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Department of Health Care Access and Information

Health Care Affordability Board Meeting

March 25, 2024

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Welcome, Call to Order, and Roll Call

Agenda

1. **Welcome, Call to Order, and Roll Call**
   Secretary Mark Ghaly, Chair

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

3. **Action Consent Item**
   Vishaal Pegany
   a) Approval of the February 28, 2024 Meeting Minutes

4. **Informational Item**
   Elizabeth Landsberg, Vishaal Pegany, CJ Howard, Assistant Deputy Director, and Michael Bailit, Bailit Health
   a) Statewide Spending Target Including Public Comments, Advisory Committee Feedback, Board Follow-up Items, and Consideration of Medi-Cal Spending

5. **Public Comment**

6. **Adjournment**

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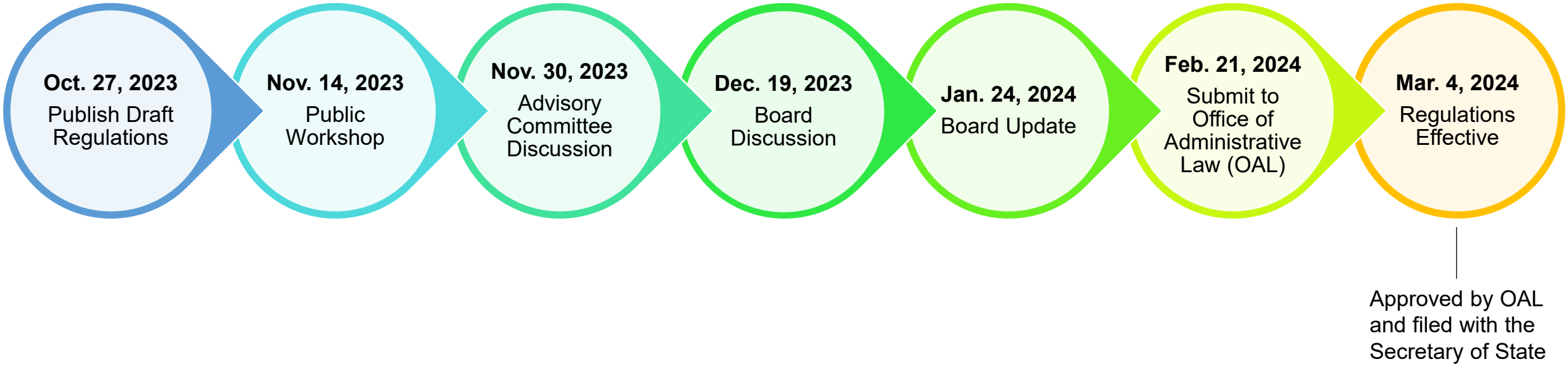
Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

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

THCE Rulemaking Timeline



Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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Public Comment

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Action Consent Item: Approval of the February 28, 2024 Board Meeting Minutes

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Informational Item

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Statewide Spending Target Including Public Comments, Advisory Committee Feedback, Board Follow-up Items, and Consideration of Medi-Cal Spending

Elizabeth Landsberg, Vishaal Pegany
CJ Howard, Assistant Deputy Director
Michael Bailit, Bailit Health

Board Follow-Up Items

Today's Follow-Up Items

During today's Board meeting, we will provide information regarding:

1. Integrated Healthcare Association's (IHA) total cost of care data (TCC).
2. Estimate of number of entities subject to the target when it becomes enforceable.

Integrated Healthcare Association (IHA): Total Cost of Care (TCC) Data

Learning from IHA's Total Cost of Care Data

At the February Board meeting, OHCA received a request for additional information about IHA's total cost of care data.

- OHCA has reviewed data on California's commercial market from the IHA Atlas tool and summarized key findings.
- In summary, available data from IHA on total cost of care between 2017 and 2021 (the years for which consistent TCC data is available):
  - Align with OHCA's findings on the 5-year rate of growth in statewide spending for health care (caveat that the measures and populations are not identical).
  - Demonstrate substantial variation in growth rate from year to year, by product type, and by geography.
  - Highlight the feasibility of achieving OHCA's proposed target of 3% annual spending growth over five years – at least for a subset of products and payment arrangements.

IHA Atlas: What's In The Data?

Payer Type	Product Type	Enrollment in Atlas							% of CA Enrollment
		2013	2015	2017	2018	2019	2020	2021	
Commercial	HMO	10.1 M	9.3 M	9.0 M	9.9 M	9.8 M	9.8 M	9.8 M	95+%
	PPO[1]	4.3 M	4.3 M	4.7 M	5.7 M	4.2 M	4.1 M	5.1 M	60+%
	EPO	--	--	0.2 M	0.09 M	0.09 M	0.2 M	0.2 M	--
Medicare	Advantage	1.6 M	1.8 M	1.8 M	1.9 M	2.0 M	1.8 M	1.9 M	65+%
	FFS	No member level data	2.9 M	3.2 M	--	--	--	--	--
Medi-Cal (full-scope)	Managed Care (HMO)	5.7 M	9.3 M	9.8 M	--	--	--	--	--
	FFS	1.2 M	1.6 M	--	--	--	--	--	--
TOTAL		22.9 M	29.2 M	28.7 M	17.6 M	16.1 M	15.9 M	17.0 M	--

[1]PPO, including ASO.

