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

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HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Wednesday, November 20, 2024
10:00 am

Members Attending: Dr. Sandra Hernández, Dr. David Carlisle, Richard Kronick, Ian Lewis, and Dr. Richard Pan, Elizabeth Mitchell, Secretary Kim Johnson.

Members Absent: Don Moulds

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; Margareta Brandt, Assistant Deputy Director, HCAI; Sheila Tatayon, Assistant Deputy Director, HCAI; CJ Howard, Assistant Deputy Director, HCAI

Meeting Materials: https://hcai.ca.gov/public-meetings/november-health-care-affordability-board-meeting-2/

Agenda Item # 1: Welcome, Call to Order and Roll Call
Vice Chair, Dr. Sandra Hernandez
Elizabeth Landsberg, Director, HCAI

Director Landsberg opened the November meeting of California's Health Care Affordability Board, announcing that Vice Chair Hernandez will chair the first part of the meeting and following the election of the Board chair, the new chair will take over the remainder.

Roll call was taken, and quorum was established, noting that Secretary Kim Johnson and Elizabeth Mitchell would join shortly.

Director Landsberg provided an overview of the meeting agenda.

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

Director Landsberg provided HCAI Program updates, including information regarding:

- HCAI's Office of Health Workforce Development recent program awards and upcoming grant program funding cycles.

- HCAI's Healthcare Payments Data program Non-Claims Payment regulatory process and deadline to submit public comments.
- Changes in the federal administration and HCAI's efforts to monitor proposals to repeal coverage under the Affordable Care Act and the enhanced individual market subsidies under the American Rescue Plan Act.

Deputy Director Pegany provided the following Executive Updates:

- An announcement of a December 16th Board meeting in which the Office will continue the discussion of defining sectors and sector targets, among other topics.
- An overview of the 2024 Employer Premium Increases.
- A reminder about slide formatting, with a yellow arrow indicating that the Office, and a green arrow indicating that the Board, has decision-making authority over that item.

Discussion and comments from the Board included:

- A member commented that Covered California kept the average premium increase around 1% for the two years during the prior federal administration.
- A member shared that hotel workers are currently on strike in San Fransisco over the companies' proposals to terminate their health plans, entirely driven by cost and the sense that California costs (Northern California costs in particular) are out of control. Should the strike remain in effect later this week, then this strike will become the longest running multi-hotel strike in California history.
- A member stated that premiums outpaced inflation every year except for one, so it is important to understand the growth rate and the pressure on affordability, particularly for employees and families.

Public Comment was held on agenda item 2. One member of the public provided comment.

Agenda Item # 3: Action Consent Item
Vishaal Pegany, Deputy Director, HCAI

a) Approval of the October 14, 2024, Meeting Minutes

Deputy Director Pegany introduced the action item to approve the October meeting minutes.

Board member Pan motioned to approve and Board member Kronick seconded.

Public Comment was held on agenda item 3a. No public comment was made.

Voting members who were present voted to accept. There were 5 ayes, 1 absent and 1 abstained. The motion passed.

Agenda Item #5: Informational Items (out-of-order)
Margareta Brandt, Assistant Deputy Director, HCAI

a) Cost-Reducing Strategies - AltaMed

Assistant Deputy Director Brandt shared that the goal of this cost-reducing strategy project is to highlight examples of successful cost-reducing strategies that also maintain or improve quality. OHCA has not independently verified information about these strategies or results and is not endorsing any specific healthcare entity or strategy. OHCA is seeking additional examples of cost-reducing strategies and encourages all health care entities to contact OHCA using the general email inbox if they would like to propose a cost reducing strategy for consideration.

Assistant Deputy Director Brandt introduced Dr. Efrain Talamantes, Senior Vice President and Chief Operations Officer of Health Services at AltaMed, who then shared examples of AltaMed's cost-reducing strategies.

