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Department of Health Care Access and Information

Health Care Affordability Board Meeting

May 23, 2023

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Welcome, Call to Order, and Roll Call

Agenda

1. **Welcome, Call to Order, and Roll Call**
   Secretary Mark Ghaly, Chair

2. **Executive Updates**
   Elizabeth Landsberg, Director, and Vishaal Pegany, Deputy Director

3. **Action Consent Items**
   Vishaal Pegany
   a. Approval of the April 25, 2023 Meeting Minutes

4. **Action Items**
   C.J. Howard, Assistant Deputy Director
   a. Establishment of the Advisory Committee

5. **Informational Items**
   Vishaal Pegany, and Michael Bailit, Bailit Health
   a. Total Health Care Expenditures (THCE) Measurement

6. **General Public Comment**

7. **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director

Vishaal Pegany, Deputy Director

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

Board Statutory Roles and Responsibilities

	Matter
Approve/Establish	▪ **Advisory Committee Membership** ▪ **Methodology for setting and modifying spending targets** ▪ **Adjustments for organized labor costs, quality performance, and Medi-Cal** ▪ Alternative Payment Model Adoption ▪ Primary Care and Behavioral Health Spending Benchmarks ▪ Health Care Workforce Stability Standards ▪ Policies for administrative penalties ▪ Exempted Providers ▪ Statewide health care spending target ▪ Specific targets by health care sector ▪ Definitions of health care sectors ▪ Exempted Providers

Board Statutory Roles and Responsibilities

	Matter
Consult/ Discuss	▪ 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 ▪ 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

Board Statutory Roles and Responsibilities

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

Follow-up: THCE Measurement

- In April, we reviewed some considerations for defining, measuring, and reporting total health care expenditures (THCE) on a statewide basis.
- OHCA will collect and report THCE at the state level, including by market (Medi-Cal, Medicare and Commercial), in its public reports to track spending trends.
- Payers, providers (e.g., physician organizations, hospitals/health systems), and fully integrated delivery systems are the health care entities that are subject to the spending targets.
- The focus of including additional components and categories of spending, such as correctional health services or TRICARE, would be to have a comprehensive view of **statewide** spending and trends over time.
  - Statewide spending is **not** subject to the spending targets.

Board Workplan Updates

- Alternative payment models (APMs), primary care investment, and workforce stability
  - Moved up from August 2023 to June 2023.

- Cost and Market Impact Reviews
  - Updates related to timelines, regulations workshops, and proposed regulations for months of June through August.

- Total Health Care Expenditures
  - Moved OHCA submission of regulations from December 2023 to January 2024.

These changes are reflected in the 2023-24 Health Care Affordability Board 12-Month Workplan available here:

https://hcai.ca.gov/public-meetings/may-health-care-affordability-board-meeting/

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Action Consent Item: Approval of the April 25, 2023 Board Meeting Minutes

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Action Item: Establishment of the Advisory Committee

CJ Howard, Assistant Deputy Director

Background on the Health Care Affordability Advisory Committee

Advisory Committee and Board Collaboration

The Advisory Committee is charged with providing 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

Health Care Affordability Advisory Committee

Enabling statute requires:

- The Board to establish a Health Care Affordability Advisory Committee to provide the board with input and recommendations
- The Board to appoint the members of the Advisory Committee by a majority vote of the Board's voting members
- At least one member of the Board to attend the advisory committee meetings

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

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

Health Care Affordability Advisory Committee

When appointing members to the Advisory Committee 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.

When 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.

Report from the Subcommittee on Establishing the Advisory Committee

Subcommittee Deliberations

1. The optimal size of the Advisory Committee
2. Advisory Committee appointment terms
3. Appointments and reappointments to the Advisory Committee
4. Advisory Committee membership
5. Board member attendance at Advisory Committee meetings

Multiple Avenues to Engage OHCA and the Board

- Public comments at monthly Board meetings
- Submit public comment letters to ohca@hcai.ca.gov
- Advisory Committee
  - Membership
  - Public comment
- OHCA Convened Workgroups to address topics such as:
  - Primary Care
  - Alternative payment models
  - Behavioral health
  - Workforce stability
  - Collection of payer data

Advisory Committee Size, Terms & Appointments

Aims for an Advisory Committee of approximately 25 members

- Allows for inclusion of broad and diverse perspectives
- Preserves each members ability to actively participate in each meeting

Advisory Committee members would serve two-year terms

- No limit on the number of terms a member may serve
- Allows the Board flexibility to pivot and incorporate perspectives as needed
- Half of the initial appointments would serve a 1-year term (selected randomly)

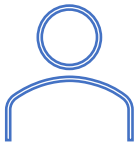
Appointments and Reappointments

- Annually a subcommittee would convene to review and evaluate new appointments and reappointments to the Advisory Committee
- The subcommittee would bring recommendations to the board

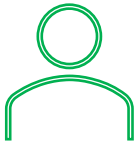
Proposed Advisory Committee Structure and Membership

Advisory Committee Structure

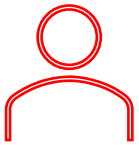
3 Payers/FIDS



3 Hospitals

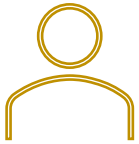


3 Medical Groups

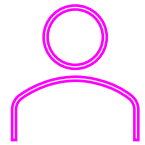


3 Physicians

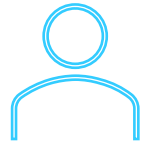
3 Health Care Workers



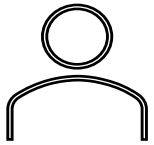
3 Organized Labor



5 Patient/Consumer Groups



3 Purchasers



26 AC Members

Advisory Committee Structure – Attributes

Payers/FIDS
-Statewide Plan
-Individual market
-Medi-Cal Plan
-Regional Plan
-FIDS
-Non-Profit

Hospitals
-Safety Net
-Large System
-Teaching/Academic
-Stand alone

Medical Groups
-IPA
-Primary Care/Family Medicine
-Capitated RBO
-Medi-Cal provider

Physicians
-Primary Care
-Specialist
-Rural Provider
-Safety Net Provider
-Behavioral Health

Health Care Workers
-Front line perspective
-Safety Net/FQHC
-Behavioral Health
-Care Coordination & Social Drivers of Health (SDOH) perspective

Organized Labor
-Represent Health Care Workers
-Administers Benefits
-Negotiates with employers for benefits

Patient/Consumer Groups
-Consumer perspective
-Diverse communities
-Disability perspective
-Children's perspective
-Tribal representation
-Elderly perspective
-Behavioral health consumer perspective

Purchasers
-Self-insured trust
-Large purchaser
-Self-insured private employer

Advisory Committee Membership Deliberations

The subcommittee reviewed more than 130 submissions and sought to include and considered the following:

- Diverse professional experiences
- Breadth and depth of the submitted responses
- Individuals currently working in the industry they represent
- Individual's lived experiences within the health care system
- Individuals reflective of the California's diversity in culture, race, ethnicity, sexual orientation, gender identity, and geography

Experience & Expertise within Proposed Advisory Committee Membership

Proposed Advisory Committee Membership

Payers/FIDS	Hospitals	Medical Groups	Physicians	Health Care Workers	Organized Labor	Patient Groups/ Consumer Advocates	Purchasers
Aliza Arjoyan, Blue Shield of California	Barry Arbuckle, MemorialCare Health System	Hector Flores, Family Care Specialists Medical Group	Parker Duncan Diaz, Santa Rosa Community Health	Sandra Pisano, AltaMed	Joan Allen, SEIU-UHW	Carolyn Nava, Disability Action Center	Ken Stuart, California Health Care Coalition
Yolanda Richardson, San Francisco Health Plan	Tam Ma, UC Health	Stacey Hrountas, Sharp Rees-Stealy Medical Centers	Adam Dougherty, Vituity	Kary Anne Weybrew, RN, Fuse Corps	Carmen Comsti, California Nurses Association	Mike Odeh, Children Now	Suzanne Usaj, The Wonderful Company
Andrew See, Kaiser Foundation Health Plan	Yvonne Wagner, San Bernadino Mountains Community Hospital District	David Joyner, Hill Physicians Medical Group	Sumana Reddy, Acacia Family Medical Group	Hold Open, Care Coordination & SDOH	Ivana Krajcinovic, Unite Here Health	Kiran Savage-Sangwan, California Pan-Ethnic Health Network	Abbie Yant, San Francisco Health Service System
						Rene Williams, United American Indian Involvement	
						Anthony Wright, Health Access California	

Draft Motion from the Subcommittee

- Approve the Proposed Advisory Committee Membership totaling 25 individuals
- Appoint the members for a 2-year term and permit OHCA staff to randomly assign half of the slate to a 1-year term, while ensuring that at least one member from each category serves a 2-year term
- Continue to receive and review submissions and subsequently incorporate a care coordination and SDOH perspective onto the Advisory committee
- Solicit applications for appointment to the Advisory Committee annually between January and March

Board Member Attendance at Advisory Committee

Options Considered:

1. One or two Board members attend all Advisory Committee meetings for a one-year period
2. Board member attendance at each Advisory Committee meeting will be determined by the board

Staff Recommendation is Option 2.

Board member attendance at each Advisory Committee meeting will be determined by the board

June Advisory Committee Attendance

- Motion and discussion for Board Member attendance at the June Advisory Committee meeting

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Informational Item: Total Health Care Expenditures (THCE) Measurement

Vishaal Pegany, Deputy Director
Michael Bailit, Bailit Health

Recap of Board Meeting #2

During the second Board meeting, we:

- Heard from two guest speakers about their states' experience with health care spending targets;
- Reviewed approaches for defining, measuring, and reporting total health care expenditures (THCE); and
- Discussed components of THCE, including sources of coverage (e.g., VHA, workers' comp) and spending (e.g., uncompensated care, care for the uninsured, administrative expenses associated with delegated arrangements).

Today's Discussion

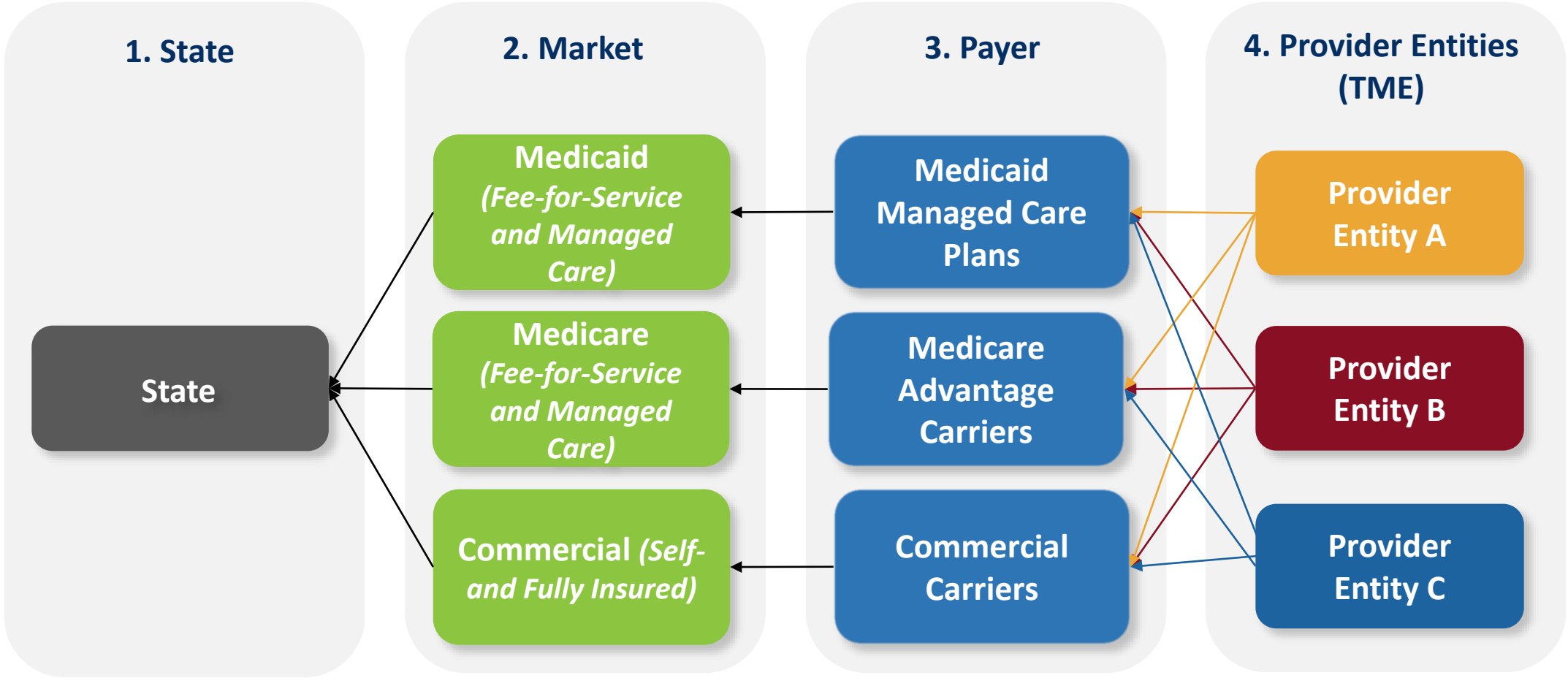
1. Reporting THCE for the baseline report
2. Measuring payer and provider spending
3. Introduce spending target program adjustments, including:
    - types of adjustments;
    - spending target adjustment vs. performance adjustment;
    - statutory provisions regarding adjustments, and
    - strengthening the accuracy and reliability of performance measurement.

