HLB
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California's Health Care Quality and Affordability Act

Hooper, Lundy & Bookman's OHCA Work Group

With the enactment of the California Health Care Quality and Affordability Act (the "Act") as part of the omnibus 2022 health trailer, California established the Office of Health Care Affordability ("OHCA"). The OHCA is responsible for analyzing cost trends and spending drivers in the health care market, developing policies for lowering health care costs for both consumers and purchasers, creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers, and enforcing cost targets that will be set by the Health Care Affordability Board (the "Board"). In addition, the OHCA is charged with reviewing a multitude of potential health care transactions based on their likely market impacts. Health care entities subject to the Act include payers, fully integrated health systems, hospitals and other health facilities, ambulatory surgical centers ("ASCs"), and certain clinics, physician organizations, clinical laboratories, and imaging facilities.

The Legislature's stated purpose in establishing the OHCA and the Board is to ensure that "all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal." The statute includes legislative findings that "affordability has reached a crisis point as health care costs continue to grow" and that escalating costs are being "driven primarily by high prices and the underlying factors or market conditions that drive prices," including consolidation and market failures. This article addresses (1) the structure and roles of the OHCA and the Board; (2) the establishment of, adjustment of, and reporting on health care cost targets, including sector- and entity-specific targets and provider exemptions; (3) the enforcement of targets, (4) the OHCA's role in promoting quality and equity, alternative payment models, and primary care and behavioral health investments, and (5) the OHCA's role in reviewing transactions and market trends.

I. The Office of Health Care Affordability and Health Care Affordability Board

The OHCA is established within the Department of Health Care Access and Information ("HCAI"), which was formerly the Office of Statewide Health Planning and Development ("OSHPD"). Among other things, the OHCA is charged with increasing health care cost transparency; supporting the Board through data collection, analysis, and recommendations; and overseeing California's progress toward meeting the health care cost targets set by the Board. The OHCA has authority to adopt and promulgate necessary rules and regulations, which may be adopted as emergency regulations until January 1, 2027, provided that each rule and regulation is discussed in at least one Board meeting before adoption.

The Board is responsible for establishing statewide health care cost targets as well as targets for particular sectors defined by the Board and defining exempted providers. It will also approve the methodology for setting targets and adjustment factors, the scope and range of penalties, benchmarks for primary care and behavioral health spending, statewide goals for alternative payment models ("APMs"), and standards to advance the stability of the health

workforce. The Board will be comprised of seven voting members and one nonvoting member—the CalPERS Chief Health Director or their deputy. The voting members will consist of four members appointed by the Governor and confirmed by the Senate, one member appointed by the Senate Committee on Rules, one member appointed by the Speaker of the Assembly, and the Secretary of Health and Human Services or their designee. Appointed members cannot receive financial compensation from or be employed by a health care entity that is subject to the cost targets, with certain exceptions.

Finally, the Board will establish a Health Care Affordability Advisory Committee to provide input and recommendations to the Board and OHCA. The Board will appoint the members of the advisory committee, aiming for broad representation, including representatives of consumer and patient groups, payers, fully integrated delivery systems, hospitals, organized labor, health care workers, medical groups, physicians, and purchasers.

II. Health Care Cost Targets (Health & Safety Code § 127502)

The establishment and enforcement of statewide and sector-specific health care cost targets is central to the Act. These targets will focus on total health care expenditures (aggregate and per capita), which is defined as all health care spending in California by public and private sources, including claims-based payments and encounters for covered health care benefits, non-claims based payments for covered health care benefits (*e.g.*, capitation, salary, global budget, other APMs, or supplemental Medi-Cal provider payments), Californian's cost sharing for covered health care benefits; administrative costs and profits, and pharmacy rebates and any inpatient or outpatient prescription drug costs not otherwise captured.

The Board will establish a statewide health care cost target for the 2025 calendar year. The first year will be a reporting year only, but in subsequent years, the statewide health care cost target will be subject to enforcement. Sector-specific targets will be adopted within six years.

