December 1, 2023

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Sent via email: *OHCA@hcai.ca.gov*

SUBJECT: CHA Comments on the Oct. 20, 2023 Version of the Total Health Care Expenditures Data Collection Draft Regulations

Dear Ms. Brubaker:

On behalf of our more than 400 hospital and health system members, the California Hospital Association (CHA) thanks the Office of Health Care Affordability (OHCA) for the opportunity to comment on the Oct. 20, 2023 version of the Total Health Care Expenditures (THCE) Data Collection draft regulations.

CHA Supports the Overall Approach of Collecting Data from Health Plans and Insurers

We believe the proposed approach of collecting the THCE data from health plans and insurers for enrolled and insured state residents makes sense. Unlike providers, health plans and insurers come the closest to having the necessary data to comprehensively identify and report the THCE of their members. By contrast, looking to providers for these data would exponentially increase the complexity of the data collection process and introduce serious data commensurability and quality issues that would undermine the spending target program.

While we support OHCA's overall approach to data collection, we have a number of concerns with the regulations and supplementary guidance, as currently proposed. Our most fundamental concerns relate to there being no process for validating the expenditures that health plans and insurers attribute to providers and essentially no rules around how health plans and insurers perform this attribution. Additionally, we remain troubled by the decision against using clinical risk adjustment, as reflected in there being no mechanism for gathering clinical risk information in the proposed regulations. Finally, we have questions and concerns with the lack of specificity around how stakeholders will be consulted when changes to the data collection regulations and guidance are being made, how these data will be

supplemented and merged with statutorily required data from other sources, and several other technical issues.

Providers Must Have an Opportunity to Validate Attributed Expenditures

Accurate Attribution of THCE Is Absolutely Essential. The THCE data submitted by health plans and insurers will form the backbone of the spending target program, determining which health care entities made or missed the spending target. Accordingly, payer decisions on how to attribute patient spending will very likely determine which providers are found to be in compliance with the spending targets. Moreover, health plans and insurers are being asked (under section 5.1.2 of the Data Submission Guide (DSG)) to *estimate* non-claims payments that will be made to providers beyond the claims run-out period of 180 days, as well as for carved-out services. Including *estimates* of these payments adds significant potential for error in the THCE data, such as for certain value-based payment programs where the payments are at risk against performance against quality measures.

Inaccurate or manipulated THCE data would severely damage the credibility of the spending target program. Problematically, the proposed regulations assure no line of sight for providers into the expenditures that health plans and insurers attribute to them. This leaves both providers and the office itself with no ability to validate the accuracy and appropriateness of the attributed expenditures.

Establish a Process for Provider Review of Attributed Expenditures. To prevent the pitfalls described above, OHCA must establish a process for providers to review and validate the accuracy of the expenditures that are attributed to them. Doing so would significantly increase confidence in the data underlying the spending target program and place the THCE data submission process at a similar standard as other major health care programs, such as:

- The Maryland All-Payer Model, under which hospitals and other key stakeholders have access to the data that determines hospitals' global budgets, including data on which patients are attributed to which hospitals
- California's Hospital Quality Assurance Fee program, under which hospitals review data submitted by Medi-Cal managed care plans on contracted utilization prior to the data being used to determine payment distributions
- Various quality programs that hospitals participate in, where hospitals are afforded an opportunity to review their performance data before it is finalized

At minimum, the validation process should involve health plans and insurers sharing with affected providers information on which patients are attributed to them and under what methodology the attribution occurred. If the methodology is payer-developed, as afforded under step 4 in DSG section 5.4, health plans and insurers should share in detail the payer-developed methodology as well as the data used to make the attribution decision. Then, providers should have an opportunity to correct any inaccuracies in the attribution decisions both before and after final data on attributed expenditures is shared with the department. We recommend the following language be added to the proposed regulations to establish a THCE data validation process:

Proposed 22 CCR § 97449

…

(d) Coordination of Data Submission.
(1) Required submitters are responsible for reporting data for all plan members. If a required submitter is the Directly Contracted Plan in a Plan-to-Plan contract, the Directly Contracted Plan shall obtain any necessary data from the Subcontracted Plan and submit the data to the System.
(2) Affiliated required submitters are responsible for coordinating data submission amongst their affiliates to ensure compliance with this Article.
(3)(A) Required submitters are responsible for validating the accuracy of attribution of member-level expenditures. For any organization to which a required submitter attributes a member's total medical expenditures to pursuant to the THCE Data Submission Guide, and without regard to whether the organization is listed on the OHCA Attribution Addendum, the required submitter shall do both of the following prior to submitting the data to the System:
(i) Provide the attributed organization with notice of the members attributed to their organization, and the basis, methodology, and associated data as applicable for attributing the member-level expenditures to such organization.
(ii) Provide a reasonable opportunity of at least 10 business days for the attributed organization to validate or correct the required submitter's attribution of member-level expenditures to such organization.
(B) If the required submitter and the attributed organization are unable to reach agreement as to the attribution of member-level expenditures to such organization prior to submission to the System, the Office shall allow the attributed organization to petition the Office directly in writing to request correction. The attributed organization's request shall describe in sufficient detail the correction(s) being sought, the basis for such correction(s), and any data supporting the request. The Office shall respond to the attributed organization's request within 5 business days of the date the request was submitted and notify the affected attributed organization(s) and required submitter of its decision.
…

(k) Data Acceptance and Correction.
(1) Data files that are submitted to the System but do not meet the file intake specifications detailed in the Guide will be rejected. Registered submitters will be notified within 5 business days of submission whether a data file has been accepted or rejected. Reasons for rejection include:
(A) Invalid file format, file layout, or data types.
(B) Incomplete or illogical data.
(C) Other technical deficiencies related to file submission, storage, or processing.
(2) If the Office determines that a previously accepted file contains initially unidentified errors, **including but not limited to an error in the attribution of member-level expenditures to an organization that the Office identifies in reviewing a request for correction pursuant to (d)(3)(B) of this section,** the submitter shall be notified through the data portal. The submitter shall respond through the data portal within 3 business

days of notification by the Office. The Office may make multiple requests for corrections or resubmissions.

Plan for a Standardized Patient Attribution Methodology

We are concerned with the lack of clear and consistent standards for how health plans and insurers must attribute their members to providers when assignment is not clearly determined by contractual arrangement (i.e., for members who cannot be attributed via steps 1 through 3 of DSG section 5.4). Unfortunately, the discretion proposed to be given to payers around patient attribution will:

- Increase the incidence of misattributing patients to providers — as has frequently been the case under the Maryland All-Payer Model, where hospitals frequently have reported never having seen patients that are attributed to them
- Risk attributing patients to providers who lack a meaningful influence on their patients' utilization patterns and costs — such as a specialist who performs a single high-cost procedure on a patient
- Not allow for apples-to-apples comparisons of expenditures across payers and providers – since payers will likely adopt a wide range of different methodologies
- Create opportunities for gaming by payers – given there are no requirements other than that the methodology be "rule-based."

Establish a Process to Properly Evaluate Patient Attribution Methodologies. Despite these clear downsides, we understand that OHCA may wish to test different patient attribution methodologies before deciding on a statewide standard. Given the complexity of California's health care market, using the first year of implementation to learn about which approaches to patient attribution do and do not work may be appropriate, provided OHCA transitions to a stakeholder-informed, standardized methodology prior to the implementation of a spending target. To maximize this limited window of opportunity to learn which patient attribution methodologies work and prepare for the adoption of a standardized approach, we ask OHCA to establish a process now to work towards this important goal. Specifically, we ask OHCA to establish the following:

- A distinct reporting mechanism for obtaining detailed information on each health plan and insurer's attribution methodology. (The current field for gathering this information, SQS009, is limited to 500 characters and thus insufficient for the purpose of obtaining the information needed to make educated decisions on this important issue)
- Release of the above reports on OHCA's website to allow for public review and feedback
- A workgroup of payers and providers to review the attribution methodologies utilized (as well as preexisting models such as under the Medicare Shared Savings Program and recommended by the Integrated Healthcare Association) and offer recommendations on a standardized methodology applicable to all payers
- A predetermined deadline by which OHCA must establish the standardized methodology via regulations. (This deadline should be no later than April 1, 2025 to allow for the standardized methodology to be in place prior to reporting against the first spending target)

In the Meantime, Place Guardrails on Patient Attribution Methodologies. As noted, we recognize additional learning may be needed before adopting a fully standardized payers' patient attribution methodology. But guardrails are needed now to ensure the consistency of payers' approaches with OHCA's vision and to prevent abuse of the latitude proposed to be given. Accordingly, we ask OHCA to add the following requirements to provision 4 of DSG section 5.4:

4. Any members who cannot be attributed using one of the above methods may be attributed to an organization listed on the OHCA Attribution Addendum or other organization using a submitter-developed, rules-based approach for assigning total medical expenditures. Report data for these members using the attribution method Payer-Developed Attribution.

a. Report data in separate records for any organization not listed on the OHCA Attribution Addendum with at least 1,000 attributed members. Include the full legal name in the Organization Name field and use the Organization Code '7777'.

b. Report data for all organizations not listed on the OHCA Attribution Addendum with 1-999 attributed members in a single record leaving the Organization Name field blank and using the Organization Code '8888'.

c. The Payer-Developed Attribution methodology must meet the following requirements:

i. Attribution may only be made to organizations responsible for providing primary care to the member. Attribution shall not be made to providers based on the specialty or acute care delivered to the member.

ii. Payers' rules-based approach for patient attribution shall be consistently applied to all medical expenditures reported in the two years comprising each applicable data submission.

iii. In reporting to OHCA on or before June 1, 2024, payers must describe their rules-based approach to Payer-Based Attribution. The description shall be in sufficient detail to allow provider organizations to infer which of their patients will be attributed to them by the payer, including but not limited to the payers' operative definition of what services qualify as primary care. OHCA shall publish the payer reports on their website no later than July 1, 2024. Within one week of the proposed effective date for any change to its rules-based approach, payers shall report to OHCA a sufficient description of its revised approach, which OHCA shall promptly publish on their website.

A Meaningful Process Is Needed for Stakeholder Consultation for Future Changes to Sub-Regulatory Guidance

With certain exceptions, CHA supports the Office's approach to defer data requirements to the Submission Guide rather than formal regulatory text, as long as there is an ongoing and meaningful opportunity for all relevant health care entities to provide input as the rules evolve and are implemented. While these initial THCE regulations and technical Guide only require payers to report, it is vitally important to consider the hospital perspective given the significance of patient attribution to future enforcement of provider spending targets. This was recognized by the Legislature in the OHCA authorizing statute at Health and Safety Code § 127501.4(k). It requires OHCA to engage relevant stakeholders, hold a public meeting to solicit input, and provide a response to input received prior to adopting regulations or approving associated technical specifications or guidance related to data submission, including rules adopted on an emergency basis.

CHA acknowledges the approach to incorporate the Guide by reference within proposed 22 CCR § 97445(s), which will afford an opportunity for traditional notice and comment under the State Administrative Procedure Act to the extent the incorporated version of the Guide is subsequently changed. We also note that OHCA is authorized until Jan. 1, 2027 to adopt any rules implementing the Health Care Affordability chapter of the code using the emergency rulemaking process, which provides only a truncated and relatively narrow opportunity for affected stakeholders to comment on changes prior to them becoming effective. In addition, comments on proposed emergency regulations are made directly to the Office of Administrative Law and the rulemaking agency is not required to respond to input made with respect to the emergency rulemaking action. As a result, we urge OHCA to continue employing a suitably robust stakeholder process, consistent with the above referenced statutory command and prior to the limited opportunity for input within the emergency rulemaking context, that allows hospitals and other regulated provider entities to offer feedback to changes to the Submission Guide and associated reporting framework. We appreciate OHCA's efforts to this effect in this immediate rulemaking, and ask that the same or similar process accompany any future Guide updates or changes.

