2024 HOSPITAL FINANCE & REIMBURSEMENT SACRAMENTO

Office of Health Care Affordability (OHCA) Presentation & Panel

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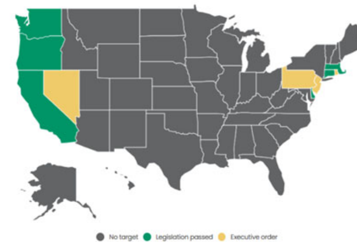
Political and Policy Backdrop

- Significant progress toward reaching universal coverage
- Concerns among policymakers and the public around health care costs
- Various policies considered in recent years to address affordability
  - Rate setting
  - Expanded oversight of market activity
  - Single payer
- Cost growth benchmarking programs being implemented across the country
- Political support from:
  - Governor Newsom and the then Chair of the Assembly Health Committee, Jim Wood
  - Blue Shield, California Labor Federation, and Health Access



California Office of Health Care Affordability authorized in the state budget via Senate Bill 184 (2022)

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Main Objectives and Responsibilities

Increase transparency on spending and quality

Set spending targets for the health care field

Enforce compliance, including through financial penalties

Monitor and review market transactions

Establish new standards, including for quality, equity, workforce

Division of Roles and Responsibilities

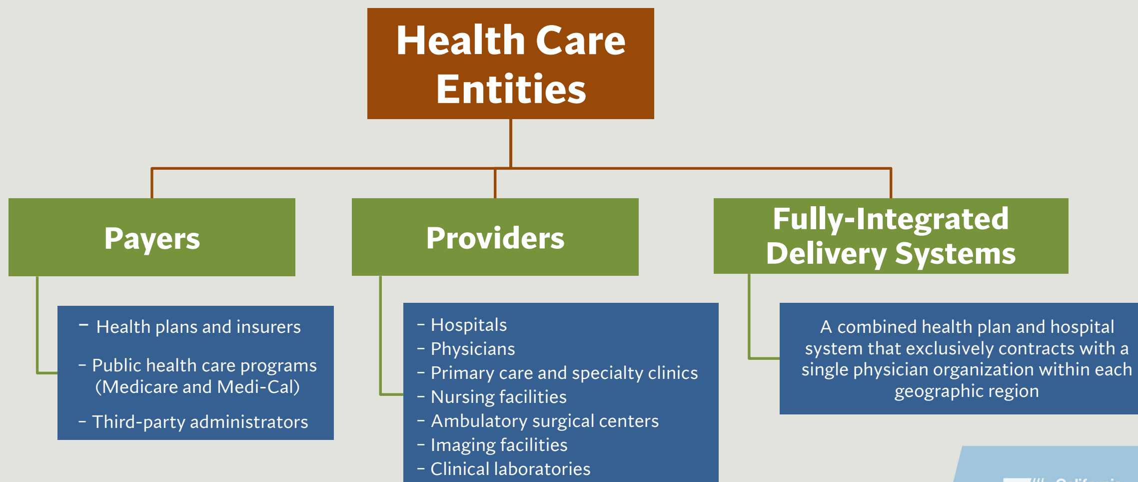
Housed within the Department of Health Care Access and Information (HCAI)

- Provided $32 million in ongoing resources for 142 positions (currently ramping up)
- Led by HCAI Director Elizabeth Landsberg and Deputy Director Vishaal Pegany

Governance Structure

Body	Responsibilities
Office/Director	• Establish reporting requirements • Analyze and publish reports on health care spending • Advise on and carry out progressive enforcement actions • Monitor and review market transactions
Board	• Establish spending targets and associated methodologies and adjustments • Define sectors and, as appropriate, geographic regions and individual health care entities • Approve range and scope of administrative penalties
Advisory Committee	• Provide input and recommendations on matters under consideration

OHCA Regulates "Health Care Entities"



California Hospital Association

Exempt Health Care Providers and Suppliers

Various health care providers and suppliers are directly or indirectly exempt:

- ❑ Physician organizations with fewer than 25 physicians*
- ❑ Dentists
- ❑ Pharmacy (including manufacturers and retail pharmacies)
- ❑ Durable medical equipment suppliers
- ❑ Home health agencies
- ❑ Emergency medical transportation

These entities will not specifically be subject to reporting requirements, cost targets, or market oversight…

However, the spending associated with exempt entities generally will be included in payers' costs.

