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Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

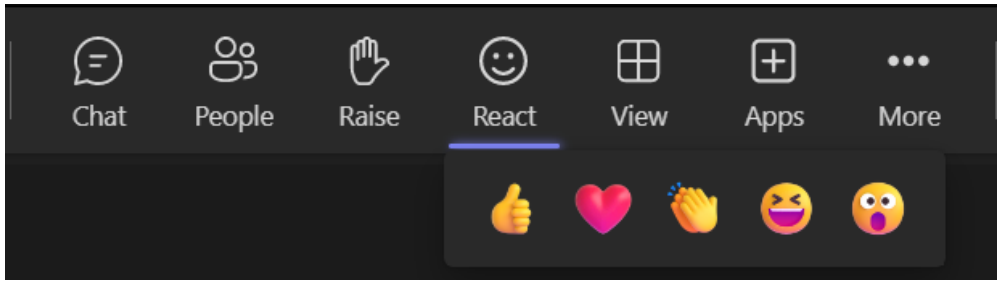
October 18th, 2023

Agenda

9:00 a.m.	**1. Welcome and Updates**
9:10 a.m.	**2. Feedback on Alternative Payment Model (APM) Standards and Implementation Guidance**
9:30 a.m.	**3. Discuss Tradeoffs of Approaches to APM Goals and Definitions**
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, October 18, 2023

Time
9:00 am PST

Microsoft Teams Link
for Public Participation:

Meeting ID: 231 506 203 671
Passcode: XzTN6r

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

Conference ID:
261 055 415#

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Feedback on APM Standards and Implementation Guidance

Margareta Brandt, Assistant Deputy Director

Approach to APM Standards and Implementation Guidance

Standards

- Best practices to approach contracting decisions that are common across APMs
- Not enforceable by OHCA
- Strategic, not tactical or prescriptive – not aiming to create an APM
- Grounded in evidence

Implementation Guidance

- Supplement the standards
- Provide specific actions health care entities can take to meet the standard
- Offer examples of successful APM implementation related to the standard

Vision of APM Standards Success

Stakeholders Endorse

- Health care entities, purchasers commit to use standards to inform future contracting

Alignment Increases

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

Performance Improves

- Standards result in increased APM adoption
- Performance on measures of quality, equity, and affordability improve

Draft APM Standards

1. **Use prospective, budget-based, and quality-linked payment models** when possible.
2. **Implement payment models that improve affordability** for consumers and purchasers.
3. **Recognize and reward the essential role of primary care teams** in improving health and generating value through payment models.
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.
6. **Measure performance** using a focused set of nationally-standardized and locally adopted measures and technical specifications.
7. **Collect demographic data**, including RELD-SOGI* data, to enable stratifying performance.
8. **Use data to address inequities** in access and outcomes.
9. **Equip providers with 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).
Draft standards released for Investment and Payment Workgroup feedback on 9/29/23.

Workgroup Feedback Generally Supportive of APM Standards and Implementation Guidance

Themes from comments received include:

1. **Support for models that are budget-based and linked to quality**; these models should be designed to improve affordability, quality, equity, and access
2. **Aligning APM model design and performance measures** accelerates APM adoption and reduces provider burden
3. **Collection of demographic information,** including RELD-SOGI data, **should be improved upon** and **more broadly used to adjust payments** to address health-related social needs and inequities
4. **APMs should recognize and reward the essential role of multidisciplinary primary care teams** in improving health and generating value

Suggestions for Additions to APM Standards and Implementation Guidance

Workgroup members shared some suggestions to add to the existing standards and implementation guidance. Themes included:

1. Include pay-for-performance (HCP-LAN Category 2C) as a recommended payment model
2. Measure sets should recognize populations served (e.g., children and adults) and focus on outcomes
3. Data exchange across providers, health plans, and community-based organizations is critical to equip providers with actionable data

For Discussion:

1. What are your reactions to the suggested additions?
2. Should the theme be included in the Standards and/or Implementation Guidance?

Suggestions to Strengthen APM Standards and Implementation Guidance

Workgroup members also shared ideas for strengthening the existing standards and implementation guidance. Themes included more explicitly stating the following concepts:

1. Efficiency and cost-savings generated through APMs should lead to lower costs for consumers and decrease barriers to care
2. Realign financial incentives to promote upstream intervention and prevention to achieve improvements in population health and affordability
3. Increase investment in primary care continuity, integrated behavioral health, and care coordination
4. APMs should facilitate equitable access to a diverse, sustainable workforce
5. More focused, tailored engagement will be required to achieve broad adoption across providers and populations

For Discussion:

1. What are your reactions to the suggestions?
2. Should the theme be more explicit in the Standards and/or Implementation Guidance?

