HCAi
Department of Health Care Access and Information

Health Care Affordability Advisory Committee Meeting

March 19, 2024

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Welcome, Call to Order, and Roll Call

Agenda

1. **Welcome and Call to Order**

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

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

4. **Workforce Stability Standards**
   Margareta Brandt, Assistant Deputy Director

5. **Primary Care Definition and Investment Benchmark**
   Margareta Brandt, Assistant Deputy Director

6. **Out-of-Plan Spend**
   Vishaal Pegany, Deputy Director, CJ Howard, Assistant Deputy Director, KeriAnn La Spina, Senior Health Researcher, Mathematica

7. **Examples of Cost-Reducing Strategies**
   Margareta Brandt, Assistant Deputy Director

8. **General Public Comment**

9. **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

Black Liberation Statement

At HCAI, we acknowledge the devasting and longstanding impacts racism, oppression, and white supremacy has had on Black and African American communities. We also believe it is critical to acknowledge that Black communities have been treated inhumanely by the U.S. government through enslavement, segregation, mass incarceration and exploitation through medical experimentation used to advance medicine resulting in longstanding inequities. To begin to rectify these wrongs, there must be an explicitly anti-racist approach to reduce racial disparities in health care and more broadly.

At HCAI, we envision a health care system where doctors listen to their Black patients, center their experiences, and take proactive steps to counter implicit bias resulting in quality care and improved patient outcomes. In solidarity and allyship with California's Black communities, HCAI centers and amplifies the voices of our Black partners, leaders, colleagues, and community members. We uplift Black resilience, education, and health. We fully commit to revisiting HCAI's programs, policies, and procedures to ensure state resources are distributed equitably in a manner that recognizes our responsibility to address disparities impacting Black communities.

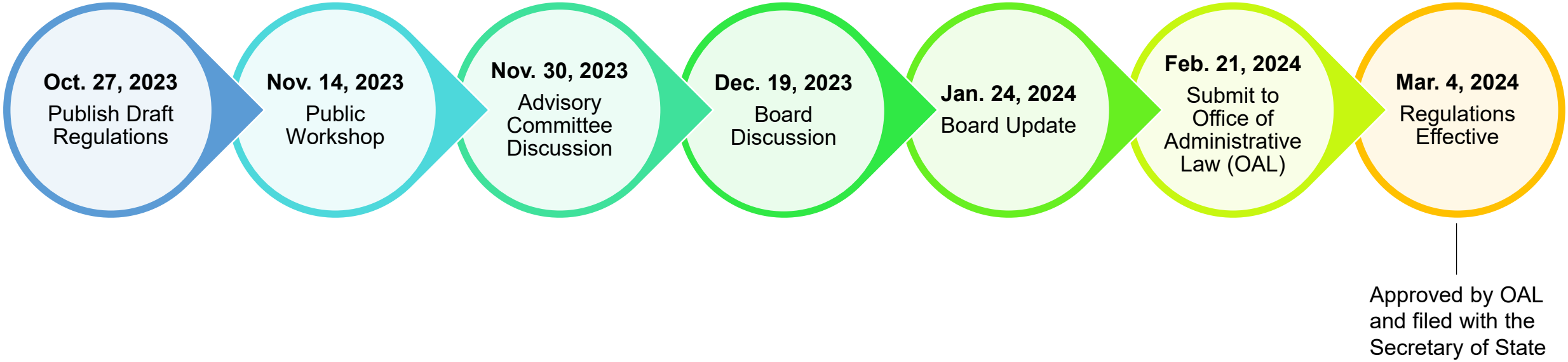
Senate Confirmation of Board Members

The California Senate recently confirmed Governor Newsom's four Health Care Affordability Board appointees.

- Elizabeth Mitchell
- Sandra Hernández
- David Carlisle
- Richard Kronick

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

THCE Rulemaking Timeline



2024 AC Member Selection Process February - May

February 1

- AC application goes live

February 28- Board Meeting

- Live application link announced

March 15 - AC Meeting

- Live application link announced

April 1

- AC submission form closes.

April 1 - May 15

- Submissions evaluated.

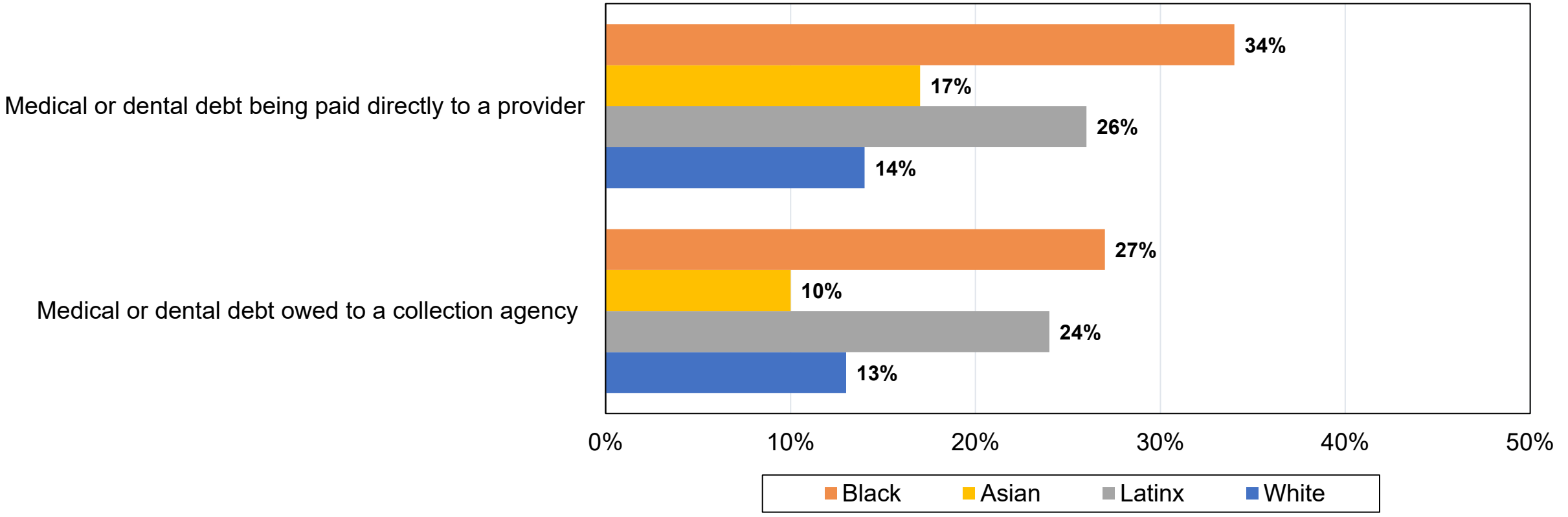
Slide Formatting

Indicates items that the Advisory Committee provides input or recommendations on based on statute and other areas as requested by the Board or OHCA.

CHCF/NORC California Health Policy Survey

Black and Latinx Residents Are More Likely to Report Different Types of Medical Debt

Percentage of Those Who Say They Have Each Type of Medical Debt



Source: CHCF/NORC California Health Policy Survey (September 18–October 25, 2023).

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High Costs Contribute to Personal Bankruptcy

Nationally

- A 2019 National Institutes of Health survey reported that nearly 60% of respondents cited medical expenses as a contributor to their bankruptcy.
- In 2021, the U.S. Census Bureau found that Americans owe at least $220 billion of medical debt.
- Some estimate $140 billion of medical debt is in collections.

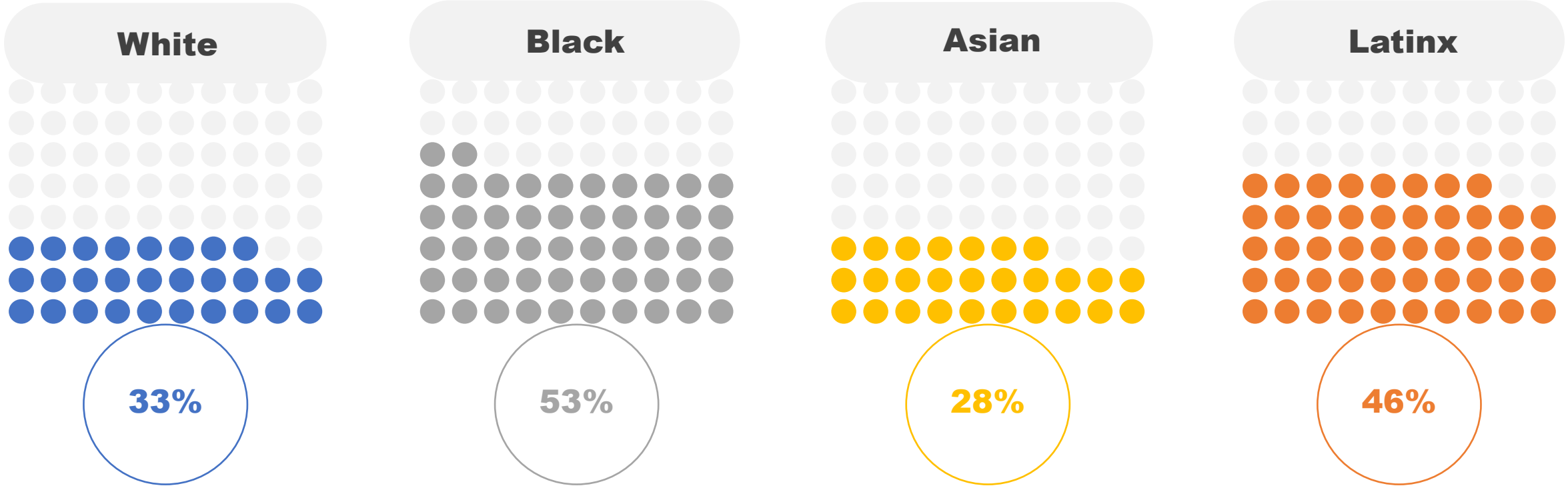
California

- 38% of Californians report having medical debt.
- 2 in 10 Californians report having trouble paying medical bills.

Sources: National Institutes of Health (March 2019).*Medical Bankruptcy: Still Common Despite the Affordable Care Act*.; U.S. Census Bureau. *Wealth, Asset Ownership, & Debt of Households Detailed Tables: 2021*.; Toddy, M. (August 18, 2021). *Medical Debt in Collection Estimated at $140 Billion.* UCLA Anderson Review.; Joynt, J. et al. (2024 January). *The 2024 California Health Policy Survey.* California Health Care Foundation.; Planalp, C. et al. (September 4, 2020). *Weighed Down: Californians and the Financial Burden of Health Care Coverage.* California Health Care Foundation.

High Costs Contribute to Personal Bankruptcy

Medical debt is more likely to be experienced by communities of color than by white communities.



Source: CHCF/NORC California Health Policy Survey (September 18–October 25, 2023).

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Advisory Committee Discussion

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Public Comment

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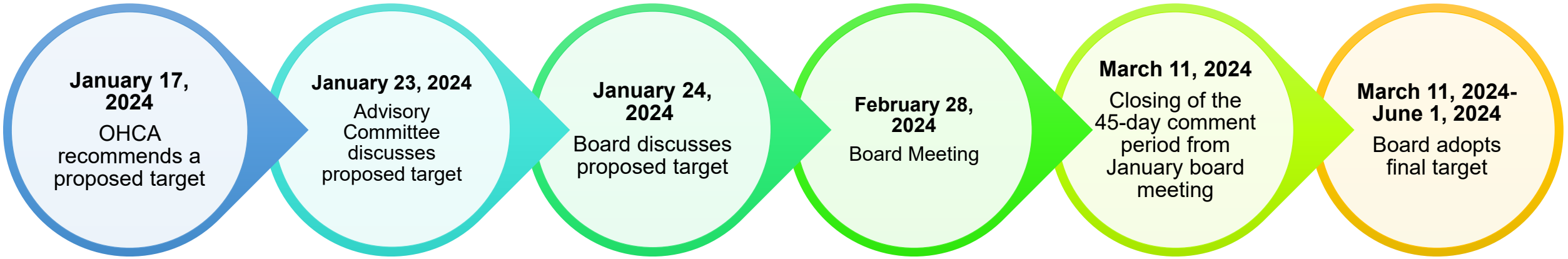
Statewide Spending Target Methodology and Value Including Assessing Performance Against the Statewide Spending Target, Consideration of Medi-Cal Spending, and Public Comments

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

OHCA's Recommendation for the Health Care Spending Target

Timeline for Adopting the Spending Target for 2025



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

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

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

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

Assessing Performance Against the Statewide Spending Target

Elements of Spending Target(s) Implementation

1. Set Statewide Spending Target

- On or before June 1, 2024, the board must establish a statewide spending target for 2025.
- Target setting methodology discussions have been rooted in consumer affordability.
- A statewide target cannot uniformly account for circumstances impacting each entity's performance against the target.

2. Assess Entity Performance Against the Statewide Spending Target

- **The office will assess each entity's performance against the target.**
- **The office will consider circumstances that may have impacted performance.**

3. Progressive Enforcement

- Technical Assistance
- Public Testimony
- Performance Improvement Plans
- Financial Penalties

Authority to Assess Performance Against the Spending Target

127502.5 (a): “The director shall enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets, allows each health care entity opportunities for remediation, and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access, quality, equity, or workforce stability. **The director shall consider each entity’s contribution to cost growth in excess of the applicable target and any actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target.** The director shall review information and other relevant data from additional sources, as appropriate, including data from the Health Care Payments Data Program, to determine the appropriate health care entity that may be subject to enforcement actions under this section…”

Authority to Assess Performance Against the Spending Target

127502.5 (a): "…Commensurate with the health care entity's offense or violation, the director may take the following progressive enforcement actions:

1) Provide technical assistance to the entity to assist it to come into compliance.
2) Require or compel public testimony by the health care entity regarding its failure to comply with the target.
3) Require submission and implementation of performance improvement plans, including input from the board.
4) Assess administrative penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets."

Assessing Performance Against the Target

- OHCA has heard from the board and the public about potential factors that should be considered when assessing an entity's performance against the target. Such factors may contextualize an entity's spending growth as well as potentially mitigate steps in the progressive enforcement process.
- Some of the potential factors that have been surfaced to OHCA by the Board, Advisory Committee, and stakeholders, as well as described in the statute include:
  - Statutory changes impacting health care costs
  - Changes in Medicare and Med-Cal reimbursement
  - Investments to improve care and reduce future costs
  - Acts of God or catastrophic events
  - Emerging and unforeseen advances in medical technology
  - Emerging high-cost / high-value pharmaceuticals and cost increases related to specialty pharmaceuticals
  - Costs associated with increased organized labor costs
  - Annual changes in age and sex of the entity's population
  - Changes in an entity's patient base / acuity

Assessing Performance Against the Target

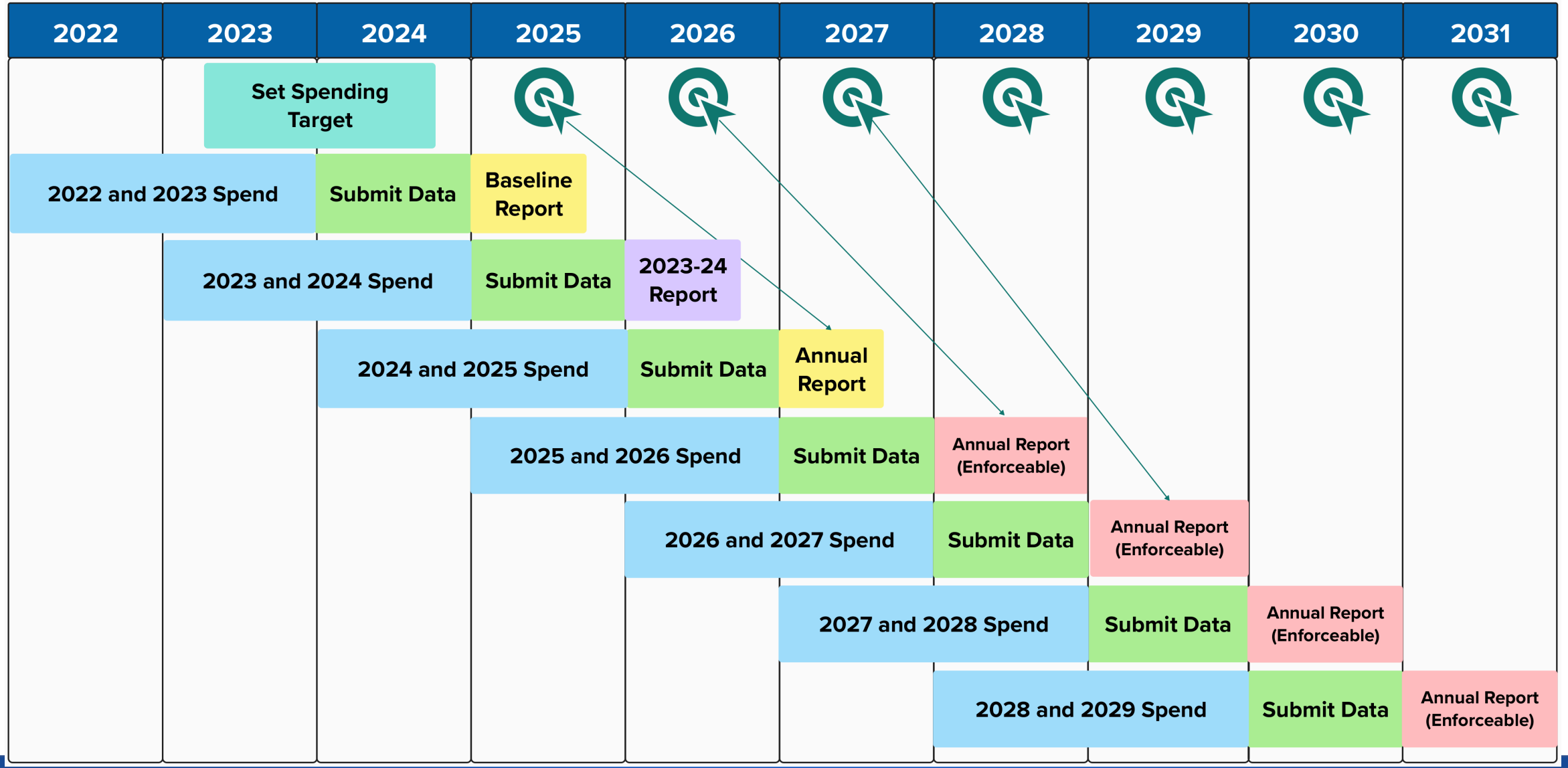
Are there additional reasonable factors that may impact entity performance against the target?

