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Department of Health Care Access and Information

Health Care Affordability Board Meeting

April 24, 2024

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Welcome, Call to Order, and Roll Call

Agenda

1. **Welcome, Call to Order, and Roll Call**
   Secretary Mark Ghaly, Chair

2. **Executive Updates**
   Elizabeth Landsberg, Director, and Vishaal Pegany, Deputy Director

3. **Action Consent Item**
   Vishaal Pegany
   a) Approval of the March 25, 2024 Meeting Minutes

4. **Action Item**
   Vishaal Pegany, CJ Howard, Assistant Deputy Director
   a) Establish a Statewide Spending Target Value - On or before June 1, 2024, the Board will establish a statewide spending target value.[1]

5. **Informational Item**
   Vishaal Pegany, CJ Howard, Margareta Brandt, Assistant Deputy Director
   a) Statewide Spending Target Including Board Follow-up Items
   b) Update on Draft Alternative Payment Model Standards and Adoption Goal
   c) Draft Workforce Stability Standards, Including Summary of Advisory Committee Feedback
   d) Draft Primary Care Spending Definition and Investment Benchmark, Including Summary of Advisory Committee Feedback

6. **Public Comment**

7. **Adjournment**

[1] From April through June 1, 2024, this item will appear as an action item on the meeting agendas to give the Board flexibility. The Board is not required to take action in April. Additionally, the Board is not allowed to discuss or act on any item unless it is listed on the agenda.

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

Quarterly Work Plan*

	Health Care Affordability Board	Health Care Affordability Advisory Committee
APRIL 2024	• Discuss and approve statewide spending target • Workforce stability standards, including January Advisory Committee feedback • Primary care spending definitions, data collection, and investment benchmark, including March Advisory Committee feedback • Update on Alternative Payment Model (APM) standards and goals	
MAY 2024	• Discuss and approve statewide spending target • Update on workforce stability standards • Update on primary care investment benchmark • Appoint Advisory Committee Members **Board votes on spending target by June 1, 2024**	• Examples of cost-reducing strategies • Out-of-pocket, out-of-plan spend • Consumer affordability measures • Update on workforce stability standards • Update on primary care investment benchmark • Update on APM standards and goals
JUNE 2024	• Approve APM standards and goals • Discuss workforce stability standards • Examples of cost-reducing strategies • Appoint Advisory Committee Members	

* Work plan is subject to change.

Future Topics Beyond June 2024

THCE & Spending Target

- Introduction on payer administrative cost and profits.
- Discuss public reporting of spending in baseline report.
- Progressive enforcement discussion.
- Sector target discussion.

Promoting High Value

- Approve primary care spending benchmark.
- Updates on alternative payment model (APM) and primary care spending data collection processes.
- Progress defining behavioral health and developing behavioral health spending benchmark.

Assessing Market Consolidation

- Updates on material change notices received, transactions receiving waiver or warranting a cost and market impact review (CMIR), and timing of reviews for notices and CMIRs.

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Public Comment

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Action Consent Item: Approval of the March 25, 2024 Board Meeting Minutes

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Public Comment

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Informational Item

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Statewide Spending Target Including Board Follow-up Items

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

Today's Follow-Up Items

During today's Board meeting, we will provide information regarding:

1. How OHCA attributes members and applies the target to fully integrated delivery systems (FIDS) and how OHCA will measure hospitals without attributed lives.
2. Member request for January 2024 meeting slide data showing 5-year rolling averages.
3. Projection of per member increase in Medi-Cal spending over the 5-year target period.
4. Industry ideas for cost savings in the system.

FIDS Member Attribution

- Kaiser Permanente is currently the only health care entity meeting the definition of a FIDS.[1]
- OHCA will attribute member spending (including hospital spending) to Kaiser's two physician organizations:
  1. Kaiser Permanente Medical Group in Northern California
  2. Southern California Permanente Medical Group in Southern California
- OHCA will apply the statewide spending target to each of these systems (northern and southern).

[1] Health and Safety Code § 127500.2 (h). "Fully integrated delivery system" means a system that includes a physician organization, health facility or health system, and a nonprofit health care service plan that provides health care services to enrollees in a specific geographic region of the state through an affiliate hospital system and an exclusive contract between the nonprofit health care service plan and a single physician organization in each geographic region to

Order of Operations for Attributing Total Medical Expenses to Physician Organizations

To determine total medical expenses (TME) for a health care entity subject to the spending target, including physician organizations affiliated or under common ownership with hospitals, OHCA will use the following order of operations:

1. **Capitated, Delegated Arrangement**: If members for whom utilization management and claims payment functions have been delegated to an organization listed on the Attribution Addendum through a capitated arrangement, the member's TME are attributed to that organization.
2. **Total Cost of Care Accountable Care Organization (ACO) Arrangement**: For remaining members, if any are enrolled in a total cost of care ACO arrangement, the member's TME are attributed to an organization listed on the Attribution Addendum (i.e., the physician organization participating in that ACO arrangement).
3. **For remaining members**, if any can be attributed to an organization ***not*** listed on the OHCA Attribution Addendum using steps 1 and 2, the attributed TME for those organizations can be reported along with the organization's legal name. These additional organizations can later be added to the Attribution Addendum.

Order of Operations for Attributing Total Medical Expenses to Physician Organizations

After attributing members using steps 1-3, attribute TME for remaining members using the following:

4. **Payer-Developed Rules-Based Attribution:** For remaining members, if any can be attributed to an organization using a **payer-developed rules-based attribution** methodology, the member's total medical expenses are attributed to that organization.
5. **Not Attributed:** Not all members will be attributed. Data for members who cannot be attributed to any organization using any of the attribution methods shall be reported using the Not Attributed attribution method.

Measuring Hospital Performance Relative to the Spending Target

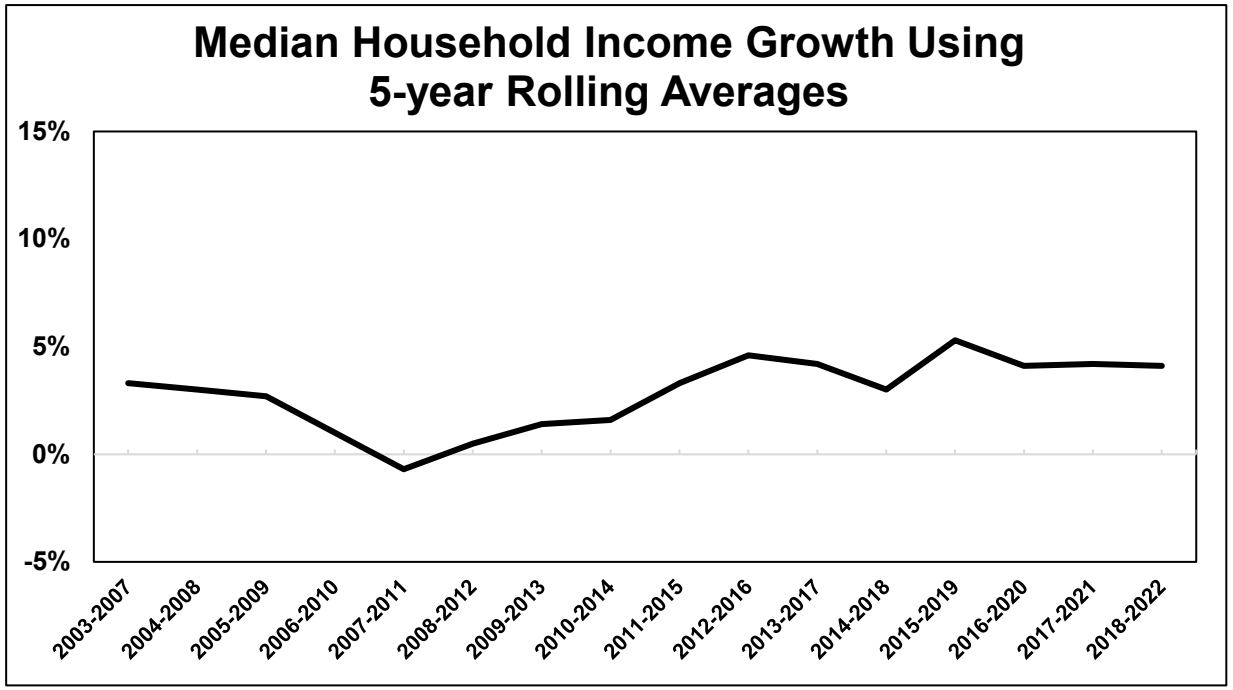
- OHCA expects the current TME approach to measure spending performance for provider organizations with attributed lives, such as physician organizations affiliated or under common ownership with hospitals.

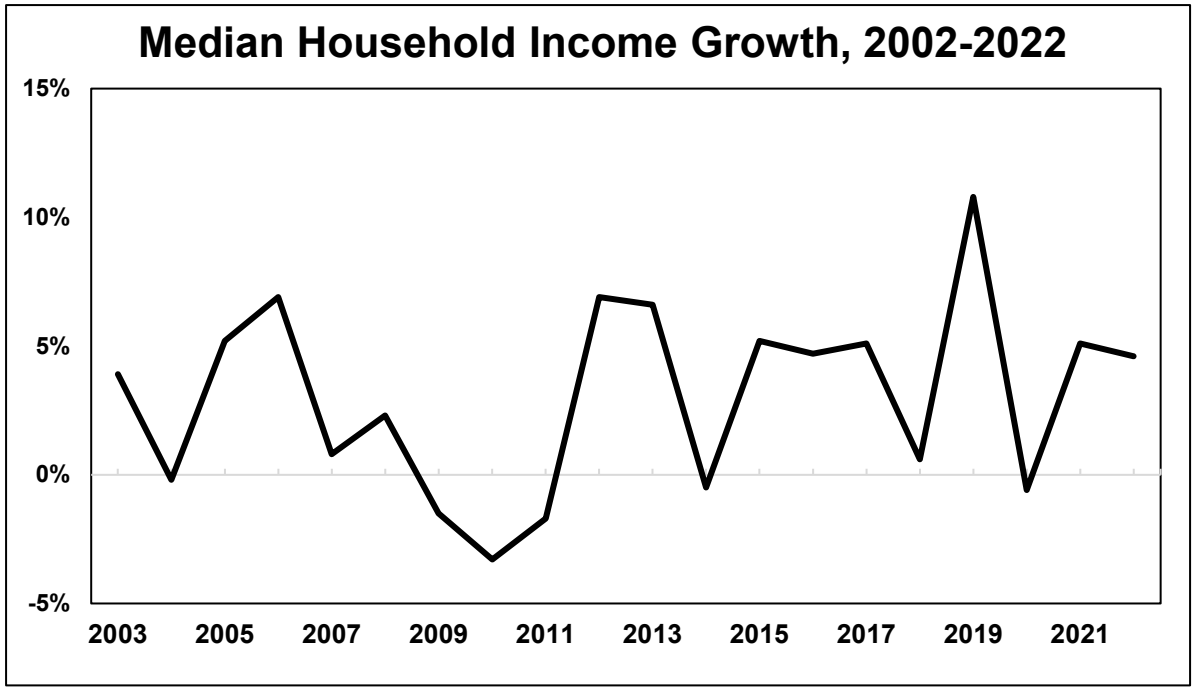
- To achieve success in spending targets, there is a need for strategies to better understand hospital spending across all patients, in addition to provider organizations with attributed lives.

- OHCA will be convening a multi-stakeholder workgroup and technical advisory panel to inform the development of measurement methodologies for hospitals and enable more effective accountability for performance relative to the target.

2002-2022 Median Household Income Growth Under 5-Year Rolling Averages

- From 2002 to 2022, the average of the 5-year rolling averages is 2.9% and yields a minimum of -0.7% and a maximum of 5.3%.
- In the absence of 5-year rolling averages, the minimum and maximum is -3.3% to 10.8%, respectively.





Source: U.S. Census Bureau, Median Household Income in California [MEHOINUSCAA646N], retrieved from FRED, Federal Reserve Bank of St. Louis. https://fred.stlouisfed.org/series/MEHOINUSCAA646N

Historical Per Member Medi-Cal Spending Growth in California, 2014 to 2023

- Following is Medicaid Budget and Expenditure System (MBES) quarterly CMS 64 expenditure data for California.
- From 2014 to 2023, the annual average growth in per member Medi-Cal spending was 5.9%. There was marked variation, ranging from a low of -5.4% to a high of 29.5%. Excluding the 29.5% change from 2014 to 2015 yields an overall average change of 3% from 2015-2023.

Calendar Year	Medi-Cal CMS 64 Total Expenditures	Average Monthly Enrollment CMS 64	Per Member Medi-Cal Expenditures	Average Change (%) in Per Member Medi-Cal Spending
2014	$71,833,605,914	13,788,775	$5,210	N/A
2015	$90,675,779,474	13,438,351	$6,748	29.5%*
2016	$92,895,142,387	12,491,056	$7,437	10.2%
2017	$81,057,842,509	11,517,799	$7,038	-5.4%
2018	$87,467,487,819	12,928,543	$6,765	-3.9%
2019	$96,724,560,374	12,561,914	$7,700	13.8%
2020	$108,943,688,426	12,657,433	$8,607	11.8%
2021	$118,663,837,139	13,694,199	$8,665	0.7%
2022	$127,296,712,518	14,578,506	$8,732	0.8%
2023	$126,502,604,311	15,147,236	$8,352	-4.4%

*ACA expansion, Coordinated Care Initiative implementation, and an 1115 waiver renewal (related to Bridge to Reform Low-Income Health Program), with ACA expansion being the biggest contributer.
Source: Staff analysis of CMS-64 Medicaid Budget and Expenditure System (MBES).

Projected Per Member National Medicaid Spending Growth, 2024 to 2031

- While long-term state-level per member Medi-Cal projections are not available, for fiscal year 2024-2025, the DHCS budget includes a 9% increase in per member spending. This above-average per capita growth reflects several policy changes, including a full-year of full-scope benefits expansion for the undocumented population aged 26 to 49 and the proposed new managed care organization tax and related provider payment increases.
- In addition, CMS projections suggest national Medicaid per member spending will grow an annual average of 5.4% from 2024 to 2031.

Calendar Year	Per Member Projected Medicaid Expenditures	Average Change (%) in Per Member Projected Medicaid Spending
2024	$8,844	7.8%
2025	$9,303	5.2%
2026	$9,751	4.8%
2027	$10,257	5.2%
2028	$10,813	5.4%
2029	$11,328	4.8%
2030	$11,880	4.9%
2031	$12,462	4.9%

Source: Centers for Medicaid and Medicare Services. National Health Expenditures Projected. *National Health Expenditure Data.* https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected

Industry Ideas for Cost Savings

Public comment letters from hospitals, health systems, and health care industry stakeholders mentioned key themes for cost savings:

- Paying Differently for Health Care
- Shifting Away from a Fragmented System
- Pursuing Legislative Policy Changes

Industry Ideas for Cost Savings

Paying Differently for Health Care

- Reducing the share of health care expenditures paid via Fee-For-Service (FFS), including a market shift to HMO rather than PPO or FFS plans.
- Tying providers to a risk-adjusted global budget that encompasses the full spectrum of a population's health care needs.
- Creating new performance requirements and incentive funds for achieving cost containment, productivity, efficiency, and access goals.
- Changing physician compensation models to incentivize primary care practice in underserved areas and reduce the income gap between primary care physicians and other specialties.

Industry Ideas for Cost Savings

Shifting Away from a Fragmented System

- A shift towards integrated care systems composed of sufficiently scaled medical groups, hospitals, and health systems can provide the platform for effective stewardship of both the health and financial risk of a population across settings, conditions, and time.
- Reorganizing delivery models with a comprehensive focus on health equity has the potential for long-term savings.
  - Studies show that robust systems of primary care can lower overall health care utilization, disease, and death rates and increase the use of preventive services.
  - Strong primary care also may reduce the negative effects of income inequality and is associated with more effective and equitable health services.

Industry Ideas for Cost Savings

Pursuing Legislative Policy Changes

- Statutory requirements for offering coverage models that provide lower total cost of care and higher quality outcomes.
- Prescription drug reform
  - Preventing harmful mark-ups and increased costs for patients by protecting the use of specialty pharmacies to access lower drug costs, and
  - Increasing drug cost transparency by requiring price disclosure from drug manufacturers at time of launch and at time of list price increases and requiring disclosure of patient assistance programs.
- Prohibiting billing by off-campus hospital-owned providers.
- Addressing anti-competitive contracting practices by consolidated health systems such as all-or-nothing, anti-tiering, and anti-steering clauses in provider contracts.
- Addressing administrative inefficiencies, requiring payers to standardize and streamline their utilization management and payment rules.

