HCAi
Department of Health Care Access and Information

Health Care Affordability Advisory Committee

September 18, 2023

AGENDA

1. **Welcome, Call to Order, and Roll Call**

2. **Member Oath of Office and Introductions**
   Elizabeth Landsberg, Director

3. **Director's Remarks**
   Elizabeth Landsberg, Director

4. **Cost and Market Impact Review (CMIR) Proposed Draft Regulations Review**
   Sheila Tatayon, Assistant Deputy Director

5. **Total Health Care Expenditures (THCE) Measurement including Risk Adjustment; Overview of OHCA Draft Decisions for the Baseline Report; and Introduction to Methodology Considerations for the Statewide Spending Target**
   Vishaal Pegany, Deputy Director, CJ Howard, Assistant Deputy Director, and Michael Bailit, Bailit Health

6. **Alternative Payment Models, Primary Care and Behavioral Health Investment, and Workforce Stability**
   Margareta Brandt, Assistant Deputy Director

7. **General Public Comment**

8. **Adjournment**

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Welcome, Call To Order, Roll Call

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Member Oath of Office and Introductions

Elizabeth Landsberg, HCAI Director

Advisory Committee Oath

Oath for the Heath Care Affordability Advisory Committee

I,_____, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter.

New Member Introductions

Please share your name, role, organization, and what drew you to this work.

Please keep your response to one minute.

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Executive Updates

Elizabeth Landsberg
Vishaal Pegany, Deputy Director

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.

Board Member Role at Advisory Committee Meetings

- Board members attend Advisory Committee meetings as an observer.
- “Observers” are prohibited from asking questions or making statements at the meeting and can only watch and listen.
- The designated board member representative and OHCA staff will relay recommendations and input from the Advisory Committee to the Board.

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Proposed Draft Regulations Review for Assessing Market Consolidation – Cost and Market Impact Review (CMIR)

Sheila Tatayon, Assistant Deputy Director

Statutory Finding of Emergency for Rulemaking

Statute

Health and Safety Code §127501.2(a)

Until January 1, 2027, any necessary rules and regulations for the purpose of implementing this chapter may be adopted as **emergency regulations** in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of emergency regulations pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

Emergency vs. Regular Rulemaking

Emergency Rulemaking

- Posted online for **5** days before submission to the Office of Administrative Law
- Comments may only relate to necessity of emergency
- Once approved, goes into effect the next day
- Will only last 5 years; must be followed by a regular rulemaking or else will expire

Regular Rulemaking

- Posted online for **45** days before submission to the Office of Administrative Law
- Comments on text must be summarized and responded to in the rulemaking file
- Once approved, usually goes into effect the following quarter
- Permanent

Statute to Implementing Regulations

1. Material Change Notice Filing Requirements
    - Who Must File?
    - Do the Health Care Entities Meet the Thresholds?
    - Do the Circumstances of the Proposed Transaction Require Filing?
2. Health Care Services Defined
3. When Do HCEs Need to File Their MCNs?
4. Filing the MCN – Summary of Information Required
5. What Happens After an MCN is Filed? – OHCA's Process
6. OHCA's Decision to Issue Waiver or Conduct CMIR - Factors
7. Conducting the CMIR – Factors
8. Timeline for MCN Review, CMIR, Preliminary, Final Report, and Transaction Implementation

Who Must File Notice of a Material Change Transaction?

Statute

Health Care Entities (HCE) defined in statute as payers, providers, or fully integrated delivery systems (§127500.2(k).)

Proposed Regulation July Draft

Regulations Clarify HCEs Who Must File Material Change Notice (MCN):
§97431(g)

- All Payers, Providers, and Fully Integrated Delivery Systems
- Pharmacy Benefit Managers (PBMs) defined as payer per statute
- Management Service Organizations (MSOs) qualify as “payers”
- Affiliates, subsidiaries, or entities that control, govern, or are financially responsible for the HCE
- Affiliates, subsidiaries, or entities subject to control, governance or financial control of the HCE
- Any HCE entering into a transaction with a physician organization of less than 25 physicians (Less than 25 is exempt, but greater than 25 remains subject to requirement.)

Transactions already subject to review by the Attorney General, Department of Insurance, and Department of Managed Health Care, as well as county transactions, are exempt from notice requirements. HCEs under common ownership or corporate restructuring are exempt from notice requirements.

Do the Health Care Entities (HCEs) Meet the Thresholds?

Statute

OHCA shall adopt regulations for proposed material changes that warrant a notification, establish appropriate fees, and *consider appropriate thresholds, including, but not limited to annual gross and net revenues and market share in a given service or region*. (§127507(c)(3).)

Proposed Regulation July Draft

Regulations Define the Thresholds for Filing MCN:
§97435(b)(1)-(3)

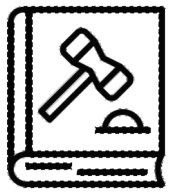
- HCE has annual revenue of at least $25M or owns or controls California assets of at least $25M, **or**
- HCE has annual revenue of at least $10M or owns or controls California assets of at least $10M and are involved in a transaction with any HCE satisfying the above $25M threshold, **or**
- HCE is located in or serving at least 50% of patients residing in a health professional shortage area (HPSA), as defined in Part 5 of Subchapter A of Chapter 1 of Title 42 of the Code of Federal Regulations https://data.hrsa.gov

Revenue means total average annual California-derived revenue received for all health care services by all affiliates over the three most recent fiscal years calculated and reported by type of HCE specified in the regulation. § 97435(d)(1)-(7)

Do the Circumstances of the Proposed Transaction Require the HCEs to File?

Statute

OHCA shall adopt regulations for proposed *material changes that warrant a notification*, establish appropriate fees, and consider appropriate thresholds, including, but not limited to annual gross and net revenues and market share in a given service or region. (§127507(c)(3).)



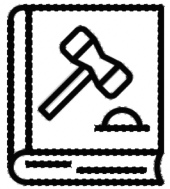
Proposed Regulation July Draft

Regulations Specify Transaction Circumstances that Trigger Filing Requirement
§97435(c)(1)-(9)

(1) The fair market value is $25M or more and involves provision of health care services (specifically defined in the regulation)
(2) Is likely to increase annual revenue of any HCE (that is a party to the transaction) by at least $10M or 20% of annual revenue
(3) Involves the sale, transfer lease, exchange, option, encumbrance, or disposition of 20% or more of assets of any HCE (that is a party to the transaction)
(4) Involves the transfer or change in control, responsibility, or governance of the submitting HCE

OHCA will not charge fees to HCE for filing MCNs, but will seek reimbursement for reasonable costs for review of MCNs and conducting CMIRs (exclusive of OHCA staff time). § 127507.4(b)(1)-(2)

Do the Circumstances of the Proposed Transaction Require the HCEs to File? (cont.)



Proposed Regulation July Draft

Proposed Regulations Specify Transaction Circumstances that Trigger Filing Requirement
§97435(c)(1)-(9)

(5) The terms contemplate an entity negotiating or administering contracts with payers on behalf of one or more providers and the transaction involves an affiliation, partnership, joint venture, accountable care organization, parent corporation, MSO, or other organization

(6) Involves the formation of a new HCE, affiliation, partnership, joint venture, or parent corporation for the provision of health care services in California projected to have at least $25M in annual revenue or have control of assets related to the provision of health care services valued at $25M or more

(7) Involves a HCE joining, merging, or affiliating with another HCE, affiliation, partnership, joint venture, or parent corporation related to the provision of health care services where any HCE has at least $10M in annual revenue (Affiliations for clinical trials or graduate medical education excluded)

(8) Changes the form of ownership of a HCE, including but not limited to change from physician-owned to private equity-owned and publicly held to privately held

(9) A HCE that is a party has consummated any transaction regarding provision of health care services in California with another party to the transaction within the prior ten years

Health Care Services Defined for Purposes of the Regulation

Proposed Regulation July Draft §97431(h)

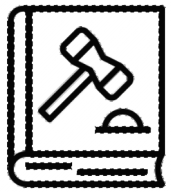
"Health care services," for purposes of this Article, are services for the care, prevention, diagnosis, treatment, cure, or relief of a medical or behavioral health (mental health or substance use disorder) condition, illness, injury, or disease, including but not limited to:

(1) Acute care, diagnostic, or therapeutic inpatient hospital services;
(2) Acute care, diagnostic, or therapeutic outpatient services;
(3) Pharmacy, retail and specialty, including any drugs or devices;
(4) Performance of functions to refer, arrange, or coordinate care;
(5) Equipment used such as durable medical equipment, diagnostic, surgical devices, or infusion; and
(6) Technology associated with the provision of services or equipment in paragraphs (1) through (5) above, such as telehealth, electronic health records, software, claims processing, or utilization systems.

When Do the HCEs Need to File their MCNs?

Statute

A HCE shall provide OHCA with written notice of agreements or transactions that will occur on or after April 1, 2024, that transfer material amount of assets or operations. Written notice *shall be provided to OHCA at least 90 days prior to entering into the agreement or transaction*. (§127507(c)(1)-(2).)



Proposed Regulation July Draft

Regulations Define "entering into the agreement or transaction" so HCEs may calculate the date for 90-day advance notice.
§97435(a)

Effective January 1, 2024, pursuant to section 127507 of the Code, a HCE who meets any threshold in subsection (b) (hereinafter referred to as a "submitter") shall provide the Office with at least 90 days' advance notice of transactions that will be entered into on or after April 1, 2024. For purposes of section 127507(c)(2) of the Code, the phrase "entering into the agreement or transaction" refers to **the date any parties' respective rights vest in a binding agreement or all contingencies to the agreement or transaction are met or waived**.

§ 97437. Pre-Filing Questions. Health care entities that are unsure if they must file a notice under this Article may contact the Office at CMIR@hcai.ca.gov.

Filing the Material Change Notice via OHCA's Electronic Submission Portal – Required Information

Proposed Regulation
July Draft

HCEs Information

- Register in the Portal
- Submission is made under penalty of perjury
- Respond to questions about the HCE submitting MCN
- Provide general information about other HCEs involved in transaction

Transaction Information

- Proposed/anticipated closing date
- Transaction description
- Necessity, public impact, benefits
- Whether review required by other state or federal agency
- Prior health care services related transactions with the same HCEs

Post Transaction Information

- Expected competitive impacts
- Mitigation of potential adverse impacts
- Current health care services provided and post-transaction impacts
- Changes to staffing levels, employee wages, benefits, working conditions, and employment protections

§ 97439 Filing of Notices of Material Change Transactions.
Note: No fees to submit MCN, but HCEs shall reimburse OHCA for costs (excludes OHCA staff time).

What Happens After the HCEs Submit Their MCN?

Proposed Regulation July Draft

Preliminary 60-day Review of MCN - Upon determination the MCN is complete, OHCA will post the MCN on its website and begin 60-day review to determine whether the transaction must undergo a Cost and Market Impact Review (CMIR). The 60-day clock can be tolled if additional information is required. OHCA may complete review in less than 60 days.

Determination: Waiver or CMIR Required – At conclusion of 60-day review (or sooner), OHCA notifies HCEs of Waiver or CMIR. The HCEs have 10 business days to request a review of the determination to conduct CMIR and the HCAI Director has 5 business days to respond that CMIR will proceed or will be waived.

OHCA will post the MCN Supporting Documentation on its website and conduct the CMIR within 90 days but may extend for 45 days if needed. (This time frame may be tolled if OHCA is waiting on documents requested from the parties or impacted parties outside the transaction.) OHCA will issue a Preliminary Report. Parties and the public may submit comments for 10 business days.

OHCA will issue its Final Report within 30 days of the close of the comment period. The HCEs may not implement the transaction until 60 days after the Final Report.

§ 97441 Cost and Market Impact Reviews.

