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Health Care Affordability
Board August 22, 2023
MEETING MINUTES

Members Attending: David Carlisle, Richard Pan, Richard Kronick, Don Moulds, Ian Lewis, Elizabeth Mitchell, Mark Ghaly (joined at 1:52 PM)

Members Not Present: Sandra Hernandez

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; CJ Howard, Assistant Deputy Director, HCAI; Michael Bailit, Bailit Health; Michael Valle Deputy Director CIO HCAI; Jill Yegian, Yegian Health Consulting

Meeting Recording: https://www.youtube.com/watch?v=RfjLfqeiErk
Meeting Materials: https://hcai.ca.gov/public-meetings/august-health-care-affordability-Board-meeting/

Agenda Item # 1: Welcome and Call to Order
Richard Kronick, sub-chair

Richard Kronick opened the August meeting of California's Health Care Affordability Board. Quorum was established. Elizabeth Landsberg provided an overview of the agenda.

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

Elizabeth Landsberg provided HCAI department updates and an update about the Distressed Hospital Loan Program, which was included in this year's budget in response to the closure of Madera Hospital and the financial distress that other hospitals are facing. Elizabeth Landsberg noted that the program received 30 applications and looks forward to announcing awards in the coming days.

In June, the Centers for Medicare and Medicaid Services Office of the Actuary released projections of national health expenditures for 2022 through 2031. The Director shared that

CMS projects that over this period, the average annual growth in national health expenditures will be 5.4%, outpacing the average 4.6% annual growth in gross domestic product. This growth in national health expenditures would result in an increase in the health spending share of GDP from 18.3% to 19.6% in 2031. CMS highlights the trends for the three largest spending categories: hospital; physician and clinical services; and retail prescription drugs. Hospital spending is expected to grow fastest, averaging 5.8% for 2022 to 2031, followed by spending for physician and clinical services projected at an average of 5.3%. Spending for prescription drugs is estimated to be an average growth of 4.6%.

Vishaal Pegany, Deputy Director, reminded the Board about the slide formatting key. The statute denotes different roles for the Board in different areas. A yellow arrow is used in the presentation for areas over which OHCA has decision-making authority and noted that it's important to get stakeholder input on these areas. For areas where the Board has ultimate decision-making authority, they note it with the green arrow.

A member asked about the national health expenditure in the CMS paper and if much of the increase was perhaps driven by the aging population in the United States. The member commented that when they looked at aging in California, they were looking at long-term care spending and long-term support services and anticipated a 5% increase per year driven by demographics alone.

The Director and Deputy Director responded that CMS looked at demographic changes in population as well as the effects of baby boomers getting into Medicare as well as the Inflation Reduction Act shifting cost of drug spending to the government, which could be offset by government negotiation to save money on drugs.

Another member added that population aging is going to affect utilization, but that price is an independent consideration. Aging adds to spending, but price is an independent factor to consider when analyzing spending increases.

A member noted that added aging effects are small, maybe two tenths of a percent a year. The member noted that to the extent that they're comparing the 5.4% increase in health spending to 4.6% increase in GDP, that's a 0.8% difference. He noted though that if two tenths of a percent is coming from aging, that's a quarter of that .8% difference.

One member noted the breakaway of pharmaceutical price increases. Another member noted that the negotiation authorized by the Inflation Reduction Act may have a significant effect on price increases for pharmaceuticals.

A member also noted trying to tease out the impact on the commercial sector versus public purchasers because the member’s organization is seeing double digit, up to 25%, increases right now that aren't driven by aging. The member noted it's really about pricing and market consolidation. The member marked the importance of understanding commercial vs public purchaser cost drivers.

Public Comment on agenda item 2 (see recording for comments).

Agenda Item # 3: Approval of June Meeting Minutes

The Deputy Director introduced the action item to approve the June meeting minutes. The Sub-chair invited a motion to approve. Board member Richard Pan motioned to approve, and member David Carlisle seconded.

Public Comment on agenda item 3 (see recording for comments).

