HCAI Department of Health Care Access and Information
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Health Care Affordability
Board April 24, 2024
MEETING MINUTES

Members Attending: Secretary Mark Ghaly, David Carlisle, Sandra Hernández, Richard Kronick, Ian Lewis, Elizabeth Mitchell, Don Moulds, Richard Pan

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

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

Agenda Item # 1: Welcome, Call to Order and Roll Call
Secretary Mark Ghaly, Chair
Dr. Sandra Hernández, Vice-chair

Dr. Hernández opened the April meeting of California's Health Care Affordability Board. A quorum was established. Chair Secretary Mark Ghaly arrived later.

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

Director Landsberg and Deputy Director Pegany gave an overview of the agenda, noting that agenda item 6a would be held with agenda item 5, and provided updates on the work of the Department of Health Care Access and Information (HCAI) including:

- Approval of HCAI's remaining Distressed Hospital Loan Program loan to Madera Community Hospital.
- Ongoing progress of wellness coach scholarship program.
- Review of Board meeting slide formatting key.
- Quarterly work plan (April, May, and June) for the Board and the Advisory

Committee.
- Future topics and presentations: THCE and spending target; promoting high value; assessing market consolidation.

Public Comment was held on agenda item 2. No public comment.

Agenda Item # 3: Approval of March Meeting Minutes
Dr. Sandra Hernández, Vice-chair
Vishaal Pegany, Deputy Director, HCAI

Dr. Sandra Hernández, Vice-chair introduced the action item to approve the March meeting minutes.

- A Board member requested a correction to the March meeting minutes. It was noted that the Song-Brown Primary Care Residency Program was incorrectly referenced as the Brown Primary Care Residency Program.

Board member David Carlisle motioned to approve with the correction, and board member Ian Lewis seconded.

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

Voting members who were present voted to accept. The motion passed.
Agenda Item #4a: Action Item, Establish a Statewide Spending Target Value and Agenda Item #5a: Statewide Spending Target Including Board Follow-up Items
Vishaal Pegany, Deputy Director, and CJ Howard, Assistant Deputy Director, HCAI

Deputy Director Pegany provided information on how OHCA attributes members and applies the target to fully integrated delivery systems (FIDS) and how OHCA will measure hospitals without attributed lives, a member request for January 2024 meeting slide data showing 5-year rolling averages, projection of per member increase in Medi-Cal spending over the 5-year target period, and industry ideas for cost savings in the system from public comment letters.

Discussion and comments from the Board included:
- A member asked if the Kaiser physician group is being evaluated separately from the Kaiser health plan and if admin costs and profits would be accounted for.
    - The office answered that Kaiser falls under the Fully Integrated Delivery System definition in the statute. For total medical expenses, the admin cost and profits portion is going to be derived from the medical loss ratio reports. Once the total medical expense is added to health plan administrative costs and profits, then that would result in a measure for total health care expenditures that is inclusive of the health plan. Kaiser will be assessed as a health plan, physician organization and hospital system, for each of its northern and southern regions, per statute.
- A member highlighted that many ACO members are not enrolled with an organization, but there is an attribution process that the payer engages to attribute

members to an organization.
    - The office acknowledged that ACOs would be treated as a distinct category. The office's approach is to gather information about how payers perform attribution once the data submission is received. The submission will include a high-level description from the payer and OHCA expects to follow up for further details.
- A member asked if the payer developed rules based on attribution will be standard across all payers.
    - The office answered that it will not be standard under the initial approach for baseline reporting. The approaches for attribution are relatively similar, so there may be commonalities that we determine when looking at the data, which may inform a standard approach in the future.
- Board members raised concern over the impact of inflation and the possibility of adding an inflation adjustment.
- Regarding historical and projected per member Medi-Cal spending, a member asked for an explanation of why the per member costs jumped up year after year.
    - The office answered that they had asked DHCS for this information, but DHCS did not have this available at the time. The office will follow up with the board when information is available.
- A member suggested the idea that budgets tied to population health needs could be compared with individual states with similar successful Medicaid programs. For example, looking at per member expenses in Medicaid in New York could be a better benchmark than national averages that include states with smaller populations.
- Regarding industry ideas for cost savings, discussions highlighted the importance of continuity in patient care, stressing the value of strong patient-care team relationships and continuous engagement with primary care providers for improved healthcare outcomes. Efforts to promote continuity were underscored, emphasizing patient satisfaction and overall well-being.
    - The office responded that these topics represent a major theme in the OHCA Investment and Payment Workgroup, and it would be a good topic to which to return.
- In the context of cost-savings initiatives, a Board member suggested the benefit of having full visibility into the new Equity and Practice Transformation Payments Program, which is administered by DHCS.

Deputy Director Pegany provided an overview of the spending target discussion history, the process for establishing the statewide spending target, and two draft motions for the board's consideration. The first draft motion was a 3% spending target for years 2025 – 2029. The second draft motion included a "phase-in" with the target set at 3.5% for years 2025-26, 3.2% for years 2027-28, and 3% for 2029.

Discussion and comments from the Board included:

- Regarding the phase-in approach, a member cautioned that with each increment, individuals will continue to suffer the effects of increasing health care cost.
- A member commented that any target above 0% is too high, citing that other

developed countries provide better health care for half of the cost.

