HCAi
Department of Health Care Access and Information

Health Care Affordability Advisory Committee

November 30, 2023

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Department of Health Care Access and Information

Welcome, Call to Order, and Roll Call

Agenda

1. **Welcome and Call to Order**

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

3. **Cost and Market Impact Review (CMIR) Regulations Update**
   Sheila Tatayon, Assistant Deputy Director

4. **Draft Alternative Payment Model Standards and Adoption Goals**
   Margareta Brandt, Assistant Deputy Director

4. **Total Health Care Expenditures Regulations Update**
   Vishaal Pegany, Deputy Director, CJ Howard, Assistant Deputy Director

5. **Spending Target Discussion**
   Vishaal Pegany, Deputy Director, CJ Howard, and Michael Bailit, Bailit Health

6. **General Public Comment**

7. **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

Slide Formatting

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

2024 Public Meeting Calendar

Department of Health Care Access and Information

Health Care Affordability Board Meetings*

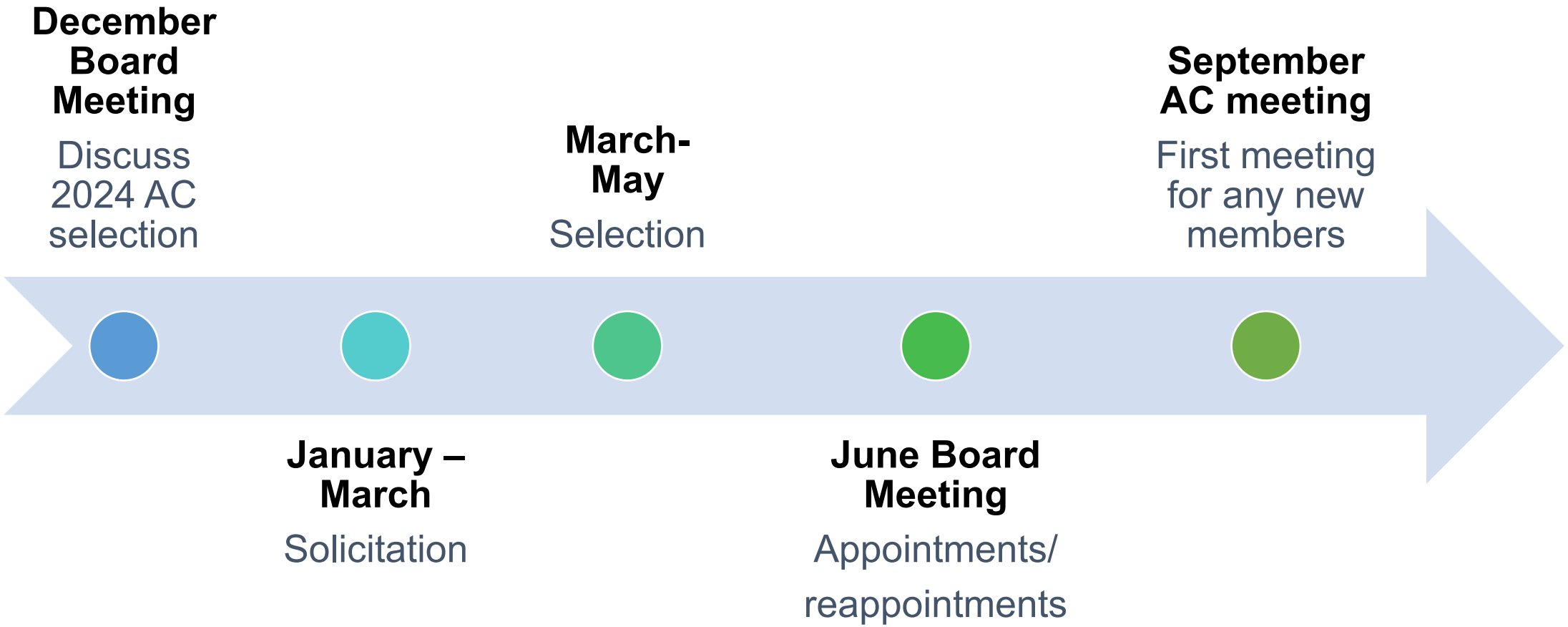
Wednesday, January 24
Wednesday, February 28
Wednesday, March 27
Wednesday, April 24
Wednesday, May 22
Wednesday, June 26
Wednesday, July 24
Wednesday, August 28
Wednesday, September 25
Wednesday, October 23
Wednesday, November 20

Health Care Affordability Advisory Committee Meetings*

Tuesday, January 23
Tuesday, April 23
Thursday, June 27
Thursday, September 26

*Dates subject to change

Advisory Committee (AC) Member Selection Timeline



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Cost and Market Impact Review (CMIR) Regulations Update

Sheila Tatayon, Assistant Deputy Director

Regulation Drafts Posted Comments Received and Considered

July 31st Draft Posted/August 31st Comment Deadline	August 15th Public Workshop (on the July 31st Draft)	October 9th Revised Draft Posted/October 17th Comment Deadline
21 commenters provided written comments.	13 commenters shared comments at the workshop.	16 commenters provided written comments.

These totals included multiple comments (workshop & written) from the same commenter for a total of 29 different commenters.

- Commenters included physician groups, health plans, hospital systems, consumer advocacy groups, unions, and medical, hospital, and nursing associations.

Changes to the Proposed Regulations since the September Meeting

Changes to Definitions

- "**Affiliation**" – was amended to clarify that clinical trials, medical education programs, and other types of education or research are excluded from consideration.
- "**Health care entity**" – was amended to remove the definition of MSOs and to clarify the circumstances when an affiliate or subsidiary would quality as a health care entity.
- "**Material change transaction**" – was amended to clarify situations that do not qualify as material change transactions including those in the regular course of business.
- "**Transaction**" – was amended to clarify that transactions are between a "health care entity" and one or more entities, to clarify that out-of-state transactions may be subject to filing requirements, and to clarify that OHCA will review transactions that *transfer* a material amount of control, responsibility, or governance of the assets or operations of the health care entity to one more entities.

Changes to the Proposed Regulations since the September Meeting

§ 97431(g) – Health care entity

"Health care entity" shall:

(1) Have the meaning set forth in section 127500.2(k) of the Code;

(2) Include pharmacy benefit managers as set forth in sections 127501(c)(12) and 127507(a) of the Code;

~~(3) Include a management services organization, which qualifies as a "payer" for the purposes of these regulations~~

(3) Include any parents, affiliates, subsidiaries, or other entities that act as an agent in California on behalf of a payer, provider, fully integrated delivery system, or pharmacy benefit manager, and either:

(i) control, govern, or are financially responsible for the health care entity or

(ii) ~~that~~ are subject to the control, governance, or financial control of the health care entity, such as an organization that acts as an agent of a provider(s) in contracting with payers, negotiating for rates, or developing networks; or

(iii) in the case of a subsidiary, a subsidiary acting on behalf of another subsidiary.

(4) Exclude physician organizations with less than 25 physicians, unless determined to be a high-cost outlier, as described in 127500.2(p)(6) of the Code. ~~For purposes of these regulations~~, Any health care entity entering into a transaction with a physician organization of less than 25 physicians remains subject to the notice filing requirements of section 97435.

Changes to the Proposed Regulations since the September Meeting

§ 97431(j) – Material change transaction

- "Material change transaction," as used in section 127507(c)(1) of the Code, shall mean a transaction (as defined in this section), which meets the requirements of section 97435(c). "Material change transaction" does not include:
  - (1) Transactions in the usual and regular course of business of the health care entity, meaning those that are typical in the day-to-day operations of the health care entity.
  - (2) Situations in which the health care entity directly, or indirectly through one or more intermediaries, already controls, is controlled by, or is under common control with, all other parties to the transaction, such as a corporate restructuring.

§ 97431(p) – Transaction

- "Transaction" includes mergers, acquisitions, affiliations, or ~~other~~ agreements impacting ~~involving~~ the provision of health care services in California, that involve a transfer ~~change~~ of assets (sell, ~~transfer,~~ lease, exchange, option, encumber, convey, or dispose) or transfer of control, responsibility, or governance of the assets or operations of any health care entity in whole or in part to one or more entities ~~entail a change, directly or indirectly, to ownership, operations, or governance structure involving any health care entity~~.

Changes to the Proposed Regulations since the September Meeting

Thresholds for filing

- OHCA narrowed the **HPSA threshold** so that only those health care entities *located* in a **mental health or primary care designated HPSA** must file notice if they meet the circumstances for filing.

Circumstances requiring filing

- Amended the description of entities that must file a notice of material change transaction to clarify that health care entities must file only when they are party to the transaction, meet one of the thresholds, and meet one of the material change transaction circumstances.
- Removed two circumstances: 1) when a transaction involves a health care entity joining, merging, or affiliating with another healthcare entity and 2) when the transaction changes the form of ownership of a health care entity.
- 10-year lookback: OHCA revised this provision to better align with the recently issued FTC guidelines regarding how a series of transactions may be examined and to limit the scope of transactions that require notice.
- Control, responsibility, or governance: OCHA increased the amount of assets or operations that qualifies as material from 10% to 25%.

Changes to the Proposed Regulations since the September Meeting

§ 97435. Material Change Transactions.

(b) Who must file. A health care entity who is a party to a material change transaction shall file a written notice of the ~~a~~ transaction with the Office if the party meets the thresholds ~~if the transaction involves any parties listed~~ in subsections (b)(1) through (b)(3) under any one or more of the circumstances set forth in subsection (c), unless exempted by subdivisions (d)(1) through (4) of section 127507 of the Code.

(1) A health care entity with annual revenue, as defined in subsection (d), of at least $25 million or that owns or controls California assets of at least $25 million; or

(2) A health care entity with annual revenue, as defined in subsection (d), of at least $10 million or that owns or controls California assets of at least $10 million and is a party ~~involved in~~ to a transaction with any health care entity satisfying subsection (b)(1); or

(3) A health care entity located in ~~or serving at least 50% of patients who reside~~ in a designated mental health or primary care health professional shortage area in California, as defined in Part 5 of Subchapter A of Chapter 1 of Title 42 of the Code of Federal Regulations (commencing with section 5.1), available at https://data.hrsa.gov.

Changes to the Proposed Regulations since the September Meeting

§ 97435. Material Change Transactions.

(c) Circumstances requiring filing. A transaction is a material change transaction pursuant to section 127507(c)(1) of the Code if any of the following circumstances in paragraphs (1) through (8~~10~~) below exist:

(1) The proposed fair market value of the transaction is $25 million or more and the transaction concerns the provision of health care services.

(2) The transaction is more likely than not to increase annual California-derived revenue of any health care entity that is a party to the transaction by either at least $10 million or more or 20% or more of annual California-derived revenue at normal or stabilized levels of utilization or operation.

(3) The transaction involves the sale, transfer, lease, exchange, option, encumbrance, or other disposition of 25% or more of the total California assets of the submitter(s) any health care entity in the transaction.

(4) The transaction involves a transfer of or change in control, responsibility, or governance of the submitter, in whole or in part, as defined in subsection (e).

Changes to the Proposed Regulations since the September Meeting

§ 97435. Material Change Transactions (c) continued...

(5) The transaction will result in an entity contracting with payers on behalf of consolidated or combined providers and is more likely than not to increase the annual California-derived revenue of any providers in the transaction by either $10 million or more or 20% or more of annual California-derived revenue at normal or stabilized levels of utilization or operation.

~~(5) The terms of the transaction contemplate an entity negotiating or administering contracts with payer on behalf of one or more providers and the transaction involves an affiliation, partnership, joint venture, accountable care organization, parent corporation, management services organization, or other organization.~~

(6) The transaction involves the formation of a new health care entity, affiliation, partnership, joint venture, or parent corporation for the provision of health care services in California that is projected to have at least $25 million in California-derived annual revenue at normal or stabilized levels of utilization or operation, or transfer of ~~have~~ control of California assets related to the provision of health care services valued at $25 million or more.

Changes to the Proposed Regulations since the September Meeting

§ 97435. Material Change Transactions (c) continued...

(7) The transaction is part of a series of related transactions for the same or related health care services occurring over the past ten years involving the same health care entities or entities affiliated with the same entities. The proposed transaction and its related transactions will constitute a single transaction for purposes of determining the revenue thresholds in subsection (b) and asset and control circumstances in subsection (c).

(8) The transaction involves the acquisition of a health care entity by another entity and the acquiring entity has consummated a similar transaction(s), in the last ten years, with a health care entity that provides the same or related health care services. The proposed transaction and its related transactions will constitute a single transaction for purposes of determining the revenue thresholds in subsection (b) and asset and control circumstances in subsection (c).

~~(7) The transaction involves a health care entity joining, merging, or affiliating with another health care entity, affiliation, partnership, joint venture, or parent corporation related to the provision of health care services where any health care entity has at least $10 million in annual California-derived revenue as defined in subsection (d). For purposes of this subsection, a clinical affiliation does not include a collaboration on clinical trials or graduate medical education programs.~~

~~(8) The transaction changes the form of ownership of a health care entity that is a party to the transaction, including but not limited to change from a physician owned to private equity-owned and publicly held to a privately held form of ownership.~~

~~(9) A health care entity that is a party to the transaction has consummated any transaction regarding provision of health care services in California with another party to the transaction within ten years prior to the current transaction.~~

Changes to the Proposed Regulations since the September Meeting

Reporting requirements, § 97439

- OHCA removed some duplicative or potentially burdensome filing requirements.

Confidentiality, § 97439(d)

- OHCA amended the confidentiality provisions to clarify the process for requesting, granting, or denying confidentiality.

Expedited review, § 97440

- A new section lays out a process for requesting an expedited review of the notice of material change transaction. This was added to ensure that transactions that are necessary to avoid severe financial distress or a significant reduction in the provision of critical health services may move forward more quickly.

Market failure, § 97442

- A new section clarifies that OHCA has authority to conduct cost and market impact reviews of health care entities at the Director's request.

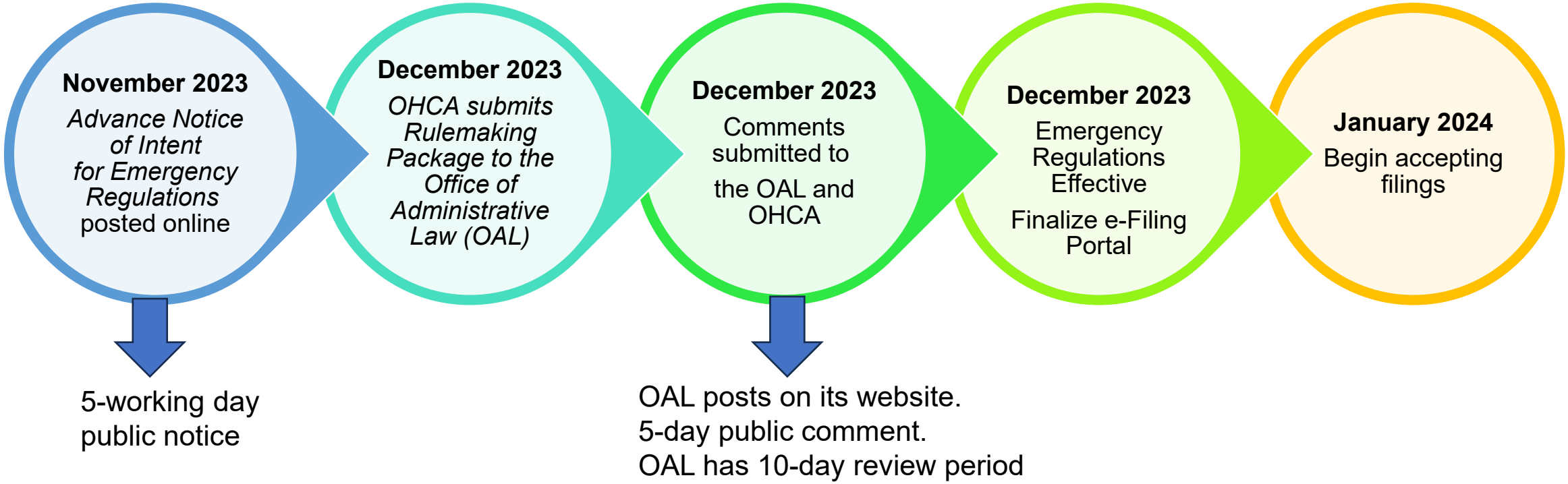
Changes to the Proposed Regulations since the September Meeting

Timeline

- The timeline to review notices of material change transactions was shortened. Health care entities will be notified within 45 days if their transaction is not going to CMIR and within 60 days if it is. § 97441(b)
- OHCA clarified the process for tolling the timelines during review of the notice and shortened the available extension period during the 90-day CMIR process. § 97441(c) and (e)
- OHCA shortened the timeline for releasing the final report from 30 days after public comment from to 15 days. § 97441(h)

CMIR Regulations and Timeline: Looking Ahead to January 1, 2024 Filings

OHCA will promulgate regulations under its emergency rulemaking authority as follows:



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Draft Alternative Payment Model Standards and Adoption Goals

Margareta Brandt, Assistant Deputy Director

Focus Areas for Promoting High Value

Primary Care Investment	• Define, measure, and report on primary care spending • Establish a benchmark for primary care spending
Behavioral Health Investment	• Define, measure, and report on behavioral health spending • Establish a benchmark for behavioral health spending
APM Adoption	• Define, measure, and report on alternative payment model adoption • Set standards for APMs to be used during contracting • Establish a goal for APM adoption
Quality and Equity Measurement	• Develop, adopt, and report performance on a single set of quality and health equity measures
Workforce Stability	• Develop and adopt standards to advance the stability of the health care workforce • Monitor and report on workforce stability measures

Investment and Payment Workgroup Members

Providers & Provider Organizations

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

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

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

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

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

Janice Rocco
Chief of Staff, California Medical Association

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

Academics/ SMEs

Sarah Arnquist, MPH
Principal Consultant, SJA Health Solutions

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

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

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

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

State & Private Purchasers

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

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

Monica Soni, MD
Chief Medical Officer, Covered California

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

Consumer Reps & Advocates

Beth Capell, PhD
Contract Lobbyist, Health Access California

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

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

Hospitals & Health Systems

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

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

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

Health Plans

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

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

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

Mohit Ghose
State Affairs, Anthem

Key Workgroup Discussion Topics

Alternative Payment Models

Definitions, Measurement, Reporting: Categorizing APMs, unit of reporting, health and social risk adjustment

Standards for APM Contracting: Common requirements/incentives for high quality equitable care, accelerate adoption of APMs

Statewide Goal for Adoption: Variation by market (Commercial, Medi-Cal), target timeline, unit of reporting (percent of payments, members, and/or provider contracts)

Primary Care

Definitions, Measurement, Reporting: Primary care providers, services, site of service, non-claims, integrated behavioral health

Investment Benchmark: Variation by market (Commercial, Medi-Cal) or population (adult vs. pediatric)

Behavioral Health

Definitions, Measurement, Reporting: Spending on social supports, capturing carved out behavioral health spending

Investment Benchmark: Variation by market (Commercial, Medi-Cal) or population (adult vs. pediatric)

Alternative Payment Models

Statutory Requirements

- Promote the shift of payments based on fee-for-service (FFS) to alternative payment models (APMs) that provide financial incentives for equitable high-quality and cost-efficient care.
- Convene health care entities and organize an APM workgroup, **set statewide goals** for the adoption of APMs, **measure the state's progress** toward those goals, and **adopt contracting standards** healthcare entities can use.
- Set benchmarks that include, but are not limited to, increasing the percentage of total health care expenditures delivered through APMs or the percentage of membership covered by an APM.

The APM Workstreams

Develop Standards

Best practices for APMs and contracting guidance to promote equitable, high-quality, and cost-efficient care.

Define

A framework and descriptions to identify what "counts" for each APM category.

Set Goals for Adoption

Targets to promote adoption of meaningful APMs and to promote equitable, high-quality, and cost-efficient care.

