HCAi
Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

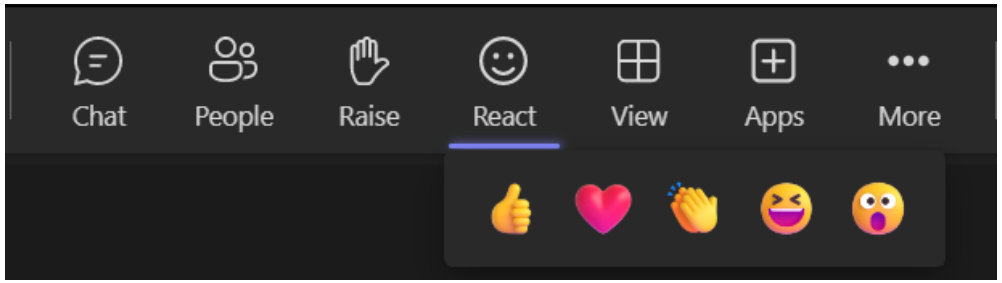
March 20th, 2024

Agenda

9:00 a.m.	**1. Welcome and Updates**
9:05 a.m.	**2. Discuss Board Feedback on APM Standards and Goals**
9:30 a.m.	**3. Discuss Advisory Committee Feedback on Primary Care Measurement and Benchmark**
10:30 a.m.	**4. Adjournment**

Meeting Format

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



Date:
Wednesday, March 20, 2024

Time
9:00 am PST

Microsoft Teams Link
for Public Participation:

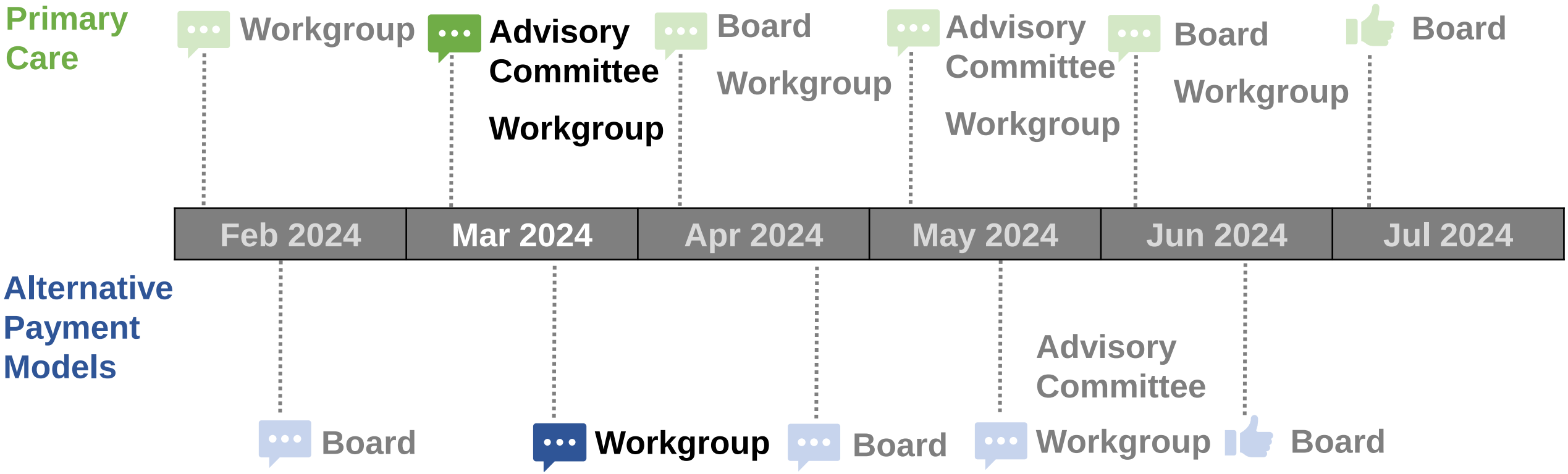
Meeting ID: 231 506 203 671
Passcode: XzTN6r

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

Conference ID:
261 055 415#

Timeline for Primary Care & APM Work

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



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Discuss Board Feedback on APM Standards and Goal

Margareta Brandt, Assistant Deputy Director
Ngan Tran, Payment Reform Group Manager

Draft APM Adoption Goal with Interim Milestones Proposed to OHCA Board

75% 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 on Draft APM Adoption Goal

- Move more quickly – 10 years is too long to wait
- Recognize existing differences in starting points across payer types may lead to different end points
- Address challenges with APMs today:
  - APMs should address hospital costs in a more meaningful way
  - APMs often don't offer providers enough opportunity to earn additional revenue and/or sufficient flexible payment to transform care delivery
  - APMs have varying terms and quality measures that make it difficult for providers to successfully engage

Potential Revised APM Adoption Goals and Interim Milestones

Revised APM Adoption Goals 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
2025	75%	20%	55%	75%
2026	80%	25%	60%	80%
2027	85%	30%	65%	85%
2028	90%	35%	70%	90%
2029	95%	40%	75%	95%

- Shortens timeline for all payers to five years from 10 years.
- Goals and interim milestones vary across payer types to recognize differences in starting points.
- Creates a glidepath that doubles Commercial PPO members attributed to HCP-LAN Categories 3 and 4.

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

Workgroup Discussion Questions

1. Does the workgroup have feedback on the revised APM adoption goals and timeline?

2. Does the workgroup have suggestions for addressing challenges with APMs raised by the Board (hospital costs, flexible payment, etc.)?

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Discuss Advisory Committee Feedback on Primary Care Measurement and Benchmark

Margareta Brandt, Assistant Deputy Director
Debbie Lindes, Health Care Delivery System Group Manager

Overview of Key Primary Care Investment Measurement Recommendations (Claims)

Include a narrow or broad set of providers?

- Include a broad set of providers to reflect statutory goal of team-based care.

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.

Overview of Key Primary Care Investment Measurement Recommendations (Claims)

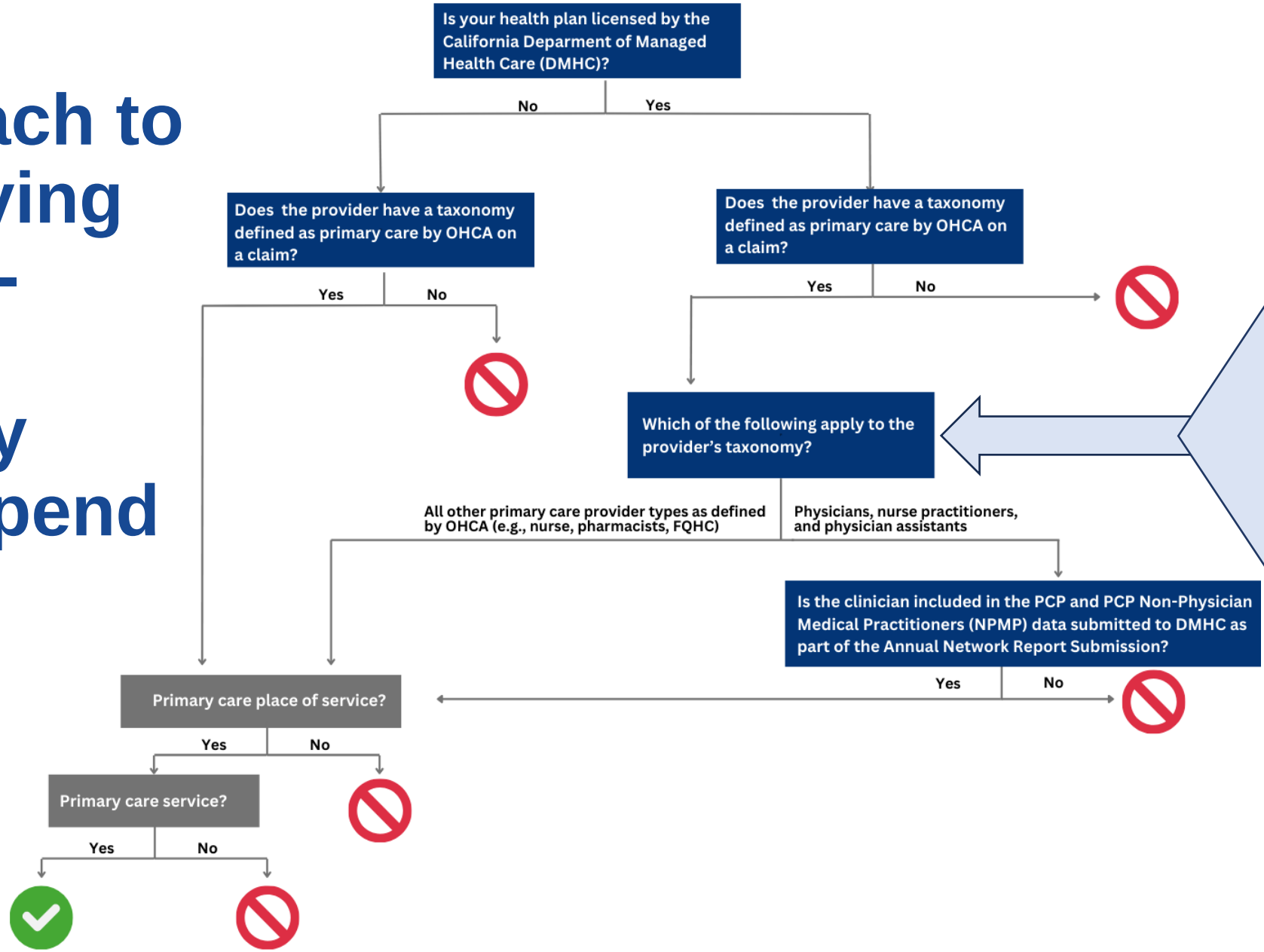
How to incorporate OB/GYN services and/or providers?

- Include some OB-GYN services to be consistent with similar services for other body systems.
- Exclude OB-GYN providers to be consistent with focus on providers caring for the whole patient (*preliminary recommendation, continuing to discuss*).

How to incorporate behavioral health services and/or providers?

- Use a modular approach to include a limited set of behavioral health services that are provided as part of primary care or integrated primary care and behavioral health.

Approach to Identifying Claims-based Primary Care Spend



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

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

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

Rationale:

- Current focus on investing in providers who provide continuous whole-person care for all body systems. OB-GYNs typically do not meet this definition.
  - For example, a person who selected an OB-GYN as a primary care provider would seek treatment for a minor acute conditions such as a sinus infection from another provider.
  - Additionally, many people with chronic conditions such as hypertension and diabetes do not visit an OB-GYN for this care.

Feedback: Stakeholder feedback to date has been mixed between support for this approach as most aligned with our future vision of primary care and concerns about potential conflict with Knox-Keene Act and other policies allowing patients to select OB-GYNs as primary care providers. Some stakeholders also noted concerns regarding the impact on equity in women's health.

Advisory Committee Feedback on Primary Care Definition

- 4 committee members (of the 6 who commented) supported excluding OB-GYNs from the primary care definition

- Committee member comments included:
  - OB-GYN is overwhelmingly a surgical specialty
  - OB-GYNs generally are not trained to provide, and do not provide, whole-person, continuous care
  - Even when OB-GYNs are designated as PCPs, they often refer to other primary care providers for common conditions

- 2 committee members supported including of OB-GYNs
  - The main concern raised with exclusion of OB-GYNs was diverging with the existing statutory and regulatory definition, e.g. DMHC's definition of primary care providers allows for inclusion of OB-GYN

Workgroup Discussion Questions

1. Does the workgroup have additional feedback on the recommended definition of primary care?

2. Is there additional feedback on the preliminary recommendation to exclude OB-GYNs in the definition?

Overview of Key Primary Care Investment Measurement Recommendations (Non-Claims)

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 in recognition of quality/outcomes 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.

Overview of Key Primary Care Investment Measurement Recommendations (Non-Claims)

Category 4: Capitation Payments

- For primary care capitation, payers allocate 100% to primary care.
- For other capitation payments, data submitters calculate a fee-for-service equivalent based on a fee schedule for primary care services multiplied by the number of encounters.

Current Recommended Approach: Primary Care Portion of Capitation Payments

All payments for Category 4a (Primary Care Capitation)

+

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

Subcategories 4b-4f

where *segment* is a combination of

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

=

Primary Care spend paid via capitation

Advisory Committee Feedback on Approach to Non-Claims Primary Care Spend Measurement

- Advisory Committee members highlighted the distinction between measuring primary care spending by **plans** and by **physician organizations**
  - Spending by physician organizations on primary care 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 physician organization (not the plan)
- Measuring payments from physician organizations receiving capitation to their downstream primary care providers would require additional, flexible data collection
  - OHCA should start investigating such data collection as part of long-term planning

Workgroup Discussion Questions

1. Does the workgroup have additional feedback on the recommended approach for determining primary care spend paid via capitation?

2. Are there other suggested approaches for determining primary care spend paid via capitation?

How Other States Address Key Decisions

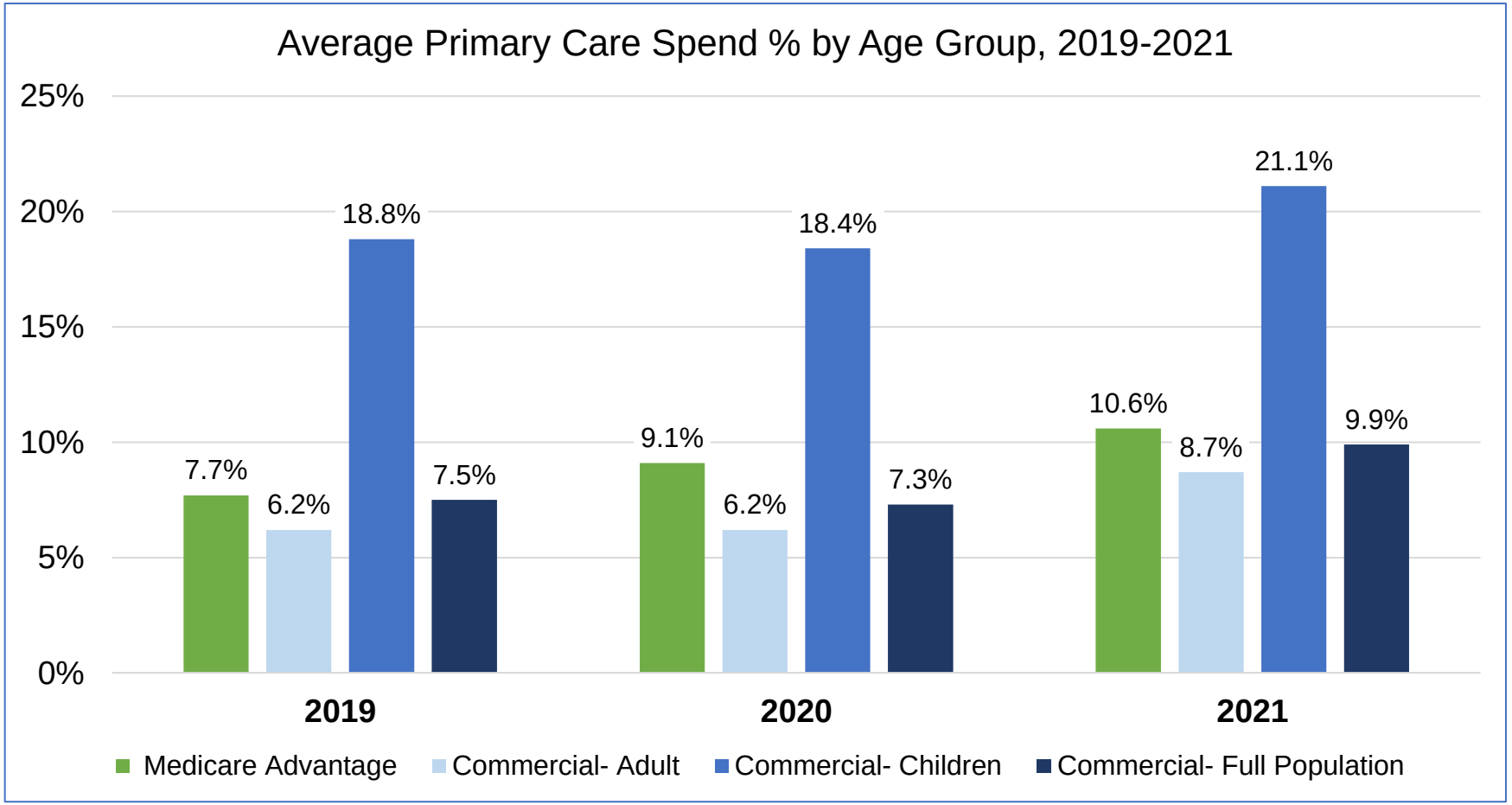
	CA*	CT	DE	RI	OR	CO
Which payer types does the benchmark apply to?	All	All	Commercial	Commercial	Commercial & Medicaid	Commercial
Single or separate benchmarks by age group?	Under discussion	Single	Single	Single	Single	Single
Percentage or Per Member, Per Month (PMPM)	%	%	%	%	%	%
Absolute or relative improvement?	Absolute (with relative)	Absolute (with stair steps)	Absolute (with stair steps)	Absolute, Previously Relative	Absolute	Relative
Benchmark/Target/ Requirement	Under discussion	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.

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

Example: 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.



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

Draft Primary Care Investment Relative Benchmark

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

Rationale for Level:

- Consistent with implementation of benchmarks in other state approaches (e.g. CO, RI, DE)
- Steady growth in primary care spending provides time for stakeholders to transform care
- Gradual reallocation as health care entities work towards affordability goals

AND

A Statewide Absolute Improvement Benchmark

Draft Primary Care Absolute Benchmark: Option 1

Statewide Absolute Benchmark Option 1:
California allocates 15% of total medical expense to primary care across all payers and populations by 2034.