- A member expressed support for a phase-in approach due to the importance of moving towards the 3% target while keeping achievability in mind.
- Aging population annual percentage increases were discussed. A board member proposed the need to acknowledge that an aging population has greater health care needs and costs, such that the target should include an explicit population adjuster, particularly since it's a 5-year target. That adjuster could also be updated if the population changes result in a younger population.
- A member highlighted the importance of having a clear target that the public can understand, and that an aging adjustment can be revisited after setting a statewide target, rather than integrating it now.
- In the context of higher health care costs for an aging population, a board member noted that there are unique opportunities to change the way care is provided for seniors and end of life care, adding that the way the aging population is met for care could be more effective, whether in an inpatient setting, in home, or in communities using different makeups of care teams.
- A member supported the first staff recommendation (without a phase in), noting that the public is currently struggling with excessive health care costs in California.
- A member noted that sector-specific analysis will be important in the future. This member supported a phase-in to allow for learning and transparency as data comes in during the early years.
- A member noted that the main challenge is to establish the legitimacy of the office and the Board, and the need to set targets that are attainable for a reasonable portion of the health care industry.
- A member brought attention to the office's proposal that the Board should commit to evaluating the target for potential adjustments on an annual basis and suggested making it an action item, so the topic is revisited regularly.
- A member asked the Board Chair for a rationale for the phase-in approach.
    - Chair Ghaly answered that the approach would be responsive to a lot of the comments and feedback the Office has received. We want to be bold, but it will take time for health care entities to implement strategies to help reduce costs. The phase-in approach also allows the Board the opportunity to reassess over time. The phase-in doesn't take away the focus on affordability but gives a longer runway to bring along partners in the implementation.
- A member expressed concerns with both proposals, noting that there is a lot of burnout in the healthcare workforce and investment will be necessary to build performance improvement plans for certain entities that are missing the target. They also repeated the call for inclusion of a population aging adjuster.
- Guidance on Bagley-Keene procedure in making an amendment to the options presented was discussed. The order of amendments, motions, and public comment was stated and clarified by the Board Chair.

The Board Chair made a motion for a 3% cost target with a glide path as presented by staff, starting at 3.5% for 2025 and 2026, down to 3.2% for 2027 and 2028, and 3% by 2029. The motion was seconded by Member Hernandez.

After discussion about the impact of aging on health care costs, an amended motion was developed to include an aging adjustment, called Motion 2 with amendments. Member Kronick proposed the motion and it was seconded by Member Pan.

The language of both proposals was displayed during Board discussion, public comment, and voting.

After board discussion and significant public comment, the Board Chair motioned for a vote on Motion 2 with amendments: Establish a base 2.5% per person spending target, based on the average annual rate of change in historical median household income from 2002-2022 of 3.0% minus 0.5%, for performance year 2029. Add to the 2.5% an adjustment for the changing age distribution of the California population. Add 0.5% for performance year 2025 and 2026 and add 0.2% for performance year 2027 and 2028.

Voting members who were present voted on Motion 2 with amendments. There were 2 ayes, and 5 nos. The motion did not pass.

The Board Chair motioned for a vote on Motion 1: Establish a base 3% spending target, based on the average annual rate of change in historical median household income from 2002-2022, for performance year 2029. Add 0.5% to the 3% base for performance year 2025 and 2026 and add 0.2% to the 3% base in performance year 2027 and 2028.

Voting members who were present voted on Motion 1. There were 6 ayes, and 1 no. The motion carried.

Agenda Item # 5: Informational Items
Margareta Brandt, Assistant Deputy Director, HCAI
Janet Coffman, Institute for Health Policy Studies, UCSF

Agenda Items #5b and #5d were postponed to a future meeting.

c) Draft Workforce Stability Standards, Including Summary of Advisory Committee Feedback

Deputy Director Brandt provided an overview of Draft Workforce Stability Standards, including statutory requirements and a summary of Advisory Committee feedback.

Discussion and comments from the Board included:

- A Board member asked if metrics describing the failure of the health care system or the workforce to serve underserved areas were available. They mentioned that it is important to track these data by region.
    - The office answered that OHCA intends to track occupations at regional levels, including underserved areas, and that there are several sources of data available to them to be able to do so.
- A Board member raised concerns regarding equity and access for rural and minority

communities, citing specifically in-language doctors and doctors that are culturally attuned to the community. They also pointed out that there is some gray area regarding the term frontline healthcare worker and suggested physicians, dentists, and pharmacists should be included as frontline healthcare workers.

- A Board member underscored that it is an evolving process and obtaining the data is essential for identifying opportunities for improvement, especially for integrated delivery systems and ambulatory care settings. They mentioned the network adequacy lists are a potential data source and stated that there is a lot of work to do to improve the accuracy of the lists.
- A Board member requested clarification regarding terminology for standards.
    - The office stated that currently, the standards are best practices gleaned from a literature review and expert and stakeholder interviews use to inform the workforce stability standards, and the office will work on improving the language to be clearer.
- A Board member stated that the term "center" in the context of "center culturally and linguistically competent care" does not seem to have the same weight as the other words and suggested that language be added to ensure it is given appropriate weight.
- A Board member suggested the standards should incorporate equity principles, especially across regions, and should emphasize the importance of continuity of care through a stable workforce. They mentioned that it will be important to measure retention.
    - Janet Coffman suggested data is available on languages spoken by providers and OHCA is exploring additional data sources or new data collection processes to collect data in a standardized way across providers.
- A Board member asked if metrics data regarding turnover and retention could be obtained. The Board member suggested employer filings could provide useful information.
    - Janet Coffman answered that Employment Development Department (EDD) Worker Adjustment and Retraining Notification (WARN) notices are publicly available, but OHCA may need to allocate staff resources to turn one-by-one notices into a data set.
- Discussion of the availability of different data sources with mention of the potential to look into an interagency agreement with EDD and California Franchise Tax Board (FTB).

Public Comment was held on agenda item 5c and 3 members of the public provided comments.

Agenda Item #7: General Public Comment

Public Comment was held on agenda items 7 and 5 members of the public provided comments.

Agenda Item #8: Adjournment

The Chair adjourned the meeting.