Health Care Affordability Board Meeting

June 20, 2023
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
   Secretary Mark Ghaly
   a) Approval of the May 23, 2023 Meeting Minutes
   b) Approval of Richard Pan to attend the September Advisory Committee meeting, and Richard Kronick and Sandra Hernández to attend the November Advisory Committee Meeting

4. Action Items
   C.J. Howard, Assistant Deputy Director
   a) Advisory Committee Membership

5. Informational Items
   a) Cost and Market Impact Review
      Sheila Tatayon, Assistant Deputy Director, and Katherine Gudiksen, Senior Health Policy Researcher, The Source on Health Care Price and Competition
   b) Alternative Payment Models, Primary Care and Behavioral Health Investment, and Workforce Stability
      Margareta Brandt, Assistant Deputy Director
   c) Total Health Care Expenditures (THCE) Measurement
      Vishaal Pegany, and Michael Bailit, Bailit Health

6. General Public Comment

7. Adjournment
Executive Updates
Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director
Key Components

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

Engagement and Governance Group - 6
• Health Program Manager II
• Health Program Specialist II - 2
• Health Program Specialist I - 3

Health System Compliance - 6
• Attorney IV – 4
• Attorney III - 2

Administration and Management Support - 4
• Staff Services Manager I
• Associate Governmental Program Analyst - 2
• Office Technician

Recruitments in Progress - 14
• Assistant Chief Counsel/Manager (Health System Compliance)
• Pharmacy Consultant II (will report to the Deputy Director)
• Health Program Manager II (Health System Performance) – 2
• Health Program Specialist II/I (Health System Performance) – 5
• Research Scientist Manager (Research and Analysis Group)
• Research Scientist Supervisor I (Research and Analysis Group)
• Research Data Specialist II (Research and Analysis Group)
• Research Data Specialist III (Research and Analysis Group)
• Associate Governmental Program Analyst (Administration and Management Support)
Slide Formatting

- Indicates informational items for the Board and decision items for OHCA

- Indicates current or future action items for the Board
Action Consent Item: Approval of the May 23, 2023 Board Meeting Minutes
Action Consent Item: Approval of Board Member Attendance at Advisory Committee Meetings
Board Member Attendance at Advisory Committee Meetings

Motion to approve that Board Member Richard Pan attend the September Advisory Committee meeting, and Board Members Sandra Hernández and Richard Kronick attend the November Advisory Committee meeting.
Action Item: Advisory Committee Membership
Proposed Additional Membership

At the May Board meeting the board tasked the subcommittee with:

• revisiting the health care worker category with a focus on finding frontline health care workers to serve on the committee

• identifying an individual that would represent a public sector labor union perspective in the organized labor category
# Approved Advisory Committee Membership

<table>
<thead>
<tr>
<th>Payers/FIDS</th>
<th>Hospitals</th>
<th>Medical Groups</th>
<th>Physicians</th>
<th>Health Care Workers</th>
<th>Organized Labor</th>
<th>Patient Groups/Consumer Advocates</th>
<th>Purchasers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aliza Arjoyan, Blue Shield of California</td>
<td>Barry Arbuckle, MemorialCare Health System</td>
<td>Hector Flores, Family Care Specialists Medical Group</td>
<td>Parker Duncan Diaz, Santa Rosa Community Health</td>
<td>Hold Open</td>
<td>Joan Allen, SEIU-UHW</td>
<td>Carolyn Nava, Disability Action Center</td>
<td>Ken Stuart, California Health Care Coalition</td>
</tr>
<tr>
<td>Yolanda Richardson, San Francisco Health Plan</td>
<td>Tam Ms, UC Health</td>
<td>Stacey Houmtas, Sharp Rees-Stealy Medical Centers</td>
<td>Adam Dougherty, Vituity</td>
<td>Hold Open</td>
<td>Carmen Comstil, California Nurses Association</td>
<td>Mike Odeh, Children Now</td>
<td>Suzanne Usaj, The Wonderful Company</td>
</tr>
<tr>
<td>Andrew See, Kaiser Foundation Health Plan</td>
<td>Yvonne Wagner, San Bernardino Mountains Community Hospital District</td>
<td>David Joyner, Hill Physicians Medical Group</td>
<td>Sumana Reddy, Acacia Family Medical Group</td>
<td>Hold Open</td>
<td>Ivana Krajnovic, Unite Here Health</td>
<td>Kiran Savage-Sangwan, California Pan-Ethnic Health Network</td>
<td>Abbie Yant, San Francisco Health Service System</td>
</tr>
</tbody>
</table>

**Hold Open**
Composition of Submissions Received

REPRESENTING HEALTH CARE WORKERS (SELF-ATTESTED) (N=43)
- Current Frontline Worker, 6 (14%)
- Other, 37 (86%)

BEHAVIORAL HEALTH EXPERIENCE (SELF-ATTESTED) (N=100)
- Management/Frontline Experience, 7 (7%)
- Other, 92 (92%)
- Current Frontline Worker (non-supervisory), 1 (1%)
<table>
<thead>
<tr>
<th>Payers/FIDS</th>
<th>Hospitals</th>
<th>Medical Groups</th>
<th>Physicians</th>
<th>Health Care Workers</th>
<th>Organized Labor</th>
<th>Patient Groups/Consumer Advocates</th>
<th>Purchasers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aliza Arjoyan, Blue Shield of California</td>
<td>Barry Arbuckle, MemorialCare Health System</td>
<td>Hector Flores, Family Care Specialists, Medical Group</td>
<td>Parker Duncan Diaz, Santa Rosa Community Health</td>
<td>Stephanie Cline, Kaiser</td>
<td></td>
<td>Joan Allen, SEIU-UHW</td>
<td>Ken Stuart, California Health Care Coalition</td>
</tr>
<tr>
<td>Yolanda Richardson, San Francisco Health Plan</td>
<td>Tam M., UC Health</td>
<td>Stacey Hountas, Sharp Rees-Steele Medical Centers</td>
<td>Adam Dougherty, Vituity</td>
<td>Sara Gavin, CommunityCare Health Centers</td>
<td></td>
<td>Carmen Comsti, California Nurses Association</td>
<td>Suzanne Uraj, The Wonderful Company</td>
</tr>
<tr>
<td>Andrew See, Kaiser Foundation Health Plan</td>
<td>Yvonne Wagner, San Bernadino Mountains Community Hospital District</td>
<td>David Joyner, Hill Physicians Medical Group</td>
<td>Sumana Reddy, Acacia Family Medical Group</td>
<td>Sara Soroken, Solano County Mental Health</td>
<td></td>
<td>Ivana Krajçovic, Unite Here Health</td>
<td>Abbie Yant, San Francisco Health Service System</td>
</tr>
</tbody>
</table>

**Recommended Advisory Committee Membership**

- **Payers/FIDS**
  - Aliza Arjoyan, Blue Shield of California
  - Yolanda Richardson, San Francisco Health Plan
  - Andrew See, Kaiser Foundation Health Plan

- **Hospitals**
  - Barry Arbuckle, MemorialCare Health System
  - Tam M., UC Health
  - Yvonne Wagner, San Bernadino Mountains Community Hospital District

- **Medical Groups**
  - Hector Flores, Family Care Specialists Medical Group
  - Stacey Hountas, Sharp Rees-Steele Medical Centers
  - David Joyner, Hill Physicians Medical Group

- **Physicians**
  - Parker Duncan Diaz, Santa Rosa Community Health
  - Adam Dougherty, Vituity
  - Sumana Reddy, Acacia Family Medical Group

- **Health Care Workers**
  - Stephanie Cline, Kaiser
  - Sara Gavin, Community Care Health Centers
  - Sara Soroken, Solano County Mental Health

- **Organized Labor**
  - Joan Allen, SEIU-UHW
  - Carmen Comsti, California Nurses Association
  - Ivana Krajçovic, Unite Here Health

- **Patient Groups/Consumer Advocates**
  - Joan Allen, SEIU-UHW
  - Carmen Comsti, California Nurses Association
  - Ivana Krajçovic, Unite Here Health

- **Purchasers**
  - Ken Stuart, California Health Care Coalition
  - Suzanne Uraj, The Wonderful Company
  - Abbie Yant, San Francisco Health Service System
Draft Motion from the Subcommittee

• Approve the three proposed members under the Health Care Workers category.
• Approve the additional Organized Labor proposed member.
• Allow OHCA staff to randomly assign new members one- or two-year terms.
Informational Items
Cost Market and Impact Review

Sheila Tatayon, Assistant Deputy Director
Katherine Gudiksen, Executive Editor and Senior Health Policy Researcher
The Source on Healthcare Price and Competition, UC Law SF
Context: Impact of Consolidation and Market Power
## Impact of Hospital Mergers

<table>
<thead>
<tr>
<th>Cost Impacts: Within Market Consolidation</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Hospital price increases of 20-44% (some as high as 55-65%)</td>
</tr>
<tr>
<td>- Bystander hospitals also raise prices following a merger</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost Impacts: Cross-Market Consolidation</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Prices rise 7-9% at <em>acquiring</em> hospitals, 17% at <em>acquired</em> hospitals with out-of-state purchaser</td>
</tr>
<tr>
<td>- Bystander hospitals also raise prices</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Most studies find no significant quality benefits</td>
</tr>
<tr>
<td>- A few have shown modest improvements in a few measures</td>
</tr>
<tr>
<td>- Other studies indicated higher mortality and worse quality when there is less competition</td>
</tr>
</tbody>
</table>
Merger & Acquisition (M&A) Trend – Hospital Growth into Regional and National Health Systems

https://sourceonhealthcare.org/cross-market/
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 prices
    - Increased utilization of high-cost services
    - Mixed quality measures
    - Lower patient experience scores

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

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

- PE acquisition is not uniform geographically or by specialty

- California has regions with a high percentage of PE-owned physician practices
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).
Market Concentration in California Matches the National Trends

Percentage of Physicians in Practices Owned by a Hospital/Health System in California, by Type of Physician, 2010–2018

Note: All measures are calculated at the state level.
Source: Authors’ analysis of data provided by the SK&A Office-Based Physicians Database provided by QuintilesIMS (now IQVIA).

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

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
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)
Escalating health care costs are driven primarily by high prices and the 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.
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.
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.
# Existing Merger Oversight in California

<table>
<thead>
<tr>
<th>Attorney General</th>
<th>Department of Managed Health Care</th>
<th>California Department of Insurance</th>
</tr>
</thead>
</table>
| • Approval Authority for non-profit health facilities  
• Authority to investigate and enforce laws relating to antitrust, unfair competition, and consumer protection | • 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. | • Approval Authority for mergers of domestic health insurers.  
• CDI reviews impact on the marketplace and consumers. |
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 the 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.
Notices of Material Change Transactions

• Health care entities must submit notices of agreements or transactions that will occur on or after April 1, 2024, and:
  o Sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of its assets to one or more entities; or
  o Transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities.

• Health care entities must submit notices to OHCA 90 days before the agreement or transaction will occur.

• OHCA will promulgate regulations for required notices and documentation and will start collecting notices January 1, 2024.

• Notices are not required for transactions subject to DMHC, CDI, or AG review, or county transactions for continued access.

Health and Safety Code 127507(c)(1)-(3)
OHCA’s Review of Notices of Material Change Transactions

• Upon OHCA’s determination the Notice of Transaction is complete, OHCA will conduct a 60-day preliminary review to determine whether the agreement or transaction must undergo a CMIR.

  o If OHCA finds that a material change noticed pursuant to Section 127507 is likely to have a risk of a significant impact on market competitions, the state’s ability to meet cost targets, or costs for purchasers and consumers, the office shall conduct a CMIR.

  o OHCA may also conduct a CMIR based on Director’s determination if spending target data indicate adverse impacts on cost, access, quality, equity, or workforce stability from consolidation, market power, or other market failures.

  o OHCA may also conduct a CMIR for agreements or transactions referred to OHCA by the DMHC, CDI, or the AG.

• OHCA will promulgate regulations regarding the decision to conduct a CMIR.
A CMIR will examine factors relating to a health care entity’s business and relative market position, including changes in size and market share in a given service/geographic region, prices for services compared to other providers for the same services, quality, equity, cost, access, or other factors OHCA determines to be in the public interest.

OHCA will also consider the benefits of the material change to consumers of health care services, where those benefits could not be achieved without that transaction, including increased access to health care services, higher quality, and more efficient health care services where consumers benefit directly from those efficiencies.
CMIR Factors for Analysis, Factual Findings, and Preliminary and Final Report

- OHCA will make factual findings, issue a preliminary report, allow for written responses from the affected parties and the public, and issue a final report.

- Agreements or transactions subject to a CMIR may not be implemented until 60 days after OHCA issues its final report.

- OHCA will promulgate regulations regarding the factors OHCA will consider when performing a CMIR and the timeline for conducting CMIRs.
OHCA will promulgate regulations under its emergency rulemaking authority as follows:

- **July 25, 2023**
  Update board on date that draft regulation text will be posted on OHCA website and date for public workshop

- **Prior to July 31, 2023**
  Publish draft regulation text on OHCA website

- **Mid-August 2023**
  Hold public workshop on draft regulation text and receive public comments until August 31, 2023

- **August 22, 2023**
  Board discussion on draft regulation text and provide oral summary of public workshop

- **September 19, 2023**
  Update board on status of regulation text and discussion

- **October 2023**
  Submit emergency rulemaking package to the Office of Administrative Law

- **January 1, 2024**
  Begin receiving notices of material change transactions
Alternative Payment Models, Primary Care and Behavioral Health Investment, and Workforce Stability

Margareta Brandt, Assistant Deputy Director
### Focus Areas for Promoting High Value

<table>
<thead>
<tr>
<th>Area</th>
<th>Focus Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Investment</td>
<td>- Define, measure, and report on primary care spending</td>
</tr>
<tr>
<td></td>
<td>- Establish a benchmark for primary care spending</td>
</tr>
<tr>
<td>Behavioral Health Investment</td>
<td>- Define, measure, and report on behavioral health spending</td>
</tr>
<tr>
<td></td>
<td>- Establish a benchmark for behavioral health spending</td>
</tr>
<tr>
<td>APM Adoption</td>
<td>- Define, measure, and report on alternative payment model adoption</td>
</tr>
<tr>
<td></td>
<td>- Set standards for APMs to be used during contracting</td>
</tr>
<tr>
<td></td>
<td>- Establish a goal for APM adoption</td>
</tr>
<tr>
<td>Quality and Equity Measurement</td>
<td>- Develop, adopt, and report performance on a single set of quality and</td>
</tr>
<tr>
<td></td>
<td>health equity measures</td>
</tr>
<tr>
<td>Workforce Stability</td>
<td>- Develop and adopt standards to advance the stability of the health care</td>
</tr>
<tr>
<td></td>
<td>workforce</td>
</tr>
<tr>
<td></td>
<td>- Monitor and report on workforce stability measures</td>
</tr>
</tbody>
</table>
Primary Care & Behavioral Health Investments

**Statutory Requirements**

- Measure and promote a sustained systemwide investment in primary care (PC) and behavioral health (BH).

- **Measure the percentage of total health care expenditures allocated to PC and BH** and set spending benchmarks that consider current and historic underfunding of primary care services.

- **Develop benchmarks** with the intent to build and sustain infrastructure and capacity and shift greater health care resources and investments away from specialty care and toward supporting and facilitating innovation and care improvement in PC and BH.

- Promote improved outcomes for PC and BH.

---

Health and Safety Code 127505(a-c)
Why Primary Care?

- High functioning health care systems require high quality primary care as a foundation.
- Primary care investment in the United States – which typically ranges from 4% to 7% – lags other high-income nations with higher performing health care systems. In these countries, primary care investment tends to be 12% to 15% of total spending.
- Primary care investment in California was 6.3% of total spending across all payers in 2020, compared to 4.6% nationally, a recent study found.
Over a dozen states have launched efforts to allocate a greater proportion of the health care dollar to primary care.

Most begin with measurement and reporting, but definitions vary.

