HCAi
Department of Health Care Access and Information

Health Care Affordability Advisory Committee

June 21, 2023

AGENDA

1. **Welcome, Call to Order, and Roll Call**
   Elizabeth Landsberg, Director, and Karin Bloomer, Leading Resources

2. **Member Oath of Office**
   Elizabeth Landsberg

3. **Member Introductions**
   Elizabeth Landsberg

4. **Advisory Committee Orientation**
   Elizabeth Landsberg and Vishaal Pegany, Deputy Director

5. **Bagley-Keene Overview**
   Jean-Paul Buchanan, Counsel

6. **Cost and Market Impact Review**
   Sheila Tatayon, Assistant Deputy Director

7. **Total Health Care Expenditures (THCE) Measurement**
   Vishaal Pegany, and Michael Bailit, Bailit Health

8. **General Public Comment**

9. **Adjournment**

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Welcome, Call To Order, Roll Call

Elizabeth Landsberg, HCAI Director
Karin Bloomer, Leading Resources

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Member Oath of Office

Advisory Committee Oath

Oath for the Heath Care Affordability Advisory Committee

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

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Member Introductions

Elizabeth Landsberg

Advisory Committee Members

Payers

Aliza Arjoyan
Senior Vice President of Provider Partnership and Network Management, Blue Shield of California

Yolanda Richardson,
Chief Executive Officer, San Francisco Health Plan

Andrew See
Senior Vice President, Chief Actuary, Kaiser Foundation Health Plan

Hospitals

Barry Arbuckle
President & Chief Executive Officer, Memorial Care Health System

Tam Ma
Vice President, Health Policy and Regulatory Affairs, University of California Health

Yvonne Waggener
Chief Financial Officer, San Bernardino Mountains Community Hospital District

Medical Groups

Hector Flores
Medical Director, Family Care Specialists Medical Group

Stacey Hrountas
Chief Executive Officer, Sharp Rees-Stealy Medical Centers

David S. Joyner
Chief Executive Officer, Hill Physicians Medical Group

Physicians

Adam Dougherty
Emergency Physician, Vituity

Parker Duncan Diaz
Clinician Lead, Santa Rosa Community Health

Sumana Reddy
President, Acacia Family Medical Group

Consumer Representatives & Advocates

Carolyn J Nava
Senior Systems Change, Disability Action Center

Mike Odeh
Senior Director of Health, Children Now

Kiran Savage-Sangwan
Executive Director, California Pan-Ethnic Health Network (CPEHN)

Rene Williams
Vice President of Operations, United American Indian Involvement

Anthony Wright
Executive Director, Health Access California

Organized Labor

Joan Allen
Government Relations Advocate, SEIU United Healthcare Workers West

Carmen Comsti
Lead Regulatory Policy Specialist, California Nurses Association/National Nurses United

Ivana Krajcinovic
Vice President of Health Care Delivery, Unite Here Health

Slot Held Open

Purchasers

Ken Stuart
Chairman, California Health Care Coalition

Suzanne Usaj
Senior Director, Total Rewards, The Wonderful Company LLC

Abbie Yant
Executive Director, San Francisco Health Service System

Health Care Workers

Slot Held Open

Slot Held Open

Slot Held Open

Member Introductions

Please share your name, role, organization,

and what drew you to this work.

.

Please keep your response to one minute.

Board Member Role at AC Meetings

Board members attend the Advisory Committee meetings as observers. The designated board member representative and OHCA staff will relay recommendations and input from the Advisory Committee.

- Board members attend AC meetings as an observer.
- “Observers” are prohibited from asking questions or making statements at the meeting and can only watch and listen.

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Advisory Committee Orientation

Elizabeth Landsberg and Vishaal Pegany

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

HCAI Overview

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

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

Our Mission

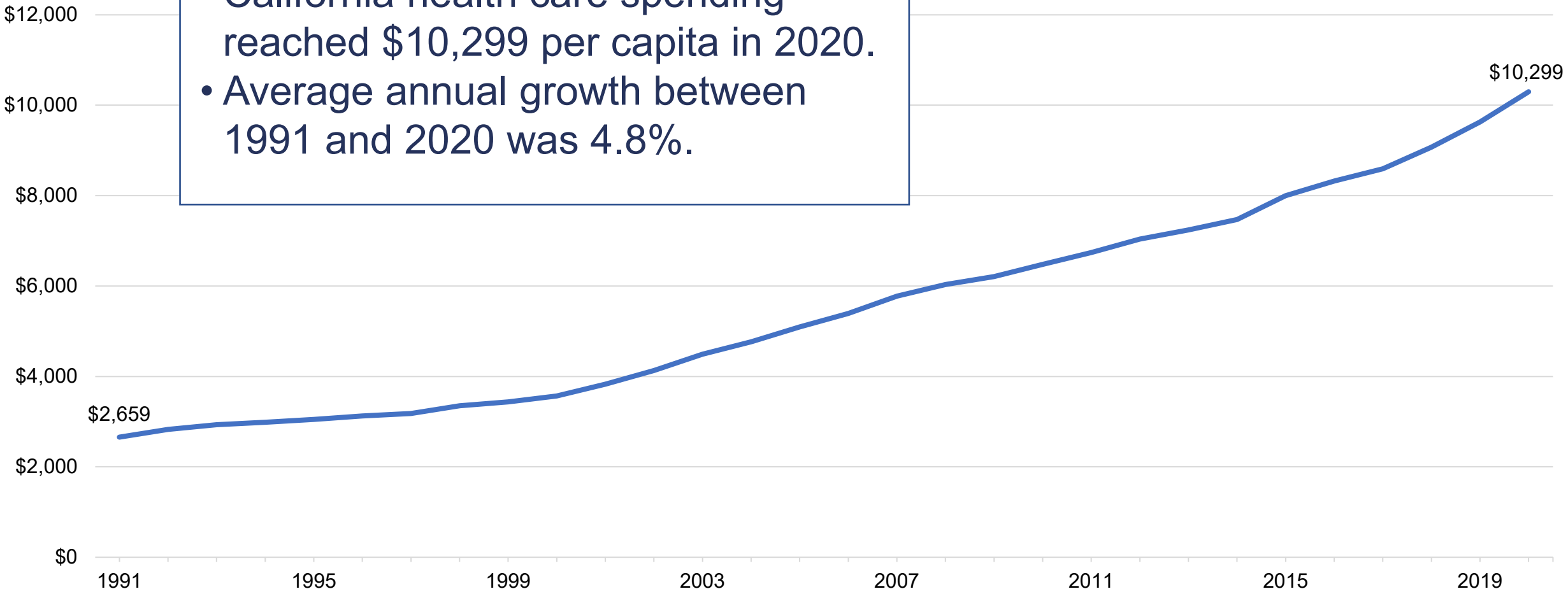
HCAI expands equitable access to quality, affordable health care for all Californians through resilient facilities, actionable information, and the health workforce each community needs.

HCAI's Five Program Areas

- **Facilities**: monitor the construction, renovation, and seismic safety of California's hospitals and skilled nursing facilities.
- **Financing**: provide loan insurance for nonprofit healthcare facilities to develop or expand services.
- **Workforce**: promote a culturally competent and diverse healthcare workforce.
- **Data**: collect, manage, analyze and report information about California's healthcare infrastructure and patient outcomes.
- **Affordability:** analyze health care cost trends and drivers of spending, enforce health care cost targets, and develop, produce, and distribute generic drugs and sell them at low cost.

Per Capita Health Spending in California

- California health care spending reached $10,299 per capita in 2020.
- Average annual growth between 1991 and 2020 was 4.8%.



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

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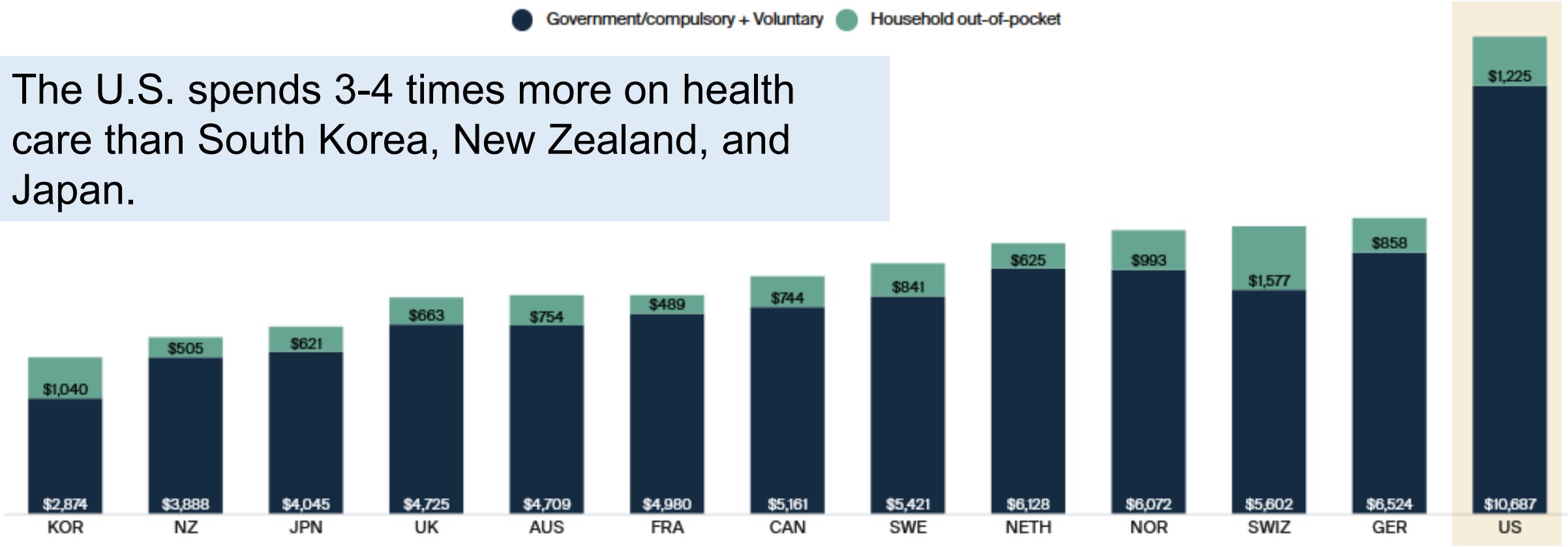
Compared to Other Wealthy Countries, U.S. Spends Substantially More For Worse Outcomes

Dollars (USD) per capita spend on health expenditures



The U.S. spends 3-4 times more on health care than South Korea, New Zealand, and Japan.

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

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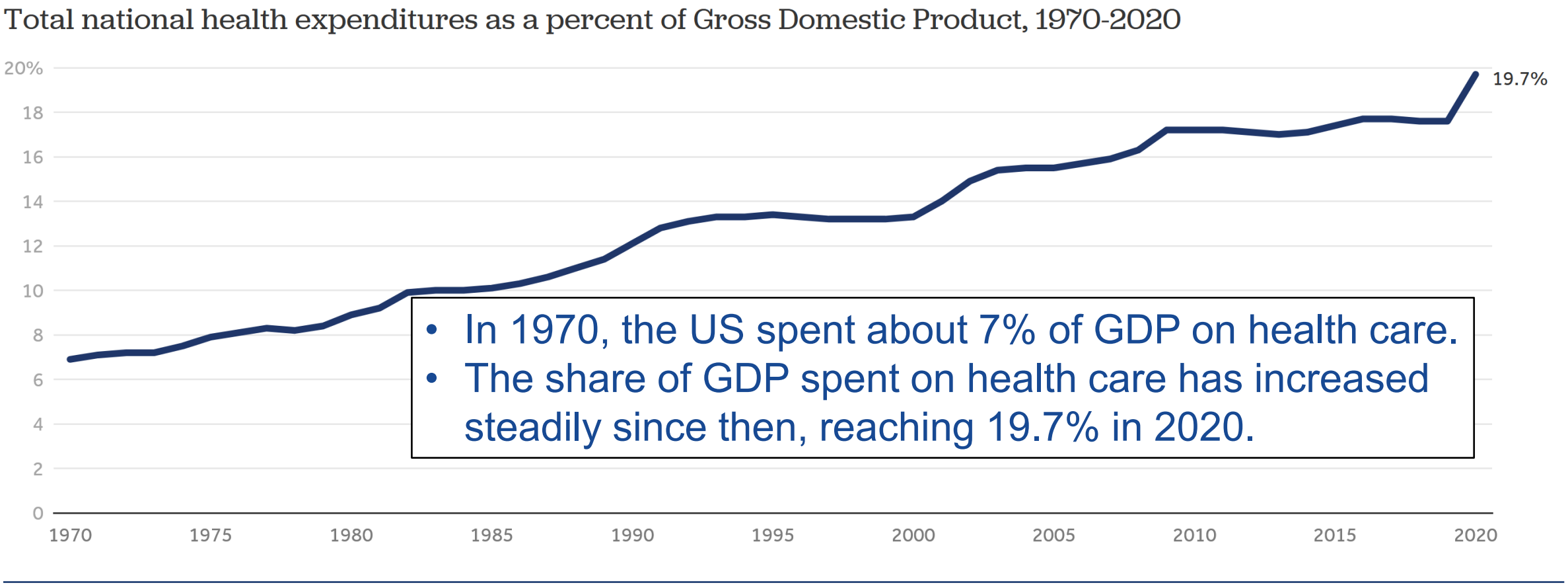
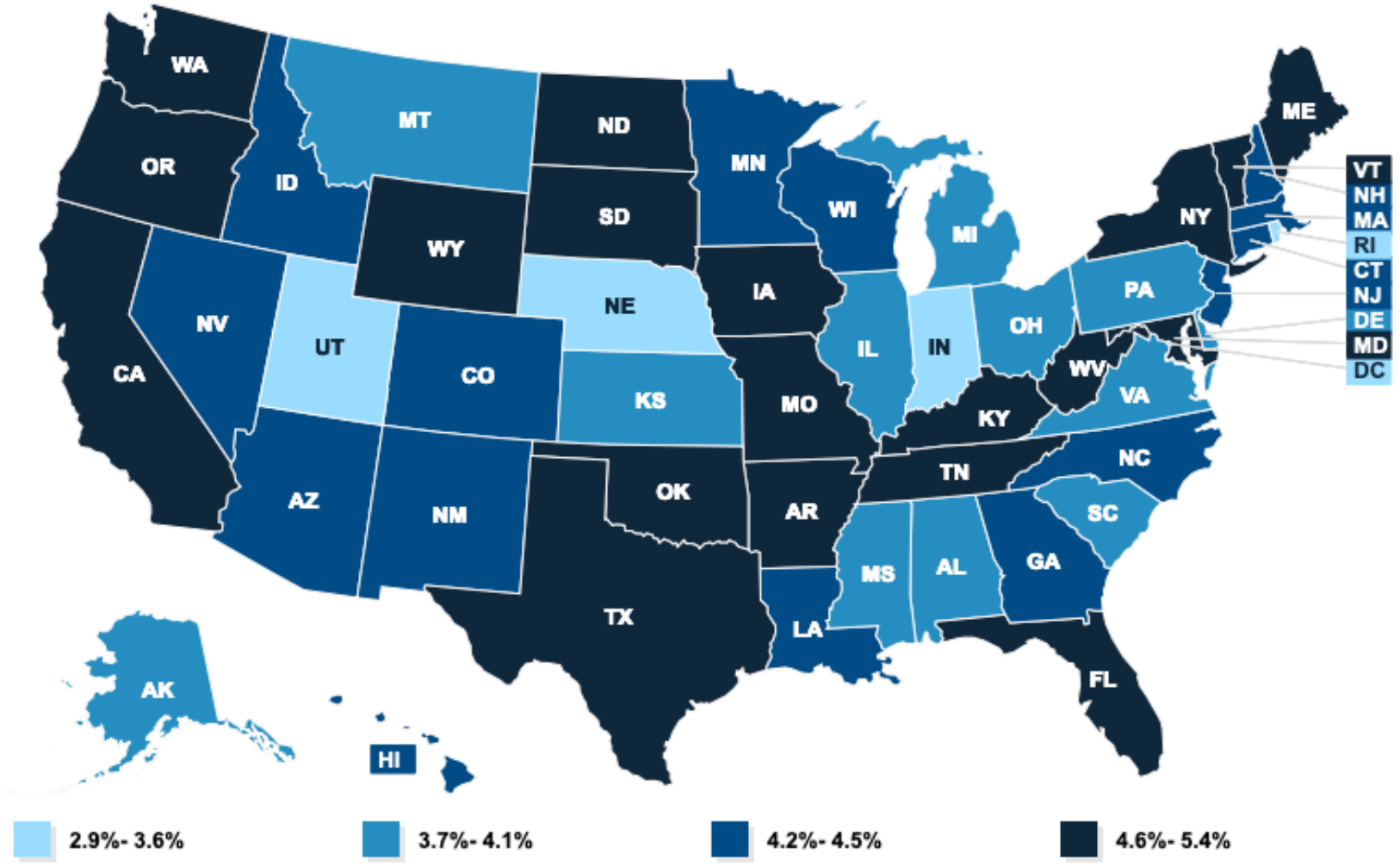
U.S. Health Care Spending as Share of GDP



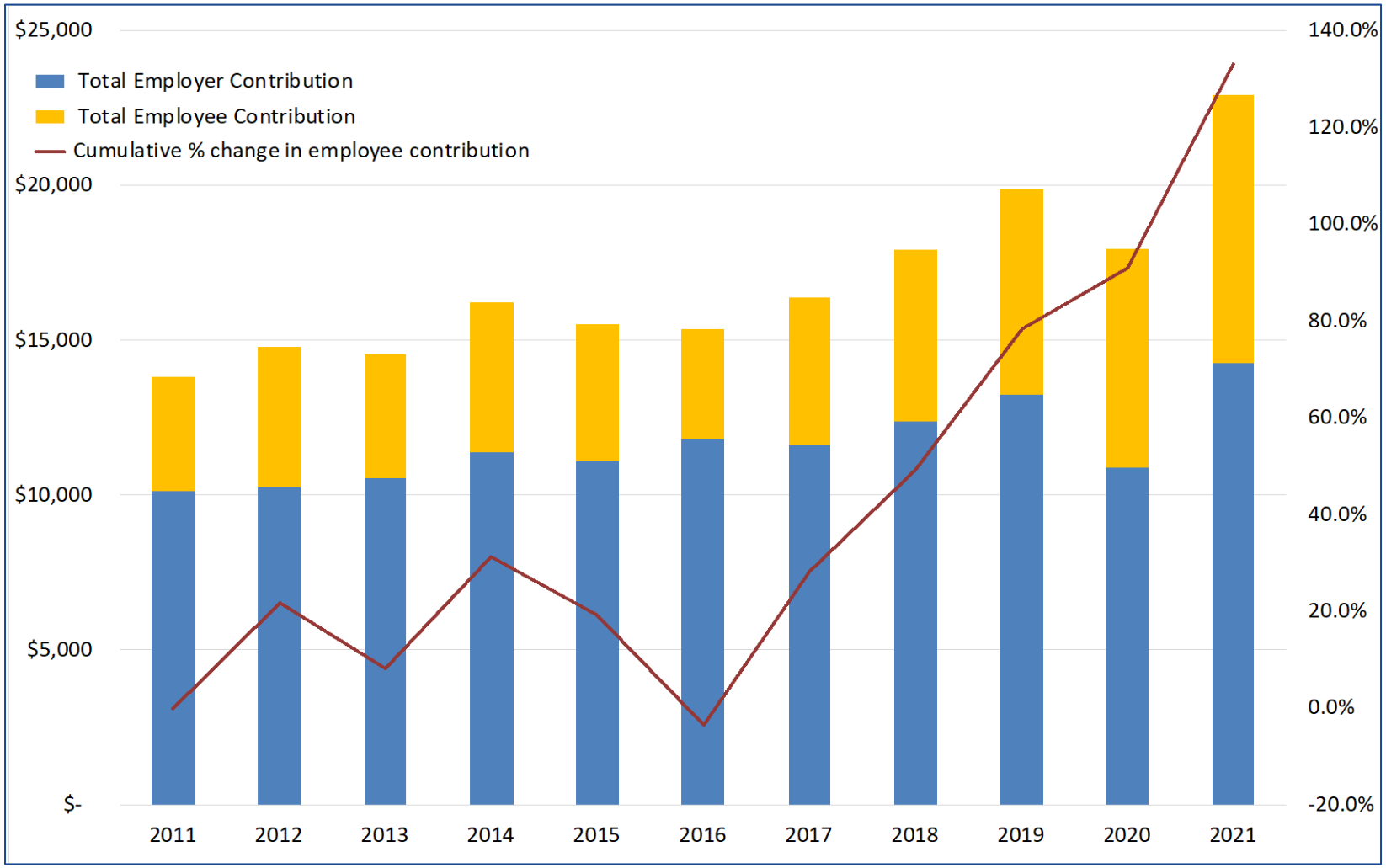
Source: KFF analysis of National Health Expenditure (NHE) data. Available at Peterson-KFF Health System Tracker.