A. General Requirements for Targets and Methodology

The Board will establish targets after receiving input from the OHCA and the advisory committees and public comments, but the adoption of targets is exempt from the requirements of California's Administrative Procedures Act. Both the statewide and sector-specific health care cost targets must meet all of the following statutory requirements:

- Promote a predictable and sustainable rate of change;
- Be based on a target percentage, considering economic indicators (*e.g.*, measures reflecting the roader economy, labor markets, and consumer cost trends) or population-based measures (*e.g.*, demographic factors that may influence demand for services);
- Be developed based on a methodology that is available and transparent to the public;
- Be set for each calendar year, considering multiyear targets to promote consistency;

- Be updated periodically;
- Consider relevant adjustment factors;
- Be developed, applied, and enforced;
- Promote the goal of improved affordability, while maintaining quality and equitable care, including consideration of the impact on persons with disabilities and chronic illness;
- Promote the stability of the health care workforce, including the development of the future workforce (*e.g.*, graduate medical education teaching, training, apprenticeships, and research); and
- Be adjusted for a provider or fully integrated delivery system's cost target upon a showing that nonsupervisory employee organized labor costs are projected to grow faster than the rate of any applicable cost targets.

The methodology for setting health care cost targets will be developed by OHCA and approved by the Board. The methodology must conform with the following requirements:

- Review historical trends and projections for economic indicators and population-based measures;
- Review historical trends in costs for Medi-Cal, Medicare, and commercial health care coverage;
- Provide differential treatment of historical trends in 2020 and 2021 due to the impacts of COVID-19 on health care spending and health care entities;
- Review potential factors to adjust future cost targets (*e.g.*, health care employment cost index, labor costs, the consumer price index for urban wage earners and clerical workers, impacts due to known emerging diseases, trends in the price of health care technologies, provider payer mix, state or local mandates such as required capital improvement projects, and any relevant state and federal policy changes impacting covered benefits, provider reimbursement, and costs);
- Consider, with respect to Medi-Cal, provision of the nonfederal share associated with Medi-Cal payments, such as expenditures by providers or provider affiliated entities that serve as the nonfederal share associated with Medi-Cal reimbursement;
- Allow the Board to adjust any targets for Medi-Cal participating providers upon DHCS request and to the extent necessary for the Medi-Cal program to comply with federal requirements to help ensure that full federal financial participation is available.
- Allow the Board to adjust cost targets downward and upward when warranted based on cost and quality (*see* Part II.B, below);

- Require the Board to adjust cost targets for a provider or fully integrated delivery system to account for actual or projected nonsupervisory employee organized labor costs (*see* Part II.B, below).

In addition, the methodology may consider (i) supplemental payments to qualifying providers who provide services to Medi-Cal and underinsured patients; (ii) reimbursements and fees assessed by DHCS as determined appropriate by the DHCS director; and (iii) health care-related taxes or fees that provide the nonfederal share or support the Medi-Cal program.

B. Adjustments

The Act contemplates (or, in the case of adjustments accounting for nonsupervisory organized labor costs, requires) certain adjustment methodologies and adjustments to cost targets:

- *Cost and Quality Adjustments (Health & Safety Code § 127502(d)(6)).* OHCA's methodology for setting targets must allow the Board to adjust cost targets downward (for entities that deliver high-cost care that is not commensurate with quality) and upward (for entities that deliver low-cost, high-quality care) when warranted. Data sources on cost and quality may include cost and quality performance data reported by or sourced from recognized quality improvement and transparency initiatives, relevant supplemental data (*e.g.*, financial data submitted to California agencies and data on costs, payments and quality from California's all-payer claims database), and relevant federal, state, or local data.

- *Labor Adjustments (Health & Safety Code § 127502(d)(7))* With respect to adjustments based on nonsupervisory employee organized labor costs, in order for the adjustment to be effectuated, the provider, the fully integrated delivery system, or other associated part must submit a request with supporting documentation in an OHCA-prescribed format. OHCA may request or accept further information (*e.g.*, any single labor agreement that is final and reflects the actual or projected increase in nonsupervisory employee organized labor costs) to validate the basis for the requested adjustment. OHCA may audit the submitted data and supporting information as necessary.

- *Risk Adjustment Methodologies (Health & Safety Code § 127502(f)).* The OHCA is also charged with establishing risk adjustment methodologies. These methodologies may rely on existing methodologies and must consider the impact of perverse incentives that may inflate the measurement of population risk (*e.g.*, upcoding). To the extent that upcoding or other factors skew risk factor reporting, the OHCA may audit submitted data and make periodic adjustments.

- *Equity Adjustment Methodologies (Health & Safety Code § 127502(g)).* The OHCA is also required to establish equity adjustment methodologies to take into account social determinants of health and other factors related to health equity, to the extent data is available and the methodology has been developed and validated.

C. Specific Targets

The Board is also charged with developing specific targets by health care sector, including for individual health care entities. In preparation for developing sector-specific health care targets, the Board will define initial health care sectors (*e.g.*, geographic regions and individual health care entities) by October 1, 2027. Then, by June 1, 2028, the Board will establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate. The setting of sector-specific targets must be informed by historical cost and other data as well as consideration of access, quality, equity, and health care workforce stability and quality jobs. The Board may adjust cost targets by health care sector to account for the baseline costs in comparison to other health care entities in the sector and geographic region.

The Act includes additional requirements for targets for individual health care entities, payers, and fully integrated delivery systems, as set forth below.

- ***Sector Target for Individual Health Care Entity (Health & Safety Code § 127502(e)).*** The Act further specifies that the methodology for setting a sector target for an individual health care entity (*i.e.*, a payer, provider, or fully integrated delivery system) must consider an entity's status as a high-cost outlier, and permit targets that encourage the entity to serve populations with greater health care risks through risk factor, equity, and geographic cost adjustments.

- ***Payer Targets (Health & Safety Code § 127502(h)).*** Payer is broadly defined as private and public health care payers, including publicly funded health care programs (*e.g.*, Medi-Cal and Medicare), Knox-Keene Plans, health insurers (including behavioral health-only policies), Medi-Cal managed care plans, third party administrators, and any other public or private entity other than an individual that pays for arranges for the purchase of health care services on behalf of employees, dependents, or retirees. In setting targets for payers, the Board will establish targets on payers' administrative costs and profits. OHCA will consult with California's Department of Health Care Services ("DHCS"), Department of Managed Care ("DMHC"), and Department of Insurance to ensure that targets for payers consider actuarial soundness and rate review requirements.

- ***Fully Integrated Delivery System Targets (Health & Safety Code § 127502(i)).*** Under the Act, each fully integrated delivery system will be a sector subject to sector-specific targets. A fully integrated delivery system is a system that includes: (i) a physician organization, (ii) a health facility or health system, and (iii) a nonprofit health care service plan that provides services through an affiliate hospital system and an exclusive contract with a single physician organization in each geographic region. The Board will set targets that will be applicable to each of the system's geographic service areas. Targets for fully integrated delivery systems will include all health care services, costs, and lines of business managed by the system (*i.e.*, individual, small, and large group plans, Medi-Cal, Medicare, Covered California, and self-insured public employee health plans). Until the Board approves sector targets for fully integrated delivery systems, the systems will be required to comply with the statewide cost target.

D. Exempted Providers (Health & Safety Code §§ 127500.2(g); 127501.4(a), (i), (k); 127501.11(a)(3); 127502(o), (p); 127507(b))

The statute requires that certain physician practices and other qualifying providers are "exempted providers" that are not subject to statewide and sector-specific health care targets and direct data collection requirements. OHCA will promulgate regulations defining who is an exempted provider, but the definition must be first approved by the Board, which is charged with establishing the standards that need to be met for exemption.

Exempted providers must include any physician practice that is not a "physician organization" (*i.e.*, a risk-bearing organization or a similar organization; a restricted or limited health care service plan; a § 1206(*l*) medical foundation; an organization—including a medical group practice, professional medical corporation, or medical partnership—that is comprised of 25 or more physicians; an organization of less than 25 physicians that is a high-cost outlier) under the Act. Other providers may be exempted based on standards established by the Board. Factors for exemption may include annual gross and net revenues, patient volume, and high-cost outliers in a given service or geographic region. The Board will consider any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the provider or vice versa. The regulations on data collections specify that the OHCA will not collect data and other information from exempted providers, including exempted providers that are part of a fully integrated delivery system, suggesting that a provider that is part of a fully integrated delivery system may nonetheless qualify as an exempted provider.

