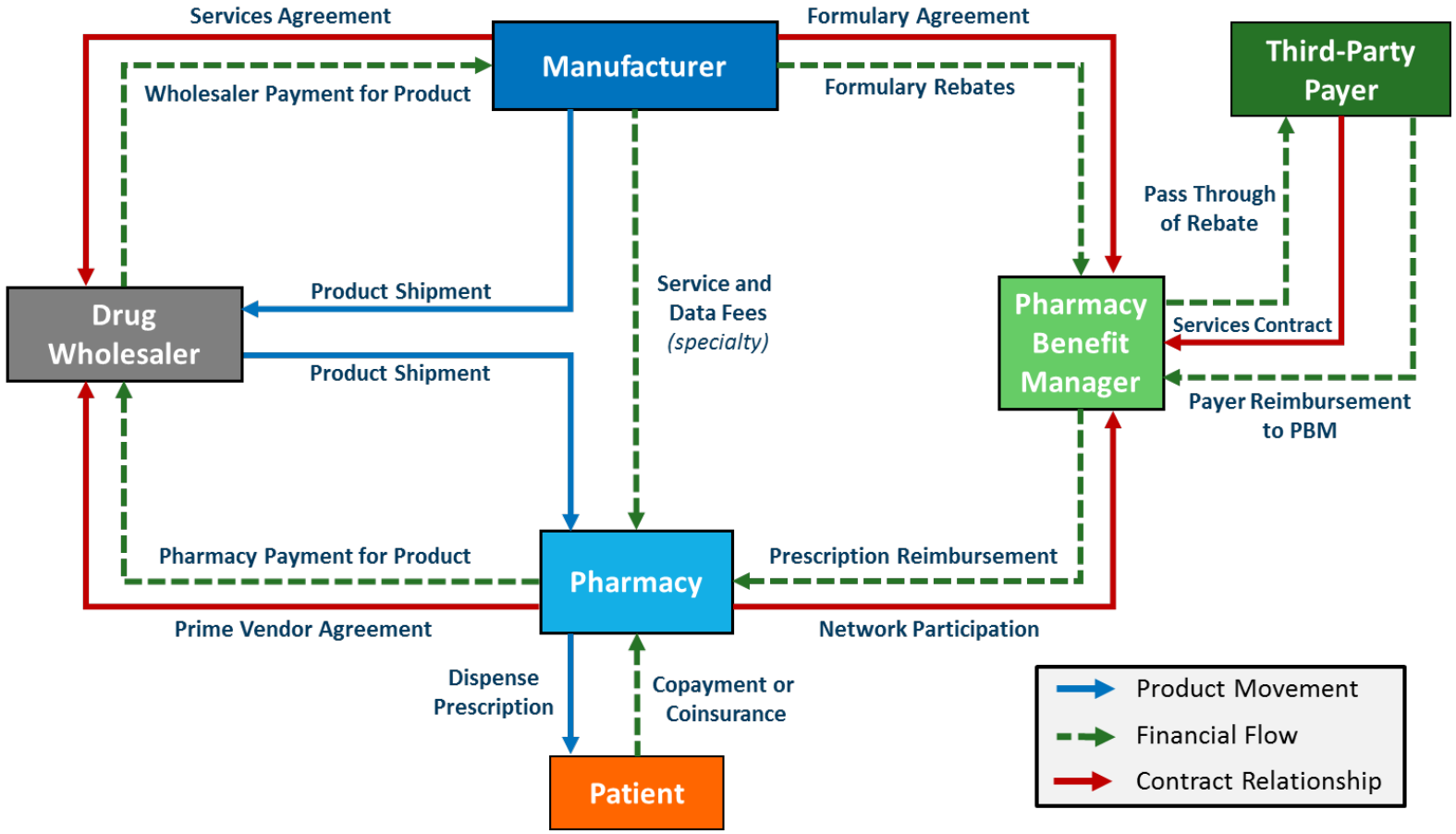
Complex Pharmaceutical Distribution and Payment Systems

The U.S. Pharmacy Distribution and Reimbursement System for Patient-Administered, Outpatient Prescription Drugs



Source: Fein, Adam J. "Follow the Dollar: The U.S. Pharmacy Distribution and Reimbursement System." *Drugchannels.net*, 3 Feb. 2016, www.drugchannels.net/2016/02/follow-dollar-us-pharmacy-distribution.html.

Multiple and Systemic Drivers of High Costs

- Research and Development Costs
- Rebates
- Lack of transparency
  - Introduction of non-rebate, non-spread pricing fees by pharmacy benefit managers (PBMs)
- Concentration and vertical integration in PBM & wholesaler markets
- Anti-competitive practices like evergreening, product hopping, patent thickets, pay-for-delay, rebate walls
- New high utilization/high-cost drugs
  - GLP-1s
  - Cell and Gene Therapies

Vertical Business Relationships Within the U.S. Drug Channel, 2025

PBM = pharmacy benefit manager; GPO = group purchasing organization; LTC = long-term care
1. Prime Therapeutics sources formulary rebates from—and has a minority ownership interest in—Ascent Health Solutions, which is part of Cigna's Evernorth segment.
2. Synergie is a buying group focused on medical benefit drugs. Its ownership includes the Blue Cross Blue Shield (BCBS) Association, Prime Therapeutics, Elevance Health, and other independent BCBS health plans.
3. Prime Therapeutics Pharmacy was previously known as Magellan Rx Pharmacy. Prime's clients have the option to use Express Scripts for mail/specialty pharmacy services.
4. In 2022, Cigna invested $2.7 billion for an estimated 14% ownership stake in VillageMD. In 2024, it wrote down the full value of this investment. Walgreens Boots Alliance owns a majority of VillageMD.
5. Centene began outsourcing its PBM operations to Express Scripts in 2024. In 2023, Centene rebranded its Envolve Pharmacy Solutions pharmacy benefit subsidiary as Centene Pharmacy Services.
6. CVS Caremark provides certain PBM services to CarelonRx business. CarelonRx also sources formulary rebates from—and has a minority interest in—Zinc Health Services, which is a subsidiary of CVS Health.
Source: *The 2025 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*, Exhibit 261. Exhibit does not illustrate every subsidiary business operated by each company.

DRUG CHANNELS INSTITUTE
An HMP Global Company

Source: Fein, Adam J. "Mapping the Vertical Integration of Insurers, PBMs, Specialty Pharmacies, and Providers: DCI's 2025 Update and Competitive Outlook." *Drugchannels.net*, 9 Apr. 2025, www.drugchannels.net/2025/04/mapping-vertical-integration-of.html.

What HCAI is Doing

Pharmaceutical References in OHCA Statute

Statutory Requirements

Legislative Intent

It is the intent of the Legislature to analyze cost and quality trends in the pharmaceutical sector, study the impact of drug prices and pharmaceutical market failures on affordability, and inform policy interventions to improve competition and lower consumer costs.

Definitions

“Total health care expenditures” means all health care spending in the state by public and private sources, including: (5) Pharmacy rebates and any inpatient or outpatient prescription drug costs not otherwise included in this subdivision.

Board Responsibilities

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

(6) Factors that contribute to cost growth within the state's health care system, including the pharmaceutical sector.

Pharmaceutical References in OHCA Statute

Statutory Requirements

Data Collection Requirements

The office shall obtain from the Department of Managed Health Care and the Department of Insurance information about health care services plans...The information shall include, but not be limited to... (v) Prescription drug costs consistent with Section 1367.243 and Article 6.1 (commencing with Section 1385.001) of Chapter 2.2 of Division 2 of this code and Section 10123.205 of the Insurance Code.

Establishment and Duties of OHCA

(c) The office shall do all of the following:
(5) Analyze cost and quality trends for drugs covered by pharmaceutical and medical benefits. The office shall consider the data in the reports required pursuant to Section 1367.243 and Section 10123.205 of the Insurance Code and pharmaceutical data reported in the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671).

Reporting Requirements

Any analysis of cost trends in the pharmaceutical sector shall account for the effect of drug rebates and other price concessions in the aggregate, without disclosing any product- or manufacturer-specific rebate or price concession information, and without limiting or otherwise affecting the confidential or proprietary nature of any rebate or price concession agreement.

Pharmaceutical References in OHCA Statute

Statutory Requirements

Establishment and Duties of OHCA

(c) The office shall do all of the following:

(12) Review and evaluate consolidation, market power, and other market failures through cost and market impact reviews of mergers, acquisitions, or corporate affiliations involving health care service plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities.

Monitor Trends

The office shall monitor cost trends, including conducting research and studies on the health care market, including, but not limited to, the impact of consolidation, market power, venture capital activity, profit margins, and other market failures on competition, prices, access, quality, and equity. …the office shall promote competitive health care markets by examining mergers, acquisitions, corporate affiliations, or other transactions that entail a material change to ownership, operations, or governance structure involving health care service plans, health insurers, hospitals or hospital systems, physician organizations, providers, pharmacy benefit managers, and other health care entities. The office shall prospectively analyze those transactions likely to have significant effects, seek input from the parties and the public, and report on the anticipated impacts to the health care market.

OHCA is Building Analytical Capacity for Pharmaceutical Policy Research and Analysis

Spending Target Analysis & Support

- **Public Reporting:** Analysis of current spending trends and significant drivers of increased spending.
- **Progressive Enforcement:** Considering high-cost drugs as a potential reasonable factor for exceeding spending target.

Research and Analysis of the Pharmaceutical Market

- Supporting state efforts to enable Californians to afford and access the medications they need for healthy lives.
- Data analysis and research, including review of best practices in other states that make drugs more affordable and accessible.
- Recommend policy actions on the pharmaceutical sector in forthcoming annual reports.

Using Data to Inform Work on Pharmaceutical Sector

OHCA is using data to identify and address strategies for drug access and affordability issues in California. These data sources include:

- Medi-Span data to track Wholesale Acquisition Cost (WAC) and Average Wholesale Price (AWP) for drugs.
- Healthcare Payments Data (HPD) to assess diabetes prevalence by geographic region.
- Board of Pharmacy data to identify pharmacy closures and potential pharmacy deserts.
- American Community Survey (ACS) census data to assess social determinants of health and identify vulnerable populations.
- Data from HCAI's Prescription Drug Cost Transparency Program program on list price increases
- SB17 reporting on high-cost and high-utilization drugs from the Department of Managed Health Care

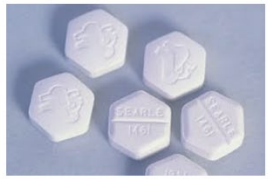
If enacted, the Governor's May Revise PBM reform proposal would add PBM data to the HPD, including:

- Drug cost and spending information
- Rebate information
- PBM payments to PBM-owned pharmacies
- Prescription counts
- Distribution channel information

CalRx®: State-powered market intervention for better drug affordability and access

- The California Affordable Drug Manufacturing Act of 2020 empowered California to enter into partnerships resulting in the production, procurement, or distribution of generic drugs and sell them at a low cost.
- Target areas are drugs where the U.S. health care system has failed to lower drug costs, even when a generic or biosimilar medication is available.
- All CalRx® pricing is clear, transparent, based on actual costs, and doesn't include rebates (other than federally mandated ones).

CalRx® Biosimilar Insulin Initiative



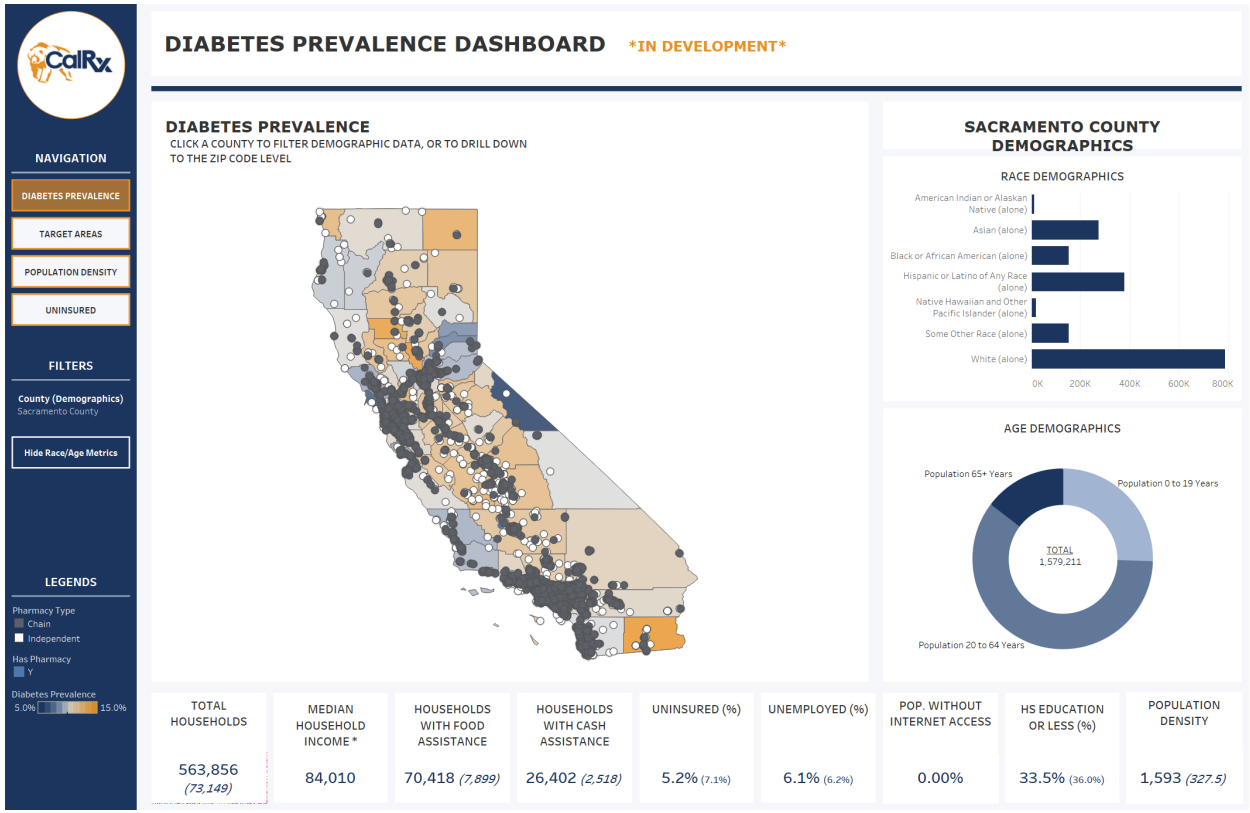
Reproductive Health Stockpile

CalRx® Naloxone Access Initiative

CalRx® Insulin Dashboard

- Using HPD data, ACS census data (2022), and pharmacy location data from the Board of Pharmacy, HCAI created a visualization to map vulnerable populations by county and zip code to inform the Civica/CalRx® insulin distribution strategy.

- When Civica/CalRx® insulins are available, HCAI will work with stakeholders in these areas to identify strategies to improve insulin access. This could include:
  - Alternative distribution methods.
  - Partnering with local community health organizations.
  - Direct-to-consumer (DTC) and mail-order options.



The CalRx Insulin dashboard uses data from the following sources: diabetes prevalence data from the HPD, demographic data from the ACS Census data (2022), and pharmacy locations from the California Board of Pharmacy.

