HCAi
Department of Health Care Access and Information

Health Care Affordability Board Meeting

January 24, 2024

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Department of Health Care Access and Information

Welcome, Call to Order, and Roll Call

Agenda

1. **Welcome, Call to Order, and Roll Call**
   Secretary Mark Ghaly, Chair

2. **Executive Updates**
   Elizabeth Landsberg, Director, and Vishaal Pegany, Deputy Director

3. **Action Consent Item**
   Vishaal Pegany
   a) Approval of the December 19, 2023 Meeting Minutes

4. **Informational Items**
   a) Spending Target Methodology and Statewide Spending Target Value Including Feedback from January 23, 2024 Advisory Committee Meeting
      Vishaal Pegany and CJ Howard, and Michael Bailit, Bailit Health
   b) Examples of Cost-Reducing Strategies Employed by Elevance and Sharp Rees-Stealy
      Margareta Brandt, Assistant Deputy Director
   c) Consumer Stories on Affordability
      Megan Brubaker, Engagement and Governance Manager
   d) Update on Total Health Care Expenditure (THCE) Proposed Regulations and Data Submission Guide
      CJ Howard, Assistant Deputy Director
   e) Hospital Measurement: Introductory Discussion of OHCA's Plan for Measuring Hospital Spending
      Vishaal Pegany, and John Freedman, Mary Jo Condon, Sarah Lindberg, and Gary Swan, Freedman Health Care

5. **Public Comment**

6. **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

Quarterly Work Plan*

	THCE & Statewide Spending Targets	Cost and Market Impact Review (CMIR)	Promoting High Val	Advisory Committee
JAN 2024	• Update on THCE proposed regulations and data submission guide • Examples of cost-reducing strategies • Consumer stories on affordability • Spending target methodology and statewide spending target value including feedback from January 23, 2024 Advisory Committee meeting • Hospital Measurement: Introductory discussion of OHCA's plan for measuring hospital spending **OHCA Posts Recommended Spending Target**	• Update on go live for Material Change Notice portal	• Progress update on alternative payment model (APM) and primary care workstreams • Examples of cost-reducing strategies	• Review OHCA's spending target recommendation • Examples of cost-reducing strategies • Progress update on workforce stability standards
FEB 2024	• Consumer stories on affordability • Consumer affordability measures: Impact of program on affordability for consumers and purchasers of health care • Follow up on spending target methodology and statewide spending target value **OHCA Submits THCE Data Collection Regulations to OAL**		• Examples of cost-reducing strategies	
MAR 2024	• Board discussion of public comments received on recommendations for proposed spending target		• Draft APM definitions, data collection approach, goals & standards	

* Work plan is subject to change.

Future Topics Beyond March 2024

THCE & Spending Target

- Introduction on payer administrative cost and profits
- Considerations for public reporting of spending in baseline report
- Approach for measuring out-of-pocket spending

Promoting High Value

- Introduction to APM standards and adoption goal, primary care spending definitions and benchmark, and workforce stability standards for feedback
- Adopt primary care spending benchmark
- Adopt APM standards and adoption goal
- Review final workforce stability standards

Assessing Market Consolidation

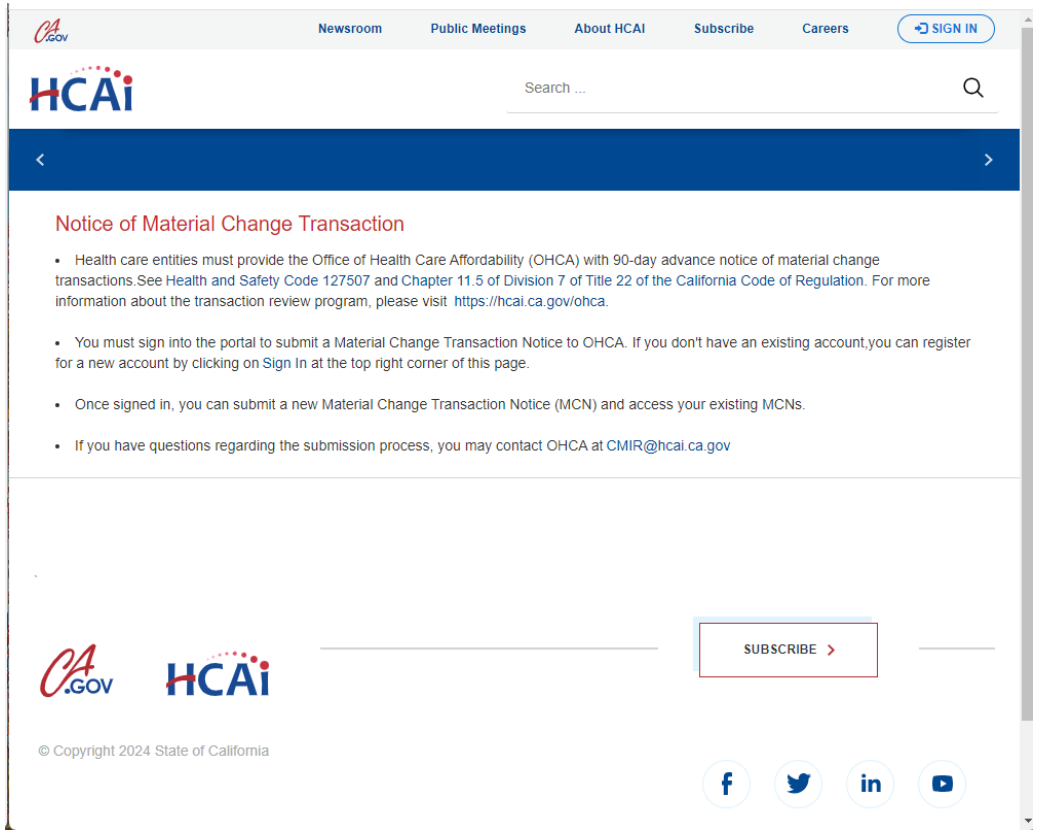
- Updates on material change notices received, transactions receiving waiver or warranting a CMIR, and timing of reviews for notices and CMIRs

Addressing Market Consolidation

Health System Compliance Branch Updates

Reviews of Material Change Transactions Update:

- Regulations Effective December 18, 2023.
- Submission Portal Live
  December 28, 2023
  - Available from HCAI home page
    “Login” or OHCA page
  - Direct link: https://ohca-mcn.hcai.ca.gov/
  - Notice sent to Listserv
    Tuesday, January 2, 2024



Reviews of Material Change Transactions Going Forward:

- Material Change Transaction Notices (MCNs) will be reviewed by OHCA Staff with assistance from economic experts, as needed.
- Notices will be posted on OHCA's web site.
- If warranted, transactions will undergo a cost and market impact review (CMIR).
- Any CMIR will result in a preliminary report which the parties and public can review and comment on before a final report issued.
- OHCA will report regularly to the Board on numbers of MCNs reviewed, transactions undergoing CMIRs, and length of time for MCN and CMIR review.

Promoting High Value

Health System Performance Branch Updates

Focus Areas for Promoting High Value

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

Investment and Payment Workgroup Members

Providers & Provider Organizations

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

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

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

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

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

Janice Rocco
Chief of Staff, California Medical Association

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

Academics/ SMEs

Sarah Arnquist, MPH
Principal Consultant, SJA Health Solutions

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

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

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

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

State & Private Purchasers

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

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

Monica Soni, MD
Chief Medical Officer, Covered California

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

Consumer Reps & Advocates

Beth Capell, PhD
Contract Lobbyist, Health Access California

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

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

Hospitals & Health Systems

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

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

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

Health Plans

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

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

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

Mohit Ghose
State Affairs, Anthem

OHCA Investment and Payment Workgroup information and meeting materials available here: https://hcai.ca.gov/affordability/ohca/ohca-investment-and-payment-workgroup/

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

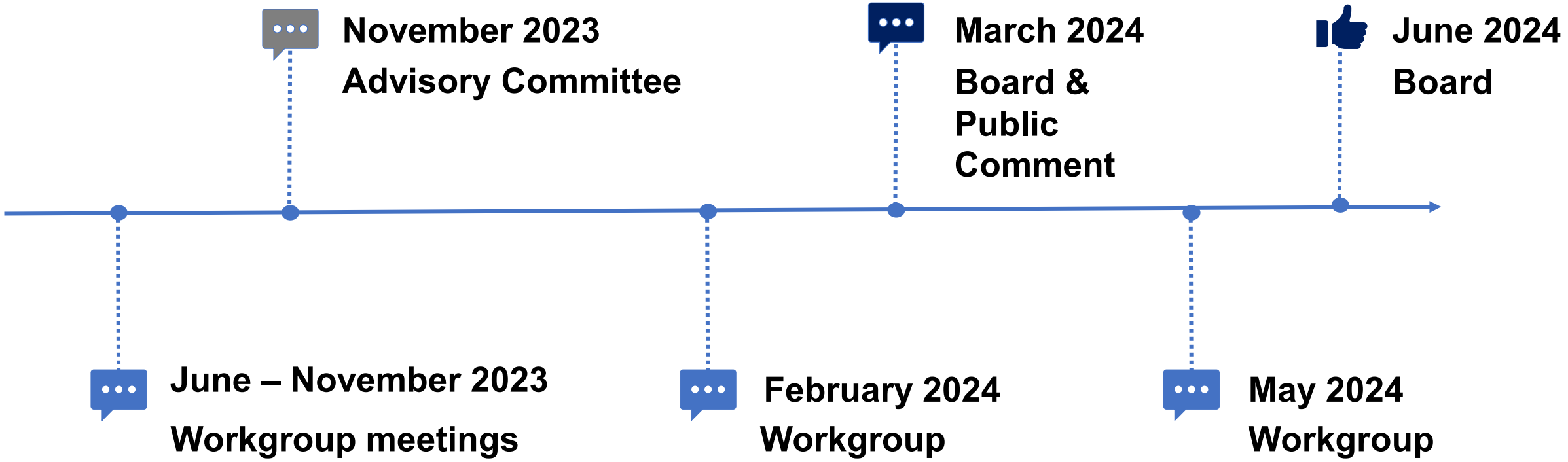
Investment Benchmark:
Variation by market (Commercial, Medi-Cal) or population (adult vs. pediatric)

APM Standards and Adoption Goals Progress

- Worked with the Investment and Payment Workgroup from June through November 2023 to develop draft standards for APM contracting and draft APM adoption goals:
  - Discussed strategic decisions for defining APMs, standards, and adoption goals
  - Considered examples of APM standards and adoption goals from other states
  - Developed criteria, approach, and vision for standards and goals
- Presented draft standards and adoption goals to Advisory Committee in November 2023.
- Revising draft standards and adoption goals based on Advisory Committee feedback and debriefing with Workgroup.
- Will present draft standards and adoption goals to Board in March 2024 for feedback and release for public comment.

OHCA Draft APM Standards and Adoption Goals available here: https://hcai.ca.gov/public-meetings/november-ohca-investment-and-payment-workgroup/

Timeline for APM Standards and Adoption Goals

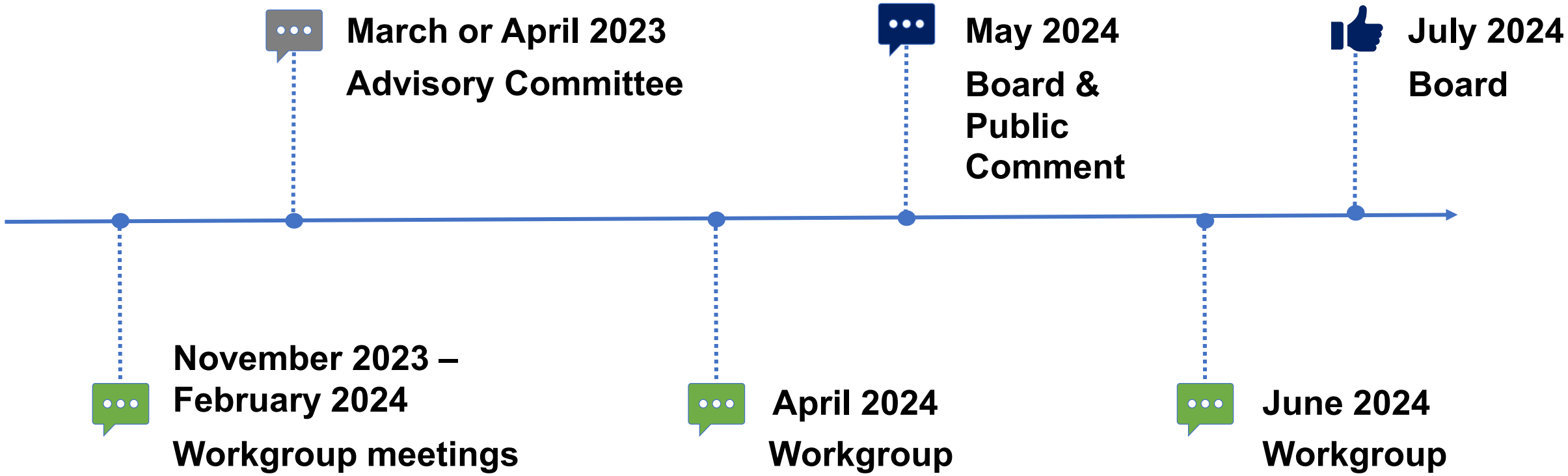


Between each meeting, OHCA and Freedman HealthCare will revise draft APM standards and goals based on feedback.

Primary Care Investment Progress

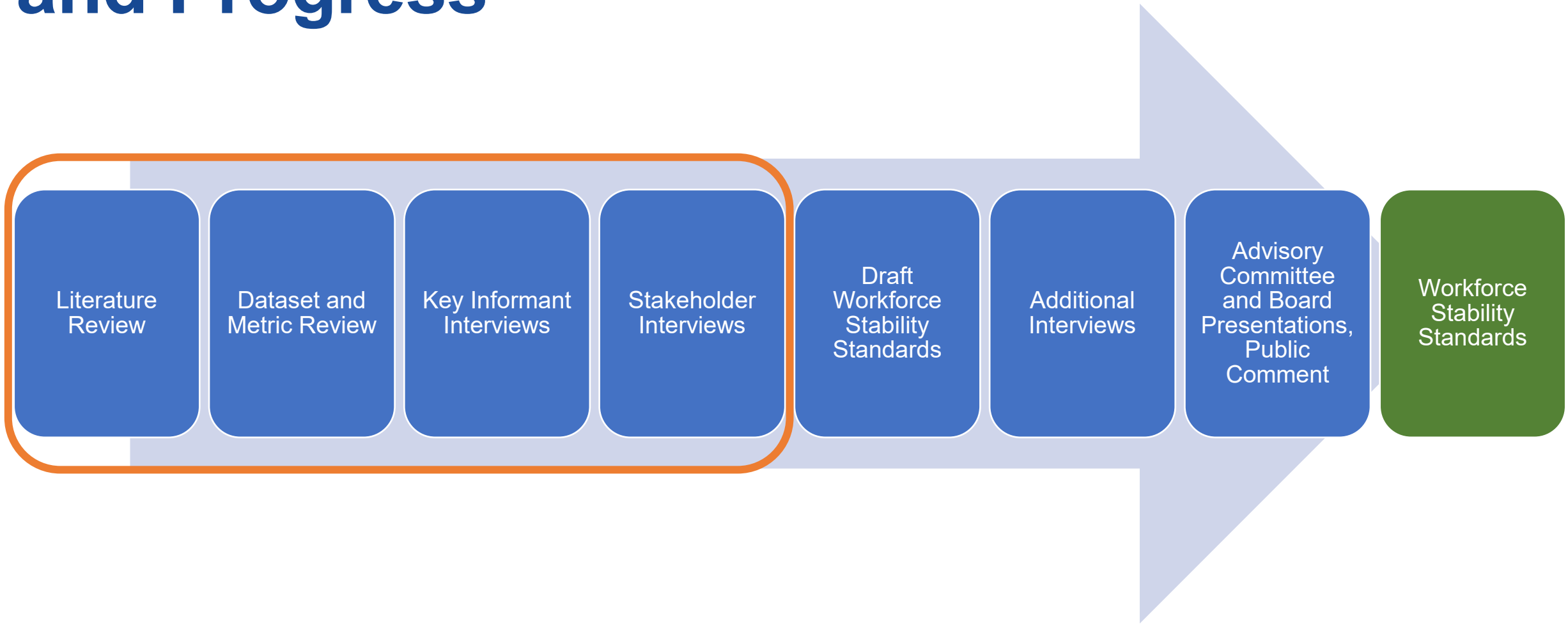
- Started discussions of primary care spend in Investment and Payment Workgroup in November 2023.
- Launched a technical subgroup to support the development of the definition of primary care:
  - Subgroup met in November-December 2023 and January 2024
  - Considered primary care definitions used in other states
  - Developed a draft definition of providers, sites of service, and services for claims-based primary care spend
  - Discussed approaches to measuring non-claims based primary care spend
- Will bring proposals from the subgroup to the Investment and Payment Workgroup for further discussion this winter and spring.
- Will present primary care investment benchmark to Board in May 2024 for feedback and release public comment.

Timeline for Primary Care Investment

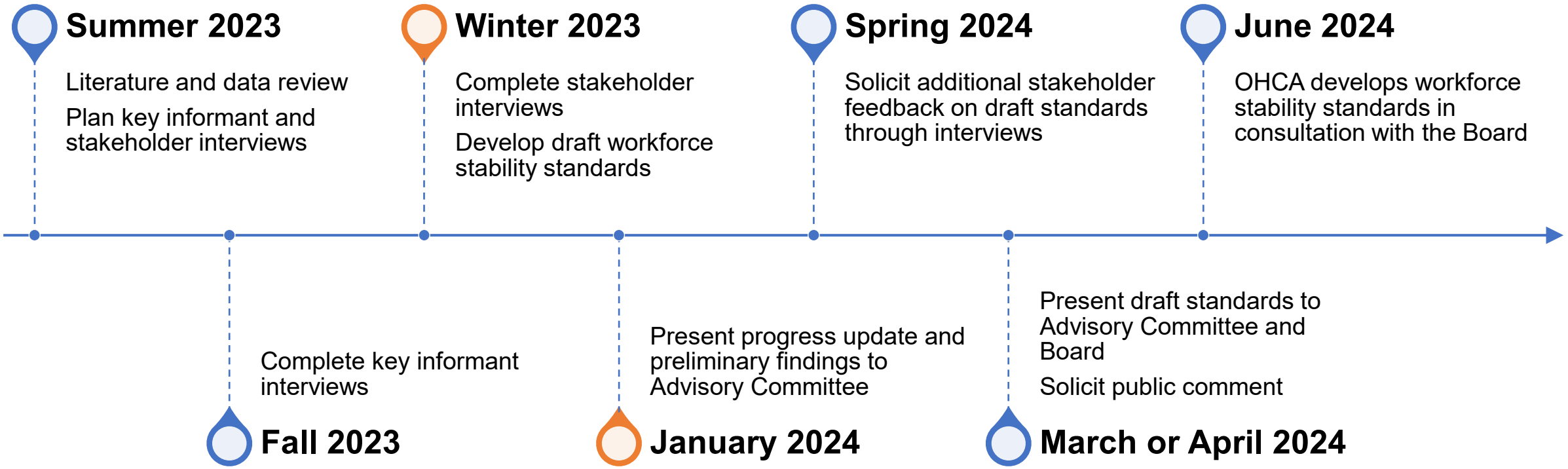


Between each meeting, OHCA and Freedman HealthCare will revise draft primary care definitions and benchmarks based on feedback.

Workforce Stability Standards Approach and Progress



Timeline for Workforce Stability Standards



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Public Comment

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Action Consent Item: Approval of the December 19, 2023 Board Meeting Minutes

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Public Comment

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Informational Items

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Spending Target Methodology and Statewide Spending Target Value

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

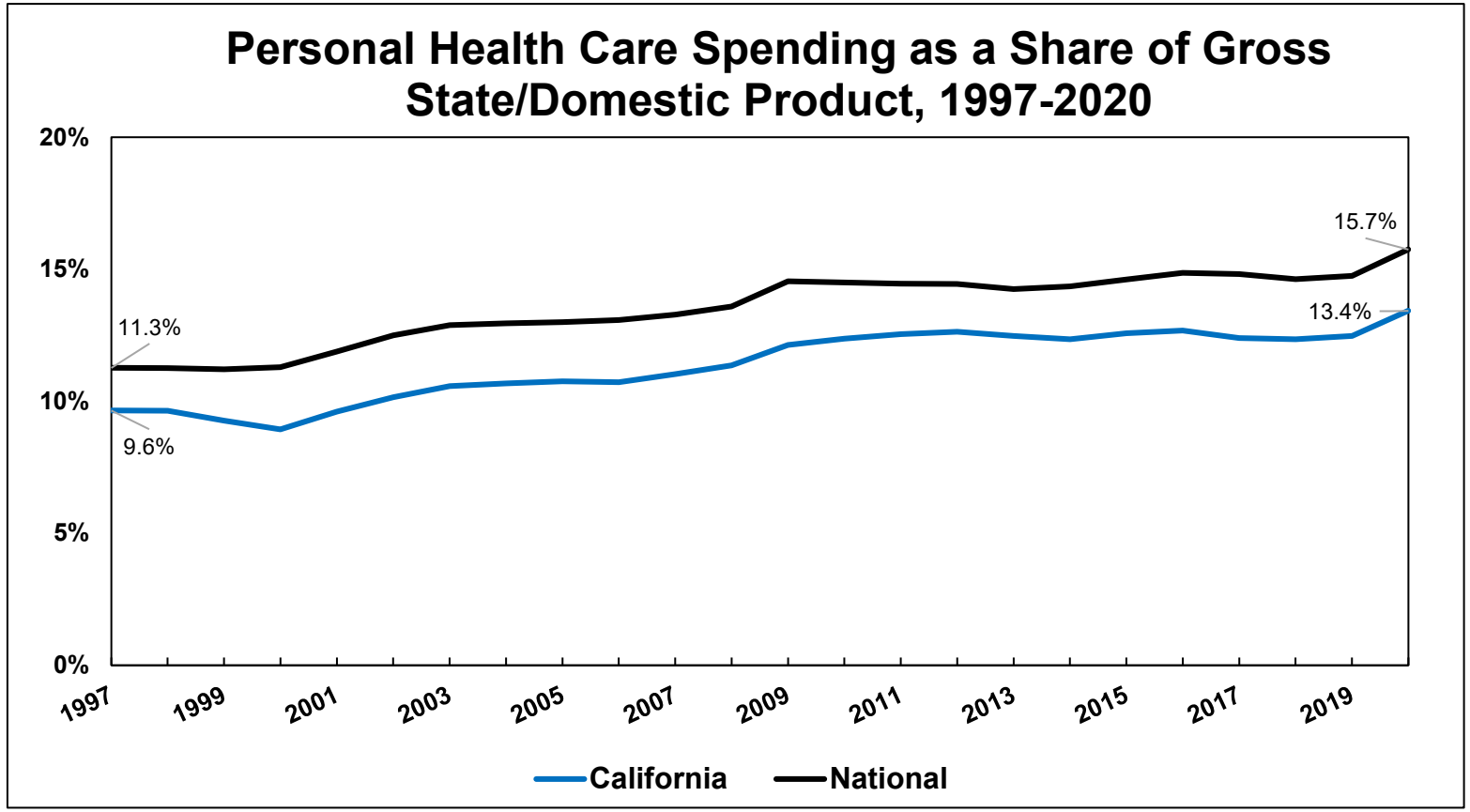
Board Follow-Up Items

Board Follow-Up Items

1. Request for information about health care spending as a share of gross state product (GSP).
2. Request for alternative approaches to analyzing median household income data:
    - Update the 20-year time-series of median household income data to include 2022.
    - Examine 5-year running averages starting from 2018-2022, then 2017-2021, then 2016-2020 etc.
    - Examine weighted averages that assign 100% weight to the most recent decade (i.e., 2013-2022)
3. Request for information about the large increase in median household income growth from 2018 to 2019.
4. Request for downward adjustments for efficiencies related technology.
5. Request for state spending target performance.

Health Care Spending as a Share of Gross State/Domestic Product, 1997-2020

- Between 1997 and 2020, personal health care spending as a share of gross state product (GSP) grew by 3.8 percentage points, from 9.6% to 13.4%.
- Nationally, personal health care spending as a share of gross domestic product (GDP) grew by 4.4 percentage points, from 11.3% to 15.7%.



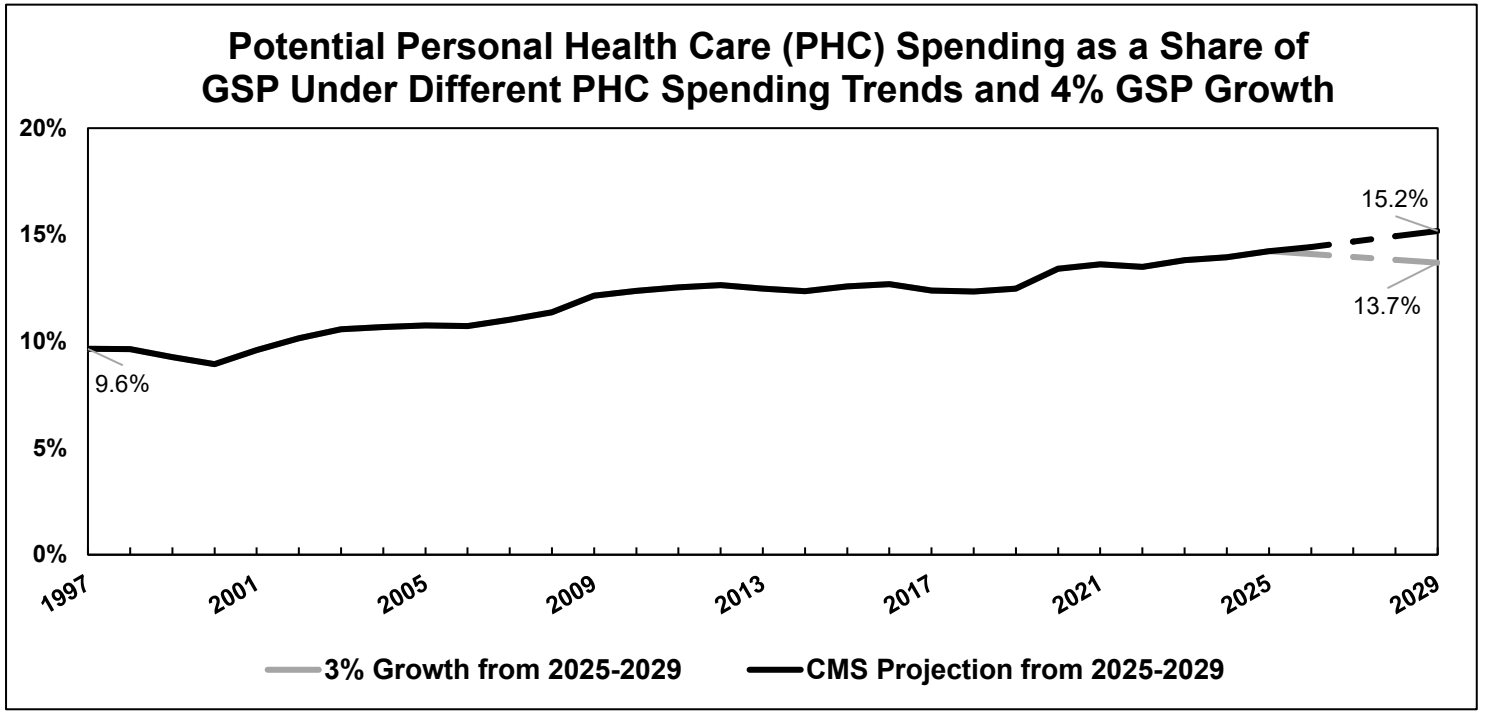
Note: Personal health care spending does not include public health activities, health insurer administrative expenses and profit, government administration, and investment.

Sources: Department of Finance. Gross State Product. https://dof.ca.gov/forecasting/economics/economic-indicators/gross-state-product/; U.S. Bureau of Economic Analysis, Gross Domestic Product, retrieved from FRED, Federal Reserve Bank of St. Louis. https://fred.stlouisfed.org/graph/?id=GDPA

Potential Health Care Spending as a Share of Gross State Product

- At the December Board meeting, a Board member asked for more information about the extent to which a 3% spending target would affect health care spending as a share of GSP.

- If personal health care spending grew at 3% from 2025-2029, it would amount to 13.7% of gross state product, returning to 2021 levels. By contrast, if personal health care spending grew in accordance with CMS national projections from 2025-2029, it would amount to 15.2% of gross state product.



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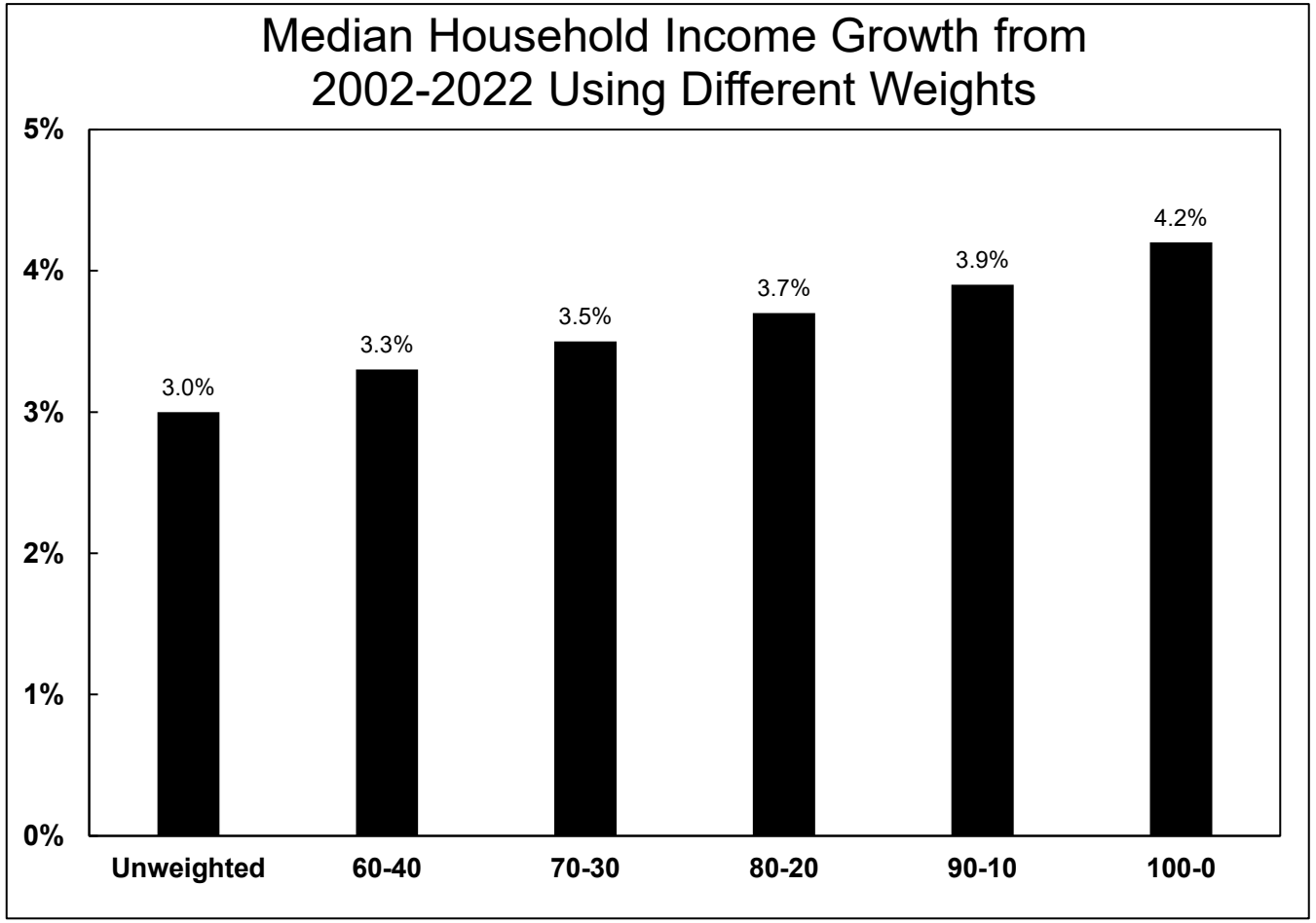
Source: Department of Finance. Gross State Product. https://dof.ca.gov/forecasting/economics/economic-indicators/gross-state-product/

2002-2022 Median Household Income Growth Under Variable Weights

- From 2002 to 2022, the unweighted average change in median household income growth was 3.0%.
- At the request of a Board member, assigning 100% weight to the 10-year period from 2013-2022 and 0% to the 10-year period from 2003-2012 yields 4.2%.



Source: U.S. Census Bureau, Median Household Income in California [MEHOINUSCAA646N], retrieved from FRED, Federal Reserve Bank of St. Louis. https://fred.stlouisfed.org/series/MEHOINUSCAA646N

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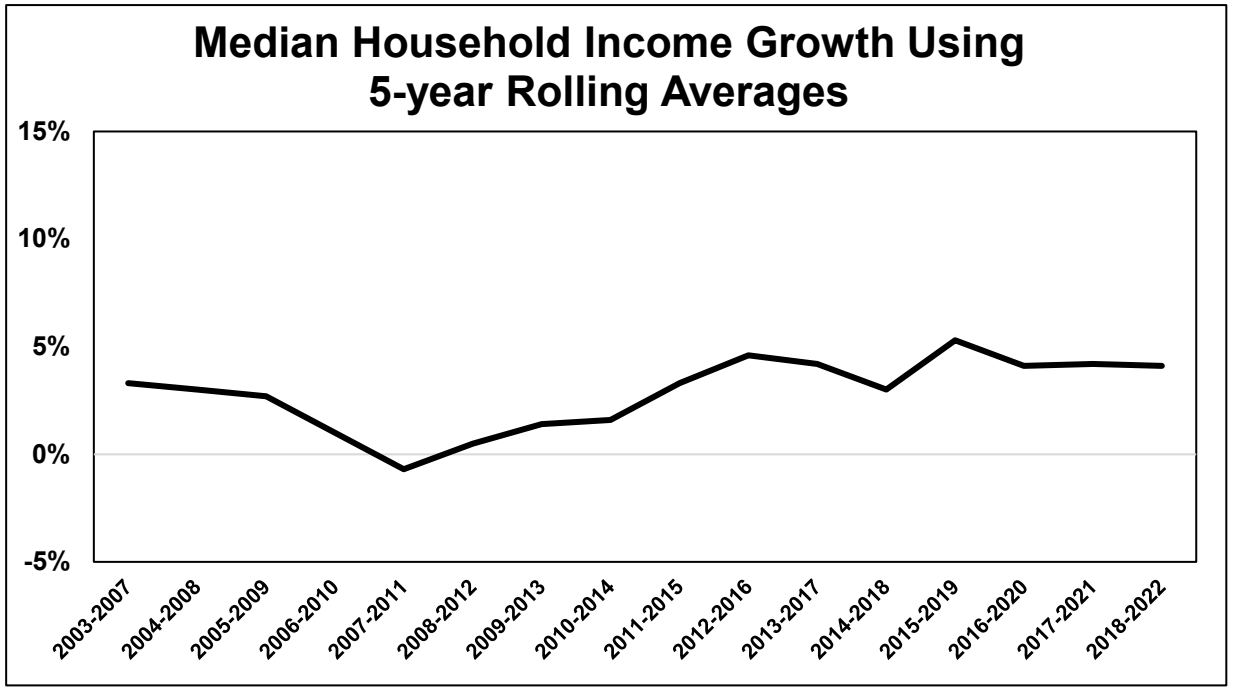
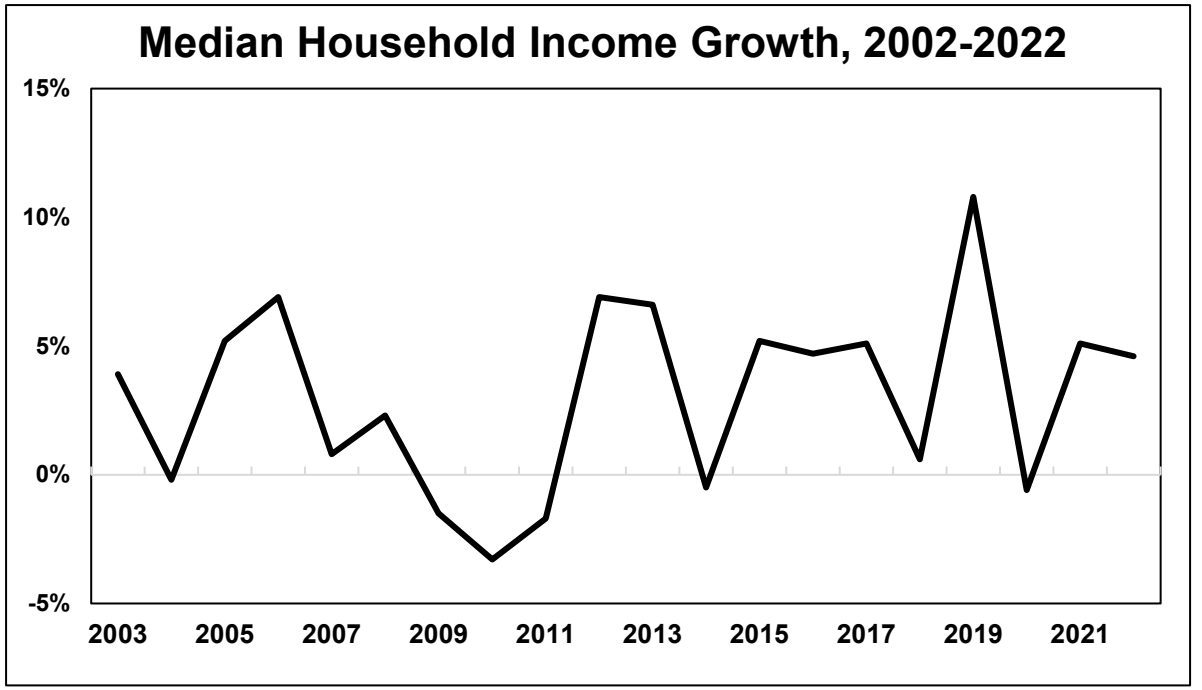
2002-2022 Median Household Income Growth Under 5-Year Rolling Averages

- From 2002 to 2022, the average of the 5-year rolling averages is 2.9% and yields a minimum of -0.7% and a maximum of 5.3%.
- In the absence of 5-year rolling averages, the minimum and maximum is -3.3% to 10.8%, respectively.





Source: U.S. Census Bureau, Median Household Income in California [MEHOINUSCAA646N], retrieved from FRED, Federal Reserve Bank of St. Louis. https://fred.stlouisfed.org/series/MEHOINUSCAA646N

Background on Median Household Income Growth from 2018 to 2019

- During the December Board meeting, OHCA staff flagged 2019 as a year with high median household income growth and a Board member requested more information about this data point.
- A working paper by two Census Bureau economists linked Internal Revenue Service (IRS) income records to the survey sample frame for the Current Population Survey Annual Social and Economic Supplement (CPS), which enabled the researchers to compare respondents and non-respondents on observable characteristics.
- Importantly, interviews for the 2020 CPS (that captures income information for 2019) began in March 2020 amid the onset of the COVID-19 pandemic, which presented considerable data collection challenges.
- The authors find evidence of differential nonresponse – wherein higher-income households were more likely to respond – and estimate that it upwardly biased income statistics by 2.8%.

Source: Source: Rothbaum, J. and Bee, A. (2021, March 30) "*Coronavirus Infects Surveys, Too: Survey Nonresponse Bias and the Coronavirus Pandemic.*" U.S. Census Bureau. https://www.census.gov/library/working-papers/2020/demo/SEHSD-WP2020-10.html

Background on Median Household Income Growth from 2018 to 2019

If one were to apply the differential nonresponse adjustment for 2019 to the California time-series, the changes would be minimal:

- The unweighted average remains unchanged.
- The 5-year rolling average now yields a minimum of -0.7% and a maximum of 4.7% (down from 5.3%).
- Assigning 100% weight to the 10-year period from 2013-2022 and 0% to the 10-year period from 2003-2012 now yields 4.1% (down from 4.2%).

Source: Rothbaum, J. and Bee, A. (2021, March 30) "*Coronavirus Infects Surveys, Too: Survey Nonresponse Bias and the Coronavirus Pandemic*." U.S. Census Bureau. https://www.census.gov/library/working-papers/2020/demo/SEHSD-WP2020-10.html

Downward Adjustments to the Spending Target for Technology

- During the December Board meeting, Board members noted that artificial intelligence (AI) and other technological advances could help improve health care operations, which in turn could reduce spending, without compromising quality or access.

- A 2023 study estimated that widespread adoption of AI nationally could yield estimated annual savings between $200 billion to $360 billion.

- Applying the study findings to California could mean estimated annual savings between $20 to $41 billion, or health care spending annually changing by -5% to -10% compared to the status quo.

- These estimates assume widespread adoption of AI. As we noted at the December 2023 meeting, however, there is differential adoption of technology across health care entities. Additionally, AI is continually evolving and the extent of its impact within the health care ecosystem remains uncertain.

Sources: Sahni, N., Stein, G., Zemmel, R. & Cutler, D. (2023 January). "*The Potential Impact of Artificial Intelligence on Healthcare Spending*." NBER. https://www.nber.org/papers/w30857; Garthwaite, C. Ody, C, & Starc, A. (2020 June). "*Endogenous Quality Investments in the U.S. Hospital Market*." NBER. https://www.nber.org/papers/w27440

State Spending Target Performance

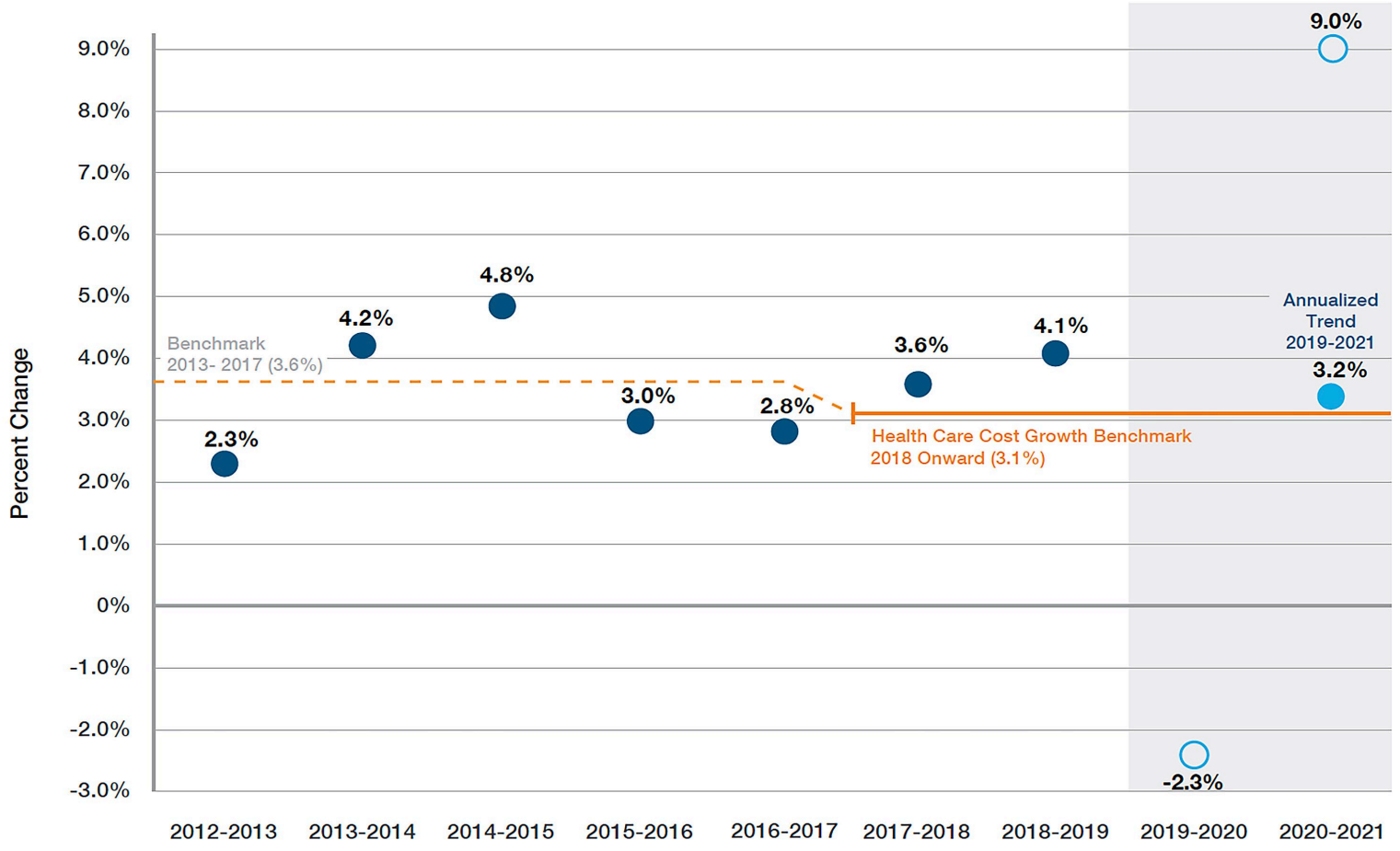
Massachusetts

- Prior to 2019, Massachusetts was the only state to report spending target performance.
- From 2012 to 2021, the average annual growth rate for health care spending in Massachusetts was 3.5%, below the initial target of 3.6%.
- Massachusetts' annual report presented data annualized over a 3-year period (2019-2021) to account for COVID-19 disruptions, and for calendar year 2021 only.
  - From 2019 to 2021, THCE per capita increased at an annualized rate of 3.2%, reflecting compound annual growth.
  - THCE per capita increased 9.0% in 2021 to $9,715 per resident, following a 2.3% decline in 2020. Growth in 2021 commercial spending (the largest increase by payer type) was due to a rebound in the use of care following the COVID-19 pandemic, as well as price increases across all broad categories of care.