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."*
- Today we will discuss assessing spending at multiple levels, and disaggregating data by geography and service categories.

*Specific targets for health care sectors shall be established no later than June 1, 2028.

Levels of Reporting THCE in Other States



Levels of 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 how the state is performing relative to the spending target over time.
  - 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.

Levels of Reporting- *Payers and Provider Entities*

- Measuring and reporting at the **payer and provider entity levels** promote transparency and provide an opportunity for stakeholder engagement in conversations about spending growth drivers and strategies to slow growth.
- Health plans and provider entities may be motivated to implement strategies to slow costs if their performance is compared to a target and made available to their peers, regulators, legislators, and the public at large.

Levels of Reporting- *Other*

- States that include other sources of coverage and spending may report those as distinct categories or collectively in an “other” category.
  - For example, Massachusetts reports spending for the state’s veterans and spending in the state’s Health Safety Net program in an “other public programs” category.
- States may include other sources to obtain a more comprehensive picture of total health care spending in the state, but “other” categories are not subject to spending targets.

OHCA's Approach for Levels of Reporting

- For the baseline report, OHCA's preliminary approach is to report at the following level:
  - ***State*** and ***Market*** THCE
  - ***Payer: Insurer*** THCE (inclusive of total medical expenses and insurer administrative costs and profits)
  - ***Payer: Other*** (e.g., other programs subject to data availability)
  - ***Provider entity*** (TME)
- OHCA anticipates measuring insurer and provider entity level spending for accountability purposes in a phased manner:
  - 2025: Year 1 statewide spending target, performance is not subject to enforcement
  - 2026: Year 2 statewide spending target, performance is subject to enforcement

OHCA's Approach for Levels of Reporting

Does the Board have questions regarding OHCA's contemplated approach for reporting baseline spending at the state, market, payer and provider entity levels?

Disaggregating THCE-Geography A Tale of Two Californias

Northern CA	vs.	Southern CA		% difference
$30,079	Inpatient Hospital Prices (2018)[1]	$23,025	=	31%
280%	Hospital Prices (2018)[1]	227%	=	23%
2,994	Hospital Market Concentration (HHI) (2018)[1]	1,807	=	66%
$10,889	Average ACA Silver Plan Annual Premium (Unsubsidized 55-Year-Old) (2020)[2]	$7,605	=	43%
$57,049	Average Income (2018)[3]	$54,766	=	4%
$436,416	Average Home Value (2019)[4]	$550,510	=	-21%

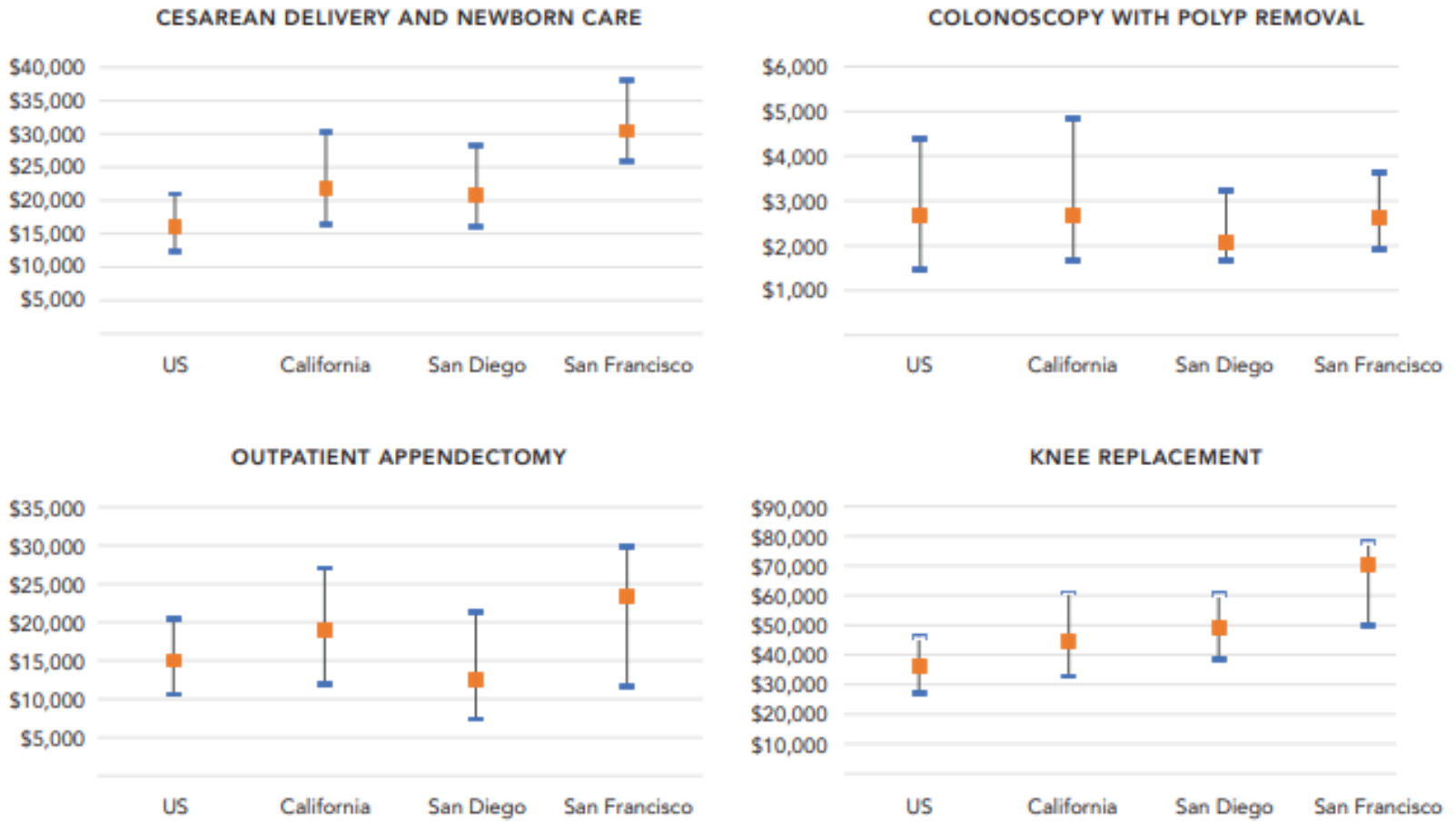
SOURCES: 1) RAND Hospital Price Transparency Study (2020; 2) Covered California; 3) U.S. Bureau of Economic Analysis; 4) National Association of Realtors)

Source: C. Whaley, RAND Corporation, Addressing Health Care Affordability in California, California Assembly Committee on Health Informational Hearing on Health Care Affordability, 10/27/2020

Prices Vary for Common Procedures

- Prices vary significantly within California – even for common, standard procedures.
- Prices in Northern California are generally higher than in Southern California.
- For example, the average price of a cesarean delivery in San Diego was just over $20,000, compared with just over $30,000 in San Francisco.

