HCAi
Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

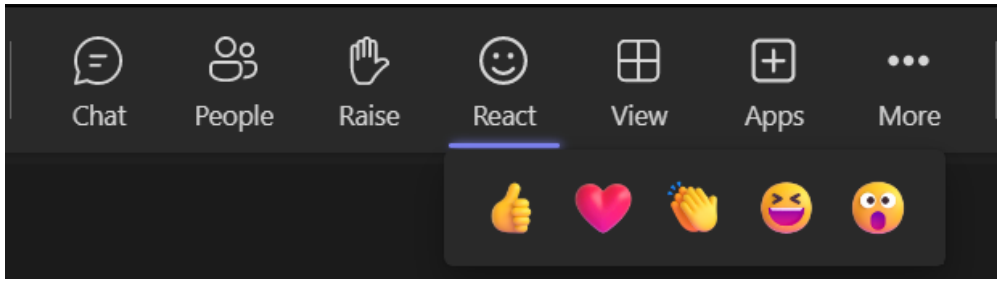
July 19, 2023

Agenda

9:00 a.m.	**1. Welcome, Updates, and Charter Review**
9:10 a.m.	**2. Use Cases for APM Measurement**
9:40 a.m.	**3. Categorizing APMs to Support California Use Cases**
10:10 a.m.	**4. Introduction to Health Equity in APM Measurement**
10:30 a.m.	**5. Adjournment**

Meeting Format

- Remote participation via Teams Webinar only
- Meeting recurs the third Wednesday of every month
- We will be using reaction emojis, breakout rooms, and chat functions:



Date:
Wednesday, July 19, 2023

Time:
9:00 am PST

Microsoft Teams Link
for Public Participation:
Click here to join the meeting

Meeting ID: 231 506 203 671
Passcode: XzTN6r

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

Conference ID:
261 055 415#

Investment and Payment Workgroup Members

Providers & Provider Organizations

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Chief of Staff, California Medical Association

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Assistant Chief, Clinical Policy & Programs Division, CalPERS

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Chief Medical Officer, Covered California

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

Consumer Reps & Advocates

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Contract Lobbyist, Health Access California

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Transplant Recipient and Cancer Survivor, Patients for Primary Care

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

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Ben Johnson, MPP
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Chief Health Officer, California Health Care Safety Net Institute

Health Plans

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

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

To be selected

Charter Feedback

- Clarify that there will be continued emphasis on all three topics e.g., alternative payment models, primary care, and behavioral health throughout the Workgroup's lifecycle.

- Better articulate that the goal of the primary care and behavioral health benchmarks are to ensure sufficient investment ***not*** constrain spending in these high value areas.

- Clearly state that the Workgroup will inform development of measurement, reporting, benchmark setting and standards development.

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Use Cases for APM Measurement

Vinayak Sinha, MPH, CSM, Consultant

Alternative Payment Models

Statutory Requirements

- Promote the shift of payments based on fee-for-service (FFS) to alternative payment models (APMs) that provide financial incentive 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.

What Data May OHCA Obtain?

Statutory Requirements

- Require **payers, fully integrated delivery systems, restricted and limited health care service plans** to submit data and other information to measure adoption of APMs.
- Data may include, but is not limited to, types of payment models, adoption by line of business, the number of members covered by APMs, the percent of budget dedicated to alternative payments, or cost and quality performance measures tied to the payment models.

OHCA can collect data at the contract level, but data will not provide insight into how payments are distributed within a provider organization. We will be able to understand the intent of payments through payer-submitted data.

Health and Safety Code 127501.4(a-k)

We Are Seeking Input On

- What other use cases may be important to promote movement from FFS to APMs for equitable high-quality and cost-efficient care?
- Which use cases may be a lower priority?
- Are there any use cases where you have questions or would like to review in more detail?

Definitions and Framing

Alternative Payment Models and Non-Claims Payments

Non-Claims Payments: Payments for health care services made outside the fee-for-service system and not on the basis of a claim.

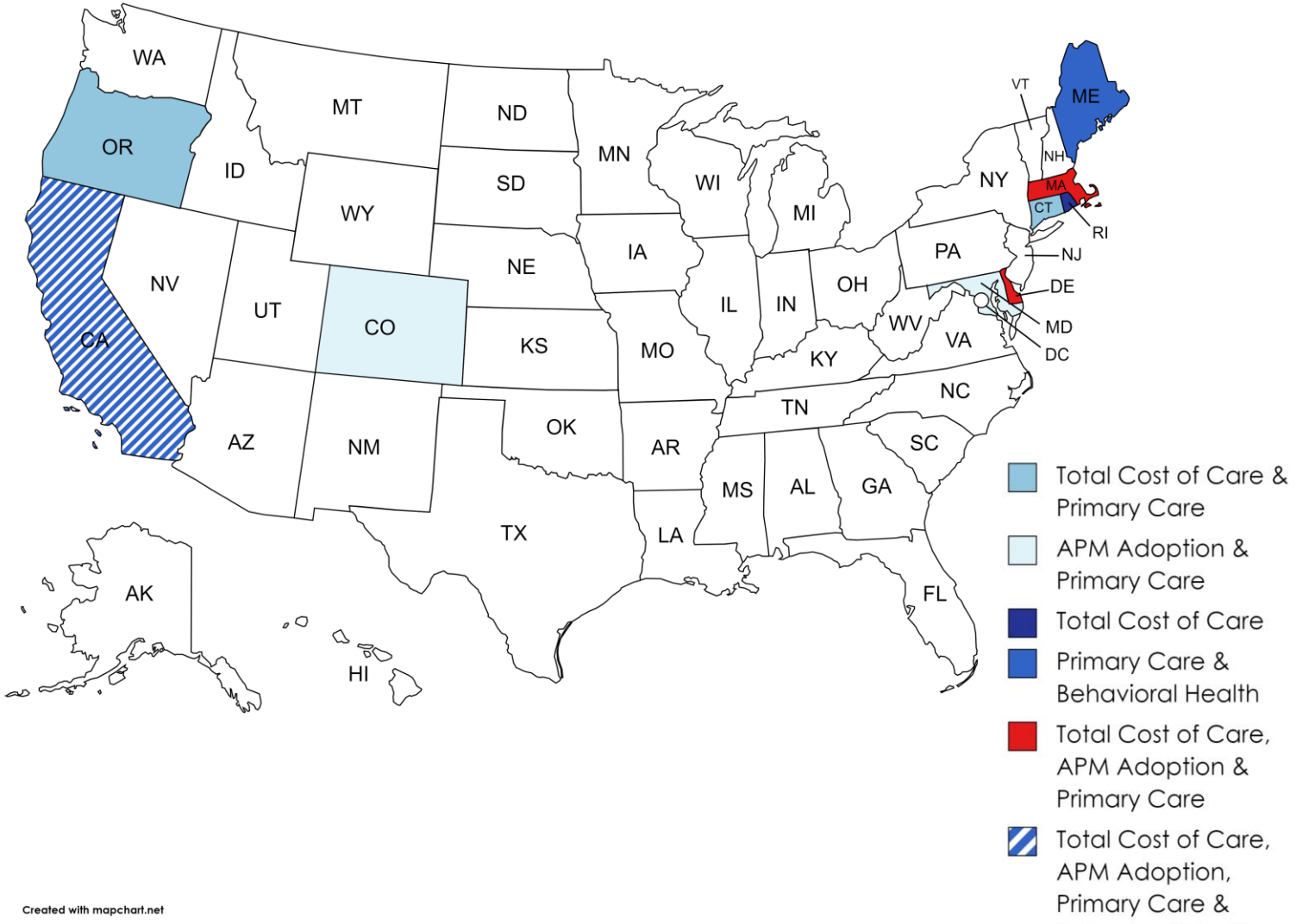
Alternative Payment Models: A payment approach that incentivizes high-quality and cost-efficient care.

Not all non-claims payments are value-based payments or APMs. Not all value-based payments or APMs are non-claims, but there is significant overlap.

Adapted from the Centers for Medicare and Medicaid Services Quality Payment Program, https://qpp.cms.gov/apms/overview

What's Occurring in Other States

- Nine states collect APM data from payers with different authority and use cases.
- Some collect data multiple ways for different use cases.
- Definitions and payment categories vary.
- Payers report little insight into the distribution of non-claims payments within provider organizations.



OHCA APM Adoption Use Cases

Data collection will help OHCA understand the APM landscape, assess the effectiveness of APMs, and quantify the role APMs play in care delivery primary care and behavioral health care delivery.

Collecting data on APMs provides insight into:

- Provider risk in contracting
- Total dollars moving through non-claims payments
- Comparative performance of APMs
- Differences in APM adoption by geographic market
- Attributes of successful APM adoption
- APMs to support primary care

Identifying priority use cases will inform:

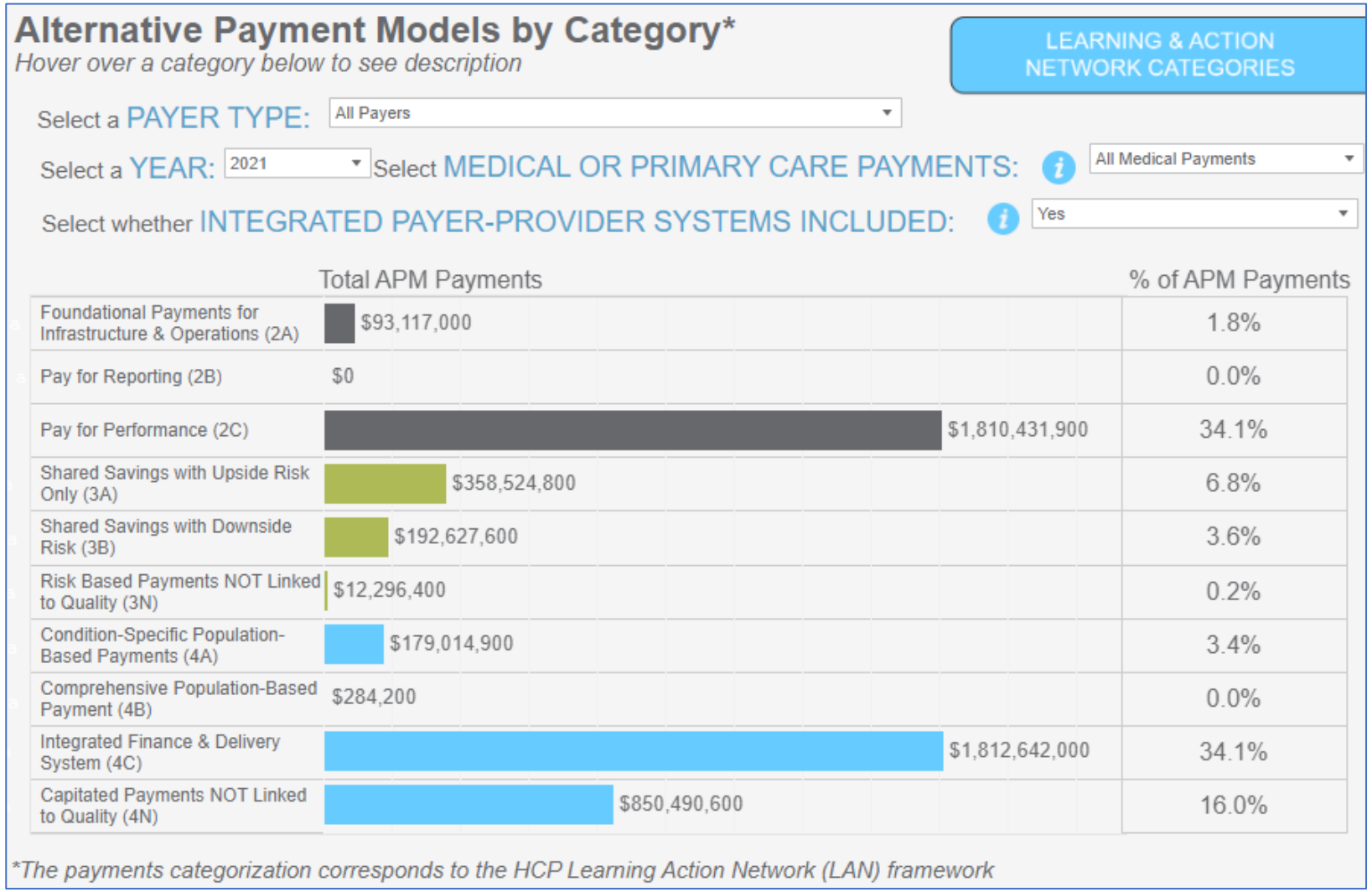
- How APM data is initially collected and reported
- Ways stakeholders may benefit from APM reporting, adoption and standards
- Opportunities to assess and promote health equity

Provider Risk in Contracting

Why it's important:

Knowing how much risk providers can successfully accept can guide and align future efforts to transform care delivery and payment.

Providers in Colorado are more likely to be paid via capitated and pay for performance payments. Payers may consider terms to incent adoption of other arrangements.

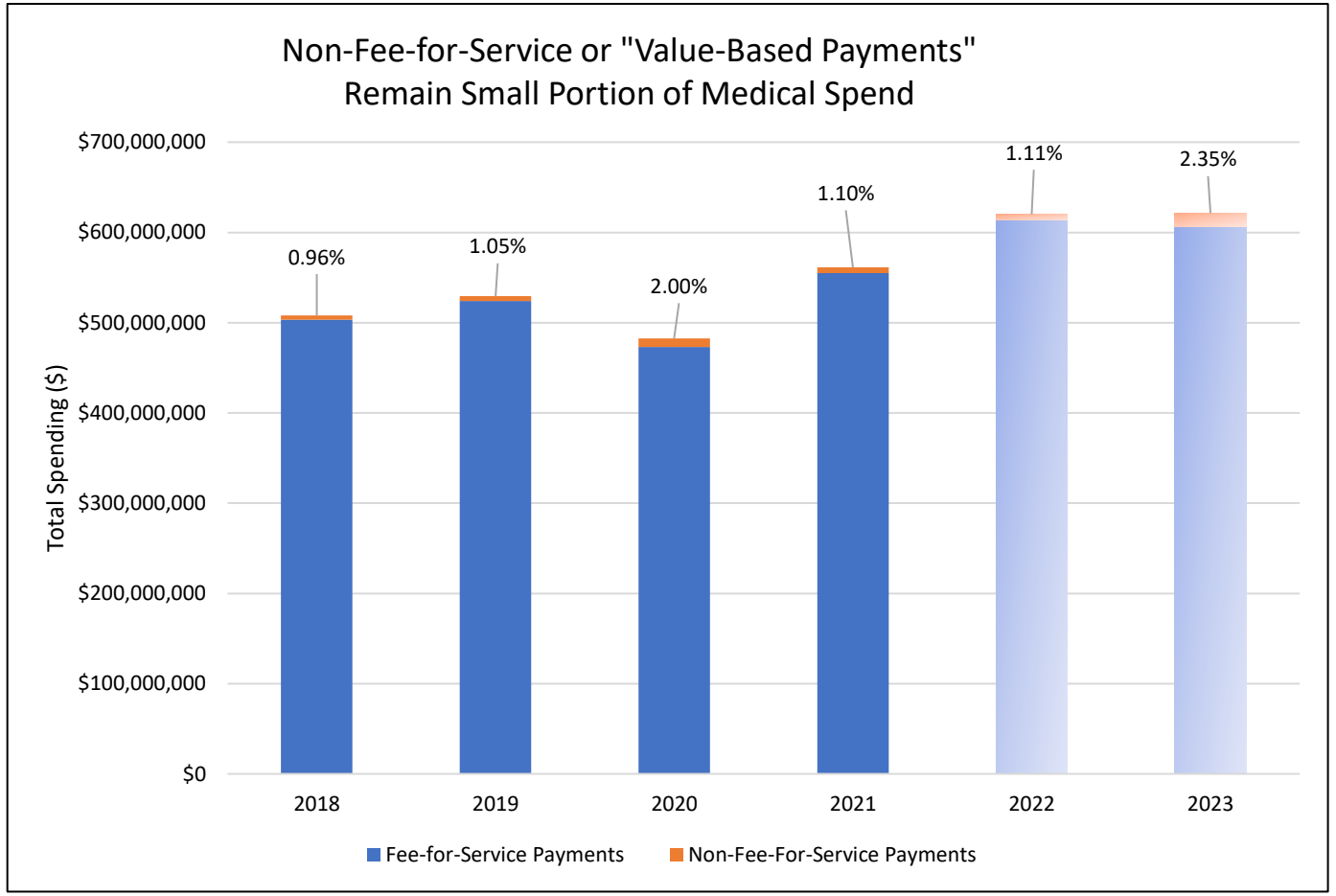


Center for Improving Value in Health Care, Affordability Dashboard, 2022.

Total Dollars Moving Through Non-Claims Payments

Why it's important:

Non-claims payments help support sustainable care transformation and promote APM adoption. What portion of dollars moving through an APM should be non-claims payments to achieve care transformation?



Over 60% of Delaware's commercial fully-insured payments were in APMs, but non-claims payments made up a small portion of spending. Collecting data both ways highlighted this challenge.

Performance of APM Arrangements

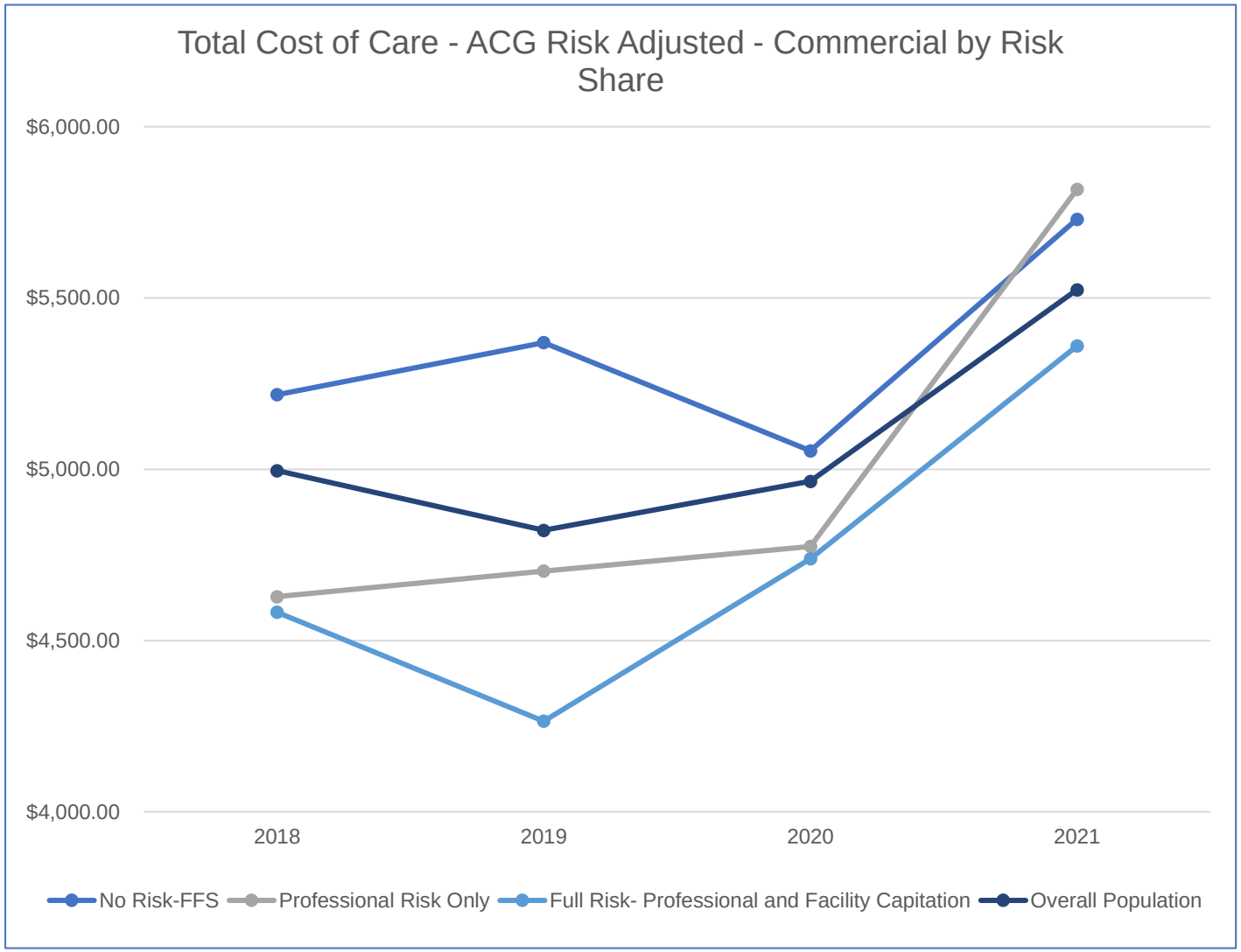
Why it's important:

Informs a shared understanding of the types of APM arrangements most likely to improve value and/or quality.

The average total cost of care for CA commercial payers has typically been higher in FFS arrangements. Further investigation of professional risk only arrangements in 2021 is needed.

Note: Kaiser data excluded.

The Johns Hopkins ACG tool adjusts payments to account for the health of the population served by a provider.



Differences by Geographic Market

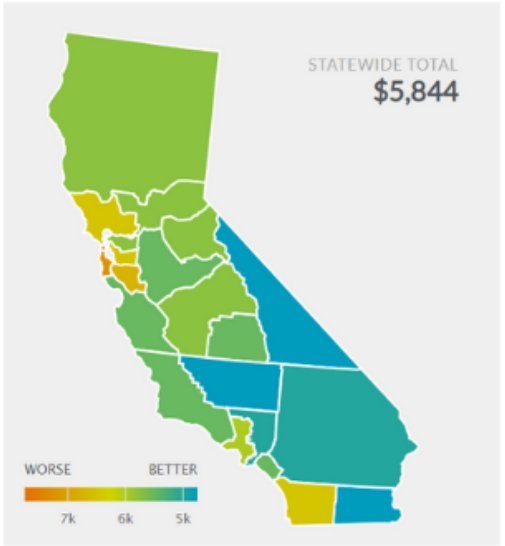
Why it's important:

Provides insight into characteristics of the geographic market (i.e., types of plans, products, and providers). Identifies high performers and opportunities.

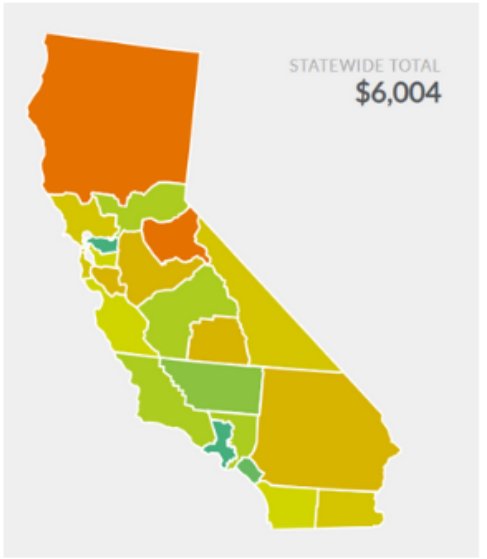
Total Cost of Care - Geography and ACG Risk Adjusted - Commercial

Lower is Better

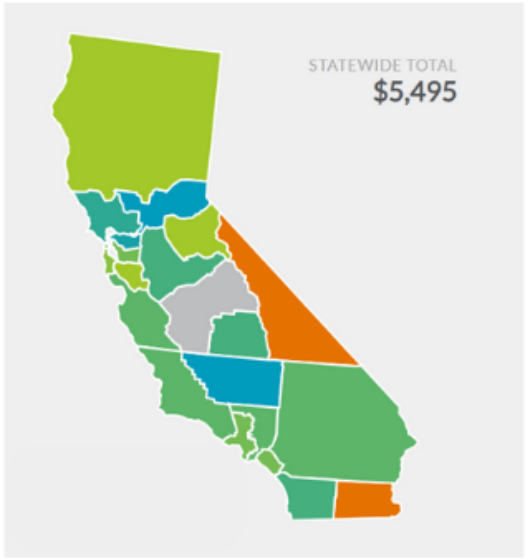
The average geography and risk-adjusted total payments by insurance and by members to providers to care for a Commercial member 1 to 64 years of age for a year.



No Risk- FFS



Professional Risk Only



**Full Risk-
Professional & Facility Capitation**

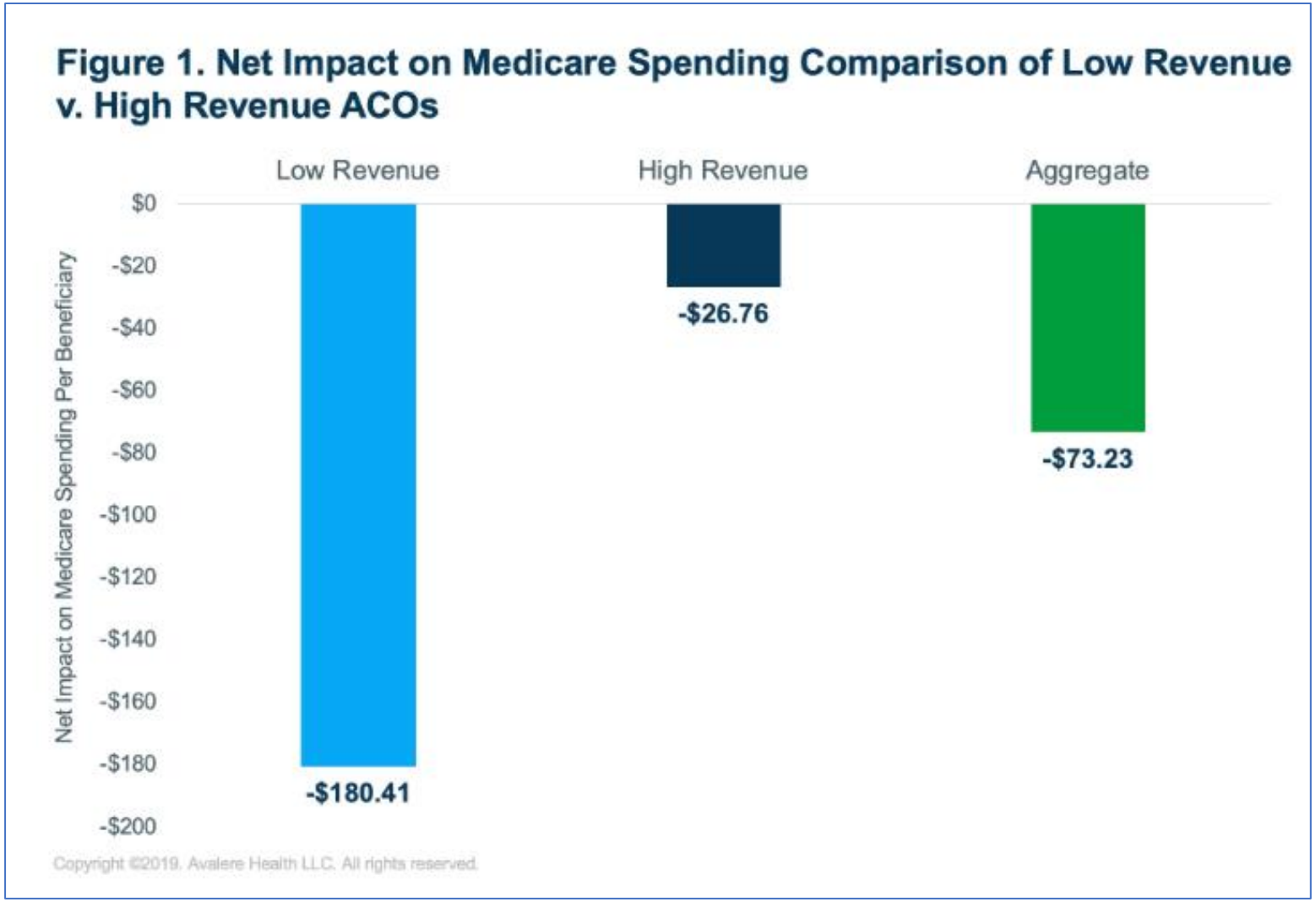
Total cost of care varies by APM arrangement and geography. In 2021, the total cost of care in FFS arrangements varied by region and was lower in parts of southern California.

Attributes of Successful APMs

Why it's important:

APM results are mixed. Its critical to understand the factors that contribute to success, share them, and replicate.

Low revenue ACOs, which are more likely to be led by physician organizations, were more likely to lower costs. This suggests high revenue ACOs, which are more likely to be led by hospitals, may face conflicting incentives.



Avalere Health, Physician-Led Accountable Care Organizations Outperform Hospital-Led Counterparts, 2019.

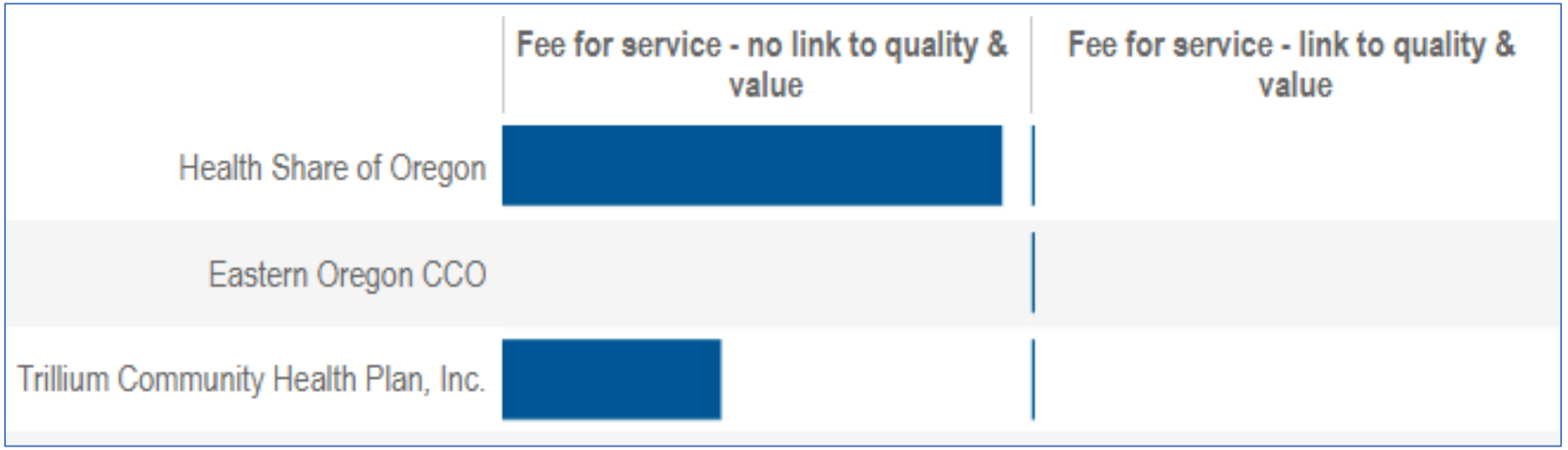
APMs to Support Primary Care Delivery

Why it's important:

Experts recommend supporting primary care through flexible, predictable, and prospective revenue. Reporting these payments by provider organization offers transparency into the type of payment and amount received.

Some provider organizations in Oregon receive very few non-claims primary care payments. To support care transformation at these practices, payers may need to adapt their payments.

Non-claims primary care spending, by category



Oregon Health Authority. Primary Care spending in Oregon 2021, 2023.

Data to Support Use Cases

- A single data collection process can measure the volume of non-claims payments, quantify provider risk, and give insights into geographic variation.

- Performance over multiple data collection cycles can measure comparative performance, attributes of successful APMs, and stability of primary care non-claims revenue.

- As data collection matures, evaluating the movement from FFS to APMs may be pursued and give way to additional use cases.

Questions for Discussion

- What other use cases may be important to promote movement from FFS to APMs for equitable high-quality and cost-efficient care?
- Which use cases may be a lower priority?
- Are there any use cases where you have questions or would like to review in more detail?

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Categorizing APMs to Support California Use Cases

Mary Jo Condon, MPPA, Principal Consultant

Efforts to Measure Non-Claims Spending in California

Total Health Care Spending Target	• What is the purpose of non-claims spending? • What are we buying and is it high value?
Primary Care/Behavioral Health Investment Targets	• How much (non-claims) are we spending on PC/BH? • Does the payment structure support care delivery goals?
Alternative Payment Model Adoption	• How much risk are providers taking on? • Is it improving care delivery, value and equity?
Health Care Payments Database	• How does total cost of care vary by provider organization and service type?

We Are Seeking Input On

- Based on your knowledge of California APM arrangements, will the following framework capture these types of payments?
- What type of guidance will be helpful to payers to accurately categorize payments?

Two National Frameworks for Categorizing Non-Claims Payments/APMs

HCPLAN
Health Care Payment Learning & Action Network

Milbank Memorial Fund
Using evidence to improve population health

Milbank Memorial Fund

Year: 2021

Developer: Bailit Health, with support from Milbank

Purpose: Support states in categorizing non-claims payments. It initially aimed to measure non-claims primary care spend. States have refined it to categorize all non-claims spending to support tracking total health care spending. It works well for identifying the purpose and structure of payments.

Example: If total spending went up more than desired, why? If due to an increase in primary care salaries, that may drive a different policy conversation than if due to case rates for hospital services.

Table 1: Categories of Non-Claims-Based Primary Care Spending

Category	Subcategory
1. Prospective capitated case rate, or episode-based payments	• Capitation payments • Global budget payments • Prospective case rate payments • Prospective episode-based payments
2.Primary care performance incentive payments	• Risk-based payments (shared savings distributions, shared risk recoupments) • Retrospective/prospective incentive payments (pay-for-performance, pay-for-reporting)
3. Payments for primary care provider salaries	• Provider salary payments (physician and nonphysician)
4. Payments to support population health and practice infrastructure	• Care management/care coordination/population health • Electronic health records/health information technology infrastructure and other data analytics payments • Medication reconciliation • Patient-centered medical home recognition payments • Primary care and behavioral health integration
5. Recovery	• Recoveries, or payment received that are later recouped by the payer
6. Other payments	• Other, such as governmental payer shortfall payments, grants, or other surplus payments.

Health Care Payment Learning and Action Network

Year: 2016, updated in 2017

Developer: HCP-LAN, a collaboration of Centers for Medicare and Medicaid Services (CMS) and large national payers

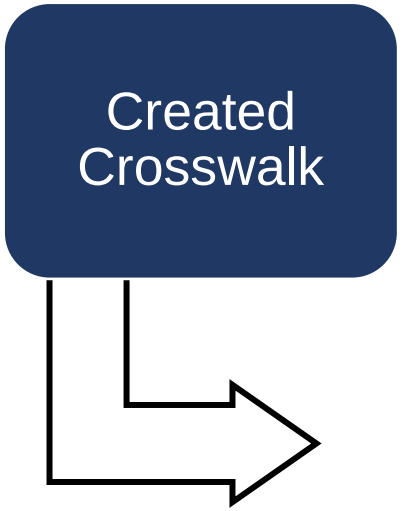
Purpose: Support payers and states in categorizing alternative payment models to support clarity and accountability in contracting terms and measurement of APM adoption.

Example: If a contract requires movement to value-based care, how will we define it? How will we measure progress?

HCP-LAN APM Framework

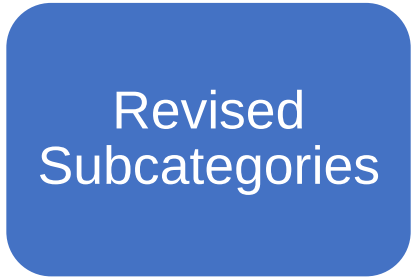
Category 1	Category 2	Category 3	Category 4
FEE FOR SERVICE- NO LINK TO VALUE	FEE FOR SERVICE- LINK TO QUALITY & VALUE	APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	POPULATION-BASED PAYMENT
	A	A	A
	Foundational Payments for Infrastructure & Operations	APMs with Shared Savings	Condition-Specific Population-Based Payment
	B	B	B
	Pay for Reporting	APMs with Shared Savings and Downside Risk	Comprehensive Population-Based Payment
	C		C
	Pay-for-Performance		Integrated Finance & Delivery System
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

Developing a California Option



Developed a crosswalk to show how the Milbank and HCP-LAN frameworks could be overlaid

Updated the payment categories to reflect common payment types in California; informed by IHA Atlas



Revised structure to show risk progression and payment purpose

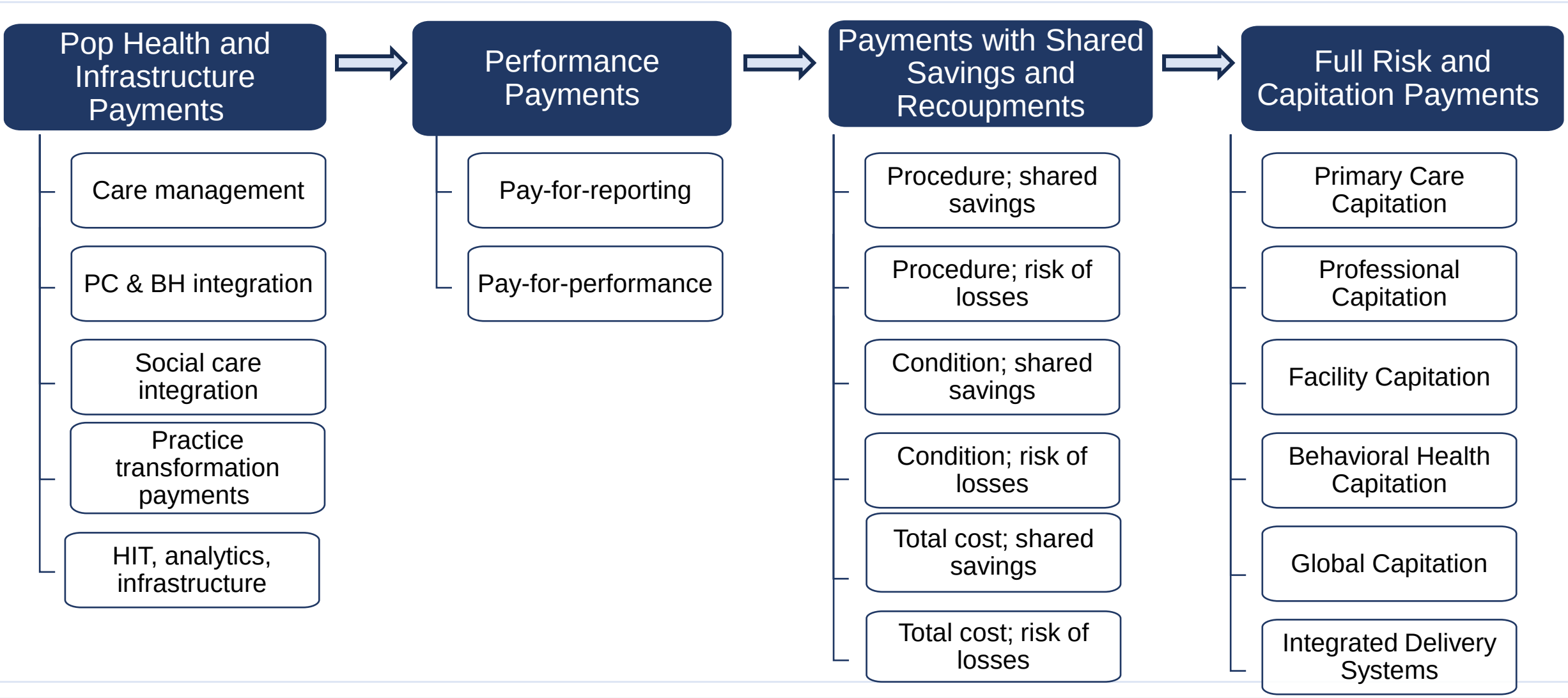
Draft Unified Framework Crosswalks Milbank and HCP-LAN

#	Milbank Non-Claims-Based Payment Categories and Subcategories Modified to Reflect California Care Delivery	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
4.	**Capitation and Full Risk Payments**	
a.	Primary Care Capitation	4A
b.	Professional Capitation	4A
c.	Facilty 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**	**N/A**
6	**Pharmacy Rebates**	**N/A**
	Total Non-Claims Payments	

Purpose of Unified Framework

- Update Milbank categories and subcategories to reflect care delivery in California
- Allow single framework to support multiple use cases
  - Define payment purpose
  - Measure provider risk
- Crosswalk Milbank categories with HCP-LAN categories
- Data collection tool designed to capture non-claims payments and portion of total spend by level of provider risk

Draft Unified Framework for Discussion



Questions for Discussion

- Thoughts on the framework presented?
- Are these the right categories and subcategories? Is anything missing?
- What type of guidance will be helpful to payers to accurately categorize payments?

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Introduction to Health Equity in APM Measurement

Robert Seifert, MPA, Consultant

Payers and Health Plans Are Addressing Equity in APMs By:

- Elevating equity as a goal and developing strategies to achieve it
- Adding flexibility to provide supplemental benefits
- Developing screening tools and quality measures
- Improving data collection
- Adjusting payments

We Are Seeking Input On

- How to incorporate equity into APM measurement and reporting?
- Whether to adjust for differences in health status and/or social needs when measuring and reporting APM results?
- Which APM contracting terms accelerate adoption of APMs that encourage high quality, equitable care?

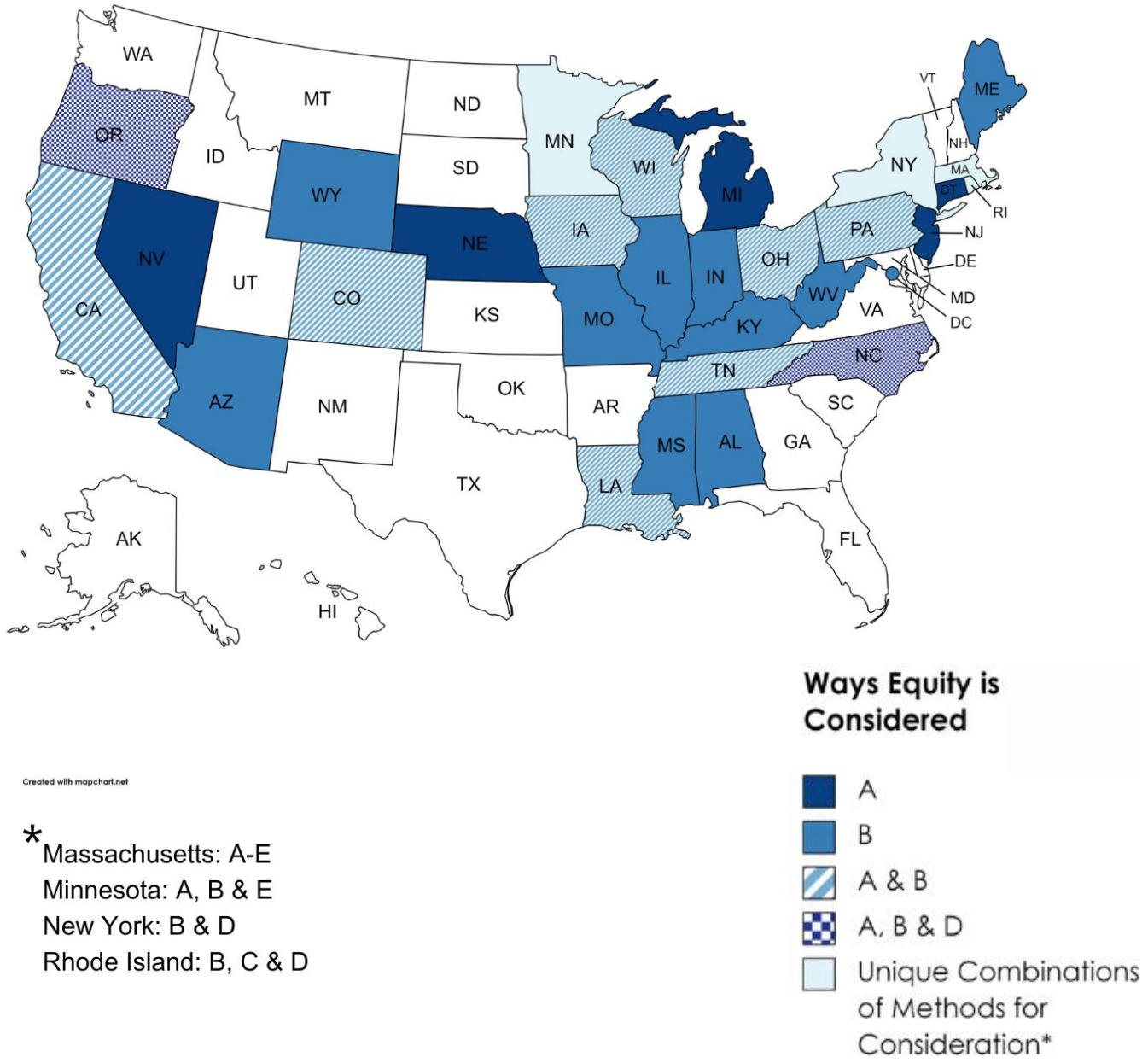
Examples of Adjusting Payment for Equity

- State strategies to improve completeness of Medicaid data
  - Requirements that managed care organizations collect data from members, and other approaches to improve the completeness of demographic data (for example, RELD-SOGI*) needed to measure equity
- Payment for SDOH screening
  - Quality metrics for ACOs related to screening members for social risks
- Payments for SDOH services or partnerships
  - Incentives or requirements for health plans to partner with community organizations
- Social needs risk adjustment
  - Value-based payment adjusted to account for social factors, in addition to clinical and demographic

*Race, Ethnicity, Language, Disability - Sexual Orientation & Gender Identity

Where is Equity Considered in APM Payment and Measurement?

Ways Equity is Considered	
A	Medicaid MCO financial incentives[1]
B	State strategies to improve completeness of Medicaid race, ethnicity, and language (REL) data[1]
C	Payment for SDOH screening[2]
D	Payments for SDOH services/partnerships[3]
E	Social needs risk adjustment[4]



*Massachusetts: A-E
Minnesota: A, B & E
New York: B & D
Rhode Island: B, C & D

1. Kaiser Family Foundation. How the Pandemic Continues to Shape Medicaid Priorities: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023. 2022.
2. Milbank Memorial Fund. Marrying Value-Based Payment and the Social Determinants of Health through Medicaid ACOs: Implications for Policy and Practice. 2020.
3. Milbank Memorial Fund. How are Payment Reforms Addressing Social Determinants of Health? Policy Implications and Next Steps. 2021.
4. State Health Access Data Assistance Center at the University of Minnesota. Risk Adjustment Based on Social Factors: State Approaches to Filling Data Gaps. 2020.

Examples from Other States: Medicaid

- Most state activity is in Medicaid programs
  - Payments for SDOH screening (MA, RI)
    - Majority of states with Medicaid managed care require screening and referral for social needs
  - Equity incentives
    - Withholds (LA, MI)
    - Risk corridor adjustments (MN)
    - P4P (CT, PA, MA)
    - Medical Loss Ratio expenses (NC)
    - Requirements to develop VBP strategies that address health equity (NE, NV, NC)
  - Payments for SDOH services/partnerships (NC, NY, MA, RI, OR)
  - Social needs risk adjustment (MN, MA)

Examples from Other States: Medicare and Commercial

- Medicare
  - HEART (Health Equity Advancement Resource and Transformation) Payments (MD): PMPM payment to Maryland Primary Care Program participants for patients with high medical complexity living in an area with high Area Deprivation Index
- Commercial
  - Blue Cross and Blue Shield of MA: Provider contracts reward reductions in disparities
  - Blue Cross and Blue Shield of KC: Pay for SDOH screening

Lessons Learned from Other States

- **RELD/SOGI Data Incomplete:** Incentives introduced to improve collection and completeness; results TBD
- **Limited Evidence**: SDOH requirements, incentives for ACOs and MCOs are new
- **Wide Variation**: Requirements and goals vary across states
- **"Bridge to Nowhere"**: Under-resourced social service systems may lack capacity to deliver the services indicated by screening
- **Provider buy-in essential and complex**: They appreciate flexibility and dollars to address social needs, but limited capacity and resources
- **Adjustments needed but tricky**: Adjusting for social risk avoids penalizing those caring for high-need, high-cost patients without compromising the standard of care for those with social needs
- **Misaligned incentives**: As in many areas of health care, the benefits of addressing health disparities and promoting health equity will be dispersed across the health care system and may not accrue to those who made the investments.

Freedman HealthCare analysis of state reports and data collection materials

Considerations for California

- Align with ongoing work across state agencies
- APMs can be a vehicle for investing in social needs to promote health equity
- APM contracting standards
  - Could incorporate screening for social needs *plus* investments to address the need
- Measurement will evolve as data improve
  - Analysis by geography
  - Assessing quality and cost by demographic factors
  - Social risk adjustment

Questions for Discussion

- How to incorporate equity into APM measurement and reporting?
- Whether to adjust for differences in health status and/or social needs when measuring and reporting APM results?
- Which APM contracting terms accelerate adoption of APMs that encourage high quality, equitable care?

Adjournment

Margareta Brandt, MPH, Assistant Deputy Director

Health System Performance

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Appendix
Examples of State Developed Solutions to Categorize APMs

Examples of State Developed Solutions

New York State Roadmap for Medicaid Payment Reform

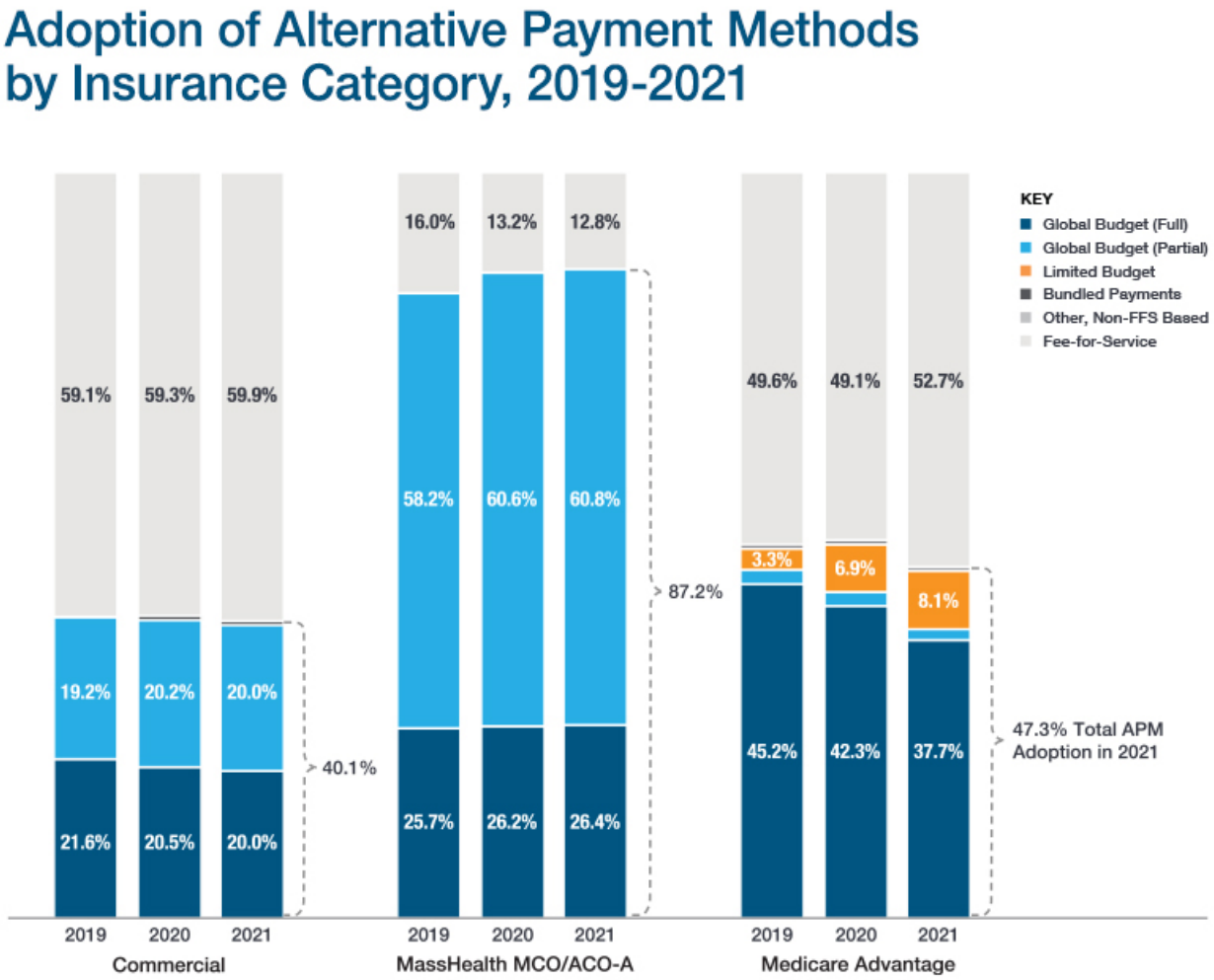
Initially designed in 2012 and updated in 2019, the Roadmap supports the New York Medicaid program in its goal of moving 80% to 90% of payments to providers to value-based methodologies.

Options	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature VBP contractor)
Total Care for General Population	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings when quality scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	Global capitation (with quality-based component)
Integrated Primary Care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM add-on) with upside- only shared savings based on bundle of care (savings available when quality scores are sufficient)	FFS (plus PMPM add-on) with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	PMPM capitated payment =(with quality-based component)
Maternity Care	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (savings available when quality scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	Prospective bundled payment (with quality-based component)

Examples of State Developed Solutions

Massachusetts Center for Health Information and Analysis (CHIA)

CHIA developed its non-claims payment categories to support total cost of care data collection and APM adoption.



New York State Department of Health Medicaid Redesign Team, A Path toward Value Based Payment: Annual Update, 2019

Examples of State Developed Solutions

Integrated Healthcare Association (IHA)

IHA developed APM categories to support its Cost and Quality Atlas.