E. Data Collection, Analysis, and Reporting (Health & Safety Code §§ 127501(c), 127501.4, 127501.6, 127501.7, 127501.11, 127502)

Data will be important to both informing cost-containment policies and targets as well as enforcement. The OHCA will collect data from health care entities, payers, and fully integrated delivery systems. In order to minimize administrative burdens and duplicative reporting, the OHCA may make use of public and private data sources. In particular, the OHCA will coordinate with DHCS, DMHC, and the Department of Insurance to obtain data on expenditures, premiums, cost sharing, benefits, medical loss ratios, and health equity and quality measures for Medi-Cal and the individual, small group, and large group markets. Fully integrated delivery systems will be required to provide sufficient data and information to enable analysis and public reporting on performance. That data must be comparable to the data provided by other unintegrated payers and providers.

September 1, 2024 will be the first deadline for data submissions by payers and fully integrated delivery systems. On or before June 1, 2025, the OHCA will release its report on baseline health care spending in 2022 and 2023. Thereafter, staring on or before June 1, 2027, OHCA will prepare and publish annual reports on health care spending trends and underlying factors with recommendations to control costs and improve quality performance and equity. Stakeholders and the public will have an opportunity to comment on the findings of the OHCA's annual reports, and the OHCA will also direct public reporting of performance on the heath care cost targets.

F. Monitoring Workforce Stability (Health & Safety Code § 127506).

The Act requires the OHCA to monitor health care workforce stability with the goal that workforce shortages do not undermine health care affordability, access, quality, equity, and culturally and linguistically competent care and to promote affordability while recognizing the need to maintain and increase the supply of trained health care workers. In order to assist entities in implementing cost-reducing strategies that advance the stability of the health care workforce (and do not exacerbate existing shortages), the OHCA will develop standards to advance the stability of the health care workforce. These standards will be developed on or before July 2024 in consultation with the Board and with input from organized labor, health care entities, and other entities and individuals with expertise in the health care workforce. These standards may be considered in setting cost targets or in the approval of performance improvement plans (discussed in the following section).

III. Enforcement of Cost Targets (Health and Safety Code § 127502.5)

The Act provides the Director of HCAI (the "Director") with the power to enforce cost targets against health care entities, including the ability to assess administrative penalties following progressive enforcement measures. Health care entities may seek waivers of enforcement actions due to reasonable factors outside the entity's control and consistent with OHCA waiver requirements. In addition, the Director may impose administrative penalties directly in the case of the repeated failure to file or implement an acceptable performance improvement plan, the willful failure to report complete and accurate data, the knowing failure to provide required information, or the knowing falsification of information as specified in Section Health & Safety Code § 127502.5(h). Because the setting of cost targets is a necessary predicate to most enforcement actions, the first enforcement actions will likely not begin for several years.

A. Types of Enforcement Actions and Considerations

Enforcement actions will generally consist of the following progressive enforcement actions:

1. Providing technical assistance to the entity to assist the entity to come into compliance;

2. Requiring or compelling the entity's public testimony on its failure to comply with the target;

3. Requiring the submission and implementation of performance improvement plans; and

4. Assessing administrative penalties on an escalating scale.

In taking enforcement actions, the Director considers each health care entity's contribution to cost growth in excess of the applicable target, factors contributing to that growth, and the extent to which the entity has control over spending growth.

B. Pre-Enforcement Procedures

Before taking any enforcement action, the OHCA must:

1. Notify the health care entity that it has exceeded the health care cost target.

2. Give the health care entity at least 45 days to respond and provide additional data, including information in support of a waiver.

3. Modify its findings as appropriate if OHCA determines that the additional data and information provided by the health care entity meets the burden to explain all or a portion of the excess cost growth.

4. In the case of a payer regulated by DMHC, DHCS, or the Department of Insurance, consult with the applicable agency to ensure any measures are consistent with laws applicable to the payer.

C. Performance Improvement Plans

The OHCA may require a health care entity to submit and implement a performance improvement plan that identifies the causes for spending growth and includes, among other things, specific strategies, adjustments, and action steps the entity proposes to implement to improve spending performance during a specified time period. Performance improvement plans may be approved for up to three years, and a plan will not be approved if it is likely to erode access, quality, equity, or workforce stability. As part of the approval process, the OHCA will request further information, as needed. The OHCA will publicly post a detailed summary of the health care entity's compliance with the performance improvement plan while it is in effect and will transmit the approved plan to the appropriate state regulators for the entity.

The OHCA will monitor the health care entity for compliance with the approved performance improvement plan. The Director will not assess administrative penalties from an entity that fully complies with an approved performance improvement plan by the OHCA-established deadline but nonetheless does not meet the cost target, but the Director may require a modification to the performance improvement plan until the cost target is met.

