HCAi
Department of Health Care Access and Information

Health Care Affordability Board Meeting

December 19, 2023

HCAi
Department of Health Care Access and Information

Welcome, Call to Order, and Roll Call

Agenda

1. **Welcome, Call to Order, and Roll Call**
   Secretary Mark Ghaly, Chair

2. **Executive Updates**
   Elizabeth Landsberg, Director, and Vishaal Pegany, Deputy Director

3. **Action Consent Items**
   Vishaal Pegany
   a) Approval of the October 24, 2023 Meeting Minutes

4. **Action Item**
   Vishaal Pegany
   a) Establish a Committee for the Selection of New Advisory Committee Members

5. **Informational Items**
   a) Status Update on Cost and Market Impact Review Regulations, including November Advisory Committee Member Feedback
      Sheila Tatayon, Assistant Deputy Director
   b) Total Health Care Expenditures (THCE) Data Collection Proposed Emergency Regulations, including Overview of Public Input and November Advisory Committee Member Feedback
      Vishaal Pegany and CJ Howard, Assistant Deputy Director
   c) Spending Target Methodology and Statewide Spending Target Value, including November Advisory Committee Member Feedback
      Vishaal Pegany, CJ Howard, and Michael Bailit, Bailit Health

6. **Public Comment**

7. **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

2024 Public Meeting Calendar

JANUARY

M	T	W	TH	F	SA	SU
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NOVEMBER

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30	31					

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Health Care Affordability Board Meetings*

Wednesday, January 24
Wednesday, February 28
Wednesday, March 27
Wednesday, April 24
Wednesday, May 22
Wednesday, June 26
Wednesday, July 24
Wednesday, August 28
Wednesday, September 25
Wednesday, October 23
Wednesday, November 20

Health Care Affordability Advisory Committee Meetings*

Tuesday, January 23
Tuesday, April 23
Thursday, June 27
Thursday, September 26

*Dates subject to change

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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Public Comment

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Action Consent Item: Approval of the October 24, 2023 Board Meeting Minutes

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Public Comment

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Action Item

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Advisory Committee Solicitation Process: 2024

Advisory Committee – Solicitation of New Members

- 27 current members
- 15 members whose terms end on June 30, 2024
- Solicitation January – March 2024
- 2-year terms
- Option to reappoint current members

Advisory Committee Members

Payers

Aliza Arjoyan
Senior Vice President of Provider Partnership and Network Management, Blue Shield of California

Yolanda Richardson,
Chief Executive Officer, San Francisco Health Plan

Andrew See
Senior Vice President, Chief Actuary, Kaiser Foundation Health Plan

Hospitals

Barry Arbuckle
President & Chief Executive Officer, MemorialCare Health System

Tam Ma
Associate Vice President, Health Policy and Regulatory Affairs, University of California Health

Yvonne Waggener
Chief Financial Officer, San Bernardino Mountains Community Hospital District

Medical Groups

Hector Flores
Medical Director, Family Care Specialists Medical Group

Stacey Hrountas
Chief Executive Officer, Sharp Rees-Stealy Medical Centers

David S. Joyner
Chief Executive Officer, Hill Physicians Medical Group

Physicians

Adam Dougherty
Emergency Physician, Vituity

Parker Duncan Diaz
Clinician Lead, Santa Rosa Community Health

Sumana Reddy
President, Acacia Family Medical Group

Consumer Representatives & Advocates

Carolyn J Nava
Senior Systems Change, Disability Action Center

Mike Odeh
Senior Director of Health, Children Now

Kiran Savage-Sangwan
Executive Director, California Pan-Ethnic Health Network (CPEHN)

Rene Williams
Vice President of Operations, United American Indian Involvement

Anthony Wright
Executive Director, Health Access California

Purchasers

Ken Stuart
Chairman, California Health Care Coalition

Suzanne Usaj
Senior Director, Total Rewards, The Wonderful Company LLC

Abbie Yant
Executive Director, San Francisco Health Service System

Health Care Workers

Stephanie Cline
Respiratory Therapist, Kaiser

Sarah Soroken
Mental Health Clinician, Solano County Mental Health

Sara Gavin
Chief Behavioral and Community Health Officer, CommuniCare Health Centers

Organized Labor

Joan Allen
Government Relations Advocate, SEIU United Healthcare Workers West

Carmen Comsti
Lead Regulatory Policy Specialist, California Nurses Association/National Nurses United

Ivana Krajcinovic
Vice President of Health Care Delivery, UNITE HERE HEALTH

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

The highlighted members' terms end June 30, 2024.

HCAI Department of Health Care Access and Information

Advisory Committee Appointments: Statute

Representative Groups:

When appointing members to the advisory committee, the board shall aim for broad representation, including, at a minimum:

- representatives of consumer and patient groups
- payers
- fully integrated delivery systems
- hospitals
- organized labor
- health care workers
- medical groups
- physicians
- purchasers

Source: Article 2. Office of Health Care Affordability [Health and Safety Code section 127501.12]

Advisory Committee Appointments: Statute

Demonstrated and acknowledged expertise in at least one of the following areas:

- health care economics
- health care delivery
- health care management or health care finance and administration, including payment methodologies
- health plan administration and finance
- health care technology
- research and treatment innovations
- competition in health care markets
- primary care
- behavioral health, including mental health and substance use disorder services
- purchasing or self-funding group health care coverage for employees
- enhancing value and affordability of health care coverage, or
- organized labor that represents health care workers.

Source: Article 2. Office of Health Care Affordability [Health and Safety Code section 127501.12]

Advisory Committee Appointments: Statute

Group Composition

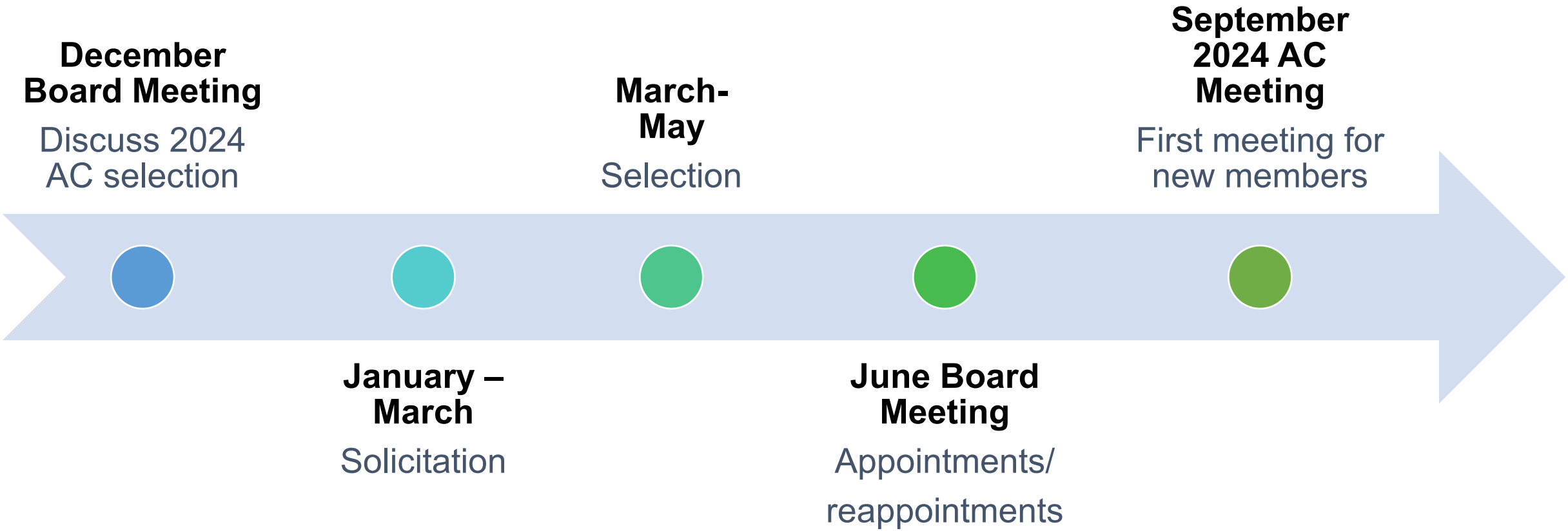
Shall consider the expertise of the other members and attempt to make appointments so that the composition of members reflects a diversity of expertise on health care entities, purchasers, and consumer advocacy groups.

