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Agenda Item 3:

Office of Health Care Affordability (OHCA) and Health Workforce

Facilitator: Margareta Brandt, Assistant Deputy Director, Office of Health Care Affordability (OHCA), HCAI

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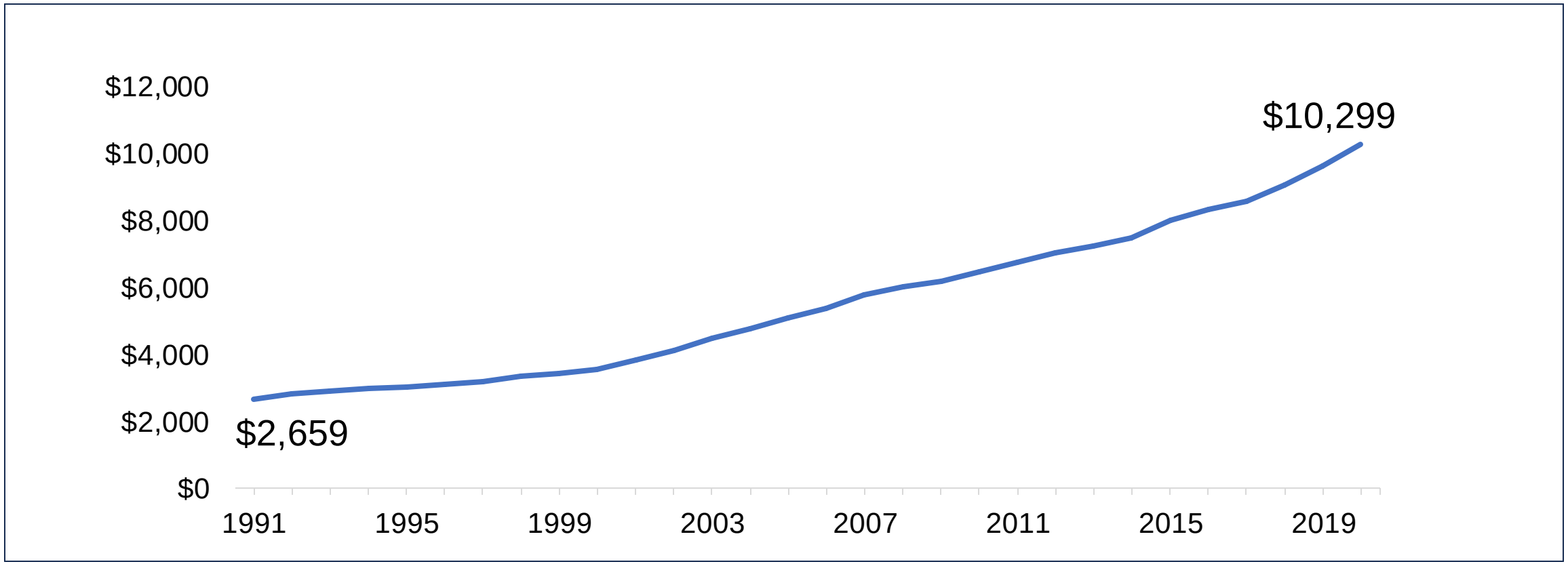
OHCA Overview

Per Capita Health Spending in California, 1991-2020

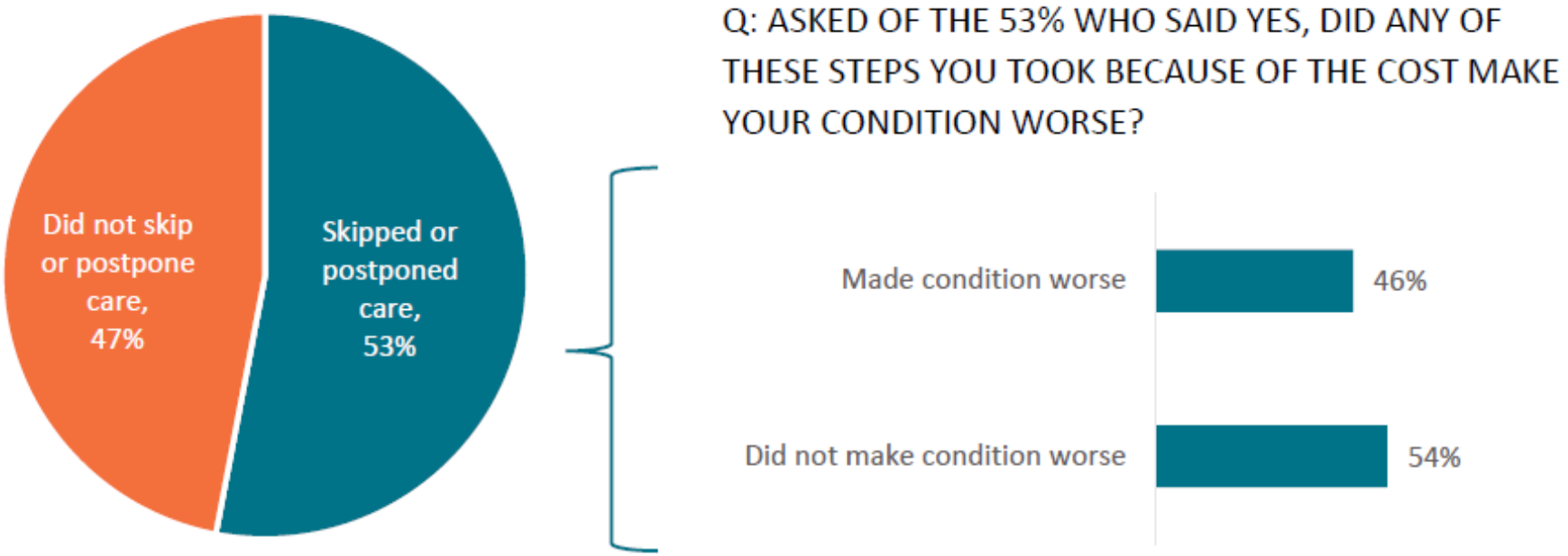
- California health care spending reached $10,299 per capita in 2020.
- Average annual growth between 1991 and 2020 was 4.8%.