HCAI Prescription Drug Cost Transparency Data Reporting: SB 17

Effective 2019, SB 17 required prescription drug manufacturers to submit:

- 60-day advance notice to purchasers of wholesale acquisition cost (WAC, or "list price") increases for drugs with WAC increase above 16 percent over three years and information about those WAC increases to HCAI.
- Three-day advance notice to HCAI of the introduction of new drugs to market for drugs above the threshold set for a specialty drug under Medicare Part D ($950 per month in 2024) per course of treatment and additional information about those new drugs.

Source: Health and Safet Code Sections 127675 – 127686.

HCAI Prescription Drug Cost Transparency Data Reporting: SB 17

- HCAI has published 7,500 reports in total from 2019 through 2023. Here report means specified prescription drug cost information that is required to be filed under SB 17 by National Drug Code.
- In addition to making the information collected public on the HCAI website, HCAI takes the additional step of producing online reports with interactive visualizations from the data.
- Data visualizations include:
  - Cumulative Wholesale Acquisition Cost (WAC) Price Increases from 2019 to current year[1]
  - Current Year WAC Price Increases[2]
  - New prescription drugs introduced to market in California with a WAC that exceeds the Medicare Part D specialty drug cost threshold[3]

1. https://hcai.ca.gov/visualizations/wholesale-acquisition-cost-wac-increase-report-data-cumulative/
2. https://hcai.ca.gov/visualizations/wholesale-acquisition-cost-wac-increase-report-data-current-year/
3. https://hcai.ca.gov/visualizations/drugs-introduced-to-market/

HCAI Prescription Drug Cost Transparency Data Reporting: HPD

- HCAI collects healthcare claims and encounters from payers as part of the Healthcare Payment Data (HPD) Program, California's All-Payer Claims Database.
- For fee-for-service prescription drug costs in the commercial market in 2021, HCAI data shows the monthly median out-of-pocket cost for the 25 prescription drugs with the highest monthly median out-of-pocket cost ranged from $150 to $250 for all drugs reported. The range was $50 to $190 for generic drugs.
- Later this year, HPD will begin collecting pharmacy rebate information from payers as part of the Non-Claims Payments expanded data collection.

Source: HCAI – Healthcare Payments Database – Healthcare Payments Data (HPD) Fee-For-Service Drug Costs in the Commercial Market, 2021 hcai.ca.gov/visualizations/healthcare-payments-data-hpd-fee-for-service-drug-costs-in-the-commercial-market; CCR § 9730 *et. seq*.

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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Public Comment

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Action Consent Item: Vote to Approve April 22, 2025 Meeting Minutes

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Informational Items

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Presentation of the Baseline Report: Key Highlights

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director
Andrew Feher, Research and Analysis Group Manager

HCAI

Department of Health Care Access and Information

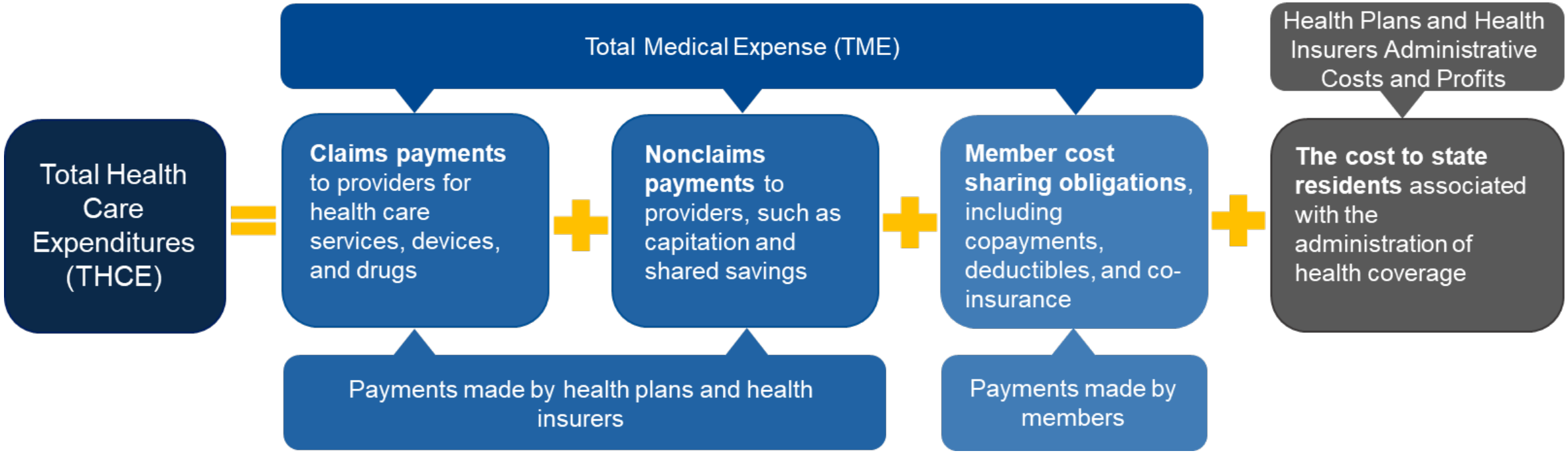
2022-2023 Baseline Report

Background on Data Collection Engagement

- Starting in September 2022, OHCA facilitated multiple technical workgroups with data submitters to address reporting questions, clarify specifications, and provide technical assistance throughout the submission process.
- Through Summer 2024, OHCA accepted and reviewed test submissions in advance of the formal submission window to ensure system readiness and troubleshoot data formatting issues.
- In Summer/Fall 2024, OHCA performed data validation and engaged directly with submitters to resolve discrepancies, clarify anomalies, and support resubmissions as needed.
- In November/December 2024, OHCA held individual “payer preview” meetings with all submitters to review preliminary results, ensure accuracy, and provide transparency regarding how their data would be reflected in the final report.
- For Medi-Cal spending, OHCA has continually collaborated with the Department of Health Care Services (DHCS) to collect, review, and validate managed care organization (MCO) data submitted through the state’s Medical Loss Ratio (MLR) template.
- OHCA also acquired CMS reports that were used to generate administrative cost and profit figures.

2022-2023 Baseline Report

This graphic provides a reminder of how OHCA defines Total Health Care Expenditures (THCE) as composed of Total Medical Expense (TME)—which includes claims payments, non-claims payments and member cost sharing—plus health plan administrative costs and profits. These components form the foundation of OHCA's baseline report and spending target monitoring.



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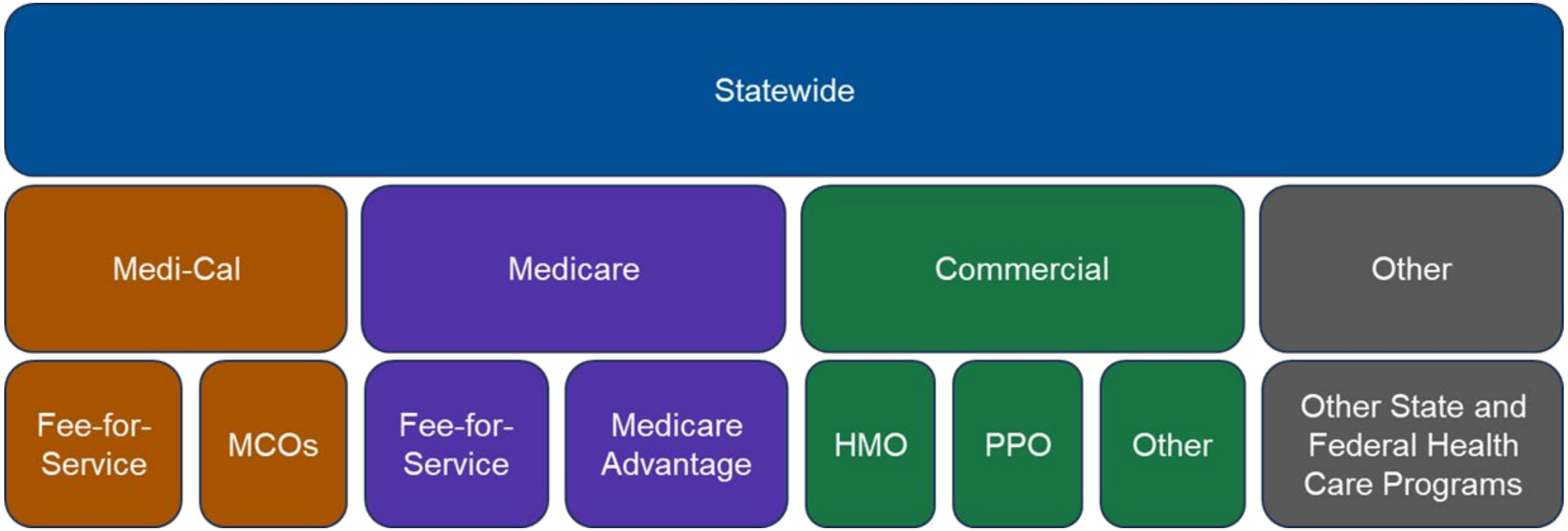
2022-2023 Baseline Report

The report presents results at both the statewide and market levels, as shown here. Each major market—Medi-Cal (orange), Medicare (purple), Commercial (green), and Other (gray)—is color-coded and further broken out by coverage type to reflect how data are analyzed and reported.



2022-2023 Baseline Report

Changes in THCE

- Between 2022 and 2023, THCE changed as follows for the three major markets: Commercial spending grew 5.8%, Medicare (non-dual) spending grew 6.0%, and Medi-Cal spending grew 6.5%.
- Total health care expenditures per member per year (PMPY) growth for Medi-Cal and Medicare (including duals) averaged 2.9% and 5.4%, respectively, compared with an average of 6.4% for Commercial payers.
- When aggregating market level spending with other state and federal health care program spending, statewide THCE totaled $377.6 billion in 2022 and $408.6 billion in 2023, an increase of $31.0 billion or 8.2%.
- On a per capita basis (THCE divided by California's population), total health care expenditures were $9,676 in 2022 and $10,847 in 2023, an increase of $811 or 8.4%.

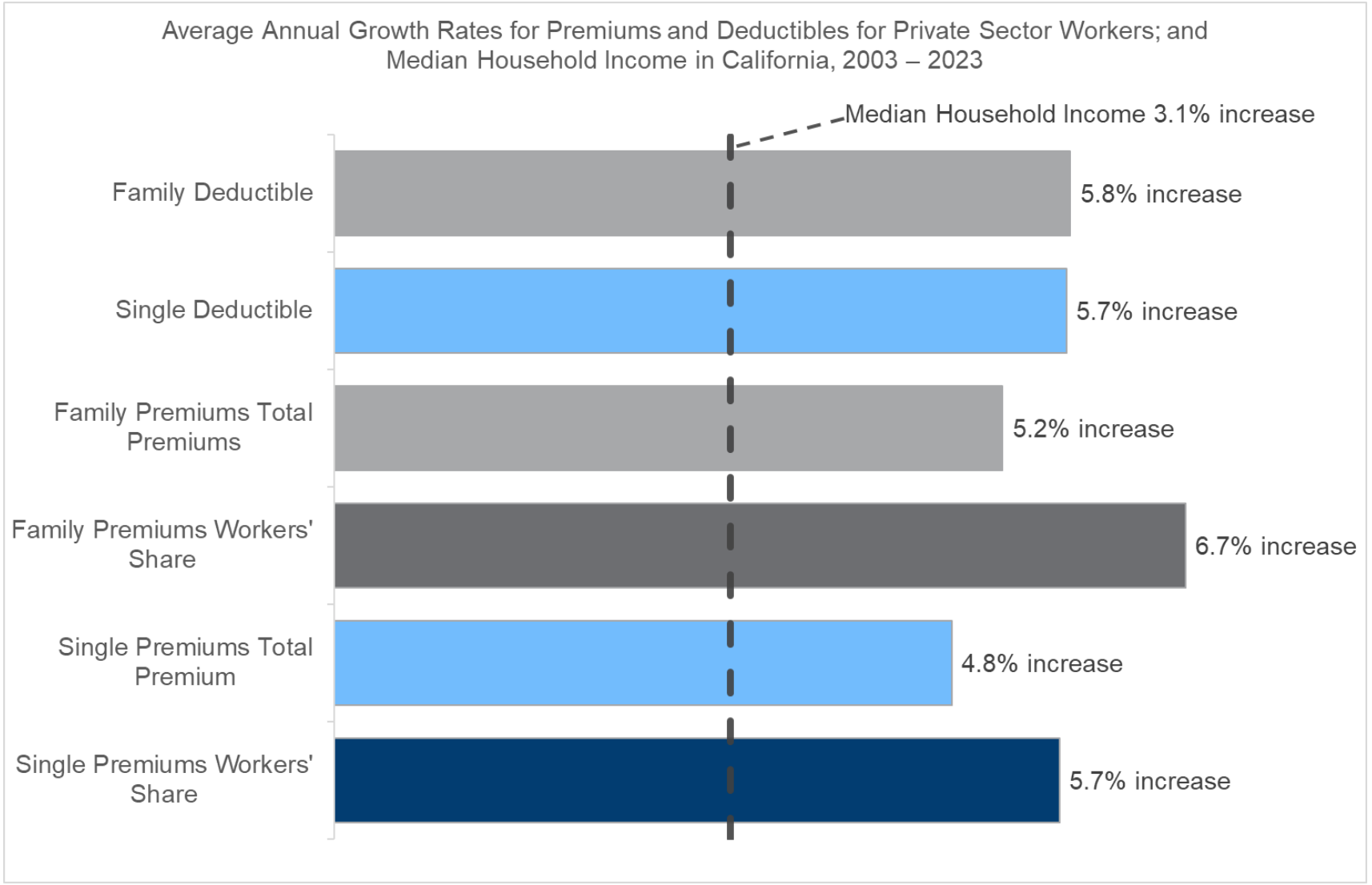
Changes in TME

- Growth in spending varied across markets, payers, regions, and service categories between 2022 and 2023.
- Total medical expenses (TME) PMPY growth among Medi-Cal and Medicare (including duals) markets averaged 1.2% and 6.1%, respectively, compared with an average of 5.0% for Commercial.

2022-2023 Baseline Report

Consumer Affordability – Premiums and Deductibles Continue to Outpace Household Income Growth

Over the past 20 years, the financial burden on California workers with private coverage—driven by rising deductibles and their share of premiums—has grown faster than total premiums and median household income, highlighting a persistent affordability challenge.



