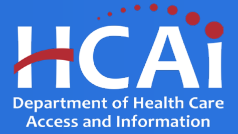
Health Care Affordability Board Meeting

October 14, 2024

Welcome, Call to Order, and Roll Call



Agenda

1. **Welcome, Call to Order, and Roll Call**
   Sandra Hernández, Vice Chair
2. **Executive Updates**
   Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director
3. **Action Consent Item**
   Vishaal Pegany
   a) Vote to Approve August 28, 2024 Meeting Minutes
4. **Action Items**
   Vishaal Pegany; Margareta Brandt, Assistant Deputy Director
   a) Vote to Approve Primary Care Investment Benchmark
5. **Informational Items**
   Vishaal Pegany; Margareta Brandt; Sheila Tatayon, Assistant Deputy Director; CJ Howard, Assistant Deputy Director
   a) Update on Primary Care Definition and Investment Benchmark
   b) Update on Cost and Market Impact Review Program
   c) Discussion of Office of Health Care Affordability's Statutory Authority to Address High Costs, Continued
6. **Public Comment**
7. **Adjournment**

Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

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

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

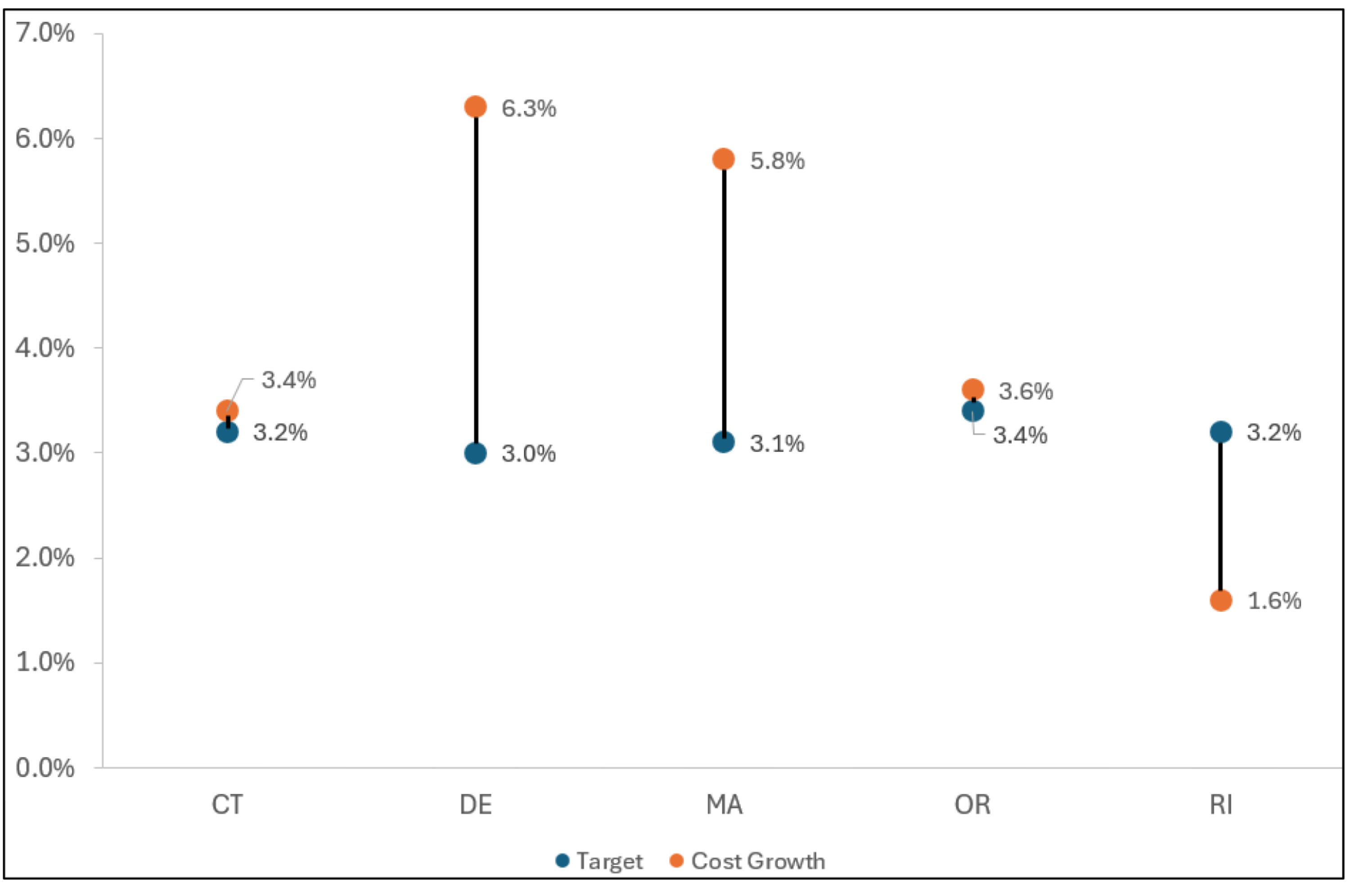
OHCA is responsible for "***analyzing the health care market for cost trends*** and drivers of spending, developing data informed policies for lowering health care costs for consumers and purchasers, creating a state strategy for controlling the cost of health care and ***ensuring affordability for consumers 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.)

Health Affairs: Health Care Spending Growth in 2022

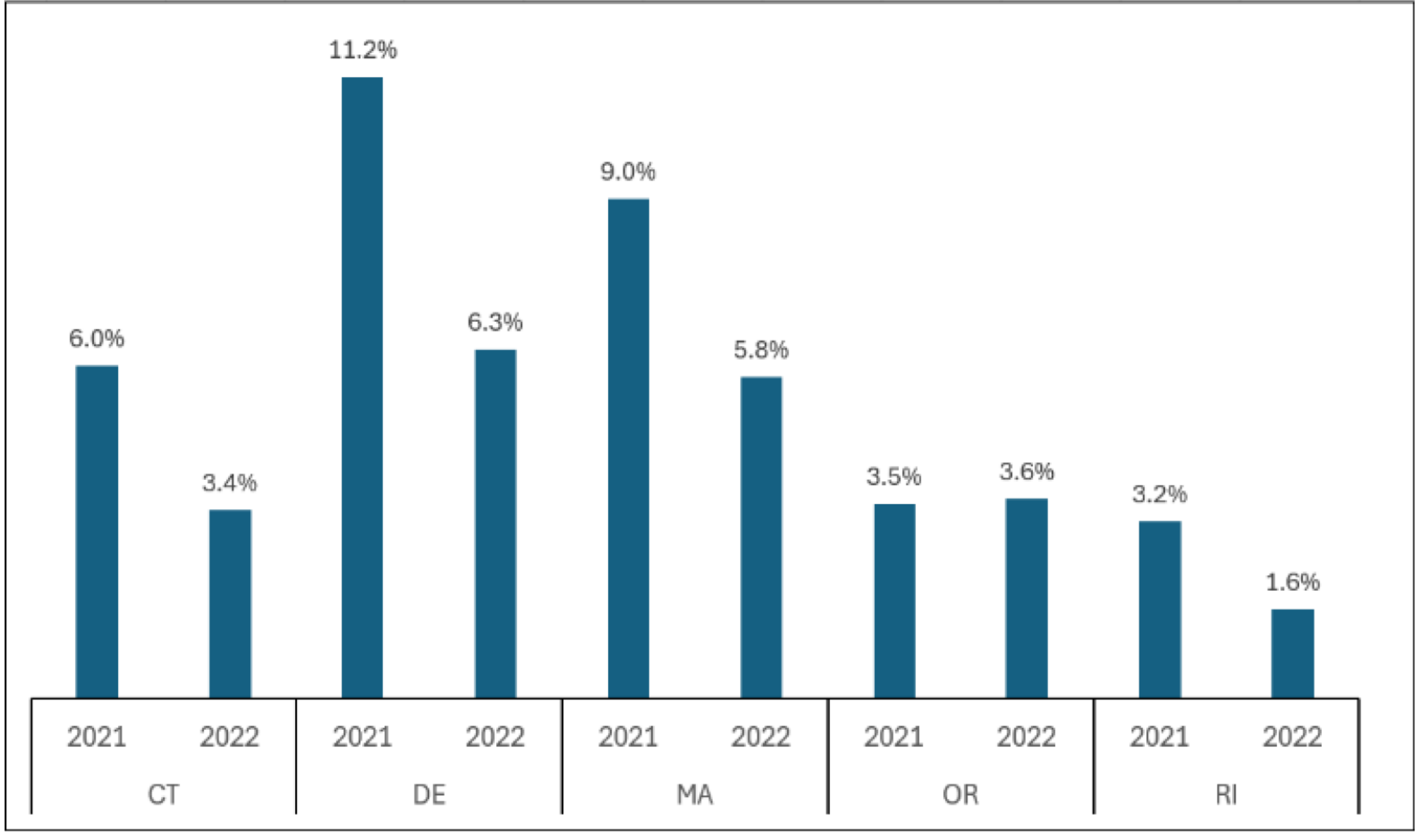
- In four of the five states that reported 2022 performance, spending growth exceeded the spending target.



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.



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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

2025 Public Meeting Calendar

Health Care Affordability Board Meetings

Tuesday, January 28
Tuesday, February 25
Tuesday, March 25
Tuesday, April 22
Tuesday, May 27
Tuesday, June 24
Tuesday, July 22
Tuesday, August 26
Tuesday, September 30
Tuesday, October 28
Tuesday, November 18
Tuesday, December 16

Health Care Affordability Advisory Committee Meetings

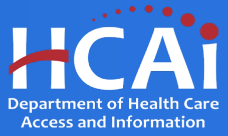
Tuesday, January 21
Monday, March 17
Monday, June 16
Monday, September 22

Slide Formatting

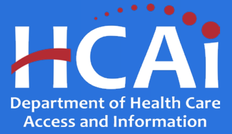
Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

Public Comment

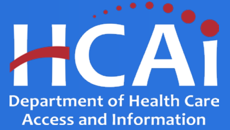


Action Consent Item: Vote to Approve August 28, 2024 Meeting Minutes



Update on the Primary Care Definition and Investment Benchmark

Margareta Brandt, Assistant Deputy Director



Today’s Follow-Up Items

1. OHCA’s approach to measuring primary care spending.

2. OHCA’s draft motion to establish a primary care investment benchmark.

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.
- 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.

Investment and Payment Workgroup Members

Providers & Provider Organizations

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

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

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

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

Parnika Prashasti Saxena, MD
Chair, Government Affairs Committee, California State Association of Psychiatrists

Catrina Reyes, Esq.
Deputy General Counsel, California Primary Care Association (CPCA)

Janice Rocco
Chief of Staff, California Medical Association

Hospitals & Health Systems

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

Kirsten Barlow, MSW
Vice President Policy, California Hospital Association (CHA)

Jodi Nerell, LCSW
Director of Local Mental Heath Engagement, Sutter Health

Health Plans

Stephanie Berry, MA
Government Relations Director, Elevance Health (Anthem)

Rhonda Chabran, LCSW
Vice President, Behavioral Health & Wellness, Kaiser Foundation Health Plan, Southern CA & HI

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

Nicole Stelter, PhD, LMFT
Director of Behavioral Health, Commercial Lines of Business, Blue Shield of California

Yagnesh Vadgama, BCBA
Vice President of Clinical Care Services, Autism, Magellan

Consumer Reps & Advocates

Beth Capell, PhD
Contract Lobbyist, Health Access California

Jessica Cruz, MPA
Executive Director, National Alliance on Mental Illness (NAMI) CA

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

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

Academics & SMEs

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Professor of Family and Community Medicine, UC San Francisco

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

Vicky Mays, PhD
Professor, UCLA, Dept. of Psychology and Center for Health Policy Research

Catherine Teare, MPP
Associate Director, Advancing People-Centered Care, California Health Care Foundation (CHCF)

State & Private Purchasers

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

Teresa Castillo
Chief, Program Policy Section, Medical Behavioral Health Division, Department of Health Care Services

Jeffrey Norris, MD
Value-Based Care Payment Branch Chief, California Department of Health Care Services (DHCS)

Monica Soni, MD
Chief Medical Officer, Covered California

Dan Southard
Chief Deputy Director, Department of Managed Health Care

One Vision for Primary Care Delivery in CA

Accessible

Relationship-based

Team-based

Comprehensive

Person- and family-centered

Integrated

Coordinated

Equitable

The Investment and Payment Workgroup noted the need for sustainable and well-resourced primary care to achieve the vision.

Source: California Quality Collaborative (CQC). (June 2020, revised April 2022). *Advanced Primary Care: Defining a Shared Standard*. Purchaser Business Group on Health (PBGH). https://www.pbgh.org/wp-content/uploads/2022/04/advanced-primary-care-shared-standard.pdf

Proposed Primary Care Spending Measurement Definition and Methodology

Primary Care Measurement Definition Updates

To reflect Board feedback, Workgroup feedback, and public comment, OHCA updated its definition to include the following:

- **Provider taxonomy codes**: Community Health Worker, Community Health Center/Clinic, Family Medicine (adult)*
- **Place of service codes**: Telehealth provided somewhere other than patient's home, independent clinic, Indian Health Service facilities, prison/correctional facility, Programs for All-Inclusive Care for the Elderly (PACE) Center
- **CPT/HCPCS service codes**: Digital Evaluation and Management*, Medicare-specific Certification for Home Health Care, Cognition and Functional Assessment with Developed Care Plan, new CMS Chronic Care Management codes, Behavioral Health Integration/Collaborative Care, 2025 CMS Advanced Primary Care Management

Note: OHCA may make minor adjustments to the Behavioral Health in Primary Care module definition based on Workgroup discussions to define the behavioral health spending.

* Note: Code officially replaced by other codes but still sometimes billed.

Framing the Measurement

What will be measured

Money **payers paid** to providers in support of primary care services.

What won't be measured

Money providers spent delivering primary care services.

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

Overview of Claims-based Primary Care Spending Measurement Approach

Include a narrow or broad set of providers?

- Include a broad set of providers to reflect statutory goal of team-based care.
- Filter by providers designated as PCPs by health plans, as reported to DMHC.
- Exclude OB-GYN providers to be consistent with focus on providers caring for the whole patient.

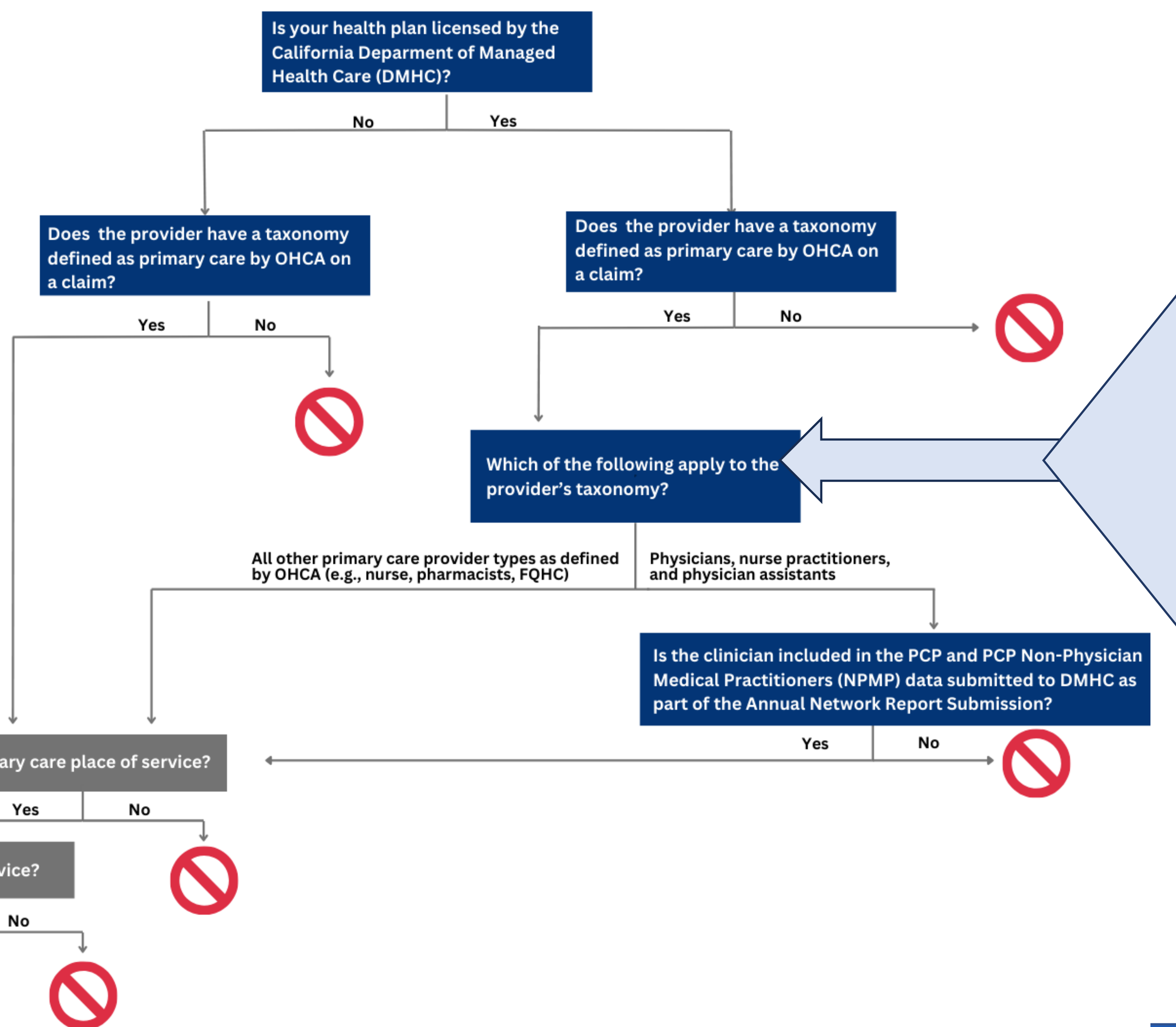
Should the definition be limited to certain places of service?

- Include restrictions on places of service to reflect vision of continuous and coordinated care.

Include a narrow or expanded set of services, or all?

- Include an expanded set of services to encourage as much care as possible and appropriate to be delivered in a primary care setting.
- Include a limited set of behavioral health services when provided by a PCP.

Using PCP Designation to Identify Claims-based Primary Care Spend



Note:
An internal medicine physician who is not identified as a PCP in the payer's Annual Network Report Submission is removed at this step.

Provider Taxonomies Included as Primary Care

Please note provider taxonomy criteria would be paired with place of service and service criteria.

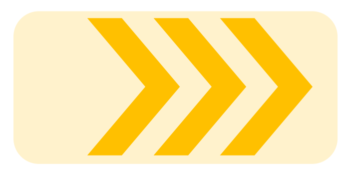
National Uniform Claim Committee (NUCC) Taxonomies

- Family Medicine (General/Adult/Adolescent/Geriatric)
- Internal Medicine (General/Adolescent/Geriatric)
- General Practice
- Pediatrics (General, Adolescent)
- Nurse Practitioner
  - Adult Health
  - Family
  - Community Health
  - Pediatrics
  - Gerontology
  - Primary Care
  - School
- Physician Assistant, Medical
- Pharmacist
- Primary Care & Rural Health Clinic/Center
- Federally Qualified Health Center
- Certified clinical nurse specialist
  - Adult Health
  - Community/Public Health
  - Pediatrics
  - Chronic Health
  - Family Health
  - Gerontology
- Community Health Worker
- Nurse, non-practitioner
- Critical Access Hospital Clinic/Center

Rationale:

- Focus on providers offering whole-person continuous, coordinated care.
- Include care team members – even those less likely to bill via claims – to acknowledge their importance. This definition also guides allocation of non-claims payments.
- Provider taxonomies would be combined with service, place of service criteria, list of PCPs in the DHMC Annual Network Report Submission to help address taxonomy limitations.

Green text represents codes added after the June 2024 Board meeting to reflect Board and public comment.



Excluding OB-GYNs from Primary Care Measurement Definition

OHCA Approach: Include women's health services provided by a primary care provider at a primary care place of service and exclude all services provided by an OB-GYN in the primary care definition. OHCA will conduct analyses using HPD to identify the proportion of OB-GYNs providing primary care consistent with vision.

Rationale: The majority of feedback received supports investing in providers who provide coordinated, comprehensive care for all body systems. Evidence is lacking to assess whether OB-GYNs typically meet this definition.

- Some stakeholders stated that patients typically do not receive care from OB-GYNs for common primary care services, such as treatment of a sinus infection or management of chronic conditions.
- Excluding OB-GYNs does not change a consumer's right under the Knox Keene Act to select an OB-GYN as their primary care provider.
- Developing a separate definition for OB-GYNs would be overly burdensome for data submitters, especially when applied to non-claims payments.

Services Included as Primary Care

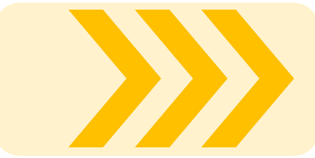
Please note services criteria would be paired with place of service and provider criteria.

Service (HCPCS & CPT) Codes	
• Office/Home/Telehealth visits • Preventive visits and screenings • Immunization administration • Transitional care • Chronic care management • Health risk assessment • Advanced care planning • Minor tests and procedures • Interprofessional consults (e-consult) • Remote patient monitoring • Lab tests (*point of care tests only)* • Digital evaluation and management • Medicare-specific certification for home health care • Advanced Primary Care Management	• Cognition and functional assessment with developed care plan • Team conference w or w/o patient • Prolonged preventive service • Domiciliary or rest home care/ evaluation • Group visits • Women's health services: preventive screenings, immunizations, minor procedures including insertion/removal of contraceptive device, maternity care • Behavioral Health Integration/ Collaborative Care

Rationale:

- Broad set of services to promote comprehensive primary care and primary care providers working at the top of their license.
- Use in combination with other criteria to focus on primary care spending.

Green text represents codes added after the June 2024 Board meeting to reflect Workgroup feedback and public comment.



Care Settings Included as Primary Care

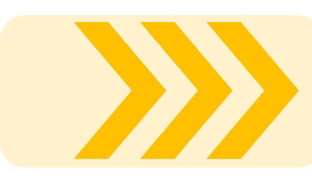
Please note place of service criteria would be paired with provider and service criteria.

CMS Place of Service (POS) Codes	
• Office • Telehealth, in and out of patient's home • School • Home • Federally Qualified Health Center • Public Health & Rural Health Clinic • Programs of All-Inclusive Care for the Elderly (PACE) Center	• Worksite* • Hospital Outpatient • Homeless Shelter • Assisted Living Facility • Group Home • Mobile Unit • Street Medicine • Independent Clinic • Tribal/Indian Health Service Facility • Prison/Correctional Facility

Rationale:

- Restrict by place of service to improve identification of primary care services.
- Include traditional, home, and community-based sites of service to promote expanded access.
- Exclude retail and urgent cares due to lack of coordinated, comprehensive primary care.

Green text represents codes added after the June 2024 Board meeting to reflect Board and public comment.
*Includes Military Treatment Facility



Non-Claims Primary Care Measurement Approach

Category A & B: Population Health, Practice Infrastructure and Performance Payments

- Include payments for primary care programs such as care management, care coordination, population health, health promotion, behavioral health or social care integration; performance incentives of patients attributed to primary care providers.
- Limit the portion of practice transformation and IT infrastructure payments that “count” as primary care to 1% of total medical expense.

Category C: Shared Savings and Recoupments

- Limit portion of risk settlement payments that “count” as primary care to the same proportion that claims-based professional spend represents as a percent of claims-based professional and hospital spending.

Category D: Capitation and Full Risk Payments

- For primary care capitation, payers allocate 100% to primary care.
- For others, data submitters calculate a ratio of fee-for-service equivalents for primary care services to all services in the capitation. Multiply the ratio by the capitation payment.

See Appendix for detailed approach to measuring non-claims-based primary care spend.

Workgroup Discussions Identify Potential Future Analyses

The Workgroup identified additional analyses using the HPD that could further inform OHCA's understanding of primary care delivery and spending in California. OHCA will pursue these analyses using HPD data, as feasible.

Examples include:

- Amount of primary care services provided by OB-GYNs using its current definition and/or with a modified list of primary care services.
- Proportion of OB-GYNs providing primary care aligned with Workgroup's vision.
- Total primary care spending if not restricted by service and/or place of service.
- Spending on primary care services delivered at retail clinics and urgent care sites.

Recommended Primary Care Investment Benchmark

Experience in Other States

Commercial Percent Spend on Primary Care Over Time by State, 2008-2023

16%
14%
12%
10%
8%
6%
4%
2%
0%

2008 2011 2014 2017 2020 2023

13.6%
12.3%
12.5%
10.1%
9.9%
8.9%
8.9%
6.3%
5.7%
4.2%
4.2%
4.8%
3.9%

Colorado, Delaware, Oregon, Rhode Island, Connecticut

- **Colorado** primary care progress focused on movement to APMs.
- **Delaware** requires minimum fee-for-service payments, overall investment; increases in primary care non-claims payments.
- **Oregon's** PCMH initiative increased primary care investment percentage; excludes pharmacy from denominator; includes OB/GYN and BH.
- **Rhode Island** slowed spending with price growth limits while primary care spend increased; robust care transformation initiatives.
- **Connecticut** total medical expense increases have outpaced primary care investment.

Note: State definitions and total cost of care differ, which contributes to differences in investment percentages. The Delaware 2023 figure is a projection.
Source: Baum, Aaron, et al. (2019, February). Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers. *Health Affairs*. https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05164

Medi-Cal Primary Care Spending by Population

- In 2018, Medi-Cal health plans spent **an average of 11%** on primary care services. Results were based on a study of 13 plans (27 plan-county pairs).
- While this data offers helpful direction, it was calculated using a different methodology and data source than proposed by OHCA. The OHCA methodology is likely to produce a lower result.

Table 1. Range of Primary Care Spending Across County-Specific Health Plans (*N* = 27)

POPULATION	PERCENTAGE OF STUDY POPULATION	PER MEMBER PER MONTH			PERCENTAGE		
		MINIMUM	MEAN	MAXIMUM	MINIMUM	MEAN	MAXIMUM
Adult	15.6%	$13.01	$35.87	$57.85	5.0%	11.6%	20.2%
Child	45.9%	$5.90	$20.49	$34.10	9.6%	28.2%	37.4%
ACA optional expansion	30.8%	$10.97	$32.12	$67.91	4.1%	9.7%	18.9%
SPD	7.7%	$18.67	$44.49	$123.85	2.3%	4.9%	14.7%
All	**100.0%**	**$8.85**	**$28.50**	**$61.24**	**5.0%**	**11.3%**	**18.7%**

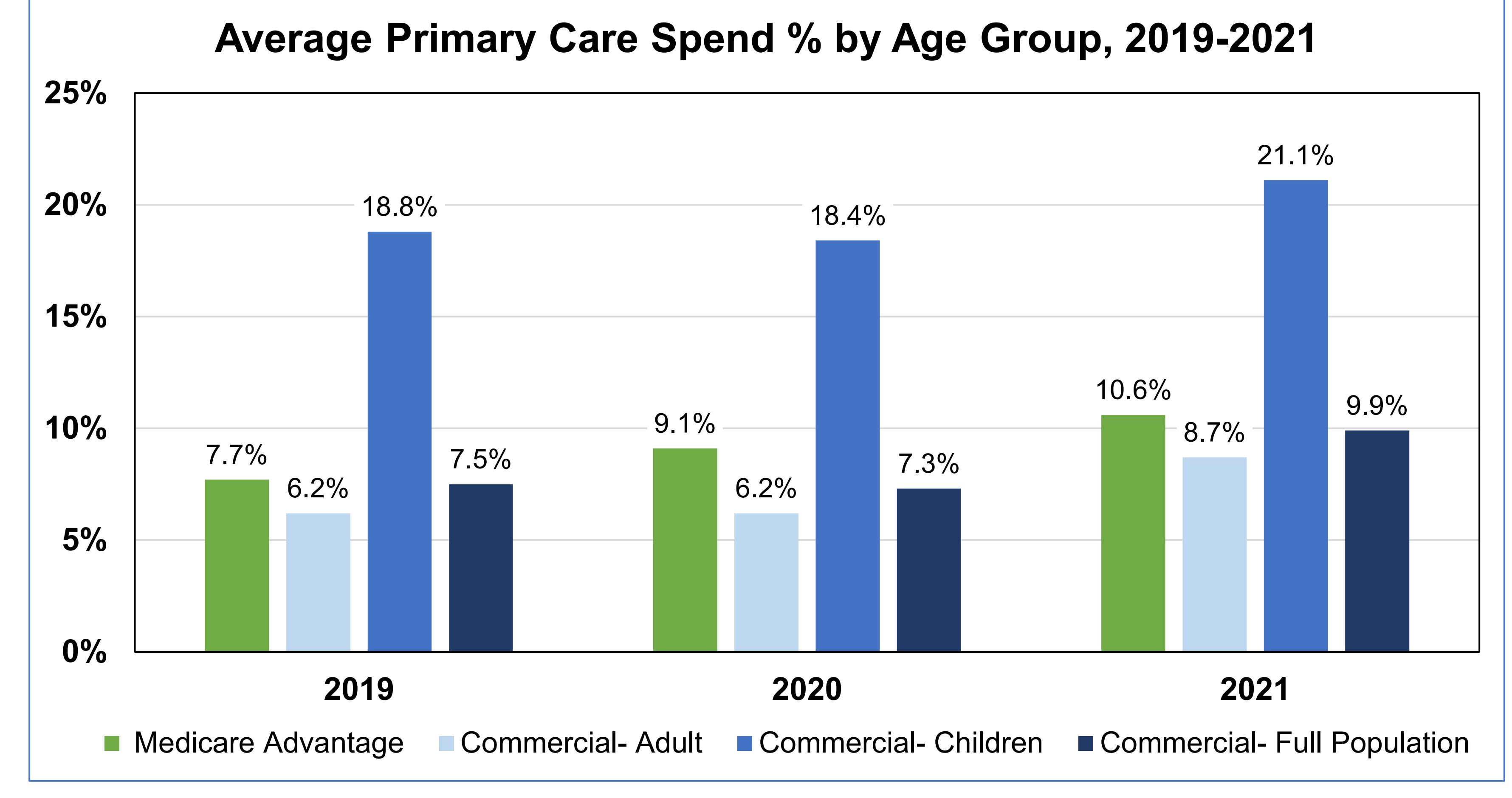
Note: *ACA* is Affordable Care Act; *SPD* is seniors and persons with disabilities.

Source: Edrington Health Consulting analysis of CY 2019 rate development templates; direct plan submission of proprietary data, July 2022.

Source: California Health Care Foundation. (2022, July 25). *Investing in Primary Care: Why it Matters for Californians with Medi-Cal Coverage*. https://www.chcf.org/publication/investing-in-primary-care-why-it-matters-for-californians-with-medi-cal-coverage/

Primary Care Spending for Children and Adults in California

- California commercial plans spent **an average of 7.3% to 9.9%** on primary care services from 2019 to 2021.
- California Medicare Advantage plans spent a similar percentage as commercial plans, with **an average of 7.7%-10.6%** spent on primary care services from 2019 to 2021.



Source: Integrated Healthcare Association analysis of California Commercial primary care spending from 2019-2021. Chart developed using the same methodology described in California Health Care Foundation's *Investing in Primary Care: Why it Matters for Californians with Commercial Coverage.* (2022, April). https://www.chcf.org/wp-content/uploads/2022/04/InvestingPrimaryCareWhyItMattersCommercialCoverage.pdf

Primary Care Spending by Commercial Payer-Product Type

- 2021 commercial data from the Integrated Healthcare Association shows that primary care spend varies by product type and within product types.
- PPO/EPO (6.3%) had a lower average percent primary care spend for 2021 than HMO (9.2%).
- Primary care spending for Medi-Cal plans also showed variation, ranging from 5% - 18.7%.
- The recommended primary care benchmark seeks to reflect these differences.

2021 Percent Primary Care Spend by Health Plan Product

HMO
PPO/EPO

6.5%
7.2%
7.4%
7.7%
8.1%
9.2%
10.1%
11.1%
11.3%
13.7%
3.8%
4.4%
5.8%
6.4%
6.6%
6.6%
7.5%
9.6%

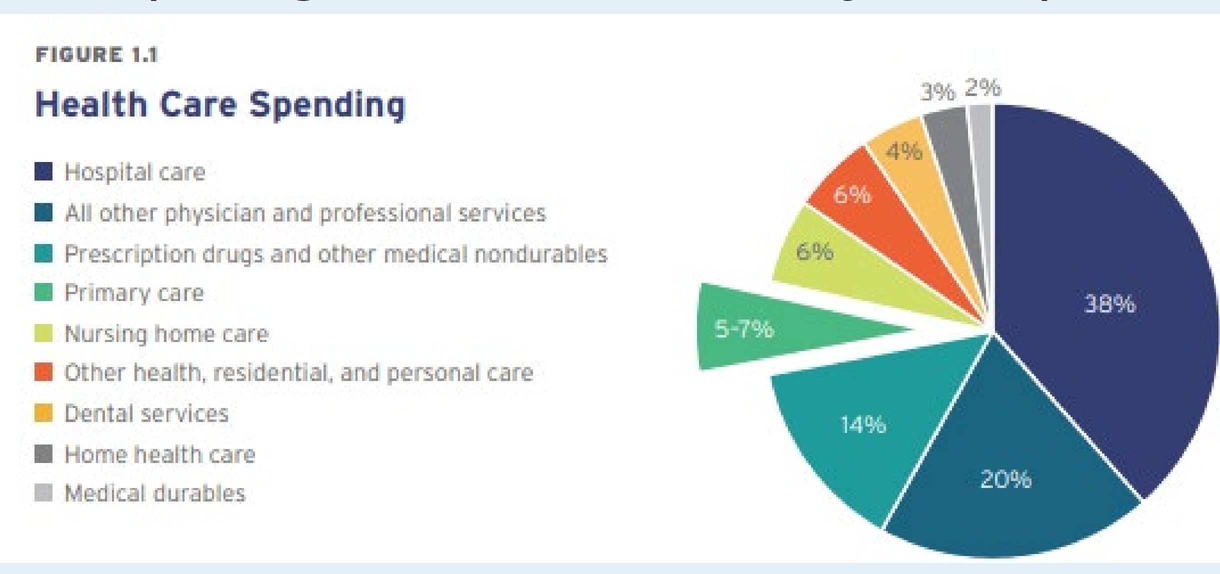
0.0% 2.0% 4.0% 6.0% 8.0% 10.0% 12.0% 14.0%

Primary Care Spending (%)

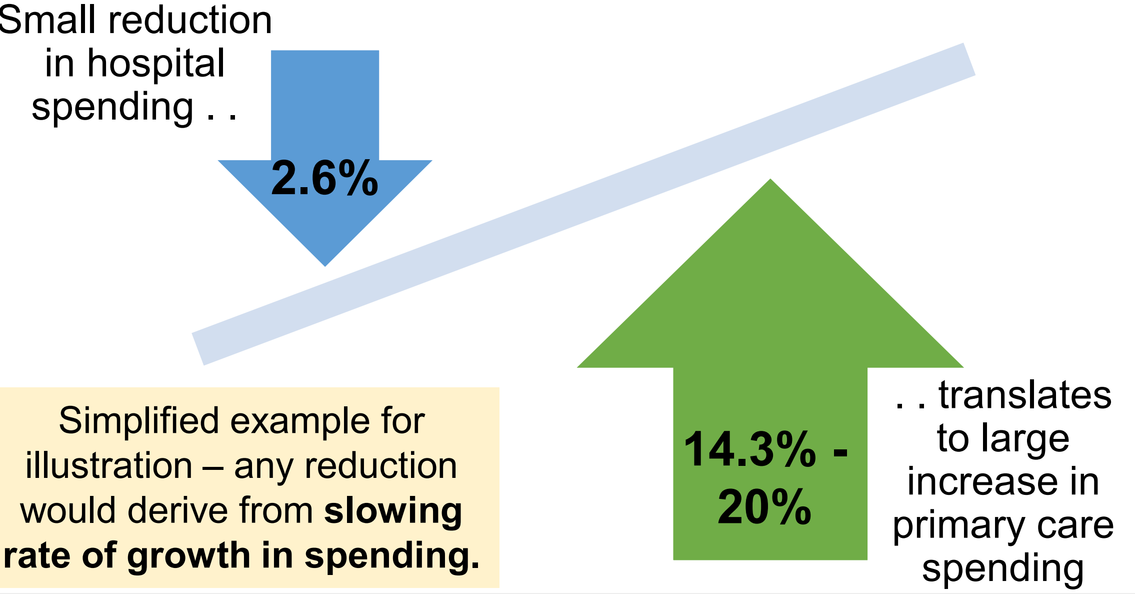
Source: Integrated Healthcare Association analysis of California Commercial primary care spending in 2021. Chart developed using the same methodology described in California Health Care Foundation's *Investing in Primary Care: Why it Matters for Californians with Commercial Coverage.* (2022, April). https://www.chcf.org/wp-content/uploads/2022/04/InvestingPrimaryCareWhyItMattersCommercialCoverage.pdf

Example: Reallocating Spending Growth to Primary Care

Only about 5-7% of health care spending is for primary care, compared to 38% for hospital care in this national study. **What if one percentage point shifted from hospital care to primary care (in alignment with statutory intent)?**



Reallocating one percentage point of spend from hospital care (from 38%→37% TME) to primary care (5-7%→6-8% TME) would **generate substantial primary care investment.**



Draft Motion: Primary Care Investment Benchmark (OHCA Recommendation)

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

Rationale and Considerations:

- Has received strong stakeholder support from Workgroup and public commenters.
- Gives all payers reasonable opportunity to demonstrate immediate progress and sustained success.
- Emphasizes demonstrating annual progress
- Offers gradual glidepath to ambitious but achievable 15% goal.
- Offers some flexibility since OHCA does not have exact measures of current spend using its definition.

* Payers at or above 15% of total medical expense may refrain from continued increases if not aligned with care delivery or affordability goals.

Action Item: Vote to Approve Primary Care Investment Benchmark

Margareta Brandt, Assistant Deputy Director

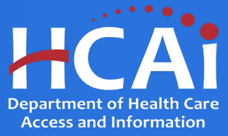
Draft Motion: Primary Care Investment Benchmark

Approve:

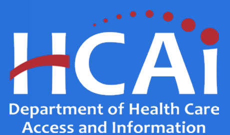
- Annual improvement benchmark: 0.5 percentage points to 1 percentage point per year increase in primary care spending as a percent of total medical expense for each payer for performance years 2025 through 2033; and
- Statewide investment benchmark: 15 percent of total medical expense allocated to primary care across all payers by performance year 2034.

The annual improvement benchmark applies to each payer by line of business and product type, resulting in four market segments for public reporting: commercial HMO/POS, commercial PPO/EPO, Medicare Advantage, and Medi-Cal. The statewide investment benchmark will be measured across payers, lines of business, and product types.

Public Comment

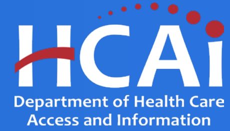


Informational Items



Update on Cost and Market Impact Review Program

Sheila Tatayon, Assistant Deputy Director



CMIR Program Update: *Material Changes 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	
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

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

CMIR Program Update: *Material Changes 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

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

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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.

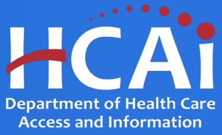
(I) The transaction between a health care entity located in this state and an out-of-state entity may negatively impact affordability, quality, or limit access to health care services in California, or undermine the financial stability or competitive effectiveness of a health care entity located in this 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 76 email questions. • OHCA generally provides responses within 48 hours.	• OHCA has hosted 16 meetings with potential submitters. • Of these, 10 were with law firms that filed MCNs with OHCA for their clients. • Other meetings re: pending transactions.

Public Comment



OHCA Statutory Authority to Address High Costs, Continued

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

Defining Sectors and Establishing Sector Targets

Health Care Sectors and Spending Targets

Statutory Requirements for Timing and Process

- **On or before October 1, 2027**, the board shall define initial health care sectors, which may include geographic regions and individual health care entities, as appropriate, except fully integrated delivery systems, considering factors such as delivery system characteristics. Sectors may be further defined over time. The office shall promulgate regulations accordingly.
- **Not later than June 1, 2028**, the board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, in accordance with this chapter.
- Once sectors are defined in regulation, the office and board will follow the statutory requirements for setting sector targets by June 1, 2028, as these requirements pertain to all spending targets established by the board.

Process for Public Meetings

- The board shall hold a public meeting to discuss the development and adoption of recommendations for specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities.
- The board shall deliberate and consider input, including recommendations from the office, the advisory committee, and public comment. Cost targets and other decisions of the board consistent with this section shall not be adopted, enforced, revised, or updated until presented at a subsequent public meeting.

Health and Safety Code § 127502

Health Care Sectors and Spending Targets

Statutory Requirements for Timing and Process

- The office shall publish on its internet website its recommendations for proposed cost targets for the board's review and consideration. The board shall discuss recommendations at a public meeting for proposed targets **on or before March 1** of the year prior to the applicable target year.
- The board shall receive and consider public comments for 45 days after the board meeting.
- **Not later than June 1, 2028**, the board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, in accordance with this chapter.

Health Care Sectors and Spending Targets

Statutory Requirements for Setting Sector Targets

- The setting of different targets by health care sector shall be informed by historical cost data and other relevant supplemental data, such as financial data on health care entities submitted to state agencies and the Health Care Payments Data Program, as well as consideration of access, quality, equity, and health care workforce stability and quality jobs.
- Development of sector targets will be done in a manner that minimizes fragmentation and potential cost shifting.
- The board may adjust sector targets as necessary to account for baseline costs in comparison to other health care entities in the health care sector and geographic region.
- It shall also encourage cooperation in meeting the statewide and geographic region targets.
- Sector target definitions will specify the single sector target that is applicable if an entity falls within multiple sectors.

Health and Safety Code § 127500.2 and § 127502

Timeline for Establishing Sector Target Definition

TBD*
OHCA recommends definitions of specific health care sectors at a Board meeting.

On or before October 1, 2027**
The Board shall define initial health care sectors, excluding FIDS

TBD*
OHCA promulgates regulations based on Board definitions

On or before March 1, 2028
OHCA shall publish its proposed recommendations for sector targets for the Board's review.

March - April 2028
The Board shall receive and consider public comments for 45 days after the board meeting.

On or before June 1, 2028**
The Board shall establish specific sector targets, including FIDS, at a Board meeting.

* To be determined
** For the definition of sectors and for the establishment of sector targets, two Board meetings are required – one for discussion and one for the vote.

Defining Sectors and Setting Sector Targets

Options

- Definitions for the Board's consideration may include but are not limited to:
    1. Geographic Regions
    2. Categories of Provider Organizations
    3. Categories of Payer Markets
    4. Individual Health Care Entities
- Fully integrated delivery systems are already defined in the statute and are required to have their own target.
- The statute also requires that the definition of health care sectors consider factors such as delivery system characteristics and allows sectors to be further defined over time.

Geographic Regions

Geographic regions may either be:

1. The regions specified in Section 1385.01 of the California Health and Safety Code,

2. Or may be otherwise defined by the board.

Note: OHCA is collecting spending data to support geographic analysis by Covered California rating regions, except for Los Angeles County. For Los Angeles County, OHCA is collecting data by Service Planning Areas.

Individual Health Care Entities

The OHCA statute defines health care entities as a **payer**, **provider,** or **fully integrated delivery systems (FIDS).** Because FIDS are already defined as a sector, individual health care entity sectors could apply to payer and/or provider entities.

Payers include:

- Health care or specialized mental health plans.
- Licensed health insurers (also includes specialized behavioral health-only policies)
- Publicly funded health care programs, including Medi-Cal and Medicare
- A third-party administrator
- Any other public or private entity, other than an individual, that pays for or arranges for the purchase of health care services on behalf of employees, dependents, or retirees

Providers include:

- Physician organizations comprised of 25 or more physicians
- Hospitals
- Clinics
- Ambulatory surgical centers, or outpatient settings
- Clinical laboratories
- Imaging facilities

Health and Safety Code §§ 127500.2 (o) and (q)

Individual Health Care Entities – Methodology

The methodology for setting a sector target for an individual health care entity shall be developed to:

(1) Allow for the setting of cost targets based on the entity's **status as a high-cost outlier**.

(2) Allow for the setting of cost targets that encourage an individual health care entity to serve populations with greater health care risks by incorporating all of the following:

A. A **risk factor adjustment** reflecting the health status of the entity's patient mix.

B. An **equity adjustment** accounting for the social determinants of health and other factors related to health equity for the entity's patient mix.

C. A **geographic cost adjustment** reflecting the relative cost of doing business, including labor costs in the communities the entity operates.

Health and Safety Code § 127502 (e)

Determining High-Cost Outlier Status

- While OHCA has a definition for high-cost outlier status, that definition is for the purpose of subjecting organizations with less than 25 physicians to the spending target.
  - "…an organization of less than 25 physicians, but that is a high-cost outlier is an entity whose costs for the same services provided in a geographic region are substantially higher compared to the statewide average, as identified through data sources that include, but are not limited to, data from state and federal agencies, other relevant supplemental data, such as financial data on providers that is submitted to state agencies, or data reported to HCAI…. The cost of delivering the same services in a geographic region shall be considered to the extent that cost substantially deviates from the statewide average and reflects higher costs in that region unrelated to the market dominance of providers in that region or unrelated to the ownership, management, or asset structure chosen by the organization."
- To determine an individual health care entity's status as a high-cost outlier, the above definition could be leveraged, or a new approach could be developed.

Health and Safety Code § 127500.2 (p)

Fully Integrated Delivery Systems

- A fully integrated delivery system (FIDS) is a system that includes a physician organization, health facility or health system, and a nonprofit health care service plan that provides health care services to enrollees in a specific geographic region of the state through an affiliate hospital system and an exclusive contract between the nonprofit health care service plan and a single physician organization in each geographic region to provide those medical services.
- Kaiser is currently the only health system in California that meets this definition of a fully integrated delivery system.
- OHCA has instructed submitters to attribute member spending (including hospital spending) to Kaiser's two physician organizations:
    1. The Permanente Medical Group in Northern California
    2. Southern California Permanente Medical Group in Southern California
- OHCA will apply the statewide spending target to each of these systems (northern and southern).

Health and Safety Code § 127500.2 (h)

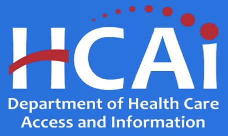
Fully Integrated Delivery Systems - Methodology

Until the board approves sector targets for fully integrated delivery systems, fully integrated delivery systems shall comply with the statewide cost target.

- Targets set for fully integrated delivery systems shall include:
  - All health care services, costs, and lines of business managed by that system in each separately administered geographic service area of the state.
  - Targets on payer administrative costs and profits.
- The system shall provide sufficient data and information, comparable to other unintegrated payers and providers, including patient risk mix, to the office to enable analysis and public reporting of performance, including by sector, insurance market, line of business, and separately administered geographic service area.
- After the board approves sector targets for fully integrated delivery systems, a fully integrated delivery system shall be subject to a target for each of its geographic service areas in which a single medical group is responsible for providing, or arranging for the provision of, all professional services to the payer's enrollees.

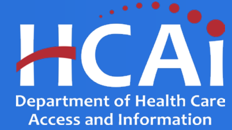
Health and Safety Code § 127502 (i)

Public Comment



General Public Comment

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

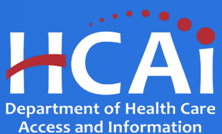


Next Board Meeting:

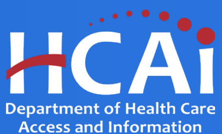
November 20, 2024
10:00 a.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

Adjournment



Appendix



Primary Care Definition and Benchmark

Stakeholder Input on Primary Care Recommendations

2023

Nov
- Primary care vision (comprehensive and continuous) endorsed.
- Technical subgroup holds 1st meeting.

Dec
- Challenges identifying primary care providers noted.
- Initial subgroup recommendations discussed.

2024

Jan
- Support for select OB-GYN services.
- Retail clinics and urgent care discussed.
- General support for recommended types of services.

Feb
- Added step for payers to use their DMHC Annual Network Report Submission to identify primary care providers.
- Benchmark options introduced: a single benchmark or separate by age groups.
- Decision to exclude OB-GYNs as PCPs.

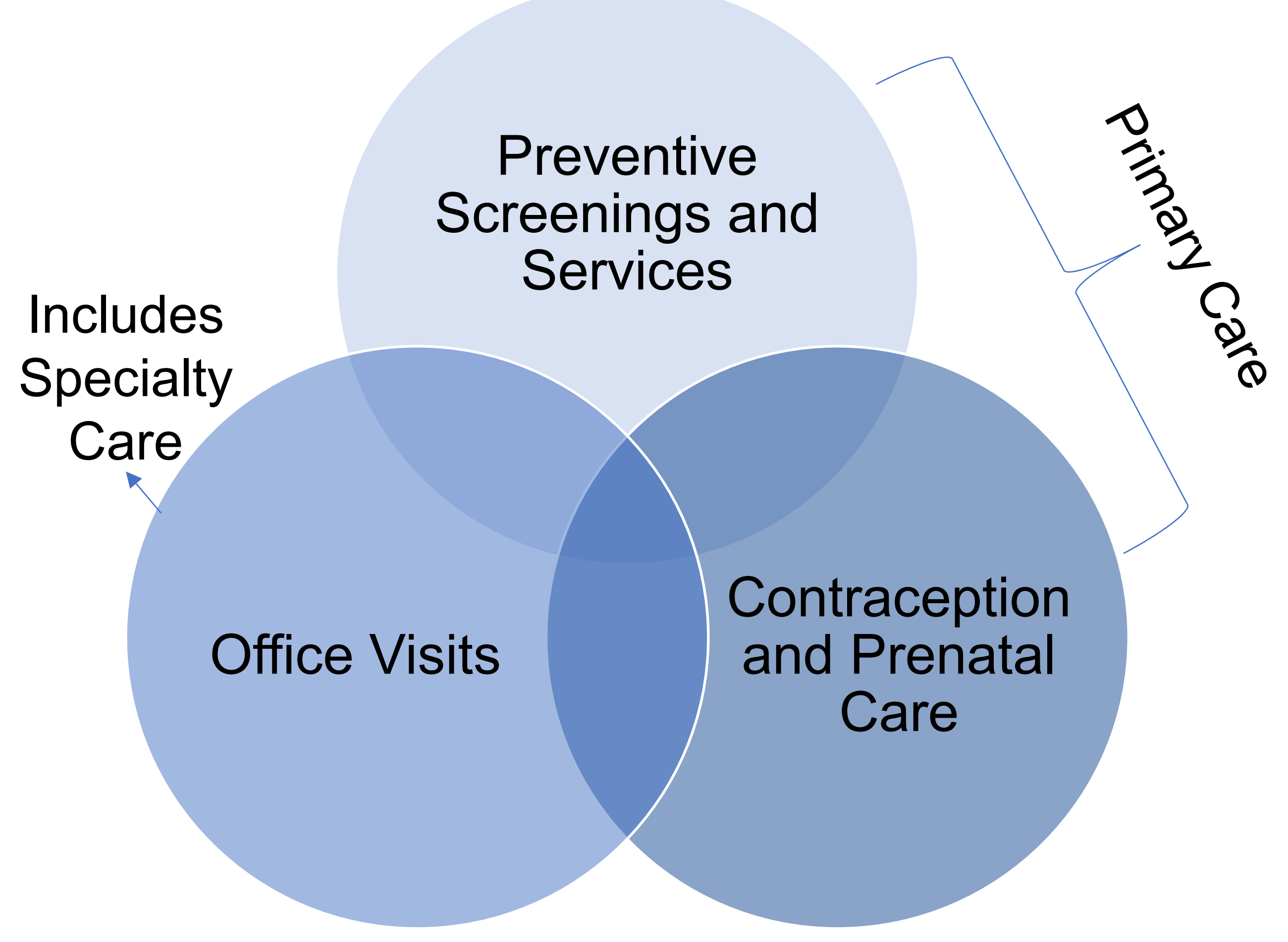
Mar
- Majority of Advisory Committee feedback supports excluding OB-GYNs.
- Discuss revised 2034 benchmark options: 15% for all ages or 12% & 24% for adults and peds.
- Challenges separating non-claims by age group discussed.

Apr
- DHCS Targeted Rate Increase service codes added to definition as appropriate.
- Options for non-claims approach reviewed.
- Payer annual improvement benchmark and statewide investment benchmark discussed.

May
- Public comments generally support definition; some stakeholders find 15% to be an ambitious benchmark.
- Discussed combination of an annual improvement and 10-year investment benchmark. Single benchmark across age groups, but progress by age group monitored.

Jun
- More stakeholder feedback supports excluding OB-GYNs than including.
- Continued support for benchmark recommendation.

Including vs Excluding OB-GYNs - Overcounting vs Undercounting Primary Care Spend



- Including OB-GYNs as PCPs would count all care they provide that meets the service and place of service definitions. The definition does not restrict based on diagnosis.
  - Office visits for OB-GYN specialty care would be counted as primary care.

- Excluding OB-GYNs as PCPs would mean that the preventive screenings and other primary care services they provide are not counted.

- Developing a separate definition for OB-GYNs would be overly burdensome for data submitters, especially when applied to non-claims payments.

Overview of Non-claims Primary Care Spending Measurement Approach

<table>
<tr><th colspan="2">Expanded Framework Category</th><th>Allocation to Primary Care Spending</th></tr>
<tr><td>A</td><td colspan="2">Population Health and Practice Infrastructure Payments</td></tr>
<tr><td>A1</td><td>Care management/care coordination/population health/medication reconciliation</td><td rowspan="3">Include payments for primary care programs such as care management, care coordination, population health, health promotion, behavioral health, or social care integration.</td></tr>
<tr><td>A2</td><td>Primary care and behavioral health integration</td></tr>
<tr><td>A3</td><td>Social care integration</td></tr>
<tr><td>A4</td><td>Practice transformation payments</td><td rowspan="2">Limit the portion of practice transformation and IT infrastructure payments that are allocated to primary care spending to 1 percent of total medical expense.</td></tr>
<tr><td>A5</td><td>EHR/HIT infrastructure and other data analytics payments</td></tr>
<tr><td>B</td><td colspan="2">Performance Payments</td></tr>
<tr><td>B1</td><td>Retrospective/prospective incentive payments: pay-for-reporting</td><td rowspan="2">Include performance incentives in recognition of reporting, quality, and outcomes of patients attributed to primary care providers.</td></tr>
<tr><td>B2</td><td>Retrospective/prospective incentive payments: pay-for-performance</td></tr>
</table>

Overview of Non-claims Primary Care Spending Measurement Approach

<table>
<tr><th colspan="2">Expanded Framework Category</th><th>Allocation to Primary Care Spending</th></tr>
<tr><td>C</td><td colspan="2">Payments with Shared Savings and Recoupments</td></tr>
<tr><td>C1</td><td>Procedure-related, episode-based payments with shared savings</td><td rowspan="6">Limit the portion of risk settlement payments that are allocated to primary care spending to the same proportion that claims-based professional spending represents as a percent of claims-based professional and hospital spending.</td></tr>
<tr><td>C2</td><td>Procedure-related, episode-based payments with risk of recoupments</td></tr>
<tr><td>C3</td><td>Condition-related, episode-based payments with shared savings</td></tr>
<tr><td>C4</td><td>Condition-related, episode-based payments with risk of recoupments</td></tr>
<tr><td>C5</td><td>Risk for total cost of care (e.g., ACO) with shared savings</td></tr>
<tr><td>C6</td><td>Risk for total cost of care (e.g., ACO) with risk of recoupments</td></tr>
</table>

Overview of Non-claims Primary Care Spending Measurement Approach

<table>
<tr><th colspan="2">Expanded Framework Category</th><th>Allocation to Primary Care Spending</th></tr>
<tr><td>D</td><td colspan="2">Capitation and Full Risk Payments</td></tr>
<tr><td>D1</td><td>Primary Care capitation</td><td>Allocate full primary care capitation amount to primary care spending.</td></tr>
<tr><td>D2</td><td>Professional capitation</td><td>Calculate a ratio of fee-for-service equivalents for primary care services to fee-for-service equivalents for all services in the capitation. Multiply the capitation payment by the ratio. Divide the result by total medical expense.</td></tr>
<tr><td>D3</td><td>Facility capitation</td><td>Not applicable.</td></tr>
<tr><td>D4</td><td>Behavioral Health capitation</td><td rowspan="3">Calculate a ratio of fee-for-service equivalents for primary care services to fee-for-service equivalents for all services in the capitation. Multiply the capitation payment by the ratio. Divide the result by total medical expense.</td></tr>
<tr><td>D5</td><td>Global capitation</td></tr>
<tr><td>D6</td><td>Payments to Integrated, Comprehensive Payment and Delivery Systems</td></tr>
<tr><td>E</td><td>Other Non-Claims Payments</td><td>Not applicable.</td></tr>
<tr><td>F</td><td>Pharmacy Rebates</td><td>Not applicable.</td></tr>
</table>

OHCA Approach to Primary Care Portion of Capitation Payments*

All payments for Category 4a (Primary Care Capitation)

+

Subcategories 4b-4f

$$\frac{\Sigma\,(\#\text{ of PC Encounters } \times \text{ FFS-equivalent Fee})_{segment}}{\Sigma\,(\#\text{ of All Prof* Encounters } \times \text{ FFS-equivalent Fee})_{segment}} \times \text{Prof* Capitation}$$

=

Primary Care spend paid via capitation

*Revised approach is consistent with Blue Shield of California recommendation.

*This example envisions a professional capitation. Under a global capitation, the professional encounters and capitation would be replaced with all encounters and the global capitation rate.

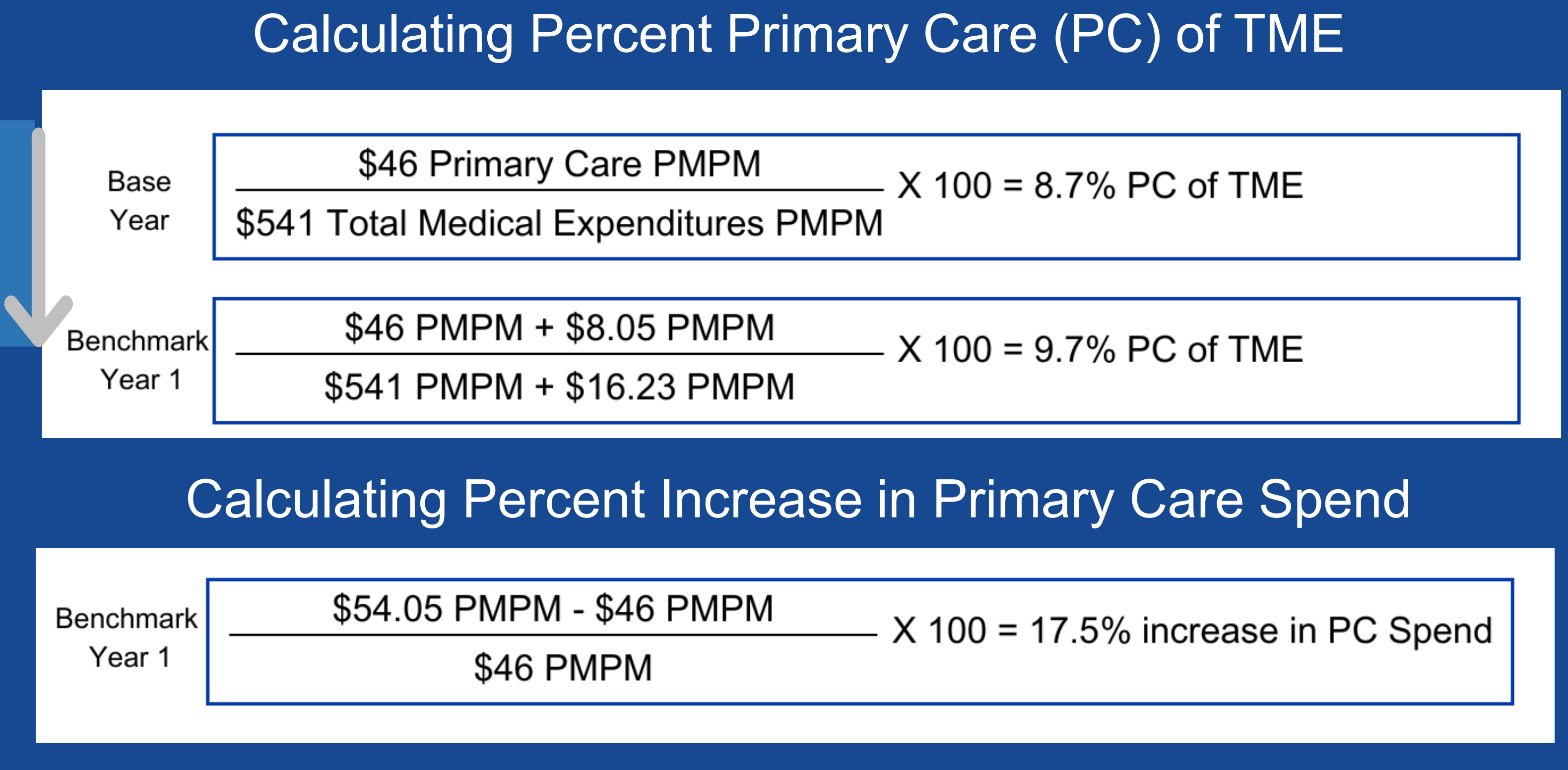
Comparing OHCA and IHA Primary Care Definitions

Component	Similarities	Differences	Impact
Providers	Use provider taxonomies to define primary care specialties.	OHCA also requires providers to be designated as primary care in DMHC Annual Network report.	OHCA slightly lower
Services	Include a broad scope of services when performed by a primary care provider.	OHCA includes the broadest service list of any state primary care definition. IHA includes all services performed by primary care providers.	OHCA slightly lower
Places of Service	Include a wide range of care settings.	OHCA excludes certain care settings to align with vision of comprehensive, coordinated primary care.	OHCA slightly lower
Non-Claims Payments	Include capitation and incentive payments.	OHCA also includes certain care management, infrastructure and portions of risk settlement payments.	OHCA higher

OHCA estimates the combined impact of the differences will result in OHCA's primary care spend being 1% to 2% less than the IHA analysis.

Impact of 1% TME Increase

- To increase primary care investment by 1% of TME, increases in TME must be considered.
- The box to the right assumes a 3% increase in all TME.
- Primary care spending increased 17.5% over the previous year to generate a 1% increase in primary care spend as a % of TME.



Source: Integrated Healthcare Association. California Commercial Primary Care Spending Results. 2019-2021. Table developed using the same methodology described in California Health Care Foundation's *Investing in Primary Care: Why it Matters for Californians with Commercial Coverage (2022).*