Department of Health Care Access and Information
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HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Wednesday, June 26, 2024
10:00 am

Members Attending: Secretary Dr. Mark Ghaly, Dr. David Carlisle, Dr. Sandra Hernández, Richard Kronick, Ian Lewis, and Don Moulds

Members Absent: Elizabeth Mitchell, and Dr. Richard Pan

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

Meeting Materials: https://hcai.ca.gov/public-meetings/june-health-care-affordability-board-meeting-2/

Agenda Item # 1: Welcome, Call to Order and Roll Call
Chair Secretary, Dr. Mark Ghaly

Dr. Ghaly opened the June meeting of California's Health Care Affordability Board and attended the meeting virtually. Roll call was taken, and a quorum was established.

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

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

- Agenda item 5(b) – Update on Draft Alternative Payment Model Standards and Adoption Goals would be taken before agenda item 4(a) – Vote to Establish Alternative Payment Model Standards and Adoption Goals.

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

- Announcement that CalRx branded Naloxone nasal spray is now available for free to eligible organizations through the DHCS Naloxone Distribution Project and available to certain organizations for $24 per twin pack through a contract with Amneal Pharmaceuticals. This is a 40% reduction from the $41 price that California has been paying for this product. In May, the State purchased 24,000 units for the DHCS Naloxone Distribution Project, which is more than $400,000 in savings.
    - California businesses and entities seeking to purchase the twin pack can

do so by visiting the CalRx website at calrx.ca.gov.
    - Eligible entities can obtain the over-the-counter Naloxone for free through the Naloxone Distribution Project.
    - The State is exploring the option for individuals to buy the product, and if this becomes an option, more information will be provided.
- Announcement that two new clinical positions with HCAI have been filled:
    - Chief Medical Officer & Deputy Director for Clinical Innovation – Dr. Lemeneh Tefera
    - Chief Pharmacy Officer – Dr. Helen Lee
- Review of the work plan for the upcoming quarters and topics beyond 2024.
- Update on CMIR Program Implementation.
- Review of Oregon's recently published Sustainable Health Care Cost Growth Target Annual Report, which presents health care spending and cost growth from 2021 to 2022.
- Review of latest projections from the Centers for Medicare & Medicaid Services national health expenditures for years 2023 to 2032.
- Reminder that the Office of Health Care Affordability (OHCA) is still accepting submissions of interest to fill a vacancy on the Advisory Committee from individuals who bring a hospital perspective, with an emphasis on rural hospitals. Submissions will be accepted through June 30th and can be found on the OHCA website: https://hcai.ca.gov/affordability/ohca/health-care-affordability-advisory-committee/.
- Reminder of the slide formatting key.

Discussion and comments from the Board included:

- A member inquired whether there will be a special work group created for the work plan related to behavioral health and behavioral health spend, or if this will be handled strictly through the advisory group.
    - The office advised that they will be using the same Investment and Payment Workgroup that was launched in June 2023, with a turn to focus on behavioral health. They will be expanding the workgroup membership in July, inviting more specific behavioral health experts to join.
- A member expressed that the Oregon reports were interesting, and they are looking forward to the office having their own versions of those reports. The member then inquired whether there was an analysis regarding why there was such a significant difference between the administrative cost and profit line versus the actual spending on care, as well as why that same difference was not reflected on the commercial side.
    - The office responded, clarifying that the growth cited for Medicare and Medicaid was for the non-claims. However, the administrative costs and profits are measured outside of health care spending. Some of that growth has to do with some of the pandemic-era Medicaid policies that were paused and then resulted in greater enrollment of populations during the public health emergency. The 8% growth is in terms of dollar amounts. It is a much smaller component of health care spending. When that number is isolated and the focus is on more of the medical expense, that's when the numbers stack up against the target value.
- A member inquired about the difference between the number of CMIR system registrations versus the number of submissions.
    - The office clarified that they had encouraged people to explore the system once it went live on January 1st. To explore the system, they first must

register as a user. Once registered, they can explore the submission process. Nothing is submitted until they hit the "submit" button on the last page.

- A member inquired about the expedited processing provided to one of the submissions due to that entity being in bankruptcy, and whether that sets a precedent that any other entity who is in bankruptcy and submits a transaction will receive expedited processing.
    - The office stated that this instance did not set a precedent, and each submission is thoroughly evaluated. The decision to expedite will vary depending on the details of each submission.
- A member inquired whether the data presented in the Oregon reports showing the impact of enrollment trends and population growth affecting Medicare and Medicaid per capita growth is a true representation of the per capita growth based on the entire population, or if it is per recipient in the program.
    - The office answered that this statistic is per each enrollee of the program.
- A member commented that connecting with DMHC and some of the other sibling departments to HCAI will be helpful as they explore how cost trends and rates get built around behavioral health.

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

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

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

Board member David Carlisle motioned to approve, and board member Ian Lewis seconded.

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

Voting members who were present voted to accept. There were 5 ayes, and 2 absent. The motion passed.

Agenda Item #5b: Update on Draft Alternative Payment Model Standards and Adoption Goals
Margareta Brandt, Assistant Deputy Director, HCAI

Assistant Deputy Director Brandt reviewed the proposed Alternative Payment Model (APM) Standards and Adoption Goals, incorporating revisions based on feedback from the Board discussion in May, and the office's responses to Board member questions. She also introduced Mary Jo Condon from Freedman Health Care, who was present to assist with answering questions from the Board.

The discussion and comments from the Board included:

- A member inquired whether the smaller Federally Qualified Health Centers (FQHCs) are considered smaller medical groups in terms of implementation.
    - The office confirmed that small FQHCs would be considered small practices in terms of APM Standards implementation. The Department of Health Care

Services (DHCS) is making significant progress implementing an FQHC alternative payment model, with several FQHCs electing to join the APM demonstration.

- A member asked about the perceived obstacles regarding the uptake of FQHCs in the DHCS APM pilot.
    - Another member responded that while some clinic systems are moving forward, others are waiting to see what data will be used and how the process will work.
- A member commented on the need for caution with clinical risk adjustment, inquiring whether each payer would implement its own risk adjustment system and if the office would have information about what they are doing. They also asked if the Health Care Payments Data (HPD) program could implement a more consistent risk adjustment system and if HPD would have information on whether a person is in an APM.
    - The office advised that the HPD will not specifically show that an individual is in an APM. However, the HPD collects data on non-claims payments, allowing an understanding of whether a portion of their care is paid for outside of the fee-for-service system.
    - Each payer would have its own methodology for assessing the clinical risk score for members in an APM and those not in an APM, and the office would request description of these methods.
- A member inquired about specific definitions of various terms listed in the APM Adoption Goals, such as the link to quality.
    - The office stated that they have defined the terms which are available in the presentation appendix. It was explained that a link to quality means the payer's payment to the provider is at risk based on quality performance such as upside or downside risk, incentive payments, or bonuses. For shared savings and shared risk payments, the office has defined minimum thresholds for the amount of savings or risk included in the payment model in order to count towards the APM Adoption Goals. Definitions were released several months ago, and feedback has been collected from the Investment and Payment Workgroup and the Advisory Committee.
- A member inquired if the dataset will be publicly available.
    - The office responded that they will publicly report APM adoption by payer.
- A member expressed skepticism that APM adoption alone will incentivize better care or reduce duplicative care, suggesting that it might motivate withholding care. They asked whether the office could develop a common risk grouping approach to analyze how APM adoption affects needed services, and consumer affordability.
    - The office advised that this quality analysis could be approached through the HPD, or OHCA could conduct analysis to understand health care entity performance using its quality and equity measure set, which is still being developed.
- A member inquired how continuity of primary care might manifest.
    - The office responded that they aim to increase payments to primary care providers to support advanced primary care attributes, such as team-based care, continuity of care with the same provider or care team, and integrated behavioral health and primary care. Members should be assigned a primary care provider to facilitate and encourage this relationship.
- A member inquired whether the HPD has the capability to track primary care provider continuity.
    - The office stated that while the HPD is still being established, mature

APCDs generally can track primary care provider continuity using various attribution rules. They can look at how frequently members see the primary care provider they were attributed to, and the duration of these relationships. Rough estimates can be also obtained by looking at billing by the organization, focusing on attachment to a care team rather than a specific individual provider.

- A member appreciated the Advisory Committee for moderating the Board's enthusiasm for the adoption rate and highlighted the importance of having expert input from the Advisory Committee.
- A member, noting the importance of the discussion and the absence of two Board members, had reached out to those members for their feedback while in compliance with Bagley-Keene requirements. The absent members provided the following feedback:
    - The Board should consider rewarding improved health outcomes in addition to the process measures related to section 3 on primary care. They emphasized incentivizing continuous relationships with primary care teams and expanding provider networks to prevent patients from having to change their primary care team. They also inquired about requiring data on patient and network continuity over several years.
    - In section 3.5 of the APM Standards, a member recommended to substitute "visits" with "services" to reflect that not all primary care services are visit-based.
    - In section 5 of the APM Standards, they suggested changing "appeal" to "are fiscally feasible" to make the language more actionable for small, independent practices.
    - One member expressed concern that the proposed changes might not truly improve accountability or enable positive care delivery changes, indicating potential non-support for these changes.

Assistant Deputy Director Brandt reviewed the proposed ten APM Standards for Payer Provider Contracting and APM Adoption Goals.

Agenda Item #4: Action Items
Margareta Brandt, Assistant Deputy Director, HCAI
a) Vote to Establish Alternative Payment Model Standards and Adoption Goals

Assistant Deputy Director Brandt introduced the action item to vote on establishing Alternative Payment Model Standards and Adoption Goals and facilitated the vote.

Board Member Hernández made a motion to adopt the ten high-level APM Standards and the Adoption Goals, with a note that the additional language in the standards would be revised as suggested. Specifically, in section 3.5 of the APM payment model, a member recommended to substitute "visits" with "services" to reflect that not all primary care services are visit-based. As well, in section 5 of the APM Standards, changing "appeal" to "are fiscally feasible" to make the language more actionable for small, independent practices. Board Member Carlisle seconded the motion.

The language of the amended APM Standards and the APM Adoption Goals were displayed during Board discussion, public comment, and voting.

Public Comment was held on agenda item 5b. Four members of the public provided

comments.

Voting members who were present voted on the amended APM Standards and the APM Adoption Goals. There were 5 ayes, and 2 absent. The motion did pass.

Chair Ghaly announced that he would not be in attendance for the remainder of the meeting.

Agenda Item #5: Informational Items
Vishaal Pegany, Deputy Director, HCAI
Margareta Brandt, Assistant Deputy Director, HCAI
Sheila Tatayon, Assistant Deputy Director, HCAI

5a) Cost Reducing Strategies
Board Member Don Moulds joined the meeting.

Assistant Deputy Director Brandt provided a reminder regarding the goal of the cost reducing strategy project, which is to highlight examples of successful cost reducing strategies that also maintain or improve quality. OHCA has not independently verified information about the strategies, or the results provided by health care entities and are not endorsing any strategies. They are seeking additional examples of cost reducing strategies and encourage all health care entities to contact OHCA using their general email inbox if they would like to propose a cost reducing strategy for consideration.

Assistant Deputy Director Brandt introduced Peter Long, PhD, Executive Vice President, Strategy in Health Solutions at Blue Shield of California, and invited him to share examples of cost reducing strategies at Blue Shield.

Discussion and comments from the Board:

- A member observed that there was a slide regarding behavioral health and scaling behavioral health which is a challenging area. The member asked for thoughts and progress Blue Shield has made in this area.
    - Peter Long advised that they have insourced behavioral health services from Beacon for Medi-Cal and Medicare. Currently, they have completed the design of the future state. Their initial investment is in navigation, because most patients seem to be unsure of how to navigate the behavioral health system to obtain the care that they need. Their second big investment is in the collaborative care model. Peter Long shared that for very little new investment, there has been a significant uptake from primary care providers wanting to integrate care for mild and moderate behavioral health conditions into their practice. Next on their list of priorities is a deep investment in behavioral health transformation.
- A member inquired whether Blue Shield considers OB-GYN to be a primary care entry point.
    - Peter Long stated that they have not yet included OB-GYNs in their models for advanced primary care, as that currently falls under a separate model. They can adapt their model and expressed appreciation for bringing this issue to light, since there is unmet need and people access the system in different ways Up to this point, their focus has been on family practitioners, internists, and pediatricians. However, it is a good next step for them to consider how the model can be flexible to reflect who patients identify as

their primary care physicians.

- A member inquired whether Blue Shield's investment in primary care has increased.
    - Peter Long advised that, starting with the 2019 model, they increased the investment in each practice that participates in their advanced primary care models by 10%. The 9% savings in total cost of care includes the additional investment in primary care.
- A member inquired what fraction of their spending is in primary care.
    - Peter Long shared that they are still in the single digits but will be ramping up their investment.
- A member inquired what a macro story looks like, and whether they're moving the market.
    - Peter Long advised that they have a detailed plan to get to their target amount for primary care investment, which they think will be market leading. Investments have been made in pharmacy and administrative fields, and the benefits have not been reaped yet. He believes that their pay-for-value models are working and stated that they have a pathway to get them to 100%. By 2028, their goal is to be at target and market leading.
- A member inquired about Blue Shield's 2% pledge [in the presentation, Peter Long indicated that Blue Shield caps its operating margin at 2% and excess operating income is donated to their charitable foundation, returned to members as a rebate, or investment in something for the good of the state], specifically their investment in Manifest Medex and in data exchange, and what Peter Long's opinion is regarding the progress of those two efforts.
    - Peter Long advised that California has done foundational infrastructure work on data exchange and now needs to scale that to deliver value. Movement toward data sharing is happening, needs to get more force behind it to see the market deliver value. Clear expectations of the policy framework are helpful and now the market needs to deliver on those use cases.

Public Comment was held on agenda item 5a. One member of the public provided comment.

Assistant Deputy Director Brandt introduced Kerry Heinrich, President and CEO, as well as John Beaman, Chief Financial Officer from Adventist Health to share examples of cost reducing strategies at Adventist Health.

Discussion and comments from the Board:

- A member inquired how Adventist Health has built out their infrastructure to grow their primary care workforce.
    - Kerry Heinrich advised of the physician staffing shortages affecting the entire country and shared that Adventist Health has grown and expanded residency programs with a very specific focus on recruiting physicians out of medical school that have ties to a given community. They prioritize recruiting physician trainees to their residency programs in East Los Angeles and the Central Valley who have a high probability of staying in the community where they are needed.
- A member recalled that the presentation revealed that Adventist Health has approximately 165,000 members who are not in a fee-for-service payment model, and inquired what fraction of their total patient base that number equates to.
    - Adventist Health advised that the 165,000 members who are not in a fee-

for-service payment model equates to less than 10% of their total patient base. Adventist Health noted that this number needs to be higher than 50% to get enough scale to invest in the ambulatory facilities needed in East Los Angeles or some of the rural communities.

- A member recalled one of the slides indicated that 79% Adventist Health's business is government funded and asked for clarification of level of fee-for-service payment they receive from government payers, given the high level of Medicare Advantage and managed Medi-Cal enrollment.
    - Kerry Heinrich and John Beaman stated that even though a professional capitation is paid to a physician group, Adventist Health is still paid on a fee-for-service basis for hospital care in most of those cases. There is movement toward other alternative payment models they would like to see for hospital services, but Adventist would like to see this movement happen faster.

Public Comment was held on agenda item 5a. No public comment.

5c) Update on Workforce Stability Standards, Including Summary of Public Comment Feedback

Assistant Deputy Director Brandt reviewed the updates to the workforce stability standards, which incorporated changes recommended following the April Board meeting. OHCA adopted the workforce stability standards and published final standards along with Board materials.

Discussion and comments from the Board:

- A member of the Board expressed support for the standards as written.
- Another member of the Board expressed appreciation for changes incorporated since the last meeting, felt they strengthen the standards. They also noted that they look forward to OHCA setting performance standards in the future.
- A member of the board expressed dissatisfaction with the current standards presented, as they will only minimally increase transparency. However, they are hopeful that there will be a greater line of sight towards increased transparency and more information in that regard come Fall.
- Several members expressed appreciation for all the work that has gone into developing these standards.
- A member commented that the State is making efforts to address some of the significant cultural and linguistic gaps in the physician workforce. At some point in time, it would be helpful to shed some light on the work that is being done within the State to address those significant gaps.
    - The office responded that the workforce research data center at HCAI under the workforce team is making efforts to increase the linguistic, cultural, and racial diversity of the workforce. The workforce team would welcome the opportunity to present some of that data.

Public Comment was held on agenda item 5c. Two members of the public provided comment.

5d) Cost and Market Impact Review Draft Regulations Revisions

Assistant Deputy Director Tatayon reiterated Deputy Director Pegany's earlier statement

that their team has responded to over 50 emails to the CMIR inbox. They encourage the use of that inbox, as it is helpful to the team as well as to the regulated public. Their goal is to respond to those emails within 48 hours and have invited people who have sent emails to that inbox to ask further questions. Their team has also held virtual meetings with several entities who have asked questions. Assistant Deputy Director Tatayon then provided an overview of the proposed revisions to the Cost and Market Impact Review (CMIR) Regulations.

Discussion and comments from the Board:

- A member stated that the volume and turnaround on the submission demonstrate that this office is taking this issue seriously and is taking a balanced approach on confidentiality requests. \
- A member asked how "reasonable attestation," would be defined. Additionally, the member asked whether there were legal underpinnings, and how this would be adjudicated.
    - The office responded that "reasonable" is one word in the law that is often challenged. The notices are submitted under penalty of perjury, so that is the attestation. Once the notice is submitted, the entity is attesting that, under penalty of perjury, they have reasonably tried to find out about the other entities in the transaction. The Office would assess reasonableness, but that could be subject to challenge through litigation.
- A member expressed support of the proposed revisions and had questions regarding the CMIR presentation. They expressed concern that there were only three CMIR submissions, as they had expected the office to receive 70-100 submissions per year. They inquired whether the other Board members were also surprised by that number.
    - The office responded that they were surprised and not surprised by that number due to the layered and complex processing of these transactions. It further responded that they had received information that many entities "worked day and night" to complete their transactions before April 1, 2024. Notices are required for transactions that close on or after April 1, 2024. The office reached out to the entities, advising that they were available to help with the submissions, if needed. In addition, there are exemptions for notice to OHCA when an entity must file with the Department of Managed Health Care, the California Department of Insurance, or with the Attorney General's Office,, or if it is a county acquiring a health care entity for continued access. The HCAI Director added that the Department believes that health care entities may be structuring deals to avoid having to file. The proposed changes to the regulations will clarify that a health care entity that is the subject of a material transaction may need to provide notice even if not a party to the transaction. This should help to address issues related to private equity firms.

Public Comment was held on agenda item 5d. Three members of the public provided comment.

5e) Update on Primary Care Definition and Investment Benchmark, Including Summary of Public Comment Feedback

Assistant Deputy Director Brandt provided a summary of the feedback received from the Board and public comments on the proposed primary care definition and investment

benchmark. She advised that Mary Jo Condon from the Freedman HealthCare team was present to answer questions from the Board on this topic.

Discussion and comments from the Board:

- A member expressed concern regarding the data surrounding OB-GYNs as primary care providers not being as complete as it could be. They do recognize that a patient with no other health care problems may receive primary care from that specialty. They also noted that, pediatricians may be globally considered as primary care providers, yet within that category are pediatric oncologists, pediatric cardiologists, pediatric infectious disease specialists, all of whom would not be providing primary care but whose services could be considered primary care under the construct.
    - The office responded that they are requiring the provider to be listed as a primary care provider with the Department of Managed Health Care, which is an important step to ensure that the provider is in fact providing primary care services.
- A member recalled that 9 of the 15 states did not include behavioral health. They inquired what the other states did.
    - The office responded that, of those 6 states who did include behavioral health, only one of them has a separate mechanism to measure behavioral health care spending. The other 5 states who chose to include behavioral health care providers in their measurement of primary care spending have no mechanism to measure behavioral health spending. That is different from California, which has another mechanism to measure behavioral health spending, which the office will work on soon. OHCA is proposing to include a module within the primary care definition that is specific to behavioral health services provided by primary care providers in a primary care setting.
- A member expressed that integrating behavioral health into whole person care in a primary care setting is critical.
    - Other members agreed and further stated that most integrated behavioral health is paid separately through non-claims payments. Those integrated behavioral health payments paid through non-claims are included in the primary care definition and would be included as primary care spending in that behavioral health primary care module.
- A member recalled that community health workers were not listed as one of the types of positions being considered for the primary care spending. They inquired how the office thinks of that in terms of advanced primary care, and if there is a way to capture those workers as part of the primary care team.
    - The office clarified that the community health workers did not have a defined taxonomy for claims-based spending at the time the office developed the taxonomy code list. The care or services provided by a community health worker would be included in the non-claims primary care spending, which is also measured. The office can include additional providers who may be part of the primary care team on the taxonomy list.
    - The member further stated that it is important for the office to appreciate the complexity of what they would like to see in a comprehensive primary care team, and it is highly important not to leave outcommunity health workers. The member recommended considering the creation of a taxonomy for those workers.
- A member inquired whether there were two delivery environments included in the

place of service codes, specifically county public outpatient centers and Kaiser Permanente outpatient centers.
    - The office will review and make sure that the outpatient centers are properly identified.
- A member inquired about providers who are essentially providing primary care but in alternative settings, such as via telehealth or in an urgent care clinic.
    - The office stated that services provided via telehealth would be included in the primary care services definition. However, they are proposing to exclude primary care services provided at an urgent care clinic from the primary care spending definition. This is the result of many workgroup discussions focused on the primary care definition and the vision for future primary care.
- A member shared that in their preferred provider organizations (PPOs), they are moving forward with supplementing primary care with a virtual primary care network, recognizing that people in some parts of the state do not have access to primary care when they need it. However, they envision that type of telehealth to be provided for urgent needs, so some telehealth services may fall under urgent care.
    - The office advised that any services paid for directly by a purchaser, but not through a payer, would not be included in the primary care spending measurement.
- A member advised that the office keep track of the utilization of urgent care clinics, even if that spending is not included in the benchmark, to monitor how utilization of urgent care clinics for primary care needs is changing over time.
    - The office stated that they are researching this and consulting with the HPD team in terms of how they can track this information and better understand the amount of primary care services that is provided in urgent care centers.
- A member expressed appreciation for the explanation regarding the rationale for not having separate adult and child benchmarks statewide. However, they would be concerned if this is ever used to compare how Medicare Advantage plans are doing compared to Medi-Cal plans, considering the stark difference in age distribution.

Agenda Item #6: General Public Comment

Public Comment was held on agenda items 5e and 6. Four members of the public provided comments.

Agenda Item #7: Adjournment

The Vice-Chair adjourned the meeting.