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Department of Health Care Access and Information

Summit on Revitalizing Primary Care

OHCA Primary Care Investment Measurement and Benchmark

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Our Mission

HCAI expands equitable access to quality, affordable health care for all Californians through resilient facilities, actionable information, and the health workforce each community needs.

Our Vision

A healthier California where all receive equitable, affordable, and quality health care.

HCAI Program Areas

- **Facilities**: Monitor the construction, renovation, and seismic safety of California's hospitals and skilled nursing facilities.
- **Financing**: Provide loan insurance for non-profit healthcare facilities to develop or expand services.
- **Workforce**: Promote a culturally competent and diverse healthcare workforce.
- **Data**: Collect, manage, analyze, and report actionable information about California's healthcare landscape.
- **Affordability:** Improve health care affordability through data analysis, spending targets, and measures to advance value. Enforce hospital billing protections, and provide generic drugs at a low, transparent price.

HCAI Health Workforce Approach and Strategy

HCAI enables the expansion and development of a **health workforce that reflects California's diversity in order to address supply shortages and inequities**, by administering programs and funding and generating actionable data.

Focus Our Programs in Four Areas

Develop, support and expand a health workforce that:

- Serves medically underserved areas
- Serves Medi-Cal members
- Represents the California it serves through racial and language diversity

Offer programs that provide financial support for:

- Organizations building the workforce pipeline
- Organizations expanding educational capacity
- Individuals pursuing health careers
- Organizations supporting providers and addressing retention

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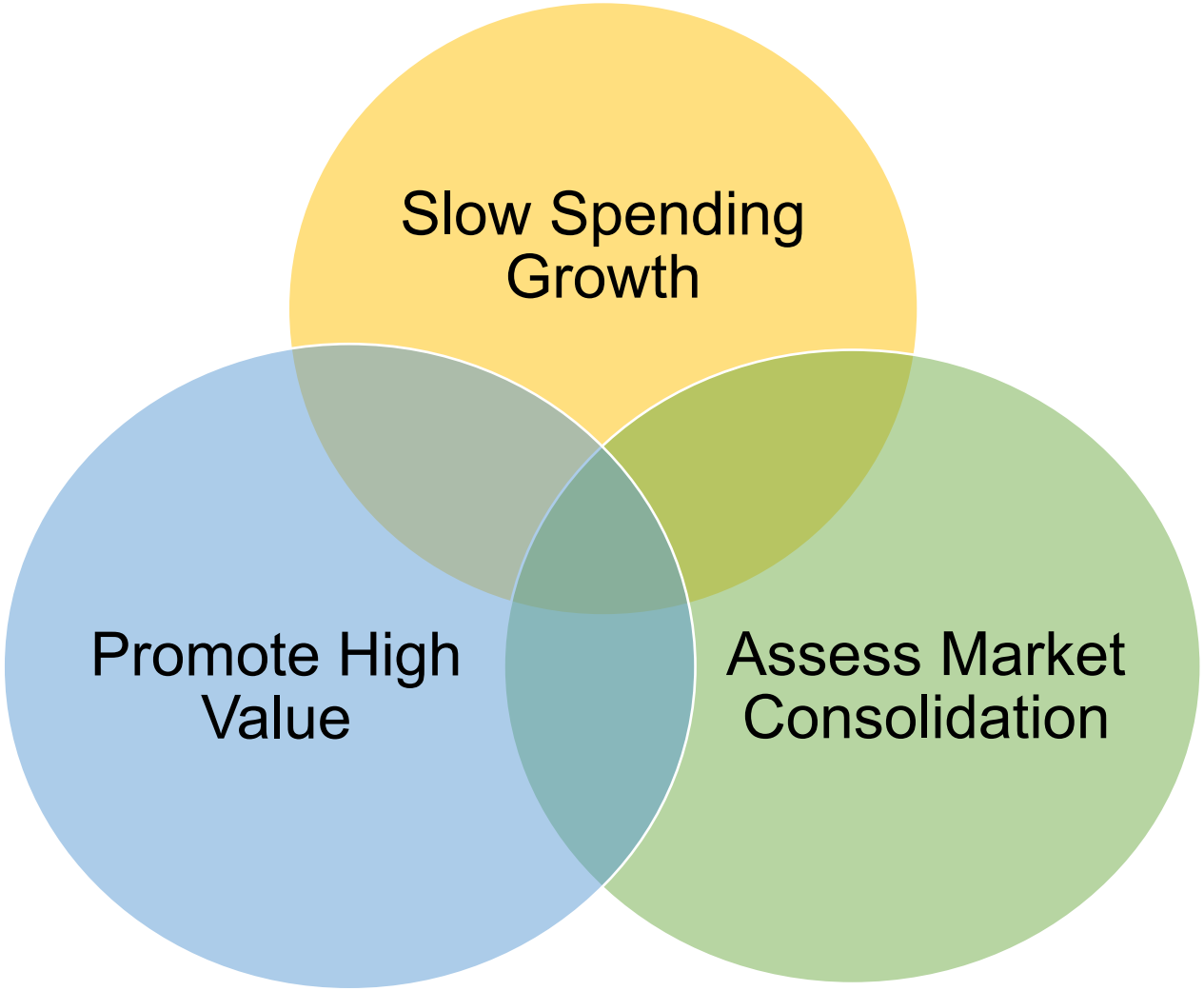
Office of Healthcare Affordability (OHCA)

Key Components of OHCA's Work



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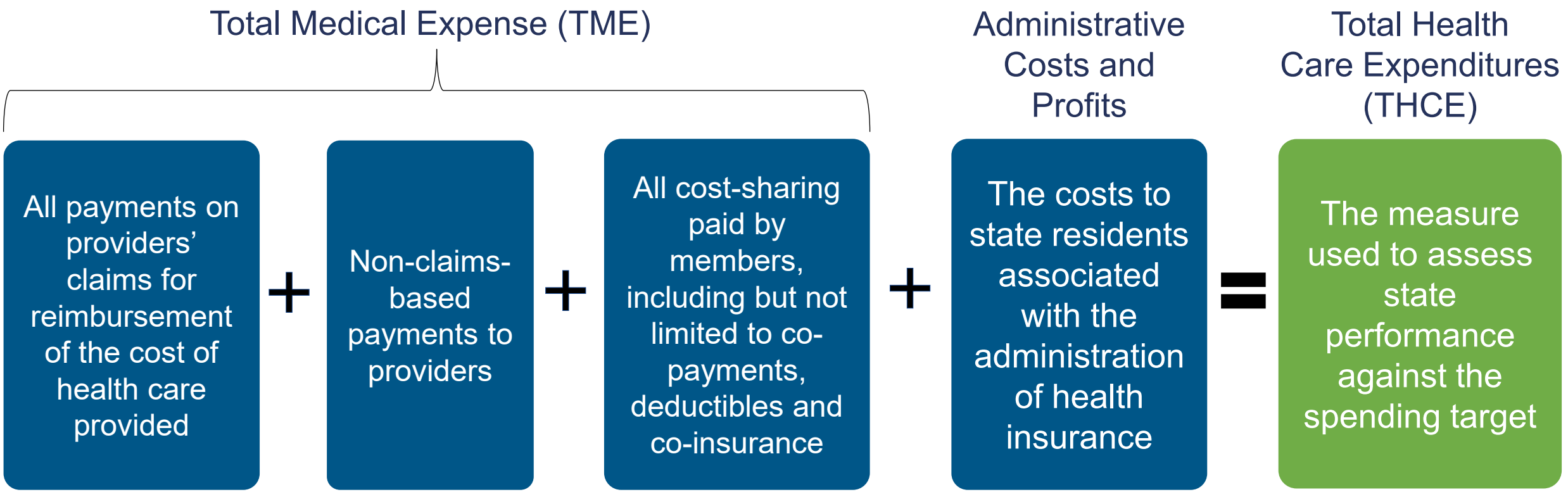
Total Health Care Expenditures Calculation



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Statewide Per Capita Health Care Spending Target

On April 24, 2024, the California Health Care Affordability Board established a base 3% spending target for performance year 2029, based on the average annual rate of change in historical median household income growth from 2002-2022, ***signaling that health care spending should not grow faster than the income of California families***.

Performance Year	Per Capita Spending Growth Target
2025	3.5%
2026	3.5%
2027	3.2%
2028	3.2%
2029	3.0%

Focus Areas for Promoting High Value

Primary Care Investment	• Define, measure, and report on primary care spending • Establish a benchmark for primary care spending
Behavioral Health Investment	• Define, measure, and report on behavioral health spending • Establish a benchmark for behavioral health spending
Alternative Payment Model Adoption	• Define, measure, and report on alternative payment model adoption • Set standards for APMs to be used during contracting • Establish a goal for APM adoption
Quality and Equity Performance	• Develop, adopt, and report performance on a single set of quality and health equity measures
Workforce Stability	• Develop and adopt standards to advance the stability of the health care workforce • Monitor and report on workforce stability measures

OHCA webpage: https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/

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OHCA Primary Care Spending Measurement

OHCA Statute: Primary Care Investment

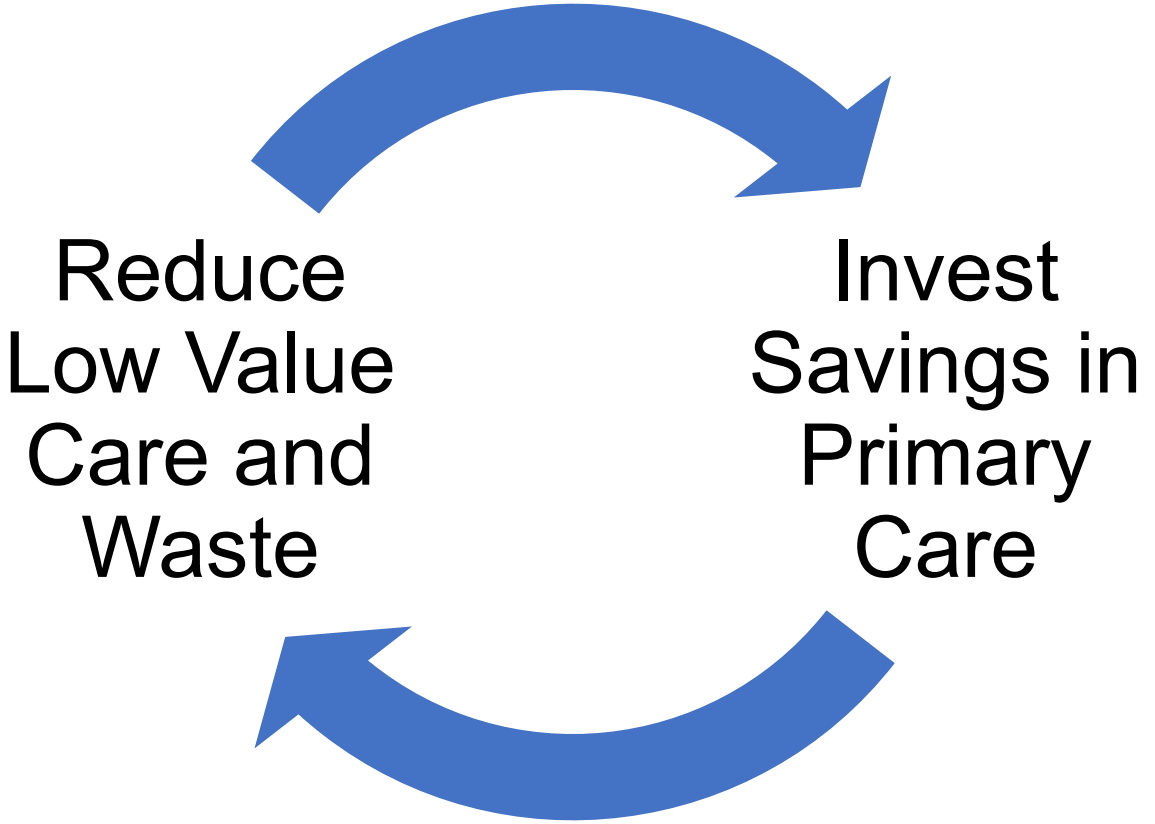
Statutory Requirements

- **Measure the percentage of total health care expenditures allocated to primary care and set spending benchmarks** that consider current and historic underfunding of primary care services.
- Build and sustain methods of reimbursement that shift greater health care resources and investments away from specialty care and toward primary care and behavioral health.
- Promote improved outcomes for primary care and sustained systemwide investment in primary care.
- Include an analysis of primary care spending and growth in the annual report.
- Consult with state departments, external organizations promoting investment in primary care, and other entities and individuals with expertise in primary care.

Health and Safety Code § 127505 (a) – (c)

Impact of Investing in Primary Care

"In addition to improving health outcomes and equity, primary care contributes to lower overall health care spending. In recent years, studies have shown **associations between more primary care and less low-value care**, both among health systems and in the Medicare fee-for-service population; **higher primary care continuity and lower costs and hospitalizations**; and broader, more **robust practice capabilities and lower utilization and spending**. As the evidence mounts, it has become clear that a health care system with sustainable costs will rely on robust primary and preventive care that **keeps people healthy and reduces unnecessary and low-value care**."



Yegian, J. *The Case for Investing in Primary Care in California.* California Health Care Foundation. April 2022 (page 3, footnotes 18-21). https://www.chcf.org/wp-content/uploads/2022/04/CaseInvestingPrimaryCare.pdf.

One Vision for Primary Care Delivery in CA

- Accessible
- Person- and family-centered
- Relationship-based
- Integrated
- Team-based
- Coordinated
- Comprehensive
- Equitable

OHCA's Investment and Payment Workgroup noted the need for sustainable and well-resourced primary care to achieve the vision.

Source: California Quality Collaborative (CQC). (June 2020, revised April 2022). *Advanced Primary Care: Defining a Shared Standard*. Purchaser Business Group on Health (PBGH). https://www.pbgh.org/wp-content/uploads/2022/04/advanced-primary-care-shared-standard.pdf

Framing the Measurement

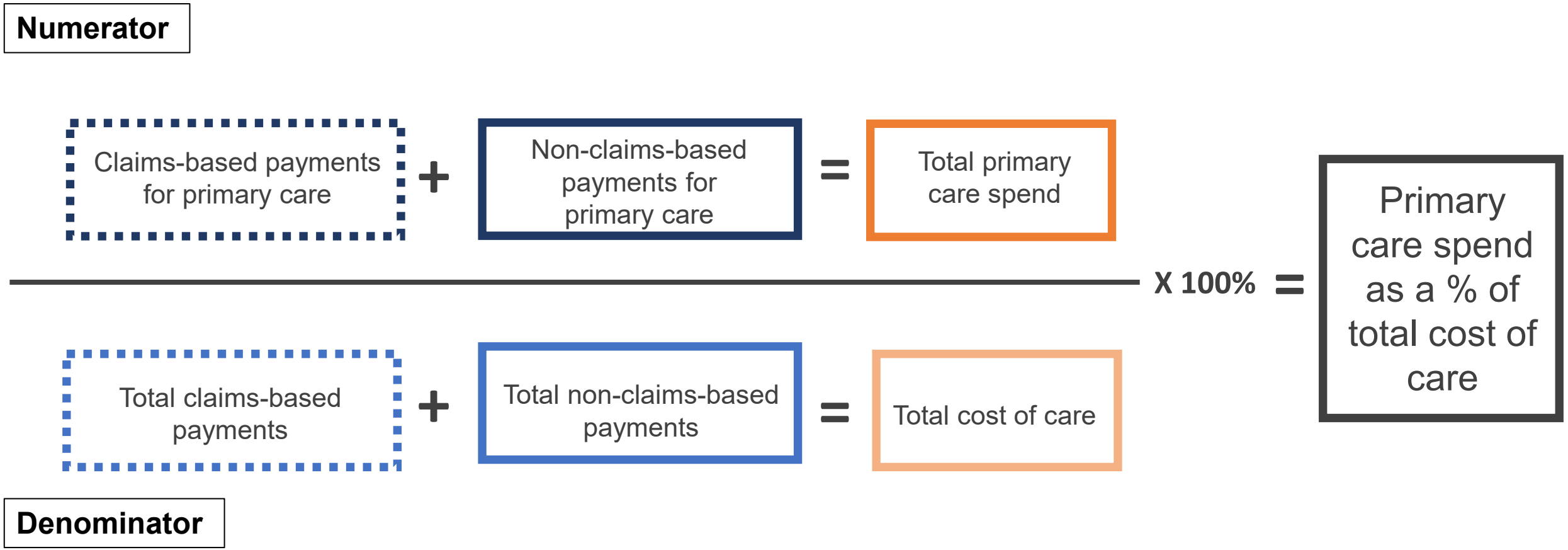
What will be measured

Money **payers paid** to providers in support of primary care services.

What won't be measured

Money providers spent delivering primary care services.

Measuring Primary Care Spending



Adapted from Erin Taylor, Michael Bailit, and Deepti Kanneganti. Measuring Non-Claims-Based Primary Care Spending. Milbank Memorial Fund. April 15, 2021

Three Modules for Measuring Primary Care Spending

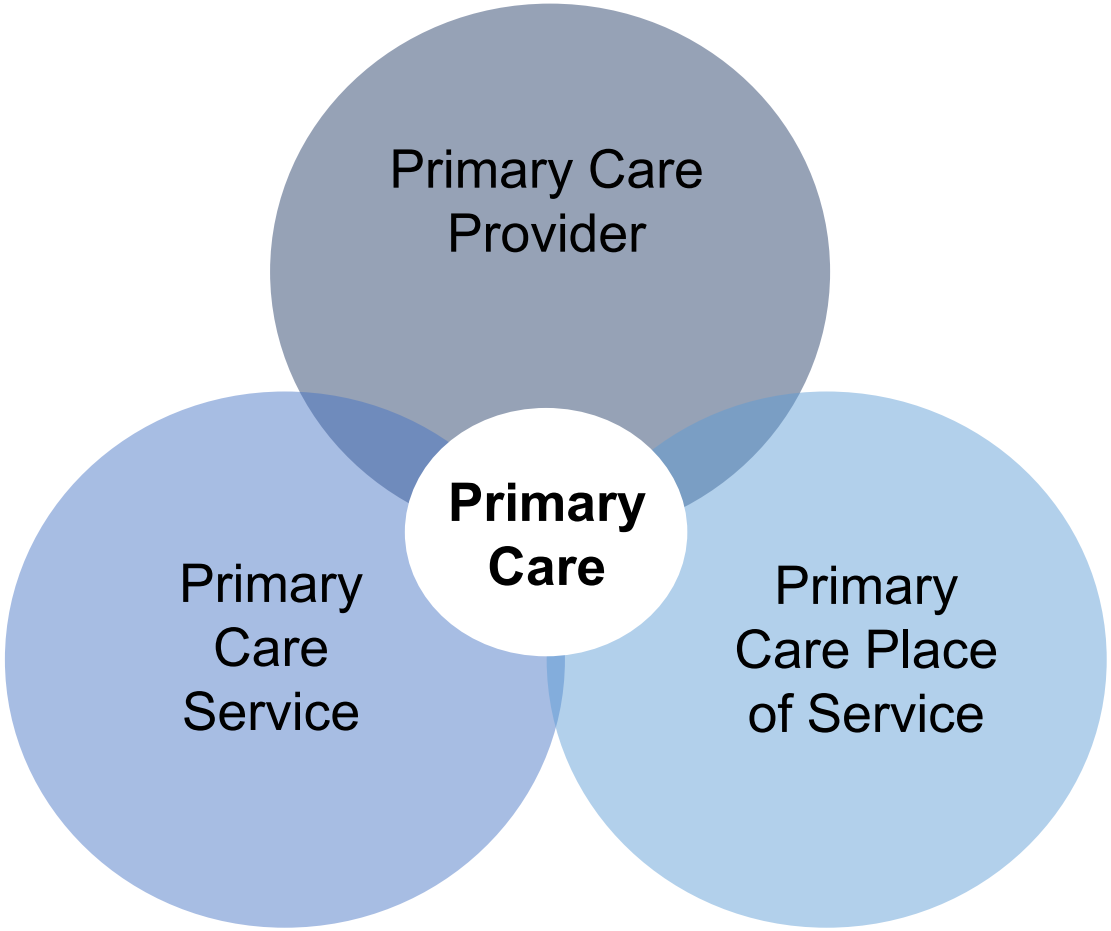
Benchmark calculation will include all three modules.

Primary Care Paid Via Claims	Primary Care Paid Via Non-Claims	Behavioral Health in Primary Care
• Combination of primary care provider, service, and place of service.	• Allocate a portion of non-claims spend to primary care.	• Screening, office visits for BH diagnosis with PCPs. • Counseling, therapy when by a PCP or via integrated behavioral health.

Could be added to BH or PC spend calculation.

Primary care measurement could be supplemented with additional analysis through the Health Care Payments Data program (HPD).

Defining Primary Care in Claims-Based Payments



Details of OHCA's approach to measuring claims-based primary care spend can be found in its Recommendations to the Health Care Affordability Board: Proposed Primary Care Investment Benchmark memo.

Overview of Claims-based Primary Care Spending Measurement Approach

Include a narrow or broad set of providers?

- Include a broad set of providers to reflect statutory goal of team-based care.
- Filter by providers designated as PCPs by health plans, as reported to DMHC.
- Exclude OB-GYN providers to be consistent with focus on providers caring for the whole patient.

Should the definition be limited to certain places of service?

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

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

- Include an expanded set of services to encourage as much care as possible and appropriate to be delivered in a primary care setting.
- Include a limited set of behavioral health services when provided by a PCP.

Details of OHCA's approach to measuring claims-based primary care spend can be found in its Recommendations to the Health Care Affordability Board: Proposed Primary Care Investment Benchmark memo.

Providers Included as Primary Care

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

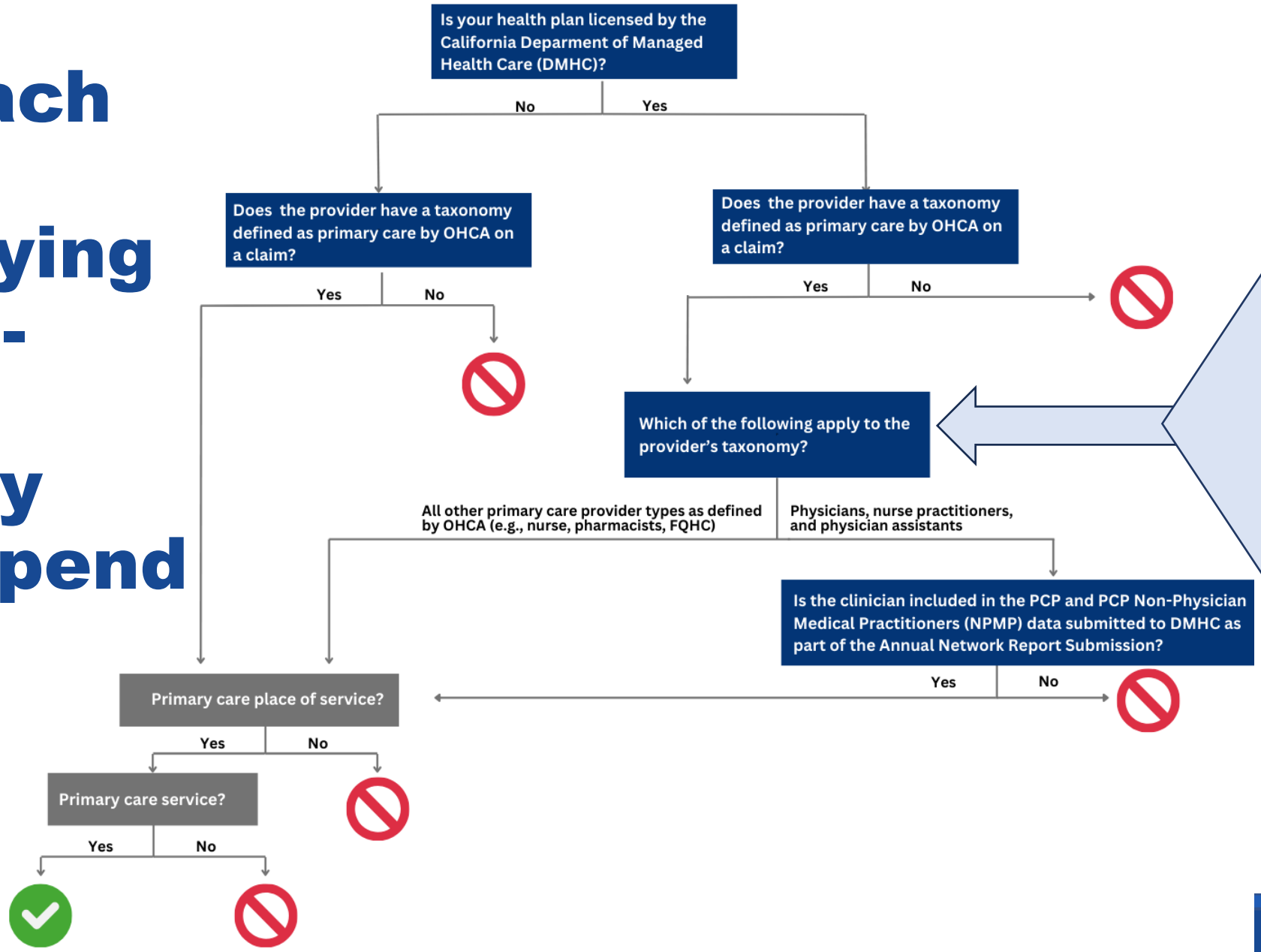
National Uniform Claim Committee (NUCC) Taxonomies	

• Family Medicine (General/Adult/Adolescent/ Geriatric)
• Internal Medicine (General/Adolescent/Geriatric)
• General Practice
• Pediatrics (General, Adolescent)
• Nurse Practitioner
  ○ Adult Health
  ○ Family
  ○ Community Health
  ○ Pediatrics
  ○ Gerontology
  ○ Primary Care
  ○ School
• Physician Assistant, Medical
	• Pharmacist
	• Primary Care & Rural Health Clinic/Center
	• Federally Qualified Health Center
	• Certified clinical nurse specialist
	  ○ Adult Health
	  ○ Community/Public Health
	  ○ Pediatrics
	  ○ Chronic Health
	  ○ Family Health
	  ○ Gerontology
	• Community Health Worker
	• Nurse, non-practitioner
	• Critical Access Hospital Clinic/Center

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.

Approach to Identifying 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.

Services Included as Primary Care

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

Service (HCPCS & CPT) Codes	
• Office/Home/Telehealth visits • Preventive visits and screenings • Immunization administration • Transitional care • Chronic care management • Health risk assessment • Advanced care planning • Minor tests and procedures • Interprofessional consults (e-consult) • Remote patient monitoring • Lab tests (*point of care tests only)* • Digital evaluation and management • Medicare-specific certification for home health care • Advanced Primary Care Management	• Cognition and functional assessment with developed care plan • 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 device, maternity care • Behavioral Health Integration/ Collaborative 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, in and out of patient's home • School • Home • Federally Qualified Health Center • Public Health & Rural Health Clinic • Programs of All-Inclusive Care for the Elderly (PACE) Center	• Worksite* • Hospital Outpatient • Homeless Shelter • Assisted Living Facility • Group Home • Mobile Unit • Street Medicine • Independent Clinic • Tribal/Indian Health Service Facility • Prison/Correctional Facility

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.

*Includes Military Treatment Facility

Non-Claims Primary Care Measurement Approach

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.

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.

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.

Details of OHCA's approach to measuring claims-based primary care spend can be found in its Recommendations to the Health Care Affordability Board: Proposed Primary Care Investment Benchmark memo.

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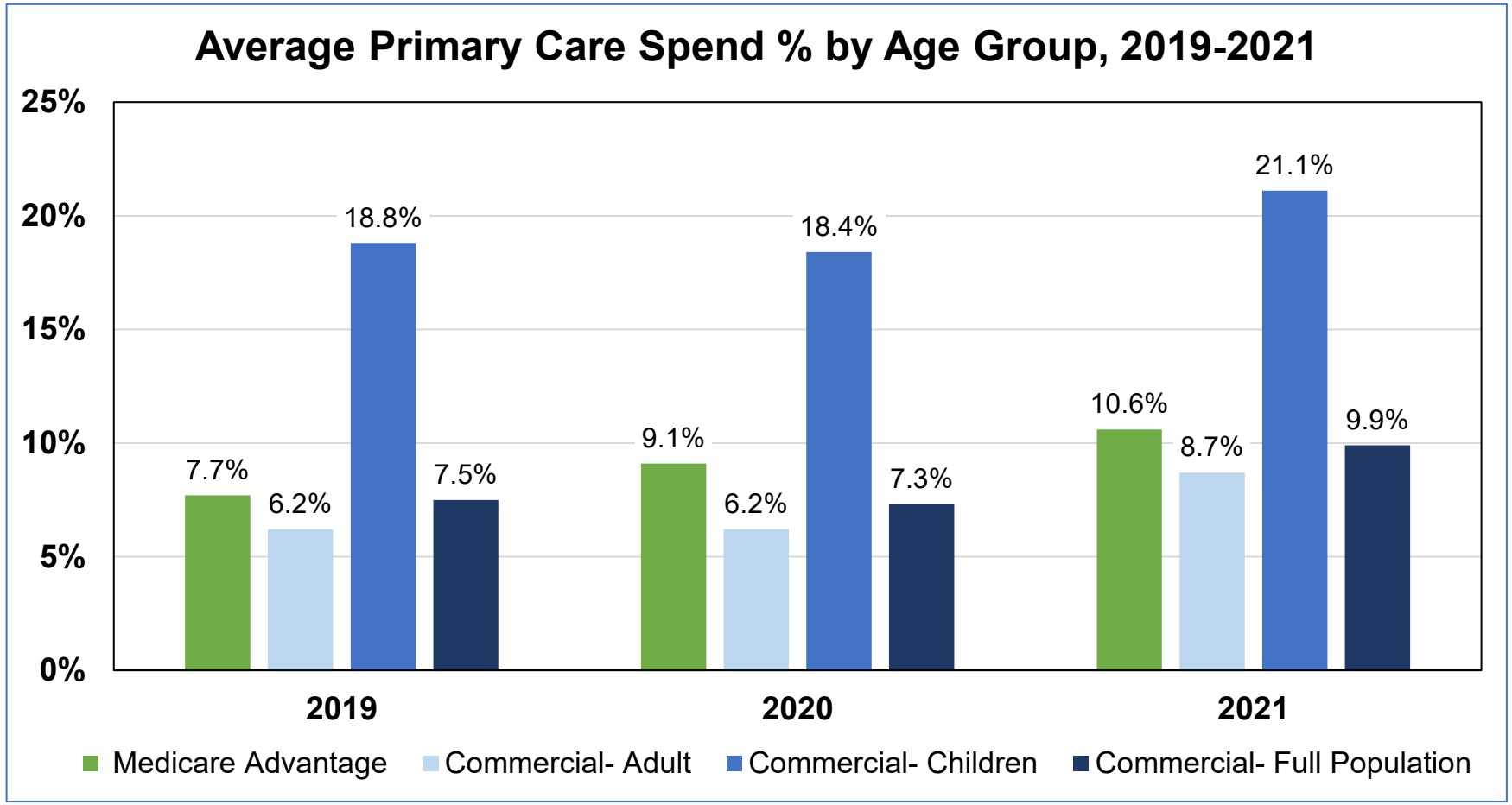
OHCA Primary Care Investment Benchmark

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

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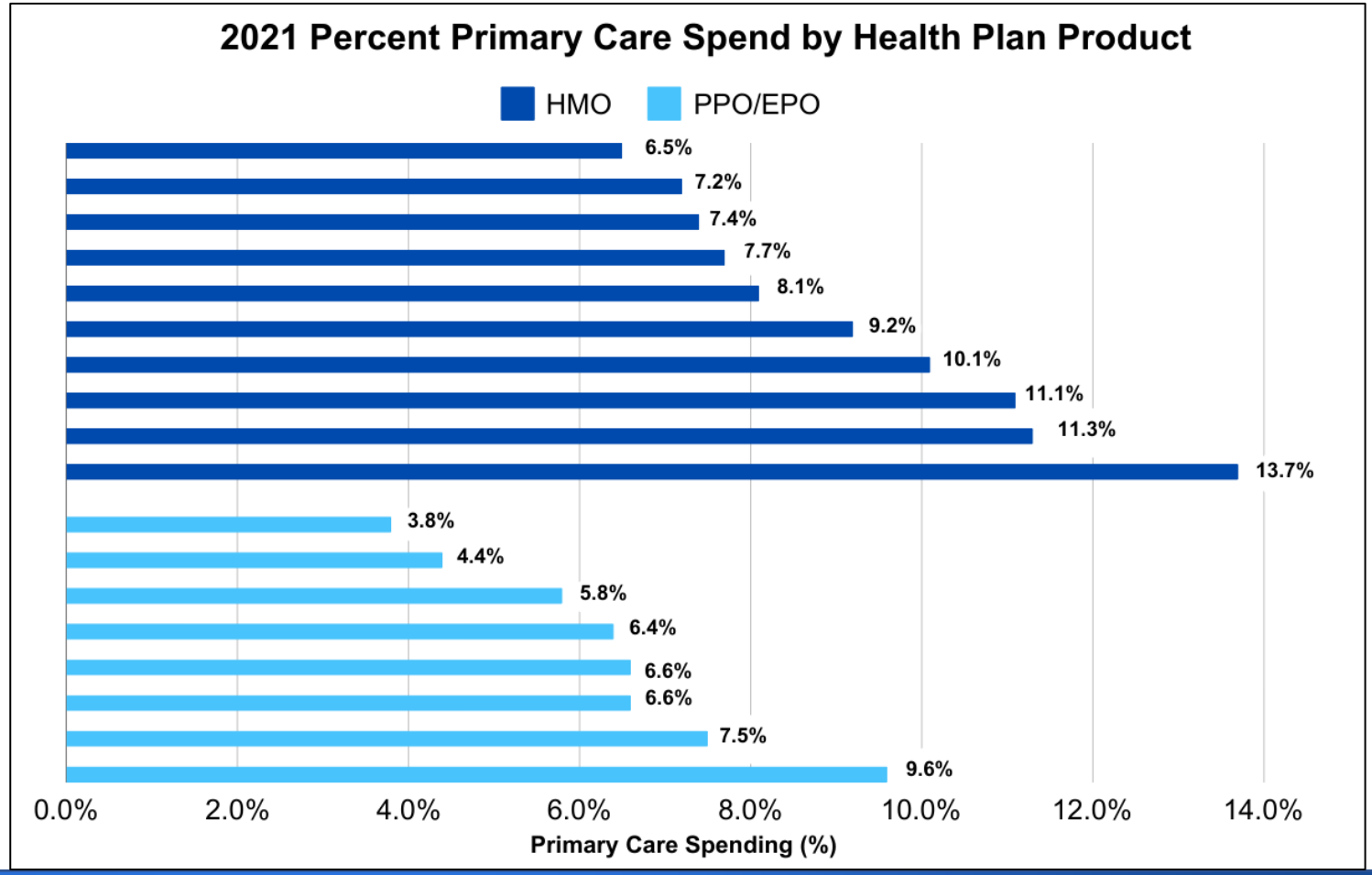
Primary Care Spending by Commercial Payer-Product Type

- 2021 commercial data from the Integrated Healthcare Association shows that primary care spend varies by product type and within product types.
- PPO/EPO (6.3%) had a lower average percent primary care spend for 2021 than HMO (9.2%).
- The primary care benchmark seeks to reflect these differences.



Integrated Healthcare Association analysis of California Commercial primary care spending in 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

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Three Lessons Learned from Other States

1. **The most successful efforts gradually reallocate spending to primary care.** Efforts to increase investment too quickly may accelerate growth in total cost of care.

2. **Sustainable delivery transformation requires multi-payer investment** to support all populations in accessing high-value primary care. However, four of six states with investment requirements only focus on either commercial or Medicaid (not both), nor do they include Medicare Advantage.

3. **Increases in total cost of care hinder benchmark success.** As total cost of care increases, achieving primary care benchmarks based on percent total medical expense becomes more difficult.

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OHCA Primary Care Investment Benchmark

Performance Years	Annual Improvement Benchmark
2025-2033	0.5 - 1% per year for each payer and product*
Performance Year	**Investment Benchmark**
2034	**15% statewide for all payers and products**

Rationale and Considerations:

- Has received strong stakeholder support from Workgroup and public commenters
- Gives all payers reasonable opportunity to demonstrate immediate progress and long-term success
- Emphasizes demonstrating annual progress
- 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

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

Investment benchmark was approved at the October 14, 2024 OHCA Board meeting.

Accountability for Primary Care Investment Benchmark Performance

- **Transparency**: Public reporting by payer of primary care spending level and performance against benchmark.
- **Performance Improvement Plan (PIP):** Primary care investment performance goals could be incorporated into PIPs for entities that exceed OHCA's spending growth target.

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