HCAi
Department of Health Care Access and Information

Health Care Affordability Advisory Committee Meeting

May 14, 2024

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Welcome, Call to Order, and Roll Call

Agenda

Item #1	**Welcome and Call to Order**
Item #2	**Executive Updates** *Elizabeth Landsberg, Director, and Vishaal Pegany, Deputy Director*
Item #3	**Update on Draft Alternative Payment Model Standards and Adoption Goal** *Margareta Brandt, Assistant Deputy Director*
Item #4	**Update on Draft Workforce Stability Standards** *Margareta Brandt, Assistant Deputy Director*
Item #5	**Examples of Cost-Reducing Strategies Employed by Blue Shield of California (Postponed)** *Peter Long, PhD, Executive Vice President, Strategy and Health Solutions*
Item #6	**Update on Draft Primary Care Definition and Investment Benchmark** *Margareta Brandt, Assistant Deputy Director*
Item #7	**Measuring Consumer Affordability** *Vishaal Pegany, and Miranda Dietz, Policy Research Specialist and Project Director for CalSIM, and Laurel Lucia, Director of the Health Care Program, UC Berkeley Labor Center*
Item #8	**Measuring Out-of-Plan Spend** *Vishaal Pegany, and KeriAnn La Spina, Senior Health Researcher, Mathematica*
Item #9	**Public Comment**
Item #10	**Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

Statewide Per Capita Health Care Spending Target

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

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

Quarterly Work Plan*

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

* Work plan is subject to change.

Future Topics Beyond June 2024

THCE & Spending Target

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

Promoting High Value

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

Assessing Market Consolidation

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

Assessing Performance and Enforcement for Entities Participating in Medi-Cal

- Medi-Cal MCO rates are set by DHCS actuaries for each plan, rating region and population, based on several factors, including historical cost and utilization data, program changes, directed payments (e.g., supplemental payments), and consideration of reasonable, appropriate, and attainable spending for a typical Medi-Cal plan in the same geography.
- Rates are certified as sound by professional actuaries and, in most cases, subject to rigorous review and approval by federal actuaries. Because the rates are already subject to extensive state and federal oversight and examination under Medi-Cal requirements, Medi-Cal MCO spending is significantly different than that of commercial spending.
- DHCS and its actuaries also annually evaluate how the rates MCOs pay providers for many services compare to Medicare and commercial coverage. DHCS provides its analysis to federal reviewers as part of the MCO rate review process. In general, federal requirements prevent DHCS from funding MCOs for payment levels that exceed average commercial rates. Except for inpatient care, current Medi-Cal payment levels for many services are below Medicare on average.

Assessing Performance and Enforcement for Entities Participating in Medi-Cal

- OHCA will coordinate with DHCS on factors, such as rate increases, investments, and other program changes so that Medi-Cal spending growth is contextualized.
- Given the extensive state and federal oversight for Medi-Cal spending and rates set for MCOs, OHCA would not levy financial penalties on MCOs and/or their contracted providers solely due to operational or policy decisions made by DHCS.

Assessing Performance and Enforcement for Medicare Advantage

- Given the federal oversight for Medicare spending and rates set for MA plans, OHCA would not levy financial penalties on MA plans and providers that contract with MA plans solely due to operational or policy decisions made by CMS.

- Additionally, OHCA will contextualize spending growth driven by program changes and requirements implemented by Medicare for providers that exceed the target for their MA line of business.

Sources: The Commonwealth Fund (2024, January 31). *Medicare Advantage: A Policy Primer (2024 Update).* https://www.commonwealthfund.org/publications/explainer/2024/jan/medicare-advantage-policy-primer#12; Maeda J. and Nelson, L. (2018, Jan-Dec; 55). *How Do the Hospital Prices Paid by Medicare Advantage Plans and Commercial Plans Compare with Medicare Fee-for-Service Prices?.* National Library of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6050995/#bibr5-0046958018779654.

Slide Formatting

Indicates items that the Advisory Committee provides input or recommendations on based on statute and other areas as requested by the Board or OHCA.

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Public Comment

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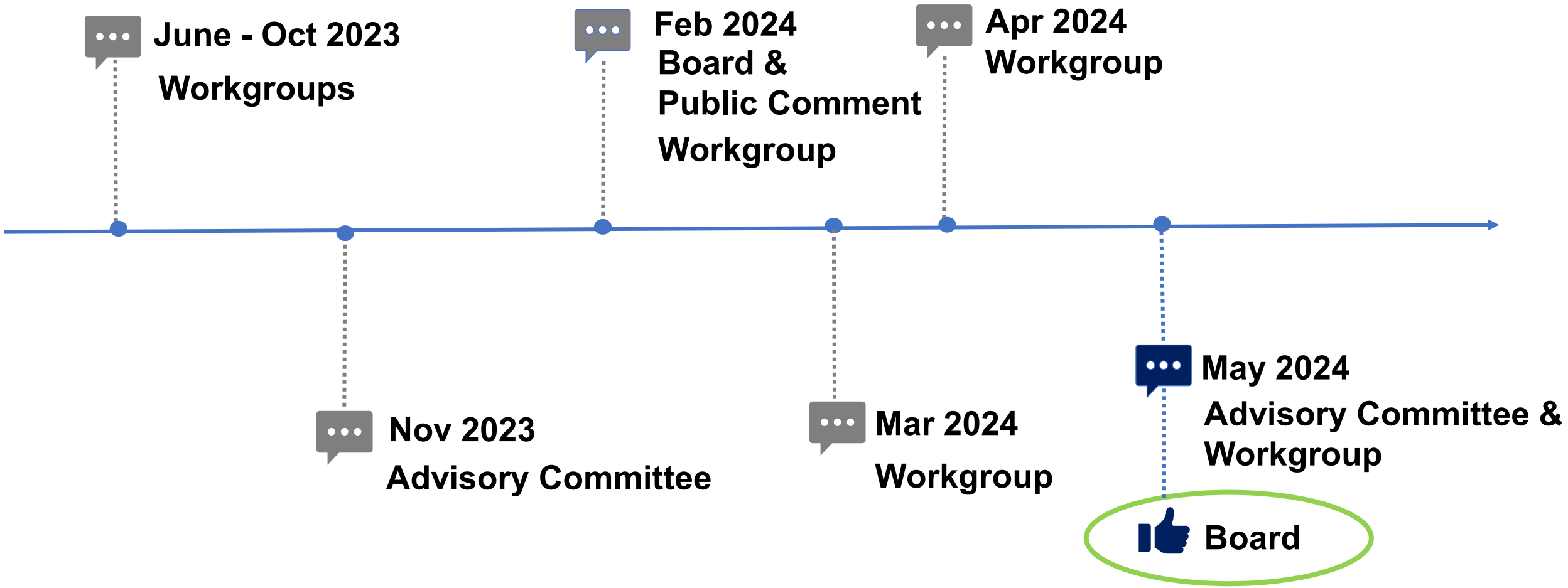
Update on Draft Alternative Payment Model Standards and Adoption Goal

Margareta Brandt, Assistant Deputy Director

Timeline for APM Workstreams



* Dates subject to change.

Provide Feedback Board Approval

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Vision of APM Standards and Goals Success

Stakeholders Endorse

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

Alignment Increases

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

Performance Improves

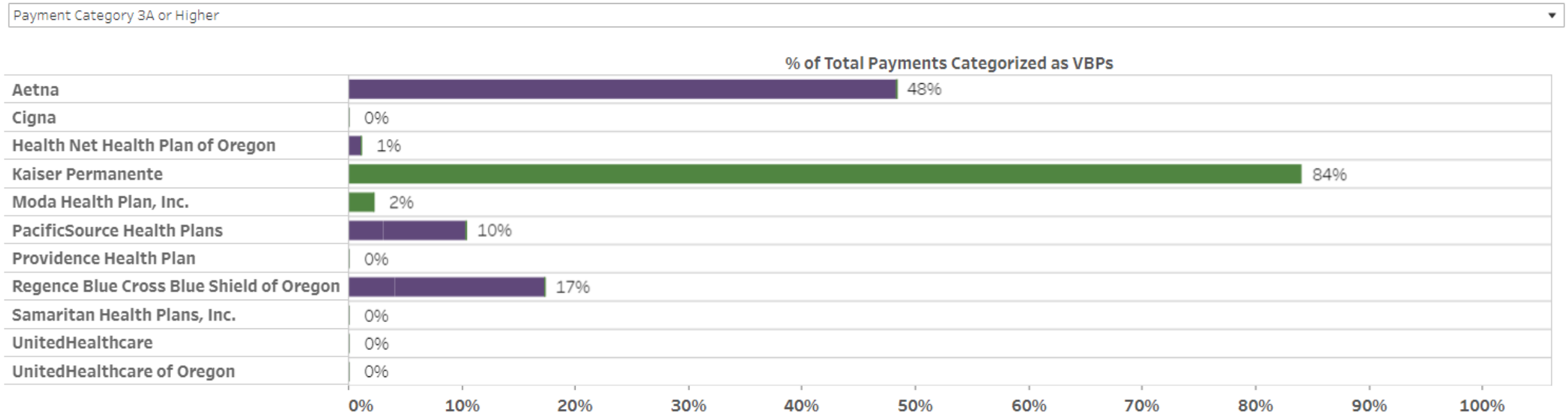
- Standards and goals support increased APM adoption
- Performance on measures of quality, equity, and affordability improve

Accountability through Transparency

Oregon Commercial Payer APM Reporting Example

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

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



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

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

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Accountability for APM Standards and Goals

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

Draft Alternative Payment Model Standards

Draft APM Standards

1. **Use prospective, budget-based, and quality-linked payment models** that improve health, affordability, and equity.
2. **Implement payment models that improve affordability** for consumers and purchasers.
3. **Allocate spending upstream to primary care and other preventive services** to create lasting improvements in health, access, equity, and affordability.
4. **Be transparent** with providers in all aspects of payment model design and terms including attribution and performance measurement.
5. **Engage a wide range of providers** by offering payment models that appeal to entities with varying capabilities and appetites for risk, including small independent practices and historically under-resourced providers.

Draft APM Standards

6. **Collect demographic data**, including RELD-SOGI* data, to enable stratifying performance.
7. **Measure and stratify performance** to improve population health and address inequities.
8. **Invest in strategies to address inequities** in access, patient experience, and outcomes.
9. **Equip providers with accurate, actionable data** to inform population health management and enable their success in the model.
10. **Provide technical assistance** to support new entrants and other providers in successful APM adoption.

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

Public Comment on Draft APM Standards Recommendations

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

Proposed Revisions to Draft APM Implementation Guidance

There are no proposed changes to the draft APM Standards.

Proposed revisions to the draft Implementation Guidance are:

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

Revised Alternative Payment Model Adoption Goals

Draft APM Adoption Goal and Milestones Proposed at February Board Meeting

APM Adoption Goal for Percent of Members Attributed to HCP-LAN Categories 3 and 4 by Payer Type with Interim Milestones				
	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	65%	35%	55%	55%
2028	70%	45%	60%	60%
2030	75%	55%	65%	65%
2032	75%	65%	70%	70%
2034	75%	75%	75%	75%

Board Feedback:

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

Public Comments on APM Adoption Goals

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

Workgroup and Other Recent Stakeholder Feedback on APM Goal Options

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

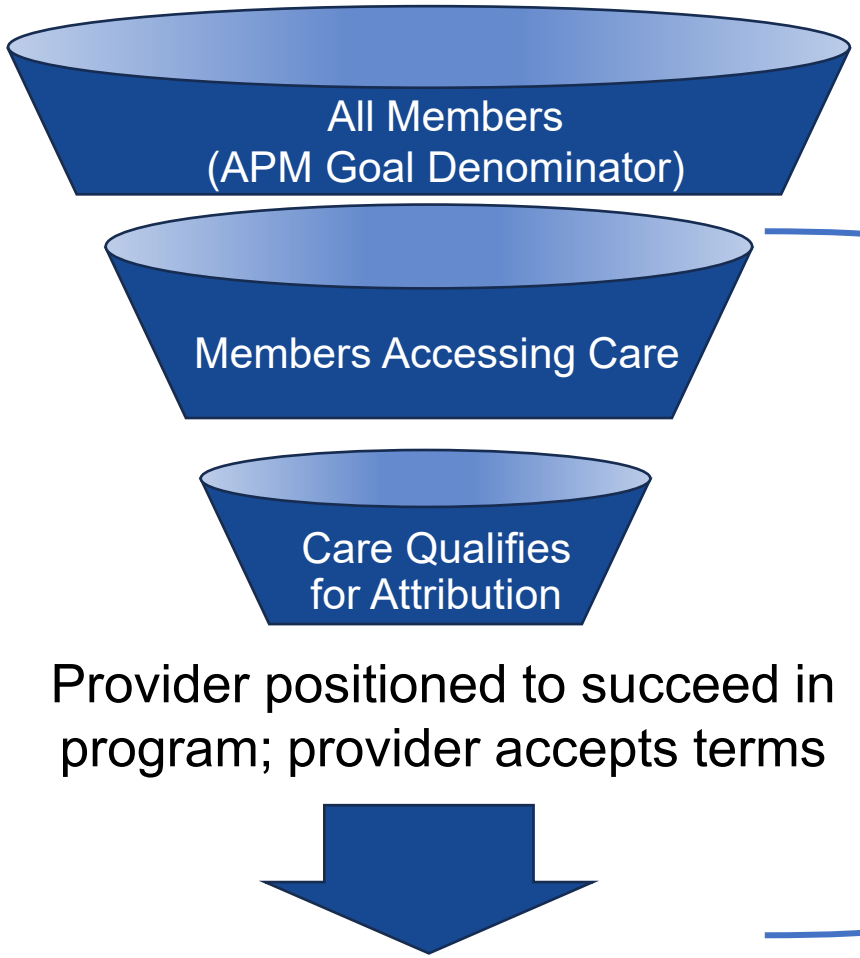
Iterations of Goals:

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

Attribution in Accountable Care

OHCA plans to include all members in APM denominator.

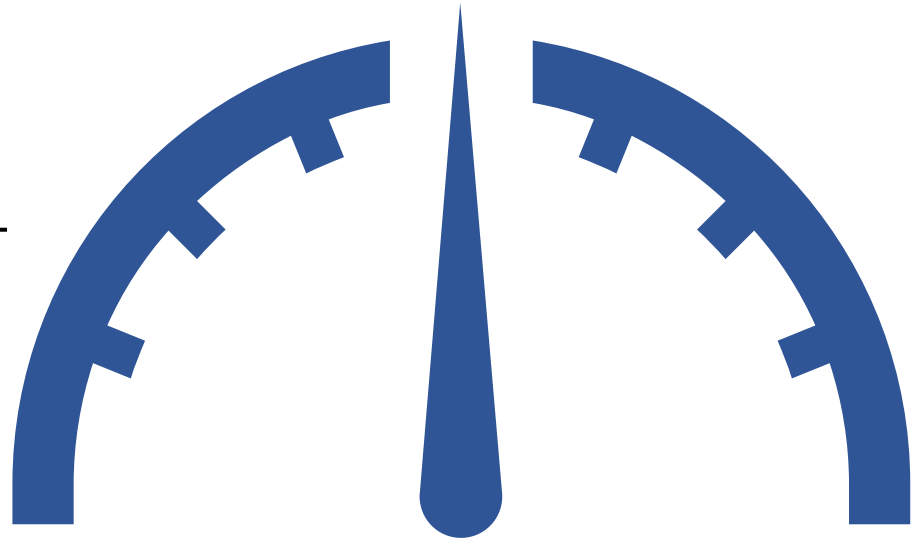
Aligns with population health goals including engaging those who may be less likely to receive care.



