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Office of Health Care Affordability

PROMOTION OF COMPETITIVE HEALTH CARE MARKETS;
HEALTH CARE AFFORDABILITY;
HEALTH CARE SPENDING TARGETS
TOTAL HEALTH CARE EXPENDITURES DATA COLLECTION

Five comment letters were received for the draft comment period ending December 1, 2023, and are attached, as follows:

1. California Medical Association (CMA)
2. California Association of Health Plans (CAHP)
3. California Hospital Association (CHA)
4. Health Access California
5. America's Physician Groups (APG)

CALIFORNIA MEDICAL ASSOCIATION

December 1, 2023

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

Dear Ms. Brubaker:

On behalf of the California Medical Association (CMA) and our nearly 50,000 physician and medical student members, CMA writes to respectfully provide feedback on the proposed Promotion of Competitive Health Care Markets; Health Care Affordability (Total Health Care Expenditures Data Collection) regulations including the draft 53-page Total Health Care Expenditures Data Submission Guide (Guide). CMA offers this feedback to the California Department of Health Care Access and Information's Office of Health Care Affordability (OHCA) to advance our common goals of improving access, affordability, and equity for all Californians, all while maintaining high-quality health care.

CMA appreciates OHCA's thoughtfulness in preparing these proposed regulations and acknowledges the gravity of these regulations as the total health care expenditures (THCE) measurement will inform the spending target values and have real-life impacts, including potential financial penalties for some health care entities in the future.

Total Health Care Expenditures Data Submission Guide

The Guide uses the terminology "doctor of medicine or osteopathy", However, CMA recommends using the term "licensed physician and surgeon", which is used throughout state statute, and under Business and Professions Code section 2453 it includes osteopaths in addition to those who are medical doctors.

Risk Adjustment

One of the statutory requirements of the health care cost targets is to "[p]romote the goal of improved affordability for consumers and purchasers of health care, while maintaining quality and equitable care, including consideration of the impact on persons with disabilities and chronic illness." (Health & Safety Code § 127502(c)(5).) Because the THCE data outlined in these regulations will form the basis of the spending target measures, it is critical that OHCA collect the information necessary to meet its statutory goals.

However, there is a noticeable gap in information being collected as it relates to risk adjustment. The Guide asks only for age (in broad age bands) and sex. This is despite concerns expressed by members of both the Health Care Affordability Board and the Advisory Committee, as well as CMA members and other stakeholders. The Agency for Healthcare Research and Quality's 2019 study, *the Medical Expenditure Panel Survey*, showed that 5% of the population accounted for nearly half of all health spending. The survey goes on to say that people with current or prior diagnoses of certain chronic health condition(s) have much higher

spending on average than people without these conditions.[1] Adjusting for only sex and age—in bands far broader than the mandatory age bands set in state and federal law for health insurance premium rating[2]—will ultimately penalize providers who care for patients with disabilities and chronic illness. This policy decision by OHCA has the potential to worsen access to high-quality care and exacerbate health inequities—contrary to the goal of the statute. Accordingly, CMA strongly urges the Office to expand its risk adjustment methodology to consider disabilities, chronic illness, and other complex health conditions, as well as to use more granular age bands consistent with state and federal laws for health premium rating.

Attribution

Attribution is a crucial part of these regulations, and the Guide's explanation for how to appropriately attribute member-level expenditures lacks clarity. There is no explanation for the basic question of how to determine which health care entity to attribute members to when they have expenditures with more than one health care entity. Moreover, the "Payer-Developed Attribution" provides no parameters or guidance whatsoever and gives payers carte blanche to attribute member-level expenditures. Allowing submitters to create their own rules-based approach in the "Payer-Developed Attribution" method also does not appear to require any review or approval by the Office. The overall lack of safeguards and guidance oversimplifies the attribution methodologies and will create inconsistencies between payers. This, in turn, will degrade the accuracy and reliability of the data and eventual THCE measures that OHCA will subsequently use to assess health care entities' compliance with health care spending growth targets when they go into effect.

Further, it is unclear why members could not be more accurately attributed by the percentage of expenditures incurred at each health care entity each month. It also seems remiss to not include a mechanism for entities to review and dispute a payer's attribution. CMA recommends a more symmetrical approach, with the opportunity for providers to review and appeal their attribution, consistent with the standard practice of all-payer claims databases to provide a review window and verification process for providers and facilities to review and reconcile cost and quality measures and other data being attributed to them prior to making such data publicly available. CMA strongly urges more detailed guidance and parameters on the attribution methodologies and suggests that the Office reconsider its current approach.

Run-Out Period

CMA appreciates the 180-day period following December 31 to allow for claims to be fully adjudicated, but is concerned the run-out period is not long enough to account for all claims in their final disposition. Providers have 365 days from the payer's most recent action to dispute a claim. (28 CCR § 1300.71.38(d)(1).) OHCA's proposed 180 days doesn't cover the timeframe allotted to dispute the claim, especially for services performed near the end of the year, and as such, will not include many claims in their final disposition.

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[1] Ortaliza et al. (2019) https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population/#Average%20adult%20total%20health%20spending%20based%20on%20diagnosis%20status,%202019

[2] 45 CFR § 147.102(d) (using one-year bands for age 21-63). California adopted the federal age bands for individual and small group market coverage. Health & Safety Code §§ 1357.512(a)(1) & 1399.855(a)(1); Ins. Code §§ 10753.14(a)(1) & 10965.9(a)(1).

The limited run-out period also creates complications with recoupment. There was no mention in the Guide of how to handle recoupment for claims data and, like the dispute resolution concern stated above, payers also have 365 days from date of payment to recoup payments from providers. (28 CCR § 1300.71(b)(5).) It would not be uncommon for large payers to pursue tens of millions of dollars annually for recoupment. The lack of a process to amend this information will skew the data, leading to inaccurate assessments about health care entity compliance with spending growth targets.

It is also unclear which year(s) the annual reports being issued beginning in 2027 will be based on. The September presentation[3] to the Health Care Affordability Board offers a timeline indicating each annual report will in fact be based on the THCE from the two and three prior years' data.

Given the above, CMA recommends giving payers the opportunity to update claims data to reflect their final disposition, including recoupments. Without this opportunity, the proposed 180-day timeframe is too limiting as it does not account for the existing timeframes to appeal and recoup payments in law (28 CCR § 1300.71.38(d)(1) & 28 CCR § 1300.71(b)(5)). Allowing for updated claims data will provide a more accurate reflection of health care costs. For example, if the 2027 report is based on the 2024 and 2025 data and the 2028 report is based on the 2025 and 2026 data, payers will have the opportunity to revise the 2025 spending data in the 2028 report to account for claims in their final disposition.

Incorporation by Reference

The majority of the substantive requirements and standards in these draft regulations are only stated in the Office's draft **THCE Data Submission Guide**, which are then incorporated by reference into the draft regulations. An agency that seeks to adopt regulatory requirements through incorporation by reference must "demonstrate … that it would be cumbersome, unduly expensive, or otherwise impractical to publish the document in the California Code of Regulations." (1 CCR § 20(c)(1).)

The draft regulations primarily reiterate statutory definitions and a limited set of basic requirements regarding who must submit data and annual submission deadlines. Missing from the draft regulations are provisions defining the key operative details necessary to implement the underlying statutes: reporting periods, runout periods, attribution methods, risk adjustment, data review and verification, and (in a general, non-technical manner) the types of data to be submitted. These are critical aspects of implementing and complying with the substantive requirements of Health and Safety Code section 127501 *et seq*. But they are absent from the draft regulations.

