HCAI Department of Health Care Access and Information
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Health Care Affordability Advisory Committee May 14, 2024 MEETING MINUTES

Members Attending: Joan Allen, Barry Arbuckle, Stephanie Cline, Adam Dougherty, Parker Duncan Diaz, Hector Flores, Stacey Hrountas, David Joyner, Carolyn Nava, Tam Ma, Mike Odeh, Janice O'Malley, Sumana Reddy, Andrew See, Sarah Soroken, Ken Stuart, Suzanne Usaj, Anthony Wright, Abbie Yant, Kiran Savage-Sangwan

Members Absent: Yvonne Waggener, Carmen Comsti, Sara Gavin, Ivana Krajcinovic, Aliza Arjoyan, Yolanda Richardson, Rene Williams

Health Care Affordability Board Member Attending: Ian Lewis and Dr. David Carlisle (virtual)

HCAI: Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director; Jean-Paul Buchanan, Counsel; Margareta Brandt, Assistant Deputy Director

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; Margareta Brandt, Assistant Deputy Director; Peter Long, PhD, Executive Vice President, Strategy and Health Solutions; Miranda Dietz, Policy Research Specialist and Project Director for CalSIM, and KeriAnn La Spina, Senior Health Researcher, Mathematica

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

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

Agenda Item # 1: Welcome and Call to Order

Elizabeth Landsberg, Director, HCAI
Vishaal Pegany, Deputy Director, HCAI

The facilitator called roll; quorum was established.

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

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

- The Health Care Affordability Board's approval of a statewide health care spending target of 3 percent. The spending target will be phased in over time, initially starting at 3.5 percent for 2025 and 2026. For years 2027 and 2028, the target will be adjusted downward to 3.2 percent before ultimately reaching 3 percent for 2029 and beyond.
- On April 29, 2024, Governor Newsom announced that HCAI's CalRx's Naloxone Distribution Project has partnered with Amneal Pharmaceuticals and has secured the right to purchase CalRx branded OTC naloxone for $24 which represents a 40% price reduction. This partnership would allow California to purchase 3.2 million twin-packs of naloxone instead of the 2 million twin-packs purchased at the previous price.
- On April 8, HCAI approved a key $57 Million no-interest loan for Madera Community Hospital through the Distressed Hospital Loan Program, which was established by Governor Newsom in partnership with the Legislature to help hospitals in severe financial stress stay open and keep crucial medical care available in communities across the state. This loan will be used to help reopen the hospital, which has been closed since January 3, 2023.
- The Governor released the May Revision of the budget on Friday to address a $45b shortfall which is an increase since January. The revised budget takes a 2-year approach and of course a number of painful proposed cuts.
- Blue Shield has a schedule conflict, so today's cost-reducing strategy presentation will be postponed to a future Advisory Committee meeting.

Deputy Director Pegany then provided updates on the Board and Advisory Committee quarterly workplan and assessing performance and enforcement for entities participating in Medi-Cal and Medicare.

Discussion from the Advisory Committee included:

- A member commented on the interrelationship between Medicare, Medi-Cal and commercial needs to be looked at in the context of health care cost growth. The reimbursements from these segments have to make up for inflation. Looking at the three sectors in isolation misses the dynamic that providers face, that Medicare and Medi-Cal reimbursement haven't kept pace with inflation; therefore, commercial rates have risen faster and it forces providers to charge more. Look holistically to get the full picture when measuring providers against the spending target.
    - OHCA responded that we plan look at spending by payer, as well as holistically, to better understand the market dynamics. It is also important to note, as we've done, that Medi-Cal spending increases due to policy changes will be considered.
- Another member mentioned that with commercial subsidization/cost shift, employers also cost shift onto employees with higher premiums/cost sharing. The member also

expressed needing to track private equity profits in the PACE program as the Medicare population ages.