Rationale for Level:

- Internationally, high performing health systems spend 12% to 15% of total healthcare spending on primary care
- The recommended benchmark is higher than other states, recognizing California's healthcare delivery goals, delivery system, younger population, and 10-year time horizon

Draft Primary Care Absolute Benchmark Option 2

Statewide Absolute Benchmark* Option 2:
California allocates the following by 2034:

- *12% of total medical expense to primary care for all adults*
- *24% of total medical expense to primary care for all children*

Rationale for Level:

- Optimal primary care spend looks different for children and adults
- Primary care spending using OHCA approach likely to be lower than previously published estimates

*OHCA is assessing the additional data submitter burden required for this approach and the additional complexity of allocating certain non-claims payments by age group.

Challenges of Non-Claims Primary Care Payments by Age Group

- Most non-claims payments cannot be tied to a specific provider, patient, or set of primary care services.
- Non-claims payments are typically made in lump sum, not delineated by patient age group.
- A methodology for allocating payments to adults vs. pediatrics moves farther away from the actual intent of payments.

Example of Procedure-Based Shared Savings Non-Claims Payment

A provider group receives a shared savings payment for patients receiving hip/knee replacements.

A portion of the payment is allocated to primary care based on OHCA's methodology.

The primary care portion is then allocated to adults vs. pediatrics based on an additional standardized OHCA methodology.

The original payment was not made for any pediatric patients.

Advisory Committee Feedback on the Primary Care Benchmark Options

- 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
- The main feedback on the 10-year horizon was that change takes time and OHCA should allow for that

Workgroup Discussion Questions

1. Does the workgroup have suggestions for how to balance targets that represent optimal primary care for age groups vs. data submitter burden?

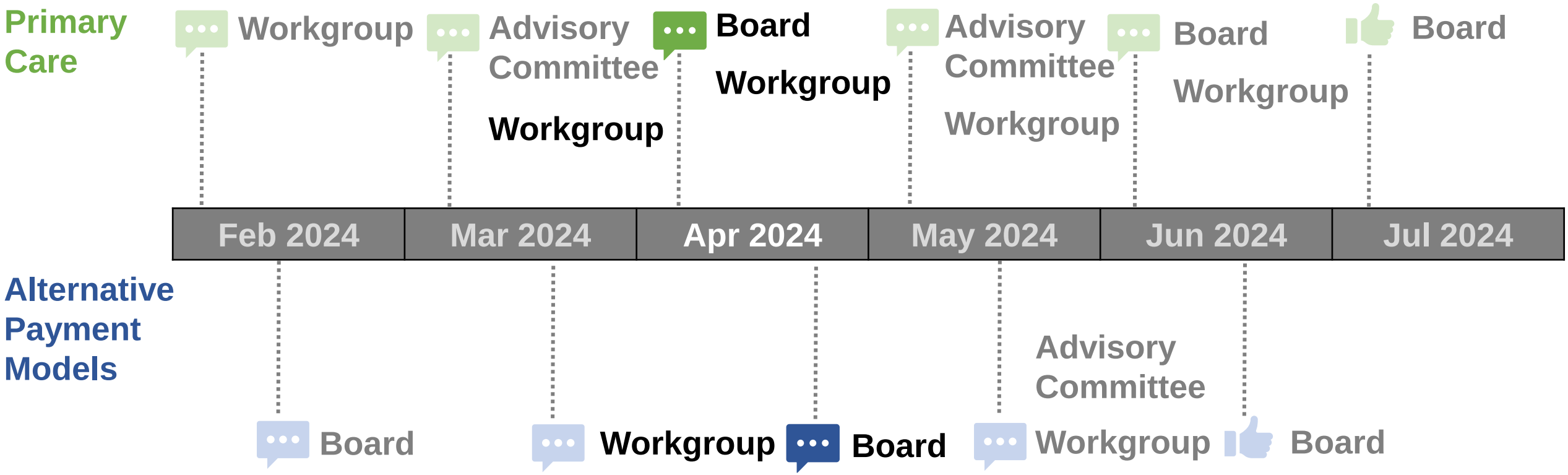
2. If OHCA establishes a single absolute benchmark, is 15% of total medical expense the right amount?

3. If OHCA establishes adult and children absolute benchmarks, is 12 and 24% of total medical expense, respectively, the right amount?

4. The Board provided feedback that a 10-year timeline for APM goals was too long. Does a 10-year timeline to achieve the absolute primary care benchmark provide timely investment to sustainably transform primary care delivery?

Next Steps

OHCA will incorporate feedback and input and then share revised primary care and APM recommendations with the Board in April. The revised primary care recommendations will also be shared with the Workgroup in April.



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Adjournment