D. Administrative Penalties.

The OHCA may levy administrative penalties against an entity that is not compliant with an approved performance plan and does not meet the cost target. The amount of an administrative penalty must generally be commensurate with the failure of the health care entity to meet the target. But, if the entity is repeatedly noncompliant with the performance improvement plan, the Director may assess escalating administrative penalties. In assessing administrative penalties, the Board will consider the following factors:

1. The nature, number, and gravity of the offenses.

2. The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity.

3. The market impact of the health care entity.

The Director may also directly assess administrative penalties without a performance improvement plan where an entity (1) willfully fails to report complete and accurate data, (2) repeatedly neglects to file a performance improvement plan with the OHCA, (3) repeatedly fails to file an acceptable performance improvement plan with the OHCA, (4) repeatedly fails to implement the performance improvement plan, (5) knowingly fails to provide information required by this section to the OHCA, and (6) knowingly falsifies information. In these cases, the Director may also notify the public of the violation at a public meeting and may "declare the entity as imperiling the state's ability to monitor and control health care growth."

Administrative penalties are not considered expenditures for the purposes of meeting cost targets, and do not relieve the penalized entity of the obligation to meet previously established or subsequent cost targets. Penalties recovered will be deposited into the Health Care Affordability Fund. Note, administrative penalties are not expenditures for the purpose of meeting cost targets. The imposition of administrative penalties shall not alter or otherwise relieve the health care entity of the obligation to meet a previously established cost target or a cost target for subsequent years.

E. Waiver of Enforcement Action

The OHCA can require health care entities to file for a waiver of enforcement actions because of reasonable factors outside the entity's control, such as changes in state or federal law or anticipated costs for investments and initiatives to minimize future costly care. The health care entity must submit documentation or supporting evidence of the reasonable factors, anticipated costs, or extraordinary circumstances. The OHCA may request further information, as needed, to approve or deny an application for a waiver.

In addition, if data indicate adverse impacts on cost, access, quality, equity, or workforce stability from consolidation, market power, or other market failures, the Director may, at any point, require that a cost and market impact review on a health care entity.

F. Payers and Fully Integrated Delivery Systems

With respect to payers and fully integrated delivery systems, the Act also authorizes the enforcement of cost targets against the cost growth for administrative costs and profits. If a payer exceeds the target for per capita growth in total health care expenditures but has met its target for the administrative costs and profit, the payer must submit relevant documentation to support the excess growth.

G. Review and Appeal Rights

Although the Act does not explicitly set out the requirements concerning administrative and judicial review of administrative penalties, it does confirm the use of an administrative hearing process and the availability of independent judicial review of the order. After issuance of the final order imposing the administrative penalty, an entity adversely affected by the order may seek independent judicial review by filing a petition for a writ of mandate in accordance with Section 1094.5 of the Code of Civil Procedure. Section 1094.5 authorizes judicial review of the following questions: (1) did the agency proceed without or in excess of jurisdiction, (2) was there a fair trial, and (3) was there any prejudicial abuse of discretion because the agency did not proceed in the manner required by law, the order was not supported by the findings, or the

findings were not supported by the evidence. In general, Government Code section 11523 requires that such a petition for writ of mandate be filed within 30 days after the last day on which reconsideration could be ordered, but this time is extended to no later than 30 days after delivery of the administrative record if the petitioner requests that the agency prepare all or any part of the record within 10 days after the last day on which reconsideration could be ordered.

If a petition for writ of mandate is not timely filed after issuance of a final order, the OHCA may apply to the clerk of the appropriate court for a judgment in the amount of the administrative penalty by filing a certified copy of the final order of the administrative hearing officer. The court clerk will then enter the judgment immediately, and the judgment will have the same force and effect as a judgment in a civil action.

H. Confidentiality of Information

The Act requires that the OHCA keep all nonpublic information and documents it obtains as confidential. The OHCA will not disclose the confidential information or documents to any person without the consent of the source of the information or documents, except in an administrative penalty action, to the Attorney General, or at a public meeting. Before disclosure in a public meeting, the OHCA will notify the relevant party and give the source of nonpublic information an opportunity to state why release of the information is damaging to it and why the public interest is served in withholding the information. All nonpublic information and documents obtained under this subdivision is not disclosable to the California Public Records Act.

