HCAi
Department of Health Care Access and Information

Health Care Affordability Board Meeting

April 25, 2023

10:00 a.m.	**1.**	**Welcome and Call to Order** Mark Ghaly, Chair • Welcome • Call to Order • Establish Quorum
10:10 a.m.	**2.**	**Approval of the March 21, 2023 Meeting Minutes** Mark Ghaly, Chair
10:15 a.m.	**3.**	**Director's Remarks** Elizabeth Landsberg, Director
10:30 a.m.	**4.**	**Meeting Plan Review** Vishaal Pegany, Deputy Director
11:00 a.m.	**5.**	**State Presentations** David Seltz, Executive Director, Massachusetts Health Policy Commission • Overview of Massachusetts Health Care Cost Growth Benchmark Program Sarah Bartelmann, Cost Growth Target & Health Care Market Oversight Program Manager, Oregon Health Authority • Overview of Oregon Sustainable Health Care Cost Growth Target Program
12:00 p.m.	**6.**	**Lunch Break**
12:30 p.m.	**8.**	**Advisory Committee Membership** *(agenda item to be discussed out of order)* Vishaal Pegany, Deputy Director • Determine Advisory Committee selection process • Board member attendance requirements
12:40 p.m.	**7.**	**Discussion of Total Health Care Expenditures (THCE) Measurement Design Considerations** Michael Bailit, Bailit Health • Components and categories to measure THCE • Determining whose spending will be measured • Population to use as the denominator for calculating per capita spending • Considerations for inclusion and exclusion of expenditures • Levels of reporting THCE *(time permitting)*
2:40 p.m.	**9.**	**General Public Comment**
	10.	**Adjournment**

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Welcome and Call to Order

Mark Ghaly, CalHHS Secretary & Board Chair

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Approval of the March 21, 2023 Board Meeting Minutes

Mark Ghaly, CalHHS Secretary & Board Chair

HCAi
Department of Health Care Access and Information

Director's Remarks

Elizabeth Landsberg, HCAI Director

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Department of Health Care Access and Information

Meeting Plan Review

Vishaal Pegany, Deputy Director OHCA

2023-24 Health Care Affordability Board 12-Month Workplan

	THCE & Statewide Spending Target	Cost and Market Impact Review (CMIR)	Health Systems Performance	Advisory Committee (AC)
MAR 2023	• Introduction & Current State • Spending Target Development Timeline			
APR 2023	• Other State Approaches • Total Health Care Expenditures (THCE): Components & Categories, Whose Spending, Denominator, Exclusions • Measurement and Reporting: Levels of Reporting			
MAY 2023	• Measurement & Reporting: Data Submission Thresholds, Provider Entities, and Patient Attribution Methods • Statistical Confidence • Introduction to adjustments, such as for Health Status, Quality, Equity, & Organized Labor Costs			

Dynamic workplan; subject to change.

2023-24 Health Care Affordability Board 12-Month Workplan

	THCE & Statewide Spending Target	Cost and Market Impact Review (CMIR)	Health Systems Performance	Advisory Committee (AC)
JUN 2023	• Statistical Confidence and Adjustments (Cont'd) • Data Sources • Process & Timeline for Collection, Analysis, & Reporting	• Overview of CMIR Approach		• Introduction & Current State • Spending Target Development Timeline • THCE Design Considerations • Overview of CMIR Approach
JUL 2023	• AC Input on THCE Design Considerations • Data Collection, Validation and Analysis Process • Public Reporting of Baseline Spending	• AC Input on CMIR Approach • Draft CMIR Regulations and Timeline to Submit to OAL		
AUG 2023	• Follow-up Discussion of Any Unresolved THCE Design Considerations • Comprehensive Recap of THCE Design Considerations	• Status Update on Draft CMIR Regulations	• Overview of Alternative Payment Models (APMs), Primary Care Investment, Workforce Stability	
SEP 2023	• Review of Draft THCE Data Collection Regulations • Preview the next phase of the Board's Work	**Deadline: OHCA Submits CMIR Regulations to OAL[1]**		• Recap of THCE Design Considerations • Draft THCE Data Collection Regulations • Overview of APMs, Primary Care Investment, Workforce Stability

[1] Office of Administrative Law

2023-24 Health Care Affordability Board 12-Month Workplan

	THCE & Statewide Spending Target	Cost and Market Impact Review (CMIR)	Health Systems Performance	Advisory Committee (AC)
OCT 2023	• AC Input on THCE Design Considerations • Requirements and Considerations for Spending Targets • Statewide Spending Target Methodology: Historical Trends and Projections and Adjustment Factors			
NOV 2023	• Status Update on THCE Regulations • Statewide Spending Target Methodology: Considerations for Setting a Value			
DEC 2023	• Statewide Spending Target Methodology (Cont'd) • Payer Administrative Costs and Profits **Deadline: OHCA Submits THCE Data Collection Regulations to OAL**			

2023-24 Health Care Affordability Board 12-Month Workplan

	THCE & Statewide Spending Target	Cost and Market Impact Review (CMIR)	Health Systems Performance	Advisory Committee (AC)
JAN 2024	• AC Input on Spending Target Methodology • Review Preliminary Decisions & Recommendations for Statewide Spending Target Methodology • Considerations for Public Reporting of Performance and Assessing Program Impact			• Statewide Spending Target Methodology
FEB 2024	• Board Process for Finalization of the Statewide Spending Target for Calendar Year 2025 • Preview the next phase of the Board's Work related to APMs, Primary Care Investment, and Workforce Stability **Deadline: OHCA Posts Proposed Spending Target for Calendar Year 2025**			

Follow-Up: Spending Targets and Public Health Investments

In March, the board discussed potentially including public health expenditures in the Total Health Care Expenditures (THCE) definition. The enabling statute **does not** include public health investment in the definition of THCE and the definition of health care entities **does not** include state and local public health departments.

Though public health spending has public policy importance, it may divert from OHCA's and the Board's already significant workload. Exploring measurement of public health investment would require a deeper dive regarding:

- Defining Public Health Expenditures
  - All public health department budgets/expenditures may not constitute public health spending.
  - Would the definition focus on expenditures impacting medical spending?
  - What about other spending, such as vital records, facility licensing and regulatory enforcement?

- Measuring Public Health Expenditures
  - Universe of Reporting Entities:
    - State and local public health departments?
    - Community-based organizations?
    - Investments from nonprofits and philanthropy?

Follow-Up: Spending Targets and Public Health Investments (cont.)

Exploring measurement of public health investment would require a deeper dive regarding (cont.):

- Interaction with Spending Targets
  - Spending targets are a tool to slow health care spending growth and improve consumer affordability.
  - Including public health spending in THCE would combine spending that is for the benefit of a broader population or community with medical spending for an enrolled population.
  - Consider how public health investment (statewide or regionally) factors into a health care entity's performance relative to the target.

2023 Meeting Calendar

March 21, 2023
April 25, 2023
May 23, 2023
June 20, 2023
July 25, 2023
August 22, 2023
September 19, 2023
October 24, 2023
November 28, 2023
December 19, 2023

All meetings will take place at 2020 West El Camino Avenue, Sacramento, CA 95833 and be viewable online. Additional information will be posted at: https://hcai.ca.gov/public-meetings/.

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State Presentations

David Seltz, Executive Director, Massachusetts Health Policy Commission

Sarah Bartelmann, Cost Growth Target & Health Care Market Oversight Program Manager, Oregon Health Authority

MASSACHUSETTS
HEALTH POLICY COMMISSION

Introduction to the Health Policy Commission and Path to Affordability in Massachusetts

April 25, 2023

David Seltz, Executive Director

Agenda

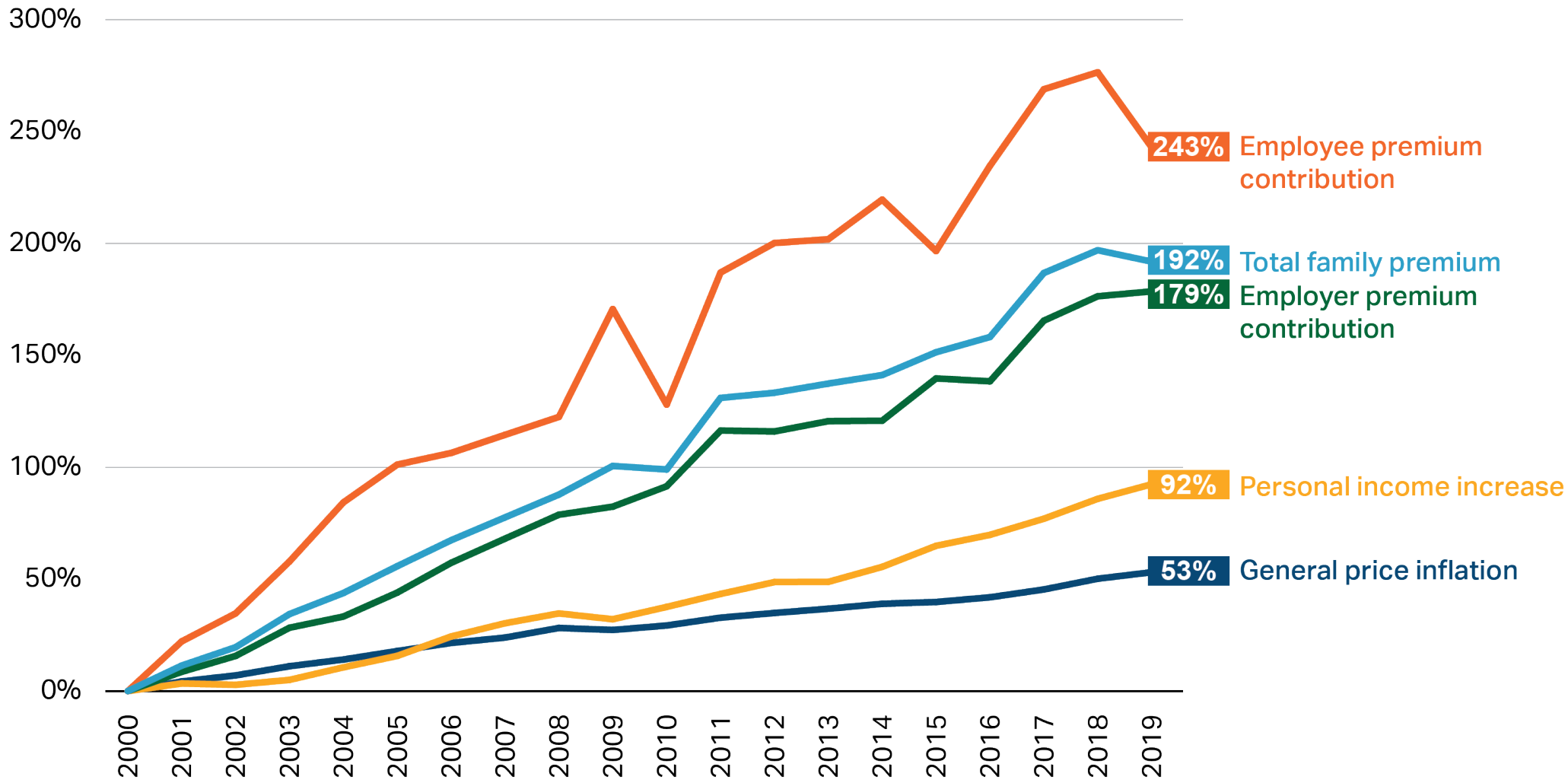
Role of the HPC

10-Year Trend Review

What's Next? HPC Policy Recommendations

Discussion

The Urgent Imperative for Action: When health spending grows faster than the rest of the economy, residents, and employers are acutely impacted.



