OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Advisory Committee Meeting

October 30, 2024

HCAI

Department of Health Care Access and Information

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Office of Health Care Affordability

Department of Health Care Access and Information

Welcome, Call to Order, and Roll Call

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Department of Health Care Access and Information

Agenda

1. **Welcome, Call to Order, and Roll Call**
   Elizabeth Landsberg, Director
2. **Executive Updates and New Member Introduction**
   Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director
3. **Update on Cost and Market Impact Review Program Including Revised Regulations**
   Sheila Tatayon, Assistant Deputy Director
4. **Introduce Quality and Equity Measure Set Proposal**
   Margareta Brandt, Assistant Deputy Director, Janna King, Health Equity and Quality Performance Group Manager
5. **Update on the THCE Data Submission Guide & Regulations**
   Margareta Brandt; CJ Howard, Assistant Deputy Director
6. **Introduce Behavioral Health Definition and Investment Benchmark**
   Margareta Brandt, Debbie Lindes, Health Care Delivery System Group Manager
7. **Public Comment**
8. **Adjournment**

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Office of Health Care Affordability

Department of Health Care Access and Information

Executive Updates and New Member Introduction

Elizabeth Landsberg, Director

Vishaal Pegany, Deputy Director

HCAI

Department of Health Care Access and Information

Land Acknowledgement

The Department of Health Care Access and Information's (HCAI) Sacramento and Los Angeles offices sit on land stolen from the Miwok ("mee-waak"), Nisenan ("nish-n-non"), Chumash ("choo-mash") and Gabrielino-Tongva ("gab-ree-uh-lee-noh"- "to-VAA-ngar") peoples.

We acknowledge the resilience and fortitude of the Miwok ("mee-waak"), Nisenan ("nish-n-non"), Chumash ("choo-mash"), Gabrielino-Tongva ("gab-ree-uh-lee-noh"- "to-VAA-ngar") and other native peoples, who despite efforts at genocide, survive as cultures and communities today.

Cross-generational trauma, systemic racism and historic discrimination have taken a toll on native peoples contributing to health disparities, a lack of access to health care services, and barriers for native peoples to become part of the health workforce. We commit to evaluating our efforts in these areas to advance justice, rectify past injustices, and ensure historic wrongs are not repeated.

In solidarity and allyship with native peoples, we commit to being positive catalysts for change, not culprits or passive witnesses of the injustices perpetuated throughout our history. We acknowledge inaction as the fuel that sustains inequality.

. . . we commit to using the demographic data we receive to illuminate disparities in health delivery systems and disseminate this actionable information to expose the lingering impact of past actions against native peoples and underserved communities.

. . . we commit to advancing our understanding of the tribal health delivery system and listening to tribal voices to guide us in eliminating barriers native people face in becoming part of the health workforce and other barriers that prevent access to quality care.

. . . we commit to revisiting HCAI's programs, policies, and procedures to allocate state resources equitably in a manner that recognizes our responsibility to address disparities.

With Appreciation

“Dr. Ghaly’s heroic service to the people of our state and his profound contribution to reshaping California’s health and social services cannot be overstated.

“For more than five years at the helm of CalHHS, his visionary and compassionate leadership and unwavering focus on protecting the most vulnerable among us has seen our state through unprecedented challenges and historic victories that improve the lives of Californians.

“He has been a driving force for transformative changes to make health care more affordable and accessible, and has overseen the state’s overhaul of our behavioral health system to better reach those most in need. His steadfast leadership of California’s nation-leading response to the pandemic saved countless lives and set the stage for our state’s strong recovery.

“I thank Dr. Ghaly for his tireless work to build a Healthy California for All, which will continue to make an impact in the lives of millions for decades to come.”

Governor Gavin Newsom

Welcome Secretary Johnson

Governor Newsom appointed Kim Johnson as Secretary of the California Health and Human Services Agency, effective October 1.

“Kim has been an indispensable partner in delivering foundational services that millions of Californians rely on, bringing decades of experience and expertise in this space. I’m grateful to her for stepping into this new role and look forward to her continued leadership and partnership in our work to advance the health and well-being of all Californians.”

Governor Gavin Newsom

Summary of OHCA's August Board Meeting in Monterey County

- On August 28, 2024, OHCA held its monthly board meeting in Monterey, California to learn more about the high health care costs concerns from the many Monterey residents who had previously travelled to Sacramento board meeting to express their concerns.
- The stakeholders who attended and made public comment included: teachers and school superintendents, farmworkers, hospitality workers, union stewards and leaders, and other community residents.
- OHCA staff and leaders from Covered California and CalPERS presented data demonstrating that hospitals in Monterey are high-cost outliers. The presentations highlighted data in response to several possible explanations for high costs – risk mix, higher quality, more charity care and bad debt, or payer mix. None of those directly explain the higher costs.
- Brown Professor Christopher Whaley outlined policy steps other states have taken to address high hospital costs, which include increasing the use of ambulatory service centers, taking action against consolidation in the health care market, and capping hospital prices.

Summary of OHCA's August Board Meeting in Monterey County (cont'd)

- Key findings of the meeting include:
  - Health care prices in the Salinas-Monterey area are both high and growing fast: Overall health care prices – both inpatient and outpatient -- are well above statewide and national averages. The area experienced a 19 percent price increase between 2017 and 2021.
  - The Covered California region that covers Monterey County has consistently experienced higher costs and premium growth compared to the rest of the state, even though its risk pool is generally healthier compared to the rest of the state.
  - HCAI Annual Hospital Financial Data finds Monterey County hospitals have positive operating margins, indicating profitability. The compiled data showed that, from 2018 to 2022, Community Hospital of the Monterey Peninsula (CHOMP) and Salinas Valley Memorial Hospital had operating margins that were between 4 to 6 times higher than the statewide average.

OHCA Will Conduct an Investigative Study of Hospital Market Competition in Monterey County

OHCA is responsible for "***analyzing the health care market for cost trends*** and drivers of spending, developing data informed policies for lowering health care costs for consumers and purchasers, creating a state strategy for controlling the cost of health care and ***ensuring affordability for consumers and purchasers***, and enforce cost targets."
(Cal. Health & Saf. Code, §127501.2, subd (b).)

OHCA is directed to "***monitor*** cost trends, ***including conducting research and studies on the health care market***, including, but not limited to, ***the impact of consolidation, market power***, venture capital activity, ***profit margins, and other market failures on competition, prices, access, quality, and equity.***"
(Cal. Health & Saf. Code, §127507, subd. (a).)

The Director, as head of HCAI and OHCA is authorized to make **investigations** concerning "(a) All matters relating to the business activities and subjects under the jurisdiction of the department; . . . and (c) [s]uch other matters as may be provided by law." (Cal. Gov. Code, §11180.)

THCE Data Submission Update

OHCA thanks payers as well as state and federal agencies for their continued partnership in sharing enrollment and expenditure data.

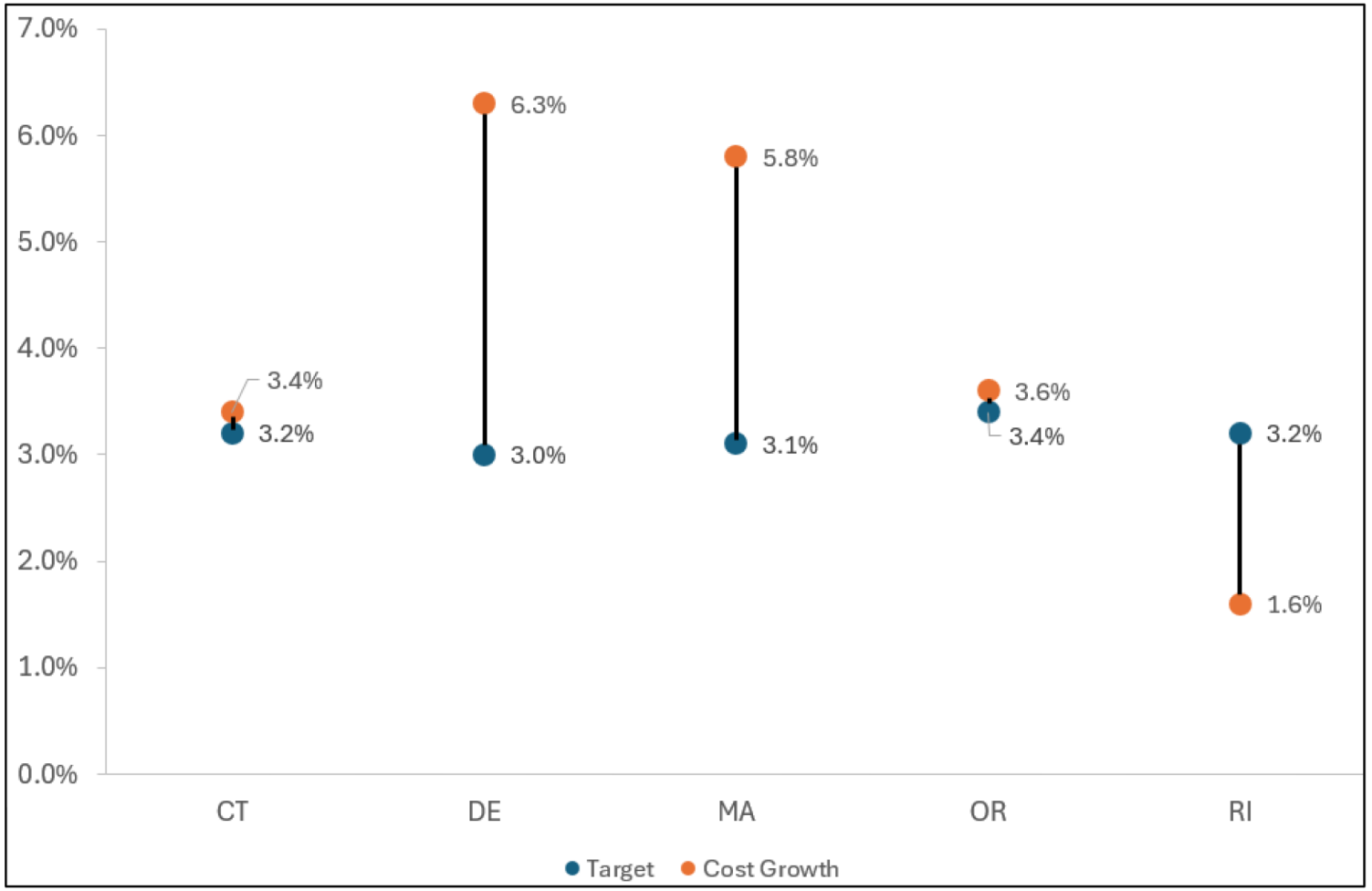
In August, OHCA received aggregate Medicare FFS expenditure and enrollment data from CMS for calendar year 2022 and 2023.

The TME data submission deadline for Commercial and Medicare Advantage plans for calendar year 2022 and 2023 data was September 1.

- In preparation, in July and August, OHCA held one-on-one meetings with submitters to answer questions and provide technical assistance.
- OHCA has received Total Medical Expense (TME) submissions from 17 submitters
- OHCA has been carrying out data quality assessments and is beginning to schedule another round of one-on-one meetings to review each submitter's enrollment and TME data.
- In February 2025, OHCA expects to receive TME files from DHCS for MCO plans.

