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Department of Health Care Access and Information

Health Care Affordability Board Meeting

June 20, 2023

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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
Secretary Mark Ghaly
a) Approval of the May 23, 2023 Meeting Minutes
b) Approval of Richard Pan to attend the September Advisory Committee meeting, and Richard Kronick and Sandra Hernández to attend the November Advisory Committee Meeting

4. Action Items
C.J. Howard, Assistant Deputy Director
a) Advisory Committee Membership

5. Informational Items
a) Cost and Market Impact Review
Sheila Tatayon, Assistant Deputy Director, and Katherine Gudiksen, Senior Health Policy Researcher, The Source on Health Care Price and Competition
b) Alternative Payment Models, Primary Care and Behavioral Health Investment, and Workforce Stability
Margareta Brandt, Assistant Deputy Director
c) Total Health Care Expenditures (THCE) Measurement
Vishaal Pegany, and Michael Bailit, Bailit Health

6. General Public Comment

7. Adjournment

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Executive Updates

Elizabeth Landsberg, Director

Vishaal Pegany, Deputy Director

Key Components

- Slow Spending Growth
- Promote High Value
- Assess Market Consolidation

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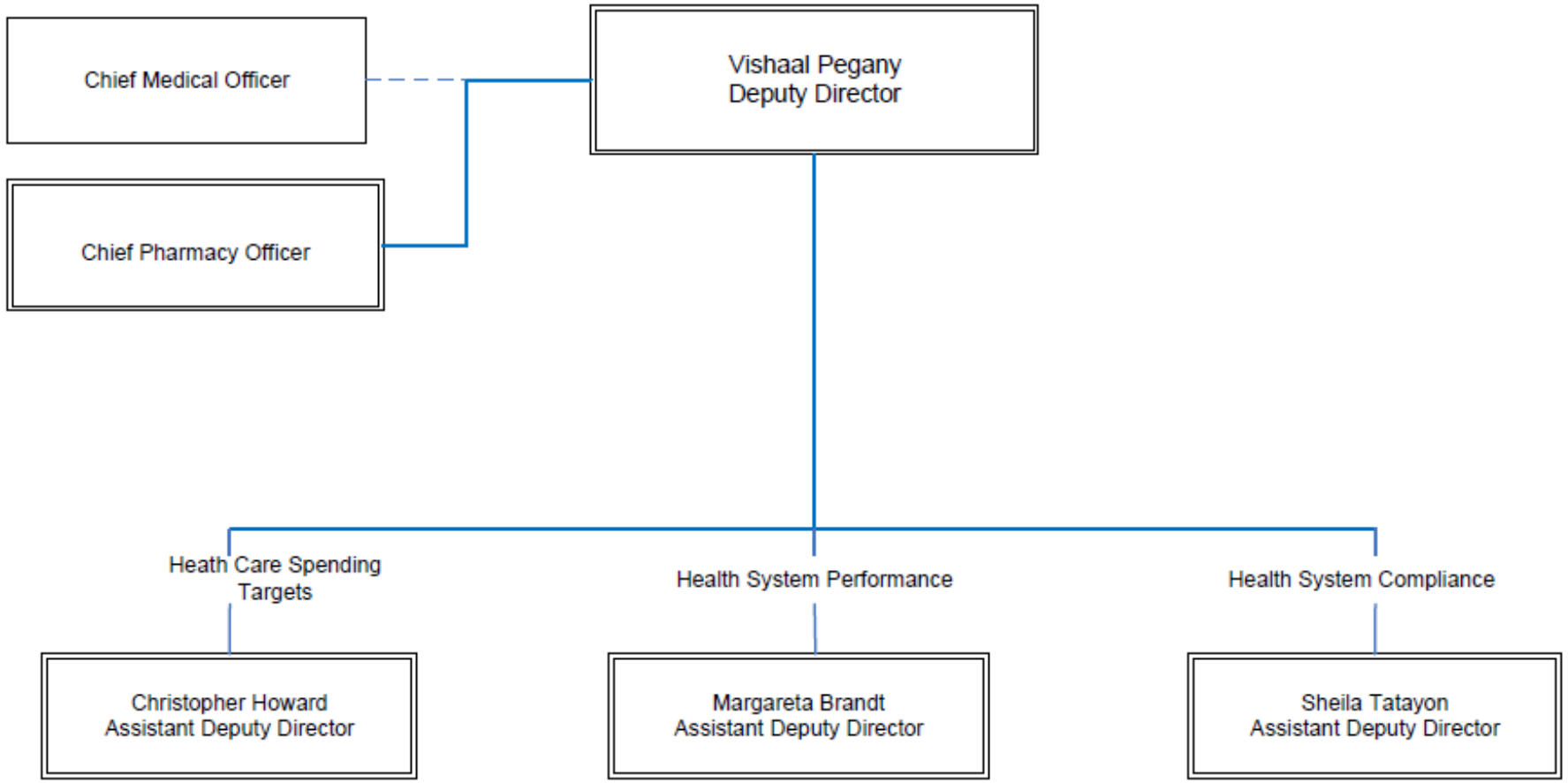
Office of Health Care Affordability



Staffing Updates

Engagement and Governance Group - 6

- Health Program Manager II
- Health Program Specialist II - 2
- Health Program Specialist I - 3

Health System Compliance - 6

- Attorney IV – 4
- Attorney III - 2

Administration and Management Support - 4

- Staff Services Manager I
- Associate Governmental Program Analyst - 2
- Office Technician

Recruitments in Progress - 14

- Assistant Chief Counsel/Manager (Health System Compliance)
- Pharmacy Consultant II (will report to the Deputy Director)
- Health Program Manager II (Health System Performance) – 2
- Health Program Specialist II/I (Health System Performance) – 5
- Research Scientist Manager (Research and Analysis Group)
- Research Scientist Supervisor I (Research and Analysis Group)
- Research Data Specialist II (Research and Analysis Group)
- Research Data Specialist III (Research and Analysis Group)
- Associate Governmental Program Analyst (Administration and Management Support)

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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Action Consent Item: Approval of the May 23, 2023 Board Meeting Minutes

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Action Consent Item: Approval of Board Member Attendance at Advisory Committee Meetings

Board Member Attendance at Advisory Committee Meetings

Motion to approve that Board Member Richard Pan attend the September Advisory Committee meeting, and Board Members Sandra Hernández and Richard Kronick attend the November Advisory Committee meeting.

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Action Item: Advisory Committee Membership

Proposed Additional Membership

At the May Board meeting the board tasked the subcommittee with:

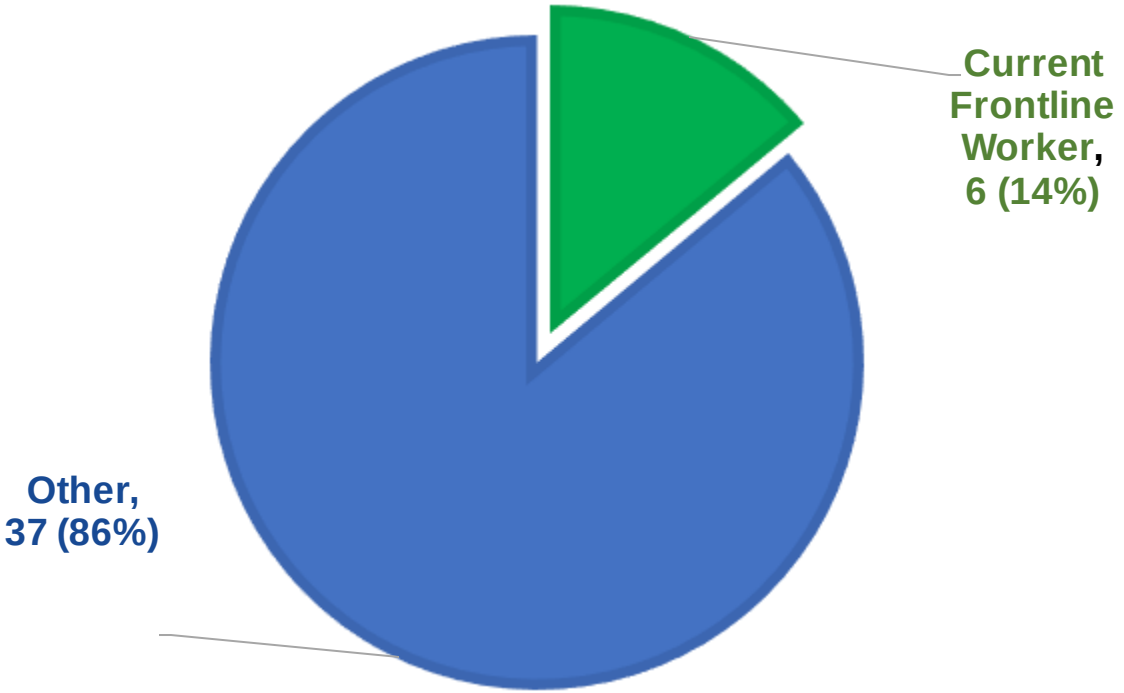
- revisiting the health care worker category with a focus on finding frontline health care workers to serve on the committee
- identifying an individual that would represent a public sector labor union perspective in the organized labor category

Approved Advisory Committee Membership

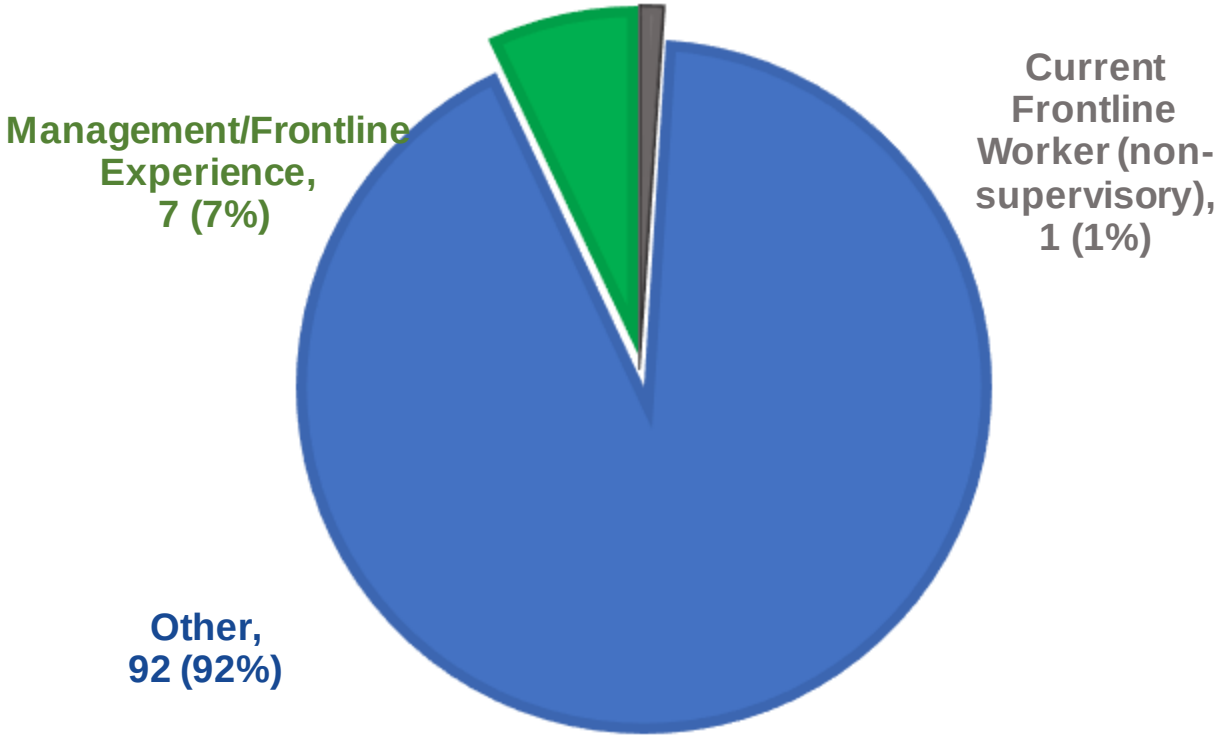
Payers/FIDS	Hospitals	Medical Groups	Physicians	Health Care Workers	Organized Labor	Patient Groups/ Consumer Advocates	Purchasers
Aliza Arjoyan, Blue Shield of California	Barry Arbuckle, MemorialCare Health System	Hector Flores, Family Care Specialists Medical Group	Parker Duncan Diaz, Santa Rosa Community Health	Hold Open	Joan Allen, SEIU-UHW	Carolyn Nava, Disability Action Center	Ken Stuart, California Health Care Coalition
Yolanda Richardson, San Francisco Health Plan	Tam Ma, UC Health	Stacey Hrountas, Sharp Rees-Stealy Medical Centers	Adam Dougherty, Vituity	Hold Open	Carmen Comsti, California Nurses Association	Mike Odeh, Children Now	Suzanne Usaj, The Wonderful Company
Andrew See, Kaiser Foundation Health Plan	Yvonne Wagner, San Bernadino Mountains Community Hospital District	David Joyner, Hill Physicians Medical Group	Sumana Reddy, Acacia Family Medical Group	Hold Open	Ivana Krajcinovic, Unite Here Health	Kiran Savage-Sangwan, California Pan-Ethnic Health Network	Abbie Yant, San Francisco Health Service System
					Hold Open	Rene Williams, United American Indian Involvement	
						Anthony Wright, Health Access California	

