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Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

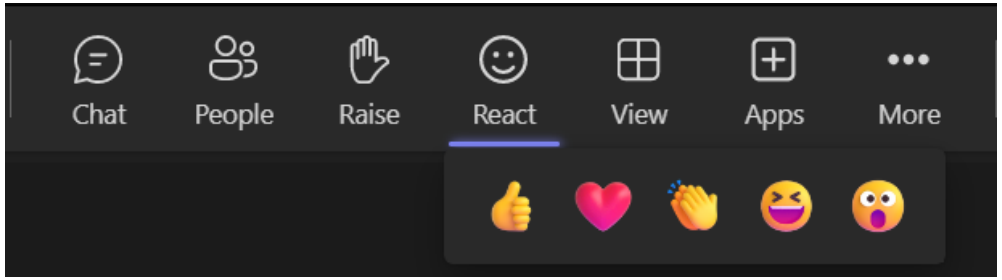
November 15th, 2023

Agenda

9:00 a.m.	**1. Welcome and Updates**
9:10 a.m.	**2. Revised Alternative Payment Model (APM) Standards and Implementation Guidance**
9:30 a.m.	**3. Revised APM Goals and Definitions Recommendations**
10:00 a.m.	**4. Introduction to Primary Care Investment Measurement**
10:30 a.m.	**5. 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, November 15, 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#

Mid-Point Survey on Workgroup Process

As we reach the midpoint of our collaboration and shift our focus from alternative payment models to primary care spending, the OHCA and FHC teams seek your input on your workgroup experience. We will send out a survey via email within the next week.

Please share any suggestions for enhancing your experience regarding:

- Value of meeting material
- Pace of meetings
- Level of detail provided in meetings
- Value of group discussions

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Revised APM Standards and Implementation Guidance

Margareta Brandt, Assistant Deputy Director

Mary Jo Condon, Principal Consultant

Revised 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.

Text in blue indicates revisions to the APM Standards.

Note: A revised version of the APM Standards and Implementation Guidance can be found in the Appendix. Clean and redline documents were also emailed to workgroup members.

Revised 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 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).

Text in blue indicates revisions to the APM Standards.

Note: A revised version of the APM Standards and Implementation Guidance can be found in the Appendix. Clean and redline documents were also emailed to workgroup members.

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Revised APM Goals and Definitions Recommendations

Mary Jo Condon, Principal Consultant
Vinayak Sinha, Senior Consultant

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

Workgroup Feedback Generally Supportive of Draft APM Goals and Definitions

Themes from comments received include:

- **Support for inclusion of HCP-LAN Categories 3A, 3B, 4A, 4B, 4C and exclusion of 3N and 4N,** consider inclusion of 2C arrangements**.**
- **Support for link to quality** for all HCP-LAN categories counting toward statewide APM adoption goal**.**
- **Aligning HCP-LAN Category 3A and 3B minimum shared savings/loss thresholds** with existing models, such as Medicare Shared Savings Program.
- **Consider absolute improvement goal with stairsteps** and whether to vary stairsteps by payer or product type.
- **APM adoption goals should align across payers.**
- **Monitor APM adoption across multiple metrics,** of which % of members in APMs and % of total health care spending in APMs are favored.
- **Questions on pathway forward for self-insured plans and fully-insured PPO plans.**

Revised APM Goals and Definitions Recommendations

1. **Only certain types of payment models count towards the APM adoption goals.**
   a. The following HCP-LAN Categories count towards the APM adoption goals:
      - 3A FFS Architecture with Shared Savings
      - 3B FFS Architecture with Shared Savings and Downside Risk
      - 4A Condition-Specific, Population-Based Payments
      - 4B Comprehensive, Population-Based Payments
      - 4C Financially Integrated Delivery Systems

   b. APMs not linked to quality* (3N, 4N) do not count toward the APM adoption goals.
   c. Require Category 3A and 3B APMs meet a minimum threshold for shared savings/risk˜

* Payments are considered "linked to quality" if the provider is eligible to receive a financial bonus or is at risk for a financial penalty based on performance on specific predefined 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."

˜ Full definition provided in Expanded Framework for Non-Claims Payments in Appendix.

Revised APM Goals and Definitions Recommendations

2. APM absolute improvement goal does not vary by payer or product type.

3. Goal to follow stairstep structure with an absolute improvement target by 2034. Steps will vary to recognize differences in starting points.

4. Measure APM adoption based on percent of members.

- Payer data will be collected using Expanded Framework categories.
- Data submitters will report member months attributed to each category.
- OHCA will cross-walk membership from Expanded Framework category to HCP-LAN categories.
- OHCA will also monitor percent of total health care spending in each HCP-LAN category.
- **Note**: Integrated Healthcare Association (IHA) found little to no difference in the percent of members attributed to an APM and the percent total spending.

Text in blue indicates revisions to the APM goals and definitions.

Recap of Recommended APM Adoption Goals

- Goals based on percent of members attributed to HCP-LAN Categories 3A, 3B, 4A, 4B, and 4C arrangements.
- Goals are structured as stairsteps, with all payers expected to reach 75% adoption by 2034.
- All qualifying APM arrangements must include a link to quality.
- All qualifying HCP-LAN Category 3A and 3B arrangements must meet minimum thresholds for shared savings and risk.

Recommended APM Adoption Goals				
	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	55%	35%	55%	55%
2028	60%	45%	60%	60%
2030	65%	55%	65%	65%
2032	70%	65%	70%	70%
2034	75%	75%	75%	75%

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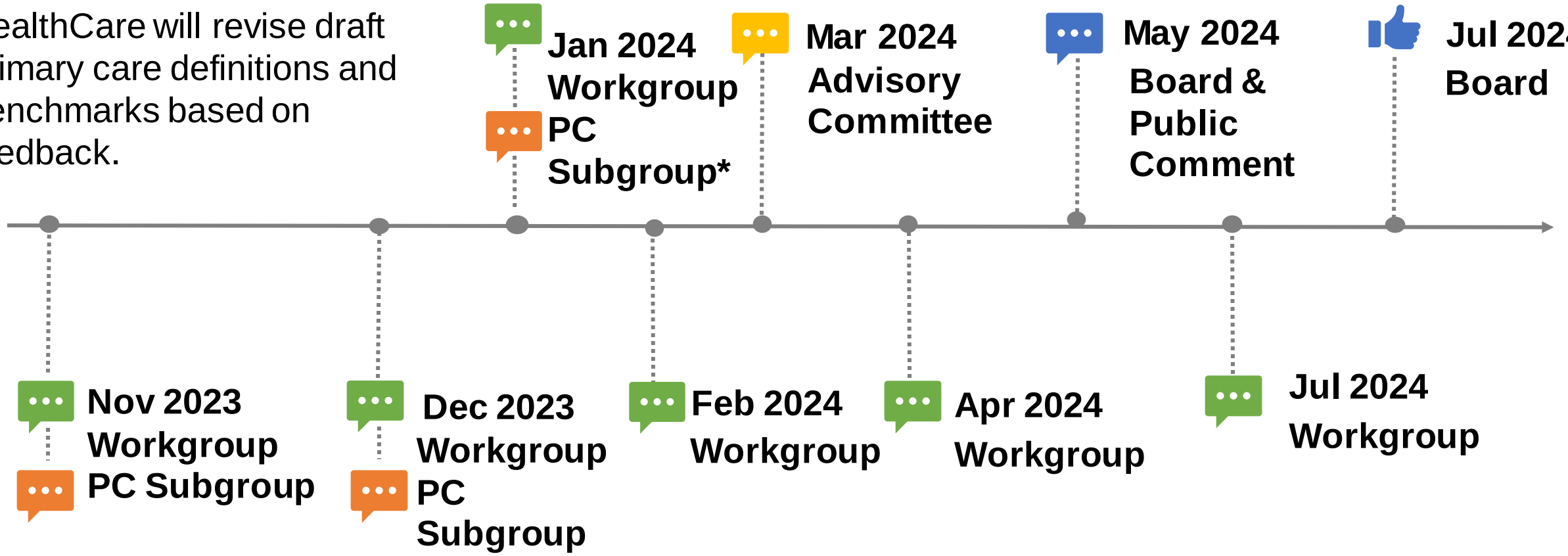
Introduction to Primary Care Investment Measurement

Mary Jo Condon, Principal Consultant
Vinayak Sinha, Senior Consultant

Timeline for Primary Care Workstream

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



*If Needed

Provide Feedback

Board Approval

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Primary Care & Behavioral Health Investments

Statutory Requirements

- **Measure and promote a sustained systemwide investment in primary care** and behavioral health.
- **Measure the percentage of total health care expenditures allocated to primary care** and behavioral health and **set spending benchmarks**. Spending benchmarks for primary care shall consider current and historic underfunding of primary care services.
- Include an analysis of primary care and behavioral health spending and growth, and relevant quality and equity performance measures, in the annual report.
- Consult with state departments, external organizations promoting investment in primary care and behavioral health, and other entities and individuals with expertise in primary care, behavioral health, and health equity.
- Benchmarks and public reporting shall consider differences among payers and fully integrated delivery systems, including plan or network design or line of business, the diversity of settings and facilities through which primary care can be delivered, including clinical and nonclinical settings, the use of both claims-based and non-claims-based payments, and the risk mix associated with the covered lives or patient population for which they are primarily responsible.

Primary Care & Behavioral Health Investments

Statutory Requirements

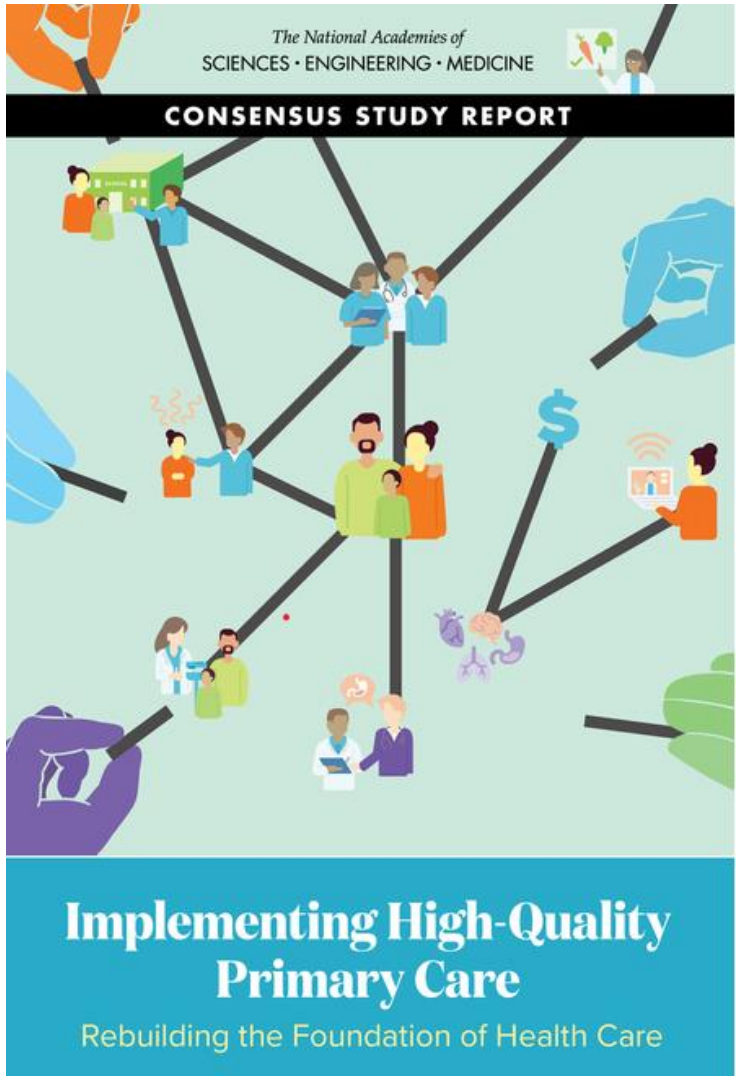
Promote improved outcomes for primary care, including, but not limited to, health care entities making investments in, or adopting models that do, any or all of the following:

a. Promote the importance of primary care and adopt practices that give consumers a regular source of primary care.
b. Increase access to advanced primary care models and adoption of measures that demonstrate their success in improving quality and outcomes.
c. Integrate primary care and behavioral health services, including screenings for behavioral health conditions in primary care settings or delivery of behavioral health support.
d. Leverage APMs that provide resources at the practice level to enable improved access and team-based approaches for care coordination, patient engagement, quality, and population health.
e. Deliver higher value primary care services with an aim toward reducing disparities.
f. Leverage telehealth and other solutions to expand access to primary care, care coordination, and care management.
g. Implement innovative approaches that integrate primary care and behavioral health with broader social and public health services.

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 study found.



National Academies of Sciences, Engineering, and Medicine (NASEM). Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. 2021.
Jabbarpour Y., Petterson S., Jetty A., Byun H. The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care, 2023.

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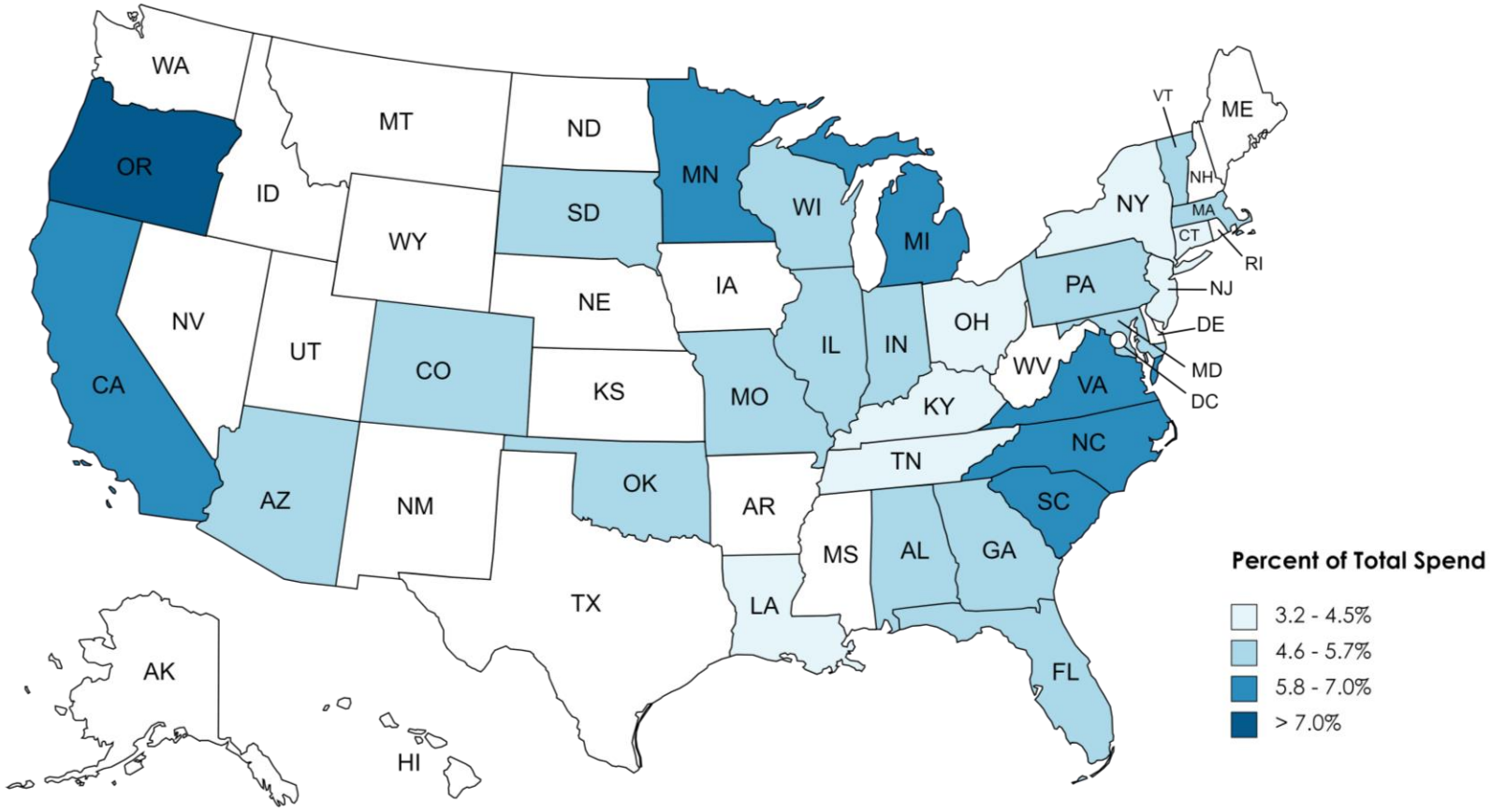
The Health of US Primary Care: A Baseline Scorecard

In 2023, the Milbank Memorial Fund, with the Robert Graham Center, published a scorecard that measured primary care spending across 19 states using publicly available survey data from the Medical Expenditure Panel Survey (MEPS).

Percent of Total Spend Going to Primary Care - All Payers (2019)



Jabbarpour Y., Petterson S., Jetty A., Byun H.The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care, The Milbank Memorial Fund and The Physicians Foundation. February 22, 2023.

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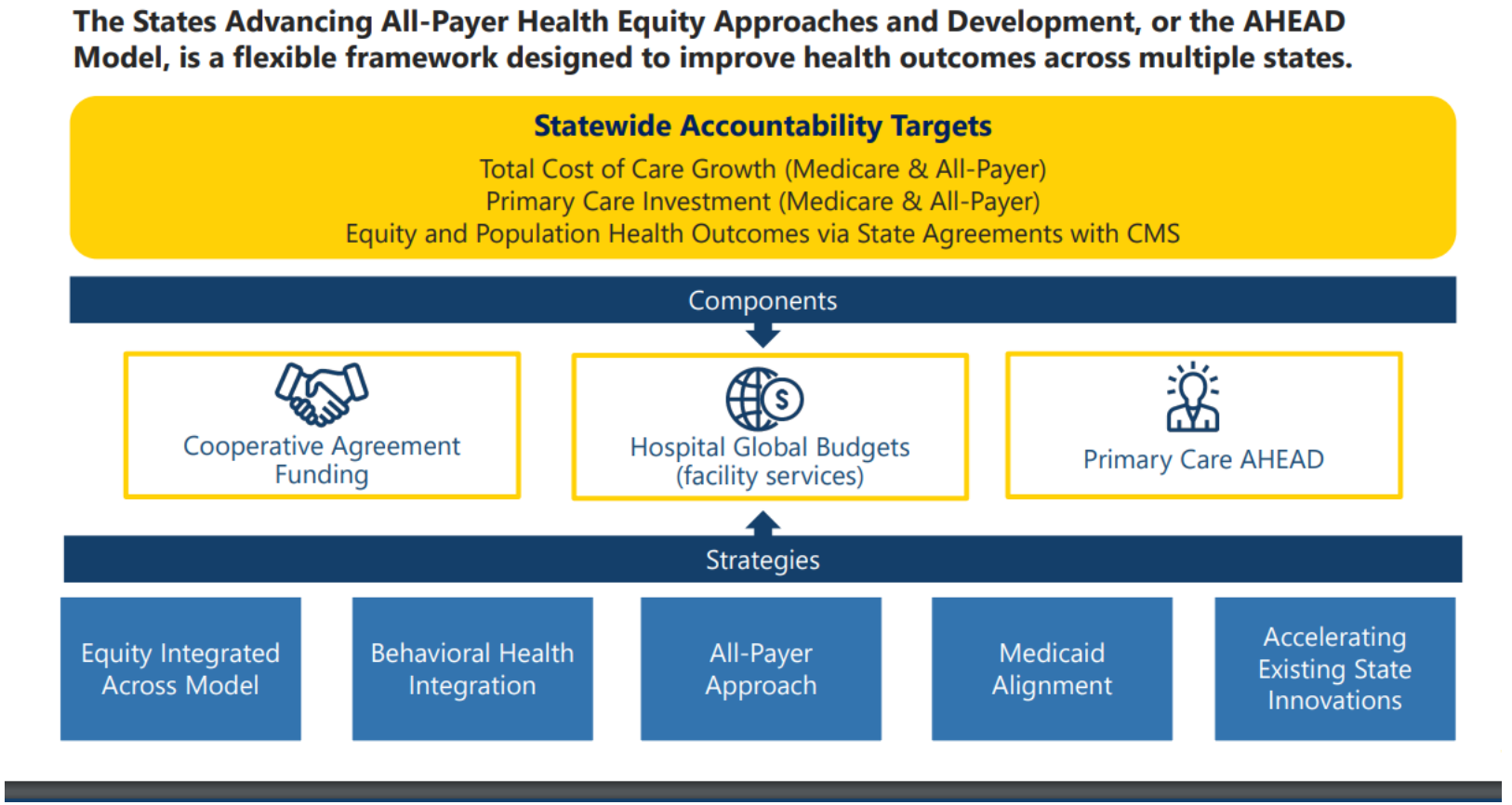
The Multi-State, Multi-Payer AHEAD

States are considering whether to apply. CMMI plans to fund up to 8.

First notice of funding opportunity to be available later this month.

As part of model, CMMI will release a definition of primary care (claims and non-claims) but not require states use it for commercial or Medicaid measurement.

States will have up to 2.5 years for planning; model will run until 2034.

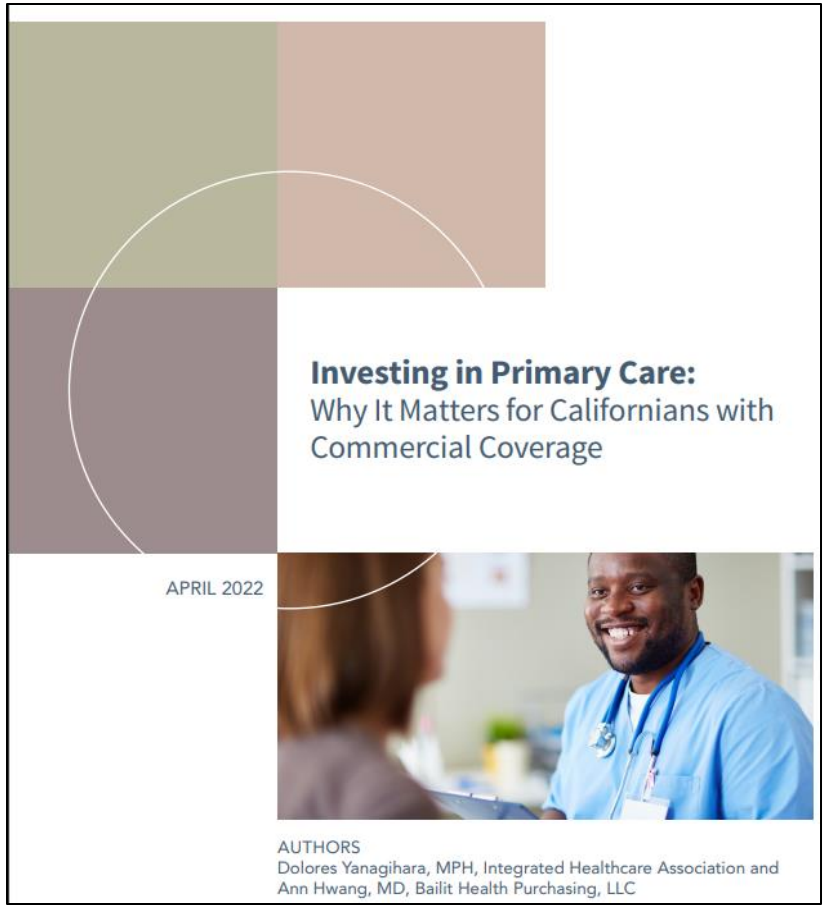


Evidence of Impact in California

A study by the Integrated Healthcare Association (IHA) and commissioned by the California Health Care Foundation (CHCF) found increased primary care investment results in better outcomes.

A study of 80% of Californians with commercial HMO coverage found higher spending on primary care was associated with….

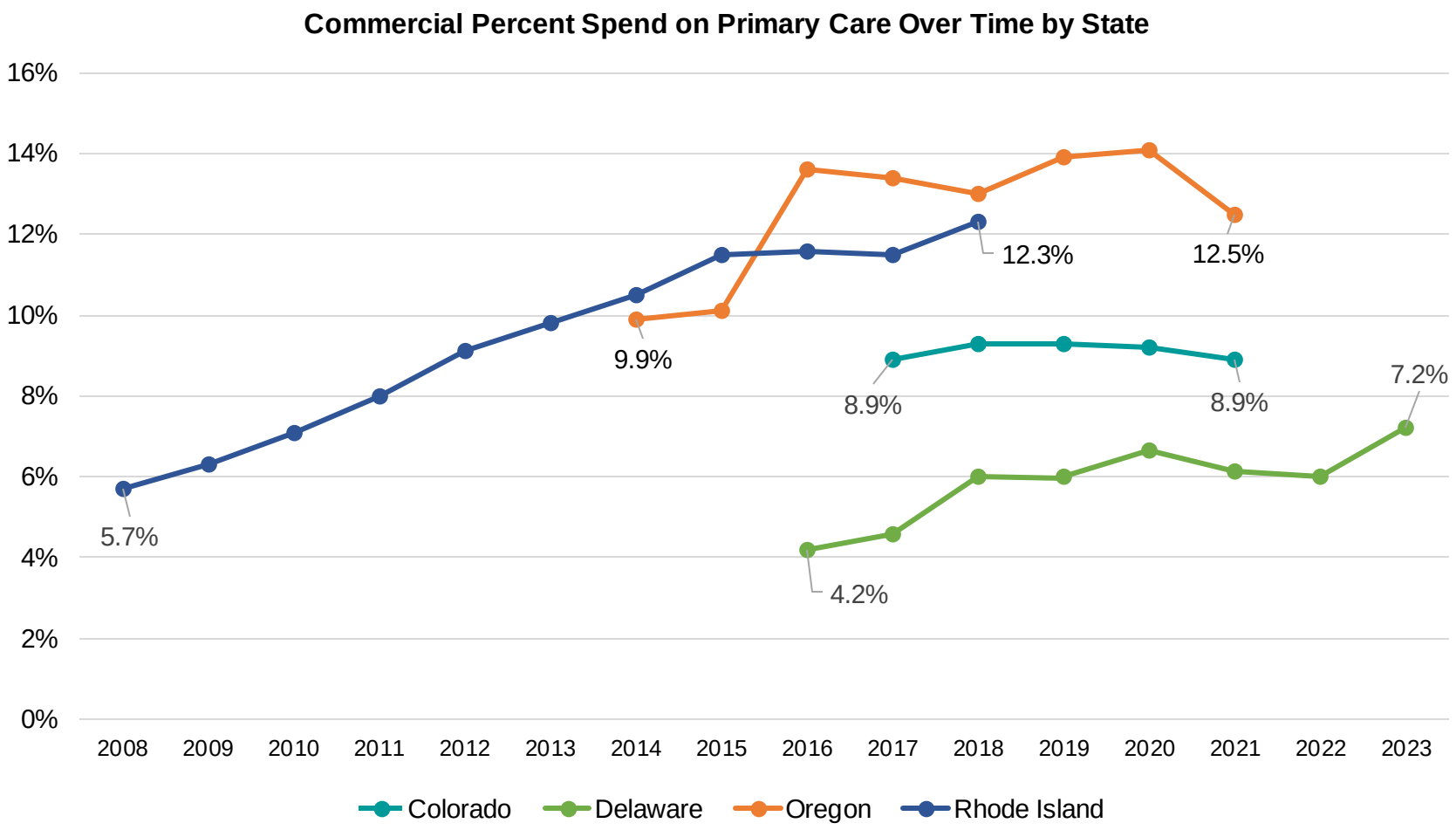
- Better performance on quality and patient experience measures
- Lower hospital and emergency department use
- Lower total cost of care



National Study Finds Higher Investment in Primary Care Associated with Better Outcomes

A 2019 study by the Patient-Centered Primary Care Collaborative and the Robert Graham Center found states with higher primary care investment had lower rates of hospitalizations and emergency department visits.

States See Investment Increase



RHODE ISLAND MILESTONES

2010–2014 Carriers required to increase by 1% per year.

2015 Carriers required to spend at least 10.7% on primary care.

COLORADO MILESTONE

2019 Primary care spending first reported; 1% increase not required until 2022 and 2023.

OREGON MILESTONES

2015 Law passed that requires reporting of pri care spend percentage by payer.

2017 Carriers/CCOs required to allocate at lea 12% to primary care in 2023.

DELAWARE MILESTONES

2019 PCRC set target to increase primary care investment to 12%.

2022 Carriers required to increase primary care spend to 7%, then 1.5% a year until 11.5

Note: State definitions and total cost of care differ which contributes to differences in investment percentages. Delaware definition changed slightly in 2022.

Author analysis of primary care investment reports publicly available on state governmental websites.

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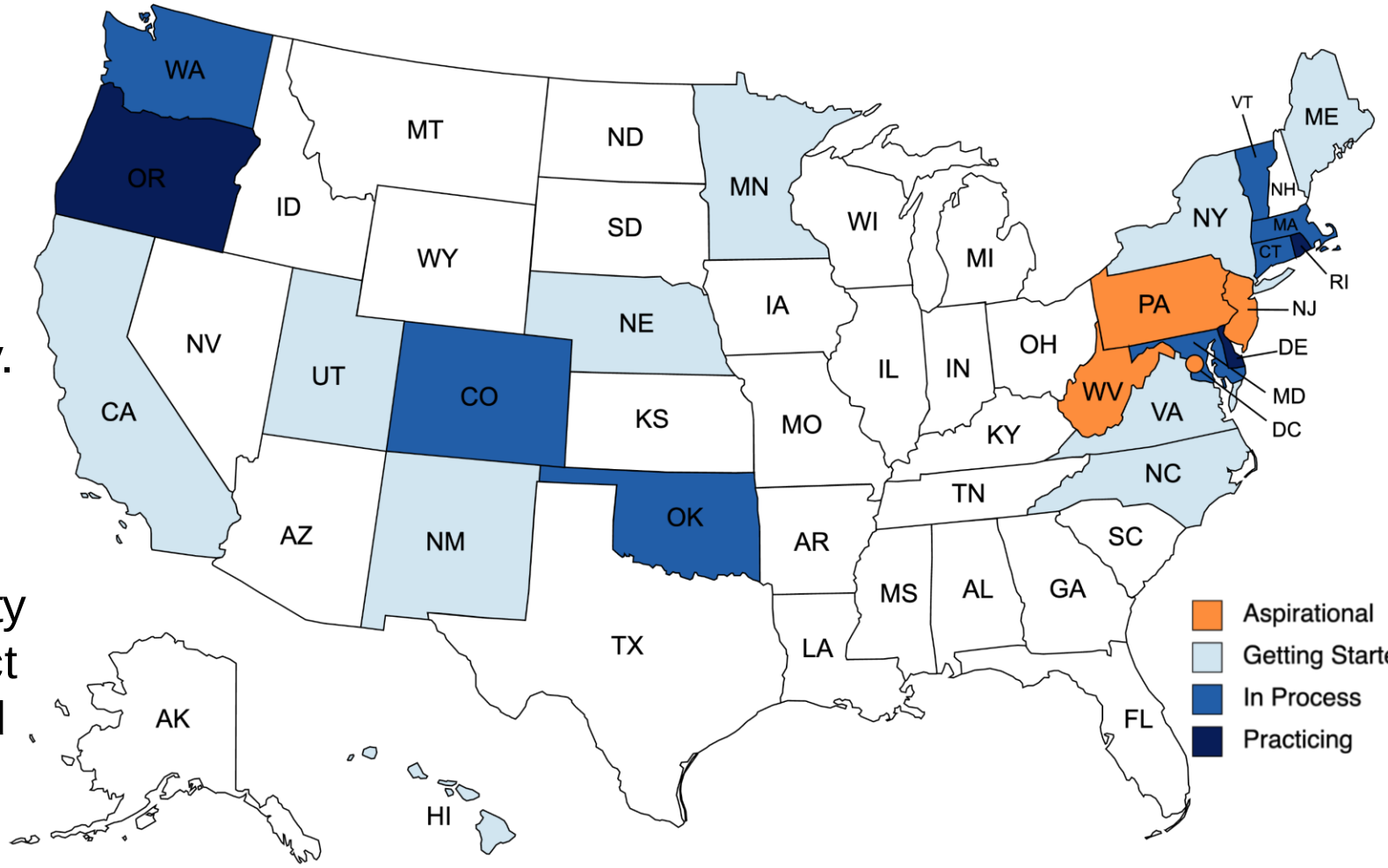
State Efforts to Measure Primary Care Investment

- Over a dozen states have launched efforts to allocate a greater proportion of the health care dollar to primary care.
- Most begin with measurement and reporting, but definitions vary.
- Researchers at Oregon Health and Science University are supporting the federal Agency for Health Care Research and Quality (AHRQ) in a new research project to document methods being used to measure primary care spending.



California Health Care Foundation. Investing in Primary Care: Lessons from State-Based Efforts. April 2022.

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One Vision for Primary Care Delivery in California

- Accessible
- Relationship-based
- Team-based
- Comprehensive

- Person- and family- centered
- Integrated
- Coordinated
- Equitable

Primary Care Subgroup noted the need for sustainable and well-resourced primary care to achieve the vision.

California Quality Collaborative (CQC). Advanced Primary Care: Defining a Shared Standard, April 2022.

Lessons Learned from Other State Efforts

- Need for multi-payer alignment; 4 of 5 states with investment requirements only focus on commercial or Medicaid not both or Medicaid Advantage
- Difficulty transforming care delivery, especially for small providers
- Difficulty reallocating spending to fund primary care investment in the short-term
- Difficulty determining how to account for risk settlement payments in primary care measurement
  - How much was really spent on primary care?

Approach to Measuring Primary Care Spending

Clarifying the measurement approach is an important first step in measuring primary care spending.

Approach	Trade Offs
Core Services: Is spending on core primary care services sufficient?	• Helpful starting point to identify populations or geographic areas in need of additional access. • May miss important aspects of care delivery.
Future Vision: Is primary care spending adequate to support future vision for primary care delivery?	• May be helpful to setting a future target and monitoring progress. • May include services not currently provided on a routine basis.

Note: Some spending will not be captured (e.g., uninsured, third-party vendors, concierge care and worksite clinics).

Primary Care Investment Measurement Decisions for OHCA to Consider

1. Include a narrow or expanded set of services, or all?
2. Include a narrow or broad set of providers?
3. How to incorporate behavioral health services and/or providers?
4. How to incorporate OB/GYN services and/or providers?
5. Should the definition be limited to certain places of service?
6. Include or exclude pharmacy spending in denominator?
7. Design a modular definition to support different use cases?
8. How should non-claims payments be apportioned to primary care?

The Primary Care Subgroup will develop recommendations for the Investment & Payment Workgroup to consider at its December and January meetings.

Primary Care Investment Benchmark Setting Decisions for OHCA to Consider

1. Single benchmark or benchmarks for each payer type?
2. Single benchmark, or separate benchmarks for children and adults?
3. Absolute, relative improvement, or stairstep benchmark?
4. Benchmark based on percent of spending or defined amount?

The Investment & Payment Workgroup will discuss and consider these questions at its January meeting.

Next Steps

November 2023

- OHCA shares revised APM standards with workgroup in early November and discusses during workgroup meeting
- Advisory Committee provides feedback on draft APM standards, definitions, and goals
- Primary Care Technical Subgroup discusses measurement decisions

December 2023

- Primary Care Technical Subgroup provides recommendations on primary care investment measurement decisions
- Workgroup reviews Subgroup recommendations on primary care investment measurement decisions

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Adjournment

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Appendix A: Revised APM Standards and Implementation Guidance

Revised APM Standards & Implementation Guidance

1. Use prospective, budget-based, and quality-linked payment models that improve health, affordability, and equity.

1. Pay providers in advance to provide a defined set of services to a population when possible. HCP-LAN classifies these models as Category 4A, 4B, and 4C. Research finds that prospective payment of at least 60% of a provider organization's total payments results in meaningful change in clinical practice and reduces administrative burden.
2. If Category 4 payment is not feasible for a certain line of business or provider, advanced payment models that include shared savings and when appropriate, downside risk, should be used when possible. This includes models that promote higher value hospital and specialty care. HCP-LAN classifies these models as Category 3A and 3B.
3. Design core model components to align with models already widely adopted in California whenever possible. Examples include the Medicare Shared Savings Program (MSSP) and the Realizing Equity, Access, and Community Health (REACH) program. Core components may include prospective payment, benchmarking and attribution methodologies, performance measures, minimum shared savings and risk thresholds, and risk corridors. If full alignment with an existing model is not feasible, review and incorporate stakeholder perspectives and lessons learned from the CMS published reports on models.

Text in blue indicates revisions to the APM Standards.

Revised APM Standards & Implementation Guidance

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

1. Align financial incentives to reduce utilization and excess spend on high-cost care such as specialty pharmacy, unnecessary specialty care, and hospital-based care.
2. Create incentives to reduce harmful or low value care.
3. Reduce administrative inefficiency across the health care payment and delivery system by streamlining contracting, billing, credentialing, performance programs, and other documentation such as prior authorization.
4. Efficiency and cost savings generated through APMs should lead to lower costs for consumers and decrease barriers to care.

Text in blue indicates revisions to the APM Standards.

Revised APM Standards & Implementation Guidance

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

1. Provide sufficient primary care payment to support the adoption and maintenance of advanced primary care attributes such as primary care continuity, accessible and integrated behavioral health, and specialty care coordination.
2. Facilitate equitable access to diverse, interdisciplinary care teams to assess and address consumers' medical, behavioral, and social needs.
3. Support use of technology to strengthen consumer-care team relationships, make care more accessible and convenient, and increase panel capacity without increasing provider workload.
4. Encourage consumers to choose a primary care team to promote access to and use of primary care and enable payment model success.
5. Reduce financial barriers for primary care visits by decreasing or eliminating copays and not applying the deductible in benefit designs.

Text in blue indicates revisions to the APM Standards.

Revised APM Standards & Implementation Guidance

4. Be transparent with providers in all aspects of payment model design and terms including attribution and performance measurement.

1. Share attribution methodologies and outputs widely and in formats accessible to providers.
2. Clearly articulate the performance measures used, provide the technical specifications including risk adjustment methods, and share how incentive payments are calculated.

Revised APM Standards & Implementation Guidance

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.