* Physician organizations with fewer than 25 physicians that are determined to be high-cost outliers may have their exemption removed

California Hospital Association

OHCA Will Collect Total Health Care Expenditures Data

Total Health Care Expenditures (THCE) is intended to include essentially all private and public spending in the state, including:

- Claims-based payments
- Non-claims-based payments
  - Capitation
  - Supplemental provider payments
  - Global budget
  - Other alternative payment methods
  - Salary
- Estimated patient cost sharing
- Net pharmacy spending
- Health plans and insurers' administrative costs and profits

Office will primarily collect and analyze cost data from payers (e.g., health plans), but may supplement this with data from providers and the Health Care Payments Data Program.

Data will be collected annually, starting September 2024

Total Medical Expenditures Will Be Attributed to Physician Organizations

Total Medical Expenditures (TME)

- Equal THCE minus health plan administrative expenditures and profit
- Expenditures: defined at the payer level, *reflecting provider revenues*
- Expenditures = payment × utilization
- Payment = *allowed amount* reflecting a payer's contracted/paid amount + estimated patient share of cost
- Reporting year reflects the *service* year for which data are reported

Attribution of TME

- TME to be allocated to providers through physician organizations with at least 1,000 attributable members
- Attribution to providers based on a 3-step methodology:
  - Capitated/delegated members
  - Total cost of care Accountable Care Organizations
  - Payer-developed methodology

Per Capita Expenditures

Payers
- TME per enrolled or insured member

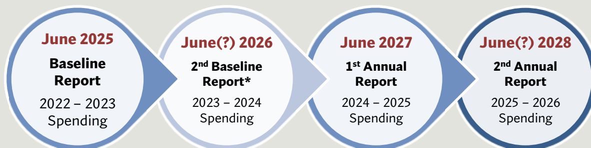
Providers
- TME per member attributed to the physician organization responsible for providing member's primary care

Payers and Providers
- TME calculated on a per member per month basis

Annual Reports on Health Care Spending

Topics Covered

- Total and per capita health care expenditure growth
  - Broken down, as appropriate, by service category, geographic region, and source of funds
- Recommendations and best practices for controlling costs and improving quality and equity
- State's progress toward meeting cost target and other goals
- Drivers of cost growth
- Performance on access, quality, and equity measures
- Summaries of enforcement actions



*Not required in law, but OHCA has committed to releasing.

Executive Summary

This report presents data on health care spending and health care cost growth in Oregon from 2020 to 2021. This report uses a total cost of care approach for a comprehensive look at health care spending across the state between 2020 and 2021.

This is the first cost growth report that includes cost growth for individual payers and provider organizations.

Every year, Oregon's Sustainable Health Care Cost Growth Target Program collects data from payers and other sources to provide this comprehensive view into health care spending and spending growth.

By identifying drivers of health care cost growth in Oregon, this report sets the stage for policymakers, health system partners, and other stakeholders to identify opportunities and strategies to slow cost growth and address growing affordability concerns across public and private markets.

HEALTH CARE COST GROWTH TARGET — Click the icon to explore the Cost Growth Target 2020-2021 Databook

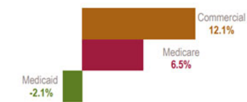
Key Findings

In 2021, total health care spending in Oregon totaled $31.07 billion dollars.

On a per person per year basis, Total Health Care Expenditures increased 3.5% between 2020-2021, just above the cost growth target of 3.4%.

Cost growth for the commercial market was 12.1%, compared to 6.5% for Medicare and -2.1% for Medicaid.

Percent change in total health care expenditures, by market, 2020-2021



Oregon Health Authority — Health Care Cost Trends, 2020-2021 — 3

Spending Targets Background

Key Statutory Requirements on Spending Targets

- Based on a **target percentage for annual growth** in per capita total health care expenditures
- **Promote affordability** and a predictable and sustainable rate of change in costs
- Set with consideration of **economic indicators** like inflation and population-based measures like aging
- Maintain **quality, equity**, and workforce stability
- Optional or required adjustments to spending targets to account for:
  - Risk of patient populations
  - Equity
  - Inflation
  - Labor costs
  - Policy changes
  - Payer mix
  - Prices of health care technologies
  - Emerging diseases
  - Growth in nonsupervisory organized labor costs
  - High-cost, low-quality health care entities