To reinforce this requirement, CHA proposes adding the following language to the Submission Guide at a new Section 1.3:

> **1.3 Stakeholder Engagement for Subsequent Changes to this Guide**
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> **Consistent with Health and Safety Code section 127501.4, subdivision (k), OHCA will engage with all relevant stakeholders, including but need not be limited to payers and providers, hold at least one public meeting to solicit input from relevant stakeholders, post to its website any written materials or proposals at least five business prior to any public meeting, and provide a timely response to all input received during this engagement, prior to formally adopting any changes to the version of the THCE Data Submission Guide dated ____, 2023.**

Test the Use of Clinical Risk Adjustment

Concerns With OHCA's Approach to Risk Adjustment. We remain troubled by OHCA's decision against using clinical risk adjustment to distinguish between unjustified spending growth and growth due to changes in the underlying health care needs of health care entities' patient populations. With this decision, OHCA will disincentivize health care entities from serving high-risk and high-cost patients – including individuals with behavioral health disorders. This undermines OHCA's foundational goal of improving health equity and ignores its statutory directive to consider the unique health care needs of people with disabilities and chronic illnesses. Our concerns related to the unintended consequences of not utilizing clinical risk adjustment, which performs orders of magnitude better than OHCA's preferred approach of only risk adjusting based on age and sex, are not merely theoretical. Studies have repeatedly shown how risk selection, when left unaddressed through the use of appropriate risk adjustment, harms vulnerable populations.[1] Most notably, Black infants died or had complications at higher rates after

[1] In addition to the study described in the body, see the following for evidence of the negative impact that unmitigated risk selection can have on vulnerable populations, including high-cost patients generally and cancer patients specifically:
• Wynand P. M. M. van de Ven, Richard C. van Kleef, and Rene C. J. A. van Vliet; Risk Selection Threatens Quality of Care for Certain Patients: Lessons from Europe's Health Insurance Exchanges; Health Affairs 2015 34:10, 1713-1720

Texas' Medicaid program introduced new opportunities for risk selection without compensating mechanisms to control and compensate health care entities for the predictable variation in costs between Black and other infant populations.[2]

Recommend OHCA Test Clinical Risk Adjustment Alongside Sex- and Age-Only Risk Adjustment. OHCA has previously stated a willingness to reconsider, in the future, its approach to risk adjustment. However, without testing and comparing the outcomes of the two distinct approaches to risk adjustment (one with and one without clinical risk adjustment), it is unclear what information OHCA would use as the basis of a future change in approach. Accordingly, we recommend that OHCA simultaneously pilot the two forms of risk adjustment and decide, with information in hand, on the appropriate approach on an ongoing basis. Now is the right time to do so as data collection mechanisms are being set up but before spending targets are implemented and enforced. Specifically, we ask OHCA to select a clinical risk adjustment methodology for all payers to utilize, collect aggregated data on the clinical risk scores of payers' members, report on per capita spending growth using both forms of risk adjustment, and perform a formal evaluation of both forms of risk adjustment looking specifically at health care entities' responses to the different financial incentives each form introduces. We also ask OHCA to consider the use of truncation as an additional means to control for unpredictable year-to-year variation in health expenditures and minimize the troubling incentives introduced by the spending target program that will encourage health care entities to avoid high-risk patients.

Clarify How OHCA Will Collect Data on Certain Major Expenditures

State law clearly specifies the many elements that must be included in the definition and scope of THCE (see, for example, Health and Safety Code §§ 127500.2(s) and 127501.4(a)). However, several key elements specified in law are missing from what OHCA has proposed to collect from health plans and insurers via this regulation and the accompanying DSG. As we describe in greater detail below, we ask OHCA to add these elements to the DSG as appropriate, or communicate in upcoming public meetings and supplemental information published on its website, including but not limited to the publication of any related interagency agreements, how OHCA intends to collect the missing information from other sources and merge it with the data from health plans and insurers to create comprehensive measures of THCE and attributed total medical expenditures. Such communications must also provide an opportunity for meaningful stakeholder input.

