HCAi
Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

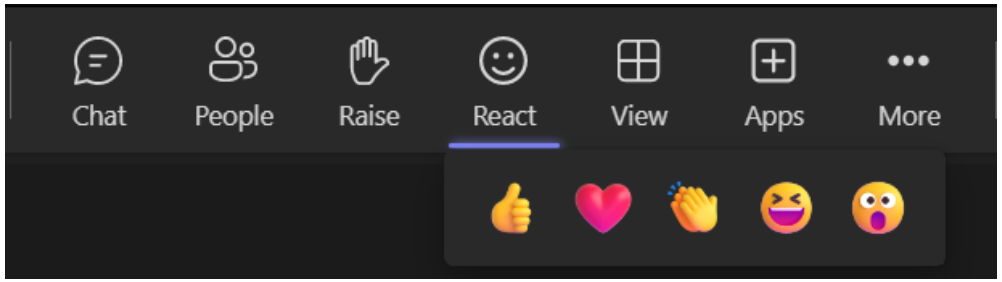
September 20, 2023

Agenda

9:00 a.m.	**1. Welcome and Updates**
9:15 a.m.	**2. Discuss Draft Alternative Payment Model (APM) Standards and Implementation Guidance**
9:45 a.m.	**3. Discuss Defining APMs and Developing Adoption Goals**
10:30 a.m.	**4. 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, September 20, 2023

Time
9:00 am PST

Microsoft Teams Link
for Public Participation:

Meeting ID: 231 506 203 671
Passcode: XzTN6r

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

Conference ID:
261 055 415#

Investment and Payment Workgroup Members

Providers & Provider Organizations

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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
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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

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State & Private Purchasers

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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

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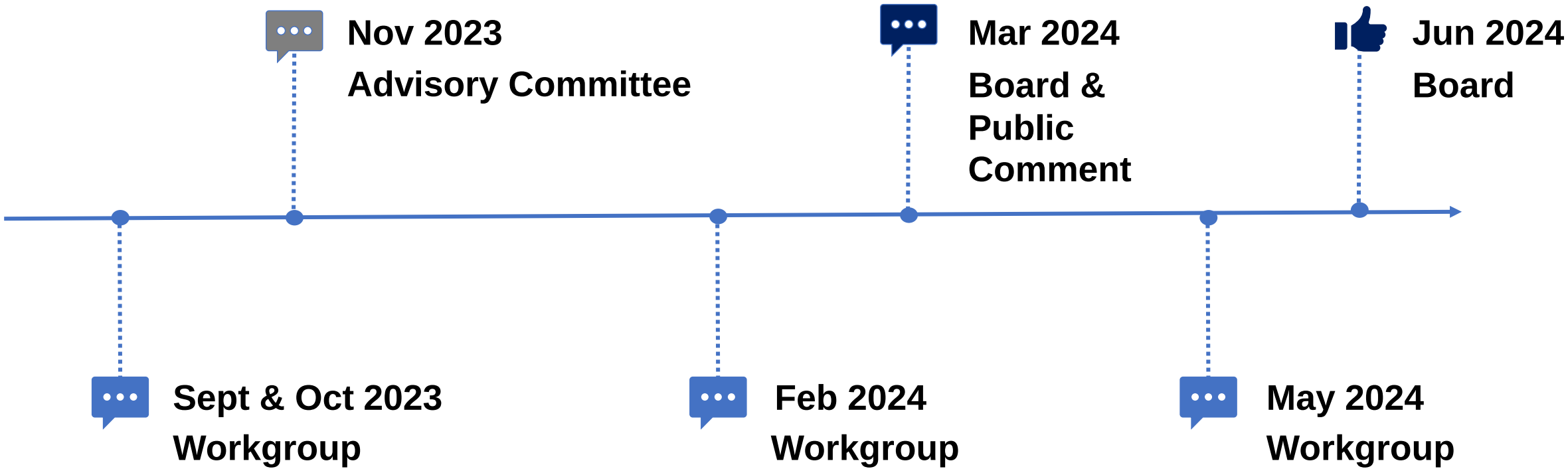
Principal Program Manager, Industry Initiatives, Blue Shield of California

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

Timeline Update for APM Adoption



Between each meeting, OHCA and Freedman HealthCare will revise draft APM standards, definitions, and goals based on feedback.

Timeline Update for Primary Care

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

Primary Care Subgroup

Purpose: Begin work on more technical aspects of primary care measurement to support full workgroup discussions beginning in November. Subgroup recommendations will be brought to the full workgroup for discussion.

Examples of Topics: Defining the services and providers included as primary care; accounting for differences in populations and plan design

Two Proposed Meeting Dates: Wednesday, 11/1 and Wednesday, 12/6 from 9:00-10:30 AM

How to Sign Up: Interested workgroup members may join one or both subgroup meetings. Email Margareta Brandt at margareta.brandt@hcai.ca.gov

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Discuss Draft APM Standards and Implementation Guidance

Margareta Brandt, Assistant Deputy Director

Mary Jo Condon, Principal Consultant

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.

Standards for 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.

Health and Safety Code 127504(a-d)

Standards for Alternative Payment Models

Additional Statutory Guidance for Standards

The standards for alternative payment models shall focus on:

- Encouraging and facilitating multi-payer participation and alignment
- Improving affordability, efficiency, equity, and quality by considering current best evidence for strategies such as quality-based or population-based payments
- Including minimum criteria for alternative payment models but be flexible enough to allow for innovation and evolution
- Aligning with the quality and equity measures used in the OHCA quality and equity measure set to the extent possible
- Addressing appropriate incentives to physicians and other providers and balancing measures, including total cost of care and quality, access, and equity to protect against perverse incentives and unintended consequences
- Attempting to reduce administrative burden by incorporating APMs that facilitate multi-payer participation and align with other state payers and programs or national models

Objective and Criteria for APM Standards

Objective: Develop a set of contracting standards that health care entities can use as best practices to facilitate adoption of APMs, enhance alignment with other state initiatives, and promote equitable, high-quality, and cost-efficient care.

Criteria to Guide APM Standards Development:

- Support transition to value-based payment that incentivizes high-quality, equitable, and cost-efficient care
- Relevant across markets (commercial, Medi-Cal, Medicare Advantage) and products (HMO, PPO, EPO)
- Based on state and national research and experience
- Applicable to a wide range of providers
- Useful to purchasers, payers, and providers
- Reflect California's varied market and delivery system
- Informed by stakeholder input

Approach to APM Standards and Implementation Guidance

Standards

- Best practices to approach contracting decisions that are common across APMs
- Strategic, not tactical or prescriptive
- Grounded in evidence

Implementation Guidance

- Supplement the standards
- Provide specific actions health care entities can take to meet the standard
- Offer examples of successful APM implementation related to the standard

Draft APM Standards

1. **Use prospective, budget-based, and quality-linked payment models** when possible.
2. **Be transparent** with providers in all aspects of payment model design and terms including attribution and performance measurement.
3. **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.
4. **Measure performance** using a focused set of nationally-standardized and locally adopted measures and technical specifications.
5. **Collect demographic data**, including RELD-SOGI* data, to enable stratifying performance.
6. **Use data to address inequities** in access and outcomes.
7. **Equip providers with actionable data** to inform population health management and enable their success in the model.
8. **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).

Example of Implementation Guidance

1. **Use prospective, budget-based, and quality-linked payment models** when possible.

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].

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. HCP-LAN classifies these models as Category 3A and 3B.

1.3 Design core model components 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 Centers for Medicare and Medicaid Services (CMS) published reports on models.

Basu S, Phillips RS, Song Z, Bitton A, Landon BE. High Levels Of Capitation Payments Needed To Shift Primary Care Toward Proactive Team And Nonvisit Care. Health Aff (Millwood). 2017 Sep 1;36(9):1599-1605. doi: 10.1377/hlthaff.2017.0367. PMID: 28874487.

Vision of APM Standards Success

Stakeholders Endorse

- Health care entities, purchasers commit to use standards to inform future contracting

Alignment Increases

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

Performance Improves

- Standards result in increased APM adoption
- Performance on measures of quality, equity, and affordability improve

Questions for Discussion

- Do these draft APM standards resonate? Are any important concepts missing?
- How can “implementation guidance” best support stakeholders?
- How could OHCA promote broad use of the standards?

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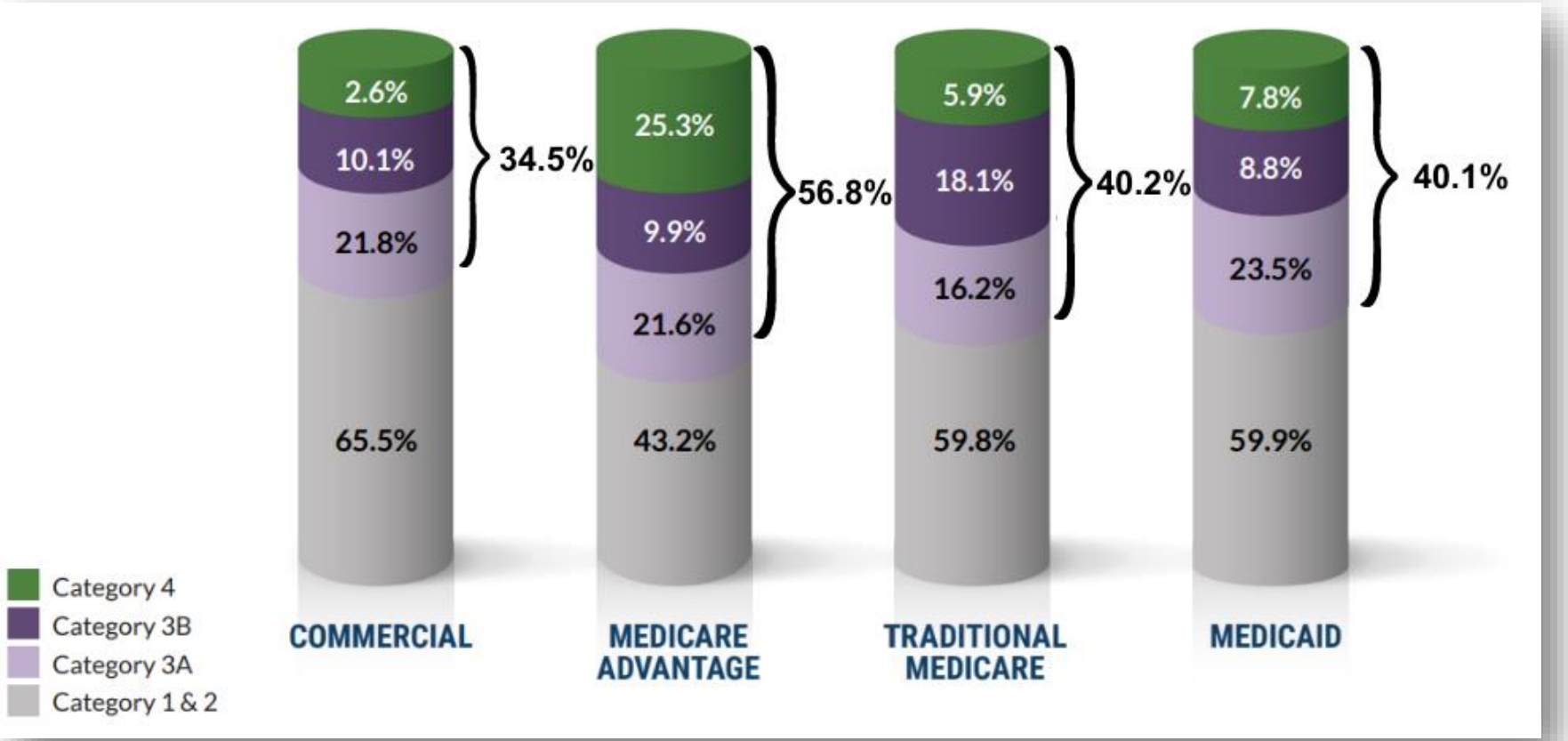
Discuss Defining APMs and Developing Adoption Goals

Mary Jo Condon, Principal Consultant, FHC

Dolores Yanagihara, Vice President, IHA

APM Adoption Nationally



In 2021, the percent of payments going to HCP-LAN Categories 3 and 4 varied by payer type.

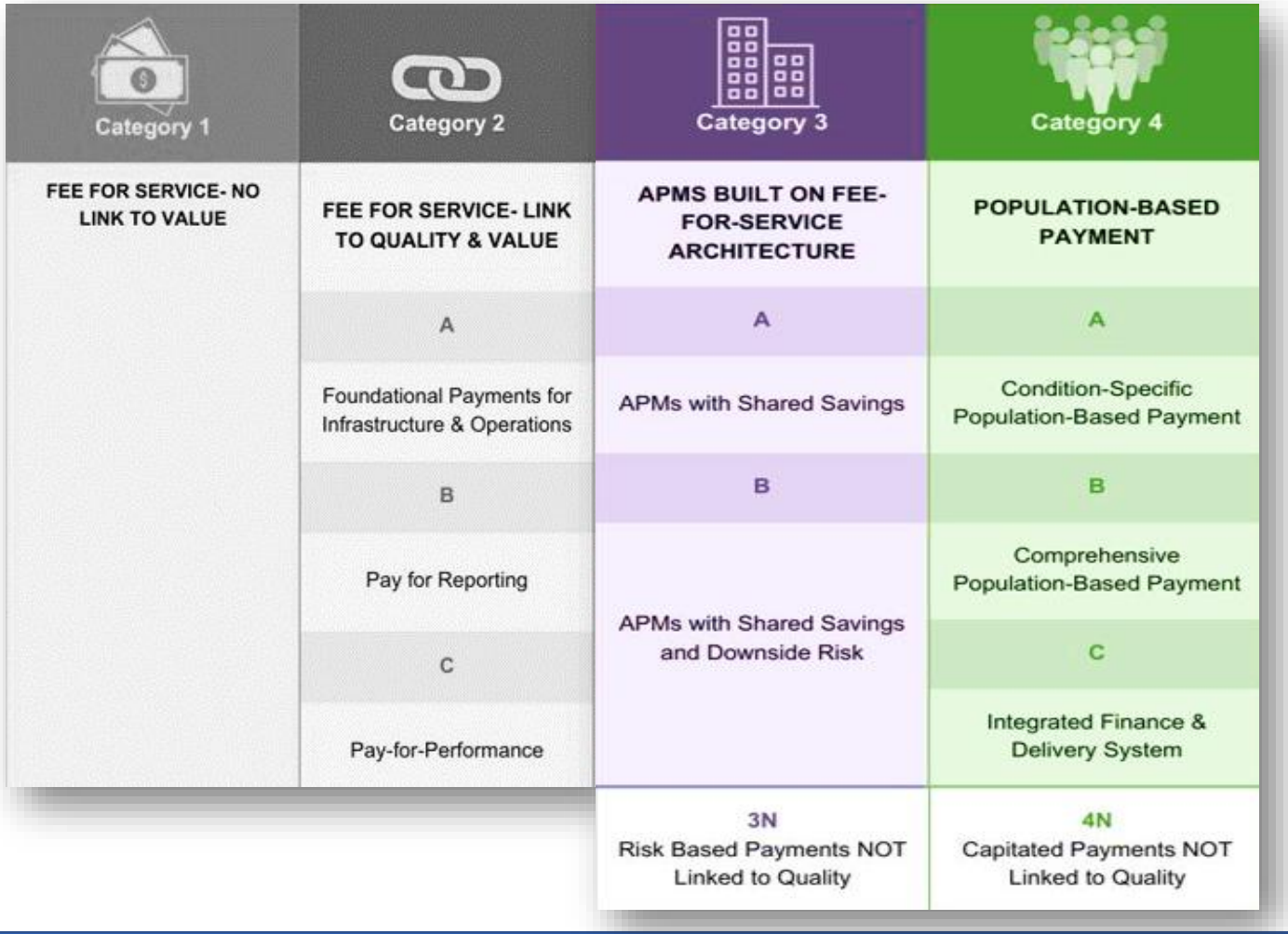
Less than 35% of commercial payments flowed through these categories compared to about 40% for Medicaid and Traditional Medicare. Medicare Advantage plans reported 57% of payments flowing through these categories.

Health Care Payment Learning and Action Network Framework

States, payers, and other stakeholders frequently use the HCP-LAN framework to measure APM adoption.

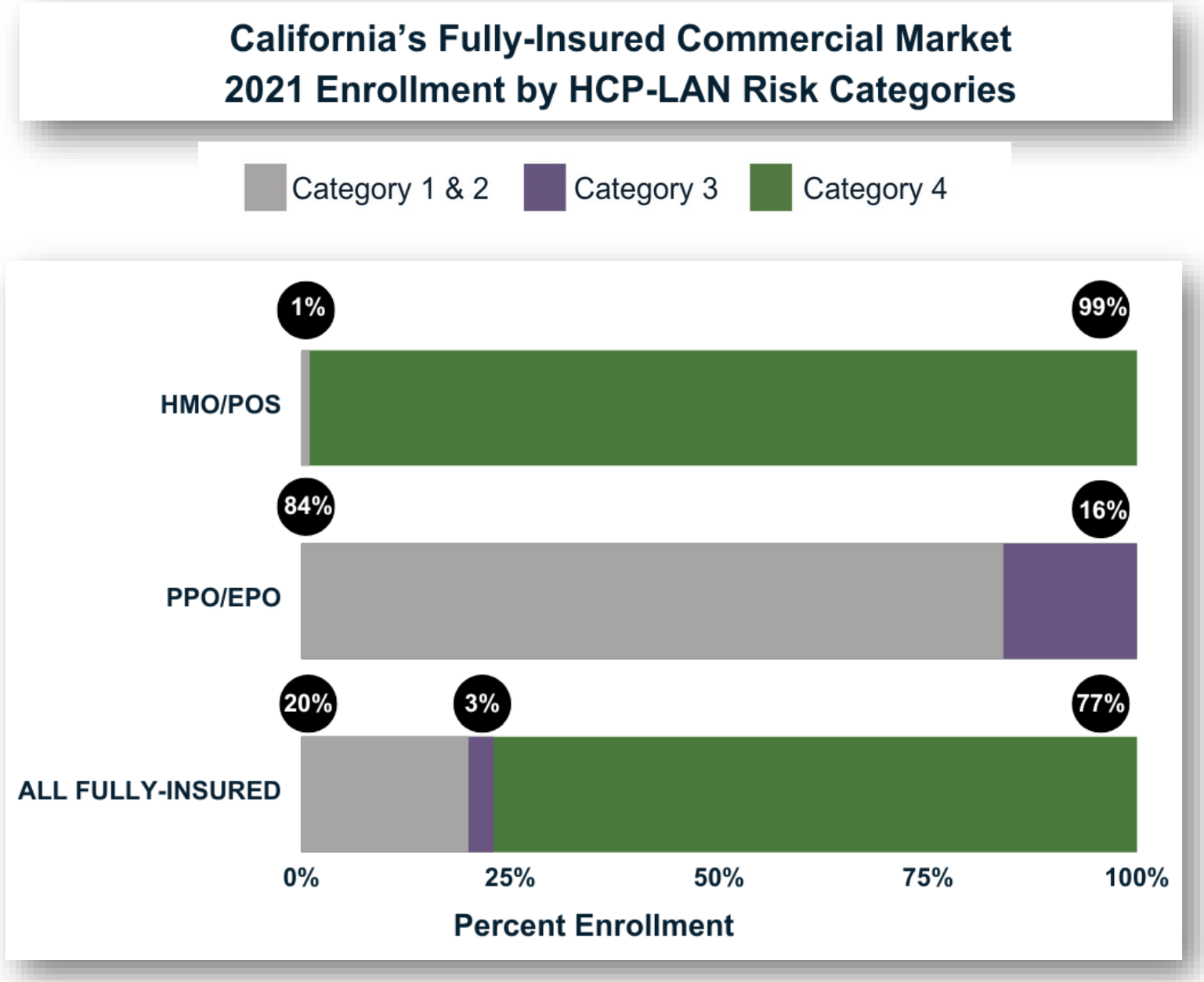
OHCA plans to collect data using the Expanded Framework and crosswalk to HCP-LAN.

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.



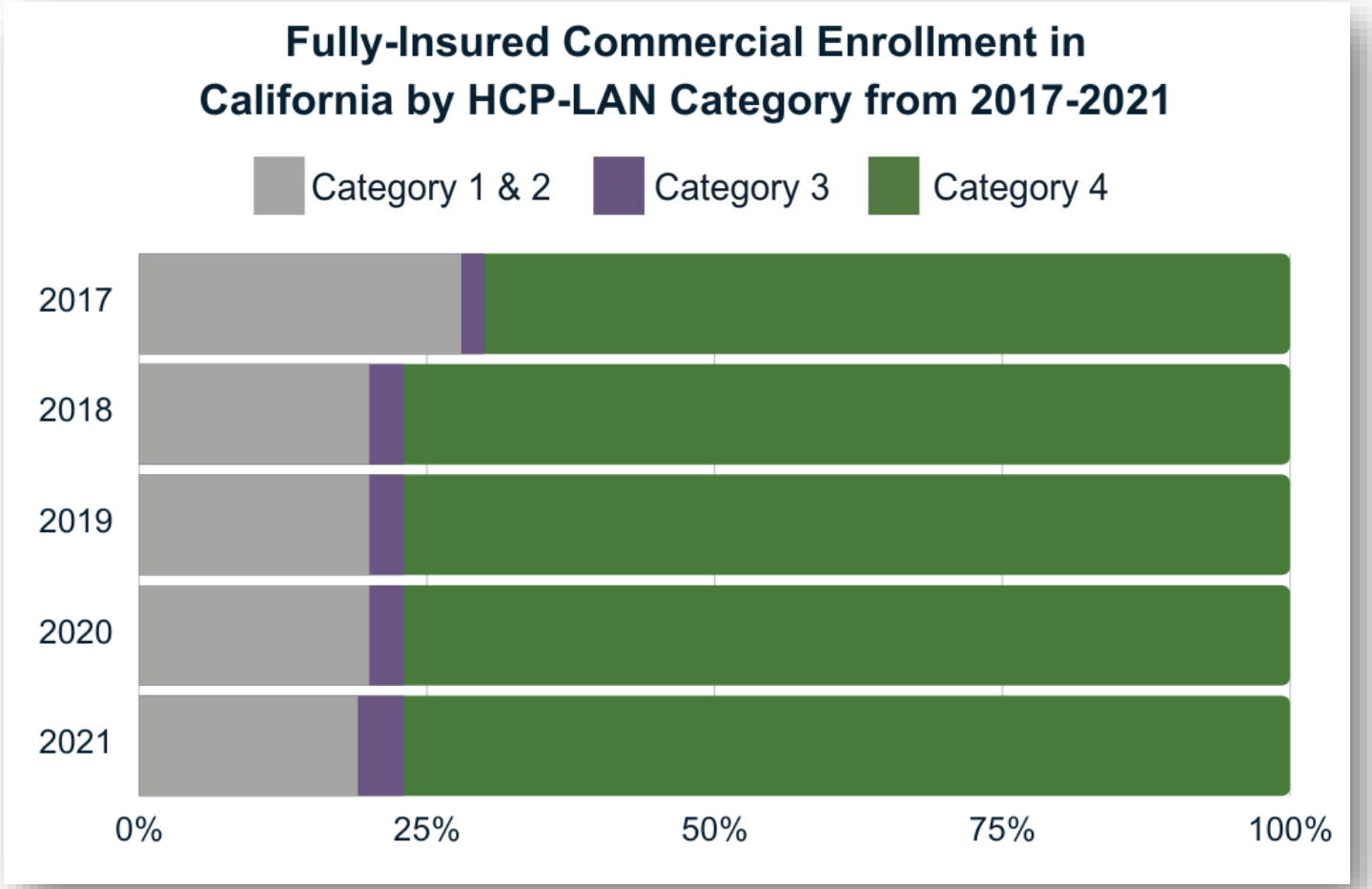
Commercial APM Adoption in CA

APM adoption among the fully-insured population in California is more than 75 percent, far higher than commercial plans nationally.



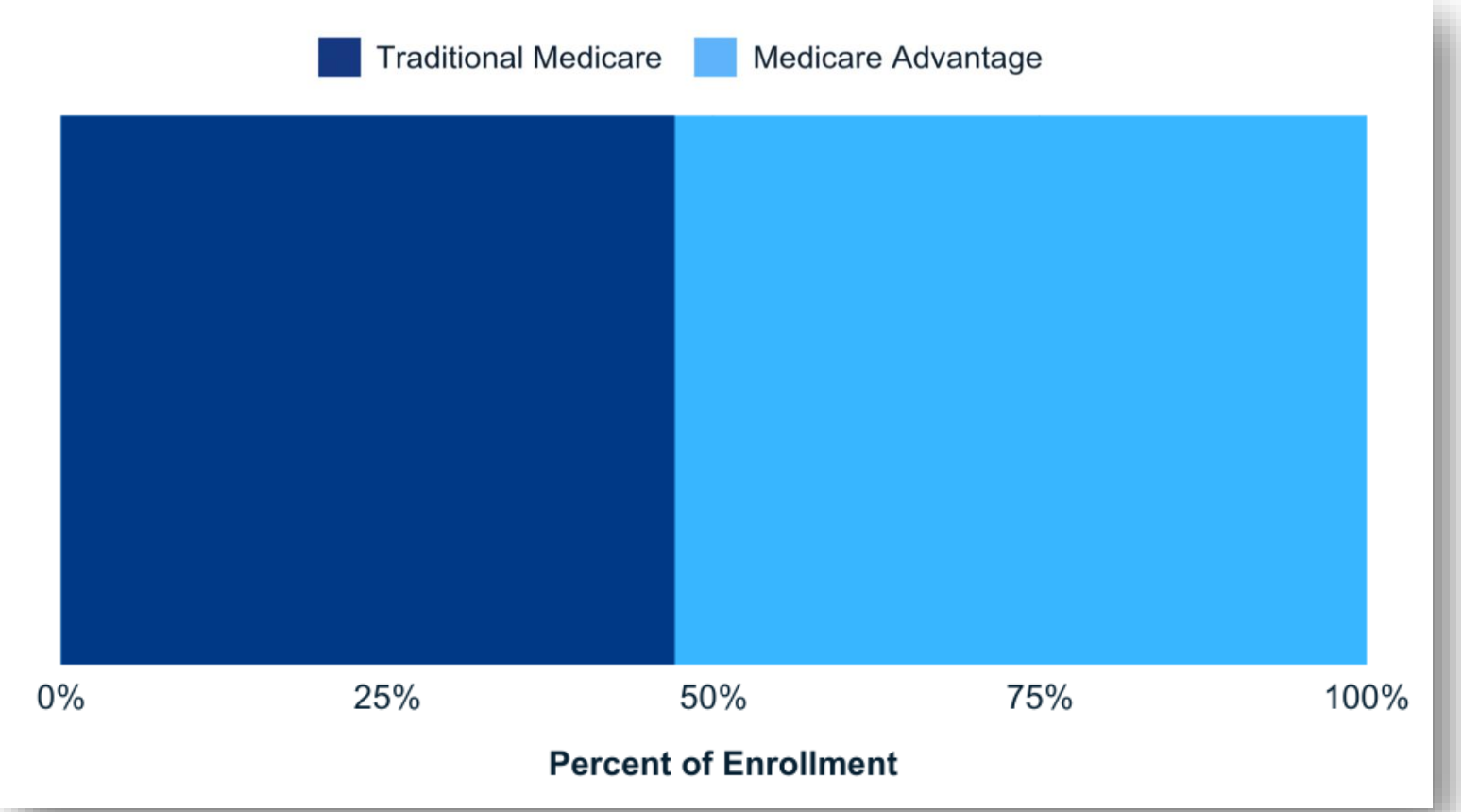
Commercial APM Adoption Stable

- APM adoption has been largely stable among California's commercial, fully-insured over the past five years.
- One unknown is the percent of Category 4 APMs *not tied to quality (4N).*



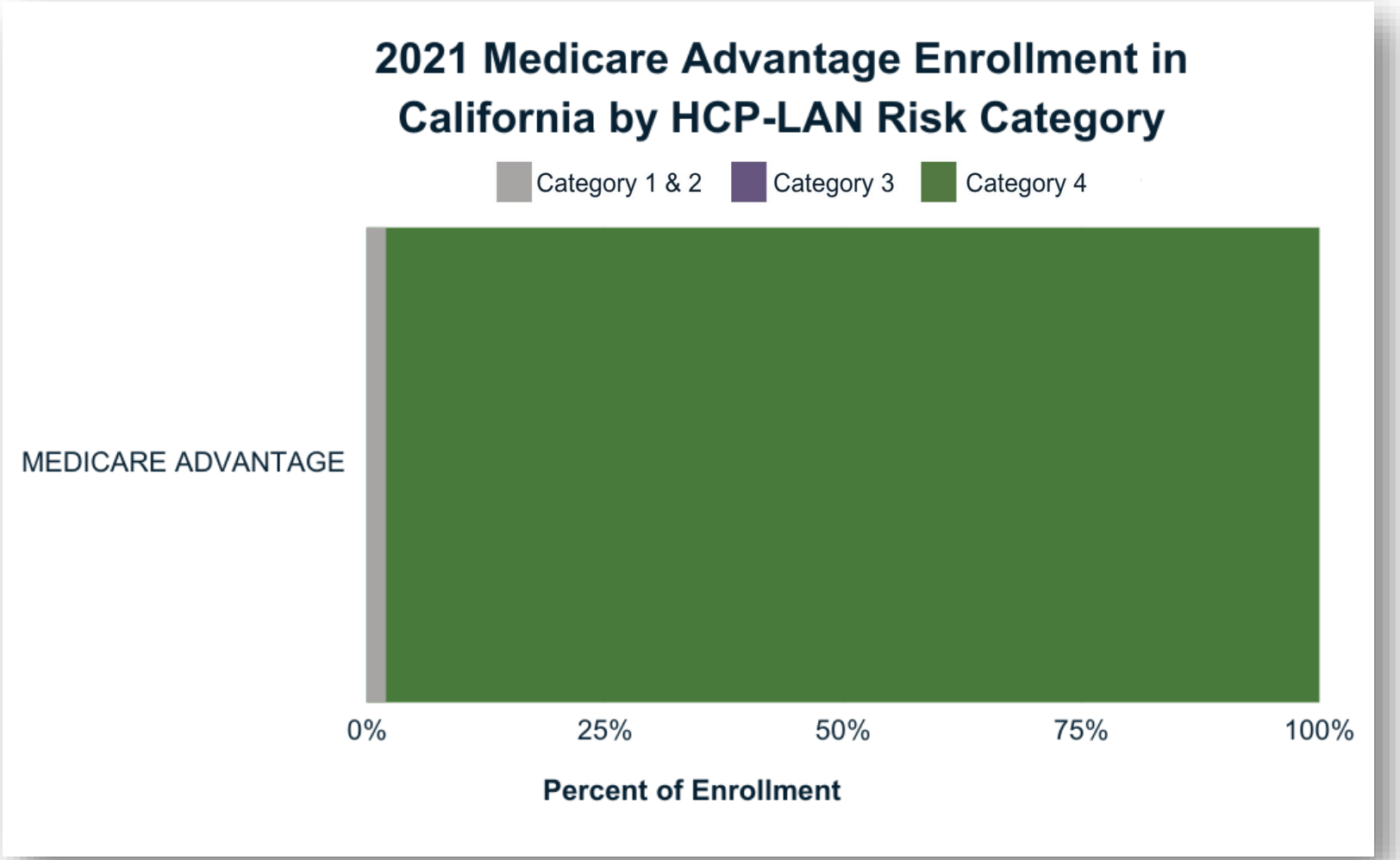
California Medicare Enrollment by Plan Type

In 2021, just under half of California Medicare beneficiaries participated in Traditional Medicare. The rest were enrolled in a Medicare Advantage plan.



Medicare Advantage APM Adoption in CA

Approximately 98% of California Medicare Advantage beneficiaries were enrolled in a risk arrangement in 2021.



Medicare Shared Savings Program (MSSP)

In California in 2021:

- All ACOs that earned shared savings were considered low revenue, which typically means they are owned by physicians
- *All* participating ACOs met CMS's quality performance standards

Strong performance in MSSP can signal readiness to take on more advanced risk sharing arrangements with CMS and other payers.

	Low Revenue	High Revenue
One-Sided (3A)	12	4
Two-Sided (3B)	7	4
Number of ACOs earning "shared savings"	12	0
Quality Score Range	62 - 99%	90 - 96%

Achieving APM Adoption Goals in Traditional Medicare

Medicare Shared Savings Program

- Largest ACO initiative
- Permanent program
- Over 400k CA beneficiaries
- 2024 changes aim to increase enrollment, especially among new provider entrants

Realizing Equity, Access and Community Health

- New program (2023-2026); replaces Direct Contracting
- Professional or global risk
- Focus on health equity, particularly in underserved communities
- 2024 changes aim to improve predictability, risk adjustment and further health equity

CMS Goal: 100% of Traditional Medicare and Medicare Advantage in APM (HCP-LAN 3b or 4) by 2030

Centers for Medicare and Medicaid Services, 2023; Kaiser Family Foundation, 2023

APM Adoption Goals

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.**

Health and Safety Code 127504(a-d)

Role of Definitions in Process

- An early step in developing APM adoption goals is defining “what counts” as an APM.
- Definitions may require payment models meet certain conditions to be included toward adoption goals.
- These definitions can include language to help ensure APMs align with contracting standards and support quality, affordability, and equity goals.

Key Design Decisions for Developing APM Definitions and Goals

Definitions

- Require alignment with certain programs?
- Require APMs include a tie to quality performance?
- Require APMs include a certain level of risk sharing? Allow that risk sharing to vary by type of provider?
- Require APMs include a certain amount of prospective payment?

Goals

- Which HCP-LAN categories should be included?
- Should goals vary by payer or product type?
- What unit of measurement (e.g., members, dollars, providers) should goals be based on?
- How should goals be structured?

What Counts? Defining APMs to Promote High-Quality, Cost-Efficient Care

Below are examples of states with APM adoption goals and how they defined what was required for an APM to be counted toward the goal.

Definition Strategy	Example
Align with CMS programs	**Delaware**: HCP-LAN 3A and 3B models must align risk sharing, risk corridors, and other key design features with MSSP Pathways[1]
Tie to quality performance	**HCP-LAN:** Risk-based payments not linked to quality (3N and 4N) not considered "advanced" APMs or counting toward APM goals[2]
Appeal to a wide range of providers	**Rhode Island**: Allows payment models to require less risk sharing for low-revenue (physician-led) ACOs than high-revenue ACOs (health system led)[3,4]
Support new entrants	**Oregon:** Coordinated Care Organizations must make prospective, foundational infrastructure, and operations payments to primary care medical home clinics[5]

1.18 DAC 1322 8.2
2.Health Care Payment Learning & Action Network (HCPLAN), 2022
3.RI Affordability Standards Policy Manual, 2022
4.Bailit Health. Minimum Downside Risk Report and Recommendations: Prepared for the RI Office of the Health Insurance Commissioner, 2016
5.Oregon Health Authority. Value-Based Payment Technical Guide: for Coordinated Care Organizations, 2022

National HCP-LAN APM Adoption Goals

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2018	8%	11%	24%	18%
2021	17%	13%	35%	24%
2024	25%	25%	55%	50%
2025	30%	30%	65%	60%
2030	50%	50%	100%	100%

HCP-LAN bases its APM adoption goals on Category 3B and 4 only.

Nationally, commercial and Traditional Medicare payers will need to nearly double APM adoption from 2021 to 2024 to achieve the HCP-LAN goals.

Examples of APM Adoption Goals in California

- **Public Purchaser Alignment[1]:** Covered California (2023), CalPERS (HMO 2024), and Department of Health Care Services (2024) will require contractors to “adopt and progressively expand the percentage of primary care clinicians paid” through HCP-LAN Categories 3 and 4.
- **Covered California[2]:** Covered California has a series of stairstep goals and penalties to promote greater adoption. For example, by 2025, it will require contractors have at least 70% of primary care providers contracted under a Category 3 or 4 APM to avoid a penalty.
- **Department of Health Care Services[3]:** Medi-Cal 2020 waiver required 60% of enrollees assigned to public hospitals receive care under an APM.

[1]California Public Purchaser Contract Provisions on Primary Care, Primary Care Investment Coordinating Group of California, 2023.
[2]Attachment 2, Covered California, 2023-2025 Individual Market QHP Issuer Contract
[3]Public Hospital Redesign & Incentives in Medi-Cal Program, Department of Health Care Services, 2023

Where to Set the Bar? Designing APM Adoption Goals

Below are examples of states with APM adoption goals and how they approached various design decisions.

Design Decision	Example
Which HCP-LAN categories should be included?	**NY Medicaid**: 80% of MCO spend in Level 1 (similar to HCP-LAN 3A); 35% of spend in Level 2 or higher (similar to HCP-LAN 3B)[1]
Should goals vary by payer type?	**HCP-LAN:** Separate targets for Medicaid, Commercial, Medicare Advantage, Traditional Medicare[2]
Should goals vary by product type (e.g., HMO/PPO)?	**AZ Medicaid:** Separate targets for AHCCCS Complete Care, Department of Child Safety Health Plan, and other plan types[3]
Which unit of measurement should goals be based on?	Adoption targets typically based on 1) percent spend tied to APM, 2) % members attributed to APM, and/or 3) % providers contracted under APM

1.New York State Medicaid Redesign Team. Value-Based Payment Update: New York State, 2022
2.Health Care Payment Learning & Action Network (HCPLAN), 2022
3.Bailit Health. Bailit Health's Recommendations to AHCCCs on ACOM 306 & ACOM 307, 2022

Structuring Goals

The percentages below are examples for discussion and do not reflect a recommendation.

Goal Structure	Example
Stairstep Improvement	Fifty percent of all payments to health care providers should be tied to an alternative payment model by 2026. This percentage should increase to 60% by 2027 and 70% by 2028.
Absolute Improvement	Seventy percent of all payments to health care providers should be tied to an advanced alternative payment model by 2027, defined as HCP-LAN Categories 3A, 3B, 4A, 4B, 4C.
Relative Improvement	The percentage of all payments to health care providers tied to an advanced alternative payment model should increase 10% annually.

Questions for Discussion

- Should goals focus on **advanced** APMs (Categories 3 and 4)?
- What are the trade-offs of basing goals on percent **spend** tied to APMs versus percent **members** attributed to APMs?
- Should goals vary by payer type (commercial, Medicare, Medi-Cal)? By product type (HMO, PPO)?
- What are the trade-offs of stairstep improvement, absolute improvement, and relative improvement goals?

Next Steps

September 2023

- Workgroup provides feedback on draft APM standards and implementation guidance
- OHCA & FHC develop draft APM definitions and goals

October 2023

- Workgroup provides feedback on draft APM definitions and goals

November 2023

- Advisory Committee provides feedback on draft APM standards, definitions, and goals

Adjournment

Margareta Brandt, MPH, Assistant Deputy Director

Health System Performance

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Appendix

Appendix - Expanded Framework, Categories A-C

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	2A
A2	Primary care and behavioral health integration	2A
A3	Social care integration	2A
A4	Practice transformation payments	2A
A5	EHR/HIT infrastructure and other data analytics payments	2A
B	**Performance Payments**	
B1	Retrospective/prospective incentive payments: pay-for-reporting	2B
B2	Retrospective/prospective incentive payments: pay-for-performance	2C
C	**Payments with Shared Savings and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	3A
C2	Procedure-related, episode-based payments with risk of recoupments	3B
C3	Condition-related, episode-based payments with shared savings	3A
C4	Condition-related, episode-based payments with risk of recoupments	3B
C5	Risk for total cost of care (e.g., ACO) with shared savings	3A
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B

Appendix - Expanded Framework, Categories D-F

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
D	**Capitation and Full Risk Payments**	
D1	Primary Care capitation	4A
D2	Professional capitation	4A
D3	Facility capitation	4A
D4	Behavioral Health capitation	4A
D5	Global capitation	4B
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C
E	**Other Non-Claims Payments**	
F	**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.