IV. Promotion of Quality, Equity, Alternative Payment Models, Primary Care, and Behavioral Health

A. Quality and Equity (Health and Safety Code § 127503)

Health and Safety Code section 127503 requires the OHCA to adopt a set of standard measures for assessing health care quality and equity across health care service plans, health insurers, hospitals, and physician organizations ("Quality & Equity Measures"). The statute does not provide much detail on how the OHCA will draft these standards, but does provide a broad outline of what the OHCA will consider, including recognized clinical quality, patient experience, patient safety, and utilization measures. Furthermore, the Quality & Equity Measures must reflect the diversity of California and consider available means for measuring disparities in terms of "race, ethnicity, sex, age, language, sexual orientation, gender identity and disability status." Performance on the Quality & Equity Measures will be included in the OHCA's annual reports concerning health care spending trends and underlying factor, the first of which is scheduled for release on or before June 1, 2027 (*see* Part II.E, above). Future rulemaking will likely provide further clarity on the Quality & Equity Measures.

To reduce administrative burden, the OHCA will select Quality & Equity Measures that simplify reporting and align performance measurement with other payers, programs, and state agencies and use existing voluntary and required reporting, such as the National Quality Forum Clinical Quality composite measures, as much as possible. The OHCA will also encourage all payers and programs to use the same reporting mechanisms. Any public reporting developed from the Quality & Equity Measures will consider the differences among health care service plans, health insurers, hospitals, and physicians.

The OHCA will consider input from other state departments and stakeholders in drafting the Quality & Equity Measures. In particular, the OHCA will coordinate with the DMHC to align with requirements under Article 11.9 of the Health & Safety Code, which establishes the Health Equity and Quality Committee under the DMHC. The OHCA will also consult with other governmental and private entities, including state departments, external quality improvement organizations and other stakeholders with expertise in quality or equity measurement, in adopting the Quality & Equity Measures. Finally, the Quality & Equity Measures will be reviewed and updated annually.

As more fully described in Part II, above, health care cost targets will reflect and may be adjusted based on quality and equity considerations, and the quality and equity components of these targets and adjustments will presumably be informed by Quality & Equity Measures.

B. Alternative Payment Models (Health and Safety Code § 127504)

In pursuit of the goal of "rewarding equitable high-quality and cost-efficient care," the OHCA is charged with convening an APM working group, developing standards for APMs, and measuring progress against those standards. The benchmarks must include "increasing the percentage of total health care expenditures delivered through [APMs] or the percentage of membership covered by an [APM]."

An APM is defined under the Act as "state or nationally recognized payment approach that financially incentivizes high-quality and cost-efficient care." The standards set for APMs must meet various statutory requirements, including a "focus on encouraging and facilitating multipayer participation and alignment, improving affordability, efficiency, equity and quality by considering the current best evidence for strategies such as investments in primary care and behavioral health, shared risk arrangements, or quality-based or population-based payments." The standards must be set by July 1, 2024, and be reviewed and updated at least once every five years. The statute does not set out consequences for failure to meet the benchmarks, but payers and fully integrated health systems will be required to submit data and other information to OHCA to measure the adoption of APMs.

C. Primary Care and Behavioral Health Spending Benchmarks and Promotion (Health and Safety Code § 127505)

In recognition of the foundational nature of both primary and behavioral health care to an effective health care system, OHCA is charged with measuring and promoting investment in primary and behavioral health care in California. In particular, OHCA will set spending benchmarks for primary care and behavioral health care. These benchmarks are intended to "build and sustain infrastructure and capacity," with a particular focus on "methods of reimbursement that 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." In setting these spending benchmarks, OHCA will consider current and historical underfunding of primary care services as well as differences among payers and fully integrated delivery systems (*e.g.*, plan or network design or line of business, diversity in primary care settings and facilities, the use of claims- and non-claims-based payments, and population risk mix). The spending benchmarks are not intended to increase costs, either to consumers of primary and/or behavioral health care or to the total costs of health care, although the proposed

legislation acknowledges that shifting resources within the systems may be an extended process that will not result in immediate cost savings.

OHCA will also be responsible for promoting improved outcomes for primary care and behavioral health. These efforts will include promoting, among other things, health care entities making investments in, or adopting models that do any or all of the following:

1. Promote the importance of primary care and adopt practices that give consumers a regular source of primary care.

2. Increase access to advanced primary care models and adoption of measures that demonstrate their success in improving quality and outcomes.

