California Advanced Primary Care Initiative: Payment Model Demonstration Project & Technical Assistance Program

PBGH California Quality Collaborative | Integrated Healthcare Association

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Payment Model Demonstration Project: Technical Assistance Program Overview

Demonstration Project: Technical Assistance Program

The technical assistance program will focus on building quality improvement and advanced primary care capabilities across approximately 30 independent practices. The program aims:

- To pay practices more, through a prospective, flexible structure (test a new common payment model)
- To build advanced primary care capabilities within participating practices, through payment, direct technical assistance, and data exchange through a common platform, to enable care team success in value-based payment models and
- To improve outcomes for people served by the participating practices

Technical Assistance Program

The Technical Assistance will utilize concepts from evidence-based frameworks and best practices, including:

1) Model for Improvement

   A widely used, simple framework for developing, testing and implementing changes leading to improvement

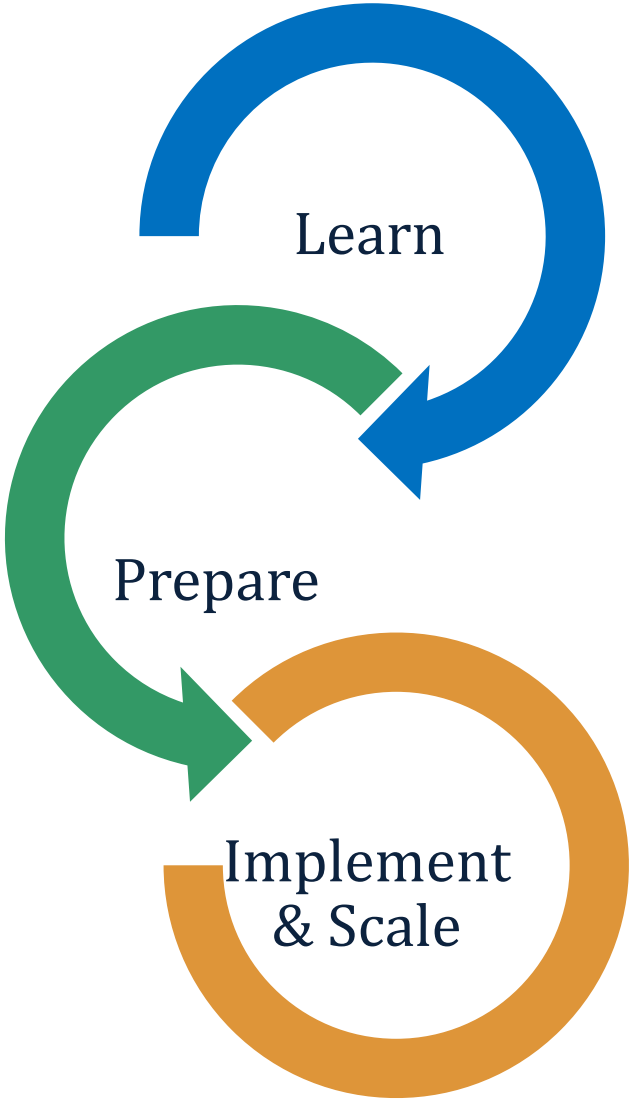
2) 10 Building Blocks of High Performing Primary Care

   Building blocks include practice-level advanced primary care capabilities like engaged leadership, data-driven improvement, team-based care and population management.

Curriculum Areas of Focus:

- Project planning/ quality improvement
- Patient/family engagement
- Workforce
- Health IT
- Clinical/care models
- Data/reporting
- Financing
- Sustainability
- Health equity

Program Timeline



Mar. 2024 – May 2024
- 1:1 conversations with potential practice participants and CQC/CMA/IHA team to learn about the program

June 2024 – Sept 2024
- Verbally commit and connect with participating health plans
- Communicate with and sign contracts with participating health plans
- Conduct needs assessment, coaches design tailored technical assistance plans for practices

Oct 2024 – Dec. 2025
- Practices launch the payment model through new contracts with health plans
- Build advanced primary care capabilities and test a new innovative payment model

Who can participate?

CQC and IHA have identified practices across California that best fit this Demonstration Project. Health plans have indicated eagerness for your participation.

Ideal candidates:

- Have contracts with at least one health plan participating in the Demonstration Project (Aetna, Anthem, Blue Shield of California, Health Net)
- Total combined adult patient membership at least (approx.) 750 at each practice. (Same applies for pediatric practices.)
- Are innovative-minded and open to the idea of piloting a new payment model

What will participants achieve?

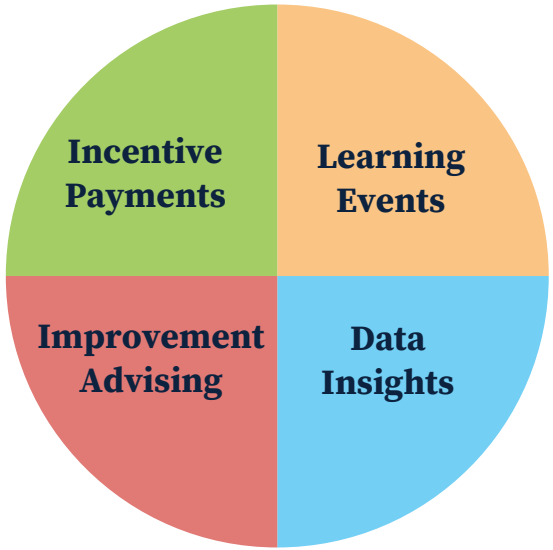
With support from the practice coaches, participants will:

- **Identify and document** a quality improvement plan tailored to your organization
- **Adopt and spread** best practices across your practice
- Outline a **sustainability** plan to maintain improved health services
- **Maximize investment** into their practice received under the new payment model, due to multiple plan (and more patient) involvement.

How will the Demonstration Project support participants?

Participants will have access to a variety of technical assistance, including:

- **Funding**
  - A monthly population health management payment
  - Incentive payments based on strong performance on key measures (for either improvement or attainment)
  - Combination of population health management payments and incentive payments will equal up to 30% increase from base payment
- **Coaching –** Shoulder to shoulder support from CQC and CMA's team of experienced practice coaches
- Virtual **Learning Events –** Access to subject matter experts and a network of peers
- **Data Insights –** Guidance to build data collection systems to support integration. Access to analysis, insights and impact of work on performance.



How will we monitor the impact?

The Demonstration Project will monitor improvement efforts across a suite of measures.

Data will be submitted by participating practices and health plans to a common reporting platform, Cozeva, on a monthly basis.

Quality Domain	Measure	NQF ID		Commercial[1]	Medi-Cal[2]	CMS[3]	DMHC[4]
Health Outcomes & Prevention	Asthma Medication Ratio	1800	Pediatric/Adult	●	●	●	●
	Childhood Immunization Status (Combo 10)*	0038	Pediatric	●	●	●	●
	Colorectal Cancer Screening*	0034	Adult	●	●	●	●
	Controlling High Blood Pressure*	0018	Adult	●	●	●	●
	Diabetes HbA1c Poor Control (>9%)*	0059	Adult	●	●	●	●
	Immunizations for Adolescents	1407	Pediatric	●	●	●	●
Patient Reported Outcomes	Depression Screening and Follow-Up for Adolescents and Adults (DSF)	–	Pediatric/Adult	●	●	●	●
	Depression Remission or Response for Adolescents and Adults (DRR-E)**	–	Pediatric/Adult		●		
Patient Safety	Concurrent use of Opioids and Benzodiazepines was removed due to stakeholder feedback. A replacement will be chosen in 2023 during updates post testing.						●
Patient Experience	Patient Experience (CG-CAHPS)	0005	Pediatric/Adult	●		●	●
High Value Care	Emergency Department Visits	–	Pediatric/Adult				
	Inpatient/Acute Hospital Utilization	–	Pediatric/Adult				
	Total Cost of Care	1604	Pediatric/Adult				

Your commitment as a participant

Supported by a knowledgeable and committed team, participants will:

- Identify a team to engage and collaborate with the Demonstration Project team including:
  - Regular touchpoints with your practice coach
  - Participation in virtual learning events
  - Monthly submission of data across the measure set
- Utilize funding to support QI efforts (e.g., staffing, technology, etc.)

The Payment Model Summary

For participating practices under the common payment model, there is a potential to earn up to an additional 30% above base payments across the three elements listed below. While the distribution of the increased payment allocation amongst the three elements may differ from plan to plan, the initiative aligns on the unified target of 30% potential increase in payment

Element 1
Payment for direct patient care using a mix of capitation and FFS (Two Tracks)

Track 1 FFS+

Pays FFS for all direct services and participate in the PHM PMPM and the incentive (Elements 2 and 3)

Track 2 Hybrid

Pays a prospective, adjusted PMPM payment for specific primary care services, with all other services paid FFS

+

Element 2
PMPM payment to support population health management

A prospective, adjusted PMPM pay ment to support population health management functions

- referral & follow up
- patient outreach
- coordination with other resources
- transitions of care
- team care
- infrastructure, data & reporting, etc.

+

Element 3
Performance-based payment based on standard APC measure set

Performance incentive based on a common measure set

- Payment for meaningful improvement (10% relative) if original score is between the national 25th to 66th percentile benchmark
- Payment for attainment if scores above the 66th percentile (higher)
- Pay more for improvement or attainment on equity sensitive measures.

Payment Elements 1 and 2 will be adjusted for clinical and social risk

Joint Payment Model Risk Adjustment

Payment Elements 1 and 2 will be adjusted for clinical and social risk

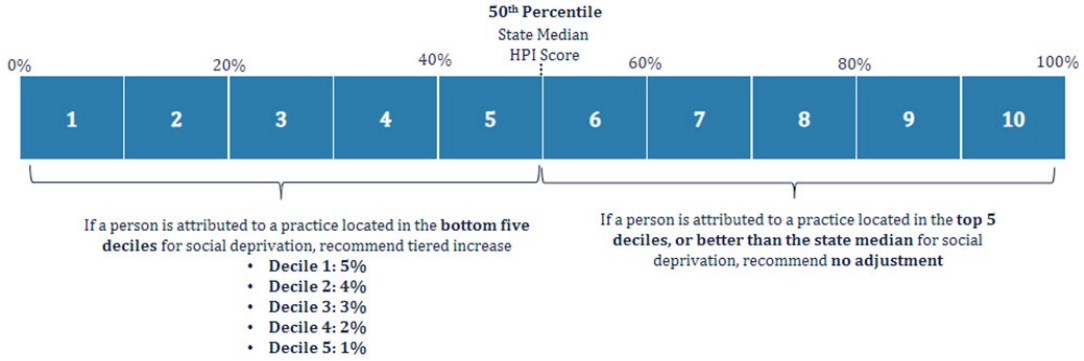
Recommended Clinical Risk Adjustment Method

The initiative seeks to align with the Office of Health Care Affordability (OHCA) and will adjust for age and gender in the payment demonstration project

Recommended Social Risk Adjustment Method

The initiative will use the California Healthy Places Index (HPI) to adjust payments for both direct service capitation and population health payment. HPI scores will be calculated based on practice location and every practice will be attributed to a decile.

- Payments adjusted upwards only for populations lower than the California state median HPI score



Participant Funding: Core & Incentive

Two FFS+ Scenarios Modeled Based on Different Levels of Performance on Measure Set.
All dollar amounts listed are for illustration only and may vary by plan.

	Direct Services Payment	Population Health PMPM	Performance Incentive	Total Core & Incentive Annual Payment	Total Core & Incentive Program Duration Payment
Scenario 1: The Newcomer	Direct services are paid Fee-For-Service and not included in modeled payment scenarios; assume status quo payments	1,000 attributed lives multiplied by recommended PMPM of $7.00 = **$7,000 Monthly***	Received an improvement incentive for closing 10% of gap between score and benchmark for 1/10 measures, earning a PMPM of $0.25 Received an attainment incentive for 2/10 measures, earning a PMPM of $1.14 Combined PMPM of $1.39 = **$1,390 Monthly or about 20% of maximum****	**$100,680**	**$151,020**
Scenario 2: The Strong Performer	Direct services are paid Fee-For-Service and not included in modeled payment scenarios; assume status quo payments	1,000 attributed lives multiplied by recommended PMPM of $7.00 = **$7,000 Monthly***	Received an improvement incentive for closing 10% of gap between score and benchmark for 5/10 measures, earning a PMPM of $1.45 Received an attainment incentive for scoring at the threshold for 5/10 measures, earning a PMPM of $2.30 Combined PMPM of 3.75 = **$3,750 Monthly or about 55% of maximum****	**$129,000**	**$193,500**

*The population health PMPM will be adjusted for clinical (age/gender) and social risk
*The recommended maximum potential payment for the performance incentive is $7.00PMPM, which for 1,000 members would be $7,000 monthly or $84,000 annually

Frequently Asked Questions (FAQ)

- **What is the California Advanced Primary Care Initiative Payment Model Demonstration Project?**
  - This project is an eighteen-month technical assistance program aimed at transforming primary care delivery in California. It is a collaborative effort between the California Quality Collaborative (CQC), the Integrated Healthcare Association (IHA), the California Medical Association (CMA), and leading health plans.
- **What is the objective of the program?**
  - The primary goal is to test a new common payment model that rewards practices for delivering advanced primary care services. The program aims to improve patient outcomes, enhance care team satisfaction, and reduce healthcare costs.
- **How were practices selected to participate?**
  - Practices are being outreached based on high patient volume with the participating health plans and potential to improve access to high quality primary care. Up to 30 practices will be chosen to participate in this initiative, across all of the participating payers.
- **What are the benefits of participating in the program?**
  - Participating practices will receive funding opportunities through regular population health management payments and incentives based on performance, personalized coaching from experienced practice coaches, access to virtual learning events, access to a common reporting platform and data insights and support.
- **How will the funding be utilized within my practice?**
  - Funding can be used to support the implementation of innovative care delivery models, enhance staff training, resources and process improvement, invest in technology and infrastructure improvements, and support other initiatives aimed at improving patient care.

Frequently Asked Questions (FAQ) continued

- **What are the requirements for participating practices?**
    - Participating practices are expected to actively engage in program activities, implement recommended practice transformations, participate in coaching sessions and virtual learning events, and contribute to data collection and reporting efforts.
- **Will participating in this program require significant time commitment from our practice?**
    - While participation does require dedication and engagement, the program is designed to be flexible and accommodating to the needs of participating practices. Coaching sessions and virtual learning events are structured to fit within your practice's schedule.
- **How will the program measure success?**
    - Success will be measured based on various performance metrics, including improvements in patient outcomes, care team satisfaction, healthcare utilization rates, and cost savings. Participating practices will receive regular feedback and support to track progress.
- **How can I learn more about the program and its requirements?**
    - You can visit the program's website for additional information, review the PDF provided in the invitation email, or schedule a call with your designated coach to discuss program details and ask any questions you may have.

The California Quality Collaborative, a program of the Purchaser Business Group on Health, and the Integrated Healthcare Association are proud to offer this program in collaboration with Aetna, Anthem Blue Cross, Blue Shield of California, Health Net, and the California Medical Association.

CQC is a health care improvement program dedicated to helping ambulatory care teams gain the expertise, infrastructure and tools they need to advance care quality, be patient-centered, improve efficiency and thrive in today's rapidly changing environment. The program is dedicated to advancing the quality and efficiency of the health care delivery system across all payers, and its multiple initiatives bring together providers, health plans, state agencies and purchasers to align goals and take action to improve the value of health care for Californians.

IHA brings the healthcare community together to solve industry- wide challenges that stand in the way of high-value care. As a non-profit industry association, we use our decades of expertise, objective data, and our unique role as a trusted facilitator to make the healthcare system work better for everyone.

To learn more, contact Julie Malonzo at jmalonzo@pbgh.org.