Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

Health Care Affordability Advisory Committee
November 30, 2023
MEETING MINUTES

Members Attending: Joan Allen, Barry Arbuckle, Aliza Arjoyan, Stephanie Cline, Adam Dougherty, Parker Duncan Diaz, Sara Gavin, Stacey Hrountas, David S. Joyner, Ivana Krajcinovic, Caroline Nava, Tam Ma, Mike Odeh, Janice O'Malley, Sumana Reddy, Yolanda Richardson, Andrew See, Sarah Soroken, Ken Stuart, Suzanna Usaj, Rene Williams, Anthony Wright, Abbie Yant; Yvonne Waggener, Carmen Comsti, Kiran Savage-Sangwan

Members Absent: Hector Flores

Health Care Affordability Board Member Attending: Sandra Hernandez and Rick Kronick (virtual)

HCAI: Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director; Jean-Paul Buchanan, Counsel; Sheila Tatayon, Assistant Deputy Director; CJ Howard, Assistant Deputy Director

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; Sheila Tatayon, Assistant Deputy Director; CJ Howard, Assistant Deputy Director; Michael Bailit, Bailit Health; Margareta Brandt, Assistant Deputy Director

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

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

Agenda Item # 1: Welcome and Call to Order
Elizabeth Landsberg, Director, HCAI
Vishaal Pegany, Deputy Director, HCAI

The facilitator called roll; quorum was established. The Director reviewed the meeting agenda.

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

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

- Bills impacting HCAI's funding, health care data collection, hospital compliance milestones, and minimum wage for health care workers.
- A new behavioral health role called the Wellness Coach being developed to provide support and skills training to youth facing mental health crises, along with a new website for wellness coaches along with radio ads promoting their services.
- Upcoming Health Care Payment Data (HPD) Advisory Committee meetings will be discussing the reporting on social drivers of health, pharmaceutical cost data, hospital spending, and non-claims data collection framework development with OHCA's involvement.

Deputy Director Pegany then provided an update on the process and calendar for selecting Advisory Committee members for 2024.

Discussion and comments from the Advisory Committee included a concern about meeting proximity and cadence between Advisory Committee meetings and Board meetings.

Public Comment was held on agenda item 2 and one member of the public provided comment.

Agenda Item # 3: Cost and Market Impact Review (CMIR) Regulations Update
Sheila Tatayon, Assistant Deputy Director, HCAI

Sheila Tatayon presented an overview of the process and timeline for reviewing regulations. Discussion and comments from the Advisory Committee included:

- Operating revenue and non-operating revenue should be included beyond the patient revenue to give a complete picture of the financial standing of the entity.
- The informal process for information sharing.
- Questions regarding timelines, responsiveness to comments, and visibility in health care ownership structures.

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

Agenda Item # 4: Draft Alternative Payment Model Standards and Adoption Goals
Margareta Brandt, Assistant Deputy Director, HCAI

Assistant Deputy Director Brandt presented the draft Alternative Payment Model (APM) standards and adoption goals, which aim to promote high-value health care systems by focusing on primary care and behavioral health investment, APM adoption, quality measurement, equity measurement, and workforce stability.

Discussion and comments from the Advisory Committee included:

- Using prospective budget-based payment models linked to quality outcomes, improving affordability for consumers and purchasers, allocating spending upstream to primary care and preventive services, being transparent with providers in all aspects of payment model design, and engaging a wide range of providers in APMs.
- Need for actuarily sound transfer of risk from health plans to provider organizations within APMs and transparency around utilization history.
- Potential inequities caused by alternative payment models (APMs) and the need for careful implementation.
- Use of algorithms in APMs, with concerns raised about algorithmic bias and its impact on equity.
- Implementation guidance related to monitoring unintended consequences and providing appropriate care.
- Experience with Medicare as being effective in terms of payment and real-time data availability, while highlighting the challenges faced with other payers like Medi-Cal managed care.
- Concern around standardized data collection, privacy concerns, equity issues in rural areas, and burden on smaller practices.
- Data collection standards along with collaboration efforts to improve demographic data collection.
- Use of frameworks like California's Data Exchange Framework as a recommendation for better data exchange.
- Some members expressed support for alternative payment models based on reports showing higher quality and lower total cost of care when providers take risks.
- The importance of consistent quality metrics across different plans and uniform attribution methods used by health plans.
- Need for harmonization of measures and metrics for quality, access, and equity.
- Concerns about under-resourced providers taking downside risk and suggestion of a stepwise pathway for those providers.