Composition of Submissions Received

REPRESENTING HEALTH CARE WORKERS (SELF-ATTESTED) (N=43)



BEHAVIORAL HEALTH EXPERIENCE (SELF-ATTESTED) (N=100)



Recommended Advisory Committee Membership

Payers/FIDS

- Aliza Arjoyan, Blue Shield of California
- Yolanda Richardson, San Francisco Health Plan
- Andrew See, Kaiser Foundation Health Plan

Hospitals

- Barry Arbuckle, MemorialCare Health System
- Tam Ma, UC Health
- Yvonne Wagner, San Bernadino Mountains Community Hospital District

Medical Groups

- Hector Flores, Family Care Specialists Medical Group
- Stacey Hrountas, Sharp Rees-Stealy Medical Centers
- David Joyner, Hill Physicians Medical Group

Physicians

- Parker Duncan Diaz, Santa Rosa Community Health
- Adam Dougherty, Vituity
- Sumana Reddy, Acacia Family Medical Group

Health Care Workers

- Stephanie Cline, Kaiser
- Sara Gavin, CommuniCare Health Centers
- Sara Soroken, Solano County Mental Health

Organized Labor

- Joan Allen, SEIU-UHW
- Carmen Comsti, California Nurses Association
- Ivana Krajcinovic, Unite Here Health
- Janice O'Malley, American Federation of State, County and Municipal Employees

Patient Groups/ Consumer Advocates

- Carolyn Nava, Disability Action Center
- Mike Odeh, Children Now
- Kiran Savage-Sangwan, California Pan-Ethnic Health Network
- Rene Williams, United American Indian Involvement
- Anthony Wright, Health Access California

Purchasers

- Ken Stuart, California Health Care Coalition
- Suzanne Usaj, The Wonderful Company
- Abbie Yant, San Francisco Health Service System

Draft Motion from the Subcommittee

- Approve the three proposed members under the Health Care Workers category.
- Approve the additional Organized Labor proposed member.
- Allow OHCA staff to randomly assign new members one- or two-year terms.

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Informational Items

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Cost Market and Impact Review

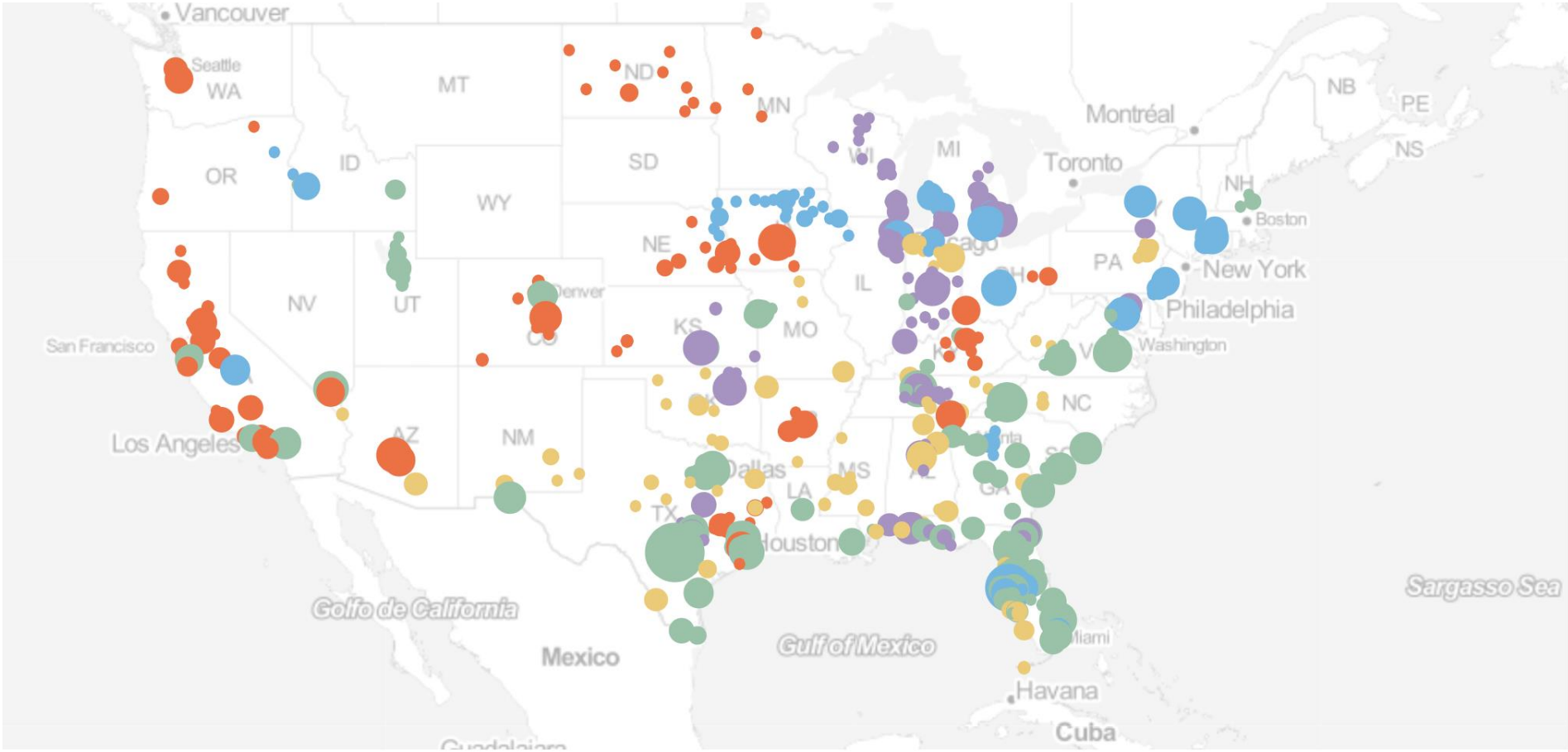
Sheila Tatayon, Assistant Deputy Director
Katherine Gudiksen, Executive Editor and Senior Health Policy Researcher
The Source on Healthcare Price and Competition, UC Law SF

Context: Impact of Consolidation and Market Power

Impact of Hospital Mergers

Cost Impacts: Within Market Consolidation	- Hospital price increases of 20-44% (some as high as 55-65%) - Bystander hospitals also raise prices following a merger
Cost Impacts: Cross-Market Consolidation	- Prices rise 7-9% at *acquiring* hospitals, 17% at *acquired* hospitals with out-of-state purchaser - Bystander hospitals also raise prices
Quality	- Most studies find no significant quality benefits - A few have shown modest improvements in a few measures - Other studies indicated higher mortality and worse quality when there is less competition

Merger & Acquisition (M&A) Trend – Hospital Growth into Regional and National Health Systems



https://sourceonhealthcare.org/cross-market/

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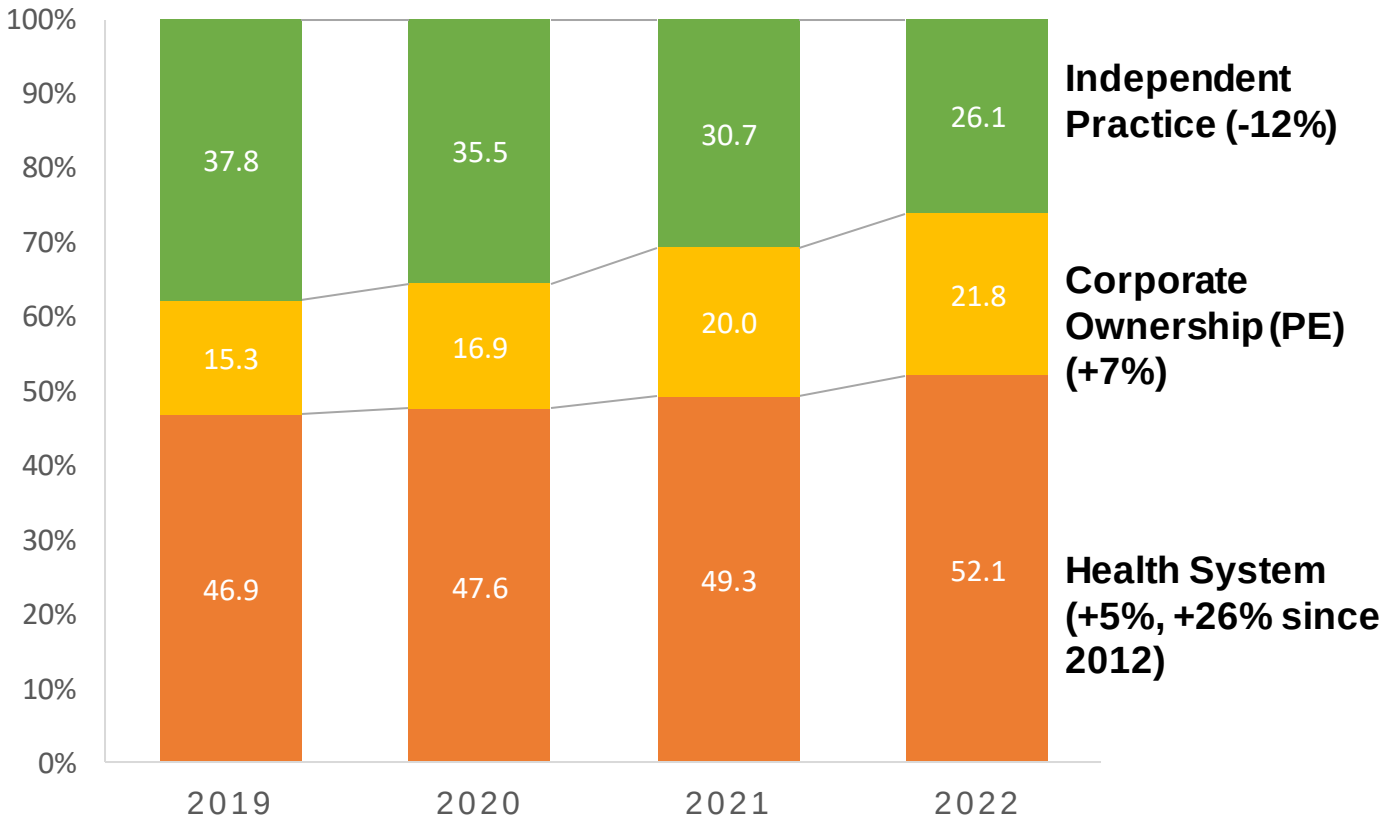
M&A Trend: Acquisition of Physicians

- Vertical integration could reduce administrative burdens, streamline care, and reduce duplicative services.

- But the evidence is…
  - **Health system ownership:**
    - Higher prices and spending (10-20%)
    - Higher use of high intensity services
  - **Private equity ownership:**
    - Higher prices
    - Increased utilization of high-cost services
    - Mixed quality measures
    - Lower patient experience scores

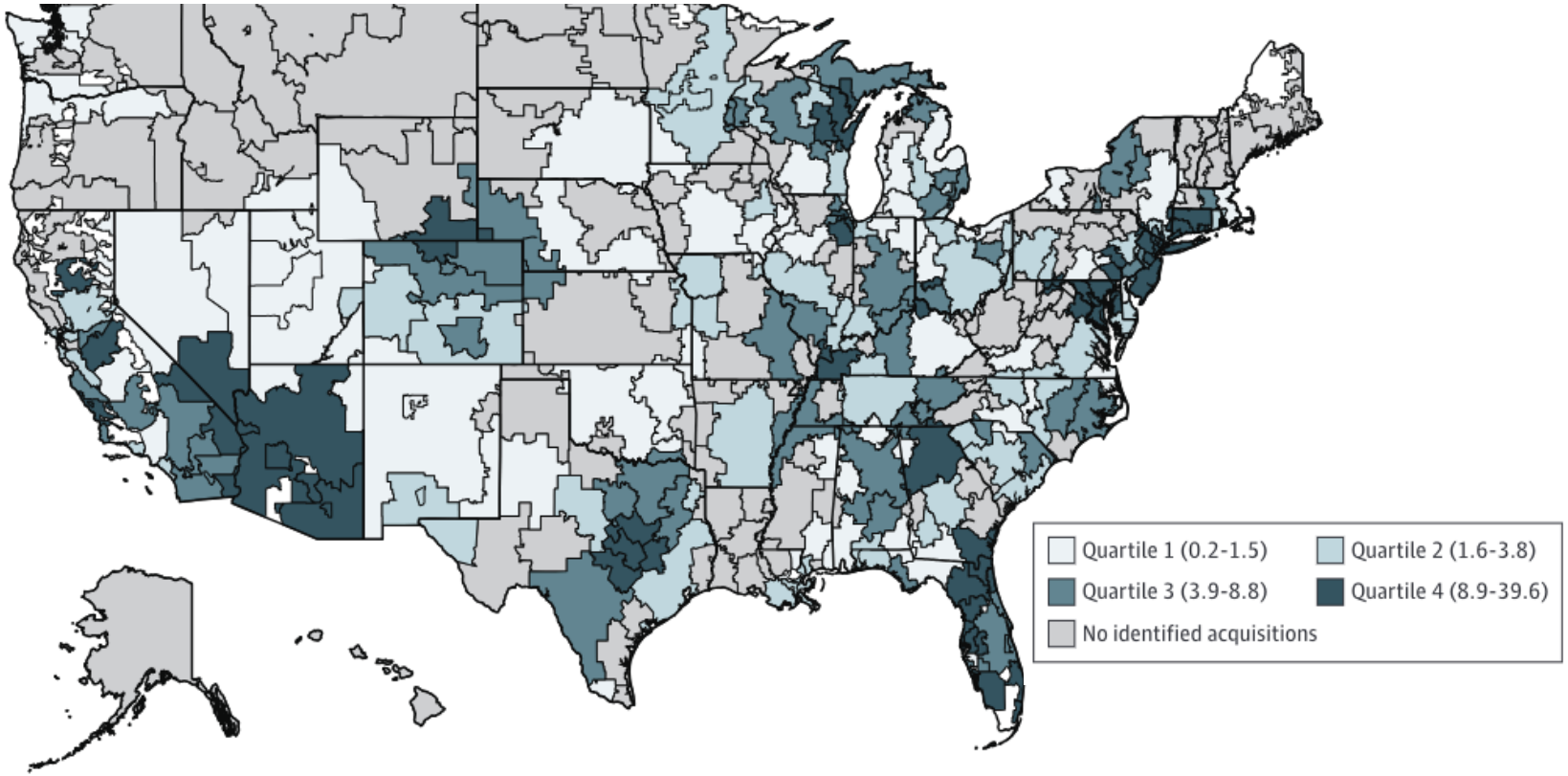


Data from PAI-Avalere Health Report on Trends in Physician Employment and Acquisitions of Medical Practices: 2019-2021

M&A Trend: Private Equity (PE) Owned-Physician Practices

- PE acquisition is not uniform geographically or by specialty
- California has regions with a high percentage of PE-owned physician practices

Figure 1. Private Equity (PE) Penetration Across 6 Office-Based Specialties by Hospital Referral Region (HRR)



Singh et. al., *Geographic Variation in Private Equity Penetration Across Select Office-Based Physician Specialties in the US*. JAMA Health Forum 3(4):e220825 (April 2022).

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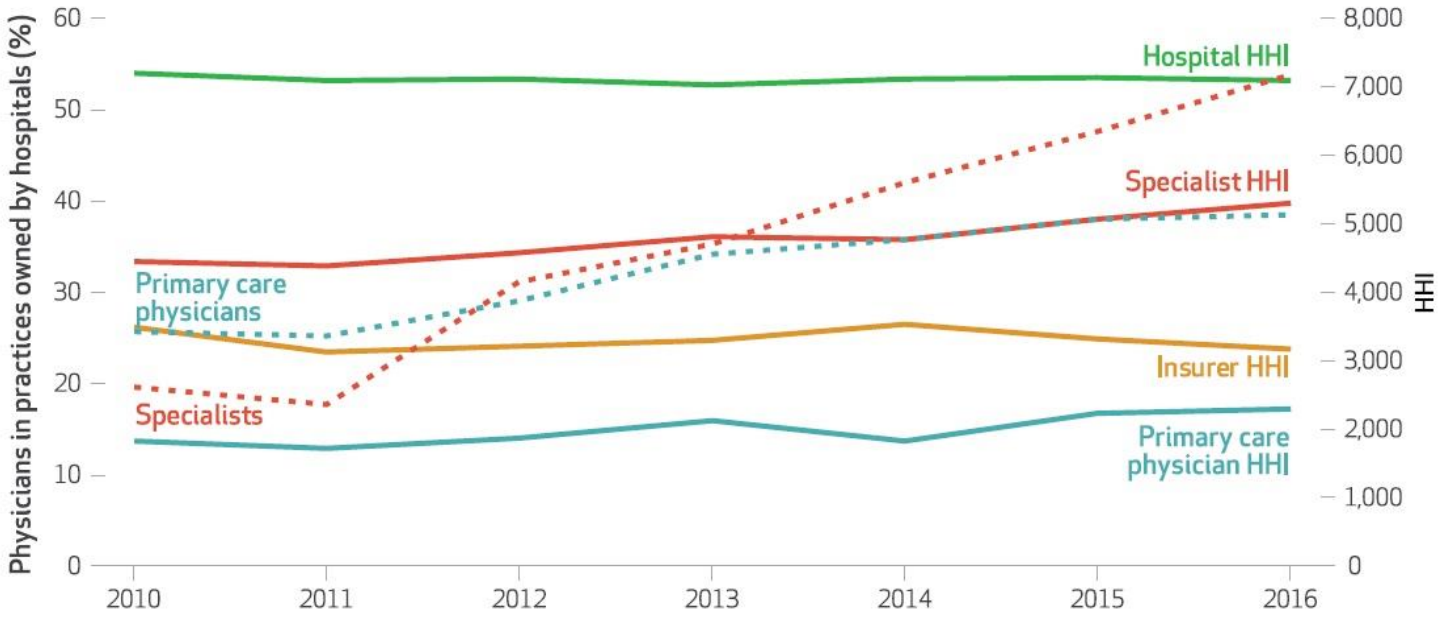
Market Concentration in California Matches the National Trends

EXHIBIT 1

Horizontal concentration and vertical integration in selected California counties, 2010–16



SOURCE Authors' analysis of data for health insurers from the Managed Market Surveyor provided by Decision Resources Group (formerly HealthLeaders-Interstudy), for hospitals from the American Hospital Association Annual Survey Database, and for physicians from the SK&A Office Based Physicians Database provided by QuintilesIMS. **NOTES** Herfindahl-Hirschman Indices (HHIs) indicate market concentration and are explained in the text. The figure shows unweighted data for forty-one California counties with populations of less than 500,000. Specialists include physicians in the fields of cardiology, oncology, radiology, and orthopedics. The dashed lines refer to percentages of primary care physicians and specialists in practices owned by hospitals.

Scheffler et. al., *Consolidation Trends In California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices*. Health Affairs 37:9, p. 1409-1416 (September 2018).

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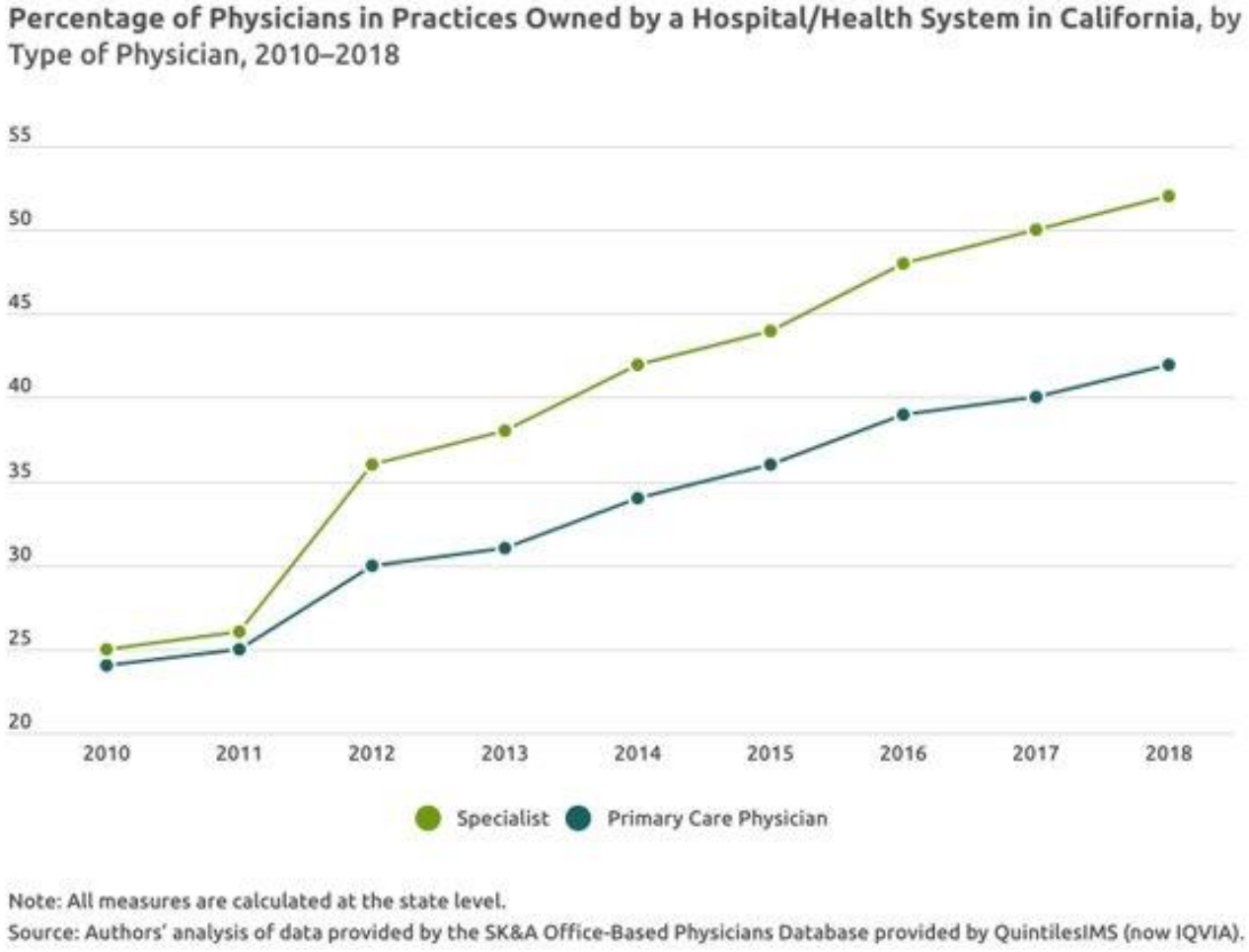
Market Concentration in California Matches the National Trends



Scheffler et. al., *The Sky's the Limit: Health Care Prices and Market Consolidation in California*. California Health Care Foundation (October 3, 2019).

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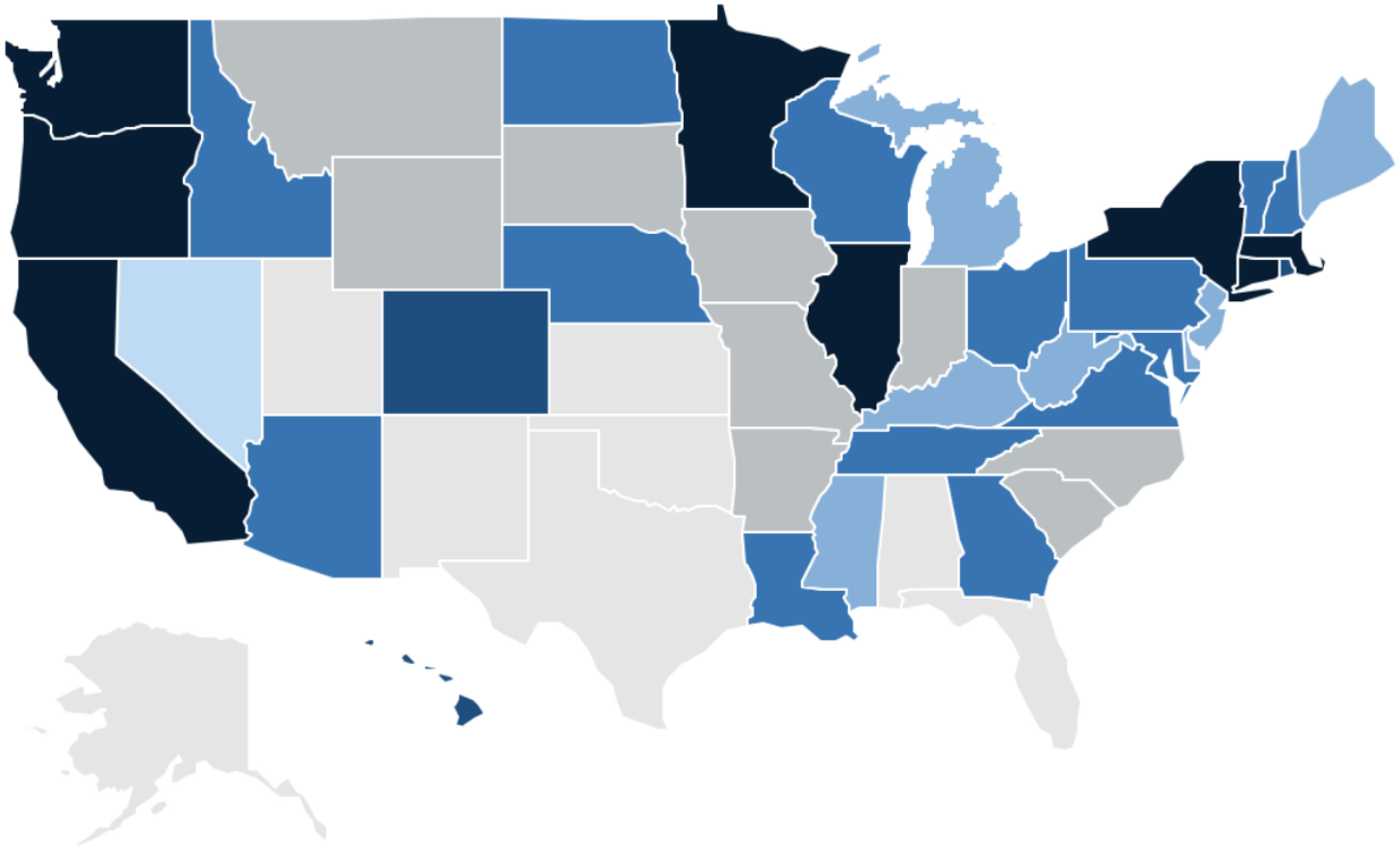
Federal Action to Address Health Care Consolidation

Executive Order on Promoting Competition in the American Economy

DOJ's Withdrawal of Policies on Healthcare Antitrust Safety Zones

House Energy & Commerce bill (H.R. 3561) on transparency of health-related ownership

States Requiring Pre-transaction Filing by Health Care Providers



- No required notice
- Notice of general nonprofit transactions (not healthcare specific)
- Notice of limited provider group transactions
- Notice of nonprofit healthcare transactions
- Notice to CON program
- Notice of all hospital transactions
- Notice of all hospital and most provider group transactions

https://sourceonhealthcare.org/market-consolidation/

States with Agencies to Oversee Consolidation

Massachusetts Health Policy Commission (HPC)

- Providers and provider organizations
- Conducts a Cost and Market Impact Review (CMIR)
- Relies on AG or other agency to block or place conditions on a merger

Oregon Health Authority

- Health care entities (includes payers, providers)
- Two-stage review (like initial review and CMIR)
- Has the authority to block or place conditions on mergers

California Office of Health Care Affordability

- Health care entities (includes payers, providers, fully integrated delivery systems)
- Conducts a CMIR
- Relies on AG or other agency to block or place conditions on a merger

Example: Beth Israel Lahey Health Merger

In July 2017, Lahey Health & Beth Israel submitted a Material Change Notice to become Beth Israel Lahey Health (BILH)

After 30-day review, HPC determined the transaction was likely to have a significant impact on market function

The HPC issued a preliminary report in July and a final report in September 2018 expressing concern of substantially increased commercial prices

The HPC referred the final report to the AG and made recommendations to the Department of Public Health (DPH) to impose conditions on the transaction

In October 2018, the AG entered a consent decree with BILH to impose 7-year prices caps and financial commitments to support underserved communities in Massachusetts AND DPH included conditions in its approval in response to concerns raised by the HPC

Cost and Market Impact Review Program (CMIR)

OHCA Enabling Statute: Legislative Findings

Escalating health care costs are driven primarily by high prices and the underlying factors or markets conditions that drive prices, particularly in geographic areas and sectors where there is a *lack of competition due to consolidation*.

Consolidation through *acquisitions, mergers, or corporate affiliations* is pervasive across the industry and involves health care service plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities.

Market consolidation occurs in various forms

- horizontal, vertical and cross industry mergers,
- transitions from nonprofit to for-profit status or vice versa, and
- any combination involving for-profit and nonprofit entities

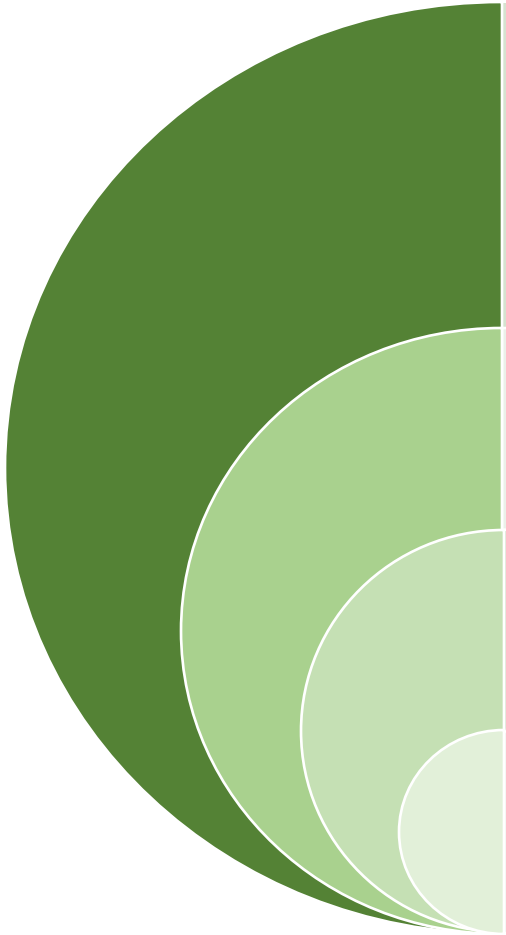
OHCA Enabling Statute: Office Responsibilities

Review and evaluate consolidation, market power, and other market failures through cost and market impact reviews of mergers, acquisitions, or corporate affiliations involving:

- health care service plans,
- health insurers,
- hospitals or hospital systems,
- physician organizations,
- pharmacy benefit managers, and
- other health care entities

Consistent with the Legislative Intent to increase transparency on transactions that may impact competition and affordability for consumers and purchasers.

OHCA's Oversight Role in Assessing Health Care Consolidation



- Support efforts of the Attorney General, the Department of Managed Health Care, and the Department of Insurance and examine impact, both negative and positive, on access and quality in addition to cost for consumers.
- Seek input from the parties and the public and report on the anticipated impacts to the health care market.
- Collect and report information that is informative to the public.
- Refer transactions that may reduce market competition or increase costs to the Attorney General for further review.

Existing Merger Oversight in California

Attorney General

- Approval Authority for non-profit health facilities
- Authority to investigate and enforce laws relating to antitrust, unfair competition, and consumer protection

Department of Managed Health Care

- Approval Authority for major transactions of health care service plans
- DMHC evaluates the impact on enrollees and the stability of the health care delivery system.

California Department of Insurance

- Approval Authority for mergers of domestic health insurers.
- CDI reviews impact on the marketplace and consumers.

Gaps in California's Market Oversight

Agreements or transactions:

- Involving for-profit hospitals and health facilities
- Among physician organizations
- Involving health plan or health insurer purchase or affiliation with another health care entity, such as a physician group
- Involving health plans or health insurers and management service organizations (MSOs)
- Involving Private Equity
- Involving exclusive contracting

CMIR Program Will Fill in Gaps and Increase Public Transparency

Collect and publish notices of material change transactions that will occur on or after April 1, 2024. Health care entities must submit notices to OHCA 90 days before the agreement or transaction will occur.

Upon determination the notice is complete, OHCA will determine within 60-days whether the agreement or transaction must undergo a Cost and Market Impact Review (CMIR).

Conduct CMIR for agreements or transactions after OHCA determines a CMIR is warranted, make factual findings and issue preliminary report, allow written responses from affected parties and the public, and issue final report.

Notices of Material Change Transactions

- Health care entities must submit notices of agreements or transactions that will occur on or after April 1, 2024, and:
  - Sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of its assets to one or more entities; or
  - Transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities.
- Health care entities must submit notices to OHCA 90 days before the agreement or transaction will occur.
- **OHCA will promulgate regulations for required notices and documentation and will start collecting notices January 1, 2024.**
- Notices are not required for transactions subject to DMHC, CDI, or AG review, or county transactions for continued access.

OHCA's Review of Notices of Material Change Transactions

- Upon OHCA's determination the Notice of Transaction is complete, OHCA will conduct a 60-day preliminary review to determine whether the agreement or transaction must undergo a CMIR.
    - If OHCA finds that a material change noticed pursuant to Section 127507 is likely to have a risk of a significant impact on market competitions, the state's ability to meet cost targets, or costs for purchasers and consumers, the office shall conduct a CMIR.
    - OHCA *may* also conduct a CMIR based on Director's determination if spending target data indicate adverse impacts on cost, access, quality, equity, or workforce stability from consolidation, market power, or other market failures.
    - OHCA *may* also conduct a CMIR for agreements or transactions referred to OHCA by the DMHC, CDI, or the AG.
- **OHCA will promulgate regulations regarding the decision to conduct a CMIR.**

CMIR Factors for Analysis, Factual Findings, and Preliminary and Final Report

- A CMIR will examine factors relating to a health care entity's business and relative market position, including changes in size and market share in a given service/geographic region, prices for services compared to other providers for the same services, quality, equity, cost, access, or other factors OHCA determines to be in the public interest.

- OHCA will also consider the benefits of the material change to consumers of health care services, where those benefits could not be achieved without that transaction, including increased access to health care services, higher quality, and more efficient health care services where consumers benefit directly from those efficiencies.

CMIR Factors for Analysis, Factual Findings, and Preliminary and Final Report

- OHCA will make factual findings, issue a preliminary report, allow for written responses from the affected parties and the public, and issue a final report.
- Agreements or transactions subject to a CMIR may not be implemented until 60 days after OHCA issues its final report.
- **OHCA will promulgate regulations regarding the factors OHCA will consider when performing a CMIR and the timeline for conducting CMIRs.**

CMIR Implementation: Looking Ahead

OHCA will promulgate regulations under its emergency rulemaking authority as follows:

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Alternative Payment Models, Primary Care and Behavioral Health Investment, and Workforce Stability

Margareta Brandt, Assistant Deputy Director

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

Primary Care & Behavioral Health Investments

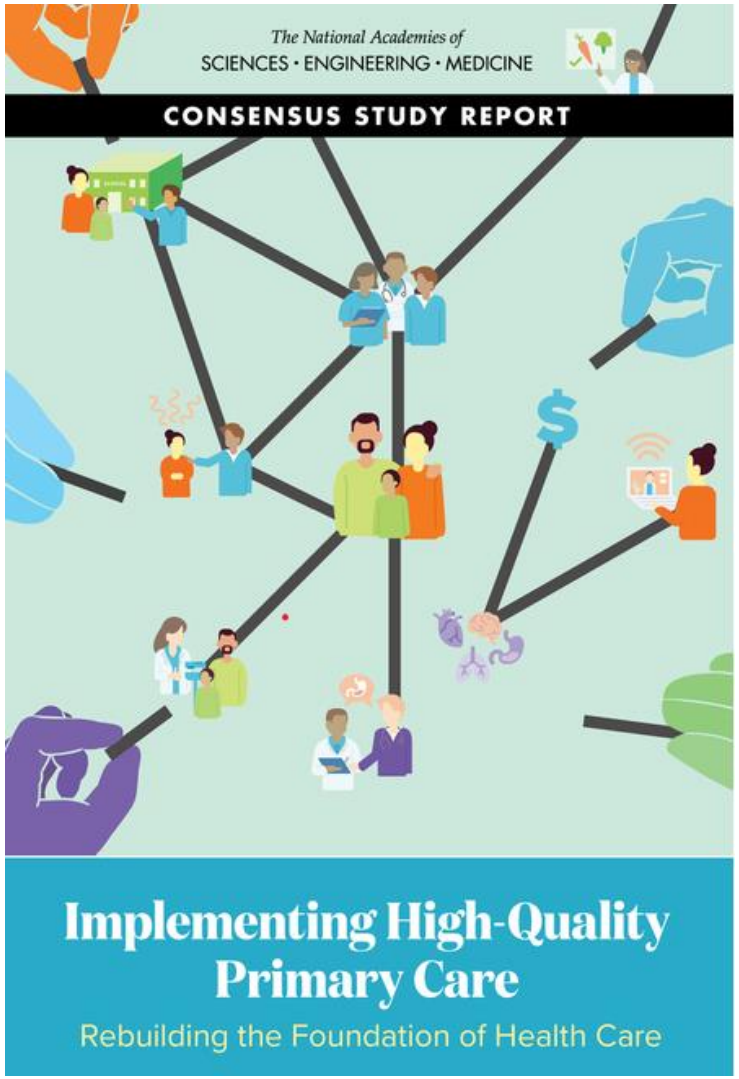
Statutory Requirements

- Measure and promote a sustained systemwide investment in primary care (PC) and behavioral health (BH).
- **Measure the percentage of total health care expenditures allocated to PC and BH** and set spending benchmarks that consider current and historic underfunding of primary care services.
- **Develop benchmarks** with the intent to build and sustain infrastructure and capacity and shift greater health care resources and investments away from specialty care and toward supporting and facilitating innovation and care improvement in PC and BH.
- Promote improved outcomes for PC and BH.

Why Primary Care?

Increased supply of primary care services leads to more equitable outcomes and improved population health (e.g., life expectancy, rates of chronic disease, and other critical measures).

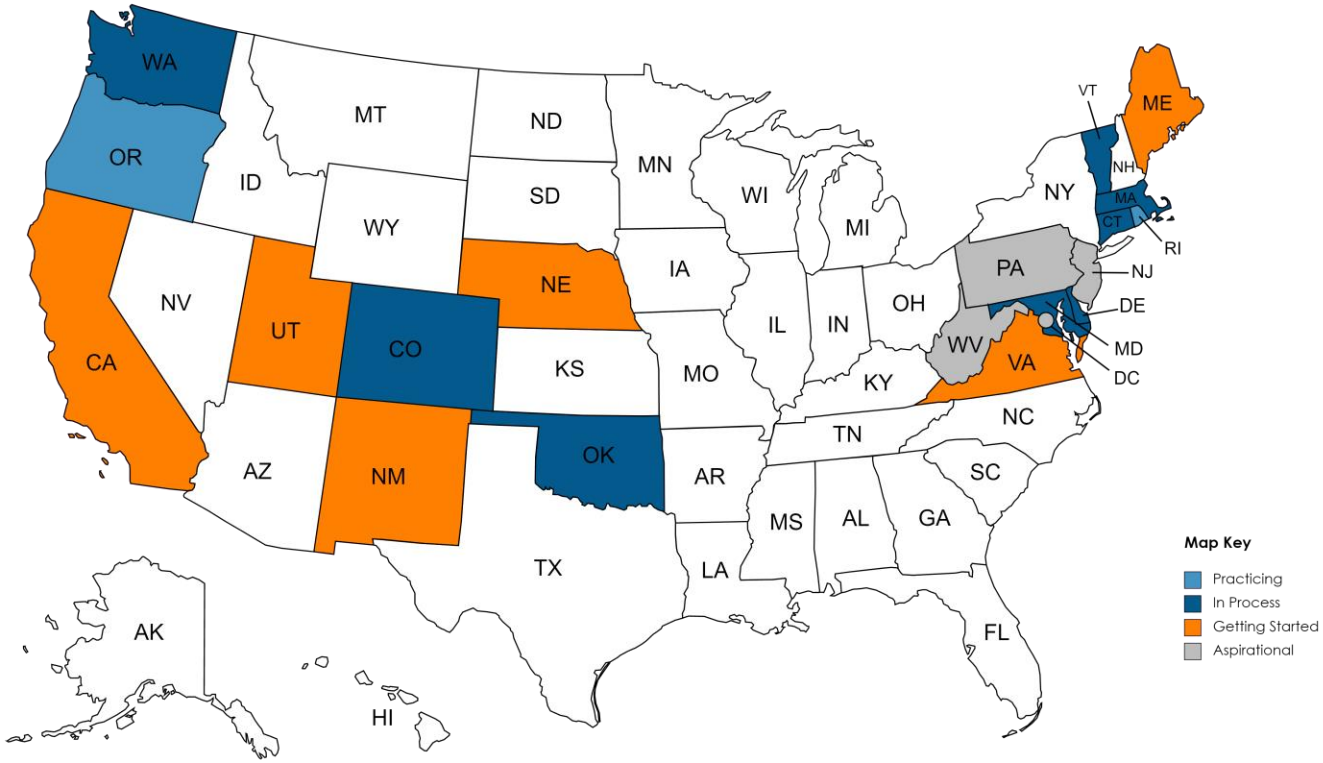
- High functioning health care systems require high quality primary care as a foundation.
- Primary care investment in the United States – which typically ranges from 4% to 7% – lags other high-income nations with higher performing health care systems. In these countries, primary care investment tends to be 12% to 15% of total spending.
- Primary care investment in California was 6.3% of total spending across all payers in 2020, compared to 4.6% nationally, a recent study found.



National Academies of Sciences, Engineering, and Medicine (NASEM). Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. 2021.
Jabbarpour Y., Petterson S., Jetty A., Byun H. The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care, 2023.

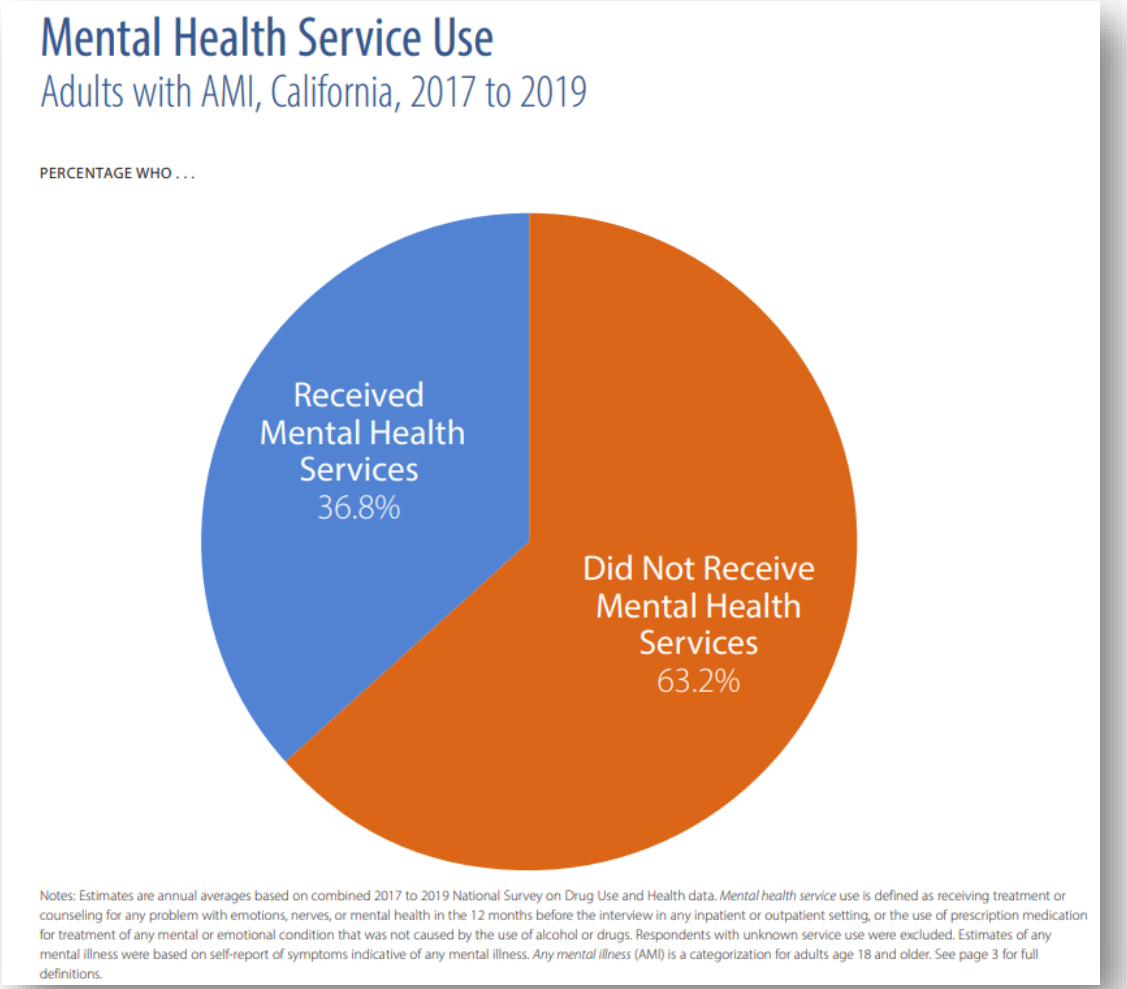
State Efforts to Measure Primary Care Investment

- Over a dozen states have launched efforts to allocate a greater proportion of the health care dollar to primary care.
- Most begin with measurement and reporting, but definitions vary.
- Five states — RI, OK, OR, CO, DE – require a defined level of primary care spend for at least one payer type.
- A growing number of efforts include certain behavioral health services and non-claims spend in their primary care definitions.



Why Behavioral Health?

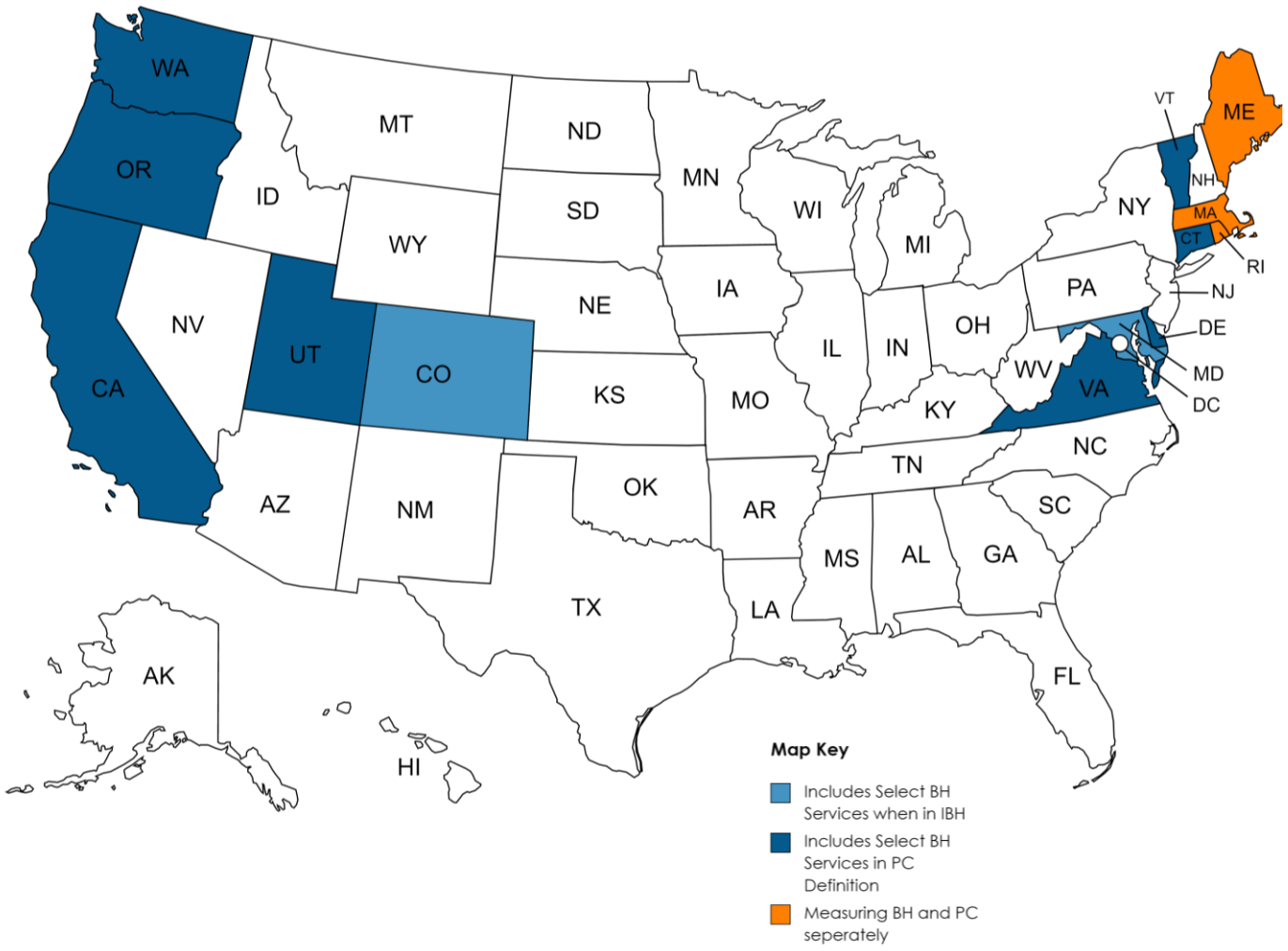
- Nationally, the percent of adults reporting symptoms of anxiety and/or depression increased during the pandemic and remains just above 32%.
- Similarly in California, nearly 32% of adults report symptoms of anxiety and/or depression. Further, nearly two-thirds of California adults with mental illness reported not receiving treatment.
- Health care delivery models that integrate primary care and behavioral health have been shown to improve access to effective behavioral health services that improve health outcomes, as well as deliver a return on investment by reducing downstream health care costs.



California Health Care Almanac. Mental Health in California: Waiting for Care. California Health Care Foundation. July 2022.
NASEM. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. 2021.
Kaiser Family Foundation. Mental Health and Substance Use Fact Sheets 2023.

State Efforts to Measure Behavioral Health Investment

- Three states measure behavioral health investment across all clinical services.
- Nine states include some behavioral health services in their primary care investment definitions. Of these, three calculate spending on integrated behavioral health or are considering it.
- Best practices are emerging regarding diagnoses, services, and providers to include but there is no standard definition.



Alternative Payment Models

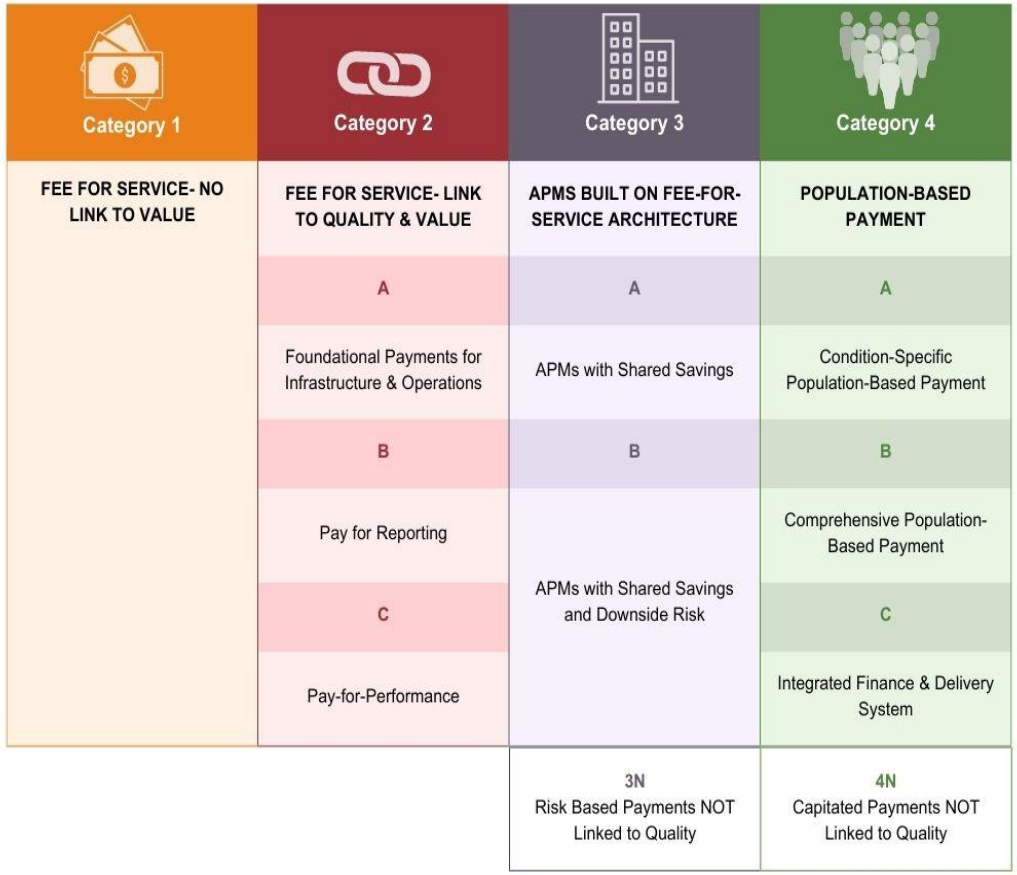
Statutory Requirements

- Promote the shift of payments based on fee-for-service (FFS) to alternative payment models (APMs) that provide financial incentive 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.

Why Alternative Payment Models?

- Alternative Payment Models (APMs), or value-based payments, align payer-provider payment approaches to incent high-quality, cost-efficient care.
  - Models span the continuum of clinical responsibility and financial risk moving from volume to value.
- In 2016, the Centers for Medicare and Medicaid Services and large payers established the Health Care Payment Learning and Action Network (HCP-LAN) framework for categorizing APM arrangements according to the level of risk assumed by a provider. It is one of a few commonly used categorizations of value-based payments.
- Overall, movement to APMs has been slower than many hoped. Nationally in 2021, over 40% of payments were still in FFS payment arrangements (Category 1).
- In 2021 in California's commercial market, 64% of members were in capitation-based arrangements, followed by 36% in fee-for-service arrangements.

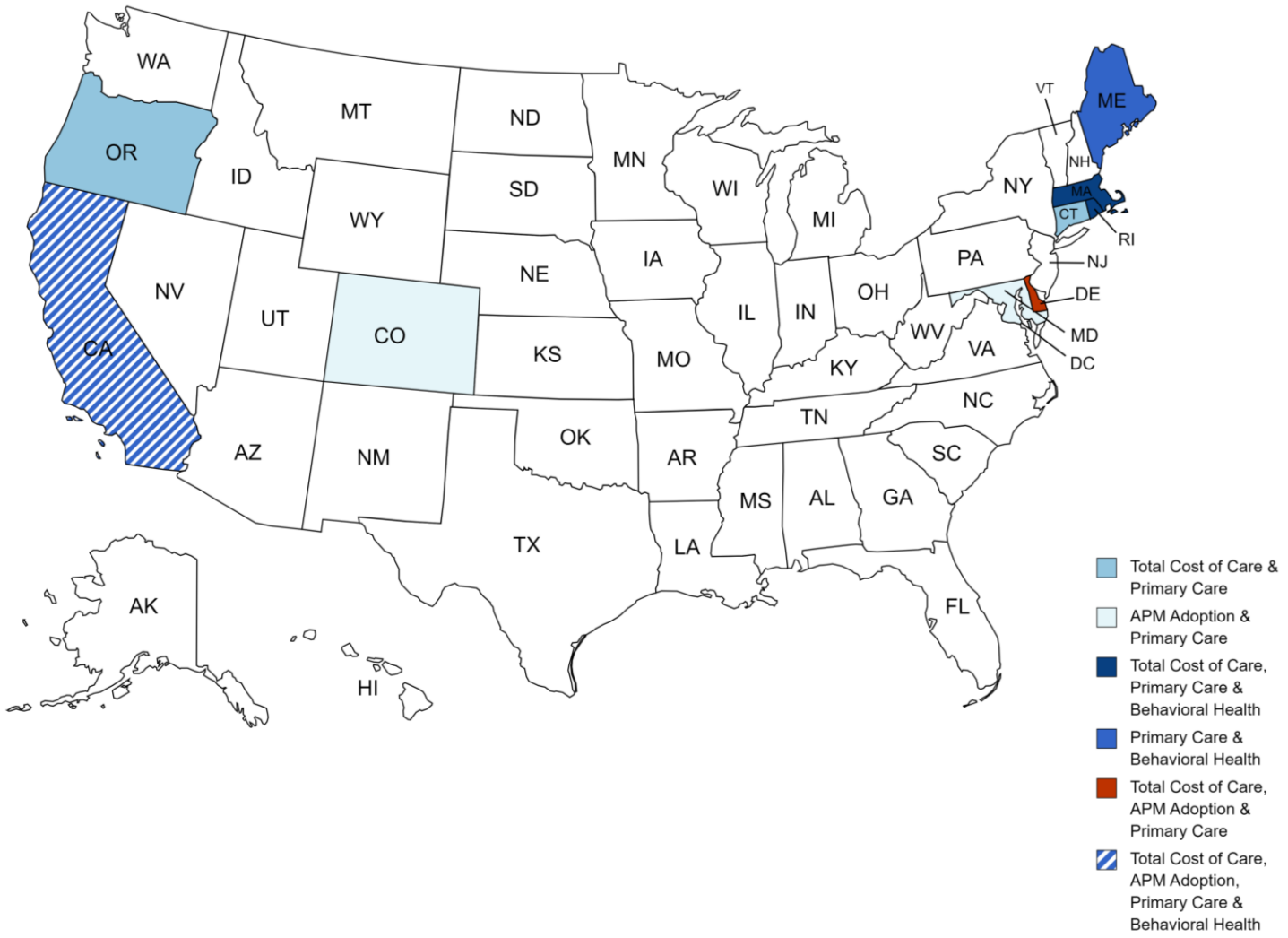
HCP-LAN APM Framework



Health Care Payment Learning and Action Network, HCP-LAN APM Measurement Effort Results APM Measurement Survey, 2022
California Regional Health Care Cost & Quality Atlas, Integrated Healthcare Association, 2023.

What's Occurring in Other States

- There are nine states collecting APM data from payers with different authority and use cases.
- Some states collect data through multiple avenues for different use cases.
- Definitions and categories of value-based payments vary.
- Payers report little insight into the distribution of non-claims payments within provider organizations.



Freedman HealthCare analysis of state reports and data collection materials

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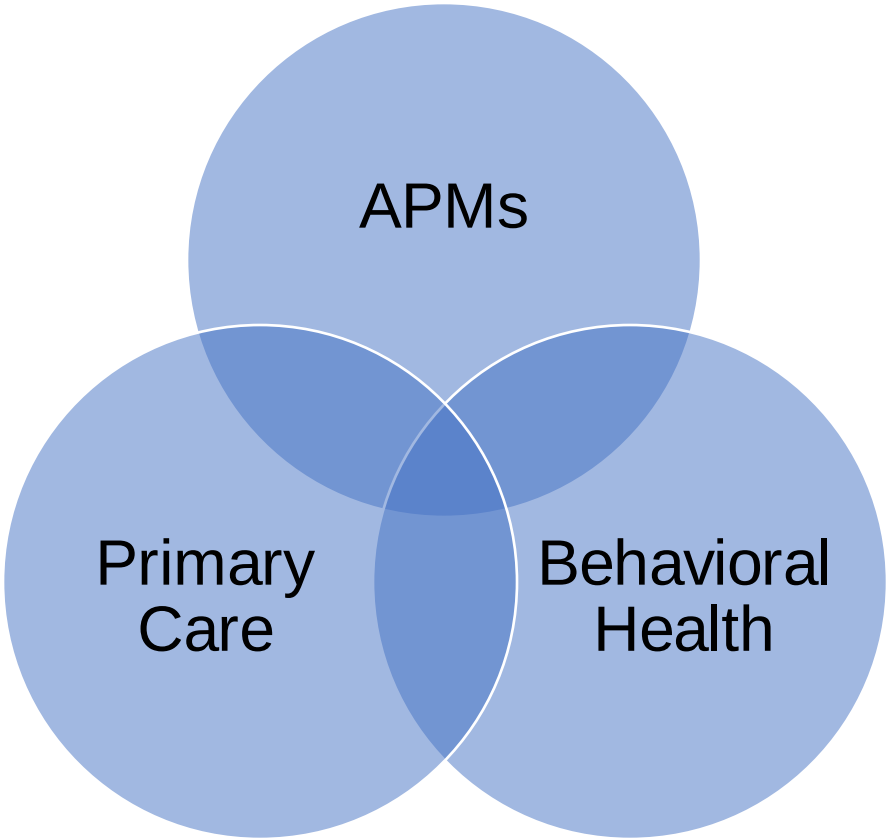
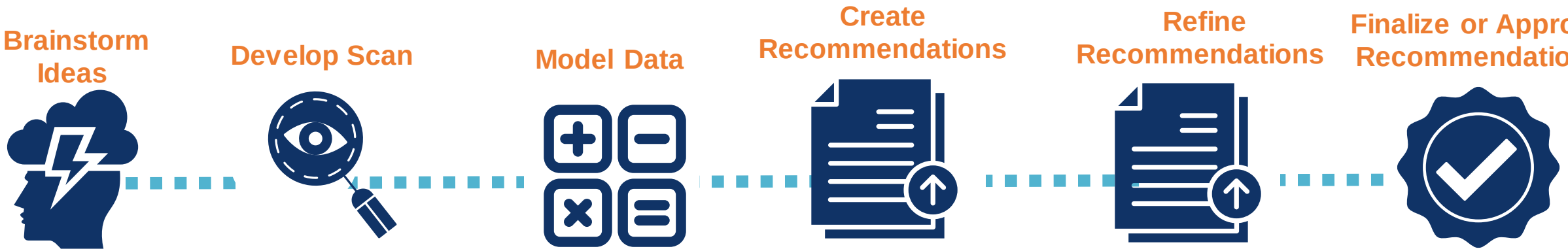
APMs, Primary Care, and Behavioral Health Are Interconnected

- APMs often support advanced primary care including integrated behavioral health.
- APM performance frequently is tied to the primary care relationship and performance.
- Behavioral health is an important and growing component of primary care.
- Integration and coordination across behavioral health and primary care is critical to achieving the best outcomes.



Planned Approach for APM Adoption, Primary Care and Behavioral Health Workstreams



Gain Input
(Investment & Payment Workgroup, Stakeholder Interviews)

Incorporate Feedback
(Board, Advisory Committee, Workgroup)

Workgroup to Engage Stakeholders on APM Adoption, Primary Care and Behavioral Health Investment

OHCA is launching the Investment and Payment workgroup to support the development of the APM, primary care, and behavioral health definitions, data collection processes, and benchmarks.

The workgroup will:

- Ensure stakeholder engagement in key program development decisions about definitions and data collection
- Provide input and feedback as OHCA develops recommendations for benchmarks
- Identify and discuss the relationships and interactions between the APM, primary care, and behavioral health components

Workgroup members will include representatives from:

- Patients/families
- Primary care clinicians
- Physician organizations (medical group, IPA, FQHC)
- Hospitals/health systems
- Health plans
- Consumer advocates
- Researchers/experts
- State departments engaged in related work

Examples of 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 Goal 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

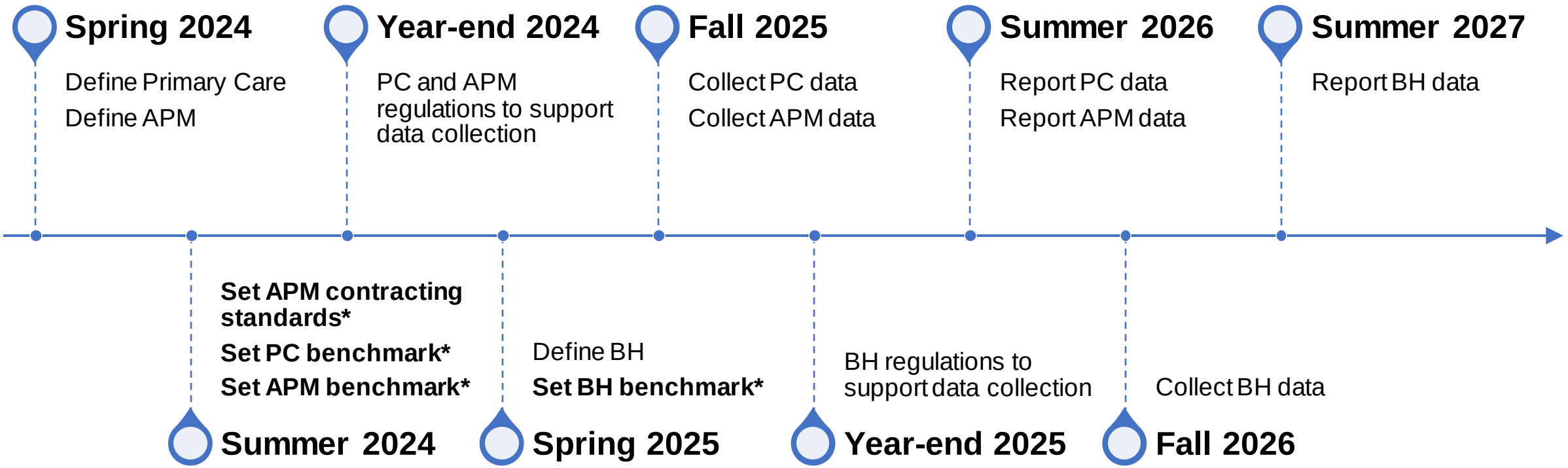
Investment Benchmark: Variation by market (Commercial, Medi-Cal) or population (adult vs. pediatric)

Behavioral Health

Definitions, Measurement, Reporting: Behavioral health providers, services, site of service, non-claims; capturing carved out behavioral health spending

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

Preliminary Timeline for APM, Primary Care, and Behavioral Health Workstreams



***Board approval required**

All included in the first annual report, due June 2027

Health Care Workforce Stability

Statutory Requirements

- Monitor the effects of spending growth targets on health care workforce stability, high-quality jobs, and training needs of health care workers.
- Monitor health care workforce stability with the goal that workforce shortages do not undermine health care affordability, access, quality, equity, and culturally and linguistically competent care.
- Promote the goal of health care affordability, while recognizing the need to maintain and increase the supply of trained health care workers.
- **Develop standards, in consultation with the Board, to advance the stability of the health care workforce.**

Health Care Workforce Stability

Statutory Requirements

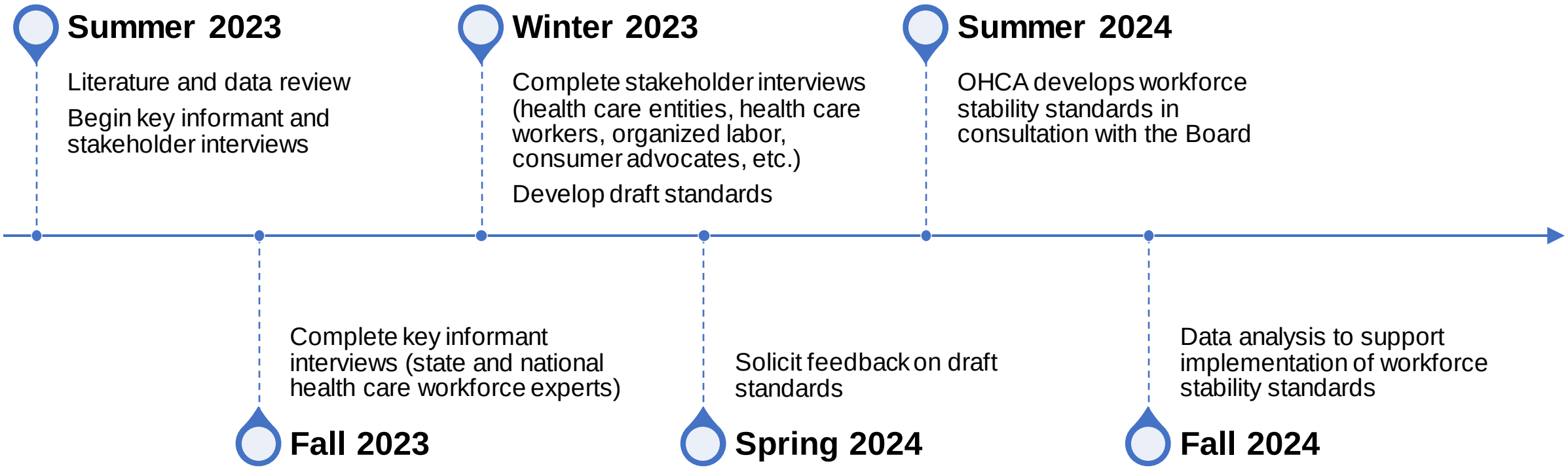
- **The Board approves standards to advance the stability of the health workforce that may apply in the approval of performance improvement plans.**
- OHCA may require a health care entity to implement a performance improvement plan that identifies the causes for spending growth and shall include specific strategies, adjustments, and action steps the entity proposes to implement to improve spending performance during a specified time period. The director shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode access, quality, equity, or workforce stability.

Health and Safety Code 127501.11, 127502.5

Why Workforce Stability?

- California currently faces a significant health workforce shortage, including an imbalanced geographic distribution of health care workers.
- Health workforce challenges contribute to lack of access to needed services, including preventive services; delays in receiving appropriate care; and preventable hospitalizations.
- Efforts to slow spending growth may have unintended negative consequences if health care entities reduce labor costs through staffing reductions.
- A stable, well-prepared, and adequately supplied workforce is essential to a sustainable health care system that provides high-quality, equitable care to all Californians.
- No other state has included workforce stability standards in its spending growth target efforts.

Preliminary Timeline for Workforce Stability Workstream



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Total Health Care Expenditures (THCE) Measurement

Vishaal Pegany, Deputy Director
Michael Bailit, Bailit Health

Recap of May Board Meeting

During the third Board meeting in May, we:

1. Reviewed OHCA's contemplated approach for reporting and disaggregating THCE, including:
   - Levels of reporting: State, market, payer, and provider entity
   - Considerations for regional and service category level analyses of THCE
2. Described OHCA's considerations for measuring total medical expenses (TME) at the large provider entity level
3. Began discussion of spending target program adjustments, including risk adjustment methodologies for the reporting of THCE

Today's Discussion

Continue discussion of spending target program adjustments

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Spending Target Program Adjustments

Spending Target Program Adjustments by Reporting Years

Baseline Reporting 2022-2023

Risk Adjustment; Statute requires adjustment for reporting of data on total health care expenditures.

Annual Performance Starting 2024-2025

Risk Adjustment; Statute requires adjustment for reporting of data on total health care expenditures

Equity
Statute requires adjustment, with flexibility on how to implement

Quality
Optional adjustment per statute, with flexibility on how to implement

Organized Labor; Statute requires target adjustment based on non-supervisory labor costs

Medi-Cal
Optional adjustment per statute, with flexibility on to how to implement

Risk Adjustment

Risk Adjustment (Recap)

- **Enabling statute:** “In consultation with the board, the office shall establish risk adjustment methodologies for the reporting of data on total health care expenditures and may rely on existing risk adjustment methodologies. The methodology shall be available and transparent to the public….
- The risk adjustment methodologies selected or used to inform any adjustments shall take into account the impact of perverse incentives that may inflate the measurement of population risk, such as upcoding. The office may audit submitted data and make periodic adjustments to address those issues as necessary.”

What is Risk Adjustment?

- **Risk adjustment** (or health status adjustment) is a process whereby a payment, quality, or performance measure is modified (typically multiplied or divided) by a risk score.
- A **risk score** is used to estimate how much it will cost to care for a patient based on their underlying characteristics relative to a population average.
  - Risk scores are typically derived from equations that relate health care expenditures to patient characteristics using health care claims data.
  - Most risk score formulas rely on the patient's (or population's) "claims history" – and particularly their accumulated diagnoses, plus age and gender.
- In payer/provider contracts, risk scores can be used to "adjust" the dollar amounts allocated to that patient's (or population's) care, so that resources will be matched to projected need for services and care.

Diagnosis-based Risk Adjustment

- Using risk adjustment based on diagnosis raises concerns about equity as ***utilization reflects both need and access to care***
  - When risk adjustment is based on utilization history, the calculation assigns higher risk scores to those with higher utilization.
- Diagnosis-based risk adjustment is also heavily influenced by provider claim coding practices.

States' Experience with Rising Risk Scores

- **MA** has observed steadily rising risk scores, amounting to an 11.7% increase between 2013 and 2018 with only a small portion explained by demographic trends or changes in disease prevalence.
  - The MA Health Policy Commission now recommends evaluating payer and provider performance based on growth in *unadjusted* spending.
- Payer risk scores in **RI** grew 4.6% from 2018 to 2019 (excluding Medicare-Medicaid plans).
  - Rising risk scores had the effect of raising the cost growth rate that would meet the target, increasing the effective target from 3.2% to 6.4%.
  - The state *moved to age / sex adjustment* as a result.

➢ NJ, OR, RI and WA are now using age / sex adjustment; NV's governing body recommended no risk adjustment.

Risk Adjustment Model Options

1. **Clinical risk adjustment**
   - Used to assess conditions diagnosed and treated during the performance year to predict spending in the same year.
   - Available models use claim and encounter data, such as diagnoses, procedures, and prescription drugs. They do not include medical record information (e.g., clinical indicators of severity, measures of prior use, lifestyle or supplemental demographic information).
   - The best risk adjustment models can explain about half of the variation on health care spending, and a little more if spending for the highest cost outliers is truncated.
2. **Age/Sex factors**
   - Risk adjust spending using standard **age/sex factors** only. Payers report spending by age/sex. Spending at the payer and provider levels are adjusted based on relative weighting. The weights can be calculated using market-specific payer-submitted data or be initially defined.

	Advantages	Disadvantages
Option 1: Clinical	• Explains variation in spending at the member/patient level. • Ensures assessments of entity performance are not influenced by changes in the health status of their populations during the measurement period.	• May not fully capture or reflect the need or health status of individuals who experience barriers to accessing care (Based on claims history). • Can change annually without changes in the population's underlying risk due to improved coding, distorting changes in population health status. • Can penalize entities that effectively manage care of members/patients with significant chronic conditions. • Methodologies vary across payers and specifying a standard methodology (either an existing one or OHCA developing one) would increase administrative burden.
Option 2: Age/Sex	• Captures the impact of an incrementally aging population, which may be the most significant change affecting population health status over the course of one year. • Standardizes the risk adjustment methodology within a market across insurers. • Not subject to gaming that leads to inflation of population risk. • Removes biases from utilization history, which does not accurately reflect both need and equitable access to care.	• Does not reflect differences in expected spending across subpopulations, e.g., patients with multiple chronic conditions and patients without any. • Does not capture more substantive annual changes in health status due to shifts in membership, such as when a payer's risk mix improves due to new contracts.

OHCA's Approach for Risk Adjustment

- Risk adjusting for age/sex factors only to:
  - capture the impact of an incrementally aging population, and
  - avoid the distortion associated with coding practices.

- OHCA would establish reporting of age/sex data and in some fashion develop relative weighting for uniform application across insurers and provider entities within a market (i.e., commercial, Medi-Cal, Medicare).

Quality and Equity Adjustments

Quality and Equity Adjustments

Quality Adjustments

Enabling statute: The spending target methodology "shall allow the board to adjust cost targets downward, when warranted, for health care entities that deliver high-cost care that is not commensurate with improvements in quality, and upward, when warranted, for health care entities that deliver low-cost, high-quality care."

Equity Adjustments

Enabling statute: "the office shall establish equity adjustment methodologies to take into account social determinants of health and other factors related to health equity, to the extent data is available and methodology has been developed and validated."

OHCA's Approach: Quality Adjustments

OHCA is currently performing analysis to identify data sources and develop approaches for performing quality adjustments.

OHCA's Approach: Quality Adjustments

The Board has approval authority for adjustments pertaining to quality.

OHCA's Approach: Equity Adjustments

OHCA is currently performing analysis to identify data sources and develop approaches for performing equity adjustments.

Organized Labor Adjustments

Organized Labor Adjustments: Statutory Language

- The office shall develop a methodology that shall allow the board to **adjust cost targets to account for organized labor costs.**

- The spending target methodology shall require the board to adjust cost targets as appropriate for a provider or a fully integrated delivery system to account for **actual or projected nonsupervisory employee organized labor costs, including increased expenditures related to compensation.**

- The target shall be adjusted for a provider or fully integrated delivery system's cost target, as appropriate **upon a showing that nonsupervisory employee organized labor costs are projected to grow faster than the rate of any applicable cost targets.**

Organized Labor Adjustment: Statutory Language

- For an adjustment to be effectuated, the provider, the fully integrated delivery system, or other associated party **shall submit a request with supporting documentation in a format prescribed by the office.**

- To validate the basis for the requested adjustment, the office may request or accept further information, such as any single labor agreement that is final and reflects the actual or projected increased nonsupervisory employee organized labor costs. The office may audit the submitted data and supporting information as necessary.

OHCA's Approach: Organized Labor Adjustment

OHCA will develop the process for evaluating requests for an adjustment to the target based on actual or projected nonsupervisory organized labor costs increases impacting the entity's ability to meet the target. This will include collection, required format, and validation of supporting documentation.

OHCA's Approach: Organized Labor Adjustment

The Board has approval authority for adjustments pertaining to organized labor costs.

Medi-Cal

Medi-Cal Adjustment: Statutory Language

- …shall allow the board, to the extent necessary for the Medi-Cal program to comply with federal requirements…to adjust any targets, when warranted, as they pertain to health care entities in the Medi-Cal program, upon the request of the Director of Health Care Services."

- OHCA is coordinating with DHCS on data collection and any proposed adjustments to the spending target.

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Other Options for Refining Statistical Confidence and Understanding of Spending

Additional Adjustments for Future Reporting of Performance Relative to the Spending Target

- States have implemented strategies to increase statistical confidence in performance relative to the spending target at the payer and provider levels.
  - At the state and market levels, population sizes are significant enough that measurements are statistically stable (i.e., not impacted by random variability in utilization and patient conditions).
- At the payer and provider levels, states incorporate other adjustments, *in addition to risk adjustment*, to increase statistical confidence in assessment of spending growth.
  1. **Truncation** of high-cost outlier spending at established thresholds
  2. Use of **confidence intervals** around spending growth rates to report performance
  3. Reporting performance only for insurers and large provider entities that meet a **minimum threshold** for attributed lives. *(To be discussed at a future meeting.)*

Truncation

Truncation of High-Cost Outlier Spending

- High-cost outlier spending represents extremely high levels of annual health care spending for individual patients/members.
  - This is real spending that is incorporated into measurement of spending growth.
  - The spending mostly presents randomly in a population.
  - There are limits to how much of the spending can be influenced due to individuals' complex medical conditions and high-intensity care needs.
- Outlier spending may inflate the base year upon which performance against a spending target is measured.

Truncation of High-Cost Outlier Spending (cont'd)

- It is common practice in total cost of care contracts to truncate expenditures to prevent annual swings in the number of extremely costly patients/members from significantly affecting payers' and providers' per capita expenditures.
- For spending target purposes, truncation involves capping individual patient annual spending so that spending above the truncation point is excluded from the trend calculation.

Rhode Island's Experience

- In RI, analyses showed that high-cost outlier spending significantly affected performance of provider entities.
  - For one RI ACO, including high-cost outlier spending raised the growth rate by several percentage points in one year.
- The differential treatment of high-cost outliers in the spending growth program and in total cost of care (TCOC) contracts led to confusion and tension around reporting of performance.
- As a result, RI began truncating high-cost outliers starting with 2020 performance data. This has become practice across many states.

Example of Truncation Points from Washington

Market	Per Member Truncation Point
Medicare	$125,000
Medicaid	$125,000
Commercial	$200,000

Truncation

OHCA is assessing the application of high-cost outlier truncation, and specifically the operational considerations given the prevalence of capitated payment arrangements in California.

Confidence Intervals

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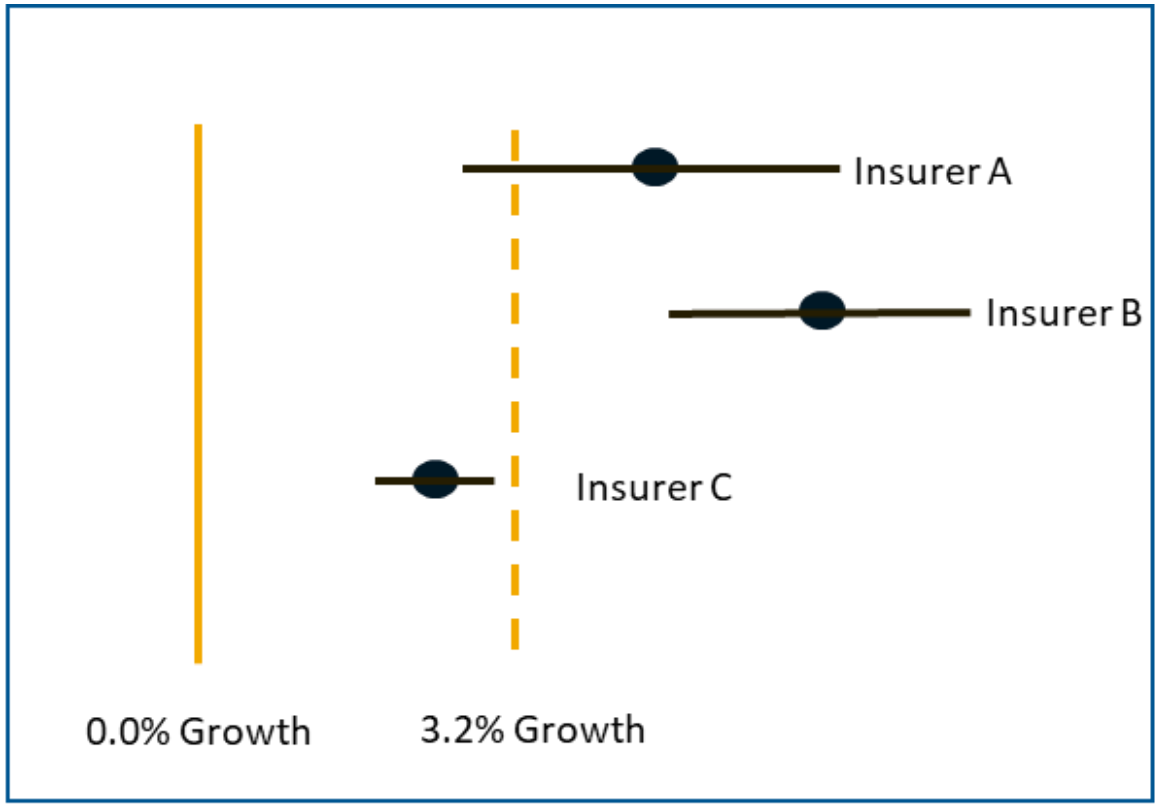
Confidence Intervals

- When measuring change in spending from one year to the next, states often perform statistical testing on payer and entity-level performance to confirm whether the spending target was met.
- A confidence interval shows the possible range of values in which we are fairly certain the spending increase that is within the entities' control lies.
  - In practice, it allows us to make the following statement: “We are 95% confident that the interval between A [lower bound] and B [upper bound] contains the rate of spending growth for the entity.
- This is especially helpful when measuring small populations (which could occur at the payer or provider entity level).

What Performance Measurement Using Confidence Intervals May Look Like

- Performance *cannot be determined* when upper or lower bound intersects the benchmark (e.g., Insurer A).
- Benchmark has *not been achieved* when lower bound is fully over the benchmark (e.g., Insurer B).
- Benchmark has been *achieved* when the upper bound is fully below the benchmark (e.g., Insurer C).



Note: Figure is not to scale

OHCA's Approach for Using Confidence Intervals

- OHCA is assessing the possible application of confidence intervals for payer and provider entity reporting. In doing so, OHCA is considering the implications of the common use of capitated payments in California.

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General Public Comment

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

Next Meeting:

July 25, 2023
10:30 am

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

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Adjournment

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Appendix

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