The Board voted to accept unanimously.

Agenda Item # 4a: Cost and Market Impact Review (CMIR) Including: June Advisory Committee Member Feedback; and CMIR Proposed Regulations and Workshop
CJ Howard, Assistant Deputy Director, OHCA
Sheila Tatayon, Assistant Deputy Director

CJ Howard, Assistant Deputy Director, shared a brief overview of the process OHCA will use to present feedback to the Board from the Advisory Committee. He noted that OHCA staff and Board members who attended the Advisory Committee would provide the Board with a summary of the issues and topics that were addressed in the Advisory Committee. OHCA staff will aim to integrate Advisory Committee discussions, deliberations, and feedback into the relevant agenda items. CJ Howard noted that OHCA staff will attempt to present the Board with as many viewpoints as possible and that generally, they don't strive for consensus but use the Advisory Committee meeting as information gathering to hear multiple points of view. They plan to convey how much support they might have heard for any particular theme. If the Advisory Committee did reach consensus through discussions, they would report that back to the Board as well.

CJ Howard encouraged Board members who attend the Advisory Committee meeting to bring forth any additional elements and themes from their attendance. Ian Lewis attended the June Board meeting and CJ Howard asked him to add any highlights from the Advisory Committee deliberations and discussions as it is being presented.

CJ Howard reviewed a summary of the Advisory Committee member feedback related to CMIR.

Ian Lewis, the Board member who attended that Advisory Committee meeting, commented that the meeting was a very substantive conversation and got deep into the same technical weeds as the Board.

Assistant Deputy Director Sheila Tatayon provided the Board with an overview of the proposed regulations and a briefing of what the Office has done in terms of taking the statute and turning it into implementing regulations.

Sheila Tatayon started with the material change notice filing requirements: who must file, the developed thresholds, and the types of transactions. If the transaction meets any of nine circumstances, it meets the parameters of a transaction that OHCA would review.

A member spoke to the need for clarity around who must file and asked how many filings there can be for a single transaction. Sheila Tatayon clarified that however many entities meet the various thresholds in the regulation would have to file. Thus, there could be multiple filings for a transaction. Each party would be providing information about itself and its description of the transaction and what it thinks its benefits are.

A member asked about Health Profession Shortage Areas (HPSAs), noting that California has a broader definition of medically sensitive underserved areas like Medically Underserved Areas (MUA) or Medically Underserved Populations (MUP). The member asked if the Office considered expanding the definition of these areas. Sheila Tatayon said that they had considered it and for rulemaking purposes, wanted to tie it to something that already existed. She noted they started with MUAs, but those aren't updated as frequently. The Office looked for something they could tie it to that is verifiable and is updated often enough, and that's why HPSAs were chosen over MUAs or MUPs. Vishaal Pegany noted that the MUAs are broader and some haven't been updated since the 1980's or 1990's. HPSAs are more current and the subregions are more targeted.

Another member noted that in rural and underserved communities, most or all providers in low population areas may be part of a HPSA and the filing process would create a burden to entities serving those areas. The member noted that as written, OHCA may be asking very small entities in lightly populated areas to file notices because they meet the 50 percent HPSA threshold. Sheila Tatayon replied that the threshold would be 50 percent of patients residing in the HPSA and reiterated that there were other criteria that the entity would have to meet, not just the 50 percent HPSA requirement.

Sheila Tatayon continued to review of the types of circumstances that would trigger a filing requirement.

A member asked about the definition of transaction and the inclusion of any transaction in ten years. The member expressed concern of the amount of review required to determine the significant transactions. Sheila Tatayon replied that it is any transaction related to the provision of health care services. Vishaal Pegany asked if Sheila Tatayon would like to speak to the direction the Federal Trade Commission (FTC) is going with their recent revisions to merger guidelines. She shared the direction of the FTC recent draft revisions to its merger guidelines are very similar to what the Office is doing. Many of those factors that they have in the nine circumstances are aligned with the new draft FTC guidelines.