Considerations for Progressive Enforcement

Progressive Enforcement Considerations

- OHCA proposes establishing a target for 5 performance years (2025-2029). Note 2025 is a reporting year and not subject to progressive enforcement while 2026 and beyond are subject to progressive enforcement.
- Progressive enforcement involves OHCA:
  - Engaging in technical assistance discussions,
  - Requiring entities to provide public testimony,
  - Establishing performance improvement plans (PIP), and
  - Ultimately levying financial penalties after non-compliance with a PIP.
- The annual report for performance year 2026 will not be published until spring 2028.
  - A PIP established in 2028 would relate to prospective performance years (i.e., 2029 and beyond). Statute provides that an entity may be subject to a PIP for up to three years.
  - While OHCA has authority to assess financial penalties on a standalone basis, OHCA is more likely to assess penalties when an entity is non-compliant with the terms of a performance improvement plan.
- Performance years 2027 and 2028 are subject to progressive enforcement actions, and non-compliance with the target may result in technical assistance, public testimony, PIPs and/or financial penalties.

Progressive Enforcement Considerations



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Considerations for Medi-Cal Spending

Medi-Cal Spending Measurement and Enforcement Requires a Coordinated and Tailored Approach

- Consumer affordability is fundamentally different in Medi-Cal than in commercial coverage and Medicare. While a small percentage of Medi-Cal members have a share of cost, similar to a monthly deductible, most Medi-Cal members have no cost-sharing, so consumer affordability is not a barrier to accessing care.
- OHCA's approach for Medi-Cal requires a coordinated and tailored approach regarding data, measurement, and enforcement for Medi-Cal managed care organizations (MCOs) and their contracted providers.
- OHCA will report spending data that includes MCOs and their contracted providers, since they are health care entities under the statute.

Background: Base and Supplemental Payments and Nonfederal Share Financing in Medi-Cal

- Medi-Cal pays for services through a combination of base and supplemental payments. Supplemental payments are separate from and in addition to the base payments for services rendered to Medi-Cal beneficiaries. These payments utilize federally approved financing mechanisms to increase reimbursements to providers.
- With some exceptions, the nonfederal share of base payments is financed predominantly using state General Fund. The nonfederal share of supplemental payments, on the other hand, is largely financed using locally generated funds.
- Supplemental payments often afford DHCS opportunities to maximize federal financial participation and increase provider reimbursement in Medi-Cal without correspondingly raising state General Fund costs.

Consideration of Supplemental Payments, Nonfederal Share, and Taxes or Fees

"With respect to Medi-Cal, the methodology shall consider provision of nonfederal share, determined to be appropriate by the Director of Health Care Services, associated with Medi-Cal payments, such as expenditures by providers or provider-affiliated entities that serve as the nonfederal share associated with Medi-Cal reimbursement.

The methodology may also consider all of the following:

- Supplemental payments to qualifying providers who provide services to Medi-Cal and underinsured patients.
- Provisions of nonfederal share or reimbursement of state costs not associated with specific Medi-Cal reimbursement, but that supports the Medi-Cal program, and any other reimbursements and fees assessed by the State Department of Health Care Services, as determined appropriate by the Director of Health Care Services.
- Health care-related taxes or fees that, in whole or in part, provide the nonfederal share associated with Medi-Cal payments or support the Medi-Cal program, as determined appropriate by the Director of Health Care Services."

Source: Health and Safety Code § 127502(d)(5)(A) and (B)

Consideration of Non-Federal Share by Providers During Progressive Enforcement

"Prior to assessing an administrative penalty against a health care entity, the director may consider related provision of nonfederal share, determined to be appropriate by the Director of Health Care Services, associated with Medi-Cal payments, such as expenditures by providers or provider-affiliated entities that serve as the nonfederal share associated with Medi-Cal reimbursement."

Source: Health and Safety Code § 127502.5(d)(3)

Status Update on Data Reporting: Medi-Cal MCO Spending

- Under the THCE data collection regulations, payers and fully integrated delivery systems have a one-year exemption from reporting Medi-Cal lines of business (22 CCR sections 97445 and 97449). For the baseline report on calendar years 2022-23, OHCA will leverage existing data from DHCS to publicly report MCO spending.
- At a statewide level, OHCA will report supplemental payments and the provision of nonfederal share by providers.
- OHCA is still evaluating existing MCO data from DHCS and will need to determine if additional data is needed directly from MCOs to report attributed total medical expenses for enrollees assigned to physician organizations.
- OHCA is developing additional strategies to measure hospital spending, across all patients, in addition to hospitals that are part of a health system with attributed lives. Developing this approach is likely to require inclusion of spending by lines of business and consideration of Medi-Cal program requirements.

Note: Data on calendar years 2022 and 2023 for the baseline report is due September 1, 2024.

OHCA and DHCS Coordination on Spending Target Enforcement for Medi-Cal MCOs

- OHCA is required to coordinate enforcement actions with DHCS, DMHC, and CDI, as relevant, and would take into consideration Medi-Cal program changes that impacted spending.
  - "The director shall consult with the Director of Managed Health Care, the Director of Health Care Services, or the Insurance Commissioner, as applicable, prior to taking any of the enforcement actions specified in this section with respect to a payer regulated by the respective department to ensure any technical assistance, performance improvement plans, or other measures authorized by this section are consistent with laws applicable to regulating health care service plans, health insurers, or a Medi-Cal managed care plan contracted with the State Department of Health Care Services."

Source: Health and Safety Code § 127502.5(b)(4)

Background on Changes to the Medi-Cal MCO Tax

- Additional revenues from the MCO tax will be used to support the Medi-Cal program, including, but not limited to, new targeted provider rate increases and other investments that advance access, quality, and equity for Medi-Cal members and promote provider participation in the Medi-Cal program.
- Targeted rate increases and other investments for primary care and specialty care, hospital and community outpatient care, emergency and inpatient care, behavioral health, and workforce will be implemented as follows:
  - As part of Phase 1, targeted rate increases for primary care, obstetric (including doula), and non-specialty mental health services providers became effective for dates of service on or after January 1, 2024.
  - As part of Phase 2, DHCS has submitted a plan to the Legislature for additional targeted rate increases and other investments through Fiscal Year 2027-28.

Note: Assembly Bill 119 (Chapter 13, Statutes of 2023) authorized a MCO Tax, effective April 1, 2023, through December 31, 2026. The Centers for Medicare & Medicaid Services (CMS) formally approved the State of California's MCO Tax on December 15, 2023.

Assessing Performance and Enforcement for Entities Participating in Medi-Cal

- Medi-Cal MCO rates are actuarially sound rates set by DHCS for each plan, rating region and population, based on several factors, including historical cost and utilization data, program changes, directed payments (e.g., supplemental payments), and consideration of reasonable, appropriate, and attainable spending for a typical Medi-Cal plan in the same geography.
- Rates are certified as sound by professional actuaries and, in most cases, subject to rigorous review and approval by federal actuaries. Because the rates are already subject to extensive state and federal oversight and examination under Medi-Cal requirements, Medi-Cal MCO spending is significantly different than that of commercial spending.
- DHCS and its actuaries also annually evaluate how the rates MCOs pay providers for many services compare to Medicare and commercial coverage. DHCS provides its analysis to federal reviewers as part of the MCO rate review process. In general, federal requirements prevent DHCS from funding MCOs for payment levels that exceed average commercial rates. Except for inpatient care, current Medi-Cal payment levels for many services are below Medicare on average.

Assessing Performance and Enforcement for Entities Participating in Medi-Cal

- OHCA will coordinate with DHCS on factors, such as rate increases, investments, and other program changes so that Medi-Cal spending growth is contextualized.
- Given the extensive state and federal oversight for Medi-Cal spending and rates set for MCOs, OHCA would not pursue progressive enforcement for MCOs.
- For providers that exceed the target for their Medi-Cal line of business, OHCA will contextualize spending growth driven by program changes and requirements implemented by Medi-Cal.

Considerations for Medicare Spending

Assessing Performance and Enforcement for Medicare Advantage

- The rates the federal government pays Medicare fee-for-service (FFS) providers are set administratively through laws and regulations.
- The federal government pays Medicare Advantage (MA) plans a set rate per person, per year, with additional various adjustments such as for quality.
  - The benchmarks for determining federal payments to MA plans are tied to local per capita Medicare FFS spending, which means the rates MA plans pays to providers are similar or slightly above Medicare FFS.
  - Additionally, federal law (Section 1866 of the Social Security Act and implementing regulation 42 CFR 422.214) requires providers to accept Medicare FFS rates as payment in full for out-of-network services received by MA enrollees.
- Because MA rates are governed by the federal Centers for Medicare and Medicaid Services, this would mitigate the need for OHCA to pursue progressive enforcement for MA plans.

- For providers that exceed the target for their MA line of business, OHCA will contextualize spending growth driven by program changes and requirements implemented by Medicare.

Sources: The Commonwealth Fund (2024, January 31). *Medicare Advantage: A Policy Primer (2024 Update).* https://www.commonwealthfund.org/publications/explainer/2024/jan/medicare-advantage-policy-primer#12; Maeda J. and Nelson, L. (2018, Jan-Dec; 55). *How Do the Hospital Prices Paid by Medicare Advantage Plans and Commercial Plans Compare with Medicare Fee-for-Service Prices?.* National Library of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6050995/#bibr5-0046958018779654.

Public Comments on Proposed Statewide Spending Target

Public Comment Overview

- OHCA received 224 public comments related to its spending target recommendation.
- Comment letters came from individuals, unions, consumer advocacy groups, equity-focused organizations, purchaser organizations, individual hospitals, physician and medical groups, and health plan, medical, nursing, orthopedic, and hospital associations, among others.
- The summary slides that follow group the comments into broad theme categories of spending target, methodology, and duration. Comments are then further broken down into the following:

  - Access and Quality of Care
  - Target Value
  - Adjustments
  - Economic Indicator
  - Duration of the Initial Target
  - Other Comments

Target Value

Theme: Access and Quality of Care

Concerns

- To meet and maintain the target, hospitals will have to reduce services or close certain service lines and exacerbate an already difficult health care workforce shortage.
- Ability to deliver high quality health care to those in need is detrimentally impacted by any decrease in reimbursement.
- Concern that an unrealistic target will result in longer patient wait times, reducing patient access to care, and penalize physicians who care for more complex patients with disabilities and chronic disease. The most vulnerable patients might not be able to find physician practices or medical groups able to take them and meet targets.
- Forces providers to cut back on care or face penalties.
- OHCA has not performed sufficient analysis of the trends in health care labor costs, the potential impacts of a 40% drop in health care spending growth on workforce stability, or the effects of negative real spending growth on access and quality.

Support

- Any increases in cost of care will exacerbate problems with access, equity, and public health, furthering lack of access, affordability, and equity. These effects are particularly hard on minorities and those with disabilities.
- Lack of affordability impairs quality because consumers skip or delay going to the doctor, filling prescriptions, and getting other necessary care.
- Californians, especially those with employer-based coverage, are paying more and getting less: less care, less access to care, lower quality in terms of managing chronic conditions and less health equity.
- OHCA's proposed 3% cost growth target is desperately needed TODAY to help California families who are insured be able to use their health insurance. This target will help California strengthen health care quality and achieve more equitable care.

Target Value

Theme: 3% Target Value

Concerns	Support
• Recommendation for a target framework of one-year at 6.3% in 2025 which accounts for inflation, aging, technology/labor, and major policy impacts (e.g., health care worker minimum wage, Medi-Cal investment, seismic compliance); also includes a 5.3% average for years 2025-2029. • The average annual growth in per capita health care spending should be considered when setting a spending growth target…the 10-year average annual change in per capita health care spending from 2010-2020 was 4.7%, and the 20-year average annual change in per capita heath care spending from 2000-2020 was 5.4%. • Recommendation for a target of at least 4.6% to not lose ground. CMS projected that the increase in the Medicare Economic Index (MEI) – the cost to practice medicine - will be 4.6% in 2024. It is critical to consider, rather than ignore, the cost of providing health care when setting California's spending growth target.	• 3% each year is not a reduction or freeze, but a goal that the health care industry must live within the same constraints as a median California family does. • 3% is the upper bounds of what is sustainable and may not even go far enough because it won't do much to reduce high outlier prices. • OHCA's 3% spending target puts California squarely in the same range as other states. Other states with cost commissions have targets for 2024-2027 in the range of 2.8%-3.3%. A target of 3.5% or 4% would be far higher than the targets in other states. • Support for the proposal for a cost growth target to be 3% or lower to provide real relief for California consumers and communities. • Target should be less than 3% but 3% allows costs to increase at same rate as median household income.

Target Setting Methodology

Theme: Adjustments

Concerns	Support
• Without incorporating inflation projections in the spending target, the state's health care system will be unable to afford medical supplies and upgrades to its physical and technological infrastructure. • 3% target is well below inflation projections for California and would remove $4 billion annually from the health care system ultimately impacting quality and access to care, as well as investments in care quality improvements. • Historically, other spending target states have struggled to meet the target and had to readjust the target. • COVID-19 significantly impacted hospitals and could face similar pandemic events in the future. • Proposal does not take into consideration market growth for health care worker wages. • Proposing an unadjusted target based on median family income growth is setting a target lower than recent years' GDP growth, making California an outlier when compared to the eight other states with similar cost growth targets.	• 3% exceeds recent inflation projections by the Department of Finance and the Congressional Budget Office for 2025 and beyond. • OHCA's 3.0% spending target puts California squarely in the same range as other states. Other states with cost commissions have targets for 2024-2027 in the range of 2.8%-3.3%. A target of 3.5% or 4% would be far higher than the targets in other states. • The recent spate of inflation will already be built into the baseline, and not need to further influence the growth target. The 2025 target will be reported in 2027. By then, the inflation of 2022 and 2023 will be years in the rearview mirror. If there is a reversal of trend, the Board has the flexibility to review the target. • After years of conversations and now implementation of this new Office of Health Care Affordability, Californians should not have to settle for a target that is less ambitious than what Washington, Oregon, Massachusetts, and other states around the country are using for a goal in the next several years.

Target Setting Methodology

Theme: Adjustments

Concerns	Support
• Aging is projected to increase health care spending by 0.7% annually. • The increasingly aging population of California results in higher costs of care for health care entities. • Government reimbursement for Medi-Cal and Medicare has not kept pace with rising cost of labor, supplies, and drugs, leading to fiscal losses for safety-net providers. • MCO Tax: Failing to account for this critical new spending that will improve access to care for Californians when setting the spending growth target undermines all of the work we are collectively doing to improve patient care in the Medi-Cal system. • Methodology does not account for the costs of new health care technology. • Methodology doesn't take into account the rising costs due to key industries driving rising costs, such as insurance companies, pharmaceutical manufacturers, and PBMs. • 2030 Seismic operational mandates for hospitals (SB 1953) are unfunded and require hospitals to take loans with interest rates greater than 3%.	• OHCA should not apply any prospective adjustments to the target that may increase provider/plan costs. These adjustments are speculative and hard to quantify in advance. There will be a mechanism to account for major unexpected cost drivers in retrospectively assessing entities' performance against the targets in future years. • OHCA should quickly set sector targets--geographic, industry, and entity-specific. A statewide-only target allows high-cost providers to increase costs at same rate as low-cost providers—focus on high-cost outliers and set their target below the statewide average. • Writing in support of OHCA's suggested statewide spending target of at most 3% without any further delays and without population or new technology adjustments. This target makes sure that health care costs don't outpace what every day Californians can afford.