OHCA's Decision to Issue Waiver or Conduct CMIR

Statute
§127507.2(a)(1)

- If the office finds that a material change noticed pursuant to Section 127057 is likely to have a risk of significant impact on
  - Market competitions,
  - The state's ability to meet cost targets, or
  - Costs for purchasers and consumers, the office shall conduct a cost and market impact review.

OHCA's Determination To Conduct CMIR - Factors

Proposed Regulation
July Draft
§97441(a)(2)

(2)The Office may base its decision to conduct a cost and market impact review on any one or more of the following factors:

(A) If the transaction may result in a negative impact on the availability or accessibility of health care services, including the HCE's ability to offer culturally competent care.

(B) If the transaction may result in a negative impact on costs for payers, purchasers, or consumers, including the ability to meet any health care cost targets established by the Health Care Affordability Board.

(C) If the transaction may lessen competition or tend to create a monopoly in any geographic service areas impacted by the transaction.

(D) If the transaction directly affects a general acute care or specialty hospital.

(E) If the transaction may negatively impact the quality of care.

(F) If the transaction between a HCE located in this state and an out-of-state entity may increase the price of health care services or limit access to health care services in California.

§ 97441 OHCA may conduct CMIR based on market failure, market power, or OHCA's finding the transaction is likely to impact competition or state's ability to meet spending target.

Factors Considered in the CMIR

Statute
§127507.2(a)(1)-(2)

- A CMIR will examine factors relating to a health care entity's business and relative market position, including changes in size and market share in a given service/geographic region, prices for services compared to other providers for the same services, quality, equity, cost, access, or other factors OHCA determines to be in the public interest.

- OHCA will also consider the benefits of the material change to consumers of health care services, where those benefits could not be achieved without that transaction, including increased access to health care services, higher quality, and more efficient health care services where consumers benefit directly from those efficiencies.

Factors Considered in the CMIR

Proposed Regulation
July Draft
§97441(e)

- A CMIR shall examine factors related to the HCE's business and its relative market position, including, but not limited to:
- The effect on:
  - the availability or accessibility of health care services to the community affected by the transaction, including the accessibility of culturally competent care,
  - the quality of health care services to the community affected by the transaction,
  - the lessening competition or tending to create a monopoly which could result in raising prices, reducing quality or equity, restricting access, or innovating less.
  - any health care entity's ability to meet any health care cost targets established by the Board.
- Whether the parties to the transaction have been parties to any other transactions in the past ten years that have been below the thresholds set forth in section 97435(b).
- Consumer concerns including, but not limited to, complaints or other allegations against any health care entity that is a party to the transaction related to access, care, quality, equity, affordability, or coverage.
- Any other factors the Office determines to be in the public interest.

August 15th CMIR Workshop Overview

- Attended by approximately 120 virtual participants and 20 in-person participants.
- Participants included representatives from unions, physician groups, health plans, hospital systems, private equity, consumer advocacy groups, and medical, hospital, and nursing associations.
- Thirteen commenters shared feedback on the proposed regulations during the workshop.
- General appreciation was expressed by many for the detail of the proposed regulations and for the lengthy opportunity to comment in writing as well as at the Workshop.

Overview of Written Comments on Proposed CMIR Regulations

- A total of 20 comment letters were received. Six letters came from organizations that had made verbal comments at the August 15th regulations workshop.
- Comment letters came from unions, physician groups, health plans, hospital systems, private equity, consumer advocacy groups, and medical, hospital, and nursing associations.

Written Comments Similar to Comments from the August 15th Workshop

Thresholds & Circumstances for Filing Notice

- Some commenters identified that the revenue thresholds for filing a material change notice were too low while others said they were not low enough. Instead of $10-25 Million, suggestions ranged from $3-6 Million to $50-100 Million.

Management Services Organizations (MSOs)

- Several commenters opposed the inclusion of MSOs in the definition of health care entity as “payers” and suggested they should be exempt from filing. Other written commenters, however, expressed a need for MSOs to be included.

Timing Issues

- Requests for clarity around the timing for filing a notice. Specifically, when OHCA would consider a transaction *closed*.
- Concern at the length of time needed to review notices and conduct CMIRs.
- Requests for an expedited review process.

Written Comments Similar to Comments from the August 15th Workshop (cont.)

CMIR Criteria / Factors

- Several commenters suggested the review criteria / thresholds were too broad. Others wanted more criteria.
- Requested clarification and inclusion of factors for consideration of the benefits of the transaction.
- Requested inclusion of the full range of reproductive and sexual health services including contraception, abortion, and LGBTQ+ health services.
- Requested inclusion of behavioral health services.
- Requested including labor market impacts as a sole reason for conducting a CMIR.

Written Comments Similar to Comments from the August 15th Workshop (cont.)

Confidentiality

- Requests that that additional documents be expressly confidential.
- Requests that additional attestations be made with requests for confidential treatment of documents, to ensure that submitters verify they have always maintained these documents as confidential.

Reporting requirements

- Commenters suggested two additional reporting requirements when filing:
  (1) the source of funding for the transaction and
  (2) the evidence used to determine that a transaction is beneficial.

Public Input into CMIR process

- Requests for additional public input (including hearings) in the review process.

Fees

- Requested capping reimbursement (fees).

Additional Issues Raised from Written Comments

Definitions

- Support and Opposition to broaden (make more inclusive) / narrow: **Transactions**
- Support and Opposition to broaden (include parents) / narrow (exclude categories): **Affiliates**

Thresholds & Circumstances for Filing Notice

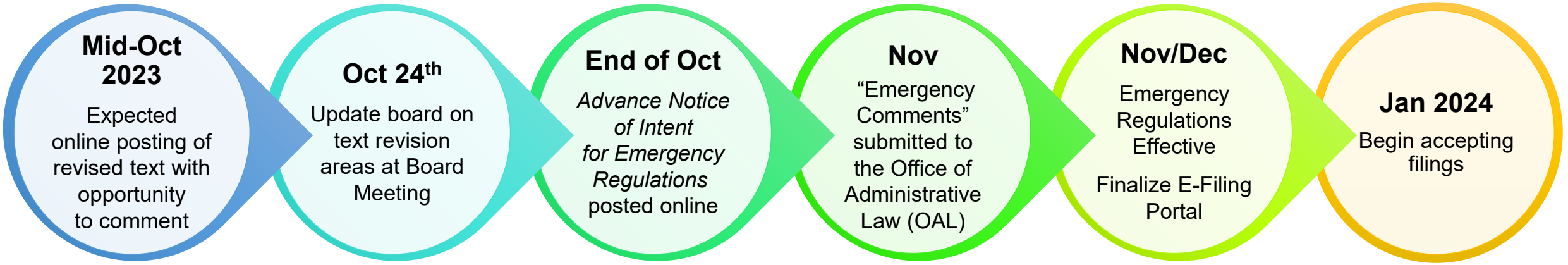
- Requests to require more detail on **Labor/staffing**, **Benefits** proposed from transaction
- Requests to require less detail for material filed (burdensome)
- Support and Opposition to revenue definitions, materiality, control

Requests for more “Market Failure” text

Support and Opposition for “look-backs” / prior transactions

CMIR Regulations and Timeline: Looking Ahead to January 1, 2024 Filings

OHCA will promulgate regulations under its emergency rulemaking authority as follows:



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Total Health Care Expenditures (THCE) Measurement

Vishaal Pegany, Deputy Director,
CJ Howard, Assistant Deputy Director,
Michael Bailit, Bailit Health

Recap of June Advisory Committee Meeting

During the first Advisory Committee meeting in June, we:

- provided introductory information on health care spending targets, including a look at the experience in Massachusetts;
- reviewed California's spending target development timeline;
- discussed the measurement of Total Health Care Expenditures (THCE) in California; and
- began discussion of spending target program adjustments, including risk adjustment methodologies for the reporting of THCE.

Today's Discussion

1. Continued discussion of risk adjustment
2. Measuring health care spending of health plans and provider entities
3. OHCA major draft decisions for collecting 2022-2023 THCE data from payers and fully integrated delivery systems for the baseline report
4. Process and timeline for regulation promulgation
5. Introduction to setting the statewide target

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Risk Adjustment

Risk Adjustment: *Recap*

- **OHCA's enabling statute** states:
  - "*the office shall establish risk adjustment methodologies for the reporting of data on total health care expenditures…The risk adjustment methodologies selected or used to inform any adjustments shall take into account the impact of perverse incentives that may inflate the measurement of population risk, such as upcoding...*"
- During the first Advisory Committee meeting in June, we discussed OHCA's approach to risk adjustment using age / sex factors.
- Advisory Committee members expressed interest in additional discussion of this topic during today's meeting.

What is Risk Adjustment?

- **Risk adjustment** (or health status adjustment) is a process whereby a payment, quality, or performance measure is modified (typically multiplied or divided) by a risk score.
- A **risk score** is used to estimate how much it will cost to care for a patient based on their underlying characteristics relative to a population average.
  - Risk scores are typically derived from equations that relate health care expenditures to patient characteristics using health care claims data.
  - Most risk score formulas rely on the patient's (or population's) "claims history" – and particularly their accumulated diagnoses, plus age and gender.
- In payer/provider contracts, risk scores can be used to "adjust" the dollar amounts allocated to that patient's (or population's) care, so that resources will be matched to projected need for services and care.

States' Experience with Rising Risk Scores

- **MA** has observed steadily rising risk scores, amounting to an 11.7% increase between 2013 and 2018 with only a small portion explained by demographic trends or changes in disease prevalence.
  - The MA Health Policy Commission now recommends evaluating payer and provider performance based on growth in *unadjusted* spending.
- Payer risk scores in **RI** grew 4.6% from 2018 to 2019 (excluding Medicare-Medicaid plans).
  - Rising risk scores had the effect of raising the cost growth rate that would meet the target, increasing the effective target from 3.2% to 6.4%.
  - The state *moved to age / sex adjustment* as a result.
- NJ, OR, RI and WA are using age / sex adjustment; NV's governing body recommended no risk adjustment.

Risk Adjustment Model Options

1. Clinical risk adjustment

- Used to assess conditions diagnosed and treated during the performance year to predict spending in the same year.
- Available models use claim and encounter data, such as diagnoses, procedures, and prescription drugs. They do not include medical record information (e.g., clinical indicators of severity, measures of prior use, lifestyle or supplemental demographic information).
- The best risk adjustment models can explain about half of the variation on health care spending, and a little more if spending for the highest cost outliers is truncated.

2. Age/Sex factors

- Risk adjust spending using standard age/sex factors. Payers report spending by age/sex. Spending at the payer and provider levels are adjusted based on relative weighting. The weights can be calculated using market-specific payer-submitted data or be initially defined.

OHCA's Approach for Risk Adjustment: *Recap*

- OHCA will collect age and sex data to enable demographic adjustment when measuring year-over-year spending growth to:
  - Capture the impact of an incrementally aging population, which may be the most significant change affecting population health status over the course of a year
  - Avoid having to account for variation in diagnostic intensity across health care entities
- OHCA will establish age/sex bands that will be adjusted based on relative weighting of those bands and uniformly apply them across payers, by market.
  - This will standardize the risk adjustment methodology.

OHCA's Approach for Risk Adjustment

- Does the Advisory Committee have questions, input, or recommendations regarding OHCA's approach to risk adjustment?