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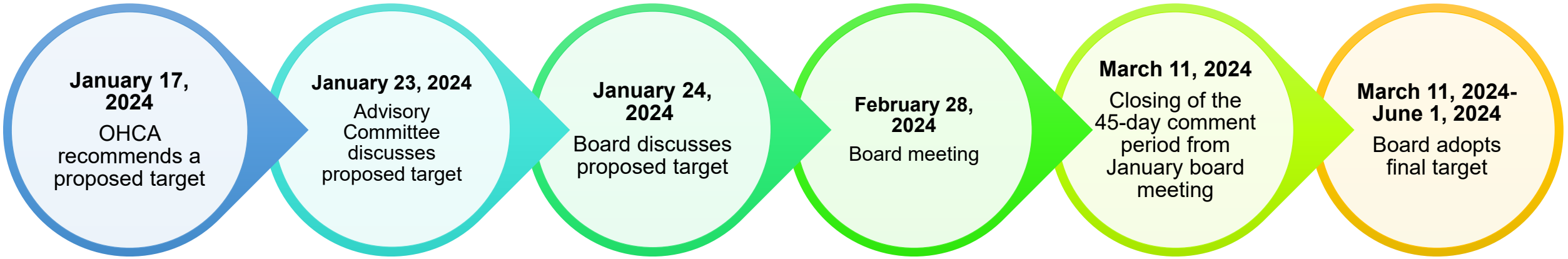
Action Item: Establish a Statewide Spending Target

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

Timeline for Adopting the Spending Target for 2025



Per the California Health Care Quality and Affordability Act: The board shall adopt final targets on or before June 1, at a board meeting. The Board's adoption of the target is exempt from the rulemaking provisions of the Administrative Procedure Act.

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Statute

127502.

(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.

(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.

Source: Health and Safety Code § 127502

Spending Target Discussion History

The following slides are a summary of spending target discussions held regarding the target value over the last six months.

In September, OHCA and the Board:

- Reviewed spending target statutory requirements and considerations, including Board and Office responsibilities and the spending target timeline.
- Reviewed other states' target setting methodologies.
- Assessed economic indicators and population-based measures, including:
  - Gross State Product
  - Potential Gross State Product
  - Median Family Income
  - Average Wage
  - Inflation (measured by CPI-U)
  - Median Age
- Discussed use of historical and forecasted data.
- Reviewed spending target adjustment factors identified in statute.

Spending Target Discussion History

In October, OHCA and the Board:

- Reviewed statutory requirements for developing the statewide spending target methodology and the target percentage value.
- Discussed historical spending growth in California over varying time horizons.
- Continued discussions regarding economic indicators and the differences between actual historical data vs. forecasted data.
- Discussed OHCA's preliminary recommendation that the statewide spending target should:
  - Be a single economic indicator
  - Rely on median household income
  - Use historical data
- Discussed population-based research to inform the target value, including:
  - Age and sex
  - Chronic disease prevalence
  - Disability status
- Discussed the pros and cons of multi-year targets, including duration and a fixed vs. phased-in approach.
- Discussed OHCA's preliminary recommendation of a 5-year initial target for calendar years 2025 – 2029 with a phased-in target value over the first 2-5 years of the program, then remaining fixed.
- Discussed the impacts of revisiting the target mid-year or mid-cycle.

Spending Target Discussion History

In December, OHCA and the Board:

- Discussed potential adjustments related to trends in technology and the price of health care technologies but OHCA recommended no adjustment.
- Presented OHCA preliminary proposal: adoption of a 3% statewide per capita spending targets for 2025-2029 based on a weighted average of historical median household income change over the 20-year period from 2002-2021 with no phase-in.
- Presented background on median household income changes from 2002-2021.
- Discussed OHCA reasoning for not recommending population-based adjustments.
- Proposed that the Board commit to evaluating the target for potential adjustments on an annual basis.

Spending Target Discussion History

In January, OHCA and the Board:

- Recapped affordability challenges in California, including disproportionate impacts on communities of color.
- Discussed research on opportunities for savings that could slow spending growth.
- Discussed OHCA recommendation for the statewide spending target, including rationale for:
  - An economic indicator of historical median household income based on the average rate of change over the last 20 years (2002-2022).
  - Not applying population- or technology-based adjustments.
  - Meeting annually to consider whether there are needed updates to the target, including adjustments for unforeseen circumstances.

Spending Target Discussion History

In February, OHCA and the Board:

- Discussed Advisory Committee summary feedback on OHCA's recommendation
- Discussed factors for consideration that may contextualize spending growth when assessing against the target.

In March, OHCA and the Board:

- Discussed written public comment summary feedback on OHCA's recommendation, as well as Advisory Committee responses to public comments.

Population Aging

- The proportion of Californians 65 and older is projected to increase; the costs of this population are predominantly covered by Medicare.
- Initially, OHCA will report THCE adjusted for changes in the age and sex composition of an entity's population. These adjustments will account for year-over-year changes in an entity's population.
- OHCA is committed to continually evaluating the impact of aging on THCE. Based on baseline and other annually reported data, OHCA will assess whether adjustments to the approach or the target(s) are merited.
- An aging population will impact spending growth. Health care for seniors and end-of-life care present an important opportunity to improve care, enhance patient satisfaction, and improve consumer affordability.

OHCA's Recommendation: Statewide Per Capita Health Care Spending Target

OHCA recommends the adoption of the following statewide per capita health care spending targets for 2025-2029, based on the average annual rate of change in historical median household income over the 20-year period from 2002-2022.

Performance Year	Per Capita Spending Growth Target
2025	3.0%
2026	3.0%
2027	3.0%
2028	3.0%
2029	3.0%

Options For Board Consideration

- The Board may vote to adopt the Office's recommendation or propose another value and/or methodology for discussion and ultimate adoption.
- Other options for the Board to consider include:
  - Creating a target phase-in
  - Modifying the methodology for arriving at a target value
  - Changing the economic indicator
  - Changing the target value
  - Changing the target duration
- The Board is required to adopt a final target by June 1st at a public meeting of the Board.
- If the Board does not establish a Statewide Spending Target today for at least 2025, establishing the Statewide Spending Target Value and Methodology will be listed as an action item for the Board to act on at the Health Care Affordability Board Meeting in May.

Draft Motion Option 1: OHCA's Recommendation

Establish a 3% spending target, based on the average annual rate of change in historical median household income from 2002-2022, for performance years 2025, 2026, 2027, 2028, and 2029.

Performance Year	Per Capita Spending Growth Target
2025	3.0%
2026	3.0%
2027	3.0%
2028	3.0%
2029	3.0%

Draft Motion Option 2: 3% with Phase-In

Establish a base 3% spending target, based on the average annual rate of change in historical median household income from 2002-2022, for performance year 2029. Add 0.5% to the 3% base for performance year 2025 and 2026 and add 0.2% to the 3% base in performance year 2027 and 2028.

Performance Year	Per Capita Spending Growth Target
2025	3.5%
2026	3.5%
2027	3.2%
2028	3.2%
2029	3.0%

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Informational Items

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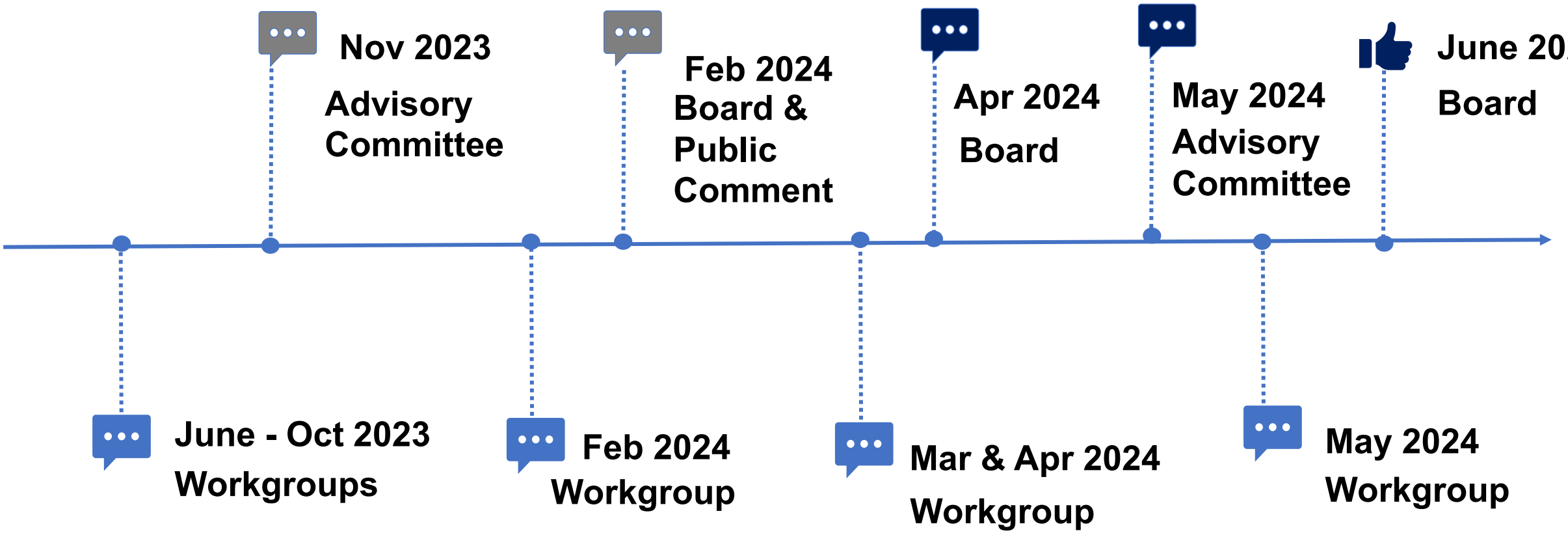
Update on Draft Alternative Payment Model Standards and Adoption Goal

Margareta Brandt, Assistant Deputy Director

Timeline for APM Workstreams



Between each meeting, OHCA and Freedman HealthCare will revise draft APM standards, definitions, and goals based on feedback.

* Dates subject to change.

Provide Feedback Board Approval

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Vision of APM Standards and Goals Success

Stakeholders Endorse

- Health care entities, purchasers commit to APM standards and goals to inform future contracting

Alignment Increases

- APMs become more aligned
- Standardization makes participation easier
- Barriers to adoption decrease

Performance Improves

- Standards and goals support increased APM adoption
- Performance on measures of quality, equity, and affordability improve

Opportunities for Accountability for APM Standards and Goals

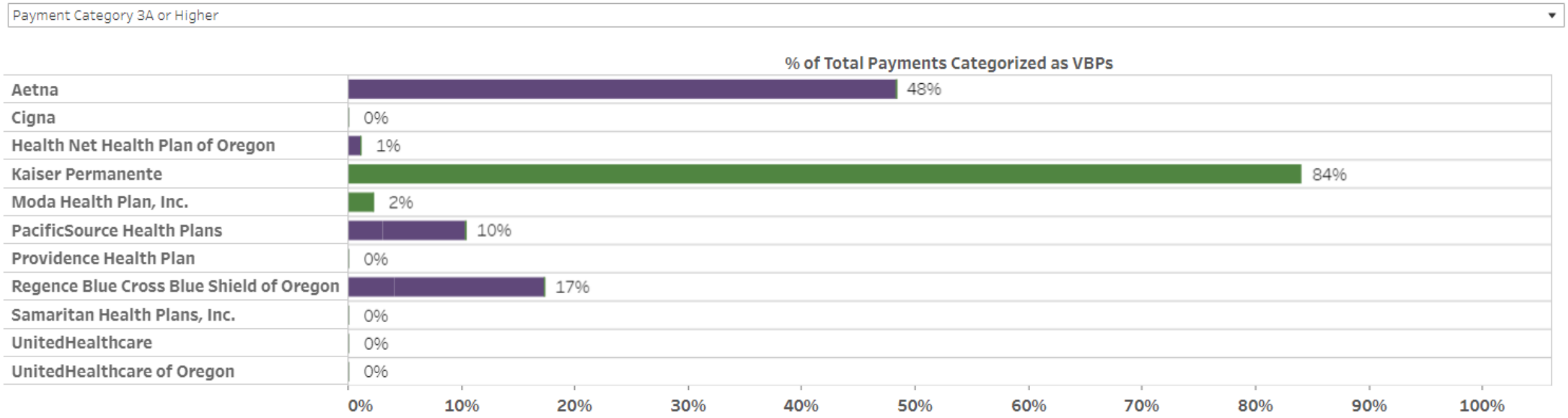
- **Transparency**: Reporting on goals and aspects of standards by payer type and payer or fully integrated delivery system.
- **Contracting**: Purchasers, particularly public purchasers, align contracts with endorsed APM adoption standards and goals.
- **Performance Improvement Plan (PIP):** Achievement of APM adoption goals and implementing APM standards could be incorporated into PIPs.

Opportunities for Accountability

Oregon Commercial Payer APM Reporting Example

For each payer, what is the percentage of payments that are Value-Based Payments (VBPs).

VBPs include the following HCP-LAN categories: pay for performance (2C), shared savings (3A), shared savings and risk (3B), and population-based capitation with link to quality (4A, 4B, 4C).
Use the drop-down list below to select VBP categories you are interested in.



This 2021 data shows the variation in APM adoption across payers. Three payers that have greater than 1% adoption of HCP-LAN Category 3 payer and only one payer, Kaiser, has high Category 4 adoption.

Source: Oregon Health Authority (2023). *Oregon's Health Care Payment Arrangements in 2021. May* 2023. Workbook: VBP2021 (state.or.us)

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Draft Alternative Payment Model Standards

Draft 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.

Draft APM Standards

6. **Collect demographic data**, including 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.

*Race, ethnicity, language, disability status (RELD), sex, sexual orientation and gender identity (SOGI).

Public Comment on Draft APM Standards Recommendations

- Overarching support of OHCA's proposed APM Standards and Implementation Guidance; only two suggestions for specific language changes.
- Recommend emphasizing that physicians should be part of the design, implementation, and evaluation of APMs.
- Recommend more explicitly stating need to increase primary care resources and reduce administrative burden.
- Recommend naming the types of clinical staff that can provide health care teams with the resources and services needed to address social, mental, and behavioral health needs, such as PharmD and RNs.
- Encourage OHCA to include a new standard that provides access to clinical data registries and support teams to treat patients with chronic conditions.

Proposed Revisions to Draft APM Implementation Guidance

There are no proposed changes to the draft APM Standards.

Proposed revisions to the draft Implementation Guidance are:

- Included guidance to obtain input from providers on the design, implementation, and evaluation of APMs.
- Included examples of primary care team members that can support addressing social, medical, and behavioral health needs, such Registered Nurses, Doctors of Pharmacy, and community health workers.
- Included sharing clinical registry data to support providers in population health management and success in APMs.

Revised Alternative Payment Model Adoption Goals

APM Adoption Goal and Milestones Proposed at February Board Meeting

APM Adoption Goal for Percent of Members Attributed to HCP-LAN Categories 3 and 4 by Payer Type with Interim Milestones				
	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%

Board Feedback:

- Consider shortening timeline.
- Recognize existing differences in starting points across payer types may lead to different end points.
- Reflect cost drivers in the health system.

Public Comments on APM Adoption Goals

- Concern that the 75% goal is overly ambitious and may be unattainable for Commercial PPO or Medi-Cal.
- Concern that the proposed goals and timeframe oversimplify the significant shift in the health care delivery system required.
- Recommend that for purposes of APM adoption in Medi-Cal the goal should be based on a denominator that includes only those non-dually eligible Medi-Cal members.
- Recommend that the definition of denominator be clear in the THCE Data Submission Guide.

Workgroup and Other Recent Stakeholder Feedback on APM Goal Options

Commercial PPO Denominator	Five-Year Commercial PPO 40% Goal	Five-Year Commercial HMO and MA 95% Goal
• Objection to using all members. Consider only including attributed instead. • Feasibility to achieve goals is impacted if all members are included in the denominator.	• Even 40% may be too high in 5 years • Support for higher goal. • Support for longer timeline. • Concerns about self-funded plans meeting the goal. • Prior proposal of 75% was not realistic, payers would be unlikely to meet goal	• Goal is too high. • 90% may be more realistic. • Willing to support if payers believe benchmark to be feasible. • Goals should align across product types.

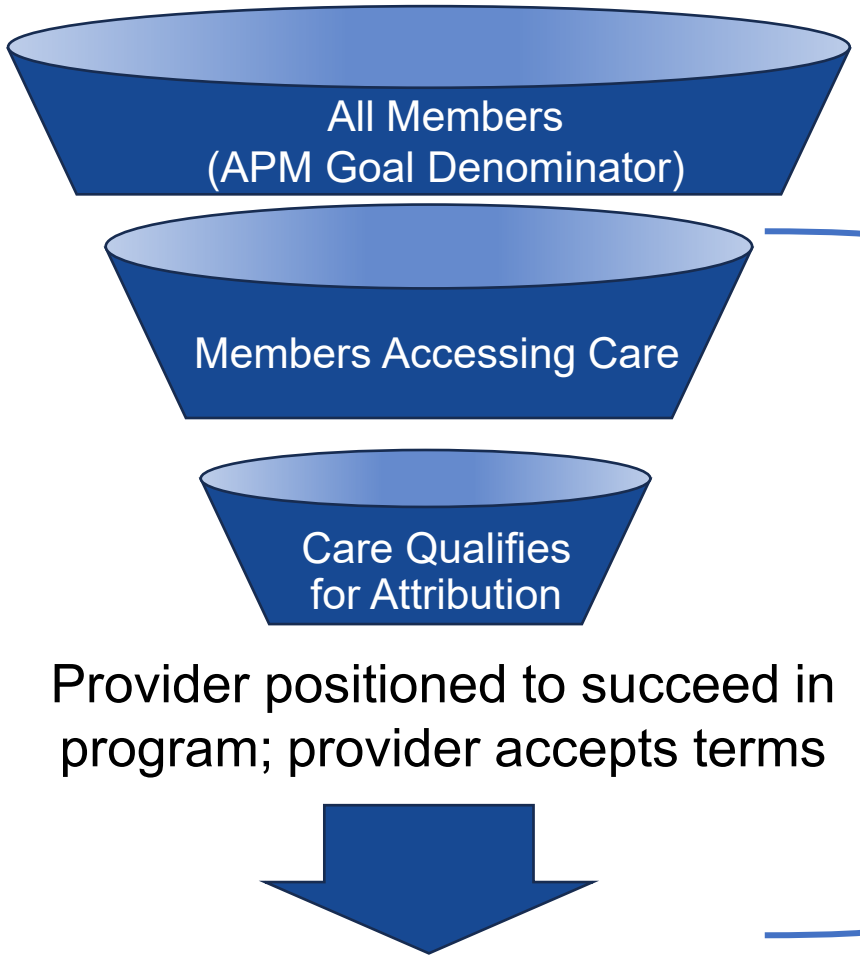
Iterations of Goals:

OHCA reviewed options for APM goals with a shorter timeframe and adjusted payer goal percentages with the Investment and Payment Workgroup in March. Their feedback is included here.

Attribution in Accountable Care

OHCA plans to include all members in APM denominator.

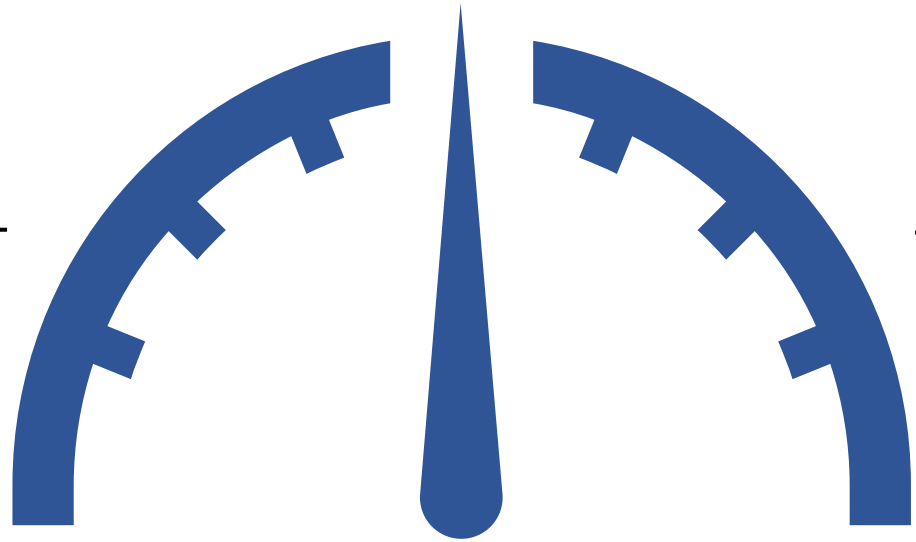
Aligns with population health goals including engaging those who may be less likely to receive care.



This funnel represents the most common attribution approach in Commercial PPO.

Attributing members this way results in a lower attribution rate than other APM arrangements, particularly capitation arrangements which often require members identify a provider or be assigned.

Balancing the Pace of Change



Not too slow…

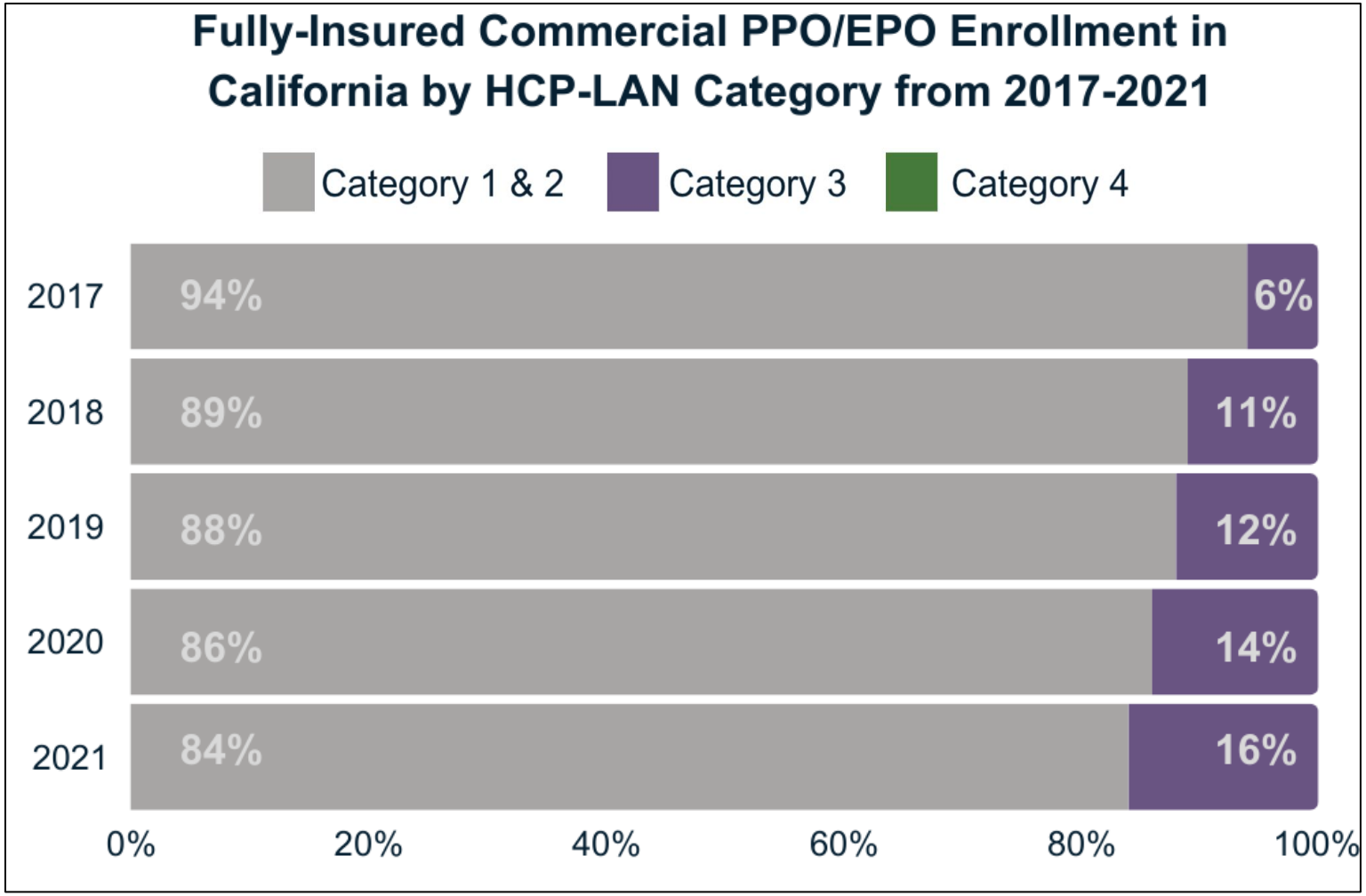
- The time for more affordable, higher value care is now.
- Timely accountability motivates quick action.

Not too fast…

- Care delivery redesign, contracting take time.
- Overambitious goals may discourage stakeholder participation.
- Broad provider participation and meaningful arrangements are key.

California Commercial PPO APM Adoption

- APM adoption has been largely stable among California's commercial, fully-insured PPO (shown at right) and HMO markets (not shown) over the past five years.
- Category 3 enrollment for Commercial PPOs has increased from 6% to 16% from 2017 to 2021, but only increased 2 percentage points between 2020 and 2021.
- Less understood is the percent of arrangements *tied to quality.*



Source: Internal analysis by the Integrated Healthcare Association (2022)

Revised APM Adoption Goals

Revised APM Adoption Goals for Percent of Members Attributed to HCP-LAN Categories 3 and 4 by Payer Type				
	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	65%	25%	55%	55%
2028	75%	35%	60%	65%
2030	85%	45%	65%	75%
2032	90%	55%	70%	85%
2034	95%	60%	75%	95%

- Two-year interim goals leading to a 10-year goal.
- Reinforces public reporting on interim goals.
- Recognizes different starting and ending points for payers.
- Recognizes that all arrangements must include a link to quality.
- Creates a glidepath that more than triples Commercial PPO members attributed to HCP-LAN Categories 3 and 4 from 16% in 2021.

These revised adoption goals are also under discussion with sibling state departments.

Examples of Questions OHCA Could Explore through Reporting

Reporting will occur annually and by payer and product type. The goal is to use reporting to answer questions such as:

- **Percent of members attributed to APMs – *basis for APM adoption goal;***
- Percent of dollars paid via APMs;
- Percent of dollars paid via non-claims;
- Percent of dollars paid via facility capitation;
- Percent of primary care spend paid via capitation;
- Changes in spending to support infrastructure and practice transformation;
- Changes in spending on episodes and bundles of care.

Alternative Payment Model Adoption Standards and Goals: Discussion

Does the Board have additional feedback on:

1. Revisions to the APM Standards and Implementation Guidance?

2. The revised APM adoption goals and timeline?

HCAi
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Public Comment

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Draft Workforce Stability Standards, Including Summary of Advisory Committee Feedback

Margareta Brandt, Assistant Deputy Director

Health Care Workforce Stability

Statutory Requirements

- Monitor the effects of spending targets on health care workforce stability, high-quality jobs, and training needs of health care workers.
- Monitor health care workforce stability with the goal that workforce shortages do not undermine health care affordability, access, quality, equity, and culturally and linguistically competent care.
- Promote the goal of health care affordability, while recognizing the need to maintain and increase the supply of trained health care workers.
- **To assist health care entities in implementing cost-reducing strategies that advance the stability of the health care workforce, and without exacerbating existing health care workforce shortages, develop standards, in consultation with the Board.**

Health Care Workforce Stability

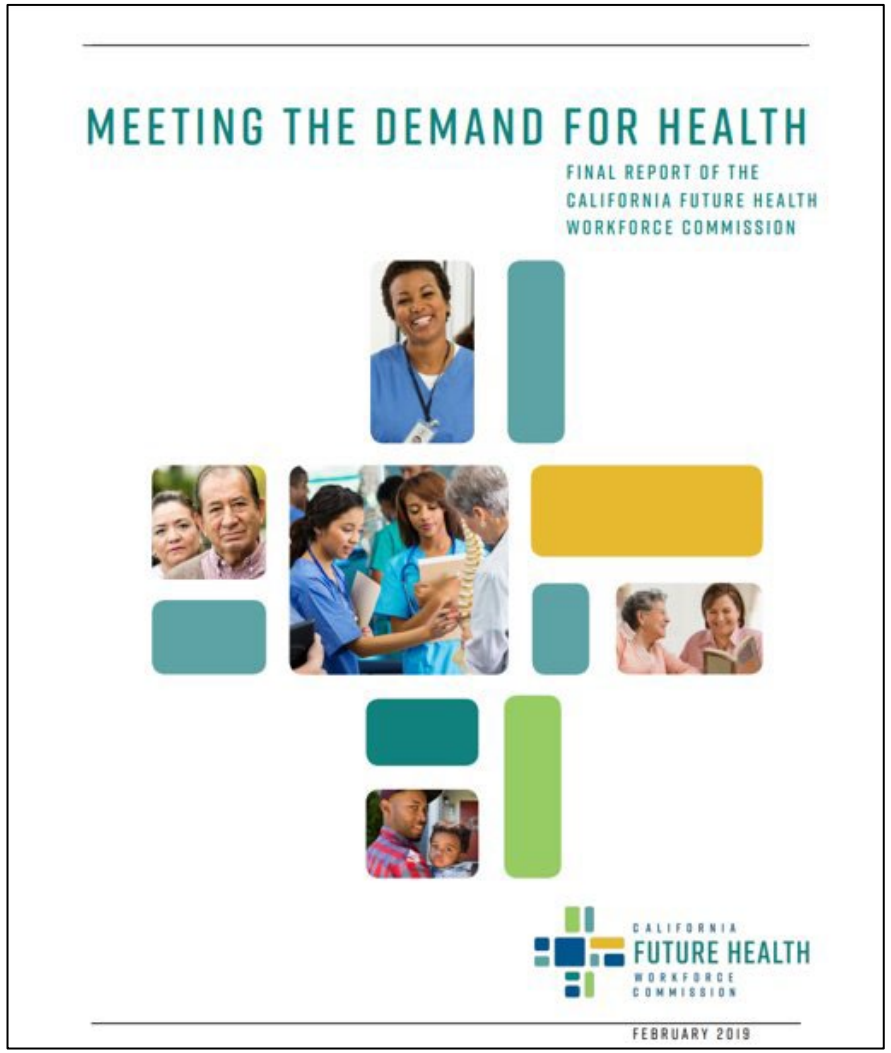
Statutory Requirements

- **The Board approves standards to advance the stability of the health workforce that may apply in the approval of performance improvement plans.**
- OHCA may require a health care entity to implement a performance improvement plan that identifies the causes for spending growth and shall include specific strategies, adjustments, and action steps the entity proposes to implement to improve spending performance during a specified time period. 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.

Health and Safety Code §§ 127501.11 and 127502.5

Why Workforce Stability?

- California currently faces a significant health workforce shortage, including an imbalanced geographic distribution of health care workers.
- Health workforce challenges contribute to lack of access to needed services, including preventive services; delays in receiving appropriate care; and preventable hospitalizations.
- Efforts to slow spending growth may have unintended negative consequences if health care entities reduce labor costs through staffing reductions.
- A stable, well-prepared, and adequately supplied workforce is essential to a sustainable health care system that provides high-quality, equitable care to all Californians.
- No other state has included workforce stability standards in its spending target efforts.



Sources: California Future Health Workforce Commission (2019, February 1). *Meeting the demand for health: Final report of the California Future Health Workforce Commission*. https://futurehealthworkforce.org/our-work/finalreport/; Health Affairs Council on Health Care Spending & Value (2023, February). *A Road Map for Action.* https://www.healthaffairs.org/pb-assets/documents/CHS_Report/CHS_Report_2022_R5-1675432678.pdf

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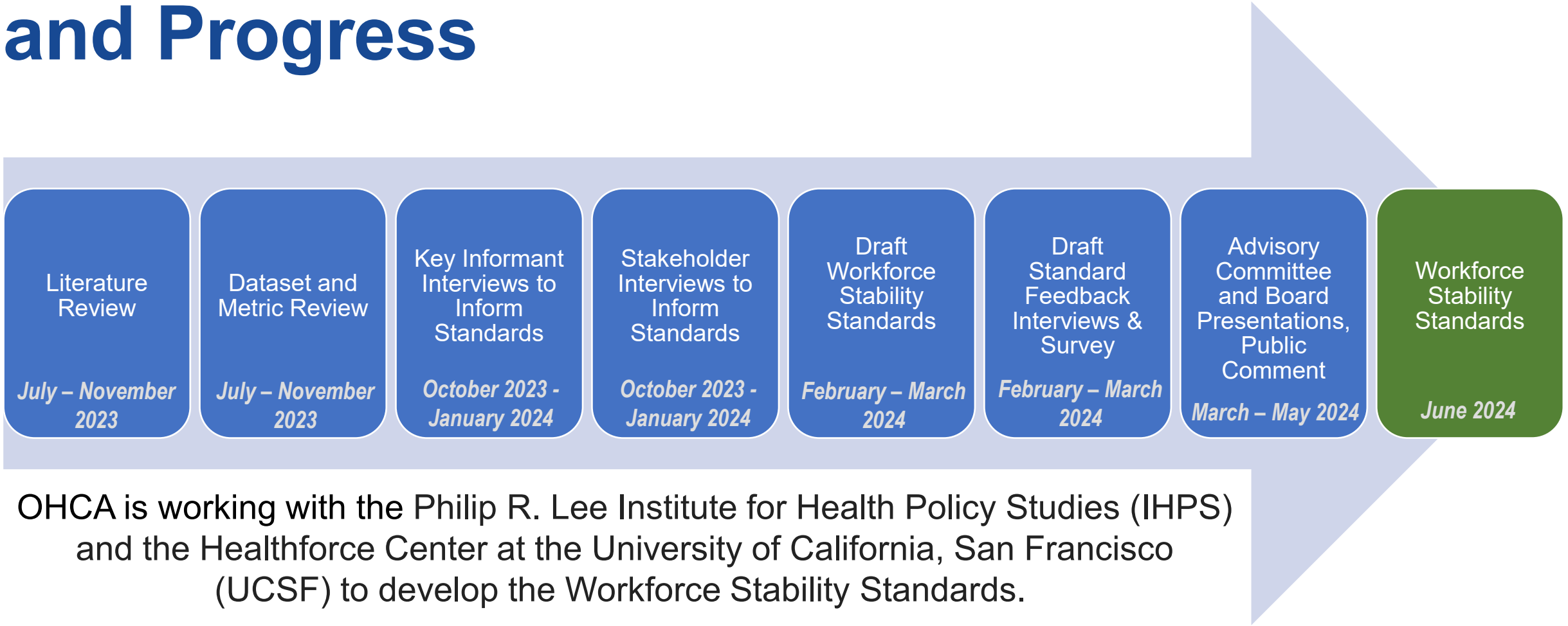
Workforce Stability Standards Process and Progress



OHCA is working with the Philip R. Lee Institute for Health Policy Studies (IHPS) and the Healthforce Center at the University of California, San Francisco (UCSF) to develop the Workforce Stability Standards.

* Dates subject to change.

Literature Review Key Takeaways

Organization Level

- There is no consensus definition for health workforce stability.
- Definitions and measures for turnover and retention vary from study to study:
  - Intention to leave and intention to stay are proxies that are often used to determine turnover and retention.
  - Most studies evaluate voluntary (vs. involuntary) turnover.

Labor Market Level

- Labor costs are one of the most significant contributors to health care expenditures.
- Market level factors contributing to workforce shortages include:
  - Licensure delays;
  - Poor working conditions;
  - Wages;
  - Population need and/or economic demand for workers; and
  - Exits from the workforce.

There is a lack of literature assessing the impact of mandatory or voluntary health care spending targets on health care workforce stability.

Dataset & Metric Review Key Takeaways

Organization Level

- HCAI collects high-quality data for specific types of health care providers (e.g., hospitals, licensed clinics).
- Employment Development Department and Civil Rights Department collect comprehensive data across settings.
- Other public data sources include CMS' Payroll-Based Journal data for federally certified nursing homes.
- The American Hospital Association Annual Survey, though proprietary, may be useful.

Labor Market Level

- State-level workforce trends can be tracked and compared across industries using national population and employer surveys.
- For licensed occupations, supply, geographic distribution, and demographic characteristics can be tracked using the HCAI Health Workforce License Renewal Survey.
- Trends in numbers of graduates and their racial/ethnic diversity can be monitored using Integrated Post-secondary Education Data System data.

Public data sources are available to support tracking several potential workforce stability metrics. Data lag for the most comprehensive sources is a challenge.

Workforce Stability Standards: Who Do They Apply To?

- Statute uses the language “nonsupervisory health care workforce” and “frontline health care workers."
- OHCA interprets the statute to exclude the supervisory workforce, including physicians, dentists, and pharmacists, from the workforce stability standards.
- Several stakeholders suggested including physicians, particularly primary care providers (PCPs), in the standards.
- In the future, OHCA may broaden the standards and metrics to include PCPs or other supervisory providers. OHCA proposes to focus on nonsupervisory health care workers in the initial standards and metrics.
- OHCA will collaborate with HCAI’s Office of Health Workforce Development to understand trends in the physician workforce.

Findings from Interviews to Inform Standards

Suggested Potential Benefits of Standards	• Illuminate drivers of workforce challenges. • Create a common language about workforce needs. • Identify employers that may be responding to the spending targets in ways that negatively impact patients and the workforce. • A more stable workforce has the potential to reduce healthcare costs.
Suggested Potential Challenges of Standards	• Each health care entity is unique, which could create challenges in developing statewide standards. • Care delivery innovation could be stifled. • Administrative burden of potential new reporting requirements.
Opinions on Focus of Workforce Standards	• Some advocate for equal consideration of all settings and professions. • Others suggest focusing on specific settings (hospitals, nursing homes, primary care) and professions (e.g., behavioral health, primary care workforce, nurses, CHWs / Promotores).

List of key informant and stakeholder interviewees to inform workforce stability standards available in Appendix.

Approach to Workforce Stability Standards and Metrics

Standards

- Best practices for health care organizations to adopt.
- Organizations should implement these practices and track related key performance indicators to help ensure a stable workforce.
- No financial penalties associated with noncompliance, but these standards will inform the development of standards that may apply in performance improvement plans for entities exceeding the spending target.

Metrics

- Use publicly available data to monitor workforce stability at the organization level and the market level to complement the standards.
- Evaluate collection of new data for KPIs and may add performance expectations to the standards in future years.
- Publicly report on metrics in OHCA's annual report.

Draft Workforce Stability Standards

1. Monitor a priority set of key performance indicators of health care workforce stability. Relevant indicators to monitor include:

- Turnover rates;
- Retention rates;
- Vacancy rates;
- Contract and temporary labor use rates;
- Time to fill vacant positions;
- Percentage of employees eligible for benefits (e.g., health benefits, paid time off, and retirement);
- Employee engagement, including assessing for job satisfaction, burnout, and moral injury;
- Investment in continuing education, professional development, and training programs; and
- Diversity of workforce and languages spoken in relation to the population served.

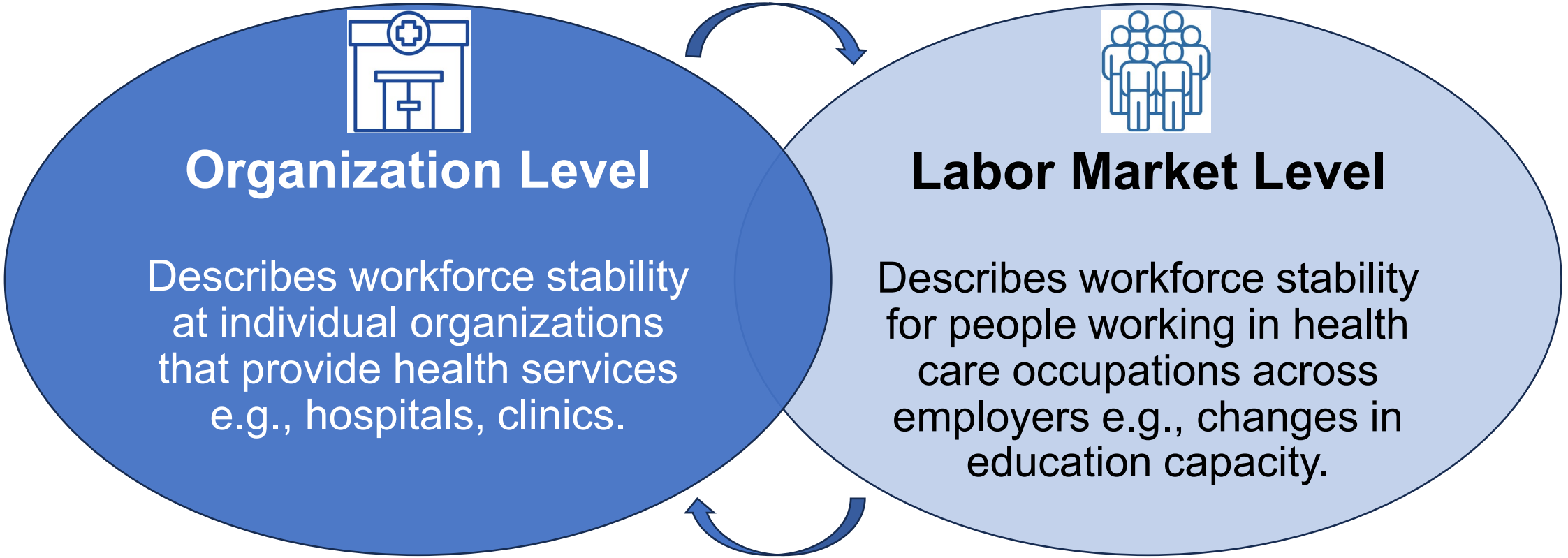
2. Develop formal processes to adapt to changing workforce conditions. Establish policies and procedures to adjust hiring, training, and other practices based on the key performance indicators and market level influences.

Draft Workforce Stability Standards

3. Invest in training opportunities for health care workers. Such training includes developing new skills to adapt to changing health care delivery models that support affordability, access, quality, equity, and culturally and linguistically competent care, and supporting advancement of entry-level and non-clinical workers (e.g., housekeeping staff) to other occupations within the organization through career ladders.
4. Increase the use of interdisciplinary health care teams and other care delivery innovations to improve affordability, access, quality, and equity. Interdisciplinary teams allow workers to practice at the top of their scope, training and license or certificate, improve care, incorporate emerging worker classifications, and may reduce burnout.
5. Center culturally and linguistically competent care. Access to high-quality, equitable care across all communities requires a health care workforce that represents California's people, speaks their languages, and understands their cultures. Prioritize hiring, employee advancement, and care delivery practices that advance equitable care.
6. Monitor and address workplace safety and violence. Continually monitor workplace safety and violence and implement policies and procedures to ensure safe working conditions for all health care workers.

Workforce Stability: Levels of Analysis

OHCA will monitor workforce stability at the organization and the labor market levels.



Draft Workforce Stability Metrics: Organization Level Monitoring

Organization	Data Source	Example Occupations	Example Metrics
Hospitals	HCAI Hospital Annual Financial Disclosure Reports	• Registered nurses • Clerical & other administrative staff • Environmental & food service staff • Registry nursing personnel	• Average hours per patient day for daily hospital services, for each occupation. • Average hourly pay rate for daily hospital services, per occupation. • Contract nursing personnel hours divided by total nursing hours, for daily hospital services. • Average hourly rate of contract nursing personnel divided by average hourly rate of staff registered nurses. • Salaries, wages, and benefits costs as percentage of total operating expenses.

Note: Other entities to be monitored using HCAI data are nursing homes/skilled nursing facilities and community clinics. The complete set of draft metrics for organization level monitoring can be found in the Appendix.

Draft Workforce Stability Metrics: Market Level Monitoring

Data Source	Geographic Areas	Example Occupations	Example Metrics
California Licensure Board records and HCAI license renewal surveys	• Statewide • CBSAs & CSAs* • Counties • California Economic Strategy Panel regions	• Advanced Practice Registered Nurses • Licensed Marriage and Family Therapists • Occupational Therapists	• Number licensed • Age distribution • Race/ethnicity • Languages spoken • Average number of hours worked per week
US Integrated Postsecondary Education Data System	• Statewide • CBSAs & CSAs • Counties • California Economic Strategy Panel regions	• Dozens of program classifications, in category “51. Health Professions and Related Clinical Services”	• Awards/degrees conferred • Awards/degrees by race/ethnicity
California Board of Registered Nursing Annual Schools Survey	• Statewide • California BRN regions (based on California Economic Strategy Panel regions) • Counties	• Registered nurses	• New student enrollments • Number of completions • Race/ethnicity, gender, and age distribution of completions

*CBSA = Core Based Statistical Area, CSA = Combined Statistical Area, as defined by U.S. Census Bureau.
The complete set of draft metrics for market level monitoring can be found in the Appendix.

Key Themes from Advisory Committee, Interviews, and Surveys

Workforce Stability Standards	
Feedback Theme	**OHCA's Response**
• Ensure standards are measurable. • Improve clarity of terms used in standards. • Address workplace safety. • Include physician workforce in standards.	• Metrics OHCA proposes to monitor are informed by standards • Updated standards for clarity and measurability. • Added standard for workplace safety. • Will collaborate with HCAI's Workforce Office to understand trends in the physician workforce using HCAI data.

Key Themes from Advisory Committee, Interviews, and Surveys

Key Performance Indicators (KPIs) in Standard 1	
Feedback Theme	**OHCA's Response**
• Include standardized definitions for KPIs. • Some stakeholders strongly favor mandatory reporting by entities, others prefer to rely on existing publicly available data. • General agreement that turnover rates, retention rates, vacancy rates, and contract/temporary labor use rates are important KPIs. • Measure use of contract labor. • Address burnout and moral injury.	• HCAI is evaluating collection of new data including turnover rates, retention rates, vacancy rates and contract/temporary labor use rates, include developing standard definitions. Evaluating options to leverage HCAI data collection processes. It will take time to adopt regulations for potential new reporting. • Modified KPI for employee engagement to include burnout and moral injury. • Added KPI for use of contract labor.

Key Themes from Advisory Committee, Interviews, and Surveys

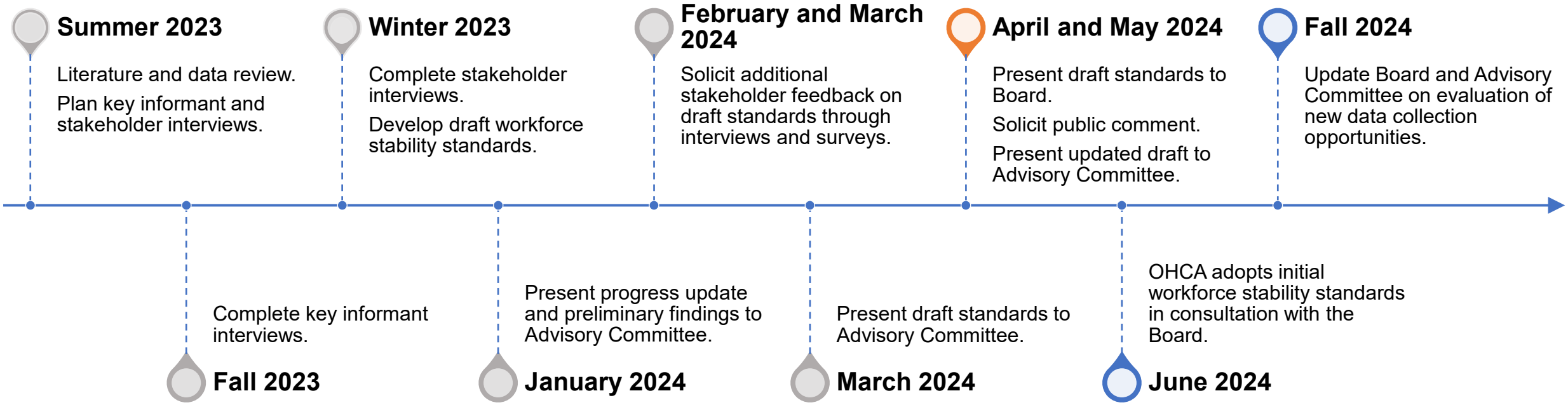
Organization and Market Level Metrics	
Feedback Theme	**OHCA's Response**
• Monitor more unlicensed occupations including CHWs, promotores, doulas, peer support specialists, violence prevision specialists. • Monitor more ambulatory settings, especially primary care and behavioral health. • Monitor worker safety and layoffs.	• Metrics include publicly available data on suggested non-licensed occupations. • Evaluating options for addressing data gaps for ambulatory settings and behavioral health. • Evaluating data sources to monitor worker safety and layoffs.

Ongoing Evaluation: Data Collection Opportunities

- Regarding the request for mandatory reporting by entities, OHCA is evaluating collection of new data for KPIs.
    - Investigating regulatory and data analytic requirements.
- OHCA is evaluating recommended external data sources for organization and market level analyses.
    - Investigating data sources that would require an MOU.
    - Assessing resources required for data extraction and analysis.
- Timeline for this work will extend beyond July 2024 deadline for OHCA to adopt initial workforce stability standards.

Next Steps

OHCA will continue to refine the draft standards and metrics based on stakeholder and public feedback, and with input from the Advisory Committee and Board, in anticipation of OHCA adoption of final standards in June 2024.



* Dates subject to change.

HCAI Department of Health Care Access and Information

Workforce Stability Standards and Metrics

Does the Board have any feedback on:

1. Proposed workforce stability standards?
2. Proposed workforce stability metrics?

HCAi
Department of Health Care Access and Information

Public Comment

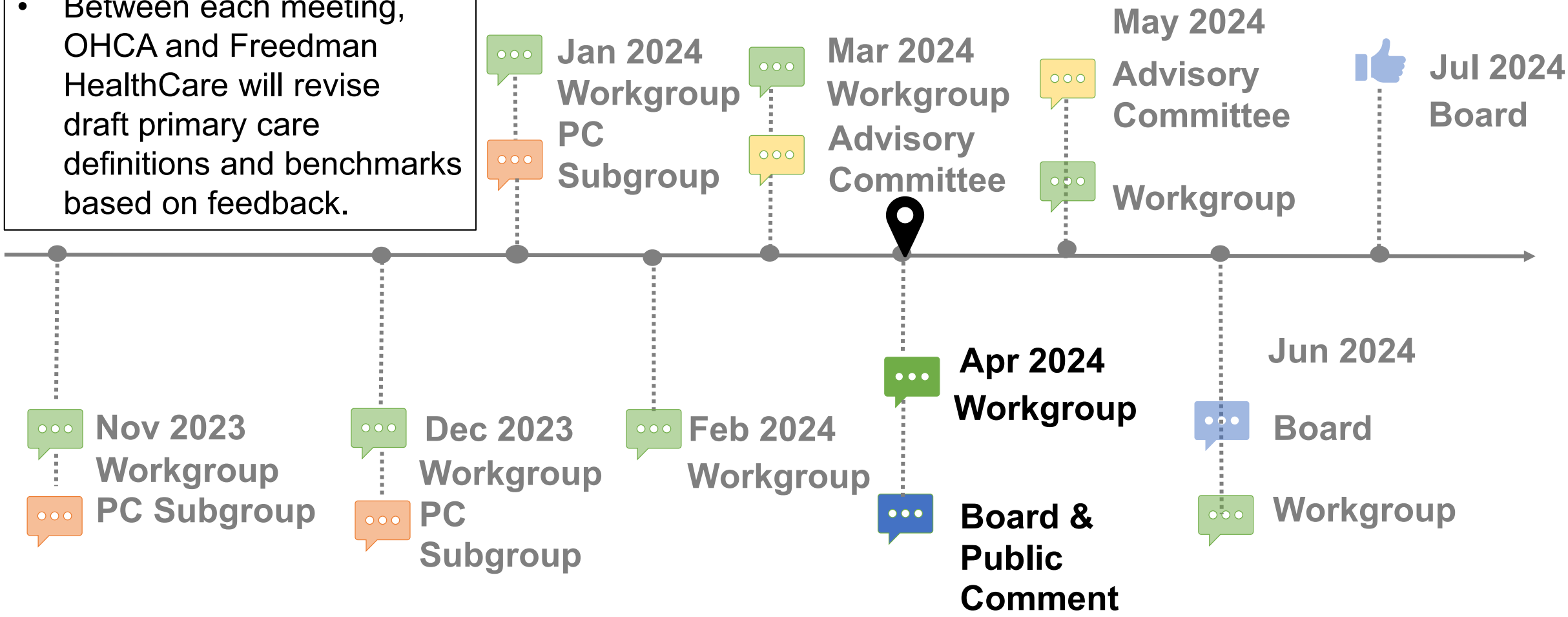
HCAi
Department of Health Care Access and Information

Draft Primary Care Spending Definition and Benchmark, Including Summary of Advisory Committee Feedback

Margareta Brandt, Assistant Deputy Director

Timeline for Primary Care Work

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



* Dates subject to change.

HCAI Department of Health Care Access and Information

Primary Care Investment

Statutory Requirements

- Measure the percentage of total health care expenditures allocated to primary care and set spending benchmarks that consider current and historic underfunding of primary care services.
- Determine the categories of providers, specific procedure codes, and non-claims payments that should be considered when determining the total amount spent on 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.
- Promote improved outcomes for primary care and sustained systemwide investment in primary care.
- Include an analysis of primary care spending and growth 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.

Primary Care Investment

Statutory Requirements

- The Board approves the benchmark for primary care spending.

Why Primary Care?

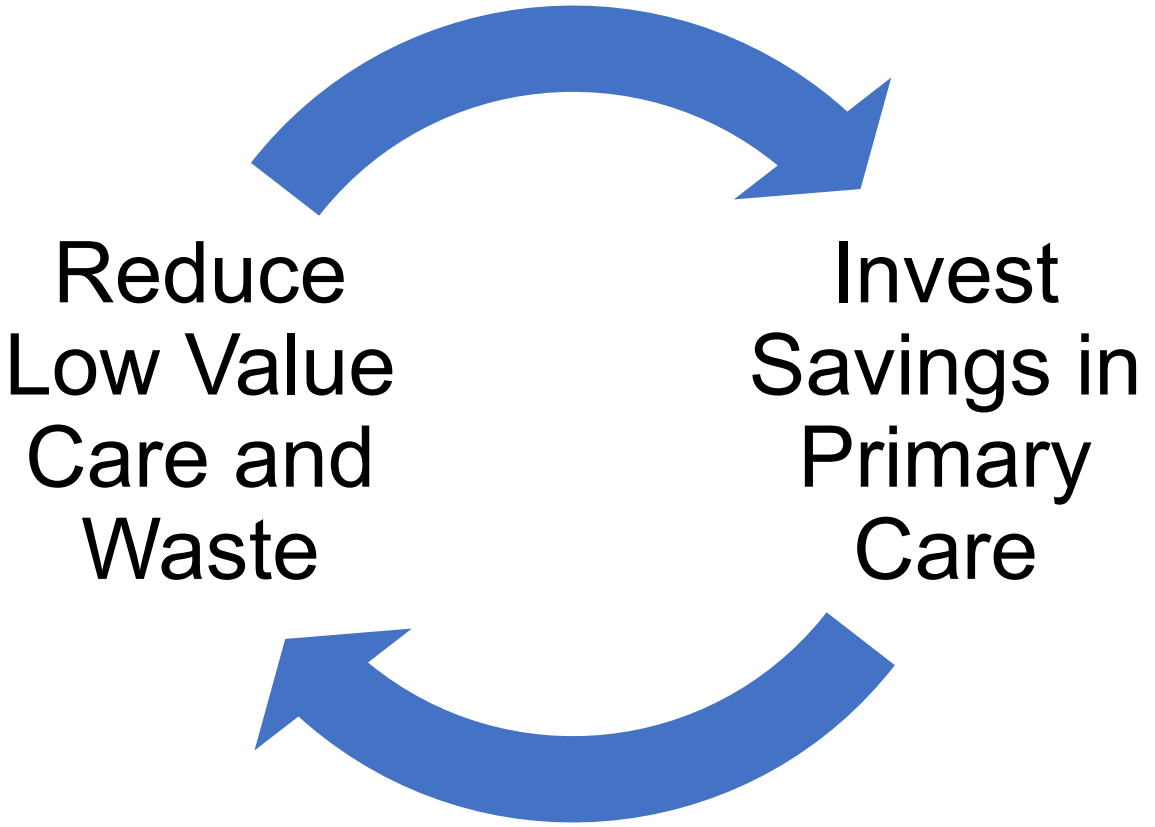
Increased supply of primary care services leads to more equitable outcomes and improved population health (e.g., life expectancy, rates of chronic disease, and other critical measures).

- High functioning health care systems require high quality primary care as a foundation.
- Primary care investment in the United States – which typically ranges from 4% to 7% – lags other high-income nations with higher performing health care systems. In these countries, primary care investment tends to be 12% to 15% of total spending.
- Primary care investment in California was 6.3% of total spending across all payers in 2020, compared to 4.6% nationally, a recent national study found.

Sources: National Academies of Sciences, Engineering, and Medicine. (2021). *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983; Jabbarpour Y. et al. (2023, February 22). Milbank Memorial Fund. *The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care*. https://www.milbank.org/publications/health-of-us-primary-

Impact of Investing in Primary Care

"In addition to improving health outcomes and equity, primary care contributes to lower overall health care spending. In recent years, studies have shown **associations between more primary care and less low-value care**, both among health systems and in the Medicare fee-for-service population; **higher primary care continuity and lower costs and hospitalizations**; and broader, more **robust practice capabilities and lower utilization and spending**. As the evidence mounts, it has become clear that a health care system with sustainable costs will rely on robust primary and preventive care that **keeps people healthy and reduces unnecessary and low-value care**."



Source: Yegian, J. *The Case for Investing in Primary Care in California*. California Health Care Foundation. April 2022 (page 3, footnotes 18-21). https://www.chcf.org/wp-content/uploads/2022/04/CaseInvestingPrimaryCare.pdf.

One Vision for Primary Care Delivery in CA

- Accessible
- Person- and family- centered
- Relationship-based
- Integrated
- Team-based
- Coordinated
- Comprehensive
- Equitable

The Investment and Payment Workgroup noted the need for sustainable and well-resourced primary care to achieve the vision.

Source: California Quality Collaborative (CQC). (June 2020, revised April 2022). *Advanced Primary Care: Defining a Shared Standard*. Purchaser Business Group on Health (PBGH). https://www.pbgh.org/wp-content/uploads/2022/04/advanced-primary-care-shared-standard.pdf

OHCA's Draft Primary Care Spending Measurement Definition and Methodology

Framing the Measurement

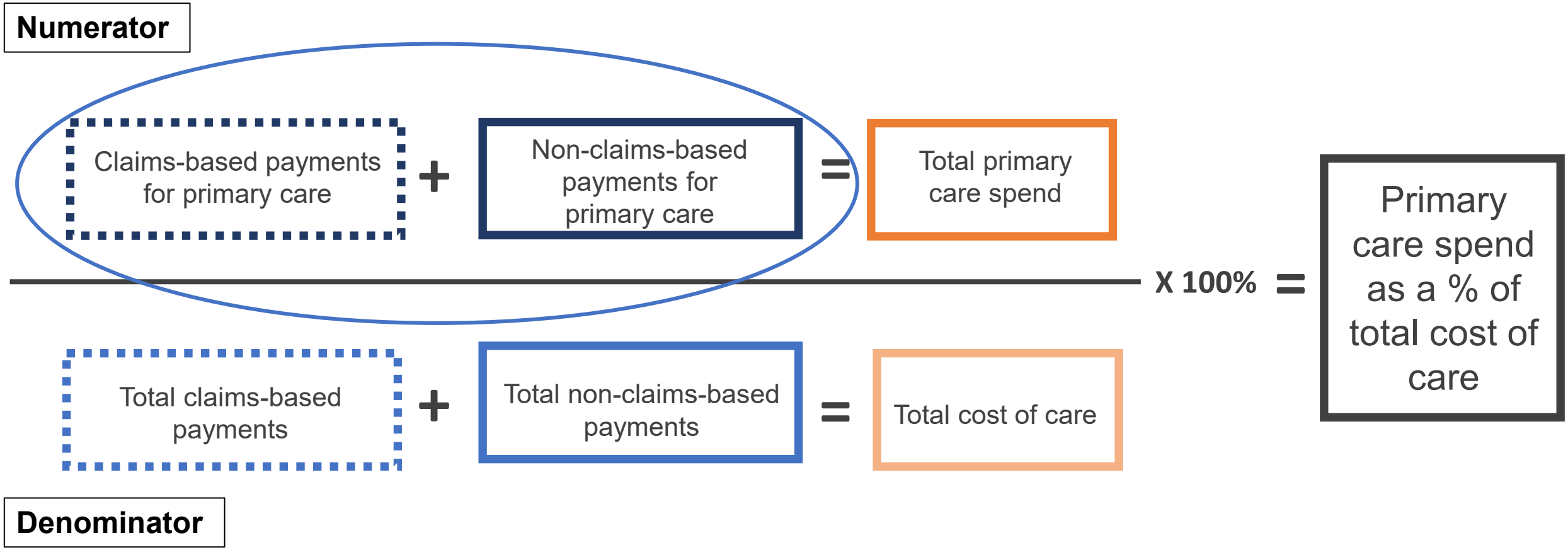
What will be measured

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

What won't be measured

Money providers spent delivering primary care services.

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

Data Source for Measuring Primary Care Spending

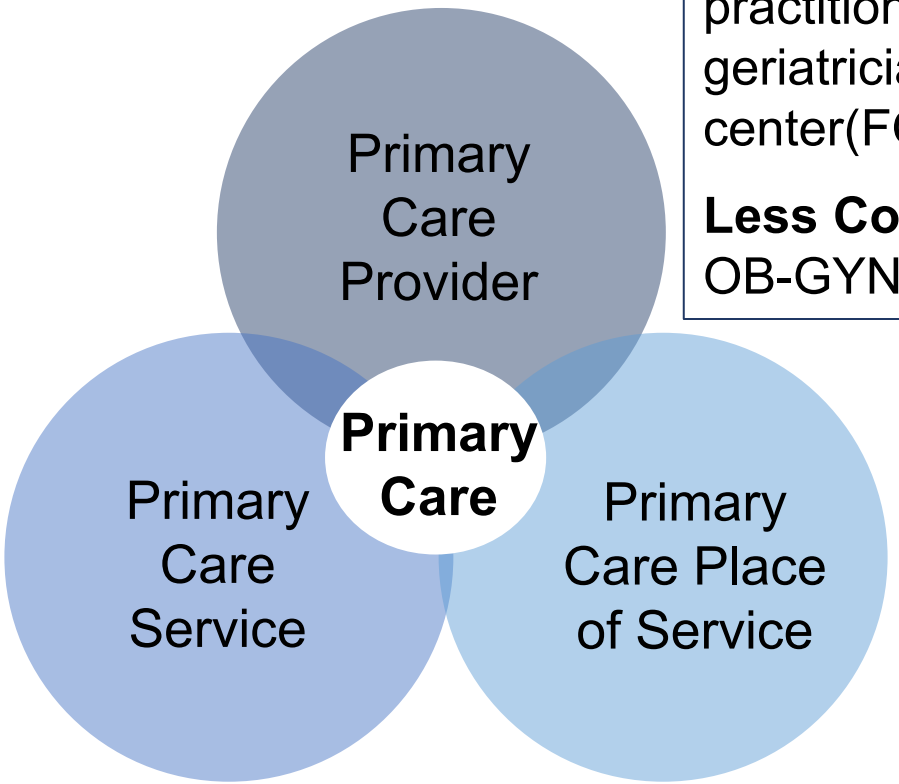
- OHCA will collect data to measure primary care spending as part of its larger Total Health Care Expenditures (THCE) data collection efforts.
- Primary care spending data will include claims and non-claims payments, which will be categorized using the Expanded Framework.*
- OHCA will provide definitions, technical specifications, and technical assistance to submitters to support accurately allocating payments to primary care, including for non-claims payment categories.

*Available in the appendix and reviewed at the February Board meeting:
https://hcai.ca.gov/wp-content/uploads/2024/02/February-2024-Board-Meeting-Presentation.pdf

Defining Primary Care

Most Common Provider Types: Family medicine, general practice, internal medicine, pediatrics, nurse practitioner(NP)/physician's assistant(PA), geriatrician, federally-qualified health center(FQHC) /rural health center (RHC).

Less Common Provider Types: Nurse, OB-GYN, behavioral health.



Most Common Service Codes: Office visits, preventive visits, vaccine admin, screenings, care coordination and management.

Less Common Service Codes: Procedures, behavioral health, maternity.

Most Common Places of Service (POS): Office, telehealth (home or other), walk-in retail clinic, FQHC/RHC, home.

Less Common POS: Worksite, urgent care, school.

Three Modules for Measuring Primary Care Spending

Benchmark calculation will include all three modules.

Primary Care Paid Via Claims

- Combination of primary care provider, service, and place of service.

Primary Care Paid Via Non-Claims

- Allocate a portion of non-claims spend to primary care.

Behavioral Health in Primary Care

- Screening, office visits for BH diagnosis with PCPs.
- Counseling, therapy when by a PCP or via integrated behavioral health.

Could be added to BH or PC spend calculation.

Primary care measurement could be supplemented with additional analysis through the Health Care Payments Data program (HPD).

Overview of Claims-based Primary Care Spending Measurement Approach

Include a narrow or broad set of providers?

- Include a broad set of providers to reflect statutory goal of team-based care.
- Exclude OB-GYN providers to be consistent with focus on providers caring for the whole patient.

Should the definition be limited to certain places of service?

- Include restrictions on places of service to reflect vision of continuous and coordinated care.

Include a narrow or expanded set of services, or all?

- Include an expanded set of services to encourage as much care as possible and appropriate to be delivered in a primary care setting.
- Include a limited set of behavioral health services when provided by a PCP.

See Appendix for detailed approach to measuring claims-based primary care spend.

Overview of Non-Claims Payments Approach

OHCA has:

- In partnership across HCAI, developed the Expanded Non-Claims Payment Framework to collect information non-claims payments data.
- Developed approaches to each non-claims category to understand the portion of payments intended for primary care.
- Collaborated with submitters on methodology to apportion shared savings and capitation payments allocated to primary care.
- Reviewed approaches to apportioning non-claims payments to primary care with the Investment and Payment Workgroup and its Primary Care Subgroup, Advisory Committee, and sibling departments.

Methods provide directional estimates of non-claims payments supporting primary care.

Source: Pegany, V., Brandt, M., Tran, N., et al. (2024, March 18). *A New Standard for Categorizing and Collecting Non-Claims Payment Data*. Milbank Memorial Fund. https://www.milbank.org/2024/03/a-new-standard-for-categorizing-and-collecting-non-claims-payment-data/

Overview of Non-Claims-Based Primary Care Investment Measurement Approach

Category 1 & 2: Population Health, Practice Infrastructure and Performance Payments

- Include payments for primary care programs such as care management, care coordination, population health, health promotion, behavioral health or social care integration; performance incentives of patients attributed to primary care providers.
- Limit the portion of practice transformation and IT infrastructure payments that "count" as primary care to 1% of total medical expense.

Category 3: Shared Savings and Recoupments

- Limit portion of risk settlement payments that "count" as primary care to the same proportion that claims-based professional spend represents as a percent of claims-based professional and hospital spending.

Category 4: Capitation Payments

- For primary care capitation, payers allocate 100% to primary care.
- For others, data submitters calculate a ratio of fee-for-service equivalents for primary care services to all services in the capitation. Multiply the ratio by the capitation payment.

See Appendix for detailed approach to measuring non-claims-based primary care spend.

Recent Workgroup and Advisory Committee Feedback on Measurement Approaches

- Highlighted the distinction between measuring primary care spending by **plans** and by **provider organizations.** Primary care spending by provider organizations may not be captured by counting encounters and applying FFS equivalents. Examples:
  - Population health management capabilities.
  - Non-billable providers.
  - Pay for performance programs managed by the provider organization (not the plan).
- Measuring how provider organizations distribute capitation payments to downstream primary care providers would require additional, flexible data collection.
  - OHCA should start investigating such data collection as part of long-term planning.
- Some concerns about whether encounter data would be of sufficient quality and completeness to support the analysis, regardless of the calculation approach.
- Payers who have provided feedback to OHCA mention that the capitation approach reflects payments intended for primary care that are not tied to encounters.

Primary Care Spending Measurement Definition and Methodology

Does the Board have any feedback on:

1. Proposed claims-based definition of primary care?
2. Proposed approach to allocating non-claims payments to primary care?

OHCA's Recommended Primary Care Investment Benchmark

Key Decisions for Setting a Primary Care Benchmark

	CA*	CT	DE	RI	OR	CO
Which payer types does the benchmark apply to?	All	All	Commercial	Commercial	Commercial & Medicaid	Commercial
Single or separate benchmarks by age group?	Single	Single	Single	Single	Single	Single
Percentage or Per Member, Per Month (PMPM)	%	%	%	%	%	%
Absolute or relative improvement?	Absolute (with relative)	Absolute (with stair steps)	Absolute (with stair steps)	Absolute, Previously Relative	Absolute	Relative
Benchmark/Target/ Requirement	0.5% to 1% annually; 15% by 2034	10% in 2025	11.5% in 2025**	10.7%	12%	1% annually

*OHCA's preliminary recommendations.
**Primary care investment requirement only applies to members attributed to providers engaged in care transformation activities.

Three Lessons Learned from Other States

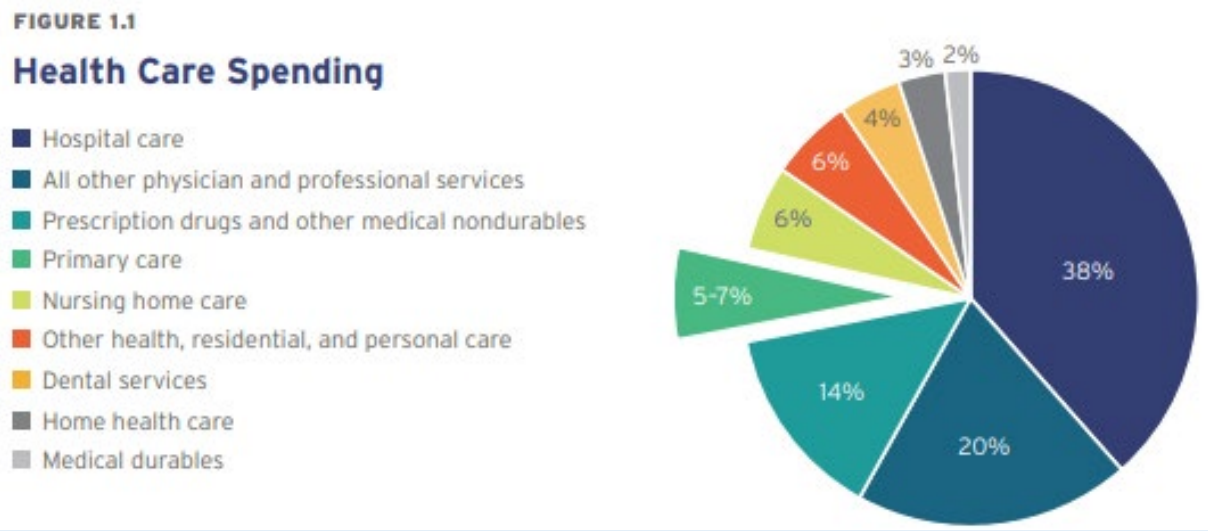
1. **The most successful efforts gradually reallocate spending to primary care.** Efforts to increase investment too quickly may accelerate growth in total cost of care.

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

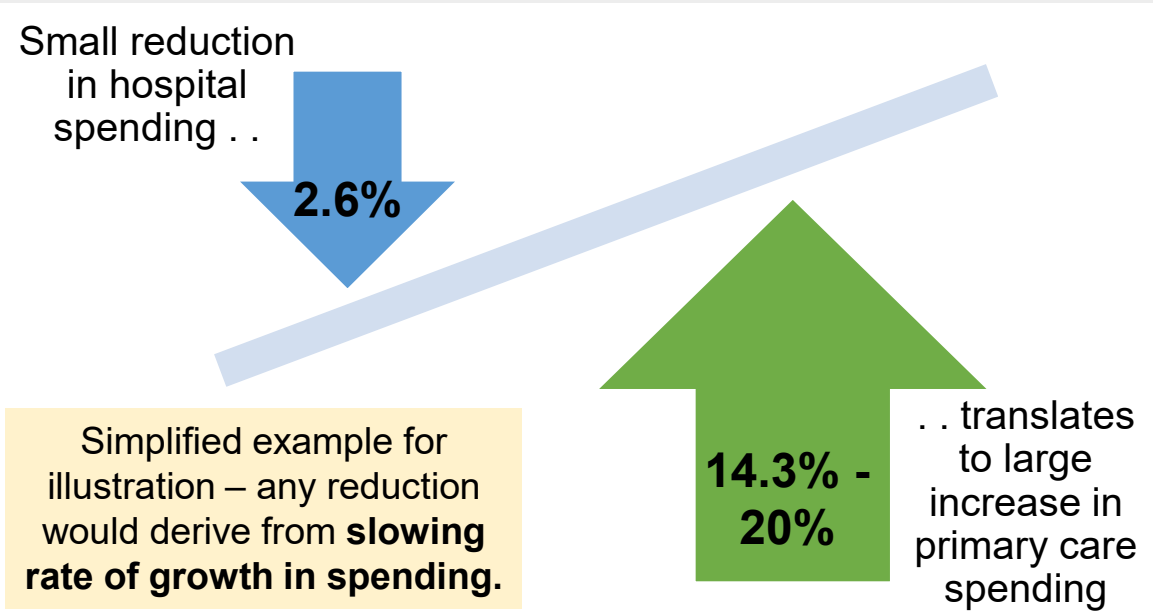
3. **Increases in total cost of care hinder benchmark success.** As total cost of care increases, achieving primary care benchmarks based on percent total medical expense becomes more difficult.

Example: Reallocating Spending Growth to Primary Care

Only about 5-7% of health care spending is for primary care, compared to 38% for hospital care in this national study. **What if one percentage point shifted from hospital care to primary care (in alignment with statutory intent)?**



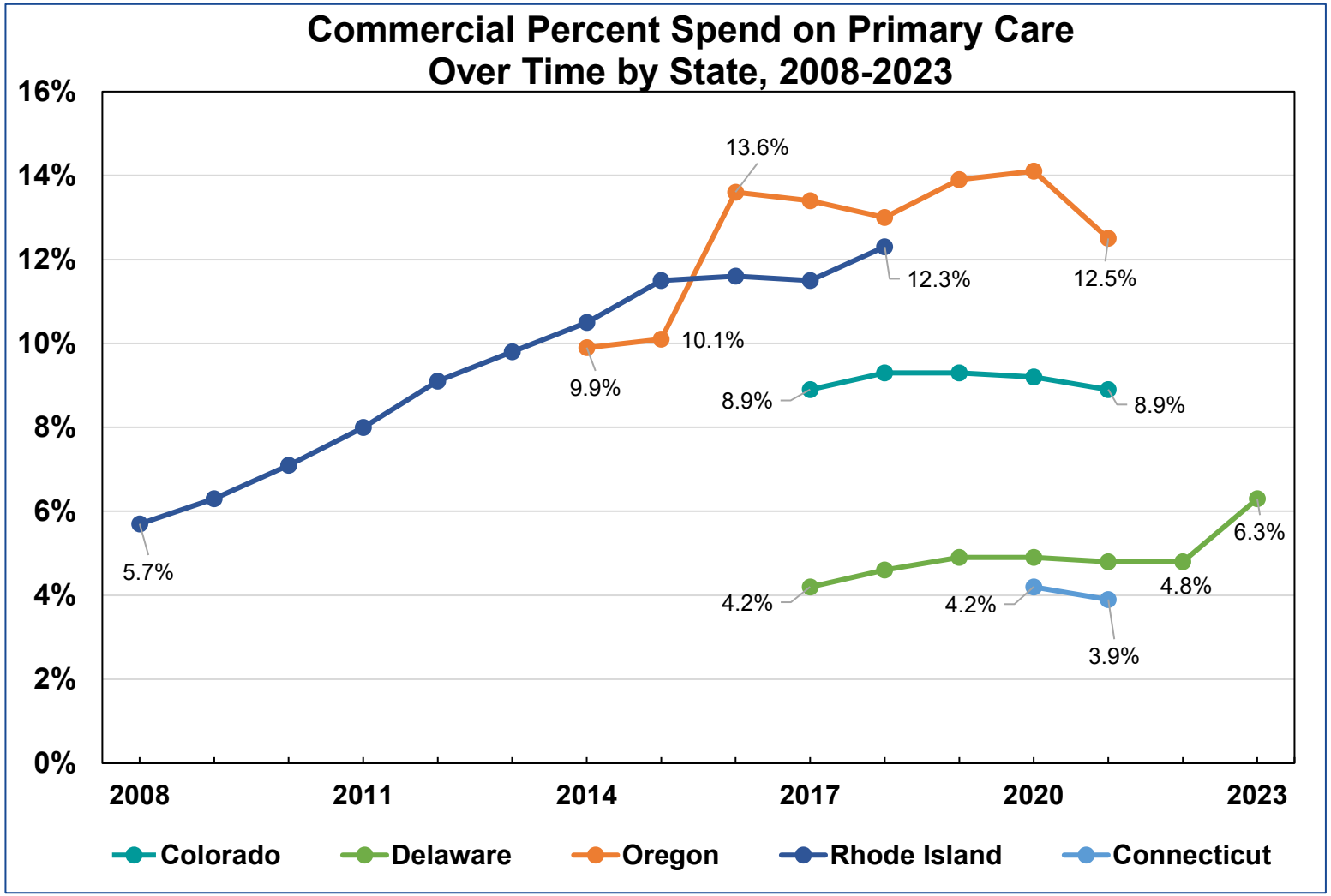
Reallocating one percentage point of spend from hospital care (from 38%→37% TME) to primary care (5-7%→6-8% TME) would **generate substantial primary care investment.**



Simplified example for illustration – any reduction would derive from **slowing rate of growth in spending.**

Source: Jabbarpour et al. Investing in Primary Care: A State-Level Analysis. Patient Centered Primary Care Collaborative, July 2019. https://www.milbank.org/wp-content/uploads/2019/07/2019-PCPCC-Evidence-Report-Final.pdf

Balancing the Pace of Change



- These states have the most experience working to increase primary care investment.
- Four of them are Cost Growth Benchmark states and like California are looking to gradually reallocate more of the healthcare dollar away from lower value services to higher value services like primary care.
- States often aim to shift 1% in TME per year.
- Actual shifts are often more modest, especially when early goals are more dramatic.

Note: State definitions and total cost of care differ, which contributes to differences in investment percentages. The Delaware 2023 figure is a projection.

Draft Primary Care Investment Benchmark Recommendation

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.

Rationale for Level:

- Consistent with other state approaches and experiences.
- Acknowledges payers are at different starting levels.
- Offers gradual reallocation of spending.
- Focus on shifting spend from specialty care and toward primary care.

AND

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

Rationale for Level:

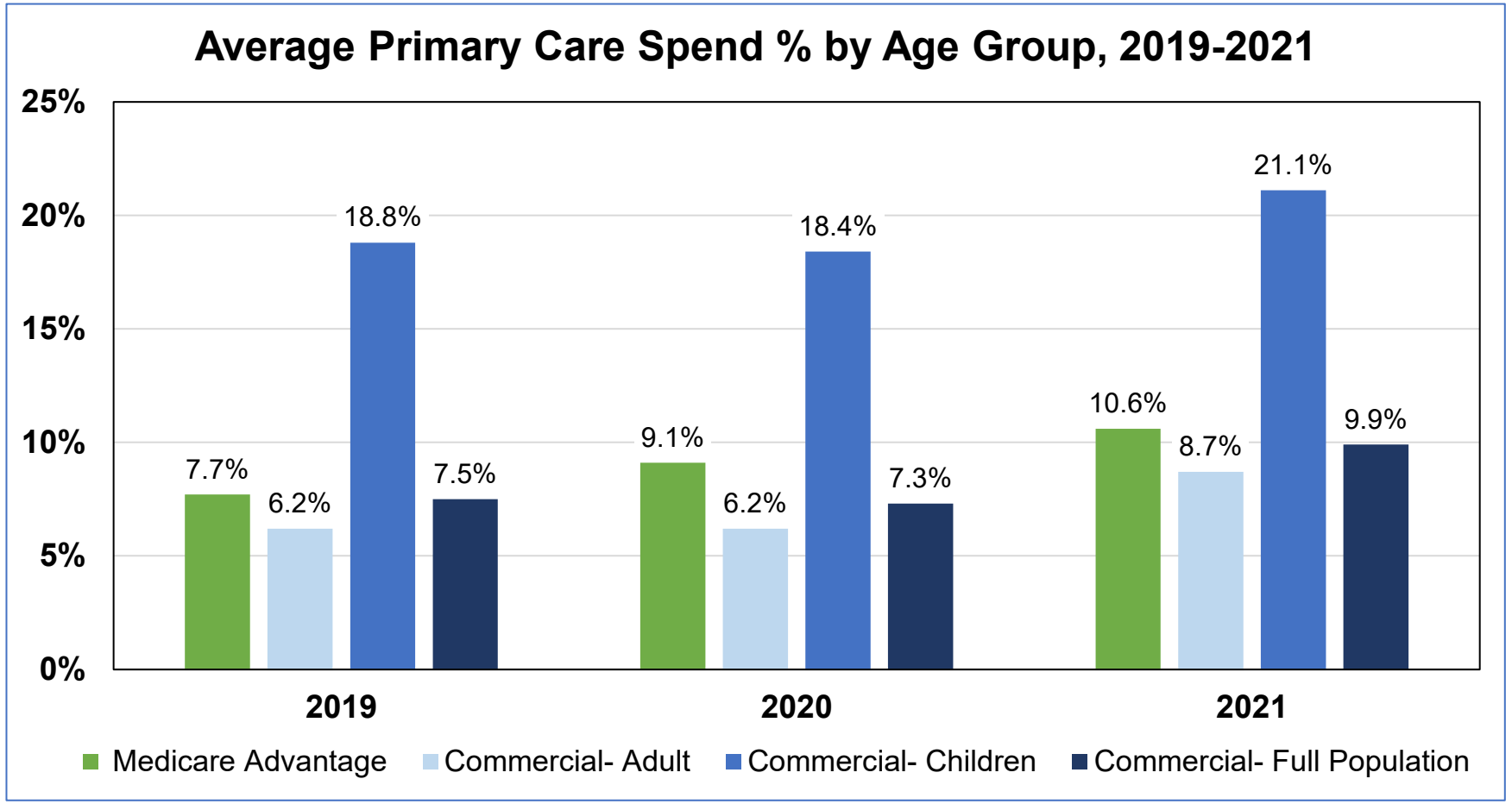
- Internationally, high performing health systems spend 12% to 15% of total spending on primary care.[1]
- States that invest more on primary care tend to spend less on avoidable hospitalizations and ED use.[2]
- Slightly higher than other states, recognizing California's healthcare delivery goals, delivery system, younger population, and time horizon.

*Payers at or above 15% of total medical expense may refrain from continued increases if not aligned with care delivery or affordability goals.

Sources: Jabbarpour, et al. (2019, July). *Investing in Primary Care: A State-Level Analysis*. Patient-Centered Primary Care Collaborative. https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf.; National Academies of Sciences, Engineering, and Medicine. (2021). *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National

Primary Care Spending for Children and Adults in California

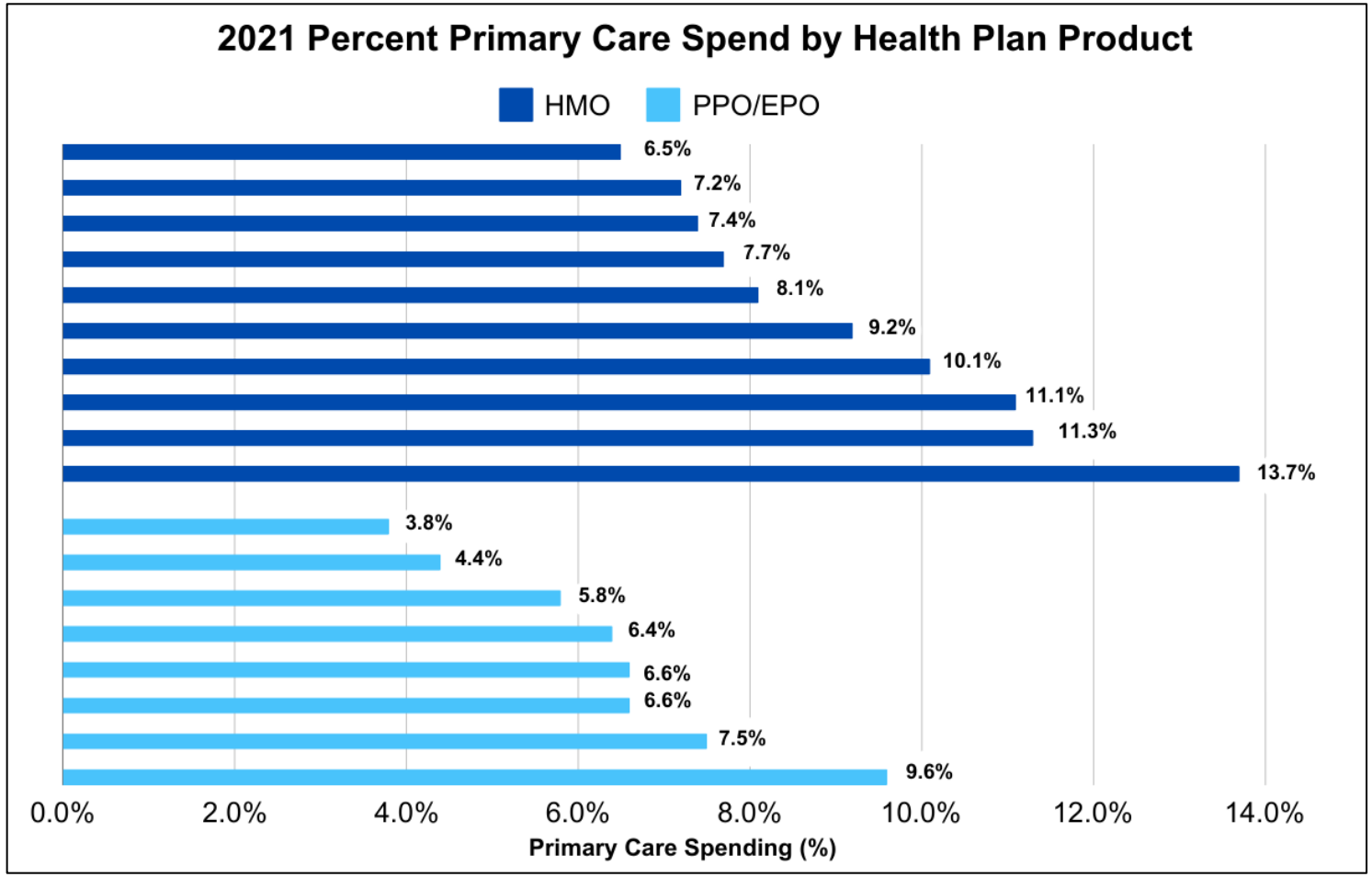
- California commercial plans spent **an average of 7.3% to 9.9%** on primary care services from 2019 to 2021.
- California Medicare Advantage plans spent a similar percentage as commercial plans, with **an average of 7.7%-10.6%** spent on primary care services from 2019 to 2021.



Source: Integrated Healthcare Association analysis of California Commercial primary care spending from 2019-2021. Chart 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, April). https://www.chcf.org/wp-content/uploads/2022/04/InvestingPrimaryCareWhyItMattersCommercialCoverage.pdf

Primary Care Spending by Commercial Payer-Product Type

- 2021 commercial data from the Integrated Healthcare Association shows that primary care spend varies by product type and within product types.
- PPO/EPO (6.3%) had a lower average percent primary care spend for 2021 than HMO (9.2%).
- The primary care benchmark seeks to reflect these differences.



Source: Integrated Healthcare Association analysis of California Commercial primary care spending in 2021. Chart 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, April). https://www.chcf.org/wp-content/uploads/2022/04/InvestingPrimaryCareWhyItMattersCommercialCoverage.pdf

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.

Source: California Health Care Foundation. (2022, July 25). *Investing in Primary Care: Why it Matters for Californians with Medi-Cal Coverage.* https://www.chcf.org/publication/investing-in-primary-care-why-it-matters-for-californians-with-medi-cal-coverage/

Recent Workgroup and Advisory Committee Feedback on the Primary Care Benchmark

- Advisory Committee members who commented were in support of separate pediatric and adult benchmarks.
    - One member suggested considering a separate benchmark for older adults.
- A few members emphasized focusing on pediatric primary care to ensure adequate investment.
- Pediatric primary care spend is higher – large number of encounters that have a lower cost.
- There is logic behind the goal, and it seems aspirational but achievable.
- The main feedback on the 10-year horizon was that change takes time and OHCA should allow for that.

Considerations for Single Benchmark

- A single benchmark based on statewide population distribution that reflects appropriate annual increases in primary care spend emerged as the best option.
- OHCA can conduct future analyses via the HPD to understand the claims-based pediatric vs. adult primary care spend. OHCA and HPD also will explore options for separating non-claims payments by age group and seek stakeholder feedback on these options.
- OHCA will monitor and report progress on the relative improvement benchmarks per payer in its annual report to ensure progress is made towards the absolute benchmark.
    - OHCA can complement reporting on progress with the distribution of each payer's population by age.

Draft Primary Care Investment Benchmark Recommendation

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.

Rationale for Level:

- Consistent with other state approaches and experiences.
- Acknowledges payers are at different starting levels.
- Offers gradual reallocation of spending.
- Focus on shifting spend from specialty care and toward primary care.

AND

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

Rationale for Level:

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Draft Recommendations for Primary Care Investment Benchmark: Discussion

Does the Board have any feedback on:

1. Using a relative improvement benchmark and a statewide absolute benchmark?
2. The recommended 15% statewide absolute benchmark?
3. The timeframe for achieving the benchmark?

HCAi
Department of Health Care Access and Information

Public Comment

HCAi
Department of Health Care Access and Information

General Public Comment

Written public comment can be emailed to: ohca@hcai.ca.gov

Next Board Meeting:

May 22, 2024
10:00 a.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

HCAi
Department of Health Care Access and Information

Adjournment

HCAi
Department of Health Care Access and Information

Appendix

Key Informant and Stakeholder Interviews to Inform Workforce Stability Standards

Key Informant & Stakeholder Interviewees

Academics & Content Experts

David Auerbach, PhD
Senior Director for Research and Cost Trends,
Massachusetts Health Policy Commission

Bianca Frogner, PhD
Professor of Family Medicine, Director of University of Washington Center for Health Workforce Studies

Polly Pittman, PhD
Professor of Health Workforce Equity, Director of Institute for Health Workforce Equity at George Washington University

University of North Carolina – Chapel Hill, Health Workforce Research Center

Kathryn Phillips, MPH*
Associate Director, Improving Access; California Health Care Foundation (CHCF)

Hemi Tewarson, JD, MPH*
Executive Director, National Academy for State Health Policy

Laurel Lucia, MPP*
Director, Health Care Program at UC Berkeley Labor Center

Paul Kumar
Health Policy and Finance Consultant

BJ Bartleson, MS, RN
Health Policy RN Consultant

Michael Bailit, MBA
President, Bailit Health

Organized Labor

Joan Allen*
Government Relations Advocate, SEIU United Healthcare Workers West

Ian Lewis
Policy Director, National Union of Healthcare Workers

Janice O'Malley
Legislative Advocate, American Federation of State, County and Municipal Employees (AFSCME)

California Nurses Association (CNA)/National Nurses United

Consumer Representatives & Advocates

Cary Sanders*
Senior Policy Director,
California Pan-Ethnic Health Network (CPEHN)

Anthony Wright
Executive Director,
Health Access California

Beth Capell, PhD
Contract Lobbyist,
Health Access California

Health Care Entities & Associations

California Hospital Association (CHA)

Katie Rodriguez, MPP
Senior Director of Policy, California Association of Public Hospitals & Health Systems (CAPH)

Nataly Diaz, MBA*
Director of Health Center Operations, California Primary Care Association (CPCA)

Kaiser Permanente

Sutter Health

Plumas District Hospital

Workforce Stability Standards Interviewees

Academics/Content Experts

- Massachusetts Health Policy Commission: David Auerbach
- George Washington University: Polly Pittman
- California Health Care Foundation (CHCF): Kathryn Phillips, Kara Carter
- UC Berkeley Labor Center: Laurel Lucia, Ken Jacobs, Miranda Dietz
- University of Washington: Bianca Frogner
- University of North Carolina, Chapel Hill
- National Academy for State Health Policy: Hemi Tewarson, Elaine Chhean, Maureen Hensley-Quinn
- Bailit Health: Michael Bailit
- Consultants: BJ Bartleson, Paul Kumar

Workforce Stability Standards Interviewees

Organized Labor

- SEIU United Healthcare Workers West: Joan Allen, Denise Tugade
- National Union of Healthcare Workers: Ian Lewis
- American Federation of State, County, and Municipal Employees (AFSCME): Janice O'Malley
- California Nurses Association (CAN)/National Nurses United

Consumer Representatives & Advocates

- California Pan-Ethnic Health Network (CPEHN): Cary Sanders, Andrea Mackey
- Health Access California: Anthony Wright, Beth Capell

Workforce Stability Standards Interviewees

Health Care Entities

- California Hospital Association (CHA)
- California Association of Public Hospitals & Health Systems (CAPH): Katie Rodriguez
- California Primary Care Association (CPCA): Nataly Diaz, Cindy Keltner, Isa Iniguez, Araceli Valencia
- Plumas District Hospital
- Sutter Health
- Kaiser Permanente

Guiding Principles to Inform Workforce Stability Standards

Principles to Guide Development of Workforce Stability Standards and Metrics

1. Address current workforce shortages and challenges impacting workforce stability (e.g., provider shortages in behavioral health occupations or in rural and underserved urban areas).
2. Monitor for emerging workforce shortages and plan for future workforce needs.
3. Incorporate flexibility to accommodate differences between settings, occupations, and regions.
4. Compare workforce composition across similar health care entities.
5. Track graduations from health professions education programs, licensure requirements, and time to licensure to improve match between workers entering workforce and need.
6. Promote diversity in the workforce and address population need for culturally and linguistically competent care.

Principles to Guide Development of Workforce Stability Standards and Metrics, continued

7. Track the impact of spending targets on most vulnerable health care workers (e.g., unlicensed direct care and long-term care workers) and those who serve vulnerable populations (e.g., disabled, elderly, safety net).
8. Consider tradeoffs of prioritizing monitoring of highest-cost, most-regulated settings (e.g., hospitals) compared to least-regulated settings (e.g., physician offices and other ambulatory care sites) that may need greater oversight.
9. Monitor indicators of understaffing or training gaps at the facility level, such as sentinel safety events or worker's compensation claims.
10. Balance reporting burden for health care entities with the value of additional data to meet OHCA's statutory requirements and goals.

Organization Level Workforce Stability Metrics

Draft Workforce Stability Metrics for Hospitals

Data Source	HCAI Hospital Annual Financial Disclosure Reports	
Occupations	• Technical and specialist staff • Registered nurses • Licensed vocational nurses • Aides and orderlies • Clerical & other administrative staff	• Environmental & food service staff • Other staff • Registry nursing personnel • Other contracted staff
Metrics	• Average hours per patient day for daily hospital services over the fiscal year, for each occupation • Average hours per emergency department visit over the fiscal year • Average hours per clinic visit over the fiscal year • Average hours per clinical laboratory test over the fiscal year • Average hourly pay rate for daily hospital services, per occupation • Average hourly pay rate for ambulatory services, per occupation • Average hourly pay rate for ancillary services, per occupation	• Contract nursing personnel hours divided by total nursing hours, for daily hospital services, over the fiscal year • Average hourly rate of contract nursing personnel divided by average hourly rate of staff registered nurses • Salaries, wages, and benefits costs as percentage of total operating expenses • Salaries & wages per adjusted patient day • Benefits per adjusted patient day

Draft Workforce Stability Metrics for Nursing Homes and Skilled Nursing Facilities

Data Source	HCAI Long-term Care Facility Integrated Disclosure and Medi-Cal Cost Report Data	
Occupations	• Geriatric nurse practitioners • Registered nurses • Licensed vocational nurses • Nurse assistants • Technicians and specialists • Psychiatric technicians • Other	• Social workers • Activity program leaders • Housekeeping • Laundry and linen • Dietary • Social services • Activity staff
Metrics	• Productive hours per resident day, overall and for selected departments • Average wages • Percent of total hours from temporary staff, overall and by occupation • Labor turnover • Personnel costs as percentage of total operating expenses	

Draft Workforce Stability Metrics for Community Clinics

Data Source	HCAI Primary Care Clinic Annual Utilization Data	
Occupations	• Visiting nurses • Registered dental hygienists – alt practice • Licensed clinical social workers • Other billable providers • Other Comprehensive Perinatal Services Program (CPSP) providers • Registered dental hygienists (not alt practice) • Registered dental assistants • Marriage and family therapists	• Registered nurses • Licensed vocational nurses • Medical assistants • Patient education staff • Substance abuse counselors • Billing staff • Other admin staff
Metrics	• Staff full-time equivalents (FTEs) • Contract FTEs • Volunteer FTEs • Staff FTEs as percent of total FTEs • Staff FTEs per patient encounter	

Market Level Workforce Stability Metrics

Draft Workforce Stability Metrics for Supply, Employment, and Diversity of Licensed Health Professionals

Data Source	California Licensure Board records and HCAI license renewal surveys	
Geographic Level	• Statewide • Census Bureau-defined Core Based Statistical Areas (CBSAs) and Combined Statistical Areas (CSAs) • Counties • California Economic Strategy Panel regions	
Occupations	• Physician Assistants • Advanced Practice Registered Nurses • Registered Nurses • Licensed Vocational Nurses • Licensed Clinical Social Workers • Licensed Marriage and Family Therapists • Licensed Professional Clinical Counselors	• Occupational Therapists • Physical Therapists • Psychologists • Respiratory Therapists • Clinical Laboratory Scientists • Medical Laboratory Technicians
Metrics	• Number licensed • Age distribution • Race/ethnicity • Gender identity • Current employment status • Languages spoken	• Self-identified disability status • Average number of hours worked per week • Primary practice setting • Secondary practice setting • Retirement plans

Draft Workforce Stability Metrics for Employment and Diversity of Unlicensed Health Care Workers

Data Source	US American Community Survey
Geographic Level	• Statewide • Large counties
Occupations	• Nursing, psychiatric, and home health aides • Occupational and physical therapist assistants and aides • Other healthcare support occupations • Substance abuse and behavioral disorder counselors
Metrics	• Number employed • Gender • Race/ethnicity • Age distribution • Presence of self-care, ambulatory, and cognitive difficulties • Languages spoken • Total earnings • Wage or salary income in past 12 months • Usual hours worked per week

Draft Workforce Stability Metrics for Employment and Wages of Health Care Workers

Data Source	**US Occupational Employment and Wage Statistics**			
Geographic Level	• Statewide			
Occupations	• Dietitians and Nutritionists • Physician Assistants • Occupational therapists • Physical therapists • Radiation therapists • Respiratory therapists • Speech-language pathologists • Registered nurses • Nurse anesthetists • Nurse midwives • Nurse practitioners • Audiologists	• Dental hygienists • Clinical laboratory techs • Cardiovascular techs • Diagnostic medical sonographers • Nuclear medicine techs • Radiologic techs • Magnetic resonance imaging techs • Emergency medical techs • Paramedics • Dietetic technicians • Pharmacy techs • Psychiatric techs • Surgical techs	• Ophthalmic medical techs • Licensed vocational nurses • Medical records specialists • Opticians, dispensing • Orthotists and prosthetists • Hearing aid specialists • Health techs, all other • Surgical assistants • Home health and personal care aides • Nursing assistants	• Orderlies • Psychiatric aides • Occupational therapy assistants • Occupational therapy aides • Physical therapist assistants • Physical therapist aides • Dental assistants • Medical assistants • Medical equipment preparers • Medical transcriptionists • Pharmacy aides • Phlebotomists • Health care support workers, all other
Metrics	• Employment • Median hourly wage • Mean hourly wage • Annual mean earnings			

Draft Workforce Stability Metrics for Health Worker Graduates

Data Source	US Integrated Postsecondary Education Data System
Geographic Level	• Statewide • Census Bureau-defined Core Based Statistical Areas (CBSAs) and Combined Statistical Areas (CSAs) • Counties • California Economic Strategy Panel regions
Occupations	• Dozens of program classifications, in category “51. Health Professions and Related Clinical Services” and “42.28 Clinical Psychology,” and “44.07 Social Work”
Metrics	• Awards/degrees conferred • Awards/degrees by race/ethnicity • Awards/degrees by gender • Awards/degrees to non-US-residents

Draft Workforce Stability Metrics for Supply and Employment of Registered Nurses

Data Source	California Board of Registered Nursing (BRN) Biennial Survey of Registered Nurses	
Geographic Level	• Statewide • California BRN regions (based on California Economic Strategy Panel regions)	
Occupations	• Registered nurses	
Metrics	• Job satisfaction • Profession satisfaction • Hours worked per day • Hours worked per week • Overtime per week • On call hours per week • Employment intentions • Employment relationship in principal position • Hours worked in principal position • Job title in principal position • Total annual earnings in principal position	• Benefits provided by principal position • Data on additional nursing jobs • For those not working: year last worked • For those not working: why not working • For those not working: employment intentions • Change in employers, positions, or intensity of work • Country of birth • Location of RN education

Draft Workforce Stability Metrics for Registered Nurse Education

Data Source	California Board of Registered Nursing (BRN) Biennial Survey of Registered Nurses	
Geographic Level	• Statewide • California BRN regions (based on California Economic Strategy Panel regions)	
Occupations	• Registered nurses	
Metrics	• Job satisfaction • Profession satisfaction • Hours worked per day • Hours worked per week • Overtime per week • On call hours per week • Employment intentions • Employment relationship in principal position • Hours worked in principal position • Job title in principal position • Total annual earnings in principal position	• Benefits provided by principal position • Data on additional nursing jobs • For those not working: year last worked • For those not working: why not working • For those not working: employment intentions • Change in employers, positions, or intensity of work • Country of birth • Location of RN education

Draft Workforce Stability Metrics for Projections of Supply and Demand for Registered Nurses

Data Source	California Board of Registered Nursing (BRN) Projections of Supply and Demand
Geographic Level	• Statewide California BRN regions (based on California Economic Strategy Panel regions)
Occupations	• Registered nurses
Metrics Appendices	• Projected supply of registered nurses (low, best, and high) • Projected demand for registered nurses to maintain current FTE per capita • Projected demand adjusted for population aging • Projected demand from California Employment Development Department

Expanded Framework for Non-Claims Payments

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

Freedman HealthCare supported the California Department of Health Care Access and Information in developing the Expanded Non-Claims Payment Framework. The framework builds on the work of Bailit Health and the Milbank Memorial Fund and the Health Care Payment Learning and Action Network.
https://hcai.ca.gov/wp-content/uploads/2023/11/HCAI-Expanded-Non-claims-Payments-Framework-Handout_11-28-23-1.pdf

HCAI Department of Health Care Access and Information

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**	

Freedman HealthCare supported the California Department of Health Care Access and Information in developing the Expanded Non-Claims Payment Framework. The framework builds on the work of Bailit Health and the Milbank Memorial Fund and the Health Care Payment Learning and Action Network.
https://hcai.ca.gov/wp-content/uploads/2023/11/HCAI-Expanded-Non-claims-Payments-Framework-Handout_11-28-23-1.pdf

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
3.	**Shared Savings Payments and Recoupments**	**Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including but not limited to episode of care and total cost of care. Dollars reported in this category should reflect only the non-claims shared savings payment or recoupment, not the fee-for-service component. Recouped dollars should be reported as a negative value. Payments in this category are considered "linked to quality" if the shared savings payment or any other component of the provider's payment was adjusted based on specific predefined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the shared savings payment, then the shared savings payment would be considered "linked to quality."**	
a.	Procedure-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3A

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
b.	Procedure-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3B
c.	Condition-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3A
d.	Condition-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3B

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
e.	Risk for total cost of care (e.g., ACO) with shared savings	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 40% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as “Performance Payments.” Providers that would be classified by CMS as “low revenue” may be eligible for shared savings at a lower rate of 20% if they do not meet minimum savings requirements.	3A
f	Risk for total cost of care (e.g., ACO) with risk of recoupments	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 50% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as “Performance Payments.” Providers that would be classified by CMS as “low revenue” may be eligible for shared savings at a lower rate of 25% if they do not meet minimum shared savings requirements. These models also must put providers at risk for at least 30% of losses. Models offering less than this degree of risk are classified as “Risk for total cost of care with shared savings.”	3B

Selected Expanded Framework Categories and Definitions

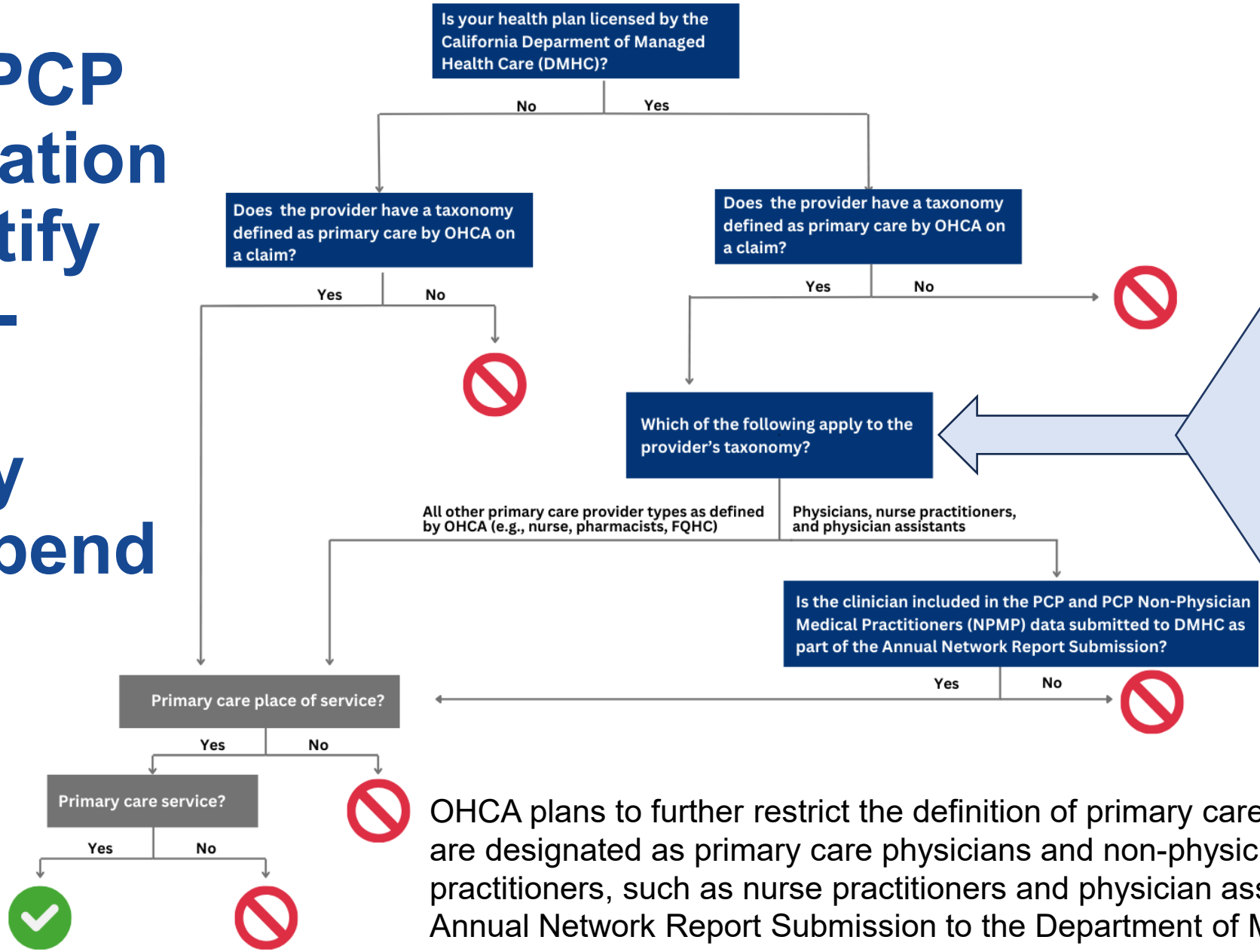
#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
4	**Capitation and Full Risk Payments**	**Per capita, non-claims payments paid to healthcare providers or organizations to provide a defined set of services to a designated population of patients over a defined period of time. Payments in this category are considered "linked to quality" if the capitation payment or any other component of the provider's payment was adjusted based on specific, pre-defined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the capitation payment, then the capitation payment would be considered "linked to quality."**	
a.	Primary Care Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide primary care services to a designated patient population over a defined period of time. Services are restricted to primary care services performed by primary care teams.	4A
b.	Professional Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide professional services to a designated patient population over a defined period of time. Services typically include primary care clinician, specialty care physician services, and other professional and ancillary services.	4A
c.	Facility Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide inpatient and outpatient facility services to a designated patient population over a defined period of time.	4A
d.	Behavioral Health Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide behavioral health services to a designated patient population over a defined period of time. May include professional, facility, and/or residential services.	4A
e.	Global Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital, and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out.	4B

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
f.	Payments to Integrated, Comprehensive Payment and Delivery Systems	Per capita, non-claims payments paid to healthcare organizations and providers to provide a comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out. This category differs from the global capitation category because the provider organization and the payer organization are a single, integrated entity.	4C
5	**Other Non-Claims Payments**	**Any other payments to a healthcare provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit. It also includes governmental payer grants and shortfall payments to providers (e.g., Disproportionate Share Hospital payments and FQHC wraparound payments).**	
6	**Pharmacy Rebates**	**Payments, regardless of how categorized, paid by the pharmaceutical manufacturer or pharmacy benefits manager (PBM) to a payer or fully integrated delivery system.**	

OHCA's Draft Primary Care Spending Measurement Definition and Methodology Details

Using PCP Designation to Identify 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.

OHCA plans to further restrict the definition of 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.

Provider Taxonomies Included as Primary Care

Please note provider taxonomy criteria would be paired with place of service and service criteria.

National Uniform Claim Committee (NUCC) Taxonomies	

• Family Medicine (General/Adult/Geriatrics)
• Internal Medicine (General/Adult/Geriatrics)
• General Practice
• Pediatrics
• Nurse Practitioner
  ○ Adult Health
  ○ Family
  ○ Pediatrics
  ○ Primary Care
• Pharmacist
• Physician Assistant, Medical
• Nurse, non-practitioner
	• Primary Care & Rural Health Clinics
	• Federally Qualified Health Center
	• Certified clinical nurse specialist
	  ○ Adult Health
	  ○ Community/Public Health
	  ○ Pediatrics
	  ○ Chronic Health
	  ○ Family Health
	  ○ Gerontology

Rationale:

- Focus on providers offering whole-person continuous, coordinated care.
- Include care team members – even those less likely to bill via claims – to acknowledge their importance. This definition also guides allocation of non-claims payments.
- Provider taxonomies would be combined with service, place of service criteria, list of PCPs in the DHMC Annual Network Report Submission to help address taxonomy limitations.

OHCA's Definition of Primary Care Excludes OB-GYNs

Approach: 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.
- Excluding OB-GYNs does not in any way change a consumer's right under the Knox Keene Act to select an OB-GYN as their primary care provider.
- According to unaudited health plan self-reported provider data submitted to DMHC, 9% of PCPs reported by health plans were identified as having a specialist type of OB-GYN and 72% of OB-GYNs reported by health plans were identified as serving as PCPs.

Feedback: Majority of stakeholder feedback to date supports this approach as most aligned with our future vision of primary care.

Additional analyses can be conducted in the future using HPD data to evaluate the proportion of OB-GYNs providing services that align with the vision of primary care. Based on future available data, OHCA can work with stakeholders to revisit whether OB-GYNs should be included.

Services Included as Primary Care

Please note services criteria would be paired with place of service and provider criteria.

Service (HCPCS & CPT) Codes	
• Office visit • Home visit • Preventive visits • Immunization administration • Transitional care & chronic care management • Health risk assessment • Advanced care planning • Minor procedures • Interprofessional consult (e-consult) • Remote patient monitoring • Labs	• Team conference w or w/o patient • Prolonged preventive service • Domiciliary or rest home care/ evaluation • Group visits • Women's health services: preventive screenings, immunizations, minor procedures including insertion/removal of contraceptive devices, maternity care.

Rationale:

- Broad set of services to promote comprehensive primary care and primary care providers working at the top of their license.
- Use in combination with other criteria to focus on primary care spending.

Approach to Developing OHCA's Primary Care Services Code Set

Applied guidance from the Investment and Payment Workgroup to a crosswalk of 15 primary care definitions, including the Integrated Health Association definition, to build the draft code set.

Compared draft OHCA recommended code set and DHCS Targeted Rate Increase (TRI) codes. Revised draft OHCA code set to include TRI codes aligned with primary care vision.

Final code set is larger than any other state, region, or national definition and includes some codes that no other definitions include.*

*Note: The OHCA claims-based primary care definition requires the primary care service to be performed by a primary care provider in a primary care place of service.

Care Settings Included as Primary Care

Please note place of service criteria would be paired with provider and service criteria.

CMS Place of Service (POS) Codes
• Office • Telehealth • School • Home • Federally Qualified Health Center • Public Health & Rural Health Clinic • Worksite • Hospital Outpatient • Homeless Shelter • Assisted Living Facility • Group Home • Mobile Unit • Street Medicine

Rationale:

- Restrict by place of service to improve identification of primary care services.
- Include traditional, home, and community-based sites of service to promote expanded access.
- Exclude retail and urgent cares due to lack of coordinated, comprehensive primary care.

Overview of Non-claims Primary Care Spending Measurement Approach

Expanded Framework Category		Allocation to Primary Care Spending
1	**Population Health and Practice Infrastructure Payments**	
a	Care management/care coordination/population health/medication reconciliation	Include payments for primary care programs such as care management, care coordination, population health, health promotion, behavioral health, or social care integration.
b	Primary care and behavioral health integration	
c	Social care integration	
d	Practice transformation payments	Limit the portion of practice transformation and IT infrastructure payments that are allocated to primary care spending to 1 percent of total medical expense.
e	EHR/HIT infrastructure and other data analytics payments	
2	**Performance Payments**	
a	Retrospective/prospective incentive payments: pay-for-reporting	Include performance incentives in recognition of reporting, quality, and outcomes of patients attributed to primary care providers.
b	Retrospective/prospective incentive payments: pay-for-performance	

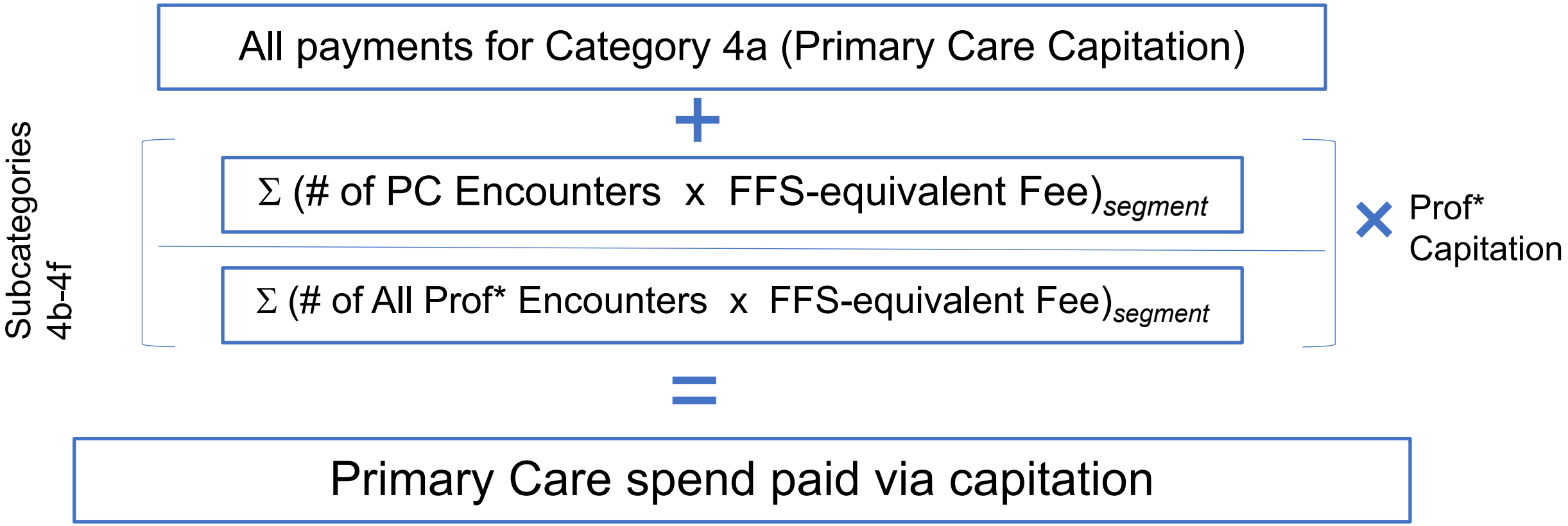
Overview of Non-claims Primary Care Spending Measurement Approach

Expanded Framework Category		Allocation to Primary Care Spending
3	**Payments with Shared Savings and Recoupments**	
a	Procedure-related, episode-based payments with shared savings	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.
b	Procedure-related, episode-based payments with risk of recoupments	
c	Condition-related, episode-based payments with shared savings	
d	Condition-related, episode-based payments with risk of recoupments	
e	Risk for total cost of care (e.g., ACO) with shared savings	
f	Risk for total cost of care (e.g., ACO) with risk of recoupments	

Overview of Non-claims Primary Care Spending Measurement Approach

Expanded Framework Category		Allocation to Primary Care Spending
4	**Capitation and Full Risk Payments**	
a	Primary Care capitation	Allocate full primary care capitation amount to primary care spending.
b	Professional capitation	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.
c	Facility capitation	Not applicable.
d	Behavioral Health capitation	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.
e	Global capitation	
f	Payments to Integrated, Comprehensive Payment and Delivery Systems	
5	**Other Non-Claims Payments**	Not applicable.
6	**Pharmacy Rebates**	Not applicable.

Primary Care Portion of Capitation Payments



This example envisions a professional capitation. Under a global capitation, the professional encounters and capitation would be replaced with all encounters and the global capitation rate.