Regulations Do Not Collect Data on Health Plans and Insurers' Administrative Costs and Profits. State law requires OHCA to collect data on payers' administrative costs and profits, and ultimately set specific spending targets for these components of plans and insurers' finances. However, the regulations do not require health plans to provide the requisite information. Clarity is needed on how OHCA intends to collect and synthesize this information. If OHCA plans to collect this data from the Department of Managed Health Care, Department of Insurance, and Department of Health Care Services (DHCS), we ask that be communicated in upcoming public meetings and supplemental information made publicly

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• Kreider, Amanda and Layton, Timothy J. and Shepard, Mark and Wallace, Jacob, Adverse Selection and Network Design Under Regulated Plan Prices: Evidence from Medicaid (December 2022). NBER Working Paper No. w30719, Available at SSRN: https://ssrn.com/abstract=4293632

[2] Kuziemko, Ilyana and Meckel, Katherine and Rossin-Slater, Maya, Do Insurers Risk-Select Against Each Other? Evidence from Medicaid and Implications for Health Reform (July 2013). NBER Working Paper No. w19198, Available at SSRN: https://ssrn.com/abstract=2289108

available on the OHCA website. Alternatively, if OHCA plans to collect this data from payers directly, changes must be made to the DSG to ensure collection and the accuracy of this critical data.

Clarity Needed for Expenditures That Do Not Flow Through Health Plans and Insurers. Total health care expenditures are intended under statute to be just that, "total." Only a little more than half of Medi-Cal and Medicare expenditures flow through plans. The remaining expenditures flow through Medi-Cal and Medicare fee for service or other delivery systems, such as counties for a significant portion of behavioral health and personal care services. The proposed regulations and guidance do not specify how this information will be collected. We ask OHCA to describe in upcoming public meetings and supplemental information online, with a meaningful opportunity for stakeholder input, how this information will be collected and wedded to the health plan- and insurer-submitted data for the purposes of monitoring THCE growth and attributing total medical expenditures to providers.

Plan Needed for Collecting Accurate Data on Medi-Cal Supplemental Payments. Supplemental payments form a substantial portion of total provider payments in Medi-Cal. This is especially true for hospitals. For example, supplemental payments to private hospitals regularly constitute more than 30% of total Medi-Cal payments. The DSG lacks clarity in how supplemental payments, including those that flow through health plans, are to be reported. While they presumably are intended to be captured within various non-claims payments categories, this is not clearly specified. Accurately reporting these payments is further complicated by the significant lag between when the services are delivered and when these payments are made, meaning these payments generally will have to be estimated rather than reflecting actuals. This is a particularly acute challenge for private hospital directed payments under the hospital quality assurance fee program, which do not flow until two years after the services were delivered. Given the inherent challenge of accurately estimating Medi-Cal supplemental payments at the health plan level and DHCS's prominent role in overseeing these payments, we recommend DHCS perform the estimates of these expenditures on OHCA's behalf.

Definition of "Allowed Amount" Raises Concerns

The DSG requires health plans and insurers to report medical expenditures based on allowed amounts. We are concerned that a lack of clarity in the definition of allowed amounts could lead to the misreporting of the actual amounts paid to providers. We ask for the following change to be made to the definition to clarify that the reporting of expenditures must be based on final adjudicated amounts, rather than negotiated rates prior to final adjudication. This change is critical given the growing prevalence of downcoding and other payer practices aimed at disallowing, reducing, and delaying payments for services previously rendered.

> The allowed amount for a covered benefit~~, which includes both the amount paid by the payer or fully integrated delivery system to the provider and the member's financial responsibility owed directly to the provider, regardless of whether the member actually made a payment,; this is also known as the negotiated rate, or the contracted rate. The allowed amount~~ is ~~not necessarily~~ the sum of what the provider was paid **by the payer or fully integrated delivery system following final adjudication of a claim and reflective of the negotiated or contracted rate, as applicable, and the member's estimated financial responsibility owed to the provider, regardless of the actual amount paid by the member to the provider.**

Conclusion

Thank you for the opportunity to comment on these important proposed regulations.

Sincerely,

Ben Johnson

cc: Members of the Health Care Affordability Board:
David M. Carlisle, MD, PhD
Secretary Dr. Mark Ghaly
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan