HCAi
Department of Health Care Access and Information

Office of Health Care Affordability (OHCA): Implementation Update

CAHP Conference

October 25, 2023

Agenda

1. HCAI Overview
2. Background: Health Care Spending Trends
3. OHCA Overview
4. Health Care Spending Target
5. High Value System Performance
6. Cost and Market Impact Review

HCAI Mission

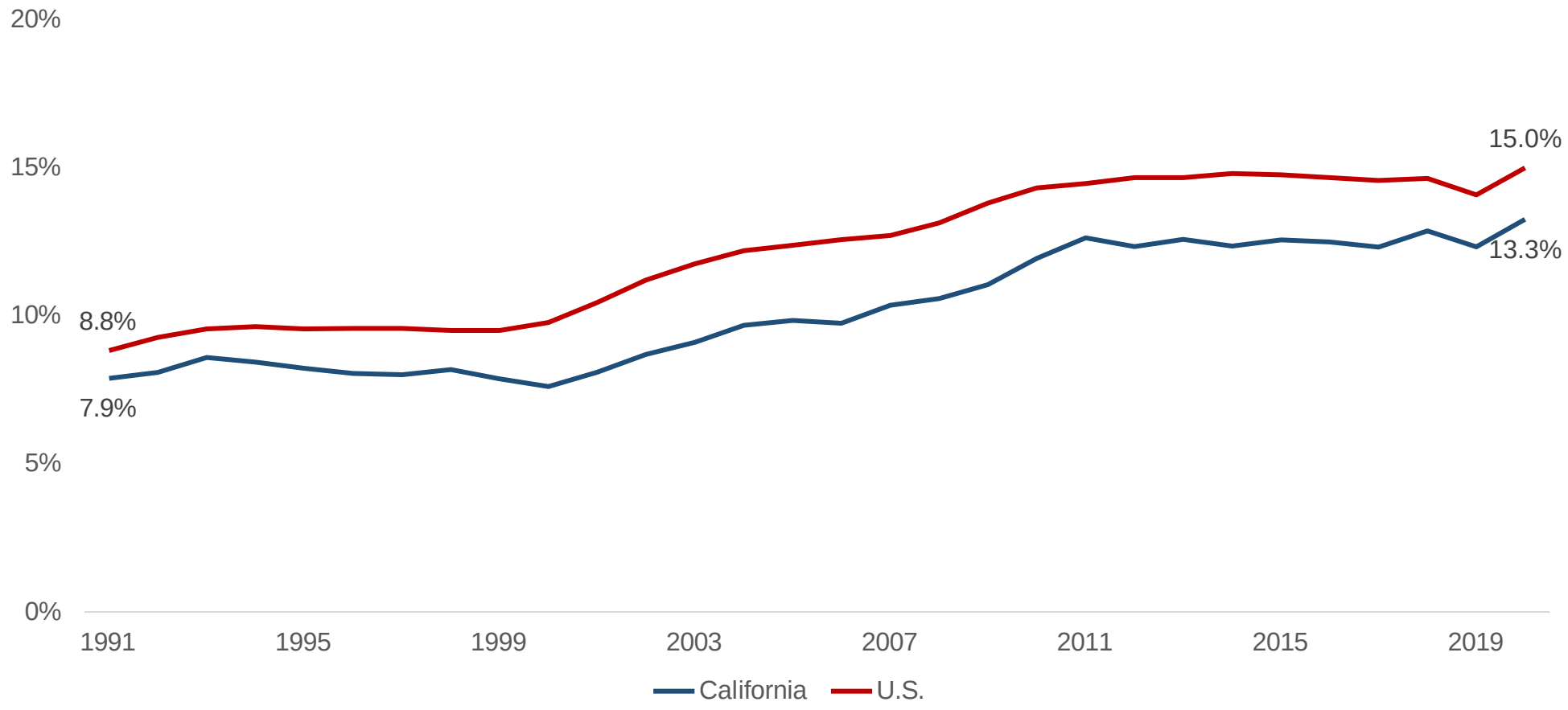
HCAI expands equitable access to quality, affordable health care for all Californians through resilient facilities, actionable information, and the health workforce each community needs.

HCAI Program Areas

- **Facilities**: Monitor the construction, renovation, and seismic safety of California's hospitals and skilled nursing facilities.
- **Financing**: Provide loan insurance for non-profit healthcare facilities to develop or expand services.
- **Workforce**: Promote a culturally competent and diverse healthcare workforce.
- **Data**: Collect, manage, analyze, and report actionable information about California's healthcare landscape.
- **Affordability:** Improve health care affordability through data analysis, spending targets, and measures to advance value. Enforce hospital billing protections, and provide generic drugs at a low, transparent price.

Context for the Office of Health Care Affordability (OHCA): National and State Health Care Spending

Per Capita Health Care Spending as a Percent of Median Income: CA & US 1991-2020



U.S. Census Bureau, Current Population Survey; estimated per capita health spending from Centers for Medicare and Medicaid Services, Health Expenditures by State of Residence

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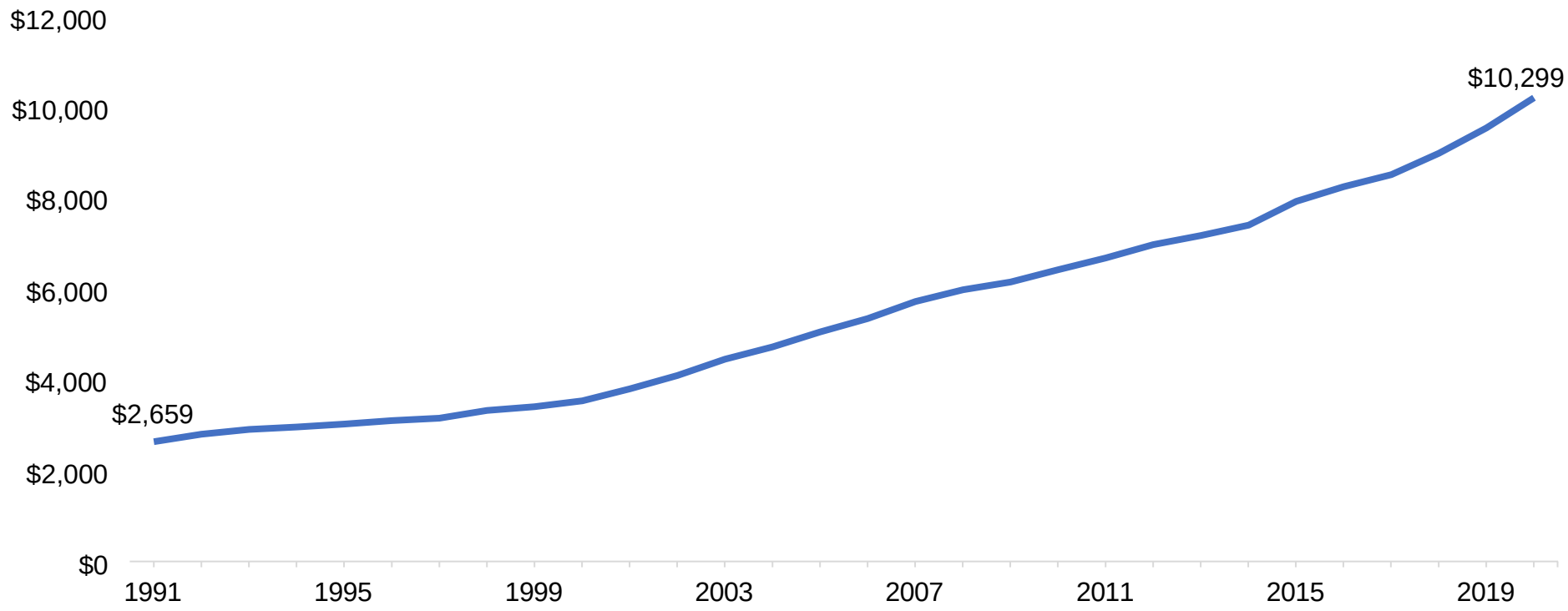
Per Capita Health Spending in California 1991-2020