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



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

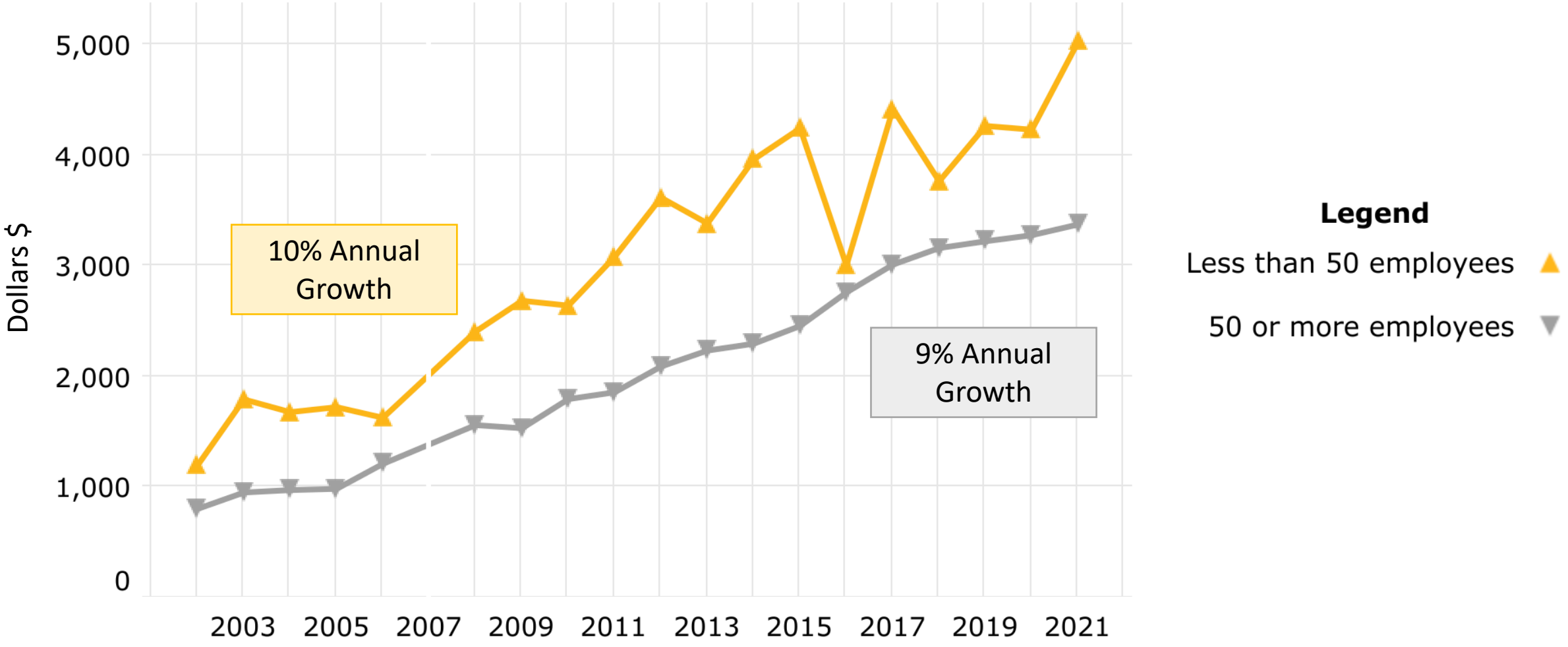
CA Workers Bear the Burden of Increasing Health Care Costs



- Total commercial premiums for Californians in small business have increased 65% since 2011.
- Employee share of premiums in small businesses has grown 133% since 2011.

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

Over the Past Two Decades Family Deductibles Quadrupled



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

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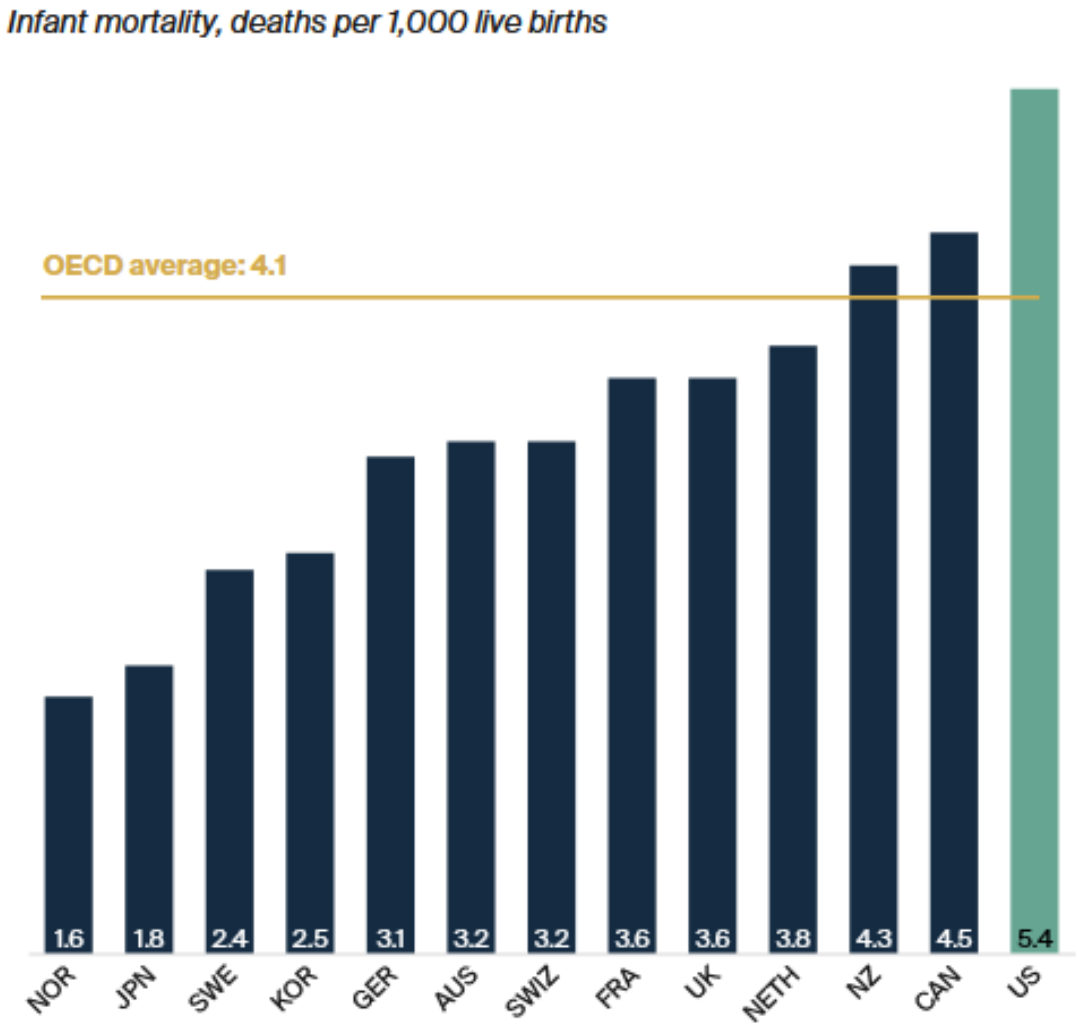
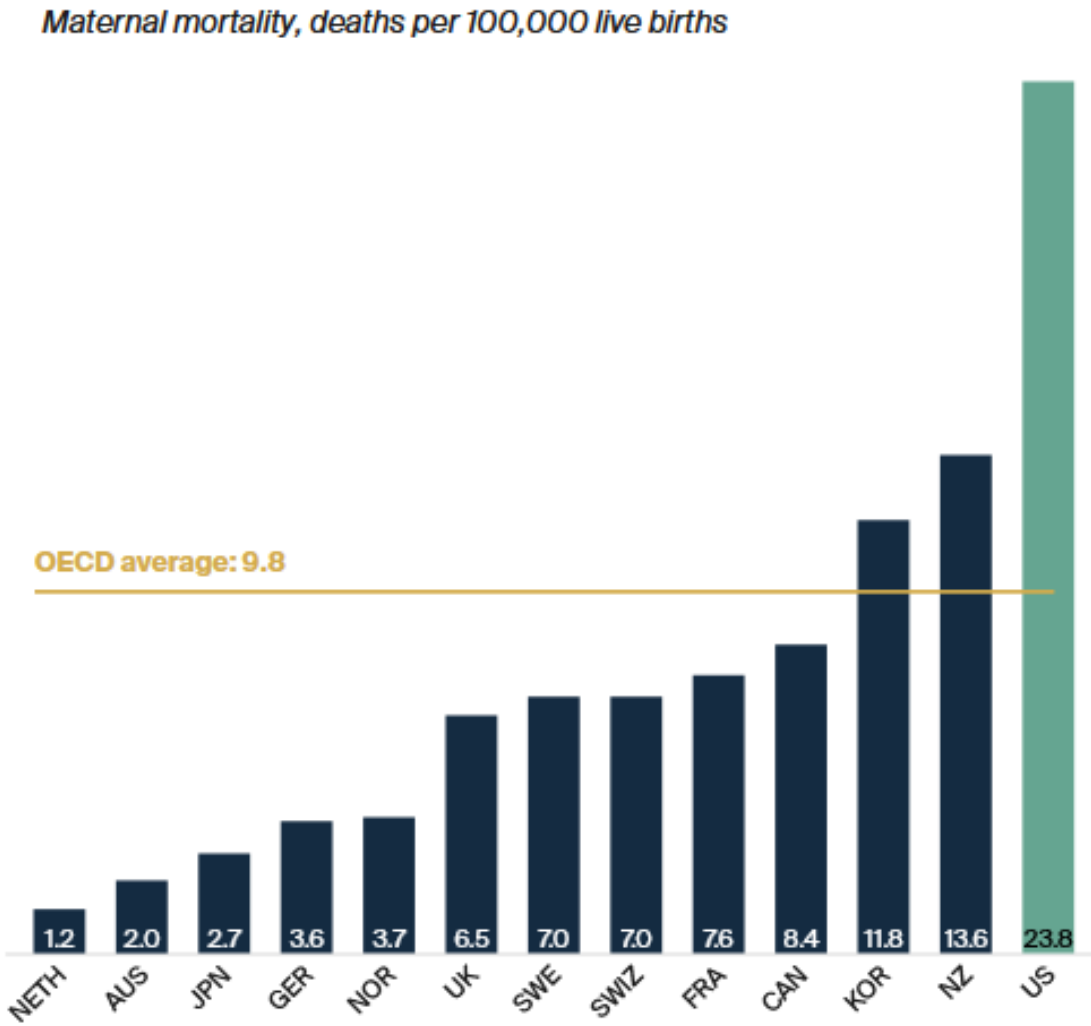
U.S. Has Highest Rate of Infant and Maternal Deaths Among OECD Countries





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

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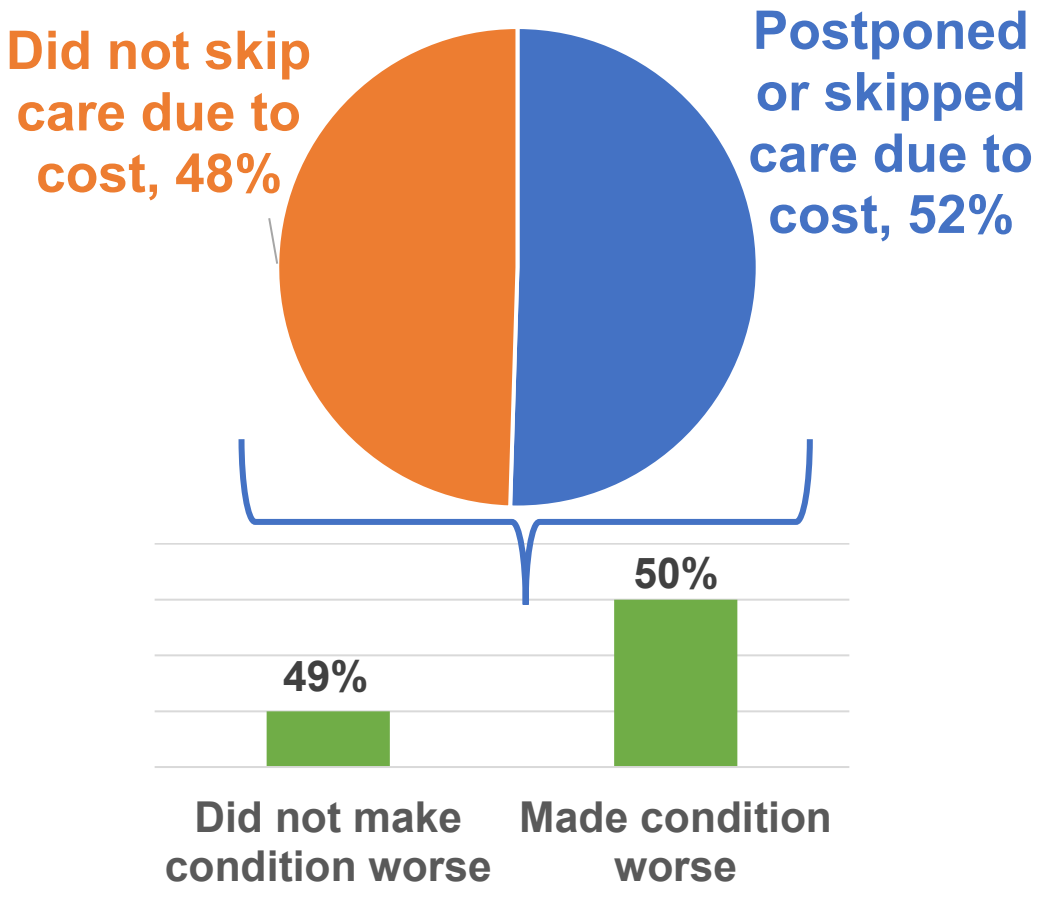
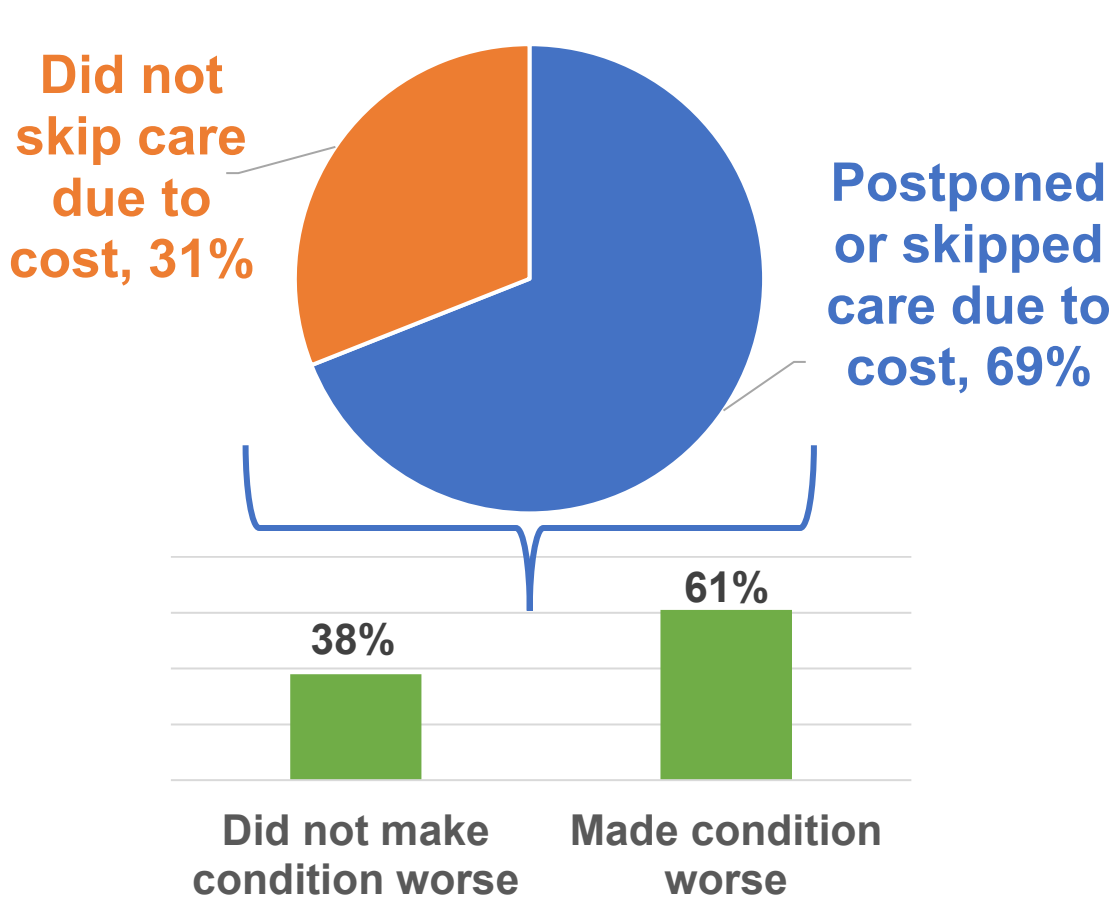
High Costs Have Created Widespread Access and Health Problems for Millions of Californians, Particularly Californians with Low Incomes

All Californians



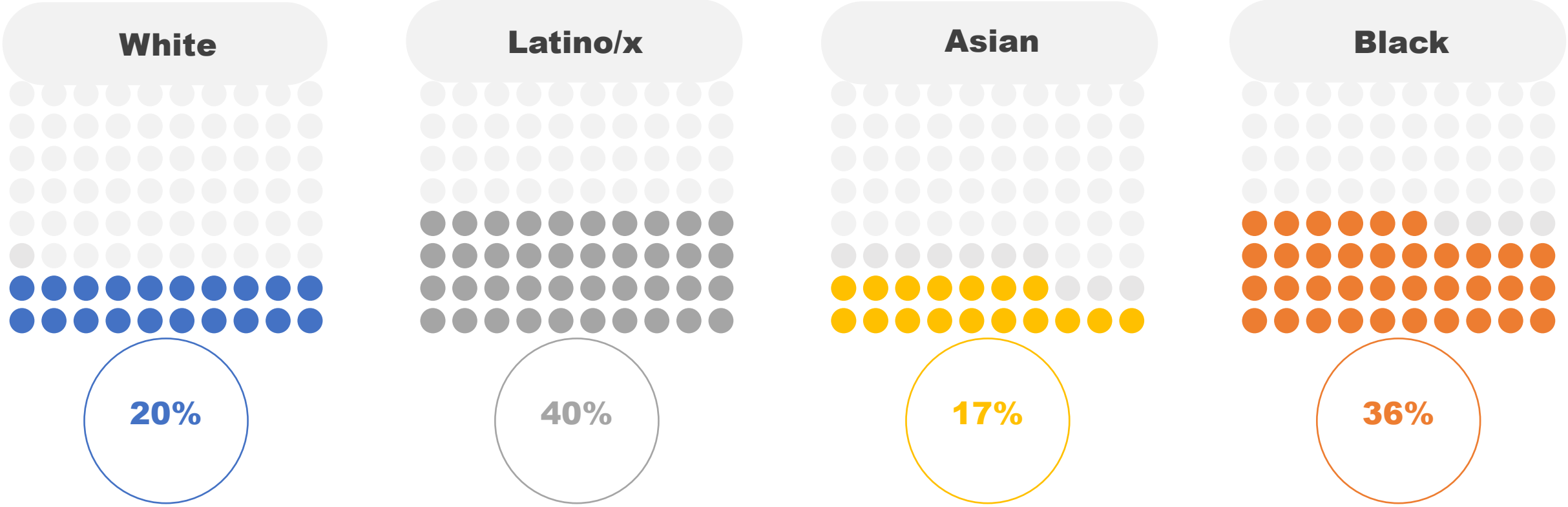
Californians with Lower Incomes



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

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

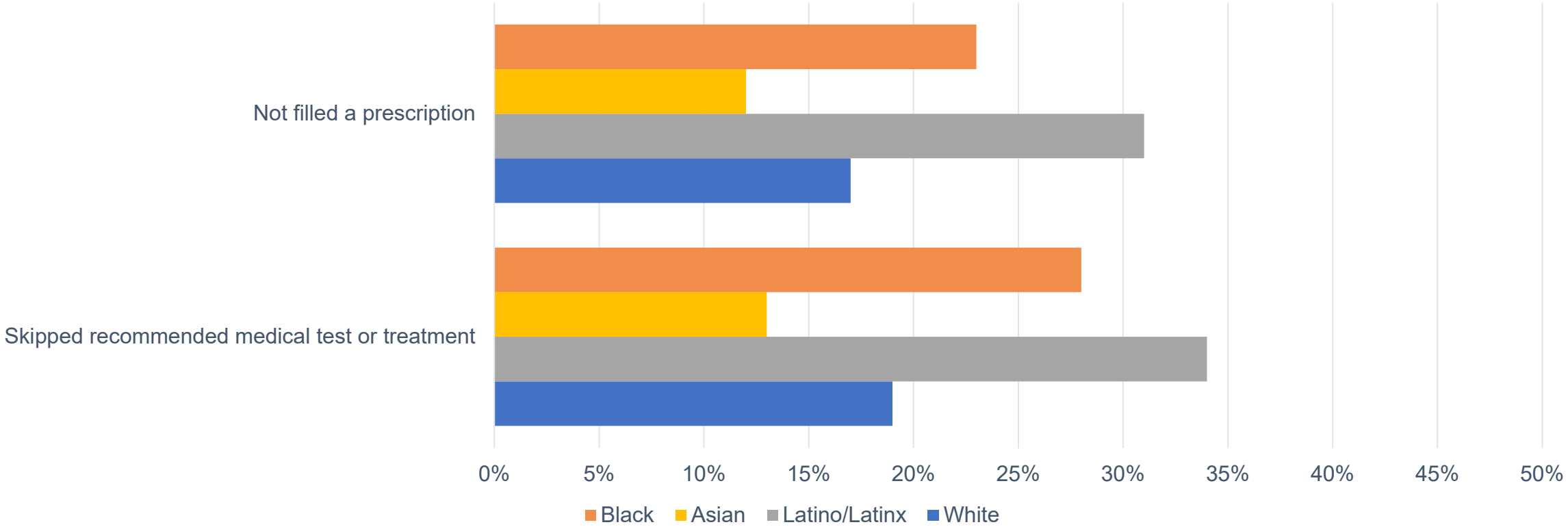
% who say that they or another family member had problems paying or an inability to pay medical bills in the last 12 months



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

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

% who say that they, or another family member, skipped care because of cost



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

High Costs Contribute to Personal Bankruptcy

Nationally

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

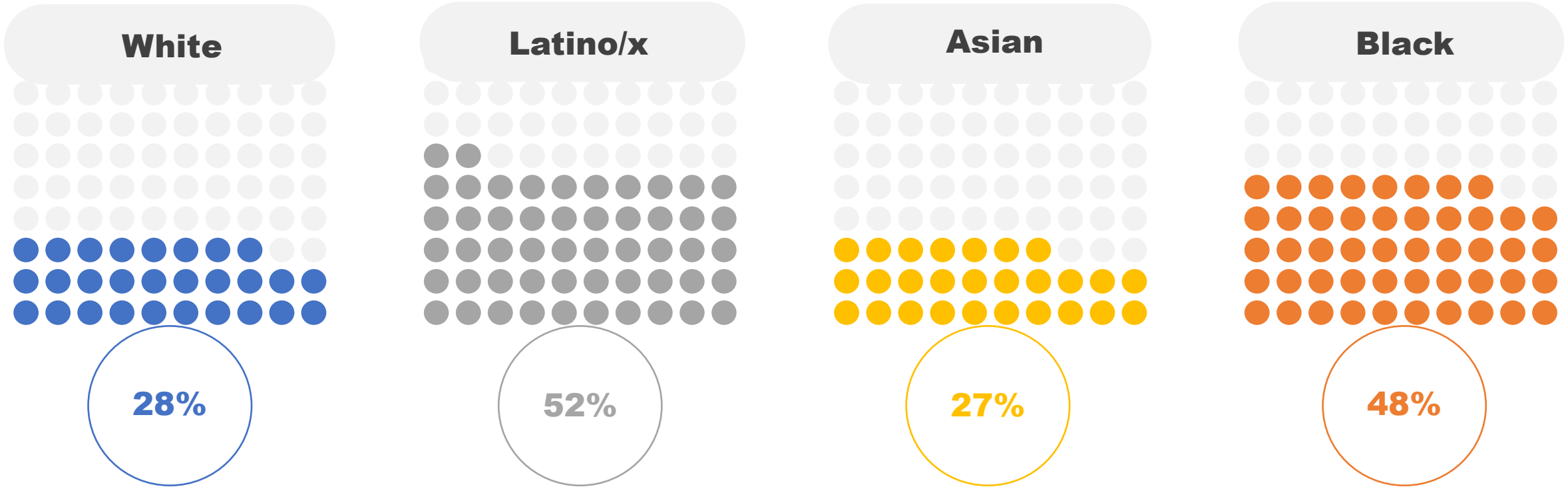
California

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

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

High Costs Contribute to Personal Bankruptcy (cont.)

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



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

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

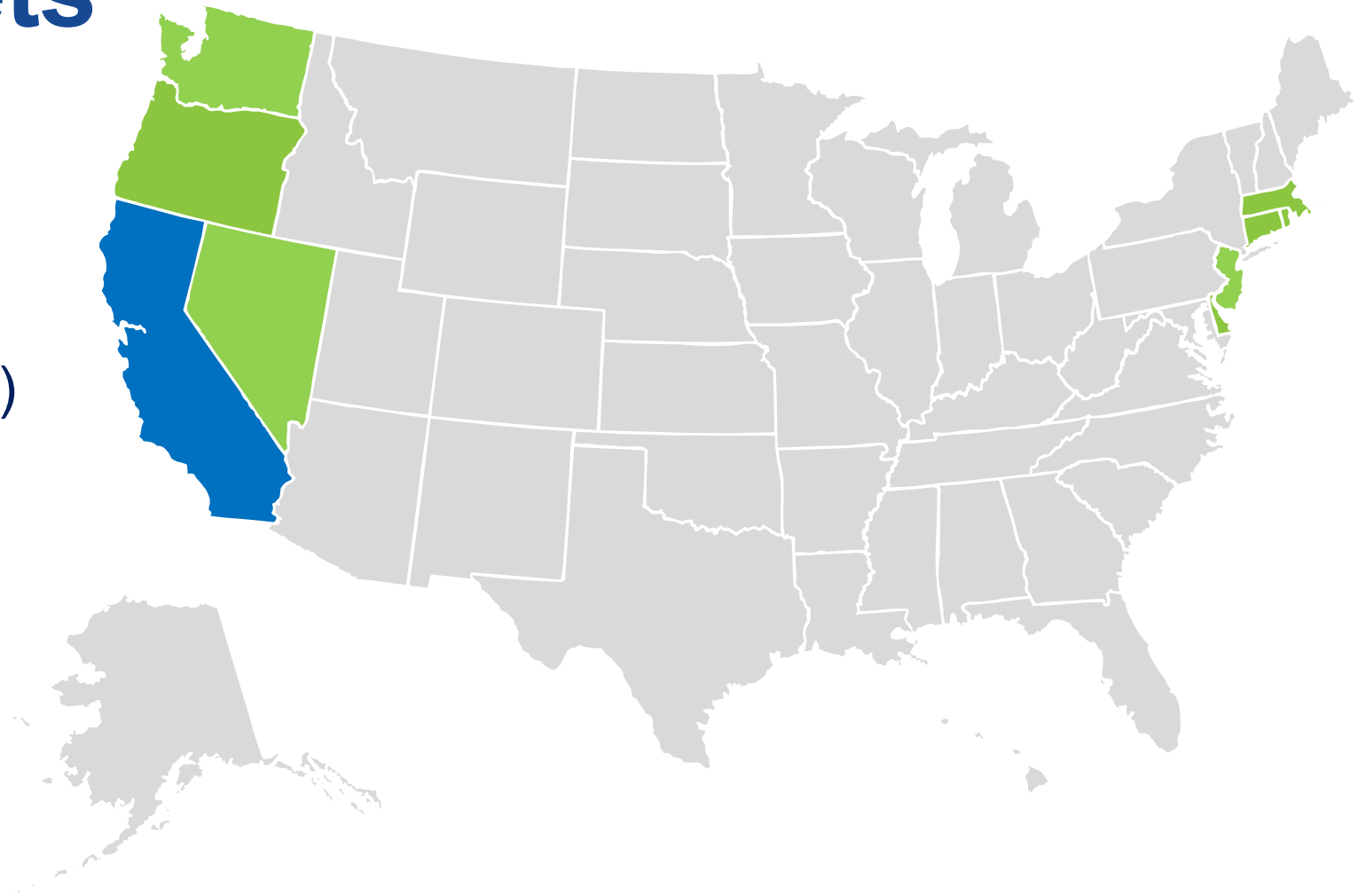
Terminology

- OHCA's enabling statute and other states use different terminology, with some using "cost growth benchmark" and others using "cost growth target." These terms are synonyms and equivalent to OHCA's use of "spending target" in California.
  - "Cost benchmark": Connecticut, Delaware, Massachusetts, Nevada, New Jersey, Washington
  - "Cost target": OHCA enabling statute, Oregon, Rhode Island

- OHCA will use "spending target" and "spending growth"; however, measurement specification definitions may use "expenses" or "expenditures" (e.g., total medical expenses, total health care expenditures).

Eight States Have Established Health Care Spending Targets

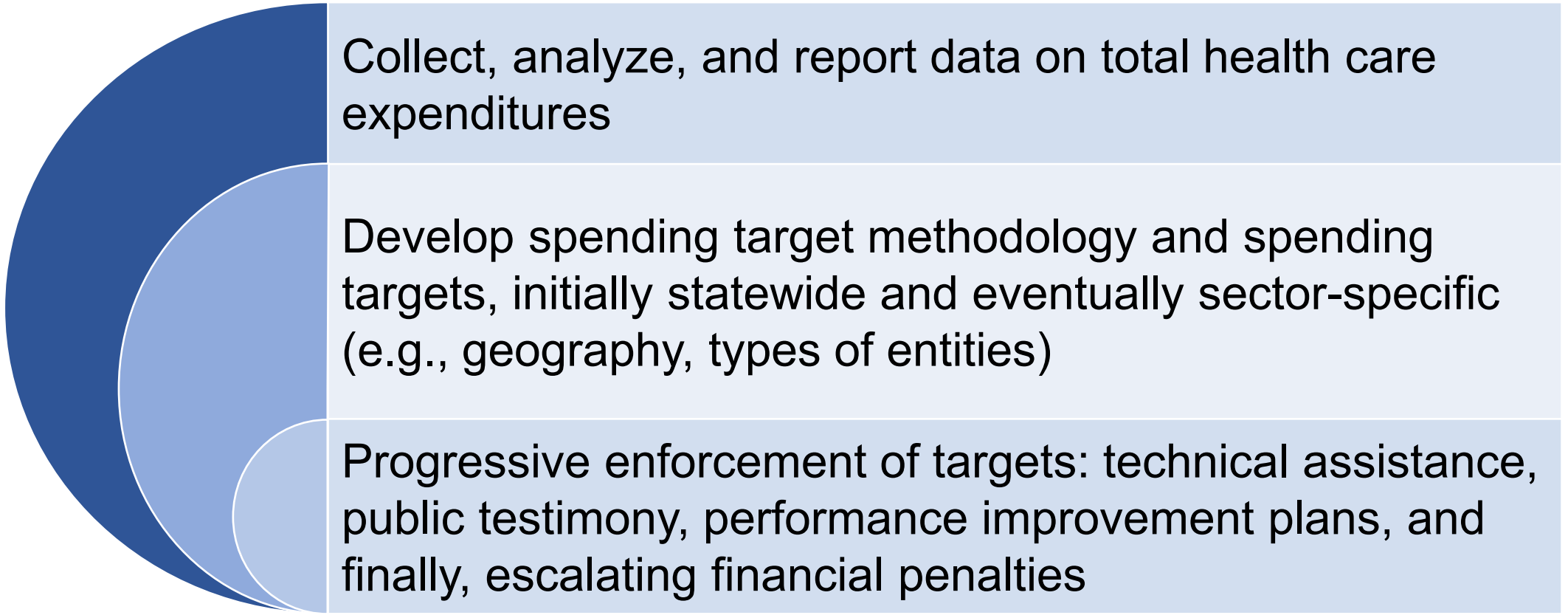
- Established (CT, DE, MA, NJ, NV, OR, RI, WA)
- In progress (CA)



Key Components

- Slow Spending Growth
- Promote High Value
- Assess Market Consolidation

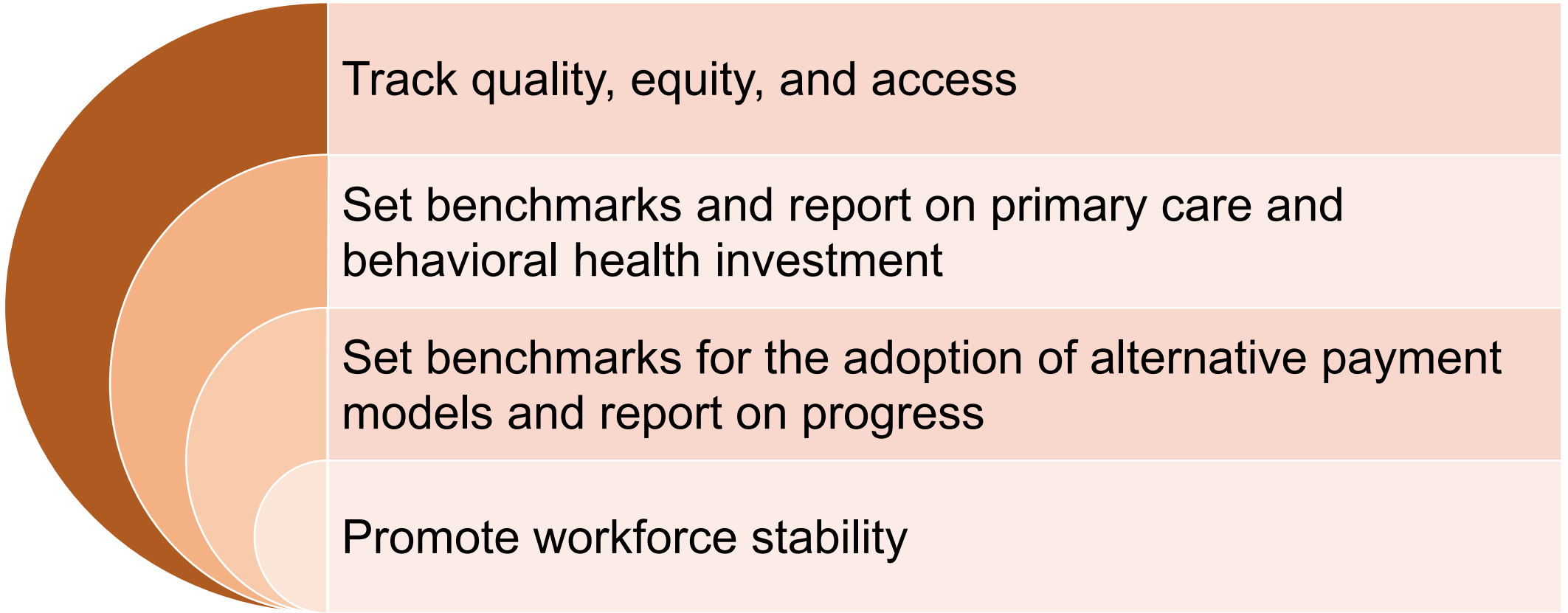
Slow Health Care Spending Growth



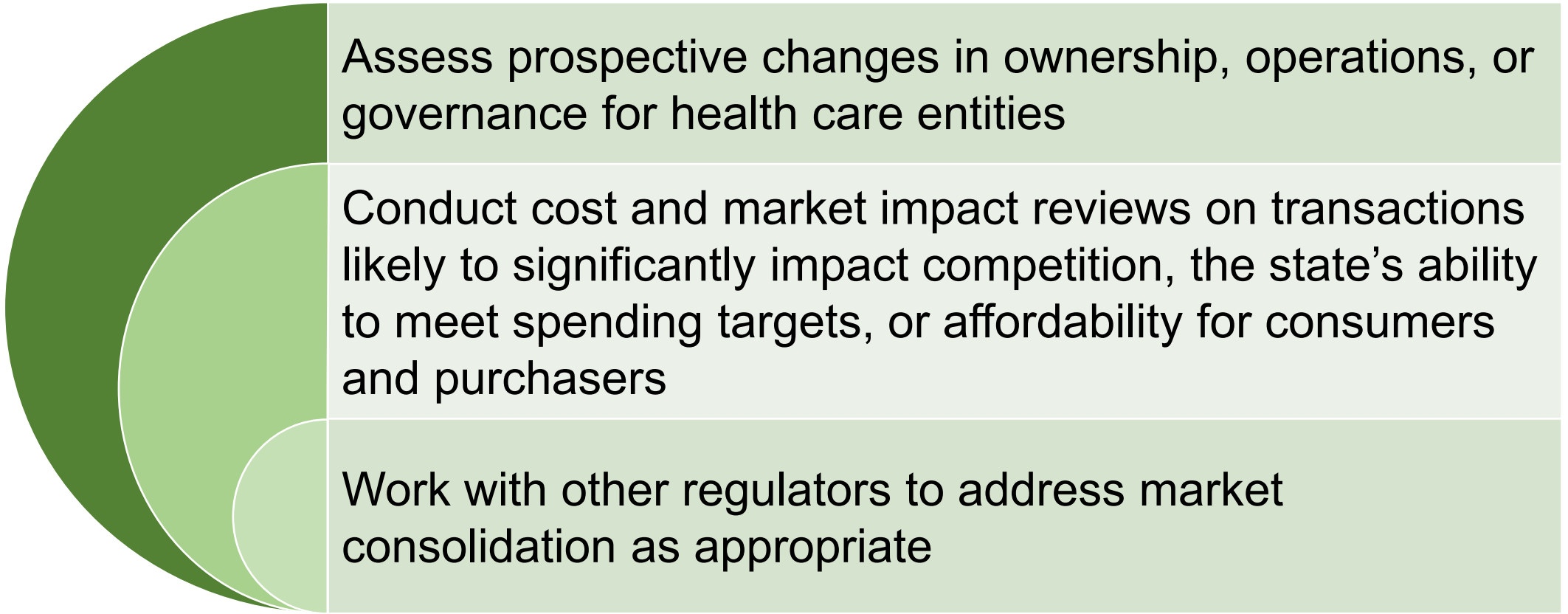
Health Care Entities Subject to the Spending Target

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

Promote High Value System Performance



Assess Market Consolidation



Board & Advisory Committee Responsibilities

Board

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

Advisory Committee

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

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

Health and Safety Code §§127500-127507.6

Timeline: Three-Year Milestones

2023

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

2024

- Set 2025 spending target
- Adopt primary care, APM, workforce stability standards
- Collect 2022 and 2023 total spending data
- Collect and review notices of market transactions, conduct CMIRs as warraned.

Timeline: Enforcement

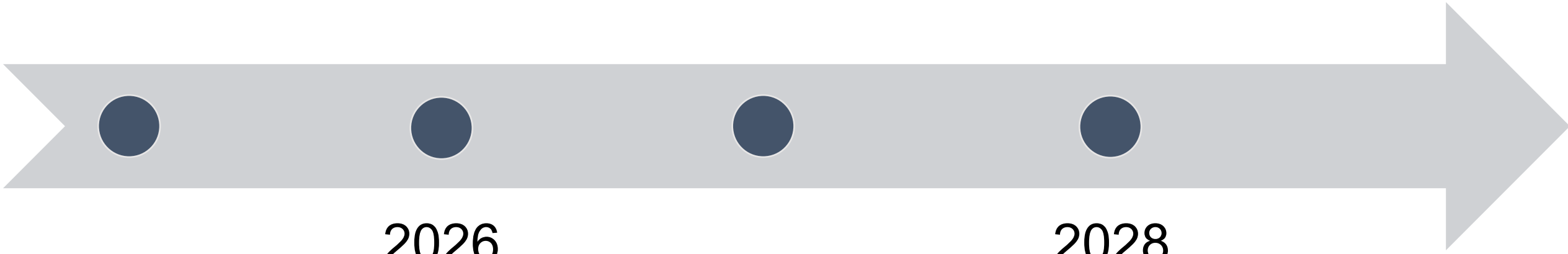
Progressive Enforcement
- Technical assistance
- Public testimony
- Performance improvement plans
- Financial penalties

2025
Set target for 2026

2026
First year of enforcement

2027
Data collection for 2026

2028
Reporting on 2026 data: progressive enforcement begins



Stakeholder Engagement with OHCA

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

Health Care Affordability Advisory Committee

Health Care Affordability Advisory Committee

Enabling statute requires:

- The Health Care Affordability 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

Advisory Committee and Board Collaboration

The Advisory Committee is charged with providing input, including 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

2023-24 Health Care Affordability Board 12-Month Workplan

	THCE & Statewide Spending Target	Cost and Market Impact Review (CMIR)	Health System Performance	Advisory Committee (AC)
JUN 2023	• Statistical Confidence and Adjustments (Cont'd) • Data Sources • Process & Timeline for Collection, Analysis, & Reporting	• Timeline of CMIR Approach	• Overview of Alternative Payment Models (APMs), Primary Care Investment, Workforce Stability	• 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	• Workshop Dates for Proposed Text of CMIR Regulations		
AUG 2023	• Follow-up Discussion of Any Unresolved THCE Design Considerations • Comprehensive Recap of THCE Design Considerations	• Status Update on Proposed Text of CMIR Regulations and Comments Received at the August Public Workshop		

2023-24 Health Care Affordability Board 12-Month Workplan

	THCE & Statewide Spending Target	Cost and Market Impact Review (CMIR)	Health System Performance	Advisory Committee (AC)
SEP 2023	• Review of Draft THCE Data Collection Regulations • Preview the next phase of the Board's Work	• Status Update on Proposed Text of CMIR Regulations and Timing of Submission to Office of Administrative Law **Deadline: OHCA Submits CMIR Regulations to OAL[1]**		• Recap of THCE Design Considerations • Review of Draft THCE Data Collection Regulations • Overview of APMs, Primary Care Investment, Workforce Stability • Status Update on Proposed Text of CMIR Regulations and Timing of Submissions to the Office of Administrative Law
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			• Status Update on THCE Regulations • Requirements and Considerations for Spending Targets • Statewide Spending Target Methodology

[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 System Performance	Advisory Committee (AC)
Dec 2023	• AC Input on THCE Design Considerations & Statewide Spending Target Methodology • Statewide Spending Target Methodology (Cont'd) • Payer Administrative Costs and Profits			
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
	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 System Performance	Advisory Committee (AC)
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**			

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Department of Health Care Access and Information

Bagley-Keene Open Meeting Act and Conflict of Interest Overview

Jean-Paul Buchanan

Purpose of the Act

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

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

Applicability to Health Care Affordability Advisory Committee

- The Act applies to "state bodies," such as "every state board… that is created by statute…"

  (Gov. Code section 111.21(a))
  - Section 127501.12 of Health & Safety Code created the Health Care Affordability Advisory Committee.

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

What Is a Meeting?

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

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

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

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

- For the Advisory Committee, a quorum is 13 members (from a total of 25 voting members). (Gov. Code section 11122.5(a))

Physical Presence/Location Requirements and COVID-19 Exception

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

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

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

Serial Communications Are Prohibited

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

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

Purpose: to prevent board/committee actions/decisions being made in secret, outside of a public meeting.
(Gov. Code section 11122.5(b))

“Meeting” Exceptions

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

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

(Gov. Code section 11122.5(c))

Notice and Agenda

Meeting notices are required to be posted at least **10 days** before the meeting.
Notices must have:

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

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

(Gov. Code section 11125)

Public Attendance and Participation

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

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

Participation: Board/committee must give the public an opportunity to directly address the members on each agenda item before or during the discussion or consideration of the item.

- Public criticism of the board/committee cannot be prohibited.

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

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

Meeting Documents

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

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

(Gov. Code section 11125.1)

Voting

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

Abstentions

- Abstentions may complicate voting.
- In general, a state body cannot act without support of at least a majority of its quorum.
- Members who voluntarily abstain are counted toward a quorum, but decisions will only require the majority of those members who actually vote, as long as there is support from a majority of the quorum.
- Members who are disqualified from voting by law are not counted toward a quorum.

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

Penalties for Non-Compliance

Civil:

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

Criminal:

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

Conflict-of-Interest and Form 700

Overview of Conflict-of-Interest Laws

Conflict of Interest Laws (non-exhaustive List):

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

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

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

Purpose of Conflict-of-Interest Laws

- The State of California's "conflict-of-interest statutes are concerned with what might have happened rather than merely what actually happened….
- They are aimed at eliminating temptation, avoiding the appearance of impropriety, and assuring the government of the member's undivided and uncompromised allegiance….
- Their objective 'is to remove or limit the possibility of any personal influence, either directly or indirectly which might bear on a member's decision....'"

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

Appearance of Impropriety

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

Exception: Financial Effect on Representative Interest

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

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

Form 700

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

OHCA **Advisory Committee members are not included** in HCAI’s Conflict-of-Interest Code and will **NOT be required to file Form 700s**. Generally, the California Political Reform Act requires a public official to disclose foreseeable conflict of interests, which HCAI specifically identifies in its Conflict-of-Interest Code.

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

HCAi
Department of Health Care Access and Information

The Health Care Affordability Board Meeting will resume at 1:00 pm

HCAi
Department of Health Care Access and Information

Cost Market and Impact Review

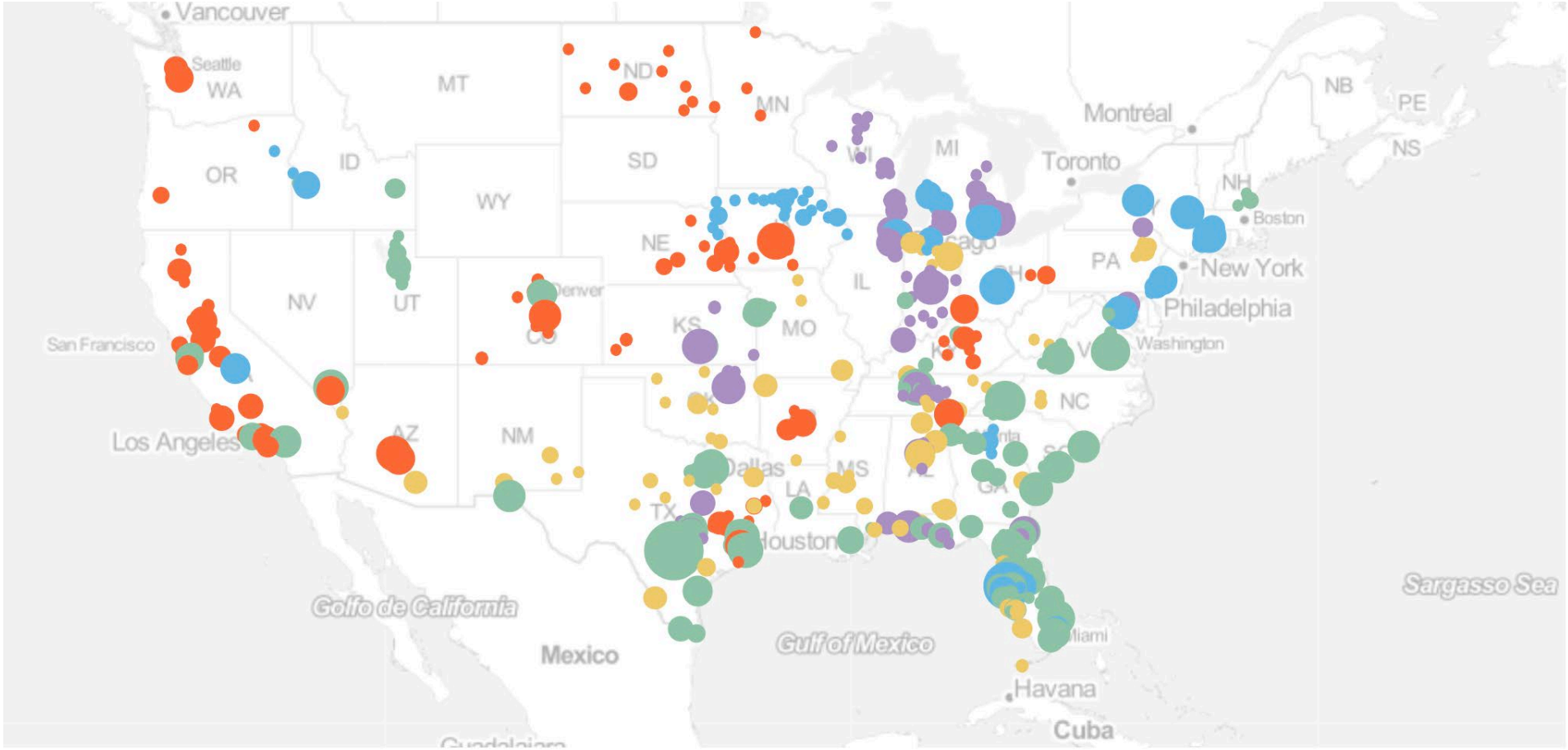
Sheila Tatayon, Assistant Deputy Director

Context: Impact of Consolidation and Market Power

Impact of Hospital Mergers

Cost Impacts: Within Market Consolidation	- Hospital price increases of 20-44% (some as high as 55-65%) - Bystander hospitals also raise prices following a merger
Cost Impacts: Cross-Market Consolidation	- Prices rise 7-9% at *acquiring* hospitals, 17% at *acquired* hospitals with out-of-state purchaser - Bystander hospitals also raise prices
Quality	- Most studies find no significant quality benefits - A few have shown modest improvements in a few measures - Other studies indicated higher mortality and worse quality when there is less competition

Merger & Acquisition (M&A) Trend – Hospital Growth into Regional and National Health Systems



https://sourceonhealthcare.org/cross-market/

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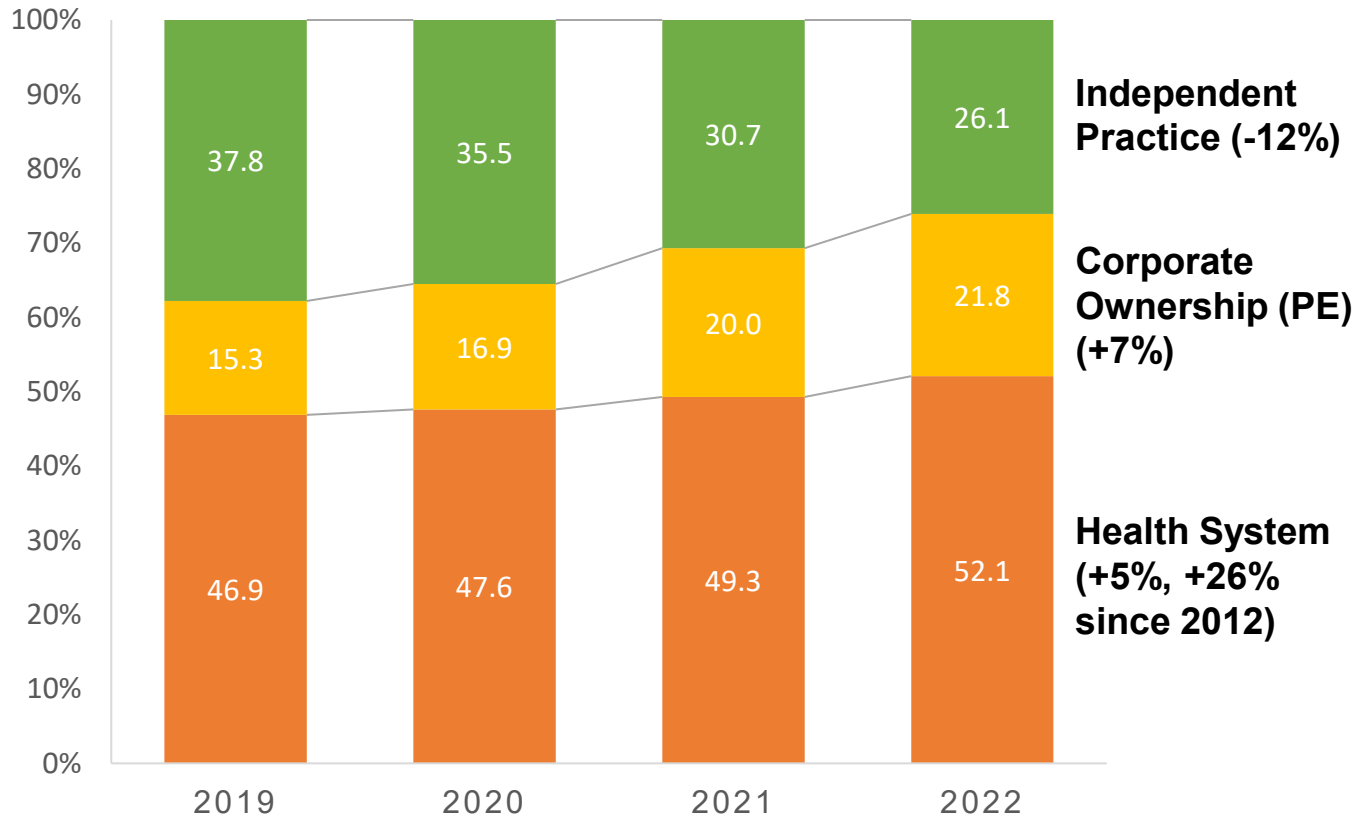
M&A Trend: Acquisition of Physicians

- Vertical integration could reduce administrative burdens, streamline care and reduce duplicative services.

- But the evidence is…
  - **Health system ownership:**
    - Higher prices and spending (10-20%)
    - Higher use of high intensity services
  - **Private equity ownership:**
    - Higher charged rates and prices
    - Increased utilization of high cost services
    - Mixed quality measures
    - Lower patient experience scores



Data from PAI-Avalere Health Report on Trends in Physician Employment and Acquisitions of Medical Practices: 2019-2021

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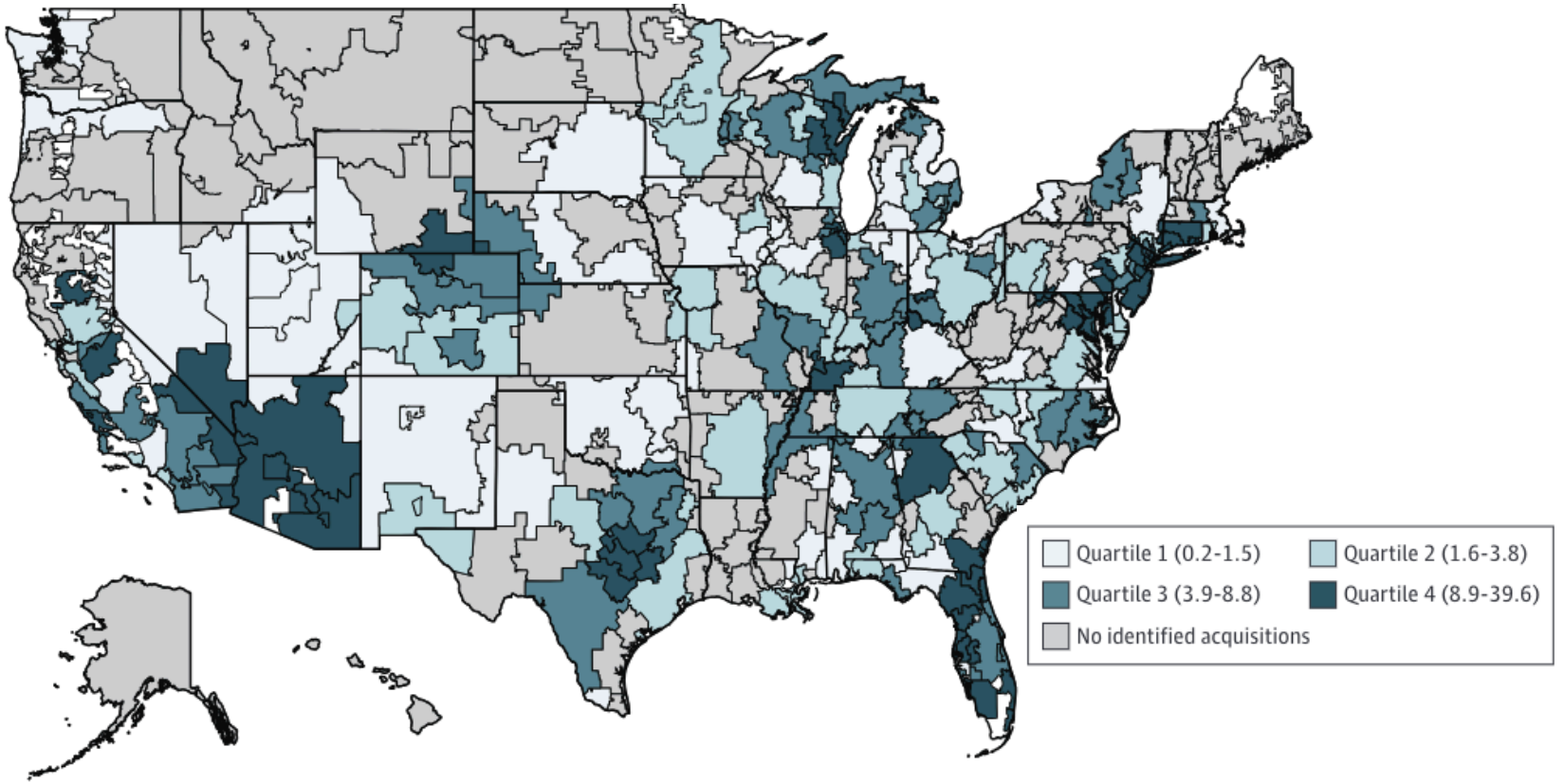
M&A Trend: Private Equity (PE) Owned Physician Practices

- PE acquisition is not uniform geographically or by specialty
- California has regions with a high percentage of PE-owned physician practices

Figure 1. Private Equity (PE) Penetration Across 6 Office-Based Specialties by Hospital Referral Region (HRR)



Singh et. al., *Geographic Variation in Private Equity Penetration Across Select Office-Based Physician Specialties in the US*. JAMA Health Forum 3(4):e220825 (April 2022).

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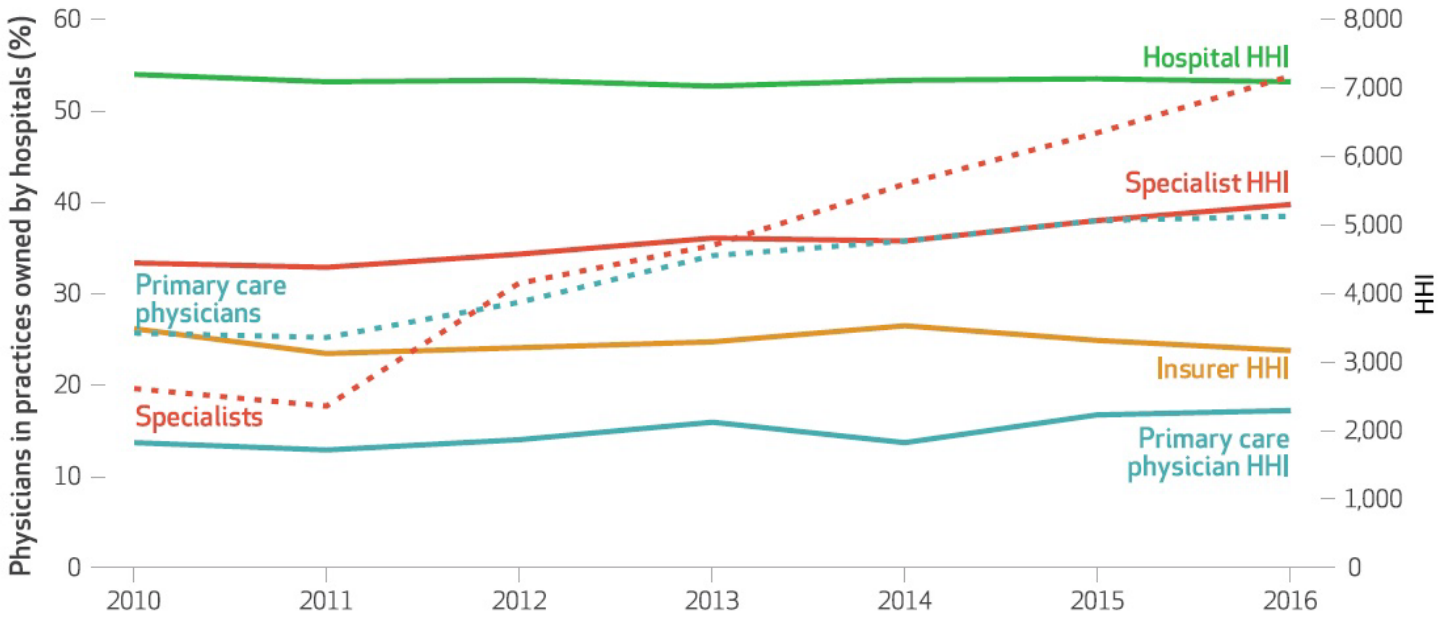
Market Concentration in California Matches the National Trends

EXHIBIT 1

Horizontal concentration and vertical integration in selected California counties, 2010–16



SOURCE Authors' analysis of data for health insurers from the Managed Market Surveyor provided by Decision Resources Group (formerly HealthLeaders-Interstudy), for hospitals from the American Hospital Association Annual Survey Database, and for physicians from the SK&A Office Based Physicians Database provided by QuintilesIMS. **NOTES** Herfindahl-Hirschman Indices (HHIs) indicate market concentration and are explained in the text. The figure shows unweighted data for forty-one California counties with populations of less than 500,000. Specialists include physicians in the fields of cardiology, oncology, radiology, and orthopedics. The dashed lines refer to percentages of primary care physicians and specialists in practices owned by hospitals.

Scheffler et. al., *Consolidation Trends In California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices*. Health Affairs 37:9, p. 1409-1416 (September 2018).

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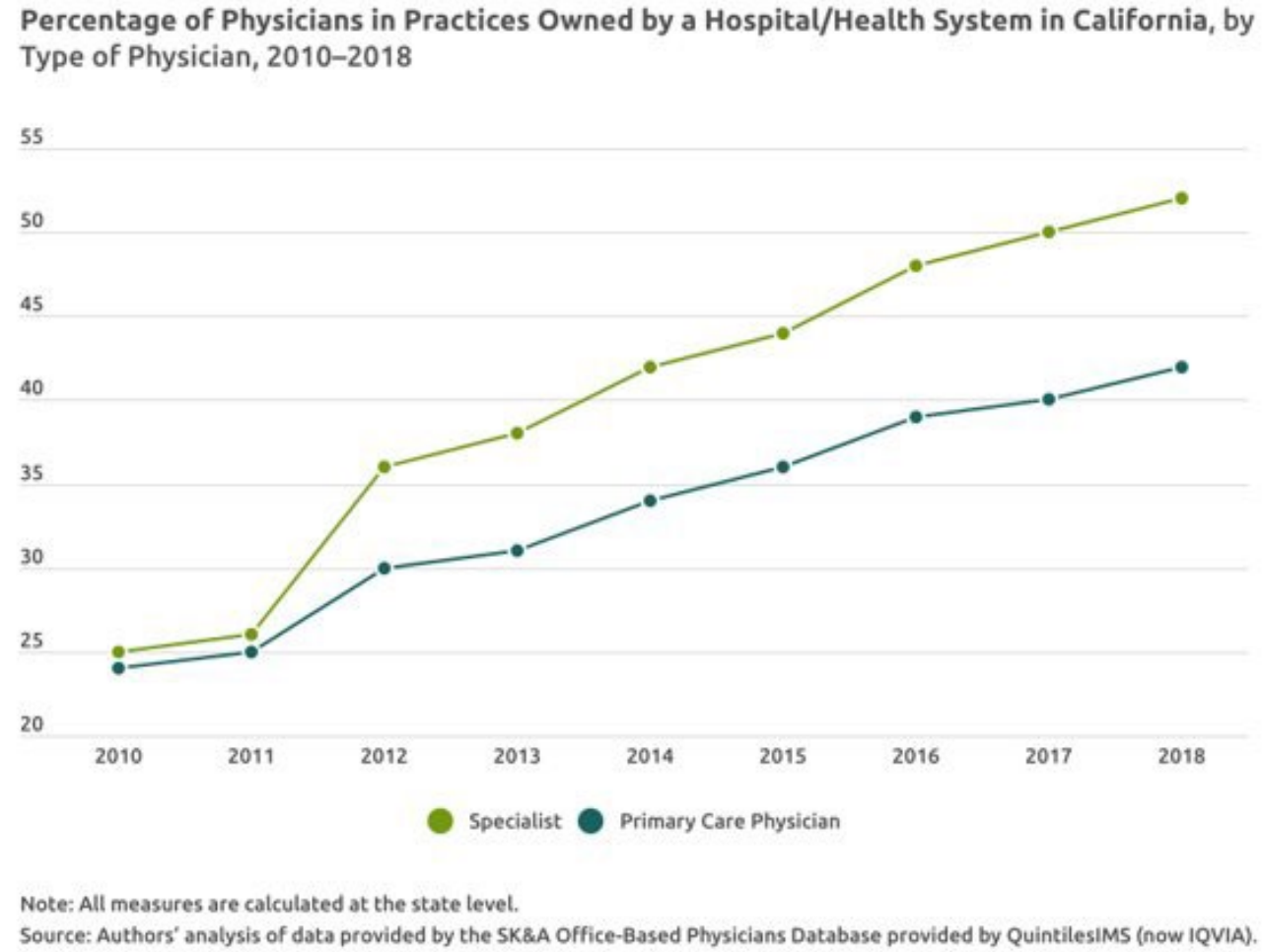
Market Concentration in California Matches the National Trends



Scheffler et. al., *The Sky's the Limit: Health Care Prices and Market Consolidation in California*. California Health Care Foundation (October 3, 2019).

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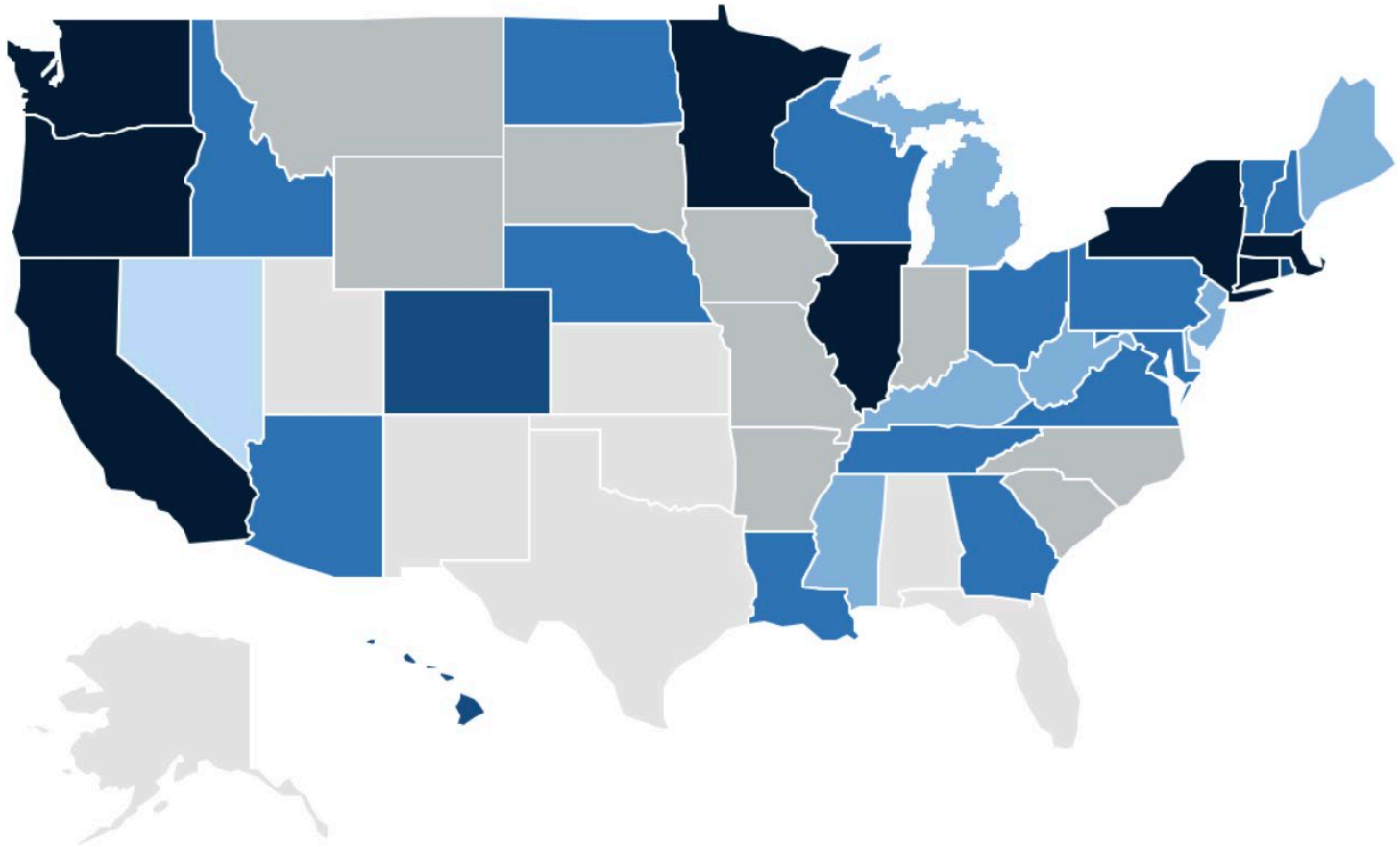
Federal Action to Address Health Care Consolidation

Executive Order on Promoting Competition in the American Economy

DOJ's Withdrawal of Policies on Healthcare Antitrust Safety Zones

House Energy & Commerce bill (H.R. 3561) on transparency of health-related ownership

States Requiring Pre-transaction Filing by Health Care Providers



- No required notice
- Notice of general nonprofit transactions (not healthcare specific)
- Notice of limited provider group transactions
- Notice of nonprofit healthcare transactions
- Notice to CON program
- Notice of all hospital transactions
- Notice of all hospital and most provider group transactions

https://sourceonhealthcare.org/market-consolidation/

States with Agencies to Oversee Consolidation

Massachusetts Health Policy Commission (HPC)

- Providers and provider organizations
- Conducts a Cost and Market Impact Review (CMIR)
- Relies on AG or other agency to block or place conditions on a merger

Oregon Health Authority

- Health care entities (includes payers, providers)
- Two-stage review (like initial review and CMIR)
- Has the authority to block or place conditions on mergers

California Office of Health Care Affordability

- Health care entities (includes payers, providers, fully integrated delivery systems)
- Conducts a CMIR
- Relies on AG or other agency to block or place conditions on a merger

Example: Beth Israel Lahey Health Merger

In July 2017, Lahey Health & Beth Israel submitted a Material Change Notice to become Beth Israel Lahey Health (BILH)

After 30-day review, HPC determined the transaction was likely to have a significant impact on market function

The HPC issued a preliminary report in July and a final report in September 2018 expressing concern of substantially increased commercial prices

The HPC referred the final report to the AG and made recommendations to the Department of Public Health (DPH) to impose conditions on the transaction

In October 2018, the AG entered a consent decree with BILH to impose 7-year prices caps and financial commitments to support underserved communities in Massachusetts AND DPH included conditions in its approval in response to concerns raised by the HPC

Cost and Market Impact Review Program (CMIR)

OHCA Enabling Statute: Legislative Findings

Escalating health care costs driven primarily by high prices and underlying factors or markets conditions that drive prices, particularly in geographic areas and sectors where there is a *lack of competition due to consolidation*.

Consolidation through *acquisitions, mergers, or corporate affiliations* is pervasive across the industry and involves health care service plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities.

Market consolidation occurs in various forms

- horizontal, vertical and cross industry mergers,
- transitions from nonprofit to for-profit status or vice versa, and
- any combination involving for-profit and nonprofit entities

Health and Safety Code §127500.5(a)(4)

OHCA Enabling Statute: Office Responsibilities

Review and evaluate consolidation, market power, and other market failures through cost and market impact reviews of mergers, acquisitions, or corporate affiliations involving:

- health care service plans,
- health insurers,
- hospitals or hospital systems,
- physician organizations,
- pharmacy benefit managers, and
- other health care entities

Consistent with the Legislative Intent to increase transparency on transactions that may impact competition and affordability for consumers and purchasers.

Existing Merger Oversight in California

Attorney General

- Approval Authority for non-profit health facilities
- Authority to investigate and enforce laws relating to antitrust, unfair competition, and consumer protection

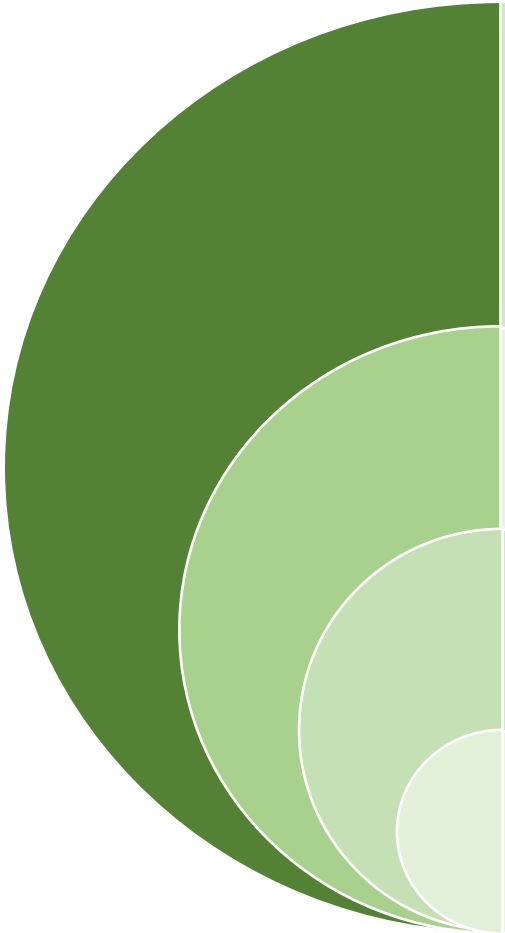
Department of Managed Health Care

- Approval Authority for major transactions of health care service plans
- DMHC evaluates the impact on enrollees and the stability of the health care delivery system.

California Department of Insurance

- Approval Authority for mergers of domestic health insurers.
- CDI reviews impact on the marketplace and consumers.

OHCA's Oversight Role in Assessing Health Care Consolidation



- Support efforts of the Attorney General, the Department of Managed Health Care, and the Department of Insurance and examine impact, both negative and positive, on access and quality in addition to cost for consumers.
- Seek input from the parties and the public and report on the anticipated impacts to the health care market.
- Collect and report information that is informative to the public.
- Refer transactions that may reduce market competition or increase costs to the Attorney General for further review.

Gaps in California's Market Oversight

Agreements or transactions:

- Involving for-profit hospitals and health facilities
- Among physician organizations
- Involving health plan or health insurer purchase or affiliation with another health care entity, such as a physician group
- Involving health plans or health insurers and management service organizations (MSOs)
- Involving Private Equity
- Involving exclusive contracting

CMIR Program Will Fill in Gaps and Increase Public Transparency

Collect and publish notices of material change transactions that will occur on or after April 1, 2024. Health care entities must submit notices to OHCA 90 days before the agreement or transaction will occur.

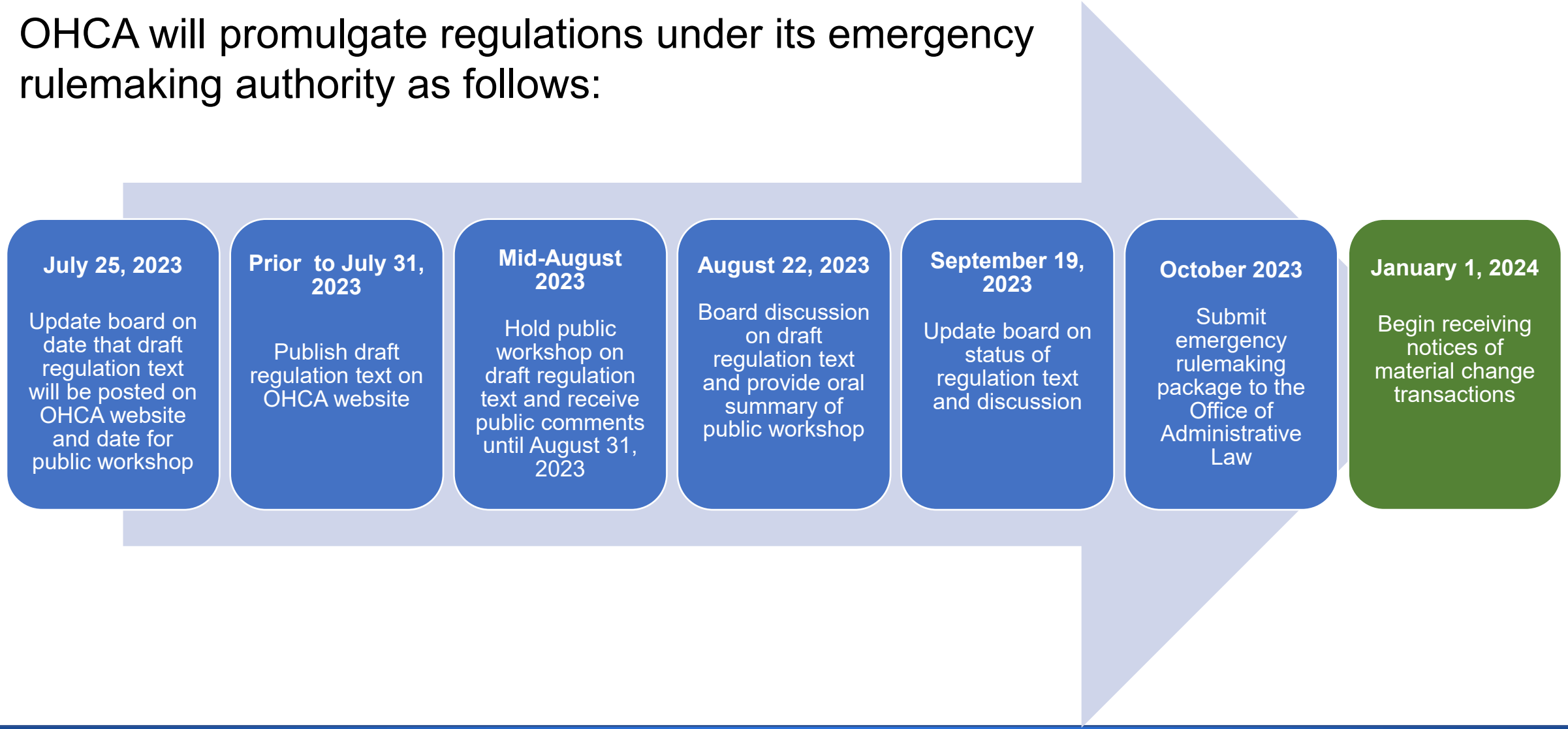
Upon determination notice is complete, OHCA will determine within 60-days whether the agreement or transaction must undergo a Cost and Market Impact Review (CMIR).

Conduct CMIR for agreements or transactions after OHCA determines a CMIR is warranted, make factual findings and issue preliminary report, allow written responses from affected parties and the public, and issue final report.

OHCA will promulgate regulations for notices, the decision to conduct a CMIR, and factors and timelines for conducting CMIRs.

CMIR Implementation: Looking Ahead

OHCA will promulgate regulations under its emergency rulemaking authority as follows:



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Total Health Care (THCE) Expenditures Measurement

Vishaal Pegany, Deputy Director
Michael Bailit, Bailit Health

Slide Formatting

Indicates items that the AC is charged with providing input or recommendations on OR other areas as requested by the Board or OHCA.

Contents

Introduction to Health Care Spending Targets

What is a Spending Target and Why Pursue One?

- A health care spending target is a per annum rate-of-growth target.
- States have adopted such targets to slow the growth in health care spending.
  - Health spending growth has long exceeded economic growth
  - Per capita spending on health care has grown faster than inflation

Logic Model for a Spending Target

Measure
Measure performance relative to the spending target

Analyze
Analyze spending to understand spending trends and drivers

Report
Publish performance against the target and analysis of spending growth drivers

Identify
Identify opportunities and strategies to slow spending growth

Implement
Implement strategies to slow spending growth

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

Analytic Workstreams in Spending Target Programs

States set their health care spending growth benchmarks, and then perform parallel analyses to understand trends. States 1) calculate the change in THCE to assess spending growth against the established benchmark and 2) examine factors contributing to spending growth.

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

1. Target Data and Analysis

Primary purpose: measure spending and assess performance against a spending target

Payer-reported data are provided in aggregate and are limited in detail but do represent all health care spending in the state (including spending in self-insured employer benefit programs).

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

2. Driver Data and Analysis

Primary purpose: identify drivers of spending and spending growth

APCD / other claim-level data from commercial, Medicaid or state-purchased insurance are more detailed than payer-reported aggregate data. Not all state spending data are included, but sufficient data to understand underlying trends.

How States Have Set Their Spending Targets

- Each state has engaged in a public process with stakeholder advisory or decision-making bodies on policy and implementation of their programs.

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

How States Have Set Their Spending Targets (cont.)

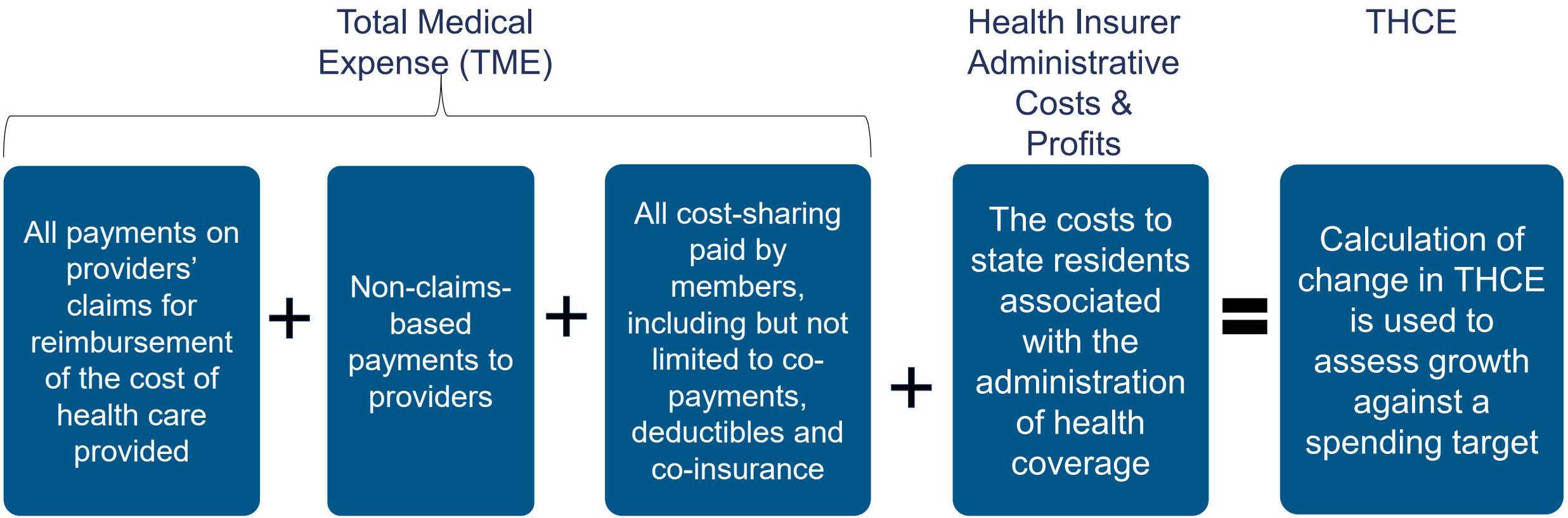
- California's enabling statute invites consideration of population-based measures, such as changes in the state's demographics (e.g., aging) that may influence future use of health care services.

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

States' Consideration of Inflation

- Most state spending target values were set prior to the sharp rise in general inflation that began in late 2021.
- As a result, targets were set based on an assumption that inflation would continue at the Federal Reserve Bank's long-term target rate of 2 percent.
- The process to develop a California spending target will include discussion of the following:
  - What we know about the impact of inflation on health care spending
  - How other states have evaluated whether to modify their target values in response to elevated inflation

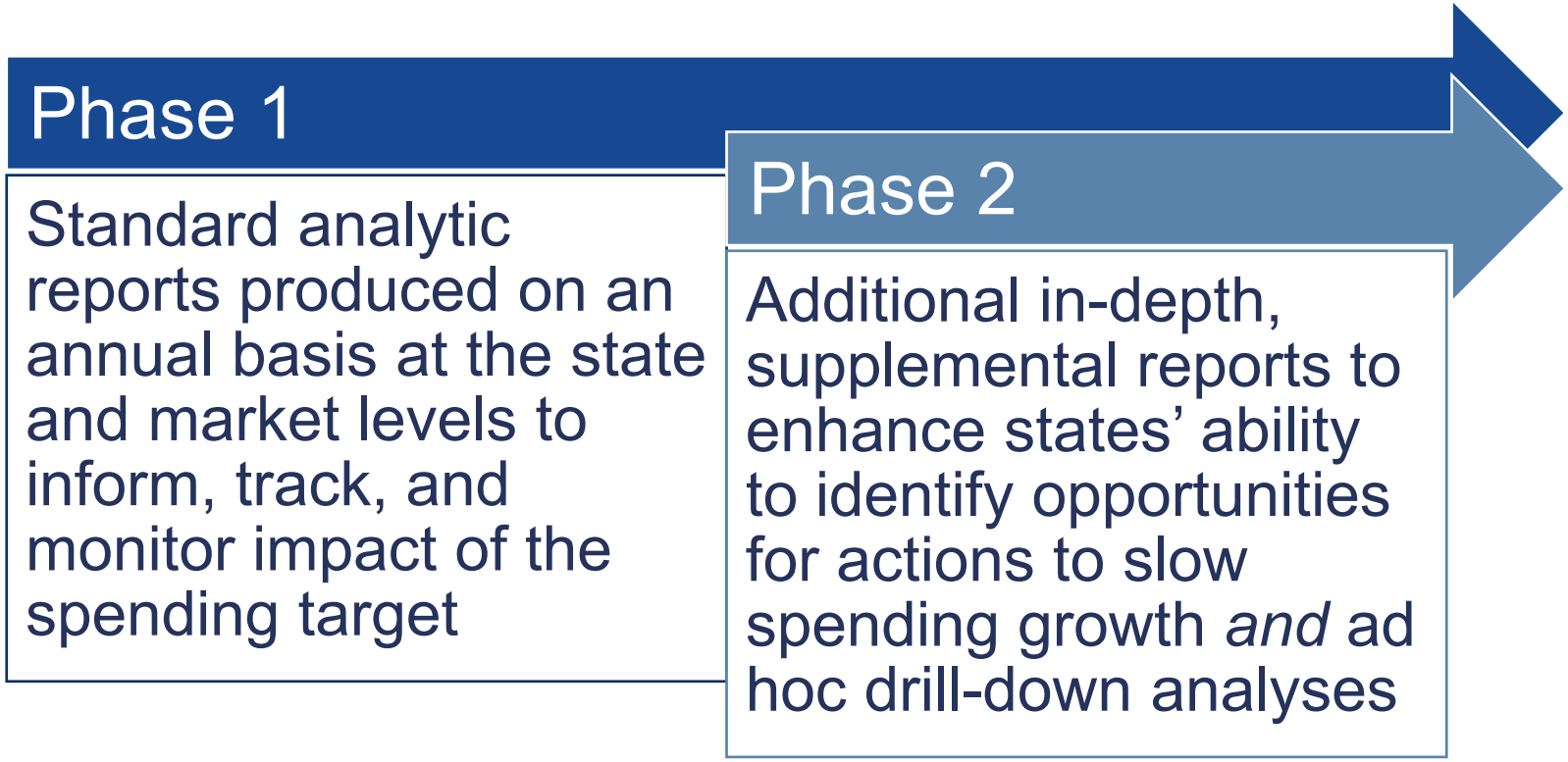
Total Health Care Expenditures (THCE)



Note: Pharmacy rebates are included in THCE and can be included under non-claims-based payments or health insurer administrative costs and profits.

Types of Underlying Driver Analyses

- States' spending driver analyses typically include two phases:



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

Drivers of Spending and Spending Growth

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

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

Framework for Analyzing Underlying Drivers

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

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

Health Care Spending Targets and Health Equity

Importance of Equity in Spending Targets

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

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

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

*May not equal 100% due to rounding.

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

A Closer Look at the Experience of Massachusetts

Background on the Massachusetts Health Care Spending Target Program

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

Massachusetts' Annual Process

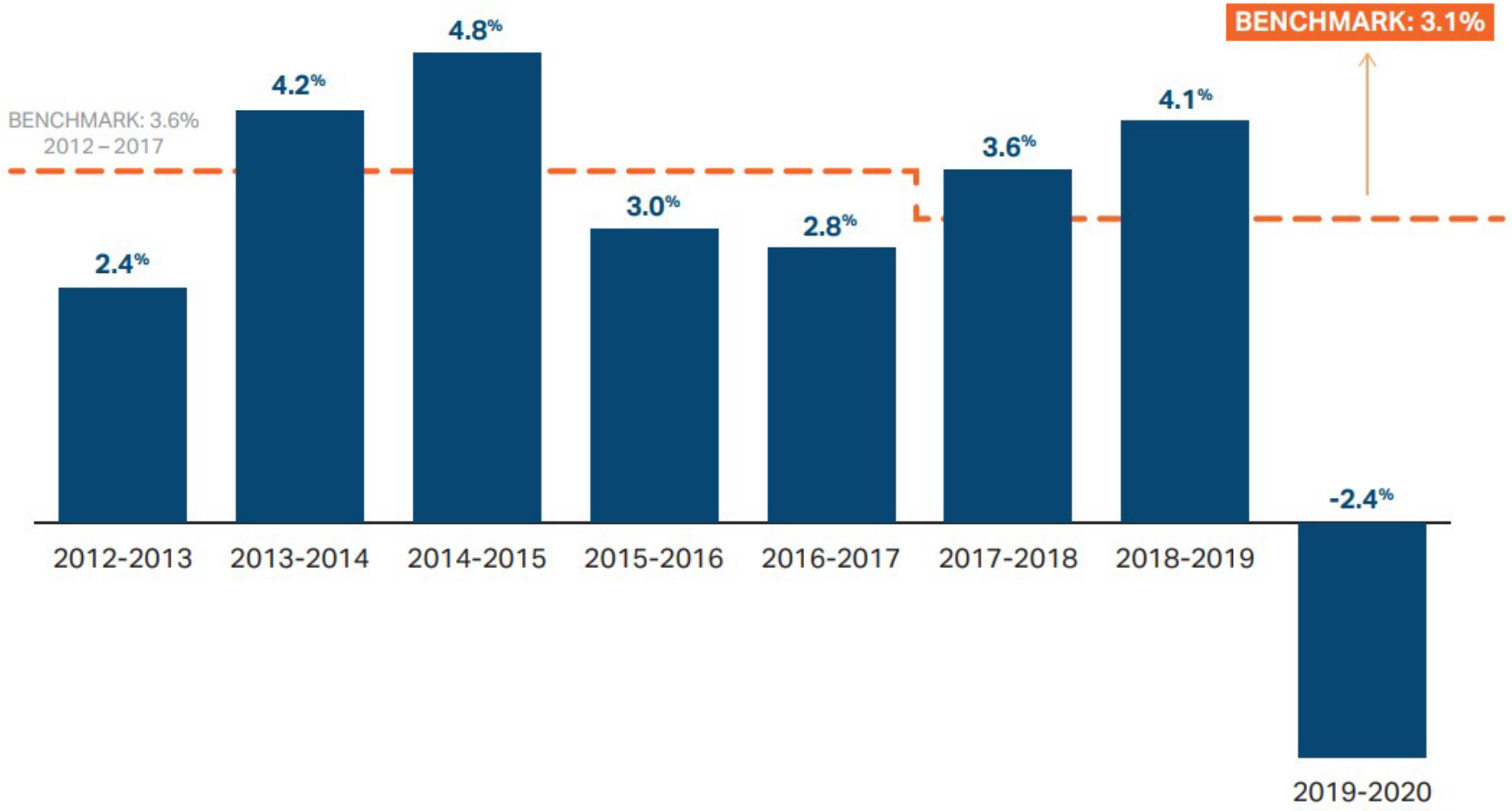
- The HPC and its sister agency, the Center for Health Information and Analysis (CHIA), engage in an annual process to monitor health care spending growth relative to the target.

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

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

Spending Growth in Massachusetts Since Implementation of a Target

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



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

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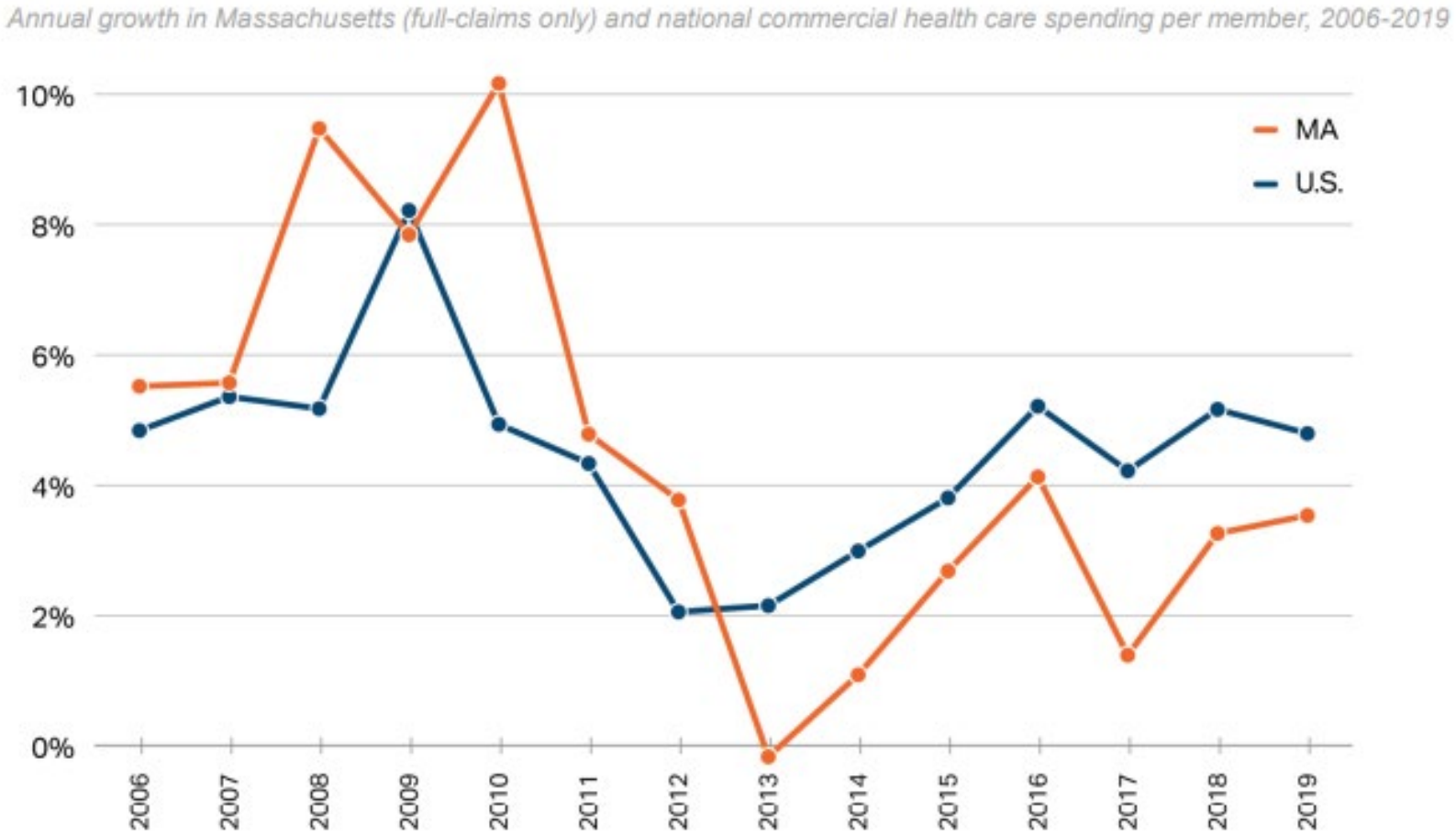
Massachusetts' Spending Growth Target Experience

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



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

Factors Contributing to the Target's Impact

Common goal

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

Total cost of care approach

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

Influence on negotiations

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

Transparency

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

Spending Target Development Timeline

Current OHCA and Health Care Affordability Board Spending Target-Related Activities

Q1-Q3 2023

- OHCA **develops the methodology for measuring and reporting THCE**, which will be included in the baseline spending report.
- *Enabling statute: OHCA "shall prepare a report on baseline health care spending…" which 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."*

Q3-Q4 2023

- OHCA and the Health Care Affordability Board (HCAB) begin **discussion of California's 2025 statewide spending target**.
- *Enabling statute: The board shall establish a statewide health care cost target for the 2025 calendar year and for each calendar year thereafter.*

Statutory Timelines Related to the Spending Target

2023

Finalize recommendations and issue regulations for 2022-2023 THCE data collection for the baseline report.

2024

Spring: Adoption of 2025* statewide spending target, following public comment period.

Summer: Payers and fully integrated delivery systems submit 2022-2023 THCE data to OHCA.

2025

Year 1 statewide spending target implementation. *(This year is not subject to enforcement.)*

Spring: Adoption of 2026 statewide spending target and publication of baseline health spending report.

2026

Year 2 statewide spending target implementation. *(Subject to enforcement.)*

2027

Spring**:** First annual report covering 2024-2025 spending target performance for payers and fully integrated delivery systems.

Fall**:** By this time, the Board will have defined initial health care sectors.

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

Total Health Care Expenditures (THCE) Measurement

Statutory Language: Measuring THCE

- **Enabling statute**: OHCA "... 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…"

- Total health care expenditures (THCE) is the basis by which OHCA will measure year-over-year performance against the spending target.

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

Statutory Language: 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

Measuring THCE for the Baseline Report

- OHCA is developing the technical specifications and instructions to collect and report on baseline (2022-2023) health care spending.
- Measuring baseline spending requires OHCA to collect data from a variety of sources, including from payers and fully integrated delivery systems.
- This involves OHCA working through a series of related THCE measurement questions and decisions, including…
  - Defining THCE components
  - Determining whose spending will be measured
  - Determining levels of reporting spending
  - How spending may be disaggregated (by region, service categories)
  - Measuring total medical expense (TME) for provider entities
- We will now provide the Advisory Committee with an update on topics discussed and approaches OHCA is considering.

THCE: Components

California 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 that will be measured and compared relative to California's spending target.

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

THCE Components: Claims-based categories

- Examples of claims-based categories of spend include:
  - Hospital Inpatient
  - Hospital Outpatient
  - Professional: Primary Care
  - Professional: Behavioral Health
  - 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 Components: Non-claims categories

- Examples of non-claims-based categories of spend included in the statute:
  - Capitation
  - Salary
  - Global budget
  - Supplemental provider payments pursuant to the Medi-Cal program
  - Pharmacy rebates

Other examples from other states: payments to support population health and practice infrastructure, prospective case rate payments, prospective episode-based payments, performance incentive payments

THCE Components: Cost-Sharing and Administrative Costs and Profits

- **Cost sharing** is defined in the statute to include, but not be limited to, copayments, coinsurance, and deductibles

- **Administrative costs and profits** is defined in the statute to include, but not be limited to:
  - 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.”

THCE Components

Does the Advisory Committee have any input or recommendations on the components of THCE?

THCE: Whose Spending to Measure

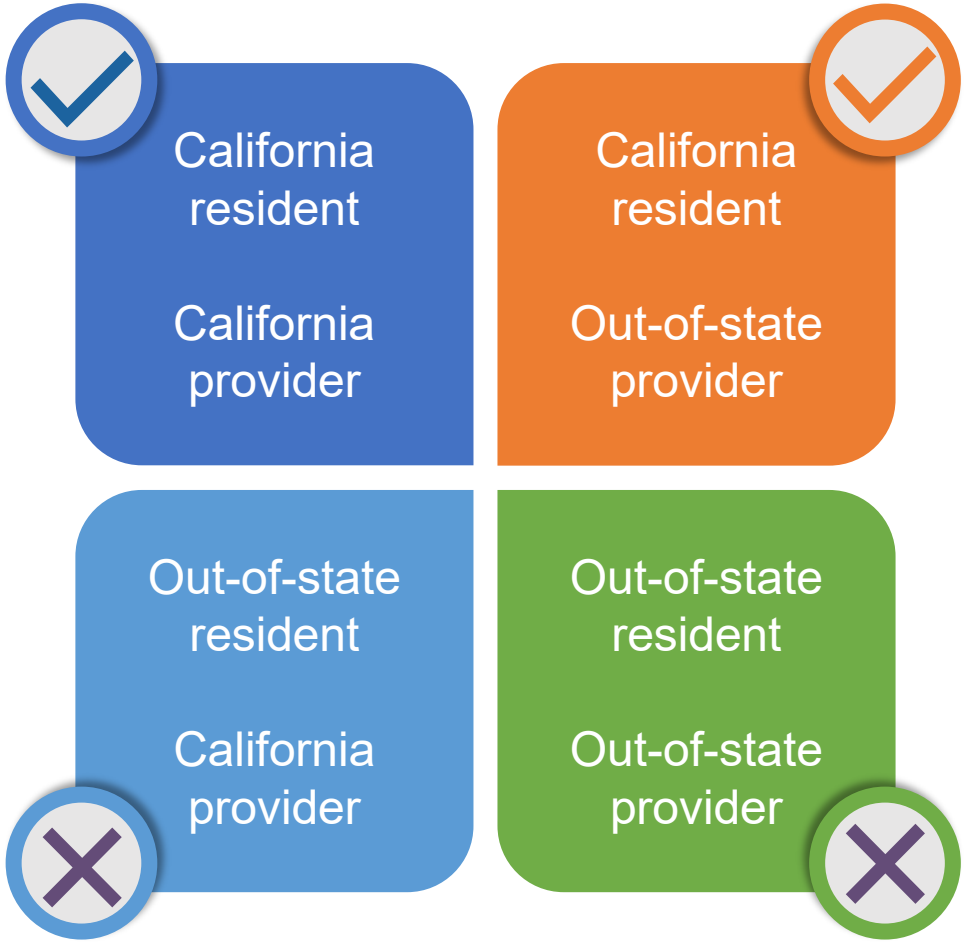
Whose Total Medical Expense to Include

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

Data sources per the statute	▪ **Medicare:** fee-for-service; Medicare Advantage ▪ **Medi-Cal:** fee-for-service; managed care ▪ **Integrated Medicare + Medicaid** plans (for individuals who are dually eligible) ▪ **Commercial**: fully-insured; self-insured
Other sources being considered by OHCA, subject to data availability	▪ Correctional Health System ▪ Indian Health Services (IHS) ▪ TRICARE ▪ Veterans Health Administration (VHA) ▪ Medically Indigent Services Program

OHCA's Approach

- OHCA needs to determine the *population* whose spending on covered services will be measured, including the state of residence and location of provider.
- OHCA is considering collecting health care spending data for services covered by payers for *all residents of California regardless of where they receive care.*



Does the Advisory Committee have any input or recommendations on the sources of coverage and spending that OHCA is considering?

What About Spending by People Who Are Uninsured?

- While there are some point in time research estimates or survey data, there is no comprehensive data source to capture out-of-pocket spending by the uninsured. Similarly, there is no comprehensive data source on what insured consumers pay for non-covered services.
- 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** is a provider cost – it is not payer or patient spending. It 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).

- If “**bad debt**” is related to covered services, it will be captured because the state is measuring payer “allowed amounts.”
  - The allowed amount is the maximum allowed charge for a covered benefit. It also known as the negotiated or contract rate.
  - Allowed amounts include the amount paid by the insurer to the provider and the patient’s financial obligation to the provider, regardless of whether the patient actually paid the amount owed to the provider. It may not be the actual amount the provider is paid.

THCE: Levels of Reporting Spending

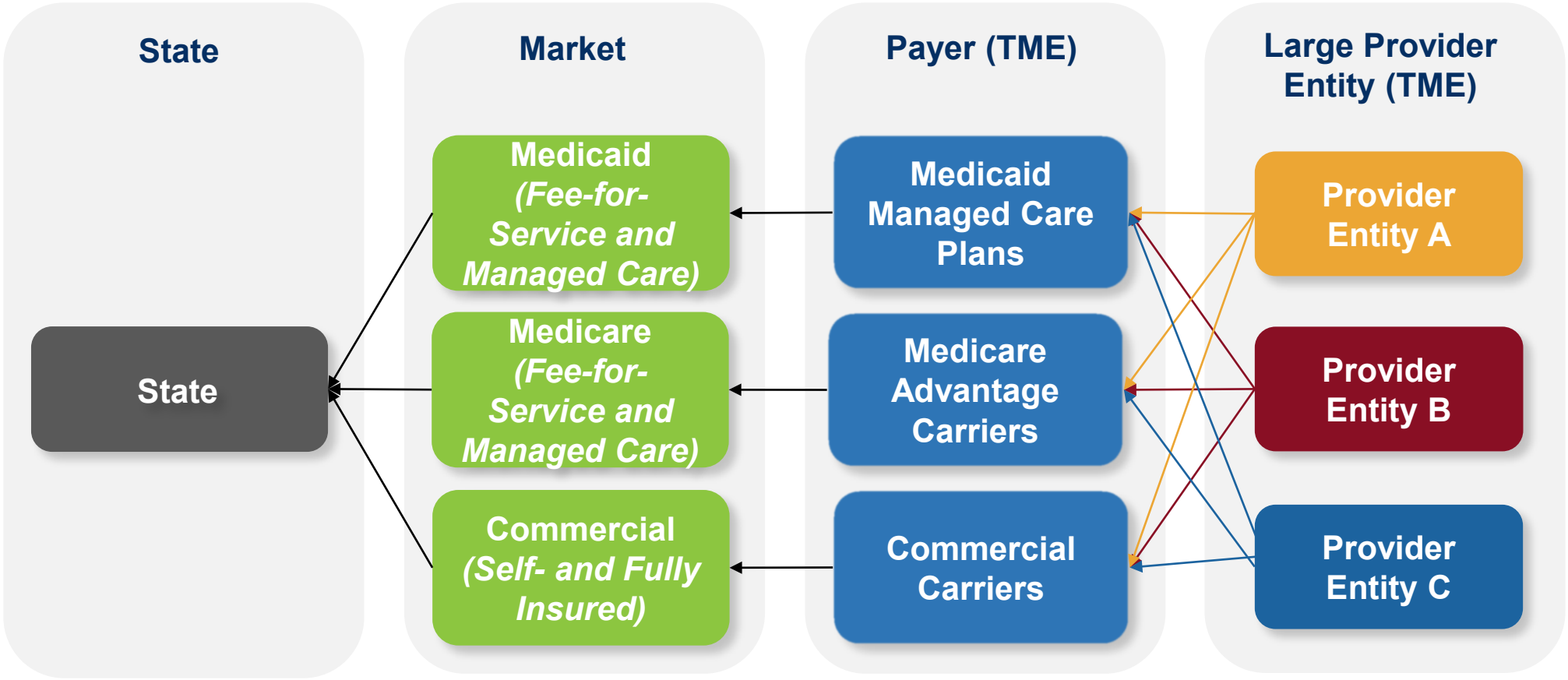
Levels of Reporting THCE

- **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.”*

- These next few slides will describe considerations and approaches for reporting disaggregated data by “levels” and categories.

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

Levels of Reporting THCE



OHCA's Approach for Levels of Reporting

- For the baseline report, OHCA is considering reporting at the following four levels:
  - ***State*** THCE
  - ***Market*** THCE
  - ***Payer: Insurer*** THCE (inclusive of total medical expenses and insurer administrative costs and profits) and ***Other*** (e.g., other programs subject to data availability)
  - ***Provider entity*** (TME)

- OHCA will measure 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

Does the Advisory Committee have any input or recommendations on the levels of reporting OHCA is considering?

THCE: Disaggregating by Geography and Service Category

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%

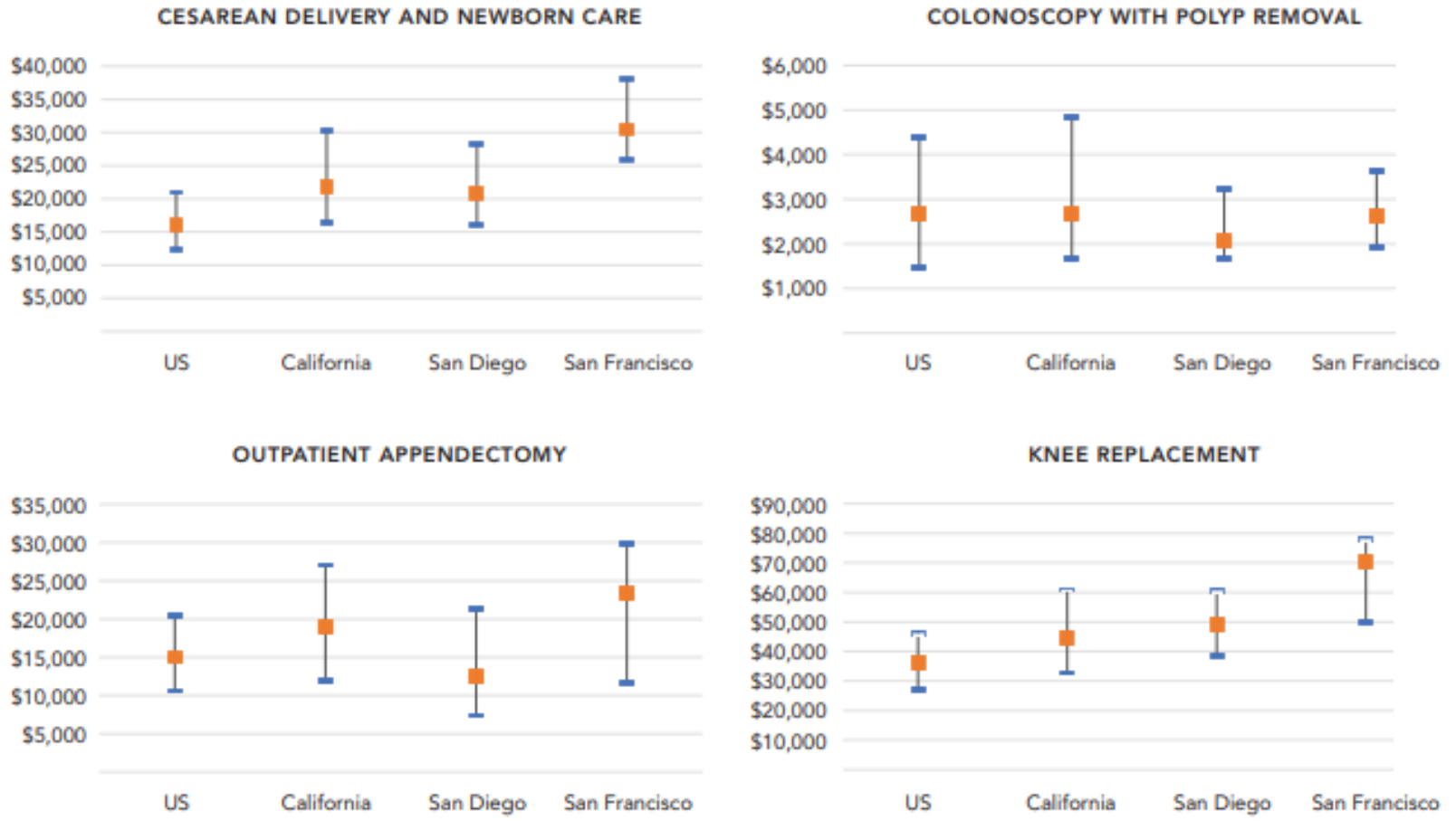
SOURCES: 1) RAND Hospital Price Transparency Study (2020; 2) Covered California; 3) U.S. Bureau of Economic Analysis; 4) National Association of Realtors)

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 the north are generally higher than in the south.
- For example, the average price of a c-section in San Diego was just over $20K, compared with just over $30K 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.

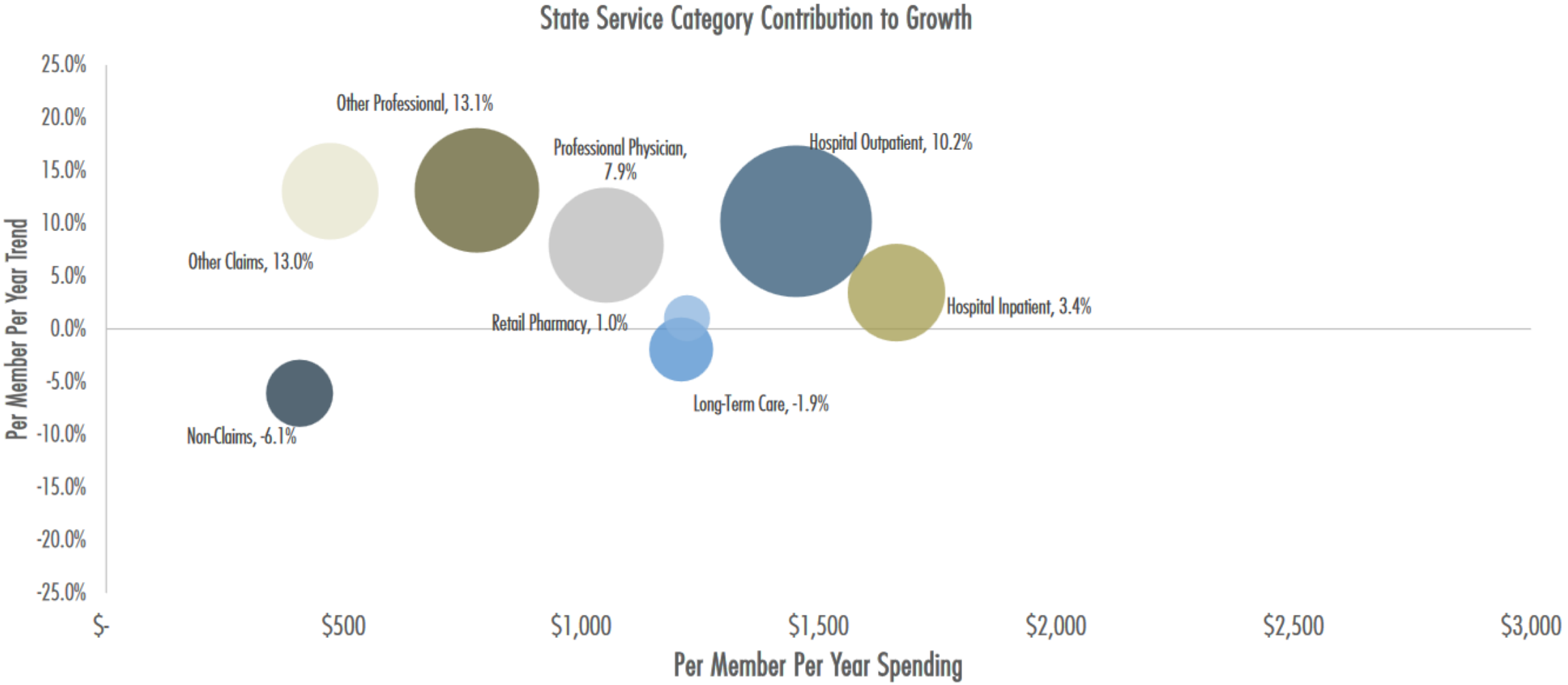
HCAI Department of Health Care Access and Information

OHCA's Approach for Geographic Reporting

- OHCA is considering collecting 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 (e.g., Covered California Rating Regions) for data collection and reporting purposes.
  - OHCA is soliciting feedback from payers about the feasibility of collecting data for this purpose, including the ability to collect spending data at a more granular level.

Does the Advisory Committee have any input or recommendations on OHCA's contemplated approach to disaggregating spending data by region?

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

OHCA's Approach for Service Category Reporting

- 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 / outpatient;
  - professional: primary care; specialty providers; behavioral health; other
  - long-term care;
  - retail pharmacy;
  - dental*, and
  - other (e.g., durable medical equipment, transportation).

- Service category-level spending analysis from payer-reported data will be constrained due to capitation payment arrangements.

Does the Advisory Committee have any input or recommendations on The contemplated approach to service category-level analysis of THCE?

*Dental spending for covered dental benefits as part of a comprehensive plan, not standalone dental plan spending.

THCE: Measuring TME

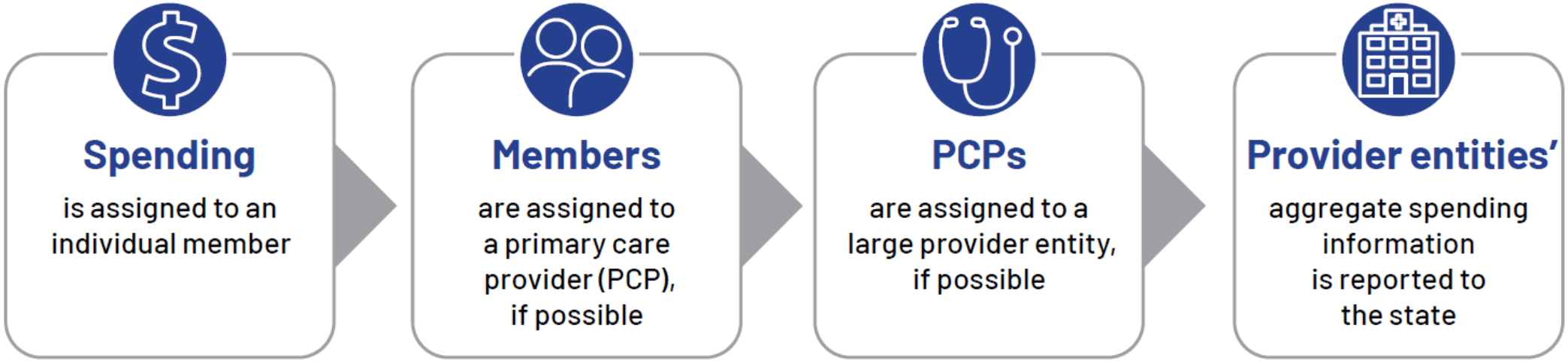
Measuring TME: Primary Care Attribution

- *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 (cont'd)

- 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.
- We will provide additional updates on this topic at a future Advisory Committee meeting.

Does the Advisory Committee have any input or recommendations on the approach OHCA is considering taking to measure TME?

Introduction to 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 (Cont'd)

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

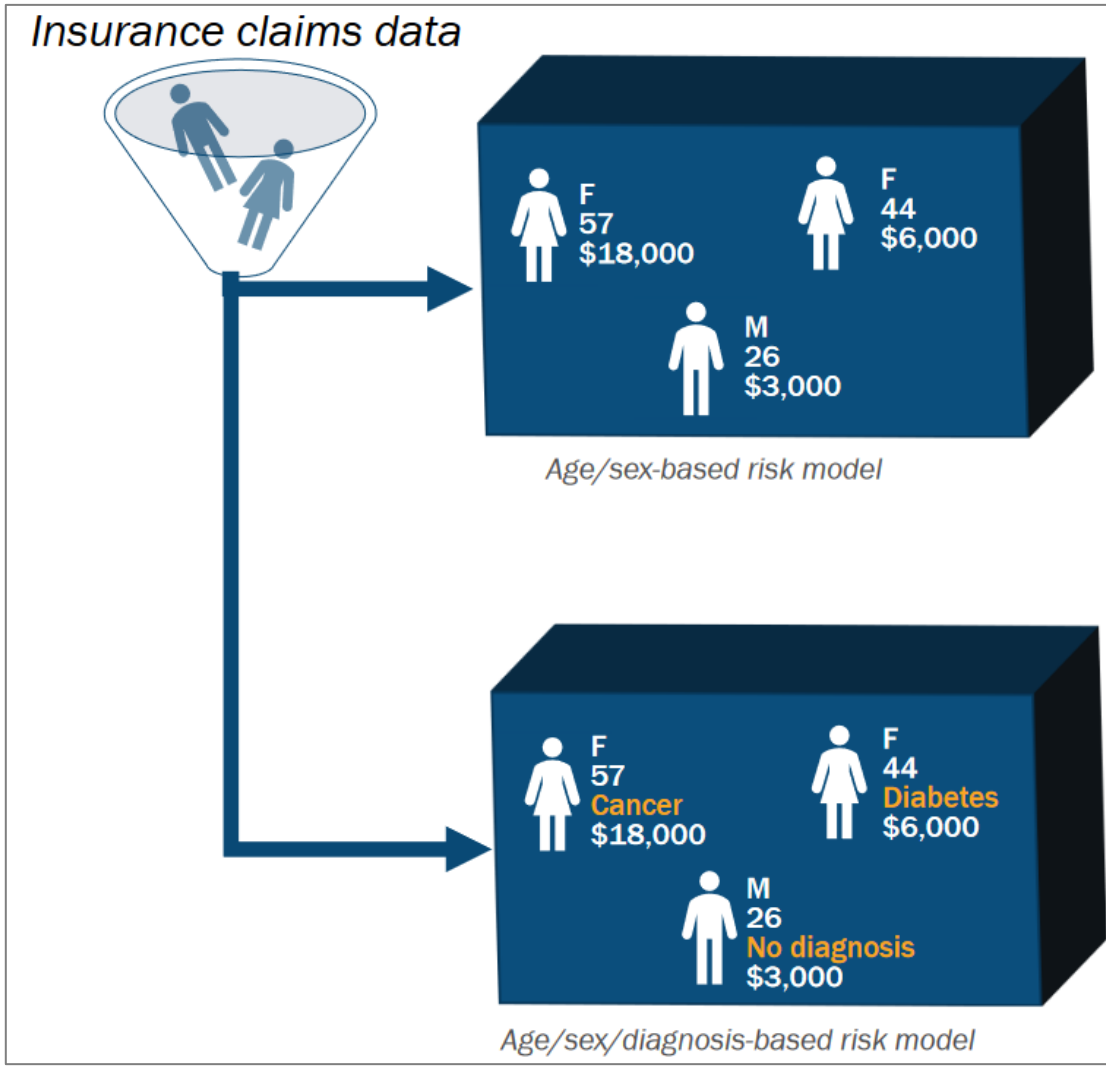
Medi-Cal
Optional adjustment per statute, with flexibility on to how to implement

Risk Adjustment

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



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

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 service use.

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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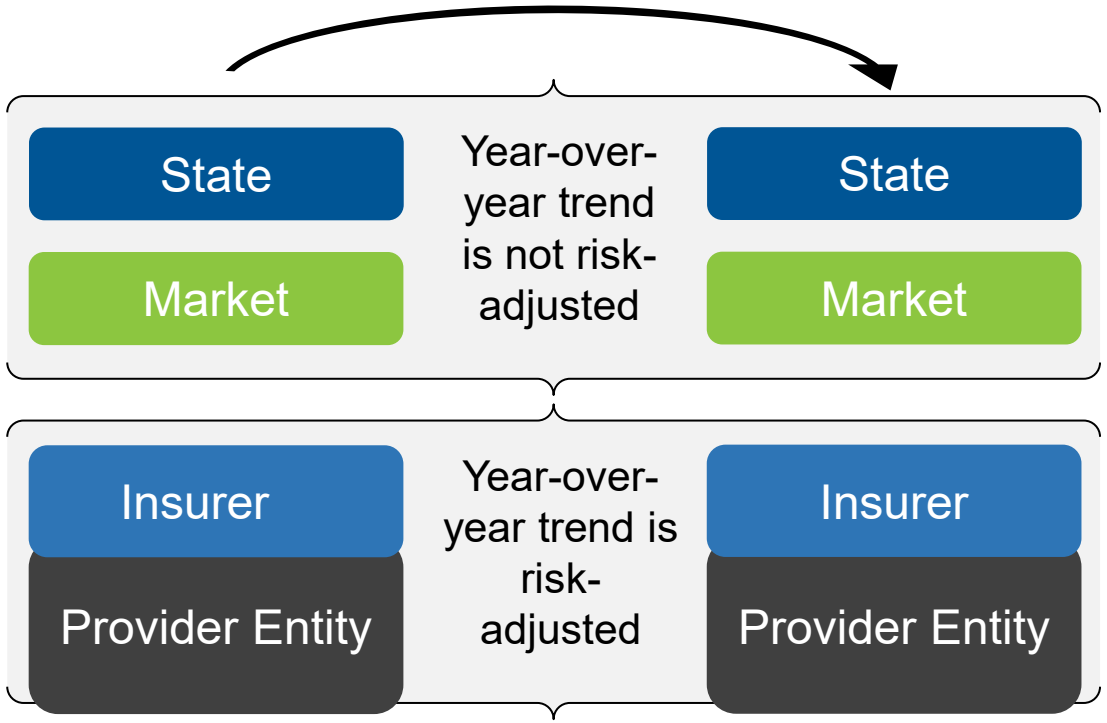
Jeron Impreso is an advisory analyst for Medicaid at Mathematica in Washington, D.C. He was a research associate for health policy, Committee for a Responsible Federal Budget, in Washington, D.C., when this

Risk Adjustment in Spending Target Programs

- Some spending target states risk adjust the data submitted by payers when assessing performance relative to a spending target
- They do so 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, RI and WA are using age / sex adjustment; NV's governing body recommended no risk adjustment.

Risk Adjustment Model Options

1. **Clinical risk adjustment**
   - 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).
   - 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.
2. **Age/Sex factors**
   - Risk adjust spending using standard **age/sex factors** only. Payers report spending by age/sex. Spending at the payer and provider levels are adjusted based on relative weighting. The weights can be calculated using market-specific payer-submitted data or be initially defined.

	Advantages	Disadvantages
Option 1: Clinical	• Explains variation in spending at the member/patient level. • Ensures assessments of entity performance are not influenced by changes in the health status of their populations during the measurement period.	• May not fully capture or reflect the need or health status of individuals who experience barriers to accessing care (Based on claims history). • Can change annually without changes in the population's underlying risk due to improved coding, distorting changes in population health status. • Can penalize entities that effectively manage care of members/patients with significant chronic conditions. • Methodologies vary across payers and specifying a standard methodology (either an existing one or OHCA developing one) would increase administrative burden.
Option 2: Age/Sex	• Captures the impact of an incrementally aging population, which may be the most significant change affecting population health status over the course of one year. • Standardizes the risk adjustment methodology within a market across insurers. • Not subject to gaming that leads to inflation of population risk. • Removes biases from utilization history, which does not accurately reflect both need and equitable access to care.	• Does not reflect differences in expected spending across subpopulations, e.g., patients with multiple chronic conditions and patients without any. • Does not capture more substantive annual changes in health status due to shifts in membership, such as when a payer's risk mix improves due to new contracts.

OHCA's Approach for Risk Adjustment

- Health care spending growth is measured and reported as year-over-year change (e.g., 2022-2023), and a payer or a provider entity's population risk is relatively stable over two years.

- OHCA is therefore considering risk adjusting using age/sex factors to
  - 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 and
  - avoid the distortion associated with coding practices.

- OHCA would establish reporting of age/sex data that would enable adjustments based on relative weighting. The weights would be uniformly applied across insurers, by market.
  - This would standardize the risk adjustment methodology across insurers.

Does the Advisory Committee have input or recommendations regarding OHCA's contemplated approach for adjusting by age/sex for the baseline report?

Next Steps

- OHCA will finalize its plans for collecting data for the Baseline Report of THCE this fall and issue draft regulations and an associated payer data submission guide for public comment.
- OHCA and the Board will then begin discussions of the methodology for establishing the State's 2025 spending target.
- During the next Advisory Committee meeting, OHCA will provide an update on THCE design considerations, regulatory process, and spending target development, and seek input from the Advisory Committee to convey to the Board.

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General Public Comment

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

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Advisory Committee Adjourned