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Total Health Care (THCE) Expenditures Measurement

Measuring THCE: Health Plans

OHCA is considering an approach to identifying which health plans will be required to submit data to measure THCE that:

1. Focuses data collection and analysis resources on payers representing most California health care spending
2. Avoids collecting data from payers that are too small to contribute to the generation of statistically meaningful results
3. Balances the administrative cost of data collection, validation, analysis and reporting with an objective of data completeness

OHCA's Considerations for Measuring THCE: Health Plans

- Health plans with at least 40,000 covered lives in any market (e.g., commercial, Medi-Cal, Medicare) will be required to submit THCE data for all three markets.
- Nearly all Medi-Cal plans will be required to submit THCE. Specialty plans (e.g., AIDS Health Foundation, On Lok) with extremely low enrollment will be excluded.
- This method will capture nearly all spending (99%) in the commercial and Medi-Cal managed care markets and the majority of spending (97%) in the Medicare Advantage market.

Proposed Health Plans Meeting Threshold

Health plans are listed in alphabetical order.

Commercial	Medi-Cal	Medicare Advantage
1. Anthem 2. Blue Shield 3. Centene (Health Net) 4. CIGNA 5. CVS (Aetna) 6. Kaiser 7. L.A. Care 8. Molina 9. Oscar 10. Sharp 11. SIMNSA 12. Sutter 13. UnitedHealthcare 14. Western Health Advantage	1. Alameda Alliance 2. Anthem 3. Blue Shield 4. CalOptima 5. CalViva Health 6. CenCal Health 7. Centene (Health Net) 8. Central California Alliance for Health 9. Community Health Group 10. Contra Costa Health Plan 11. CVS (Aetna) 12. Gold Coast Health Plan 13. Health Plan of San Joaquin 14. Health Plan of San Mateo 15. Inland Empire Health Plan 16. Kaiser 17. Kern Family Health Care 18. L.A. Care 19. Molina 20. Partnership Health Plan 21. San Francisco Health Plan 22. Santa Clara Family Health Plan	1. Alignment 2. Anthem 3. Blue Shield 4. Bright Health 5. Centene (Health Net) 6. Central Health Plan 7. CVS (Aetna) 8. Humana 9. Kaiser 10. SCAN 11. UnitedHealthcare 12. WellCare

Source: 2022 Edition – California Health Insurers, Enrollment. October 28, 2022. https://www.chcf.org/publication/2022-edition-california-health-insurers-enrollment/

OHCA's Considerations for Measuring THCE: Health Plans

Does the Advisory Committee have questions, input, or recommendations regarding OHCA's contemplated approach for health plans required to submit THCE data?

Measuring Spending: Provider Entities

- OHCA anticipates developing methods to assess performance against the target for the following provider types:
  - Large systems, physician organizations, and Federally Qualified Health Centers (FQHC) *to which spending can be attributed through direct or inferred primary care physician relationships*
  - Hospitals, specialists

- Today we will be talking about measuring spending for provider entities to which *direct or inferred* primary care attribution is possible.
  - OHCA is developing alternative methods to measure spending growth of entities without direct or inferred primary care attribution.

Measuring Provider Entity Spending: What is Being Measured?

- OHCA is measuring the *change in annual per capita health care spending* for California residents regardless of where they seek care.
- OHCA is relying on aggregated plan-reported data with spending attributed to provider entities.

Total Medical Expense (TME)

- ✓ All **claims-based** payments and encounters for covered health care benefits.
- ✓ All **non-claims-based** payments for covered health care benefits.
- ✓ All **cost sharing** for covered health benefits paid by health care consumers.*

*Consumer obligation, e.g., copayments, coinsurance, and deductibles.

Provider Entity Spending Attribution

- OHCA is creating rules to attribute member spending to provider entities through *direct or inferred attribution of individuals to entities with primary care providers*.
  - This method acknowledges the role of primary care providers (PCPs) in directing patient care, triaging patient health conditions and concerns, and referring to specialty care, as needed.
- An individual's total spending is attributed to the provider entity with which a PCP is employed or otherwise affiliated. This may include spending on services that were not provided by the PCP or PCP's affiliated entity.

Attribution Challenges

- OHCA's attribution specifications consider the following challenges:
  - California lacks a provider directory that identifies PCP affiliation with provider entities.
  - PCPs sometimes practice with multiple provider entities.
  - Health plans do not maintain lists of which individual clinicians practice at which individual practice(s), medical group(s), IPA(s), or health system(s).
  - PCP affiliations with provider entities are subject to change through mergers, acquisitions, retirements, etc.

- In addition, OHCA's specifications consider the landscape of capitated payment arrangements in California.

Engaging Stakeholders on Attribution

OHCA is completing the following steps to engage stakeholders in developing a member attribution methodology for spending:

- Discussing with health plans and providers approaches that are feasible, minimize spending that is unattributed, and limit administrative burden.
- Meeting with a group of commercial and Medicare Advantage plans to explore primary care attribution and address challenges.
- Meeting with a group of Medi-Cal managed care plans to discuss Medi-Cal-specific data collection challenges.
- Engaging providers in discussions of attribution.

OHCA's Considerations for Provider Entity Attribution (1 of 2)

OHCA is considering attributing spending to provider entities through primary care relationships as follows:

1. Direct relationships established through member selection of primary care provider (most common in the HMO market).
2. Inferred relationships through plan analysis of claims using both plan-driven parameters (e.g., those used in value-based payment contracting) and OHCA-defined parameters (to capture members whose care is not paid for through capitation or value-based payment arrangements).

Note: There will always be some level of unattributed spending.

OHCA's Considerations for Provider Entity Attribution (2 of 2)

Does the Advisory Committee have questions, input, or recommendations regarding OHCA's process for determining a member attribution methodology for spending?

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OHCA Draft Design Decisions on THCE Data Collection for the Baseline Report

OHCA 2022-2023 THCE Measurement: Summary of Key Draft Design Decisions

The next few slides will highlight OHCA's tentative decisions on the measurement methodology for the baseline report, summarized according to the following categories:

1. Spending that is being measured
2. Spending data sources
3. Spending analysis
4. Characterizing and understanding spending

1. Spending that is being measured

OHCA will measure:

- Spending for **residents of California**, regardless of where they seek care.
- **Claims payments**
  - Payments to providers for covered services.
- **Consumer out-of-pocket spending obligation**
  - Consumer obligation (i.e., copay, coinsurance, and deductible) for all claims for covered services.

1. Spending that is being measured (cont.)

OHCA will measure:

- **Non-Claims payments**
  - Population Health and Practice Infrastructure Payments
  - Performance Payments
  - Payments with Shared Savings and Recoupments
  - Capitation and Full Risk Payments
  - Other Non-Claims Payments
  - Pharmacy Rebates

2. Spending data sources

- **Commercial, Medicaid, and Medicare**: OHCA will collect aggregate health care spending data across all markets from carriers with 40,000 or more enrolled lives in their Commercial, Medi-Cal, or Medicare markets.
  - For non-Managed Care Organization (MCO) Medi-Cal spending, OHCA will collect spending data from the Department of Health Care Services (DHCS)
  - For Traditional Medicare (fee-for-service) spending and Part D, OHCA will collect spending data from the Centers for Medicare and Medicaid Services (CMS)

- **Other Spending:** for calculation of statewide THCE, OHCA will likely include:
  - Veterans Affairs
  - Indian Health Service
  - California Department of Corrections and Rehabilitation

- **Insurer administrative cost and profits** from federal and state reports, when data are available, and from insurers directly or financial statements when they are not.
  - CMS Center for Consumer Information and Insurance Oversight (CCIIO) for Commercial (examining DMHC as another possibility)
  - NAIC for Medi-Cal MCOs
  - NAIC for Medicare Advantage

3. Spending Analysis - Levels of Reporting THCE

1.State	2. Region	3. Market	4. Payer	5. Provider Entities	6. Service Category
State	25 Regions	Medicaid *(Fee-for-Service and Managed Care)*	Medicaid Managed Care Plans	Provider Entity A	Hospital Inpatient
		Medicare *(Fee-for-Service and Managed Care)*	Medicare Advantage Carriers	Provider Entity B	Hospital Outpatient
		Commercial *(Self- and Fully-Insured)*	Commercial Carriers *(including by product type)*	Provider Entity C	Professional
					Long-term care
					Retail Pharmacy
					Other

3. Spending Analysis – Geography

OHCA intends to collect spending data to support geographic analysis by Covered California rating regions, except for Los Angeles County. For Los Angeles County, OHCA intends to collect data by Service Planning Areas.

Figure 16. Nineteen California ACA Rating Areas

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3. Spending Analysis – Service Category and Product Type

- **Service Category:** OHCA will collect spending data by service category, including:
  - Hospital Inpatient
  - Hospital Outpatient
  - Professional
  - Long-Term Care
  - Retail Pharmacy
  - Other claims not categorized (e.g., durable medical equipment, transportation).

- **Product Types:** OHCA will collect spending data separately by commercial HMO/capitated and PPO/EPO/FFS product lines.

4. Characterizing and understanding spending measurement

- **Confidence Intervals:** OHCA will collect standard deviations to enable the calculation of confidence intervals and assess variability in spending.
- **Demographic Risk Adjustment:** OHCA will collect age and sex data to enable demographic adjustment when measuring year-over-year spending growth at the payer and provider entity levels.
- **Truncation:** OHCA will not collect truncated spending at the payer and provider entity levels.

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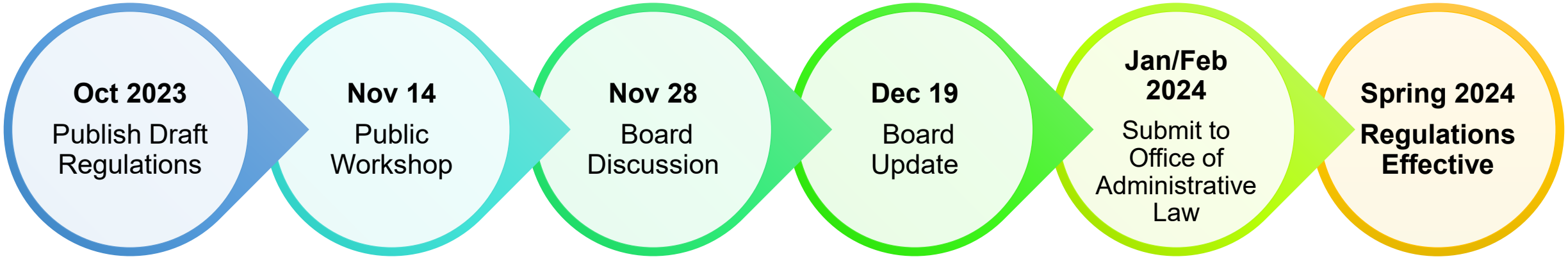
Process and Timeline for Regulation Promulgation

THCE Data Specification Regulations Timeline



Some dates are subject to change.

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Setting California's Health Care Spending Target

Review: What Is a Spending Target and Why Pursue One?

- A health care spending target is an annual rate of growth target.

- States have adopted such targets to slow the growth in health care spending.
  - Health spending growth has long exceeded economic growth.[1]
  - Per capita spending on health care has grown faster than inflation, wages and other consumer measures.[2]

1.Kaiser Family Foundation analysis of National Health Expenditure Data, February 2023 (https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/)
2. Ibid.

Developing California's Spending Target Methodology: Today's Goals

1. Review the statutory requirements and considerations, including the Board and OHCA responsibilities and timeline.
2. Review of other state's methodologies.
3. Introduce economic and population indicators and consider tying the target value to one or more of them.
   - Today we will define the indicators and describe the practical implications of tying the spending target to any of these. This will allow us to discuss the concepts in theoretical terms.
   - At our next meeting we will share historic and forecasted data for the measures that interest you the most and start the process of discussing the spending target value.
4. Review other factors identified in the statute for possible spending target adjustments.

