HCAi
Department of Health Care Access and Information

Health Care Affordability Board Meeting

February 28, 2024

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 January 24, 2024 Meeting Minutes

4. **Informational Items**
   a) Spending Target Methodology and Value including Advisory Committee Feedback and Assessing Performance Against the Statewide Spending Target
   Vishaal Pegany, CJ Howard, Assistant Deputy Director, Andrew Feher, Manager of Research and Analysis, and Michael Bailit, Bailit Health
   b) Examples of Cost-Reducing Strategies Employed by MemorialCare
   Margareta Brandt, Assistant Deputy Director
   c) Alternative Payment Model Standards and Adoption Goal
   Margareta Brandt
   d) Measuring Consumer Affordability
   Vishaal Pegany, and Miranda Dietz, Policy Research Specialist and Project Director for CalSIM, and Laurel Lucia, Director of the Health Care Program, UC Berkeley Labor Center
   e) Measuring Out-of-Plan Spend
   Vishaal Pegany, CJ Howard, and KeriAnn La Spina, Senior Health Researcher, Mathematica

5. **Public Comment**

6. **Adjournment**

HCAi
Department of Health Care Access and Information

Executive Updates

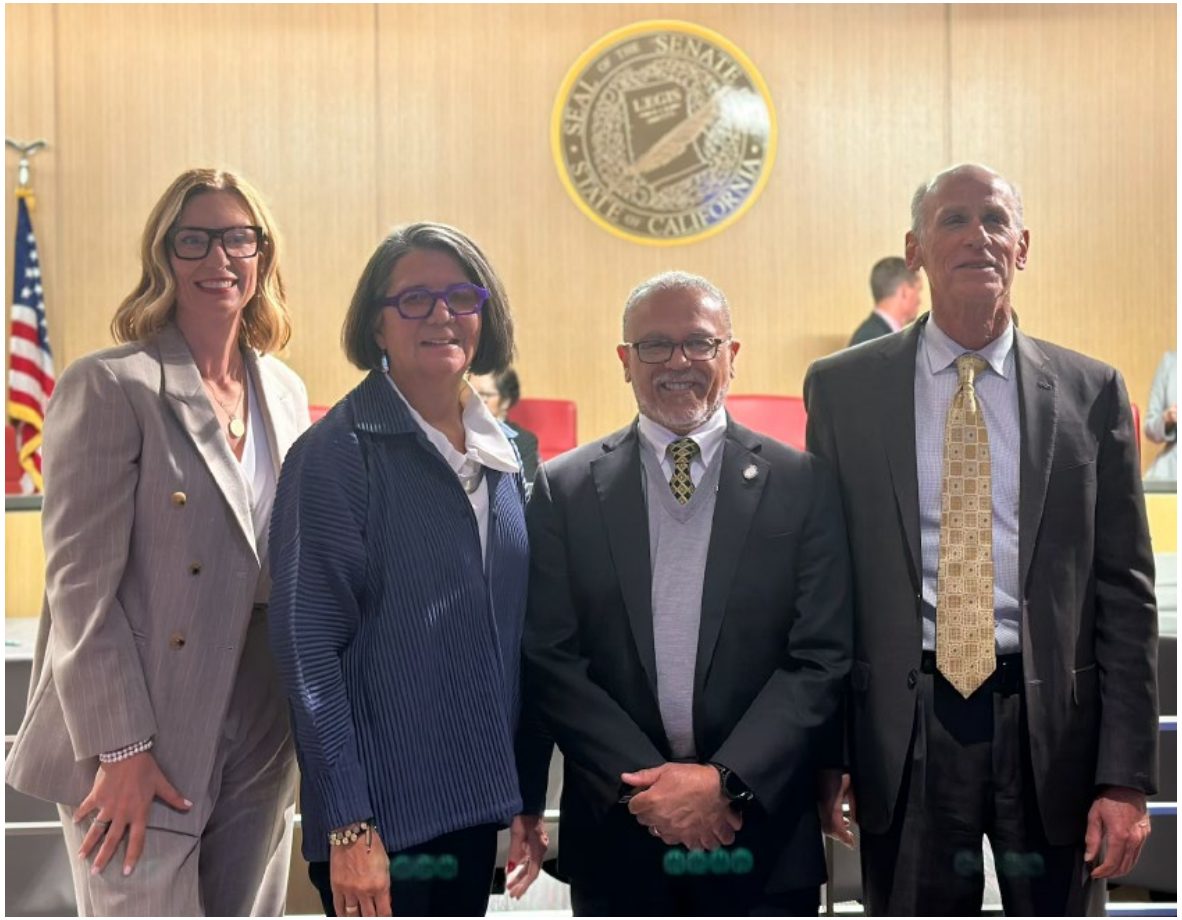
Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

Black Liberation Statement

At HCAI, we acknowledge the devasting and longstanding impacts racism, oppression, and white supremacy has had on Black and African American communities. We also believe it is critical to acknowledge that Black communities have been treated inhumanely by the U.S. government through enslavement, segregation, mass incarceration and exploitation through medical experimentation used to advance medicine resulting in longstanding inequities. To begin to rectify these wrongs, there must be an explicitly anti-racist approach to reduce racial disparities in health care and more broadly.

At HCAI, we envision a health care system where doctors listen to their Black patients, center their experiences, and take proactive steps to counter implicit bias resulting in quality care and improved patient outcomes. In solidarity and allyship with California's Black communities, HCAI centers and amplifies the voices of our Black partners, leaders, colleagues, and community members. We uplift Black resilience, education, and health. We fully commit to revisiting HCAI's programs, policies, and procedures to ensure state resources are distributed equitably in a manner that recognizes our responsibility to address disparities impacting Black communities.

Senate Confirmation of Board Members

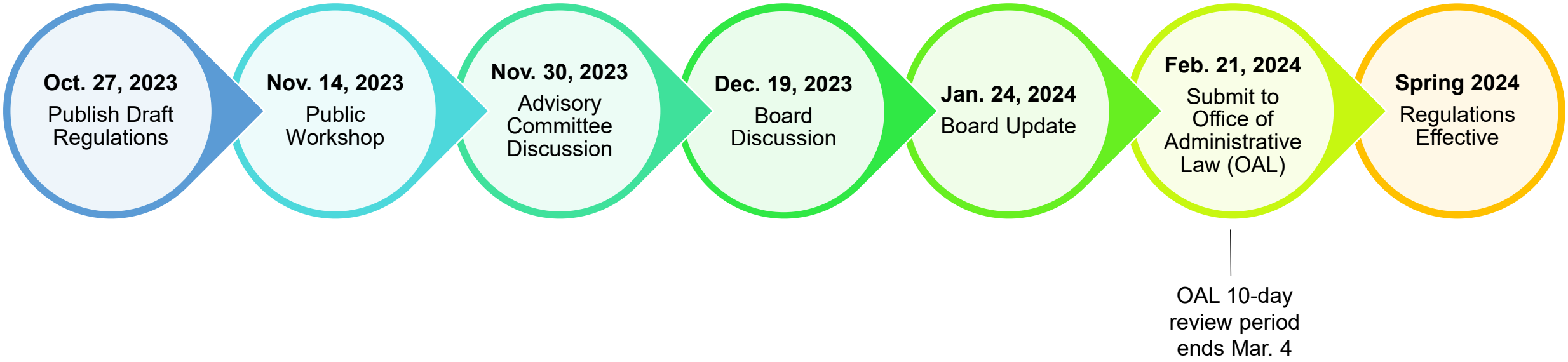


The California Senate recently confirmed Governor Newsom's four Health Care Affordability Board appointees.

- Elizabeth Mitchell
- Sandra Hernández
- David Carlisle
- Richard Kronick

Update on Total Health Care Expenditures (THCE) Proposed Regulations and Data Submission Guide

THCE Rulemaking Timeline



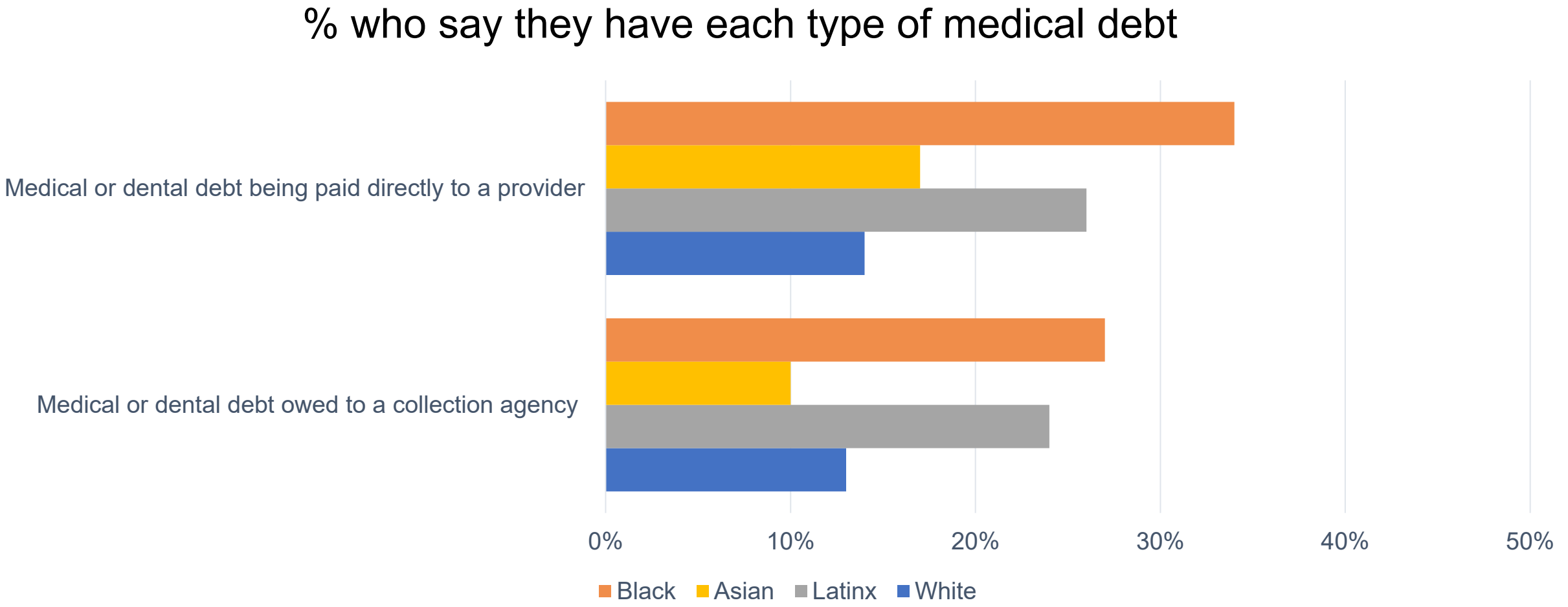
Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

CHCF/NORC California Health Policy Survey

Black and Latinx Residents Are More Likely to Report Different Types of Medical Debt



Source: CHCF/NORC California Health Policy Survey (September 18–October 25, 2023).

High Costs Contribute to Personal Bankruptcy

Nationally

- A 2019 National Institutes of Health survey reported that nearly 60% of respondents cited medical expenses as a contributor to their bankruptcy.
- In 2021, the U.S. Census Bureau found that Americans owe at least $220 billion of medical debt.
- Some estimate $140 billion of medical debt is in collections.

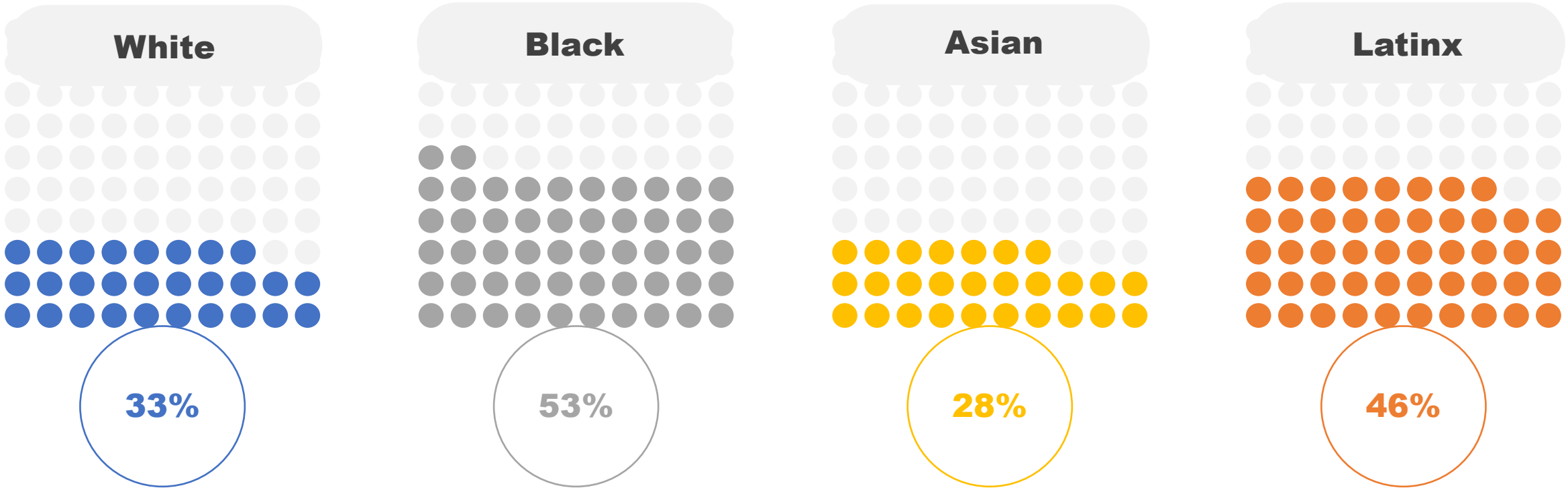
California

- 38% of Californians report having medical debt.
- 2 in 10 Californians report having trouble paying medical bills.

Sources: National Institutes of Health (March 2019).*Medical Bankruptcy: Still Common Despite the Affordable Care Act*.; U.S. Census Bureau. *Wealth, Asset Ownership, & Debt of Households Detailed Tables: 2021*.; Toddy, M. (August 18, 2021). *Medical Debt in Collection Estimated at $140 Billion.* UCLA Anderson Review.; Joynt, J. et al. (2024 January). *The 2024 California Health Policy Survey.* California Health Care Foundation.; Planalp, C. et al. (September 4, 2020). *Weighed Down: Californians and the Financial Burden of Health Care Coverage.* California Health Care Foundation.

High Costs Contribute to Personal Bankruptcy

Medical debt is more likely to be experienced by communities of color than by white communities.



Source: CHCF/NORC California Health Policy Survey (September 18–October 25, 2023).

HCAi
Department of Health Care Access and Information

Public Comment

HCAi
Department of Health Care Access and Information

Action Consent Item: Approval of the January 24, 2024 Board Meeting Minutes

HCAi
Department of Health Care Access and Information

Public Comment

HCAi
Department of Health Care Access and Information

Informational Items

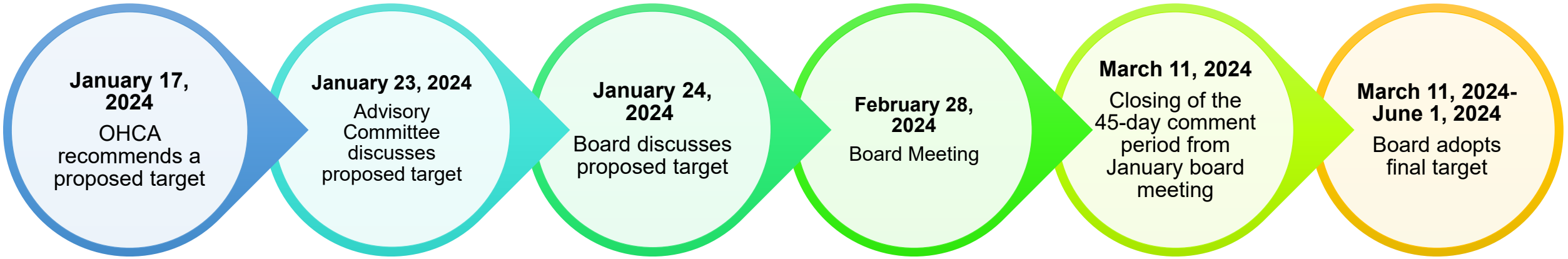
HCAi
Department of Health Care Access and Information

Spending Target Methodology and Value Including Advisory Committee Feedback and Assessing Performance Against the Statewide Spending Target

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

OHCA's Recommendation for the Health Care Spending Target

Timeline for Adopting the Spending Target for 2025



Per the California Health Care Quality and Affordability Act:
The Board shall adopt final targets on or before June 1, at a Board meeting.
The Board's adoption of the target is exempt from the rulemaking provisions of the Administrative Procedure Act.

HCAI Department of Health Care Access and Information

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

OHCA recommends the adoption of the following statewide per capita health care spending targets for 2025-2029, based on the average annual rate of change in historical median household income over the 20-year period from 2002-2022.

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

Advisory Committee Feedback Related to OHCA's Recommendation for the Health Care Spending Target

Advisory Committee Feedback

Below is a summary of feedback received at the January 23, 2024 Advisory Committee meeting regarding OHCA's recommended spending target:

Some members had comments/concerns with OHCA's recommendation to tie the spending target to historical median household income growth over the 20-year period (2002-2022), such as:

- The timeframe includes the great recession and near-zero interest rates; it's not representative of today or the future. Additionally, the population is aging.
- The timeframe doesn't account for inflation or other cost trends for uncontrollable expenses, including legislative/regulatory mandates. Access could be compromised.
- Using a different timeframe of 2013 to 2022, median household income grew by 4.1 percent.
- 20-year historical household income with low inflation has nothing to do with future medical costs. Targets must be believable and should not reduce access to care.
- Applying adjustments to historical household income growth to account for medical cost inflation and the new minimum wage law, costs will go up.
- Concerns about access to care and demands on the system, especially with CalAIM, an aging population, and higher acuity patients.

Advisory Committee Feedback

Other members were supportive of the 3% recommendation and tying it to the consumer experience and median household income. Comments are summarized below:

- Couldn't imagine a target being any higher than 3% as health care is currently unaffordable and impacting access as people skip care.
- Agree with 3% with no adjustments. There's already system gaming (rates increasing now in anticipation of a target); even 3% won't address the problem (e.g., Monterey).
- Health care is even more expensive for rural families -- keep a human impact perspective.
- Under OHCA's recommendation, at least health care costs wouldn't outgrow wages and income. It also aligns with Oregon and Washington (West coast states with targets).
- Three percent is the least we can do (with no population adjustments)—it won't make health care more affordable but may keep it from becoming more unaffordable.
- Higher wages (due to the health care worker minimum wage law or labor contracts) do not automatically mean costs will go up proportionately. Higher wages could mean more productivity, less turnover, and lower recruiting costs resulting in better care so patients are healthier, driving costs down.

Advisory Committee Feedback

Some members had concerns with the 5-year statewide target timeframe and encouraged getting to sector-specific targets as soon as possible. Comments included that:

- Different entities are starting from different places – Bay Area vs Central Valley, sector and regional diversity.
- Costs are skyrocketing due to failures (e.g., network adequacy leading to delayed care; high-cost drugs leading to medication noncompliance, comorbidities, etc.). Costs may not be realized where they were created. Don’t make the job harder/reduce costs by restricting tools providers have access to because of outside forces.
- It doesn’t make sense to assess the same target to a high-cost provider vs a low-cost provider; early sector targets would help with credibility.

Advisory Committee Feedback

Members had differing opinions/comments regarding adjusting the future cost target based on trends in the price of health care technologies, including:

- It's hard to quantify what any adjustment might be – maybe discuss in real time as new technologies are introduced?
- Consider adjusting down as well (e.g., more effective drugs should reduce costs/improve outcomes; electronic medical records and AI should increase productivity).
- Some technology components have known costs (e.g., specialty drugs/devices); look at price trend over the past 5 years and include it in the target calculation (not retrospectively), otherwise plans/providers will limit access to manage costs.
- Retrospective is the right direction. Any technology or new unknown will impact sectors differently. A new drug that increases costs may not impact other parts of the system. Adjusting prospectively will create inequalities in the system--need time for it to play out retro.
- Prospective adjustment is an inappropriate use of pharmaceuticals and would push prices up if cards are shown to Pharma.
- Retrospective sounds like a big carve out/exemption. What's the incentive to manage prospectively if folks get a hall pass on the back end?

Board Follow-Up Items

Today's Follow-Up Items

During today's Board meeting, we will provide information regarding:

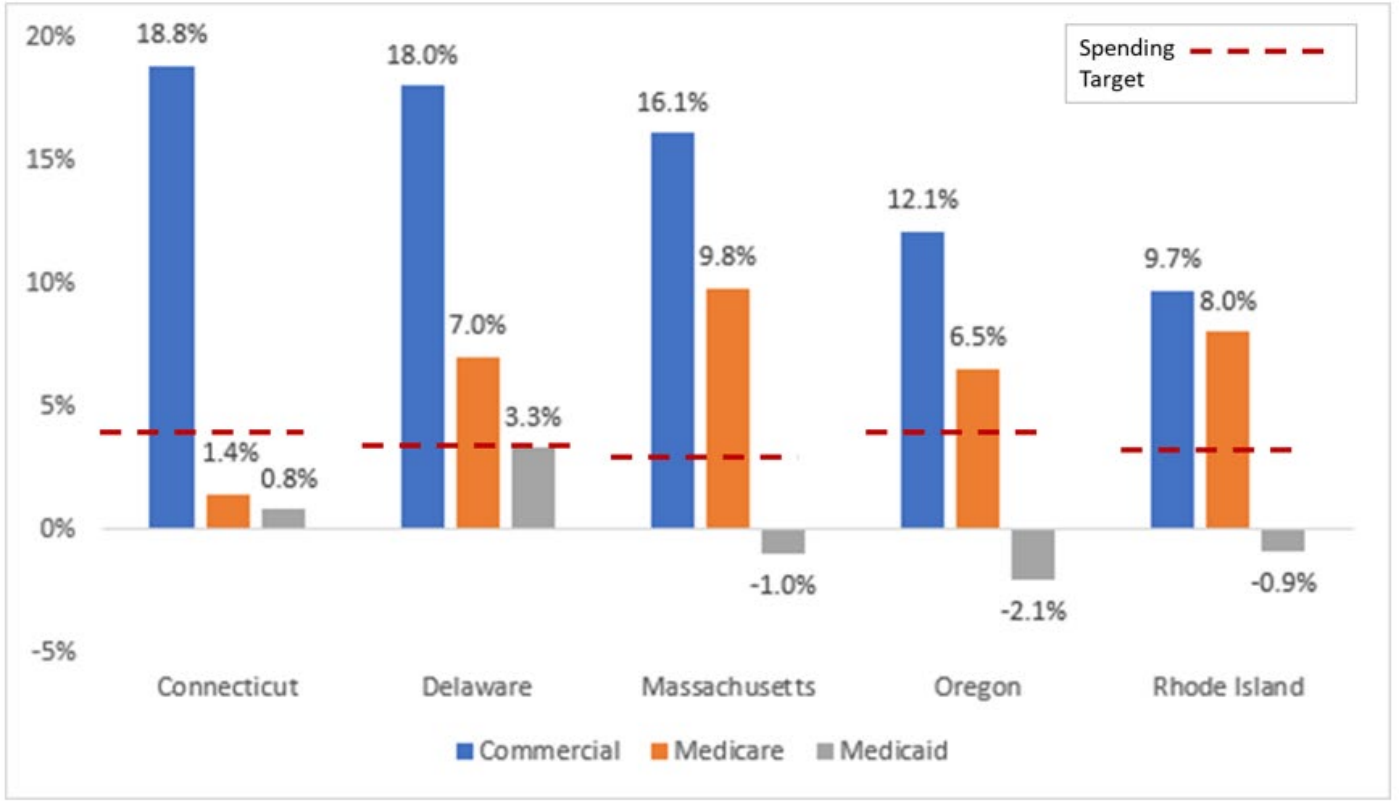
1. Changes in per capita health care spending from 2020 to 2021 for states that publicly reported such information
2. The differential between historical spending growth and state spending target values
3. The extent to which health care spending affects employment-related outcomes

Changes In Per Capita Spending from 2020 to 2021

2020 to 2021 Health Care Spending Trends Across Spending Target States

In June 2023, Bailit Health authored a *Health Affairs Forefront* blog post, summarizing 2021 health care spending performance relative to spending growth targets in five states.

- All states reported increased health care spending in 2021. This growth was expected since COVID-19 contributed to a sharp decline in utilization in 2020.
- Double-digit growth in commercial spending contributed to overall spending growth in four of the five states. Rhode Island was the exception.



State	Connecticut	Delaware	Massachusetts	Oregon	Rhode Island
Spending Target	3.4%	3.3%	3.1%	3.4%	3.2%

HCAi Department of Health Care Access and Information

Differential Between Historical Spending Growth and State Spending Target Values

Differential Between Historical Spending Growth and Spending Target Values in Other States

- Please note only in 2023 did CMS update its state-level personal health care spending time-series to include 2020. As a result, aside from California, states with spending target programs only had access to CMS's state-level historical personal health care spending data through 2014.
- States' *initial* target values ranged from between 1.3 to 2.2 percentage points of the 20-year average spending growth rate and *latest* target values between 1.4 to 2.6 percentage points of the 20-year average growth rate.
- Because most states reduced their spending target percentage over time (e.g., from 3.4% down to 3.0% in Oregon), the differences between average spending growth and the *latest* target values increase over time.

Differential Between Historical Spending Growth and Spending Target Values in Other States

State	Target Value	20-year Average Growth (1994-2014)	Difference in percentage points from *initial* target	Difference in percentage points from *latest* target
Connecticut	3.4% 2021 3.2% 2022 2.9% 2023-2025	4.8%	1.4	1.9
Delaware	3.8% 2019 3.5% 2020 3.25% 2021 3.0% 2022-2023	5.6%	1.8	2.6
Massachusetts	3.6% 2013-2017	5.0%	1.4	1.4
Oregon	3.4% 2021-2025 3.0% 2026-2030	5.6%	2.2	2.6
Rhode Island	3.2% 2019-2022	5.3%	2.1	2.1
Washington	3.2% 2022-2023 3.0% 2024-2025 2.8% 2026	5.1%	1.9	2.3
New Jersey	3.5% 2023 3.2% 2024 3.0% 2025 2.8% 2026-2027	4.8%	1.3	2.0
California	3.0% 2025-2029 (proposed)	4.7%	1.7	1.7
California	3.0% 2025-2029 (proposed)	5.4% (2000-2020)	2.4 (2000-2020)	2.4 (2000-2020)

Effects of Health Care Spending on Employment-related Outcomes

What Are the Effects of Health Care Spending on Employment-Related Outcomes?

Approach: Systematic review of three databases: National Bureau of Economic Research (NBER), JAMA and PubMed.

- We screened 1,092 titles and abstracts: NBER (n=881), JAMA (n=8) and PubMed (n=203).
- To be included, studies had to be empirical evaluations, U.S.-based and published between 2004 and 2024. We excluded editorials, commentaries or articles focused on theory.
- Used the following search terms: “health care spending” AND (“wages” OR “labor” OR “employ" OR "earnings" OR "income” OR "compensation")
- Of the 1,092 titles and abstracts screened, we included 15 articles that directly addressed the policy question of interest. The articles broadly fell into two categories: (1) the effects of premiums and spending on employment-related outcomes and (2) the effects of adverse health events – which increase spending – on employment-related outcomes.

Limitations: Does not capture unpublished research or research published outside of the typical commercial or academic publishing environment.

Key Findings: Effects of Premiums and Spending

Among the studies we identified, high and rising health insurance premiums were associated with the following:

- reduced probability of employment
- reduced hours worked
- increased likelihood of part-time employment
- lower wages, incomes and total compensation (affects women more than men).
- reductions in benefits (e.g., dental, retirement)
- greater employee cost-sharing through less generous coverage
- higher rates of unemployment in non-health care sectors and corresponding increases in mortality from overdoses and suicides

References for all findings are available in the Appendix.

Key Findings: Effects of Adverse Health Events

Among the studies we identified, adverse health events (e.g., cancer diagnoses, disability onset, hospitalizations) were associated with the following:

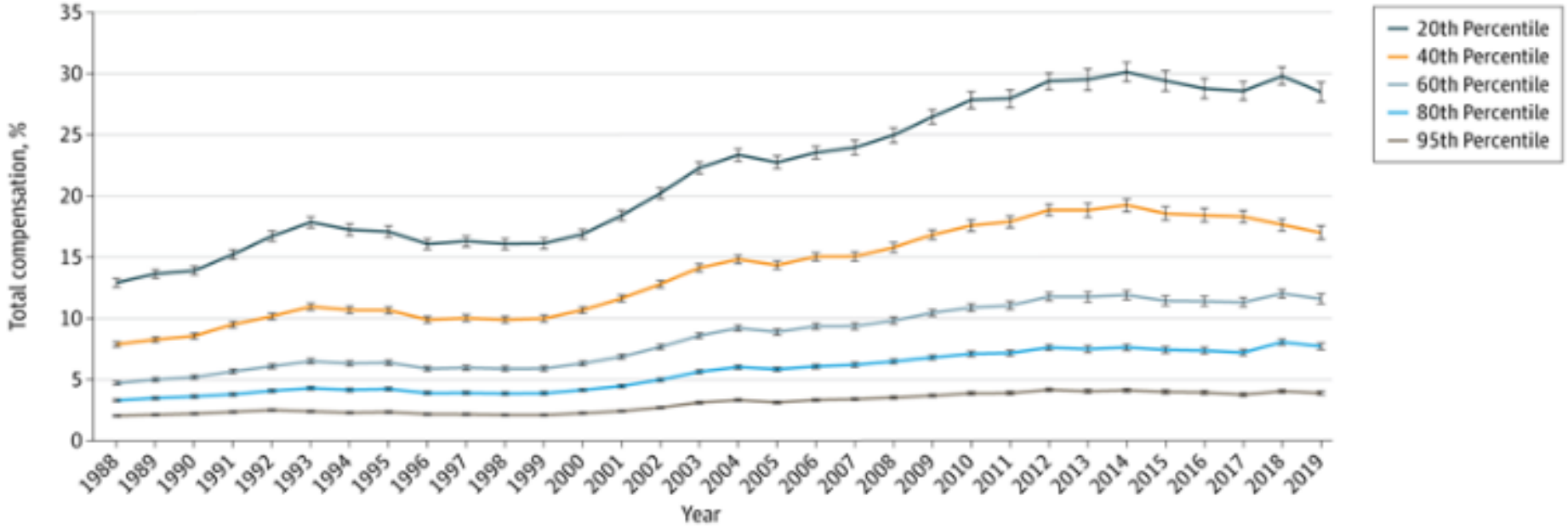
- increased likelihood of disability
- decreased likelihood of employment with spillovers to caregivers
- increased out-of-pocket medical spending
- unpaid medical bills
- higher rates of bankruptcy
- reduced earnings and income

References for all findings are available in the Appendix.

Employer-Sponsored Insurance Premium Growth and Earnings Inequality

A recent article published in JAMA Health Forum found that, between 1988 and 2019, employer-sponsored health insurance premiums as a share of compensation increased from an average of 7.9% up to 17.7%, with more pronounced effects for lower-income families.

Figure 2. Percentage of Compensation Associated With Health Care Premiums Among Families With Employer-Sponsored Health Insurance From 1988 to 2019, by Earnings Percentile

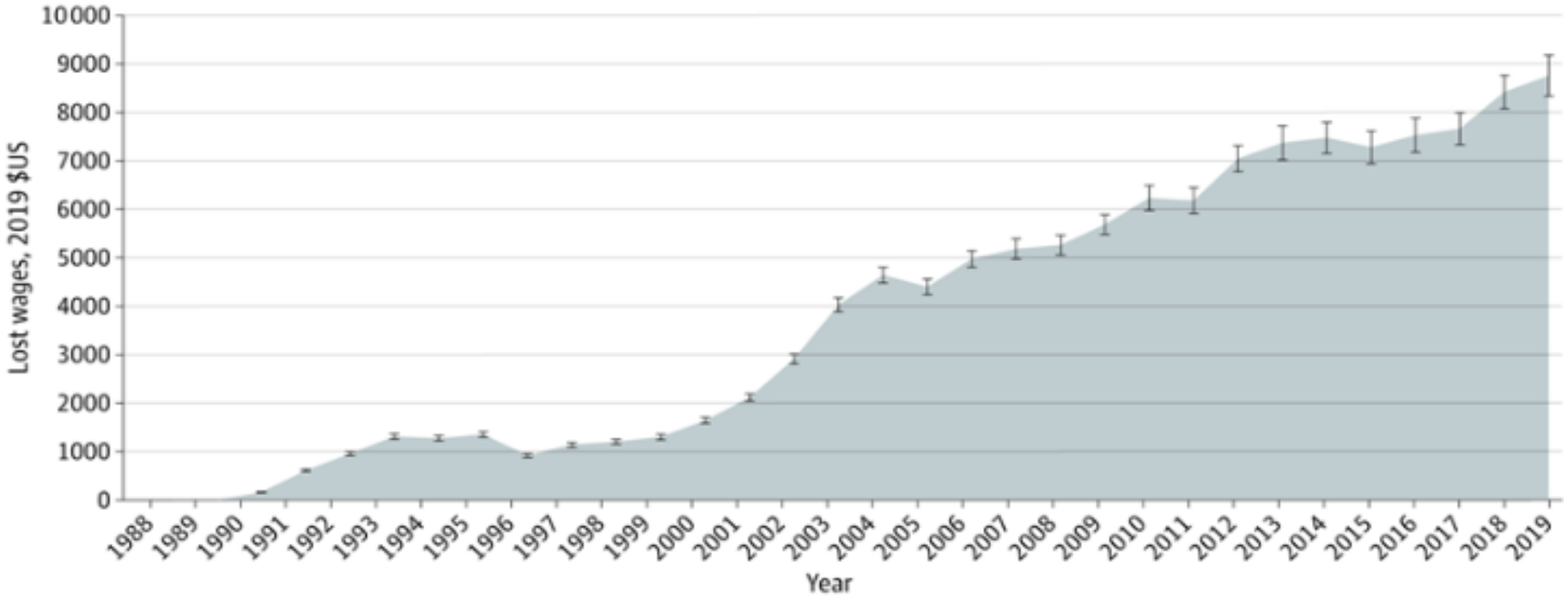


Source: Hager, K., Emanuel, E., & Mozaffarian, D. (2024 January). *Employer-Sponsored Health Insurance Premium Cost Growth and Its Associate with Earnings Inequality Among US Families.* JAMA Network Open. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2813927

Employer-Sponsored Insurance Premium Growth and Earnings Inequality

In addition, the authors estimate cumulative average lost earnings of approximately $125,000 from 1988-2019, compared to an alternative where premium costs would have remained fixed as a percentage of employee compensation at 1988 levels.

Figure 3. Lost Wages Associated With Health Care Premium Increases Among Families With Employer-Sponsored Health Insurance From 1988 to 2019



Source: Hager, K., Emanuel, E., & Mozaffarian, D. (2024 January). *Employer-Sponsored Health Insurance Premium Cost Growth and Its Associate with Earnings Inequality Among US Families.* JAMA Network Open. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2813927

Assessing Performance Against the Statewide Spending Target

Elements of Spending Target(s) Implementation

1. Set Statewide Spending Target

- On or before June 1, 2024, the board must establish a statewide spending target for 2025.
- Target setting methodology discussions have been rooted in consumer affordability.
- A statewide target cannot uniformly account for circumstances impacting each entity's performance against the target.

2. Assess Entity Performance Against the Statewide Spending Target

- **The office will assess each entity's performance against the target.**
- **The office will consider circumstances that may have impacted performance.**

3. Progressive Enforcement

- Technical Assistance
- Public Testimony
- Performance Improvement Plans
- Financial Penalties

Authority to Assess Performance Against the Spending Target

127502.5 (a): “The director shall enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets, allows each health care entity opportunities for remediation, and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access, quality, equity, or workforce stability. **The director shall consider each entity’s contribution to cost growth in excess of the applicable target and any actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target.** The director shall review information and other relevant data from additional sources, as appropriate, including data from the Health Care Payments Data Program, to determine the appropriate health care entity that may be subject to enforcement actions under this section…”

Authority to Assess Performance Against the Spending Target

127502.5 (a): "…Commensurate with the health care entity's offense or violation, the director may take the following progressive enforcement actions:

1) Provide technical assistance to the entity to assist it to come into compliance.
2) Require or compel public testimony by the health care entity regarding its failure to comply with the target.
3) Require submission and implementation of performance improvement plans, including input from the board.
4) Assess administrative penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets."

Assessing Performance Against the Target

- OHCA has heard from the board and the public about potential factors that should be considered when assessing an entity's performance against the target. Such factors may contextualize an entity's spending growth as well as potentially mitigate steps in the progressive enforcement process.
- Some of the potential factors that have been surfaced to OHCA by the Board, Advisory Committee, and stakeholders, as well as described in the statute include:
  - Statutory changes impacting health care costs
  - Investments to improve care and reduce future costs
  - Acts of god or catastrophic events
  - Emerging and unforeseen advances in medical technology
  - Emerging high-cost / high-value pharmaceuticals and cost increases related to specialty pharmaceuticals
  - Costs associated with increased organized labor costs
  - Annual changes in age and sex of the entity's population

Assessing Performance Against the Target

Are there additional reasonable factors that may impact entity performance against the target?