- The importance of supporting primary care clinicians to ensure sustainability.
- The need for alignment and technical assistance in practices new to this work.
- Investing more in primary care is crucial and urges wise spending rather than solely focusing on bending the cost curve.
- Skepticism towards value-based payments as a solution, advocating instead for a single-payer health care system.
- Monitoring whether APMs are increasing administrative burdens on providers or reducing their ability to provide care effectively.
- The inclusion of examples that address affordability from the consumer's perspective at the point-of-care as well as system-level affordability in regard to setting goals.
- Considerations regarding payment models, payer types, metrics, and structure of goals based on Oregon's example.
- Recommendations for achieving the APM adoption goals in Oregon.
- Some members suggested that only certain types of payment models should count towards the goals, excluding categories without a link to quality.
- Categories with payments linked to quality and providers being eligible for financial bonuses or penalties based on performance.
- Minimum thresholds for shared savings or shared risk in certain APM arrangements.
- Implementation of these standards being phased-in over time, with adjustments made as needed.
- Some members expressed concerns about potential impacts on smaller organizations and primary care facilities.
- Feedback given regarding Medicare Advantage models. The proposed goals are structured stepwise, aiming for 75% adoption by 2034 across different product types in California. Measurement of progress will be based on the percentage of members attributed to APMs, using payer data collected by provider group.
- Some members expressed concern about payers using ACO narrow networks as a competitive advantage in commercial PPOs and a need for consideration of overall population thresholds rather than absolute thresholds for each payer class.
- Consideration that tracking the number of providers attached to an APM arrangement is more challenging than members or dollars, presenting an administrative burden question.

Public Comment was held on agenda item 4 and one member of the public commented.

Lunch Break

Roll taken to establish a quorum; quorum was established.

Agenda Item #5: Total Health Care Expenditures (THCE) Regulations Update

Vishaal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI

Deputy Director Pegany and Assistant Deputy Director Howard presented on the regulations and plans for future meetings and reports. Discussion and comments from the Advisory Committee included:

- Attributing expenditures to provider organizations and suggested the need for standardized attribution methods.
- The order of operations for the data submitters, Capitated Delegated Arrangements, Total Cost of Care ACO Arrangements, and Payer Developed Attribution Methods.
- Standardizing attributions being done early in the process.
- Medicare Fee-For-Service in total health care expenditures, which was addressed by direct data collection from CMS.
- Adjusting capitation rates based on benefit plan factors to accurately assess performance and suggested doing so, as well as consider the value of non-claim services such as patient portal messages.
- Plans to segregate or distinguish total health care spending in terms of administrative costs to identify areas where costs can be reduced.
- Concern about the ”other” service category in total medical expenditure categories, which may include various centers and facilities that should be tracked separately due to significant price differences.
- The accuracy of data gathering and the need for timely feedback and corrections.
- Gaps in capturing certain types of health care spending, such as out-of-pocket costs for behavioral health care and inclusion of those gaps in the report.
- Inclusion of self-funded plans.
- Inclusion of capped Taft Hartley funds and Kaiser payments in the data submissions.
- HCAI’s Health Care Payments Data Program report by March 1 that will have information about data received, including a final analysis of how much self-insured data has been received.
- Granularity of the Kaiser data and if the level of granularity would break down into market category, age, sex, and region.
- Absence of Kaiser Permanente physician organizations in the attribution addendum.

Public Comment was held on agenda item 5 and one member of the public commented.