Reflect State Diversity

In making appointments, shall take into consideration the state's diversity in culture, race, ethnicity, sexual orientation, gender identity, and geography so that composition reflects the communities of California. Appointing authorities shall consider the experience the member has as a patient or caregiver of a patient with a chronic condition requiring ongoing health care, which may include behavioral health care or a disability.

Source: Article 2. Office of Health Care Affordability [Health and Safety Code section 127501.10]

AC Member Selection Timeline



Board and Public Comment Requests From Last Cycle

- Retiree perspective
- Behavioral health (commercial and non-profit)
- Small business
- Rural and frontier representation
- Academic researchers
- Frontline health care workers

Motion – AC Selection Subcommittee

Motion to appoint two Board members to a subcommittee that will work with staff to provide recommendations on Advisory Committee selection.

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Public Comment

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Informational Items

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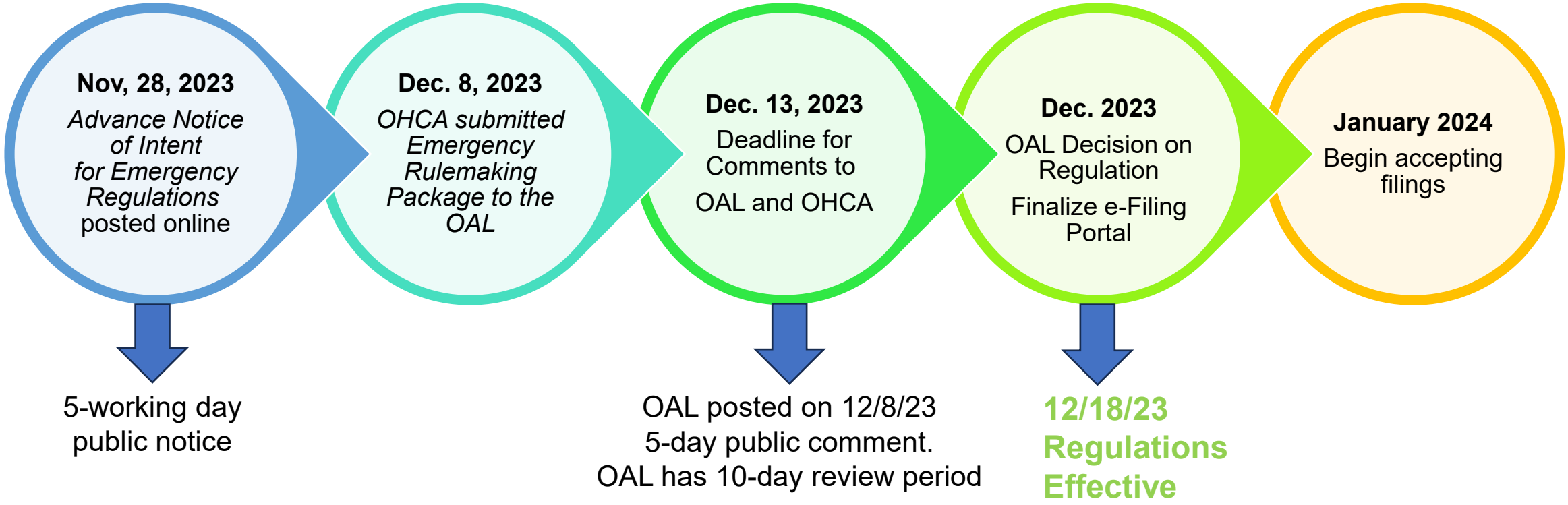
Cost and Market Impact Review Update

Sheila Tatayon, Assistant Deputy Director

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



Regulation Drafts Posted, Comments Received and Considered on Prior Drafts

July 31st Draft Posted/August 31st Comment Deadline	August 15th Public Workshop (on the July 31st Draft)	October 9th Revised Draft Posted/October 17th Comment Deadline
21 commenters provided written comments.	13 commenters shared comments at the workshop.	16 commenters provided written comments.

These totals included multiple comments (workshop & written) from the same commenter for a total of 29 individual commenters.

- Commenters included physician groups, health plans, hospital systems, consumer advocacy groups, unions, and medical, hospital, and nursing associations.

Stakeholder Comments on Proposed Regulation Text Submitted to OAL

- 9 Commenters sent letters to the Office of Administrative Law, including America's Physician Groups, Anthem Blue Cross, California Association of Health Plans, California Independent Physician Practice Association, California Hospital Association, California Medical Association, Health Access California, Kaiser Permanente, and Sutter Health.
- The letters generally restated prior comments regarding:
  - Definitions for health care entity, health care services, and revenue
  - Thresholds and material change circumstances
  - Out-of-state activity
  - Factors for deciding to conduct a CMIR
  - Confidentiality of documents
  - Timelines

Final Regulation Text Highlights

- Health Care Entity Definition – only parents, affiliates, or subsidiaries that act on behalf of a payer will be considered an HCE.
- Mental Health HPSA was removed as a threshold for filing.
- Change of control no longer includes “a transfer of 25% or more of the governance of the management and policies of at least one health care entity that is a party to the transaction.”
- OHCA shall toll the timeline for review of the notice of transaction when it has requested and is awaiting further information from the parties, or when another state agency, federal regulatory agency, or court may impact OHCA’s determination.
- Ability of a health care entity to meet the cost targets is no longer a factor for deciding whether to conduct a CMIR or a factor in the CMIR because the targets have not yet been set.

Changes Reflected in Final Regulation Text

Changes to Definitions

- "**Affiliation**" – was amended and finalized to clarify that clinical trials, medical education programs, and other types of education or research are excluded from consideration.
- "**Material change transaction**" – was amended and finalized to clarify situations that do not qualify as material change transactions including those in the regular course of business.
- "**Transaction**" – was amended and finalized to clarify that transactions are between a "health care entity" and one or more entities, to clarify that out-of-state transactions may be subject to filing requirements, and to clarify that OHCA will review transactions that *transfer* a material amount of control, responsibility, or governance of the assets or operations of the health care entity to one more entities.

Changes Reflected in Final Regulation Text

§ 97431(g) – Health care entity

"Health care entity" shall:

(1) Have the meaning set forth in section 127500.2(k) of the Code;

(2) Include pharmacy benefit managers as set forth in sections 127501(c)(12) and 127507(a) of the Code; and

~~(3) Include a management services organization, which qualifies as a "payer" for the purposes of these regulations~~

(3) Include any parents, affiliates, or subsidiaries, ~~or other entities~~ that act in California on behalf of a payer, ~~provider, fully integrated delivery system, or pharmacy benefit manager~~, and ~~either~~:

(A) control, govern, or are financially responsible for the health care entity or are subject to the control, governance, or financial control of the health care entity, ~~such as an organization that acts as an agent of a provider(s) in contracting with payers, negotiating for rates, or developing networks; or~~

(B) in the case of a subsidiary, are a subsidiary acting on behalf of another subsidiary~~.~~ but

(4) Exclude physician organizations with less than 25 physicians, unless determined to be a high-cost outlier, as described in 127500.2(p)(6) of the Code. ~~For purposes of these regulations~~, Any health care entity entering into a transaction with a physician organization of less than 25 physicians remains subject to the notice filing requirements of section 97435.