- A member noted that the Office was created because of cost shifting to consumers due to historically underfunded public systems and encouraged OHCA to consider ways to shine a light on mal-incentives that some plans use to avoid high-cost patients or to maximize profits or limit access.
- A member asked two operational questions: 1) Opportunities for the Advisory Committee to provide formal feedback to the board since the next meeting isn't until September; and 2) Appointment of individuals to the hospital spending workgroup (notes the workgroup is not referenced on the website) and whether the public can access materials and listen in.
    - OHCA responded: 1) we will discuss with the board in the next few months all the items on today's Advisory Committee agenda and will include the Advisory Committee's feedback. In addition, board member Lewis and Carlisle are in attendance today and that we encourage submitting written comments; and 2) at January Board and Advisory Committee meetings, we discussed the limitations of attribution and how OHCA needs additional ways to measure hospitals relative to the spending target. We convened a workgroup with hospitals, payers, purchasers and consumer advocates to solicit input on potential measurement attribution methodologies. It is an OHCA-convened workgroup, not a public meeting, but we will ultimately bring the input and approach to the Advisory Committee and the board.
- A member asked about factors that could impact the commercial market relative to the target.
    - OHCA responded that for progressive enforcement, there are reasonable factors for exceeding the target (e.g., changes to federal/state law and high-cost drugs); we will contextualize this spending in public reporting.
- A member appreciated OHCA's look at the health system as a whole while recognizing Medi-Cal and Medicare have their own rate setting mechanisms and also celebrates that we have set a spending target.
- A member asked whether Medi-Cal inpatient rates are now on par with Medicare.
    - OHCA responded that it is complicated by the many supplemental payments that go to hospitals.
- A member asked whether there is data from systems that only take Medi-Cal showing there are more denials or delays in care, or lower quality care, v. systems that only take commercial or commercial and Medi-Cal.
    - OHCA responded that we can follow up.
- A member asked how OHCA is thinking about presenting data, once collected, regarding cost-shifting that is being presented as factual.
    - OHCA responded we would seek literature on the issue, as well as analyze the data to the extent possible as spending data will be aggregated. There could also be future work through the APCD or other data sets that gets at cost-shifting/cross subsidization.

Public Comment was held on agenda item 2 and 1 member of the public commented.

Agenda Item # 3: Update on Draft Alternative Payment Model Standards and Adoption Goal
Margareta Brandt, Assistant Deputy Director

Assistant Deputy Director Brandt provided an update on Draft Alternative Payment Model Standards and Adoption Goals. Discussion from the Advisory Committee included:

- A member expressed appreciation for the work of the office and highlighted the need for payers to determine how to effectively promote any alternative payment model program to clinicians.
- Another member expressed support for alternative payment models and raised concerns about achieving the proposed goals for PPO within the timeframe without certain services being delegated to providers in contracts.
- A member was concerned about the ambitious Medi-Cal goal, citing significant churn and the number of external factors affecting payer-provider contracting. An example was given in Yolo County, where patients were being assigned to providers three ZIP codes away. For APM standard #10, there is significant investment required for solo practices and small groups, and even those that want to meet these goals face difficulties. The member recommended including care transformation funding in addition to technical assistance to successfully initiate progress for these groups.
- A member asked for clarification on measurement in a scenario where all of Aetna's statewide penetration is in Commercial PPO, and whether the payer will be reporting about the health care entities.
    - The office answered yes, the payer will report for health care entities using the nonclaims framework and the total health care expenditure data collection process. Additionally, they noted that provider level reporting on the adoption of alternative payment models was of interest and the statute requires limited and restricted Knox-Keene Act plans to report, providing a mechanism for provider analysis of APM adoption in the future.
- A member mentioned that there are Medicare Shared Savings plans in the state and suggested starting slow with those PPO providers to ensure meaningful arrangements. The member also suggested providing technical assistance. The member is working with the Pacific Business Group on Health on transitioning solo and small practices to greater participation in APMs, noting that the change is expensive and small practices need funding. It will also be important to address how physicians are being trained in California, including graduate medical education strategy requiring cross-sector collaboration.
- A member who works primarily in an FQHC mentioned that the current incentive is not to transition to an alternative payment model. The member supported the use of technical assistance, getting input from providers, and keeping things simple to focus on continuity of primary care physicians. The member supported the 10 APM standards, emphasizing simplicity and building on core principles as the system transitions to APM.
- A member suggested the following: to add another standard that is an alternative payment model that is actuarily sound and sustainable for the provider.
    - The office responded that actuarily sounds alternative payment models was

added to the implementation guidance and that a fully insured PPO could pay capitation, while self-funded PPOs are not able to pay capitation.

- Another member supported the inclusion of limited Knox-Keene license entities in the future and suggested asking for narrative reports on what is working or not to determine commonalities among payers.
- A member suggested making payers more accountable for having accurate data, considering challenges of attribution in Medi-Cal, challenges of payment via pay for performance for providers, and other issues.
- A member supported ambitious goals to change the current model of care and acknowledged that getting people to change from PPO is difficult since they chose PPO for greater choices. We need to spur more innovation in PPO models that offer choices, while also bringing in different payment models and coordinated efforts of care.
- A member emphasized that actuarily sound rates are needed for all products. They noted PPOs need benefit plan designs to support the ability for providers to take on more risk. These might include PCP assignment and in-network incentives for better coordinated care.
- One member emphasized the importance of the little details and the impact they have on consumers, citing an example of Medi-Cal patients being assigned primary care physicians that are, on average, 2 hours away from where they live.

