Office of Health Care Affordability Recommendations to the California Health Care Affordability Board: Proposed Primary Care Investment Benchmark

The Office of Health Care Affordability's Mission and Purpose

In 2022, the California Health Care Quality and Affordability Act (SB 184, Chapter 47, Statutes of 2022) established the Office of Health Care Affordability (OHCA) within the Department of Health Care Access and Information (HCAI). Recognizing that health care affordability has reached a crisis point as health care costs continue to grow, OHCA's enabling statute emphasizes that it is in the public interest that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal.

Health care spending in California reached $10,299 per capita and $405 billion overall in 2020, up 30% from 2015.[1] Californians with job-based coverage are facing higher out-of-pocket costs, with the share of workers with a large deductible ($1,000 or more) increasing from 6% in 2006 to 54% in 2020.[2] For the fourth consecutive year, the 2024 California Health Care Foundation California Health Policy Survey reports that more than half of Californians (53%) – and nearly three-fourths (74%) of those with lower incomes (under 200% of the federal poverty level) – reported skipping or delaying at least one kind of health care due to cost in the past 12 months.[3] Among those who reported skipping or delaying care due to cost, about half reported their conditions worsened as a result. Further, high costs for health care disproportionately affect Black and Latino Californians who report they had problems paying or could not pay medical bills (40% and 36%, respectively, compared to White Californians at 25%).[3]

OHCA has three primary responsibilities to achieve its mission of improved consumer affordability:

1. Slow health care spending growth through collection and reporting on total health care expenditure data and enforcing spending targets set by the Board.

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[1] "Health Expenditures by State of Residence, 1991-2020," Data sets, *Health Accounts by State of residence*, September 2023, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence.
[2] Heidi Whitmore and Jennifer Sartorius, "California Employer Health Benefits: Are Workers Covered?," California Health Care Almanac, California Health Care Foundation, August 2021. https://www.chcf.org/wp-content/uploads/2021/08/CAEmployerHealthBenefitsAlmanac2021.pdf.
[3] Jen Joynt, Rebecca Catterson, and Emily Alvarez, "The 2024 CHCF California Health Policy Survey," California Health Care Foundation, January 31, 2024. https://www.chcf.org/publication/2024-chcf-california-health-policy-survey/.

2. Promote high-value health system performance.
3. Assess market consolidation.

In enacting the California Health Care Quality and Affordability Act, the Legislature declared that "primary care is foundational to an effective health care system and evidence supports that greater use of primary care has been associated with lower costs, higher patient satisfaction, reduced low birth weight, fewer hospitalizations and emergency department visits, and lower mortality, among other key outcomes. However, the United States as a whole spends a far lower share of health care expenditures on primary care and experiences worse outcomes in life expectancy and mortality than other countries."[4]

Statutory Requirements

As described in the OHCA enabling statute and summarized here, the statutory requirements related to primary care investment include:

- Measure the percentage of total health care expenditures allocated to primary care and set a spending benchmark.
- Consider current and historic underfunding of primary care services in a spending benchmark.
- Promote a sustained systemwide investment in 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.
- Consider differences among payers and fully integrated delivery systems, including factors such as plan or network design or line of business; the diversity of settings and facilities through which primary care can be delivered, including clinical and nonclinical settings; the use of both claims-based and non-claims-based payments; and the risk mix associated with the covered lives or patient population for which they are primarily responsible.
- Analyze primary care spending and growth, and relevant quality and equity performance measures, and incorporate 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, behavioral health, and health equity.[5]

The California Health Care Quality and Affordability Act also specifies that OHCA shall promote improved outcomes for primary care including:

- Promote the importance of primary care and adopt practices that give consumers a regular source of primary care.

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[4] Health and Safety Code Section 127500.5, subdivision (a)(7).

[5] These requirements are summarized from Health and Safety Code Section 127505, subdivision (a)..

- Increase access to advanced primary care models and adoption of measures that demonstrate their success in improving quality and outcomes.
- Integrate primary care and behavioral health services, including screenings for behavioral health conditions in primary care settings or delivery of behavioral health support for common behavioral health conditions, such as anxiety, depression, or substance use disorders.
- Leverage alternative payment models that provide resources at the practice level to enable improved access and team-based approaches for care coordination, patient engagement, quality, and population health. Team-based approaches support the sharing of accountability for delivery of care between physicians and nurse practitioners, physician assistants, medical assistants, nurses and nurse case managers, social workers, pharmacists, and traditional and nontraditional primary and behavioral health care providers, such as peer support specialists, community health works, and others.
- Deliver higher value primary care with an aim toward reducing disparities.
- Leverage telehealth and other digital health solutions to expand access to primary care services, care coordination, and care management.
- Implement innovative approaches that integrate primary care and behavioral health with broader social and public health services.[6]

To measure the percent of total health care expenditures allocated to primary care, OHCA is statutorily required to:

- Use the Health Care Payments Data Program (HPD), established pursuant to Chapter 8.5 (commencing with Section 127671), to the greatest extent possible, to minimize reporting burdens for health care entities.
- Determine the categories of health care professionals who should be considered primary care providers and consider existing state and national approaches, as appropriate.
- Determine specific procedure codes that should be considered primary care services and consider existing state and national approaches, as appropriate.
- Determine the categories of payments to primary care providers and practices, including non-claims-based payments, such as alternative payment models, that should be included when determining the total amount spent on primary care.[7]

The Board shall approve the Primary Care Investment Benchmark.[8]

Background

OHCA promotes high-value system performance through its work in five focus areas: (1) primary care investment, (2) behavioral health investment, (3) alternative payment model (APM) adoption goals and standards, (4) quality and equity measurement, and

[6] These requirements are summarized from Health and Safety Code Section 127505.
[7] These requirements are summarized from Health and Safety Code Section 127501.4, subdivision (h)(2).
[8] These requirements are summarized from Health and Safety Code Section 127501.11.

(5) workforce stability. Across all these areas, the goal is to reorient the health care system towards greater value, with the vision of creating a sustainable health care system that provides high-quality, equitable care to all Californians.

High functioning health care systems require high quality primary care as a foundation. Primary care investment in the United States, typically four percent to seven percent of total health care spending, lags far behind other high-income countries with higher performing health care systems, where primary care spending typically ranges from 12 to 15 percent.[9] Importantly, increased supply of primary care services leads to more equitable outcomes and improved population health.[10] In recommending its Primary Care Investment Benchmark, OHCA seeks to align California with the share of spending on primary care in high performing health systems internationally.

OHCA launched the Investment and Payment Workgroup in June 2023, bringing together stakeholders representing providers and provider organizations, academics and subject matter experts, state and private purchasers, sibling state departments, consumer advocates, patient representatives, hospitals and health systems, and health plans.[11] The Workgroup convenes monthly to provide input as OHCA develops definitions and recommends targets or benchmarks in the areas of APMs, primary care investment, and behavioral health investment. At the outset of its primary care work, the Workgroup supported using the attributes of advanced primary care developed by the California Quality Collaborative (CQC) as the guiding vision to inform OHCA's development of its Primary Care Spending Measurement Definition and Methodology. The CQC describes advanced primary care as person- and family-centered, relationship-based, accessible, comprehensive, team-based, integrated, coordinated, and equitable.[12] The Workgroup emphasized the need for sustainable and well-resourced primary care to achieve the vision.

OHCA presented draft versions of the Primary Care Spending Measurement Definition and Methodology and Investment Benchmark to the Health Care Affordability Advisory Committee on March 19, 2024, along with several questions for specific Advisory Committee feedback. The benchmark recommendations, along with the draft definition and supporting data collection processes, were informed by months of discussion with the Investment and Payment Workgroup and additional stakeholder feedback, including

[9] Yalda Jabbarpour, et al., "Investing in Primary Care: A State-Level Analysis," Patient-Centered Primary Care Collaborative, 2019. https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf

[10] National Academies of Sciences, Engineering, and Medicine, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* (Washington, DC: The National Academies Press, 2021). https://nap.nationalacademies.org/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health

[11] OHCA Investment and Payment Workgroup meetings and materials are publicly available.

[12] California Quality Collaborative, "Advanced Primary Care: Defining a Shared Standard," 2022. https://www.pbgh.org/wp-content/uploads/2022/04/advanced-primary-care-shared-standard.pdf

from sibling state departments. Additional refinements were made based on feedback from the Health Care Affordability Advisory Committee.

While OHCA will promote, measure, and report primary care investment, at this time OHCA does not have authority to enforce the Primary Care Investment Benchmark as a standalone requirement but does have authority for payer data collection and public reporting. As such, OHCA will partner with stakeholders to promote adoption of, and make progress towards the Primary Care Investment Benchmark. OHCA commits to transparency and accountability by publishing progress towards the stated benchmark for each payer in its annual report. As health care spending shifts over time away from specialty care and toward primary care, OHCA anticipates that health system performance will improve, leading to higher quality, more equitable, and more affordable care.

OHCA Recommendations

Primary Care Investment Benchmark

OHCA proposes the following Primary Care Investment Benchmark for Board consideration and approval. OHCA recommends two related benchmarks for increasing primary care investment:

1) Relative improvement benchmark for each payer: 0.5 percentage points to 1 percentage point per year increase in primary care spending as a percent of total medical expense through 2034; and
2) Statewide absolute benchmark: 15 percent of total medical expense allocated to primary care by 2034.

Rationale

OHCA recommends a **relative improvement benchmark** such that all payers increase primary care spending by 0.5 percentage points to 1 percentage point per year for each line of business (commercial, Medicare Advantage, and Medi-Cal), acknowledging that payers are starting at different levels of primary care spending. Payers at or above the statewide absolute benchmark of 15 percent of total medical expense (see below) may opt to maintain their primary care spending if further increases are not aligned with care delivery or affordability goals. The intention of the relative improvement benchmark is to motivate ongoing incremental increases in investment in primary care, with annual milestones to mark progress. OHCA will monitor and report each payer's progress on the relative improvement benchmark in its annual report by line of business.

OHCA recommends a **statewide absolute benchmark** of 15 percent of total medical expense allocated to primary care across all payers, lines of business (commercial, Medicare Advantage, and Medi-Cal), and populations by 2034. This benchmark is aligned with the share of spending on primary care in high performing health systems internationally, as described above. This recommended benchmark is aspirational while addressing historic underinvestment in primary care.[13] It is also a higher benchmark than those implemented by other states to recognize the 10-year timeline and California's younger and healthier population. OHCA considered separate absolute benchmarks for pediatric and adult populations based on analyses that show variation between pediatric and adult primary care spending in California.[14] However, after careful consideration and extensive stakeholder input, OHCA recommends one statewide benchmark that combines the pediatric and adult populations. A key

[13] National Academies of Sciences, Engineering, and Medicine, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* (Washington, DC: The National Academies Press, 2021). https://nap.nationalacademies.org/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health

[14] See OHCA Investment and Payment Workgroup February 21, 2024 presentation, slides 32-33: https://hcai.ca.gov/wp-content/uploads/2024/02/02-21-24-Investment-and-Payment-Workgroup-Presentation-1.pdf

consideration in that recommendation is the administrative complexity of reporting, especially separating non-claims payments by pediatric and adult populations.

Note: OHCA will measure primary care spending as described in **Appendix A: Primary Care Spending Measurement Definition and Methodology**.

Appendix A: Primary Care Spending Measurement Definition and Methodology

OHCA will measure primary care spending paid through claims and non-claims payments. A limited number of behavioral health services delivered in a primary care setting will be included in the primary care definition. Data will be collected in a way that allows OHCA to attribute this spending to primary care or to future calculations of behavioral health spending. Primary care claims payments, primary care non-claims payments, and behavioral health services delivered in a primary care setting will count towards meeting the Primary Care Investment Benchmark.

Claims-based Primary Care Spending Definition

Claims-based primary care spending is defined as a primary care **service** delivered in a primary care **place of service** by a primary care **provider**. All three aspects of the definition must be met for the spend to count as primary care spending.

Primary care services are defined by Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes on claims.[15] OHCA plans to include a broad set of services to promote comprehensive primary care. The definition includes the following primary care services in the claims-based definition of primary care:

- Office visit
- Home visit
- Preventive visits
- Immunization administration
- Transitional care and chronic care management
- Health risk assessment
- Advanced care planning
- Minor procedures
- Interprofessional consult (e-consult)
- Remote patient monitoring
- Labs
- Team conference with or without the patient
- Prolonged preventive service
- Domiciliary or rest home care and evaluation
- Group visits
- Women's health services: preventive screenings, immunizations, minor procedures including insertion or removal of contraceptive devices, and maternity care

Primary care places of service are defined by the Centers for Medicare and Medicaid Services (CMS) Place of Service (POS) codes on claims.[16] OHCA plans to include office settings, home, and community-based sites of service and to exclude retail and urgent care sites due to a lack of coordinated, comprehensive care. The following

[15] HCPCS and CPT codes are maintained by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA): https://www.cms.gov/medicare/regulations-guidance/physician-self-referral/list-cpt/hcpcs-codes

[16] CMS Place of Service Code Set: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

primary care places of service, in combination with service and provider criteria, are included in the claims-based definition of primary care:

- Office
- Telehealth
- School
- Home
- Federally Qualified Health Center
- Public Health Clinic
- Rural Health Clinic
- Worksite
- Hospital Outpatient
- Homeless Shelter
- Assisted Living Facility
- Group Home
- Mobile Unit
- Street Medicine

Primary care providers are defined by National Uniform Claim Committee (NUCC) taxonomy codes on claims.[17] OHCA plans to include primary care providers offering whole-person, continuous, coordinated care and primary care team members. The following primary care providers, in combination with service and place of service criteria, are included in the claims-based definition of primary care:

- Family medicine (general/adult/geriatrics)
- Internal medicine (general/adult/geriatrics)
- General practice
- Pediatrics
- Nurse practitioner:
  - Adult health
  - Family
  - Pediatrics
  - Primary care
- Pharmacist
- Physician assistant, medical
- Nurse, non-practitioner
- Primary care clinics
- Rural health clinics
- Federally qualified health centers
- Certified clinical nurse specialist:
  - Adult health
  - Community/public health
  - Pediatrics
  - Chronic health
  - Family health
  - Gerontology

OHCA plans to exclude obstetrician gynecologist (OB-GYN) providers from the primary care provider definition based on feedback from Investment and Payment Workgroup members and Advisory Committee members. While a few Workgroup members recommended including OB-GYNs in the definition, most feedback supported excluding OB-GYNs to align with OHCA's focus on investing in providers delivering continuous whole-person care for all body systems.

In addition to using the NUCC taxonomy codes on claims, OHCA plans to further restrict the definition of primary care providers to those who are designated as primary care physicians and non-physician medical practitioners, such as nurse practitioners and physician assistants, in the payer's Annual Network Report Submission to the

[17] National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy: https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40

Department of Managed Health Care (DMHC).[18] This additional criteria helps ensure that care provided by specialists is excluded from the primary care spending analysis. For example, internal medicine physicians often practice as specialists (e.g., endocrinologists or gastroenterologists) rather than as primary care providers.

Non-Claims Primary Care Spending Definition

OHCA is using the Expanded Non-Claims Payments Framework (Expanded Framework) to categorize non-claims payment data in the total medical expenses data collection. OHCA plans to follow the approach outlined below to allocate a portion of non-claims payments to primary care spending. OHCA developed the approach outlined below with input from the Investment and Payment Workgroup and other stakeholders.[19]

Expanded Framework Category		Allocation to Primary Care Spending
1	**Population Health and Practice Infrastructure Payments**	
a	Care management/care coordination/population health/medication reconciliation	Include payments for primary care programs such as care management, care coordination, population health, health promotion, behavioral health, or social care integration.
b	Primary care and behavioral health integration	
c	Social care integration	
d	Practice transformation payments	Limit the portion of practice transformation and IT infrastructure payments that are allocated to primary care spending to 1 percent of total medical expense.
e	EHR/HIT infrastructure and other data analytics payments	
2	**Performance Payments**	
a	Retrospective/prospective incentive payments: pay-for-reporting	Include performance incentives in recognition of reporting, quality, and outcomes of patients attributed to primary care providers.
b	Retrospective/prospective incentive payments: pay-for-performance	
3	**Payments with Shared Savings and Recoupments**	
a	Procedure-related, episode-based payments with shared savings	Limit the portion of risk settlement payments that are allocated to primary care spending to the same proportion that claims-based professional spending represents as a percent of claims-based professional and hospital spending.
b	Procedure-related, episode-based payments with risk of recoupments	
c	Condition-related, episode-based payments with shared savings	
d	Condition-related, episode-based payments with risk of recoupments	
e	Risk for total cost of care (e.g., ACO) with shared savings	
f	Risk for total cost of care (e.g., ACO) with risk of recoupments	

[18] DMHC Annual Network Reporting Requirements: https://www.dmhc.ca.gov/LicensingReporting/SubmitHealthPlanFilings/TimelyAccessComplianceandAnnualProviderNetworkReporting.aspx

[19] See OHCA Investment and Payment Workgroup February 2024 and March 2024 presentations: https://hcai.ca.gov/affordability/ohca/ohca-investment-and-payment-workgroup/

<table>
<tr><th>4</th><th colspan="2">Capitation and Full Risk Payments</th></tr>
<tr><td>a</td><td>Primary Care capitation</td><td>Allocate full primary care capitation amount to primary care spending.</td></tr>
<tr><td>b</td><td>Professional capitation</td><td>Calculate a ratio of fee-for-service equivalents for primary care services to fee-for-service equivalents for all services in the capitation. Multiply the capitation payment by the ratio. Divide the result by total medical expense.</td></tr>
<tr><td>c</td><td>Facility capitation</td><td>Not applicable.</td></tr>
<tr><td>d</td><td>Behavioral Health capitation</td><td rowspan="3">Calculate a ratio of fee-for-service equivalents for primary care services to fee-for-service equivalents for all services in the capitation. Multiply the capitation payment by the ratio. Divide the result by total medical expense.</td></tr>
<tr><td>e</td><td>Global capitation</td></tr>
<tr><td>f</td><td>Payments to Integrated, Comprehensive Payment and Delivery Systems</td></tr>
<tr><td>5</td><td>Other Non-Claims Payments</td><td>Not applicable.</td></tr>
<tr><td>6</td><td>Pharmacy Rebates</td><td>Not applicable.</td></tr>
</table>

OHCA will, by regulation, update the Total Health Care Expenditures Data Submission Guide by year-end 2024 to include detailed explanations of how to allocate non-claims payments to primary care spending.[20]

[20] Total Health Care Expenditures (THCE) Data Submission Guide (DSG): https://hcai.ca.gov/wp-content/uploads/2024/03/THCE-Data-Submission-Guide.pdf, incorporated by reference in 22 CCR 97445.