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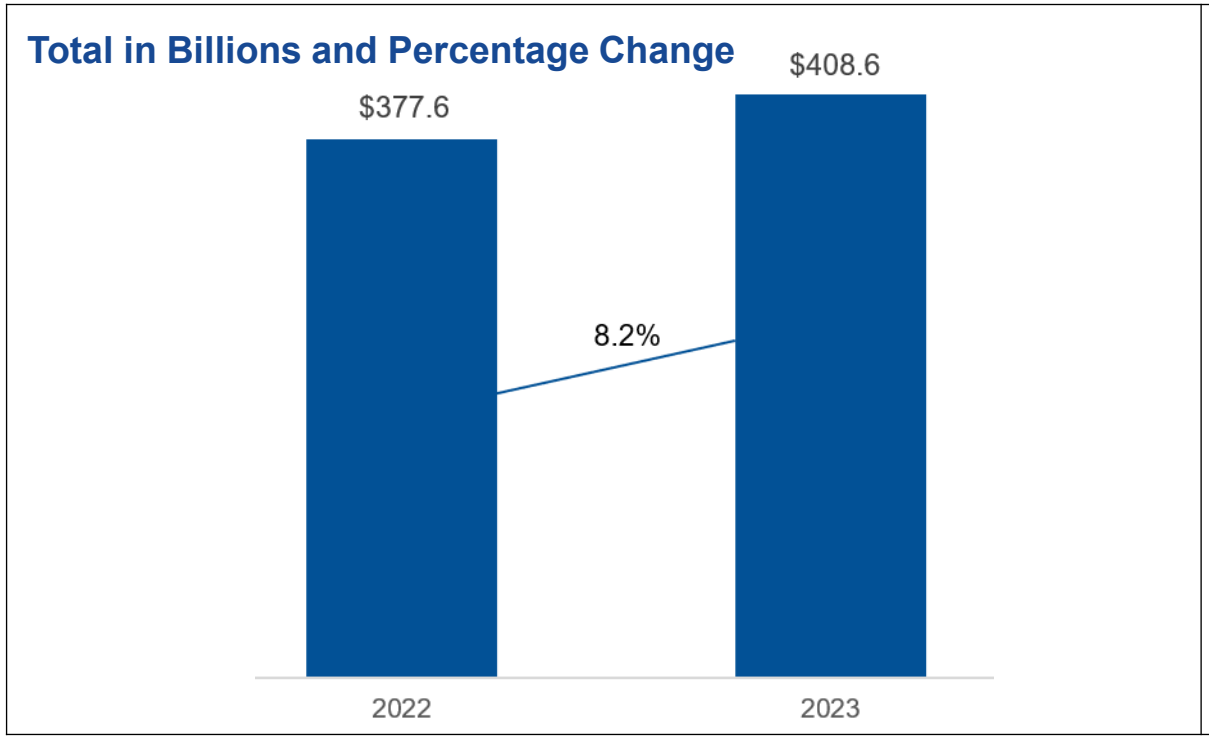
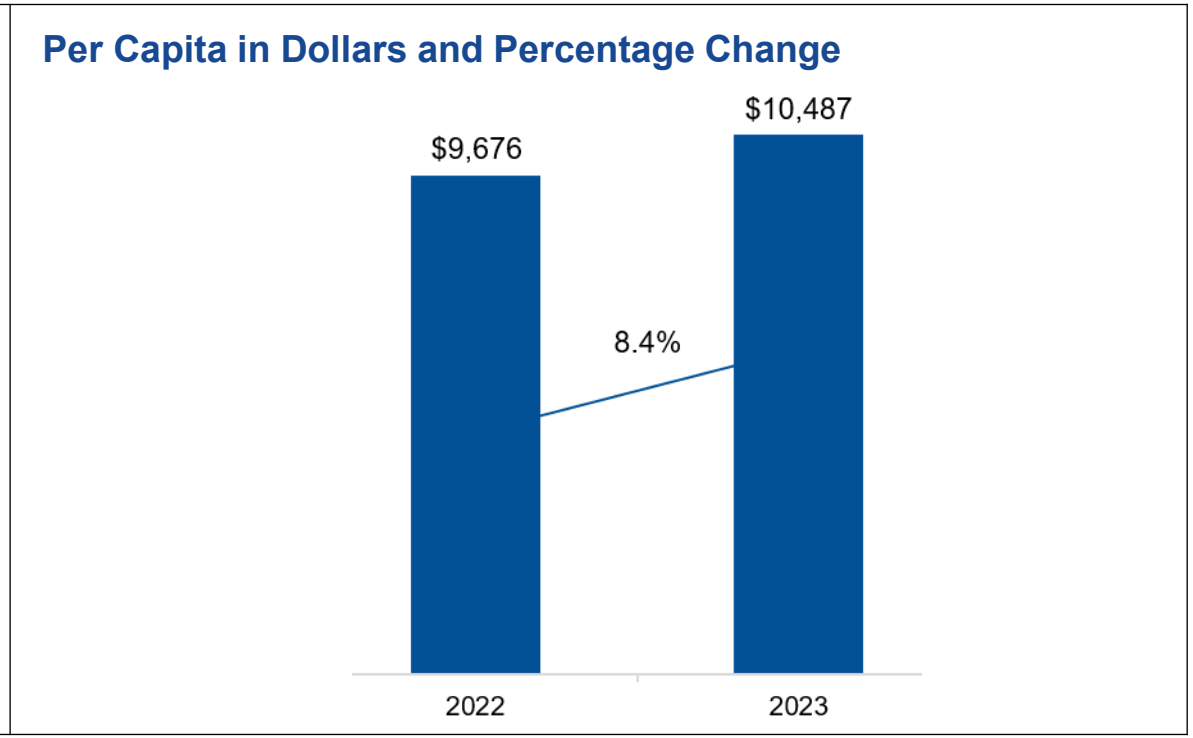
2022-2023 Baseline Report

Statewide Total Health Care Expenditures (THCE):

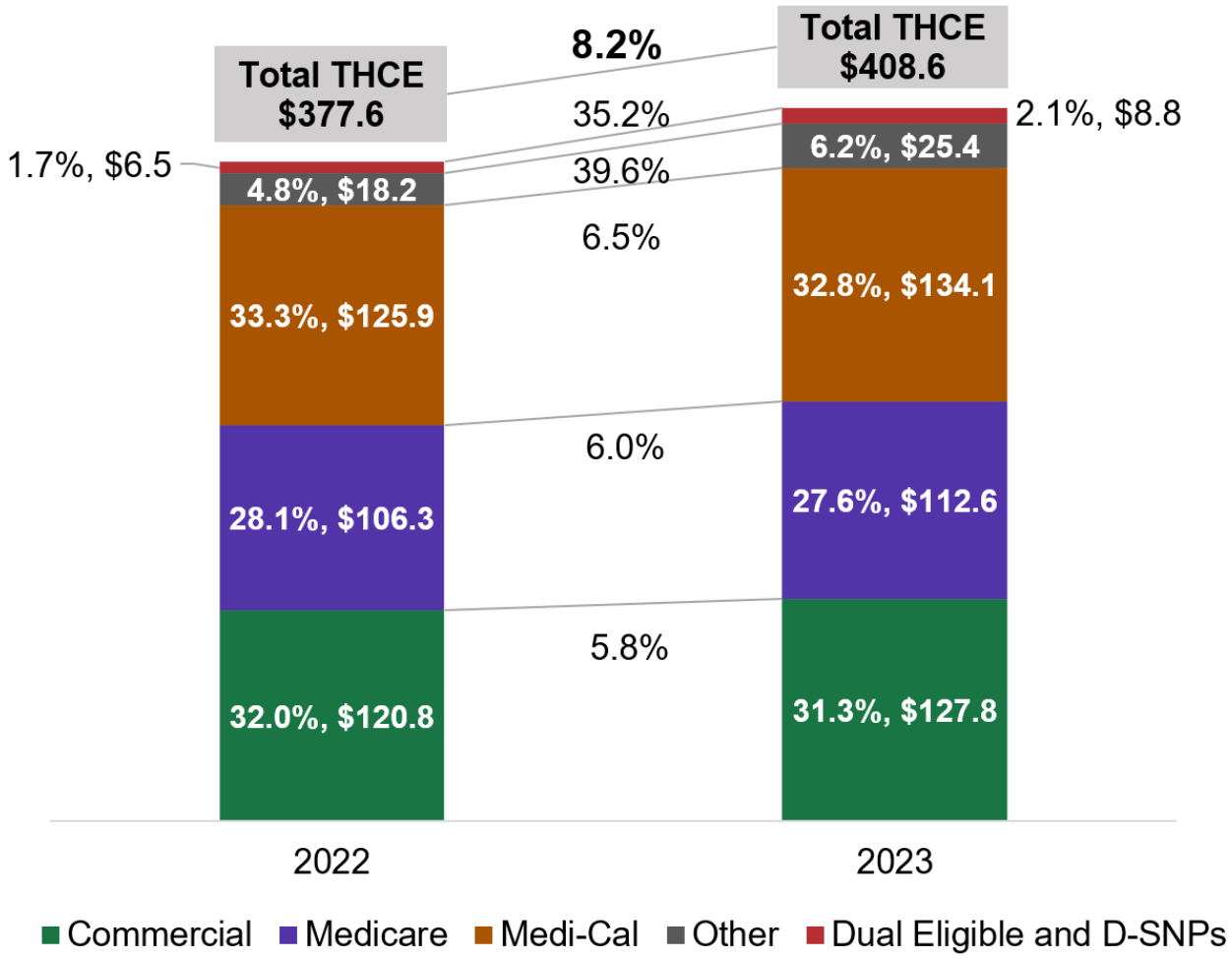




- Statewide THCE were $377.6 billion in 2022 and $408.6 billion in 2023, an increase of $31.0 billion or 8.2%.
- On a per capita basis (THCE divided by California's population), the expenditures were $9,676 in 2022 and $10,847 in 2023, an increase of $811 or 8.4%.

2022-2023 Baseline Report

THCE by Market (in billions):

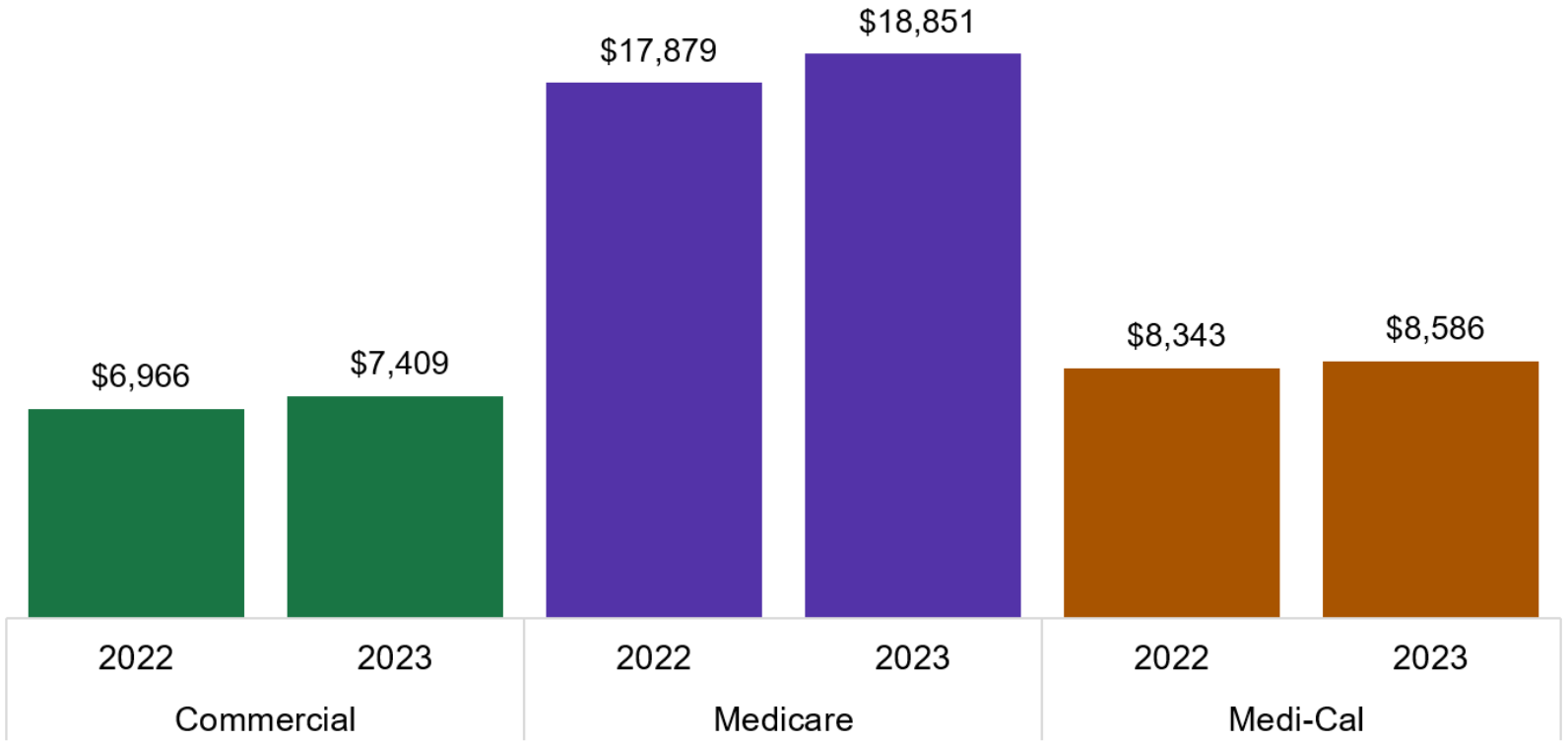


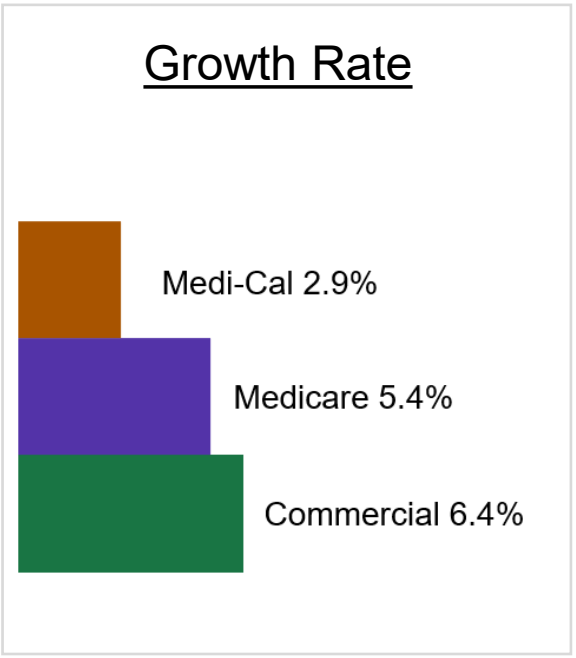
- Commercial spending was $120.8 billion in 2022 and $127.8 billion in 2023, an increase of $6.9 billion or 5.8%. It captured about 31% of the 2023 statewide THCE.
- Medicare (excluding Duals Eligibles*) spending was $106.3 billion in 2022 and $112.6 billion in 2023, an increase of $6.4 billion or 6.0%. In 2023, its share represented about 28% of statewide THCE.
- Medi-Cal spending was $125.9 billion in 2022 and $134.1 billion in 2023, an increase of $8.2 billion or 6.5%. Its share was just below 33% of statewide THCE.
- Dual Eligibles in Medicare Advantage plans and D-SNPs* represented about 2% of statewide THCE, but its spending grew more than 35% from $6.5 billion in 2022 to $8.8 billion in 2023, an increase of $2.3 billion.

* Dual Eligibles are individuals who qualify for both Medicare and Medi-Cal benefits. Dual Eligible Special Needs Plans (D-SNPs) are specialized Medicare Advantage plans designed to deliver tailored care to a subgroup of Dual Eligibles.

