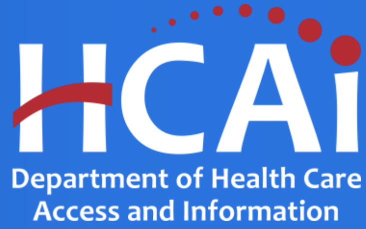


OHCA Investment and Payment Workgroup

June 20th, 2024

Agenda

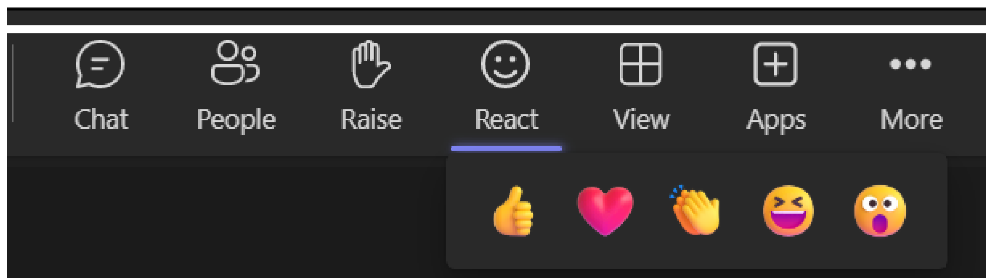
9:00 a.m.	**1. Welcome and Updates**
9:05 a.m.	**2. Review Board Feedback on Alternative Payment Model Standards and Adoption Goals**
9:45 a.m.	**3. Review Board and Public Comment Feedback on Primary Care Recommendations**
10:30 a.m.	**4. Adjournment**

HCAI Department of Health Care Access and Information

Meeting Format

Reminder: Please introduce yourself in the chat with your name, title, and organization.

- 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: June 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#

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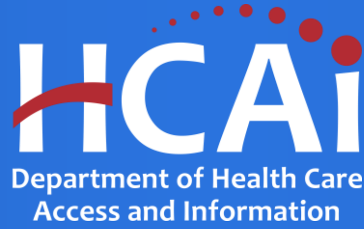

Review Board Feedback on Alternative Payment Model Standards and Adoption Goals

Ngan Tran, Value-Based Payment Group Manager

Board Feedback on APM Standards and Implementation Guidance

#	Feedback Theme	OHCA's Response
1.	Incorporate more guidance on the need to design APMs to serve consumers that require the most care.	Added that APMs should address the needs of consumers with highest healthcare costs and most to gain from comprehensive, coordinated care delivery. OHCA will collect risk score data for members in APM and not in an APM (fee-for-service).
2.	Include stronger focus on continuity of care, consider how plans are allowing members to keep their PCP when moving between plans.	Added emphasis on supporting continuous relationship with primary care providers. Include focus on payment to support primary care continuity.
3.	Emphasize importance of prospective attribution for PPO plans.	Revised to include prospective attribution as a core component of payment models.
4.	Help small practices implement APMs.	Standards emphasize using a gradual approach for small practices to take on financial risk in APMs and providing technical assistance to support success in APMs.
5.	Align quality measures in APMs with those used by sibling departments.	Added list of five aligned, priority measures across sibling departments.

Redlined versions of Implementation Guidance can be found in the Appendix of this deck.

APM Standards for Payer-Provider Contracting

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.

Redlined versions of Implementation Guidance can be found in the Appendix.

APM Standards for Payer-Provider Contracting

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).

Redlined versions of Implementation Guidance can be found in the Appendix.

Alternative Payment Model Data Collection and Goals

Board Feedback on APM Data Collection

<table>
<tr><th>#</th><th>Feedback Theme</th><th>OHCA’s Response</th></tr>
<tr><td>1.</td><td>Need clear approach for tracking the success of APMs; consider collecting additional data from payers, provider organizations in the future.</td><td rowspan="2">Will provide more information today on initial data collection and opportunities for future analyses. OHCA will collect risk score data for members in APM and not in an APM (fee-for-service).</td></tr>
<tr><td>2.</td><td>Collect data on how many high utilizers/high risk consumers are covered under APMs.</td></tr>
<tr><td>3.</td><td>Collect data on how many people are covered under an APM in PPOs.</td><td>Basis for APM adoption goal, will report on members in an APM in Commercial PPOs.</td></tr>
<tr><td>4.</td><td>Collect data on results of direct contracting between purchasers/employers and providers.</td><td>OHCA data submitters are health plans and third-party administrators, not employers.</td></tr>
<tr><td>5.</td><td>Add reporting on APM contract structure and requirements between payer and provider.</td><td>Significantly increases reporting burden. However, using the Expanded Framework definitions will provide some qualitative information, which we will discuss today.</td></tr>
</table>

State APM Data Collection

Data Element	CA*	CO	DE	MA	MD	OR
% Providers in APMs	Yes	Yes	PC only	Yes	Yes	Yes
% Members in APMs	Yes	Yes	PC only	Yes	No	Yes
% Contract dollars in APMs	Yes	Yes	Yes	Yes	Yes	Yes
Non-Claims Spending	Yes	Yes	Yes	Yes	No	Yes
Health Status of members	Risk Score	No	No	Risk Score	Age/Gender Factor	No

*OHCA APM data collection regulations will be publicly discussed later this fall.