Changes Reflected in Final Regulation Text

§ 97431(j) – Material change transaction

- "Material change transaction," as used in section 127507(c)(1) of the Code, shall mean a transaction as defined in subsection (p), that meets the requirements of section 97435(c). "Material change transaction" does not include:
  - (1) Transactions in the usual and regular course of business of the health care entity, meaning those that are typical in the day-to-day operations of the health care entity.
  - (2) Situations in which the health care entity directly, or indirectly through one or more intermediaries, already controls, is controlled by, or is under common control with, all other parties to the transaction, such as a corporate restructuring.

§ 97431(p) – Transaction

- "Transaction" includes mergers, acquisitions, affiliations, and agreements impacting ~~involving~~ the provision of health care services in California, that involve a transfer (sale, lease, exchange, option, encumbrance, conveyance, or disposition) ~~change~~ of assets or a transfer of control, responsibility, or governance of the assets or operations, in whole or in part, of any health care entity to one or more entities. ~~entail a change, directly or indirectly, to ownership, operations, or governance structure involving any health care entity~~.

Changes Reflected in Final Regulation Text

Thresholds for filing

- OHCA narrowed the **HPSA threshold** so that only those health care entities *located* in a **primary care designated HPSA** must file notice if they meet the circumstances for filing.

Circumstances requiring filing

- Amended the description of entities that must file a notice of material change transaction to clarify that health care entities must file only when they are party to the transaction, meet one of the thresholds, and meet one of the material change transaction circumstances.
- Removed two circumstances: 1) when a transaction involves a health care entity joining, merging, or affiliating with another healthcare entity and 2) when the transaction changes the form of ownership of a health care entity.
- 10-year lookback: OHCA revised this provision to better align with the recently issued FTC guidelines regarding how a series of transactions may be examined and to limit the scope of transactions that require notice.
- Control, responsibility, or governance: OCHA increased the amount of assets or operations that qualifies as material from 10% to 25%.

Changes Reflected in Final Regulation Text

§ 97435. Material Change Transactions.

(b) Who must file. A health care entity who is a party to a material change transaction shall file a written notice of the ~~a~~ transaction with the Office if the party meets the thresholds ~~if the transaction involves any parties listed~~ in subsections (b)(1) through (b)(3) under any one or more of the circumstances set forth in subsection (c), unless exempted by subdivisions (d)(1) through (4) of section 127507 of the Code.

(1) A health care entity with annual revenue, as defined in subsection (d), of at least $25 million or that owns or controls California assets of at least $25 million; ~~or~~

(2) A health care entity with annual revenue, as defined in subsection (d), of at least $10 million or that owns or controls California assets of at least $10 million and is a party ~~involved in~~ to a transaction with any health care entity satisfying subsection (b)(1); or

(3) A health care entity located in ~~or serving at least 50% of patients who reside~~ in a designated ~~mental health or~~ primary care health professional shortage area in California, as defined in Part 5 of Subchapter A of Chapter 1 of Title 42 of the Code of Federal Regulations (commencing with section 5.1), available at https://data.hrsa.gov.

Changes Reflected in Final Regulation Text

§ 97435. Material Change Transactions.

(c) Circumstances requiring filing. A transaction is a material change transaction pursuant to section 127507(c)(1) of the Code if any of the following circumstances in paragraphs (1) through (8~~10~~) below exist.

(1) The proposed fair market value of the transaction is $25 million or more and the transaction concerns the provision of health care services.

(2) The transaction is more likely than not to increase annual California-derived revenue of any health care entity that is a party to the transaction by either at least $10 million or more or 20% or more of annual California-derived revenue at normal or stabilized levels of utilization or operation.

(3) The transaction involves the sale, transfer, lease, exchange, option, encumbrance, or other disposition of 25% or more of the total California assets of the submitter(s).

(4) The transaction involves a transfer of or change in control, responsibility, or governance of the submitter, in whole or in part, as defined in subsection (e).

Changes Reflected in Final Regulation Text

§ 97435. Material Change Transactions (c) continued...

(5) The transaction will result in an entity contracting with payers on behalf of consolidated or combined providers and is more likely than not to increase the annual California-derived revenue of any providers in the transaction by either $10 million or more or 20% or more of annual California-derived revenue at normal or stabilized levels of utilization or operation.

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

(6) The transaction involves the formation of a new health care entity, affiliation, partnership, joint venture, or parent corporation for the provision of health care services in California that is projected to have at least $25 million in California-derived annual revenue at normal or stabilized levels of utilization or operation, or transfer of ~~have~~ control of California assets related to the provision of health care services valued at $25 million or more.

Changes Reflected in Final Regulation Text

§ 97435. Material Change Transactions (c) continued...

(7) The transaction is part of a series of related transactions for the same or related health care services occurring over the past ten years involving the same health care entities or entities affiliated with the same entities. The proposed transaction and its related transactions will constitute a single transaction for purposes of determining the revenue thresholds in subsection (b) and asset and control circumstances in subsection (c).

(8) The transaction involves the acquisition of a health care entity by another entity and the acquiring entity has consummated a similar transaction(s), in the last ten years, with a health care entity that provides the same or related health care services. The proposed transaction and its related transactions will constitute a single transaction for purposes of determining the revenue thresholds in subsection (b) and asset and control circumstances in subsection (c).

~~(7) The transaction involves a health care entity joining, merging, or affiliating with another health care entity, affiliation, partnership, joint venture, or parent corporation related to the provision of health care services where any health care entity has at least $10 million in annual California-derived revenue as defined in subsection (d). For purposes of this subsection, a clinical affiliation does not include a collaboration on clinical trials or graduate medical education programs.~~

~~(8) The transaction changes the form of ownership of a health care entity that is a party to the transaction, including but not limited to change from a physician owned to private equity-owned and publicly held to a privately held form of ownership.~~

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

Changes Reflected in Final Regulation Text

Reporting requirements, § 97438 (was § 97439, but some sections were re-numbered)

- OHCA removed some duplicative or potentially burdensome filing requirements.

Confidentiality, § 97438(d) (was § 97439, but some sections were re-numbered)

- OHCA amended and finalized the confidentiality provisions to clarify the process for requesting, granting, or denying confidentiality.

Expedited review, § 97439 (was § 97440, but some sections were re-numbered)

- A new section lays out a process for requesting an expedited review of the notice of material change transaction. This was added to ensure that transactions that are necessary to avoid severe financial distress or a significant reduction in the provision of critical health services may move forward more quickly.

Market failure, § 97442 – Removed in Final Text

- A section had been added to clarify that OHCA has authority to conduct cost and market impact reviews of health care entities at the Director's request. Removed because it duplicated the statute.

Changes Reflected in Final Regulation Text

Timeline

- The timeline to review notices of material change transactions was shortened. Health care entities will be notified within 45 days if their transaction is not going to CMIR and within 60 days if it is. § 97440(a)(1) (formerly § 97441(b).)
- OHCA clarified the process for tolling the timelines during review of the notice § 97440(b) (formerly § 97441(c).)
- OHCA shortened the timeline for releasing the final report from 30 days after public comment from to 15 days. § 97442(d).

Comments/Questions from Advisory Committee Members and OHCA Responses

Comment / Question	OHCA Response
Regulations retain the concept and function of a management services organization (MSO) in proposed section 97431(g)(3)(ii).	OHCA clarified any entity acting as an agent of provider(s) in a health care transaction would be considered as a health care entity. *However final regulation limits to payers only.
Section 97431(p), transaction definition - transfer of control, responsibility, or governance of the assets or operations of any health care entity in whole **or in part** to one or more entities -*Is there any materiality threshold for "in part"?*	"In part" materiality thresholds are in section 97435(e).
Section 97435(c)(5) "The transaction will result in an entity contracting with payers on behalf of consolidated or combined providers and is more likely than not to increase the annual California-derived revenue of any providers in the transaction by either $10 million or more or 20% or more of annual California-derived revenue at normal or stabilized levels of utilization or operation" – will this be determined by reference to the current revenue of the organization that is being acquired and concern about manipulating revenue reporting.	OHCA will evaluate and review based on the detailed financial information of the entities required to be submitted with the notice of transaction.

Comments/Questions from Advisory Committee Members and OHCA Responses

Comment / Question	OHCA Response
How is California-derived revenue calculated for purposes of the circumstances in proposed section 97435(c)?	OHCA drafted regulation to align with current financial reporting to other California regulators to alleviate administrative burden. AC member encouraged including non-operating revenue in the revenue definitions of revenue; OHCA can still obtain that information during review process.
Some hospitals may report zero net assets (Kaiser) and how would this work in determining whether a threshold is met?	Revenue is net patient revenue and reported based on three-year average.
Whether software and EHR transactions would be considered to the usual and regular course of business. Technology defined as health care services.	It is a fact specific analysis. The HCE should evaluate the 2-part test for filing and if the EHR transaction is in its usual and regular course of business. The HCE can have a dialogue with OHCA by email or phone. OHCA also plans to provide FAQs and more information as program is implemented and various types of notices of material change transactions are received over time.

Comments/Questions from Advisory Committee Members and OHCA Responses

Comment / Question	OHCA Response
Question about OHCA granting confidentiality in perpetuity.	OHCA will not grant confidentiality for publicly available documents, and we ask for the submitter to specify the time it wishes the information to be confidential. If confidentiality granted for document that is later required by law to be public, OHCA will no longer treat as confidential.
What is OHCA doing to prepare for the notices that will be filed in January 2024?	OHCA is hiring and has hired staff and are retaining consultants, and the data portal will receive and track the filed notices.
Comment about the shortened timelines and whether OHCA has the resources and ability to be responsive to issues that come up from the public.	Comment acknowledged.

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Public Comment

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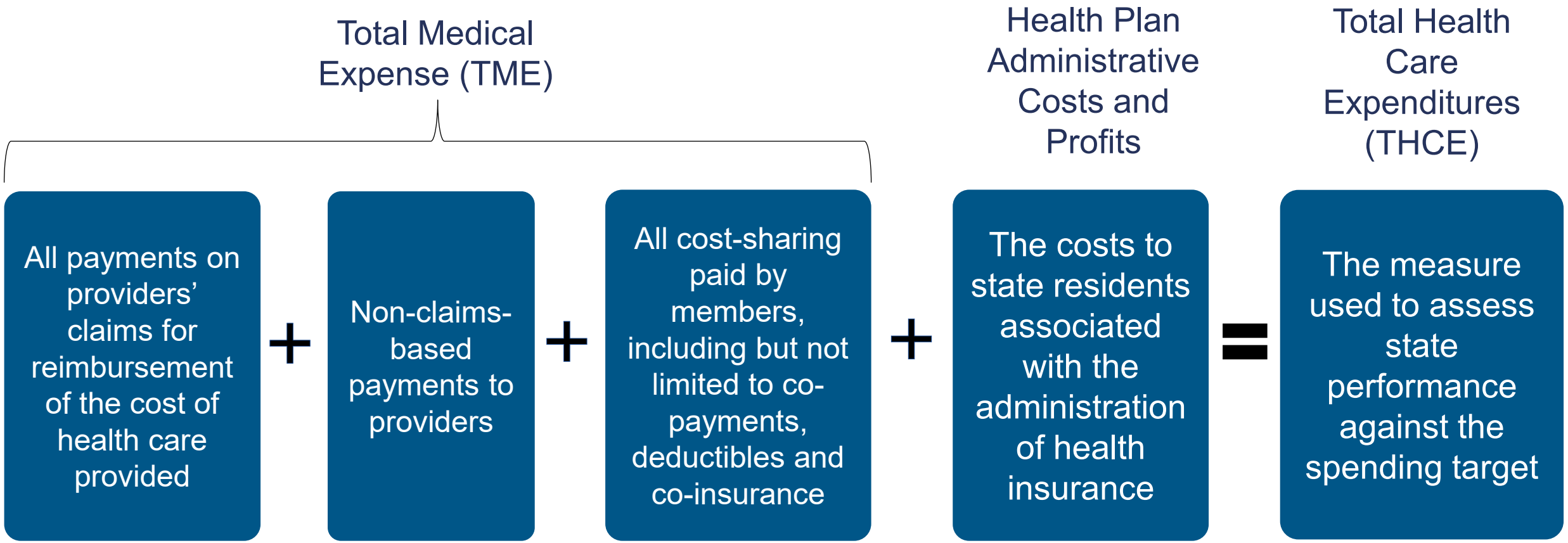
Total Health Care Expenditures (THCE) Data Collection Progress

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

The THCE Calculation Previously Shared



Total Medical Expense (TME)

TME Data	
Type	Source
Commercial Market Data	Payer-submitted data
Medicare Advantage	
Medi-Cal MCOs	DHCS (for the first year)
Medi-Cal Fee for Service	DHCS (for the first year)
Medicare Fee for Service	CMS
Other TME Data	-Veterans Affairs (VA) -Indian Health Services (IHS) -Correctional Health (CCHCS)

Administrative Costs & Profits

Admin Cost & Profit Data	
Type	Source
Commercial Data	Fully Insured: Center for Consumer Information and Insurance Oversight (CCIIO) Self Insured: Payer-submitted data
Medicare Advantage	CCIIO and DMHC annual report data
Medi-Cal MCOs	CCIIO and DHCS MLR data

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Total Health Care Expenditures (THCE) Data Collection Proposed Emergency Regulations

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

Statute to Implementing Regulations

- OHCA is required to adopt emergency regulations to establish requirements for payers and fully integrated delivery systems (FIDS) to submit data and other information necessary to measure total health care expenditures (THCE) and per capita THCE. (§§ 127501.2 and 127501.4 (b).)
- OHCA will use this information to prepare a report on baseline health care spending by June 1, 2025. (§ 127501.6 (a).)
- Annually thereafter, OHCA will prepare a report concerning health care spending trends and underlying factors, along with policy recommendations to control costs and improve quality performance and equity of the health care system while maintaining access to care and high-quality jobs and workforce stability. (§ 127501.6 (b).)
- OHCA must publish its first annual report by June 1, 2027, based on its analysis of THCE data for the 2024 and 2025 calendar years. (*Id.)*

* All references are to the Health and Safety Code unless otherwise indicated.

Proposed Emergency Regulations Overview

The proposed emergency regulations for THCE Data Submission:

- Define terms used in the regulations. (Proposed § 97445.)
- Outline the scope of the regulations. (Proposed § 97447.)
- Specify who is a required submitter and how voluntary submitters may request to participate. (Proposed § 97449(a)-(c).)
- Explain how submitters in Plan-to-Plan contracts should coordinate data submission with Subcontracted Plans. (Proposed § 97449(d).)
- Establish deadlines for submitter registration and data file submission. (Proposed § 97449(e)-(h).)
- Establish other requirements related to data file specifications, test files, data acceptance and correction, and variance requests. (Proposed § 97449(i)-(l).)

Data Submission Guide and Attribution Addendum

The proposed emergency rulemaking package also incorporates by reference the:

1. Total Health Care Expenditures Data Submission Guide, which:
   - Is intended for payers and FIDS (“submitters”) to use when extracting and aggregating data for submission to OHCA. Submitter interactions described in the Guide will occur via the secure THCE Data Portal--the platform for submitter registration, data submission, and submission status information.
   - Provides technical specifications, file layouts, reporting schedules, and other instructions to ensure the submission of accurate THCE data in a standardized format.
   - Specifies that submitters will not be required to submit data files for the Medi-Cal Managed Care market category until the September 1, 2025 annual submission deadline. OHCA will get Medi-Cal MCO data from DHCS for the first year.
2. The Office of Health Care Affordability Attribution Addendum, which:
   - Contains a list of provider organizations and unique identifiers to be used when attributing total medical expenditures.

Data Submission Guide and Attribution Addendum

Submitters will report Total Medical Expense (TME) using pipe (“|”) delimited text files to the forthcoming THCE Data Portal. A complete submission contains all of the following files:

File Type	Contents
Statewide TME	Total medical expense broken out by market category (e.g., Commercial or Medicare Advantage).
Attributed TME	Total medical expense attributed to organizations listed on the Attribution Addendum and broken out by market category, age, and sex.
Regional TME	Total medical expense broken out by market category and geographic region (Covered California rating region or Los Angeles County Service Planning Area).
Pharmacy Rebates	Statewide medical and retail pharmacy rebates broken out by market category.
Submission Questions	Attestations and confirmations that instructions in the Guide were followed when preparing data for submission.

Data Submission Guide and Attribution Addendum

Submitters will report Total Medical Expense categorized by:

Claims Payments

- Hospital Inpatient
- Hospital Outpatient
- Professional
- Long-Term Care
- Retail Pharmacy
- Other

Other Member-Level Payments

- Capitation and Full Risk Payments
- Member Responsibility Amounts

Non-Claims Payments

- Population Health and Practice Infrastructure Payments
- Performance Payments
- Payments with Shared Savings and Recoupments
- Other

Data Submission Guide and Attribution Addendum

In addition to file layouts and field specifications, the Data Submission Guide provides instructions on:

- Reporting allowed amounts from claims, including member responsibility, after a run-out period of at least 180 days.
- Including claims for all California residents, regardless of site of care, when the payer is primary on the claim.
- Attributing member-level expenditures to organizations listed on the Attribution Addendum using an ordered methodology.
- Including estimates for members when certain benefits are carved out and claims data are not available.
- Calculating standard deviation as a per-member, per-month value.
- Requesting data variances if data submission requirements cannot be met.

THCE Rulemaking Timeline

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THCE Data Collection Proposed Emergency Regulations: Summary of Public Comments

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

Overview of Written Comments: Proposed THCE Regulations

OHCA received written comments from the following organizations, most of which also made verbal comments at the November 14th workshop:

1. California Medical Association
2. California Association of Health Plans
3. California Hospital Association
4. Health Access California
5. America's Physician Groups

The slides that follow summarize high-level themes in the written comments.

After hearing from the Board, OHCA plans to consolidate and respond to comments in January. OHCA will provide an update on any resulting changes to the proposed regulations at January's Board and Advisory Committee meetings.

Comment Themes

Data Submission Guide (Guide) Definitions

Commenters' request revisions to definitions, including:

- Allowed Amount
- Attribution Method
- Claims Run-Out Period
- Claims Service Categories
- Long-Term Care
- Market Categories
- Non-Claims Payment Categories
- Pharmacy Rebates

Comment Themes

Risk Adjustment

- One commenter requests that OHCA expand its risk adjustment methodology to consider disabilities, chronic illness, and other complex health conditions, as well as more granular age bands.

- Another commenter requests that OHCA formally evaluate clinical risk adjustment, alongside age / sex risk adjustment, prior to spending target enforcement. This commenter also asks OHCA to consider the use of truncation.

Comment Themes

Attribution

The majority of public comments received by OHCA were related to the challenges surrounding attribution of Total Medical Expense (TME) to provider organizations:

- One commenter requests that data collection distinguish between PPO and HMO product lines.
- Two commenters express concerns about OHCA's use of payer-developed attribution methodologies; one commenter expresses an understanding of why OHCA took this approach.
- Two commenters request a process for attribution review, validation, and dispute prior to making data publicly available.
- One commenter expresses that TME attribution will generally work for HMO members and providers but not PPOs / EPOs; they suggest working with providers to develop a Physician Organization registry.

Comment Themes

Attribution

- One commenter expresses concern that OHCA's attribution approach would not sufficiently mask individual member-level data.
- One commenter requests that OHCA work toward a standardized patient attribution methodology.
- One commenter expresses concern that OHCA's attribution methodology would not attribute TME for a majority of Californians.
- All commenters express concerns regarding omissions from OHCA's Attribution Addendum and a lack of clarity regarding how the Addendum will be updated.

Comment Themes

Claims Run-out Period

- Commenters express concerns that the proposed 180-day claims run-out period is too short in light of Knox-Keene Act provisions regarding prompt payment and recoupment.

Incorporation by Reference

- One commenter expresses concerns regarding OHCA's use of a data submission guide (DSG) incorporated by reference; another commenter generally supported use of a DSG, but requests assurance that changes to submission requirements would involve robust stakeholder engagement.

Comment Themes

Fully Integrated Delivery Systems

- Several commenters request clarity regarding data submission expectations for Kaiser.

Self-Insured Lines of Business

- One commenter recommends not requiring plans to report ASO fees.

Comment Themes

Administrative Costs & Profits

- Several commenters request clarity regarding how payer/FIDS administrative costs and profits data will be collected.

Non-Payer Submitted Data

- Similarly, several commenters request clarification on how and when Medi-Cal supplemental, FFS, and dual-eligible payment information will be collected, as well as traditional Medicare.

Comment Themes

Medi-Cal Data Collection Delay

- One commenter requests more information regarding OHCA's decision to delay collection of data from Medi-Cal managed care plans.

Health Systems

- One commenter requests more information on OHCA's plans to collect data regarding hospital systems.

Advisory Committee Feedback

Some Advisory Committee members offered feedback on the draft regulations for data collection and total health care spending measurement, including:

- provider suggestions that OHCA define a standard provider attribution methodology for insurers to use.
- a provider suggestion that OHCA account for changes in plan design when assessing provider organization capitation payment trend.
- a provider suggestion to create a category for spending associated with alternative sites of care to hospital outpatient, for example, imaging centers, physical therapy centers.
- a recommendation to add the two Permanente Medical Groups to the provider organization list.

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Spending Target Methodology and Statewide Spending Target Value

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

Today's Discussion Topics

During today's Board meeting, we will:

1. Review Advisory Committee feedback on Board discussions of the spending target methodology.
2. Respond to a Board member request that OHCA consider an adjustment to the spending target for technology-related factors.
3. Present OHCA's proposal for multi-year statewide health care spending targets.

Advisory Committee Meeting Update

During the November Advisory Committee meeting, members provided input on the following topics:

- Historical health care spending growth in California.
- Economic indicators and use of historical vs. forecasted growth to derive spending target value(s).
- Population-based measures to inform spending target values.
- Setting the duration of spending target.
- Adjusting the spending target.

Advisory Committee Feedback: Spending Target Value

- Members were divided on limiting the target to historical spending growth (5%) or linking it to historical median income growth.
  - Industry members raised concerns that past performance is not reflective of future trends, especially given the rise in inflation beginning in late 2021. Other members generally supported the recommendation to link the target value to median household income.
- Some members voiced support for a more aggressive target to address lack of consumer affordability, while others argued that the target be realistic and reflect actual provider costs. Some industry members expressed concern that a too-aggressive target would mean fewer providers to care for patients.
- Member views on setting a fixed target value or phasing in a target were also mixed. Most members favored a fixed target value for a duration of 3-5 years, although a plan argued for a phase-in given multi-year provider contracts.

Advisory Committee Feedback: Spending Target Adjustments

In general, providers and plans supported adjustment, while consumer and labor advocates did not.

- A member asked for additional information about the age / sex analysis OHCA performed and suggested that weights be California-specific.
- Industry members suggested that OHCA perform additional analyses, indicating that "every dollar counts," while others said adjustments are too complicated and that chronic illness status adjustments may have negative equity implications. Some advocated for deferring a decision on adjustments until the program evolves and more information is available.
- Members agreed that the Board should selectively utilize its authority to prospectively adjust the spending target when conditions warrant. Members further said the Board should be transparent about the rationale for revisiting and / or adjusting the target.

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Potential Adjustments Related to Health Care Technology

Key Statutory Concepts

The Methodology	The Target
• 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, the health care employment cost index, labor costs, the consumer price index for urban wage earners and clerical workers, 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, and any relevant state and federal policy changes impacting covered benefits, provider reimbursement, and costs.**	• Be developed with a methodology that is transparent and available to the public. • 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 set for each calendar year, with consideration of multi-year targets. • 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.

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

Potential Adjustments to Spending Targets Due to Trends in Price of Health Care Technologies

- During the October meeting a Board member requested OHCA consider how to adjust the spending target to account for **technologies** based on the statutory language.
- The statute requires that "the methodology shall review potential factors to adjust future cost targets, including, but not limited to….**trends in the price of health care technologies**…."
  - It applies to future targets and not to the initially set targets.
- The following slides share available information related to trends in *technologies* and in the *price* of health care technologies.

Source: Article 3. Health Care Cost Targets [Health and Safety Code section 127502]

Defining Health Care Technologies

- The World Health Organization defines health care technology as the "application of organized knowledge and skills in the form of **devices**, **medicines**, **vaccines**, **procedures** and **systems** developed to solve a health problem and improve quality of lives."

- This definition encompasses reimbursable technologies (e.g., devices, drugs, diagnostic and therapeutic procedures) and non-reimbursable technologies used to deliver and/or organize medical care (e.g., algorithms, block chain, AI, etc.).

- The Kaiser Family Foundation has reported that "*there is very little in the field of medicine that does not use some type of medical technology and that has not been affected by new technology*."

Sources: World Health Care Organization. *Health products policy and standards*. https://www.who.int/teams/health-product-policy-and-standards/assistive-and-medical-technology/medical-devices. Retrieved November 3, 2023.; KFF. (2007, March 2) *Snapshots: How Changes in Medical Technology Affect Costs. https://www.kff.org/health-costs/issue-brief/snapshots-how-changes-in-medical-technology-affect/*

Spending Impact of New Health Care Technology

- There is no doubt that health care technology has impacted the cost of health care. Research as early as the 1970s pointed to technology as being a driver in health care spending.
  - Technology may produce cost savings in the short and long term for providers and/or individual patients but showing overall net cost savings is difficult.
- To adjust the spending target to account for technology, OHCA would need to predict the cost impact of new technology *in advance* of it coming to market because the spending target is set in advance of the performance year.
  - This would be difficult as most innovation is unpredictable, and could be a result of unforeseeable events, like the advancements in mRNA technology being applied to develop vaccines in response to the COVID-19 pandemic.

Sources: Worthington, Nancy. "Expenditures for Hospital Care and Physicians Services: Factors Affecting Annual Changes." Social Security Bulletin (November 1975): 3-15.; KFF. (2007, March 2) *Snapshots: How Changes in Medical Technology Affect Costs.* https://www.kff.org/health-costs/issue-brief/snapshots-how-changes-in-medical-technology-affect/.

Spending Impact of Trends in the Price of Health Care Technology

- Prices of health care technology are set through negotiation between payers, providers, and manufacturers/developers.
  - Providers directly bear the cost of some health care technology (e.g., implementing telemedicine platforms, purchasing new imaging equipment, etc.). These costs may or may not be directly reimbursable but are indirectly considered in overall price negotiations with payers.
- Identifying health care technology price trends would be difficult; at a minimum, it would require OHCA to:
  a. define ”health care technology” in a precise and inclusive manner;
  b. track and trend payer-reported *prices* for the precise definition; and
  c. consider how to reflect prices for technologies that do not yet exist or are adopted by providers at varying rates.

Adjusting the Target as a Result of Trends in Technology and/or the Price of Health Care Technology

OHCA recommends no adjustment to the value of the spending target to account for trends in the price of health care technologies.

Does the Board have any input on OHCA's recommendation?

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OHCA's Preliminary Proposal for the Health Care Spending Target

Timeline for Adopting the Spending Target for 2025

[1]Statute:The board shall adopt final targets on or before June 1, at a board meeting.

OHCA's Proposal for the Spending Target: Context

- During the October Board meeting, we considered design questions specific to the spending target values. During the ensuing conversation, Board members voiced their preferences.
- Today, informed by Board input during the October conversation and the November Advisory Committee, OHCA presents a proposed methodology and value for the statewide spending target.
- We will first present the proposal elements, including target values and related methodology.
- We will then review each underlying design proposal, including the rationale, and seek Board input.

State Cost Growth Target Methodologies

State	Target Methodology	Target Value
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
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
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
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
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
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
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

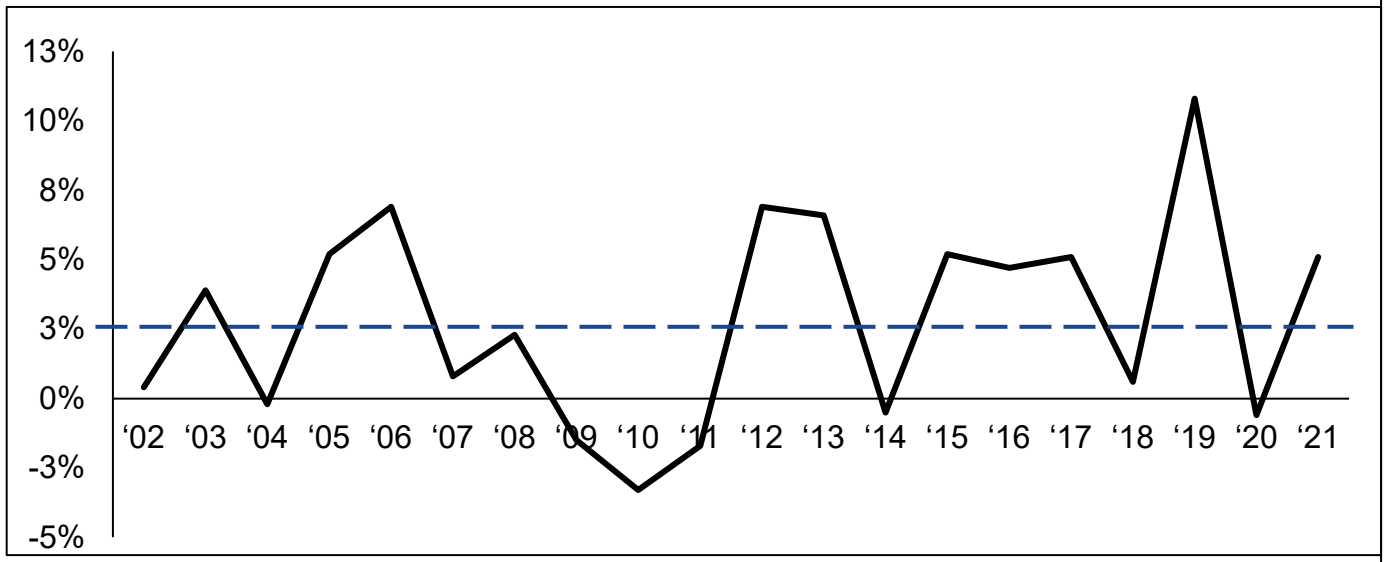
OHCA's Proposal: Statewide Per Capita Health Care Spending Target

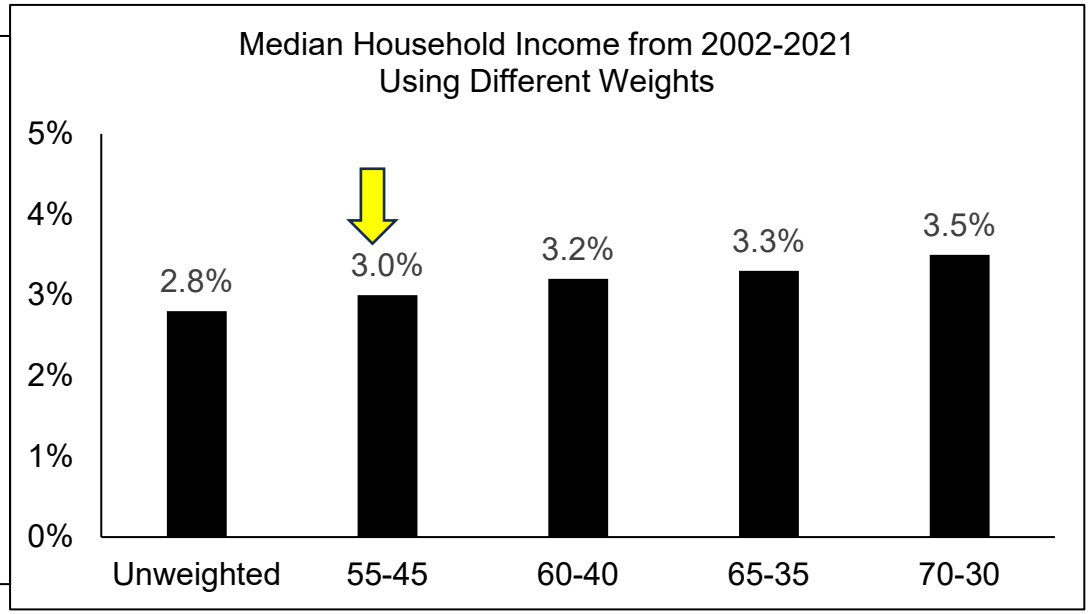
OHCA's preliminary proposal: adoption of the following statewide per capita health care spending targets for 2025-2029, based on a weighted average of historical median household income growth over the 20-year period from 2002-2021.

Performance Year	Per Capita Spending Growth Target
2025	3.0%
2026	3.0%
2027	3.0%
2028	3.0%
2029	3.0%

Background on Median Household Income Change from 2002-2021

- The 2008 Financial Crisis was associated with large decreases in median household income, and so those years have an undue influence on the unweighted average across the 20-year time-series.
- If we assign less weight to the 10-year period from 2002-2011 and more weight to the 10-year period from 2012-2021, median household income growth steadily increases.





Source: U.S. Census Bureau, Median Household Income in California [MEHOINUSCAA646N], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/MEHOINUSCAA646N

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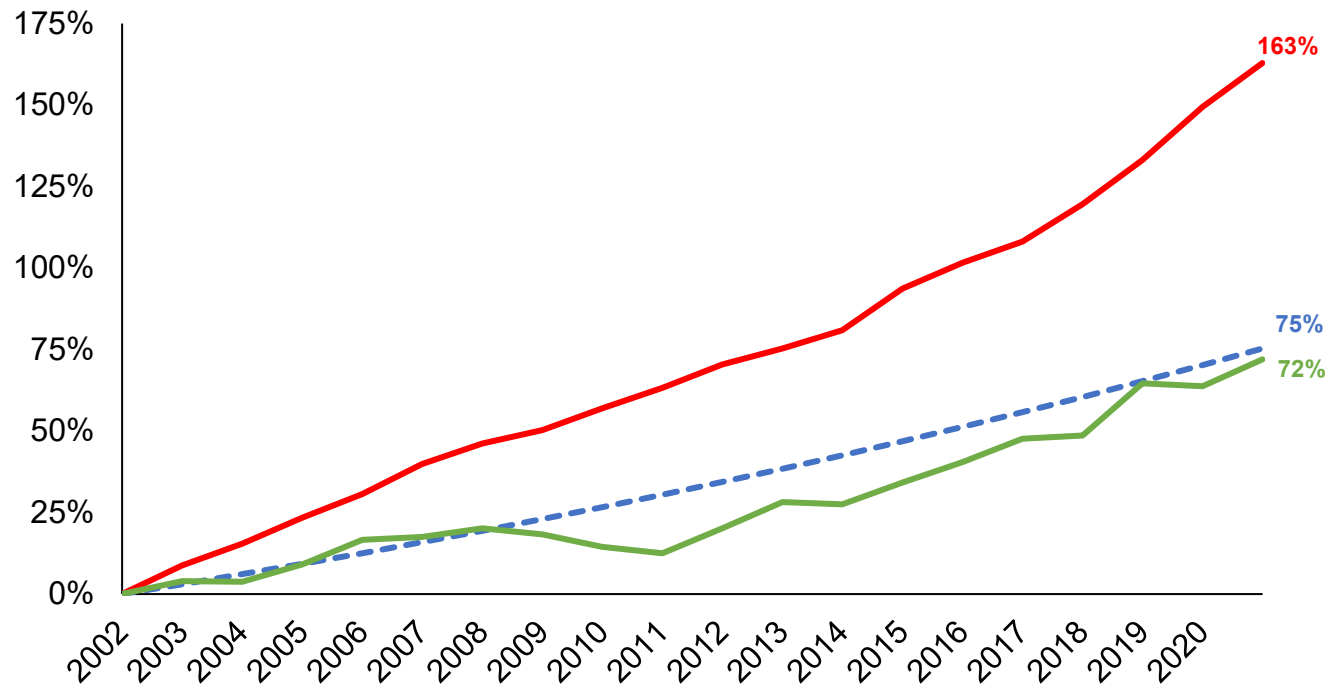


Sources: UC Berkeley Labor Center. What Can We Afford? Aligning Office of Health Care Affordability spending target with Californians' ability to afford 24 increases. September 2023. https://laborcenter.berkeley.edu/wp-content/uploads/2023/09/What-can-we-afford.pdf; Centers for Medicaid and Medicare Services (n.d.). Health Expenditures by State of Residence, 1991-2020. National Health Expenditure Data. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence

Potential Savings in Per Capita and Aggregate Health Care Spending

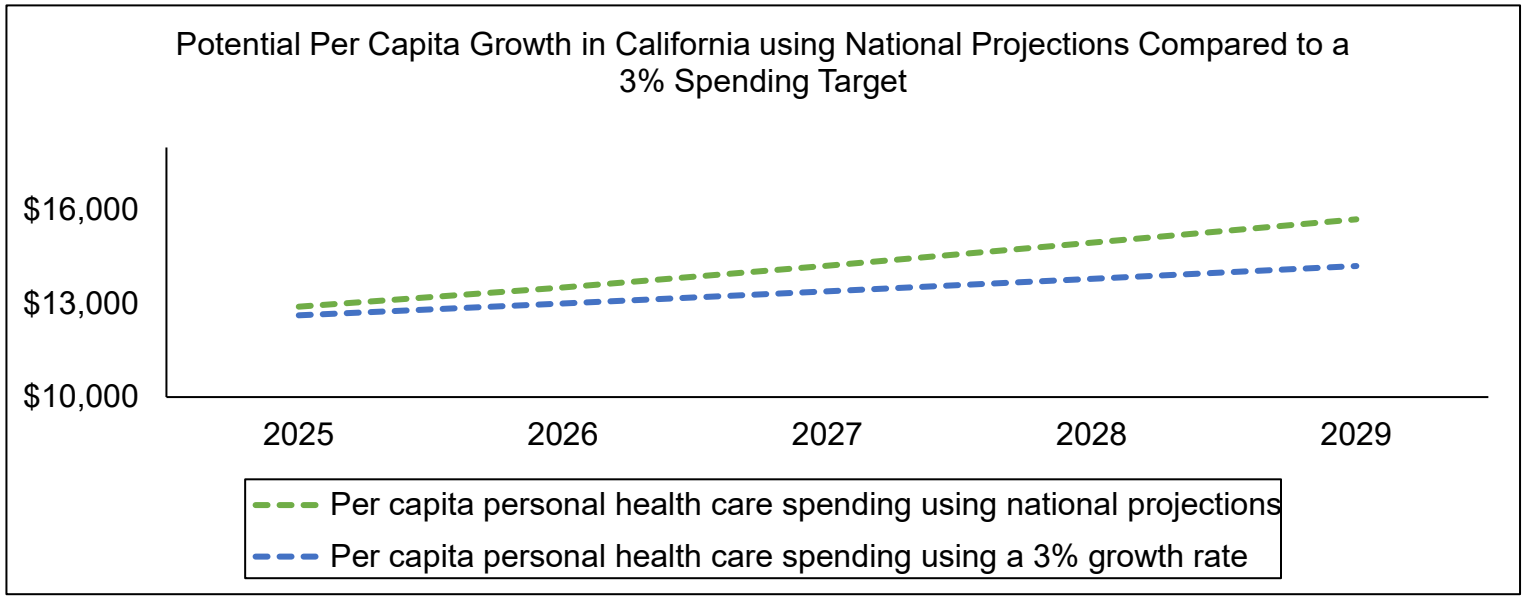
- As an illustrative example of potential savings in personal health care expenditures over the 5-year period from 2025-2029, we can draw on national projections in the annual growth rates of health care expenditures developed by the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary.
- To do so, we trend forward the per capita and aggregate personal health care spending in California using CMS's national projections, comparing them to an alternative scenario where trend instead grows at 3.0%.

Caveats:

- Setting a 3.0% spending target does not automatically reduce the growth of health care spending to 3.0%, but requires health care entities to proactively implement changes over time.
- To the extent the spending target is met, the level of consumer spending may not decrease but may grow at a slower pace. (Note: The baseline and annual reports will include information on consumer spending.)

Potential Savings in Per Capita Health Care Spending

If health care spending were to grow at 3% from 2025-2029 – instead of at the rate of national projections – the per capita amounts would be between $280-$1,500 lower per year.



	2025	2026	2027	2028	2029
Per capita health care spending using national projections	$12,900	$13,510	$14,210	$14,950	$15,700
Per capita health care spending using a 3% growth rate	$12,620	$13,000	$13,390	$13,790	$14,200
Difference	$280	$510	$820	$1,160	$1,500

Sources: Centers for Medicaid and Medicare Services (n.d.-a). Health Expenditures by State of Residence, 1991-2020. *National Health Expenditure Data.* *https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence* ; Centers for Medicaid and Medicare Services (n.d.-b). National Health Expenditure Projections. *National Health Expenditure Data.* *https://www.cms.gov/files/zip/nhe-projections-tables.zip*

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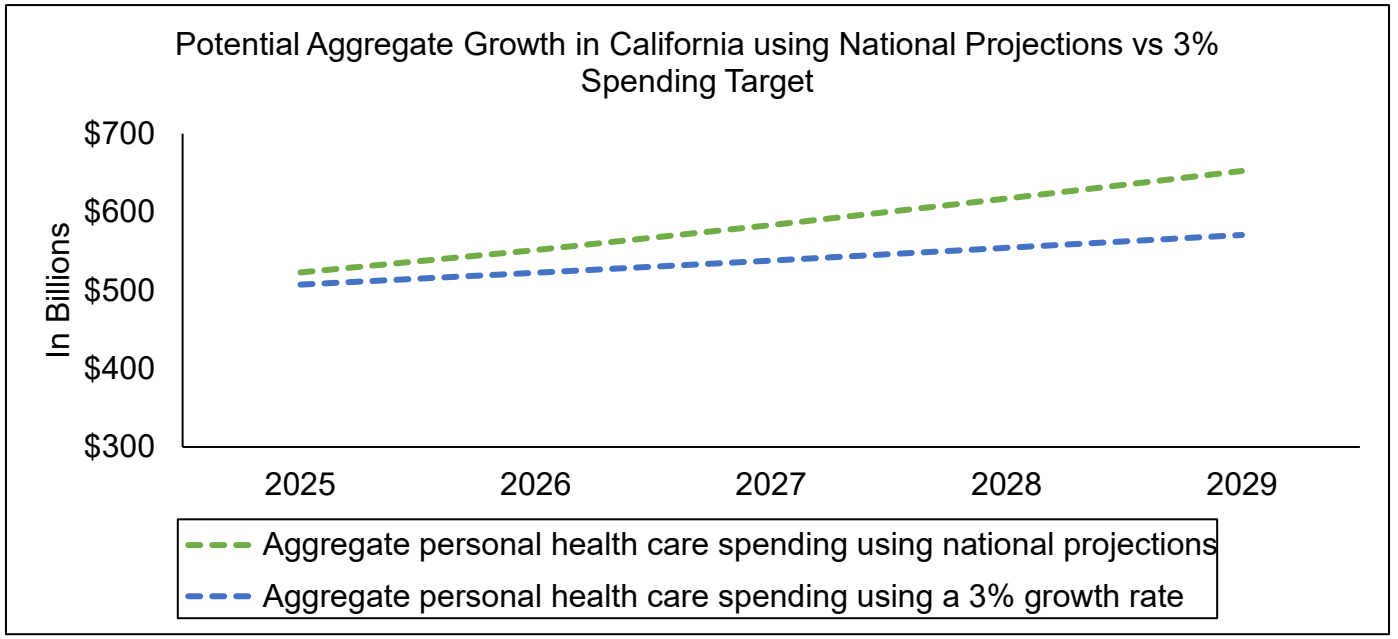
Potential Savings in Aggregate Health Care Spending

If aggregate health care spending were to grow at 3% from 2025-2029 – instead of at the rate of national projections – the aggregate amounts would be between $15 billion-$81.6 billion lower per year, which could amount to approximately $230 billion over the 5-year period.



	2025	2026	2027	2028	2029
Aggregate health care spending using national projections	$522.7	$551.5	$583.5	$617.3	$652.5
Aggregate health care spending using a 3% growth rate	$507.4	$522.6	$538.2	$554.3	$570.9
Difference (in billions)	$15.3	$28.9	$45.3	$63.0	$81.6

Sources: Centers for Medicaid and Medicare Services (n.d.-a). Health Expenditures by State of Residence, 1991-2020. *National Health Expenditure Data.* *https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence* ; Centers for Medicaid and Medicare Services (n.d.-b). National Health Expenditure Projections. *National Health Expenditure Data.* *https://www.cms.gov/files/zip/nhe-projections-tables.zip*

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OHCA's Preliminary Proposal: Statewide Per Capita Spending Target

OHCA's preliminary proposal:

- establish a statewide spending target that is lower than the state's long-term health care spending growth rate.
- set a fixed spending target for a duration of five years.
- tie the target to average median household income.
- do not adjust for population-based measures.
- evaluate the target annually for potential adjustments.

OHCA's Proposal: Economic Indicator

OHCA's preliminary proposal ties the target to historical **median household income based on a weighted average annual rate of change over the last 20 years (2002-2021).**

- Basing the target on this measure of consumer affordability signals that spending on health care should not grow faster or take up a greater proportion of the income of Californians than it currently does.
- A single economic indicator promotes transparency and public accessibility.
- Historical data reflects long-term patterns and does not rely upon uncertain forecasting.
- Using a weighted average treats more recent years as more informative.

Does the Board have input on OHCA's preliminary proposal?

OHCA's Proposal: Population-based Adjustments

OHCA preliminarily proposes **not making population-based adjustments** to the target.

- OHCA found adjustments based on population-based measures, including age / sex, disability status, and prevalence of chronic conditions appear to be small and correlated with one another and potentially other economic indicators.
- OHCA also found that limited data were available to forecast the impact of some population-based indicators on future spending growth.

Does the Board have input on OHCA's preliminary proposal?

Key Statutory Concepts

The Methodology	The Target
• 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, the health care employment cost index, labor costs, the consumer price index for urban wage earners and clerical workers, 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, and any relevant state and federal policy changes impacting covered benefits, provider reimbursement, and costs.	• Be developed with a methodology that is transparent and available to the public. • 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 set for each calendar year, with consideration of multi-year targets. • **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.

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

OHCA Proposal: Revisiting the Target

In the statute, the board has the authority to revisit the target to update it periodically and consider any relevant adjustment factors.

OHCA preliminarily proposes that the board commits to evaluating the target for potential adjustments on an annual basis.

Does the Board have input on OHCA's preliminary proposal?

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General Public Comment

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

Next Board Meeting:

January 24, 2023
10:00 a.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

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Department of Health Care Access and Information

Adjournment