Statutory Requirements for Setting the Target

The Board shall establish a statewide health care [spending] target for the 2025 calendar year and for each calendar year thereafter. The statewide target must meet the following criteria:

- Promote a **predictable and sustainable** rate of change in per capita THCE.
- Be based on a target percentage, with **consideration of economic indicators and/or population-based measures.**
- Be developed with a methodology that is **transparent** and available to the public.
- Be set **for each calendar year, with consideration of multi-year targets.**

* These criteria are summarized from Article 3. Health Care Cost Targets [Health and Safety Code section 127502].

Statutory Requirements for Setting the Target (cont.)

- Be **developed, applied and enforced**.
- Be **updated periodically** and consider relevant adjustment factors.
- Promote **improved affordability,** while maintaining **quality and equitable care**, including consideration of persons with disabilities and chronic illness.
- Promote the **stability of the health care workforce**.
- Be **adjusted for provider entities** to account for growth in organized labor costs.

* These criteria are summarized from Article 3. Health Care Cost Targets [Health and Safety Code section 127502].

Statutory Requirements for Setting the Target (cont.)

- The Board shall [also] establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, except for fully integrated delivery systems.

- Sector targets must be established on or before June 1, 2028; therefore, the Board will focus only on the **statewide target** this year.*

*Per Health and Safety Code Section 127502: On or before October 1, 2027, the board shall define initial health care sectors. Not later than June 1, 2028, the board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, in accordance with this chapter.

Health Care Spending Target Methodology Development

OHCA is responsible for developing a methodology, to be approved by the Board. The methodology must meet the following criteria*:

- Be available and **transparent** to the public.
- Based on a review of **historical trends and projections** (forecasts) of economic and population-based measures.
- Based on a review of historical cost trends, with **differential treatment for COVID-19 years.**
- Consider potential **factors to adjust future cost targets**, including but not limited to health care employment cost index, labor costs, CPI-U and other factors.
- Consider several **criteria related to Medi-Cal**, including but not limited to the non-federal share of spending, maintaining federal requirements to ensure full federal financial participation and health care related taxes or fees provide the non-federal share.

* These criteria are summarized from Article 3. Health Care Cost Targets [Health and Safety Code section 127502].

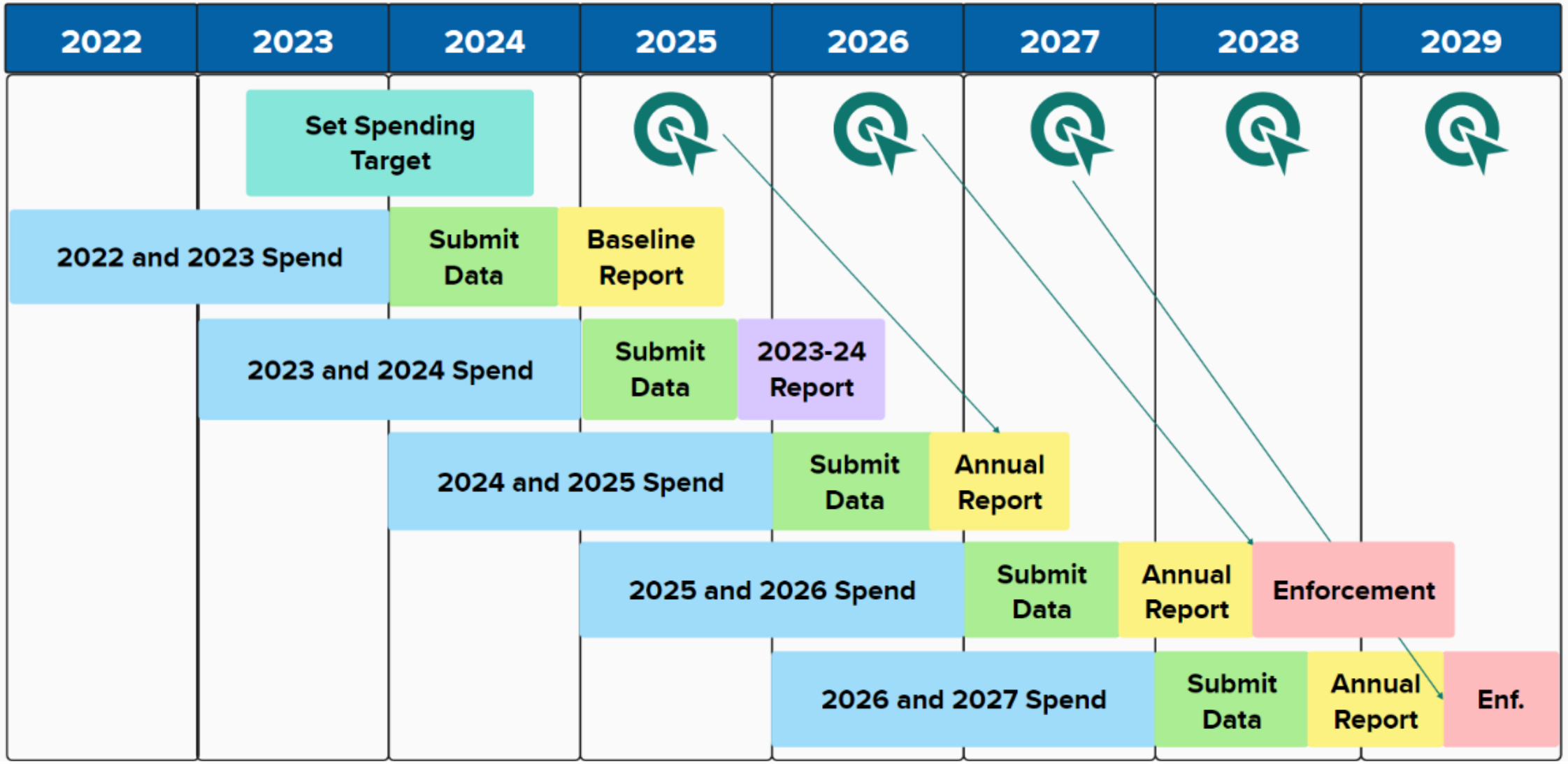
Health Care Spending Target Methodology Development (cont.)

- **Allow** the board to adjust cost targets downward, when warranted for health care entities that deliver high-cost care that is not commensurate with improvements in quality.
- **Allow** the board to adjust cost targets upward, when warranted, for health care entities that deliver low-cost, high-quality care.
- **Require** the board to adjust cost targets, as appropriate, for a provider or a fully integrated delivery system to account for actual or projected nonsupervisory employee organized labor costs.

Additional criteria apply when setting sector-specific targets. These will be reviewed during a future meeting.

* These criteria are summarized from Article 3. Health Care Cost Targets [Health and Safety Code section 127502].

Spending Target Timeline



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How Other States Have Set Their Spending Targets

- To date, eight states have set health care spending targets (CT, DE, MA, NJ, NV, OR, RI, WA).
- All tied their targets to some measure of the economy, including state economic growth and/or indicators of resident income growth.
- For most states, the governing body reviewed several different economic indicators and considered:
  - What the indicator measured, and how relevant it was to their charge?
  - What would be “the message” if they linked future health care spending growth to the indicator?

How Other States Have Set Their Spending Targets (cont.)

- When setting the values, states also considered prior spending growth in their state commercial, Medicaid, and Medicare markets.
- All of the states set multi-year targets at the outset. One state for as few as four years, one for as long as 10. Most set five-year targets.
- Between 2018 and 2022, states established target values ranging from 2.9 percent to 3.8 percent.
  - Target values were roughly 2 percentage points less than the average annual state health care spending growth over the prior decade in each state.

State Cost Growth Target Methodologies

State	Target Methodology	Target Value	Avg Annual Spending Growth (2011-2020)
Connecticut	80/20 blend of forecasted median wage and Potential Gross State Product (PGSP) Add-on factors: +0.5% for CY 2021, +0.3% for CY2022, +0.0% for CY 2023-2025	3.4% for 2021 3.2% for 2020 2.9% for 2023-2025	3.9%
Delaware	PGSP Add-on factors: +0.25% for 2021, +0.0% for CY2022-2023	3.8% for 2019 3.5% for 2020 3.25% for 2021 3.0% for 2022-2023	5.2%
Massachusetts	2018-2022: PGSP (3.6% in 2018) minus 0.5 2023 and beyond: default rate of PGSP	3.6% for 2013-2017 3.1% for 2018-2022 3.6% for 2023-2024	5.4%
Nevada	Changing blend of forecasted median wage and PGSP, with increasing weight on forecasted median wage over time.	3.19% for 2022 2.98% for 2023 2.78% for 2024 2.58% for 2025 2.37% for 2026	6.2%

State Cost Growth Target Methodologies

State	Target Methodology	Target Value	Avg Annual Spending Growth (2011-2020)
New Jersey	75/25 blend of median projected household income and PGSP Add-on factors: +0.3% for 2023, +0.0% for 2024, -0.2% for 2025, -0.4% for CY2026-2027	3.5% for 2023 3.2% for 2024 3.0% for 2025 2.8% for 2026-2027	5.4%
Rhode Island	PGSP for 2019-2022; 75/25 blend of PGSP and median household income for 2023-2027 2023-2025 PGSP input accounts for lagged inflation impact; 2026 and 2027 utilize long-term inflation forecasts	3.2% for 2019-2022 6.0% for 2023 5.1% for 2024 3.6% for 2025 3.3% for 2026 and 2027	5.1%
Oregon	Non-formulaic consideration of: historical Gross State Product (GSP); historical median wage; CMS waiver & legislative growth caps applied to the state's Medicaid and publicly purchased programs	3.4% for 2021-2025 3.0% for 2026-2030	5.8%
Washington	70/30 blend of historical median wage and PGSP, with a downward adjustment starting in 2024	3.2% for 2022-2023 3.0% for 2024-2025 2.8% for 2026	4.9%

Development of Spending Target Methodology: Reviewing Possible Indicators

- The statute requires the spending target to consider economic indicators and population-based measures.
- We will review possible economic indicators and population-based measures based on publicly available and transparent data.

Development of Spending Target Methodology: Possible Economic & Population Indicators

The statute states that economic indicators may include established measures reflecting the broader economy, the labor markets, and consumer cost trends.

We will present several indicators for consideration and describe:

1. What each of these indicators represent.
2. What the “message” would be if the spending target was pegged to one of these indicators.

Possible Economic and Population-Based Indicators

- California Gross State Product
- California's Potential Gross State Product
- Median Family Income of Californians
- Average Wage of Californians
- Inflation, as Measured by the Consumer Price Index (CPI-U)
- Median Age

* Each of these indicators would be calculated using annual growth rates.

What We Will Learn About Each of the Indicators

What each indicator measures

What the "message" would be if the target was pegged to one of these indicators

What the annual rate of change has been and (when available) forecasted data. (These data will be shared during the October meeting.)

Economic Indicators: Historical and Forecasted Experience

There are differences in economic indicators calculated using historical actual data vs. forecasts. We will consider both.

Historical Data

- Historical data reflects, to varying degrees, the volatility of year-over-year changes, including booms and busts; or pandemic times and healthy times.
- Historical figures are relatively easy mathematical calculations (straight average growth over prior time periods).
- Unexpected events can be addressed through smoothing or by extending the time period.

Forecasted Data

- Forecasted data are designed to be predictable, stable figures and are often calculated by government agencies and private firms.
- The California Department of Finance regularly forecasts economic indicators for use in budget setting and for other purposes.
- Methods of forecasting vary by the organization performing the forecast, including by the philosophy and outlook of chief economists at each organization.

1. California Gross State Product

- **Gross State Product (GSP)** is the total value of goods produced and services provided in a state during a defined time period.
- This is the state counterpart to Gross Domestic Product (GDP), which is measured at the national level, with a few methodological differences in how the figures are calculated.

GSP is often considered the main measure and key target of economic policy at all levels of government. The growth in GSP tells us how fast the state's economy is growing.

Tying the benchmark to GSP signals that health care spending should not grow faster than the economy.

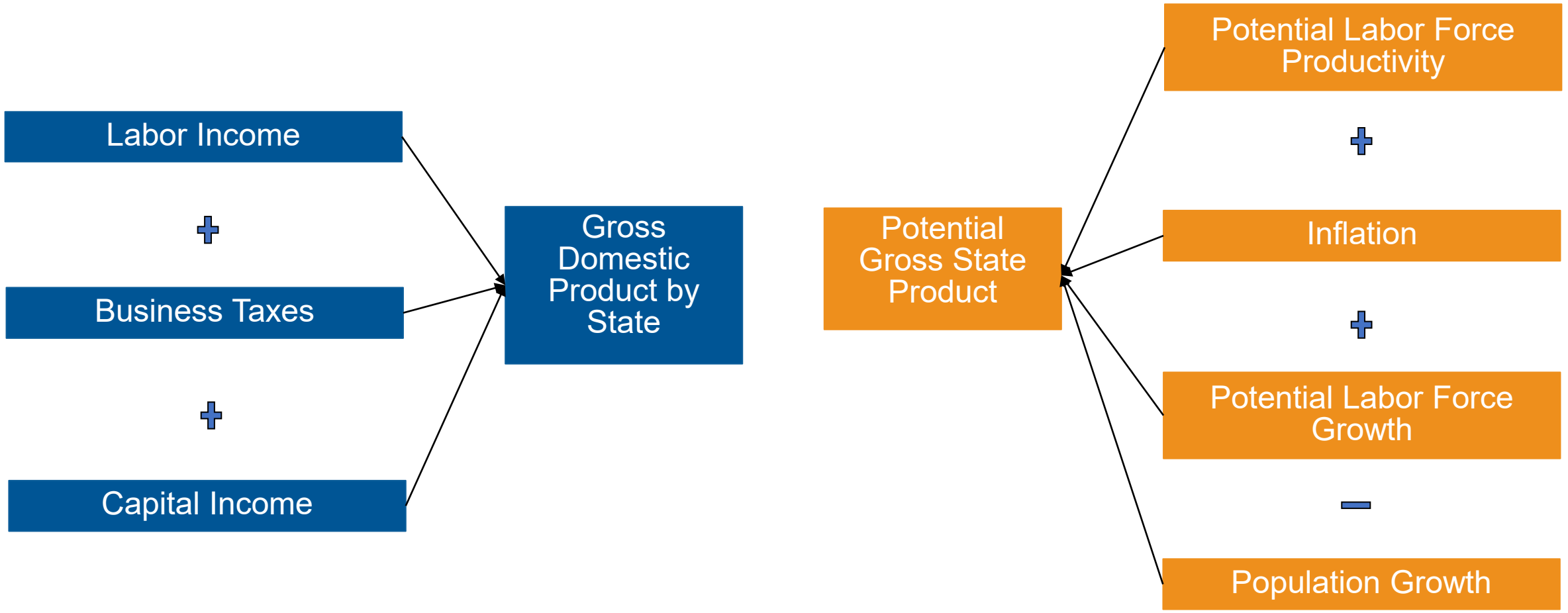
2. California's Potential Gross State Product (PGSP)

- **Potential Gross State Product (PGSP)** measures the long-run average growth rate of a state economy, excluding fluctuations that may occur due to the business cycle.
- It differs from GSP in that it is a forecasted measure of the economy and takes into account labor force productivity and participation, and inflation.

PGSP shows us what state economic growth is likely to be in the future. It is designed to be a stable benchmarking figure, one that many cost growth target states use.

Tying the benchmark to PGSP signals that health care spending should not grow faster than the state economy is forecasted to grow.

How GSP and PGSP Measures Differ



3. Median Family Income of Californians

- **Median Family Income** measures the long-run median growth rate of all income in a household among members related by blood, marriage, or adoption.
- Family income reflects that family members often pool their resources (and expenses) together.

Median family income represents the financial health of families in the state and their purchasing power.

Tying the target to median family income signals that health care spending should not grow faster than the income of California's families.

4. Average Wage of Californians

- **Wage Growth** measures the change in compensation individuals receive for work as an employee or a contractor with an employer. It doesn't capture income such as capital gains, dividends, rent, or interest. Wage growth does not factor in inflation.
- Wages have risen in California and recovered to pre-pandemic levels, but wages are down in the context of inflation.*

Wage growth closely represents "take-home pay" for most individuals within a state.

Tying the spending target to wage growth for California residents signals that health care spending should not grow faster than CA residents' "paychecks."

"Inflation squeezes Californians' budgets despite wage growth." Public Policy Institute of California. Blog post Nov. 3, 2022.

5. Inflation, Consumer Price Index (CPI)

- **Consumer Price Index (CPI)** is a measures price changes for a “market basket” of retail goods purchased out of pocket by consumers.
- It is most often measured using “CPI All Urban (CPI-U) which captures the experience of 94% of all Americans.

CPI measures inflation as experienced by consumers in their day-to-day living expenses and gives a sense of how prices have risen over time, and consumer purchasing power.

Setting the target to the rate of inflation signals that health care spending should not grow faster than the rise in consumer prices.

6. Median Age

- **Median Age** is a population indicator that may be measured to identify change in the state's demographics due to births, deaths, in-migration and out-migration.
- Researchers have found that aging contributes to health care growth, but how much it impacts *overall* growth relative to other factors is less clear.
- Note that OHCA is intending to measure year-over-year changes in age/sex at the plan and provider level.

Median age growth rate measures the long-run demographic shift in the aging of a population.

Tying the spending target to growth in median age signals that the target needs to reflect any additional spending that may occur due to age.

Economic Indicators and Population-Based Measures

- Does the Advisory Committee have questions or suggestions regarding the use of one or more of the economic indicators or population-based measure previously reviewed?
- Are there additional economic indicators or population-based measures that you would like to consider? If so, which one(s), and why?

Potential Factors to Adjust Future Targets

The statute requires the methodology to consider possible adjustments for *at least* these potential factors:

- Health care employment cost index
- Labor costs
- Consumer Price Index- All Urban Consumers (CPI-U) *(included in the suite of economic indicators previously reviewed)*
- Impacts due to known emerging diseases
- Trends in the price of health care technologies
- Provider payer mix
- State or local mandates such as required capital improvement projects
- Relevant state and federal policy changes impacting covered benefits, provider reimbursement and costs

Next Steps

- During the next meeting on November 30, 2023, we will continue discussion of California's spending target.

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Alternative Payment Models, Primary Care and Behavioral Health Investment, and Workforce Stability

Margareta Brandt, Assistant Deputy Director

Focus Areas for Promoting High Value

Primary Care Investment	• Define, measure, and report on primary care spending • Establish a benchmark for primary care spending
Behavioral Health Investment	• Define, measure, and report on behavioral health spending • Establish a benchmark for behavioral health spending
APM Adoption	• Define, measure, and report on alternative payment model adoption • Set standards for APMs to be used during contracting • Establish a goal for APM adoption
Quality and Equity Measurement	• Develop, adopt, and report performance on a single set of quality and health equity measures
Workforce Stability	• Develop and adopt standards to advance the stability of the health care workforce • Monitor and report on workforce stability measures

Primary Care & Behavioral Health Investments

Statutory Requirements

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

Why Primary Care?

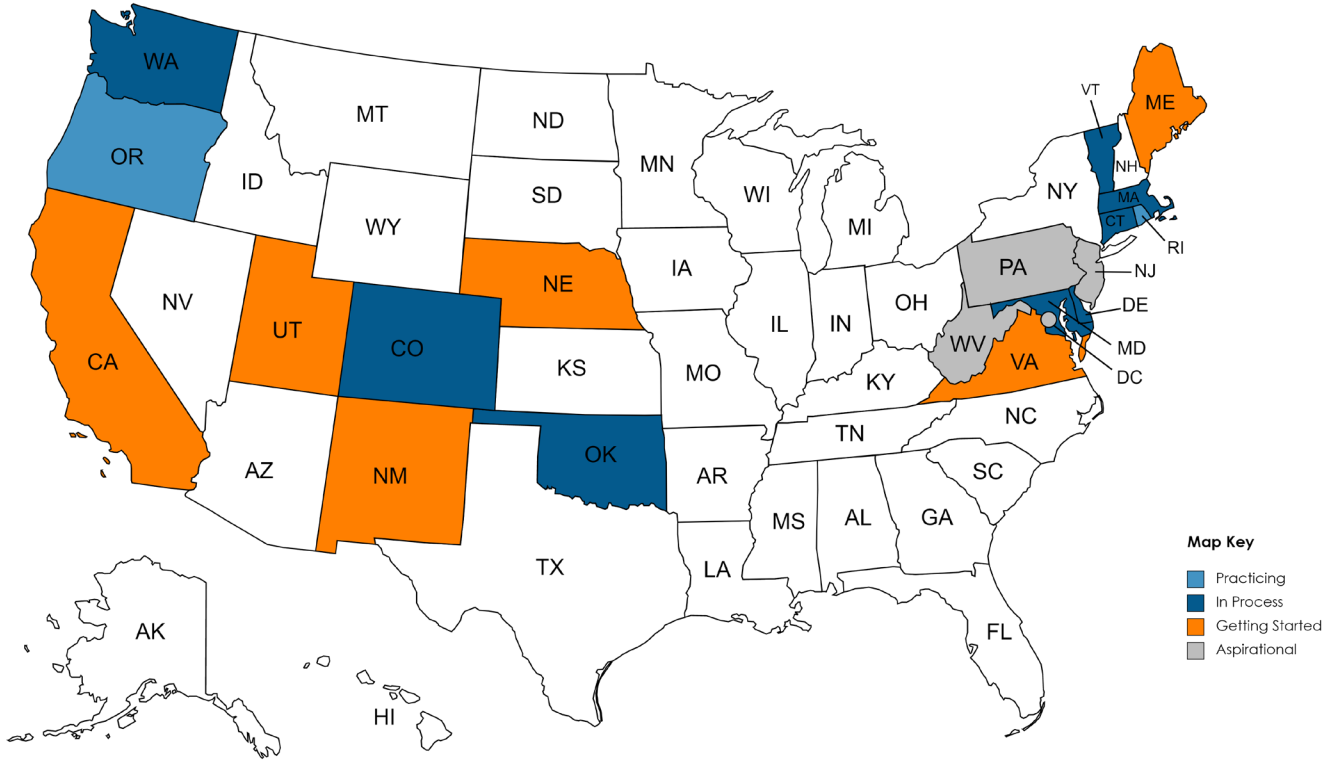
Increased supply of primary care services leads to more equitable outcomes and improved population health (e.g., life expectancy, rates of chronic disease, and other critical measures).

- High functioning health care systems require high quality primary care as a foundation.
- Primary care investment in the United States – which typically ranges from 4% to 7% – lags other high-income nations with higher performing health care systems. In these countries, primary care investment tends to be 12% to 15% of total spending.
- Primary care investment in California was 6.3% of total spending across all payers in 2020, compared to 4.6% nationally, a recent study found.

National Academies of Sciences, Engineering, and Medicine (NASEM). Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. 2021. Jabbarpour Y., Petterson S., Jetty A., Byun H. The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care, 2023.