2022-2023 Baseline Report

THCE PMPY (Per Member Per Year) by Market:

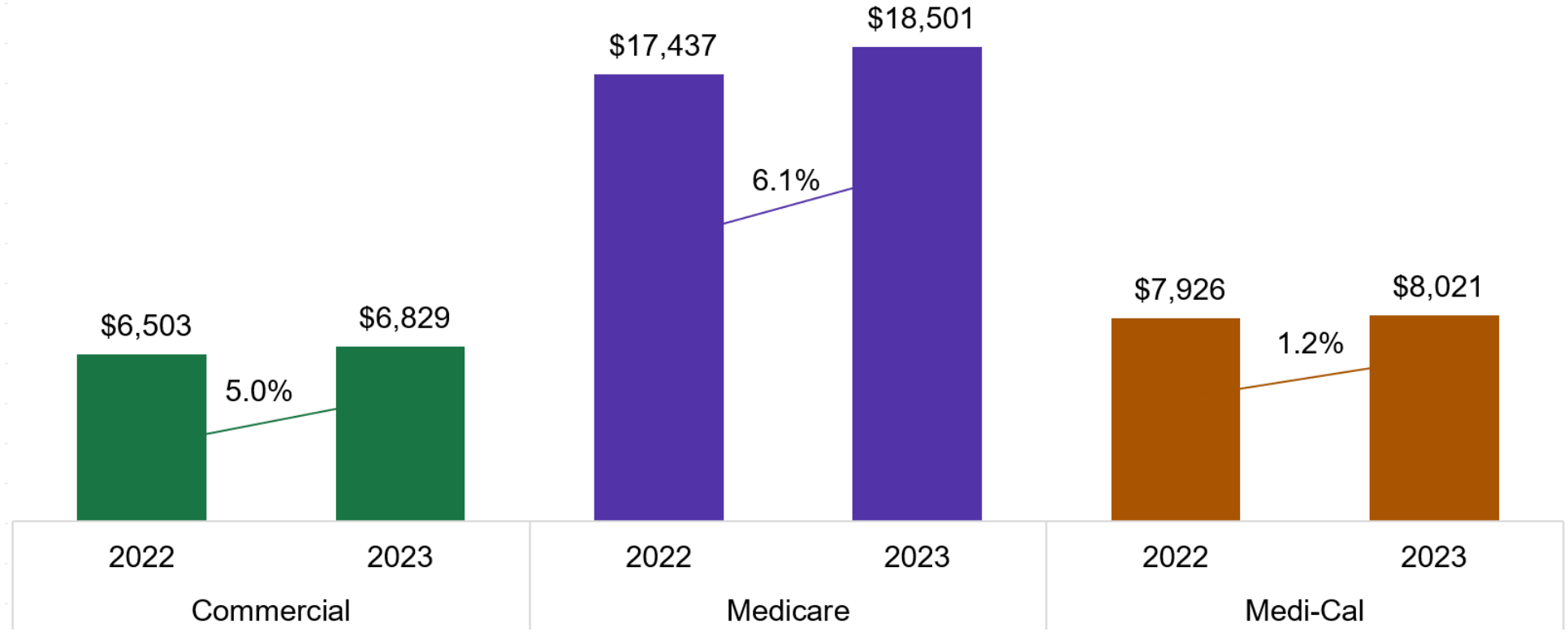




- Commercial THCE PMPY was $6,966 in 2022 and $7,409 in 2023, an increase of $443 or 6.4%.
- For Medicare (including duals), THCE PMPY was $17,879 in 2022 and $18,851 in 2023, an increase of $972 or 5.4%.
- Medi-Cal THCE PMPY was $8,343 in 2022 and $8,586 in 2023, an increase of $243 or 2.9%.

2022-2023 Baseline Report

Total Medical Expense (TME) PMPY by Market:

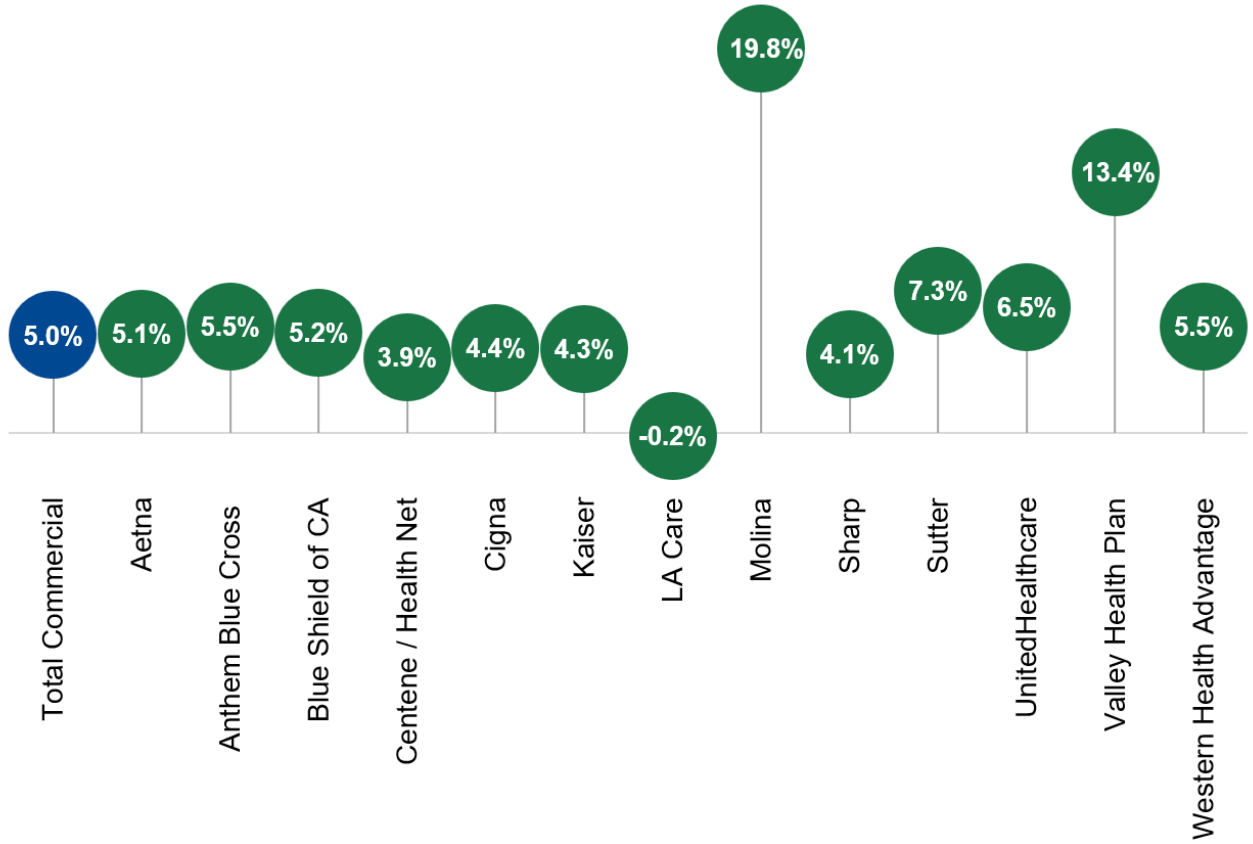


- TME PMPY for the Commercial market was $6,503 in 2022 and $6,829 in 2023, an increase of $326 or 5.0%.
- For Medicare (including duals), the figure was $17,437 in 2022 and $18,501 in 2023, an increase of $1,064 or 6.1%.
- Medi-Cal TME PMPY was $7,926 in 2022 and $8,021 in 2023, an increase of $95 or 1.2%.

2022-2023 Baseline Report

Commercial: Market Share and TME PMPY Growth by Payer

Commercial Payers	2023 Market share
Kaiser	41.2%
Blue Shield of CA	15.6%
Anthem Blue Cross	14.3%
UnitedHealthcare	8.1%
Aetna	7.3%
Cigna	7.1%
Centene / Health Net	2.9%
LA Care	1.0%
Sharp	0.8%
Western Health Advantage	0.6%
Sutter	0.6%
Molina	0.3%
Valley Health Plan	0.3%
Total members	**17,243,069**



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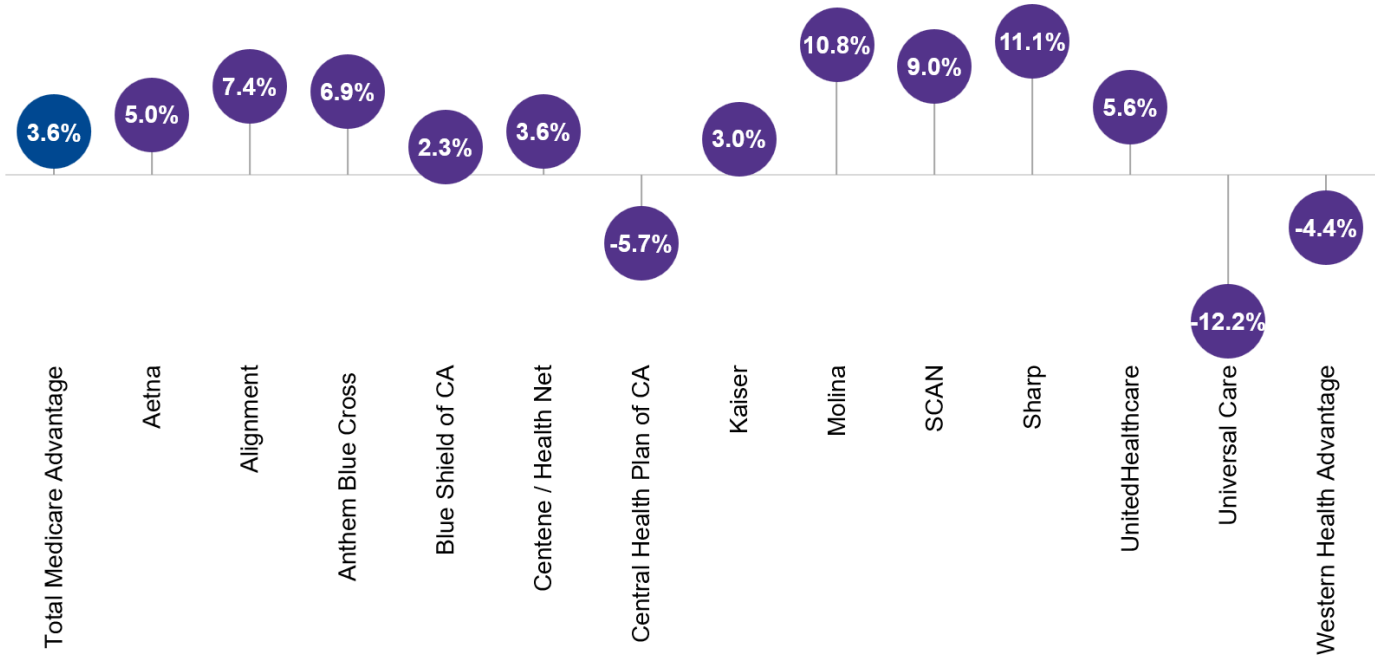
Medicare Advantage: Market Share and TME PMPY Growth by Payer:

Medicare Advantage Payers	2023 Market share
Kaiser	48.5%
UnitedHealthcare	17.9%
SCAN	9.4%
Blue Shield of CA	4.6%
Centene / Health Net	4.6%
Anthem Blue Cross	4.5%
Aetna	2.9%
Alignment	2.8%
Universal Care	2.7%
Central Health Plan of CA	1.5%
Sharp	0.5%
Western Health Advantage	0.1%
Molina	0.02%
Total members	**2,636,959**

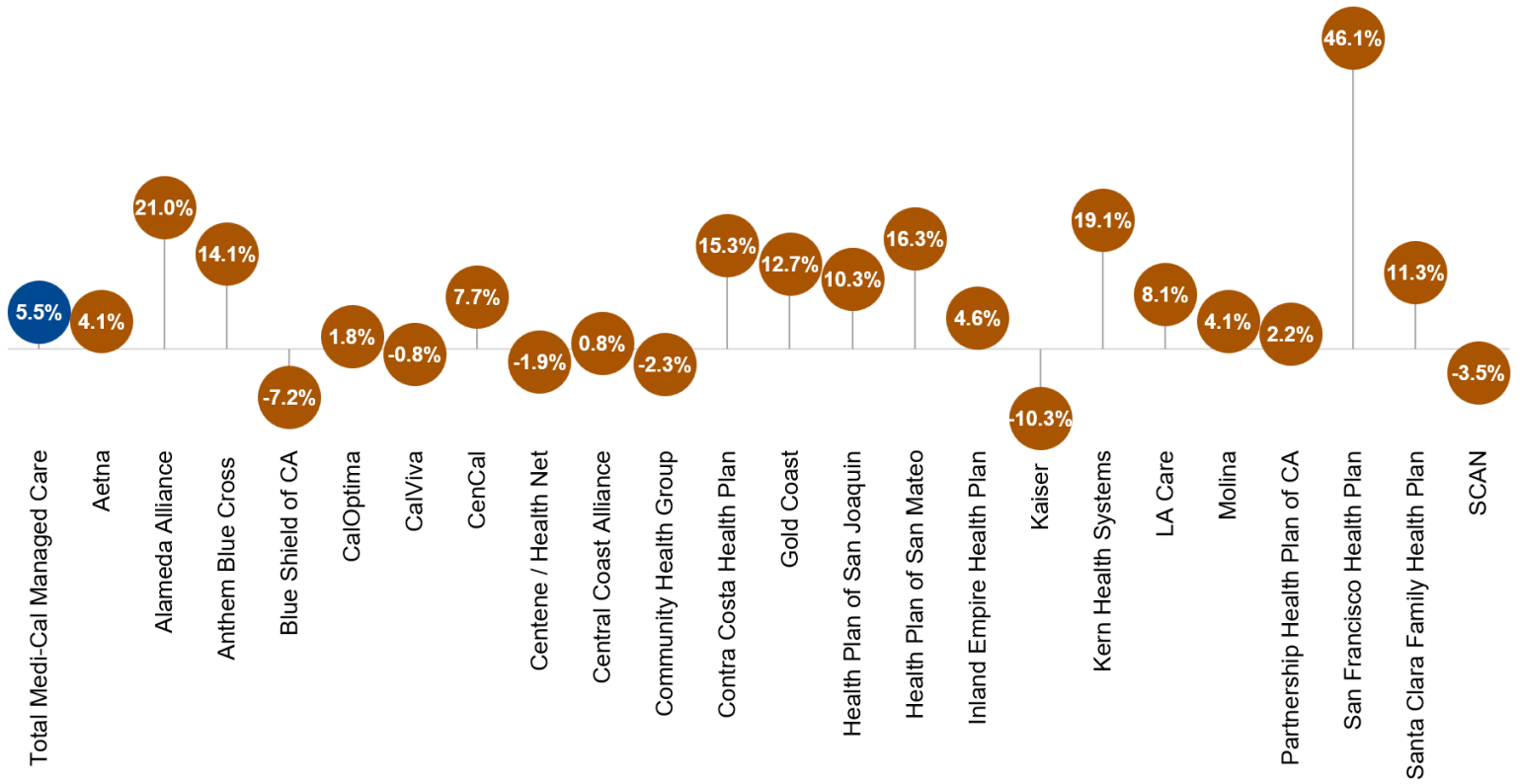


*A Cal-AIM policy change has resulted in an ongoing transition of dual eligible members to dedicated D-SNPs, for this reason D-SNP and dual eligible market expenditures are not included in the Medicare payer level reporting.