HCAI Developed Expanded Framework for Collecting Non-Claims Payment Data

	Expanded Non-Claims Payments Framework Categories
1	**Population Health and Practice Infrastructure Payments**
2	**Performance Payments**
3	**Payments with Shared Savings and Recoupments**
4	**Capitation and Full Risk Payments**
5	**Other Non-Claims Payments**
6	**Pharmacy Rebates**

- Developed Expanded Framework to support OHCA and HPD non-claims data collection
- Expanded Framework crosswalks Milbank non-claims-payment categories with HCP-LAN categories for the purpose of reporting on APM adoption
- Updates categories and subcategories to reflect care delivery and payment models in California
- Allow single framework to support multiple use cases
  - Define payment purpose
  - Measure provider risk

For additional background and details, see V. Pegany et al, "A New Standard for Categorizing and Collecting Non-Claims Payment Data", Milbank Memorial Fund, March 18, 2024. https://www.milbank.org/2024/03/a-new-standard-for-categorizing-and-collecting-non-claims-payment-data/

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

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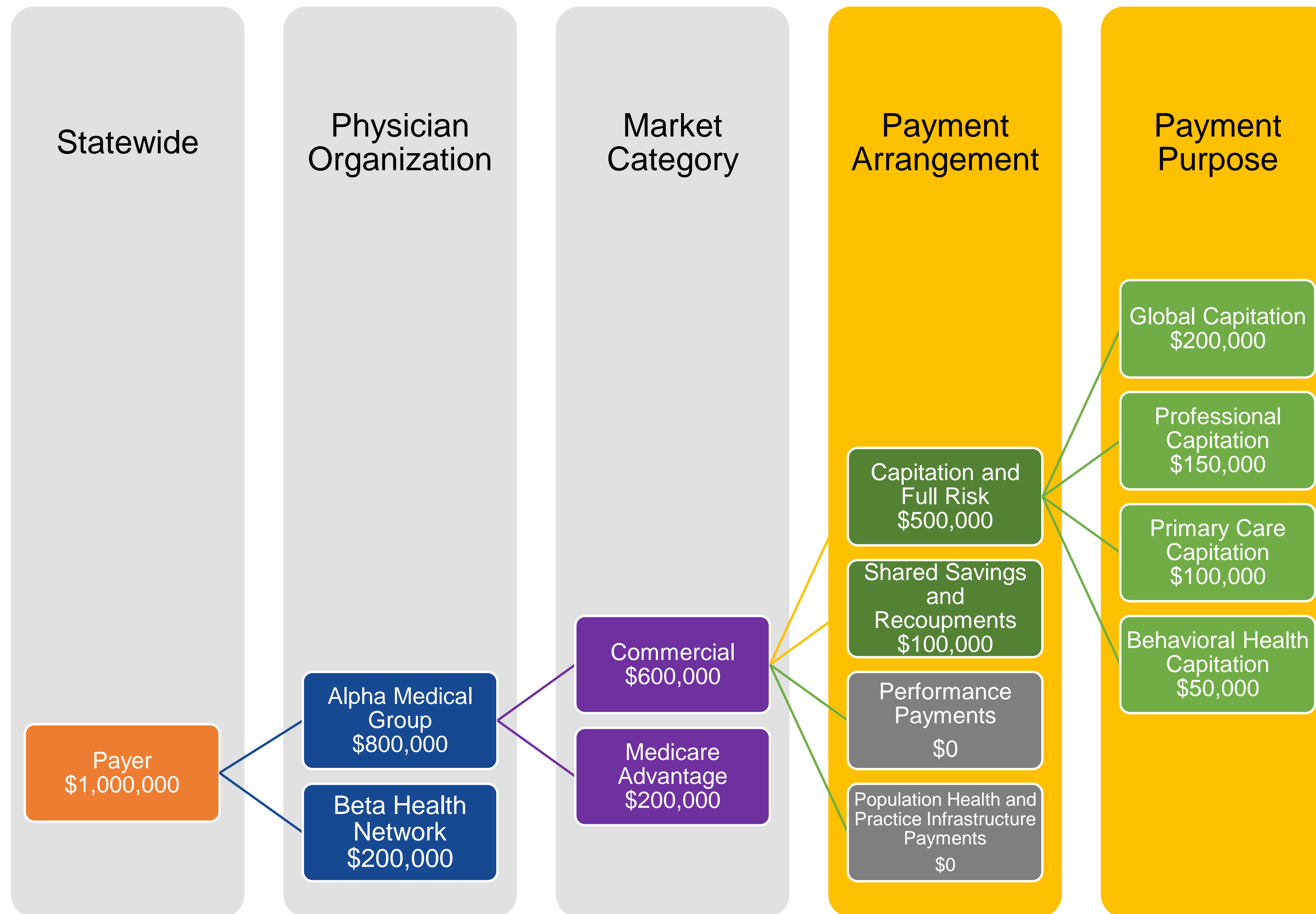
Expanded Framework, Categories 4-6

	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**	

APM Data Collection



Data elements collected will support reporting on:

- Numbers and types of APM arrangements
- Percent of members in APMs (target)
- Percent of providers in APMs
- Percent of spending in APMs
- Differences in total spending by arrangement type
- Relative health status of patients in APMs (risk scores) vs. those not in APMs

Expanded Framework Definitions Provide Some Qualitative Information

Information Collected	CA*	CO	MD
Type of payments (claims and non-claims)	Yes	Yes	Yes
Services covered (non-medical, subset of medical, comprehensive)	Yes	Yes	Yes
Whether arrangement includes measurement of quality?	Yes	Yes	Yes
Whether arrangement includes measurement of spending target (benchmark)?	Yes	Yes	Yes
Prospective, retrospective, population-based payments?	Yes	Yes	Yes
Risk to provider (upside, downside, both)?	Yes	Yes	Yes

*OHCA APM data collection regulations will be publicly discussed later this fall.

Potential Questions OHCA Could Answer

The Expanded Framework's use of descriptive, more granular payment arrangement categories paired with the data collection structure will allow OHCA to ask additional questions of the data.

Examples:

- Are APMs engaging patients with higher needs?
- Is total spending lower if APM adoption is higher?
- Is non-claims spending increasing as a percent of total spending?
- What types of payment arrangements are gaining traction?
- What portion of dollars are being paid prospectively?

Board Feedback on APM Goals

#	Feedback Theme	OHCA's Response
1.	Consider faster timeline to achieve goals.	Workgroup, Advisory Committee members, and public comment emphasized contracting changes take time. The recommended approach offers short and long-term goals that increase commercial PPO APM adoption by nearly 50% by 2026 (i.e., estimated 17% of members today to 25%) and by nearly 400% by 2034.
2.	Consider aligning Commercial PPO and Medi-Cal goals at 75%.	Most Medi-Cal enrollees are covered through Medi-Cal managed care plans. These plans will need to add a quality link if one does not exist. PPO products will require significant shifts in member engagement, contracting, payment, and provider readiness. The attribution approach most used in PPO products arrives at a lower percentage of attributed members who participate in an APM.
3.	Support for 75% Medi-Cal target due to large portion of population in Medi-Cal.	OHCA agrees that having 75% of Medi-Cal members in APM arrangements will have significant impact on moving Californians into APMs.

Key Design Decisions and Rationale for APM Goals

Design Decision	Rationale
Base on members	Promotes population health focus
Count APMs farthest along the continuum *(i.e., HCP-LAN 3A - 3B, 4A – 4C)*	Focuses in on arrangements most likely to improve affordability
Require link to quality	Emphasizes need to improve quality while lowering costs
Tie goals to HCP-LAN categories	Aligns with national and sibling department approaches and allows for comparisons; eases data submitter burden
Collect data with Expanded Framework	Offers more detail on type and purpose of the payment
Leverage definitions to drive preferred approaches	Minimum risk requirements and other language in definitions reflects research and stakeholder preferences in APM design

*OHCA APM adoption target decisions are not final and subject to change.

APM Adoption Goals (May Recommendation)

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%

Considerations:

- Represents compromise reached in the Workgroup over 10 months of discussion.
- Developed in collaboration with sibling departments.
- Reflects Commercial PPO contracting cycles.
- Allows time to engage members and strengthen provider readiness; less risk of promoting greater consolidation.

Dept. of Health Care Access and Information (2024). *APM Standards and Adoption Goals Memo for Board Adoption.* May 2024 OHCA Health Care Affordability Board. https://hcai.ca.gov/wp-content/uploads/2024/05/APM-Standards-and-Adoption-Goals-Memo-for-Board-Adoption.pdf

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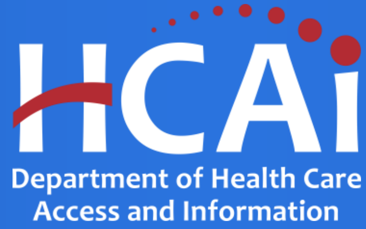


Review Board and Public Comment Feedback on Primary Care Recommendations

Debbie Lindes, Health Care Delivery System Group

Proposed Primary Care Spending Measurement Definition and Methodology

Board Feedback on Primary Care Definition

#	Feedback Theme	OHCA's Response
1.	Concerns about current exclusion of OB-GYN providers.	Most feedback from stakeholders including the Investment and Payment Workgroup, the Advisory Committee, and public comment has preferred to exclude OB-GYN providers. We will review feedback received and discuss the rationale for OHCA's proposal to exclude OB-GYNs as PCPs.
2.	Concern about broadly capturing behavioral health in primary care, although reassured knowing there is a separate behavioral health workstream.	OHCA appreciates the need to fully and accurately capture behavioral health spending. This will occur through the behavioral health measurement process. Behavioral health services performed in a primary care setting will be captured as part of the primary care spending measurement process. OHCA will have the ability to add this spending to analyses of primary care or behavioral health spending depending on the use case.

Public Comments on Primary Care Measurement Approaches

#	Feedback Theme	OHCA's Response
1.	Endorse proposed definitions for primary care services, places of service, and provider types.	OHCA appreciates the significant and thoughtful contributions of so many stakeholders throughout the process.
2.	Endorse focusing primary care definition on providers and services that support holistic, person-centered primary care.	
3.	Agree with use of the Expanded Framework to define non-claims spending.	
4.	Endorse excluding OB-GYNs as PCPs (5 letters).	Most feedback from stakeholders including the Investment and Payment Workgroup, the Advisory Committee, and public comment has preferred to exclude OB-GYN providers. We will review feedback received and discuss the rationale for OHCA's proposal to exclude OB-GYNs as PCPs.
5.	Oppose excluding OB-GYNs (3 letters).	

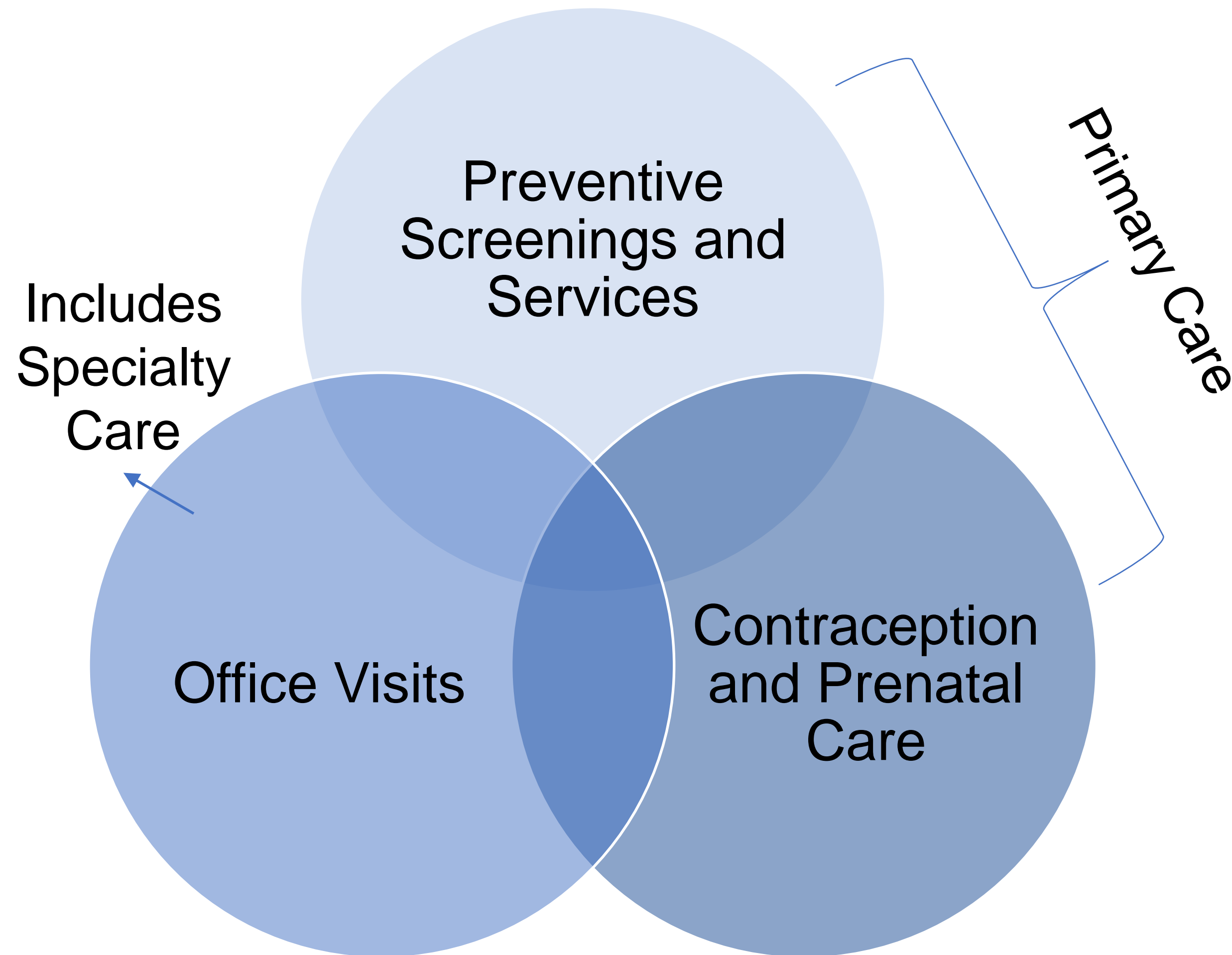
OHCA's Proposed Definition of Primary Care Excludes OB-GYNs

OHCA's Proposal: Include OB-GYN services provided by a primary care provider at a primary care place of service and exclude all services provided by an OB-GYN in the primary care definition. OHCA will conduct analyses using HPD to identify proportion of OB-GYNs providing primary care consistent with vision.

Rationale: Majority of feedback received supports investing in providers who provide continuous whole-person care for all body systems. Evidence is lacking to assess whether OB-GYNs typically meet this definition.

- Some stakeholders stated that patients typically do not receive care from OB-GYNs for common primary care services, such as treatment of a sinus infection or management of chronic conditions such as hypertension and diabetes. Others expressed that OB-GYNs do provide comprehensive care.
- 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.

Including vs. Excluding OB-GYNs - Overcounting vs. Undercounting Primary Care Spend



Including OB-GYNs as PCPs would count all care they provide that meets the service and place of service definitions. The definition does not restrict based on diagnosis.

- Office visits for OB-GYN specialty care would be counted as primary care.

Excluding OB-GYNs as PCPs would mean that the preventive screenings and other primary care services they provide are not counted.

Developing a separate definition for OB-GYNs would be overly burdensome for data submitters, especially when applied to non-claims payments.

OB-GYN Options for OHCA's Consideration

Option	Considerations	Public Comment Examples
1. **Exclude OB-GYNs (current recommendation):** Include a limited set of 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.	• Does not count preventive services and other primary care by OB-GYNs • Underestimates primary care spend	"OHCA's charge is to move the health care delivery systems towards high-value, primary care-focused care … data has not supported that OBGYNs coordinate and manage health care across the lifespan inclusive of total body systems."
2. **Include OB-GYNs as PCPs:** Include OB-GYNs when designated as primary care providers in a DMHC-regulated health plan network combined with recommended primary care services and places of service.	• Counts all OB-GYN specialty care office visits as primary care services • Overestimates primary care spending	"OB/GYNs provide essential primary care services, especially in underserved and rural communities … OB/GYNs are statutorily eligible primary care providers and should be included in this definition."

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Behavioral Health Providers

Primary Care Approach to Behavioral Health	Behavioral Health Spending Approach
Captures a limited set of behavioral health services provided by primary care providers in a primary care setting and payments to support integrated behavioral health.	OHCA will measure behavioral health spending and set spending benchmarks as part of the Behavioral Health Investment workstream – this will include all other "primary" behavioral health care.

State Definition Comparison: Nine of the 15 state primary care definitions reviewed by the OHCA team exclude behavioral health providers. Only one state includes behavioral health providers in their primary care definition and measures behavioral health spending separately.

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Draft Primary Care Investment Benchmark

Board Feedback on Primary Care Investment Benchmark Recommendation

#	Feedback Theme	OHCA's Response
1.	Interest in faster progress in the early years of benchmark implementation.	There are trade offs of steeper increases early on to fund infrastructure development and workflow redesign versus later when more providers are likely to be engaged in more complex care management activities with broader care teams.
2.	Interest in setting two goals, one each for pediatric and adult populations primary care investment.	Data submitter burden for two benchmarks, especially for non-claims spending, is large. Requires additional assumptions on non-claims spend. Will collect and report on claims-based primary care investment by age group; benchmark will be set for all ages.
3.	Interest in data collection at the medical group level.	OHCA plans to begin by collecting and reporting data from payers at the medical group level. OHCA is planning to collect data from Restricted or Limited Knox Keene licenses in the future. OHCA has not determined whether it will collect data from other entities in the future.
4.	Interest in understanding how OHCA definition compares to IHA definition	Will provide more information today on the definition differences between OHCA and IHA definitions and their associated impact.
5.	Interest in experience in other states that contributes to progress.	Will provide more information today on the experience of other states.

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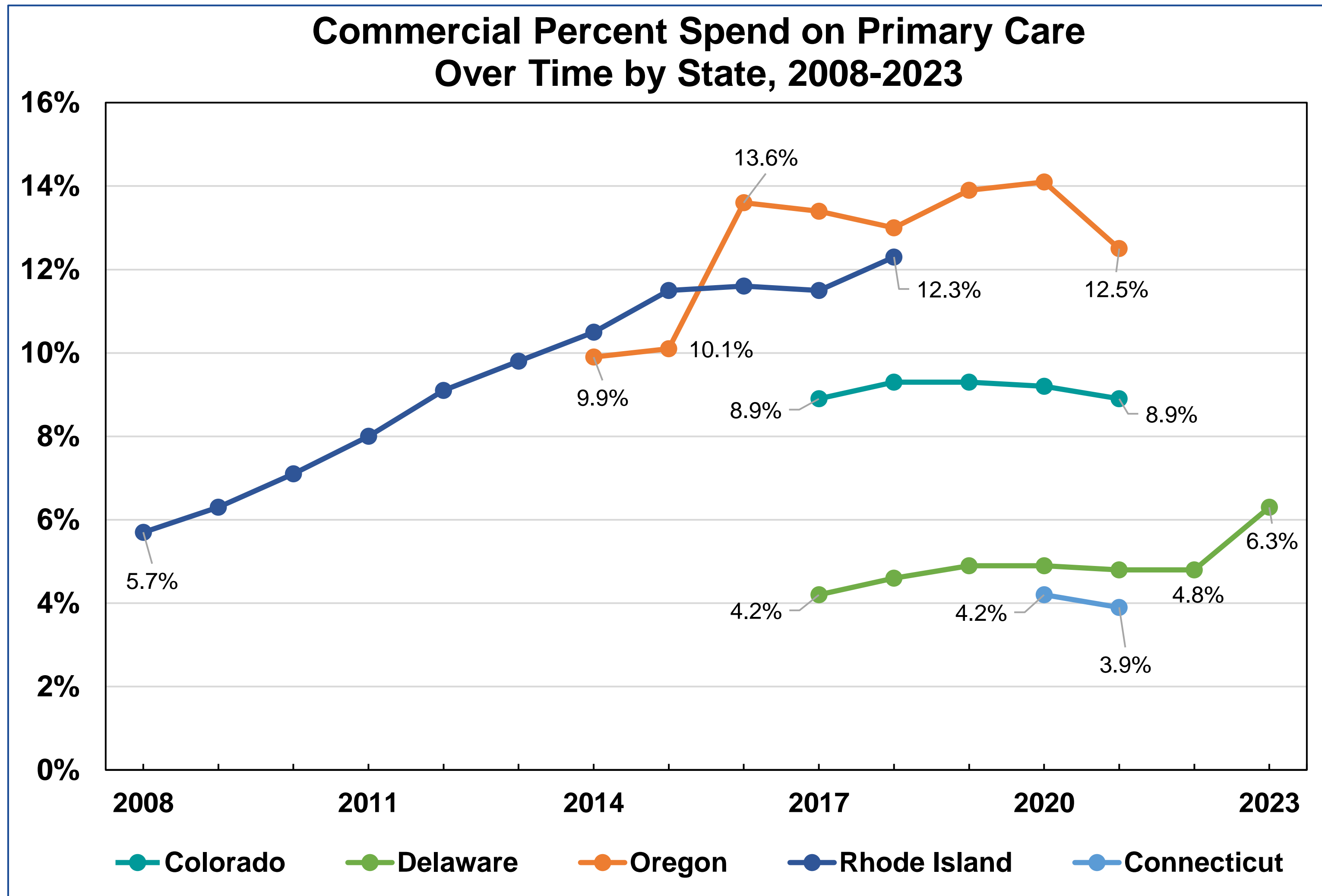
Public Comments on Primary Care Investment Benchmark Recommendation

#	Feedback Theme	OHCA's Response
1.	Strong support for primary care investment benchmark, including 15% benchmark for 2034.	This level of investment reflects stakeholders' vision for primary care in California, as sufficiently resourced to provide whole-person, coordinated care.
2.	Request to consider extending time frame to achieve 15% benchmark; concern benchmark may be unrealistic.	The 10-year timeline aims to gradually reallocate investment over time while still recognizing the critical and immediate need to improve primary care access.
3.	Support for annual improvement benchmark of 0.5%-1% per year.	The annual improvement benchmark offers an important milestone for monitoring the contributions of each payer towards achieving the statewide goals.
4.	Support for a single benchmark for all ages due to increase in reporting complexity and burden.	Benchmark will be set for all ages, OHCA will collect and report primary care investment by age group.

Experience in Other States



- **Colorado** primary care progress focused on movement to APMs
- **Delaware** requires minimum fee-for-service payments, overall investment; increases in primary care non-claims payments
- **Oregon's** PCMH initiative increased primary care investment percentage; excludes pharmacy from denominator; includes OB/GYN and BH
- **Rhode Island** slowed spending with price growth limits while primary care spend increased; robust care transformation initiatives
- **Connecticut** total medical expense increases outpaced primary care investment

Note: State definitions and total cost of care differ, which contributes to differences in investment percentages. The Delaware 2023 figure is a projection. Baum, Aaron, et al. (2019, February). Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers. *Health Affairs*. https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05164

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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%**

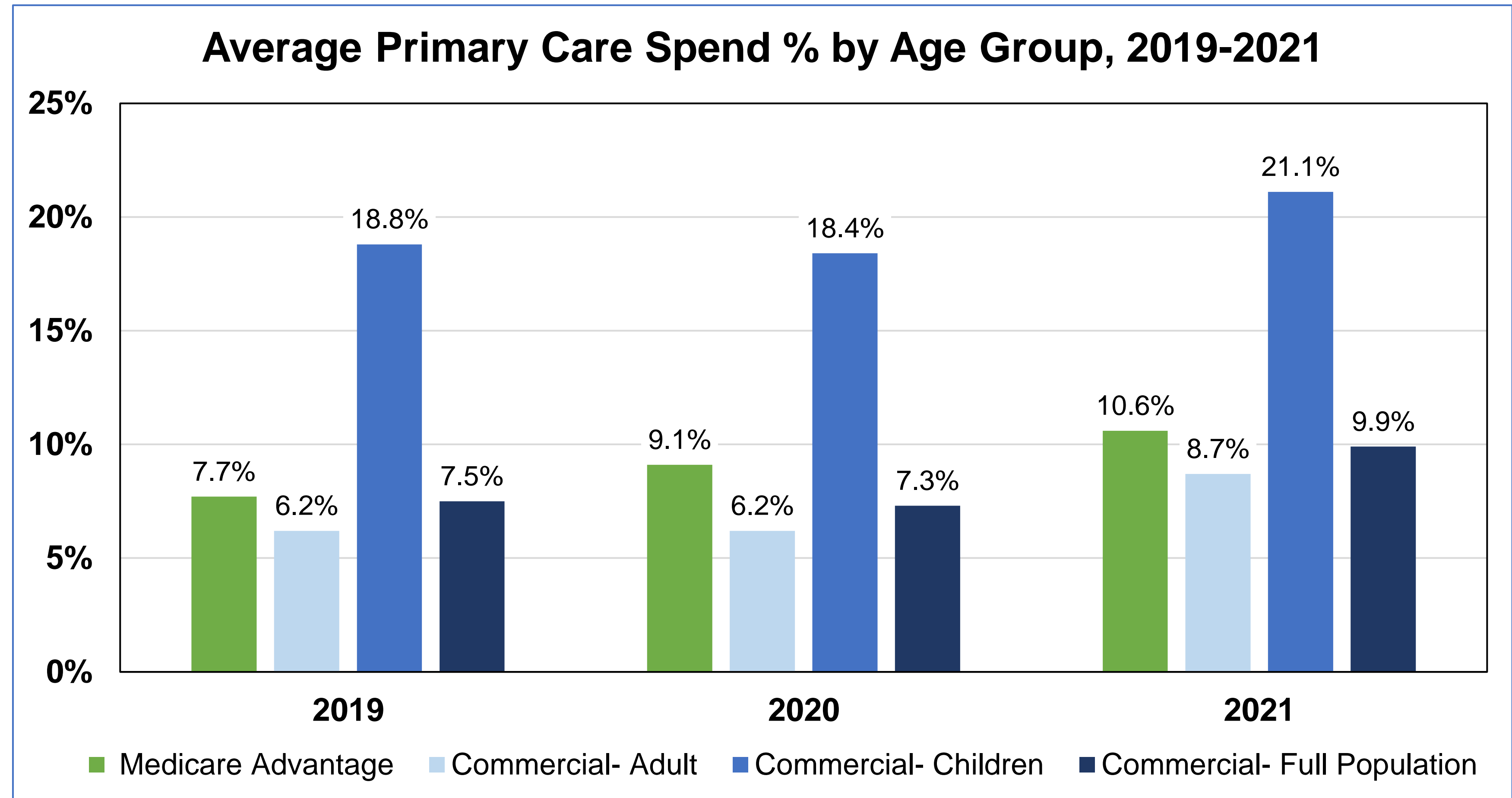
Note: *ACA* is Affordable Care Act; *SPD* is seniors and persons with disabilities.

Source: Edrington Health Consulting analysis of CY 2019 rate development templates; direct plan submission of proprietary data, July 2022.

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/

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 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

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Comparing OHCA and IHA Primary Care Definitions

Component	Similarities	Differences	Impact
Providers	Use provider taxonomies to define primary care specialties.	OHCA also requires providers to be designated as primary care in DMHC Annual Network report.	OHCA slightly lower
Services	Include a broad scope of services when performed by a primary care provider.	OHCA includes the broadest service list of any state primary care definition. IHA does not restrict.	OHCA slightly lower
Places of Service	Include a wide range of care settings.	OHCA excludes certain care settings to align with vision of comprehensive, coordinated primary care.	OHCA slightly lower
Non-Claims Payments	Include capitation and incentive payments.	OHCA also includes certain care management, infrastructure and portions of risk settlement payments.	OHCA higher

OHCA estimates the combined impact of the differences will result in OHCA's primary care spend being 1% to 2% less than the IHA analysis.

Draft Primary Care Investment Benchmark Recommendation

Annual Improvement Benchmark: Each payer* increases primary care spending by 0.5 percentage points to 1 percentage point per year, depending on current level of investment.

AND

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

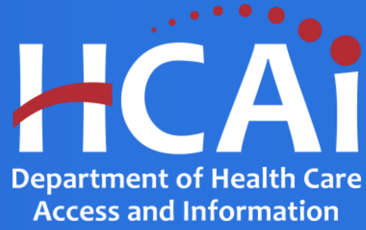
Rationale:

- Gives all payers reasonable opportunity to demonstrate immediate progress and long-term success
- Offers gradual glidepath to ambitious but achievable 15% goal
- Offers some flexibility since OHCA does not have exact measures of current spend using its definition
- Has received strong stakeholder support

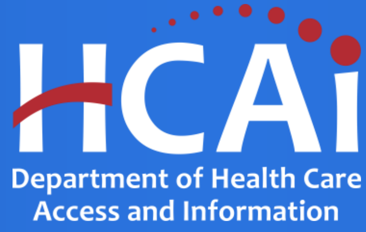
*Payers at or above 15% of total medical expense may refrain from continued increases if not aligned with care delivery or affordability goals.
Note: The Annual Improvement Benchmark was previously referred to as the Relative Improvement Benchmark and the 2034 Investment Benchmark was previously referred to as the Absolute Improvement Benchmark.

Next Steps

- In the June 26th Board meeting, OHCA will present:
  - Update on Draft Alternative Payment Model Standards and Adoption Goals
  - Update on Primary Care Definition and Investment Benchmark, Including Summary of Public Comment Feedback
- Reminder, the July 17th Investment and Payment Workgroup meeting will be the first meeting fully dedicated to behavioral health. An updated meeting invitation will be sent shortly.



Adjournment



Appendix

APM Standards and Implementation Guidance

APM Standard 1 and Implementation Guidance

1. **Use prospective, budget-based, and quality-linked payment models** that improve health, affordability, and equity.
   1.1. 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.[2] 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.

   1.2. 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.

   1.3. Design core model components, with input from providers, 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~~ should include prospective payment and attribution methodologies, 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.

Red text indicates changes made based on Board, Workgroup, and public comments from the May 2024 version: https://hcai.ca.gov/wp-content/uploads/2024/05/APM-Standards-and-Adoption-Goals-Memo-for-Board-Adoption.pdf

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APM Standard 2 and Implementation Guidance

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

    2.1. 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.

    2.2. Create incentives to reward prevention, disease management, and evidence-based care while discouraging harmful, low value care, and over-treatment.

    2.3. 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.

    2.4. Efficiency and cost savings generated through APMs should lead to lower costs for consumers and decrease barriers to care.

    2.5. Design innovative APMs to address the needs of all consumers, particularly those with the highest healthcare costs and most to gain from comprehensive, coordinated care delivery.

Red text indicates changes made based on Board, Workgroup, and public comments from the May 2024 version: https://hcai.ca.gov/wp-content/uploads/2024/05/APM-Standards-and-Adoption-Goals-Memo-for-Board-Adoption.pdf

APM Standard 3 and Implementation Guidance

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

   3.1. 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.

   3.2. Facilitate equitable access to diverse, interdisciplinary care teams (e.g., Registered Nurses, Doctors of Pharmacy, and Community Health Workers, among others) to assess and address consumers' medical, behavioral, and social needs.

   3.3. Support use of technology to strengthen consumer-care team relationships, make care more accessible and convenient, and increase panel capacity without increasing provider workload.

   3.4. Encourage consumers to develop a continuous relationship with ~~choose~~ a primary care team to promote access to and use of primary care and enable payment model success.

   3.5. Reduce financial barriers for primary care visits, behavioral health visits, and preventive services by decreasing or eliminating out-of-pocket costs for consumers (e.g., copays, co-insurance, or deductibles in benefit design).

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APM Standard 4, 5 and Implementation Guidance

4. **Be transparent** with providers in all aspects of payment model design and terms including attribution and performance measurement.
    - 4.1. Share attribution methodologies and outputs widely and in formats accessible to providers.
    - 4.2. Clearly articulate the performance measures used, provide the technical specifications including risk adjustment methods, and share how incentive payments are calculated.
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.
    - 5.1. 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.
    - 5.2. Make timely incentive payments that reward improvement and attainment, ideally no later than six to nine months after the performance period.
    - 5.3. Give providers – particularly those with lower revenues – a gradual, stepwise approach for assuming financial risk that protects provider financial solvency and supports sustainability.
    - 5.4. 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 methodologies.

APM Standard 6 and Implementation Guidance

6. **Collect demographic data**, including RELD-SOGI data, to enable stratifying performance.

    6.1. Participate in state and national efforts to identify and promote emerging best practices in accurate and complete health equity data collection, such as those identified in the CMS Framework for Health Equity.

    6.2. 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.

    6.3. Support providers in collecting information on individual consumers' social needs through standardized, validated screening tools.

    6.4. Prioritize using self-reported demographic data. When self-reported data is incomplete or unavailable, leverage population-level data or indices.

APM Standard 7 and Implementation Guidance

7. **Measure and stratify performance** to improve population health and address inequities.
   - 7.1. 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.
   - 7.2. 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. In particular, include Childhood Immunization Status – Combination 10, Colorectal Cancer Screening, Controlling High Blood Pressure, Glycemic Status Assessment for Patients with Diabetes, and Depression Screening and Follow-Up for Adolescents and Adults whenever appropriate as these quality measures are the most commonly aligned across state departments.
   - 7.3. Include measures that monitor for unintended consequences of the payment model, such as withholding appropriate, necessary care to consumers to save money. For example, track changes in potentially avoidable emergency department visits and hospital admissions.

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APM Standard 8, 9 and Implementation Guidance

8. **Invest in strategies to address inequities** in access, patient experience, and outcomes.
    8.1. Increase payments to providers serving populations with higher health-related social needs to support enhanced medical and behavioral care and social care coordination.
    8.2. Support providers in using data to identify and address inequities, including by providing care consistent with the National Culturally and Linguistically Appropriate Services Standards.
    8.3. Develop partnerships with community-based organizations and leverage local resources to address health-related social needs.
9. **Equip providers with accurate, actionable data** to inform population health management and enable their success in the model.
    9.1. Data and information shared should reflect providers' varying analytic needs and capabilities ranging from clear actionable reports to clinical registry and claims-level data.
    9.2. 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.
    9.3. Facilitate data exchange across providers, community-based organizations, and payers, particularly through use of the California's Health and Human Services Data Exchange Framework.

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APM Standard 10 and Implementation Guidance

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

10.1. 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.

10.2. Technical assistance should focus on supporting providers to perform well on the metrics that impact their payment.

10.3. Develop partnerships with collaborative technical assistance organizations or other payers to collectively support technical assistance to providers.

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

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

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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

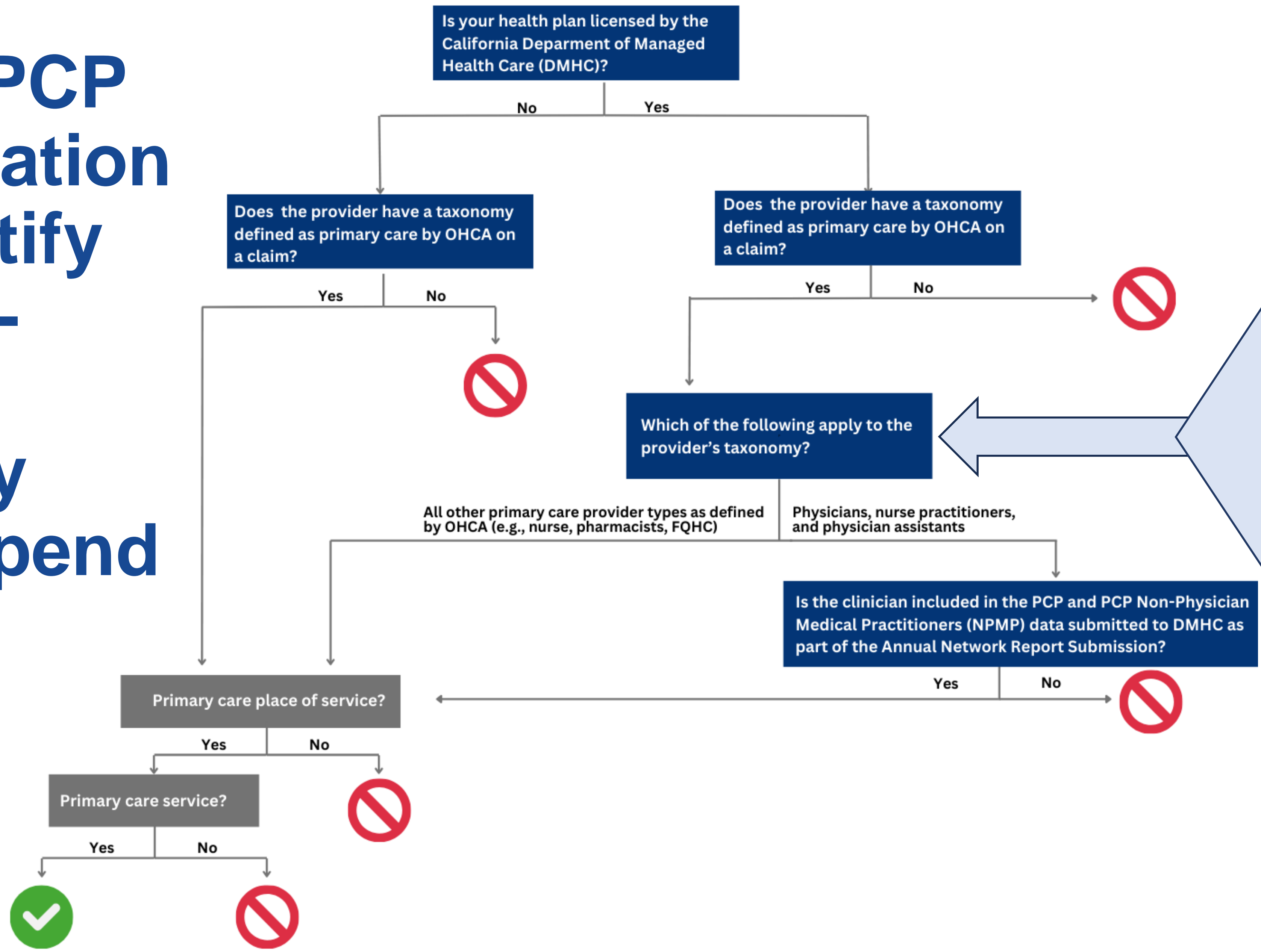
#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
4	**Capitation and Full Risk Payments**	**Per capita, non-claims payments paid to healthcare providers or organizations to provide a defined set of services to a designated population of patients over a 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.**	

Draft Primary Care Spending Measurement Definition and Methodology

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.

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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.

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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.

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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.

Non-Claims Primary Care 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

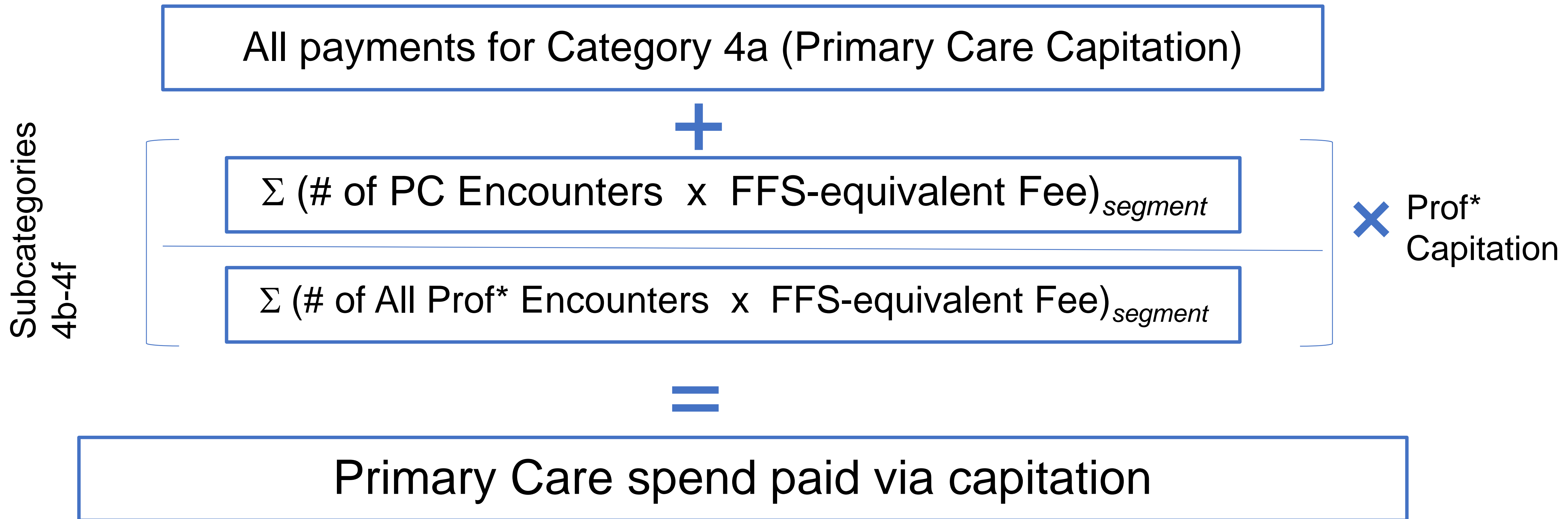
- Limit portion of risk settlement payments that “count” as primary care to the same proportion that claims-based professional spend represents as a percent of claims-based professional and hospital spending.

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.

OHCA Approach to Primary Care Portion of Capitation Payments*



*Revised approach is consistent with Blue Shield of California recommendation.

*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.

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