Health Expenditures by State of Residence, 1991-2020, Centers for Medicare & Medicaid Services.

Postponing or Skipping Care

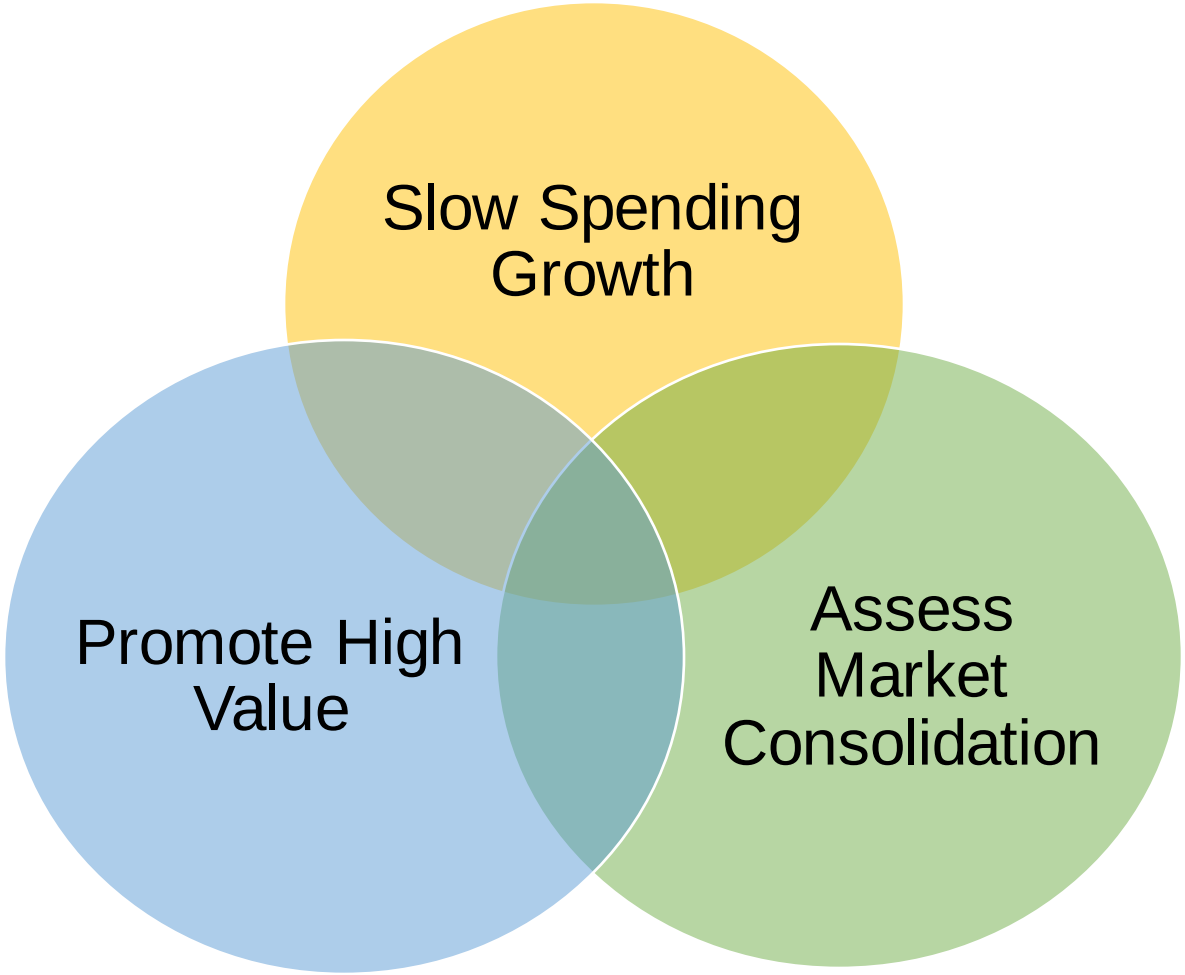
Figure 19. More Than Half of Californians Report Skipping Care in the Past Year Due to Cost; Nearly Half of Those Say Skipping Care Made Their Condition Worse



Notes: Sample includes 3,431 California residents age 18 and older. See topline for full question wording and response options. Figures may not sum due to rounding.

Joynt, J., Cañerson, R., Alverez, E., Bye, L., Pineau, V., & Liu, L., NORC at the University of Chicago, The 2024 California Health Policy Survey, CHCF, January 2024

Key Components of OHCA's Work



Board and Advisory Committee Responsibilities

Health Care Affordability Board

- Sets spending targets, both statewide and sector-specific
- Approves key benchmarks, such as statewide goals for alternative payment model adoption
- Appoints a Health Care Affordability Advisory Committee to provide input on a range of topics
- Members may not receive compensation from health care entities
- Eight members:
  - California Health and Human Services Secretary
  - CalPERS Chief Health Director (nonvoting)
  - Four appointees from Governor's Office
  - One appointee each from Assembly and Senate

Advisory Committee

- May make recommendations, but no approval authority or access to nonpublic information
- Members appointed by the Health Care Affordability Board; representation to include:
  - Consumer and patient groups
  - Payers
  - Fully integrated delivery systems
  - Hospitals
  - Organized labor
  - Health care workers
  - Medical groups
  - Physicians
  - Purchasers

Board and Advisory Committee are both subject to Bagley-Keene Open Meeting Act

Source: HSC § 127501.11(a)(b)(d)