Target Setting Methodology

Theme: Economic Indicator

Concerns	Support
• The Office has yet to collect data to inform the establishment of a credible, attainable target. • Using a 20-year period for the historical median income is flawed/skewed because it includes the Great Recession. Using a 10-year period instead is more representative of the current climate. • It is more realistic to base the proposed target on projections for median household income growth over the next 5 years. • It is more appropriate to look at the median income over the last ten years, which is 4.1%, and the current projection for median household income growth for 2026, which is 3.6%.	• A longer lookback period creates more stable spending growth over time and provides a steadier foundation to which the health care industry can sustainably and structurally adjust. • The only metric that is tied to affordability relates to income. Other suggested metrics may be useful for management and analysis but do not seem to relate to affordability. • Anchor the methodology on affordability metrics, not the spending trend. • Using growth in median household income aims to keep household spending from growing no faster than income and help prevent further erosion of affordability. • The first step in changing health care costs is setting a target that, for the first time, reflects the experience of consumers and other purchasers rather than letting the health care industry charge whatever it can. • The Board has discussed at length the critical importance of basing the spending growth target on median household income which reflects the ability of consumers to afford both health care and coverage rather than the wealth of the California economy as reflected in measures such gross domestic product (GDP).

Target Duration

Theme: Duration of the Initial Target

Concerns	Support
• Set a single-year target to allow time to resolve challenges (e.g., staffing and labor costs, rising pharmaceutical, medical device, and supply costs, the potential for reduced federal Medicare/Medicaid reimbursements), as well as provider attribution, Medi-Cal data collection, treatment of supplemental payments and provider self-financing clarity. • Statute allows for OHCA to adopt a single year-target, rather than a 5-year target immediately. • Set a 1-year baseline target for 2025 and use 2025 to collect data to inform the first enforceable target for 2026. This allows hospitals to develop ways to reduce costs/slow spending without major detrimental impacts on care, medical education, and research.	• A “glide-path” or “phase-in” of as-yet-unspecified parameters that allows industry to grow that much further, only prolongs the pain of consumers and other purchasers beyond the intent of the long-debated law by allowing industry more time to undercut the need for change. • Setting a five-year target allows the Board the flexibility to adjust the target if necessary, such as for an extraordinarily expensive new drug, or cost savings due to widespread adoption of technology, or other efficiency improvements.

Other Comments

Concerns	Support
• OHCA has not communicated rules around how the data would be analyzed. • OHCA has not yet laid out rules for how entities would be held accountable for the target. • According to a 2019 California Health Care Foundation Report, prices for both inpatient and outpatient services increase when there is more market concentration or consolidation. If the Board sets the health care growth spending target too low, high-cost outliers will continue to be just that – high-cost outliers, and smaller entities will give up and be swallowed up by larger, often more expensive systems. Setting the targets too low will drive the very consolidation that leads to increased health care costs that you hope to prevent.	• The target should not simply codify the existing cost trends that led to today's crisis of affordability where low- and middle-income families choose between getting care and paying for housing and other necessities. The target and the other important elements of the law are designed to foster structural and systemic change that improves outcomes, quality and equity while slowing the growth in health care costs. • Spending that does not go to health care cost growth is available to other parts of the economy, starting with the wages of workers who do not work in health care but also for other purposes of employers. • The OHCA staff proposal is not a reduction nor a freeze but a goal for the health care industry to compete within the same constraints as a median California family. • The health industry should not simply be able to charge whatever its inflated costs are and expect Californians to sign the check no matter the cost. • Set a goal aligned with the actual experience of California families and give the industry the tools, flexibility, and incentives to innovate to meet the targets of lower costs and improved quality and equity.

Public Comment Feedback

Do Advisory Committee Members have feedback on the public comments presented and the public comments posted with meeting materials?

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Advisory Committee Discussion

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Public Comment

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Workforce Stability Standards

Margareta Brandt, Assistant Deputy Director

Health Care Workforce Stability

Statutory Requirements

- Monitor the effects of spending targets on health care workforce stability, high-quality jobs, and training needs of health care workers.
- Monitor health care workforce stability with the goal that workforce shortages do not undermine health care affordability, access, quality, equity, and culturally and linguistically competent care.
- Promote the goal of health care affordability, while recognizing the need to maintain and increase the supply of trained health care workers.
- **Develop standards, in consultation with the Board, to advance the stability of the health care workforce.**

Health Care Workforce Stability

Statutory Requirements

- **The Board approves standards to advance the stability of the health workforce that may apply in the approval of performance improvement plans.**
- OHCA may require a health care entity to implement a performance improvement plan that identifies the causes for spending growth and shall include specific strategies, adjustments, and action steps the entity proposes to implement to improve spending performance during a specified time period. The director shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode access, quality, equity, or workforce stability.

Health and Safety Code § § 127501.11 and 127502.5

Workforce Stability Standards Process and Progress

OHCA is working with the Philip R. Lee Institute for Health Policy Studies (IHPS) and Healthforce Center at the University of California, San Francisco (UCSF) to develop the workforce stability standards.

Key Takeaways from Key Informant & Stakeholder Interviews

Potential Benefits of Workforce Standards	• Transparency in staffing and costs • Identification of workforce challenges • Improved quality of care
Challenges of Workforce Standards	• Difficult to apply statewide standards to diverse healthcare entities • Potential to inhibit care delivery innovations • Administrative burden of reporting
Opinions on Workforce Standards Focus	• Some advocate for equal consideration of all settings and professions • Others suggest focusing on specific settings (hospitals, nursing homes, primary care) and professions (e.g., behavioral health, primary care workforce, nurses, CHWs/promotores)

Workforce Stability Standards: Who Do They Apply To?

- Statute uses the language “nonsupervisory health care workforce” and “frontline health care workers."
- OHCA interprets the statute to exclude the supervisory workforce, including physicians, dentists, and pharmacists, from the workforce stability standards.
- Several stakeholders suggested including physicians, particularly primary care providers (PCPs), in the standards.
- In the future, OHCA may broaden the standards and tracking metrics to include PCPs or other supervisory providers.
- OHCA will collaborate with OHWD to understand the physician workforce.

Principles to Guide Workforce Stability Standards and Metrics

1. Address current workforce shortages and challenges impacting workforce stability (e.g., provider shortages in behavioral health or in rural areas).
2. Monitor for emerging workforce shortages and plan for future workforce needs.
3. Incorporate flexibility to accommodate differences between settings, occupations, and regions.
4. Compare workforce composition across similar health care entities.
5. Track graduations from health professions education programs, licensure requirements, and time to licensure to improve match between workers entering workforce and need.

Principles to Guide Workforce Stability Standards and Metrics

6. Promote diversity in the workforce and address population need for culturally and linguistically competent care.
7. Track the impact of spending targets on most vulnerable health care workers (e.g., unlicensed direct care and long-term care workers) and those who serve vulnerable populations (e.g., disabled, elderly, safety net).
8. Consider tradeoffs of prioritizing monitoring of highest-cost, most-regulated settings (e.g., hospitals) compared to least-regulated settings that may need greater oversight.
9. Monitor indicators of workforce shortages at the facility level, such as sentinel safety events or worker's compensation claims.
10. Minimize reporting burden for health care entities.

Approach to Workforce Stability Standards and Metrics

Standards

- Best practices for health care organizations to adopt
- Organizations should implement these practices and track related key performance indicators to help ensure a stable workforce
- Not enforceable by OHCA

Metrics

- Use publicly available data to monitor workforce stability at the organization level and the market level to complement the standards
- Will establish baseline data on proposed metrics and may add benchmarks to the standards in future years

Draft Workforce Stability Standards

1. **Monitor a priority set of key performance indicators of workforce stability.** Relevant metrics to monitor include:
   - Turnover rates
   - Retention rates
   - Vacancy rates
   - Time to fill vacant positions
   - Job satisfaction
   - Investment in continuing education, professional development, and training programs for current employees and for new entrants to key occupations, measured in dollars and as a percentage of total wage spending
   - Diversity of its workforce and languages spoken in relation to the population served

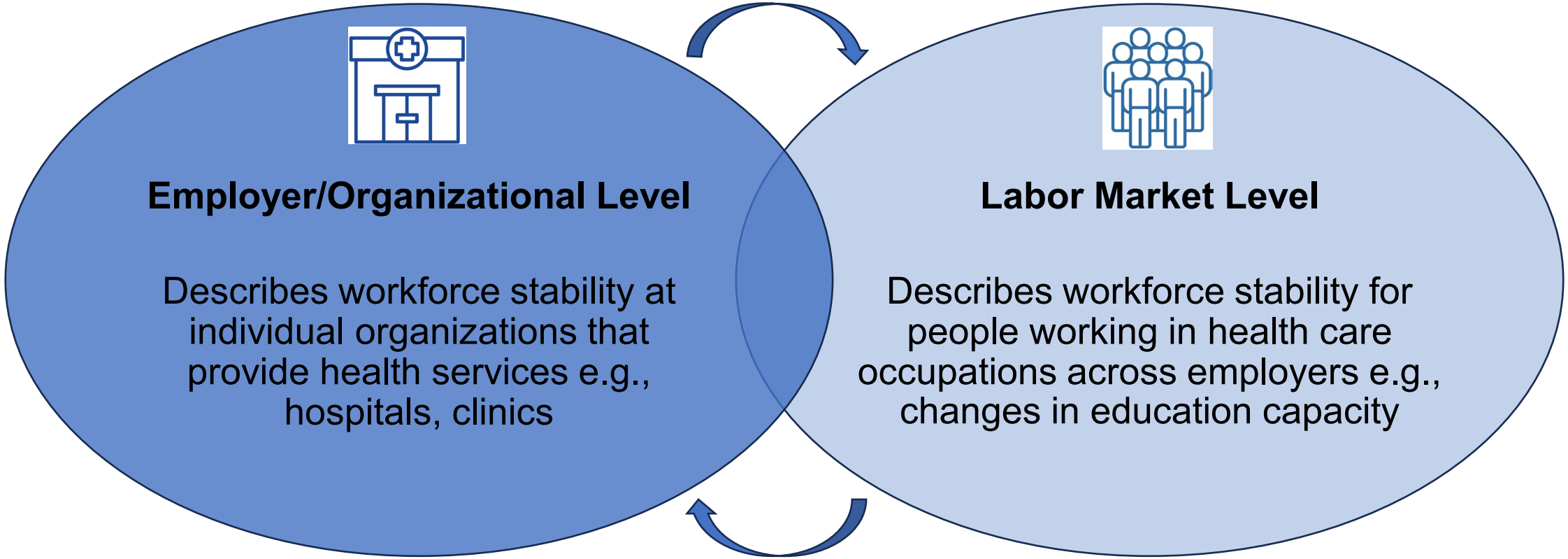
2. Develop formal processes to adapt to changing workforce stability. Use tools such as a workforce development plan to adjust hiring, training, and other practices based on organizational key performance indicators and market level influences.

Draft Workforce Stability Standards

3. Invest in training opportunities for workers. Such training includes development of new skills to adapt to changing health care delivery models (e.g., use of technology, team-based care) and supporting advancement of entry-level and non-clinical workers (e.g., housekeeping staff) to other occupations within the organization through career ladders.
4. Increase use of team-based care models and other care delivery innovations to improve quality, equity, and efficiency of care. Multi-disciplinary health care teams allow workers to practice at the top of their licenses, improve quality, equity, and efficiency of care, and may reduce burnout.
5. Center culturally and linguistically competent care. Access to high-quality, equitable care across all communities requires a workforce that represents California's people, speaks their languages, and understands their cultures. Organizations should prioritize hiring and employee advancement practices that advance equitable care for their communities.
6. Treat workers as an organizational asset rather than a cost center. Investments in a well-trained, adequately compensated workforce can lead to substantial returns in the form of higher quality care, reduced turnover and contract labor costs, which together can contribute to lower overall costs and improved outcomes for patients.

Workforce Stability: Levels of Analysis

OHCA will monitor workforce stability at the organizational and the labor market levels.



Draft Workforce Stability Metrics: Organization Level Monitoring

Organization	Data Source	Example Occupations	Example Metrics
Hospitals	HCAI Hospital Annual Financial Disclosure Reports	• Registered nurses • Clerical & other administrative staff • Environmental & food service staff • Registry nursing personnel	• Average hours per patient day for daily hospital services, for each occupation • Average hourly pay rate for daily hospital services, per occupation • Contract nursing personnel hours divided by total nursing hours, for daily hospital services • Average hourly rate of contract nursing personnel divided by average hourly rate of staff registered nurses • Salaries, wages, and benefits costs as percentage of total operating expenses

Note: Other entities to be monitored using HCAI data are nursing homes/skilled nursing facilities and community clinics. The complete set of draft metrics for organization level monitoring can be found in the Appendix.

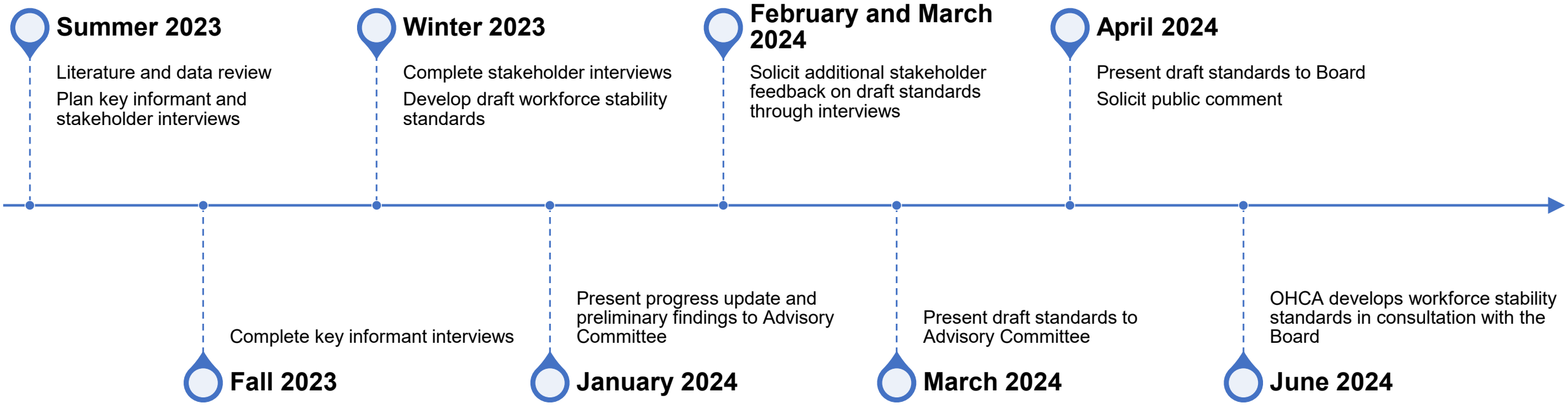
Draft Workforce Stability Metrics: Market Level Monitoring

Data Source	Geographic Areas	Example Occupations	Example Metrics
California Licensure Board records and HCAI license renewal surveys	• Statewide • CBSAs & CSAs* • Counties • California Economic Strategy Panel regions	• Advanced Practice Registered Nurses • Licensed Marriage and Family Therapists • Occupational Therapists	• Number licensed • Age distribution • Race/ethnicity • Languages spoken • Average number of hours worked per week
US Integrated Postsecondary Education Data System	• Statewide • CBSAs & CSAs • Counties • California Economic Strategy Panel regions	• Dozens of program classifications, in category "51. Health Professions and Related Clinical Services"	• Awards/degrees conferred • Awards/degrees by race/ethnicity
California Board of Registered Nursing Annual Schools Survey	• Statewide • California BRN regions (based on California Economic Strategy Panel regions) • Counties	• Registered nurses	• New student enrollments • Number of completions • Race/ethnicity, gender, and age distribution of completions

*CBSA = Core Based Statistical Area, CSA = Combined Statistical Area, as defined by U.S. Census Bureau.
The complete set of draft metrics for market level monitoring can be found in the Appendix.

Next Steps

OHCA's draft standards and metrics will be refined based on stakeholder feedback, and with input from the Advisory Committee and Board, in anticipation of final standards adoption in June 2024.



