OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Board Meeting

November 20, 2024

HCAI

Department of Health Care Access and Information

OHCA

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Welcome, Call to Order, and Roll Call

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Agenda

Item #1 **Welcome, Call to Order, and Roll Call**
Elizabeth Landsberg, Director

Item #2 **Executive Updates**
Elizabeth Landsberg; Vishaal Pegany, Deputy Director

Item #3 **Action Consent Item**
Vishaal Pegany

a) Vote to Approve October 14, 2024 Meeting Minutes

Item #4 **Action Items**
Elizabeth Landsberg

a) Vote to Elect Health Care Affordability Board Chair

Item #5 **Informational Items**
Vishaal Pegany; Margareta Brandt, Assistant Deputy Director; CJ Howard, Assistant Deputy Director; Janna King, Health Equity and Quality Performance Group Manager; Mary Jo Condon and Sarah Lindberg, Freedman Health Care; Debbie Lindes, Health Care Delivery System Group Manager

a) Cost-Reducing Strategies -- AltaMed
b) Updates to Data Submission Guide to Add Alternative Payment Model Arrangements and Primary Care Spending Data Collection, Including Advisory Committee Feedback
c) Introduce Quality and Equity Measure Set Proposal, Including Advisory Committee Feedback
d) Provisional Approach to Hospital Spending Measurement
e) Sector Targets
f) Introduce Behavioral Health Definition and Investment Benchmark, Including Advisory Committee Feedback

Item #6 **Public Comment**

Item #7 **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

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Premium Increases Persist in 2024

- In the November 2024 issue of Health Affairs, researchers presented findings from the 26th annual Kaiser Family Foundation (KFF) Employer Health Benefits survey.

- The researchers surveyed approximately 25,000 employers. The benefit managers were presented questions related to premiums and deductibles for the top two plan offerings that enrolled the largest percentage of employees.

- 84% of employees were enrolled in the largest plan type offered by their employer and 99% of employees were enrolled in the top two plan offerings.

- Plan designs were broken down into four specific plan types: (1) Health maintenance organizations (HMOs), (2) Preferred Provider Organizations (PPOs), (3) Point-of-Service Plans (POS), and (4) High Deductible Health Plans with a Savings Option (HDHP/SOs).

- The Kaiser Family Foundation defined small employers as those with 3-199 employees, and large employers that employed more than 200 workers; the researchers further categorized employers with “many lower wage workers” as those in which at least 35% of employees had earnings of less than $35,000 per year.

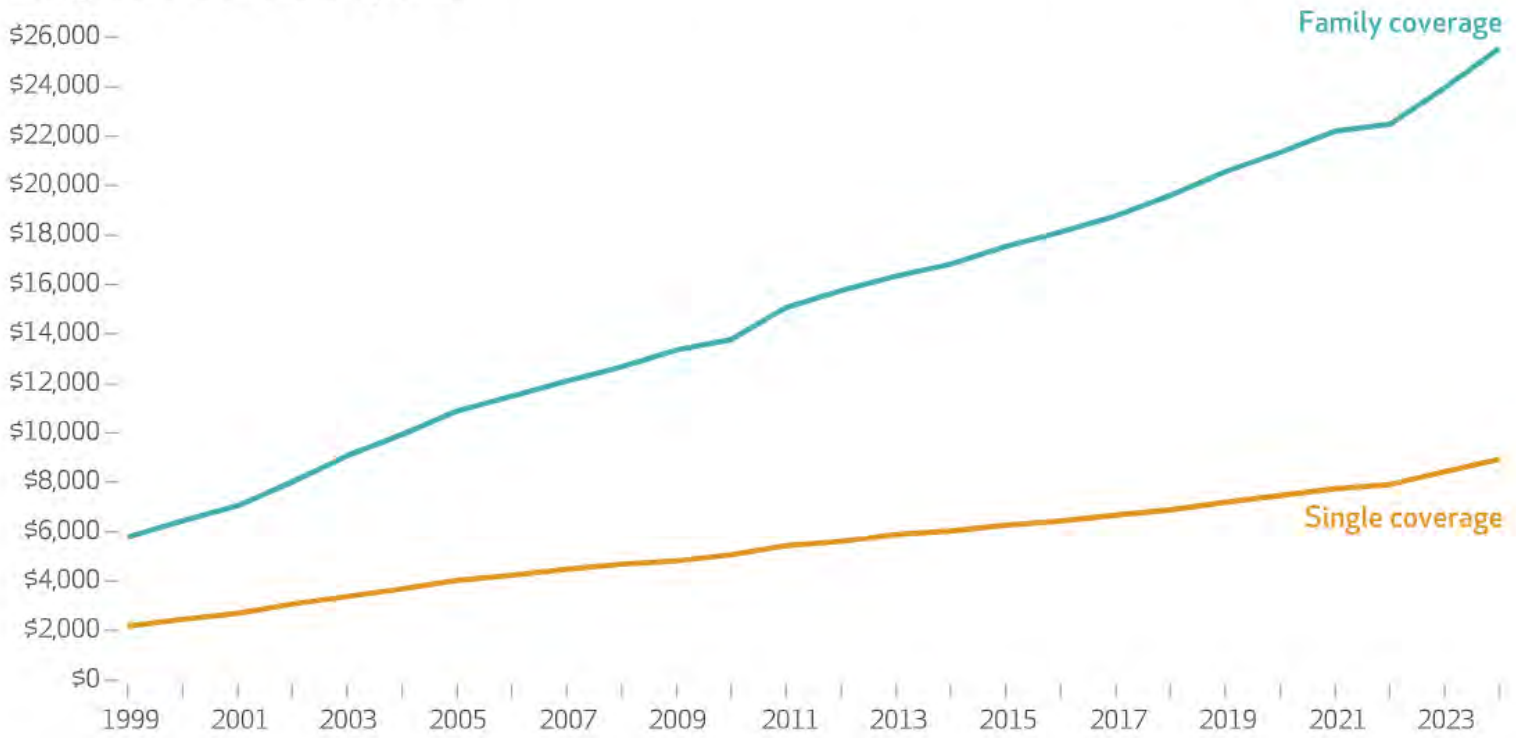
Claxton, G., Rae, M., Damico, A., Winger, A., & Wager, E. (2024). Health benefits in 2024: Higher premiums persist, employer strategies for GLP-1 coverage and family-building benefits. *Health Affairs*, *43*(11), 1491–1501. https://doi.org/10.1377/hlthaff.2024.01006

Premium Increases Persist in 2024

- Exhibit 1 shows family coverage increased at a higher rate than for single coverage (self-only).
- In 2024, the average annual premium for employer sponsored insurance was $8,951 for single coverage and $25,572 for family coverage.

EXHIBIT 1

Average annual employer-sponsored health insurance premiums for single and family coverage, 1999–2024



SOURCES KFF Employer Health Benefits Survey, 2018–24; and Kaiser/Health Research and Educational Trust Survey of Employer-Sponsored Health Benefits, 1999–2017. **NOTES** All estimates except for single coverage (2009, 2014, 2016, and 2022) and family coverage (2022) are significantly different from the estimate for the previous year ($p < 0.05$). The estimates for 1999 were not tested.

Claxton, G., Rae, M., Damico, A., Winger, A., & Wager, E. (2024). Health benefits in 2024: Higher premiums persist, employer strategies for GLP-1 coverage and family-building benefits. *Health Affairs*, *43*(11), 1491–1501. https://doi.org/10.1377/hlthaff.2024.01006

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Premium Increases Persist in 2024

Premiums

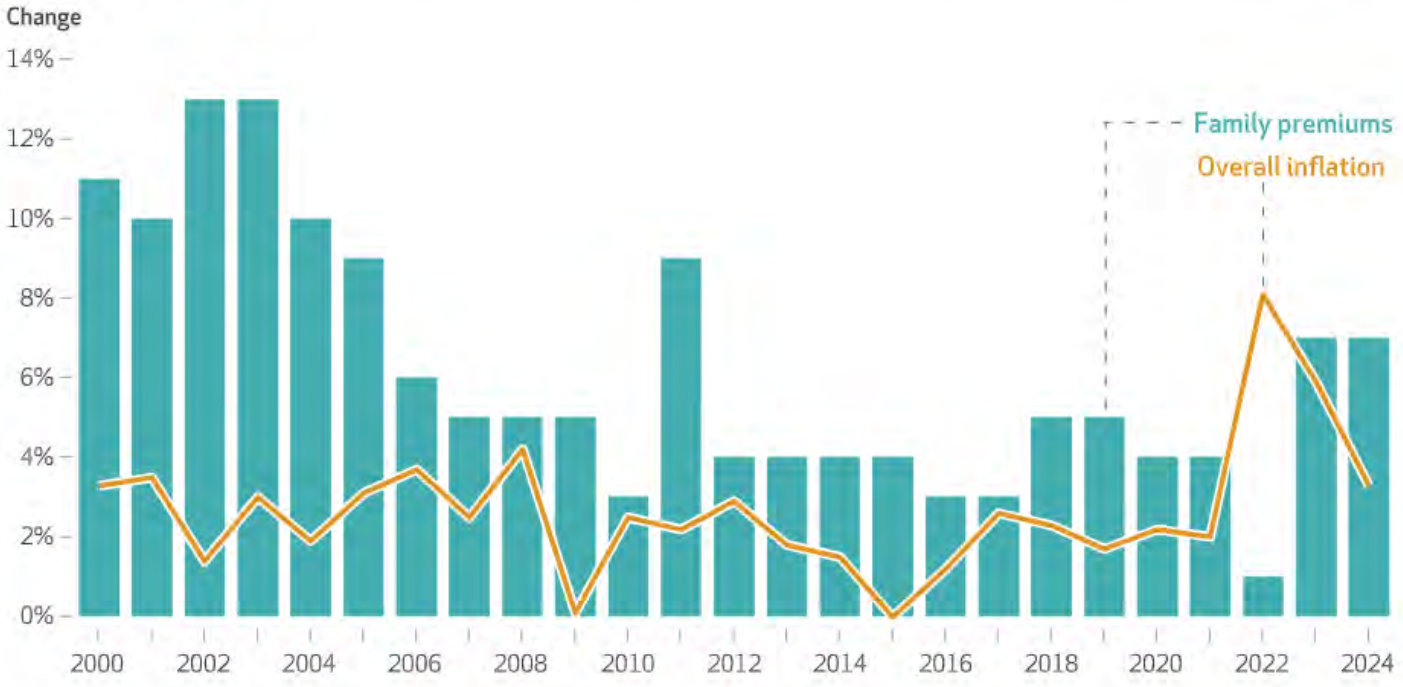
- In the past 5 years, the average premium for family coverage has risen from $20,576 to $25,572, a 24% increase.
- The rate of premium increase over this same 5-year period is slightly higher than inflation at 23% and slightly lower than wage growth at 28% (data not shown).

Deductibles

- In 2024, 87% of covered workers were enrolled in a plan with a general annual deductible for single coverage and 32% of covered workers were enrolled in a plan with a deductible of $2,000 or more.
- The average deductible for single coverage was $2,575 for small employers and $1,538 for large employers.

EXHIBIT 2

Average annual change in employer-sponsored health insurance premiums for family coverage compared to the rate of inflation, 1999–2024



SOURCES KFF Employer Health Benefits Survey, 2018–24; Kaiser/Health Research and Educational Trust Survey of Employer-Sponsored Health Benefits, 1999–2017; and Bureau of Labor Statistics, Consumer Price Index, U.S. city average of annual inflation, 1999–2024. **NOTES** Each bar represents the percent change in premiums from the previous year (for example, the bar for 2000 represents the change from 1999 to 2000). Percent changes in family premiums are significantly different from the estimate for the previous year in 2004, 2006, 2011, 2012, and 2023 ($p < 0.05$).

Claxton, G., Rae, M., Damico, A., Winger, A., & Wager, E. (2024). Health benefits in 2024: Higher premiums persist, employer strategies for GLP-1 coverage and family-building benefits. *Health Affairs*, *43*(11), 1491–1501. https://doi.org/10.1377/hlthaff.2024.01006

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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Public Comment

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Action Consent Item: Vote to Approve October 14, 2024 Meeting Minutes

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Informational Items

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Cost-Reducing Strategies: AltaMed

Margareta Brandt, Assistant Deputy Director

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Seeking Additional Examples of Cost-Reducing Strategies

- OHCA is working with health plans, hospitals, and physician organizations to highlight examples of cost-reducing strategies – efforts to reduce cost while improving or maintaining quality – that have demonstrated results.

- OHCA is seeking additional examples of cost-reducing strategies. Examples might include a program that addresses a specific population, implementation of best practices for more efficient resource use, or an effort to increase care coordination, etc. Contact OHCA at ohca@hcai.ca.gov if you would like to propose a cost-reducing strategy for consideration.

Advancing High Value System Performance to Eliminate Disparities

Efrain Talamantes, MD, MBA, MSc,

SVP & COO, Health Services

AltaMed

OBJECTIVES

Overview

- History, Vision, Mission, Values & Strategy
- Our Services & Commitment to Health Equity

Our Journey to Value-Based Care: Progress & Lessons Learned

- AltaMed Viva Gold Senior Care & Enhanced Care Management (ECM)
- AltaMed Workforce & Pipelines

Next Steps

- Value-Based Care (VBC) Opportunities & Challenges
- Value-Based Care (VBC) Horizon

FOUNDED IN EAST LOS ANGELES IN 1969

From a volunteer-staffed storefront clinic…

…Today, We are the largest independent Federally Qualified Community Health Center in the U.S.

MISSION, VISION, VALUES, STRATEGY

Mission

To eliminate disparities in health care access and outcomes by providing superior quality health and human services through an integrated world-class service delivery system for Latino, multi-ethnic and underserved communities in Southern California.

Vision

To be the leading community-based provider of quality health care and human services.

Core Values

- Patients always come first.
- Employees are our most valuable asset.
- Encourage process excellence and innovation for quality outcomes.
- Promote wellness and advocate for strong and healthy communities.
- Integrity, honesty and respect in all of our endeavors.
- Commitment to teamwork.

Strategy

By 2030, AltaMed Health Services and its affiliates will reach the 90th percentile for all Medi-Cal priority HEDIS measures and achieve a 4.5-star rating in national Medicare benchmarks. AltaMed will grow to care for more than 500K full risk members and increase its geographic footprint in Southern California.

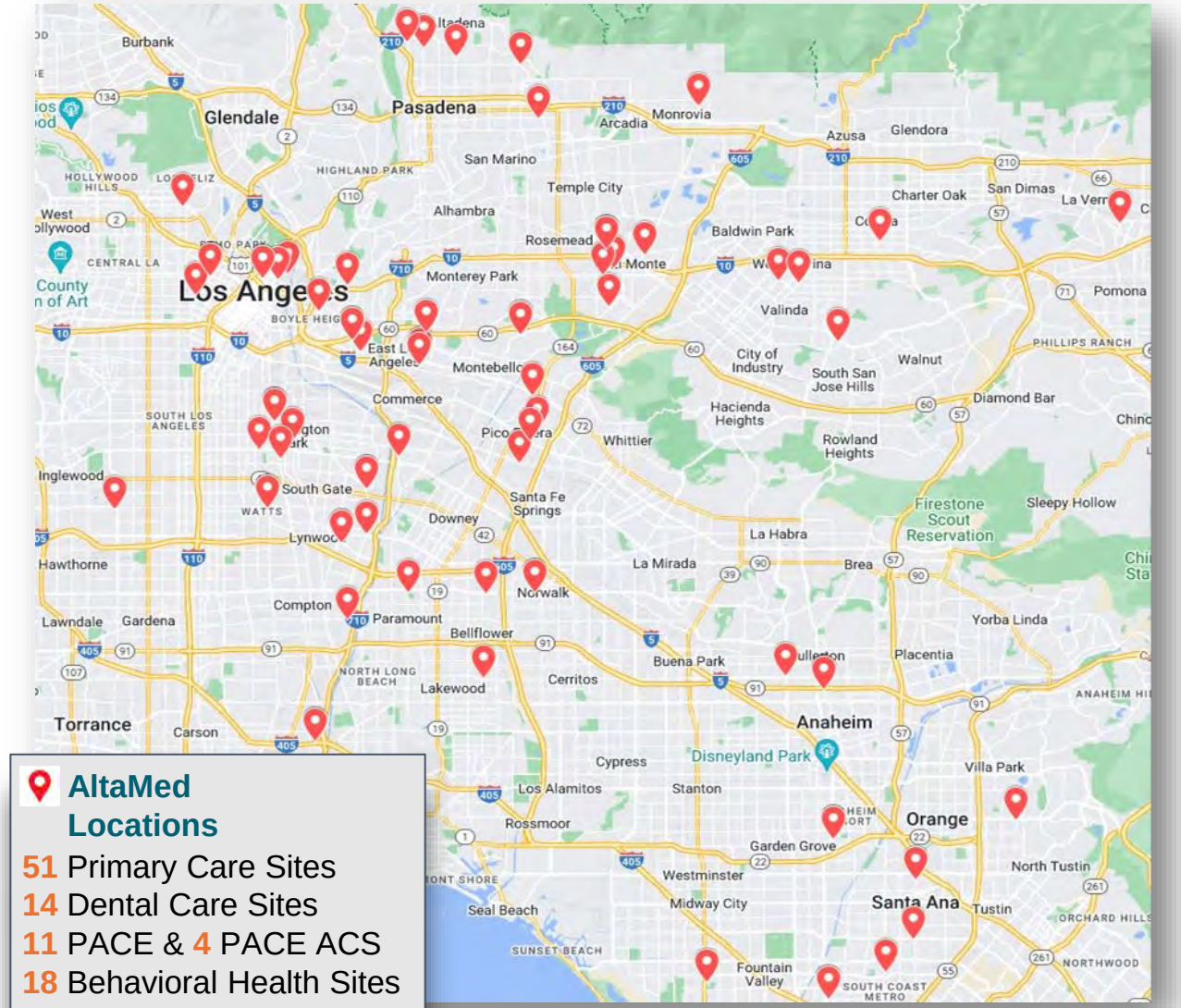
FAST FACTS: LARGEST INDEPENDENT FQHC IN THE U.S.

5,200 employees working across
67+ sites in Southern California
500K patients served annually
2.89M annual in-clinic & virtual visits

Our providers and employees reflect the communities we serve in both culture and language.

Who We Serve

84% Medi-Cal
74% Hispanic/Latinos
40% Language Other than English
62% Spanish Language Preference
50% Below Federal Poverty Level
0.937 Social Vulnerability Index
0.87 Housing Stability Score



AltaMed Locations
51 Primary Care Sites
14 Dental Care Sites
11 PACE & **4** PACE ACS
18 Behavioral Health Sites
13 Retail Pharmacies
4 HIV Services Sites

OUR HEALTH SERVICES

Primary Care
- Urgent Care
- Senior Care
- Women's Health
- Pediatrics
- Family Medicine
- Radiology Services

Dental Care & Oral Health
- Preventive & Restorative Services
- Extractions
- Exams & X-Rays
- 5 Mobile vans
- 6 Oral Health Units

Mobile Health Clinics
- 4 Mobile Health
- 6 Mobile Dental

Hospitalist/Transitions of Care/ Clinician Home Visit Program
- Clinical teams serving more chronically ill patients in the hospital / home / street

Infectious Disease & HIV Services
- Hepatitis C Treatment
- HIV Prevention and Testing
- Mental Health, Case Management

Pharmacy Services
- Online refills and text reminders
- Same day delivery

Behavioral Health
- Individual Psychosocial Therapy

Onsite Specialty Care
- *Pediatric:* Neurology, Urology, Dermatology, Gastroenterology, Orthopedics, Ophthalmology, Allergy/Immunology, Cardiology
- *Adult:* Psychiatry, Podiatry, Dermatology, Sports Medicine, Cardiology, Maternal Fetal Medicine, Urogynecology, Palliative Care

Health Equity
- Research/Evaluation & Medical Education
- Pipeline & Workforce
- Youth Services Linkages to Care
- Adolescent Family Life Program
- Certified Parenting Classes/ Family Planning

Program of All-Inclusive Care for the Elderly (PACE)
- Largest PACE provider in CA
- Full Service PACE Sites- 9
- Alternative Care Settings (ACS)- 4

ALTAMED & AFFILIATED COMPANIES

Infrastructure to Support Value-Based Care

- Largest independent FQHC in the U.S, IPA, MSO, RKK, Foundation
- Full and shared risk value-based care across multiple businesses
- Diverse portfolio, including Medi-Cal, Medicare, Dual-Eligibles, Managed Care, Commercial, HIV, Behavioral Health, Dental, Pharmacy, and PACE

VALUE-BASED CARE: THROUGH THEIR EYES

Our Patients

Excellence in patient care, medical knowledge, diagnosis, outcomes throughout care continuum

Our Teams

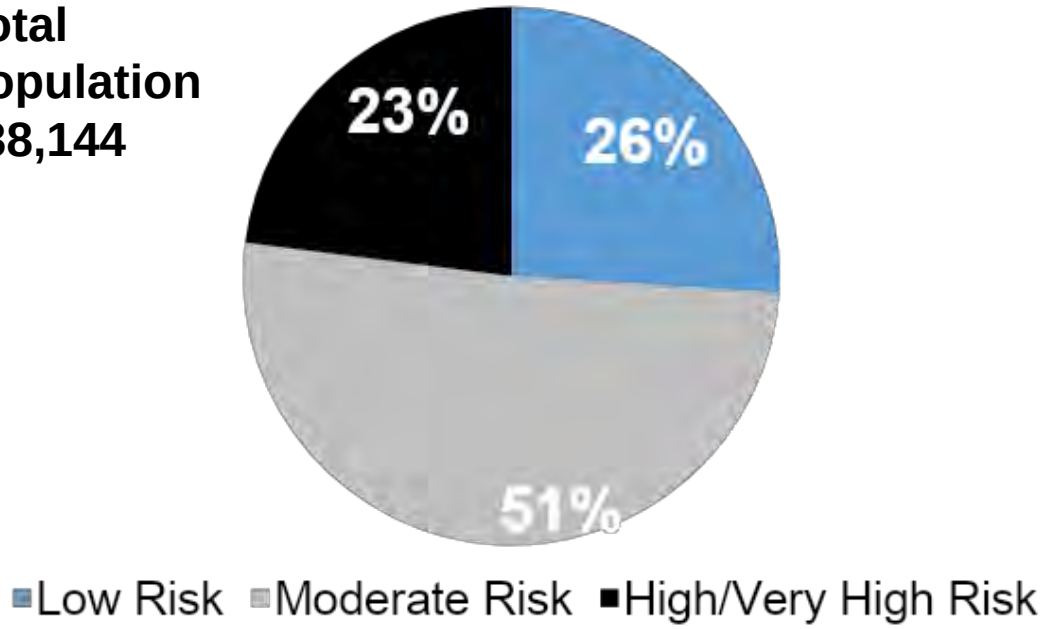
Strong relationship with leadership, peers, and multi-disciplinary teams to achieve maximum scope of practice