1. Provide upfront financial support to new entrants to assist them in hiring care team members, improving analytic capabilities, and making other investments to foster long-term success in the model.
2. Make timely incentive payments that reward improvement and attainment, ideally no later than six to nine months after the performance period.
3. Give providers – particularly those with lower revenues – a gradual, stepwise approach for assuming financial risk and moving into downside risk arrangements.
4. Utilize risk adjustment methodologies that incorporate clinical diagnoses, demographic factors, and other relevant information. Monitor emerging methodologies and explore opportunities to incorporate social determinants of health in risk adjustment

Text in blue indicates revisions to the APM Standards.

Revised APM Standards & Implementation Guidance

6. **Collect demographic data**, including RELD-SOGI* data, to enable stratifying performance.
    1. Participate in state and national efforts to identify and promote emerging best practices in health equity data collection, such as those identified in the CMS Framework for Health Equity.
    2. Align internal race, ethnicity, language, disability status, sex, sexual orientation, and gender identity (RELD-SOGI) data collection with the United States Core Data for Interoperability (USCDI) set where applicable and appropriate to reduce administrative burden.
    3. Support providers in collecting information on individual consumers' social needs through standardized, validated screening tools.
    4. Prioritize using self-reported demographic data. When self-reported data is incomplete or unavailable, leverage population-level data or indices.

Text in blue indicates revisions to the APM Standards.

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

Revised APM Standards & Implementation Guidance

7. Measure and stratify performance to improve population health and address inequities.

1. Select a limited number of nationally standardized measures that reflect multiple domains (e.g., quality, equity, utilization, cost, consumer experience) and populations (e.g., pediatric, adult, older adults). Prioritize outcome measures, whenever possible.
2. Align measures and technical specifications with those used by the Department of Managed Health Care, California Department of Health Care Services, Covered California, the California Public Employees' Retirement System, and the Office of Health Care Affordability, when available.
3. Include measures that monitor for unintended consequences of the payment model, such as stinting or not providing appropriate, necessary care to consumers to save money. For example, track changes in potentially avoidable emergency department visits and hospital admissions.

Text in blue indicates revisions to the APM Standards.

Revised APM Standards & Implementation Guidance

8. Invest in strategies to address inequities in access and outcomes.

1. Increase payments to providers serving populations with higher health-related social needs to support enhanced medical and behavioral care and social care coordination.
2. Support providers in using data to identify and address inequities, including by providing care consistent with the National Culturally and Linguistically Appropriate Services Standards.
3. Develop partnerships with community-based organizations and leverage local resources to address health-related social needs.

Text in blue indicates revisions to the APM Standards.

Revised APM Standards & Implementation Guidance

9. Equip providers with actionable data to inform population health management and enable their success in the model.

1. Data and information shared should reflect providers' varying analytic needs and capabilities ranging from clear actionable reports to claims-level data.
2. Offer analytic support, such as hands-on training and example dashboards, to develop the capacity of providers, interdisciplinary care teams, and non-clinical staff to ingest and benefit from information.
3. Facilitate data exchange across providers, community-based organizations, and payers, particularly through use of the California's Health and Human Services Data Exchange Framework.

Text in blue indicates revisions to the APM Standards.

Revised APM Standards & Implementation Guidance

10. Provide technical assistance to support new entrants and other providers in successful APM adoption.

1. Payers and providers should work collaboratively to develop a technical assistance plan that identifies potential barriers to success and conditions necessary to build capacity in these areas. The plan should offer clear action steps for what assistance will be provided and the format and frequency of the assistance.
2. Develop partnerships with collaborative technical assistance organizations or other payers to collectively support technical assistance to providers.

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Appendix B: HCP-LAN Framework and Expanded Non-Claims Payments Framework

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

Draft Expanded Framework Categories A, B, C

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	2A
A2	Primary care and behavioral health integration	2A
A3	Social care integration	2A
A4	Practice transformation payments	2A
A5	EHR/HIT infrastructure and other data analytics payments	2A
B	**Performance Payments**	
B1	Retrospective/prospective incentive payments: pay-for-reporting	2B
B2	Retrospective/prospective incentive payments: pay-for-performance	2C
C	**Payments with Shared Savings and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	3A
C2	Procedure-related, episode-based payments with risk of recoupments	3B
C3	Condition-related, episode-based payments with shared savings	3A
C4	Condition-related, episode-based payments with risk of recoupments	3B
C5	Risk for total cost of care (e.g., ACO) with shared savings	3A
C6	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.

Draft Expanded Framework Categories D, E, F

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
D	**Capitation and Full Risk Payments**	
D1	Primary Care capitation	4A
D2	Professional capitation	4A
D3	Facility capitation	4A
D4	Behavioral Health capitation	4A
D5	Global capitation	4B
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C
E	**Other Non-Claims Payments**	
F	**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.

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 are considered "linked to quality" if the provider is eligible to receive a financial bonus or is at risk for a financial penalty based on performance 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 meeting 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 are considered "linked to quality" if the provider is eligible to receive a financial bonus or is at risk for a financial penalty based on performance on specific predefined 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
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 s, 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

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
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	Price concessions, price discounts, or discounts of any sort that reduce payments, including a partial refund of payments or any reductions to the ultimate amount paid; a financial reward for inclusion of a drug in a preferred drug list or formulary or preferred formulary position; market share incentive payments and rewards; credits; remuneration or payments for the provision of utilization or claim data to manufacturers for rebating, marketing, outcomes insights, or any other purpose; rebates, regardless of how categorized, and all other compensation to carriers, their pharmacy benefit managers (PBMs), rebate aggregators, or subsidiaries.	