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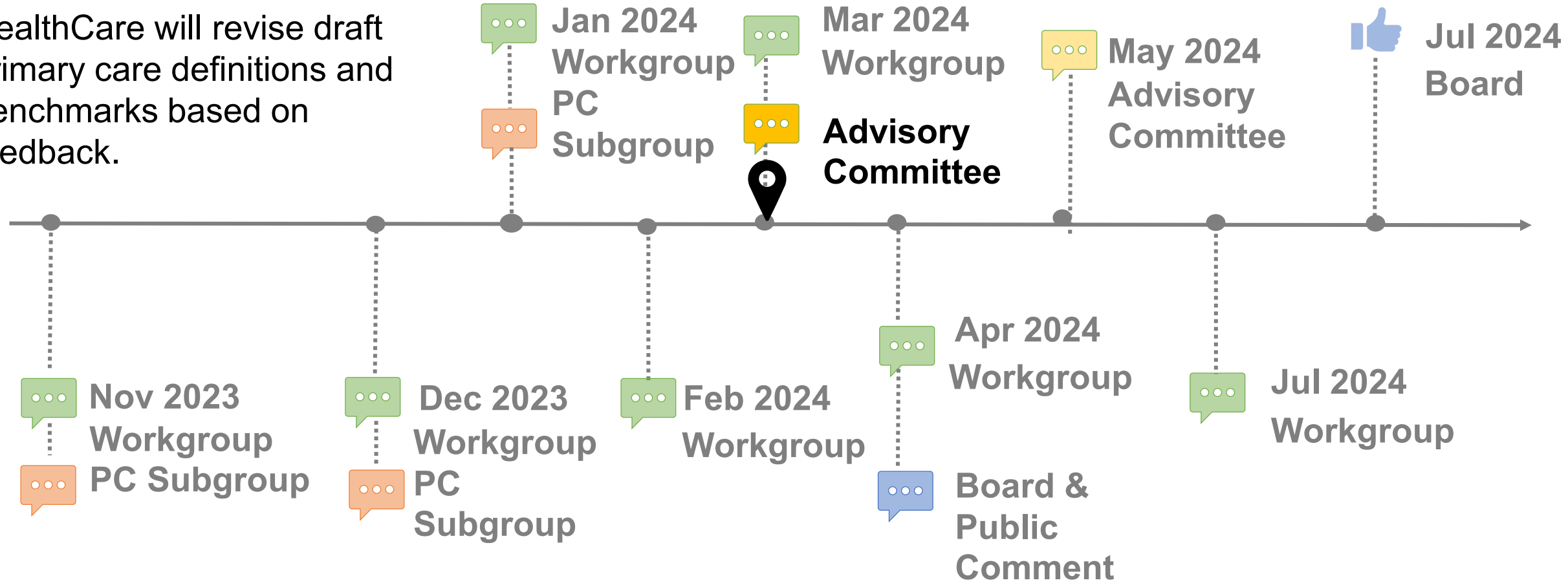
Primary Care Definition and Investment Benchmark: Draft Recommendations

Margareta Brandt, Assistant Deputy Director

Timeline for Primary Care Work

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



Primary Care & Behavioral Health Investments

Statutory Requirements

- Measure and promote a sustained systemwide investment in primary care and behavioral health.
- Measure the percentage of total health care expenditures allocated to primary care and behavioral health and set spending benchmarks. Spending benchmarks for primary care shall consider current and historic underfunding of primary care services.
- Include an analysis of primary care and behavioral health spending and growth, and relevant quality and equity performance measures, in the annual report.
- Consult with state departments, external organizations promoting investment in primary care and behavioral health, and other entities and individuals with expertise in primary care, behavioral health, and health equity.
- Benchmarks and public reporting shall consider differences among payers and fully integrated delivery systems, including plan or network design or line of business, the diversity of settings and facilities through which primary care can be delivered, including clinical and nonclinical settings, the use of both claims-based and non-claims-based payments, and the risk mix associated with the covered lives or patient population for which they are primarily responsible.

Primary Care & Behavioral Health Investments

Statutory Requirements

Promote improved outcomes for primary care, including, but not limited to, health care entities making investments in, or adopting models that do, any or all of the following:

a. Promote the importance of primary care and adopt practices that give consumers a regular source of primary care.
b. Increase access to advanced primary care models and adoption of measures that demonstrate their success in improving quality and outcomes.
c. Integrate primary care and behavioral health services, including screenings for behavioral health conditions in primary care settings or delivery of behavioral health support.
d. Leverage APMs that provide resources at the practice level to enable improved access and team-based approaches for care coordination, patient engagement, quality, and population health.
e. Deliver higher value primary care services with an aim toward reducing disparities.
f. Leverage telehealth and other solutions to expand access to primary care, care coordination, and care management.
g. Implement innovative approaches that integrate primary care and behavioral health with broader social and public health services.

OHCA's Recommended Definition of Primary Care and Approach to Measuring Claims-based Primary Care Spend

One Vision for Primary Care Delivery in California

- Accessible
- Relationship-based
- Team-based
- Comprehensive

- Person- and family- centered
- Integrated
- Coordinated
- Equitable

The Investment and Payment Workgroup noted the need for sustainable and well-resourced primary care to achieve the vision.

Advanced Primary Care: Defining a Shared Standard, April 2022. California Quality Collaborative (CQC).

Three Recommended Modules

All three modules would be included in benchmark calculation.

Primary Care Paid Via Claims	Primary Care Paid Via Non-Claims	Behavioral Health in Primary Care
• Combination of primary care provider, service, and place of service	• Allocate a portion of non-claims spend to primary care	• Screening, office visits for BH diagnosis with PCPs • Counseling, therapy when by a PCP or via integrated behavioral health

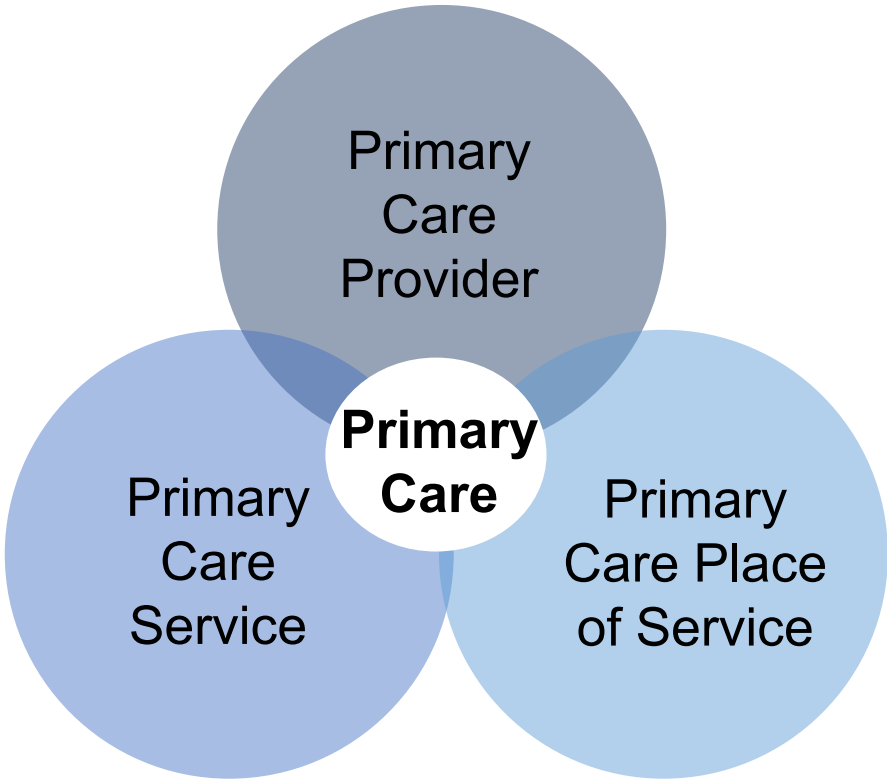
Could be added to BH or PC spend calculation.

Primary care measurement could be supplemented with additional analysis through the Health Care Payments Data program (HPD).

Defining Primary Care in Claims-Based Payments

Most Common Service Codes:
Office visits, preventive visits, vaccine admin, screenings, care coordination and management

Less Common Service Codes:
Procedures, behavioral health, maternity



Most Common Provider Types:
Family medicine, general practice, internal medicine, pediatrics, nurse practitioner(NP)/physician's assistant(PA), geriatrician, federally-qualified health center(FQHC)/rural health center(RHC)

Less Common Provider Types:
Nurse, OB-GYN, behavioral health

Most Common Places of Service (POS): Office, telehealth (home or other), walk-in retail clinic, FQHC/RHC, home

Less Common POS: Worksite, urgent care, school

Overview of Key Primary Care Investment Measurement Recommendations (Claims)

Include a narrow or broad set of providers?

- Include a broad set of providers to reflect statutory goal of team-based care.

Should the definition be limited to certain places of service?

- Include restrictions on places of service to reflect vision of continuous and coordinated care.

Include a narrow or expanded set of services, or all?

- Include an expanded set of services to encourage as much care as possible and appropriate to be delivered in a primary care setting.

Overview of Key Primary Care Investment Measurement Recommendations (Claims)

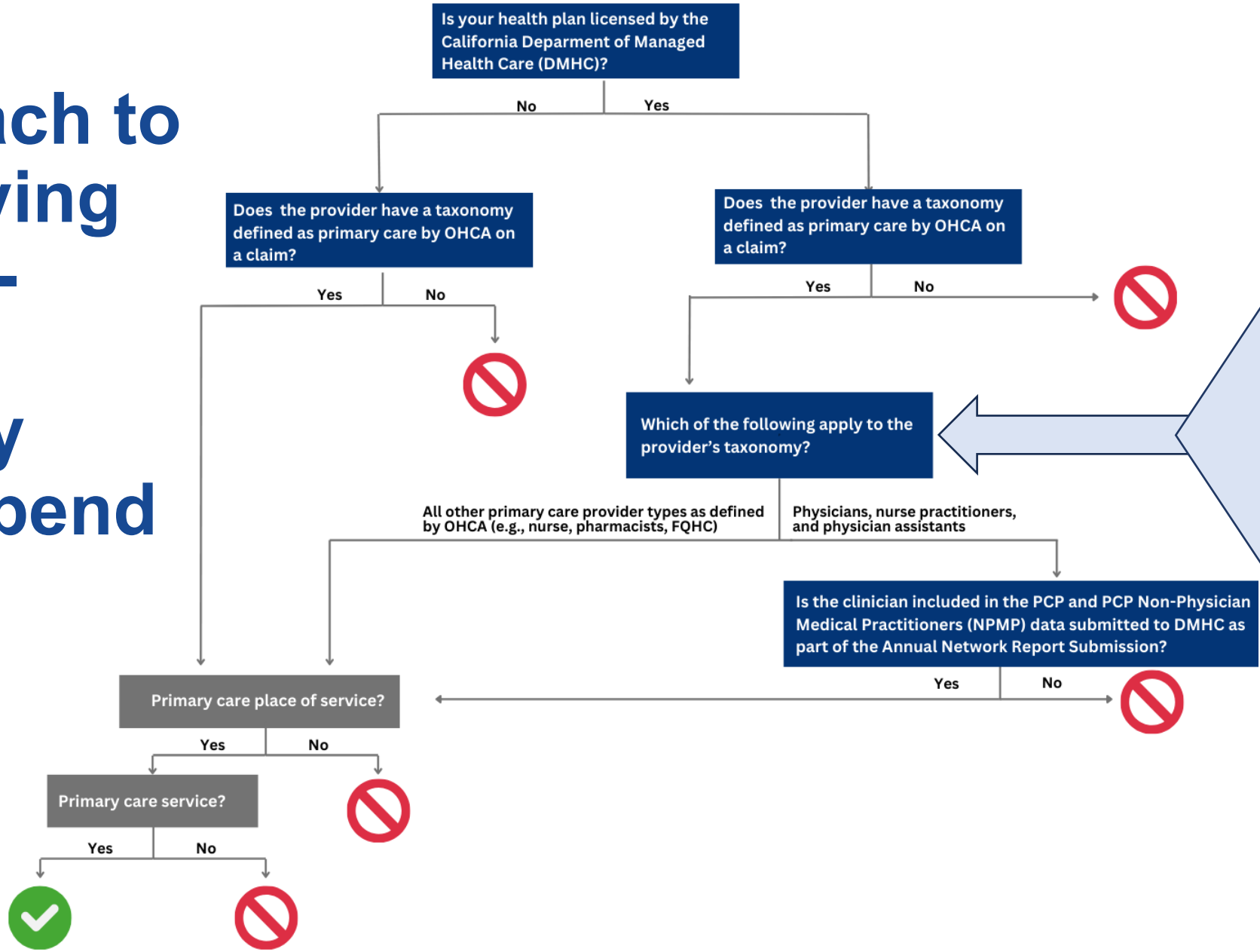
How to incorporate OB/GYN services and/or providers?

- Include some OB-GYN services to be consistent with similar services for other body systems.
- Exclude OB-GYN providers to be consistent with focus on providers caring for the whole patient (*preliminary recommendation, continuing to discuss*).

How to incorporate behavioral health services and/or providers?

- Use a modular approach to include a limited set of behavioral health services that are provided as part of primary care or integrated primary care and behavioral health.

Approach to Identifying Claims-based Primary Care Spend



For example, an internal medicine physician who is not identified as a PCP in the payer's Annual Network Report Submission is removed at this step.

Recommended Provider Taxonomies

Please note provider restrictions would be paired with place of service and service restrictions.

National Uniform Claim Committee (NUCC) Taxonomies	

• Family Medicine (General/Adult/Geriatrics)
• Internal Medicine (General/Adult/Geriatrics)
• General Practice
• Pediatrics
• Nurse Practitioner
  ○ Adult Health
  ○ Family
  ○ Pediatrics
  ○ Primary Care
• Pharmacist
• Physician Assistant, Medical
• Nurse, non-practitioner
	• Primary Care & Rural Health Clinics
	• Federally Qualified Health Center
	• Certified clinical nurse specialist
	  ○ Adult Health
	  ○ Community/Public Health
	  ○ Pediatrics
	  ○ Chronic Health
	  ○ Family Health
	  ○ Gerontology

Rationale:

- Focus on providers offering whole-person continuous, coordinated care.
- Include care team members – even those less likely to bill via claims – to acknowledge their importance. This definition also guides allocation of non-claims payments.
- Combine with service, place of service restrictions, list of PCPs in the DHMC Annual Network Report Submission to help address taxonomy imperfections.

OHCA's Preliminary Recommended Definition of Primary Care Excludes OB-GYNs

Recommendation: Include OB-GYN services when provided by a primary care provider at a primary care place of service. All services provided by an OB-GYN are excluded.

Rationale:

- Current focus on investing in providers who provide continuous whole-person care for all body systems. OB-GYNs typically do not meet this definition.
  - For example, a person who selected an OB-GYN as a primary care provider would seek treatment for a minor acute conditions such as a sinus infection from another provider.
  - Additionally, many people with chronic conditions such as hypertension and diabetes do not visit an OB-GYN for this care.

Feedback: Stakeholder feedback to date has been mixed between support for this approach as most aligned with our future vision of primary care and concerns about potential conflict with Knox-Keene Act and other policies allowing patients to select OB-GYNs as primary care providers. Some stakeholders also noted concerns regarding the impact on equity in women's health.

Example: Include or Exclude OB-GYN Providers

California's Integrated Health Association found that including OB-GYNs and selected OB-GYN services in the definition of primary care **does not have a major impact** on the overall percent of primary care spend in the commercial market.

	Current Estimated Primary Care (PC) Spend	Additional Estimated PC Spend if OB-GYNs Added for Selected PC Services
Commercial	9.9%	+ 0.3%-0.4%
Medicare Advantage	10.6%	0%

The Maine Quality Forum and the New England States Consortium Systems Organization both reported similar results when they undertook similar analyses on commercial, Medicaid and Medicare Advantage.

Integrated Healthcare Association analyses, 2024.

Approaches to Including or Excluding OB-GYN Services and Providers

People may receive certain OB-GYN services from a primary care provider and/or an OB-GYN. Below are two types of approaches commonly used in definitions.

Approach	Considerations and Trade Offs
Limited: Include a limited set of OB-GYN services such as screenings and insertion or removal of contraceptive devices when performed by a primary care provider.	• Primary care providers tend to provide few OB-GYN services. • OB-GYNs provide some primary care services, but stakeholders differ on whether they are primary care providers. • Including OB-GYNs as primary care providers results in all OB-GYN office visits being included as primary care. Most are not.
Broader: Include OB-GYNs as primary care providers and/or a broader set of OB-GYN services.	• It is difficult to determine whether certain OB-GYN services (e.g., office visits) should be included as primary care. • OB-GYNs might be most consistent source of primary care for some people, especially pregnant people. • Some broader definitions include OB-GYNs but only for a limited set of services which increases data submitter burden.

Recommended Services

Please note service restrictions would be paired with place of service and provider restrictions.

