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

Health Care Affordability Board
May 22, 2024
Public Comment

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

| Date | Name | Written Comment |
|---|---|---|
| 5/31/2024 | California Primary Care Association | See Attachment #1.<br>On behalf of our nearly 1,300 community health centers, the California Primary Care Association is writing to express our sincere gratitude for the Office of Health Care Affordability's commitment to high-value health system performance, investments in primary care, and promoting alternative payment models. California's network of CHCs provide high-quality, comprehensive, coordinated, accessible, equitable, patient-centered care to 1 in 3 Medi-Cal patients. As a substantial part of the Medi-Cal delivery system, we believe the State needs to ensure that CHCs are captured in any investments in primary care and that Medi-Cal policies promote rather than inhibit health center participation in an alternative payment methodology (APM), otherwise the State will not be able to meet the APM adoption goal for Medi-Cal of 55% by 2026.<br>Thank you for the opportunity to provide comments in response to the May 22nd HCAI Affordability Board meeting. We look forward to working with the Board and other stakeholders to ensure we achieve our collective goal of promoting greater investments in primary care and APM adoption. Please do not hesitate to contact me for more information or clarification. |
| 6/21/2024 | California Hospital Association | See Attachment #2. |
| 6/24/2024 | Health Access California | See Attachment #3. |

May 31, 2024

Health Care Affordability Board
Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 1200
Sacramento, CA 95833

*Sent via email to OHCA@hcai.ca.gov*

**Re: Response to 5/22/24 HCAI Health Care Affordability Board Meeting and Medi-Cal Federally Qualified Health Center Alternative Payment Methodology**

Dear Health Care Affordability Board Members:

On behalf of our nearly 1,300 community health centers (CHCs), the California Primary Care Association (CPCA) is writing to express our sincere gratitude for the Office of Health Care Affordability's commitment to high-value health system performance, investments in primary care, and promoting alternative payment models. California's network of CHCs provide high-quality, comprehensive, coordinated, accessible, equitable, patient-centered care to 1 in 3 Medi-Cal patients[1]. As a substantial part of the Medi-Cal delivery system, we believe the State needs to ensure that CHCs are captured in any investments in primary care and that Medi-Cal policies promote rather than inhibit health center participation in an alternative payment methodology (APM), otherwise the State will not be able to meet the APM adoption goal for Medi-Cal of 55% by 2026.

**Investments in Primary Care**

Given the historic underinvestment in primary care, statewide efforts to increase primary care spend is crucial. As presented to the Board, decades of research have consistently proven that greater investment in primary care services are associated with more equitable outcomes, lower total cost of care, and better quality of care, including lower mortality, fewer hospitalizations, and enhanced patient satisfaction.[2] Despite this strong investment, California spends from 6.1 percent to 10.8 percent on primary care, while the average among OECD countries is 14 percent.[3] A Commonwealth Fund analysis identified this underinvestment in primary care as one of four fundamental reasons the U.S. health system ranks last

[1] Data source: Health Resource Services Administration Uniform Data System, California Aggregate, Reporting Year 2022.
[2] Barbara Starfield, Leiyu Shi, and James Macinko, "Contribution of Primary Care to Health Systems and Health," The Milbank Quarterly 83, no. 3 (Sept. 2005): 457–502.
[3] Investing in Primary Care: A State-Level Analysis, Patient-Centered Primary Care Collaborative and Robert Graham Center (July 2019), available at https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_2019.pdf.

among high-income countries.[4] Moreover, the COVID-19 pandemic further strained an already overwhelmed and understaffed primary care system.[5] However, investing in primary care can increase the supply of primary care providers which would increase access. For example, Rhode Island experienced an increased supply of primary care providers per capita during the time period in which the state increased primary care investments.[6] Accordingly, investments in primary care are critical, and must reach *all* Medi-Cal providers, including community health centers.

In Medi-Cal, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are paid under a Prospective Payment System (PPS), which is a predetermined rate set at the time the FQHC/RHC is established or during a change in scope request, based on their audited costs that cover reimbursement for all services provided during a single visit. PPS rates are adjusted annually for inflation and are subject to reconciliation. At the end of each fiscal year, the Department of Health Care Services (DHCS) audits the total payments received by the health center and takes back any payments that were received in overpayment or in error (e.g., payments received for non-covered services). They adjust the total annual payments to ensure the PPS rate is met but not exceeded. Because of PPS, any investments in primary care may ultimately be reconciled back to the Medi-Cal program. Given that FQHCs and RHCs are a significant part of the primary care delivery system - on average, more than 1 in 4 Medi-Cal beneficiaries receives their care from an FQHC/RHC (a subset of the overall community health centers category)[7] - any investments in primary care must take the FQHC/RHC PPS payment model into account and ensure these crucial Medi-Cal providers can access investments in primary care. Otherwise, the State would not be making meaningful investments in primary care.

In order to ensure we are accurately measuring primary care spend, it is important to appropriately define primary care. Primary care can be defined broadly or narrowly, and it is important to strike the right balance. One the on one hand, if primary care is defined too broadly, the actual primary care spend could be overinflated. On the other hand, if it is too narrowly defined, we may not be encouraging as much care as possible and appropriate to be delivered in a primary care setting. CPCA supports a definition of primary care that strikes the right balance between these two considerations and that we are making sufficient investments in primary care that includes community health centers.

**FQHC APM**

Since 2016, CHCs and DHCS have been negotiating an APM for FQHCs. Almost a decade later, we look forward to launching the APM on July 1, 2024. DHCS and CHCs hoped for strong participation in the APM, including a diverse participation across health center size and geography. However, unanticipated challenges have arisen during the design and pre-implementation stages. The resulting APM design is not well suited to the typical health center and only four percent of the selected sites intend to implement it in July 2024. In this letter we explain the major pitfalls of the APM design and the implication for health centers and the State's APM adoption goals.

**Health centers are at substantial financial risk if they participate.**

[4] Eric C. Schneider and David Squires, From Last to First – Could the U.S. Health Care System Become the Best in the World?, THE COMMONWEALTH FUND (July 17, 2017), available at https://www.commonwealthfund.org/publications/journal-article/2017/ jul/last-first-could-us-health-care-system-become-best-world.

[5] Melissa K. Filippi et al., "COVID-19's Financial Impact on Primary Care Clinicians and Practices," Journal of the American Board of Family Medicine 34, no. 3 (May 2021): 489–97.

[6] *Supra* at 3.

[7] https://www.chcf.org/wp-content/uploads/2021/08/MediCalFactsFiguresAlmanac2021.pdf

The current design of the California FQHC APM is revenue neutral to the State and affords health centers flexibility to the traditional PPS. The design of the APM intends to pay health centers a monthly per member per month (PMPM) rate developed using historical utilization data from a State-selected base year. Health centers may then adopt non-traditional PPS billable encounter types (e.g. group visits) or providers (e.g. nurses and community health workers) that more closely align with evolving practice needs and the effective delivery of health care services. If health centers maintain access and quality benchmarks, they may retain any excess revenues between the actual PPS utilization and historic PPS utilization (aka pay for transformation dollars). If heath centers do not perform, the state will recoup those payments in a quality withhold.

One of the major concerns we have shared with DHCS is that health center draft PMPM rates are not reflective of actual CHC costs. The main reason for this is a crucial downward adjustment that DHCS' actuary, Mercer, made to the PMPM capitated rate calculation. Mercer removed up to 20% of a health center's actual historic utilization from patients who are unassigned to the health center site. If health centers transition to the APM with this adjustment in place, they would not be able to transform care from traditionally billable providers to alternative staff and services and would rely on federally mandated PPS reconciliation to be made whole. Consequently, the entire incentive for participation is eliminated because the pay for transformation dollars are eliminated.

For every one percent below the unassigned utilization threshold, health centers lose 1.5% in revenue, making the model not financially viable, as confirmed by CPCA's actuaries. This issue is representative of a larger problem with managed care assignment that must be addressed. Without addressing the assignment issue, and the resulting unassigned utilization penalty, the future viability of the APM model is at risk thereby also risking the State's ability to meet its APM adoption goal for Medi-Cal. Some health centers have also found that the data included in the rate setting includes non-APM services (e.g. dental visits), raising doubts about the integrity of the rate setting process.

We made several suggestions to mitigate these concerns that were in line with actuarial soundness, federal guidelines, and Medicaid norms. For example, in preparation for their FQHC APM, Illinois is working with Centers for Medicare and Medicaid Services to effectuate a one-time roster reconciliation to assign patients to their actual medical home. CPCA requested that DHCS investigate this. We also suggested that DHCS use a phased in assignment threshold on a rolling basis. The APM design to date does not include these recommendations.

CPCA supports progress towards value-based alternative payment models, however given the current design of the FQHC APM and the timeline for participation, CPCA is concerned that the State will not be successful in meeting its APM adoption goals for Medi-Cal. According to DHCS data sent to CPCA, 94 sites applied for Cohort 1 of the APM and 71 sites were selected by DHCS. Only 15 sites were able to set a rate without the unassigned utilization adjustment. The withdrawal deadline for the APM is June 3rd and thus far only three sites are electing to participate. The next opportunity to participate for those health center sites selected for Cohort 1 is January 2025. However, without substantial changes to the underlying APM policies, few health centers will feel confident participating. The application period for APM participation is yearly and the next opportunity to participate in Cohort 2 is January 2026.

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Thank you for the opportunity to provide comments. We look forward to working with the Board and other stakeholders to ensure we achieve our collective goal of promoting greater investments in primary care and APM adoption. For clarification or additional information regarding CPCA's comments, please contact me at abudenz@cpca.org.

Sincerely,

Allie Budenz
Vice President of Health Center Optimization

CC:
Rafael Davtian
Palav Babaria, MD

California Hospital Association

June 21, 2024

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

**Subject:** **Comments Following the May 2024 Health Care Affordability Meeting**
*(Submitted via Email to Megan Brubaker)*

Dear Dr. Ghaly:

Californians rely on hospitals for lifesaving care in their time of greatest need. California's hospitals recognize that accessible, affordable care is out of reach for too many patients and stand ready to work with the Office of Health Care Affordability (OHCA) and other stakeholders to transform our health care system into one that best serves patients. On behalf of more than 400 hospital and health system members, the California Hospital Association (CHA) appreciates the opportunity to comment on the May Health Care Affordability Board meeting.

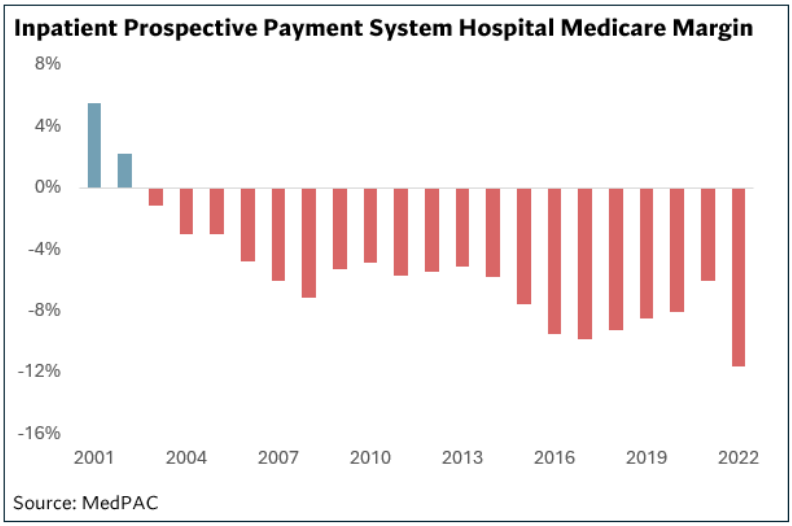
## New Research and Developments Should Inform OHCA's Approach

**National Projections Place Health Care Spending Growth Ahead of the Spending Target.** This month, actuaries at the Centers for Medicare & Medicaid Services (CMS) released updated national health expenditure (NHE) projections, which provide a fresh look at recent health care spending trends and an updated outlook for expected expenditures over the next decade.[1] The updated data underscore the divergence between OHCA's spending target of 3% to 3.5% over the next five years and what economic and demographic fundamentals indicate will be the likely pace of future health care spending growth. Nationally, federal actuaries and forecasters expect per capita health care spending to grow by between 4.8% and 5.8% while California's approved statewide spending target is in place — meaning statewide health care spending, if comparable to national trends (which historically has been the case), is likely to be more than 50% higher than the state spending target. In addition to revealing the gap between

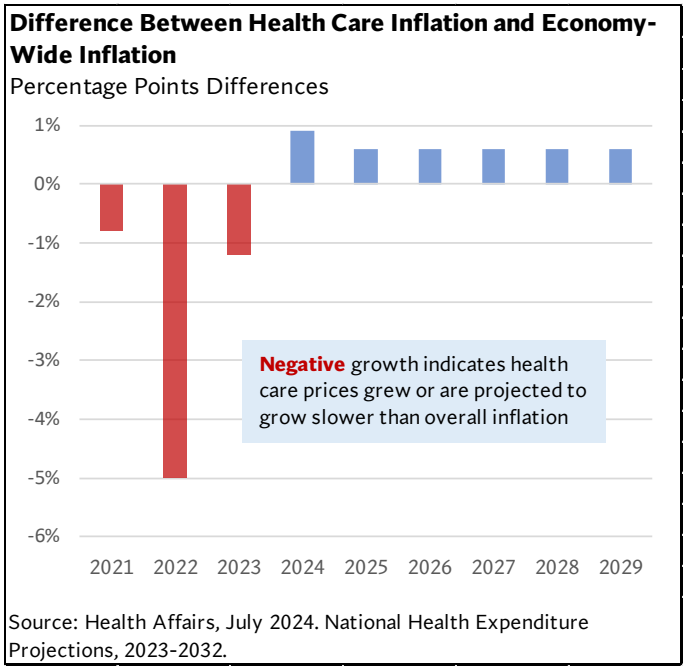
[1] Fiore, J. et al. (2024) National Health Expenditure Projections, 2023–32: Payer Trends Diverge As Pandemic-Related Policies Fade. Health Affairs. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2024.00469

projected trends and the state's goals, the CMS projections discuss the drivers of health care spending both over the past several years and as anticipated in the next decade.

- **Aging and Higher Demand for Care.** Demographic changes are a major factor behind CMS' updated projections, finding that population aging will drive increased demand for care and shifts in coverage from private health insurance to Medicare. Between 2024 and 2032, CMS projects Medicare enrollment to grow by 17%, Medicaid enrollment to grow by 5%, and private coverage to drop by 2%. The shift from private to public coverage, combined with the yawning disparity between private and public payment levels, will severely test hospitals and other providers, forcing them to increase capacity while simultaneously planning for enormous drops in reimbursement. As the figure above shows, Medicare inpatient reimbursement last came in above cost in 2002, and since has declined to more than 12% less than cost in 2022. The shortfall of Medicare payments is even more severe in California, where hospitals only receive 73 cents for every dollar of care they provide to Medicare patients.




- **Price Growth to Make Up for Recent Revenue Shortfalls.** Updated CMS data for 2021 through 2023 show that health care prices grew much slower than prices in the broader economy. Most notably, in 2022, general price inflation was 7.1% while that for health care services came in at just 2.3%. Despite low growth in patient revenues over the last three years, health care input costs grew closer to (if not in excess of) overall inflation, creating a growing financial imbalance between health care providers' revenues and costs. As the figure on the left shows, CMS expects this imbalance to correct over the next decade, with health care prices growing moderately faster than overall inflation.




CMS' choice of health care inflation measures cannot be ignored. First, unlike the most well-known inflation measure — the consumer price index — the health

care inflation measure used by CMS includes all payers, not just private plans and the uninsured. By including all payers, CMS avoids painting an overstated and misleading picture of health care inflation, as has been done by other researchers (and previously shared by OHCA). Despite these advantages, CMS' figures still likely overstate health care inflation given the well-documented deficiencies in appropriately adjusting for quality improvements for medical care broadly[2] and hospital care specifically.[3] These quality improvements, stemming from the introduction and dissemination of new technologies, advances in best safety practices, and improved screening and diagnosis, mean that the extra dollars spent on health care are buying more and more health improvements every year. By failing to appropriately capture these improvements, CMS' and other measures of health care inflation fail to properly reflect the value of the health care patients receive. Going forward, OHCA should carefully consider the tradeoffs and shortcomings of different measures of inflation when assessing health care spending growth.

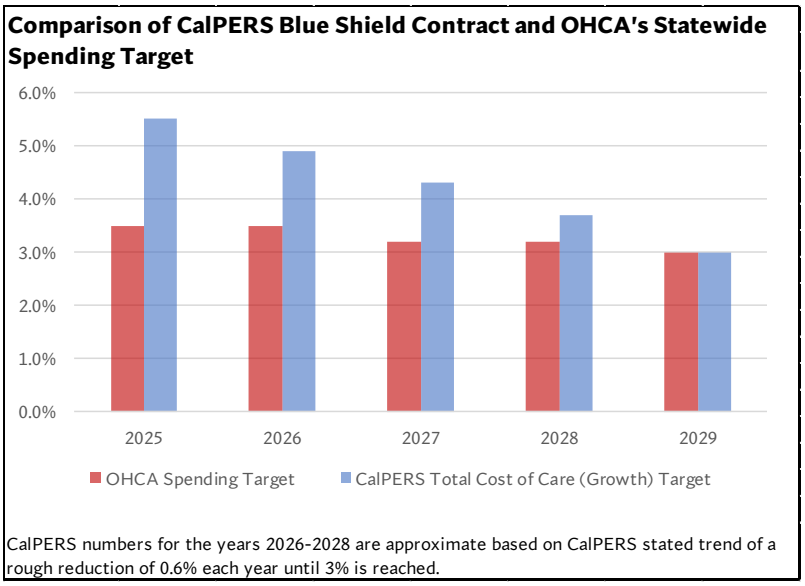
- **Stable Shares of Spending by Major Category of Service.** CMS expects the share of total spending going to hospitals, physicians and clinics, and prescription drugs to remain relatively stable due to similar growth rates for each category of service.
- **Increased Share of Gross Domestic Product (GDP) Going to Health Care.** CMS projects health care spending to grow faster than economic growth, resulting in the share of GDP going to health care growing from 17.3% to 19.7% by 2032. This is attributable to the aging population, increased demand for health care as incomes rise, and price increases to close the gap that rose during the pandemic between general price inflation and health care price inflation (discussed above).
- **Anticipated Coverage Losses Will Reduce Spending.** CMS anticipates a 2 percentage point increase in the percent of the population that is uninsured, largely due to the continuous coverage requirement in Medicaid and the scheduled expiration of enhanced federal subsidies for individual market coverage. These coverage reductions are expected to temper future health care spending increases, but for the wrong reason — families without coverage will be less likely to seek timely, preventive health care services. California must work to avoid this outcome, which would temporarily reduce spending at the expense of Californians' long-term health. This would only add to the affordability crisis as sicker patients seek acute care services that could have been avoided.

**What Lessons Can Be Drawn from Recent CalPERS Contract?** Earlier this month, CalPERS announced a new contract with Blue Shield of California starting in 2025 aimed at improving affordability, quality, and equity for state employees and retirees enrolled in the insurer's preferred provider organization plan. Specifically, the contract:

- Sets a total cost of care growth target starting at 5.5% in 2025 and ramping down to 3% in 2029
- Places $464 million at risk if the insurer does not meet the contract's affordability and quality goals
- Adds a new partnership with Included Health, a provider of virtual care and navigation services

[2] Dunn, A., Hall, A. and Dauda, S. (2022), Are Medical Care Prices Still Declining? A Re-Examination Based on Cost-Effectiveness Studies. Econometrica, 90: 859-886. https://doi.org/10.3982/ECTA17635
[3] Matsumoto, B. (2021), Producing Quality Adjusted Hospital Price Indexes. U.S. Bureau of Labor Statistics, Working Paper. https://www.bls.gov/osmr/research-papers/2021/pdf/ec210090.pdf

The new CalPERS contract presents a great opportunity to learn how the state and its selected vendor aim to realize OHCA's goals. Accordingly, the OHCA board should dedicate time to learning more about the new CalPERS contract, including:




- How the cost growth targets were set and how Blue Shield expects to meet the ambitious targets
- How improved care coordination is expected to improve health outcomes
- The details of the at-risk payments
- The exclusion of pharmacy costs from the target
- The treatment of high-cost outliers
- Other interesting facets of CalPERS' innovative approach to contracting

While exploring the contract design on its own will be illuminating, the OHCA board should monitor performance over the full life of the contract to draw lessons about how OHCA — and the health care field at large — can best achieve our shared affordability goals.

## Alternative Payment Model (APM) Goals Are Bold and Will Require Ongoing Monitoring

OHCA is currently considering standards for promoting the adoption of APMs, with a goal of more closely tying payment methodologies to quality outcomes. While the goals behind this effort are worthy, OHCA should continue to consider how its APM adoption goals fit alongside its other activities and monitor for unintended consequences. Such factors and questions to consider include:

- To what extent is California ahead of other states in the adoption of APMs? How would this affect the state's ability to realize additional savings from the spread of APMs?
- How might providers' capacities to adopt APMs differ? (Small providers, for example, often lack the scale and financial wherewithal to implement risk-based payments.)
- How might OHCA's rules related to market oversight impair providers' efforts to improve clinical integration? What impact would this chilling effect have on the state's ability to meet its APM goals?
- Would patients seek to avoid health insurance products that extensively incorporate APMs, if the plans limit patients' choice of providers and/or ability to obtain the care they need?

## Conclusion

OHCA must plan for the health care system Californians need and deserve. The state must address affordability challenges while meaningfully and measurably improving access to high-quality, equitable, and innovative care. As work toward that multi-faceted goal progresses, California's hospitals are eager to help the OHCA board more fully understand the ever-changing health care landscape. We are grateful for the opportunity to comment and look forward to continued collaboration on this important work.

Sincerely,

Ben Johnson
Vice President, Policy

cc: Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Members of the Health Care Affordability Board:
David M. Carlisle, MD, PhD
Secretary Dr. Mark Ghaly
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan

HEALTH ACCESS CALIFORNIA



June 24, 2024

Mark Ghaly, Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Department of Health Care Access and Information

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

2020 W. El Camino Ave, Ste. 800
Sacramento, CA 95833

**Re: Revised Alternative Payment Model Standards and Primary Care Standards**

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

Health Access, the statewide health care consumer advocacy coalition committed to quality, affordable health care for all Californians, offers comments to the Health Care Affordability Board on alternative payment model (APM) standards, which is up for action at this board meeting, and primary care standards.

Health Access has actively participated in the Investment and Payment Workgroup and benefitted from the Board discussion last month on both APM standards and primary care standards.

**APM Standards**

The lively Board discussion last month has led to some improvements in the proposed APM standards. Health Access supports these improvements and clarifications though we have some questions about both process and the proposed changes. Whether these changes are sufficient to accomplish the clear goal articulated by the Board to distinguish between alternative payment models that improve outcomes and equity while reducing costs and those that have failed or are likely to fail to achieve that triple aim is an important question where others may have greater expertise. It may be that the changes proposed by staff are not sufficient to accomplish what the Board members sought in terms of distinguishing APMs that are effective at reducing costs while improving outcomes as opposed to those that do not accomplish these desired outcomes.

*2.5. Design innovative APMs to address the needs of all consumers, particularly those with the highest healthcare costs and most to gain from comprehensive, coordinated care delivery.*



1127 11th Street, Suite 925, Sacramento, CA 95814 | (916) 497-0923 health-access.org

This added standard responds to the comments by Board members about those with the greatest health care needs benefiting the most from coordinated care delivery. We agree that there are very high need patients enrolled in commercial and Medicare coverage as well as in Medi-Cal, particularly but not only those who are duly eligible. The Board has heard from some consumers in this category, such as those with advanced multiple sclerosis and others with family members with major ongoing needs.

The staff has also proposed that "OHCA will collect risk score data for members in APM and not in an APM (fee-for-service)". One of our questions is what the risk score methodology will be, whether it will be publicly knowable, and whether it will be standardized. We are familiar with the risk adjustment methodology used for individual and small group insurance markets under the ACA and that methodology is public, updated annually, and standardized across carriers. A plethora of proprietary unstandardized methodologies will lead to a plethora of results, and the potential that the books can be cooked to improve apparent results without achieving actual results in terms of costs and quality. The danger of upcoding and miscoding remains though it is less worrisome in this context than in the context of cost targets where those health care entities doing the coding benefit financially from upcoding.

*3.4. Encourage consumers to develop a continuous relationship with ~~choose~~ a primary care team to promote access to and use of primary care and enable payment model success.*

This revised APM standard is consistent with the vision for the primary care standard. We support this revision because it strengthens both the APM standard and the primary care goals.

However, in our judgement, it does not respond to the comment of one Board member regarding the importance of a patient maintain their ongoing relationship with a primary care doctor even when the patient has a change of coverage, either due to a change in coverage sources such as from Medi-Cal to commercial or a change in coverage offered by their employer.

Existing California law has provisions on "continuity of care" and "block transfers"[1]. The existing law on continuity of care and block transfers is focused on those patients with acute, serious conditions, facing imminent surgery or in the midst of a pregnancy when an employer changes health plans or when the contracts between a health plan and a hospital or provider group are terminated. This law may sometimes be helpful to a patient with an established primary care relationship, but it is not focused on those situations. Because all too often, contract disputes between health plans and doctors, hospitals or health systems are driven by costs, the requirement that the provider accept the in-network rate makes these provisions less useful than we would wish. Unfortunately, changing this would require a change in law, something beyond the reach of the OHCA Board or staff.

*Standard 7.2 Align measures and technical specifications with those used by the Department of Managed Health Care, California Department of Health Care Services, Covered California, the California Public Employees' Retirement System, and the Office of Health Care Affordability, when available. In particular, include Childhood Immunization Status – Combination 10, Colorectal Cancer Screening, Controlling High Blood Pressure, Glycemic Status Assessment for Patients with Diabetes, and Depression Screening and*

[1] Health and Safety Code Sections 1373.65, 1373.95 and 1373.96.



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*Follow-Up for Adolescents and Adults whenever appropriate as these quality measures are the most commonly aligned across state departments.*

Health Access has participated in both public and private discussions of equity and quality measures, including those that led to the adoption of standard measures by the Department of Managed Health Care, California Department of Health Care Services, and Covered California. We look forward to working with the Office and this Board to review and adopt equity and quality measures to guide the work of the Office moving forward. The OHCA enabling statute requires the adoption of equity and quality measures as well as APM standards for the same reason: to transform California's health system into a well-functioning health system that serves consumers rather than the providers who work in it and the plans that finance it. The goal is not simply cost containment but lower costs along with higher quality and greater equity.

The five measures proposed to be identified in the APM standards address high prevalence conditions able to be managed effectively through primary and preventive care, from childhood immunizations to cancer screening, high blood pressure, diabetes and depression screening. These are basic, concrete interventions to improve health and reduce costs over a consumer's lifespan. We support that. We also look forward in future years to discussions about what additional measures should be added.

**Primary Care Standards**

We continue to support the staff's recommendations with respect to primary care standards. We also support the collection of data over time on two points which have been controversial, the role of obstetricians-gynecologists in primary care and the use of retail clinics and urgent care centers in lieu of a continuous primary care relationship.

With respect to OB-GYNs, if that physician is responsible for a broad range of immunizations, including flu and COVID shots, as well as screening and treatment of asthma, diabetes, depression, and hypertension, then we agree: that OB-GYN is a primary care provider within the vision of primary care that underpins OHCA. If not, then not. Similarly, with respect to retail clinics and urgent care centers, if those sources of care are responsible for screening and ongoing management of common chronic conditions such as asthma, diabetes, hypertension and depression as well as immunizations and other preventive care, then retail clinics and urgent care centers are providing continuous primary care. If not, then not. The work of specialists in obstetrics and gynecology is valuable work that many persons rely on, but that work is distinct from the vision of primary care that the Office is charged with promoting.

On behalf of Health Access, we look forward to adoption of the APM standards and continuing work on equity and quality measures as well as primary care standards and the forthcoming efforts on behavioral health.



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Sincerely,

Beth Capell. Ph. D.
Policy Consultant

Anthony Wright
Executive Director

CC: Margareta Brandt, Assistant Deputy Director, Department of Health Care Access and Information
Assemblymember Robert Rivas, Speaker of the Assembly
Senator Mike McGuire, Senate President Pro Tempore
Assemblymember Mia Bonta, Chair, Assembly Health Committee
Senator Richard Roth, Chair, Senate Health Committee
Assemblymember Akilah Weber, M.D., Chair, Budget Subcommittee on Health
Senator Caroline Menjivar, Chair, Senate Budget Subcommittee on Health and Human Services Chair
Members of the Office of Health Care Affordability Board



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