Department of Health Care Access and Information
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Health Care Affordability Advisory Committee June 21, 2023 MEETING MINUTES

Members Attending: Joan Allen, Barry Arbuckle, Carmen Comsti, Adam Dougherty, Hector Flores, Stacey Hrountas, Ivana Krajcinovic, Tam Ma, Carolyn J. Nava, Sumana Reddy, Yolanda Richardson, Andrew See, Ken Stuart, Yvonne Waggener, Anthony Wright, Sara Gavin, Kiran Savage-Sangwan

Members Attending Virtually: Abbie Yant, Suzanna Usaj, Mike Odeh, David S. Joyner, Rene Williams

Members Absent: Aliza Arjoyan, Stephanie Cline, Parker Duncan Diaz, Janice O'Malley, Sarah Soroken

Health Care Affordability Board Member Attending: Ian Lewis
HCAI: Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director; Jean-Paul Buchanan, Counsel; Sheila Tatayon, Assistant Deputy Director; CJ Howard, Assistant Deputy Director

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

Facilitators: Karin Bloomer and Jane Harrington, Leading Resources Inc.

Meeting Recording: https://www.youtube.com/watch?v=6NpfRbeUTko
Meeting Materials: https://hcai.ca.gov/public-meetings/june-health-care-affordability-advisory-committee-meeting/

Agenda Item # 1: Welcome and Call to Order
Elizabeth Landsberg, Director, HCAI
Karin Bloomer, Leading Resources Inc.

Elizabeth Landsberg welcomed the Advisory Committee ("Committee") and thanked them for their work. She introduced herself as the Director of the Department of Health Care Access and Information ("HCAI"). She provided background information on the Office of Health Care Affordability ("OHCA" or "Office"). The facilitators called roll; quorum was established.

Agenda Item # 2: Member Oath of Office
Elizabeth Landsberg, Director, HCAI

Elizabeth Landsberg led Committee members in reciting the Oath of Office and instructed them to sign the Oath and give to staff.

Agenda Item # 3: Member Introductions
Elizabeth Landsberg, Director, HCAI

Elizabeth Landsberg introduced Health Care Affordability Board ("Board") Member Ian Lewis to the Committee. She explained that statute requires a Board Member to attend every Committee meeting. She introduced the facilitators from Leading Resources Inc. as the neutral third party to facilitate the meeting. The slate of the Committee was presented, and it was explained that two members were not present due to being voted into membership by the Health Care Affordability Board on the previous day. She invited all members present to share their name, role, organization and what drew them to this work; Committee members did so. Member Renee Williams was unable to introduce herself virtually due to technical issues. HCAI Deputy Director Vishaal Pegany also introduced himself.

Agenda Item # 4: Advisory Committee Orientation
Elizabeth Landsberg, Director, HCAI
Vishaal Pegany, Deputy Director, HCAI

Elizabeth Landsberg began with an overview of HCAI's history, mission, and five program areas: Facilities, Financing, Workforce, Data, and Affordability. She then presented information on health care affordability.

Vishaal Pegany provided an overview of the Heath Care Affordability and Quality Act and the Office. He reviewed terminology, presented other states with established health care spending targets, and the key components for the work of the Office. He shared the timeline for reporting, enforcement, and future activities. He addressed the role of the Committee and shared the dynamic 12-month work plan, divided between Board and Committee activities. He invited questions from the Committee.

Committee members asked if equity is defined in the statute. Vishaal Pegany clarified

what the statute requires around quality and equity. Members asked if pharmaceuticals and devices will be tracked in terms of contributions to cost increases. Elizabeth Landsberg affirmed that they would be tracking. Members asked about the definition of "fully integrated delivery system"; Elizabeth Landsberg shared that Kaiser Permanente currently meets the definition in the statute.

Members asked about the Committee meeting prior to Board meetings. Elizabeth Landsberg confirmed that meetings topics are scheduled to get input to the Board. Members asked about providing recommendations. Elizabeth Landsberg confirmed that Committee feedback will be captured in the minutes and presented to the Board by the Office and the attending Board member.

Members asked, regarding equity, if they would be receiving a clear definition of that before discussion. Elizabeth Landsberg invited input on that definition and shared that a workgroup would be working on that.

Members noted there is not much in the materials on long-term supportive services and that is a gap. Elizabeth Landsberg clarified that to the extent Medi-Cal covers long-term care services, the Office will be capturing data on that. To the extent individuals have their own long-term care insurance or are paying out-of-pocket, that won't be captured.

Members asked about consensus recommendations and had to ensure the nuances of the discussions are conveyed when there will likely be different opinions. Elizabeth Landsberg confirmed that, as this is a very diverse group, the Office anticipated gathering individual recommendations and reflecting the diversity of opinion. Members asked if they would have any voting power. Elizabeth Landsberg replied that was not envisioned for Committee but could be considered, and that can be an ongoing conversation.

Public Comment on agenda item 4. No comment.

Agenda Item # 5: Bagley-Keene Overview
Jean-Paul Buchanan, HCAI Counsel

Jean-Paul Buchanan provided an overview of the Bagley-Keene Open Meeting Act and Conflict of Interest. He defined the meeting guidelines including public notice, agenda, voting and how many people establish a quorum. He reviewed the guidelines and finished with the penalties for non-compliance. Jean-Paul Buchanan then discussed conflicts of interest.

Members asked for clarification around representation of their organizations and if that is a conflict. Elizabeth Landsberg responded that in this case a conflict only occurs if there is a personal financial interest. The Committee is not a decision-making body and does not set the spending targets. The Committee was selected to represent the interests of their entities. Elizabeth Landsberg suggested the Office will provide additional guidance to members later in the meeting.

Elizabeth Landsberg also noted that if a member was approached by the press, they may say they are a member of the Committee but do not speak on behalf of the Committee, OHCA, HCAI, or the Board. Lastly, the members do not need to fill out a Form 700. One member suggested including presentations in future Committee meetings where each major sector business model is explained for the education of the public.

Public Comment on agenda item 5. No comment.

Lunch Break

Roll taken to establish a quorum; quorum was established.

Elizabeth Landsberg began by clarifying that the members are there to represent their organizations and since this is not a decision-making body, members do not need to worry about conflict of interest in representing their respective organizations. The conflict-of-interest provisions do apply to personal financial interests.

Agenda Item # 6: Cost and Market Impact Review
Katherine Gudiksen, Senior Health Policy Researcher
Sheila Tatayon, Assistant Deputy Director, HCAI

Vishaal Pegany introduced Katherine Katherine Gudiksen who presented a background and provided context for the underpinning of the cost and market impact review ("CMIR") work at OHCA.

Members asked what timeframe the study on hospital mergers is referring to and Katherine Gudiksen replied it is a summary of about forty articles dating back to the 1990's and the citations could be made available.

Members inquired about the trends around mergers and acquisitions, particularly the acquisition of physicians, and how the categories of "health system ownership" and "private equity ownership" don't include a large aggregator, Optum. Katherine Gudikesen explained that, in this data set, it labels "physician ownership" as "health system ownership" if it is in the same system as an acute care facility.

Members asked about the difference between a high-intensity service and a high-cost service. Katherine Gudiksen explained that in trying to simplify a large body of research, she's referring to services like MRIs, colonoscopies, and other imaging services, but that these studies tend to be about a particular specialty.

Katherine Gudiksen presented data on market concentration in California matching national trends; federal action to address health care consolidation; and the state requiring pre-transaction filing by health care providers. She then provided detail on the three states that have created agencies tasked with oversight of the healthcare

market.

Members inquired about whether any studies looking at those being merged or acquired and what the scope of contracts they had with insurance companies, the state of the health care delivery system, and the financial status—the pre-scenario before merger/acquisition. Katherine Gudiksen noted there are a number of case studies of particular mergers but nothing nationwide. Additionally, specifics of contracts are not well-known to researchers.

Members inquired about where Katherine Gudiksen might see holes in the data, or what are some of the elements that she wished researchers had been able to do a better job of analyzing M&A trends. Katherine Gudiksen replied that in terms of trends and costs, she feels the data is good, but that data is missing around access, and quality. She called out that researchers are looking at quality in the private equity space and emphasized the importance of analyzing specific mergers and not just compiling information to a national level.

Members asked about what recourse is available where the market is already concentrated (using Monterey County as an example) where they believe area hospitals are shadow pricing off another area hospital. Katherine Gudiksen cited work she had done in other states. She discussed that once a market is dominated by one player, either because of mergers or because it is a rural area, she believes regulation is necessary in many cases.

Members asked if there is much in the research on the labor market monopsonies in mergers and acquisitions. Katherine Gudiksen replied that she is aware of a good study on this issue. Members also asked about access issues in consolidations. Katherine Gudiksen responded she is not aware of a nationwide study on this issue, and that it is hard to study.

Members asked about how OHCA will look at competition. Katherine Gudiksen replied that she will leave questions about how OHCA will act to OHCA staff.

Members asked about numbers related to increase of pricing for private equity ownership. Katherine Gudiksen responded that based on the types of studies for private equity, it is difficult to put exact numbers on it.

Members inquired about hospitals acquiring primary care physician practices and then putting pressure on specialty practices to join the hospital foundation. Katherine Gudiksen replied that she has not seen any peer-reviewed studies on that.

Members asked if the price increases at acquired facilities of 17%, almost twice as much as the acquiring facility, was due to the contracted rates with health plans automatically passing on to the acquirer. Katherine Gudiksen replied that is not well known and would be good for a study, and that it depends on the target of the acquisition. Members commented that they believe OHCA should pay attention to

when an acquired provider starts billing under a larger group's taxpayer identification. number but they are still in the same location doing the same thing.

Members asked about the minimum cut-off for review from the HPC being $25 million in revenue and Katherine Gudiksen confirmed and shared what Oregon has in statute.

Members asked about consolidation as it applies to providers, and whether there is analysis on health plans. Katherine Gudiksen replied that they have not looked at insurers per se, but commented that health plans are expanding, and that there is ongoing research about this.

Vishaal Pegany introduced Sheila Tatayon who presented on CMIR, starting with the legislative intent and findings, the role of the Office, and the existing gaps in California's market oversight and intent to fill them. She shared a timeline for regulations and submission to the Office of Administrative Law and the plan to receive notices of material change transactions by January 1, 2024. Sheila Tatayon invited questions from Committee members.

Members asked about OHCA's authority and the types of transactions it will be looking at, the definitions of markets and consolidations, and specifically whether it will look at cross-market mergers and vertical transactions, and what is a material change. Sheila Tatayon shared that some of those definitions will be shared in the upcoming regulations. Sheila Tatayon shared they will begin by collecting notices based on dollar threshold and type of transaction, so vertical and horizontal will be included. Vishaal Pegany added that there might be some transactions where assets are not combined or transferred, so affiliations would be included. Sheila Tatayon also addressed that particular geographic markets will be part of the analysis in a CMIR. Members asked to look beyond the current analysis regulators look at today. Sheila Tatayon confirmed that the statute is designed to be broad and get beyond the traditional approaches used in antitrust analysis and cited One Medical as an example. Vishaal Pegany added that they won't be duplicating what the AG is doing but will be filling gaps in looking at impacts on market competition.

Members asked about the extent to which the impact review will look at quality and appropriateness of care. Sheila Tatayon shared that they are constructing the regulations to address quality, which can be somewhat hard to measure, and that they hope to learn and improve as they go.

Members shared a scenario where one entity might be acquiring small specialty practices in an area, but none of those transactions on their own rises to a particular dollar threshold. In the aggregate they could be many times that threshold. How will the Office address those issues? Sheila Tatayon replied that they have considered these issues, and that it may not be caught the first time but would in later notices and described the process for that.

Members followed up on the quality and the difficulty of measuring it, along with

overuse of services, and suggested that what is happening to those under 25 still need to be considered, because those small practices that are closing are part of the bigger picture. Sheila Tatayon appreciated the input and looks forward to member input on the CMIR proposed regulations. Members also stated the importance of looking at waste.

