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HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Wednesday, May 22, 2024
10:00 am

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

*Attended virtually

Members Absent: None

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

Meeting Materials:

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

Vice-chair Hernández opened the May meeting of California's Health Care Affordability Board. Roll call was taken, and a quorum was established. Chair Secretary Mark Ghaly arrived later.

Vice-chair Hernández proposed a motion to include Board Member Richard Kronick in the meeting virtually. Board Member Pan seconded the motion.

Voting members who were present voted to accept. The motion passed.

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

Director Landsberg gave an overview of the agenda, with the following updates:

- Agenda item 5(a) – Update on Draft Alternative Payment Model Standards and Adoption Goals would be taken before agenda item 4(b) – Establish Alternative Payment Model Standards and Adoption Goals.
- The discussion of Cost and Market Impact Review Regulations Revisions was postponed, with more information forthcoming.

Director Landsberg and Deputy Director Pegany provided the following Executive Updates:

- Reappointment of Board Member Ian Lewis by Assembly Speaker Rivas for an additional four-year term.
- Discussion about the May revision to the 2024-25 state budget and a proposal to cut more than $855M in General Fund from Health Workforce Development programs over the next five years.
- Reminder that hospital patients are eligible to apply for a hospital's discount payment or charity care program if they meet eligibility criteria. In addition, HCAI administers the Hospital Fair Billing Program, in alignment with the California Hospital Fair Pricing Act. Since the January launch, the program received 73 patient complaints, with approximately $316,000 in patient debt relieved. OHCA provided the website to file a complaint or for more information (http://hospitalbillcomplaintprogram.hcai.ca.gov) and provided program flyers in English and Spanish at the meeting.
- Update on Workforce Stability Standards and Metrics progress. OHCA will use feedback from the Board, Advisory Committee, and public comments to inform revisions and will present a final set of standards and metrics to the Board at the June meeting, after which OHCA will adopt.
- Review of Board accomplishments and work ahead. OHCA is reassessing its monthly meeting cadence and will share a revised meeting schedule for the remainder of 2024.

Discussion and comments from the Board included a member congratulating HCAI for the Hospital Fair Billing Program and shared a personal story that underscored the importance of the program.

Public Comment was held on agenda item 2. One member of the public provided comment.

Agenda Item # 3: Approval of April Meeting Minutes
Vishaal Pegany, Deputy Director, HCAI

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

Board Member Carlisle proposed a motion to approve. Board Member Lewis seconded.

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

Voting members who were present voted to accept. The motion passed.

Agenda Item #4: Action Items
Vishaal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI

Prior to introducing action items, Deputy Director Pegany invited HCAI legal counsel Jean-Paul Buchanan to describe the process for motioning and approving action items. A member asked if the Board was following specific rules of order. Jean-Paul Buchanan answered that the Board follows Robert's Rules of Order.

a) Advisory Committee Member Appointment

Assistant Deputy Director Howard provided an overview for the Advisory Committee selection process. Fifteen members' terms are ending. The Subcommittee recommended a slate of 28 members (including one vacancy) as follows:

- Appoint 12 current members to new terms.
- Appoint four new members being assigned to organized labor, health care workers, consumer representatives/advocates, and academics/researchers.
- Fill current vacant position in the hospital category, with an emphasis on rural hospitals and a goal of soliciting more applicants within this area of specialty.

Discussion and comments from the Board included:

- A member asked for a reminder on how the terms were originally designed. The Office responded that it assigned people randomly to either a one- or two-year term. Roughly half of members each year will have a term expiring.
- A member asked if an Advisory Committee member can be reappointed if their term expired and whether there is a term limit. The Office responded that they can be reappointed and that there is no term limit.
- A member asked how OHCA conducts outreach when it calls for nominations. The Office responded that it uses a listserv to provide information, as well as through word of mouth.
- A Subcommittee member explained that although at one point the Board discussed adding a retiree position, the Subcommittee did not receive a wide breadth of candidates so it decided to not move forward with that category.
- A Subcommittee member noted that there was almost 100% reapplication and that the process is working, as it continues to evolve.
- A member asked about filling the newly vacated position. The Office described the timeline and process.

Board Member Pan made a motion to approve the Recommended Advisory Committee Membership proposed by the Subcommittee. Board Member Mitchell seconded.
Public Comment was held on agenda item 4(a) and three members of the public provided comments.

Voting members who were present voted to accept. The motion passed.

Agenda Item #5a: Informational Items- Update on Draft Alternative Payment Model Standards and Adoption Goals, Including Summary of Advisory Committee Feedback and Agenda Item #4b: Action Item- Establish Alternative Payment Model Standards and Adoption Goals

Vishaal Pegany, Deputy Director, HCAI
Margareta Brandt, Assistant Deputy Director, HCAI

5a) Update on Draft Alternative Payment Model Standards and Adoption Goals, Including Summary of Advisory Committee Feedback

Assistant Deputy Director Brandt reviewed the proposed Alternative Payment Model (APM) Standards and Adoption goals with revisions, covering the themes of Advisory Committee and Workgroup feedback, along with the Office's response.

Discussion and comments from the Board included:

- A member who attended the Advisory Committee meeting commented on the value of the feedback and high degree of participation.
- A member provided more detail about the sentiments expressed by Medi-Cal providers and their receptivity to APMs but also fear of the downside financial risk and capital cost of administering such a system, e.g., the unknown financial risk of participating in a capitated model, especially for smaller practices.
- A member inquired about the incentive structure in the legislation and/or regulations to encourage APMs and what the Board can do to promote APMs.
    - The Office responded that the legislation is centered on data collection and reporting on APM adoption. Currently, there is no payer-specific data being reported on APM adoption.
- A member commented about standard APMs and novel APMs which involves a level of experimentation and how that factors in. The member inquired about what factors will be considered to exceed the target and the experimentation providers might do to meet APMs.
    - The Office noted that a performance improvement plan could require a regulated entity to start working on APMs or invest more in primary care.
    - The Office confirmed that the Board will have future input on enforcement.
- A member commented about the value of continuity of care in APMs, and how to address it, and that sufficient payment may not be a strong response to support continuity. The member noted that the plan might have a capitated model but at the provider level it may be an RVU (relative value unit payment structure).
    - The Office clarified that the APMs Standards to are best practices to guide contracting efforts between plans and providers that emphasize primary care continuity and population-based payment models.
- A member mentioned the challenge of attribution, and the requirement that patients affirmatively affiliate with a practice for purposes of attribution and the challenges posed when the payment is connected to quality metrics, especially in a PPO environment.
- A member asked about APMs for those who are not utilizing care as much, and whether there is discussion of focusing on those with the highest utilization.
    - Another member confirmed that was not a big discussion in the Advisory Committee.
    - The Office added that it was not a strong emphasis in the workgroup's discussion. The workgroup focused on prevention and population health management.
- A member noted the importance of visibility in commercial contracts and consistency across Medi-Cal and commercial.
    - The Office noted that the APM Standards and Implementation Guidance does

focus on alignment across payer types to ensure APM adoption is easier for providers.

Assistant Deputy Director Brandt provided background and overview of the Revised Alternative Payment Model Adoption Goals.

Discussion and comments from the Board included:

- A member clarified that some of that data presented on APM adoption was based on percent of payment, not percent of members.
- A member commented about the challenges of APM adoption in PPOs and the importance of the definition and attribution for PPO APMs in relation to the APM Adoption Goals. The member highlighted that PPOs allow people to go outside of the network, which could be a challenge for APMs. The member inquired who the members are in the PPO and what the PPO provides for them to go out of the network, and whether there was discussion of who is in the APM part of the PPO.
  - The Office clarified that the data collected currently may not be able to answer that question. The member asked if the Office could look at the Health Care Payments Database at who is going in-network and not; the Office replied they would look into it.
- A member noted that the tools used by PPO plans are generally outside of the APM framework (e.g., population health managers, curated networks, and benefit design for non-medical interventions).
- A member inquired about whether information from payers about the share of members in APMs will be a single membership number or available by medical group.
  - The Office responded that data will be collected at the payer level and that it expects to collect data by contract, with percent of dollars and members in an APM arrangement. The member noted it would be useful to develop medical group level information to increase information about the impact of APMs.
- A member noted the importance of having data at the payer level and the medical group level.
  - The Office noted APM data collection will first occur at the payer level, then include entities that take global risk, such as limited or restricted Knox Keene Act licensees. OHCA has the authority to implement provider-level data collection and reporting but is not planning to do so at this time.
- A member noted that data at the provider level and how it is transforming delivery of care is the most important, and that measuring at the plan level will not tell us as much.
- A member commented that if quality and cost are not being measured at the provider level, there is no point in this work, and that outcomes and total cost of care must be tracked.
- A member asked why there is a higher bar for Medi-Cal than commercial PPOs.
  - The Office described it as a challenge of attributing PPO members to an APM. The member noted they believe there should be consistent expectations.
- A member asked what accounts for the slower adoption of APMs in Medi-Cal than in commercial.
  - The Office replied that in discussions with DHCS, they signaled the challenges of payment structures particular to the Medi-Cal market. A member commented on

how clinics are reimbursed and the lack of infrastructure to implement APMs.

- A member commented on the importance of the Medi-Cal population and the vulnerability of these populations, supporting the 75% target, even 10 years out.
- A member noted that the promise of the APM is the behavior change of the people who see patients, and how they invest time, effort, money.
- A member noted that Medi-Cal and small practices that provide culturally competent care exist in other populations, and that this should be considered when setting percentages.
- A member asked how direct contracting (e.g., between purchasers or employers and providers) would be tracked in the data.
    - The Office answered that it may not have that data because it will receive data from payers, not purchasers or employers.
- A member commented on the explosion of "value enablers" that may add costs and may not actually add value and suggested being sensitive about giving credit towards meeting the spending target for using these "value enablers".
- A member asked about collecting income in addition to demographic information.
    - The Office confirmed that this was a topic of discussion and that standard six of the APM Standards (which recommends collecting demographic data, including race, ethnicity, language, disability status (RELD) and sex, sexual orientation, and gender identity (SOGI) data) is intended to be broad to encompass other demographic data such as income.
- A member noted it would be helpful to note the measures that are most important in quality and encouraged the Office to align with Covered California's quality measures.
- A member suggested that knowing where individuals in PPOs get their primary care could be helpful. Another member suggested tracking the percentage of APM adoption at the primary care level for PPOs.
- A member commented that if the lever for exceeding the spending target is in the assessment, it is important to be specific about the rules to send clear signals about what counts and what does not.
- A member noted a concern with the legislation that goals are being set with no lever to enforce, and that the Board should consider how it addresses this.

4b) Establish Alternative Payment Model Standards and Adoption Goals
Margareta Brandt, Assistant Deputy Director, HCAI

Chair Ghaly asked the Board to delay the vote until next month's board meeting to obtain additional specific information and facilitate further discussion regarding the APM Standards and Goals.

Discussion and comments from the Board included:

- A member acknowledged the hard work that was done and that more refinement is necessary before a vote.
- A member noted that percentages may not measure care getting better and costs going down. A member suggested that additional information should include a clear plan to connect adoption of targets to improvements in quality and reduction in cost.
- A member agreed that more time would be helpful, but that the Board's opportunity to

get to the “how” and the “what” is based on goals and standards.

- A member asked whether there will be visibility into specific contracts.
    - The Office replied no, there will not be visibility into specific contracts and that we will only see the numerical goal in data from the payers. The member noted that more transparency is required.
- A member mentioned additional measures might include percentage of providers in a PPO that are in an APM; top utilizers in APM vs. entire population; linkage to APMs and quality; and what providers see as the incentives.
- A member inquired whether there was any learning about APMs from other states that could be examined.
- A member commented expanding broadly what counts as an APM to include care models or payment models that are easier to fit into a PPO model.
- A member commented that data needs to be stratified and asked that the PPO target percentage level be revisited.
- Director Landsberg expressed appreciation for the expertise of the Board and explained that provider data will not be captured immediately, and that the Office will continue to iterate on these goals and standards.

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

Agenda Item #5b: Informational Items- Draft Primary Care Definition and Investment Benchmark, Including Summary of Advisory Committee Feedback

Assistant Deputy Director Brandt reviewed the timeline for primary care work, the reason for focus on primary care, and the vision for primary care delivery in California. The draft primary care spending measurement definition and methodology and draft primary care investment benchmark was also shared.

Discussion and comments from the Board:

- A member inquired about the definition of primary care, whether there is any measure of continuity, and whether a "one-off" visit counts.
- A member inquired about OB-GYNs playing a role in primary care and what services would count as primary care. Another member noted that the Advisory Committee and workgroup suggested excluding OB-GYN. Other members requested the Office provide more background information on the proposal to exclude OB-GYNs as primary care providers in the definition of primary care and continue to evaluate the proposal.
- A member asked whether behavioral health is included in the definition and recommended including behavioral health provider types in the definition.
    - The Office answered that some behavioral health services are included in the primary care spending definition.
- The member noted that primary care doctors may not receive good behavioral health training.
- A member inquired whether the definition includes all internal medicine providers.
    - The Office answered that internal medicine providers are included the primary care spending definition. The Office noted that the proposed definition includes

filtering some provider types to only include those providers identified as primary care providers in the payer's Department of Managed Health Care Annual Network Report Submissions, with the aim of excluding providers who may be practicing under a non-primary care subspeciality.

- A member commented about non-claims payments and not having good data and that this is a proxy approach.
- A member noted that OB-GYN inclusion is important especially for rural areas.
- A member noted that they consider mental health care as primary care.
- A member noted that capturing behavioral health care in another workstream would be valuable.
- A member had a question about capitation ratios and whether everyone is using the same formula.
    - The Office confirmed they are recommending everyone use the same formula.

Assistant Deputy Director Brandt shared the draft primary care investment benchmark recommendation from the Office.

Discussion and comments from the Board:

- A member observed that an Advisory Committee member had noted not just tracking how increased investment in primary care leads to better outcomes but also that it leads to reduced barriers to access. There was consensus in the Committee around the benchmark recommendation.
- A member asked about the timeline and why we are proposing it take 10 years to reach the goal.
    - The Office answered that this was discussed in the workgroup. They considered that those plans who currently spend in the 3-6 percent range and how much time it would take to reach the 15 percent benchmark. Also, to reallocate spending and not increase it, it will take a fair amount of care delivery transformation that will also take time. An example was provided of what a 3 percent increase in TME would look like if payers reallocated spending to increase primary care spend by 1 percent of TME; it would be about a 17 percent increase in primary care spending overall, translating into $9 per member per month. This would be an effort each year for payers and this would get us to 15 percent in 10 years.
- A member stated that there is a good amount of consensus around having more primary care, and that the timeframe could be more aggressive.
- A member commented on the pace of change and how other states did this and was curious about Oregon's total spend. The member commented that faster investment in primary care spend will accelerate the delivery system transformation and that a ten-year timeline is longer than ideal.
- A member noted that investment in primary care reduces total spend and challenged the assumption that it would increase total spend.
    - The Office confirmed that investment in primary care does reduce total spend overtime which requires long-term delivery system transformation and re-allocation of spending. There was additional discussion about the impact of primary care investment on reducing overall cost of care and that it takes time.
- A few members inquired about Rhode Island's shift, what changed in primary care there,

and where they could find more information.
    - The Office mentioned a Health Affairs paper written by Bruce Landon at Harvard Medical School and colleagues looking at what drove Rhode Island's primary care spending increases. The paper shows that primary care providers referred to less expensive hospital and other facilities and also an overall decrease in hospital spending contributed to increased primary care spending.
- A member inquired about what will be known at the medical group level.
    - The Office answered that right now data will be collected at the payer level and that it will take that under consideration. It is not yet decided what level of granularity the primary care spending data will be collected beyond the payer level.
- A member stated it would be helpful to have an estimate of current spending and how it is measured in the proposed way before voting on the benchmark.
- A member asked why primary care spending wouldn't be adjusted for age given the differences in populations.
    - The Office answered that they will be reporting claims-based primary care spending by age group (pediatric and adult) and reporting on health plan's member age distribution as context, but the benchmark will be based on all populations.
- A member noted the challenge of certain requirements for different populations and age adjustments. A member also noted a complication for percentages and specialty care.
- A member noted a missing piece might be what the Board is looking for from this effort, and that the benchmark should be attached to quality, satisfaction, and equity.
- A member commented that OB-GYN is a provider type that might not be easily included but would like to see a recommendation. A member added that it should be the group accepting responsibility for total needs of the patient and coordinating care, and that is conceptually what the Board wants to explore.

Public Comment was held on agenda item 5(b). Nine members of the public provided comments.

Agenda Item #6: General Public Comment

- A member asked about an item for the future about how cost reductions get reflected into rates for consumers. The Office agreed they could address that in a future meeting.

Public Comment was held on agenda item 6. Six members of the public provided comments.

Agenda Item #7: Adjournment

The Vice-chair adjourned the meeting.