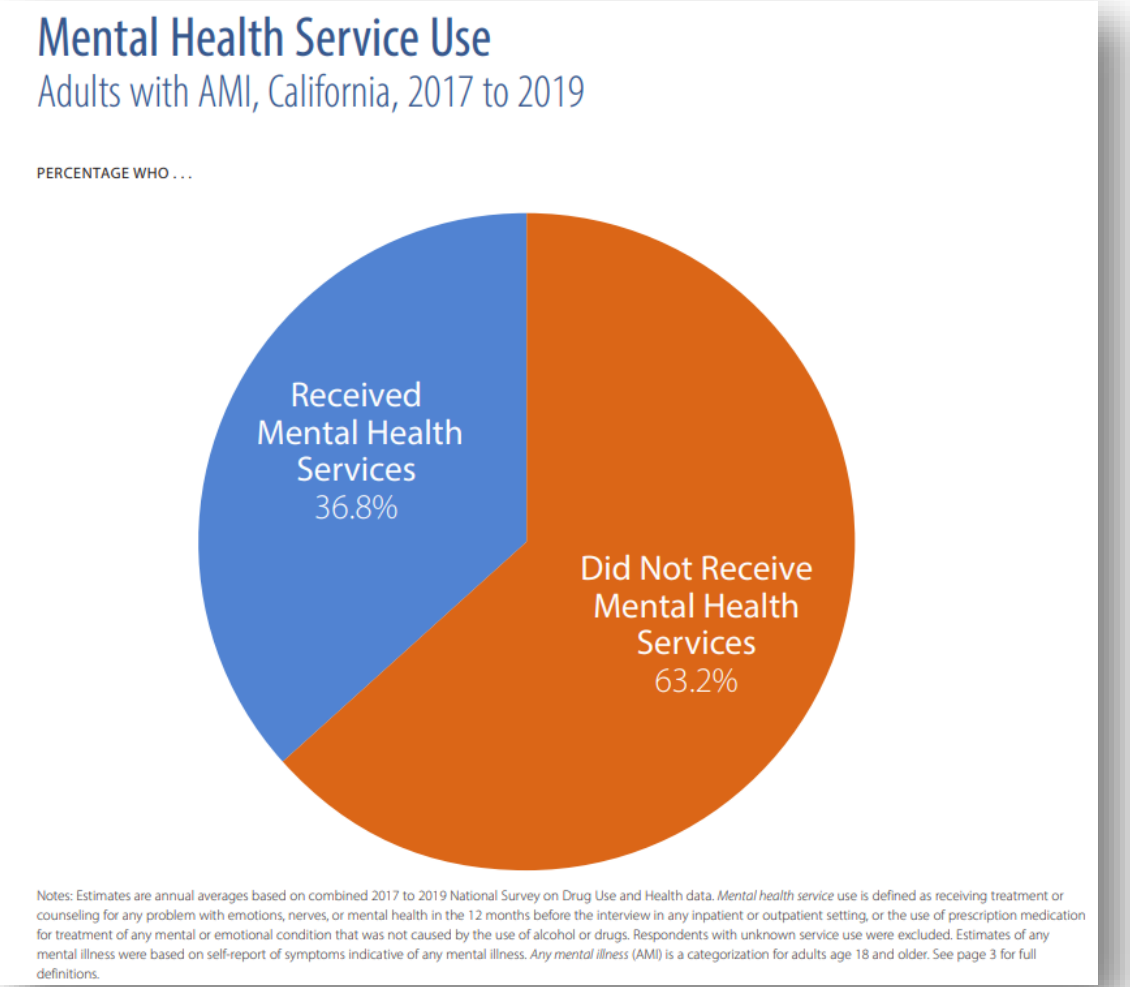
State Efforts to Measure Primary Care Investment

- Over a dozen states have launched efforts to allocate a greater proportion of the health care dollar to primary care.
- Most begin with measurement and reporting, but definitions vary.
- Five states — RI, OK, OR, CO, DE – require a defined level of primary care spend for at least one payer type.
- A growing number of efforts include certain behavioral health services and non-claims spend in their primary care definitions.



Why Behavioral Health?

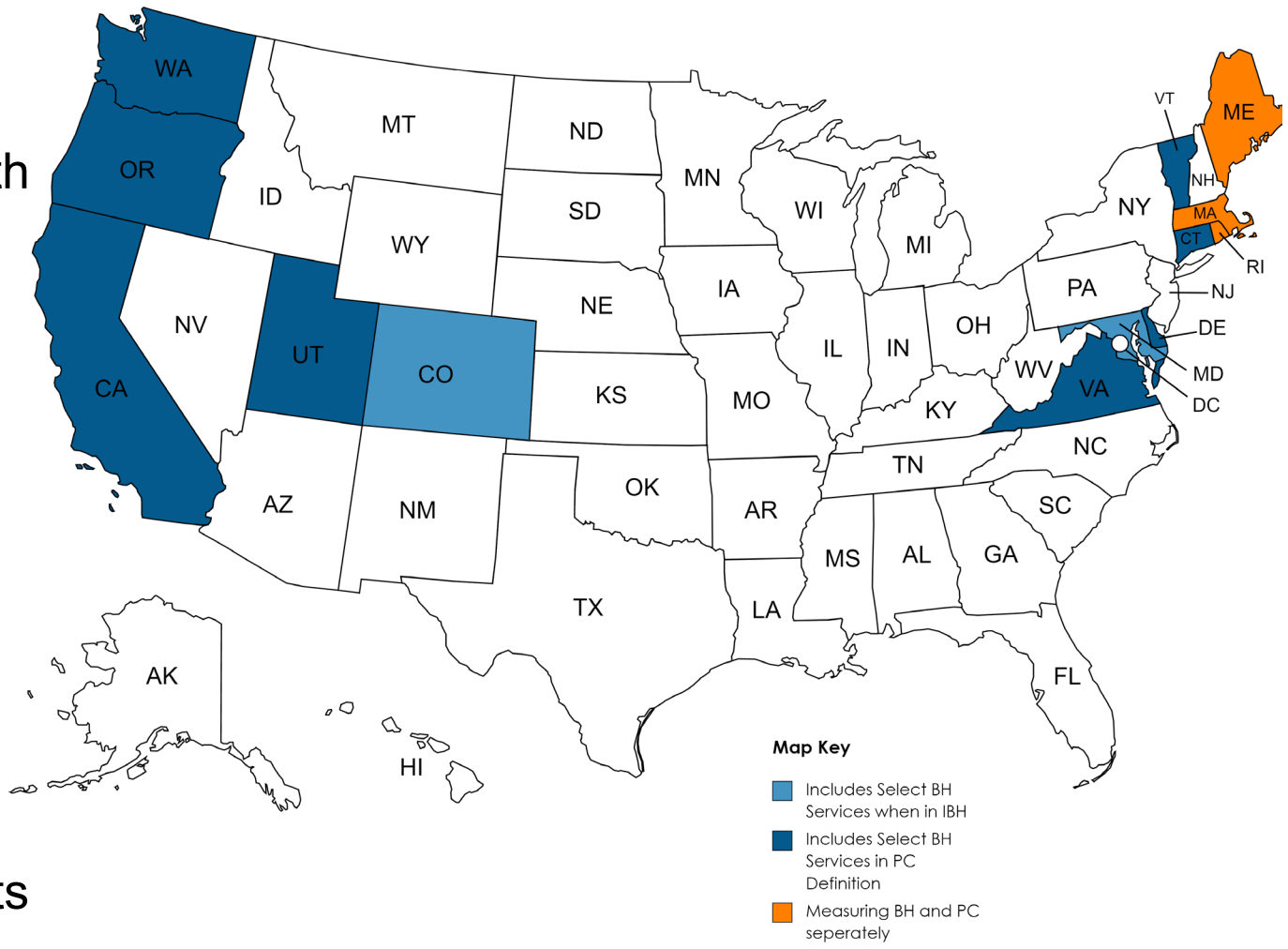
- Nationally, the percent of adults reporting symptoms of anxiety and/or depression increased during the pandemic and remains just above 32%.
- Similarly in California, nearly 32% of adults report symptoms of anxiety and/or depression. Further, nearly two-thirds of California adults with mental illness reported not receiving treatment.
- Health care delivery models that integrate primary care and behavioral health have been shown to improve access to effective behavioral health services that improve health outcomes, as well as deliver a return on investment by reducing downstream health care costs.



California Health Care Almanac. Mental Health in California: Waiting for Care. California Health Care Foundation. July 2022.
NASEM. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. 2021. Kaiser Family Foundation.
Mental Health and Substance Use Fact Sheets 2023.

State Efforts to Measure Behavioral Health Investment

- Three states measure behavioral health investment across all clinical services.
- Nine states include some behavioral health services in their primary care investment definitions. Of these, three calculate spending on integrated behavioral health or are considering it.
- Best practices are emerging regarding diagnoses, services, and providers to include but there is no standard definition.
- Whether and how to include spending on social services and other state investments is another emerging area.



Alternative Payment Models

Statutory Requirements

- Promote the shift of payments based on fee-for-service (FFS) to alternative payment models (APMs) that provide financial incentive for equitable high-quality and cost-efficient care.
- Convene health care entities and organize an APM workgroup, **set statewide goals** for the adoption of APMs, **measure the state's progress** toward those goals, and **adopt contracting standards** healthcare entities can use.
- Set benchmarks that include, but are not limited to, increasing the percentage of total health care expenditures delivered through APMs or the percentage of membership covered by an APM.

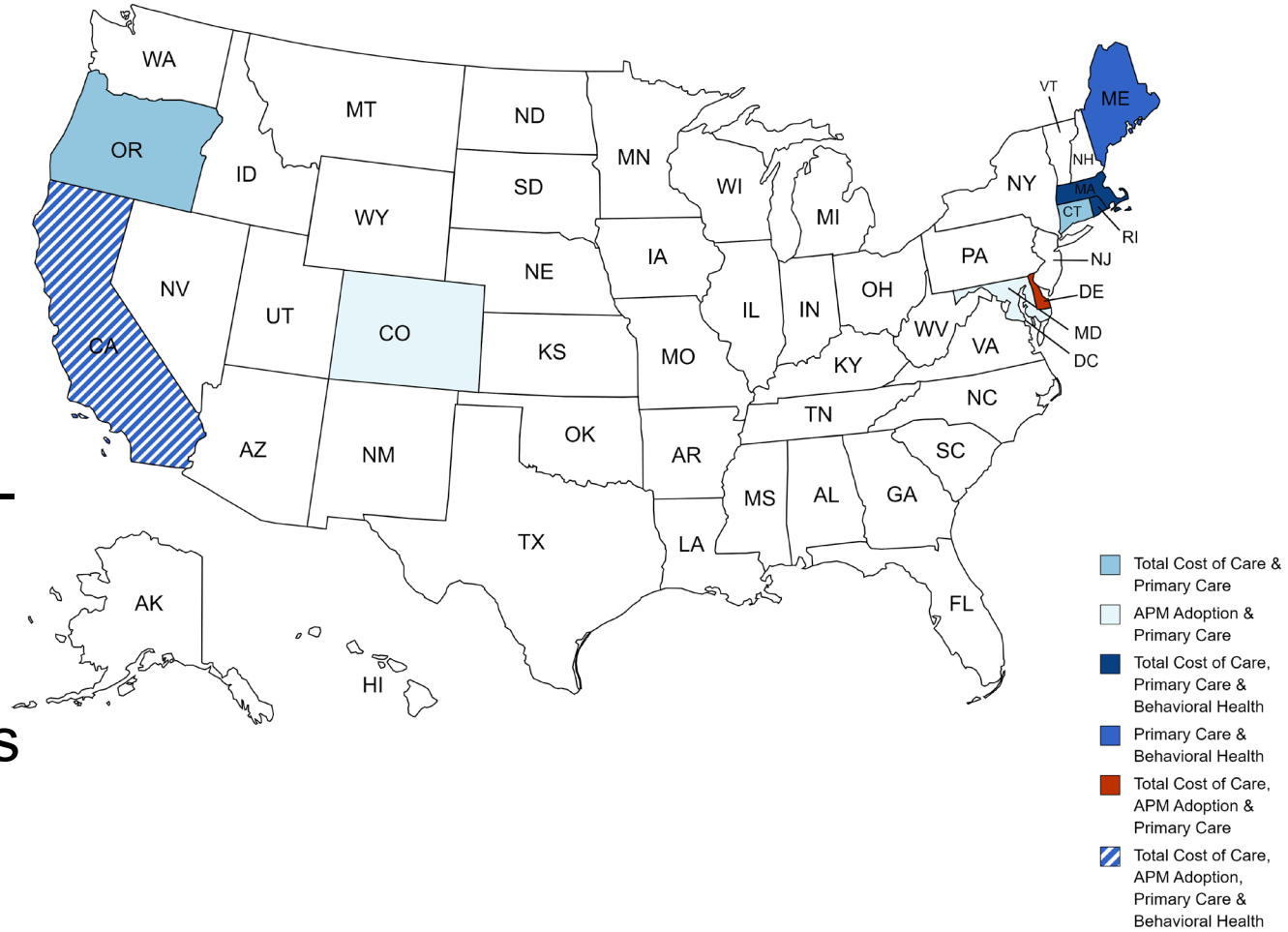
Why Alternative Payment Models?