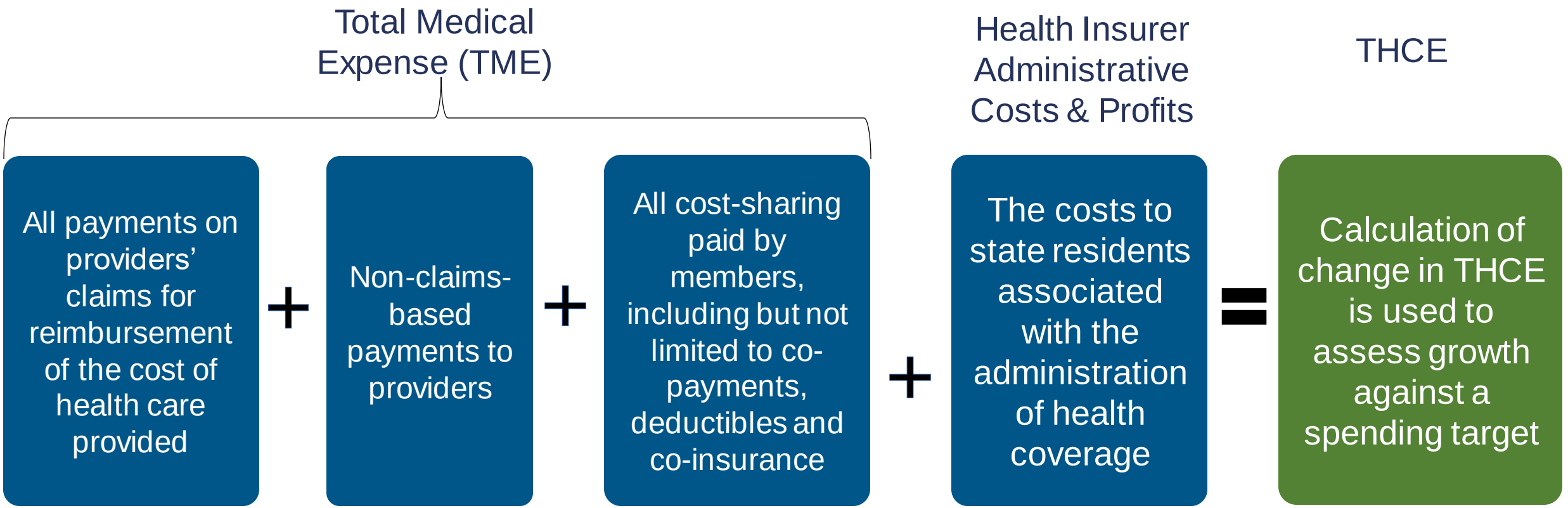
Slow Health Care Spending Growth

Collect, analyze, and report data on total health care expenditures (THCE) for payers, providers, and integrated delivery systems

Develop spending growth target methodology and spending targets, initially statewide and eventually sector-specific (e.g., geography, types of entities)

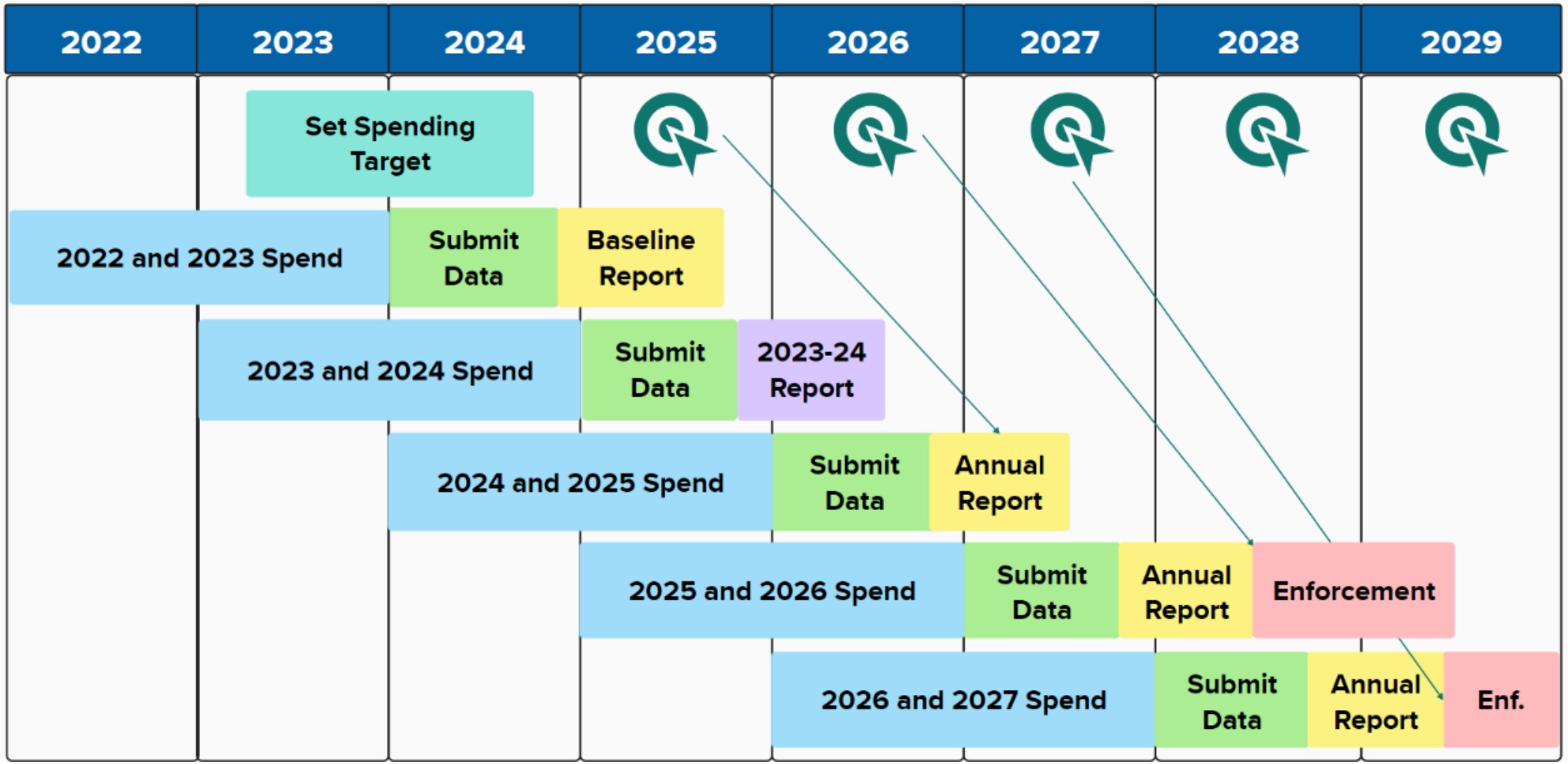
Progressive enforcement of targets: technical assistance, public testimony, performance improvement plans, and escalating financial penalties

Total Health Care Expenditures (THCE)



Note: Pharmacy rebates are included in THCE and can be included under non-claims-based payments or health insurer administrative costs and profits.