In 2012, Massachusetts became the first state set a target for reducing total health care spending growth. A new state agency, the HPC, was charged with oversight.

CHAPTER 224 OF THE ACTS OF 2012

An Act **Improving the Quality** of Health Care and **Reducing Costs** through Increased **Transparency**, **Efficiency**, and **Innovation.**

GOAL

Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

VISION

A **transparent**, **equitable,** and **innovative** healthcare system that is **accountable** for producing **better health** and **better care** at a **lower cost** for all the people of the Commonwealth.

The Health Care Cost Growth Benchmark

- Sets a **target** for moderating the growth of total health care expenditures across all payers (public and private) and is set to the state's long-term economic growth rate.

  The health care cost growth benchmark:

2013 - 2017	2018 - 2022	2023 - 2024
3.6%	3.1%	3.6%

- If target is not met, the HPC can require health care providers and health plans to implement Performance Improvement Plans and submit to strict public monitoring.

TOTAL HEALTH CARE EXPENDITURES

Definition: Annual per capita sum of all health care expenditures in the Commonwealth from public and private sources

Includes:

- All categories of medical expenses and all non-claims related payments to providers
- All patient cost-sharing amounts, such as deductibles and copayments
- Administrative cost of private health insurance

The work of the HPC is overseen by an 11-member Board of Commissioners who are appointed by the Governor, Attorney General, and State Auditor.

GOVERNOR
Maura Healey

- Chair with expertise in health care delivery, health plan administration
- Primary care physician
- Secretary of Administration and Finance
- Secretary of Health and Human Services

ATTORNEY GENERAL
Andrea Campbell

- Expertise as a health economist
- Expertise in behavioral health
- Expertise in health care consumer advocacy

STATE AUDITOR
Diana DiZoglio

- Expertise in innovative medicine
- Expertise in representing the health care workforce
- Expertise as a purchaser of health insurance

HEALTH POLICY COMMISSION BOARD
Deborah Devaux, Chair

EXECUTIVE DIRECTOR
David Seltz

ADVISORY COUNCIL

Even a modest reduction in growth of commercial spending leads to better care and significant savings for Massachusetts families.

If Massachusetts health care spending grew 2.5% annually from 2020 to 2026 versus the current trajectory of 4%:

Total spending on health care would be reduced by

$13.7 billion

10% lower
family premiums ($25,500 vs. $28,200)
**in 2026*

$8,700 more
in take-home pay per worker
**2020-2026*

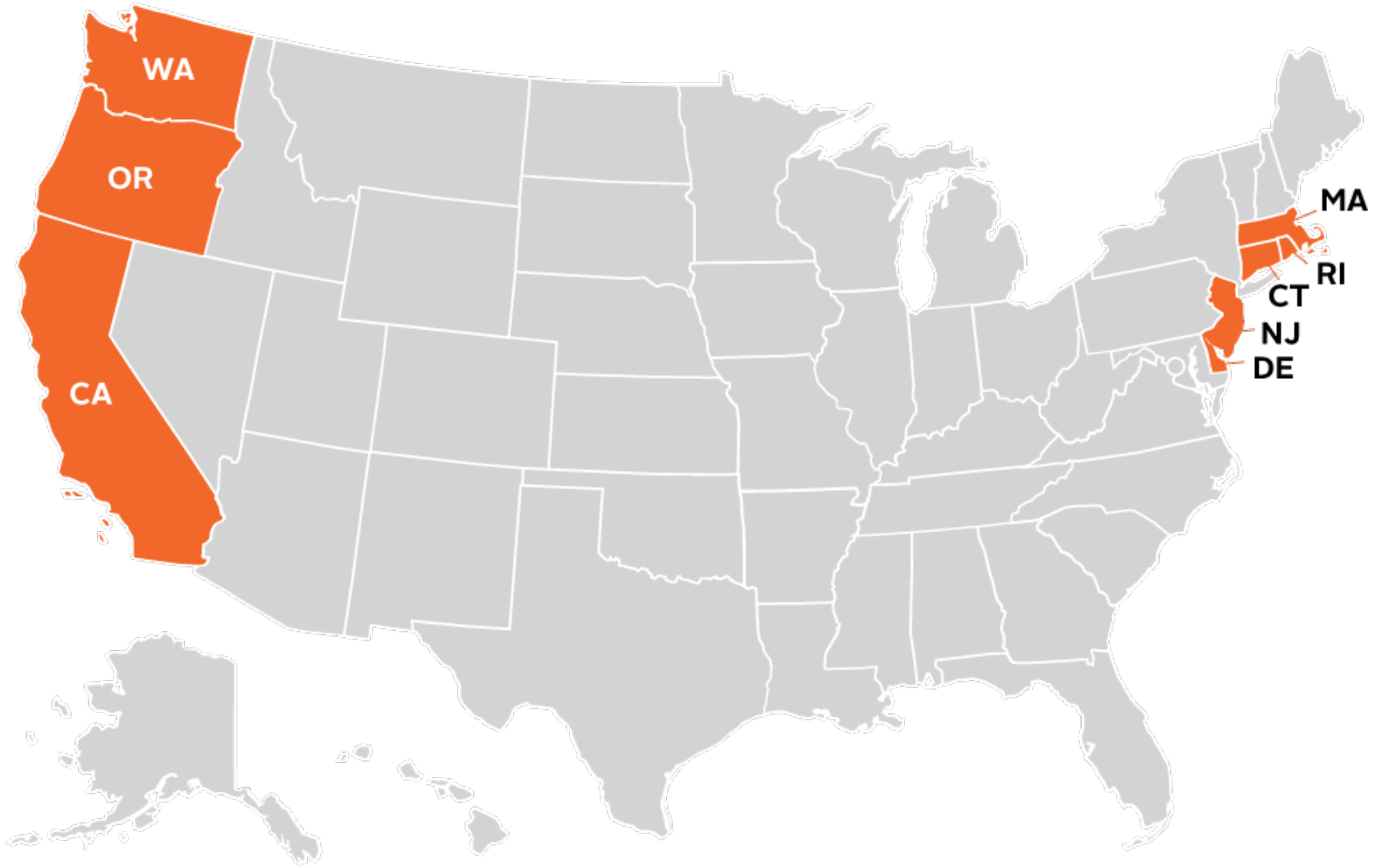
$1,024 saved
saved in out-of-pocket spending
**2020-2026*

- **Less care avoided due to cost**
- **Fewer financial harms**

Premium data based on the Medical Expenditure Panel Survey – Insurance component. Calculations assume a 25% family tax rate and that reductions in premium spending are converted to employee wages that face federal and state taxes. Out of pocket cost estimates from Massachusetts Center for Health Information and Analysis (CHIA) data showing that these costs are roughly 10% as high as premiums. Total enrollment in commercial insurance is from CHIA's enrollment trends data.

Eight states have now established statewide health care cost growth targets, cumulatively representing one in five residents in the U.S.

Many other states are building on the Massachusetts model and are adopting new strategies to promote transparency, oversight, and accountability.



How states use cost-growth benchmark programs to contain health care costs. The National Academy for State Health Policy. (2022, February 1). Retrieved from https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/

The HPC employs four core strategies to realize its vision of better care, better health, and lower costs for all people of the Commonwealth.

MARKET MONITOR

Monitor and intervene when necessary to assure market performance

CONVENE

Bring together stakeholder community to influence their actions on a topic or problem

RESEARCH AND REPORT

Investigate, analyze, and report trends and insights

PARTNER

Engage with individuals, groups, and organizations to achieve mutual goals

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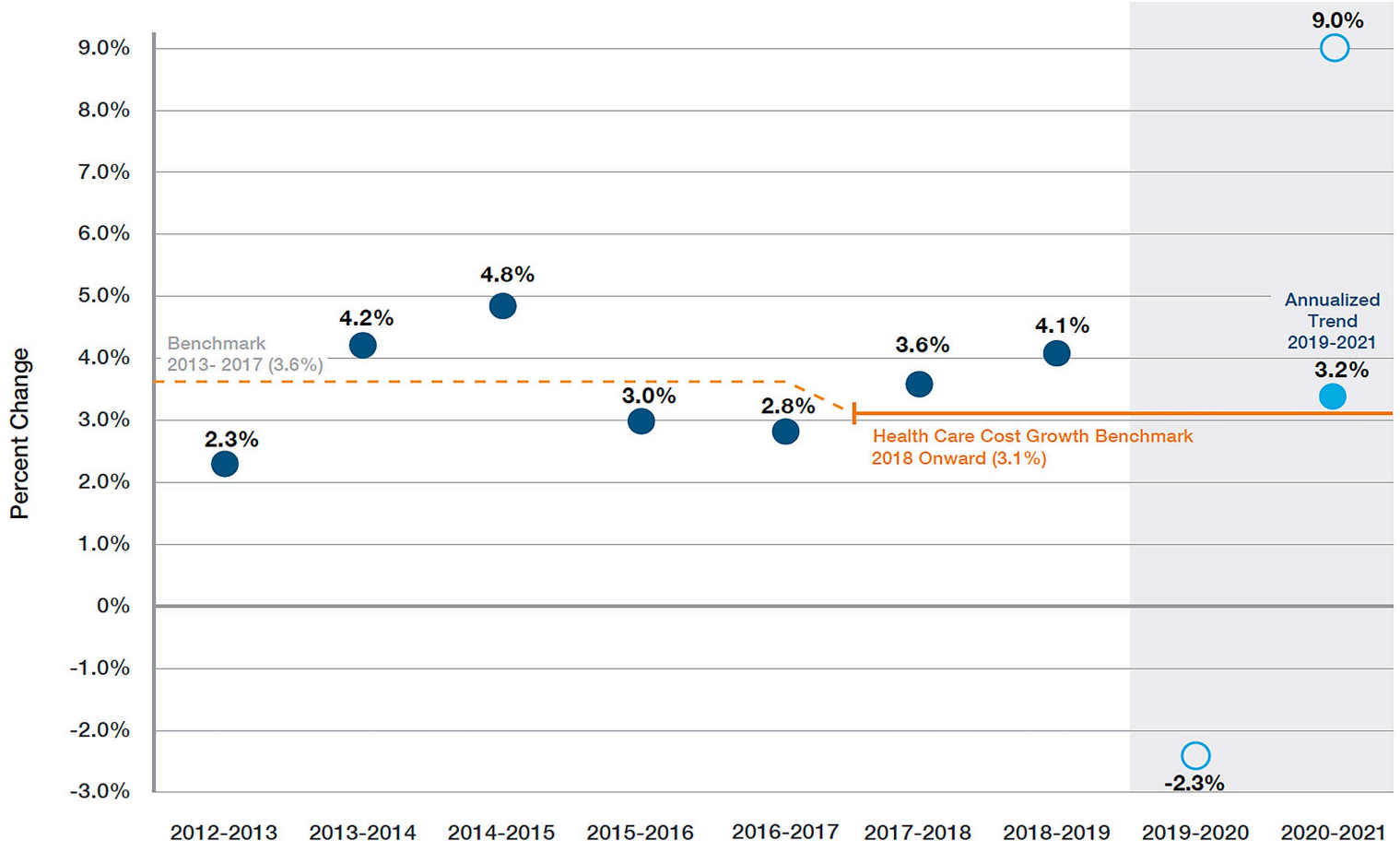
From 2012 to 2021, the average annual growth rate for health care spending in Massachusetts was 3.5%, below the initial target of 3.6%.

Massachusetts annual growth in per capita total health care spending relative to the benchmark, 2012 to 2021

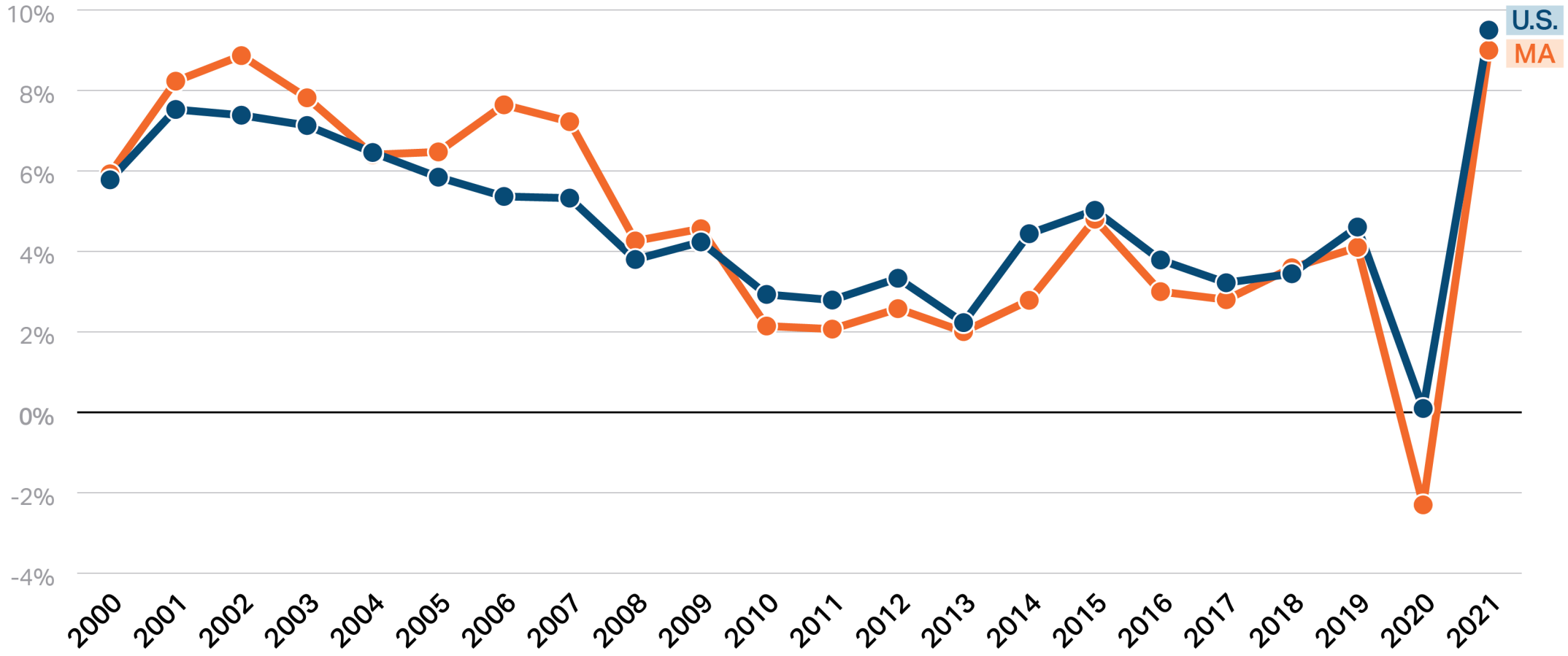


The average annual growth rate for the first two years of the COVID-19 pandemic was **3.2%.**

Source: Massachusetts Center for Health Information and Analysis, Annual Reports on the Performance of the Massachusetts Health Care System 2013-2023.

Massachusetts' overall rate of total spending growth was below the comparable U.S. rate for 11 of the past 12 years.

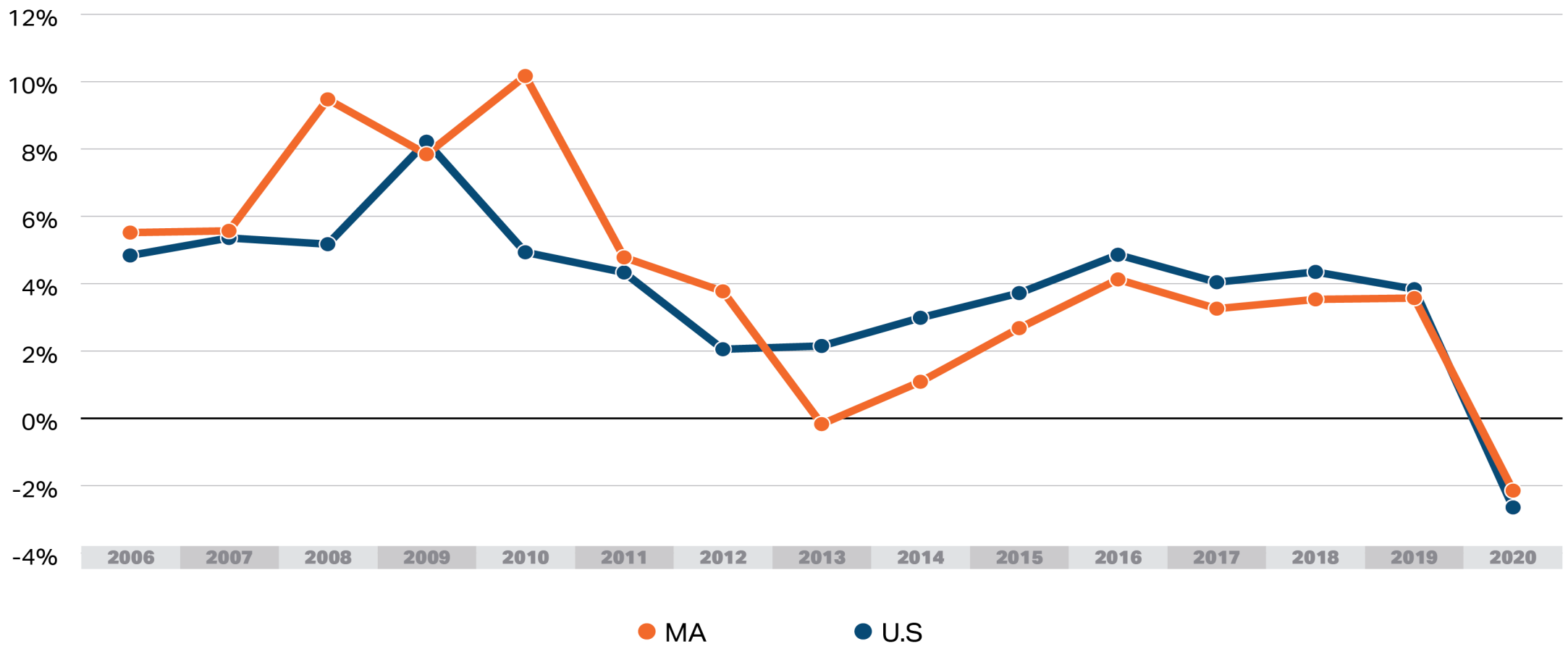
Annual growth in per capita health care spending from the previous year to the year shown, Massachusetts and the U.S., 2006-2021



Notes: U.S. data includes Massachusetts. Massachusetts and US data exclude federal COVID-19 relief funding.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures Data, 2014-2021 and State Healthcare Expenditure Accounts, 1999-2014; Center for Health Information and Analysis, growth in Total Health Care Expenditures per capita, 2014-2021.

Since the benchmark was established, Massachusetts' commercial spending growth was below the U.S. rate in nearly every year, resulting in billions of dollars in avoided spending.

Annual growth in per capita commercial health care spending, Massachusetts and the U.S., 2006-2020



Notes: Massachusetts data include full-claims members only. Commercial spending is net of prescription drug rebates and excludes net cost of private health insurance.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures, 2014-2019 and State Healthcare Expenditure Accounts 2005-2014; Center for Health Information and Analysis, Total Health Care Expenditures, 2014-2020

The HPC employs four core strategies to realize its vision of better care, better health, and lower costs for all people of the Commonwealth.

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PARTNER

Engage with individuals, groups, and organizations to achieve mutual goals

The HPC monitors changes in the health care market and provides objective, data-driven analyses of likely impacts in order to increase public transparency and accountability.

- Market structure and new provider changes, including consolidations and alignments, have been shown to impact health care system performance and total medical spending.
- State law directs the HPC to track “material change[s] to [the] operations or governance structure” of provider organizations and to engage in a more **comprehensive review** of transactions anticipated to have a significant impact on health care costs or market functioning.
- For provider changes that require the filing of a determination of need (DoN) application with the Department of Public Health (DPH), Chapter 224 provides that the HPC may comment on any application.
- The goal of the HPC’s market reviews is to **promote transparency and accountability** in engaging in market changes, ensure consistency with the **state’s cost containment goals**, and encourage market participants to **minimize negative impacts** and **enhance positive outcomes** of any given material change.

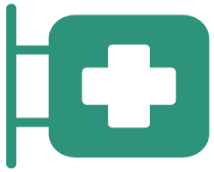
The HPC's reviews are focused on spending, quality, and access and includes both quantitative and qualitative analysis.

What were the **priorities** for the parties, and what impacts would these have on competition, insurance companies, and patients?

What were the **prices** of the parties, and how would the transaction impact price and spending?

What current **patient care patterns** existed, and how would the transaction impact these patterns?

How do the parties perform in terms of **clinical quality**, and how would the transaction impact the quality of care patients receive?



How would the transaction impact **access** to needed care for patients in the parties' service areas?

Public Benefits of Provider Market Oversight

The Material Change Notice (MCN) and Cost and Market Impact Review (CMIR) process, in addition to increasing public awareness of provider affiliations, has produced the following benefits for consumers in Massachusetts:

Future Accountability: Requiring entities to disclose goals for a transaction allows the HPC and others to assess whether those goals have been achieved in the future.

Voluntary Commitments: Some entities have addressed concerns raised by the HPC by making certain public commitments (e.g., increasing access for Medicaid patients, not implementing facility fees at acquired physician clinics).

Support for Enforcement Actions: Findings in CMIR reports have been used by the Massachusetts Attorney General and Department of Public Health to negotiate enforceable commitments to address cost, market, quality, and access concerns.

- CMIR findings may be considered as evidence in Massachusetts antitrust or consumer protection actions, and in Determination of Need reviews.

Impacts on Transaction Plans: In some cases, entities have planned affiliations in part based on the likelihood of a CMIR, and in other cases have decided not to pursue an affiliation after the HPC raised concerns in the MCN or CMIR process.

What’s next for the HPC?

HPC Agenda for Action - 2023

To kick off 2023, the HPC is pursuing an ambitious action plan to reduce health care cost growth, promote affordability, and advance equity, in addition to ongoing workstreams and responsibilities.

This comprehensive plan will prioritize disseminating data-driven insights and policy recommendations to address the critical challenges facing the health care system today: the workforce crisis, high costs, and persistent health inequities.

- **Bolster the HPC's Cost Containment Activities**
- **Address Health Care Workforce Challenges and Identify Solutions**
- **Advance Health Equity**
- **Enhance Pharmaceutical Pricing Transparency and Accountability**
- **Reduce Unnecessary Administrative Complexity**
- **Upcoming Topics of Actionable Research**

Bolstering Cost Containment Activities: The HPC recommends policy action to improve state oversight and accountability.

- **Target Above Benchmark Spending Growth.** The Commonwealth should take action to strengthen the Performance Improvement Plan (PIP) process, the HPC's primary mechanism for holding providers, payers, and other health care actors responsible for health care spending growth. Specifically, the HPC recommends that the metrics used by CHIA to identify and refer organizations to the HPC should be expanded to include measures that account for the underlying variation in provider pricing and baseline spending, and by establishing escalating financial penalties to deter excessive spending.

- **Constrain Excessive Provider and Pharmaceutical Prices.** The Commonwealth should take action to constrain excessive price levels, variation, and growth for health care services and pharmaceuticals, by imposing hospital price growth caps, enhancing scrutiny of provider mergers and expansions, limiting hospital facility fees, and expanding state oversight and transparency of the entire pharmaceutical sector, including how prices are set in relation to value.

- **Limit Increases in Health Insurance Premiums and Cost-Sharing.** The Commonwealth should take action to hold health insurance plans accountable for affordability and ensure that any savings that accrue to health plans are passed along to businesses and consumers, including by setting affordability targets and standards as part of the annual premium rate review process.

The 2022 Policy Recommendations reflect a comprehensive approach to reduce health care cost growth, promote affordability, and advance equity.

Contact Us

Follow-up questions?


David.Seltz@mass.gov


mass.gov/HPC


@Mass_HPC

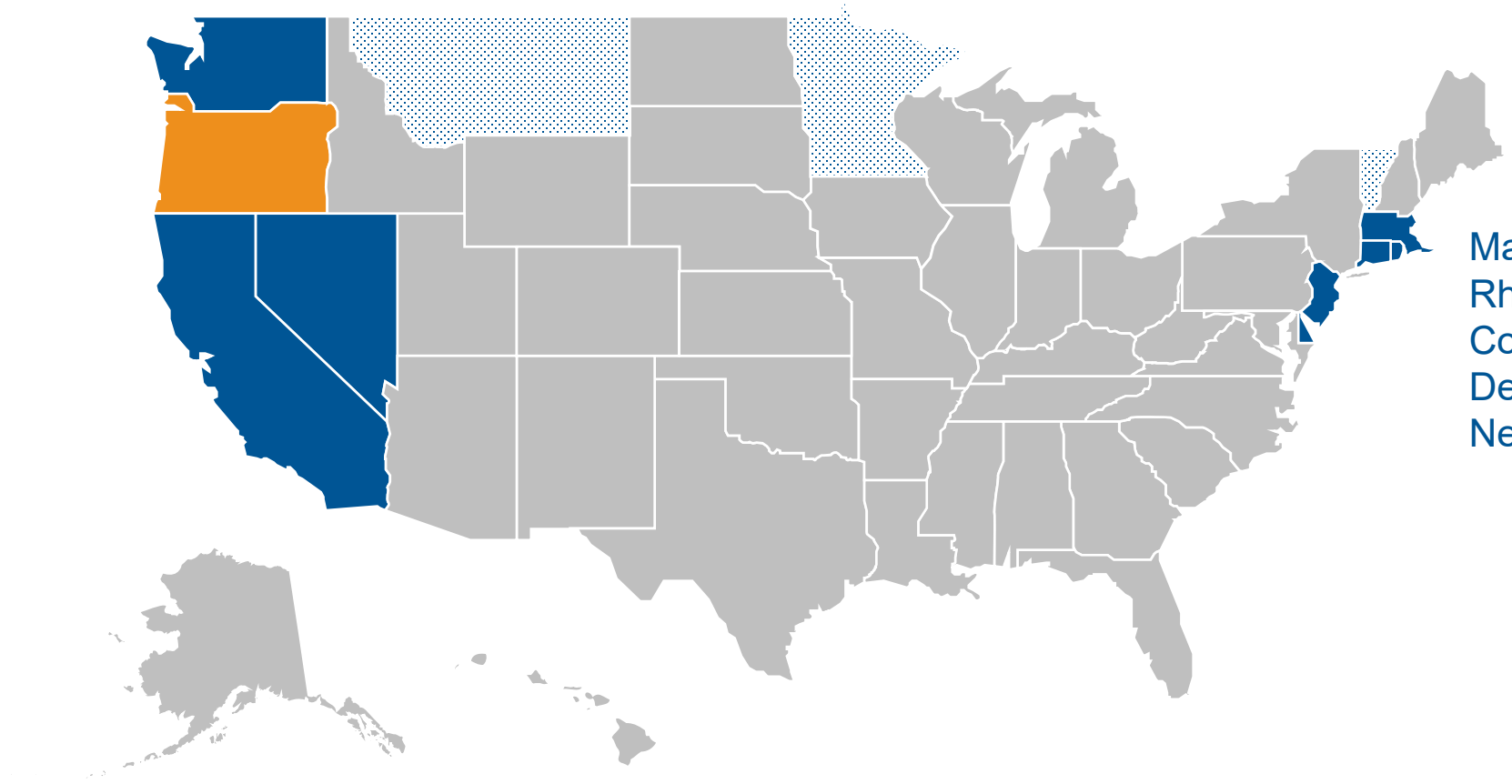

tinyurl.com/hpc-video

Oregon's Sustainable Health Care Cost Growth Target Program

April 25, 2023 | Sarah Bartelmann

About Oregon’s Program

Oregon was the 4th state to establish a health care cost growth target program.

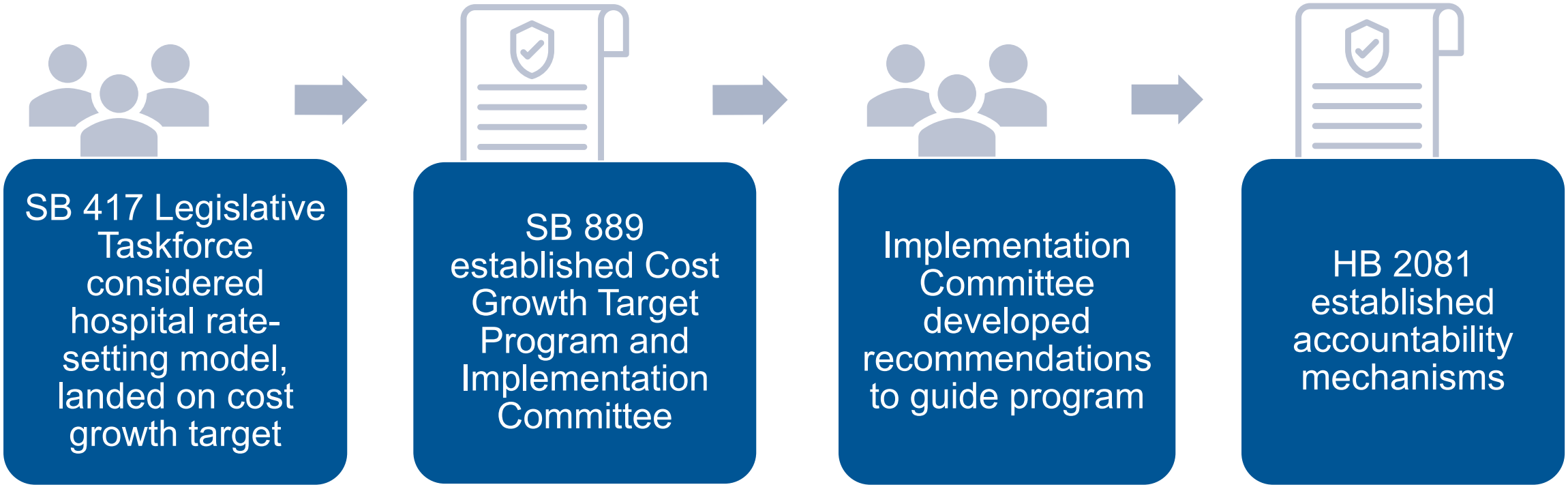


Massachusetts
Rhode Island
Connecticut
Delaware
New Jersey

States with a cost growth target program

States that are considering a cost growth target

Oregon’s path to a cost growth target program.

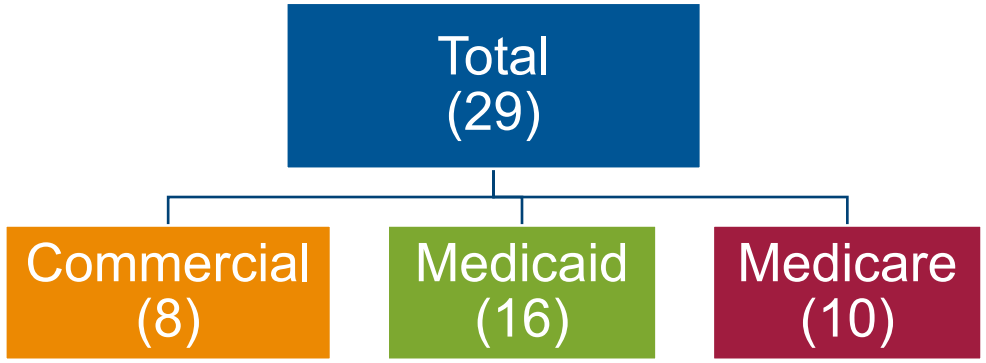


Select elements of Oregon's cost growth target: Inclusion Criteria

Oregon's health care cost growth target must "Apply to **all** providers and payers in the health care system in this state"

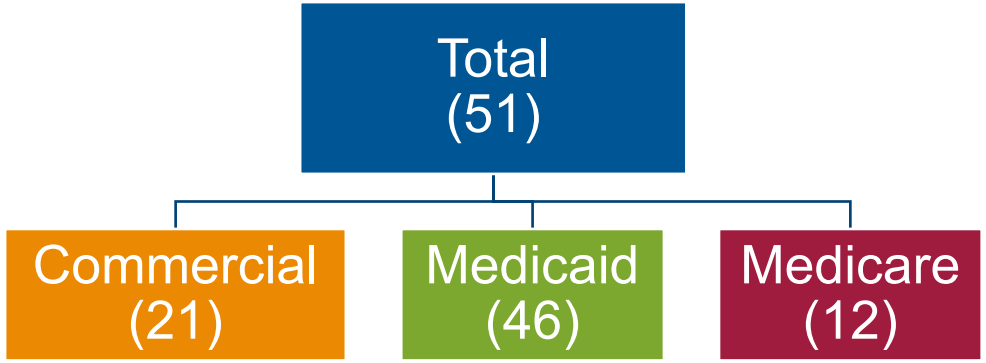
Payers

At least 1,000 covered lives in Oregon across all lines of business



Provider Organizations

Can be held accountable for total medical expenses AND have at least 10,000 unique attributed patients



