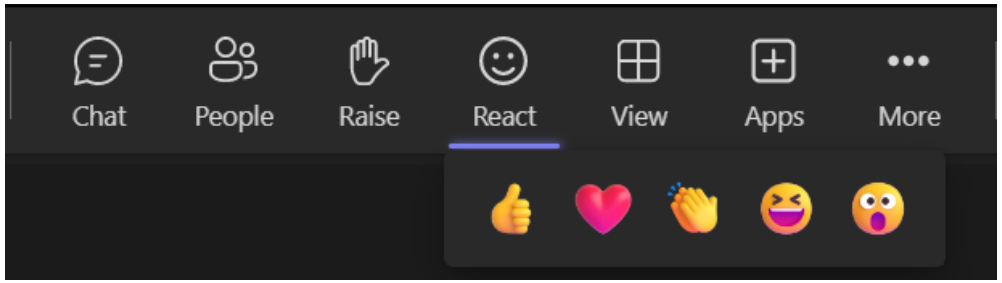
HCAi
Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

February 21st, 2024

Meeting Format

- Workgroup purpose and scope can be found in the Investment and Payment Workgroup Charter
- Remote participation via Teams Webinar only
- Meeting recurs the third Wednesday of every month
- We will be using reaction emojis, breakout rooms, and chat functions:



Date:
Wednesday, December 20, 2023

Time
9:00 am PST

Microsoft Teams Link
for Public Participation:

Meeting ID: 231 506 203 671
Passcode: XzTN6r

Or call in (audio only):
+1 916-535-0978

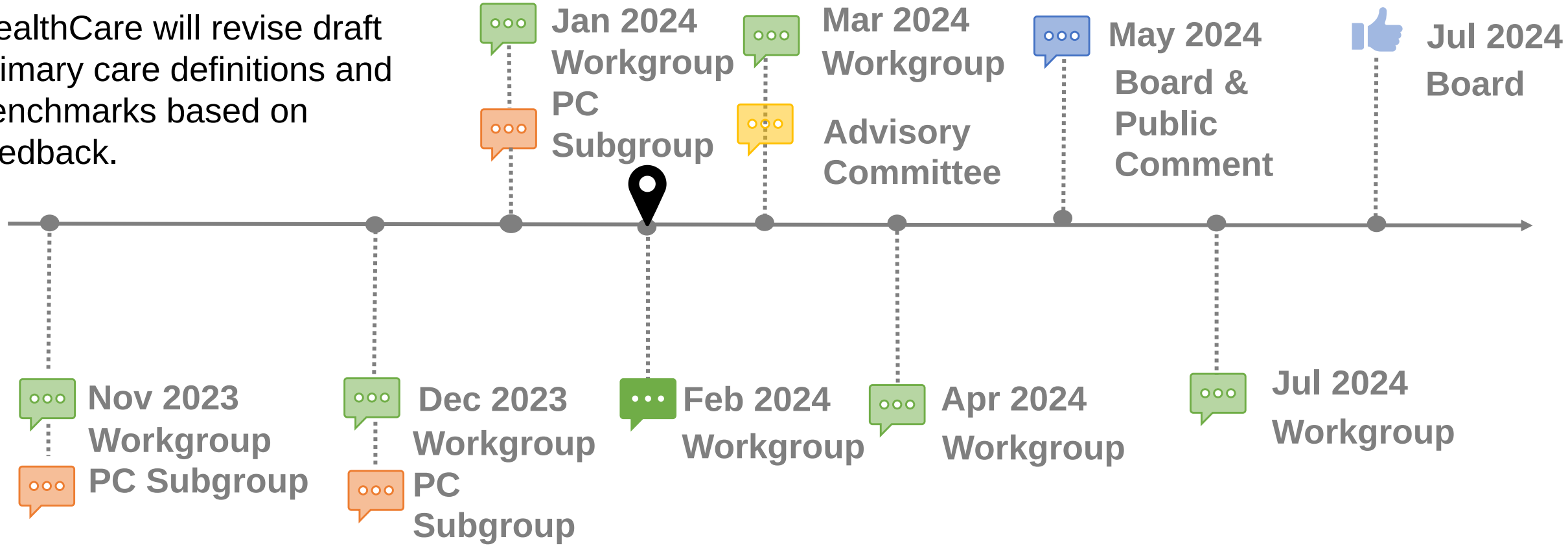
Conference ID:
261 055 415#

Agenda

9:00 a.m.	**1. Welcome and Updates**
9:05 a.m.	**2. Discuss Revised Recommended Approach to Measuring Non-Claims Primary Care Spend**
9:40 a.m.	**3. Overview of Key Decisions for Benchmark Setting**
10:30 a.m.	**4. Adjournment**

Timeline for Primary Care Work

Between each meeting, OHCA and Freedman HealthCare will revise draft primary care definitions and benchmarks based on feedback.



Provide Feedback

Board Approval

HCAI Department of Health Care Access and Information

Alternative Payment Model Updates from OHCA Advisory Committee Feedback

- Updates to APM Standards and Implementation Guidance
  - Specificity on improving affordability
  - Detail on reducing patients' financial barriers for preventive services
  - Additional emphasis on supporting a wide range of providers
  - Addressing inequities in patient experience
  - Technical assistance to support provider performance on metrics impacting payment

- APM Standards (clean and redline version) shared with workgroup members with revisions based on November Advisory Committee feedback

- Next Steps
  - Introduce APM recommendations to Board and release for public comment on February 28th

Revised APM Goal Recommendations

OHCA increased initial percentage of commercial HMO members meeting interim milestones towards the APM Adoption Goal due to additional information on percent of current Category 4 arrangements linked to quality.

Recommended APM Adoption Goal				
	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	**65%**	35%	55%	55%
2028	**70%**	45%	60%	60%
2030	**75%**	55%	65%	65%
2032	**75%**	65%	70%	70%
2034	**75%**	75%	75%	75%

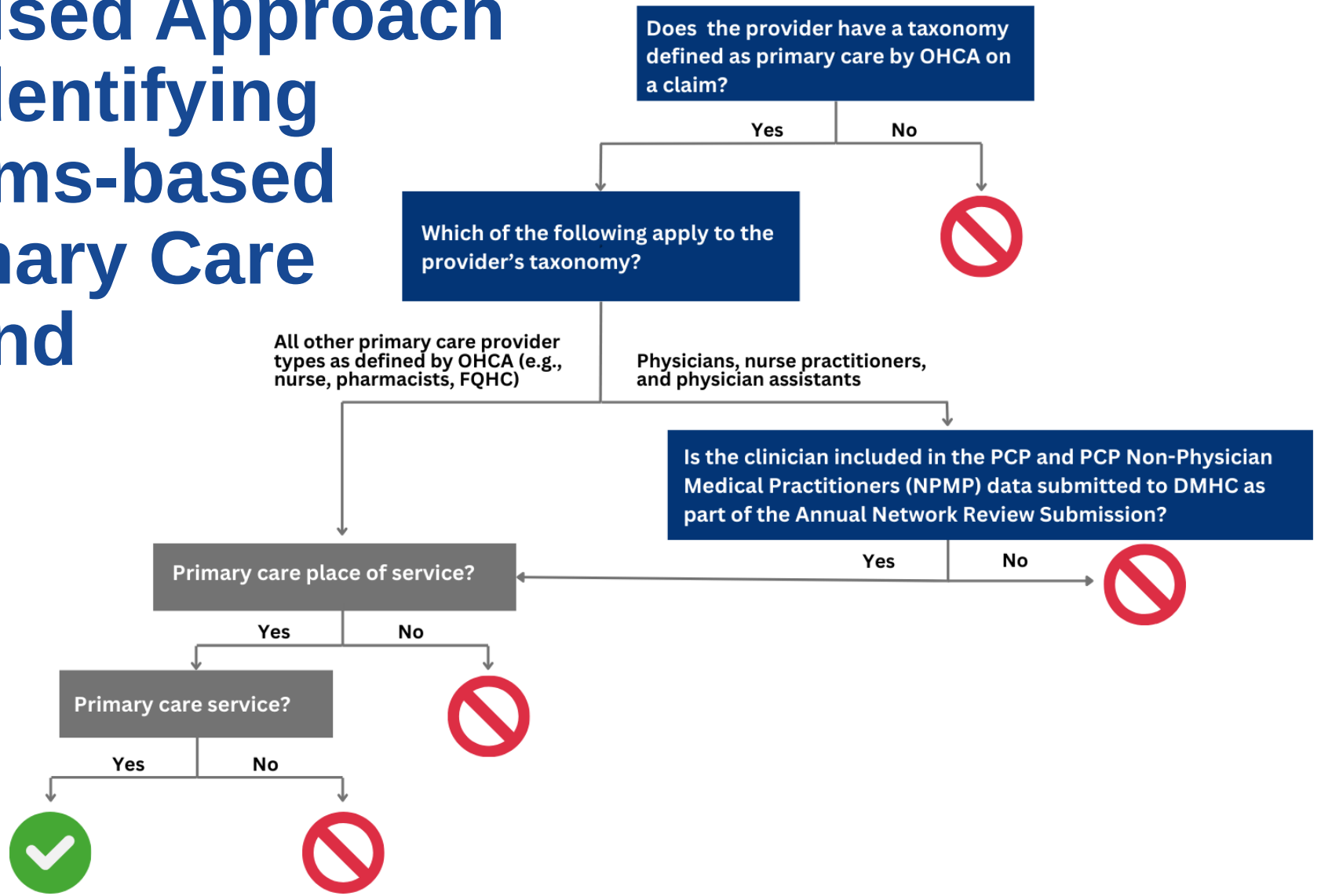
OHCA's Recommended Definition of Primary Care Excludes OB-GYNs

OHCA's Recommendation: Include OB-GYN services when provided by a primary care provider at a primary care place of service. All services provided by an OB-GYN are excluded.

Rationale:

- Current focus on investing in providers who provide continuous whole-person care for all body systems. OB-GYNs typically do not meet this definition.
  - For example, a person who selected an OB-GYN as a primary care provider would seek treatment for a minor acute conditions such as a sinus infection from another provider.
  - Additionally, many people with chronic conditions such as hypertension and diabetes do not visit an OB-GYN for this care.
- Some workgroup members said state laws or regulations to promote consumer choice could define primary care differently than those to promote increased spending on primary care aligned with a specific vision of primary care.

Revised Approach to Identifying Claims-based Primary Care Spend



For example, an internal medicine physician who is not identified as a PCP in the payer's Annual Network Report Submission is removed at this step.

HCAi
Department of Health Care Access and Information

Discuss Revised Recommended Approach to Measuring Non-Claims Primary Care Spend

Margareta Brandt, Assistant Deputy Director
Mary Jo Condon, Principal Consultant
Robert Seifert, Consultant

Framing the Measurement

What will be measured

Money payers paid to providers in support of primary care services.

What won't be measured

Money providers spent delivering primary care services.

Recap: Expanded Framework, Categories 1-3

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
1	**Population Health and Practice Infrastructure Payments**	
a	Care management/care coordination/population health/medication reconciliation	2A
b	Primary care and behavioral health integration	2A
c	Social care integration	2A
d	Practice transformation payments	2A
e	EHR/HIT infrastructure and other data analytics payments	2A
2	**Performance Payments**	
a	Retrospective/prospective incentive payments: pay-for-reporting	2B
b	Retrospective/prospective incentive payments: pay-for-performance	2C
3	**Payments with Shared Savings and Recoupments**	
a	Procedure-related, episode-based payments with shared savings	3A
b	Procedure-related, episode-based payments with risk of recoupments	3B
c	Condition-related, episode-based payments with shared savings	3A
d	Condition-related, episode-based payments with risk of recoupments	3B
e	Risk for total cost of care (e.g., ACO) with shared savings	3A
f	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B

Recap: Expanded Framework, Categories 4-6

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
4	**Capitation and Full Risk Payments**	
a	Primary Care capitation	4A
b	Professional capitation	4A
c	Facility capitation	4A
d	Behavioral Health capitation	4A
e	Global capitation	4B
f	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C
5	**Other Non-Claims Payments**	
6	**Pharmacy Rebates**	

Overview of Challenges of Non-Claims Payments

- High percentage of professional and global capitation in California increases need to accurately capture non-claims payments.
- Currently, there is no standard method among states for allocating non-claims payments to primary care.
- The methods proposed today are used in other states and refined to meet the needs of California, but they are blunt instruments and not ideal. There is no ideal.
- Most non-claims payments cannot be tied to a specific (primary care) provider.
- Most non-claims payments cannot be tied to specific services, let alone primary care services.

Overview of Draft Recommendations for Non-Claims Primary Care Measurement

Category 1 & 2 (Population Health, Practice Infrastructure and Performance Payments): Non-claims payments in these categories are typically allocated to primary care when paid to primary care providers and organizations. For multi-specialty practices and health systems, payers identify their primary care programs and allocate only the payments associated with those programs. Limit the portion of practice transformation and IT infrastructure payments that "count" as primary care.

Category 3 (Payments with Shared Savings and Recoupments): Limit the portion of the risk settlement paid to provider organizations that is allowed to be allocated to primary care.

Category 4 (Capitation and Full Risk Payments): For primary care capitation, payers allocate 100% to primary care. For other capitation payments, data submitters calculate a fee-for-service equivalent based on a fee schedule for primary care services multiplied by the number of encounters.

What Portion of Spending is Paid Via Non-Claims Payment in California?

- **Commercial HMO**
  - Capitation (Expanded Framework category 4) and incentive/risk settlement payments (category 2 or 3) are by far the most common types of non-claims payments
  - Capitation on average accounted for 98% of non-claims payment dollars, which was about 29% of total cost
  - Incentive payments were generally under 2% of non-claims payments, or 0.6% of total cost
  - Population health and practice infrastructure payments (category 1) are much less common and smaller amounts as they are usually included in capitation
- **Commercial PPO**
  - Non-claims payments are not common
  - Care management fees (category 1) and shared savings related to ACO arrangements (category 3) were reported but infrequently

Payments “in Support of Primary Care Services” Category 1 & 2 Examples

Population Health, Practice Infrastructure, and Performance Incentives		
Included	Excluded	Trickier
• Prospective payments to support care management, care coordination, population health, diabetes education, health promotion, BH or social care integration • Performance incentives in recognition of quality/outcomes of patients attributed to primary care providers	• Payments to support hospitalists • Utilization management programs	• Practice transformation • IT infrastructure **Recommendation:** Limit portion of payments that “count” to 1% of total medical expense.

Note: Not all actual spending for primary care will be captured and some submitted spending may pay for activities broader than primary care.

Payments “in Support of Primary Care Services” Category 3 Examples

Payments with Shared Savings and Recoupments		
Included	Excluded	Trickier
• Risk settlement payments paid to primary care provider organizations	• Procedure episodes/ bundles	• Risk settlements paid to multi-specialty provider organizations and health systems

Recommendation:
Limit portion of payments that “count” to claims-based professional spend as a percent of claims-based professional and hospital spending.

Note: Not all actual spending for primary care will be captured and some submitted spending may pay for activities broader than primary care.

Workgroup Members Proposed Approach

Recommendation:
Limit portion of risk settlement payments that "count" as primary care to equal to claims-based professional spend as a percent of claims-based professional and hospital spending.

Step 1: OHCA calculates claims-based professional spend as a percent of claims-based professional and hospital spending statewide. THCE previous year annual data collection serves as source.

Step 2: OHCA publishes percentage calculated in Step 1 after first year of data submission in THCE Data Submission Guide.

Step 3: Payers calculate risk settlement payments counted as primary care by multiplying all risk settlement payments by percentage published by OHCA in Step 2.

Payments “in Support of Primary Care Services” Category 4 Examples

Capitation		
Included	Excluded	Trickier
• Primary care capitation	• Facility capitation	• Professional capitation • Global capitation

Recommendation: Estimate based on encounters for primary care services

Note: Not all actual spending for primary care will be captured and some submitted spending may pay for activities broader than primary care.

Example of Non-Claims Capitation Formula

Payer A has four types of capitation arrangements with provider groups. Three of them cover some primary care services. The table below describes the portion of the payer's capitation payments that would be allocated to primary care.

	Total Dollars Paid Via Capitation Category	Dollars Attributed to Primary Care	Dollars Attributed to Primary Care Equal To
Primary Care Capitation	$100,000,000	$100,000,000	Total amount paid in primary care capitation
Professional Capitation	$250,000,000	$100,000,000	Use formula on the previous slide to calculate FFS equivalents for primary care services.
Global Capitation	$1,000,000,000	$100,000,000	Use formula on the previous slide to calculate FFS equivalents for primary care services.
Facility Capitation	$500,000,000	$0	N/A

Hypothetical Equation for Determining Primary Care Portion of Capitation Payments

All payments for Category 4a (Primary Care Capitation)

+

Σ (# of Encounters x FFS-equivalent Fee)$_{segment}$

Subcategories 4b-4f

where *segment* is a combination of

- Year
- Geographic Region
- OHCA FFS Primary Care Definition
- Payer Type

=

Primary Care portion of capitation payments

Comparison of Approaches to Determining Primary Care Non-Claims Spend

	OHCA Proposal	IHA	CO, MA, OR
Uses same primary care definition to define claims and non-claims	✓	✓	✓
Guidance on allocating a portion of capitation to primary care	FFS equivalents based on encounter data for primary care services	FFS equivalents based on encounter data for all capitated services	None
Approach to allocating portion of capitation to primary care	Data submitters apply their own fee schedules	Standardized fee schedule, scaled to actual capitation amount	N/A

Differences reflect OHCA and IHA data collection approaches and OHCA's interest in reflecting variation in payer fee schedules.

HCAi
Department of Health Care Access and Information

Overview of Key Decisions for Setting a Benchmark

Margareta Brandt, Assistant Deputy Director
Mary Jo Condon, Principal Consultant

Primary Care & Behavioral Health Investments

Statutory Requirements

- Measure and promote a sustained systemwide investment in primary care and behavioral health.
- Measure the percentage of total health care expenditures allocated to primary care and behavioral health and **set spending benchmarks. Spending benchmarks for primary care shall consider current and historic underfunding of primary care services.**
- Include an analysis of primary care and behavioral health spending and growth, and relevant quality and equity performance measures, in the annual report.
- Consult with state departments, external organizations promoting investment in primary care and behavioral health, and other entities and individuals with expertise in primary care, behavioral health, and health equity.
- **Benchmarks and public reporting shall consider differences among payers and fully integrated delivery systems**, including plan or network design or line of business, the diversity of settings and facilities through which primary care can be delivered, including clinical and nonclinical settings, the use of both claims-based and non-claims-based payments, and the risk mix associated with the covered lives or patient population for which they are primarily responsible.

Primary Care & Behavioral Health Investments

Statutory Requirements

Promote improved outcomes for primary care, including, but not limited to, health care entities making investments in, or adopting models that do, any or all of the following:

a. Promote the importance of primary care and adopt practices that give consumers a regular source of primary care.
b. Increase access to advanced primary care models and adoption of measures that demonstrate their success in improving quality and outcomes.
c. Integrate primary care and behavioral health services, including screenings for behavioral health conditions in primary care settings or delivery of behavioral health support.
d. Leverage APMs that provide resources at the practice level to enable improved access and team-based approaches for care coordination, patient engagement, quality, and population health.
e. Deliver higher value primary care services with an aim toward reducing disparities.
f. Leverage telehealth and other solutions to expand access to primary care, care coordination, and care management.
g. Implement innovative approaches that integrate primary care and behavioral health with broader social and public health services.

Three Lessons Learned from Other States

1. **Sustainable delivery transformation requires multi-payer investment** to support all populations in access to high-value primary care. However, four of six states with investment requirements only focus on commercial or Medicaid not both, nor do they include Medicare Advantage.

2. **It is difficult to reallocate spending to fund primary care** investment in the short-term. Efforts to increase investment too quickly may be inflationary in the short-term.

3. **Increases in total cost of care hinder benchmark success.** As total cost of care increases, achieving primary care benchmarks based on percent total medical expense becomes more difficult to achieve.

Key Decisions for Setting a Primary Care Benchmark

1. Set a single benchmark or set benchmarks by payer type?

2. Set a single benchmark across adults and pediatric populations or separate benchmarks by age group (e.g., adult, pediatrics)?

3. Set a benchmark based on the percent of total medical expense allocated to primary care or a per member, per month amount?

4. Set a relative or an absolute improvement benchmark? Or some combination?

How Other States Address Key Decisions

	CT	DE	RI	OR	CO
Which payer types does the benchmark apply to?	All	Commercial	Commercial	Commercial & Medicaid	Commercial
Single or separate benchmarks by age group?	Single	Single	Single	Single	Single
Percentage or Per Member, Per Month (PMPM)	%	%	%	%	%
Absolute or relative improvement?	Absolute (with stairsteps)	Absolute (with stairsteps)	Absolute, Previously Relative	Absolute	Relative
Benchmark/Target/ Requirement	10% in 2025	11.5% in 2025*	10.7%	12%	1% annually

Maryland, North Carolina, Oklahoma and Washington also are developing primary care investment targets or benchmarks.

*Primary care investment requirement only applies to members attributed to providers engaged in care transformation activities.

Set a single benchmark or set benchmarks by payer type?

Data finds primary care spending by payer type can vary, often due to the needs of different populations covered, age mix, and services provided.

Reasons for Single

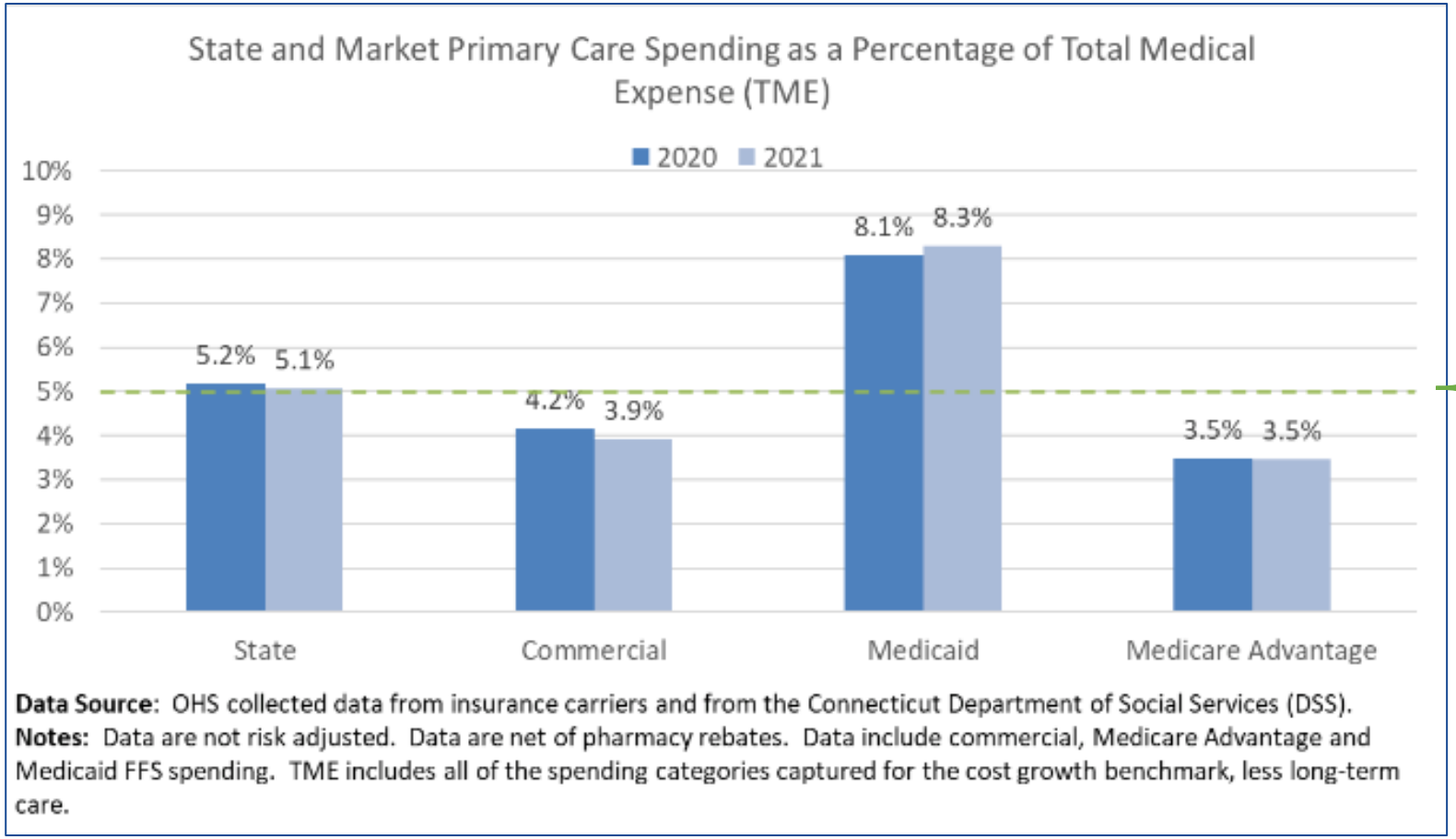
- All states with benchmarks have a single goal for all payer types.
- If set as a relative improvement benchmark, it will provide flexibility to meet payers where they are at today.
- Easier to communicate

Reasons for Multiple

- Recognizes differences in populations and covered services across payer types

Example: Single Benchmark Versus Benchmarks for Each Payer Type

In Connecticut, primary care spending as a percent of total medical expense by commercial payers was approximately half as much as spending by Medicaid payers. Medicaid Advantage payers spent even less. Differences in the age mix of the populations was likely one driver.



Set a single benchmark or separate benchmarks by age group?

Setting separate goals by age group would be different than other state approaches but may better reflect differences in care needs.

Reasons for Separate

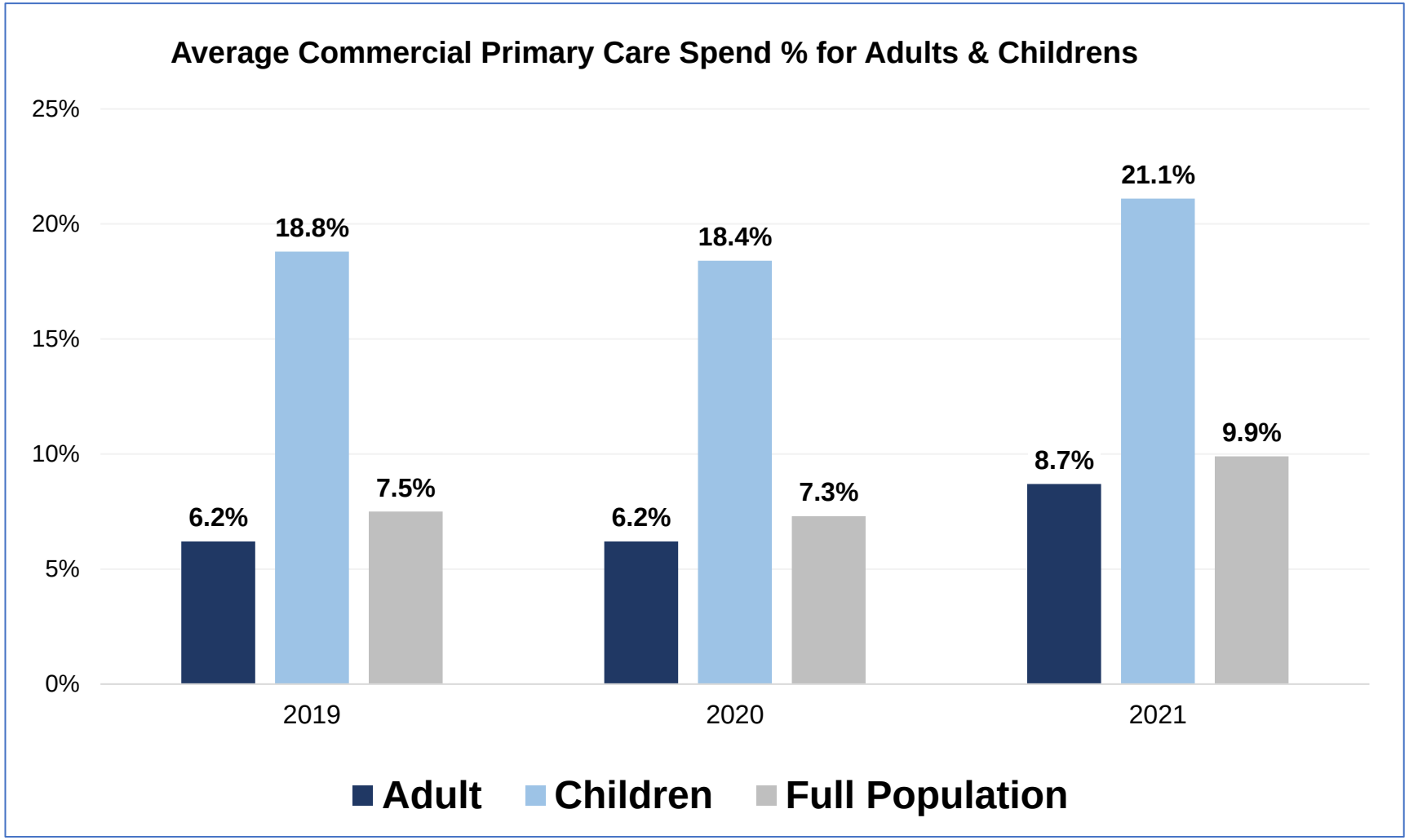
- Optimal primary care spend often looks different for pediatrics, adults, and older adults

Reasons for Single

- All states with benchmarks have a single goal for age groups
- If set as a relative improvement benchmark, it will provide flexibility to meet payers with different population mixes where they are at today
- Easier to communicate

Example: Commercial Primary Care Spending for Children and Adults in California

- California commercial plans spent **an average of 7.5% to 9.9%** on primary care services from 2019 to 2021.
- The two-step process for primary care provider identification will result in a lower primary care spend than if a "taxonomy only" approached is used, as it was in the IHA methodology.



Integrated Healthcare Association. California Commercial Primary Care Spending Results. 2019-2021. Table developed using the same methodology described in California Health Care Foundation's *Investing in Primary Care: Why it Matters for Californians with Commercial Coverage (2022).*

Example: Medi-Cal Primary Care Spending by Population

- In 2018, Medi-Cal health plans spent **an average of 11%** on primary care services. Results were based on a study of 13 plans (27 plan-county pairs).
- While this data offers helpful direction, it was calculated using a different methodology and data source than proposed by OHCA. The OHCA methodology is likely to produce a lower result.

Table 1. Range of Primary Care Spending Across County-Specific Health Plans (*N* = 27)

POPULATION	PERCENTAGE OF STUDY POPULATION	PER MEMBER PER MONTH			PERCENTAGE		
		MINIMUM	MEAN	MAXIMUM	MINIMUM	MEAN	MAXIMUM
Adult	15.6%	$13.01	$35.87	$57.85	5.0%	11.6%	20.2%
Child	45.9%	$5.90	$20.49	$34.10	9.6%	28.2%	37.4%
ACA optional expansion	30.8%	$10.97	$32.12	$67.91	4.1%	9.7%	18.9%
SPD	7.7%	$18.67	$44.49	$123.85	2.3%	4.9%	14.7%
All	**100.0%**	**$8.85**	**$28.50**	**$61.24**	**5.0%**	**11.3%**	**18.7%**

Note: *ACA* is Affordable Care Act; *SPD* is seniors and persons with disabilities.

Source: Edrington Health Consulting analysis of CY 2019 rate development templates; direct plan submission of proprietary data, July 2022.

Set a benchmark based on the percent of total medical expense or a per member, per month amount?

Statute seems to suggest a preference for using percent of total medical expense (TME) as a basis for benchmarking, which would be consistent with other approaches.

Reasons for Percent of TME

- Statute suggests preference for this approach
- Consistent with other state and national approaches
- Communicates that increased spending on primary care should reallocate rather than increase total spending

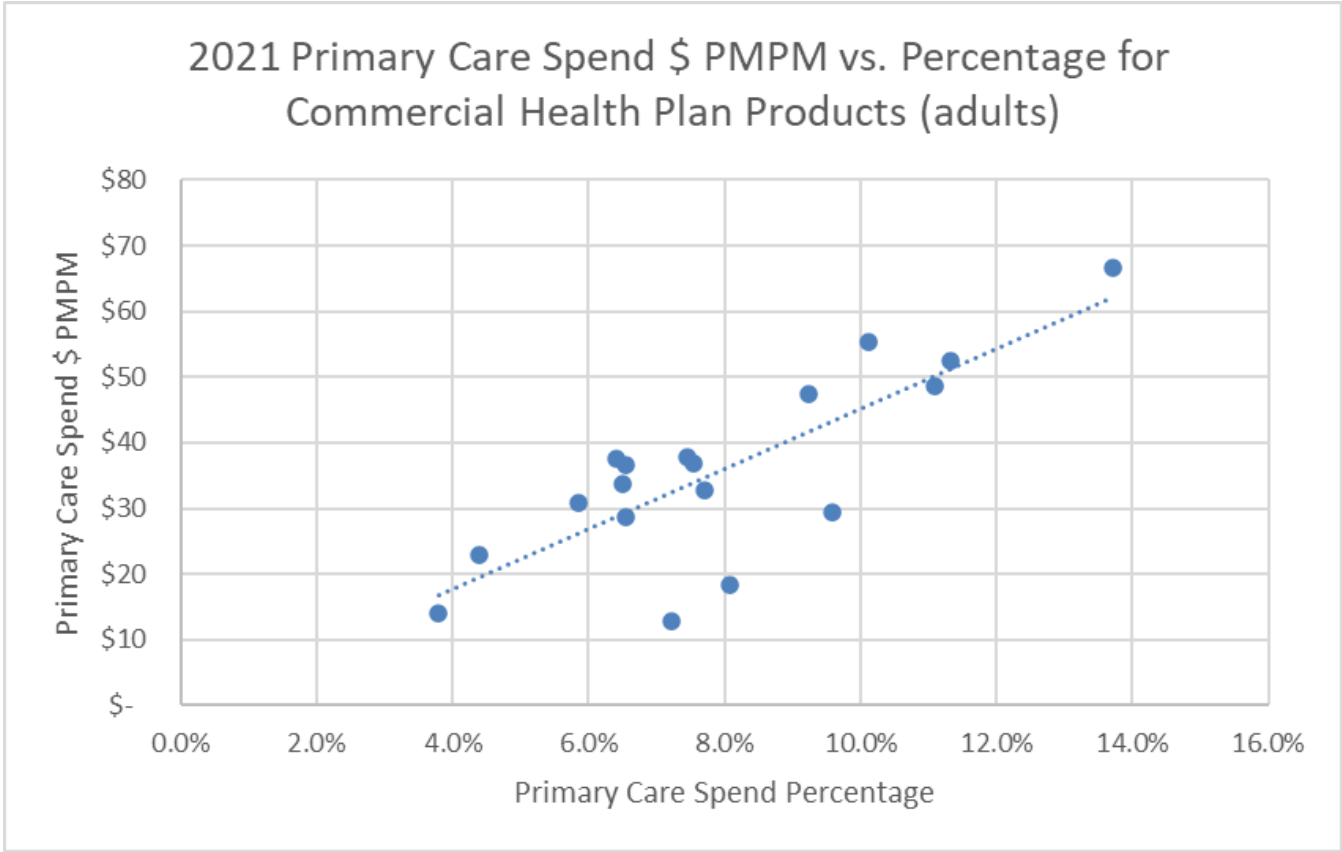
Reasons for Per Member, Per Month (PMPM)

- Easier to reflect the cost of achieving primary care delivery goals
- May guard against the benchmark becoming unnecessarily inflationary if total medical expense increases are higher than expected
- More consistent with how payers typically measure health care costs

Example: Percent of Spending vs. Per Member, Per Month

- Integrated Healthcare Association completed additional analysis using the same methodology as in its report discussed on slide 30. It showed primary care spending on a percentage basis and as a per member, per month amount are highly correlated, with an R2 value of 0.80.

- The graph shows 18 commercial plan-product data points for 2021 comparing spending when measured as percent of total spending vs. a per member per month amount.



*OHCA is recommending that per member, per month spending also is monitored.

Integrated Healthcare Association, California Commercial Primary Care Spending Results, 2021

Set a relative or an absolute benchmark? Or some combination?

A relative improvement benchmark meets payers where they are today, and the absolute improvement benchmark offers a shared vision for the future.

Reasons for Relative –

- Consistent with statutory guidance to recognize differences across payers and patient populations
- Acknowledges care delivery transformation takes time

Reasons for Absolute –

- Sets a vision for the future
- Can reflect the potential budget needed to implement primary care capabilities
- Can reflect current thinking on the “right” level of primary care investment

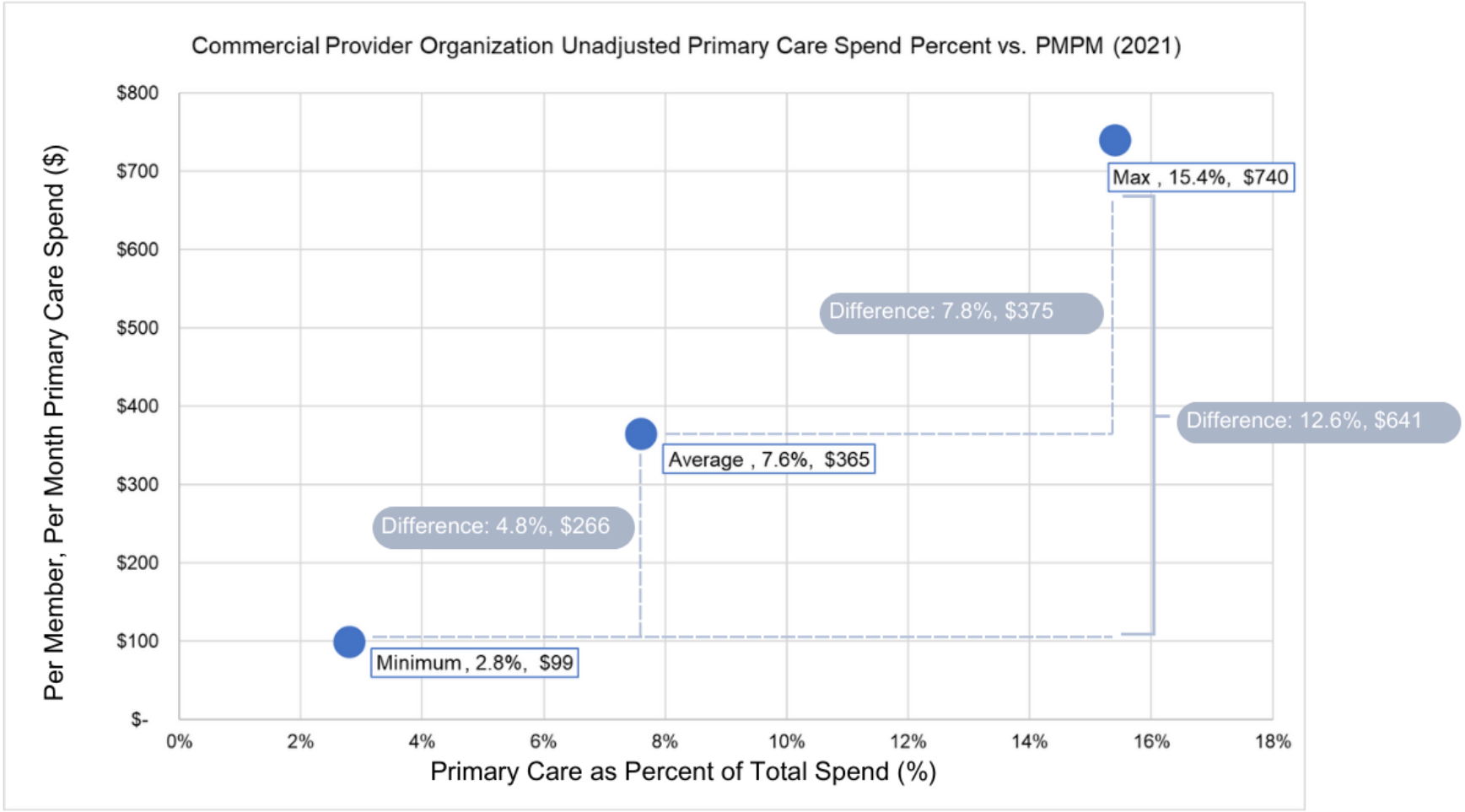
Reasons for Combination –

- Allows all to succeed at a reasonable pace.

Example: Variation in Primary Care Spend in California

- The IHA primary care spend analysis found the percentage of primary care spending varied more than twofold among plans, from a minimum of 2.8% to a maximum of 15.4%.

- Primary care spending for Medi-Cal plans also showed variation, ranging from 5% - 18.7%.



Draft Primary Care Investment Benchmark
Option 1: Single Absolute Benchmark

Payer Relative Improvement Benchmark: All payers increase primary care spending by 0.5 percentage points to 1 percentage point per year, depending on current level of investment. Payers at 15% or above may opt to maintain their primary care spend if increases are not aligned with care delivery or affordability goals. Some payers may not reach 15% due to population composition.

Rationale for Level:

- Consistent with other state approaches and experiences.
- Gradual reallocation as stakeholders work towards affordability goals.

AND

Statewide Absolute Benchmark:
California allocates 15% of total medical expense to primary care across all payers and populations by 2034.

Rationale for Level:

- Internationally, high performing health systems spend 12% to 15% of total healthcare spending on primary care.
- The recommended benchmark is slightly higher than other states, recognizing California's healthcare delivery goals, delivery system, younger population, and time horizon.

Draft Primary Care Investment Benchmark
Option 2: Adult and Pediatric Absolute Benchmarks

Payer Relative Improvement Benchmark: All payers increase primary care spending by 0.5 percentage points to 1 percentage point per year, depending on current level of investment. Payers at or above the statewide absolute benchmark may opt to maintain their primary care spend if increases are not aligned with care delivery or affordability goals.

Rationale for Level:

- Consistent with other state approaches and experiences.
- Gradual reallocation as stakeholders work towards affordability goals.

AND

Statewide Absolute Benchmark:
California allocates 12% of total medical expense to primary care for all adults and 24% of total medical expense to primary care for all children by 2034.

Rationale for Level:

- Optimal primary care spend looks different for different age groups.
- Primary care spending using OHCA approach likely to be lower than previously published estimates.

HCAi
Department of Health Care Access and Information

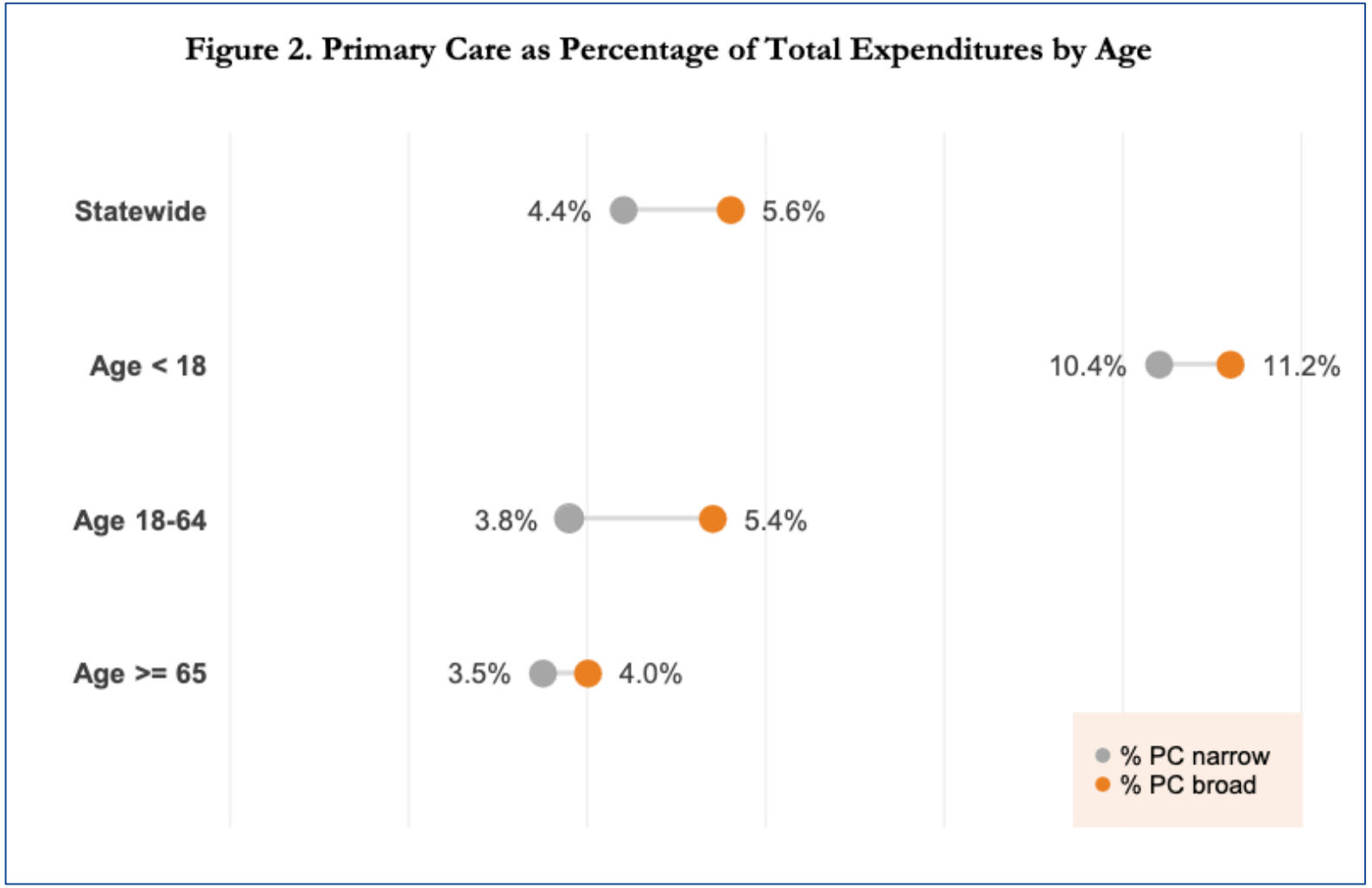
Adjournment

HCAi
Department of Health Care Access and Information

Appendix

Additional Example: Single or Separate Benchmarks for Children and Adults

- All current state targets are a single target; no separate targets by age group
- This example from Washington shows wide variation by age
- Pediatric primary care has a “unique value proposition” that may warrant special focus



Perrin et al., “The Unique Value Proposition of Pediatric Health Care.” *Pediatrics*. 2023;151(2):e2022060681

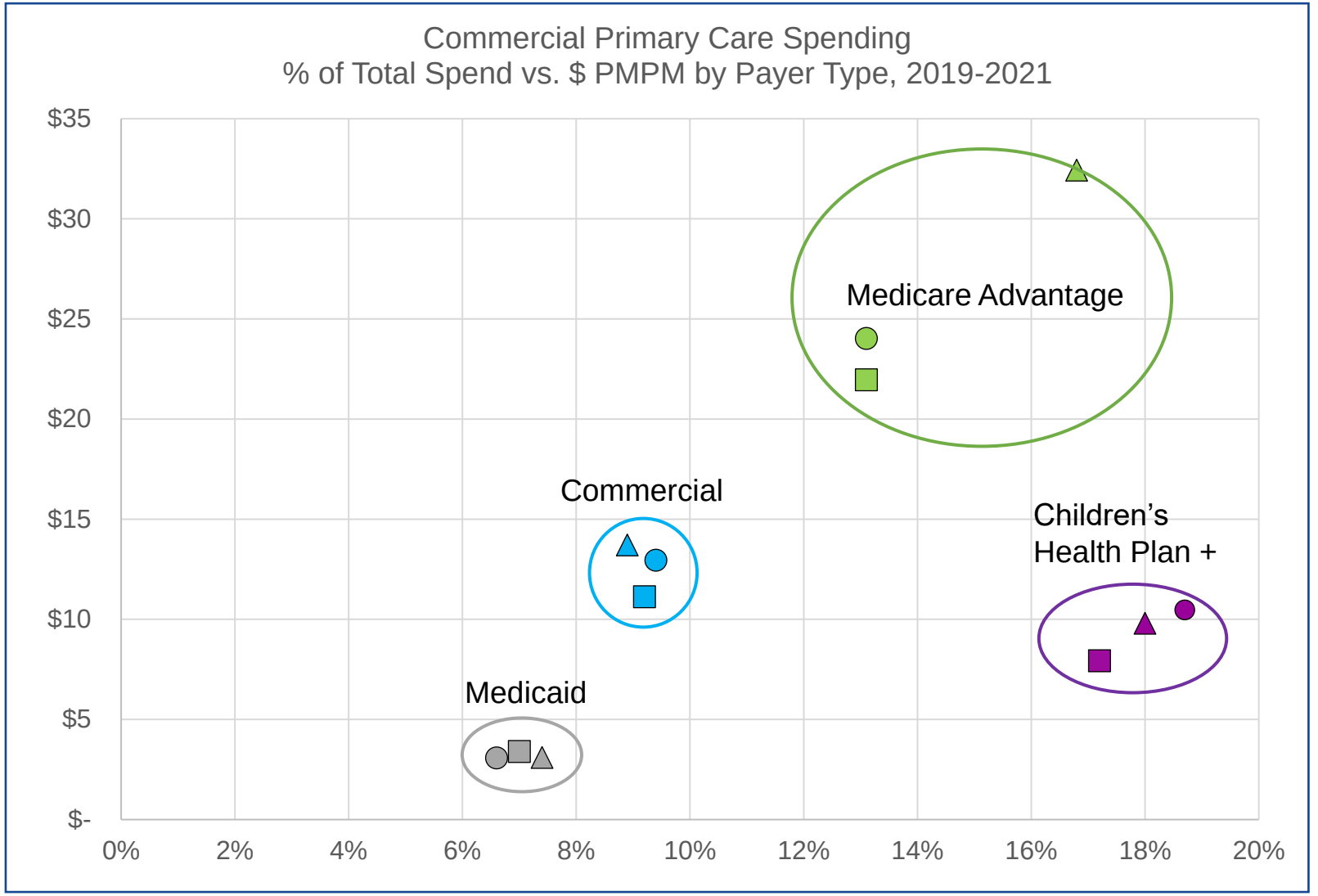
Primary Care Expenditures: Summary of current primary care expenditures and investment in Washington. December 2019. WA Office of Financial Management.

HCAI Department of Health Care Access and Information

Additional Example: Percent Spending or Per Member, Per Month Amount

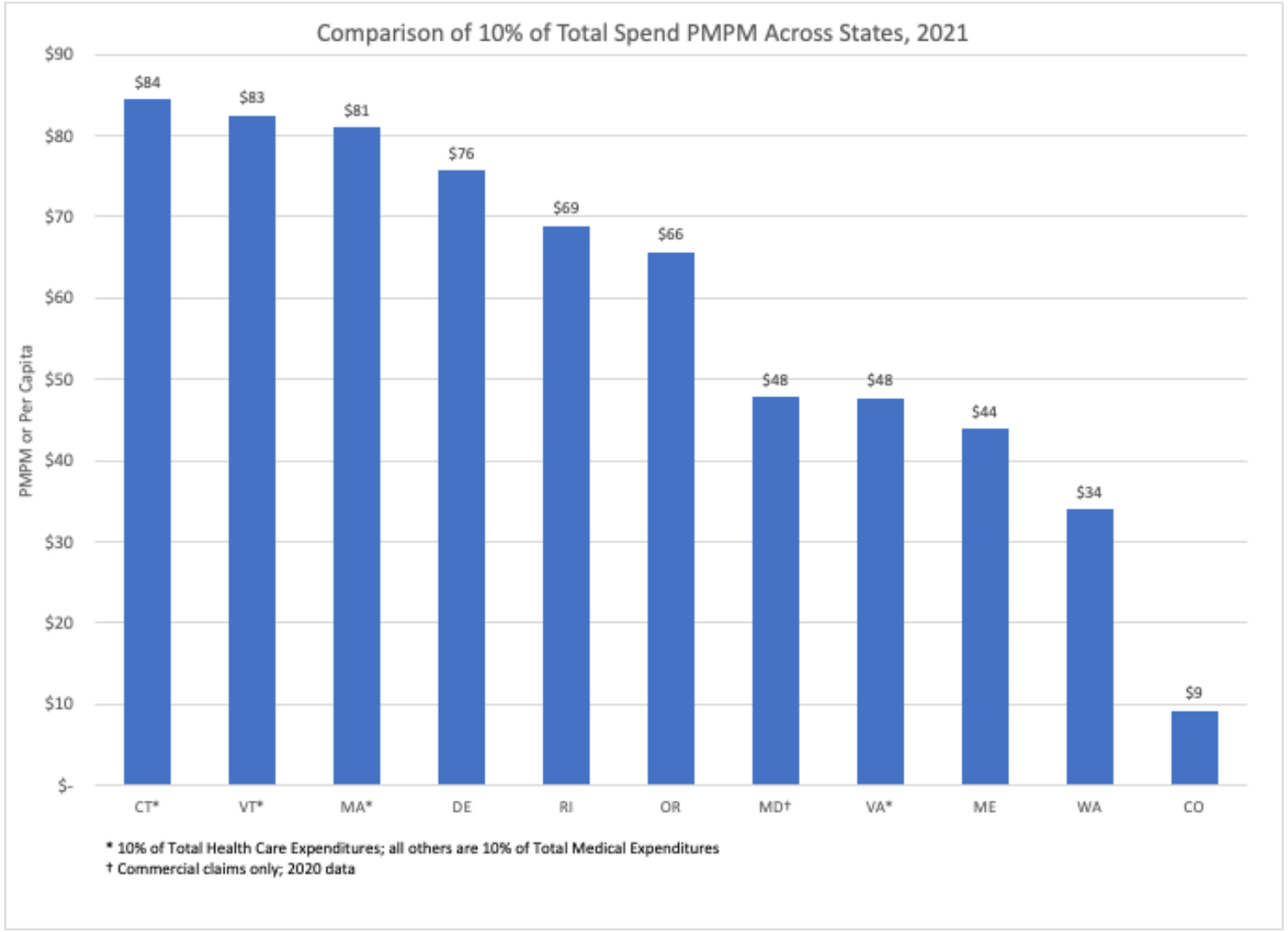
- Colorado and Delaware primary targets are a percentage of total spending. Both states also report PMPMs, as shown in this data from Colorado.
- Comparisons by payer type show the influence of total spending on the primary care percentage.

		
2019	2020	2021



How Much is 10% of Total Spend in Other States?

- Equivalent primary care investments percentages, but not equal payments
- Highlights the interaction between primary care investment and total per member, per month spend
- Approach is determined by goal



HCAI Department of Health Care Access and Information