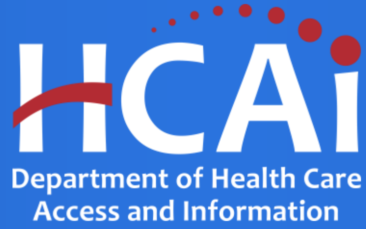

Health Care Affordability Board Meeting

March 21, 2023

1:00 p.m.	**1. Welcome and Introductions** Elizabeth Landsberg, Director • Welcome • Call to Order • Swearing in of Board Members • Establish Quorum • Opening remarks by Board Members
1:10 p.m.	**2. Board Orientation** Elizabeth Landsberg, Director Vishaal Pegany, Deputy Director, OHCA • Overview of HCAI • Context for the Office of Health Care Affordability: Current State in California • Overview of the California Health Care Quality and Affordability Act • Board Roles and Responsibilities • Review of Board Manual
2:20 p.m.	**3. Bagley-Keene Open Meeting Act and Conflict of Interest Overview** Jean-Paul Buchanan, Attorney
3:00 p.m.	**4. Election of a Chair** Elizabeth Landsberg, Director
3:30 p.m.	**5. Health Care Spending Targets** Vishaal Pegany, Michael Bailit • Introduction to Spending Targets • Review of 2023 Meeting Plan
4:30 p.m.	**6. General Public Comment**
	7. Adjournment

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Board Member Oath

Oath for the Office of Heath Care Affordability

I,_______________, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter.

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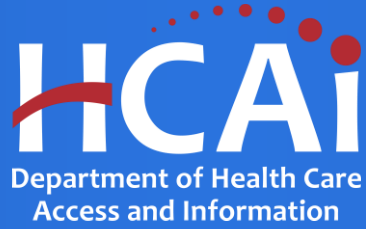
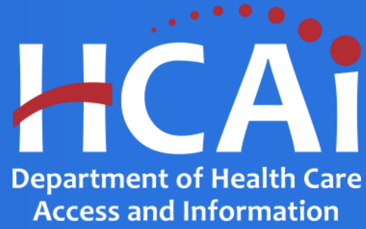


Board Member Opening Remarks



Board Orientation

Elizabeth Landsberg, HCAI Director
Vishaal Pegany, OHCA Deputy Director

HCAI Overview

- Established in 1978 as **OSHPD** — the Office of Statewide Health Planning and Development — to ensure health care accessibility in California

- Transitioned to the Department of Health Care Access and Information (**HCAI**) in 2021 to reflect a growing portfolio and a more descriptive name

Our Mission

HCAI expands equitable access to quality, affordable health care for all Californians through resilient facilities, actionable information, and the health workforce each community needs.

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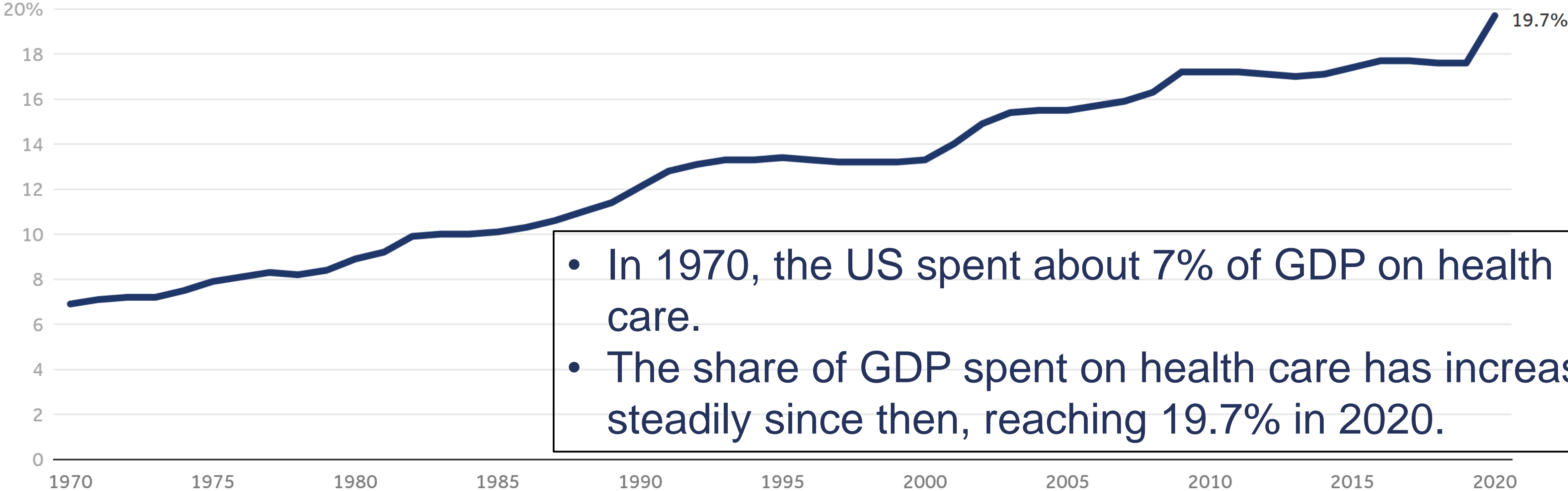
HCAI Program Areas

- **Facilities:** monitor the construction, renovation, and seismic safety of California's hospitals and skilled nursing facilities
- **Financing:** provide loan insurance for nonprofit health care facilities to develop or expand services
- **Workforce:** promote a culturally competent and diverse health care workforce
- **Data:** collect, manage, analyze, and report information about California's health care infrastructure and patient outcomes
- **Affordability:** analyze health care cost trends and drivers of spending, enforce health care cost targets, and conduct cost and market impact reviews of proposed health care consolidations

Context for the Office of Health Care Affordability: Current State in California

U.S. Health Care Spending as Share of GDP

Total national health expenditures as a percent of Gross Domestic Product, 1970-2020



- In 1970, the US spent about 7% of GDP on health care.
- The share of GDP spent on health care has increased steadily since then, reaching 19.7% in 2020.

Source: KFF analysis of National Health Expenditure (NHE) data. Available at Peterson-KFF Health System Tracker

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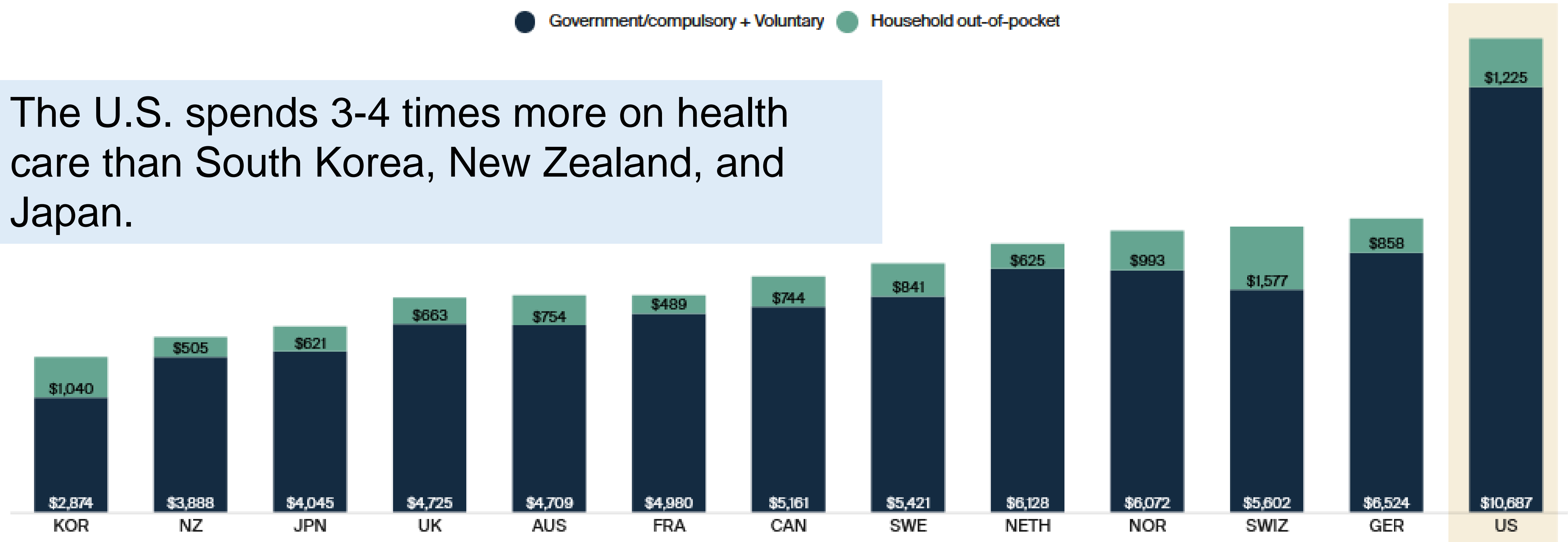
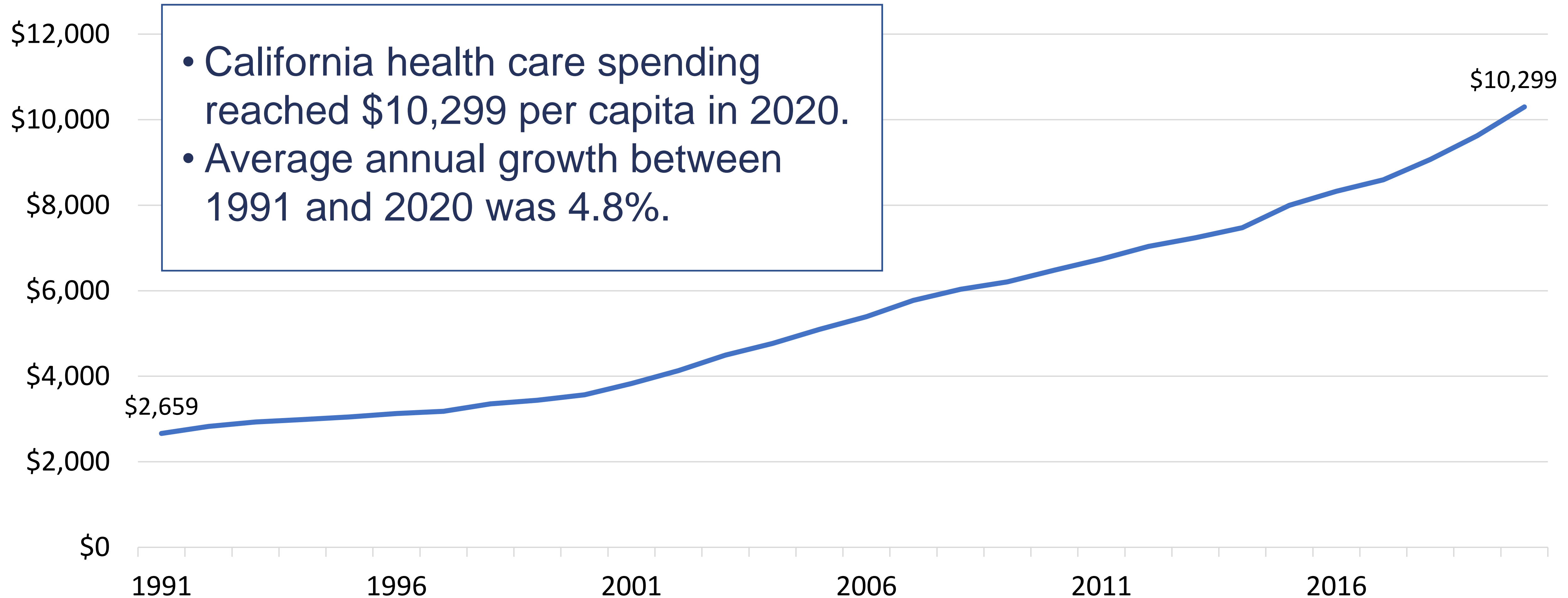
Compared to Other Wealthy Countries, U.S. Spends Substantially More For Worse Outcomes



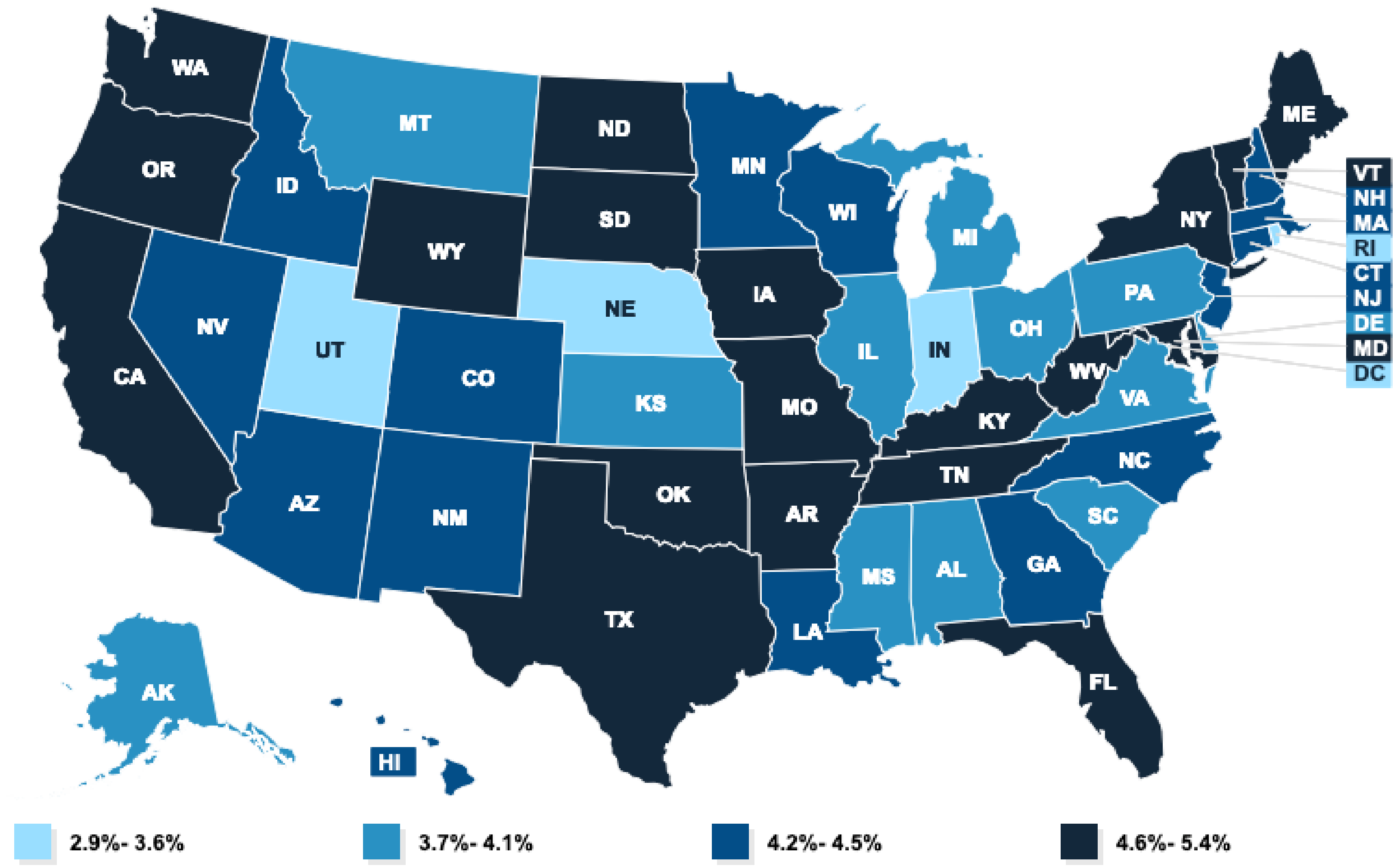
Source: Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes (Commonwealth Fund, Jan. 2023).

Per Capita Health Spending in California



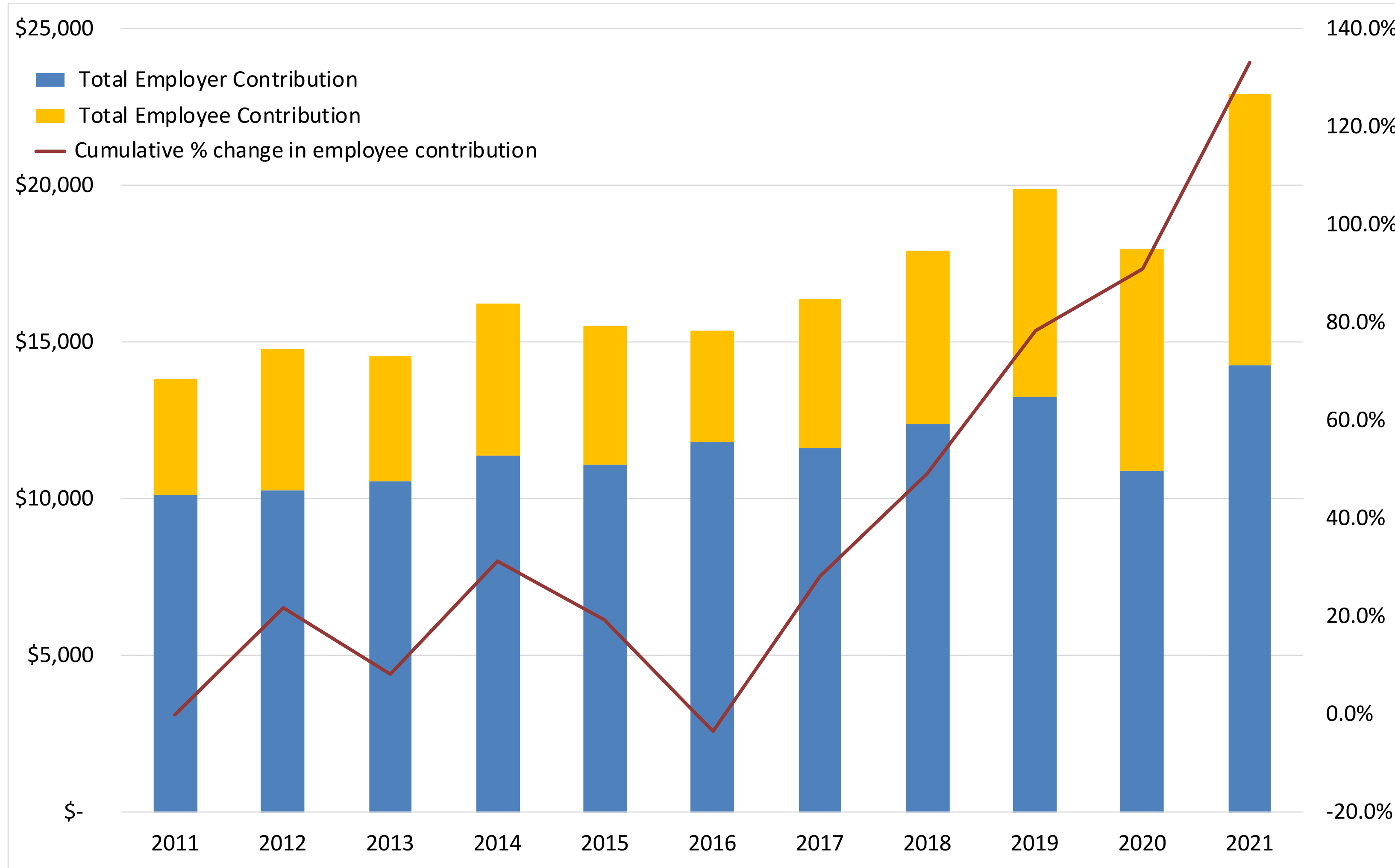
Source: "Health Expenditures by State of Residence, 1991-2020," Centers for Medicare & Medicaid Services.

CA Had Second Highest Average Annual Percent Growth Rate in Per Enrollee Spending for Privately Insured, 2001-2020 (5.1%)



Source: Kaiser Family Foundation and the Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Expenditures Group

CA Workers Bear the Burden of Increasing Health Care Costs



Total commercial premiums for Californians in small business have increased 65% since 2011.

Employee share of premiums in small businesses has grown 133% since 2011.

Note: Data are average total family premium and average total employee contribution per enrolled employee at private sector establishments with fewer than 50 employees.
Source: Medical Expenditure Panel Survey (MEPS) Insurance Component (IC)

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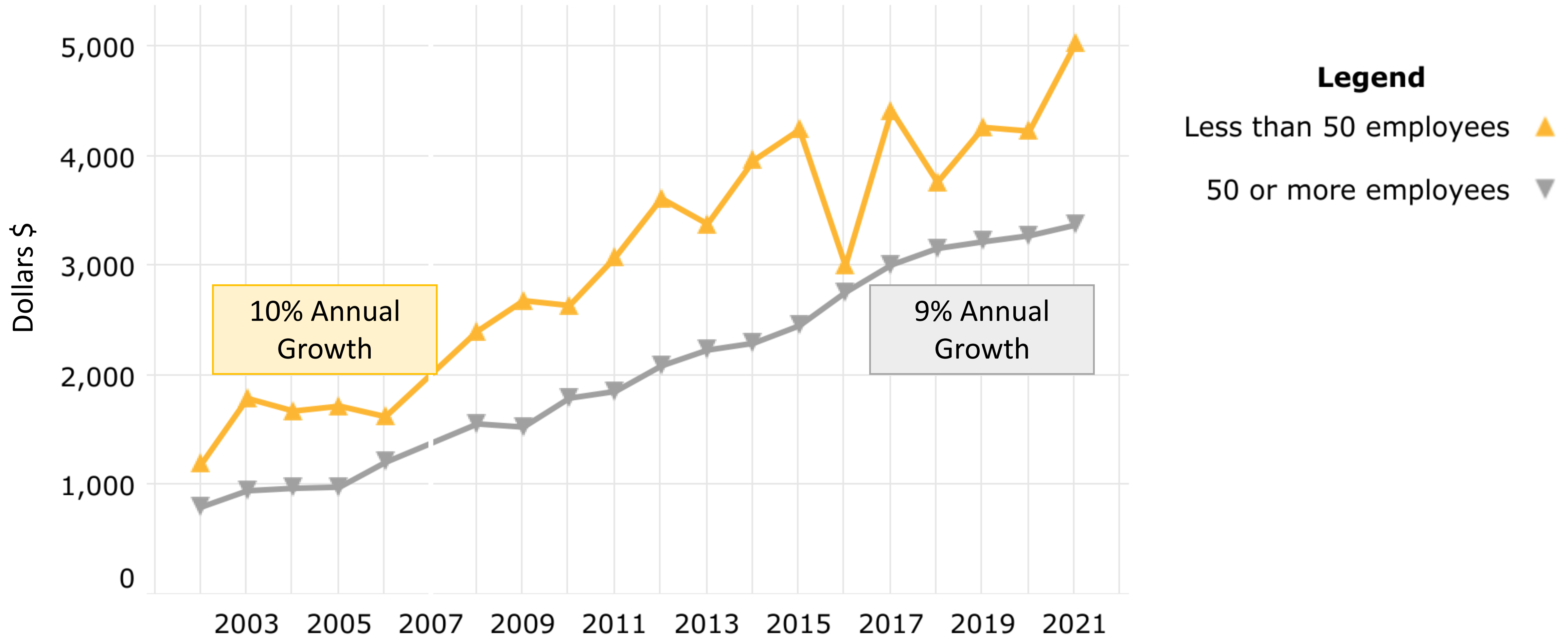
Over the Past Two Decades Family Deductibles Quadrupled



Note: 2007 data were not collected for the Insurance Component of the MEPS
Source: Medical Expenditure Panel Survey (MEPS) Insurance Component (IC)

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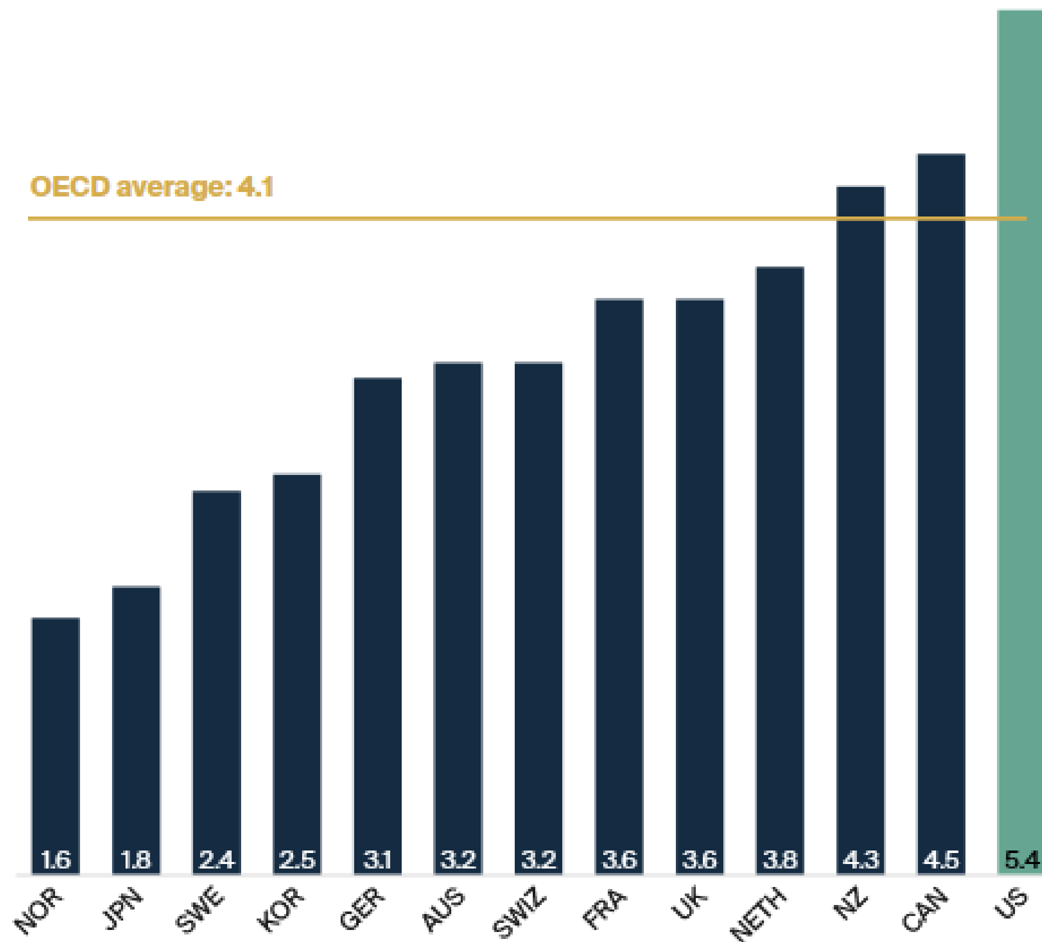
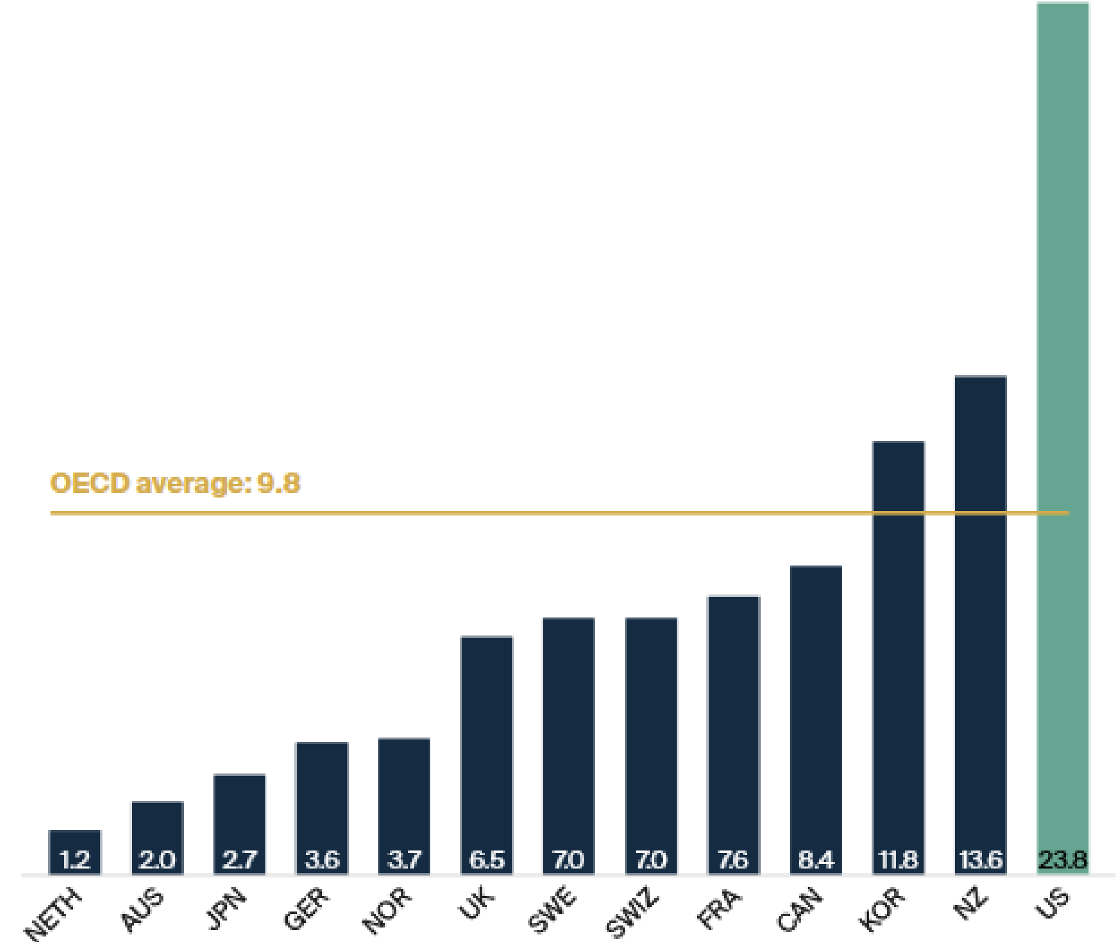
U.S. Has Highest Rate of Infant and Maternal Deaths Among OECD Countries





Source: Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes (Commonwealth Fund, Jan. 2023).

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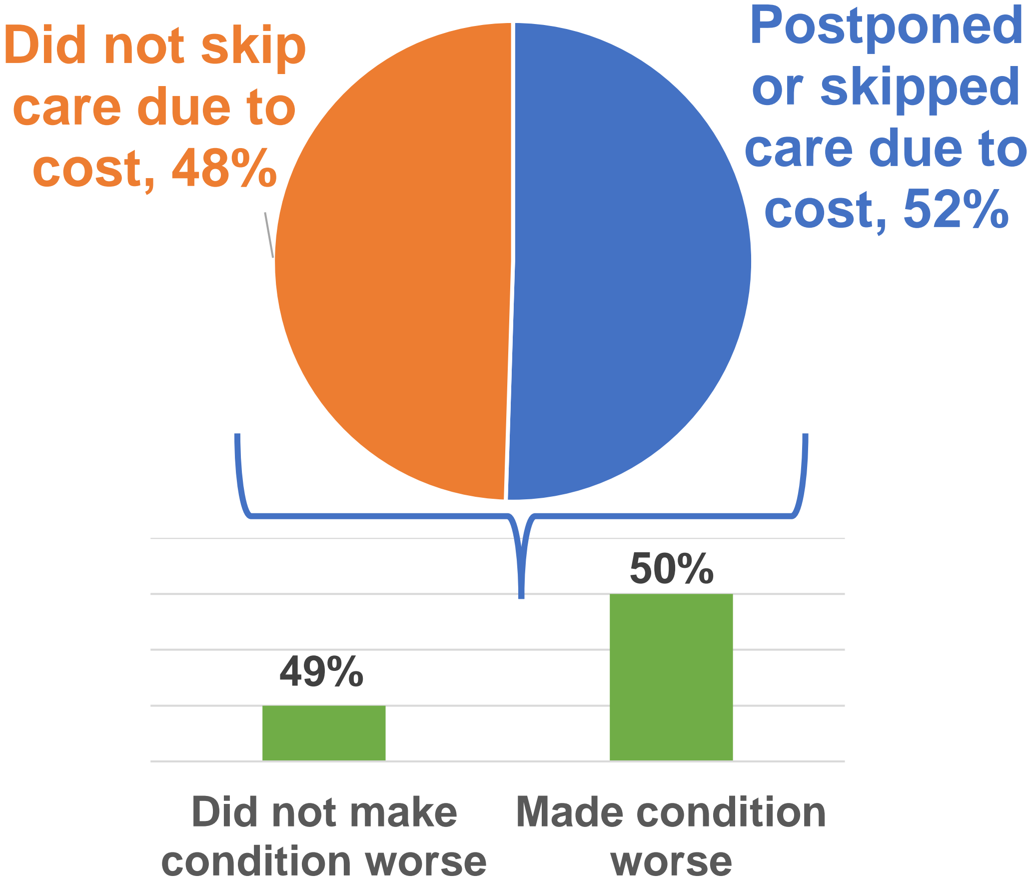
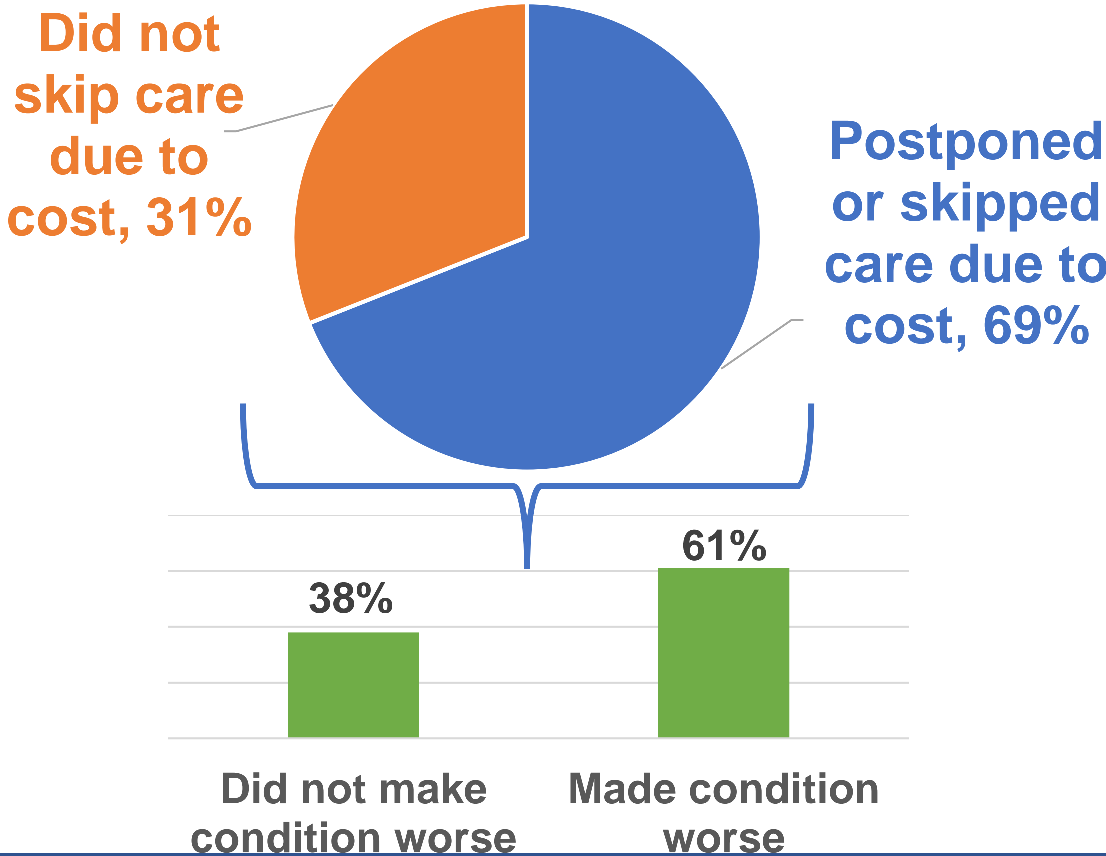
High Costs Have Created Widespread Access and Health Problems for Millions of Californians, Particularly Californians with Low Incomes





Source: CHCF/NORC California Health Policy Survey (September 30-November 1, 2022).

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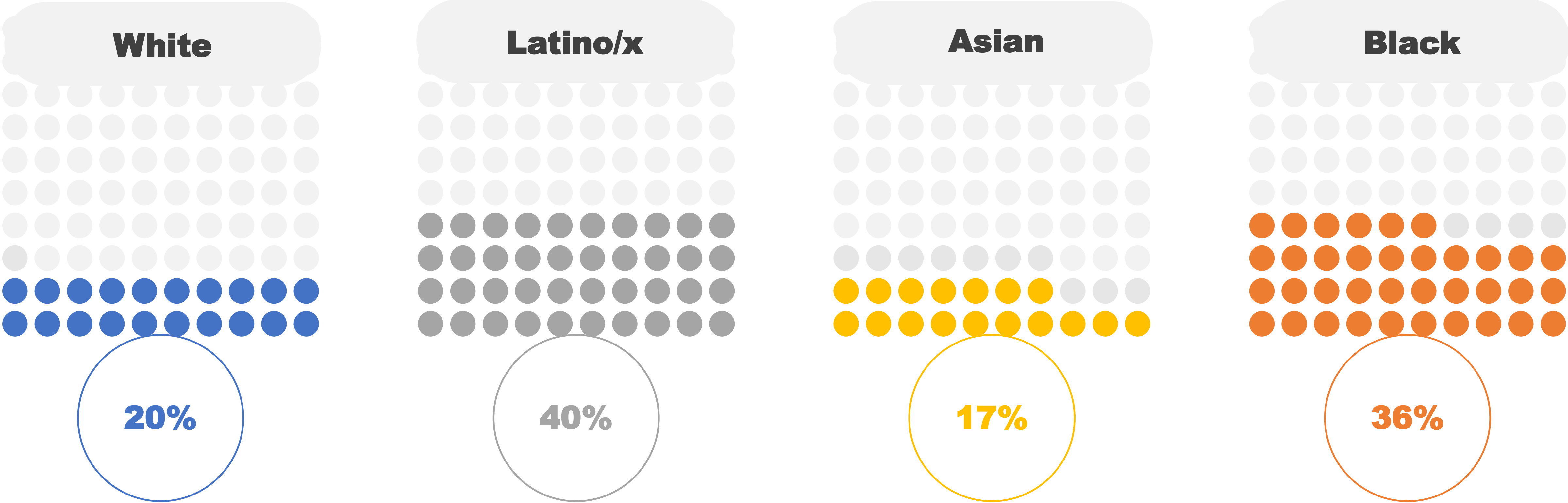
High Health Care Costs Are Disproportionately Affecting Black and Latino/x Californians

% who say that they or another family member had problems paying or an inability to pay medical bills in the last 12 months



Source: CHCF/NORC California Health Policy Survey (September 30-November 1, 2022).

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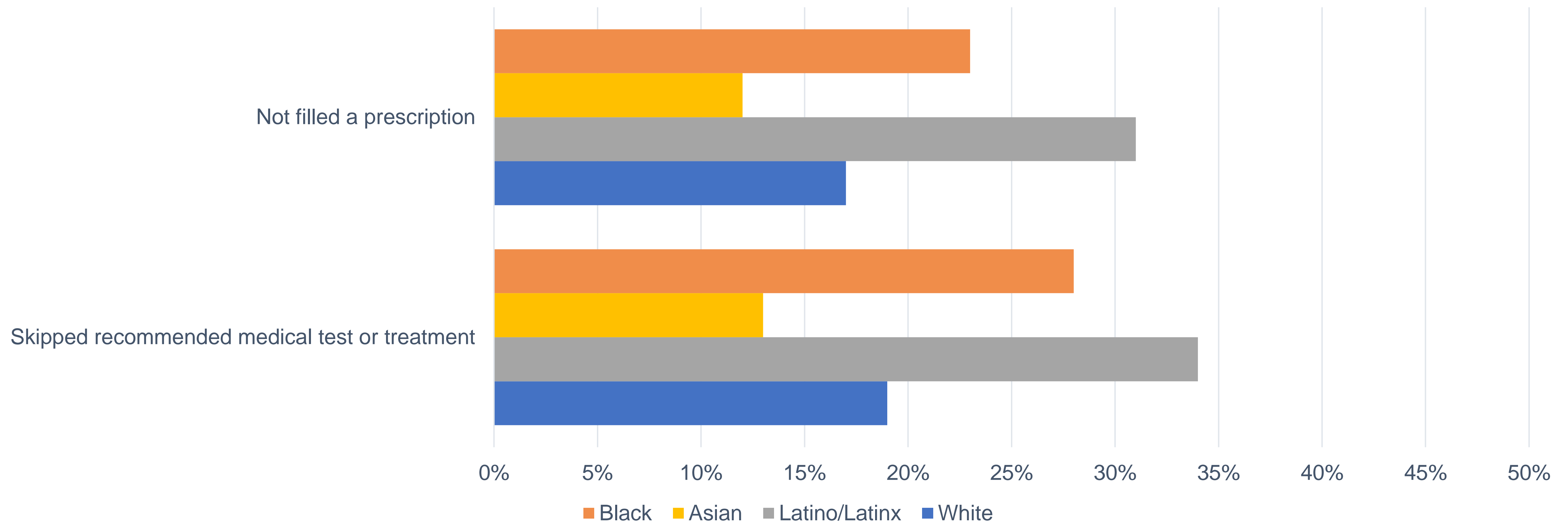
Black and Latino/x Residents Are More Likely to Skip Care Due to Costs



Source: CHCF/NORC California Health Policy Survey (September 30-November 1, 2022).

High Costs Contribute to Personal Bankruptcy

Nationally

- 67% of personal bankruptcy is caused by medical debt.
- In 2019, the U.S. Census Bureau found that Americans owe at least $195 billion of medical debt.
- Some estimate $140 billion of medical debt is in collections.

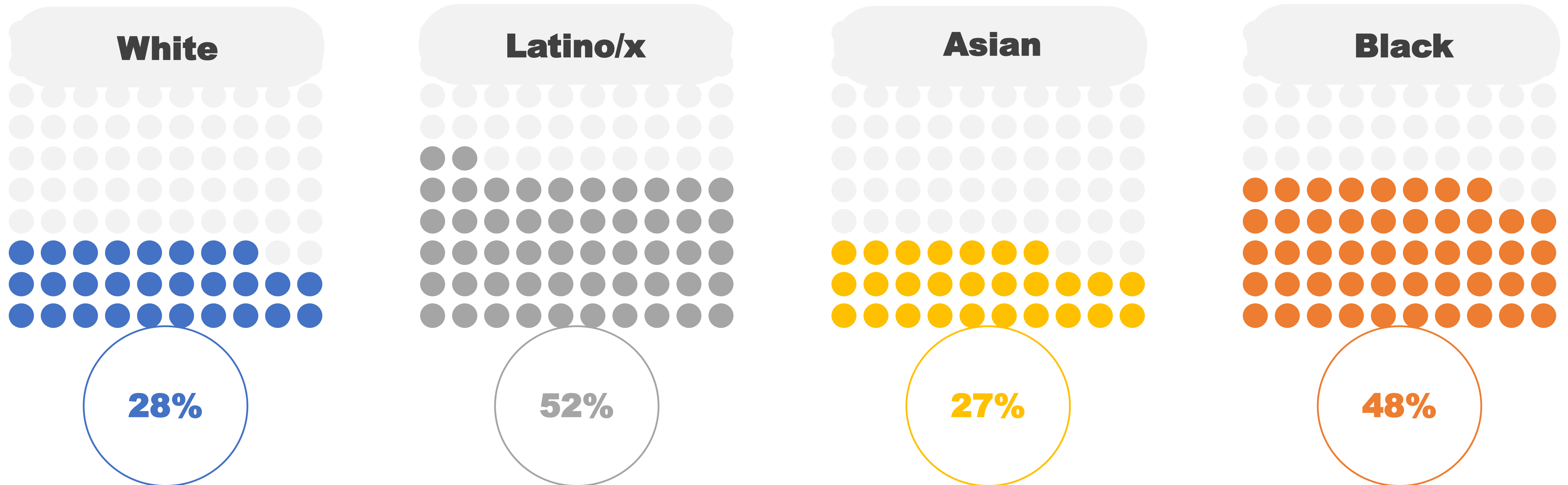
California

- 36% of Californians report having medical debt.
- 1 in 10 Californians report having trouble paying medical bills.

Sources: Urban Institute (June 23, 2022).“Debt in America: An Interactive Map.”; U.S. Census Bureau. 2019 Survey of Income and Program Participation Data.; Toddy, M. (August 18, 2021). “Medical Debt in Collection Estimated at $140 Billion.” UCLA Anderson Review.; Rabinowitz Bailey, L. et al. (February 16, 2023). “The 2023 California Health Policy Survey.” California Health Care Foundation.; Planalp, C. et al. (September 4, 2020). “Weighed Down: Californians and the Financial Burden of Health Care Coverage.” California Health Care Foundation.

High Costs Contribute to Personal Bankruptcy (cont.)

- Medical debt is more likely to be experienced by communities of color than by white communities.



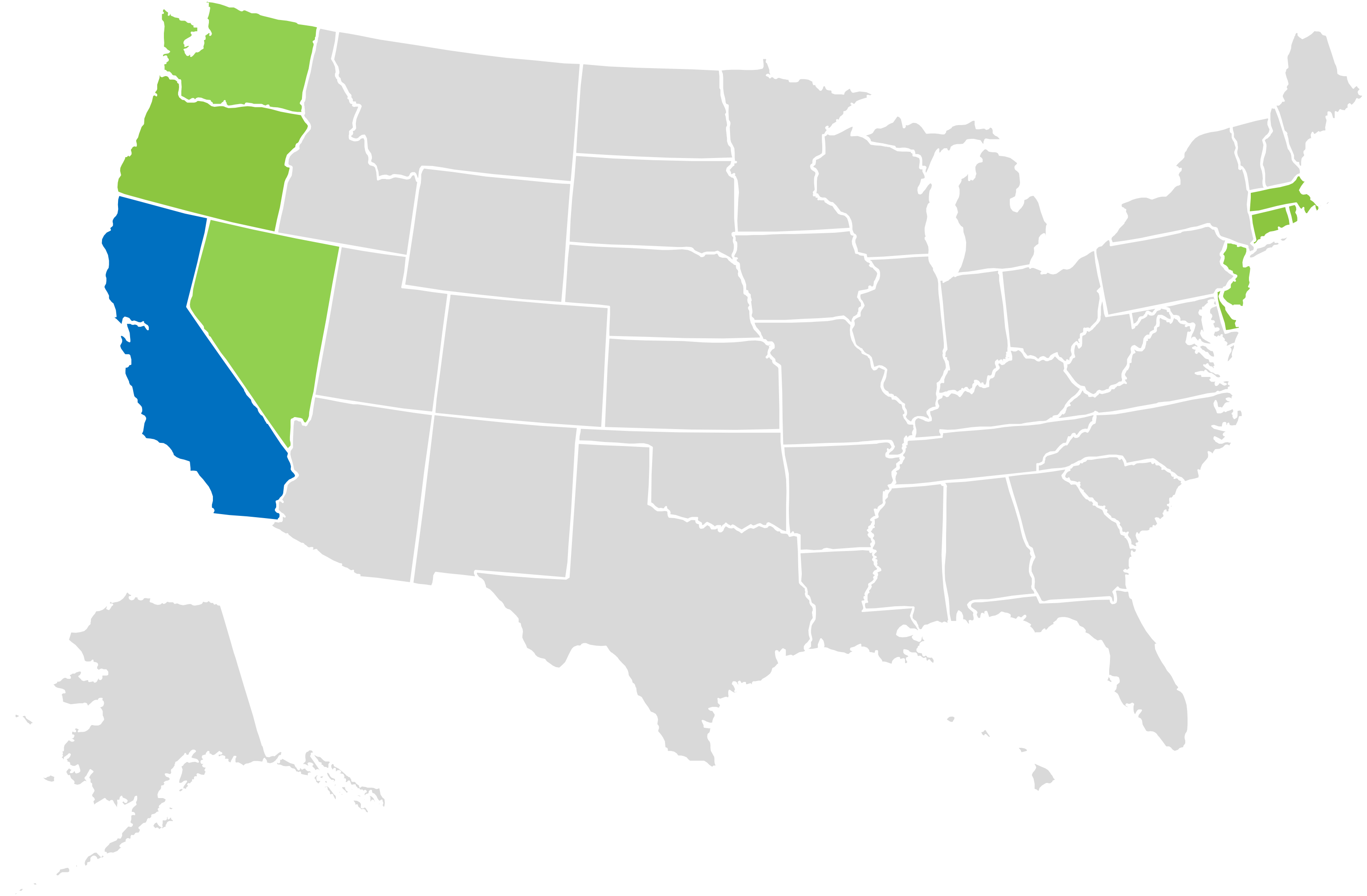
Overview of the Health Care Affordability and Quality Act and the Office of Health Care Affordability (OHCA)

Terminology

- OHCA's enabling statute and other states use different terminology, with some using "cost growth benchmark" and others using "cost growth target." These terms are synonyms and equivalent to OHCA's use of "spending target" in California.
  - "Cost benchmark": Connecticut, Delaware, Massachusetts, Nevada, New Jersey, Washington
  - "Cost target": OHCA enabling statute, Oregon, Rhode Island
- OHCA will use "spending target" and "spending growth"; however, measurement specification definitions may use "expenses" or "expenditures" (e.g., total medical expenses, total health care expenditures).

Eight States Have Established Health Care Spending Targets

- Established (CT, DE, MA, NJ, NV, OR, RI, WA)
- In progress (CA)



Key Components

Slow Spending Growth

Promote High Value

Assess Market Consolidation

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Slow Health Care Spending Growth

Collect, analyze, and report data on total health care expenditures

Develop spending target methodology and spending targets, initially statewide and eventually sector-specific (e.g., geography, types of entities)

Progressive enforcement of targets: technical assistance, public testimony, performance improvement plans, and finally, escalating financial penalties

Health Care Entities Subject to the Spending Target

Payers	Providers	Fully Integrated Delivery System
•Health plans, health insurers, Medi-Cal managed care plans •Publicly funded health care programs •Third party administrators •Other entities that pay or arrange for the purchase of health care services	• Physician organizations • Health facility, including acute care hospital • Outpatient hospital department • Clinic, general or specialty • Ambulatory surgery center • Clinical laboratory • Imaging facility	• A system that includes a physician organization, health facility or health system, and a nonprofit health care service plan, and meets specific additional criteria

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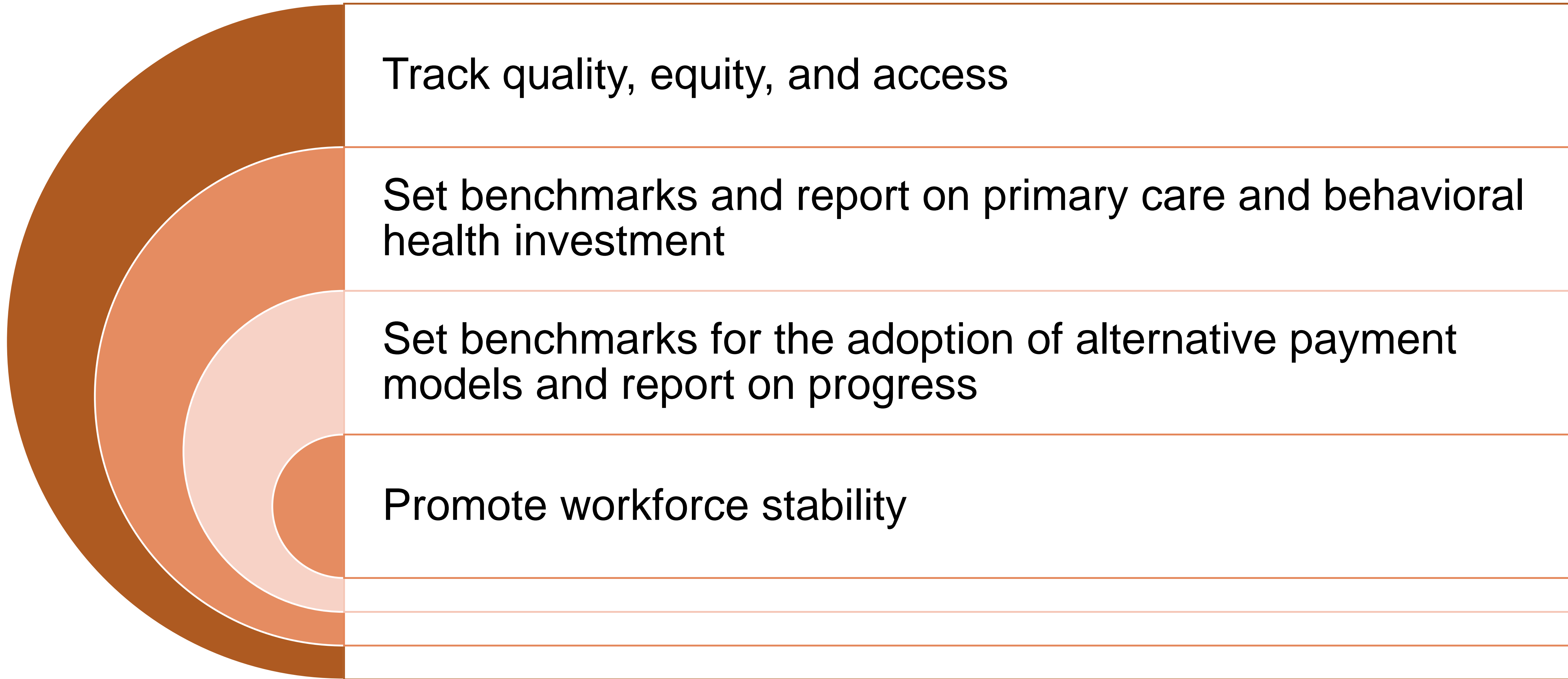
Promote High Value System Performance



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Assess Market Consolidation

Assess prospective changes in ownership, operations, or governance for health care entities

Conduct cost and market impact reviews on transactions likely to significantly impact competition, the state’s ability to meet spending targets, or affordability for consumers and purchasers

Work with other regulators to address market consolidation as appropriate

Board & Advisory Committee Responsibilities

Board

- Sets spending targets, both statewide and sector-specific
- Approves key benchmarks, such as statewide goals for alternative payment model adoption
- Appoints a Health Care Affordability Advisory Committee to provide input on a range of topics
- Members may not receive compensation from health care entities
- Eight members:
  - California Health and Human Services Secretary
  - CalPERS Chief Health Director (nonvoting)
  - Four appointees from Governor's Office
  - One appointee each from Assembly and Senate

Advisory Committee

- May make recommendations, but no approval authority or access to nonpublic information
- Members appointed by the Health Care Affordability Board; representation to include:
  - Consumer and patient groups
  - Payers
  - Fully integrated delivery systems
  - Hospitals
  - Organized labor
  - Health care workers
  - Medical groups
  - Physicians
  - Purchasers

Board and Advisory Committee are both subject to Bagley-Keene Open Meeting Act

Source: Health and Safety Code §§127500-127507.6

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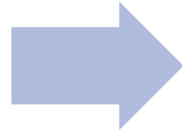
Timeline: Three-Year Milestones

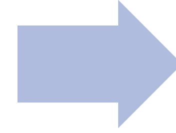
2022

- Hired leadership, build the team
- Plan implementation
- Brought on contracted resources



2023

- Convene Health Care Affordability Board
- Develop spending target methodology
- Convene Advisory Committee
- Develop regulations
- Begin work on primary care and APM components
- Hiring state staff



2024

- Set 2025 spending target
- Adopt primary care, APM, workforce stability standards
- Collect 2022 and 2023 total spending data
- Collect notices of market transactions

Timeline: Enforcement

Progressive Enforcement
- Technical assistance
- Public testimony
- Performance improvement plans
- Financial penalties

2025
Set target for 2026

2026
First year of enforcement

2027
Data collection for 2026

2028
Reporting on 2026 data: progressive enforcement begins

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Stakeholder Engagement with OHCA

- Contact us at ohca@hcai.ca.gov with your comments and questions
- Subscribe to the OHCA listserv on the HCAI website
- Visit HCAI's public meeting page for Health Care Affordability Board materials and information
- Visit the OHCA landing page on the HCAI website for:
  - FAQs, fact sheet, and statute link
  - Advisory Committee application
  - Future regulations "workshopping" meetings and opportunities to provide input to OHCA on key aspects of implementation policy

Board Roles and Responsibilities

Activities in the Health Care Affordability and Quality Act

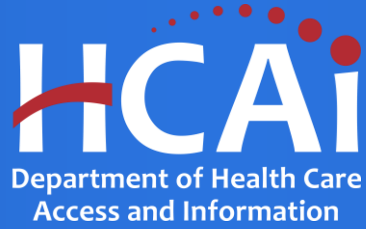
	Matter
Approve	▪ Advisory Committee Membership ▪ Methodology for setting and modifying spending targets ▪ Alternative Payment Model Adoption ▪ Primary Care and Behavioral Health Spending Benchmarks ▪ Health Care Workforce Stability Standards ▪ Policies for administrative penalties ▪ Exempted Providers
Establish	▪ Statewide health care spending target ▪ Specific targets by health care sector ▪ Definitions of health care sectors ▪ Exempted Providers
Consult	▪ Health Care Workforce Stability Standards ▪ Risk adjustment methodologies for reporting of data on total health care expenditures ▪ Equity adjustment methodologies for reporting of data on total health care expenditures ▪ Spending target enforcement

Activities in the Health Care Affordability and Quality Act (cont.)

	Matter
Discuss	▪ Director's presentation of key items for discussion, including: o Options for statewide health care spending targets o Collection, analysis, and public reporting of data o Risk adjustment methodologies for the reporting of data on total health care expenditures o Review and input on performance improvement plans prior to approval o Review and input on administrative penalties o Factors that contribute to spending growth within the state’s health care system o Strategies to improve affordability for both individual consumers and purchasers of health care o Recommendations for administrative simplification in the health care delivery system o Approaches for measuring access, quality, and equity of care o Recommendations for updates to statutory provisions necessary to promote innovation and to enable the increased adoption of alternative payment models o Methods of addressing consolidation, market power, and other market failures

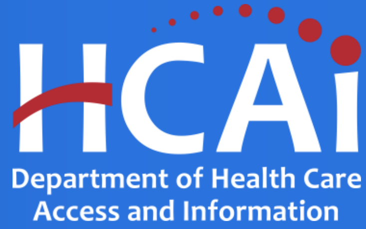
Activities in the Health Care Affordability and Quality Act (cont.)

	Matter
Discuss (cont.)	▪ Rulemaking Packages o Total Health Care Expenditures Data Collection o Written notice of health care entity agreements or transactions and Cost and Market Impact Review o Alternative Payment Model Data Collection o Primary Care and Behavioral Health Spending Data Collection o Standard Quality and Equity Measures Data Collection o Audited Financial Reports or Comprehensive Financial Reports from Providers ▪ Annual Report ▪ Baseline Report



Public Comment

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



Bagley-Keene Open Meeting Act and Conflict of Interest Overview

Jean-Paul Buchanan

Purpose of the Act

To allow members of the public to attend and participate as fully as possible in a state body's decision-making processes.

(Gov. Code section 11120; 103 Ops.Cal.Atty.Gen. 42)

Applicability to Health Care Affordability Board

- The Act applies to "state bodies," such as "every state board… that is created by statute…" (Gov. Code section 111.21(a))
  - Section 127501.10 of Health & Safety Code created the Health Care Affordability Board.

- **Committees:** The Act also applies to any advisory committee created if the committee consists of 3 or more persons. (Gov. Code section 111.21(c))

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What Is a Meeting?

Every “meeting” is subject to The Act’s requirements.

“Meeting” Definition: A quorum of the Board/committee convening, at the same time and place, to hear, discuss, or deliberate on any item within the subject matter of the Board/committee.

- A “quorum” is the minimum number of members who must be present for the Board to transact business and California law generally states that a quorum is a majority of members.

  (94 Ops.Cal.Atty.Gen. 100.)

- For the full Board, a quorum is 4 members (from a total of 7 voting members). (Gov. Code section 11122.5(a))

Physical Presence/Location Requirements and COVID-19 Exception

Normally, the Act requires the physical presence of Board members at meetings and a physical meeting location where the public may go. The Act allows some teleconferencing, but still requires physical presence and location.

Because of COVID-19, the Legislature suspended the physical presence/location requirements until July 1, 2023. (Gov. Code section 11133.)

The Health Care Affordability Board must still comply with the notice and public participation requirements of the Act.

- Statute urges state bodies to adhere as closely to the Act as possible to "maximize transparency and provide the public access to meetings."

Serial Communications Are Prohibited

A quorum of members should not, outside of a meeting:

- communicate in a series of communications of any kind,
- directly or through intermediaries,
- regarding items within the subject matter of the Board/committee.

Purpose: to prevent Board actions/decisions being made in secret, outside of a public meeting.

(Gov. Code section 11122.5(b))

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“Meeting” Exceptions

The Act does not consider the following to be “meetings”:

- **Public Contacts:** a member of the public contacting a majority of Board
  members if Board members do not solicit such contacts.

- **Social Gatherings:** a majority of the Board may attend a purely social event, if they do not discuss Board issues among themselves.
- **Conferences**: Conferences are exempt as long as they are open to the public and involve subject matter of general interest, and a majority of Board members do not discuss Board issues among themselves, other than as part of the scheduled program.

(Gov. Code section 11122.5(c))

Board Member Attendance at Subcommittee Meetings

If a majority of the board will be present at a subcommittee meeting, a board member, who is **not** a member of the subcommittee, may only attend as an ***observer***.
(Gov. Code section 11122.5(c)(6))

"**Observers**" are prohibited from asking questions or making statements at the meeting and can only watch and listen.
(81 Ops.Cal.Atty.Gen.156.)

Notice and Agenda

Meeting notices are required and must be posted at least **10 days** before the meeting.

Notices must have:

- Time and place(s) of the meeting.
- A **specific agenda** for the meeting that contains a brief description of all items to be discussed/transacted at the meeting.
  - The description should provide enough information to allow the public to understand what issues will be discussed or considered.
  - Generally, if an issue is not on the agenda, the Board cannot consider it. However, a new issue can be mentioned for the purpose of including it at a future meeting.

The 10-day notice requirement does not apply for “emergency” or “special” meetings as defined under statute.

(Gov. Code section 11125)

Public Attendance and Participation

Generally, meetings must be **open and public**.

- Conditions on public attendance at the meeting cannot be imposed. An individual is not required to identify themselves or sign-in to attend.

Participation: Board must give the public an opportunity to directly address the board on each agenda item before or during the board's discussion or consideration of the item.

- Public criticism of the board cannot be prohibited.

Broadcasting/Recording of Meetings: Members of the public are allowed to record and broadcast meetings.

(Gov. Code sections 11123, 11124, 11124.1, and 11125.7)

Closed Sessions

“Closed sessions” are parts of meetings without the public and are allowed only for specific reasons, e.g., to discuss pending litigation or to discuss employment issues.

These sessions must be included on the agenda and the specific statutory authority allowing the closed sessions must be stated.

(See Gov. Code section 11126)

Meeting Documents

Generally, materials distributed to the Board prior to, or during, a meeting in connection with an issue to be discussed or considered at the meeting are public records.

- Such materials prepared by Board members or Board staff are required to be available to the public at the meeting.
- Such materials prepared by others are required to be available to the public after the meeting.

(Gov. Code section 11125.1)

Voting

- The vote or abstention of each Board member must be publicly reported. (Gov. Code section 11123(c).)
  - If teleconferencing, votes must be taken by rollcall. (Gov. Code sections 11123(b); and 11123.5(e).)
- Vote by secret ballot at a meeting is not allowed. (68 Ops.Cal.Atty.Gen. 65.)
- Vote by proxy is not authorized. (68 Ops.Cal.Atty.Gen. 65.)

Abstentions

Abstentions may complicate voting.

In general, a state body cannot act without support of at least a majority of its quorum. For the full Health Care Affordability Board, this is at least 4 members.

Members who voluntarily abstain are counted toward a quorum, but decisions will only require the majority of those members who actually vote, as long as there is support from a majority of the quorum.

Members who are disqualified from voting by law are not counted toward a quorum.

(94 Ops.Cal.Atty.Gen. 100.)

Penalties for Non-Compliance

Civil:

- Any interested person, the Attorney General, or a district attorney can commence court action to stop or prevent violations of the Act. (Gov. Code section 11130.)
- Any interested person can also commence court action to declare a Board action taken in violation of the Act's notice, agenda, and public attendance requirements as "null and void." (Gov. Code section 11130.3.)
- If successful, a plaintiff can obtain a court order, court costs, and attorneys' fees. (Gov. Code section 11130.5.)

Criminal:

- It is also a misdemeanor for any Board member to attend a meeting in violation of the act and where the member "intends to deprive the public of information to which the member knows… the public is entitled." (Gov. Code section 11130.7.)

Conflict of Interest and Form 700

Overview of Conflict-of-Interest Laws

Conflict of Interest Laws (non-exhaustive List):

(1) **Financial Conflicts**: A board member "shall not make, participate in making, or in any way attempt to use the [their] official position to influence a governmental decision in which the [member] knows or has reason to know the [member] has a financial interest."

(2) **Common Law Doctrine:** A board member is "prohibit[ed] from placing themselves in a position where their private, personal interests may conflict with their official duties."

(3) **Incompatible Activities:** A board member "shall not engage in any employment, activity, or enterprise which is clearly inconsistent, incompatible, in conflict with, or inimical to his or her duties as a state officer or employee."

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Purpose of Conflict-of-Interest Laws

The State of California's "conflict-of-interest statutes are concerned with what might have happened rather than merely what actually happened….

They are aimed at eliminating temptation, avoiding the appearance of impropriety, and assuring the government of the officer's undivided and uncompromised allegiance….

Their objective 'is to remove or limit the possibility of any personal influence, either directly or indirectly which might bear on an official's decision....'"

(*People v. Honig* (1996) 48 Cal.App.4th 289, 314.)

Appearance of Impropriety

The State of California is concerned with not just actual conflicts of interest, but also the appearance of impropriety. This is to instill confidence and build public trust in government and that its decisions are legitimate.

Exception: Financial Effect on Representative Interest

There is no conflict of interest if a decision would generally impact the industry, trade, profession, or other identified interest the board member legally represents on the board.

(Cal. Code Regs., title 2, section 18703(e).)

Disqualification and Recusal

A member disqualified from making, or participating in, a decision must not take part in the decision, and the member's recusal from the decision must meet the following requirements:

(1) The member's determination of a conflict of interest may be accompanied by an oral or written disclosure of the conflicting interest.

(2) The member's presence will not be counted toward achieving a quorum.

(3) During a closed session, a disqualified member must not be present when the decision is considered, or knowingly obtain or review a recording or any other nonpublic information regarding the governmental decision.

(4) The Board may adopt a local requiring the member to step down from the dais or leave the chambers.

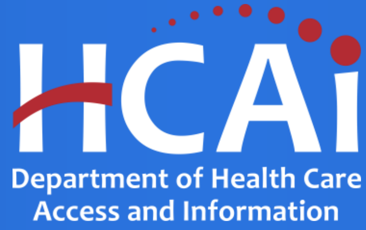
(Cal. Code Regs., title 2, section 18707(b).)

Form 700

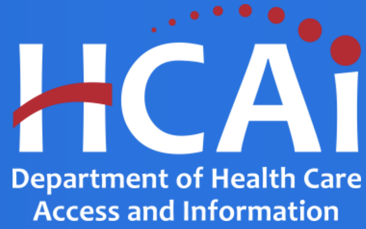
HCAI is required to have a Conflict-of-Interest Code which identifies its positions that involve the making, or participation in the making, of decisions that may have financial effects. These positions are required to file a “Statement of Economic Interests,” also known as the “Form 700.”

HCAB members will be included in HCAI’s Conflict-of-Interest Code and will be required to file Form 700s about relevant financial interests. Generally, Form 700s require a member to disclose foreseeable conflict of interests, which HCAI will specifically identify in its Conflict-of-Interest Code.

This serves to provide transparency to the public, as well as acts as a reminder to members of potential conflicts of interest.

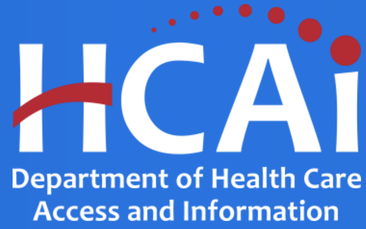


Election of Chair



Public Comment

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



Health Care Spending Targets

Michael Bailit, President, Bailit Health

Introduction to Health Care Spending Targets

What Is a Spending Target and Why Pursue One?

- A health care spending target is a per annum rate-of-growth target.

- States have adopted such targets to slow the growth in health care spending.
  - Health spending growth has long exceeded economic growth
  - Per capita spending on health care has grown faster than inflation

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Reasons Other States Cited For Pursuing Spending Targets

- **Massachusetts**: State-purchased health care rose 40% over 12 years, while spending on other services decreased by 17%.
- **Delaware**: The state’s per capita total health care spending was the third highest nationwide.
- **Rhode Island**: 7 of 10 health insurance filings in the large and small group market outpaced annual wage growth.
- **Oregon**: Health insurance premiums cost 29% of a family’s total income.
- **Connecticut**: Health care costs grew faster than the economy, taking up a larger portion of the state’s gross domestic product.

How States Have Set Their Spending Targets

- Each state engaged in a public process, with a stakeholder body deciding, or advising the state, on the policy and implementation of the program.

- States in the past have tied the target value to one economic indicator or a combination of indicators (e.g., growth in wages, household income, or state economic growth).

How States Have Set Their Spending Targets (cont.)

- California's enabling statute invites consideration of population-based measures too, such as changes in the state's demographics (e.g., aging) that may influence future use of health care services.

- Spending target values in other states for 2018-22 ranged from 2.8 percent to 3.8 percent.
  - States' target values were roughly 2 percentage points less than average annual state health care spending growth over the prior decade.

States’ Consideration of Inflation

- Most state spending target values were set prior to the sharp rise in general inflation that began in late 2021.
- As a result, targets were set based on an assumption that inflation would continue at the Federal Reserve Bank’s long-term target rate of 2 percent.
- In future meetings we will discuss inflation, including:
  - What we know about its impact on health care spending
  - How other states have evaluated whether to modify their target values in response to elevated inflation
  - Methodology options for California’s spending target

Logic Model For Spending Target

- **The spending target is not an end, but a means** to slow spending growth.
- Complementary actions are required to attain that goal.

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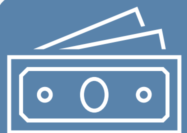
Spending Target Analysis vs. Spending Driver Analysis

Spending Target Data and Analysis

- **Primary purpose**: measure spending and assess performance against a spending target
- **Payer-reported data** are provided in aggregate and are limited in detail, but do represent all health care spending in the state (including spending in self-insured employer benefit programs).



How much did spending increase or decrease from one year to the next?

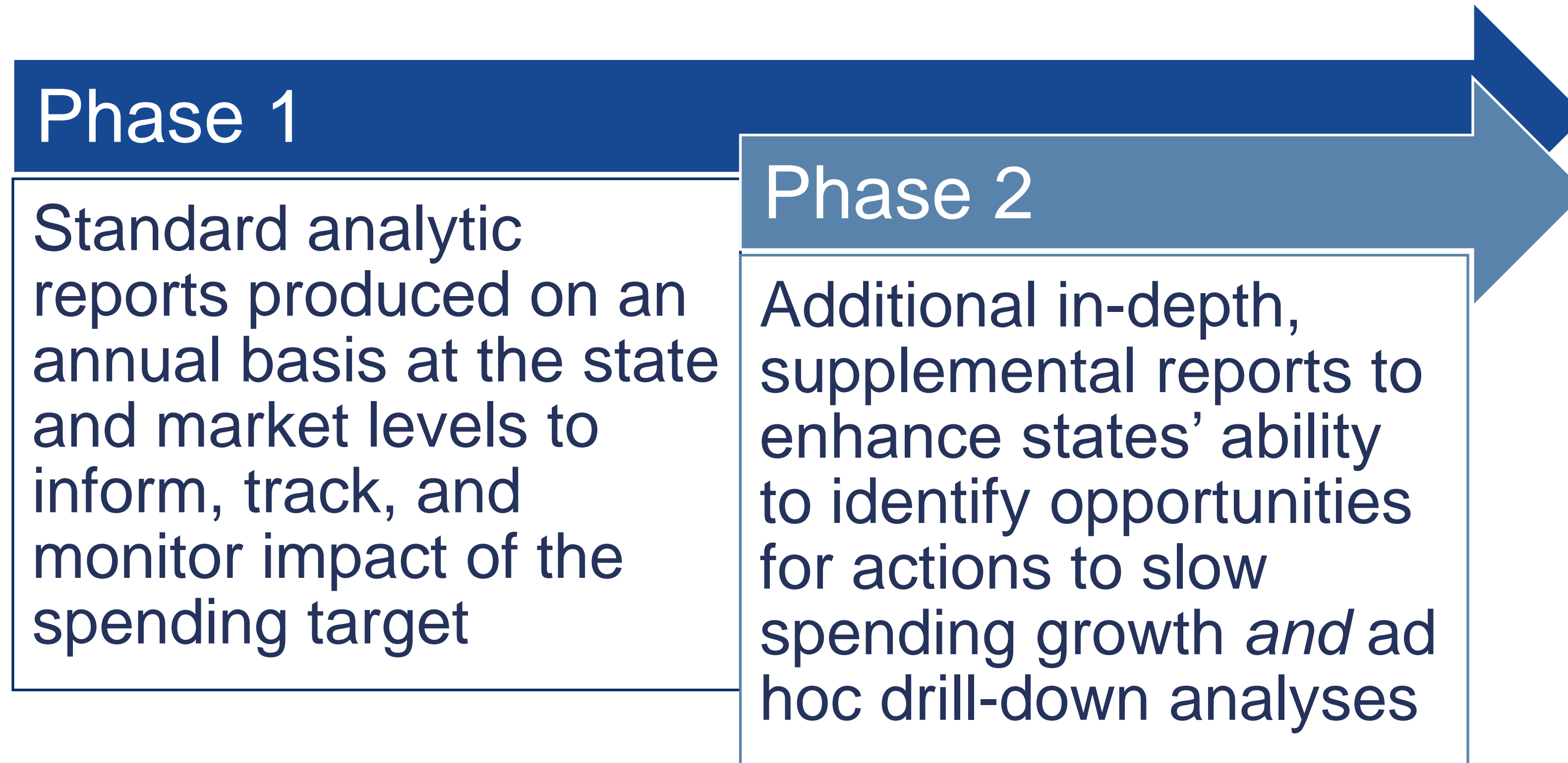
Spending Driver Data and Analysis

- **Primary purpose**: identify underlying drivers of spending and spending growth to target mitigating actions
- **APCD and other claim-level data** from Medicaid or state-purchased insurance are more detailed than payer-reported aggregate data. Not all state spending data are included, but sufficient data to understand underlying trends.

What is driving overall spending and trends? Where are opportunities?

Types Of Underlying Driver Analyses

- States' spending driver analyses typically include two phases:



The subsequent slides include details on Phase 1 analyses, which serve as a starting point for understanding health care spending patterns and trends.

Framework For Analyzing Underlying Drivers

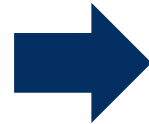
- Analyses to inform efforts to slow health care spending growth is organized around three major questions:

1. Where is spending a potential cause for concern?	2. What is causing the problem?	3. Who is accountable?
• High spending • Growing spending • Variation • Benchmark comparison	• Price • Volume • Intensity • Population characteristics	• State • Market • Payer • Provider

Where is Spending a Potential Cause For Concern?

- Answering this question allows states to determine where the greatest opportunity to achieve impact lies.
- There are many ways to analyze potentially concerning spending.

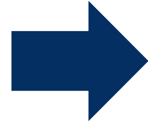
Spending that is **high at a point** in time and/or is **growing at a high rate** over time



- Spending **by service category** can identify where expenditures are the highest (e.g., pharmaceuticals)
- Spending by **rates of growth** can identify what is driving per capita growth over time

Where is Spending a Potential Cause For Concern? (cont.)

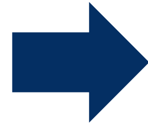
Spending that **varies greatly** across regions, payers, or providers



- Reflects the outcome of inconsistent practice patterns, variation in competitiveness and composition of provider markets, and patient population characteristics

Where is Spending a Potential Cause for Concern? (cont.)

Spending that is far **above external benchmarks**



- Sheds light on spending pattern differences that exist across states using data from CMS, HCCI, RAND, etc.

Drivers of Spending and Spending Growth

- There are five primary drivers of health care spending and spending growth that will inform the design of the standard analytic reports.

1. Price	• The amount a payer reimburses for a service, plus patient payments. • The primary driver of health care spending growth in the commercial market.
2. Volume	• The quantity of service units or treatment episodes delivered.
3. Intensity	• The scope and types of services utilized for a treatment. • Captures differences in site of care (e.g., inpatient vs. outpatient) and treatment modality (e.g., robot-assisted vs. manual surgery).
4. Population Characteristics	• The illness burden ("clinical risk"), demographic characteristics, and social risk of a population that all influence health care needs, access to care, and service utilization.
5. Provider Supply	• The availability of provider resources correlates with increased utilization and spending.

Health Care Spending Targets and Health Equity

Importance of Equity in Spending Targets

- Inequities within the health care system are well documented and are reflected in persistent health disparities and elevated disease burden.
- Inequities are present in higher health care spending, higher cost burdens, and an imbalanced distribution of resources.
- Inequities can occur across a broad range of dimensions including race and ethnicity, socioeconomic status, age, geography, language, gender, disability status, citizenship status, and sexual orientation and gender identity.
- We will consider and discuss equity throughout the spending target development process.

Estimated U.S. Health Care Spending by Race/Ethnicity from 2002-2016

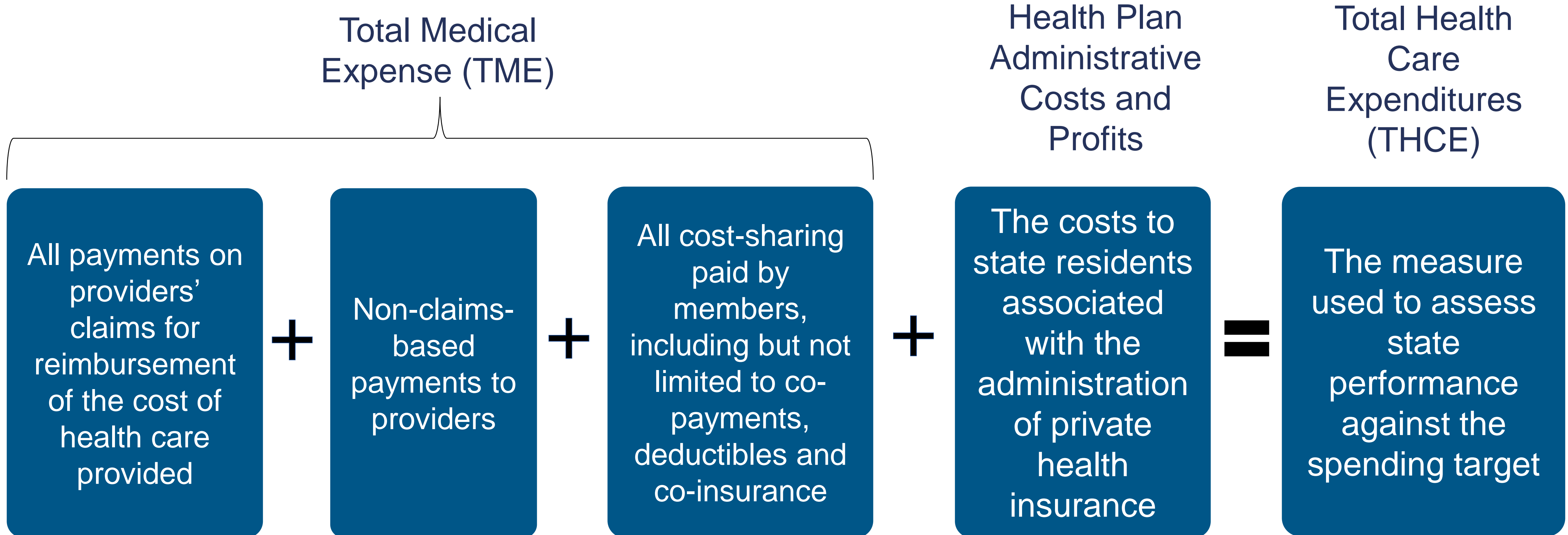
Race/ Ethnicity	American Indian, Alaska Native	Asian, Native Hawaiian, Pacific Islander	Black	Latino/x	Multiple races	White
Percentage of Population*	1%	6%	12%	18%	2%	61%
Percentage of Associated Health Care Spending (age-adjusted)	1%	3%	11%	11%	2%	72%

*May not equal 100% due to rounding.

***Source**: Dieleman JL, Chen C, Crosby SW, et al. US Health Care Spending by Race and Ethnicity, 2002-2016. JAMA.*

Measurement and Reporting of Total Health Care Expenditures (THCE)

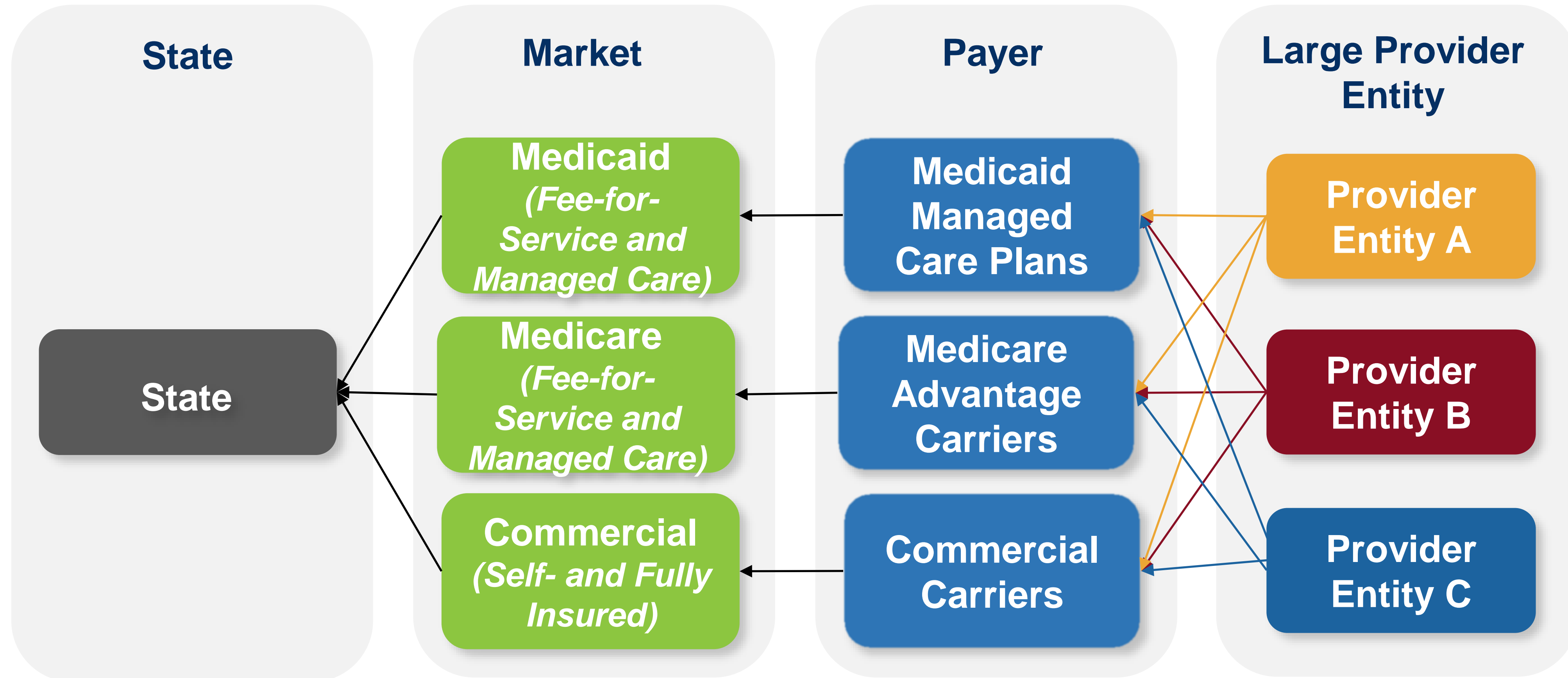
What is Being Measured Against the Target?



Categories Used To Report Total Medical Expense

Claims-based spending, e.g.,	Non-claims-based spending, e.g.,
• Hospital inpatient • Hospital outpatient • Professional primary care • Professional specialty care • Retail pharmacy	• Capitated, global budget, case rate or episode-based payments • Performance incentive payments • Payments to support population health and practice infrastructure

Four Levels Of Reporting On Spending Growth In Other States



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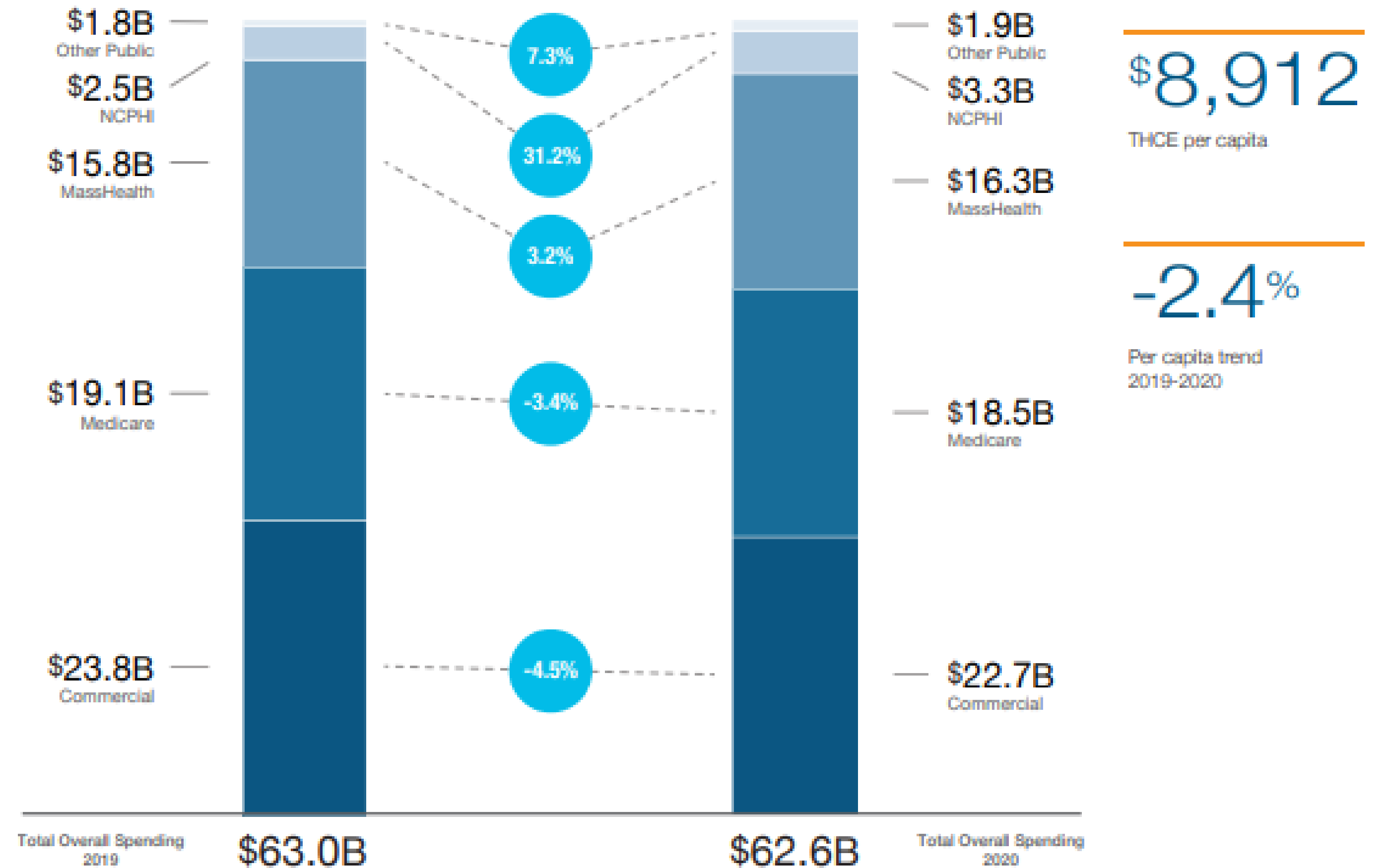
State Level Analysis: Massachusetts



Source: Center for Health Information and Analysis, "Annual Report on the Performance of the Massachusetts Health Care System," March 2022.

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Market Level Analysis: Massachusetts

Components of Total Health Care Expenditures:

MassHealth by Program Type, 2019-2020

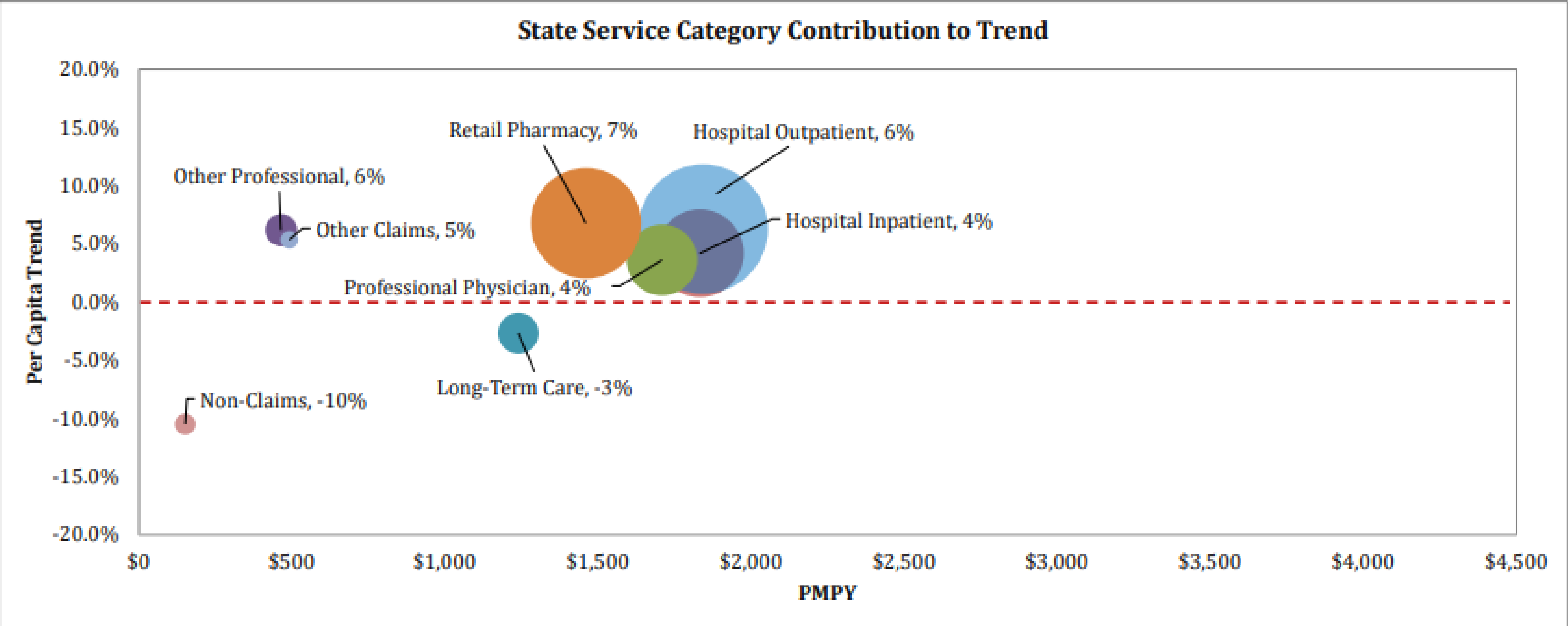
THCE COMPONENTS
Detailed View

Component	2019	Change	2020
Supplemental Payments	$1.3B	43.0%	$1.8B
Programs for Dually Eligible Members (Managed Care Plans)	$2.2B	6.8%	$2.3B
Primary Care Clinician (PCC) Plan (Managed Care Plans)	$0.9B	-12.4%	$0.8B
Primary Care ACO (ACO-B) (Managed Care Plans)	$2.6B	5.4%	$2.7B
MCO/ACO-A (Managed Care Plans)	$4.5B	1.1%	$4.6B
Fee-For-Service (FFS)	$4.3B	-6.2%	$4.0B
Total Overall Spending	$15.8B	3.2%	$16.3B

Overall MassHealth spending increased 3.2% between 2019 and 2020, driven by increased enrollment and new supplemental payments related to COVID-19.

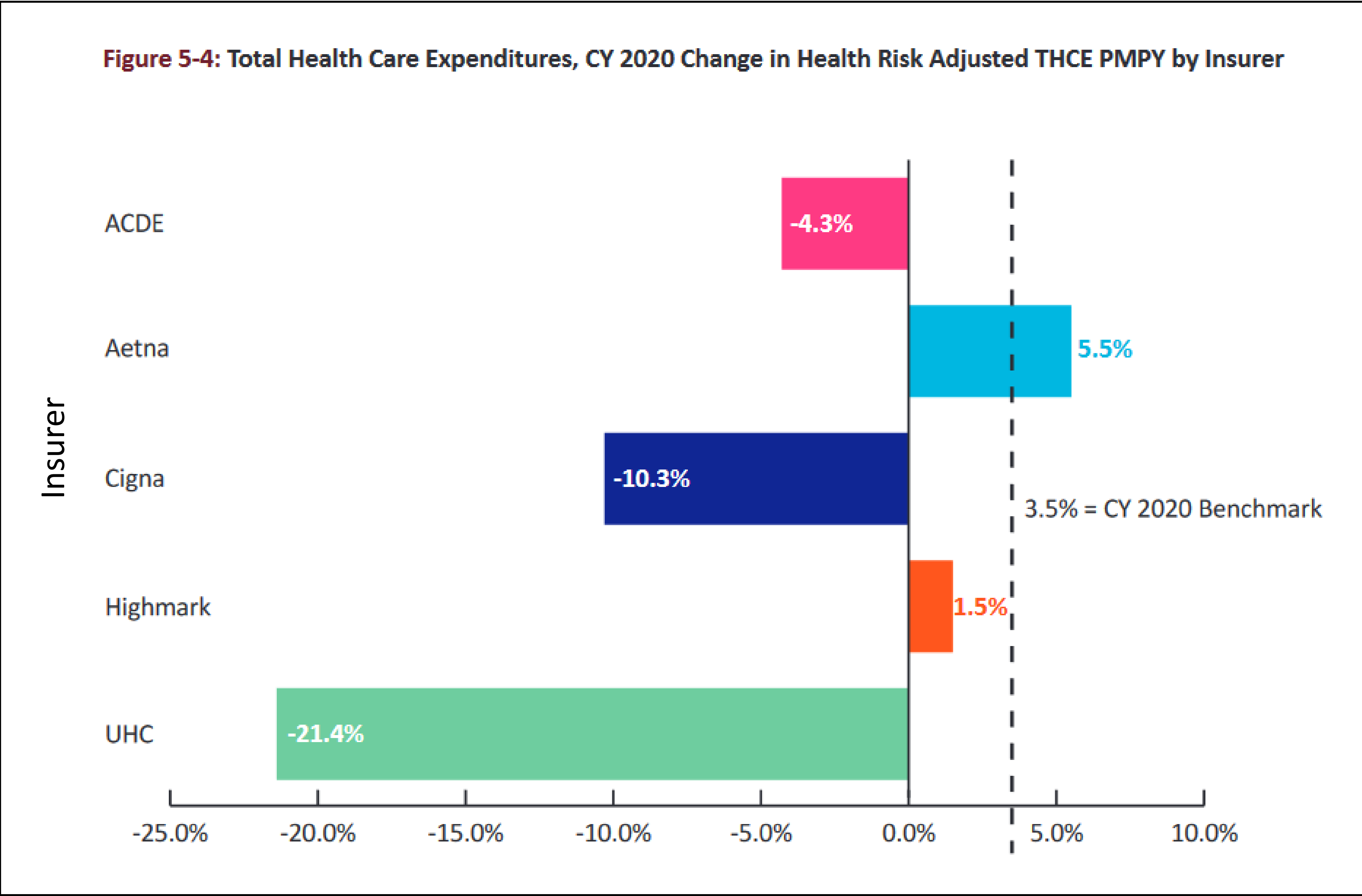
Source: Center for Health Information and Analysis, "Annual Report on the Performance of the Massachusetts Health Care System," March 2022.

Service Category Contribution To Trend: Connecticut



Source: Connecticut Office of Health Strategy, "Healthcare Benchmark Initiative Stakeholder Advisory Board," March 10, 2022.

Insurer Level Analysis: Delaware



Source: *Delaware Department of Health and Human Services and Delaware Health Care Commission, "Benchmark Trend Report: Calendar Year 2020 Results," 2022.*

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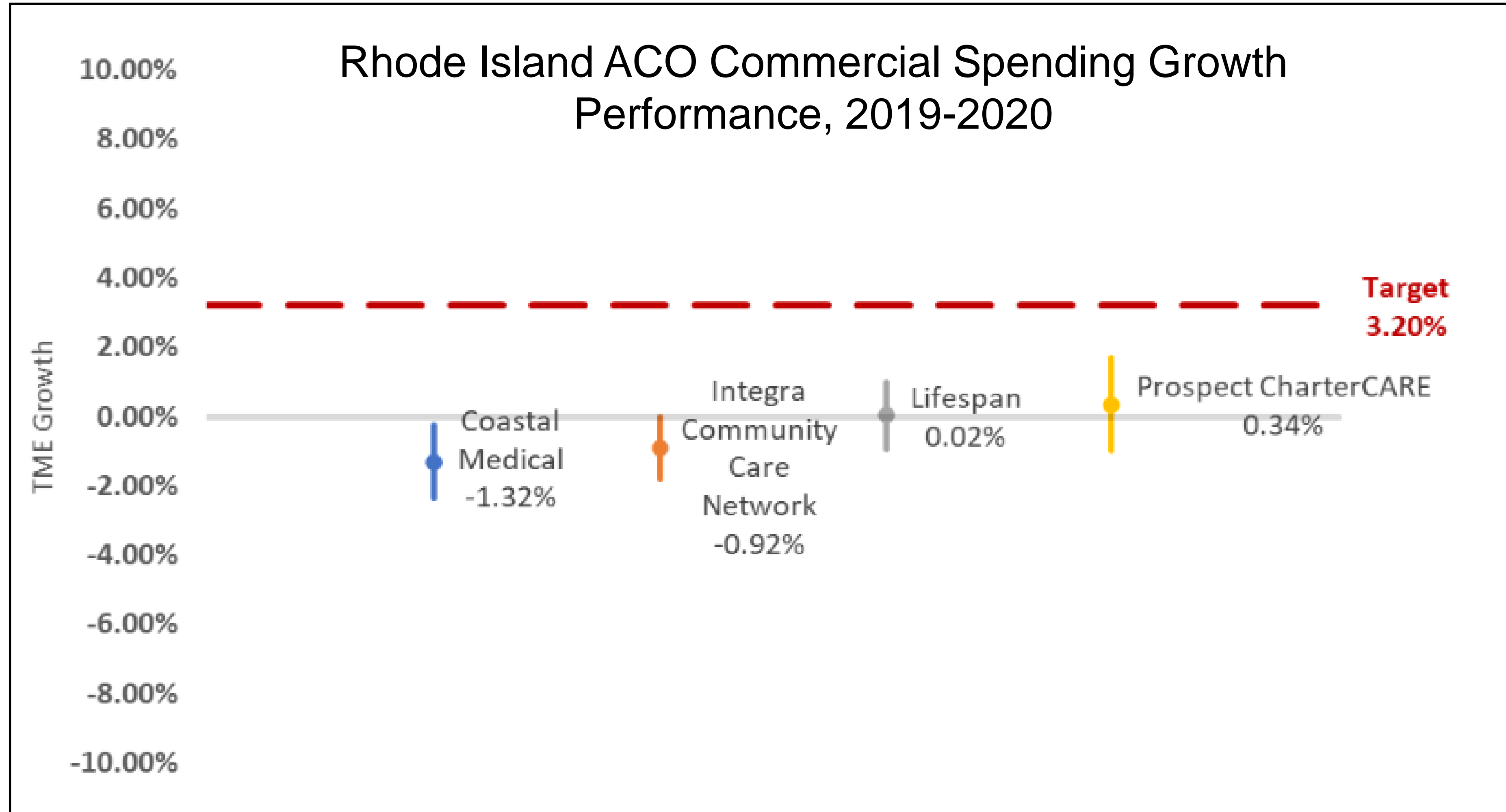
Provider Level Analysis: Rhode Island



Source: Rhode Island Office of the Health Insurance Commissioner, *"RI Health Care Cost Trends Project: 2020 Cost Growth Target Performance," April 27, 2022.*

A Closer Look at the Experience of Massachusetts (or, “Do Spending Targets Actually Work?”)

Background on the Massachusetts Health Care Spending Target Program

- In 2012, Massachusetts adopted legislation establishing a spending target program.
- The legislation also established the Health Policy Commission which has the authority to monitor compliance with the target through a set of accountability mechanisms.
- The HPC also oversees health care system performance and provides data-driven policy recommendations on health care delivery and payment system reform.

Massachusetts' Annual Process

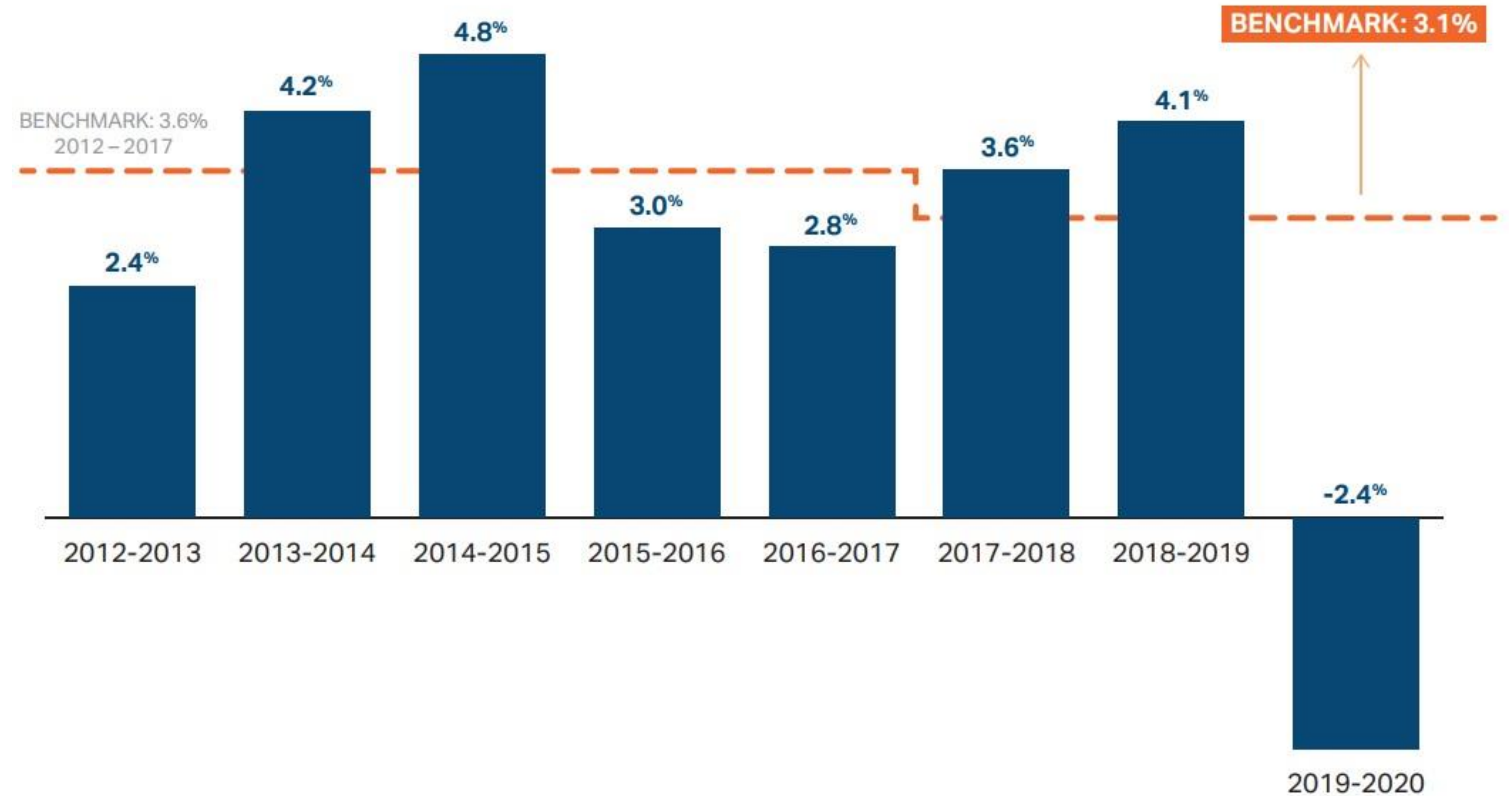
- The HPC and its sister agency, the Center for Health Information and Analysis (CHIA), engage in an annual process to monitor health care spending growth relative to the target.

Process Step	Timeframe
1. HPC sets the target	Spring
2. CHIA collects data from payers	Spring
3. CHIA analyzes data	Summer
4. CHIA publishes annual report	Fall
5. HPC, CHIA, and the Attorney General's Office hold annual cost trends hearings	Fall
6. CHIA refers high-growth payers and providers to HPC	Winter
7. HPC may require performance improvement plans	Winter
8. HPC publishes cost trends report	Winter

Source: Massachusetts Health Policy Commission, "HPC DataPoints, Issue 10: Health Care Cost Growth Benchmark," February 11, 2019.

Spending Growth in Massachusetts Since Implementation of a Target

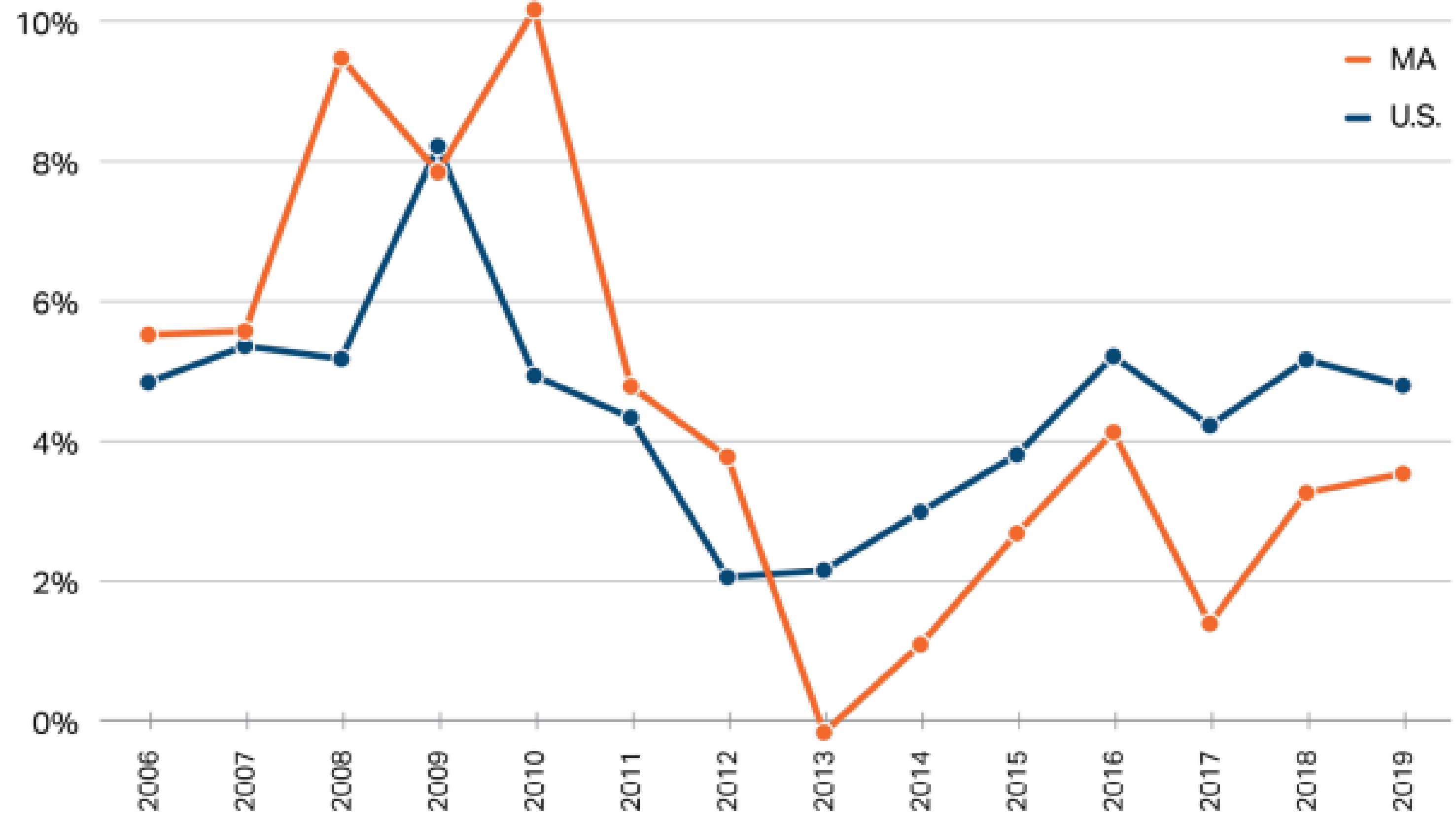
- Over the first six years, annual cost growth averaged the target value of 3.6%



Source: Center for Health Information and Analysis, Annual Reports 2013-2022.

Massachusetts' Spending Growth Target Experience

- Commercial medical spending growth in MA was below the national rate every year between 2013 and 2019.
- Commercial spending in 2020 declined at about the same rate as the nation.



Source: Auerbach, David. "Report on State Spending Performance," Presentation at the 2021 Health Care Cost Growth Benchmark Hearing, March 25, 2021.

Factors Contributing to the Target's Impact

Common goal

Payers and providers aligned on a common target for reducing health care cost growth.

Total cost of care approach

The target was consistent with a TCOC contracting approach which has become the common contracting structure.

Influence on negotiations

Negotiations between payers and providers were influenced by the target, thereby tempering price growth.

Transparency

Reasons for cost growth have been studied and publicized, keeping the policy and its consequences in the public eye.

Additional Spending Target Resources and Information

- Additional Information: State Cost Growth Target Methodologies
- Between 2018 and 2022, states established target values ranging from 2.8 percent to 3.8 percent.

	Target Methodology	Target Value	Average Annual Growth (2011-2020)
Connecticut	80/20 blend of forecasted median wage and PGSP Add-on factors: +0.5% for CY 2021, +0.3% for CY2022, +0.0% for CY 2023-2025	3.4% for 2021 3.2% for 2020 2.9% for 2023-2025	3.9%
Delaware	PGSP Add-on factors: +0.25% for 2021, +0.0% for CY2022-2023	3.8% for 2019 3.5% for 2020 3.25% for 2021 3.0% for 2022-2023	5.2%
Massachusetts	2018-2022: PGSP (3.6% in 2018) minus 0.5 2023 and beyond: default rate of PGSP	3.6% for 2013-2017 3.1% for 2018-2022	5.4%
Nevada	Changing blend of forecasted median wage and PGSP, with increasing weight on forecasted median wage over time.	3.19% for 2022 2.98% for 2023 2.78% for 2024 2.58% for 2025 2.37% for 2026	6.2%
New Jersey	75/25 blend of median projected household income and PGSP Add-on factors: +0.3% for 2023, +0.0% for 2024, -0.2% for 2025, -0.4% for CY2026-2027	3.5% for 2023 3.2% for 2024 3.0% for 2025 2.8% for 2026-2027	5.4%
Rhode Island	PGSP	3.2% for 2019-2022	5.1%
Oregon	Non-formulaic consideration of: historical GSP; historical median wage; CMS waiver & legislative growth caps applied to the state's Medicaid and publicly purchased programs	3.4% for 2021-2025 3.0% for 2026-2030	5.8%
Washington	70/30 blend of historical median wage and PGSP, with a downward adjustment starting in 2024	3.2% for 2022-2023 3.0% for 2024-2025 2.8% for 2026	4.9

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Spending Target Development Timeline/ Review of Meeting Plan

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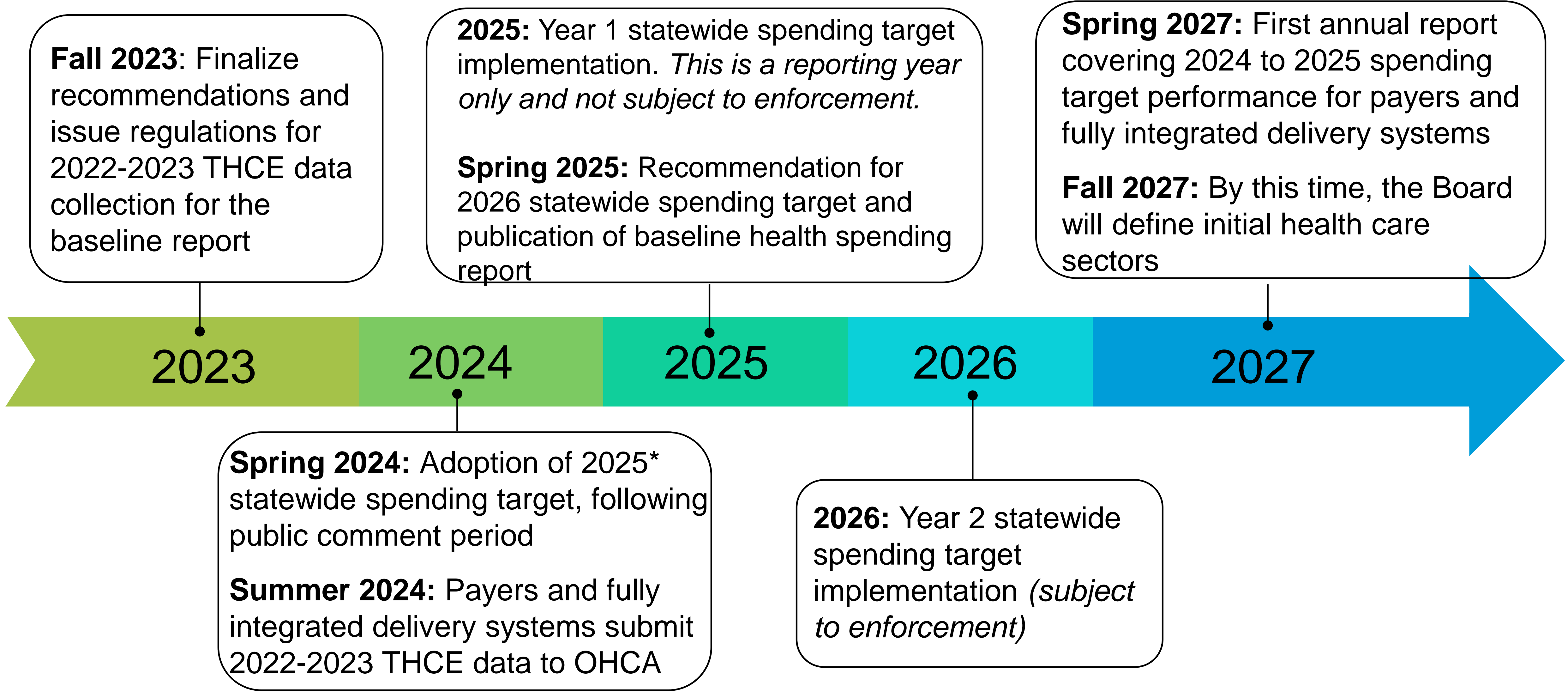
Statutory Timelines Related to the Spending Target



*It is possible that the Board may adopt multi-year statewide targets.

Next Meeting:

April 25th, 2023

Location:

2020 West El Camino Avenue,
Sacramento, CA 95833

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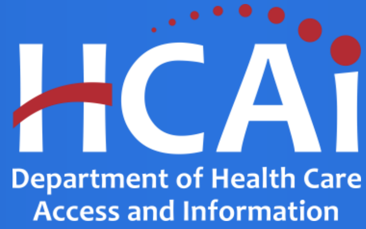

General Public Comment

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