2022-2023 Baseline Report

Medi-Cal Managed Care: Market Share and TME PMPY Growth by Payer:

Medi-Cal Payers	2023 Market Share
LA Care	19.1%
Centene / Health Net	15.3%
Inland Empire Health Plan	11.8%
Anthem Blue Cross	7.6%
CalOptima	6.8%
Partnership Health Plan of CA	4.9%
Molina	4.0%
CalViva	3.4%
Health Plan of San Joaquin	3.2%
Central Coast Alliance	3.0%
Community Health Group	2.7%
Kern Health Systems	2.6%
Alameda Alliance	2.5%
Santa Clara Family Health Plan	2.3%
Contra Costa Health Plan	1.9%
Gold Coast	1.8%
CenCal	1.6%
Kaiser	1.6%
San Francisco Health Plan	1.3%
Health Plan of San Mateo	1.1%
Blue Shield of CA	1.1%
Aetna	0.5%
SCAN	0.1%
Total members	**14,106,699**



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TME PMPY Growth by Spending Category

Category	Statewide	Commercial	Medicare Advantage, non-Duals	Medicare FFS
Hospital inpatient	2.3%	1.5%	2.0%	3.4%
Hospital outpatient	6.5%	7.3%	7.2%	4.8%
Professional	7.6%	6.6%	3.4%	10.0%
Long-term care	4.2%	8.5%	13.5%	2.6%
Pharmacy (gross of rebates)	12.0%	11.6%	9.0%	10.9%
Other	0.3%	-13.7%	3.0%	12.0%
Capitation	7.0%	5.6%	3.0%	
Non-claims, non-capitation	0.9%	4.2%	-18.6%	
	6.2%	**5.0%**	**3.6%**	**7.3%**

- Statewide TME PMPY increased 6.2% in 2023. Retail pharmacy (12.0%), professional services (7.6%), and capitation (7.0%) had the highest growth rates among service categories.
- The largest dollar contributors to total statewide PMPY growth were retail pharmacy, capitation and hospital outpatient services, accounting for 75% of the overall increase.

*Includes Commercial and Medicare Advantage populations (dual eligibles and D-SNPs). Medicare FFS is limited to claims data; non-claims are excluded.

2022-2023 Baseline Report

Market TME PMPY Growth by Spending Category

Commercial

- TME PMPY grew from $6,503 in 2022 to $6,829 2023 — an increase of $326 or 5.0%
- Retail pharmacy increased by $117 which is 36% of the growth
- Hospital outpatient spending increased by $94 which is 29% of the growth

Medicare Advantage (Non-Duals)

- TME PMPY grew from $15,139 to $15,679 — an increase of $540 or 3.6%
- Retail pharmacy increased by $224 which is 42% of the growth
- Capitation increased by $202 which is 37% of the growth

Medicare Fee-for-Service

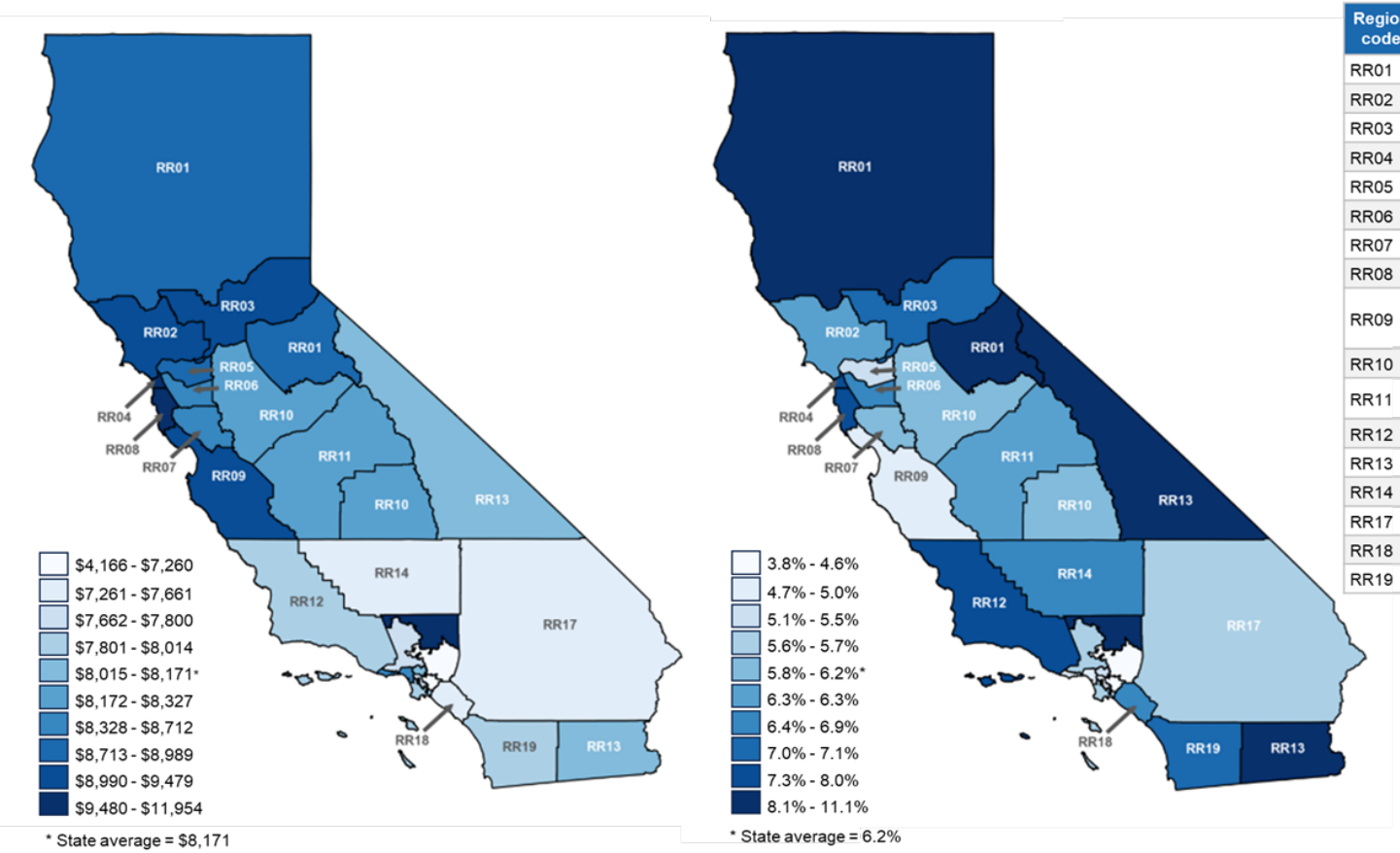
- TME PMPY grew from $18,924 to $20,301 — an increase of $1,377 or 7.3%
- Retail pharmacy increased by $410 which is 30% of the growth
- Professional services increased $379 which is 28% of the growth

*PMPY= Per Member Per Year
**TME= Total Medical Expense

2022-2023 Baseline Report

Claims and Capitation* PMPY by Region:

- 2023 PMPY values (left) are shown alongside 2022–2023 growth rates (right) to highlight that regions with higher baseline spending do not consistently exhibit the highest growth.
- Aside from a select SPA within Los Angeles County, PMPY spending tends to be higher in Northern California and lower in Southern California.



Region code	Region name
RR01	Northern counties
RR02	North Bay Area
RR03	Greater Sacramento
RR04	San Francisco County
RR05	Contra Costa County
RR06	Alameda County
RR07	Santa Clara County
RR08	San Mateo County
RR09	Santa Cruz, San Benito, Monterey counties
RR10	Central Valley
RR11	Fresno, Kings, Madera counties
RR12	Central Coast
RR13	Eastern counties
RR14	Kern County
RR17	Inland Empire
RR18	Orange County
RR19	San Diego County

*Data is limited to claims and capitation spending, which can be attributed to individual members and geographic regions. Non-claims payments, typically made as lump sums to providers, cannot be reliably linked to specific members or locations.
**PMPY= Per Member Per Year

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Update on Hospital Spending Measurement

Vishaal Pegany, Deputy Director

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Recap of Work to Date on Hospital Measurement

- At the January 2024 Board meeting, OHCA held an introductory discussion on hospital measurement.
- Between April and September 2024, OHCA convened monthly meetings of a Hospital Spending and Measurement Workgroup to provide input on measuring hospital spending. The workgroup included representatives from hospitals and health systems, health plans, state and private purchasers, and consumer advocacy. Representatives from hospital associations and organized labor participated as observers.
- In November 2024, OHCA presented a provisional approach for hospital measurement. Board and public feedback primarily focused on improving the outpatient measurement to include a more refined data source for intensity adjustment.
- At the January 2025 Board meeting, OHCA confirmed the approach for measuring inpatient hospital spending.
- At the April 2025 Board meeting, OHCA provided key updates on the outpatient intensity adjustment factor, including data sources and methodology.

Hospital Measurement Approaches

OHCA will measure hospital performance against the target based on the following measures:

Inpatient (IP):

$$Estimated\ IP\ Net\ Patient\ Revenue\ (NPR)\ per\ CMAD\ = \frac{IP\ NPR}{CMAD}$$

Example: $35 million Net IP Revenue÷1,750 CMADs = $20,000 Estimated IP NPR per CMAD

Outpatient (OP):

$$OP\ NPR\ per\ Adjusted\ Outpatient\ Visit = \frac{OP\ NPR}{Adjusted\ Outpatient\ Visit}$$

Example: $6.5 million Outpatient NPR÷13,000 Adjusted Outpatient Visits = $500 OP NPR per Adjusted Outpatient Visit

Case Mix Adjusted Discharges (CMADS) are hospital inpatient discharges adjusted by Case Mix Index, an available adjustment factor.
Adjusted Outpatient Visits are hospital outpatient visits adjusted by the Outpatient Intensity Adjustment factor under development.

Hospital Measurement Approaches

Next Steps

- OHCA is working to finalize the data sources that it will use in the Outpatient Intensity Adjustment factor.
- This summer, OHCA will reconvene the Hospitals Spending Measurement Workgroup to provide input on the Outpatient Intensity Adjustment factor, as well as considerations for measurement and reporting.
- OHCA will continue to provide updates to the Board and the public.

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Update on Behavioral Health Investment Measurement and Benchmark

Margareta Brandt, Assistant Deputy Director
Debbie Lindes, Health Care Delivery System Group Manager

HCAI

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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.

Stakeholder Feedback

February Board Meeting

Feedback

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

March Advisory Committee Meeting

Feedback

- Support for structuring the benchmark as a per member per month (PMPM) amount.
- Mixed support for the outpatient/community-based focus of the benchmark.
  - Desire to increase access to upstream care balanced by concerns that access challenges exist across the spectrum of care.
- Desire to ensure that behavioral health integration and whole person care is incentivized and measured.
  - Concern about missing care from PCPs if only primary diagnosis is considered.
  - Interest in understanding if encounter data diagnosis fields are well populated to identify behavioral health spend.
- Concern that measuring clinical spending paid by payers misses important parts of the behavioral health support system that occur outside health care settings.
- Concerns about the possibility of incentivizing use of untested approaches such as artificial intelligence through the investment benchmark.

March and April Workgroup Meetings

Feedback

- Preventive services in behavioral health are critical, and measurement efforts should capture this spending to the greatest extent possible
- Support for including payments to peer support specialists in the measurement of non-claims payments for social care integration
- Clarification that mobile crisis services are included in the outpatient and community-based services proposed for the benchmark
- Regarding key decisions to develop the benchmark:
  - Consensus that spending should be measured and reported as both percentage of TME and PMPM, with overall preference for structuring the benchmark as PMPM
  - Support for a longer time horizon for achieving benchmark, aligned with primary care and alternative payment model adoption timelines
  - However, also important to evaluate progress at shorter intervals and make adjustments as more data become available

Out-of-Pocket (OOP) Cost Burden for Behavioral Health Care

Unmet need due to cost

- Over a third of California adults who needed mental health treatment or counseling reported not receiving treatment due to cost.

High OOP costs impact low-income individuals the most

- One in eight patients with family income below 100% FPL spent at least 10% of disposable family income on mental health services.

OOP costs are higher for individuals with mental illness

- Among privately insured individuals, adults treated for depression and/or anxiety in 2021 spent almost twice as much out-of-pocket than adults without mental health diagnoses.

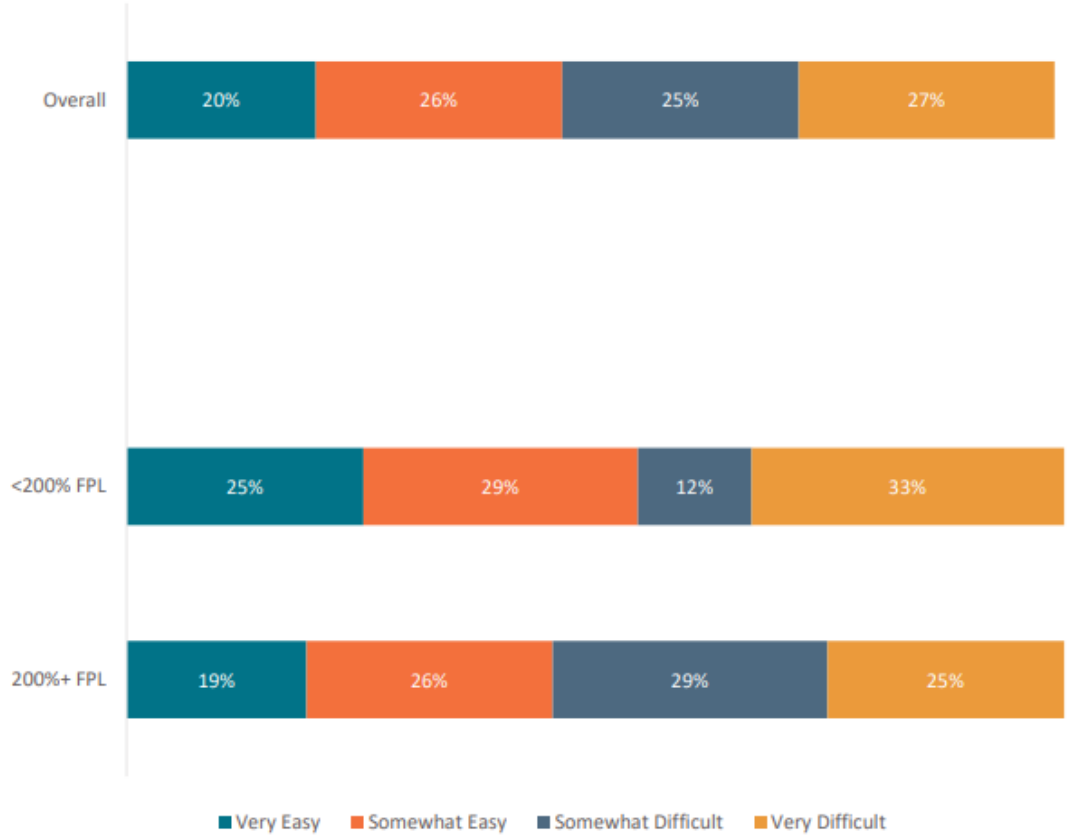
Sources: California Health Care Foundation. 2022. Mental Health in California. https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022.pdf.; Gao and Olfson. 2024. High Out-of-Pocket Cost Burden of Mental Health Care for Adult Outpatients in the United States. https://pmc.ncbi.nlm.nih.gov/articles/PMC11786981/.; Schwartz, et al. 2023. Privately insured people with depression and anxiety face high out-of-pocket costs. https://www.healthsystemtracker.org/brief/privately-insured-people-with-depression-and-anxiety-face-high-out-of-pocket-costs/

Low In-Network Access to Behavioral Health Care

- Among Californians who tried to make a mental health appointment in 2023, more than half (52%) reported difficulty finding a provider that takes their insurance.
- Californians used out-of-network psychiatrists and psychologists in 2021 more than 15 times as frequently as out-of-network medical/surgical specialist physicians.
- The 2024 California Department of Managed Health Care (DMHC) investigations report found that enrollees from 3 out of 4 plans experienced difficulty obtaining behavioral health services.

