The California Office of Health Care Affordability's (OHCA) draft Alternative Payment Model (APM) adoption goals are based on the Health Care Payment Learning and Action Network (HCP-LAN) framework described in detail below. OHCA is proposing that only APM arrangements classified as HCP-LAN Categories 3A, 3B, 4A, 4B, and 4C count toward the goal.

Health Care Payment Learning and Action Network (HCP-LAN)

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 (APMs) according to the level of risk taken on by the provider organization to understand accountability in contracting terms and inform measurement of APM adoption.

Source: Health Care Payment Learning and Action Network. Alternative Payment Model (APM) Framework White Paper. Released July 11, 2017. https://hcp-lan.org/apm-framework/

Payers will submit data according to the Expanded Non-Claims Payments Framework (Expanded Framework) as part of the total health care expenditure (THCE) data collection. Freedman HealthCare supported the California Department of Health Care Access and Information in developing the Expanded Framework and associated definitions. It builds on the work of Bailit Health and the Milbank Memorial Fund and the HCP-LAN. The Expanded Framework organizes payments according to their purpose and then crosswalks them to the HCP-LAN Framework. OHCA will crosswalk the data after it is submitted to evaluate progress towards its APM adoption goal.

Draft Expanded Non-Claims Payments Framework

Year: 2023

Developer: Freedman HealthCare, on behalf of the California Department of Health Care Access and Information (HCAI)

Purpose: Provide a single framework to support multiple use cases including defining payment purpose and measurement of provider risk. Subcategories aim to reflect care delivery in California.

	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	Pay-for-reporting payment	2B
b	Pay-for-performance payment	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	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**	

*Descriptions of the corresponding HCP-LAN categories:

2A	Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
2B	Pay for Reporting: Bonuses for reporting data or penalties for not reporting data
2C	Pay for Performance: Bonuses for quality performance
3A	Shared Savings: Shared savings with upside risk only
3B	Shared Savings and Downside Risk: Episode-based payments for procedures and comprehensive payments with upside and downside risk
4A	Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health
4B	Comprehensive Population-based Payment: Global budgets or full/percent of premium payments
4C	Integrated Finance and Delivery Systems: Global budgets or full/percent of premium payments in integrated systems

Draft Definitions of Expanded Non-Claims Payments Framework

The Expanded Framework includes detailed definitions to support payers in categorizing payments. It also provides detail on how APMs will be considered "linked to quality" and the minimum thresholds for programs to be considered shared savings and downside risk programs linked to quality (HCP-LAN Category 3A and 3B) (indicated in *italics* in respective definitions).

#	Non-claims-based Payment Categories and Subcategories	Draft Definition	Corresponding HCP-LAN Category
1	**Population Health and Infrastructure Payments**	**Prospective, non-claims payments paid to healthcare providers or organizations to support specific care delivery goals; not tied to performance metrics. Does not include costs associated with payer personnel, payer information technology systems or other internal payer expenses.**	
a.	Care management/care coordination/population health/medication reconciliation	Prospective, non-claims payments paid to healthcare providers or organizations to fund a care manager, care coordinator, or other traditionally non-billing practice team member (e.g., practice coach, patient educator, patient navigator, pharmacist, or nurse care manager) who helps providers organize clinics to function better and helps patients take charge of their health.	2A
b.	Primary care and behavioral health integration	Prospective, non-claims payments paid to healthcare providers or organizations to fund integration of primary care and behavioral health and related services that are not typically reimbursed through claims (e.g., funding behavioral health services not traditionally covered with a fee-for-service payment when provided in a primary care setting). Examples of these services include a) substance use disorder or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, c) supporting health behavior change, such as diet and exercise for managing pre-diabetes risk, d) brief interventions with a social worker or other behavioral health clinician not reimbursed via claims.	2A
c.	Social care integration	Prospective, non-claims payments paid to healthcare providers or organizations to support screening for health-related social needs, connections to social services and other interventions to address patients' social needs, such as housing or food insecurity, that are not typically reimbursed through claims.	2A
d.	Practice transformation payments	Prospective, non-claims payments paid to healthcare providers or organizations to support practice transformation which may include care team members not typically reimbursed by claims, technical assistance and training, and analytics.	2A

#	Non-claims-based Payment Categories and Subcategories	Draft Definition	Corresponding HCP-LAN Category
e.	EHR/HIT infrastructure and other data analytics payments	Prospective, non-claims payments paid to healthcare providers or organizations to support providers in adopting and utilizing health information technology, such as electronic medical records and health information exchanges, software that enables practices to analyze quality and/or costs, and/or the cost of a data analyst to support practices.	2A
2.	**Performance Payments**	**Non-claims bonus payments paid to healthcare providers or organizations for reporting data or achieving specific goals for quality, cost reduction, equity, or another performance achievement domain.**	
a.	Pay-for-reporting payment	Non-claims bonus payments paid to healthcare providers or organizations for reporting data related to quality, cost reduction, equity, or another performance achievement domain.	2B
b.	Pay-for-performance payments	Non-claims bonus payments paid to healthcare providers or organizations for achieving specific, predefined goals for quality, cost reduction, equity, or another performance achievement domain.	2C
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
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

#	Non-claims-based Payment Categories and Subcategories	Draft Definition	Corresponding HCP-LAN Category
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
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 meeting 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

#	Non-claims-based Payment Categories and Subcategories	Draft 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
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 s, 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).**	

#	Non-claims-based Payment Categories and Subcategories	Draft Definition	Corresponding HCP-LAN Category
6	Pharmacy Rebates	Price concessions, price discounts, or discounts of any sort that reduce payments, including a partial refund of payments or any reductions to the ultimate amount paid; a financial reward for inclusion of a drug in a preferred drug list or formulary or preferred formulary position; market share incentive payments and rewards; credits; remuneration or payments for the provision of utilization or claim data to manufacturers for rebating, marketing, outcomes insights, or any other purpose; rebates, regardless of how categorized, and all other compensation to carriers, their pharmacy benefit managers (PBMs), rebate aggregators, or subsidiaries.	