Discussion and comments from the Board included:

- A member stated that OHCA intends to increase investment in primary care up to 15% within the next ten years, and asked if that will enable and accelerate some of the work that AltaMed is hoping to accomplish, such as keeping people out of the hospital and emergency department.
    - Dr. Talamantes replied that, in reviewing what other states have experienced, they have seen that an increase in how much is spent in primary care leads to an overall decrease in cost and increase in positive outcomes. The primary care spend helps AltaMed work better with specialists. Electronic consultations save a significant amount of time in getting the patient the care that they need.
- A member asked how AltaMed feels about the proposed metrics for hospitals.
    - Dr. Talamantes responded that AltaMed is aligned with the proposed metrics for hospitals. They have been tracking this work across the state. They want to share what they have done and how they might help others get to the same place.
- A member expressed appreciation for AltaMed's willingness to do the necessary work to transform the health care system. They further acknowledged AltaMed's participation in the California Quality Collaborative's initiative on behavioral health integration for youth and in the Equity and Quality at Independent Practices in Los Angeles County (EQuIP-LA). The member then asked what AltaMed's leadership and mindset that is makes all this possible as opposed to the mindset that this is too difficult. They further inquired what is the leadership quality that leads to this mindset and how that could be scaled.
    - Dr. Talamantes advised that it starts with listening to their board of directors, through the AltaMed Institute for Health Equity and leveraging community, participatory or partnered research, and a lot of information from the patients. They listen to their patients' struggles and have a desire to act. Their leadership focuses on strategies to recognize where the

problem is and what support must be developed to improve the issue. Castulo de la Rocha, AltaMed's President and CEO, has a mindset of "whatever it takes," which trickles down to his leadership, to the site medical director and university, so that their medical directors understand the call to action.

- A member stated that a typical primary care doctor has approximately 2,000 patients. However, AltaMed's Viva Gold model provides a primary care team that takes care of approximately 900 patients. The member asked whether the reduction in utilization pays for the primary care team.
    - Dr. Talamantes stated that risk stratification has allowed AltaMed to look at these smaller panels for the highest risk seniors. They are spending much less on the institutional side as they are in risk sharing arrangements there. On the professional side, they see that there are less referrals to other providers. This does work out both in utilization and in affordability, but it is an investment. Looking at the future in fully capitated payment arrangements, they are looking forward to having the flexibility to support the whole care team. Their early experiences have been great using their Registered Nurse (RN) clinics, where the doctors see their scheduled patients next door and the nurses see the extra patients who come in. However, seeing nurses, rather than a doctor, is something that patients must become accustomed to. AltaMed has been very proactive in ensuring they have a conversation with the patient to decide what will work best rather than telling them that they must do something. This has slowed them down a bit, but it is necessary to help them understand whether the patient needs to see a doctor. Approximately one third of their patients want their care expedited via a nurse and do not want to have to wait for their primary care doctor.
- A member advised that this Board has decided on a global cap of 3.5% down to 3% over five years. The member asked whether AltaMed will be able to keep their capitation rate growth to under 3% year-by-year.
    - Dr. Talamantes replied that AltaMed will need to do some calculations to figure that out. However, some of the changes that they have made have been in anticipation of knowing that they may not have additional dollars, knowing there's not enough money and that they must make better use of their existing dollar, better use of their existing teams, leveraging opportunities around scope of practice, technology, and making care more accessible.
    - The member expressed that, if AltaMed as an exemplar will have struggles doing so, then OHCA must recognize that other entities will struggle as well.
- A member asked for any words of encouragement to share with OHCA as they move forward to try to control health care costs more effectively from his perspective on the front lines of care delivery.
    - Dr. Talamantes responded that they face the same challenges in discovering what is the value, not only for the patient, but the value proposition for specialists and for hospitals. For delivery systems that are

not fully integrated, they need to ensure that the world is one that allows for better collaboration, and that there are opportunities to make health care more affordable. He recommends multistakeholder engagement that it is inclusive of hospitals and specialists. There are many things that can be done for the underserved communities that are community driven. Enhanced Care Management has garnered much enthusiasm among primary care providers. Primary care is a solution, but there is also an opportunity to make sure that other providers are included who may be more influential at the state and federal levels regarding how payment models are developed.