Process for APM Standards and Goals Development

Brainstorm Ideas

Develop Scan

Review Data

Create Recommendations

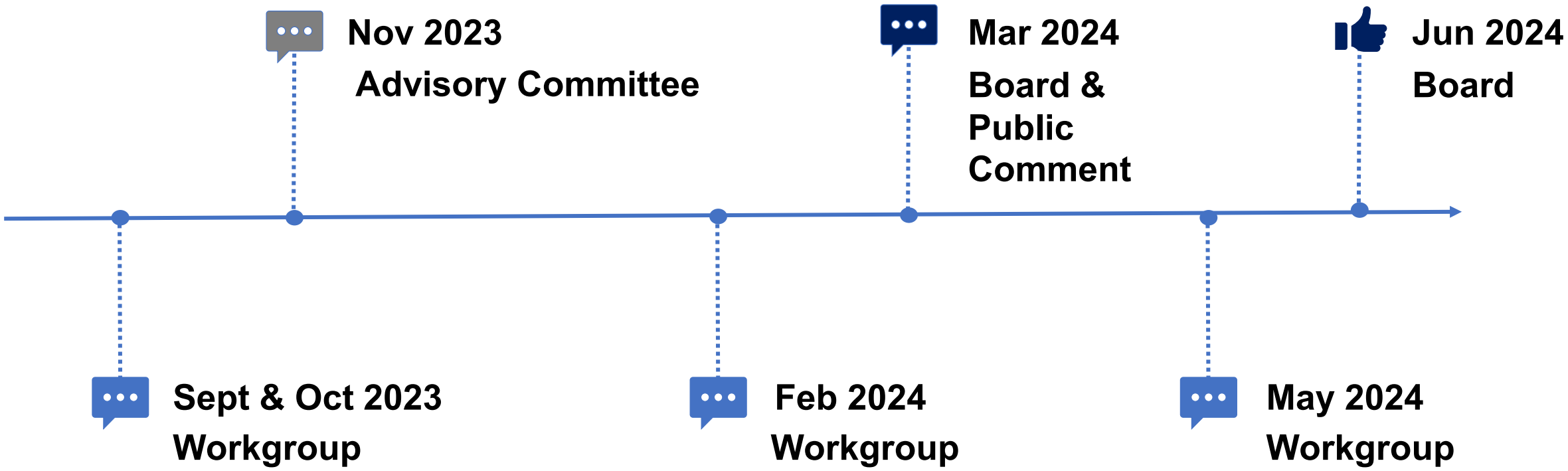
Refine Recommendations

Finalize or Approve Recommendations

Gain Input
(Investment & Payment Workgroup, Stakeholder Interviews, Sibling Departments)

Incorporate Feedback
(Board, Advisory Committee, Workgroup, Sibling Departments)

Timeline for APM Workstreams



Between each meeting, OHCA and Freedman HealthCare will revise draft APM standards, definitions, and goals based on feedback.

Draft APM Standards and Implementation Guidance

Standards for Alternative Payment Models

Additional Statutory Guidance for Standards

The standards for alternative payment models shall focus on:

- Encouraging and facilitating multi-payer participation and alignment
- Improving affordability, efficiency, equity, and quality by considering current best evidence for strategies such as quality-based or population-based payments
- Including minimum criteria for alternative payment models but be flexible enough to allow for innovation and evolution
- Aligning with the quality and equity measures used in the OHCA quality and equity measure set to the extent possible
- Addressing appropriate incentives to physicians and other providers and balancing measures, including total cost of care and quality, access, and equity to protect against perverse incentives and unintended consequences
- Attempting to reduce administrative burden by incorporating APMs that facilitate multi-payer participation and align with other state payers and programs or national models

California Legislative Information (2022). Health and Safety Code 127504(b). *Alternative Payment Models.* https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=107.&title=&part=2.&chapter=2.6.&article=5.

Approach to APM Standards and Implementation Guidance

Standards

- Best practices to approach contracting decisions that are common across APMs
- Not enforceable by OHCA
- Strategic, not tactical or prescriptive – not aiming to create an APM
- Grounded in evidence

Implementation Guidance

- Supplement the standards
- Provide specific actions health care entities can take to meet the standard
- Offer examples of successful APM implementation related to the standard

Vision of APM Standards Success

Stakeholders Endorse

- Health care entities, purchasers commit to use standards to inform future contracting

Alignment Increases

- APMs become more aligned
- Standardization makes participation easier
- Barriers to adoption decrease

Performance Improves

- Standards result in increased APM adoption
- Performance on measures of quality, equity, and affordability improve

Draft APM Standards

1. **Use prospective, budget-based, and quality-linked payment models** that improve health, affordability, and equity.
2. **Implement payment models that improve affordability** for consumers and purchasers.
3. **Allocate spending upstream to primary care and other preventive services** to create lasting improvements in health, access, equity, and affordability.
4. **Be transparent** with providers in all aspects of payment model design and terms including attribution and performance measurement.
5. **Engage a wide range of providers** by offering payment models that appeal to entities with varying capabilities and appetites for risk, including small independent practices and historically under-resourced providers.

Draft APM Standards

6. **Collect demographic data**, including RELD-SOGI* data, to enable stratifying performance.
7. **Measure and stratify performance** to improve population health and address inequities.
8. **Invest in strategies to address inequities** in access and outcomes.
9. **Equip providers with actionable data** to inform population health management and enable their success in the model.
10. **Provide technical assistance** to support new entrants and other providers in successful APM adoption.

*Race, ethnicity, language, disability status (RELD), sex, sexual orientation and gender identity (SOGI).

Draft APM Adoption Goals and Definitions

Approach to APM Adoption Goals and Definitions

Adoption Goals

- Promote shift from fee-for-service based payments to APMs
- Align financial incentives for equitable high-quality and cost-efficient care
- Progress towards goals measured by OHCA, not enforceable
- Use Health Care Payment Learning and Action Network (HCP-LAN) framework to monitor progress toward goals
- Accountability through transparent public reporting

Definitions

- Define what payment models “count” towards APM adoption goals
- Utilize Expanded Non-Claims Payments Framework (see Appendix A) for data collection – aligned with other data collection efforts at OHCA and HCAI

Health Care Payment Learning and Action Network

Year: 2016, updated in 2017

Developer: HCP-LAN, a collaboration of Centers for Medicare and Medicaid Services (CMS) and large national payers

Purpose: Support payers and states in categorizing alternative payment models to support clarity and accountability in contracting terms and measurement of APM adoption.

HCP-LAN APM Framework

Category 1	Category 2	Category 3	Category 4
FEE FOR SERVICE- NO LINK TO VALUE	FEE FOR SERVICE- LINK TO QUALITY & VALUE	APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	POPULATION-BASED PAYMENT
	A	A	A
	Foundational Payments for Infrastructure & Operations	APMs with Shared Savings	Condition-Specific Population-Based Payment
	B	B	B
	Pay for Reporting	APMs with Shared Savings and Downside Risk	Comprehensive Population-Based Payment
	C		C
	Pay-for-Performance		Integrated Finance & Delivery System
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

Strategic Decisions for Developing APM Adoption Goals

1. **Should certain types of payment models count towards the APM adoption goal?**
   - HCP-LAN Category 3A (shared savings only; no downside risk) and above?
   - HCP-LAN Category 3 (APMs built on a fee-for-service architecture) models with minimal shared savings/risk?
   - APMs not linked to quality?
2. **Should goals vary by payer type (commercial, Medi-Cal, Medicare)? By product type (HMO, PPO)?**
3. **Should APM adoption goals be based on…?**
   - % of total health care spending
   - % of members
   - % non-claims payments
   - % of providers
4. **How should goals be structured?**
   - a series of stairstep goals
   - a single absolute goal
   - a relative improvement goal

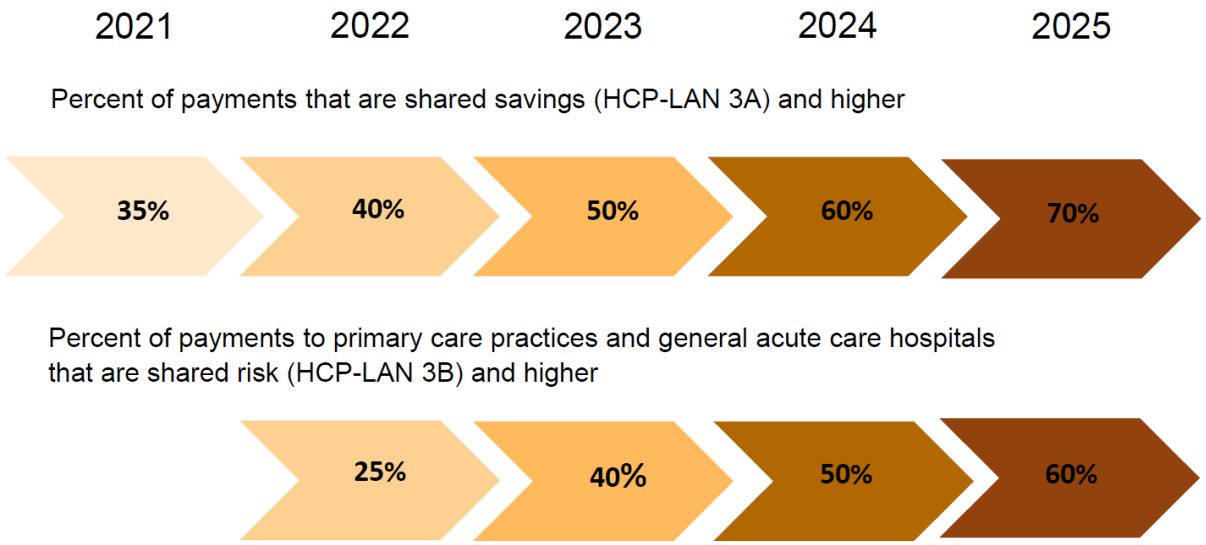
   } Can be layered

Example from California's Neighbor to the North

Oregon has made many of these same decisions in its designing of APM goals.

- Oregon limits the types of payment models that count towards the APM adoption goal.
- Oregon APM adoption goals do not vary by payer or product type.
- Oregon APM adoption goals are based on percent of total health care spending.
- Oregon includes a series of stairstep goals until 2025.