Five states — RI, OK, OR, CO, DE — require a defined level of primary care spend for at least one payer type.

A growing number of efforts include certain behavioral health services and non-claims spend in their primary care definitions.
Why Behavioral Health?

• Nationally, the percent of adults reporting symptoms of anxiety and/or depression increased during the pandemic and remains just above 32%.

• Similarly in California, nearly 32% of adults report symptoms of anxiety and/or depression. Further, nearly two-thirds of California adults with mental illness reported not receiving treatment.

• Health care delivery models that integrate primary care and behavioral health have been shown to improve access to effective behavioral health services that improve health outcomes, as well as deliver a return on investment by reducing downstream health care costs.

NASEM. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. 2021.
Three states measure behavioral health investment across all clinical services.

Nine states include some behavioral health services in their primary care investment definitions. Of these, three calculate spending on integrated behavioral health or are considering it.

Best practices are emerging regarding diagnoses, services, and providers to include but there is no standard definition.
Alternative Payment Models

Statutory Requirements

• Promote the shift of payments based on fee-for-service (FFS) to alternative payment models (APMs) that provide financial incentive for equitable high-quality and cost-efficient care.

• Convene health care entities and organize an APM workgroup, set statewide goals for the adoption of APMs, measure the state’s progress toward those goals, and adopt contracting standards healthcare entities can use.

• Set benchmarks that include, but are not limited to, increasing the percentage of total health care expenditures delivered through APMs or the percentage of membership covered by an APM.
Why Alternative Payment Models?

- Alternative Payment Models (APMs), or value-based payments, align payer-provider payment approaches to incent high-quality, cost-efficient care.
  - Models span the continuum of clinical responsibility and financial risk moving from volume to value.
- In 2016, the Centers for Medicare and Medicaid Services and large payers established the Health Care Payment Learning and Action Network (HCP-LAN) framework for categorizing APM arrangements according to the level of risk assumed by a provider. It is one of a few commonly used categorizations of value-based payments.
- Overall, movement to APMs has been slower than many hoped. Nationally in 2021, over 40% of payments were still in FFS payment arrangements (Category 1).
- In 2021 in California’s commercial market, 64% of members were in capitation-based arrangements, followed by 36% in fee-for-service arrangements.
What’s Occurring in Other States

- There are nine states collecting APM data from payers with different authority and use cases.
- Some states collect data through multiple avenues for different use cases.
- Definitions and categories of value-based payments vary.
- Payers report little insight into the distribution of non-claims payments within provider organizations.
APMs, Primary Care, and Behavioral Health Are Interconnected

- APMs often support advanced primary care including integrated behavioral health.

- APM performance frequently is tied to the primary care relationship and performance.

- Behavioral health is an important and growing component of primary care.

- Integration and coordination across behavioral health and primary care is critical to achieving the best outcomes.
Planned Approach for APM Adoption, Primary Care and Behavioral Health Workstreams

1. Brainstorm Ideas
2. Develop Scan
3. Model Data
4. Create Recommendations
5. Refine Recommendations
6. Finalize or Approve Recommendations

Gain Input (Investment & Payment Workgroup, Stakeholder Interviews)

Incorporate Feedback (Board, Advisory Committee, Workgroup)
Workgroup to Engage Stakeholders on APM Adoption, Primary Care and Behavioral Health Investment

OHCA is launching the Investment and Payment workgroup to support the development of the APM, primary care, and behavioral health definitions, data collection processes, and benchmarks.

The workgroup will:

• Ensure stakeholder engagement in key program development decisions about definitions and data collection
• Provide input and feedback as OHCA develops recommendations for benchmarks
• Identify and discuss the relationships and interactions between the APM, primary care, and behavioral health components

Workgroup members will include representatives from:

• Patients/families
• Primary care clinicians
• Physician organizations (medical group, IPA, FQHC)
• Hospitals/health systems
• Health plans
• Consumer advocates
• Researchers/experts
• State departments engaged in related work
## Examples of Workgroup Discussion Topics

### Alternative Payment Models
**Definitions, Measurement, Reporting:**
Categorizing APMs, unit of reporting, health and social risk adjustment