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

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

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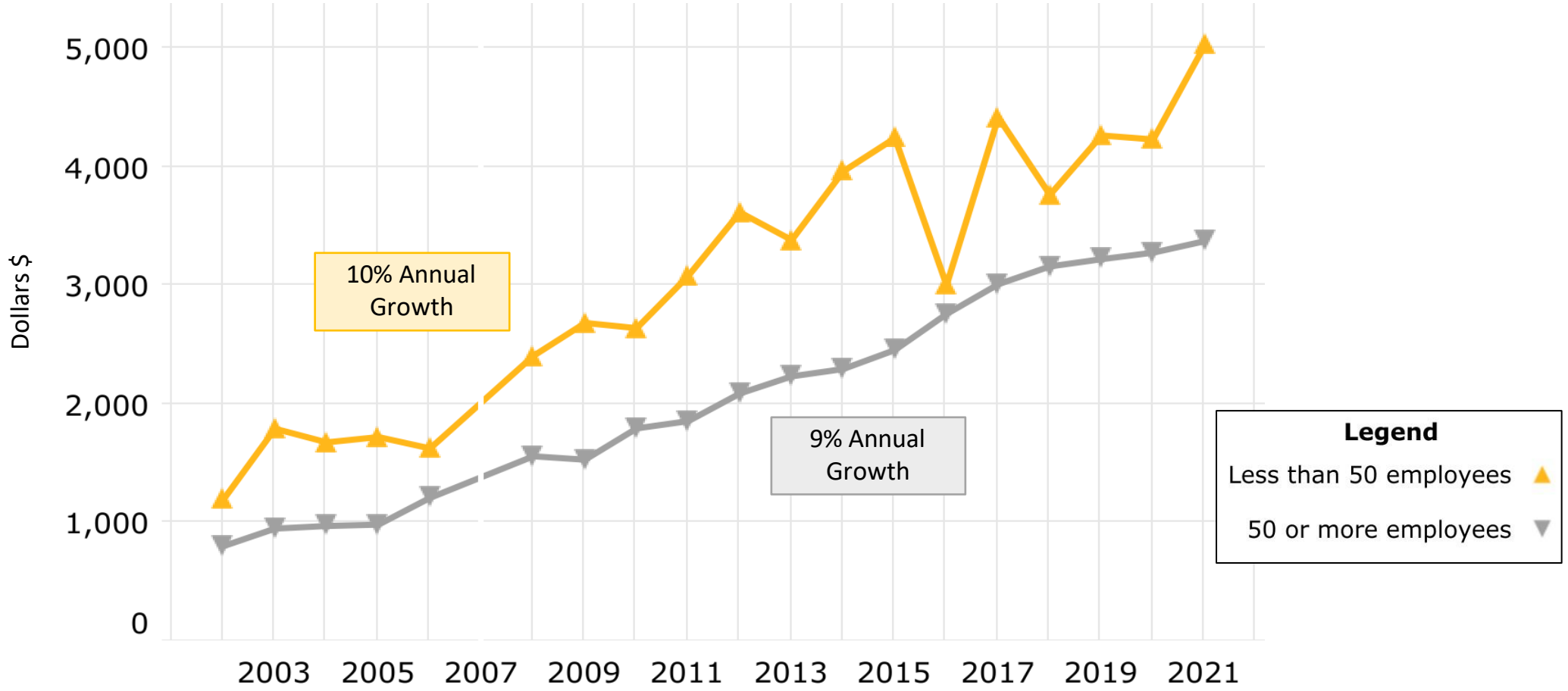
Over the Past Two Decades Family Deductibles Quadrupled in California



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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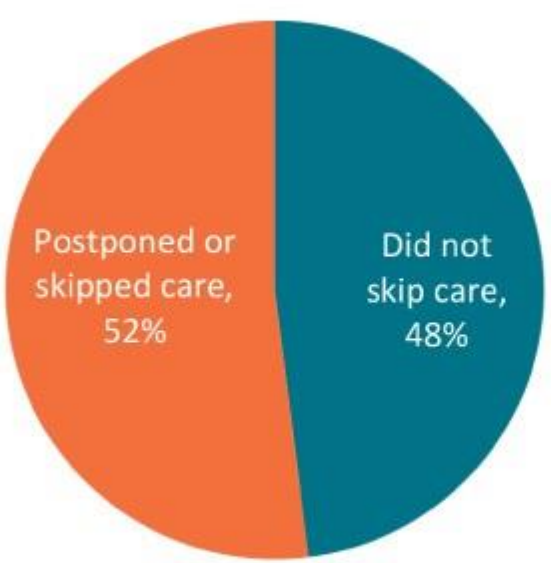
Postponing or Skipping Care

Figure 15. Half of Californians Say They or a Family Member Skipped Health Care in the Past Year Due to Cost; Many Say This Made Their Health Condition Worse



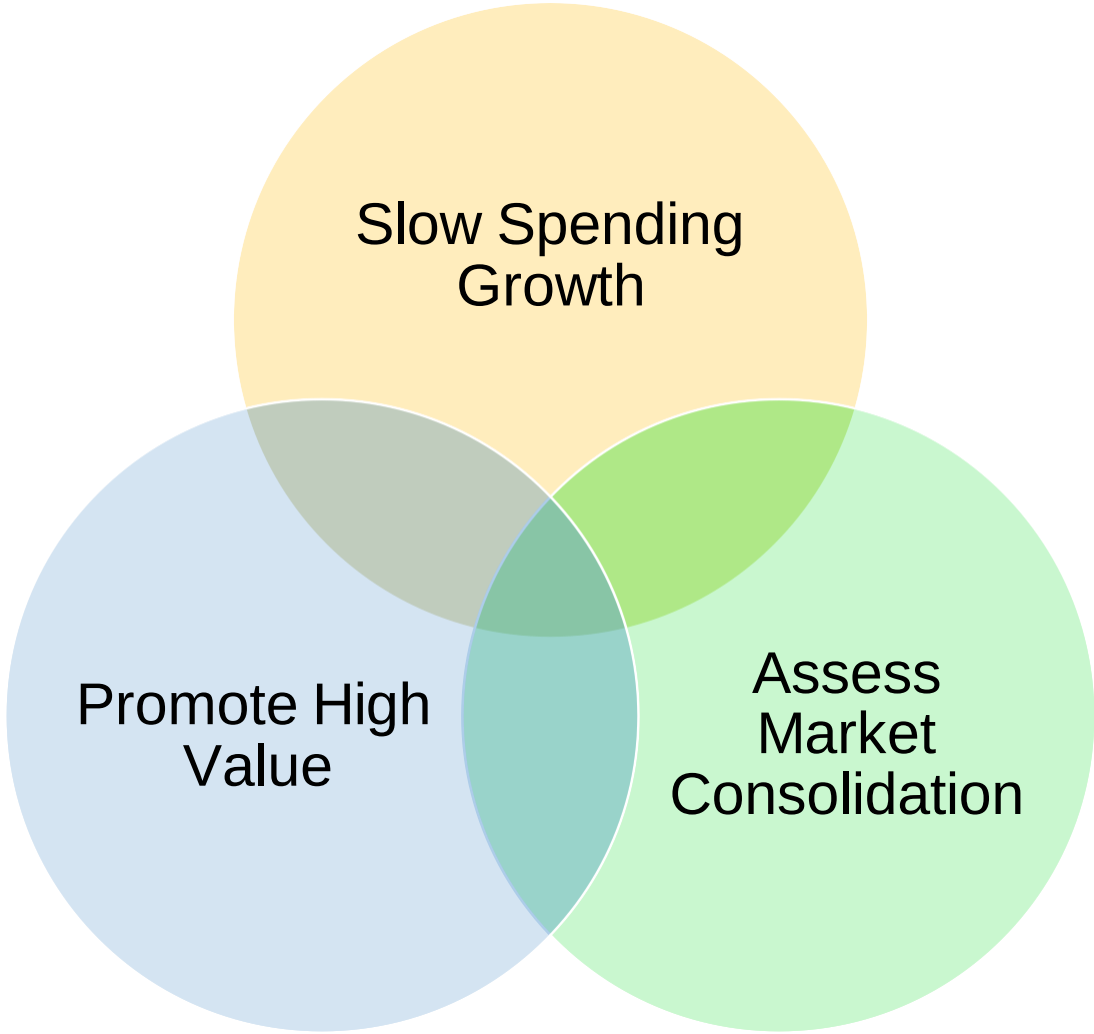
Q: ASKED OF THE 52% WHO POSTPONED OR SKIPPED CARE DUE TO COST: DID ANY OF THE STEPS YOU TOOK BECAUSE OF COST MAKE YOUR CONDITION WORSE?

Notes: CHCF/NORC California Health Policy Survey (September 30–November 1, 2022). See topline for full question wording and response options. Figures may not sum due to rounding.

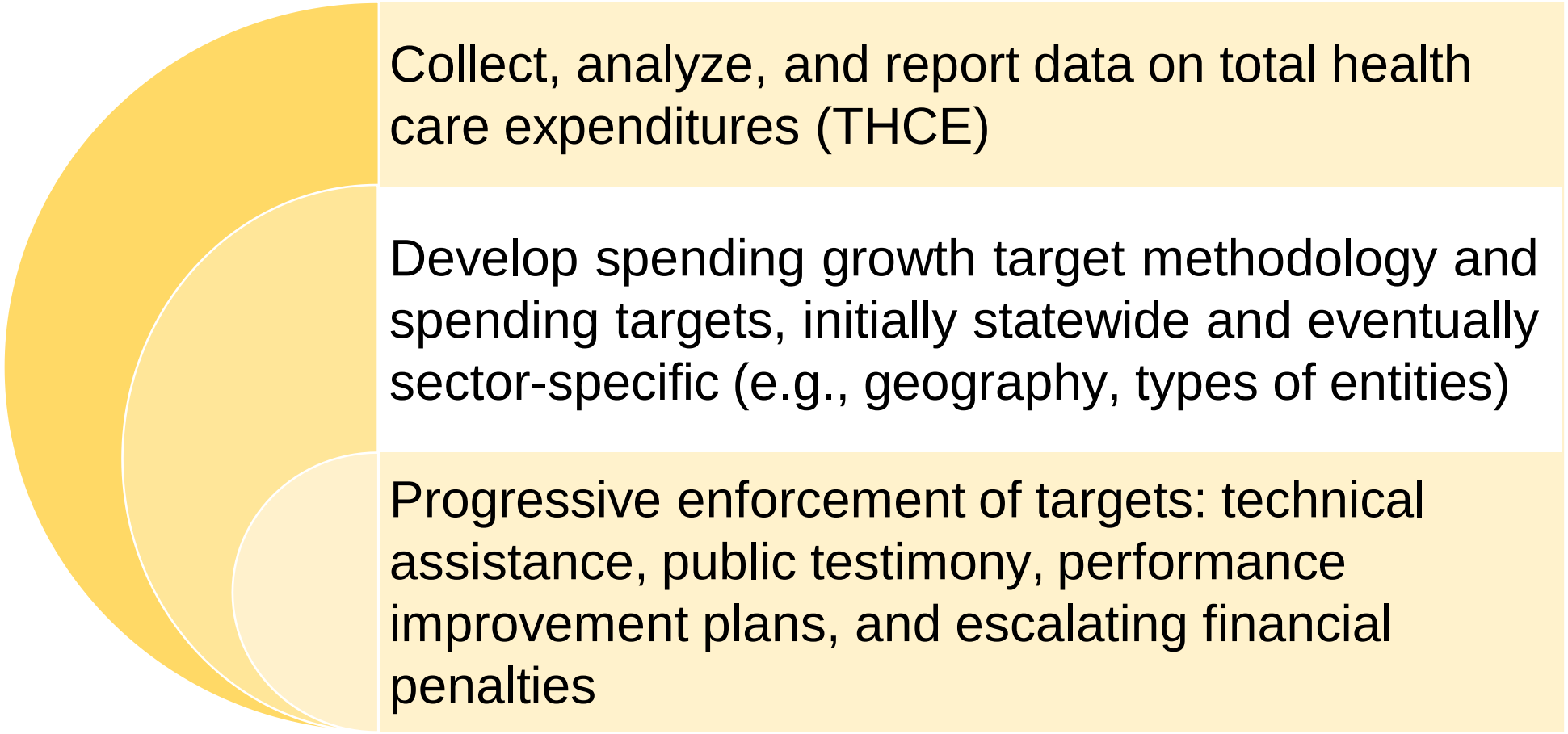
Source: Lucy Rabinowitz Bailey, Rebecca Catterson, Emily Alvarez, and Sangeetha Noble, NORC at the University of Chicago, The 2023 California Health Policy Survey, CHCF, February 2023

The Office of Health Care Affordability (OHCA)

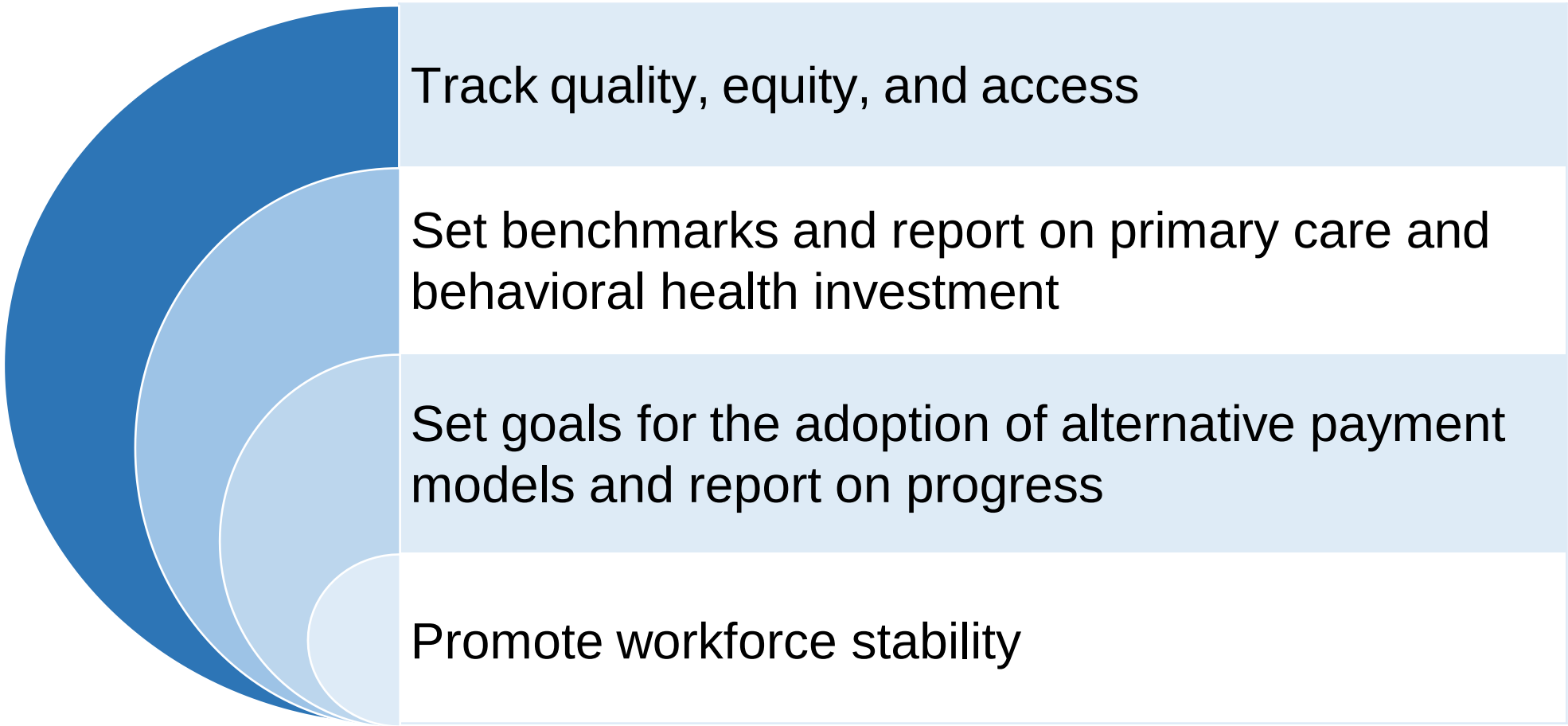
OHCA Key Components



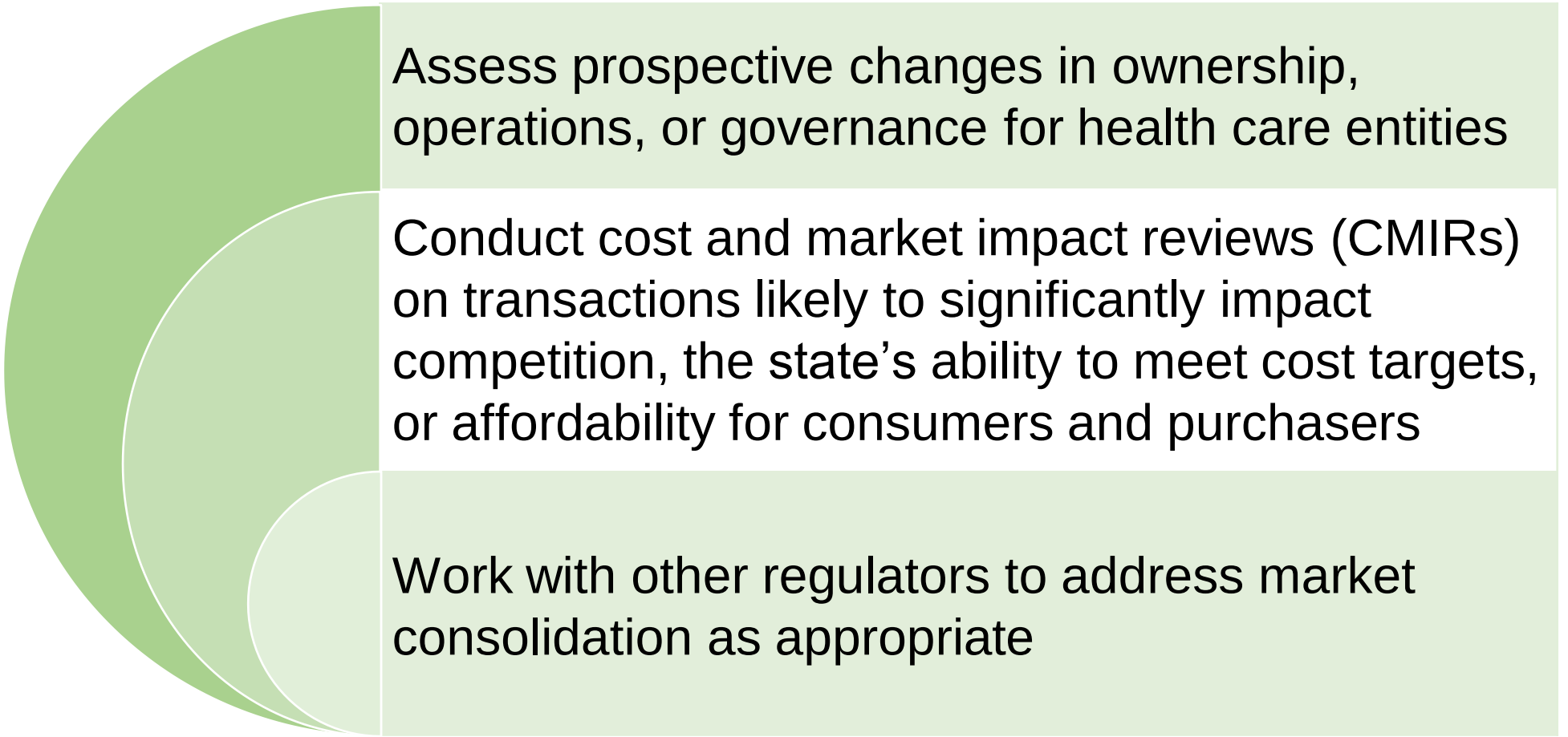
Slow Health Care Spending Growth



Promote High Value System Performance

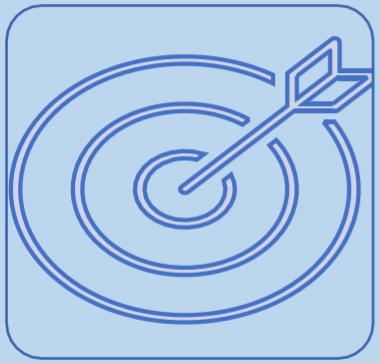


Assess Market Consolidation



Slowing Spending Growth: Health Care Spending Target

Spending Target - Defined

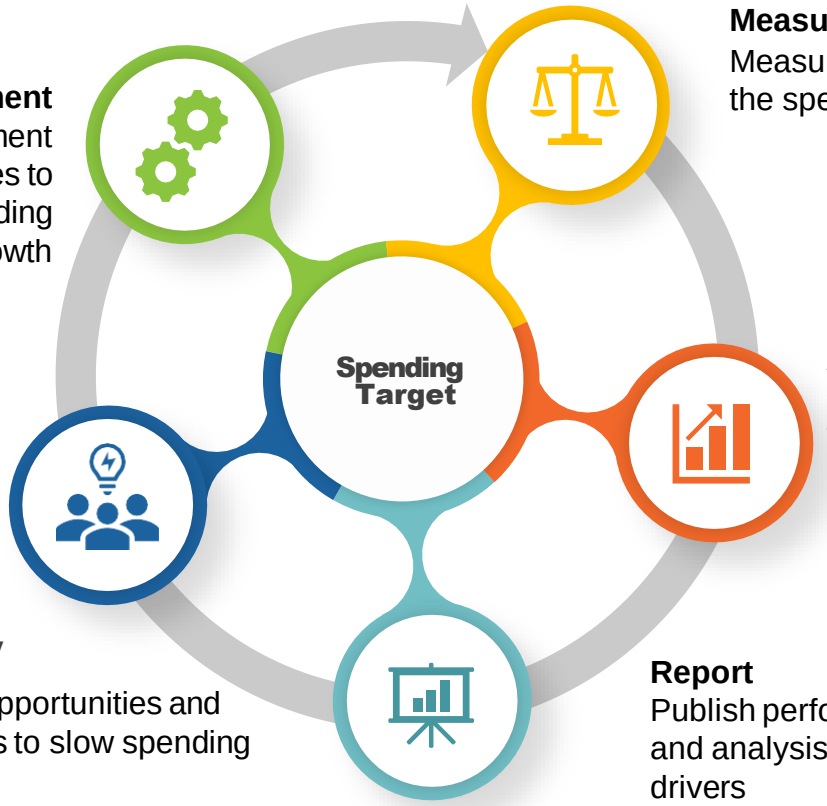


A health care spending target establishes a maximum limit on an acceptable rate of spending growth for health care entities. The goal is to slow the growth of health care spending and make health care more affordable.

The Health Care Affordability Board, with input from the Advisory Committee, will establish California's 2025 statewide health care spending target.*

*Spending performance will not be subject to enforcement until measurement year 2026.

Logic Model for a Spending Target



Implement
Implement strategies to slow spending growth

Measure
Measure performance relative to the spending target

Analyze
Analyze spending to understand spending trends and drivers

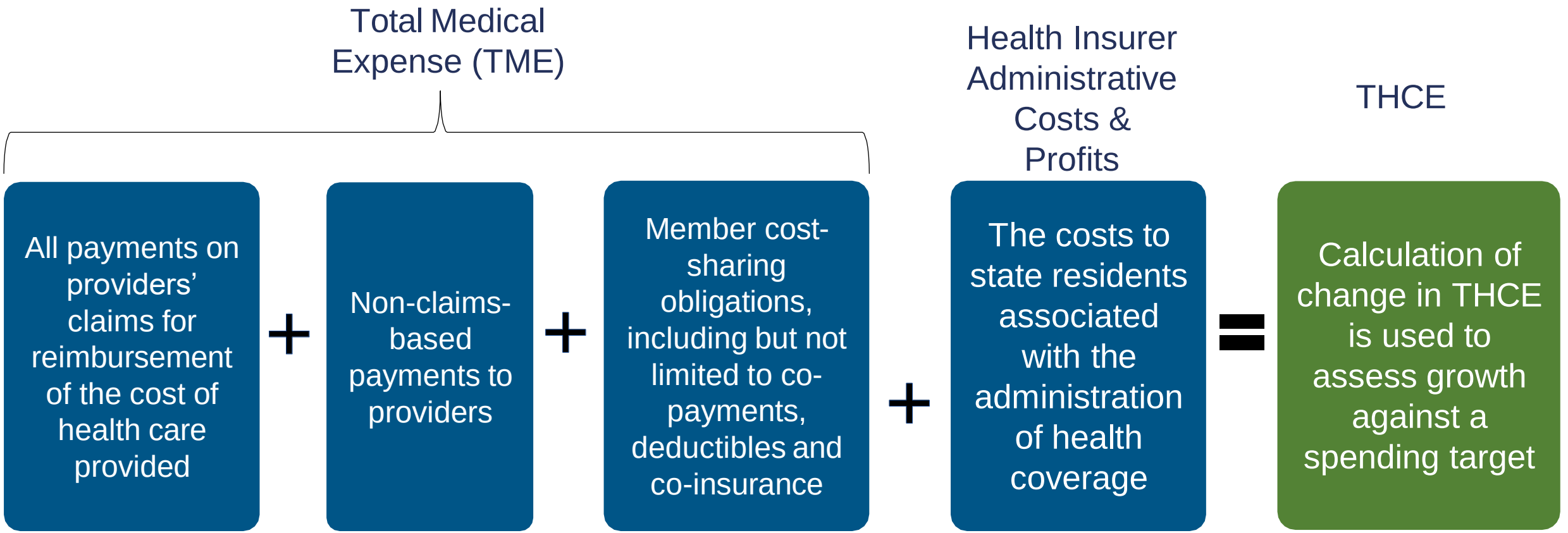
Identify
Identify opportunities and strategies to slow spending growth

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

The spending target is not an end, but a means to slow spending growth.

Complementary actions are required to attain that goal.

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.

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 in 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

Health Care Entities Subject to the Spending Target

Payers

- 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

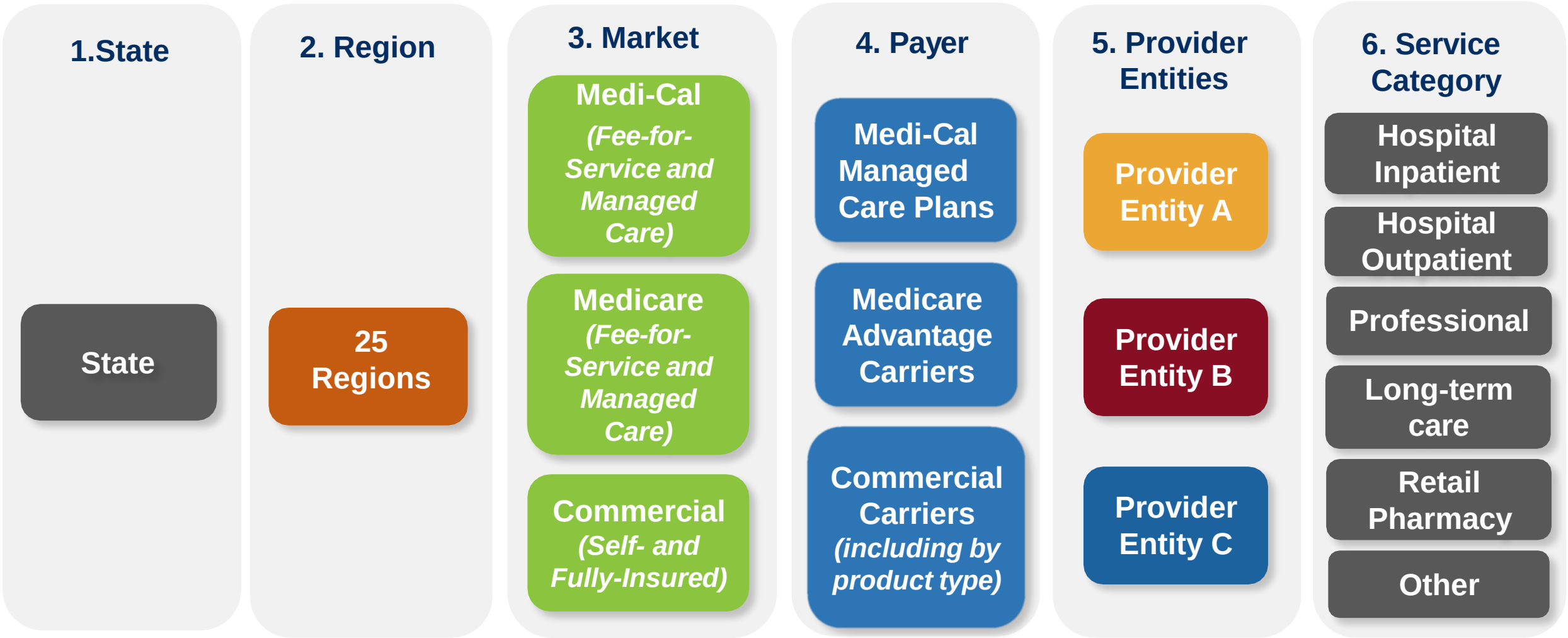
Providers

- Physician organizations
- Health facility, including acute care hospital
- Outpatient hospital department
- Clinic, general or specialty
- Ambulatory surgery centers
- Clinical laboratory
- Imaging facility

Fully Integrated Delivery Systems

- A system that includes a physician organization, health facility or health system, and a nonprofit health care service plan and meets specific additional criteria

