HCAi
Department of Health Care Access and Information

FREQUENTLY ASKED QUESTIONS: OFFICE OF HEALTH CARE AFFORDABILITY

What is the Office of Health Care Affordability?

Established in 2022, the Office of Health Care Affordability (OHCA) analyzes California's health care market for cost trends and drivers of spending, enforces health care cost targets, and conducts cost and market impact reviews of proposed health care consolidations. A new Health Care Affordability Board will advise on key activities and approve specific aspects of OHCA's work, with input from an Advisory Committee and the public. To prevent unintended consequences associated with the cost targets, OHCA will measure and publicly report on quality, equity, adoption of alternative payment models, investment in primary care and behavioral health, and workforce stability.

In creating OHCA, California joins a growing number of states using health care cost growth targets or benchmarks to address affordability. At least nine states have taken this path, focusing on statewide targets, data collection and public reporting on total health care expenditures, and analysis of detailed claim-level data to better understand cost drivers. See the resources section for more information about related activities in other states.

What is the role of the Health Care Affordability Board? How are members selected and when will they begin meeting?

The Health Care Affordability Board (Board) is a decision-making body charged with setting the statewide and sector-specific cost growth targets, among other responsibilities. The Board has eight members: California's Health and Human Services Secretary, the CalPERS Chief Health Director (non-voting), four appointees from the Governor's Office, and one each from the Assembly and the Senate. Members may not receive compensation from health care entities.

Other responsibilities of the Board include appointing a Health Care Affordability Advisory Committee; approving key benchmarks, such as statewide goals for alternative payment model adoption and share of spending dedicated to primary care and behavioral health; and approving the scope and range of administrative penalties and penalty justification factors to apply in enforcing the cost targets.

It is anticipated that the Board members will be selected by the end of 2022 and will begin meeting during the first quarter of 2023. The Board will meet at least quarterly, or at the call of the chair. Meetings are subject to the Bagley-Keene Open Meeting Act.

The Board may hold closed sessions when considering administrative penalties, performance improvement plans, or nonpublic information.

What is the role of the Health Care Affordability Advisory Committee? How are members selected and when will they begin meeting?

The Health Care Affordability Advisory Committee may make recommendations but does not have decision-making authority or access to non-public information. Advisory Committee members will be appointed by the Board, with representation to include consumer and patient groups, payers, fully integrated delivery systems, hospitals, organized labor, health care workers, medical groups, physicians, and purchasers. Assuming the Board begins to meet in the first half of 2023, the Advisory Committee may begin to meet in the second half of 2023. The Advisory Committee will meet at least quarterly, or when requested by the Board. Meetings are subject to the Bagley-Keene Open Meeting Act.

Who is required to submit data to OHCA? What data must be submitted?

OHCA's first public reporting on total health expenditure data will be the baseline health care spending report, which will cover calendar years 2022 and 2023. For this report, payers (including health plans, health insurers, and Medi-Cal managed care plans) and fully integrated delivery systems will submit data on total health care expenditures by September 1, 2024. As defined in statute, a fully integrated delivery system includes a physician organization, health system, and health plan and meets several additional criteria (see HSC 127500.2(f)); Kaiser Permanente is the only health care entity that meets the definition.

In 2023, in advance of the data submission deadline, OHCA will undertake an emergency regulations process, including obtaining input from stakeholders through regulations "workshopping," and develop data specifications and guidance for submitters. OHCA will present the key findings of the baseline health care spending report at a public meeting of the Board and will release the baseline report by June 1, 2025.

Following baseline health care data submission, it is anticipated that payers and fully integrated delivery systems will submit total health care expenditure data on an annual basis on a reporting schedule set by OHCA.

Additional data will be needed for OHCA to implement the legislation. When all legislative provisions are fully implemented, OHCA will monitor quality, equity, spending on primary care and behavioral health, adoption of alternative payment models, and workforce stability. Existing data from the Healthcare Payments Data Program, the Department of Managed Health Care, the Department of Health Care Services, Covered California and other sources will be leveraged to reduce the need for new data collection.

What are cost growth targets? When will they take effect?

Historically, growth in health care costs has substantially exceeded overall economic growth in California. Without bringing health care cost growth down, spending on health care will continue to crowd out other important investments by state and county governments and priorities in household budgets. A statewide health care cost growth target creates a clear expectation about an acceptable rate of growth. For example, Oregon's annual target is 3.4% through 2025, then 3.0% annually for the next five years.

Initially, California's target will be set at a statewide level. The Board will set a cost growth target for each year, with consideration of multi-year targets to support long-term planning. The cost target percentage will consider economic indicators such as the gross state product, household income, and the consumer price index; targets may also consider population indicators such as aging. The target-setting methodology may allow adjustments for relevant factors such as labor costs and relevant federal and state policy changes impacting covered benefits and provider reimbursement. The initial target will not rely on data submitted by health care entities, but subsequent targets and/or sector-specific targets may take such data into account.

The Board will set the first statewide target, for 2025, by June 1, 2024. Progress against the target will be publicly reported in the first Annual Report to be released in June 2027. The 2025 target will not be subject to enforcement, and the results are for reporting purposes only; enforcement will begin with the 2026 target (for which results will be reported in 2028).

The Board also may develop targets that apply to specific sectors, such as geographic regions, as well as targets specific to fully integrated delivery systems, types of health care entities and individual health care entities. The Board will define sectors by October 1, 2027, and set sector-specific targets by June 1, 2028.

Who will be subject to the cost targets?

All health care entities – payers, providers, and fully integrated delivery systems – will be subject to the cost targets, except for exempted providers. The Board will set the standards for exemption from statewide and sector-specific cost targets, considering factors such as annual revenue, patient volume, and high-cost outlier status in a geographic region or service line. Physician organizations with fewer than 25 physicians are exempt unless the practice is a high-cost outlier.

How will OHCA ensure the cost targets don't lead to unintended consequences, such as wage cuts?

The enabling legislation includes several provisions to guard against unintended consequences of cost targets. OHCA will track key elements of system performance,

including quality, equity, workforce stability, adoption of alternative payment models, and investment in primary care and behavioral health.

For example, OHCA is charged with monitoring health care workforce stability with the goal that workforce shortages do not undermine affordability, access, quality, equity, and culturally and linguistically competent care. By July 2024, OHCA will develop standards to advance the stability of the health care workforce. The Board may consider those standards in setting cost targets or in approving performance improvement plans. OHCA will also establish a process to adjust cost targets based on organized labor costs.

Other key provisions include:

- OHCA will measure and publicly report on performance on quality and equity indicators, leveraging quality and equity metrics used by the Department of Health Care Services, the Department of Managed Health Care, and Covered California.

- The Board will set a statewide goal for adoption of alternative payment models that promote shifting payments from fee-for-service to payments that reward high quality and cost-efficient care. OHCA will measure progress towards the goal and adopt standards for alternative payment models.

- OHCA will measure and promote a sustained systemwide investment in primary care and behavioral health. The Board will adopt spending benchmarks for the percentage of total health expenditures allocated to primary and behavioral health care, and OHCA will measure and publicly report on performance against the benchmarks.

What happens if the cost targets are not met?

Compared to other state health care cost benchmarking programs, California's law provides stronger enforcement authority. The progressive stages of enforcement are intended to support health care entities to meet the cost targets, with increasing scrutiny of costs and performance improvement expectations, followed by financial penalties if cost growth does not come in line with the target. The specific steps outlined in statute are:

- technical assistance, such as analysis of cost drivers or identification of best practices

- public testimony

- a performance improvement plan

- financial penalties “in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.”

The first enforcement period will be on the 2026 statewide cost growth target. Data collection will take place in 2027 and public reporting in 2028. Based on that timeline, the soonest enforcement actions would take place would be sometime in 2028.

What are Cost and Market Impact Reviews?

Consolidation in California’s health care market is growing, with potential implications for cost, access, and affordability. In response, OHCA will monitor the impact of market consolidation on cost trends and will evaluate and review prospective transactions that could adversely impact competition and affordability in California’s market.

Starting in January 2024, health care entities will be required to provide OHCA with 90-day advance notice of material changes in ownership or governance such as mergers, acquisitions, and corporate affiliations.

OHCA will decide within 60 days whether to conduct a cost and market impact review or issue a waiver from the review. If the transaction or other material change is likely to have a significant impact on market competition, the state’s ability to meet cost targets, or costs for purchasers and consumers, OHCA will conduct a cost and market impact review. Upon completion of the review, OHCA will make its findings public and issue a preliminary report. After allowing affected parties and the public to respond to the preliminary report, OHCA will issue a final report. The transaction that triggered the cost and market review may not be implemented until 60 days after OHCA issues its final report. Based on the results, OHCA will then work with other state agencies to address market consolidation as appropriate.

In 2023, OHCA will undertake a regulations development process to define the key provisions of the cost and market impact review program, including material changes that warrant notification, thresholds (e.g., annual revenues or market share) for determining which health care entities or prospective transactions will be subject to the noticing requirements, factors to be considered in the reviews, requests for data, and relevant timelines. OHCA plans to convene regulations “workshopping” sessions to gather input from stakeholders prior to finalizing the regulations.

How is OHCA different from the Health Care Payments Data Program?

The Health Care Payments Data Program (HPD), housed at HCAI, is California’s All-Payer Claims Database (APCD). The HPD, which is on target to reach substantial completion in July 2023, gathers claims and encounter data from the commercial market, Medi-Cal, and Medicare. The granular data available through the HPD supports detailed analysis of utilization and spending patterns; variation across payers,

geographic regions, populations, and care settings; and investigation of cost drivers such as inpatient services or prescription drugs.

OHCA will track aggregate cost growth and assess the performance of health care entities against the cost growth target. It is anticipated that data will be submitted annually. OHCA will collect total health care expenditure data broken down by service category (e.g., hospital, physician services, prescription drugs, etc.). As in all states that have both a cost growth target program and an APCD, payer submission of the THCE data is needed to capture information not available in the HPD.

OHCA and the HPD Program will collaborate on data collection and reporting to ensure efforts are complementary. For example, OHCA will rely on the HPD System for detailed analyses of cost drivers. To the extent feasible, standards and measures for topics such as alternative payment models and primary care spending will align across the two programs.

How can stakeholders and members of the public get involved or stay up to date on OHCA's work?

Transparency and stakeholder engagement are central tenets of the enabling legislation and of OHCA. For example:

- Meetings of the Board and the Advisory Committee are public and subject to the Bagley-Keene Open Meeting Act: agendas will be posted 10 days in advance, and materials and minutes will be posted following each meeting.

- Findings of the baseline report and annual reports will be presented by OHCA at a public meeting of the Board and public comment will be solicited.

- Proposed cost growth targets, both statewide and sector-specific, will be posted on OHCA's website and discussed at a public meeting of the Board; the public then has 45 days to comment prior to finalization and adoption at a subsequent public Board meeting.

An early opportunity for stakeholder input on OHCA's work will be "workshopping" the 2023 regulations to support: 1) data collection from payers and fully integrated delivery systems on total health care expenditures; and 2) development of the cost and market impact review program.

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