Cost target timeline

2025 Statewide non-enforceable cost target

2026 Statewide enforceable cost target

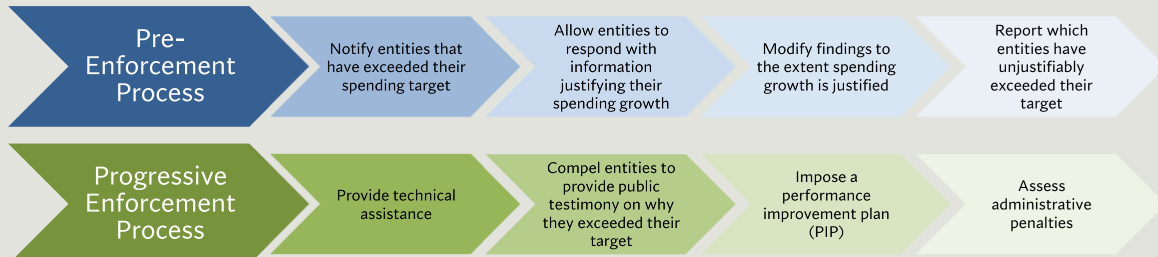
2027 Establish definitions for non-statewide cost targets
- Sectors *(e.g. hospital services, physician services)*
- Geographic regions *(optional)*
- Individual health care entities *(optional)*

2028

2029 Enforceable statewide, sector and, if adopted, regional and individual entity cost targets

What's Behind a Spending Target?
- Based on both reimbursement and utilization levels
- Performance will be assessed based on payers' costs and providers' revenues
- Per capita:
  - For payers, measured on a per-enrollee or per-insured basis
  - For providers, initially measured on an attributed-patient basis

Enforcement Against Spending Targets



Massachusetts Case Study

January 2022: A PIP is imposed on Mass General Brigham after the state found:

- $293 million in cumulative commercial spending growth in excess of the target over 5 years
- Higher prices than other providers
- Inadequate cost containment strategies

September 2022: State approves PIP on Mass General, committing it to reduce annual spending by $128 million through

- Price reductions
- Reducing utilization (e.g., MRIs)
- Shifting care to lower-cost sites
- Increasing the use of APMs

2028
First enforcement actions on cost targets expected (for 2026 targets)

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OHCA Staff Recommendation

3.0% Statewide Spending Target for 2025-2029

- To promote improved affordability, the annual per capita health care spending growth **target** percentage **should be below** the long-term [health care cost growth] trend of **5%**
- To promote transparency and public accessibility, the basis for establishing a statewide spending target should be a **single economic indicator**
- The methodology should rely on an indicator of consumer affordability, specifically, **median family income,** because it captures retirees and others not in the labor market
- The methodology should **rely on historical data** over projections. Specifically, the methodology is the average annual growth in median household income in CA over for the period 2002-2022
- Initial targets should be **set for five calendar years** to provide for sufficient planning

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CHA Advocacy, in Summary

Proposed 3% Spending Target

- Ignores external factors that influence health care costs, such as inflation and California's aging population
- Sets California apart as an outlier from other states that have struggled to meet their spending targets
- Fails to strike a balance between promoting affordability and maintaining access to high quality, equitable care

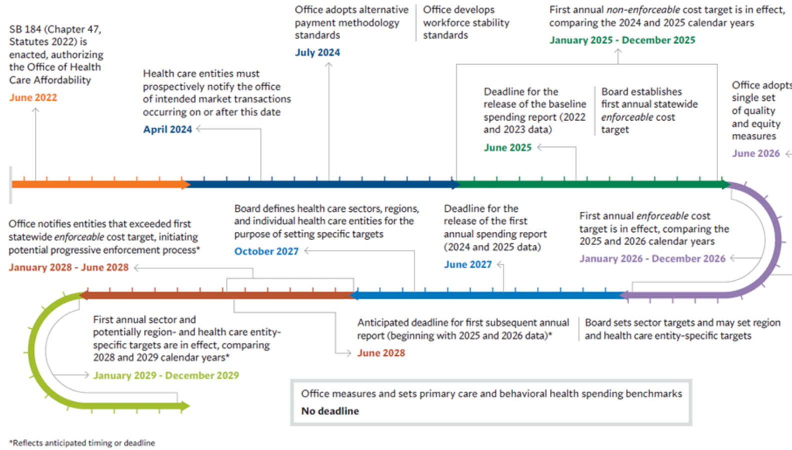
Alternative Spending Target Framework

Framework for a Sustainable Spending Target

	2025	2025-2029 Average
1) Economy-Wide Inflation	**3.3%**	**3.4%**
2) Aging	**0.8%**	**0.7%**
3) Technology and Labor:	**0.6%**	**0.6%**
A) Drug and Medical Supplies	0.4%	0.4%
B) Labor Intensivity	0.2%	0.2%
4) Major Policy Impacts:	**1.6%**	**0.6%**
A) Health Care Worker Minimum Wage	0.4%	0.2%
B) Investments in Medi-Cal	1.1%	0.3%
C) Seismic Compliance	0.1%	0.1%
Totals	**6.3%**	**5.3%**

OHCA Implementation Is Happening Now

Office of Health Care Affordability Implementation Timeline



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Questions?

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Cost and Market Impact Review Process

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OCHA Transaction Review

This is happening now

OHCA must be provided notice of transactions subject to the reporting requirements that "close" on or after April 1, 2024

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Key Issues

- Who is subject to the reporting requirements?
- What transactions must be reported?
- What must be reported?
- What does OHCA do when a transaction is reported?
- Timeline: What delay on closing transactions results from OHCA?
- Enforcement: What are the consequences of non-compliance?

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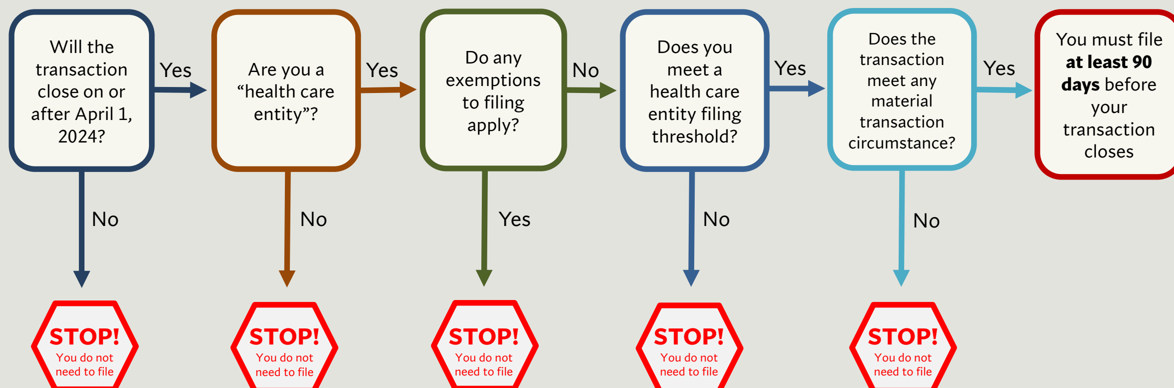
Decision Tree



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Who is Subject to the Reporting Requirements?

Must be a "health care entity":

- **Payers** (*e.g.*, public and private payers, third-party administrators, any other entity that pays for or arranges for the purchase of health care services on behalf of employees, dependents, or retirees);
- **Providers** (*e.g.*, physician orgs with 25+ physicians (or high-cost outliers), RBOs, H&S 1250 health facilities, certain clinics, ASCs or accredited outpatient settings, clinical labs, certain imaging facilities)*;*
- **Fully integrated delivery systems**;
- **Pharmacy benefit managers**;
- **Any parent, affiliate, subsidiary, or other entity that acts as an agent in California on behalf of a payer, and**:
  a) control, govern or are financially responsible for the health care entity; OR
  b) is subject to the control, governance, or financial control of the health care entity; OR
  a) in the case of a subsidiary, a subsidiary acting on behalf of another subsidiary

What Health Care Entities Must Report?

1. A health care entity with annual revenue of at least $25 million OR that owns or controls California assets of at least $25 million;
2. A health care entity with annual revenue of at least $10 million OR that owns or controls California assets of at least $10 million, AND is a party to a transaction with any health care entity satisfying (1) above.
3. A health care entity located in a designated mental health or primary care health professional shortage area in California.

How do you Calculate Revenue?

Revenue = Total average annual **California-derived revenue** received for all health care services by the health care entity and all affiliates over the three most recent fiscal years. Calculation of revenue varies by the type of health care entity.
For example:

- For hospitals, "net patient revenue as reported to the Department in accordance with the Accounting and Reporting Manual for California Hospitals"
- For "all other providers" (except long-term care facilities and RBOs), "net patient revenue, which includes the total revenue received for patient care, as it was generated or occurred in California rather than when revenue is booked, accrued, or taxed"

What "Transactions" Must be Reported?

Must be a "Material Change Transaction

First, is the arrangement a "transaction":

> "… mergers, acquisitions, affiliations, and agreements impacting the provision of health care services in California that involve a transfer (sale, lease, exchange, option, encumbrance, conveyance, or disposition) of assets or a transfer of control, responsibility, or governance of the assets or operations, in whole or in part, of any health care entity to one or more entities."

What about an agreement for services that doesn't involve a transfer of assets?

Exempt Transactions

- Agreements or transactions involving:
  - *health care service plans subject to review by DMHC for cost impact or market consolidation under the Knox-Keene Health Care Services Plan Act of 1975*
  - *health insurers that are subject to review by the Insurance Commissioner*
  - *where a county is purchasing, acquiring, or taking control, responsibility, or governance of an entity to ensure continued access in that county; and*
  - *nonprofit corporations that are subject to review by the Attorney General*
- Transactions in the usual and regular course of business of the health care entity, meaning those that are typical in the day-to-day operations of the health care entity
- Situations in which the health care entity directly, or indirectly through one or more intermediaries, already controls, is controlled by, or is under common control with, all other parties to the transaction, such as a corporate restructuring

Is the Transaction "Material"?

1. The proposed fair market value of the transaction is $25 million or more, and the transaction concerns the provision of health care services
2. The transaction is more likely than not to increase annual California-derived revenue of any health care entity that is a party to the transaction by either $10 million or more or 20% or more of annual California-derived revenue at normal or stabilized levels of utilization or operation
3. The transaction involves the sale, transfer, lease, exchange, option, encumbrance, or other disposition of 25% or more of the total California assets of the submitter(s)
4. The transaction involves a transfer of control, responsibility, or governance of the submitter, in whole or in part. A transaction meets this circumstance if the transaction:
   a. Would result in a transfer of 25% or more of the voting power of the members of the governing body of a health care entity, such as by adding one or more members, substituting one or more members, or through any other type of arrangement, written or oral; **or**
   b. Would vest voting rights significant enough to constitute a change in control such as supermajority rights, veto rights, and similar provisions even if ownership shares or representation on a governing body are less than 25%; **or**
   c. Would result in the transfer of 25% or more of the governance of the management and policies of at least one health care entity that is a party to the transaction

Is the Transaction Material? (cont.)

5. The transaction will result in an entity contracting with payers on behalf of consolidated or combined providers and is more likely than not to increase the annual California-derived revenue of any providers in the transaction by either $10 million or more or 20% or more of annual California-derive revenue at normal or stabilized levels of utilization or operation.
6. The transaction involves the formation of a new health care entity, affiliation, partnership, joint venture, or parent corporation for the provision of health care services in California that is projected to have at least $25 million in California-derived annual revenue at normal or stabilized levels of utilization or operation, or transfer control of California assets related to the provision of health care services valued at $25 million or more.
7. The transaction is **part of a series of related transactions for the same or related health care services occurring over the past ten years involving the same health care entities or entities affiliated with the same entities**. The proposed transaction and its related transactions will constitute a single transaction for purposes of determining the revenue thresholds in 22 CCR 97435(b) and asset and control circumstances in 22 CCR 97435(c).
8. The transaction **involves the acquisition of a health care entity by another entity and the acquiring entity has consummated a similar transaction(s), in the last ten years, with a health care entity that provides the same or related health care services**. The proposed transaction and its related transactions will constitute a single transaction for purposes of determining the revenue thresholds in 22 CCR 97435(b) and asset and control circumstances in 22 CCR 97435(c).

Notice Requirements

The filing requirements are substantial:

1. **General information of the submitter** (e.g., business info, description of org., business lines/segments, governance and operational structure, ownership of or by a health care entity, licenses; additional info required for providers/fully integrated delivery systems and for payers)
2. **Primary languages used by submitter** (when providing services to the public, threshold languages used when serving Medi-Cal beneficiaries)
3. **Description and information of all other parties to the transaction** (e.g., business info, ownership, governance and operational structure, annual revenues for prior 3 years, county(ies) of operation, to the extent available; additional info required for providers/fully integrated delivery systems and for payers)
4. **Proposed or anticipated date of transaction closure**
5. **Description of transaction** (e.g., goals, summary of terms, public impact or benefits, competitive impacts, actions/activities to mitigate any potential adverse impacts on the public)
6. **Information and documents submitted to or required by any other state/federal agency regarding the proposed transaction** (e.g. FTC, DOJ)

Notice Requirements (cont.)

7. **Case information, if proposed transaction has been the subject of any court proceeding**
8. **Description of current services and expected post-transaction impact on health care services** (e.g., county(ies) where services are performed, levels and types of health care services, summary of number and type of patient services by demographic/payer category, community needs assessments, charity care, community benefits, Medi-Cal and Medicare)
9. **If the transaction is a merger or acquisition, descriptions of prior mergers or acquisitions that involve the same/related health care services, involved at least one of the entities or their parents, subsidiaries, predecessors, or successors in the proposed transaction, and were closed in the last 10 years**
10. **Description of potential post-transaction changes** (e.g., to ownership/governance/operational structure, employee-related changes, city/county contracts, seismic compliance, competition within 20 miles of any physical facility offering comparable patient services)
11. **Description of the nature, scope, and dates of any pending or planned material change transactions involving the submitter, within the next 12 months**

Required Documents with Notice

1. A copy of any Premerger Notification and Report Form (including attachments) if the submitter has filed notice of the transaction with the FTC pursuant to the Hart-Scott-Rodino Antitrust Improvements Act.
2. Copies of all current agreement(s) and term sheets (including appendices and exhibits) governing or related to the proposed material change (e.g. definitive agreements, affiliation agreements, stock purchase agreements)
3. Documents sufficient to show the valuation of the transaction;
4. Contact information for any individuals signing or responsible for the transaction or side/related agreements;
5. If applicable, any pro forma post-transaction balance sheet for any surviving or successor entity;
6. A current organizational chart of the organization of any entity party to the transaction, including charts of any parent and subsidiary org(s) and proposed organizational chart(s) for any post-acquisition or transaction;
7. Existing documentation identifying the number of patients per zip code or enrollees per zip code in the last year;

Required Documents (cont.)

8. Certified financial statements for the prior 3 years and any documentation related to the liabilities, debts, assets, balance sheets, statements of income and expenses, any accompanying footnotes, and revenue of all entities that are parties to the transaction
    a. Certified financial statements = audited financial reports, or if not routinely prepared, a comprehensive financial statement (including details re: annual costs, annual receipt, realized capital gains and losses, and accumulated surplus and accumulated reserves using the standard accounting method routinely used by the health care entity → must be supported by sworn written declarations)
9. Governing documents (e.g. articles or organization/incorporation, bylaws, partnership agreements) of all parties to the transaction, including any proposed updates that occur as a result of the transaction
10. Any documentation related to the mitigation of any potential adverse impacts of the transaction on the public; and
11. Any analytic support for and/or documents supporting the submitter's responses to the narrative answers provided

CMIR Filings

- **Confidentiality:** Notices are treated as part of the public record, unless confidentiality is requested and granted.
    - Confidentiality is not absolute. OHCA is permitted to disclose confidential information (1) to the Attorney General, or (2) if subject to CMIR, if OHCA believes disclosure should be made in the public interest after taking into account any privacy, trade secret, or anticompetitive considerations
- **Expedited Review: Submitters can request expedited review in limited circumstances.**

Cost and Market Impact Review (CMIR)

- OHCA has **45-days to notify the submitter if CMIR is not triggered, and 60-days to notify the submitter if CMIR is triggered**, from the filing a complete pre-transaction notice (except where expedited review is granted)
- OHCA can extend the 45-day and 60-day periods for the various reasons, such as where OHCA has requested further information from the parties to a material change transaction necessary to complete its review and it is awaiting the provision of such information
- **Notice of Amendments, Alterations, or Cancellations:** Submitters also must notify OHCA within 5 business days if the transaction is amended, altered or cancelled. OHCA may require the submitter to re-notice any material changes following the same procedure
- **Withdrawal of Pre-Transaction Notices:** Submitters may withdraw pre-transaction notices for any reason by written request at any time after submission and until OHCA issues a final cost and market impact review report

