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Department of Health Care Access and Information

Health Care Affordability Board Meeting

June 26, 2024

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Welcome, Call to Order, and Roll Call

Agenda

1. **Welcome, Call to Order, and Roll Call**
   Secretary Mark Ghaly, Chair

2. **Executive Updates**
   Elizabeth Landsberg, Director, and Vishaal Pegany, Deputy Director

3. **Action Consent Item**
   Vishaal Pegany
   a) Approval of the May 22, 2024 Meeting Minutes

4. **Action Items**
   Vishaal Pegany, Margareta Brandt, Assistant Deputy Director
   a) Vote to Establish Alternative Payment Model Standards and Adoption Goals

5. **Informational Items**
   Vishaal Pegany, Margareta Brandt, Assistant Deputy Director, Sheila Tatayon, Assistant Deputy Director
   a) Cost Reducing Strategies -- Blue Shield of California and Adventist Health
   b) Update on Draft Alternative Payment Model Standards and Adoption Goals
   c) Update on Workforce Stability Standards, Including Summary of Public Comment Feedback
   d) Cost and Market Impact Review Draft Regulations Revisions
   e) Update on Primary Care Definition and Investment Benchmark, Including Summary of Public Comment Feedback

6. **Public Comment**

7. **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

Quarter 2 Work Plan*

	Health Care Affordability Board	Health Care Affordability Advisory Committee
APRIL 2024	• Discuss and adopt statewide spending target • Workforce stability standards, including Advisory Committee feedback	N/A
MAY 2024	• Primary care spending definitions, data collection, and investment benchmark, including Advisory Committee feedback • Update on alternative payment model (APM) standards and goals • Appoint Advisory Committee members	• Out-of-pocket out-of plan spend • Consumer affordability measures • Update on workforce stability standards • Update on primary care investment benchmark • Update on APM standards and goals
JUNE 2024	• Establish APM standards and goals (on or before July 1, 2024) • Update on OHCA's adoption of workforce stability standards (on or before July 2024), including summary of public comment feedback • Update on primary care definition and investment benchmark, including summary of public comment feedback • Cost and market impact review draft regulations revisions • Examples of cost-reducing strategies	N/A

* Work plan is subject to change.

Quarter 3 Work Plan*

	Health Care Affordability Board	Health Care Affordability Advisory Committee
JULY 2024	**Cancel Meeting**	N/A
AUG 2024	• Approve primary care spending benchmark (no statutory deadline, but Sep/Aug timeframe is ideal for data collection regulations) • Advisory Committee member appointment • Regional variation in health care costs • Case Study: Monterey as a high-cost outlier **Meeting in Monterey**	N/A
SEP 2024	• Approve primary care spending benchmark (no statutory deadline, but Sep/Aug timeframe is ideal for data collection regulations) • Update on THCE data collection • Update on hospital spending measurement • Update on healthcare payments database	**Rescheduled to October**

* Work plan is subject to change.

Quarter 4 Work Plan*

	Health Care Affordability Board	Health Care Affordability Advisory Committee
OCT 2024	**Cancel Meeting**	• Updates to Data Submission Guide to incorporate data collection for alternative payment model arrangements and primary care spending • Update on hospital spending measurement • Introduce behavioral health and discuss progress defining behavioral health spending • Introduce quality and equity measure set proposal • Update on data collection related to workforce stability • Update on Cost and Market Impact Review regulations revisions
NOV 2024	• Updates to Data Submission Guide to incorporate data collection for alternative payment model arrangements and primary care spending • Update on hospital spending measurement • Introduce behavioral health and discuss progress defining behavioral health spending • Introduce quality and equity measure set proposal • Update on data collection related to workforce stability	N/A
DEC 2024	**No Meeting Scheduled**	

* Work plan is subject to change.

Future Topics Beyond 2024

THCE & Spending Target

- Update on total health care expenditures data collection progress.
- Introduction on payer administrative cost and profits.
- Discuss public reporting of spending in baseline report.
- Discuss progressive enforcement.

Promoting High Value

- Updates on alternative payment model (APM) and primary care spending data collection processes.
- Progress defining behavioral health and developing behavioral health spending benchmark.
- Progress developing OHCA's quality and equity measure set.

Assessing Market Consolidation

- Updates on material change notices received, transactions receiving waiver or warranting a cost and market impact review (CMIR), and timing of reviews for notices and CMIRs.

CMIR Program: Implementation Update

Unique Registrations in System: over 125

Transactions Submitted To-Date: 3

Transaction: Businesses Involved	Santa Monica Rehabilitation Center	Labcorp Purchase of Invitae	Labcorp Purchase of BioReference
Summary of Transaction	Skilled nursing facility changing operators after lease expiration	Labcorp acquisition of Invitae's genetic testing / clinical laboratory (Invitae in bankruptcy). *Expedited Review Requested*	Labcorp acquisition of BioReference's laboratory testing businesses focused on clinical diagnostics and reproductive and women's health.
Submission Status	Deemed complete: April 12, 2024	Deemed complete: June 5, 2024	Awaiting additional party information before notice can be deemed complete.
Review Status	**Review completed** (CMIR Waived): May 16, 2024 (24 working days)	**Review completed** (CMIR Waived): June 20, 2024 (11 working days)	

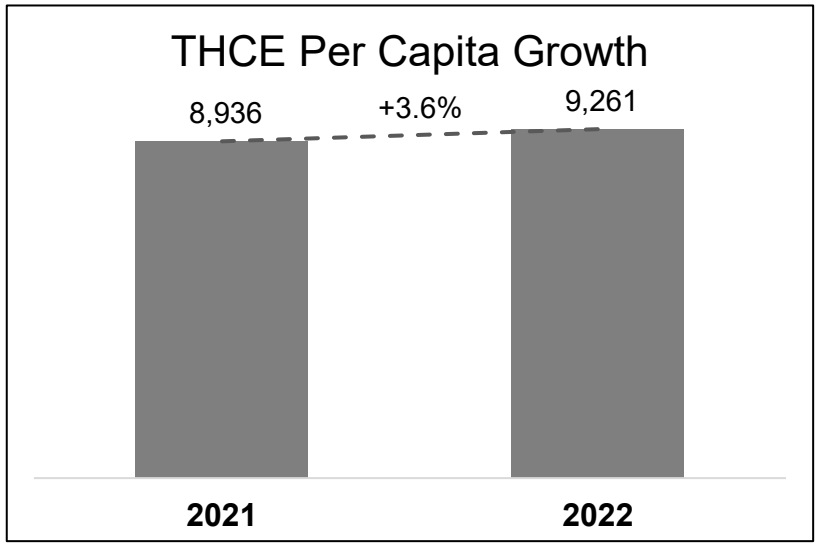
Transactions listed and linked at:
https://hcai.ca.gov/affordability/ohca/assess-market-consolidation/material-change-transaction-notices-mcn-and-cost-and-market-impact-review-cmir/

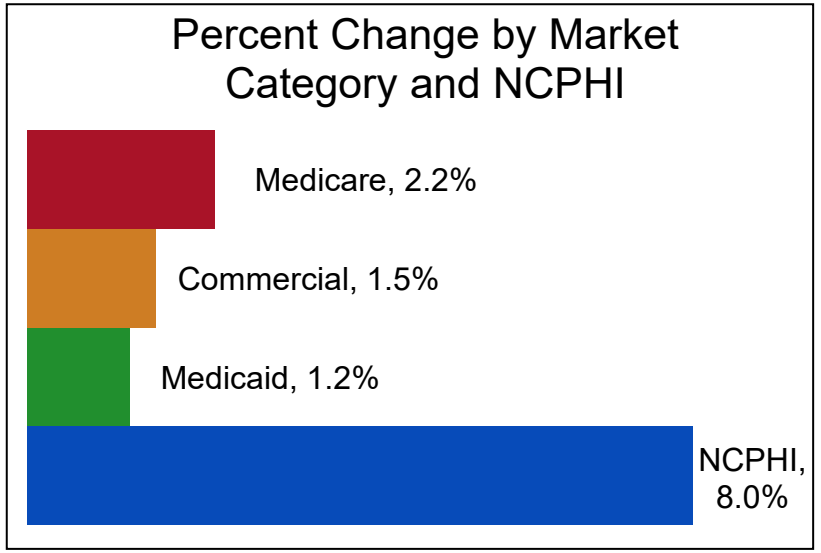
Highlights from Oregon 2021 – 2022 Cost Growth Report

- Total Health Care Expenditure (THCE) spending per person grew 3.6%, slightly above the cost growth target of 3.4%.

- After removing Net Cost of Private Health Insurance (NCPHI), each market category came in below the target as excess growth was mostly in the NCPHI and Other categories.

(Note: NCPHI = Admin Costs and Profits for California)

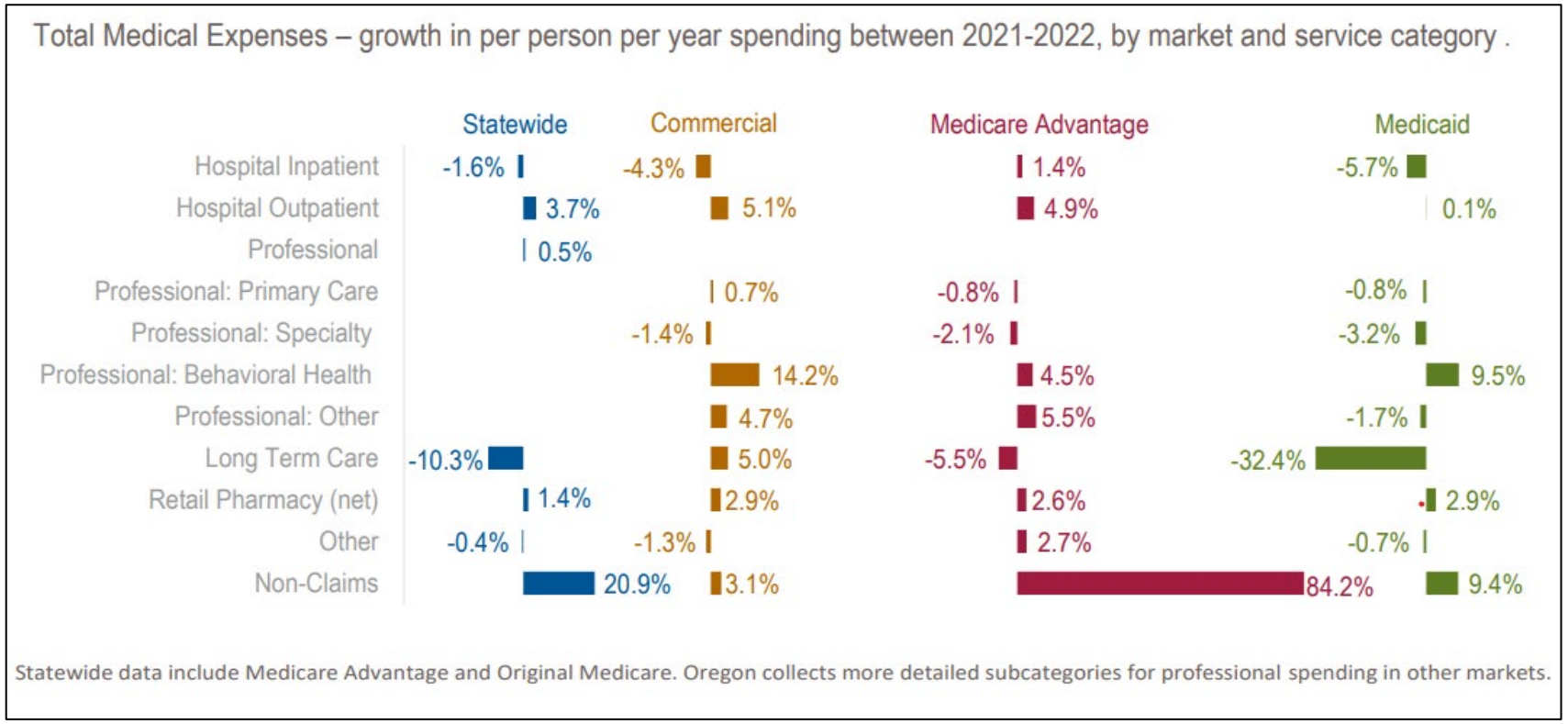




Source: Health Care Cost Growth Trends in Oregon. 2021-2022
Note: Oregon does not include NCPHI when measuring cost growth against the target at the market level because it only applies to specific parts of the Medicare and Medicaid markets.

Highlights from Oregon 2021 – 2022 Cost Growth Report

- The 1.5% growth in statewide Total Medical Expenses (TME) was driven by high growth in non-claims spending, mostly in Medicare Advantage and Medicaid.



Source: Health Care Cost Growth Trends in Oregon. 2021-2022
Note: TME is reported unadjusted for state population changes.

CMS Aggregate National Health Expenditure (NHE) Projections from 2023- 2032

- Aggregate health care spending is projected to have grown by 7.5% in 2023, up from 4.1% in 2022, and exceed GDP growth of 6.1%
  - CMS analysts cite an increase in the insured share of the population to 93.1% as one of the primary reasons for this higher rate of growth.
- From 2023 to 2032, the average annual growth rate in aggregate NHE is projected to average 5.6%, exceeding the nominal GDP growth rate of 4.3%. CMS analysts cite the following reasons for their projections:
  - Faster growth in personal health care prices relative to economywide price growth.
  - Continued aging of population through 2029 where enrollment levels off as the last of the baby boomers enroll.
  - Increasing demand for health care relative to income growth.
- These factors contribute to projected increases in the health care share of GDP reaching 19.7% by 2032 up from 17.3 in 2022.

Source: Fiore, J. et al. (2024, June 12). *National Health Expenditure Projections, 2023–32: Payer Trends Diverge As Pandemic-Related Policies Fade.* Health Affairs. https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00469

CMS Per Capita National Health Expenditure (NHE) Projections from 2023- 2032

- Overall, between 2023-2032, growth projections for per capita personal health care expenditures range between 4.3% and 8.4%.
- Over that same time period, CMS's growth projections for per capita private health insurance expenditures range between 4.8% and 8.0%, between 4.0% and 5.9% for Medicare, and between 5.2% and 10.2% for Medicaid.

Projected Average Annual Growth	2023	2024	2025-26	2027-2032
NHE per capita	6.9%	4.5%	4.3%	5.0%
PHC per capita	8.4%	4.6%	4.3%	5.1%
Private health Insurance per capita	8.0%	6.0%	4.8%	4.8%
Medicare per capita	5.9%	4.0%	4.7%	5.7%
Medicaid per capita	5.2%	10.2%	5.8%	5.2%

Source: Fiore, J. et al. (2024, June 12). *National Health Expenditure Projections, 2023–32: Payer Trends Diverge As Pandemic-Related Policies Fade.* Health Affairs. https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00469

Advisory Committee Vacancy

Until June 30, 2024, OHCA is accepting Advisory Committee submissions of interest from individuals who bring a hospital perspective, with an emphasis on a rural hospitals.

The Submission of Interest form can be found on OHCA's Advisory Committee website:

https://hcai.ca.gov/affordability/ohca/health-care-affordability-advisory-committee/

Next Steps:

- The Board subcommittee will review submissions in July and propose a member at the August Board meeting.

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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Public Comment

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Action Consent Item: Approval of the May 22, 2024 Board Meeting Minutes

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Update on Alternative Payment Model Standards and Adoption Goals

Margareta Brandt, Assistant Deputy Director

Investment and Payment Workgroup Members

Providers & Provider Organizations

Bill Barcellona, Esq., MHA
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
Senior Vice President for Population Health, AltaMed

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

Sarah Arnquist, MPH
Principal Consultant, SJA Health Solutions

Crystal Eubanks, MS-MHSc
Vice President Care Transformation, California Quality Collaborative (CQC)

Kevin Grumbach, MD
Professor of Family and Community Medicine, UC San Francisco

Reshma Gupta, MD, MSHPM
Chief of Population Health and Accountable Care, UC Davis

Kathryn Phillips, MPH
Associate Director, Improving Access, California Health Care Foundation (CHCF)

State & Private Purchasers

Lisa Albers, MD
Assistant Chief, Clinical Policy & Programs Division, CalPERS

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

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

Hospitals & Health Systems

Ben Johnson, MPP
Vice President Policy, California Hospital Association (CHA)

Sara Martin, MD
Program Faculty, Adventist Health, Ukiah Valley Family Medicine Residency

Ash Amarnath, MD, MS-SHCD
Chief Health Officer, California Health Care Safety Net Institute

Health Plans

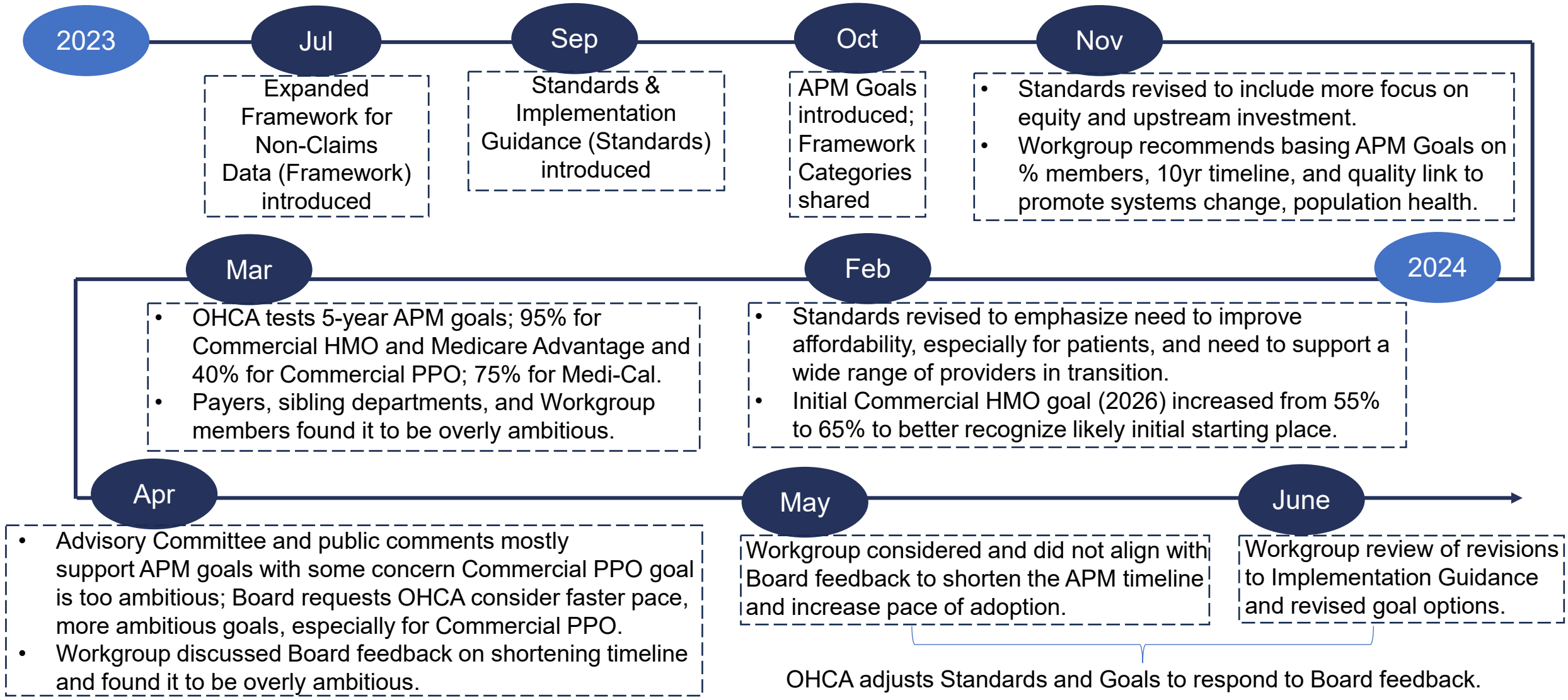
Joe Castiglione, MBA
Principal Program Manager, Industry Initiatives, Blue Shield of California

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

Stakeholder Input on APM Recommendations



Today's Follow-Up Items

1. Updates to Alternative Payment Model (APM) Standards and Implementation Guidance following the May Board meeting
2. Data OHCA plans to collect regarding APM adoption and its impact
3. APM Adoption Goals for Board consideration and adoption

Alternative Payment Models

Statutory Requirements

- Promote the shift of payments based on fee-for-service (FFS) to alternative payment models (APMs) that provide financial incentive for equitable high-quality and cost-efficient care.
- Convene health care entities and organize an APM workgroup, **set statewide goals** for the adoption of APMs, **measure the state's progress** toward those goals, and **adopt contracting standards** healthcare entities can use.
- Set benchmarks that include, but are not limited to, increasing the percentage of total health care expenditures delivered through APMs or the percentage of membership covered by an APM.