Health Affairs: Health Care Spending Growth in 2022

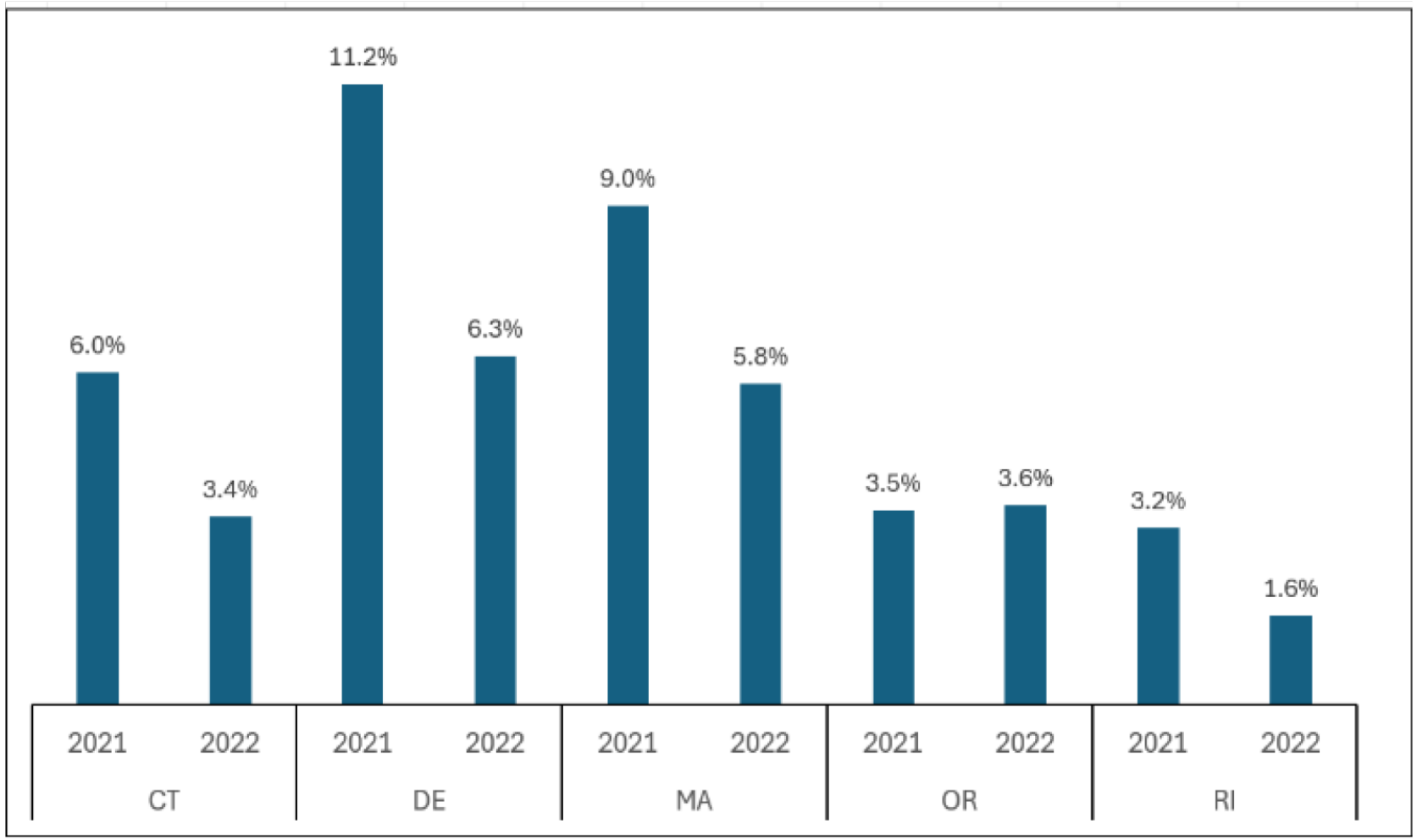
In four of the five states that reported 2022 performance, spending growth exceeded the spending target.



Source: Mar, J. & Angeles, J. (August 8, 2024). Health Affairs. *In States with Health Care Spending Targets, Spending Growth Moderated in 2022 but Still Exceeded Targets.* https://www.healthaffairs.org/content/forefront/states-health-care-spending-targets-spending-growth-moderated-2022-but-still-exceeded

Health Affairs: Health Care Spending Growth in 2022

2022 spending growth was lower than 2021 spending growth.



Source: Mar, J. & Angeles, J. (August 8, 2024). Health Affairs. *In States with Health Care Spending Targets, Spending Growth Moderated in 2022 but Still Exceeded Targets.* https://www.healthaffairs.org/content/forefront/states-health-care-spending-targets-spending-growth-moderated-2022-but-still-exceeded

Health Affairs: Health Care Spending Growth in 2022

- Retail prescription drug spending was generally the fastest growing spending category across states
  - When Connecticut's Office of Strategy asked three pharmaceutical manufacturers to appear for public testimony, they refused.
- In 2022, hospital inpatient spending dropped in four states and remained flat in one.
- The authors suggest that the 2022 slowdown in spending is unlikely to be long-lasting and to expect high spending growth in 2023 and 2024.
  - The significant reimbursement increases that health care providers sought in their contract negotiations with health insurers following the period of high inflation in late 2021 through 2022 are likely to play out in the form of high spending growth in both 2023 and 2024.
- Now that these states have collected and analyzed several years of data to understand the drivers of health care spending and spending growth, the focus must turn to implementing policies that address high and rising spending and make health care more affordable.

Source: Mar, J. & Angeles, J. (August 8, 2024). Health Affairs. *In States with Health Care Spending Targets, Spending Growth Moderated in 2022 but Still Exceeded Targets.* https://www.healthaffairs.org/content/forefront/states-health-care-spending-targets-spending-growth-moderated-2022-but-still-exceeded

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.

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New Member Introductions

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Advisory Committee Members*

Payers

Aliza Arjoyan
Senior Vice President of Provider Partnership and Network Management, Blue Shield of California

Yolanda Richardson,
Chief Executive Officer, San Francisco Health Plan

Andrew See
Senior Vice President, Chief Actuary, Kaiser Foundation Health Plan

Hospitals

Barry Arbuckle
President & Chief Executive Officer, MemorialCare Health System

Tam Ma
Associate Vice President, Health Policy and Regulatory Affairs, University of California Health

Travis Lakey
Chief Financial Officer, Mayers Memorial Hospital District

Medical Groups

Hector Flores
Medical Director, Family Care Specialists Medical Group

Stacey Hrountas
Chief Executive Officer, Sharp Rees-Stealy Medical Centers

David S. Joyner
Chief Executive Officer, Hill Physicians Medical Group

Physicians

Adam Dougherty
Emergency Physician, Vituity

Parker Duncan Diaz
Clinician Lead, Santa Rosa Community Health

Sumana Reddy
President, Acacia Family Medical Group

Purchasers

Ken Stuart
Chairman, California Health Care Coalition

Suzanne Usaj
Senior Director, Total Rewards, The Wonderful Company LLC

Abbie Yant
Executive Director, San Francisco Health Service System

Health Care Workers

Stephanie Cline
Respiratory Therapist, Kaiser

Sarah Soroken
Mental Health Clinician, Solano County Mental Health

Cristina Rodriguez
Physician Assistant, Altura Centers for Health

Consumer Representatives & Advocates

Carolyn J Nava
Senior Systems Change, Disability Action Center

Mike Odeh
Senior Director of Health, Children Now

Kiran Savage-Sangwan
Executive Director, California Pan-Ethnic Health Network (CPEHN)

Rene Williams
Vice President of Operations, United American Indian Involvement

Marielle A. Reataza
Executive Director, National Asian Pacific American Families Against Substance Abuse (NAPAFASA)

Organized Labor

Joan Allen
Government Relations Advocate, SEIU United Healthcare Workers West

Carmen Comsti
Lead Regulatory Policy Specialist, California Nurses Association/National Nurses United

Janice O'Malley
Legislative Advocate, American Federation of State, County and Municipal Employees

Kati Bassler
President, California Federation of Teachers, Salinas Valley

Academics/ Researchers

Stephen Shortell
Professor, UC Berkeley School of Public Health

*As of August 28, 2024

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Update on Cost and Market Impact Review Program Including Revised Regulations

Sheila Tatayon, Assistant Deputy Director

HCAI

Department of Health Care Access and Information

Overview of Revisions, effective 8/22/24

- **Definition of Affiliation** - “affiliate” removed.
- **Material Change Transactions** – removed April 1, 2024, date.
- **Who must file a material change notice** – “subject of the transaction”.
- **Fully Integrated Delivery System** – specified as needed.
- **Health Professional Shortage Area** – “provides health care services in”.
- **Calculating “annual California-derived revenue”** – whether:
  - entity meets revenue threshold.
  - transaction meets material change circumstances.
- **Reasonable Diligence Attestation** – added.
- **Requests for Confidentiality** – added expedite requests and ability to withdraw if confidentiality request denied .
- **Decision to conduct CMIR** – added ability to meet Spending Target.
- **Non-substantive grammatical changes** – where needed.

Affiliation and Affiliate

§ 97431(a) "Affiliation"

"Affiliation," **as used in sections 97431(p), 97435(c)(6), and 97438(c)(2) of these regulations,** refers to a situation in which an entity ~~**("affiliate")**~~ controls, is controlled by, or is under common control with another legal entity in order to collaborate for the provision of health care services. "Affiliation" does not include a collaboration on clinical trials, graduate medical education programs, health professions training programs, health sciences training programs, or other education and research programs.

Definition of affiliation – is not the definition of "affiliate" for purposes of calculating annual California-derived revenue

§ 97435(d) Revenue.

For purposes of subsection (b) of this regulation only, "revenue" means the total average annual California-derived revenue received for all health care services by the submitter and all affiliates over the three most recent fiscal years, as follows:

April 1, 2024, Date Removed

§ 97435. Material Change Transactions.

(a) A health care entity ~~(hereinafter referred to as a "submitter")~~ ~~who~~ that meets the criteria of subsection (b) shall provide the Office with notice of a material change transaction as described in subsection (c) at least 90 days before the closing date of the transaction~~, for those transactions expected to close on or after April 1, 2024~~. For purposes of section 127507(c)(2) of the Code, the phrase "entering into the agreement or transaction" refers to the closing date.

Who Must File & Health Professional Shortage Area

§ 97435. Material Change Transactions.

(b) Who must file. A health care entity who is a party to**, or a subject of,** a material change transaction, shall file a written notice of the material change transaction with the Office if the ~~party~~ health care entity (hereinafter referred to as a "submitter") meets any of the thresholds in subsections (b)(1) through (b)(3) under any of the circumstances set forth in subsection (c), unless exempted by subdivisions (d)(1) through (4) of section 127507 of the Code. **Being a subject of a transaction means the transaction, as defined in section 97431(p), concerns a health care entity's assets, control, responsibility, governance, or operations, in whole or in part.**

(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~~;~~.

(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 to**, or a subject of,** a transaction with:

(A) any health care entity satisfying subsection (b)(1); or
(B) any entity that owns or controls a health care entity satisfying subsection (b)(1).

(3) **A provider or fully integrated delivery system that is a party to, or a subject of, the transaction and provides health care services** ~~**A health care entity located**~~ in a designated 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.

Revenue for Calculating Filing Thresholds & Circumstances

Does Health Care Entity Meet the Revenue Filing Thresholds?

§ 97435(b) Who must file

(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~~;~~.

(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 to, or a subject of, a transaction with: . . .

§ 97435(d) Revenue For purposes of subsection (b) of this regulation only, "revenue" means

the total average annual California-derived revenue received for all health care services by the submitter and all affiliates over the three most recent fiscal years, as follows: . . .

Do Transaction Circumstances Meet the Revenue Thresholds?

§ 97435(c) Circumstances requiring filing

Circumstances requiring filing. A transaction is a material change transaction pursuant to section 127507(c)(1) of the Code if any of the circumstances in paragraphs (1) through (8) below exist. **For purposes of this subsection only, "annual California-derived revenue" means revenue from the provision of health care services in California**. . . .

(2) The transaction is more likely than not to increase annual California-derived revenue of any health care entity that is a party to, or a subject of, 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 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 that is a party to, or a subject of, ~~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.

(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 annual California-derived ~~annual~~ revenue at normal or stabilized levels of utilization or operation, or transfer of control of California assets related to the provision of health care services valued at $25 million or more.

Reasonable Diligence Attestation

§ 97438. Filing of Notices of Material Change Transactions.

(a)A notice of material change transaction pursuant to section 127507 of the Code required to be filed under this section ("notice") shall be made under penalty of perjury using the portal on the Office's website at www.hcai.ca.gov/login. **A health care entity shall also attest it used reasonable diligence to ascertain the information required by this section.** A health care entity or its agent filing via the portal shall create a portal account by inputting a first and last name, valid e-mail account, display name, and password, and submit a system-generated verification code. Alternatively, the health care entity or agency may use an existing media account from Microsoft or Google to access the portal.

(b)(3) Identification of all ~~other~~ parties to the transaction and indication whether any health care entities who are parties to the transaction will be submitting a notice. For each ~~other~~ entity that is a party to the transaction, **the submitter shall exercise reasonable diligence to ascertain** and ~~to the extent the submitter has access to the information,~~ shall describe the following:

Reasonable Diligence Attestation

§ 97438(b)(3). Filing of Notices of Material Change Transactions.