Revised Oregon VBP Compact targets



APM Goals and Definitions Recommendations

1. **Only certain types of payment models count towards the APM adoption goals.**
   a. The following HCP-LAN Categories count towards the APM adoption goals:
      - 3A FFS Architecture with Shared Savings
      - 3B FFS Architecture with Shared Savings and Downside Risk
      - 4A Condition-Specific, Population-Based Payments
      - 4B Comprehensive, Population-Based Payments
      - 4C Financially Integrated Delivery Systems

   b. APMs not linked to quality* (3N, 4N) do not count toward the APM adoption goals.
   c. Require Category 3A and 3B APMs meet a minimum threshold for shared savings/risk.˜

*Payments are considered “linked to quality” if the provider is eligible to receive a financial bonus or is at risk for a financial penalty based on performance on specific predefined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to a capitation payment, then the capitation payment would be considered “linked to quality.”

˜ Full definition provided in Expanded Framework for Non-Claims Payments in Appendix B.

APM Goals and Definitions Recommendations

2. APM absolute improvement goal does not vary by payer or product type.

3. Goal to follow stairstep structure with an absolute improvement target by 2030. Steps will vary to recognize differences in starting points.

4. Measure APM adoption based on percent of members.

- Payer data would be collected by provider group using Expanded Framework categories.
- Data submitters would report member months attributed to each category.
- OHCA would cross-walk membership from Expanded Framework Category to HCP-LAN Categories.
- OHCA will also monitor percent of total health care spending in each HCP-LAN category.
- **Note**: Integrated Healthcare Association (IHA) found little to no difference in the percent of members attributed to an APM and the percent total spending.

Recap of Recommended APM Adoption Goals

- Goals based on percent of members attributed to HCP-LAN Categories 3A, 3B, 4A, 4B, and 4C arrangements.
- Goals are structured as stairsteps, with all payers expected to reach 75% adoption by 2034.
- All qualifying APM arrangements must include a link to quality.
- All qualifying HCP-LAN Category 3A and 3B arrangements must meet minimum thresholds for shared savings and risk.

Recommended APM Adoption Goals				
	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	55%	35%	55%	55%
2028	60%	45%	60%	60%
2030	65%	55%	65%	65%
2032	70%	65%	70%	70%
2034	75%	75%	75%	75%

Next Steps for APM Standards and Goals

November 2023

- Advisory Committee provides feedback on draft APM standards, definitions, and goals

February 2024

- Investment and Payment Workgroup reviews Advisory Committee feedback and makes recommendations for changes for Board review

March 2024

- Board provides feedback on draft APM standards, definitions, and goals and materials published for public comment

May 2024

- Investment and Payment Workgroup reviews Board feedback on draft APM standards, definitions, and goals and makes recommendations for Board review

June 2024

- Board approval of APM standards and goals

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Department of Health Care Access and Information

Total Health Care Expenditures(THCE) Regulations Update

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

Statute to Implementing Regulations

- OHCA is required to adopt emergency regulations to establish requirements for payers and fully integrated delivery systems (FIDS) to submit data and other information necessary to measure total health care expenditures (THCE) and per capita THCE. (§§ 127501.2 and 127501.4 (b).)
- OHCA will use this information to prepare a report on baseline health care spending by June 1, 2025. (§ 127501.6 (a).)
- Annually thereafter, OHCA will prepare a report concerning health care spending trends and underlying factors, along with policy recommendations to control costs and improve quality performance and equity of the health care system while maintaining access to care and high-quality jobs and workforce stability. (§ 127501.6 (b).)
- OHCA must publish its first annual report by June 1, 2027, based on its analysis of THCE data for the 2024 and 2025 calendar years. (*Id.)*

California Legislative Information (2022). Health and Safety Code 127501 to 127502.5 *Office of Health Care Affordability.* https://leginfo.legislature.ca.gov/faces/codes_displayexpandedbranch.xhtml?tocCode=HSC&division=107.&title=&part=2.&chapter=2.6.&article=.

Proposed Emergency Regulations Overview

The proposed emergency regulations for THCE Data Submission:

- Define terms used in the regulations. (Proposed § 97445.)
- Outline the scope of the regulations. (Proposed § 97447.)
- Specify who is a required submitter and how voluntary submitters may request to participate. (Proposed § 97449(a)-(c).)
- Explain how submitters in Plan-to-Plan contracts should coordinate data submission with Subcontracted Plans. (Proposed § 97449(d).)
- Establish deadlines for submitter registration and data file submission. (Proposed § 97449(e)-(h).)
- Establish other requirements related to data file specifications, test files, data acceptance and correction, and variance requests. (Proposed § 97449(i)-(l).)

Data Submission Guide and Attribution Addendum

The proposed emergency rulemaking package also incorporates by reference the:

1. Total Health Care Expenditures Data Submission Guide, which:
    - Is intended for payers and FIDS (“submitters”) to use when extracting and aggregating data for submission to OHCA. Submitter interactions described in the Guide will occur via the secure THCE Data Portal--the platform for submitter registration, data submission, and submission status information.
    - Provides technical specifications, file layouts, reporting schedules, and other instructions to ensure the submission of accurate THCE data in a standardized format.
    - Specifies that submitters will not be required to submit data files for the Medi-Cal Managed Care market category until the September 1, 2025 annual submission deadline.
2. The Office of Health Care Affordability Attribution Addendum, which:
    - Contains a list of provider organizations and unique identifiers to be used when attributing total medical expenditures.

Data Submission Guide and Attribution Addendum

Submitters will report Total Medical Expenditures (TME) using pipe (“|”) delimited text files to the forthcoming THCE Data Portal. A complete submission contains all of the following files:

File Type	Contents
Statewide TME	Total medical expenditures broken out by market category (e.g., Commercial or Medicare Advantage).
Attributed TME	Total medical expenditures attributed to organizations listed on the Attribution Addendum and broken out by market category, age, and sex.
Regional TME	Total medical expenditures broken out by market category and geographic region (Covered California rating region or Los Angeles County Service Planning Area).
Pharmacy Rebates	Statewide medical and retail pharmacy rebates broken out by market category.
Submission Questions	Attestations and confirmations that instructions in the Guide were followed when preparing data for submission.

Data Submission Guide and Attribution Addendum

Submitters will report Total Medical Expenditures categorized by:

Claims Payments

- Hospital Inpatient
- Hospital Outpatient
- Professional
- Long-Term Care
- Retail Pharmacy
- Other

Other Member-Level Payments

- Capitation and Full Risk Payments
- Member Responsibility Amounts

Non-Claims Payments

- Population Health and Practice Infrastructure Payments
- Performance Payments
- Payments with Shared Savings and Recoupments
- Other

Data Submission Guide and Attribution Addendum

In addition to file layouts and field specifications, the Data Submission Guide provides instructions on:

- Reporting allowed amounts from claims, including member responsibility, after a run-out period of at least 180 days.
- Including claims for all California residents, regardless of site of care, when the payer is primary on the claim.
- Attributing member-level expenditures to organizations listed on the Attribution Addendum using an ordered methodology.
- Including estimates for members when certain benefits are carved out and claims data are not available.
- Calculating standard deviation as a per-member, per-month value.
- Requesting data variances if data submission requirements cannot be met.

THCE Rulemaking Timeline

HCAi
Department of Health Care Access and Information

Spending Target Setting Discussion

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

Today's Discussion Topics

1. Historical health care spending growth in California
2. Economic indicators and use of historical vs. forecasted growth to derive spending target value(s)
3. Population-based measures to inform spending target values
4. Setting the duration of spending target(s)
5. Adjusting the spending target

Your input today will be conveyed to the Board when it next meets in December.

Statutory Concepts For Today's Discussion

The enabling statute requires OHCA to develop a methodology, for approval by the Board, to set spending targets. The spending targets themselves also have certain requirements. Following is a distinction between the two terms:

- **Target Methodology:** The process and review of data to perform the following:
  - Inform spending target setting;
  - Consider potential adjustment factors for future targets;
  - Consider criteria and adjustment factors related to Medi-Cal;
  - Evaluate adjustments related to quality performance; and
  - Adjust for organized labor costs.

- **Target Setting:** The actual spending growth target percentage value(s).

Statutory Concepts For Today's Discussion

The Methodology	The Target
• Be available and transparent to the public. • Based on a review of historical trends and projections (forecasts) of economic and population-based measures. • Based on a review of historical cost trends, with differential treatment for COVID-19 years. • Consider potential factors to adjust future cost targets, including but not limited to health care employment cost index, labor costs, CPI-U, and other factors.	• Be developed with a methodology that is transparent and available to the public. • Promote a predictable and sustainable rate of change in per capita THCE. • Be based on a target percentage, with consideration of economic indicators and/or population-based measures. • Be set for each calendar year, with consideration of multi-year targets. • Be updated periodically and consider relevant adjustment factors. • Promote improved affordability, while maintaining quality and equitable care, including consideration of persons with disabilities and chronic illness.

California Legislative Information (2022). Health and Safety Code 127502 Health Care Cost Targets. *Office of Health Care Affordability.* https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=107.&title=&part=2.&chapter=2.6.&article=3.

Statutory Concepts For Future Discussions

The Methodology	The Target	Sector Targets
• Consider several criteria related to Medi-Cal, including but not limited to the non-federal share of spending, maintaining federal requirements to ensure full federal financial participation and health care related taxes or fees provide the non-federal share. • Allow the board to adjust cost targets downward, when warranted for health care entities that deliver high-cost care that is not commensurate with improvements in quality. • Allow the board to adjust cost targets upward, when warranted, for health care entities that deliver low-cost, high-quality care. • Require the board to adjust cost targets, as appropriate, for a provider or a fully integrated delivery system to account for actual or projected nonsupervisory employee organized labor costs. • Review potential factors to adjust future cost targets, including, but not limited to, the health care employment cost index, labor costs, the consumer price index for urban wage earners and clerical workers, impacts due to known emerging diseases, trends in the price of health care technologies, provider payer mix, state or local mandates such as required capital improvement projects, and any relevant state and federal policy changes impacting covered benefits, provider reimbursement, and costs.	• Be developed, applied and enforced. • Promote improved affordability, while maintaining quality and equitable care, including consideration of persons with disabilities and chronic illness. • Promote the stability of the health care workforce. • Be adjusted for provider entities to account for growth in organized labor costs.	• The board can set targets by sector including by geographic regions, types of health care entities and individual health care entities.

California Legislative Information (2022). Health and Safety Code 127502 Health Care Cost Targets. *Office of Health Care Affordability.* https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=107.&title=&part=2.&chapter=2.6.&article=3.

