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Health Care Affordability Board
May 23, 2023
Written Public Comment

The following table reflects written public comments that were sent to the Office of Health Care Affordability email inbox.

Date	Name	Written Comment
5/24/2023	Craig Simmons	Dear Board Members, The April 2022 final report of the Healthy CA for all Commission estimates total healthcare expenditures (THCE) to be in excess of $500 billion within the next few years. Yesterday's meeting indicated that spending targets are in line with the Commission's estimates with no accountability nor enforcement procedures forecast to control healthcare costs. One slide accurately stated: "Prices vary for common practices". As evidenced by Monterey county participants, healthcare costs are out of control for low income and underserved populations. The main goal of the Commission was development of a unified financing system to control healthcare costs, no easy task when THCE are a half trillion dollars annually. In my opinion, there are two ways to address the situation. First, the standardization of healthcare costs in alignment with Kaiser and the University of Utah studies. Second, establishment of a voter approved payroll healthcare tax to cover surgeries, outpatient services, prescription drugs, preventive care, behavioral pathologies, and long term care.

Date	Name	Written Comment
		I would welcome the opportunity to be considered for the advisory committee as a representative of organized labor for the purpose of researching the standardization of healthcare costs and drafting a ballot measure to be presented to the legislature for inclusion on the November, 2024 ballot. I am a member of SAG-AFTRA. I was employed as an organizer for a Teamsters union project that provided cannery workers with multiphasic health screenings funded by a one cent per hour payroll deduction from employers. We screened 200-500 people per day on a voluntary employee basis. Results were sent to each patient's private physician within two weeks of the exam for further diagnosis and treatment. Under my proposal, a state-wide patient data base would be created with access for hospitals, urgent care and community health centers. Sign-ups would be voluntary and participants would be eligible to access healthcare services at any California hospital or community health center. Patients with employer provided and private insurance would be able to keep their policies. Medi-Cal and Medicare would remain unchanged. Patients would have the ability to utilize healthcare services regardless of their insurance status. If selected for the advisory committee, I will be available to attend the June meeting to further explain the details of my proposal and answer questions. Thank you for your interest and consideration. Sincerely, Craig Simmons
5/31/2023	Gerald Rogan	I watched the last half hour. An outline would be helpful so I can pick topics to which to listen.

Date	Name	Written Comment
		I would like to know how you will implement a risk adjustment score. Will you use it to adjust a capitated payment to Medi-Cal managed care plans? Will you apply it to commercial insurance premiums? If Dr. Pan is correct and providers bail from low paid plans, or sicker pateints are deslected, will you know this is happening? What will you do about it? Are you going to look at where medical care resources are wasted, such as unnecessary imaging, unnecessary cardiac stent placement, unnecessary use of the emergency department, underuse of urgent care centers? Or are you going to stay at a high level and ignore the weeds?
5/31/2023	Gerald Rogan	No matter which risk score parameters you adopt, your provider groups will try to scam you for more money. You will have to audit and adjust. Use the Medicare risk score method for its Medicare Advantage providers and figure out a way to identify scammers. Don't bother reinventing the wheel. Improve upon what Medicare has done with superior audits. Also, women who have more children will cost more for each plan, so perhaps add extra for each pregnancy. Without this, you will descriminate against those who want more children and those groups who typically have more children. I would not worry about sex defined by birth or preference. Go with the sex stated by the patient.
6/01/2023	Gerald Rogan	You should have at least two physicians on your board who represent practicing physicians whose income will be affected by the possible success of your cost containment activities. Consider adding

Date	Name	Written Comment
		other medical care providers who can own their own businesses, such as physical therapists, psychologists. California has the corporate practice of medicine bar which can help guide you to choose which provider groups will be affected by reimbursement rates and capitation amounts. Nurses, for example, cannot own a medical practice. Perhaps the group can be advisory whose task would be to review the proceedings of your board and provide written comments.: in order to have fewer participants at the board meetings. Do not expect to increase the percentage of State funds that pay for medical care. Collectively we pay too much already. Cutting reimbursement rates for properly priced services will impair access. Unlike some countries, such as Indonesia, California does not have the power to require physicians to acceot Medi-Cal patients in order to have a medical license. California must use other methods to improve access, such as student loan forgiveness. This is why I believe your success in cost containment will require indentification and mitigation of medically unnecessary services. Medicare is not doing as good a job with Program Integrity as it could. Medi-Cal was doing even worse so properly abandoned fee for service reimbursement. Theoretically, under managed care, waste, abuse and fraud at the provider level is contained. What are the facts? Did the abuse transfer to managed care plans who attempted to falsely justify their patients are sicker, or by lmiiting access for patients? Do you have any data?

