Office of Health Care Affordability
Alternative Payment Model (APM) Standards and Adoption Goals
Approved by California Health Care Affordability Board, June 2024

The Office of Health Care Affordability's Mission and Purpose

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

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

[1] State Health Expenditure Accounts by State of Residence, 1991-2020, Centers for Medicare & Medicaid Services. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence.
[2] Whitmore, H., & Satorius, J. (2021, August). *California Health Care Almanac, California Employer Health Benefits: Are Workers Covered?* California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2021/08/CAEmployerHealthBenefitsAlmanac2021.pdf
[3] Joynt, J., Catterson, R., & Alvarez, E. (2024, January 31). *The 2024 CHCF California Health Policy Survey.* California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2024/01/2024CHCFCAHealthPolicySurvey.pdf

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

1. Slow health care spending growth through collection and reporting on total health care expenditure data and enforcing spending targets set by the Board.
2. Promote high-value health system performance; and
3. Assess market consolidation.

As part of its work to promote high-value health system performance, the Health Care Affordability Board approved the Alternative Payment Model (APM) Standards and Adoption Goals described below in June 2024. OHCA defines an APM as a state or nationally recognized payment approach that financially incentivizes equitable, high-quality, and cost-efficient care.[4]

Statutory Requirements

As described in the OHCA enabling statute and summarized here[5], the statutory requirements related to APMs include:

- Promote the shift from fee-for-service (FFS) payments to 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 health care 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.
- Require payers, fully integrated delivery systems, and restricted and limited health care service plans to submit data and other information to measure adoption of APMs.
- Data collected by OHCA to measure APM adoption 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.

The OHCA enabling statute also specifies additional statutory guidance for APM standards that may be used between payers and providers during contracting, as follows:

- Encourage and facilitate multi-payer participation and alignment.

[4] Health and Safety Code §127500.2 (d).
[5] These requirements are summarized from Article 5. Alternative Payment Models, Health and Safety Code §127504.

- Improve affordability, efficiency, equity, and quality by considering current best evidence for strategies such as quality-based or population-based payments.
- Include minimum criteria for APMs but be flexible enough to allow for innovation and evolution.
- Align with the quality and equity measures used in the OHCA quality and equity measure set to the extent possible.
- Address 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.
- Attempt to reduce administrative burden by incorporating APMs that facilitate multi-payer participation and align with other state payers and programs or national models.

The statute also requires OHCA to review the standards at least every five years to determine whether the standards are rewarding high-quality, cost-efficient, and equitable care.

Background

OHCA promotes high-value system performance through its work in five focus areas: (1) primary care investment, (2) behavioral health investment, (3) APM adoption goals and standards, (4) quality and equity measurement, and (5) workforce stability. Across all these areas, the goal is to reorient the health care system towards greater value, with the vision of creating a sustainable health care system that provides high-quality, equitable care to all Californians.

OHCA launched the Investment and Payment Workgroup[6] in June 2023, bringing together stakeholders representing providers and provider organizations, academics and subject matter experts, state and private purchasers, sibling state departments, consumer advocates, patient representatives, hospitals and health systems, and health plans. The Workgroup convenes monthly to provide input as OHCA develops recommendations in the areas of APMs, primary care investment, and behavioral health investment.

OHCA presented draft recommendations for APM Standards and APM Adoption Goals to the Health Care Affordability Advisory Committee on November 30, 2023, and to the Health Care Affordability Board on February 28, 2024 and May 22, 2024. Additionally, OHCA received public comment from February 28, 2024 to March 29, 2024. The APM Standards and APM Adoption Goals, along with supporting definitions and data collection processes, were informed by extensive discussions in the Investment and Payment Workgroup and incorporated feedback from various stakeholders, including sibling state departments. The APM Standards and APM Adoption Goals were further

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

refined based on feedback from the Health Care Affordability Board, the Health Care Affordability Advisory Committee, and public comment.[7]

OHCA's vision of success for the APM Standards is for stakeholders to endorse the Standards and for payers and purchasers to commit to using the Standards to guide their future contracting efforts. While OHCA will promote and monitor use of the APM Standards by contracting entities, at this time OHCA does not have standalone authority to enforce the Standards. OHCA intends for the Standards to result in greater alignment across APMs and make participation in APMs easier for payers and providers. Similarly, OHCA will partner with stakeholders to promote achievement of the APM Adoption Goals. OHCA commits to transparency and accountability by publicly reporting progress towards the stated goals. Achievement of APM adoption goals and implementation of APM standards could be incorporated into performance improvement plans for health care entities that exceed the spending target. As APM adoption increases, health system performance should improve, leading to higher quality, more equitable, and more affordable care.

[7] Summaries of feedback from public comment, Board and Advisory Committee members, and Investment and Payment Workgroup and sibling state departments are available here: April 2024 Health Care Affordability Board Meeting, May 2024 Health Care Affordability Board Meeting, May 2024 Health Care Affordability Advisory Committee Meeting.

APM Standards for Payer-Provider Contracting (APM Standards)

The Health Care Affordability Board approved the following APM Standards. The APM Standards provide a set of ten best practices that are grounded in evidence to approach contracting decisions between payers and providers that are common across APMs.

1. **Use prospective, budget-based, and quality-linked payment models** that improve health, affordability, and equity.[8]
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 are fiscally feasible to entities with varying capabilities and appetites for risk, including small independent practices and historically under-resourced providers.
6. **Collect demographic data**, including race, ethnicity, language, disability status, sex, sexual orientation, and gender identity (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.

OHCA developed the implementation guidance in **Appendix A** as technical assistance to support the APM Standards.

[8] Any health care entity taking significant financial risk needs to be regulated by the Department of Managed Health Care (DMHC). Compliance with these APM Standards does not obviate the need for compliance with other provisions of California law.

APM Adoption Goals

The Board approved a set of two-year goals, that differ by payer and product type, leading to a final ten-year goal for the percent of members attributed to Health Care Payment Learning and Action Network (HCP-LAN) Categories 3 and 4 by 2034: 95% for Commercial HMO and Medicare Advantage, 75% for Medi-Cal, and 60% for Commercial PPO (see Table 1 below).

Table 1: APM Adoption Goals for Percent of Members Attributed to HCP-LAN Categories 3 and 4 by Payer and Product 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%

The APM Adoption Goals:

- Recognize different starting and ending points for payers.[9]
- Recognize that all arrangements will need a link to quality.
- Create a glidepath that more than triples Commercial PPO members attributed to HCP-LAN Categories 3 and 4 from 16% in 2021; and
- Reinforce public reporting on progress on biannual goals.

OHCA may consider revisions to APM Adoption Goals after the first two years of data collection, when a baseline has been established and progress to meet the first biannual goal is evaluated.

OHCA will use the HCP-LAN framework to monitor progress towards the APM Adoption Goals.[10] The APM Adoption Goals are based on the percent of members attributed to HCP-LAN Categories 3A, 3B, 4A, 4B, and 4C arrangements. That is, only members enrolled in one of the following types of payment arrangements count toward the APM Adoption Goals:

- 3A: APMs with Shared Savings
- 3B: APMs with Shared Savings and Downside Risk
- 4A: Condition-Specific Population-Based Payment

[9] In the September 2023 Investment and Payment Workgroup, OHCA reviewed national and California APM adoption rates across payer type, slides 19-24.
[10] See Health Care Payment Learning and Action Network APM Framework.

- 4B: Comprehensive Population-Based Payment
- 4C: Integrated Finance and Delivery System

The purpose of the APM Adoption Goals is to promote a shift from fee-for-service based payments to APMs and better align financial incentives for equitable, high-quality, and cost-efficient care.

To count towards adoption goals, APMs must include:

1. **Meaningful Risk Sharing:** Category 3A and 3B APMs must meet a minimum threshold for shared savings or shared risk. This requirement ensures that APM arrangements built on a fee-for-service architecture have tangible financial incentives or penalties contingent upon the provider's attainment of predefined spending and quality benchmarks.[11]
2. **A Link to Quality:** Payments must be "linked to quality" such that they include potential for financial bonuses or penalties based on the provider's performance against predetermined quality benchmarks. This excludes HCP-LAN Categories 3N and 4N (risk-based payments and capitation payments that are not linked to quality). This requirement ensures that APM arrangements have a substantive connection between payments and quality outcomes.

OHCA will assess APM Adoption Goals based on the percentage of members attributed to such models. OHCA intends to monitor the percentage of total health care spending within each HCP-LAN category as a complementary measure.

OHCA will use the HCAI Expanded Non-Claims Payments Framework to collect data on APM adoption.[12] Payers will submit data according to the Expanded Non-Claims Payments Framework as part of the total health care expenditure (THCE) data collection. Developed by HCAI, the Expanded Non-Claims Payments Framework organizes payments according to their purpose and provides a crosswalk to the HCP-LAN framework. OHCA will crosswalk the data after it is submitted to evaluate and publicly report on progress towards the APM Adoption Goals using HCP-LAN categories. This data collection framework is aligned with other non-claims payments data collection efforts across HCAI.

[11] The minimum thresholds are provided in the February 28, 2023 Health Care Affordability Board Presentation – Appendix: Expanded Non-Claims Payments Framework, slides 136-139.
[12] Pegany S, Brandt M, Tran N, Valle M, Krawczyk C. A New Standard for Categorizing and Collecting Non-Claims Payment Data, Milbank Memorial Fund. 2024 Mar 18.

Appendix A: Implementation Guidance for APM Standards

As technical assistance to support the APM Standards, OHCA developed implementation guidance for each standard that provides examples of specific actions health care entities can take to meet the standards. The purpose is to encourage alignment across current and future APM arrangements, not to develop standardized contract terms and language for APMs.

1. **Use prospective, budget-based, and quality-linked payment models** that improve health, affordability, and equity.[13]

   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.[14] 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.[15]

   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. This includes models that promote higher value hospital and specialty care. HCP-LAN classifies these models as Category 3A and 3B.

   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)[16] and the Realizing Equity, Access, and Community Health (REACH)[17] program. Core components should include prospective payment and attribution methodologies, benchmarking, 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.

2. **Implement payment models that improve affordability** for consumers and purchasers.

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[13] Any health care entity taking significant financial risk needs to be regulated by the Department of Managed Health Care (DMHC). Compliance with these APM Standards does not obviate the need for compliance with other provisions of California law.
[14] Health Care Payment Learning & Action Network (HCP-LAN) 2022
[15] 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.
[16] Centers for Medicare & Medicaid Services (CMS) 2022
[17] Centers for Medicare & Medicaid Services (CMS) 2023

2.1. Align financial incentives to reduce utilization and excess spend on high-cost care such as low-value specialty pharmacy, unnecessary specialty care, and avoidable emergency room and hospital care.
2.2. Create incentives to reward prevention, disease management, and evidence-based care while discouraging harmful, low value care, and over-treatment.
2.3. Reduce administrative inefficiency across the health care payment and delivery system by streamlining contracting, billing, credentialing, performance programs, and other documentation such as prior authorization.[18]
2.4. Efficiency and cost savings generated through APMs should lead to lower costs for consumers and decrease barriers to care.
2.5. Design innovative payment models to address the needs of all consumers, particularly those with the highest healthcare costs and most to gain from comprehensive, coordinated care delivery.

3. **Allocate spending upstream to primary care and other preventive services** to create lasting improvements in health, access, equity, and affordability.
   3.1. Provide sufficient primary care payment to support the adoption and maintenance of advanced primary care attributes such as primary care continuity, accessible and integrated behavioral health, and specialty care coordination.
   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. Support use of technology to strengthen consumer-care team relationships, make care more accessible and convenient, and increase panel capacity without increasing provider workload.
   3.4. Encourage consumers to develop a continuous relationship with a primary care team to promote access to and use of primary care and enable payment model success.
   3.5. Reduce financial barriers for primary care services, behavioral health services, and preventive services by decreasing or eliminating out-of-pocket costs for consumers (e.g., copays, co-insurance, or deductibles in benefit design).
4. **Be transparent** with providers in all aspects of payment model design and terms including attribution and performance measurement.

[18] Bentley TG, Effros RM, Palar K, Keeler EB. Waste in the U.S. Health care system: a conceptual framework. Milbank Q. 2008 Dec;86(4):629-59. doi: 10.1111/j.1468-0009.2008.00537.x. PMID: 19120983; PMCID: PMC2690367.

4.1. Share attribution methodologies and outputs widely and in formats accessible to providers.

4.2. Clearly articulate the performance measures used, provide the technical specifications including risk adjustment methods, and share how incentive payments are calculated.

5. **Engage a wide range of providers** by offering payment models that are fiscally feasible to entities with varying capabilities and appetites for risk, including small independent practices and historically under-resourced providers.

5.1. Provide upfront financial support to new entrants to assist them in hiring care team members, improving analytic capabilities, and making other investments to foster long-term success in the model.

5.2. Make timely incentive payments that reward improvement and attainment, ideally no later than six to nine months after the performance period.

5.3. Give providers – particularly those with lower revenues – a gradual, stepwise approach for assuming financial risk that protects provider financial solvency and supports sustainability.

5.4. Utilize risk adjustment methodologies that incorporate clinical diagnoses, demographic factors, and other relevant information. Monitor emerging methodologies and explore opportunities to incorporate social determinants of health in risk adjustment methodologies.

6. **Collect demographic data**, including RELD-SOGI[19] data, to enable stratifying performance.

6.1. Participate in state and national efforts to identify and promote emerging best practices in accurate and complete health equity data collection, such as those identified in the CMS Framework for Health Equity.[20]

6.2. Align internal RELD-SOGI data collection with the United States Core Data for Interoperability (USCDI) set where applicable and appropriate to reduce administrative burden.[21]

6.3. Support providers in collecting information on individual consumers' social needs through standardized, validated screening tools.

6.4. Prioritize using self-reported demographic data. When self-reported data is incomplete or unavailable, leverage population-level data or indices.

7. **Measure and stratify performance** to improve population health and address inequities.

[19] Race, ethnicity, language, disability status, sex, sexual orientation, and gender identity data
[20] Centers for Medicare & Medicaid Services, The CMS Framework for Health Equity (2022-2032) (2022).
[21] United States Core Data for Interoperability: Updates for Versions 2 and 3, USCDI+ 2022

7.1. Select a limited number of nationally standardized measures that reflect multiple domains (e.g., quality, equity, utilization, cost, consumer experience) and populations (e.g., pediatric, adult, older adults). Prioritize outcome measures, whenever possible.

7.2. Align measures and technical specifications with those used by the Department of Managed Health Care, California Department of Health Care Services, Covered California, the California Public Employees' Retirement System, and the Office of Health Care Affordability, when available. In particular, include Childhood Immunization Status – Combination 10, Colorectal Cancer Screening, Controlling High Blood Pressure, Glycemic Status Assessment for Patients with Diabetes, and Depression Screening and Follow-Up for Adolescents and Adults whenever appropriate as these quality measures are the most commonly aligned across state departments.

7.3. Include measures that monitor for unintended consequences of the payment model, such as withholding appropriate, necessary care to consumers to save money. For example, track changes in potentially avoidable emergency department visits and hospital admissions.

8. **Invest in strategies to address inequities** in access, patient experience, and outcomes.

8.1. Increase payments to providers serving populations with higher health-related social needs to support enhanced medical and behavioral care and social care coordination.

8.2. Support providers in using data to identify and address inequities, including by providing care consistent with the National Culturally and Linguistically Appropriate Services Standards.[22]

8.3. Develop partnerships with community-based organizations and leverage local resources to address health-related social needs.

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. Offer analytic support, such as hands-on training and example dashboards, to develop the capacity of providers, interdisciplinary care teams, and non-clinical staff to ingest and benefit from information.

[22] U.S. Department of Health and Human Services Office of Minority Health, National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, 2013. https://thinkculturalhealth.hhs.gov/clas

9.3. Facilitate data exchange across providers, community-based organizations, and payers, particularly through use of the California's Health and Human Services Data Exchange Framework.

10. **Provide technical assistance** to support new entrants and other providers in successful APM adoption.

10.1. Payers and providers should work collaboratively to develop a technical assistance plan that identifies potential barriers to success and conditions necessary to build capacity in these areas. The plan should offer clear action steps for what assistance will be provided and the format and frequency of the assistance.

10.2. Technical assistance should focus on supporting providers to perform well on the metrics that impact their payment.

10.3. Develop partnerships with collaborative technical assistance organizations or other payers to collectively support technical assistance to providers.