HCAi
Department of Health Care Access and Information

Public Comment

HCAi
Department of Health Care Access and Information

Examples of Cost-Reducing Strategies

Vishaal Pegany, Deputy Director

Cost-Reducing Strategies Project

- OHCA is working with health plans, hospitals, and physician organizations to highlight examples of cost-reducing strategies – efforts to reduce cost while improving or maintaining quality – that have demonstrated results.
- To start this project, OHCA spoke with industry associations, quality improvement collaboratives, and others to understand their approach to cost-reducing strategies and seek introductions to health care entities implementing successful strategies.
- OHCA interviewed health care entities across California to identify strategies that reduce overall system costs and are sustainable for the entity to implement and maintain.
- From these interviews, OHCA is working with several organizations to develop a summary of their cost reducing strategy to share through a new HCAI webpage.
- These strategies can be a resource to support health care entities in meeting OHCA's health care spending growth targets.

Seeking Additional Examples of Cost-Reducing Strategies

OHCA is seeking additional examples of cost-reducing strategies. Examples might include a program that addresses a specific population, implementation of best practices for more efficient resource use, or an effort to increase care coordination, etc. OHCA is interested in the following:

- **Description:** Overview of the cost-reducing strategy, what it is, and how it functions. Explain what was implemented, who the population of focus is, who the market is, etc.
- **Purpose:** Rationale for implementation and the problems it is/was addressing.
- **Results:** Quantitative and/or qualitative indicators of success that demonstrate how the cost-reducing strategy reduced cost and improved or maintained quality of care.
- **Barriers or challenges:** Description of barriers or challenges your organization faced in implementing the strategy and if or how the strategy has evolved over time to address these.

Contact OHCA at ohca@hcai.ca.gov if you would like to propose a cost-reducing strategy for consideration.

MemorialCare Cost-Reducing Strategies

Barry Arbuckle, PhD, President and CEO of MemorialCare

MemorialCare™

Cost-Reducing Strategies

Presented to:
Office of Healthcare Affordability
Department of Health Care Access and Information

February 28, 2024

Barry Arbuckle, PhD
President and Chief Executive Officer

An Integrated Health System

4 Hospitals: Teaching Hospital, Women's & Children's Hospital, and 2 Community Hospitals

> 100 Community-based centers including:

- **24** Imaging centers
- **32** Physical Therapy clinics
- **22** Dialysis sites (in-center and home-based)
- **12** Urgent Care centers
- **13** Breast centers
- **9** Ambulatory Surgical Centers
- **1** Co-located primary & specialty, dental practice site

~400 primary care physicians; **1,500+** affiliated specialists

A Full Knox-Keene Health Plan

An Innovation Investment Fund

Each Year We Manage...

MemorialCare

Inpatient Days

Emergency Room Visits

Deliveries

Hospital Surgeries

Physician Visits

Ambulatory Surgeries

Imaging Studies

Dialysis Treatments

Physical Therapy Visits

Navigation Center Calls


Los Angeles County
Orange County
Downey
Brea
Yorba Linda
Torrance
Anaheim
Anaheim Hills
Westminster
Fountain Valley
Long Beach
Irvine
Huntington Beach
Laguna Hills
Mission Viejo
Newport Beach
Laguna Niguel
Dana Point
San Clemente
710
605
91
57
55
5
22
405
261
133
241
73
74
1
110
N
NW
NE
W
E
SW
SE
S
MemorialCare Medical Centers
Miller Children's & Women's Hospital Long Beach
MemorialCare Shared Services
Children's Specialty Care Centers
Urgent Care Centers
MemorialCare Medical Group
Hospital-Based Imaging Centers
Community-Based Imaging Centers
Breast Centers
Dialysis Centers
MemorialCare Surgical Centers
Community-Based Physical Therapy Centers
(Beverly Hills and West Covina Locations not shown)
Hospital-Based Physical Therapy Centers
Greater Newport Physicians MemorialCare

Value-Based Care
Health Plan Partnerships

MemorialCare

2014
- PPO ACO — Anthem BlueCross
- HMO ACO — Vivity offered by Anthem BlueCross
  7 Founding Health Systems added Providence (2020)

2015
- PPO ACO — aetna | MemorialCare
  60 employer partners and growing

2016
- PPO ACO — MemorialCare Health Alliance
  Direct contract with Boeing; contract extended (2016 – 2023)

2017
- HMO ACO — CMS
  Next Gen ACO
- Center for Medicare & Medicaid INNOVATION
  BPCI
- aetna MemorialCare

2018
- HMO ACO

2019
- EPO ACO — MemorialCare
  Created in response to employer demand
- HMO ACO — UnitedHealthcare SignatureValue Alliance
- HMO ACO — blue california trio HMO
  MemorialCare – Long Beach
- HMO ACO
- blue california tandem PPO

2020
- PPO ACO

2021
- EPO ACO — MemorialCare
  Direct contract with F&M Bank and Novartis
- HMO ACO — blue california trio HMO
  Expanded to include our Orange County network
- HMO ACO — UnitedHealthcare Harmony
- HMO ACO — Cigna Select and Value

2022
- EPO ACO — MemorialCare
  Direct contract with Activision Blizzard/now Microsoft

2023
- HMO ACO — MemorialCare
  New Blue Shield / new to Trio w/expanding employer base

New Value-Based Health Plans
- United Healthcare Harmony
- Blue Shield Trio
- Cigna Select & Value Plans
- Direct-to-Employer
- Activision/now Microsoft

Key Ingredients to Success

MemorialCare

Key Ingredients:

Invest in robust “ACO infrastructure” including:

- Data, data, and data
- Care management
- Pharmacy management
- Broad PCP and ambulatory access points
- Behavioral Health

Patient access and engagement vehicles

Standardized metrics for quality and cost containment across ACOs

IDS committed to “real” value

Extensive portfolio of Virtual Care options (e.g., virtual visits, eVisits, virtual behavioral health, eConsults, remote patient monitoring)

MemorialCare™

Cost-Reducing Strategies

Lowering the Total Cost-of-Care through Most Appropriate Site of Care

Outpatient procedures (imaging, surgery, testing, therapies, other) can be done in:

1) Hospital Outpatient Departments (HOPD)
2) Community-Based Ambulatory Centers

- Cost to payer/employer can vary considerably between HOPDs and community-based ambulatory centers
- Clinical criteria can (does) determine which setting is most appropriate for the patient
- CMS uses a '*blunt instrument*' of site neutrality

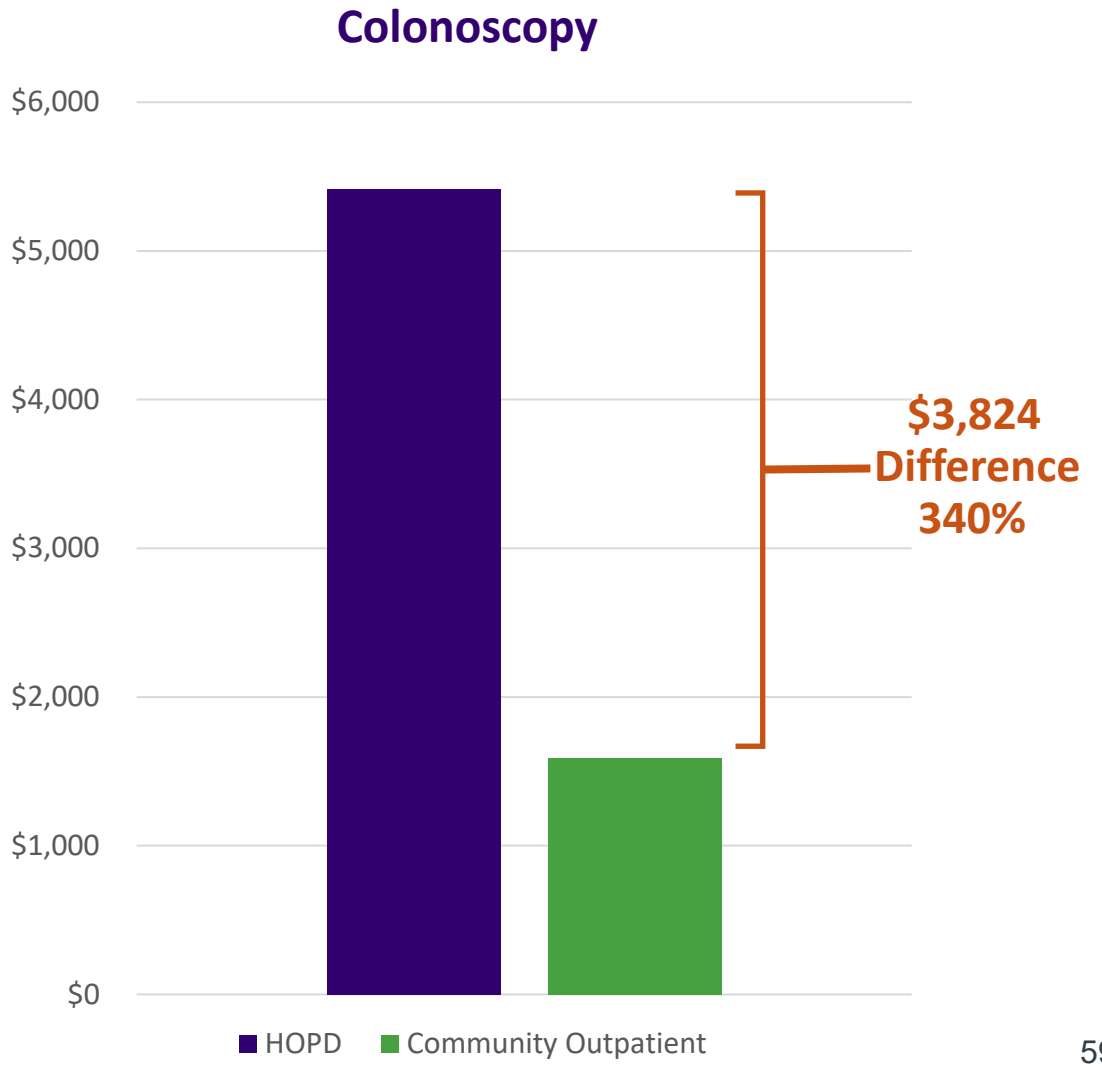
What is Right for the Patient Determines Right Site of Care

MemorialCare

Clinical Rationale for use of HOPD

(not all inclusive)

- Patient is moderately to morbidly obese
- Patient has multiple co-morbidities
- Patient with certain drug allergies



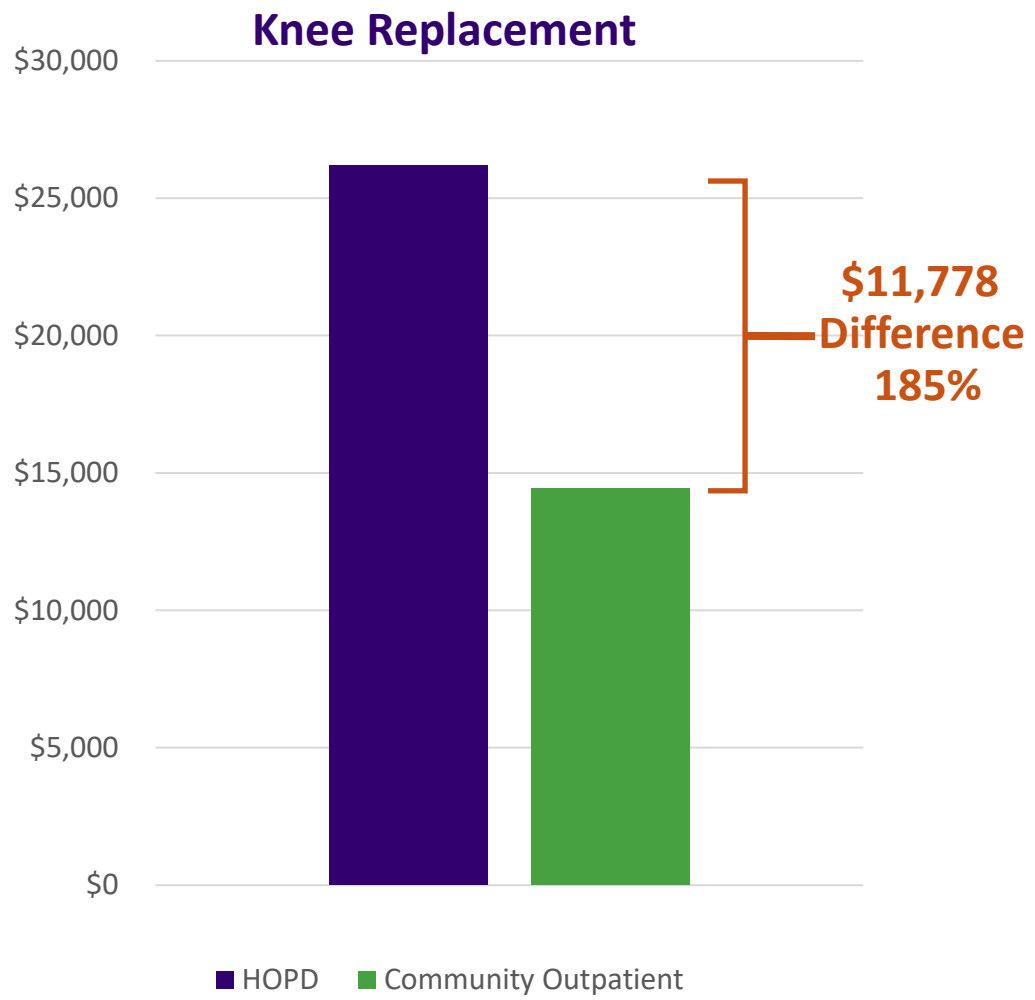
What is Right for the Patient Determines Right Site of Care

MemorialCare

Clinical Rationale for use of HOPD

(not all inclusive)

- Patient has multiple co-morbidities
- Patient has history of difficulty with anesthesia



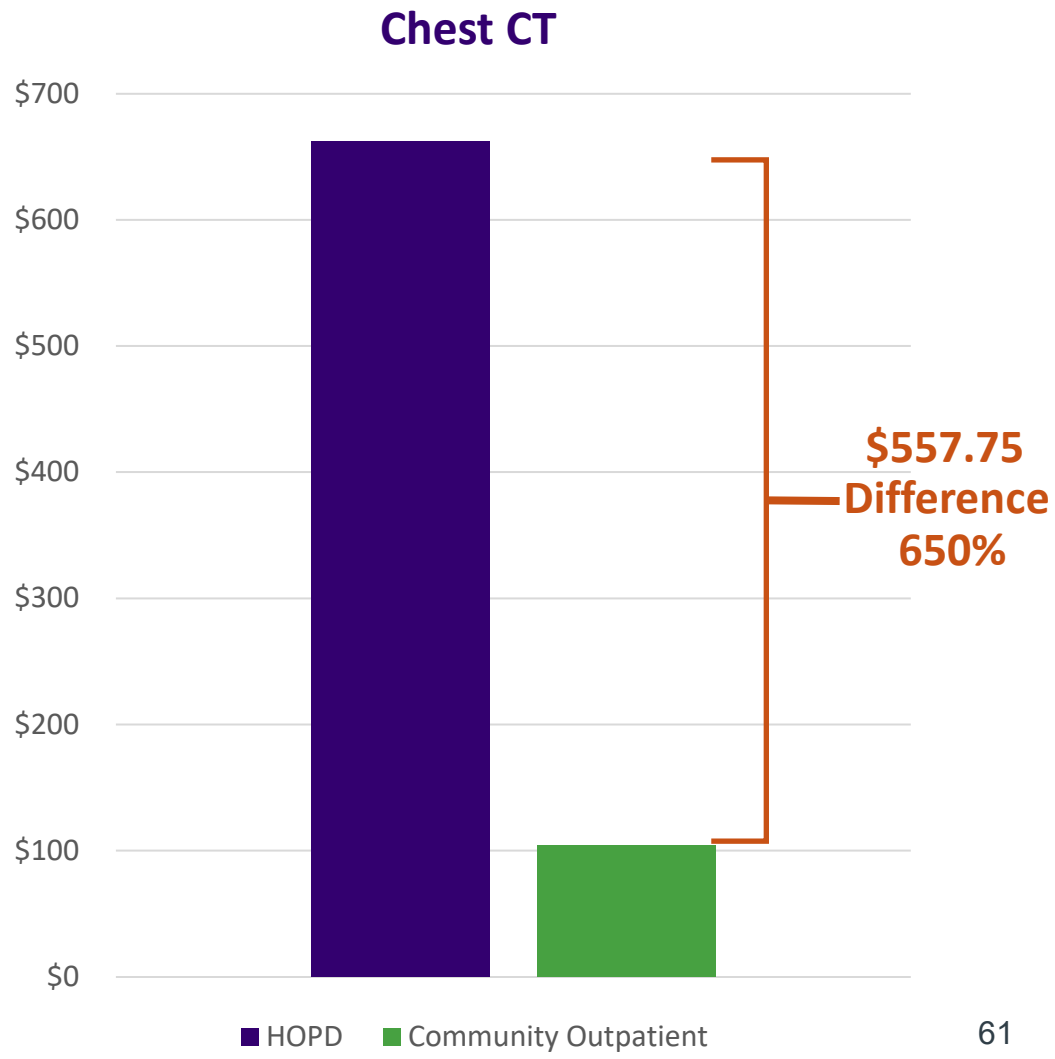
What is Right for the Patient Determines Right Site of Care

MemorialCare

Clinical Rationale for use of HOPD

(not all inclusive)

- Patient requires obstetrical or perinatal observation
- Patient has known contrast allergy
- Patient is under age 18
- Patient has multiple co-morbidities including obesity



Accounting for the price delta…

MemorialCare

- **HOPDs are licensed under/operated by hospitals which must be available 24/7/365**
- **Regulatory and Compliance requirements drive up the cost**
  - e.g., Installing/Maintaining the SAME equipment in a hospital environment costs 30%-100% more than at a community site (e.g., an imaging center in a strip mall)
- **Patient condition and the resources required to care for them**
- **Hospitals take all comers**
- **Specialty physician costs for required coverage are skyrocketing due to physician shortages, more opportunities in the ambulatory sector, etc.**

Barriers and Challenges

MemorialCare

Hospitals and Health Systems

- Many have not invested in a robust network of community-based ambulatory sites
- In FFS contracts, the ‘value’ created by investing in this network accrues to another entity (e.g., health plan)
- Challenges in integrating patient records across sites of care
- Some/many community-based ambulatory sites do not accept certain insurance coverage

Other Challenges

- Clinical criteria to determine site of care has many gaps (some health plans have no published criteria) and has been slow to evolve

A Final Word

The **Office of Healthcare Affordability** goal of increasing adoption of Alternative Payment Models (APM) where provider reimbursement is at-risk, shifting away from FFS, will accelerate *right site of care* - once a substantial portion of providers' reimbursement is in HCP-LAN Categories 3B, 4A, 4B, or 4C.

