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Department of Health Care Access and Information

Health Care Affordability Board Meeting

August 22, 2023

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Welcome, Call to Order, and Roll Call

AGENDA

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

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

3. **Action Consent Item**
   Vishaal Pegany
   a) Approval of the June 20, 2023 Meeting Minutes

4. **Informational Items**
   a) Cost and Market Impact Review (CMIR) including: June Advisory Committee Member Feedback; and CMIR Proposed Regulations and Workshop
      CJ Howard, Assistant Deputy Director, and Sheila Tatayon, Assistant Deputy Director

   b) Total Health Care Expenditures Measurement including: June Advisory Committee Member Feedback; and Measuring Health Care Spending of Health Plans and Provider Entities
      Vishaal Pegany and Michael Bailit, Bailit Health

   c) Health Care Payments Data Program Overview
      Michael Valle, Deputy Director, Chris Krawczyk, Chief Analytics Officer, and Jill Yegian, Yegian Health Insights

5. **Public Comment**

6. **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

National Health Expenditure (NHE) Projections

~20%	CMS projects that over 2022-2031, average annual growth in NHE (5.4%) will outpace average annual growth in GDP (4.6%), resulting in an increase in the health spending share of GDP from 18.3% in 2021 to 19.6% in 2031.
5.8%	**Hospital Trends:** Over 2022-2031, hospital spending growth is expected to average 5.8% annually.
5.3%	**Physician & Clinical Services Trends:** Over 2022-2031, growth in physician and clinical services spending is expected to average 5.3%.
4.6%	**Prescription Drug Trends:** Over 2022-2031, total expenditures for retail prescription drugs are expected to grow at an average annual rate of 4.6%.

Source: National Health Expenditure Projections, 2022–31: Growth To Stabilize Once The COVID-19 Public Health Emergency Ends. Sean P. Keehan, Jacqueline A. Fiore, John A. Poisal, Gigi A. Cuckler, Andrea M. Sisko, Sheila D. Smith, Andrew J. Madison, and Kathryn E. Rennie Health Affairs 2023 42:7, 886-898.

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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Action Consent Item: Approval of the June 20, 2023 Board Meeting Minutes

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Informational Items

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Cost and Market Impact Review

CJ Howard, Assistant Deputy Director
Sheila Tatayon, Assistant Deputy Director

Advisory Committee Member Feedback Process

OHCA staff and Board members who attended the Advisory Committee meeting will provide the Board with a summary of issues and topics addressed by the Advisory Committee and include feedback on items before the Board.

OHCA staff will aim to integrate Advisory Committee discussions, deliberations, and feedback into relevant agenda items (e.g., today we integrate Advisory Committee member feedback into the CMIR and THCE agenda items, respectively).

OHCA staff will attempt to present to the Board as many points of view from the Advisory Committee as possible but note there are some areas where Committee members offered differing opinions. OHCA staff will attempt to characterize the level of support for an issue raised.

OHCA encourages the Board member(s) who attended the prior Advisory Committee meeting to bring forth any additional elements and themes from the Advisory Committee's discussions.

Advisory Committee Member Feedback: CMIR

The following is a summary of feedback and input from the Advisory Committee related to Cost and Market Impact Review (CMIR).

- OHCA should account for situations in which an acquiring entity engages in serial acquisitions within a health care sector and/or geographic region where a single transaction may fall below a dollar threshold, but the cumulative impact of the serial transactions significantly impacts the market.
- OHCA should conduct market consolidation analyses, such as cross-market mergers or vertical integrations beyond a geographic market demarcation, that do not fall under the jurisdiction of the Attorney General or Federal Trade Commission.

Advisory Committee Member Feedback: CMIR (cont.)

- OHCA should promulgate regulations that reflect OHCA's authority to identify and review potential market failures and address trends not captured within existing regulatory structures.
- OHCA should consider quality, appropriate use of care, overall delivery of care, and sources of community care when evaluating market impact, in addition to cost.
- OHCA should consider Medicare Shared Savings Programs (MSSP) and Accountable Care Organizations (ACO) in which competitor organizations band together (i.e., Medicare product lines could become monopolistic).

A Committee member also cautioned that CMIR public noticing has the potential to exacerbate an unlevel playing field (e.g., unregulated private equity or publicly traded companies can view notice transactions and increase bidding).

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Overview of Proposed Regulations for Assessing Market Consolidation (CMIR)

Statute to Implementing Regulations

1. Material Change Notice Filing Requirements
    - Who Must File?
    - Do the Health Care Entities Meet the Thresholds?
    - Do the Circumstances of the Proposed Transaction Require Filing?
2. Health Care Services Defined
3. When Do HCEs Need to File Their MCNs?
4. Filing the MCN – Summary of Information Required
5. What Happens After an MCN is Filed? – OHCA's Process
6. OHCA's Decision to Issue Waiver or Conduct CMIR - Factors
7. Conducting the CMIR – Factors
8. Timeline for MCN Review, CMIR, Preliminary, Final Report, and Transaction Implementation

Who Must File Notice of a Material Change Transaction?

Statute

Health Care Entities (HCE) defined in statute as payers, providers, or fully integrated delivery systems (§127500.2(k).)

Proposed Regulation

Regulations Clarify HCEs Who Must File Material Change Notice (MCN):
§97431(g)

- All Payers, Providers, and Fully Integrated Delivery Systems
- Pharmacy Benefit Managers (PBMs) defined as payer per statute
- Management Service Organizations (MSOs) qualify as “payers”
- Affiliates, subsidiaries, or entities that control, govern, or are financially responsible for the HCE
- Affiliates, subsidiaries, or entities subject to control, governance or financial control of the HCE
- Any HCE entering into a transaction with a physician organization of less than 25 physicians (Less than 25 is exempt, but greater than 25 remains subject to requirement.)