Instead, the draft regulations include purely informational provisions that do not pertain to any legal requirements in the underlying statute these draft regulations seek to implement. For example, draft subdivision (j) of section 97449 informs submitters they may submit test files through the submission portal. This provision would be more appropriate in a submission guide than the implementing regulations.

[3] HCAI (2023), *Health Care Affordability Board Meeting September 19,2023* at slide 32, https://hcai.ca.gov/wp-content/uploads/2023/09/September-Health-Care-Affordability-Board-Meeting.pdf

While we appreciate the Office's desire to provide the submission requirements in a more user-friendly guide format, we urge OHCA to include any key standards and requirements directly in the regulation instead of relying primarily on incorporation by reference as the regulatory mechanism. Considering that OHCA drafted the Guide specifically for this purpose, it is difficult to see how the Office's use of incorporation by reference would meet the conditions of 1 CCR § 20(c)(1) that including these critical provisions directly in the proposed regulations would be "cumbersome, unduly expensive, or otherwise impractical."

With this in mind, CMA encourages the Office to include the most pertinent portions of the Guide directly in the proposed regulation, including but not limited to: risk adjustment, attribution methods, verification processes, reporting periods, and general data elements.

Thank you for your consideration of our feedback. If you have additional questions or would like to discuss further, I can be reached by phone at (916) 551-2560 or by email at jrocco@cmadocs.org. CMA appreciates the opportunity to provide input to OHCA on the development of these important regulations.

Sincerely,

Janice Rocco
Chief of Staff
California Medical Association

Cc: Elizabeth Landsberg, Director, California Department of Health Care Access and Information

OHCA Draft THCE Regulations and Data Submission Guide – CAHP General Comments (*dated 12/01/23*)

1. **We request that OCHA clarify its statutory authority to collect self-insured and fully insured ERISA plan expenditure data.** In particular, the 2016 decision by the United States Supreme Court in *Gobeille v. Liberty Mutual Ins. Co.* ruled that the Employee Retirement Income Security Act of 1974 (ERISA) pre-empts state APCD laws when the state mandates collection of ERISA plan data. The decision by the Supreme Court means that ERISA plans cannot be required to submit data, but may opt in voluntarily to the extent permitted by HIPAA.

2. **We request that OHCA clarify its statutory authority to collect Medicare Advantage expenditure data.** The State's oversight authority for MA plans is limited to solvency and this expenditure data is not a condition of licensure.

3. **Attributing Total Medical Expenses (TME) to certain provider organizations.**
   - The regulation, data submission guide, and attribution addendum approach will generally work for HMO members and providers. Significant work and time has been spent with the Integrated Healthcare Association (IHA) on this.
   - This approach will not work for non-HMO/ broader network members and providers (e.g., PPO, EPO products). There is no easy solution. To get to a place where OHCA can obtain reliable data will require OHCA to work with providers and carriers to drive fundamental changes in how providers are contracted. Specifically, the state will need to work with providers to develop a registry of Physician Organizations that are uniquely identified and this will then need to cascade throughout the delivery system in terms of payer/provider contracting, significant system updates, etc.

4. **Membership and healthcare spend attribution to provider entities in a PPO/fee-for-service environment does not work.** The cost benchmarking data collection assumes a false construct in two main ways: (1) As currently structured, there are a significant number of situations where members and their costs for the year will be assigned to the wrong provider entity via the cost benchmarking data collection construct. Fee-for-service (FFS) claims adjudication is set up to pay for services. These claims adjudication systems, contracts, etc. are not set up in a way to drive accurate reporting to provider entities as OHCA is defining those entities; and (2) It assumes a false premise in the existing healthcare system that a PCP is driving a member's care in a broad network environment. That is sometimes the case but often is not.

   This is driving our recommendations that OHCA data collection have a first order differentiation in data collection and reporting to distinguish between PPO and HMO product lines. When PPO data is reported to stakeholders and analyzed by OHCA staff, it is very important that the limitations in the PPO data and attribution are clearly communicated and understood.

   We appreciate that this is making everything more complex and difficult for the entire OHCA team. However, in the context of our shared goals, we want to be transparent about the inherent limitations on the data OHCA will be collecting. The vision for payers and

policymakers is to move FFS toward greater risk sharing arrangements. As that transition happens, the cost benchmarking data collection should increasingly approach a reasonable quality in line with what we describe with HMO reporting above. That said, the runway for the broader California healthcare delivery system to get there from where we are today (and where we envision the future state) will be long.

5. **Payers do not have a "line of sight" to the "correct" provider entity via TINs.** OHCA's recommendation for a survey has been very helpful because it has brought to light several flaws or concerns that have surfaced around the "Direct-to-TIN" attribution concept. For example, there are a number of provider entities that OHCA will be defining where payers have no direct contract. Rather, the doctors are using a TIN to bill a payer that is affiliated with the "wrong" provider entity in the context of what OHCA is trying to obtain. The same TIN can be used by doctors across provider entities, and issuers' data is blind to the underlying provider entity.

   Examples:
   - One Medical, which is operating throughout the state, has no TINs outside of the San Francisco Bay area. Outside of San Francisco, One Medical will work with local physician groups who will use a TIN affiliated with a different provider entity. UC San Diego Health providers are an example. Payers will get claims and TINs where some are, in reality, for US San Diego Health and others are for One Medical. Because the providers are using the same TINs, payers cannot identify which claims and spend to assign to One Medical. The current data collection will assign all of these members and spend to UC San Diego Health.
   - There are often no TINs for aggregators. Providers working with an aggregator will bill using a TIN associated with a provider entity other than the aggregator. For example, a payer has a TIN for Sansum Clinic. Some of the claims are directly related to Aledade and others are not. Under the direct-to-TIN approach, Sansum will have all of the members and spend when in reality Aledade is really the key provider entity operating in the background. The payer's data is not structured in a way that allows them to be able to accurately attribute spend and membership to Aledade.
   - As described in the August payer technical assistance workgroup, some of these provider entity TINs are being used by hospitals and urgent care centers. An urgent care center may have its own TIN but others use a provider entity TIN. In the latter, payers' data cannot parse out the urgent care professional spending.

6. **The data submission guide and addendum are silent on how these data submissions will be structured and handled for integrated delivery systems. Integrated delivery systems should be included. We request more detail and clarity.** For example, why does the data submission guide omit "Non-Claims: Provider Salaries" that is seen in other states? Connecticut defines this data field as "All payments for salaries of providers who provide healthcare services not otherwise included in other claims and non-claims categories." This category is typically only applicable to closed delivery systems.

7. **We recommend revising the definition of pharmacy rebates.** The current definition is overly broad (see detailed comments below on p. 4-5). We recommend aligning with what is currently reported for SB 17 (drug cost reporting) to keep data apples-to-apples across reporting requirements, or revising to the following as preferred language:

"Rebates" means any retroactive, volume-based discount paid by the pharmaceutical manufacturer, developer, or labeler to a pharmacy benefit manager that is based on the utilization of a prescription drug in this state."

8. **Can OHCA clarify why it does not include the following data field seen in other states' cost benchmarking programs?: "Non-Claims: Total Primary Care Non-Claims-Based Payment".** We recommend that OHCA work with payers to determine how to calculate the portion of non-claims payments related to primary care. The CA cost benchmarking program will have a target for the percentage of total medical expenses (TME) spent on primary care. Accounting for the primary care non-claims-based payments is important to get a more accurate picture of the percent of TME spent on primary care.