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Discuss Tradeoffs of Approaches to APM Goals and Definitions

Margareta Brandt, Assistant Deputy Director
Mary Jo Condon, Principal Consultant
Vinayak Sinha, Senior Consultant

Approach to APM Adoption Goals and Definitions

Adoption Goals

- Promote shift from fee-for-service based payments to APMs
- Align financial incentives for equitable, high-quality and cost-efficient care
- Use HCP-LAN framework (see appendix) to monitor progress toward goals
- Progress towards goals measured by OHCA, not enforceable
- Accountability through transparent public reporting

Definitions

- Define what payment models “count” towards APM adoption goals
- Utilize Expanded Framework for Non-Claims Payments (see appendix) for data collection – aligned with other data collection efforts at OHCA and HCAI

Strategic Decisions for Developing APM Adoption Goals

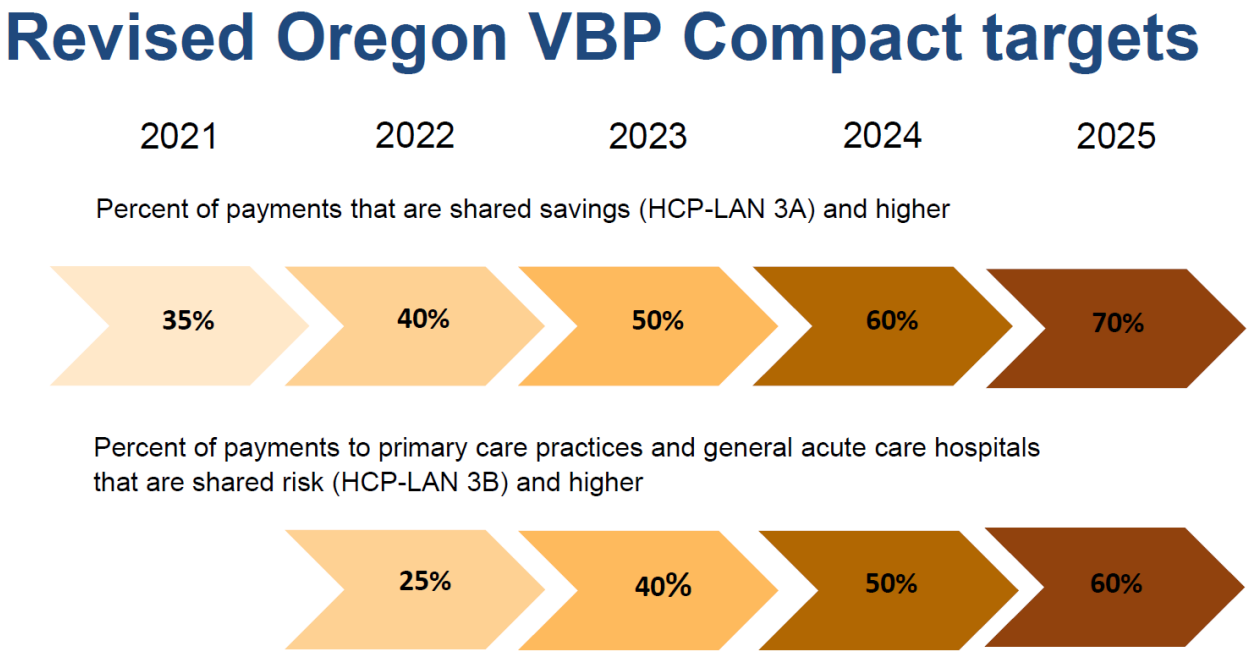
1. **Should certain types of payment models count towards the APM adoption goal?**
   - HCP-LAN Category 3A (shared savings only; no downside risk) and above?
   - HCP-LAN Category 3 (APMs built on a fee-for-service architecture) models with minimal shared savings/risk?
   - APMs not linked to quality?
2. **Should goals vary by payer type (commercial, Medi-Cal, Medicare)? By product type (HMO, PPO)?**
3. **Should APM adoption goals be based on…?**
   - % of total health care spending
   - % of members
   - % non-claims payments
   - % of providers
4. **How should goals be structured?**
   - a series of stairstep goals
   - a single absolute goal
   - a relative improvement goal

   } Can be layered

Example from California's Neighbor to the North

Oregon has made many of these same decisions in its designing of APM goals.

- Oregon limits the types of payment models that count towards the APM adoption goal.
- Oregon APM adoption goals do not vary by payer or product type.
- Oregon APM adoption goals are based on percent of total health care spending.
- Oregon includes a series of stairstep goals until 2025.