Members inquired when in the process of reviewing these transactions will information become public. Sheila Tatayon described the process, sharing in part that a notice of material change will be posted on the Office website, and they will conduct their preliminary review to determine whether it will go to CMIR. Members commented on the impact of making this information public.

Members shared the importance of public oversight and made the case that the differentials suggest there is still a lot of potential consolidation that could happen, and public transparency is needed. On the issue of highly concentrated markets, members highlighted it isn't just about transactions, but it is also about market failures, and the Director has that discretion to identify and address market failures.

Members asked how the Office will be looking at Accountable Care Organizations (ACO) and cited Canopy as an example. Sheila Tatayon described the factors and analysis. A member clarified that none of the providers involved in Canopy have been acquired by Canopy.

Public comment on Agenda item 6. No comment.

Agenda Item # 7: Total Health Care Expenditures (THCE) Measurement
Vishaal Pegany, Deputy Director, HCAI
Michael Bailit, Bailit Health

Vishaal Pegany introduced Michael Bailit of Bailit Health who presented on health care spending targets; spending targets and equity; Massachusetts' experience with spending targets; a spending target development timeline; the measurement of total health care expenditures (THCE) in California; spending target adjustments; and next steps.

Vishaal Pegany highlighted that slides are formatted so that a blue arrow indicates where the Committee is charged with providing input or recommendations.

Members asked if there are states that have incorporated provider level cost structure information, the payer prices, and what assumptions are being made. Michael Bailit stated that it varies by the state, and that the primary data source has been payer data. Members asked if payer data means the prices, they are paying the providers or is it the premiums that are charged to consumers and employers. Michael Bailit answered that it is primarily what they are paying to the providers, because the spending target is a measure of payments to providers. Members commented that it

seems like an assumption is being made that if provider increase go up, for example, two percent a year to what they charge payers, that the payers are actually following that trend. Michael Bailit clarified that in addition there is measurement of insurer administrative costs and profit margin that is collected. Members also asked about out-of-pocket expenses and Michael Bailit stated he would cover that in later slides. He noted that there is some spending that is not easy to break out further.

Michael Bailit presented on the experience of Massachusetts. Members commented that by taking out Medicare and Medicaid—which is about 40% of the delivery system—and just focusing on commercial, that seems counterintuitive when the delivery system needs to be managed as a whole. Michael Bailit clarified the prior slide was total focus, and that he was comparing Massachusetts to external benchmarks and looking at big opportunities for slowed growth. Members noted the issue of cost shifting and public payers.

Members asked if the analysis looked at the margin of healthcare organizations and what they did over that time frame? Michael Bailit answered no, this is just in terms of spending growth. Members also commented about percent increase being heavily impacted by where they begin and that they believed Massachusetts was in the top decile. Michael Bailit confirmed that Massachusetts was at the top. Members commented that should be factored in as parallels are being drawn between Massachusetts and California. Michael Bailit shared that as the data showed, healthcare expenditures and the problems of affordability are high in every state, that there is opportunity everywhere and that the base spending level was higher in Massachusetts and growing at a high rate that they couldn't bring down.

Members commented they believe that upwards of 18% or more of commercial rates factor in the shortcoming from reimbursements for Medi-Cal and Medicare, so that might be more of a reasonable comparison. Michael Bailit acknowledged the cost-shifting argument but said he didn't want to address it at that point and shared that there is extensive research on the topic. He stated that he did not believe that Massachusetts high commercial spending was the result of poor public payer paying, noting that Medicaid is a very good payer in Massachusetts. He affirmed that it is a conversation they could have in the future.

Members asked if the spending target in Massachusetts was for health plans as well as providers. Michael Bailit confirmed that it was, and that the 3.6% target was for the health plans including all of their pharmacy costs, vision, dental, etc. Members asked about what year the drug Sovaldi came out, and Michael Bailit shared that was one of the years they exceeded their spending target and said Sovaldi played a big role and they felt okay about not hitting the spending target because of that.

Vishaal Pegany spoke about Current OHCA and Health Care Affordability Spending Target-Related Activities. Members clarified that the measurement year is the first year for the basis of any corrective action and that would be 2026 with the data

coming in 2027.

15-minute break

Michael Bailit presented on Total Health Care Expenditures (THCE). In discussing the components of THCE, and the claims-based categories, Elizabeth Landsberg noted there is a line item for long-term care.

Members asked about community-based outpatient services and where those would be included. Michael Bailit noted that was something OHCA would have to decide in how specific it wants to be in its instructions to payers. States vary in how prescriptive they are.

Members asked about dental, considering how much is not covered or tracked, how is that accounted for. Michael Bailit confirmed there is a lot of off-ledger health care spending in the commercial market like behavioral health that's not paid for by health insurance. He noted the challenge is the data source for collecting payments that are happening outside of benefit plans. Members inquired further if a topic like this is something they can take to the board saying that it needs to go deeper. Elizabeth Landsberg confirmed that it is an important point, one that the board has discussed multiple times, and remains a shortcoming with the data.

Members commented that because dental benefits are so structured and limited, there may not be much to measure. They asked if there is access to claims from Delta Dental and Guardian—not just what they paid but also what the consumer paid. Elizabeth Landsberg noted that dental won't be captured unless it is part of a comprehensive health plan. Members noted the nexus between gum and periodontal disease and diabetes, cardiovascular, Alzheimer's etc. Members noted the ability to chew, eat, and digest food is the first step to proper health and that if a majority of the population doesn't have dental, a huge element is being missed. Members complemented that by similarly linking behavioral health and substance use treatment. It was clarified that the behavioral health category is just claims based. A member noted that a hole in the underlying statute is that dental-only plans are not considered a reporting entity and that this committee might consider making recommendations around that.

Members noted that there is an estimate that people are using about $20 billion of alternative medicine services or complimentary medicine along with buying medications from other countries, and the importance of collecting that information. Members suggested to the Committee think about issues such as direct billing and surprise billing and trying to incorporate that information into recommendations to the Board.

Michael Bailit continued to present on the components of THCE, specifically non-claims categories. Members commented on the importance of population health and those costs. Michael Bailit clarified that when talking about spending, that doesn't

include provider costs. He acknowledged that spending and costs may not be aligned every year.

Members inquired about how CalAIM fits in. Elizabeth Landsberg confirmed that OHCA is in conversations with Department of Health Care Services.

Vishaal Pegany asked if the Committee had any additional input or recommendations on the components of THCE. Members asked about how state mandates and the costs associated with those will be considered. Vishaal Pegany suggested that would be part of the board process for setting targets and that there is language about the board considering state and federal policy changes when adjusting the targets. Michael Bailit confirmed that future conversations should discuss what considerations are taken when an organization exceeds the spending target.

Members asked about where administrative costs and profits would mirror or diverge from the MLR (medical loss ratio). Elizabeth Landsberg confirmed that it would mirror MLR.

Members inquired about high deductible plans, will FSA and HSAs be considered in looking at out-of-pocket. Elizabeth Landsberg suggested there may not be data on that.

Members inquired whether vision was included. Michael Bailit confirm that it is included when it is part of a comprehensive health plan but not as a standalone.

Members asked about administrative costs and what is included in that, and where it is captured. Michael Bailit stated it does not include provider costs. Members asked about for national plans, will it just be state performance. Michael Bailit confirmed.

Michael Bailit presented on whose total medical expense is included in THCE. Members asked about where workers compensation comes into this. Michael Bailit responded that only one state includes workers compensation because they have a state administered workers compensation pool that pays all healthcare benefits but otherwise workers compensation are a completely different set of insurers and states have opted not to try to include that spending because it increases the administrative complexity. It would be a huge amount of burden to get data from them for, relatively speaking, a small amount of spend.

Michael Bailit presented on determining the population whose spending will be measured. Members asked if out-of-state provider meant out of California but still within the boundaries of the United States. Michael Bailit explained that if it was out of the country but paid for by a submitting insurer or payer, then it is included. If it’s out of the country but it wasn’t paid for by the payer, then it is not included.

Members asked about how big the out of state resident California provider could be, or how big it might be for other states. Michael Bailit shared that other states didn’t size it

or seriously consider it.

Members asked about states' definitions of residency. Elizabeth Landsberg confirmed in California it's about residency, not citizenship, so individuals that live in California and intend to live in California.

Members asked about including a California resident receiving care from an out-of-state provider. Michael Bailit explained the rationale for why other states have included them. Other states have determined that they want to measure spending associated with care for their state's population. The anchor is the population, so they include spending even if it's out of state. He noted that based on geography, this may be more significant for some states than California. Members asked about the example of a dependent college student who receives most of the care out of state and whether they are included. Michael Bailit stated that other states included it and to not would create a fair amount of administrative burden to detect who those people are, and it usually doesn't account for a large percentage of spend. Members also considered snowbirds (retirees who for example live in Palm Springs six months of the year) that may inflate the costs but not be counted. Michael Bailit pointed out that this is an example of where members can weigh in and offer recommendations. He is presenting what other states do and California does not need to follow those models. Michael Bailit stated that the question of including this spending comes back to what's the objective of the spending target. Most states have said it is to slow spending for people who live in their state and have not included this category of health spending as a result. Members shared that usually a claim is going to go back to the source of the coverage.

Members commented about the focus on the total spend for the providers but noted that people who have signed up for high deductible plans that can't afford to pay the deductibles, apply for charity care. Elizabeth Landsberg affirmed that we do want to see what data is out there on premiums to have the full picture of the impact on consumers. Members provided examples of high costs for consumers and speculated there are a lot of gaps in information for consumer spending. Michael Bailit confirmed that consumer spending will be tracked for what is covered by the plan, but that consumer spending for what consumers get outside of the plan can't be captured.

Members asked about occupational medicine and workers compensation claims. Michael Bailit responded that the issue with workers compensation is that it is administered by a whole different set of insurance companies that are not health insurers. Other states have chosen not to try and collect that data because the administrative effort for the amount of spend is not worth it. Members noted the workers compensation is complex and the value of improving that. Elizabeth Landsberg noted the Office is assessing the feasibility of getting some additional data but is not currently exploring workers compensation data. Members noted the presumptive diagnosis for cancer for firefighters and heart disease for police officers as a big spend and to continue to explore how to include that data.

Members also noted spending around alternative medicine like chiropractic, acupuncture, massage, etc. and that these are non-trivial spends that could be considered, along with subscription care.

Members asked what it is called when a patient doesn't provide an appropriate card within 90 days and the insurer refuses to pay. Michael Bailit described that as bad debt, where no payment is made, and that the spending target only measures payments that are made. Members pointed out that money that wasn't paid to the provider is going to show as paid even though it never was, so the provider will look like they got more money than they actually did. Michael Bailit confirmed and stated that he doesn't know how big that is but guesses it may be growing because cost sharing obligations are growing. The challenge is that there is no basis for knowing what portion wasn't paid. He reaffirmed for the group that the limitation is the available data, and that makes it imperfect, but not meaningless.

Members asked about the timeframe for making decisions on some of this, and the sense the Committee is missing information, asking if the Committee has the leeway to pause and establish recommendations in gathering this information. Members wanted to understand where some of the holes are and that by looking at the provider revenue side, OHCA will have the ability to do the analysis of how much revenue providers are receiving once data collection starts. Members expressed the importance of some of the categories presenting concern, but that those areas might be address in year 3 or 4. It is important to focus on what the main problems are now and to not slow the process down allowing perfect to be the enemy of the good. Members suggested moving forward with the data available and to continue to have discussions on other data but not let it get in the way.

Members inquired if other states had scopes around where they started and where they wanted to be in five or ten years to address the issues of having more data included. Michael Bailit responded that he has not seen that; most states set the categories and focus on them. He echoed what Members had shared—that Medicare, Medi-Cal and commercial are going to be 98 percent of the spending and some of the other categories are small. Vishaal Pegany shared that the regulated entities are the ones subject to the spending target. Members commented that the cost shifting that occurs because of the shortfalls in Medi-Cal and Medicare spending is creating the crisis from the employer point of view and the importance of understanding that sooner.