Figure 43. More Than Half of Californians Who Tried to Make a Mental Health Appointment Report Having Difficulty Finding a Mental Health Care Provider Who Takes Their Insurance

Q: OVERALL, HOW EASY OR DIFFICULT IS IT FOR YOU TO FIND A MENTAL HEALTH PROVIDER WHO TOOK YOUR INSURANCE?



Notes: Sample includes 3,431 California residents age 18 and older. "I don't have insurance" or did not answer not shown. See topline for full question wording and response options. *FPL* is federal poverty level.

Sources: California Health Care Foundation. The 2024 CHCF California Health Policy Survey. 2024. https://www.chcf.org/wp-content/uploads/2024/01/2024CHCFCAHealthPolicySurvey.pdf.; Mark and Parish. 2024. Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue. RTI International. https://dpjh8al9zd3a4.cloudfront.net/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf .; California Department of Managed Health Care. 2024. Behavioral Health Investigations: Phase Two Summary Report. https://www.dmhc.ca.gov/Portals/0/Docs/DO/BHIPhase2SummaryReportFINAL.pdf

Barriers to Behavioral Health Provider Participation in Health Plan Networks

Low Reimbursement Rates In-Network vs. Out-Of-Network

- Reimbursement rates are significantly lower in-network compared to earnings out-of-network.

Solo Practices and Heavy Administrative Burden

- Solo practices often do not have the infrastructure to manage the administrative tasks required to contract with insurance companies.

Insurer Interference with Patient Care

- Providers report that insurers may limit or question necessity of care through benefit design, prior authorizations, or claims denial.

"Ghost" Networks

- Insurer provider directories are not always up-to-date or accurate, and listed providers may not be accepting new patients.

Sources: Bishop, et al. 2014. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care. JAMA Psychiatry:https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1785174.; American Psychological Association. 2024. Barriers to Care in a Changing Practice Environment: 2024 Practitioner Pulse Survey. https://www.apa.org/pubs/reports/practitioner/2024/practitioner-pulse-2024-full-report.pdf.; Dolotina & Turban. 2022. Phantom Networks Prevent Children And Adolescents From Obtaining The Mental Health Care They Need. Health Affairs: https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00588.; GAO. 2022. Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts. GAO-22-104597. https://www.gao.gov/assets/gao-22-104597.pdf

Impact of Integrated Behavioral Health Care on Health Outcomes

- A Cochrane review of randomized controlled trials of collaborative care for patients with depression or anxiety found significantly greater improvement in depression and anxiety outcomes for adults treated with the Collaborative Care Model (CoCM) compared to comparison groups.
- A randomized controlled trial of patients with depressive disorders found that a collaborative care approach resulted in a significant improvement in number of depression-free days over 24 months compared to usual primary care.
- A randomized controlled trial found that adults with depression and poorly controlled diabetes or cardiovascular disease had improved diabetes and cardiovascular disease control, as well as better depression outcomes and improved quality of life, under a collaborative care management approach.

Sources: Archer, et al. 2012. Collaborative care for depression and anxiety problems. Cochrane Database of Systematic reviews: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006525.pub2/full.; Katon, et al. 2010. Collaborative Care for Patients with Depression and Chronic Illnesses. The New England Journal of Medicine: https://www.nejm.org/doi/full/10.1056/NEJMoa1003955; Katon, et al 2005. Cost-effectiveness of Improving Primary Care Treatment of Late-Life Depression. Arch Gen Psychiatry. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/209123

Impact of Behavioral Health Care on Total Health Care Spending

- A large cohort study found that among individuals newly diagnosed with a behavioral health condition, receiving any amount of outpatient behavioral health treatment significantly reduced per-member, per-month medical and pharmacy costs over the 27 months after diagnosis. Average total costs decreased from $464 PMPM to $391 PMPM with treatment.
- A Milliman modeling study from 2018 estimated that integrating behavioral health care with primary medical care could reduce overall healthcare costs by $38-$68 billion annually in the US.
- A 2024 pilot study reported that over a 2-year timeframe, risk-adjusted per-member per-month (PMPM) spending decreased $31 for all claims and $140 for mental health claims for patients receiving direct care in a CoCM-based program.

Sources: Bellon, Quinlan, Taylor, et al. 2022. Association of Outpatient Behavioral Health Treatment With Medical and Pharmacy Costs in the First 27 Months Following a New Behavioral Health Diagnosis in the US. JAMA Network: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2799220; Melek, et al. 2017. Potential economic impact of integrated medical-behavioral health care. Retrieved from Milliman research report: https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/importedfiles/uploadedFiles/insight/2018/Potential-Economic-Impact-Integrated-Healthcare.pdf; Ruggiero, et al. 2024. Psychiatric Health, Life Skills, and Opportunities for Wellness Program: Addressing psychiatric need through integrated consultation, collaboration, and brief episodes of care. American Psychological Association. https://doi.org/10.1037/fsh0000930

Behavioral Health Spending Analysis

Background and Purpose

- HCAI's Healthcare Payments Data (HPD) program team analyzed claims data (2018-2023) to determine behavioral health spending based on a standardized methodology developed by the Milbank Memorial Fund
- This information provides OHCA with a preliminary understanding of baseline behavioral health spending, including mental health (MH) and substance use disorder (SUD) spending

Milbank Memorial Fund

Technical Specifications for a Standardized State Methodology to Measure Behavioral Health Clinical Spending

By Vinayak Sinha and Janice Bourgault

August 2024

Introduction

Background

States are facing an unprecedented rise in the rates of behavioral health conditions. To address this health crisis, state policymakers are increasingly focused on identifying ways to improve access to high-quality behavioral health care, including defining and tracking how much payers spend to treat behavioral health conditions. Understanding how much is spent and on what services is the first step to knowing if spending is sufficient to support a growing need. Several states plan to use the data to set targets for how much payers should spend on behavioral health clinical services.

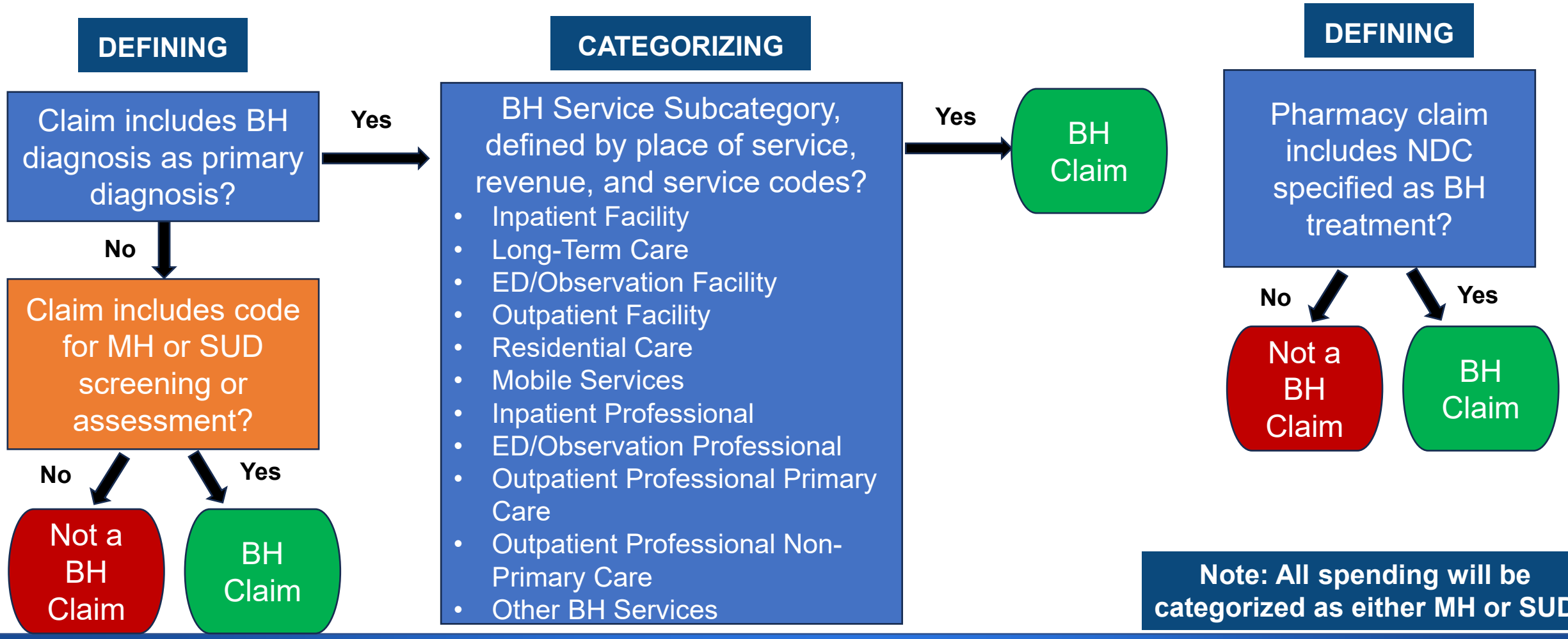
Purpose

In April 2024, the Milbank Memorial Fund (Milbank) in collaboration with Freedman HealthCare (FHC) published Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending. These recommendations were developed with input from an Advisory Group of state behavioral health leaders and subject matter experts. The FHC and Milbank teams used the Advisory Group recommendations to develop a code set (Appendix A) to support more standardized measurement of behavioral health spending across states.

This document provides technical specifications to support states in implementing the code set. Informed by stakeholder feedback, the specifications provide a base for

Source: Milbank Memorial Fund, August 2024. *Technical Specifications for a Standardized State Methodology to Measure Behavioral Health Clinical Spending.* https://www.milbank.org/wp-content/uploads/2024/08/BH-Measurement-Technical-Specifications.pdf

Process Map for Identifying Behavioral Health (BH) Claims



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

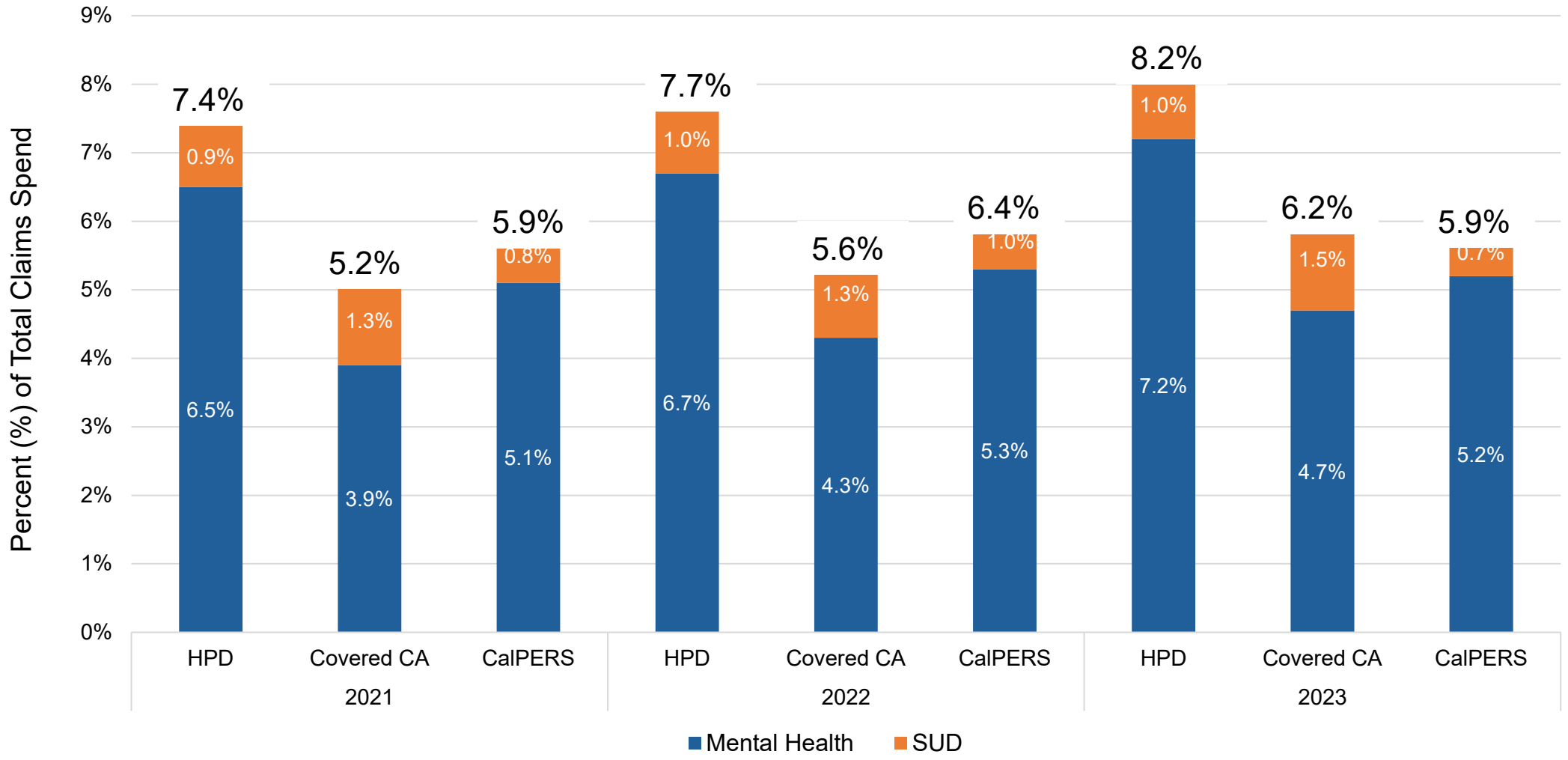
Source: The Milbank Memorial Fund, April 2024. Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending. https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

HPD Data Analysis – Methodology Details

- HPD spending analysis presented here is limited to the Commercial market
- Spending analysis was performed on claims data with associated spending in the HPD
- Covered California and CalPERS conducted similar analyses with their data
- Results presented today are preliminary

Note: Per de-identification guidelines claims records with fewer than 30 claims, and the associated spend, were suppressed.

Preliminary BH Spending Comparison: HPD Commercial, Covered CA, CalPERS 2021-2023



Note: Total claims spend includes medical and pharmacy claims spend.

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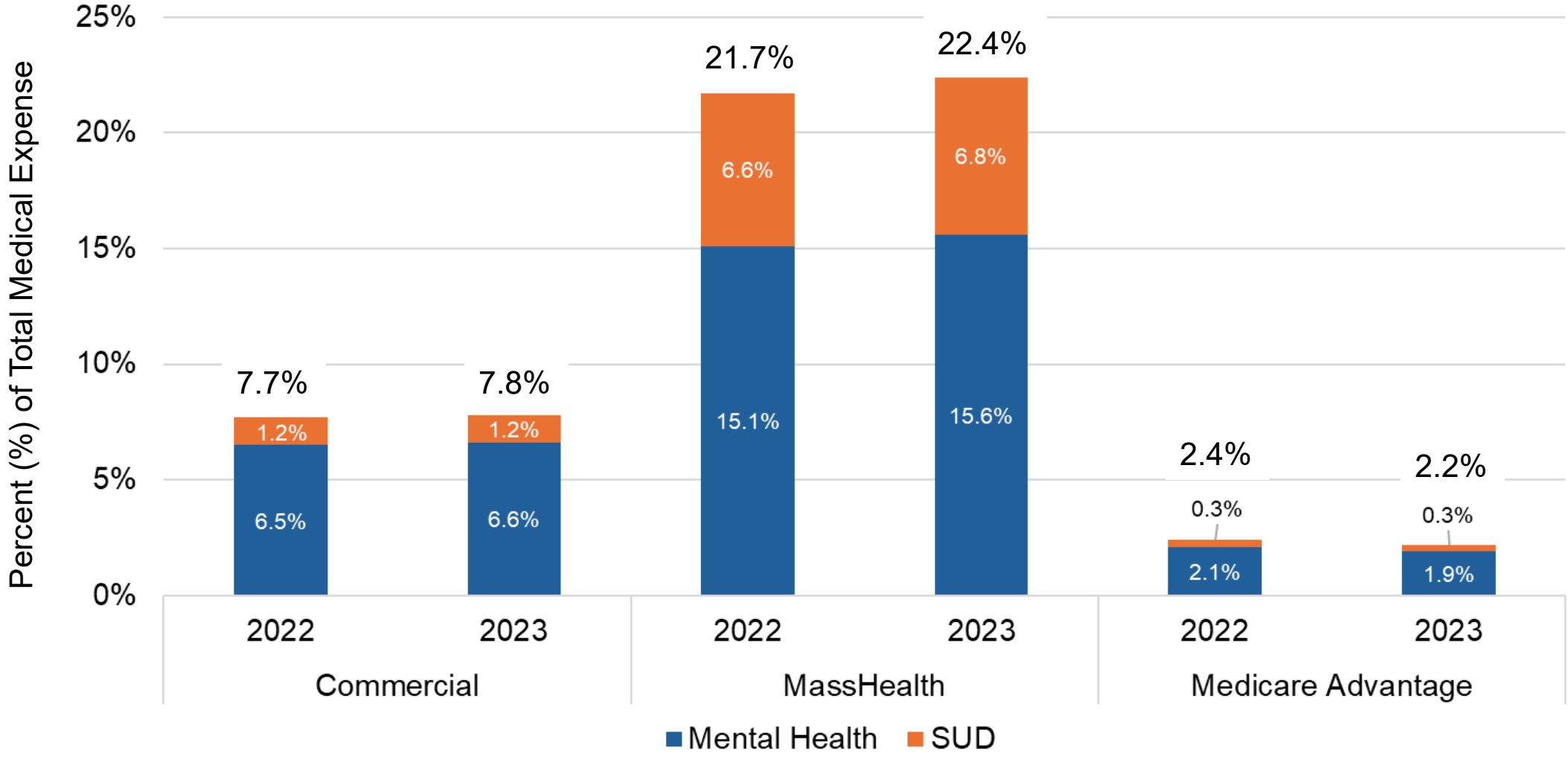
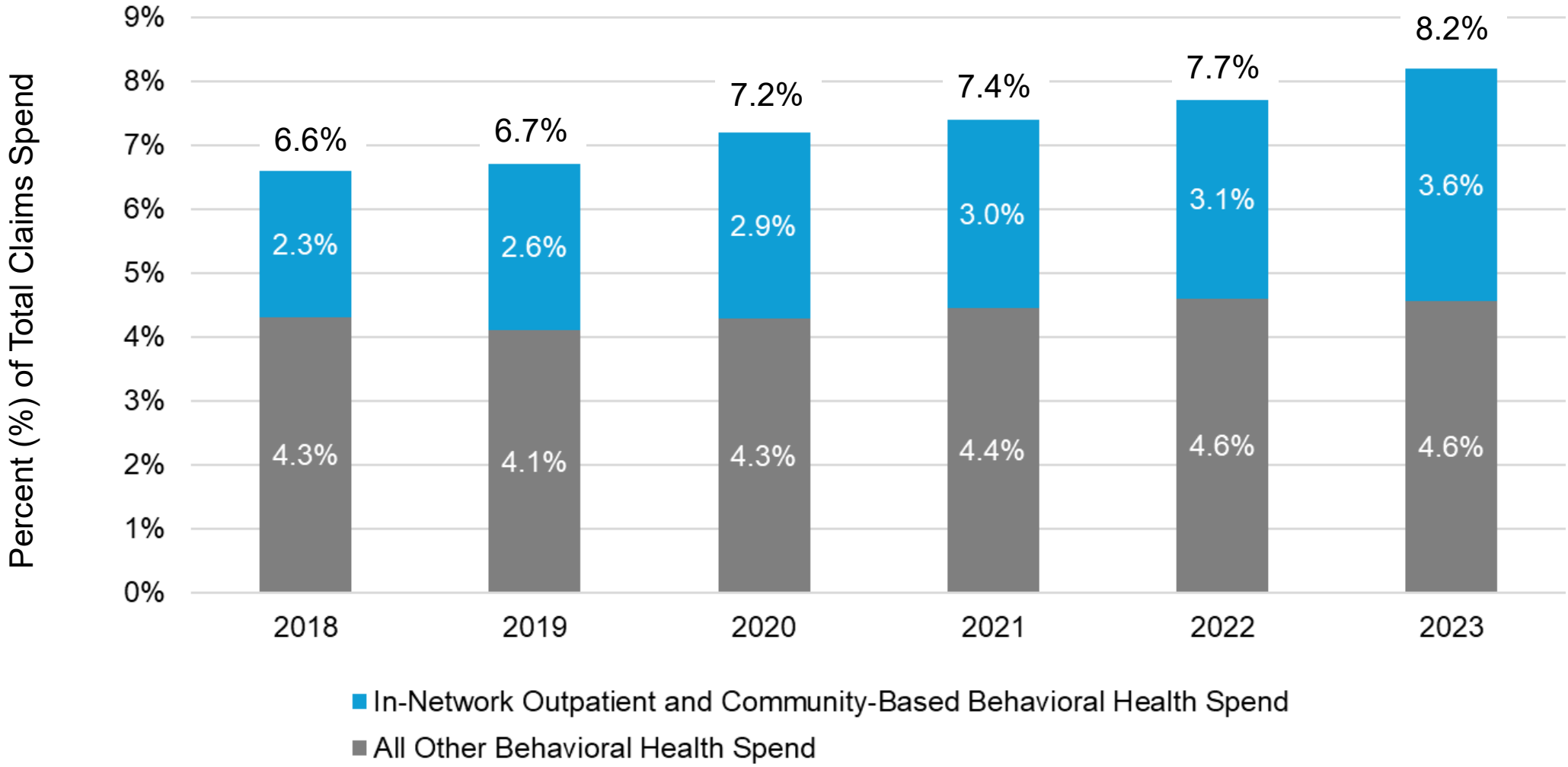
Example: Massachusetts BH Spend as a % of TME 2022-2023



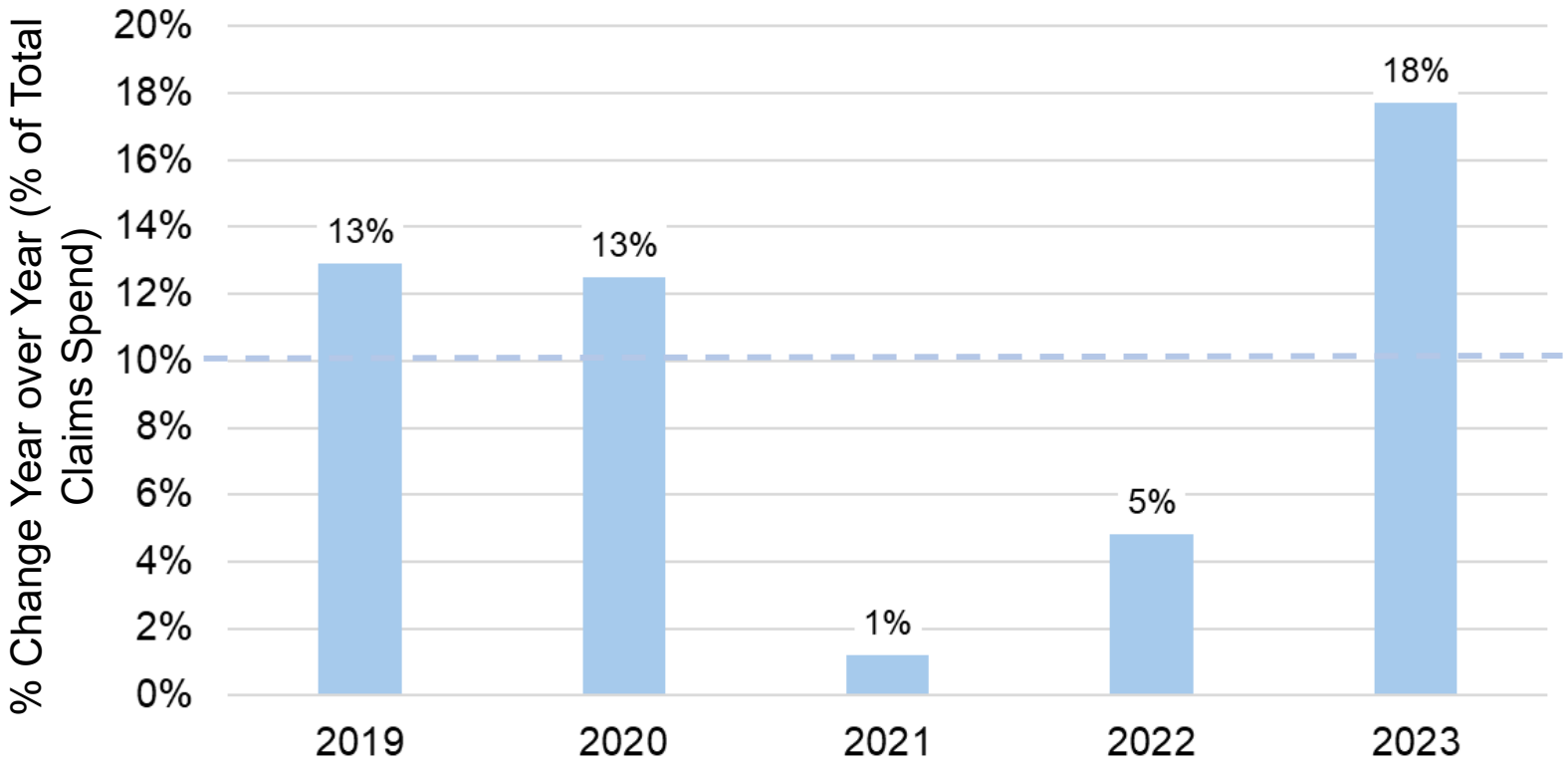
Source: Massachusetts Center for Health Information and Analysis. Primary Care and Behavioral Health Care (PCBH) Spending CY 2022 and CY 2023 Databook. https://www.chiamass.gov/primary-care-and-behavioral-health-care-pcbh-expenditures

Preliminary HPD Commercial In-Network Outpatient and Community-Based BH Spend 2018-2023



Note: Total claims spend includes medical and pharmacy claims spend.

Annual Change in Commercial In-Network Outpatient and Community-Based Behavioral Health Spending: % of Total Claims Spend



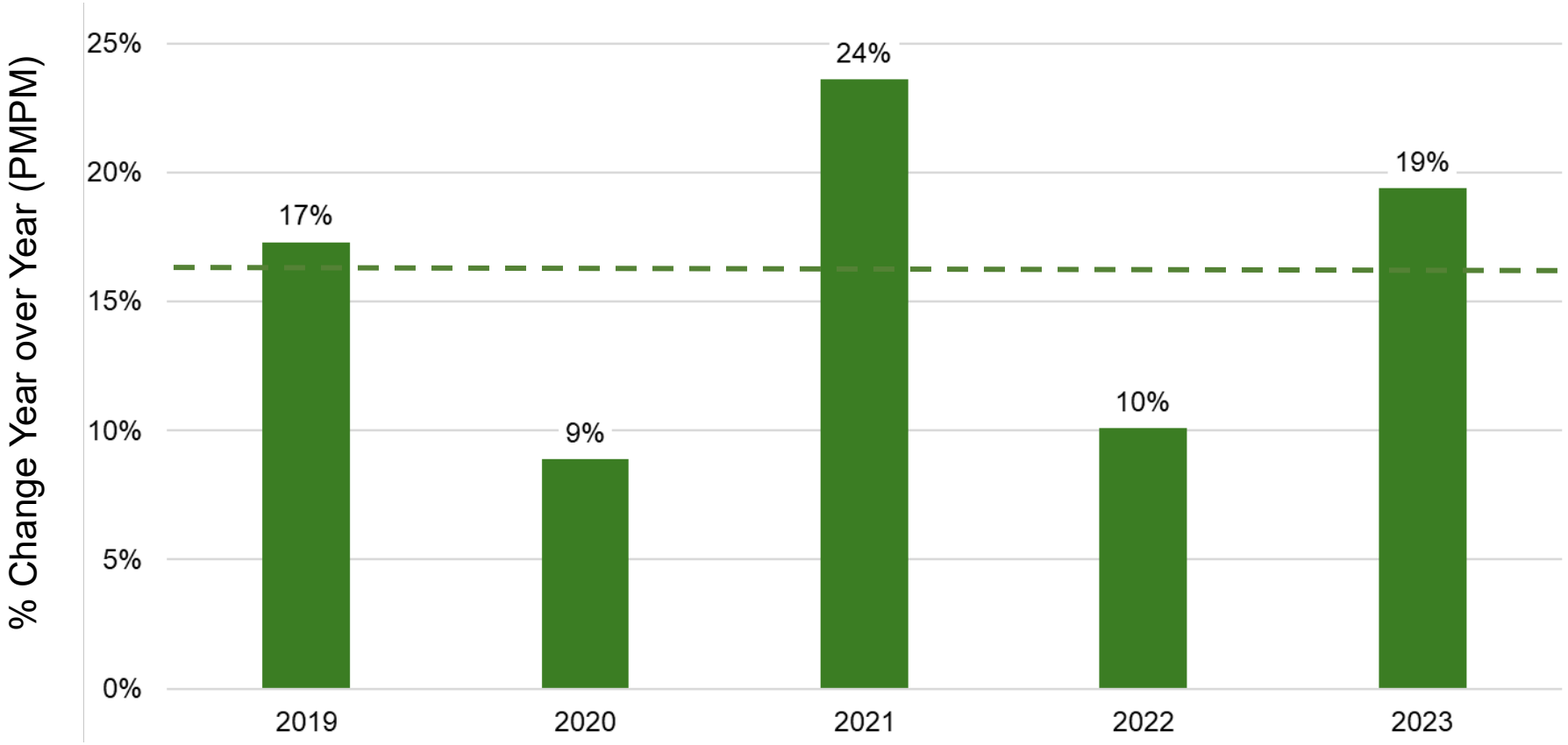
Increases reflect relative rates of change in

- Spend for outpatient/ community-based behavioral health services (numerator), and
- Total claims spend (denominator)

Shows slower growth than when measured as PMPM increase (next slide)

Preliminary analysis of HPD data. Note: Dotted line represents average year over year change across all five years. Total claims spend includes medical and pharmacy claims spend.

Annual Change in Commercial In-Network Outpatient and Community-Based Behavioral Health Spending: PMPM



- Increases reflect rate of change in spend for outpatient/community-based behavioral health services not due to membership changes.
- Change in total claims spend is not a factor in this measure.

Preliminary analysis of HPD data.
Note: Dotted line represents average year over year change across all five years.