Agenda Item # 6: Spending Target Discussion
Vishaal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI
Michael Bailit, Bailit Health

Deputy Director Pegany, Assistant Deputy Director Howard, and Michael Bailit

presented on the topic of historical health care spending growth in California as well as different types of economic indicators and population-based measures used to set multi-year spending targets and potential adjustment factors. Discussion and comments from the Advisory Committee included:

- Annual per capita health care spending target percentage being below 5% to improve affordability compared to the long-term trend of health care spending growth.
- Suggestion to update trend figures due to an increase in costs.
- Health insurance administrative expenses and profits excluded from the chart.
- Some members expressed concern about setting a conservative 5% target without considering factors such as minimum wage increases, health care innovation, and staffing costs.
- Incentives for innovation.
- Prices of drugs like Ozempic and hospital prices.
- Inefficient aspects of the health care system, such as excessive middle management that contribute to high costs.
- The challenge regarding setting targets for cost reduction and aiming to bend the cost curve and make health care more affordable.
- The importance of data collection and analysis in identifying unnecessary spending.
- Reduction of health care worker wages negatively impacting care quality, and any necessary expenditure increases coming from profit rather than raising overall costs.
- Setting aggressive targets and wishful thinking caveats; setting intelligent targets that are reflective of reality.

Assistant Deputy Director Howard presented on the topic of economic indicators. Discussion and comments from the Advisory Committee included:

- Some members expressed concerns about the spending target being 2.8% considering high inflation rates.
- The need to consider health care costs and waste.
- Regulating health care as a public utility and the importance of considering behavioral economics in determining affordability goals.
- Reducing costs, increasing access, and gathering data on health care spend before making any changes or setting standards.
- A personal experience of spending $45,000 in a hospital without control over the costs.
- How health care costs are determined by health systems and health plans and the need for a reasonable number to address affordability issues.

Break

Deputy Director Pegany and Michael Bailit presented on population-based

measures such as age and sex trends, chronic illness prevalence, and disability status adjustments. Discussion and comments from the Advisory Committee included:

- The impact of these factors on health care spending growth being analyzed using data from different sources.
- Question of whether or not there are population-based trends that would influence health care spending growth if everything else was held constant.
- Review of the four population-based measures identified by the Board for staff to research.
- The definition of a disability being determined by the survey questions and being based on self-assessment by individuals.
- COVID-related disability and fluctuations in prevalence rates during different years, indicating that the data may not be as robust due to pandemic effects.
- Some members expressed concerns about the accuracy of the data based on their experience working in the field of disability and the potential for cross-comparing with other organizations' data for more accurate results.
- Some members expressed concerns about the usefulness and complexity of the adjustments and potential equity issues.
- Considering race and ethnicity in measuring disability and chronic illness rates to avoid disparities in access to care.
- Inclusion of virtual care spend and nontraditional providers in total spend.
- The recommendation regarding underserved areas and rural areas as potential contemplation for adjustment consideration by the Board.
- Oral health spending adjustments.
- Opinions on the timing and ambition of implementing a phase-in approach for setting spending targets.
- Some member expressed concerns about providers raising rates in anticipation of the target being set.
- Some members supported a longer phase-in period for planning purposes and to allow for adjustments and ease of implementation.
- Some member supported fixed targets.
- Adjusting the target mid-cycle based on external events or economic factors.
- Different perspectives on whether adjustments should be made and under what conditions.
- Qualifications or limitations to ensure fairness and transparency.
- The importance of predictability and accountability, as well as the need to balance adjustments with clear targets.
- Impact of inflation, retrospective assessment for organizations exceeding the target, the role of economic factors, and adjustments based on new data.
- The Board's decision-making power and the importance of transparency.

- Percentage of providers in other states that have met their set targets being mixed over the years where most of the states do not have programs with a long track, pre-COVID, except Massachusetts.
- Next steps, involving presenting a proposal for spending target values and related policy questions to the Board and gathering feedback from the Advisory Committee before a final vote by the board.

Public Comment for this item was combined with Agenda Item #7: general public comment.

Agenda Item # 7: General Public Comment

Public Comment was held on agenda item 7 and 0 members of the public commented.

Agenda Item # 8: Adjournment

The Leading Resources Inc facilitator adjourned the meeting.