**Standards for APM Contracting:**
Common requirements/incentives for high-quality, equitable care; accelerate adoption of APMs

**Statewide Goal for Adoption:**
Variation by market (Commercial, Medi-Cal), target timeline, unit of reporting (percent of payments, members, and/or provider contracts)

### Primary Care
**Definitions, Measurement, Reporting:**
Primary care providers, services, site of service, non-claims; integrated behavioral health

**Investment Benchmark:**
Variation by market (Commercial, Medi-Cal) or population (adult vs. pediatric)

### Behavioral Health
**Definitions, Measurement, Reporting:**
Behavioral health providers, services, site of service, non-claims; capturing carved out behavioral health spending

**Investment Benchmark:**
Variation by market (Commercial, Medi-Cal) or population (adult vs. pediatric)
Preliminary Timeline for APM, Primary Care, and Behavioral Health Workstreams

- **Spring 2024**
  - Define Primary Care
  - Define APM

- **Summer 2024**
  - Set APM contracting standards*
  - Set PC benchmark*
  - Set APM benchmark*

- **Year-end 2024**
  - PC and APM regulations to support data collection

- **Fall 2025**
  - Define BH
  - Set BH benchmark*

- **Spring 2025**
  - Collect PC data
  - Collect APM data

- **Summer 2026**
  - BH regulations to support data collection
  - Collect BH data

- **Fall 2026**
  - Report PC data
  - Report APM data

- **Year-end 2025**
  - Report BH data

- **Summer 2027**
  - Collect BH data

*Board approval required

All included in the first annual report, due June 2027
Health Care Workforce Stability

Statutory Requirements

- Monitor the effects of spending growth targets on health care workforce stability, high-quality jobs, and training needs of health care workers.
- Monitor health care workforce stability with the goal that workforce shortages do not undermine health care affordability, access, quality, equity, and culturally and linguistically competent care.
- Promote the goal of health care affordability, while recognizing the need to maintain and increase the supply of trained health care workers.
- Develop standards, in consultation with the Board, to advance the stability of the health care workforce.
Statutory Requirements

- The Board approves standards to advance the stability of the health workforce that may apply in the approval of performance improvement plans.
- OHCA may require a health care entity to implement a performance improvement plan that identifies the causes for spending growth and shall include specific strategies, adjustments, and action steps the entity proposes to implement to improve spending performance during a specified time period. The director shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode access, quality, equity, or workforce stability.
Why Workforce Stability?

• California currently faces a significant health workforce shortage, including an imbalanced geographic distribution of health care workers.

• Health workforce challenges contribute to lack of access to needed services, including preventive services; delays in receiving appropriate care; and preventable hospitalizations.

• Efforts to slow spending growth may have unintended negative consequences if health care entities reduce labor costs through staffing reductions.

• A stable, well-prepared, and adequately supplied workforce is essential to a sustainable health care system that provides high-quality, equitable care to all Californians.

• No other state has included workforce stability standards in its spending growth target efforts.
Preliminary Timeline for Workforce Stability Workstream

**Summer 2023**
- Literature and data review
- Begin key informant and stakeholder interviews

**Fall 2023**
- Complete key informant interviews (state and national health care workforce experts)

**Winter 2023**
- Complete stakeholder interviews (health care entities, health care workers, organized labor, consumer advocates, etc.)
- Develop draft standards

**Spring 2024**
- Solicit feedback on draft standards

**Summer 2024**
- OHCA develops workforce stability standards in consultation with the Board
- Data analysis to support implementation of workforce stability standards

**Fall 2024**
Total Health Care Expenditures (THCE) Measurement

Vishaal Pegany, Deputy Director
Michael Bailit, Bailit Health
Recap of May Board Meeting

During the third Board meeting in May, we:

1. Reviewed OHCA’s contemplated approach for reporting and disaggregating THCE, including:
   • Levels of reporting: State, market, payer, and provider entity
   • Considerations for regional and service category level analyses of THCE

2. Described OHCA’s considerations for measuring total medical expenses (TME) at the large provider entity level

3. Began discussion of spending target program adjustments, including risk adjustment methodologies for the reporting of THCE
Today’s Discussion

Continue discussion of spending target program adjustments
Spending Target Program Adjustments
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 based on non-supervisory labor costs
- ** Medi-Cal**
  Optional adjustment per statute, with flexibility on how to implement
Risk Adjustment
Risk Adjustment (Recap)

• **Enabling statute:** “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….