. . .

the submitter shall exercise reasonable diligence to ascertain and ~~to the extent the submitter has access to the information,~~ shall describe the following:

(A) The entity's business (including business lines or segments);

(B) Ownership type (corporation, partnership, limited liability company, etc.), including any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the health care entity or that are subject to the control, governance, or financial control of the health care entity;

(C) Governance and operational structure (including ownership of or by a health care entity);

(D) Annual revenue for the three most recent fiscal years used in calculating revenue in accordance with section 97435(d);

(E) Current county or counties of operation;

(F) If a health care provider or a fully integrated delivery system is a party to, or the subject of, the transaction, include a summary of provider type (hospital, physician group, etc.), facilities owned or operated, service lines, number of staff, geographic service area(s), and capacity (e.g., number of licensed beds) or patients served (e.g., number of patients per county) in California in the last year;

(G) Primary and threshold languages, as determined by the Department of Health Care Services, used;

(H) If a payer or a fully integrated delivery system is a party to, or the subject of, the transaction, include a list of all counties where coverage is sold, counties in which they are licensed to operate by the Department of Managed Health Care and/or the Department of Insurance, and the number of enrollees residing in each listed county in the year preceding the transaction; and

Decision to Conduct CMIR Includes Spending Target

§ 97441. Review of Material Change Transaction Notice: Decision to Conduct Cost and Market Impact Review.

(a) Office Determination Whether to Conduct a Cost and Market Impact Review (CMIR).

(1) The Office shall base its decision whether to conduct a CMIR on any of the following factors: . . .

(B) The transaction may result in a negative impact on costs for payers, purchasers, or consumers, **including the ability to meet any health care cost targets established by the Health Care Affordability Board.**

OHCA Statute – 127507.2(a)(1) If the office finds that a material change noticed pursuant to Section 127507 is likely to have a risk of a significant impact on market competitions, the state's ability to meet cost targets, or costs for purchasers and consumers, the office shall conduct a cost and market impact review

CMIR Program Update: *Material Change Notices (MCNs) Received Since April 2024*

MCN Submitters	Transaction Summary	Submission Complete	CMIR?
Western Sierra Medical Clinic and Sierra Family Medical Clinic	Merger of two Federally Qualified Health Centers (FQHCs) with Western Sierra Medical Clinic as the surviving entity.	September 17, 2024	CMIR Waived
Carelon Health Of California, Inc. (f/k/a CareMore Health Plan	A joint venture between Elevance and Clayton Dubilier & Rice, LLC to build a payor-agnostic, advanced primary care and physician enablement business serving consumers in several states.	September 13, 2024	CMIR Waived
The Cigna Group and Health Care Service Corporation (HCSC)	HCSC is acquiring all of the assets relating to The Cigna Group's Medicare Advantage Plan Business, Medicare PDP Business, Supplemental Health Plans Business, and CareAllies Business.	August 16, 2024	CMIR Waived

CMIR Program Update: *Material Change Notices (MCNs) Received Since April 2024*

MCN Submitters	Transaction Summary	Submission Completed	CMIR?
Laboratory Corporation of America Holdings and BioReference Health, LLC	Labcorp will acquire BioReference's laboratory testing businesses focused on clinical diagnostics and reproductive and women's health across the United States outside of New York and New Jersey.	July 11, 2024	CMIR Waived
Invitae Corporation and Laboratory Corporation of America Holdings	The transaction is an asset sale, through which LabCorp Genetics, Inc., a newly formed entity, will acquire certain assets of Invitae Corporation in accordance with the negotiated Asset Purchase Agreement and certain requirements under the bankruptcy code.	June 5, 2024	CMIR Waived
Rehabilitation Center of Santa Monica Operating Company, LP	The submitter's lease for the skilled nursing facility property is expiring and the landlord requested submitter's cooperation in remaining the operator until the new operator/tenant obtains its license to operate the facility.	April 12, 2024	CMIR Waived

OHCA's Determination To Conduct (or Waive) CMIR - Factors

The Office shall base its decision to conduct a CMIR on any of the following factors:

(A) The transaction may result in a negative impact on the availability or accessibility of health care services, including the health care entity's ability to offer culturally competent care.

(B) The transaction may result in a negative impact on costs for payers, purchasers, or consumers, including the ability to meet any health care cost targets established by the Health Care Affordability Board.

(C) The transaction may lessen competition or create a monopoly in any geographic service areas impacted by the transaction.

(D) The transaction may lessen competition for health care entities to hire workers or may negatively impact the labor market by, for instance, lowering wages or slowing wage growth, worsening benefits or working conditions, or resulting in other degradations of workplace quality.

(E) The transaction negatively impacts a general acute care or specialty hospital by, for instance, restricting or reducing the health care services offered.

(F) The transaction may negatively impact the quality of health care services available to patients from the parties to the transaction.

(G) The transaction is part of a series of similar transactions by the health care entity or entities that furthers a trend toward consolidation.

(H) The transaction may entrench or extend a dominant market position of any health care entity in the transaction, including extending market power into related markets through vertical or cross-market mergers.

(I) The transaction between a health care entity located in this state and an out-of-state entity may negatively impact affordability, quality, or limit access to health care services in California, or undermine the financial stability or competitive effectiveness of a health care entity located in this state.

Source: Cal. Code Regs., tit. 22, § 97441(a)(1)

CMIR Program Update

CMIR Inbox CMIR@HCAI.ca.gov	Virtual Teams Meetings
• OHCA has received and provided written responses to 91 email questions. • OHCA generally provides responses within 48 hours.	• OHCA has hosted 19 meetings with potential submitters. • Of these, most were with law firms that filed MCNs with OHCA for their clients. • Other meetings re: pending transactions.

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Public Comment

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Introduce Quality and Equity Measure Set Proposal

Margareta Brandt, Assistant Deputy Director

Janna King, Health Equity and Quality Performance Group Manager

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Department of Health Care Access and Information

OHCA's Quality and Equity Measure Set

Statutory Requirements

- **Adopt and track performance on a single set of standard measures for assessing health care quality and equity across payers, fully integrated delivery systems, hospitals, and physician organizations.**
- **Use recognized clinical quality, patient experience, patient safety, and utilization measures**.
- Consider available means for **reliable measurement of disparities in health care**, including race, ethnicity, sex, age, language, sexual orientation, gender identity, and disability status.
- **Reduce administrative burden** by selecting quality and equity measures that simplify reporting and align performance measurement with other payers, programs, and state agencies, including leveraging existing voluntary and required reporting to the greatest extent possible.
- **Coordinate with DMHC, DHCS, Covered California, and CalPERS**, and consult with external quality improvement organizations and forums, payers, physicians, other providers, and consumer advocates or stakeholders.

These criteria are summarized from Article 2. Office of Health Care Affordability, Health and Safety Code § 127501-127501.12 and Article 4. Quality and Equity Performance, Health and Safety Code § 127503.

OHCA's Quality and Equity Measure Set

Statutory Requirements

- **Promote the goal of improved affordability** for consumers and purchasers of health care, **while maintaining quality and equitable care**.
- OHCA may require a health care entity to implement a performance improvement plan that identifies the causes for spending growth and shall include specific strategies, adjustments, and action steps the entity proposes to implement to improve spending performance during a specified time period. **The director shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode access, quality, equity, or workforce stability.**

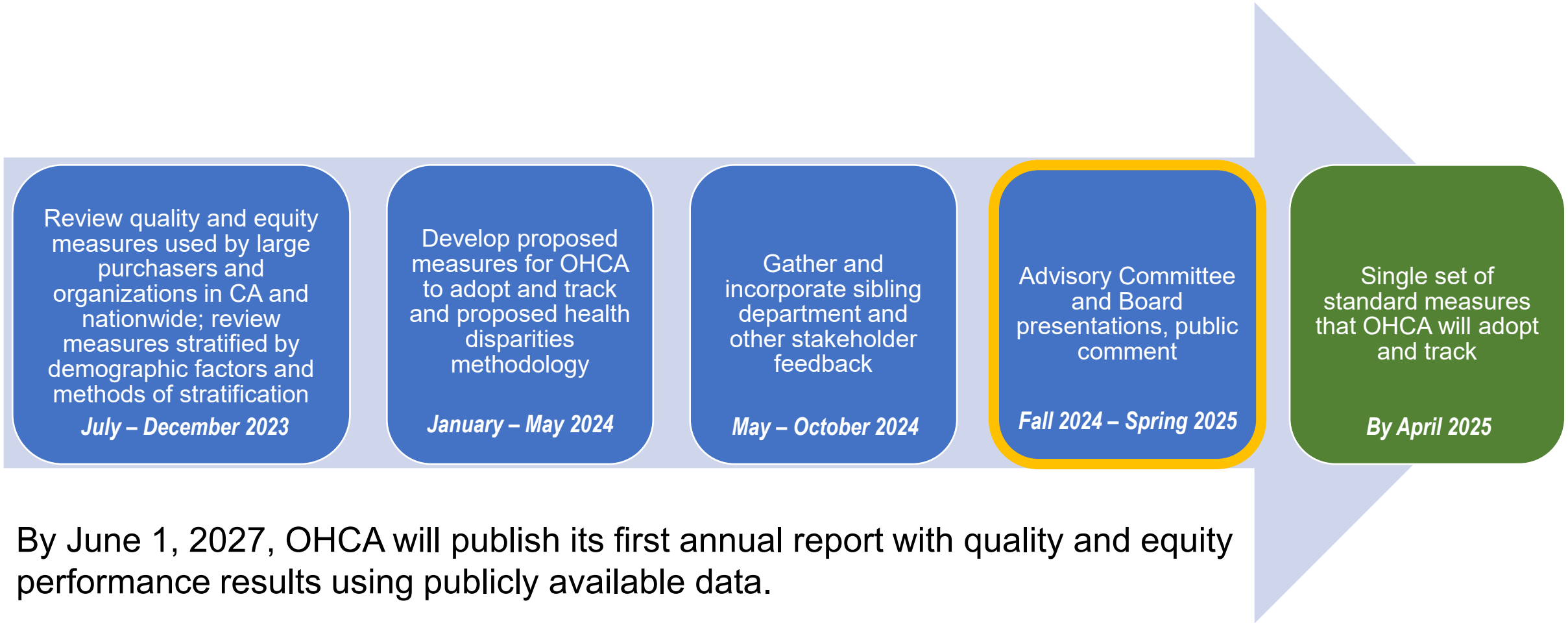
These criteria are summarized from Article 3. Office of Health Care Affordability, Health and Safety Codes § 127502(c)(5) and § 127502.5.

OHCA's Quality and Equity Measure Set

Purpose

- Promote high quality and more equitable health care for all Californians.
- Monitor changes in quality and equity as health care entities work to meet the spending growth target.
- Track progress towards OHCA's goals to improve access, affordability, and equity of health care for all Californians.

Process and Tentative Timeline



By June 1, 2027, OHCA will publish its first annual report with quality and equity performance results using publicly available data.

Completed Analyses

Analyzed over 300 quality measures used by prominent health care organizations in California and nationally.

- CA state departments: HCAI, DMHC, DHCS, Covered California, CalPERS, OPA, and CDPH.
- California-specific initiatives: Cal Hospital Compare, California Quality Collaborative.
- National: CMS Universal Foundation, NCQA HEDIS®[1].

Identified measures consistently used across organizations.

Reviewed how health care organizations in California and nationally are measuring, analyzing, and reporting health equity and disparities.

Met with internal and external partners to gather feedback and align efforts.

- Met with sibling state departments, Integrated Healthcare Association, and internal partners within HCAI.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Proposed Quality and Equity Measure Set

- OHCA is proposing to adopt all or a subset of three publicly available measure sets to measure quality and equity across health care entities.

Payers	Physician Organizations	Hospitals
Fully Integrated Delivery Systems[1]		
Adopt the full Department of Managed Health Care's (DMHC) Health Equity and Quality Measure Set measures and stratification requirements	Adopt a subset of the Center for Data Insights and Innovation's Office of the Patient Advocate (OPA) Health Care Quality Report Card measures[2]	Adopt the full Department of Health Care Access and Information's (HCAI) Hospital Equity Measures Reporting Program measures and stratification requirements

[1] For fully integrated delivery systems, which include a payer, physician organization, and hospital component, OHCA will measure performance of each of these component entities.
[2] OPA does not report measures stratified by demographic characteristics.

Considerations for Quality and Equity Measure Set Proposal

Advantages

- Uplifts measure sets developed through intensive multi-stakeholder processes.
- Leverages existing publicly reported performance measure results.
- Does not add administrative burden to health care entities.
- Promotes alignment between state departments, major public purchasers, and payers.

Limitations

- Includes a small number of behavioral health measures.
- OPA Health Care Quality Report Card measures are not stratified by demographic characteristics.
- For payers, performance results will not be collected or publicly reported by the DMHC for all lines of business.
- For physician organizations, performance results are not publicly reported for commercial PPO, Medi-Cal, and Medicare fee-for-service members.[1]

[1] Attributing commercial PPO members to a physician organization is a larger industry-wide challenge. Performance is not reported for Medi-Cal members at the physician organization level. Medicare fee-for-service members are not assigned to a physician organization because CMS contracts directly with the provider.