Historical Health Care Spending Growth in California

Statutory Concepts For Today's Discussion

The Methodology	The Target
• Be available and transparent to the public. • Based on a review of historical trends and projections (forecasts) of economic and population-based measures. • **Based on a review of historical cost trends, with differential treatment for COVID-19 years.** • Consider potential factors to adjust future cost targets, including but not limited to health care employment cost index, labor costs, CPI-U and other factors.	• Be developed with a methodology that is transparent and available to the public. • Promote a predictable and sustainable rate of change in per capita THCE. • Be based on a target percentage, with consideration of economic indicators and/or population-based measures. • Be set for each calendar year, with consideration of multi-year targets. • Be updated periodically and consider relevant adjustment factors. • Promote improved affordability, while maintaining quality and equitable care, including consideration of persons with disabilities and chronic illness.

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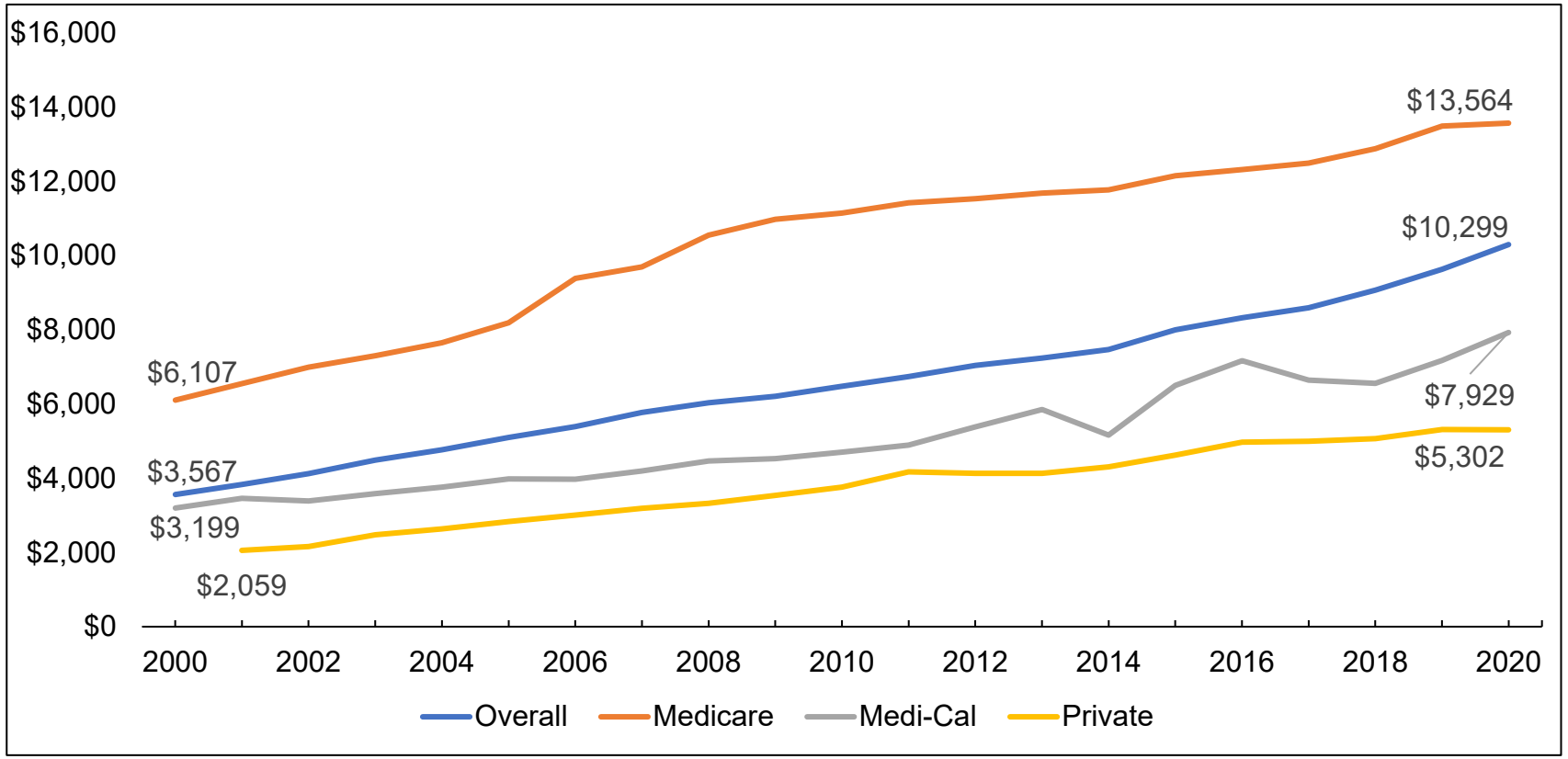
Per Capita Health Care Spending in California, 2000-2020



- From 2000 to 2020, overall per capita health care spending grew by over 5% annually.
- Over that same period:
  - Medicare spending grew annually by 4.1%;
  - Medi-Cal spending grew by 4.6%; and
  - Private health insurance spending grew by 5.1%

Note: Health care spending refers to personal health care spending, which excludes public health activities, health insurer administrative expenses and profit, government administration, and investment.

Centers for Medicaid and Medicare Services (n.d.). Health Expenditures by State of Residence, 1991-2020. *National Health Expenditure Data.* https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence

Per Capita Health Care Spending Growth in California

Time horizon	Average change (%) in per capita health spending
5-year change (2015-2020)	5.2%
10-year change (2010-2020)	4.7%
15-year change (2005-2020)	4.8%
20-year change (2000-2020)	5.4%

Note: Health care spending refers to personal health care spending, which excludes public health activities, net cost of health insurance, government administration, and investment. Medicaid figures exclude the Children's Health Insurance Program and fully state-funded spending.

Centers for Medicaid and Medicare Services (n.d.). Health Expenditures by State of Residence, 1991-2020. *National Health Expenditure Data*. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence

Staff Recommendations to the Board Related to Historical Cost Trends

- To promote improved affordability, the annual per capita health care spending growth target percentage should be below the long-term trend of 5%.
  - There are anomalies associated with the impact of COVID on health care spending. This recommendation does not consider calendar years 2020 and 2021. When state-level per capita spending for 2021 and beyond are fully realized, the Office and Board may revisit any impacts on spending associated with COVID-19.

Does the Advisory Committee have questions or input in response to the two OHCA staff recommendations?

Economic Indicators and Use of Historical vs. Forecasted Growth to Derive Spending Target Value(s)

Statutory Concepts For Today's Discussion

The Methodology	The Target
• Be available and transparent to the public. • **Based on a review of historical trends and projections (forecasts) of economic and population-based measures.** • Based on a review of historical cost trends, with differential treatment for COVID-19 years. • Consider potential factors to adjust future cost targets, including but not limited to health care employment cost index, labor costs, CPI-U and other factors.	• Be developed with a methodology that is transparent and available to the public. • Promote a predictable and sustainable rate of change in per capita THCE. • **Be based on a target percentage, with consideration of economic indicators and/or population-based measures.** • Be set for each calendar year, with consideration of multi-year targets. • Be updated periodically and consider relevant adjustment factors. • Promote improved affordability, while maintaining quality and equitable care, including consideration of persons with disabilities and chronic illness.

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Economic Indicators: Historical and Forecasted Experience

There are differences in economic indicators calculated using actual historical data vs. forecasts.

Historical Data

- Historical data reflects, to varying degrees, the volatility of year-over-year changes, including booms and busts, and pandemic times and healthier times.
- Historical figures are relatively easy mathematical calculations (straight average growth over prior time periods).
- Unexpected events can be addressed through smoothing or by extending the time-period.

Forecasted Data

- Forecasted data are designed to be predictable, stable figures and are calculated by government agencies and private firms.
- The California Department of Finance regularly forecasts economic indicators for use in budget setting and for other purposes.
- Methods of forecasting vary by the organization performing the forecast and are affected by the philosophy and outlook of economists at each organization.

Economic Indicators

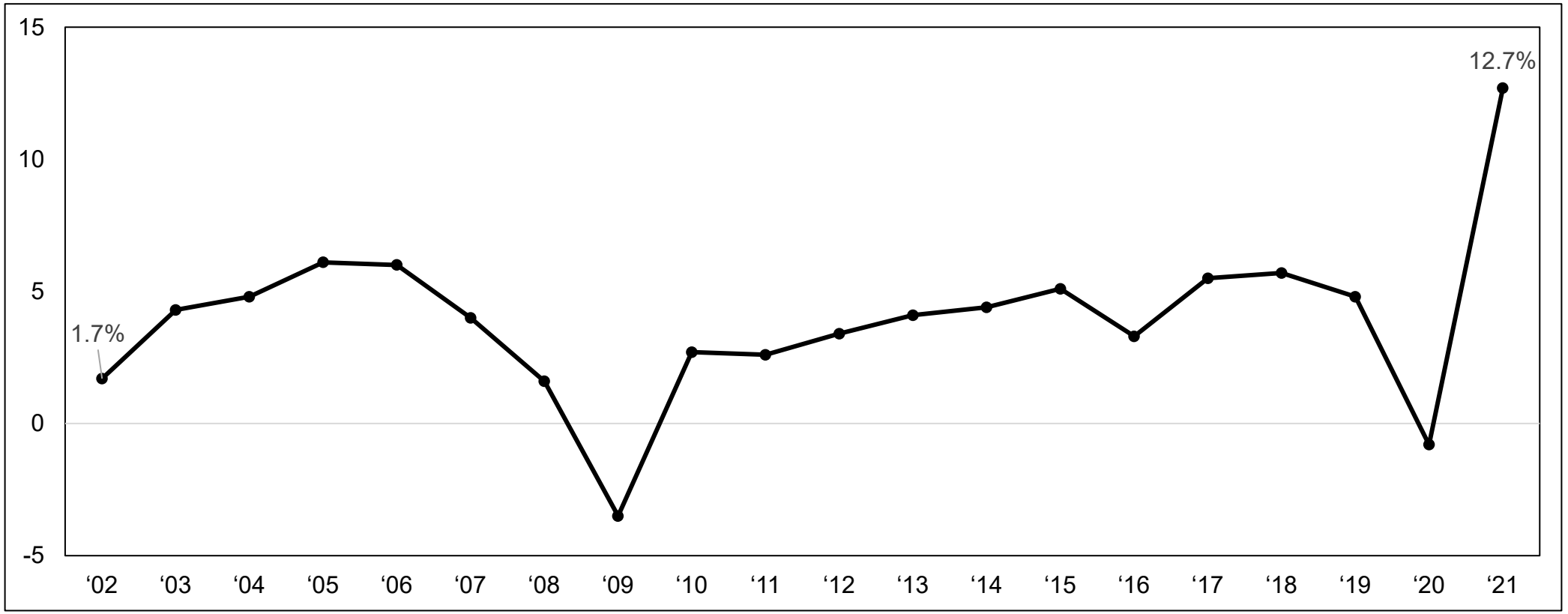
Indicator	Historical	Forecast
Gross State Product	**3.9%** *(2002-2021)*	*N/A*
Potential Gross State Product (PGSP)	*N/A*	**4.0%** *(2029-2033)*
Median Hourly Wage	**2.8%** *(2002-2021)*	**2.8%** *(2026)*
Median Household Income	**2.8%** *(2002-2021)*	**3.6%** *(2026)*