Members affirmed moving ahead with available data and noted the goal of creating the target and the other goal of getting an overall sense of the system, and that the Office might do that in parallel. Members expressed that there is another metric around healthcare costs that needs to be explored, and cited Massachusetts later desire to build in consumer metrics that can be considered sooner, and suggested OHCA do both.

Michael Bailit summarized that the Committee had a rich conversation that conveyed

both a frustration with the available data and a feeling that the committee needs to move forward with what is available to start to address affordability. He shared that these are the messages that can be conveyed back to the Board, even though there are different messages, the Committee doesn't need to agree. There are themes that came up that need to be shared with the Board and Office. Members affirmed the idea of parallel tracks. Members clarified roles, noting that there are both provider perspectives and consumer perspectives and that Members are there to represent those. Elizabeth Landsberg affirmed that. Members noted that OHCA doesn't have unlimited resources, how far a program like HPD can go with the resources it has, and that there are limited dollars.

Michael Bailit presented on THCE and reporting levels of spending and OHCA's approach.

Members asked when and how payer and provider level baseline report data are being collected. Vishaal Pegany shared they will collect aggregate payer data and then disaggregate that payer data by provider. There are algorithms to attribute spending to provider entities. Members asked whether the first round will show fee-for-service versus capitated data by the payer or product like PPO versus HMO, self-funded versus fully funded, or whether it is stopping at just the payer level combing whatever products they have and markets they are in. Vishaal Pegany shared that a decision had not been made on that and asked for a recommendation. Members shared one recommendation to get it to that level of detail, like Medicare Advantage versus Medicare fee-for-service, commercial HMO versus PPO and self-funded versus fully funded. Vishaal Pegany confirmed the interest in Medicare Advantage and traditional Medicare and that data comes from CMS. For commercial, OHCA could consider going even further into measuring performance by HMO and PPO.

Elizabeth Landsberg did a time check to review the remaining topics and choose what to cover and assured the Committee written input is welcome before the next meeting on the risk adjustment information and also the regulations package.

Vishaal Pegany presented OHCA's approach for geographic reporting and asked for input on using the Covered California rating regions. Members expressed that the Covered California regions are a good starting point but had a small concern on the size of the Los Angeles regions. Michael Bailit presented the Rhode Island example of service category reporting and Vishaal Pegany reviewed OHCA's approach for service category reporting and asked for input. Members suggested the inclusion of specialty pharmacy and high-cost drugs and separating out hospital licensed outpatient and community-based outpatient and imaging.

Members commented that in regard to the health payments database, there has been conversation on how to capture spend on capitated payments and more broadly on the capitated arrangements and the various APMs. Members noted that they may not want to lock anything in stone right now in the regulations and leave room for the data to improve.

Members echoed some of distinctions in pharmacy, like mail-order. Members also recommended looking into stand-alone outpatient facilities and/or community outpatient, and also imaging and labs.

Michael Bailit continued to present on how to measure total medical expense at the provider entity level. Vishaal Pegany presented OHCA's approach and invited input. Members suggested adding Accountable Care Organization (ACO) activities, both payer and provider. Members noted that there are several types of provider entities not called out, like specialty physicians. Vishaal Pegany noted that TME would also include not just primary care spending but also inpatient. Members noted specialty clinics will need to be included. Michael Bailit replied there will be certain regulated entities that will require different methodologies of collecting the data and they will be developed at a later time.

Michael Bailit continued to present on spending target program adjustments. As the meeting end time neared, it was noted that adjustments were discussed in detail during the Board meeting the previous day (Members can view the recording).

Due to technical difficulties, the virtual participants were no longer able to hear or see the presentation, so the presentation was stopped and not resumed later. Once the technical difficulties were resolved and virtual members could hear and see the meeting, public comment was invited. Members were also invited to submit written comments to the Office.

Public Comment on agenda item 7. No comment.

Agenda Item # 8: General Public Comment

General Public Comment. No comment.

Agenda Item # 9: Adjournment
Elizabeth Landsburg adjourned the meeting.