Spending Target Timeline



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Assess Market Consolidation

Assess prospective changes in ownership, operations, or governance for health care entities

Conduct cost and market impact reviews (CMIRs) on transactions likely to significantly impact competition, the state's ability to meet spending targets, or affordability for consumers and purchasers

Work with other regulators to address market consolidation as appropriate

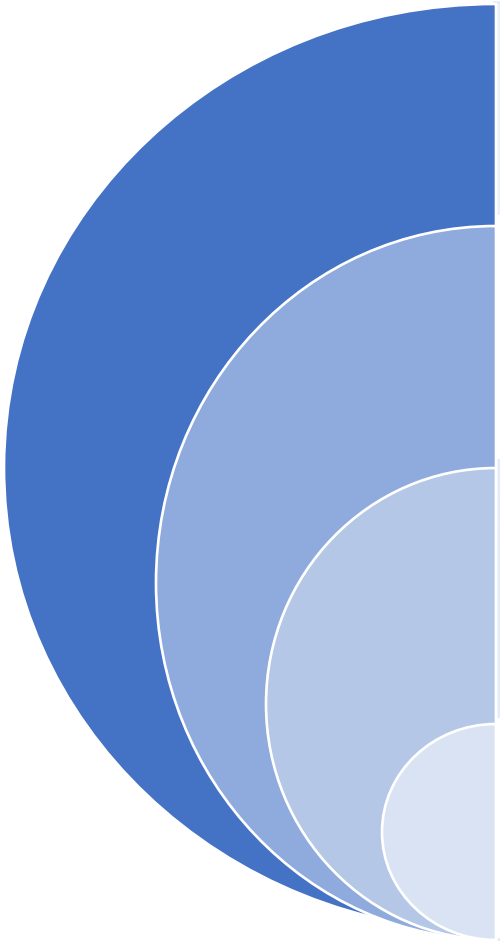
CMIR Program Will Increase Public Transparency

Collect and publish notices of material change transactions that will occur on or after April 1, 2024. Health care entities must submit notices to OHCA 90 days before the agreement or transaction will occur.

Upon determination the notice is complete, OHCA will determine within 60-days whether the agreement or transaction must undergo a Cost and Market Impact Review (CMIR).

Conduct CMIR for agreements or transactions after OHCA determines a CMIR is warranted, make factual findings and issue preliminary report, allow written responses from affected parties and the public, and issue final report.

Promote High Value System Performance



- Track quality, equity, and access using a single set of quality and health equity measures
- Set benchmarks and report on primary care and behavioral health investment
- Set standards and goals for the adoption of alternative payment models and report on progress
- Promote workforce stability through standards and monitoring

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OHCA Workforce Stability Standards

Health Care Workforce Stability

Statutory Requirements

- Monitor the effects of spending 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 and Safety Code 127506(a-c)

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

Workforce Stability Standards Process and Progress

- OHCA is working with the Philip R. Lee Institute for Health Policy Studies (IHPS) and Healthforce Center at the University of California, San Francisco (UCSF) to develop the workforce stability standards.

Key Takeaways from Key Informant & Stakeholder Interviews

Potential Benefits of Workforce Standards	• Transparency in staffing and costs • Identification of workforce challenges • Improved quality of care
Challenges of Workforce Standards	• Difficult to apply statewide standards to diverse healthcare entities • Potential to inhibit care delivery innovations • Administrative burden of reporting
Diverse Opinions on Workforce Standards Focus	• Some advocate for equal consideration of all settings and professions • Others suggest focusing on specific settings (hospitals, nursing homes, primary care) and professions (e.g., behavioral health, primary care workforce, nurses, CHWs/promotores)

Workforce Standards: Who Do They Apply To?

- Statute uses the language “nonsupervisory health care workforce” and “frontline health care workers."
- OHCA interprets the statute to exclude the supervisory workforce, including physicians, dentists, and pharmacists, from the workforce stability standards.
- Several stakeholders suggested including physicians, particularly primary care providers (PCPs), in the standards.
- In the future, OHCA may broaden standards and tracking metrics to include PCPs or other supervisory providers.
- OHCA will collaborate with OHWD to understand the physician workforce.

Principles to Guide Workforce Stability Standards and Metrics

1. Address current workforce shortages and challenges impacting workforce stability (e.g., provider shortages in behavioral health or in rural areas).
2. Monitor for emerging workforce shortages and plan for future workforce needs.
3. Incorporate flexibility to accommodate differences between settings, occupations, and regions.
4. Compare workforce composition across similar health care entities.
5. Track graduations from health professions education programs, licensure requirements, and time to licensure to improve match between workers entering workforce and need.

Principles to Guide Workforce Stability Standards and Metrics (continued)

6. Promote diversity in the workforce and address population need for culturally and linguistically competent care.
7. Track the impact of spending targets on most vulnerable health care workers (e.g., unlicensed direct care and long-term care workers) and those who serve vulnerable populations (disabled, elderly, safety net).
8. Consider tradeoffs of prioritizing monitoring of highest-cost, most-regulated settings (e.g., hospitals) compared to least-regulated settings (e.g., SNFs) that may need greater oversight.
9. Monitor indicators of inadequate workforce at the facility level, such as sentinel safety events or worker's compensation claims.
10. Minimize reporting burden for health care entities.