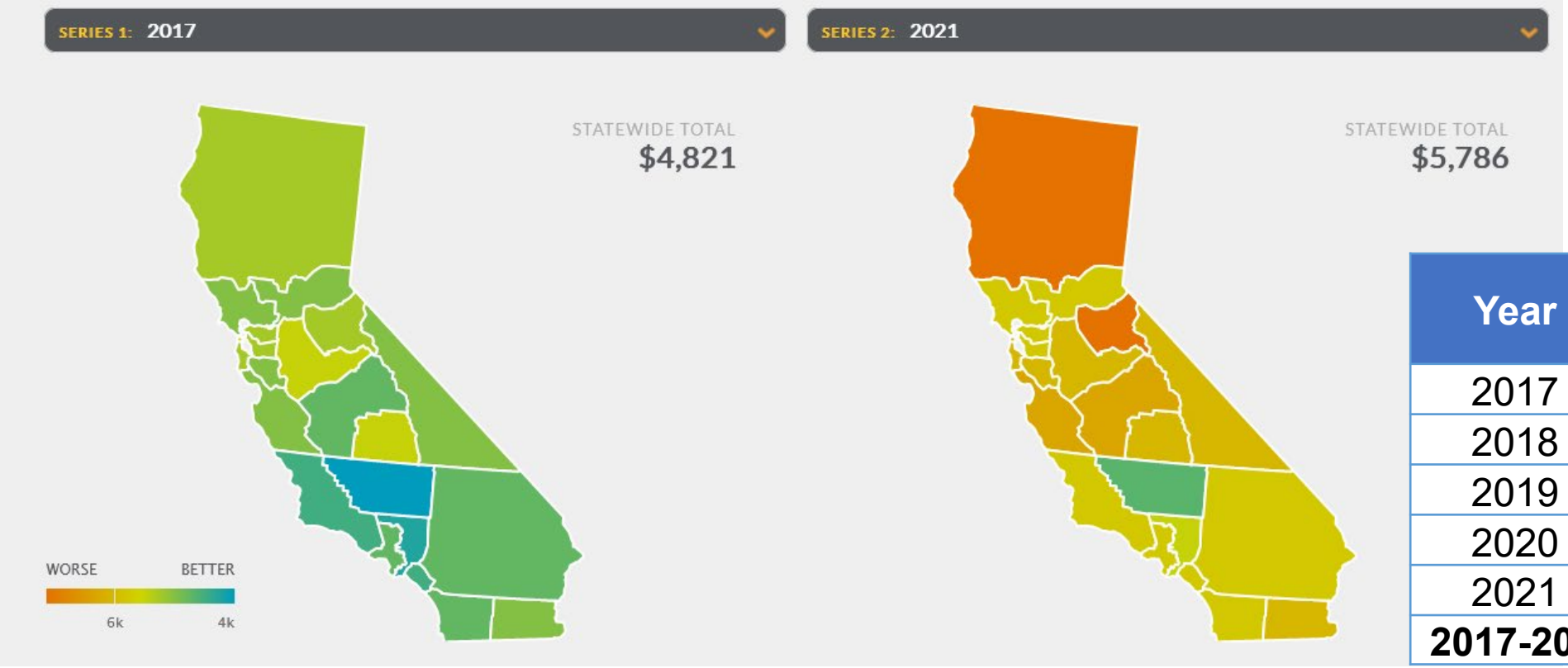
Source: Integrated Healthcare Association. *About the Data: California Regional Health Care Cost & Quality Atlas*. https://cost-atlas-iha.s3-us-west-2.amazonaws.com/downloads/About+the+Data+2021.pdf

IHA Atlas: Health Plan Data Contributors

Health Plan Data Contributors	
Aetna	Molina (starting 2021)
Anthem Blue Cross	Oscar Health Plan of California (starting 2020)
Blue Shield of California	SCAN Health Plan (until 2020)
Cigna	Sharp Health Plan
Health Net	Sutter Health Plan (starting 2019)
Inter Valley Health Plan (starting 2020)	United Healthcare
Kaiser Permanente	Western Health Advantage
L.A. Care (starting 2017)	

Source: Integrated Healthcare Association. *About the Data: California Regional Health Care Cost & Quality Atlas*. https://cost-atlas-iha.s3-us-west-2.amazonaws.com/downloads/About+the+Data+2021.pdf

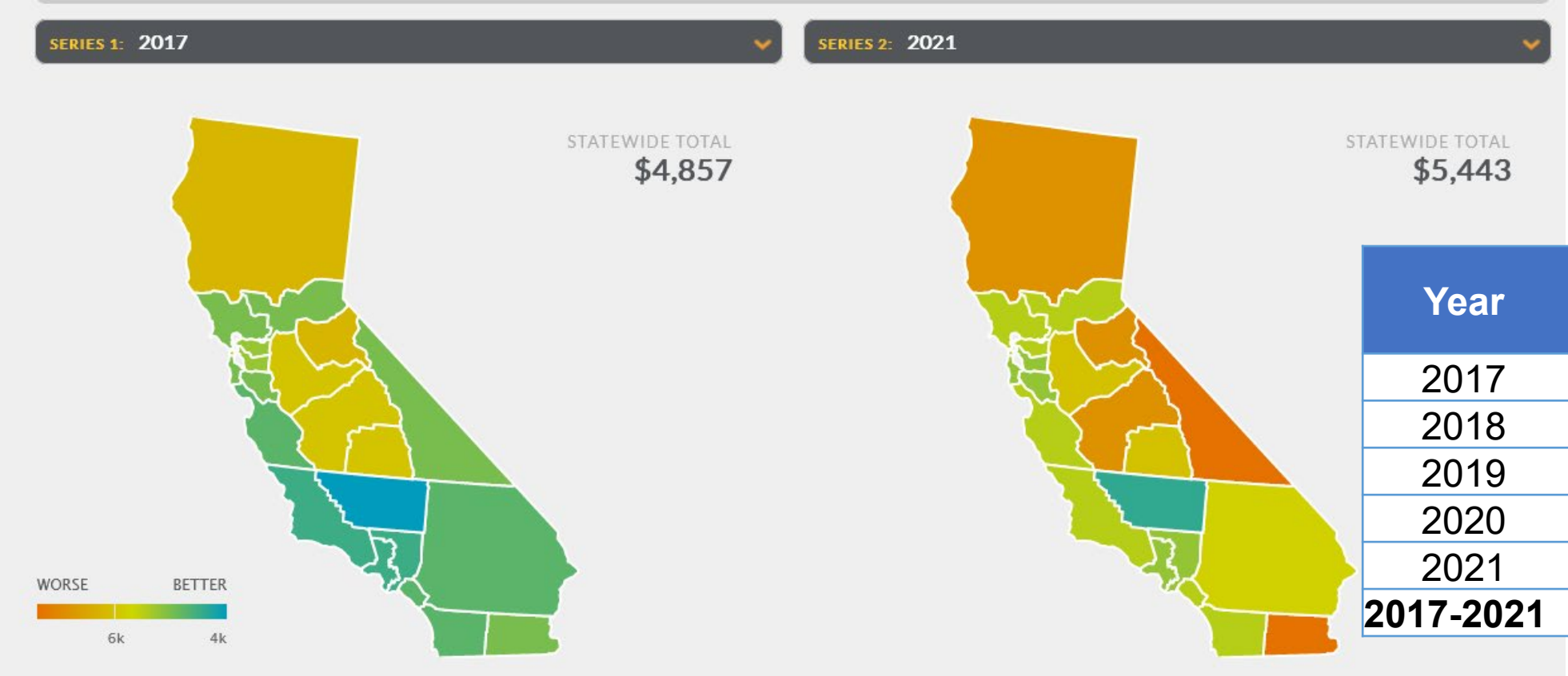
Atlas Data: 5% Average Annual Increase in Total Cost of Care 2017-2021 (Commercial)