Other members shared understanding of the ways that market consolidation plays out but expressed concern about creating bureaucratic hurdles and disincentives instead of incentives to expand health care in rural or underrepresented areas. A member echoed concern about OHCA requesting and sorting through lots of information from entities, rather than targeting the requests. Sheila Tatayon expressed appreciation for the comments, and also the vulnerability for small areas when there is no competition, and that it is a balancing act. A member noted in small areas, a change that may not meet the threshold can still have

a significant impact on a very small population that could be vulnerable.

A member noted that the burden of these filings as compared to the due diligence that goes into these investments is relatively small and that the public are not served well by the lack of transparency into the markets. The member noted that an especially meaningful piece of this statute is that it takes a prospective approach to the market, whereas most other activity looks back. An approach that collects more information, that captures more, is a good thing. The member noted that the thresholds to require a filing seem high to the degree they're stricter than those of Attorney General. Sheila Tatayon noted that OHCA's charge is public transparency and that it does not have the authority to stop a transaction. The charge is to collect information that's informative to the public and that while these are very broad thresholds and may pull in a lot of transactions, that is consistent with the charge to collect information that is informative to the public. She reiterated that not every transaction will go to a full cost and market impact review. She cited Massachusetts which has done 10 full reviews in approximately 10 years.

A member underscored monitoring the impact on rural and underserved areas, given growing maternity deserts, primary care deserts, and that the Board needs to be mindful of discouraging providers from going into these underserved areas. The member noted that it's very hard to work in California because of regulation, so if the Board is creating additional barriers to value-based payment transactions, particularly in rural areas, that will be an unintended deterrent given what the Board is trying to achieve.

Sheila Tatayon next reviewed the factors for OHCA's consideration to issue a waiver or conduct a CMIR, as laid out in statute and implemented in the proposed regulation.

Sheila Tatayon then reviewed the factors considered in the CMIR and the timeframes for notice review and CMIR preliminary and final reports. A member asked for clarification on the 90-day requirement to file before closing a transaction and the potential delays associated with needing to do a CMIR. They asked how OHCA can prioritize reviews so that the consequences of delays can be mitigated. The Director replied that OHCA is aware of the concerns around timeliness. The member requested that OHCA report to the Board what happens to these transactions—how many transactions actually terminate because of delays. The Director confirmed that OHCA is building a system aimed at tracking these transactions. Sheila Tatayon noted that the regulation requires 90 days before the anticipated closing date but that the entities can file sooner.

Sheila Tatayon then reviewed the public comments received in the August 15 regulations workshop where an estimated 120 people attended virtually and 20 attended in-person.

One member asked about confidentiality. Sheila Tatayon answered that proposed regulations allow for healthcare entities to submit a request for confidential treatment with an accompanying public-facing version. OHCA would then review the request for confidential treatment. It is expected that a document requested to be treated as confidential should have been maintained confidentially all along and cannot be claimed to be confidential retroactively. Also, a material change notice is submitted under penalty of perjury.

One member asked, regarding confidentiality, if the regulation would track federal requirements for transparency of pricing and pricing impact. Sheila Tatayon responded that if the entity is required to make it public under another law, then it would be hard to argue it should be treated confidentially. The member asked a question regarding requirements for significant evidence of benefits. Sheila Tatayon answered that anything asserted in the material change notice will have to be verifiable with supporting documentation. OHCA will mark the submission as incomplete if they do not provide sufficient evidence. Another member asked if OHCA will have the authority to require information a year or two after the transaction has been completed to see if what's been promised has been delivered. Sheila Tatayon answered that nothing in the statute precludes OHCA from doing so.

A member asked why MSOs are being considered payers. Sheila Tatayon stated that it was based on the statutory definition of payer. She shared that MSOs perform multiple functions, some limited, some expansive, and that under the language of the statute, any entity that arranges for the payment of services is considered a payer. The member questioned if that was certain MSOs, or all MSOs. Sheila Tatayon stated that the proposed regulation includes all MSOs. The member stated they think the Office might be going beyond the statute. They stated that there are entities that play different roles. They stated that it also depends on how many filings OHCA is going to review and that staff is limited. Would all MSOs be required to submit a filing? Sheila Tatayon shared that being an MSO doesn't mean you're an automatic filer. They still must meet the thresholds and circumstances laid out in the proposed regulations.

Public Comment on agenda item 4a (See recording for comments).

Lunch Break

Agenda Item # 4b: Total Health Care Expenditures Measurement including: June Advisory Committee Member Feedback; and Measuring Health Care Spending of Health Plans and Provider Entities
Vishaal Pegany, Deputy Director, HCAI
Michael Bailit, Bailit Health

Vishaal Pegany and Michael Bailit co-presented on the item. Michael Bailit first recapped the June Board Meeting. Vishaal Pegany covered the feedback received from the Advisory Committee with respect to the topic of Total Health Care Expenditures (THCE).

Ian Lewis added that a number a committee members suggested having an expansive set of data tfor THCE. Three other members said some variation of not letting the perfect be the enemy of the good, and to recognize that over time we will be able to capture more information, but we shouldn't get bogged down in the pursuit of perfection.

A member asked Ian Lewis and Vishaal Pegany to provide some thoughts about how the Advisory Committee is advising the Board as the Board is advising OHCA. The member appreciated the summary and asked for suggestions of how the Board might respond to the

suggestions of the Advisory Committee. Members inquired about the process of the Advisory Committee's feedback being relayed and considered by the Board. The Director affirmed that staff will provide summaries and expressed openness to suggestions about other approaches. The Director noted that many of the groups on the Advisory Committee are also coming in and giving their perspectives in the Board meetings. She described the Advisory Committee meetings as one of many avenues for a broad array of stakeholders to convey their views. Michael Bailit shared that he has observed in other states with similar arrangements, the presentation of the Advisory Committee is shared and the Board might agree and suggest that it is something it wants to suggest to the Office. A member asked what process the Board might use. OHCA staff confirmed the purpose of the summaries are to inform the Board and that staff are open to guidance from the Board.

Michael Bailit shared that one idea the Advisory Committee brought forward that the Board may not have brought up was the idea about collecting data for the commercial market separately for PPO and HMO. He shared that as a good example of where the Office then had conversation and that can be shared with this Board. A board member noted that the Advisory Committee addressed the idea of additional data like Tricare and Correctional Health System data and the Director shared her impression of the Committee's discussion. A board member brought up risk adjustment as a topic that would be revisited.

Michael Bailit presented on measuring spending, starting with who gets measured. He began with payers. A member asked about third-party administrators (TPAs). Michael Bailit suggested OHCA would have to do an assessment of who is in the market to determine that, and that the list would change over time. A Board member asked about ERISA arrangements and reporting. Michael Bailit responded that for the commercial market, payers will be asked to submit total health care expenditures for their full population combined so that includes if they are a carrier for ERISA arrangements. A Board member asked about the ERISA preemption for submission of data. Vishaal Pegany explained how the OHCA data is different. Elizabeth Landsberg added that OHCA is working closely with their sister departments, DHCS and DMHC to get lists of enrollment data as well. She clarified that all of the plans they will get data from will also be the plans they get HPD claims data on. A Board member commented that the threshold makes sense to them and that it would be useful to see a list of plans that are below the threshold.

Michael Bailit then presented on measuring spending in regards to provider entities, and the connection to primary care providers (PCPs). One member asked if you have out-of-network utilization, is it still attributed back to the PCP organization. Michael Bailit answered that when measuring THCE for the organization, they're measuring total spending for its patients regardless of where they receive services. In fact, even if they receive services out of state, it's included.

Michael Bailit continued to present on measuring provider entity spending and what is being measured along with provider entity spending attribution. A Board member commented that spending is different than encounters and that if you are using expenditures to identify the PCP relationship if might look very different than using encounters. A Board member commented that when there is capitation, it doesn't seem there should be much of a problem because you know who it is being paid to. A Board member asked how it is known which physicians are practicing together or where they're practicing, noting that a compendium of health systems was

created using Medicare billing data. It included for each National Provider Identifier (NPI) what taxpayer identification number they use for billing.