Our Physicians

Practice evidence-based high-quality care to improve health, making a greater impact

ALTAMED PATIENT RISK STRATIFICATION

Total Population 338,144



Utilization	Implications for VBC
• Emergency Department Utilization*	• 54.5% of all ED Visits are from High/Very High Risk

High/Very High Risk (N=77,774)

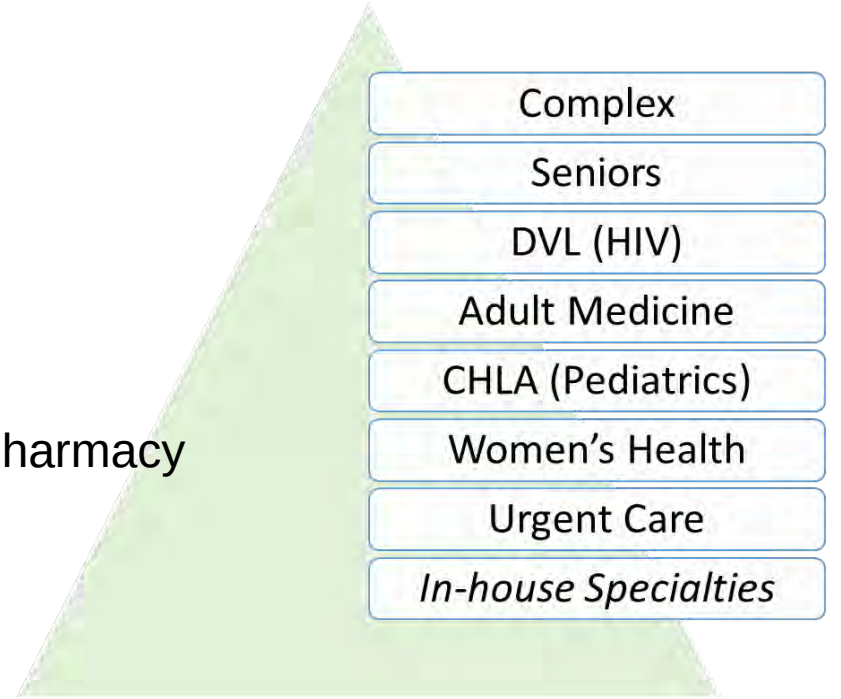
Top Diagnoses	Utilization	
	High	Very High
Chronic renal failure	2042	3496
Disorders of the immune system	2249	2332
Congestive heart failure	915	1941
Chronic ulcer of the skin	559	1335
Complications of mechanical devices	543	990
AIDS and or HIV complications	771	739
Cardiomyopathy	487	881
Spinal cord injury/disorders	551	785
Autoimmune / connective tissue diseases	756	553
Hepatitis C	298	593

Data Sources:
*ACG Dashboard

ALTAMED VALUE-BASED CARE CONTINUUM

Global Risk Patients and Complex Clinical & Social Care Needs

- Medical Management (Altura MSO/AHN)
- Hospitalists
- Transitions of Care
- Clinician Home Visitation Program
- Urgent Care / 24/7 Virtual Care Access
- Behavioral Health / Psychiatry
- Diabetes Chronic Disease Management Clinic / Clinical Pharmacy
- Complex Care / Enhanced Care Management
- In-house Specialties

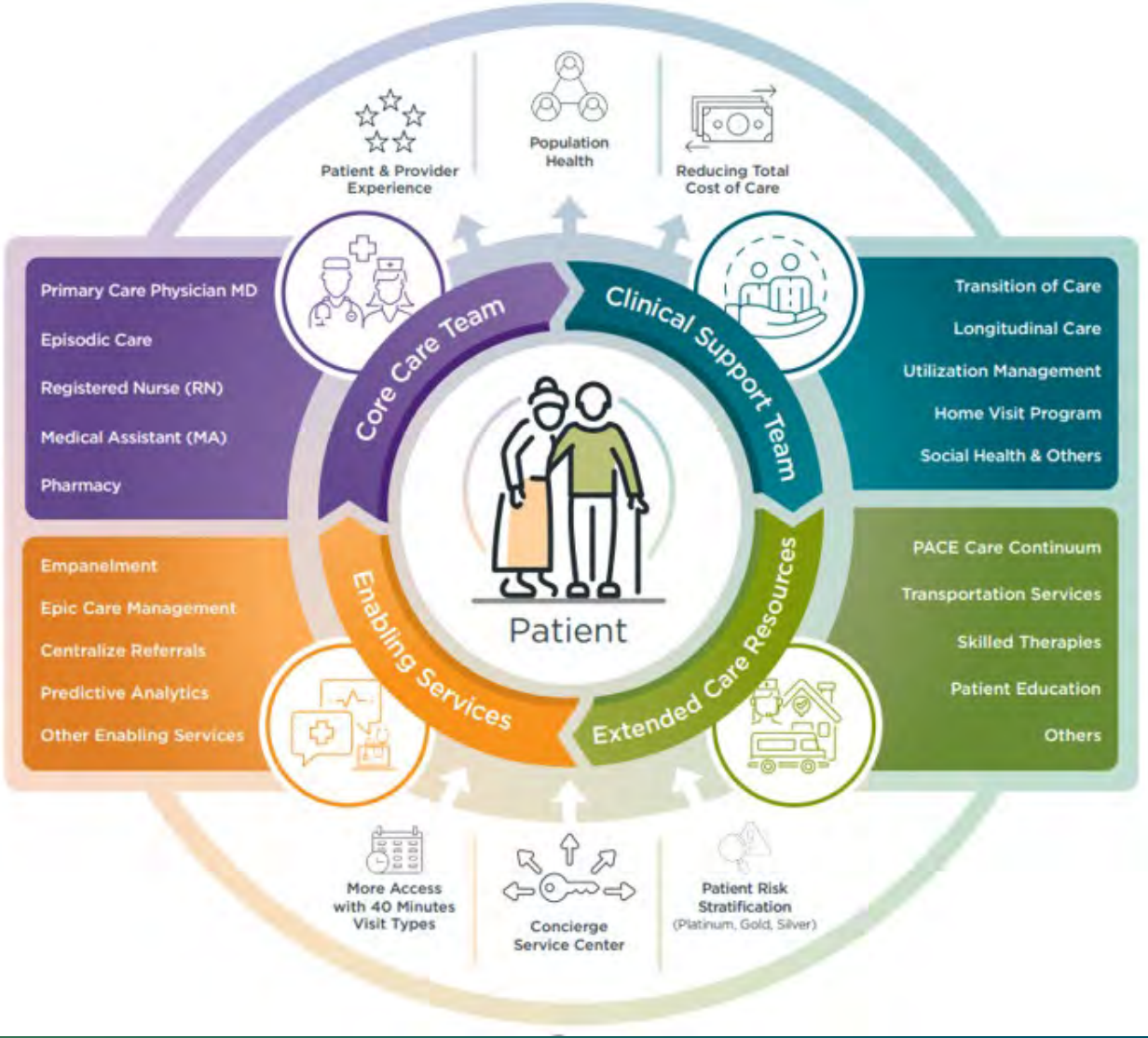


Enhanced Coordination of Care	Coordination & Referral to Community & Social Services	Comprehensive Transition Care	Health Promotion

ALTAMED VIVA GOLD SENIOR CARE MODEL

Expanded Care Team

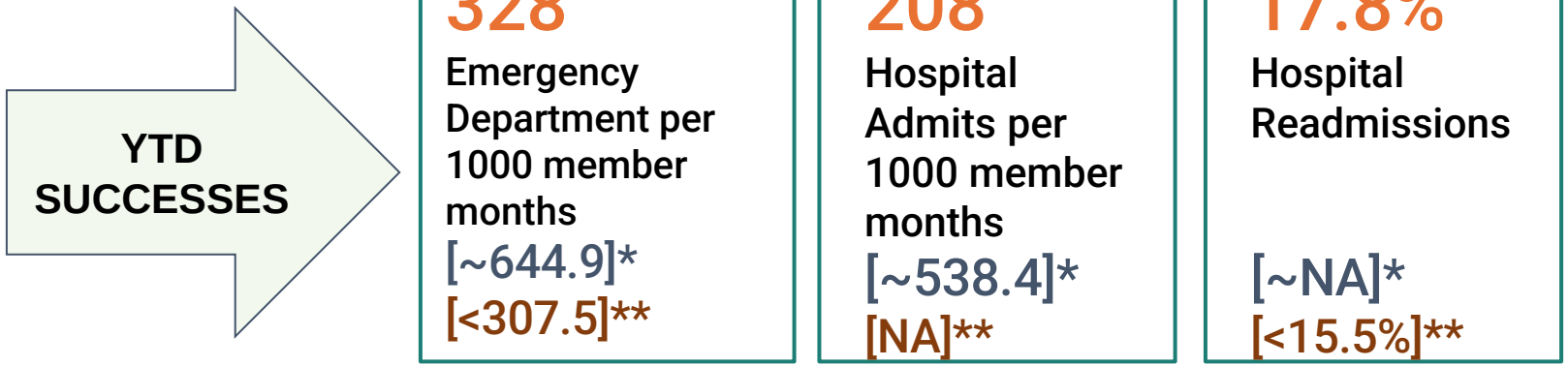
- Concierge Service
- Each Care Team cares for 900 patients
  - 1 Team Physician
  - 1 Advance Practice Provider
  - 2 Provider Partners (MA or LVN)
  - Care Manager RN



ALTAMED VIVA GOLD SENIOR CARE RESULTS

Performance

- As of 11/1/24: Total Members 2,074 out of 18,806 Medicare lives (>53% Duals)
- 74% of members completed their Medicare Health Assessment
- Recognition for Excellence in Dementia Care by the Healthy Brain LA Coalition



Lessons Learned & Scalability

- PCP – Patient bonding are difficult to overcome, but possible over time
- Hospital and Specialty Contracting require different approaches

*DHCS Managed Care Performance Monitoring Dashboard Data, April 2024, Data from Dual Members Jul 2023 – Jun 2024, 12 mo average rate in member months **National Medicare Benchmark for 2024

ENHANCED CARE MANAGEMENT RESULTS

Performance

- As of 11/1/24: 972 out of 1,092 enrolled members
- In 2023: 433 unique patients receiving enhanced care management
- ~3.8X PCP visits per year compared to 2.4X for non ECM eligible members
- Reduced ER visits in the first 3 months of enrollment

YTD SUCCESSES

40% DECREASE
Emergency Department Utilization

35% DECREASE
Hospital Admissions

28% DECREASE
Hospital Readmissions

5 out of 7
Quality HEDIS measures exceeded

Lessons Learned & Scalability

- Turnover due to Community Health Worker capacity, health plan pausing enrollment
- Opportunity for increased enrollment into ECM

WORKFORCE & PIPELINES TO ADDRESS PROVIDER SHORTAGE

AltaMed Institute for Health Equity

Established in 2017, the AltaMed Institute for Health Equity is our incubator for research & evaluation, medical and clinical education in underserved communities

Institute Initiatives

Undergrad, Graduate & Continuing Medical Education

- **Site Medical University**
- Nursing University
- AltaMed Family Medicine Residency Program
- Nurse Practitioner Fellowship
- Sports Medicine Fellowship
- Community Medicine Fellowship
- CHLA Pediatric Residency Rotations
- USC FM Residency Rotations
- White Memorial FM Residency Rotation
- AB 1045- Licensed Physicians from Mexico Program
- UCLA, UCI, USC, CDU
- National Medical Fellowships

School of Nursing Collaborative

- Certified Nursing Assistant (CNA) Program
- Licensed Vocational Nurse (LVN) Program
- LVN to Associates Degree Nursing (ADN) Program
- ADN to Bachelors Science Nursing (BSN) Program
- Bachelors Science Nursing (BSN) Leadership Program
- Phlebotomy Skills Training Program

Clinical Training Programs

- USC Pediatric Dentistry Fellowship
- Masters of Public Health (MPH) Field Study Program
- Masters of Social Work (MSW) Field Study Program
- Associate Clinical Social Worker (ACSW) Program

PHYSICIAN LEADERSHIP AND PROVIDER RETENTION

Training Our Own Leaders: Site Medical Director University Successes

See appendix for AltaMed provider demographics

Performance

- **Savings: $>1-1.5M per provider leader.** Savings based on projected loss of visits, recruitment fees, onboarding, and leadership development investments
- **Investment: $>5 per day per SMDU leader** based on associated costs of the program.
- **Retention/Leadership Growth: 100% retention and several have been promoted into key executive leadership roles.** SMDU survey shows SMDs plan to continue working at AltaMed for 3+ years in the future.
- **Access:** Supports retention and recruitment of culturally and linguistically concordant physician leaders

Lessons Learned & Scalability

- Retention rate for Medical Director leadership increased from 30% to 100% after 3 years of SMDU implementation.
- SMDU:
  - **Race Ethnicity:** 32% of Medical Directors identify as Latino, 23% Asian, 3% Black or AA, 3% Pacific Islander,10% White, and 29% did not respond or other.
  - **Gender**: 35% of Medical Directors identify as Female, versus 58% as Male, and 7% as other.
- Physicians' leadership development is critical to be successful in VBC transformation: clinical care, access, revenue, and VBC health outcomes.

VALUE-BASED CARE: OPPORTUNITIES & CHALLENGES

Risk

AltaMed is leveraging its successful track record in VBC, however taking full risk across its entire patient population and a growing population poses greater challenges.

Opportunities

- Focus on VBC care models that are proactive about provider and patient engagement
- Manage growing volume in more efficient and effective ways
- Medi-Cal Enrollment/ Membership Retention
- PCP Continuity of Care
- Support transitions of care between Hospital, Specialty, Primary Care, and Ancillary Services.
- Re-design care teams, existing roles, and develop roles that align with VBC goals
- Integrated Care Management
- Invest in provider leadership and address provider shortage

ALTAMED VALUE-BASED CARE HORIZON

Short Term (6 months)	Midterm (7-24 months)	Long Term (2026 +)

• VBC Leadership and Clinical Committee
• Population health analysis & segmentation with targeted interventions
• Integrate metrics and analysis for systems (PCP Continuity of Care, High-risk Programs, Specialty & Hospital)
• Re-design care teams: patient service-advocates, nursing, pre-visit planning/huddling
	• Leverage Physician, RNs and NPs – working at top of license – with focus on high risk patients, while achieving population health acute & chronic needs
	• Develop high-value specialist & hospital network using quality and affordability metrics
	• SDOH System & Workflow Integration
	  • CBO registry
	  • Predictive high-risk patient analysis
		• Adopt capitated APM model that further enhances VBC outcomes / affordability
		• Further align payment models to credit providers/clinics/regions for high-value quality outcomes
		• Scale VBC to new sites/regions

Questions

AltaMed

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Vote to Elect Health Care Affordability Board Chair

Elizabeth Landsberg, Director

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Data Submission Guide Updates to Add Alternative Payment Model Arrangements and Primary Care Data Collection, Including Advisory Committee Feedback

CJ Howard, Assistant Deputy Director
Margareta Brandt, Assistant Deputy Director

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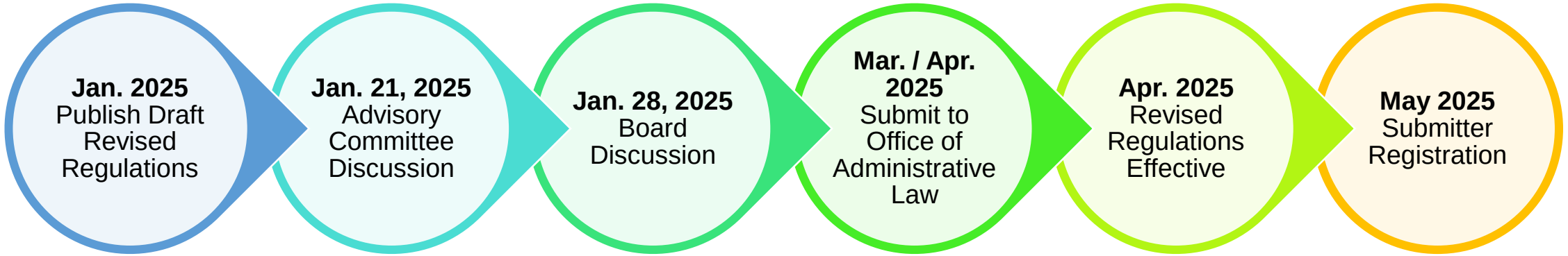
Data Submission Guide 2.0

- DSG 2.0 outlines requirements for submission of 2023-2024 data in 2025
- Draft will be shared for public comment in early 2025
- Annual registration due by May 31, 2025
- Data submission due by September 1, 2025

DSG 2.0 Proposed Changes

- Require licensed health plans and insurers to register and submit data separately
- Remove PO/TIN list requirement from 2025 registration
- Remove Los Angeles SPAs from Regional file; use two Covered CA rating regions for Los Angeles members
- Remove some duplicative fields in response to submitter feedback (e.g., drop Member Responsibility from Attributed and Regional files)
- Add two new files for Alternative Payment Model and Primary Care data

DSG 2.0 Timeline



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Alternative Payment Model Data Collection

Alternative Payment Models

Statutory Requirements

- Promote the shift of payments based on fee-for-service (FFS) to alternative payment models (APMs) that provide financial incentive for equitable high-quality and cost-efficient care.
- Convene health care entities and organize an APM workgroup, **set statewide goals** for the adoption of APMs, **measure the state's progress** toward those goals, and **adopt contracting standards** healthcare entities can use.
- Set benchmarks that include, but are not limited to, increasing the percentage of total health care expenditures delivered through APMs or the percentage of membership covered by an APM.

APM Standards and Goals Approved

At the June 2024 meeting, the Board approved the APM Standards and Adoption Goals.

Baseline established on 2024 data collected in 2025, to be categorized via Expanded Framework. **Data on 2026 goal collected in 2027, reported in 2028.**

APM Adoption Goals for Percent of Members Attributed to HCP-LAN Categories 3 and 4 by Payer Type				
	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	65%	25%	55%	55%
2028	75%	35%	60%	65%
2030	85%	45%	65%	75%
2032	90%	55%	70%	85%
2034	95%	60%	75%	95%

See OHCA website for APM Standards and Goals: https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/apm-standards-and-adoption-goals/

HCAI Non-Claims Data Collection

Data Collection Consideration	APM	Primary Care	TME	HPD
Reporting Expanded Framework subcategory?	Yes	Yes	No	Yes
Reporting payments in categories/ subcategories	All member TME in one subcategory furthest along the continuum of provider financial risk	Actual non-claims payments	Actual non-claims payments	Actual non-claims payments
Granularity of reporting member months	Collected by subcategory	Collected by subcategory	Collected in aggregate	Collected by subcategory
Frequency of data collection	Annual	Annual	Annual	Annual; monthly capitation

Expanded Non-Claims Payments Framework, Categories A-C

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	2A
A2	Primary care and behavioral health integration	2A
A3	Social care integration	2A
A4	Practice transformation payments	2A
A5	EHR/HIT infrastructure and other data analytics payments	2A
B	**Performance Payments**	
B1	Retrospective/prospective incentive payments: pay-for-reporting	2B
B2	Retrospective/prospective incentive payments: pay-for-performance	2C
C	**Payments with Shared Savings and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	3A, 3N
C2	Procedure-related, episode-based payments with risk of recoupments	3B, 3N
C3	Condition-related, episode-based payments with shared savings	3A, 3N
C4	Condition-related, episode-based payments with risk of recoupments	3B, 3N
C5	Risk for total cost of care (e.g., ACO) with shared savings	3A, 3N
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B, 3N

See Expanded Non-Claims Payments Handout: https://hcai.ca.gov/wp-content/uploads/2024/09/HCAI-Expanded-Non-claims-Payments-Framework-Handout_v2.pdf

Expanded Non-Claims Payments Framework, Categories D-F

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
D	**Capitation and Full Risk Payments**	
D1	Primary Care capitation	4A, 4N
D2	Professional capitation	4A, 4N
D3	Facility capitation	4A, 4N
D4	Behavioral Health capitation	4A, 4N
D5	Global capitation	4B, 4N
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C, 4N
E	**Other Non-Claims Payments**	
F	**Pharmacy Rebates**	

See Expanded Non-Claims Payments Handout: https://hcai.ca.gov/wp-content/uploads/2024/09/HCAI-Expanded-Non-claims-Payments-Framework-Handout_v2.pdf

Summary of APM Data Collection Approach

- ✓ APMs that count towards adoption goals are defined by HCP-LAN Category 3 and 4 and spending data is collected via Expanded Framework
- ✓ APM membership data collected by market category and product type at payer level to meet APM adoption goal requirement
- ✓ APM spending data as per member, per month and as a percent of total medical expense is collected at Expanded Framework subcategory level
- ✓ Membership and spending in episode-based care models is collected by episode type and Expanded Framework subcategory level

Primary Care Data Collection

Primary Care Investment

Statutory Requirements

- Measure the **percentage of total health care expenditures allocated to primary care** and **set spending benchmarks** that consider current and historic underfunding of primary care services.
- Determine the categories of providers, specific procedure codes, and non-claims payments that should be considered when determining the total amount spent on primary care.
- Build and sustain methods of reimbursement that shift greater health care resources and investments away from specialty care and toward primary care and behavioral health.
- Promote improved outcomes for primary care and sustained systemwide investment in primary care.
- Include an analysis of **primary care spending and growth in the annual report.**
- Consult with state departments, external organizations promoting investment in primary care, and other entities and individuals with expertise in primary care.

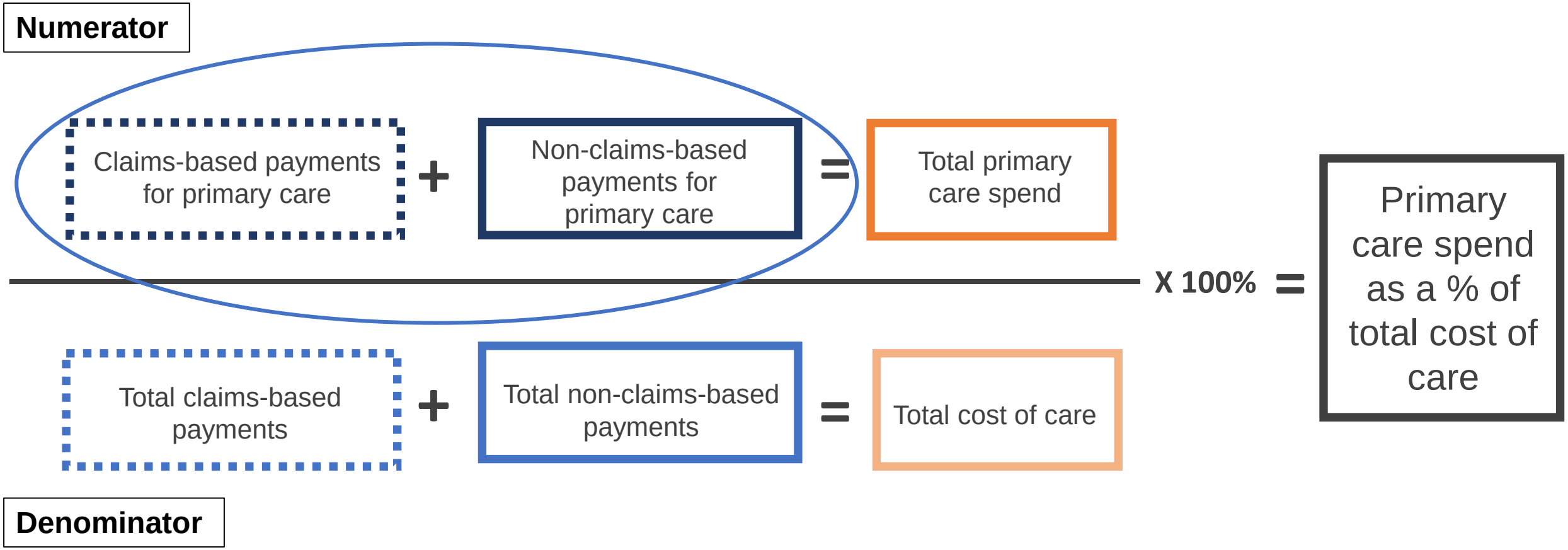
Primary Care Investment Benchmark Approved

- **Baseline** for 0.5 – 1 percentage point increase per year for each payer **established on performance year 2024 data collected in 2025.**
- Progress towards first **annual improvement benchmark** will be assessed for **performance year 2025 on data collected in 2026.**

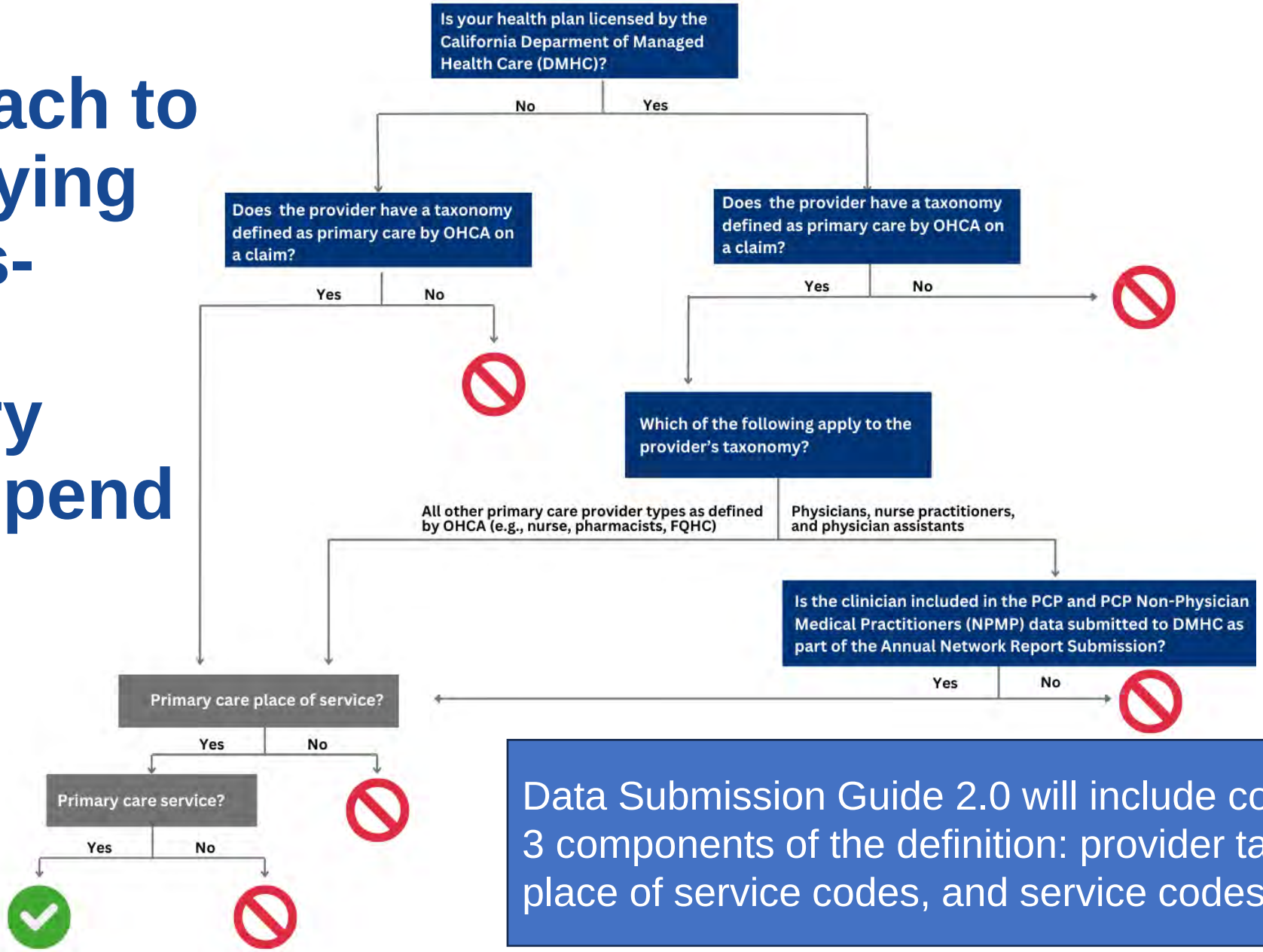
Performance Years	Annual Improvement Benchmark
2025-2033	0.5 – 1 percentage point per year for each payer by line of business and product type
Performance Year	**Investment Benchmark**
2034	15 percent statewide across all payers, lines of business, and product types

*Payers at or above 15% of total medical expense may refrain from continued increases if not aligned with care delivery or affordability goals.
See OHCA website for Primary Care Investment Benchmark: https://hcai.ca.gov/affordability/ohca/primary-care-investment-benchmark/

Measuring Primary Care Spending



Approach to Identifying Claims-based Primary Care Spend



Data Submission Guide 2.0 will include code sets for the 3 components of the definition: provider taxonomy codes, place of service codes, and service codes.

Expanded Non-Claims Payments Framework

Required for Primary Care

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	2A
A2	Primary care and behavioral health integration	2A
A3	Social care integration	2A
A4	Practice transformation payments	2A
A5	EHR/HIT infrastructure and other data analytics payments	2A
B	**Performance Payments**	
B1	Retrospective/prospective incentive payments: pay-for-reporting	2B
B2	Retrospective/prospective incentive payments: pay-for-performance	2C
C	**Payments with Shared Savings and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	3A, 3N
C2	Procedure-related, episode-based payments with risk of recoupments	3B, 3N
C3	Condition-related, episode-based payments with shared savings*	3A, 3N
C4	Condition-related, episode-based payments with risk of recoupments*	3B, 3N
C5	Risk for total cost of care (e.g., ACO) with shared savings	3A, 3N
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B, 3N

*Condition-related, episode-based payments are included as some of these payments are for chronic conditions that may be managed in primary care. Data submitters will follow OHCA's methodology for allocating a portion of these payments to primary care.

Expanded Non-Claims Payments Framework

Required for Primary Care

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
D	**Capitation and Full Risk Payments**	
D1	Primary Care capitation	4A, 4N
D2	Professional capitation	4A, 4N
D3	Facility capitation	4A, 4N
D4	Behavioral Health capitation	4A, 4N
D5	Global capitation	4B, 4N
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C, 4N
E	**Other Non-Claims Payments**	
F	**Pharmacy Rebates**	

Summary of Primary Care Data Collection Approach

- ✓ Claims and non-claims primary care spending collected by market category and product type at payer level to track progress towards the benchmarks
- ✓ Claims and non-claims primary care spending collected by subcategory level based on methodology developed by OHCA with input from the Investment and Payment Workgroup
- ✓ Behavioral health in primary care collected as part of primary care spending

October Advisory Committee Feedback

- Requests for clarification on:
  - What behavioral health services are included in the primary care definition
  - Which types of APMs count towards the APM adoption goals
  - How the Medi-Cal APM adoption goal was developed
  - Whether primary care telehealth spending is captured
- Acknowledgement that meeting the APM adoption goals for PPOs will be challenging
- Concern that the methodology to allocate a portion of capitation spend to primary care is not sufficient to capture all spending under capitation that supports primary care
- Emphasis that APM and primary care data collection will be a learning process
- Appreciation that the APM adoption goals and primary care investment benchmark are both on a 10-year timeline
- Request to include TINs and NPIs in the provider attribution addendum

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Introduce Quality and Equity Measure Set Proposal, Including Advisory Committee Feedback

Margareta Brandt, Assistant Deputy Director
Janna King, Health Equity and Quality Performance Group Manager

HCAI
Department of Health Care Access and Information

OHCA's Quality and Equity Measure Set

Statutory Requirements

- **Adopt and track performance on a single set of standard measures for assessing health care quality and equity across payers, fully integrated delivery systems, hospitals, and physician organizations.**
- **Use recognized clinical quality, patient experience, patient safety, and utilization measures**.
- Consider available means for **reliable measurement of disparities in health care**, including race, ethnicity, sex, age, language, sexual orientation, gender identity, and disability status.
- **Reduce administrative burden** by selecting quality and equity measures that simplify reporting and align performance measurement with other payers, programs, and state agencies, including leveraging existing voluntary and required reporting to the greatest extent possible.
- **Coordinate with DMHC, DHCS, Covered California, and CalPERS**, and consult with external quality improvement organizations and forums, payers, physicians, other providers, and consumer advocates or stakeholders.

These criteria are summarized from Article 2. Office of Health Care Affordability, Health and Safety Code § 127501-127501.12 and Article 4. Quality and Equity Performance, Health and Safety Code § 127503.

OHCA's Quality and Equity Measure Set

Statutory Requirements

- **Promote the goal of improved affordability** for consumers and purchasers of health care, **while maintaining quality and equitable care**.
- OHCA may require a health care entity to implement a performance improvement plan that identifies the causes for spending growth and shall include specific strategies, adjustments, and action steps the entity proposes to implement to improve spending performance during a specified time period. **The Director shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode access, quality, equity, or workforce stability.**

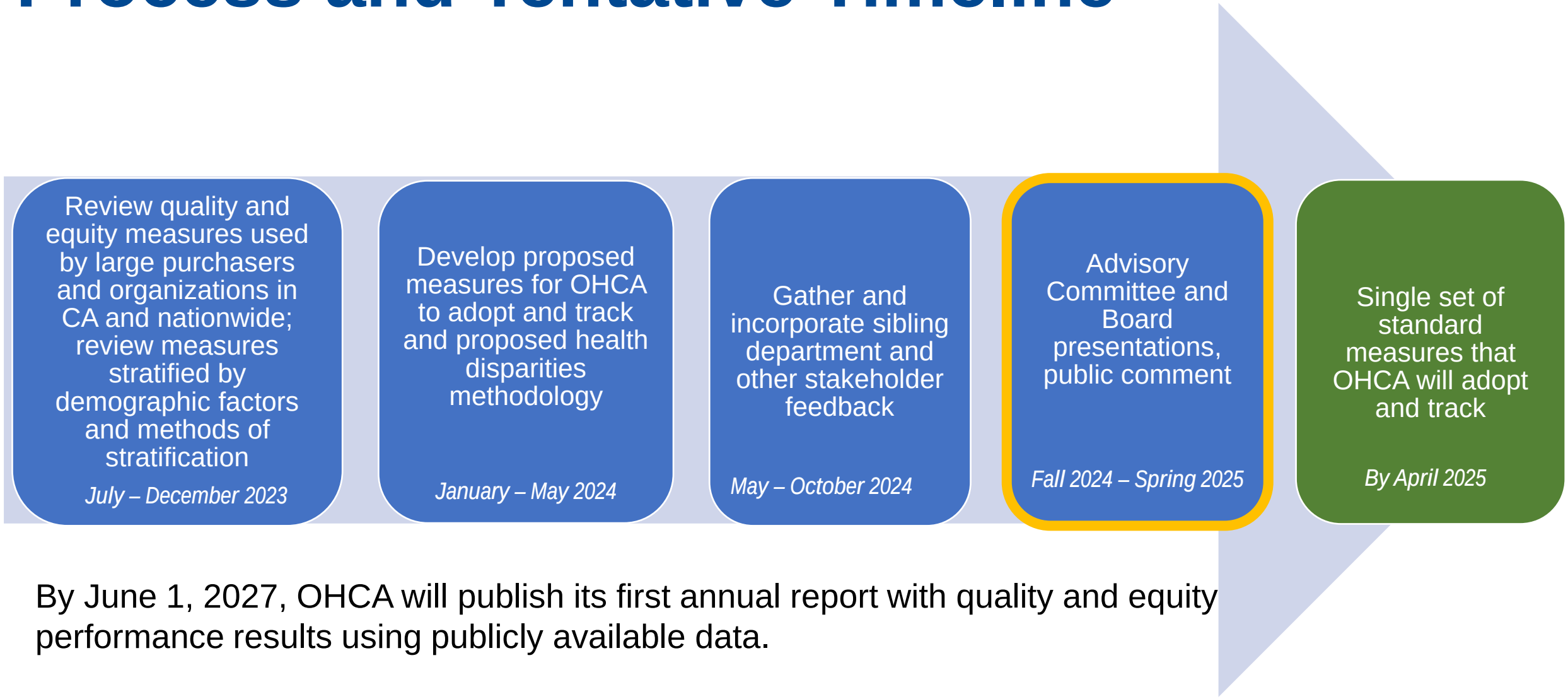
These criteria are summarized from Article 3. Office of Health Care Affordability, Health and Safety Code § § 127502(c)(5) and 127502.5.

OHCA's Quality and Equity Measure Set

Purpose

- Promote high quality and more equitable health care for all Californians.
- Monitor changes in quality and equity as health care entities work to meet the spending growth target.
- Track progress towards OHCA's goals to improve access, affordability, and equity of health care for all Californians.

Process and Tentative Timeline



By June 1, 2027, OHCA will publish its first annual report with quality and equity performance results using publicly available data.

Completed Analyses

Analyzed over 300 quality measures used by prominent health care organizations in California and nationally.

- CA state departments: HCAI, DMHC, DHCS, Covered California, CalPERS, OPA, and CDPH.
- California-specific initiatives: Cal Hospital Compare, California Quality Collaborative.
- National: CMS Universal Foundation, NCQA HEDIS®[1].

Identified measures consistently used across organizations.

Reviewed how health care organizations in California and nationally are measuring, analyzing, and reporting health equity and disparities.

Met with internal and external partners to gather feedback and align efforts.

- Met with sibling state departments, Integrated Healthcare Association, Health Access, California Pan-Ethnic Health Network, and internal partners within HCAI.
- Introduced proposal to Health Care Affordability Advisory Committee.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Proposed Quality and Equity Measure Set

- OHCA is proposing to adopt all or a subset of three publicly available measure sets to measure quality and equity across health care entities.

Payers	Physician Organizations	Hospitals
Fully Integrated Delivery Systems[1]		
Adopt the full Department of Managed Health Care's (DMHC) Health Equity and Quality Measure Set and stratification requirements	Adopt a subset of the Center for Data Insights and Innovation's Office of the Patient Advocate (OPA) Health Care Quality Report Card measures[2]	Adopt the full Department of Health Care Access and Information's (HCAI) Hospital Equity Measures Reporting Program measure set and stratification requirements

[1] For fully integrated delivery systems, which include a payer, physician organization, and hospital component, OHCA will measure performance of each of these component entities.
[2] OPA does not report measures stratified by demographic characteristics.

Considerations for Quality and Equity Measure Set Proposal

Advantages

- Uplifts measure sets developed through intensive multi-stakeholder processes.
- Leverages existing publicly reported performance measure results.
- Does not add administrative burden to health care entities.
- Promotes alignment between state departments, major public purchasers, and payers.

Limitations

- Includes a small number of behavioral health measures.
- OPA Health Care Quality Report Card measures are not stratified by demographic characteristics.
- For payers, performance results will not be collected or publicly reported by the DMHC for all lines of business.
- For physician organizations, performance results are not publicly reported for commercial PPO, Medi-Cal, and Medicare fee-for-service members.[1]

[1] Attributing commercial PPO members to a physician organization is a larger industry-wide challenge. Performance is not reported for Medi-Cal members at the physician organization level. Medicare fee-for-service members are not assigned to a physician organization because CMS contracts directly with the provider.

Measures for Payers: Background on the DMHC Health Equity and Quality Measure Set

- AB 133 (Chapter 143, Statutes of 2021) required the DMHC to establish and convene a Health Equity and Quality Committee to recommend a health equity and quality measure set and benchmarks with the goal to address long-standing health inequities and to ensure equitable delivery of high-quality health care across all market segments.
  - The Committee was comprised of consumer representatives, health plan representatives, providers, quality measurement and health equity experts, and representatives from state agencies.
- Based on the Committee's recommendations, the DMHC established the Health Equity and Quality Measure Set and measure stratification requirements, effective beginning measurement year 2023.
- The DMHC may reconvene the Committee to reevaluate the effectiveness of the Health Equity and Quality Measure Set and measure stratification requirements.
- Payers[1] subject to reporting on the DMHC Health Equity and Quality Measure Set: all Commercial and Covered California market segments, including the individual, small, and large group markets, and the Medi-Cal Managed Care program.

[1] DMHC uses the term health care service plans and only those with direct enrollment are required to report on Health Equity and Quality Measure Set. Health care service plans excluded from reporting are Medicare Advantage-only plans, plans with no direct enrollment, specialized dental, vision, chiropractic, or acupuncture health plans, and Employee Assistance Plans.

Source: DMHC Licensing eFiling. (2024, June 28). APL 24-013 – Health Equity and Quality Program Policies and Requirements (6/28/2024). https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL24-013-HealthEquityandQualityProgramPoliciesandRequirements(6_28_2024).pdf?ver=9wJvJOJ61DNjXvVpRgHqeQ%3d%3d

Measures for Payers: DMHC Health Equity and Quality Measure Set

Measures (Measurement Year 2024)	
Colorectal Cancer Screening*	Childhood Immunization Status: Combination 10*
Breast Cancer Screening*	Child and Adolescent Well-Care Visits*
Glycemic Status Assessment for Patients with Diabetes (<8.0% and >9.0%)*	Well-Child Visits in the First 30 Months of Life (0 to 15 Months and 15 to 30 Months)*
Controlling High Blood Pressure*	Plan All-Cause Readmissions
Asthma Medication Ratio*	Immunizations for Adolescents: Combination 2*
Depression Screening and Follow-Up for Adolescents and Adults (Depression Screening and Follow-Up on Positive Screen)	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey: Getting Needed Care (adult and child survey) or Qualified Health Plan (QHP) Enrollee Experience Survey[1]
Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care)*	

* Measure results stratified by race and ethnicity for measurement year 2024.

Source: DMHC Licensing eFiling. (2024, June 28). APL 24-013 – Health Equity and Quality Program Policies and Requirements (6/28/2024). https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL24-013-HealthEquityandQualityProgramPoliciesandRequirements(6_28_2024).pdf?ver=9wJvJOJ61DNjXvVpRgHqeQ%3d%3d

[1] CAHPS Child Survey is only for applicable Medicaid plans. CAHPS health plan survey does not apply to Exchange plans. Exchange plans will report to the DMHC on the QHP Enrollee Experience Survey in measurement year 2024.

Measures for Physician Organizations: Background on OPA Health Care Quality Report Cards

- Assembly Bill 172 (Chapter 696, Statutes of 2021) moved the Office of the Patient Advocate (OPA) to the Center for Data Insights and Innovation (CDII) in October 2021. CDII is now responsible for statutory mandates to publish report cards on health care quality per California Health and Safety Code § 130200.
- OPA's Health Care Quality Report Cards are public reports that rate physician organizations on quality, patient experience, and total cost of care to help consumers make informed decisions about their health care.
- Quality ratings for the Health Care Quality Report Cards come from the Integrated Healthcare Association's Align. Measure. Perform. (AMP) program.
- The Integrated Healthcare Association's Technical Measurement Committee serves as an advisory body for the Health Care Quality Report Cards.
  - The Committee is comprised of representatives from health plans, physician organizations, and health care purchasers.
- Physician organizations included in Health Care Quality Report Cards: physician organizations who voluntarily participate in the Integrated Healthcare Association's AMP Commercial HMO and Medicare Advantage programs.
  - No performance for commercial PPO, Medi-Cal, and Medicare fee-for-service members.[1]

Source: Center for Data Insights and Innovation. (2024). Health Care Quality Report Cards. https://www.cdii.ca.gov/consumer-reports/health-care-quality-report-cards/.

[1] Attributing commercial PPO members to a physician organization is a larger industry-wide challenge. Performance is not reported for Medi-Cal members at the physician organization level. Medicare fee-for-service members are not assigned to a physician organization because CMS contracts directly with the provider.

Measures for Physician Organizations: OPA Health Care Quality Report Cards

Measures (Measurement Year 2024)	
Asthma Medication Ratio	Immunizations for Adolescents: Combination 2
Breast Cancer Screening	Kidney Health Evaluation in Patients with Diabetes
Cervical Cancer Screening	Osteoporosis Management in Women Who Had a Fracture
Child and Adolescent Well-Care Visits	Plan All-Cause Readmissions
Childhood Immunization Status: Combination 10	Prenatal Immunization Status
Chlamydia Screening in Women	Proportion of Days Covered by Medications (Diabetes All Class, Renin Angiotensin System Antagonists, and Statins)
Colorectal Cancer Screening	Statin Therapy for Patients With Cardiovascular Disease
Controlling High Blood Pressure	Statin Use in Persons with Diabetes
Eye Exam for Patients with Diabetes	Total Cost of Care, incl service categories
Glycemic Status Assessment for Patients with Diabetes (<8.0% and/or >9.0%)	

- No patient experience measures for measurement year 2024.[1]

Source: Center for Data Insights and Innovation. (2024). Health Care Quality Report Cards. https://www.cdii.ca.gov/consumer-reports/health-care-quality-report-cards/.

[1] PBGH sunset the Patient Assessment Survey (PAS) program effective July 31, 2024. OPA used the PAS program results to publicly report patient experience measures.

Measures for Hospitals: Background on HCAI Hospital Equity Measures Reporting Program

- Assembly Bill 1204 (Chapter 751, Statutes of 2021) required HCAI to convene a Health Care Equity Measures Advisory Committee to make recommendations on the development of a hospital equity reporting program to collect and post annual hospital equity reports that include measures on patient access, quality, and outcomes by race, ethnicity, language, disability status, sexual orientation, gender identity, and payer.
  - The Committee was comprised of representatives from academic institutions focused on health care quality and equity measurement, associations representing public hospitals and health systems, associations representing private hospitals and health systems, organized labor, organizations representing consumers, and organizations representing vulnerable populations.
- HCAI is finalizing the Hospital Equity Measures Reporting Program via the regulatory process in early 2025.
- The Committee will reconvene after the first year of reporting to make a second set of recommendations to HCAI regarding the submitted hospitals' health equity plans.
- Hospitals subject to reporting on the HCAI Hospital Equity Measures Reporting Program measures: licensed general acute care hospitals (includes children's hospitals), acute psychiatric hospitals, specialty hospitals, and hospital systems with at least two general acute care hospitals.

Source: HCAI. (n.d.). *Hospital Equity Measures Reporting Program*. https://hcai.ca.gov/data/healthcare-quality/hospital-equity-measures-reporting-program/

Measures for Hospitals: HCAI Hospital Equity Measures Reporting Program

Measures (Measurement Year 2024)	
Designate an individual to lead hospital health equity activities	All-Cause Unplanned 30-Day Hospital Readmission Rate*
Hospital Commitment to Health Equity Structural Measure	Cesarean Birth Rate (NTSV)*
Provide documentation of policy prohibiting discrimination	Death Rate among Surgical Inpatients with Serious Treatable Complications*
Report percentage of patients by preferred language spoken	Exclusive Breast Milk Feeding*
Screen Positive Rate for Social Drivers of Health	Vaginal Birth After Cesarean Rate (VBAC)*
Screening for Social Drivers of Health	All-Cause Unplanned 30-Day Hospital Readmission Rate in an inpatient psychiatric facility*
All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavior health diagnosis*	Screening for metabolic disorders*
HCAHPS survey (Received information and education and would recommend hospital)*	SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge*
Pneumonia Mortality Rate*	Pediatric experience survey with scores of willingness to recommend the hospital*

* Core quality measures that will be stratified by race/ethnicity, age, sex assigned at birth, expected payer, preferred language, disability status, sexual orientation, and gender identity to the extent that the data is available.

Source: HCAI. (n.d.). *Hospital Equity Measures Reporting Program*. https://hcai.ca.gov/data/healthcare-quality/hospital-equity-measures-reporting-program/

Proposed Quality and Equity Measure Set

- OHCA is proposing to adopt all or a subset of three publicly available measure sets to measure quality and equity across health care entities.

Payers	Physician Organizations	Hospitals
Fully Integrated Delivery Systems[1]		
Adopt the **full** DMHC Health Equity and Quality Measure Set and stratification requirements	Adopt a **subset** of the OPA Health Care Quality Report Card measures[2]	Adopt the **full** HCAI Hospital Equity Measures Reporting Program measure set and stratification requirements

[1] For fully integrated delivery systems, which include a payer, physician organization, and hospital component, OHCA will measure performance of each of these component entities.
[2] OPA does not report measures stratified by demographic characteristics.

Measures for Payers and Physician Organizations (Plus Measures for Hospitals)

Measures	OHCA	
Childhood Immunization Status[1]	Payers	Physician organizations
Colorectal Cancer Screening[1]		
Controlling High Blood Pressure[1]		
Glycemic Status Assessment for Patients With Diabetes (<8.0% and/or >9.0%)[1]		
All-Cause Readmissions		
Asthma Medication Ratio		
Breast Cancer Screening Rate		
Child and Adolescent Well-Care Visits		
Immunizations for Adolescents		
Depression Screening and Follow-Up for Adolescents and Adults (Depression Screening and Follow-Up on Positive Screen)		
CAHPS Health Plan Survey: Getting Needed Care (Adult and Child survey) or QHP Enrollee Experience Survey[2]		
Prenatal and Postpartum Care (Postpartum Care and Timeliness of Prenatal Care)		
Well-Child Visits in the First 30 Months of Life (0 to 15 Months and 15 to 30 Months)		
HCAI Hospital Equity Measures Reporting Program measure set (full)		☑

- OHCA proposes to adopt the full DMHC measure set for payers, the overlap of DMHC and OPA measure sets for physician organizations, and all HCAI Hospital Equity Measures Reporting Program measures.
- The payer and physician organization measure sets should become more aligned as measures are added to the OPA Health Care Quality Report Cards.

[1] Measures that align across all California State Departments for payers and physician organizations.
[2] In the DMHC Health Equity and Quality Measure Set, CAHPS Child Survey is only for applicable Medicaid plans. CAHPS health plan survey does not apply to Exchange plans. Exchange plans will report to the DMHC on the QHP Enrollee Experience Survey in measurement year 2024.

Measures for Hospitals (Plus Measures for Payers and Physician Organizations)

HCAI Hospital Equity Measures Reporting Program Measure Name	General Acute Hospital Measures	Acute Psychiatric Hospital Measures	Children's Hospital Measures	OHCA
Designate an individual to lead hospital health equity activities[1]	X	X	X	Hospitals
Hospital Commitment to Health Equity Structural Measure[1]	X	X	X	
Provide documentation of policy prohibiting discrimination[1]	X	X	X	
Report percentage of patients by preferred language spoken[1]	X	X	X	
Screen Positive Rate for Social Drivers of Health[1]	X	X	X	
Screening for Social Drivers of Health[1]	X	X	X	
All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavior health diagnosis	X	X		
HCAHPS survey (Received information and education and would recommend hospital)	X	X		
Pneumonia Mortality Rate	X	X		
All-Cause Unplanned 30-Day Hospital Readmission Rate	X		X	
Cesarean Birth Rate (NTSV)	X			
Death Rate among Surgical Inpatients with Serious Treatable Complications	X			
Exclusive Breast Milk Feeding	X			
Vaginal Birth After Cesarean Rate (VBAC)	X			
All-Cause Unplanned 30-Day Hospital Readmission Rate in an inpatient psychiatric facility		X		
Screening for metabolic disorders		X		
SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge		X		
Pediatric experience survey with scores of willingness to recommend the hospital			X	
DMHC Health Equity and Quality Measure Set (full) and OPA Health Care Quality Report Card Measures (subset)				☑

Source: HCAI. (n.d.). *Hospital Equity Measures Reporting Program*. https://hcai.ca.gov/data/healthcare-quality/hospital-equity-measures-reporting-program/.

[1] Structural measures for all hospitals. For more detail on these measures, see Appendix.

Broad Measurement with Key Highlights in Public Reporting

- One purpose of the OHCA quality and equity measure set is to monitor changes in quality and equity as health care entities work to meet the spending target.
- In OHCA's public reporting, OHCA will explore highlighting a subset of key measures that are particularly important to the goal of improved affordability of health care, while maintaining quality and equitable care.

Equity Analyses

Payer Equity Analyses: Stratifying Quality Measures

- OHCA will align with the stratification requirements and reporting used in the DMHC's Health Equity and Quality Measure Set.
- Health plans must report to the DMHC aggregate measure results for all measures and measure results stratified by the National Committee for Quality Assurance (NCQA) for some measures.
- The NCQA has a health equity methodology for stratifying its measures by race and ethnicity.[1]
    - The NCQA follows the Office of Management and Budget (OMB) Standards for stratification.[2]

NCQA Stratification Categories for Race and Ethnicity[1]

Race	Ethnicity
White	Hispanic or Latino
Black or African American	Not Hispanic or Latino
American Indian or Alaska Native	Asked but no answer
Asian	Unknown
Native Hawaiian or Other Pacific Islander	
Some other race	
Two or more races	
Asked but no answer	
Unknown	

Sources: DMHC Licensing eFiling. (2024, June 28). APL 24-013 – Health Equity and Quality Program Policies and Requirements (6/28/2024). https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL24-013-HealthEquityandQualityProgramPoliciesandRequirements(6_28_2024).pdf?ver=9wJvJOJ61DNjXvVpRgHqeQ%3d%3d.[1] As of March 28, 2024, the OMB issued revised race and ethnicity stratification standards, which must be implemented as soon as possible, but no later than March 28, 2029.
[2] The DMHC will attempt to align future MY HEQMS stratification requirements with the NCQA's implementation of these new OMB standards.

Physician Organization Equity Analyses

- OPA's Health Care Quality Report Cards do not include quality measures stratified by demographic characteristics.
- OHCA will consider including additional population health analyses to supplement its equity analyses and will continue to explore and assess options to expand its equity analyses in the future.

Hospital Equity Analyses: Stratifying Quality Measures

- OHCA will align with the stratification requirements and reporting used in HCAI's Hospital Equity Measures Reporting Program.
- AB 1204 requires all core quality measures to be stratified to the extent that the data is available at the hospital and hospital system level.
- The numerator, denominator, and rate for all core quality measures will be stratified by the following categories: race/ethnicity, age, sex assigned at birth, expected payer, preferred language, disability status, sexual orientation, and gender identity.

For more information, see the HCAI Hospital Equity Measures Reporting Program.

Additional Equity Analyses

- OHCA will explore including analyses on population health measures by other state departments, California specific surveys, reports, and SDOH indices, and national surveys to provide additional context for interpreting and understanding performance on the quality and equity measure sets.
  - OHCA may include key pieces from existing reports that are the most relevant to the quality and equity measure set and statewide spending target.
- For payers, OHCA is considering reporting information from the DMHC Health Plan Demographic Data Metric.
- For payers, OHCA is also considering reporting which payers have achieved NCQA Health Equity Accreditation and NCQA Health Equity Plus Accreditation.
- For all measure sets, OHCA will consider adopting changes implemented by the respective departments, such as adding new measures or updating the stratification requirements.
- OHCA will continue to explore and assess options to expand its equity analyses in the future.

Sources: DMHC Licensing eFiling. (2024, June 28). APL 24-013 – Health Equity and Quality Program Policies and Requirements (6/28/2024). https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL24-013-HealthEquityandQualityProgramPoliciesandRequirements(6_28_2024).pdf?ver=9wJvJOJ61DNjXvVpRgHqeQ%3d%3d.;
NCQA. (n.d.). NCQA's Health Equity Accreditation Programs. https://www.ncqa.org/programs/health-equity-accreditation/.

October Advisory Committee Feedback

- General support for proposed quality and equity measure set and additional equity analyses.
- Several members noted the need to continue working to remedy missing data and other problems with individual-level demographic data and to stratify more measures, including by race and ethnicity, age, disability status, and geographic region, especially for physician organizations.
- Suggestions to add measures on health care access, behavioral health, and cultural and linguistic appropriateness of care for all entities; for payers and physician organizations to add process and structural measures, including SDOH screening; and for hospitals to add safety measures.
- Concerns that quality measures are limited in what they can capture and that providers with more resources may be able to “game” them.
- Concerns that some physician organizations are not included in the OPA report cards and interest in the overlap between physician organizations reported on through THCE and those in the OPA report cards.
- Several members pushed to focus on OHCA’s purpose and report information that is easily understandable, meaningful, and actionable, and suggested grouping measures (e.g., preventive care) and highlighting subgroups (e.g., older adults and people with disabilities).

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Provisional Approach to Hospital Spending Measurement

Vishaal Pegany, Deputy Director

CJ Howard, Assistant Deputy Director

HCAI

Department of Health Care Access and Information

Statute

Hospitals are included in our statute under the provider definition:

(q) “Provider” means any of the following that delivers or furnishes health care services:

(1) A physician organization.

(2) A health facility, as defined in Section 1250, including a general acute care hospital.

(3) A clinic conducted, operated, or maintained as an outpatient department of a hospital, as described in subdivision (d) of Section 1206. …

Providers are a type of health care entity. Health care entities are subject to the statewide spending target.

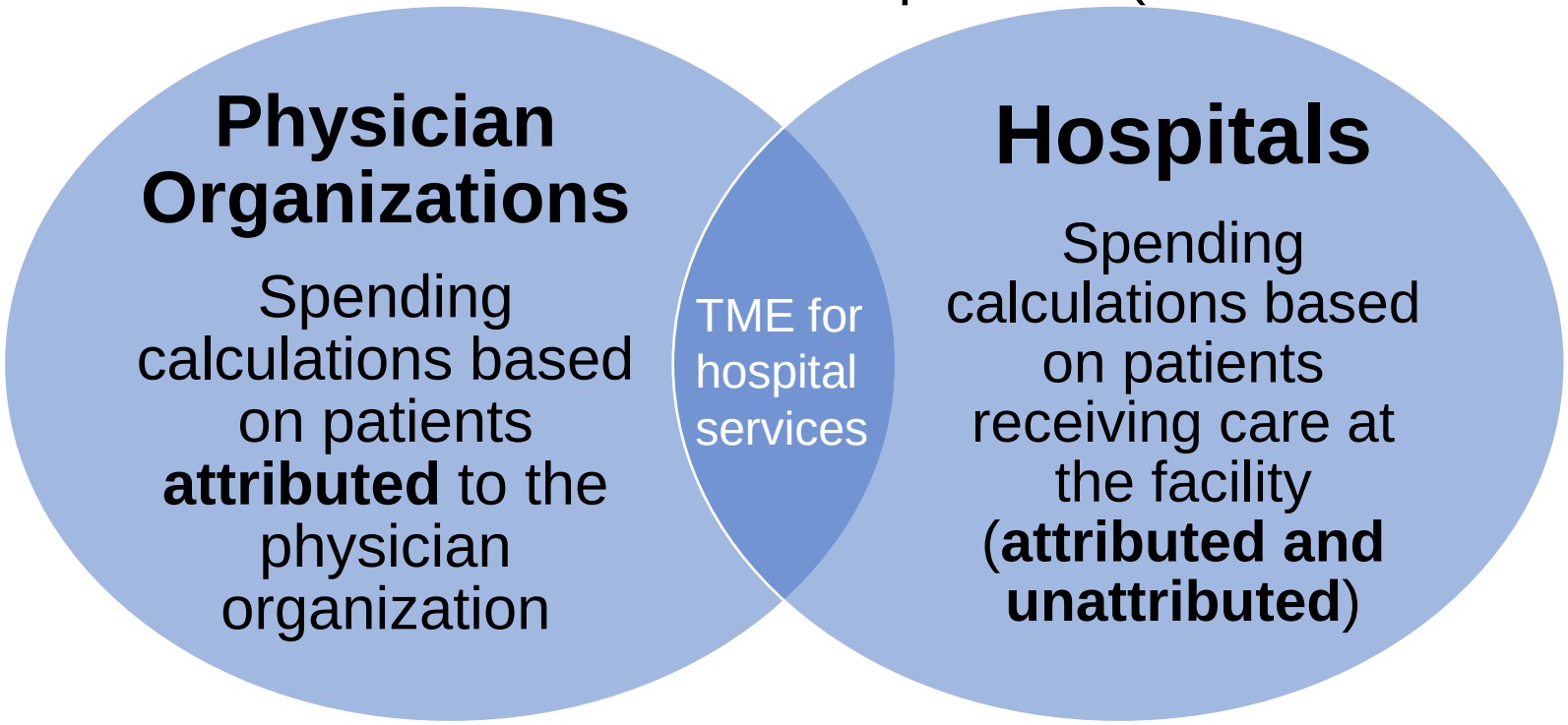
Measuring Hospital Spending

- Spending targets typically focus on calculating year-over-year growth of total medical expenditures (TME):
    1. at the payer level for all enrollees; or
    2. attributing patients to physician organizations and calculating total medical expenses for attributed patients;
- OHCA expects the current TME approach to measure spending of attributed lives in physician organizations affiliated with or under common ownership as hospitals.
    - This approach does not work well for hospitals and specialists with few to no attributed patients.
- Other states are not currently measuring hospital spending relative to a target.
- OHCA has developed a provisional measurement approach that would enable reporting of spending for California's hospitals.

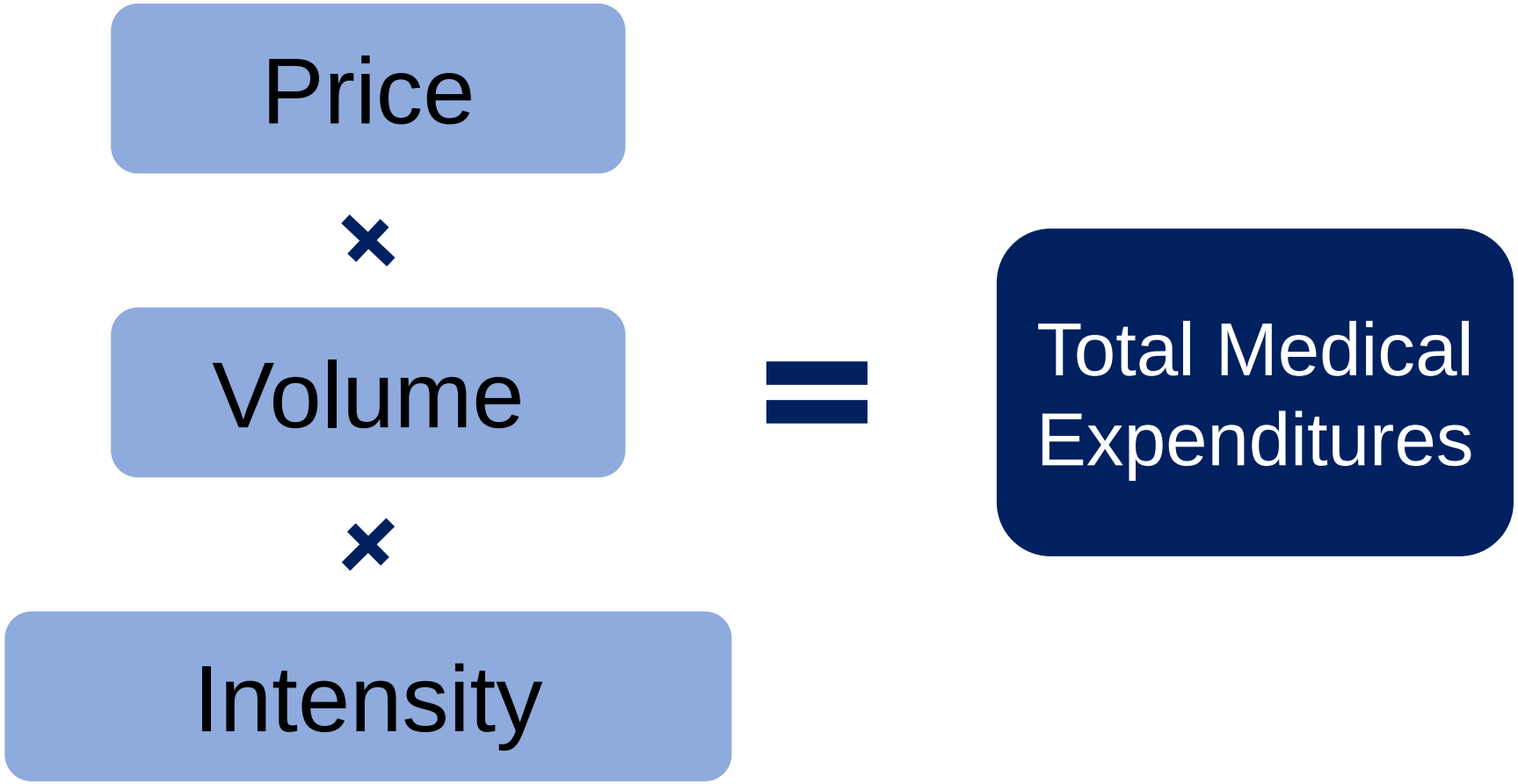
Measuring Hospital Spending

Payers

Captures TME for all services and all insured patients (attributed and unattributed)



Measuring Hospital Spending Using Hospital Revenue



Components of Hospital Revenue

Price = Payment per Unit

The amount of money a hospital is paid for a service. This may vary based on:

- *Payer type*: payment amounts for services may differ depending on rates contracted by Medicare, Medi-Cal and commercial payers.
- *Price*: rate changes will depend on the payer and service.
- *Coding intensity*: how claims are billed may change the payment amount.

Volume

The number and types of services a hospital provides. Spending and revenue may vary based on:

- Doing more joint replacements, imaging, office visits, or intensive care may all increase the amount the hospital spends to take care of patients.
- However, the relative profitability of service often varies.

Intensity

Intensity of care varies and may affect the revenue for a hospital.

- Advanced imaging will increase the expenses and payments associated with a medical complaint.
- Use of a case mix index can track changes in resource intensity, complexity, and severity of care over time.
- Treatment decisions include factors sensitive to both *patient* and *provider* preference.

Hospital Spending and Measurement Workgroup Members

Hospitals & Health Systems

Kiyomi Ross, MBA, MPH
Director of Financial Planning and Performance
Santa Clara Valley Health care

Tina Mycroft, CPA
Senior Vice President and Chief Financial Officer
Valley Children's Hospital

Jason Whitney, MBA
Finance Officer
Adventist Health Lodi Memorial

Kelly Martin
Chief Financial Officer
Fairchild Medical Center

Lori R. Donaldson
Chief Financial Officer
UC San Diego Health

James Washecka, FHFMA, MBA
VP of Financial Planning and Performance
Kaiser

Craig Partridge, MBA
VP Payer Analytics and Economics
CommonSpirit Health

Consumer Advocacy

Beth Capell, Ph.D.
Contract Lobbyist
Health Access

Health Plans

Alexander Vojta, FSA, MAAA
Senior Director, Actuarial – Network Analytics / Corporate Forecasting and Planning
Blue Shield of California

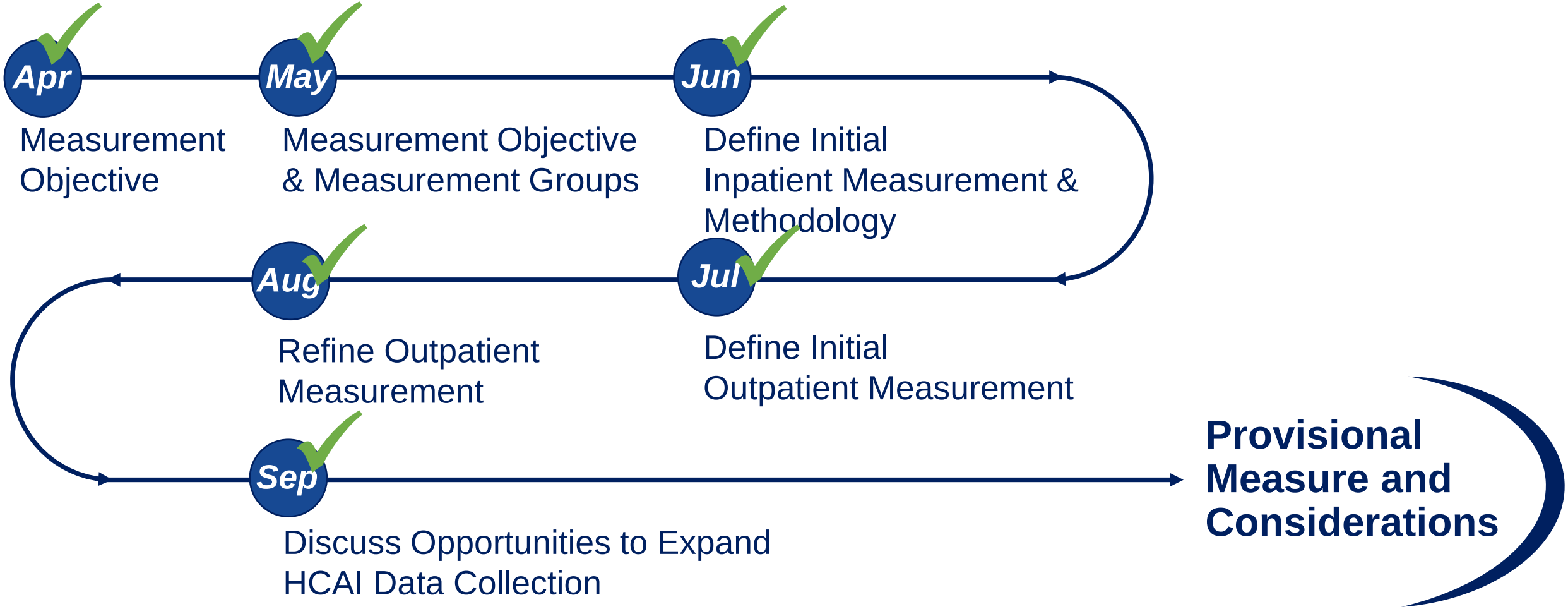
Matt Low, MBA
Staff VP for Provider Economics
Elevance Health

State & Private Purchasers

Julia Logan, MD MPH
Chief Medical Officer
CalPERS

Won Andersen
Chief Operating Officer
Purchaser Business Group on Health

Developing a Provisional Approach with the Workgroup



Data Sources Considered by the Workgroup

Initial Data Sources

- HCAI Hospital Annual Disclosure Report (HCAI HADR)
- HCAI Case Mix Index Public Use File (HCAI CMI PUF)

Potential Future Data Sources

- HCAI Patient Discharge Data Limited Data Set (HCAI PDD)
- HCAI Health Care Payments Database (HPD)
- Supplemental data collection from Payers and/or Providers
- Healthcare Provider Cost Reporting Information System (HCRIS)

Criteria for Determining Initial Data Sources

Use data that is timely and available now and enhance data over time to refine the initial provisional measurement methodology:

- Leverage existing data in initial approach.
- Explore publicly available data first.
- Identify potential opportunities and limitations.
- Add additional data sets over time to enhance the measurement methodology.
- Limit burden on payers and providers.

Initial Data Source: HCAI Hospital Annual Financial Data Report

Opportunities	Limitations
• Uses self reported hospital financial data that is attested to and audited. • Shows revenue and expense patterns, providing a view of the hospital's fiscal standing. • Provides certain cost allocations and revenue sources. • Provides contextual information on a hospital’s revenue and expenses.	• Limited utilization data prevents calculating outpatient utilization and intensity. Inpatient data is used to estimate outpatient utilization. o OHCA is exploring ways to leverage existing data or collecting new data to overcome this limitation (e.g., PDD, HPD). • Data does not allow separating inpatient Net Patient Revenue from outpatient Net Patient Revenue for some payer types.

HCAI Annual Financial Data: Types of Hospital Revenue

Total Revenue	=	Net Patient Revenue (NPR)	+	Other Operating Revenue	+	Non-operating Revenue
		Payments collected by hospitals for inpatient and outpatient care delivered to patients from payers and patients.		Other payments collected by the hospital from operations, such as cafeterias, parking, and COVID relief funds (such as those from the CARES Act).		Revenue from sources other than patient care or activities supporting patient care, such as investment and rental income.

Provisional Approach for Financial Metric

Measure	Definition	Considerations
Net Patient Revenue (NPR)	Payments collected by hospitals from payers and patients for care delivered to patients. Estimated and used for both inpatient and outpatient services.	• Most direct representation of revenue from patient care. • Highly correlated with other financial measures of interest (e.g., price). • When volume and services provided are accounted for, it can serve as a proxy for changes in price. • May be impacted by changes in payer mix, service volume, services provided, and other factors.

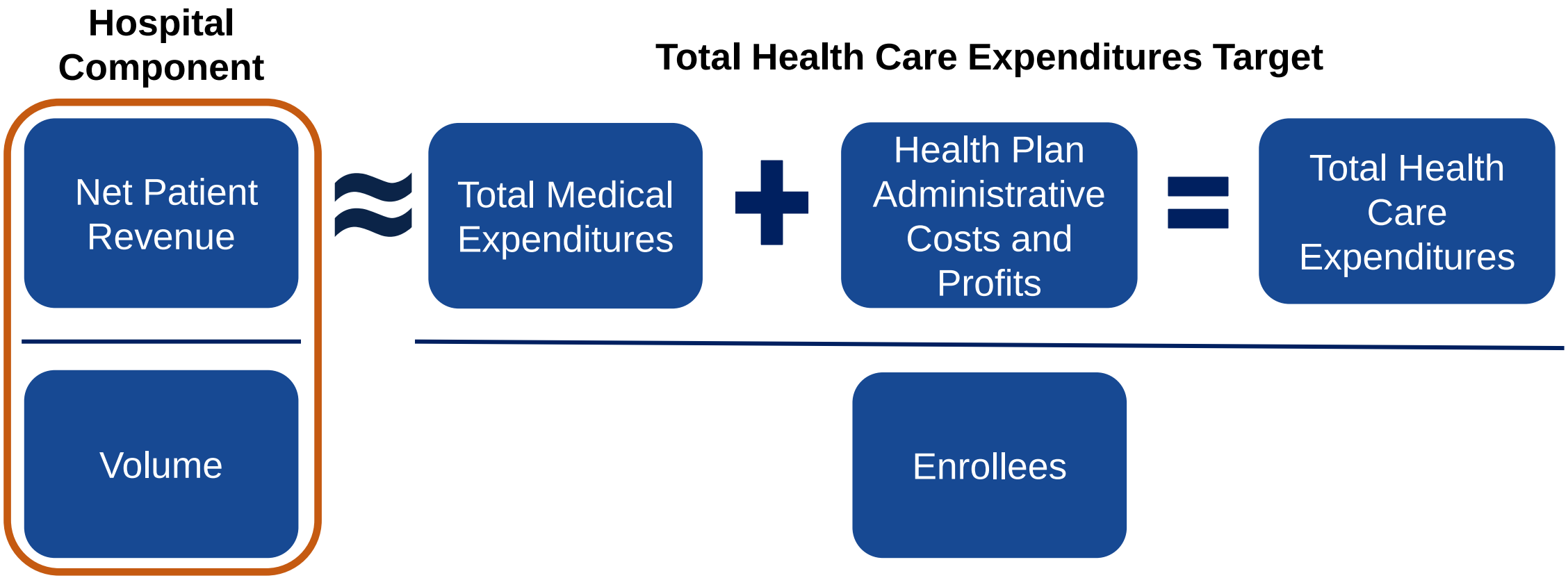
Note: Medi-Cal supplemental payments are reported as credit to contractual adjustments (reduces deductions) and results in increased NPR (higher reimbursement).

Alternative Financial Metrics Considered

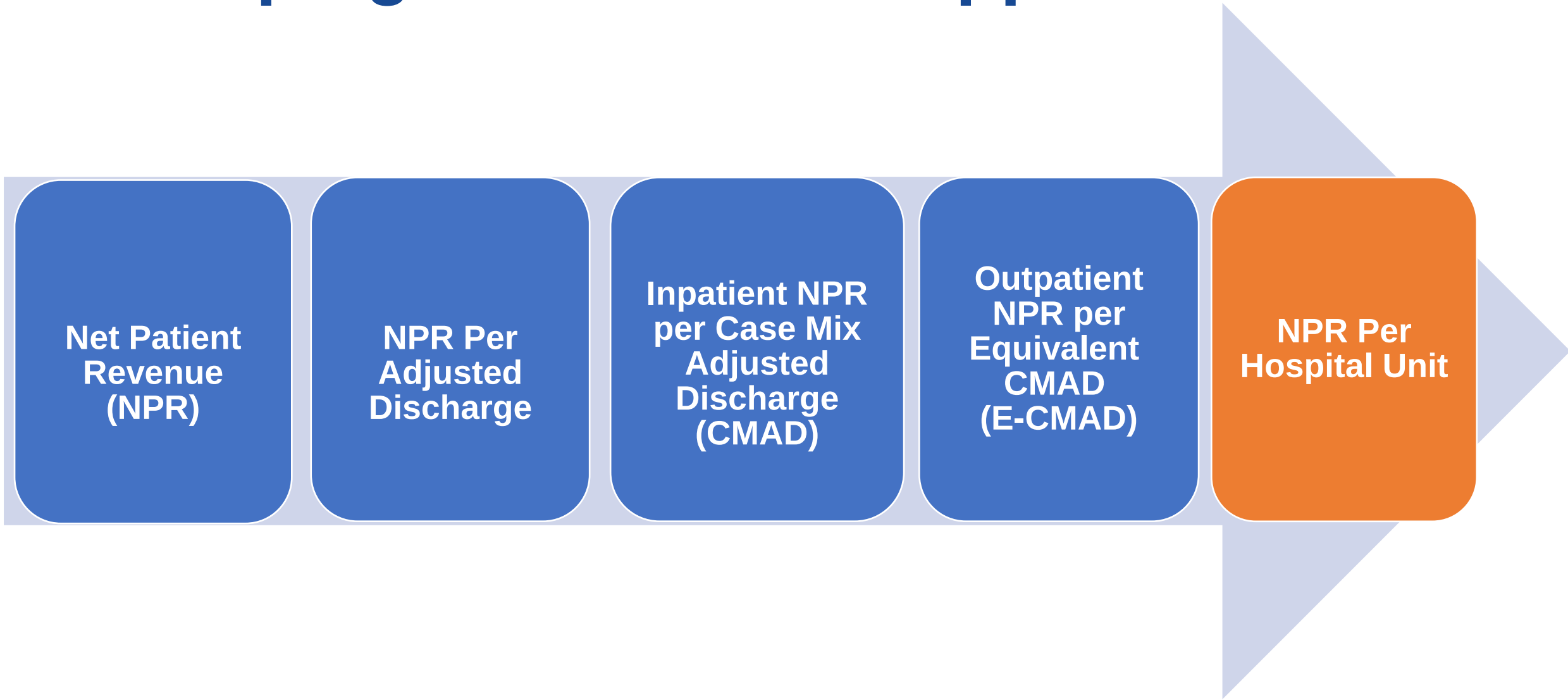
Measure	Definition	Considerations
Total Operating Revenue	NPR **and** other operating revenue (e.g., CARES Act Provider Relief Fund, Public Hospital Redesign and Incentives in Medi-Cal (Prime) Payments).	• Captures some payments from payers to hospitals that are not included in NPR. • Includes revenue not tied to a specific payer and from activities less directly associated with providing care to patients (e.g., cafeteria, COVID relief funds, research, education). • Less aligned with measures of TME and THCE.
Non-operating Revenue	Non-operating Revenue captures how hospitals manage their assets such as cash and securities, real estate, IP derived from research, and alternative investments (hedge funds, VC, private equity, etc.).	• Non-operating Revenue is not associated with patient care. • May obscure hospital payments from the payer. • Fluctuates based on external factors (e.g., investment performance). • May promote changes in investments to moderate growth and favors hospitals with considerable resources.

Net Patient Revenue - Basis of Measurement

Net Patient Revenue is closely connected to hospitals' performance against the spending target. It is the data point most analogous to hospitals' TME component of THCE.



Developing a Provisional Approach



Developing a Provisional Approach

Metric	Inpatient Volume	Inpatient Intensity	Inpatient Revenue	Outpatient Revenue
Net Patient Revenue (NPR)			**X**	**X**

Developing a Provisional Approach

Metric	Definition	Outcome
Net Patient Revenue (NPR)	The amount of money a hospital generates from patient services, excluding charity care, bad debt, and contractual allowances.	Gives us how much revenue is generated, but not how much care is provided (volume) or which services are provided more than others (intensity of inpatient or outpatient services).

Developing a Provisional Approach

Metric	Inpatient Volume	Inpatient Intensity	Inpatient Revenue	Outpatient Revenue
Net Patient Revenue (NPR)			X	X
NPR Per Adjusted Discharge	X		X	X

Developing a Provisional Approach

Metric	Definition	Outcome
NPR Per Adjusted Discharge	The amount of money a hospital generates from patient services, excluding charity care, bad debt, and contractual allowances ***adjusted by the number of hospitalizations to account for inpatient volume***.	Gives us how much revenue is generated and how much care is provided (volume), but not which services are provided more than others (intensity of inpatient or outpatient services).

Developing a Provisional Approach

Metric	Inpatient Volume	Inpatient Intensity	Inpatient Revenue	Outpatient Revenue
Net Patient Revenue (NPR)			X	X
NPR Per Adjusted Discharge	X		X	X
Inpatient NPR per Case Mix Adjusted Discharge (CMAD)	X	X	X	

Note: CMAD is not available on the HCAI Hospital Annual Financial dataset and would necessitate the use/inclusion of HCAI's Case Mix Index dataset.

Developing a Provisional Approach

Metric	Definition	Outcome
Inpatient NPR per Case Mix Adjusted Discharge (CMAD)	The amount of money a hospital generates for patient services, excluding charity care, bad debt, and contractual allowances ***adjusted by the number of hospitalizations to account for inpatient volume and inpatient intensity of services***.	Gives us how much revenue is generated and how much care is provided (volume), and which services are provided more than others in an inpatient care setting (intensity of inpatient services).

Note: CMAD is not available on the HCAI Hospital Annual Financial dataset and would necessitate the use/inclusion of HCAI's Case Mix Index dataset.

Applying Case Mix Index to Hospital Discharges

Description: Hospitals provide different types and intensities of care, which may change over time. Accounting for service mix aims to dull the impact of those changes.

Provisional approach for Inpatient Service Mix: Apply case mix index (CMI).

Rationale: OHCA collects TME by age and gender to account for changes at the population level. For hospital services, case mix index is more appropriate.

Option	Description	Considerations
Case Mix Adjusted Discharges (CMADs)	Uses a standardized factor (i.e., MS-DRG average relative weights) to account for the complexity of inpatient care (or discharges).	• Widely accepted standardized approach; CMI is a factor in many hospitals' payments from Medicare. • Accounts for changes in resource intensity, complexity, and severity of care across entities or over time. • Dulls shift to more expensive services, regardless of whether necessary or appropriate. • Depends on quality, consistency, and accuracy of coding; incentives for diagnostic intensity are difficult to control. • Facilities with fewer resources to dedicate to coding may be penalized.

Inpatient Intensity Methodology

What is Case Mix Index (CMI)?

- The average intensity of care provided by a hospital.

How is it determined?

- For most inpatient stays, a diagnostic-related group (DRG) can be applied to categorize what the hospitalization was for with an estimate of the typical resources required to deliver the service.
  - An average service would have a weight of 1 with higher weights for more resource-intensive care.

$$\boldsymbol{CMI} = \frac{Total\ DRG\ Weights}{Number\ of\ Discharges}$$

Example: Inpatient Provisional Approach

$$CMAD = Total\ inpatient(IP)\ discharges\ * CMI$$

*Example: 1,400 discharges * 1.25 CMI = 1,750 Case Mix Adjusted Discharges*

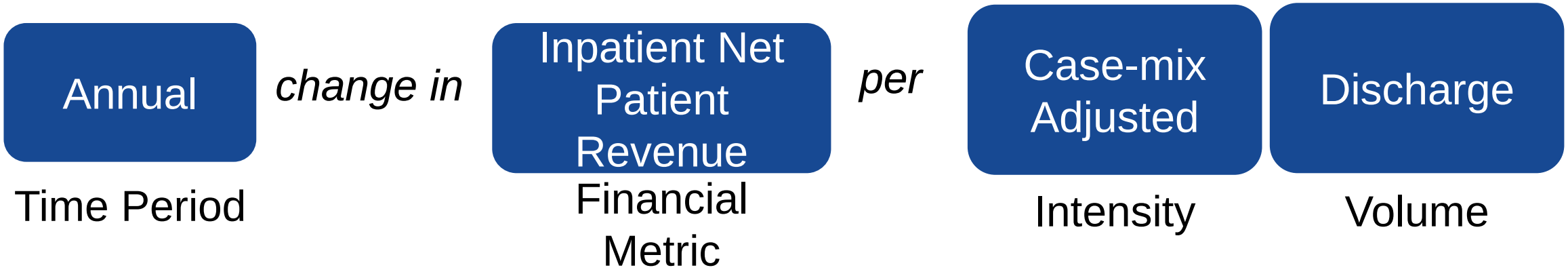
$$Estimated\ IP\ NPR\ per\ CMAD\ = \frac{IP\ NPR}{CMAD}$$

Example: $35 million Net IP Revenue ÷ 1,750 CMADs = $20,000 Estimated IP NPR per CMAD

Inpatient Provisional Approach

Inpatient NPR would be reported in two ways:

1. By payer type (Medi-Cal, Medicare, Commercial).
2. As a single weighted average from a baseline period to show what the change would have been if payer type mix was held constant.



Developing a Provisional Approach

Metric	Inpatient Volume	Inpatient Intensity	Inpatient Revenue	Outpatient Revenue
Net Patient Revenue (NPR)			X	X
NPR Per Adjusted Discharge	X		X	X
Inpatient NPR per Case Mix Adjusted Discharge (CMAD)	X	X	X	
Outpatient NPR Per Equivalent CMAD	X	X		X

* ECMAD is not available on the HCAI Hospital Annual Financial dataset and would necessitate the use/inclusion of HCAI's Case Mix Index dataset.

Background: Outpatient Services

In the HCAI data, total outpatient visits is a sum of various services:

- Emergency services (including psych ER)
- Clinic (including satellite clinics)
- Observation care visits
- Psychiatric Day-Night care visits
- Home health care services
- Hospice – outpatient
- Outpatient surgeries
- Private referred
- Other (including chemical dependency services, adult day health care, and renal dialysis visits)

- **As shown left, the types of outpatient services vary.**
- **While the HCAI data includes a count of total outpatient visits, it is difficult to interpret what is changing, in particular the resource-intensity of outpatient services.**

Accounting for Outpatient Volume

Description: The number of services provided varies by hospital and over time for the same hospital.

Provisional approach for Outpatient Intensity and Volume: Equivalent Case Mix Adjusted Discharge (E-CMAD)

Rationale: Using available data, OHCA needs a measure that accounts for the intensity and volume of services provided. E-CMAD is analogous to IP CMAD and offers a nationally consistent approach.

Option	Description	Considerations
Equivalent Case Mix Adjusted Discharge (E-CMAD)	Estimate of the number of inpatient CMADs that would be needed to equal total outpatient NPR	• Can complete with available data. • Accounts for volume. • Used in Maryland and CMS' AHEAD model. Rhode Island is considering for its global budget model. • Simplistic – does not account for the variety of outpatient services delivered.

Example: Outpatient Provisional Approach

E-CMADs estimate the number of CMADs that would be necessary to equal Total Outpatient NPR. It offers a common unit of measurement across inpatient (IP) and outpatient.

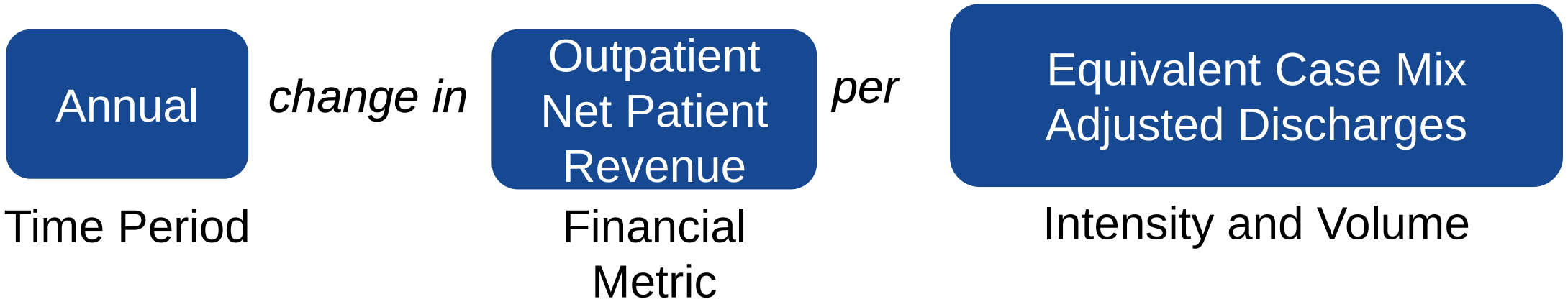
$$E\text{-}CMAD = \frac{Total\ NPR\ - Estimated\ IP\ NPR}{Estimated\ IP\ NPR\ per\ CMAD}$$

Example: ($150 million Total NPR - $35 million Estimated IP NPR) ÷ $20,000 = 5,750 E-CMADs

Outpatient Provisional Approach

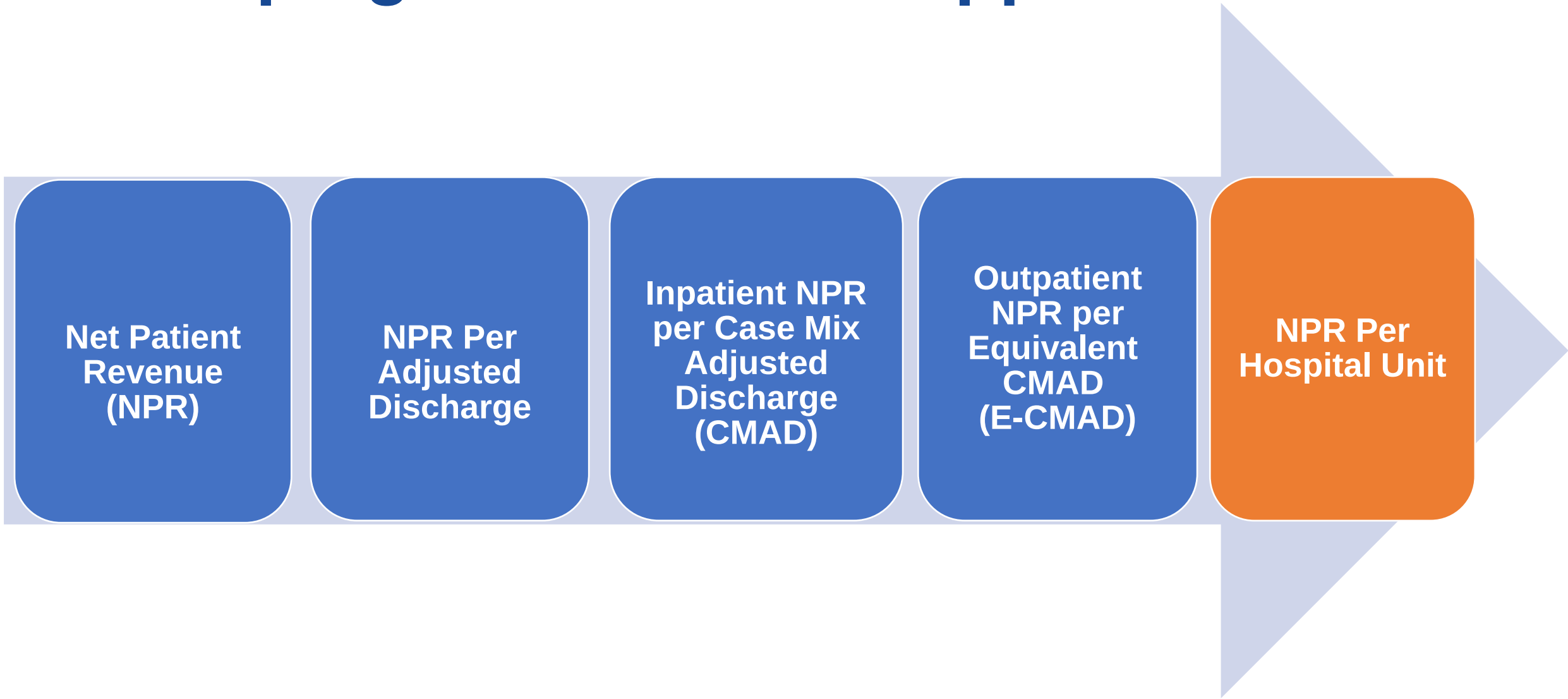
Outpatient NPR would be reported in two ways:

1. By payer type (Medi-Cal, Medicare, Commercial) to show payer specific changes year over year.
2. As a single weighted average from a baseline period to show what the change would have been if payer type mix was held constant.



Care in an outpatient setting is different from care in an inpatient setting because outpatient visits may include emergency services (including psych emergency response), clinic (including satellite clinics), observation care days, psychiatric day-night care days, home health care services, outpatient hospice and surgeries, chemical dependency services, adult day health care, and renal dialysis visits.

Developing a Provisional Approach



Developing a Provisional Approach

Metric	Inpatient Volume	Inpatient Intensity	Inpatient Revenue	Outpatient Revenue
Net Patient Revenue (NPR)			X	X
NPR Per Adjusted Discharge	X		X	X
Inpatient NPR per Case Mix Adjusted Discharge (CMAD)	X	X	X	
Outpatient NPR Per Equivalent CMAD	X	X		X
NPR Per Hospital Unit*	X	X	X	X

*The final measure, Net Patient Revenue Per Hospital Unit, uses inpatient volume and intensity to adjust Outpatient Net Patient Revenue and does not account for outpatient volume and intensity.

Example: Inpatient Provisional Approach

$$CMAD = Total\ inpatient\ discharges\ * CMI$$

*Example: 1,400 discharges * 1.25 CMI = 1,750 Case Mix Adjusted Discharges*

$$Estimated\ IP\ NPR\ per\ CMAD\ = \frac{IP\ NPR}{CMAD}$$

Example: $35 million Net IP Revenue ÷ 1,750 CMADs = $20,000 Estimated IP NPR per CMAD

Example: Outpatient Provisional Approach

E-CMADs estimate the number of CMADs that would be necessary to equal Total Outpatient NPR.

- It offers a common unit of measurement across inpatient and outpatient

$$E\text{-}CMAD = \frac{Total\ NPR\ - Estimated\ IP\ NPR}{Estimated\ IP\ NPR\ per\ CMAD}$$

Example: ($150 million Total NPR - $35 million Estimated IP NPR) ÷ $20,000 = 5,750 E-CMADs

NPR per Hospital Unit: Measuring Inpatient and Outpatient Spending Together

Together, having a common unit of measurement allows OHCA to track annual changes in a hospital's total net patient revenue, while accounting for inpatient intensity and volume and scaling outpatient volume by inpatient intensity.

$$NPR\ per\ Hospital\ Unit = \frac{Total\ NPR}{CMAD + E\text{-}CMAD}$$

Example: $150 million Total NPR ÷ (1,750 CMADs + 5,750 E-CMADs) = $20,000 NPR per Hospital Units

Hospital Spending Measurement

Does the board have any input to the provisional approach for hospital measurement?

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Public Comment

HCAI

Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Sector Targets

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

HCAI

Department of Health Care Access and Information

Health Care Sectors and Spending Targets

Statutory Requirements for Timing and Process

- **On or before October 1, 2027**, the board shall define initial health care sectors, which may include geographic regions and individual health care entities, as appropriate, except fully integrated delivery systems, considering factors such as delivery system characteristics. Sectors may be further defined over time. The office shall promulgate regulations accordingly.
- **Not later than June 1, 2028**, the board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, in accordance with this chapter.
- Once sectors are defined in regulation, the office and board will follow the statutory requirements for setting sector targets by June 1, 2028, as these requirements pertain to all spending targets established by the board.

Process for Public Meetings

- The board shall hold a public meeting to discuss the development and adoption of recommendations for specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities.
- The board shall deliberate and consider input, including recommendations from the office, the advisory committee, and public comment. Cost targets and other decisions of the board consistent with this section shall not be adopted, enforced, revised, or updated until presented at a subsequent public meeting.

Health Care Sectors and Spending Targets

Statutory Requirements for Timing and Process

- The office shall publish on its internet website its recommendations for proposed cost targets for the board's review and consideration. The board shall discuss recommendations at a public meeting for proposed targets **on or before March 1** of the year prior to the applicable target year.
- The board shall receive and consider public comments for 45 days after the board meeting.
- **Not later than June 1, 2028**, the board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, in accordance with this chapter.

Health Care Sectors and Spending Targets

Statutory Requirements for Setting Sector Targets

- The setting of different targets by health care sector **shall be informed by historical cost data and other relevant supplemental data**, such as financial data on health care entities submitted to state agencies and the Health Care Payments Data Program, as well as consideration of access, quality, equity, and health care workforce stability and quality jobs.
- Development of sector targets will be done in a manner that minimizes fragmentation and potential cost shifting.
- The board may adjust sector targets as necessary to account for baseline costs in comparison to other health care entities in the health care sector and geographic region.
- It shall also encourage cooperation in meeting the statewide and geographic region targets.
- Sector target definitions will specify the single sector target that is applicable if an entity falls within multiple sectors.

Health and Safety Code § 127500.2 and § 127502

Sector Target Options

- Definitions for the Board's consideration may include but are not limited to:
  1. Geographic Regions
  2. Provider Category (e.g., Hospitals, Physician Organizations)
  3. Payer and/or Provider by Market Category
  4. Individual Health Care Entities
- Fully integrated delivery systems are already defined in the statute and the board may establish a fully integrated delivery system target.
- The statute also requires that the definition of health care sectors consider factors such as delivery system characteristics and allows sectors to be further defined over time.

Considerations: Geographic Region, Market, Physician Organizations, and Fully Integrated Delivery System Sector

- OHCA has just begun the process of collecting payer-level and regional TME. OHCA collected the first submission of 2022-2023 data in September 2024 and will feature this data in the baseline report published in June 2025.
- Currently, OHCA has limited data to inform the establishment of potential sectors. It would be more informative to have more than one year of spending growth trend before establishing sectors based on geographic region, market, payer, physician organizations, and/or fully integrated delivery system.
- However, OHCA does have historical data on hospital spending, and OHCA has developed a provisional measurement for hospitals using existing HCAI Hospital Annual Financial Data.

Recap of Board Feedback as Options for a Hospital Sector

Based on the considerations above, and input received from the board, OHCA is focusing today's discussion on potential approaches to establishing hospital sectors.

Options mentioned in the October 2024 meeting include:

1. Define individual hospitals as a sector (i.e., Three Monterey County Hospitals) and set a lower target.
2. Set lower spending targets on high-cost hospitals.

Note: Currently all hospitals are subject to the statewide spending target and those not included in a sector target remain subject to the statewide target.

Landscape of California Hospitals

Hospitals in California

- California has 439* hospitals, ranging from large academic medical centers to community-based hospitals.
- Hospitals are distributed across urban and rural areas, with the highest concentration in major metropolitan areas like Los Angeles, San Francisco, and San Diego.
- California hospitals include general, children's, psychiatric, academic medical centers/teaching hospitals, county hospitals, small and rural hospitals, critical access hospitals and specialty care facilities providing specialized services (e.g., rehabilitation, cancer treatment, heart surgery, addiction recovery, respiratory care, neurological services, long-term care, orthopedic surgery, and mental health care).

* This number represents a distinct count of health care facilities subject to filing HCAI Hospital Annual Disclosure Reports. Source: 2023 CY Hospital Annual Selected File (October 2024 Extract), https://data.chhs.ca.gov/dataset/ea0c8ca9-023e-46a3-b95b-b9d4ab8ec195/resource/244efb23-daf0-4137-9609-1bc25e4612b8/download/hadr-2023.xlsx.

Design Consideration: High-Cost Hospitals

Should OHCA focus on high-cost hospitals, high-growth hospitals, or a combination of both?

- Focusing on high-cost only may narrowly focus on hospitals with a high per unit measurement due to the intensity of services provided and patient population served.
- Focusing on growth only may disregard hospitals that have established high costs and represent high percentage of overall spend but are not growing quickly.
- A combined focus may be the most reliable way to identify hospitals that contribute toward THCE growth.

Should OHCA focus on hospitals with higher total revenue?

- Higher revenue facilities are also a proxy for larger hospitals.
- Higher revenue facilities contribute more towards the state's TME/THCE measures.

Design Consideration: High-Cost Hospitals

There are various categories of hospitals that are high-cost.

If addressing high-cost hospitals, should all hospital categories be treated the same or should some be treated differently?

Potential Hospital Categories to Consider

1. Critical Access Hospitals
2. Small Hospitals
3. Psychiatric Hospitals
4. Children’s Hospitals
5. Teaching Hospitals/Academic Medical Centers
6. Specialty Hospitals
7. State Hospitals
8. County Hospitals
9. Hospitals with long average lengths of stays

1. Critical Access Hospitals

Context:

There are 38 Critical Access Hospitals in California. These hospitals are in rural parts of California and are the only sources of care available for residents in these areas.

Considerations:

- Rely predominantly on public payers (Medicare & Medicaid).
- Very small commercial coverage patient populations.
- Represent a small percentage of total hospital spending in the state.
- High operating costs to provide essential services in remote areas with small patient populations.
- Typically have small operating margins.

Note: Full definition of a Critical Access Hospital can be found in the appendix. Source: Health Resources and Services Administration Data Explorer, https://data.hrsa.gov/tools/data-explorer?paramServiceId=CMS&paramCMSSubCat=Critical%20Access%20Hospitals.

2. Small Hospitals

Context:

There are multiple ways to define small hospitals (e.g., licensed bed count, total discharges, total operating revenues, other).

Consideration:

- Tend to vary greatly year-to-year in spending, with small changes leading to significant fluctuations.
- Represent a small portion of overall statewide hospital spending, specifically 3% of the total Net Patient Revenue.

3. Psychiatric Hospitals

Context:

Based on HCAI data, there are 66 psychiatric hospitals in California. The designation of a psychiatric hospital is self-reported/identified. These hospitals provide a preponderance of psychiatric services.

Considerations:

- Only 1% of Net Patient Revenue and Total Operating Revenue across all hospitals.
- For psychiatric hospitals in California, the average length of stay is 12.4 days, while for general acute care hospitals it is 5.7 days.

Source: 2023 CY Hospital Annual Selected File (October 2024 Extract), https://data.chhs.ca.gov/dataset/ea0c8ca9-023e-46a3-b95b-b9d4ab8ec195/resource/244efb23-daf0-4137-9609-1bc25e4612b8/download/hadr-2023.xlsx.

4. Children’s Hospitals

Context:

Based on HCAI data, there are 10 children’s hospitals in California. The designation of a Children’s Hospital is self-identified in HCAI data. There are likely facilities that specialize in or focus on care for children that do not self-identify as a Children’s Hospital.

Considerations:

- Children’s Hospitals generally specialize in higher acuity care or specialized services.

Source: 2023 CY Hospital Annual Selected File (October 2024 Extract), https://data.chhs.ca.gov/dataset/ea0c8ca9-023e-46a3-b95b-b9d4ab8ec195/resource/244efb23-daf0-4137-9609-1bc25e4612b8/download/hadr-2023.xlsx.

5. Teaching Hospitals

Context:

Based on HCAI data, there are 44 teaching hospitals* in California. HCAI identified teaching hospitals based primarily on the American Medical Association's Graduate Medical Education (GME**) Directory.

Considerations:

- Costs associated with GME and other resources may skew upward the average cost per discharge.
- Although there are only 44 Teaching hospitals, they make up 40% of total operating revenue for all hospitals.

*Includes Academic Medical Centers. **Graduate Medical Education is more commonly referred to as "residency" and "fellowship" training. The 3 to 9 years of training allows physicians to specialize and practice independently following medical school. Source: 2023 CY Hospital Annual Selected File (October 2024 Extract), https://data.chhs.ca.gov/dataset/ea0c8ca9-023e-46a3-b95b-b9d4ab8ec195/resource/244efb23-daf0-4137-9609-1bc25e4612b8/download/hadr-2023.xlsx.

6. Specialty Hospitals

Context:

There is not a statutory definition of what constitutes a specialty hospital, however, based on HCAI data there are 38 self-reported specialty hospitals. Examples of care provided by specialty hospitals may include rehabilitation, cancer treatment, heart surgery, addiction recovery, respiratory care, neurological services, long-term care, orthopedic surgery, and mental health care.

Considerations:

These facilities may offer services that are not always widely available throughout California's hospital network and may have different cost structures or cost drivers leading to higher average costs and/or higher average growth rates.

Source: 2023 CY Hospital Annual Selected File (October 2024 Extract), https://data.chhs.ca.gov/dataset/ea0c8ca9-023e-46a3-b95b-b9d4ab8ec195/resource/244efb23-daf0-4137-9609-1bc25e4612b8/download/hadr-2023.xlsx.

7. State Hospitals

Context:
Based on HCAI data, there are 6* state hospitals in California that provide mental and behavioral health services to patients referred by a county court, a prison, or a parole board. California's state hospitals are Atascadero, Coalinga, Metropolitan (in Los Angeles County), Napa, Patton, and Porterville. Funding for these hospitals is through the General Fund and reimbursements from counties.

Considerations:
- These state-run facilities support correctional health care services.
- Their funding comes through a state appropriation determined through the state budget process.
- They do not submit all financial exhibits to HCAI.

*The Department of State Hospitals operates Atascadero, Coalinga, Metropolitan, Napa and Patton. Porterville Developmental Center (https://hcai.ca.gov/facility/porterville-developmental-center/) is operated by the Department of Development Services and is licensed as a general acute hospital.
Source: 2023 CY Hospital Annual Selected File (October 2024 Extract), https://data.chhs.ca.gov/dataset/ea0c8ca9-023e-46a3-b95b-b9d4ab8ec195/resource/244efb23-daf0-4137-9609-1bc25e4612b8/download/hadr-2023.xlsx

8. County Hospitals

Context:

Counties are responsible for health care for low-income uninsured residents who have no other sources of care. There are 12 counties that run hospitals or health care systems. Some counties own and operate hospitals and clinics; some counties only operate clinics and contract with private or University of California hospitals for care.

Considerations:

- County hospitals are core providers to Medi-Cal and uninsured patients.
- There is significant variation among counties regarding program design, eligibility, administration and funding.

9. Hospitals with long average lengths of stays

Context:

Some hospitals tend to have relatively longer lengths of stay. Based on HCAI data, in 2023 the median hospital has an average length of stay of 5.8 days and the average length of stay across all discharges statewide is 6.7 days. 66 hospitals have an average length of stay of 20 or more days.

Considerations:

These facilities often have high costs on a per discharge basis regardless of measurement approach.

Source: Internal Analysis of 2023 CY Hospital Annual Selected File (October 2024 Extract), https://data.chhs.ca.gov/dataset/ea0c8ca9-023e-46a3-b95b-b9d4ab8ec195/resource/244efb23-daf0-4137-9609-1bc25e4612b8/download/hadr-2023.xlsx.

Other Hospital Categories

Are there other categories of hospitals that may merit differential treatment or consideration in defining a potential sector?

Next Steps

The Board will have a meeting in December 2024 to discuss further design considerations and any follow-up items discussed today.

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Public Comment

HCAI

Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Introduction to Behavioral Health Spending and Defining Behavioral Health Spending, Including Advisory Committee Feedback

Margareta Brandt, Assistant Deputy Director

HCAI

Department of Health Care Access and Information

Focus Areas for Promoting High Value

APM Adoption	• Define, measure, and report on alternative payment model adoption • Set standards for APMs to be used during contracting • Establish a benchmark 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

Primary Care & Behavioral Health Investments

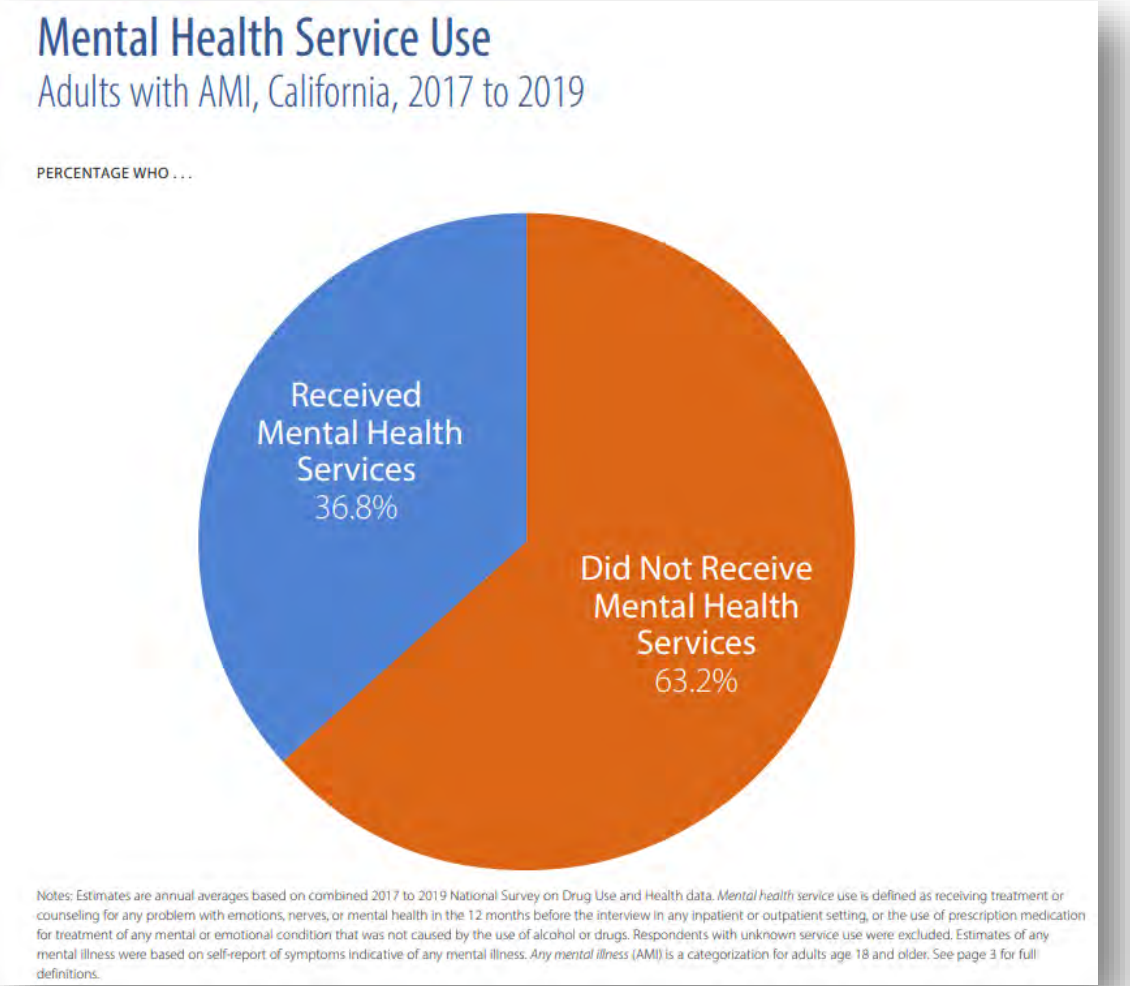
Statutory Requirements

- Measure and promote a sustained systemwide investment in primary care and behavioral health.
- **Measure the percentage of total health care expenditures allocated to primary care and behavioral health** and set spending benchmarks that consider current and historic underfunding of primary care services.
- **Develop benchmarks** with the intent to build and sustain infrastructure and capacity and shift greater health care resources and investments away from specialty care and toward supporting and facilitating innovation and care improvement in primary care and behavioral health.
- Promote improved outcomes for primary care and behavioral health.

Why Behavioral Health?

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

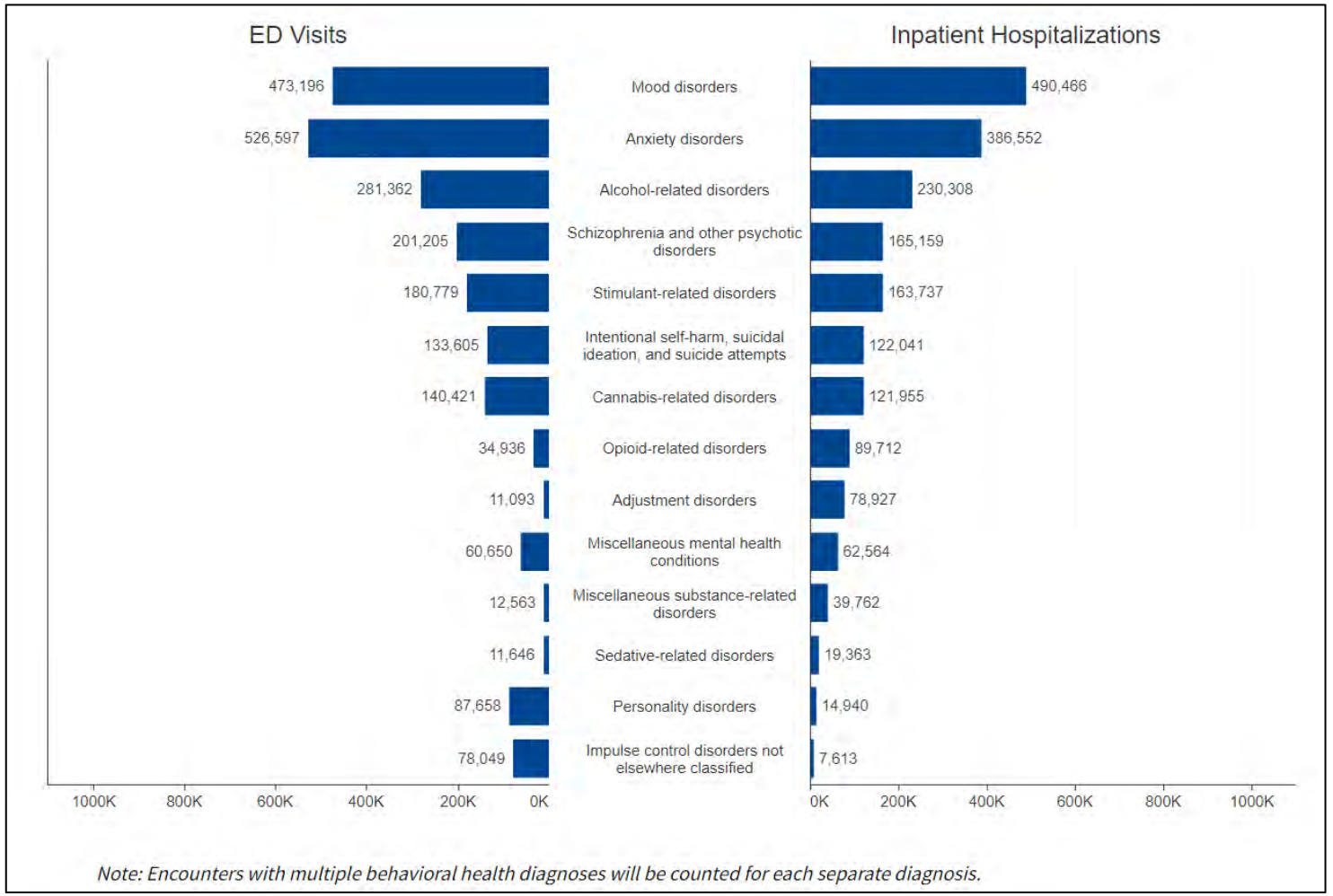
- Evidence indicates that effective treatment for behavioral health conditions, especially in integrated care settings, contributes to better behavioral and overall health outcomes and correlates to reduced health care costs.



California Health Care Foundation, July 2022. *Mental Health in California: Waiting for Care*. https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022.pdf
Bellon, et al. Association of Outpatient Behavioral Health Treatment with Medical and Pharmacy Costs in the First 27 Months following a New Behavioral Health Diagnosis in the US. *JAMA Network Open.* 2022;5(12):e2244644. doi:10.1001/jamanetworkopen.2022.44644
Katon, et al. Collaborative Care for Patients with Depression and Chronic Illnesses. N Engl J Med 2010;363:2611-20. https://www.nejm.org/doi/full/10.1056/nejmoa1003955
Unutzer and Katon. Long-term Cost Effects of Collaborative Care for Late-life Depression. American Journal of Managed Care Feb 2008,14(2):95-100. https://www.ajmc.com/view/feb08-2835p095-100

Patient Discharge Data: Behavioral Health Diagnoses in Acute Care Settings, 2021

- Encounters for nearly 1 million emergency department visits and over 877,000 hospitalizations in California in 2021 included a mood or anxiety disorder diagnosis.
- Substance use disorders were the primary or secondary diagnosis for over 1.3 million hospitalizations and emergency department visits.



Investment and Payment Workgroup Members

Providers & Provider Organizations

Bill Barcellona, Esq., MHA
Executive Vice President of Government Affairs, America's Physician Groups

Lisa Folberg, MPP
Chief Executive Officer, California Academy of Family Physicians (CAFP)

Paula Jamison, MAA
Senior Vice President for Population Health, AltaMed

Amy Nguyen Howell MD, MBA, FAAFP
Chief of the Office for Provider Advancement (OPA), Optum

Parnika Prashasti Saxena, MD
Chair, Government Affairs Committee, California State Association of Psychiatrists

Catrina Reyes, Esq.
Deputy General Counsel, California Primary Care Association (CPCA)

Janice Rocco
Chief of Staff, California Medical Association

Hospitals & Health Systems

Ash Amarnath, MD, MS-SHCD
Chief Health Officer, California Health Care Safety Net Institute

Kirsten Barlow, MSW
Vice President Policy, California Hospital Association (CHA)

Jodi Nerell, LCSW
Director of Local Mental Heath Engagement, Sutter Health

Health Plans

Stephanie Berry, MA
Government Relations Director, Elevance Health (Anthem)

Rhonda Chabran, LCSW
Vice President, Behavioral Health & Wellness, Kaiser Foundation Health Plan, Southern CA & HI

Keenan Freeman, MBA
Chief Financial Officer, Inland Empire Health Plan (IEHP)

Nicole Stelter, PhD, LMFT
Director of Behavioral Health, Commercial Lines of Business, Blue Shield of California

Yagnesh Vadgama, BCBA
Vice President of Clinical Care Services, Autism, Magellan

Consumer Reps & Advocates

Beth Capell, PhD
Contract Lobbyist, Health Access California

Jessica Cruz, MPA
Executive Director, National Alliance on Mental Illness (NAMI) CA

Nina Graham
Transplant Recipient and Cancer Survivor, Patients for Primary Care

Héctor Hernández-Delgado, Esq.
Senior Attorney, National Health Law Program

Cary Sanders, MPP
Senior Policy Director, California Pan-Ethnic Health Network (CPEHN)

Academics & SMEs

Sarah Arnquist, MPH
Principal Consultant, SJA Health Solutions

Crystal Eubanks, MS-MHSc
Vice President Care Transformation, California Quality Collaborative (CQC)

Kevin Grumbach, MD
Professor of Family and Community Medicine, UC San Francisco

Reshma Gupta, MD, MSHPM
Chief of Population Health and Accountable Care, UC Davis

Vicky Mays, PhD
Professor, UCLA, Dept. of Psychology and Center for Health Policy Research

Catherine Teare, MPP
Associate Director, Advancing People-Centered Care, California Health Care Foundation (CHCF)

State & Private Purchasers

Lisa Albers, MD
Assistant Chief, Clinical Policy & Programs Division, CalPERS

Teresa Castillo
Chief, Program Policy Section, Medical Behavioral Health Division, Department of Health Care Services

Jeffrey Norris, MD
Value-Based Care Payment Branch Chief, California Department of Health Care Services (DHCS)

Monica Soni, MD
Chief Medical Officer, Covered California

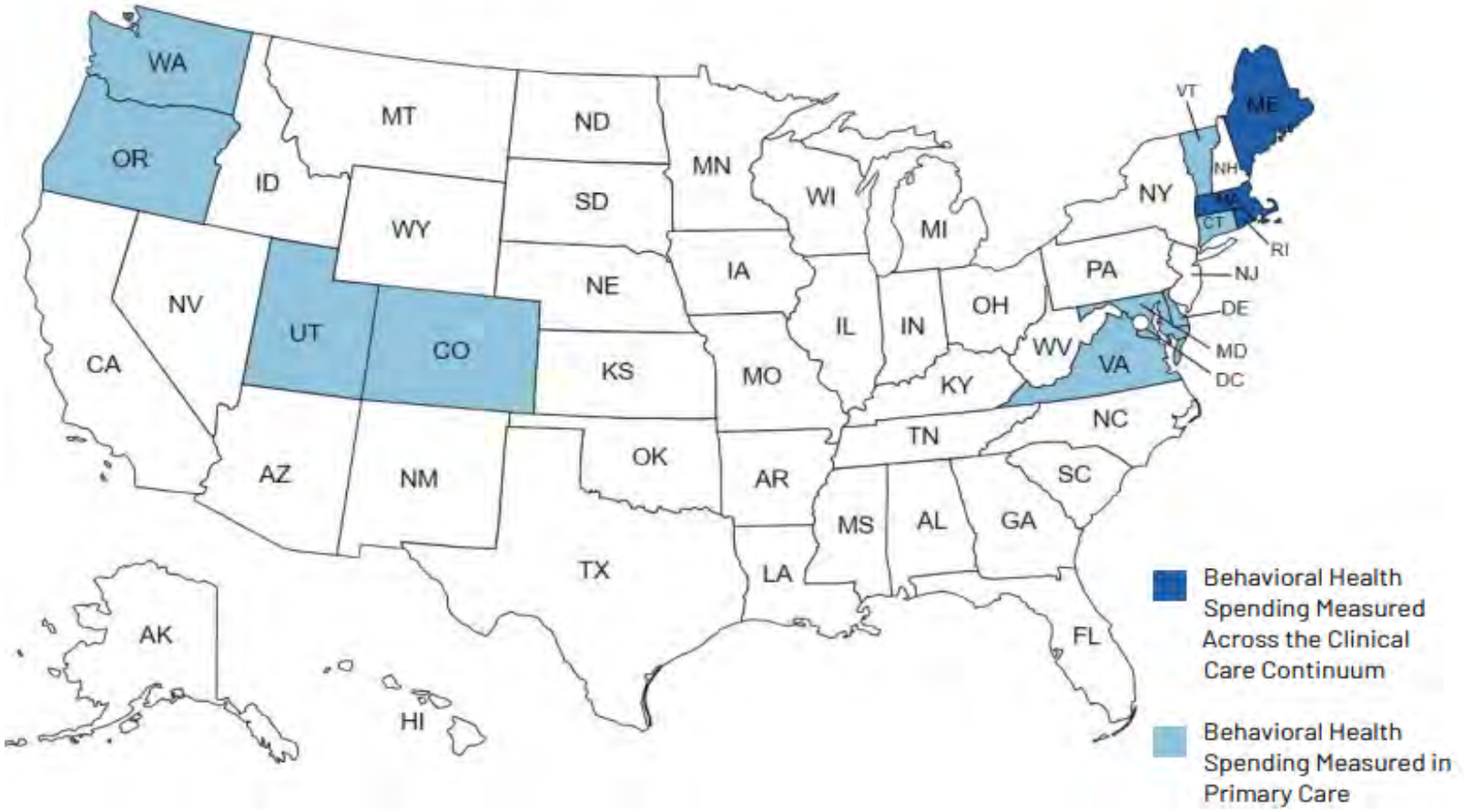
Dan Southard
Chief Deputy Director, Department of Managed Health Care

Behavioral Health Spending Measurement Framework

States Measuring Behavioral Health Clinical Spending

Nine states measure behavioral health spending as part of their efforts to measure primary care spending.

Three states measure behavioral health spending across the full care continuum (Maine, Massachusetts, and Rhode Island). This is California's mandate as well.

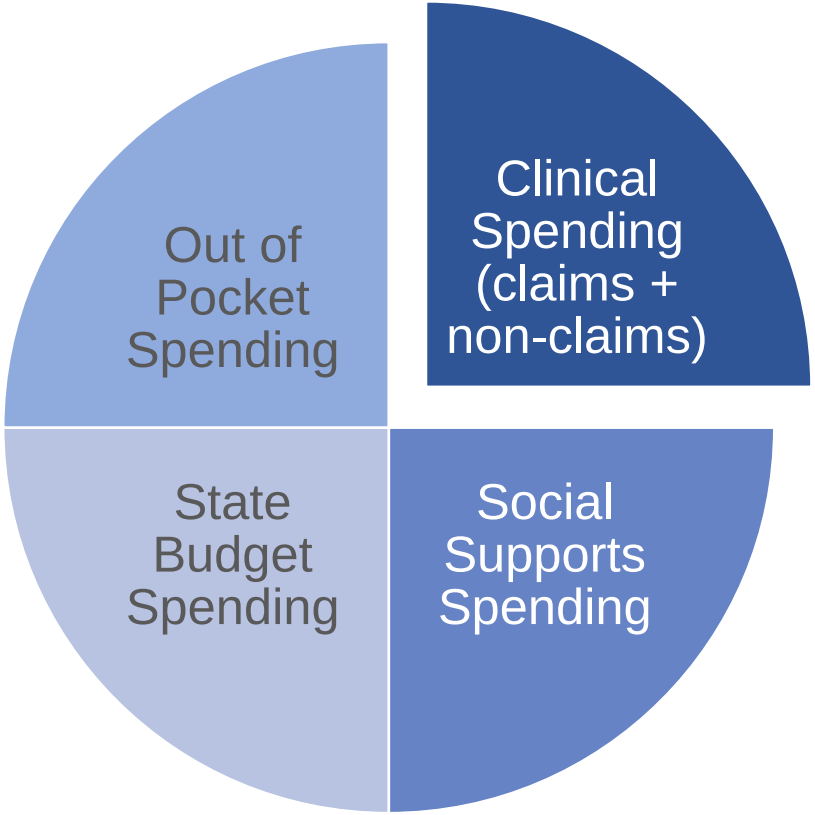


Potential Use Cases for OHCA's Behavioral Health Measurement

- Measure behavioral health spending as a percentage of Total Health Care Expenditures (THCE)
- Understand spending on mental health care and substance use disorder services
- Understand spending on behavioral health services in primary care settings
- Understand the distribution of behavioral health spending across different types of services and care settings
- Establish a focused benchmark for behavioral health spending that supports statewide goals and priorities

Data Collection and Measurement Scope

Clinical services are services provided by medical and allied health professionals to prevent, treat, and manage illness, and to preserve mental well-being across the clinical care continuum, paid via claims and non-claims payments (e.g., outpatient therapy visit, day treatment programs).



- Initial focus on clinical services and health care payers (e.g., commercial and Medicare Advantage)
- Possibility of using supplemental data sources to capture spending from other categories in the future

Adapted from Milbank Memorial Fund, April 2024. *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.* https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

Measuring Behavioral Health Investment

Numerator

Claims-based payments for behavioral health + Non-claims-based payments for behavioral health = Total behavioral health investment

Denominator

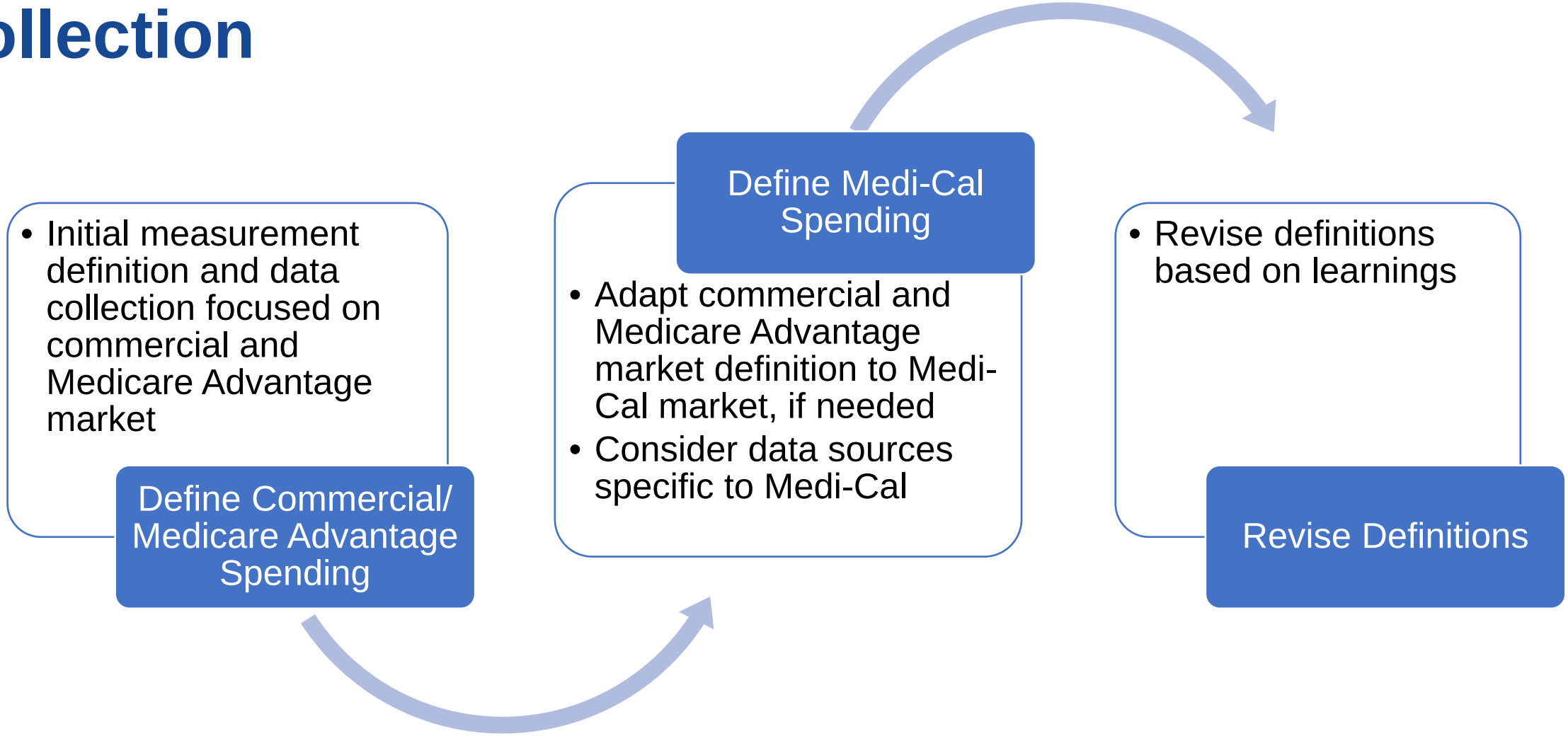
Total claims-based payments + Total non-claims-based payments = Total cost of care

X 100% = Behavioral health investment as a % of total cost of care

Three Recommended Modules for Behavioral Health Spending Measurement

OHCA proposes to use three modules to measure behavioral health spending, following the approach for measuring primary care spending. Behavioral health in primary care will be measured separately so it can be included in analyses of behavioral health or primary care spending.

Proposed Phased Approach to Behavioral Health Spending Measurement Definition and Data Collection



Other State Approaches to Defining Behavioral Health

States develop behavioral health definitions to support data collection and measurement, reporting, all-payers claims databases analyses, and to inform state policy.

Behavioral Health Spend Definition	Restrict by Diagnosis	Categorize Services by Care Setting	Limit to Certain Provider Types
Milbank Memorial Fund	✓	✓	
Maine	✓		
Massachusetts	✓	✓	
Rhode Island	✓		

Milbank Memorial Fund, April 2024. *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.* https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

High-Level Considerations and Trade Offs

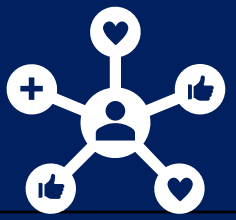
Key Decision	Considerations	Related Decisions
Restrict by Diagnosis	Necessary to: • Measure substance use disorder (SUD) and mental health (MH) separately • Capture spend by non-behavioral health clinicians (e.g., PCPs) and in non-behavioral health care settings (e.g., ED, acute care hospitals) due to broad service codes • Support a benchmark focused on specific diagnoses	• Which diagnoses to include? • Include primary diagnosis or more? • Filter by diagnosis in the same way across all providers/facilities?
Categorize Services by Care Setting	Necessary to: • Understand spend by care setting (e.g., inpatient, outpatient) • Support a benchmark focused on certain care settings	• Which care settings to include? • Which services to include? • How to treat behavioral health in primary care?
Limit to Certain Provider Types	• Excludes some behavioral health spend • With categorization, could support understanding spend by certain provider types • Necessary to support a benchmark focused on certain providers	• Which types of providers to include? • Limit to certain providers for all care settings or only primary care?

OHCA Data Sources for Measuring Behavioral Health Investment

- OHCA will collect the data to measure behavioral health spending as part of its Total Health Care Expenditures (THCE) data collection efforts; THCE data submissions do not capture all sources of behavioral health spending
- Behavioral health spending data will include claims and non-claims payments, which will be categorized using the Expanded Framework
- OHCA will provide definitions, technical specifications, and technical assistance to support submitters accurately allocating payments to behavioral health, particularly for non-claims payment categories
- OHCA is planning for initial behavioral health data collection and measurement efforts to focus on the commercial and Medicare Advantage populations

Behavioral Health Investment Benchmark

Proposed Goals for Improved Behavioral Health Care

				
Accessible	**Comprehensive**	**Coordinated**	**Equitable**	**High Quality**
• Providers and services are available when and where needed • Culturally responsive and linguistically concordant • Affordable	• Services across the continuum • More treatment in community and ambulatory settings, reduced need in emergency departments and correctional facilities	• Services integrated across behavioral health settings and with primary care • Attentive and responsive to health-related social needs	• Reduced disparities in utilization and outcomes • Reduced misinformation, stigma, and discrimination	• Improved behavioral health and overall health outcomes • Low frustration, high satisfaction

Adapted from CalHHS, "Policy Brief: Understanding California's Recent Behavioral Health Reform Efforts." March 2023. https://www.chhs.ca.gov/wp-content/uploads/2023/03/CalHHS-Behavioral-Health-Roadmap-_-ADA-03.02.23.pdf

OHCA's Role in Improving Behavioral Health Outcomes

Systemwide Behavioral Health Goals

Behavioral health care that is:

- Accessible
- Comprehensive
- Coordinated
- Equitable
- High Quality

Motivate

Resulting In

California Stakeholder Actions

- Identify and support higher value care
- Build and sustain infrastructure and capacity
- Promote behavioral health integration with primary care and social and public health services
- Reduce disparities

Supports

OHCA's Behavioral Health Workstream

- Promote sustained systemwide investment in behavioral health
- **Measure and report** the percentage of total health care expenditures allocated to behavioral health care
- Set focused **spending benchmarks** to support improved behavioral health outcomes
- Conduct analysis

Examples of how OHCA can support better behavioral health outcomes

Measure mental health spending and substance use disorder spending separately

Show how spending differs; compare to need as represented in prevalence data (from other sources)

Measure spending across service and treatment categories (e.g., primary care, outpatient, emergency/ observation, inpatient)

Highlight goal to rebalance care toward prevention and outpatient care

Set spending benchmarks that focus on specific populations, services, or care settings

Motivate positive change towards meeting goals of an improved behavioral health system

Key Decisions for Measuring Behavioral Health Spending and Benchmark Setting

- Determine priorities for measuring behavioral health spending
- Consider need for a phased approach
- Define approach to claims payments: diagnoses, services, care settings, providers
- Define approach to non-claims payments
- Define benchmark focus – conditions, care settings, population
- Define benchmark structure and timing

Example: Rhode Island Behavioral Health Investment Benchmark

The Rhode Island Office of the Health Insurance Commissioner (OHIC)'s **behavioral health spending obligation** focuses on community-based behavioral health care for commercial fully-insured children and adolescents, ages 0-18.

Spending obligation (benchmark):

- In 2025, carriers must increase per member, per month spending on community-based behavioral health care for target population to 200% of baseline (defined as calendar year 2022 spending)
- After 2025, carriers must have annual expenditures on community-based behavioral health care for the target population at the market average as determined by OHIC
- Includes claims and non-claims spending for community-based behavioral health care
- Applies to spending for residents of Rhode Island who receive care from providers located in Rhode Island
- If carriers do not reach the benchmark, they will be subject to penalties determined by the Commissioner

Tentative Timeline for Behavioral Health Work

Between meetings, OHCA will revise draft behavioral health definitions and investment benchmarks based on feedback.

	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
Workgroup	X	X	X	X	X	X	X	X	X	X	X
Advisory Committee				X			X		X		
Board					X		X	X		X	✓

X Provide Feedback ✓ Board Approval

October Advisory Committee Feedback

- Suggestion to engage additional stakeholders, such as: clinical professional organization representatives, behavioral health providers not in managerial roles, emergency medical services personnel, and people with lived experiences.
- Questions on how diagnosis codes will be used to measure behavioral health care.
- Discussion of Behavioral Health in Primary Care module
  - Questions about how it will be defined
  - Availability of primary care clinicians trained to provide behavioral health services is a concern
  - Care management and care team infrastructure may not be adequate to support need
- Prevention is important – not all is through the health care system.
- More behavioral health spend, such as through institutional care, does not necessarily mean better outcomes.
- Important to capture behavioral health spend via telehealth and spend under capitation.
- Access to care is critical with focus on therapy, peer support, wrap around services, etc.
- Affordability should be a goal for measuring and benchmarking
  - Especially out-of-plan spending

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General Public Comment

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

HCAI

Department of Health Care Access and Information

Next Board Meeting:

December 16, 2024
10:00 a.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

OHCA

Office of Health Care Affordability

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Adjournment

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Appendix

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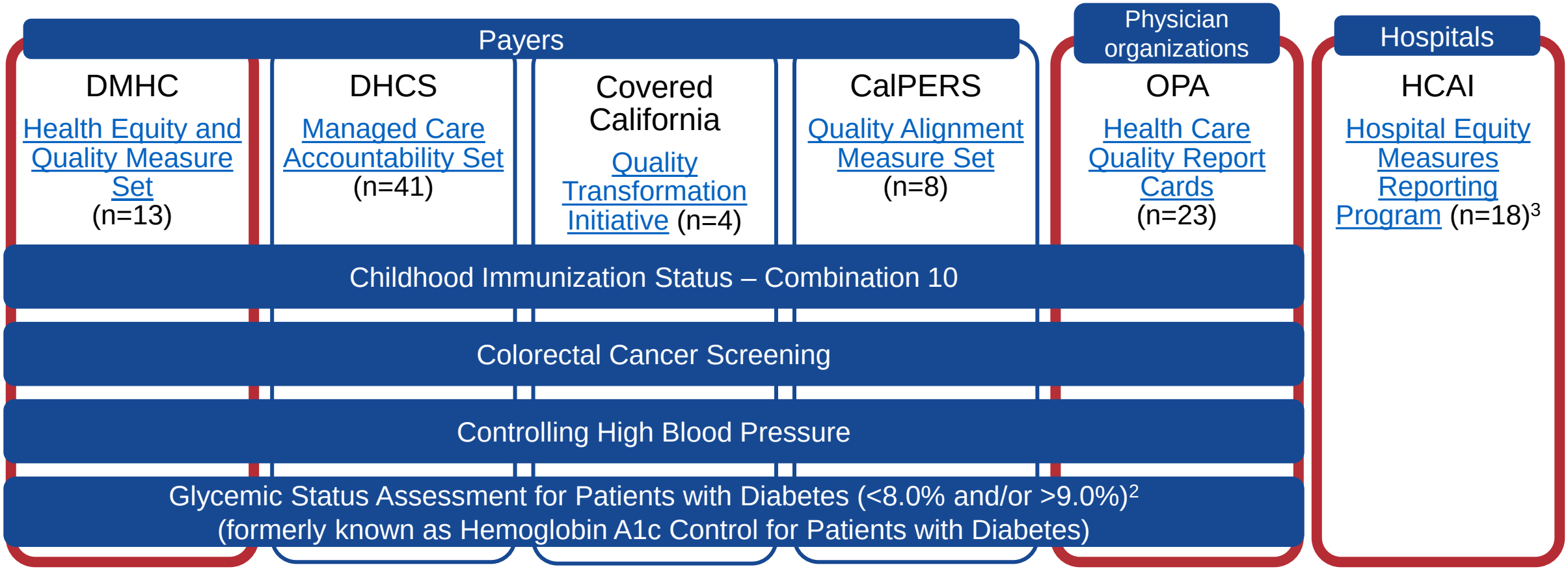
Quality and Equity Measure Set Proposal

Core Measures[1] Aligned Across State Departments for Payers and Physician Organizations

Since core measures are for payers and physician organizations (not hospitals), there is no overlap with HCAI measures. The measure sets that OHCA is proposing to adopt are highlighted in red.



[1] Depression Screening and Follow-Up for Adolescents and Adults and Pharmacotherapy for Opioid Use Disorder have also been discussed as potential core measures once benchmarks have been established.
[2] This measure replaced Hemoglobin A1c Control for Patients with Diabetes starting in measurement year 2024. The new measure includes glucose management indicator, calculated using data from continuous glucose monitoring devices, alongside HbA1c for numerator criteria.
[3] The HCAI Hospital Equity Measures Reporting Program is not finalized. By 2025, HCAI will establish regulations to specify reporting requirements. This timeframe may be extended per development and release of the CMS Heath Equity Measures. See Hospital Equity Measures Reporting Program Fact Sheet for details.

Overlap Between OPA, DMHC, DHCS, Covered CA, and CalPERS Measure Sets

Measures	OPA Commercial HMO Health Care Quality Report Cards	OPA Medicare Advantage Health Care Quality Report Cards	DMHC Health Equity and Quality Measure Set	DHCS Managed Care Accountability Set [2]	Covered CA Quality Transformation Initiative	CalPERS Quality Alignment Measure Set	OHCA
Colorectal Cancer Screening[1]	X	X	X		X	X	
Controlling High Blood Pressure[1]	X	X	X	X	X	X	
Glycemic Status Assessment for Patients with Diabetes (<8% and/or >9.0%)[1]	X	X	X	X	X	X	
Childhood Immunization Status: Combination 10[1]	X		X	X	X	X	
Plan All-Cause Readmissions	X	X	X				
Breast Cancer Screening	X	X	X	X			
Asthma Medication Ratio	X		X	X			
Child and Adolescent Well-Care Visits	X		X	X			
Immunizations for Adolescents: Combination 2	X		X	X			
Depression Screening and Follow-Up for Adolescents and Adults (Depression Screening and Follow-Up on Positive Screen)			X		X	X	
Prenatal and Postpartum Care (Postpartum Care and Timeliness of Prenatal Care)			X	X		X	
Well-Child Visits in the First 30 Months of Life (0 to 15 Months and 15 to 30 Months)			X	X			
CAHPS Health Plan Survey: Getting Needed Care (Adult and Child survey) or QHP Enrollee Experience Survey[3]			X				
Eye Exam for Patients with Diabetes	X	X					
Kidney Health Evaluation in Patients with Diabetes	X	X					
Osteoporosis Management in Women Who Had a Fracture		X					
Proportion of Days Covered by Medications (Diabetes All Class, Renin Angiotensin System Antagonists, and Statins)		X					
Statin Therapy for Patients With Cardiovascular Disease		X					
Statin Use in Persons with Diabetes		X					
Cervical Cancer Screening	X			X			
Chlamydia Screening in Women	X			X			
Prenatal Immunization Status	X						
Total Cost of Care, incl service categories	X						
Pharmacotherapy for Opioid Use Disorder					X	X	
Developmental Screening in the First Three Years of Life				X			
Follow-Up After ED Visit for Mental Illness – 30 days				X			
Follow-Up After ED Visit for Substance Abuse – 30 days				X			
Lead Screening in Children				X			
Topical Fluoride for Children				X			

[1] Measures that align across all California State Departments for payers and physician organizations.
[2] DHCS measures include Managed Care Accountability Set measures held to minimum performance level for measurement year 2024.
[3] In the DMHC Health Equity and Quality Measure Set, CAHPS Child Survey is only for applicable Medicaid plans. CAHPS health plan survey does not apply to Exchange plans. Exchange plans will report to the DMHC on the QHP Enrollee Experience Survey in measurement year 2024.

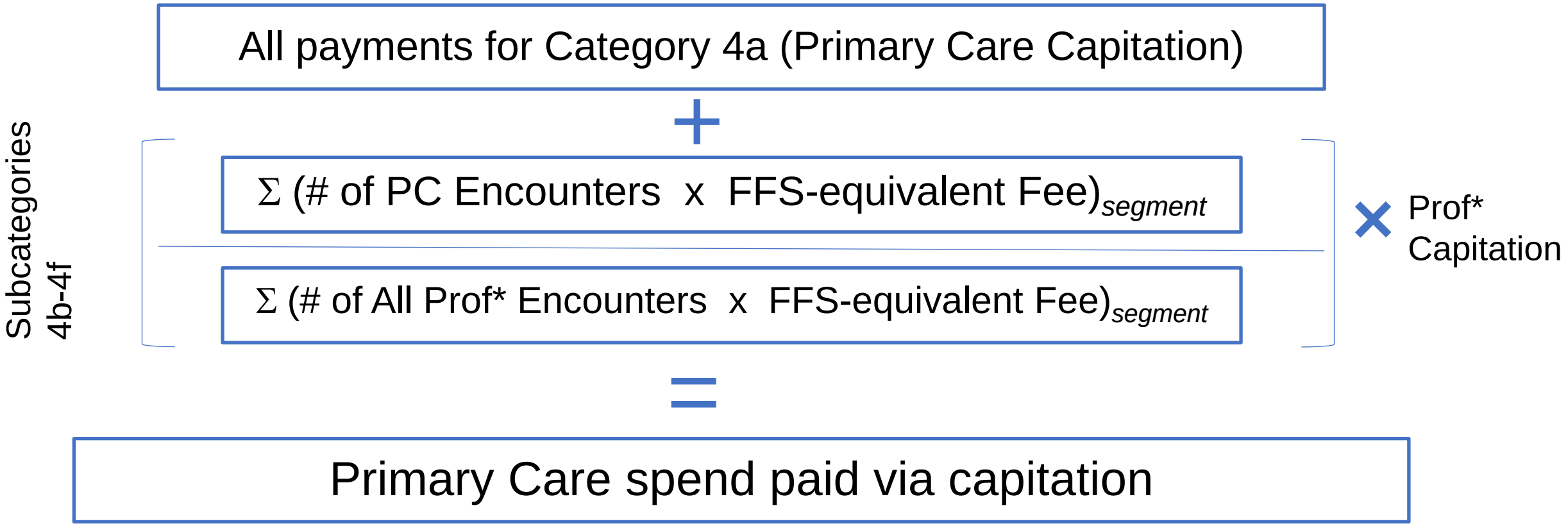
HCAI Hospital Equity Measures Reporting Program Structural Measures

- Designate an individual to lead hospital health equity activities.
- Provide documentation of policy prohibiting discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sexual orientation, and gender identity or expression and how workers are trained on that policy.
- Report percentage of patients by preferred language spoken.
- CMS Hospital Commitment to Health Equity Structural Measure
  - Hospital attests that hospital has a strategic plan for advancing health equity.
  - Hospital attests that hospital engages in demographic and social determinant/drivers of health data collection.
  - Hospital attests that hospital engages in data analysis activities to identify equity gaps.
  - Hospital attests that hospital engages in local, regional, or national quality improvement activities focused on reducing health disparities.
  - Hospital attests that hospital engaged in leadership activities, annually reviewing strategic plan for achieving health equity, and annually reviewing key performance indicators stratified by demographic and/or social factors.
- CMS Screening Rate and Positive Rate for Social Drivers of Health - The percentage of members who were screened, using pre-specified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.

Source: HCAI. (n.d.). Hospital Equity Measures Reporting Program. https://hcai.ca.gov/data/healthcare-quality/hospital-equity-measures-reporting-program/.

Primary Care Capitation Allocation Methodology

OHCA Approach to Primary Care Portion of Capitation Payments



*This example envisions a professional capitation. Under a global capitation, the professional encounters and capitation would be replaced with all encounters and the global capitation rate.

Definitions of Hospital Categories

Critical Access Hospitals- Definition

- Be located in a State that has established a State Medicare Rural Hospital Flexibility Program;
- Be designated by the State as a CAH;
- Be located in a rural area or an area that is treated as rural;
- Be located either more than 35-miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads; OR prior to January 1, 2006, were certified as a CAH based on State designation as a “necessary provider” of health care services to residents in the area.
- Maintain no more than 25 inpatient beds that can be used for either inpatient or swing-bed services;
- Maintain an annual average length of stay of 96 hours or less per patient for acute inpatient care (excluding swing-bed services and beds that are within distinct part units);
- Demonstrate compliance with the CAH CoPs found at 42 CFR Part 485 subpart F; and
- Furnish 24-hour emergency care services 7 days a week;
- In addition to the 25 inpatient CAH beds, a CAH may also operate a psychiatric and/or a rehabilitation distinct part unit of up to 10 beds each. These units must comply with the Hospital Conditions of Participation.

Source: https://www.cms.gov/medicare/health-safety-standards/certification-compliance/critical-access-hospitals

HCAI Hospital Categories

Hospitals can self-identify in HCAI Hospital Annual Financial Reports their type of control, type of care and type of hospital. Additional attributes are determined by statute or by HCAI separately.

Type of Control	Type of Care	Type of Hospital	Additional Attributes
• Non-Profit • Investor • State • Government • District	• General • Children's • Psychiatric • Specialty	• Kaiser • State • Psychiatric Health Facility* • Long Term Care	• Critical Access** • Small/Rural • Teaching
Hospital reported ownership and/or legal organization.	Hospital reported preponderance of care provided.	Hospital reported unique operating characteristics.	Determined by HCAI and/or statute, or federal definition.

*Psychiatric Health Facility is not self reported; it is a license category. **Critical Access is a Federal definition. Source: HCAI Hospital Annual Financial Data, Selected Data File Documentation For Report Periods Ended on or After June 30, 2004.

HCAI Hospital Categories

Type of Control		Type of Care		Type of Hospital		Additional Attributes	
Non-Profit	Includes hospitals operated by a Church, Non-Profit Corporation, or Non-Profit Other	General	General acute care such as Medical/Surgical Acute, Obstetrics Acute, Definitive Observation, Medical and/or Surgical Intensive Care, and Coronary Care.	Kaiser	Includes hospitals operated by Kaiser Hospital Foundation.	Critical Access	State and/or CMS designated medical centers that provide health care services to underserved communities.
Investor	Includes hospitals operated by an Investor-Individual, Investor-Partnership, or Investor-Corporation	Children's	Primarily treats children.	State	Includes State hospitals, which provide care to the mentally disordered and developmentally disabled.	Rural	Small hospitals defined as rural by statute, providing a narrow range of services with primary emphasis on simpler medical and surgical care.
State	Includes State hospitals, which provide care to the mentally disordered and developmentally disabled.	Psychiatric	Emphasizes psychiatric care including Psychiatric Acute - Adult and Psychiatric Intensive (Isolation) Care.	Psychiatric Health Facility	Includes hospitals licensed as Psychiatric Healthy Facilities, which provide mental health services.	Teaching	Emphasis on teaching by graduate medical education programs and number of post-graduate medical students, interns and residents.
Government	Includes hospitals operated by a County, County/City or City	Specialty	Focuses on a specific area of care, such as cardiac care or orthopedic care.	Long Term Care Emphasis	provision of long-term care services, such as, Sub-Acute Care, Skilled Nursing Care, and Intermediate Care; Includes large hospitals which emphasize long-term care (LTC) services.		
District	Includes District hospitals that provide access to essential health services and are directly accountable at the community level.						
Hospitals self report "Type of Control" to denote the type of ownership and/or legal organization of a hospital licensee.		Hospitals self report "Type of Care" to indicate the preponderance of care provided at the hospital.		Hospitals self report "Type of Hospital" to indicate their unique operating characteristics.		Other attributes may be assigned by HCAI (Teaching), by statute (Rural), or by federal designation (Critical Access).	

Sources: HCAI Hospital Annual Financial Data, Selected Data File Documentation For Report Periods Ended on or After June 30, 2004; California Health Facilities Commission, Hospital peer grouping for efficiency comparison (1982)