9. **Technical Questions:**
    - How do payers prevent double counting/overstating THCE?
        - Fully integrated provider systems may also be those that health plans contract with, and both must report. This offers potential for double counting.
        - For a health plan a capitated amount is an amount to be reported, and for a provider the actual expense for which the capitation is reported is potentially an amount to be reported – and this would double count.
    - Please confirm that Medi-Cal Managed Care and Medicaid are interchangeable terms.
    - Please confirm whether the first submission in 2024 should exclude Medi-Cal Managed Care and Medi-Cal Dual Eligibles.
    - Would OHCA consider delaying/deferring implementation of these regulations as it entails operationalizing a massive unfunded administrative requirement?
    - For Plans with multi-lines of business, of which Medi-Cal managed care is a majority of the Plan's annual revenue, then the request/recommendation is to defer the Plan's required submissions for Commercial and Medicare lines of business until such time Medi-Cal Managed Care is required.
        - Scale back or phase in the initial scope of submission. As outlined in the Data Submission Guide, this will require significant investments by submitters to comply.

Proposed THCE Data Submission Guide (*dated 10/27/23*)			
Page	**Section**	**Draft Language**	**Comment or Recommended Edit**
11	4. Definitions	"**Market Category:** A segment within the public or private health insurance market for the purposes of reporting total medical expenditures. The market categories are: 1. Commercial (Full Claims) – Fully-insured or self-insured members for which the submitter is able to collect information on all direct medical claims and any claims paid by a delegated entity. 2. Commercial (Partial Claims) – Fully-insured or self-insured members for which the submitter does not have access to claims or encounter data to accurately report all claims-based payments. Refer to Specialty or Carved-Out Services for more information."	How do payers know which Commercial category to report spend in? The break between the two Commercial categories is not clear. Many PPO Fee-For-Service plans have some level of capitated expense – carve-outs for behavioral health, or pharmacy, etc. – and thus are not technically "Full Claims." A cleaner break would be to give a definition to each of these. Products with the member assigned to a specific PCP where a capitation is paid could fall into 2 (Partial), and products where the member is not assigned to a PCP and no capitation is paid for any primary services would be 1 (Full Claims).
12, 36	4. Definitions; 6.6 Pharmacy Rebates File	**4.4. Definitions** "**Pharmacy Rebates:** Price concessions, price discounts, or discounts of any sort that reduce payments, including a partial refund of payments or any reductions to the ultimate amount paid; a financial reward for inclusion of a drug in a preferred drug list or formulary or preferred formulary position; market share incentive payments and rewards; credits; remuneration or payments for the provision of utilization or claim data to manufacturers for rebating, marketing, outcomes insights, or any other purpose; rebates, regardless of how categorized, and all other	The Data Submission Guide provides a very broad definition of rebates (see Page 12), which seems to capture nearly any type of discount, price concession, or rebate on drugs. Based on this broad definition, "Pharmacy Rebates" could include discounts received at purchase, rebates received in exchange for formulary tiering, value-based discounts, and nearly any other discount that serves to "reduce payments" on drug prices. The data elements descriptions on page 36 are not any more clarifying, although they seem to suggest that the rebates the regulators are interested in are those that plans receive in exchange for coverage and not necessarily what discounts plans receive when they pay to purchase drugs:

Proposed THCE Data Submission Guide (*dated 10/27/23*)			
Page	**Section**	**Draft Language**	**Comment or Recommended Edit**
		compensation to carriers, their pharmacy benefit managers (PBMs), rebate aggregators, or subsidiaries." **6.6. Pharmacy Rebates File** **Medical Pharmacy Rebate**: "Report the total amount of pharmacy rebates (see the definition) applicable to pharmacies paid under the member's medical coverage for the reporting year." **Retail Pharmacy Rebate Amount**: "Report the total amount of pharmacy rebates (see the definition) applicable to pharmacies paid under the member's pharmacy coverage for the reporting year."	**Medical Pharmacy Rebate**: "Report the total amount of pharmacy rebates (see the definition) applicable to pharmacies paid under the member's medical coverage for the reporting year." **Retail Pharmacy Rebate Amount**: "Report the total amount of pharmacy rebates (see the definition) applicable to pharmacies paid under the member's pharmacy coverage for the reporting year." These descriptions are currently unclear and arguably inaccurate. Pharmacy rebates are not "applicable to pharmacies," nor are the pharmacies paid rebates under a member's medical or pharmacy coverage. Perhaps, what is meant is "applicable to claims paid" under the member's medical/pharmacy coverage, but it's not clear. In short, without clearer definitions/drafting, it's not evident which rebates/discounts plans would have to report pursuant to these draft regulations. We recommend aligning with what is currently reported for SB 17 (drug cost reporting) to keep data apples-to-apples across reporting requirements, or revising to the following as preferred language: "Rebates" means any retroactive, volume-based discount paid by the pharmaceutical manufacturer, developer, or labeler to a pharmacy benefit manager that is based on the utilization of a prescription drug in this state."

Proposed THCE Data Submission Guide (*dated 10/27/23*)			
Page	**Section**	**Draft Language**	**Comment or Recommended Edit**
			Ultimately, reporting should align across state entities that require that information.
15	5.4 Member Attribution	"Member attribution should be performed in the following order: 1. First, identify members for whom utilization management and claims payment functions have been delegated to an organization listed on the OHCA Attribution Addendum through a capitated payment arrangement. Report data for these members using the Capitated, Delegated Arrangement attribution method."	Other states with similar total medical expenditure/Affordability regulations do not require member level claims data for cost growth target programs. We recommend some level of aggregation vs. individual rows of data for each member. There could also be issues around ASO claims data. We would need clarity on ERISA/Non-ERISA rules on what we are able to release under ERISA. The format as it exists now does not sufficiently mask individual member level data as each row will identify a member's age, location, and physician group they have seen. More generally, attributing data to Primary Care Physicians for Fee-For-Service products may be misleading in that members may be making their own care and thus spending choices, and attributing these to a provider group would not be accurate. OHCA's enabling legislation specifically requires that spending targets be set per capita, but does not require that the data collection be in that form: "4) Collect and analyze data from existing and emerging public and private data sources that allow the office to track spending, set cost targets, approve performance improvement plans, monitor impacts on health care workforce stability, and carry out all other functions of the office." We would continue to encourage that for FFS products payers report total amounts paid to each provider system and they can also provide information on utilization. The total

Proposed THCE Data Submission Guide (*dated 10/27/23*)			
Page	**Section**	**Draft Language**	**Comment or Recommended Edit**
			spend by provider and number of members served in that total spend will provide a much more accurate view of the FFS products than attribution will – particularly if targets at a provider level will be any part of the future state.
16	5.5. Self-Insured Plans	"For self-insured lines of business, the administrative cost and profit portion of THCE is calculated using additional data submitted by self-insured payers on the income from fees from any self-insured accounts. OHCA requests submitters with self-insured lines of business report aggregate information on the fees earned from their self-insured accounts (e.g., "fees from uninsured plans") as part of the THCE data submission. Submitters should follow the instructions for Part 1, Line 12 on the NAIC Supplemental Health Care Exhibit (SHCE) for their California-situs self-insured accounts. The amount should be entered on the Submission Questions file in the Self-Insured Business field (SQS021)."	In calculating the Net Cost of Private Health Insurance (NCPHI) as part of the cost growth benchmarking process in other states, they try to estimate premiums. However, ASO fees are not premiums. And based on the DSG, OHCA is gathering data to calculate Total Health Care Expense (THCE), which can be done without the ASO fee data. We recommend that plans do not report ASO fees in the cost growth data. As ASO/self-insured business is written on a non-insurance entity, the fee revenue is not considered health premiums. Administrative rates on a per capita basis are proprietary and non-public information between the employer group and the health plan. If OHCA must include the fees, public information or financial filings submitted to the state can be used (as is done today in Rhode Island, Connecticut, Washington and Oregon for their total medical expense calculations).

December 1, 2023

Megan Brubaker
Engagement and Governance Manager
Office of Health Care Affordability
Department of Health Care Access and Information
2020 West El Camino Ave., Suite 1200
Sacramento, CA 95833

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

SUBJECT: CHA Comments on the Oct. 20, 2023 Version of the Total Health Care Expenditures Data Collection Draft Regulations

Dear Ms. Brubaker:

On behalf of our more than 400 hospital and health system members, the California Hospital Association (CHA) thanks the Office of Health Care Affordability (OHCA) for the opportunity to comment on the Oct. 20, 2023 version of the Total Health Care Expenditures (THCE) Data Collection draft regulations.

CHA Supports the Overall Approach of Collecting Data from Health Plans and Insurers

We believe the proposed approach of collecting the THCE data from health plans and insurers for enrolled and insured state residents makes sense. Unlike providers, health plans and insurers come the closest to having the necessary data to comprehensively identify and report the THCE of their members. By contrast, looking to providers for these data would exponentially increase the complexity of the data collection process and introduce serious data commensurability and quality issues that would undermine the spending target program.

While we support OHCA's overall approach to data collection, we have a number of concerns with the regulations and supplementary guidance, as currently proposed. Our most fundamental concerns relate to there being no process for validating the expenditures that health plans and insurers attribute to providers and essentially no rules around how health plans and insurers perform this attribution. Additionally, we remain troubled by the decision against using clinical risk adjustment, as reflected in there being no mechanism for gathering clinical risk information in the proposed regulations. Finally, we have questions and concerns with the lack of specificity around how stakeholders will be consulted when changes to the data collection regulations and guidance are being made, how these data will be

supplemented and merged with statutorily required data from other sources, and several other technical issues.

Providers Must Have an Opportunity to Validate Attributed Expenditures

Accurate Attribution of THCE Is Absolutely Essential. The THCE data submitted by health plans and insurers will form the backbone of the spending target program, determining which health care entities made or missed the spending target. Accordingly, payer decisions on how to attribute patient spending will very likely determine which providers are found to be in compliance with the spending targets. Moreover, health plans and insurers are being asked (under section 5.1.2 of the Data Submission Guide (DSG)) to *estimate* non-claims payments that will be made to providers beyond the claims run-out period of 180 days, as well as for carved-out services. Including *estimates* of these payments adds significant potential for error in the THCE data, such as for certain value-based payment programs where the payments are at risk against performance against quality measures.

Inaccurate or manipulated THCE data would severely damage the credibility of the spending target program. Problematically, the proposed regulations assure no line of sight for providers into the expenditures that health plans and insurers attribute to them. This leaves both providers and the office itself with no ability to validate the accuracy and appropriateness of the attributed expenditures.

Establish a Process for Provider Review of Attributed Expenditures. To prevent the pitfalls described above, OHCA must establish a process for providers to review and validate the accuracy of the expenditures that are attributed to them. Doing so would significantly increase confidence in the data underlying the spending target program and place the THCE data submission process at a similar standard as other major health care programs, such as:

- The Maryland All-Payer Model, under which hospitals and other key stakeholders have access to the data that determines hospitals' global budgets, including data on which patients are attributed to which hospitals
- California's Hospital Quality Assurance Fee program, under which hospitals review data submitted by Medi-Cal managed care plans on contracted utilization prior to the data being used to determine payment distributions
- Various quality programs that hospitals participate in, where hospitals are afforded an opportunity to review their performance data before it is finalized

At minimum, the validation process should involve health plans and insurers sharing with affected providers information on which patients are attributed to them and under what methodology the attribution occurred. If the methodology is payer-developed, as afforded under step 4 in DSG section 5.4, health plans and insurers should share in detail the payer-developed methodology as well as the data used to make the attribution decision. Then, providers should have an opportunity to correct any inaccuracies in the attribution decisions both before and after final data on attributed expenditures is shared with the department. We recommend the following language be added to the proposed regulations to establish a THCE data validation process:

Proposed 22 CCR § 97449

...

(d) Coordination of Data Submission.
(1) Required submitters are responsible for reporting data for all plan members. If a required submitter is the Directly Contracted Plan in a Plan-to-Plan contract, the Directly Contracted Plan shall obtain any necessary data from the Subcontracted Plan and submit the data to the System.
(2) Affiliated required submitters are responsible for coordinating data submission amongst their affiliates to ensure compliance with this Article.
(3)(A) Required submitters are responsible for validating the accuracy of attribution of member-level expenditures. For any organization to which a required submitter attributes a member's total medical expenditures to pursuant to the THCE Data Submission Guide, and without regard to whether the organization is listed on the OHCA Attribution Addendum, the required submitter shall do both of the following prior to submitting the data to the System:
(i) Provide the attributed organization with notice of the members attributed to their organization, and the basis, methodology, and associated data as applicable for attributing the member-level expenditures to such organization.
(ii) Provide a reasonable opportunity of at least 10 business days for the attributed organization to validate or correct the required submitter's attribution of member-level expenditures to such organization.
(B) If the required submitter and the attributed organization are unable to reach agreement as to the attribution of member-level expenditures to such organization prior to submission to the System, the Office shall allow the attributed organization to petition the Office directly in writing to request correction. The attributed organization's request shall describe in sufficient detail the correction(s) being sought, the basis for such correction(s), and any data supporting the request. The Office shall respond to the attributed organization's request within 5 business days of the date the request was submitted and notify the affected attributed organization(s) and required submitter of its decision.
...

(k) Data Acceptance and Correction.
(1) Data files that are submitted to the System but do not meet the file intake specifications detailed in the Guide will be rejected. Registered submitters will be notified within 5 business days of submission whether a data file has been accepted or rejected. Reasons for rejection include:
(A) Invalid file format, file layout, or data types.
(B) Incomplete or illogical data.
(C) Other technical deficiencies related to file submission, storage, or processing.
(2) If the Office determines that a previously accepted file contains initially unidentified errors, **including but not limited to an error in the attribution of member-level expenditures to an organization that the Office identifies in reviewing a request for correction pursuant to (d)(3)(B) of this section,** the submitter shall be notified through the data portal. The submitter shall respond through the data portal within 3 business

days of notification by the Office. The Office may make multiple requests for corrections or resubmissions.

Plan for a Standardized Patient Attribution Methodology

We are concerned with the lack of clear and consistent standards for how health plans and insurers must attribute their members to providers when assignment is not clearly determined by contractual arrangement (i.e., for members who cannot be attributed via steps 1 through 3 of DSG section 5.4). Unfortunately, the discretion proposed to be given to payers around patient attribution will:

- Increase the incidence of misattributing patients to providers — as has frequently been the case under the Maryland All-Payer Model, where hospitals frequently have reported never having seen patients that are attributed to them
- Risk attributing patients to providers who lack a meaningful influence on their patients' utilization patterns and costs — such as a specialist who performs a single high-cost procedure on a patient
- Not allow for apples-to-apples comparisons of expenditures across payers and providers – since payers will likely adopt a wide range of different methodologies
- Create opportunities for gaming by payers – given there are no requirements other than that the methodology be "rule-based."

Establish a Process to Properly Evaluate Patient Attribution Methodologies. Despite these clear downsides, we understand that OHCA may wish to test different patient attribution methodologies before deciding on a statewide standard. Given the complexity of California's health care market, using the first year of implementation to learn about which approaches to patient attribution do and do not work may be appropriate, provided OHCA transitions to a stakeholder-informed, standardized methodology prior to the implementation of a spending target. To maximize this limited window of opportunity to learn which patient attribution methodologies work and prepare for the adoption of a standardized approach, we ask OHCA to establish a process now to work towards this important goal. Specifically, we ask OHCA to establish the following:

- A distinct reporting mechanism for obtaining detailed information on each health plan and insurer's attribution methodology. (The current field for gathering this information, SQS009, is limited to 500 characters and thus insufficient for the purpose of obtaining the information needed to make educated decisions on this important issue)
- Release of the above reports on OHCA's website to allow for public review and feedback
- A workgroup of payers and providers to review the attribution methodologies utilized (as well as preexisting models such as under the Medicare Shared Savings Program and recommended by the Integrated Healthcare Association) and offer recommendations on a standardized methodology applicable to all payers
- A predetermined deadline by which OHCA must establish the standardized methodology via regulations. (This deadline should be no later than April 1, 2025 to allow for the standardized methodology to be in place prior to reporting against the first spending target)

In the Meantime, Place Guardrails on Patient Attribution Methodologies. As noted, we recognize additional learning may be needed before adopting a fully standardized payers' patient attribution methodology. But guardrails are needed now to ensure the consistency of payers' approaches with OHCA's vision and to prevent abuse of the latitude proposed to be given. Accordingly, we ask OHCA to add the following requirements to provision 4 of DSG section 5.4:

4. Any members who cannot be attributed using one of the above methods may be attributed to an organization listed on the OHCA Attribution Addendum or other organization using a submitter-developed, rules-based approach for assigning total medical expenditures. Report data for these members using the attribution method Payer-Developed Attribution.

a. Report data in separate records for any organization not listed on the OHCA Attribution Addendum with at least 1,000 attributed members. Include the full legal name in the Organization Name field and use the Organization Code '7777'.

b. Report data for all organizations not listed on the OHCA Attribution Addendum with 1-999 attributed members in a single record leaving the Organization Name field blank and using the Organization Code '8888'.

c. The Payer-Developed Attribution methodology must meet the following requirements:

i. Attribution may only be made to organizations responsible for providing primary care to the member. Attribution shall not be made to providers based on the specialty or acute care delivered to the member.

ii. Payers' rules-based approach for patient attribution shall be consistently applied to all medical expenditures reported in the two years comprising each applicable data submission.

iii. In reporting to OHCA on or before June 1, 2024, payers must describe their rules-based approach to Payer-Based Attribution. The description shall be in sufficient detail to allow provider organizations to infer which of their patients will be attributed to them by the payer, including but not limited to the payers' operative definition of what services qualify as primary care. OHCA shall publish the payer reports on their website no later than July 1, 2024. Within one week of the proposed effective date for any change to its rules-based approach, payers shall report to OHCA a sufficient description of its revised approach, which OHCA shall promptly publish on their website.

A Meaningful Process Is Needed for Stakeholder Consultation for Future Changes to Sub-Regulatory Guidance

With certain exceptions, CHA supports the Office's approach to defer data requirements to the Submission Guide rather than formal regulatory text, as long as there is an ongoing and meaningful opportunity for all relevant health care entities to provide input as the rules evolve and are implemented. While these initial THCE regulations and technical Guide only require payers to report, it is vitally important to consider the hospital perspective given the significance of patient attribution to future enforcement of provider spending targets. This was recognized by the Legislature in the OHCA authorizing statute at Health and Safety Code § 127501.4(k). It requires OHCA to engage relevant stakeholders, hold a public meeting to solicit input, and provide a response to input received prior to adopting regulations or approving associated technical specifications or guidance related to data submission, including rules adopted on an emergency basis.

CHA acknowledges the approach to incorporate the Guide by reference within proposed 22 CCR § 97445(s), which will afford an opportunity for traditional notice and comment under the State Administrative Procedure Act to the extent the incorporated version of the Guide is subsequently changed. We also note that OHCA is authorized until Jan. 1, 2027 to adopt any rules implementing the Health Care Affordability chapter of the code using the emergency rulemaking process, which provides only a truncated and relatively narrow opportunity for affected stakeholders to comment on changes prior to them becoming effective. In addition, comments on proposed emergency regulations are made directly to the Office of Administrative Law and the rulemaking agency is not required to respond to input made with respect to the emergency rulemaking action. As a result, we urge OHCA to continue employing a suitably robust stakeholder process, consistent with the above referenced statutory command and prior to the limited opportunity for input within the emergency rulemaking context, that allows hospitals and other regulated provider entities to offer feedback to changes to the Submission Guide and associated reporting framework. We appreciate OHCA's efforts to this effect in this immediate rulemaking, and ask that the same or similar process accompany any future Guide updates or changes.

To reinforce this requirement, CHA proposes adding the following language to the Submission Guide at a new Section 1.3:

> **1.3 Stakeholder Engagement for Subsequent Changes to this Guide**
>
> **Consistent with Health and Safety Code section 127501.4, subdivision (k), OHCA will engage with all relevant stakeholders, including but need not be limited to payers and providers, hold at least one public meeting to solicit input from relevant stakeholders, post to its website any written materials or proposals at least five business prior to any public meeting, and provide a timely response to all input received during this engagement, prior to formally adopting any changes to the version of the THCE Data Submission Guide dated ____, 2023.**

Test the Use of Clinical Risk Adjustment

Concerns With OHCA's Approach to Risk Adjustment. We remain troubled by OHCA's decision against using clinical risk adjustment to distinguish between unjustified spending growth and growth due to changes in the underlying health care needs of health care entities' patient populations. With this decision, OHCA will disincentivize health care entities from serving high-risk and high-cost patients – including individuals with behavioral health disorders. This undermines OHCA's foundational goal of improving health equity and ignores its statutory directive to consider the unique health care needs of people with disabilities and chronic illnesses. Our concerns related to the unintended consequences of not utilizing clinical risk adjustment, which performs orders of magnitude better than OHCA's preferred approach of only risk adjusting based on age and sex, are not merely theoretical. Studies have repeatedly shown how risk selection, when left unaddressed through the use of appropriate risk adjustment, harms vulnerable populations.[1] Most notably, Black infants died or had complications at higher rates after

[1] In addition to the study described in the body, see the following for evidence of the negative impact that unmitigated risk selection can have on vulnerable populations, including high-cost patients generally and cancer patients specifically:
• Wynand P. M. M. van de Ven, Richard C. van Kleef, and Rene C. J. A. van Vliet; Risk Selection Threatens Quality of Care for Certain Patients: Lessons from Europe's Health Insurance Exchanges; Health Affairs 2015 34:10, 1713-1720

Texas' Medicaid program introduced new opportunities for risk selection without compensating mechanisms to control and compensate health care entities for the predictable variation in costs between Black and other infant populations.[2]

Recommend OHCA Test Clinical Risk Adjustment Alongside Sex- and Age-Only Risk Adjustment. OHCA has previously stated a willingness to reconsider, in the future, its approach to risk adjustment. However, without testing and comparing the outcomes of the two distinct approaches to risk adjustment (one with and one without clinical risk adjustment), it is unclear what information OHCA would use as the basis of a future change in approach. Accordingly, we recommend that OHCA simultaneously pilot the two forms of risk adjustment and decide, with information in hand, on the appropriate approach on an ongoing basis. Now is the right time to do so as data collection mechanisms are being set up but before spending targets are implemented and enforced. Specifically, we ask OHCA to select a clinical risk adjustment methodology for all payers to utilize, collect aggregated data on the clinical risk scores of payers' members, report on per capita spending growth using both forms of risk adjustment, and perform a formal evaluation of both forms of risk adjustment looking specifically at health care entities' responses to the different financial incentives each form introduces. We also ask OHCA to consider the use of truncation as an additional means to control for unpredictable year-to-year variation in health expenditures and minimize the troubling incentives introduced by the spending target program that will encourage health care entities to avoid high-risk patients.

Clarify How OHCA Will Collect Data on Certain Major Expenditures

State law clearly specifies the many elements that must be included in the definition and scope of THCE (see, for example, Health and Safety Code §§ 127500.2(s) and 127501.4(a)). However, several key elements specified in law are missing from what OHCA has proposed to collect from health plans and insurers via this regulation and the accompanying DSG. As we describe in greater detail below, we ask OHCA to add these elements to the DSG as appropriate, or communicate in upcoming public meetings and supplemental information published on its website, including but not limited to the publication of any related interagency agreements, how OHCA intends to collect the missing information from other sources and merge it with the data from health plans and insurers to create comprehensive measures of THCE and attributed total medical expenditures. Such communications must also provide an opportunity for meaningful stakeholder input.

Regulations Do Not Collect Data on Health Plans and Insurers' Administrative Costs and Profits. State law requires OHCA to collect data on payers' administrative costs and profits, and ultimately set specific spending targets for these components of plans and insurers' finances. However, the regulations do not require health plans to provide the requisite information. Clarity is needed on how OHCA intends to collect and synthesize this information. If OHCA plans to collect this data from the Department of Managed Health Care, Department of Insurance, and Department of Health Care Services (DHCS), we ask that be communicated in upcoming public meetings and supplemental information made publicly

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• Kreider, Amanda and Layton, Timothy J. and Shepard, Mark and Wallace, Jacob, Adverse Selection and Network Design Under Regulated Plan Prices: Evidence from Medicaid (December 2022). NBER Working Paper No. w30719, Available at SSRN: https://ssrn.com/abstract=4293632

[2] Kuziemko, Ilyana and Meckel, Katherine and Rossin-Slater, Maya, Do Insurers Risk-Select Against Each Other? Evidence from Medicaid and Implications for Health Reform (July 2013). NBER Working Paper No. w19198, Available at SSRN: https://ssrn.com/abstract=2289108

available on the OHCA website. Alternatively, if OHCA plans to collect this data from payers directly, changes must be made to the DSG to ensure collection and the accuracy of this critical data.

Clarity Needed for Expenditures That Do Not Flow Through Health Plans and Insurers. Total health care expenditures are intended under statute to be just that, "total." Only a little more than half of Medi-Cal and Medicare expenditures flow through plans. The remaining expenditures flow through Medi-Cal and Medicare fee for service or other delivery systems, such as counties for a significant portion of behavioral health and personal care services. The proposed regulations and guidance do not specify how this information will be collected. We ask OHCA to describe in upcoming public meetings and supplemental information online, with a meaningful opportunity for stakeholder input, how this information will be collected and wedded to the health plan- and insurer-submitted data for the purposes of monitoring THCE growth and attributing total medical expenditures to providers.

Plan Needed for Collecting Accurate Data on Medi-Cal Supplemental Payments. Supplemental payments form a substantial portion of total provider payments in Medi-Cal. This is especially true for hospitals. For example, supplemental payments to private hospitals regularly constitute more than 30% of total Medi-Cal payments. The DSG lacks clarity in how supplemental payments, including those that flow through health plans, are to be reported. While they presumably are intended to be captured within various non-claims payments categories, this is not clearly specified. Accurately reporting these payments is further complicated by the significant lag between when the services are delivered and when these payments are made, meaning these payments generally will have to be estimated rather than reflecting actuals. This is a particularly acute challenge for private hospital directed payments under the hospital quality assurance fee program, which do not flow until two years after the services were delivered. Given the inherent challenge of accurately estimating Medi-Cal supplemental payments at the health plan level and DHCS's prominent role in overseeing these payments, we recommend DHCS perform the estimates of these expenditures on OHCA's behalf.

Definition of "Allowed Amount" Raises Concerns

The DSG requires health plans and insurers to report medical expenditures based on allowed amounts. We are concerned that a lack of clarity in the definition of allowed amounts could lead to the misreporting of the actual amounts paid to providers. We ask for the following change to be made to the definition to clarify that the reporting of expenditures must be based on final adjudicated amounts, rather than negotiated rates prior to final adjudication. This change is critical given the growing prevalence of downcoding and other payer practices aimed at disallowing, reducing, and delaying payments for services previously rendered.

> The allowed amount for a covered benefit~~, which includes both the amount paid by the payer or fully integrated delivery system to the provider and the member's financial responsibility owed directly to the provider, regardless of whether the member actually made a payment.; this is also known as the negotiated rate, or the contracted rate. The allowed amount~~ is ~~not necessarily~~ the sum of what the provider was paid **by the payer or fully integrated delivery system following final adjudication of a claim and reflective of the negotiated or contracted rate, as applicable, and the member's estimated financial responsibility owed to the provider, regardless of the actual amount paid by the member to the provider.**

Conclusion

Thank you for the opportunity to comment on these important proposed regulations.

Sincerely,

[redacted]

Ben Johnson

cc: 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

December 1, 2023,

Mark Ghaly, M.D., Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Health Care Access and Information Department

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

C.J. Vance, Assistant Deputy Director
Office of Health Care Affordability

Re: "Total" Health Care Expenditures: Regulations, Data Submission Guide, and Attribution Addendum: Lack of Clarity for Stakeholders, Omissions and Inconsistency with Statute

Dear Secretary Ghaly, Director Landsberg, Deputy Director Pegany and Assistant Deputy Director Vance:

Health Access, the statewide health care consumer advocacy coalition committed to quality, affordable health care for all Californians, offers comments on the lack of clarity of the proposed regulations, data submission guide and attribution addendum on Total Health Care Expenditures. As presented in writing, these regulations and other materials contain significant omissions and errors including inconsistency with the statute. The proposed regulations and data submission guide raise numerous questions that should be answered at the Affordability Board or that may represent other omissions and problems. In addition, some provisions of the data submission guide request information on services or care in a manner contrary to other provisions of California law.

Health Access supports the collection of "Total" Health Care Expenditures data, but we raise these major problems with the proposed regulations, data submission guide and attribution addendum so that they can evolve to better serve the goals of the Office. We recognize some of the verbal comments made by staff at the Health Care Affordability Advisory Committee on November 30, 2023, the day before the deadline for formal comments, provide some additional context but there is literally nothing in writing in a public document that indicates that this is only an initial set of regulations relating to the baseline data and reporting or that there is continuing development of data reporting. The staff presentation at the

regulatory workshop failed to provide any information beyond the plain language of the regulation. Even such simple questions as how information on Medi-Cal fee-for-service or traditional Medicare would be collected were not answered at the workshop or in writing.

We recognize that these regulations are intended to collect information on "total" health care spending at the state and regional level, but they also begin the process of creating the data reporting infrastructure for measuring compliance with the statewide spending targets not only by payers but also by physician organizations, hospitals, health systems and the many layers of delegation in the California market. If OHCA is to accomplish its mission of slowing unchecked health care cost growth and improving affordability for consumers and other purchasers, then the regulations on reporting health care spending begin the work of creating that infrastructure. If staff plans to get to this work in future regulations, it would be helpful if that intent and context was communicated in writing so that there is a record for the future.

Omissions and Errors Inconsistent with the Statute

- Silent on Health Systems or Hospital Systems

Health care organizations make many of their strategic and financial decisions at the health system level where they also hold centralized financial assets, such as reserves. The existing HCAI data set which we anticipate OHCA will use to provide part of the understanding on health system financials focuses on individual hospitals and is not sufficient to provide information on hospital systems. We know from a robust literature specific to California that consolidation of health systems, involving not just hospitals but physician practices and more services, is driving health care costs across California without improving quality, mortality, or equity. Yet these regulations appear to default to the existing, inadequate HCAI data. If there is a plan to correct this at a later date or in a later set of information, that has not been discussed. Not taking into account the many hospital and health systems in California is a glaring omission.

- Attribution to Physician Organizations Captures Only a Quarter to a Half of Californians with commercial coverage or Medi-Cal managed care and not consistent with the law.

The primary data source for the attribution addendum appears to be the list of Risk Bearing Organizations regulated by DMHC plus 35-40 other physician organizations. RBOs serve 2.6 million of 19.8 million Californians with commercial coverage and 5.6 million of the 14.1 million Californians in Medi-Cal managed care, thus totaling 8.2 million of the 33.9 million Californians in commercial coverage or Medi-Cal managed care, or a quarter of

Californians[1]. While it seems unlikely that the other 35-40 physician organizations listed in the addendum serve another quarter of Californians, there is no readily available public data source on these physician groups. Charitably we assume that the attribution addendum reaches as much as 50% of California consumers but it could be as little as 25% or 30%. It is not clear from the written materials that the attribution addendum is a living document that will be added to and improved over time. Without that context, it appears that these regulations will miss the care delivered to most Californians.

The law is clear: it includes every physician organization with 25 or more physicians. Nowhere in the regulations or the presentation was there any mention of how OHCA intends to comply with the law. The proposal to account for any physician organization with 1,000 or more consumers for a particular payer is not consistent with the law.

Also, the attribution addendum makes no effort to determine the affiliation of these physician organizations even though many are plainly associated with health systems and some, such as Optum, with health plans. An affiliation registry is an important tool in Massachusetts and should be a goal here as well.

If there is a plan to develop a registry of physician organizations consistent with the law, there is no indication of that in the presentation or the regulations. Without this, we stand opposed to these regulations as directly contrary to the language of the law.

- Medi-Cal providers are largely absent.

For reasons not explained in any public document, there is a delay in collecting information on Medi-Cal managed care plans.

No mention is made of community clinics (though a few are in the attribution addendum) or county hospital systems, even though Los Angeles County Department of Health Systems is one of the top employers of physicians in California and other county hospital systems are similarly large players in their counties.

While much of our focus has been on the runaway costs in the commercial sector which are hurting those California consumers who rely on the most common and most regressive form of coverage, employer coverage, we acknowledge that Medi-Cal which serves 14-15 million out of 39 million Californians is an important part of the picture of the cost of health care in California.

- Contrary to the statute, Kaiser is treated as a black box.

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1 https://www.dmhc.ca.gov/Portals/0/Docs/DO/FSSBNov2023/AgendaItem10.ProviderSolvencyQuarterlyUpdate.pdf and https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Medi-Cal-at-a-Glance-July2023.pdf

The law says that Kaiser must produce information comparable to other payers. Health and Safety Code 127502 (i) (2) states:

> 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.

Yet, on p. 44 of the data submission guide, "payments to integrated, comprehensive payment and delivery systems" are to be reported as "global budgets or full/percent of premium payments in integrated systems", again directly contrary to the letter and spirit of the law. This is a single number, not broken out by benefit category. If OHCA's intent is different, as suggested in the Advisory Committee discussion on November 30, 2023, then that should be explicit in the regulations. Kaiser consistently fails to provide information by benefit category to the Department of Managed Health Care in the rate review process, contrary to explicit requirements in law to do so.

Kaiser serves 8.5 million Californians. In some market segments and some regions, it exceeds 40% of the enrollment. It is a major player in terms of cost, quality and equity. To treat its costs as a black box not capable of comparison with other payers and other health systems is not consistent with the law or the intent of OHCA.

- Consumer Cost-Sharing by Benefit Category

While Health Access appreciates the staff's inclusion of a new "Member Responsibility" field in the TME specification, from a consumer perspective, this critically important information should not be limited to a single data-point of aggregate cost sharing. Consistent with the discussion of Alternative Payment Methods and the emphasis on primary care and behavioral health, consumer cost sharing barriers to appropriate and necessary care should be tracked and monitored. Covered California benefit design which advantages primary care and generic drugs with significant cost barriers for emergency care and hospitalization is a good example of the use of benefit design to encourage the use of primary care. A single data point on consumer cost sharing will not allow OHCA to see whether it is achieving its goals of achieving consumer affordability along with encouraging primary care and behavioral health.

Health Access strongly recommends that the aggregate claims data provided by payers by benefit category (for example, hospital inpatient, hospital outpatient, professional, retail pharmacy) should be segmented into "Payer Paid" and "Member Paid" amounts, which would equal the "Allowed Amount" presently proposed. This segmentation will allow Californian policymakers to not only understand the extent to which health care costs are being directly borne by Californians, but also what types of services are driving these costs.

- Capturing health care system spending in a delegated health care system

OHCA and the cost growth target program can and should account for profits and administrative costs embedded within each layer of health care service delivery delegation present in the California market. However, the regulations and the data submission guide do not describe how OHCA intends to capture the cost for the layers of payer and provider administration that are often present in the premium paid to a member's "Directly Contracted Plan". Delegation in the California health care market has the potential to hide significant costs in layers of overhead, and it is unclear how those costs will be reflected in California's health care cost target program.

- Attributing patients to physician organizations: Problems Caused by Each Payer Choosing its own Methodology

From the language of the regulations, it appears that each payer is free to choose the methodology to use to attribute patients to physician organizations. If this is the approach, it will lead to a Tower of Babel in which the most basic information underlying "total" health care expenditures is a methodological mess. The current methodology allows many payers to use payer-specific methodology: this is problematic even as a baseline that will allow comparison year over year.

- Medi-Cal Fee-For-Service and traditional Medicare Omitted

Nowhere in any presentation or the regulations is there a description of how OHCA intends to gather information on Medi-Cal fee-for-service, about 1.4 million Californians as of July 2023[2] or traditional Medicare, serving 3.4 million Californians[3]. If OHCA intends to collect this information directly from DHCS and CMS, then OHCA should say so in written documents such as presentations. We acknowledge the verbal statements by staff at the Advisory Committee the day before the deadline for written comments but nowhere in writing is there a reference for future discussions.

- Insurer Profits and Administrative Costs

Similarly, nowhere in any presentation or the regulations is there a description of how OHCA intends to gather information on insurer and health plan profits and administrative costs, as the law requires. If OHCA intends to collect this information directly from DMHC and CDI, then OHCA should say so in written documents such as presentations. We again

[2] https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Medi-Cal-at-a-Glance-July2023.pdf
[3] https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

acknowledge the verbal statements by staff at the Advisory Committee the day before the deadline for written comments.