Approach to Workforce Stability Standards and Metrics

Standards

- Best practices for health care organizations to adopt
- Organizations should implement these practices and track related key performance indicators to help ensure a stable workforce
- Not enforceable by OHCA

Metrics

- Use publicly available data to monitor workforce stability at the organization level and the market level to complement the standards
- Will establish baseline data on proposed metrics and may add benchmarks to the standards in future years

Draft Workforce Stability Standards

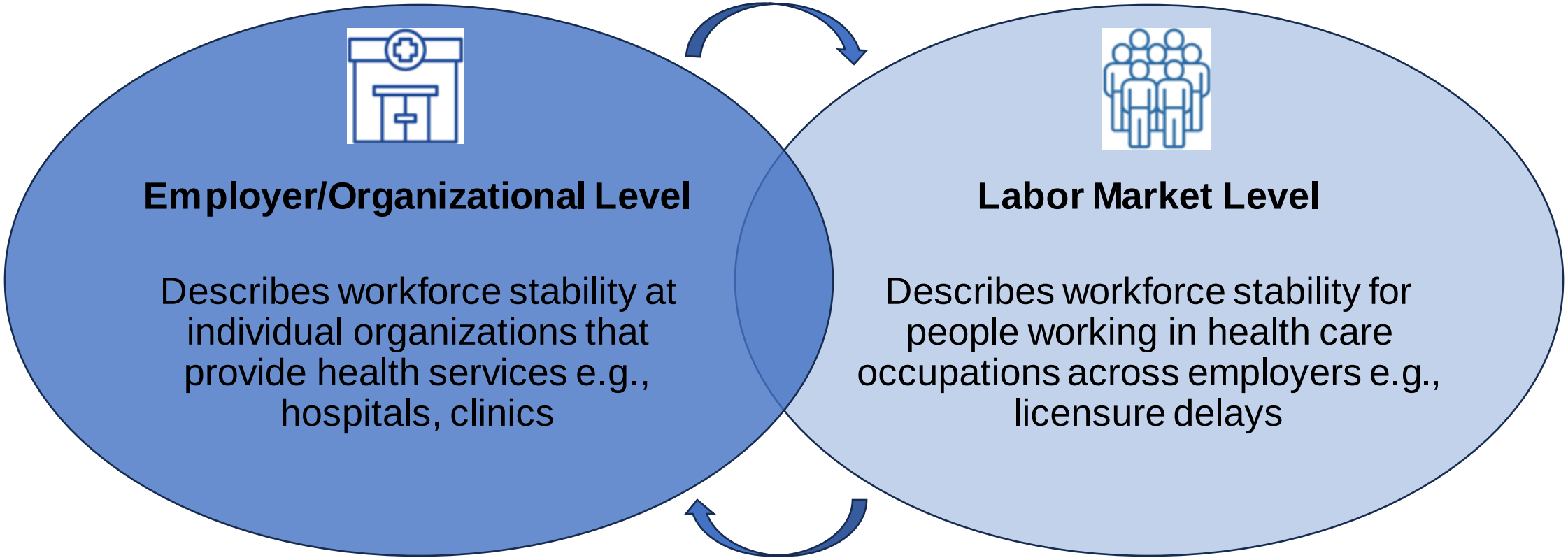
1. **Monitor a priority set of key performance indicators of workforce stability.** Relevant metrics to monitor include:
   - Turnover rates
   - Retention rates
   - Vacancy rates
   - Time to fill vacant positions
   - Job satisfaction
   - Investment in continuing education, professional development, and training programs for current employees and for new entrants to key occupations, measured in dollars and as a percentage of total wage spending
   - Diversity of its workforce and languages spoken in relation to the population served
2. **Develop formal processes to adapt to changing workforce stability**. Use tools such as a workforce development plan to adjust hiring, training, and other practices based on organizational key performance indicators and market level influences.

Draft Workforce Stability Standards (continued)

3.	**Invest in training opportunities for workers.** Such training includes development of new skills to adapt to changing health care delivery models (e.g., use of technology, team-based care) and supporting advancement of entry-level and non-clinical workers (e.g., housekeeping staff) to other occupations within the organization through career ladders.
4.	**Increase use of team-based care models and other care delivery innovations to improve quality, equity, and efficiency of care**. Multi-disciplinary health care teams allow workers to practice at the top of their licenses, improve quality, equity, and efficiency of care, and may reduce burnout.
5.	**Center culturally and linguistically competent care**. Access to high-quality, equitable care across all communities requires a workforce that represents California's people, speaks their languages, and understands their cultures. Organizations should prioritize hiring and employee advancement practices that advance equitable care for their communities.
6.	**Treat workers as an organizational asset rather than a cost center**. Investments in a well-trained, adequately compensated workforce can lead to substantial returns in the form of higher quality care, reduced turnover and contract labor costs, which together can contribute to lower overall costs and improved outcomes for patients.

Workforce Stability: Levels of Analysis

- OHCA will monitor workforce stability at the organizational and the labor market levels.



Draft Workforce Stability Metrics: Organization Level Monitoring

Organization	Data Source	Example Occupations	Example Metrics
Hospitals	HCAI Hospital Annual Financial Disclosure Reports	• Registered nurses • Clerical & other administrative staff • Environmental & food service staff • Registry nursing personnel	• Annual hours per patient day for daily hospital services, for each occupation • Average hourly pay rate for daily hospital services, per occupation • Contract nursing personnel hours divided by total nursing hours, for daily hospital services • Average hourly rate of contract nursing personnel divided by average hourly rate of staff registered nurses • Salaries, wages, and benefits costs as percentage of total operating expenses

Note: Other entities to be monitored using HCAI data are nursing homes/skilled nursing facilities and community clinics.

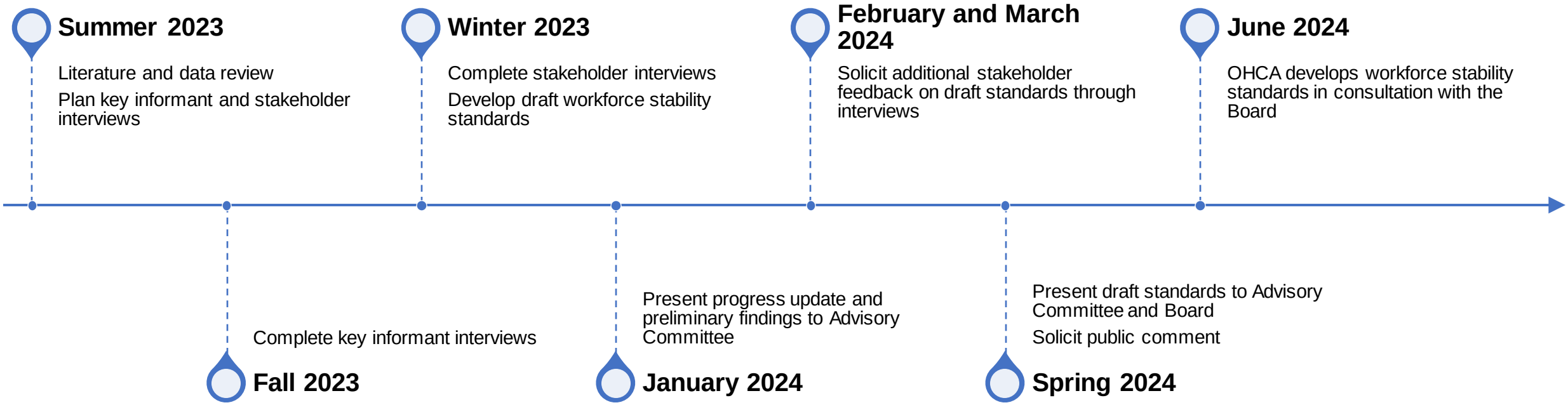
Draft Workforce Stability Metrics: Market Level Monitoring (continued)

Data Source	Geographic Areas	Example Occupations	Example Metrics
California Licensure Board records and HCAI license renewal surveys	• Statewide • CBSAs & CSAs* • Counties • California Economic Strategy Panel regions	• Advanced Practice Registered Nurses • Licensed Marriage and Family Therapists • Occupational Therapists	• Number licensed • Age distribution • Race/ethnicity • Languages spoken • Average number of hours worked per week
US Integrated Postsecondary Education Data System	• Statewide • CBSAs & CSAs • Counties • California Economic Strategy Panel regions	• Dozens of program classifications, in category "51. Health Professions and Related Clinical Services"	• Awards/degrees conferred • Awards/degrees by race/ethnicity
California Board of Registered Nursing Annual Schools Survey	• Statewide • California BRN regions (based on California Economic Strategy Panel regions) • Counties	• Registered nurses	• New student enrollments • Number of completions • Race/ethnicity, gender, and age distribution of completions

*CBSA = Core Based Statistical Area, CSA = Combined Statistical Area, as defined by U.S. Census Bureau.
A complete list of data sources for market level monitoring can be found in the Appendix.

Next Steps

- OHCA is in the process of refining the workforce stability standards and metrics. These will undergo further refinement based on stakeholder feedback and will be presented to the OHCA Advisory Committee and Board this spring.



Resources

- OHCA webpage
  - Notice of Publication- Proposed Statewide Spending Target
  - Proposed Statewide Spending Target Recommendation
- Public meetings
  - Health Care Affordability Board
  - Health Care Affordability Advisory Committee
  - OHCA Investment and Payment Workgroup
  - Total Health Care Expenditure (THCE) Data Submitter Workgroup

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Appendix
Promoting High-Value OHCA Health System Performance Branch Overview and Progress

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

Investment and Payment Workgroup Members

Providers & Provider Organizations

Bill Barcellona, Esq., MHA
Executive Vice President of Government Affairs, America's Physician Groups

Lisa Folberg, MPP
Chief Executive Officer, California Academy of Family Physicians (CAFP)

Paula Jamison, MAA
Senior Vice President for Population Health, AltaMed

Cindy Keltner, MPA
Vice President of Health Access & Quality, California Primary Care Association (CPCA)

Amy Nguyen Howell MD, MBA, FAAFP
Chief of the Office for Provider Advancement (OPA), Optum

Janice Rocco
Chief of Staff, California Medical Association

Adam Solomon, MD, MMM, FACP
Chief Medical Officer, MemorialCare Medical Foundation

Academics/ SMEs

Sarah Arnquist, MPH
Principal Consultant, SJA Health Solutions

Crystal Eubanks, MS-MHSc
Vice President Care Transformation, California Quality Collaborative (CQC)

Kevin Grumbach, MD
Professor of Family and Community Medicine, UC San Francisco

Reshma Gupta, MD, MSHPM
Chief of Population Health and Accountable Care, UC Davis

Kathryn Phillips, MPH
Associate Director, Improving Access, California Health Care Foundation (CHCF)

State & Private Purchasers

Lisa Albers, MD
Assistant Chief, Clinical Policy & Programs Division, CalPERS

Palav Babaria, MD
Chief Quality and Medical Officer & Deputy Director of Quality and Population Health Management, California Department of Health Care Services (DHCS)

Monica Soni, MD
Chief Medical Officer, Covered California

Dan Southard
Chief Deputy Director, Department of Managed Health Care (DHMC)

Consumer Reps & Advocates

Beth Capell, PhD
Contract Lobbyist, Health Access California

Nina Graham
Transplant Recipient and Cancer Survivor, Patients for Primary Care

Cary Sanders, MPP
Senior Policy Director, California Pan-Ethnic Health Network (CPEHN)

Hospitals & Health Systems

Ben Johnson, MPP
Vice President Policy, California Hospital Association (CHA)

Sara Martin, MD
Program Faculty, Adventist Health, Ukiah Valley Family Medicine Residency

Ash Amarnath, MD, MS-SHCD
Chief Health Officer, California Health Care Safety Net Institute

Health Plans

Joe Castiglione, MBA
Principal Program Manager, Industry Initiatives, Blue Shield of California

Rhonda Chabran, LCSW
Director of Behavioral Health Quality & Regulatory Services, Kaiser Foundation Health Plan/Hospital, Southern CA & HI

Keenan Freeman, MBA
Chief Financial Officer, Inland Empire Health Plan (IEHP)

Mohit Ghose
State Affairs, Anthem

OHCA Investment and Payment Workgroup information and meeting materials available here:
https://hcai.ca.gov/affordability/ohca/ohca-investment-and-payment-workgroup/

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 Goals 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)

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** health care 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.