Service (HCPCS & CPT) Codes	
• Office visit • Home visit • Preventive visits • Immunization administration • Transitional care & chronic care management • Health risk assessment • Advanced care planning • Minor procedures • Interprofessional consult (e-consult) • Remote patient monitoring • Labs	• Team conference w or w/o patient • Prolonged preventive service • Domiciliary or rest home care/ evaluation • Group visits • OB-GYN Services: preventive screenings, immunizations, minor procedures including insertion/removal of contraceptive devices, maternity care.

Rationale:

- Broad set of services to promote comprehensive primary care and primary care providers working at the top of their license.
- Use in combination with other restrictions to focus on primary care spending.

Recommended Places of Service

Please note place of service restrictions would be paired with provider and service restrictions.

CMS Place of Service (POS) Codes
• Office • Telehealth • School • Home • Federally Qualified Health Center • Public Health & Rural Health Clinic • Worksite • Hospital Outpatient • Homeless Shelter • Assisted Living Facility • Group Home • Mobile Unit • Street Medicine

Rationale:

- Restrict by place of service to improve identification of primary care services.
- Include traditional, home, and community-based sites of service to promote expanded access.
- Exclude retail and urgent cares due to lack of coordinated, comprehensive primary care.

OHCA's Recommended Approach to Measuring Non-Claims Primary Care Spend

Framing the Measurement

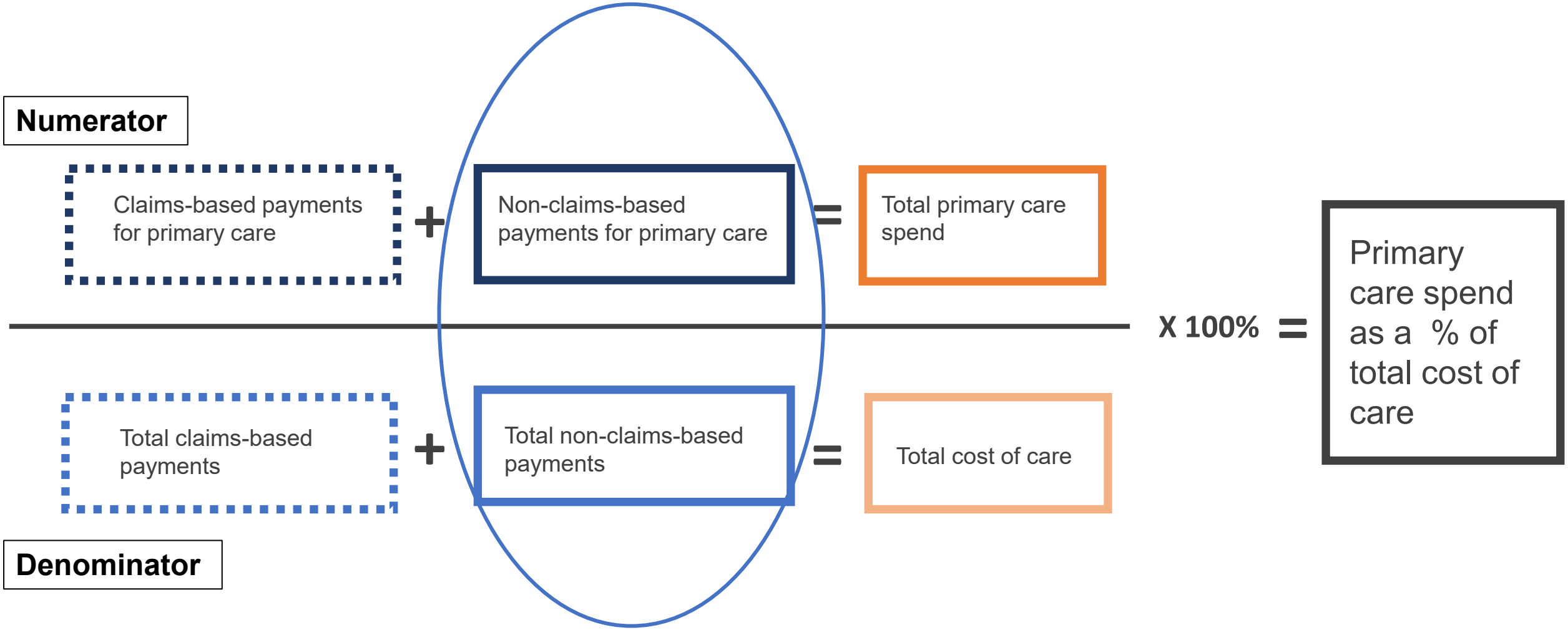
What will be measured

Money payers paid to providers in support of primary care services.

What won't be measured

Money providers spent delivering primary care services.

Measuring Primary Care Investment



Adapted from Erin Taylor, Michael Bailit, and Deepti Kanneganti. Measuring Non-Claims-Based Primary Care Spending. Milbank Memorial Fund. April 15, 2021

Data Source for Measuring Primary Care Investment

- OHCA will collect the data to measure primary care as part of its larger Total Health Care Expenditures (THCE) data collection efforts.
- Primary care spending data will include claims and non-claims payments, which will be categorized using the Expanded Framework.*
- OHCA will provide definitions, technical specifications, and technical assistance to submitters to support accurately allocating payments to primary care, particularly for non-claims payment categories.

*Available in the appendix and reviewed at the November Advisory Committee meeting: https://hcai.ca.gov/wp-content/uploads/2023/11/November-2023-HCAB-Advisory-Committee-Presentation-1.pdf

Overview of Challenges of Non-Claims Payments

- High percentage of professional and global capitation in California increases need to accurately capture non-claims payments.
- Currently, there is no standard method among states for allocating non-claims payments to primary care.
- The methods proposed today are used in other states and refined to meet the needs of California, but they are blunt instruments and not ideal. There is no ideal.
- Most non-claims payments cannot be tied to a specific (primary care) provider.
- Most non-claims payments cannot be tied to specific services, let alone primary care services.

Overview of Key Primary Care Investment Measurement Recommendations (Non-Claims)

Category 1 & 2: Population Health, Practice Infrastructure and Performance Payments

- Include payments for primary care programs such as care management, care coordination, population health, health promotion, behavioral health or social care integration; performance incentives in recognition of quality/outcomes of patients attributed to primary care providers.
- Limit the portion of practice transformation and IT infrastructure payments that “count” as primary care to 1% of total medical expense.

Category 3: Shared Savings and Recoupments

- Limit portion of risk settlement payments that “count” as primary care to the same proportion that claims-based professional spend represents as a percent of claims-based professional and hospital spending.

Overview of Key Primary Care Investment Measurement Recommendations (Non-Claims)

Category 4: Capitation Payments

- For primary care capitation, payers allocate 100% to primary care.
- For other capitation payments, data submitters calculate a fee-for-service equivalent based on a fee schedule for primary care services multiplied by the number of encounters.

Recommended Approach: Primary Care Portion of Capitation Payments

All payments for Category 4a (Primary Care Capitation)

+

Σ (# of Encounters x FFS-equivalent Fee)$_{segment}$

Subcategories 4b-4f

where *segment* is a combination of

- Year
- Geographic Region
- OHCA FFS Primary Care Definition
- Payer Type

=

Primary Care spend paid via capitation

OHCA's Recommended Primary Care Investment Benchmark

Key Decisions for Setting a Primary Care Benchmark

1. Set a single benchmark or set benchmarks by payer type?

2. Set a single benchmark across adults and pediatric populations or separate benchmarks by age group (e.g., adult, pediatrics)?

3. Set a benchmark based on the percent of total medical expense allocated to primary care or a per member, per month amount?

4. Set a relative or an absolute improvement benchmark? Or some combination?

Three Lessons Learned from Other States

1. **Sustainable delivery transformation requires multi-payer investment** to support all populations in access to high-value primary care. However, four of six states with investment requirements only focus on either commercial or Medicaid (not both), nor do they include Medicare Advantage.

2. **It is difficult to reallocate spending to fund primary care** investment in the short-term. Efforts to increase investment too quickly may be inflationary in the short-term.

3. **Increases in total cost of care hinder benchmark success.** As total cost of care increases, achieving primary care benchmarks based on percent total medical expense becomes more difficult to achieve.

How Other States Address Key Decisions

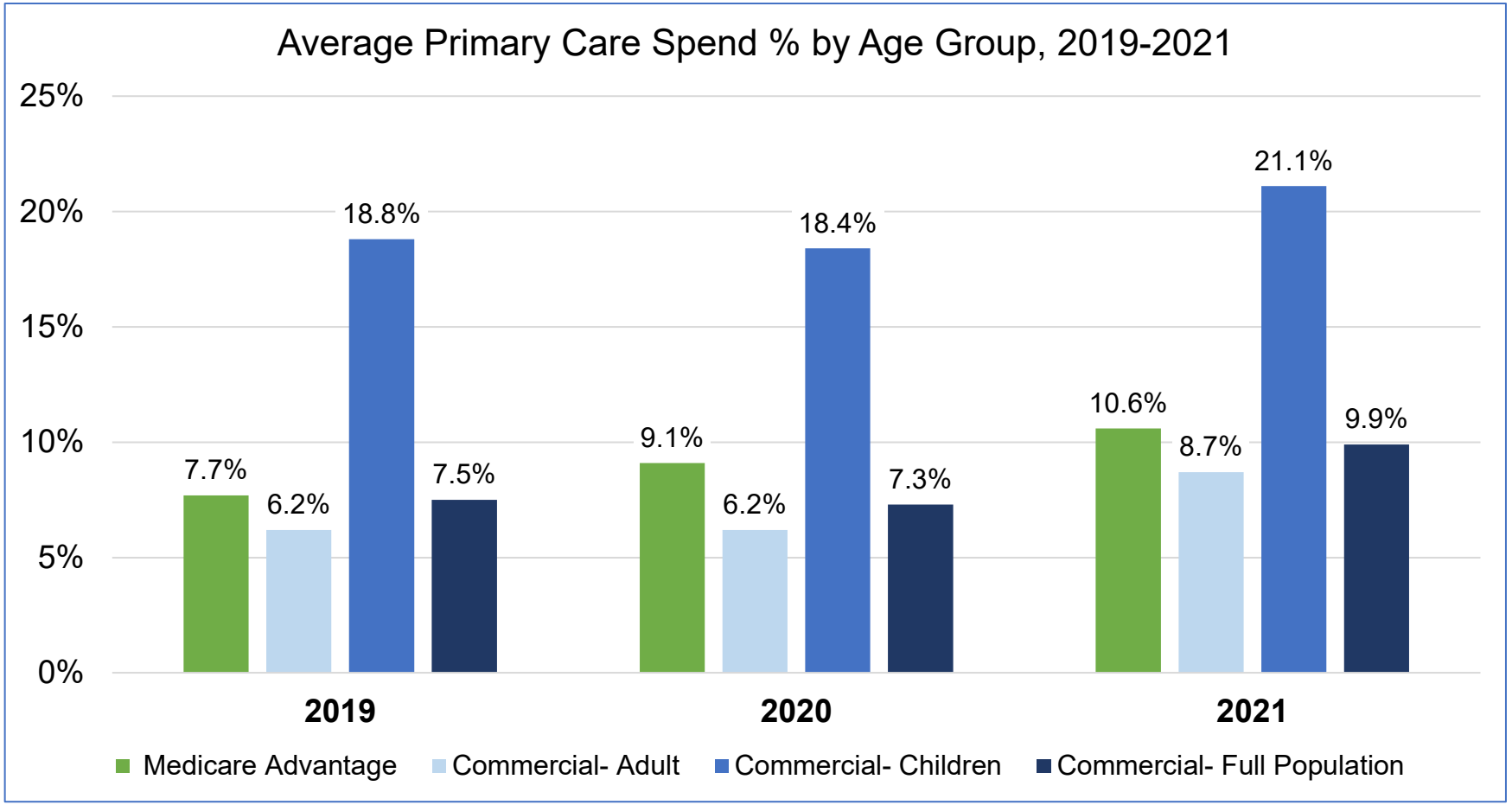
	CA*	CT	DE	RI	OR	CO
Which payer types does the benchmark apply to?	All	All	Commercial	Commercial	Commercial & Medicaid	Commercial
Single or separate benchmarks by age group?	Under discussion	Single	Single	Single	Single	Single
Percentage or Per Member, Per Month (PMPM)	%	%	%	%	%	%
Absolute or relative improvement?	Absolute (with relative)	Absolute (with stair steps)	Absolute (with stair steps)	Absolute, Previously Relative	Absolute	Relative
Benchmark/Target/ Requirement	Under discussion	10% in 2025	11.5% in 2025**	10.7%	12%	1% annually

*OHCA's preliminary recommendations.
**Primary care investment requirement only applies to members attributed to providers engaged in care transformation activities.

Maryland, North Carolina, Oklahoma and Washington also are developing primary care investment targets or benchmarks.

Example: Primary Care Spending for Children and Adults in California

- California commercial plans spent **an average of 7.3% to 9.9%** on primary care services from 2019 to 2021.
- California Medicare Advantage plans spent a similar percentage as commercial plans, with **an average of 7.7%-10.6%** spent on primary care services from 2019 to 2021.



Integrated Healthcare Association. California Commercial Primary Care Spending Results. 2019-2021. Table developed using the same methodology described in California Health Care Foundation's *Investing in Primary Care: Why it Matters for Californians with Commercial Coverage (2022).*

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Example: Medi-Cal Primary Care Spending by Population

- In 2018, Medi-Cal health plans spent **an average of 11%** on primary care services. Results were based on a study of 13 plans (27 plan-county pairs).
- While this data offers helpful direction, it was calculated using a different methodology and data source than proposed by OHCA. The OHCA methodology is likely to produce a lower result.

Table 1. Range of Primary Care Spending Across County-Specific Health Plans (*N* = 27)

POPULATION	PERCENTAGE OF STUDY POPULATION	PER MEMBER PER MONTH			PERCENTAGE		
		MINIMUM	MEAN	MAXIMUM	MINIMUM	MEAN	MAXIMUM
Adult	15.6%	$13.01	$35.87	$57.85	5.0%	11.6%	20.2%
Child	45.9%	$5.90	$20.49	$34.10	9.6%	28.2%	37.4%
ACA optional expansion	30.8%	$10.97	$32.12	$67.91	4.1%	9.7%	18.9%
SPD	7.7%	$18.67	$44.49	$123.85	2.3%	4.9%	14.7%
All	**100.0%**	**$8.85**	**$28.50**	**$61.24**	**5.0%**	**11.3%**	**18.7%**

Note: *ACA* is Affordable Care Act; *SPD* is seniors and persons with disabilities.

Source: Edrington Health Consulting analysis of CY 2019 rate development templates; direct plan submission of proprietary data, July 2022.

Draft Primary Care Investment Relative Benchmark

Payer Relative Improvement Benchmark: All payers increase primary care spending by 0.5 percentage points to 1 percentage point per year, depending on current level of investment. Payers at or above the statewide absolute benchmark may opt to maintain their primary care spend if increases are not aligned with care delivery or affordability goals.

Rationale for Level:

- Consistent with other state approaches and experiences.
- Gradual reallocation as stakeholders work towards affordability goals.

AND

A Statewide Absolute Improvement Benchmark

Draft Primary Care Investment Absolute Benchmark: Option 1

Statewide Absolute Benchmark Option 1:
California allocates 15% of total medical expense to primary care across all payers and populations by 2034.

Rationale for Level:

- Internationally, high performing health systems spend 12% to 15% of total healthcare spending on primary care.
- The recommended benchmark is slightly higher than other states, recognizing California's healthcare delivery goals, delivery system, younger population, and time horizon.

Draft Primary Care Investment Absolute Benchmark: Option 2

Statewide Absolute Benchmark* Option 2:

California allocates the following by 2034:

- *12% of total medical expense to primary care for all adults*
- *24% of total medical expense to primary care for all children*

Rationale for Level:

- Optimal primary care spend looks different for children and adults
- Primary care spending using OHCA approach likely to be lower than previously published estimates.

*OHCA is assessing the additional data submitter burden required for this approach and the additional complexity of allocating certain non-claims payments by age group.

Primary Care Definition and Investment Benchmark: Draft Recommendations

Does the Advisory Committee have any recommendations on:

1. Including or excluding OB-GYN provider taxonomies in the definition of primary care?
2. Allocating capitation payments to primary care?
3. Setting a single absolute benchmark for all ages or setting separate benchmarks for the Adult and Pediatric populations?
4. Timeframe for achieving the benchmark?

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Out-of-Pocket Out-of-Plan Spend

Vishaal Pegany
CJ Howard
KeriAnn La Spina, Senior Health Researcher, Mathematica

Definitions

Cost sharing
Member's financial responsibility including copay, coinsurance, and deductibles

+

Out-of-plan spending
Costs for services not covered by insurance & costs paid outside insurance

=

Total out-of-pocket spending*

Included in OHCA THCE

Not included in OHCA THCE

* Consumers may also pay premiums, but these costs are not included in our definition of out-of-pocket spending.

Why Measure Out-of-Plan Spending?

- The Board and Advisory raised concerns that OHCA's Total Health Care Expenditures (THCE) measure does not include out-of-plan spending.
- Some possible reasons out-of-plan spending include:
  - **Provider Preferences for Cash Payments:** Recent research suggests that a growing portion of behavioral health providers do not accept insurance, and that fewer psychiatrists accept insurance compared to other specialties.
  - **Barriers to Accessing Providers/Convenience:** Many patients struggle to find in-network providers, especially behavioral health providers, due in part to provider and prescriber shortages and delays in getting appointments.
  - **Changes in Benefit Design:** Changes in benefit design and covered services could compel more patients to seek out-of-plan care.

- Fewer providers accepting insurance reduces access to care for those unable/unwilling to self-pay and may introduce inequities in access to and quality of care.
- To shed light on the scope of this problem and its implications for potential public policy, OHCA proposes a supplemental analysis to estimate out-of-plan spending,

Sources: Bishop, Tara et al. (2014 February). *Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care*. JAMA Network.; National Alliance on Mental Illness. (2016 November). *Out-of-Network, Out-of-Pocket, Out-of-Options: The Unfulfilled Promise of Parity.;* Benjenk, I., Chen, J. (15, July 2020). *Trends in Self-payment for Outpatient Psychiatrist visits*. JAMA Psychiatry.

Estimating Out-of-Plan Spending Using the Medical Expenditure Panel Survey

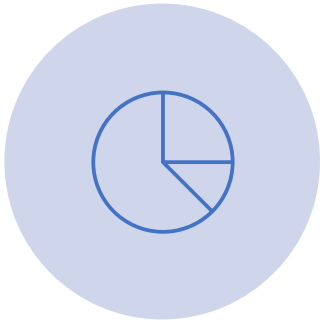
- The Medical Expenditure Panel Survey Household Component (MEPS-HC) is a nationally representative sample of the civilian noninstitutionalized population
- It includes information from consumers on health insurance coverage and healthcare utilization and costs, including out-of-pocket spending:
  - Spending in the MEPS-HC is defined for each medical event (office visit, inpatient stay, outpatient visit, etc.)
  - For each event, data shows spending by private insurance, public programs, and self-pay (out-of-pocket)
  - Each event includes type of provider, diagnosis codes, and procedure codes
- Allows for the generation of California-specific estimates, but may need to pool years to produce reliable results
- MEPS-HC out-of-pocket spending variable includes but does not differentiate payment for out-of-plan events
- OHCA will build decision rules to estimate the portion of MEPS out-of-pocket spending allocated to out-of-plan events
- OHCA is developing a methodology to estimate out-of-plan spending based on payment source and timing of medical events in MEPS-HC data.

Example of Analysis: MEPS-HC and Behavioral Health Spending

What can we measure?

- MEPS-HC can be used to estimate:
  - Out-of-plan spending for behavioral health services,
  - Out-of-plan spending for other service types
  - Out-of-plan spending as a percentage of total behavioral health spending
- The types of research questions we aim to answer:

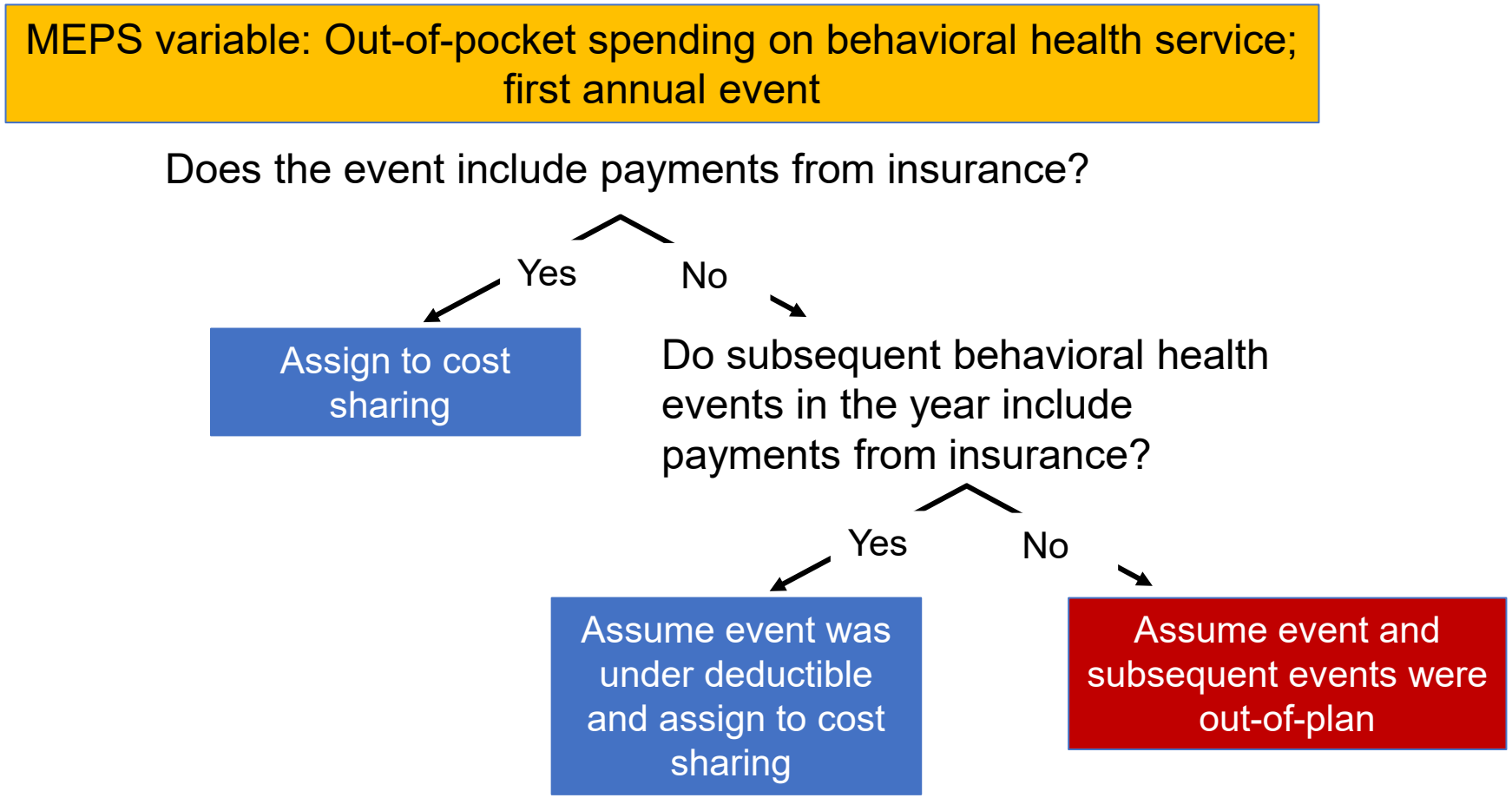
What is the level and change in out-of-plan spending for behavioral health services over time in California?



How much are Californians spending out-of-plan on behavioral health conditions compared with other types of services?

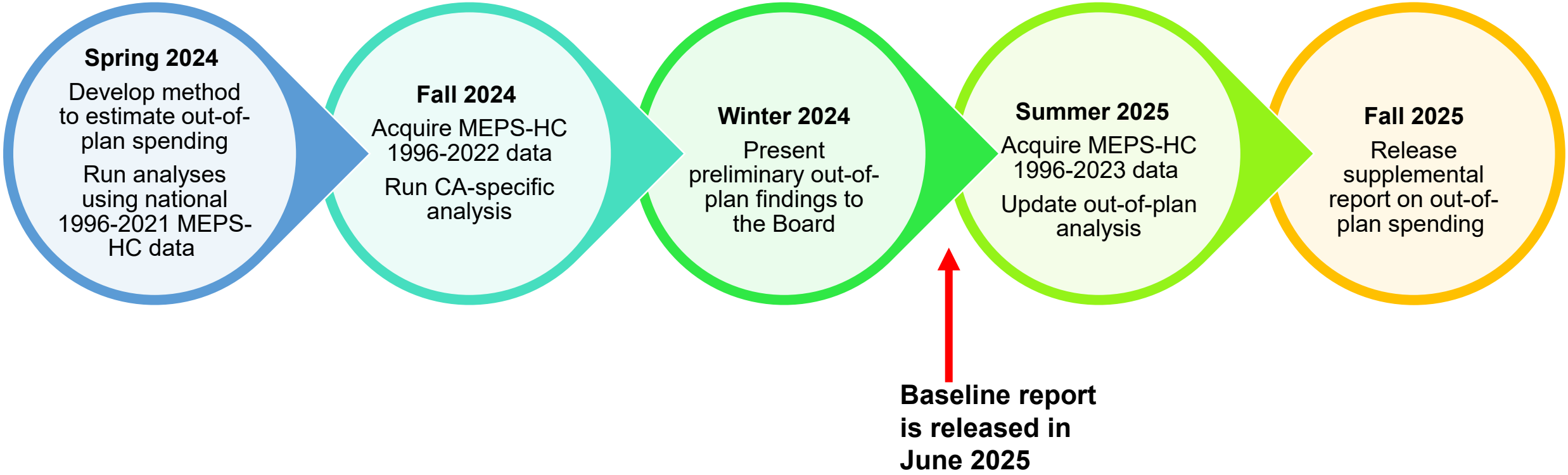
How Can We Estimate These Costs?

Example: Estimating out-of-plan behavioral health spending



Note: Method to estimate out-of-plan events still in development.

Timeline for Measuring Out-of-Plan Spending



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Examples of Cost-Reducing Strategies

Margareta Brandt, Assistant Deputy Director,
Health System Performance

Cost-Reducing Strategies Project

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

Seeking Additional Examples of Cost-Reducing Strategies

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

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

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

MemorialCare Cost-Reducing Strategies

Barry Arbuckle, PhD, President and CEO of MemorialCare

MemorialCare™

g strategies

Presented to:
Office of Healthcare Affordability
Department of Health Care Access and Information

February 28, 2024

Barry Arbuckle, PhD
President and Chief Executive Officer

An Integrated Health System

4 Hospitals: Teaching Hospital, Women's & Children's Hospital, and 2 Community Hospitals

> 100 Community-based centers including:

- **24** Imaging centers
- **32** Physical Therapy clinics
- **22** Dialysis sites (in-center and home-based)
- **12** Urgent Care centers
- **13** Breast centers
- **9** Ambulatory Surgical Centers
- **1** Co-located primary & specialty, dental practice site

~400 primary care physicians; **1,500+** affiliated specialists

A Full Knox-Keene Health Plan

An Innovation Investment Fund

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Each Year We Manage...

Inpatient Days

Emergency Room Visits

Deliveries

Hospital Surgeries

Physician Visits

Ambulatory Surgeries

Imaging Studies

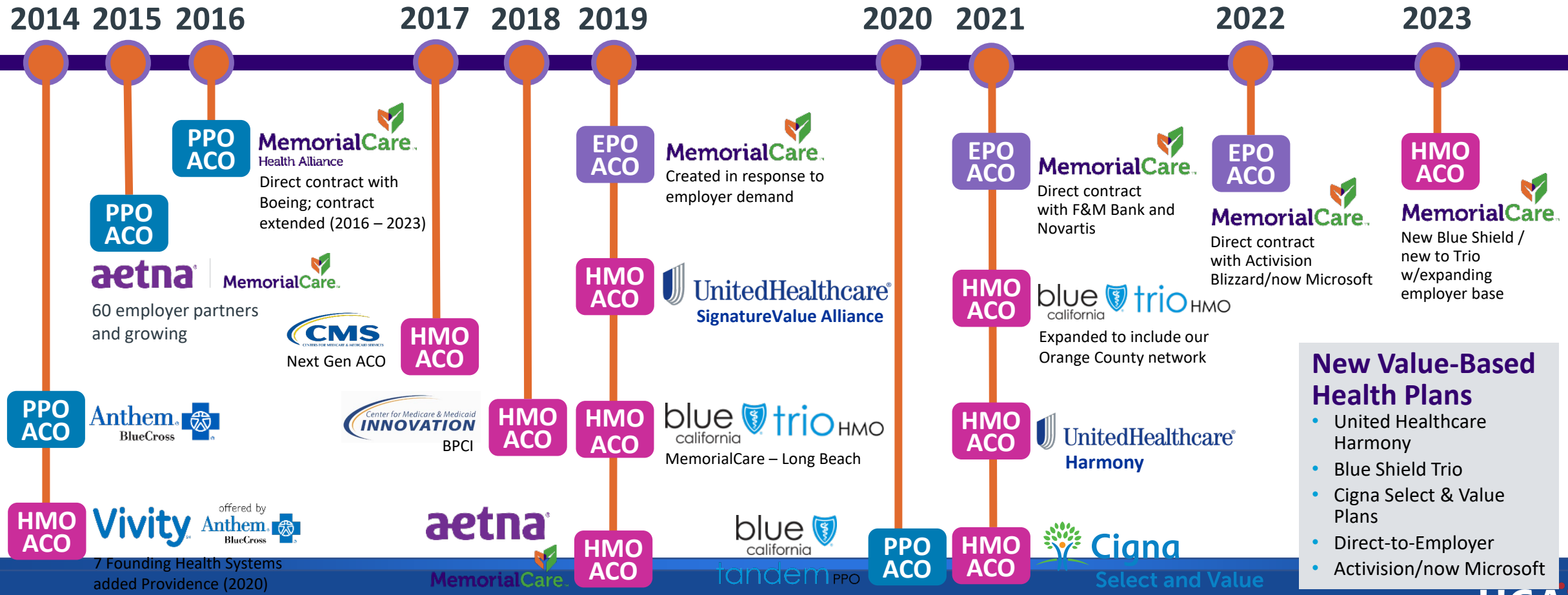
Dialysis Treatments

Physical Therapy Visits

Navigation Center Calls


Los Angeles County
Orange County
Downey
Brea
Yorba Linda
Torrance
Anaheim
Anaheim Hills
Westminster
Fountain Valley
Long Beach
Irvine
Huntington Beach
Laguna Hills
Mission Viejo
Newport Beach
Laguna Niguel
Dana Point
San Clemente
MemorialCare Medical Centers
Miller Children's & Women's Hospital Long Beach
MemorialCare Shared Services
Children's Specialty Care Centers
Urgent Care Centers
MemorialCare Medical Group
Hospital-Based Imaging Centers
Community-Based Imaging Centers
Breast Centers
Dialysis Centers
MemorialCare Surgical Centers
Community-Based Physical Therapy Centers
(Beverly Hills and West Covina Locations not shown)
Hospital-Based Physical Therapy Centers
Greater Newport Physicians MemorialCare

Value-Based Care
Health Plan Partnerships



New Value-Based Health Plans

- United Healthcare Harmony
- Blue Shield Trio
- Cigna Select & Value Plans
- Direct-to-Employer
- Activision/now Microsoft

Key Ingredients to Success

- Key Ingredients:
  - Invest in robust “ACO infrastructure” including:
    - Data, data, and data
    - Care management
    - Pharmacy management
    - Broad PCP and ambulatory access points
    - Behavioral Health
  - Patient access and engagement vehicles
  - Standardized metrics for quality and cost containment across ACOs
  - IDS committed to “real” value
  - Extensive portfolio of Virtual Care options (e.g., virtual visits, eVisits, virtual behavioral health, eConsults, remote patient monitoring)

Cost-Reducing Strategies

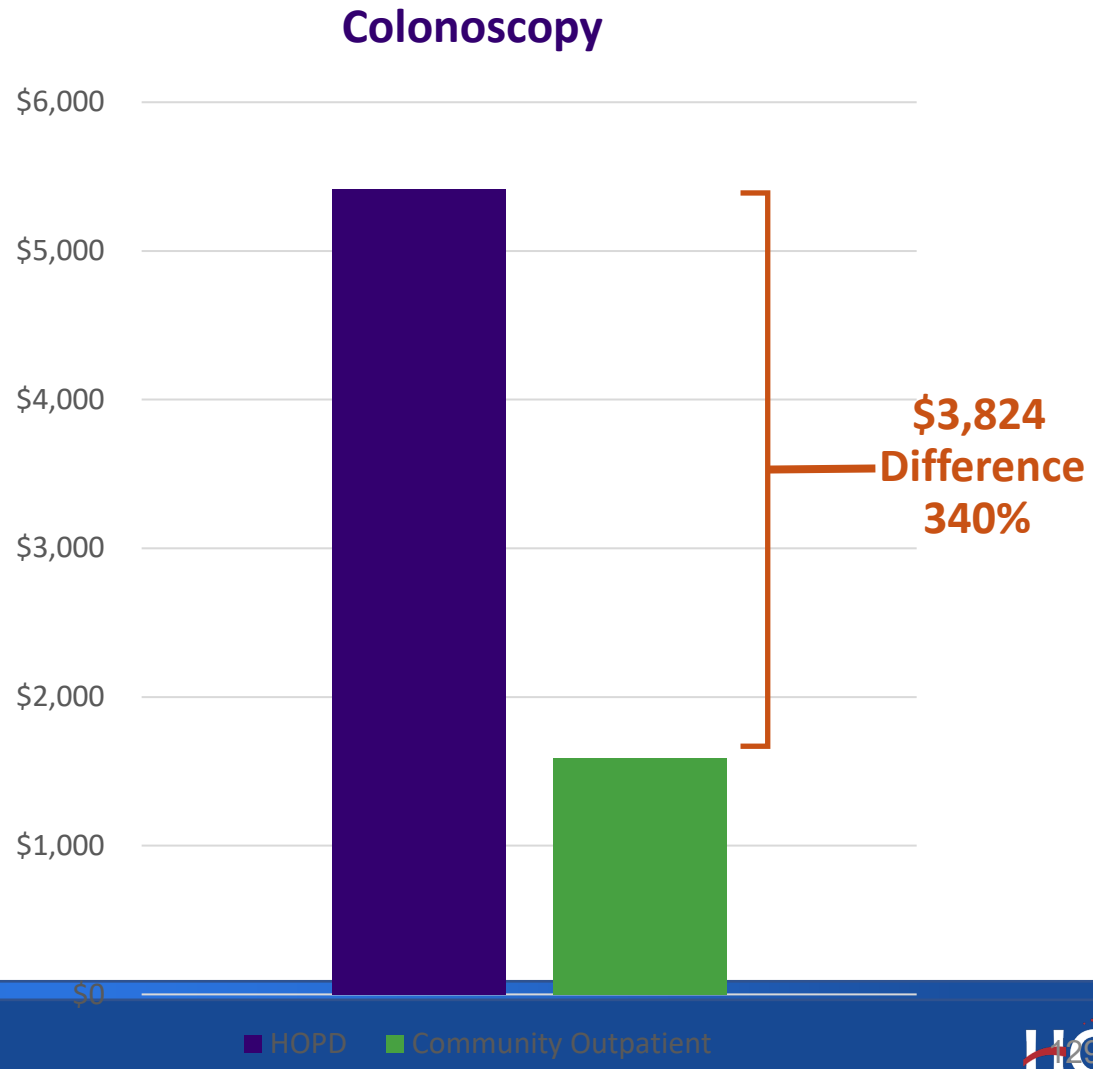
Lowering the Total Cost-of-Care through Most Appropriate Site of Care

- Outpatient procedures (imaging, surgery, testing, therapies, other) can be done in:
  1) Hospital Outpatient Departments (HOPD)
  2) Community-Based Ambulatory Centers
- Cost to payer/employer can vary considerably between HOPDs and community-based ambulatory centers
- Clinical criteria can (does) determine which setting is most appropriate for the patient
- CMS uses a '*blunt instrument*' of site neutrality

What is Right for the Patient Determines Right Site of Care

- Clinical Rationale for use of HOPD
  - *(not all inclusive)*

- Patient is moderately to morbidly obese
- Patient has multiple co-morbidities
- Patient with certain drug allergies



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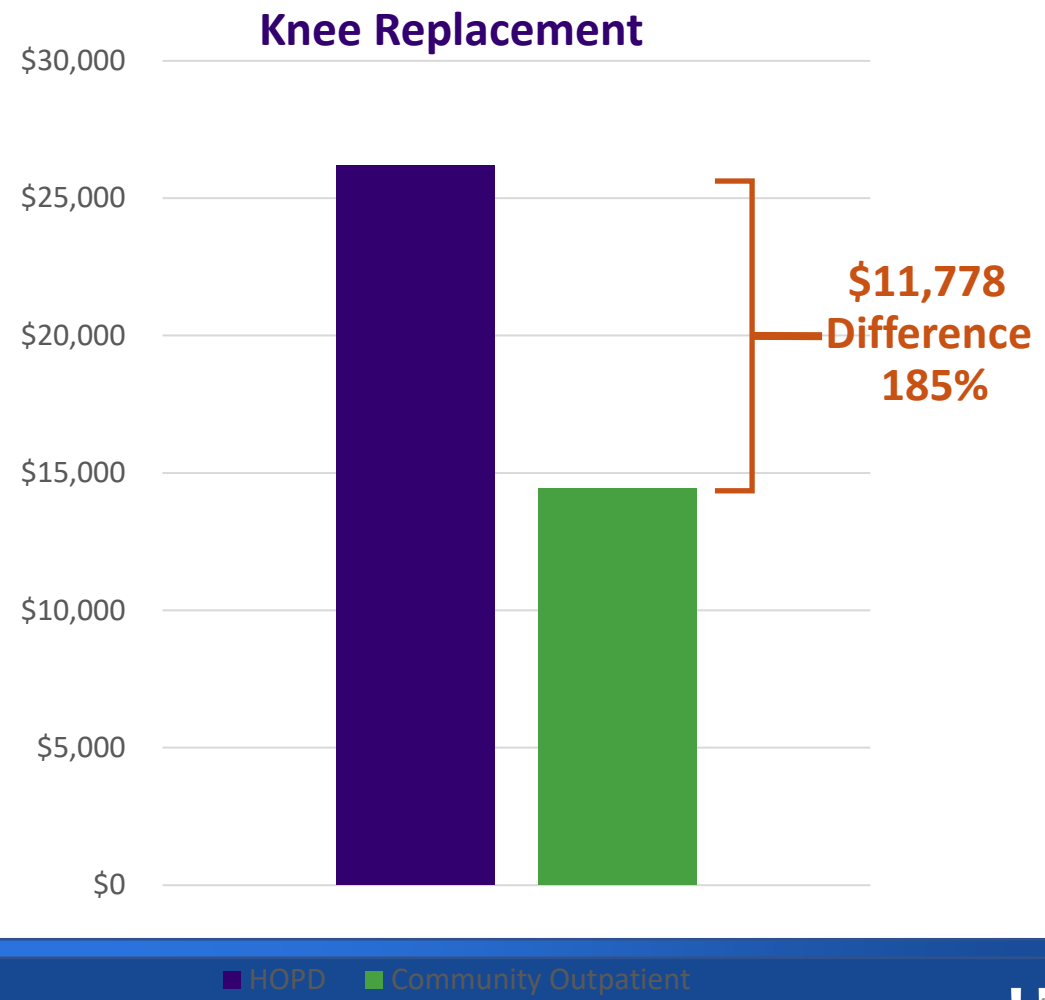
What is Right for the Patient Determines Right Site of Care

- Clinical Rationale for use of HOPD
  - *(not all inclusive)*

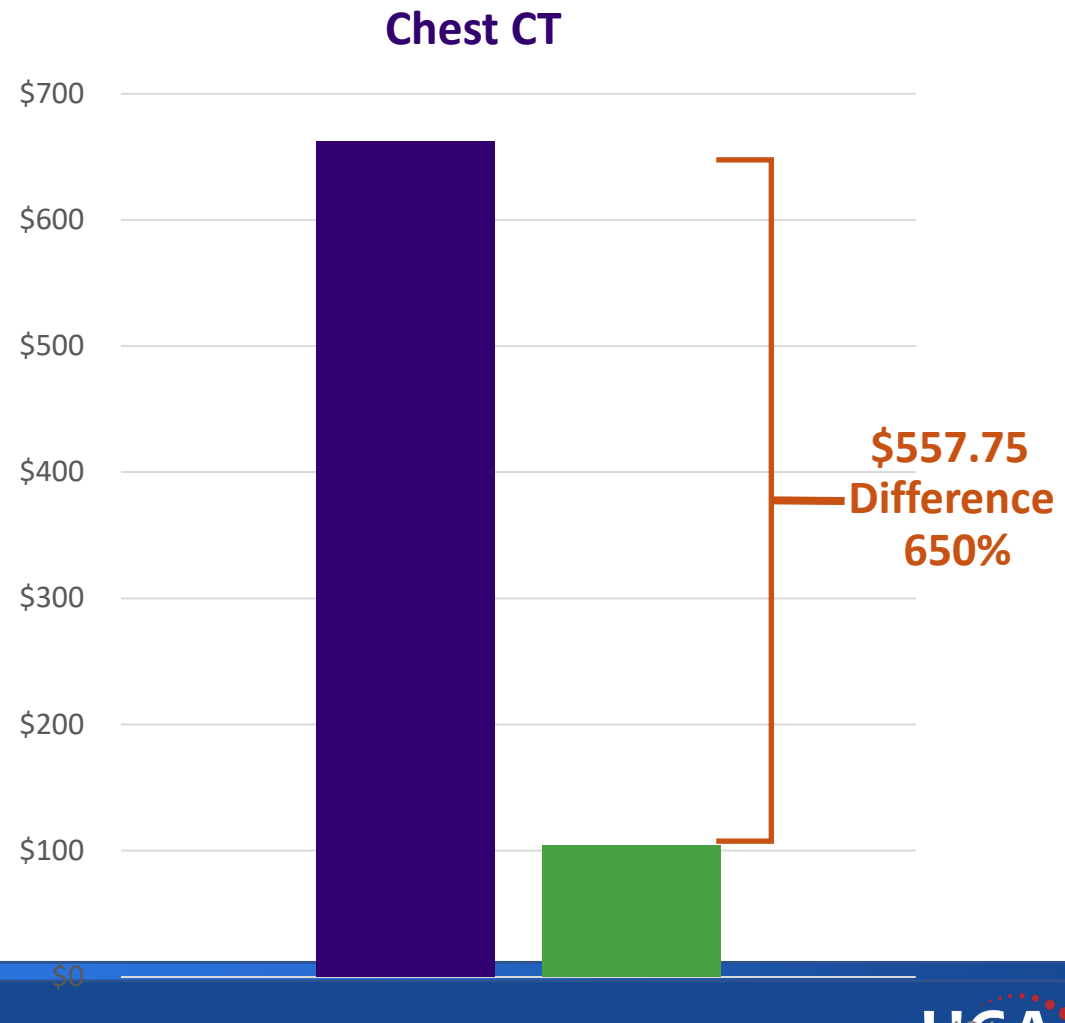
- Patient has multiple co-morbidities
- Patient has history of difficulty with anesthesia



What is Right for the Patient Determines Right Site of Care

- Clinical Rationale for use of HOPD
  - *(not all inclusive)*

- Patient requires obstetrical or perinatal observation
- Patient has known contrast allergy
- Patient is under age 18
- Patient has multiple co-morbidities including obesity



Accounting for the price delta…

- HOPDs are licensed under/operated by hospitals which must be available 24/7/365
- Regulatory and Compliance requirements drive up the cost
  - e.g., Installing/Maintaining the SAME equipment in a hospital environment costs 30%-100% more than at a community site (e.g., an imaging center in a strip mall)
- Patient condition and the resources required to care for them
- Hospitals take all comers
- Specialty physician costs for required coverage are skyrocketing due to physician shortages, more opportunities in the ambulatory sector, etc.

Barriers and Challenges

- Hospitals and Health Systems
- Many have not invested in a robust network of community-based ambulatory sites
- In FFS contracts, the ‘value’ created by investing in this network accrues to another entity (e.g., health plan)
- Challenges in integrating patient records across sites of care
- Some/many community-based ambulatory sites do not accept certain insurance coverage
- Other Challenges
- Clinical criteria to determine site of care has many gaps (some health plans have no published criteria) and has been slow to evolve

A Final Word

- The Office of Healthcare Affordability goal of increasing adoption of Alternative Payment Models (APM) where provider reimbursement is at-risk, shifting away from FFS, will accelerate *right site of care* - once a substantial portion of providers' reimbursement is in HCP-LAN Categories 3B, 4A, 4B, or 4C.
- Until then, accelerating the establishment/proliferation of clinical criteria published by the health plans will move the dial.

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General Public Comment

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

Next Advisory Committee Meeting:

May 14, 2024
10:00 a.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

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Adjournment

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Appendix:

Primary Care Definition and Investment Benchmark

Investment and Payment Workgroup Members

Providers & Provider Organizations

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

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

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

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

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

Janice Rocco
Chief of Staff, California Medical Association

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

Academics/ SMEs

Sarah Arnquist, MPH
Principal Consultant, SJA Health Solutions

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

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

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

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

State & Private Purchasers

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

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

Monica Soni, MD
Chief Medical Officer, Covered California

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

Consumer Reps & Advocates

Beth Capell, PhD
Contract Lobbyist, Health Access California

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

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

Hospitals & Health Systems

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

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

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

Health Plans

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

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

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

Mohit Ghose
State Affairs, Anthem

Recap: Expanded Framework, Categories 1-3

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
1	**Population Health and Practice Infrastructure Payments**	
a	Care management/care coordination/population health/medication reconciliation	2A
b	Primary care and behavioral health integration	2A
c	Social care integration	2A
d	Practice transformation payments	2A
e	EHR/HIT infrastructure and other data analytics payments	2A
2	**Performance Payments**	
a	Retrospective/prospective incentive payments: pay-for-reporting	2B
b	Retrospective/prospective incentive payments: pay-for-performance	2C
3	**Payments with Shared Savings and Recoupments**	
a	Procedure-related, episode-based payments with shared savings	3A
b	Procedure-related, episode-based payments with risk of recoupments	3B
c	Condition-related, episode-based payments with shared savings	3A
d	Condition-related, episode-based payments with risk of recoupments	3B
e	Risk for total cost of care (e.g., ACO) with shared savings	3A
f	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B

Freedman HealthCare supported the California Department of Health Care Access and Information in developing the Expanded Non-Claims Payment Framework. The framework builds on the work of Bailit Health and the Milbank Memorial Fund and the Health Care Payment Learning and Action Network.

Recap: Expanded Framework, Categories 4-6

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
4	**Capitation and Full Risk Payments**	
a	Primary Care capitation	4A
b	Professional capitation	4A
c	Facility capitation	4A
d	Behavioral Health capitation	4A
e	Global capitation	4B
f	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C
5	**Other Non-Claims Payments**	
6	**Pharmacy Rebates**	

Example: Include or Exclude OB-GYN Providers

- Maine Quality Forum's 3rd Annual Primary Care Spending Report assessed the impact of including OB/GYN providers and selected primary care procedures on primary care spending.

- Including OB/GYNs as primary care providers had **minimal impact** (<0.5%) on the total primary care spending estimates, regardless of the payer type or whether a "broad" or "narrow" definition was used.

Table 4. Primary Care as Percentage of Total Spending if OB/GYN Providers for Selected Services are Omitted vs Included, Broad and Narrow Definitions, 2020

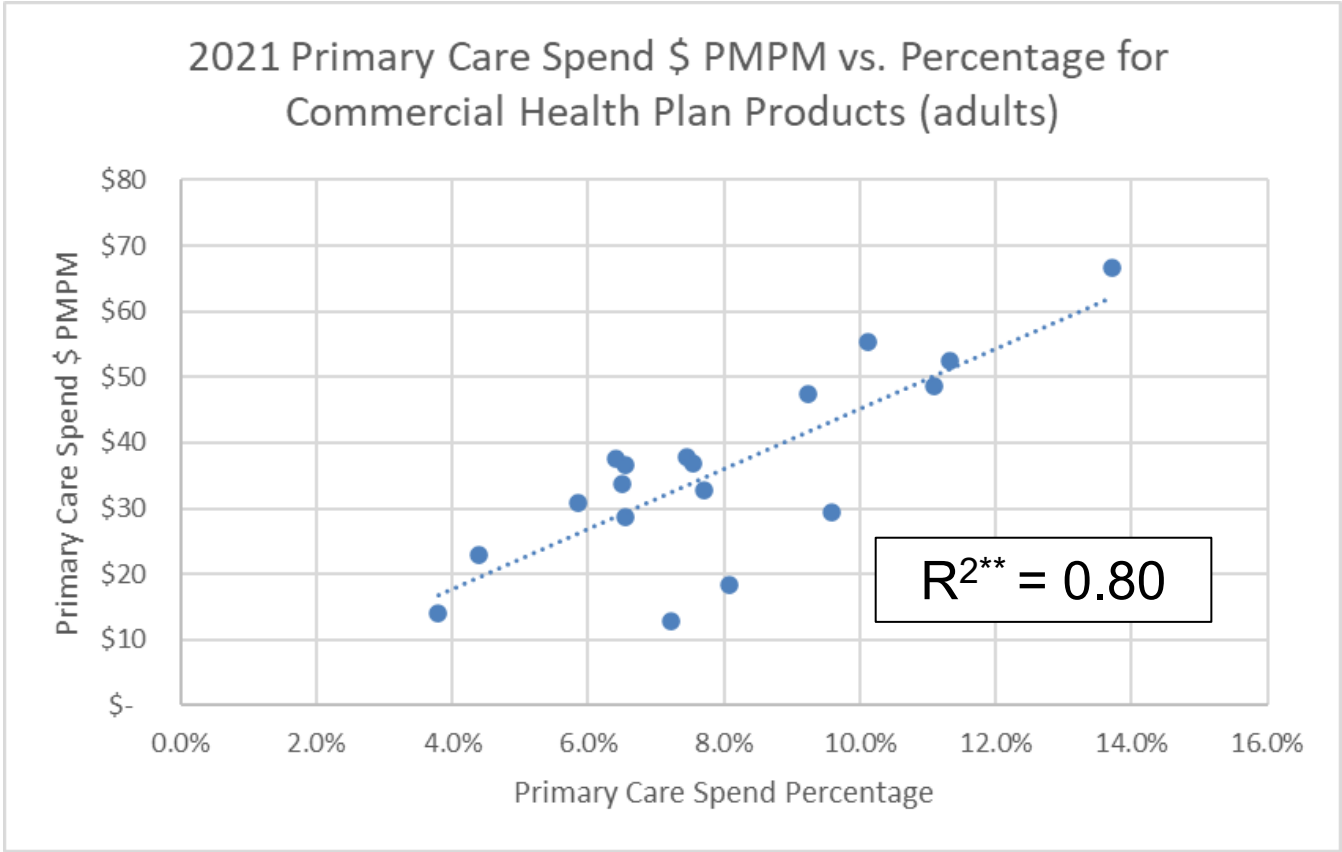
	Commercial		MaineCare		Medicare	
Definition	**OB/GYN for selected services OMITTED**	**OB/GYN for selected services INCLUDED (Current Definitions)**	**OB/GYN for selected services OMITTED**	**OB/GYN for selected services INCLUDED (Current Definitions)**	**OB/GYN for selected services OMITTED**	**OB/GYN for selected services INCLUDED (Current Definitions)**
Broad Definition	10.1%	10.4%	10.6%	10.8%	7.3%	7.3%
Narrow Definition	4.9%	5.3%	7.4%	7.5%	4.5%	4.5%

Data Source: MHDO APCD claims data; Reported medical spending reflects plan paid amounts

The Integrated Healthcare Association in California and the New England States Consortium Systems Organization both reported similar results when they undertook similar analyses.

Example: Percent of Spending vs. Per Member, Per Month

- Integrated Healthcare Association completed additional analysis using the same methodology as in its report discussed on slide 30. It showed primary care spending on a percentage basis and as a per member, per month amount are highly correlated.
- The graph shows 18 commercial plan-product data points for 2021 comparing spending when measured as percent of total spending vs. a per member per month amount.



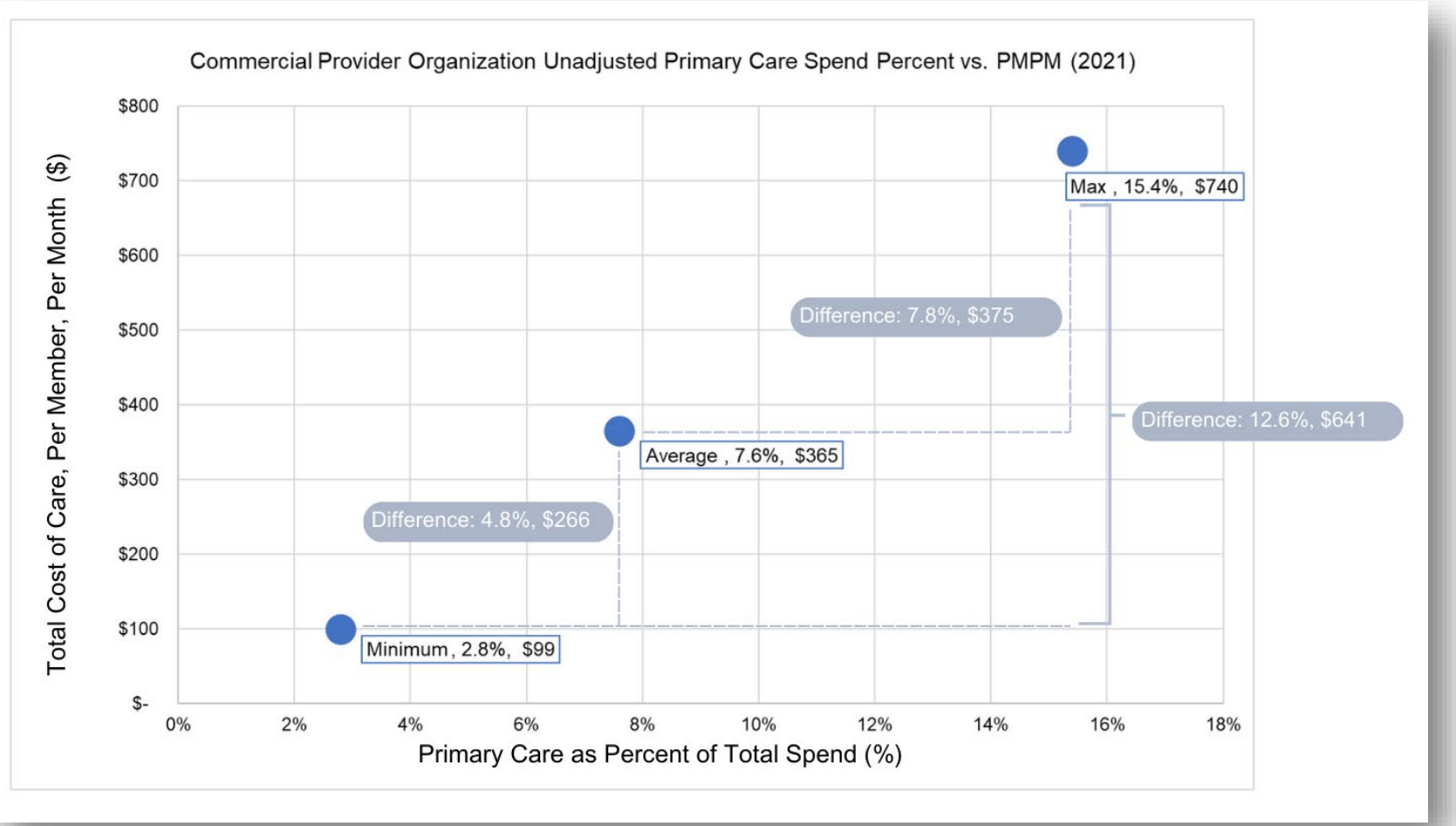
*OHCA is recommending that per member, per month spending also is monitored.

**R^2 measures the strength of the relationship between the model and the dependent variable on a 0-1.0 scale.

Example: Variation in Primary Care Spend in California

- The IHA primary care spend analysis found the percentage of primary care spending varied more than twofold among provider organizations, from a minimum of 2.8% to a maximum of 15.4%.

- Primary care spending for Medi-Cal plans also showed variation, ranging from 5% - 18.7%.



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Appendix:

Key Informant and Stakeholder Interviews to Inform Workforce Stability Standards

Key Informant & Stakeholder Interviewees

Academics & Content Experts

David Auerbach, PhD
Senior Director for Research and Cost Trends,
Massachusetts Health Policy Commission

Bianca Frogner, PhD
Professor of Family Medicine, Director of University of Washington Center for Health Workforce Studies

Polly Pittman, PhD
Professor of Health Workforce Equity, Director of Institute for Health Workforce Equity at George Washington University

University of North Carolina – Chapel Hill, Health Workforce Research Center

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

Hemi Tewarson, JD, MPH*
Executive Director, National Academy for State Health Policy

Laurel Lucia, MPP*
Director, Health Care Program at UC Berkeley Labor Center

Paul Kumar
Health Policy and Finance Consultant

BJ Bartleson, MS, RN
Health Policy RN Consultant

Michael Bailit, MBA
President, Bailit Health

Organized Labor

Joan Allen*
Government Relations Advocate, SEIU United Healthcare Workers West

Ian Lewis
Policy Director, National Union of Healthcare Workers

Janice O'Malley
Legislative Advocate, American Federation of State, County and Municipal Employees (AFSCME)

California Nurses Association (CNA)/National Nurses United

Consumer Representatives & Advocates

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

Anthony Wright
Executive Director,
Health Access California

Beth Capell, PhD
Contract Lobbyist,
Health Access California

Health Care Entities & Associations

California Hospital Association (CHA)

Katie Rodriguez, MPP
Senior Director of Policy, California Association of Public Hospitals & Health Systems (CAPH)

Nataly Diaz, MBA*
Director of Health Center Operations, California Primary Care Association (CPCA)

Kaiser Permanente

Sutter Health

Plumas District Hospital

Workforce Stability Standards Interviewees

Academics/Content Experts

- Massachusetts Health Policy Commission: David Auerbach
- George Washington University: Polly Pittman
- California Health Care Foundation (CHCF): Kathryn Phillips, Kara Carter
- UC Berkeley Labor Center: Laurel Lucia, Ken Jacobs, Miranda Dietz
- University of Washington: Bianca Frogner
- University of North Carolina, Chapel Hill
- National Academy for State Health Policy: Hemi Tewarson, Elaine Chhean, Maureen Hensley-Quinn
- Bailit Health: Michael Bailit
- Consultants: BJ Bartleson, Paul Kumar

Workforce Stability Standards Interviewees

Organized Labor

- SEIU United Healthcare Workers West: Joan Allen, Denise Tugade
- National Union of Healthcare Workers: Ian Lewis
- American Federation of State, County, and Municipal Employees (AFSCME): Janice O'Malley
- California Nurses Association (CAN)/National Nurses United

Consumer Representatives & Advocates

- California Pan-Ethnic Health Network (CPEHN): Cary Sanders, Andrea Mackey
- Health Access California: Anthony Wright, Beth Capell

Workforce Stability Standards Interviewees

Health Care Entities

- California Hospital Association (CHA)
- California Association of Public Hospitals & Health Systems (CAPH): Katie Rodriguez
- California Primary Care Association (CPCA): Nataly Diaz, Cindy Keltner, Isa Iniguez, Araceli Valencia
- Plumas District Hospital
- Sutter Health
- Kaiser Permanente

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Appendix:

Organization Level Workforce Stability Metrics

Draft Workforce Stability Metrics for Hospitals

Data Source	HCAI Hospital Annual Financial Disclosure Reports	
Occupations	• Technical and specialist staff • Registered nurses • Licensed vocational nurses • Aides and orderlies • Clerical & other administrative staff	• Environmental & food service staff • Other staff • Registry nursing personnel • Other contracted staff
Metrics	• Average hours per patient day for daily hospital services over the fiscal year, for each occupation • Average hours per emergency department visit over the fiscal year • Average hours per clinic visit over the fiscal year • Average hours per clinical laboratory test over the fiscal year • Average hourly pay rate for daily hospital services, per occupation • Average hourly pay rate for ambulatory services, per occupation • Average hourly pay rate for ancillary services, per occupation	• Contract nursing personnel hours divided by total nursing hours, for daily hospital services, over the fiscal year • Average hourly rate of contract nursing personnel divided by average hourly rate of staff registered nurses • Salaries, wages, and benefits costs as percentage of total operating expenses • Salaries & wages per adjusted patient day • Benefits per adjusted patient day

Draft Workforce Stability Metrics for Nursing Homes and Skilled Nursing Facilities

Data Source	**HCAI Long-term Care Facility Integrated Disclosure and Medi-Cal Cost Report Data**	
Occupations	• Geriatric nurse practitioners • Registered nurses • Licensed vocational nurses • Nurse assistants • Technicians and specialists • Psychiatric technicians • Other	• Social workers • Activity program leaders • Housekeeping • Laundry and linen • Dietary • Social services • Activity staff
Metrics	• Productive hours per resident day, overall and for selected departments • Average wages • Percent of total hours from temporary staff, overall and by occupation • Labor turnover • Personnel costs as percentage of total operating expenses	

Draft Workforce Stability Metrics for Community Clinics

Data Source	HCAI Primary Care Clinic Annual Utilization Data	
Occupations	• Visiting nurses • Registered dental hygienists – alt practice • Licensed clinical social workers • Other billable providers • Other Comprehensive Perinatal Services Program (CPSP) providers • Registered dental hygienists (not alt practice) • Registered dental assistants • Marriage and family therapists	• Registered nurses • Licensed vocational nurses • Medical assistants • Patient education staff • Substance abuse counselors • Billing staff • Other admin staff
Metrics	• Staff full-time equivalents (FTEs) • Contract FTEs • Volunteer FTEs • Staff FTEs as percent of total FTEs • Staff FTEs per patient encounter	

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Appendix:

Market Level Workforce Stability Metrics

Draft Workforce Stability Metrics for Supply, Employment, and Diversity of Licensed Health Professionals

Data Source	California Licensure Board records and HCAI license renewal surveys	
Geographic Level	• Statewide • Census Bureau-defined Core Based Statistical Areas (CBSAs) and Combined Statistical Areas (CSAs) • Counties • California Economic Strategy Panel regions	
Occupations	• Physician Assistants • Advanced Practice Registered Nurses • Registered Nurses • Licensed Vocational Nurses • Licensed Clinical Social Workers • Licensed Marriage and Family Therapists • Licensed Professional Clinical Counselors	• Occupational Therapists • Physical Therapists • Psychologists • Respiratory Therapists • Clinical Laboratory Scientists • Medical Laboratory Technicians
Metrics	• Number licensed • Age distribution • Race/ethnicity • Gender identity • Current employment status • Languages spoken	• Self-identified disability status • Average number of hours worked per week • Primary practice setting • Secondary practice setting • Retirement plans

Draft Workforce Stability Metrics for Employment and Diversity of Unlicensed Health Care Workers

Data Source	US American Community Survey	
Geographic Level	• Statewide • Large counties	
Occupations	• Nursing, psychiatric, and home health aides • Occupational and physical therapist assistants and aides • Other healthcare support occupations • Substance abuse and behavioral disorder counselors	
Metrics	• Number employed • Gender • Race/ethnicity • Age distribution • Presence of self-care, ambulatory, and cognitive difficulties	• Languages spoken • Total earnings • Wage or salary income in past 12 months • Usual hours worked per week

Draft Workforce Stability Metrics for Employment and Wages of Health Care Workers

Data Source	**US Occupational Employment and Wage Statistics**
Geographic Level	• Statewide
Occupations	• Dietitians and Nutritionists • Physician Assistants • Occupational therapists • Physical therapists • Radiation therapists • Respiratory therapists • Speech-language pathologists • Registered nurses • Nurse anesthetists • Nurse midwives • Nurse practitioners • Audiologists • Dental hygienists • Clinical laboratory techs • Cardiovascular techs • Diagnostic medical sonographers • Nuclear medicine techs • Radiologic techs • Magnetic resonance imaging techs • Emergency medical techs • Paramedics • Dietetic technicians • Pharmacy techs • Psychiatric techs • Surgical techs • Ophthalmic medical techs • Licensed vocational nurses • Medical records specialists • Opticians, dispensing • Orthotists and prosthetists • Hearing aid specialists • Health techs, all other • Surgical assistants • Home health and personal care aides • Nursing assistants • Orderlies • Psychiatric aides • Occupational therapy assistants • Occupational therapy aides • Physical therapist assistants • Physical therapist aides • Dental assistants • Medical assistants • Medical equipment preparers • Medical transcriptionists • Pharmacy aides • Phlebotomists • Health care support workers, all other
Metrics	• Employment • Median hourly wage • Mean hourly wage • Annual mean earnings

Draft Workforce Stability Metrics for Health Worker Graduates

Data Source	US Integrated Postsecondary Education Data System
Geographic Level	• Statewide • Census Bureau-defined Core Based Statistical Areas (CBSAs) and Combined Statistical Areas (CSAs) • Counties • California Economic Strategy Panel regions
Occupations	• Dozens of program classifications, in category “51. Health Professions and Related Clinical Services” and “42.28 Clinical Psychology,” and “44.07 Social Work”
Metrics	• Awards/degrees conferred • Awards/degrees by race/ethnicity • Awards/degrees by gender • Awards/degrees to non-US-residents

Draft Workforce Stability Metrics for Supply and Employment of Registered Nurses

Data Source	California Board of Registered Nursing (BRN) Biennial Survey of Registered Nurses	
Geographic Level	• Statewide • California BRN regions (based on California Economic Strategy Panel regions)	
Occupations	• Registered nurses	
Metrics	• Job satisfaction • Profession satisfaction • Hours worked per day • Hours worked per week • Overtime per week • On call hours per week • Employment intentions • Employment relationship in principal position • Hours worked in principal position • Job title in principal position • Total annual earnings in principal position	• Benefits provided by principal position • Data on additional nursing jobs • For those not working: year last worked • For those not working: why not working • For those not working: employment intentions • Change in employers, positions, or intensity of work • Country of birth • Location of RN education

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