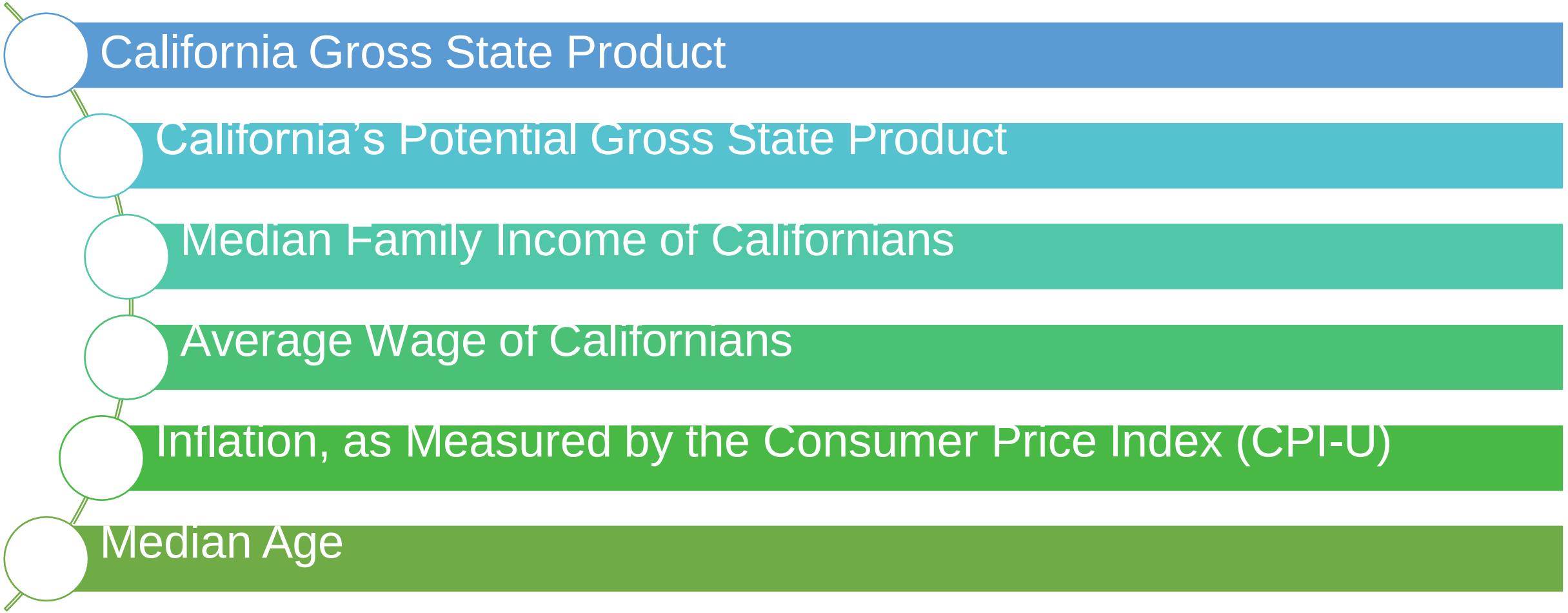
Levels of Reporting THCE



Methodology for Developing California's Spending Target

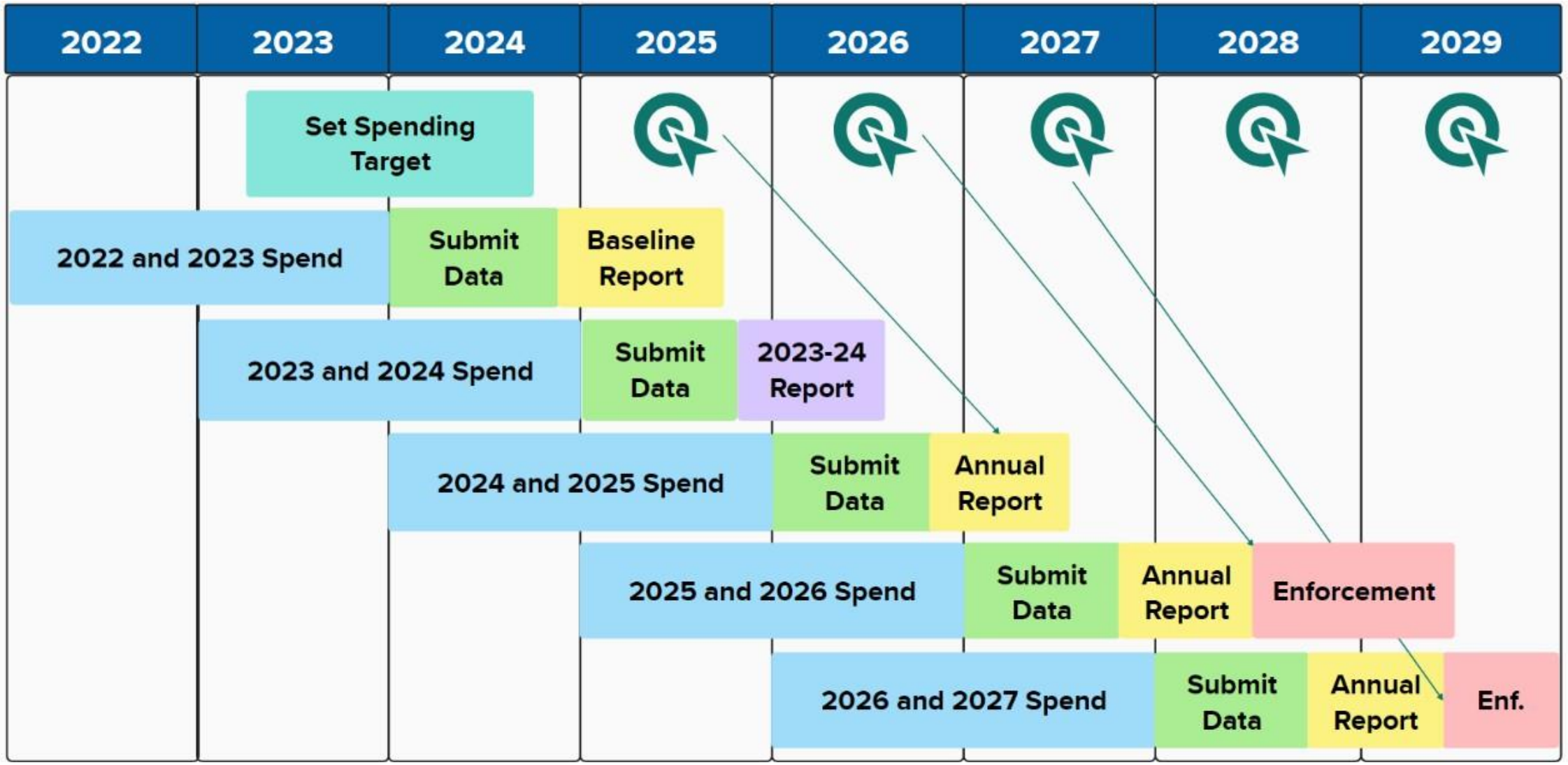
- Consider statutory requirements, including the Board and OHCA responsibilities.
- Review the methodologies of other states.
- Introduce economic and population indicators and consider tying the target value to one or more of them.
- Review other factors identified in the statute for possible spending target adjustments.

Possible Economic and Population-Based Indicators



* Each of these indicators would be calculated using annual growth rates.

Spending Target Timeline



Baseline Report Design Decisions

What will be measured:

- Spending for residents of California
- Claims payments
- Non-claims payments
- Consumer out-of-pocket spending obligation

Data Sources

- Commercial, Medicaid, and Medicare
- Other spending:
  - Veterans Affairs
  - Indian Health Service
  - California Department of Corrections and Rehabilitation
- Insurer administrative cost and profits

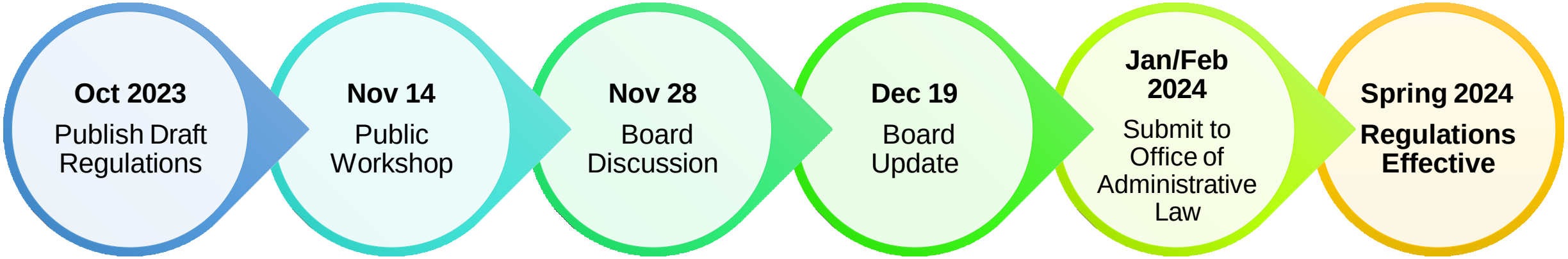
Spending by:

- State
- Region
- Market
- Payer
- Provider Entity
- Service Category
- Product Type
- Geography

Spending Measurement Considerations

- Confidence Intervals
- Demographic Risk Adjustment

THCE Data Specification Regulations Timeline



Some dates are subject to change.

High Value System Performance

Focus Areas for Promoting High Value System Performance

APM Adoption	• Define, measure, and report on alternative payment model adoption • Set standards for APMs to be used during contracting • Establish a goal for APM adoption
Primary Care Investment	• Define, measure, and report on primary care spending • Establish a benchmark for primary care spending
Behavioral Health Investment	• Define, measure, and report on behavioral health spending • Establish a benchmark for behavioral health spending
Quality and Equity Measurement	• Develop, adopt, and report performance on a single set of quality and health equity measures
Workforce Stability	• Develop and adopt standards to advance the stability of the health care workforce • Monitor and report on workforce stability measures

Investment and Payment Workgroup

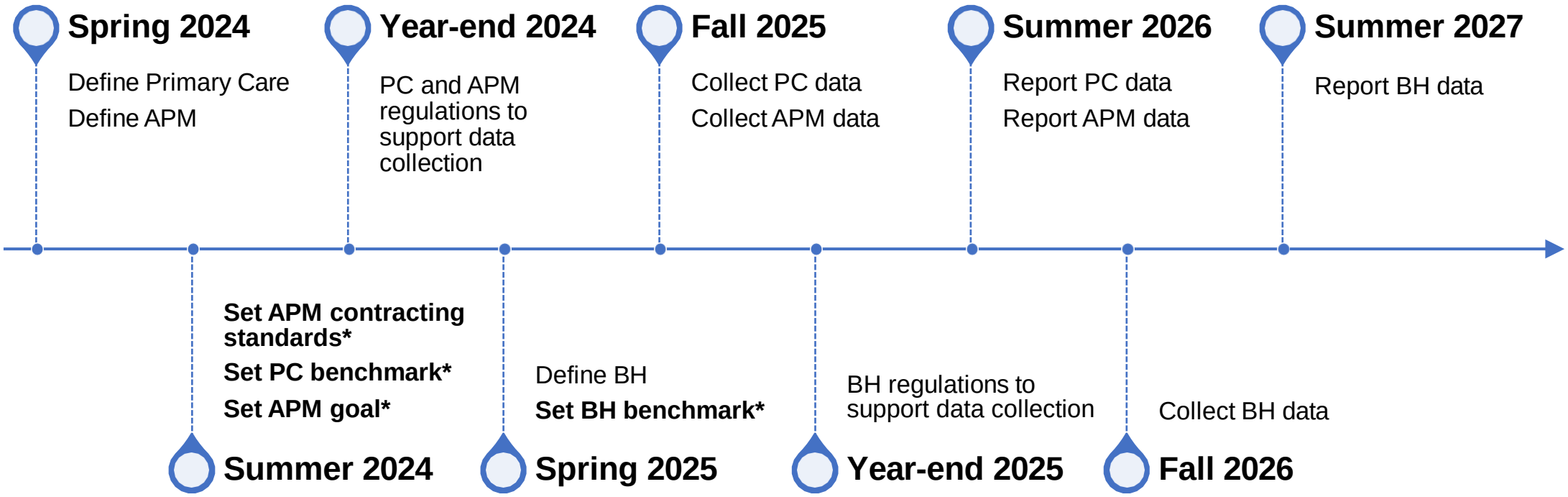
A monthly public workgroup that provides input to OHCA on the development of primary care, alternative payment model (APM), and behavioral health definitions, data collection processes, and benchmarks. OHCA will gather information from this stakeholder engagement to develop proposals for these areas.

Upcoming meetings: November 15, December 20

Workgroup Webpage: OHCA Investment and Payment Workgroup for schedule, agendas, presentations, and workgroup charter

Upcoming Primary Care Subgroup: A focus on technical aspects of primary care spending measurement to support full workgroup discussions, beginning in November

Preliminary Timeline for APM, Primary Care, and Behavioral Health Workstreams



*Board approval required

All included in the first annual report, due June 2027

Standards for Alternative Payment Models

Statutory Requirements

- **Promote the shift of payments based on fee-for-service (FFS) to alternative payment models (APMs)** that provide financial incentives 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.

Approach to APM Standards and Implementation Guidance

Standards

- Best practices to approach contracting decisions that are common across APMs
- Strategic, not tactical or prescriptive
- Grounded in evidence

Implementation Guidance

- Supplement the standards
- Provide specific actions health care entities can take to meet the standard
- Offer examples of successful APM implementation related to the standard

Draft APM Standards Under Discussion

1. **Use prospective, budget-based, and quality-linked payment models** when possible.
2. **Implement payment models that improve affordability** for consumers and purchasers.
3. **Recognize and reward the essential role of primary care teams** in improving health and generating value through payment models.
4. **Be transparent** with providers in all aspects of payment model design and terms including attribution and performance measurement.
5. **Engage a wide range of providers** by offering payment models that appeal to entities with varying capabilities and appetites for risk, including small independent practices.
6. **Measure performance** using a focused set of nationally-standardized and locally adopted measures and technical specifications.
7. **Collect demographic data**, including RELD-SOGI* data, to enable stratifying performance.
8. **Use data to address inequities** in access and outcomes.
9. **Equip providers with actionable data** to inform population health management and enable their success in the model.
10. **Provide technical assistance** to support new entrants and other providers in successful APM adoption.

*Race, ethnicity, language, disability status (RELD), sex, sexual orientation and gender identity (SOGI).
Draft standards released for Investment and Payment Workgroup feedback on 9/29/23. Revisions to draft standards in progress.

Example of Implementation Guidance

1. Use prospective, budget-based, and quality-linked payment models when possible.

1. Pay providers in advance to provide a defined set of services to a population when possible. HCP-LAN classifies these models as Category 4A, 4B, and 4C. Research finds that prospective payment of at least 60% of a provider organization's total payments results in meaningful change in clinical practice and reduces administrative burden.
2. If Category 4 payment is not feasible for a certain line of business or provider, advanced payment models that include shared savings and when appropriate, downside risk, should be used when possible. This includes models that promote higher value hospital and specialty care. HCP-LAN classifies these models as Category 3A and 3B.

1.3 Design core model components to align with models already widely adopted in California whenever possible. Examples include the Medicare Shared Savings Program (MSSP) and the Realizing Equity, Access, and Community Health (REACH) program. Core components may include prospective payment, benchmarking and attribution methodologies, performance measures, minimum shared savings and risk thresholds, and risk corridors. If full alignment with an existing model is not feasible, review and incorporate stakeholder perspectives and lessons learned from the CMS published reports on models.

Health Care Payment Learning & Action Network (HCP-LAN) 2022
Basu S, Phillips RS, Song Z, Bitton A, Landon BE. High Levels Of Capitation Payments Needed To Shift Primary Care Toward Proactive Team And Nonvisit Care. Health Aff (Millwood). 2017 Sep 1;36(9):1599-1605. doi: 10.1377/hlthaff.2017.0367. PMID: 28874487.
Centers for Medicare & Medicaid Services (CMS) 2022, 2023

Vision of APM Standards Success

Stakeholders Endorse

- Health care entities, purchasers commit to use standards to inform future contracting

Alignment Increases

- APMs become more aligned
- Standardization makes participation easier
- Barriers to adoption decrease

Performance Improves

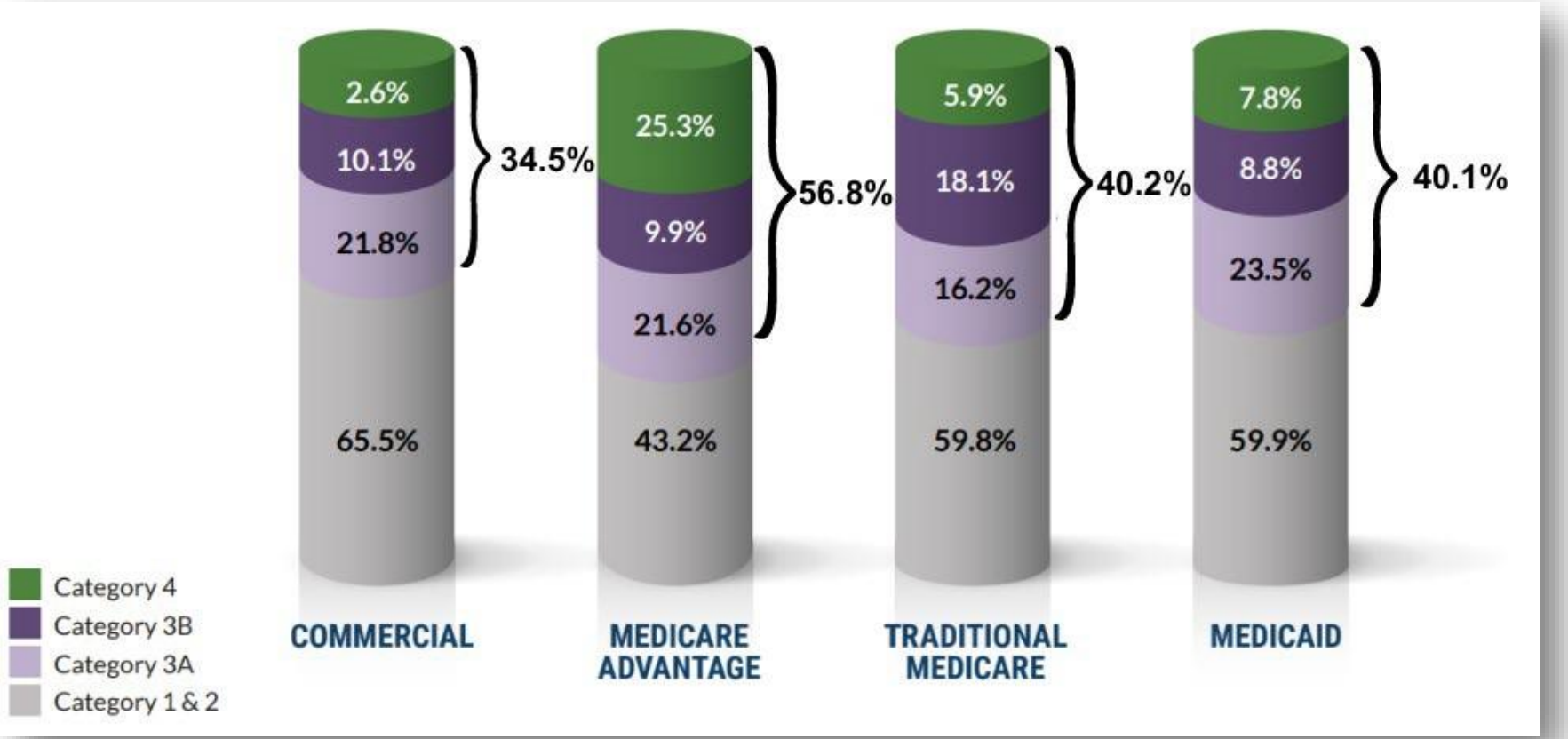
- Standards result in increased APM adoption
- Performance on measures of quality, equity, and affordability improve

APM Adoption Goals

Statutory Requirements

- **Promote the shift of payments based on fee-for-service (FFS) to alternative payment models (APMs)** that provide financial incentives 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.**

APM Adoption Nationally



In 2021, the percent of payments going to HCP-LAN Category 3, Shared Savings with or without Downside Risk, and Category 4, Population-based Payment, varied by payer type.