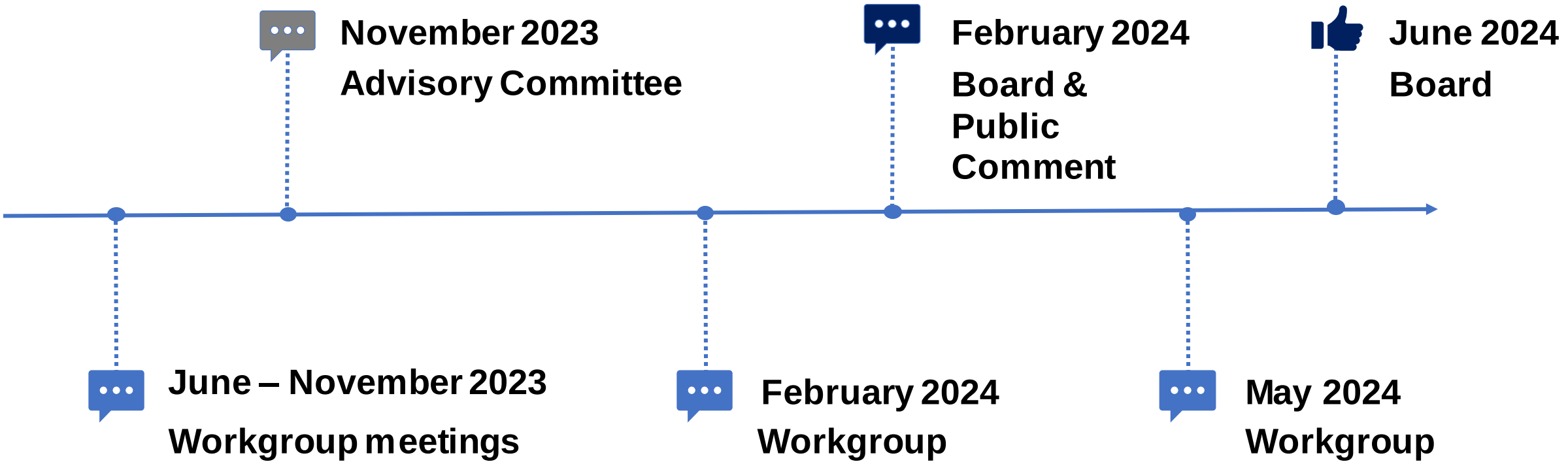
Health and Safety Code 127504(a-d)

APM Standards and Adoption Goal Progress

- Worked with the Investment and Payment Workgroup from June through November 2023 to develop draft standards for APM contracting and draft APM adoption goal:
  - Discussed strategic decisions for defining APMs, standards, and adoption goal
  - Considered examples of APM standards and adoption goals from other states
  - Developed criteria, approach, and vision for standards and goal
- Presented draft standards and adoption goals to Advisory Committee in November 2023, incorporated feedback from Advisory Committee and Workgroup.
- Draft standards and adoption goal presented to Board in February 2024 for feedback and release for public comment.

OHCA Draft APM Standards and Adoption Goals available here: https://hcai.ca.gov/public-meetings/february-ohca-investment-and-payment-workgroupfebruary/

Timeline for APM Standards and Adoption Goal



Between each meeting, OHCA and Freedman HealthCare will revise draft APM standards and goals based on feedback.

Provide Feedback Board Approval

Primary Care & Behavioral Health Investments

Statutory Requirements

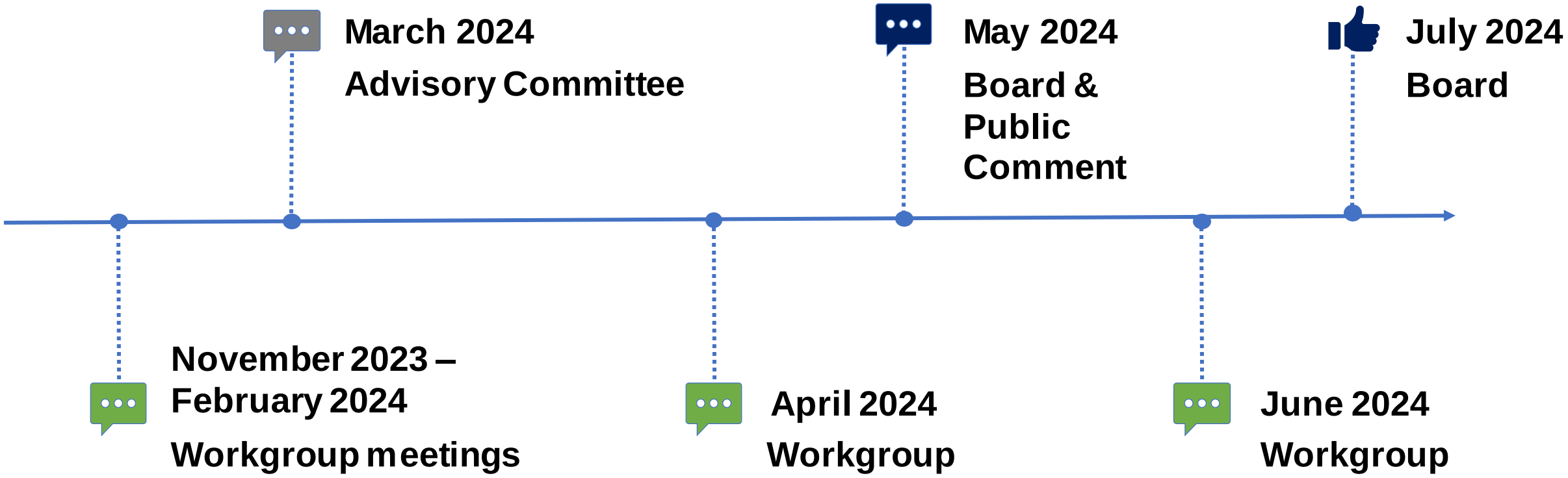
- Measure and promote a sustained systemwide investment in primary care (PC) and behavioral health (BH).
- **Measure the percentage of total health care expenditures allocated to PC and BH** and set spending benchmarks that consider current and historic underfunding of primary care services.
- **Develop 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.