Public Comment was held on agenda item 3 and 2 members of the public commented.

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

Assistant Deputy Director Brandt presented an update of the draft workforce stability standards. Discussion from the Advisory Committee included:

- A suggestion to include primary care physicians, because we are losing doctors from primary care to hospitalists, telehealth, etc. and the need to track how many trained primary care physicians are turning to other areas due to the complexity of what they do.
- A suggestion to coordinate with Integrated Healthcare Association who curates the Symphony Provider Directory. Additionally, the California Medical Board licensing surveys are a great opportunity to collect data on licensed physicians.
- A member asked how OHCA is thinking about the competing goals of the cost target and higher compensation as suggested by these standards.
    - The office responded that the statutory purpose of this element is to ensure that this conflict is resolved in other ways, for example, by achieving efficiencies and increasing retention.
- One member was in support of contract labor being included in the metrics as this type of labor is not cost-effective.
- A member asked if OHCA will need new legislation for this reporting, or if there is already the authority cover this?
    - The office answered that they do have authority to collect data and would use existing mechanisms and data where possible.

- Another member mentioned wanting to see behavioral health billing streams incorporated into other billing and the need to integrate behavioral health and primary care teams and financing toward global models, which will also support workforce stability.
- A member supported having contract labor added to the key performance indicators. This has been shown to be a big problem area on quality side and also as a sign of broader financial problems at a provider organization. Workforce standards can help reinforce information about the overall health of provider organizations, but only if the information gets back to the Board timely.
- A member supported standard 6 about safety citing the example of ultrasonographers working with existing, chronic repetitive strain injuries because their work has been accelerated by digital imaging (they do many more ultrasounds per day than they used to). It will be important to understand and elevate these occurrences.

Public Comment was held on agenda item 4 and 2 members of the public commented.

Agenda Item #5: Examples of Cost-Reducing Strategies Employed by Blue Shield of California
Peter Long, PhD, Executive Vice President, Strategy and Health Solutions

This agenda item was postponed to a future advisory committee meeting.

Agenda Item # 6: Update on Draft Primary Care Definition and Investment Benchmark
Margareta Brandt, Assistant Deputy Director
Assistant Deputy Director Brandt presented an update on OHCA's draft primary care spending measurement definition and methodology and OHCA's recommended primary care investment benchmark. Discussion from the advisory committee included:

- A member commented that pediatrics-only groups would not benefit from a single benchmark, if they are already getting a higher than the benchmark level of spending. The member provided an example of recruiting more kids to her practices, but accountable care organizations (ACOs) and other provider organizations are pushing primary care physicians to get more Medicare patients since they bring in revenue. The member asked how the office would account for this scenario.
    - The office responded that it is measuring primary care investment at the payer level, not the provider organization level.
- Some members expressed that adult and pediatric primary care spending needs to be measured separately and the office may come to wrong conclusions by measuring these groups against a single benchmark. A member suggested that groups should have to explain why they aren't or are meeting the benchmark and that OHCA should gain insight into how primary care spending is spent downstream from payers to avoid inaccurate conclusions.
    - The office responded that the primary care capitation payments formula looks at both encounters and total amount of spend, resulting in a ratio such that other expenditures are included.
- One member asked about clarification on the formula to measure primary care

capitation payment, specifically they thought the office was multiplying the total professional capitation by the ratio of all primary care encounters to all fee-for-service encounters. If this is the case, the formula would substantially undercount primary care spending based on how some entities distribute their capitation payments.
    - The office responded by welcoming further feedback adding that the Investment and Payment Workgroup has struggled with this methodology. The office will investigate collecting data from restricted Knox-Keene licensed entities and eventually other provider organizations.
    - The member suggested the office has a mechanism for groups to explain and justify how they invested primary care funds, so OHCA does not reach wrong conclusions.
- A member commented that the pediatric community is in crisis with fewer trainees overall and lower percent practicing in general pediatrics. Close to 50% of kids in California are in Medi-Cal and suggested testing out the capitation formula with some provider organization's data to see how accurate it is.
- A member agreed with others about capitation payment stating that many of their programs are not compensated on a claims basis, for example, portal messages. These aren't captured in either the numerator or the denominator of the proposed capitation formula. The member suggested either a lower benchmark if the current formula will be used or to change the formula.
- One member expressed concern about inadvertently reducing primary care spending for kids by having a single benchmark and suggests reporting and transparency to ensure we're not disinvesting in kids.
- Support was expressed for the big picture idea of starting to count primary care and increase it and a member endorsed keeping a broad definition of primary care. The member does not think the office should separate out the pediatric population.
- A member expressed concern that this single measure is gameable and asked how the office can use this data and compare it to other data, including patient experience data to see whether primary care investment translates into improved experience. The member appreciates not including retail clinics as they're a stop gap measure, not a solution and agrees that OB-GYN does not meet the definition of a primary care physician. The member suggested that if OHCA adopts a single benchmark, it should monitor for unintended consequences in the pediatric population.
- A member supported the 15% benchmark and cited a recent Commonwealth report that showed that CA's racial disparities are wider than those in Oregon. Greater access to primary care can close these disparities and would like to see tracking of that correlation.
- A member asked the office to confirm that they are looking at both claims and non-claims spend?
    - The office responded that they are looking at both.
- Another member supported the ambitious benchmark and noted that this is a proxy measure and ideally the office would measure patient primary care investment, but for now will be measuring plan payments to provider groups. The member suggested that it would be great over time to study this proxy via looking at medical group financials.
- One member would like to see the timeline presented accelerated.

- The office called for further feedback on how to capture non-claims primary care spending given the current limitation to collecting payer data. The office will investigate the use of the healthcare payments database (HPD) to investigate pediatric versus adult primary care spend, continuity of care, or other measures to build out primary care definition and supplement analysis. OHCA will take lessons learned from payers and restricted Knox-Keene licensed entities to develop a more accurate approach for provider organizations in the future.

Public Comment was held on agenda item 6 and 2 members of the public commented.

Agenda Item #7: Measuring Consumer Affordability
Vishaal Pegany, and Miranda Dietz, Policy Research Specialist and Project Director for CalSIM

Deputy Director Pegany introduced the presenter, Miranda Dietz. Miranda Dietz presented on the finding from a report authored by herself and Laurel Lucia titled “Measuring Consumer Affordability is Integral to Achieving the Goals of the California Office of Health Care Affordability”. Discussion from the Advisory Committee included:

- A member mentioned that employers are trending toward PPOs for their employees so they can shift to a higher deductible/lower premium plan that saves them money. The unintended consequence is that PPOs have much weaker levers to control total cost of care. It would be ideal to see a trend toward more comprehensive coverage with more risk transfer.
- A member asked when employers move into self-funded plans, which they growingly are doing, does that data collections disappear?
    - The office responded that self-funded plans are not required to report data to DMHC which may mean that many high-deductible PPO plans are missing from the analysis of administrative data.
- One member commented that deductibles discriminate against the sick in their essence. It is important to look at financial barriers to care and copays aren't as problematic as deductibles and coinsurance that can lead to financial crisis.

Public Comment was held on agenda item 7 and 2 members of the public commented.

Agenda Item #8: Measuring Out-of-Plan Spend
Vishaal Pegany, and KeriAnn La Spina, Senior Health Researcher, Mathematica

Deputy Director Pegany presented on the office’s approach to measuring out-of-plan spending. Discussion from the advisory committee included:

- A member mentioned a Research Triangle Institute study that used 2019-2021 data citing that out-of-network care for behavioral health was many times higher than for medical-surgical care. Office visits reimbursements were much lower as a percent of Medicare than medical-surgical visits as well. One conclusion is that provider shortages don't explain these disparities. Primary care physicians are in shorter supply than behavioral health providers but have much lower out-of-network use. The member concluded that it is possible mental health parity laws aren't being complied

with.

- One member asked if concierge payments for primary care is included in the office's methodology. For example: when a primary care physician opts out of insurance arrangements altogether and the patients pay out-of-pocket; or an annual retainer charged by practice on top of insurance payments. The second example is not allowed per DMHC, but usually when these are reported, provider will refund the patient, but it's rarely reported.
    - The office responded that concierge fees are not captured in the Medical Expenditure Panel Survey (MEPS) so would not be part of the office's proposed methodology.
- One member mentioned the importance of tracking behavioral health providers being hired by private telehealth companies and primary care physicians joining concierge practices and the impacts to access to care.
- Another member emphasized focus on the concierge care issue before primary care physicians start becoming out-of-network and becomes a problem similar to what we see in behavioral health.
- One member suggested also looking at coverage limits and prior authorizations, citing substance use disorders as an example where this is an issue and limiting access to care.

Public comment on this agenda item was combined with agenda item 9 general public comment.

Agenda Item #9: General Public Comment

Public Comment was held on agenda item 8 and 9 and there were no public comments.

Agenda Item #10: Adjournment