Less than 35% of commercial payments flowed through these categories compared to about 40% for Medicaid and Traditional Medicare. Medicare Advantage plans reported 57% of payments flowing through these categories.

National HCP-LAN APM Adoption Goals

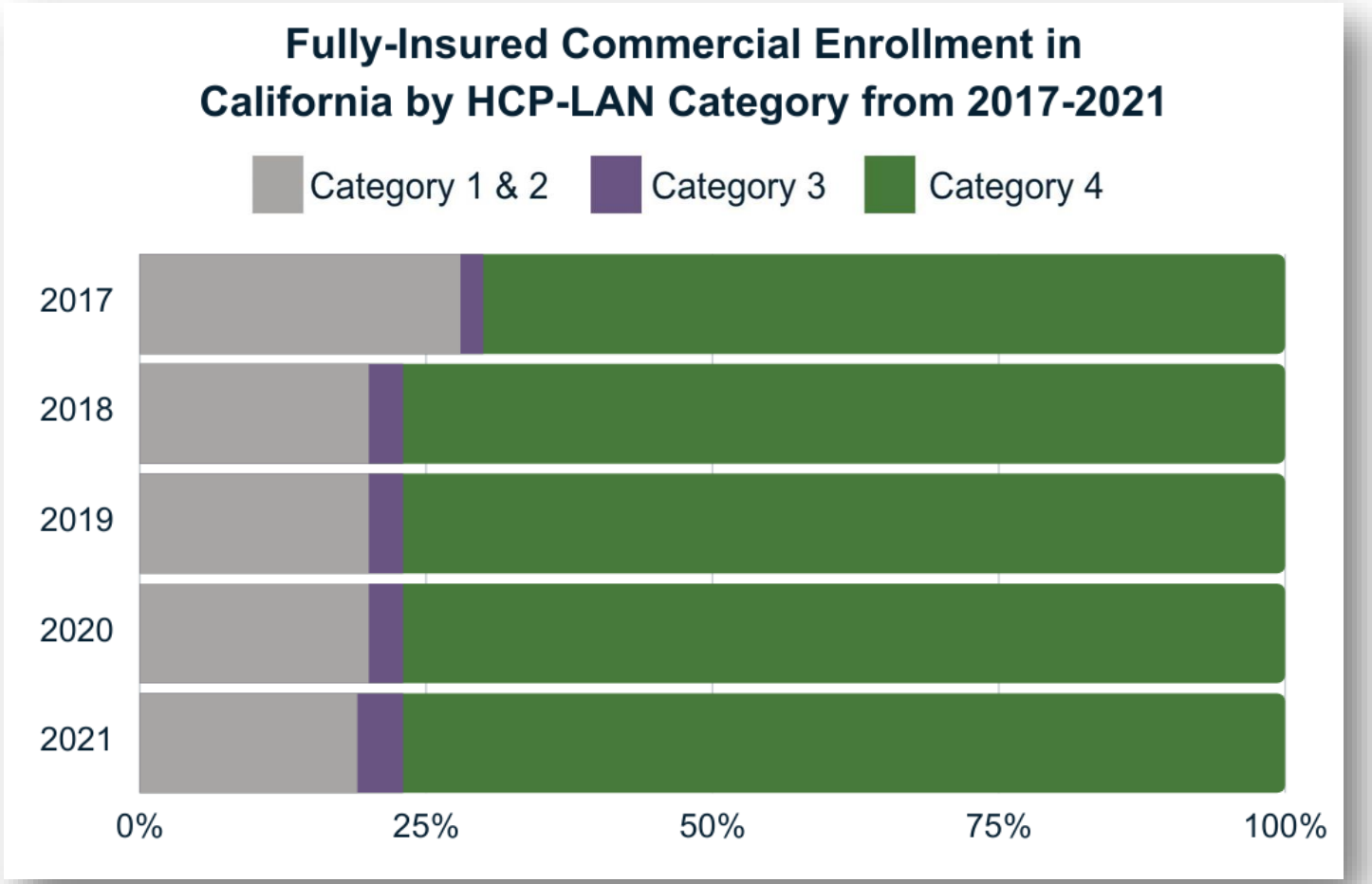
	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2018	8%	11%	24%	18%
2021	17%	13%	35%	24%
2024	25%	25%	55%	50%
2025	30%	30%	65%	60%
2030	50%	50%	100%	100%

HCP-LAN bases its APM adoption goals on Category 3B, Shared Savings and Downside Risk, and Category 4, Population-based Payment, only.

Nationally, commercial and Traditional Medicare payers will need to nearly double APM adoption from 2021 to 2024 to achieve the HCP-LAN goals by 2024.

Commercial APM Adoption Stable in CA

- APM adoption among the fully-insured population in California is more than 75 percent, far higher than commercial plans nationally.
- APM adoption has been largely stable among California's commercial, fully-insured over the past five years.
- One unknown is the percent of HCP-LAN Category 4 APMs, Population-based Payment, *not tied to quality (4N).*



Examples of APM Adoption Goals in CA

- **Public Purchaser Alignment[1]:** Covered California (2023), CalPERS (HMO 2024), and Department of Health Care Services (2024) will require contractors to "adopt and progressively expand the percentage of primary care clinicians paid" through HCP-LAN Categories 3 and 4.
- **Covered California[2]:** Covered California has a series of stairstep goals and penalties to promote greater adoption. For example, by 2025, it will require contractors have at least 70% of primary care providers contracted under a Category 3 or 4 APM to avoid a penalty.
- **Department of Health Care Services[3]:** Medi-Cal 2020 waiver required 60% of enrollees assigned to public hospitals receive care under an APM.

OHCA will build on the current APM adoption in California and national and state adoption goals in developing the OHCA APM adoption goal.

[1]California Public Purchaser Contract Provisions on Primary Care, Primary Care Investment Coordinating Group of California, 2023.
[2]Attachment 2, Covered California, 2023-2025 Individual Market QHP Issuer Contract
[3]Public Hospital Redesign & Incentives in Medi-Cal Program, Department of Health Care Services, 2023

Cost and Market Impact Review Program (CMIR)

OHCA Enabling Statute: Legislative Findings

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

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.

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 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.

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.

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

When Do HCEs Need to File?

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 closing date**.

§ 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.

What Happens After an HCE Submits an 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 the 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 the conclusion of the 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.

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.

Timeframes for 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.

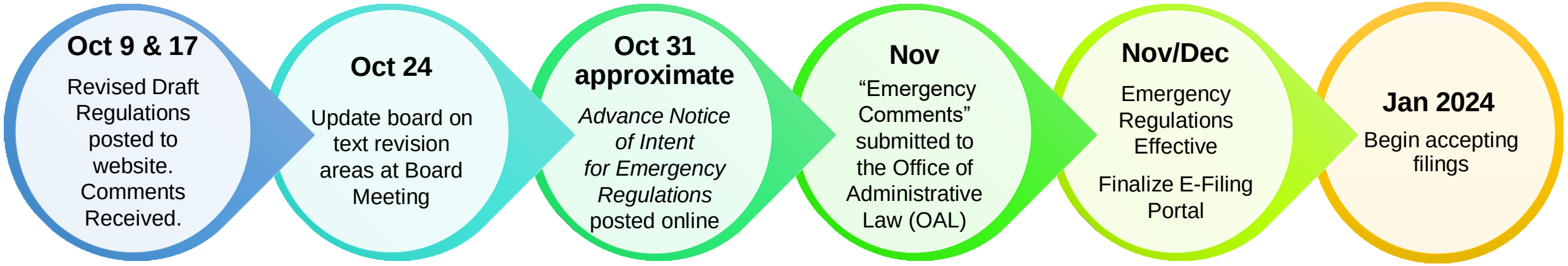
60 days after Final Report

HCE's Implement Transaction

§ 97440. Note: * Regulation sets out limited circumstances for requests for expedited review.
§ 97441. Notes: HCEs may withdraw notice any time until Final Report Issued. HCE must start over if material changes to transaction.

CMIR Regulations and Timeline: Looking Ahead to January 1, 2024 Implementation

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



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