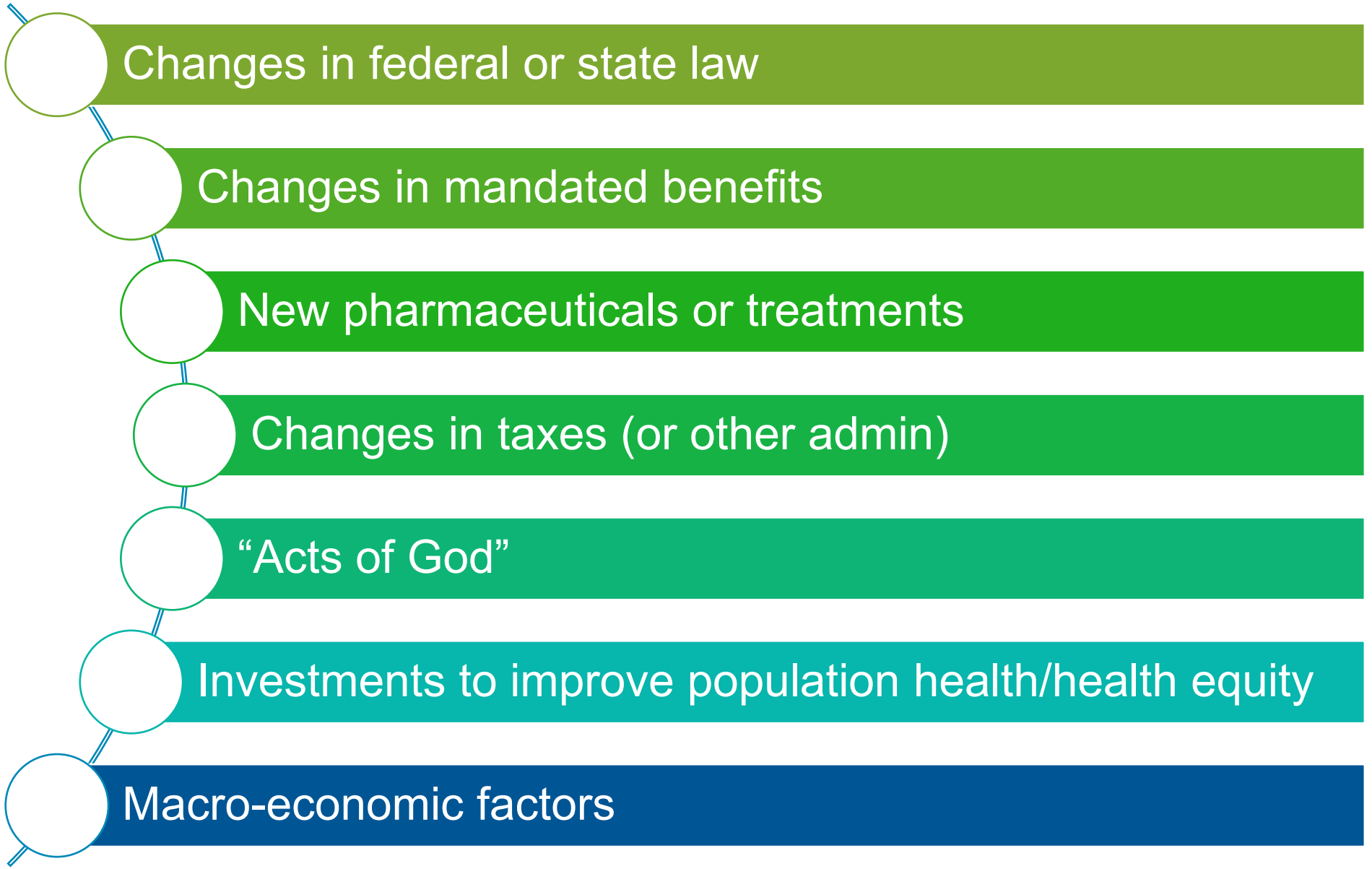
Select elements of Oregon's cost growth target: **Accountability**

Transparency

Performance Improvement Plans

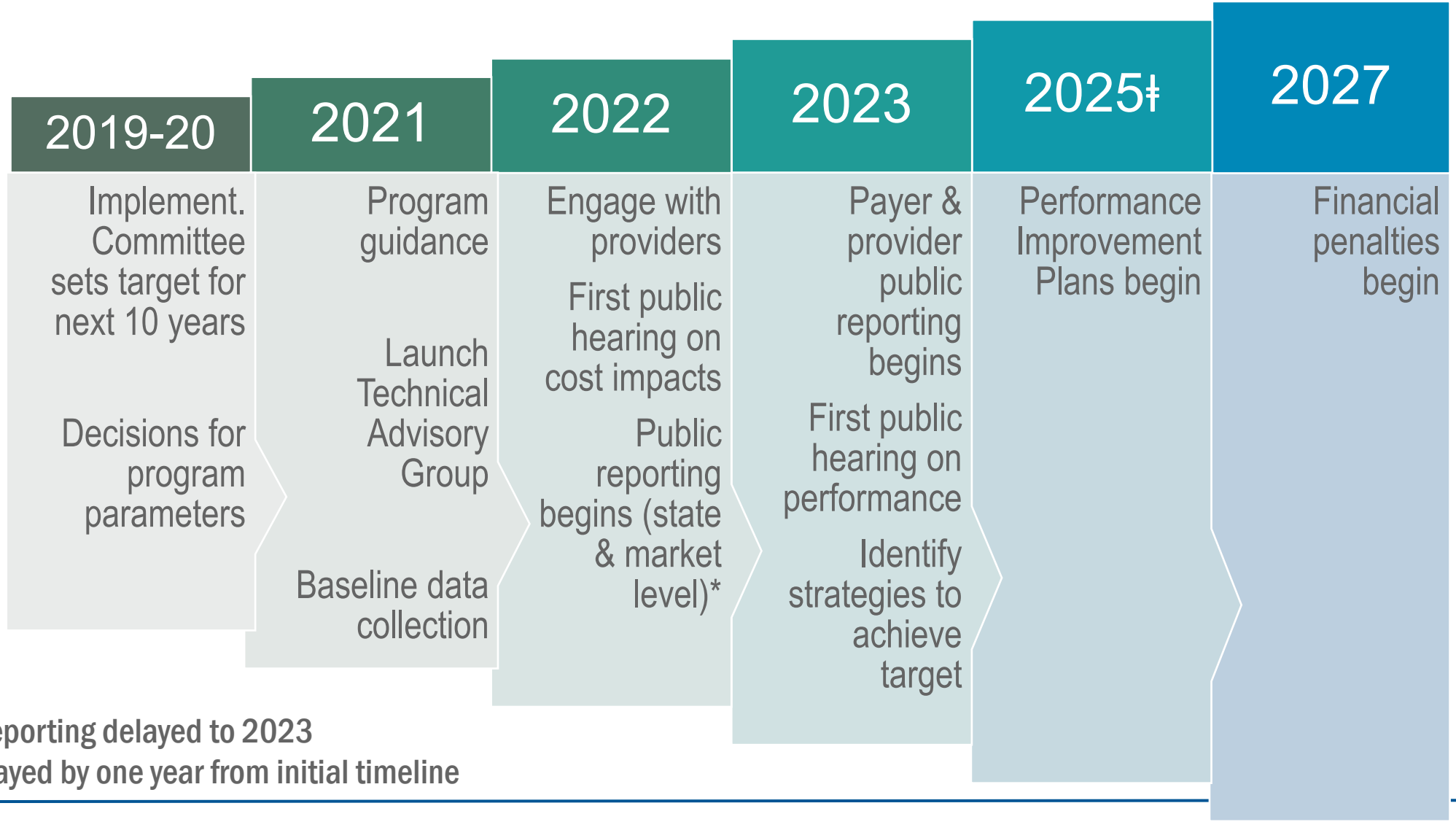
Financial Penalties

Ongoing conversations to understand cost growth drivers and reasons for exceeding the cost growth target in a given year



The cost growth target program has built-in flexibility to identify factors that drive costs that are outside of a payer or provider organization’s control

Oregon's program has a long on-ramp



*Public reporting delayed to 2023

‡ PIPs delayed by one year from initial timeline

Oregon’s Governance Structure

2019-2021

Oregon Health Policy Board

CGT Implementation Committee

Technical Advisory Group (TAG)

2022+

Oregon Health Policy Board

CGT Advisory Committee

TAG

Cost & Equity

Implementation Committee Charge

Implementation Committee Recommendations Report, Jan 2021

Advisory Committee Membership

20 members, with representation carefully balanced across 3 domains

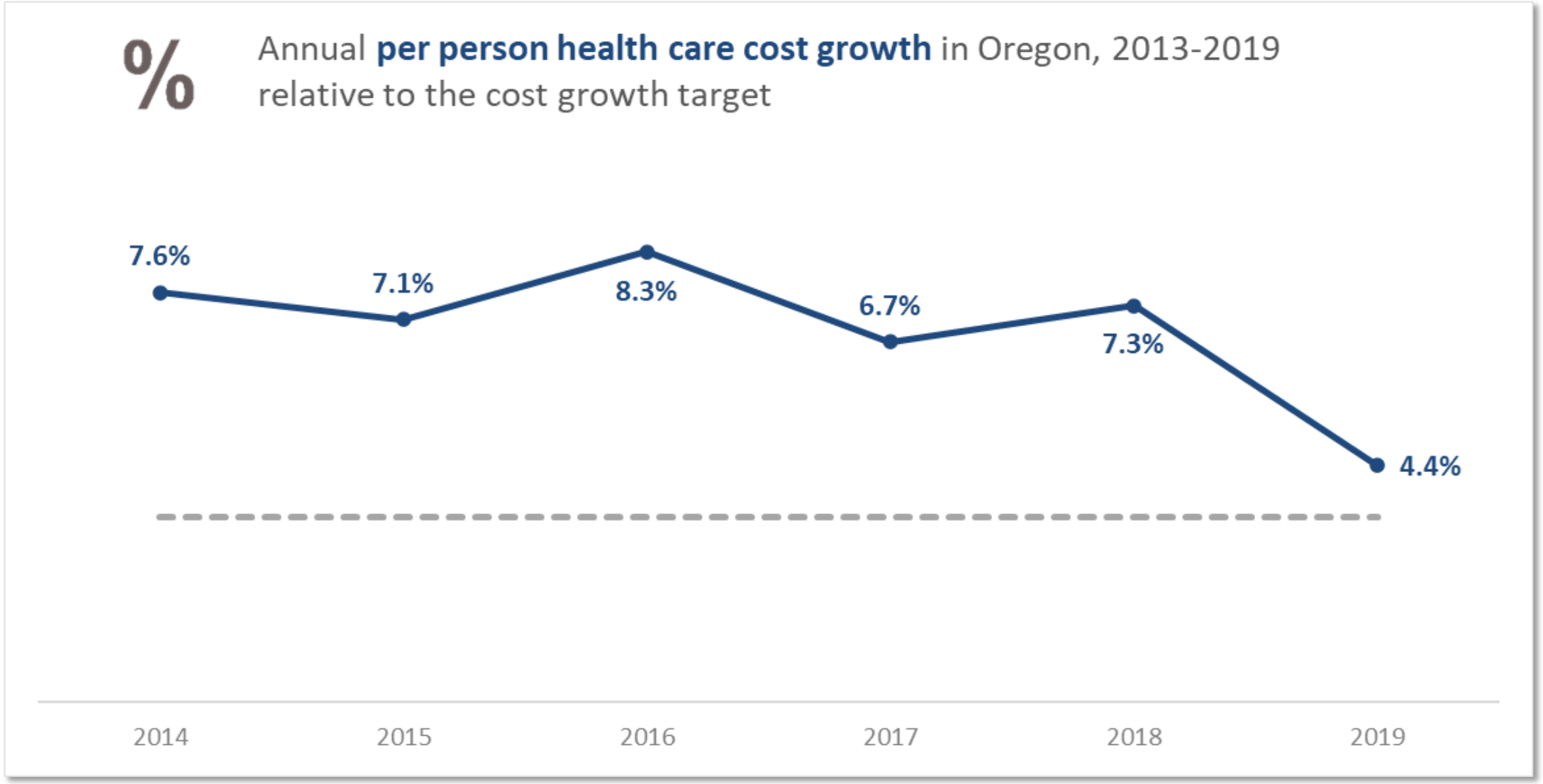
Sector

Demographics

Expertise

	Sector
Health Care Industry	**50%**
Health plan/ payer	5
Large health system	2
Small/ rural hospital	1
Large provider group	1
Independent provider	1
Non-Health Care Industry	**50%**
Consumer advocate	6
Larger employer/ purchaser	1
Small employer/ purchaser	2
Research/ academic	1

Reflections



Source: Oregon Health Authority. Health Care Cost Trends: State and Market-Level Cost Growth in Oregon, 2013-2019. July 2022
https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/Oregon-Health-Care-Cost-Trends-Report-2013-2019-FINAL.pdf

For More Information

Email:

Sarah.E.Bartelmann@oha.oregon.gov

HealthCare.CostTarget@oha.oregon.gov

Website:

https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx

HCAi
Department of Health Care Access and Information

Advisory Committee Membership

Vishaal Pegany, Deputy Director OHCA

Health Care Affordability Advisory Committee

Enabling statute requires the Board to:

- Establish a Health Care Affordability Advisory Committee to provide input and recommendations.
- Appoint the members of the Advisory Committee by a majority vote of the Board's voting members.

When appointing members, the Board shall aim for broad representation from:

- Consumer and patient groups;
- Payers;
- Fully integrated delivery systems;
- Hospitals;
- Organized labor;
- Health care workers;
- Medical groups;
- Physicians; and
- Purchasers.

Health Care Affordability Advisory Committee (cont.)

The Board must consider areas of expertise in the following areas:

- Health care economics;
- Health care delivery;
- Health care management or health care finance and administration;
- Health plan administration and finance;
- Health care technology;
- Research and treatment innovations;
- Competition in health care markets;
- Primary care;
- Behavioral health;
- Purchasing or self-funding group health care coverage for employees;
- Enhancing value and affordability of health care coverage; or
- Organized labor that represents health care workers.

In making appointments, the Board shall consider diversity of expertise; the state's diversity in culture, race, ethnicity, sexual orientation, gender identity, and geography; and any experience as a patient or caregiver of a patient with a chronic condition, including behavioral health care or a disability.

Advisory Committee and Board Collaboration

The Advisory Committee provides input and recommendations to the Board on the following:

- Statewide health care cost target and specific targets by health care sector and geographic region.
- Methodology for setting cost targets and adjustment factors to modify cost targets when appropriate.
- Definitions of health care sectors.
- Benchmarks for primary care and behavioral health spending.
- Statewide goals for the adoption of alternative payment models and standards.
- Quality and equity metrics.
- Standards to advance the stability of the health care workforce.
- Other areas requested by the board or office.

In addition, the Board shall consider input, including recommendations, from the Advisory Committee, along with public comments, in the Board's deliberation and decision making.

Determine Advisory Committee Selection Process

Selection Process

Options for Board Action

1. The office can evaluate the submissions that it has received, and present to the board recommended individuals in alignment with the statutory criteria.
2. The board could vote today to establish a subcommittee of 2 board members to work with staff to evaluate and review the received applications and present to the board recommended individuals in alignment with statutory criteria.
3. Others?

Recommendation

Option 2 optimizes Board input and alignment on Advisory Committee participants. The subcommittee may also consider other details to present for the Board's considerations (e.g., term limits, process to add/remove members, etc.)

Board Member Attendance Requirements at Advisory Committees

Advisory Committee (AC) Attendance Requirements

Requirement

- At least one member of the board shall attend the Advisory Committee meetings.

Key Considerations

- Bagley Keene – avoid a majority of the quorum
- The board may appoint 1 or 2 members to attend the AC meetings
- The board may appoint the same board member(s) to attend all meetings
- The board may appoint the board member(s) to attend each AC meeting in the preceding board meeting

Next step

Decide at the May 2023 meeting Board member participation in the June AC meeting.

HCAi
Department of Health Care Access and Information

Discussion of Total Health Care Expenditures (THCE) Design Considerations

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Measuring Total Health Care Expenditures

Recap of Board Meeting #1

- During the first Board meeting, we reviewed:
  - The California Health Care Quality and Affordability Act
  - The health care landscape in California
  - An introduction to spending targets
- As a reminder, Board meetings during Q1-Q3 of 2023 will focus on the **methodology for measuring and reporting Total Health Care Expenditures (THCE),** which will be included in the baseline spending report.
- We will begin discussion of California's statewide spending target later in the year.

Discussion Today: Review of Considerations for Defining THCE

- Total health care expenditures (THCE) is the basis for which OHCA will measure year-over-year performance against the spending target.
- OHCA's first public reporting on THCE data will be the baseline spending report covering calendar years 2022 and 2023. This report is expected by June 2025.
- Progress against the 2025 target will be publicly reported in the first Annual Report expected by June 2027, and annually thereafter.

Discussion Today: Review of Considerations for Defining THCE (cont.)

1. Components and categories of spending to measure THCE
2. Determining whose spending will be measured
3. Population to use as the denominator for calculating per capita spending
4. Levels of reporting THCE

Process to Facilitate Defining THCE

- Our plan is to present the Board with a series of sequenced “design considerations.” We will…
  - Review options for different considerations, as needed
  - Share approaches adopted by other states
  - Facilitate discussion to reach agreement on an approach
- There will be structured time for reconsideration of tentative considerations during future meetings, including after receipt of Advisory Committee input and public comment.

California Health Care Quality and Affordability Act: Definition of THCE

- THCE means **all health care spending in the state by public and private sources**, including all of the following:
  - All **claims-based payments** and encounters for *covered* health care benefits
  - All **non-claims-based payments** for covered health care benefits, *such as* capitation, salary, global budget, other alternative payment models, or supplemental provider payments pursuant to the Medi-Cal program
  - All **cost sharing** for covered health benefits paid by residents of the state, *including, but not limited to*, copayments, coinsurance, and deductibles
  - **Insurer administrative costs and profits**
  - **Pharmacy rebates**

THCE Components

Total Medical Expense (TME)	+	Insurer Administrative Costs and Profits	=	Total Healthcare Expenditures (THCE)
✓ All **claims-based** payments and encounters for covered health care benefits. ✓ All **non-claims-based** payments for covered health care benefits. ✓ All **cost sharing** for covered health benefits paid by residents of the state.		✓ Including but not limited to administration expenditure; net additions to reserves; rate dividends or rebates; profits or losses; taxes and fees.*		Spending we will be measuring when assessing performance against the target.

*"Administrative costs and profits" for a fully integrated delivery system means those associated with its nonprofit health care services plan.

THCE Component: Claims-based Payments

- **Enabling statute:** "All claims-based payments and encounters for *covered* health care benefits"

Typical claims-based categories	
• Hospital Inpatient • Hospital Outpatient • Professional: Primary Care • Professional: Specialty • Professional: Other	• Long-Term Care • Retail Pharmacy[1] • Dental[2] • Other (e.g., durable medical equipment, transportation)

[1] Medical pharmacy is typically captured in the hospital outpatient and professional service categories.
[2] Dental spending for covered dental benefits as part of a comprehensive plan, and not standalone dental plan spending.

THCE Component: Non-claims Payments

- **Enabling statute:** “All non-claims-based payments for covered health care benefits, **such as** capitation, salary, global budget, other alternative payment models, or supplemental provider payments pursuant to the Medi-Cal program.”
- Non-claims categories will be further defined and refined as the spending program develops, and specifically as OHCA considers standards to promote alternative payment model (APM) adoption.
- The following non-claims categories are presented as examples of potential future non-claims subcategories.

Non-Claims-based Spending Identified in Statute

- **Capitation**: per capita payments to providers to provide healthcare services over a defined period.
- **Salary:** payments for salaries of providers who provide health care services not otherwise included in other claims and non-claims categories.
- **Global budget:** prospective payments made to providers for a comprehensive set of services for a designated patient population or a more narrowly defined set of services where certain benefits (e.g., behavioral health, pharmacy) are carved out.
- **Supplemental provider payments pursuant to the Medi-Cal program:** payments to qualifying providers who provide services to Medi-Cal and underinsured patients, for example.

Other Examples of Non-Claims-based Spending

1. **Payments to support population health and practice infrastructure:** payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality, and control costs.
2. **Prospective case rate payments:** prospective payments made to providers in a given provider organization for a patient receiving a defined set of services for a specific period.
3. **Prospective episode-based payments:** payments received by providers (which can span multiple provider organizations) for a patient receiving a defined set of services for a specific condition across a continuum of care, or care for a specific condition over a specific time period.

Other Examples of Non-Claims-based Spending (cont.)

4. **Performance incentive payments:** payments made to providers for achieving quality or cost-savings goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target (e.g., pay-for-performance; pay-for-reporting; shared savings distribution, etc.)
5. **Recoveries:** payments received from a provider, member/beneficiary or other payer, which were distributed by a payer and then later recouped due to a review, audit, or investigation (reported as a negative number).
6. **Pharmacy rebates:** Rebates and other price concessions paid by a PBM or drug manufacturer to a health insurer or public payer.
7. **Other:** Payments pursuant to a payer's contract with a provider that were not made on the basis of a claim for health care benefits / services and not classified elsewhere, e.g., governmental payer shortfall payments, grants, or surplus payments.

Design Consideration: Non-Claims-based Spending

- Are there any other categories of non-claims-based payments that OHCA should consider?

Statute	Other Categories for Consideration
1. Capitation 2. Salary 3. Global budget 4. Other alternative payment models 5. Supplemental provider payments pursuant to the Medi-Cal program	1. Payments to support population health management and practice infrastructure 2. Prospective case rates 3. Prospective episode-based payments 4. Performance incentive payments 5. Recoveries 6. Pharmacy rebates 7. Other payments (e.g., governmental payer shortfall payments, grants, etc.)

THCE Component: Cost Sharing

- **Enabling statute:** “All cost sharing for **covered** health benefits paid by residents of the state, **including, but not limited to**, copayments, coinsurance, and deductibles”

- The statute allows for inclusion of additional cost-sharing costs, so the methodology will need to be explicit about which cost-sharing costs are included and excluded.

Design Consideration: Capturing Cost-sharing Spending

- Are there additional categories of cost-sharing, including, but not limited to, copayments, coinsurance, and deductibles that should be **included**?
- Should the methodology explicitly **exclude** other out-of-pocket costs?
- Only cost sharing for **covered services** are required to be included. Payers generally lack data on spending for non-covered services.

THCE Component: Insurer Administrative Costs and Profits

- **Enabling statute:** "Administrative costs and profits" means "the total sum of all expenses not included in the numerator of the medical loss ratio calculation under state or federal law, **including, but not limited to**, all of the following:
  - All categories of administrative expenditures
  - Net additions to reserves[1]
  - Rate dividends or rebates
  - Profits or losses
  - Taxes and fees"

[1] For not-for-profit insurers, profits are often referred to as "contributions to reserves."

Design Consideration: Insurer Administrative Costs and Profits

- The statute lists a range of administrative costs and profits. Are there other administrative costs and profits to consider?

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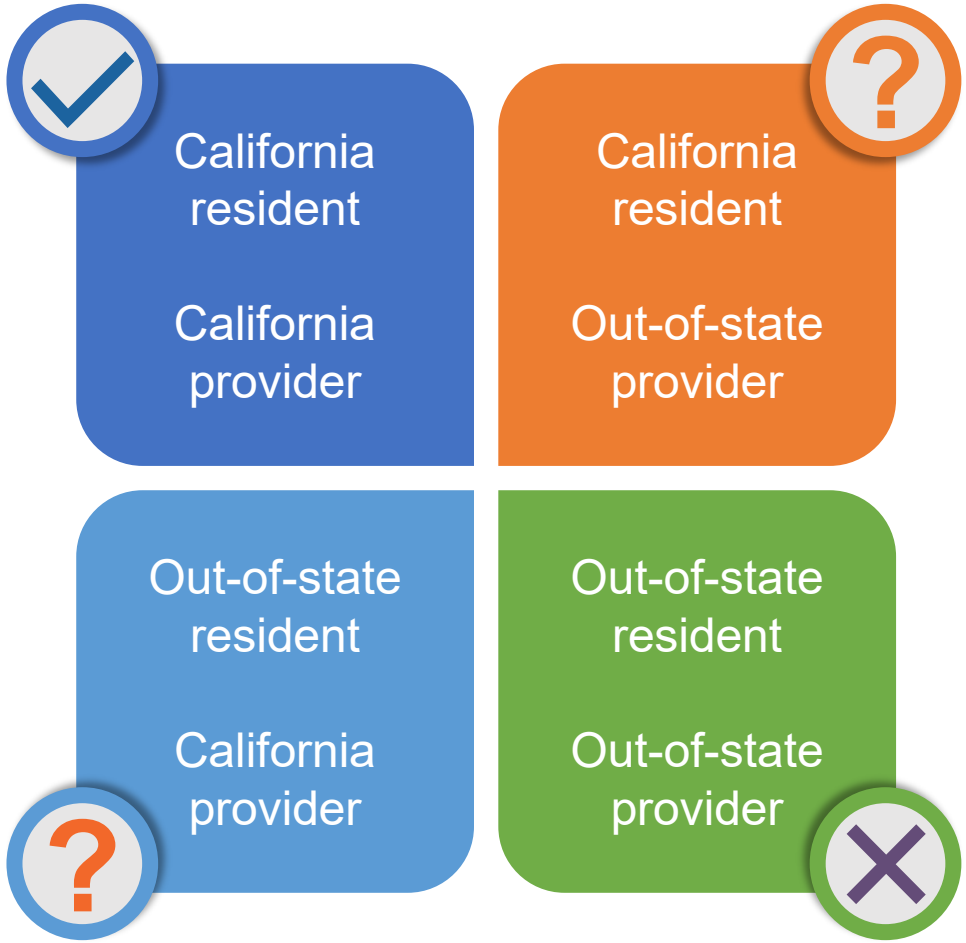
Whose Total Medical Expense to Include

- **Enabling statute**: THCE means “all health care spending in the state by public and private sources”
- We need to determine the population whose spending will be measured. For the services covered by payers, should we include spending based on:
  - Residence of the individual?
  - Location of the provider?
- We will also present considerations of sources of coverage.

State of Residence and Location of Care

- Include California residents who received care from California providers
- Exclude out-of-state residents who received care from out-of-state providers
- What about
  - California resident receiving care from an out-of-state provider?
  - Non-California resident receiving care from a California provider?



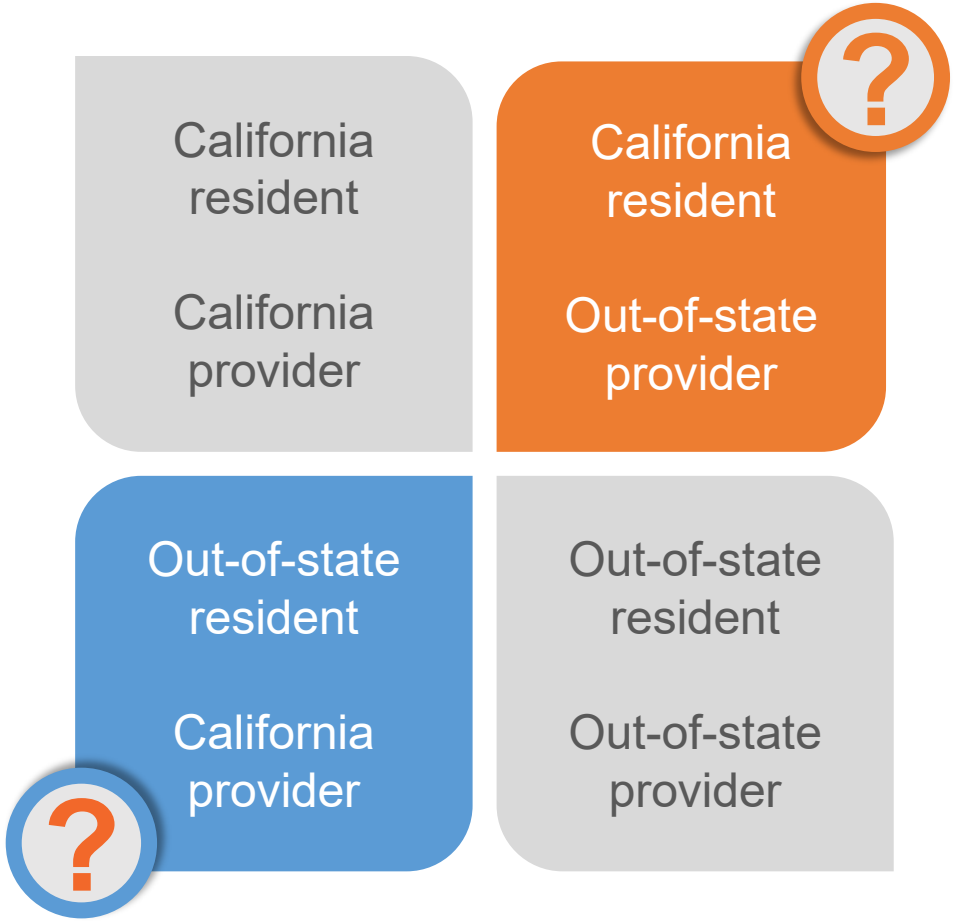
Considerations: California Resident, Out-of-state Provider

- Some provider organizations have affiliated or employed physicians who practice in bordering states.
- Some residents split their time between California and other states, e.g., live in a border community, commute across the border, spend winter or summer in another state.
- MA, DE, RI, OR, CT and WA include spending by state residents with out-of-state providers.

Considerations: Non-state Resident, California Provider

- State employees and other workers who are non-state residents may commute into the state for work and receive their health care in the state. This spending represents an expense for California employers.
- These dollars can only be captured with certainty from those insurers that will be required to report; insurers not licensed in the state will be less likely to report.
- This is not spending on behalf of California residents, but it is spending in California.
  - MA, DE, RI, OR, CT and WA do not include this type of expenditures.

Design Consideration: State of Residence and Care Location



- Include health care spending incurred out-of-state by California residents?
- Include health care spending for non-state residents who receive care from California providers?

Sources of Health Care Coverage

- **Enabling statute:** THCE means all health care spending in the state "by public and private sources"

All spending target states include these sources of coverage	▪ **Medicare:** fee-for-service; Medicare Advantage ▪ **Medicaid:** fee-for-service; managed care ▪ **Integrated Medicare + Medicaid** plans (for individuals who are dually eligible) ▪ **Commercial**: fully-insured; self-insured
Other sources of coverage for possible inclusion	▪ Correctional Health System ▪ Indian Health Services (IHS) ▪ TRICARE ▪ Veterans Health Administration (VHA)

Considerations:
Other Sources of Coverage

Source of coverage	Considerations
Correctional Health System* (CT, OR, WA)	• In 2018, 239,000 individuals were incarcerated in CA, which is approximately 0.6% of the state population. • State spending for correctional health may be available but is unlikely to be reported using the same methodology as other payer spending.
Indian Health Service (no other state)	• In 2020, 1.7% of CA's population was Native American/Alaskan Native, though not all were likely served by the IHS. • Data collection requires consent from all tribes following tribal consultations.

**In certain circumstances, inpatient spending for individuals in the correctional system are reported under Medi-Cal. In addition, Medi-Cal is building towards covering certain assessment, treatment, and care management services for eligible individuals who are incarcerated for up to 90 days prior to release. This spending would be captured by Medi-Cal.*

Considerations:
Other Sources of Coverage (cont.)

Source of coverage	Considerations
TRICARE (no other state)	• As of December 2022, 769,362 Californians were enrolled in TRICARE (~2% of California's population). • Assistance from TRICARE will likely be necessary since the plan administrator is not regulated by the state.
Veterans Health Administration (CT, DE, MA)	• In 2016, 7.2% of CA residents were veterans. • Data are available, but not using the same methodology and format as other payer spending.

Design Consideration: Including Other Sources of Coverage

- Should California's THCE definition include any of the following other sources of coverage?
  - Correctional Health System
  - Indian Health Service
  - TRICARE
  - Veterans Health Administration

- Are there any other sources of coverage to consider for inclusion?

What About Spending by People Who Are Uninsured?

- There is no comprehensive data source to capture out-of-pocket spending by the uninsured.
- THCE spending is typically calculated using payer-submitted data.
- We lack a means to capture all payments made by individuals who are uninsured.

What About Uncompensated Care and Bad Debt?

- Uncompensated care includes:
  - the provision of care at no charge or at discounted rates (“charity care”); and
  - no payment for services provided (“bad debt” and write-offs).
- Other states have chosen not to include these amounts.
  - Uncompensated care is a provider cost – it is not payer or patient spending.
  - Bad debt is also a provider cost. If related to covered services, it is already captured because we are measuring payer “allowed amounts.”

Discussion Today: Review of Considerations for Defining THCE

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3. **Population to use as the denominator for calculating *statewide* per capita spending**
4. Levels of reporting THCE

Population Denominator for Calculating *Statewide* Per Capita Spending

- Reporting on a per capita basis allows states to account for migration and population changes that could significantly affect total health care spending.
- Per capita analysis also facilitates comparisons of spending growth across states of different population sizes.
- Two options to consider for the population denominator for measuring trend at the state level*:
  1. Use membership figures reported by payers
  2. Use the state's total population

*Measuring spend at the market, payer, fully integrated delivery system, and provider levels use enrolled / attributed individuals.

Considerations: Population Denominator for Calculating *Statewide* Per Capita Spending

1. Membership figures reported by payers (CT, OR, RI, WA)	• Provides an accurate picture of per member spending for the reported population
2. State's total population (MA)	• Using the total population in the denominator with spending reported by payers in the numerator could mask the true spending growth if there is a significant shift in the number of people in the population who are insured/uninsured • Does not tie directly to the covered lives reported by payers

Design Consideration: Population Denominator for Calculating *Statewide* Per Capita Spending

- Use membership figures reported by payers?
- Use the state's total population?
- Is there another proposed approach?

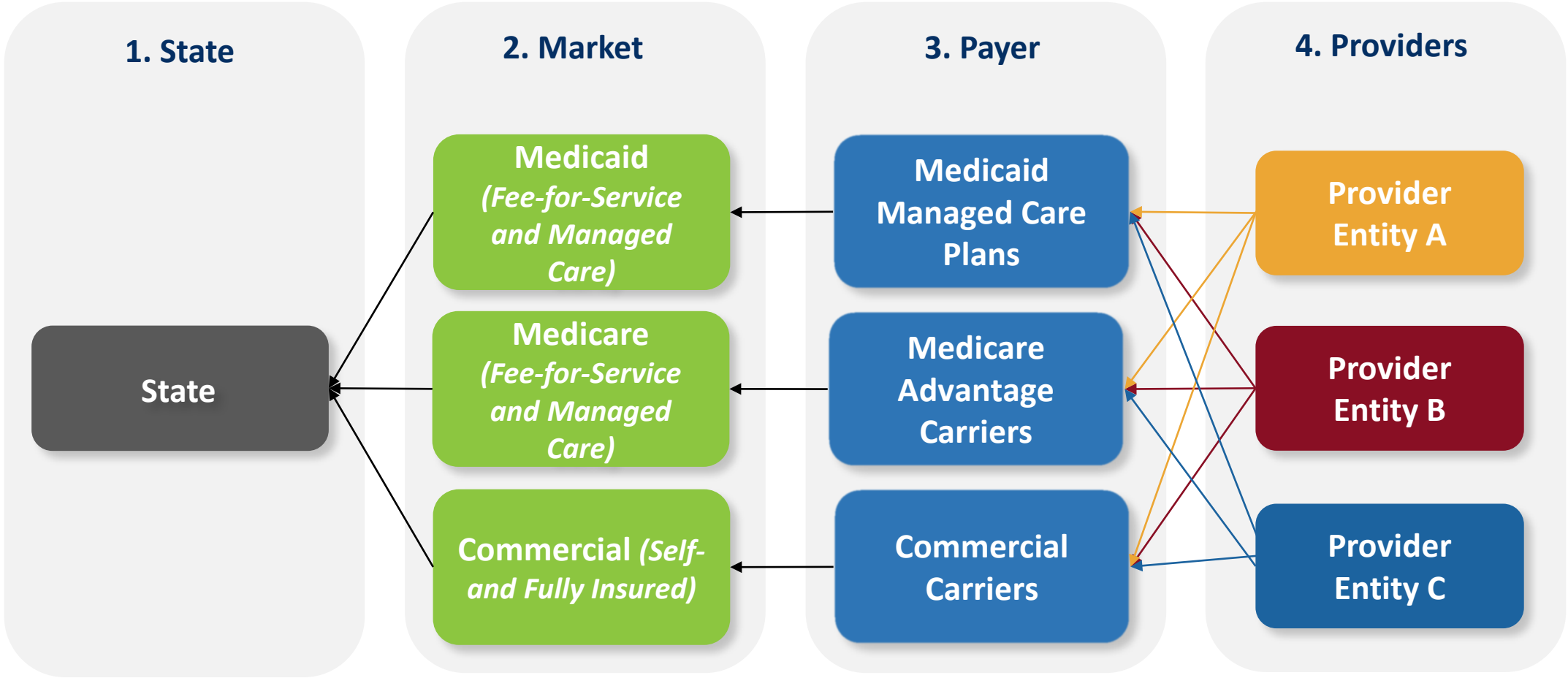
Discussion Today: Review of Considerations for Defining THCE

1. Components and categories of spending to measure THCE
2. Determining whose spending will be measured
3. Population to use as the denominator for calculating *statewide* per capita spending
4. **Levels of reporting THCE**

Levels of Reporting THCE

- **Enabling statute:** OHCA "shall prepare a report on baseline health care spending…".
  - The baseline report shall include "total health care expenditures, per capita total health care expenditures, and, as appropriate, **disaggregated data by categories** such as service category, consumer out-of-pocket spending, and health care sector or geographic region."
- We need to discuss the categories for disaggregating data for measurement and reporting.
- These next few slides will present a few options for reporting disaggregated data by "levels". During the next meeting, we will continue discussion of disaggregation.

Levels of Reporting THCE in Other States



Levels for THCE Reporting: State and Market

- Other states report total spend / trend and per capita spend / trend at the state and market levels.
- State level measurement and reporting provide a broad view of spend and trend in California enabling stakeholders to see over time how the state is performing relative to the spending target.
- State-level THCE can also be measured and reported by subcategories, including TME by market, administrative costs and profit, other public spending, etc.
- Market level measurement allows the state insight into growth at each level to inform specific interventions and policies to slow spending.

2022-23 THCE: Payer and Provider Levels

- After the baseline report, the future objective of measuring entities' spending growth will be to hold them accountable for meeting the target.
- Measuring and reporting payer and provider level spending growth promotes transparency and provides an opportunity for stakeholder engagement in conversations about drivers of spending growth and strategies to slow the growth.
- Health plans and providers may be motivated to implement strategies to slow spending if their performance is compared to a target and made available to their peers, regulators, legislators, and the public at large.
- As a reminder, payer and provider entity reporting measures changes in per capita spending over time.

2022-23 Measurement and Reporting: Payers

- OHCA is working on a methodology to identify the payers that will be required to submit THCE data to OHCA.
- The objectives of the methodology will be to:
  1. Focus resources on payers representing most health care spending
  2. Avoid collecting data from payers:
     - that are too small to contribute to the generation of statistically meaningful results, and
     - whose data contributions would be outweighed by the administrative cost of data collection, validation, analysis and reporting.

2022-23 Measurement and Reporting: Providers

- **Enabling statute**: "...The office shall establish requirements for payers and fully integrated delivery systems to submit data and other information necessary to do all of the following:…(1) Measure total health care expenditures and per capita total health care expenditures; (2) Determine whether health care entities met health care cost targets; (3) Identify the annual change in health care costs of health care entities…"
- Based on the statutory language, OHCA anticipates developing methods to assess performance against the target for the following provider types:
  - Large systems, medical groups, and FQHCs to which TME can be attributed through primary care physician relationships
  - Hospitals
  - Physician organizations
- We'll discuss this in more detail in future meetings as work develops.

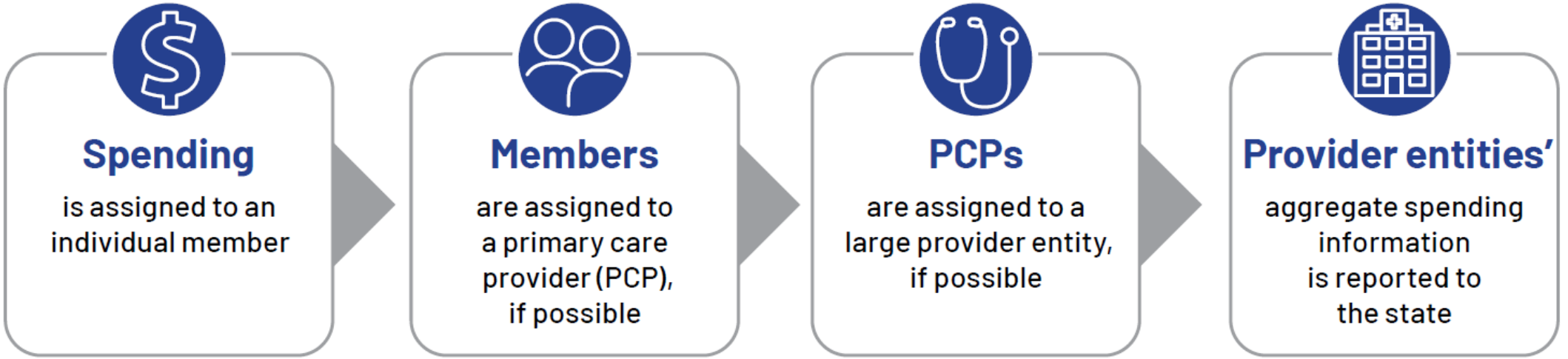
"Health care entity" means a payer, provider, or a fully integrated delivery system.

2022-23 Measurement and Reporting: Providers (cont.)

- OHCA is currently meeting with payers to gain a better understanding of the complex and layered contracting practices of health plans, particularly the effect of global risk contracting and capitation payments.
- Analysis will inform OHCA's ability to gather TME data from downstream contracting entities and identify provider entities that can reasonably influence spending.

2022-2023 Measurement and Reporting: Primary Care Attribution

- In other states provider entity TME measurement occurs through attribution of individuals to primary care providers and then primary care clinicians to provider entities.



Design Consideration: Reporting Levels

- Should OHCA report spending at the following levels?
  - State
  - Market
  - Payer
  - Provider

2022-23 THCE Measurement and Reporting: Other Categories

- **Enabling statute:** The baseline report shall include "total health care expenditures, per capita total health care expenditures, and, as appropriate, disaggregated data by categories such as service category, consumer out-of-pocket spending, and health care sector or geographic region."
  - During the next Board Meeting, we will discuss service categories, out-of-pocket spending, and California regions for measurement and reporting.
  - The definition and methodology for health care sectors will be discussed at a future Board Meeting. (The statute requires that health care sectors be defined on or before October 1, 2027.)

Plan for Next Meeting

- May 23, 2023, 10:30 a.m.
- Continue discussion of measurement of THCE
- Statistical confidence in spending measurement
- Introduction to adjustments

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General Public Comment

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

Next Meeting:

May 23, 2023
10:30 a.m.

Location:
2020 West El Camino Avenue,
Sacramento, CA 95833

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Adjournment

Mark Ghaly, CalHHS Secretary & Board Chair