Provisions We Support

Health Access supports reporting spending by the 17 of the 19 Covered California regions which are also used for rating in the broader individual and small group market as well as the SPAs used in Los Angeles County. Most of these regions have populations comparable to the population of states such as Oregon and Rhode Island.

We also support having data on benefit categories such as hospital inpatient, hospital outpatient, physician services by payer and by region though we have specific comments on conforming the data submission guide to existing California law and excluding provisions that are in violation of California hospital licensing requirements (see below).

Other Questions and Areas of Concern: Data Submission Guide

Health Access offers additional comments to assure that the data submission guide to be consistent with state law.

- Section 3.1,3.2, 3.3 Total Medical Expenditures: Will these also be broken out by benefit category as well as geographic region and market category?
- Section 4: Definitions:
    - "Attribution Method": to the best of our knowledge, accountable care organization is not defined in state law. So what definition is used for this?
    - "Capitation and Full Risk Payments": the law requires that fully integrated delivery systems provide information that allows comparison to other payers.
    - "Hospital Inpatient" and "Hospital Outpatient": California law does not permit "outpatient observation stays": if a patient stays more than 23 hours and 59 minutes in a hospital, then the patient is admitted to the hospital. Delete "outpatient observation stays" to be consistent with state law on facility licensure. While other states may have different laws on this topic, OHCA's regulation should be consistent with California law.
    - Long-Term Care: does this include IHSS? If so, please state.
    - Run-Out Period: is 180 days consistent with the prompt pay sections of the Knox-Keene Act?
- Section 5: General Information: Claims and Non-Claims Payments: again is 180 days consistent with the prompt pay provisions of the Knox-Keene Act?
    - Section 5.4: Member Attribution: The regulation states that the "members must only be attributed to one organization at any given time". Does this reflect the actual complexity of care delivery in California?

- Section 5.4.3 and 5.4.4: Member Attribution to an organization not listed in the Attribution Addendum: will OHCA be adding organizations to the Attribution Addendum as it receives information about those organizations? If so, say so.
- Section 5.5 Self-insured plans: "fees from *uninsured* plans": we are not familiar with this phrase, and it is not otherwise recognized in state law or regulation. Most self-insured plans do in fact purchase stop-loss insurance, so they are not truly "uninsured". Is this the appropriate phrase or would it be more appropriate to refer to "self-insured plans" that are not state-regulated?
- Section 5.5 Self-insured plans: Does this also include CalPERS, VEBAs and other self-insured plans subject to Health and Safety Code 1349.2?
- Section 5.6 Specialty or Carved-Out Services: As drafted this is likely too confusing or unhelpful results.

- Appendix A:
  - Hospital Inpatient: California law requires that "observation stays" are hospital inpatient care. Please delete "outpatient observation services".
  - Hospital Outpatient: In California, a critical access hospital provides inpatient care. Please delete "critical access hospital" from "hospital outpatient".
  - Other: "Licensed Freestanding Emergency Facility": Again, California law does not permit a freestanding emergency facility. Please delete "freestanding emergency facility". It does not exist in California.
- Appendix B: It would be helpful to remind payers of the need to comply with the Knox-Keene Act with respect to risk-bearing organizations.

We appreciate your consideration of our comments and are happy to answer any questions. We thank you for the opportunity to comment on draft emergency regulations early in the process of the development of those regulations.

Sincerely,

[redacted]

Beth Capell, Ph.D.
Policy Consultant

[redacted]

Anthony Wright
Executive Director

CC: Members, Health Care Affordability Board
Assemblymember Robert Rivas, Speaker of the Assembly
Senator Toni Atkins, Senate President Pro Tempore
Assemblymember Mia Bonta, Assembly Health Committee Chair
Senator Susan Eggman, Senate Health Committee Chair

AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

December 1, 2023

APG Comments on Total Health Care Expenditures Data Collection

Submitted electronically to: Megan Brubaker OHCA@HCAI.CA.GOV

America's Physician Groups is a national association representing more than 335 physician groups with approximately 170,000 physicians providing care to nearly 90 million patients. APG's motto, 'Taking Responsibility for America's Health,' represents our members' commitment to clinically integrated, coordinated, value-based healthcare in which physician groups are accountable for the costs and quality of patient care. We appreciate the opportunity to comment on this proposed data collection regulation.

Establishing a Level Playing Field for Monitoring the Provider Market: APG had significant concerns during the drafting of the OHCA legislation that the Risk Bearing Organization ("RBO") and Restricted Licensees ("RKK") would not be the sole focus of market cost trend oversight within the physician organization sector, simply because it is easier to pull information on these entities through Department of Managed Health Care databases, while for other types of provider groups, there is no means of systematic data collection. Our concern was heightened again when the proposed OHCA Attribution Addendum was released for comment on October 27th and contained only RBO and RKK organizations. Since that time, we acknowledge statements from OHCA staff that it is not their intention to single out this corner of the physician organization market. We have provided a further list of California medical groups under separate cover to the Office staff. We hope this is helpful to your effort to identify other entities that fit within the 25 or greater physician range but that are neither capitated nor identified as an RBO by the Department of Managed Health Care. As pointed out during the November 30 Advisory Committee meeting, some large physician organizations operate under fee-for-service models within 1206L foundations, which are not classified as RBOs under the enacting statute, SB 260 (Speier 1999).

Potential Need to Further Clarify the Designation of "25 or more Physicians:" Some APG members expressed confusion over the method of identifying whether a physician organization has 25 or more physicians. Some organizations contract with licensed physicians and surgeons on a less than FTE basis. Others have employed models. Medical group models can be organized on shareholder basis, with non-shareholder employed or contracted physicians as well. Another commenter asked whether a group that had 25 physicians for only a short period of time during a full calendar year should be counted. We can only suggest that one method to potentially clarify any ambiguity is to rely on the annual network data files submitted by plans to the DMHC on May 31st each year. Non-RBO Providers contracted under

Knox Keene Health Care Service plans are required to provide updated information on their practices on a semi-annual basis.

Submission of Member Attribution Data under Section 5.4: APG had initially thought that a standardized method of provider attribution would be preferrable to allowing submitters to use their own methodologies. Upon further explanation by OHCA staff at the November 30 Advisory Committee meeting, we now better understand the Office's thinking in gathering this provider network information under each plan's own unique attribution method. We noted comments from one Committee member that indicated it was cumbersome from the provider organization perspective to respond to ACO plan enquiries under a

We do wish to note, however, that the Office's secondary identification tier under Member Attribution, subsection 2, directs submitters to the OHCA Attribution Addendum. Since this addendum only contains global risk and RBO entities at present, it's important to acknowledge that RBOs, by definition, do not participate in fee-for-service based ACO Arrangements. An IPA model that is capitated for HMO business may create a separate clinically integrated network that can be used in an ACO Arrangement, but this is not the RBO entity that is identified under the current Attribution Addendum. The subsection that we refer to is stated as follows:

> *2. Next, attribute remaining members to a total cost of care ACO arrangement that includes an organization listed on the OHCA Attribution Addendum. Report data for these members using the ACO Arrangement attribution method.*

It is very likely that non-capitated, non-RBO physician organizations exist that have less than 1,000 attributed members of the submitter but do have 25 or more physicians. We encourage the Office to seek input from state and national provider databases to identify these organizations, and to create a separate tier for submitters.

Thank you for the opportunity to provide comments on this proposed regulation. We are available for questions at your convenience.

Sincerely,

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