Year	Total Cost of Care ($)	% Change
2017	4,821	
2018	4,994	3.59
2019	5,299	6.11
2020	4,965	-6.30
2021	5,786	16.54
2017-2021		**4.98**

Source: Integrated Healthcare Association. *California Regional Health Care Cost & Quality Atlas*.
https://atlas.iha.org/atlas?c=eyJiaW5kaW5ncyI6eyJncm91cGJ5IjoiY2NfcmVnaW9uIiwic2VyaWVzIjpbeyJkYXRhX3N1cHBsaWVyIjpudWxsLCJtZWFzdXJlX3IlYXIiOjIwMTd9LHsiZGF0YV9zdXBwbGllciI6bnVsbCwibWVhc3VyZV95ZWFyIjoyMDIxfV0sInNoYXJlZCI6eyJtZWFzdXJlX2NvZGUiOiJUQ09DX0dFT19SSVNLQURKX0MiLCJwYXIlciI6IkMiLCJwcm9kdWN0IjpudWxsfX0sImV4cGxvcmF0aW9uSWQiOiJtZWFzdXJlX3IlYXIiLCJpZCI6MCwicXVlcnkiOnt9LCJzZWN0aW9ucyI6W119

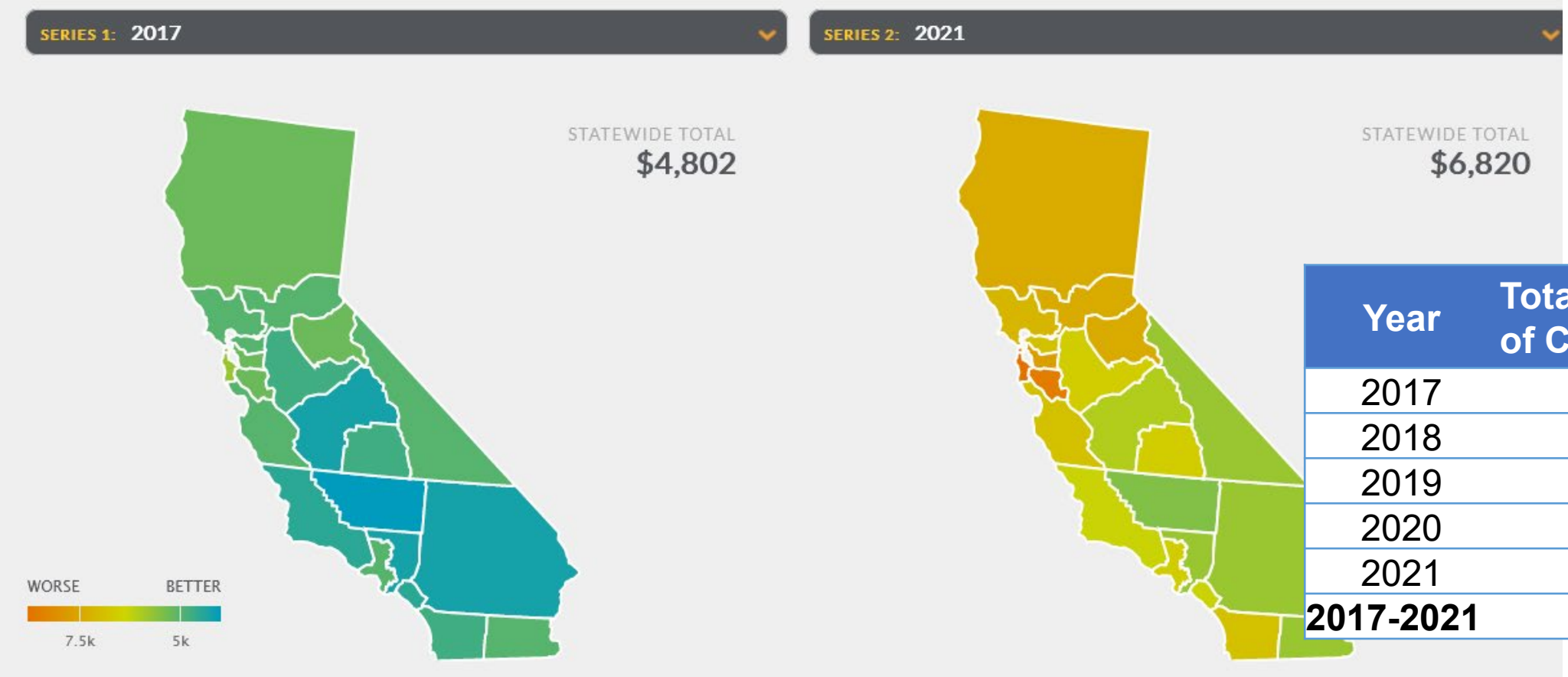
Atlas Data: 3% Average Annual Increase in Commercial HMO Total Cost of Care