Figure 11. Price Ranges for Four Common Health Care Services, US, California, San Diego, and San Francisco



C. Eibner, et al., Getting to Affordability: Spending Trends and Waste in California's Health Care System, RAND Corporation, CHCF, January 2020.
Note: Data are based on claims paid between July 1, 2014, and June 30, 2016, trended forward to 2018 price levels.
Source: Authors' calculations based on Guroo Price Transparency Tool. Accessed December 2019.

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Covered California Premiums

- In 2019, average Covered California premiums were 19-25% higher in Northern California (rating region 1-14) than in Southern California (rating region 15-19) – even after adjusting for local wages.

- Bronze, silver, and gold plans have actuarial value of 60%, 70%, and 80%, respectively. The “benchmark” plan refers to the second-lowest cost silver plan in a rating area, used for calculating subsidies (premiums shown do not include any subsidies).

Figure 16. Nineteen California ACA Rating Areas

Table 3. Wage-Adjusted Average Annual ACA Premiums for a 50-Year-Old Individual
by California ACA Rating Area, 2019

	BENCHMARK	BRONZE	SILVER	GOLD
1	$13,331	$11,115	$16,480	$17,767
2	$10,128	$8,345	$12,544	$13,386
3	$9,278	$8,236	$11,187	$12,164
4	$5,382	$4,317	$6,366	$6,965
5	$8,303	$7,045	$10,464	$11,196
6	$7,861	$6,213	$8,491	$9,297
7	$3,535	$3,489	$4,793	$5,343
8	$5,269	$4,439	$6,395	$6,941
9	$11,960	$10,914	$14,327	$15,450
10	$11,328	$10,070	$14,963	$16,043
11	$9,690	$7,405	$10,259	$11,412
12	$8,918	$7,749	$10,116	$11,350
13	$11,893	$11,004	$14,555	$15,642
14	$10,673	$8,082	$11,007	$12,316
15	$5,667	$4,794	$6,438	$7,181
16	$6,090	$5,420	$7,300	$8,100
17	$9,493	$7,906	$10,275	$11,596
18	$7,438	$5,898	$8,222	$9,266
19	$7,236	$6,522	$8,431	$9,237

OHCA's Approach for Disaggregating THCE

- OHCA would like to collect data from payers in a manner that will enable geographic analysis.
  - This would allow OHCA to examine regional variation and inform discussions of the potential consequences of regional spending variation, including on access, equity, and affordability.
- OHCA would define geographic regions for data collection and reporting purposes and is considering for initial reporting in the baseline report:
  - Covered California Rating Regions
- OHCA will solicit feedback from payers about the feasibility of collecting data for this purpose, including the ability to collect spending data at a more granular level.

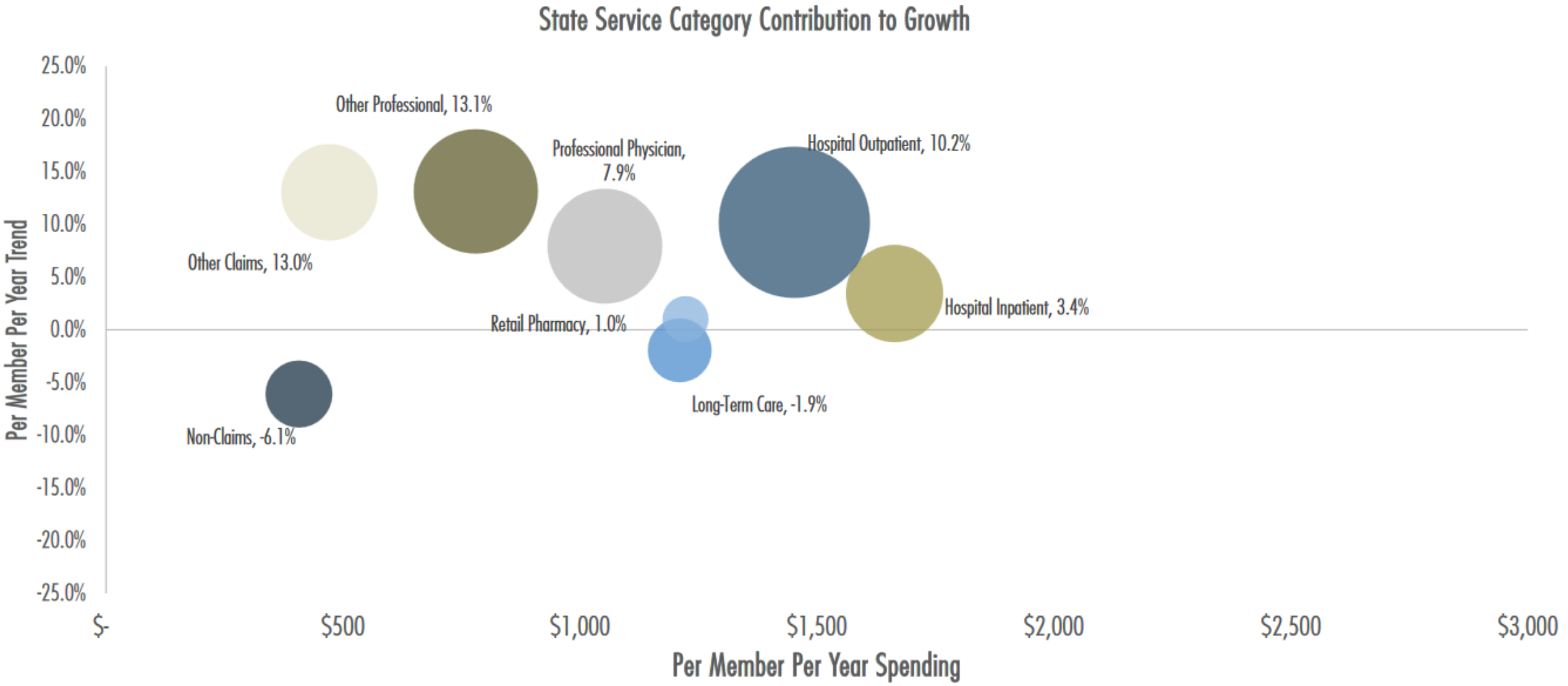
OHCA's Approach for Disaggregating THCE

Does the Board have questions regarding OHCA's contemplated approach to analyze and report baseline spending by geographic regions?

Disaggregating THCE by Service Categories

- When payer data allow for it, OHCA is considering collecting spending data in aggregate according to specified service categories, including, but not limited to:
  - Hospital inpatient
  - Hospital outpatient
  - Professional Services: Primary Care
  - Professional Services: Specialty Care
  - Professional Services: Other
  - Pharmacy
  - Long-term care
- Please note that service category-level spending analysis from payer-reported data will be constrained due to capitation payment arrangements.

Rhode Island Example: Service Category Analysis



Rhode Island Office of the Health Insurance Commissioner. Data are not risk-adjusted and are reported net of pharmacy rebates. The width of the bubbles represents contribution to growth. Source: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-05/public%20forum%202023%2005-08%20cost%20trends%20and%20quality%20reporting%20for%202021_EMBEDDED.pdf

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OHCA's Approach for Disaggregating THCE

Does the Board have questions regarding OHCA's contemplated approach for disaggregating THCE by service category?

Measuring THCE

- **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…"

- Today we will focus on measurement of 2022-2023 THCE to assess baseline spending (1) and spending growth (3).

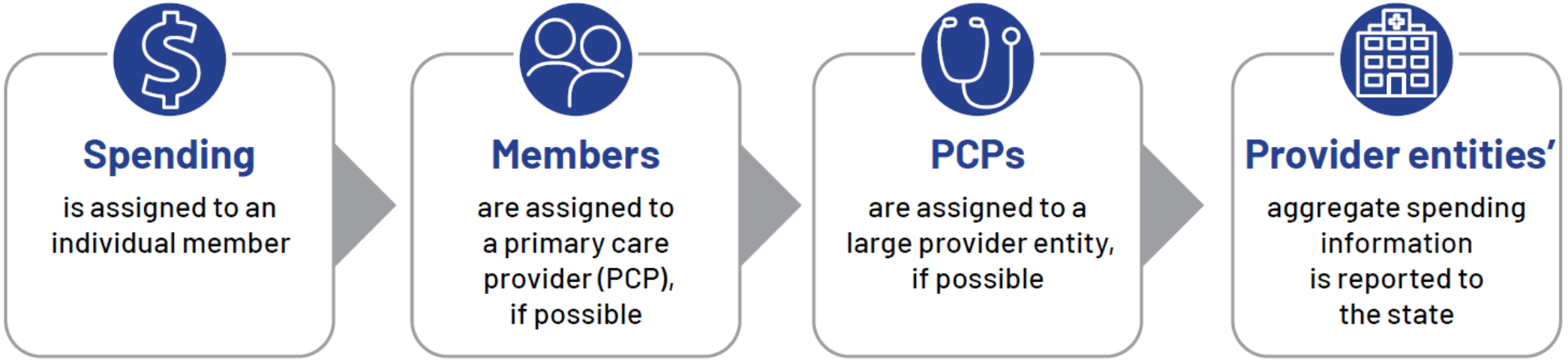
"Health care entity" means a payer, provider, or a fully integrated delivery system.

Measuring TME: Primary Care Attribution

- Under capitated arrangements in which a primary care physician is contracted and capitated for providing and directing a member's care, primary care attribution can be leveraged for measuring TME for entities with primary care clinicians.
- When there are non-capitated provider contracts, it requires clear attribution rules for attributing individual members to primary care clinicians and attributing primary care clinicians to provider entities to measure spending.

Measuring TME: Primary Care Attribution

- Being attributed to a clinician for the purpose of analyses doesn't mean:
  - the member was required to see that clinician; or
  - the clinician delivered all of the care the patient received.



OHCA's Approach for Measuring TME

- OHCA is developing methods to measure performance against the target for the following provider types:
  - Large health systems, physician organizations, and FQHCs to which TME can be attributed through primary care relationships
  - Hospitals
  - Physician organizations (without primary care clinicians)
- OHCA will use:
  - primary care attribution for measurement of TME for entities with primary care clinicians, and
  - alternative methods for assessing health care spending for provider entities for which primary care attribution is not possible.

OHCA's Approach for Measuring TME

- OHCA is examining global risk contracting, capitation payments, and other delegated arrangements for the purposes of identifying provider entities and measuring spend.
- OHCA will also identify other provider entities for spending measurement and accountability purposes.

OHCA's Approach for Measuring TME

Does the Board have any questions regarding OHCA's contemplated approach to measuring provider entity spending?

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Spending Target Program Adjustments

Introduction to Spending Target Adjustments

States incorporate different types of adjustments into their spending target programs, including:

1. Adjusting the value of a spending target when the methodology has been established
   - Connecticut's target methodology yielded 2.9% but was adjusted + 0.5%, and 0.3% for the first two years, respectively, to acknowledge that meeting the target initially may be difficult for the State, payers, and providers
2. Determining conditions that warrant re-visiting and possibly adjusting the established spending target after implementation
   - Rhode Island established that "only highly significant changes in the economy will trigger re-visiting of the target methodology."

Introduction to Spending Target Adjustments

3. Applying adjustments to strengthen the accuracy and reliability of performance assessment
   - Oregon developed confidence intervals and risk adjustment to improve its statistical understanding of spending growth. Other states, including Washington, truncate high-cost outlier spending.

4. Adjusting the spending target to which entities are subject
   - California statute allows for adjustments to targets based on certain parameters such as being a Medi-Cal provider entity or for having nonsupervisory organized labor cost growth that exceeds the target.

Application of Adjustments to Spending Target Programs

Spending target adjustments can modify the target to which an entity is held accountable

- The statewide spending target for which an entity is subject would be adjusted for that entity based on specific factors.
- The result is different entity targets based on adjustment factors.
- The methodology for adjustments needs to be clear and transparent.

Performance adjustments can modify an entity's total medical expenses (TME) calculation

- Performance adjustments impact the assessment of spending relative to the target, e.g., an entity's TME calculation is adjusted for the health status of the population served, high-cost outlier spending, quality performance, or equity.
- Entities are subject to the same statewide spending target with the same adjustment methodologies applied to their spending performance.

Spending Target Program Adjustments by Reporting Years

Baseline Reporting 2022-2023

Risk Adjustment; Statute requires adjustment for reporting of data on total health care expenditures.

Annual Performance Starting 2024-2025

Risk Adjustment; Statute requires adjustment for reporting of data on total health care expenditures

Equity
Statute requires adjustment, with flexibility on how to implement

Quality
Optional adjustment per statute, with flexibility on how to implement

Organized Labor
Statute requires target adjustment upon sufficient showing

Medi-Cal
Optional adjustment per statute, with flexibility on to how to implement

Risk Adjustment

Risk Adjustment

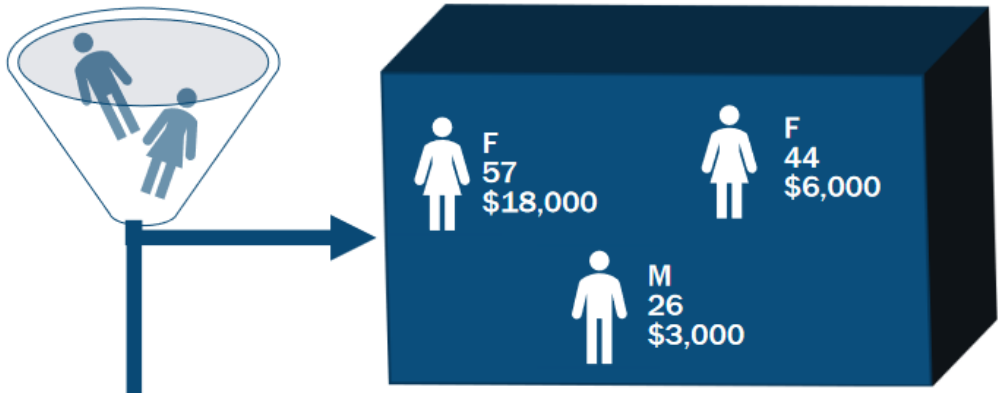
- **Enabling statute:** “(1) In consultation with the board, the office shall establish risk adjustment methodologies for the reporting of data on total health care expenditures and may rely on existing risk adjustment methodologies. The methodology shall be available and transparent to the public.…
- (3) The risk adjustment methodologies selected or used to inform any adjustments shall take into account the impact of perverse incentives that may inflate the measurement of population risk, such as upcoding. The office may audit submitted data and make periodic adjustments to address those issues as necessary.”

What is Risk Adjustment?

- **Risk adjustment** (or health status adjustment) is a process whereby a payment, quality, or performance measure is modified (typically multiplied or divided) by a risk score.
- A **risk score** is used to estimate how much it will cost to care for a patient based on their underlying characteristics relative to a population average.
  - Risk scores are typically derived from equations that relate health care expenditures to patient characteristics using health care claims data.
  - Most risk score formulas rely on the patient's (or population's) "claims history" – and particularly their accumulated diagnoses, plus age and gender.
- In payer/provider contracts, risk scores can be used to "adjust" the dollar amounts allocated to that patient's (or population's) care, so that resources will be matched to projected need for services and care.

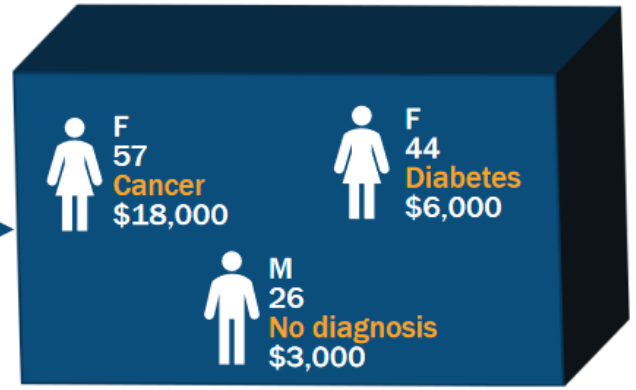
Risk Score

Insurance claims data



Age/sex-based risk model

Factor	Additional cost
Age	$100 per year of age
Gender	$1,000 higher for females



Age/sex/diagnosis-based risk model

Factor	Additional cost
Age	$100 per year of age
Gender	$1,000 higher for females
Diabetes	$3,000

*The risk score is the **sum** of an individual's factors expressed relative a population average of 1.0.*

Courtesy of Massachusetts Health Policy Commission: https://www.mass.gov/doc/presentation-board-meeting-december-14-2022/download

Risk Adjustment and Access Barriers

- A higher risk score, in theory, reflects a sicker patient or population.
- But ***utilization reflects both need and access to care.***
- When risk adjustment is based on utilization history, the calculation rewards those with higher utilization.

Alice, lives in Oakland with her two children. She works two jobs and uses her sick time to take her children to their annual physical exams. Alice has been having cold-like symptoms along with recurrent fevers but has not seen a doctor due to limited childcare and her work schedules. Recently, she noticed a lump under her arm. She decided to wait to see if her symptoms resolve or worsen before making a doctor's appointment.

Gabrielle, lives in Westwood with her child. She notices some changes in her health that concern her, so she takes the day off work as a lawyer to drive to her doctor for an appointment the second week after her symptoms start. At her appointment, Gabrielle's provider runs blood tests, records several diagnoses on her chart, and schedules follow-up appointments for an MRI and further diagnostic tests, which Gabrielle confirms work for her schedule.

Courtesy Massachusetts Attorney General's Office: https://www.mass.gov/doc/ago-presentation-board-meeting-december-14-2022/download

Research on Rising Risk Scores

"*During 2013–16 HCC-based risk scores grew faster than CAHPS-based risk scores (2.1 percent versus 0.3 percent annually)…The average gap in risk score growth appears to be the result primarily of HCC coding practices…,* ***suggesting that coding…may account for most of the observed risk score growth for ACO beneficiaries.***"

ACCOUNTABLE CARE

By Michael E. Chernew, Jessica Carichner, Jeron Impreso, J. Michael McWilliams, Thomas G. McGuire, Sartaj Alam, Bruce E. Landon, and Mary Beth Landrum

Coding-Driven Changes In Measured Risk In Accountable Care Organizations

DOI: 10.1377/hlthaff.2021.00361
HEALTH AFFAIRS 40,
NO. 12 (2021): 1909–1917

ABSTRACT Claims data, which form the foundation of risk adjustment in payment for health care services, may reflect efforts to capture more—or more severe—clinical conditions rather than true changes in health status. This can distort payments. We quantify this in the context of Medicare's accountable care organization (ACO) program by comparing risk scores derived from two different measurement approaches. One approach uses diagnoses coded on claims based on Centers for Medicare and Medicaid Services Hierarchical Condition Categories (HCC), and the other uses self-reported, survey-based health data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). During 2013–16 HCC-based risk scores grew faster than CAHPS-based risk scores (2.1 percent versus 0.3 percent annually), and the gap in HCC- and CAHPS-based risk score growth varied widely across ACOs. The average gap in risk score growth appears to be the result primarily of HCC coding practices rather than poor performance of the CAHPS model, suggesting that coding practices (not necessarily driven by ACO contracts) may account for most of the observed risk score growth for ACO beneficiaries.

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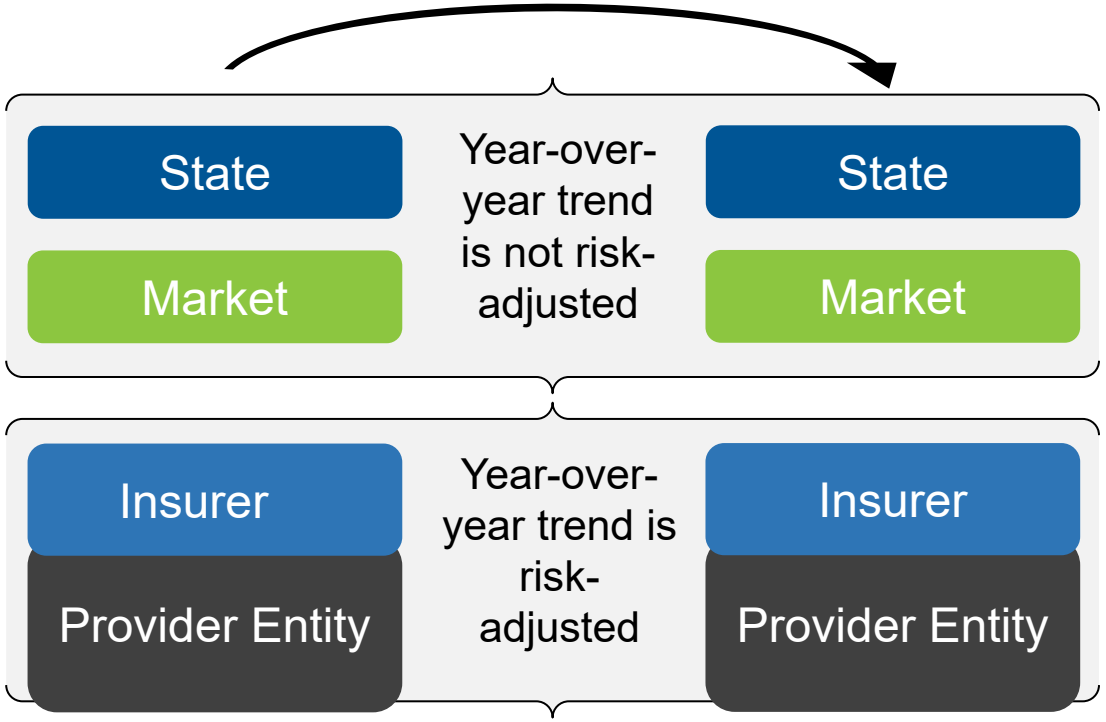
Health Affairs, December 2021

HCAI Department of Health Care Access and Information

Risk Adjustment in Spending Target Programs

- Health care spending growth is measured and reported as year-over-year change (e.g., 2022-2023).
- A payer or a provider entity's population risk is relatively stable over two years
- However, some spending target states risk adjust the data submitted by payers when assessing performance relative to a spending target to account for the attributed population's underlying health status.



States' Experience with Rising Risk Scores

- **MA** has observed steadily rising risk scores, amounting to an 11.7% increase between 2013 and 2018 with only a small portion explained by demographic trends or changes in disease prevalence.
  - The MA Health Policy Commission now recommends evaluating payer and provider performance based on growth in *unadjusted* spending.
- Payer risk scores in **RI** grew 4.6% from 2018 to 2019 (excluding Medicare-Medicaid plans).
  - Rising risk scores had the effect of raising the cost growth rate that would meet the target, increasing the effective target from 3.2% to 6.4%.
  - The state *moved to age / sex adjustment* as a result.
- NJ, OR and WA are using age / sex adjustment; NV's governing body recommended no risk adjustment.

Risk Adjustment Models

1. Clinical risk adjustment is used to assess conditions diagnosed and treated during the performance year to predict spending in the same year.

- Available models use claim and encounter data, such as diagnoses, procedures, and prescription drugs. They do not include medical record information (e.g., clinical indicators of severity, measures of prior use, lifestyle or supplemental demographic information).
- Clinical risk scores can change annually without changes in the population's underlying risk due to improved documentation of patient condition on claims. Therefore, using clinical risk scores overcompensates for yearly changes in population health status and creates distortion.

- The best risk adjustment models can explain about half of the variation on health care spending, and a little more if spending for the highest cost outliers is truncated.*

*Accuracy of Claims-Based Risk Scoring Models, Society of Actuaries, October 2016.

Risk Adjustment Models

2. Adjust using **age/sex factors** only.
   - Age/sex adjustment will capture the impact of an incrementally aging population, which may be the most significant change affecting population health status over the course of a year.
   - Age/sex adjustment will not capture more substantive changes in health status due to shifts in membership, such as when an insurer acquires a large new employer contract.
3. Make **no adjustment** for changing population risk.
   - The one-year impact of changes in age/sex composition on spending trend may not be substantive and requires significant data analysis.
   - Making no adjustment could disadvantage a plan or provider entity with a large population change over the course of a year.

OHCA's Approach for Risk Adjustment

OHCA is considering using age/sex adjustment only. Doing so will:

- Capture the impact of an incrementally aging population, which may be the most significant change affecting population health status over the course of a year
- Avoid the distortion associated with coding practices

OHCA will establish age/sex bands that will be adjusted based on relative weighting of those bands and uniformly applied across insurers, by market.

- This would standardize the risk adjustment methodology across insurers.

OHCA's Approach for Risk Adjustment

Does the Board have questions regarding OHCA's contemplated approach for adjusting by age/sex for the baseline report?

Quality and Equity Adjustments

Quality and Equity Adjustments

Quality Adjustments

Enabling statute: The methodology "shall allow the board to adjust cost targets downward, when warranted, for health care entities that deliver high-cost care that is not commensurate with improvements in quality, and upward, when warranted, for health care entities that deliver low-cost, high-quality care."

Equity Adjustments

Enabling statute: "the office shall establish equity adjustment methodologies to take into account social determinants of health and other factors related to health equity, to the extent data is available and methodology has been developed and validated."

Organized Labor Adjustments

Organized Labor Adjustments: Statutory Language

- The office shall develop a methodology that shall allow the board to **adjust cost targets to account for organized labor costs.**

- The methodology shall require the board to adjust cost targets, as appropriate, for a provider or a fully integrated delivery system to account for **actual or projected nonsupervisory employee organized labor costs, including increased expenditures related to compensation.**

- [The target shall] be adjusted for a provider or fully integrated delivery system's cost target, as appropriate, **upon a showing that nonsupervisory employee organized labor costs are projected to grow faster than the rate of any applicable cost targets.**

Organized Labor Adjustment: Statutory Language

- For an adjustment to be effectuated, the provider, the fully integrated delivery system, or other associated party **shall submit a request with supporting documentation in a format prescribed by the office.**

- To validate the basis for the requested adjustment, the office may request or accept further information, such as any single labor agreement that is final and reflects the actual or projected increased nonsupervisory employee organized labor costs. The office may audit the submitted data and supporting information as necessary.

OHCA's Approach: Organized Labor Adjustment

OHCA will develop a methodology consistent with statute that will provide an entity the opportunity to request an adjustment to the target should its growth in nonsupervisory union wage growth exceed the target.

OHCA's Approach: Organized Labor Adjustment

Does the Board have questions regarding OHCA's forthcoming work on adjustments for union labor wage growth?

Medi-Cal

Medi-Cal Adjustment: Statutory Language

- …shall allow the board, to the extent necessary for the Medi-Cal program to comply with federal requirements…to adjust any targets, when warranted, as they pertain to health care entities in the Medi-Cal program, upon the request of the Director of Health Care Services."

- OHCA is coordinating with DHCS on data collection and any proposed adjustments to the spending target.

