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March 29. 2024

Mark Ghaly, MD
Secretary of Health and Human Services
Office of Health Care Affordability
2020 West El Camino Ave Conference Room 900
Sacramento, CA 9583

Sent via email to OHCA@hcai.ca.gov

RE: Office of Health Care Affordability (OHCA) Proposed Alternative Payment Model (APM) Standards and Adoption Goal

Dear Dr. Ghaly,

The California Academy of Family Physicians (CAFP) and our more than 10,000 family physicians and medical students thank you for considering feedback regarding the proposed alternative payment model (APM) standards and adoption goals. CAFP commends the Office of Health Care Affordability (OHCA) for its invaluable work promoting equitable, high-quality, and cost-efficient care. To achieve this shared goal, the Department must use its authority to significantly increase our nation's investment in primary care, improve patient access and connections with primary care, grow and diversify the primary care workforce, and address the administrative requirements that drive care delays and physician burnout. The standards put forward make significant strides to accomplish this goal, such as highlighting primary care, the need to reduce administrative burdens, utilizing interdisciplinary "clinical" care teams to assess and address patients' medical, behavioral, and social needs, and increasing payments for providers serving populations with higher health- related social needs. We believe the standards can be strengthened with the following recommendations on the Implementation Guidance put forth in the recommendations to the Board.

Section 2. Implement payment models that improve affordability for consumers and purchasers.

Reduce Administrative Burdens

Physician burnout is a national epidemic, with multiple studies indicating that approximately half of all physician's experience symptoms of burnout, including exhaustion, cynicism, and feelings of reduced effectiveness. One of the primary causes of physician burnout is administrative burdens. Accordingly, OCHA should take steps to identify and eliminate components that contribute to administrative burdens. We appreciate that Standard 2.3 highlights prior

authorization as an administrative burden, and the need for documentation support to reduce administrative inefficiency.

Section 3. Allocating spending upstream to primary care and other preventive services to create lasting improvements in health, access, equity, and affordability.

Increase Investment in Primary Care and Building Systems to Support Integrated Care

CAFP strongly believes that a shift in health care spending to support greater access to comprehensive, coordinated primary care is imperative to achieving a more robust, higher-performing health care system. Research has shown that more investment in primary care is associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality. Yet the U.S., on average, spends only about five cents of every healthcare dollar on primary care, falling significantly behind compared to similar investments in other high-income countries.[1]

CAFP commends OHCA for making primary care spending a standard outlined in Standard 3. We recommend the standards language is explicit in the need for more resources to primary care, specifically, **'transparently measure and increase primary care spending to create lasting improvements in access, health, equity, and affordability.'** This language may help avoid non-primary care specialty opposition.

Build Systems to Support Integrated Care

Primary care takes a whole-person approach to caring for patients and often the complexity of a patient visit is not accounted for in the current fee-for-service system. Primary care physicians are playing an increasingly larger role in mental health care. Up to 75 percent of primary care visits include mental or behavioral health components.[2] Yet, fee-for-service encourages payers to carve out mental health services from primary care rather than support the integration of the two. Similarly, our current healthcare system does not provide coverage for social determinants of Health (SDOH) screenings at the primary care level, despite well-documented evidence that clinical care impacts only 20 percent of the county-level variation in health outcomes while SDOH affects as much as 50 percent of health outcomes.[3]

The challenge for physician practices is the need for more resources to operationalize a large task with many factors into a busy practice environment in a manner that is actionable and practical. For patients and health care teams, the need for linkages to community resources and the complex web of accessing these community resources are also hurdles to addressing SDOH.

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[1] Primary Care Collaborative, Robert Graham Center. (2019). "Investing in Primary Care: A State- Level Analysis." Web.

[2] Schrager, S. (n.d.). *Integrating behavioral health into primary care*. AAFP. https://www.aafp.org/pubs/fpm/issues/2021/0500/p3.html

[3] Hood, CM, Gennuso KP, Swain GR, et al. County Health Rankings: Relationships Between Determinant Factors and Health Outcomes in 45 States. American Journal of Preventive Medicine. February 2016; 50(2): 129-35. doi: 10.1016/j.amepre.2015.08.024

However, integrating multidisciplinary care teams to assess and manage patients' medical, behavioral, and social needs can alleviate staffing concerns and deficiency in resources to treat high-risk patients, which is alluded to in Standard 3.2.

CAFP appreciates that OHCA has named the importance of interdisciplinary care teams, however, it is important that the resources and teams augment the clinical care of the patient. CAFP recommends strengthening Standard 3.2 by explicitly naming the clinical staff that can provide health care teams with the resources and services needed to address SDOH mental and behavioral health needs, such as PharmD and RNs. The standard would then read, "**Facilitate equitable access to diverse clinical interdisciplinary care teams (RNs, PharmD, and clinical licensed staff) to assess and address patients' medical, behavioral, and social needs.**

Section 5. Engage a wide range of providers by offering payment models that appeal to entities with varying capabilities and appetites for risk, including small independent practices and historically under-resourced providers.

Insulating Smaller Practices from Excessive Risk

Many claims' data reporting initiatives fail to appropriately risk adjust for patient behavior and severity of illness, which penalize physicians who treat patients who are less willing or able to adhere to treatment recommendations or are otherwise higher risk for negative outcomes. We do not want to create incentives for physicians to stop seeing higher-risk patient populations and appreciate OHCA's including that consideration in Standard 5.

Standard 5 emphasizes the importance of engaging a range of provider types. It is important to account for the capability of practices of various sizes to take on the financial risk of a high-risk patient needing exceptionally expensive care. **CAFP would appreciate more detail for how OHCA plans to ensure smaller practices are able to participate with smaller patient risk pools.**

Clinical Data Registries and Resource Navigators

Access to clinical registries and population support staff to aid patients with chronic conditions can improve health equity and optimal health outcomes for all California patients. Clinical registries can help improve health care systems by assisting providers in tracking information about the health status of patients and the care they receive to contextualize extensive data sets better and analyze trends or patterns in treatments and outcomes to help inform best practices, guidelines, and treatment decisions. In addition, providing access to population support teams to serve as navigators between health and social services once chronic conditions are identified can help providers achieve optimal care for their patients. Therefore, **CAFP would encourage OHCA to include a new standard 5.5, that provides access to clinical data registries and support teams to treat patients with chronic conditions.**

Section 7. Measure and stratify performance.

Measure Performance

To date, quality measures have focused on the minutiae of hundreds of clinical processes for managing specific diseases and performing procedures but still need to adequately address factors that have the greatest impact on overall individual and population health. The eagerness to measure has burdened physicians, especially primary care physicians, with the onerous task of capturing structured electronic data, taking time away from patients and leading to physician fatigue. Rather than prioritizing quality measurements to improve patient health outcomes, measurement is often too focused on financial concerns. Thirty-three percent of family physicians cited the lack of evidence that using performance measures results in better patient care as a significant weakness of value-based payment systems, and an additional 29 percent cited this as a minor weakness.[4] The burden of measurement reporting falls especially hard on office-based, primary care teams which is associated with burnout and lower quality of care.[5]

CAFP would like to underscore the importance of Standard 7.3 and ask that OHCA consider the measures used to evaluate the adoption goals put forth in the recommendations to ensure that quality, preventive patient care is incentivized and that providers are not penalized for caring for consumers with high, expensive health needs.

Thank you for the opportunity to provide information and recommendations on steps that can be taken to strengthen California's health care systems and prioritize greater investments in primary care. Should you have any questions, please contact Marissa Montano at mmontano@familydocs.org.

Sincerely,

Raul Ayala, MD, MHCM
President, California Academy of Family Physicans

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[4] American Academy of Family Physicians." Vision and Principles of a Quality Measurement Strategy for Primary Care (Position Paper)". Accessed October 11, 2023

[5] Edwards ST, Marino M, Balasubramanian BA, et al. Burnout among physicians, advanced practice clinicians, and staff in smaller primary care practices [published ahead of print October 1, 2018]. *J Gen Intern Med*. Accessed October 11, 2023.

AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

Office of Health Care Affordability
Submitted via: OHCA@HCAI.CA.GOV.

March 1, 2023

Re: Alternative Payment Model Standards and Adoption Goal Recommendation

America's Physician Groups is a national association representing more than 350 physician groups with approximately 170,000 physicians providing care to 90 million patients. APG's motto, 'Taking Responsibility for America's Health,' represents our members' commitment to clinically integrated, coordinated, value-based healthcare in which physician groups are accountable for the costs and quality of patient care. APG is honored to have participated in the development of the Alternative Payment Model Standards and Adoption Goal Recommendation and supports the adoption of this important policy goal by the OHCA Advisory Committee and Affordability Boards.

Building on the Berkeley Forum Report: We support this first step in the transformation of the California health care system toward a higher quality and more equitable, accessible delivery system. It has been a long road since the release of the 2013 Berkeley Health Care Forum Report: A New Vision for California's Healthcare System: Integrated Care with Aligned Financial Incentives.[i] This report expressed a vision for the positive transformation of our health care system:

> *In response to our healthcare challenges, the Forum Vision calls for a rapid shift towards integrated systems that coordinate care for patients across conditions, providers, settings, and time, along with risk-adjusted global budgets that encompass the vast majority of an individual's healthcare expenditures. Specifically, the Forum endorses two major goals for California to achieve by 2022: 1) Reducing the share of healthcare expenditures paid for via fee-for-service from the current 78% to 50%; and 2) Doubling, from 29% to 60%, the share of the state's population receiving care via fully- or highly-integrated care systems. The Berkeley Forum also calls for greater emphasis on population health, including lifestyle and environmental factors that promote good health.*[ii]

Recent California Atlas Data Supports Adoption of Integrated Delivery Models: The Integrated Healthcare Association has released a new public report that reveals such delivery systems significantly outperform their fee for service-based counterparts. Between 2017 and 2021, these models successfully contained the growth of health care spending at a 3.12% rate, compared to a 9.93% rate in coverage models using disaggregated networks. At the same time, the integrated models delivered care at 60% lower patient out of pocket cost, and at 10% greater measured quality performance. This report signals that California can and should

increase the transition to integrated delivery models paid for through first-dollar coverage HMO plans, as urged under the Berkeley Forum Report of 2013.

Further Action is Required: The imposition of growth caps is a rough approach to achieving the goals of affordability and quality of care improvement. Changing the inputs to our health care system – by moving away from fragmented care delivery in disaggregated coverage plans will produce faster and more sustainable results. Over ten years ago, the Report envisioned a progressive shift toward integrated delivery system models based on global budgets that would generate savings to the California health care system of approximately $110 billion over a decade. California missed the opportunity to adopt this model formally and largely ignored the supportive data contained therein until the passage of SB 184, which contained the provisions for adoption of alternative payment models. The provision now expressed in the Alternative Payment Model Standards and Adoption Goal Recommendation is a modest step forward toward the transformative goals expressed in the Report. APG urges the Legislature, Administration and the OHCA Affordability Board to adopt additional goals that would support proven cost savings and quality of care improvement strategies – including the following:

- Comparative public transparency of the overall total cost of care for various coverage models within the traditional Medicare, Medicare Advantage, Self-funded employer market, Fully Insured PPO and HMO markets, and Medi-Cal managed care.
- Comparative, uniform quality measurement of outcomes in the foregoing market segments that is publicly transparent for consumers.
- Statutory requirements for the offering of coverage models that provide lower total cost of care and higher quality outcomes.

We believe that these additional actions will raise awareness among California consumers to seek out health coverage models that deliver lower total cost of care and higher quality outcomes, or to demand their offering. Public transparency of total cost of care is a powerful tool to educate consumers on the value of their health care dollar spend. Following up greater transparency with requirements to adopt coverage plans that provide lower total cost of care helps consumers even more. We believe that these actions will increase the rate of transformation of the California health care system toward a more affordable, accessible, and equitable system, which is the underlying goal of the SB 184 legislation.

Thank you for the opportunity to participate in this effort and to provide comments on this important recommendation.

Sincerely,

William Barcellona, Esq, MHA
Executive Vice President for Government Affairs

[redacted]

[i] Accessed on February 27, 2024, at: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/http://berkeleyhealthcareforum.berkeley.edu/wp-content/uploads/A-New-Vision-for-California%E2%80%99s-Healthcare-System.pdf. Hereinafter referenced as "Report."
[ii] Report, at page 8.

CALIFORNIA MEDICAL ASSOCIATION

March 29, 2024

Megan Brubaker
Office of Health Care Affordability
Department of Health Care Access and Information
2020 West El Camino, Suite 1200
Sacramento, CA 95833

Re: Comments regarding the "Proposed Alternative Payment Model (APM) Standards and Adoption Goal"

Dear Ms. Brubaker:

On behalf of our nearly 50,000 physician and medical student members, the California Medical Association (CMA) appreciates the opportunity to provide comments regarding the Office of Health Care Affordability's (OHCA) proposed Alternative Payment Model (APM) Standards and Adoption Goal. CMA appreciates the robust discussion and thoughtfulness put into these proposed recommendations. CMA offers this input to advance our common goals of health care affordability and equity for all Californians, all while maintaining access to high-quality care.

APM Standards for Payer-Provider Contracting

CMA is overarchingly supportive of OHCA's proposed recommendations for the APM Standards for Payer-Provider Contracting (APM Standards). These proposed standards provide a framework that is based on quality, aims to reduce health care costs, and incentivizes primary and preventative care, all while meaningfully engaging physicians in multiple specialties and modes of practice. Further, designing the core model components to align with existing, widely adopted models will make adoption more attainable. CMA also appreciates the requirement to be transparent about the attribution methodologies, which performance measures are used, and how incentive payments are calculated. How performance measures are determined, and which measures are included are both crucial to the success of the initial and sustained adoption of APMs. Carefully considering the right measures should be a top priority – requiring too many cost and quality measures to be met would be unattainable and would disincentivize participation. CMA urges OHCA to ensure physicians are part of the design, implementation, and evaluation processes for all APMs.

The proposed standards also focus on collecting demographic data, measuring and stratifying performance to improve population health and address inequities, investing in strategies to address inequities measured, dispensing accurate and actionable data to enable success in the model, and providing technical assistance to support new entrants in APM adoption. It is our hope that these standards will drive the goal of providing high-quality, equitable care; a goal that CMA shares.

While there is reference to administrative burdens in Appendix A, it is worth highlighting that any and all new processes have a learning curve and as such, preventing further administrative

burdens is extremely important. The fewer administrative burdens physicians have, the more time they can dedicate to providing high-quality care to their patients.

CMA is also very supportive of the inclusion of
technical assistance. This assistance should focus on long-term practice transformation. Without this assistance, new entrants, especially independent, rural, and/or socioeconomically disadvantaged practices will be at risk of being left behind or becoming acquisition targets accelerating consolidation. Before the OHCA statute was passed by the Legislature, part of the agreement that was negotiated with the Administration was the inclusion of $200 million in the state budget to help small and medium-size physician practices that wanted to shift to APMs with the transition, such as funding for infrastructure improvements and accessing technical assistance. Unfortunately, this funding will be difficult to access for its intended purpose, as the Department of Health Care Services (DHCS) has subsumed this funding within a larger grant program. Approximately half of that funding remains, and we would be happy to work with OHCA and DHCS to ensure that some of the remaining funds can be utilized by physician practices for costs associated with shifting to APMs.

APM Adoption Goal

OHCA's proposed APM Adoption Goal of 75% of members attributed to Health Care Payment Learning and Action Network (HCP-LAN) Categories 3 and 4 arrangements across payer types (Commercial, Medi-Cal, and Medicare Advantage) by 2034 is a very ambitious goal. CMA is supportive of the inclusion of HCP-LAN Categories 3 and 4 across payer types over 10 years but is concerned that the 75% goal is overly ambitious and may be unattainable for Commercial PPO or Medi-Cal.

The existing data on where California's APM adoption currently stands makes it difficult to understand what the path to 75% really looks like. As presented to the Health Care Affordability Board on February 28, 2024, APM adoption in California in 2021[1] for commercial plans shows HMO/POS at 99% enrollment in HCP-LAN Category 4, but notes that it is unclear if they're linked to quality, rendering an undetermined percentage potentially ineligible for HCP-LAN categories 3 and 4. And PPO/EPO APM adoption stands at just 16%. With these numbers (including a lack of a definitive HMO number and the lack of a Medi-Cal number at all), the interim milestones laid out in Appendix B seem unlikely to be attainable. For instance, Appendix B shows a 2026 milestone for commercial PPOs at 35% APM adoption. The expectation of more than doubling the 2021 adoption in the next two years is unreasonable.

More than just the interim milestones being unrealistic, the 75% goal is too high of a bar to set from the outset. APMs are not a one size fits all solution and will vary depending on the type of practice. CMA is concerned that this goal and timeframe are oversimplifying the significant shift in the health care delivery system this will create. It is critical for this goal to account for the creation of, interest in, implementation of, and evaluation of this process – all of which may take time. Unlike Medicare, Medi-Cal and some commercial coverages have significantly more churn in their patients in products and plans, making continuity of care, and APMs more difficult to adopt. It is also the case that the early adopters of APMs are those who were

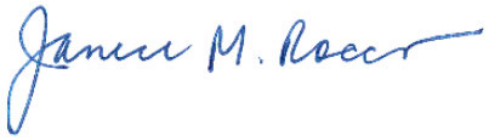
[1] https://hcai.ca.gov/wp-content/uploads/2024/02/February-2024-Board-Meeting-Presentation.pdf

interested in making the shift, but those who have not yet done so will need some convincing that this will work for their practice and some support before they will be willing to attempt APM adoption. Further, while we are supportive of the state promoting the adoption of APMs, participation should be voluntary.

CMA urges OHCA to continue the discussion of the proposed APM adoption goal, specifically as it relates to Medi-Cal and commercial PPOs to help think through what is realistic or even appropriate in these market segments. Additionally, in order to provide a more realistic path to successful adoption, we encourage you to work with CMA to ensure that the state funds that were included in the 2023-23 budget to assist small and medium-sized practices in shifting to APMs are utilized for their intended purpose.

We look forward to continuing to work with you on these issues. For more information or questions, please contact me at (916) 551-2560 or jrocco@cmadocs.org.

Sincerely,



Janice Rocco
Chief of Staff
California Medical Association

OHCA Proposed APM Standards and Adoption Goals – CAHP Comments (*dated 03/29/24*)			
Page	**Section**	**Topic**	**Comment or Recommended Change**
4	APM Standards for Payer-Provider Contracting	**Standards** "OHCA recommends the adoption of the following APM Standards. The APM Standards provide a set of ten best practices that are grounded in evidence to approach contracting decisions between payers and providers that are common across APMs. The Board shall approve the APM Standards. 1. **Use prospective, budget-based, and quality-linked payment models** that improve health, affordability, and equity. 2. **Implement payment models that improve affordability** for consumers and purchasers. 3. **Allocate spending upstream to primary care and other preventive services** to create lasting improvements in health, access, equity, and affordability. 4. **Be transparent** with providers in all aspects of payment model design and terms including attribution and performance measurement. 5. **Engage a wide range of providers** by offering payment models that appeal to entities with varying capabilities and appetites for risk, including small independent practices and historically under-resourced providers.	We support these standards for contracting, as they reflect those discussed in Investment and Payment Workgroup sessions and plans' goals of supporting APM adoption and primary care investment.

OHCA Proposed APM Standards and Adoption Goals – CAHP Comments (*dated 03/29/24*)			
Page	**Section**	**Topic**	**Comment or Recommended Change**
		6. **Collect demographic data**, including race, ethnicity, language, disability status, sex, sexual orientation, and gender identity (RELD-SOGI) data, to enable stratifying performance. 7. **Measure and stratify performance** to improve population health and address inequities. 8. **Invest in strategies to address inequities** in access, patient experience, and outcomes. 9. **Equip providers with accurate, actionable data** to inform population health management and enable their success in the model. 10. **Provide technical assistance** to support new entrants and other providers in successful APM adoption."	
5	APM Adoption Goal	**HCP-LAN Category 3 and 4** "OHCA recommends an APM Adoption Goal of 75% of members attributed to Health Care Payment Learning and Action Network (HCP-LAN) Categories 3 and 4 arrangements across payer types (Commercial, Medi-Cal, and Medicare Advantage) by 2034."	We support the goal of achieving HCP-LAN Category 3 of 4 payment arrangements to better promote pay for value. • Achievement of HCP-LAN Category 3/4 will take all payers and providers participating to ensure alignment of resources and incentives. Our members have identified issues in achieving Category 3 based on payer misalignment and allocation of resources, so this cross-payer approach should address those alignment issues.

OHCA Proposed APM Standards and Adoption Goals – CAHP Comments (*dated 03/29/24*)			
Page	**Section**	**Topic**	**Comment or Recommended Change**
5	APM Adoption Goal	**PPO Measurement**	We request clarification on the denominator used to classify payment arrangements. OHCA should clarify that for purposes of APM adoption in the PPO market, this should be based on a denominator that includes only those PPO members that utilized care in a given plan year. Using this approach to the denominator makes sense, given that in the PPO market members are not attributed and payers will not have claims data for those members who do not utilize care each year. Due to the nature of PPO products, whereby contracting is not done on a managed care basis, and given that plans do not attribute members who do not seek care for PPO products, meeting a 75% will be unattainable unless measurement is based on those members seeking care. OHCA should also clarify that for purposes of APM adoption in Medi-Cal, this should be based on a denominator that includes only those non-dually eligible Medi-Cal members. Removing the duals in the Medi-Cal denominator makes sense given that dually eligible Medi-Cal members in Original Medicare are not attributed and payers will only have COB claims data for those members who utilize services. We also recommend that OHCA make the definition of denominator clear in the THCE Data Submission Guide.
5	APM Adoption Goal	**Inclusion of self-funded plans in commercial HMO and PPO APM data submission and measurement**	We request clarification on data reporting for self-funded plans. We recommend HCAI legal counsel communicate the Department's interpretation of payers' abilities to report data to OHCA. Doing so would provide clarity to payers on the type of self-funded data they can provide.

OHCA Proposed APM Standards and Adoption Goals – CAHP Comments (*dated 03/29/24*)			
Page	**Section**	**Topic**	**Comment or Recommended Change**
			Additionally, we request that OHCA make clear that self-funded plan data, if submitted, will be counted separate from that of the health plan administering its benefits. Given that payers only provide administrative services to self-funded plans and have limited influence on network management and contracting, any measurement of APM adoption in the self-funded space should be done separate from that of other commercial HMO and PPO lines of business.