Alternative Payment Model Standards

Board Feedback on APM Standards and Implementation Guidance

	Feedback Theme	OHCA's Response
1.	Incorporate more guidance on the need to design APMs to serve consumers that require the most care.	Added that APMs should address the needs of consumers with highest healthcare costs and most to gain from comprehensive, coordinated care delivery. OHCA will collect risk score data for members in APM and not in an APM (fee-for-service).
2.	Include stronger focus on continuity of care, consider how plans are allowing members to keep their PCP when moving between plans.	Added emphasis on supporting continuous relationship with primary care providers. Include focus on payment to support primary care continuity.
3.	Emphasize importance of prospective attribution for PPO plans.	Revised to include prospective attribution as a core component of payment models.
4.	Help small practices implement APMs.	Standards emphasize using a gradual approach for small practices to take on financial risk in APMs and providing technical assistance to support success in APMs.
5.	Align quality measures in APMs with those used by sibling departments.	Added list of five aligned, priority measures across sibling departments.

Redlined versions of Implementation Guidance can be found in the Appendix.

Draft Motion: APM Standards for Payer-Provider Contracting

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.

Redlined versions of Implementation Guidance can be found in the Appendix of this deck.

Draft Motion: APM Standards for Payer-Provider Contracting

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).

Redlined versions of Implementation Guidance can be found in the Appendix of this deck.

Alternative Payment Model Data Collection and Goals

Board Feedback on APM Data Collection

	Feedback Theme	OHCA's Response
1.	Need clear approach for tracking the success of APMs; consider collecting additional data from payers, provider organizations in the future.	Will provide more information today on initial data collection and opportunities for future analyses. OHCA will collect risk score data for members in APM and not in an APM (fee-for-service).
2.	Collect data on how many high utilizers/high risk consumers are covered under APMs.	
3.	Collect data on how many people are covered under an APM in PPOs.	Basis for APM adoption goal, will report on members in an APM in Commercial PPOs.
4.	Collect data on results of direct contracting between purchasers/employers and providers.	OHCA data submitters are health plans and third-party administrators, not employers.
5.	Add reporting on APM contract structure and requirements between payer and provider.	Significantly increases reporting burden. However, using the Expanded Framework definitions will provide some qualitative information, which we will discuss today.

State APM Data Collection

Data Element	CA*	CO	DE	MA	MD	OR
% Providers in APMs	Yes	Yes	PC only	Yes	Yes	Yes
% Members in APMs	Yes	Yes	PC only	Yes	No	Yes
% Contract dollars in APMs	Yes	Yes	Yes	Yes	Yes	Yes
Non-Claims Spending	Yes	Yes	Yes	Yes	No	Yes
Health Status of members	Risk Score	No	No	Risk Score	Age/Gender Factor	No

***OHCA APM data collection regulations will be publicly discussed later this fall.**

HCAI Developed an Expanded Framework for Collecting Non-Claims Payment Data

	Expanded Non-Claims Payments Framework Categories
1	Population Health and Practice Infrastructure Payments
2	Performance Payments
3	Payments with Shared Savings and Recoupments
4	Capitation and Full Risk Payments
5	Other Non-Claims Payments
6	Pharmacy Rebates

- Developed Expanded Framework to support OHCA and HPD non-claims data collection.
- Expanded Framework crosswalks Milbank non-claims-payment categories with HCP-LAN categories for the purpose of reporting on APM adoption.
- Updates categories and subcategories to reflect care delivery and payment models in California.
- Allow single framework to support multiple use cases:
  - Define payment purpose
  - Measure provider risk

For additional background and details, see Pegany, V. et al. (2024, March 18). *A New Standard for Categorizing and Collecting Non-Claims Payment Data*. Milbank Memorial Fund. https://www.milbank.org/2024/03/a-new-standard-for-categorizing-and-collecting-non-claims-payment-data/

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

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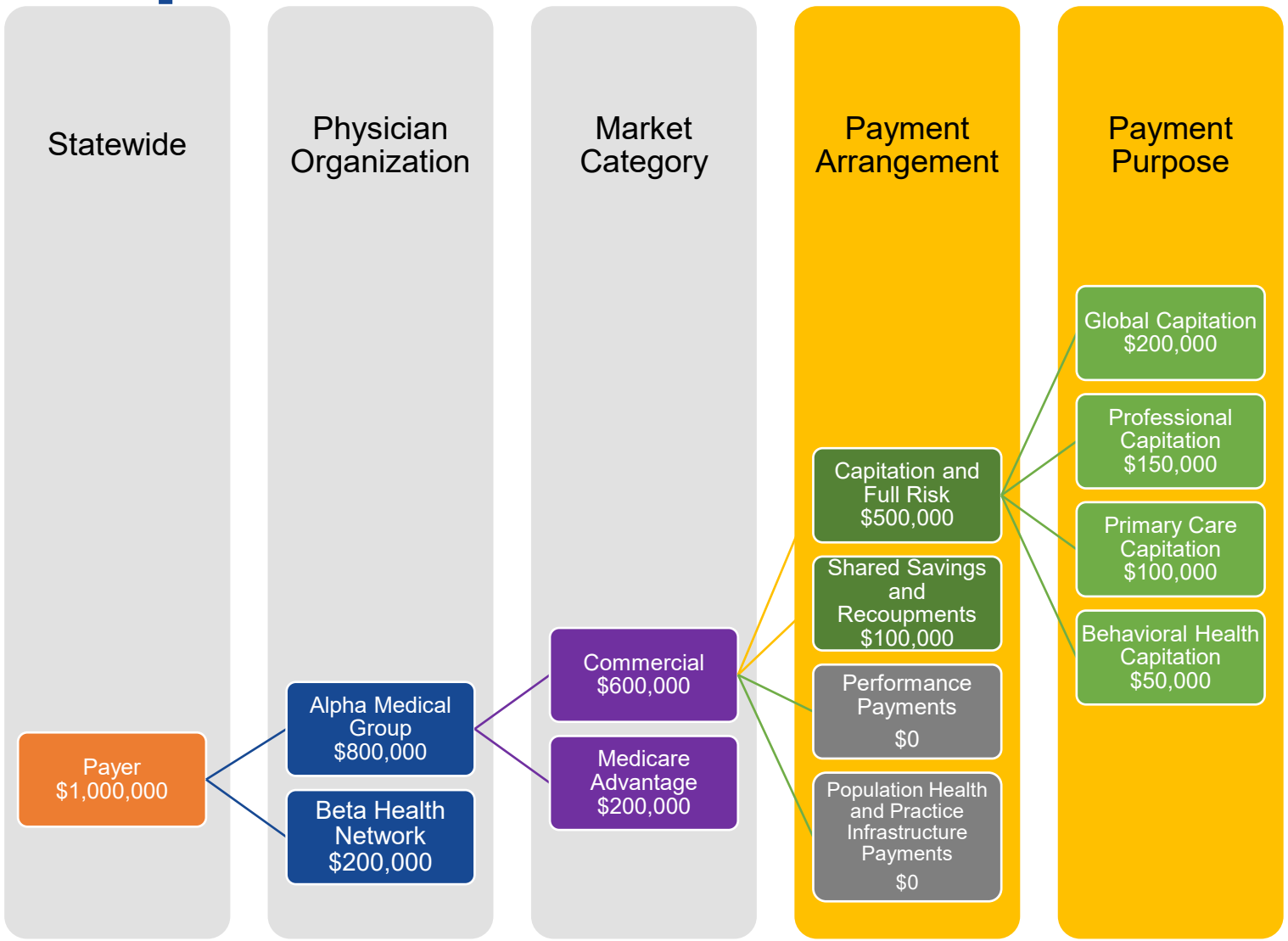
Expanded Framework, Categories 4-6

	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

Proposed APM Data Collection



Data elements collected will support reporting on:

- Numbers and types of APM arrangements
- Percent of members in APMs (target)
- Percent of providers in APMs
- Percent of spending in APMs
- Differences in total spending by arrangement type
- Relative health status of patients in APMs (risk scores) vs. those not in APMs

Expanded Framework Definitions Provide Some Qualitative Information

Information Collected	CA*	CO	MD
Type of payments (claims and non-claims)	Yes	Yes	Yes
Services covered (non-medical, subset of medical, comprehensive)	Yes	Yes	Yes
Whether arrangement includes measurement of quality?	Yes	Yes	Yes
Whether arrangement includes measurement of spending target (benchmark)?	Yes	Yes	Yes
Prospective, retrospective, population-based payments?	Yes	Yes	Yes
Risk to provider (upside, downside, both)?	Yes	Yes	Yes

***OHCA APM data collection regulations will be publicly discussed later this fall.**

Potential Questions OHCA Could Answer

The Expanded Framework's use of descriptive, more granular payment arrangement categories paired with the data collection structure will allow OHCA to ask additional questions of the data.

Examples:

- Are APMs engaging patients with higher needs?
- Is spending trend lower if APM adoption is higher?
- Is non-claims spending increasing as a percent of total spending?
- What types of payment arrangements are gaining traction?
- What portion of dollars are being paid prospectively?

Board Feedback on APM Goals

	Feedback Theme	OHCA's Response
1.	Consider faster timeline to achieve goals.	Workgroup, Advisory Committee members, and public comment emphasized contracting changes take time. The recommended approach offers short and long-term goals that increase commercial PPO APM adoption by nearly 50% by 2026 (i.e., estimated 17% of members today to 25%) and by nearly 400% by 2034.
2.	Consider aligning Commercial PPO and Medi-Cal goals at 75%.	The vast majority of Medi-Cal members are enrolled in Medi-Cal managed care plans which are HMOs. These plans will need to add a quality link if one does not exist. PPO products will require significant shifts in member engagement, contracting, payment, and provider readiness. The attribution approach most used in PPO products arrives at a lower percentage of attributed members who participate in an APM.
3.	Support for 75% Medi-Cal target due to large portion of population in Medi-Cal.	OHCA agrees that having 75% of Medi-Cal members in APM arrangements will have significant impact on moving Californians into APMs.

Key Design Decisions and Rationale for APM Goals

Design Decision	Rationale
Base on members	Promotes population health focus.
Count APMs farthest along the continuum *(i.e., HCP-LAN 3A - 3B, 4A – 4C)*	Focuses in on arrangements most likely to improve affordability.
Require link to quality	Emphasizes need to improve quality while lowering costs.
Tie goals to HCP-LAN categories	Aligns with national and sibling department approaches and allows for comparisons; eases data submitter burden.
Collect data with Expanded Framework	Offers more detail on type and purpose of the payment.
Leverage definitions to drive preferred APM models	Minimum risk requirements and other language in definitions reflects research and stakeholder preferences in APM design.

*OHCA APM adoption target decisions are not final and subject to change.

Draft Motion: APM Adoption Goals (May – OHCA Recommendation)

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%

Considerations:

- Represents compromise reached in the Workgroup over 10 months of discussion.
- Developed in collaboration with sibling departments.
- Reflects Commercial PPO contracting cycles.
- Allows time to engage members and strengthen provider readiness; less risk of promoting greater consolidation.

Dept. of Health Care Access and Information (2024). *APM Standards and Adoption Goals Memo for Board Adoption.* May 2024 OHCA Health Care Affordability Board. https://hcai.ca.gov/wp-content/uploads/2024/05/APM-Standards-and-Adoption-Goals-Memo-for-Board-Adoption.pdf

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Action Item: Establish Alternative Payment Model Standards and Adoption Goals

Margareta Brandt, Assistant Deputy Director

Draft Motion: APM Standards and Adoption Goals

Approve:

- Ten APM Standards for Payer-Provider Contracting; and
- APM Adoption Goals for the percent of members attributed to HCP-LAN Categories 3 and 4 by 2034: 95% for Commercial HMO and Medicare Advantage, 75% for Medi-Cal, and 60% for Commercial PPO.

Draft Motion: APM Standards for Payer-Provider Contracting

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.

Redlined versions of Implementation Guidance can be found in the Appendix of this deck.

Draft Motion: APM Standards for Payer-Provider Contracting

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.
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Draft Motion: APM Adoption Goals

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2034	95%	60%	75%	95%

Dept. of Health Care Access and Information (2024). *APM Standards and Adoption Goals Memo for Board Adoption.* June 2024 OHCA Health Care Affordability Board. https://hcai.ca.gov/document/apm-standards-and-adoption-goals-memo/

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Board Discussion

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Public Comment

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Informational Item

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Cost Reducing Strategy: Blue Shield of California

Peter Long, PhD, Executive Vice President, Strategy and Health Solutions

blue california

An Ecosystem Approach to Cost Reduction

Presentation to Office of Health Care Affordability

We are rebels with a cause

We are a non-profit, tax-paying health plan on a mission to create a healthcare system that is worthy of our family and friends and sustainably affordable for everyone.

7,500+
employees

4.8M
Californians served across all 58 counties

$24B
in revenue

2%
pledge

Our North Star

To create a healthcare system that is worthy of our family and friends and sustainably affordable.

How we'll get there

- Create a personal, high-quality experience
- Serve more people
- Be financially responsible
- Be a great place to do meaningful work
- Stand for what's right
- Be digital-first; make health care simple

Who we are

Human. Honest. Courageous.

Achieving our North Star requires **bold** moves

To radically transform healthcare and create real change for our members, we are taking on some key initiatives to:

- Reimagine pharmacy care
- Make member interactions real-time and seamless
- Enable comprehensive digital health records for our members
- Scale behavioral health services

To achieve equitable and high-quality care, improve member and provider experience, and reduce costs we believe we have to work across the ecosystem - pairing broad foundational changes with targeted interventions.

Blue Shield of California's Pay for Value Strategy is designed to achieve the quadruple aim

Pay for Value Goals

Guiding Philosophy

1. Fee-for-service is a broken system, and we need to drive transformational changes to payment.
2. High-quality care can also be efficient care.
3. Build trust and improve the relationship with providers by paying them for the right work.
4. Incentives must improve outcomes in an equitable manner.

We are implementing pay for value models across the spectrum of care

Primary Care

Primary Care Hybrid

Fee for Service Plus

Large System Primary Care

ACO 2.1

Hospitals

Hospital Value Model

ACO 2.1

Specialty Episodes of Care

Orthopedics

Gastroenterology

Maternity

Cardiology

Oncology Care

Radiation Therapy Episodes of Care

Palliative care

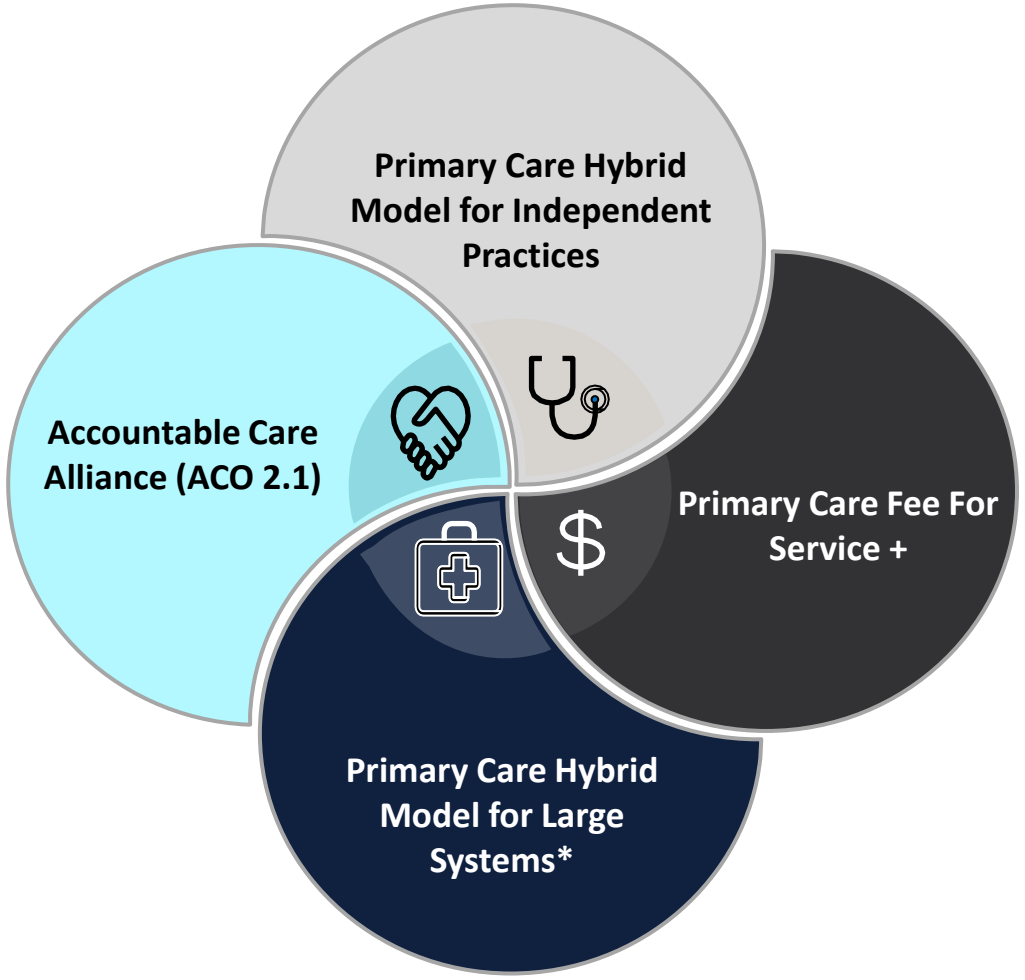
Chronic Disease Management & Behavioral health

Crohn's and Colitis

Rheumatoid arthritis

Cardiology

We have a big opportunity to impact cost and outcomes through our Advanced Primary Care models



Early Results

9%

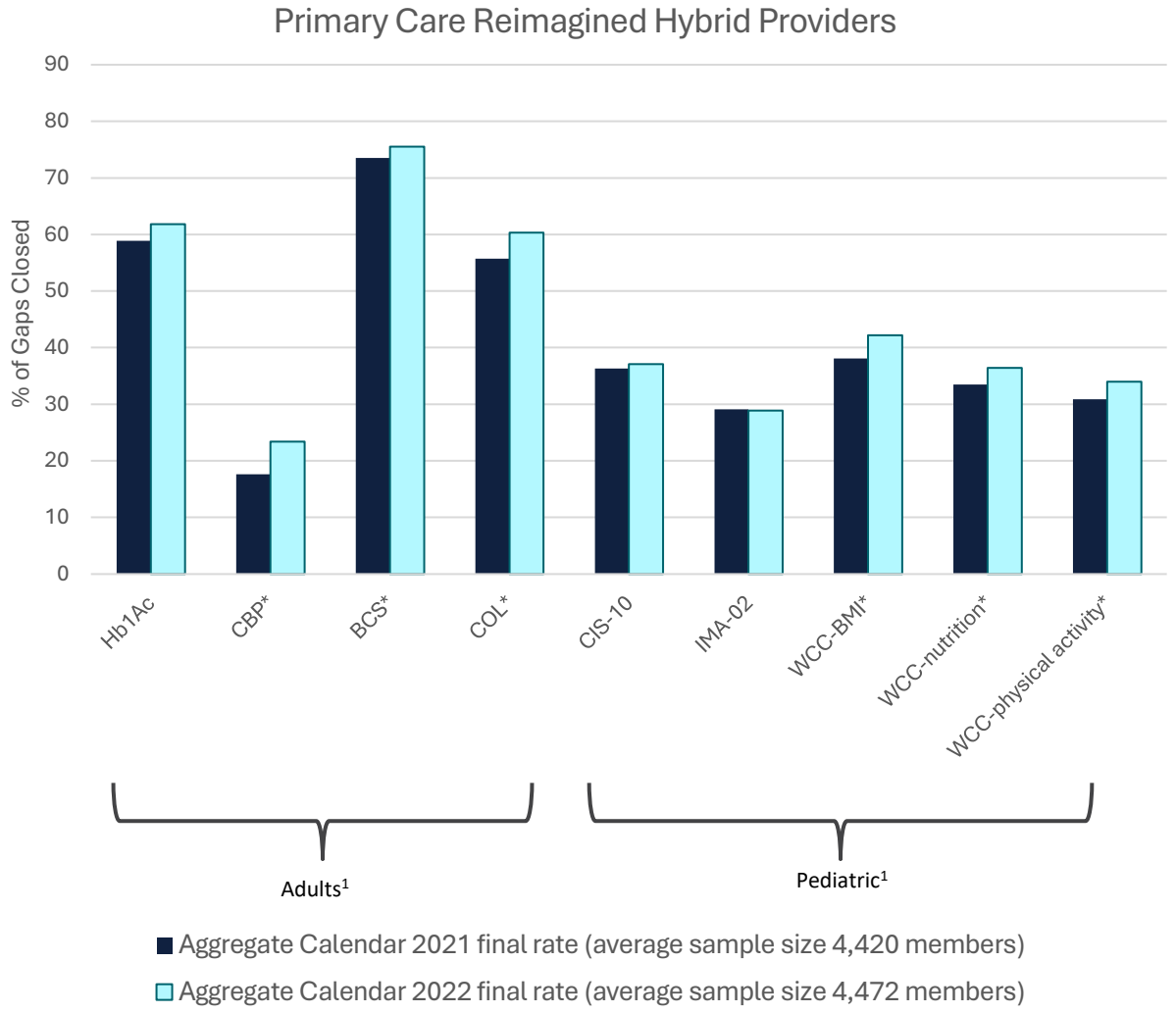
net savings*

45%

eligible independent practices on the model

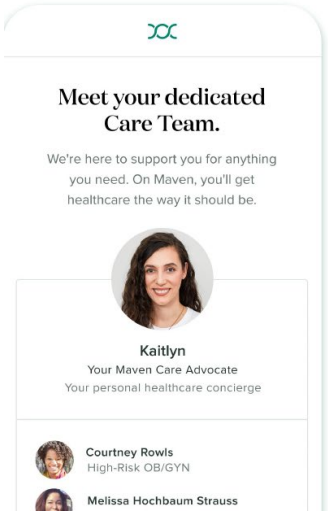
** Net Savings results are preliminary and based on an internal study performed by Blue Shield of California. We are continuing to refine and evolve our measurement methodology.*
***Large system to go live in 2024*

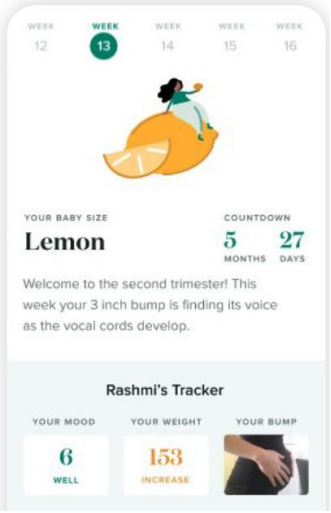
Preliminary results* are indicating quality improvement in key quality measures from baseline to the first measurement year



** Improvement results are preliminary and based on an internal study performed by Blue Shield of California. We are continuing to refine and evolve our measurement methodology.*

**Indicates significant p <=.05*





MAVEN

We are also rapidly moving the needle for targeted populations by leveraging partnerships

Maven

Maven is a virtual platform that offers our members a dedicated Care Advocate to help them navigate services, a specialized virtual care team to supplement care, and content and community resources to support decision making.

Through Maven, Blue Shield of California members have access to a suite of maternity services through their pre- to post-natal journey including:

- Mental health providers
- OB-GYNs
- Nutritionists
- Community forums
- Articles
- Doulas
- Lactation consultants
- Pediatric sleep coaches

Targeted interventions like Maven deliver meaningful results for our members

Access & Experience

- 3,000+ participants annually
- 24/7 access to dedicated Care Advocate
- Early identification and intervention: 65% joined in 1st or 2nd trimester
- Inclusive support: 40% identify as BIPOC
- Resources for those who need it: 60% high-risk
- Access to 35+ types of specialists, with 32% identifying as BIPOC: 9,650 appointments
- High utilization: 700+ classes attended, 30+ articles per participant
- Sustained engagement: 80-100+ minutes on platform per trimester
- High satisfaction: 75 Net Promoter Score

Outcomes

- $4,585 gross average annual savings per engaged member
- $0.48 pmpm gross average savings
- 39% reduction in NICU days
- 2% reduction in C-section deliveries
- 10% reduction in ER visits
- 60% reduction in inpatient days unrelated to delivery

Study performed by Blue Shield Data & Analytics team comparing Maven participants to a matched control group of non-participants

HCAi
Department of Health Care Access and Information

Public Comment

HCAi
Department of Health Care Access and Information

Cost Reducing Strategy: Adventist Health

Kerry Heinrich, President and CEO
John Beaman, Chief Financial Officer

Adventist Health
Value of Operating as a System

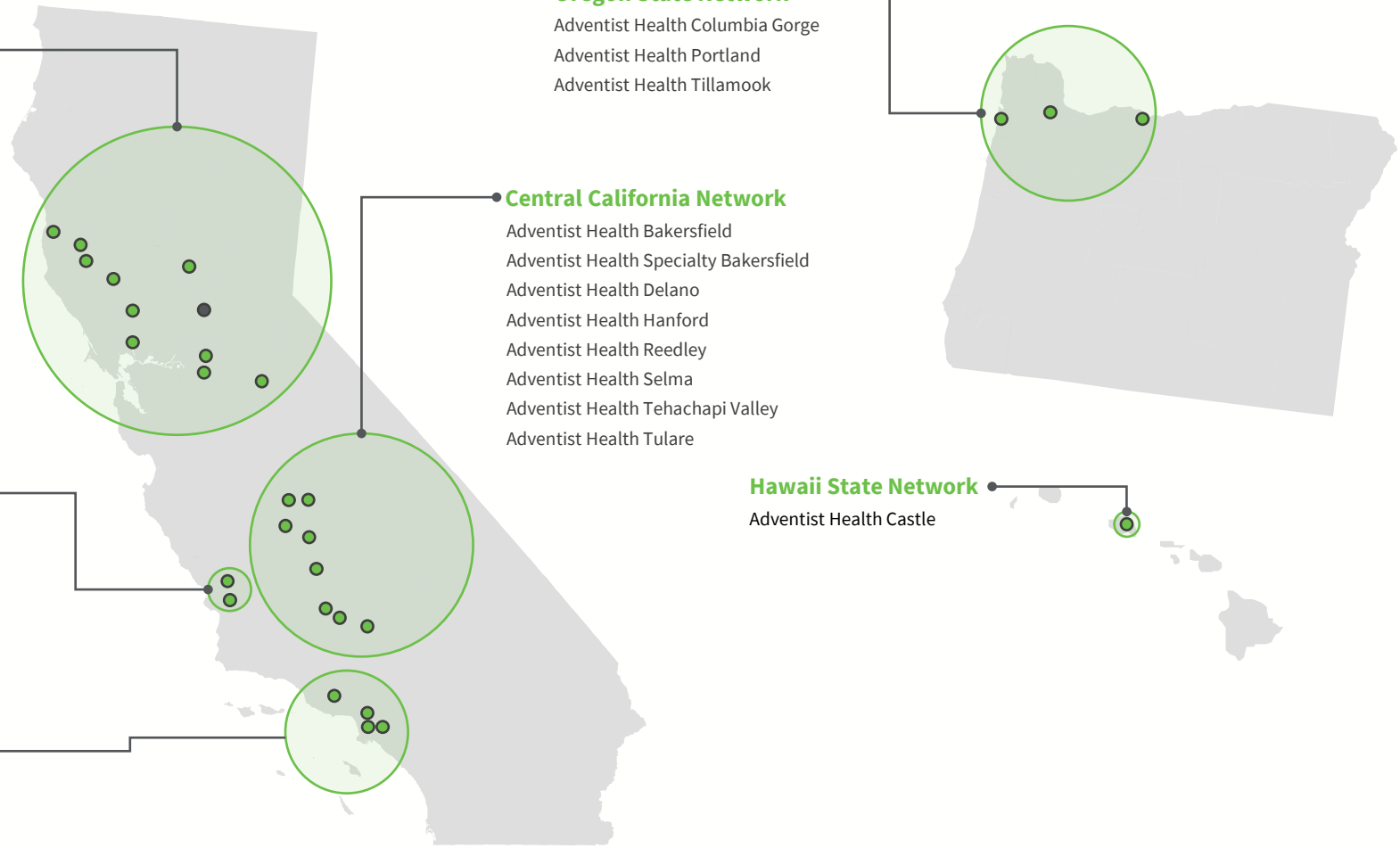
Office of Health Care Affordability | June 2024

Adventist Health

Living God's love by inspiring health, wholeness and hope

AdventistHealth

Adventist Health Networks



Northern California Network
Adventist Health Clear Lake
Adventist Health Howard Memorial
Adventist Health Lodi Memorial
Adventist Health Mendocino Coast
Adventist Health and Rideout
Adventist Health Sonora
Adventist Health St. Helena
Adventist Health Vallejo
Adventist Health Ukiah Valley
Dameron Hospital*

Oregon State Network
Adventist Health Columbia Gorge
Adventist Health Portland
Adventist Health Tillamook

Central California Network
Adventist Health Bakersfield
Adventist Health Specialty Bakersfield
Adventist Health Delano
Adventist Health Hanford
Adventist Health Reedley
Adventist Health Selma
Adventist Health Tehachapi Valley
Adventist Health Tulare

Central Coast Service Area
Adventist Health Sierra Vista
Adventist Health Twin Cities

Hawaii State Network
Adventist Health Castle

Southern California Network
Adventist Health Glendale
Adventist Health Simi Valley
Adventist Health White Memorial
Adventist Health White Memorial Montebello

*Managed facility

Networks by the Numbers

$6.0B
Total revenue
in FY 2023

$6.6B
Total forecasted revenue
in FY 2024

4
States house the
communities we serve

38k
Associates, including physicians,
allied health professionals and
support services

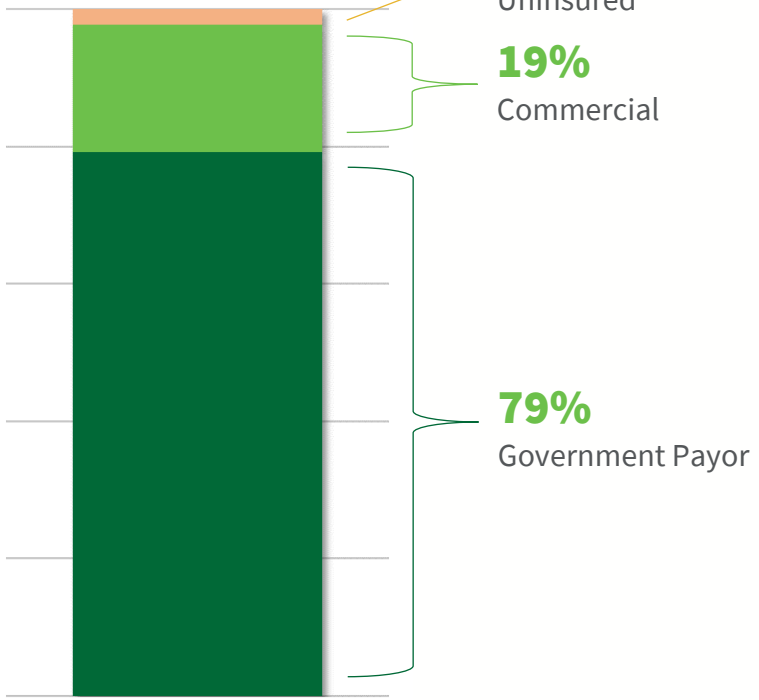
28
Hospitals
with 4,167 beds

442
Clinics

15 / 8
Home care agencies /
Hospice agencies

2.7M
Clinic visits per year

People Served



AdventistHealth

Definition of Scale

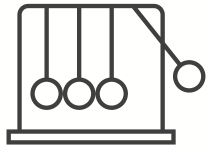
Possess sufficient scale to systematically increase access to health care delivery and reduce associated administrative costs for a specific geographic area or population base

By operating as a system, we can create expertise and efficiencies in cost to mitigate the impact of inflation and enable us to maximize dollars spent on patient connections and care

Administrative Cost

Backend services that:

- Ensure the appropriate delivery of supplies, staff, and other resources
- Compliance with billing requirements and regulatory standards



Clinical Care

Advancing quality care through:

- Systematic review and implementation of standards of care
- Dedicated quality programs to improve patient safety
- Manage Risk Responsibility

Reduced Variation and Redundancy

Controls to implement standard processes to ensure a reliable and consistent delivery of support services for health care providers and our patients

Automation

Tools to leverage automation and other systems streamlining repetitive tasks and reducing the administrative burden of care

Placement of Service

Evaluate on-site and off-site locations for support services to maximize value generated for investments in clinical services

Scale Definition: Aggregation of expertise and spend to standardize process, modernize systems and create efficiencies.

Risk: Higher labor inflation than revenue increases.

Objectives and Results

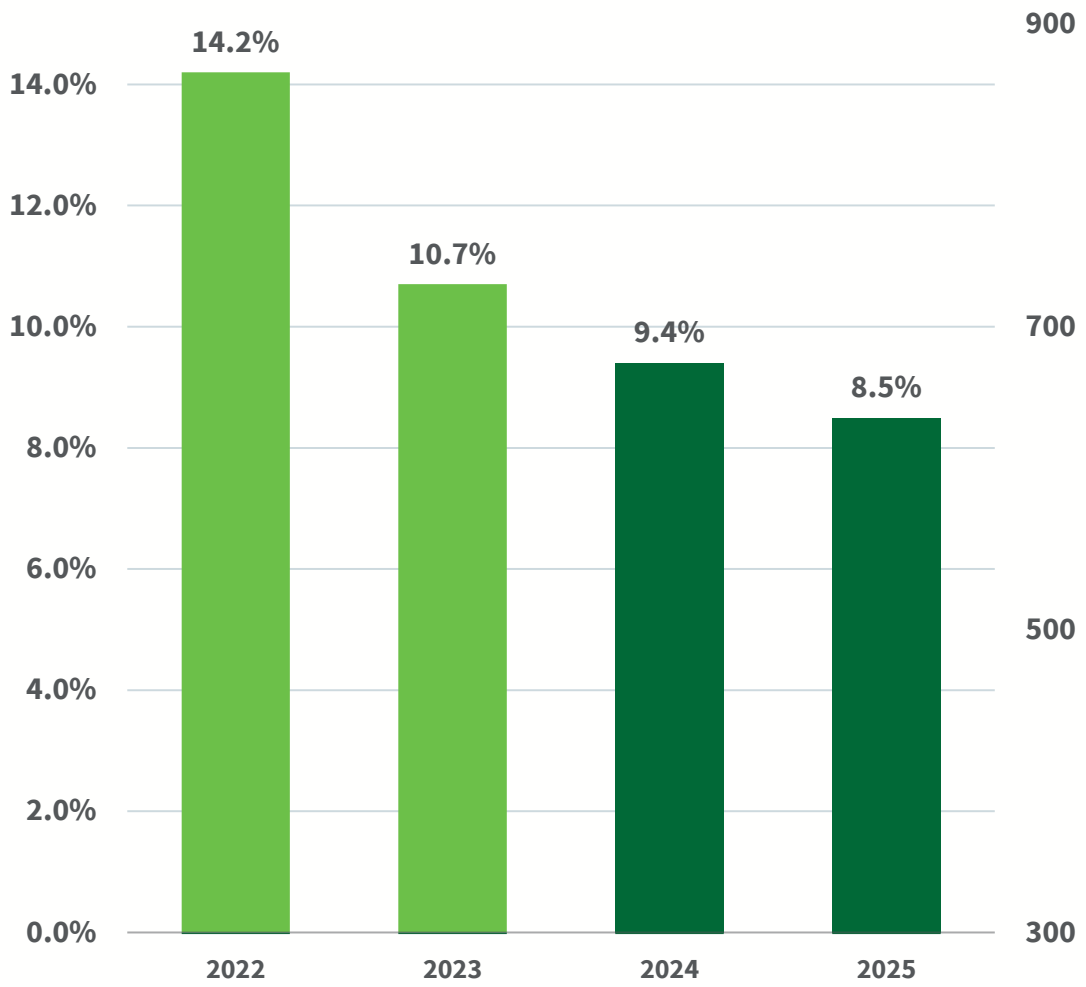
- Leverage scale for expense structure optimization, moving system shared service costs to 7% by 2027
- $100M of savings executed Q1 2023 (focus on core services)