- Alternative Payment Models (APMs), or value-based payments, align payer-provider payment approaches to incent high-quality, cost-efficient care.
  - Models span the continuum of clinical responsibility and financial risk moving from volume to value.
- In 2016, the Centers for Medicare and Medicaid Services and large payers established the Health Care Learning and Action Network (HCP-LAN) framework for categorizing APM arrangements according to the level of risk assumed by a provider. It is one of a few commonly used categorizations of value-based payments.
- Overall, movement to APMs has been slower than many hoped. Nationally in 2021, over 40% of payments were still in FFS payment arrangements (Category 1).
- In 2021 in California's commercial market, 64% of members were in capitation-based arrangements. Fee-for-service was the next largest category of payments at 36%.

Health Care Payment Learning and Action Network, HCP-LAN APM Measurement Effort Results APM Measurement Survey, 2022.
California Regional Health Care Cost & Quality Atlas, Integrated Healthcare Association, 2023.

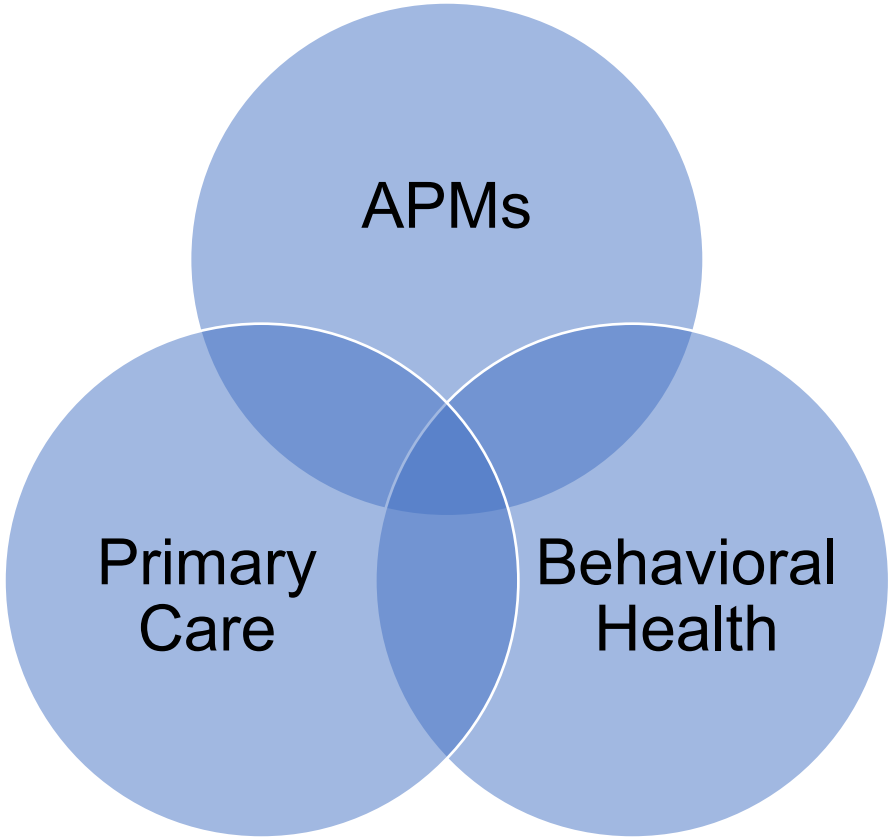
What's Occurring in Other States

- There are nine states collecting APM data from payers with different authority and use cases.
- Some states collect data through multiple avenues for different use cases.
- Definitions and categories of value-based payments vary.
- Payers report little insight into the distribution of non-claims payments within provider organizations.

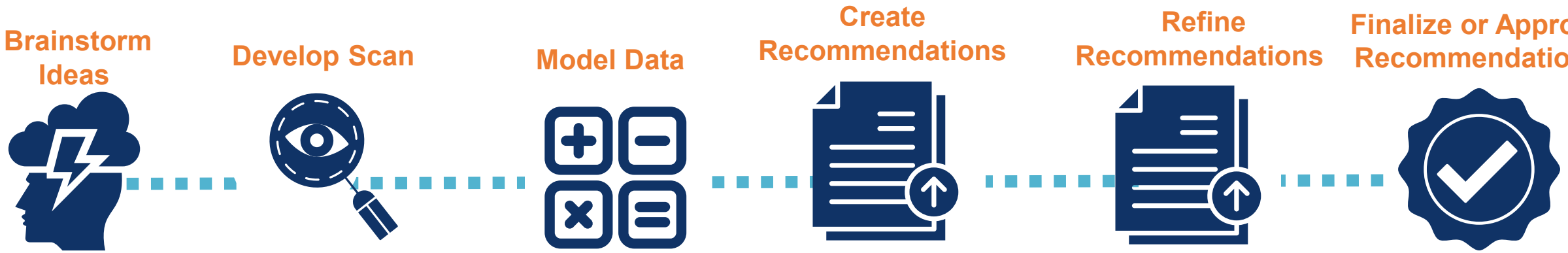


APMs, Primary Care, and Behavioral Health are Interconnected

- APMs often support advanced primary care including integrated behavioral health.
- APM performance frequently is tied to the primary care relationship and performance.
- Behavioral health is an important and growing component of primary care.
- Integration and coordination across behavioral health and primary care is critical to achieving the best outcomes.



Planned Approach for APM Adoption, Primary Care and Behavioral Health Workstreams



Gain Input
(Investment & Payment Workgroup, Stakeholder Interviews)

Incorporate Feedback
(Board, Advisory Committee, Workgroup)

Workgroup to Engage Stakeholders on APM Adoption, Primary Care and Behavioral Health Investment

OHCA launched the monthly Investment and Payment workgroup in June to support the development of the APM, primary care, and behavioral health definitions, data collection processes, and benchmarks.

The workgroup is:

- Soliciting stakeholder engagement in key program development decisions about definitions and data collection
- Providing input and feedback as OHCA develops recommendations for benchmarks
- Identifying and discussing the relationships and interactions between the APM, primary care, and behavioral health components

Workgroup members include representatives from:

- Patients/families
- Primary care clinicians
- Physician organizations (medical group, IPA, FQHC)
- Hospitals/health systems
- Health plans
- Consumer advocates
- Researchers/experts
- State departments engaged in related work

Examples of Workgroup Discussion Topics

Alternative Payment Models

Definitions, Measurement, Reporting: Categorizing APMs, unit of reporting, health and social risk adjustment

Standards for APM Contracting: Common requirements/incentives for high quality equitable care, accelerate adoption of APMs

Statewide Goal for Adoption: Variation by market (Commercial, Medi-Cal), target timeline, unit of reporting (percent of payments, members, and/or provider contracts)

Primary Care

Definitions, Measurement, Reporting: Primary care providers, services, site of service, non-claims, integrated behavioral health

Investment Benchmark: Variation by market (Commercial, Medi-Cal) or population (adult vs. pediatric)

Behavioral Health

Definitions, Measurement, Reporting: Spending on social supports, capturing carved out behavioral health spending

Investment Benchmark: Variation by market (Commercial, Medi-Cal) or population (adult vs. pediatric)

Measuring Non-Claims Spending across HCAI

OHCA: Total Health Care Expenditures

OHCA: Primary Care/Behavioral Health Spend

Health Care Payments Database

OHCA: Alternative Payment Model Adoption

- Non-claims payments are an important component of spending across multiple HCAI efforts.
- A consistent approach across all HCAI measurement efforts will reduce burden and increase comparability.
- Measuring the purpose of the spending is important, as well as the amount.

Milbank Memorial Fund

Year: 2021

Developer: Bailit Health, with support from Milbank

Purpose: Support states in categorizing non-claims payments. It initially aimed to measure non-claims primary care spend. States have refined it to categorize all non-claims spending to support tracking total health care spending. It works well for identifying the purpose and structure of payments.

Table 1: Categories of Non-Claims-Based Primary Care Spending

Category	Subcategory
1. Prospective capitated case rate, or episode-based payments	• Capitation payments • Global budget payments • Prospective case rate payments • Prospective episode-based payments
2.Primary care performance incentive payments	• Risk-based payments (shared savings distributions, shared risk recoupments) • Retrospective/prospective incentive payments (pay-for-performance, pay-for-reporting)
3. Payments for primary care provider salaries	• Provider salary payments (physician and nonphysician)
4. Payments to support population health and practice infrastructure	• Care management/care coordination/population health • Electronic health records/health information technology infrastructure and other data analytics payments • Medication reconciliation • Patient-centered medical home recognition payments • Primary care and behavioral health integration
5. Recovery	• Recoveries, or payment received that are later recouped by the payer
6. Other payments	• Other, such as governmental payer shortfall payments, grants, or other surplus payments.

Health Care Payment Learning and Action Network

Year: 2016, updated in 2017

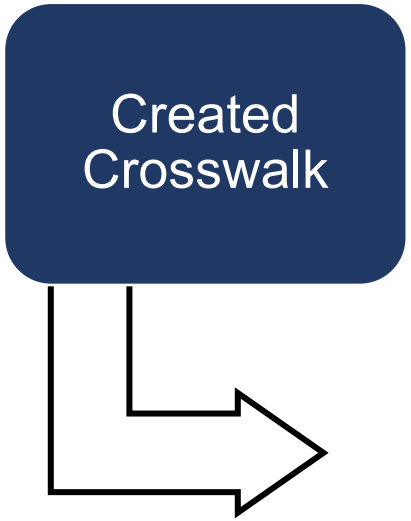
Developer: HCP-LAN, a collaboration of Centers for Medicare and Medicaid Services (CMS) and large national payers

Purpose: Support payers and states in categorizing alternative payment models to support clarity and accountability in contracting terms and measurement of APM adoption.