Date	Name	Written Comment
		Jerry Rogan, MD Fairfax, Virginia Sacramento, California Office: 916-978-9636 Cell: 530-514-1139
6/10/2023	Gerald Rogan	Comment. California should instititionalize root cause analysis of medical disasters so we can learn how health systems have failed to assure services provided were medically necessary, so we can impose corrective action. Jerry Rogan MD
6/10/2023	Gerald Rogan	Comment: Good morning. Dr. Richard Kronick suggests in The promise and peril of health systems - PubMed • "Application of the measures of system performance to create a report card of health system performance. Such a report card, if accepted as valid, would likely motivate performance improvement." To evaluate **"systemic performance"** I recommend the State **Department of Licensing and Certification** establish a process to perform **root cause analysis** of hospitals that have failed, as did Redding Medical Center in Redding California 1998-2002, and St. Helena Hospital more than a decade later. Both of these insitutions were fined millions of dollars because they provided medically unnecessary services. The root cause analysis would have identified how the "systemic performance" of these institutions failed (i.e. the patient

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		safety systems), how government oversight failed, and how JCAHO failed. When a hospital and some of its medical staff pay a large fine to the government for provision of medically unnecessary care, such as several million dollars, and when the miscreant behavior is discovered through a **Qui Tam Law suit**, this constitutes **evidence** of a failure of government oversight of that institution. In the case of RMC, government oversight failed to indentify a failure of medical staff peer review. A RCA, which my team provided in the RMC case, discovered the failure of its peer review. One remedy we suggested is to make medical staff peer review effective. In the case of RMC it was ineffective because the lay leaders of the hospital had the power to appoint the leader of the medical staff peer review for the Departments of Cardiology and Cardiac Surgery. The physicians selected was the miscreant physicians, Chae Moon, MD, and Fidel Realyvasquez. Over 700 patients were damaged. By establishing a RCA process of medical disasters, we can identify how hospitals and their medical staff fail and what remedies would be helpful. Where a 747 to crash into Mt. Shasta, killing everyone, the FAA would performs a root cause analysis. When a greater number of patients were damaged at RMC, no government sponsored RCA was peformed. Only fines were paid and the hospital lost its license. We did not learn anythiing to prevent a similar disaster, which then happened again at St. Helena Hospital.

Date	Name	Written Comment
		Jerry Rogan, MD Fairfax, Virginia Sacramento, California Office: 916-978-9636 Cell: 530-514-1139 www.roganconsulting.com
6/12/2023	Ben Johnson on behalf of California Hospital Association	See attachment #1.
6/16/2023	Beth Capell on behalf of Health Access	See attachment #2

California Hospital Association

June 12, 2023

Mark Ghaly, MD
Chair, Health Care Affordability Board
1215 O St.
Sacramento, CA 95814

SUBJECT: Comments on the May 23, 2023, Health Care Affordability Board Meeting

Dear Dr. Ghaly:

Just like the Health Care Affordability Board, California's hospitals are dedicated to ensuring patients receive high-quality, timely, equitable, and affordable health care. The California Hospital Association (CHA), on behalf of its more than 400 hospital and health system members, appreciates the opportunity to engage with the governing board and staff of the Office of Health Care Affordability and offers comments on the presentations and proceedings of the May 23, 2023, Health Care Affordability Board meeting.

Advisory Committee Structure and Appointments

CHA Appreciates the Appointment of Hospital Experts but Is Concerned About Potential Changes to the Committee's Composition. Close engagement with health care stakeholders is essential in order for the office to fulfill its multifaceted mission. The establishment of a carefully crafted advisory committee is vital to this purpose. The May board meeting included thoughtful deliberation about the construction of the advisory committee and the appointments of most of its members. CHA appreciates that hospital voices will be able to provide their input and expertise on the committee. We further recognize that a delicate balance was struck in appointing members with different experiences and backgrounds. However, we find it troubling that changes are under consideration that would disturb this balance. We urge the board to consider how any further changes to the composition of the committee must be balanced by additional appointments, including an appointee who adds expertise on statewide hospital finance, operations, and policy issues.

It Is Essential to Distinguish Between Health Care Workers and the Political Organizations That Represent Some of Them. CHA recognizes that the representation of organized labor on the advisory committee is both warranted and consistent with the intent of the authorizing legislation. However, during the advisory committee discussion, it gave us pause to hear remarks that conflated the roles and expertise of frontline health care workers and union representatives, which we regard as distinct. In selecting payer and provider representatives on the committee, the board clearly sought to obtain *on-the-ground* expertise from members working directly for payers and providers. Selecting political

organizations to represent health care workers would be inconsonant with this approach. Accordingly, in considering the outstanding appointments, we urge the board to draw a clear distinction between frontline health care workers and the political organizations that represent a portion of them at the state level.

The Limits of Payer Reporting

We understand that getting data in quickly is critical for the office to meet its statutory timelines. However, tight timelines do not absolve the office from thoughtful and transparent deliberation over key data collection approaches. Overall, we agree with the office that collecting health care cost data from payers is a reasonable approach to gathering the information needed to set and monitor compliance with the health care targets. Nevertheless, it is critical for the office to recognize and address the major shortcomings of this approach to data collection.

