Office of Health Care Affordability Primary Care Investment Benchmark

Updated December 2024 to Reflect Benchmark Approval by the Health Care Affordability Board

The Office of Health Care Affordability's Mission and Purpose

In 2022, the California Health Care Quality and Affordability Act[1] (SB 184, Chapter 47, Statutes of 2022) established the Office of Health Care Affordability (OHCA) within the Department of Health Care Access and Information (HCAI). Recognizing that health care affordability has reached a crisis point as health care costs continue to grow, OHCA's enabling statute emphasizes that it is in the public interest that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal.

Health care spending in California reached $10,299 per capita and $405 billion overall in 2020, up 30% from 2015.[2] Californians with job-based coverage are facing higher out-of-pocket costs, with the share of workers with a large deductible ($1,000 or more) increasing from 6% in 2006 to 54% in 2020.[3] For the fourth consecutive year, the 2024 California Health Care Foundation California Health Policy Survey reports that more than half of Californians (53%) – and nearly three-fourths (74%) of those with lower incomes (under 200% of the federal poverty level) – reported skipping or delaying at least one kind of health care due to cost in the past 12 months.[4] Among those who reported skipping or delaying care due to cost, about half reported their conditions worsened as a result. Further, high costs for health care disproportionately affect Black and Latino Californians who report they had problems paying or could not pay medical bills (40% and 36%, respectively, compared to White Californians at 25%).[3]

[1] Health and Safety Code Sections 127500-127507.6.
[2] "Health Expenditures by State of Residence, 1991-2020," Data sets, *Health Accounts by State of residence*, September 2023, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence.
[3] Heidi Whitmore and Jennifer Sartorius, "California Employer Health Benefits: Are Workers Covered?," California Health Care Almanac, California Health Care Foundation, August 2021. https://www.chcf.org/wp-content/uploads/2021/08/CAEmployerHealthBenefitsAlmanac2021.pdf.
[4] Jen Joynt, Rebecca Catterson, and Emily Alvarez, "The 2024 CHCF California Health Policy Survey," California Health Care Foundation, January 31, 2024. https://www.chcf.org/publication/2024-chcf-california-health-policy-survey/.

OHCA has three primary responsibilities to achieve its mission of improved consumer affordability:

1. Slow health care spending growth through collection and reporting on total health care expenditure data and enforcing spending targets set by the Board;
2. Promote high-value health system performance; and
3. Assess market consolidation.

In enacting the California Health Care Quality and Affordability Act, the Legislature declared that "primary care is foundational to an effective health care system and evidence supports that greater use of primary care has been associated with lower costs, higher patient satisfaction, reduced low birth weight, fewer hospitalizations and emergency department visits, and lower mortality, among other key outcomes. However, the United States as a whole spends a far lower share of health care expenditures on primary care and experiences worse outcomes in life expectancy and mortality than other countries."[5]

Statutory Requirements

As described in the OHCA enabling statute and summarized here, the statutory requirements related to primary care investment include:

- Measure the percentage of total health care expenditures allocated to primary care and set a spending benchmark.
- Consider current and historic underfunding of primary care services in a spending benchmark.
- Promote a sustained systemwide investment in primary care.
- Build and sustain methods of reimbursement that shift greater health care resources and investments away from specialty care and toward primary care and behavioral health.
- Consider differences among payers and fully integrated delivery systems, including factors such as 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.
- Analyze primary care spending and growth, and relevant quality and equity performance measures, and incorporate in the annual report.
- Consult with state departments, external organizations promoting investment in primary care, and other entities and individuals with expertise in primary care, behavioral health, and health equity.[6]

[5] Health and Safety Code Section 127500.5, subdivision (a)(7).
[6] These requirements are summarized from Health and Safety Code Section 127505, subdivision (a).

The California Health Care Quality and Affordability Act also specifies that OHCA shall promote improved outcomes for primary care including:

- Promote the importance of primary care and adopt practices that give consumers a regular source of primary care.
- Increase access to advanced primary care models and adoption of measures that demonstrate their success in improving quality and outcomes.
- 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.
- 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.
- Deliver higher value primary care with an aim toward reducing disparities.
- Leverage telehealth and other digital health solutions to expand access to primary care services, care coordination, and care management.
- Implement innovative approaches that integrate primary care and behavioral health with broader social and public health services.[7]

To measure the percent of total health care expenditures allocated to primary care, OHCA is statutorily required to:

- Use the Health Care Payments Data Program (HPD)[8] to the greatest extent possible, to minimize reporting burdens for health care entities.
- Determine the categories of health care professionals who should be considered primary care providers and consider existing state and national approaches, as appropriate.
- Determine specific procedure codes that should be considered primary care services and consider existing state and national approaches, as appropriate.
- Determine the categories of payments to primary care providers and practices, including non-claims-based payments, such as alternative payment models, that should be included when determining the total amount spent on primary care.[9]

The Board shall approve the Primary Care Investment Benchmark.[10]

[7] These requirements are summarized from Health and Safety Code Section 127505.
[8] HPD was established pursuant to Chapter 8.5 (starting with Health and Safety Code Section 127671).
[9] These requirements are summarized from Health and Safety Code Section 127501.4, subdivision (h)(2).
[10] These requirements are summarized from Health and Safety Code Section 127501.11.

Background

OHCA promotes high-value system performance through its work in five focus areas: (1) primary care investment, (2) behavioral health investment, (3) alternative payment model (APM) adoption goals and standards, (4) quality and equity measurement, and (5) workforce stability. Across all these areas, the goal is to reorient the health care system towards greater value, with the vision of creating a sustainable health care system that provides high-quality, equitable care to all Californians.

High functioning health care systems require high quality primary care as a foundation. Primary care investment in the United States, typically four percent to seven percent of total health care spending, lags far behind other high-income countries with higher performing health care systems, where primary care spending typically ranges from 12 to 15 percent.[11] Importantly, increased supply of primary care services leads to more equitable outcomes and improved population health.[12] In establishing its Primary Care Investment Benchmark, OHCA seeks to align California with the share of spending on primary care in high performing health systems internationally.

OHCA launched the Investment and Payment Workgroup in June 2023, bringing together stakeholders representing providers and provider organizations, academics and subject matter experts, state and private purchasers, sibling state departments, consumer advocates, patient representatives, hospitals and health systems, and health plans.[13] The Workgroup convenes monthly to provide input as OHCA develops its measurement approach and recommends targets or benchmarks in the areas of APMs, primary care investment, and behavioral health investment. At the outset of its primary care work, the Workgroup supported using the attributes of advanced primary care developed by the California Quality Collaborative (CQC) as the guiding vision to inform OHCA's development of its primary care spending measurement methodology. The CQC describes advanced primary care as person- and family-centered, relationship-based, accessible, comprehensive, team-based, integrated, coordinated, and equitable.[14] The Workgroup emphasized the need for sustainable and well-resourced primary care to achieve the vision.

OHCA presented draft versions of the primary care spending measurement methodology and investment benchmark to the Health Care Affordability Advisory Committee in March and May 2024, and to the Health Care Affordability Board in May

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[11] Yalda Jabbarpour, et al., "Investing in Primary Care: A State-Level Analysis," Patient-Centered Primary Care Collaborative, 2019. https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf

[12] National Academies of Sciences, Engineering, and Medicine, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* (Washington, DC: The National Academies Press, 2021). https://nap.nationalacademies.org/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health

[13] OHCA Investment and Payment Workgroup meetings and materials are publicly available.

[14] California Quality Collaborative, "Advanced Primary Care: Defining a Shared Standard," 2022. https://www.pbgh.org/wp-content/uploads/2022/04/advanced-primary-care-shared-standard.pdf

and June 2024. OHCA collected public comment on the draft benchmark recommendation from April 22 through May 31, 2024. The draft benchmark recommendations, along with the draft measurement methodology and supporting data collection processes, were informed by months of discussion with the Investment and Payment Workgroup and additional stakeholder feedback, including from sibling state departments. Additional refinements were made based on feedback from the Health Care Affordability Advisory Committee, Health Care Affordability Board, and public comments.

Currently, OHCA has authority for payer data collection and public reporting but does not have authority to enforce the Primary Care Investment Benchmark as a standalone requirement. As such, OHCA will partner with stakeholders to promote adoption of, and make progress towards, the Primary Care Investment Benchmark. OHCA commits to transparency and accountability by publishing progress towards the stated benchmark for each payer in its annual report. As health care spending shifts over time away from specialty care and toward primary care, OHCA anticipates that health system performance will improve, leading to higher quality, more equitable, and more affordable care.

Primary Care Investment Benchmark

At its October 2024 meeting, the Health Care Affordability Board approved two related benchmarks for increasing primary care investment:

1) Annual improvement benchmark: 0.5 percentage points to 1 percentage point per year increase in primary care spending as a percent of total medical expense for each payer for performance years 2025 through 2033; and
2) Statewide investment benchmark: 15 percent of total medical expense allocated to primary care across all payers by performance year 2034.[15]

The annual improvement benchmark applies to each payer by line of business and product type, resulting in four market segments for public reporting: commercial HMO/POS, commercial PPO/EPO, Medicare Advantage, and Medi-Cal. The statewide investment benchmark will be measured across payers, lines of business, and product types.

Rationale

The Board approved an **annual improvement benchmark** such that each payer increases primary care spending by 0.5 percentage points to 1 percentage point per year, acknowledging that payers are starting at different levels of primary care spending. Payers at or above the statewide investment benchmark of 15 percent of total medical expense may opt to maintain their current level of primary care spending if further

[15] Prior to June 2024, the Annual Improvement Benchmark was referred to as the Relative Improvement Benchmark and the Statewide Investment Benchmark was referred to as the Absolute Improvement Benchmark.

increases are not aligned with care delivery or affordability goals. The intention of the annual improvement benchmark is to motivate ongoing incremental increases in investment in primary care, with annual milestones to mark progress. OHCA will monitor and report each payer's progress on the annual improvement benchmark in its annual report by product type (e.g., HMO/POS and PPO/EPO) and line of business (commercial, Medicare Advantage, Medi-Cal).

The Board approved a **statewide investment benchmark** of 15 percent of total medical expense allocated to primary care across all payers by performance year 2034. This benchmark is aligned with the share of spending on primary care in high performing health systems internationally, as described above. This benchmark is aspirational while addressing historic underinvestment in primary care.[16] It is also a higher benchmark than those implemented by other states, to recognize the 10-year timeline and California's younger and healthier population.[17] OHCA considered separate statewide investment benchmarks for pediatric and adult populations based on analyses that show variation between pediatric and adult primary care spending in California.[18] However, after careful consideration and extensive stakeholder input, OHCA recommended one statewide benchmark that combines the pediatric and adult populations. A key consideration in that recommendation is the complexity of reporting, especially separating non-claims payments by pediatric and adult populations, and the resulting administrative burden on health care entities.

The combination of an annual improvement benchmark with a 2034 statewide benchmark is designed to give all payers a reasonable opportunity to demonstrate both immediate progress and sustained success. It offers some flexibility in the early years of measurement, acknowledging the uncertainty of baseline spending levels using OHCA's primary care measurement methodology.

Note: OHCA will measure primary care spending as described in the **Appendix: Primary Care Spending Measurement Methodology**.

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[16] National Academies of Sciences, Engineering, and Medicine, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* (Washington, DC: The National Academies Press, 2021). https://nap.nationalacademies.org/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health

[17] California's population is the eleventh youngest in the United States. (Public Policy Institute of California, January 2024. Fact Sheet: California's Population. https://www.ppic.org/publication/californias-population/#:~:text=The%20median%20age%20in%20California,the%202022%20American%20Community%20Survey)

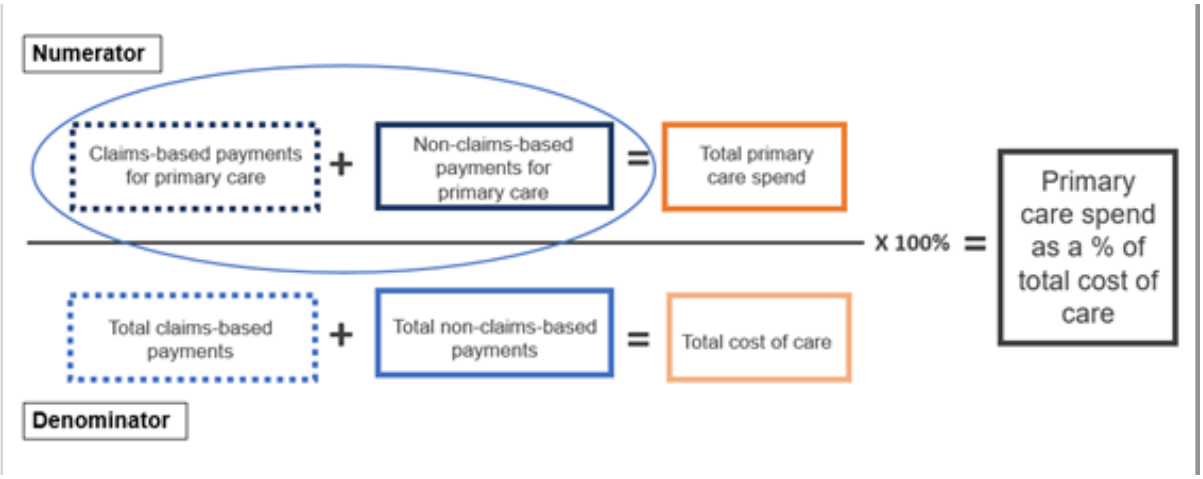
[18] See OHCA Investment and Payment Workgroup February 21, 2024 presentation, slides 32-33: https://hcai.ca.gov/wp-content/uploads/2024/02/02-21-24-Investment-and-Payment-Workgroup-Presentation-1.pdf

Appendix: Primary Care Spending Measurement Methodology

OHCA will measure primary care spending through claims and non-claims payments. The methodology described below and an accompanying code set specify how data submitters will measure primary care spending to determine progress towards the OHCA Primary Care Investment Benchmark. The accompanying code set data submitters will use to report claims-based primary care spending, and detailed explanations of how to allocate non-claims payments to primary care spending, will be included in the 2025 Data Submission Guide and incorporated into the regulation.[19]

A high-level equation showing how OHCA will calculate primary care spending as a percent of total spending is shown in **Figure 1**. More detailed information on OHCA's methodology for measuring Primary Care Paid via Claims and Primary Care Paid via Non-Claims payments can be found in their respective sections below.

Figure 1. Equation for Measuring Primary Care Spending

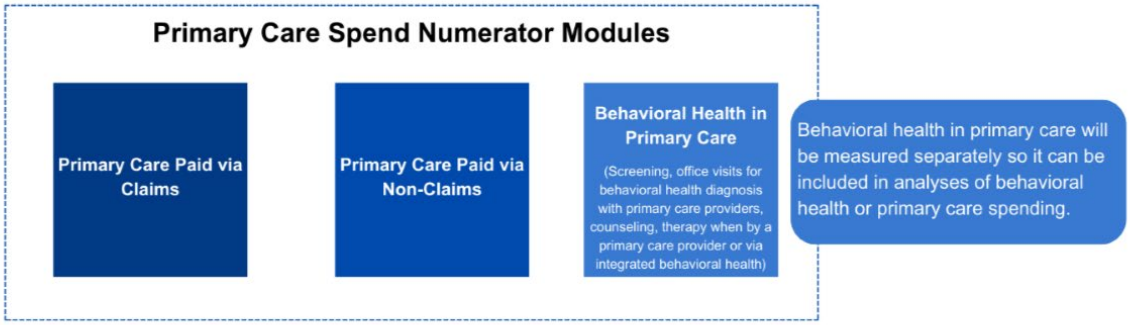


Source: Adapted from Erin Taylor, Michael Bailit, and Deepti Kanneganti. Measuring Non-Claims-Based Primary Care Spending. Milbank Memorial Fund. April 15, 2021.

OHCA will measure primary care spending using three modules as shown in **Figure 2**. The modules allow OHCA to monitor each of these types of primary care spending separately. Note the third module, Behavioral Health in Primary Care, consists of a limited number of behavioral health services when provided in collaboration with primary care. The third module is described in more detail below.

[19] Total Health Care Expenditures (THCE) Data Submission Guide (DSG) https://hcai.ca.gov/wp-content/uploads/2024/07/THCE-Data-Submission-Guide-v1.1_Update-1.pdf, incorporated by reference in 22 CCR 97445.

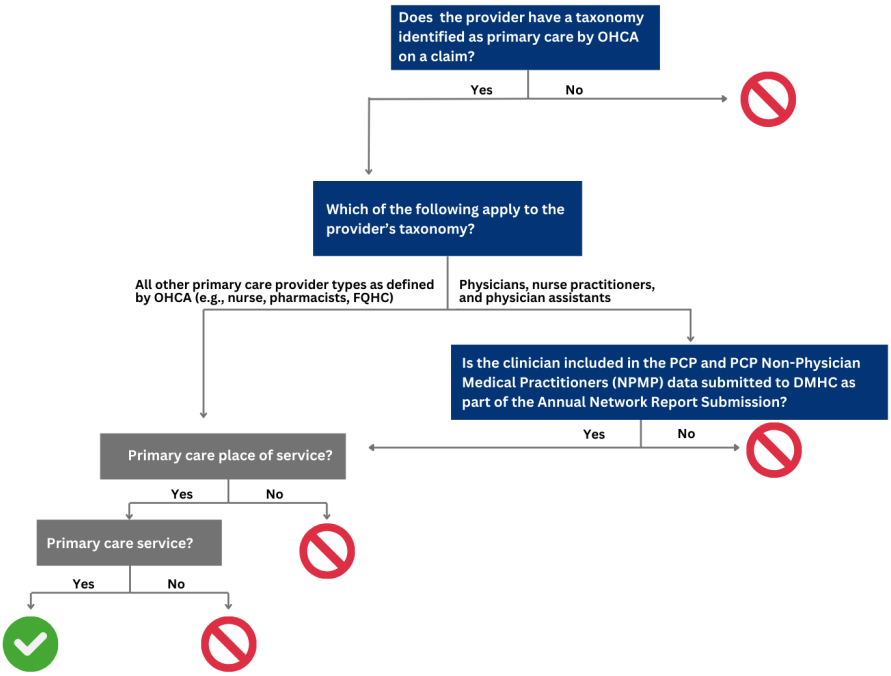
Figure 2. OHCA's Three Primary Care Modules



Claims-based Primary Care Spending

OHCA measures claims-based primary care spending using three elements: primary care **service** delivered in a primary care **place of service** by a primary care **provider**. All three aspects must be met for the spending to count as primary care spending. **Figure 3** shows how to identify primary care paid via claims. The codes used on claims to identify primary care providers, primary care places of service, and primary care services are described below.

Figure 3. Identifying Primary Care Paid via Claims



Primary care providers are identified by National Uniform Claim Committee (NUCC) taxonomy codes on claims.[20] OHCA includes primary care providers offering comprehensive, continuous, coordinated care and primary care team members. The following primary care providers, in combination with service and place of service criteria, are included in OHCA's measurement of claims-based primary care:

- Family medicine physician (general/adult/adolescent/geriatric)
- Internal medicine physician (general/adolescent/geriatric)
- General practice physician
- Pediatric physician (general/adolescent)
- Nurse practitioner:
  - Adult health
  - Family
  - Community health
  - Pediatrics
  - Gerontology
  - Primary care
  - School
- Physician assistant, Medical
- Critical Access Hospital Clinic/Center
- Primary Care Clinic/Center
- Rural Health Clinic/Center
- Federally Qualified Health Center
- Certified clinical nurse specialist:
  - Adult health
  - Community/public health
  - Pediatrics
  - Chronic health
  - Family health
  - Gerontology
- Pharmacist
- Community Health Worker
- Nurse, non-practitioner

In addition to using the NUCC taxonomy codes on claims, OHCA further restricts primary care providers to those who are designated as primary care physicians and non-physician medical practitioners, such as nurse practitioners and physician assistants, in the payer's Annual Network Report Submission to the Department of Managed Health Care (DMHC).[21] This additional criterion helps ensure that care provided by specialists is excluded from the primary care spending analysis. For example, internal medicine physicians often practice as specialists (e.g., endocrinologists or gastroenterologists) rather than as primary care providers.

Primary care places of service are identified using the Centers for Medicare and Medicaid Services (CMS) Place of Service (POS) codes on claims.[22] OHCA includes office settings, home, and community-based sites of service and excludes retail and urgent care sites due to a lack of coordinated, comprehensive care. The following

[20] National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy: https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40
[21] DMHC Annual Network Reporting Requirements: https://www.dmhc.ca.gov/LicensingReporting/SubmitHealthPlanFilings/TimelyAccessComplianceandAnnualProviderNetworkReporting.aspx
[22] CMS Place of Service Code Set: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

primary care places of service, in combination with service and provider criteria, are included in OHCA's measurement of claims-based primary care:

- Office
- Telehealth, in and out of patient's home
- School
- Home
- Federally Qualified Health Center
- Public Health Clinic & Rural Health Clinic
- Indian Health Service and Tribal Free-Standing Facility
- Prison/Correctional Facility
- Worksite
- Hospital Outpatient
- Homeless Shelter
- Assisted Living Facility
- Group Home
- Mobile Unit
- Street Medicine
- Independent Clinic
- Programs of All-Inclusive Care for the Elderly (PACE) Center
- Military Treatment Facility

Primary care services are identified using Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes on claims.[23] OHCA includes a broad set of services to promote comprehensive primary care. The following types of primary care services, in combination with provider and place of service criteria, are included in OHCA's claims-based measurement of primary care:

- Office/Home/Telehealth visits
- Preventive visits and screenings
- Immunization administration
- Transitional care
- Chronic care management
- Health risk assessment
- Advanced care planning
- Minor tests and procedures
- Interprofessional consults (e-consult)
- Remote patient monitoring
- Lab tests *(point of care tests only)*
- Digital evaluation and management
- Medicare-specific certification for home health care
- Advanced Primary Care Management
- Cognition and functional assessment with developed care plan
- Team conference with or without the patient
- Prolonged preventive service
- Domiciliary or rest home care and evaluation
- Group visits
- Women's health services: preventive screenings, immunizations, minor procedures including insertion or removal of contraceptive device, and maternity care
- Behavioral Health Integration/ Collaborative Care

Rationale for Select Methodologic Decisions

OHCA excludes obstetrician gynecologist (OB-GYN) providers from the primary care provider methodology based on feedback from Investment and Payment Workgroup members, Advisory Committee members, and public comment. While some

[23] HCPCS and CPT codes are maintained by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA): https://www.cms.gov/medicare/regulations-guidance/physician-self-referral/list-cpt/hcpcs-codes

stakeholders recommended including OB-GYNs, the majority of feedback supported excluding OB-GYNs to align with OHCA's focus on investing in providers delivering coordinated, comprehensive care for all body systems. OHCA will analyze data from the Health Care Payments Data (HPD) Program to understand the extent to which OB-GYNs provide comprehensive primary care services and can reconsider its decision to exclude OB-GYNs based on the findings of this analysis.

Based on Investment and Payment Workgroup input, OHCA excludes behavioral health providers from the primary care provider methodology. Instead, OHCA will measure behavioral health spending separately from primary care spending except for behavioral health care provided in primary care, as measured by the Behavioral Health in Primary Care Module discussed below.

OHCA includes pharmacists, community health workers, and nurses as primary care team members. Place of service and service code restrictions ensure that services delivered by pharmacists independently from a primary care team will not be included in primary care spending measurements.

OHCA's measurement of primary care includes Federally Qualified Health Centers (FQHCs) and a few other care sites both as providers and as places of service. OHCA's intent with this decision is to be as inclusive as possible, particularly for locations serving underserved populations. If excluded, claims that identify FQHCs and the other listed care sites as the provider would not be "counted" as primary care spending. This approach is consistent with the methodology of other states that include FQHCs both as a POS code and a taxonomy code in their primary care measurement (Delaware, Maryland, Massachusetts).

Behavioral Health in Primary Care Module

Recognizing the high degree of overlap between primary care and behavioral health service delivery, OHCA plans to measure behavioral health care delivered in the primary care setting as a discrete module that could be included in analyses of either primary care or behavioral health spending. OHCA anticipates this module will be included as part of its future behavioral health spending measurement activities. It will enable OHCA to capture behavioral health spending in both primary care and other settings without double counting. OHCA plans for this module to include screening and office visits for behavioral health diagnoses delivered by primary care providers, as well as counseling or therapy when delivered by a primary care provider or via integrated behavioral health, when data allows.

The Investment and Payment Workgroup identified services to include in this module and this methodology may be updated as the Workgroup develops its behavioral health measurement criteria.

Prior to adoption of the Behavioral Health in Primary Care module, all spending for behavioral health services delivered by primary care providers in primary care settings will be included as part of the primary care spending data collection.

Non-Claims Primary Care Spending

OHCA is using the Expanded Non-Claims Payments Framework (Expanded Framework) to categorize non-claims payment data in the total medical expenses data collection. OHCA will follow the approach outlined below to allocate a portion of non-claims payments to primary care spending. OHCA developed the approach outlined below with input from the Investment and Payment Workgroup and other stakeholders.[24]

Note: Some categories of non-claims payments should be fully allocated to primary care spending, other categories should be partially allocated to primary care spending, and a few categories are not applicable to primary care and should not be allocated to primary care spending.

[24] See OHCA Investment and Payment Workgroup February 2024 and March 2024 presentations: https://hcai.ca.gov/affordability/ohca/ohca-investment-and-payment-workgroup/

Expanded Framework Category		Full or Partial Allocation to Primary Care	Allocation to Primary Care Spending
A	**Population Health and Practice Infrastructure Payments**		
A1	Care management/care coordination/population health/medication reconciliation	Partial	Include payments for care management, care coordination, population health, and medication reconciliation when paid to a primary care provider, care team or provider organization, or to a primary care program within a multi-specialty practice.
A2	Primary care and behavioral health integration	Full	Allocate all Primary Care and Behavioral Health Integration payments to primary care spending.
A3	Social care integration	Partial	Include payments for social care integration when paid to a primary care provider, care team or provider organization, or to a primary care program within a multi-specialty practice.
A4	Practice transformation payments	Partial	Allocate all practice transformation payments to primary care spending when paid to a primary care provider, care team, or provider organization. Allocate only a portion of these payments as primary care spending when paid to multi-specialty practices and health systems. Determine the portion of these payments paid in support of primary care and limit the portion of practice transformation payments allocated to primary care to a maximum of 1% of total medical expense.
A5	EHR/HIT infrastructure and other data analytics payments	Partial	Allocate all EHR/HIT infrastructure and data analytics payments as primary care spending when paid to a primary care provider, care team, or provider organization. Allocate only a portion of these payments as primary care spending when paid to multi-specialty practices and health systems. Estimate the portion of these payments paid in support of primary care and limit the portion of practice transformation payments allocated to primary care to a maximum of 1% of total medical expense.
B	**Performance Payments**		
B1	Retrospective/prospective incentive payments: pay-for-reporting	Partial	Include performance incentives in recognition of reporting, quality, and outcomes of patients attributed to primary care providers.
B2	Retrospective/prospective incentive payments: pay-for-performance	Partial	

Expanded Framework Category		Full or Partial Allocation to Primary Care	Allocation to Primary Care Spending
C	**Shared Savings Payments and Recoupments**		
C1	Procedure-related, episode-based payments with shared savings	Not Applicable	
C2	Procedure-related, episode-based payments with risk of recoupments	Not Applicable	
C3	Condition-related, episode-based payments with shared savings	Partial	Limit the portion of risk settlement payments that are allocated to primary care spending to the same proportion that claims-based professional spending represents as a percent of claims-based professional and hospital spending.
C4	Condition-related, episode-based payments with risk of recoupments	Partial	
C5	Risk for total cost of care (e.g., ACO) with shared savings	Partial	
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	Partial	
D	**Capitation and Full Risk Payments**		
D1	Primary Care capitation	Full	Allocate full primary care capitation amount to primary care spending.
D2	Professional capitation	Partial	Calculate a ratio of fee-for-service equivalents for primary care services to fee-for-service equivalents for all services in the capitation. Multiply the capitation payment by the ratio. Divide the result by total medical expense.
D3	Facility capitation	Not Applicable	
D4	Behavioral Health capitation	Not Applicable	
D5	Global capitation	Partial	Calculate a ratio of fee-for-service equivalents for primary care services to fee-for-service equivalents for all services in the capitation. Multiply the capitation payment by the ratio. Divide the result by total medical expense.
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	Partial	
E	**Other Non-Claims Payments**	Not applicable.	
F	**Pharmacy Rebates**	Not applicable.	