SB 184:
Office of Health Care Affordability

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HFMA – San Diego

ATHENE LAW LLP

Today's Webinar

- How Did We Get Here?
- Nuts and Bolts of the Office of Health Care Affordability ("OHCA") and the Health Care Affordability Board
- Data as the Start of Everything
- Development and Imposition of Health Care Cost Targets
- Other Legislative Goals (Quality, Equity, Workforce, Primary Care/Behavioral Health)
- Enhanced Governmental Scrutiny over Healthcare Transactions

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How Did We Get Here?

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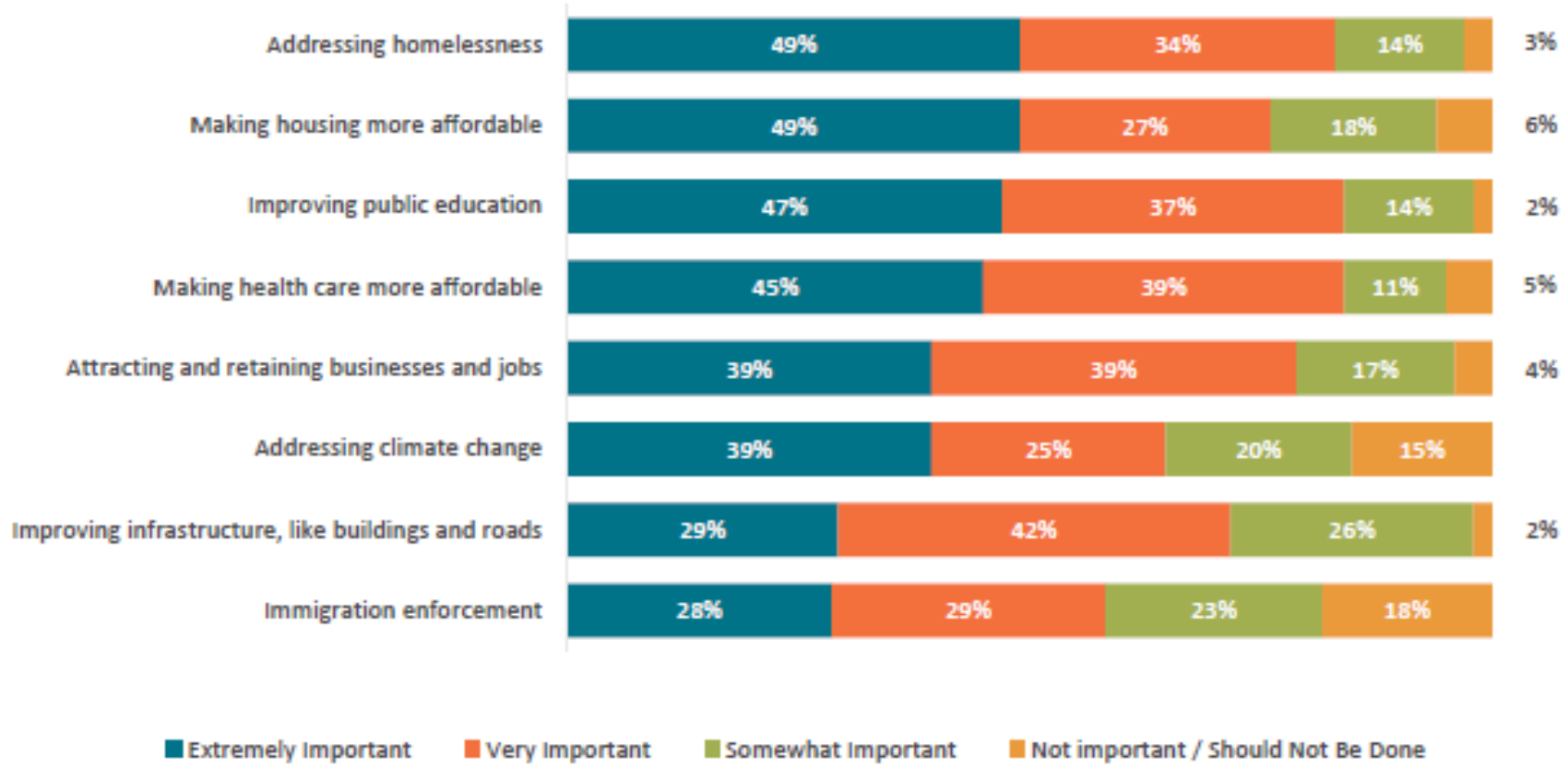
Californians Are Worried about Health Care Affordability

Figure 1. Homelessness and Affordable Housing Rank High as Priorities for Californians

Q: HOW IMPORTANT DO YOU THINK IT IS FOR CALIFORNIA'S GOVERNOR AND LEGISLATURE TO WORK ON EACH OF THESE AREAS IN 2020?



California Health Care Foundation, Health Care Priorities and Experiences of California Residents: Findings from the Health Policy Survey (Feb. 2020).

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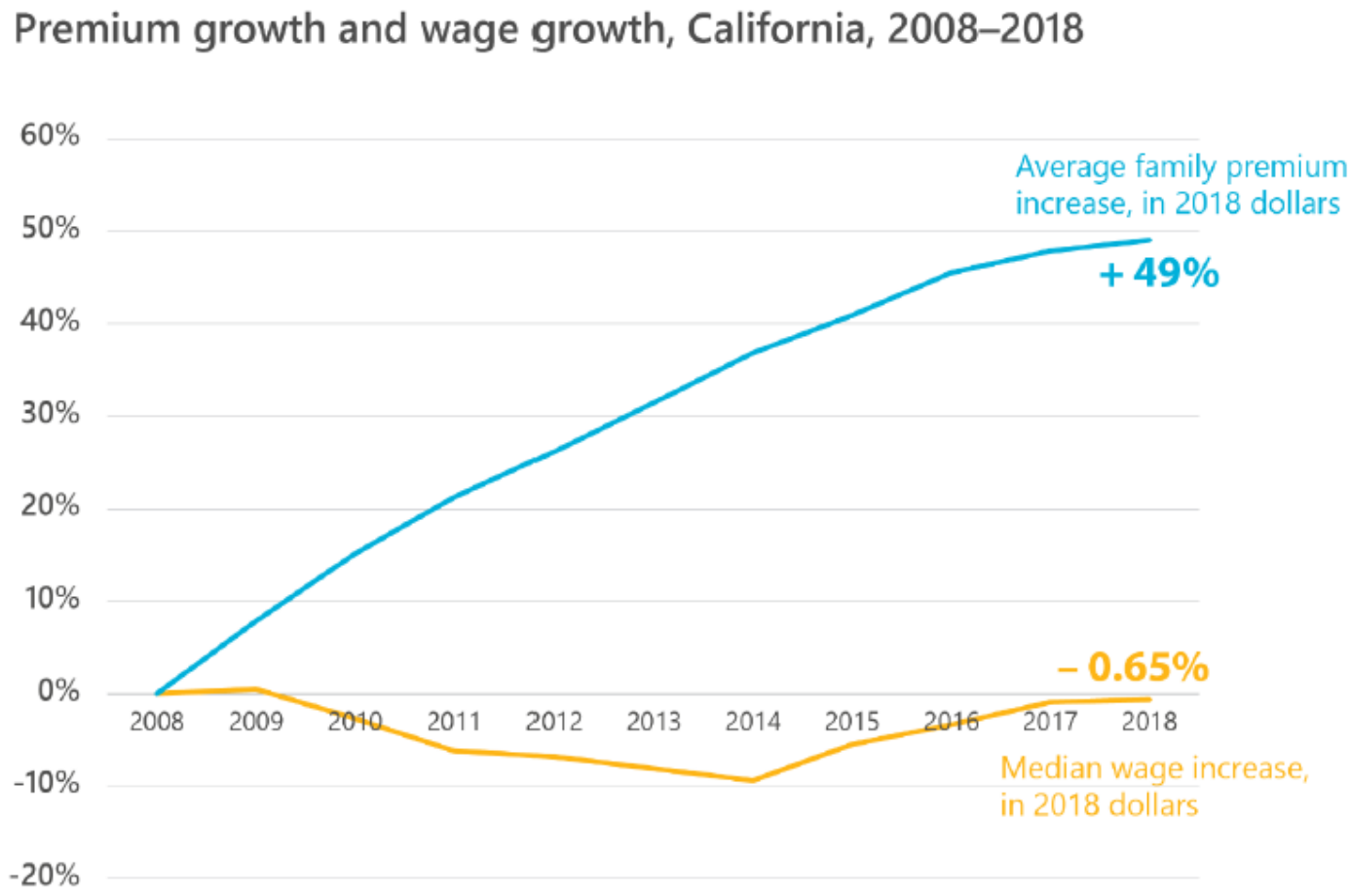
Health Care Costs Compared to Wages



Lucia, Laurel, Testimony to the Assembly Committee on Health re: Health Care Affordability: How to Control Costs in California (Oct. 27, 2020).

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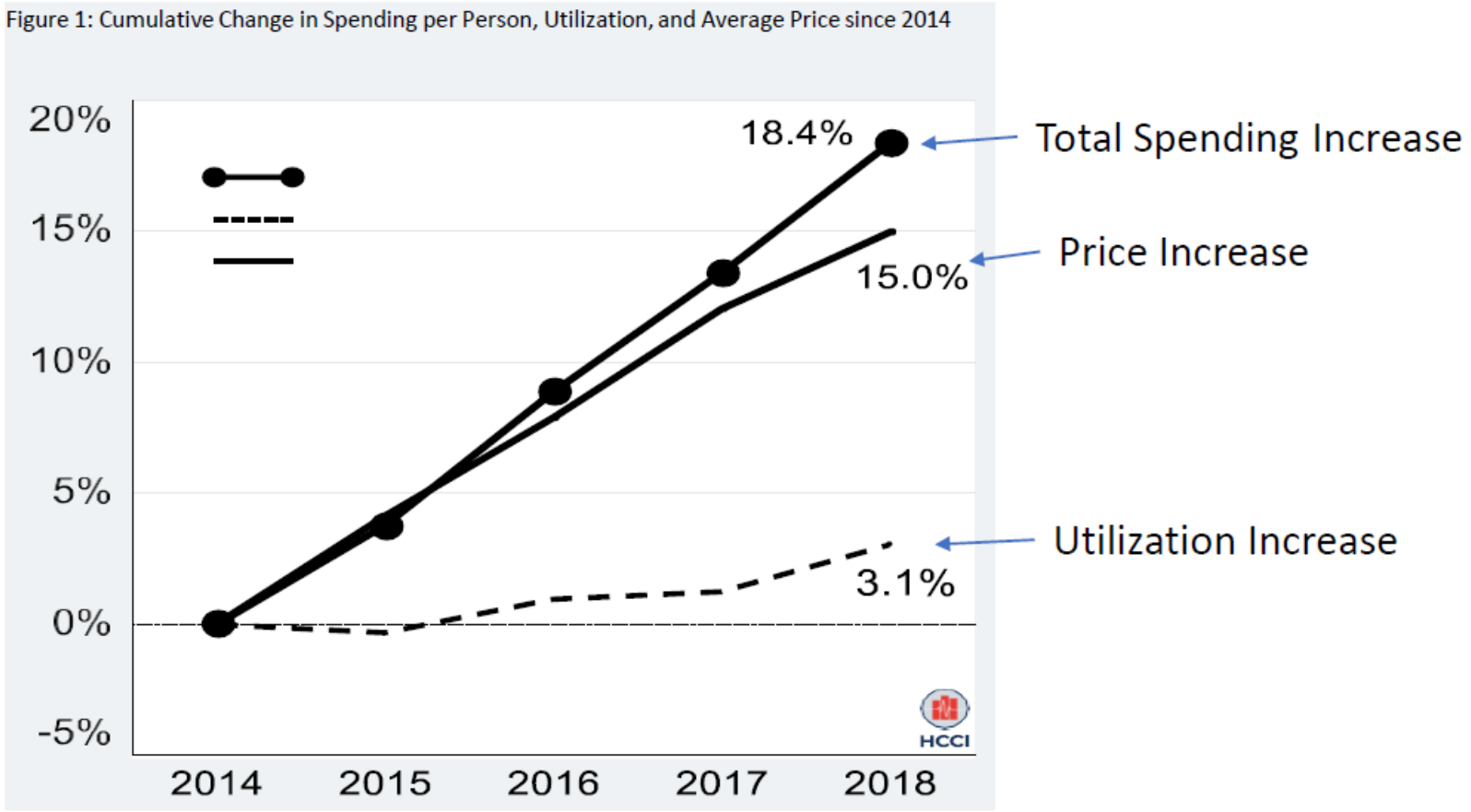
Asserted Growth Drivers



Melnick, Glenn, Testimony to the Assembly Committee on Health re: Health Care Affordability: How to Control Costs in California (Oct. 27, 2020).

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Other States Have Attempted to Constrain Growths in Health Care Costs

- Connecticut, Delaware, Massachusetts, Nevada, New Jersey, Oregon, Rhode Island and Washington have authorized state commissions to monitor and limit growth in health care spending
- Different states constrain different market segments and in different ways (e.g., hospitals only, health insurance premiums, total spending, etc.)
- Common components include: authority, governance body/administrative infrastructure, targets for cost growth, data collection, subpayer data collection, and strategies and procedures to enforce targets

Legislative Intent

- Focus on “health care that is accessible, affordable, equitable, high-quality and universal”
- Increased cost shifting to patients
- Target on high prices and market conditions (consolidation)
- Racial disparities
- Target on fee-for-service payments in favor of alternative payments
- Focus on primary care and behavioral health
- Explicit focus on high drug costs
- Protection of workforce spending

Office of Health Care Affordability

Governance and Administrative Infrastructure

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Three Bodies within HCAI

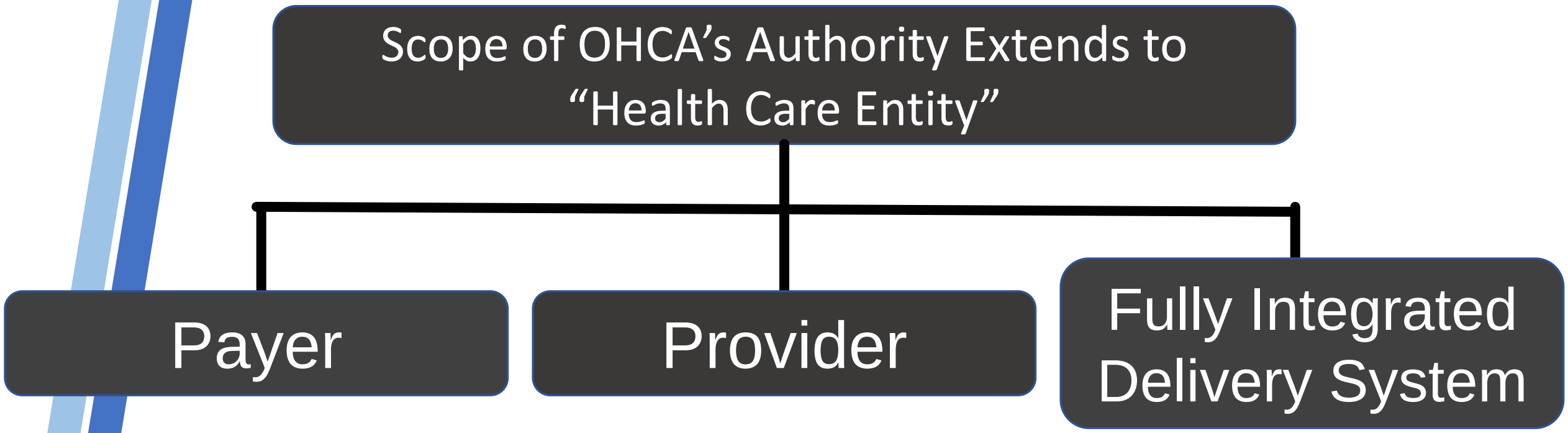
- Health Care Affordability Board
  - Political appointees (Governor with Senate confirmation (4), Senate Rules Committee (1), Speaker of the Assembly (1), Secretary of Health and Human Services/designee (1), and CalPERS (1, nonvoting))
    - Focus on areas of expertise and diversity; cannot receive financial compensation from a health care entity
  - Authorities:
    - Approves statewide health care cost target, including definition of health care sectors; define exempt providers
    - Approve scope and range of administrative penalties
    - Approve workforce stability and training standards
    - Approve primary care and behavioral health benchmarks
    - Approve goals for adoption of alternative payment models (“APMs”) and standards

Three Bodies within HCAI

- Office of Health Care Affordability
  - Develops recommendations to Board on health care targets, standards for workforce stability and training, benchmarks for primary care and behavioral health and APMs
  - Assess administrative penalties through enforcement actions
  - Review and evaluate consolidation, market power, and other market failures through cost and market impact reviews
- Health Care Affordability Advisory Committee
  - Established by the Board to advise Board and OHCA

Devil is in the Details!

- Legislation appears to have been rushed
  - Cross-references are incorrect; certain definitions don't make a lot of sense
  - A lot of deference given to the Board for definitions, e.g., health care sectors
- Outstanding questions about how broad the scope of the legislation can be
  - E.g., application to Medicare/Medicare Advantage or ERISA plans
  - Much focus on drug costs but no clear authority over drug manufacturers



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Scope of OHCA's Authority Extends to "Health Care Entity"

Payer

Provider

- ***Physician organization (see next slide)***
- *General acute care hospitals*
- *Skilled nursing facilities*
- *Ambulatory Surgical Center (ASC)*
- *Licensed or Registered Clinical Laboratory*
- *Imaging facility*

- *Clinic conducted, operated, or maintained as outpatient departments of hospitals.*
- *Medical Foundations*
- *Primary Care Clinics eligible for licensure*
- *Specialty Clinics eligible for licensure*

Fully Integrated Delivery System

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Scope of OHCA's Authority Extends to "Health Care Entity"

- Payer
- Provider
  - Physician Organization
    - *Medical foundations*
    - *Risk-bearing organizations (including those exempted under H&S section 1375.4(g)(2))*
    - *Restricted health care service plans*
    - *Limited health care service plans*
    - *Any organized group of physicians and surgeons that is comprised of 25 or more physicians*
    - *An organization of less than 25 physicians, but whose costs are substantially higher compared to the statewide average*
- Fully Integrated Delivery System

Exempt Providers

- Any physician practice not described above
- Other entities defined by Board based on factors such as annual gross and net revenues, patient volume, and high-cost outliers in a given service or geographic region

Data, Data and More Data

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Health Care Payments Data Program

- Also called an All Payer Claims Database
- Collection of administrative data from payers (e.g., claims and encounters, inclusive of medical, pharmacy, and dental services)
  - Does not require submissions from ERISA plans (15-30% of Californians), but they can voluntarily submit
- Data files, excluding dental data, for the time period from June 29, 2017 through December 2021 by 10/28/2022. [Dental data to be submitted by 10/28/2024.]
- 2022 data due 2/1/2023
- Intended to go live July 2023

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Broad Data Collection by OHCA

- To minimize reporting burdens, use Health Care Payments Data Program ("HPD") "to the greatest extent possible" and federal agency data
- Can collect any data and other information OHCA determines *necessary* from health care entities, except exempted providers
  - "[M]ay request additional data from health care entities if it finds that data is needed to effectively monitor impacts to health care workforce stability and training needs"
  - "[M]ay annually request from health care entities that are in compliance with the cost target, a summary of best practices"
- May enter into data sharing agreements with the Department of Health Care Services, the Department of Managed Health Care, the Department of Insurance, Covered California, Labor and Workforce Development Agency, and Business, Consumer Services, and Housing Agency

Specific Data Collection from Payers/Fully Integrated Delivery Systems

- Establishment of requirements for data and information submission for OHCA to –
  - Measure total health care expenditures and per capita total health care expenditures (on or before 9/1/2024 for CYs 2022 and 2023)
  - Determine whether health care entities met health care cost targets.
  - Identify the annual change in health care costs of health care entities.
  - Assess performance on quality and equity measures.
  - Measure the adoption of alternative payment models.
  - Approve and monitor implementation of performance improvement plans
  - Total health care expenditures allocated to primary care and behavioral health

Specific Data Collection from Fully Integrated Delivery Systems

- Fully integrated delivery system = “system that includes a physician organization, health facility or health system, and a nonprofit health care service plan that provides health care services to enrollees in a specific geographic region of the state through an affiliate hospital system and an exclusive contract between the nonprofit health care service plan and a single physician organization in each geographic region to provide those medical services.”
- Providers and any physician organizations part of a fully integrated delivery system *must* submit audited financial reports
  - If there is no audited financial reports, providers who are not a physician organization part of a fully integrated delivery system can submit comprehensive financial statements

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Additional Reporting

- Future submission of data by payers, fully integrated delivery systems, hospitals, and physician organizations for quality measures, TBD

Reports to Look Out For

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Reports!

- First health care spending report to be issued by OHCA for by 6/1/2025
- First annual report on health care spending trends and underlying factors for CYs 2024 and 2025 by 6/1/2027
  - Total health care expenditures, per capita health care expenditures, etc.
  - Progress towards achieving health care cost target
  - Cost trends by sector
  - Factors contributing to cost growth
  - Access, quality, and equity of care measures
  - Performance improvement plans and other administrative actions
  - Summary of best practices
- Public meetings after posting of each report, opportunity for comment

A Different Kind of Report

- Embedded is this nugget –

  “The office shall notify the relevant regulatory agency and the Attorney General if a health care entity is impacting health care workforce stability or quality jobs, lowering quality, or reducing access or equity of care.”

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Overview of Health Care Cost Target

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Health Care Cost Target

- Health Care Affordability Board charged with setting health care cost targets
  - Statewide heath care cost targets for the 2025 calendar year (by June 1, 2024), Not enforced for the first year
  - Sector health care cost targets by June 1, 2028 (presumably for 2029 calendar year)
  - Set per calendar year (based on DOS) but can set for multiple years at a time
  - Serious timing problems?
- Defined as a target percentage for the maximum annual increase in per capita total health care expenditure
- Many states have set targets at the range of 3.2-3.6%
- Anticipates risk adjustment and equity adjustment

Total Health Care Cost Expenditures

- Total health care expenditures means all health care spending in the state by public and private sources including –
  - Claims-based payments and encounters for covered health care benefits
  - Non-claims-based payments for covered health care benefits (capitation, global budget, etc.)
  - Cost sharing for covered health care benefits paid by residents of the state
  - Administrative costs and profits
  - Pharmacy rebates and any inpatient or outpatient drug costs not otherwise included

Goals of Health Care Cost Targets

- Predictable and sustainable rate of change
- Consider economic indicators (broader economy, etc.) and population-based measures (e.g., aging)
- Affordability, quality and equitable care, including consideration of impact on persons with disabilities and chronic illnesses
- Promote workforce stability, including training and development

Overarching Principles

- Data driven
- Focus on “value”
- Availability and transparency of data, methodologies and proposals
- Public reporting of performance on the health care cost targets

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Health Care Cost Target Methodology

- By Dec. 2023, Board will approve the publicly available methodology for setting cost targets and adjustment factors to modify cost targets.
- Based on historical trends, with a nod to the impact of COVID on 2020 and 2021 (but not 2022)
- Factors for future adjustments (cost index, labor costs, emerging diseases, health care technologies, payer mix, etc.)
- Consideration of provider provision of nonfederal share of Medi-Cal (IGTs, provider fees) and supplemental payment programs; special authority for DHCS to request adjustments to targets for health care entities in the Medi-Cal program
- Adjustments for “value” and for nonsupervisory workforce costs (latter based on provider/delivery system request)

Definition of Health Care Sectors

- By October 1, 2027, Board must define initial “health care sectors”
  - Can be geographic regions, or individual health care entities
    - Likely can include individual fully integrated delivery systems but not individual entities within those
  - Can change over time
  - Should minimize fragmentation and potential cost shifting
  - May consider strategies that encourage cooperation in meeting statewide and geographic region targets
  - Each entity can only fall into a single target

Targets Specific to Individual Health Care Entities

- Focus on entities considered “high-cost outlier” whose costs for the same services provided are substantially higher compared to the statewide average [reports suggest this is targeting consolidation]
- May adjust for
  - Patient mix
  - Social determinants of health and other factors related to health equity
  - Relative cost of doing business, including labor costs

Timeline for Setting Cost Targets

- Ex: Cost Target for Calendar Year 2025
  - March 1, 2024 – Board discuss proposed targets at public meeting
    - Proposed cost targets will be publicly available
  - April 14, 2024 - Minimum 45-day public comment period on proposed target
  - June 1, 2024 – Board adopts final targets at board meeting

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Other Authorities Conferred on OHCA

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Other Legislative Goals

- Standard measures for assessing health care quality and equity
  - Clinical quality but also eye toward disparities in health care
- Standards for alternative payment models
  - Established by July 1, 2024, reviewed at least every 5 years
  - Focus on encouraging multipayer participation and alignment, improving affordability, efficiency, equity and quality
  - Define APM and address “appropriate incentives to physicians and other providers”

Other Legislative Goals (cont.)

- Primary care and behavioral health investments
  - Measure baseline percentage of health care expenditures for these services and set spending benchmarks
  - Promote improved outcomes for primary care and behavioral health
  - Will need appropriate definitions
- Health care workforce stability
  - Monitor health care workforce stability, including wages and benefits and the professional judgment of health professionals
  - Standards to advance stability of health care workforce by July 2024

Review of Agreement and Transactions Involving “Material Change”

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Requirement of Notification to OHCA

- Must report transactions that trigger a “material change” at least 90 days before “entering” the transaction
- Applicable to agreements or transactions that will “occur” on or after April 1, 2024
- Different definitions of “material change” in the legislation
  - “any change in ownership, operations, or governance for a heath care entity, involving a material amount of assets of a health care entity”
  - Or could mean a heath care entity transaction that does either of the following:
    - Sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of the entity’s assets to one or more entities
    - Transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities

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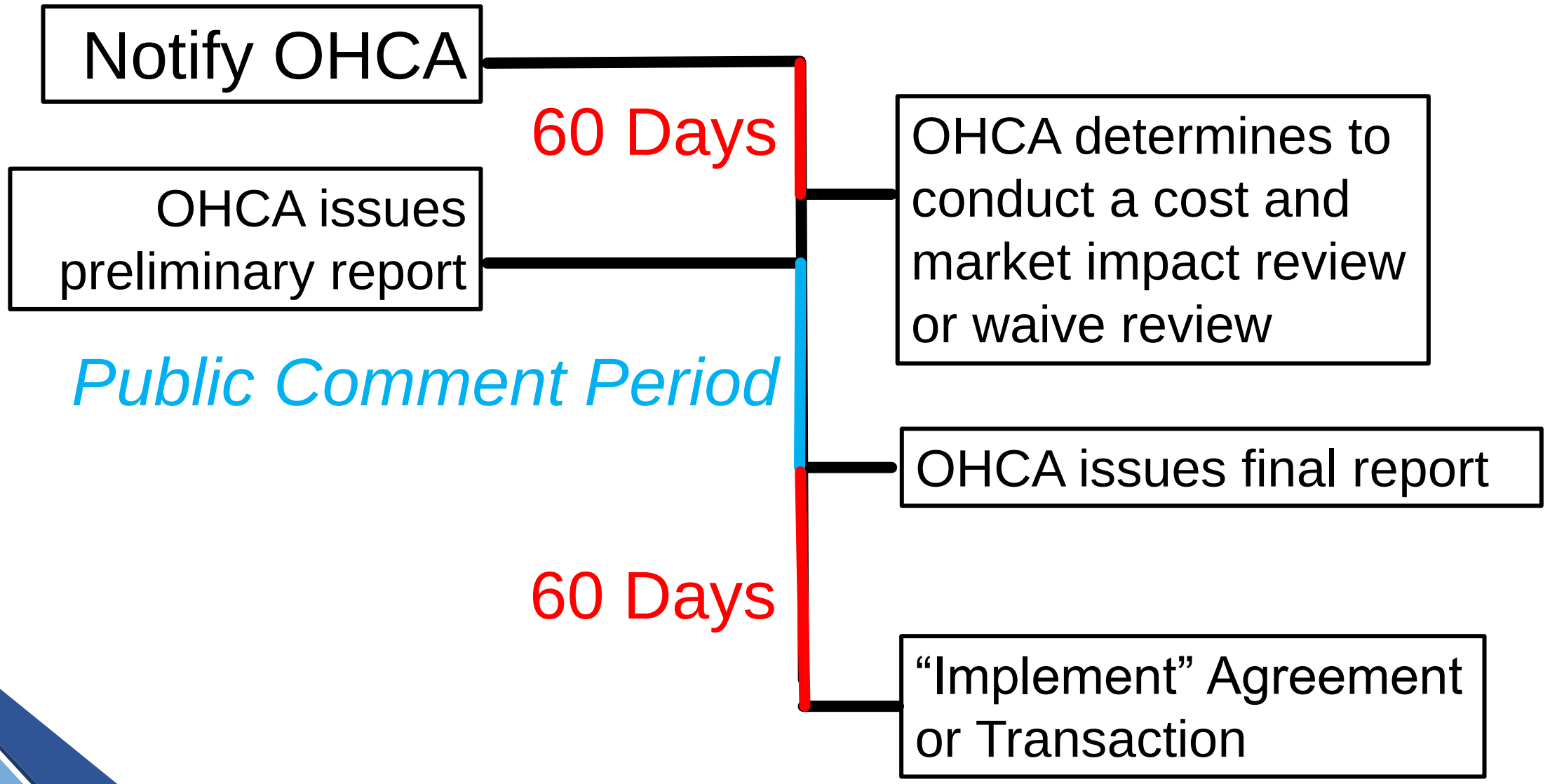
Cost and Market Impact Review



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Factors for Cost and Market Impact Review

- Changes in size and market share in a given service or geographic region
- Prices for services compared to other providers for the same services
- Changes in equity
- Higher quality
- Increased access to care
- More efficient health care services
- Any other factors the OHCA determines to be in the public interest.

Cost and Market Impact Review

- OHCA can subpoena relevant market participants to submit data and documents.
- OHCA may refer its findings and documents to the Attorney General
- Further regulations on:
  - Notification to affected parties for the basis of the review,
  - Factors considered in the review,
  - Requests for data and information from affected parties, the public, and other relevant market participants, and
  - Relevant timelines
- Director of HCAI can also require cost and market impact reviews to be performed on any entity based on adverse impacts of cost, access, quality, equity, or workforce stability from consolidation

Exemptions to Notification

- Notice is not required if DMHC, Insurance Commissioner, or Attorney General reviews the agreement or transaction
  - However, these agencies may request a cost and market impact review from OHCA
- Notice is not required when county is purchasing, acquiring, or taking control, responsibility, or governance of an entity to ensure continued access in that county (*see, e.g.* Santa Clara County)

Enforcement Actions

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Overarching Goals

- Compliance with targets
- Allows remediation
- Protect access, quality, equity, and workforce stability
- Focus on “progressive enforcement”, which could be defined as an “escalating series of actions that allows for the efficient and effective use of enforcement resources to: (1) assist cooperative [violators] in achieving compliance; (2) compel compliance for repeat violations and recalcitrant violators; and (3) provide a disincentive for noncompliance”

Progressive Enforcement of Cost Target

(starting calendar year 2026)

1. Provide technical assistance to the entity

2. Require or compel public testimony by the entity

3. Implement performance improvement plans (“PIP”) for up to three years

4. Assess and escalate administrative penalties

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Performance Improvement Plans

- Up to three years
- Standards to “advance the stability of the health care workforce” may be used for PIPs
- OHCA cannot implement PIPs that “likely … erode access, quality, equity, or workforce stability.”

Cost Target Administrative Penalties

- If entity violates PIP and does not meet the cost target, may trigger cost penalties (presumes that administrative penalty conditioned on prior PIP)
  - Also enforce administrative cost and profit targets against payers and fully integrated delivery systems
- No penalty if entity “fully complied” with PIP by OHCA’s deadline
- Board will set range of administrative penalties and the penalty justification factors, e.g., nature, number and gravity of offenses, fiscal condition of entity, and market impact of entity
- No legislative limit to administrative penalties, but excessive penalties can trigger due process concerns, especially if provider does not have a real way of avoiding penalties (e.g., timing problems)
- Special “consideration” with re: Medi-Cal expenditures in coordination with DHCS
- Not expenditures for purpose of meeting cost targets (but from provider perspective, how else can it make money to pay penalties?

Other Administrative Penalties

- Grounds
  - Willfully failing to report complete and accurate data
  - Repeatedly neglecting to file performance improvement plan or acceptable performance improvement plan
  - Repeatedly failing to implement performance improvement plan
  - Knowingly failing to provide information required by OHCA to enforce the cost target
  - Knowingly falsifying information required for OHCA to enforce the cost target
- Public meeting to notify public about violation and “declare the entity as imperiling the state’s ability to monitor and control health care cost growth”

Procedural Protections

- Notification that entity exceeded cost target
- Give entity at least 45 days to respond and provide additional data
- Potential modification of findings based on additional data
- Potential for waiver based on reasonable factors outside the entity's control (changes in law, anticipated costs for investments and initiatives to minimize future costly care, extraordinary circumstances, etc.)

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Appeals and Judicial Review

- Presumes an administrative hearing for administrative penalties; may not meet constitutional requirement for legislative authorization for an appeal process
  - Really needs clarification whether these can go directly to court
- After formal appeal, entity can seek independent judicial review of administrative penalty by filing a petition for a writ of mandate (time limit a bit unclear, probably safe within 30 days)
- If not appealed, OHCA can go to the clerk of the court for a judgment on the administrative penalty

Questions?

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Thank You!

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