HCAi
Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

April 17th, 2024

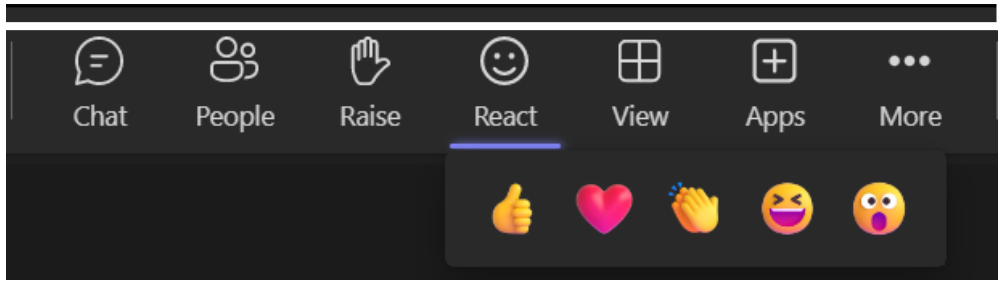
Agenda

9:00 a.m.	**1. Welcome and Updates**
9:05 a.m.	**2. Discuss Revised APM Standards and Goals Recommendations**
9:40 a.m.	**3. Discuss Revised Primary Care Measurement and Benchmark Recommendations**
10:30 a.m.	**4. Adjournment**

Meeting Format

Reminder: Please introduce yourself in the chat with your name, title, and organization.

- Workgroup purpose and scope can be found in the Investment and Payment Workgroup Charter
- 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: April 17, 2024

Time: 9:00 am PST

Microsoft Teams Link
for Public Participation:

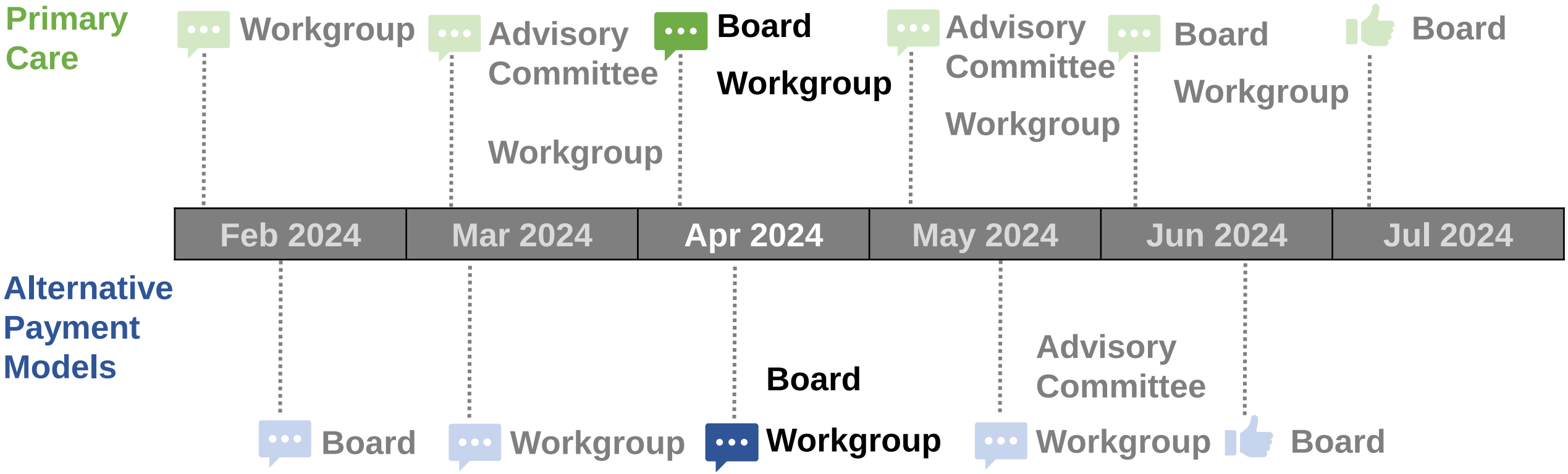
Meeting ID: 231 506 203 671
Passcode: XzTN6r

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

Conference ID:
261 055 415#

Timeline for Primary Care & APM Work

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



Board Approval

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Discuss Revised APM Standards and Goals Recommendations

Margareta Brandt, Assistant Deputy Director
Ngan Tran, Payment Reform Group Manager

Draft APM Standards

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

Draft APM Standards

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

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

Public Comment on Draft APM Standards and Implementation Guidance

- Overarching support of OHCA's proposed APM Standards and Implementation Guidance; only two suggestions for specific language changes.
- Recommend emphasizing that physicians should be part of the design, implementation, and evaluation of APMs.
- Recommend more explicitly stating need to increase primary care resources and reduce administrative burden.
- Recommend naming the types of clinical staff that can provide health care teams with the resources and services needed to address social, mental, and behavioral health needs, such as PharmD and RNs.
- Encourage OHCA to include a new standard that provides access to clinical data registries and support teams to treat patients with chronic conditions.

Proposed Changes to Draft APM Implementation Guidance

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

   1.1 [Implementation Guidance unchanged].

   1.2 [Implementation Guidance unchanged].

   1.3 Design core model components, ***with input from providers,*** to align with models already widely adopted in California whenever possible. Examples include the Medicare Shared Savings Program (MSSP) and the Realizing Equity, Access, and Community Health (REACH) program. Core components may include prospective payment, benchmarking and attribution methodologies, performance measures, minimum shared savings and risk thresholds, and risk corridors. If full alignment with an existing model is not feasible, review and incorporate stakeholder perspectives and lessons learned from the CMS published reports on models.

Proposed Changes to Draft APM Implementation Guidance

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

   3.1 [Implementation Guidance unchanged].

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

   3.3 [Implementation Guidance unchanged].

   3.4 [Implementation Guidance unchanged].

   3.5 [Implementation Guidance unchanged].

Proposed Changes to Draft APM Implementation Guidance

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

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

9.2 [Implementation Guidance unchanged].

9.3 [Implementation Guidance unchanged].

Draft APM Adoption Goals Proposed in March Workgroup

Draft APM Adoption Goals for Percent of Members Attributed to HCP-LAN Categories 3 and 4 by Payer Type				
	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2025	75%	20%	55%	75%
2026	80%	25%	60%	80%
2027	85%	30%	65%	85%
2028	90%	35%	70%	90%
2029	95%	40%	75%	95%

Updates from Initial Proposal Based on Board Feedback:

- Shortens timeline from 10 years to five years.
- Varies goals by payer type to recognize differences in starting points.
- Creates a glidepath that doubles Commercial PPO members attributed to HCP-LAN Categories 3 and 4.

Workgroup and Other Recent Stakeholder Feedback on March Proposal

Commercial PPO Denominator	Five Year Commercial PPO 40% Goal	Five Year Commercial HMO and MA 95% Goal
• Objection to using all members. Consider only including attributed members instead. • Feasibility to achieve goals is impacted if all members are included in the denominator.	• Even 40% may be too high in 5 years • Support for higher goal. • Support for longer timeline. • Concerns about self-funded plans meeting the goal. • Prior proposal of 75% was not realistic, payers would be unlikely to meet goal.	• Goal is too high. • 90% may be more realistic. • Willing to support if payers believe benchmark to be feasible. • Goals should align across product types.

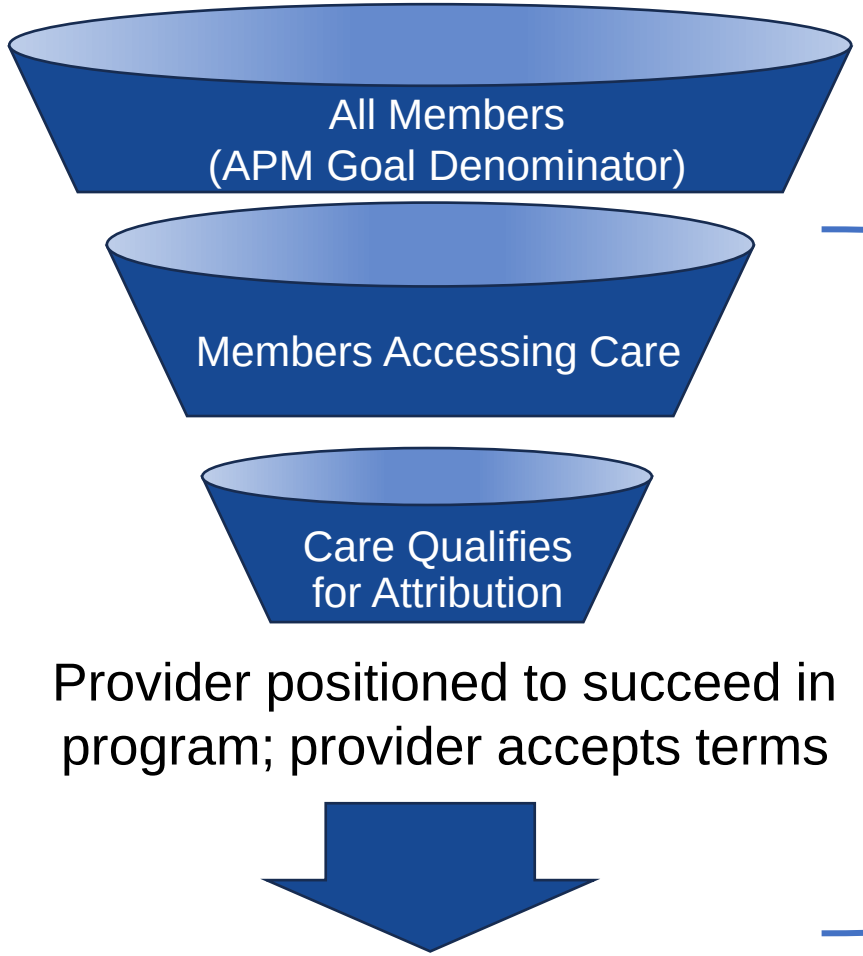
Public Comments on APM Adoption Goals

- Concern that the 10-year 75% goal (proposed in February) is overly ambitious and may be unattainable for Commercial PPO or Medi-Cal.
- Concern that the proposed goals and timeframe oversimplify the significant shift in the health care delivery system required.
- Recommend that for purposes of APM adoption in Medi-Cal the goal should be based on a denominator that includes only those non-dually eligible Medi-Cal members.
- Recommend that the definition of denominator be clear in the THCE Data Submission Guide.
- Request clarification on data reporting for self-funded plans.
- Request that self-funded plan data, if submitted, will be counted separate from that of the fully-insured membership of the health plan administering its benefits.

Attribution in Accountable Care

OHCA recommends including all members in APM denominator.

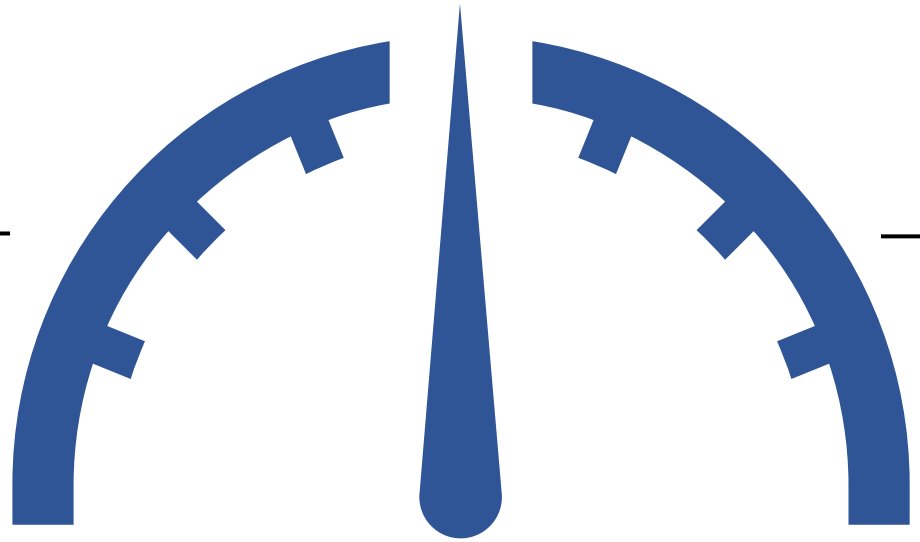
Aligns with population health goals including engaging those who may be less likely to receive care.



This funnel represents the most common attribution approach in Commercial PPO.

Attributing members this way results in a lower attribution rate than other APM arrangements, particularly capitation arrangements which often require members identify a provider or be assigned.

Balancing the Pace of Change



Not too slow…

- The time for more affordable, higher value care is now
- Immediate accountability motives quick action

Not too fast…

- Care delivery redesign, contracting take time
- Overambitious goals may discourage stakeholder participation
- Broad provider participation and meaningful arrangements are key

Revised APM Adoption Goals

APM Adoption Goals for Percent of Members Attributed to HCP-LAN Categories 3 and 4 by Payer Type				
	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	65%	25%	55%	55%
2028	75%	35%	60%	65%
2030	85%	45%	65%	75%
2032	90%	55%	70%	85%
2034	95%	60%	75%	95%

- Two-year interim goals leading to a 10-year goal.
- Reinforces public reporting on interim goals.
- Recognizes different starting and ending points for payers.
- Recognizes that all arrangements will need a link to quality.
- Creates a glidepath that more than triples Commercial PPO members attributed to HCP-LAN Categories 3 and 4 from 16% in 2021.

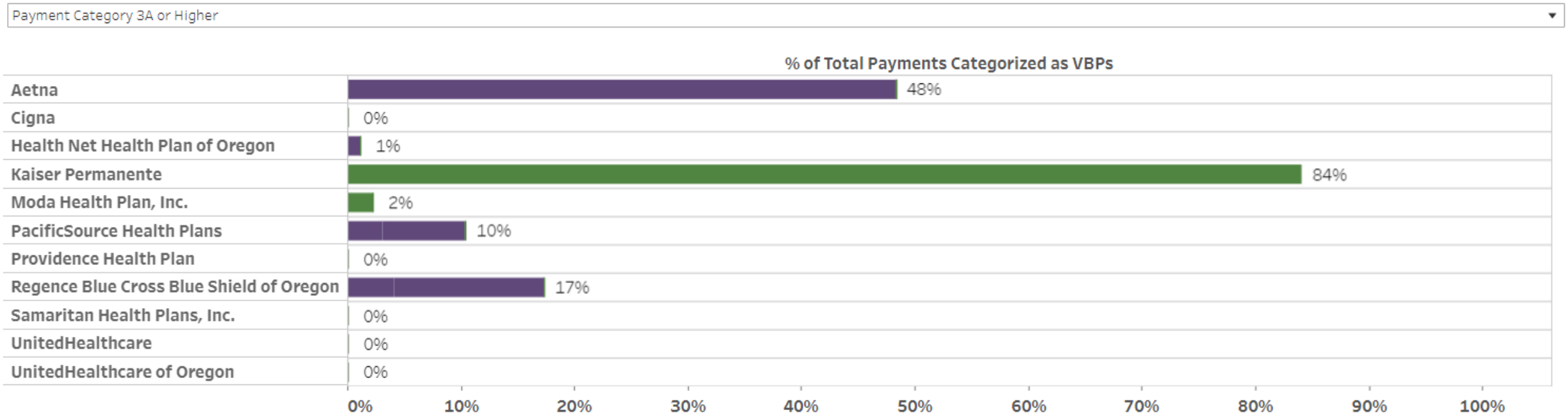
These revised adoption goals are also under discussion with sibling state departments.

Opportunities for Accountability

- **Transparency**: Reporting on goals by payer type and payer or fully integrated delivery system
- **Contracting**: Purchasers, particularly public purchasers, could align contracts with endorsed APM adoption standards and goals
- **Performance Improvement Plan (PIP):** Achievement of APM adoption goals and implementing APM standards could be incorporated into PIPs

Oregon Commercial Payer APM Adoption Reporting Example

For each carrier, what is the percentage of payments that are VBPs?
VBPs include the following HCP-LAN categories: pay for performance (2C), shared savings (3A), shared savings and risk (3B), and population-based capitation with link to quality (4A, 4B, 4C).
Use the drop-down list below to select VBP categories you are interested in.



This 2021 data shows the variation in APM adoption across payers with only three payers that have greater than 1% adoption of Category 3 arrangements.

Examples of Questions OHCA Could Explore through Reporting

Reporting will occur annually and by payer and product type. The goal is to use reporting to answer questions such as:

- **Percent of members attributed to APMs – *basis for APM adoption goal***
- Percent of dollars paid via APMs
- Percent of dollars paid via non-claims
- Percent of dollars paid via facility capitation
- Percent of primary care spend paid via capitation
- Changes in spending to support infrastructure and practice transformation
- Changes in spending on episodes and bundles of care

Discussion Questions

1. Any additional feedback or reactions to the public comment and feedback?

2. Does the workgroup have feedback on the revised APM adoption goals and timeline?

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Discuss Revised Primary Care Measurement and Benchmark Recommendations

Margareta Brandt, Assistant Deputy Director
Debbie Lindes, Health Care Delivery System Group Manager

Outstanding Primary Care Draft Recommendations

1. Whether to exclude or include OB-GYNs in the definition of primary care
2. Alignment with the DHCS Targeted Rate Increases (TRI) codes
3. Approach to allocating primary care spend paid via capitation
4. Approach to setting primary care investment benchmark

OHCA's Preliminary Definition of Primary Care Excludes OB-GYNs

Recommendation: Include OB-GYN services when provided by a primary care provider at a primary care place of service. All services provided by an OB-GYN are excluded.

Rationale:

- Current focus on investing in providers who provide continuous whole-person care for all body systems. OB-GYNs typically do not meet this definition.
- Excluding OB-GYNs does not in any way change a consumer's right under the Knox Keene Act to select an OB-GYN as their primary care provider.
- According to unaudited health plan self-reported provider data submitted to DMHC, 9% of PCPs reported by health plans were identified as having a specialist type of OB-GYN and 72% of OB-GYNs reported by health plans were identified as serving as PCPs.

Feedback: Majority of stakeholder feedback to date supports this approach as most aligned with our future vision of primary care.

Additional analyses can be conducted in the future using HPD data to evaluate the proportion of OB-GYNs providing services that align with the vision of primary care. Based on future available data, OHCA can work with stakeholders to revisit whether OB-GYNs should be included.

Approach to Developing OHCA's Primary Care Services Code Set

Applied guidance from the Investment and Payment Workgroup to a crosswalk of 15 primary care definitions, including the Integrated Health Association definition, to build the draft code set.

Compared draft OHCA recommended code set and DHCS Targeted Rate Increase (TRI) codes. Revised draft OHCA code set to include TRI codes aligned with primary care vision.

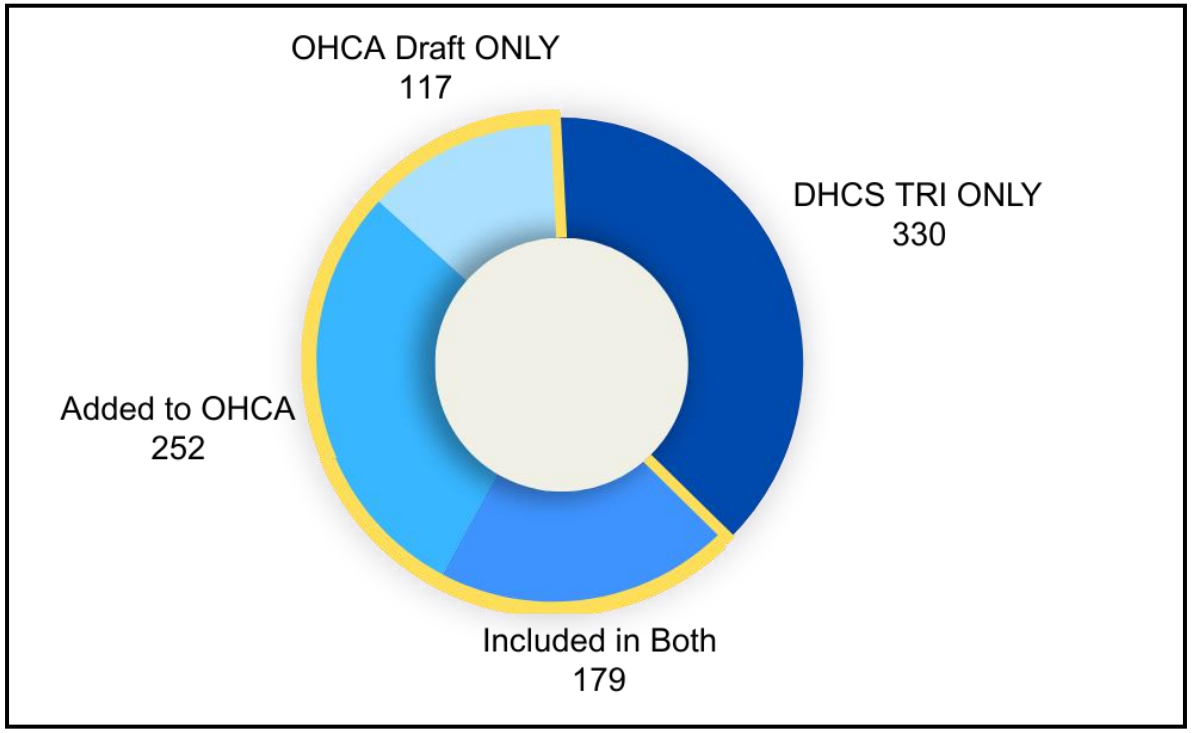
Final code set is larger than any other state, region, or national definition and includes some codes that no other definitions include.

Aligning with the DHCS TRI Code Set

After review of the DHCS TRI Codes, we have updated the OHCA draft primary care code set to include additional codes, most of which are not present in other primary care definitions, such as:

- Control of nosebleed
- Tinnitus assessment
- Allergy patch test

Proposed Revised Draft OHCA vs. DHCS TRI



***Note**: The OHCA definition requires the primary care service (as defined by this set of CPT codes) to be performed by a primary care provider (as defined by taxonomy code) in a primary care place of service (as defined by place of service code).*

California Department of Health Care Services, 2024. CY 2024 TRI Fee Schedule v1.0601082024.
California Department of Health Care Services, January 2024. DHCS News Release #24-01 California's Managed Care Organization (MCO) Tax Receives Federal Approval.

Overview of Non-claims Primary Care Spending Measurement Approach

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	

Overview of Non-claims Primary Care Spending Measurement Approach

Expanded Framework Category		Allocation to Primary Care Spending
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	

Overview of Non-claims Primary Care Spending Measurement Approach

Expanded Framework Category		Allocation to Primary Care Spending
4	**Capitation and Full Risk Payments**	
a	Primary Care capitation	Allocate full primary care capitation amount to primary care spending.
b	Professional capitation	Calculate a fee-for-service equivalent based on a fee schedule for primary care services multiplied by the number of encounters.*
c	Facility capitation	Not applicable.
d	Behavioral Health capitation	Calculate a fee-for-service equivalent based on a fee schedule for primary care services multiplied by the number of encounters.*
e	Global capitation	
f	Payments to Integrated, Comprehensive Payment and Delivery Systems	
5	**Other Non-Claims Payments**	Not applicable.
6	**Pharmacy Rebates**	Not applicable.

*Previously recommended approach. Will revise description based on discussion today.

Previously Recommended Approach: Primary Care Portion of Capitation Payments

All payments for Category 4a (Primary Care Capitation)

+

Σ (# of Encounters x FFS-equivalent Fee)$_{segment}$

Subcategories 4b-4f

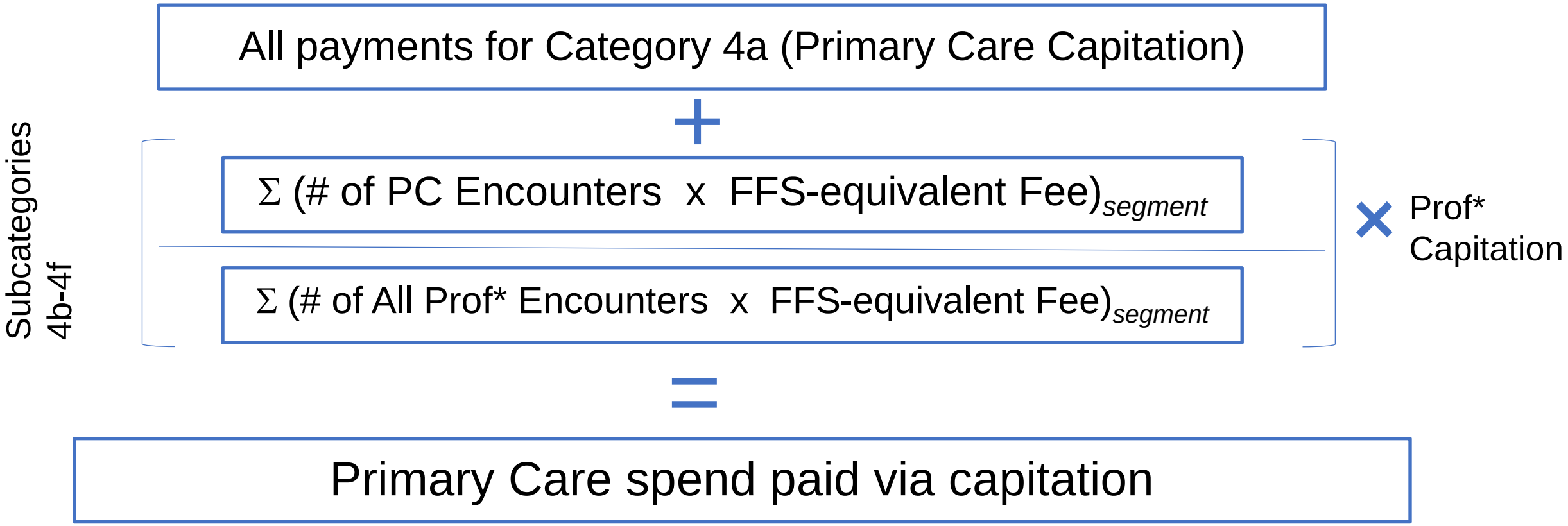
where *segment* is a combination of

- Year
- Geographic Region
- OHCA FFS Primary Care Definition
- Payer Type

=

Primary Care spend paid via capitation

Revised Recommended Approach*: Primary Care Portion of Capitation Payments



*Revised approach is consistent with Blue Shield of California recommendation.

*This example envisions a professional capitation. Under a global capitation, the professional encounters and capitation would be replaced with all encounters and the global capitation rate.

Trade Offs of Current Capitation Approach Proposals

Initial OHCA Approach

- Simpler
- Only requires primary care encounters and FFS equivalents
- Does not adjust for missing or low-quality encounter data
- Likely to result in a lower primary care spend than Blue Shield approach

Blue Shield Recommendation

- More complex
- Requires encounters and FFS equivalents for all care included in the capitation
- Adjusts for missing encounter data by allocating all dollars. Allocation may be incorrect if rate of missing encounters differs for primary care versus other services.
- Low-quality encounter data may miss some primary care
- Accounts for payments included in capitation, not captured by encounters such as care management
- Likely to result in a higher primary care spend than OHCA approach; OHCA would monitor for reasonableness

Recent Stakeholder Feedback on Approaches

- Highlighted the distinction between measuring primary care spending by **plans** and by **provider organizations.** Primary care spending by provider organizations may not be captured by counting encounters and applying FFS equivalents. Examples:
  - Population health management capabilities
  - Non-billable providers
  - Pay for performance programs managed by the physician organization (not the plan)
- Measuring how provider organizations distribute capitation payments to downstream primary care providers would require additional, flexible data collection.
  - OHCA should start investigating such data collection as part of long-term planning
- Some concerns about whether encounter data would be of sufficient quality and completeness to support the analysis, regardless of the calculation approach.
- At least one Workgroup member found OHCA's original recommendation a reasonable approach.

Discussion Questions

1. Does the workgroup have additional feedback on the recommended approach for determining primary care spend paid via capitation?

Draft Primary Care Investment Relative Benchmark

Payer Relative Improvement Benchmark: All payers increase primary care spending by 0.5 percentage points to 1 percentage point per year, depending on current level of investment. Payers at or above the statewide absolute benchmark may opt to maintain their primary care spend if increases are not aligned with care delivery or affordability goals.

Rationale for Level:

- Consistent with implementation of benchmarks in other state approaches (e.g. CO, RI, DE)
- Acknowledges payers are at different starting levels
- Offers gradual reallocation of spending
- Focus on shifting spend from specialty care and toward primary care

AND

A Statewide Absolute Benchmark

Draft Primary Care Absolute Benchmark: Option 1

Statewide Absolute Benchmark Option 1:
California allocates 15% of total medical expense to primary care across all payers and populations by 2034.

Rationale for Level:

- Internationally, high performing health systems spend 12% to 15% of total healthcare spending on primary care
- States that invest more in primary care perform better on measures of avoidable hospitalization and emergency department utilization
- The recommended benchmark is higher than other states, recognizing California's healthcare delivery goals, delivery system, younger population, and 10-year time horizon

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

Draft Primary Care Absolute Benchmark: Option 2

Statewide Absolute Benchmark* Option 2:
California allocates the following by 2034:

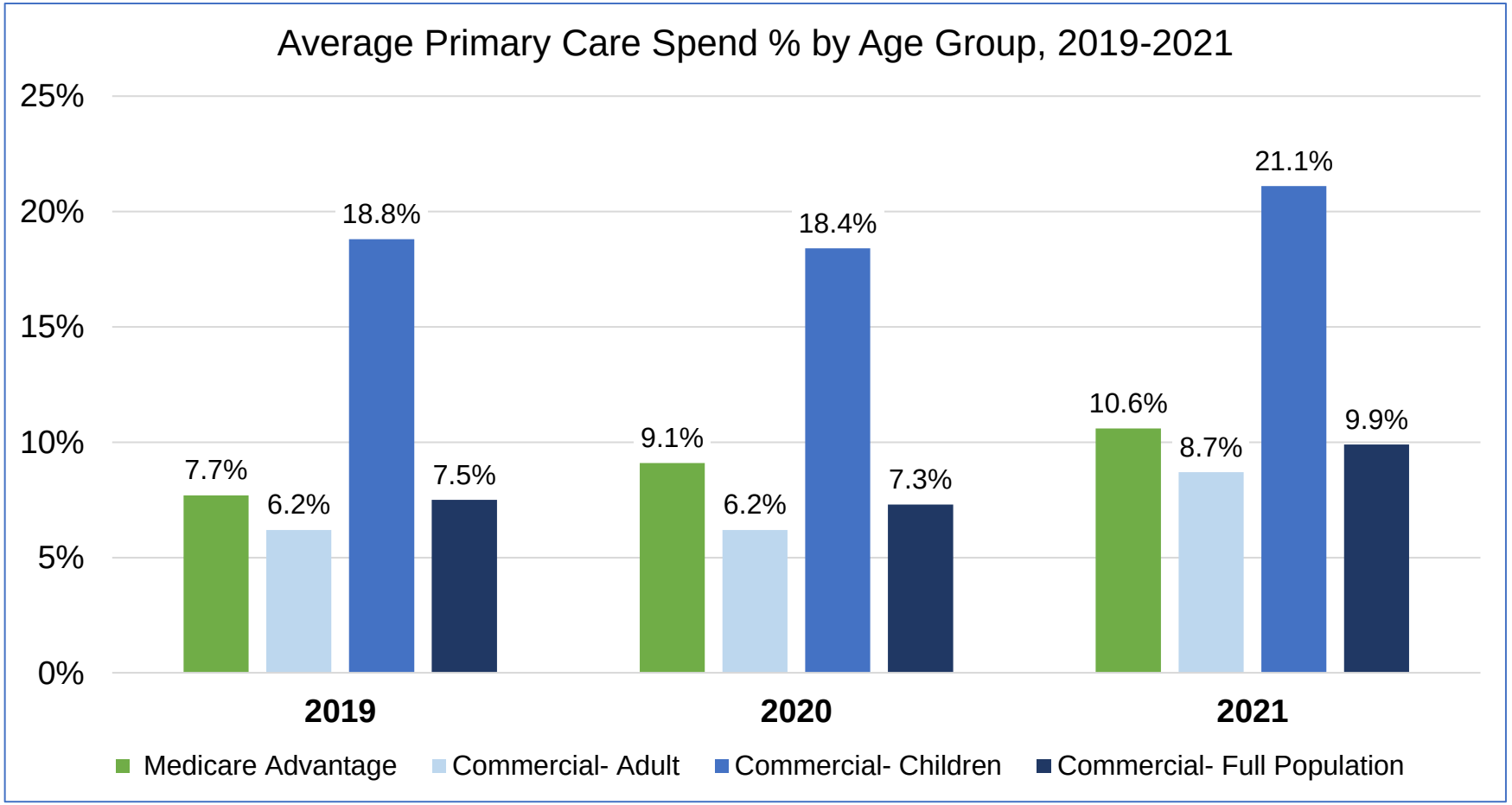
- *12% of total medical expense to primary care for all adults*
- *24% of total medical expense to primary care for all children*

Rationale for Level:

- Optimal primary care spend looks different for children and adults
- Primary care spending using OHCA approach likely to be lower than previously published estimates

Primary Care Spending for Children and Adults in California

- California commercial plans spent **an average of 7.3% to 9.9%** on primary care services from 2019 to 2021.
- California Medicare Advantage plans spent a similar percentage as commercial plans, with **an average of 7.7%-10.6%** spent on primary care services from 2019 to 2021.



Integrated Healthcare Association. California Commercial Primary Care Spending Results. 2019-2021. Table developed using the same methodology described in California Health Care Foundation's *Investing in Primary Care: Why it Matters for Californians with Commercial Coverage (2022).*

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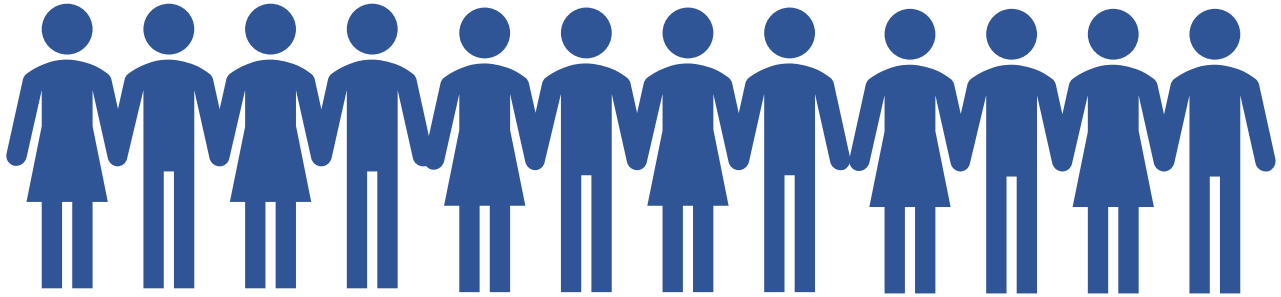
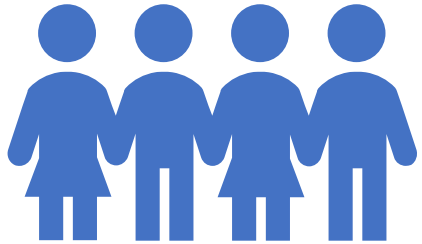
Comparing Spend Using Options 1 and 2



78.2% of California population is 18 years of age and older



21.8% of California population under 18 years of age

Weighted average of draft pediatric (24%) and adult (12%) primary care spending benchmarks: **14.62%**

Calculations are based on 2023 United States Census Bureau population estimates for California.

Challenges of Allocating Non-Claims Primary Care Payments by Age Group

- Any methodology for allocating payments to adults vs. pediatrics will add complexity and may move farther away from the actual intent or distribution of the payments.
- Many non-claims payments reflect care provided to populations and cannot be tied to a specific provider or set of primary care services.
- Non-claims payments are typically made in lump sum, not delineated by patient age group.

Example of Shared Savings Payment

A provider group receives a shared savings payment.

A portion of the payment is allocated to primary care based on OHCA's methodology.

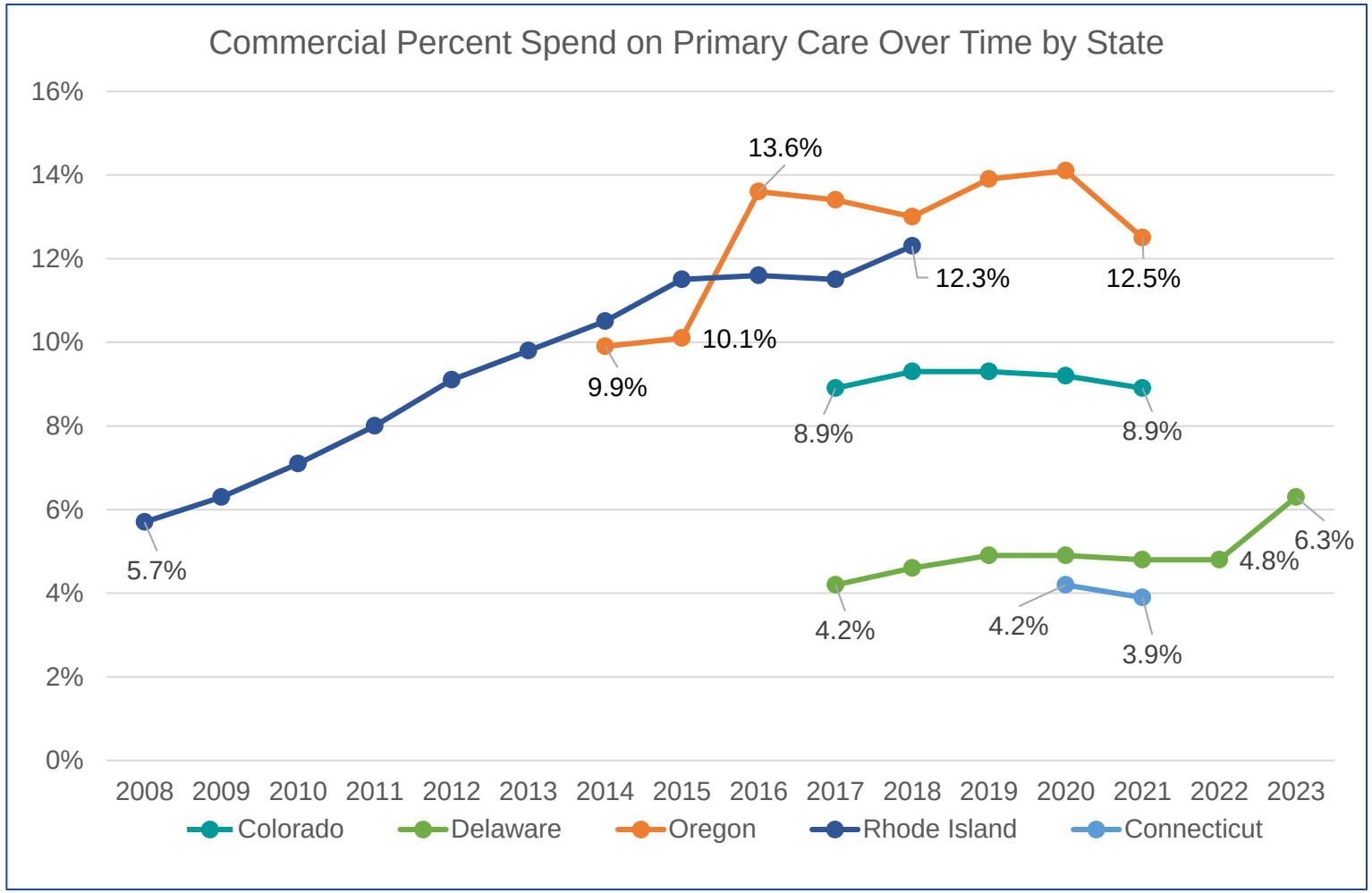
The primary care portion is then allocated to adults vs. pediatrics based on an additional standardized OHCA methodology.

The payment allocated to pediatrics may not reflect the contribution of pediatrics to the shared savings nor the amount allocated to pediatric primary care by the provider organization.

Recent Stakeholder Feedback on the Primary Care Benchmark Options

- Advisory Committee members who commented were in support of separate pediatric and adult benchmarks.
  - One member suggested considering a separate benchmark for older adults.
- A few members emphasized focusing on pediatric primary care to ensure adequate investment.
- Pediatric primary care spend is higher – large number of encounters that have a lower cost.
- There is logic behind the 15% (derived from adult and pediatric benchmark options of 12% and 24%) – aspirational but achievable.
- The main feedback on the 10-year horizon was that change takes time and OHCA should allow for that.

Balancing the Pace of Change



- These states have the most experience working to increase primary care investment.
- Four of them are Cost Growth Benchmark states and like California are looking to gradually reallocate more of the healthcare dollar away from lower value services to higher value services like primary care.
- States often aim to shift 1% in TME per year.
- Actual shifts are often more modest, especially when early goals are more dramatic.

Note: State definitions and total cost of care differ, which contributes to differences in investment percentages. The Delaware 2023 figure is a projection.

Draft Primary Care Investment Benchmark Recommendation

Payer Relative Improvement Benchmark: All payers* increase primary care spending by 0.5 percentage points to 1 percentage point per year, depending on current level of investment.

AND

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

- OHCA will monitor and report progress on the relative improvement benchmarks by payer and payer type in its annual report to motivate progress towards the absolute benchmark.
- Single absolute benchmark reduces administrative complexity of reporting.
- OHCA can conduct future analyses via the HPD to understand the claims-based pediatric vs. adult primary care spend.
- OHCA and HPD will explore options for separating non-claims payments by pediatric vs adults and seek stakeholder feedback on these options.

*Payers at or above 15% of total medical expense may refrain from continued increases if not aligned with care delivery or affordability goals.

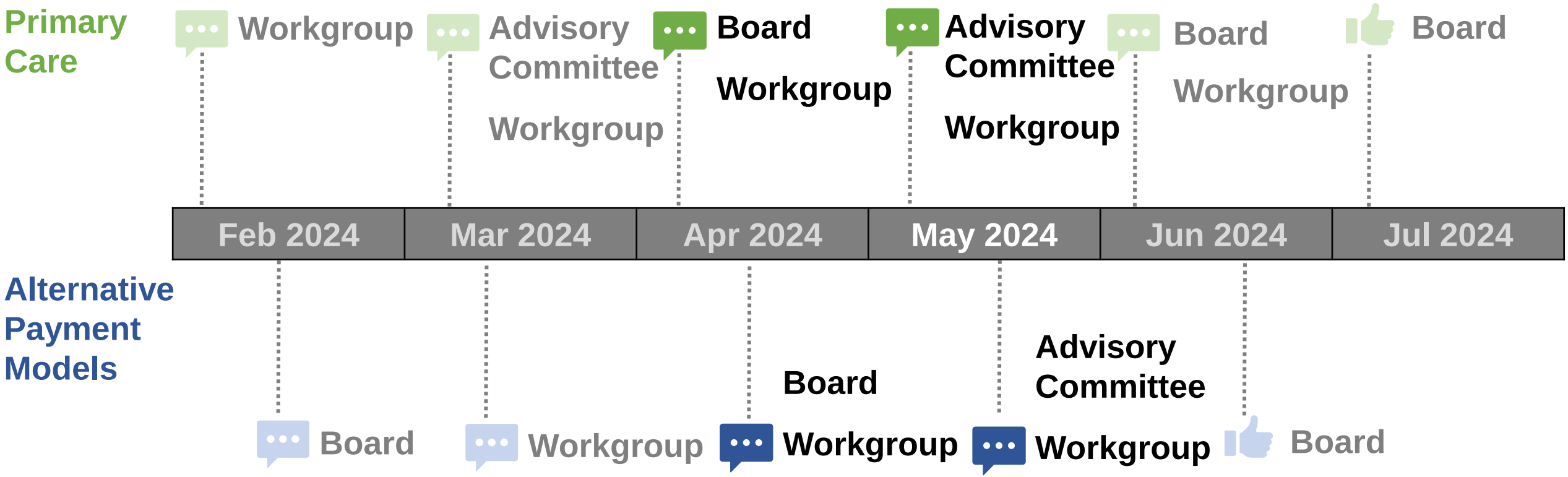
Discussion Questions

1. The Board provided feedback that a 10-year timeline for APM goals was too long. Does a 10-year timeline to achieve the absolute primary care benchmark provide timely investment to sustainably transform primary care delivery?

2. Any feedback on proposed primary care benchmark?

Next Steps

OHCA will incorporate feedback and input and then share revised primary care and APM recommendations with the Advisory Committee and Workgroup in May.



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Adjournment

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Appendix

Expanded Framework, Categories 1-3

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

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

Expanded Framework, Categories 4-6

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

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

Overview of Claims-based Primary Care Spending Measurement Approach

Include a narrow or broad set of providers?

- Include a broad set of providers to reflect statutory goal of team-based care.

Should the definition be limited to certain places of service?

- Include restrictions on places of service to reflect vision of continuous and coordinated care.

Include a narrow or expanded set of services, or all?

- Include an expanded set of services to encourage as much care as possible and appropriate to be delivered in a primary care setting.

Overview of Claims-based Primary Care Spending Measurement Approach

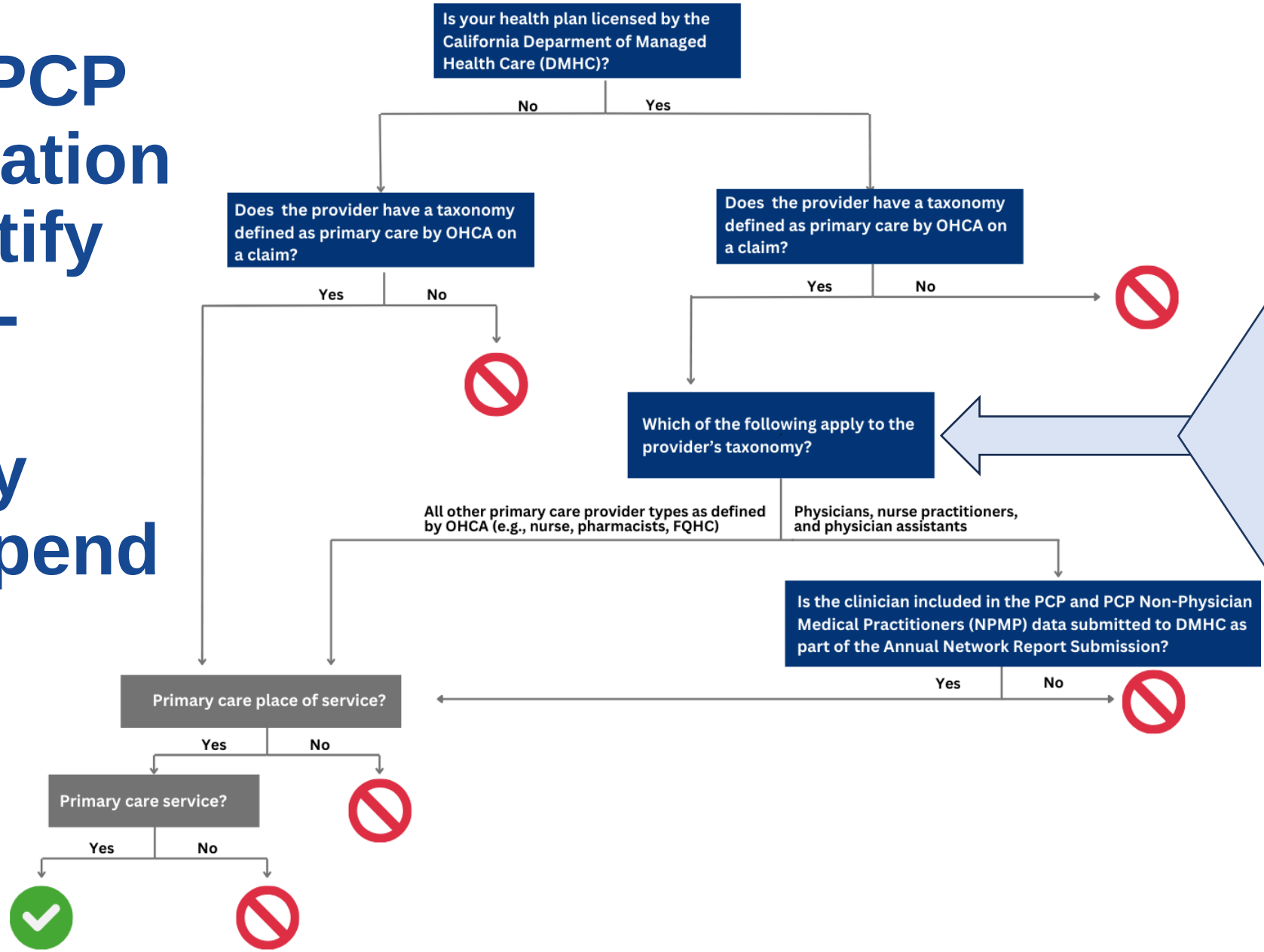
How to incorporate OB/GYN services and/or providers?

- Include some OB-GYN services to be consistent with similar services for other body systems.
- Exclude OB-GYN providers to be consistent with focus on providers caring for the whole patient.

How to incorporate behavioral health services and/or providers?

- Use a modular approach to include a limited set of behavioral health services that are provided as part of primary care or integrated primary care and behavioral health.

Using PCP Designation to Identify Claims-based Primary Care Spend



For example, an internal medicine physician who is not identified as a PCP in the payer's Annual Network Report Submission is removed at this step.

How Other States Address Key Decisions

	CA*	CT	DE	RI	OR	CO
Which payer types does the benchmark apply to?	All	All	Commercial	Commercial	Commercial & Medicaid	Commercial
Single or separate benchmarks by age group?	Single	Single	Single	Single	Single	Single
Percentage or Per Member, Per Month (PMPM)	%	%	%	%	%	%
Absolute or relative improvement?	Absolute (with relative)	Absolute (with stair steps)	Absolute (with stair steps)	Absolute, Previously Relative	Absolute	Relative
Benchmark/Target/ Requirement	0.5% to 1% annually; 15% by 2024	10% in 2025	11.5% in 2025**	10.7%	12%	1% annually

*OHCA's preliminary recommendations.

**Primary care investment requirement only applies to members attributed to providers engaged in care transformation activities.

Maryland, North Carolina, Oklahoma and Washington also are developing primary care investment targets or benchmarks.

Math of Increased Investment

- To increase primary care investment by 1% of TME, increases in TME must be considered.
- The box to the right assumes a 3% increase in all TME.
- Primary care spending increased 17.5% over the previous year to generate a 1% increase in primary care spend as a % of TME.

1% TME increase in primary care spend

Calculating Percent Primary Care (PC) of TME

Base Year:

$$\frac{\$46 \text{ Primary Care PMPM}}{\$541 \text{ Total Medical Expenditures PMPM}} \times 100 = 8.7\% \text{ PC of TME}$$

Benchmark Year 1:

$$\frac{\$46 \text{ PMPM} + \$8.05 \text{ PMPM}}{\$541 \text{ PMPM} + \$16.23 \text{ PMPM}} \times 100 = 9.7\% \text{ PC of TME}$$

Calculating Percent Increase in Primary Care Spend

Benchmark Year 1:

$$\frac{\$54.05 \text{ PMPM} - \$46 \text{ PMPM}}{\$46 \text{ PMPM}} \times 100 = 17.5\% \text{ increase in PC Spend}$$

Integrated Healthcare Association. California Commercial Primary Care Spending Results. 2019-2021. Table developed using the same methodology described in California Health Care Foundation's *Investing in Primary Care: Why it Matters for Californians with Commercial Coverage (2022).*