CMIRs

OHCA will conduct a CMIR on transactions based on any one or more of the following factors:

1. If it may result in a negative impact on the availability or accessibility of health care services, including the health care entity's ability to offer culturally competent care
2. If it may result in a negative impact on costs for payers, purchasers, or consumers, including the ability to meet any health care cost targets established by OHCA's Health Care Affordability Board
3. If the transaction may lessen competition or tend to create a monopoly in any geographic service areas impacted by the transaction
4. If it may lessen competition for workers or may negatively impact the labor market
5. If it negatively affects a general acute care or specialty hospital by, for instance, restricting or reducing the health care services offered
6. If it may negatively impact the quality of care
7. If it is part of a series of similar transactions by the health care entity or entities that furthers a trend towards consolidation
8. If it may entrench or extend a dominant market position of any health care entity in the transaction, including extending market power into related markets through vertical or cross-market mergers
9. If it is between a health care entity located in California and an out-of-state entity and may negatively impact affordability, quality, or limit access to health care services in California, or undermine the financial stability or competitive effectiveness of a health care entity located in this state

What OHCA Considers in a CMIR

- OHCA will examine factors relating to a health care entity's business and relative market position
- OHCA **must also consider the benefits of the material change** to consumers of health care services, where those benefits could not be achieved without the transaction (e.g. increased access, higher quality, more efficient health care services directly beneficial to consumers of health care services).
  - OHCA may request additional information from the submitter or other parties to the transaction
  - Submitters may also provide information demonstrating the benefits of the material change or benefits of an integrated organization where the material change would increase those benefits, and where the benefits involve cost, quality, or access to care for consumers of health are services (particularly where those benefits could not be achieved without the transaction)
  - OHCA may also issue subpoenas for health care entities and other relevant market participants documents/information necessary to complete its review

CMIR Timeline

OHCA must complete its cost and market impact review within **90 days** of the final decision by OHCA to conduct a cost and market impact review, subject to extensions/tolling:

- By an additional **30 days**, if OHCA needs additional time to complete its review
- If OHCA determines additional documents/information is necessary, it may toll either the 90-day or 30-day periods for any period of time in which it is awaiting the provision of such documents/information (including where subpoenaed)
- OHCA can toll either the 90-day or 30-day periods during any time period in which other state or federal regulatory agencies or courts are reviewing the subject transaction, and their review may impact the review of the transaction by OHCA

CMIR Reporting

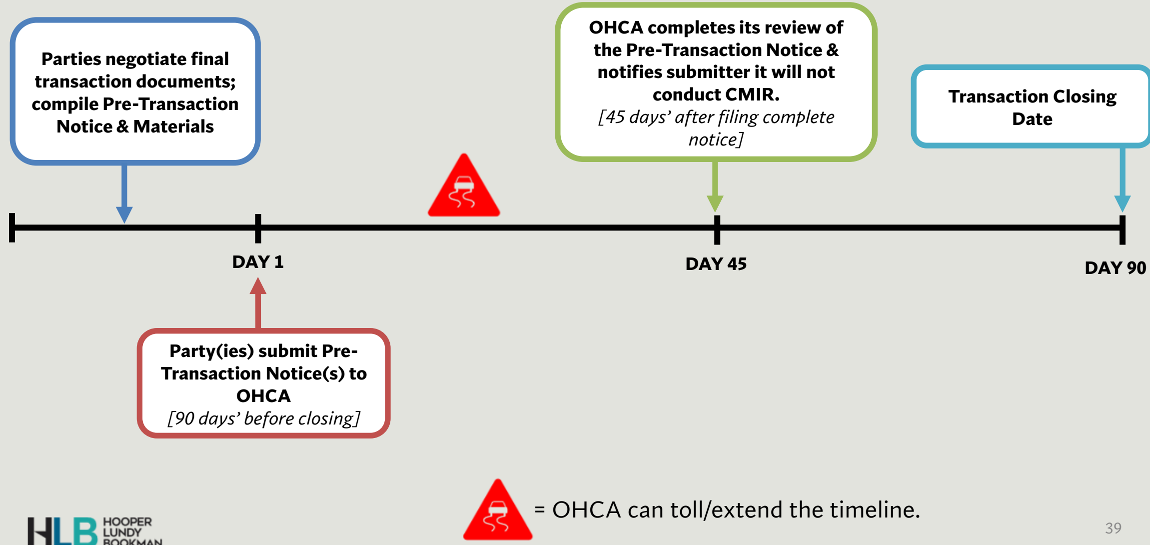
- **Preliminary Report:** Upon completing its cost and market impact review, OHCA will publish its factual findings and issue a preliminary report. The parties to the transaction and the public may submit written comments in response to the preliminary report's findings within 10 business days of the issuance of the preliminary report.
- **Final Report:** OHCA will issue its final report within 15 days of the close of the comment period on the preliminary report, unless extended by OHCA for good cause shown (i.e. a finding based upon a preponderance of the evidence there is a factual basis and substantial reason for the extension, such as where OHCA requires additional time to review and evaluate written comments on the preliminary findings)
- **Attorney General Referral:** OHCA can refer its findings to the Attorney General for further review of any unfair methods of competition, anticompetitive behavior, or anticompetitive effects

Enforcement, Fees, Inquiries

Costs on Submitters: OHCA can contract with experts and consultants to assist in reviewing a noticed transaction (not to exceed an amount reasonable and necessary to conduct the review and complete the report). OHCA is entitled to reimbursement from the submitter subject to cost and market impact review for all actual, reasonable, and direct costs incurred in reviewing, evaluating, and making the determination that cost and market impact review is required, including administrative costs.

What Happens if I Don't Comply? In addition to any legal remedies, OHCA is entitled to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for enforcement of any requirements, and OHCA shall be entitled to recover its attorney's fees and costs incurred in remedying each violation.

Pre-Filing Inquiries: Health care entities unsure if they must file a Pre-Transaction Notice can contact OHCA (CMIR@hcai.ca.gov)



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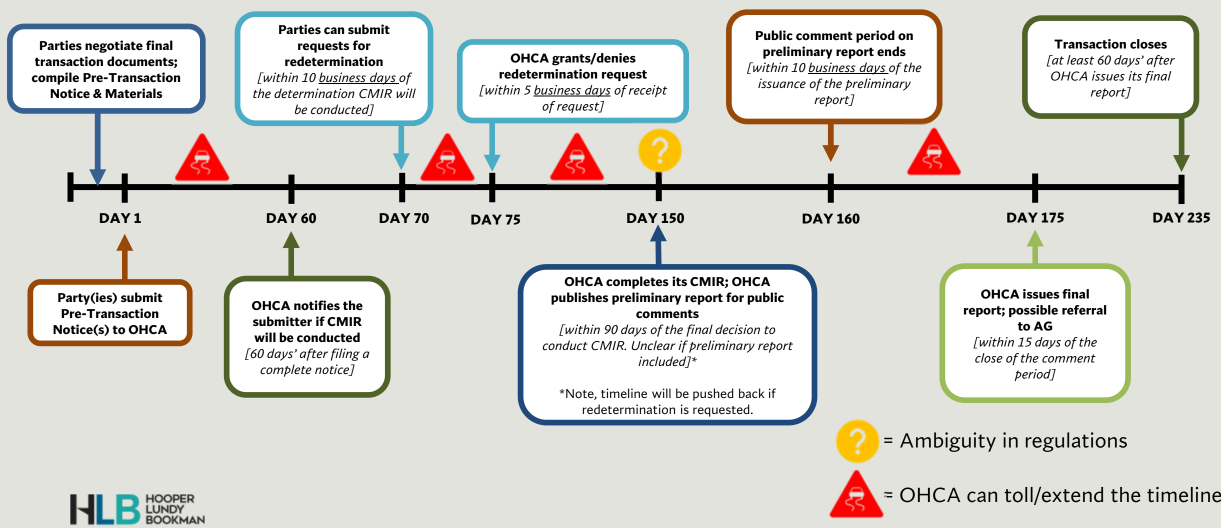

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Final Thoughts

- Try to closing current transactions before April 1, 2024
- Consider structuring transactions to avoid reporting requirements
- Prepare in advance
- Choose your deal partners with OHCA review in mind
- Address OHCA requirements in transaction documents
- Be on the lookout for additional guidance from OHCA

Questions?

Thank You

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