Until then, accelerating the establishment/proliferation of clinical criteria published by the health plans will move the dial.

HCAi
Department of Health Care Access and Information

Public Comment

HCAi
Department of Health Care Access and Information

Alternative Payment Model Standards and Goal

Margareta Brandt, Assistant Deputy Director,
Health System Performance

Focus Areas for Promoting High Value

Primary Care Investment	• Define, measure, and report on primary care spending • Establish a benchmark for primary care spending
Behavioral Health Investment	• Define, measure, and report on behavioral health spending • Establish a benchmark for behavioral health spending
APM Adoption	• Define, measure, and report on alternative payment model adoption • Set standards for APMs to be used during contracting • Establish a goal for APM adoption
Quality and Equity Measurement	• Develop, adopt, and report performance on a single set of quality and health equity measures
Workforce Stability	• Develop and adopt standards to advance the stability of the health care workforce • Monitor and report on workforce stability measures

Investment and Payment Workgroup Members

Providers & Provider Organizations

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

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

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

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

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

Janice Rocco
Chief of Staff, California Medical Association

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

Academics/ SMEs

Sarah Arnquist, MPH
Principal Consultant, SJA Health Solutions

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

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

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

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

State & Private Purchasers

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

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

Monica Soni, MD
Chief Medical Officer, Covered California

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

Consumer Reps & Advocates

Beth Capell, PhD
Contract Lobbyist, Health Access California

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

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

Hospitals & Health Systems

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

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

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

Health Plans

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

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

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

Mohit Ghose
State Affairs, Anthem

Key Workgroup Discussion Topics

Alternative Payment Models

Definitions, Measurement, Reporting: Categorizing APMs, unit of reporting, health and social risk adjustment

Standards for APM Contracting: Common requirements/incentives for high quality equitable care, accelerate adoption of APMs

Statewide Goals for Adoption: Variation by market (Commercial, Medi-Cal), target timeline, unit of reporting (percent of payments, members, and/or provider contracts)

Primary Care

Definitions, Measurement, Reporting: Primary care providers, services, site of service, non-claims, integrated behavioral health

Investment Benchmark: Variation by market (Commercial, Medi-Cal) or population (adult vs. pediatric)

Behavioral Health

Definitions, Measurement, Reporting: Spending on social supports, capturing carved out behavioral health spending

Investment Benchmark: Variation by market (Commercial, Medi-Cal) or population (adult vs. pediatric)

Alternative Payment Models

Statutory Requirements

- Promote the shift of payments based on fee-for-service (FFS) to alternative payment models (APMs) that provide financial incentives for equitable high-quality and cost-efficient care.
- Convene health care entities and organize an APM workgroup, **set statewide goals** for the adoption of APMs, **measure the state's progress** toward those goals, and **adopt contracting standards** healthcare entities can use.
- Set benchmarks that include, but are not limited to, increasing the percentage of total health care expenditures delivered through APMs or the percentage of membership covered by an APM.

Alternative Payment Models

Statutory Requirements

- Require payers, fully integrated delivery systems, and restricted and limited health care service plans to submit data and other information to measure adoption of APMs.

- Data collected by OHCA to measure APM adoption may include, but is not limited to, types of payment models, adoption by line of business, the number of members covered by APMs, the percent of budget dedicated to alternative payments, or cost and quality performance measures tied to the payment models.

The APM Workstreams

Develop Standards

Best practices for APMs and contracting guidance to promote equitable, high-quality, and cost-efficient care.

Define

A framework and descriptions to identify what "counts" for each APM category.

Set Goals for Adoption

Targets to promote adoption of meaningful APMs and to promote equitable, high-quality, and cost-efficient care.

Process for APM Workstreams

Brainstorm Ideas

Develop Scan

Review Data

Create Recommendations

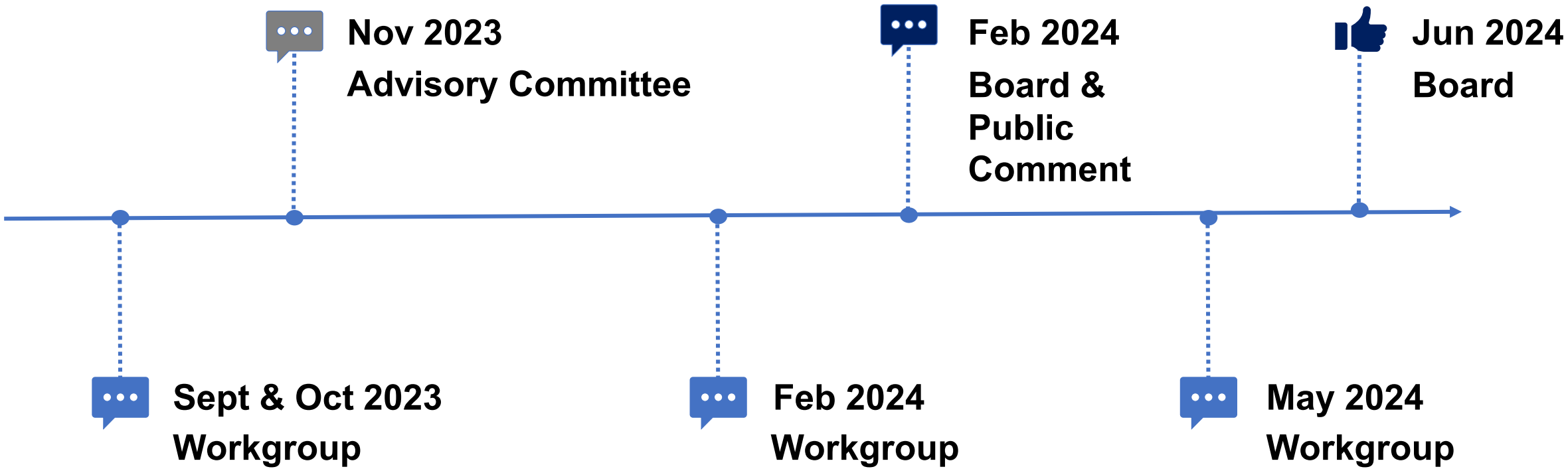
Refine Recommendations

Finalize or Approve Recommendations

Gain Input
(Investment & Payment Workgroup, Stakeholder Interviews, Sibling Departments)

Incorporate Feedback
(Board, Advisory Committee, Workgroup, Sibling Departments)

Timeline for APM Workstreams



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

APM Standards Recommendations

Standards for Alternative Payment Models

Additional Statutory Guidance for Standards

The standards for alternative payment models shall:

- Encourage and facilitate multi-payer participation and alignment
- Improve affordability, efficiency, equity, and quality by considering current best evidence for strategies such as quality-based or population-based payments
- Include minimum criteria for alternative payment models but be flexible enough to allow for innovation and evolution
- Align with the quality and equity measures used in the OHCA quality and equity measure set to the extent possible
- Address appropriate incentives to physicians and other providers and balancing measures, including total cost of care and quality, access, and equity to protect against perverse incentives and unintended consequences
- Attempt to reduce administrative burden by incorporating APMs that facilitate multi-payer participation and align with other state payers and programs or national models

Approach to APM Standards and Implementation Guidance

Standards

- Best practices to approach contracting decisions that are common across APMs
- Strategic, not tactical or prescriptive – not aiming to create an APM
- Grounded in evidence
- Not enforceable by OHCA

Implementation Guidance

- Technical assistance to supplement the standards
- Specific actions health care entities can take to meet the standard
- Examples of successful APM implementation related to the standard

Vision of APM Standards Success

Stakeholders Endorse

- Health care entities, purchasers commit to use standards to inform future contracting

Alignment Increases

- APMs become more aligned
- Standardization makes participation easier
- Barriers to adoption decrease

Performance Improves

- Standards result in increased APM adoption
- Performance on measures of quality, equity, and affordability improve

Advisory Committee Feedback Incorporated

- ✓ Specificity on improving affordability
- ✓ Detail on reducing patients' financial barriers for preventive services
- ✓ Emphasis on supporting a wide range of providers
- ✓ Addressing inequities in patient experience
- ✓ Technical assistance to support provider performance on metrics impacting payment

Draft APM Standards

1. **Use prospective, budget-based, and quality-linked payment models** that improve health, affordability, and equity.
2. **Implement payment models that improve affordability** for consumers and purchasers.
3. **Allocate spending upstream to primary care and other preventive services** to create lasting improvements in health, access, equity, and affordability.
4. **Be transparent** with providers in all aspects of payment model design and terms including attribution and performance measurement.
5. **Engage a wide range of providers** by offering payment models that appeal to entities with varying capabilities and appetites for risk, including small independent practices and historically under-resourced providers.

Draft APM Standards

6. **Collect demographic data**, including RELD-SOGI* data, to enable stratifying performance.
7. **Measure and stratify performance** to improve population health and address inequities.
8. **Invest in strategies to address inequities** in access, patient experience, and outcomes.
9. **Equip providers with accurate, actionable data** to inform population health management and enable their success in the model.
10. **Provide technical assistance** to support new entrants and other providers in successful APM adoption.

*Race, ethnicity, language, disability status (RELD), sex, sexual orientation and gender identity (SOGI).

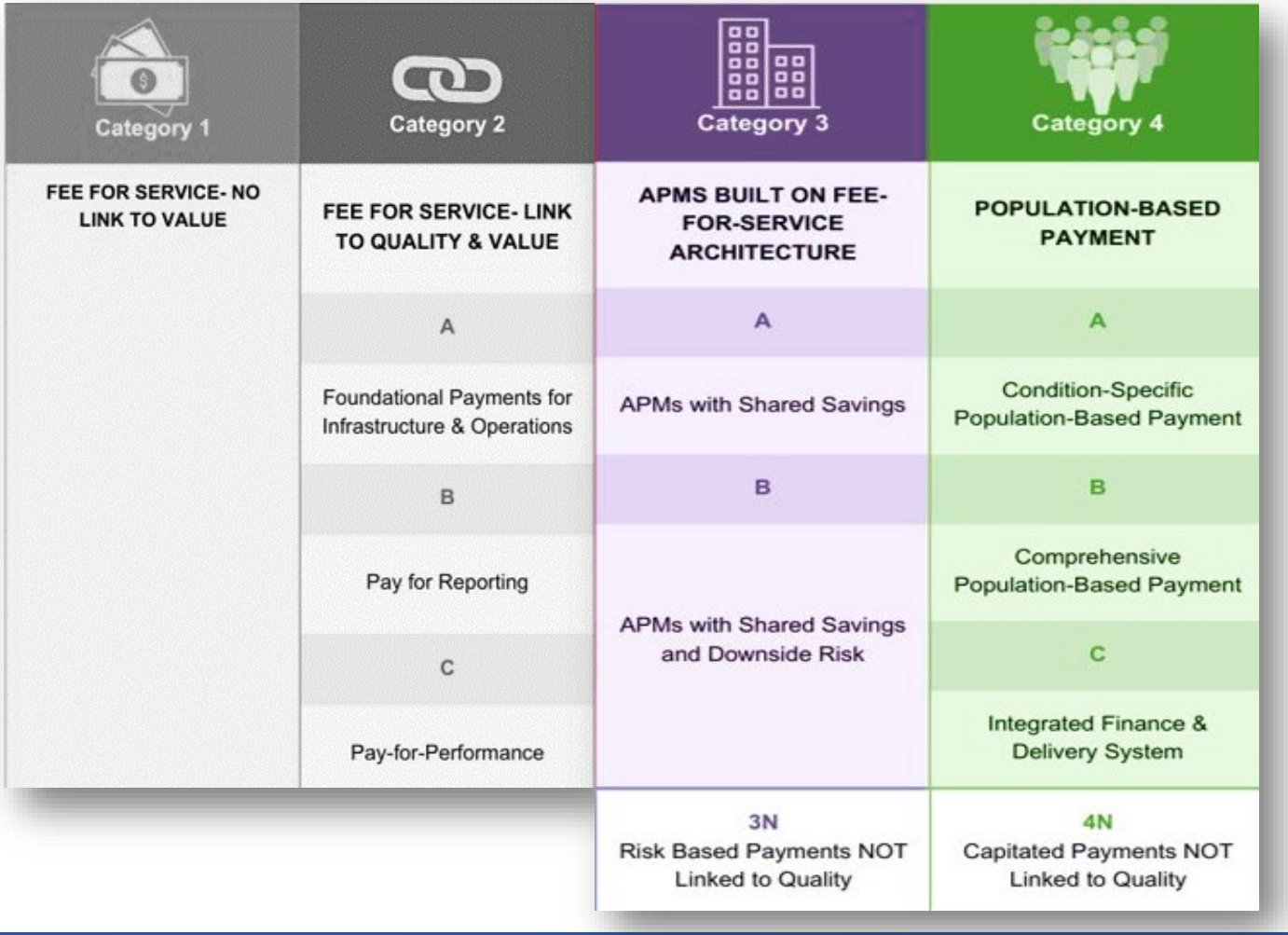
APM Adoption Goal Recommendations

Health Care Payment Learning and Action Network Framework

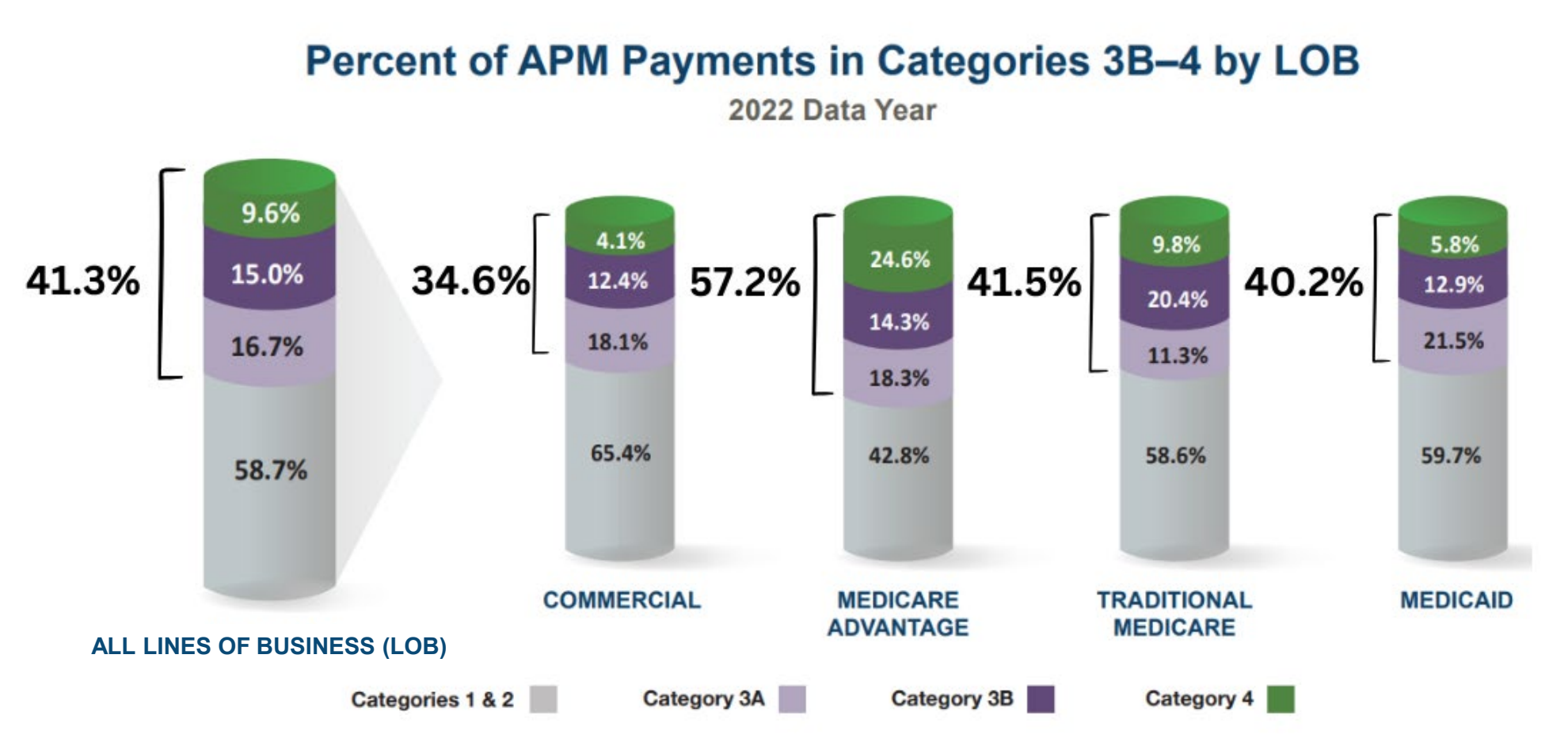
States, payers, and other stakeholders frequently use the HCP-LAN framework to measure APM adoption.

OHCA plans to collect data using the Expanded Framework for Non-Claims Payments (see appendix) and crosswalk to HCP-LAN.

Most APM adoption goals focus on Categories 3 and 4. Adoption is typically measured by the spend “flowing through” a contract with an APM, members attributed to APMs, or providers contracted under APMs.



APM Adoption Nationally



APM adoption nationally currently sits at 41% across HCP-LAN Categories 3 and 4.

