HCAi
Department of Health Care Access and Information

Health Care Affordability Board Meeting

May 22, 2024

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Welcome, Call to Order, and Roll Call

Agenda

1. **Welcome, Call to Order, and Roll Call**
   Secretary Mark Ghaly, Chair

2. **Executive Updates**
   Elizabeth Landsberg, Director, and Vishaal Pegany, Deputy Director

3. **Action Consent Item**
   Vishaal Pegany
   a) Approval of the April 24, 2024 Meeting Minutes

4. **Action Items**
   Vishaal Pegany, Margareta Brandt, Assistant Deputy Director
   a) Appoint Advisory Committee Members
   b) Establish Alternative Payment Model Standards and Adoption Goal

5. **Informational Items**
   Vishaal Pegany, Margareta Brandt, Assistant Deputy Director, Sheila Tatayon, Assistant Deputy Director
   a) Update on Draft Alternative Payment Model Standards and Adoption Goals, Including Summary of Advisory Committee Feedback
   b) Draft Primary Care Definition and Investment Benchmark, Including Summary of Advisory Committee Feedback
   c) Cost and Market Impact Review Draft Regulations Revisions

6. **Public Comment**

7. **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

Hospital Bill Complaint Program

If you believe you were wrongly denied financial assistance for a hospital bill, you may file a complaint with the Hospital Bill Complaint Program.

The Hospital Bill Complaint Program can also investigate complaints about a hospital's failure to:

- Provide patients with written notice about its discount payment and charity care programs.
- Post notices about the policies on hospital walls.
- Follow proper procedures before sending medical debt to collections.
- Follow other requirements of the Hospital Fair Pricing Act.
- **The Hospital Bill Complaint Program does not have authority over general billing or fee disputes.**

For more information, visit: http://hospitalbillcomplaintprogram.hcai.ca.gov/

Board Accomplishments and Work Ahead

To date, the Health Care Affordability Board has achieved the following:

- Established a statewide health care spending target through 2029
- Appointed an Advisory Committee
- Provided input on Cost and Market Impact Review regulations
- Provided input on Total Health Care Expenditures Data Collection regulations and Data Submission Guide

In the near- and long-term, the Board must:

- Approve alternative payment model standards and adoption goals (May or June 2024)
- Approve benchmarks for primary care spending (Summer 2024) and behavioral health spending (Spring 2025)
- Discuss OHCA's adoption of a single set of quality and equity measures (Spring 2025)
- Define initial health care sectors and establish sector targets
- Establish standards for determining and defining exempted providers
- Approve workforce stability standards that may apply in a performance improvement plan (note: distinct from overall workforce stability standards adopted by OHCA)
- Approve the scope and range of administrative penalties and penalty justification factors

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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Public Comment

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Action Consent Item: Approval of the April 24, 2024 Board Meeting Minutes

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Action Item

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Advisory Committee Member Appointment

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

AC Member Selection April - June

April 1

- Close AC solicitation

April 1 – May 15

- Evaluate submissions

Late April/ Early May

- AC Subcommittee Meetings

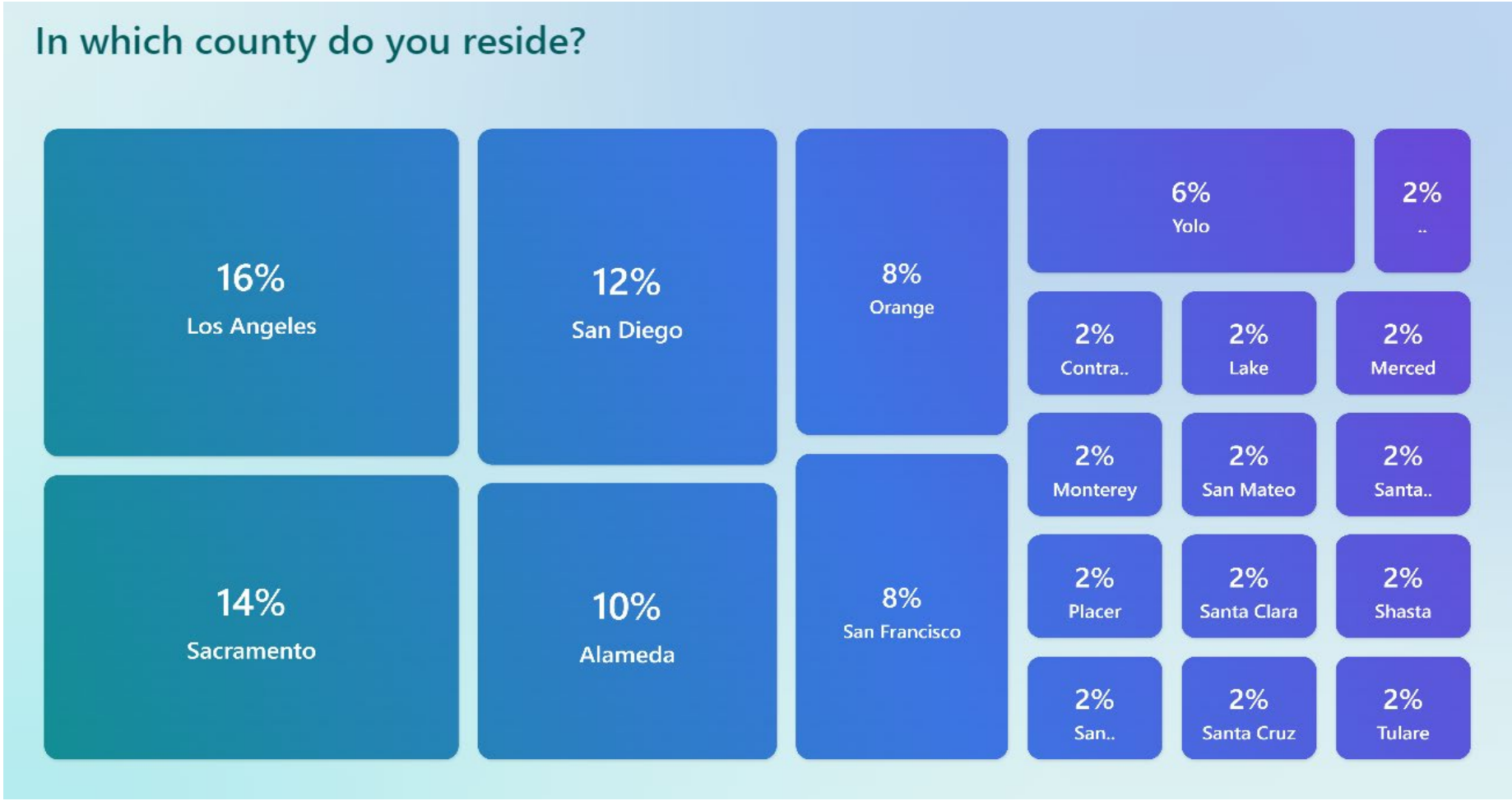
May 22 - Board Meeting

- Present potential slate to Board
- Appoint AC Members

June

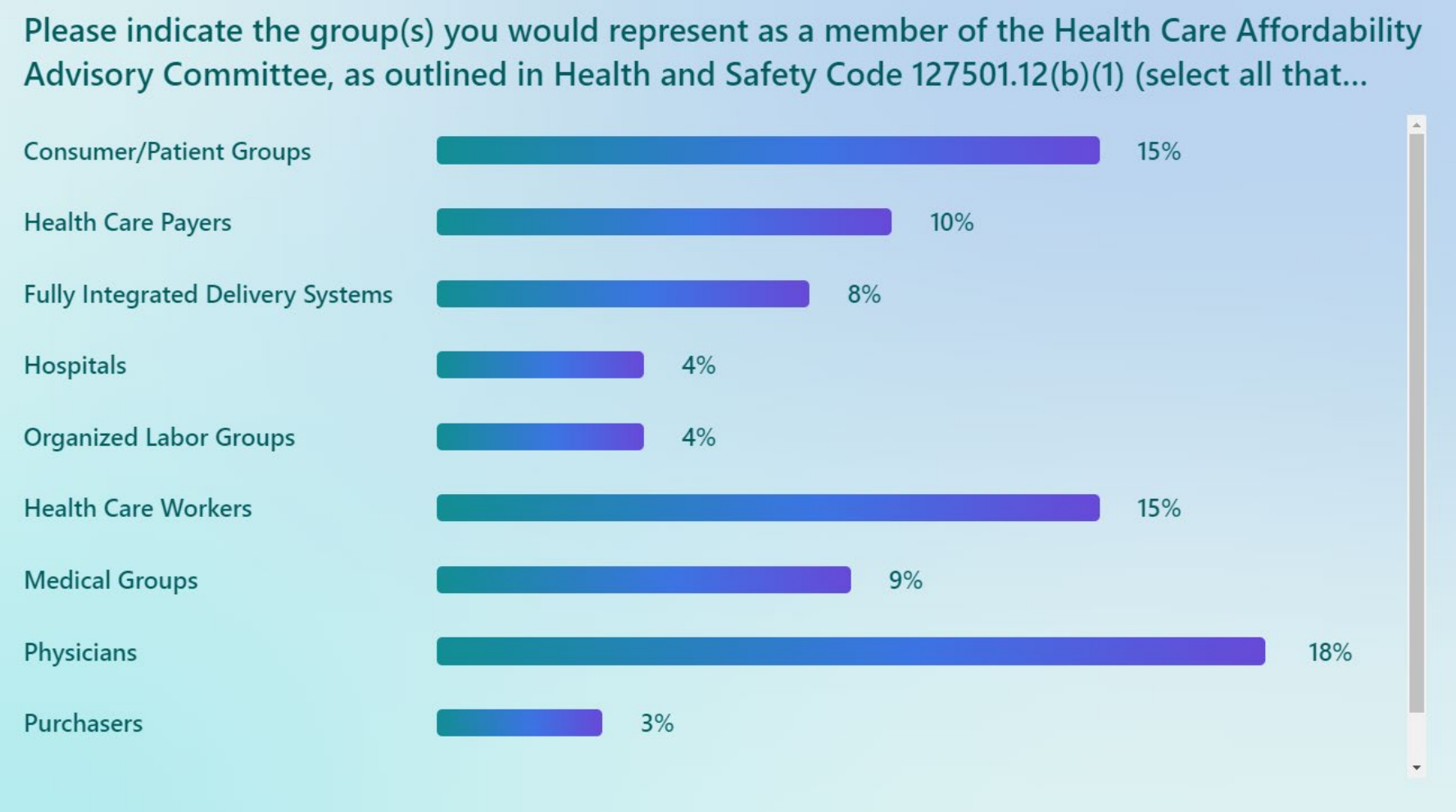
- Solicit for vacancy

Submissions of Interest – Geographic Distribution



Submissions of Interest – Expertise

- 50 individuals submitted interest forms.
- The data here reflects what was self-reported in the submissions.



Current Advisory Committee – 27 members

Payers

Aliza Arjoyan
Senior Vice President of Provider Partnership and Network Management, Blue Shield of California

Yolanda Richardson,
Chief Executive Officer, San Francisco Health Plan

Andrew See
Senior Vice President, Chief Actuary, Kaiser Foundation Health Plan

Hospitals

Barry Arbuckle
President & Chief Executive Officer, MemorialCare Health System

Tam Ma
Associate Vice President, Health Policy and Regulatory Affairs, University of California Health

Yvonne Waggener
Chief Financial Officer, San Bernardino Mountains Community Hospital District

Medical Groups

Hector Flores
Medical Director, Family Care Specialists Medical Group

Stacey Hrountas
Chief Executive Officer, Sharp Rees-Stealy Medical Centers

David S. Joyner
Chief Executive Officer, Hill Physicians Medical Group

Physicians

Adam Dougherty
Emergency Physician, Vituity

Parker Duncan Diaz
Clinician Lead, Santa Rosa Community Health

Sumana Reddy
President, Acacia Family Medical Group

Purchasers

Ken Stuart
Chairman, California Health Care Coalition

Suzanne Usaj
Senior Director, Total Rewards, The Wonderful Company LLC

Abbie Yant
Executive Director, San Francisco Health Service System

Health Care Workers

Stephanie Cline
Respiratory Therapist, Kaiser

Sarah Soroken
Mental Health Clinician, Solano County Mental Health

Sara Gavin
Chief Behavioral and Community Health Officer, CommuniCare Health Centers

Consumer Representatives & Advocates

Carolyn J Nava
Senior Systems Change, Disability Action Center

Mike Odeh
Senior Director of Health, Children Now

Kiran Savage-Sangwan
Executive Director, California Pan-Ethnic Health Network (CPEHN)

Rene Williams
Vice President of Operations, United American Indian Involvement

Anthony Wright
Executive Director, Health Access California

Organized Labor

Joan Allen
Government Relations Advocate, SEIU United Healthcare Workers West

Carmen Comsti
Lead Regulatory Policy Specialist, California Nurses Association/National Nurses United

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

Ivana Krajcinovic
Vice President of Health Care Delivery, UNITE HERE HEALTH

The highlighted members' terms end June 30, 2024.

= Did not reapply = Departing at end of term = Mid-term resignation

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Advisory Committee New Vacancy

- Yvonne Waggener recently resigned her appointment. She was in the Hospital category representing a rural hospital district. Her term does not end until 6/30/2025.
- The subcommittee recommends opening the application to solicit forms of interest from individuals who bring a hospital perspective, with an emphasis on a rural hospitals, to the Advisory Committee.

Advisory Committee Subcommittee Recommendations

15 members' terms are ending. The subcommittee recommends:

- Appointing 12 current members to new terms.
- Appointing new members to:
  - Organized Labor
  - Health Care Workers
  - Consumer Representatives/Advocates
  - Academics/Researchers (also a new category)
- Leaving a vacant position and soliciting more applications under the Hospital category.

Recommended Slate - 28 members

Payers

Aliza Arjoyan
Senior Vice President of Provider Partnership and Network Management, Blue Shield of California

Yolanda Richardson,
Chief Executive Officer, San Francisco Health Plan

Andrew See
Senior Vice President, Chief Actuary, Kaiser Foundation Health Plan

Hospitals

Barry Arbuckle
President & Chief Executive Officer, MemorialCare Health System

Tam Ma
Associate Vice President, Health Policy and Regulatory Affairs, University of California Health

Vacancy

Medical Groups

Hector Flores
Medical Director, Family Care Specialists Medical Group

Stacey Hrountas
Chief Executive Officer, Sharp Rees-Stealy Medical Centers

David S. Joyner
Chief Executive Officer, Hill Physicians Medical Group

Physicians

Adam Dougherty
Emergency Physician, Vituity

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Clinician Lead, Santa Rosa Community Health

Sumana Reddy
President, Acacia Family Medical Group

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Ken Stuart
Chairman, California Health Care Coalition

Suzanne Usaj
Senior Director, Total Rewards, The Wonderful Company LLC

Abbie Yant
Executive Director, San Francisco Health Service System

Health Care Workers

Stephanie Cline
Respiratory Therapist, Kaiser

Sarah Soroken
Mental Health Clinician, Solano County Mental Health

Cristina Rodriguez
Physician Assistant, Altura Centers for Health

Consumer Representatives & Advocates

Carolyn J Nava
Senior Systems Change, Disability Action Center

Mike Odeh
Senior Director of Health, Children Now

Kiran Savage-Sangwan
Executive Director, California Pan-Ethnic Health Network (CPEHN)

Rene Williams
Vice President of Operations, United American Indian Involvement

Marielle A. Reataza
Executive Director, National Asian Pacific American Families Against Substance Abuse (NAPAFASA)

Organized Labor

Joan Allen
Government Relations Advocate, SEIU United Healthcare Workers West

Carmen Comsti
Lead Regulatory Policy Specialist, California Nurses Association/National Nurses United

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

Kati Bassler
President, California Federation of Teachers, Salinas Valley

Academics/ Researchers

Stephen Shortell
Professor, UC Berkeley School of Public Health

Yellow highlight = term ends June 30, 2024, applied, and reappointment is recommended
Red font = new member recommendation and/or category

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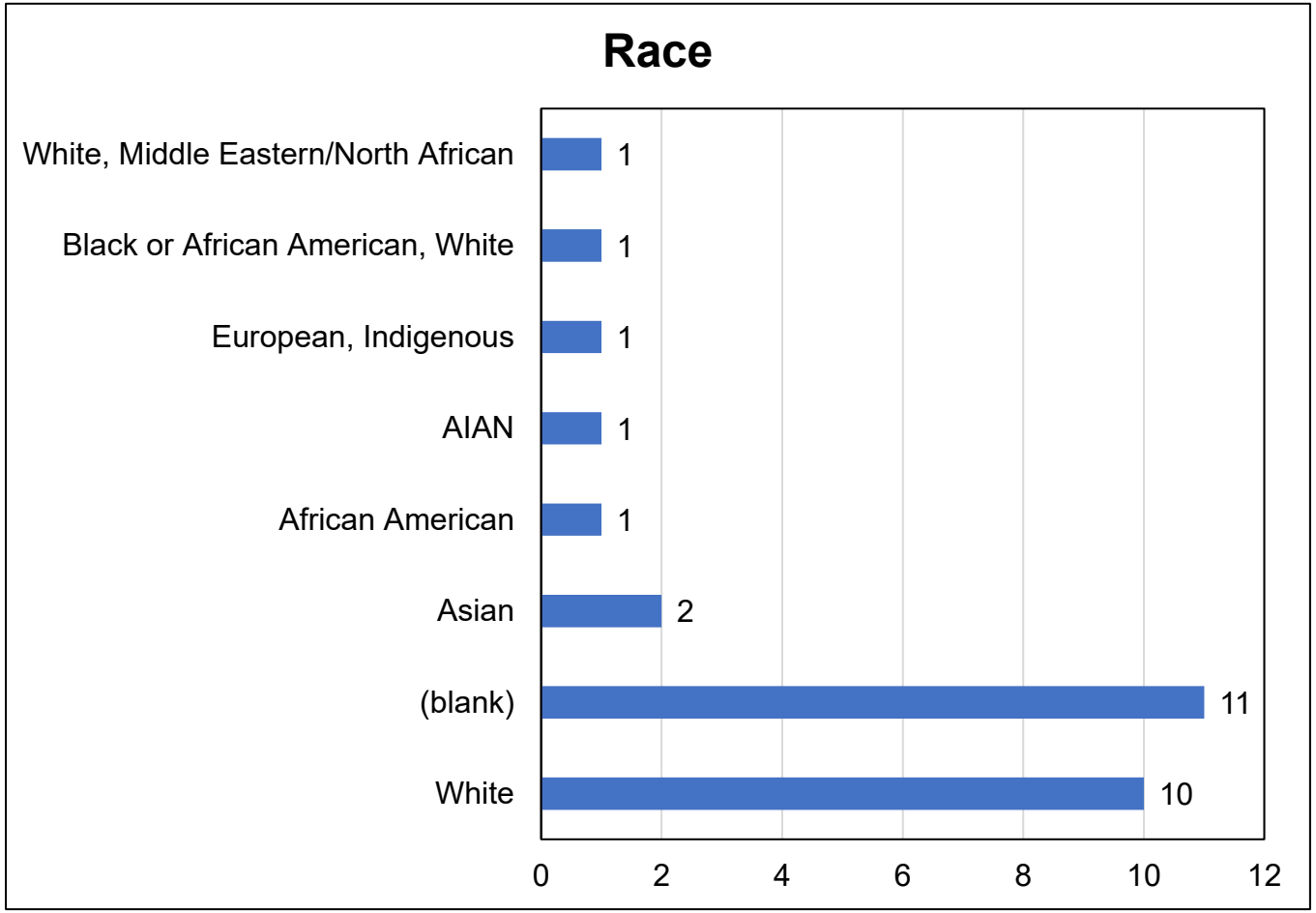
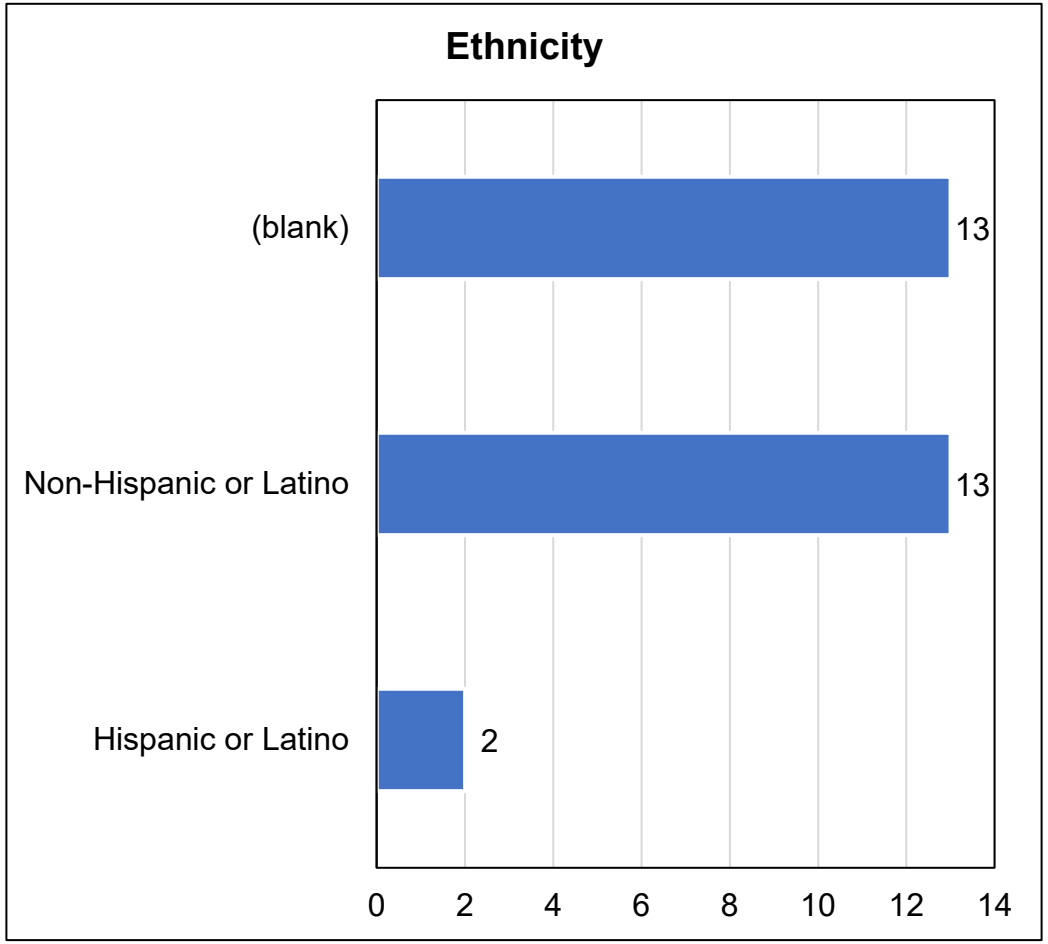
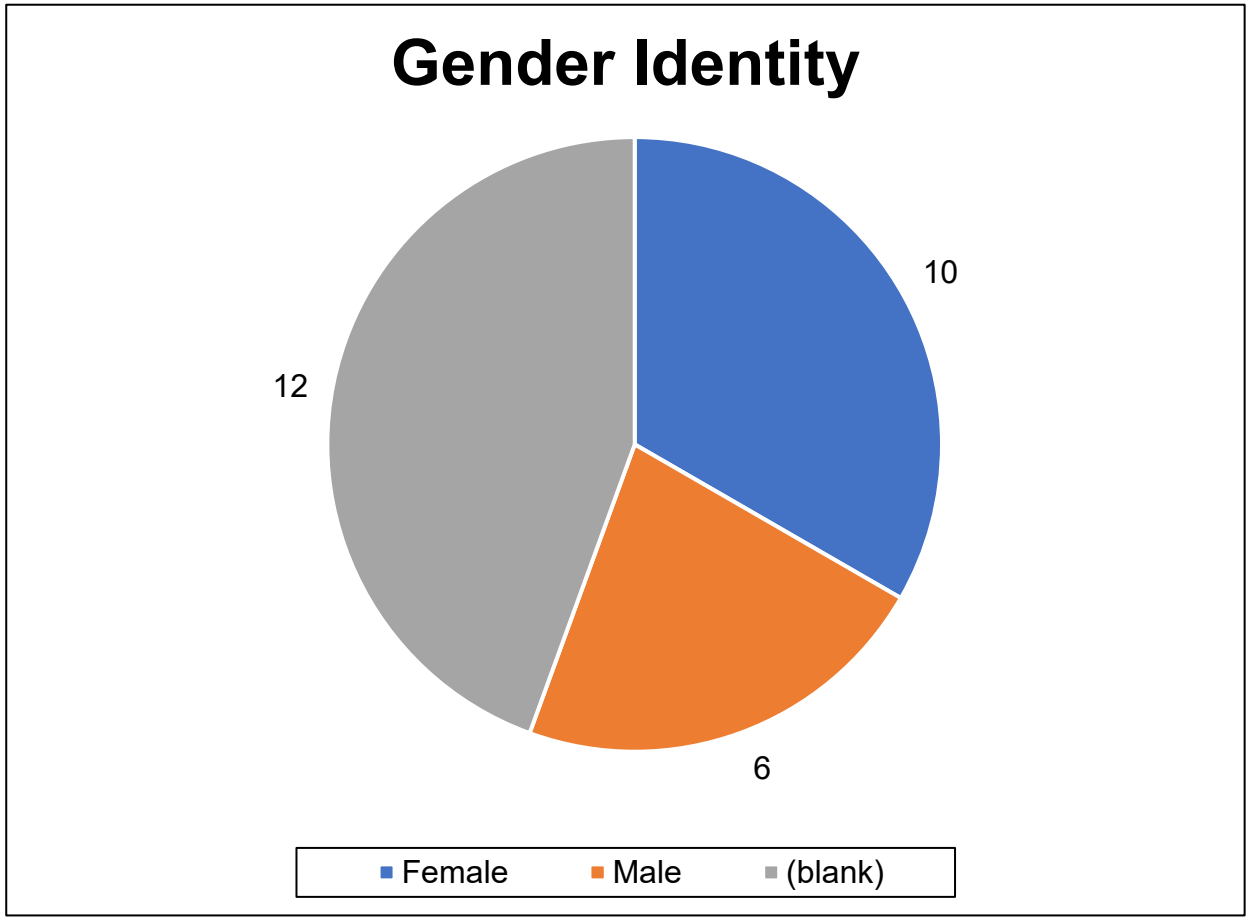
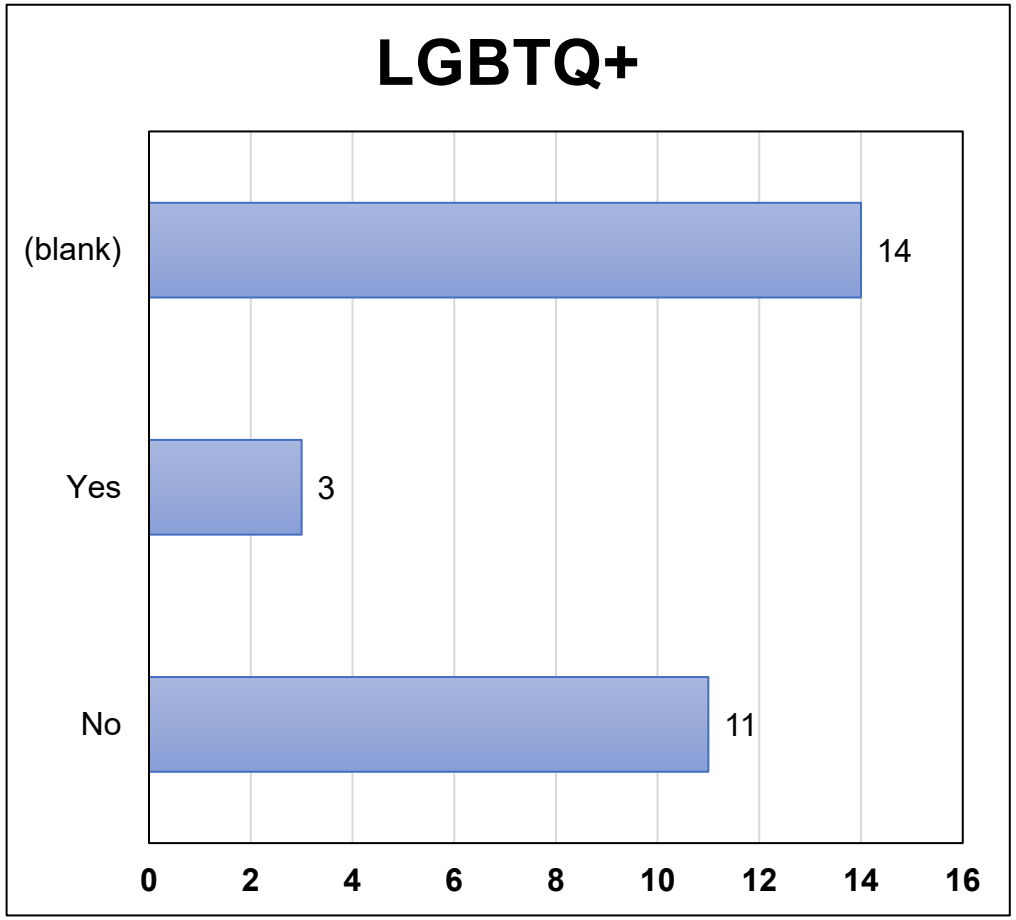
Demographics of Recommended Slate



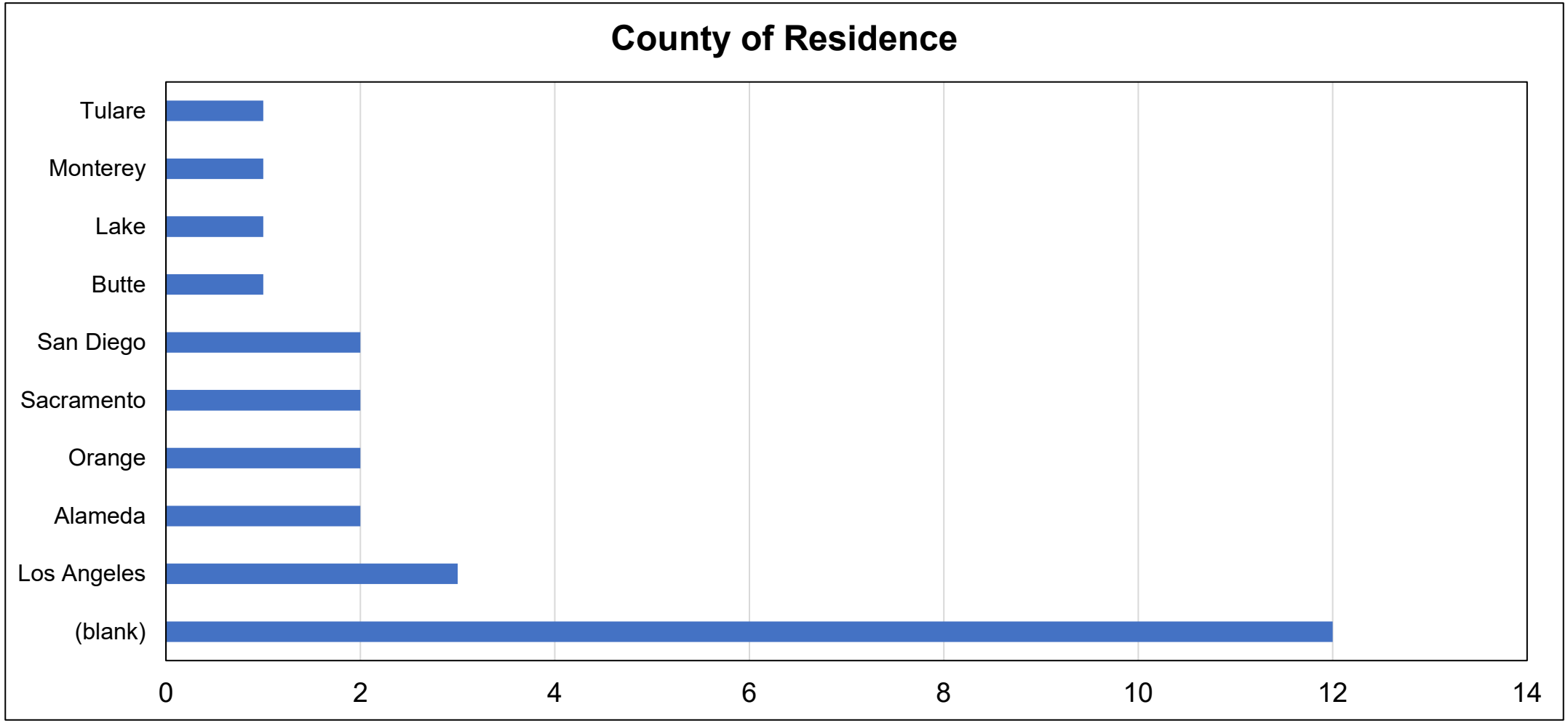


Demographics of Recommended Slate





Demographics of Recommended Slate



Draft Motion from the Subcommittee

- Approve the Recommended Advisory Committee Membership totaling 28 individuals (includes 1 vacancy).
- Appoint the new and reappointed members for a 2-year term.

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Public Comment

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Informational Item

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Update on Draft Alternative Payment Model Standards and Adoption Goals, Including Advisory Committee Feedback

Margareta Brandt, Assistant Deputy Director

Why Alternative Payment Models?

- Alternative Payment Models (APMs), or value-based payments, align payer-provider payment approaches to incent high-quality, cost-efficient care. Models span the continuum of clinical responsibility and financial risk moving from volume to value.
- Traditional fee-for-service payments do not provide flexibility to allow for innovation in how care is delivered, and fee-for-service payments incentivize providers to do more, not necessarily perform better.
- Some objectives of APMs include:

• Emphasis on patient outcomes	• Care coordination
• Equity, quality, and safety	• Patient-centered approach
• Cost efficiency	• Prevention and population health
• Improving value and affordability	• Data-driven decision making

The APM Workstreams

Develop Standards

Best practices for APMs and contracting guidance to promote equitable, high-quality, and cost-efficient care.

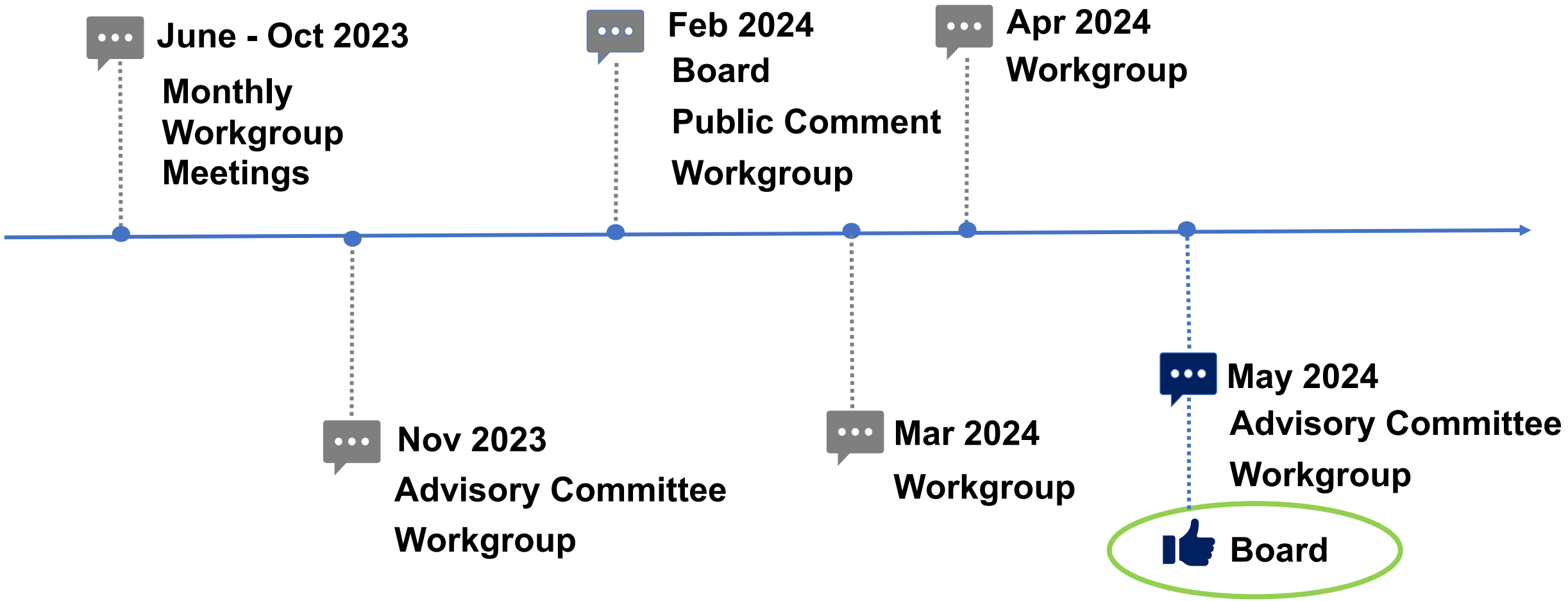
Define

A framework and descriptions to identify what "counts" for each APM category.

Set Goals for Adoption

Targets to promote adoption of meaningful APMs and to promote equitable, high-quality, and cost-efficient care.

Timeline for APM Workstreams



* Dates subject to change.

Provide Feedback Board Approval

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Investment and Payment Workgroup Members

Providers & Provider Organizations

Bill Barcellona, Esq., MHA
Executive Vice President of Government Affairs, America's Physician Groups

Lisa Folberg, MPP
Chief Executive Officer, California Academy of Family Physicians (CAFP)

Paula Jamison, MAA
Senior Vice President for Population Health, AltaMed

Cindy Keltner, MPA
Vice President of Health Access & Quality, California Primary Care Association (CPCA)

Amy Nguyen Howell MD, MBA, FAAFP
Chief of the Office for Provider Advancement (OPA), Optum

Janice Rocco
Chief of Staff, California Medical Association

Adam Solomon, MD, MMM, FACP
Chief Medical Officer, MemorialCare Medical Foundation

Academics/ SMEs

Sarah Arnquist, MPH
Principal Consultant, SJA Health Solutions

Crystal Eubanks, MS-MHSc
Vice President Care Transformation, California Quality Collaborative (CQC)

Kevin Grumbach, MD
Professor of Family and Community Medicine, UC San Francisco

Reshma Gupta, MD, MSHPM
Chief of Population Health and Accountable Care, UC Davis

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

State & Private Purchasers

Lisa Albers, MD
Assistant Chief, Clinical Policy & Programs Division, CalPERS

Palav Babaria, MD
Chief Quality and Medical Officer & Deputy Director of Quality and Population Health Management, California Department of Health Care Services (DHCS)

Monica Soni, MD
Chief Medical Officer, Covered California

Dan Southard
Chief Deputy Director, Department of Managed Health Care (DHMC)

Consumer Reps & Advocates

Beth Capell, PhD
Contract Lobbyist, Health Access California

Nina Graham
Transplant Recipient and Cancer Survivor, Patients for Primary Care

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

Hospitals & Health Systems

Ben Johnson, MPP
Vice President Policy, California Hospital Association (CHA)

Sara Martin, MD
Program Faculty, Adventist Health, Ukiah Valley Family Medicine Residency

Ash Amarnath, MD, MS-SHCD
Chief Health Officer, California Health Care Safety Net Institute

Health Plans

Joe Castiglione, MBA
Principal Program Manager, Industry Initiatives, Blue Shield of California

Rhonda Chabran, LCSW
Director of Behavioral Health Quality & Regulatory Services, Kaiser Foundation Health Plan/Hospital, Southern CA & HI

Keenan Freeman, MBA
Chief Financial Officer, Inland Empire Health Plan (IEHP)

Mohit Ghose
State Affairs, Anthem

Key Workgroup Discussion Topics

Alternative Payment Models

Definitions, Measurement, Reporting: Categorizing APMs, unit of reporting, health and social risk adjustment

Standards for APM Contracting: Common requirements/incentives for high quality equitable care, accelerate adoption of APMs

Statewide Goals for Adoption: Variation by market (Commercial, Medi-Cal), target timeline, unit of reporting (percent of payments, members, and/or provider contracts)

Primary Care

Definitions, Measurement, Reporting: Primary care providers, services, site of service, non-claims, integrated behavioral health

Investment Benchmark: Variation by market (Commercial, Medi-Cal) or population (adult vs. pediatric)

Behavioral Health

Definitions, Measurement, Reporting: Spending on social supports, capturing carved out behavioral health spending

Investment Benchmark: Variation by market (Commercial, Medi-Cal) or population (adult vs. pediatric)

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

Opportunities for 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.

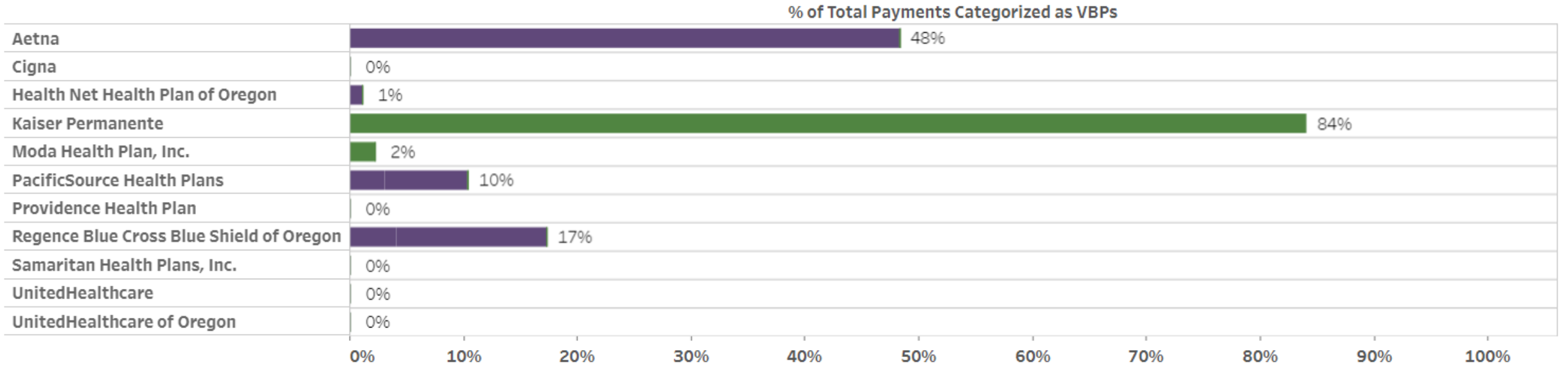
Opportunities for Accountability

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.

Payment Category 3A or Higher



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.

Alternative Payment Model Standards

Approach to APM Standards and Implementation Guidance

Standards

- Best practices to approach contracting decisions that are common across APMs
- Strategic, not tactical or prescriptive – not aiming to create an APM
- Grounded in evidence
- Not enforceable by OHCA, aspects of standards could be incorporated into Performance Improvement Plans

Implementation Guidance

- Technical assistance to supplement the standards
- Specific actions health care entities can take to meet the standard
- Examples of successful APM implementation related to the standard

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.

Dept. of Health Care Access and Information (2024). *OHCA Recommendation to Board – Proposed APM Standards and Goal.* OHCA Office Updates. https://hcai.ca.gov/wp-content/uploads/2024/02/OHCA-Recommendations-to-Board_Proposed-APM-Standards-and-Goal.pdf. See Appendix for APM Standards and Implementation Guidance.

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 APM Standards and Implementation Guidance

Feedback Theme	OHCA's Response
• Overarching support of OHCA's proposed APM Standards and Implementation Guidance. • Recommended emphasizing that physicians should be part of the design, implementation, and evaluation of APMs. • Recommended 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. • Encouraged OHCA to include a new standard that provides access to clinical data registries and support teams to treat patients with chronic conditions.	• OHCA proposes no changes to the draft standards. The following were incorporated into implementation guidance: ○ Included guidance to obtain input from providers on the design, implementation, and evaluation of APMs. ○ Included examples of primary care team members that support addressing social, medical, and behavioral 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.

Advisory Committee & Workgroup Feedback on APM Standards & Implementation Guidance

Feedback Theme	OHCA's Response
• Two Advisory Committee members suggested adding a standard that requires APMs to be actuarially sound. • Several Advisory Committee members noted the importance of emphasizing the value of the PCP-consumer relationship and continuity of care in the standards. • One Advisory Committee member suggested collecting information on use 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).

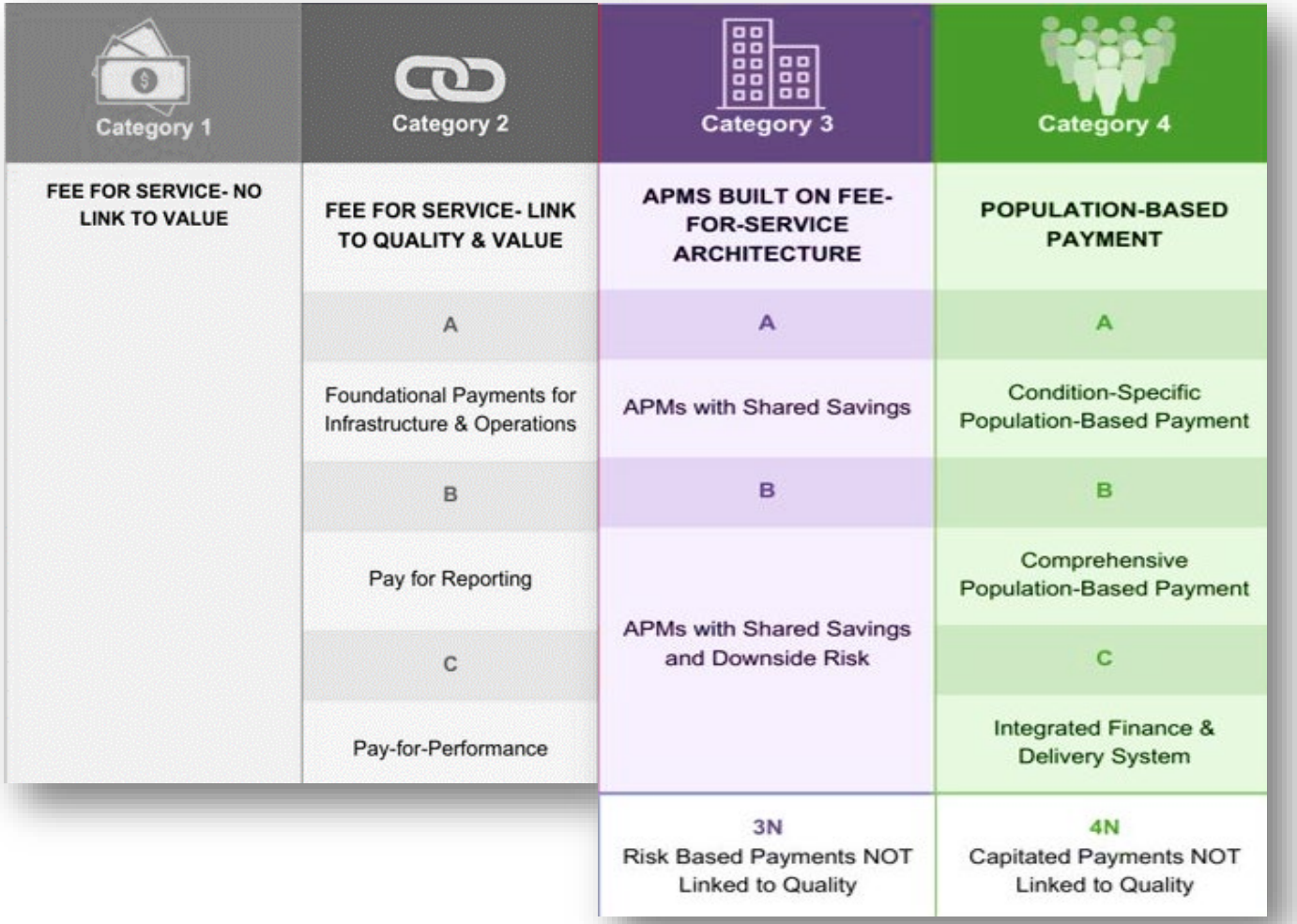
Advisory Committee & Workgroup Feedback on APM Standards & Implementation Guidance

Feedback Theme	OHCA's Response
• Several Advisory Committee members supported the inclusion of technical assistance for small practices to adopt APMs and suggested payers provide funding. • An Investment and Payment Workgroup member noted the need to increase provider readiness. • One Advisory Committee member suggested presentations by California Quality Collaborative and others leading efforts to expand APM adoption among PPO plans. • One Advisory Committee 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 payer and provider types in several areas.

Alternative Payment Model Adoption Goals

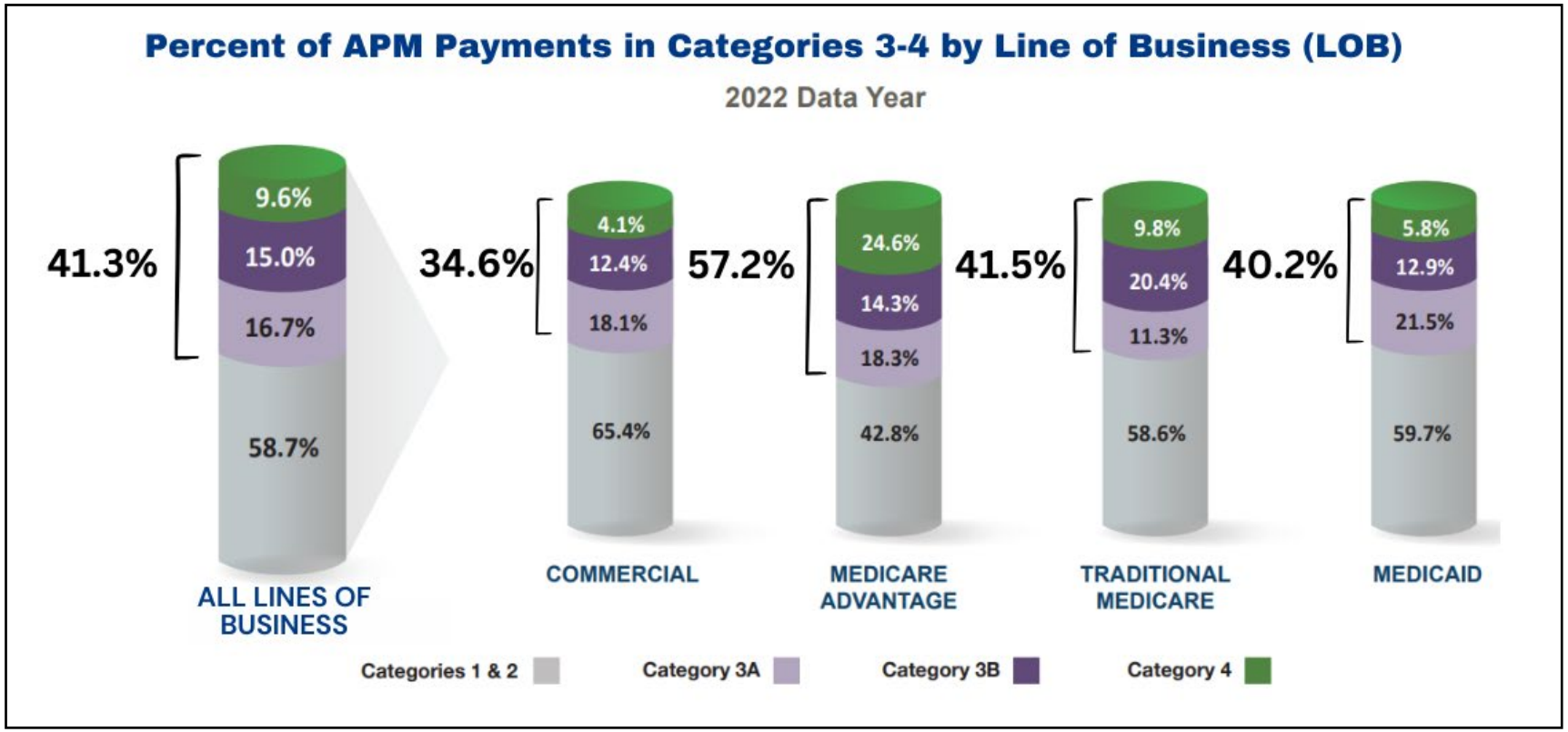
Health Care Payment Learning and Action Network Framework

- States, payers, and other stakeholders frequently use the HCP-LAN framework to measure APM adoption.
- OHCA plans to collect data using the Expanded Framework for Non-Claims Payments (see Appendix) and crosswalk to HCP-LAN.
- Most APM adoption goals focus on Categories 3 and 4. Adoption is typically measured by the spend "flowing through" a contract with an APM, members attributed to APMs, or providers contracted under APMs.



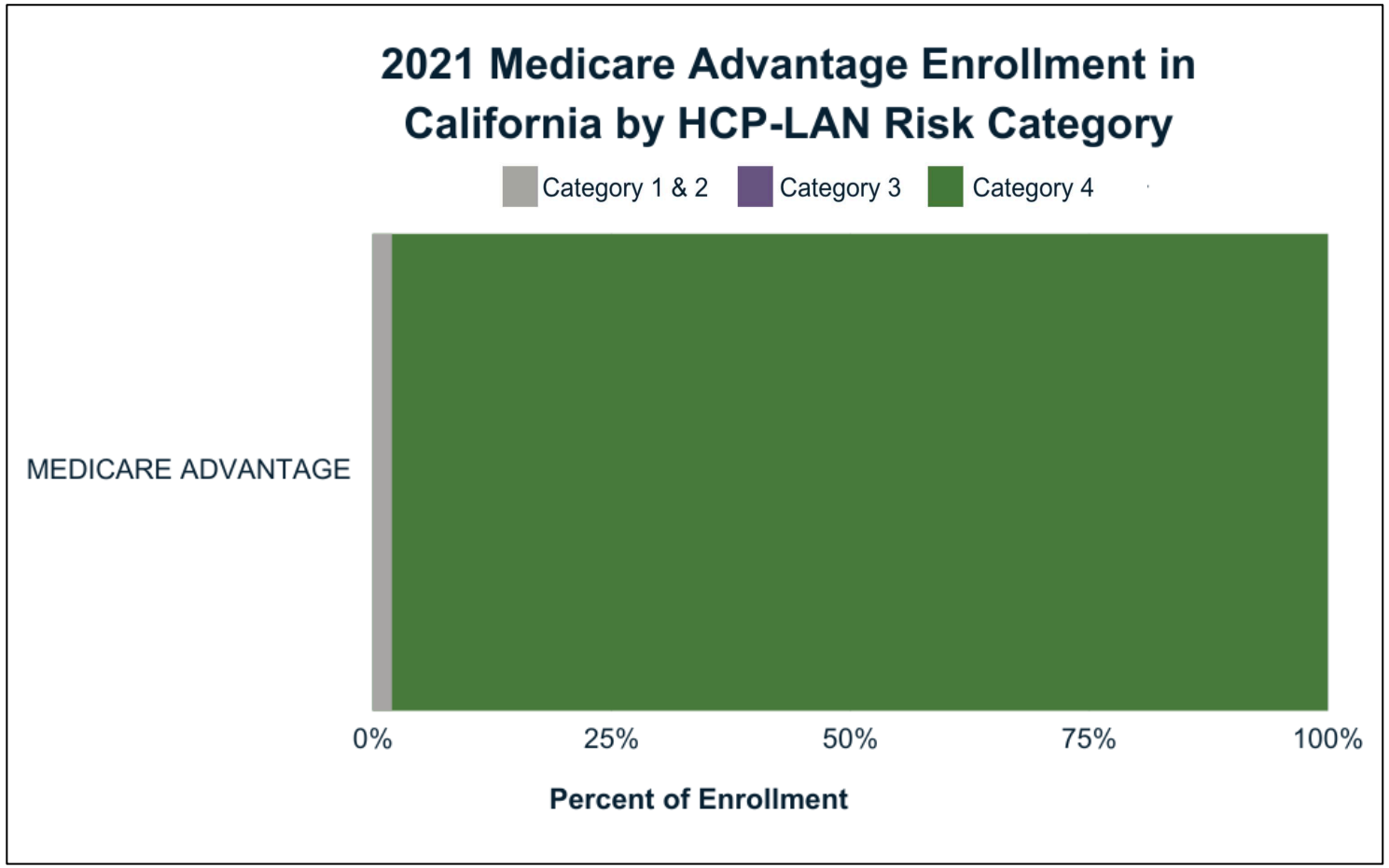
APM Adoption Nationally

- APM adoption nationally currently sits at 41% across HCP-LAN Categories 3 and 4.
- Adoption was virtually flat across payer types from 2021 to 2022.



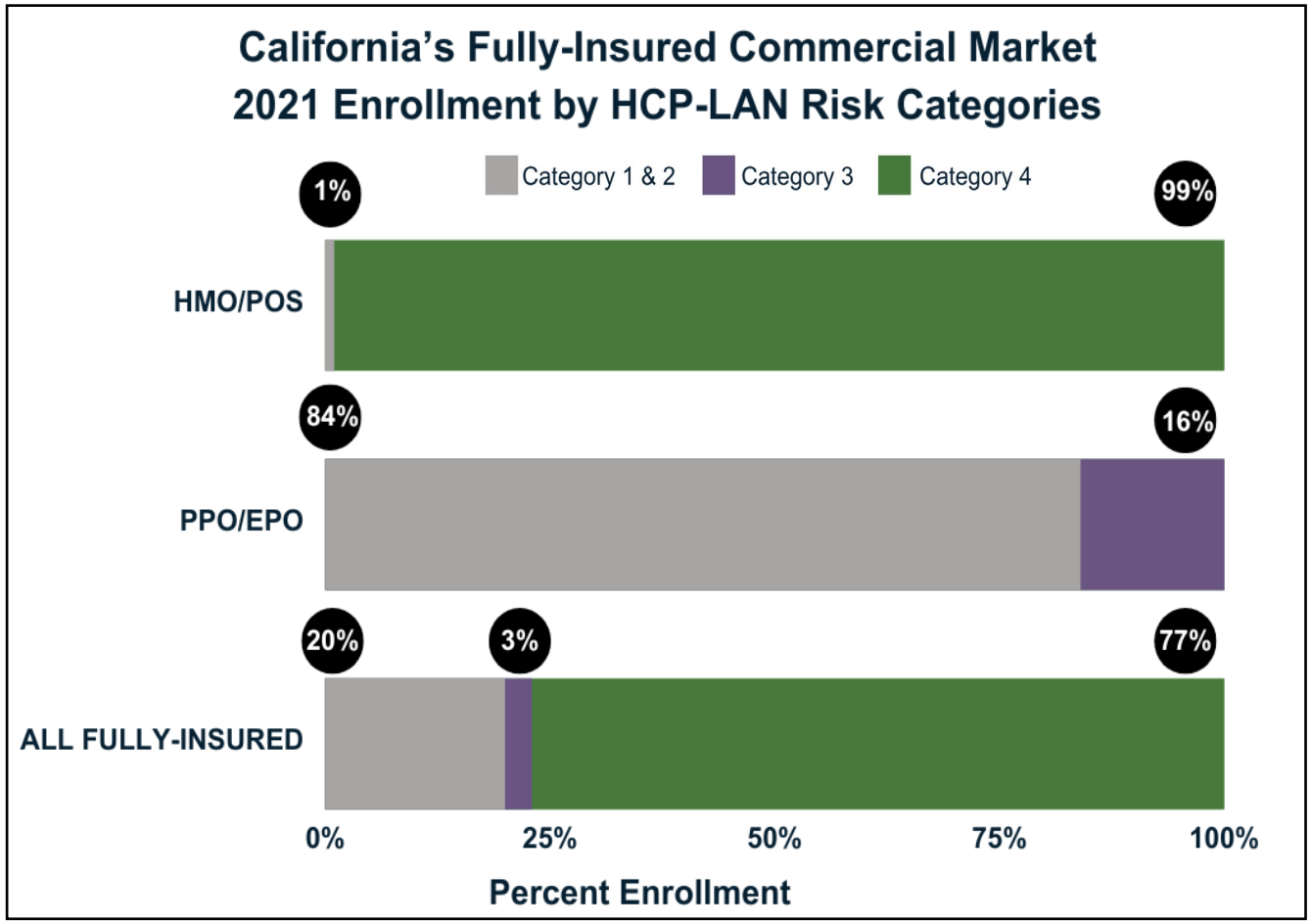
Medicare Advantage APM Adoption in CA

- In 2021, just under half of California Medicare beneficiaries participated in Traditional Medicare. The rest were enrolled in a Medicare Advantage plan.
- Of those California Medicare Advantage beneficiaries, almost all were enrolled in a risk arrangement in 2021.
- Based on informal conversations, OHCA anticipates most, but not all, of these arrangements would be considered “linked to quality.”



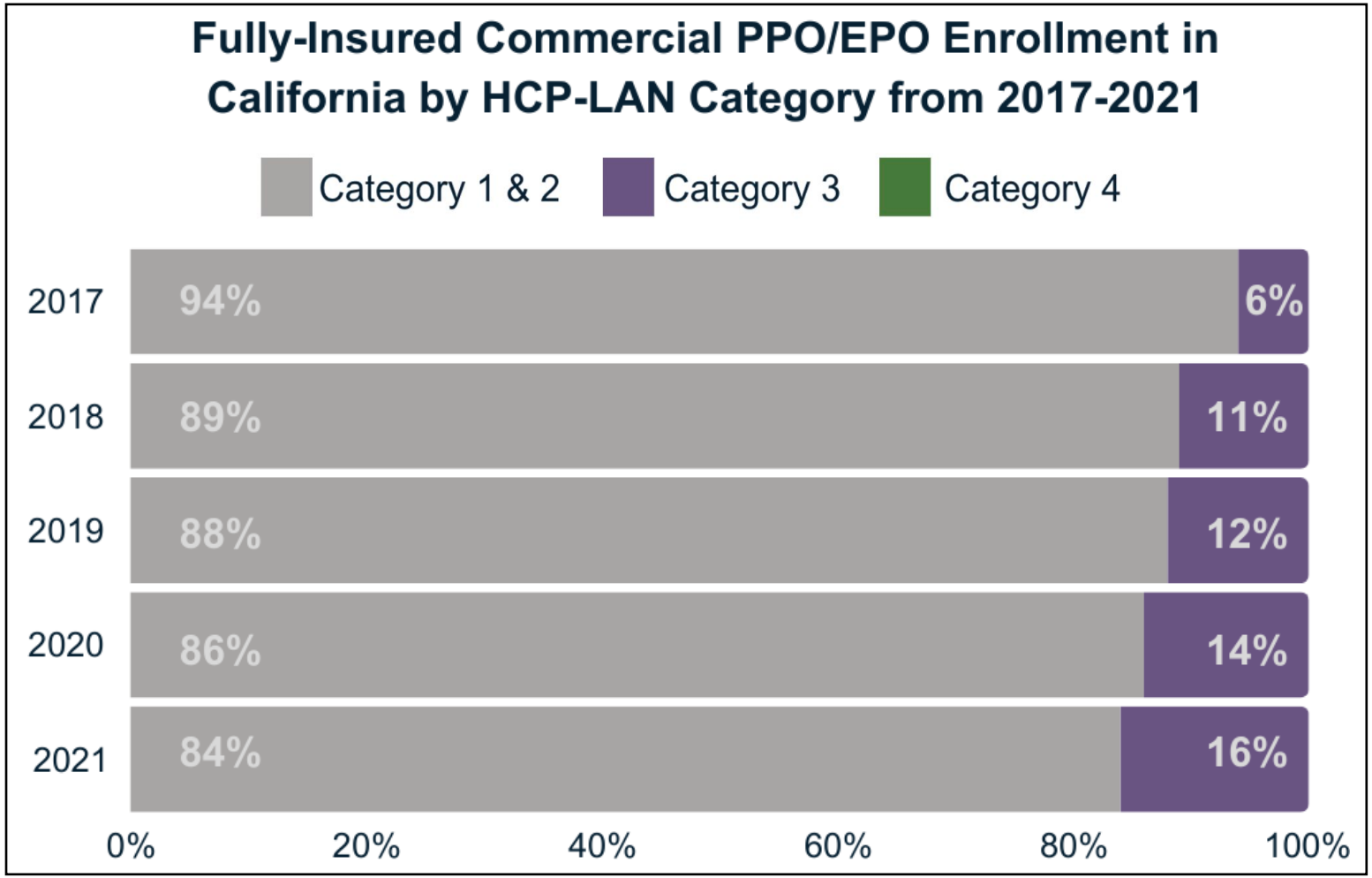
Commercial APM Adoption in CA

- APM adoption among the fully-insured population in California is more than 75 percent, far higher than commercial plans nationally. Adoption has been stable over the past five years.
- The data are from IHA's Health Care Cost & Quality Atlas | IHA. These percentages are based on membership, but the percentages are similar whether using percent of members or percent of total dollars.
- OHCA anticipates most, but not all, of these APMs that would be considered "linked to quality" (ex: Medicare Advantage).



California Commercial PPO APM Adoption

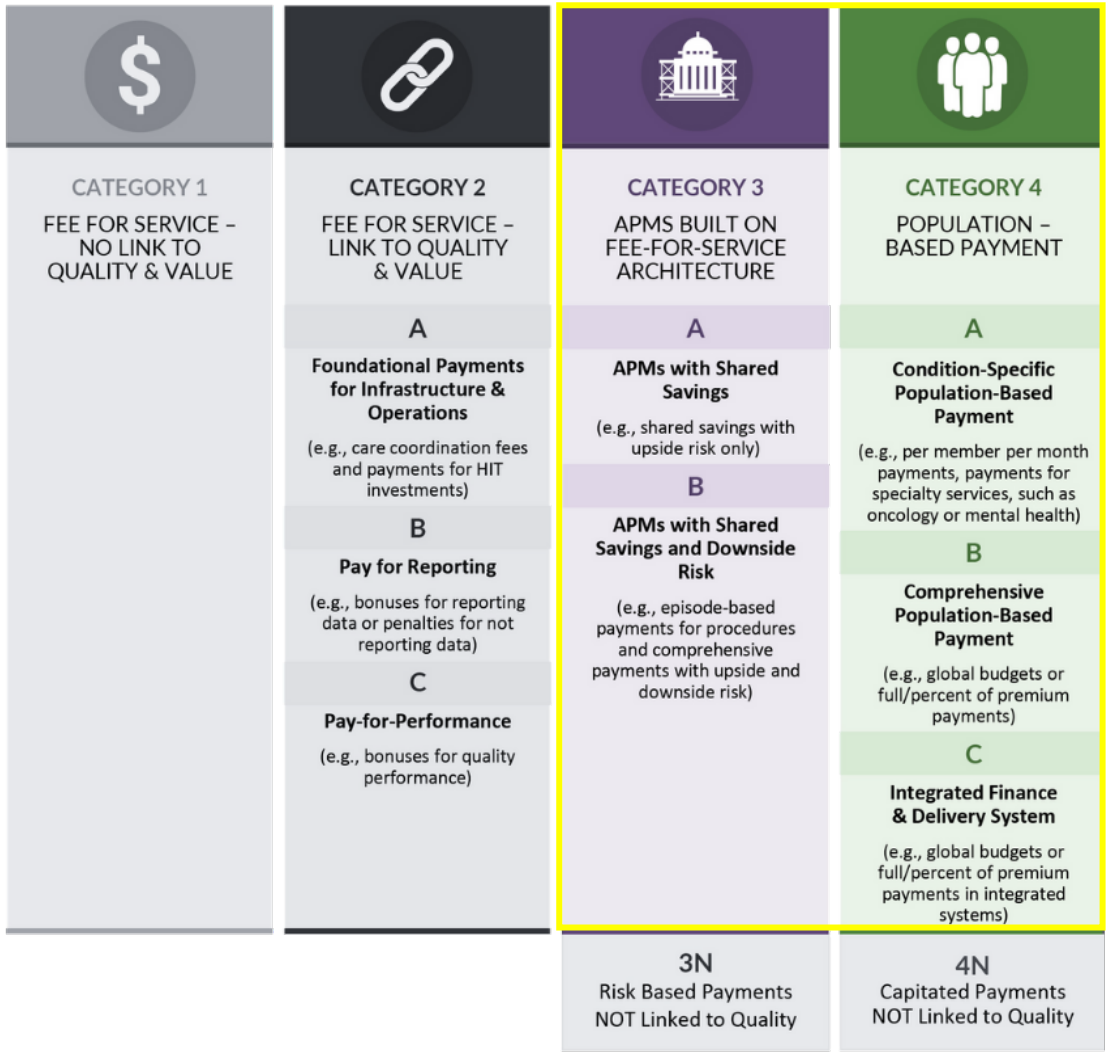
- APM adoption has been largely stable among California's commercial, fully-insured PPO (shown at right) and HMO markets (not shown) over the past five years.
- Category 3 enrollment for Commercial PPOs has increased from 6% to 16% from 2017 to 2021, but only increased 2 percentage points between 2020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



Monitoring Progress Toward APM Adoption Goal

- The recommended APM Adoption Goal is based on the percent of members attributed to HCP-LAN Categories 3A, 3B, 4A, 4B, and 4C arrangements.

- Only members enrolled in the highlighted payment arrangements count toward the goal.



Monitoring Progress Toward APM Adoption Goal

To count towards adoption goals, OHCA recommends APMs must include:

Meaningful Risk Sharing: OHCA recommends that Category 3A and 3B APMs should be required to meet a minimum threshold for shared savings or shared risk. This requirement ensures that APM arrangements built on a fee-for-service architecture have tangible financial incentives or penalties contingent upon the provider's attainment of predefined spending and quality benchmarks.

A Link to Quality: OHCA recommends defining payments as "linked to quality" if they involve potential for financial bonuses or penalties based on the provider's performance against predetermined quality benchmarks. This would exclude HCP-LAN Categories 3N and 4N (risk-based payments and capitation payments that are not linked to quality). This definition ensures that APM arrangements have a substantive connection between payments and quality outcomes.

Definitions and minimum thresholds included in Expanded Framework for Non-Claims Payments (see Category 3 and 4 definitions in Appendix).

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.

Dept. of Health Care Access and Information (2024). *OHCA Recommendation to Board – Proposed APM Standards and Goal.* OHCA Office Updates. https://hcai.ca.gov/wp-content/uploads/2024/02/OHCA-Recommendations-to-Board_Proposed-APM-Standards-and-Goal.pdf. See Appendix for APM Standards and Implementation Guidance.

Public Comment on February Board Meeting APM Adoption Goals

Feedback Theme	OHCA's Response
• Support for goal tied to advanced APMs in HCP-LAN Category 3 and 4. • 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. • Recommendation 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. • Recommendation that the definition of denominator be clear in the THCE Data Submission Guide.	• OHCA sought information from payers, sibling departments, and the Investment and Payment Workgroup on APM adoption for Commercial PPOs and adjusted the goal. • OHCA adjusted goals to reflect recent data on current APM adoption by payer type and seeks to align timeframes with primary care investment benchmarks. • OHCA will provide guidance in data collection and reporting on the denominator used to measure progress towards APM adoption goals.

Dept. of Health Care Access and Information (2024). *OHCA Recommendation to Board – Proposed APM Standards and Goal.* OHCA Office Updates. https://hcai.ca.gov/wp-content/uploads/2024/02/OHCA-Recommendations-to-Board_Proposed-APM-Standards-and-Goal.pdf. See Appendix for APM Standards and Implementation Guidance.

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.

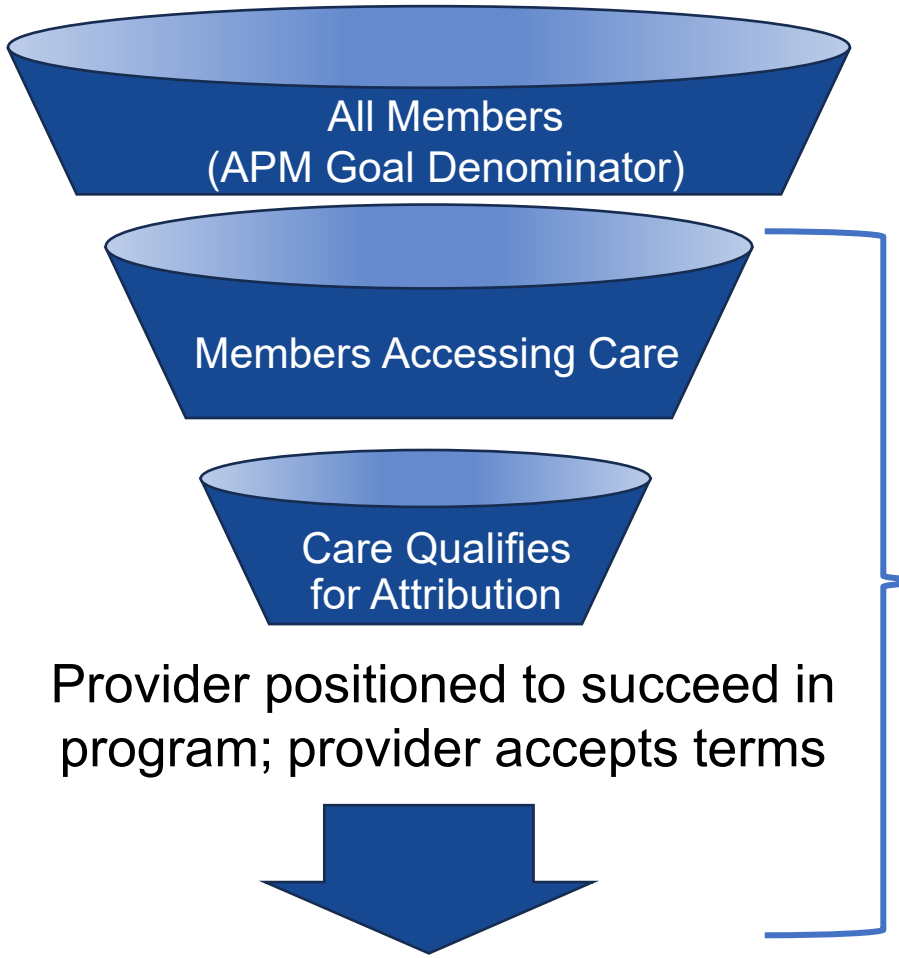
Iterations of Goals:

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.

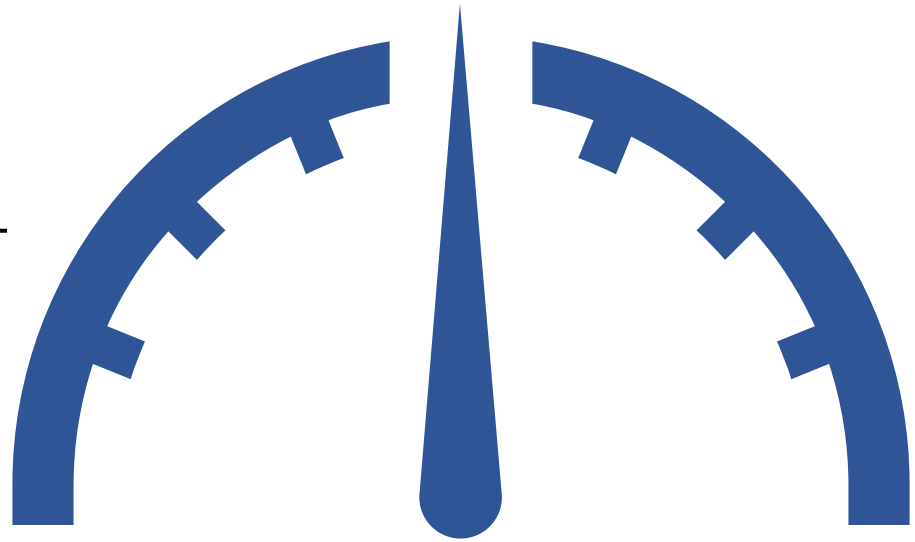
Aligns with population health goals including engaging those who may be less likely to receive care.



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.

APM Adoption Goals

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 goals culminating a 10-year goal.
- Reinforces public reporting on two-year 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.

Advisory Committee and Workgroup Feedback on APM Adoption Goals

Feedback Theme	OHCA's Response
• Most Advisory Committee members and Investment and Payment Workgroup members raised no objections. Several expressed support for the revised goals. • Several Advisory Committee members and one Investment and Payment Workgroup member recognized the challenges of increasing APM adoption in PPOs and how this influences the proposed goals. • One Advisory Committee member was concerned the Medi-Cal adoption goals may be too ambitious.	• OHCA appreciates that APM adoption varies by payer type and reflects this in the revised goals. • OHCA may consider revisions to APM adoption goals after the first two years of data collection, when a baseline has been established. With this baseline data, we can adjust, if warranted.

Advisory Committee and Workgroup Feedback on APM Adoption Goals

Feedback Theme	OHCA's Response
• Several Advisory Committee members suggested collecting data from provider organizations to understand APM adoption at the provider organization level and how provider organizations pay downstream providers.	• 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.

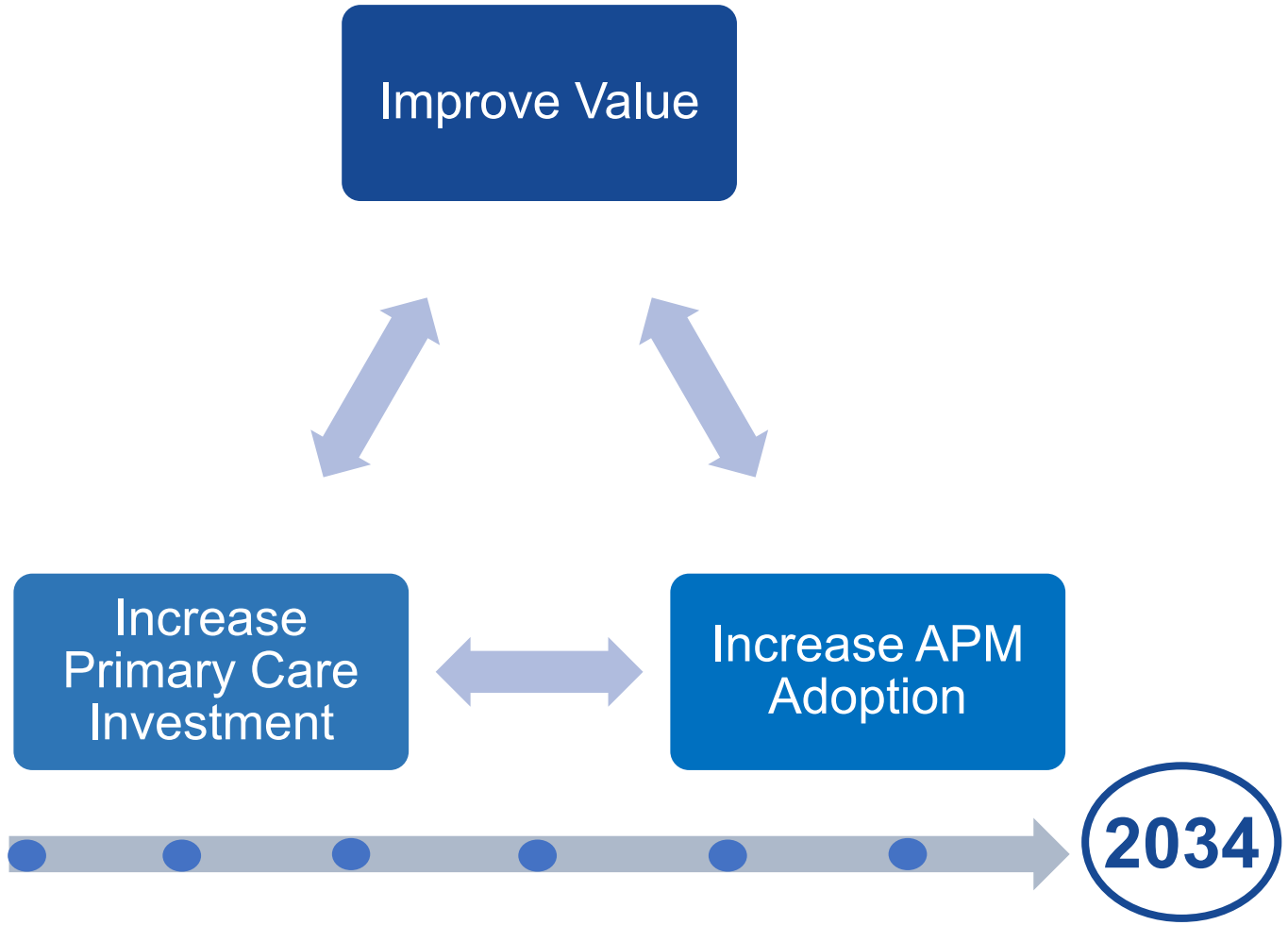
Examples of Questions OHCA Could Explore through Reporting

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



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Board Discussion

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Action Item: Establish Alternative Payment Model Standards and Adoption Goals

Margareta Brandt, Assistant Deputy Director

Alternative Payment Models

Statutory Requirements

- Promote the shift of payments based on fee-for-service (FFS) to alternative payment models (APMs) that provide financial incentives for equitable high-quality and cost-efficient care.
- Convene health care entities and organize an APM workgroup, **set statewide goals** for the adoption of APMs, **measure the state's progress** toward those goals, and **adopt contracting standards** healthcare entities can use.
- Set benchmarks that include, but are not limited to, increasing the percentage of total health care expenditures delivered through APMs or the percentage of membership covered by an APM.

Options For Board Consideration

- The Board may vote to approve the Office's recommendation or propose another goal and/or standards for discussion and ultimate adoption.
- The Board is required to approve Alternative Payment Model Standards and Adoption Goals by July 1st at a public meeting of the Board.
- If the Board does not approve Alternative Payment Model Standards and Adoption Goals, establishing the Alternative Payment Model Standards and Adoption Goals will be listed as an action item for the Board to act on at the Health Care Affordability Board Meeting in June.

Draft Motion: APM Standards and Adoption Goals

- Approve the following APM Standards for Payer-Provider Contracting and APM Adoption Goals:

Draft Motion: APM Standards for Payer-Provider Contracting

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

Draft Motion: APM Standards for Payer-Provider Contracting

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

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

Draft Motion: APM Adoption Goals

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
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2028	75%	35%	60%	65%
2030	85%	45%	65%	75%
2032	90%	55%	70%	85%
2034	95%	60%	75%	95%

- Establish two-year goals, that differ by payer and product type, culminating in a ten-year goal for the percent of members attributed to Health Care Payment Learning and Action Network (HCP-LAN) Categories 3 and 4 by 2034: 95% for Commercial HMO and Medicare Advantage, 75% for Medi-Cal, and 60% for Commercial PPO.

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

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Public Comment

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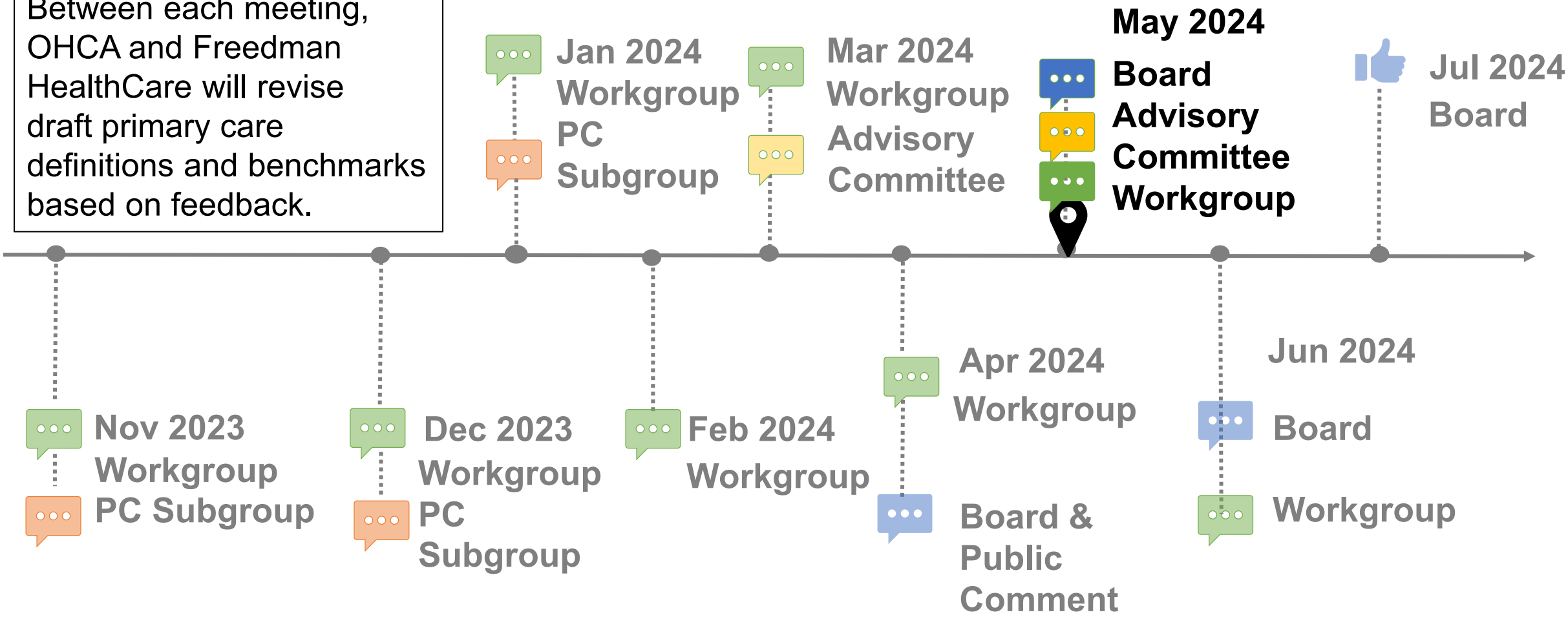
Draft Primary Care Spending Definition and Benchmark, Including Summary of Advisory Committee Feedback

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.

Primary Care Investment

Statutory Requirements

- The Board approves the benchmark for primary care spending.

Why Primary Care?

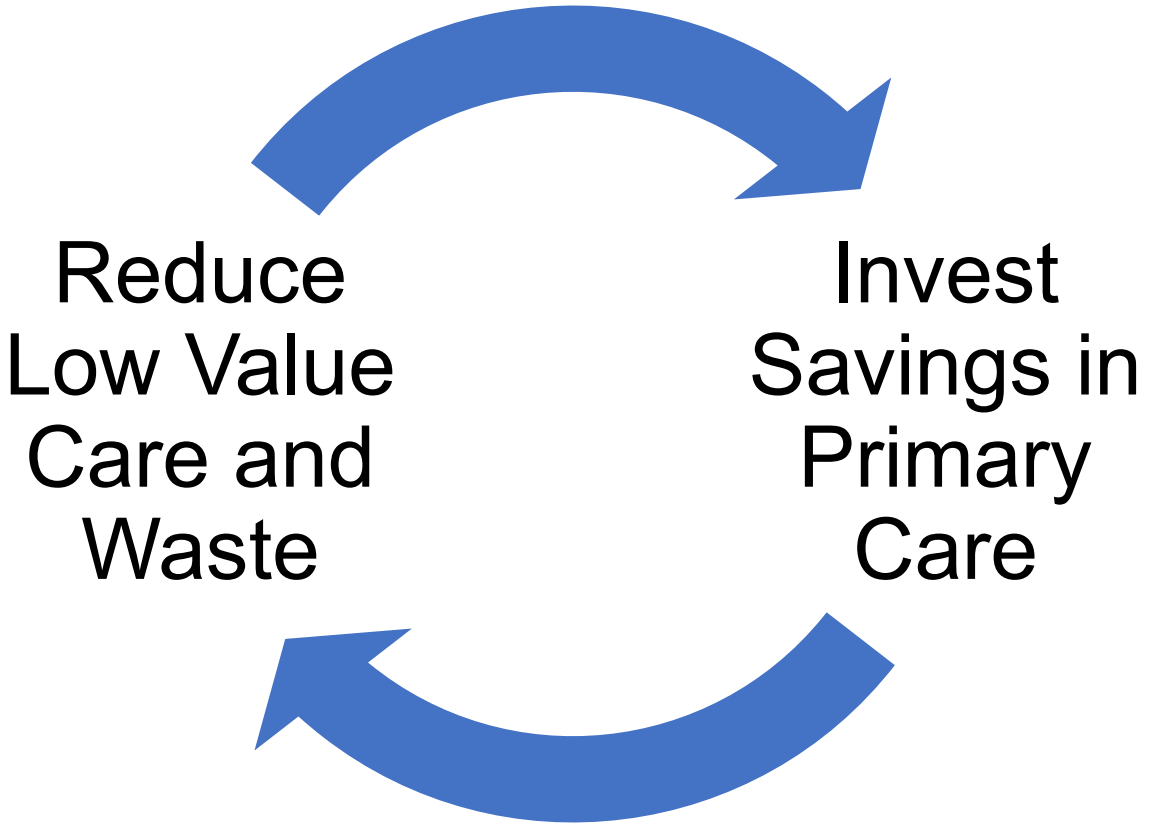
Increased supply of primary care services leads to more equitable outcomes and improved population health (e.g., life expectancy, rates of chronic disease, and other critical measures).

- High functioning health care systems require high quality primary care as a foundation.
- Primary care investment in the United States – which typically ranges from 4% to 7% – lags other high-income nations with higher performing health care systems. In these countries, primary care investment tends to be 12% to 15% of total spending.
- Primary care investment in California was 6.3% of total spending across all payers in 2020, compared to 4.6% nationally, a recent national study found.

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; Jabbarpour Y, et al. (2022, February 22). Milbank Memorial Fund. *The*

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**."



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.

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

Draft Primary Care Spending Measurement Definition and Methodology

Framing the Measurement

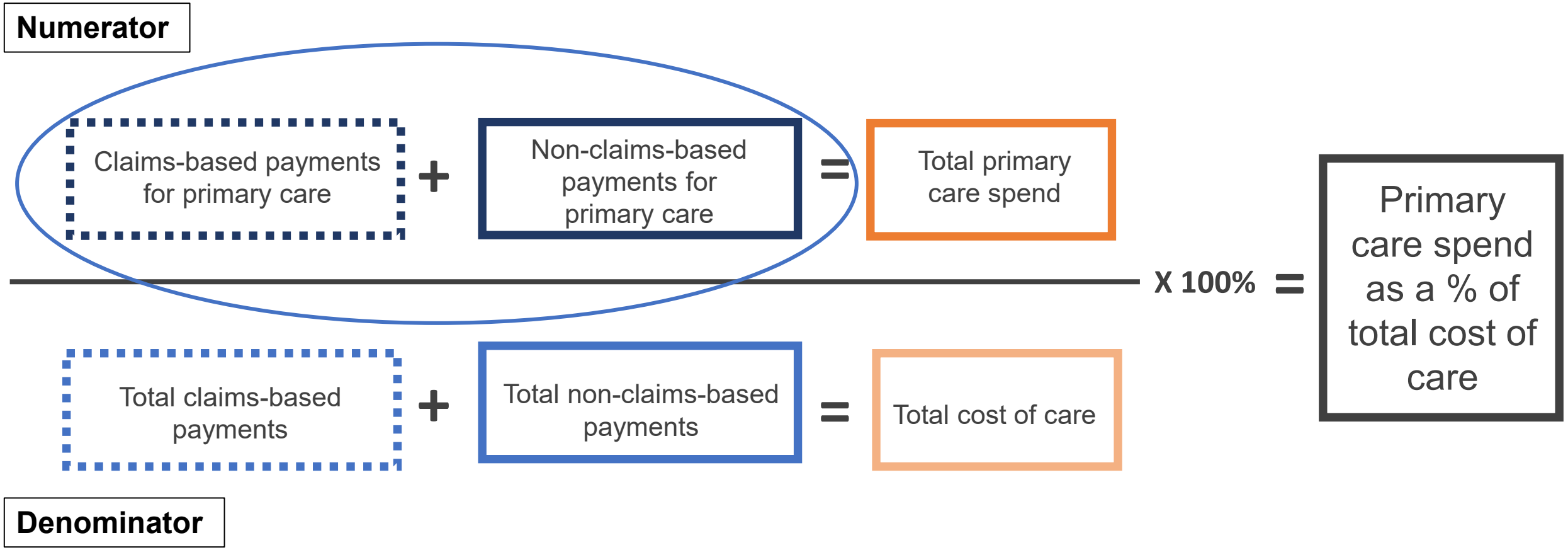
What will be measured

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

What won't be measured

Money providers spent delivering primary care services.

Measuring Primary Care Spending



Adapted from Erin Taylor, Michael Bailit, and Deepti Kanneganti. Measuring Non-Claims-Based Primary Care Spending. Milbank Memorial Fund. April 15, 2021

Data Source for Measuring Primary Care Spending

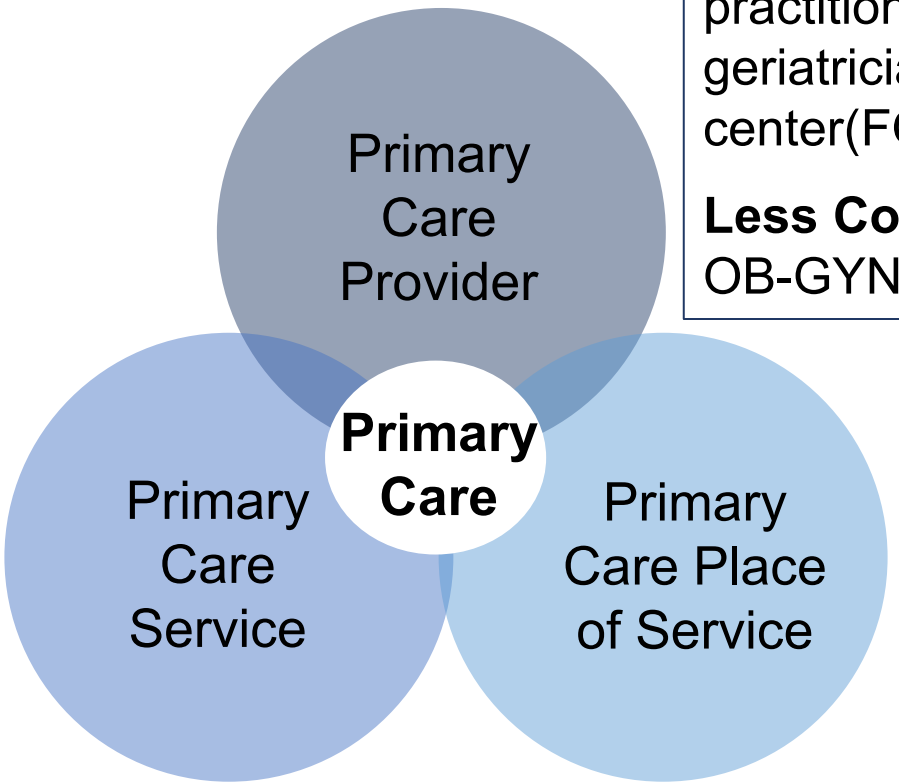
- OHCA will collect data to measure primary care spending as part of its larger Total Health Care Expenditures (THCE) data collection efforts **from payers**.
- Primary care spending data will include claims and non-claims payments, which will be categorized using the Expanded Framework.*
- OHCA will provide definitions, technical specifications, and technical assistance to submitters to support accurately allocating payments to primary care, including for non-claims payment categories.

*Available in the appendix and reviewed at the February Board meeting: https://hcai.ca.gov/wp-content/uploads/2024/02/February-2024-Board-Meeting-Presentation.pdf

Defining Primary Care

Most Common Provider Types: Family medicine, general practice, internal medicine, pediatrics, nurse practitioner(NP)/physician's assistant(PA), geriatrician, federally-qualified health center(FQHC) /rural health center (RHC).

Less Common Provider Types: Nurse, OB-GYN, behavioral health.



Most Common Service Codes: Office visits, preventive visits, vaccine admin, screenings, care coordination and management.

Less Common Service Codes: Procedures, behavioral health, maternity.

Most Common Places of Service (POS): Office, telehealth (home or other), walk-in retail clinic, FQHC/RHC, home.

Less Common POS: Worksite, urgent care, school.

Three Modules for Measuring Primary Care Spending

Benchmark calculation will include all three modules.

Primary Care Paid Via Claims	Primary Care Paid Via Non-Claims	Behavioral Health in Primary Care
• Combination of primary care provider, service, and place of service.	• Allocate a portion of non-claims spend to primary care.	• Screening, office visits for BH diagnosis with PCPs. • Counseling, therapy when by a PCP or via integrated behavioral health.

Could be added to BH or PC spend calculation.

Primary care measurement could be supplemented with additional analysis through the Health Care Payments Data program (HPD).

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 Payments Approach

OHCA has:

- In partnership across HCAI, developed the Expanded Non-Claims Payment Framework to collect information non-claims payments data.
- Developed approaches to each non-claims category to understand the portion of payments intended for primary care.
- Collaborated with submitters on methodology to apportion shared savings and capitation payments allocated to primary care.
- Reviewed approaches to apportioning non-claims payments to primary care with the Investment and Payment Workgroup and its Primary Care Subgroup, Advisory Committee, and sibling departments.

Methods provide directional estimates of non-claims payments supporting primary care.

Pegany, V., Brandt, M., Tran, N., et al. (2024, March 18). *A New Standard for Categorizing and Collecting Non-Claims Payment Data*. Milbank Memorial Fund. https://www.milbank.org/2024/03/a-new-standard-for-categorizing-and-collecting-non-claims-payment-data/

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.

Primary Care Spending Measurement Definition and Methodology

Does the Board have any feedback on:

1. Proposed claims-based definition of primary care?
2. Proposed approach to allocating non-claims payments to primary care?

Draft 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

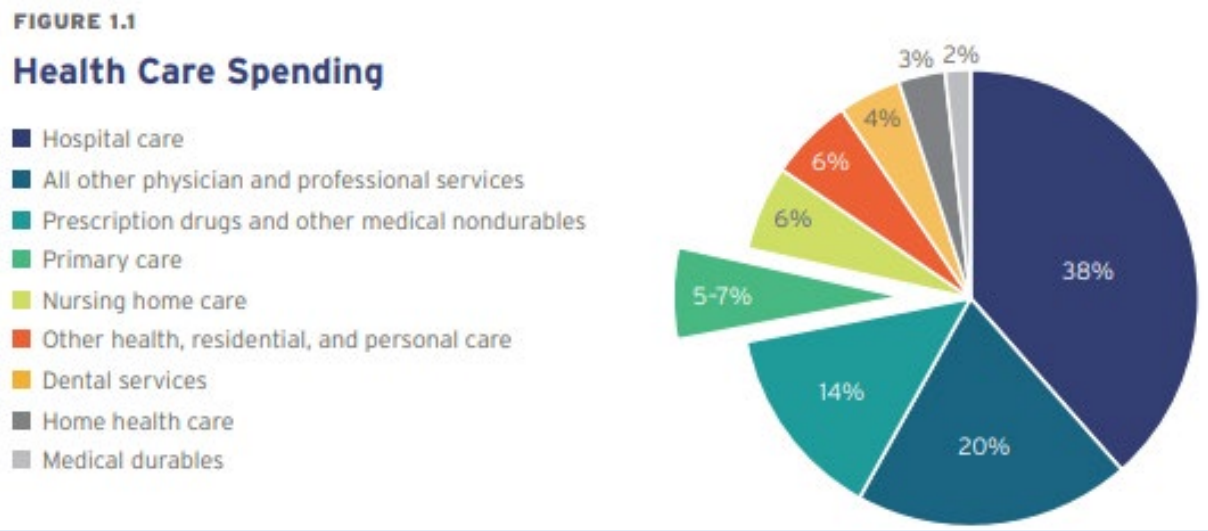
1. **The most successful efforts gradually reallocate spending to primary care.** Efforts to increase investment too quickly may accelerate growth in total cost of care.

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.

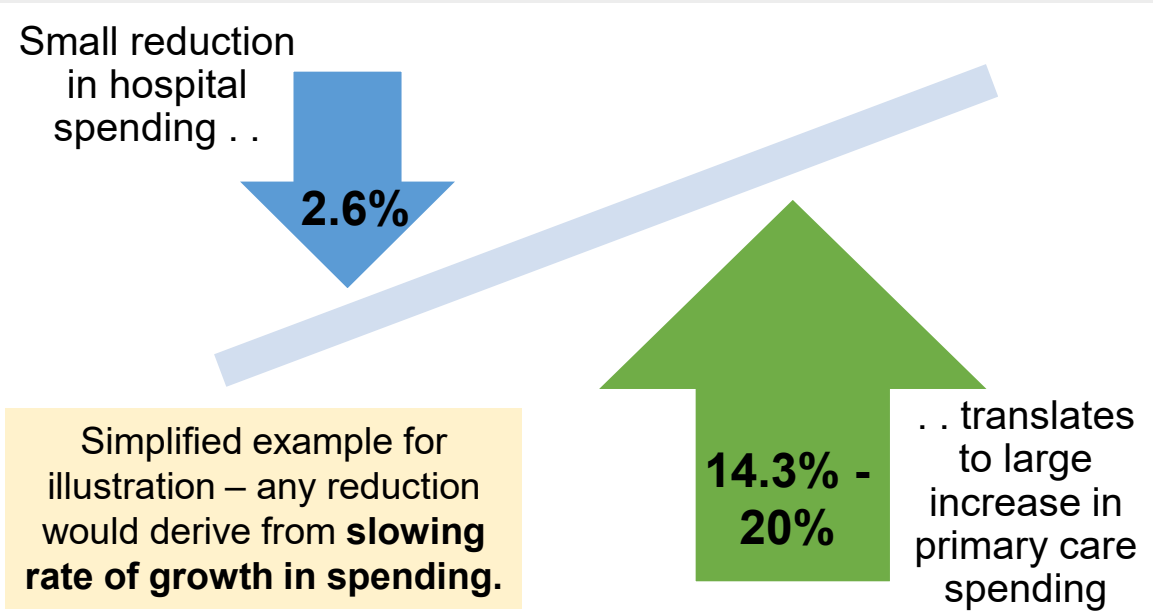
3. **Increases in total cost of care hinder benchmark success.** As total cost of care increases, achieving primary care benchmarks based on percent total medical expense becomes more difficult.

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)?**



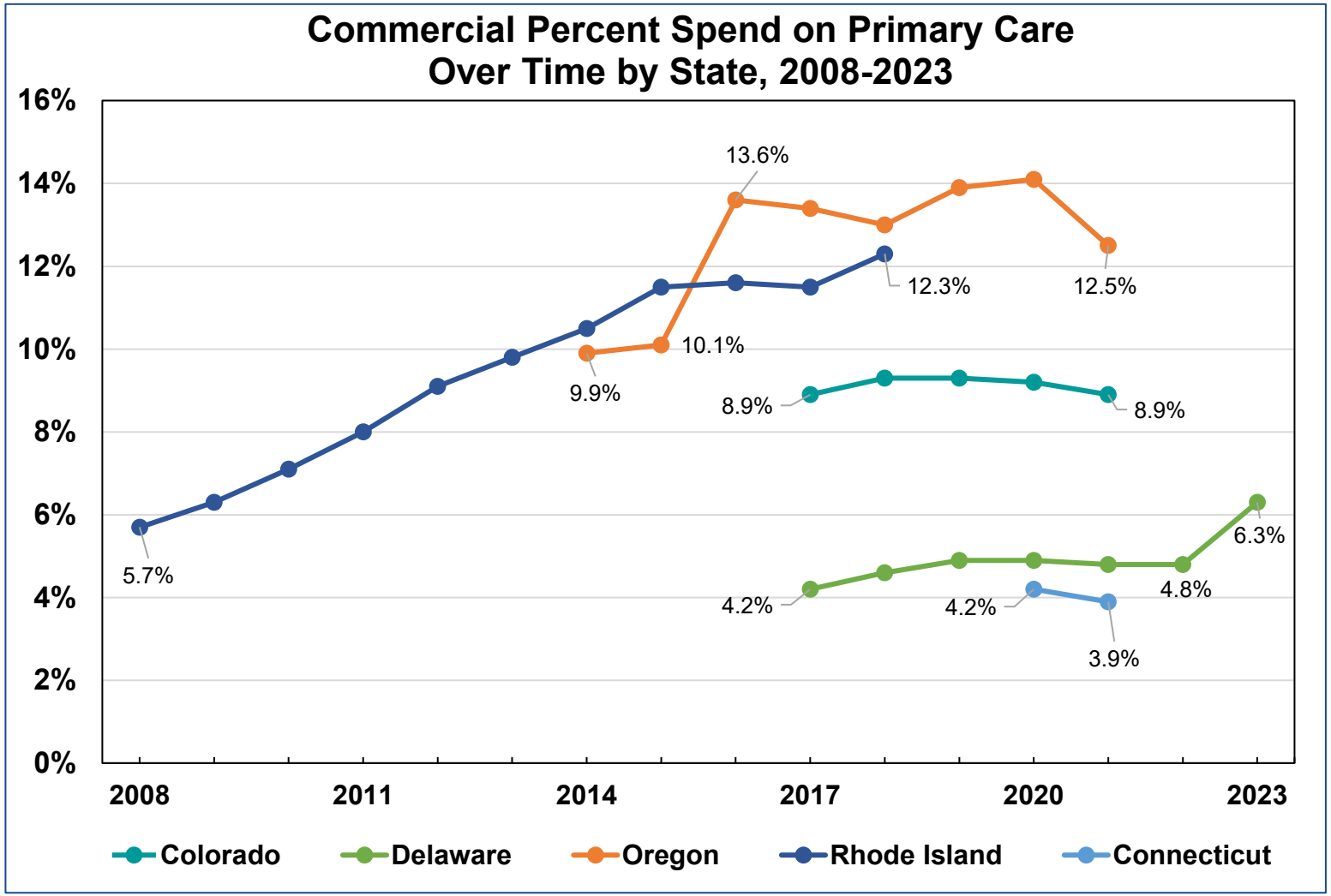
Reallocating one percentage point of spend from hospital care (from 38%→37% TME) to primary care (5-7%→6-8% TME) would **generate substantial primary care investment.**



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.

Draft Primary Care Investment Benchmark Recommendation

Annual 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 gradual reallocation of spending.
- Focus on shifting spend from specialty care and toward primary care.

AND

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

Rationale for Level:

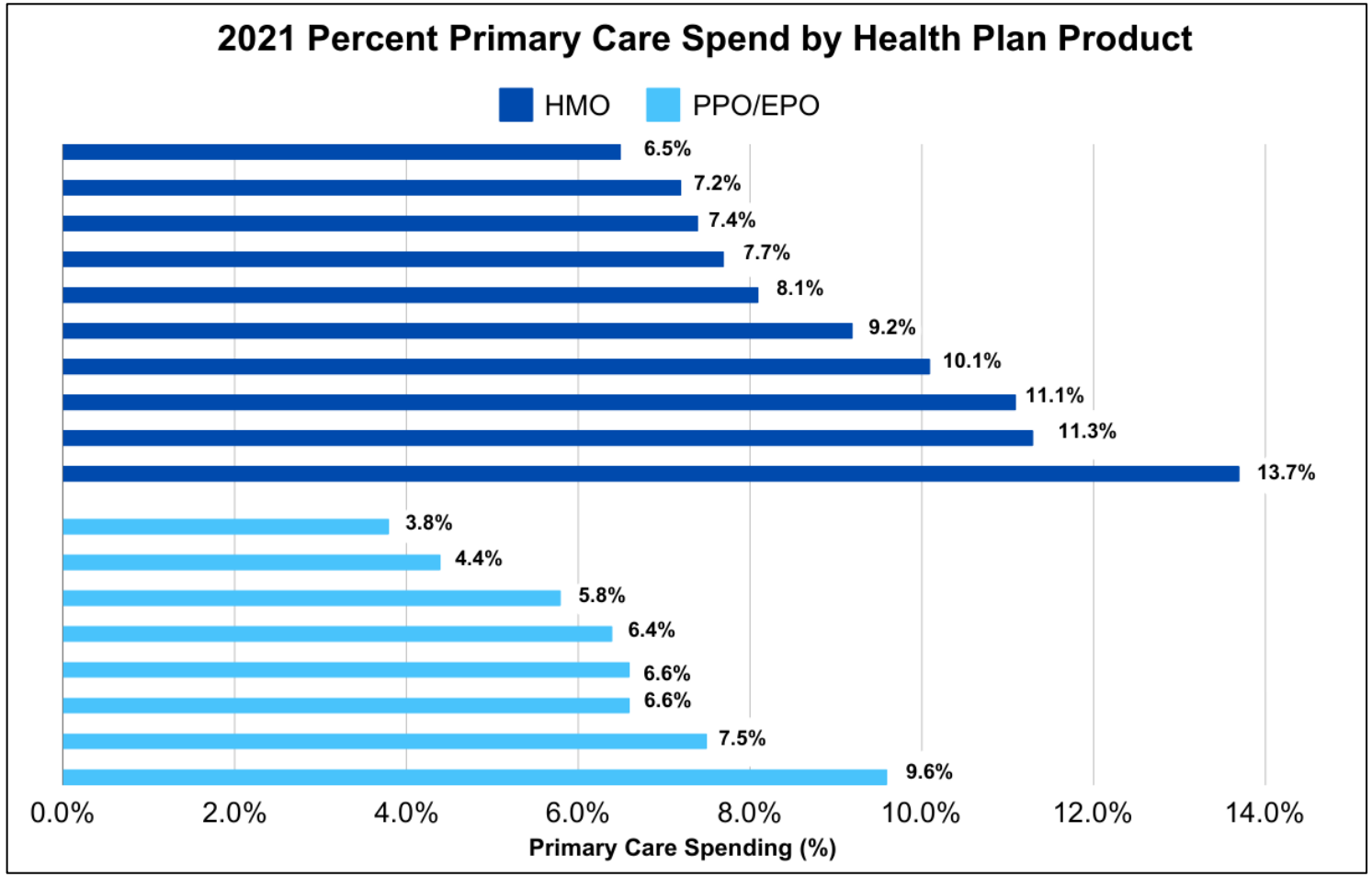
- Internationally, high performing health systems spend 12% to 15% of total spending on primary care.[1]
- States that invest more on primary care tend to spend less on avoidable hospitalizations and ED use.[2]
- Slightly higher than other states, recognizing California's healthcare delivery goals, delivery 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.
Note: The Annual Improvement Benchmark was previously referred to as the Relative Improvement Benchmark and the 2034 Investment Benchmark was previously referred to as the Absolute Improvement Benchmark.

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

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.



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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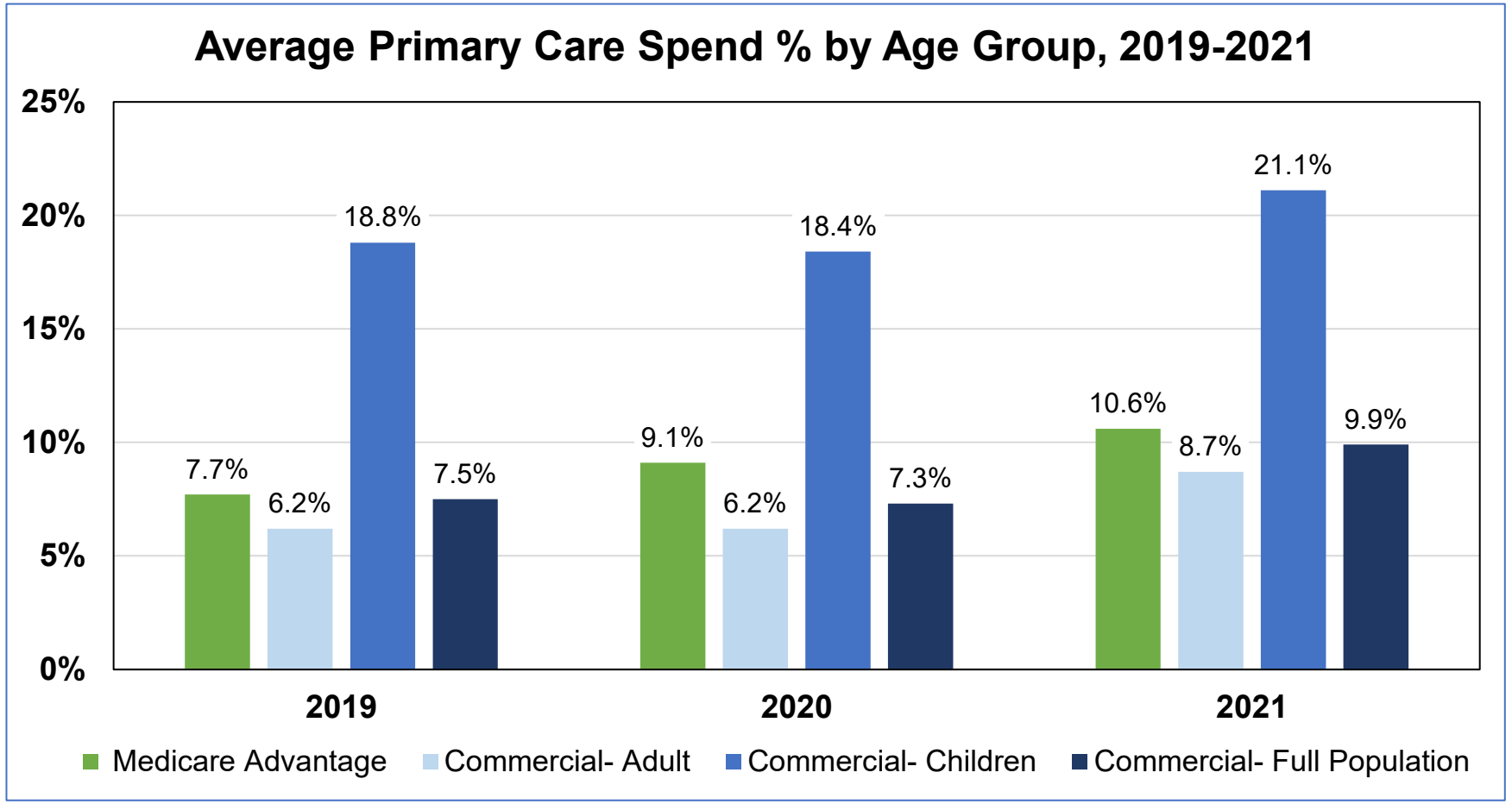
Primary Care Spending for Children and Adults in California

- 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.



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

Medi-Cal Primary Care Spending by Population

- In 2018, Medi-Cal health plans spent **an average of 11%** on primary care services. Results were based on a study of 13 plans (27 plan-county pairs).
- While this data offers helpful direction, it was calculated using a different methodology and data source than proposed by OHCA. The OHCA methodology is likely to produce a lower result.

Table 1. Range of Primary Care Spending Across County-Specific Health Plans (*N* = 27)

POPULATION	PERCENTAGE OF STUDY POPULATION	PER MEMBER PER MONTH			PERCENTAGE		
		MINIMUM	MEAN	MAXIMUM	MINIMUM	MEAN	MAXIMUM
Adult	15.6%	$13.01	$35.87	$57.85	5.0%	11.6%	20.2%
Child	45.9%	$5.90	$20.49	$34.10	9.6%	28.2%	37.4%
ACA optional expansion	30.8%	$10.97	$32.12	$67.91	4.1%	9.7%	18.9%
SPD	7.7%	$18.67	$44.49	$123.85	2.3%	4.9%	14.7%
All	**100.0%**	**$8.85**	**$28.50**	**$61.24**	**5.0%**	**11.3%**	**18.7%**

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

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

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

Advisory Committee & Workgroup Feedback on Primary Care Benchmark Recommendations

Feedback Theme	OHCA's Response
• Several Investment and Payment Workgroup members noted the 15% benchmark for 2034 seems aspirational, but achievable. • Several Advisory Committee and Investment and Payment Workgroup members supported the rationale behind the 15% benchmark. • Several Investment and Payment Workgroup members suggested that sustainable primary care investment and care transformation takes time and that the 10-year horizon should allow for that. • Another Advisory Committee preferred most increased investment to occur early on.	• OHCA continues to align APM and primary care recommendations to enable sustainable transformation based on time needed to transform payment and care delivery. • OHCA anticipates that yearly reporting on the annual improvement benchmark and 2034 benchmark will promote near-term improvement and long-term success.

Advisory Committee & Workgroup Feedback on Primary Care Benchmark Recommendations

Feedback Theme	OHCA's Response
• Several Advisory Committee and Investment and Payment Workgroup members recommended separate adult and pediatric investment benchmark to ensure adequate spending for both age groups. • Several Workgroup members appreciated the simplicity of a single investment benchmark, given the challenges of separating non-claims payments by age group. • Several Advisory Committee 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 collect and monitor claims-based primary care spending by age group. • OHCA considered benchmarks by age group. However, a single benchmark based on statewide population distribution with appropriate annual increases emerged as the best option. • 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 & Workgroup Feedback on Primary Care Benchmark Recommendations

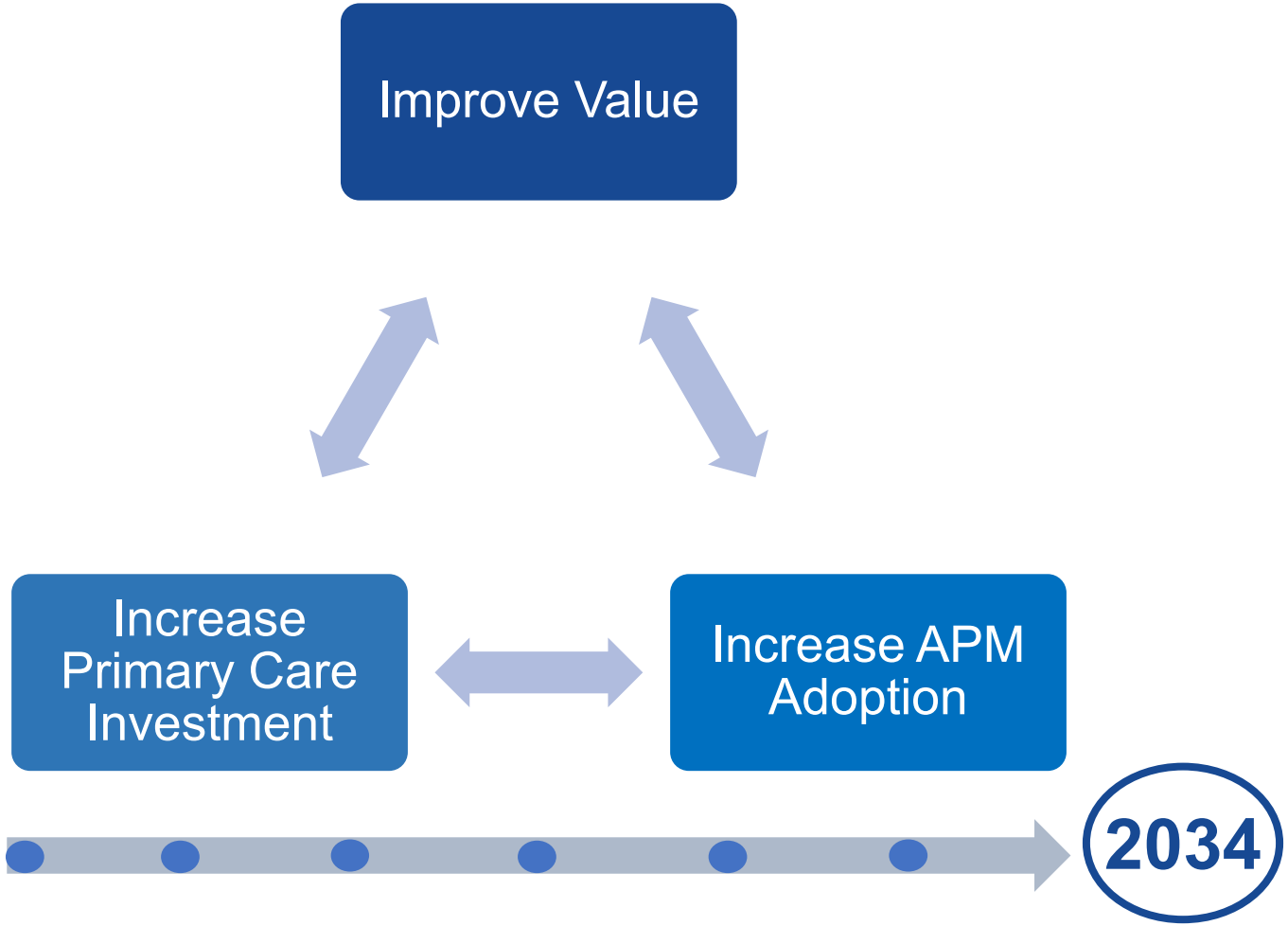
Feedback Theme	OHCA's Response
• Several Advisory Committee and Investment and Payment Workgroup members suggested collecting data from provider organizations to understand primary care spending by provider organization. • Several Advisory Committee members suggested OHCA should track complementary measures for primary care investment like PCP-consumer relationship, continuity of care, and quality.	• 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.

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 will collect and monitor 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 annual improvement benchmarks per payer in its annual report to ensure progress is made towards the 2034 investment benchmark.
    - OHCA can complement reporting on progress with the distribution of each payer's population by age.

Complementary Goals, Aligned Timeline

- APM adoption goals and primary care investment benchmark share a timeline: **a 2034 goal with milestones along the way**.
- APM adoption and primary care investment **work together toward improved value** by supporting delivery system transformation and helping moderate spending growth.



Draft Primary Care Investment Benchmark Recommendation

Annual 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 gradual reallocation of spending.
- Focus on shifting spend from specialty care and toward primary care.

AND

2034 Investment 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.
Note: The Annual Improvement Benchmark was previously referred to as the Relative Improvement Benchmark and the 2034 Investment Benchmark was previously referred to as the Absolute Improvement Benchmark.

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

Draft Recommendations for Primary Care Investment Benchmark: Discussion

Does the Board have any feedback on:

1. Using an annual improvement benchmark and a 2034 investment benchmark?
2. The recommended 15% 2034 investment benchmark?
3. The timeframe for achieving the benchmark?

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:

June 26, 2024
10:00 a.m.

Location:
2020 West El Camino Avenue
Sacramento, CA 95833

HCAi
Department of Health Care Access and Information

Adjournment

HCAi
Department of Health Care Access and Information

Appendix

APM Standards and Implementation Guidance

APM Standard 1 and Implementation Guidance

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

    1.1. Pay providers in advance to provide a defined set of services to a population when possible. HCP-LAN classifies these models as Category 4A, 4B, and 4C. Research finds that prospective payment of at least 60% of a provider organization's total payments results in meaningful change in clinical practice and reduces administrative burden.

    1.2. If Category 4 payment is not feasible for a certain line of business or provider, advanced payment models that include shared savings and when appropriate, downside risk, should be used when possible. This includes models that promote higher value hospital and specialty care. HCP-LAN classifies these models as Category 3A and 3B.

    1.3. Design core model components, with input from providers, to align with models already widely adopted in California whenever possible. Examples include the Medicare Shared Savings Program (MSSP) and the Realizing Equity, Access, and Community Health (REACH) program. Core components may 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.

APM Standard 2 and Implementation Guidance

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

    2.1. Align financial incentives to reduce utilization and excess spend on high-cost care such as low-value specialty pharmacy, unnecessary specialty care, and avoidable emergency room and hospital care.

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

    2.3. Reduce administrative inefficiency across the health care payment and delivery system by streamlining contracting, billing, credentialing, performance programs, and other documentation such as prior authorization.

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

APM Standard 3 and Implementation Guidance

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

    3.1. Provide sufficient primary care payment to support the adoption and maintenance of advanced primary care attributes such as primary care continuity, accessible and integrated behavioral health, and specialty care coordination.

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

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

    3.4. Encourage consumers to choose a primary care team to promote access to and use of primary care and enable payment model success.

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

APM Standard 4, 5 and Implementation Guidance

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

    4.1. Share attribution methodologies and outputs widely and in formats accessible to providers.

    4.2. Clearly articulate the performance measures used, provide the technical specifications including risk adjustment methods, and share how incentive payments are calculated.

5. **Engage a wide range of providers** by offering payment models that appeal to entities with varying capabilities and appetites for risk, including small independent practices and historically under-resourced providers.

    5.1. Provide upfront financial support to new entrants to assist them in hiring care team members, improving analytic capabilities, and making other investments to foster long-term success in the model.

    5.2. Make timely incentive payments that reward improvement and attainment, ideally no later than six to nine months after the performance period.

    5.3. Give providers – particularly those with lower revenues – a gradual, stepwise approach for assuming financial risk that protects provider financial solvency and supports sustainability.

    5.4. Utilize risk adjustment methodologies that incorporate clinical diagnoses, demographic factors, and other relevant information. Monitor emerging methodologies and explore opportunities to incorporate social determinants of health in risk adjustment methodologies.

APM Standard 6 and Implementation Guidance

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

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

    6.2. Align internal race, ethnicity, language, disability status, sex, sexual orientation, and gender identity (RELD-SOGI) data collection with the United States Core Data for Interoperability (USCDI) set where applicable and appropriate to reduce administrative burden.

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

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

APM Standard 7 and Implementation Guidance

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

    7.1. Select a limited number of nationally standardized measures that reflect multiple domains (e.g., quality, equity, utilization, cost, consumer experience) and populations (e.g., pediatric, adult, older adults). Prioritize outcome measures, whenever possible.

    7.2. Align measures and technical specifications with those used by the Department of Managed Health Care, California Department of Health Care Services, Covered California, the California Public Employees' Retirement System, and the Office of Health Care Affordability, when available.

    7.3. Include measures that monitor for unintended consequences of the payment model, such as withholding appropriate, necessary care to consumers to save money. For example, track changes in potentially avoidable emergency department visits and hospital admissions.

APM Standard 8, 9 and Implementation Guidance

8. **Invest in strategies to address inequities** in access, patient experience, and outcomes.

    8.1. Increase payments to providers serving populations with higher health-related social needs to support enhanced medical and behavioral care and social care coordination.

    8.2. Support providers in using data to identify and address inequities, including by providing care consistent with the National Culturally and Linguistically Appropriate Services Standards.

    8.3. Develop partnerships with community-based organizations and leverage local resources to address health-related social needs.

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

    9.1. Data and information shared should reflect providers' varying analytic needs and capabilities ranging from clear actionable reports to clinical registry and claims-level data.

    9.2. Offer analytic support, such as hands-on training and example dashboards, to develop the capacity of providers, interdisciplinary care teams, and non-clinical staff to ingest and benefit from information.

    9.3. Facilitate data exchange across providers, community-based organizations, and payers, particularly through use of the California's Health and Human Services Data Exchange Framework.

Red text indicates changes made based on Advisory Committee, Workgroup, and public comments from the February 2024 version: https://hcai.ca.gov/wp-content/uploads/2024/02/OHCA-Recommendations-to-Board_Proposed-APM-Standards-and-Goal.pdf

APM Standard 10 and Implementation Guidance

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

10.1. Payers and providers should work collaboratively to develop a technical assistance plan that identifies potential barriers to success and conditions necessary to build capacity in these areas. The plan should offer clear action steps for what assistance will be provided and the format and frequency of the assistance.

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

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

Expanded Framework for Non-Claims Payments

Expanded Framework, Categories 1-3

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
1	**Population Health and Practice Infrastructure Payments**	
a	Care management/care coordination/population health/medication reconciliation	2A
b	Primary care and behavioral health integration	2A
c	Social care integration	2A
d	Practice transformation payments	2A
e	EHR/HIT infrastructure and other data analytics payments	2A
2	**Performance Payments**	
a	Retrospective/prospective incentive payments: pay-for-reporting	2B
b	Retrospective/prospective incentive payments: pay-for-performance	2C
3	**Payments with Shared Savings and Recoupments**	
a	Procedure-related, episode-based payments with shared savings	3A
b	Procedure-related, episode-based payments with risk of recoupments	3B
c	Condition-related, episode-based payments with shared savings	3A
d	Condition-related, episode-based payments with risk of recoupments	3B
e	Risk for total cost of care (e.g., ACO) with shared savings	3A
f	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B

Freedman HealthCare supported the California Department of Health Care Access and Information in developing the Expanded Non-Claims Payment Framework. The framework builds on the work of Bailit Health and the Milbank Memorial Fund and the Health Care Payment Learning and Action Network.
https://hcai.ca.gov/wp-content/uploads/2023/11/HCAI-Expanded-Non-claims-Payments-Framework-Handout_11-28-23-1.pdf

Expanded Framework, Categories 4-6

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
4	**Capitation and Full Risk Payments**	
a	Primary Care capitation	4A
b	Professional capitation	4A
c	Facility capitation	4A
d	Behavioral Health capitation	4A
e	Global capitation	4B
f	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C
5	**Other Non-Claims Payments**	
6	**Pharmacy Rebates**	

Freedman HealthCare supported the California Department of Health Care Access and Information in developing the Expanded Non-Claims Payment Framework. The framework builds on the work of Bailit Health and the Milbank Memorial Fund and the Health Care Payment Learning and Action Network.
https://hcai.ca.gov/wp-content/uploads/2023/11/HCAI-Expanded-Non-claims-Payments-Framework-Handout_11-28-23-1.pdf

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
3.	**Shared Savings Payments and Recoupments**	**Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including but not limited to episode of care and total cost of care. Dollars reported in this category should reflect only the non-claims shared savings payment or recoupment, not the fee-for-service component. Recouped dollars should be reported as a negative value. Payments in this category are considered "linked to quality" if the shared savings payment or any other component of the provider's payment was adjusted based on specific predefined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the shared savings payment, then the shared savings payment would be considered "linked to quality."**	
a.	Procedure-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3A

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.**	