One member questioned how to attribute expenditures of patients with chronic conditions that see a specialty care provider more often than a PCP. Michael Bailit answered that if the PCP and the specialist are part of the same medical group, it will be attributed, otherwise it won't be captured. The member also commented that it would be interesting to see the PPO data for this to see how big of an issue it is. Another member suggested a plan B to measure separately for patients who are assigned or have signed up with a primary care physician, primarily HMO patients, but in the case of California, also the PPO patients who have been assigned to a PCP to measure separately for that group and for the group that we're attributing. Board members discussed other options for measuring. Board members suggested some ad hoc analysis might be appropriate.

Michael Bailit stated that at this point OHCA is continuing to gather input from payers about what they are doing now on attribution. Michael Bailit noted that there will always be a sizeable amount of unattributable spending.

Vishaal Pegany commented about OHCA gathering input from stakeholders on approaches to attribute spending that cannot be attributed using the standard methods that OHCA will use. He stated that the PCP assignment would be the first step. OHCA is trying to solve and is exploring options and getting technical assistance from plans.

Michael Bailit then previewed the content for the September Board meeting. A Board member asked if OHCA is considering how to integrate the new TiC (Transparency in Coverage, a CMS Final Rule as of 2020) data, the new transparent hospital pricing information into the dataset. Michael Bailit responded that they are not, and that the data they are using comes from the payers about what they spent on behalf of members served. He noted it is a potentially valuable data source, but not what will be used. The member asked about out-of-pocket spending. Michael Bailit noted it will be measured in two ways: payers will report allowed spending and patient out-of-pocket obligation. A Board member commented that they'd also like to not lose sight of other spending like public health. A Board member added that behavioral health out-of-pocket probably gets the most interaction with what OHCA is measuring and that over time one would hope that the cost to consumers decreases and what plans are paying increases. A member noted that attribution to primary care is the best single tool available but that it may be inaccurate when looking at PPOs and the value of looking at different tools for different populations.

Public Comment on agenda item 4b (See recording for comments).

Agenda Item # 4c: Health Care Payments Data (HPD) Program Overview
Vishaal Pegany, Deputy Director
Michael Valle, Deputy Director
Jill Yegian, Yegian Health Consulting

Deputy Director Michael Valle provided an overview of HPD including the types of data

collected and from whom. He walked through the timeline for the development of HPD, described stakeholder governance, and shared the reporting and access principles. Jill Yegian described the anticipated topics for public reporting, along with the 2023 reporting priorities, along with next steps.

A Board member noted that this is great work and spoke about non-claims data and the quality of data. The member asked about what prevents the attribution of certain costs. Jill Yegian stated that HPD is in conversation with partners about their approach to non-claims data and shared two different issues: the collection of the data itself, and then what is done with the data behind the scenes to connect the dots. She suggested the question is, for example, about having monthly capitation data and then connecting it to some form of encounter data to try and create meaning. Another Board member thanked the presenters for their work and the significance of that work. A Board member noted many states have had HPDs for a while and asked how it might help address affordability from a consumer perspective. Chair Ghaly shared that it is early in the process and that conversations will continue to keep thinking through the opportunities. Director Landsberg underscored that OHCA and HCAI continue to ground their work in consumer affordability. A Board member expressed appreciation for the presentation. A Board member asked if HPD has allowed amounts in it, and staff confirmed that it does. The Chair expressed appreciation for the work and that he understands the team is focused on continuing to evolve it into the tool others want to see so that it can address disparities. The Board discussed the opportunities and partnerships possible to work together on this.

Public Comment on agenda item 4c (See recording for comments).

Agenda Item # 5: General Public Comment

Chair invited general public comment.

Public Comment on agenda item 6 and General Public Comment (See recording for comments).

Agenda Item # 6: Adjournment

Mark Ghaly adjourned the meeting.