HCP-LAN APM Framework

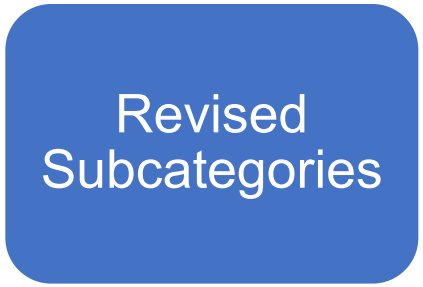
Category 1	Category 2	Category 3	Category 4
FEE FOR SERVICE- NO LINK TO VALUE	FEE FOR SERVICE- LINK TO QUALITY & VALUE	APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	POPULATION-BASED PAYMENT
	A	A	A
	Foundational Payments for Infrastructure & Operations	APMs with Shared Savings	Condition-Specific Population-Based Payment
	B	B	B
	Pay for Reporting	APMs with Shared Savings and Downside Risk	Comprehensive Population-Based Payment
	C		C
	Pay-for-Performance		Integrated Finance & Delivery System
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

Developing a California Option for HCAI



Developed a crosswalk to show how the Milbank and HCP-LAN frameworks could be overlaid

Updated the payment categories to reflect common payment types in California; informed by Integrated Healthcare Association (IHA) Atlas



Revised structure to show risk progression and payment purpose

Draft Expanded Non-Claims Framework Crosswalks Milbank and HCP-LAN

	Expanded Non-Claims Payments Framework Categories
A	Population Health and Practice Infrastructure Payments
B	Performance Payments
C	Payments with Shared Savings and Recoupments
D	Capitation and Full Risk Payments
E	Other Non-Claims Payments
F	Pharmacy Rebates

Purpose of Expanded Framework

- Update Milbank categories and subcategories to reflect care delivery in California
- Allow single framework to support multiple use cases
  - Define payment purpose
  - Measure provider risk
- Crosswalk Milbank categories with HCP-LAN categories
- Data collection tool designed to capture non-claims payments and portion of total spend by level of provider risk

Freedman HealthCare supported the California Department of Health Care Access and Information in developing the Expanded Non-Claims Payment Framework. The framework builds on the work of Bailit Health and the Milbank Memorial Fund and the Health Care Payment Learning and Action Network.

Draft Expanded Non-Claims Framework Categories A, B, C

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

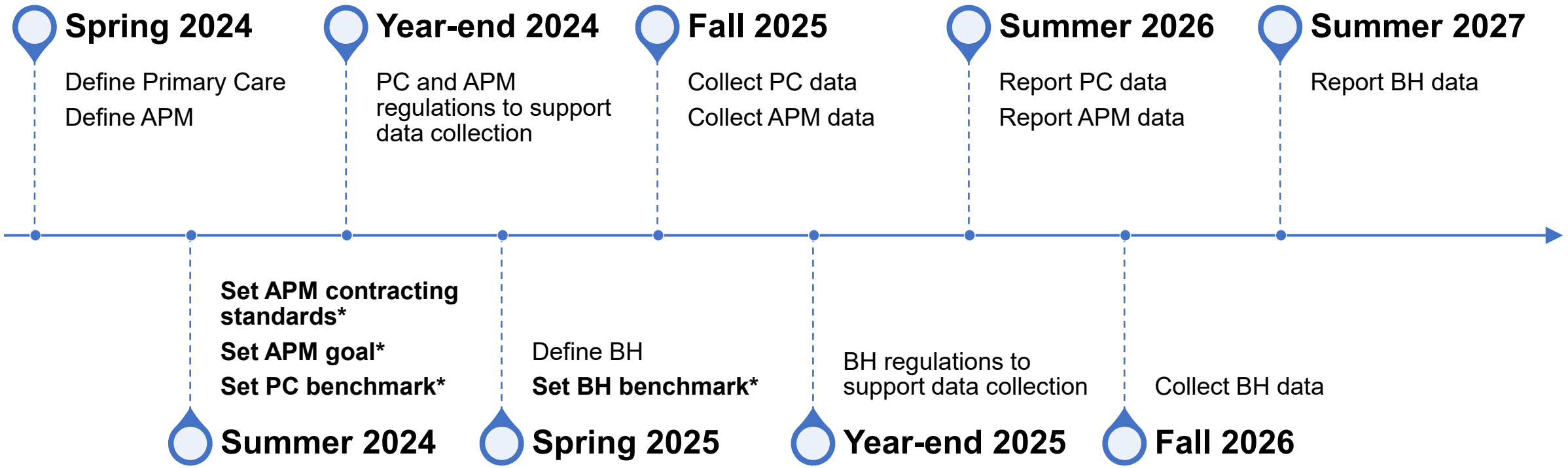
Freedman HealthCare supported the California Department of Health Care Access and Information in developing the Expanded Non-Claims Payment Framework. The framework builds on the work of Bailit Health and the Milbank Memorial Fund and the Health Care Payment Learning and Action Network.

Draft Expanded Non-Claims Framework Categories D, E, F

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

Freedman HealthCare supported the California Department of Health Care Access and Information in developing the Expanded Non-Claims Payment Framework. The framework builds on the work of Bailit Health and the Milbank Memorial Fund and the Health Care Payment Learning and Action Network.

Preliminary Timeline for APM Adoption, Primary Care, and Behavioral Health Workstreams



***Board approval required**

All included in the first annual report, due June 2027

Health Care Workforce Stability

Statutory Requirements

- Monitor the effects of spending growth targets on health care workforce stability, high-quality jobs, and training needs of health care workers.
- Monitor health care workforce stability with the goal that workforce shortages do not undermine health care affordability, access, quality, equity, and culturally and linguistically competent care.
- Promote the goal of health care affordability, while recognizing the need to maintain and increase the supply of trained health care workers.
- **Develop standards, in consultation with the Board, to advance the stability of the health care workforce.**

Health Care Workforce Stability

Statutory Requirements

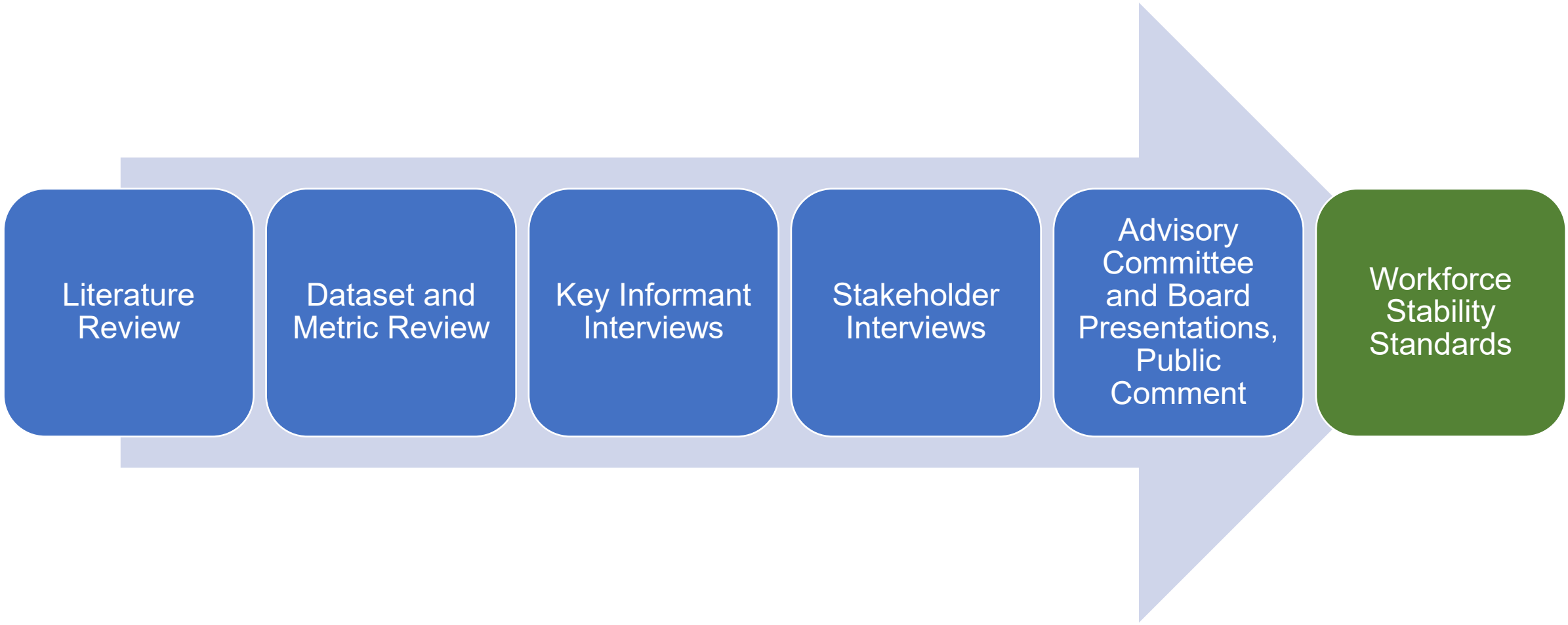
- **The Board approves standards to advance the stability of the health workforce that may apply in the approval of performance improvement plans.**
- OHCA may require a health care entity to implement a performance improvement plan that identifies the causes for spending growth and shall include specific strategies, adjustments, and action steps the entity proposes to implement to improve spending performance during a specified time period. The director shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode access, quality, equity, or workforce stability.

Health and Safety Code 127501.11, 127502.5

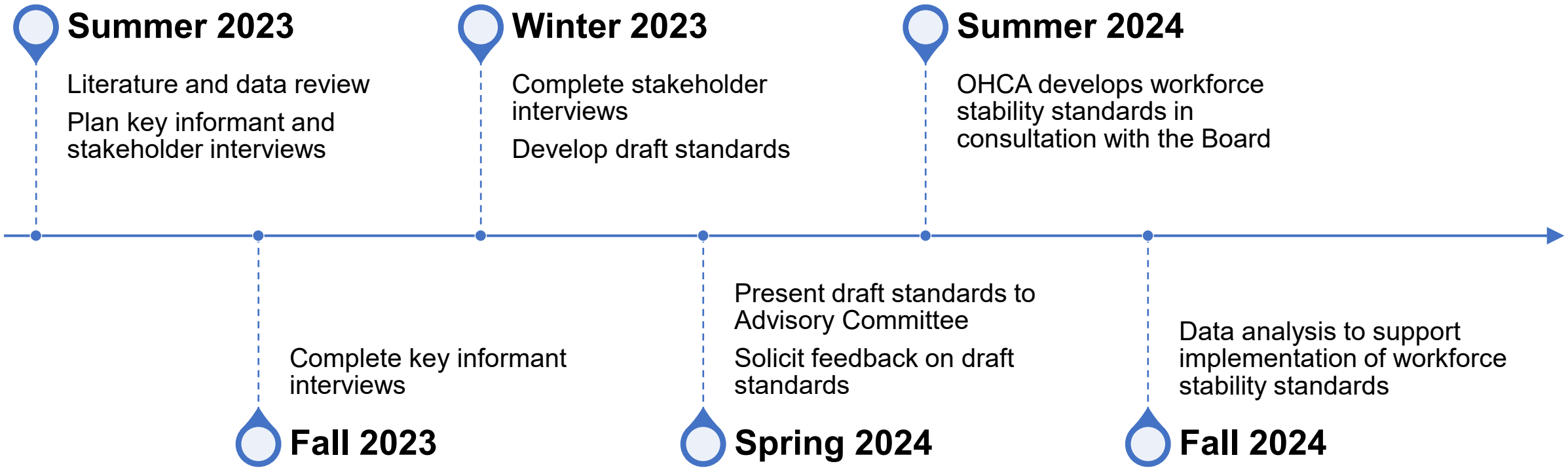
Why workforce stability?

- California currently faces a significant health workforce shortage, including an imbalanced geographic distribution of health care workers.
- Health workforce challenges contribute to lack of access to needed services, including preventive services; delays in receiving appropriate care; and preventable hospitalizations.
- Efforts to slow spending growth may have unintended negative consequences if health care entities reduce labor through staffing reductions, or wage reductions for health care workers.
- A stable, well-prepared, and adequately supplied workforce is essential to a sustainable health care system that provides high-quality care to all Californians.
- No other state has included workforce stability standards in its spending growth target efforts.

Planned Approach to Develop Workforce Stability Standards



Preliminary Timeline for Workforce Stability Workstream



HCAi
Department of Health Care Access and Information

General Public Comment

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

Next Meeting:

November 30, 2023
10 a.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

HCAi
Department of Health Care Access and Information

Advisory Committee Adjourned