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

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

Balancing the Pace of Change



Not too slow…

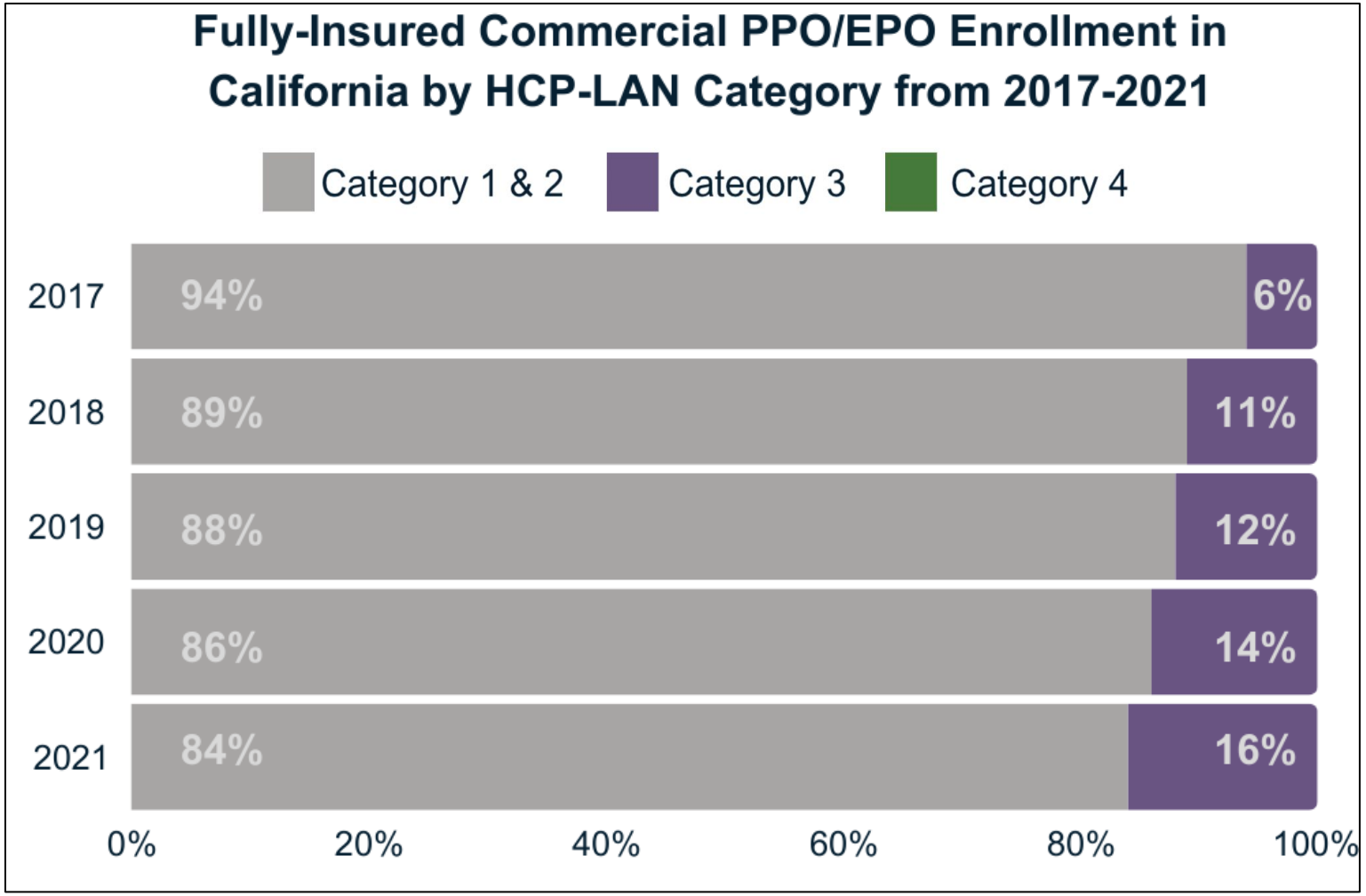
- The time for more affordable, higher value care is now.
- Timely accountability motivates quick action.

Not too fast…

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

California Commercial PPO APM Adoption

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



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

Revised APM Adoption Goals

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

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

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

Examples of Questions OHCA Could Explore through Reporting

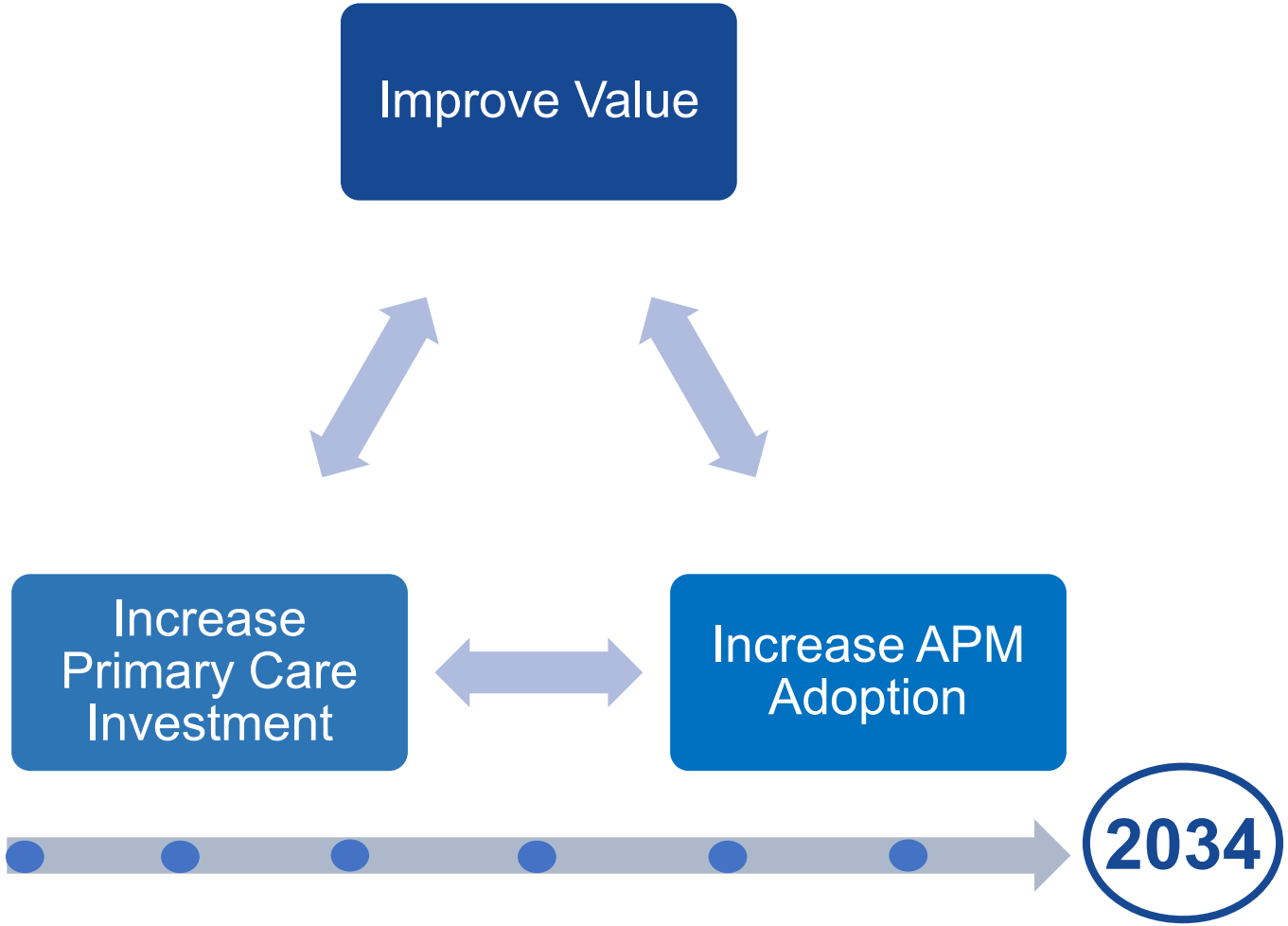
Reporting will occur annually and by payer and product type. The goal is to use reporting to answer questions such as:

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

Complementary Goals, Aligned Timeline

APM adoption goals and primary care investment benchmark share a timeline: **a 2034 goal with interim goals along the way**.

APM adoption and primary care investment **work together toward improved value** by supporting delivery system transformation and helping moderate spending growth.



Alternative Payment Model Adoption Standards and Goals: Discussion

Does the Advisory Committee have additional feedback on:

1. Revisions to the APM Implementation Guidance?
2. The revised APM adoption goals and timeline?

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Public Comment

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Update on Draft Workforce Stability Standards

Margareta Brandt, Assistant Deputy Director

Health Care Workforce Stability

Statutory Requirements

- Monitor the effects of spending targets on health care workforce stability, high-quality jobs, and training needs of health care workers.
- Monitor health care workforce stability with the goal that workforce shortages do not undermine health care affordability, access, quality, equity, and culturally and linguistically competent care.
- Promote the goal of health care affordability, while recognizing the need to maintain and increase the supply of trained health care workers.
- **Develop standards, in consultation with the Board, to advance the stability of the health care workforce.**

Health and Safety Code § 127506(a)-(c)

Health Care Workforce Stability

Statutory Requirements

- **The Board approves standards to advance the stability of the health workforce that may apply in the approval of performance improvement plans.**
- OHCA may require a health care entity to implement a performance improvement plan that identifies the causes for spending growth and shall include specific strategies, adjustments, and action steps the entity proposes to implement to improve spending performance during a specified time period. The director shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode access, quality, equity, or workforce stability.

Workforce Stability Standards Process and Progress

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

Refer to the January Advisory Committee Meetings slide decks for future details on literature review, data set review, and key informant interview findings.

Approach to Workforce Stability Standards and Metrics

Standards

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

Metrics

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

Draft Workforce Stability Standards

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

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

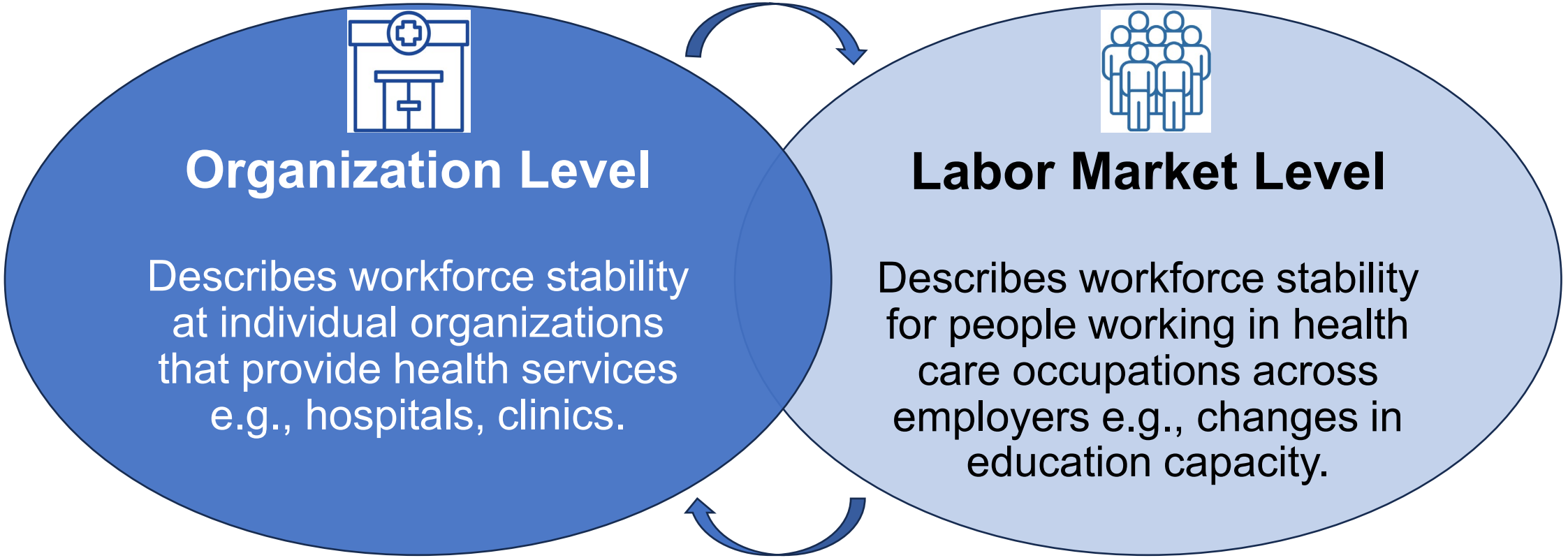
2. Develop formal processes to adapt to changing workforce conditions. Establish policies and procedures to adjust hiring, training, and other practices based on the key performance indicators and market level influences.

Draft Workforce Stability Standards

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

Workforce Stability: Levels of Analysis

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



Draft Workforce Stability Metrics: Organization Level Monitoring

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

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

Draft Workforce Stability Metrics: Market Level Monitoring

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

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

Key Themes from the Board, Advisory Committee, Interviews, and Surveys

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

Key Themes from the Board, Advisory Committee, Interviews, and Surveys

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

Key Themes from the Board, Advisory Committee, Interviews, and Surveys

Organization and Market Level Metrics	
Feedback Theme	**OHCA's Response**
• Monitor more unlicensed occupations. • Monitor more ambulatory settings, especially primary care and behavioral health. • Explore additional data sources to monitor worker safety, layoffs, turnover, and network adequacy. • Monitor availability of linguistically concordant care. • Monitor regional health care workforce.	• Metrics include publicly available data on suggested non-licensed occupations. • Evaluating options for addressing data gaps for ambulatory settings and behavioral health. • Evaluating all suggested data sources. • Some metrics include languages spoken by health care workers. • Many metrics can be analyzed by organization and/or geographic region.

Accountability for Workforce Stability Standards

- **Transparency**: Reporting will include comparative performance on organization level metrics, regional and statewide market conditions (e.g., wages, workforce demographics) across occupations.

- **Performance Expectations**: After analyzing baseline data, OHCA will consider establishing performance expectations for Key Performance Indicators in Standard One and/or organization level metrics.

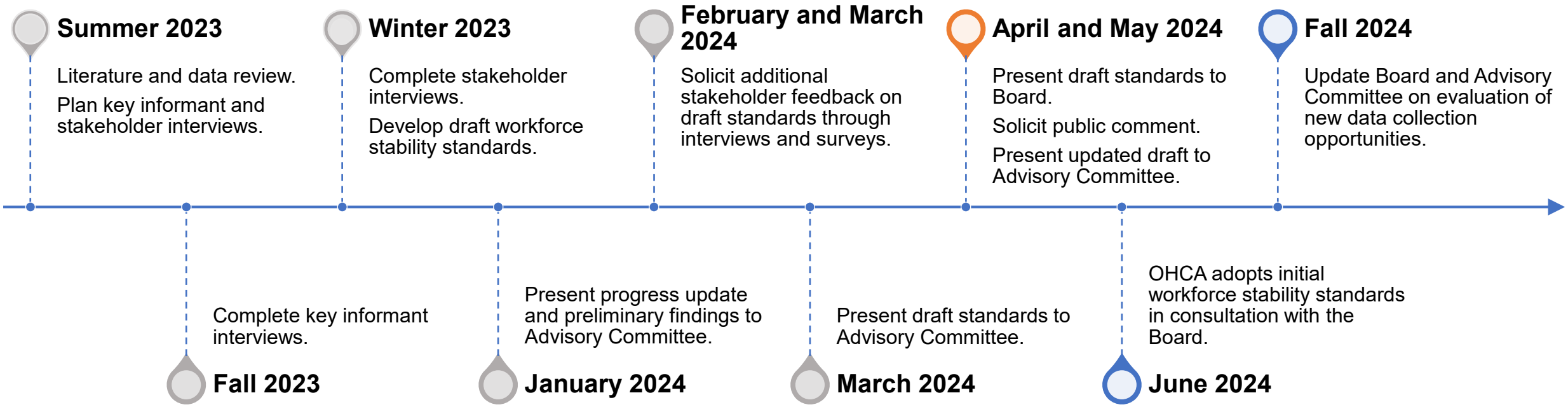
- **Performance Improvement Plan (PIP):** General workforce stability standards will inform standards that apply in PIPs for entities not meeting spending growth targets.

Ongoing Evaluation: Data Collection Opportunities

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

Next Steps

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



* Dates subject to change.

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Workforce Stability Standards and Metrics: Discussion

Does the Advisory Committee have any feedback on:

1. Proposed workforce stability standards?
2. Proposed workforce stability metrics?
3. Investigation of data collection opportunities?

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Public Comment

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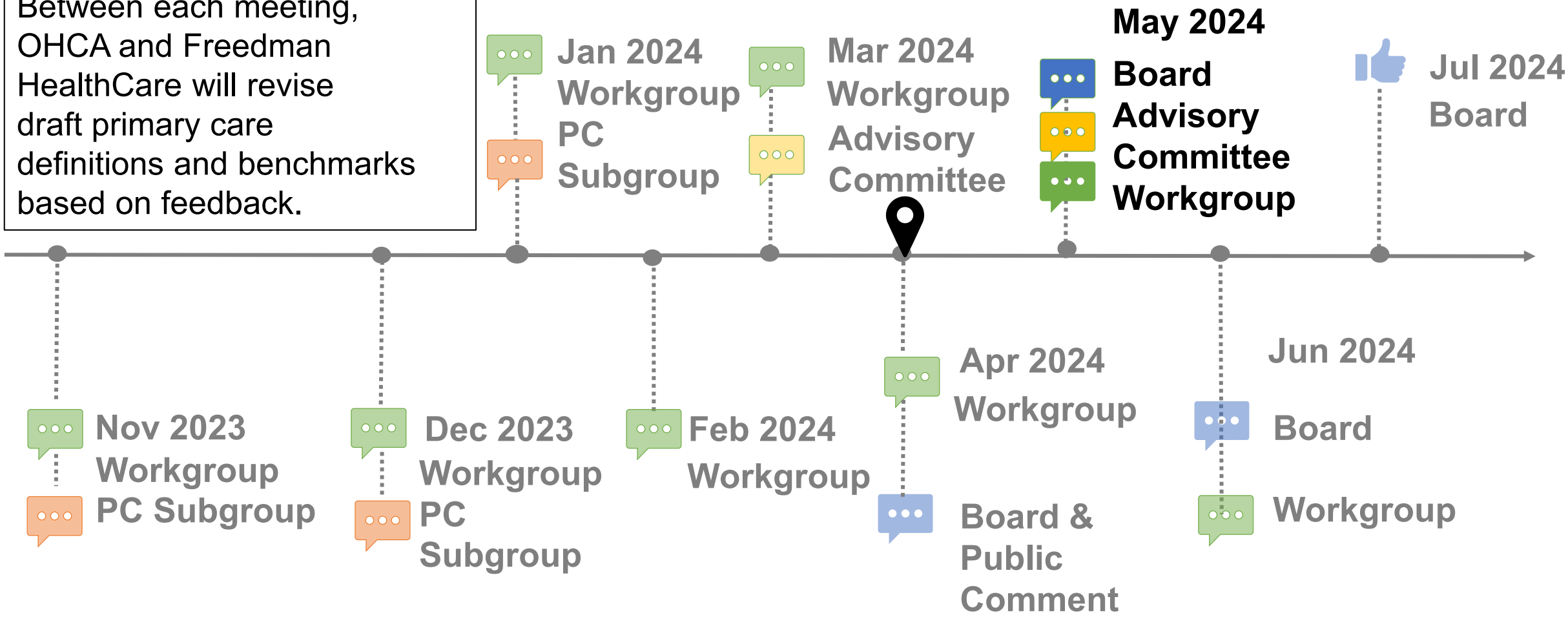
Update on Draft Primary Care Definition and Investment Benchmark

Margareta Brandt, Assistant Deputy Director

Timeline for Primary Care Work

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



* Dates subject to change.

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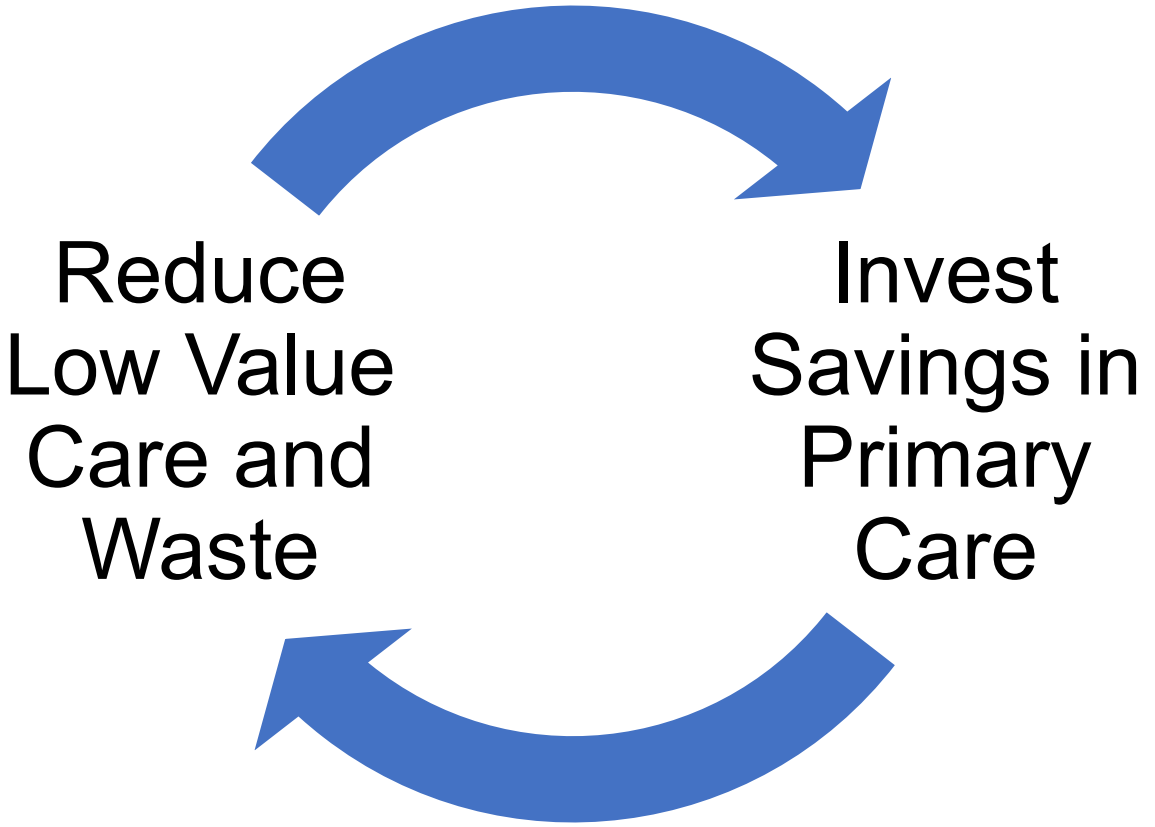
Primary Care Investment

Statutory Requirements

- Measure the percentage of total health care expenditures allocated to primary care and set spending benchmarks that consider current and historic underfunding of primary care services.
- Determine the categories of providers, specific procedure codes, and non-claims payments that should be considered when determining the total amount spent on primary care.
- Build and sustain methods of reimbursement that shift greater health care resources and investments away from specialty care and toward primary care and behavioral health.
- Promote improved outcomes for primary care and sustained systemwide investment in primary care.
- Include an analysis of primary care spending and growth in the annual report.
- Consult with state departments, external organizations promoting investment in primary care, and other entities and individuals with expertise in primary care.
- The Board approves the benchmark for primary care spending.

Impact of Investing in Primary Care

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



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

One Vision for Primary Care Delivery in CA

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

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

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

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

OHCA's Draft Primary Care Spending Measurement Definition and Methodology

Framing the Measurement

What will be measured

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

What won't be measured

Money providers spent delivering primary care services.

Overview of Claims-Based Primary Care Spending Measurement Approach

Include a narrow or broad set of providers?

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

Should the definition be limited to certain places of service?

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

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

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

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

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

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

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

Category 3: Shared Savings and Recoupments

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

Category 4: Capitation Payments

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

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

OHCA's Recommended Primary Care Investment Benchmark

Key Decisions for Setting a Primary Care Benchmark

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

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

Three Lessons Learned from Other States

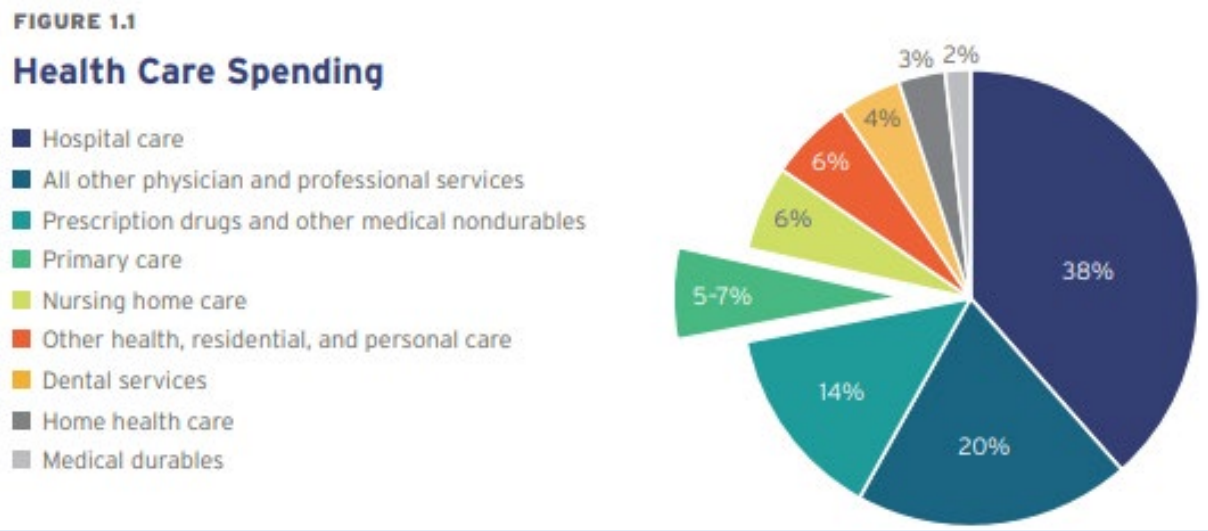
1. **The most successful efforts gradually reallocate spending to primary care.** Efforts to increase investment too quickly may accelerate growth in total cost of care.

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

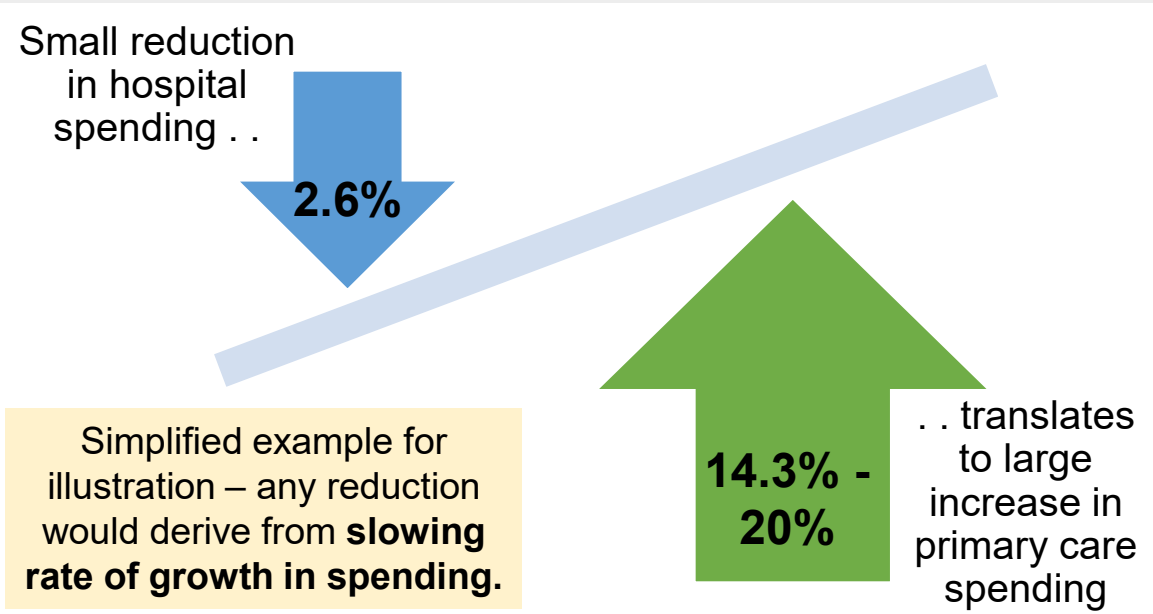
3. **Increases in total cost of care hinder benchmark success.** As total cost of care increases, achieving primary care benchmarks based on percent total medical expense becomes more difficult.

Example: Reallocating Spending Growth to Primary Care

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



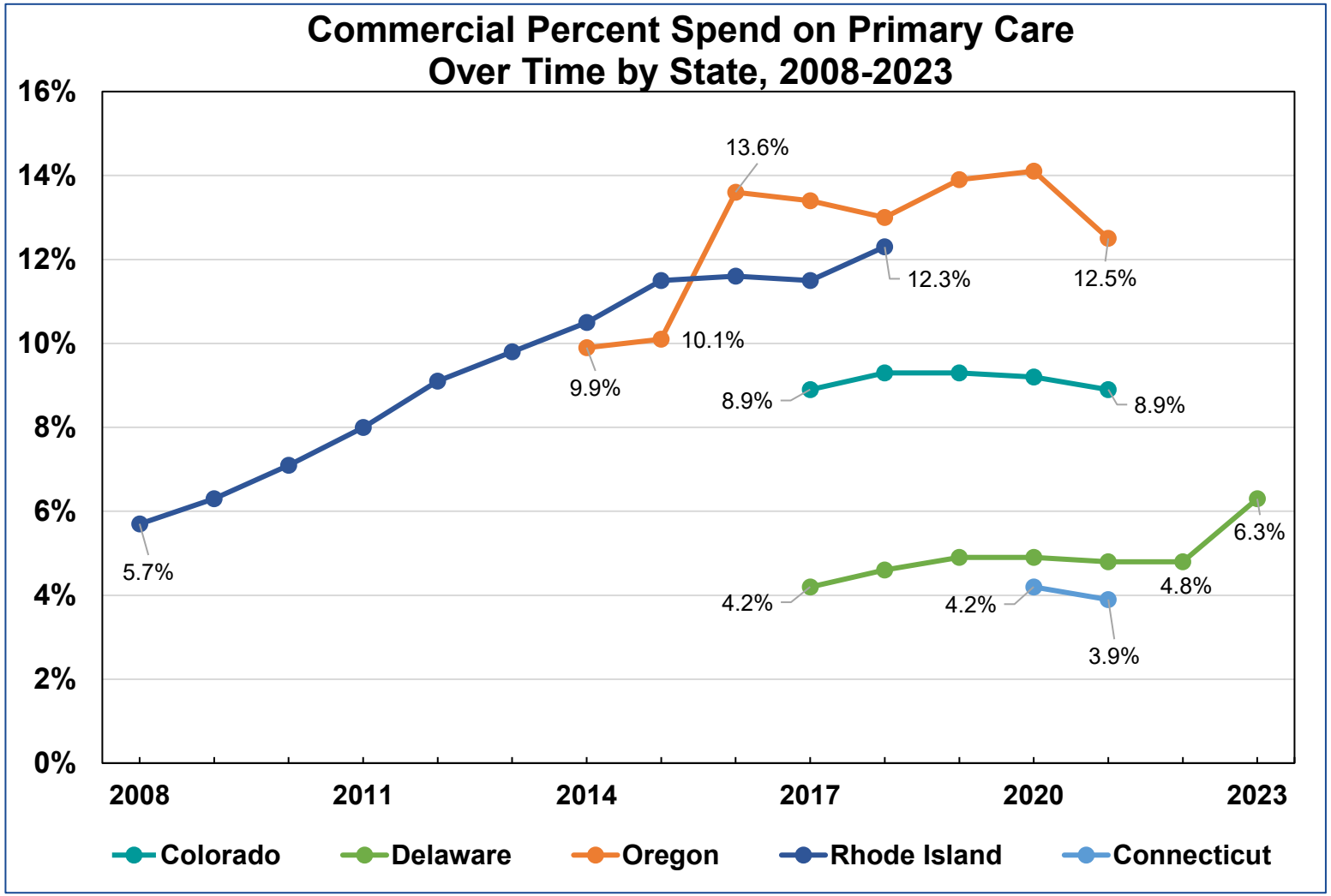
Reallocating one percentage point of spend from hospital care (from 38%→37% TME) to primary care (5-7%→6-8% TME) would **generate substantial primary care investment.**



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

Source for Figure 1.1: Jabbarpour et al. Investing in Primary Care: A State-Level Analysis. Patient Centered Primary Care Collaborative, July 2019. https://www.milbank.org/wp-content/uploads/2019/07/2019-PCPCC-Evidence-Report-Final.pdf

Balancing the Pace of Change

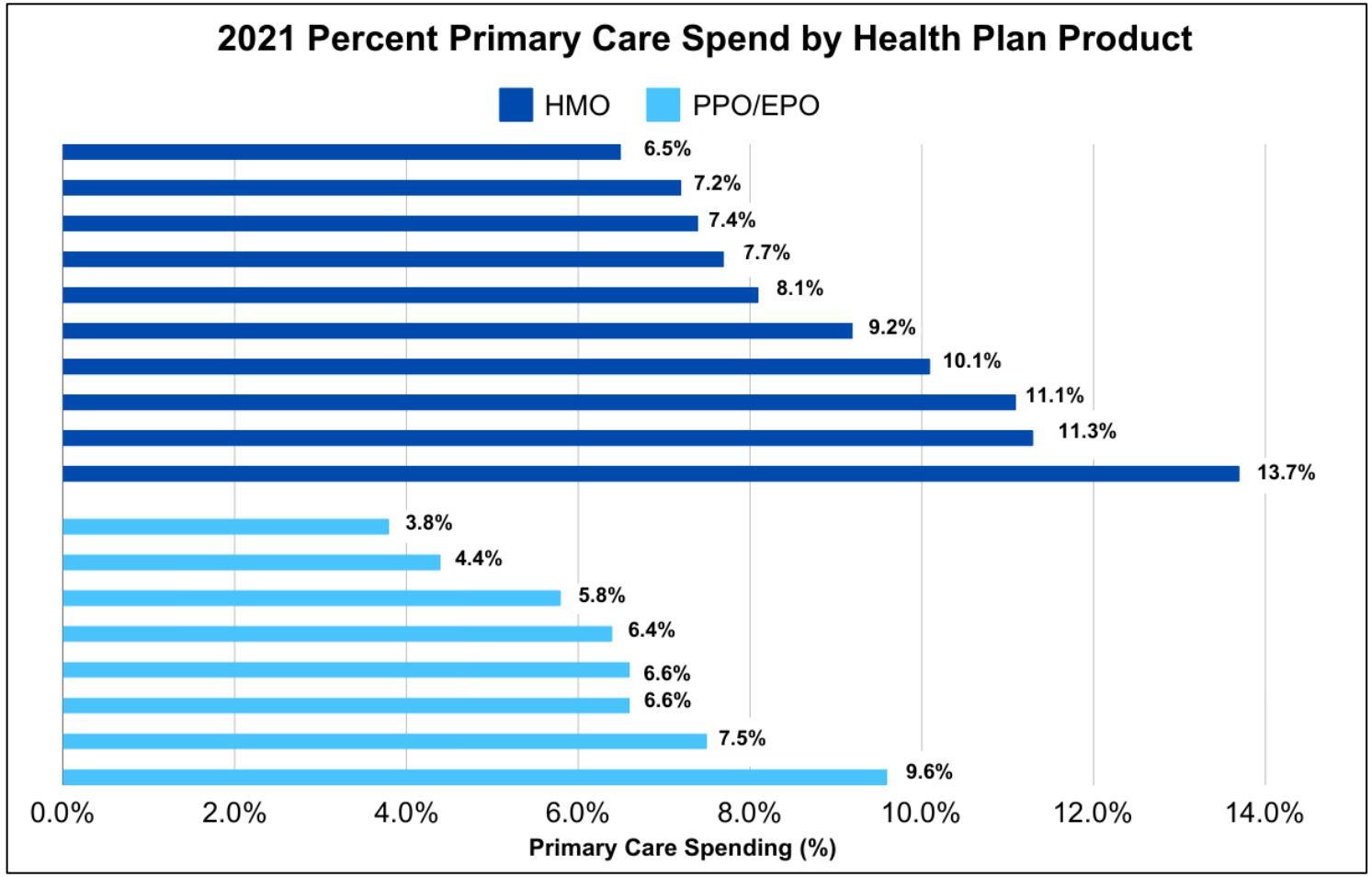


- These states have the most experience working to increase primary care investment.
- Four of them are Cost Growth Benchmark states and like California are looking to gradually reallocate more of the healthcare dollar away from lower value services to higher value services like primary care.
- States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

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

Primary Care Spending by Commercial Payer-Product Type

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



Source: Integrated Healthcare Association analysis of California Commercial primary care spending in 2021. Chart developed using the same methodology described in California Health Care Foundation's *Investing in Primary Care: Why it Matters for Californians with Commercial Coverage.* (2022, April). https://www.chcf.org/wp-content/uploads/2022/04/InvestingPrimaryCareWhyItMattersCommercialCoverage.pdf

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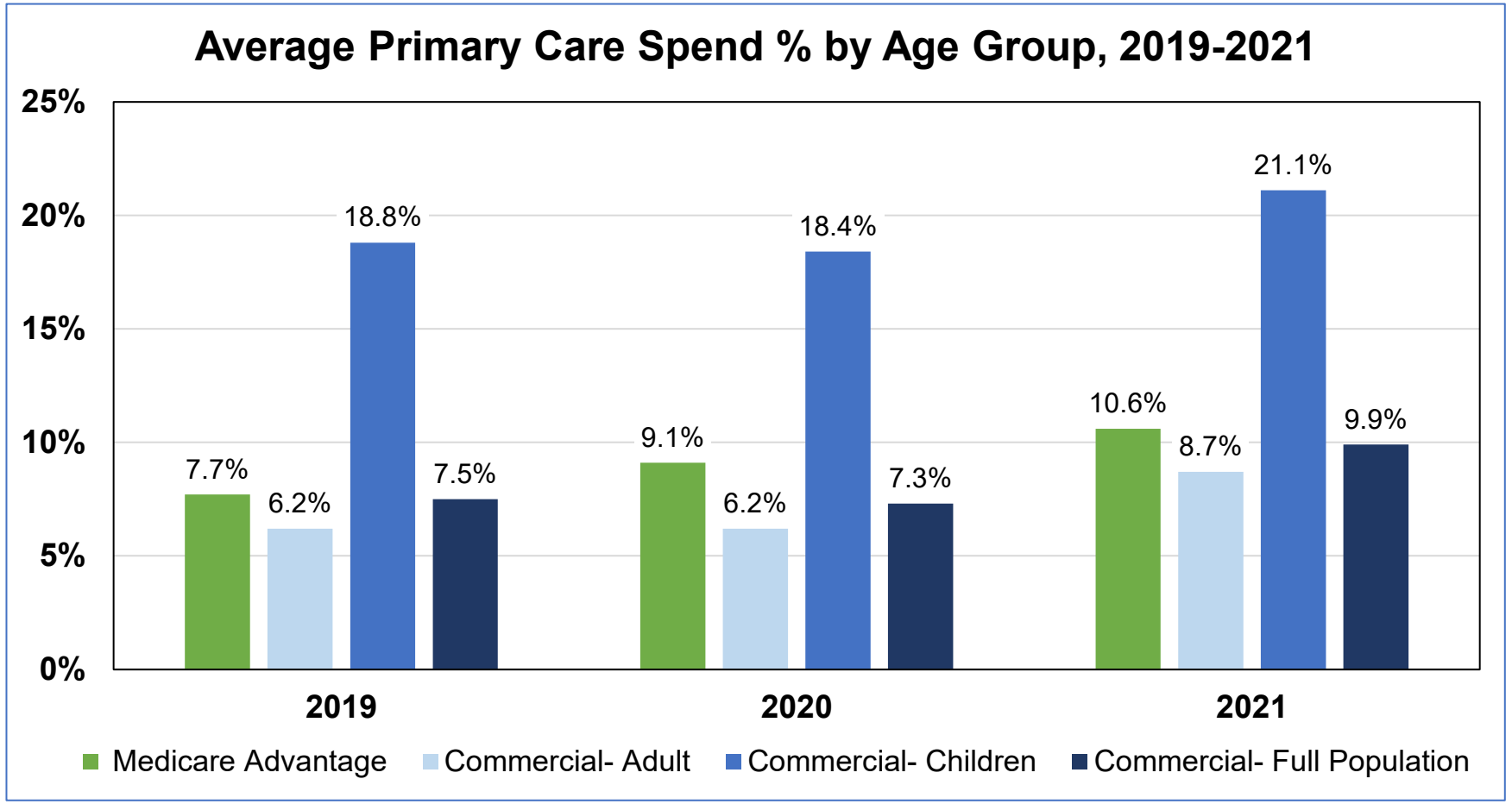
Primary Care Spending for Children and Adults in California

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



Source: Integrated Healthcare Association analysis of California Commercial primary care spending from 2019-2021. Chart developed using the same methodology described in California Health Care Foundation's *Investing in Primary Care: Why it Matters for Californians with Commercial Coverage.* (2022, April). https://www.chcf.org/wp-content/uploads/2022/04/InvestingPrimaryCareWhyItMattersCommercialCoverage.pdf

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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.

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

Challenges of Allocating Non-Claims Primary Care Payments by Age Group

- Any methodology for allocating payments to adults vs. pediatrics will add complexity and may move farther away from the actual intent or distribution of the payments.
- Many non-claims payments reflect care provided to populations and cannot be tied to a specific provider or set of primary care services.
- Non-claims payments are typically made in lump sum, not delineated by patient age group.

Example of Shared Savings Payment

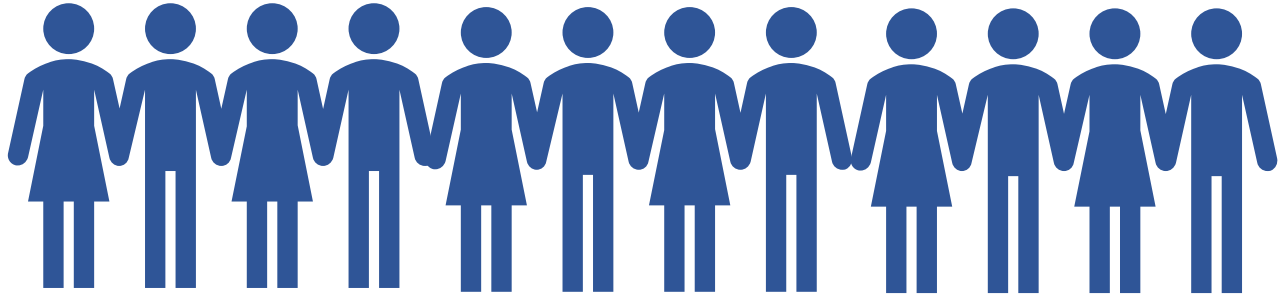
A provider group receives a shared savings payment.

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

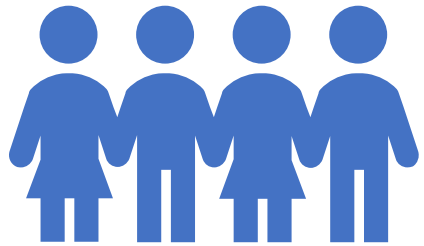
The primary care portion is then allocated to adults vs. pediatrics based on an additional standardized OHCA methodology.

The payment allocated to pediatrics may not reflect the contribution of pediatrics to the shared savings nor the amount allocated to pediatric primary care by the provider organization.

Comparing Spend Using Single or Adult and Pediatric Benchmarks



78.2% of California population is 18 years of age and older



21.8% of California population under 18 years of age

Weighted average of draft pediatric (24%) and adult (12%) primary care spending benchmarks: **14.62%**

Calculations are based on 2023 United States Census Bureau population estimates for California.

Considerations for Single Benchmark

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

Draft Primary Care Investment Benchmark Recommendation

Relative Improvement Benchmark: All payers* increase primary care spending by 0.5 percentage points to 1 percentage point per year, depending on current level of investment.

Rationale for Level:

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

AND

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

Rationale for Level:

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

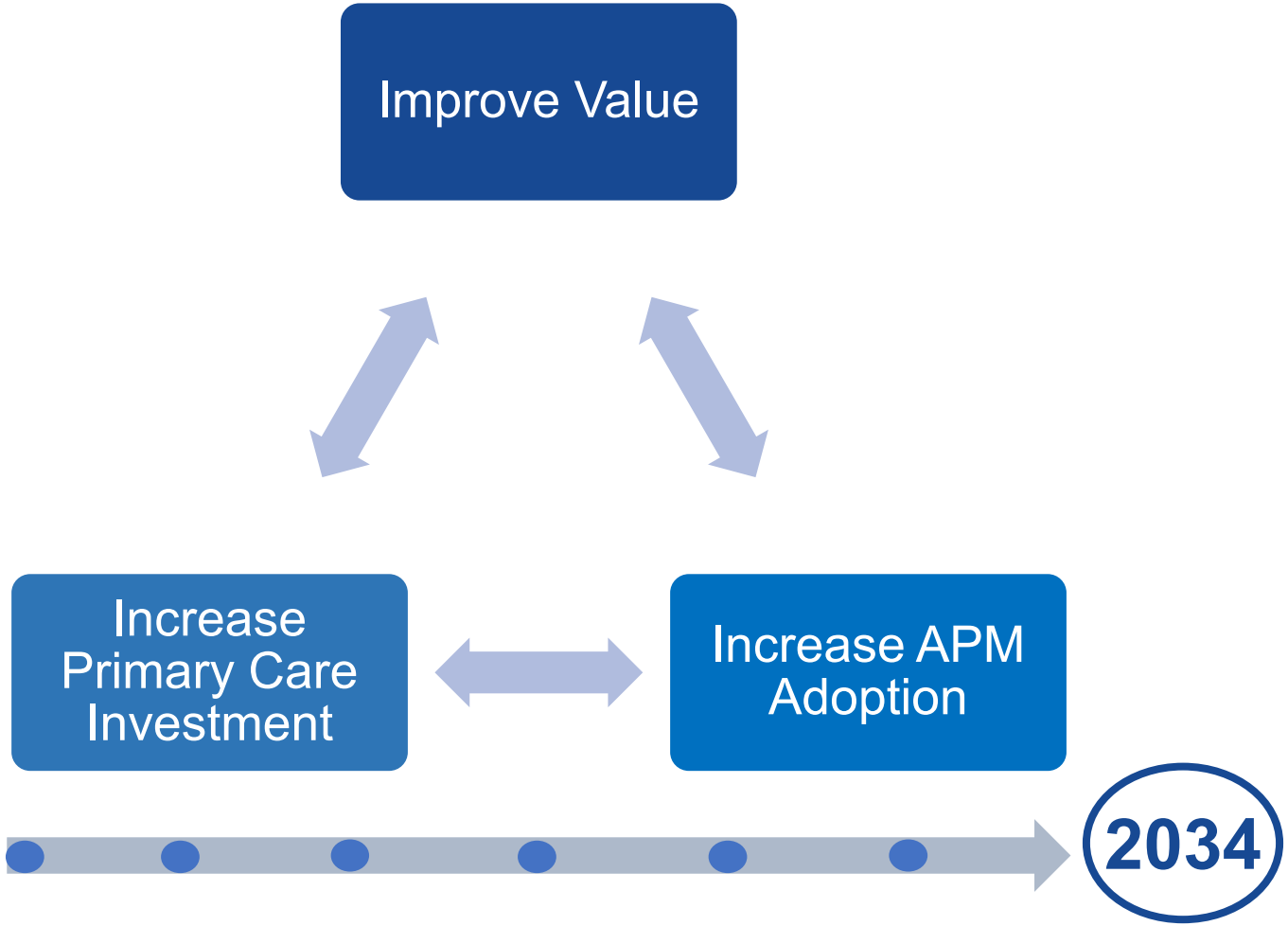
*Payers at or above 15% of total medical expense may refrain from continued increases if not aligned with care delivery or affordability goals.

Sources: Jabbarpour, et al. (2019, July). *Investing in Primary Care: A State-Level Analysis*. Patient-Centered Primary Care Collaborative. https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf.; National Academies of Sciences, Engineering, and Medicine. (2021). *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983

Recap: Complementary Goals, Aligned Timeline

APM adoption goals and primary care investment benchmark share a timeline: **a 2034 goal with interim goals along the way**.

APM adoption and primary care investment **work together toward improved value** by supporting delivery system transformation and helping moderate spending growth.



Primary Care Spend Measurement and Investment Benchmark: Discussion

Does the Advisory Committee have any feedback on:

1. Proposed primary care spending measurement definition and methodology?
2. Proposed primary care investment benchmark?

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Public Comment

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Measuring Consumer Affordability

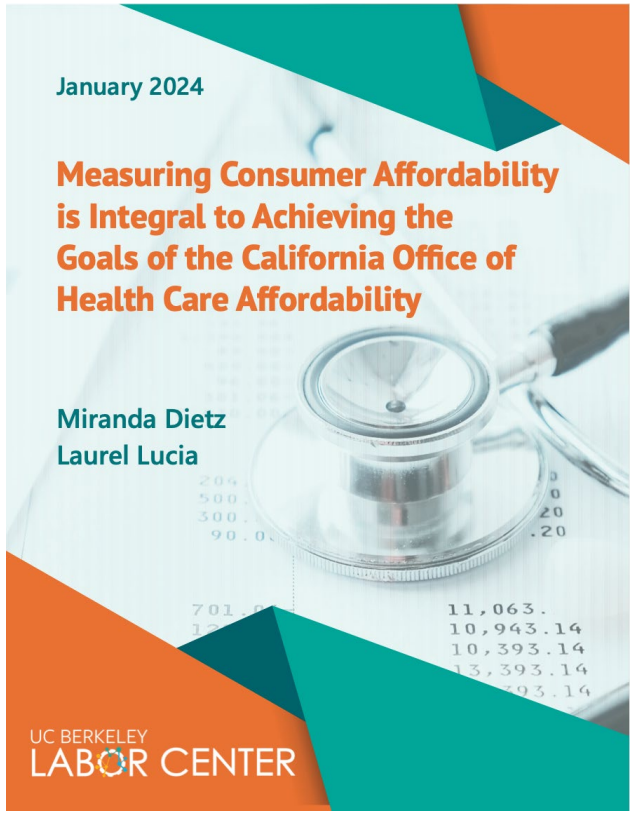
Vishaal Pegany
Miranda Dietz, Policy Research Specialist and Project Director for CalSIM
Laurel Lucia, Director of the Health Care Program, UC Berkeley Labor Center

Measuring Consumer Affordability

Miranda Dietz

Laurel Lucia

February 2024



Measuring consumer affordability is integral to achieving OHCA's goals

Statute defines this as part of OHCA's charge:

> *Developing a comprehensive strategy for cost containment in California, including measuring progress towards reducing the rate of growth in per capita total health care spending and ultimately lowering consumer spending on premiums and out-of-pocket costs, while maintaining quality, access, and equity of care, as well as promoting workforce stability and maintaining high-quality health care jobs* *§ 127500.5(o)*

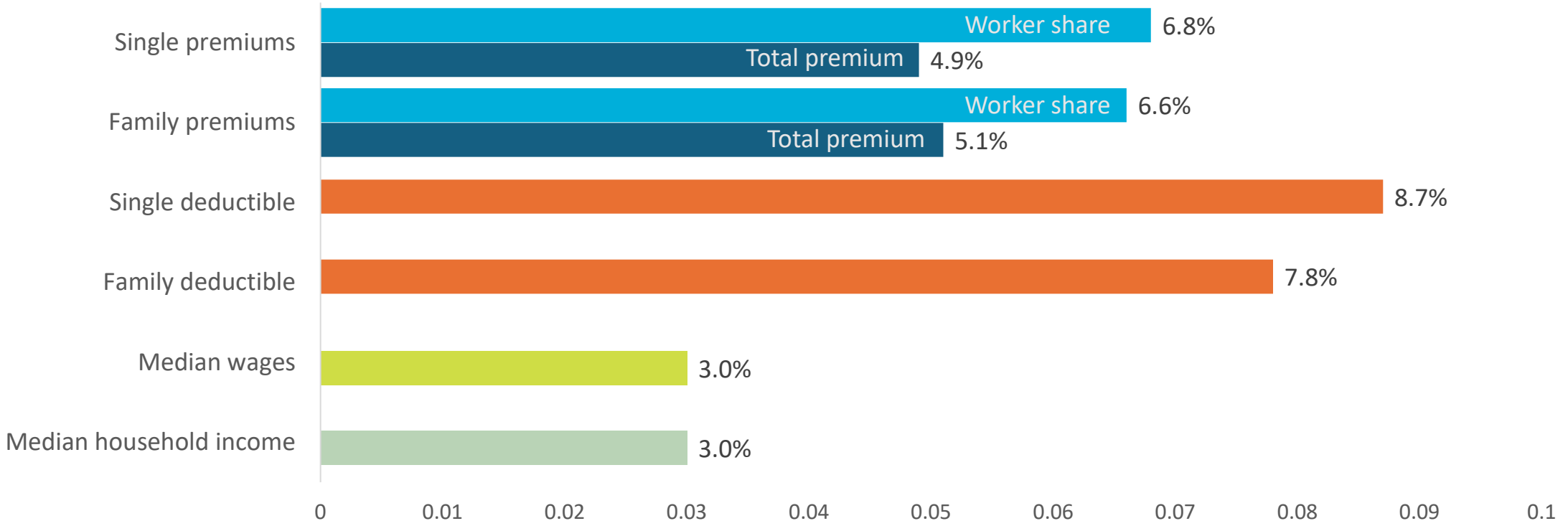
- Affordability measures should be part of the baseline annual report in 2025 and every report thereafter

Source: California Health and Safety Code § 127500.5(o)(1)

Consumer affordability has deteriorated over the last 20 years

Premiums and deductibles have grown faster than wages and incomes

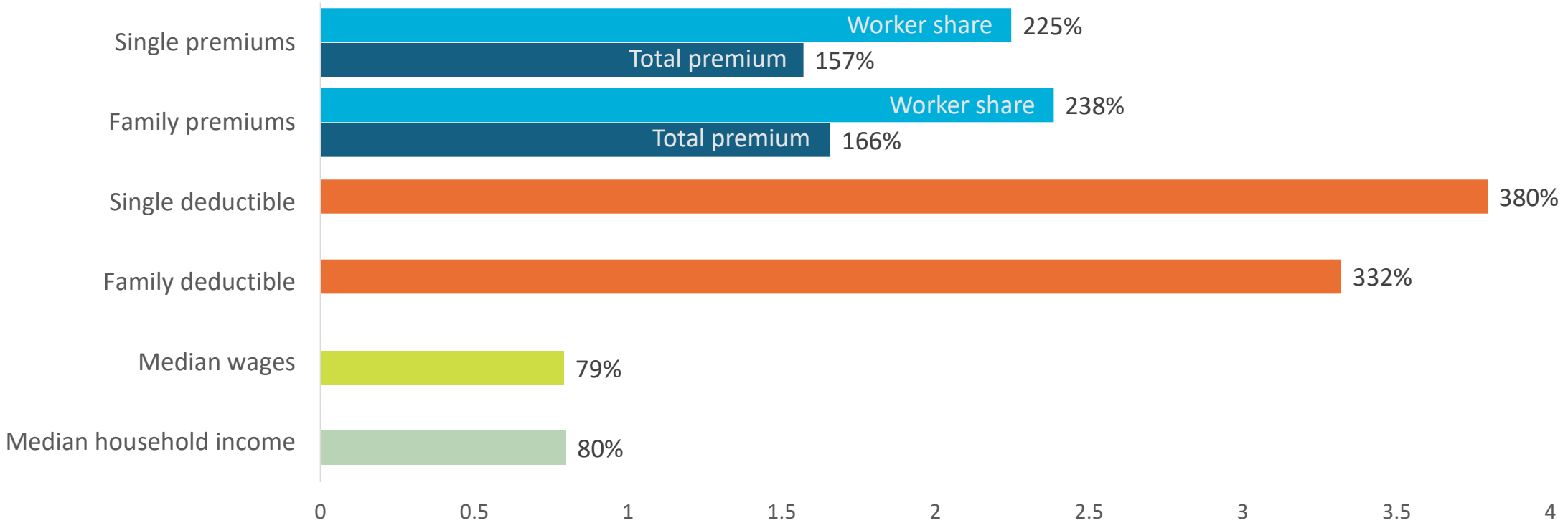
Average annual growth rates for premiums and deductibles for private-sector workers; median wages; and median household income in California, 2002-2022



Source: MEPS-IC California 2002-2022; US Census Current Population Survey

Faster growth in premiums and deductibles adds up over 20 years

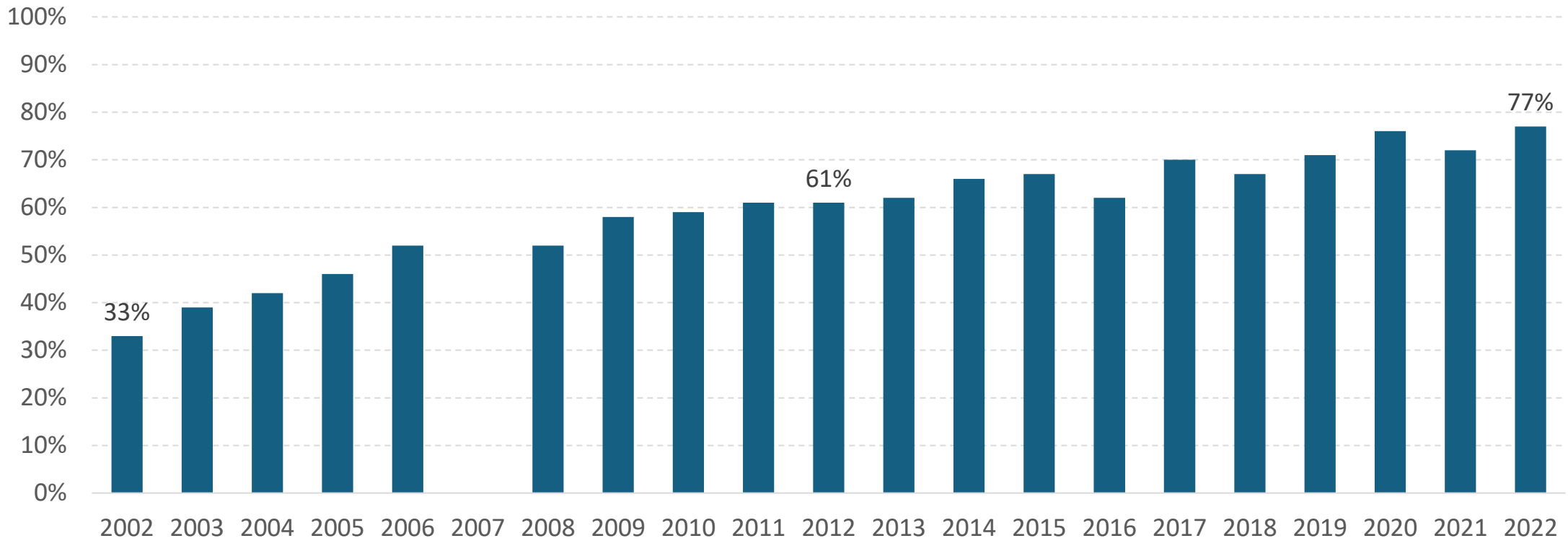
Cumulative growth for premiums and deductibles for private-sector workers; median wages; and median household income in California, 2002-2022



Source: MEPS-IC California 2002-2022; US Census Current Population Survey

Deductibles are increasingly common

Share of private-sector workers enrolled in coverage with deductibles in California, 2002-2022

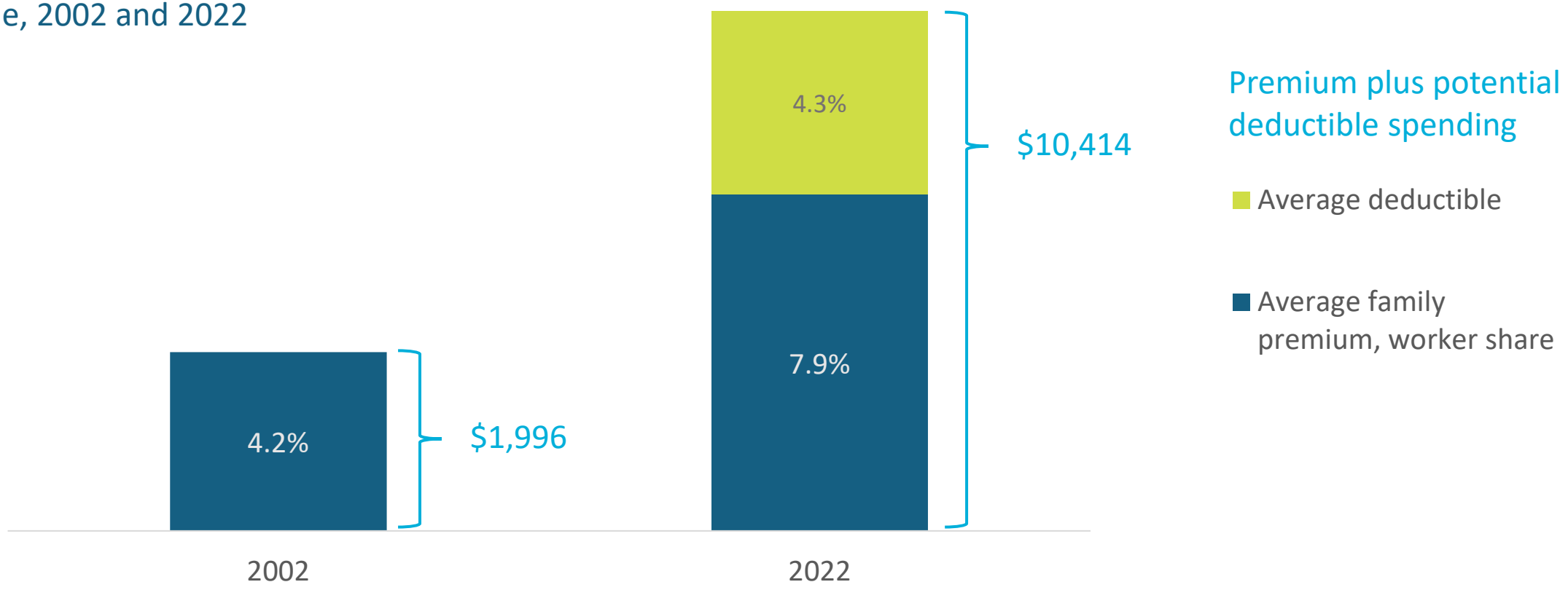


UC BERKELEY LABOR CENTER

Source: MEPS-IC California 2002-2022 (no data available for 2007)

Health care takes up an increasing share of household budgets

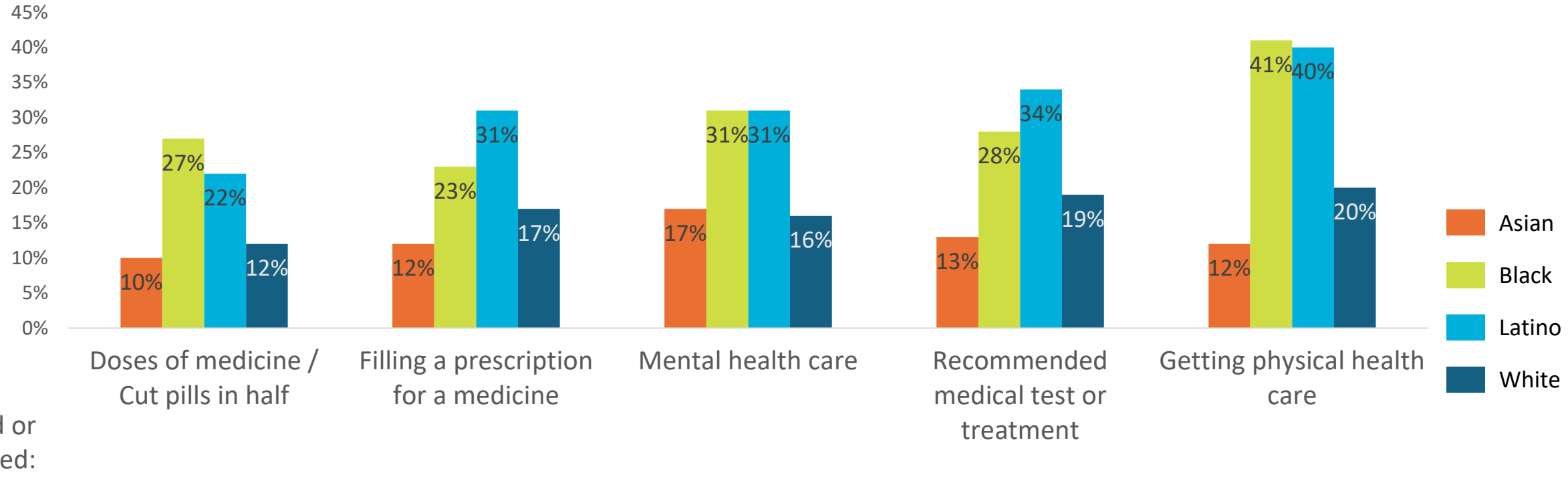
Typical private-sector family coverage premium and potential deductible spending as a share of median household income, 2002 and 2022



Source: Current Population Survey; MEPS-IC California 2002, 2022
Note: Typical plans in 2002 did not have a deductible; 33% of private-sector enrollees did have a deductible, and the average amount was $847 or 1.8% of median household income in that year. By 2022, 77% of private-sector worker enrollees had a deductible

High health care costs are a barrier to care; delays are most common for Latino and Black Californians

Share of California adults reporting that they or a family member skipped or delayed the following in the past 12 months due to cost, by race/ethnicity (2022)



Delayed or skipped:

Source: CHCF California Health Policy Survey, 2023

How OHCA can measure consumer affordability

How will we know if OHCA is having an impact for California consumers?

OHCA should track multiple consumer affordability measures in the following categories:

Cost of coverage	Cost of accessing care	Health and financial consequences
• Premiums • Offer rates • Take up rates	• Deductibles • Copays • Max out-of-pocket • Actual out-of-pocket • Actuarial value	• Skipped or delayed care • Trouble paying medical bills • Medical debt

Equity measures

Administrative and survey data are needed

Administrative data

- Can be used for year-over-year comparisons

- Department of Managed Health Care data for fully-insured plans
- OHCA THCE data

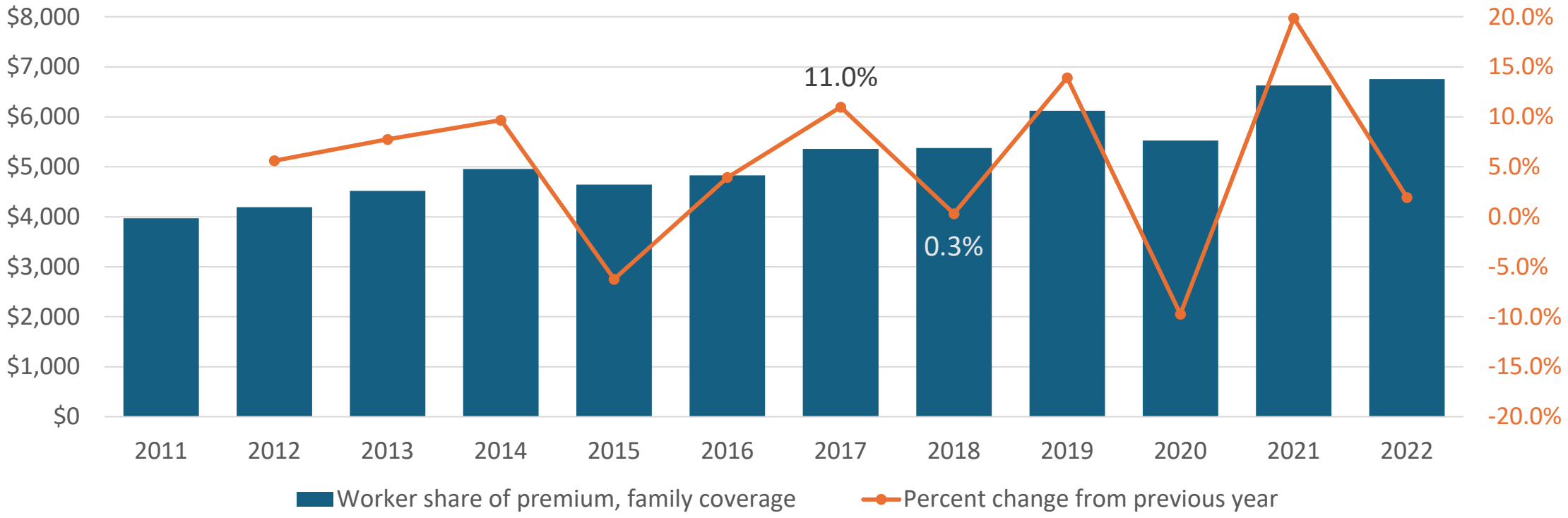
Survey data

- Track longer-term trends
- Useful for monitoring equity
- Only source currently for tracking health and financial consequences

- Medical Expenditure Panel Survey-Insurance Component
- CHCF Health Policy Survey
- Others as needed

Survey data can be volatile year-over-year but shows longer term trends

Average worker premium contribution for family coverage and percent change from previous year covered workers in private sector establishments in California 2011-2022



Source: MEPS-IC California 2011-2022

Administrative data: Premiums and out-of-pocket costs

	2022-2023 Change	Source
Premiums (average per member per month)		
Large group	+6.8%	DMHC
Small group	+7.1%	DMHC
Individual market	+5.6%	DMHC
Consumer out-of-pocket spending (average per member per month)		
Commercial market	__ %	OHCA**

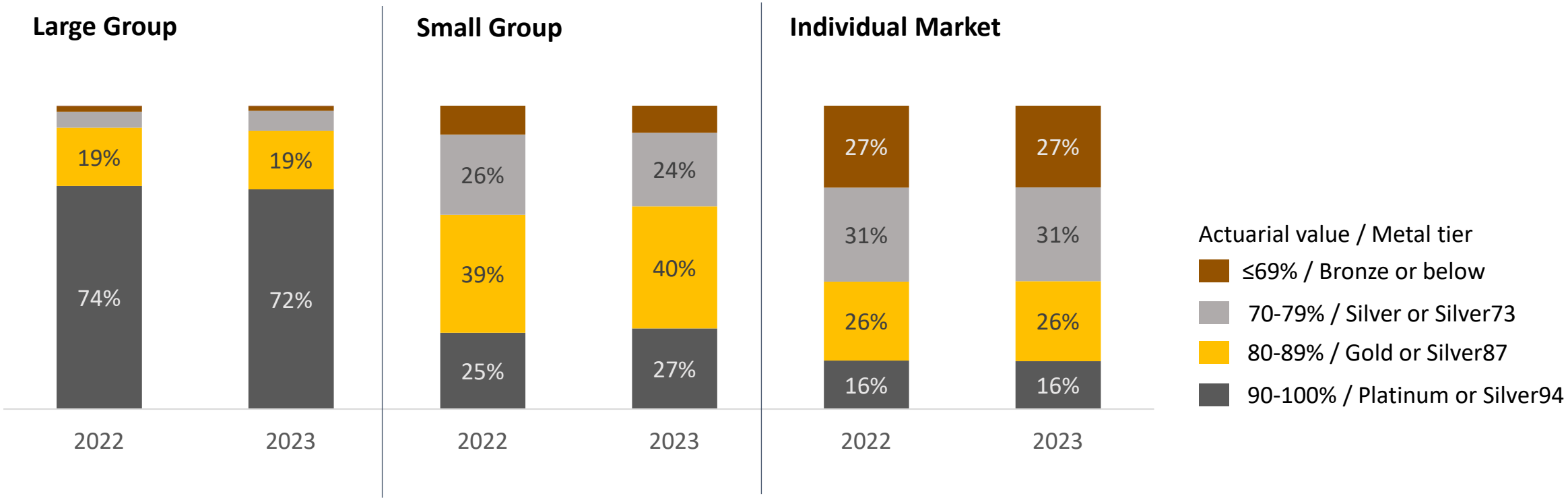
** OHCA data is not yet collected

Source: Department of Managed Health Care Annual Aggregate Rate Reports

Note: Large group shows DMHC's calculation of the adjusted average rate increase, reflecting aggregate changes in benefit designs, cost sharing, provider network, geographic rating region, and average age. Small group and individual market show the weighted average rate increase.

Administrative data: Actuarial value

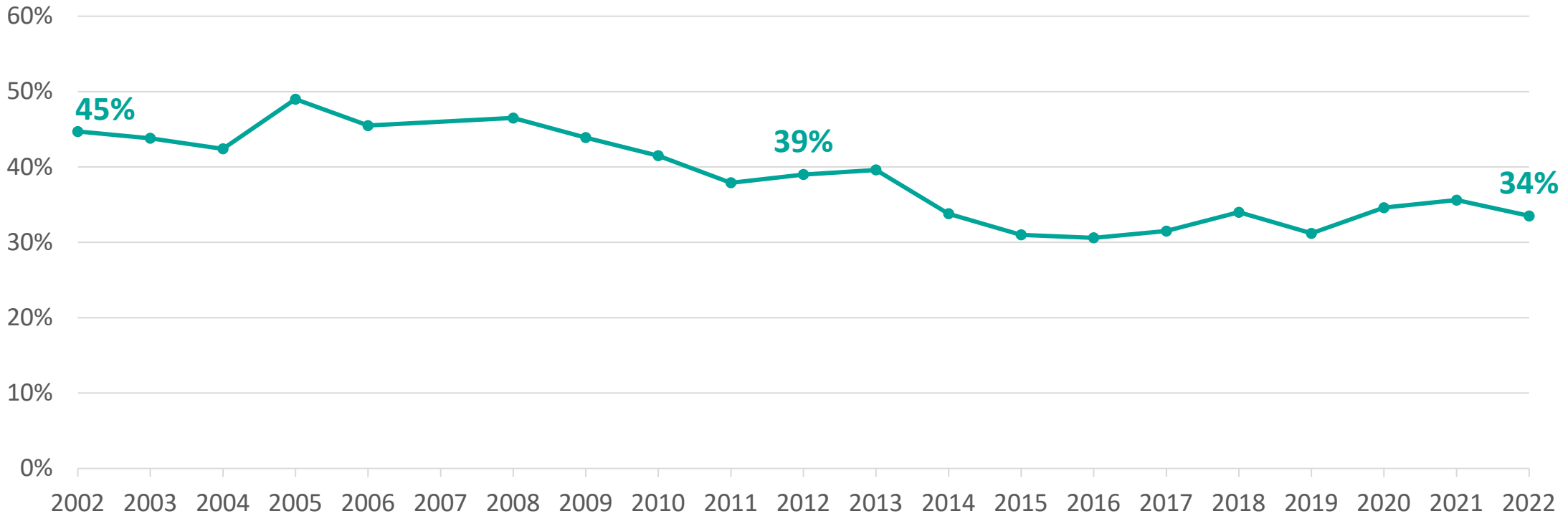
Actuarial value (average share of medical expenses that the plan will pay) by market



Source: Department of Managed Health Care Annual Aggregate Rate Reports
Individual market actuarial value data is supplemented by data from Covered California Active Member Profiles for June 2021, 2022, 2023; "Platinum" includes Silver94 plans and "Gold" includes Silver87 plans.

Survey data: cost of coverage
Offer rate among small businesses has declined

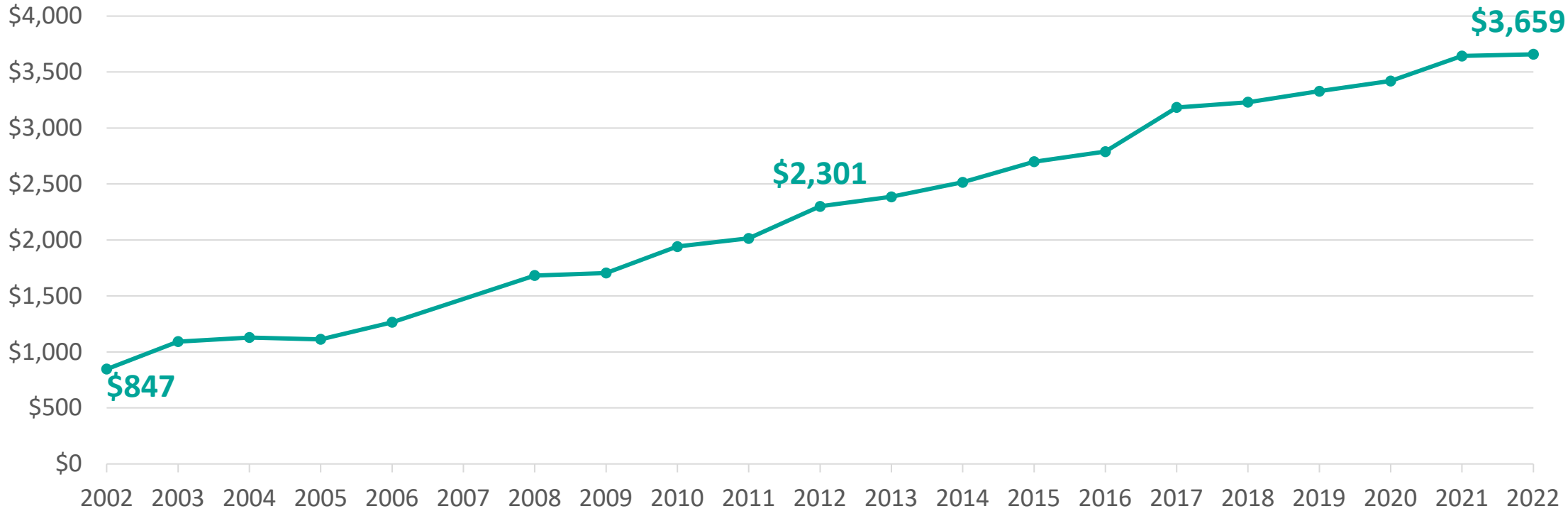
Share of California private-sector establishments with fewer than 50 employees that offer health insurance, 2002-2022



Source: MEPS-IC California 2002-2022

Survey data: cost of care
Family deductible amounts have increased

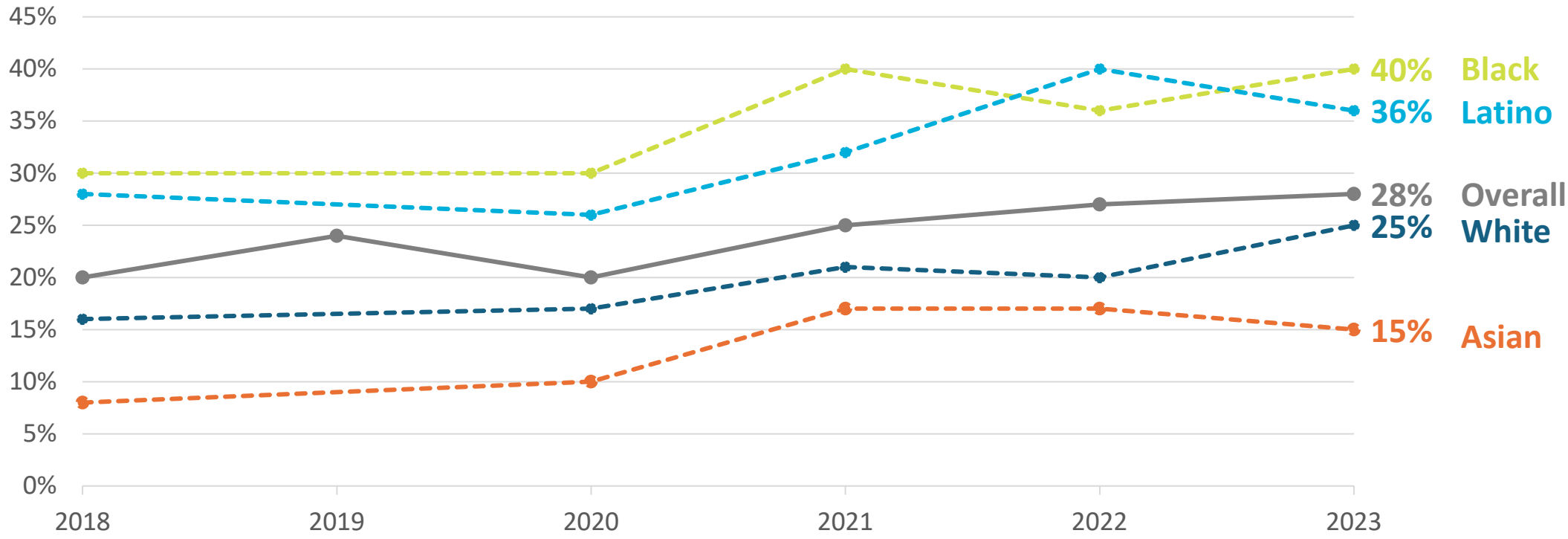
Average family deductible (among family plans with a deductible) for enrollees at California private-sector establishments, 2002 to 2022



Source: MEPS-IC California 2002-2022

Survey data: health and financial consequences
Black and Latino Californians are more likely to report trouble paying for medical bills

Share of California adults who say they or anyone in their family had trouble paying any medical bills in the past 12 months by race/ethnicity, 2018-2023



Source: CHCF California Health Policy Surveys, 2019-24

Proposed consumer affordability measures

☑ Available
❑ Unavailable currently

	Cost of coverage	Cost of accessing care	Health and Financial Consequences
Administrative data for annual assessment	☑ Total premium	☑ Consumer responsibility portion of total health care expenditures ☑ Actuarial value	
Survey data for longer-term monitoring	☑ Worker share of premium ☑ Offer rate by firm size ☑ Take up rate among eligible workers	☑ Deductible ☑ Maximum out-of-pocket ☑ Copays for office and specialist visits	☑ Skipping / delaying care due to cost ☑ Trouble paying medical bills ☑ Prevalence of medical debt
Survey data for equity impacts	❑ Premium by race/ethnicity and income	❑ Deductible by race/ethnicity and income	☑ All of the above by race/ethnicity and income

Other data needs

- As OHCA gains experience monitoring trends, other data needs will likely arise
- Data to explore include:
  - Premium and deductible data by race/ethnicity and income
  - Geographic variation
  - New possibilities for measures using the Health Payments Database

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The report *Measuring Consumer Affordability is Integral to Achieving the Goals of the California Office of Health Care Affordability* is available at *https://laborcenter.berkeley.edu/measuring-consumer-affordability/*

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Public Comment

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Measuring Out-of-Plan Spend

Vishaal Pegany
CJ Howard
KeriAnn La Spina, Senior Health Researcher, Mathematica

Definitions

Cost sharing
Member's financial responsibility including copay, coinsurance, and deductibles

+

Out-of-plan spending
Costs for services not covered by insurance & costs paid outside insurance

=

Total out-of-pocket spending*

Included in OHCA THCE

Not included in OHCA THCE

* Consumers may also pay premiums, but these costs are not included in our definition of out-of-pocket spending.

Why Measure Out-of-Plan Spending?

- The Board and Advisory raised concerns that OHCA's Total Health Care Expenditures (THCE) measure does not include out-of-plan spending.
- Some possible reasons for out-of-plan spending include:
  - **Provider Preferences for Cash Payments:** Recent research suggests that a growing portion of behavioral health providers do not accept insurance, and that fewer psychiatrists accept insurance compared to other specialties.
  - **Barriers to Accessing Providers/Convenience:** Many patients struggle to find in-network providers, especially behavioral health providers, due in part to provider and prescriber shortages and delays in getting appointments.
  - **Changes in Benefit Design:** Changes in benefit design and covered services could compel more patients to seek out-of-plan care.
- Fewer providers accepting insurance reduces access to care for those unable/unwilling to self-pay and may introduce inequities in access to and quality of care.
- To shed light on the scope of this problem and its implications for potential public policy, OHCA proposes a supplemental analysis to estimate out-of-plan spending.

Sources: Bishop, Tara et al. (2014 February). *Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care*. JAMA Network.; National Alliance on Mental Illness. (2016 November). *Out-of-Network, Out-of-Pocket, Out-of-Options: The Unfulfilled Promise of Parity.;* Benjenk, I., Chen, J. (15, July 2020). *Trends in Self-payment for Outpatient Psychiatrist visits*. JAMA Psychiatry.

Estimating Out-of-Plan Spending Using the Medical Expenditure Panel Survey

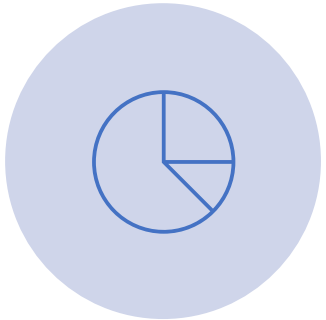
- The Medical Expenditure Panel Survey Household Component (MEPS-HC) is a nationally representative sample of the civilian noninstitutionalized population.
- It includes information from consumers on health insurance coverage and healthcare utilization and costs, including out-of-pocket spending:
  - Spending in the MEPS-HC is defined for each medical event (office visit, inpatient stay, outpatient visit, etc.).
  - For each event, data shows spending by private insurance, public programs, and self-pay (out-of-pocket).
  - Each event includes type of provider, diagnosis codes, and procedure codes.
- Allows for the generation of California-specific estimates but may need to pool years to produce reliable results.
- MEPS-HC out-of-pocket spending variable includes but does not differentiate payment for out-of-plan events.
- OHCA will build decision rules to estimate the portion of MEPS out-of-pocket spending allocated to out-of-plan events.
- OHCA is developing a methodology to estimate out-of-plan spending based on payment source and timing of medical events in MEPS-HC data.

Example of Analysis: MEPS-HC and Behavioral Health Spending

What can we measure?

- MEPS-HC can be used to estimate:
  - Out-of-plan spending for behavioral health services,
  - Out-of-plan spending for other service types
  - Out-of-plan spending as a percentage of total behavioral health spending
- The types of research questions we aim to answer:

What is the level and change in out-of-plan spending for behavioral health services over time in California?

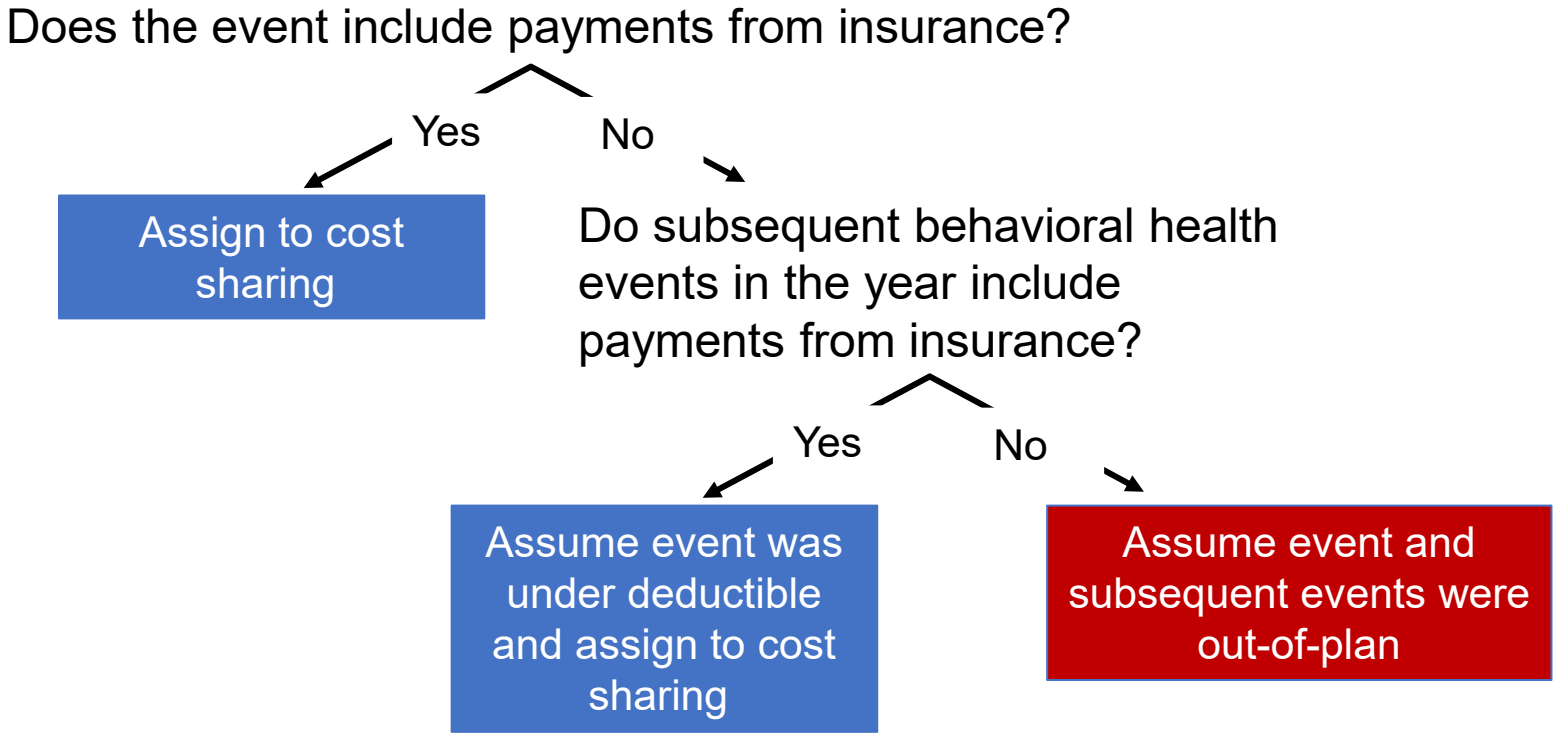


How much are Californians spending out-of-plan on behavioral health conditions compared with other types of services?

