HCAi
Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

May 15th, 2024

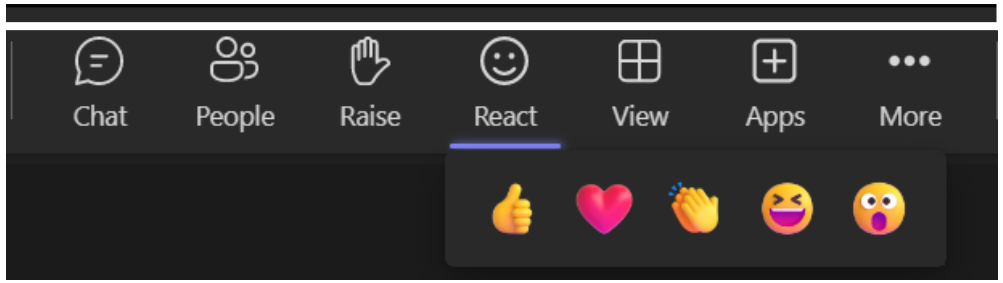
Agenda

9:00 a.m.	**1. Welcome and Updates**
9:05 a.m.	**2. Review Alternative Payment Model Recommendations and Advisory Committee Feedback**
9:20 a.m.	**3. Review Primary Care Benchmark Recommendations and Advisory Committee Feedback**
10:20 a.m.	**4. Discuss Transition to Behavioral Health Investment Work**
10:30 a.m.	**5. Adjournment**

Meeting Format

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

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



Date: May 15, 2024

Time: 9:00 am PST

Microsoft Teams Link
for Public Participation:

Meeting ID: 231 506 203 671
Passcode: XzTN6r

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

Conference ID:
261 055 415#

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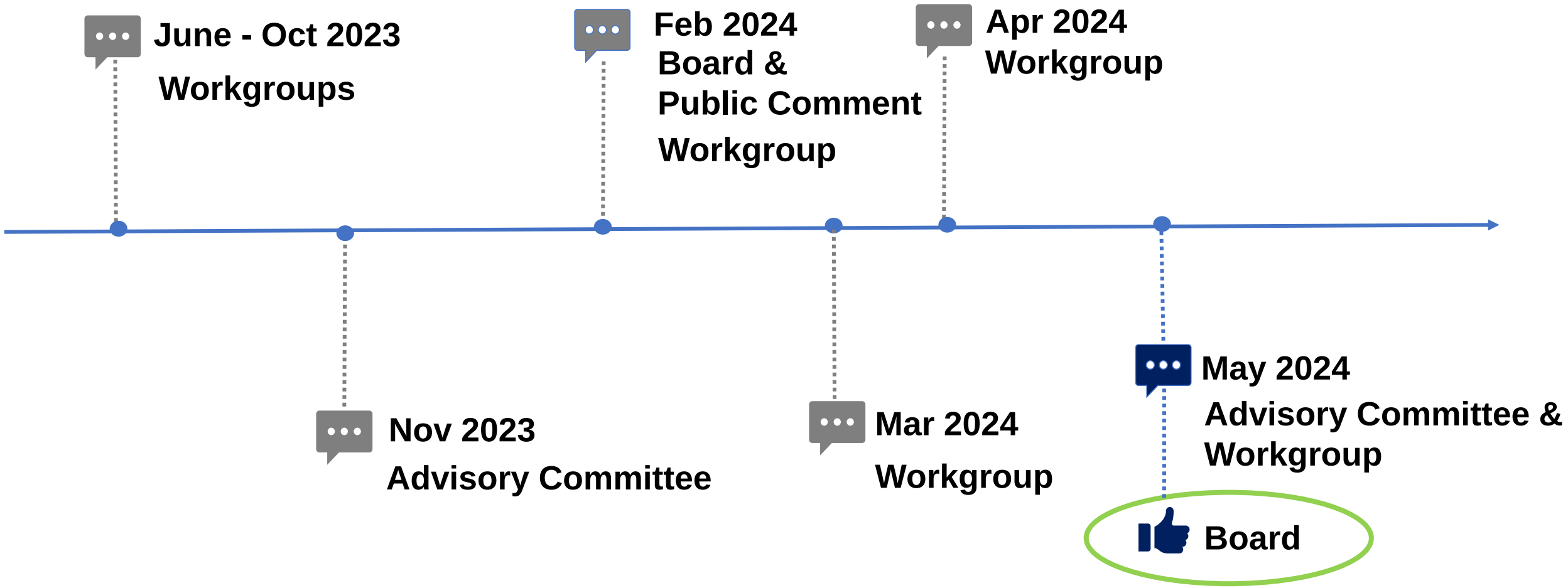
Review Alternative Payment Model Recommendations and Advisory Committee Feedback

Ngan Tran, Value-Based Payment Group Manager

Timeline for APM Workstreams



* Dates subject to change.

Provide Feedback Board Approval

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APM Standards Recommendations

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.

APM Standards Recommendations

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).

Advisory Committee Feedback on APM Standards and Implementation Guidance

Feedback Theme	OHCA's Response
• Two members suggested adding a standard that requires APMs to be actuarially sound. • Several members noted the importance of emphasizing the value of the PCP-consumer relationship and continuity of care in the standards. • One member suggested collecting information on adoption of APM Standards and Implementation Guidance to understand and share how care delivery and payment are changing.	• Implementation Guidance 5.3 includes reference to supporting providers as they assume financial risk in a way that protects financial solvency and supports sustainability. • Implementation Guidance 3.4 highlights that APM arrangements should encourage consumers to choose a primary care team. • Implementation Guidance 3.1 notes the importance of providing sufficient payments to primary care to support primary care continuity. • OHCA will consider collecting information on implementation of APM Standards in Performance Improvement Plans (PIPs).

Advisory Committee Feedback on APM Standards and Implementation Guidance Continued

Feedback Theme	OHCA's Response
• Several members supported the inclusion of technical assistance for small practices to adopt APMs and suggested payers should also provide funding to support small practices adopt APMs. • One member suggested presentations by California Quality Collaborative and others who are leading efforts to expand APM adoption among PPO plans. • One member noted the importance of meaningful data sharing, supportive benefit designs, such as PCP assignment, and other features to support APM adoption in PPO plans.	• Standard 10 is focused on technical assistance to support providers in successful APM adoption. • Implementation Guidance 5.1 highlights the need for upfront financial support to new entrants. • OHCA will consider opportunities for presentations from stakeholders and other ways to disseminate best practices. • The APM Standards and Implementation Guidance address data sharing, benefit design, and supporting APM adoption across various payers and providers in several areas.

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.

Advisory Committee Feedback on APM Adoption Goals

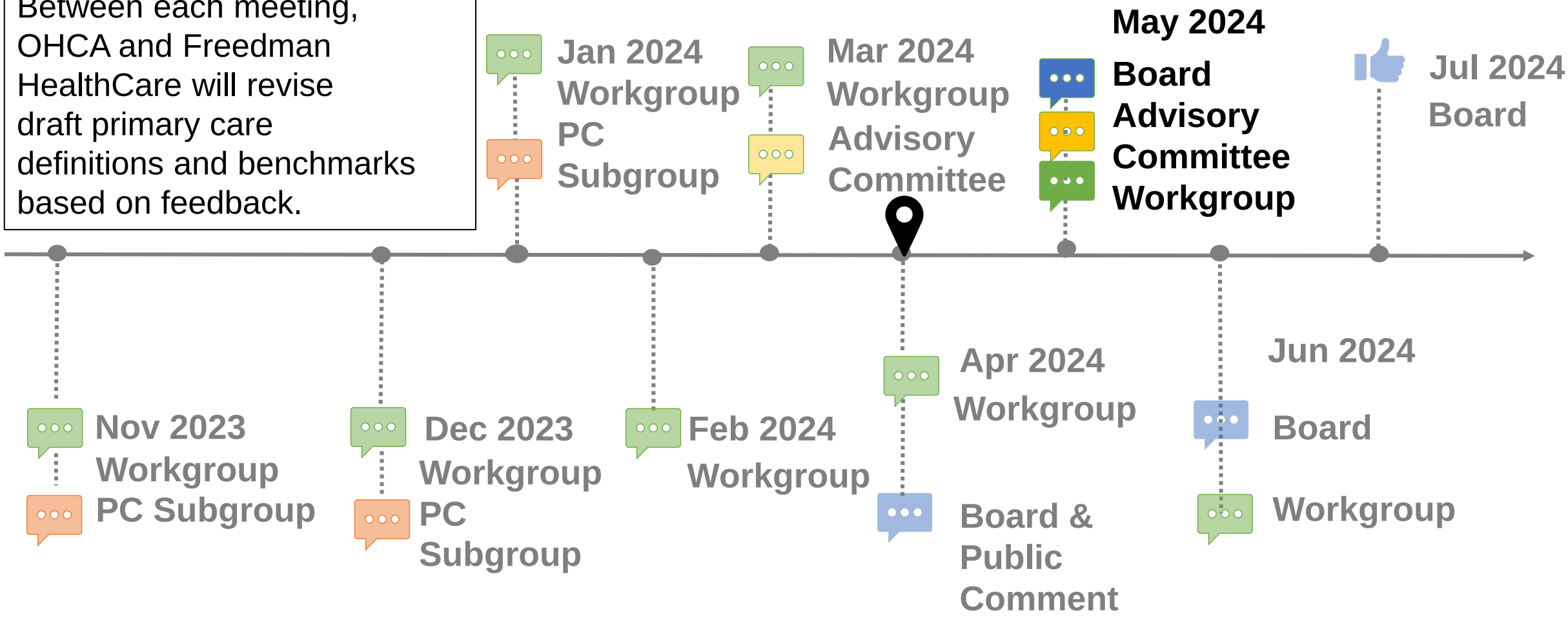
Feedback Theme	OHCA's Response
• Several members recognized the challenges of increasing APM adoption in PPOs and how this influences the proposed goals. • One member was concerned the Medi-Cal adoption goals may be too ambitious. • Several members suggested collecting data from provider organizations to understand APM adoption at the provider organization level and how provider organizations pay downstream providers.	• OHCA appreciates that APM adoption varies by payer type and reflects this in the revised goals. • Initial data collection and accountability will be at the payer level. OHCA is planning to collect data from provider organizations with Restricted or Limited Knox Keene licenses in the future; OHCA has not determined whether it will collect data from other entities in the future.

Review Primary Care Benchmark Recommendations and Advisory Committee Feedback

Debbie Lindes, Health Care Delivery System Group Manager

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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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

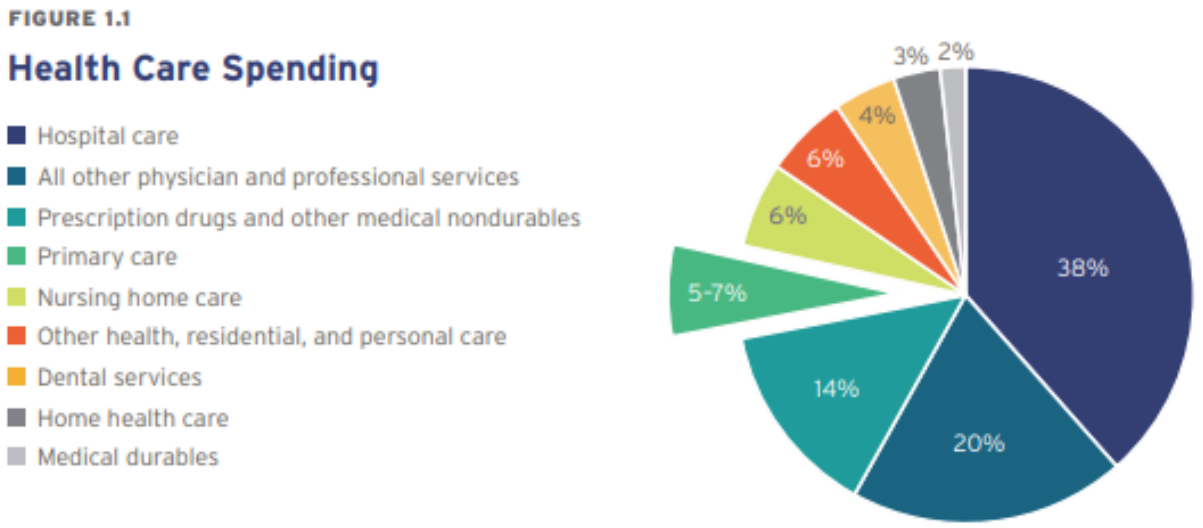
1. **The most successful efforts gradually reallocate spending to primary care.** Efforts to increase investment too quickly may accelerate growth in total cost of care.

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.

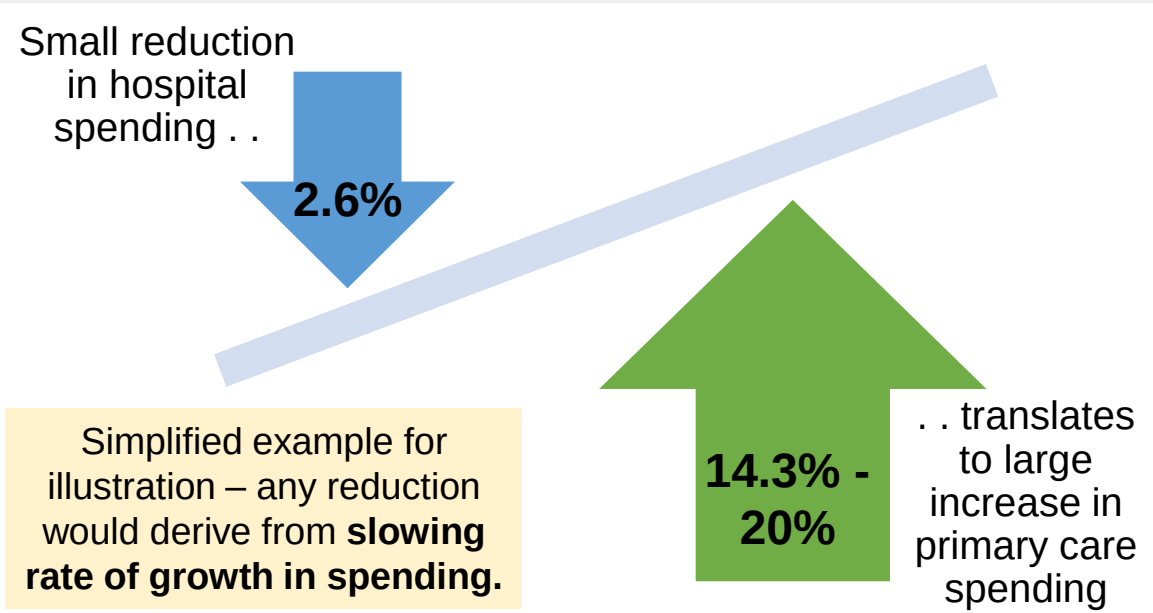
3. **Increases in total cost of care hinder benchmark success.** As total cost of care increases, achieving primary care benchmarks based on percent total medical expense becomes more difficult.

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)?**



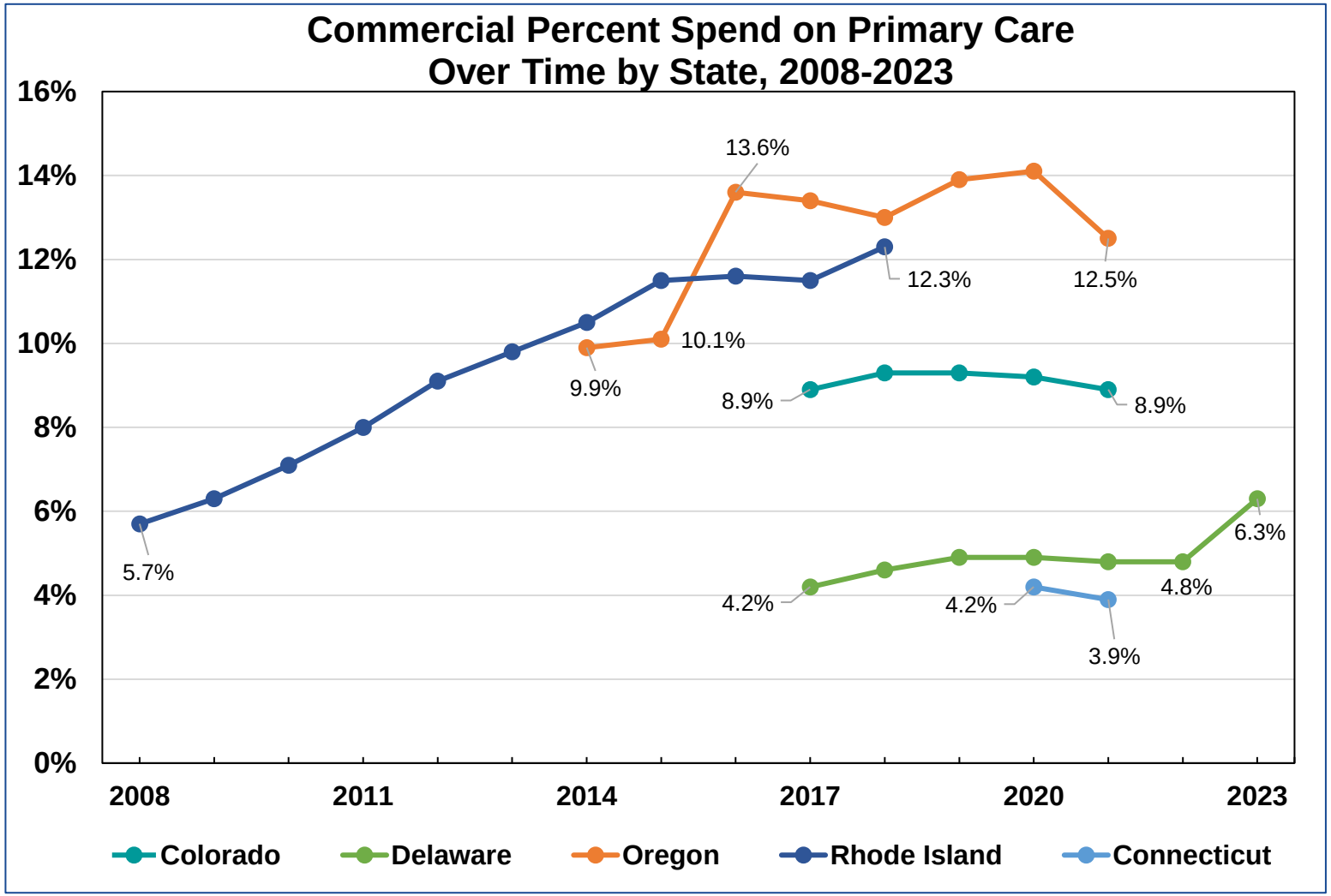
Reallocating one percentage point of spend from hospital care (from 38%→37% TME) to primary care (5-7%→6-8% TME) would **generate substantial primary care investment.**



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

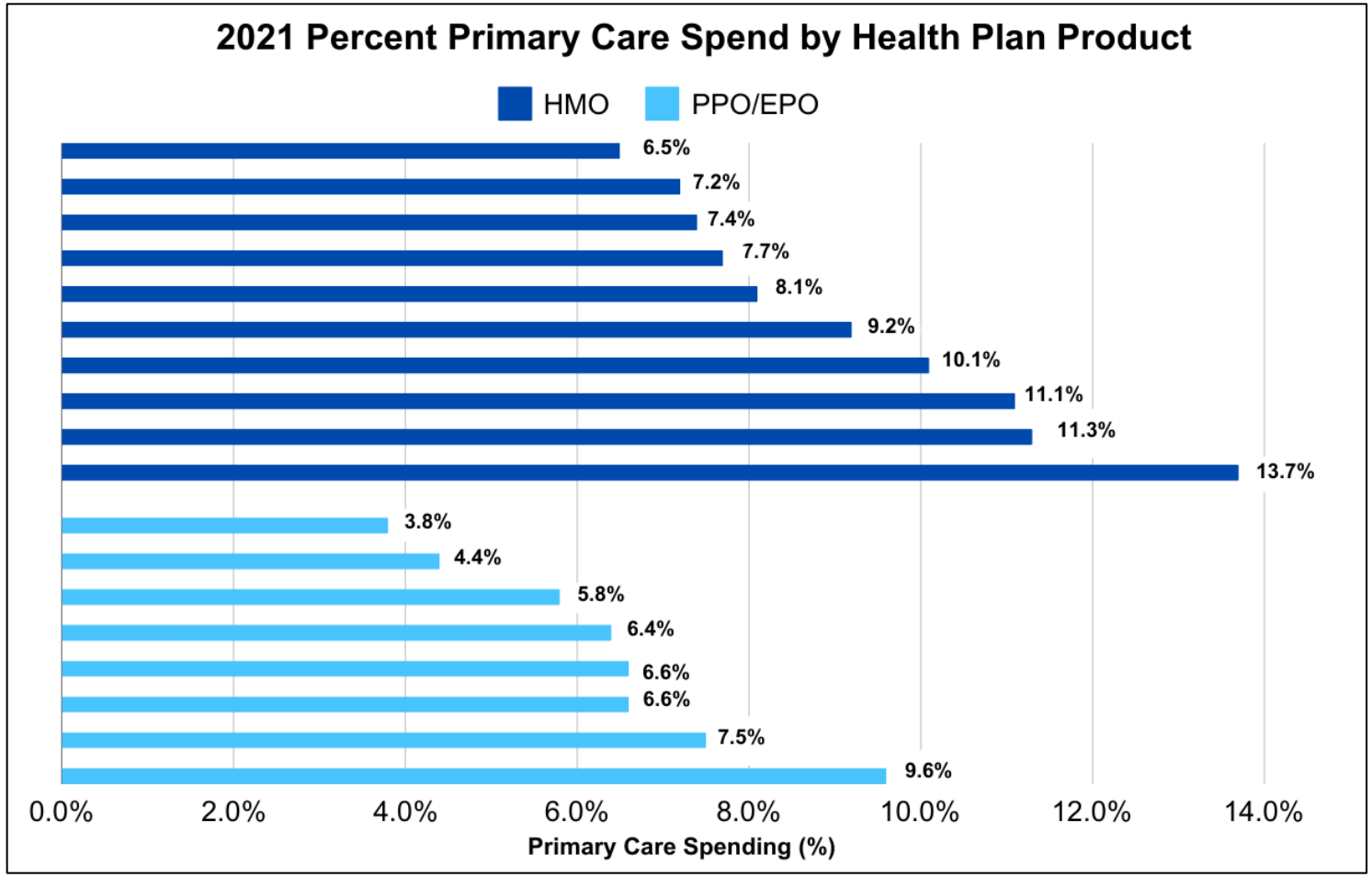


- These states have the most experience working to increase primary care investment.
- Four of them are Cost Growth Benchmark states and like California are looking to gradually reallocate more of the healthcare dollar away from lower value services to higher value services like primary care.
- States 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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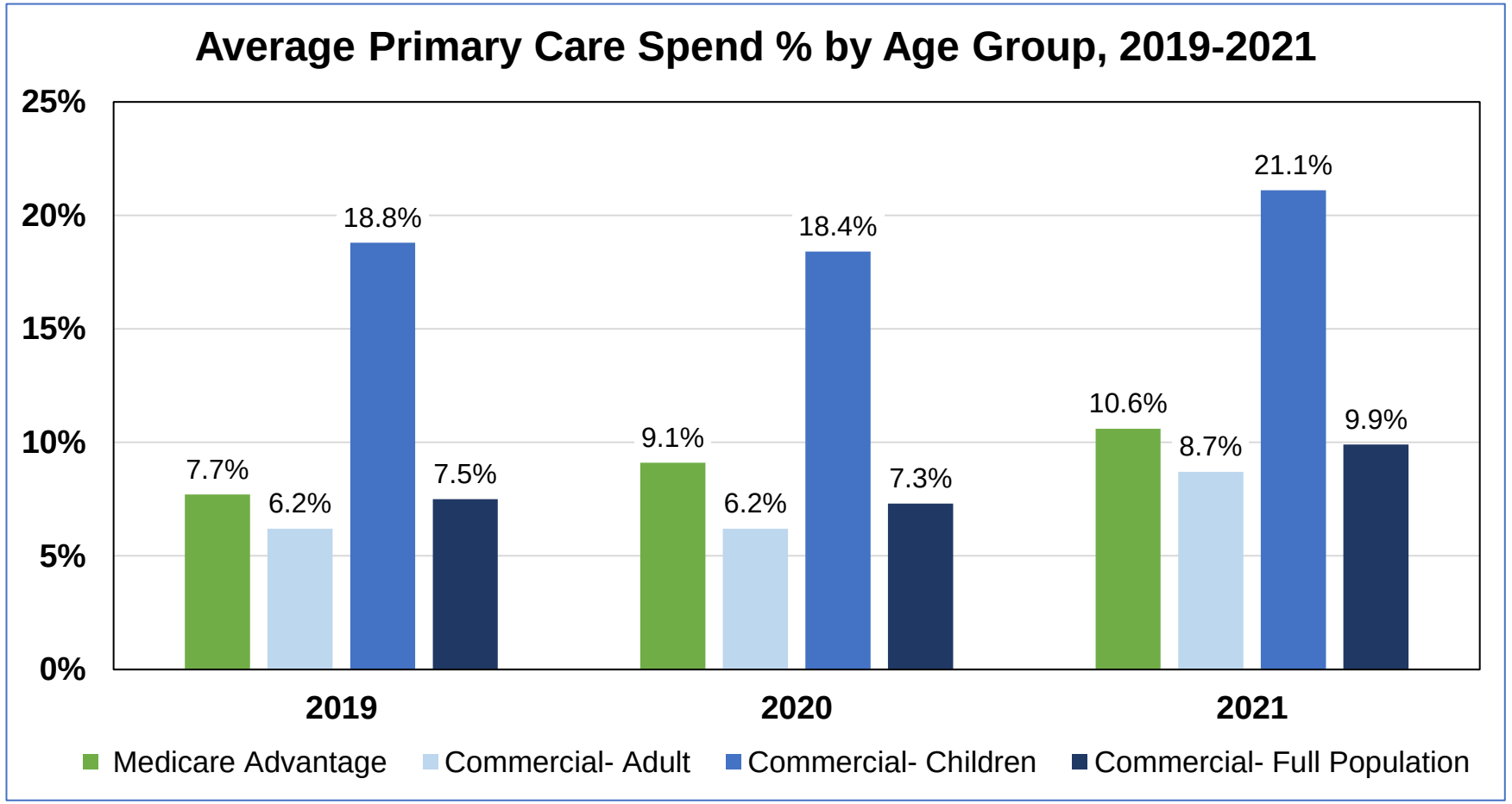
Primary Care Spending for Children and Adults in California

- 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/

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.

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

Advisory Committee Feedback on Primary Care Recommendations

Feedback Theme	OHCA's Response
• Several members supported the 15% benchmark; one commented the timeline offered a "nice runway." • Several members recommended an adult and pediatric investment benchmark to ensure adequate spending for both age groups. • Several members indicated the formula to allocate a portion of capitation to primary care would not capture all provider organization spending in support of primary care. One recommended testing the formula with payers and providers.	• OHCA will consider using HPD analysis to monitor primary care spending by age group. • OHCA reporting will include payer population age distribution to contextualize spending level. • Payers have limited insight into how providers allocate funds internally. The methodology will likely underestimate and overestimate the true allocation, depending on the provider group. • OHCA is continuing to solicit feedback on the formula for allocating capitation payments to primary care.

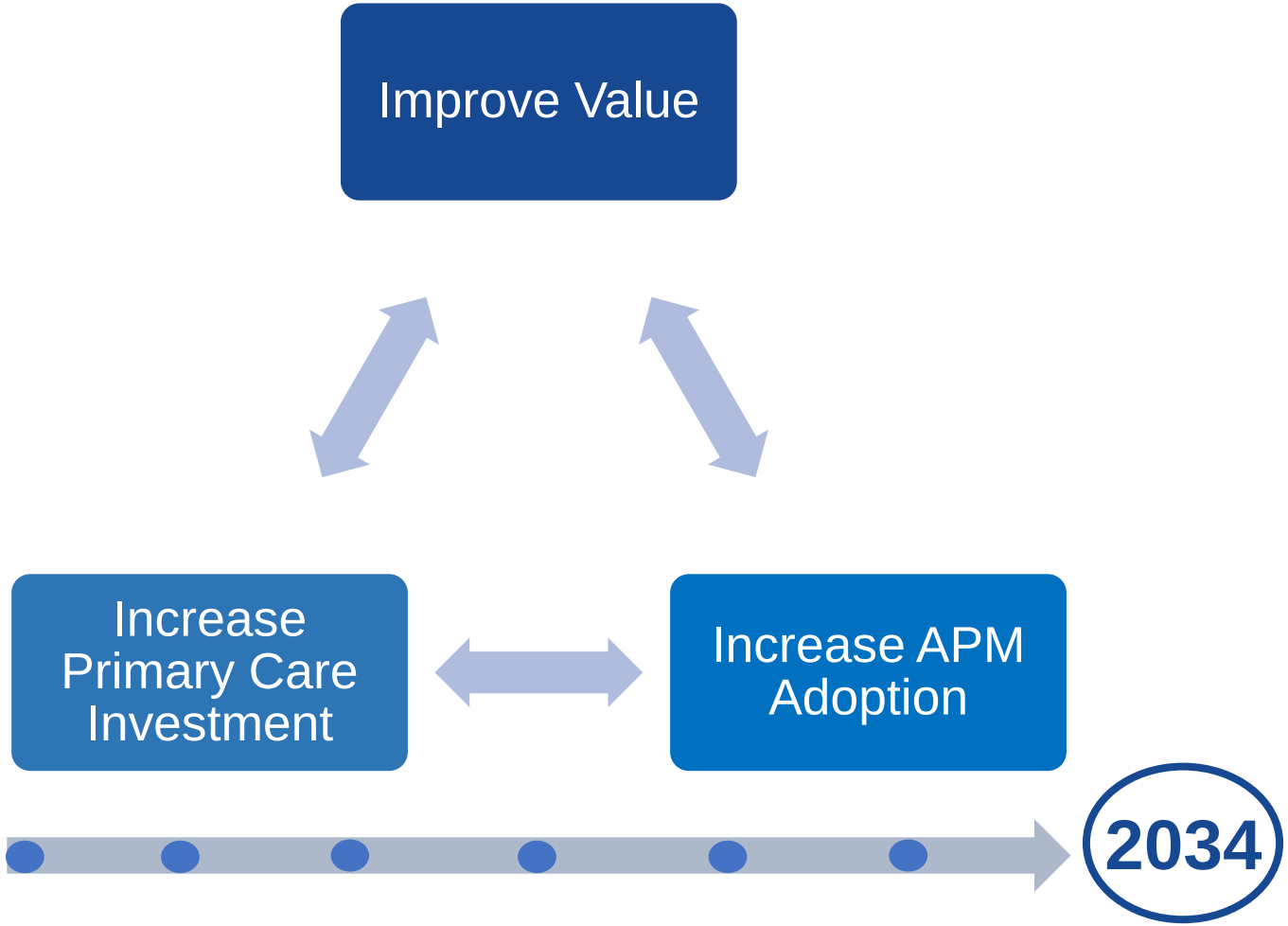
Advisory Committee Feedback on Primary Care Recommendations Continued

Feedback Theme	OHCA's Response
• One member noted the 10-year timeline is long and would like to see most of the increased investment in the first few years • Several members suggested collecting data from provider organizations to understand primary care spending by provider organization • Several members suggested OHCA should track complementary measures for primary care investment like PCP-consumer relationship, continuity of care, and quality	• OHCA anticipates annual reporting on the relative improvement benchmark and absolute benchmark will promote near-term improvement and long-term success. • Initial data collection and accountability will be at the payer level. OHCA is planning to collect data from provider organizations with Restricted Knox Keene or Limited Knox Keene licenses in the future; OHCA has not determined whether it will collect data from other entities in the future. • OHCA is exploring additional analyses using the HPD.

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.



Next Steps

- Public Comment Period for the Primary Care Definition and Benchmark: **April 24 – May 31, 2024**
  - Proposed benchmark and instructions for public comment submission here: https://hcai.ca.gov/affordability/ohca/

- **Workgroup Request:** Review the draft primary care definition code set and provide feedback by May 31st
  - Are there any codes or types of providers, services or places of service listed that you feel do not align with OHCA's recommendations?
  - Are there any codes or types of providers, services or places of services that were recommended by OHCA and are not included?
  - Any other feedback?

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Discuss Transition to Behavioral Health Investment Work

Margareta Brandt, Assistant Deputy Director

Draft Timeline for Behavioral Health Work

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

	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
Workgroup	X	X	X	X	X	X		X		X	
Advisory Committee			X				X				
Board				X	X				X		✓

* Dates subject to change.

X Provide Feedback

✓ Board Approval

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Behavioral Health Investment

Statutory Requirements

- Measure the percentage of total health care expenditures allocated to behavioral health and set spending benchmarks.
- Determine the categories of providers, specific procedure codes, and non-claims payments that should be considered when determining the total amount spent on behavioral health.
- 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 sustained systemwide investment in behavioral health care.
- Include an analysis of behavioral health spending and growth in the annual report.
- Consult with state departments, external organizations promoting investment in behavioral health, and other entities and individuals with expertise in behavioral health.

Primary Care & Behavioral Health Investments

Statutory Requirements

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

- Integrate primary care and behavioral health services, including screenings for behavioral health conditions in primary care settings or delivery of behavioral health support.
- Implement innovative approaches that integrate primary care and behavioral health with broader social and public health services.
- Leverage APMs that provide resources at the practice level to enable improved access and team-based approaches for care coordination, patient engagement, quality, and population health.
- Deliver higher value behavioral health services with an aim toward reducing disparities.
- Leverage telehealth and other solutions to expand access to behavioral health services, care coordination, and care management.

Health and Safety Code 127505(a.4)

Components of Behavioral Health Spending

Defining Components of Behavioral Health Spend for State Measurement

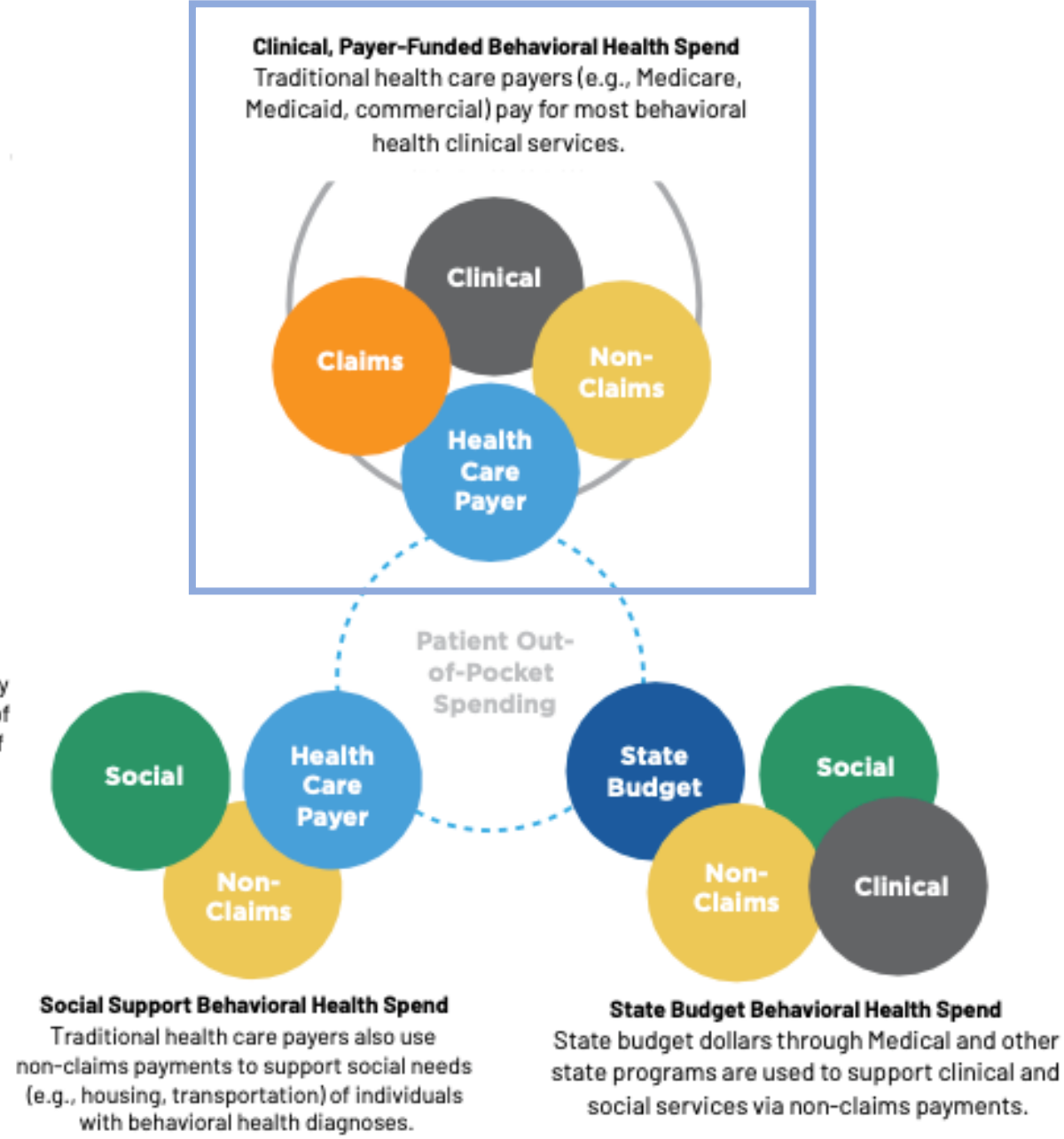
Service Type
Clinical or Social

Funding Type
Claims or Non-Claims

Payment Mechanism
Health Care Payer or State Budget

Medicaid funds behavioral health services as a health care payer and is also funded via state budgets.

Patient Out-Pocket Spending
Some behavioral health spending is paid by patients due to patient cost share, a lack of coverage of certain services, and a lack of available in-network providers.



Examples of Topics We Plan to Discuss

- Use cases for measuring behavioral health spending
- How behavioral health services are delivered and paid for in California and how these factors impact spending measurement
- Examples of how other states measure behavioral health spending and considerations for California
  - Diagnoses
  - Providers
  - Services
  - Care Settings
  - Non-Claims
- Key decisions for setting a behavioral health spending benchmark

Share Your Knowledge with Us

- Are you aware of behavioral health spending measurement or related research occurring in California?
- How do you see the structure of the behavioral health care delivery and payment systems informing our work?
- Are there other related topics you think would be important for the workgroup to discuss?

Next Steps

- Workgroup members to confirm their participation in the behavioral health phase of work by May 31st.

- If you would like to recommend transitioning your role to another member of your organization with greater behavioral health expertise, please reach out by May 31st.

- The July 24th Investment and Payment Workgroup meeting will be the first meeting fully dedicated to behavioral health.

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Adjournment

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Appendix

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.**	