Department of Health Care Access and Information
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Health Care Affordability
Board June 20, 2023
MEETING MINUTES

Members Attending: David Carlisle, Richard Pan, Richard Kronick, Don Moulds, Ian Lewis

Members Attending Virtually: Sandra Hernández, Elizabeth Mitchell

Members Not Present: Mark Ghaly

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; CJ Howard, Assistant Deputy Director; Sheila Tatayon, Assistant Deputy Director; Katherine Gudiksen, Senior Health Policy Researcher; Michael Bailit, Bailit Health

Meeting Recording: https://www.youtube.com/watch?v=RSZgwCvcH9w
Meeting Materials: https://hcai.ca.gov/public-meetings/june-health-care-affordability-board-meeting/

Agenda Item # 1: Welcome and Call to Order
David Carlisle, sub-chair

David Carlisle opened the June meeting of California's Health Care Affordability Board. All Board members were present, with the exception of Mark Ghaly, establishing a quorum. Elizabeth Landsberg provided an overview of the agenda.

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

Elizabeth Landsberg read the HCAI Black Liberation statement. Elizabeth Landsberg provided department updates. She highlighted that the Healthcare Payments Data Program (HPD) is on track, and data release regulations have been issued and are available for public comment through July 18th. The August affordability meeting will have a presentation on the HPD.

Elizabeth Landsberg provided updates on the Health Care Payment Data Program (HPD) and from the Office of Health Workforce Development.

Vishaal Pegany updated the board on the Office as an organization and presented a high-level organizational chart and reviewed the roles and backgrounds of individuals CJ Howard, Margareta Brandt and Sheila Tatayon. He noted other additional staff hirings and current open positions. Vishaal Pegany reminded the Board about slide formatting that was presented at the last Board meeting.

Vishaal Pegany returned the meeting to David Carlisle who invited public comment.

Facilitators reviewed public comment period protocol.

No Public Comment on agenda item 2.

Agenda Item # 3a: Approval of May Meeting Minutes

David Carlisle first asked Ian Lewis to confirm his attendance at the Advisory Committee the following day, June 21st. Ian confirmed.

Agenda Item # 3b: Approval of Richard Pan to attend the September Advisory Committee meeting, and Richard Kronick and Sandra Hernández to attend the November Advisory Committee Meeting

David Carlisle requested action to approve items 3a and 3b. Richard Kronick moved, seconded by Sandra Hernández.

Public comment was invited. No public comment.

No further comment from the Board. Roll call vote was performed and was unanimous to approve items 3a and 3b.

Agenda Item # 4: Advisory Committee Membership
CJ Howard, Assistant Deputy Director, OHCA

CJ Howard presented additional actions the subcommittee has taken since the last Board Meeting. He overviewed the current Advisory Committee membership and highlighted the positions remaining to be filled. CJ Howard presented the composition of submissions that were received and the individuals that the subcommittee recommended to fill the open positions.

CJ Howard presented the draft motion to approve the additional proposed members by the subcommittee (three under Health Care Workers and one organized labor) and allow OHCA staff to randomly assign these new members one- or two- year term. CJ invited the subcommittee members to make any additional comments. The subcommittee members noted that one of the requirements they agreed on was that the candidates should be

residents of California and expressed concern on the overall balance between those subject to targets and those paying for care and the desire to add a candidate on the purchaser side.

Board members commented on the lack of retiree and academic representation and agreed that for future selections, retiree and academic representation would be an important consideration. Board members also recommended to include a retiree receiving health care.

Sandra Hernández recommended moving on the recommendation from the subcommittee, and at next year's membership, the Board look specifically at a retiree as part of the patient group/consumer advocates category and look to add one or more with an academic background. Richard Pan seconded the motion.

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

Sandra Hernández repeated the motion before a vote. The motion was to accept the subcommittee's recommendations, allow OHCA staff to randomly assign new member terms, and specifically consider a retiree perspective and an academic perspective for next year's considerations. Board members suggested amendments to also include a small business representative in next year's membership and to clarify that this motion does not involve increasing the size of the Advisory Committee but would be a matter of turnover for next year's slate. Sandra Hernández clarified that these considerations would not be additions but would rather be holes to fill when current terms end and there is turnover. Sandra Hernández accepted the boards amendments to the motion.

The Board voted to accept the amended motion unanimously.

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

Agenda Item # 5a: 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

Katherine Gudiksen was introduced by Vishaal Pegany to present on Cost Market and Impact Review program.

Board members asked about the M&A trends map and asked if there something specific about Medicare that is appealing to private equity. Katherine Gudiksen replied that would require further observation, but the paper cited does go into specialties. Board members commented about private equity and the attractiveness of Medicare Advantage and inquired about how private equity could purchase medical groups in California considering the prohibition on the corporate practice of medicine. Katherine Gudiksen responded that this is being researched in academic literature and there are many states that are considering enhanced enforcement. There are instances where a private equity group could take over all the non-clinical decisions and exert ownership without being involved in any of the clinical decisions. There is also the practice of placing a friendly provider at the top of the

organization running the physician groups.

Board members asked if there has been any research on access to care impacts and if downward pressure on process and profit would deter acquisitions. Katherine Gudiksen didn't find any well-documented studies on impact to access to care, but noted anecdotal studies exist and news reports. Katherine Gudiksen noted there aren't any states with price controls yet and potentially looking at gaps in regulation to see where the industry can make money might shed some light. She also noted that one of the big problems with private equity ownership of physicians, is that most fall below the Herfindahl Hershman Index and as a result are happening without any oversight. For states that want to shed light on these transactions, she pointed to the Health Energy and Commerce Bill mentioned in her presentation.

Board members asked if there is additional data about Southern California that relates to private equity owning physician practices and if there are particular private equity groups who own physician practices. Katherine Gudiksen replied that researchers are unclear on who owns the private physician groups, but some private equity groups are known.

Board members suggested OHCA consider how metrics for performance are introduced as the result of a merger, and expressed interest in understanding if physicians or other providers are making decisions on admissions that drive the economics of the organization. Board members recommended building an inventory of tools to recommend to the legislature or the Attorney General on how anti-competitive behavior manifests itself.

Sheila Tatayon presented on the Cost and Market Impact Review Program (CMIR) including legislative findings, current oversight in California and gaps in oversight, and a timeline to promulgate emergency regulations.

Board members noted that CalPERS tracks pricing region by region, and county by county and discovered price changes are directly related to levels of competition in a region. Board members asked if OHCA was thinking about studying the markets and which are most on the precipice of consolidation and anti-competitive behavior. Sheila Tatayon replied that they are looking to Massachusetts as a model to do studies of either practices or geographic areas when staff has time when not reviewing material change transactions. . Sheila Tatayon added that once OHCA has a rich database of transactions and consolidation, they can start tracking, trending, and doing studies on impact. Board members appreciated OHCA's approach to public comment on the regulations and suggested to collect data and information from larger entities in a merger over smaller entities in considering administrative burden.

Board members suggested looking into alternatives or solutions where there are certain markets that are inherently more challenging, for example, rural communities with a smaller patient base where competition is not as prevalent. Board members asked how many material change transactions OHCA is planning for. Sheila Tatayon responded they are anticipating about a hundred notices per year.

Public Comment on agenda item 5a (See recording for comments).
Lunch Break

Roll call after break, noted that Elizabeth Mitchell was not yet present virtually.

Agenda Item # 5b: Alternative Payment Models, Primary Care and Behavioral Health Investment, and Workforce Stability
Margareta Brandt, Assistant Deputy Director

Margareta Brandt presented an overview of work underway for Alternative Payment Models (APMs), Primary Care and Behavioral Health Investment, and Workforce Stability. The overview included a review of the statutory requirements, the overall goals for each area, evidence for focusing on these areas including more equitable outcomes and improved population health, and an overall approach and timeline.

Board members suggested OHCA consider where APMs would work best in practice (i.e., primary care physician to patient relationship) and encouraged OHCA to be very precise in how we use the term "workforce", particularly, it's a workforce that is participating in the formal financing mechanism of the health care system. Board members continued to suggest that OHCA should not just use a percentage of total spend as a benchmark, but also relative pay (i.e., primary care vs. specialist or behavioral health). Board members additionally noted that labor economics should be a core piece of any analysis being done because labor economics is a driving force of market failure. Board members also expressed interest in seeing if APMS have positive effects in increasing the quality of care, health outcomes, health equity, accessibility of care, and addressing workforce imbalances. The board members discussed how it is not enough to adopt new payment models, but OHCA would need to track their impact on patients and spending, noting that a challenge may be getting commercial plans to share this data, especially behavioral health data outside of the county specialty behavioral health care system.

The board members then posed a question related to the APM, primary care, and behavioral health workstream timelines; noting that OHCA is required to set benchmarks by the spring of 2025, but the data collection doesn't begin until the fall of 2025, the board members asked what the benchmarks could look like in the absence of collected data. Margareta responded that OHCA was planning to use current data in California on primary care spending in the Commercial and Medi-Cal market. OHCA also aims to look at benchmarks other states have set to see how they'd potentially interact with California's benchmark and looking to analyze early data received from the Healthcare Payments Database or Total Health Care Expenditure data collection. The board asked if OHCA will also be looking at the regulatory barriers to APM adoption. OHCA will look at the regulatory barriers and will be working with sibling departments to see what can be done within the current California policy framework.

Public Comment on agenda item 5b (See recording for comments).

Agenda Item # 5c: Total Health Care Expenditures (THCE) Measurement
Vishaal Pegany, Deputy Director, HCAI
Michael Bailit, Bailit Health

Vishaal Pegany reviewed the organization of the presentation, and Michael Bailit did a recap of the last meeting, noting they would be focusing only on adjustment factors in the presentation. He defined risk adjustment – as a process whereby a payment, quality, or performance measure is modified (typically multiplied or divided) by a risk score. Risk adjustment is also an assessment of whether the population changed in a way that would impact spending. He reviewed some of the risk adjustment models used by other states – Massachusetts, Rhode Island, Nevada – and presented the risk adjustment model options: clinical or age/sex factors and the advantages and disadvantages of each.

Vishaal Pegany presented OHCA's approach for Risk Adjustment as establishing reporting of age/sex data and developing relative weights to apply to spending data submitted by insurers. Board members asked how OHCA would incorporate large scale health events, such as pandemics. Vishaal Pegany replied that the age/sex approach for risk adjustment is to reduce biases from upcoding practices, but on the back end ,as part of the progressive enforcement process, OHCA would consider other factors when examining an entity's performance against the target. The board members recommended that OHCA: explicitly acknowledge that the risk adjustment would not just be age/sex, take an ad hoc approach to incorporating large scale events into the risk adjustment efforts, and be aware of coding practices to address the gaps in analytics.

Michael Bailit continued to present on additional adjustment factors for quality and equity. He highlighted that the Board shall be able to make the adjustments when warranted for quality adjustments and the Office will establish an equity adjustment as long as the data is available, and a methodology has been developed and validated. Board members hoped these will be incentives for the development of methodologies for equity adjustments.

Vishaal Pegany presented OHCA's approach for quality adjustments and reminded the Board they have approval authority for quality adjustments, and noted OHCA will return with a status update in the future.

Vishaal Pegany presented OHCA's approach to equity adjustments and noted OHCA will return with a status update in the future.

Michael Bailit presented on organized labor adjustment statutory language. Vishaal Pegany presented OHCA's approach and noted the Board would have ultimate authority to approve the adjustment.

Michael Bailit continued to present on the statutory language for adjustments related to Medi-Cal and noted OHCA's early conversations with DHCS about data collection.

10 minute break

Michael Bailit continued to present on other options for refining the understanding of spending data. He introduced additional adjustments for future reporting, truncation, and confidence intervals. There was a third adjustment - minimum thresholds but it was not reviewed. Board members asked if truncation on capitated contracts was common, and

Michael Bailit was unaware and presented Rhode Island and Washington's examples of truncation points. Board members asked about the standard deviations and how the truncation points are determined. Michael Bailit responded with two ways he's seen states determine truncation points: by having a standard deviation methodology, or a fair setting point based on the consensus of the health plans and providers within the state.

Vishaal Pegany presented OHCA's approach on truncation, and noted that, due to the degree of capitation in California, OHCA is at initial stages of assessing whether touse high-cost outlier truncation and what methods to use. Currently, OHCA has reached out to a few payers to receive some technical assistance and better understand their data and operational issues for reporting. A board member expressed concerned about using truncation and would be in favor of looking at the minimum size of the group/patients that would need to be attributed and considering single year versus multi-year performance of entities when considering penalties and sanctions.

Michael Bailit continued to present on confidence intervals. A board member expressed concern over the narrowness of the observed rate and sizes of confidence interval. Michael Bailit clarified the concept of a large or small confidence interval.

Vishaal Pegany presented OHCA's approach to confidence intervals. OHCA is still assessing the issue of capitated payments and confidence intervals. Board members further reflected on truncation and threshold requirements and voiced concern with the potential threshold average still being too high. They also asked how many people OHCA is estimating would be over the threshold and why. Vishaal Pegany noted that if OHCA were to do truncation, they would look at the data with and without truncation to be able to answer the questions posed by the board members. Elizabeth Landsberg replied that OHCA would have a conversation with any entity that exceeds the cost target, and if there are reasons outside of one's control, such as a bad flu season, OHCA would likely not take enforcement actions. Michael Bailit noted that as the HPD matures, they'll be able to see outliers more clearly. Another board member suggested starting out by not doing any truncation before talking to the provider about outliers and approaching it as "learn as you go" while gathering concrete examples. Michael Bailit added another idea to have the payers report with and without truncation as a baseline to see if there is any difference in reporting.

Public Comment on agenda item 5 (See recording for comments).

Agenda Item # 6: General Public Comment

Chair invited general public comment.

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

Agenda Item # 7: Adjournment

David Carlisle adjourned the meeting.