How Can We Estimate These Costs?

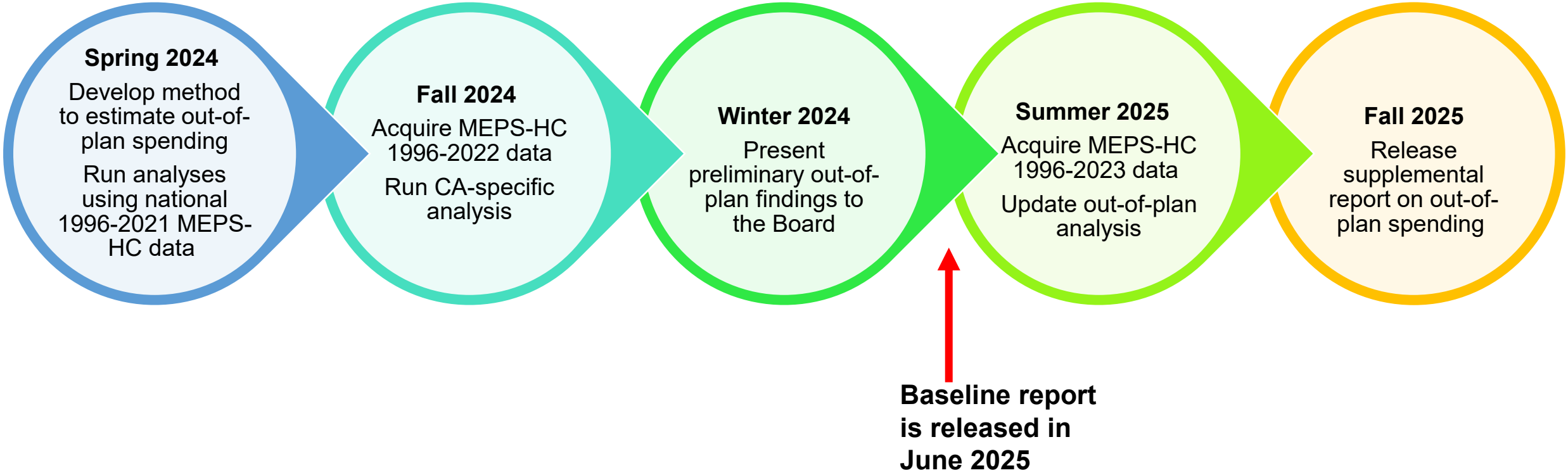
Example: Estimating out-of-plan behavioral health spending

MEPS variable: Out-of-pocket spending on behavioral health service; first annual event



Note: Method to estimate out-of-plan events still in development.

Timeline for Measuring Out-of-Plan Spending



HCAi
Department of Health Care Access and Information

Public Comment

HCAi
Department of Health Care Access and Information

General Public Comment

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

Next Board Meeting:

September 26, 2024
10:00 a.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

Department of Health Care Access and Information

Adjournment

HCAi
Department of Health Care Access and Information

Appendix

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

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 Alternative Payment Model Standards Proposed Revisions

Proposed Changes to Draft APM Implementation Guidance

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

Proposed Changes to Draft APM Implementation Guidance

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

    1. [Implementation Guidance unchanged].

    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. [Implementation Guidance unchanged].

    4. [Implementation Guidance unchanged].

    5. [Implementation Guidance unchanged].

Proposed Changes to Draft APM Implementation Guidance

9. **Equip providers with accurate, 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 ***clinical registry and*** claims-level data.

    2. [Implementation Guidance unchanged].

    3. [Implementation Guidance unchanged].

Key Informant and Stakeholder Interviews to Inform Workforce Stability Standards

Key Informant & Stakeholder Interviewees

Academics & Content Experts

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

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

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

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

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

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

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

Paul Kumar
Health Policy and Finance Consultant

BJ Bartleson, MS, RN
Health Policy RN Consultant

Michael Bailit, MBA
President, Bailit Health

Organized Labor

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

Ian Lewis
Policy Director, National Union of Healthcare Workers

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

California Nurses Association (CNA)/National Nurses United

Consumer Representatives & Advocates

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

Anthony Wright
Executive Director,
Health Access California

Beth Capell, PhD
Contract Lobbyist,
Health Access California

Health Care Entities & Associations

California Hospital Association (CHA)

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

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

Kaiser Permanente

Sutter Health

Plumas District Hospital

Workforce Stability Standards Interviewees

Academics/Content Experts

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

Workforce Stability Standards Interviewees

Organized Labor

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

Consumer Representatives & Advocates

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

Workforce Stability Standards Interviewees

Health Care Entities

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

Guiding Principles to Inform Workforce Stability Standards

Principles to Guide Development of Workforce Stability Standards and Metrics

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

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

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

Organization Level Workforce Stability Metrics

Draft Workforce Stability Metrics for Hospitals

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

Draft Workforce Stability Metrics for Nursing Homes and Skilled Nursing Facilities

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

Draft Workforce Stability Metrics for Community Clinics

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

Market Level Workforce Stability Metrics

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

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

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

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

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

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

Draft Workforce Stability Metrics for Health Worker Graduates

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

Draft Workforce Stability Metrics for Supply and Employment of Registered Nurses

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

Draft Workforce Stability Metrics for Registered Nurse Education

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

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

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

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

Provider Taxonomies Included as Primary Care

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

National Uniform Claim Committee (NUCC) Taxonomies	

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

Rationale:

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

OHCA's Definition of Primary Care Excludes OB-GYNs

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

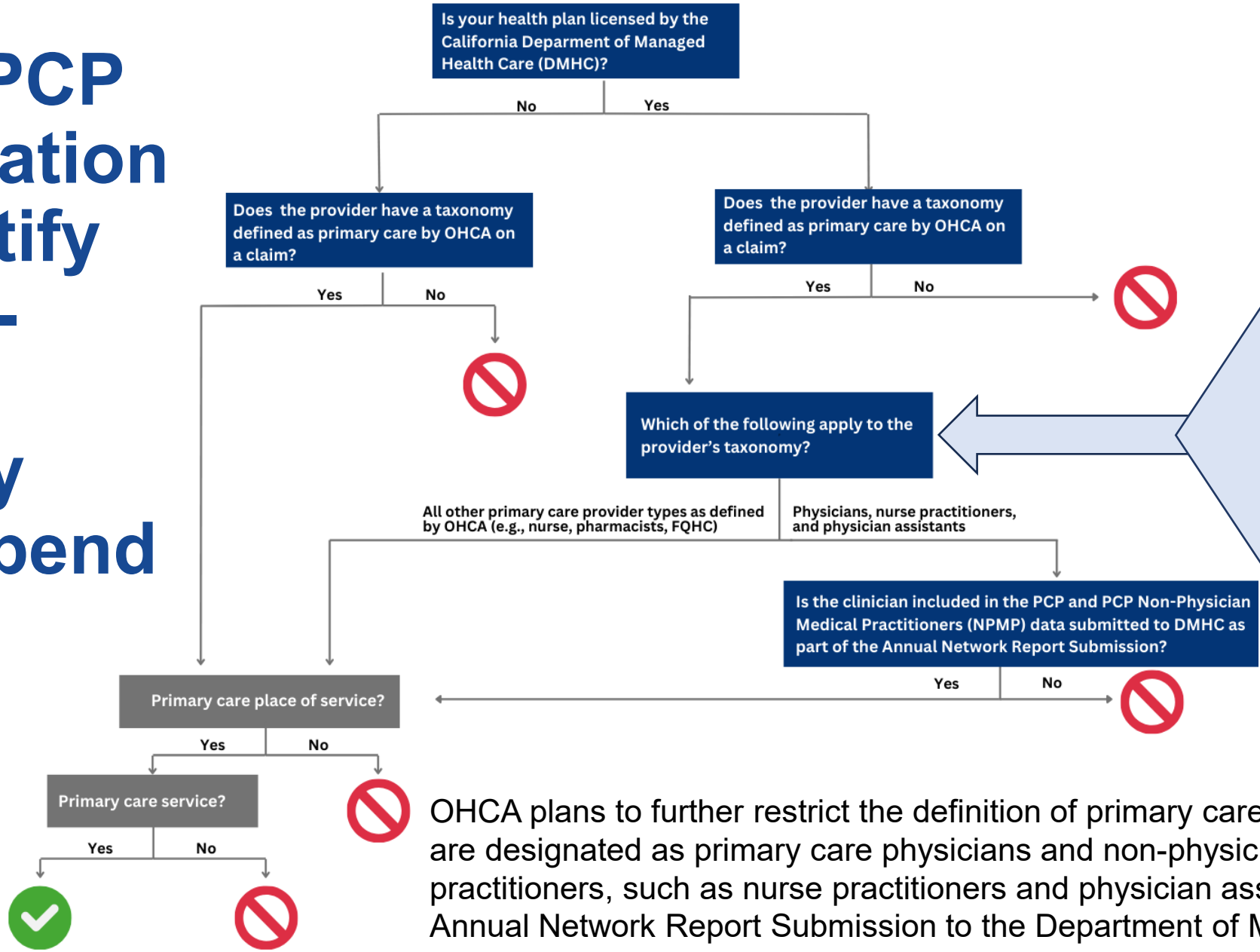
Rationale:

- Current focus on investing in providers who provide continuous whole-person care for all body systems. OB-GYNs typically do not meet this definition.
- Excluding OB-GYNs does not in any way change a consumer's right under the Knox Keene Act to select an OB-GYN as their primary care provider.
- According to unaudited health plan self-reported provider data submitted to DMHC, 9% of PCPs reported by health plans were identified as having a specialist type of OB-GYN and 72% of OB-GYNs reported by health plans were identified as serving as PCPs.

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

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

Using PCP Designation to Identify Claims-based Primary Care Spend



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

OHCA plans to further restrict the definition of primary care providers to those who are designated as primary care physicians and non-physician medical practitioners, such as nurse practitioners and physician assistants, in the payer's Annual Network Report Submission to the Department of Managed Health Care.

Services Included as Primary Care

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

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

Rationale:

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

Approach to Developing OHCA's Primary Care Services Code Set

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

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

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

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

Care Settings Included as Primary Care

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

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

Rationale:

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

Overview of Non-claims Primary Care Spending Measurement Approach

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

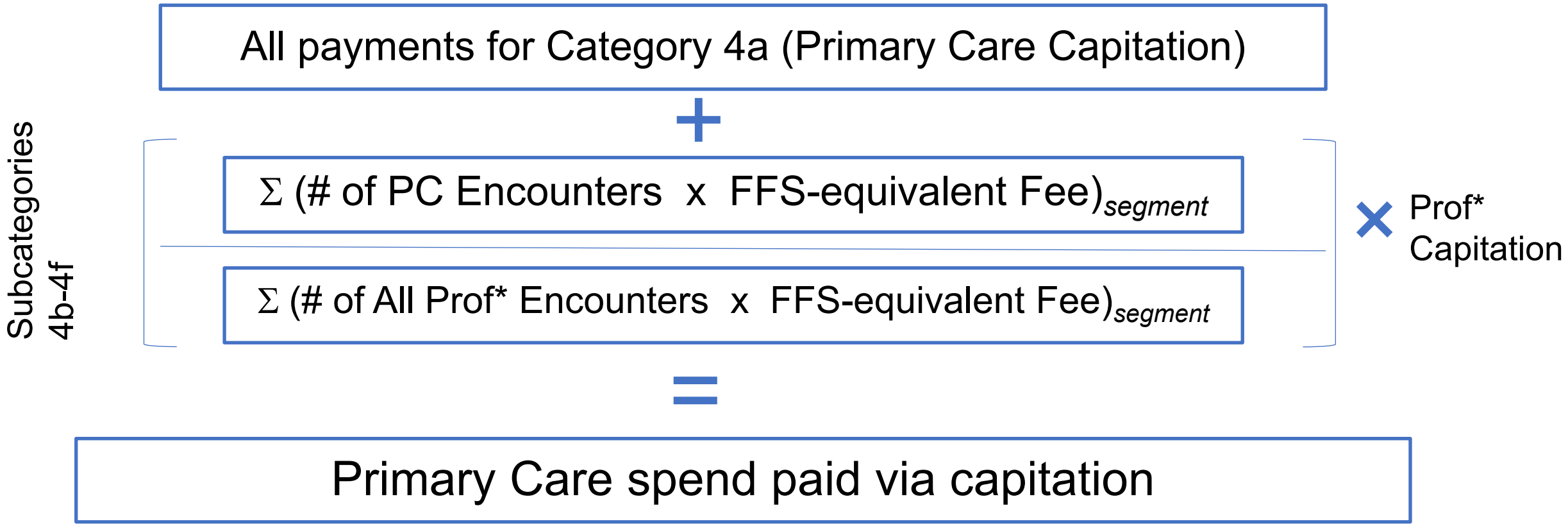
Overview of Non-claims Primary Care Spending Measurement Approach

Expanded Framework Category		Allocation to Primary Care Spending
3	**Payments with Shared Savings and Recoupments**	
a	Procedure-related, episode-based payments with shared savings	Limit the portion of risk settlement payments that are allocated to primary care spending to the same proportion that claims-based professional spending represents as a percent of claims-based professional and hospital spending.
b	Procedure-related, episode-based payments with risk of recoupments	
c	Condition-related, episode-based payments with shared savings	
d	Condition-related, episode-based payments with risk of recoupments	
e	Risk for total cost of care (e.g., ACO) with shared savings	
f	Risk for total cost of care (e.g., ACO) with risk of recoupments	

Overview of Non-claims Primary Care Spending Measurement Approach

Expanded Framework Category		Allocation to Primary Care Spending
4	**Capitation and Full Risk Payments**	
a	Primary Care capitation	Allocate full primary care capitation amount to primary care spending.
b	Professional capitation	Calculate a ratio of fee-for-service equivalents for primary care services to fee-for-service equivalents for all services in the capitation. Multiply the capitation payment by the ratio. Divide the result by total medical expense.
c	Facility capitation	Not applicable.
d	Behavioral Health capitation	Calculate a ratio of fee-for-service equivalents for primary care services to fee-for-service equivalents for all services in the capitation. Multiply the capitation payment by the ratio. Divide the result by total medical expense.
e	Global capitation	
f	Payments to Integrated, Comprehensive Payment and Delivery Systems	
5	**Other Non-Claims Payments**	Not applicable.
6	**Pharmacy Rebates**	Not applicable.

Primary Care Portion of Capitation Payments



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