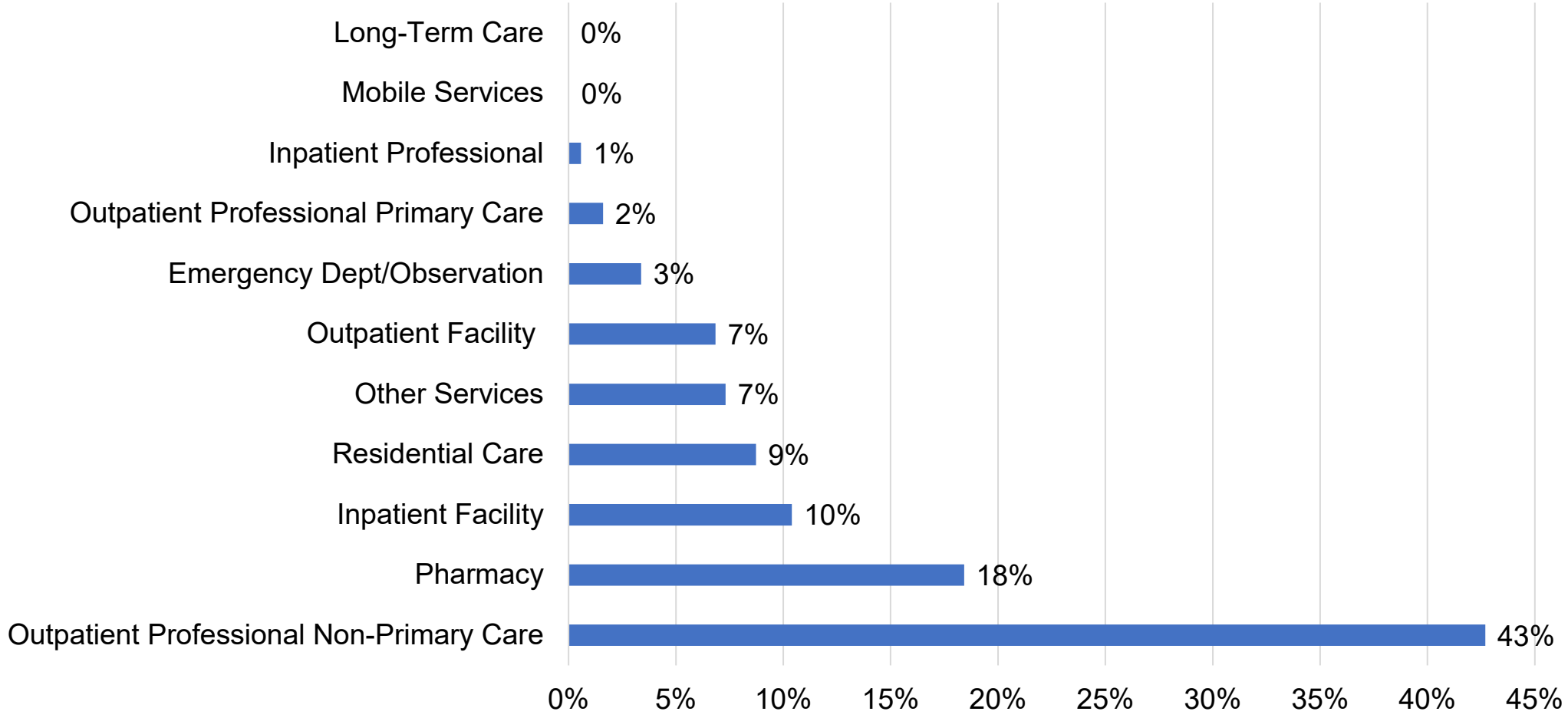
Behavioral Health Spending in the Commercial Market by Service Subcategory

	2018	2019	2020	2021	2022	2023
Emergency Dept/Observation	5%	5%	4%	4%	4%	3%
Inpatient Facility	16%	15%	15%	13%	12%	10%
Inpatient Professional	1%	1%	1%	1%	1%	1%
Long-Term Care	0%	0%	0%	0%	0%	0%
Mobile Services	0%	0%	0%	0%	0%	0%
Other	8%	6%	6%	7%	7%	7%
Outpatient Facility Non-Primary Care	7%	7%	7%	7%	7%	7%
Outpatient Professional Non-Primary Care	33%	37%	39%	38%	38%	43%
Outpatient Professional Primary Care	2%	2%	2%	2%	2%	2%
Residential Facility	4%	6%	7%	7%	8%	9%
Pharmacy	23%	21%	18%	21%	20%	18%
Total Claims Spend	**$3,095**	**$3,281**	**$3,408**	**$4,262**	**$4,662**	**$5,114**

In millions of dollars

Preliminary analysis of HPD data.

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



Preliminary analysis of HPD data.

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Potential Additional Analyses

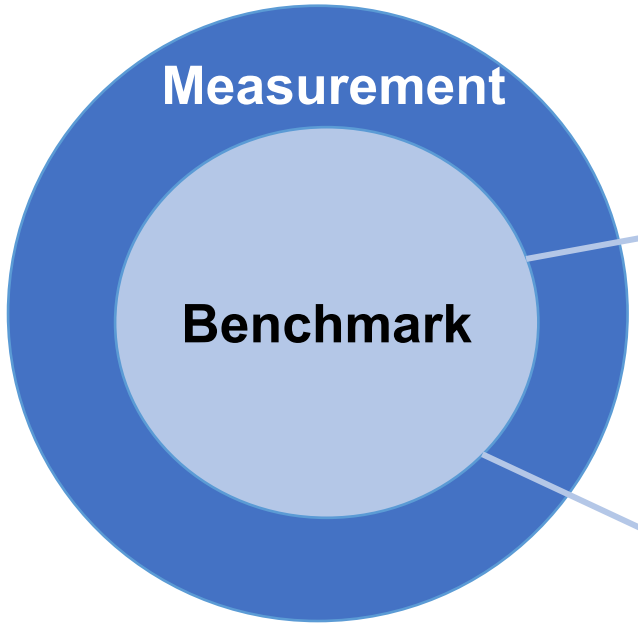
This analysis provides a preliminary understanding of baseline behavioral health spending but does not answer questions about the drivers of this spending.

OHCA is considering conducting supplemental analyses to better understand drivers of in-network, outpatient and community-based behavioral health spend. Examples include:

- Are particular services or diagnoses driving the trend?
- Is it driven more by increases in price or utilization?
- What is the variation in spending and growth in spending across payers?

Behavioral Health Investment Benchmark Proposal

What is Included in the Proposed Benchmark?



Outpatient/Community-Based Service Claims Subcategories:

- Community Based Mobile Clinic Services
- Outpatient Professional PC
- Outpatient Professional Non-PC
- Outpatient Facility

Non-claims payments in other Expanded Framework categories:

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

Other OHCA Benchmarks

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

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

Benchmark Proposal from May Workgroup: Phase 1 (2025-2029)

- Each payer is required to increase per-member, per-month spending on in-network outpatient and community-based behavioral health care by a set percentage for the performance years (PY) 2026-2029.
  - Target for percentage increase informed by pre-benchmark trends.
- Baseline is individual payer's spending in PY 2025, by line of business (commercial, Medicare Advantage).
- OHCA will assess each payer’s performance against the benchmark annually.
- In 2029, OHCA will use PY 2027 data to assess each payer’s performance against the benchmark and to inform future benchmarks.

Benchmark Proposal from May Workgroup: Phase 2 (2030-2034)

- Informed by 2029 assessment of 2027 data, OHCA will update the benchmark for the next five years (2030-2034).
- Reset annual incremental improvements, informed by payers' reported performance.
- May include long-term spending benchmark across all payers for 2034, aligned with timeframe for primary care investment and alternative payment method adoption benchmarks.
- Plan to incorporate benchmarks for Medi-Cal which would be developed in collaboration with DHCS.

Rationale

- Increasing spend on in-network outpatient and community-based behavioral health care is desirable.
    - Overall, and as a share of total behavioral health spend and of total medical expense.
- Preliminary analysis indicates these subcategories of behavioral health spending have been growing 16% per member, on average, each year without a benchmark.

However….

OHCA lacks insight into the drivers and variability in the recent spending increases.

OHCA lacks information about individual payers' starting points.

Unlike primary care, there is a dearth of research or experience about the "right" level of behavioral health spending to aim for.

Therefore,

Setting an improvement benchmark using each payer's 2025 spending as a baseline is a good place to start.

Data from 2026-2029 will fill information gaps and allow for longer term benchmark-setting.

Feedback from May Workgroup Meeting: Data Presentation

- Appreciated seeing data on behavioral health spend and year-over-year changes in the benchmark category for the commercial market to ground the benchmark discussion.
- Some were surprised by the level of 2023 spend and continued growth since 2018; others were not.
- Data raised additional questions: what factors are driving the trends, how behavioral health spending varies across payers, an interest in spending breakdown by subcategory (included here, but not presented at the Workgroup).

Feedback from May Workgroup Meeting: Benchmark Proposal

- Support for iterative, phased approach, to learn from experience and additional analysis.
- Reservations about the benchmark as proposed:
  - Interest in knowing more about past trends, including drivers of growth and year-to-year volatility.
  - Want clarity that the benchmark would support equity and access; there are many focused behavioral health programs outside of claims, suggesting a more “holistic” approach.
  - Concerns about setting a specific target for year-over-year growth due to unknown payer-specific starting points and lack of knowledge on “appropriate” level of spend.
  - More consideration required for how Medi-Cal will be phased into the benchmark, particularly payments for Specialty Mental Health services.
  - Suggestion to focus benchmark more narrowly to integrated behavioral health in primary care.

OHCA Recommendation

Recommendation	Considerations
Behavioral Health Investment Benchmark: Set in spring 2028 for performance year (PY) 2029 onwards based on OHCA data collection, while also conducting further analysis on HPD data and evaluating the impact of recent behavioral health policy efforts. **Behavioral Health Spending Measurement:** Collect and analyze behavioral health data from payers for PY 2024-2026.	• More time to learn from data submitted by payers for this measurement purpose before setting benchmark. • Also allows for identification and resolution of challenges with data submission process and measurement definitions. • Benchmark's influence on policy goals delayed by at least two years.

Recommended Next Steps for Behavioral Health Spending Measurement

- June Advisory Committee and Workgroup meetings: finalize proposed definitions for claims and non-claims behavioral health spending and behavioral health in primary care module.
- July Board meeting: solicit input on definitions.
- Summer-Fall 2025: collaborate with DHCS to ensure definition aligns with Medi-Cal Managed Care Plan covered services and payment mechanisms.
- Fall 2025-Spring 2026: develop Data Submission Guide version 3.0 to support behavioral health data collection from Commercial, Medicare Advantage, and Medi-Cal Managed Care Plans starting fall 2026.
- Ongoing: continue to work with DHCS and stakeholders to measure behavioral health spending in the broader Medi-Cal delivery system.

Discussion

- What are your reactions to the behavioral health spending data presented and to the feedback from the Workgroup?
- What are your thoughts about OHCA's recommended measurement-first approach, with benchmarking adopted in 2028?

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Public Comment

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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.

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Next Board Meeting:
July 22, 2025
10 am

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

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Adjournment

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Appendix

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Payment to Cost Ratio (PTCR) Coding Correction

- After the recalculation of PTCR with inclusion of all revenue centers, out of 1832 hospital-level observations:
- 329 observations (18%) had a change in PTCR
- 262 observations (14%) had a change of 2 percentage points or less
- Overall, the differences ranged from -25 to 13 percentage points.

Percentage Point Change in PTCR	Number of observations
[-25, -3]	30
[-2, 2]	262
[3, 13]	37
Total	**329**

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

- The table shows the pooled average PTCR that had previously been reported compared to the updated PTCR that includes all revenue centers.
- Overall, the differences ranged from 0 to 9 percentage points.

Hospital	Previous PTCR	Updated PTCR
All Other Comparable Hospitals	**200%**	**198%**
11 High-Cost Hospitals	**350%**	**348%**
Barton Memorial Hospital	773%	773%
Community Hospital of The Monterey Peninsula	*353%*	*354%*
Doctors Medical Center - Modesto	*347%*	*348%*
Dominican Hospital	331%	331%
Goleta Valley Cottage Hospital	383%	383%
Marshall Medical Center	288%	288%
Northbay Medical Center	*269%*	*260%*
Salinas Valley Memorial Hospital	475%	475%
Santa Barbara Cottage Hospital	305%	305%
Stanford Health Care	*340%*	*338%*
Washington Hospital - Fremont	*359%*	*358%*

Percentage Point Change in Commercial to Medicare Payment to Cost Ratio

Hospital	2018	2019	2020	2021	2022	Pooled Avg 2018-22
All Other Comparable Hospitals	**0**	**0**	**0**	**0**	**0**	**-2**
11 High-Cost Hospitals	**-1**	**0**	**-1**	**0**	**-1**	**-2**
Barton Memorial Hospital	0	0	0	0	0	0
Community Hospital of The Monterey Peninsula	-1	2	1	1	0	1
Doctors Medical Center - Modesto	1	1	1	1	0	1
Dominican Hospital	0	1	0	1	1	0
Goleta Valley Cottage Hospital	0	0	0	0	0	0
Marshall Medical Center	0	0	0	0	0	0
Northbay Medical Center	-11	-11	-11	-6	-5	-9
Salinas Valley Memorial Hospital	0	0	0	0	0	0
Santa Barbara Cottage Hospital	0	0	0	0	0	0
Stanford Health Care	-2	0	-2	-1	-1	-2
Washington Hospital - Fremont	-2	-2	-1	0	-1	-1

Corrected Commercial to Medicare Payment to Cost Ratio

Hospital	2018	2019	2020	2021	2022	Pooled Avg 2018-22
All Other Comparable Hospitals	**202%**	**199%**	**200%**	**190%**	**197%**	**198%**
11 High-Cost Hospitals	**327%**	**365%**	**355%**	**344%**	**351%**	**348 %**
Barton Memorial Hospital	409%	888%	981%	776%	942%	773%
Community Hospital of The Monterey Peninsula	238%	437%	353%	363%	369%	354%
Doctors Medical Center - Modesto	326%	372%	343%	325%	372%	348%
Dominican Hospital	355%	314%	336%	316%	334%	331%
Goleta Valley Cottage Hospital	368%	391%	398%	370%	384%	383%
Marshall Medical Center	266%	302%	306%	297%	267%	288%
Northbay Medical Center	385%	279%	318%	168%	160%	260%
Salinas Valley Memorial Hospital	405%	457%	461%	556%	501%	475%
Santa Barbara Cottage Hospital	293%	300%	310%	310%	311%	305%
Stanford Health Care	326%	335%	339%	351%	340%	338%
Washington Hospital - Fremont	347%	392%	352%	328%	363%	358%

Target Value for the 7 Identified High-Cost Hospitals Using Updated PTCR Calculation

Weighted Average Commercial Inpatient NPR per CMAD of High-Cost Hospitals (A)	Weighted Avg Commercial Inpatient NPR per CMAD All Other Hospitals (B)	Commercial Inpatient NPR Per CMAD Cost Relativity (C)=(A/B)	Combined Cost Relativity (G)=(C+F)/2	Statewide Spending Target for each performance year (H)		Recommended High-Cost Target Values by performance year (I)=(H/G)
$40,400	$20,300	2.0	1.9	2026	3.5%	1.8%
Weighted Average Commercial to Medicare Payment to Cost Ratio(PCTR) of High-Cost Hospitals (D)	Weighted Average Commercial to Medicare PTCR All Other Hospitals (E)	PTCR Cost Relativity (F)=(D/E)		2027 & 2028	3.2%	1.7%
351%	198%	1.8		2029	3.0%	1.6%