Transactions already subject to review by the Attorney General, Department of Insurance, and Department of Managed Health Care, as well as county transactions, are exempt from notice requirements. HCEs under common ownership or corporate restructuring are exempt from notice requirements.

Do the Health Care Entities (HCEs) Meet the Thresholds?

Statute

OHCA shall adopt regulations for proposed material changes that warrant a notification, establish appropriate fees, and *consider appropriate thresholds, including, but not limited to annual gross and net revenues and market share in a given service or region*. (§127507(c)(3).)

Proposed Regulation

Regulations Define the Thresholds for Filing MCN:
§97435(b)(1)-(3)

- HCE has annual revenue of at least $25M or owns or controls California assets of at least $25M, **or**
- HCE has annual revenue of at least $10M or owns or controls California assets of at least $10M and are involved in a transaction with any HCE satisfying the above $25M threshold, **or**
- HCE is located in or serving at least 50% of patients residing in a health professional shortage area (HPSA), as defined in Part 5 of Subchapter A of Chapter 1 of Title 42 of the Code of Federal Regulations https://data.hrsa.gov

Revenue means total average annual California-derived revenue received for all health care services by all affiliates over the three most recent fiscal years calculated and reported by type of HCE specified in the regulation. § 97435(d)(1)-(7)

Do the Circumstances of the Proposed Transaction Require the HCEs to File?

Statute

OHCA shall adopt regulations for proposed *material changes that warrant a notification*, establish appropriate fees, and consider appropriate thresholds, including, but not limited to annual gross and net revenues and market share in a given service or region. (§127507(c)(3).)

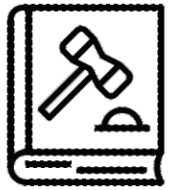
Proposed Regulation

Regulations Specify Transaction Circumstances that Trigger Filing Requirement
§97435(c)(1)-(9)

(1) The fair market value is $25M or more and involves provision of health care services (specifically defined in the regulation)
(2) Is likely to increase annual revenue of any HCE (that is a party to the transaction) by at least $10M or 20% of annual revenue
(3) Involves the sale, transfer lease, exchange, option, encumbrance, or disposition of 20% or more of assets of any HCE (that is a party to the transaction)
(4) Involves the transfer or change in control, responsibility, or governance of the submitting HCE

OHCA will not charge fees to HCE for filing MCNs, but will seek reimbursement for reasonable costs for review of MCNs and conducting CMIRs (exclusive of OHCA staff time). § 127507.4(b)(1)-(2)

Do the Circumstances of the Proposed Transaction Require the HCEs to File? (cont.)



Proposed Regulation

Proposed Regulations Specify Transaction Circumstances that Trigger Filing Requirement
§97435(c)(1)-(9)

(5) The terms contemplate an entity negotiating or administering contracts with payers on behalf of one or more providers and the transaction involves an affiliation, partnership, joint venture, accountable care organization, parent corporation, MSO, or other organization

(6) Involves the formation of a new HCE, affiliation, partnership, joint venture, or parent corporation for the provision of health care services in California projected to have at least $25M in annual revenue or have control of assets related to the provision of health care services valued at $25M or more

(7) Involves a HCE joining, merging, or affiliating with another HCE, affiliation, partnership, joint venture, or parent corporation related to the provision of health care services where any HCE has at least $10M in annual revenue (Affiliations for clinical trials or graduate medical education excluded)

(8) Changes the form of ownership of a HCE, including but not limited to change from physician-owned to private equity-owned and publicly held to privately held

(9) A HCE that is a party has consummated any transaction regarding provision of health care services in California with another party to the transaction within the prior ten years

Health Care Services Defined for Purposes of the Regulation

Proposed Regulation §97431(h)

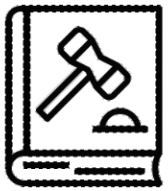
"Health care services," for purposes of this Article, are services for the care, prevention, diagnosis, treatment, cure, or relief of a medical or behavioral health (mental health or substance use disorder) condition, illness, injury, or disease, including but not limited to:

(1) Acute care, diagnostic, or therapeutic inpatient hospital services;
(2) Acute care, diagnostic, or therapeutic outpatient services;
(3) Pharmacy, retail and specialty, including any drugs or devices;
(4) Performance of functions to refer, arrange, or coordinate care;
(5) Equipment used such as durable medical equipment, diagnostic, surgical devices, or infusion; and
(6) Technology associated with the provision of services or equipment in paragraphs (1) through (5) above, such as telehealth, electronic health records, software, claims processing, or utilization systems.

When Do the HCEs Need to File their MCNs?

Statute

A HCE shall provide OHCA with written notice of agreements or transactions that will occur on or after April 1, 2024, that transfer material amount of assets or operations. Written notice *shall be provided to OHCA at least 90 days prior to entering into the agreement or transaction*. (§127507(c)(1)-(2).)



Proposed Regulation

Regulations Define "entering into the agreement or transaction" so HCEs may calculate the date for 90-day advance notice.
§97435(a)

Effective January 1, 2024, pursuant to section 127507 of the Code, a HCE who meets any threshold in subsection (b) (hereinafter referred to as a "submitter") shall provide the Office with at least 90 days' advance notice of transactions that will be entered into on or after April 1, 2024. For purposes of section 127507(c)(2) of the Code, the phrase "entering into the agreement or transaction" refers to **the date any parties' respective rights vest in a binding agreement or all contingencies to the agreement or transaction are met or waived**.

§ 97437. Pre-Filing Questions. Health care entities that are unsure if they must file a notice under this Article may contact the Office at CMIR@hcai.ca.gov.

Filing the Material Change Notice via OHCA's Electronic Submission Portal – Required Information

Proposed Regulation

HCEs Information

- Register in the Portal
- Submission is made under penalty of perjury
- Respond to questions about the HCE submitting MCN
- Provide general information about other HCEs involved in transaction

Transaction Information

- Proposed/anticipated closing date
- Transaction description
- Necessity, public impact, benefits
- Whether review required by other state or federal agency
- Prior health care services related transactions with the same HCEs

Post Transaction Information

- Expected competitive impacts
- Mitigation of potential adverse impacts
- Current health care services provided and post-transaction impacts
- Changes to staffing levels, employee wages, benefits, working conditions, and employment protections

§ 97439 Filing of Notices of Material Change Transactions. Note: No fees to submit MCN, but HCEs shall reimburse OHCA for costs (excludes OHCA staff time).

What Happens After the HCEs Submit Their MCN?

Proposed Regulation

Preliminary 60-day Review of MCN - Upon determination the MCN is complete, OHCA will post the MCN on its website and begin 60-day review to determine whether the transaction must undergo a Cost and Market Impact Review (CMIR). The 60-day clock can be tolled if additional information is required. OHCA may complete review in less than 60 days.

Determination: Waiver or CMIR Required – At conclusion of 60-day review (or sooner), OHCA notifies HCEs of Waiver or CMIR. The HCEs have 10 business days to request a review of the determination to conduct CMIR and the HCAI Director has 5 business days to respond that CMIR will proceed or will be waived.

OHCA will post the MCN Supporting Documentation on its website and conduct the CMIR within 90 days but may extend for 45 days if needed. (This time frame may be tolled if OHCA is waiting on documents requested from the parties or impacted parties outside the transaction.) OHCA will issue a Preliminary Report. Parties and the public may submit comments for 10 business days. OHCA will issue its Final Report within 30 days of the close of the comment period. The HCEs may not implement the transaction until 60 days after the Final Report.

§ 97441 Cost and Market Impact Reviews.

OHCA's Decision to Issue Waiver or Conduct CMIR

Statute
§127507.2(a)(1)

- If the office finds that a material change noticed pursuant to Section 127057 is likely to have a risk of significant impact on
  - Market competitions,
  - The state's ability to meet cost targets, or
  - Costs for purchasers and consumers, the office shall conduct a cost and market impact review.

OHCA's Determination To Conduct CMIR - Factors

Proposed Regulation
§97441(a)(2)

(2)The Office may base its decision to conduct a cost and market impact review on any one or more of the following factors**:**

(A) If the transaction may result in a negative impact on the availability or accessibility of health care services, including the HCE's ability to offer culturally competent care.

(B) If the transaction may result in a negative impact on costs for payers, purchasers, or consumers, including the ability to meet any health care cost targets established by the Health Care Affordability Board.

(C) If the transaction may lessen competition or tend to create a monopoly in any geographic service areas impacted by the transaction.

(D) If the transaction directly affects a general acute care or specialty hospital.

(E) If the transaction may negatively impact the quality of care.

(F) If the transaction between a HCE located in this state and an out-of-state entity may increase the price of health care services or limit access to health care services in California.

§ 97441 OHCA may conduct CMIR based on market failure, market power, or OHCA's finding the transaction is likely to impact competition or state's ability to meet spending target.

Factors Considered in the CMIR

Statute
§127507.2(a)(1)-(2)

- 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.

Factors Considered in the CMIR

Proposed Regulation
§97441(e)

- A CMIR shall examine factors related to the HCE's business and its relative market position, including, but not limited to:
- The effect on:
  - the availability or accessibility of health care services to the community affected by the transaction, including the accessibility of culturally competent care,
  - the quality of health care services to the community affected by the transaction,
  - the lessening competition or tending to create a monopoly which could result in raising prices, reducing quality or equity, restricting access, or innovating less.
  - any health care entity's ability to meet any health care cost targets established by the Board.
- Whether the parties to the transaction have been parties to any other transactions in the past ten years that have been below the thresholds set forth in section 97435(b).
- Consumer concerns including, but not limited to, complaints or other allegations against any health care entity that is a party to the transaction related to access, care, quality, equity, affordability, or coverage.
- Any other factors the Office determines to be in the public interest

Timeframes for Material Change Notice (MCN) Review and CMIR Preliminary and Final Reports

Proposed Regulation

MCN Complete
OHCA posts MCN to website and conducts 60-day Preliminary Review of MCNs for Transaction

(Tolled if awaiting further documents.)

OHCA notifies HCEs of Waiver or CMIR
HCEs may request review (15 business days for review process.)

CMIR or Waiver

OHCA Conducts CMIR
OHCA will post MCN supporting documentation to its website and begin CMIR.

90 days plus 45 days if needed. (Tolled if awaiting further documents)

Parties and public have 10 business days to provide comment.

Preliminary Report

OHCA Final Report for CMIR
Within 30 days of close of the comments on the Preliminary Report, OHCA will issue Final Report.

60 days after Final Report

HCE's Implement Transaction

§ 97441. Notes: HCEs may withdraw notice any time until Final Report Issued. HCE must start over if material changes to transaction.

August 15th CMIR Workshop Overview

- Attended by approximately 120 virtual participants and 20 in-person participants.
- Participants included representatives from unions, physician groups, health plans, hospital systems, private equity, consumer advocacy groups, and medical, hospital, and nursing associations.
- Thirteen commenters shared feedback on the proposed regulations during the workshop.
- General appreciation was expressed by many for the detail of the proposed regulations and for the lengthy opportunity to comment in writing as well as at the Workshop.

OHCA will continue to receive comments. Written comments are due by 5 pm August 31, 2023.

Main Takeaways from the Workshop

Thresholds

- Some commenters identified that the thresholds for filing a material change notice were too broad and they believed went beyond OHCA's statutory authority while others said they were not broad enough.

Management Services Organizations (MSOs)

- Several commenters opposed the inclusion of MSOs in the definition of health care entity as "payers" and suggested they should be exempt from filing.

Timing Issues

- Some commenters asked for clarity around the timing for filing a notice. Specifically, commenters requested clarity on when OHCA would consider a transaction closed.
- Commenters expressed concern at the length of time needed to review notices and conduct CMIRs.
- One commenter suggested including an expedited review process (such as for bankruptcies or distressed hospitals).

Confidentiality

- Commenters appreciated the process for allowing confidential treatment of information.
- One commenter recommended that additional documents be expressly confidential.
- One commenter recommended that additional attestations be made with requests for confidential treatment of documents, to ensure that submitters verify they have always maintained these documents as confidential.

Main Takeaways (cont.)

Reporting requirements

- Commenters suggested two additional reporting requirements when filing:
  (1) the source of funding for the transaction and
  (2) the evidence used to determine that a transaction is beneficial.

CMIR review criteria / factors

- Multiple commenters suggested clarification and inclusion of factors for consideration of the benefits of the transaction.
- Several commenters appreciated the inclusion of reproductive services but wanted to ensure it included the full range of reproductive and sexual health services including contraception, abortion, and LGBTQ+ health services.
- Some commenters emphasized inclusion of behavioral health services.
- One commenter suggested including labor market impacts as a sole reason for conducting a CMIR.
- Several commenters suggested the review criteria were too broad.

Public Input into CMIR process

- Two commenters recommended including additional public input (including hearings) in the review process.

Fees

- One commenter suggested capping reimbursement (fees) at $75,000.

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Total Health Care Expenditures Measurement

Vishaal Pegany, Deputy Director
Michael Bailit, Bailit Health

Recap of June Board Meeting

- During the June Board Meeting, we discussed statutory language regarding health care spending target and performance adjustments, including:
  - Quality and equity adjustments
  - Organized labor adjustments
  - Methods for characterizing health care payer and provider spending, such as confidence intervals.
- In addition, we discussed the statutory provisions related to risk adjustment and OHCA's contemplated approach to risk adjustment.

Discussion Today

1. Advisory Committee Feedback on Measuring Total Health Care Expenditure (THCE)
2. Measuring Health Care Spending of Health Plans and Provider Entities

Advisory Committee Member Feedback: THCE

Inclusion of Specific Plans and Spending in THCE:

- OHCA should consider individual member suggestions to incorporate workers' compensation, long-term support services, dental-specific plans, and vision-specific plans. Some of these items should be considered for future years of OHCA work, and others should be considered now where the data is available.
- OHCA should consider capturing spending not incorporated in the proposed methodology, including membership fees (e.g., One Medical), direct primary care, alternative medicine paid out of pocket (e.g., acupuncture), behavioral health paid out of pocket, and unpaid claims.
- Advisory Committee members supported inclusion of spending data from Correctional Health Systems and TRICARE.

Advisory Committee Member Feedback: THCE (cont.)

Data Collection and Reporting:

- OHCA should consider capturing medical debt and Health Savings Account/Flexible Spending Account data and report spending by health maintenance organization (HMO) and preferred provider organization (PPO) product types.
- OHCA should consider Advisory Committee members' suggestion for improved capture and analysis of encounter data for capitated payments.

Specific Health Care Services and Entities:

- OHCA should consider the recommendation to compare hospital outpatient with "community outpatient." The latter would include imaging services and other lab tests.
- The Advisory Committee broadly supported OHCA's contemplated methodologies for measuring services and entities.
- The Advisory Committee suggested utilizing commercial ACOs and MSSP contractors for the identification of provider entities for spending target measurement and reporting.

Advisory Committee Member Feedback: THCE (cont.)

Risk Adjustment Methodology:

- Some Advisory Committee members expressed concerns about OHCA's consideration of age / sex risk adjustment, specifically that an age / sex adjustment methodology could exacerbate health inequities and lead to selection / enrollment of healthier patients (i.e., avoidance of individuals with chronic or complex health conditions.)
- Members indicated that they would like to continue to discuss this topic and learn more at a future meeting.

Statute Language on Measuring Spending

Enabling statute: "...The office shall establish requirements for payers and fully integrated delivery systems to submit data and other information necessary to do all of the following:…

(1) Measure total health care expenditures and per capita total health care expenditures;

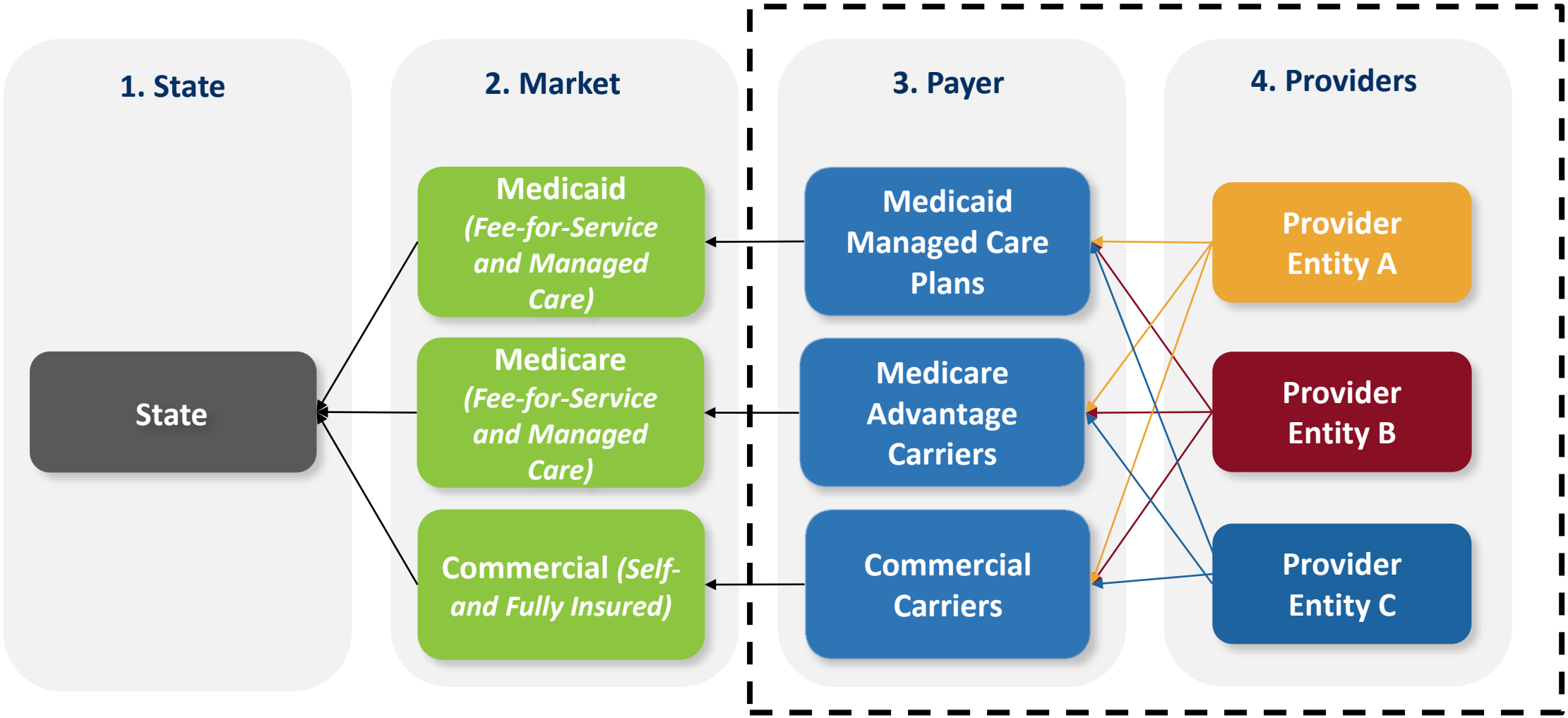
(2) Determine whether health care entities met health care cost targets;

(3) Identify the annual change in health care costs of health care entities…"

- Our focus today will be on determining for which health care entities OHCA will collect data to assess performance relative to the target, i.e., which payers and which provider entities.

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

Levels of Reporting THCE



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Measuring THCE: Health Plans

OHCA is considering an approach to identifying which health plans will be required to submit data to measure THCE that:

1. Focuses data collection and analysis resources on payers representing most California health care spending
2. Avoids collecting data from payers that are too small to contribute to the generation of statistically meaningful results
3. Balances the administrative cost of data collection, validation, analysis and reporting with an objective of data completeness

OHCA's Considerations for Measuring THCE: Health Plans

- Health plans with at least 40,000 covered lives in any market (e.g., commercial, Medi-Cal, Medicare) will be required to submit THCE data for all three markets.
- Nearly all Medi-Cal plans will be required to submit THCE. Specialty plans (e.g., AIDS Health Foundation, On Lok) with extremely low enrollment will be excluded.
- This would capture nearly all spending (99%) in the commercial and Medi-Cal managed care markets and the vast majority of spending (97%) in the Medicare Advantage market.

Proposed Health Plans Meeting Threshold

Health plans are listed in alphabetical order.

Commercial	Medi-Cal	Medicare Advantage
1. Anthem 2. Blue Shield 3. Centene (Health Net) 4. CIGNA 5. CVS (Aetna) 6. Kaiser 7. L.A. Care 8. Molina 9. Oscar 10. Sharp 11. SIMNSA 12. Sutter 13. UnitedHealthcare 14. Western Health Advantage	1. Alameda Alliance 2. Anthem 3. Blue Shield 4. CalOptima 5. CalViva Health 6. CenCal Health 7. Centene (Health Net) 8. Central California Alliance for Health 9. Community Health Group 10. Contra Costa Health Plan 11. CVS (Aetna) 12. Gold Coast Health Plan 13. Health Plan of San Joaquin 14. Health Plan of San Mateo 15. Inland Empire Health Plan 16. Kaiser 17. Kern Family Health Care 18. L.A. Care 19. Molina 20. Partnership Health Plan 21. San Francisco Health Plan 22. Santa Clara Family Health Plan	1. Alignment 2. Anthem 3. Blue Shield 4. Bright Health 5. Centene (Health Net) 6. Central Health Plan 7. CVS (Aetna) 8. Humana 9. Kaiser 10. SCAN 11. UnitedHealthcare 12. WellCare

Source: 2022 Edition – California Health Insurers, Enrollment. October 28, 2022. https://www.chcf.org/publication/2022-edition-california-health-insurers-enrollment/

OHCA's Considerations for Measuring THCE: Health Plans

Does the Board have questions regarding OHCA's contemplated approach for health plans required to submit THCE data?

Measuring Spending: Provider Entities

- OHCA anticipates developing methods to assess performance against the target for the following provider types:
  - Large systems, physician organizations, and Federally Qualified Health Centers (FQHC) *to which spending can be attributed through direct or inferred primary care physician relationships*
  - Hospitals
- Today we will be talking about measuring spending for provider entities to which *direct or inferred* primary care attribution is possible.
  - OHCA is developing alternative methods to measure spending growth of entities without direct or inferred primary care attribution (e.g., hospitals, specialists).

Measuring Provider Entity Spending: What is Being Measured?

- OHCA is measuring the *change in annual per capita health care spending* for California residents regardless of where they seek care.
- OHCA is relying on aggregated plan-reported data with spending attributed to provider entities.

Total Medical Expense (TME)

- ✓ 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 health care consumers.

Provider Entity Spending Attribution

- OHCA is creating rules to attribute member spending to provider entities through *direct or inferred attribution of individuals to entities with primary care providers*.
  - Acknowledges the role of primary care physicians (PCP) in directing patient care, triaging patient health conditions and concerns, and referring to specialty care, as needed.
- An individual's total spending is attributed to the PCP or provider entity. This may include spending on services that were not provided by the PCP or PCP's affiliated entity.
- OHCA is developing data submission specifications with instructions for attributing member spending to provider entities that will be accountable for spending growth.

Attribution Challenges

OHCA's attribution specifications consider the following challenges:

- California lacks a provider directory that identifies PCP affiliation with provider entities.
- PCPs sometimes practice with multiple provider entities.
- Health plans do not maintain lists of which individual clinicians practice at which individual practice(s), medical group(s), IPA(s), or health system(s).
- PCP affiliations with provider entities are subject to change through mergers, acquisitions, retirements, etc.

Engaging Stakeholders on Attribution

OHCA is completing the following to engage stakeholders in developing a member attribution methodology for spending:

- Discussing with health plans and providers approaches that are feasible, minimize spending that is unattributed, and limit administrative burden.
- Meeting with a group of commercial and Medicare Advantage plans to explore primary care attribution and address challenges.
- Meeting with a group of Medi-Cal managed care plans to discuss Medi-Cal specific data collection challenges.
- Engaging providers in discussions of attribution.

OHCA's Considerations for Provider Entity Attribution

- OHCA is considering primarily using member PCP selection or plan assignment in HMO and PPO populations. The health plan attributes members to provider entities when:
  - The member has actively selected a PCP within that entity
  - The plan has assigned members to a provider entity. Members who are attributed based on plan assignment may be because of total cost of care contracting or other value-based payment arrangements
- OHCA is gathering input from stakeholders on approaches to attribute spending for members that cannot be attributed using the approach described above.

Note: There will always be some level of unattributed spending.

OHCA's Considerations for Provider Entity Attribution (cont.)

Does the Board have questions regarding OHCA's process for determining a member attribution methodology for spending?

Plan for September Board Meeting

1. Report on input offered by the Advisory Committee during its September 18, 2023, meeting.
2. Review of major OHCA design decisions for collecting 2022-2023 THCE data from payers and fully integrated delivery systems for baseline reporting.
3. Review process and timeline for regulation promulgation.
4. Transition to discussion of setting the statewide spending target value.
    - Review statutory charge and target-setting provisions.
    - Begin discussion of indicators that could be used to set the target.

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Health Care Payments Data Program Overview

Michael Valle, Deputy Director
Chris Krawczyk, Chief Analytics Officer
Jill Yegian, Yegian Health Insights

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

We have nearly 50 years of experience supporting informed decisions in health care with data, transparency, and evidence-based analysis.

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Department of Health Care Access and Information

The Healthcare Payments Database (HPD) is California's All-Payer Claims Database – a large research database of healthcare administrative data.

We chose the name "healthcare payments" to recognize the prevalence of non-claims-based payments in managed care and value-based payment models in California.

We started by convening a cross-sector committee of stakeholders and experts, who unanimously ratified 36 recommendations for how to implement and operate the HPD, which were included in a 2020 report to the California Legislature.

HCAI released the first public analytic report from the database in June 2023.

HPD Program Overview

- The HPD collects four core file types:
  1. Medical claims and encounters
  2. Pharmacy claims
  3. Member eligibility
  4. Provider
- The HPD collects data from:
  1. Commercial and Medicare Advantage health plans and insurers
  2. Department of Health Care Services (Medi-Cal)
  3. Centers for Medicare and Medicaid Services (Medicare Fee-For Service)
- HPD uses the National Association of Health Data Organizations APCD Common Data Layout data file format

The HPD Program will develop:

- Approaches to incorporate other data, beyond claims
- Approaches to accept data from voluntary submitters
- Policies and procedures for access to non-public data
- A report for the Legislature by March 2024 that outlines the quality and completeness of the database
- Long-term, sustainable funding

Abbreviated HPD Program Goals

1. Provide a **public benefit**, while protecting **individual privacy**.
2. Increase **transparency**.
3. Inform **policy decisions**.
4. Support **cost-effective** care **responsive to** Californians needs.
5. Support a **sustainable healthcare system** and more **equitable access** to care.

The HPD Story…

Before 2018

Years of deliberation and various attempts to establish an All-Payer Claims Database in California.

2018 - 2020

2018-19 Budget Bill provided $60m start-up funding.

Convened stakeholder committee and submitted report to the Legislature in March 2020.

2020-21 Budget Bill provided HCAI additional enabling authority to establish the database.

2021 - 2022

Engaged data submitters and other partners, including NAHDO, to adopt the APCD-CDL format.

Developed database technology infrastructure and began data collection.

Convened Data Release Committee.

2023 - 2024+

Substantially completed the database.

Begin producing public analytic reports from the database.

Begin accepting applications for non-public data.

Develop long-term funding model.

NAHDO: National Association of Health Data Organizations
APCD-CDL: All-Payer Claims Database Common Data Layout

HPD Stakeholder Governance

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Advisory Committee

- Advises in formulating program policies regarding data collection, management, use, and access
- Provides input on priorities for the public reporting portfolio
- Provides a forum for stakeholder and public engagement

Data Release Committee

- Advises on criteria, policies, and procedures for access to nonpublic data
- Makes recommendations about applications for non-public data
- Considers whether the use of the data is consistent with the goals of the program
- Advises about privacy and security matters

Source: Committee roles described in California Health & Safety Code Sections 127671-127674

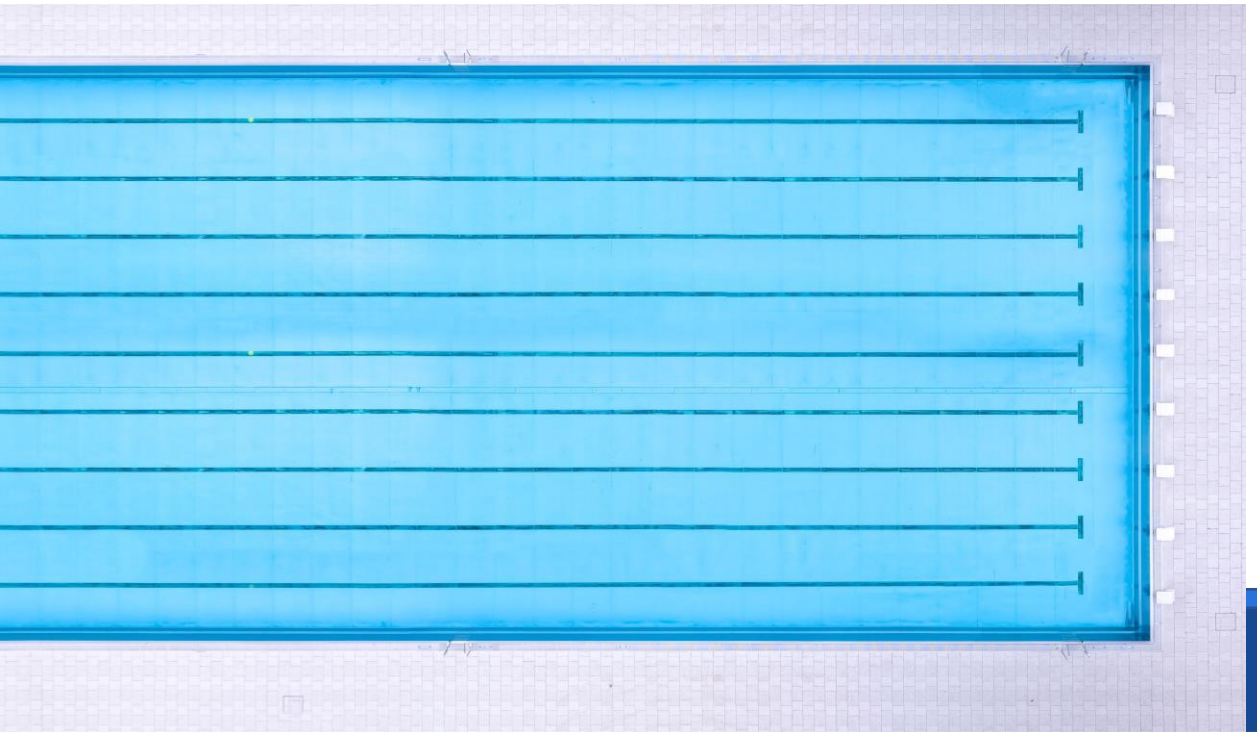
Abbreviated Reporting & Access Principles

1. Protects Patient Privacy
2. Supports Program Goals
3. Is Feasible and Credible – with Available Data & Resources
4. Supports Diverse Group of Users
5. Aligns with Existing Efforts

Complementary Views

Top-Down Perspective:
OHCA Total Health Care Expenditure Data

- Aggregate
- Annual snapshot
- From financial & accounting systems
- For tracking cost growth, year-over-year change



Bottom-Up Perspective:
HPD Data

- Record-level
- Monthly rolling
- From claims processing systems
- For longitudinal research & analysis

Public Reporting Anticipated Topics

Early Topics

- Initial Utilization Statistics
- Initial Cost Reporting
- Chronic Condition Prevalence
- Component Utilization and Cost (e.g., ED, Inpatient)
- Trends in Utilization