Measures for Payers: Background on the DMHC Health Equity and Quality Measure Set

- AB 133 (Committee on Budget, 2021) required the DMHC to establish and convene a Health Equity and Quality Committee to recommend a health equity and quality measure set and benchmarks with the goal to address long-standing health inequities and to ensure equitable delivery of high-quality health care across all market segments.
  - The Committee was comprised of consumer representatives, health plan representatives, providers, quality measurement and health equity experts, and representatives from state agencies.
- Based on the Committee's recommendations, the DMHC established the Health Equity and Quality Measure Set and measure stratification requirements, effective beginning measurement year 2023.
- The DMHC may reconvene the Committee to reevaluate the effectiveness of the Health Equity and Quality Measure Set and measure stratification requirements.
- Payers[1] subject to reporting on the DMHC Health Equity and Quality Measure Set: all Commercial and Covered California market segments, including the individual, small, and large group markets, and the Medi-Cal Managed Care program.

[1] DMHC uses the term health care service plans and only those with direct enrollment are required to report on Health Equity and Quality Measure Set. Health care service plans excluded from reporting are Medicare Advantage-only plans, plans with no direct enrollment, specialized dental, vision, chiropractic, or acupuncture health plans, and Employee Assistance Plans.

Source: DMHC Licensing eFiling. (2024, June 28). APL 24-013 – Health Equity and Quality Program Policies and Requirements (6/28/2024). https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL24-013-HealthEquityandQualityProgramPoliciesandRequirements(6_28_2024).pdf?ver=9wJvJOJ61DNjXvVpRgHqeQ%3d%3d

Measures for Payers: DMHC Health Equity and Quality Measure Set

Measures (Measurement Year 2024)	
Colorectal Cancer Screening*	Childhood Immunization Status: Combination 10*
Breast Cancer Screening*	Child and Adolescent Well-Care Visits*
Glycemic Status Assessment for Patients with Diabetes (<8.0% and >9.0%)*	Well-Child Visits in the First 30 Months of Life (0 to 15 Months and 15 to 30 Months)*
Controlling High Blood Pressure*	Plan All-Cause Readmissions
Asthma Medication Ratio*	Immunizations for Adolescents: Combination 2*
Depression Screening and Follow-Up for Adolescents and Adults (Depression Screening and Follow-Up on Positive Screen)	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey: Getting Needed Care (adult and child survey) or Qualified Health Plan (QHP) Enrollee Experience Survey[1]
Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care)*	

* Measure results stratified by race and ethnicity for measurement year 2024.

Source: DMHC Licensing eFiling. (2024, June 28). APL 24-013 – Health Equity and Quality Program Policies and Requirements (6/28/2024). https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL24-013-HealthEquityandQualityProgramPoliciesandRequirements(6_28_2024).pdf?ver=9wJvJOJ61DNjXvVpRgHqeQ%3d%3d

[1] CAHPS Child Survey is only for applicable Medicaid plans. CAHPS health plan survey does not apply to Exchange plans. Exchange plans will report to the DMHC on the QHP Enrollee Experience Survey in measurement year 2024.

Measures for Physician Organizations: Background on OPA Health Care Quality Report Cards

- Assembly Bill 172 (Committee on Budget, 2021) moved the Office of the Patient Advocate (OPA) to the Center for Data Insights and Innovation (CDII) in October 2021. CDII is now responsible for statutory mandates to publish report cards on health care quality per California Health and Safety Code § 130200.
- OPA's Health Care Quality Report Cards are public reports that rate physician organizations on quality, patient experience, and total cost of care to help consumers make informed decisions about their health care.
- Quality ratings for the Health Care Quality Report Cards come from the Integrated Healthcare Association's Align. Measure. Perform. (AMP) program.
- The Integrated Healthcare Association's Technical Measurement Committee serves as an advisory body for the Health Care Quality Report Cards.
    - The Committee is comprised of representatives from health plans, physician organizations, and health care purchasers, who are well-versed in health care quality and patient experience measurement, data collection, and public reporting.
- Physician organizations included in Health Care Quality Report Cards: physician organizations who voluntarily participate in the Integrated Healthcare Association's AMP Commercial HMO and Medicare Advantage programs.
    - No performance for commercial PPO, Medi-Cal, and Medicare fee-for-service members.[1]

Source: Center for Data Insights and Innovation. (2024). Health Care Quality Report Cards. https://www.cdii.ca.gov/consumer-reports/health-care-quality-report-cards/.

[1] Attributing commercial PPO members to a physician organization is a larger industry-wide challenge. Performance is not reported for Medi-Cal members at the physician organization level. Medicare fee-for-service members are not assigned to a physician organization because CMS contracts directly with the provider.

Measures for Physician Organizations: OPA Health Care Quality Report Cards

Measures (Measurement Year 2024)	
Asthma Medication Ratio	Immunizations for Adolescents: Combination 2
Breast Cancer Screening	Kidney Health Evaluation in Patients with Diabetes
Cervical Cancer Screening	Osteoporosis Management in Women Who Had a Fracture
Child and Adolescent Well-Care Visits	Plan All-Cause Readmissions
Childhood Immunization Status: Combination 10	Prenatal Immunization Status
Chlamydia Screening in Women	Proportion of Days Covered by Medications (Diabetes All Class, Renin Angiotensin System Antagonists, and Statins)
Colorectal Cancer Screening	Statin Therapy for Patients With Cardiovascular Disease
Controlling High Blood Pressure	Statin Use in Persons with Diabetes
Eye Exam for Patients with Diabetes	Total Cost of Care, incl service categories
Glycemic Status Assessment for Patients with Diabetes (<8.0% and/or >9.0%)	

- No patient experience measures for measurement year 2024.[1]

Source: Center for Data Insights and Innovation. (2024). Health Care Quality Report Cards. https://www.cdii.ca.gov/consumer-reports/health-care-quality-report-cards/.

[1] PBGH sunset the Patient Assessment Survey (PAS) program effective July 31, 2024. OPA used the PAS program results to publicly report patient experience measures.

Measures for Hospitals: Background on HCAI Hospital Equity Measures Reporting Program

- Assembly Bill 1204 (Chapter 751, Statutes of 2021) required HCAI to convene a Health Care Equity Measures Advisory Committee to make recommendations on the development of a hospital equity reporting program to collect and post annual hospital equity reports that include measures on patient access, quality, and outcomes by race, ethnicity, language, disability status, sexual orientation, gender identity, and payor.
  - The Committee was comprised of representatives from academic institutions focused on health care quality and equity measurement, associations representing public hospitals and health systems, associations representing private hospitals and health systems, organized labor, organizations representing consumers, and organizations representing vulnerable populations.
- Based on the Committee's recommendations, HCAI is finalizing the Hospital Equity Measures Reporting Program via the regulatory process in early 2025.
- The Committee will reconvene after the first year of reporting to make a second set of recommendations to HCAI regarding the submitted hospitals' health equity plans.
- Hospitals subject to reporting on the HCAI Hospital Equity Measures Reporting Program measures: licensed general acute care hospitals (includes children's hospitals), acute psychiatric hospitals, specialty hospitals, and hospital systems with at least two general acute care hospitals.

Source: HCAI. (n.d.). *Hospital Equity Measures Reporting Program*. https://hcai.ca.gov/data/healthcare-quality/hospital-equity-measures-reporting-program/

Measures for Hospitals: HCAI Hospital Equity Measures Reporting Program

Measures (Measurement Year 2024)	
Designate an individual to lead hospital health equity activities	All-Cause Unplanned 30-Day Hospital Readmission Rate*
Hospital Commitment to Health Equity Structural Measure	Cesarean Birth Rate (NTSV)*
Provide documentation of policy prohibiting discrimination	Death Rate among Surgical Inpatients with Serious Treatable Complications*
Report percentage of patients by preferred language spoken	Exclusive Breast Milk Feeding*
Screen Positive Rate for Social Drivers of Health	Vaginal Birth After Cesarean Rate (VBAC)*
Screening for Social Drivers of Health	All-Cause Unplanned 30-Day Hospital Readmission Rate in an inpatient psychiatric facility*
All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavior health diagnosis*	Screening for metabolic disorders*
HCAHPS survey (Received information and education and would recommend hospital)*	SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge*
Pneumonia Mortality Rate*	Pediatric experience survey with scores of willingness to recommend the hospital*

* Core quality measures that will be stratified by race/ethnicity, age, sex assigned at birth, expected payor, preferred language, disability status, sexual orientation, and gender identity to the extent that the data is available.

Source: HCAI. (n.d.). *Hospital Equity Measures Reporting Program*. https://hcai.ca.gov/data/healthcare-quality/hospital-equity-measures-reporting-program/

Proposed Quality and Equity Measure Set

- OHCA is proposing to adopt all or a subset of three publicly available measure sets to measure quality and equity across health care entities.

Payers	Physician Organizations	Hospitals
Fully Integrated Delivery Systems[1]		
Adopt the **full** DMHC Health Equity and Quality Measure Set measures and stratification requirements	Adopt a **subset** of the OPA Health Care Quality Report Card measures[2]	Adopt the **full** HCAI Hospital Equity Measures Reporting Program measures and stratification requirements

[1] For fully integrated delivery systems, which include a payer, physician organization, and hospital component, OHCA will measure performance of each of these component entities.
[2] OPA does not report measures stratified by demographic characteristics.

Measures for Payers and Physician Organizations (Plus Measures for Hospitals)

Measures	OHCA	
Childhood Immunization Status[1]	Payers	Physician organizations
Colorectal Cancer Screening[1]		
Controlling High Blood Pressure[1]		
Glycemic Status Assessment for Patients With Diabetes (<8.0% and/or >9.0%)[1]		
All-Cause Readmissions		
Asthma Medication Ratio		
Breast Cancer Screening Rate		
Child and Adolescent Well-Care Visits		
Immunizations for Adolescents		
Depression Screening and Follow-Up for Adolescents and Adults (Depression Screening and Follow-Up on Positive Screen)		
CAHPS Health Plan Survey: Getting Needed Care (Adult and Child survey) or QHP Enrollee Experience Survey[2]		
Prenatal and Postpartum Care (Postpartum Care and Timeliness of Prenatal Care)		
Well-Child Visits in the First 30 Months of Life (0 to 15 Months and 15 to 30 Months)		
HCAI Hospital Equity Measures Reporting Program measure set (full)		☑

- OHCA proposes to adopt the full DMHC measure set for payers, the overlap of DMHC and OPA measure sets for physician organizations, and all HCAI Hospital Equity Measures Reporting Program measures.
- The payer and physician organization measure sets should become more aligned as measures are added to the OPA Health Care Quality Report Cards.

[1] Measures that align across all California State Departments for payers and physician organizations.
[2] In the DMHC Health Equity and Quality Measure Set, CAHPS Child Survey is only for applicable Medicaid plans. CAHPS health plan survey does not apply to Exchange plans. Exchange plans will report to the DMHC on the QHP Enrollee Experience Survey in measurement year 2024.

Measures for Hospitals (Plus Measures for Payers and Physician Organizations)

HCAI Hospital Equity Measures Reporting Program Measure Name	General Acute Hospital Measures	Acute Psychiatric Hospital Measures	Children's Hospital Measures	OHCA
Designate an individual to lead hospital health equity activities[1]	X	X	X	Hospitals
Hospital Commitment to Health Equity Structural Measure[1]	X	X	X	
Provide documentation of policy prohibiting discrimination[1]	X	X	X	
Report percentage of patients by preferred language spoken[1]	X	X	X	
Screen Positive Rate for Social Drivers of Health[1]	X	X	X	
Screening for Social Drivers of Health[1]	X	X	X	
All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavior health diagnosis	X	X		
HCAHPS survey (Received information and education and would recommend hospital)	X	X		
Pneumonia Mortality Rate	X	X		
All-Cause Unplanned 30-Day Hospital Readmission Rate	X		X	
Cesarean Birth Rate (NTSV)	X			
Death Rate among Surgical Inpatients with Serious Treatable Complications	X			
Exclusive Breast Milk Feeding	X			
Vaginal Birth After Cesarean Rate (VBAC)	X			
All-Cause Unplanned 30-Day Hospital Readmission Rate in an inpatient psychiatric facility		X		
Screening for metabolic disorders		X		
SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge		X		
Pediatric experience survey with scores of willingness to recommend the hospital			X	
DMHC Health Equity and Quality Measure Set (full) and OPA Health Care Quality Report Card Measures (subset)				☑

Source: HCAI. (n.d.). *Hospital Equity Measures Reporting Program*. https://hcai.ca.gov/data/healthcare-quality/hospital-equity-measures-reporting-program/.

[1] Structural measures for all hospitals. For more detail on these measures, see Appendix.

Broad Measurement with Key Highlights in Public Reporting

- One purpose of the OHCA quality and equity measure set is to monitor changes in quality and equity as health care entities work to meet the spending target.
- In OHCA's public reporting, OHCA will explore highlighting a subset of key measures that are particularly important to the goal of improved affordability of health care, while maintaining quality and equitable care.

Equity Analyses

Payer Equity Analyses: Stratifying Quality Measures

- OHCA will align with the stratification requirements and reporting used in the DMHC's Health Equity and Quality Measure Set.
- Health plans must report to the DMHC aggregate measure results for all measures and measure results stratified by the National Committee for Quality Assurance (NCQA) for some measures.
- The NCQA has a health equity methodology for stratifying its measures by race and ethnicity.[1]
    - The NCQA follows the Office of Management and Budget (OMB) Standards for stratification.[2]

NCQA Stratification Categories for Race and Ethnicity[1]

Race	Ethnicity
White	Hispanic or Latino
Black or African American	Not Hispanic or Latino
American Indian or Alaska Native	Asked but no answer
Asian	Unknown
Native Hawaiian or Other Pacific Islander	
Some other race	
Two or more races	
Asked but no answer	
Unknown	

Sources: DMHC Licensing eFiling. (2024, June 28). APL 24-013 – Health Equity and Quality Program Policies and Requirements (6/28/2024). https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL24-013-HealthEquityandQualityProgramPoliciesandRequirements(6_28_2024).pdf?ver=9wJvJOJ61DNjXvVpRgHqeQ%3d%3d.

[1] As of March 28, 2024, the OMB issued revised race and ethnicity stratification standards, which must be implemented as soon as possible, but no later than March 28, 2029.

[2] The DMHC will attempt to align future MY HEQMS stratification requirements with the NCQA's implementation of these new OMB standards.

Physician Organization Equity Analyses

- OPA's Health Care Quality Report Cards do not include quality measures stratified by demographic characteristics.
- OHCA will consider including additional population health analyses to supplement its equity analyses and will continue to explore and assess options to expand its equity analyses in the future.

Hospital Equity Analyses: Stratifying Quality Measures

- OHCA will align with the stratification requirements and reporting used in HCAI's Hospital Equity Measures Reporting Program.
- AB 1204 requires all core quality measures to be stratified to the extent that the data is available at the hospital and hospital system level.
- The numerator, denominator, and rate for all core quality measures will be stratified by the following categories: race/ethnicity, age, sex assigned at birth, expected payor, preferred language, disability status, sexual orientation, and gender identity.

For more information, see the HCAI Hospital Equity Measures Reporting Program.

Additional Equity Analyses

- OHCA will explore including analyses on population health measures by other state departments, California specific surveys, reports, and SDOH indices, and national surveys to provide additional context for interpreting and understanding performance on the quality and equity measure sets.
  - OHCA may include key pieces from existing reports that are the most relevant to the quality and equity measure set and statewide spending target.
- For payers, OHCA is considering reporting information from the DMHC Health Plan Demographic Data Metric.
- For payers, OHCA is also considering reporting which payers have achieved NCQA Health Equity Accreditation and NCQA Health Equity Plus Accreditation.
- For all measure sets, OHCA will consider adopting changes implemented by the respective departments, such as adding new measures or updating the stratification requirements.
- OHCA will continue to explore and assess options to expand its equity analyses in the future.

Sources: DMHC Licensing eFiling. (2024, June 28). APL 24-013 – Health Equity and Quality Program Policies and Requirements (6/28/2024). https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL24-013-HealthEquityandQualityProgramPoliciesandRequirements(6_28_2024).pdf?ver=9wJvJOJ61DNjXvVpRgHqeQ%3d%3d.; NCQA. (n.d.). NCQA's Health Equity Accreditation Programs. https://www.ncqa.org/programs/health-equity-accreditation/.

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Public Comment

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Update on the THCE Data Submission Guide & Regulations

CJ Howard, Assistant Deputy Director
Margareta Brandt, Assistant Deputy Director

HCAI

Department of Health Care Access and Information

Data Submission Guide (DSG) 2.0

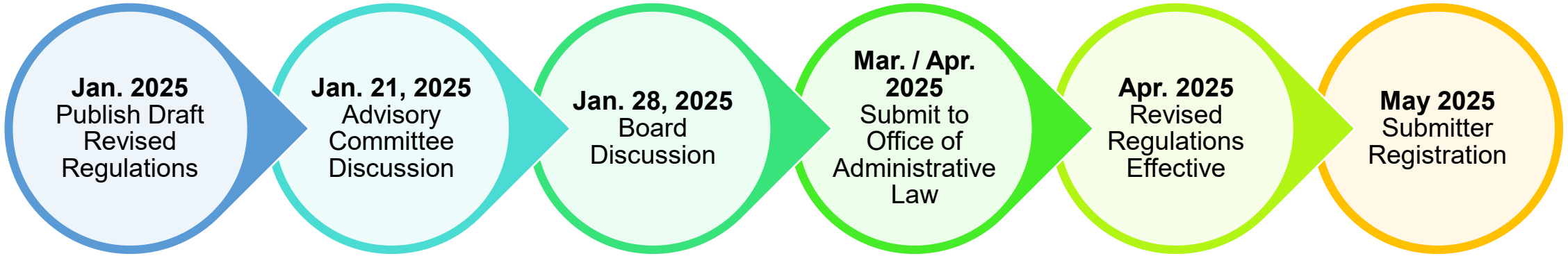
Data Submission Guide 2.0

- DSG 2.0 outlines requirements for submission of 2023-2024 data in 2025
- Draft will be shared for public comment in early 2025
- Annual registration due by May 31, 2025
- Data submission due by September 1, 2025

DSG 2.0 Proposed Changes

- Require licensed health plans and insurers to register and submit data separately
- Remove PO/TIN list requirement from 2025 registration
- Remove Los Angeles SPAs from Regional file; use two Covered CA rating regions for Los Angeles members
- Remove some duplicative fields in response to submitter feedback (e.g., drop Member Responsibility from Attributed and Regional files)
- Add two new files for Alternative Payment Model and Primary Care data

DSG 2.0 Timeline



Alternative Payment Model Data Collection

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

Alternative Payment Models

Statutory Requirements

- Promote the shift of payments based on fee-for-service (FFS) to alternative payment models (APMs) that provide financial incentive 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.

Health and Safety Code § 127504(a) - (d)

APM Standards and Goals Approved

At the June 2024 meeting, the Board approved the APM Standards and Adoption Goals.

Baseline established on 2024 data collected in 2025, to be categorized via Expanded Framework. **Data on 2026 goal collected in 2027, reported in 2028.**

APM Adoption Goals for Percent of Members Attributed to HCP-LAN Categories 3 and 4 by Payer Type				
	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	65%	25%	55%	55%
2028	75%	35%	60%	65%
2030	85%	45%	65%	75%
2032	90%	55%	70%	85%
2034	95%	60%	75%	95%

See OHCA website for APM Standards and Goals: https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/apm-standards-and-adoption-goals/

HCAI Non-Claims Data Collection

Data Collection Consideration	APM	Primary Care	TME	HPD
Reporting Expanded Framework subcategory?	Yes	Yes	No	Yes
Reporting payments in categories/subcategories	All member TME in one category	Actual non-claims payments	Actual non-claims payments	Actual non-claims payments
Frequency of data collection	Annual	Annual	Annual	Annual; monthly capitation

Expanded Non-Claims Payments Framework, Categories A-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, 3N
C2	Procedure-related, episode-based payments with risk of recoupments	3B, 3N
C3	Condition-related, episode-based payments with shared savings	3A, 3N
C4	Condition-related, episode-based payments with risk of recoupments	3B, 3N
C5	Risk for total cost of care (e.g., ACO) with shared savings	3A, 3N
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B, 3N

See Expanded Non-Claims Payments Handout: https://hcai.ca.gov/wp-content/uploads/2024/09/HCAI-Expanded-Non-claims-Payments-Framework-Handout_v2.pdf

Expanded Non-Claims Payments Framework, Categories D-F

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

See Expanded Non-Claims Payments Handout: https://hcai.ca.gov/wp-content/uploads/2024/09/HCAI-Expanded-Non-claims-Payments-Framework-Handout_v2.pdf

Summary of APM Data Collection Approach

- ✓ APM membership data collected by market category and product type at payer level to meet APM adoption goal requirement
- ✓ APM spending data as per member, per month and as a percent of total medical expense collected at Expanded Framework subcategory level
- ✓ Membership and spending in episode-based care models collected by episode type and Expanded Framework subcategory level

Primary Care Data Collection

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

Primary Care Investment

Statutory Requirements

- Measure the **percentage of total health care expenditures allocated to primary care** and **set spending benchmarks** that consider current and historic underfunding of primary care services.
- Determine the categories of providers, specific procedure codes, and non-claims payments that should be considered when determining the total amount spent on primary care.
- Build and sustain methods of reimbursement that shift greater health care resources and investments away from specialty care and toward primary care and behavioral health.
- Promote improved outcomes for primary care and sustained systemwide investment in primary care.
- Include an analysis of **primary care spending and growth in the annual report.**
- Consult with state departments, external organizations promoting investment in primary care, and other entities and individuals with expertise in primary care.

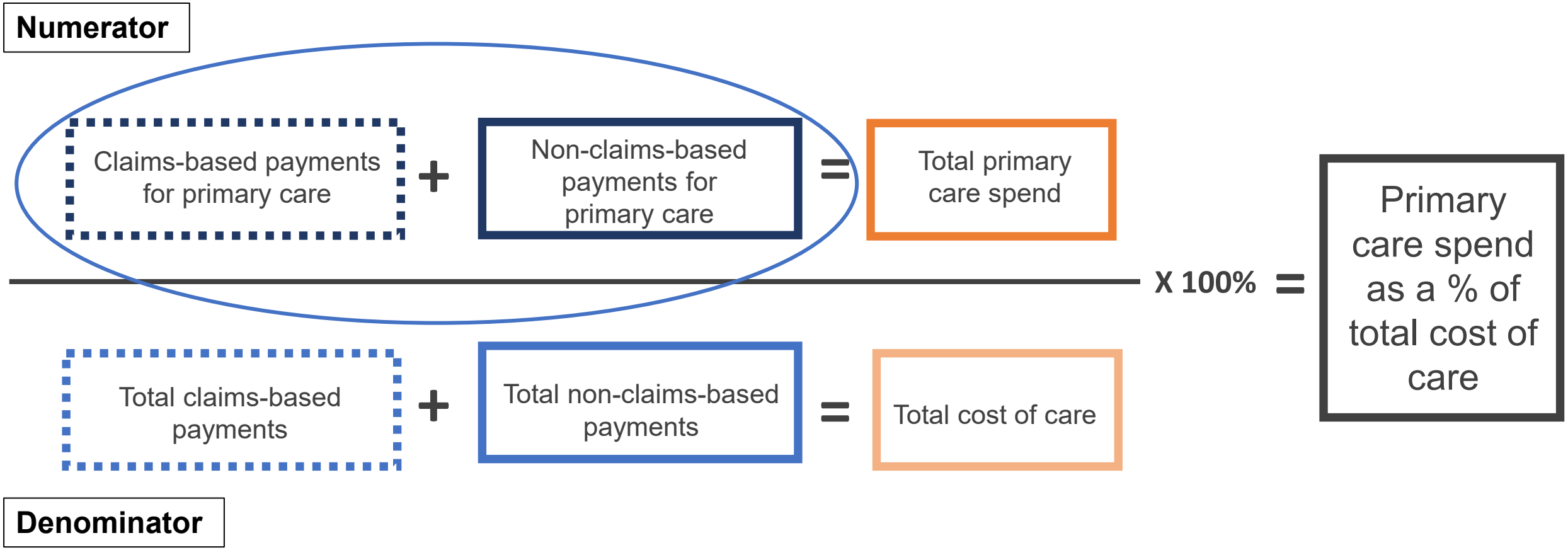
Primary Care Investment Benchmark Approved

- **Baseline** for 0.5-1% increase per year for each payer **established on performance year 2024 data collected in 2025.**
- Progress towards first **annual improvement benchmark** will be assessed for **performance year 2025 on data collected in 2026.**

Performance Years	Annual Improvement Benchmark
2025-2033	0.5 - 1% per year for each payer by line of business and product type
Performance Year	**Investment Benchmark**
2034	15% statewide across all payers, lines of business, and product types

*Payers at or above 15% of total medical expense may refrain from continued increases if not aligned with care delivery or affordability goals.
See OHCA website for Primary Care Investment Benchmark: https://hcai.ca.gov/affordability/ohca/primary-care-investment-benchmark/

Measuring Primary Care Spending



Adapted from Erin Taylor, Michael Bailit, and Deepti Kanneganti. Measuring Non-Claims-Based Primary Care Spending. Milbank Memorial Fund. April 15, 2021

Expanded Non-Claims Payments Framework

Required for Primary Care

	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, 3N
C2	Procedure-related, episode-based payments with risk of recoupments	3B, 3N
C3	Condition-related, episode-based payments with shared savings*	3A, 3N
C4	Condition-related, episode-based payments with risk of recoupments*	3B, 3N
C5	Risk for total cost of care (e.g., ACO) with shared savings	3A, 3N
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B, 3N

*Condition-related, episode-based payments are included as some of these payments are for chronic conditions that may be managed in primary care. Data submitters will follow OHCA's methodology for allocating a portion of these payments to primary care.

Expanded Non-Claims Payments Framework

Required for Primary Care

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

*OHCA is discussing whether there are Medi-Cal Other Non-Claims Payments that may be apportioned to primary care with DHCS.

Summary of Primary Care Data Collection Approach

- ✓ Claims and non-claims primary care spending collected by market category and product type at payer level
- ✓ Claims and non-claims primary care spending collected by subcategory level based on methodology developed by OHCA with input from the Investment and Payment Workgroup
- ✓ Behavioral health in primary care collected as part of primary care spending

OHCA

Office of Health Care Affordability
Department of Health Care Access and Information

Introduce Behavioral Health Definition and Investment Benchmark

Margareta Brandt, Assistant Deputy Director
Debbie Lindes, Health Care Delivery System Group Manager

HCAI

Department of Health Care Access and Information

Focus Areas for Promoting High Value

APM Adoption	• Define, measure, and report on alternative payment model adoption • Set standards for APMs to be used during contracting • Establish a benchmark for APM adoption
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
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

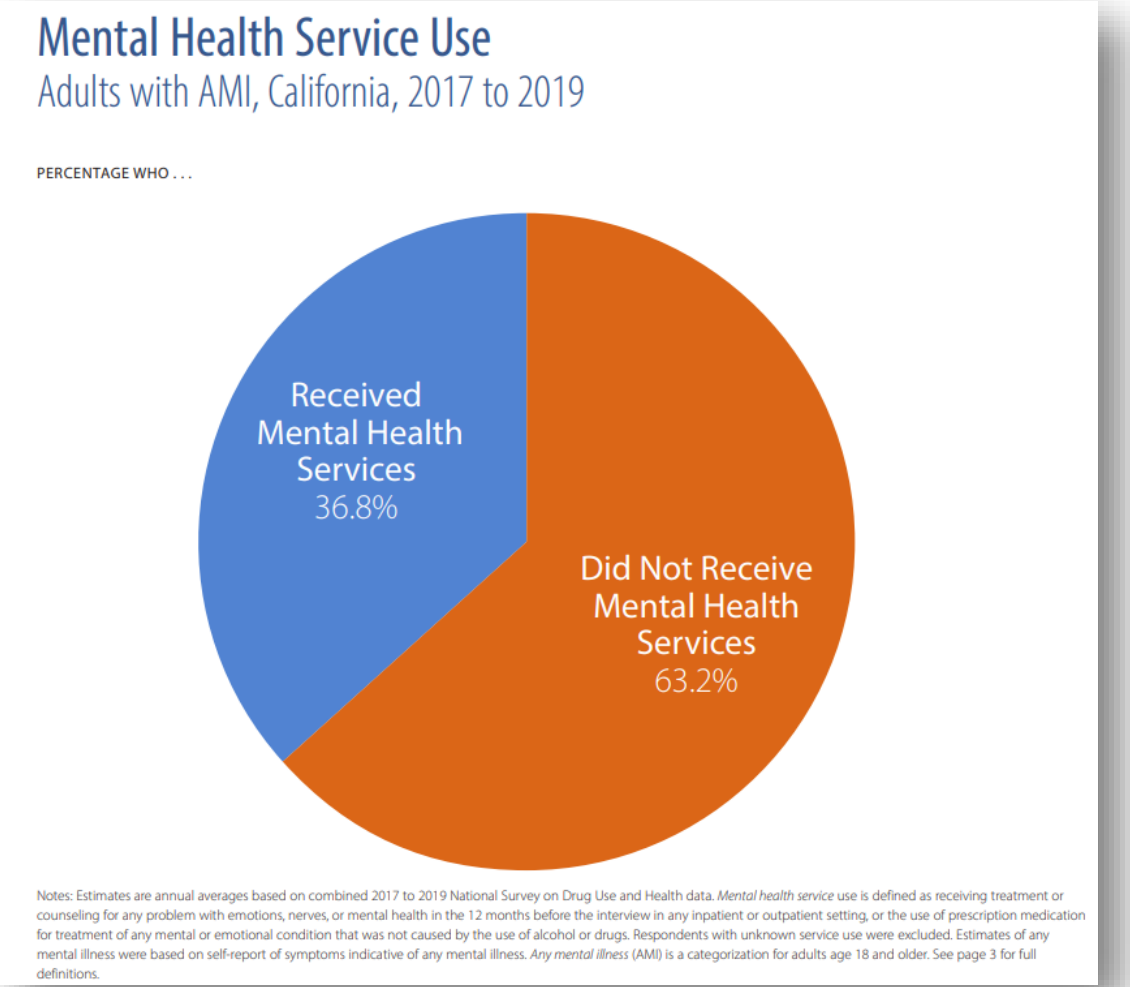
Primary Care & Behavioral Health Investments

Statutory Requirements

- Measure and promote a sustained systemwide investment in primary care (PC) and behavioral health (BH).
- **Measure the percentage of total health care expenditures allocated to PC and BH** and set spending benchmarks that consider current and historic underfunding of primary care services.
- **Develop benchmarks** with the intent to build and sustain infrastructure and capacity and shift greater health care resources and investments away from specialty care and toward supporting and facilitating innovation and care improvement in PC and BH.
- Promote improved outcomes for PC and BH.

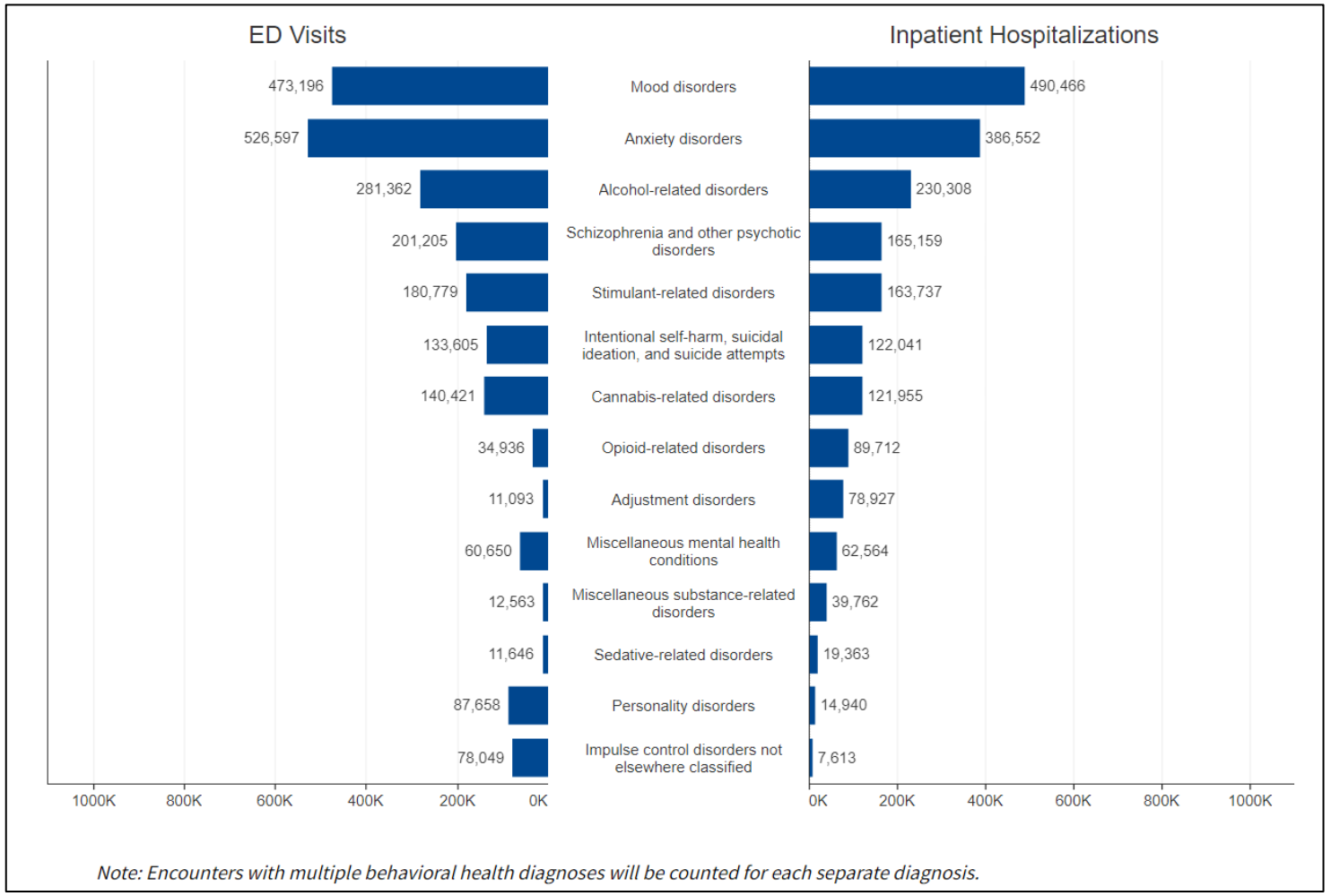
Why Behavioral Health?

- Nationally, the percent of adults reporting symptoms of anxiety and/or depression increased during the pandemic and remains just above 32%.
- Similarly in California, nearly 32% of adults report symptoms of anxiety and/or depression. Further, nearly two-thirds of California adults with mental illness reported not receiving treatment.
- Health care delivery models that integrate primary care and behavioral health have been shown to improve access to effective behavioral health services that improve health outcomes, as well as deliver a return on investment by reducing downstream health care costs.



Patient Discharge Data: Behavioral Health Diagnoses in Acute Care Settings, 2021

- Encounters for nearly 1 million emergency department visits and over 877,000 hospitalizations in California in 2021 included a mood or anxiety disorder diagnosis.
- Substance use disorders, combined, were the primary or secondary diagnosis for over 1.3 million hospitalizations and emergency department visits.



Note: Encounters with multiple behavioral health diagnoses will be counted for each separate diagnosis.

Investment and Payment Workgroup Members

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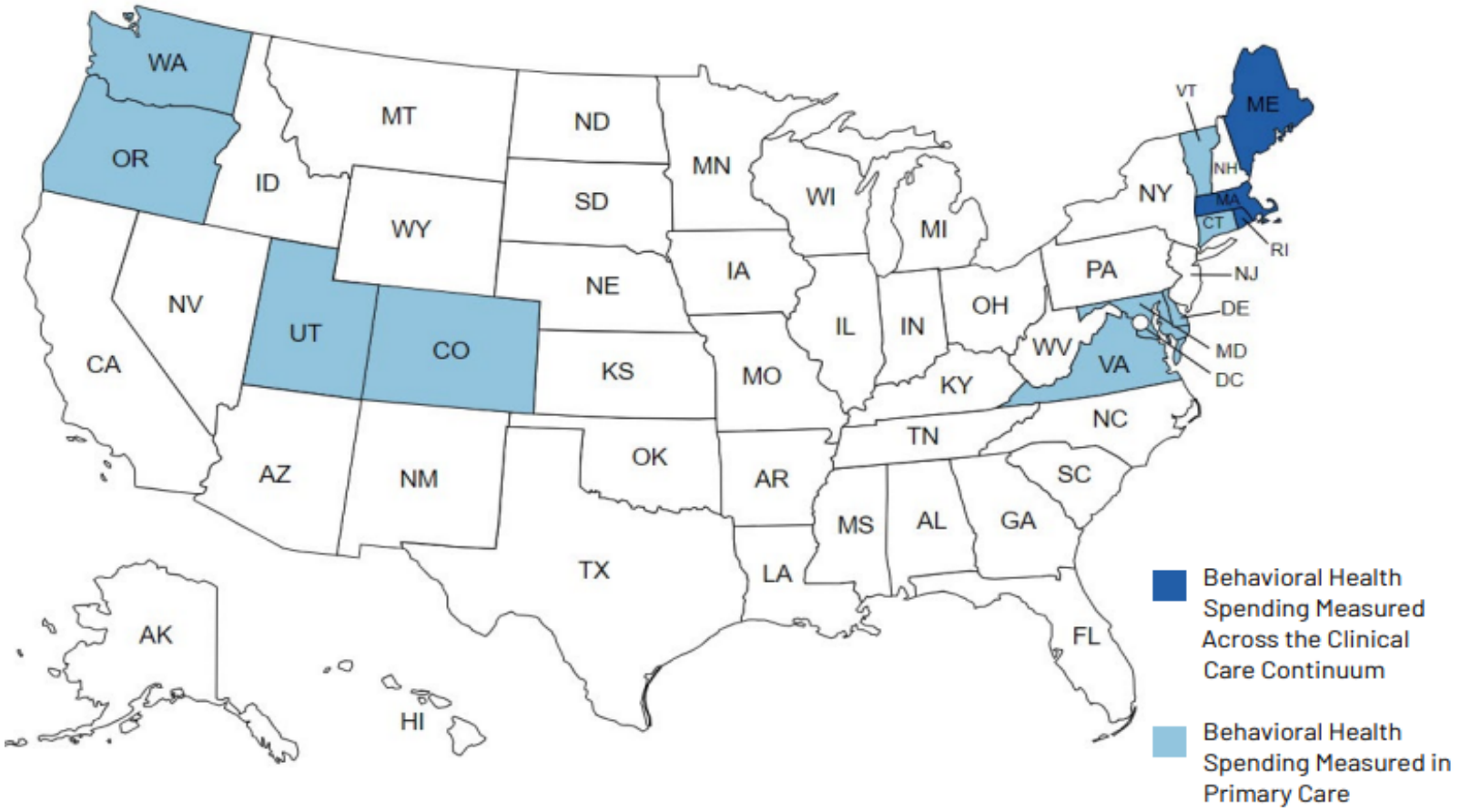
Behavioral Health Spending Measurement Framework

States Measuring Behavioral Health Clinical Spending

Nine states measure behavioral health spending as part of their efforts to measure primary care spending.

Three states measure behavioral health spending across the full care continuum (Maine, Massachusetts, and Rhode Island). This is California's mandate as well.

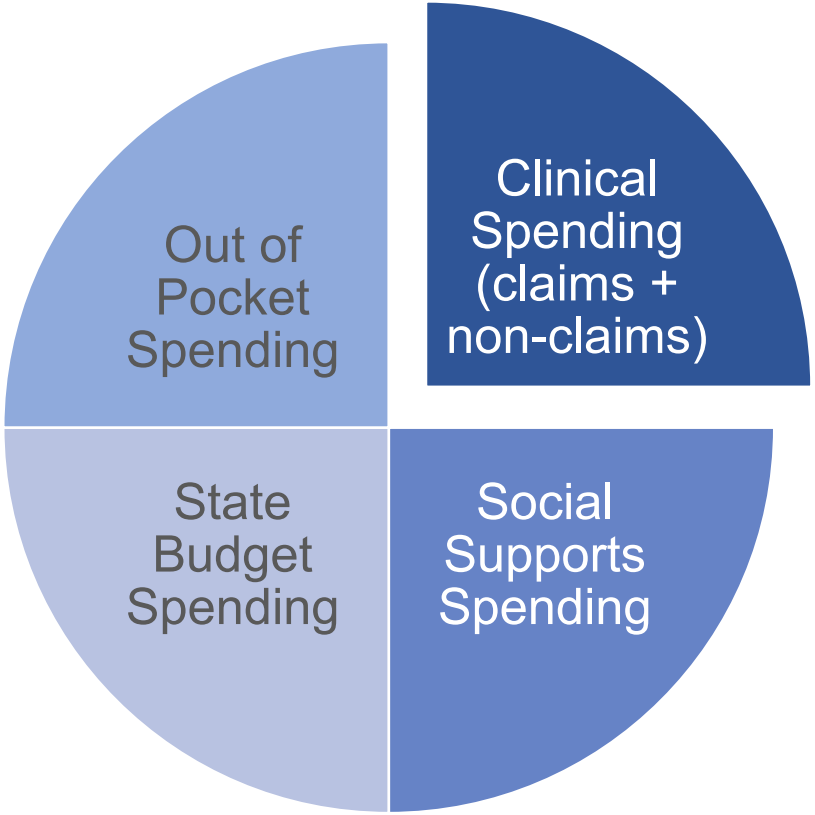


Potential Use Cases for OHCA's Behavioral Health Measurement

- Measure behavioral health spending as a percentage of Total Health Care Expenditures (THCE)
- Understand spending on mental health care and substance use disorder services
- Understand spending on behavioral health services in primary care settings
- Understand the distribution of behavioral health spending across different types of services and care settings
- Establish a focused benchmark for behavioral health spending that supports statewide goals and priorities

Data Collection and Measurement Scope

Clinical services are services provided by medical and allied health professionals to prevent, treat, and manage illness, and to preserve mental well-being across the clinical care continuum, paid via claims and non-claims payments (e.g., outpatient therapy visit, day treatment programs).



- Initial focus on clinical services and health care payers (e.g., commercial and Medicare Advantage)
- Possibility of using supplemental data sources to capture spending from other categories in the future

Adapted from Milbank Memorial Fund, April 2024. *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.* https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

Measuring Behavioral Health Investment

Numerator

Claims-based payments for behavioral health + Non-claims-based payments for behavioral health = Total behavioral health investment

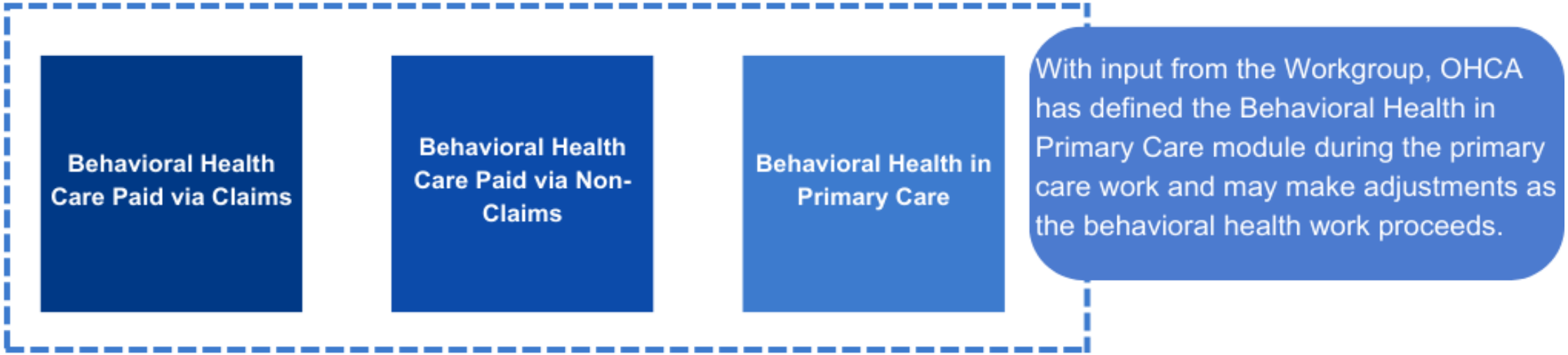
Denominator

Total claims-based payments + Total non-claims-based payments = Total cost of care

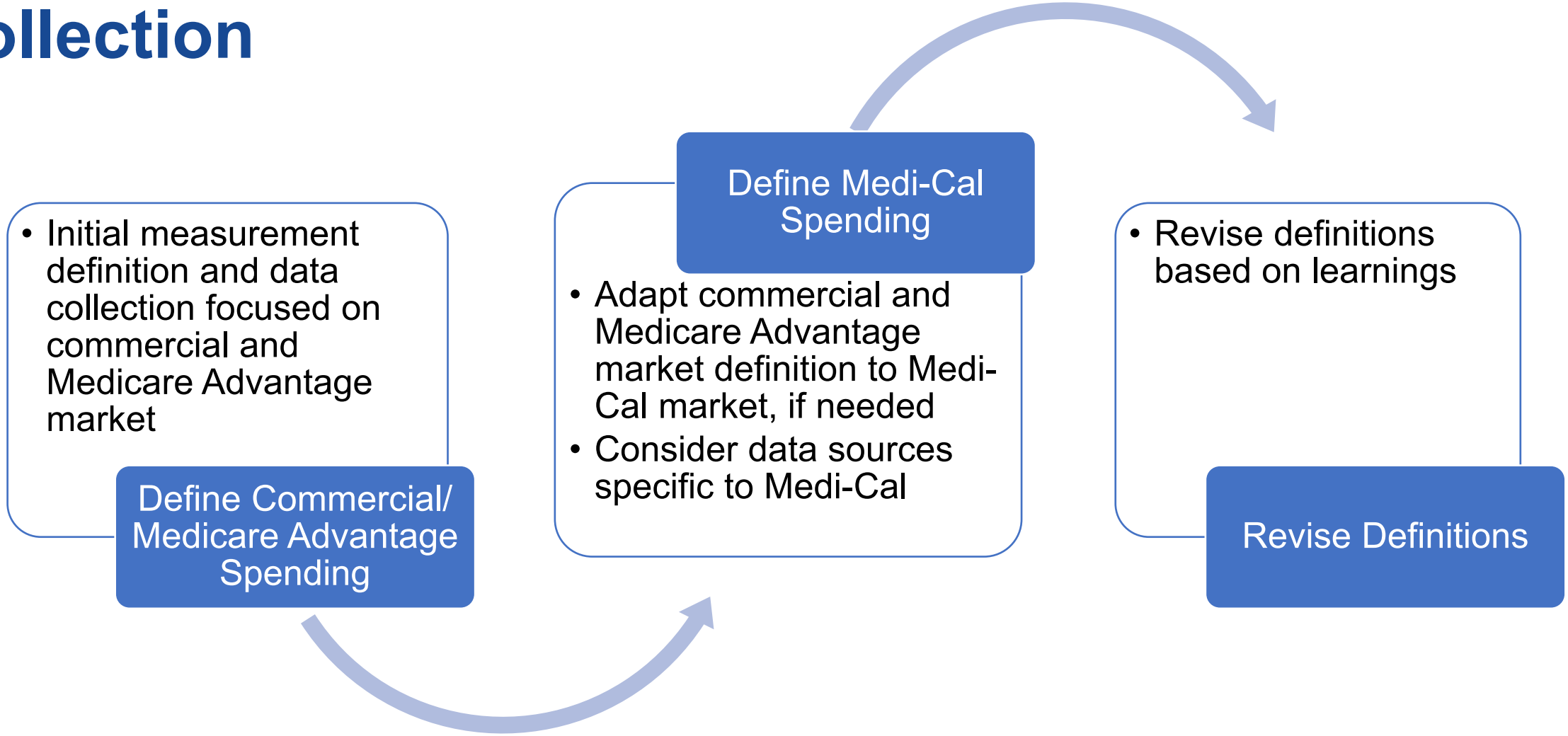
X 100% = Behavioral health investment as a % of total cost of care

Three Recommended Modules for Behavioral Health Spending Measurement

OHCA proposes to use three modules to measure behavioral health spending, following the approach for measuring primary care spending. Behavioral health in primary care will be measured separately so it can be included in analyses of behavioral health or primary care spending.



Proposed Phased Approach to Behavioral Health Spending Measurement Definition and Data Collection

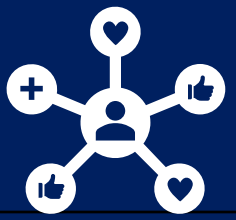


OHCA Data Sources for Measuring Behavioral Health Investment

- OHCA will collect the data to measure behavioral health spending as part of its Total Health Care Expenditures (THCE) data collection efforts; THCE data submissions do not capture all sources of behavioral health spending
- Behavioral health spending data will include claims and non-claims payments, which will be categorized using the Expanded Framework
- OHCA will provide definitions, technical specifications, and technical assistance to support submitters accurately allocating payments to behavioral health, particularly for non-claims payment categories
- OHCA is planning for initial behavioral health data collection and measurement efforts to focus on the commercial and Medicare Advantage populations

Behavioral Health Investment Benchmark

Proposed Goals for Improved Behavioral Health Care

				
Accessible	**Comprehensive**	**Coordinated**	**Equitable**	**High Quality**
• Providers and services are available when and where needed • Culturally responsive and linguistically concordant • Affordable	• Services across the continuum • More treatment in community and ambulatory settings, reduced need in emergency departments and correctional facilities	• Services integrated across behavioral health settings and with primary care • Attentive and responsive to health-related social needs	• Reduced disparities in utilization and outcomes • Reduced misinformation, stigma, and discrimination	• Improved behavioral health and overall health outcomes • Low frustration, high satisfaction

Adapted from CalHHS, "Policy Brief: Understanding California's Recent Behavioral Health Reform Efforts." March 2023. https://www.chhs.ca.gov/wp-content/uploads/2023/03/CalHHS-Behavioral-Health-Roadmap-_-ADA-03.02.23.pdf

OHCA's Role in Improving Behavioral Health Outcomes

Systemwide Behavioral Health Goals

Behavioral health care that is:

- Accessible
- Comprehensive
- Coordinated
- Equitable
- High Quality

Motivate

Resulting In

California Stakeholder Actions

- Identify and support higher value care
- Build and sustain infrastructure and capacity
- Promote behavioral health integration with primary care and social and public health services
- Reduce disparities

Supports

OHCA's Behavioral Health Workstream

- Promote sustained systemwide investment in behavioral health
- **Measure and report** the percentage of total health care expenditures allocated to behavioral health care
- Set focused **spending benchmarks** to support improved behavioral health outcomes
- Conduct analysis

Examples of how OHCA can support better behavioral health outcomes

Measure mental health spending and substance use disorder spending separately

Show how spending differs; compare to need as represented in prevalence data (from other sources)

Measure spending across service and treatment categories (e.g., primary care, outpatient, emergency/ observation, inpatient)

Highlight goal to rebalance care toward prevention and outpatient care

Set spending benchmarks that focus on specific populations, services, or care settings

Motivate positive change towards meeting goals of an improved behavioral health system

Key Decisions for Measuring Behavioral Health Spending and Benchmark Setting

- Determine priorities for measuring behavioral health spending
- Consider need for a phased approach
- Define approach to claims payments: diagnoses, services, care settings, providers
- Define approach to non-claims payments
- Define benchmark focus – conditions, care settings, population
- Define benchmark structure and timing

Other State Approaches to Defining Behavioral Health

States develop behavioral health definitions to support data collection and measurement, reporting, all-payers claims databases analyses, and to inform state policy.

Behavioral Health Spend Definition	Restrict by Diagnosis	Categorize Services by Care Setting	Limit to Certain Providers
Milbank Memorial Fund	✓	✓	
Maine	✓		
Massachusetts	✓	✓	
Rhode Island	✓		

Milbank Memorial Fund, April 2024. *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.* https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

Tentative Timeline for Behavioral Health Work

Between meetings, OHCA will revise draft behavioral health definitions and investment benchmarks based on feedback.

	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
Workgroup	X	X	X	X	X	X	X	X	X	X	X
Advisory Committee				X			X		X		
Board						X	X	X		X	✓

X Provide Feedback ✓ Board Approval

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Public Comment

HCAI

Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

General Public Comment

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

HCAI

Department of Health Care Access and Information

Next Advisory Committee Meeting:

January 21, 2025
9:00 a.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Adjournment

HCAI

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Appendix

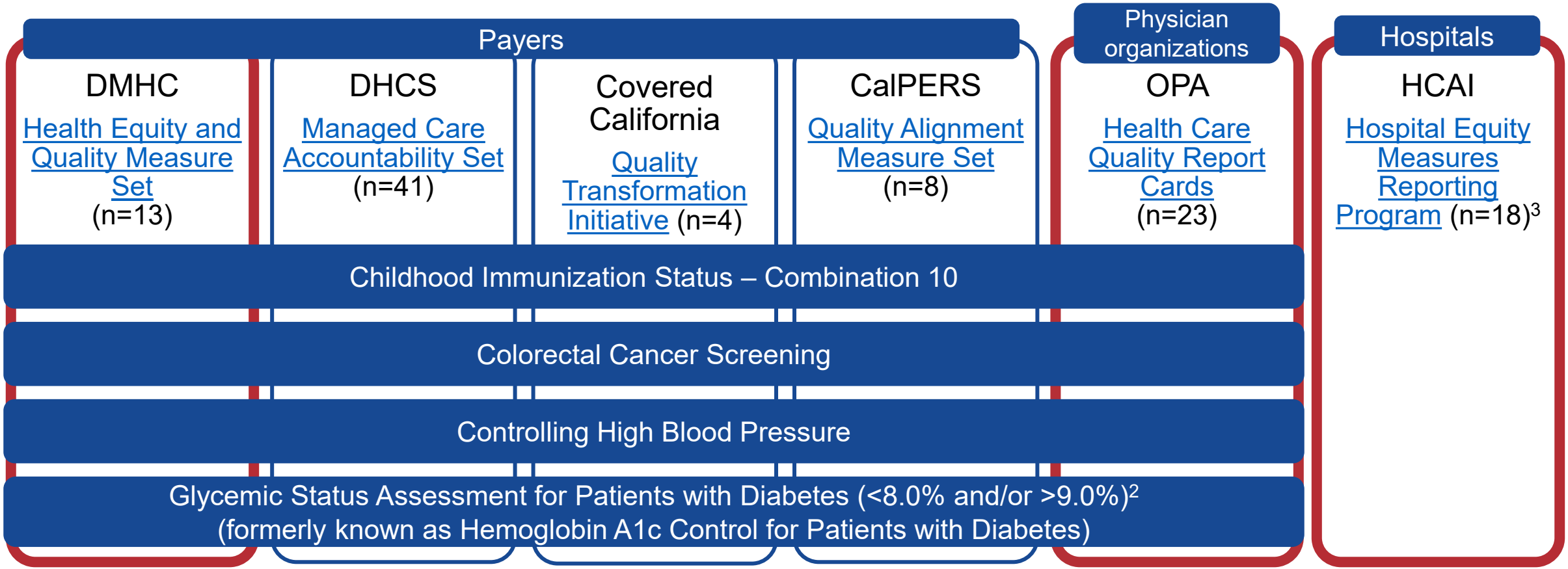
HCAI

Department of Health Care Access and Information

Quality and Equity Measure Set Proposal

Core Measures[1] Aligned Across State Departments for Payers and Physician Organizations

Since core measures are for payers and physician organizations (not hospitals), there is no overlap with HCAI measures. The measure sets that OHCA is proposing to adopt are highlighted in red.



[1] Depression Screening and Follow-Up for Adolescents and Adults and Pharmacotherapy for Opioid Use Disorder have also been discussed as potential core measures once benchmarks have been established.
[2] This measure replaced Hemoglobin A1c Control for Patients with Diabetes starting in measurement year 2024. The new measure includes glucose management indicator, calculated using data from continuous glucose monitoring devices, alongside HbA1c for numerator criteria.
[3] The HCAI Hospital Equity Measures Reporting Program is not finalized. By 2025, HCAI will establish regulations to specify reporting requirements. This timeframe may be extended per development and release of the CMS Heath Equity Measures. See Hospital Equity Measures Reporting Program Fact Sheet for details.

Overlap Between OPA, DMHC, DHCS, Covered CA, and CalPERS Measure Sets

Measures	OPA Commercial HMO Health Care Quality Report Cards	OPA Medicare Advantage Health Care Quality Report Cards	DMHC Health Equity and Quality Measure Set	DHCS Managed Care Accountability Set [2]	Covered CA Qualit Transformation Initiative	CalPERS Quality Alignment Measure Set	OHCA
Colorectal Cancer Screening[1]	X	X	X		X	X	
Controlling High Blood Pressure[1]	X	X	X	X	X	X	
Glycemic Status Assessment for Patients with Diabetes (<8% and/or >9.0%)[1]	X	X	X	X	X	X	
Childhood Immunization Status: Combination 10[1]	X		X	X	X	X	
Plan All-Cause Readmissions	X	X	X				
Breast Cancer Screening	X	X	X	X			
Asthma Medication Ratio	X		X	X			
Child and Adolescent Well-Care Visits	X		X	X			
Immunizations for Adolescents: Combination 2	X		X	X			
Depression Screening and Follow-Up for Adolescents and Adults (Depression Screening and Follow-Up on Positive Screen)			X		X	X	
Prenatal and Postpartum Care (Postpartum Care and Timeliness of Prenatal Care)			X	X		X	
Well-Child Visits in the First 30 Months of Life (0 to 15 Months and 15 to 30 Months)			X	X			
CAHPS Health Plan Survey: Getting Needed Care (Adult and Child survey) or QHP Enrollee Experience Survey[3]			X				
Eye Exam for Patients with Diabetes	X	X					
Kidney Health Evaluation in Patients with Diabetes	X	X					
Osteoporosis Management in Women Who Had a Fracture		X					
Proportion of Days Covered by Medications (Diabetes All Class, Renin Angiotensin System Antagonists, and Statins)		X					
Statin Therapy for Patients With Cardiovascular Disease		X					
Statin Use in Persons with Diabetes		X					
Cervical Cancer Screening	X			X			
Chlamydia Screening in Women	X			X			
Prenatal Immunization Status	X						
Total Cost of Care, incl service categories	X						
Pharmacotherapy for Opioid Use Disorder					X	X	
Developmental Screening in the First Three Years of Life				X			
Follow-Up After ED Visit for Mental Illness – 30 days				X			
Follow-Up After ED Visit for Substance Abuse – 30 days				X			
Lead Screening in Children				X			
Topical Fluoride for Children				X			

[1] Measures that align across all California State Departments for payers and physician organizations.
[2] DHCS measures include Managed Care Accountability Set measures held to minimum performance level for measurement year 2024.
[3] In the DMHC Health Equity and Quality Measure Set, CAHPS Child Survey is only for applicable Medicaid plans. CAHPS health plan survey does not apply to Exchange plans. Exchange plans will report to the DMHC on the QHP Enrollee Experience Survey in measurement year 2024.

HCAI Hospital Equity Measures Reporting Program Structural Measures

- Designate an individual to lead hospital health equity activities.
- Provide documentation of policy prohibiting discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sexual orientation, and gender identity or expression and how workers are trained on that policy.
- Report percentage of patients by preferred language spoken.
- CMS Hospital Commitment to Health Equity Structural Measure
  - Hospital attests that hospital has a strategic plan for advancing health equity.
  - Hospital attests that hospital engages in demographic and social determinant/drivers of health data collection.
  - Hospital attests that hospital engages in data analysis activities to identify equity gaps.
  - Hospital attests that hospital engages in local, regional, or national quality improvement activities focused on reducing health disparities.
  - Hospital attests that hospital engaged in leadership activities, annually reviewing strategic plan for achieving health equity, and annually reviewing key performance indicators stratified by demographic and/or social factors.
- CMS Screening Rate and Positive Rate for Social Drivers of Health - The percentage of members who were screened, using pre-specified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.

Source: HCAI. (n.d.). Hospital Equity Measures Reporting Program. https://hcai.ca.gov/data/healthcare-quality/hospital-equity-measures-reporting-program/.

Behavioral Health Spending Definition and Investment Benchmark

Measuring Investment: Behavioral Health vs. Primary Care

Primary Care	Behavioral Health
• Most spending can be captured from health care providers and payers • Policy goals include monitoring investment and shifting more investment to primary care to improve equity, access, quality, and lower total costs • Measures primary care ***services*** as a discrete portion of the delivery system	• More care delivered outside traditional health care delivery system; more spending not paid by health care payers • Measures treatment of behavioral health ***conditions*** across delivery system • Payment structures vary across delivery systems and payers; difficult to compare • Data can be elusive • Policy goals similar to primary care, but spread across the care continuum • Data privacy concerns

Out-of-Plan Spending

- The Investment and Payment Workgroup, Board, and Advisory Committee have raised concerns that OHCA's Total Health Care Expenditures (THCE) data collection does not include out-of-plan spending.
- Possible reasons for out-of-plan spending include:
  - Provider preferences to remain out of network and charge patients directly
  - Barriers to accessing providers or convenience
  - Changes in benefit design
- To shed light on the scope of this issue and its policy implications, including for behavioral health measurement, OHCA proposes a supplemental analysis to estimate this spending.

Sources: Bishop, Tara et al. (2014 February). *Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care*. JAMA Network.; National Alliance on Mental Illness. (2016 November). *Out-of-Network, Out-of-Pocket, Out-of-Options: The Unfulfilled Promise of Parity.;* Benjenk, I., Chen, J. (15, July 2020). *Trends in Self-payment for Outpatient Psychiatrist visits*. JAMA Psychiatry.; May 2024 Advisory Committee (slide 102). https://hcai.ca.gov/wp-content/uploads/2024/06/May-2024-Advisory-Committee-Meeting-Presentation.pdf