Sources: Center for Health Information and Analysis. (2023 March). "*Annual Report on the Performance of the Massachusetts Health Care System*." https://www.chiamass.gov/assets/2023-annual-report/2023-Annual-Report.pdf; Center for Health Information and Analysis. (2023 September). "*2023 Annual Health Care Cost Trends Report and Policy Recommendations*." https://www.mass.gov/doc/2023-health-care-cost-trends-report/download

From 2012 to 2021, the average annual growth rate for health care spending in Massachusetts was 3.5%, below the initial target of 3.6%.

Massachusetts annual growth in per capita total health care spending relative to the benchmark, 2012 to 2021



Source: Massachusetts Center for Health Information and Analysis, Annual Reports on the Performance of the Massachusetts Health Care System 2013-2023.

The average annual growth rate for the first two years of the COVID-19 pandemic was **3.2%.**

State Spending Target Performance

- Of the five states publicly reporting their performance against their targets for 2020-21, only Rhode Island met its cost growth target while Oregon exceeded their target by 0.1 percentage points, growing at 3.5%, just above their 3.4% cost target.
- The other three states (Connecticut, Delaware, and Massachusetts) surpassed their targets by 3 to 8 percentage points. However, this information should be tempered with the following caveats:
  - After experiencing decreases in health care spending in 2020 due to COVID-19 disruptions, all states reported increased spending for 2021.
  - The high spending growth observed in 2021 primarily reflects increased use rather than price changes.
  - Per capita spending growth was highest in the commercial market with outpatient hospital services being a major driver.

Source: Angeles, January. (2023, June 29). "*States Setting Health Care Spending Growth Targets Experienced Accelerated Growth In 2021*." Health Affairs. https://www.healthaffairs.org/content/forefront/6-29-angeles-piece

Timeline and Process for Adopting the Spending Target for 2025

Statute

127502.

(m) (1)The board shall hold a public meeting to discuss the development and adoption of recommendations for statewide cost targets, or specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities. The board shall deliberate and consider input, including recommendations from the office, the advisory committee, and public comment. Cost targets and other decisions of the board consistent with this section shall not be adopted, enforced, revised, or updated until presented at a subsequent public meeting.

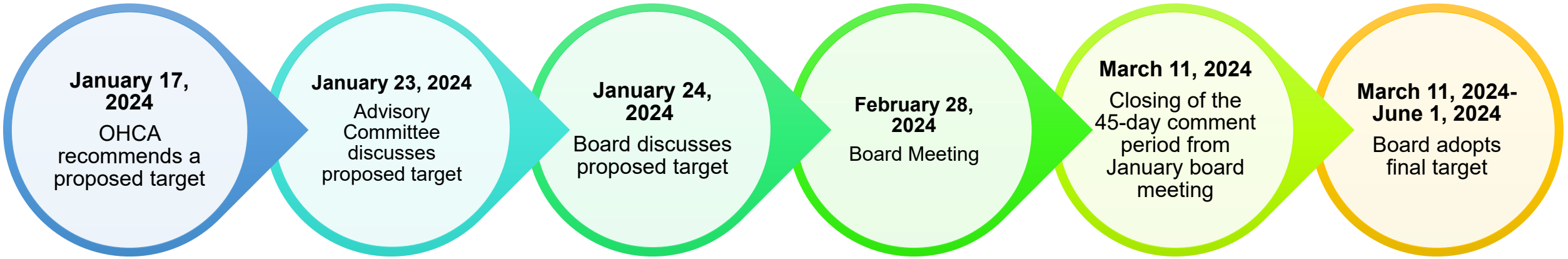
(2) The office shall publish on its internet website its recommendations for proposed cost targets for the board's review and consideration. The board shall discuss recommendations at a public meeting for proposed targets on or before March 1 of the year prior to the applicable target year.

(3) The board shall receive and consider public comments for 45 days after the board meeting.

(4) The board shall adopt final targets on or before June 1, at a board meeting. The board shall remain in session, and members shall not receive per diem under Section 127501.10, until the board adopts all required cost targets for the following calendar year.

Source: Health and Safety Code § 127502

Timeline for Adopting the Spending Target for 2025



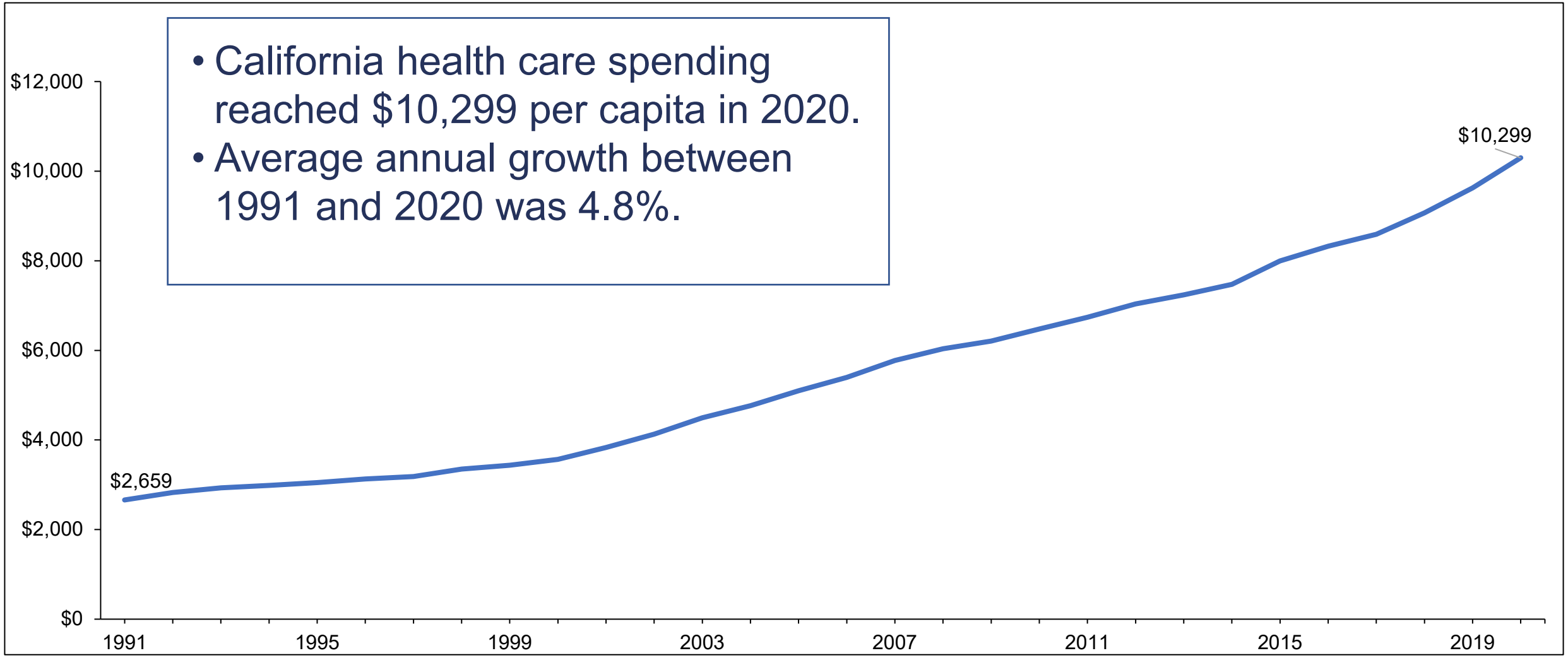
Per the California Health Care Quality and Affordability Act:
The board shall adopt final targets on or before June 1, at a board meeting.
The Board's adoption of the target is exempt from the rulemaking provisions of the Administrative Procedure Act.

Process for Adopting the Spending Target for 2025

- Today, the Office is presenting for Board discussion its recommendation, published on OHCA's website on January 17, 2024.
- The Board is required to discuss the recommendation of the Office at a Board meeting on or before March 1st.
- For 45 days after today's Board meeting, the Board shall receive and consider public comments on the recommendations for the Spending Target, including input from the Advisory Committee.
- The Board is required to adopt a final target by June 1st at a Board meeting. This final target can align with the Office's recommendation or be another value discussed by the Board.

Recap: Affordability Challenges in California

Per Capita Health Spending in California



Source: "Health Expenditures by State of Residence, 1991-2020," Centers for Medicare & Medicaid Services.

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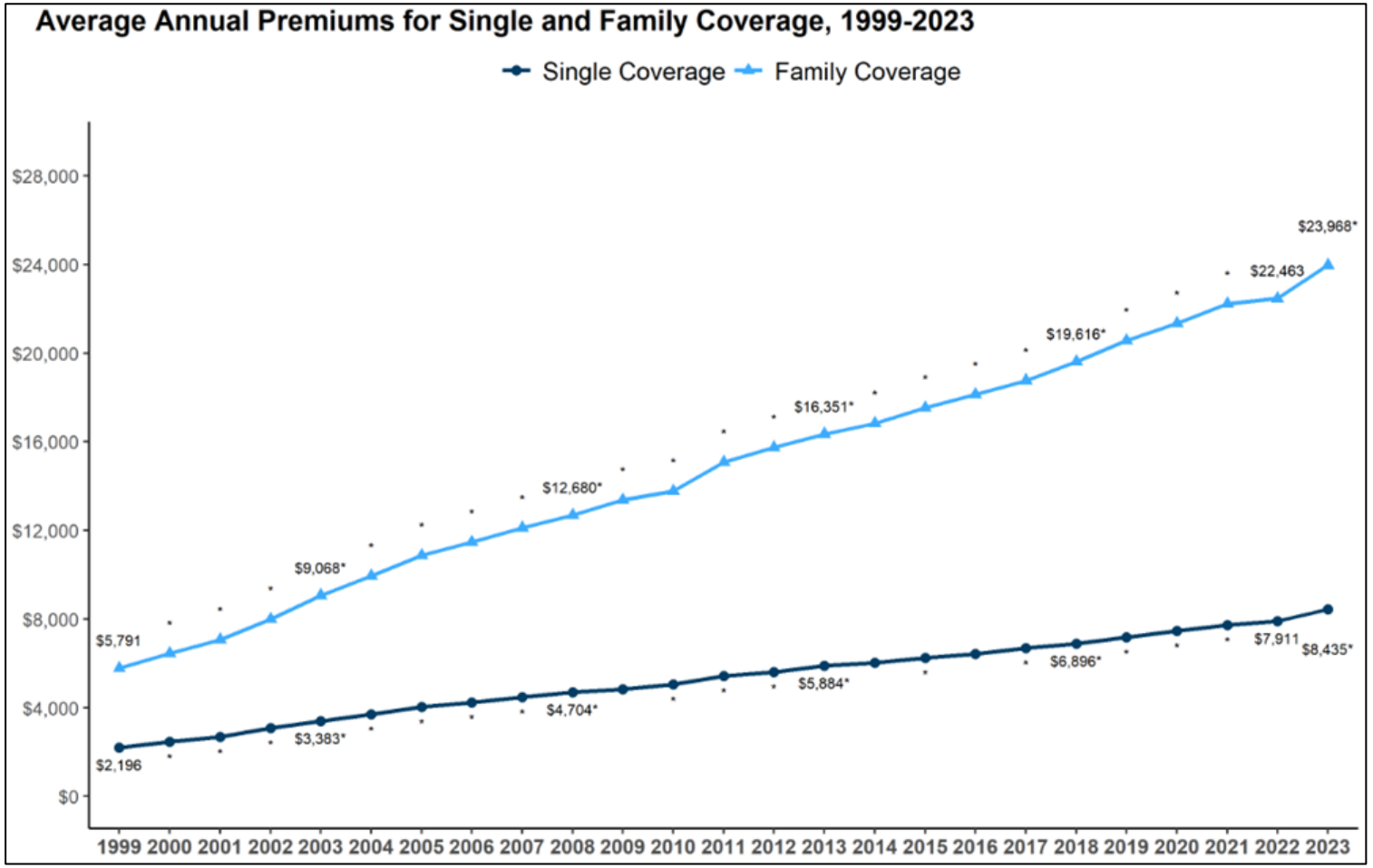
Average Annual Employer-Sponsored Premiums, 1999-2023

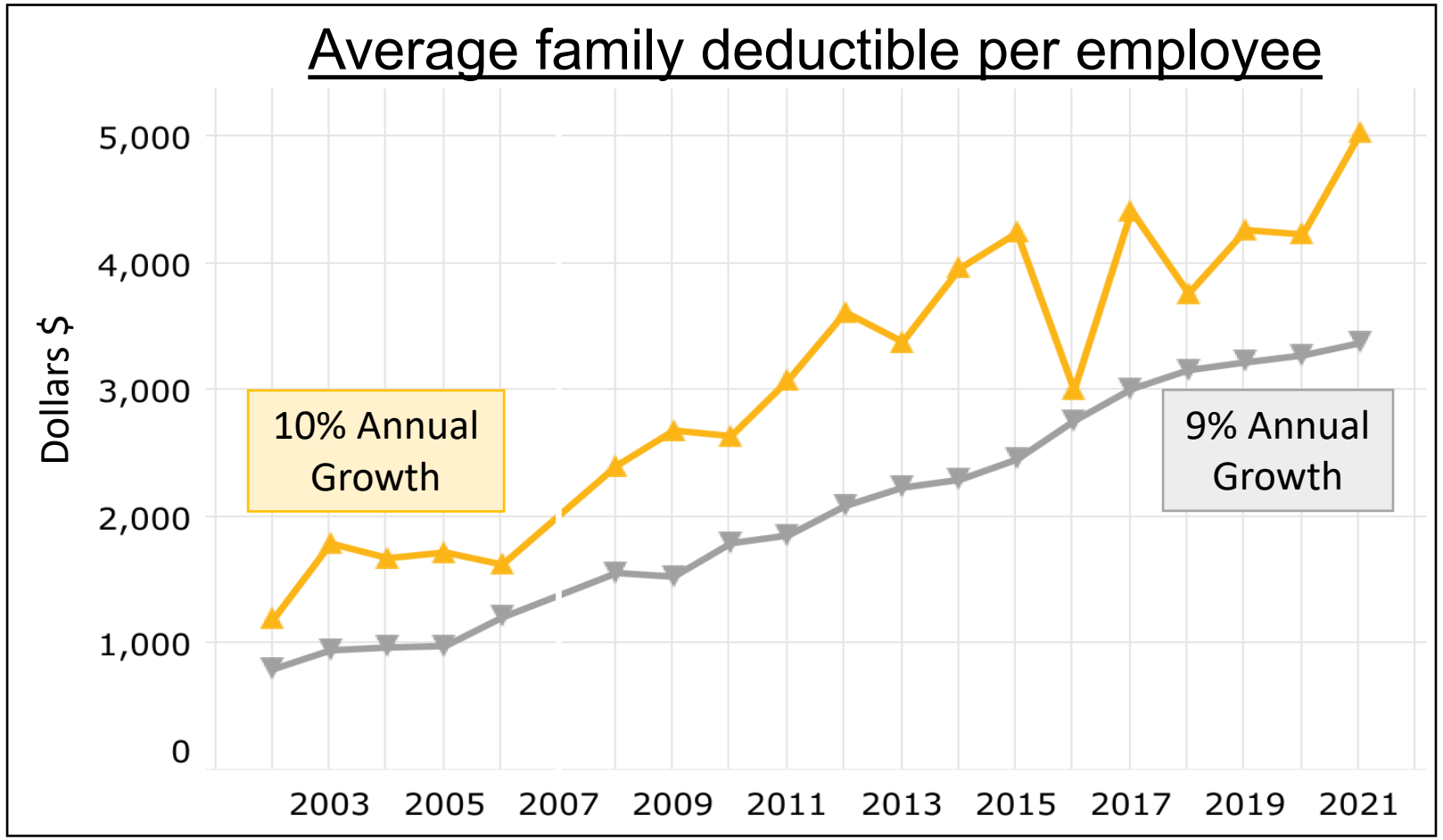
- In 2023, the average annual premium for employer-sponsored family coverage was approximately $24,000 and approximately $8,400 for single coverage.

- This is consistent with recent premium growth in California.



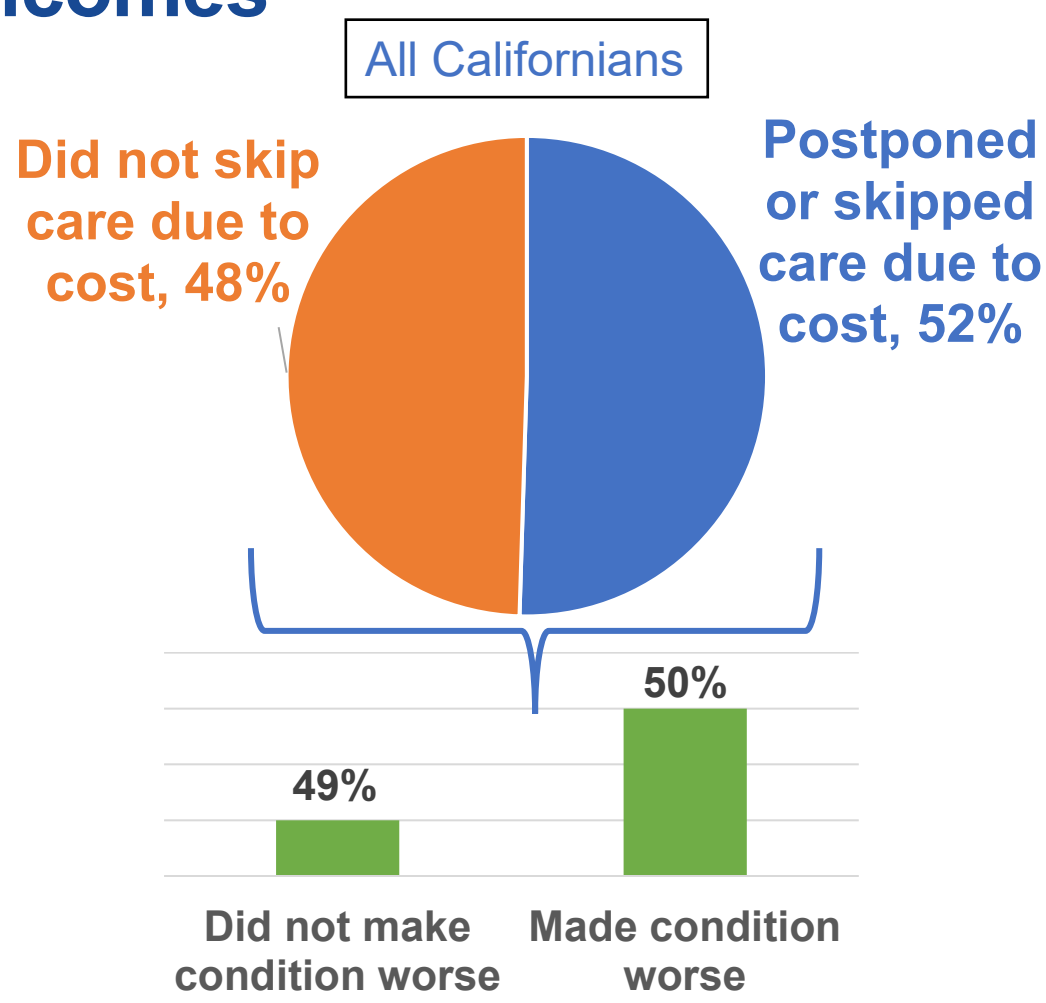
Source: Kaiser Family Foundation Employer Health Benefits Survey: https://www.kff.org/report-section/ehbs-2023-section-1-cost-of-health-insurance/

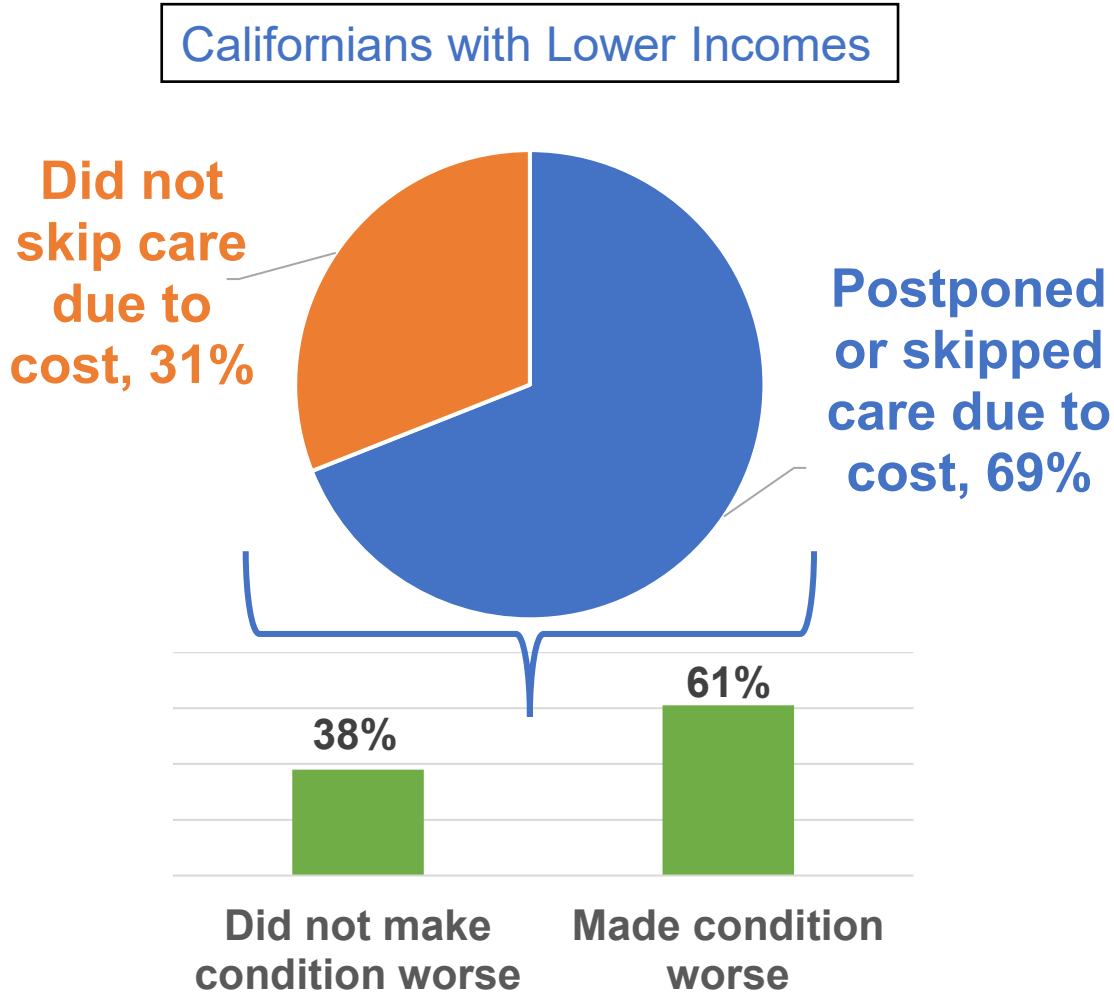
Over the Past Two Decades Family Deductibles Quadrupled



Note: 2007 data were not collected for the Insurance Component of the MEPS
Source: Medical Expenditure Panel Survey (MEPS) Insurance Component (IC)

High Costs Have Created Widespread Access and Health Problems for Millions of Californians, Particularly Californians with Low Incomes

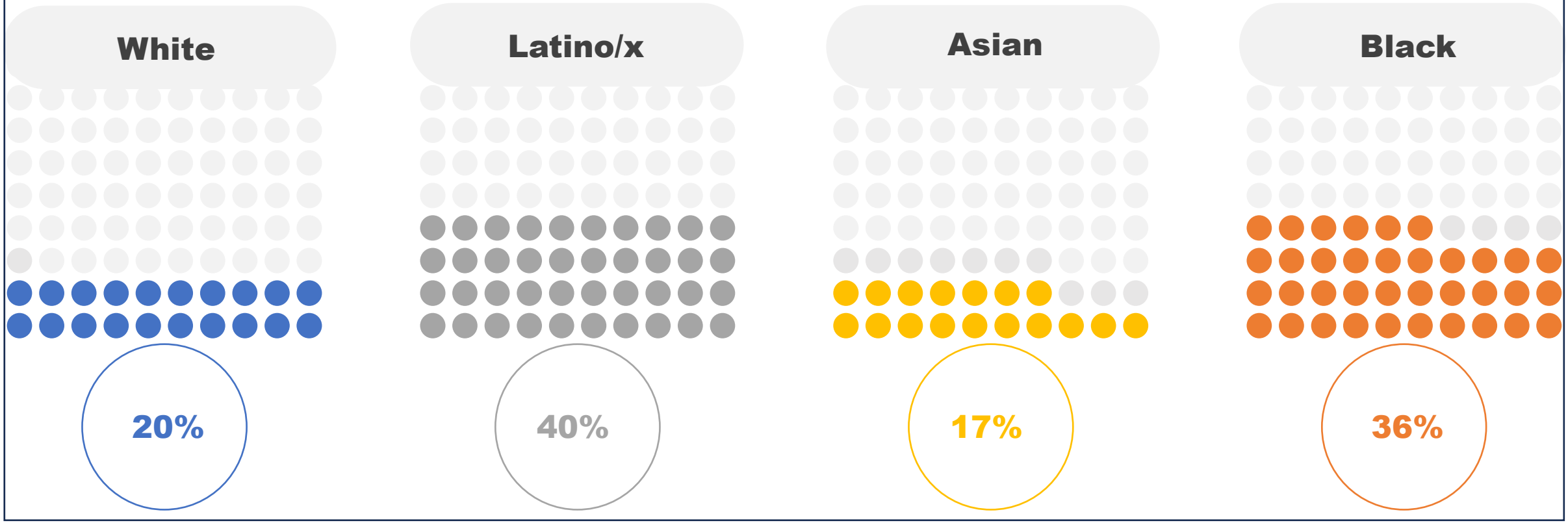




Source: CHCF/NORC California Health Policy Survey (September 30-November 1, 2022).

High Health Care Costs Are Disproportionately Affecting Black and Latino/x Californians

% who say that they or another family member had problems paying or an inability to pay medical bills in the last 12 months



Source: CHCF/NORC California Health Policy Survey (September 30-November 1, 2022).

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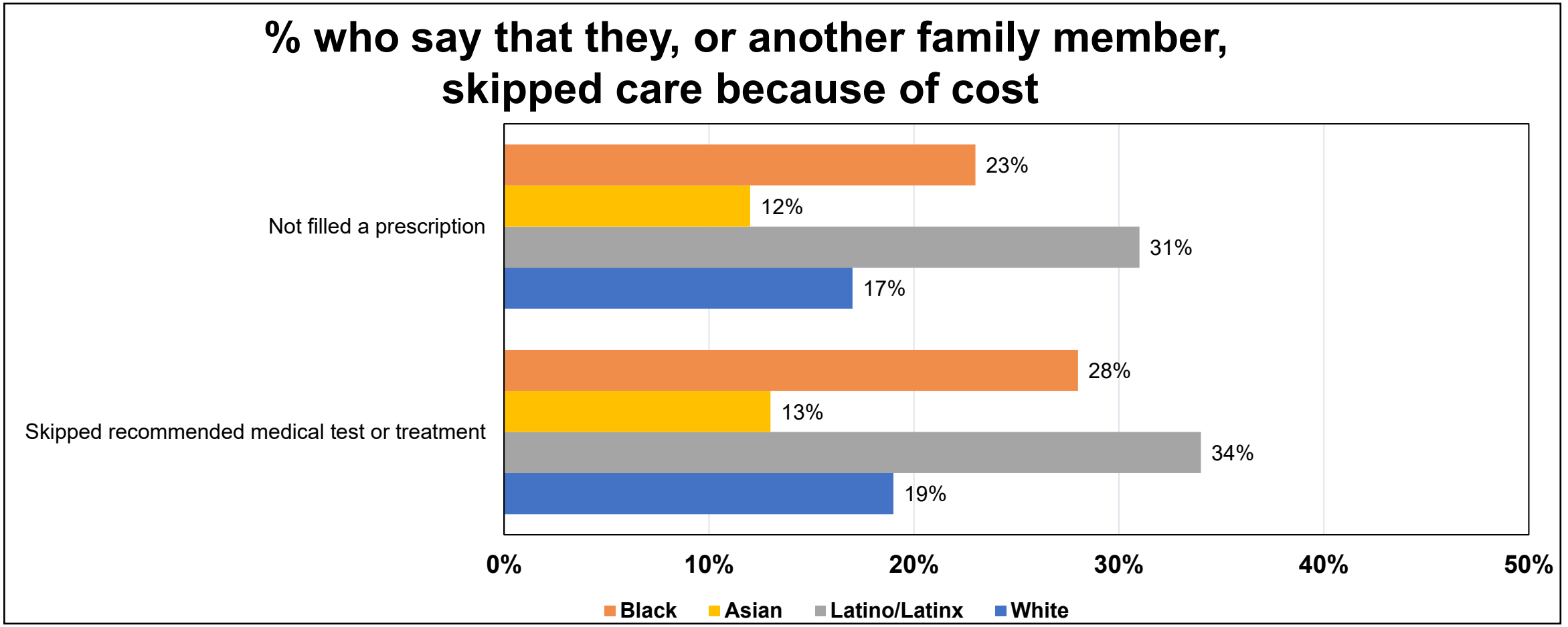
Black and Latino/x Residents Are More Likely to Skip Care Due to Costs



Source: CHCF/NORC California Health Policy Survey (September 30-November 1, 2022).

Research Indicates Opportunities for Savings that Could Slow Spending Growth

- Research by Shrank et al. examine six waste domains – failure of care delivery, failure of care coordination, overtreatment, pricing failure, fraud and abuse and administrative complexity – identified by the Institute of Medicine and conclude that "implementation of effective measures to eliminate waste represents an opportunity reduce the continued increases in US health care expenditures."
- The authors estimate that approximately 25% of national health care spending is wasteful or inefficient. While interventions can reduce wasteful spending, waste cannot be wholly eliminated.
  - For example, of the $102-$166 billion in estimated waste due to failures of care delivery, the authors find that between $44-97 billion could be reduced through effective interventions.
- Pricing failures is a waste domain that has driven commercial market spending growth.
  - For example, a 2019 study found that hospital prices for routine services—joint replacements and MRI scans— varied by a factor of more than five within major US cities.

Sources: Shrank, W. et al. (2019, October 15). "*Waste in the US Health Care System: Estimated Costs and Potential for Savings*." JAMA. https://pubmed.ncbi.nlm.nih.gov/31589283/; Samantha Liss and Nami Sumida (2021), "Hospitals Lift Curtain on Prices, Revealing Giant Swings in Pricing by Procedure," Healthcare Dive. [2]Cooper, Z., Craig, S. V., Gaynor, M., & Van Reenen, J. (2019).; The price ain't right? Hospital prices and health spending on the privately insured. The quarterly journal of economics, 134(1), 51–107. https://doi.org/10.1093/qje/qjy020.

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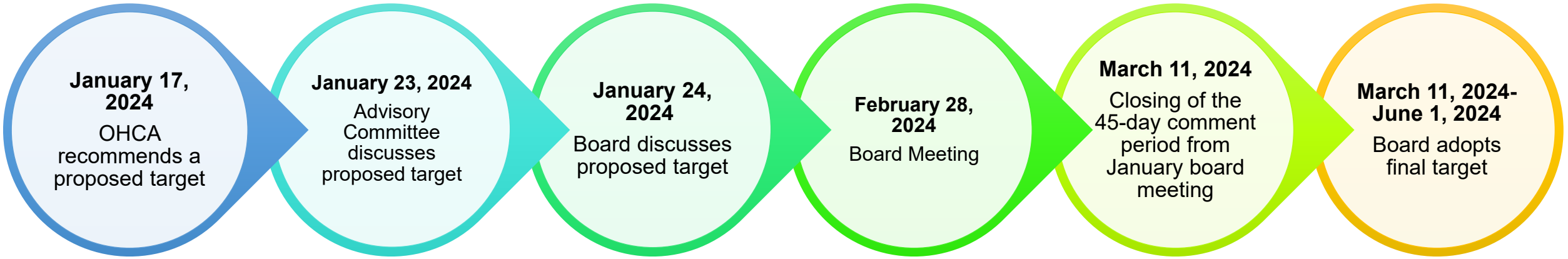
OHCA's Recommendation for the Health Care Spending Target

Timeline for Adopting the Spending Target for 2025



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

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

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

- The subsequent slides provide the rationale for this recommendation.

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

OHCA's Recommendation: Economic Indicator

OHCA's recommendation ties the target to historical median household income growth based on the average annual rate of change over the last 20 years (2002-2022).

- Basing the target on this measure adheres both to OHCA's statutory requirement to promote the goal of improved consumer affordability and to the Board's preference for using a consumer-centric economic indicator.
- In addition, it signals that health care spending should not grow faster than the income of California's families.
- A single economic indicator is simpler to publicly communicate and understand.
- Using a flat average annual percent change in median household income avoids concerns about decisions on how to weight or adjust distinct time periods within the 20 years.
- A 20-year average of historical data reflects long-term patterns and does not rely upon uncertain forecasting.

OHCA's Recommendation: Adjustments

OHCA recommends not applying adjustments to the target. OHCA found:

- Adjustments based on population-based measures, including age / sex, disability status, and prevalence of chronic conditions appear to be small and correlated with one another and potentially other economic indicators. There is also limited data available to forecast the impact of some population-based indicators on future spending growth.
- To adjust the target for technology factors, OHCA would need to predict the net impact of new technology on health care spending in advance of market entry because the target is set in advance of the performance year. Moreover, broadly applying a technology adjustment would also assume uniform adoption across all health care entities, which is inconsistent with practice and existing academic research.
- Rather than making prospective adjustments for uncertain technology impacts, other states provide context for drivers of spending when reporting unusual or infrequent events that have an outsized impact on spending growth (e.g., introduction of Sovaldi to treat Hepatitis C).

Source: Garthwaite, C. Ody, C, & Starc, A. (2020 June). "*Endogenous Quality Investments in the U.S. Hospital Market*." NBER. https://www.nber.org/papers/w27440

OHCA Recommendation: Revisiting the Target

In the statute, the board has the authority to revisit the target to update it periodically and consider any relevant adjustment factors.

- In the event of extraordinary circumstances, including highly significant changes in the economy or the health care system, the Board may consider changes to the target.
- OHCA recommends that the board meet annually to consider whether there are needed updates to the target, including adjustments for unforeseen circumstances.

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Public Comment

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Examples of Cost-Reducing Strategies

Margareta Brandt, Assistant Deputy Director,
Health System Performance

Cost-Reducing Strategies Project

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

Seeking Additional Examples of Cost-Reducing Strategies

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

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

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

Anthem Blue Cross (Elevance) Cost-Reducing Strategy

Dr. Tiffany Ingliss, National Medical Director, Women & Children's Health

Mohit Ghose, State Affairs

Improving Maternity quality, equity, and outcomes:
Health plan programs driving value

Dr. Tiffany Inglis, MD, FACOG
January 23 & 24, 2024

Anthem

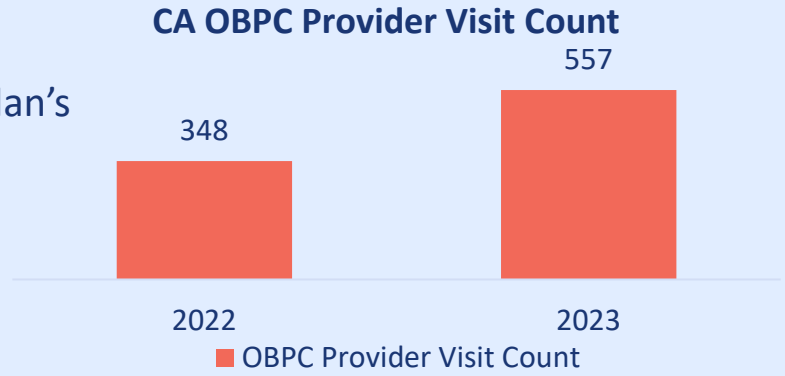
Anthem

Executive Summary: California Value Enhancement Strategies

1

OB Practice Consultants (OBPC):

- A trusted clinical liaison, facilitating engagement and alignment with the health plan's strategy
- CA has 3 OBPCs – hired in Q2 2022
- **95% Provider Satisfaction rate** since CA implementation



2

CA Doula Pilot (supported by OBPCs) that included:

- Women with doula had lower prenatal and birth costs when compared to women not using a doula
- Women using a doula had significantly lower odds of postpartum depression or postpartum anxiety

*Significant at alpha level < 0.05

3

Postpartum Maternal Morbidity and Morbidity Initiative supporting provider to educate members on next best steps for cardiovascular and behavioral health causes of M&M in post delivery time:

- Shared 82 times in 2023
- Increased value through improved outcomes

4

Coming Soon

- **Digital solution** driven by predictive analytics to provide member with education and content at their fingertips 24/7 supported by high risk personalized nursing care
- **Value Based Care** solutions to support CA state needs

Doulas at Anthem

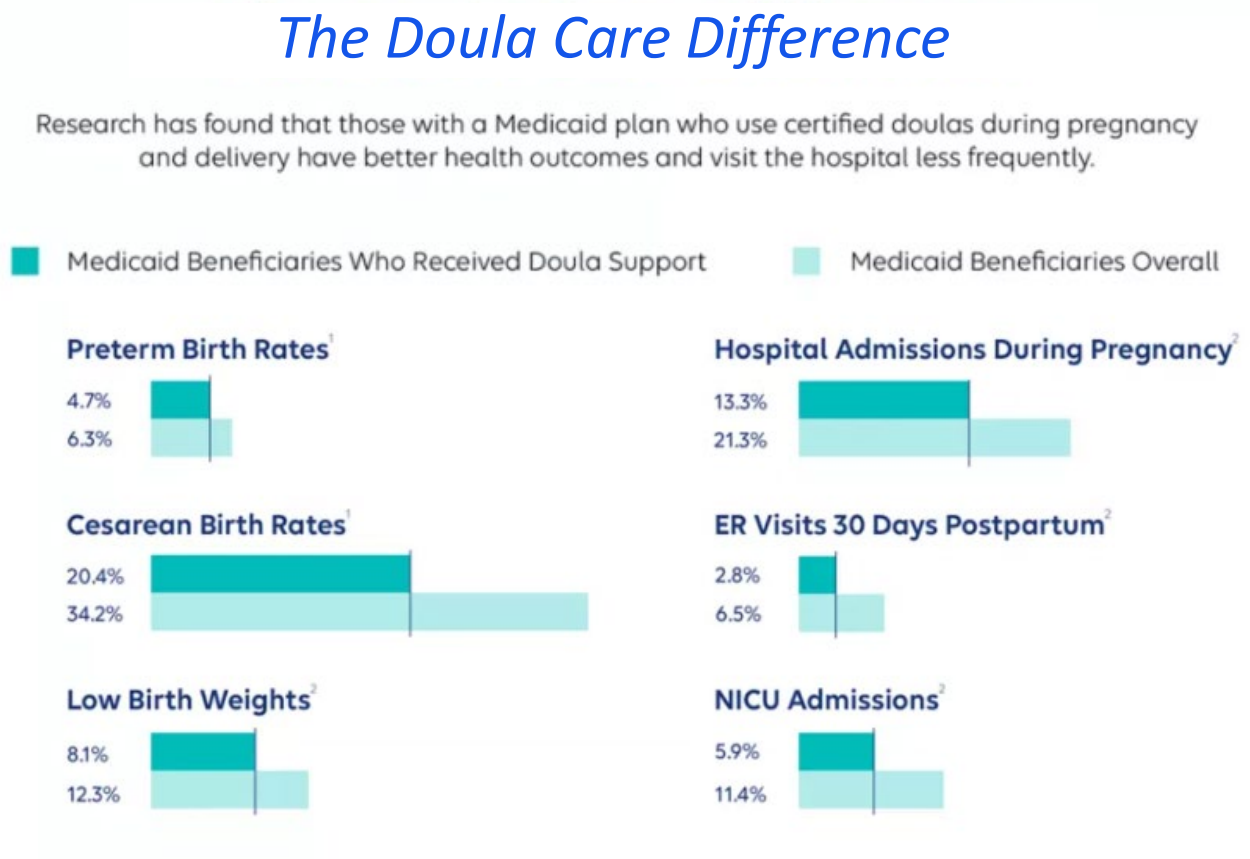
Based on extensive research proving **Doulas contribute to better member outcomes**, Anthem has prioritized the integration of doulas into care teams.

Doulas are non-clinical supports who provide person-centered care to pregnant and postpartum people through information, education, physical, social, and emotional support.

The national Doula landscape is complex:

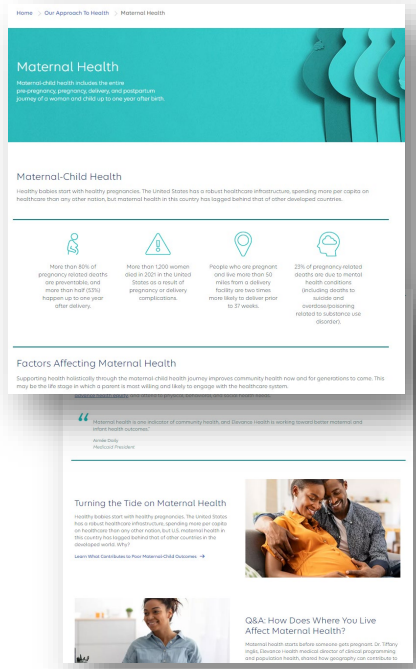
- Federal Bills for Medicaid coverage for Doula services have not advanced
- **State based coverage** for doula services have **not advanced in all states**
- Where coverage does exist, the **local landscape varies greatly by state**, including licensure, training requirements, scope, and coverage design

This study, which included CA membership, helped drive policy change and increase Doula access across the enterprise.

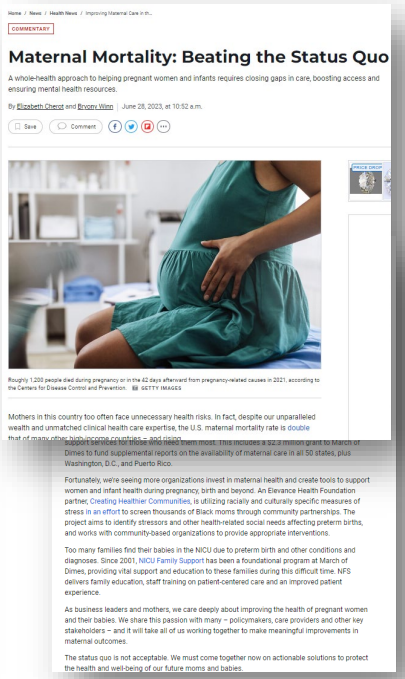


Public Policy Focus on Maternal and Child Healthcare

Corporate Communications Maternal Health Landing Page

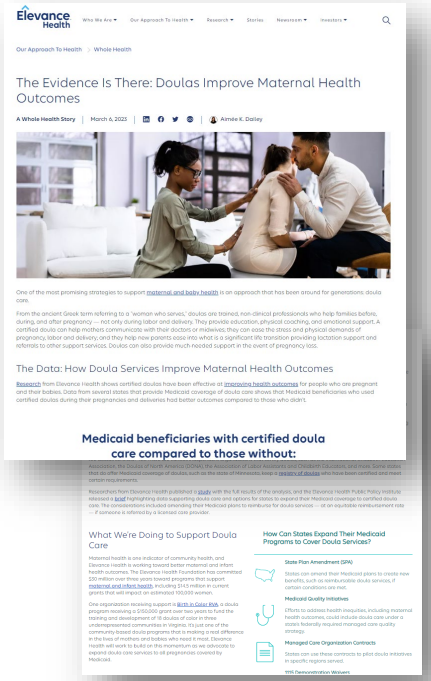


Maternal Mortality: Beating the Status Quo



Addressing Maternal Health Disparities: Doula Access in Medicaid

The Evidence Is There: Doulas Improve Maternal Health Outcomes



Partnering with Providers to Improve Maternal Health

What does an OB Practice Consultant do?

Provider

OBPCs visit network providers at least 16 times/month through virtual and in-person meetings to:

- Build consensus and commitment to change as a **trusted clinical liaison**, prioritizing high-quality, evidence-based care
- Facilitate enrollment and **engagement in OBQIP**
- Provide awareness of member and provider programs
- Share robust, **real-time data** with providers (*OBQIP scorecards, OBGYN KPI/Delivery Report data*)
- Coordinate **referrals to Case Management**

OBPC

- ✓ Clinician with maternal child expertise
- ✓ Invested member of the health plan
- ✓ Aligned to enterprise strategic framework
- ✓ Engages with all OB providers in network

Health Plan

OBPCs collaborate with health plan stakeholders and at the enterprise level to:

- Support the creation of a **high-performance network**
- Facilitate **referrals to Case Management** or other health plan services
- Participate in maternal health initiatives across the health plan to close gaps in care
- Increase **access to doula services** through collaboration with local CBOs (*Doula Grants*)
- Represent the health plan **in the community** (*Perinatal Quality Collaboratives, FIMR/MMRC meetings, health department*)

Have there been any changes in your practice as a result of discussions with your OBPC?

*"We have been more aware to **encourage smoking cessation, timeliness of prenatal & post partum care**. VBACs are encouraged and we do our best to avoid low risk c-sections."*

*"We are working on providing attestation within Availity for all new OB patients to help them **receive educational information** and additional benefits **during their care and after**."*

*"**LARC process**. Attention to cesarean rates and high-risk deliveries."*

*"We are able to catch the patients that deliver and never schedule the next visit. Helps us a lot to keep up with **post partum care**"*

Partnering OB Practice Consultants and VBS enhances quality of care

OBPCs drive birth outcomes and when combined with OBQIP deliver even greater savings and improved outcomes

	Total Birth Savings	Maternal First Year Savings	Baby First Year Savings	Low Birth Weight Rate	Timeliness of PN Care	Preterm Birth Rate	Adequacy of prenatal care measure
OBQIP	2% improvement	2% improvement	6% improvement	15% decrease	Not statistically significant change	17% decrease	*9% decrease*
OBPCs	2% improvement	2% improvement	4% improvement	6% decrease	15% increase	*5% Increase*	14% increase
OBPCs + OBQIP	**5% improvement**	**5% improvement**	**10% improvement**	**20% decrease**	**13% increase**	**12% decrease**	**5% increase**

Highlighting our success:

'The secret sauce': How Elevance Health uses obstetric liaisons and value-based incentives to boost maternal outcomes (beckerspayer.com)

Advancing Health Equity:

2023 Health Equity measure included in OBQIP around hypertension

Implicit Bias training:

- Partnered with March of Dimes to train internal staff and in network high-volume providers.

Questions & Discussion

Sharp Rees-Stealy Cost-Reducing Strategy

Stacey Hrountas, Chief Executive Officer

Andrea Snyder, Vice President, Health Services

Dr. Andy Dang, Chief Medical Officer

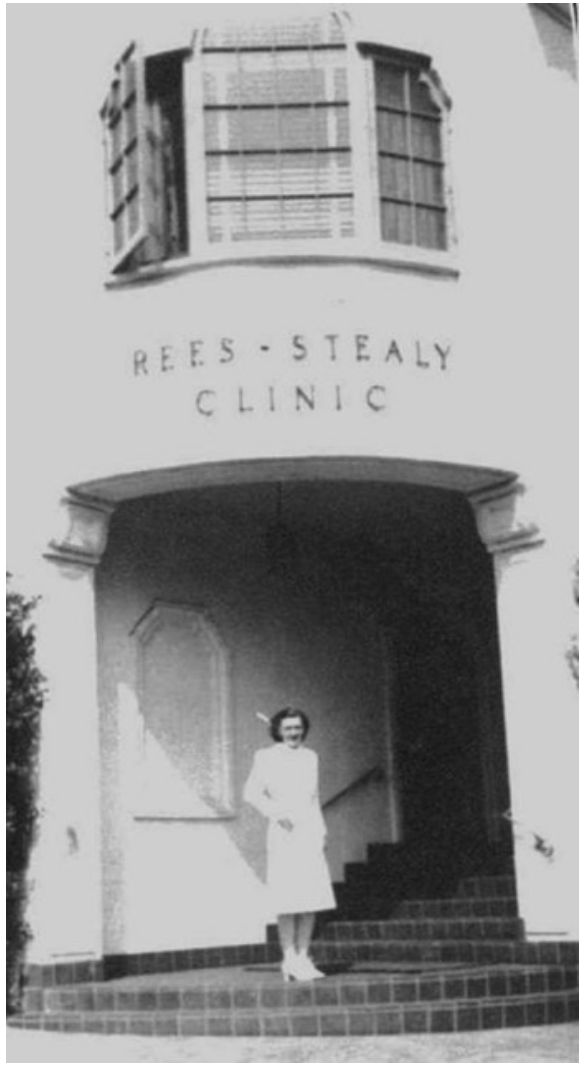
Leading the Way in Coordinated Care

SHARP Rees-Stealy Medical Group

Leading the Way in Coordinated Care

San Diego's First Multispecialty Medical Group

Founded 1923



SHARP REES-STEALY
100
YEARS OF CARING
SHARP

Sharp HealthCare's Integrated Delivery System

Not-for-profit organization serving 3.2 million San Diego County residents

Largest health care system in San Diego with highest market share

3
affiliated
medical groups

- ***Sharp Rees-Stealy Medical Group***
- **Sharp Care**
- **Sharp Community Medical Group**

4
acute care
hospitals

3
specialty
hospitals

SRSMG by the Numbers

700
Primary & Specialty Care Physicians & APPs

19
medical centers including five urgent cares

2,800
employees

70%
capitated

>183,000
HMO members

Each Year We Manage…

300,000
prescriptions

1.4 million
physician visits

26,500
patients with diabetes

1.7 million
calls

110,457
occupational health visits

349,000
radiology visits

2.1 million
lab tests

11,876
eyeglasses

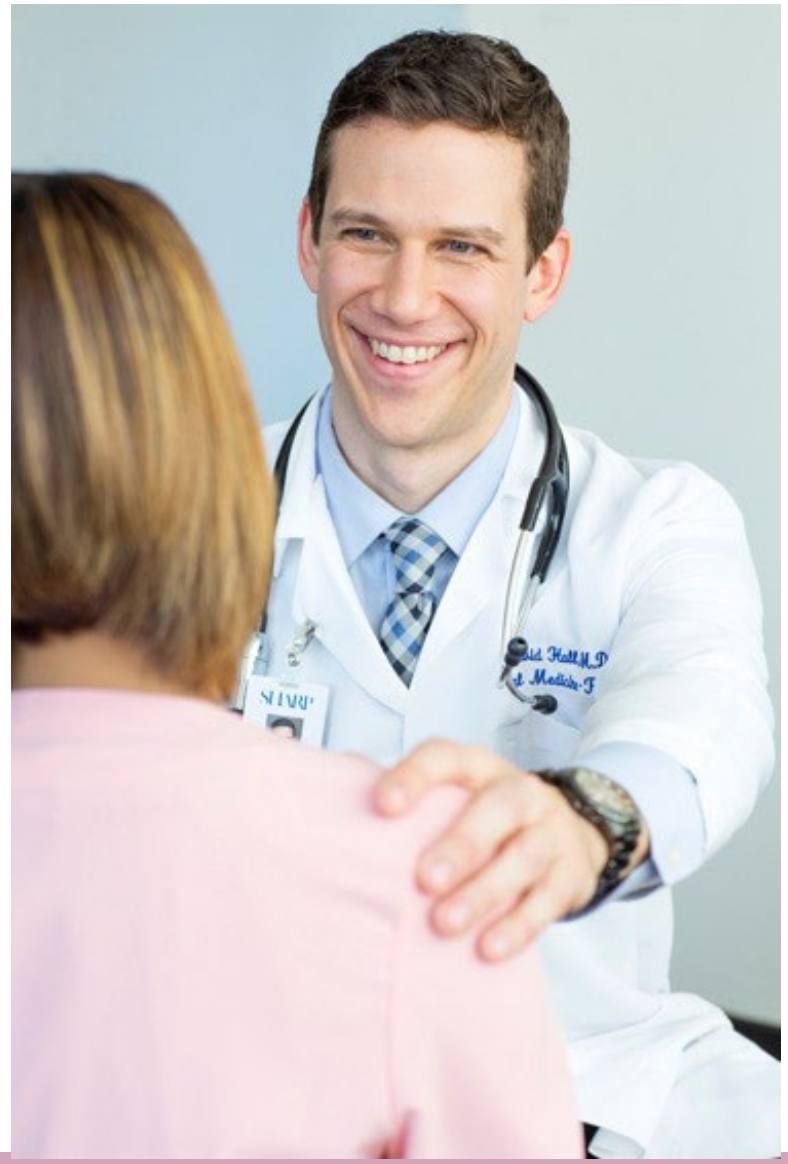
The Sharp Experience

The *best* place to work, the *best* place to practice medicine and the *best* place to receive care.

Sets the community standard for exceptional care

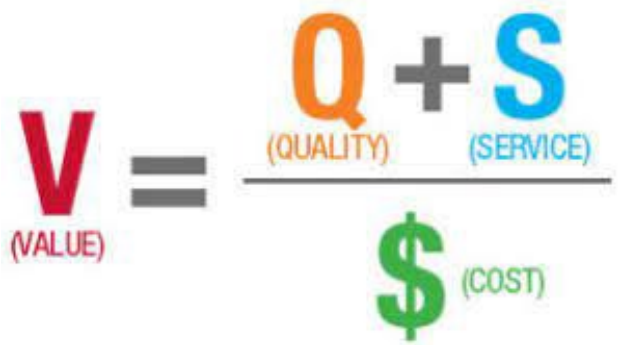
Combines clinical excellence, advanced technology and compassionate care

Goes beyond caring *for* people to caring *about* people



The SRS Value Proposition

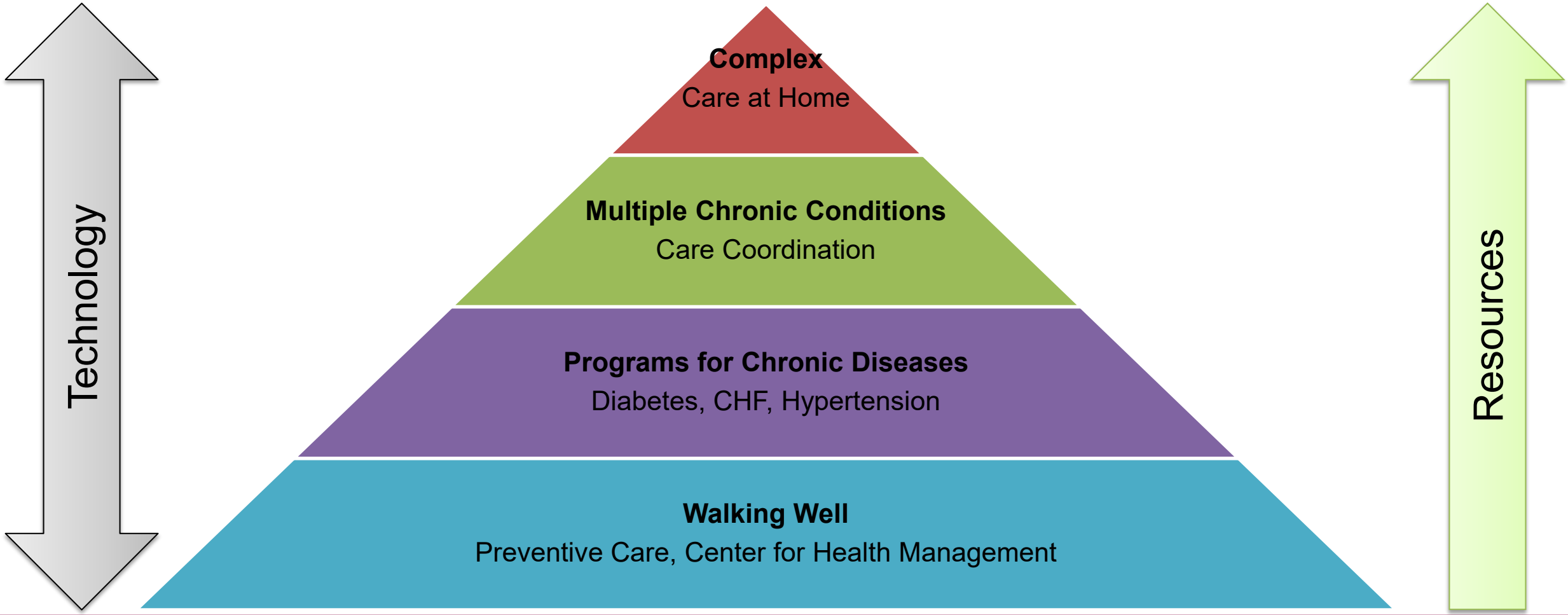
- ~ 70% of SRS revenue is capitated/HMO, which supports a care model focused on the whole patient (Population Health, Utilization Management, support teams, virtual on demand, patient portal)
- Health plans and employer groups recognize our high-quality care and cost-effective care; our inclusion helps them sell their plans
  - IHA Commercial HMO top 10% clinical quality & patient experience
  - IHA Senior Medicare Advantage 5 Star



Population Health's NCQA Model: a comprehensive strategy with the patient at the center. The coordinated care addresses patients' needs, preferences and values.

- Population Identification
- **Data Integration**
- Stratification
- Measurement
- Care Delivery Systems
- Health Plans/Payers
- Community Resources

Aligning Resources & Technology with Risk/Need



Population Health Team

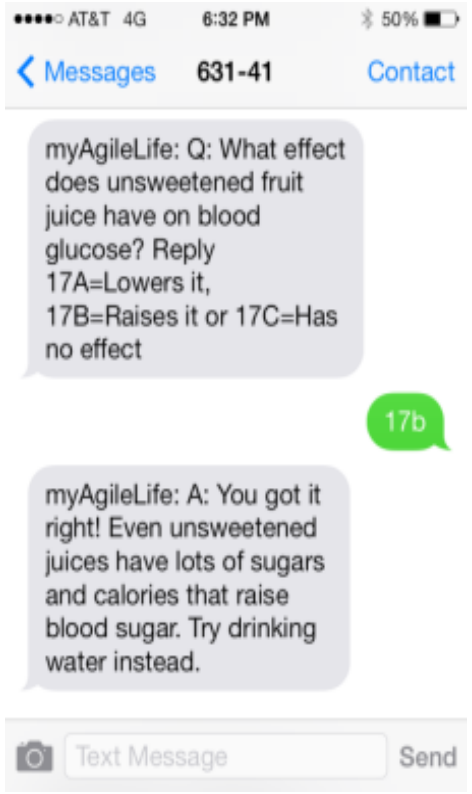
- Certified RN Case Managers
- Medical Assistants
- Licensed Social Workers
- Certified Health Coaches
- RN and Registered Dietitian Educators
- Care Specialists
- Community Health Workers
- Data Analysts
- Experienced Project Managers

Remote Patient Monitoring

iScale® *Plus*

iBloodPressure® *Classic*

For Diabetes
Blood Sugar Monitoring



Texting program

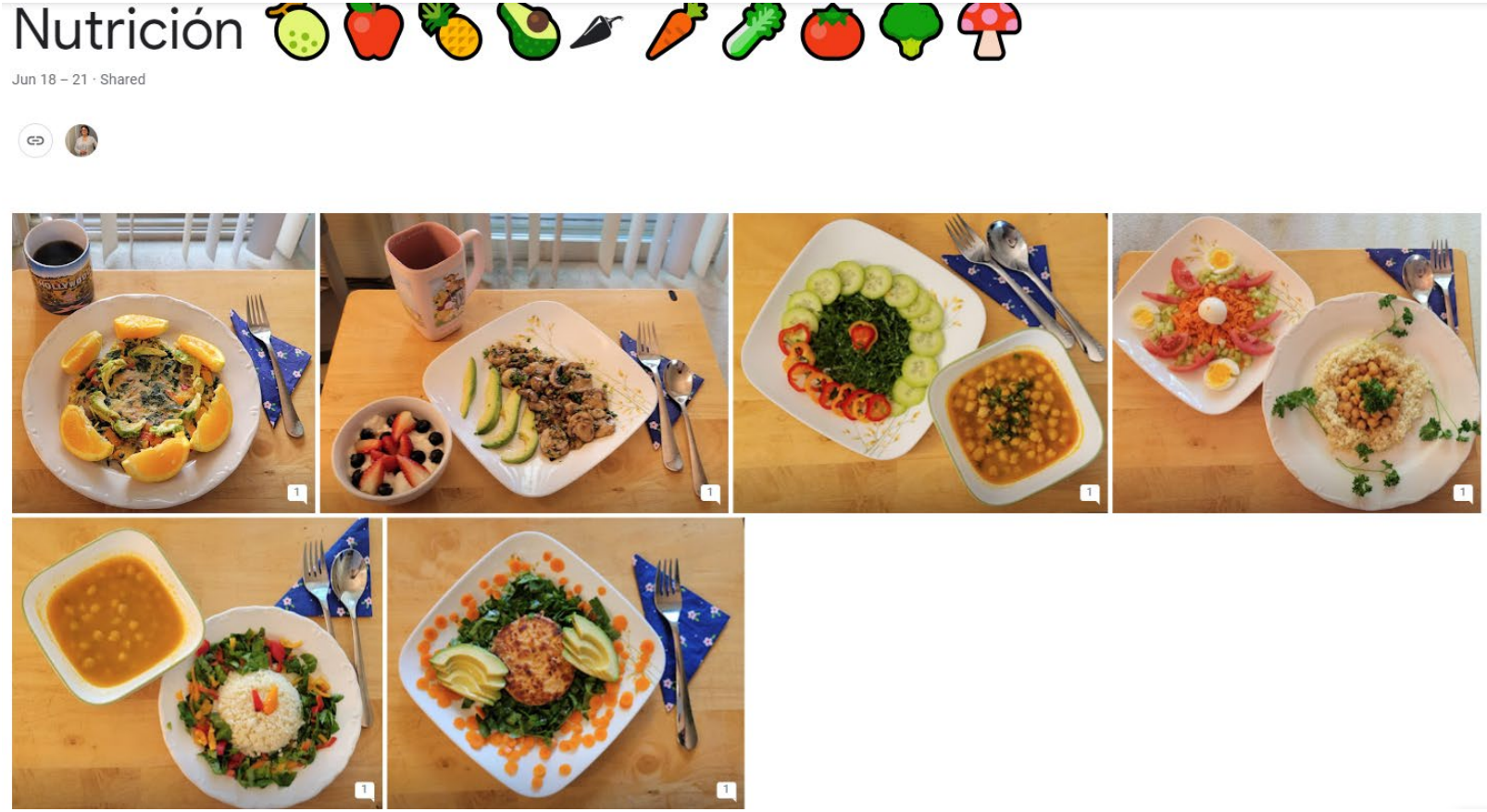
Text Messaging Programs

- Healthy Living
- Diabetes Prevention
- Diabetes
- Condition Management (HTN, Heart Disease/Coronary Artery Disease/Diabetes Medication Management)
- Post Hospital Discharge
- Kick Butts
- Medically Supervised Weight Loss
- New Weigh
- Be Well
- Post Partum Depression Screening
- Behavioral Health

Patient Stories

“Thank you for the invitation but I’m already enrolled in the DPP … then I signed up for the Healthy Living (Be Well For Life) …3 month long program. …. Because of the program my A1c has come down from 6.4 to 5.9 and I’ve lost 23lbs and I’m so much more active. I take water aerobic classes at the Kroc center 5-8 times per week(sometimes twice a day) and walk, bike ride and work in my garden. My husband says you all have created a monster. Lol! I obviously need to lose more weight but I’m on a path of good health and so active I surprise myself!”

Patient Stories

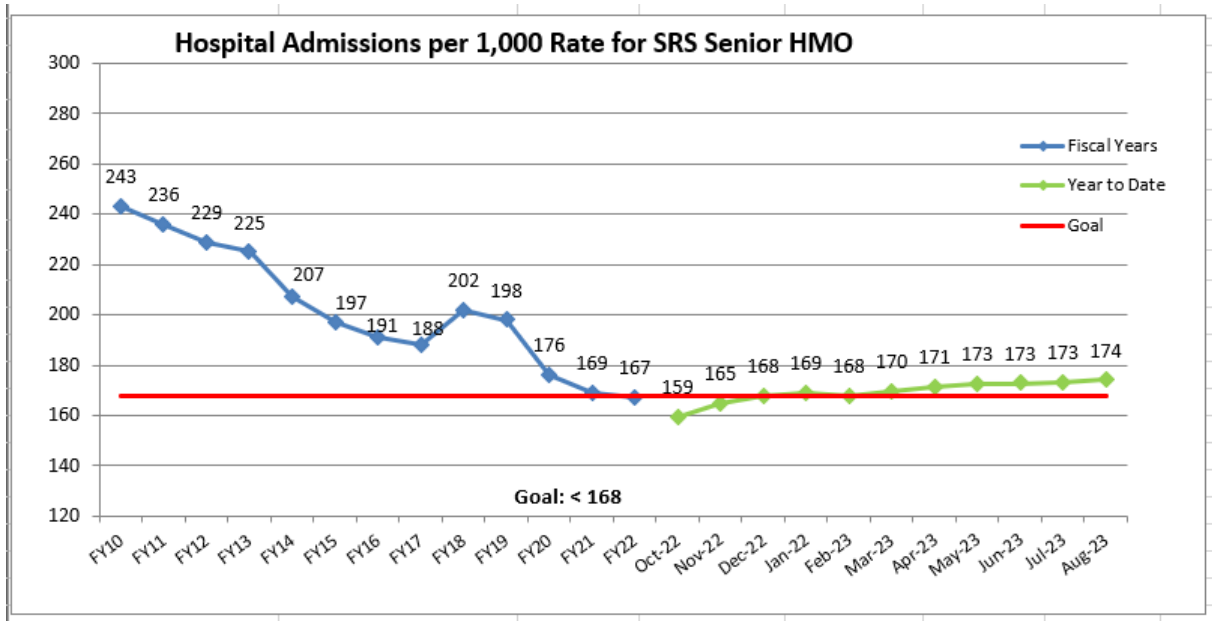


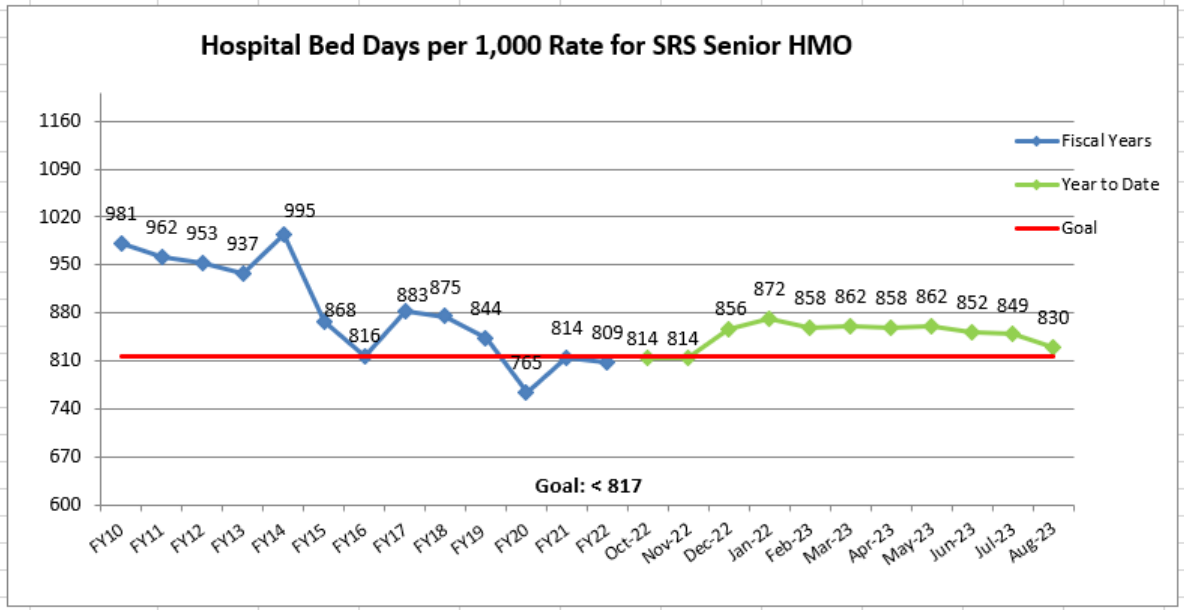
Routine colon cancer screening saves lives

By The Health News Team | April 12, 2023

Blake Miller, a healthy and fit father of two, understands the importance of screening for colon cancer even if he doesn't have symptoms.

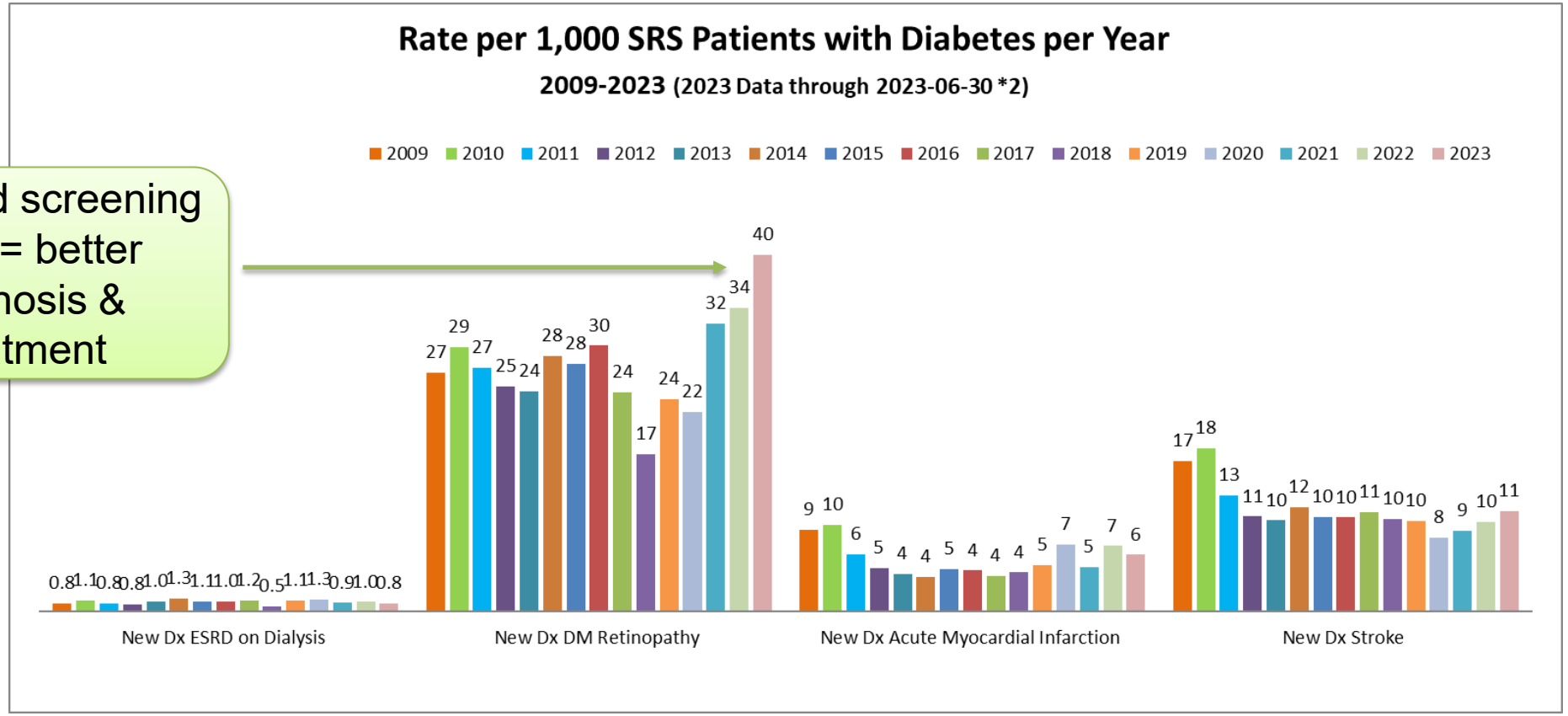
Bed Days/Admissions (Senior HMO)





Diabetes Management Results

Improved screening rates = better diagnosis & treatment



Surgical Complete Care

- Helping patients scheduled for elective procedures:
  podiatric, shoulder, amputations, knee/hip replacements, colectomies and ileostomies
- Arrange for services (PT, SNF, HH, DME) that will be needed after surgery
- Talk patients through what to expect (surgery, physical therapy, follow-up) – reduces anxiety
- Patients have one point of contact, reduces calls to physician offices

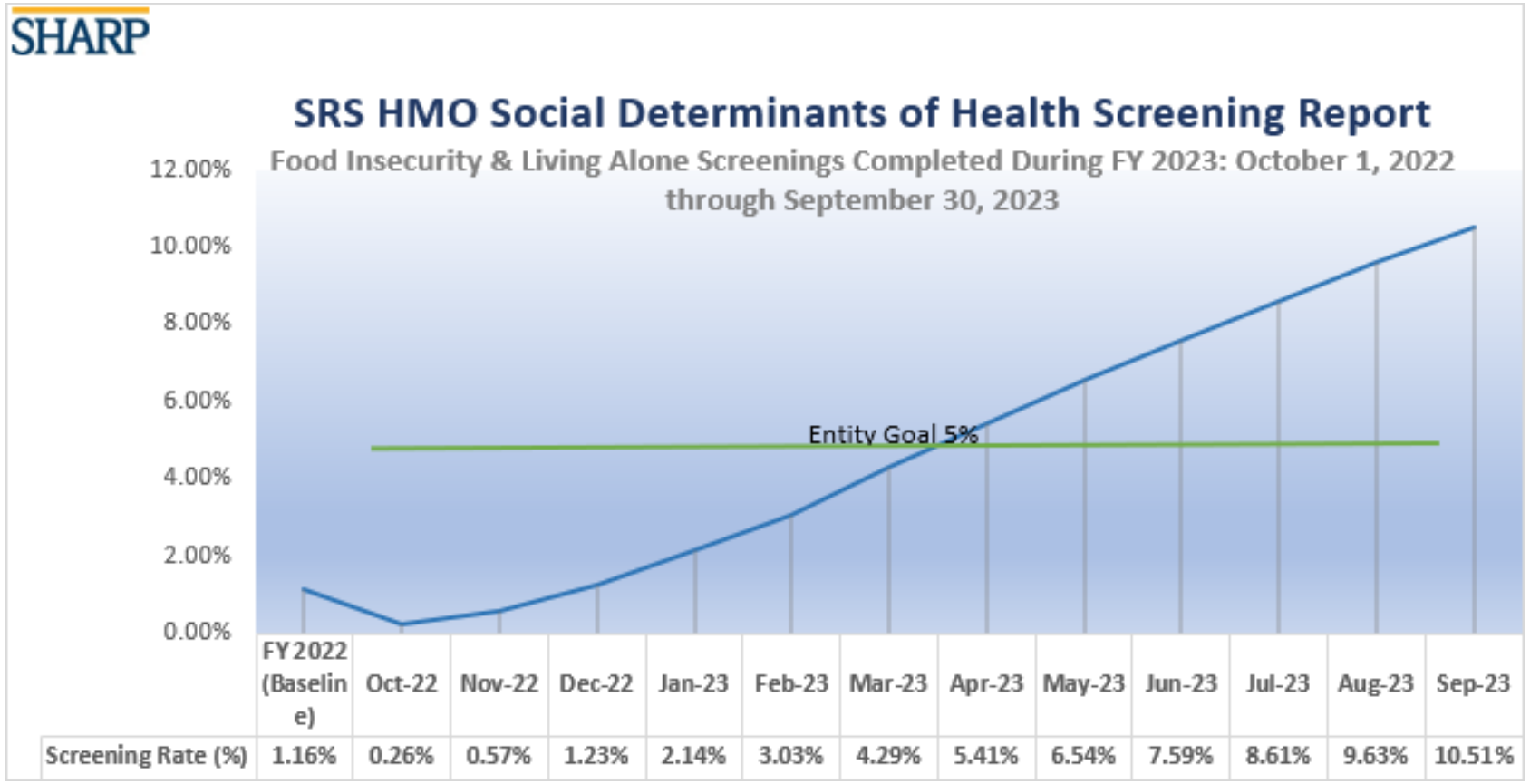
↓ Days (1.2 vs. 2.0)

ED visits - ↓40%

Readmits – ↓85%

EVOLUTION TO THE QUINTUPLE AIM

Social Determinants of Health



	FY 2022 (Baseline)	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Screening Rate (%)	1.16%	0.26%	0.57%	1.23%	2.14%	3.03%	4.29%	5.41%	6.54%	7.59%	8.61%	9.63%	10.51%

Thank you. Questions?

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Public Comment

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

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

THCE Rulemaking Timeline

Comments and Responses on Proposed Regulations

Theme	Comment/Question Summary	OHCA Response
Data Collection	Request for clarity on how to prevent double counting THCE when fully integrated delivery systems (FIDS) are contracted with another payer.	In plan-to-plan delegation arrangements, expenditures are reported by a single entity. In the example alluded to by the commenter, the fully integrated delivery system subcontracted with the member's directly contracted plan would not report spending data for the member to OHCA. The proposed regulations require a directly contracted plan to obtain any necessary data from a subcontracted plan and to submit the data to the OHCA.
	Request for clarity on how payers should determine which Commercial category to report spend in.	OHCA will amend the Data Submission Guide (Guide) to create a new section titled, "Market Categories," which includes added language and examples clarifying the distinction between the Commercial (Full Claims) and Commercial (Partial Claims) market categories.

Theme	Comment/Question Summary	OHCA Response
Attribution Methodology	Desire for a standardized patient attribution methodology, and/or more clear guidance on how to attribute member spending, especially under the "payer developed attribution" method.	OHCA will amend the language in the Guide to clarify that attribution is calculated on a monthly basis and reported in terms of mutually exclusive member months. The Guide provides an order of operations for attributing member-level expenditures and contains instructions regarding mutually exclusive attribution.
	Absence of process for validating and/or disputing expenditures attributed to providers.	OHCA acknowledges that there may be variation across payers and fully integrated delivery systems in the methods used to attribute some portion of total medical expenses (TME) to physician organizations. OHCA also acknowledges that not all TME will be attributed to physician organizations. While OHCA seeks to obtain the data necessary to effectuate its statutorily prescribed goals and objectives, it notes that it may not incorporate all data collected in the baseline or annual reports, and may not use all data collected for provider reporting, or future enforcement, and accountability. OHCA will evaluate the data collected to continue to refine attribution methodologies and inform future data collection and reporting.

Theme	Comment/Question Summary	OHCA Response
Attribution Addendum	Inadequate list of physician organizations in the Attribution Addendum (excludes medical managed care providers and many of the medical physician organizations, e.g., counties that provide care and community clinics, and restricted to RBO and RKKs).	OHCA will update the Attribution Addendum based on stakeholder feedback received through the workshop and written comments. OHCA will continue to periodically revise the Attribution Addendum based on information received from submitters, including during the submitter registration process, with an ultimate objective of data completeness. All updates to the Attribution Addendum will be made in accordance with the APA.
	Concern over omitting physician groups with 25 or more physicians.	OHCA acknowledges receipt of the "further list of California medical groups" from APG. OHCA, in consultation with its contracted experts, will amend the Attribution Addendum based on this document.
	Noted the need for a physician organization registry.	The purpose of these proposed regulations is to collect total health care expenditures data from specified payers and fully integrated delivery systems pursuant to Health and Safety Code section 127501.4(d)(1). OHCA acknowledges that because there is no existing, comprehensive list of physician organizations operating in California with unique identifiers; many issues will need to be resolved with the continued involvement of stakeholders.

Theme	Comment/Question Summary	OHCA Response
Miscellaneous	The Office should include the most pertinent portions of the Data Submission Guide (DSG) directly in the proposed regulation.	Because the proposed regulations incorporate the Guide by reference the document is part of the proposed regulations as a matter of law. (See Cal. Code Regs., tit. 1, § 20, subd. (e).) OHCA determined that publishing the Guide in the California Code of Regulations would be inordinately complicated and impractical due to its length and format. OHCA anticipates that the Guide's primary users will be the data analysts and information technology specialists charged with extracting the required data – not compliance professionals or legal staff. A user-friendly guide format is the most appropriate, least confusing means to communicate necessary information to these individuals in one convenient and comprehensive document. The purpose and structure of the Guide will be familiar for submitters that participate in HCAI's Health Care Payments Data (HPD) program. The HPD program incorporates a data submission guide with a similar format into its data collection regulations by reference. OHCA's use of the Guide will be familiar to submitters who participate in spending target programs in other states. For example, Oregon uses a Cost Growth Target Data Specification Manual, which is referenced in the state's implementing regulations, to provide instructions on data submission requirements.

Theme	Comment/Question Summary	OHCA Response
Risk Adjustment	Lack of mechanism for gathering clinical risk information could punish providers who serve particularly vulnerable populations. Including a request to formally evaluate alternative risk adjustment methodologies.	OHCA will not modify its risk adjustment methodology to consider clinical risk through these proposed regulations. OHCA staff indicated at the September 2023 Board meeting that age/sex risk adjustment will be utilized for the baseline report. OHCA will continue to assess the issue of whether clinical risk adjustment should be introduced in future reporting. OHCA remains open to other approaches to risk adjustment and will continue to assess options going forward.

Theme	Comment/Question Summary	OHCA Response
Miscellaneous	Authority to collect self-insured data.	Section 97449(b) of the proposed regulations requires submission of data for all market categories to the extent consistent with federal law. Section 97449(c) of the proposed regulations allows for voluntary data submission in scenarios where data submission cannot be required, but where an entity chooses to voluntarily submit data.
	Authority to collect Medicare Advantage data.	The DMHC licenses and oversees payer and fully integrated delivery system Medicare Advantage lines of business for administrative capacity and financial solvency. For purposes of this oversight, the DMHC already requires the submission of annual and quarterly financial statements containing specified information relating to revenue, medical expenditures, and administration, inclusive of Medicare Advantage data. The proposed regulations require submission of certain portions of the expenditure data underlying the comprehensive financial statements submitted to the DMHC, but extracted, aggregated, and submitted in a format necessary for OHCA to measure and compare total health care expenditures and per capita total health care expenditures over time.

Theme	Comment/Question Summary	OHCA Response
Miscellaneous	Claims run out period is insufficient and/or inconsistent with state law and will lead to potential for error.	OHCA does not impose a deadline for claims adjudication, it requires submitters to wait a minimum amount of time before extracting data for finalized claims. OHCA acknowledges that for some claims, run-out may exceed the minimum 180-day claims run-out period. This is one of the reasons why Section 4.1 of the DSG requires data submission for the previous two calendar years (CY) with each annual data submission. Specifically, the baseline data submission, due by September 1, 2024, will include CY 2022 data and CY 2023 data. The second data submission, due by September 1, 2025, will include updated CY 2023 data and CY 2024 data. The third submission to be used for the first annual report is due by September 1, 2026, and will include updated CY 2024 data and CY 2025 data. Because the 180-day claims run-out period is calculated from December 31 of the most recent reporting year (i.e., June 30, 2024 for 2022 and 2023 service dates), updated CY data submitted to OHCA will reflect a claims run-out period of at least 540 days. OHCA intends to use the initial data submissions received in 2024 and 2025 to develop further insight into the impact of the 180-day minimum claims run-out period on overall data completeness.

Theme	Comment/Question Summary	OHCA Response
Miscellaneous	Request new definition of “Allowed Amount”.	OHCA did not adopt the suggested definition because the existing language in the proposed regulation is sufficiently clear. The Guide specifies that the “allowed amount” includes “the amount paid by the payer or fully integrated delivery system to the provider…” Additionally, the Guide specifies that “[i]ncurred but not reported (IBNR) or incurred but not paid (IBNP) factors should not be applied” when calculating claims payments.
	Request clarity around administrative costs and profit data collection.	Data necessary to calculate administrative costs and profits for other submitters will be sourced from existing state and federal reports, including those maintained by the DMHC, DHCS, CMS Center for Consumer Information and Insurance Oversight (CCIIO), and the National Association of Insurance Commissioners (NAIC). The Guide requests submitters with self-insured lines of business report aggregate information on the fees earned from self-insured accounts in field SQS021 of the “Submission Questions” file.
	Request explanation for why Appendix B does not include “Non-Claims: Total Primary Care Non-Claims Based Payment”.	The instructions for how to calculate the portion of non-claims payments related to primary care will be determined through OHCA’s Primary Care subgroup meeting and Investment and Payment Workgroup. OHCA will solicit stakeholder feedback to inform the instructions, which will be the subject of future rulemaking.

Theme	Comment/Question Summary	OHCA Response
Miscellaneous	Request for additional clarity around what fully integrated delivery systems (FIDS) will report.	The proposed regulations have identical data submission requirements for payers and FIDS. Likewise, OHCA's expectations for data accuracy and completeness are identical for payers and FIDS. OHCA will continue to engage with FIDS stakeholders through this initial data collection process to determine whether the existing service categories and non-claims payment categories meet OHCA's data analysis and reporting needs.
	Request to report cost-sharing by benefit category (e.g., inpatient) to show where costs are being borne by consumers.	OHCA will not add an additional data field segmenting "payer paid" and "member paid" amounts in these initial data collection regulations. OHCA is committed to promoting the goal of improved affordability for consumers and purchasers of health care and will evaluate the data collected to continue to inform future data collection and reporting.
	Request new suggested definition of pharmacy rebates.	OHCA declined to adopt the suggested new definition. The Guide will contain a bulleted list of the types of pharmacy rebate data collected in the Pharmacy Rebates File. The list is intentionally inclusive to meet OHCA's overall objective of data completeness. OHCA developed this list in collaboration with the HPD program and contracted experts to ensure consistency across HCAI's data collection programs. However, OHCA will make changes to the "Pharmacy Rebates File," clarifying the descriptions of the data fields for medical pharmacy rebate amount and retail pharmacy rebate amount.

Theme	Comment/Question Summary	OHCA Response
Miscellaneous	Request changes to language in Appendix A: Service Categories.	OHCA will delete “outpatient observation services,” “critical access hospital,” and “freestanding emergency facility”
	Request change to term “doctor of medicine or osteopathy”.	OHCA will revise to “licensed physician and surgeon”
	Request stakeholder engagement language added to the Guide.	OHCA will add Section 1.3 to the Guide, “Changes to this Guide,” which will read: “Consistent with Health and Safety Code section 127501.4(k), prior to making changes to this Guide, OHCA will engage with relevant stakeholders, hold a public meeting to solicit input, and provide a response to input received. For notice of potential regulatory actions or public meetings, subscribe to OHCA’s email listservs at https://hcai.ca.gov/mailing-list/.”

HCAi
Department of Health Care Access and Information

Public Comment

HCAi
Department of Health Care Access and Information

Hospital Measurement: Introductory Discussion of OHCA's Plan for Measuring Hospital Spending

Mary Jo Condon, Freedman Healthcare, Principal Consultant
John Freedman, Freedman Healthcare, President & CEO
Sarah Lindberg, Freedman Healthcare, Senior Data Consultant
Gary Swan, Freedman Healthcare, Senior Consultant

Measuring Hospital Spending

- Spending targets typically focus on calculating total medical expenditures (TME):
    1. at the payer level; ***or by***
    2. attributing patients to health care entities and calculating total medical expenses for attributed patients; ***for either approach***
    3. calculating year-over-year rate of growth in TME for those patients.
- This approach does not work well for hospitals and specialists with few/no attributed patients.
- Nationally, there are gaps in measuring how hospital spending contributes to achieving a TME target.
- OHCA expects the current TME approach to measure spending performance for hospitals that are part of a health system with attributed lives. It will need additional strategies to better understand hospital spending across all patients.

Common Language

Hospital

- A health facility that provides emergency department services, outpatient surgeries, and inpatient care
- Includes treatment for acute conditions, with various specialized units and services

Hospital

Physician Organization

- A collection of physicians who provide a wide range of outpatient medical services
- Excludes those providers employed by hospitals

Physician Organization

Health System

- A network of health facilities providing a comprehensive range of services
- Including hospital services as well as physician and ancillary services

Hospital + Physician Organization

Goals for Hospital Spending Measurement

- Identify gaps in analytical frameworks.
- Model various methodologies to discern both advantages and challenges specific to California.
- Assess potential opportunities and hurdles in data collection and reporting.
- Formulate strategies that build on current efforts to measure hospital spending as part of the TME approach.
- Establish a recommended methodology for measuring hospital spending.
- Provide policy recommendations for accountability strategies.

Capturing Spending

Measurement Approaches

Under development

Payers & Physician Organizations

Payers

- THCE/TME

Physician Organizations

- TME based on the following attribution methods:
  - ❑ Capitated, Delegated Arrangement
  - ❑ ACO Arrangement
  - ❑ Payer-Developed Attribution

Additional Options to be Developed

Hospitals & Specialists

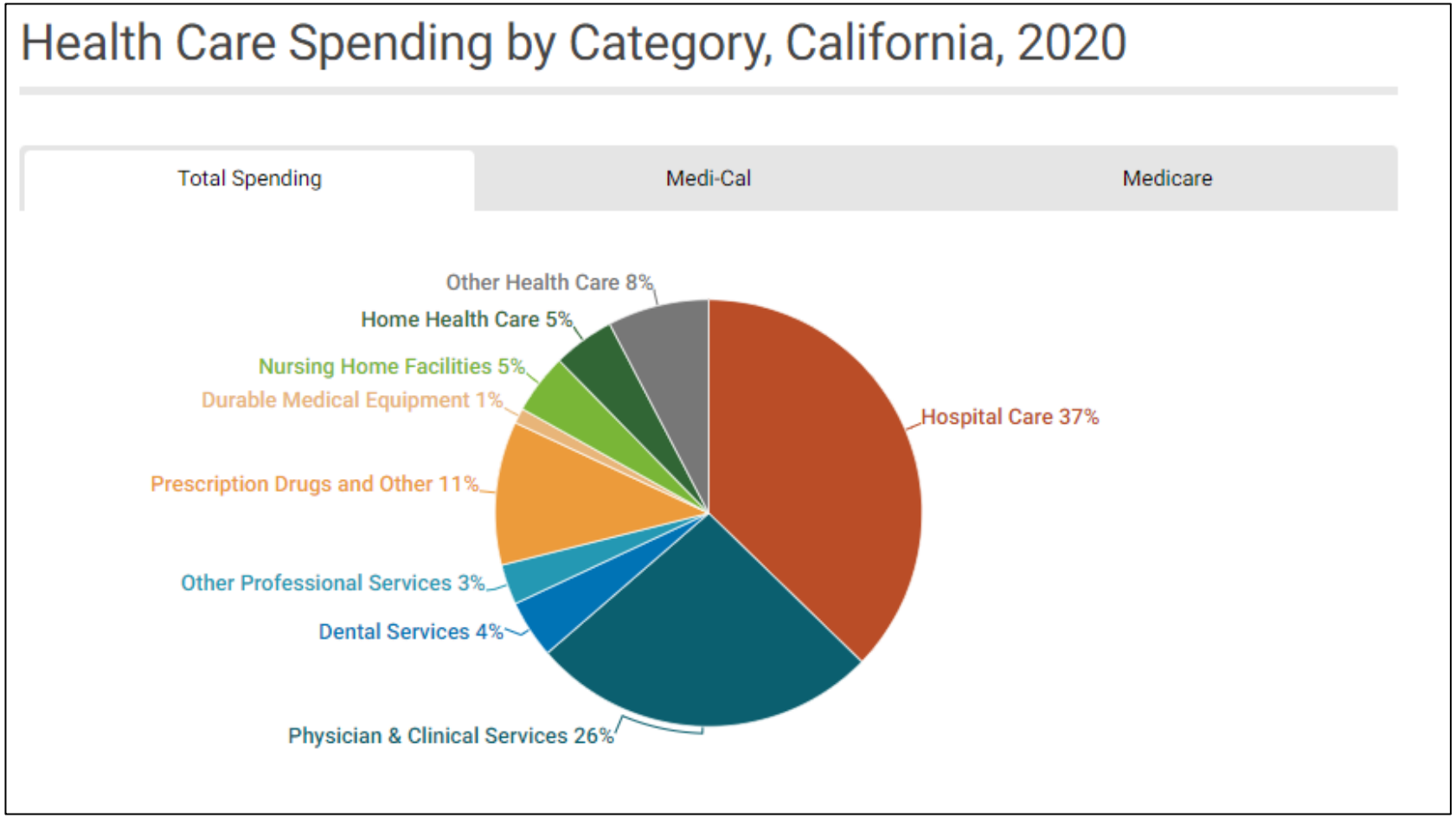
Hospitals

- Price trends for all services or a subset
- Total payment to hospitals

Specialists (TBD)

Hospital Spending as a Share of Total Health Care Spending in California

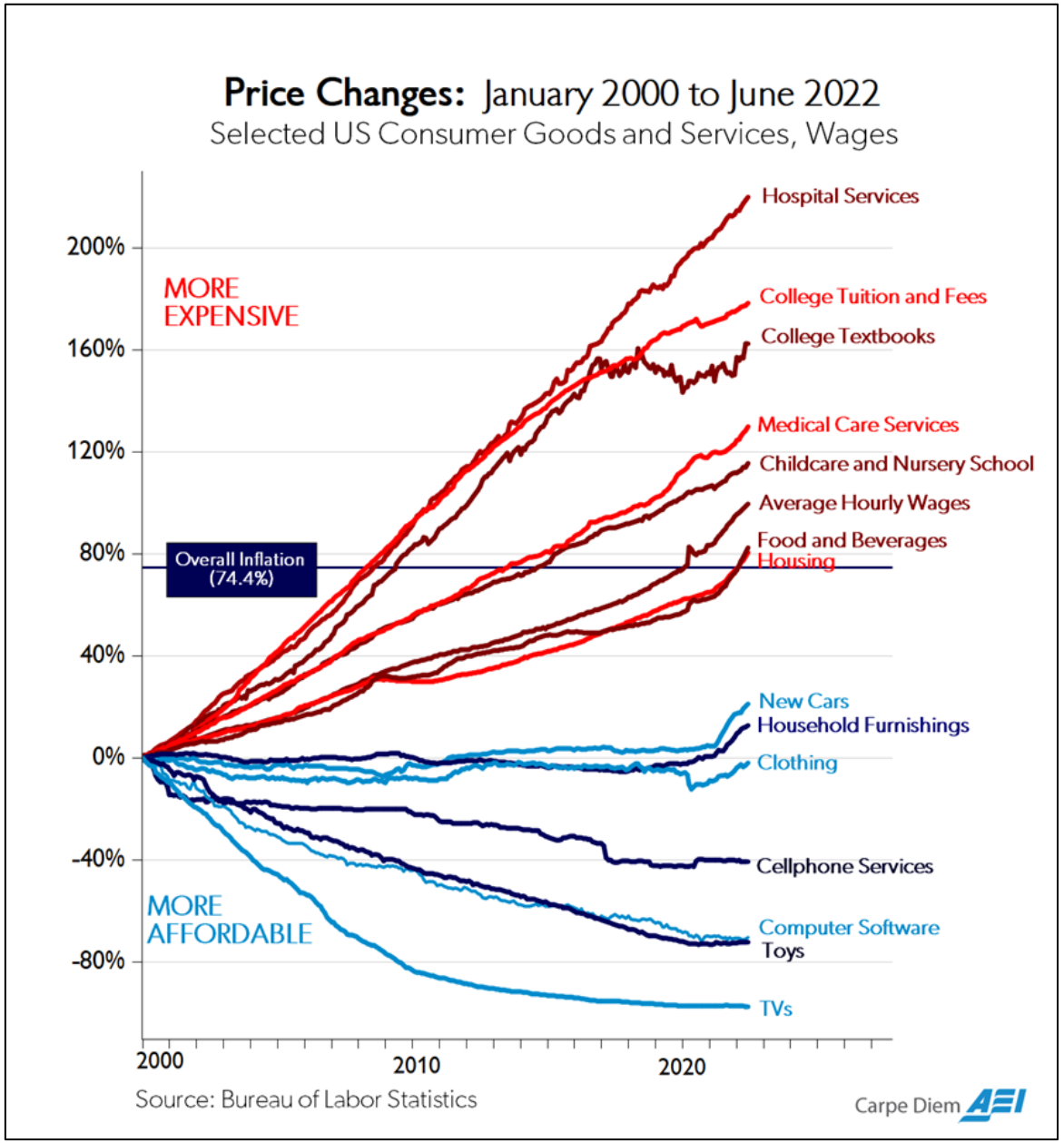
- Based on CMS data, nearly 40% of health care spending in California occurs in hospitals.



Wilson, K. (2023, March 14). "*2023 Edition – California Health Care Spending*." California Health Care Foundation. https://www.chcf.org/publication/2023-edition-california-health-care-spending/#related-links-and-downloads

Hospital Prices Are a Significant Driver of Health Care Inflation

- Over the past 20 years, the prices paid by consumers for hospital services has increased **more than 200%**, which is three times higher than overall price inflation over the same time period.



Source: Perry, Mark. (2022, July 23). “Chart of the Day…or Century?”. Carpe Diem, American Enterprise Institute. https://www.aei.org/carpe-diem/

More Common Language

Cost of Hospital Services

- Hospital cost: total fixed and variable expenses necessary to provide a service
- Costs are associated with direct patient care (e.g., supplies) and indirect overhead (e.g., rent, administration, debt service)

Fixed + Variable Expenses

Price of Hospital Services

- Hospital price: payment for a unit of service
- Payments (allowed amounts of insurer + member cost share) vary by service, provider, and payer

Payment per Unit of Service

Total Spending for Hospital Services

- Spending on hospital services: payments multiplied by the utilization of health care services*
- This is the portion of TME that reflects hospital services

Price * Utilization * Mix/Intensity

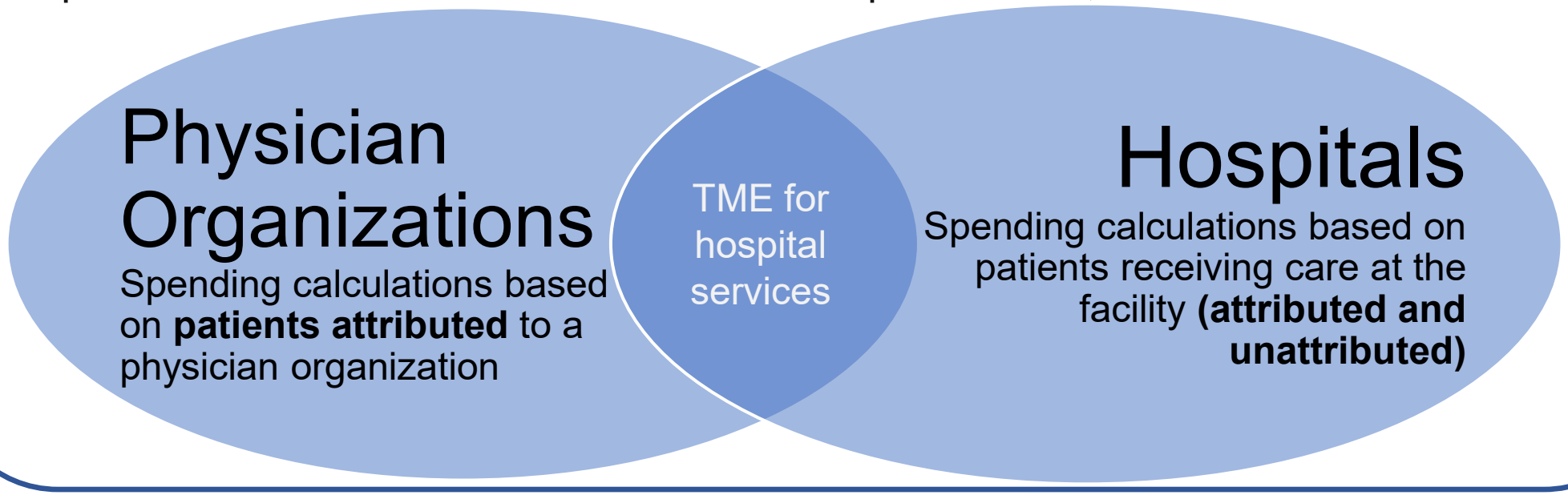
* Costs, i.e., indirect overhead not associated with patient care may be built into hospital prices or paid via other revenue sources.

Why Track Hospital Spending

Calculations of TME by physician organization only reflect hospital spending by patients attributed to that organization. To achieve success in statewide spending targets, it is important to track and measure hospital spending by hospitals for all patients.

Payers

Captures TME for all services and all insured patients i.e., unattributed and attributed



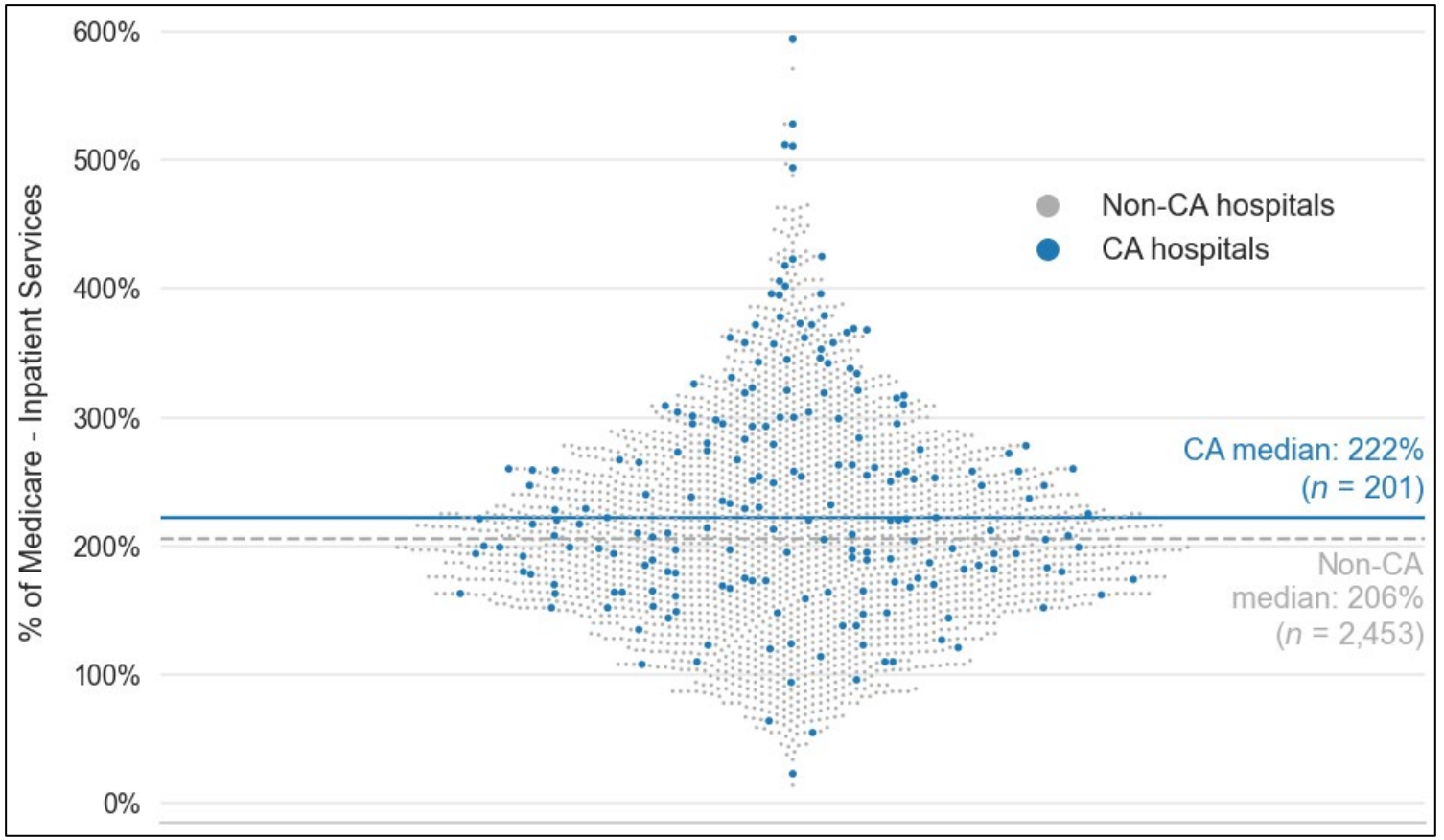
RAND's Hospital Price Transparency Study

- The RAND Corporation conducted an analysis* examining hospital prices paid by private health plans and by Medicare for the same services.
- The most recent results were released in July 2022 and included data from self-funded employers and all-payer claims databases from 11 states.
- For California, reliable results were reported for 201 hospitals for inpatient care and 256 hospitals for outpatient care (out of 337 acute care hospitals).

* Study based largely on fee-for-service payments made by self-insured employers. Did not include members covered under capitation arrangements.
Source: Whaley, C. et al. (2022 July). *"Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative."* RAND Corporation. https://www.rand.org/pubs/research_reports/RRA1144-1.html.

A Closer Look at Hospital Reimbursement

- California commercial prices for inpatient services were approximately 222% of Medicare prices, which was 8% higher than observed nationally.*

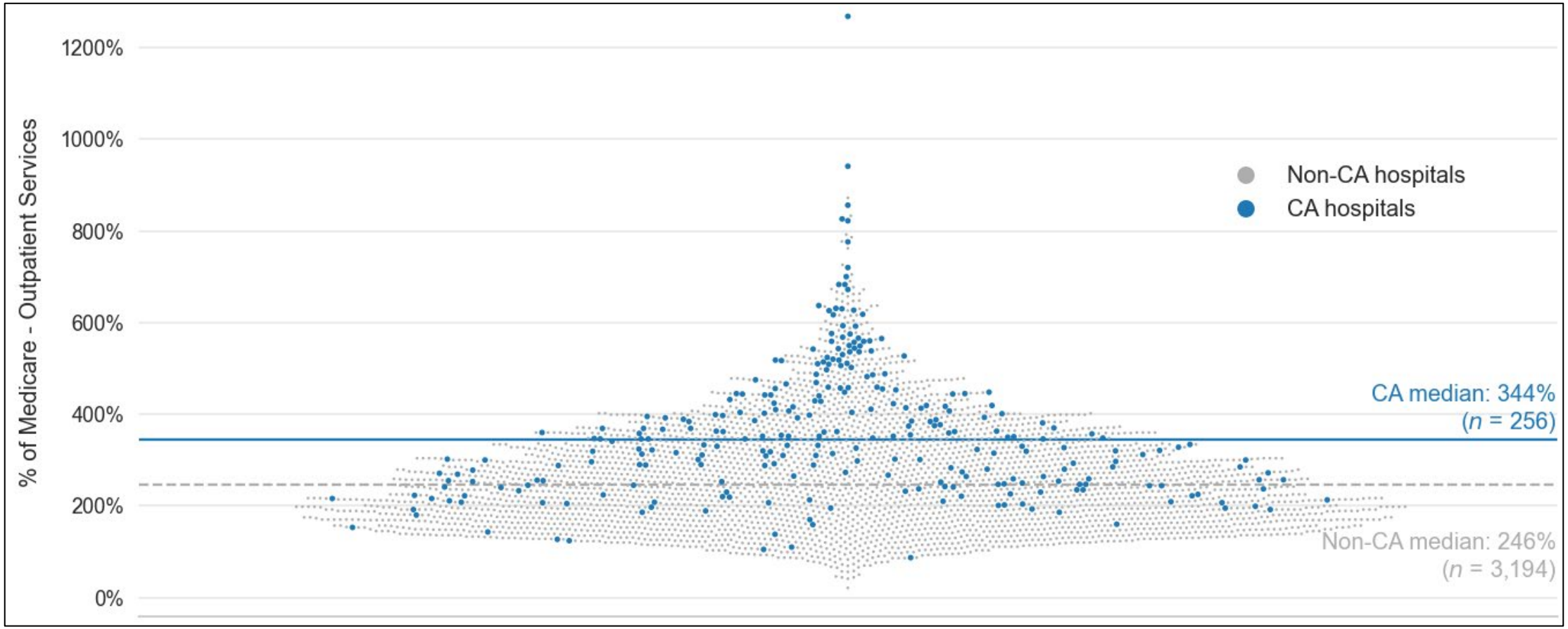


* For hospitals with 30 or more inpatient discharges.

Source: Whaley, C. et al. (2022 July). *"Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative."* RAND Corporation. https://www.rand.org/pubs/research_reports/RRA1144-1.html.

A Closer Look at Hospital Reimbursement

The same RAND study found commercial prices for outpatient hospital services were more than 340% of Medicare's prices, which was 40% higher than observed nationally.*



* For hospitals with 30 or more outpatient services.

Source: Whaley, C. et al. (2022 July). *"Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative."* RAND Corporation. https://www.rand.org/pubs/research_reports/RRA1144-1.html.

Measurement Approaches

	Direct Standardization	Indirect Standardization
Definition	• Compares prices based on a standard set of services	• Compares prices based on a standard set of services, accounting for a provider's mix of services
Differences	• Assumes a uniform service mix, which may not be representative of a given hospital	• Adjusts for hospital-specific service mix
Commonalities	• Measure negotiated prices (i.e., allowed amounts) • Based on a standard set of services • Both can be adjusted based on risk factors • Allow comparisons across time, geographies, hospital types, or other categories of interest	

Measurement Approaches: Direct Standardization

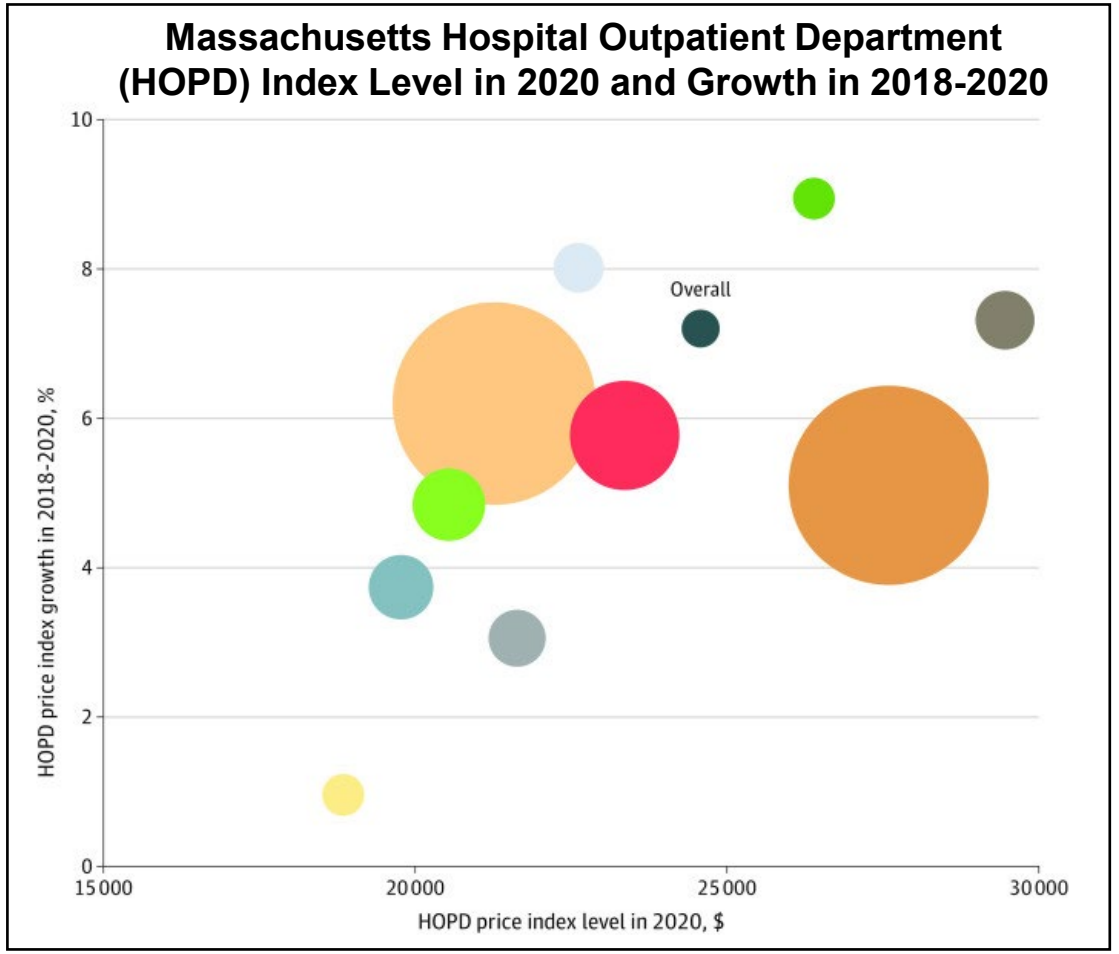
Compares price using uniform assumptions of services and their utilization in the market basket. Does not detect variations in patient revenue based on differences in utilization.

Tradeoffs and policy considerations:

- As a hospital's service mix changes, measurement may become be less reflective of reality
- Easy for reader to understand; for example, same structure as Consumer Price Index (CPI)
- May be applied to outpatient, inpatient and professional
- Limited to services included in the market basket, which may create perverse incentives
- Shifts in service utilization patterns and the introduction of new treatments or technologies may require revised weighting methodology

Measurement Approaches: Direct Standardization - Example

- Direct Standardization can show how **price** varies by facility, service, and over time.
- Massachusetts demonstrated the growth in hospital outpatient services as a principal driver of health care expenditures.
- Each bubble represents a health system in Massachusetts. The size of the bubble (except for the "Overall" data point) corresponds with the share of commercial service volume each health system provided in 2018.



Measurement Approaches: Indirect Standardization

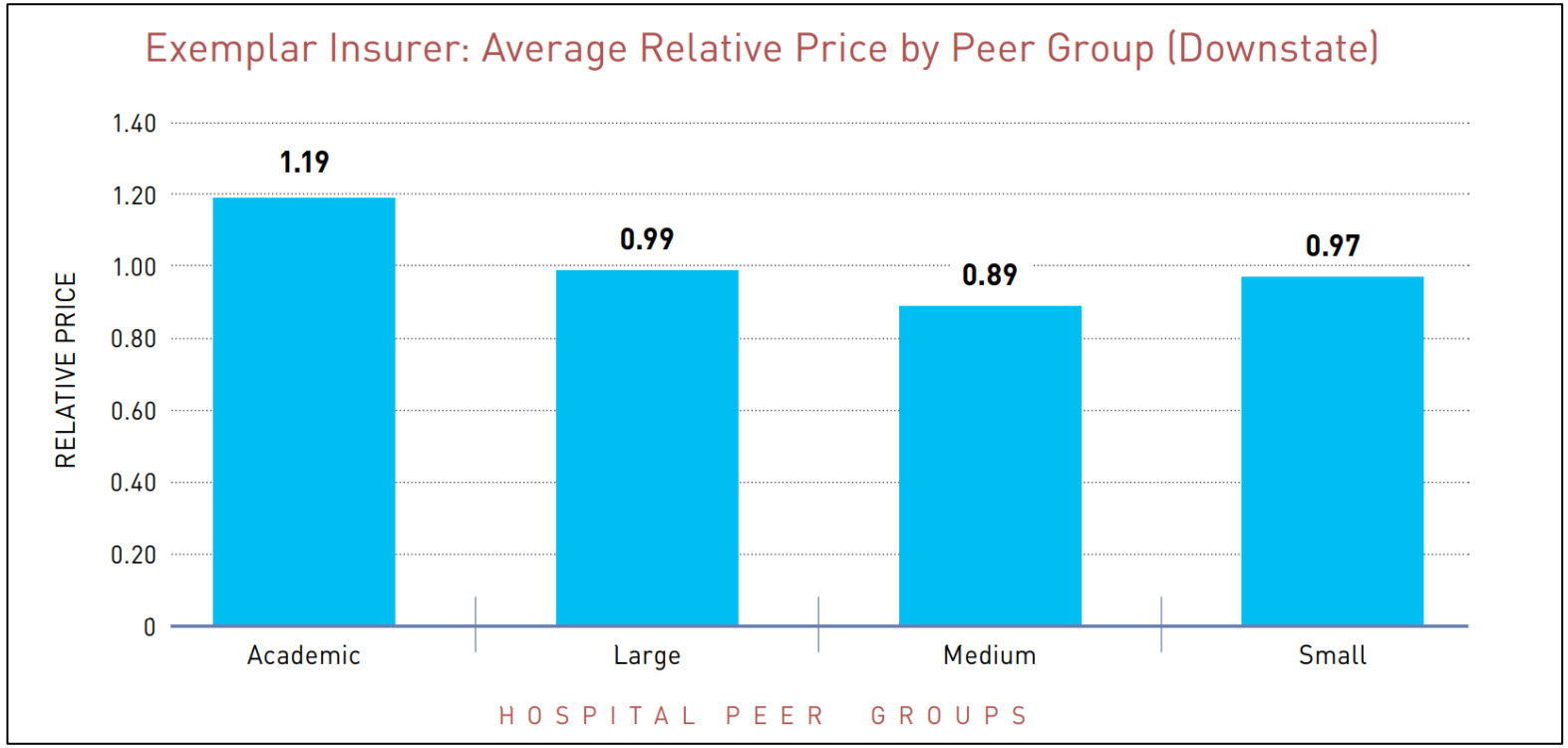
Compares prices while acknowledging utilization differences.

Tradeoffs and policy considerations:

- Changing mix over time does not skew results
- Cost drivers may be less apparent if using a broad (or universal) set of services
- May be applied to outpatient, inpatient and professional
- Relative prices are more conceptual than average prices, although they can be transformed into effective average prices for display purposes
- Mitigates risk of adverse incentives

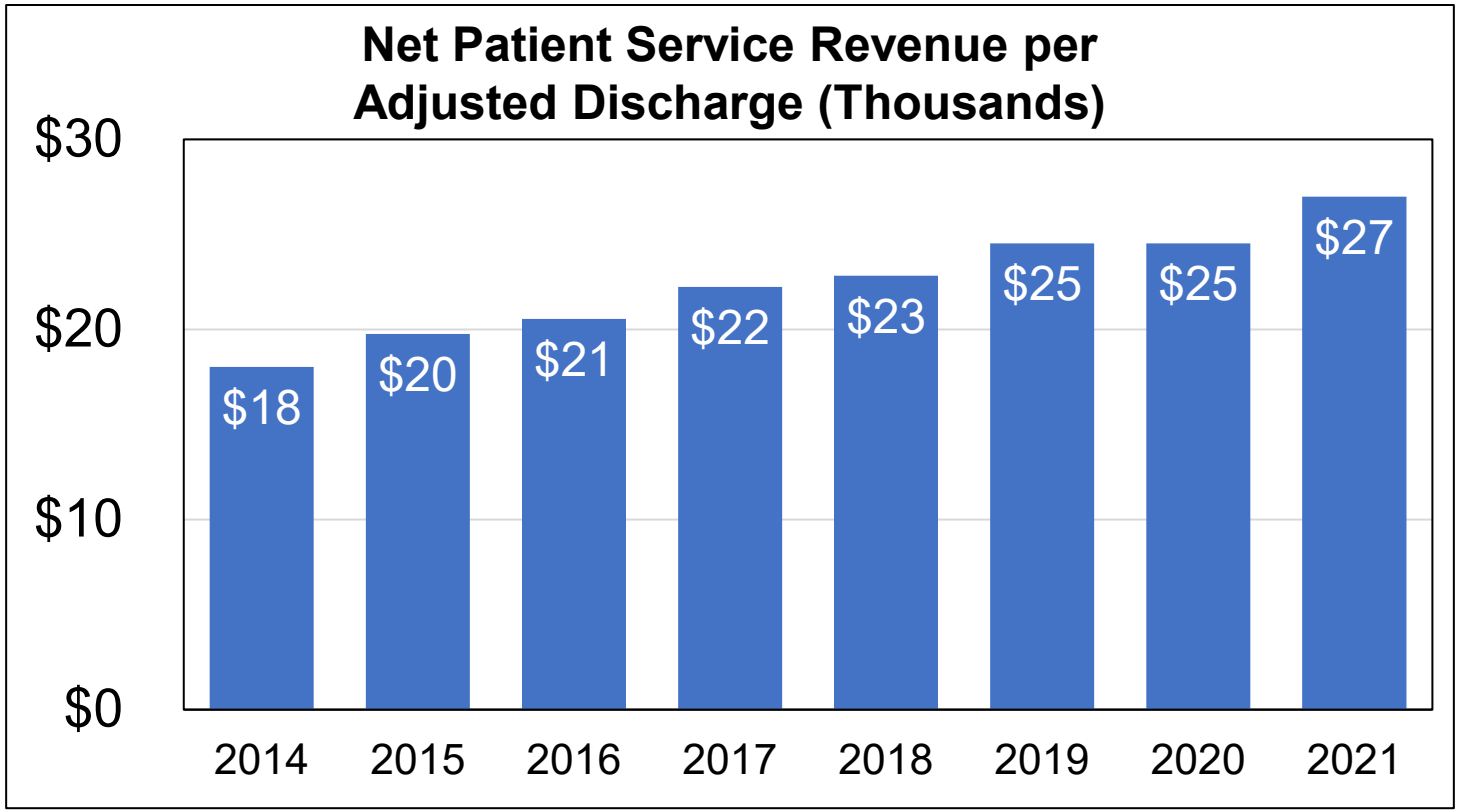
Measurement Approaches: Indirect Standardization – Example 1

- New York used this technique when examining its hospital contracting practices in the commercial market.
- Report analyzed hospital price variation and whether hospital prices are influenced by clinical quality, market leverage, or the proportion of revenue from public payers.



Source: Gorman Actuarial, Inc. (2016, December). "*Why are hospital prices different? An examination of New York hospital reimbursement.*" New York State Health Foundation. https://nyhealthfoundation.org/resource/an-examination-of-new-york-hospital-reimbursement/

Measurement Approaches: Indirect Standardization – Example 2



Note: "Adjusted" reflects adjustment for estimated proportion of outpatient services provided

- Net Patient Service Revenue per Adjusted Discharge represents the weighted average of payments per discharge.
- For California hospitals, this measure grew by 50% from 2014 to 2021.

Source: Department of Health Care Access and Information. *"Hospital Financial Data Interactive Series: Hospital Average Cost and Profitability Delivering Patient Care."* https://hcai.ca.gov/visualizations/hospital-financial-data-interactive-series-hospital-average-cost-and-profitability-delivering-patient-care/

Indirect v. Direct Standardization Compared

This example tracks changes within a single hospital over time. It contrasts indirect and direct standardization, highlighting significant annual variations in volume and price.

Year	Acute Myocardial Infarction			Vaginal Delivery			Benchmk Price	Expect Revenu @ Bench-mark	Actual Hospital Revenue	IS		DS		Notes on Result
	Volume	Price	Revenue	Volume	Price	Revenue				Result	YoY Change	Result	YoY Change	
1	100	$2,000	$200,000	100	$2,000	$200,000	$1,000	$200,000	$400,000	2.00	-	2.00	-	Twice as expensive for all DRGs
2	100	$1,000	$100,000	100	$2,000	$200,000	$1,000	$200,000	$300,000	1.50	-25%	1.50	-25%	Twice as expensive for half its volume
3	50	$1,000	$50,000	150	$2,000	$300,000	$1,000	$200,000	$350,000	1.75	+17%	1.50	0%	Twice as expensive for its larger volume service
4	150	$1,000	$150,000	50	$2,000	$100,000	$1,000	$200,000	$250,000	1.25	-29%	1.50	0%	Twice as expensive for its lower volume service

IS = Indirect Standardization; DS = Direct Standardization; YoY=Year-over-year

Next Steps

- OHCA convenes a Multi-Stakeholder Workgroup and Technical Advisory Panel to receive input on hospital measurement.
  - Review methodologies for measuring and reporting hospital expenditures.
  - Analyze the trade-offs associated with various measurement methodologies.
- OHCA develops baseline models for the selected measurement approach.
  - Perform data discovery and testing potential methodologies.
- OHCA provides regular progress updates to the Health Care Affordability Board.

Project Overview and Timeline

Health Care Affordability Board & key stakeholder engagement throughout 2024 and 2025.

Q1 2024

Consider Options for Defining, Measuring and Reporting

- Define methodology options
- Evaluate the trade-offs

Q2 2024 – Q1 2025

Model Hospital Spending Target Methodology

- Conduct testing and validation

Q1 2024 – Q3 2025

Convene Multi-Stakeholder Workgroup and Technical Advisory Panel

- Discuss methodology and policy guidance

Q1/Q2 2025

Support Regulation Development*

- Final methodology revisions

*If new data collection is needed.

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General Public Comment

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

Next Board Meeting:

February 28, 2024
10:00 a.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

HCAi
Department of Health Care Access and Information

Adjournment

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Department of Health Care Access and Information

Appendix

Waste in the US Health Care System: Estimated Costs and Potential for Savings

- If interventions addressed waste or inefficiencies, Shrank et al. estimate national annual savings between $191 billion to $286 billion, which corresponds to reductions in health care spending between 6% to 9%.

Table 3. Estimates of Savings From Interventions That Address Waste

Domain	Savings, $US Billion	
	Estimates	Total Range
Failure of Care Delivery		
Interventions to address adverse hospital events and hospital-acquired infections[45-47,49]	5.4-9.4	44.4-97.3
Incentives to increase physician efficiency[48]	47.5 million	
Integration of behavioral and physical health[50]	31.5-58.1	
Partnership for patients campaign[53]	3.4	
Standardized pathways in bundled payment models[51,52]	97.9-555.5 million	
Prevention initiatives to address diabetes, obesity, smoking, and cancer[24,25]	4.0-25.8	
Failure of Care Coordination		
Emergency department-based strategies[49,54]	3.8-7.4	29.6-38.2
Care coordination in accountable care organizations[55,56]	8.3-13.1	
Health Information Exchanges[57]	205-410 million	
Transitional care programs[58]	9.2	
Effective care management for medically complex patients[59]	8.0	

Source: Shrank, W. et al. (2019, October 15). "*Waste in the US Health Care System: Estimated Costs and Potential for Savings*." JAMA. https://pubmed.ncbi.nlm.nih.gov/31589283/

Waste in the US Health Care System: Estimated Costs and Potential for Savings

- If interventions addressed waste or inefficiencies, Shrank et al. estimate national annual savings between $191 billion to $286 billion, which corresponds to reductions in health care spending between 6% to 9%.

Overtreatment/Low-Value Care		
Optimizing medication use[33,34]	8.8-21.9	12.8-28.6
Prior authorization procedures[60]	250 million	
Pioneer accountable care organizations strategies to reduce overuse[13]	199.7 million	
Shared decision-making tactics to reduce unnecessary procedures[61]	3.2	
Expanding hospice access[62]	395 million-3.0 billion	
Pricing Failure		
Drug pricing interventions[63,64]	20.3	81.4-91.2
Insurer-based pricing interventions[38,39]	31.4-41.2	
Laboratory and office visit pricing transparency[40]	29.7	
Fraud and Abuse		
Recovery from convictions and fraud settlements[42,43,65]	2.1- 5.1	22.8-30.8
Legislative, administrative, and integrity strategies[65,66]	20.6-25.6	
Administrative Complexity		
Not applicable		
Total		191-286

Source: Shrank, W. et al. (2019, October 15). "*Waste in the US Health Care System: Estimated Costs and Potential for Savings*." JAMA. https://pubmed.ncbi.nlm.nih.gov/31589283/

Note: For the waste domain of administrative complexity, Shrank et al note that no studies were identified that focused on interventions targeting administrative complexity.

For 2024 and Onwards, Most Other States Have Set 3% or Lower Targets

- In October 2023, staff recommended that the annual per capita health care spending growth target percentage should be below the long-term trend of 5%.
- Other states generally set their target for calendar years 2024 and onwards around 3% or lower.

State	Target Value
Connecticut	3.4% for 2021 3.2% for 2020 2.9% for 2023-2025
Delaware	3.8% for 2019 3.5% for 2020 3.25% for 2021 3.0% for 2022-2024
Massachusetts	3.6% for 2013-2017 3.1% for 2018-2022 3.6% for 2023-2024
New Jersey	3.5% for 2023 3.2% for 2024 3.0% for 2025 2.8% for 2026-2027
Rhode Island	3.2% for 2019-2022 6.0% for 2023 5.1% for 2024 3.6% for 2025 3.3% for 2026 and 2027
Oregon	3.4% for 2021-2025 3.0% for 2026-2030
Washington	3.2% for 2022-2023 3.0% for 2024-2025 2.8% for 2026

Source: Rakotoniaina, A. "*How States Use Cost-Growth Benchmark Programs to Contain Health Care Costs.*" National Academy For State Health Policy. https://nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/ Updated January 18, 2023.