Later Topics

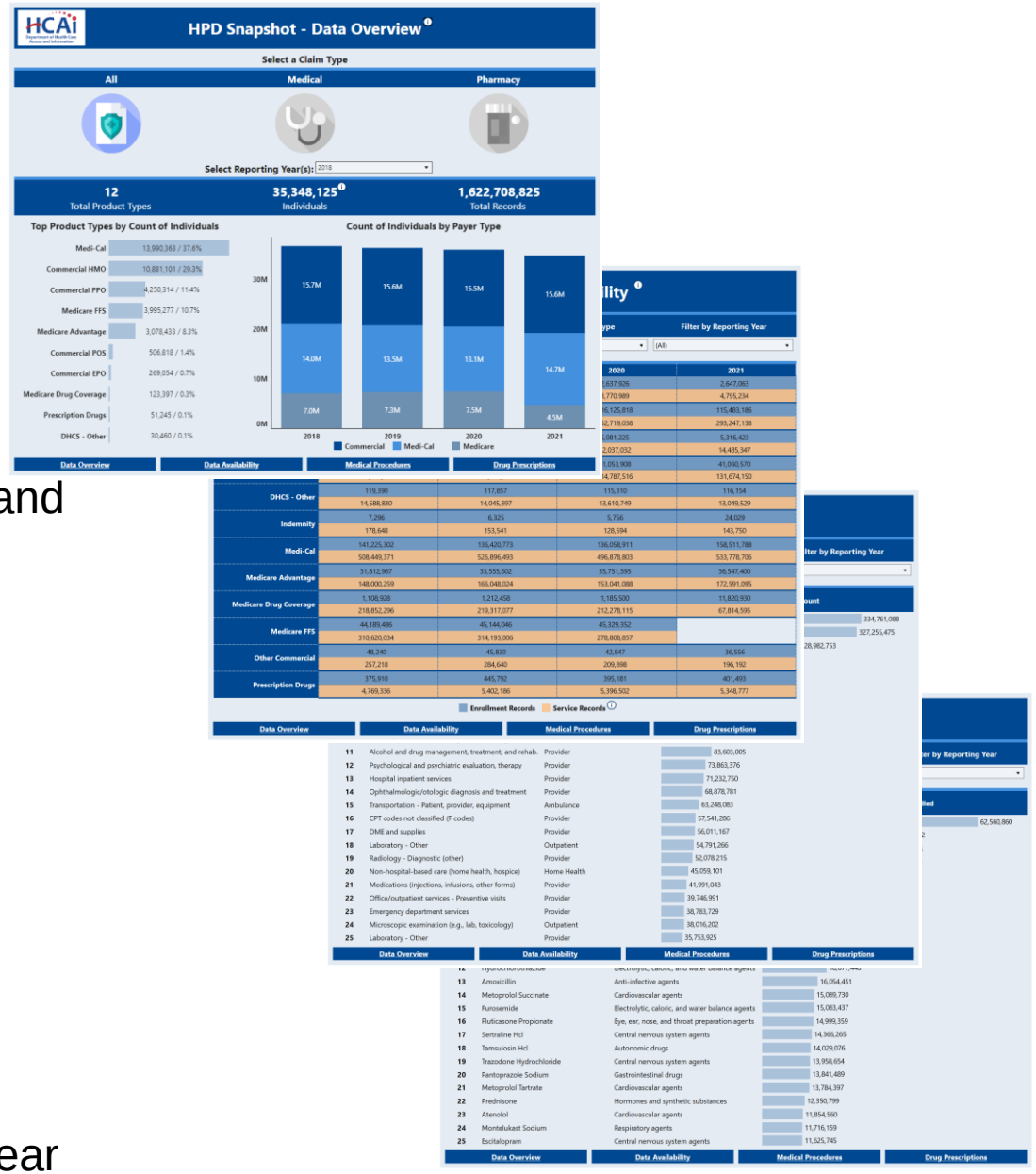
- Cost and Utilization Statistics
- Low Value Care
- Costs for Episodes of Care
- Health Disparities
- Chronic Condition Cost
- Prescription Drug Spending
- Primary Care Spending
- Behavioral Health Utilization

2023 Public Reporting Priorities

1. **HPD Snapshot**
   - High-level views of data available in HPD
   - Volume of medical procedures and pharmacy claims by payer type and year
   - Visualization and underlying data released June 2023: https://hcai.ca.gov/visualizations/healthcare-payments-data-hpd-snapshot/
2. **HPD Measures**
   - Chronic conditions, demographics, and utilization dashboards
   - User-controlled filters for location, payer, and additional demographics, such as age and sex
   - Planned release in August/September
3. **Pharmaceutical Cost**
   - Starting point for reporting on cost
   - Planned release in December

HPD Snapshot

1. **Data Overview**
   - Counts of product types, individuals, and total records by payer type, claim type, and reporting year
   - Top product types by count of individuals
2. **Data Availability**
   - Count of enrollment and service records, member months, and unique individuals by product type
   - Filters for claim type, payer type, and reporting year
3. **Medical Procedures**
   - Top 25 medical procedures by record count, procedure category, and type of setting
   - Filters for type of setting, payer type, and reporting year
4. **Drug Prescriptions**
   - Top 25 prescriptions filled by record count, drug name, and drug class
   - Filters for drug class, drug type, payer type, and reporting year



Explore the Snapshot: https://hcai.ca.gov/visualizations/healthcare-payments-data-hpd-snapshot/

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HPD Measures

- Standardized chronic conditions, demographics, and utilization measure categories
- Filters for up to 23 measure categories
- And additional filters for up to two simultaneous grouping dimensions, including age band, county, sex, product type, and reporting year
- Feature to compare to statewide averages
- With four distinct views:
    1. Measure Map
    2. Measure Trending
    3. Statewide Comparison
    4. Measure Table

Under development

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Thank You!

Next Steps

- **Continue to produce public analytic reports & refine potential use cases**
  View all of HCAI's featured data visualizations:
  hcai.ca.gov/visualizations

- **Continue to engage with stakeholders**
  Join the public discussion:
  hcai.ca.gov/hpd/#hpd-stakeholder-engagement

- **Add non-claims payment data to the database**

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General Public Comment

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

Next Meeting:

September 19, 2023
1 p.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

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Adjournment