Year	Total Cost of Care ($)	% Change
2017	4,857	
2018	4,886	0.60
2019	5,241	7.27
2020	4,901	-6.49
2021	5,443	11.06
2017-2021		**3.11**

Source: Integrated Healthcare Association. *California Regional Health Care Cost & Quality Atlas: Total Cost of Care-Geography and ACG Risk Adjusted*.
https://atlas.iha.org/atlas?c=eyJiaW5kaW5ncyI6eyJncm91cGJ5IjoiY2NfcmVnaW9uIiwic2VyaWVzIjpbeyJtZWFzdXJlX3IlYXIiOjIwMTd9LHsibWVhc3VyZV95ZWFyIjoyMDIxfV0sInNoYXJlZCI6eyJtZWFzdXJlX2NvZGUiOiJUQ09DX0dFT19SSVNLQURKX0MiLCJwYXIlciI6IkMiLCJwcm9kdWN0IjpudWxsfX0sImV4cGxvcmF0aW9uSWQiOiJtZWFzdXJlX3IlYXIiLCJpZCI6MCwicXVlcnkiOnt9LCJzZWN0aW9ucyI6W119

Atlas Data: 10% Average Annual Increase in Commercial PPO Total Cost of Care



Year	Total Cost of Care ($)	% Change
2017	4,802	
2018	5,297	10.31
2019	5,490	3.64
2020	5,216	-4.99
2021	6,820	30.75
2017-2021		**9.93**

Source: Integrated Healthcare Association. *California Regional Health Care Cost & Quality Atlas: Total Cost of Care-Geography and ACG Risk Adjusted*. https://atlas.iha.org/atlas?c=eyJiaW5kaW5ncyI6eyJncm91cGJ5IjoiY2NfcmVnaW9uIiwic2VyaWVzIjpbeyJtZWFzdXJlX3IlYXIiOjIwMTd9LHsibWVhc3VyZV95ZWFyIjoyMDIxfV0sInNoYXJlZCI6eyJtZWFzdXJlX2NvZGUiOiJUQ09DX0dFT19SSVNLQURKX0MiLCJwYXIlciI6IkMiLCJwcm9kdWN0IjpudWxsfX0sImV4cGxvcmF0aW9uSWQiOiJtZWFzdXJlX3IlYXIiLCJpZCI6MCwicXVlcnkiOnt9LCJzZWN0aW9ucyI6W119

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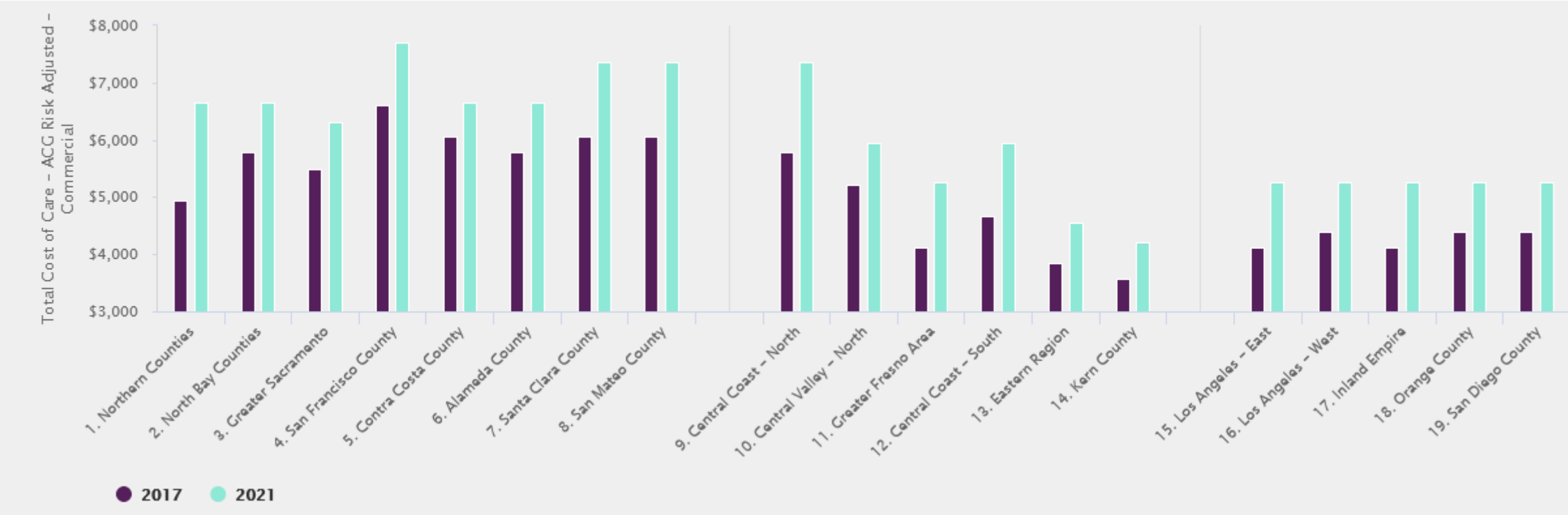
Large Regional Variation in Total Cost of Care – Both Amount and Rate of Growth



Source: Integrated Healthcare Association. *California Regional Health Care Cost & Quality Atlas: Total Cost of Care-Geography and ACG Risk Adjusted (not adjusted for geography)*. https://atlas.iha.org/atlas?c=eyJiaW5kaW5ncyI6eyJncm91cGJ5IjoiY2NfcmVnaW9uIiwic2VyaWVzIjpbeyJtZWFzdXJlX3IlYXIiOjIwMTd9LHsibWVhc3VyZV95ZWFyIjoyMDIxfV0sInNoYXJlZCI6eyJtZWFzdXJlX2NvZGUiOiJUQ09DX0dFT19SSVNLQURKX0MiLCJwYXIlciI6IkMiLCJwcm9kdWN0IjpudWxsfX0sImV4cGxvcmF0aW9uSWQiOiJtZWFzdXJlX3IlYXIiLCJpZCI6MCwicXVlcnkiOnt9LCJzZWN0aW9ucyI6W119

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Key Takeaways from the IHA Data

- Commercial market average annual growth rate in total cost of care between 2017 and 2021 is 4.98%.
- Substantial variation in annual rate of growth in commercial market total cost of care.
  - By year, between 2017 and 2021 – including the pandemic years of 2020 (-6%) and 2021 (+16%).
  - By product, comparing HMO (3%) vs. PPO/FFS products (10%).
  - By geography, with large differences in 2017 TCC (San Francisco $6,600 vs. Kern $3,575), 2021 TCC (San Francisco $7,700 vs. Kern $4,200) and in 5-year cumulative growth rate (14% Central Valley North vs. 34% Northern Counties) .

Implications for OHCA

1. OHCA finds it is feasible to hold year over year spending growth to 3% over 5 years - but there is substantial variation by year, product, and geography, indicating that some may face significant challenges meeting target.

2. Cost-reducing strategies can contribute to meeting the target, e.g.:
   - Based on IHA Atlas data: HMO products have lower cost growth trends, on average, compared to PPO/FFS.
     - Note commercial health plan enrollment data shows decline in HMO enrollment over time, outside of Kaiser.
   - OHCA's effort to showcase effective cost-reducing strategies has identified several to date, shared by health care entities:
     - Population health and chronic condition management – Sharp Rees-Stealy
     - Improving maternity quality, equity, and outcomes – Anthem
     - Lowering the total cost of care through the most appropriate site of care - MemorialCare
   - Many other promising approaches are identified in the literature.

Estimate of Entities Subject to the Target

Estimate of Entities Identified by OHCA

The estimated number of entities that may be subject to the spending target include:

- **Health plans** – based on publicly available enrollment data for calendar year 2022, there are **33** health plans with at least 40,000 covered lives.
- **Hospitals** – based on publicly available data for calendar year 2022, there are more than **400** general acute care facilities operating in California.
  - Note: Many hospitals are part of systems.
- **Physician Organizations** – as part of its THCE regulations package, OHCA included an attribution addendum with approximately **300** physician organizations. It is important to note, however, that there is currently no single source of truth regarding the universe of provider organizations in California. Systematic capture and reporting on structure, affiliation, and ownership is lacking, especially for physician organizations.

Sources: Wilkson, K. (2023, October 13). *California Health Insurers, Enrollment – 2023 Edition*. California Health Care Foundation. https://www.chcf.org/publication/ca-health-insurers-enrollment-2023-edition/; California Health and Human Services. *Licensed Healthcare Facility Listing*. https://data.chhs.ca.gov/dataset/licensed-healthcare-facility-listing

Considerations for Progressive Enforcement

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

3. Progressive Enforcement

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

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 Medi-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

Illustrative Example: Investments to Improve Care and Reduce Future Costs

- Primary care and behavioral health spending benchmarks are intended to build and sustain infrastructure and capacity, specifically reimbursement methods that shift greater health care resources and investments away from specialty care and toward support of innovation and care improvement in primary care and behavioral health. This should spur entities to reallocate spending to primary care and behavioral health and reduce utilization and excess spend on high-cost, low-value care such as specialty pharmacy, unnecessary specialty care, and avoidable emergency room and hospital stays.
- While it is intended that reallocation for improvements for primary care and behavioral health will not raise costs for consumers or increase the total costs of health care, shifting resources may take time and may not realize immediate savings.
- If a health care entity exceeds the spending target due to significant investments in primary care and behavioral health, OHCA would consider this factor when assessing performance and this could mitigate steps in the progressive enforcement process.
- OHCA will develop its approach (prior to progressive enforcement applying to the 2026 spending target) to assess performance if entities exceed the target and include reasons predominantly due to primary care and behavioral health investments. Later this year, OHCA will discuss more details of the progressive enforcement process through public board meetings.

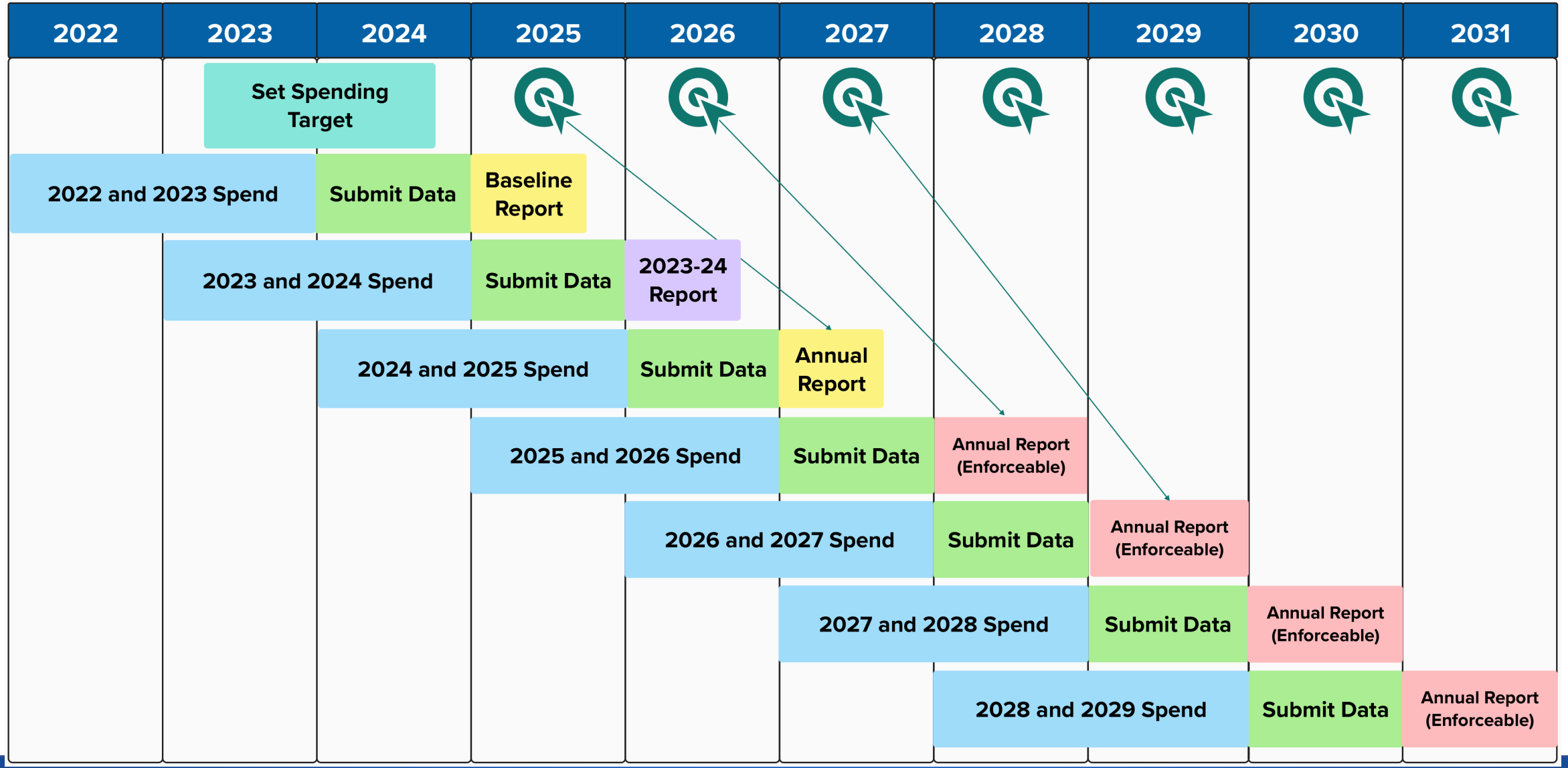
Timing of Potential Enforcement

- 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 PIP.
- 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.

Reporting Performance by Market

- Based on the experience of other states, there can be variation in overall spending growth by market.
    - For example, in Oregon total health care expenditures increased 3.5% between 2020-2021, just above the cost growth target of 3.4%. Cost growth for the commercial market was 12.1%, compared with 6.5% for Medicare and -2.1% for Medicaid.
- OHCA will report spending growth by market for each entity. Reporting by market allows for OHCA to evaluate the impact of the following on spending performance:
    - Population characteristics of each market.
    - Cost drivers unique to each market.
    - Different policy levers and tools in each market for implementing cost-reducing strategies.
- OHCA is likely to enforce the statewide spending target based on the entity's performance by market.

Spending Target Timeline



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Sector Targets

Statute: Sector Targets Timeline and Process

1. On or before October 1, 2027, the board shall define the initial health care sectors, which may include geographic regions and individual health care entities, as appropriate, except fully integrated delivery systems, considering factors such as delivery system characteristics. Sectors may be further defined over time.
2. After the board defines the health care sectors, the office shall promulgate regulations accordingly.
3. The office shall publish on its internet website its recommendations for proposed cost targets for the board's review and consideration. The board shall discuss recommendations at a public meeting for proposed targets on or before March 1 of the year prior to the applicable target year.
4. The board shall receive and consider public comments for 45 days after the board meeting.
5. The board shall adopt final targets on or before June 1, at a board meeting.
6. No later than June 1, 2028, the board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate.

The setting of different targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, must be informed by historical cost data and other relevant supplemental data, such as financial data on health care entities submitted to state agencies and the Health Care Payments Data Program, as well as consideration of access, quality, equity, and health care workforce stability and quality jobs pursuant to Section 127506 (HSC 127502 (b)(3)).

Source: Health and Safety Code § 127502(b), (l) and (m).

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.
- For OHCA to report attributed total medical expenses for enrollees assigned to physician organizations, additional data is needed directly from MCOs.
- 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 set by DHCS actuaries 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 levy financial penalties on MCOs and/or their contracted providers solely due to operational or policy decisions made by DHCS.

Considerations for Medicare Spending

Background: 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.

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.

Assessing Performance and Enforcement for Medicare Advantage

- Given the federal oversight for Medicare spending and rates set for MA plans, OHCA would not levy financial penalties on MA plans and/or their contracted providers solely due to operational or policy decisions made by CMS.

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

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.

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Public Comment

Public Comments on Proposed Statewide Spending Target and Advisory Committee Feedback

Public Comment and Advisory Committee 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
- Also included in the following slides is a summary of the March Advisory Committee's reactions to the spending target recommendation public comments.

Target Value – Access and Quality of Care

	Concerns	Support
Public Comment	• 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.	• 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 – Access and Quality of Care

	Concerns	Support
AC Feedback	N/A	• Other states that overshot their targets likely did so because there was no need to adhere to them/ no enforcement. Anything above 3% is problematic for access. • Even if many entities don't meet the target, it's helpful information. Outcome could be they meet the target by lowering costs, thus increasing access and overall spending will go down. • Hope that providers don't automatically go to reducing services and access if they exceed the target but rather look for efficiencies in the system or the prices being charged.

Target Value – 3%

	Concerns	Support
Public Comment	• 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); framework 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 Value – 3%

	Concerns	Support
AC Feedback	• 3% doesn't account for actual costs. If target is applied universally, it doesn't account for their starting point (e.g., two medical groups in the same market—one is substantially higher cost than the other). Should apply a different target to higher performing providers vs. low quality providers. • We all want health care to be affordable and high quality, but a 3% metric is not connected to costs. Entities are not all starting from the same place (e.g., some take capitated risk, some FFS)—every market is different—but we're applying one number to all areas. Also there are significant cost increases from regulatory requirements (minimum wage, seismic). OHCA should reduce the length from 20 years of median household income to something less, consider adjustment factors, and include quality (if provider is paid on a APM with high quality scores, consider different number). • Not everyone is starting at the same place. Some systems serving vulnerable populations will look bad for failing to meet the target when they are just starting behind the others. Allow time to compensate for deficiencies that have been allowed for the last 50 years.	• Support 3% since what we're doing now isn't working (premise of the statute); Board can reassess later if needed. Don't bake in what's already not working. 3% is not radical--it's incremental. Also need better data to unpack percentages in the "concerns" area to know how much is shareholder dividends and profit, for example, and where we need to invest and where to cut without impacting care or quality. • Based on new data analysis (2019-2022), per claim cost growth was kept to 2.4% a year. A 3% target can be done. • 3% is good target goal. OHCA is prepared to shift due to changes if needed. 3% is a place to create space for innovation, not continue in same direction of high-cost growth. • Regarding suggested higher targets, don't bake in the status quo or maybe even worse performance. What would we tell the public about what we are doing about affordability? • Support 3%. There's room for doing business differently (e.g., efficiencies gained through investment in prevention). • Experienced a 9.5% increase in premium costs last year. 3% would be extraordinary at this point. • Starting at 3% is a good goal to be able to see where spend is happening and adjust when needed based on that knowledge.

Target Setting Methodology - Adjustments

	Concerns	Support
Public Comment	• 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 - Adjustments

	Concerns	Support
Public Comment	• 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 - Adjustments

	Concerns	Support
AC Feedback	• Target should start with health care costs as we see it and adjust for affordability. • Concerned about setting a target that has nothing to with medical cost inflation. Also, concerned about unintended consequences -- i.e., if we're ignoring Medi-Cal, Medicare, and self-funded ERISA plans as outside of this process so just focusing on commercial, providers will have to somehow make their revenue add up to cover costs (especially with low Medi-Cal/Medicare reimbursement) and then we impose a 3% target--haven't thought through implications of that completely. Employers might shift from fully-insured to self-funded to avoid this process and it would harm consumers (without state consumer protection mandates, plan design standards, etc.)	• Regarding unintended consequences, if the premium contribution had stayed the same as inflation between 1996 and 2019, workers in a San Francisco self-funded plan would have taken home an extra $200k. For years, those picking up the tab have been working people, commercial insurers, purchasers…the tables have turned and industry has to figure out how to bring rates down. It's not sustainable. • Some adjustments are opportunities to reduce costs and provide better care (e.g., aging -- lowering costs by giving better care in their community vs. expensive institutions).

Target Setting Methodology – Economic Indicator

	Concerns	Support
Public Comment	• 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 Setting Methodology – Economic Indicator

	Concerns	Support
AC Feedback	• 3% target includes a 20-year lookback with the Great Recession; forecast of household income is 3.6%. In 10 years, when the recession is not in the historical period and the situation is reversed (historical is higher than projected), would those arguing for historical 20 stick to or look at the lower projected number? We set targets for the future; our starting point is very different than 3%. • Massachusetts and Oregon are meeting soon to probably raise their targets. Lookback period should be 10 years. With the next few years of data gathering, hopefully there's flexibility to raise the target closer to 4%.	• The 20-year lookback period is appropriate because a shorter lookback for median household income (e.g., 5 or 10 years) has higher variability and a longer lookback period helps smooth projections. Some states are talking about the period we are just coming out of with high inflation spikes that's hopefully now moderating. We have data suggesting that this inflationary period should be taken into account, but it should be spread out over time. This provides more consistency to industry.

Target Duration

	Concerns	Support
Public Comment	• 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.

Target Duration

	Concerns	Support
AC Feedback	• The starting point for entities (in which hospitals may have to close certain lines of business, inflation, etc.) is far from OHCA's 3% recommendation. Need a glidepath or a realistic target or everyone will miss it—need something providers can realistically strive for. Trying to get to something drastically different will take time.	• Support but consider getting to sector- and entity-specific targets faster than 5 years. • We are on a glide path now. Expect that 2025 union rates should be going in that direction because 2024 rates did not. Industry has been on notice, at this table, and seen this coming; it's not a surprise. Need to recognize that any target is on a glidepath already and industry needs to figure out how to get there. • The recommendation will not reduce or freeze health care costs, but it also won't make it more unaffordable for Californians, especially since progressive enforcement is going to take years. • Support multi-year target. One-year target doesn't make sense since OHCA won't even get data for a couple of years to have a conversation. If it's one year, what do we do the second year--still won't have new information to inform the process. Need multi-year to give industry something to work with and Board can change/adjust if needed.

Other Comments

	Concerns	Support
Public Comment	• 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.

Other Comments

	Concerns	Support
AC Feedback	• N/A	• Appears that many integrated systems are in the 3% range; the target would focus attention on areas with more uncoordinated and more expensive care. The target is appropriate and should not be viewed as punishment but as way to identify underlying issues and shift resources to more integrated systems and ”right care right time” and away from the patient affordability crisis.

HCAi
Department of Health Care Access and Information

Public Comment

Timeline and Process for Adopting the Spending Target for 2025

Statute

127502.

(m) (1)The board shall hold a public meeting to discuss the development and adoption of recommendations for statewide cost targets, or specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities. The board shall deliberate and consider input, including recommendations from the office, the advisory committee, and public comment. Cost targets and other decisions of the board consistent with this section shall not be adopted, enforced, revised, or updated until presented at a subsequent public meeting.

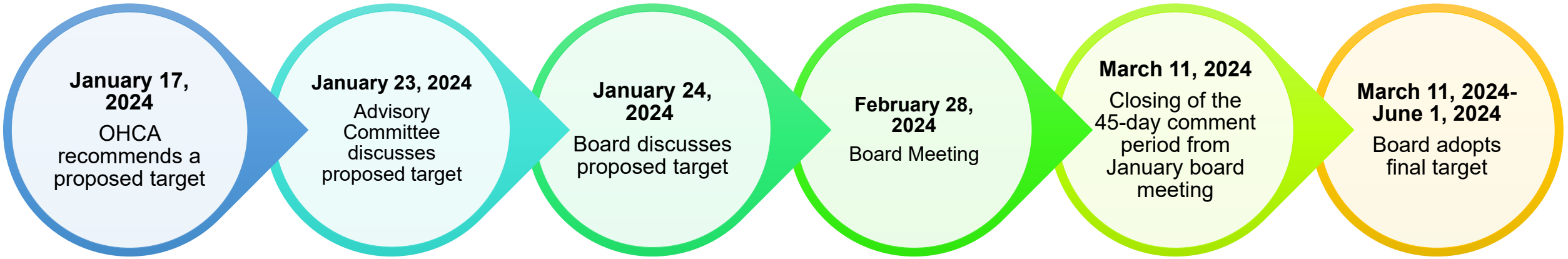
(2) The office shall publish on its internet website its recommendations for proposed cost targets for the board's review and consideration. The board shall discuss recommendations at a public meeting for proposed targets on or before March 1 of the year prior to the applicable target year.

(3) The board shall receive and consider public comments for 45 days after the board meeting.

(4) The board shall adopt final targets on or before June 1, at a board meeting. The board shall remain in session, and members shall not receive per diem under Section 127501.10, until the board adopts all required cost targets for the following calendar year.

Source: Health and Safety Code § 127502

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.

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%

Consideration of Written Public Comments and Advisory Committee Feedback

Purpose of OHCA. OHCA's enabling statute notes that:

- "...affordability has reached a crisis point as health care costs continue to grow
- As costs rise, employers are increasingly shifting the cost of premiums and deductibles to employees, negatively impacting the potential for wage growth.
- Escalating health care costs are being driven primarily by high prices and the underlying factors or market conditions that drive prices.
- Californians of color experience health disparities, including barriers to accessing care, receiving lower quality of care, lack of access to culturally and linguistically competent care, and experiencing worse health outcomes.
- Surveys show that people are delaying or going without care due to concerns about cost, or are getting care but struggling to pay the resulting bill."

Source: Health and Safety Code § 127500.5 (a)

Consideration of Written Public Comments and Advisory Committee Feedback

After reviewing the written public comments and Advisory Committee feedback, OHCA maintains its recommendation to use median family income growth to establish a 3% target from 2025-2029.

Target Value

- A 3% target based on a consumer affordability measure signals that health care spending should not grow faster than the income of California's families.
- A 3% spending target is slowing the rate at which health care spending can grow. It is not cutting current spending levels.

Access and Quality of Care

- The California Health Care Foundation's California Health Policy Survey found that 53% of Californians delay or forego necessary care altogether due to high costs and get sicker as a result. The target intends to change the orientation of the health care system toward affordability, resulting in increased access.
- The research literature finds that there are opportunities for savings and efficiencies within the health care system, which would slow spending growth compared to the historical rate of health care spending growth, while maintaining or improving quality, access, and equity.

Consideration of Written Public Comments and Advisory Committee Feedback

After reviewing the written public comments and Advisory Committee feedback, OHCA maintains its recommendation to use median family income growth to establish a 3% target from 2025-2029.

Methodology

- Some stakeholders have suggested using projected health care costs or cost drivers, rather than setting an affordability-based target. However, using projected costs would reinforce current unsustainable cost trends, and is at odds with the purpose of a spending target, which is to change the trajectory of health care spending.
- Compared to a 5- or 10-year average change in median household income, a 20-year average yields comparable predictive accuracy with the added benefit of increased stability in the spending target value.
- Adjustments (e.g., population-based measures) are not experienced uniformly across health care entities and there is not a standard methodology to accurately predict the effect of these measures on future health care spending.
- Adjustments for drivers of health care spending, such as high-cost specialty drugs or technology, do not impact every payer or provider in the same way or by the same amount. OHCA will consider reasonable factors for exceeding the target when assessing performance of entities.

Duration

- A five-year target promotes a predictable rate of change, and knowing the future targets in advance could influence negotiations for health plan contracting. The Board also has flexibility to revisit future target years, if necessary.

Next Steps

- The Board is required to adopt a final target by June 1st at a public meeting of the Board.
- This Board can vote to adopt the Office's recommendation or propose another value and/or methodology for discussion and ultimate adoption.
- Other options for the Board to consider include:
  - Modifying the methodology for arriving at a target value (e.g., adding adjustments such as population-based measures)
  - Changing the economic indicator
  - Changing the target value
  - Changing the target duration
  - Creating a target phase-in

- The Statewide Spending Target Value and Methodology will be listed as an action item for the Board to consider at the April 24, 2024, Health Care Affordability Board Meeting.
  - Placing an item on the agenda does not require the board to take action. State law does not allow the board to discuss or act on an item unless it is listed on the agenda.
  - If action is not taken in April, it will be placed on the May Agenda.

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Public Comment

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General Public Comment

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

Next Board Meeting:

April 24, 2024
10:00 a.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

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Department of Health Care Access and Information

Adjournment