- A member inquired what are the risk arrangements for Medi-Cal patients.
    - Dr. Talamantes stated that almost 90% of their patients are global risk and the other 10% are in shared risk arrangements. They started with approximately 20% and slowly increased year-over-year, which provided an opportunity to think about how to scale to that. There has been a lot of background work in changing their operations to mirror what they need for global risk.
- A member asked what the cost drivers are that AltaMed cannot manage through the strategies he has presented.
    - Dr. Talamantes replied that oftentimes when patients enroll in Medi-Cal, it is often the case that they have already been diagnosed with a severe condition which can lead to adverse selection. Disenrollment from Medi-Cal is another issue where AltaMed puts in a significant amount of work, then a patient becomes disenrolled, and the process must start all over again as they will become sicker and return for care. However, these aspects push AltaMed to grow, to diversify their risk, and to ensure that they have a model of care that is highly responsive to high-risk patients. Another barrier is that some of the hospitals in the community do not share data with AltaMed that could help them provide better care.
- A member noted that as a Federally Qualified Health Center (FQHC), a majority of AltaMed's board members be patients of the clinics.
- A member shared that there is an assumption that health equity and access and reducing costs and alternative payments somehow reduces the quality of care. AltaMed does track Healthcare Effectiveness Data and Information Set (HEDIS) measures, five of seven of which are exemplary. While this was not noted in the presentation, the member asked to state for the record what quality measures AltaMed is tracking.
    - Dr. Talamantes advised that AltaMed's teams are fully enabled and supported as a care team to ensure that any gaps in care or quality metrics can be addressed at any point of care, and they are moving away from the idea that this all must happen during a billable encounter. For example, if a patient were to be discharged from a hospital without a necessary vaccine, an AltaMed care member could bring the vaccine to the patient. That care member could be a nurse or a community health worker under the supervision of a physician. This allows AltaMed to close more care gaps.

- A member asked what work could be accelerated to align with AltaMed's visions if there was full data exchange across all the systems, if data exchange was not a barrier as it is now.
    - Dr. Talamantes stated that a live feed coming from the hospitals allows AltaMed to see that a patient was seen at the hospital the previous night and to respond to that quickly, rather than finding out about the hospital visit 90 days later. There are community-based providers who are now addressing food insecurity and housing insecurity or instability. Food and housing insecurities often lead to catastrophic health issues.
- A member stated that there has been much said regarding clinician burnout, but nothing said about community health worker burnout. The member requested insight into that.
    - Dr. Talamantes responded that while AltaMed is guided by the state requirements for community health workers, they must also be thoughtful in how they build the workers' caseloads. They must ensure that the work that the community health workers are doing is sustainable and balanced. They monitor the panel size and the number of high-risk patients in a community health worker's patient panel. AltaMed reaches out to community partners, such as the Latino Coalition for Health in California, for insight and input regarding the community health care workers.

Public Comment was held on agenda item 5a. Two members of the public provided comments.

Agenda Item #4: Action Items
Elizabeth Landsberg, Director, HCAI

a) Vote to Elect Health Care Affordability Board Chair

Vice Chair Hernandez introduced the action item to vote to elect a new Health Care Affordability Chair and invited nominations.

Vice Chair Hernandez moved to nominate Secretary Kim Johnson. Board member Carlisle seconded the motion. Board member Pan also supported the nomination and noted that this Board has the authority to elect the chair.

Public Comment was held on agenda item 4a. No members of the public provided comment.

All seven voting members who were present voted to approve. The motion passed.

Agenda Item #5: Informational Items
Vishaal Pegany; Margareta Brandt, Assistant Deputy Director; CJ Howard, Assistant Deputy Director; Janna King, Health Equity and Quality Performance Group Manager; Mary Jo

Condon and Sarah Lindberg, Freedman Health Care; Debbie Lindes, Health Care Delivery System Group Manager

b) Updates to Data Submission Guide to Add Alternative Payment Model Arrangements and Primary Care Data Collection, Including Advisory Committee Feedback

Assistant Deputy Director Howard and Assistant Deputy Director Brandt provided an overview of the updates to the Data Submission Guide.

Discussion and comments from the Board included:

- A member requested clarification regarding OHCA not counting behavioral health capitation as primary care spending but counting behavioral health when it is provided within primary care capitation or other types of capitations.
    - The Office clarified that they are not counting behavioral health capitation towards primary care spending as that is generally specific to services provided by behavioral health providers directly. The Office is developing a behavioral health spending definition to capture this spending. Some behavioral health services provided by a primary care provider in a primary care setting will be counted as primary care spending as defined in OHCA's primary care spending methodology. The Office recognizes that prevention and early intervention are critical in behavioral health.
- A member recalled the removal of the member responsibility from the regional file to prevent duplication as that data will be available at the state level. They asked if the Office will be losing any analytic ability by making that change. The member further inquired whether the Office will still have the ability to conduct regional analyses and granular analyses on members, including member responsibility.
    - The Office advised that they will follow up with the member to thoroughly answer this question to avoid oversimplifying the response.
    - Another member also expressed concern, stating that it sounds as though the member responsibility will be tracked at the state level but not at the regional level. The member is also concerned about removing the Taxpayer Identification Number (TIN) requirement from the data.
- The Office responded that they are only removing the TIN requirement from the registration where they ask the payers to provide their TINS which would align to a provider organization. The Office noticed instances where one TIN was linked to multiple provider organizations. This could occur due to being treated by a physician who is attached to multiple provider organizations. They plan to work with some of the larger provider organizations to identify a better way to define the provider organizations in data that can then also be aligned with the data that the payers have. There will still be an attribution addendum attached to the data submission guide that would instruct payers where to attribute dollars for provider organizations.
    - A member asked how a payer would know whether a particular arrangement is HCP-LAN APM subcategory 2a or 4b.

    - The Office stated that there are definitions for each category and subcategory in the Expanded Framework and the Expanded Framework subcategories crosswalk to the HCP-LAN subcategories.
- A member inquired how the primary care spend for telehealth is captured, specifically in the situation where a primary care provider reaches out to a specialist for an e-consult or any form of telehealth.
    - The Office responded that telehealth services will be counted if the services is a primary care service provided by a primary care provider in a primary care setting. They will follow up with the member to describe how e-consults will be captured under the primary care definition.

Public Comment was held on agenda item 5b. Two members of the public provided comments.

c) Introduce Quality and Equity Performance Measure Set Proposal, Including Advisory Committee Feedback

Assistant Deputy Director Brandt introduced Janna King, the Health Equity and Quality Performance Group Manager for OHCA. She then provided background information on OHCA's Quality and Equity Measure Set. Janna King then provided an overview of the proposal.

Discussion and comments from the Board included:
- A member asked what OHCA's and HCAI's plans are regarding implementing the new race and ethnicity categories that OMB released earlier this year, as well as plans for mapping past data based on the old race and ethnicity categories with new data based on the new race and ethnicity categories.
    - The Office replied that HCAI is working to adopt the changes to the race and ethnicity categories, including combining race and ethnicity rather than having those as separate categories, as well as adding the new Middle Eastern or North African (MENA) categorization though it will take time. There will be a mapping process to map past data based on the old race and ethnicity categories with new data based on the new race and ethnicity categories.
- A member expressed concern regarding linguistic data. For example, during COVID, Chinese individuals whose primary language was Chinese were dying at much higher rates than Chinese individuals whose primary language was English. Both populations would fall under the racial ethnicity of Chinese Americans, but this difference in linguistics is important. This also affects costs, as interpreter services must be provided for those whose primary language is not English.
    - The Office responded that language access is also a high priority for the governor and the California Health and Human Services Agency.
- A member expressed support for adding outcomes, and specifically recommended using patient reported outcome measures. The member further

advised that the Office should include measures focused on access and behavioral health.

- A member stated that there is a need for a more parsimonious set of measures, allowing OHCA to develop a stronger focus on outcomes while also ensuring that they are not asking providers to do more without incentives.
- A member shared that the Purchaser Business Group on Health (PBGH) ran the Patient Assessment Survey (PAS) for over 20 years, which was the largest patient experience dataset at the provider level in the country and captured race, ethnicity, and language stratification. A few months ago, the Integrated Healthcare Association (IHA) voted to sunset that survey due to cost and there will no longer be incentives for physicians to collect that information. This survey had been reported by the Office of Patient Advocate (OPA) for several years. OPA advised that this change will create a significant gap in their public reporting and the survey was highly valued by the public. The member stated that they are not convinced that the Consumer Assessment of Healthcare Providers and Systems (CAHPS) is an adequate replacement for PAS. The member also expressed concern that there would not be public reporting of physician organization performance for commercial Preferred Provider Organizations (PPOs) and stated that they do not support keeping information from the public.
    - The Office responded that they have been communicating with OPA about that gap in the public reporting and how to address it in terms of having patient experience measures at the provider organization level. The Office clarified that it would report commercial PPO data for the payer and hospital measure sets. However, IHA and OPA do not have performance on the commercial PPO population at the physician organization level. The Office also stated that one of the rationales and advantages of adopting these current measure sets is that OHCA would not be asking providers, health plans, or hospitals to add new measure sets or submit new data. While OHCA does recognize that if they do not add new measures, then they will not be addressing the gaps in current measure sets in terms of including more patient reported outcomes and behavioral health measures. OHCA looks to work collaboratively across state departments with the Department of Managed Health Care (DMHC), OPA, and HCAI to fill in those gaps and to identify where they can adjust and expand the measure sets.
- A member asked if age is one of the demographics that OHCA is considering regarding payer stratification.
    - The Office replied that the member is likely referring to the DMHC health plan Demographic Data Metric, which is information that DMHC is collecting and OHCA is considering reporting, so the Office will check to confirm whether age is part of the data set that DMHC is collecting.
- A member inquired about using metrics to determine how promptly individuals receive the care that they need, stratified so that OHCA can understand the equity implications within that data set.
    - The Office advised that timely access to care is critical and is something that the Advisory Committee also asked about. OHCA is working to

determine how to assess access, including timely access, so this is something they will further discuss. The Office encouraged the Board to share any suggestions they may have.

- A member expressed concern that these data sets do not reflect how a patient is treated, specifically those with chronic conditions or illnesses. The public would be better served with an acknowledgement of the limitations of what OHCA can do with this data.
    - The Office responded that the goal is to have a higher value system and to guard against health disparities getting worse and to lower the cost of care while ensuring that the quality of care is maintained or improved.
- A member stated that, even if none of the sister agencies have good data points yet on behavioral health following the pandemic, it is important for California as a state to understand what meaningful measures are in behavioral health. As important as depression screening is, it does not address the massive gaps in quality of care.
    - The Office responded that HCAI has spent significant time considering Proposition 1 implementation to improve the behavioral health system and recognizes that it will require a large investment.
- A member asked what statutory capabilities OHCA has if an entity meet the spending targets but performance on the quality and equity measures declines.
    - The Office advised that they do not have authority to enforce performance on the measures on a standalone basis. The Office will focus on transparency by publishing performance on the measures in its annual reports and flagging any decreases in quality and equity, including for entities that meet the spending target.
    - A member suggested that OHCA consider other agencies that may be able to act in this situation.
    - The Office shared that there is a section of the statue which states that if data indicates adverse impacts on cost, access, equity or quality from consolidation or market power, OHCA can investigate that.

Public Comment was held on agenda item 5c. Seven members of the public provided comments.

d) Provisional Approach to Hospital Spending Measurement

Deputy Director Pegany presented OHCA's Provisional Approach to Hospital Spending Measurement. Sarah Lindbergh, a Friedman Healthcare Consultant, and Mary Jo Condon, a principal consultant with Friedman Healthcare, assisted in answering questions on this topic.

Discussion and comments from the Board included:

- A member commented that the schematic on slide 85 was useful, although they do not feel that the relative proportions are helpful. The member asked if there is an estimate of what fraction of hospital spending would be accounted for by patients who would be attributed to medical groups.

- The Office replied that they recently received their first data submission for 2022 and 2023, which does include service category breakouts. They will have to review and conduct that calculation. The Office further clarified that the question is what percent of hospital spending occurs for members who are not attributed to another provider.
    - A member asked for clarification regarding the term “net patient revenue,” the definition of which is payments collected. When hearing that term, the member would assume that is the revenue minus expense, so they believe the better term for this metric would be “gross patient revenue.” Another member responded that gross patient revenue in this parlance means charges. They understand the confusion, but in this situation, net does not mean revenue minus expense, it means the total revenue that Anthem and Blue Shield, for example, pay to the hospitals.
        - The member asked for further clarity regarding where expenses are factored in this measurement.
        - The Office advised that the term “net income” would be where expenses are factored in this measurement, which is different than the revenue or operating margin.
    - A member commented that it would be helpful to see an estimate of how much inpatient and outpatient volume per person has been changing. Their sense is inpatient volume has been relatively flat or declining while outpatient has increased a lot.
        - The Office replied that they hope to bring back more data points at the December board meeting.
    - A member asked if there is a reason why OHCA is not utilizing the newly available hospital transparency reported data on pricing and the Consolidated Appropriations Act of 2021 (CAA) data on allowed amounts.

        The Office responded that they want to capture total payments to hospitals, which the net patient revenue (NPR) measure would do. The data that is being released under the federal transparency rules are for the discrete unit prices of services. OHCA would not be able to discern the total payments the hospital received from that data. They are seeking to create a similar measure as to what they have for total health care spending for the payer level and the physician organization level and are trying to determine the equivalent of that for hospitals. The Office also expressed that there are challenges with completeness of that data in terms of hospital compliance, and it is difficult to compare if they do not have a full census of that information. There will be some standardization of that data starting in 2025, but it is difficult to obtain equal comparisons for services, especially when there is no insight regarding volume.
        - A member shared that they are currently working on a project using the CAA data and standardizing it and are happy to share those results.
        - A member asked if this will only be used as the hospital measure.
        - The Office confirmed that, for the provisional approach, the net patient revenue is most associated with patient care. They do want to monitor those other measures as well. If an entity were to exceed the target, then

OHCA will create a performance improvement plan and would want to consider the full picture of other revenue.
    - A member stressed the importance of understanding a hospital's full set of resources.
- A member asked how volume is defined.
    - The Office responded that for inpatient it is case mix-adjusted discharges and for outpatient it is visits.
- A member asked if OHCA should be tracking when hospitals sell patient debts to a debt collector.
    - The Office responded that HCAI financials do include breakouts for bad debt and charity care, so there is a way to track that metric.
    - The member further inquired how the revenue from selling the debt appears in revenue.
    - The Office advised that the revenue the hospital received from selling a bad debt would be accounted for under other non-operating revenue but will not be a clean line item. They also confirmed HCAI has data about bad debt and charity care and can think more it as they count hospital spending.
    - A member commented they want to ensure the value of bad debt is not being magnified against any revenue brought in.
    - The Office responded the accounting works like a cost report starting with gross revenue, minus any bad debt or charity care, plus any supplemental payments to get to the net green dollar collected.
- A member asked for clarification on slide 104 regarding the consideration listed of "dulls shift to more expensive services regardless of whether necessary or appropriate."
    - The Office answered that they are referring to the incentive to upcode or increase coding intensity as it is beneficial for reimbursement. The result is a code that cannot be validated.
    - The member further inquired how responsive it is to changes in technology or advances in care.
    - The Office responded that these are Medicare's diagnosis related groups (DRGs). There is a bit of a lag in adopting new technology and it is referenced to the Medicare population. Populations such as children's hospitals tend to not be as correctly recognized in this coding scheme, but it is publicly available and widely utilized.
    - The member asked how accurate that is, considering it is generally used for Medicare. The member also stated that a lot of hospitals are closing their pediatric wards and there is a crisis looming in terms of pediatric care.
    - Another member added that using Medicare weights seems like it would be a significant issue, although a solvable one. They suggested that OHCA could be estimating weights using their own patient discharge data for inpatient services. The member stated that OHCA should be using weights that are appropriate for a broader population than 65 plus and that reflect utilization patterns in California. The member also noted the

weights presumably get updated every few years and suggests the Office use the patient discharge data to estimate weights.
    - The Office noted it would be a data source to enhance.
  - A member stated if we go forward with the NPR per hospital unit approach on slide 117, the outpatient side should be dropped entirely and focus on inpatient even though it's problematic.
- A member asked where the Equivalent Case Mix Adjusted Discharge (E-CMAD) is coming from, and what data is used to create the weights for that.
    - The Office advised that they're not applying outpatient weights but are essentially scaling, taking outpatient revenue and then converting it to determine the equivalent number of inpatient case mix adjusted discharges that would occur, scaled to outpatient revenue.
- A member expressed concern that this data may not be useful, especially considering that changes to both sides of the equation could have the same result as before, which would not give a true picture of the situation.
  - A member asked when the HPD will be ready.
    - The Office responded that they would have a more complete answer at the December board meeting.

Public Comment was held on agenda item 5d. Six members of the public provided comments.

e) Sector Targets

Deputy Director Howard provided a walkthrough on establishing and defining sector targets. He advised that OHCA will return to the December board meeting with more refined options for the Board's consideration relating to defining initial sectors.

Discussion and comments from the Board included:

- A member asked if they are allowed to create sectors after June 1, 2028.
    - The Office confirmed that new sectors can be created after June 1, 2028.
- A member stated that OHCA should be looking at commercial prices relative to Medicare, where prices are out of line with the rest of the state and limiting high-priced hospitals. Another member agreed with this approach and stated on the outpatient side, in the short run until Healthcare Payment Database information is available, it is the only reasonable approach.
- A member mentioned looking at high price hospitals per unit volume compared to Medicare or another standard such as the average of hospitals across the state.
- A member stated that long-term, with so much care delivered by health systems, OHCA should consider defining health systems as sectors and establishing targets for them.
- A member mentioned another approach could look at a hospital's rate of growth year over year as a potential sector but noted disadvantages for lower-than-average priced hospitals that experience growth.
- A member supports targeting commercial pricing as the driver of the affordability crisis and believes evidence shows any hospital should be fine at 160 percent of Medicare.

- A member cautions using Medicare rates universally for sectors, except for outliers, due to distortions.
- A member commented, regarding the critical access hospital category, on the importance of looking at geographic sectors and the health care market within that geography, and then hospitals within that market.
- A member asked to factor in rural areas into any hospital target, especially with health care deserts.
- A member mentioned the Legislature may want to reconsider how hospitals are financed in California, especially rural hospitals.
- A member commented that Children's Hospitals could be hard to define because some are embedded within general hospitals, and since Covid, there has been a decline in pediatric beds. There is also likely overlap with Teaching Hospitals. Maybe Teaching should not be its own category.
- A member suggested that state-operated and funded hospitals should not be penalized for exceeding the spending growth target.
- A member recommended, based on a commercial to Medicare metric, to exclude all hospital categories from a hospital sector target except Teaching Hospitals, Small Hospitals with more than a certain number of beds, and possibly Specialty Hospitals.
- A member raised the possibility of measuring county-level commercial to Medicare ratios and targeting hospitals in counties with a high average ratio.
- A member noted that a recent report has shown cost increases are being driven by increasing administrative growth and layers and would like to discuss at a future date how to look into administrative entities as well.
- A member asked if, in addition to hospitals, health plans and other contributors can be a sector target.
    - The Office confirmed the Board can define sectors to include health care entities such as payers or health plans but currently we have more hospital data.
- A member supported including County hospitals in the general hospital performance analysis as they will have low commercial to Medicare ratios.

Public Comment was held on agenda item 5e. Six members of the public provided comments.

f) Introduce Behavioral Health Definition and Investment Benchmark, Including Advisory Committee Feedback

Chair Johnson stated that item 5f will be tabled and presented at the December board meeting.

Agenda Item #6: General Public Comment

Public Comment was held on agenda item 6. No members of the public provided comment.

Agenda Item #7: Adjournment

Chair Johnson adjourned the meeting.