Opportunities

Leverage scale through standard processes and automation

Optimize investments in direct patient care and community benefit activities

Shared Service Optimization



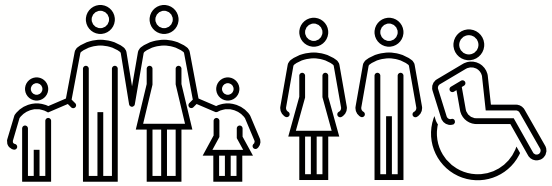
AdventistHealth

Standards of Care

Single EMR with consistently delivered care across markets and care settings

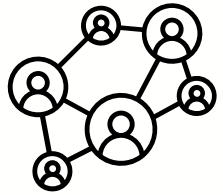
Quality Programs

Identification of best practices to improve clinical outcomes for specific disease states implementing the latest clinical guidelines



Lives at Risk

More than 165,000 Medi-Cal lives throughout California



Scale to Create Efficiencies

A critical mass of lives to mitigate systematic health risks in a population and to create capacity for support services such as: back office, referral centers, restoration houses, and residency programs

Scale Attribute: Sufficient aggregation of lives to reduce variability in the cost of care and manage spend.
Risk: Multiple intermediaries, increasing administrative costs

Appendix

Award-Winning Excellence

Adventist Health Lodi Memorial
Adventist Health and Rideout
Adventist Health White Memorial

Commission on Cancer®

Adventist Health Bakersfield
Adventist Health Glendale
Adventist Health Portland
Adventist Health and Rideout
Adventist Health Sierra Vista
Adventist Health St. Helena
Adventist Health White Memorial

Adventist Health Castle **2017**
Adventist Health White Memorial **2019**

LEAPFROG
HOSPITAL
SAFETY GRADE

2023 Award Winners

Adventist Health Bakersfield
Adventist Health Glendale
Adventist Health Hanford
Adventist Health Selma
Adventist Health Sierra Vista
Adventist Health Sonora
Adventist Health St. Helena

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

FOUR-STAR QUALITY RATED

Adventist Health Bakersfield
Adventist Health Clear Lake
Adventist Health Howard Memorial
Adventist Health Lodi Memorial
Adventist Health Sonora

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

FIVE-STAR QUALITY RATED

Adventist Health Castle
Adventist Health Glendale
Adventist Health St. Helena

HIGH PERFORMING HOSPITALS
U.S.News & WORLD REPORT

HIGH PERFORMING HOSPITALS 2023

Adventist Health Bakersfield
Adventist Health Castle
Adventist Health Clear Lake
Adventist Health Columbia Gorge
Adventist Health Glendale
Adventist Health Hanford
Adventist Health Howard Memorial
Adventist Health Lodi Memorial
Adventist Health Portland
Adventist Health and Rideout
Adventist Health Simi Valley
Adventist Health Sonora
Adventist Health St. Helena
Adventist Health White Memorial
Dameron Hospital

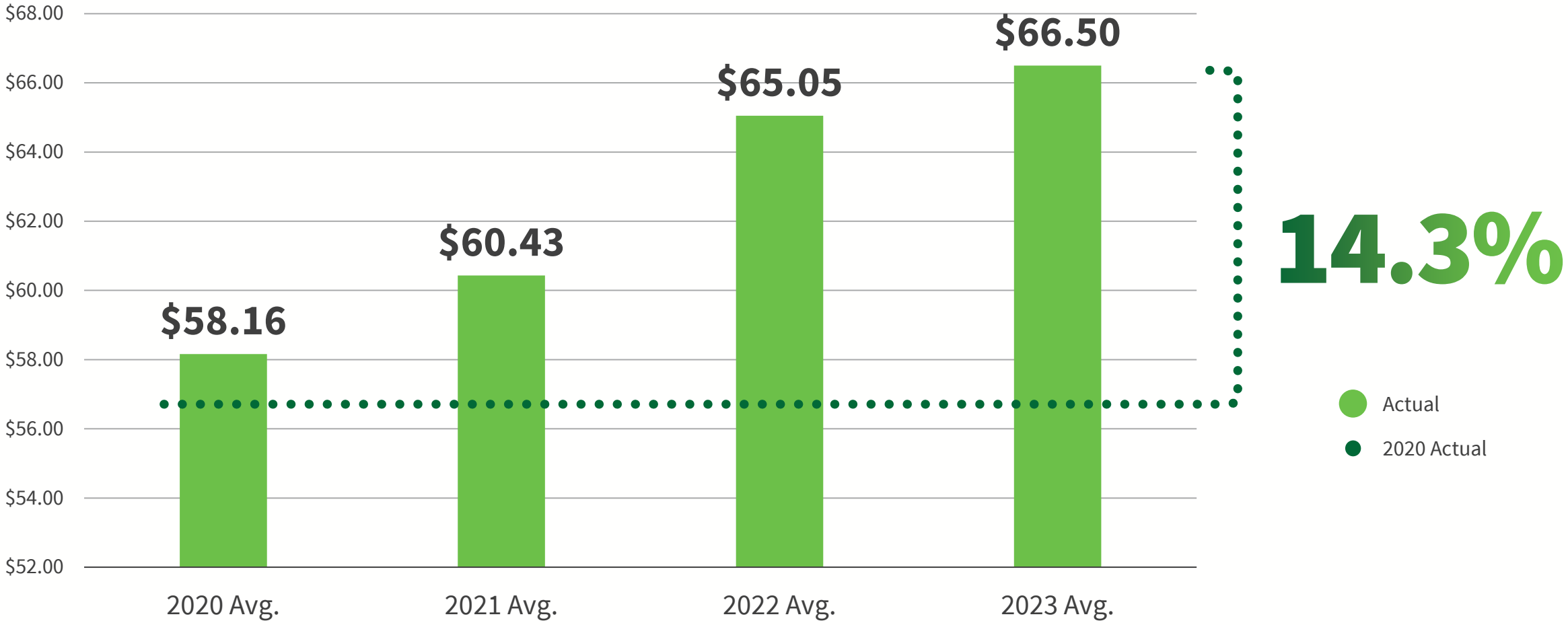
Adventist Health Glendale

Adventist Health Castle
Adventist Health Tehachapi Valley

Adventist Health Glendale
Adventist Health Hanford
Adventist Health Simi Valley
Adventist Health Sonora
Adventist Health White Memorial

AdventistHealth

Average Hourly Rate



AdventistHealth

HCAi
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Public Comment

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Department of Health Care Access and Information

Informational Items

HCAi
Department of Health Care Access and Information

Workforce Stability Standards, Including Summary of Public Comment Feedback

Margareta Brandt, Assistant Deputy Director

Health Care Workforce Stability

Statutory Requirements for the Office

- Monitor the effects of spending targets on health care workforce stability, high-quality jobs, and training needs of health care workers.
- Monitor health care workforce stability with the goal that workforce shortages do not undermine health care affordability, access, quality, equity, and culturally and linguistically competent care.
- Promote the goal of health care affordability, while recognizing the need to maintain and increase the supply of trained health care workers.
- **Develop standards, in consultation with the Board, to advance the stability of the health care workforce.**

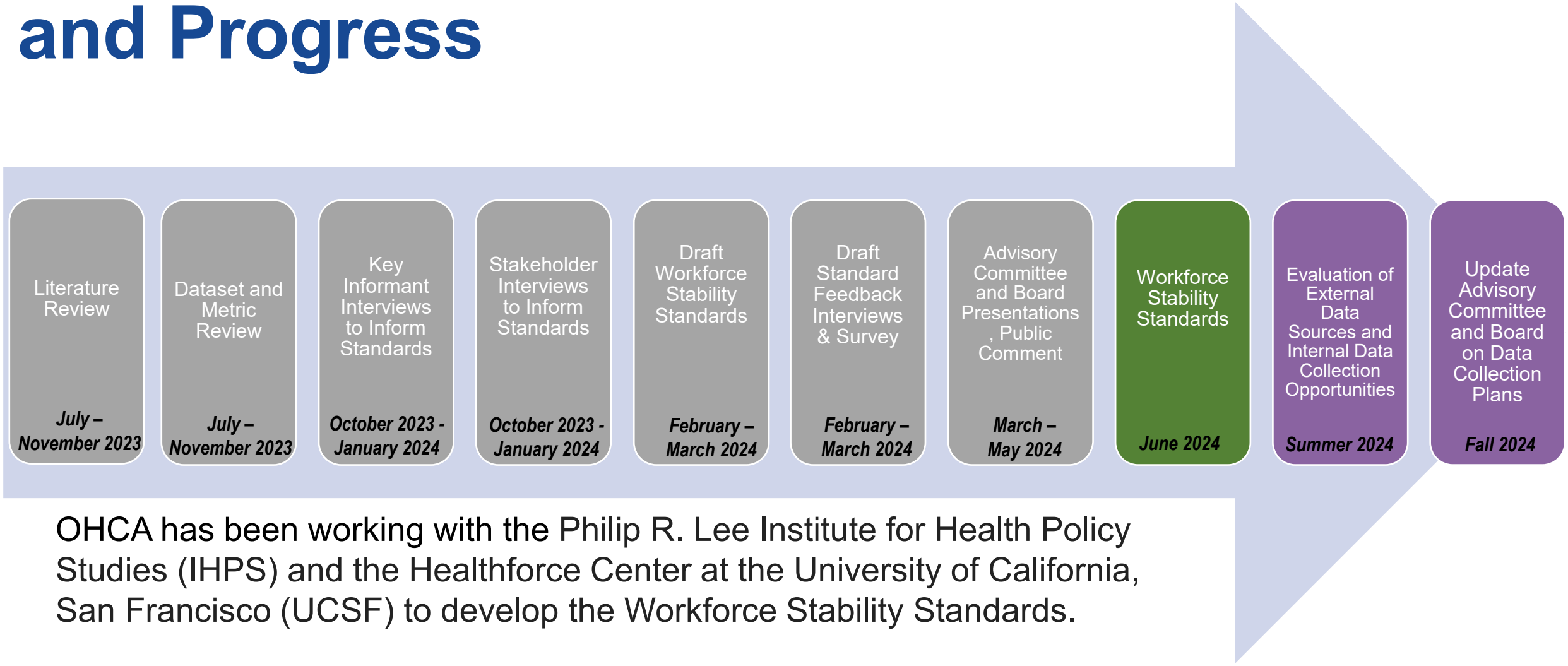
Health and Safety Code § 127506 (a)-(c)

Health Care Workforce Stability

Statutory Requirements

- **The Board approves standards to advance the stability of the health workforce that may apply in the approval of performance improvement plans.**
- OHCA may require a health care entity to implement a performance improvement plan that identifies the causes for spending growth and shall include specific strategies, adjustments, and action steps proposed by the entity to improve spending performance during a specified time period. The director shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode health care access, quality, equity, or workforce stability.

Workforce Stability Standards Process and Progress



OHCA has been working with the Philip R. Lee Institute for Health Policy Studies (IHPS) and the Healthforce Center at the University of California, San Francisco (UCSF) to develop the Workforce Stability Standards.

Refer to the January Advisory Committee Meetings slide decks for further details on literature review, data set review, and key informant interview findings.

Approach to Workforce Stability Standards and Metrics

Standards

- Best practices for health care organizations to adopt.
- Organizations should implement these practices and track related key performance indicators (KPIs) to help ensure a stable workforce.
- No financial penalties associated with noncompliance, but these standards will inform the development of standards that may apply in performance improvement plans for entities exceeding the spending target.

Metrics

- Use publicly available data to monitor workforce stability at the organization and market levels to complement the standards.
- Publicly report on metrics in OHCA's annual report.
- Develop approach to collect data for KPIs, publicly report on KPIs when data is available, and may add performance expectations to the standards in future years.

Public Comments and Board Feedback on Proposed Workforce Stability Standards and Metrics

Key Themes from Board and Public Comment Feedback

Workforce Stability Standards	
Feedback Theme	**OHCA's Response**
• Measure organizations' performance against the Standards. • Improve clarity and specificity of terms used in Standards. • Include physician workforce in Standards. • Analyze the impact of workforce stability on continuity of care.	• Workforce stability metrics are informed by Standards and statutory requirements. • Updated the standards' language to improve specificity, clarity, and measurability. • Will collaborate with HCAI's Workforce Office to understand trends in the physician workforce using HCAI data. • Included additional details on relationship between workforce stability and continuity of care in the context section of the Workforce Stability Standards and Metrics document.

Key Themes from Board and Public Comment Feedback

Key Performance Indicators (KPIs) in Standard 1	
Feedback Theme	**OHCA's Response**
• Some strongly favor mandatory reporting by entities, while others are supportive of the current proposal. • Include data on contract labor, especially in behavioral health. • Turnover and retention are top-priority key performance indicators (KPIs) to monitor. • Monitor a concise set of actionable metrics. • Measure real-time indicators of organizational performance.	• Developing options to collect data on KPIs from health care entities, leveraging existing data collection processes to minimize reporting burden. Regulations will be needed for new data collection. • Contract labor use, turnover, retention, and vacancy rates are high-priority KPIs to include in new data collection efforts. • Exploring options for timely data collection and reporting.

Key Themes from Board and Public Comment Feedback

Organization and Market Level Metrics	
Feedback Theme	**OHCA's Response**
• Monitor more ambulatory settings, including behavioral health. • Include additional data sources to monitor worker safety, layoffs, turnover, and access. • Monitor availability of linguistically concordant care. • Monitor regional health care workforce. • Monitor workforce impacts of organizations' response to spending targets.	• Evaluating options to address data gaps for ambulatory care and behavioral health. • Evaluating all suggested data sources. • OHCA metrics track race, ethnicity, and languages spoken by occupation and by region. • Many metrics can be analyzed by organization and/or geographic region. • Developing reporting structure to promote tracking of relationship between spending target performance and workforce stability.

Workforce Stability and Cost Growth Targets

- Recognizing the health care workforce as an organizational asset rather than an expense can contribute to slowing spending growth.
  - Investments in a well-trained and well-compensated workforce can decrease staff turnover, burnout, and reliance on contract labor use.[1, 2,]
  - These improvements can collectively lower health care costs and can enhance quality of care.[3]
  - Maintaining a stable health care workforce includes investing in education and training of new workers and the retention of those already in the field.[4, 5]

1. Matthew D. McHugh and Chenjuan Ma, "Wage, Work Environment, and Staffing: Effects on Nurse Outcomes," *Policy, Politics & Nursing Practice/Policy, Politics, & Nursing Practice* 15, no. 3–4 (August 1, 2014): 72–80, https://doi.org/10.1177/1527154414546868.
2. Meg Bourbonniere et al., "The Use of Contract Licensed Nursing Staff in U.S. Nursing Homes," *Medical Care Research and Review* 63, no. 1 (February 1, 2006): 88–109, https://doi.org/10.1177/1077558705283128.
3. John R. Bowblis and Amy Restorick Roberts, "Cost-Effective Adjustments to Nursing Home Staffing to Improve Quality," *Medical Care Research and Review* 77, no. 3 (June 8, 2018): 274–84, https://doi.org/10.1177/1077558718778081.
4. George J. Borjas, "Labor Market Equilibrium" and "Compensating Wage Differentials," in *Labor Economics*, Sixth Edition. (New York, NY: McGraw-Hill, 2013), 144-203. http://students.aiu.edu/submissions/profiles/resources/onlineBook/q3e6P2_Labor_Economics-_6th_Edition.pdf.
5. Joanne Spetz and Ruth Given, "The Future of the Nurse Shortage: Will Wage Increases Close the Gap?" *Health Affairs* 22, no. 6 (2003): 199–206. https://doi.org/10.1377/hlthaff.22.6.199.
6. Karen B Lasater et al., "Valuing Hospital Investments in Nursing: Multistate Matched-cohort Study of Surgical Patients," *BMJ Quality & Safety* 30, no. 1 (March 27, 2020): 46–55, https://doi.org/10.1136/bmjqs-2019-010534.
7. Aileen Murphy et al., "Estimating the Economic Cost of Nurse Sensitive Adverse Events Amongst Patients in Medical and Surgical Settings," *Journal of Advanced Nursing* 77, no. 8 (May 5, 2021): 3379–88, https://doi.org/10.1111/jan.14860.
8. Timothy M. Dall et al., "The Economic Value of Professional Nursing," *Medical Care* 47, no. 1 (January 1, 2009): 97–104, https://doi.org/10.1097/mlr.0b013e3181844da8.
9. F. Cardwell Feagin et al., "Does Interdisciplinary Care Team Care Management Improve Health Quality and Demonstrate Cost-Effectiveness?," *Medical Care Research and Review* 81, no. 1 (September 7, 2023): 19–30, https://doi.org/10.1177/10775587231197846.

Revised Workforce Stability Standards

OHCA recommends entities adopt the following best practices to ensure workforce stability.

1. Monitor a priority set of key performance indicators of health care workforce stability. Relevant indicators to monitor include:

- Turnover rates;
- Retention rates;
- Vacancy rates;
- Contract and temporary labor use rates;
- Time to fill vacant positions;
- Percentage of employees eligible for benefits (e.g., health benefits, paid time off, and retirement);
- Employee engagement, including assessing for job satisfaction, burnout, and moral injury;
- Investment in continuing education, professional development, and training programs; and
- Diversity of workforce and languages spoken in relation to the population served.

Revised Workforce Stability Standards

OHCA recommends entities adopt the following best practices to ensure workforce stability.

2. Develop formal processes to adapt to changing workforce conditions. Establish policies and procedures to adjust hiring, training, and other practices based on the key performance indicators and market level influences. ***Actively engage staff who will be impacted by these policies in the development process.***

3. ***Allocate resources for professional development for health care workers to strengthen the current and future workforce.*** Such training includes developing new skills to adapt to changing health care delivery models that support affordability, access, quality, equity, and culturally and linguistically competent care, ***sponsoring clinical placements***, and supporting advancement of entry-level and non-clinical workers (e.g., housekeeping staff) to other occupations within the organization through career ladders.

4. Increase the use of interdisciplinary health care teams ***to support worker engagement*** **and improve affordability, access, quality, and equity.** Interdisciplinary teams ***promote effective use of team members' diverse skill sets to deliver high-quality, patient-centered care. Examples of interdisciplinary team care include integrated behavioral health in primary care settings and using community health workers to address social needs.***

Green text indicates revisions made in response to Board and public comment to the April 2024 draft Workforce Stability Standards.

Revised Workforce Stability Standards

OHCA recommends entities adopt the following best practices to ensure workforce stability.

5. ***Prioritize hiring, employee advancement, and care delivery practices that ensure*** **culturally and linguistically competent care.** Access to high-quality, equitable care across all communities requires a health care workforce that represents California's people, speaks their languages, and understands their cultures. Prioritize hiring, employee advancement, and care delivery practices that advance equitable care. ***Use regional demographic data to align the workforce with the needs of the populations served.***

6. Monitor and address workplace safety and violence. Continually monitor workplace safety and violence and implement policies and procedures to ensure safe working conditions for all health care workers. ***A safe workplace supports employee well-being and workforce stability, ultimately improving the quality of patient care.***

Green text indicates revisions made in response to Board and public comment to the April 2024 draft Workforce Stability Standards.

Categories of Workforce Stability Metrics

Organization Level Metrics

- **Wages and benefits** (e.g., total cost of employee compensation; pay rates per occupation for hospitals)
- **Workforce size and composition** (e.g., total nursing hours, contract nursing hours divided by total nursing hours for hospitals; staff FTEs and contract FTEs for licensed clinics)
- **Staffing intensity** (e.g., average labor hours per emergency department visit, average labor hours per patient day, average labor hours per clinical laboratory test for hospitals)

Labor Market Level Metrics

- **Demographics** (e.g., age, race/ethnicity, languages spoken)
- **Employment information** (e.g., working hours, practice settings, compensation and earnings)
- **Training** (e.g., awards/degrees by race/ethnicity, awards/degrees by gender, California registered nurse program capacity)

The complete set of metrics for organization and market level monitoring can be found in the Appendix.

Accountability for Workforce Stability Standards and Metrics

- **Transparency**: Reporting will include comparative performance on organization level metrics and regional and statewide market conditions (e.g., wages, workforce demographics) across occupations.
- **Performance Expectations**: After analyzing baseline data, OHCA will consider establishing performance expectations for Key Performance Indicators in Standard One and/or organization level metrics.
- **Performance Improvement Plan (PIP):** General workforce stability standards may be used to inform the development of standards that apply in a performance improvement plan for entities not meeting the spending growth targets.

Updates on Additional Data Collection Opportunities

- Regarding the request for mandatory reporting by entities, OHCA is:
  - Assessing options for adding new data elements to existing HCAI data collection (e.g., Hospital Annual Financial Disclosures)
  - Investigating regulatory and data analytic requirements within HCAI
- Regarding the request for additional external data sources, OHCA is:
  - Meeting with external agencies and organizations (e.g., Employment Development Department for Worker Adjustment and Retraining Notification Data) to explore data sharing agreements
  - Assessing HCAI resources required for data extraction and analysis
- OHCA will update the Board and Advisory Committee on progress by Fall 2024.

OHCA Workforce Stability Standards

OHCA recommends entities adopt the following best practices to ensure workforce stability.

1. Monitor a priority set of key performance indicators of health care workforce stability. Relevant indicators to monitor include:

- Turnover rates;
- Retention rates;
- Vacancy rates;
- Contract and temporary labor use rates;
- Time to fill vacant positions;
- Percentage of employees eligible for benefits (e.g., health benefits, paid time off, and retirement);
- Employee engagement, including assessing for job satisfaction, burnout, and moral injury;
- Investment in continuing education, professional development, and training programs; and
- Diversity of workforce and languages spoken in relation to the population served.

OHCA Workforce Stability Standards

OHCA recommends entities adopt the following best practices to ensure workforce stability.

2. Develop formal processes to adapt to changing workforce conditions. Establish policies and procedures to adjust hiring, training, and other practices based on the key performance indicators and market level influences. Actively engage staff who will be impacted by these policies in the development process.

3. Allocate resources for professional development for health care workers to strengthen the current and future workforce. Such training includes developing new skills to adapt to changing health care delivery models that support affordability, access, quality, equity, and culturally and linguistically competent care, sponsoring clinical placements, and supporting advancement of entry-level and non-clinical workers (e.g., housekeeping staff) to other occupations within the organization through career ladders.

4. Increase use of interdisciplinary health care teams to support worker engagement and improve affordability, access, quality, and equity. Interdisciplinary teams promote effective use of team members' diverse skill sets to deliver high-quality, patient-centered care. Examples of interdisciplinary team care include integrated behavioral health in primary care settings and using community health workers to address social needs.

OHCA Workforce Stability Standards

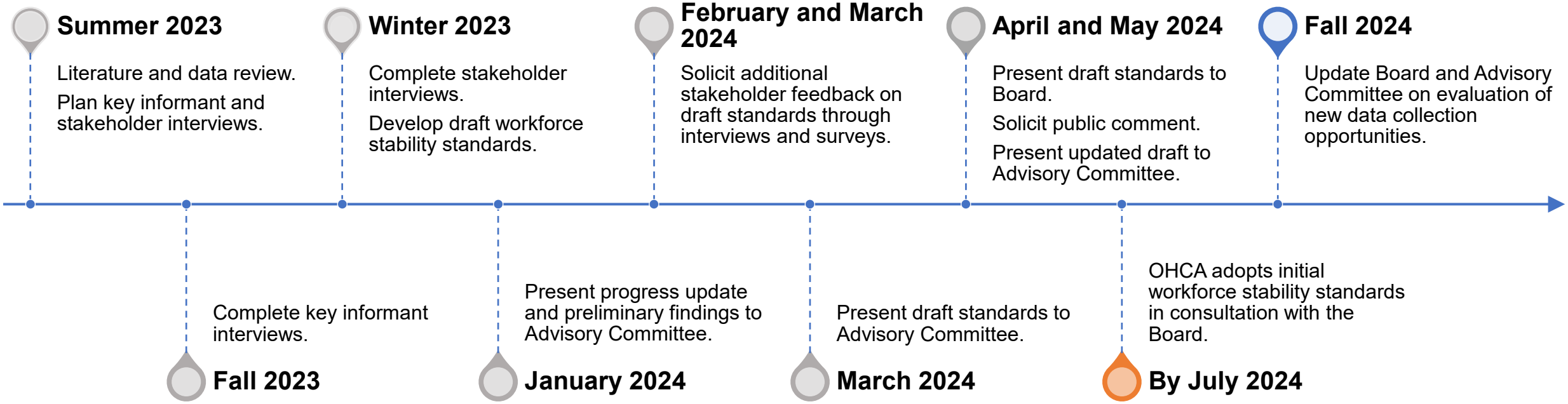
OHCA recommends entities adopt the following best practices to ensure workforce stability.

5. Prioritize hiring, employee advancement, and care delivery practices that ensure culturally and linguistically competent care. Access to high-quality, equitable care across all communities requires a health care workforce that represents California's people, speaks their languages, and understands their cultures. Prioritize hiring, employee advancement, and care delivery practices that advance equitable care. Use regional demographic data to align the workforce with the needs of the populations served.

6. Monitor and address workplace safety and violence. Continually monitor workplace safety and violence and implement policies and procedures to ensure safe working conditions for all health care workers. A safe workplace supports employee well-being and workforce stability, ultimately improving the quality of patient care.

Next Steps

OHCA will adopt and publish the Workforce Stability Standards by July 2024. This summer, OHCA will evaluate additional external data sources and work across HCAI to evaluate possible new data collection. In the fall, OHCA will update the Advisory Committee and Board on our findings and next steps.



* Dates subject to change.

HCAI Department of Health Care Access and Information

Workforce Stability Standards and Metrics

Does the Board have any feedback on OHCA's proposed planning for entity-level data collection?

HCAi
Department of Health Care Access and Information

Public Comment

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Cost and Market Impact Review (CMIR) Proposed Revisions to Regulations

Sheila Tatayon, Assistant Deputy Director
OHCA Compliance

Overview of Proposed Revisions

- **Definition of Affiliation** - “affiliate” removed.
- **Material Change Transactions** – removed April 1, 2024, date.
- **Who must file a material change notice** – “subject of the transaction”.
- **Fully Integrated Delivery System** – specified as needed.
- **Health Professional Shortage Area** – “provides health care services in”.
- **Calculating “annual California-derived revenue”** – whether:
  - entity meets revenue threshold.
  - transaction meets material change circumstances.
- **Reasonable Diligence Attestation** – added.
- **Requests for Confidentiality** – added expedite requests and ability to withdraw if confidentiality request denied .
- **Decision to conduct CMIR** – added ability to meet Spending Target.
- **Non-substantive grammatical changes** – where needed.

Affiliation and Affiliate

§ 97431(a) "Affiliation"

"Affiliation," as used in sections 97431(p), 97435(c)(6), and 97438(c)(2) of these regulations, refers to a situation in which an entity ~~**("affiliate")**~~ controls, is controlled by, or is under common control with another legal entity in order to collaborate for the provision of health care services. "Affiliation" does not include a collaboration on clinical trials, graduate medical education programs, health professions training programs, health sciences training programs, or other education and research programs.

Definition of affiliation – is not the definition of "affiliate" for purposes of calculating annual California-derived revenue

§ 97435(d) Revenue.

For purposes of subsection (b) of this regulation only, "revenue" means the total average annual California-derived revenue received for all health care services by the submitter and all affiliates over the three most recent fiscal years, as follows:

April 1, 2024, Date Removed

§ 97435. Material Change Transactions.

(a) A health care entity ~~(hereinafter referred to as a "submitter")~~ ~~who~~ that meets the criteria of subsection (b) shall provide the Office with notice of a material change transaction as described in subsection (c) at least 90 days before the closing date of the transaction~~, for those transactions expected to close on or after April 1, 2024~~. For purposes of section 127507(c)(2) of the Code, the phrase "entering into the agreement or transaction" refers to the closing date.

Who Must File & Health Professional Shortage Area

§ 97435. Material Change Transactions.

(b) Who must file. A health care entity who is a party to**, or a subject of,** a material change transaction, shall file a written notice of the material change transaction with the Office if the ~~party~~ health care entity (hereinafter referred to as a "submitter") meets any of the thresholds in subsections (b)(1) through (b)(3) under any of the circumstances set forth in subsection (c), unless exempted by subdivisions (d)(1) through (4) of section 127507 of the Code. **Being a subject of a transaction means the transaction, as defined in section 97431(p), concerns a health care entity's assets, control, responsibility, governance, or operations, in whole or in part.**

(1) A health care entity with annual revenue, as defined in subsection (d), of at least $25 million or that owns or controls California assets of at least $25 million~~;~~.

(2) A health care entity with annual revenue, as defined in subsection (d), of at least $10 million or that owns or controls California assets of at least $10 million and is a party to**, or a subject of,** a transaction with:

(A) any health care entity satisfying subsection (b)(1); or
(B) any entity that owns or controls a health care entity satisfying subsection (b)(1).

(3) **A provider or fully integrated delivery system that is a party to, or a subject of, the transaction and provides health care services** ~~**A health care entity located**~~ in a designated primary care health professional shortage area in California, as defined in Part 5 of Subchapter A of Chapter 1 of Title 42 of the Code of Federal Regulations (commencing with section 5.1), available at https://data.hrsa.gov.

Revenue for Calculating Filing Thresholds & Circumstances

Does Health Care Entity Meet the Revenue Filing Thresholds?

§ 97435(b) Who must file

(1) A health care entity with annual revenue, as defined in subsection (d), of at least $25 million or that owns or controls California assets of at least $25 million~~;~~.

(2) A health care entity with annual revenue, as defined in subsection (d), of at least $10 million or that owns or controls California assets of at least $10 million and is a party to, or a subject of, a transaction with: . . .

§ 97435(d) Revenue For purposes of subsection (b) of this regulation only, "revenue" means the total average annual California-derived revenue received for all health care services by the submitter and all affiliates over the three most recent fiscal years, as follows: . . .

Do Transaction Circumstances Meet the Revenue Thresholds?

§ 97435(c) Circumstances requiring filing

Circumstances requiring filing. A transaction is a material change transaction pursuant to section 127507(c)(1) of the Code if any of the circumstances in paragraphs (1) through (8) below exist. **For purposes of this subsection only, "annual California-derived revenue" means revenue from the provision of health care services in California**. . . .

(2) The transaction is more likely than not to increase annual California-derived revenue of any health care entity that is a party to, or a subject of, the transaction, by either $10 million or more or 20% or more of annual California-derived revenue at normal or stabilized levels of utilization or operation.

(5) The transaction will result in an entity contracting with payers on behalf of consolidated or combined providers and is more likely than not to increase the annual California-derived revenue of any provider~~s~~ in the transaction that is a party to, or a subject of, ~~in~~ the transaction by either $10 million or more or 20% or more of annual California-derived revenue at normal or stabilized levels of utilization or operation.

(6) The transaction involves the formation of a new health care entity, affiliation, partnership, joint venture, or parent corporation for the provision of health care services in California that is projected to have at least $25 million in annual California-derived ~~annual~~ revenue at normal or stabilized levels of utilization or operation, or transfer of control of California assets related to the provision of health care services valued at $25 million or more.

Reasonable Diligence Attestation

§ 97438. Filing of Notices of Material Change Transactions.

(a)A notice of material change transaction pursuant to section 127507 of the Code required to be filed under this section ("notice") shall be made under penalty of perjury using the portal on the Office's website at www.hcai.ca.gov/login. **A health care entity shall also attest it used reasonable diligence to ascertain the information required by this section.** A health care entity or its agent filing via the portal shall create a portal account by inputting a first and last name, valid e-mail account, display name, and password, and submit a system-generated verification code. Alternatively, the health care entity or agency may use an existing media account from Microsoft or Google to access the portal.

(b)(3) Identification of all ~~other~~ parties to the transaction and indication whether any health care entities who are parties to the transaction will be submitting a notice. For each ~~other~~ entity that is a party to the transaction, **the submitter shall exercise reasonable diligence to ascertain** and ~~to the extent the submitter has access to the information,~~ shall describe the following:

Reasonable Diligence Attestation

§ 97438(b)(3). Filing of Notices of Material Change Transactions.

. . .

the submitter shall exercise reasonable diligence to ascertain and ~~to the extent the submitter has access to the information,~~ shall describe the following:

(A) The entity's business (including business lines or segments);
(B) Ownership type (corporation, partnership, limited liability company, etc.), including any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the health care entity or that are subject to the control, governance, or financial control of the health care entity;
(C) Governance and operational structure (including ownership of or by a health care entity);
(D) Annual revenue for the three most recent fiscal years used in calculating revenue in accordance with section 97435(d);
(E) Current county or counties of operation;
(F) If a health care provider or a fully integrated delivery system is a party to, or the subject of, the transaction, include a summary of provider type (hospital, physician group, etc.), facilities owned or operated, service lines, number of staff, geographic service area(s), and capacity (e.g., number of licensed beds) or patients served (e.g., number of patients per county) in California in the last year;
(G) Primary and threshold languages, as determined by the Department of Health Care Services, used;
(H) If a payer or a fully integrated delivery system is a party to, or the subject of, the transaction, include a list of all counties where coverage is sold, counties in which they are licensed to operate by the Department of Managed Health Care and/or the Department of Insurance, and the number of enrollees residing in each listed county in the year preceding the transaction; and

Requests for Confidentiality

§ 97438. Filing of Notices of Material Change Transactions.

(d) Confidentiality of Documents Submitted with Notice. All of the information provided to the Office by the submitter shall be treated as a public record unless the submitter designates documents or information as confidential when submitting through the Office portal system and the Office accepts the designation in accordance with paragraphs (1) through (3) below.

(1) A submitter of a notice pursuant to this section **or a submitter requesting expedited review pursuant to section 97439** may request confidential treatment of information or documents submitted. . .
(3) A submitter claiming confidentiality in respect to portions of a notice, **a request for expedited review,**
(4) When the Office makes a determination regarding a request for confidential treatment, the submitter will be notified in writing. If a request for confidential treatment is granted, the information will be marked "Confidential" and kept separate from the public file. With the exception of disclosure to the Attorney General pursuant to sections 127507.2(c)(1) and 127507.2(d)(1) of the Code, the Office and the Department shall keep confidential all nonpublic information and documents designated as confidential pursuant to this section. **If a request for confidentiality is denied, a submitter may submit a request through the portal to withdraw any information or documents for which it requested confidentiality in its submission.**

§ 97439. Request for Expedited Review of Notices of Material Change Transaction

(c) A submitter may request that information submitted pursuant to subsection (a) be held confidential in accordance with section 97438(d). **A submitter may submit a request through the portal to withdraw a request to expedite review if its request for confidentiality is denied in any part.**

Decision to Conduct CMIR Includes Spending Target

§ 97441. Review of Material Change Transaction Notice: Decision to Conduct Cost and Market Impact Review.

(a) Office Determination Whether to Conduct a Cost and Market Impact Review (CMIR).

(1) The Office shall base its decision whether to conduct a CMIR on any of the following factors: . . .

(B) The transaction may result in a negative impact on costs for payers, purchasers, or consumers, **including the ability to meet any health care cost targets established by the Health Care Affordability Board.**

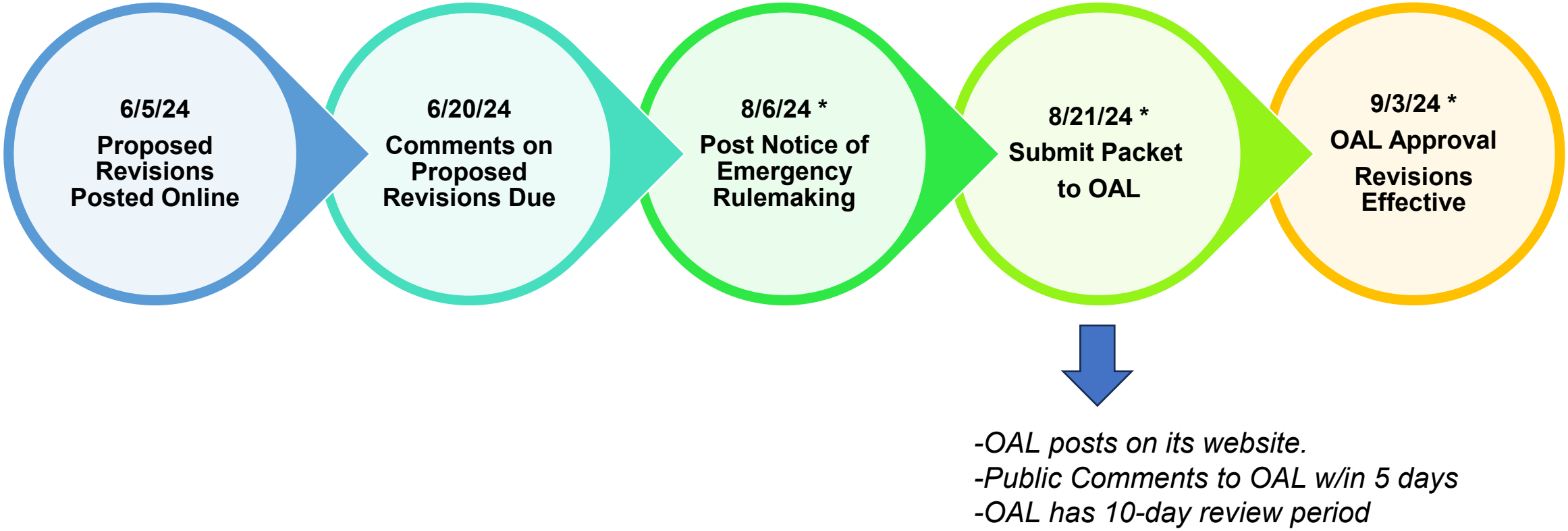
OHCA Statute – 127507.2(a)(1) If the office finds that a material change noticed pursuant to Section 127507 is likely to have a risk of a significant impact on market competitions, the state's ability to meet cost targets, or costs for purchasers and consumers, the office shall conduct a cost and market impact review

Stakeholder Comments Received

OHCA received 6 written public comment letters (by the deadline of June 20, 2024) related to the proposed revisions to the CMIR regulations.

Letters were submitted by a law firm, a provider organization, and various associations.

Projected Timeline for Revisions to CMIR Regulations



* Actual dates may be sooner or later.

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Update on Primary Care Spending Definition and Benchmark, Including Summary of Public Comment Feedback

Margareta Brandt, Assistant Deputy Director

Today's Follow-Up Items

1. OHCA's recommended approach to measuring primary care investment
    a. Exclusion of OB-GYN and behavioral health providers
2. OHCA's recommended primary care investment benchmark
    a. A combined adult and pediatric benchmark
    b. The pace of change

Investment and Payment Workgroup Members

Providers & Provider Organizations

Bill Barcellona, Esq., MHA
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
Senior Vice President for Population Health, AltaMed

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

Sarah Arnquist, MPH
Principal Consultant, SJA Health Solutions

Crystal Eubanks, MS-MHSc
Vice President Care Transformation, California Quality Collaborative (CQC)

Kevin Grumbach, MD
Professor of Family and Community Medicine, UC San Francisco

Reshma Gupta, MD, MSHPM
Chief of Population Health and Accountable Care, UC Davis

Kathryn Phillips, MPH
Associate Director, Improving Access, California Health Care Foundation (CHCF)

State & Private Purchasers

Lisa Albers, MD
Assistant Chief, Clinical Policy & Programs Division, CalPERS

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

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

Hospitals & Health Systems

Ben Johnson, MPP
Vice President Policy, California Hospital Association (CHA)

Sara Martin, MD
Program Faculty, Adventist Health, Ukiah Valley Family Medicine Residency

Ash Amarnath, MD, MS-SHCD
Chief Health Officer, California Health Care Safety Net Institute

Health Plans

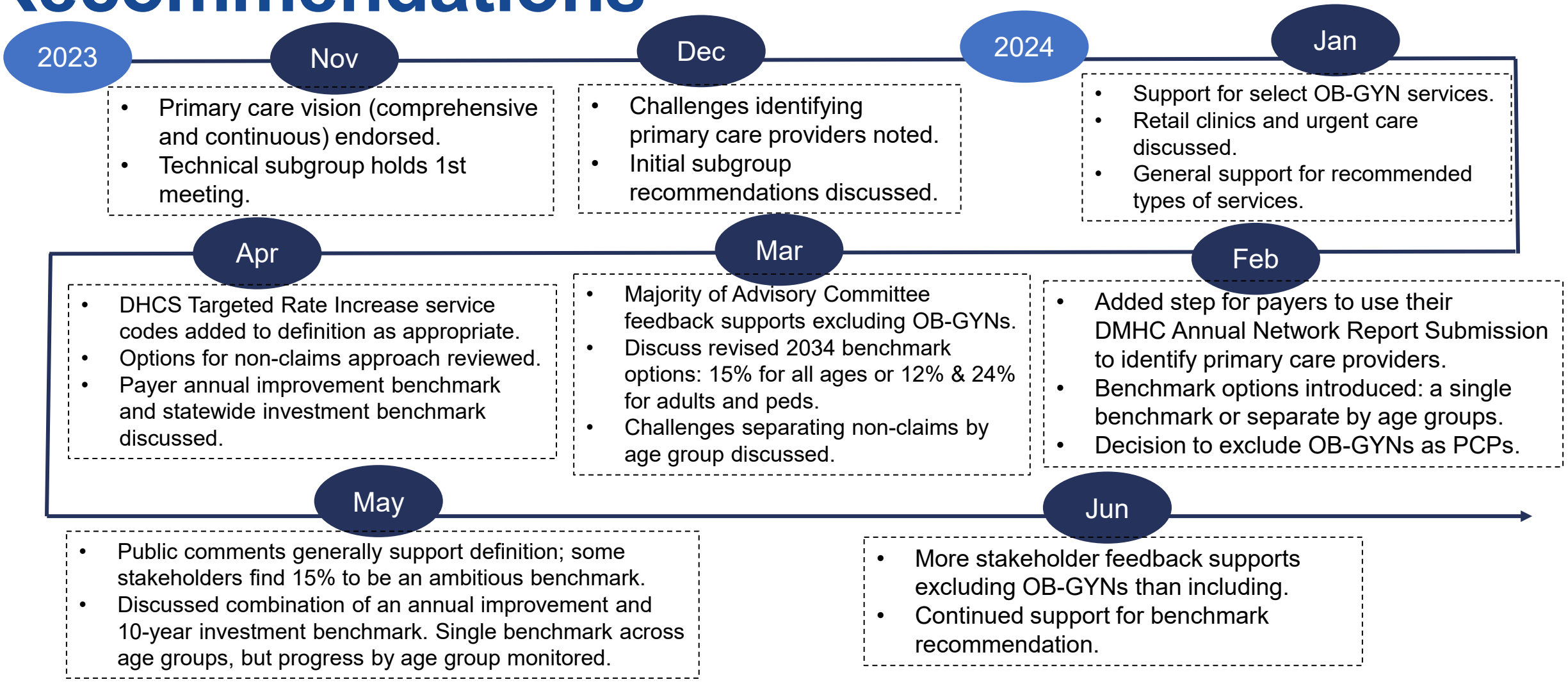
Joe Castiglione, MBA
Principal Program Manager, Industry Initiatives, Blue Shield of California

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

Stakeholder Input on Primary Care Recommendations



Proposed Primary Care Spending Measurement Definition and Methodology

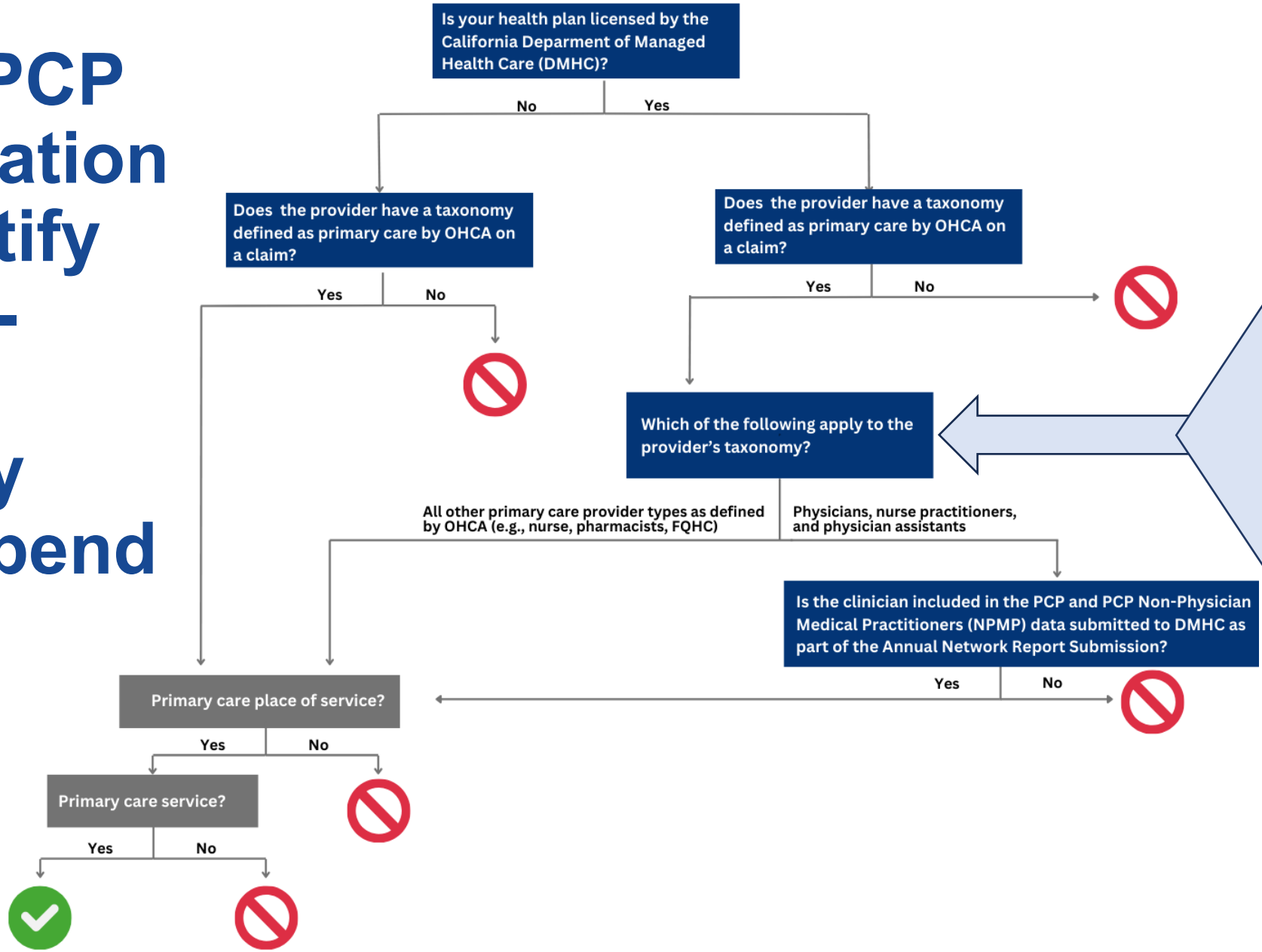
Board Feedback on Primary Care Definition

#	Feedback Theme	OHCA's Response
1.	Concerns about current exclusion of OB-GYN providers.	Most feedback from stakeholders including the Investment and Payment Workgroup, the Advisory Committee, and public comment has preferred to exclude OB-GYN providers. We will provide more information today about feedback received and rationale for OHCA's proposal to exclude OB-GYNs as PCPs.
2.	Concern about broadly capturing behavioral health in primary care, although reassured knowing there is a separate behavioral health workstream.	OHCA appreciates the need to fully and accurately capture behavioral health spending. This will occur through the behavioral health measurement process. Behavioral health services performed in a primary care setting will be captured as part of the primary care spending measurement process. OHCA will have the ability to add this spending to analyses of primary care or behavioral health spending depending on the use case.

Public Comments on Primary Care Measurement Approaches

#	Feedback Theme	OHCA's Response
1.	Endorse proposed definitions for primary care services, places of service, and provider types.	OHCA appreciates the significant and thoughtful contributions of so many stakeholders throughout the process.
2.	Endorse focusing primary care definition on providers and services that support holistic, person-centered primary care.	
3.	Agree with use of the Expanded Framework to define non-claims spending.	
4.	Endorse excluding OB-GYNs as PCPs (5 letters).	Most feedback from stakeholders including the Investment and Payment Workgroup, the Advisory Committee, and public comment has preferred to exclude OB-GYN providers. We will provide more information today about feedback received and rationale for OHCA's proposal to exclude OB-GYNs as PCPs.
5.	Oppose excluding OB-GYNs (3 letters).	

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.

Provider Taxonomies Included as Primary Care

Please note provider taxonomy criteria would be paired with place of service and service criteria.

National Uniform Claim Committee (NUCC) Taxonomies	

• Family Medicine (General/Adult/Geriatrics)
• Internal Medicine (General/Adult/Geriatrics)
• General Practice
• Pediatrics
• Nurse Practitioner
  ○ Adult Health
  ○ Family
  ○ Pediatrics
  ○ Primary Care
• Pharmacist
• Physician Assistant, Medical
• Nurse, non-practitioner
	• Primary Care & Rural Health Clinics
	• Federally Qualified Health Center
	• Certified clinical nurse specialist
	  ○ Adult Health
	  ○ Community/Public Health
	  ○ Pediatrics
	  ○ Chronic Health
	  ○ Family Health
	  ○ Gerontology

Rationale:

- Focus on providers offering whole-person continuous, coordinated care.
- Include care team members –even those less likely to bill via claims – to acknowledge their importance. This definition also guides allocation of non-claims payments.
- Provider taxonomies would be combined with service, place of service criteria, list of PCPs in the DHMC Annual Network Report Submission to help address taxonomy limitations.

Services Included as Primary Care

Please note services criteria would be paired with place of service and provider criteria.

Service (HCPCS & CPT) Codes	
• Office visit • Home visit • Preventive visits • Immunization administration • Transitional care & chronic care management • Health risk assessment • Advanced care planning • Minor procedures • Interprofessional consult (e-consult) • Remote patient monitoring • Labs	• Team conference w or w/o patient • Prolonged preventive service • Domiciliary or rest home care/ evaluation • Group visits • Women's health services: preventive screenings, immunizations, minor procedures including insertion/removal of contraceptive devices, maternity care.

Rationale:

- Broad set of services to promote comprehensive primary care and primary care providers working at the top of their license.
- Use in combination with other criteria to focus on primary care spending.

Care Settings Included as Primary Care

Please note place of service criteria would be paired with provider and service criteria.

CMS Place of Service (POS) Codes
• Office • Telehealth • School • Home • Federally Qualified Health Center • Public Health & Rural Health Clinic • Worksite • Hospital Outpatient • Homeless Shelter • Assisted Living Facility • Group Home • Mobile Unit • Street Medicine

Rationale:

- Restrict by place of service to improve identification of primary care services.
- Include traditional, home, and community-based sites of service to promote expanded access.
- Exclude retail and urgent cares due to lack of coordinated, comprehensive primary care.

Non-Claims Primary Care Measurement Approach

Category 1 & 2: Population Health, Practice Infrastructure and Performance Payments

- Include payments for primary care programs such as care management, care coordination, population health, health promotion, behavioral health or social care integration; performance incentives of patients attributed to primary care providers.
- Limit the portion of practice transformation and IT infrastructure payments that "count" as primary care to 1% of total medical expense.

Category 3: Shared Savings and Recoupments

- Limit portion of risk settlement payments that "count" as primary care to the same proportion that claims-based professional spend represents as a percent of claims-based professional and hospital spending.

Category 4: Capitation Payments

- For primary care capitation, payers allocate 100% to primary care.
- For others, data submitters calculate a ratio of fee-for-service equivalents for primary care services to all services in the capitation. Multiply the ratio by the capitation payment.

See Appendix for detailed approach to measuring non-claims-based primary care spend.

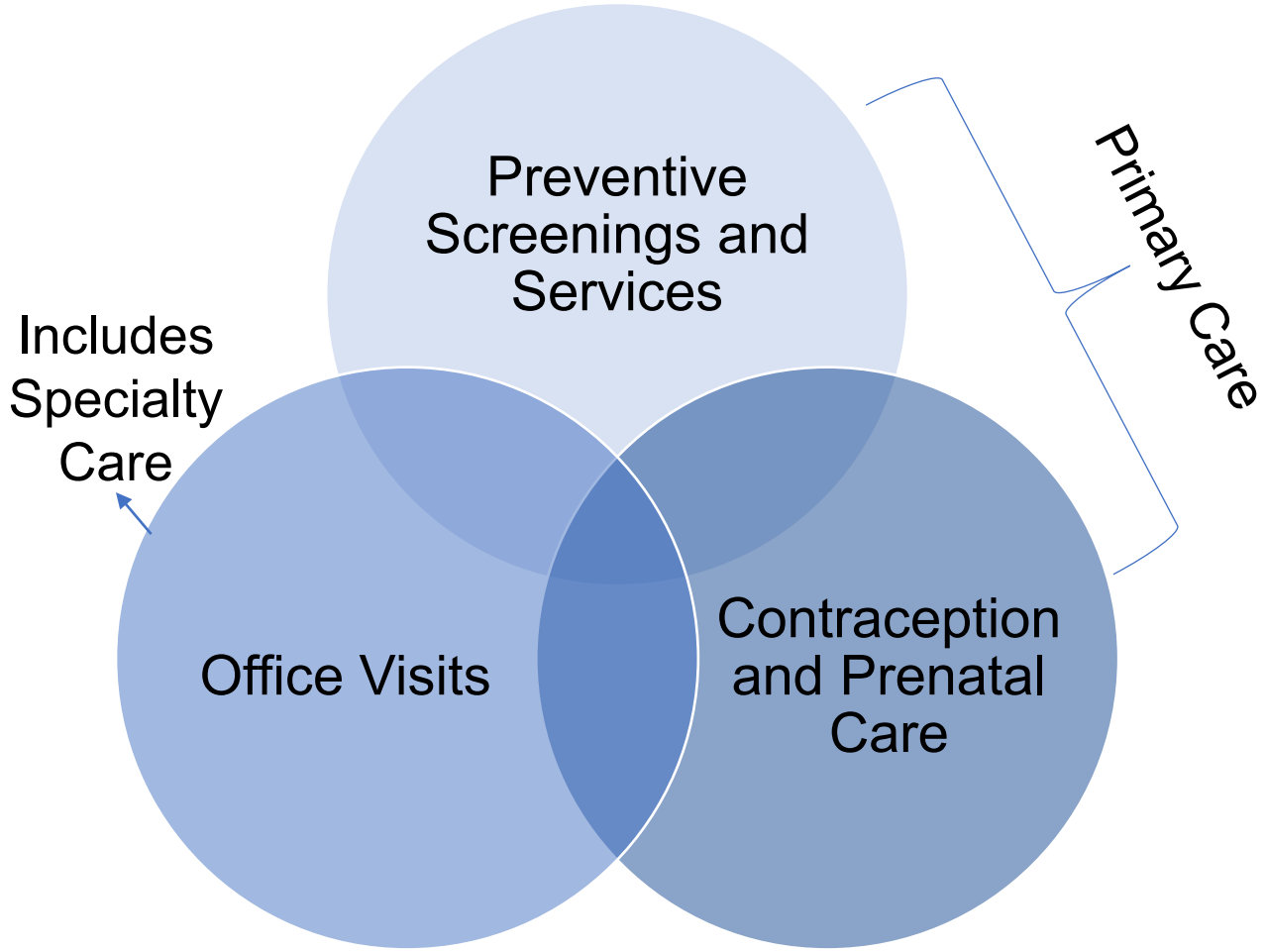
OHCA's Proposed Definition of Primary Care Excludes OB-GYNs

OHCA's Proposal: Include OB-GYN services provided by a primary care provider at a primary care place of service and exclude all services provided by an OB-GYN in the primary care definition. OHCA will conduct analyses using HPD to identify proportion of OB-GYNs providing primary care consistent with vision.

Rationale: Majority of feedback received supports investing in providers who provide continuous whole-person care for all body systems. Evidence is lacking to assess whether OB-GYNs typically meet this definition.

- Some stakeholders stated that patients typically do not receive care from OB-GYNs for common primary care services, such as treatment of a sinus infection or management of chronic conditions such as hypertension and diabetes. Others expressed that OB-GYNs do provide comprehensive care.
- Excluding OB-GYNs does not change a consumer's right under the Knox Keene Act to select an OB-GYN as their primary care provider.

Including vs Excluding OB-GYNs - Overcounting vs Undercounting Primary Care Spend



- Including OB-GYNs as PCPs would count all care they provide that meets the service and place of service definitions. The definition does not restrict based on diagnosis.
  - Office visits for OB-GYN specialty care would be counted as primary care.

- Excluding OB-GYNs as PCPs would mean that the preventive screenings and other primary care services they provide are not counted.

- Developing a separate definition for OB-GYNs would be overly burdensome for data submitters, especially when applied to non-claims payments.

OB-GYN Options for OHCA's Consideration

Option	Considerations	Public Comment Examples
1. **Exclude OB-GYNs (current proposal):** Include a limited set of 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.	• Does not count preventive services and other primary care by OB-GYNs • Underestimates primary care spend	"OHCA's charge is to move the health care delivery systems towards high-value, primary care-focused care … data has not supported that OBGYNs coordinate and manage health care across the lifespan inclusive of total body systems."
2. **Include OB-GYNs as PCPs:** Include OB-GYNs when designated as primary care providers in a DMHC-regulated health plan network combined with recommended primary care services and places of service.	• Counts all OB-GYN specialty care office visits as primary care services • Overestimates primary care spending	"OB/GYNs provide essential primary care services, especially in underserved and rural communities … OB/GYNs are statutorily eligible primary care providers and should be included in this definition."

Behavioral Health Providers

Primary Care Approach to Behavioral Health	Behavioral Health Spending Approach
Captures a limited set of behavioral health services provided by primary care providers in a primary care setting and payments to support integrated behavioral health.	OHCA will measure behavioral health spending and set spending benchmarks as part of the Behavioral Health Investment workstream – this will include all other "primary" behavioral health care.

State Definition Comparison:

Nine of the 15 state primary care definitions reviewed by the OHCA team exclude behavioral health providers. Only one state includes behavioral health providers in their primary care definition and measures behavioral health spending separately.

Workgroup Discussions Identify Potential Future Analyses

The Workgroup identified additional analyses using the HPD that could further inform OHCA's understanding of primary care delivery and spending in California. OHCA will pursue these analyses using HPD data, as feasible.

Examples include:

- Amount of primary care services provided by OB-GYNs using its current definition and/or with a modified list of primary care services
  - *Estimates from IHA and other states suggest this would be less than 0.5% of total medical expense.*
- Proportion of OB-GYNs providing primary care aligned with Workgroup's vision
- Total primary care spending if not restricted by service and/or place of service
- Spending on primary care services delivered at retail clinics and urgent cares
  - *Estimates vary across other analyses. IHA found primary care spending at these care sites to have a minimal impact, approximately 0.2%.*

Primary Care Spending Measurement Definition and Methodology

Does the Board have any additional feedback on provider types included in the definition?

Draft Primary Care Investment Benchmark

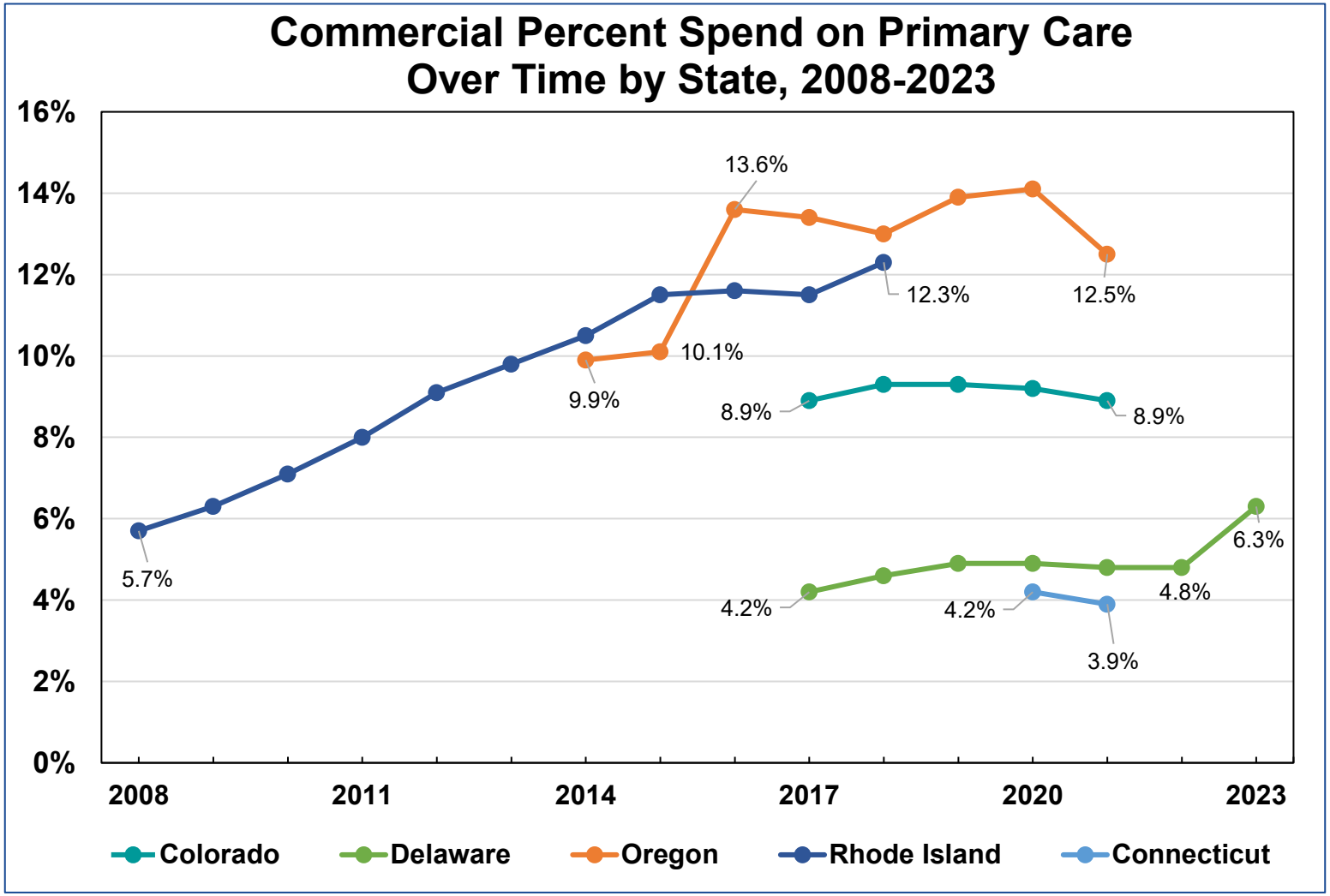
Board Feedback on Primary Care Investment Benchmark Recommendation

#	Feedback Theme	OHCA's Response
1.	Interest in faster progress in the early years of benchmark implementation.	There are trade offs of steeper increases early on to fund infrastructure development and workflow redesign versus later when more providers are likely to be engaged in more complex care management activities with broader care teams.
2.	Interest in setting two goals, one each for pediatric and adult populations primary care investment.	Data submitter burden for two benchmarks, especially for non-claims spending, is large. Requires additional assumptions on non-claims spend. Will collect and report on claims-based primary care investment by age group; benchmark will be set for all ages.
3.	Interest in data collection at the medical group level.	OHCA plans to begin by collecting and reporting data from payers at the medical group level. OHCA is planning to collect data from Restricted or Limited Knox Keene licenses in the future. OHCA has not determined whether it will collect data from other entities in the future.
4.	Interest in understanding how OHCA definition compares to IHA definition.	Will provide more information today on the definition differences between OHCA and IHA definitions and their associated impact.
5.	Interest in experience in other states that contributes to progress.	Will provide more information today on the experience of other states.

Public Comments on Primary Care Investment Benchmark Recommendation

#	Feedback Theme	OHCA's Response
1.	Strong support for primary care investment benchmark, including 15% benchmark for 2034.	This level of investment reflects stakeholders' vision for primary care in California, as sufficiently resourced to provide whole-person, coordinated care.
2.	Request to consider extending time frame to achieve 15% benchmark; concern benchmark may be unrealistic.	The 10-year timeline aims to gradually reallocate investment over time while still recognizing the critical and immediate need to improve primary care access.
3.	Support for annual improvement benchmark of 0.5%-1% per year.	The annual improvement benchmark offers an important milestone for monitoring the contributions of each payer towards achieving the statewide goals.
4.	Support for a single benchmark for all ages due to increase in reporting complexity and burden.	Benchmark will be set for all ages, OHCA will collect and report primary care investment by age group.

Experience in Other States



- **Colorado** primary care progress focused on movement to APMs.
- **Delaware** requires minimum fee-for-service payments, overall investment; increases in primary care non-claims payments.
- **Oregon's** PCMH initiative increased primary care investment percentage; excludes pharmacy from denominator; includes OB/GYN and BH.
- **Rhode Island** slowed spending with price growth limits while primary care spend increased; robust care transformation initiatives.
- **Connecticut** total medical expense increases outpaced primary care investment.

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

Baum, Aaron, et al. (2019, February). Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers. *Health Affairs*. https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05164

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Medi-Cal Primary Care Spending by Population

- In 2018, Medi-Cal health plans spent **an average of 11%** on primary care services. Results were based on a study of 13 plans (27 plan-county pairs).
- While this data offers helpful direction, it was calculated using a different methodology and data source than proposed by OHCA. The OHCA methodology is likely to produce a lower result.

Table 1. Range of Primary Care Spending Across County-Specific Health Plans (*N* = 27)

POPULATION	PERCENTAGE OF STUDY POPULATION	PER MEMBER PER MONTH			PERCENTAGE		
		MINIMUM	MEAN	MAXIMUM	MINIMUM	MEAN	MAXIMUM
Adult	15.6%	$13.01	$35.87	$57.85	5.0%	11.6%	20.2%
Child	45.9%	$5.90	$20.49	$34.10	9.6%	28.2%	37.4%
ACA optional expansion	30.8%	$10.97	$32.12	$67.91	4.1%	9.7%	18.9%
SPD	7.7%	$18.67	$44.49	$123.85	2.3%	4.9%	14.7%
All	**100.0%**	**$8.85**	**$28.50**	**$61.24**	**5.0%**	**11.3%**	**18.7%**

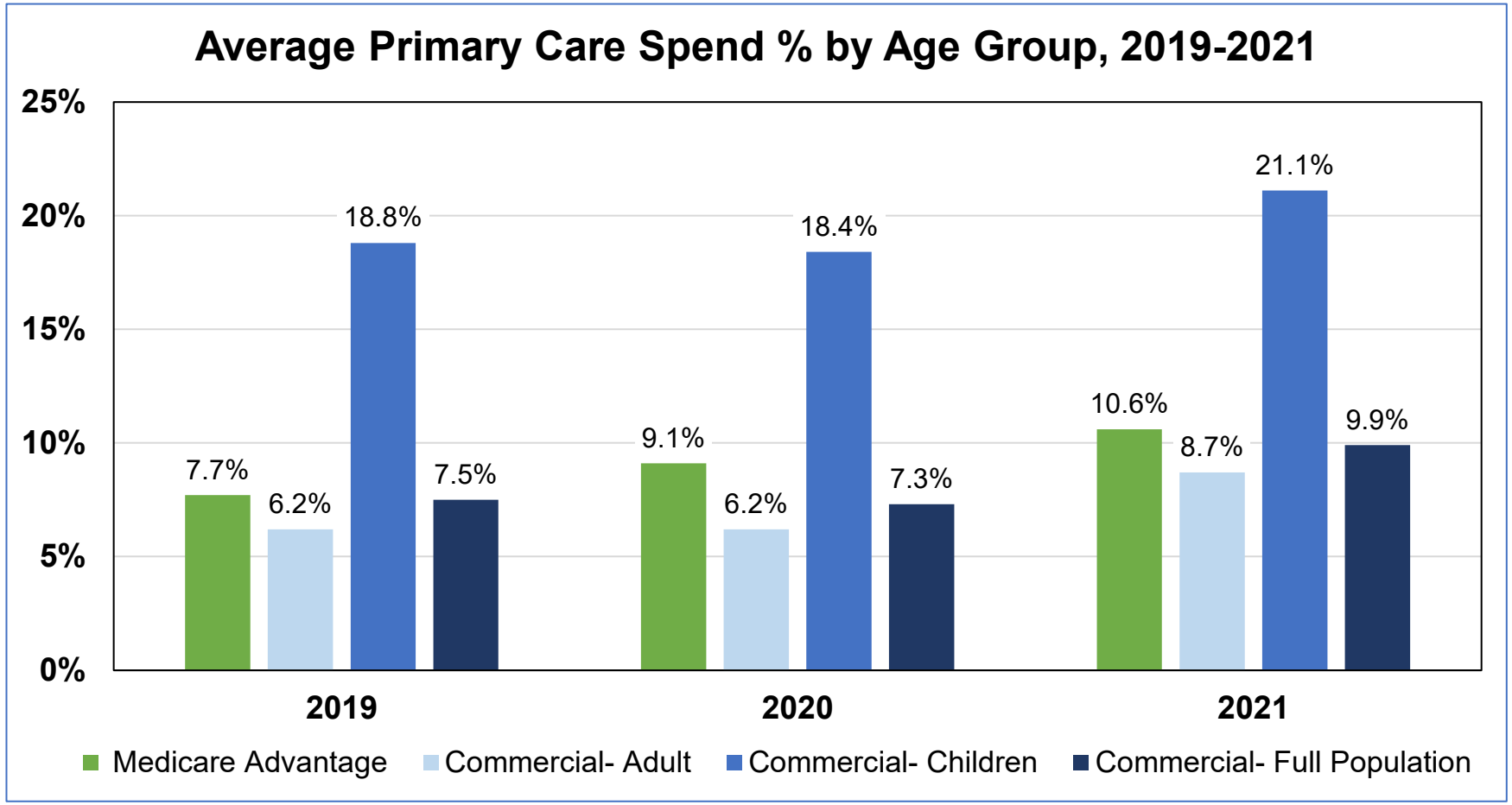
Note: *ACA* is Affordable Care Act; *SPD* is seniors and persons with disabilities.

Source: Edrington Health Consulting analysis of CY 2019 rate development templates; direct plan submission of proprietary data, July 2022.

California Health Care Foundation. (2022, July 25). *Investing in Primary Care: Why it Matters for Californians with Medi-Cal Coverage*. https://www.chcf.org/publication/investing-in-primary-care-why-it-matters-for-californians-with-medi-cal-coverage/

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 analysis of California Commercial primary care spending from 2019-2021. Chart 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, April). https://www.chcf.org/wp-content/uploads/2022/04/InvestingPrimaryCareWhyItMattersCommercialCoverage.pdf

Comparing OHCA and IHA Primary Care Definitions

Component	Similarities	Differences	Impact
Providers	Use provider taxonomies to define primary care specialties.	OHCA also requires providers to be designated as primary care in DMHC Annual Network report.	OHCA slightly lower
Services	Include a broad scope of services when performed by a primary care provider.	OHCA includes the broadest service list of any state primary care definition. IHA includes all services performed by primary care providers.	OHCA slightly lower
Places of Service	Include a wide range of care settings.	OHCA excludes certain care settings to align with vision of comprehensive, coordinated primary care.	OHCA slightly lower
Non-Claims Payments	Include capitation and incentive payments.	OHCA also includes certain care management, infrastructure and portions of risk settlement payments.	OHCA higher

OHCA estimates the combined impact of the differences will result in OHCA's primary care spend being 1% to 2% less than the IHA analysis.

Challenges of Non-Claims Primary Care Payments by Age Group

- Most non-claims payments cannot be tied to a specific provider, patient, or set of primary care services.
- Non-claims payments are typically made in lump sum, not delineated by patient age group.
- A methodology for allocating payments to adults vs. pediatrics moves farther away from the actual intent of payments.

Draft Primary Care Investment Benchmark Recommendation

Annual Improvement Benchmark: Each payer* increases primary care spending by 0.5 percentage points to 1 percentage point per year, depending on current level of investment.

AND

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

Rationale:

- Gives all payers reasonable opportunity to demonstrate immediate progress and long-term success
- Offers gradual glidepath to ambitious but achievable 15% goal
- Offers some flexibility since OHCA does not have exact measures of current spend using its definition
- Has received strong stakeholder support

*Payers at or above 15% of total medical expense may refrain from continued increases if not aligned with care delivery or affordability goals.
Note: The Annual Improvement Benchmark was previously referred to as the Relative Improvement Benchmark and the 2034 Investment Benchmark was previously referred to as the Absolute Improvement Benchmark.

Draft Recommendations for Primary Care Investment Benchmark: Discussion

Does the Board have any additional feedback on the primary care investment benchmark recommendation?

HCAi
Department of Health Care Access and Information

Public Comment

HCAi
Department of Health Care Access and Information

General Public Comment

Written public comment can be emailed to: ohca@hcai.ca.gov

Next Board Meeting
Offsite: Monterey
August 28, 2024

Planned Location:
Embassy Suites
1441 Canyon Del Rey Blvd, Seaside, CA 93955

HCAi
Department of Health Care Access and Information

Adjournment

HCAi
Department of Health Care Access and Information

Appendix

APM Standards and Implementation Guidance

APM Standard 1 and Implementation Guidance

1. **Use prospective, budget-based, and quality-linked payment models** that improve health, affordability, and equity.
   - 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.[2] 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.
   - 1.2. 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) and the Realizing Equity, Access, and Community Health (REACH) program. Core components ~~may~~ should include prospective payment and attribution methodologies, 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.

Red text indicates changes made based on Board, Workgroup, and public comments from the May 2024 version: https://hcai.ca.gov/wp-content/uploads/2024/05/APM-Standards-and-Adoption-Goals-Memo-for-Board-Adoption.pdf

APM Standard 2 and Implementation Guidance

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

   2.1. 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.

   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.

   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.

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APM Standard 3 and 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. 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 ~~choose~~ 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 visits, behavioral health visits, and preventive services by decreasing or eliminating out-of-pocket costs for consumers (e.g., copays, co-insurance, or deductibles in benefit design).

Red text indicates changes made based on Board, Workgroup, and public comments from the May 2024 version: https://hcai.ca.gov/wp-content/uploads/2024/05/APM-Standards-and-Adoption-Goals-Memo-for-Board-Adoption.pdf

APM Standard 4, 5 and Implementation Guidance

4. **Be transparent** with providers in all aspects of payment model design and terms including attribution and performance measurement.
    - 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 appeal 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.

APM Standard 6 and Implementation Guidance

6. **Collect demographic data**, including RELD-SOGI 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.

    6.2. Align internal race, ethnicity, language, disability status, sex, sexual orientation, and gender identity (RELD-SOGI) data collection with the United States Core Data for Interoperability (USCDI) set where applicable and appropriate to reduce administrative burden.

    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.

APM Standard 7 and Implementation Guidance

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

APM Standard 8, 9 and Implementation Guidance

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.

    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.

    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.

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APM Standard 10 and Implementation Guidance

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.

Expanded Framework for Non-Claims Payments

Selected Expanded Framework Categories and Definitions

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

Selected Expanded Framework Categories and Definitions

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

Selected Expanded Framework Categories and Definitions

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

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	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

Selected Expanded Framework Categories and Definitions

#	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
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, 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).**	
6	**Pharmacy Rebates**	**Payments, regardless of how categorized, paid by the pharmaceutical manufacturer or pharmacy benefits manager (PBM) to a payer or fully integrated delivery system.**	

APM Goals in Other States

Where to Set the Bar? Designing APM Goals

A few states have set APM adoption goals. All set these goals based on high-level HCP-LAN categories, consistent with OHCA's current recommendation for California.

Design Decision	DE	OR	HCP-LAN
HCP-LAN categories included?	3A – 3B	3A - 3B, 4A - 4C	3B, 4A-4C
Do goals vary by payer type?	Only applies to Commercial	No	Relative- Yes; Absolute- No
Which unit of measurement should goals be based on?	% of Contracted Dollars	% of Contracted Dollars	% of Contracted Dollars

1.Delaware Department of Insurance Office of Value-Based Health Care Delivery. Annual Review of Carrier Progress Towards Meeting Affordability Standards, 2023.
2.Oregon's Value Based Payment (VBP) Compact Workgroup (Workgroup). Paying for Value in Health Care: A Roadmap for Implementing the Oregon Value-Based Payment Compact, 2022.
3.Health Care Payment Learning & Action Network (HCPLAN), Methodology and Results Report, 2023.

Key Informant and Stakeholder Interviews to Inform Workforce Stability Standards

Key Informant & Stakeholder Interviewees

Academics & Content Experts

David Auerbach, PhD
Senior Director for Research and Cost Trends,
Massachusetts Health Policy Commission

Bianca Frogner, PhD
Professor of Family Medicine, Director of University of Washington Center for Health Workforce Studies

Polly Pittman, PhD
Professor of Health Workforce Equity, Director of Institute for Health Workforce Equity at George Washington University

University of North Carolina – Chapel Hill, Health Workforce Research Center

Kathryn Phillips, MPH*
Associate Director, Improving Access; California Health Care Foundation (CHCF)

Hemi Tewarson, JD, MPH*
Executive Director, National Academy for State Health Policy

Laurel Lucia, MPP*
Director, Health Care Program at UC Berkeley Labor Center

Paul Kumar
Health Policy and Finance Consultant

BJ Bartleson, MS, RN
Health Policy RN Consultant

Michael Bailit, MBA
President, Bailit Health

Organized Labor

Joan Allen*
Government Relations Advocate, SEIU United Healthcare Workers West

Ian Lewis
Policy Director, National Union of Healthcare Workers

Janice O'Malley
Legislative Advocate, American Federation of State, County and Municipal Employees (AFSCME)

California Nurses Association (CNA)/National Nurses United

Consumer Representatives & Advocates

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

Anthony Wright
Executive Director,
Health Access California

Beth Capell, PhD
Contract Lobbyist,
Health Access California

Health Care Entities & Associations

California Hospital Association (CHA)

Katie Rodriguez, MPP
Senior Director of Policy, California Association of Public Hospitals & Health Systems (CAPH)

Nataly Diaz, MBA*
Director of Health Center Operations, California Primary Care Association (CPCA)

Kaiser Permanente

Sutter Health

Plumas District Hospital

*Additional interviewees participated in interviews conducted at these organizations. All interviewees listed in appendix.

Workforce Stability Standards Interviewees

Academics/Content Experts

- Massachusetts Health Policy Commission: David Auerbach
- George Washington University: Polly Pittman
- California Health Care Foundation (CHCF): Kathryn Phillips, Kara Carter
- UC Berkeley Labor Center: Laurel Lucia, Ken Jacobs, Miranda Dietz
- University of Washington: Bianca Frogner
- University of North Carolina, Chapel Hill
- National Academy for State Health Policy: Hemi Tewarson, Elaine Chhean, Maureen Hensley-Quinn
- Bailit Health: Michael Bailit
- Consultants: BJ Bartleson, Paul Kumar

Workforce Stability Standards Interviewees

Organized Labor

- SEIU United Healthcare Workers West: Joan Allen, Denise Tugade
- National Union of Healthcare Workers: Ian Lewis
- American Federation of State, County, and Municipal Employees (AFSCME): Janice O'Malley
- California Nurses Association (CAN)/National Nurses United

Consumer Representatives & Advocates

- California Pan-Ethnic Health Network (CPEHN): Cary Sanders, Andrea Mackey
- Health Access California: Anthony Wright, Beth Capell

Workforce Stability Standards Interviewees

Health Care Entities

- California Hospital Association (CHA)
- California Association of Public Hospitals & Health Systems (CAPH): Katie Rodriguez
- California Primary Care Association (CPCA): Nataly Diaz, Cindy Keltner, Isa Iniguez, Araceli Valencia
- Plumas District Hospital
- Sutter Health
- Kaiser Permanente

Guiding Principles to Inform Workforce Stability Standards

Principles to Guide Development of Workforce Stability Standards and Metrics

1. Address current workforce shortages and challenges impacting workforce stability (e.g., provider shortages in behavioral health occupations or in rural and underserved urban areas).
2. Monitor for emerging workforce shortages and plan for future workforce needs.
3. Incorporate flexibility to accommodate differences between settings, occupations, and regions.
4. Compare workforce composition across similar health care entities.
5. Track graduations from health professions education programs, licensure requirements, and time to licensure to improve match between workers entering workforce and need.
6. Promote diversity in the workforce and address population need for culturally and linguistically competent care.

Principles to Guide Development of Workforce Stability Standards and Metrics, continued

7. Track the impact of spending targets on most vulnerable health care workers (e.g., unlicensed direct care and long-term care workers) and those who serve vulnerable populations (e.g., disabled, elderly, safety net).
8. Consider tradeoffs of prioritizing monitoring of highest-cost, most-regulated settings (e.g., hospitals) compared to least-regulated settings (e.g., physician offices and other ambulatory care sites) that may need greater oversight.
9. Monitor indicators of understaffing or training gaps at the facility level, such as sentinel safety events or worker's compensation claims.
10. Balance reporting burden for health care entities with the value of additional data to meet OHCA's statutory requirements and goals.

Organization Level Workforce Stability Metrics

Draft Workforce Stability Metrics for Hospitals

Data Source	HCAI Hospital Annual Financial Disclosure Reports	
Occupations	• Technical and specialist staff • Registered nurses • Licensed vocational nurses • Aides and orderlies • Clerical & other administrative staff	• Environmental & food service staff • Other staff • Registry nursing personnel • Other contracted staff
Metrics	• Average hours per patient day for daily hospital services over the fiscal year, for each occupation • Average hours per emergency department visit over the fiscal year • Average hours per clinic visit over the fiscal year • Average hours per clinical laboratory test over the fiscal year • Average hourly pay rate for daily hospital services, per occupation • Average hourly pay rate for ambulatory services, per occupation • Average hourly pay rate for ancillary services, per occupation	• Contract nursing personnel hours divided by total nursing hours, for daily hospital services, over the fiscal year • Average hourly rate of contract nursing personnel divided by average hourly rate of staff registered nurses • Salaries, wages, and benefits costs as percentage of total operating expenses • Salaries & wages per adjusted patient day • Benefits per adjusted patient day

Draft Workforce Stability Metrics for Nursing Homes and Skilled Nursing Facilities

Data Source	HCAI Long-term Care Facility Integrated Disclosure and Medi-Cal Cost Report Data	
Occupations	• Geriatric nurse practitioners • Registered nurses • Licensed vocational nurses • Nurse assistants • Technicians and specialists • Psychiatric technicians • Other	• Social workers • Activity program leaders • Housekeeping • Laundry and linen • Dietary • Social services • Activity staff
Metrics	• Productive hours per resident day, overall and for selected departments • Average wages • Percent of total hours from temporary staff, overall and by occupation • Labor turnover • Personnel costs as percentage of total operating expenses	

Draft Workforce Stability Metrics for Community Clinics

Data Source	HCAI Primary Care Clinic Annual Utilization Data	
Occupations	• Visiting nurses • Registered dental hygienists – alt practice • Licensed clinical social workers • Other billable providers • Other Comprehensive Perinatal Services Program (CPSP) providers • Registered dental hygienists (not alt practice) • Registered dental assistants • Marriage and family therapists	• Registered nurses • Licensed vocational nurses • Medical assistants • Patient education staff • Substance abuse counselors • Billing staff • Other admin staff
Metrics	• Staff full-time equivalents (FTEs) • Contract FTEs • Volunteer FTEs • Staff FTEs as percent of total FTEs • Staff FTEs per patient encounter	

Market Level Workforce Stability Metrics

Draft Workforce Stability Metrics for Supply, Employment, and Diversity of Licensed Health Professionals

Data Source	California Licensure Board records and HCAI license renewal surveys	
Geographic Level	• Statewide • Census Bureau-defined Core Based Statistical Areas (CBSAs) and Combined Statistical Areas (CSAs) • Counties • California Economic Strategy Panel regions	
Occupations	• Physician Assistants • Advanced Practice Registered Nurses • Registered Nurses • Licensed Vocational Nurses • Licensed Clinical Social Workers • Licensed Marriage and Family Therapists • Licensed Professional Clinical Counselors	• Occupational Therapists • Physical Therapists • Psychologists • Respiratory Therapists • Clinical Laboratory Scientists • Medical Laboratory Technicians
Metrics	• Number licensed • Age distribution • Race/ethnicity • Gender identity • Current employment status • Languages spoken	• Self-identified disability status • Average number of hours worked per week • Primary practice setting • Secondary practice setting • Retirement plans

Draft Workforce Stability Metrics for Employment and Diversity of Unlicensed Health Care Workers

Data Source	US American Community Survey
Geographic Level	• Statewide • Large counties
Occupations	• Nursing, psychiatric, and home health aides • Occupational and physical therapist assistants and aides • Other healthcare support occupations • Substance abuse and behavioral disorder counselors
Metrics	• Number employed • Gender • Race/ethnicity • Age distribution • Presence of self-care, ambulatory, and cognitive difficulties • Languages spoken • Total earnings • Wage or salary income in past 12 months • Usual hours worked per week

Draft Workforce Stability Metrics for Employment and Wages of Health Care Workers

Data Source	**US Occupational Employment and Wage Statistics**			
Geographic Level	• Statewide			
Occupations	• Dietitians and Nutritionists • Physician Assistants • Occupational therapists • Physical therapists • Radiation therapists • Respiratory therapists • Speech-language pathologists • Registered nurses • Nurse anesthetists • Nurse midwives • Nurse practitioners • Audiologists	• Dental hygienists • Clinical laboratory techs • Cardiovascular techs • Diagnostic medical sonographers • Nuclear medicine techs • Radiologic techs • Magnetic resonance imaging techs • Emergency medical techs • Paramedics • Dietetic technicians • Pharmacy techs • Psychiatric techs • Surgical techs	• Ophthalmic medical techs • Licensed vocational nurses • Medical records specialists • Opticians, dispensing • Orthotists and prosthetists • Hearing aid specialists • Health techs, all other • Surgical assistants • Home health and personal care aides • Nursing assistants	• Orderlies • Psychiatric aides • Occupational therapy assistants • Occupational therapy aides • Physical therapist assistants • Physical therapist aides • Dental assistants • Medical assistants • Medical equipment preparers • Medical transcriptionists • Pharmacy aides • Phlebotomists • Health care support workers, all other
Metrics	• Employment • Median hourly wage • Mean hourly wage • Annual mean earnings			

Draft Workforce Stability Metrics for Health Worker Graduates

Data Source	US Integrated Postsecondary Education Data System
Geographic Level	• Statewide • Census Bureau-defined Core Based Statistical Areas (CBSAs) and Combined Statistical Areas (CSAs) • Counties • California Economic Strategy Panel regions
Occupations	• Dozens of program classifications, in category “51. Health Professions and Related Clinical Services” and “42.28 Clinical Psychology,” and “44.07 Social Work”
Metrics	• Awards/degrees conferred • Awards/degrees by race/ethnicity • Awards/degrees by gender • Awards/degrees to non-US-residents

Draft Workforce Stability Metrics for Supply and Employment of Registered Nurses

Data Source	California Board of Registered Nursing (BRN) Biennial Survey of Registered Nurses	
Geographic Level	• Statewide • California BRN regions (based on California Economic Strategy Panel regions)	
Occupations	• Registered nurses	
Metrics	• Job satisfaction • Profession satisfaction • Hours worked per day • Hours worked per week • Overtime per week • On call hours per week • Employment intentions • Employment relationship in principal position • Hours worked in principal position • Job title in principal position • Total annual earnings in principal position	• Benefits provided by principal position • Data on additional nursing jobs • For those not working: year last worked • For those not working: why not working • For those not working: employment intentions • Change in employers, positions, or intensity of work • Country of birth • Location of RN education

Draft Workforce Stability Metrics for Registered Nurse Education

Data Source	California Board of Registered Nursing (BRN) Biennial Survey of Registered Nurses	
Geographic Level	• Statewide • California BRN regions (based on California Economic Strategy Panel regions)	
Occupations	• Registered nurses	
Metrics	• Job satisfaction • Profession satisfaction • Hours worked per day • Hours worked per week • Overtime per week • On call hours per week • Employment intentions • Employment relationship in principal position • Hours worked in principal position • Job title in principal position • Total annual earnings in principal position	• Benefits provided by principal position • Data on additional nursing jobs • For those not working: year last worked • For those not working: why not working • For those not working: employment intentions • Change in employers, positions, or intensity of work • Country of birth • Location of RN education

Draft Workforce Stability Metrics for Projections of Supply and Demand for Registered Nurses

Data Source	California Board of Registered Nursing (BRN) Projections of Supply and Demand
Geographic Level	• Statewide California BRN regions (based on California Economic Strategy Panel regions)
Occupations	• Registered nurses
Metrics Appendices	• Projected supply of registered nurses (low, best, and high) • Projected demand for registered nurses to maintain current FTE per capita • Projected demand adjusted for population aging • Projected demand from California Employment Development Department

Suggested Additional Data Sources for Workforce Stability Metrics

Evaluation of Suggested Additional Data Sources

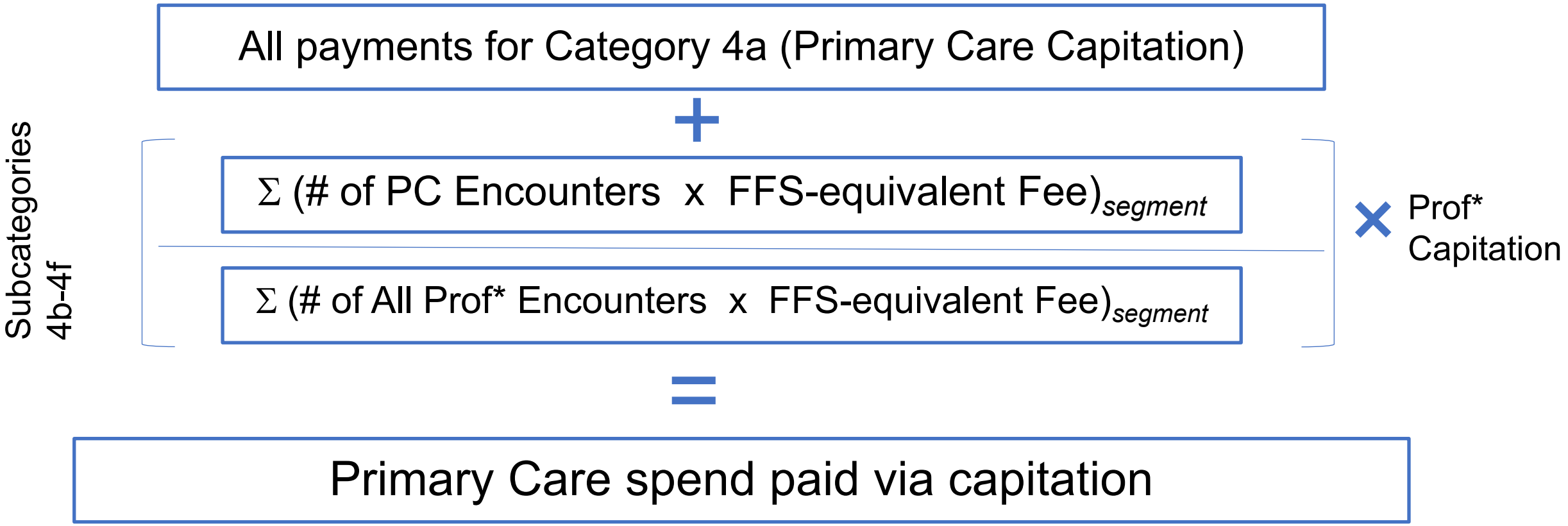
Name of Data Set	Description	OHCA Action
California Department of Civil Rights' Pay Data Reporting Program	For private employers with 100+ employees: pay, job category, race, ethnicity, gender of employee.	Investigating for future inclusion in metrics.
Cal-OSHA Enforcement Activity	Investigating for future inclusion in metrics.	Investigating for future inclusion in metrics.
DMHC & DHCS Network Adequacy Reports	Compliance with DMHC & DHCS network adequacy standards for full service and behavioral health plans.	Investigating for future inclusion in metrics.
Employment Development Department Worker Adjustment and Retraining Notification (WARN)	60-day notices provided by employers before facility closing or mass layoff, for employers with 100+ employees.	Investigating for future inclusion in metrics.
Workers' Compensation Information System (WCIS)	Records of all worker's compensation first reports of injury. Detailed information on race/ethnicity, gender, occupation, pay.	Investigating for future inclusion in metrics.

Evaluation of Suggested Additional Data Sources

Name of Data Set	Description	OHCA Action
California Community Colleges Clinical Placement Reporting	Annual number of students receiving training at individual clinical sites for multiple allied health programs.	Recommend not pursuing because reporting does not capture clinical placements for registered nurses and data source only includes education programs at community colleges.
Employment Development Department Quarterly Payroll Data	Quarterly payroll records for all employees covered by unemployment and disability insurance systems. Data include industry of employer but not occupation of employee.	Recommend not pursuing due to extensive resources required to transform the data so that turnover can be estimated and absence of data by occupation.
Franchise Tax Board	Data reported on state income tax returns.	Recommend not pursuing because publicly reported data are aggregated at the ZIP code level with no information about industry or occupation.
Internal Revenue Service	Data reported on income tax returns.	Recommend not pursuing because extensive resources required to analyze data through a Federal Statistical Research Data Center (FSRDC) and requires a lengthy approval process.
US Census Department Longitudinal Employer Household Dynamics	Longitudinal data that links employers and households	Recommend not pursuing because the public use data do not disaggregate health care organizations from social service organizations, and analyzing non-public data through a FSRDC requires a lengthy approval process.

Primary Care Definition and Benchmark

OHCA Approach to 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.

Impact of 1% TME Increase

- 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).*