Health and Safety Code 127505(a-c)

Primary Care Investment Progress

- Worked with Investment and Payment Workgroup November 2023 – February 2024 to develop draft primary care investment recommendations:
  - Technical definitions of primary care to inform measurements of claims-based and non-claims-based primary care spending
  - Benchmark for primary care spending as percent of total medical expense
- Will present draft primary care spending definitions and proposed spending benchmark to Advisory Committee in March 2024.
- After incorporating Advisory Committee and Workgroup input, will present primary care investment benchmark to Board in May 2024 for feedback and release public comment.

Timeline for Primary Care Investment Work



Between each meeting, OHCA and Freedman HealthCare will revise draft primary care definitions and benchmarks based on feedback.

Provide Feedback Board Approval

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Appendix

Key Informant and Stakeholder Interviews to Inform Workforce Stability Standards

Key Informant & Stakeholder Interviewees

Academics & Content Experts

David Auerbach, PhD
Senior Director for Research and Cost Trends,
Massachusetts Health Policy Commission

Bianca Frogner, PhD
Professor of Family Medicine, Director of University of Washington Center for Health Workforce Studies

Polly Pittman, PhD
Professor of Health Workforce Equity, Director of Institute for Health Workforce Equity at George Washington University

University of North Carolina – Chapel Hill, Health Workforce Research Center

Kathryn Phillips, MPH*
Associate Director, Improving Access; California Health Care Foundation (CHCF)

Hemi Tewarson, JD, MPH*
Executive Director, National Academy for State Health Policy

Laurel Lucia, MPP*
Director, Health Care Program at UC Berkeley Labor Center

Paul Kumar
Health Policy and Finance Consultant

BJ Bartleson, MS, RN
Health Policy RN Consultant

Michael Bailit, MBA
President, Bailit Health

Organized Labor

Joan Allen*
Government Relations Advocate, SEIU United Healthcare Workers West

Ian Lewis
Policy Director, National Union of Healthcare Workers

Janice O'Malley
Legislative Advocate, American Federation of State, County and Municipal Employees (AFSCME)

California Nurses Association (CNA)/National Nurses United

Consumer Representatives & Advocates

Cary Sanders*
Senior Policy Director,
California Pan-Ethnic Health Network (CPEHN)

Anthony Wright
Executive Director,
Health Access California

Beth Capell, PhD
Contract Lobbyist,
Health Access California

Health Care Entities & Associations

California Hospital Association (CHA)

Katie Rodriguez, MPP
Senior Director of Policy, California Association of Public Hospitals & Health Systems (CAPH)

Nataly Diaz, MBA*
Director of Health Center Operations, California Primary Care Association (CPCA)

Kaiser Permanente

Sutter Health

Plumas District Hospital

Workforce Stability Standards Interviewees

Academics/Content Experts

- Massachusetts Health Policy Commission: David Auerbach
- George Washington University: Polly Pittman
- California Health Care Foundation (CHCF): Kathryn Phillips, Kara Carter
- UC Berkeley Labor Center: Laurel Lucia, Ken Jacobs, Miranda Dietz
- University of Washington: Bianca Frogner
- University of North Carolina, Chapel Hill
- National Academy for State Health Policy: Hemi Tewarson, Elaine Chhean, Maureen Hensley-Quinn
- Bailit Health: Michael Bailit
- Consultants: BJ Bartleson, Paul Kumar

Workforce Stability Standards Interviewees

Organized Labor

- SEIU United Healthcare Workers West: Joan Allen, Denise Tugade
- National Union of Healthcare Workers: Ian Lewis
- American Federation of State, County, and Municipal Employees (AFSCME): Janice O'Malley
- California Nurses Association (CAN)/National Nurses United

Consumer Representatives & Advocates

- California Pan-Ethnic Health Network (CPEHN): Cary Sanders, Andrea Mackey
- Health Access California: Anthony Wright, Beth Capell

Workforce Stability Standards Interviewees

Health Care Entities

- California Hospital Association (CHA)
- California Association of Public Hospitals & Health Systems (CAPH): Katie Rodriguez
- California Primary Care Association (CPCA): Nataly Diaz, Cindy Keltner, Isa Iniguez, Araceli Valencia
- Plumas District Hospital
- Sutter Health
- Kaiser Permanente

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Appendix
Data Sources for Workforce Stability Monitoring Metrics

Data Sources for Draft Workforce Stability Metrics

Organizational Level	
Data Source	**Organization Monitored**
HCAI Hospital Annual Financial Disclosure Reports	Hospitals
HCAI Long-term Care Facility Integrated Disclosure and Medi-Cal Cost Report Data	Nursing homes and skilled nursing facilities
HCAI Primary Care Clinic Annual Utilization Data	Community Clinics
Market Level	
Data Source	**Area of Monitoring**
CA Licensure Boards/HCAI license renewal surveys	Supply, employment & diversity of licensed health professionals
US American Community Survey	Employment & diversity of unlicensed health care workers
US Occupational Employment and Wage Statistics	Employment & wages of health care workers
US Integrated Postsecondary Education Data System	Health Worker Graduates from US Postsecondary Programs
California Board of Registered Nursing Biennial Survey of RNs	Supply and employment of Registered Nurses
California Board of Registered Nursing Annual Schools Survey	Registered Nurse education
California Board of Registered Nursing Projections of Supply and Demand	Projected supply and demand for Registered Nurses