Draft OHCA Recommendations for Developing APM Adoption Goals

1. **Yes, only certain types of payment models should count towards the APM adoption goal.**
   - Yes, include HCP-LAN Category 3A (shared savings only; no downside risk) and above
   - Yes, require HCP-LAN Category 3 (APMs built on a fee-for-service architecture) models to have a minimal shared savings/risk
   - Yes, only count APMs linked to quality
2. **No, APM adoption goals should not vary by payer type (commercial, Medi-Cal, Medicare) or product type (HMO, PPO).**
3. **Goals should be structured as a series of stairstep goals with an absolute goal several years in the future.**
4. **Recommendation on metric to monitor APM adoption (percent of spending, percent of members, etc.) pending review of data feasibility and workgroup discussion.**

All recommendations are draft.

We look forward to your feedback during today's discussion.

Should certain types of payment models count towards APM adoption goals?

Nationally and in California, most APM adoption goals focus on Category 3 (APMs built on a fee-for-service architecture) and Category 4 (capitation and other population-based payments).

Draft Standards and Implementation Guidance recommend using these payment models whenever possible. Workgroup members generally agreed in their comments.

Questions Remaining:

1. Should OHCA include HCP-LAN Category 3A (payment models with shared savings only; no downside risk) payments?
2. Should OHCA require Category 3 payments meet a minimum threshold for shared savings/risk?
3. Should OHCA include HCP-LAN Categories 3N and 4N (no link to quality)?

Should HCP-LAN Category 3A models count toward the APM adoption goal?

Some providers lack the financial assets, experience, or willingness to engage in payment models with downside risk. HCP-LAN Category 3A does not require providers compensate payers for losses.

Reasons to Include - Recommended

- Category 3A models are often more attractive to physician-led ACOs and new entrants that lack the experience and/or financial assets to take on risk
- Engaging these ACOs is important
  - Low revenue ACOs (typically physician-led) are more likely to generate savings than high revenue ACOs (typically health systems-led) [1]
  - New entrants needed to reach adoption goals
- Covered California includes 3A models in its goals

Reasons to Exclude

- Some ACOs, particularly those led by health systems, have had difficulty achieving financial success in APMs and perform better when more risk is at stake[2]
- HCP-LAN excludes 3A models in its APM adoption goals

1. Basu S, Phillips RS, Song Z, Bitton A, Landon BE. High Levels Of Capitation Payments Needed To Shift Primary Care Toward Proactive Team And Nonvisit Care. Health Aff (Millwood). 2017 Sep 1;36(9):1599-1605. doi: 10.1377/hlthaff.2017.0367. PMID: 28874487.
2. Celli Horstman, Corinne Lewis, and Melinda Abrams, "Designing Accountable Care: Lessons from CMS Accountable Care Organizations," To the Point (blog), Commonwealth Fund, Nov. 10, 2022. https://doi.org/10.26099/8fvg-cw28

Should Category 3 payments meet a minimum threshold for shared savings/risk to be counted?

Some HCP-LAN Category 3 models have very limited opportunity for shared savings and/or put providers at very minimal risk. To address this, some APM adoption goals specify a minimum threshold for shared savings and/or downside risk. For example, in the CMS Medicare Shared Savings Program (MSSP), payment models must offer providers a minimum of 40% shared savings if quality performance and other terms are met.

Reasons to Require – Recommended

- Meaningful accountability for cost drives improvements in value
- Meaningful opportunity for shared savings will increase provider participation
- Thresholds for shared savings and shared risk may protect against gaming

Reasons to Not Require

- May seem prescriptive to contracting entities

Should payment models be required to have a link to quality count toward APM adoption goals?

The percentage of capitation payments linked to quality in California is unknown. OHCA's goal is to promote equitable, high-quality and cost-efficient APMs. OHCA could require the provider's payment be impacted by quality performance to count toward the goal. The Integrated Healthcare Association Align, Measure, Perform program is an example of how capitation payment could be linked to quality.

Reasons to Require - Recommended

- Recognizes importance of maintaining and/or improving quality through APMs
- Aligns with Workgroup member input on APM Standards and Implementation Guidance, which recommended use of quality-linked models
- Aligns with other states and national APM adoption goals (HCP-LAN)

Reasons to Not Require

- May be difficult to develop a clear definition and monitor
- Limited data is available on APMs in California linked to quality, complicates setting APM adoption goals

Should goals vary by payer type?

Commercial, Medicare Advantage, Traditional Medicare and Medicaid have varying levels of APM adoption in California and nationally. Differences in populations, contracting challenges, and priorities all contribute to this variation. To reflect this, HCP-LAN varies its goals by payer type.