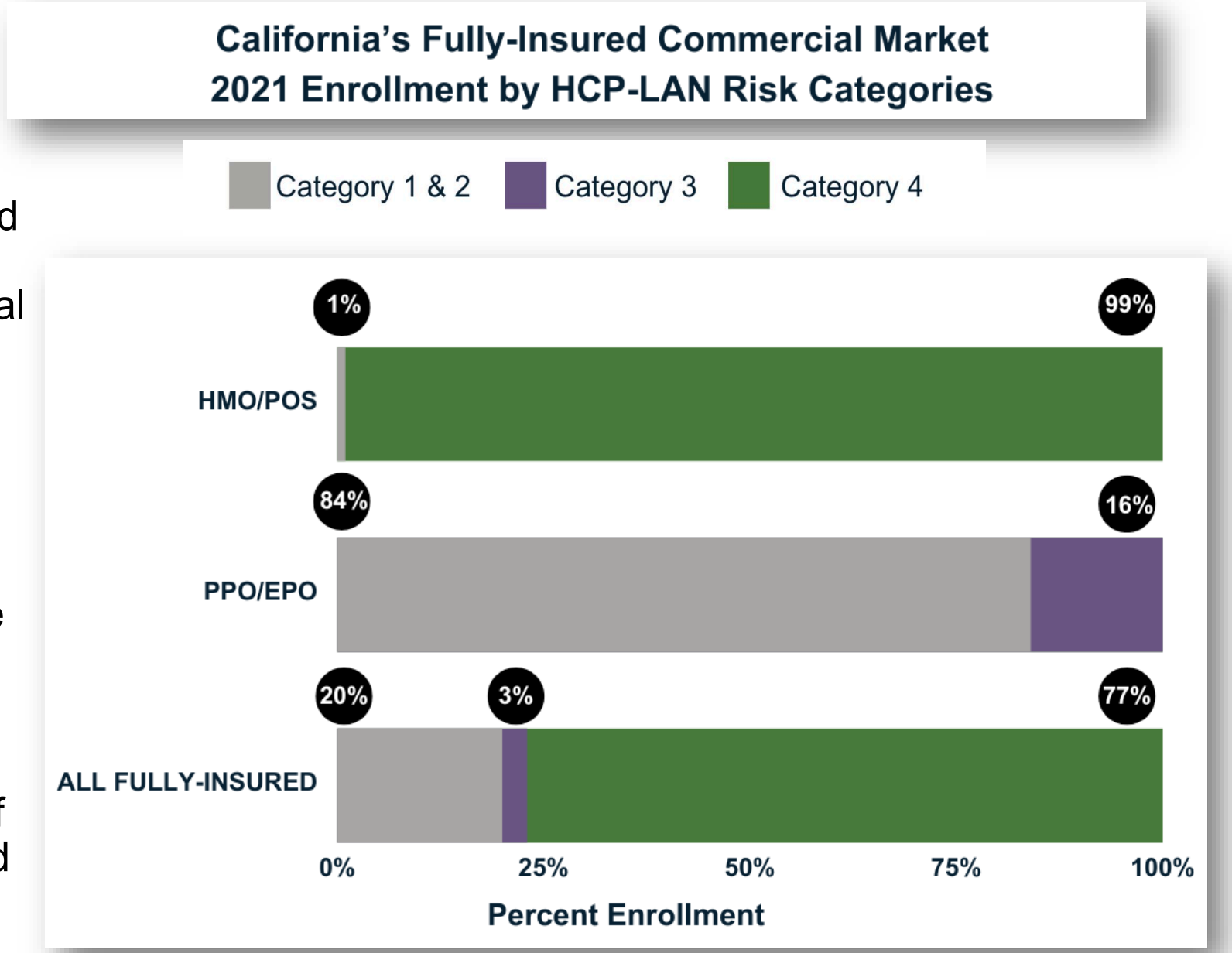
Adoption was virtually flat across payer types from 2021 to 2022.

Commercial APM Adoption in CA

APM adoption among the fully-insured population in California is more than 75 percent, far higher than commercial plans nationally. Adoption has been stable over the past five years.

The data are from IHA's [Health Care Cost & Quality Atlas | IHA]. These percentages are based on membership, but the percentages are similar whether using percent of members or percent of total dollars.

Based on informal conversations, OHCA anticipates most, but not all, of these APMs that would be considered "linked to quality."

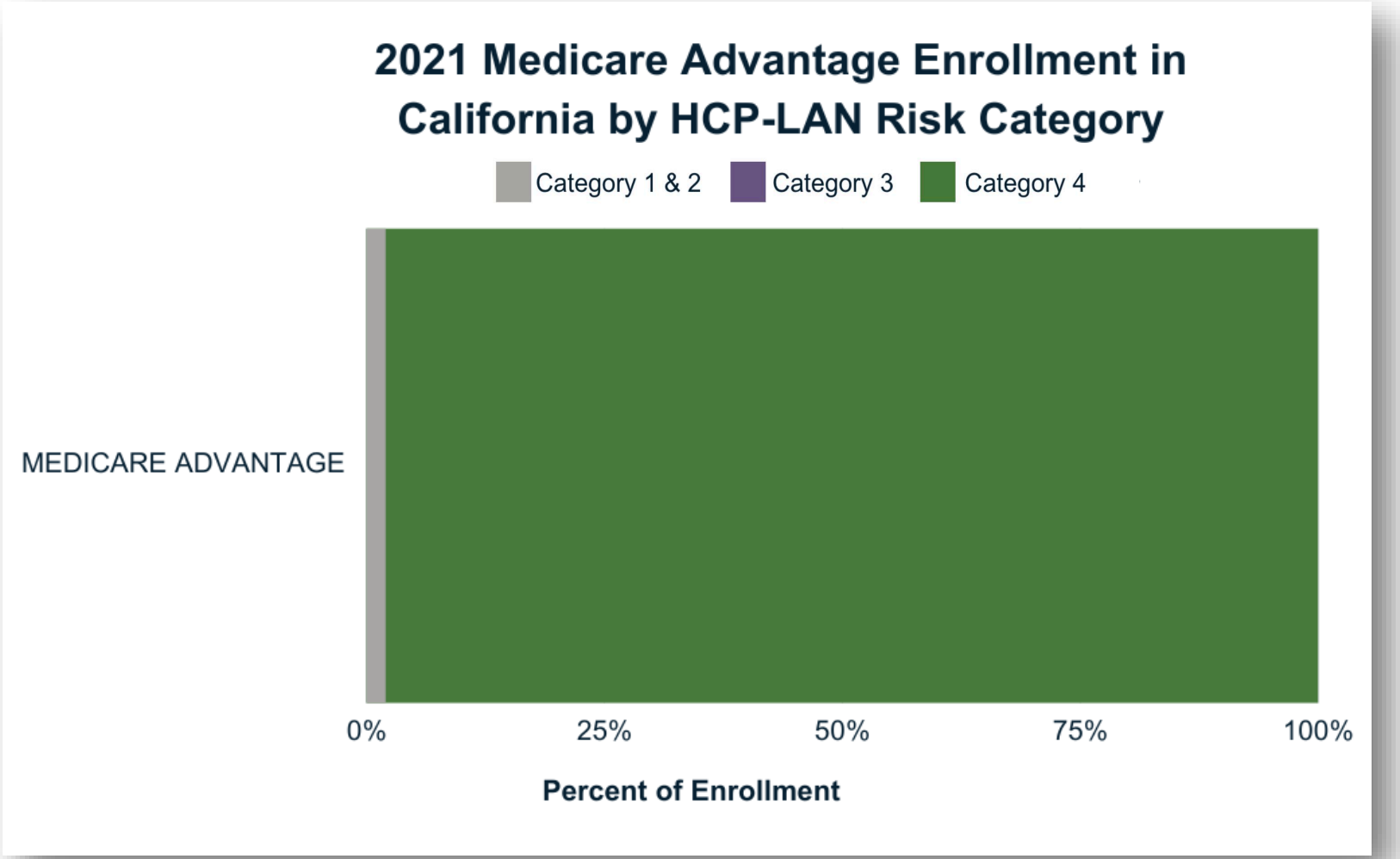


Medicare Advantage APM Adoption in CA

In 2021, just under half of California Medicare beneficiaries participated in Traditional Medicare. The rest were enrolled in a Medicare Advantage plan.

Of those California Medicare Advantage beneficiaries, almost all were enrolled in a risk arrangement in 2021.

Like commercial, OHCA anticipates most, but not all, of these arrangements would be considered “linked to quality.”



Achieving APM Adoption Goals in Traditional Medicare

Medicare Shared Savings Program

- Largest ACO initiative
- Permanent program
- Over 400k CA beneficiaries
- 2024 changes aim to increase enrollment, especially among new provider entrants

Realizing Equity, Access and Community Health

- New program (2023-2026); replaces Direct Contracting
- Professional or global risk
- Focus on health equity, particularly in underserved communities
- 2024 changes aim to improve predictability, risk adjustment and further health equity

CMS Goal: 100% of Traditional Medicare and Medicare Advantage in APM (HCP-LAN 3b or 4) by 2030

Centers for Medicare and Medicaid Services, 2023; Kaiser Family Foundation, 2023

Approach to APM Adoption Goal and Definitions

Definitions

- Define what payment models "count" towards APM Adoption Goal
- Utilize Expanded Framework for Non-Claims Payments (see appendix) categories and definitions for data collection – aligned with other data collection efforts at OHCA and HCAI

To support

Adoption Goal

- Promote shift from fee-for-service based payments to APMs
- Align financial incentives for equitable, high-quality, and cost-efficient care
- Progress towards Adoption Goal measured by OHCA, not enforceable
- Use Health Care Payment Learning and Action Network (HCP-LAN) framework to monitor progress toward goals
- Accountability through transparent public reporting

Strategic Decisions for Monitoring Progress Toward APM Adoption Goal

1. **Should only certain types of payment models count towards the APM adoption goal?**
   - HCP-LAN Category 3A (shared savings only; no downside risk) and above?
   - HCP-LAN Category 3 (APMs built on a fee-for-service architecture) models meeting a minimum level of shared savings/risk?
   - APMs linked to quality?
2. **Should goals vary by payer type (commercial, Medi-Cal, Medicare)? By product type (HMO, PPO)?**
3. **Should APM adoption goal be based on…?**
   - % of total health care spending
   - % of members
   - % non-claims payments
   - % of providers
4. **How should the goal be structured?**
   - a series of stairstep goals
   - a single absolute goal
   - a relative improvement goal

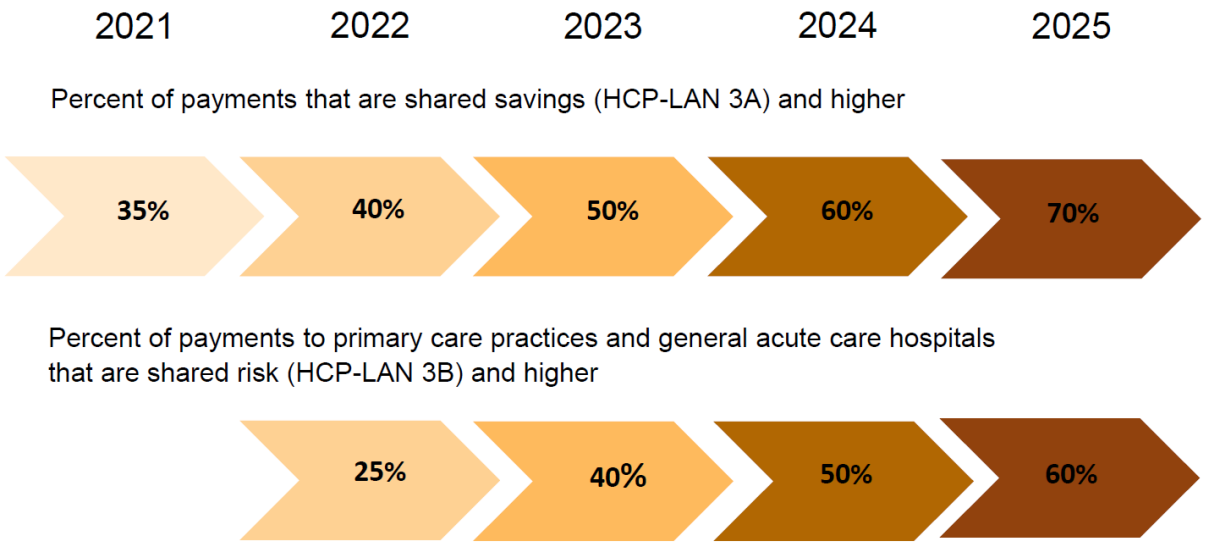
   } Can be layered

Example from California's Neighbor to the North

Oregon has made many of these same decisions in its designing of APM goals.

- Oregon limits the types of payment models that count towards the APM adoption goal.
- Oregon APM adoption goals do not vary by payer or product type.
- Oregon APM adoption goals are based on percent of total health care spending.
- Oregon includes a series of stairstep goals until 2025.

Revised Oregon VBP Compact targets



HCAI Department of Health Care Access and Information

Monitoring Progress Toward APM Adoption Goal

To count towards adoption goals, APMs must include:

Meaningful Risk Sharing: OHCA recommends that Category 3A and 3B APMs should be required to meet a minimum threshold for shared savings or shared risk. This requirement ensures that APM arrangements built on a fee-for-service architecture have tangible financial incentives or penalties contingent upon the provider's attainment of predefined spending and quality benchmarks.

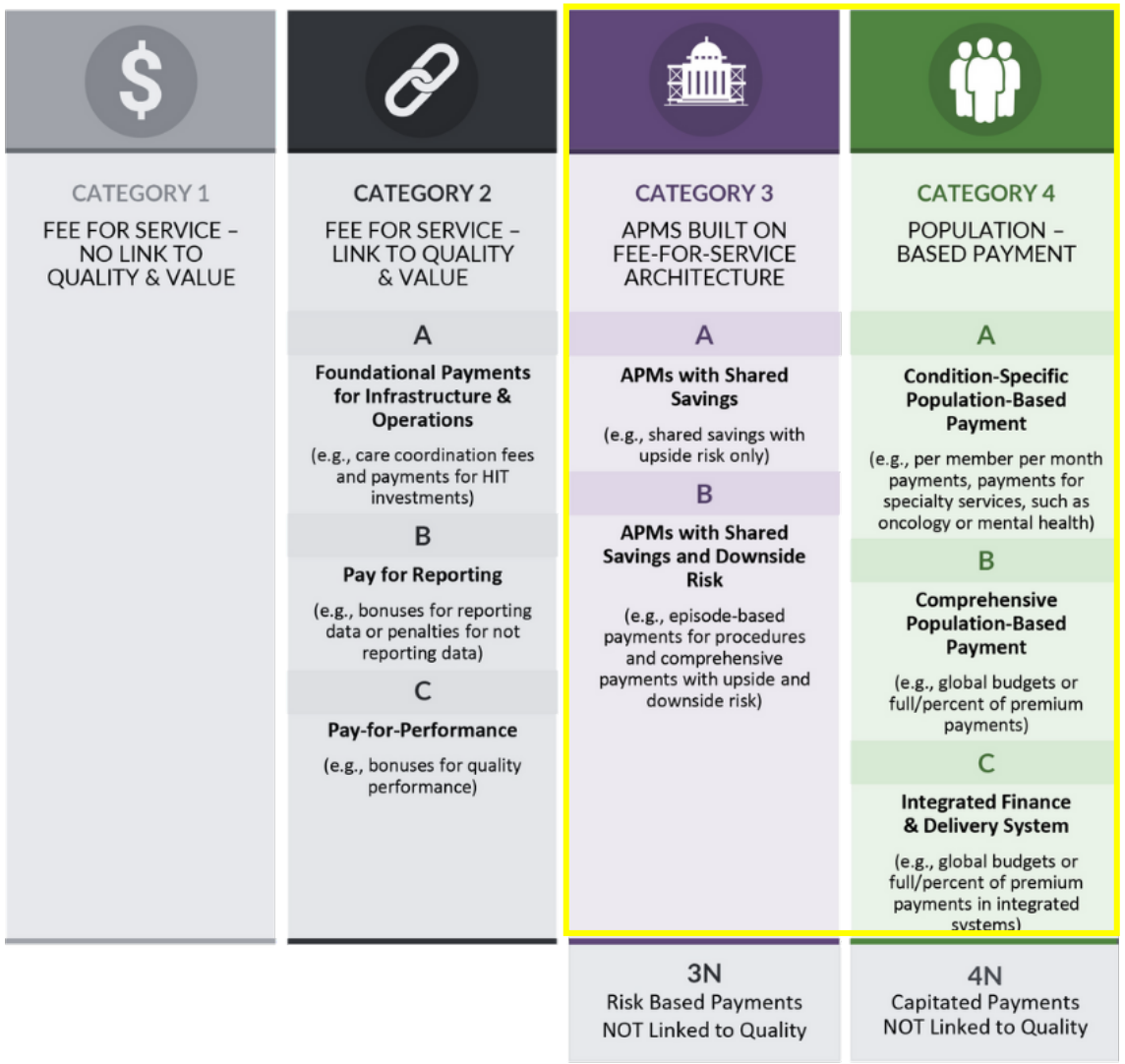
A Link to Quality: OHCA recommends defining payments as "linked to quality" if they involve potential for financial bonuses or penalties based on the provider's performance against predetermined quality benchmarks. This would exclude HCP-LAN Categories 3N and 4N (risk-based payments and capitation payments that are not linked to quality). This definition ensures that APM arrangements have a substantive connection between payments and quality outcomes.

Definitions and minimum thresholds included in Expanded Framework for Non-Claims Payments (see Appendix).

Monitoring Progress Toward APM Adoption Goal

The recommended APM Adoption Goal is based on the percent of members attributed to HCP-LAN Categories 3A, 3B, 4A, 4B, and 4C arrangements.

Only members enrolled in the highlighted payment arrangements count toward the goal.



Interim Milestones for Monitoring Progress towards APM Adoption Goal

Recommended Interim Milestones toward 75% APM Adoption Goal for Percent of Members Attributed to HCP-LAN Categories 3 and 4 by Payer Type				
	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	65%	35%	55%	55%
2028	70%	45%	60%	60%
2030	75%	55%	65%	65%
2032	75%	65%	70%	70%
2034	75%	75%	75%	75%

OHCA recommends using interim milestones in a stairstep structure to achieve the APM Adoption Goal by 2034.

This stairstep structure provides a path for each payer type to reach 75% percent of members attributed to HCP-LAN Categories 3 and 4 arrangements by 2034 while recognizing differences in starting places across payer types.

Draft APM Adoption Goal

OHCA recommends an APM Adoption Goal of 75% of members attributed to Health Care Payment Learning and Action Network (HCP-LAN) Categories 3 and 4 arrangements across payer types (Commercial, Medi-Cal, and Medicare Advantage) by 2034.

Next Steps

Now

- Board provides feedback on draft APM Standards and Adoption Goal
- OHCA solicits public comment on draft APM Standards and Adoption Goal

May 2024

- Investment and Payment Workgroup reviews Board and public comment feedback on draft APM Standards and Adoption Goal and discusses revisions
- OHCA revises draft APM Standards and Adoption Goal

June 2024

- OHCA seeks Board adoption of APM Standards and Adoption Goal

HCAi
Department of Health Care Access and Information

Public Comment

HCAi
Department of Health Care Access and Information

Measuring Consumer Affordability

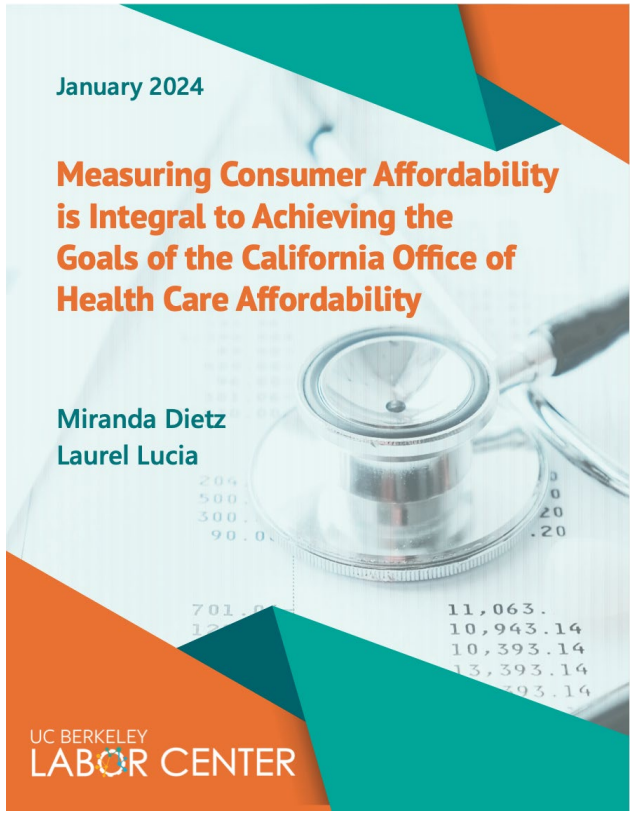
Vishaal Pegany
Miranda Dietz, Policy Research Specialist and Project Director for CalSIM
Laurel Lucia, Director of the Health Care Program, UC Berkeley Labor Center

Measuring Consumer Affordability

Miranda Dietz

Laurel Lucia

February 2024



Measuring consumer affordability is integral to achieving OHCA's goals

Statute defines this as part of OHCA's charge:

> *Developing a comprehensive strategy for cost containment in California, including measuring progress towards reducing the rate of growth in per capita total health care spending and ultimately lowering consumer spending on premiums and out-of-pocket costs, while maintaining quality, access, and equity of care, as well as promoting workforce stability and maintaining high-quality health care jobs* *§ 127500.5(o)*

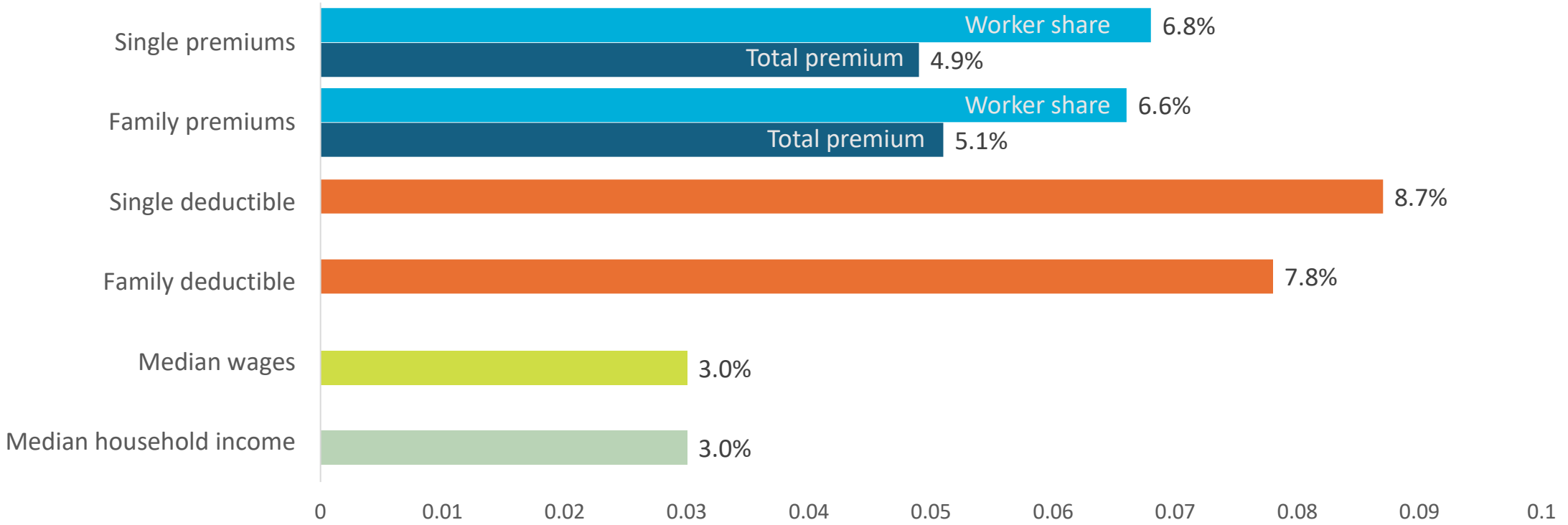
- Affordability measures should be part of the baseline annual report in 2025 and every report thereafter

Source: California Health and Safety Code § 127500.5(o)(1)

Consumer affordability has deteriorated over the last 20 years

Premiums and deductibles have grown faster than wages and incomes

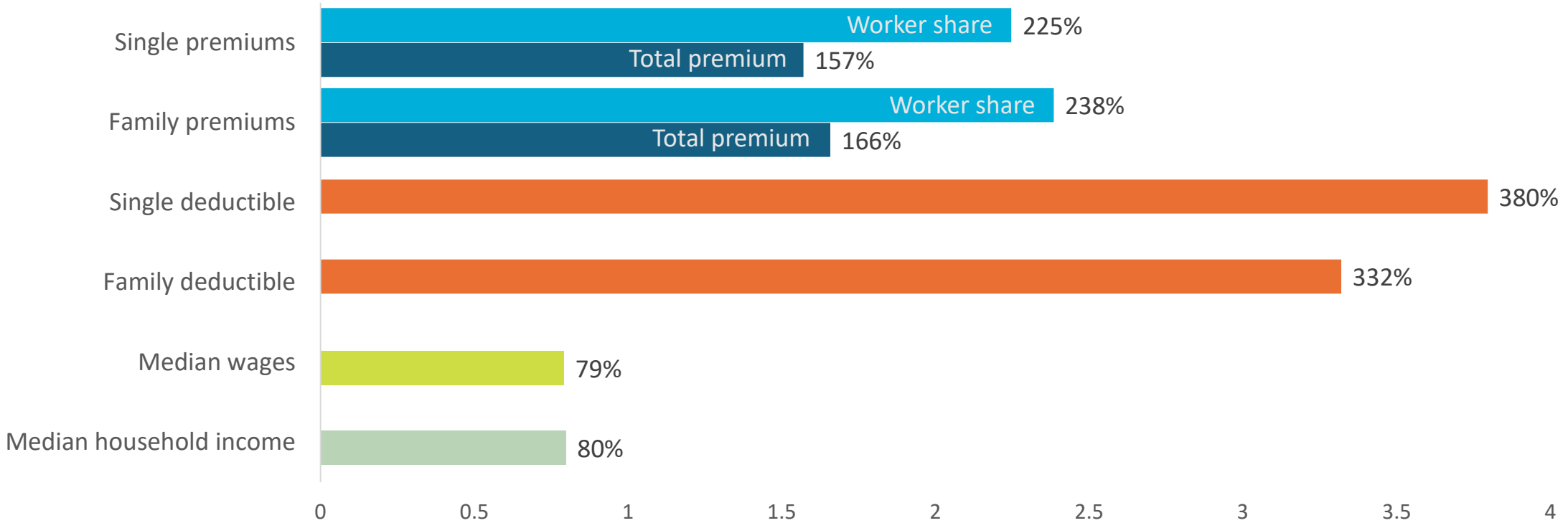
Average annual growth rates for premiums and deductibles for private-sector workers; median wages; and median household income in California, 2002-2022



Source: MEPS-IC California 2002-2022; US Census Current Population Survey

Faster growth in premiums and deductibles adds up over 20 years

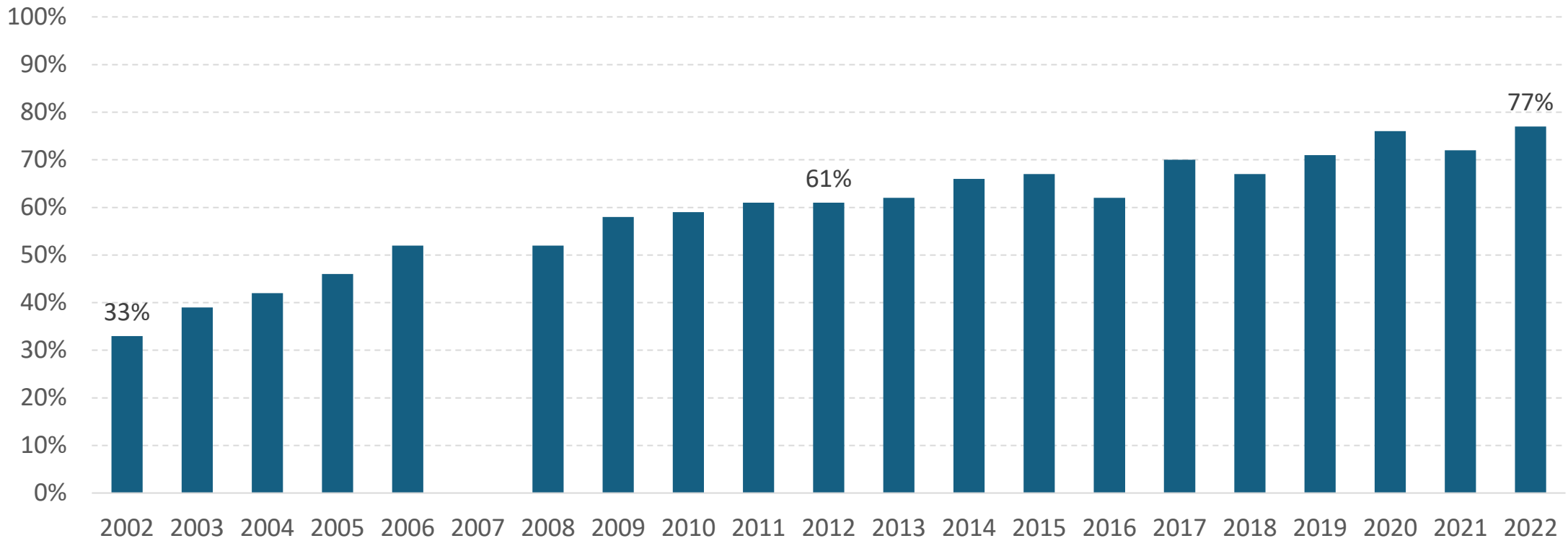
Cumulative growth for premiums and deductibles for private-sector workers; median wages; and median household income in California, 2002-2022



Source: MEPS-IC California 2002-2022; US Census Current Population Survey

Deductibles are increasingly common

Share of private-sector workers enrolled in coverage with deductibles in California, 2002-2022

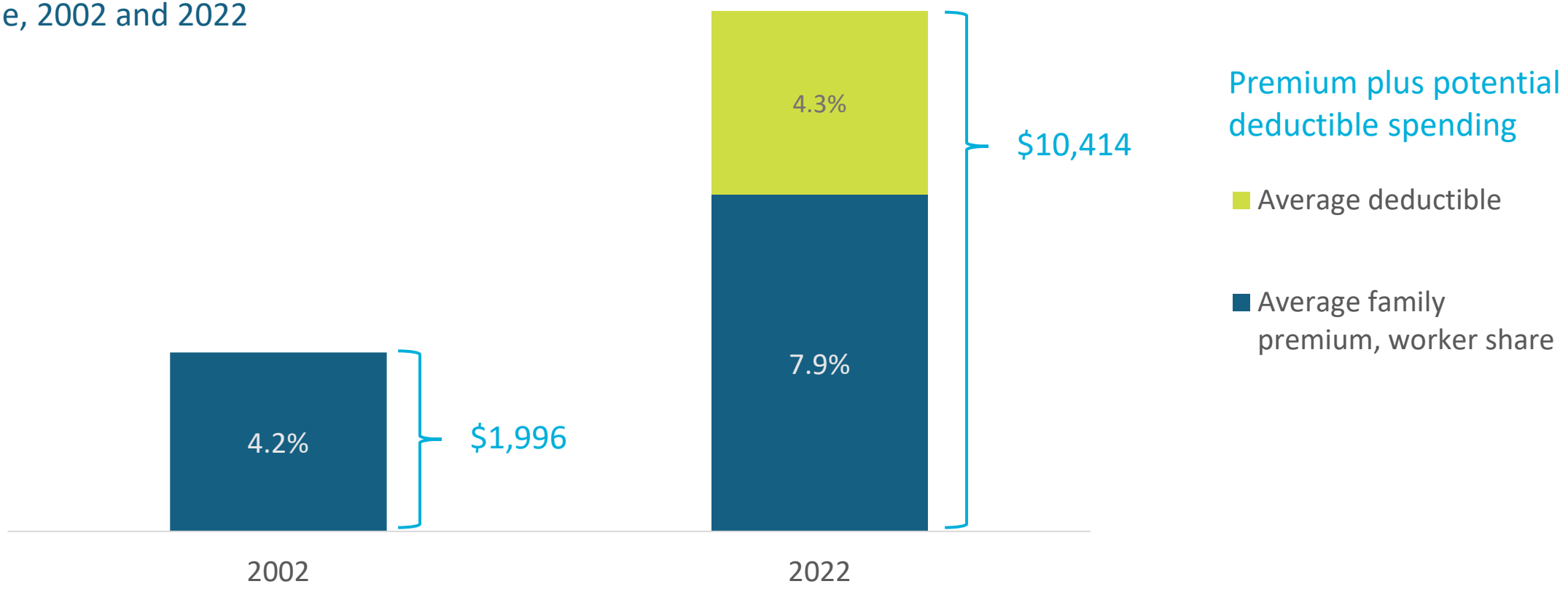


UC BERKELEY LABOR CENTER

Source: MEPS-IC California 2002-2022 (no data available for 2007)

Health care takes up an increasing share of household budgets

Typical private-sector family coverage premium and potential deductible spending as a share of median household income, 2002 and 2022

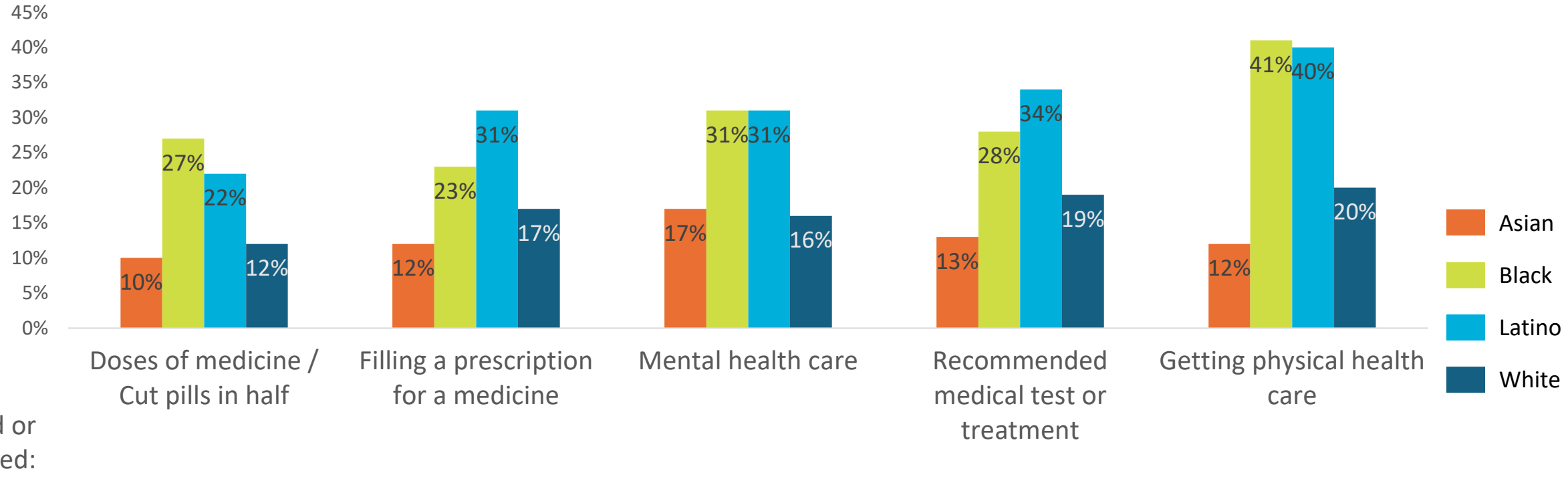


UC BERKELEY LABOR CENTER

Source: Current Population Survey; MEPS-IC California 2002, 2022
Note: Typical plans in 2002 did not have a deductible; 33% of private-sector enrollees did have a deductible, and the average amount was $847 or 1.8% of median household income in that year. By 2022, 77% of private-sector worker enrollees had a deductible

High health care costs are a barrier to care; delays are most common for Latino and Black Californians

Share of California adults reporting that they or a family member skipped or delayed the following in the past 12 months due to cost, by race/ethnicity (2022)



Delayed or skipped:

Source: CHCF California Health Policy Survey, 2023

How OHCA can measure consumer affordability

How will we know if OHCA is having an impact for California consumers?

OHCA should track multiple consumer affordability measures in the following categories:

Cost of coverage	Cost of accessing care	Health and financial consequences
• Premiums • Offer rates • Take up rates	• Deductibles • Copays • Max out-of-pocket • Actual out-of-pocket • Actuarial value	• Skipped or delayed care • Trouble paying medical bills • Medical debt

Equity measures

Administrative and survey data are needed

Administrative data

- Can be used for year-over-year comparisons

- Department of Managed Health Care data for fully-insured plans
- OHCA THCE data

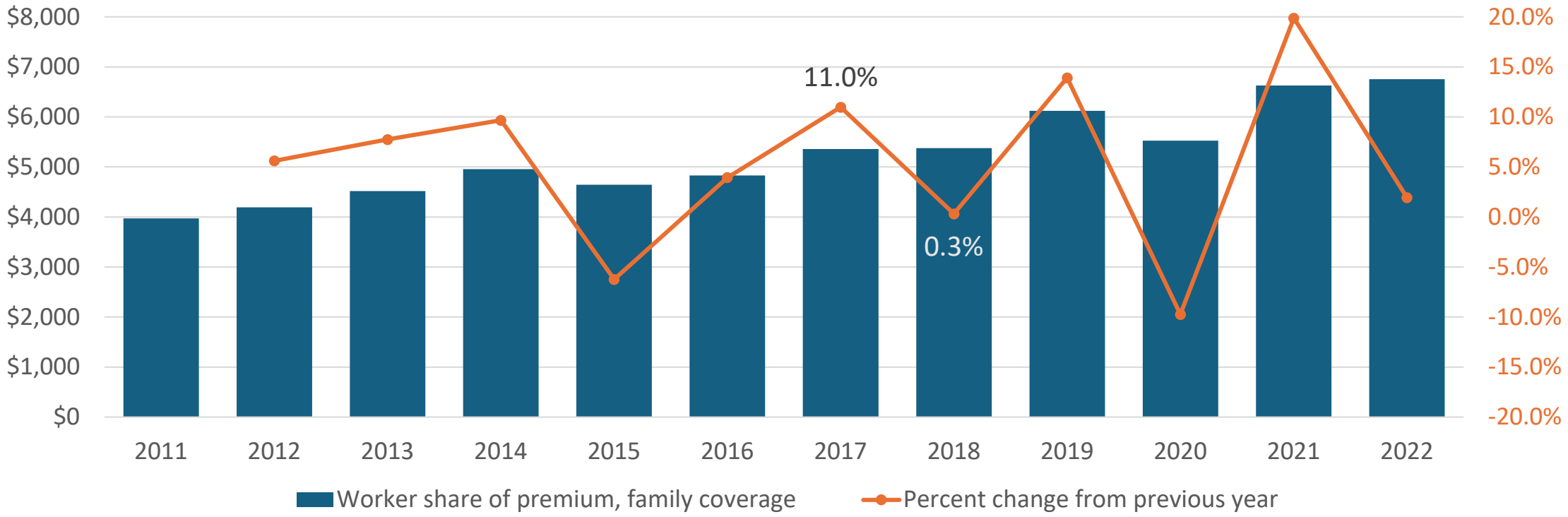
Survey data

- Track longer-term trends
- Useful for monitoring equity
- Only source currently for tracking health and financial consequences

- Medical Expenditure Panel Survey-Insurance Component
- CHCF Health Policy Survey
- Others as needed

Survey data can be volatile year-over-year but shows longer term trends

Average worker premium contribution for family coverage and percent change from previous year covered workers in private sector establishments in California 2011-2022



Source: MEPS-IC California 2011-2022

Administrative data: Premiums and out-of-pocket costs

	2022-2023 Change	Source
Premiums (average per member per month)		
Large group	+6.8%	DMHC
Small group	+7.1%	DMHC
Individual market	+5.6%	DMHC
Consumer out-of-pocket spending (average per member per month)		
Commercial market	__ %	OHCA**

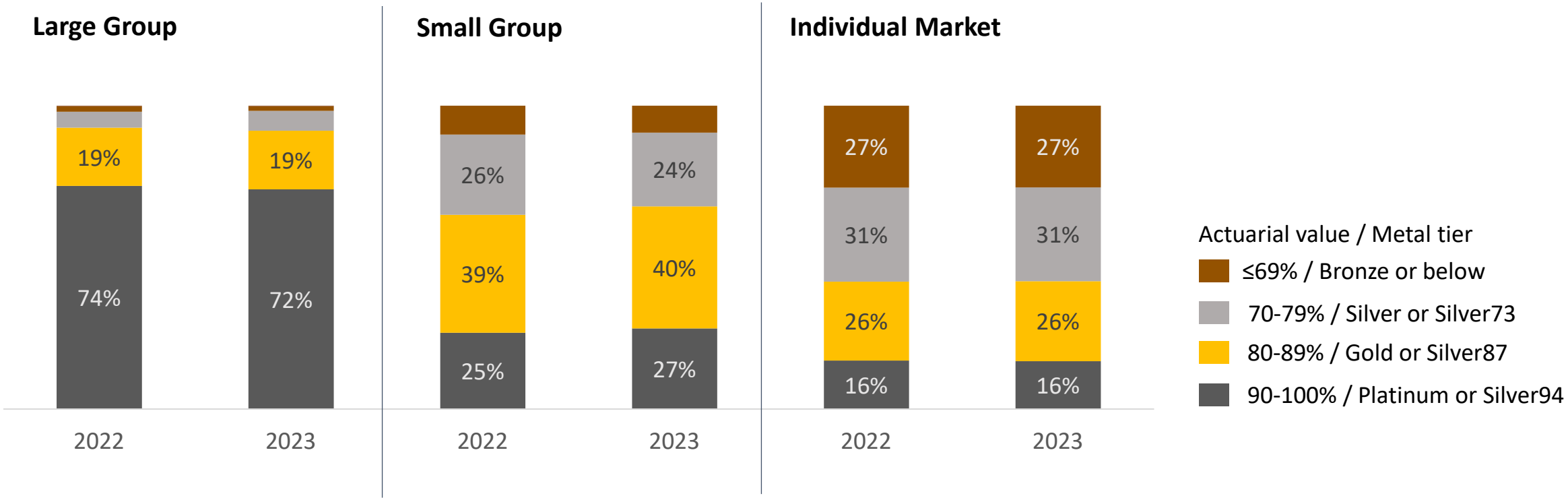
** OHCA data is not yet collected

UC BERKELEY LABOR CENTER

Source: Department of Managed Health Care Annual Aggregate Rate Reports
Note: Large group shows DMHC's calculation of the adjusted average rate increase, reflecting aggregate changes in benefit designs, cost sharing, provider network, geographic rating region, and average age. Small group and individual market show the weighted average rate increase.

Administrative data: Actuarial value

Actuarial value (average share of medical expenses that the plan will pay) by market

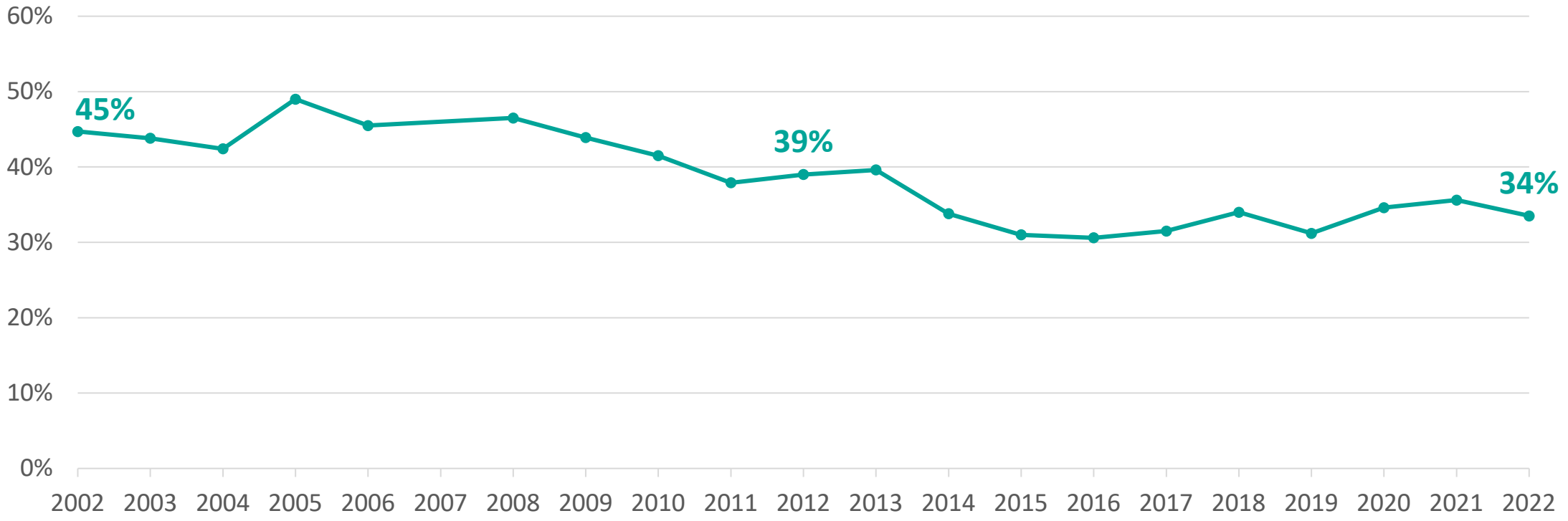


UC BERKELEY LABOR CENTER

Source: Department of Managed Health Care Annual Aggregate Rate Reports
Individual market actuarial value data is supplemented by data from Covered California Active Member Profiles for June 2021, 2022, 2023; ”Platinum” includes Silver94 plans and “Gold” includes Silver87 plans.

Survey data: cost of coverage
Offer rate among small businesses has declined

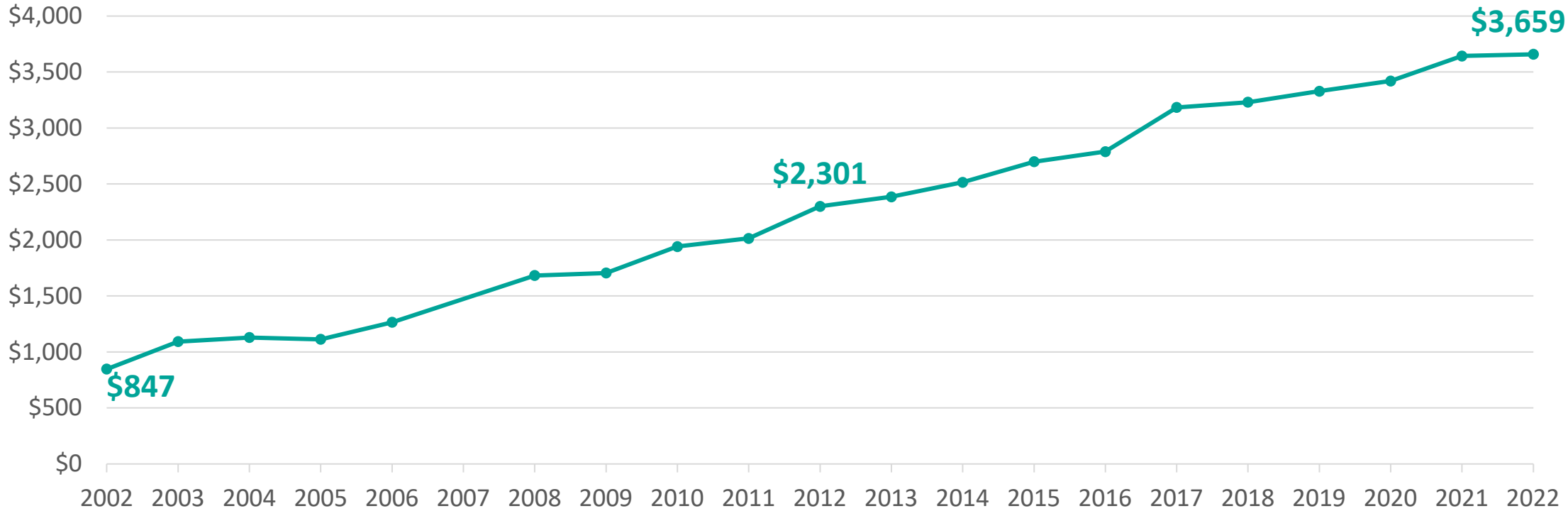
Share of California private-sector establishments with fewer than 50 employees that offer health insurance, 2002-2022



Source: MEPS-IC California 2002-2022

Survey data: cost of care
Family deductible amounts have increased

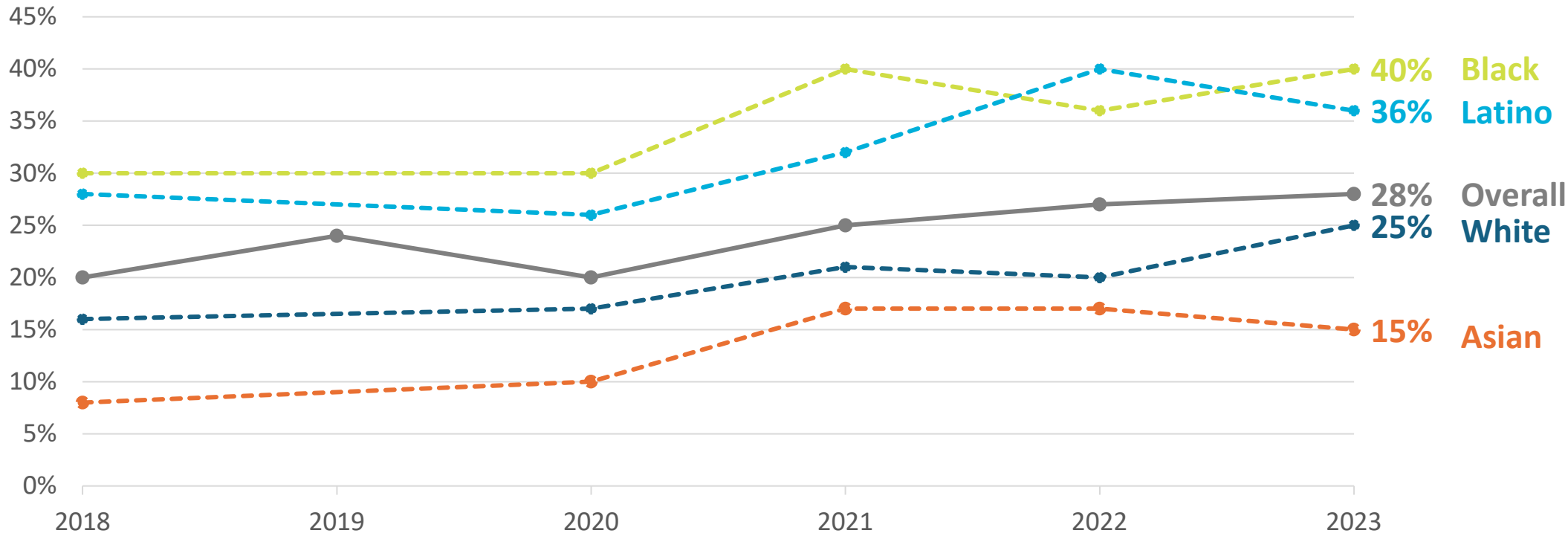
Average family deductible (among family plans with a deductible) for enrollees at California private-sector establishments, 2002 to 2022



Source: MEPS-IC California 2002-2022

Survey data: health and financial consequences
Black and Latino Californians are more likely to report trouble paying for medical bills

Share of California adults who say they or anyone in their family had trouble paying any medical bills in the past 12 months by race/ethnicity, 2018-2023



Source: CHCF California Health Policy Surveys, 2019-24

Proposed consumer affordability measures

☑ Available
❑ Unavailable currently

	Cost of coverage	Cost of accessing care	Health and Financial Consequences
Administrative data for annual assessment	☑ Total premium	☑ Consumer responsibility portion of total health care expenditures ☑ Actuarial value	
Survey data for longer-term monitoring	☑ Worker share of premium ☑ Offer rate by firm size ☑ Take up rate among eligible workers	☑ Deductible ☑ Maximum out-of-pocket ☑ Copays for office and specialist visits	☑ Skipping / delaying care due to cost ☑ Trouble paying medical bills ☑ Prevalence of medical debt
Survey data for equity impacts	❑ Premium by race/ethnicity and income	❑ Deductible by race/ethnicity and income	☑ All of the above by race/ethnicity and income

Other data needs

- As OHCA gains experience monitoring trends, other data needs will likely arise
- Data to explore include:
  - Premium and deductible data by race/ethnicity and income
  - Geographic variation
  - New possibilities for measures using the Health Payments Database

Miranda Dietz
miranda.dietz@berkeley.edu

Laurel Lucia
laurel.lucia@berkeley.edu

The report *Measuring Consumer Affordability is Integral to Achieving the Goals of the California Office of Health Care Affordability* is available at *https://laborcenter.berkeley.edu/measuring-consumer-affordability/*

HCAi
Department of Health Care Access and Information

Public Comment

HCAi
Department of Health Care Access and Information

Measuring Out-of-Plan Spend

Vishaal Pegany
CJ Howard
KeriAnn La Spina, Senior Health Researcher, Mathematica

Definitions

Cost sharing
Member's financial responsibility including copay, coinsurance, and deductibles

+

Out-of-plan spending
Costs for services not covered by insurance & costs paid outside insurance

=

Total out-of-pocket spending*

Included in OHCA THCE

Not included in OHCA THCE

* Consumers may also pay premiums, but these costs are not included in our definition of out-of-pocket spending.

Why Measure Out-of-Plan Spending?

- The Board and Advisory raised concerns that OHCA's Total Health Care Expenditures (THCE) measure does not include out-of-plan spending.
- Some possible reasons out-of-plan spending include:
  - **Provider Preferences for Cash Payments:** Recent research suggests that a growing portion of behavioral health providers do not accept insurance, and that fewer psychiatrists accept insurance compared to other specialties.
  - **Barriers to Accessing Providers/Convenience:** Many patients struggle to find in-network providers, especially behavioral health providers, due in part to provider and prescriber shortages and delays in getting appointments.
  - **Changes in Benefit Design:** Changes in benefit design and covered services could compel more patients to seek out-of-plan care.

- Fewer providers accepting insurance reduces access to care for those unable/unwilling to self-pay and may introduce inequities in access to and quality of care.
- To shed light on the scope of this problem and its implications for potential public policy, OHCA proposes a supplemental analysis to estimate out-of-plan spending,

Sources: Bishop, Tara et al. (2014 February). *Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care*. JAMA Network.; National Alliance on Mental Illness. (2016 November). *Out-of-Network, Out-of-Pocket, Out-of-Options: The Unfulfilled Promise of Parity.;* Benjenk, I., Chen, J. (15, July 2020). *Trends in Self-payment for Outpatient Psychiatrist visits*. JAMA Psychiatry.

Estimating Out-of-Plan Spending Using the Medical Expenditure Panel Survey

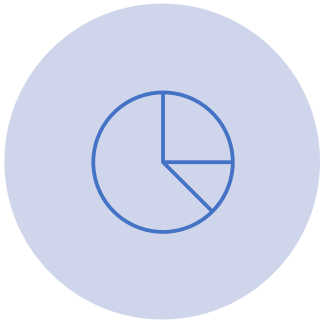
- The Medical Expenditure Panel Survey Household Component (MEPS-HC) is a nationally representative sample of the civilian noninstitutionalized population
- It includes information from consumers on health insurance coverage and healthcare utilization and costs, including out-of-pocket spending:
  - Spending in the MEPS-HC is defined for each medical event (office visit, inpatient stay, outpatient visit, etc.)
  - For each event, data shows spending by private insurance, public programs, and self-pay (out-of-pocket)
  - Each event includes type of provider, diagnosis codes, and procedure codes
- Allows for the generation of California-specific estimates, but may need to pool years to produce reliable results
- MEPS-HC out-of-pocket spending variable includes but does not differentiate payment for out-of-plan events
- OHCA will build decision rules to estimate the portion of MEPS out-of-pocket spending allocated to out-of-plan events
- OHCA is developing a methodology to estimate out-of-plan spending based on payment source and timing of medical events in MEPS-HC data.

Example of Analysis: MEPS-HC and Behavioral Health Spending

What can we measure?

- MEPS-HC can be used to estimate:
  - Out-of-plan spending for behavioral health services,
  - Out-of-plan spending for other service types
  - Out-of-plan spending as a percentage of total behavioral health spending
- The types of research questions we aim to answer:

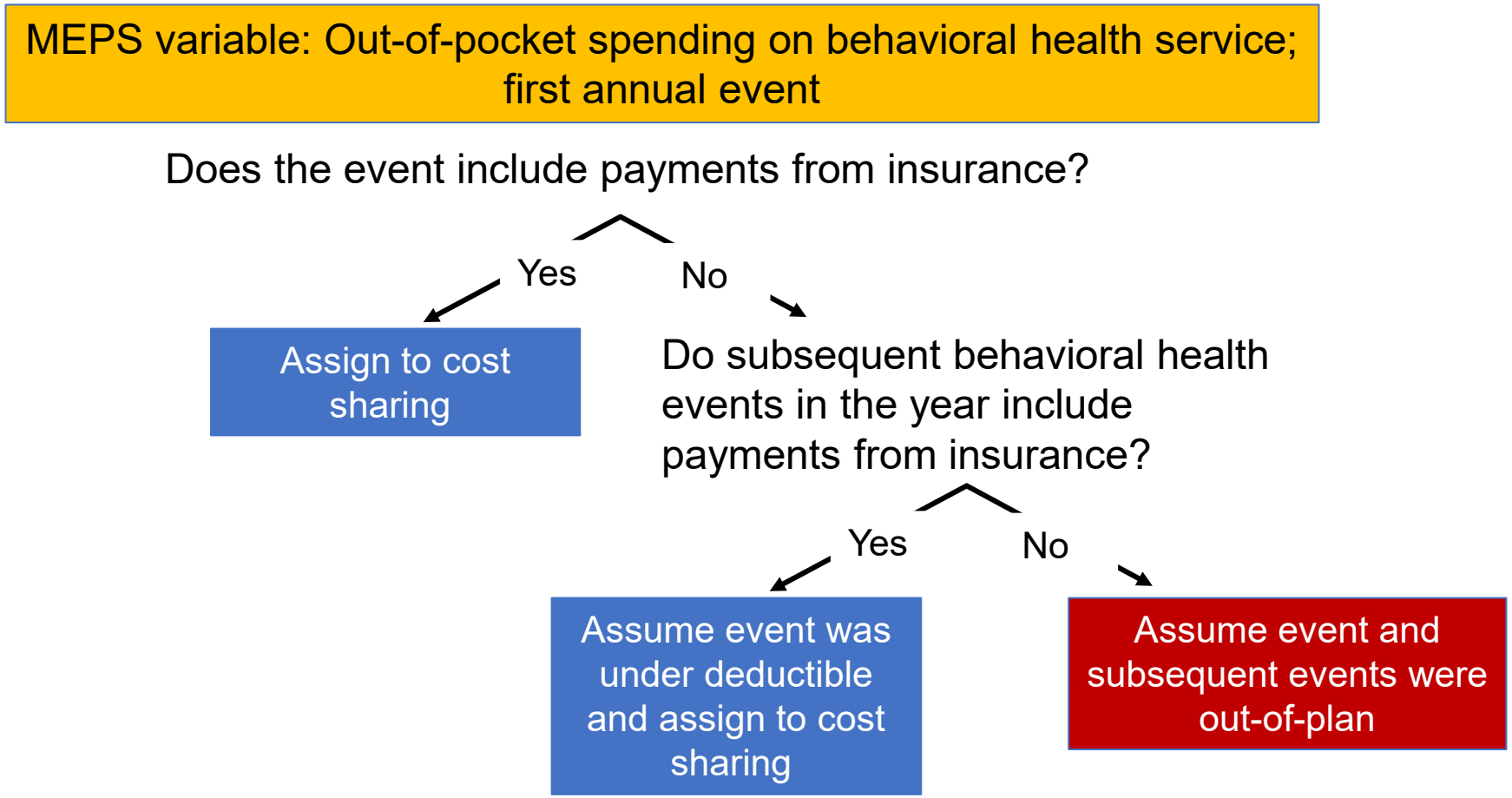
What is the level and change in out-of-plan spending for behavioral health services over time in California?



How much are Californians spending out-of-plan on behavioral health conditions compared with other types of services?

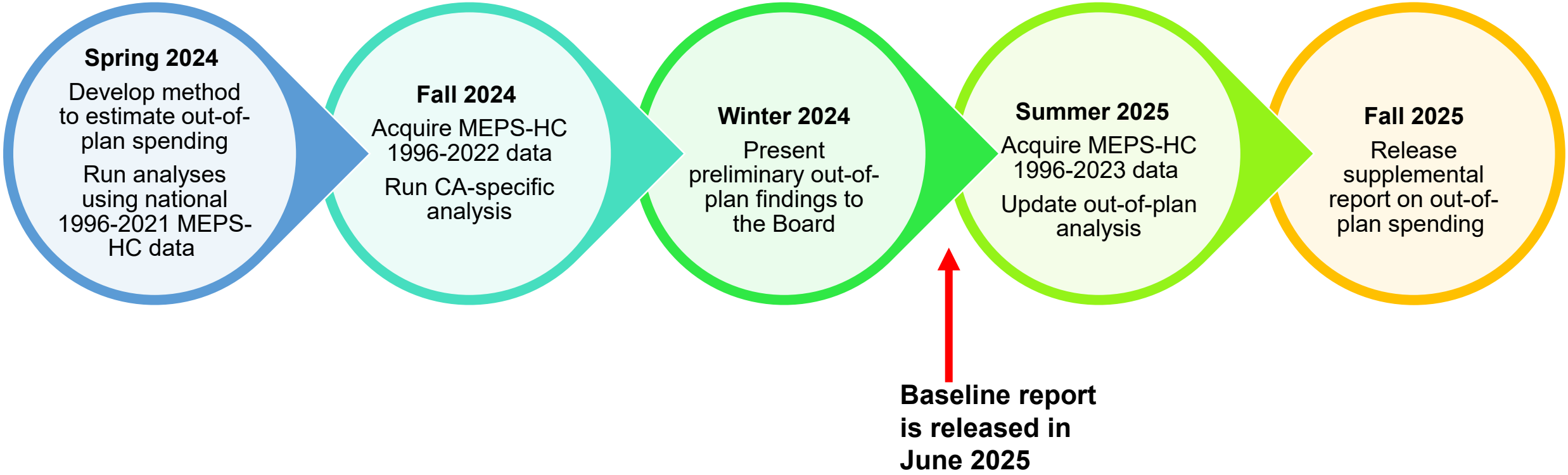
How Can We Estimate These Costs?

Example: Estimating out-of-plan behavioral health spending



Note: Method to estimate out-of-plan events still in development.

Timeline for Measuring Out-of-Plan Spending



HCAi
Department of Health Care Access and Information

Public Comment

HCAi
Department of Health Care Access and Information

General Public Comment

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

Next Board Meeting:

March 25, 2024
10:00 a.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

HCAi
Department of Health Care Access and Information

Adjournment

HCAi
Department of Health Care Access and Information

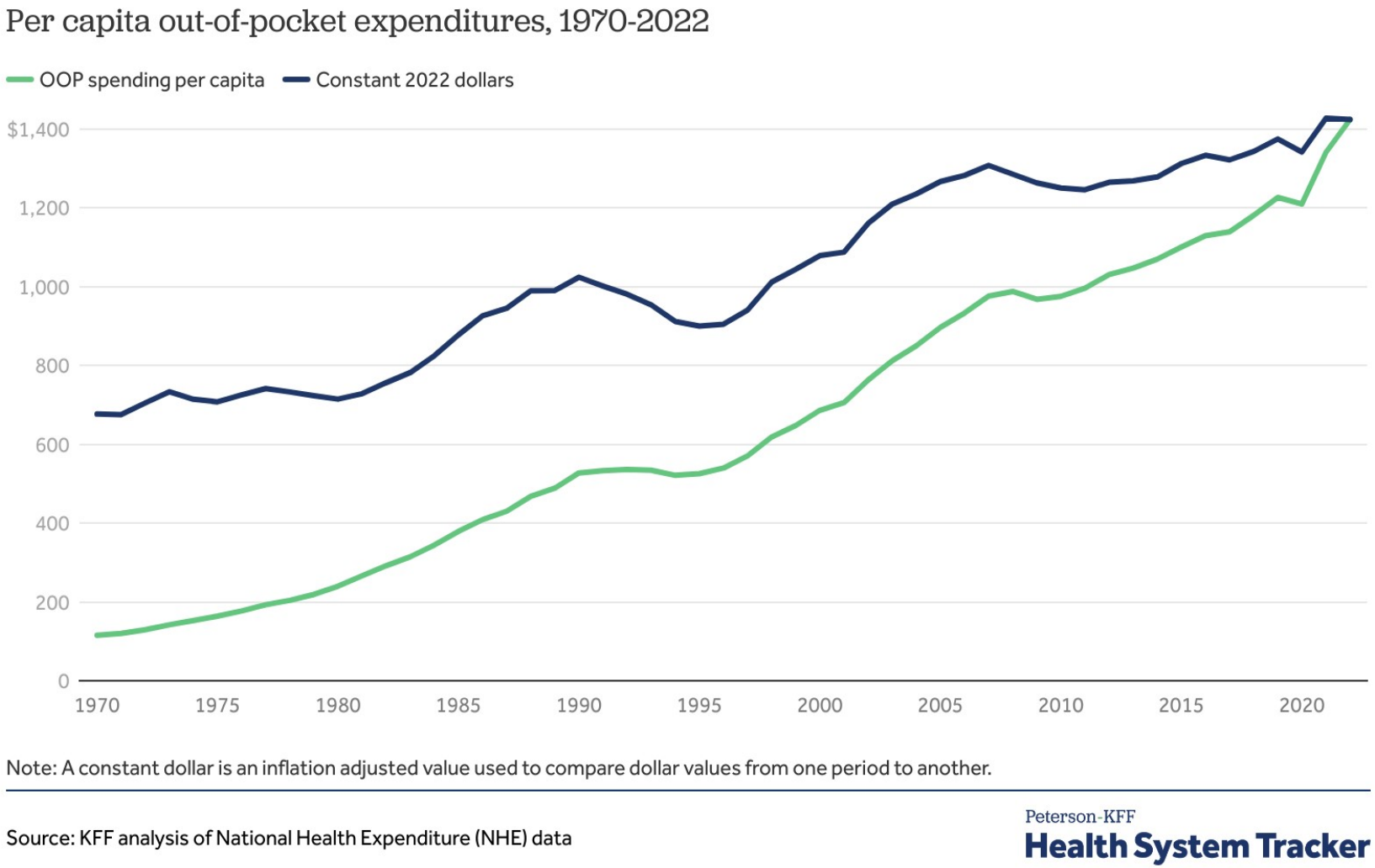
Appendix

References for Key Findings: Effects of Premiums and Spending, Adverse Health Events

- Baicker, K. & Chandra, A. (2005 February). “The Labor Market Effects of Rising Health Insurance Premiums.” National Bureau of Economic Research. https://www.nber.org/papers/w11160
- Goldman, D., Sood, N., & Leibowitz, A. (2005 January). “Wage and Benefit Changes in Response to Rising Health Insurance Costs.” National Bureau of Economic Research. https://www.nber.org/papers/w11063
- Brot-Goldberg, Z., Cooper, Z., Craig, S., Klarnet, L. & Lurie, I. (2022 December). “Who Bears the Burden of Rising Health Care Spending in the US?” Institution for Social and Policy Studies, Yale University. https://isps.yale.edu/sites/default/files/publication/2022/12/cooperisps22-38_whobearstheburden_abstract.pdf (presented at NBER Spring 2023; https://www.nber.org/conferences/public-economics-program-meeting-spring-2023)
- Hager, K., Emanuel, E., & Mozaffarian, D. (2024 January). “Employer-Sponsored Health Insurance Premium Cost Growth and Its Associate with Earnings Inequality Among US Families. JAMA Network Open. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2813927
- Antwi Y. & Maclean, J. (2017 February). "State Health Insurance Mandates and Labor Market Outcomes: New Evidence on Old Questions." National Bureau of Economic Research. https://www.nber.org/papers/w23203
- Grabowski, D. Anuraag, K, & Goldman, D. (2023 May). “Assessment of Medical and Public Assistance Expenditures and Employment Among US Adults with Cancer Diagnoses.” JAMA Network Open. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2805325
- Anand, P., Dague, L. & Wagner, K. (2021 May). “The Role of Paid Family Leave in Labor Supply Responses to a Spouse’s Disability or Health Shock.” National Bureau of Economic Research. https://www.nber.org/papers/w28808
- Dobkin, C., Finkelstein, A., Kluender, R. & Notowidigdo, M. (2018 February). “The Economic Consequences of Hospital Admissions.” American Economic Review. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5809140/
- Powell, D. & Seabury, S. (2018 October). “Medical Care Spending and Labor Market Outcomes: Evidence from Worker’s Compensation Reforms.” American Economic Review. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6166442/
- Meyer, B. & Mok. W. (2013 March). “Disability, Earnings, Income and Consumption.” National Bureau of Economic Research. https://www.nber.org/papers/w18869
- De Nardi, M., French, E., & Jones, J. (2006 October). “Differential Mortality, Uncertain Medical Expenses, and the Saving of Elderly Singles.” National Bureau of Economic Research. https://www.nber.org/papers/w12554
- Kolstad, J. & Kowalski, A. (2012 March). "Mandate-Based Health Reform and the Labor Market: Evidence from the Massachusetts Reform." National Bureau of Economic Research. https://www.nber.org/papers/w17933
- Cowan, B. & Schwab, B. (2016 January). "Employer-Sponsored Health Insurance and the Gender Gap." Journal of Health Economics. https://www.sciencedirect.com/science/article/abs/pii/S0167629615001095
- Anand, P. (2017 December). "Health Insurance Costs and Employee Compensation: Evidence from the National Compensation Survey." Health Economics. https://pubmed.ncbi.nlm.nih.gov/28026085/
- Arnold, D. & Whaley, C. (2020 July). "Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages." SSRN. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3657598

Growing Out-of-Pocket Costs in the U.S.

- Out-of-pocket spending in the U.S. has increased substantially over the past 42 years
  - It "increased by **6.6%** to **$471.4 billion** in 2022, or 11% of total national health expenditure (NHE)" (NHE Fact Sheet)*
  - Cost-sharing, as presented by increasing deductibles for covered workers, has also increased since 2006, from **$303** to **$1,568 (**KFF Employer Health Benefits Survey)
- Out-of-pocket costs are mainly driven by durable medical equipment, outpatient services, dental services, long-term services and support, and prescription drugs (U.S. Health Care Coverage and Spending)



* Includes both insured and uninsured individuals.

Expanded Framework for Non-Claims Payments

Expanded Framework, Categories 1-3

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
1	**Population Health and Practice Infrastructure Payments**	
a	Care management/care coordination/population health/medication reconciliation	2A
b	Primary care and behavioral health integration	2A
c	Social care integration	2A
d	Practice transformation payments	2A
e	EHR/HIT infrastructure and other data analytics payments	2A
2	**Performance Payments**	
a	Retrospective/prospective incentive payments: pay-for-reporting	2B
b	Retrospective/prospective incentive payments: pay-for-performance	2C
3	**Payments with Shared Savings and Recoupments**	
a	Procedure-related, episode-based payments with shared savings	3A
b	Procedure-related, episode-based payments with risk of recoupments	3B
c	Condition-related, episode-based payments with shared savings	3A
d	Condition-related, episode-based payments with risk of recoupments	3B
e	Risk for total cost of care (e.g., ACO) with shared savings	3A
f	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B

Freedman HealthCare supported the California Department of Health Care Access and Information in developing the Expanded Non-Claims Payment Framework. The framework builds on the work of Bailit Health and the Milbank Memorial Fund and the Health Care Payment Learning and Action Network.
https://hcai.ca.gov/wp-content/uploads/2023/11/HCAI-Expanded-Non-claims-Payments-Framework-Handout_11-28-23-1.pdf

Expanded Framework, Categories 4-6

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
4	**Capitation and Full Risk Payments**	
a	Primary Care capitation	4A
b	Professional capitation	4A
c	Facility capitation	4A
d	Behavioral Health capitation	4A
e	Global capitation	4B
f	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C
5	**Other Non-Claims Payments**	
6	**Pharmacy Rebates**	

Freedman HealthCare supported the California Department of Health Care Access and Information in developing the Expanded Non-Claims Payment Framework. The framework builds on the work of Bailit Health and the Milbank Memorial Fund and the Health Care Payment Learning and Action Network.
https://hcai.ca.gov/wp-content/uploads/2023/11/HCAI-Expanded-Non-claims-Payments-Framework-Handout_11-28-23-1.pdf

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
3.	**Shared Savings Payments and Recoupments**	**Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including but not limited to episode of care and total cost of care. Dollars reported in this category should reflect only the non-claims shared savings payment or recoupment, not the fee-for-service component. Recouped dollars should be reported as a negative value. Payments in this category are considered "linked to quality" if the shared savings payment or any other component of the provider's payment was adjusted based on specific predefined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the shared savings payment, then the shared savings payment would be considered "linked to quality."**	
a.	Procedure-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3A

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
b.	Procedure-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3B
c.	Condition-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3A
d.	Condition-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3B

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
e.	Risk for total cost of care (e.g., ACO) with shared savings	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 40% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as “Performance Payments.” Providers that would be classified by CMS as “low revenue” may be eligible for shared savings at a lower rate of 20% if they do not meet minimum savings requirements.	3A
f	Risk for total cost of care (e.g., ACO) with risk of recoupments	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 50% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as “Performance Payments.” Providers that would be classified by CMS as “low revenue” may be eligible for shared savings at a lower rate of 25% if they do not meet minimum shared savings requirements. These models also must put providers at risk for at least 30% of losses. Models offering less than this degree of risk are classified as “Risk for total cost of care with shared savings.”	3B

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
4	**Capitation and Full Risk Payments**	**Per capita, non-claims payments paid to healthcare providers or organizations to provide a defined set of services to a designated population of patients over a defined period of time. Payments in this category are considered "linked to quality" if the capitation payment or any other component of the provider's payment was adjusted based on specific, pre-defined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the capitation payment, then the capitation payment would be considered "linked to quality."**	
a.	Primary Care Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide primary care services to a designated patient population over a defined period of time. Services are restricted to primary care services performed by primary care teams.	4A
b.	Professional Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide professional services to a designated patient population over a defined period of time. Services typically include primary care clinician, specialty care physician services, and other professional and ancillary services.	4A
c.	Facility Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide inpatient and outpatient facility services to a designated patient population over a defined period of time.	4A
d.	Behavioral Health Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide behavioral health services to a designated patient population over a defined period of time. May include professional, facility, and/or residential services.	4A
e.	Global Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital, and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out.	4B

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
f.	Payments to Integrated, Comprehensive Payment and Delivery Systems	Per capita, non-claims payments paid to healthcare organizations and providers to provide a comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out. This category differs from the global capitation category because the provider organization and the payer organization are a single, integrated entity.	4C
5	**Other Non-Claims Payments**	**Any other payments to a healthcare provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit. It also includes governmental payer grants and shortfall payments to providers (e.g., Disproportionate Share Hospital payments and FQHC wraparound payments).**	
6	**Pharmacy Rebates**	**Payments, regardless of how categorized, paid by the pharmaceutical manufacturer or pharmacy benefits manager (PBM) to a payer or fully integrated delivery system.**	