3. Integrate primary care and behavioral health services, including screenings for behavioral health conditions in primary care settings or delivery of behavioral health support for common behavioral health conditions, such as anxiety, depression, or substance use disorders.

4. Leverage alternative payment models that provide resources at the practice level to enable improved access and team-based approaches for care coordination, patient engagement, quality, and population health. Team-based approaches support the sharing of accountability for delivery of care between physicians and nurse practitioners, physician assistants, medical assistants, nurses and nurse case managers, social workers, pharmacists, and traditional and nontraditional primary and behavioral health care providers, such as peer support specialists, community health works, and others.

5. Deliver higher value primary care and behavioral health services with an aim toward reducing disparities.

6. Leverage telehealth and other digital health solutions to expand access to primary care and behavioral health services, care coordination, and care management.

7. Implement innovative approaches that integrate primary care and behavioral health with broader social and public health services.

In adopting spending benchmarks, measuring performance with spending benchmarks, and promoting improved outcomes for behavioral health, OHCA is directed to consult with stakeholders such as state departments, as well as external organizations, entities, and individuals that are promoting investment in primary care and behavioral health or that have expertise in primary care, behavioral health, and health equity.

OHCA's analysis of primary care and behavioral health spending and growth, and the relevant quality and equity performance measures will be included in the annual report described in Part II.E, above.

V. Transaction Review and Market Trends (Health and Safety Code § 127507 *et seq*.)

The OHCA is in charge of reviewing a multitude of potential transactions, with a view toward analyzing their likely effect on the health care marketplace. Specifically, any payer,

provider, or fully integrated delivery system must provide the OHCA with 90 days prior written notice of any agreement or transaction that will occur on or after April 1, 2024, and involve either:

> (1) a sale, transfer, lease, exchange, option, encumbrance, conveyance, or other disposition of a material amount of its assets to one or more entities, or
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> (2) a transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities (any such transaction or agreement is referred to in the bill as a "material change").

The OHCA then has 60 days to decide if the proposed material change is likely to have a significant impact on competition, on California's ability to meet cost targets, or on costs for purchasers and consumers, in which case the OHCA notifies the health care facility that it will conduct a "cost and market impact review" of the health care entity's market position, including size and market share by service or geographic region, prices compared to competitors, quality, equity, cost, access, or "any other factors" the OHCA determine to be in the public interest.

If the OHCA determines such a review is not needed, then it can grant a waiver. The bill prohibits a material change from moving forward unless a final report has been issued or the OHCA has issued a waiver. In addition to preparing a report, the OHCA may refer its findings, including documents gathered and data analysis performed, to the Attorney General for further review of any unfair competition, anticompetitive behavior, or anticompetitive effects.

The health care entity must promptly reimburse the OHCA for the actual, reasonable, and direct costs it incurs reviewing, evaluating, and making its determination, upon request by the office. In addition to any other available legal remedies, the OHCA is entitled to specific performance, injunctive relief, and other equitable remedies to enforce these laws, and is entitled to attorneys' fees and costs incurred in remedying any violation.

Notably, the requirement to provide notice of a material change does not apply to certain organizations, some of which are already subject to comparable regulatory oversight: (1) health care service plans subject to review by DMHC; (2) health insurers subject to review by the Insurance Commissioner; (3) health care entities under the control of, and operated by, a political subdivision; and (4) agreements or transactions involving nonprofits for which the Attorney General's approval is required. The requirement generally applies to the same "health care entities" that are subject to the cost targets also established under the statute, and the same set of "exempted providers" are exempt, though a transaction is subject to review if an exempted provider is being acquired by, or affiliating with, an entity that is not an exempted provider. Specifically, an "exempted provider" includes certain physician organizations with fewer than 25 physicians, and any other provider that satisfies standards to be set by the Board for exemption. The definition of an "exempted provider" is discussed in more detail above in Section II.

The OHCA is also directed to adopt regulations setting appropriate criteria for the types of agreements or transactions for which a notice must be submitted (*e.g.*, based on patient revenue, or market share in a given service or region), as well as regulations outlining factors to be considered in the OHCA's review, and relevant timelines, and to establish appropriate fees.