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

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HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Monday, December 16, 2024
10:00 am

Members Attending: Secretary Kim Johnson, Dr. David Carlisle, Richard Kronick, Elizabeth Mitchell, Dr. Richard Pan, Don Moulds

Members Absent: Dr. Sandra Hernández, Ian Lewis

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; Margareta Brandt, Assistant Deputy Director, HCAI; Debbie Lindes, Health Care Delivery System Group Manager, HCAI; CJ Howard, Assistant Deputy Director, HCAI

Meeting Materials: **https://hcai.ca.gov/public-meetings/december-health-care-affordability-board-meeting-3/**

Agenda Item # 1: Welcome and Call to Order
Chair, Secretary Kim Johnson
Elizabeth Landsberg, Director, HCAI

Chair Johnson opened the December meeting of California's Health Care Affordability Board. Roll call was taken, and a quorum was established.

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 reflected on the 2024 accomplishments of both the Office and the Board and then provided the following Executive Updates:

- OHCA's three branches now have a staff of 47.
- Director Landsberg attended the California Hospital Building Safety Board meeting where a presentation from UC Irvine discussed the first all-electric hospital building in the country. The presentation focused on both electrification and decarbonization at the campus, which is driven by climate change and green goals. Over time, this will produce health care savings.

- Additionally, the Director discussed OHCA's work with the hospital spending measurement workgroup, including progress made on measuring inpatient spending and data sources that could be used to refine an approach for measuring outpatient hospital spending This topic will be revisited at a future Board meeting.

Deputy Director Pegany provided the following Executive Updates:

- The next Board meeting on January 28, 2025, will be held at the new May Lee State Office Complex located off Richards Boulevard in Sacramento. This will be HCAI's new headquarters beginning in the summer of 2025. The exact address is on the meeting website.
- Reminder about slide formatting: a yellow arrow indicates that the Office has decision-making authority over that item and a green arrow indicates that the Board has ultimate decision-making authority over that item.

Discussion and comments from the Board included:

- A member inquired about the annual financial disclosure data for hospitals and whether there could be greater granularity about actual expenditures for inpatient care.
  - The Office responded that the concerns this member raised were also discussed in the hospital spending measurement workgroup. They did provide suggestions for enhancing the HCAI financials, one of which could potentially be to have the hospitals provide HCAI with the actual amounts rather than to apply HCAI's methodology for estimation, and a few hospitals did state that they could provide that data.
- A member requested enhanced data on some of the specialty groups that may be below the system level, particularly the acquired practices rather than only at the hospital level.
  - The Office replied that the goal for the Physician Organization Index would be to obtain data from specialty groups as well as hospital groups and primary care.

Public Comment was held on agenda item 2. Three members of the public provided comments.

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

a) Approval of the November 20, 2024, Meeting Minutes

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

Board member Richard Kronick motioned to approve, and board member Elizabeth Mitchell seconded.

Board discussion and public comment on item 3a was held out-of-order after

Agenda Item 4.

Agenda Item #4: Informational Items
Margareta Brandt, Assistant Deputy Director, HCAI
Debbie Lindes, Health Care Delivery System Group Manager, HCAI
Vishaal Pegany, Assistant Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI

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

Assistant Deputy Director Brandt provided an overview of OHCA's behavioral health spending definition and investment benchmark work stream.

Debbie Lindes provided an overview of the spending measurement framework and OHCA's initial thoughts on an investment benchmark, as well as a summary of the feedback from the Advisory Committee.

Discussion and comments from the Board included:

- A member asked if OHCA has obtained data from the other states who are measuring behavioral health spending and whether they have departures that are significant from the methodology that OHCA is proposing. They further inquired whether data has been gathered regarding lessons learned from those states that may be relevant.
    - The Office advised that there are three states who are currently measuring behavioral health spending, but Rhode Island is the only state at this point that has introduced a benchmark or obligation. Regarding the measurement from other states, HCAI will be looking at definitions from Massachusetts, Rhode Island, and Maine. Also, the Milbank Memorial Fund brought together several states that already have definitions, and OHCA participated in an advisory group to develop recommendations for a standardized definition. OHCA is relying on those current definitions and the recommendations from Milbank as their starting point and will then explore whether the Investment and Payment Workgroup would like to make different adjustments or different decisions.
- A member inquired whether OHCA noticed a fair amount of variance across the states' definitions or whether there is a fair amount of consistency.
    - The Office replied that there does seem to be a fair amount of consistency. While there are a few differences, most of the states focus on diagnosis as the starting point for measuring behavioral health spending. There are two areas of diagnosis where there is some difference across states' definitions that may impact spending measurement. One area is whether to include diagnoses related to dementia, and the other area is whether to include diagnoses related to autism and other developmental disorders. The Investment and Payment Workgroup will be talking through this question along with others during its next meeting later this week.

- A member commented that while they know that OHCA is starting with commercial and Medicare Advantage in terms of total behavioral health spending, they would like to know at which point will Medi-Cal be included considering that Medi-Cal covers one third of all state residents and half of all children. Medi-Cal is also a major mental health provider and long-term care provider, and both county and managed care plan spending should be included.
    - The Office responded that they are aiming to incorporate Medi-Cal as part of their work to collect data from the Medi-Cal managed care organization (MCOs). They are actively working with the Department of Health Care Services (DHCS) to develop a definition that is specific to Medi-Cal and discussing their different sources of funding and the behavioral health coverage in the Medi-Cal program.
- A member expressed concern that institutional care is a big portion of overall spend and may not always be associated with improved outcomes. If the benchmark covers all spending, we may incentivize the wrong thing.
- A member commented that they hope that access to behavioral health services will increase and become better in commercial plans, Medicare Advantage and other parts of the system. However, there is a substantial portion of people who are paying out-of-pocket for their behavioral health services as the networks are currently very narrow, and there isn't a way for OHCA to track that. If access to care through plans increases, this may be a shift of spending from people paying out-of-pocket to the plans paying, rather than a true increase in the total spending.
- A member expressed hope that the MCOs will consider contracting with behavioral health professionals in school districts to assist with developmental issues such as Attention Deficit/Hyperactivity Disorder (ADHD). The member explained that there are occasions when a parent may be in denial of the child's diagnosis and will therefore not seek the proper care that the child needs, in which case having that care available at the school would be most beneficial.
    - The Chair replied that at DHCS, the fee schedules for youth behavioral services are being set for schools that have youth behavioral health initiatives, which will become more of a pathway over time.
- A member stated that there is currently little access to behavioral health on the commercial side, and even those who do have coverage often can't find a provider. This has led employers and purchasers to almost duplicate their spend on point solutions such as private companies who provide these services via telehealth, and OHCA needs a way to capture that spending because it is significant. The member also shared that the number of hospitalizations and emergency department visits for behavioral health are shocking and could be driven by the lack of access to services in more appropriate settings. The member asked how this spending in different settings will be tracked.
    - The Office advised that many of these points have been discussed in the Investment and Payment Workgroup, and one of the initial discussions they have had around the benchmark is potentially focusing on community-based and outpatient services that are in-network to increase investment and shift resources towards the outpatient community-based services. There has also been much discussion about supplemental analysis that could be conducted

using OHCA's data collection or the Health Care Payments Data (HPD) program. The Office is considering how to measure the current spending and how to set the behavioral health investment benchmark potentially as a subset of that total behavioral health spending, as well as what analysis can supplement the spending analysis to track how the care is being provided.

- A member urged OHCA to include Medi-Cal spending in its measurement as quickly as it can. Medi-Cal spending is especially important for behavioral health. The member also encouraged OHCA to prioritize progress on measuring out of plan spending.
- A member inquired why traditional Medicare is not included in the baseline with commercial insurance and Medicare Advantage.
    - The Office replied that they have received some total medical expense data for traditional Medicare that is aggregated to reflect professional services, but it is not necessarily broken out by behavioral health. The HPD is also collecting fee-for-service claims data. OHCA will have to analyze the data to decide whether they can use CMS data or whether they need to compile it themselves using the claims data.
- A member asked if estimates of the status quo regarding how much is spent in various settings will be provided by May when the Board is asked to vote on the benchmarks.
    - The Office responded that they are actively working with state departments such as Covered California and CalPERS to find out whether they could run a behavioral health spending analysis using their claims and databases and exploring whether that's possible through the HPD. They do not have an estimate of when that spending analysis might be available, but that is something they are actively working on.
- A member suggested that OHCA should articulate its reasons for measuring and benchmarking behavioral health spending. There are many reasons to focus on it and it's important to be clear about OHCA's reasons, so we know what we are trying to accomplish. Benchmarks will be difficult to set and will need to account for uncertainties and changes over time, such as what we saw during and after the pandemic, to be meaningful.
- A member pointed out that California is transforming behavioral health care and OHCA will need to consider current and future investments, may want to engage with other departments working on these efforts. Unpacking OHCA's logic model further may be helpful.
- A member stated that a vast majority of mental health conditions are chronic, so cost savings come from care coordination, similar to primary care. While under-diagnosis and lack of access to care are issues within behavioral health, for those who can successfully get care, they have the challenge of continuity of care. Discontinuity is costly, and there may be cross-cutting themes across behavioral health and primary care about what types of investments can meet the goals.

Public Comment was held on agenda item 4a. Four members of the public provided comments.

Board discussion and public comment on item 3a (out-of-order):

- A member advised of a correction to the November minutes, stating that a member advising that "Covered California was under one percent recently," but "recently" should be replaced by "during the last presidential administration" as that is more accurate. The member also suggested including more detail in the comment regarding the geographic description of Medicare.
    - The Board agreed to make the requested corrections during the lunch break and approve once the meeting reconvenes.

Public comment was held on item 3a. No members of the public provided comment.

Agenda Item #3a resumed as follows:
The following corrections were made to the November 20, 2024, Board Meeting minutes:

- On page two, the first bullet point under Discussion and Comments from Board Members, the language should read "A member commented that Covered California kept the average premium increase around one percent for two years during the prior federal administration."

Member Pan moved to accept the amendment to the meeting minutes, Member Kronick seconded.

Voting members who were present voted to accept. There were 5 ayes and 2 absent. The motion passed.

Agenda Item # 4b) Sector Targets, Continued from November Board Meeting

Assistant Deputy Director Howard provided an overview of the process for implementing sector targets and stated that today's discussion will focus primarily on how to define a hospital sector.

Discussion and comments from the Board included:

- A member asked whether there is a standard definition for inpatient and outpatient services.
    - The Office responded that HCAI provides specifications to the hospitals regarding how to categorize a service as inpatient or outpatient. HCAI's definition of inpatient services may be different than those of some other organizations.
- A member inquired if any quality metrics were analyzed, including basic Medicare quality metrics, and whether there were any correlations.
    - The Office replied that for this analysis they did not look at quality metrics. They recalled that, when Chris Whaley presented during the August Board meeting, he did show that there was not a strong correlation between quality and price.
- A member commented that the lack of correlation between the average inpatient NPR for CMAD and the average payment to third party Medicare ratio is striking.

- A member asked why Monterey Park Hospital in Los Angeles is at 800 percent of the Medicare ratio.
    - The Office responded that Medicare payments recognize differences across hospitals' input costs. For example, hospitals in higher wage areas of the state have higher Medicare payments. They also recognize that teaching hospitals have higher costs so payments to those hospitals are higher. For case mix adjusted discharge, Medicare payments are higher. The payment to cost ratio assumes that the Medicare methodology is a good starting point, and comparing the ratio of what private insurers are paying compared to what Medicare is paying is a good way to assess commercial pricing behaviors.
- A member asked whether the indirect medical education payment is incorporated into the reimbursement rate for the DRGs for teaching hospitals.
    - The Office advised that, if the hospitals reported in the annual financial disclosure data their full payments for Medicare as they are instructed to do, then that data should be included.
- A member requested clarification regarding the geographic designations of the cities, as areas who were classified as rural when Medicare was first established may now be urban, which would result in a lower baseline but higher costs.
    - The Office replied that hospital payments are handled differently by CMS using a wage index at the county level.
- A member asked if OHCA noticed any measures that may correlate more strongly with others than is apparent in the data presented.
    - The Office responded that the average inpatient NPR per CMAD and the payment ratio each measure different things. The average inpatient NPR is measuring all payers versus the ratio which accounts for expenses. Sarah Lindberg from Freedman Healthcare further advised that the average inpatient NPR per CMAD is a measure based purely on revenue and includes all payers combined. The payment ratio reflects the cost coverage in a private plan versus the cost coverage for Medicare. However, the cost per adjusted admission was very highly correlated with the average inpatient NPR per CMAD, with the payment ratio being higher because it includes all revenue rather than just the inpatient revenue.
- A member commented on the absence of Los Angeles facilities. The member recalled that Los Angeles used to house as much as 20-25 percent of California's hospitals and seem to be underrepresented in the data presented.
- A member advised that it would be helpful to look at the average payment to cost ratio measure at a geographic level, with the county level likely being the easiest and best place to start.
- A member shared that there is significant concern regarding rural access and inquired whether a filter has been or could be applied to the data to sort the hospitals by rural versus urban. They recommended looking beyond the critical access hospitals.
    - The Office shared that they are concerned about the rural hospitals as well and have stood up the distressed hospital loan program. They will evaluate how to look at that piece most effectively.

- A member asked whether a hospital will show as being under the 3 percent cap if they have a negative growth percentage but are already at over 800 percent of the Medicare rate.
    - The Office replied that yes, in that scenario, the hospital will show as having a growth rate below the cap because they will be starting from where the hospital's current rate is at.
- A member commented that information on volume will be very important to have as they're looking at the relationship between what they're looking at in hospitals and the statewide target. For example, if the number of admissions at a hospital were to increase, then even if the inpatient revenue per CMAD were at 3.5 percent, the total spending would be much higher than 3.5 percent. Conversely, if the number of admissions were to decrease, then they could hit 3.5 percent even if the revenue per CMAD were at 6 percent. There is still not a good measure of outpatient volume yet.
    - A member mentioned that, as OHCA is notating what cannot be done at this point but is important to consider for the future, they would like to see a sector targets for health systems or health plans added to that list.
- The Office replied that the current focus is on hospital sector targets in response to stakeholder concerns raised and board interests. However, now that the office has collected THCE data and is working on a baseline report, the office could look into other entities for a sector target in the coming year.
- A member commented that it is the Board's responsibility to set the sector targets and to agree on approaches of what types of hospitals might potentially have different targets. The member asked whose responsibility it is to define the data to be measured to inform whether a hospital has met this target.
    - The Office responded that it would be OHCA's responsibility to define the data to be measured.
- A member asked that, if they are to vote on sector targets in the June meeting and potentially on the characteristics of facilities that might have different targets than the overall target for the hospital sector, will they be advised at that meeting what data will be measured.
    - The Office advised they are still working on that piece. They will come back in a couple of months to provide an update on the outpatient piece. Similar to the way the statewide spending target was adopted, the office worked in parallel on the hospital measurements. The Office does not have to decide the measurement piece before a target is adopted.
- A member requested confirmation that, in discussing hospital sectors, they are discussing any associated health system that may be at the center of and not just the inpatient part of the hospital.
    - The Office stated that the measurement approach would not be limited to inpatient but would also include outpatient services.
- Many members expressed alignment with hospital sector option four, of the options that were presented.
- A member asked for clarification regarding the differences between options three and four, as they appear to be very similar.

- The Office responded that the distinction with option three is that it would take longer to develop a rules-based approach.

Public Comment was held on agenda item 4b. Six members of the public provided comments.

Agenda Item #5: General Public Comment

Public Comment was held on agenda item 5. No members of the public provided comment.

Agenda Item #6: Adjournment

Chair Johnson adjourned the meeting.