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Other Options for Refining Statistical Confidence and Understanding of Spending

Additional Adjustments for Future Reporting of Performance Relative to the Spending Target

- States have implemented strategies to increase confidence in spending measurement at the payer and provider levels.
  - At the state and market levels, population sizes are significant enough that measurements are statistically stable.
- At the payer and provider levels, states incorporate other adjustments, *in addition to risk adjustment*, to increase statistical confidence in assessment of spending growth.
  1. **Truncation** of high-cost outlier spending at established thresholds
  2. Use of **confidence intervals** around spending growth rates to report performance
  3. Reporting performance only for insurers and large provider entities that meet a **minimum threshold** for attributed lives. *(To be discussed at a future meeting.)*

Truncation

Truncation of High-Cost Outlier Spending

- High-cost outlier spending represents extremely high levels of annual health care spending for individual patients / members.
  - This is real spending that is incorporated into measurement of spending growth.
  - The spending mostly presents randomly in a population.
  - There are limits to how much of the spending can be influenced due to individuals' complex medical conditions and high-intensity care needs.
- It is not fair to judge insurer and provider performance relative to a spending growth target when it is significantly influenced by spending on high-cost outliers.

Truncation of High-Cost Outlier Spending (cont.)

- It is common practice in total cost of care contracts to truncate expenditures to prevent annual swings in the number of extremely costly patients/members from significantly affecting payers' and providers' per capita expenditures.
- For spending target purposes, truncation involves capping individual patient annual spending so that spending above the truncation point is excluded from the trend calculation.

Rhode Island's Experience

- In RI, analyses showed that high-cost outlier spending significantly affected performance of provider entities.
  - For one RI ACO, including high-cost outlier spending raised the trend rate by several percentage points in one year.
- The differential treatment of high-cost outliers in the spending growth program and in TCOC contracts led to confusion and tension around reporting of performance.
- As a result, RI began truncating high-cost outliers starting with 2020 performance data. This has become standard across states.

Example of Truncation Points from Washington

Market	Per Member Truncation Point
Medicare	$125,000
Medicaid	$125,000
Commercial	$200,000

Truncation

OHCA is considering including high-cost outlier truncation in its baseline report methodology.

Does the Board have questions on the use of truncation, including whether it should be employed by OHCA, and if so, the threshold values and whether they should vary by market?

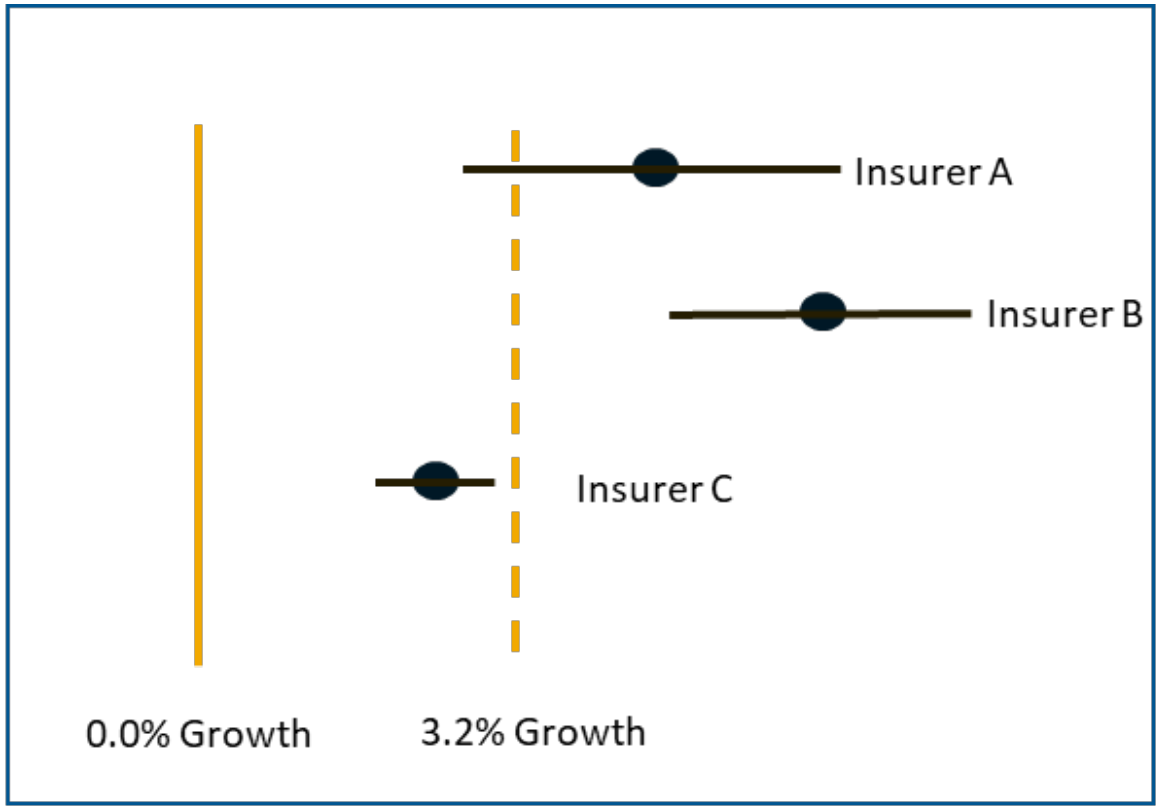
Confidence Intervals

Confidence Intervals

- When measuring change in spending from one year to the next, states often perform statistical testing on payer and entity-level performance to confirm whether the spending target was met.
- A confidence interval shows the possible range of values in which we are fairly certain the true value lies.
  - In practice, it allows us to make the following statement: “We are 95% confident that the interval between A [lower bound] and B [upper bound] contains the true rate of spending growth for the entity.
- This is especially helpful when measuring small populations (which could occur at the payer or provider entity level).

What Performance Measurement Using Confidence Intervals May Look Like

- Performance *cannot be determined* when upper or lower bound intersects the benchmark (e.g., Insurer A).
- Benchmark has *not been achieved* when lower bound is fully over the benchmark (e.g., Insurer B).
- Benchmark has been *achieved* when the upper bound is fully below the benchmark (e.g., Insurer C).



Note: Figure is not to scale

OHCA's Approach for Using Confidence Intervals

- OHCA is considering using confidence intervals to analyze and report baseline report findings at the payer and provider entity levels.
- There are data specifications that have been tried and tested in other states.
  - CT, OR, RI and WA all use confidence intervals.
- Payers would be required to submit the data necessary for OHCA to calculate confidence intervals for each payer and entity whose performance is being measured.

OHCA's Approach for Using Confidence Intervals

Does the board have any questions regarding OHCA's contemplated use of confidence intervals to assess and report spending target performance?

Next Steps

Next steps for items discussed today:

- For items requiring board input and consultation, the office will bring back a final approach for further discussion.
- For items requiring board action, the office will bring back a complete proposed approach for further discussion and action.

Plan for our Next Meeting:

- Data collection, validation, analysis and reporting – process and timeline
- Possible follow-up on today's discussion topics

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General Public Comment

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

Next Meeting:

June 20, 2023

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

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Department of Health Care Access and Information

Adjournment