HEALTH AND SAFETY CODE - HSC

DIVISION 107. HEALTH CARE ACCESS AND INFORMATION [127000 - 130079] *(Heading of Division 107 amended by Stats. 2021, Ch. 143, Sec. 28.)*

PART 2. HEALTH POLICY AND PLANNING [127280 - 127697] *(Part 2 added by Stats. 1995, Ch. 415, Sec. 9.)*

CHAPTER 2.6. Health Care Affordability [127500 - 127507.6] *(Chapter 2.6 added by Stats. 2022, Ch. 47, Sec. 19.)*

ARTICLE 3. Health Care Cost Targets [127502 - 127502.5] *(Article 3 added by Stats. 2022, Ch. 47, Sec. 19.)*

127502. (a) The board shall establish a statewide health care cost target.

(b) (1) The board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate. The board shall define health care sectors, which may include geographic regions and individual health care entities, as appropriate, except for fully integrated delivery systems, and the office shall promulgate regulations accordingly.

(2) The board may adjust cost targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, when warranted to account for the baseline costs in comparison to other health care entities in the health care sector and geographic region.

(3) The setting of different targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, shall be informed by historical cost data and other relevant supplemental data, such as financial data on health care entities submitted to state agencies and the Health Care Payments Data Program, as well as consideration of access, quality, equity, and health care workforce stability and quality jobs pursuant to Section 127506.

(c) The health care cost targets shall meet all of the following requirements:

(1) Promote a predictable and sustainable rate of change in per capita total health care expenditures.

(2) (A) Be based on a target percentage, with consideration of economic indicators or population-based measures, and be developed based on a methodology that is available and transparent to the public.

(B) Economic indicators may include established measures reflecting the broader economy, the labor markets, and consumer cost trends.

(C) Population-based measures may include changes in the state's demographic factors that may influence demand for health care services, such as aging.

(3) Be set for each calendar year, with consideration of multiyear targets to provide health care entities with consistency, be updated periodically, and shall consider relevant adjustment factors.

(4) Be developed, applied, and enforced.

(5) Promote the goal of improved affordability for consumers and purchasers of health care, while maintaining quality and equitable care, including consideration of the impact on persons with disabilities and chronic illness.

(6) Promote the stability of the health care workforce, including the development of the future workforce, such as graduate medical education teaching, training, apprenticeships, and research.

(7) Be adjusted for a provider or fully integrated delivery system's cost target, as appropriate upon a showing that nonsupervisory employee organized labor costs are projected to grow faster than the rate of any applicable cost targets.

(d) (1) Consistent with paragraph (1) of subdivision (b) of Section 127501.11, the office shall develop a methodology, for approval by the board, to set health care cost targets. The methodology shall be available and transparent to the public.

(2) The methodology shall review historical trends and projections for economic indicators and population-based measures.

(3) The methodology shall review historical trends in costs for Medi-Cal, Medicare, and commercial health care coverage. The methodology shall provide differential treatment of the 2020 and 2021 calendar years due to the impacts of COVID-19 on health care spending and health care entities.

(4) The methodology shall review potential factors to adjust future cost targets, including, but not limited to, the 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.

(5) (A) With respect to Medi-Cal, the methodology shall consider provision of nonfederal share, determined to be appropriate by the Director of Health Care Services, 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.

(B) The methodology may also consider all of the following:

(i) Supplemental payments to qualifying providers who provide services to Medi-Cal and underinsured patients.

(ii) Provisions of nonfederal share or reimbursement of state costs not associated with specific Medi-Cal reimbursement, but that supports the Medi-Cal program, and any other reimbursements and fees assessed by the State Department of Health Care Services, as determined appropriate by the Director of Health Care Services.

(iii) Health care-related taxes or fees that, in whole or in part, provide the nonfederal share associated with Medi-Cal payments or support the Medi-Cal program, as determined appropriate by the Director of Health Care Services.

(C) The methodology shall allow the board, to the extent necessary for the Medi-Cal program to comply with federal requirements to help ensure that full federal financial participation is available and not otherwise jeopardized related to services, programs, benefits, and contracts that involve funds disbursed by the State Department of Health Care Services, including but not limited to funds authorized pursuant to Title XIX (42 U. S.C. Sec. 1396 et seq.) of the Social Security Act or Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.), to adjust any targets, when warranted, as they pertain to health care entities in the Medi-Cal program, upon the request of the Director of Health Care Services.

(6) (A) The methodology shall allow the board to adjust cost targets downward, when warranted, for health care entities that deliver high-cost care that is not commensurate with improvements in quality, and upward, when warranted, for health care entities that deliver low cost, high quality care.

(B) Data sources on cost and quality performance of health care entities may include, but are not limited to, all of the following:

(i) Cost and quality performance data reported by or sourced from recognized quality improvement and transparency initiatives.

(ii) Any other relevant supplemental data, such as financial data on health care entities, submitted to state agencies, and data on costs, payments, and quality from the Health Care Payments Data Program established pursuant to Chapter 8.5 (commencing with Section 127671).

(iii) Any relevant federal, state, or local data.

(7) The methodology shall require the board to adjust cost targets for a provider or a fully integrated delivery system as appropriate to account for actual or projected nonsupervisory employee organized labor costs, including increased expenditures related to compensation. For an adjustment to be effectuated, the provider, the fully integrated delivery system, or other associated party shall submit a request with supporting documentation in a format prescribed by the office. To validate the basis for the requested adjustment, the office may request or accept further information, such as any single labor agreement that is final and reflects the actual or projected increased nonsupervisory employee organized labor costs. The office may audit the submitted data and supporting information as necessary.

(e) The methodology for setting a sector target for an individual health care entity shall be developed taking into account the following:

(1) Allow for the setting of cost targets based on the entity’s status as a high-cost outlier.

(2) Allow for the setting of cost targets that encourage an individual health care entity to serve populations with greater health care risks by incorporating all of the following:

(A) A risk factor adjustment reflecting the health status of the entity's patient mix, consistent with risk adjustment methodology developed under subdivision (f).

(B) An equity adjustment accounting for the social determinants of health and other factors related to health equity for the entity's patient mix, consistent with subdivision (g).

(C) A geographic cost adjustment reflecting the relative cost of doing business, including labor costs in the communities the entity operates.

(f) (1) In consultation with the board, the office shall establish risk adjustment methodologies for the reporting of data on total health care expenditures and may rely on existing risk adjustment methodologies. The methodology shall be available and transparent to the public.

(2) To select appropriate risk adjustment methodologies or inform the way any adjustments are applied to unadjusted data to account for the underlying health status of the population, the office may convene technical committees, as necessary.

(3) The risk adjustment methodologies selected or used to inform any adjustments shall take into account the impact of perverse incentives that may inflate the measurement of population risk, such as upcoding. The office may audit submitted data and make periodic adjustments to address those issues as necessary.

(g) In consultation with the board, the office shall 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 methodology has been developed and validated.

(h) (1) Targets set for payers shall also include targets on administrative costs and profits to deter growth in administrative costs and profits.

(2) The targets established for a payer's administrative costs and profits under this subdivision may be subject to annual adjustment, but shall not increase to the extent the costs for the medical care portion of the medical loss ratio exceed a target.

(3) The office shall consult with the Department of Managed Health Care, the State Department of Health Care Services, and the Department of Insurance to ensure any targets for payers established by the office consider actuarial soundness and rate review requirements imposed by or upon those departments.

(i) (1) Until the board approves sector targets for fully integrated delivery systems, fully integrated delivery systems shall comply with the statewide cost target.

(2) Targets set for fully integrated delivery systems shall include all health care services, costs, and lines of business managed by that system in each separately administered geographic service area of the state. The system shall provide sufficient data and information, comparable to other unintegrated payers and providers, including patient risk mix, to the office to enable analysis and public reporting of performance, including by sector, insurance market, line of business, and separately administered geographic service area.

(3) Targets for fully integrated delivery systems shall include targets on payer administrative costs and profits.

(4) After the board approves sector targets for fully integrated delivery systems, a fully integrated delivery system shall be subject to a target for each of its geographic service areas in which a single medical group is responsible for providing, or arranging for the provision of, all professional services to the payer's enrollees.

(j) The office shall direct the public reporting of performance on the health care cost targets, which may include analysis of changes in total health care expenditures on an aggregate and per capita basis for all of the following:

(1) Statewide.

(2) By geographic region.

(3) By insurance market and line of business, including for each payer.

(4) For health care entities, both unadjusted and using a risk adjustment methodology against the covered lives or patient populations, as applicable, for which they serve.

(5) For impact on affordability for consumers and purchasers of health care.

(k) The office shall direct the analysis and public reporting of contributions of health care entities to cost growth in the state using data that includes, but is not limited to, data submitted to the office, data from state and federal agencies, other relevant

supplemental data, such as financial data on health care entities, that is submitted to state agencies, and the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671).

(l) (1) The board shall establish a statewide health care cost target for the 2025 calendar year and for each calendar year thereafter. The 2025 baseline target shall be a reporting year only and shall not be subject to enforcement pursuant to Section 127502.5. The targets established for the 2026 calendar year, and each calendar year thereafter, shall be enforced for compliance pursuant to Section 127502.5.

(2) (A) On or before October 1, 2027, the board shall define initial health care sectors, which may include geographic regions and individual health care entities, as appropriate, except fully integrated delivery systems, considering factors such as delivery system characteristics. Sectors may be further defined over time.

(B) Not later than June 1, 2028, the board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, in accordance with this chapter.

(C) The development of sector targets shall be done in a manner that minimizes fragmentation and potential cost shifting and that encourages cooperation in meeting statewide and geographic region targets.

(D) Sector targets adopted under this subdivision shall specify which single sector target is applicable if a health care entity falls within two or more sectors.

(m) (1) The board shall hold a public meeting to discuss the development and adoption of recommendations for statewide cost targets, or specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities. The board shall deliberate and consider input, including recommendations from the office, the advisory committee, and public comment. Cost targets and other decisions of the board consistent with this section shall not be adopted, enforced, revised, or updated until presented at a subsequent public meeting. The meetings shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code) consistent with paragraph (2) of subdivision (e) of Section 127501.10.

(2) The office shall publish on its internet website its recommendations for proposed cost targets for the board's review and consideration. The board shall discuss recommendations at a public meeting for proposed targets on or before March 1 of the year prior to the applicable target year.

(3) The board shall receive and consider public comments for 45 days after the board meeting.

(4) The board shall adopt final targets on or before June 1, at a board meeting. The board shall remain in session, and members shall not receive per diem under Section 127501.10, until the board adopts all required cost targets for the following calendar year.

(n) The adoption of cost targets under this section is exempt from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(o) For purposes of this section, "individual health care entity" does not include an exempted provider.

(p) (1) Statewide and sector-specific health care cost targets do not apply to exempted providers. Upon approval by the board, the office shall promulgate regulations defining who is an exempted provider.

(2) This section does not exempt claims and non-claims-based payments for exempted providers, and associated cost-sharing amounts paid by consumers, from inclusion in the calculation of total health care expenditures and per capita total health care expenditures that uses data submitted by payers.

(Amended by Stats. 2022, Ch. 738, Sec. 5. (AB 204) Effective September 29, 2022.)

127502.5. (a) The director shall enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets, allows each health care entity opportunities for remediation, and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access, quality, equity, or workforce stability. The director shall consider each entity's contribution to cost growth in excess of the applicable target and any actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target. The director shall review information and other relevant data from additional sources, as appropriate, including data from the Health Care Payments Data Program, to determine the appropriate health care entity that may be subject to enforcement actions under this section. Commensurate with the health care entity's offense or violation, the director may take the following progressive enforcement actions:

(1) Provide technical assistance to the entity to assist it to come into compliance.

(2) Require or compel public testimony by the health care entity regarding its failure to comply with the target.

(3) Require submission and implementation of performance improvement plans, including input from the board.

(4) Assess administrative penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

(b) Prior to taking any enforcement action, the office shall do all of the following:

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

(2) Give the health care entity not less than 45 days to respond and provide additional data, including information in support of a waiver described in subdivision (i).

(3) If the office determines that the additional data and information meets the burden established by the office to explain all or a portion of the entity's cost growth in excess of the applicable target, the office may modify its findings, as appropriate.

(4) The director shall consult with the Director of Managed Health Care, the Director of Health Care Services, or the Insurance Commissioner, as applicable, prior to taking any of the enforcement actions specified in this section with respect to a payer regulated by the respective department to ensure any technical assistance, performance improvement plans, or other measures authorized by this section are consistent with laws applicable to regulating health care service plans, health insurers, or a Medi-Cal managed care plan contracted with the State Department of Health Care Services.

(c) (1) If a health care entity exceeds an applicable cost target, the office shall notify the health care entity of their status and provide technical assistance. The office shall make public the extent to which the health care entity exceeded the target. The office may require a health care entity to submit and implement a performance improvement plan that identifies the causes for spending growth and shall include, but not be limited to, specific strategies, adjustments, and action steps the health care entity proposes to implement to improve spending performance during a specified time period. The office shall request further information, as needed, in order to approve a proposed performance improvement plan. The director may approve a performance improvement plan consistent with those areas requiring specific performance or correction for up to three years. The director shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode access, quality, equity, or workforce stability. The standards developed under Article 7 (commencing with Section 127506) may be considered in the approval of a performance improvement plan.

(2) The office shall monitor the health care entity for compliance with the performance improvement plan. The office shall publicly post the identity of a health care entity implementing a performance improvement plan and, at a minimum, a detailed summary of the entity's compliance with the requirements of the performance improvement plan while the plan remains in effect and shall transmit an approved performance improvement plan to appropriate state regulators for the entity.

(3) A health care entity shall work to implement the performance improvement plan as submitted to, and approved by, the office. The office shall monitor the health care entity for compliance with the performance improvement plan.

(4) The board, the members of the board, the office, the department, and employees, contractors, and advisors of the office and the department shall keep confidential all nonpublic information and documents obtained under this subdivision, and shall not disclose the confidential information or documents to any person, other than the Attorney General, without the consent of the source of the information or documents, except in an administrative penalty action, or a public meeting under this section if the office believes that disclosure should be made in the public interest after taking into account any privacy, trade secret, or anticompetitive considerations. Prior to disclosure in a public meeting, the office shall notify the relevant party and provide the source of nonpublic information an opportunity to specify facts documenting why release of the information is damaging or prejudicial to the source of the information and why the public interest is served in withholding the information. Information that is otherwise publicly available, or that has not been confidentially maintained by the source, shall not be considered nonpublic information. This paragraph does not limit the board's discussion of nonpublic information during closed sessions of board meetings.

(5) Notwithstanding any other law, all nonpublic information and documents obtained under this subdivision shall not be required to be disclosed pursuant to the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records.

(d) (1) If the director determines that a health care entity is not compliant with an approved performance improvement plan and does not meet the cost target, the director may assess administrative penalties commensurate with the failure of the health care entity to meet the target. An entity that has fully complied with an approved performance improvement plan by the deadline established by the office shall not be assessed administrative penalties. However, the director may require a modification to the performance improvement plan until the cost target is met.

(2) The administrative penalty shall be deposited into the Health Care Affordability Fund.

(3) Prior to assessing an administrative penalty against a health care entity, the director may consider related provision of nonfederal share, determined to be appropriate by the Director of Health Care Services, 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.

(4) To the extent that an administrative penalty is related to a Medi-Cal expenditure, including federal financial participation, the office shall coordinate with the State Department of Health Care Services to ensure appropriate treatment and return of any federal funds pursuant to Subpart F commencing with Section 433.300 of Part 433 of Title 42 of the Code of Federal Regulations.

(5) If, after the implementation of one or more performance improvement plans, the health care entity is repeatedly noncompliant with the performance improvement plan, the director may assess escalating administrative penalties that exceed the penalties imposed under paragraphs (1) and (2) of this subdivision and paragraph (4) of subdivision (a).

(6) The director shall consider all of the following to determine the penalty:

(A) The nature, number, and gravity of the offenses.

(B) 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.

(C) The market impact of the entity.

(e) Administrative penalties shall not constitute 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.

(f) (1) For payers and fully integrated delivery systems, the director also shall enforce cost targets established by Section 127502 against the cost growth for administrative costs and profits.

(2) If a payer exceeds the target for per capita growth in total health care expenditures, but has met its target for administrative costs and profits, the payer shall submit relevant documentation or supporting evidence for the drivers of excess cost growth.

(3) This subdivision does not relieve a payer of its obligation to meet targets for per capita growth in total health care expenditures established by Section 127502, and does not limit enforcement actions for payers under this section.

(g) 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 be performed on a health care entity, consistent with Section 127507.2.

(h) (1) The director may directly assess administrative penalties when a health care entity has failed to comply with this chapter by doing any of the following:

(A) Willfully failing to report complete and accurate data.

(B) Repeatedly neglecting to file a performance improvement plan with the office.

(C) Repeatedly failing to file an acceptable performance improvement plan with the office.

(D) Repeatedly failing to implement the performance improvement plan.

(E) Knowingly failing to provide information required by this section to the office.

(F) Knowingly falsifying information required by this section.

(2) The director may call a public meeting to notify the public about the health care entity’s violation and declare the entity as imperiling the state’s ability to monitor and control health care cost growth.

(i) The office may establish requirements for health care entities to file for a waiver of enforcement actions due to 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, such as increasing access to primary and preventive services, or under extraordinary circumstances, such as an act of God or catastrophic event. The entity shall submit documentation or supporting evidence of the reasonable factors, anticipated costs, or extraordinary circumstances. The office shall request further information, as needed, in order to approve or deny an application for a waiver.

(j) As applied to the administrative penalties for acts in violation of this chapter, the remedies provided by this section and by any other law are not exclusive and may be sought and employed in any combination to enforce this chapter.

(k) Following an administrative hearing, a health care entity adversely affected by a final order imposing an administrative penalty authorized by this chapter 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.

(l) After an order imposing an administrative penalty becomes final, and if a petition for a writ of mandate has not been filed within the time limits prescribed in Section 11523 of the Government Code, the office may apply to the clerk of the appropriate court for a judgment in the amount of the administrative penalty. The application, which shall include a certified copy of the final order of the administrative hearing officer, shall constitute a sufficient showing to warrant the issuance of the judgment. The court clerk shall enter the judgment immediately in conformity with the application. The judgment so entered has the same force and effect as, and is subject to all the provisions of law relating to, a judgment in a civil action, and may be enforced in the same manner as any other judgment of the court in which it is entered.

(Amended by Stats. 2023, Ch. 131, Sec. 130. (AB 1754) Effective January 1, 2024.)