• 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.”

Health and Safety Code 127502(f)
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.
Diagnosis-based Risk Adjustment

• Using risk adjustment based on diagnosis raises concerns about equity as *utilization reflects both need and access to care*
  
  • When risk adjustment is based on utilization history, the calculation assigns higher risk scores to those with higher utilization.

• Diagnosis-based risk adjustment is also heavily influenced by provider claim coding practices.
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 now 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.
<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Option 1: Clinical</strong></td>
<td><strong>Option 2: Age/Sex</strong></td>
</tr>
</tbody>
</table>
| • 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. | • 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. |
| • 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. | • 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

• Risk adjusting for age/sex factors only to:
  • capture the impact of an incrementally aging population, and
  • avoid the distortion associated with coding practices.

• OHCA would establish reporting of age/sex data and in some fashion develop relative weighting for uniform application across insurers and provider entities within a market (i.e., commercial, Medi-Cal, Medicare).
Quality and Equity Adjustments
Quality and Equity Adjustments

Quality Adjustments

Enabling statute: The spending target 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.”
OHCA is currently performing analysis to identify data sources and develop approaches for performing quality adjustments.
OHCA’s Approach: Quality Adjustments

The Board has approval authority for adjustments pertaining to quality.
OHCA’s Approach: Equity Adjustments

OHCA is currently performing analysis to identify data sources and develop approaches for performing equity adjustments.
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 spending target 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.

Health and Safety Code 127501.4(j)(2) and 127502(d)(7)
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.

Health and Safety Code 127501.4(j)(2) and 127502(d)(7)
OHCA’s Approach: Organized Labor Adjustment

OHCA will develop the process for evaluating requests for an adjustment to the target based on actual or projected nonsupervisory organized labor costs increases impacting the entity’s ability to meet the target. This will include collection, required format, and validation of supporting documentation.
OHCA’s Approach: Organized Labor Adjustment

The Board has approval authority for adjustments pertaining to organized labor costs.
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.
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 statistical confidence in performance relative to the spending target at the payer and provider levels.
  • At the state and market levels, population sizes are significant enough that measurements are statistically stable (i.e., not impacted by random variability in utilization and patient conditions).
• 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.

• Outlier spending may inflate the base year upon which performance against a spending target is measured.
Truncation of High-Cost Outlier Spending (cont’d)

• 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 growth rate by several percentage points in one year.

• The differential treatment of high-cost outliers in the spending growth program and in total cost of care (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 practice across many states.
Example of Truncation Points from Washington

<table>
<thead>
<tr>
<th>Market</th>
<th>Per Member Truncation Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>$125,000</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$125,000</td>
</tr>
<tr>
<td>Commercial</td>
<td>$200,000</td>
</tr>
</tbody>
</table>
Truncation

OHCA is assessing the application of high-cost outlier truncation, and specifically the operational considerations given the prevalence of capitated payment arrangements in California.
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 spending increase that is within the entities' control 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 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 \textit{cannot be determined} when upper or lower bound intersects the benchmark (e.g., Insurer A).

- Benchmark has \textit{not been achieved} when lower bound is fully over the benchmark (e.g., Insurer B).

- Benchmark has been \textit{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 assessing the possible application of confidence intervals for payer and provider entity reporting. In doing so, OHCA is considering the implications of the common use of capitated payments in California.
General Public Comment

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

July 25, 2023
10:30 am

Location:
2020 West El Camino Avenue
Sacramento, CA 95833
Adjournment
Appendix
CMIR References

Within Market Consolidation:


CMIR References (cont’d)


Cross-market Consolidation:


Quality:


CMIR References (cont’d)


Hospital Ownership of Physician Groups:

CMIR References (cont’d)


Private Equity Ownership:


CMIR References (cont’d)