Where Is the Strategy for Analyzing Cost Drivers? We understand that payer data will show where costs are growing but will provide little to no information on the drivers of health care cost growth. When asked by a board member how the office would evaluate administrative cost shifts from payers to providers, the office's response fell short of demonstrating a commitment to carefully considering this important issue. This raises further questions about whether the office is adequately preparing to develop a strategy to thoughtfully analyze cost drivers and incorporate this analysis into its overall policy approach. For the office to be successful in supporting a high-value health care system — rather than a low-cost, low-quality, and low-access one — it must develop and release for public consideration a strategy to thoughtfully analyze the underlying drivers of health care cost growth, including those associated with payer policies that shift and hide the true costs of providing health care.

External Validation of Payer Data is a Necessity. Early indications reveal that payer-reported data will be the spine supporting most of the office's oversight and enforcement activities. Bad or politicized data would seriously undermine the office's credibility and mission. For this reason, external checks on the validity of payer-reported data will be critical. Here, Maryland can serve as a model for the office, where the state and provider community work together to ensure the reliability of the data underpinning its health care affordability programs. We recommend the office begin public deliberations now on data transparency and approaches for ensuring the validity of payer-reported data.

Patient Attribution Policies Merit Scrutiny. During the board meeting, patient attribution was portrayed as a relatively straightforward and noncontroversial component of state health care affordability programs. We would challenge this portrayal. Maryland, which has led the nation in implementing a global payment system for hospital services and operates under total cost of care targets, has spent years trying — with mixed success — to develop and implement a rational patient attribution process. Its chosen approaches have proven controversial to this day as hospitals regularly report not having seen patients who are attributed to them, and vice versa.

While the misattribution of patients might be of small consequences for low-cost patients at large health care entities, a single high-cost patient (who might incur millions of dollars in expenses in a single year) misattributed to even a medium-sized health care entity could be the difference between whether that entity makes or misses its cost target. We recommend that the office and board carefully consider this scenario in the development of a reasonable patient attribution policy.

Furthermore, letting payers select their own patient attribution methodologies has serious potential to introduce unreliable, incommensurable, and potentially manipulated data into the cost target program. We recommend the office set clear and consistent standards for patient attribution, including ways to facilitate external validation of the associated data.

Cost Target Adjustments

We appreciated the overview of required and potential adjustments to the cost targets at the May board meeting. This is a complex area, both in terms of the requirements under state law and the technicalities of how to appropriately implement the adjustments. While significant further deliberation of these adjustments clearly is warranted, we would raise three initial issues for consideration:

Regulations Must Strike a Balance Between Flexibility and Rigidity. The success of California's cost target program depends on the ability to strike an appropriate balance between flexibility and rigidity in the setting and enforcement of the cost targets. Flexibilities that must be considered include opportunities to modify targets or their enforcement based on economic and public health trends and shocks, policy changes that affect the cost of care, and other difficult-to-control inputs and drivers of underlying costs. On the other hand, clearly defined processes and rules are necessary to avoid arbitrary and capricious penalization of health care entities that do everything to meet the spirit but not the letter of the authorizing law. We look forward to engaging with the office on an ongoing basis on how to strike this delicate balance.

A Glide Path Is Essential. The diffusion of new policies and practices to improve the value of care will be necessary to achieve the office's multipronged mission. The fruits of these innovations will take time to germinate. For this reason, it is critical that the office create a glide path that gives the health care system time to adapt to the new equilibrium that will exist under office oversight. As the May board meeting presentation showed, other states recognized the importance of not shocking the system with cost targets that are significantly at odds with prior spending trajectories.

Urge Greater Public Involvement and Deliberation Before Arriving at Even Preliminary Decisions, Including Risk Adjustment. Risk adjustment is a critically important component of the cost targets that is intended to ensure that the targets do not inappropriately penalize health care entities for factors beyond their control. Moreover, it is a complex area that is subject to active and ongoing academic and policy debates. We question the prudence of staking even a provisional position on risk adjustment at the very first public meeting on the topic, without releasing any detailed assessment of the benefits *and tradeoffs* of the preferred approach, and without gathering input from stakeholders. Specifically, when it comes to risk adjustment, the office stated a preference for only risk adjusting based on age and sex, a form of risk adjustment that explains a paltry 1% of the variance in health care spending across patients.[1] Adopting this approach could cause health care entities to think twice about caring for the most vulnerable patients, such as those with mental illness and other chronic diseases, when doing so could raise their costs over time and limit their ability to meet their cost target. A more holistic approach to risk adjustment has the potential to address this shortcoming, albeit while introducing other tradeoffs that should also be considered. Ultimately, the discussion revealed a troubling lack of public engagement

[1] Joseph P. Newhouse, Melinda Beeuwkes Buntin, and John D. Chapman. 1999. "Risk Adjustment and Medicare." *The Commonwealth Fund.* https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_1997_apr_risk_adjustment_and_medicare_newhouse_riskadj_revised_232_pdf.pdf

and transparent assessment of key decisions that the office is already arriving at, even if preliminarily. Going forward, we urge the office to demonstrate more diligence in involving the public prior to arriving at important policy decisions such as this.

Sincerely,

Ben Johnson
Vice President, Policy

cc: Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Members of the Health Care Affordability Board

HEALTH ACCESS CALIFORNIA

June 9, 2023

The Honorable Mark Ghaly, M.D., Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Department of Health Care Affordability and Information

Vishaal Pegany, Deputy Director
Department of Health Care Affordability and Information
Office of Health Care Affordability

Re: May 2023 Health Care Affordability Board: Comments

Dear Dr. Ghaly, Ms. Landsberg, Mr. Pegany,

Health Access California, the statewide health care consumer advocacy coalition committed to quality, affordable health care for all Californians, offers comments on the May 2023 Health Affordability Board presentation and actions. We again point to our guiding principles which we hope will also guide the work of the Board, staff, Advisory Committee and workgroups.

Key Points:

- Board process and responsibilities: We appreciate the helpful clarity provided by the delineation of board, staff, and advisory committee responsibilities.
- Advisory board composition: We support a balance between those who represent health care entities subject to the target, including managers and administrators, as opposed to those who purchase or pay for care and coverage, as consumers, workers, unions and other purchasers.
- Measuring consumer affordability: We believe that "total" health care expenditure (THCE) data reported by payers can, and should, be reported as "consumer paid" and "payer paid".
- Reporting THCE: We support using Covered California regions, which applies to the entire individual and small group markets for

- rating and rate review and creates units of analysis comparable in the total population of other states.
- Disaggregating THCE by service categories: We suggest alignment with existing California law, particularly rate review. If good policy suggests other categories, then please consider revising that law.
- Primary care attribution: We support the staff proposal that for those provider entities that include primary care clinicians, primary care attribution be used but not for the physician organizations subject to the cost targets consist of specialists without primary care clinicians. We also ask whether or not primary care attribution is appropriate for PPOs, fee-for-service Medicare and fee-for-service Medi-Cal.
- Risk adjustment: We offer the following comments:
    - The statute requires risk adjustment at the entity level but not necessarily at the state or regional level, but leaves the determination of the risk adjustment methodology to OHCA.
    - Entity level risk adjustment: Given the "perverse incentives" created at the entity level to upcode, we support either adjusting risk on age and sex as proposed by staff or not at all. It is also worth considering whether there are clinical indicators that are not subject to gaming by the entity itself.
    - State or regional level adjustment of targets: In addition to age and sex, the Board and staff should consider race and ethnicity as well as some measure of ability to afford care and coverage such as the tightly interrelated measures of income, education and occupation.
- Truncating patient outliers without consideration of the policy implications: We are concerned with the recommendation to truncate patient outliers, which may undercut the role of OHCA as providing an overview of the health care system as a whole and risks ignoring significant cost drivers, both those raising legitimate clinical concerns and those that are indicators of inappropriate or excessive utilization.

Board Process and Responsibilities
First, we appreciate the clarity of the board agenda which separated into three buckets the items to be presented:

- Action items for the Board
- Discussion items on which future Board action may be taken
- Information items which the staff is presenting the Board for its input but which are not subject to Board action.

The division of labor among the Health Care Affordability Board, the Advisory Committee and the HCAI staff is complicated and not readily obvious. Outlining who does what at each meeting is helpful and we trust will continue.

The lack of clarity at the second Board meeting about the role of the Board and the implications of the Board votes without public comment was troubling. We appreciate the steps taken to rectify this.

Advisory Committee
Health Access appreciates its inclusion in the advisory committee alongside other strong consumer advocates.

We support a balance within the advisory committee—meaning a balance between the perspectives of the entities to which the targets apply and those who pay for care and coverage, either as individual consumers, those who pay for coverage through collectively bargaining for health benefits, or as purchasers who are employers of the working families.

Since we do not have access to the applications to the Advisory Committee, we offer recommendations based on our long experience working with various parties on cost, quality and equity issues.

- Add a small business representative: We appreciate the purchasers already selected, but that representation could be broadened. The Wonderful Company has over 9,000 employees. Similarly, CHCC represents mostly purchasers with several thousand or more employees. The San Francisco Health Service System is a large purchaser on behalf of the employees of the City and County of San Francisco. One strong option would be Small Business Majority, which Health Access has worked with since the fight to enact the ACA and before, on a wide range of health issues, from the coverage to cost

containment. We know they strive to represent the voice of small business without having health industry representation in their organization.

- Add a health researcher and subject matter expert: One strong candidate would be Cheryl Damberg, senior RAND researcher, with whom Health Access has served on both the HCAI Health Payments Database committee and DMHC's quality and equity committee. In each case, we have found her a valuable committee member that brings a deep understanding of cost implications as well as quality and equity measures. Given OHCA's charge to monitor quality and equity alongside the cost targets, her deep knowledge would be helpful. Our experience is that a committee member serves a different role in such discussions than an occasional presentation by a researcher.
- Ensure adequate labor representation: We also commend to the subcommittee and staff the labor representatives from Monterey who have made the long journey to Sacramento to share their stories of the impact of health care costs in one of the most expensive regions in California. This is a region where in the past, a single hospital, Community Hospital of the Monterey Peninsula (CHOMP) was an outlier but now the two other hospitals in the region have prices reportedly as high as 800%-1,000% of Medicare, an astonishing run-up in costs with apparently little or no improvement in quality or equity.

We leave to our friends in the labor movement the definition of "worker" but observe that directors, administrators and managers generally are not considered "workers".

Consumer Affordability: "Consumer Paid" and "Payer Paid"

We encourage the staff to investigate whether plans can report "payer paid" amounts, including incurred amounts, as well as "consumer paid" data rather than grouping both together as the "allowed amount" or negotiated rate. This would allow tracking of "consumer paid" amounts over time.

It is our understanding that plans have the capacity to separate "consumer paid" from "payer paid" and do so consistently over time. This may already be occurring in other states such as Massachusetts. Our review of the California HPD data submission manual suggests that the HPD may already be collecting this data for the state-regulated part of the market, including state-regulated self-insured plans such as the CalPERS self-insured plan. HPD Data Submission Guide - Final Copy (ca.gov) includes deductibles, copays, coinsurance and other consumer paid

amounts. It would take further research by the staff to determine whether "consumer paid" amounts and the data already planned to be collected by the California HPD are identical or differ in some ways that may not be obvious.

When Massachusetts began its health care cost growth benchmarking, it was focused on overall costs rather than consumer affordability. It is our understanding that Massachusetts had the opportunity to collect "payer paid" separately from "consumer paid" but did not do so initially though it does so now. Subsequent states used the templates developed in Massachusetts replicating the initial approach in Massachusetts rather than improving on what was learned there. Having data that separates "allowed amounts" into "consumer paid" and "payer paid" would fill an important data gap so that the OHCA staff and board could track consumer affordability as envisioned in the statute.

One limitation of this data will be that it does not include data about care in which a consumer pays out-of-pocket for benefits that should have been covered in-network such as behavioral health. This sort of out-of-network care is extremely common for behavioral health. For physical health, most care is provided in-network (or as if in-network) and would be included in the HPD data set.

We note that this data set does not eliminate the need for other measures of consumer affordability, including the ability to afford care as well as coverage and the impacts of the lack of affordability, particularly on low- and moderate-income Californians. These impacts include not only medical debt but the challenges affording other needs, such as food and housing.

"Total" Health Care Spending: Levels of Reporting: State/Covered California Regions

Health Access supports the adoption of the Covered California regions for baseline reporting of "total" health care expenditures. If the unit of comparison is Rhode Island, with a population of less than 1.1 million, then reporting on the City and County of San Francisco with its almost 900,000 people as a reporting region is analogous. Similarly, each of the two Los Angeles County regions with 5-6 million Californians is roughly comparable to the total population of several relatively large states.

As shown in the presentation, Covered California wage-adjusted premiums[1] for Region 1, the North Coast, are literally 2.5 times higher than the premiums for the Los Angeles County region. Monterey is Region 9: Covered California premiums

there are about twice the premiums for the LA regions. This regional variation was at the heart of the legislative debate about the creation of OHCA and should be reflected in the initial reporting by OHCA.

While the 19 regions are commonly referred to as the Covered California regions, these regions apply to the entire individual and small group markets for purposes of both developing rates, including both premiums and cost sharing. These regions are also the basis of reporting for the state-regulated large group market. Rate review in the individual and small group markets has been in place since 2011. Using the same rating regions as are used rate review will facilitate translating the cost targets into rate review. The enabling statute contemplates the use of these regions in the definition of geographic regions in Health and Safety Code 1385.01.

Disaggregating "Total" Health Care Spending by Service Categories

The proposed service categories may be used in other states but it is fair to ask whether they are appropriate to California's need and current law. The proposed categories are different than those used for other purposes in California, such as rate review. If the determination is made to use different categories, how the categories align or do not should be considered and there should be valid policy reasons for using different categories. We also note that the enabling statute tends to refer to categories used in rate review.

With respect to service level categories when payment is made on a capitated basis, again California law provides an answer that may not be available in other states. Whether payments are made on a capitated or non-capitated basis to providers, California law already requires reporting by service categories. Specifically, California rate review law provides that a fully integrated delivery system report projected trend by service categories and if that entity is unable to report project trend, that it shall report by budget categories that provide the same information. If Kaiser is failing to do so, then they are failing to comply with the law and that is a good discussion to have with DMHC, the regulator. For risk bearing organizations which are capitated at the group level and which are the only medical groups permitted to take risk under state law, DMHC may also be able to provide insight into whether and how many groups take risk only for professional services or take full risk, including both professional services and institutional care.

Reporting by service category, for both capitated and non-capitated payers and other entities, should be readily feasible given current California law. We also note that if the determination is made to alter the service categories, the Administration

may wish to consider sponsoring legislation to align the categories used in rate review.

Measuring Total Medical Expenditure by Entity: Not Just Primary Care

Health Access supports, at a high level, the proposed direction of staff to use:

- Primary care attribution for measurement of total medical expenditure (TME) for provider entities with primary care clinicians
- Alternative methods of assessing health care spending for provider entities for which primary care attribution is not possible (or appropriate).

The spending targets under California law encompass not just payers but also providers. The law defines physician organization as any lawfully organized group of physicians with 25 or more physicians or a smaller group of physicians which are high-cost outliers compared to the statewide average (H&S 127500.2 (p)).

Examples of provider entities for which primary care attribution is not appropriate and to which California law says the spending targets apply include but are not limited:

- Vituity which began as California Emergency Physicians and now includes over 5,000 clinicians, either hospital-based or urgent care but not ongoing primary care.
- Another example, Envision includes various hospital-based specialties but no primary care physicians, as best we can determine.
- A gastroenterology group with 50-60 physicians in the North Bay and East Bay of the Bay Area which used its monopoly position as the only non-Kaiser provider of such services in the commercial market to bargain for higher commercial reimbursements during the launch of Covered California.

In developing its roster of physician organizations, OHCA should determine whether or not physician organizations include primary care clinicians and if not, whether the physician organization has an exclusive relationship with a health system or health plan that does include primary care.

The Board discussion focused on primary care attribution at the payer level, not the provider level. In keeping with that discussion, we suggest some caveats or revisions to the staff recommendation. We appreciate the discussion of the Board members about the challenges with primary care attribution for PPOs and fee for service in Medicare and presumably Medi-Cal. While the fraction of Medi-Cal enrollees in fee-for-service is only 6% of the total enrollment, this includes some of

the most expensive and high need patients in any system, specifically many of those who are dually eligible for both Medicare and Medi-Cal. Whether it is a PPO in which there is no primary care physician associated with an enrollee or fee-for-service Medicare or fee-for-service Medi-Cal, is primary care attribution appropriate for patients without primary care providers? Or perhaps OHCA in its primary care workgroup should consider adopting the policy already implemented by Covered California to ensure that every Covered California enrollee has a primary care provider and move this policy statewide as part of its mission to improve reliance on primary care in California.

Risk Adjustment: Statewide versus Entity Level: The Statute

The presentation and discussion in May 2023 did not clearly distinguish between risk adjustment at the entity level and the statewide level. Section 127502 on cost targets appears to distinguish between entity level targets and statewide targets. Risk adjustment is clearly contemplated for entity level targets in (e). What is left to implementation in (f) is what that methodology should be, other than that it should be "available and transparent to the public" and set by the Office in consultation with the Board. The appendix includes the relevant provisions of state law.

Taken together, the statute clearly contemplates the advantages and disadvantages of risk adjustment at the entity level but does not clearly require the use of risk adjustment at the state or regional level. The law points to the good policy reasons for doing risk adjustment: the danger in the pursuit of lower costs, payers or providers will avoid high risk populations or fail to pay for their care. But the law also points to the potential perverse consequences of risk adjustment such as upcoding.

The law leaves to implementation the methodology for risk adjustment at the entity level. Distinguishing adjustments made at the entity level from those at the statewide/regional level may facilitate the discussion. We turn first to the entity level and then to the statewide or regional level.

Risk Adjustment: Entity Level

Given the experience in other states as presented, OHCA staff is considering using age and sex adjustment only. The experience in other states combined with the Medicare Advantage experience suggests to us that at least initially, limiting risk adjustment to age and sex only is likely an appropriate approach, though we would benefit from the discussion of the Board and others. Another approach to consider

is that adopted in Massachusetts and other states to allow no risk adjustment based on clinical status.

The enabling statute envisions the possibility of clinical risk adjustment at the entity level but allows for "other adjustments". The statute points to some of the reasons that clinical risk adjustment may be appropriate at the entity level. Specifically, the law says:

> 127502 (e) (2) Allow for the setting of cost targets that encourage an individual health care entity to serve populations with greater health care risks

The law then goes on to talk about risk adjustment reflecting the health status of the entity's patient mix as well as equity adjustments to account for social determinants of health and geographic cost adjustments, including labor costs. The purpose is to encourage health systems and payers not to avoid high risk populations or shortchange the care of such populations.

This provision must be balanced against the next sentence which speaks to the "perverse incentives that inflate the measurement of population risk" in H&S 127502 (e) (3). As the presentation indicates, the incentives for upcoding at an entity level are considerable and well established in the experience of cost commissions in other states such as Rhode Island and Massachusetts. This has also been the experience in Medicare Advantage which pays in part based on the health status of the population, creating a considerable incentive for Medicare Advantage plans to search for diagnoses that increase reimbursement to the plan. In other states with cost commissions, the material presented by staff suggests that upcoding has driven the cost curve upwards to the cost trend of 6%-7% or even 7%-8%. Since underlying medical trend in California has run about 6%-7% or higher over the course of the last decade, the achievement of the cost commissions in other states in bending the cost curve is significantly diminished in light of the evidence of upcoding. Based on this experience, Massachusetts now recommends evaluating payer and provider performance on growth in unadjusted spending as does Nevada. Other states have moved to risk adjustment based only on age and sex.

A policy question to consider is whether there is a more limited set of clinical indicators that is less subject to gaming by providers or payers. Disability status for purposes of other programs, such as Medicare, Medicaid, California Children's Services or regional centers, might constitute part of an approach but that requires

matching eligibility status with claims data, a chore in itself. Is there a limited set of clinical conditions that is not easily gamed by either payers or providers short of outright fraud? Perhaps. Perhaps a review of the ACA benefit and payment parameters risk adjustment policy might allow development of such a subset of clinical risk factors. Entity-level targets are not required to be set until 2027 which would allow time for further research and analysis.

Payer risk mix in the individual and small group markets is subject to standardized, transparent risk adjustment methodology as is Medicare Advantage payer risk mix. It remains unclear to us whether health plans that are lower risk in the individual and small group markets have healthier populations, better managed care, less inappropriate utilization, or some combination of all three—or none of these. There is now almost a decade of experience under the ACA, sufficient time to allow independent analysis of this question.

We would note that some of the plans that appear lower risk in the commercial market have in recent years been subject to assertions of upcoding in the Medicare Advantage market. Given the stability of enrollment for carriers, it seems unlikely that risk profile of those ages 50 or 54 to 64 is significantly different than the risk profile of those ages 65-75 or 65-80. Again, there may be research which illuminates this particular question with which we are not familiar. Or it may just be that the financial incentives flip when enrollees turn age 65.

For all of these reasons, for risk adjustment at the entity level, we support either the use of age and sex as recommended by staff or no adjustment at all. Again our thinking would benefit from Board discussion and any further considerations presented by staff.

Risk Adjustment: State/Regional Level

The statute requires statewide or regional targets to take into account population indicators, such as aging, and economic indicators. The statute does not clearly require risk adjustment at the state or regional level. It does require development of a risk adjustment methodology at the "sector" or entity level. The May 2023 presentation and the discussion did not clearly separate the entity level from the state/regional level.

At a state or regional level, the law speaks to "population-based measures", including changes in demography such as aging (H&S 127502 (c) (1) (C)). Here both age and sex seem appropriate adjustment factors and readily available from the

data. Those in the health care industry frequently point to the aging of the population to justify cost increases. It is correct that some regions have different age profiles than others: for example, school age children are more prevalent where housing costs are lower while some parts of rural California seem to be disproportionately over age 65.

Given the diversity of California, we ask whether race and ethnicity should be considered as adjustment factors at the state/regional level. We also ask that some measures of income or other related measures be considered. Affluence, both individual level and zip code level, is clearly correlated with better health status as well as with education and occupation. The relationship of income and race/ethnicity to health care utilization is more muddled and perhaps non-linear because of the barriers to obtaining care that the staff identified, briefly on slide 63. Someone living in East Oakland has considerably more barriers to care than someone living in Westwood, in an affluent part of Los Angeles near UCLA. This is true even if the health needs of someone living on a modest income in a difficult neighborhood are likely to be greater than those of an affluent woman of the same age, making a comfortable living in a quiet neighborhood that facilitates outdoor activity. That example is a good example of higher utilization not necessarily reflecting higher health care needs. Adjusting for race and ethnicity as well as income at a state or regional level should be possible and help to adjust for underlying health care needs.

With respect to equity adjustments, because the literature and the data collection is not as yet fully developed, yet we feel the urgency of doing the work for as long as it takes to get it right and have it be foundational to the Office. The Office should continue to work on analysis and reports as the data and the science improves. We regret that neither the current data or the current literature permit adjustments based on sexual orientation and gender identity (SOGI) and encourage revisiting this and other equity adjustments in future years.

Truncating Patient Outliers: Why Do Patient Outliers Occur?

Health Access opposes the proposal to truncate the outliers for statistical reasons without examining the reasons for the outliers. The right answer is to investigate why the outliers are occurring, whether the care is clinically appropriate, and whether the outliers reflect clusters of cost drivers that are well within OHCA's domain as well as whether further state action is warranted.

If outliers appear to be genuinely random and not concentrated in particular diagnoses or particular populations, then truncating them may be appropriate--but not without first asking some questions about what the outliers reveal, and not without thinking through this suggestion in terms of both statistical implications and policy impacts. Patient outliers may reflect random distribution, areas of concern for clinical reasons or indicators of inappropriate, even excessive utilization to the point of fraud.

In cases of genuine clinical concern, truncating outliers at the state or regional level may obscure real health care needs. Examples in which high-cost patients are not random but instead a clinical concern come from long COVID today but also include the early days of the AIDS epidemic in the late 1980s as well as Black maternal and infant mortality and many other examples of patient outliers. In each of these examples, the high-cost patient outliers indicate a clinical need that the health care expenditure data may expose and that should be addressed by other parts of state government or the health system.

How to deal with a specific health plan or health system that cares for a disproportionate number of such cases is a different question. The law regarding enforcement of cost targets provides numerous steps in which such concerns may be raised by a payer or health system.

However, there are also instances in which "high cost" patients reflect inappropriate or excessive utilization, sometimes to the point of fraud. In one famous case here in California, a hospital system in Redding and Red Bluff had a large number of kwashiorkor cases, a protein deficiency most commonly seen in children in the tropics, but in this instance the California cases were people in the 50s and older[2]. Similarly, there was excessive utilization of other procedures, to the enrichment of the health system and the risk of patients[3] which finally resulted in federal Department of Justice false claims act settlement. In these cases, outliers were not occurring "randomly" and drove costs in the system as well as potential harm to patients. Even less extreme examples of inappropriate or excessive utilization may reflect avoidable cost drivers such as the need to better manage care for ambulatory sensitive conditions. In instances of patient outliers due to inappropriate utilization, OHCA should determine whether such "outliers" should be referred to other state agencies such as CDPH, DHCS, DMHC and California Department of Justice.

One cluster of cost drivers already brought to the attention of the board are hospitals in a geographic region such as Monterey or Santa Barbara. Another example familiar to this Administration is physician specialties using the leverage of functional monopolies to drive prices, as was done prior to the enactment of the prohibitions on surprise medical bills by facility-based physicians that failed to contract and had charges as high as 900% of Medicare. These are provider cost outliers, not high-cost patient outliers. Provider cost outliers are clearly part of OHCA's statutory responsibility.

Part of the role of OHCA is to provide an overview of the health care system: truncating patient outliers on statistical grounds alone is a disservice to that role and to Californians. It may be that some outliers, or even clusters of outliers, are truly random but it may not be. Truncating patient outliers without further examination of the reasons for the outliers is something we oppose based on our experience.

Conclusion

Health Access appreciates the opportunity created by the public Board meetings to offer public comment before, during and after the meetings on topics of importance considered by the Board. We will continue our participation in this and other venues provided by HCAI and specifically OHCA.

Thank you for your work on this important project.

Sincerely,

Beth Capell, Ph.D. Anthony Wright, Executive Director

CC: Susan Eggman, Chair, Senate Health Committee
Jim Wood, DDS, Chair, Assembly Health Committee
Caroline Menjivar, Chair, Senate Budget Subcommittee on Health and Human Services
Joaquin Arambula, M.D., Chair Assembly Budget Subcommittee on Health and Human Services

Appendix: Risk Adjustment: Relevant Statutory Provisions

On entity-level targets, the law in H&S 127502 says:

> (e) The methodology for setting a sector target for an individual health care entity shall be developed taking into account the following:
> (1) Allow for the setting of cost targets based on the entity's status as a high-cost outlier.
> (2) Allow for the setting of cost targets that encourage an individual health care entity to serve populations with greater health care risks by incorporating all of the following:
> (A) A risk factor adjustment reflecting the health status of the entity's patient mix, consistent with risk adjustment methodology developed under subdivision (f).
> (B) An equity adjustment accounting for the social determinants of health and other factors related to health equity for the entity's patient mix, consistent with subdivision (g).
> (C) A geographic cost adjustment reflecting the relative cost of doing business, including labor costs in the communities the entity operates.

On targets that apply statewide as well as at the entity level, the law in H&S 127502 says:

> (c) The health care cost targets shall meet all of the following requirements:
> (1) Promote a predictable and sustainable rate of change in per capita total health care expenditures.
> (2) (A) Be based on a target percentage, with consideration of economic indicators or population-based measures, and be developed based on a methodology that is available and transparent to the public.
> (B) Economic indicators *may* include established measures reflecting the broader economy, the labor markets, and consumer cost trends.
> (C) Population-based measures *may* include changes in the state's demographic factors that may influence demand for health care services, such as aging.

And on public reporting, the law also in H&S 127502 says

> (j) The office shall direct the public reporting of performance on the health care cost targets, which *may* include analysis of changes in total health care expenditures on an aggregate and per capita basis for all of the following:
> (1) Statewide.
> (2) By geographic region.

(3) By insurance market and line of business, including for each pa yer.

(4) For health care entities, both *unadjusted and using a risk adjustment methodology* against the covered lives or patient populations, as applicable, for which they serve.

(5) For impact on affordability for consumers and purchasers of health care.

This section does not appear to contemplate use of risk adjustment at a state or regional level.

The section cited by staff in part reads in full:

(f) (1) In consultation with the board, the office shall establish risk adjustment methodologies for the reporting of data on total health care expenditures and may rely on existing risk adjustment methodologies. The methodology shall be available and transparent to the public.

(2) To select appropriate risk adjustment methodologies or *inform the way any adjustments are applied to unadjusted data* to account for the underlying health status of the population, the office may convene technical committees, as necessary.

(3) The risk adjustment methodologies selected *or used to inform any adjustments* shall take into account the impact of perverse incentives that may inflate the measurement of population risk, such as upcoding. The office may audit submitted data and make periodic adjustments to address those issues as necessary.