Lucia L., Dietz M., and Challenor, T. (2023, September). *What Can We Afford? Aligning Office of Health Care Affordability spending target with Californians' ability to afford increases.* UC Berkeley Labor Center. https://laborcenter.berkeley.edu/wp-content/uploads/2023/09/What-can-we-afford.pdf

*Historical column data from UC Berkeley; Forecasted column data provided by Bailit Health

Annual Growth Rate In Gross State Product

From 2002 to 2021, overall gross state product per capita grew by approximately 3.9% annually.

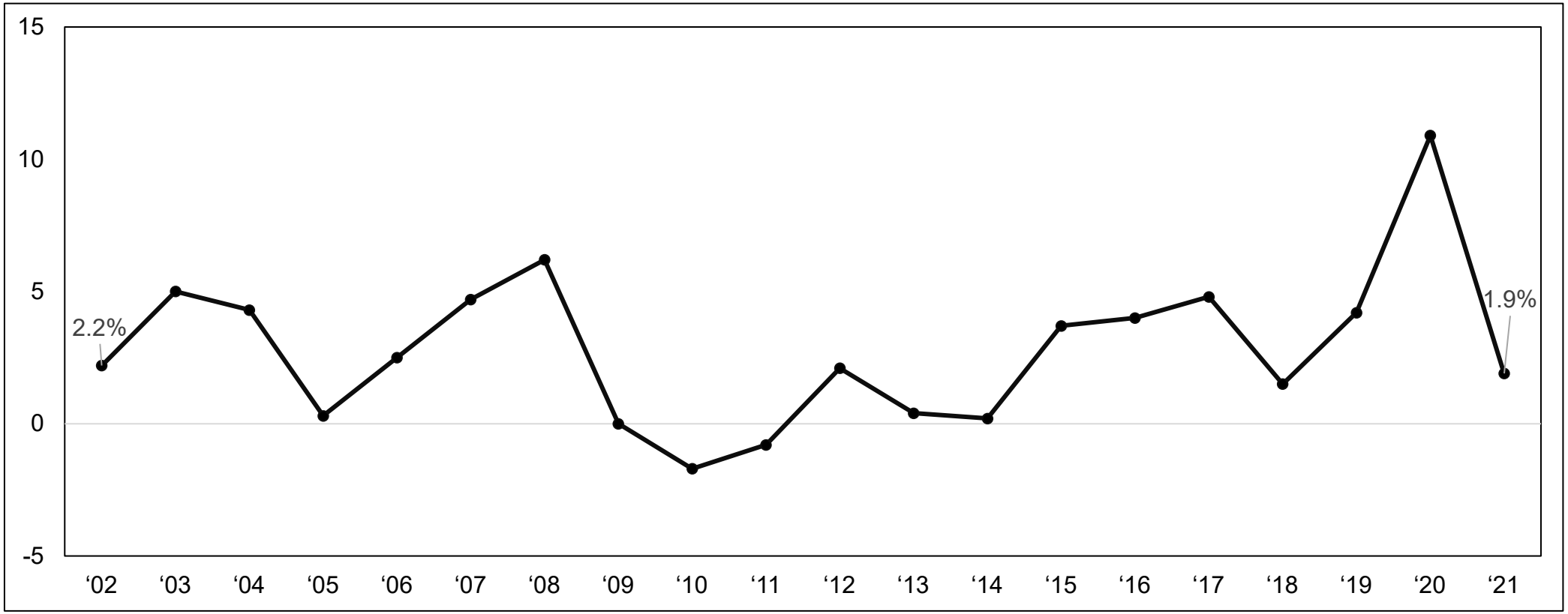


UC Berkeley Labor Center (n.d.). *Analysis of data from U.S. Bureau of Economic Analysis.* https://laborcenter.berkeley.edu/low-wage-work-in-california-data-explorer/

California Department of Finance (2023). *U.S. Census Bureau Current Population Survey.* Demographic. https://dof.ca.gov/forecasting/demographics/

Annual Growth Rate In Median Hourly Wages

From 2002 to 2021, overall median wages grew by approximately 2.8% annually.

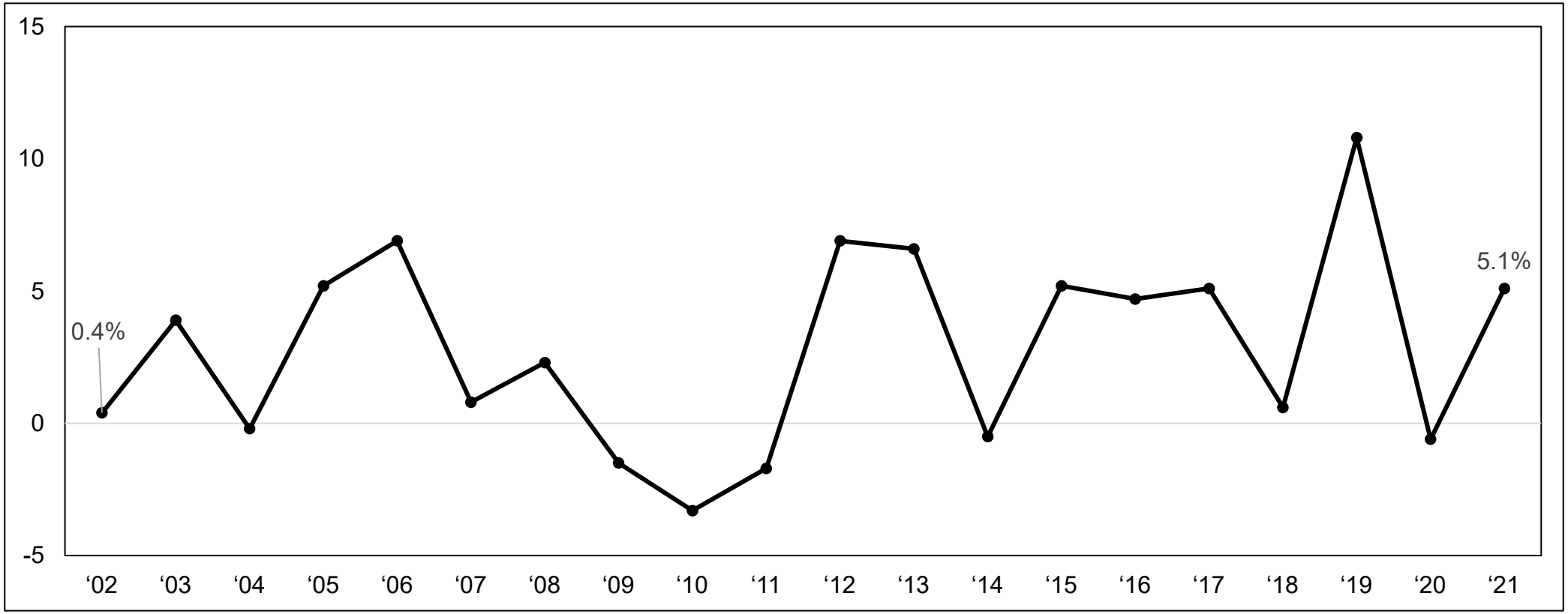


UC Berkeley Labor Center (n.d.). *Analysis of data from U.S. Bureau of Economic Analysis.* https://laborcenter.berkeley.edu/low-wage-work-in-california-data-explorer/

California Department of Finance (2023). *U.S. Census Bureau Current Population Survey.* Demographic. https://dof.ca.gov/forecasting/demographics/

Annual Growth Rate In Median Household Income

From 2002 to 2021, overall median household income grew by approximately 2.8% annually.



UC Berkeley Labor Center (n.d.). *Analysis of data from U.S. Bureau of Economic Analysis.* https://laborcenter.berkeley.edu/low-wage-work-in-california-data-explorer/

California Department of Finance (2023). *U.S. Census Bureau Current Population Survey.* Demographic. https://dof.ca.gov/forecasting/demographics/

Staff Recommendations to the Board Related to Economic Indicators

- To promote transparency and public accessibility, the basis for establishing a statewide spending target should be a single economic indicator.
- The methodology to establish a statewide spending target should rely heavily on a single indicator of consumer affordability, specifically, median household income, because it captures retirees and others not in the labor market.
    - In several states that have used blended approaches, the average change in median household income over the past 20 years closely aligns with their selected spending target.
- The methodology should rely on historical data over projections.

Does the Advisory Committee have questions or input in response to the three OHCA staff recommendations?

Population-Based Measures to Inform Spending Target Values

Statutory Concepts For Today's Discussion

The Methodology	The Target
• Be available and transparent to the public. • **Based on a review of historical trends and projections (forecasts) of economic and population-based measures.** • Based on a review of historical cost trends, with differential treatment for COVID-19 years. • Consider potential factors to adjust future cost targets, including but not limited to health care employment cost index, labor costs, CPI-U and other factors.	• Be developed with a methodology that is transparent and available to the public. • Promote a predictable and sustainable rate of change in per capita THCE. • **Be based on a target percentage, with consideration of economic indicators and/or population-based measures**. • Be set for each calendar year, with consideration of multi-year targets. • Be updated periodically and consider relevant adjustment factors. • **Promote improved affordability, while maintaining quality and equitable care, including consideration of persons with disabilities and chronic illness.**

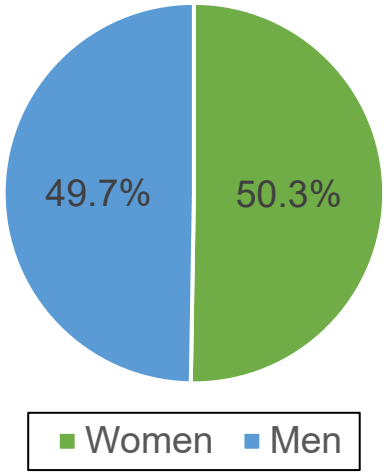
California Legislative Information (2022). Health and Safety Code 127502 Health Care Cost Targets. *Office of Health Care Affordability.* https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=107.&title=&part=2.&chapter=2.6.&article=3.

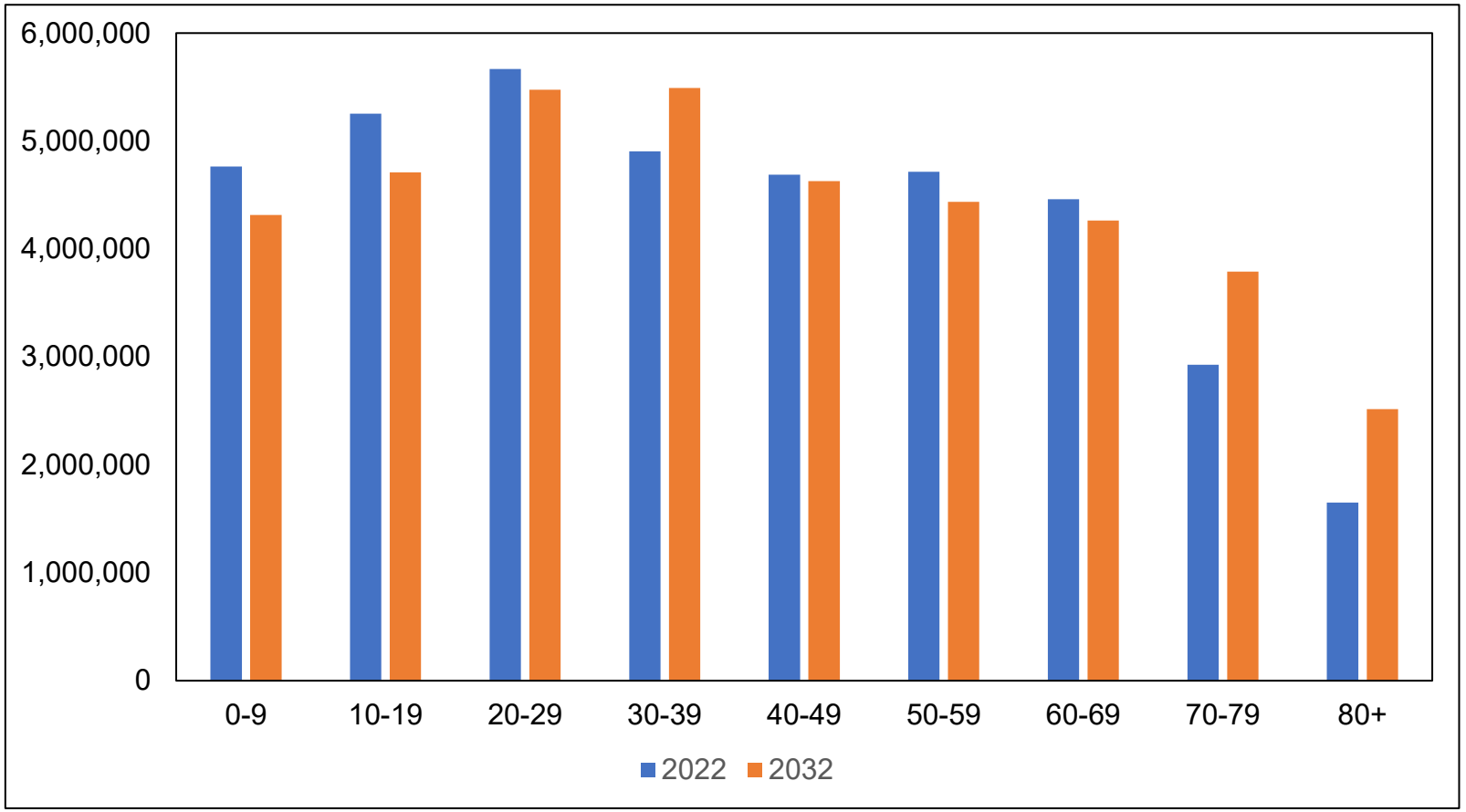
Should the Target be Adjusted for Projected Changes in Population-Based Measures?

- In October OHCA discussed with the Board the following population-based measures to adjust the spending target value(s):
  - Age and sex
  - Chronic disease prevalence
  - Disability status
  - *Health care utilization*
- Health care utilization was not pursued further as it would be a self-referencing adjustment.
- OHCA found that adjustments based on the other three population-based measures would be very small and are correlated with one another.

Forecasted California Age/Sex Trends for 2022-2032

- California is expected to age over the next 10 years, with the largest relative increase in the 70+ population.
- The sex distribution in CA is expected to stay almost identical





California Department of Finance (2022, December). State population projections. *Projections.* *Retrieved* September 2023. https://dof.ca.gov/forecasting/demographics/projections/

Models to Forecast Changes in Health Care Spending Due to Age/Sex Trends

- Using population projections provided by the Department of Finance and both Medical Expenditure Panel Survey (MEPS) data and Connecticut's (CT) spending target age/sex risk scores, OHCA generated two sets of projections to model changes in risk due to age/sex factors.
  - MEPS data were collected by the Agency for Health Research and Quality (AHRQ).
    - Utilized a subset of risk scores provided by MEPS created from data from 2002 to 2009
    - Generated using nationwide surveys – data included over 100,000 participants
  - CT's age/sex risk scores were generated using demographic and spending data reported by payers to the state.
    - Utilized a subset of the population: Medicare Advantage, Commercial Full Claims, and Medicaid (non-duals)

Potential Adjustments to Spending Targets Due to Changes in Forecasted Age/Sex

The table below displays the expected change in spending due to age/sex factors alone for 2022-2032 using MEPS and CT age/sex risk scores.

Market	10-Year Change in Risk due to MEPS Age/Sex Factors	10-Year Change in Risk due to CT Age/Sex Factors	Potential Annual Target Adjustments
Commercial	0.3%	0.2%	0.02% - 0.05%
Medicare	3.9%	2.6%	0.30% - 0.40%
Medi-Cal	1.3%	0.3%	0.05% - 0.15%
Cross-Payer	1.6%	0.9%	0.10% - 0.15%

Disability Status Adjustment

The American Community Survey, administered by the US Census Bureau, estimates disability prevalence nationwide and by state.

- The survey is sent to a sample of 3.5 million people every year, nationwide.
- The response rate was greater than 80% in all years between 2010-2021, except for 2020.
- The survey estimates that about 11.2% of Californians had a disability as of 2021.
- The primary limitation of the survey – for our purposes - is that it relies upon self-report rather than an objective functional measure of disability status.

Disability Status Adjustment

Two separate studies, using MEPS data, found that spending for individuals with disabilities was several times more than those without disabilities:

- One study utilized data from all persons 18-64 in the 2014 MEPS panel (N = 20,898) to compare the spending among those with disabilities to those without a disability and found a spending ratio of **$13,492 to $2,835 (or 4.8 to 1)**.
- A second study used 2013-2015 MEPS data (N = ~100,000) data to produce a counterfactual analysis (i.e., assuming adults with disabilities had no disabilities, but all else was held constant, what would their spending have been). This study found a spending ratio of **$24,114 to $6,683 (or 3.6 to 1)** for a person with disability compared to the same person's spending had they not had a disability.
- Limitations: Prevalence correlated with aging. Also, the studies did not generate a spending differential by market.

(1) Kennedy et al. 2017. Disparities in Insurance Coverage, Health Services Use, and Access Following Implementation of the Affordable Care Act: A Comparison of Disabled and Nondisabled Working-Age Adults. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5798675/; (2) Khavjou et al. National Health Care Expenditures Associated With Disability. Med Care. 2020 Sep;58(9):826-832. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7505687/

Disability Status Adjustment

In California, from 2010-2021, disability prevalence increased about 0.1% on a year-over-year basis.

While people with disabilities tend to have 4-5 times higher spending than people without disabilities, the net impact of this tiny increase in prevalence in expected spending is quite small.

Market	Potential Annual Disability Adjustment
Commercial	0.2% - 0.3%
Medicare	0.1% - 0.2%
Medi-Cal	0.1% - 0.2%

Chronic Illness Adjustment

The California Department of Public Health and UC Davis jointly studied the change in spending from 2010 to 2016 for patients with chronic conditions.

- Spending on chronic illness was estimated using the CDC cost calculator (based on MEPS data) and total spending using CMS average annual per person medical expenditure.
- Prevalence and spending was assessed from six chronic illnesses: arthritic, asthma, cancer, cardiovascular disease, diabetes, and depression.
  - Sources: California Health Interview Survey, the Surveillance Epidemiology and End Results (SEER) data, and the American Diabetes Association
- Limitations: Chronic illness prevalence correlated with aging and with disability status. Also, data not disaggregated by market.

Chronic Illness Adjustment

For the six conditions, there was an observed (weighted) average increase of about 1.6%, while spending on chronic illness as a proportion of total spending increased about 2.1% over the six-year period.

- This is likely captured, to a significant extent, by increases in the rates of disability and by changes in age/sex factors.

Potential Annual Chronic Illness Adjustment
0.3% - 0.4%

Staff Recommendation to the Board Related to Population-Based Measures

OHCA advised the Board that further analysis on the use of population-based metrics to adjust the statewide spending target was needed.

- OHCA noted that no other state has incorporated population-based measures and adjustments based on population-based measures would be minimal.

Does the Advisory Committee have questions or input in response to the OHCA staff recommendation regarding target adjustment using population-based measures?

Multi- or Single-Year Target Setting

Statutory Concepts For Today's Discussion

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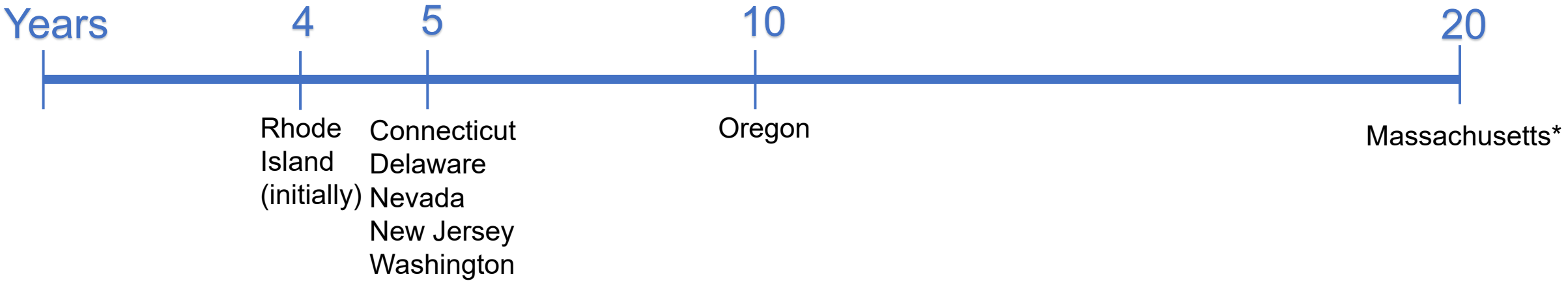
Other States' Approaches to Target Duration

- Other states have set target values that span multiple years, so plans and providers know what the target value will be well ahead of time.
- The length of time for which states have set spending targets ranges from 4-20 years.



* Established in statute.

One Year or Multi-Year Target: Pros and Cons

	Pros	Cons
One Year	• Can adjust the target value for changing environmental circumstances (allowing for adjustments relative to the target is another way).	• Time consuming and does not provide plans and providers with as much notice to respond to the target. • Target setting is best informed by prior years' target performance, but reporting is delayed two years after the performance year.
Multiple Years	• Knowing future targets in advance could influence negotiations for health plan contracting. • Promotes *predictable and sustainable* rates of change.	• Cannot anticipate the impact of significant future events (e.g., COVID-19's impact in service utilization in 2020 and 2021) that may change the pattern of health care spending.

If Setting Multi-Year Targets… For How Many Years?

	Pros	Cons
2-3 years	• Aligns with health plan contracting cycles that are typically 2-3 years.	• Public results of Year 1 data will not be available until Year 3, so 2-3 years may not be long enough.
4-5+ years	• Making the required changes in health plan and provider operations takes time. Having a 4+ year target can assist strategic planning.	• Would not account for unknown events that may significantly influence health care spending and utilization (e.g., pandemics, significant macroeconomic changes), but can be mitigated through establishing criteria for revisiting the target.

Fixed or Phased-in Multi-Year Target?

Fixed Target: One target value set for a predetermined number of years.

Phased-In: The target value progressively decreases in the first several years of implementation to reach an ideal target (e.g., Connecticut set a value of 2.9%, but added 0.5% for the first year of implementation and 0.3% for the second year.)

	Pros	Cons
Fixed	• Creates a steady, easy-to-remember, expectation.	• Does not facilitate a slow transition for providers and payers – if one is believed to be needed to be successful.
Phased-In	• Allows for an “ease-in” period for health plans and providers.	• Small incremental changes may not be meaningful compared to one larger change.

Staff Recommendation Related to Target Setting Duration and Phase-in

- Initial targets should be set for five calendar years (i.e., 2025, 2026, 2027, 2028, and 2029) to provide for sufficient planning.
  - After the first annual report on calendar year 2026 is released in 2027, the board will have an opportunity to review the effectiveness of the target values and compliance by health care entities.
- The target value should be phased-in over the five years, progressively decreasing, and then remain fixed.

Does the Advisory Committee have questions or input in response to the two OHCA staff recommendations?

Adjusting the Spending Target

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Other States' Criteria For Changing the Target Methodology and/or Target

- **Connecticut** may revisit the methodology and calculation should there be a sharp rise in inflation between 2021 and 2025.
- **Delaware**'s State's Finance Committee annually reviews the target methodology and can change the target if the PGSP forecast changes in a "material way."
- **Massachusetts** set the target in statute but there is a process for the Health Policy Commission to modify the value, subject to legislative review.
- **Oregon** and **Washington** do not have official adjustment triggers, but both states revisited their methodologies as a result of the inflation experienced in 2021 and 2022.
- In **Rhode Island**, "highly significant" changes in the economy can trigger re-visiting of the target methodology.

Are There Conditions That Warrant Revisiting the Target Mid-year or Mid-cycle?

Yes	No
Allowing for adjustments in the target because of external events that impact health care spending can ensure that plans and providers are not held accountable for growth that is beyond their control (e.g., future pandemics).	While certain events can trigger a significant increase in health care spending, allowing the target to be adjusted as a result means: a) the consumer will bear the burden of increased costs; and b) plans and providers cannot plan and manage to the target.

Feedback on Adjusting the Spending Target

OHCA staff did not offer a recommendation regarding conditions that may warrant adjustment to the target, and Board members did not offer comment when presented with the question.

Does the Advisory Committee have questions or input, related to target setting adjustments?

Next Steps

- OHCA staff will present a proposal to the Board for spending target values and related policy questions during the Board's December meeting.
- The Advisory Committee will meet again in January to consider the proposed model and Board member suggestions for modifications to that model.

HCAi
Department of Health Care Access and Information

General Public Comment

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

Next Advisory Committee Meeting:

January 23, 2024
10:00 a.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

Department of Health Care Access and Information

Adjournment

HCAi
Department of Health Care Access and Information

Appendix A: Expanded Non-Claims Payments Framework

Draft Expanded Framework Categories A, B, C

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category*
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	2A
A2	Primary care and behavioral health integration	2A
A3	Social care integration	2A
A4	Practice transformation payments	2A
A5	EHR/HIT infrastructure and other data analytics payments	2A
B	**Performance Payments**	
B1	Retrospective/prospective incentive payments: pay-for-reporting	2B
B2	Retrospective/prospective incentive payments: pay-for-performance	2C
C	**Payments with Shared Savings and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	3A
C2	Procedure-related, episode-based payments with risk of recoupments	3B
C3	Condition-related, episode-based payments with shared savings	3A
C4	Condition-related, episode-based payments with risk of recoupments	3B
C5	Risk for total cost of care (e.g., ACO) with shared savings	3A
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B

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

Draft Expanded Framework Categories D, E, F

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category*
D	**Capitation and Full Risk Payments**	
D1	Primary Care capitation	4A
D2	Professional capitation	4A
D3	Facility capitation	4A
D4	Behavioral Health capitation	4A
D5	Global capitation	4B
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C
E	**Other Non-Claims Payments**	
F	**Pharmacy Rebates**	

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
3.	**Shared Savings Payments and Recoupments**	**Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including but not limited to episode of care and total cost of care. Dollars reported in this category should reflect only the non-claims shared savings payment or recoupment, not the fee-for-service component. Recouped dollars should be reported as a negative value. Payments are considered "linked to quality" if the provider is eligible to receive a financial bonus or is at risk for a financial penalty based on performance on specific predefined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the shared savings payment, then the shared savings payment would be considered "linked to quality."**	
a.	Procedure-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3A

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
b.	Procedure-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3B
c.	Condition-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3A
d.	Condition-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3B

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
e.	Risk for total cost of care (e.g., ACO) with shared savings	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. **These models must offer providers a minimum of 40% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as "Performance Payments." Providers that would be classified by CMS as "low revenue" may be eligible for shared savings at a lower rate of 20% if they do not meet minimum savings requirements.**	3A
f	Risk for total cost of care (e.g., ACO) with risk of recoupments	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 50% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as "Performance Payments." **Providers that would be classified by CMS as "low revenue" may be eligible for shared savings at a lower rate of 25% if they do not meeting minimum shared savings requirements. These models also must put providers at risk for at least 30% of losses. Models offering less than this degree of risk are classified as "Risk for total cost of care with shared savings."**	3B

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
4	**Capitation and Full Risk Payments**	**Per capita, non-claims payments paid to healthcare providers or organizations to provide a defined set of services to a designated population of patients over a defined period of time. Payments are considered "linked to quality" if the provider is eligible to receive a financial bonus or is at risk for a financial penalty based on performance on specific predefined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the capitation payment, then the capitation payment would be considered "linked to quality."**	
a.	Primary Care Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide primary care services to a designated patient population over a defined period of time. Services are restricted to primary care services performed by primary care teams.	4A
b.	Professional Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide professional services to a designated patient population over a defined period of time. Services typically include primary care clinician, specialty care physician services, and other professional and ancillary services.	4A
c.	Facility Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide inpatient and outpatient facility services to a designated patient population over a defined period of time.	4A
d.	Behavioral Health Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide behavioral health services to a designated patient population over a defined period of time. May include professional, facility, and/or residential services.	4A
e.	Global Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital, and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out.	4B
f.	Payments to Integrated, Comprehensive Payment and Delivery Systems	Per capita, non-claims payments paid to healthcare organizations and providers to provide a comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care s, other professional and ancillary, inpatient hospital and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out. This category differs from the global capitation category because the provider organization and the payer organization are a single, integrated entity.	4C

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
5	Other Non-Claims Payments	Any other payments to a healthcare provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit. It also includes governmental payer grants and shortfall payments to providers (e.g., Disproportionate Share Hospital payments and FQHC wraparound payments).	
6	Pharmacy Rebates	Price concessions, price discounts, or discounts of any sort that reduce payments, including a partial refund of payments or any reductions to the ultimate amount paid; a financial reward for inclusion of a drug in a preferred drug list or formulary or preferred formulary position; market share incentive payments and rewards; credits; remuneration or payments for the provision of utilization or claim data to manufacturers for rebating, marketing, outcomes insights, or any other purpose; rebates, regardless of how categorized, and all other compensation to carriers, their pharmacy benefit managers (PBMs), rebate aggregators, or subsidiaries.	