Reasons to Align - Recommended

- Holds all payer types (or those that are aligned) accountable to the same goals
- Promotes all populations having access to the same opportunity for value-based care regardless of payer type
- Consistent with HCP-LAN (varies only for Medicare)

Reasons to Vary

- APM adoption differs today; putting payers at a different starting point
- APM contracting is more complicated for some payer types
- Would allow for more ambitious goals for payers with greater adoption today

Should goals vary by product type?

APM adoption today differs dramatically across product types in California, which has the nation's highest prevalence of HMO plans. Differences in provider networks, regulatory requirements, and purchaser preferences all contribute.

Reasons to Align - Recommended

- Holds all product types accountable to the same goals
- Promotes all populations having access to the same opportunity for value-based care regardless of product type
- If HCP-LAN Category 3 and 4 models count towards goals, all product types have pathway to achievement

Reasons to Vary

- HMO plans include mostly population-based payment (HCP-LAN Category 4) models but percent linked to quality is unknown
- Regulatory requirements limit adoption of HCP-LAN Category 4 APMs, particularly by self-insured purchasers
- Allows OHCA to set more ambitious goals for product types with greater adoption today

How should goals be structured?

APM goals can be structured to focus on a long-term vision or shorter-term progress. Approaches can be combined to provide payers pathways to increasing adoption of APMs.

Approach	Definition	Trade Offs
Stairstep - **Recommended**	Smaller targets that lead to improvement goal	• Consistent with other APM goals in California and nationally, including HCP-LAN • Interim touchpoints to gauge progress • Typically terminates with an absolute goal that offers aspirational vision
Absolute - **Recommended**	Specific improvement goal	• Provides long-term aspirational vision
Relative	Improvement goal relative to current performance	• Meets each payer where its at • Helpful when data on current adoption is lacking • Does not set a goal for payers to work towards long-term • Can require same pace of progress for all payers

What metric should goals be based on?

Different metrics can be used to measure progress towards shifting from fee-for-service payments to APMs. **Recommendation pending data collection feasibility and workgroup input.**

Metric	Definition	Tradeoffs
Percent of total health care spending flowing through an APM contract	Percent of total health care spend flowing through an APM contract	• Aligns with Covered CA data collection, HCP-LAN APM adoption goals • May be easiest to reach since all contract dollars "count" • Less motivation to engage providers, members who are more difficult to engage; more motivation to engage providers with large spend
Percent of members	Percent of members attributed to an APM	• Most aligned with population health philosophy that health care entities are accountable for all patients, even those that don't seek care • Promotes attribution rules that capture more patients • Encourages engaging members who may not easily engage

What metric should goals be based on?

Different metrics can be used to measure progress towards shifting from fee-for-service payments to APMs. **Recommendation pending data collection feasibility and workgroup input.**

Metric	Definition	Tradeoffs
Non-claims payments	Percent of total health care spend paid via a non-claims payment	• Promotes prospective payments and other payments to transform care • Promotes more meaningful opportunities for shared savings • May be viewed as more prescriptive
Percent of providers	Percent of providers participating in an APM	• Requires payers to engage rural, small providers which may be more difficult to engage • May be difficult to measure given the amount of delegation in California • Would require additional data to be collected

Next Steps

October 2023

- Workgroup reviews feedback on APM standards and implementation guidance
- Workgroup discusses considerations and tradeoffs for key decisions related to APM goals and definitions

November 2023

- OHCA shares revised APM standards with workgroup in early November and discusses during workgroup meeting
- Workgroup provides feedback on draft APM goals and definitions
- Advisory Committee provides feedback on draft APM standards, definitions, and goals

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Adjournment

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Appendix

Expanded Framework, Categories A-C

	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

Expanded Framework, Categories D-F

	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**	

Health Care Payment Learning and Action Network

Year: 2016, updated in 2017

Developer: HCP-LAN, a collaboration of Centers for Medicare and Medicaid Services (CMS) and large national payers

Purpose: Support payers and states in categorizing alternative payment models to support clarity and accountability in contracting terms and measurement of APM adoption.

HCP-LAN APM Framework

Category 1	Category 2	Category 3	Category 4
FEE FOR SERVICE- NO LINK TO VALUE	FEE FOR SERVICE- LINK TO QUALITY & VALUE	APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	POPULATION-BASED PAYMENT
	A	A	A
	Foundational Payments for Infrastructure & Operations	APMs with Shared Savings	Condition-Specific Population-Based Payment
	B	B	B
	Pay for Reporting	APMs with Shared Savings and Downside Risk	Comprehensive Population-Based Payment
	C		C
	Pay-for-Performance		Integrated Finance & Delivery System
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality