HCAI Department of Health Care Access and Information
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Health Care Affordability Advisory Committee
March 19, 2024
MEETING MINUTES

Members Attending: Joan Allen; Barry Arbuckle; Stephanie Cline; Carmen Comsti; Adam Dougherty; Hector Flores*; Sara Gavin; Stacey Hrountas; Ivana Krajcinovic; David Joyner; Tam Ma; Carolyn Nava; Mike Odeh*; Janice O'Malley; Sumana Reddy; Kiran Savage-Sangwan; Andrew See; Sarah Soroken*; Ken Stuart; Suzanne Usaj*; Anthony Wright; Abbie Yant

*Attended virtually

Members Absent: Aliza Arjoyan; Parker Duncan Diaz; Yolanda Richardson; Yvonne Waggener; Rene Williams

Health Care Affordability Board Member Attending: David Carlisle (attended virtually)

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

Presenters: Vishaal Pegany, Deputy Director, HCAI; CJ Howard, Assistant Deputy Director, HCAI; Margareta Brandt, Assistant Deputy Director, HCAI; Michael Bailit, Bailit Health*; KeriAnn La Spina, Senior Health Researcher, Mathematica

Facilitators: Jane Harrington, Leading Resources Inc.

Meeting Materials: https://hcai.ca.gov/public-meetings/april-advisory-committee/

Agenda Item # 1: Welcome and Call to Order

The facilitator called the roll. Director Landsberg reviewed the meeting agenda.

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

Director Landsberg and Deputy Director Pegany provided updates on the work of the Department of Health Care Access and Information including:

- Statistics highlighting deep equity divide entrenched in California's health care system, as well as structural racism that impacts black maternal health.
- Updates and overview of the Health Care Payments Data (HPD) program.
- An update on OHCA's proposed emergency regulations regarding total health care expenditures data collection after posting the notification.
- A reminder of the Advisory Committee selection process underway and invitation for submissions of interest.
- A review of updated data on consumer affordability challenges from the California Health Care Foundation NORC California health policy survey.

Discussion and comments from the Advisory Committee included:

- The rise in high deductible plans that put burden on patient members being an additional driver in the rise is medical debt, not just increasing cost of health care.
- Some members were concerned about holding the Medi-Cal managed health plans accountable to the same standards as commercial health plans. Specifically, making sure Medi-Cal managed care networks (particularly specialty care) are not presenting access challenges and driving care to higher cost settings.
- A member questioned how much out-of-pocket spend factors into medical debt.
- A member questioned if there was a way to capture what is being paid for, especially regarding Medi-Cal managed care plans. Medical debt is rising but patient care is not getting better; there are more costs associated with these plans but often care is not received. This happens disproportionately in communities of color. Using the HPD to identify higher quality and more appropriate providers and eliminating fraud, waste and abuse in the system as a way to reduce costs.

Public Comment was held on agenda item 2. No public comment.

Agenda Item #3: Statewide Spending Target Methodology and Value Including Assessing Performance Against the Statewide Spending Target, Consideration of Medi-Cal Spending, and Public Comments
Vishaal Pegany, Deputy Director, HCAI

CJ Howard, Assistant Deputy Director, HCAI
Michael Bailit, Bailit Health

Deputy Director Pegany presented on the topic of the spending target methodology and the statewide spending target value, along with assessing entity performance against the statewide target, and considerations regarding Medi-Cal and Medicare Advantage spending. Assistant Deputy Director Howard provided context related to the considerations, timing, and implementation of progressive enforcement. Public comments related to the office's proposed statewide spending target recommendation were summarized.

Discussion and comments from the Advisory Committee included:

- A member questioned if the office is also looking at factors that reduce costs, for example, a more efficient staffing model where the managerial level is most efficient to prioritize direct-care provider staff.
    - Another member provided an example of the arrival of new expensive drugs while comparable drugs are losing their patents and therefore coming down in cost.
- Regarding factors that may impact entity performance against the target, a member suggested looking at plan design changes and their impact on utilization patterns. Specifically, looking at how the actuarial values of the design change, and governmental mandates that no cost-sharing for certain types of care (e.g., the Affordable Care Act's guidelines relating to preventive care) and how this increases utilization.
- Some members stated that there are many factors that will increase costs faster than just the rate of inflation or household income and suggested that there should be analysis to include other factors in the target setting methodology before setting the target at 3%.
- A member asked about the timeline of digging into information regarding measurement of access and quality.
    - The office stated that if an entity exceeds the target, and there's valid reasons for doing so, they will take that into consideration. If an entity meets the target and did it in a way that eroded access, then the office would look at that scenario.
- A member asked whether OHCA will still focus on evaluating actual known systemic cost-drivers even if an entity meets the target or has a valid reason not to meet it. The mental health sector served as their example, as the lack of access to lower levels of care (visits with a therapist) often leads to more people needing to access higher levels of care (hospitalization).
- A member expressed the need for clarification of the process of progressive enforcement.
    - The office clarified that enforcement is not automatic, and it is the perspective of OHCA that no adjustment of the target setting methodology is necessary. Adjustments are not necessary on the front end because, for example, high-cost specialty drugs or technology, are not experienced by

all providers uniformly. Additionally, the office could contextualize reasonable factors for exceeding spending growth when it assesses entity performance and this could potentially mitigate the steps in the progressive enforcement process.

- A member emphasized that other factors such as minimum wage should be considered upfront.
- A member disagreed with the need for immediate consideration of additional factors because over 30% of Americans are in medical debt and something needs to happen to address affordability.
- A member asked how the spending target impacts the FQHC system.
    - The office answered that they will report Medi-Cal spending, which will encompass FQHC services, but not at the provider-level until they are able to collect data from Medi-Cal MCOs.
- A member asked what was meant by “contextualize” regarding Medi-Cal requirements.
    - The office answered that they would look to see if there are program changes and requirements that led to an increase in spending for Medicare and Medi-Cal spending.
- A member asked for clarification on how providers that exceeded the target for their Medicare Advantage line of business will be assessed.
    - The office responded that while discussions with DHCS have occurred to determine the office’s approach regarding Medi-Cal, discussions still need to take place with our federal partners to determine how the office will approach Medicare and Medicare Advantage.
- A member raised the topic of developing a more robust way to evaluate community benefit. Their point focused on providers writing off a significant amount of funds as community benefit due to their claim that they subsidize care for Medi-Cal enrollees.
- A member asked a question about how OHCA might account for cost shifting by providers to account for unreimbursed costs. And how does that play into this conversation?
    - The office reiterated they are having these discussions with DHCS and have yet to meet with CMS.
- A member asked about the proportion of public comment in favor or not of the spending target.
    - The office answered there was slightly more public comment in support of the 3% target and all comments can be viewed online.
- A member asked if for states that have spending targets, did the target result in reduced services or the closing of certain service lines?
    - Michael Bailit answered that he is unaware of any structured evaluations to assess impact on service offerings or on access, but also that he has not heard of that being an issue.
- A member commented that entities could possibly meet the target by lowering costs, increasing access, and overall health care spending will go down

because people will receive preventive or lower level of care before needing very expensive care and experiencing increased comorbidity and disability due to putting off care.

- Comments supported setting targets quickly and the need for sector targets.
- Members questioned the referenced publication from UC Berkeley on a new vision for California's health care system and it was pointed out that there is a newer published version.
- A member suggested a multi-year, phase-in approach for the target.
- A member questioned if the public comments addressed the topic of getting to sector and entity specific targets faster than five years.
    - The office replied that it was represented in the public comments.

Public Comment was held on agenda item 3 and 4 members of the public provided comments.

Agenda Item #4: Workforce Stability Standards
Margareta Brandt, Assistant Deputy Director

Assistant Deputy Director Brandt provided an overview of OHCA's draft workforce stability standards, monitoring metrics, the progress made thus far, and key takeaways from stakeholder interviews.

Discussion and comments from the Advisory Committee included:

- A member asked if the office was looking at turnover rate by position type, not just site facility.
    - The office answered that many metrics can be tracked by occupation or position type in HCAI's hospital and community clinic data and that the standards encourage entities to track turnover rates. More detail can be added to the standards if that is helpful.
- A member asked how the office will ensure data is actually collected.
    - The office answered that it will not collect key performance indicators from entities but instead will use publicly available market and organizational-level metrics to track workforce stability, then publicly report and look for trends and outliers.
- A member asked how the office will monitor substantial reductions in labor in the type of data being collected.
    - The office answered that some of the metrics include wages, benefits, and salaries for a variety of occupations and that is where they would begin looking. They are also looking into reviewing layoff notices as part of the workforce stability metrics.
- A member expressed concern about relying on existing datasets and voluntary information from employers, as well as ensuring entities trying to meet the target do not do so on the backs of workers.
- A member expressed the need to focus on how workers are protected, and how

to make sure that the direct care providers can actually do the jobs that they need to and are fully staffed.
- A member noted the shift in health care services to outpatient and in-home care and a lot of the health care workforce leaving as a result.
- A member shared the importance of tracking workforce metrics and addressing the implementation of targets on workforce stability.
- A member asked why primary care physicians were excluded from this voluntary effort.
    - The office answered that statute mentions frontline workers and nonsupervisory health care workers. OHCA will also complement its data with HCAI's Office of Health Workforce Development data on physicians.
- Multiple members want mandatory metrics and note the high level of burnout and turnover for health care workers.
- A member commented that requiring this data to be submitted and properly monitoring it to ensure the bad players don't get the benefit is important.

Public Comment was held on agenda item 4. No public comment.

Agenda Item #5: Primary Care Definition and Investment Benchmark
Margareta Brandt, Assistant Deputy Director

Assistant Deputy Director Brandt presented a review of the primary care definition and options for an investment benchmark.

Discussion and comments from the Advisory Committee included:
- A few members agreed with the recommendation to exclude OB-GYN provider taxonomies. A member agreed unless the OB-GYN has a primary care physician included in their practice.
- A member noted that some OB-GYN's do provide primary care, but the number of them might be inconsequential.
- Three members stated that allocating capitation payments to primary care is difficult.
- Members were in favor of setting separate benchmarks for the adult and pediatric population and it was suggested evaluating whether there should be a different benchmark for Medicare age versus adult commercial.
- A member commented on management around data collection and shifting processes, highlighting communication challenges between payers and providers on correcting data errors.

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

Agenda Item #6: Out-of-Plan Spend
Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director
KeriAnn La Spina, Senior Health Researcher, Mathematica

This agenda item was postponed.

Agenda Item #7: Examples of Cost-Reducing Strategies
Margareta Brandt, Assistant Deputy Director

Barry Arbuckle was invited to share a cost-reducing strategy from MemorialCare based on community-based ambulatory care centers.

- Questions and comments from the committee members addressed the number of employed physicians, workforce structure, and rural community recommendations.
- Members suggested that investment is needed for organizations moving into alternative payment models. A member noting the state is taking a step with the Equity and Practice Transformation Fund.
- A member asked about staffing in emergency departments and incentives for care providers, noting that some care does not need a full hospital bed and hospital at home care is one innovation.
    - The speaker answered with the opinion that hospital at home care is an innovation in California that will not take root in any foreseeable future for economic reasons, except perhaps at Kaiser because it is a closed system.

Agenda Item # 8: General Public Comment

Public Comment on agenda item 8. No public comment.

Agenda Item # 9: Adjournment

Leading Resources Inc. facilitator adjourned the meeting.