October 1, 2024 – December 31, 2025

Common Value-Based Payment Model Guide for Primary Care Physicians & Payers

Payment Model Demonstration Project
California Advanced Primary Care Initiative

PBGH California Quality Collaborative | Integrated Healthcare Association

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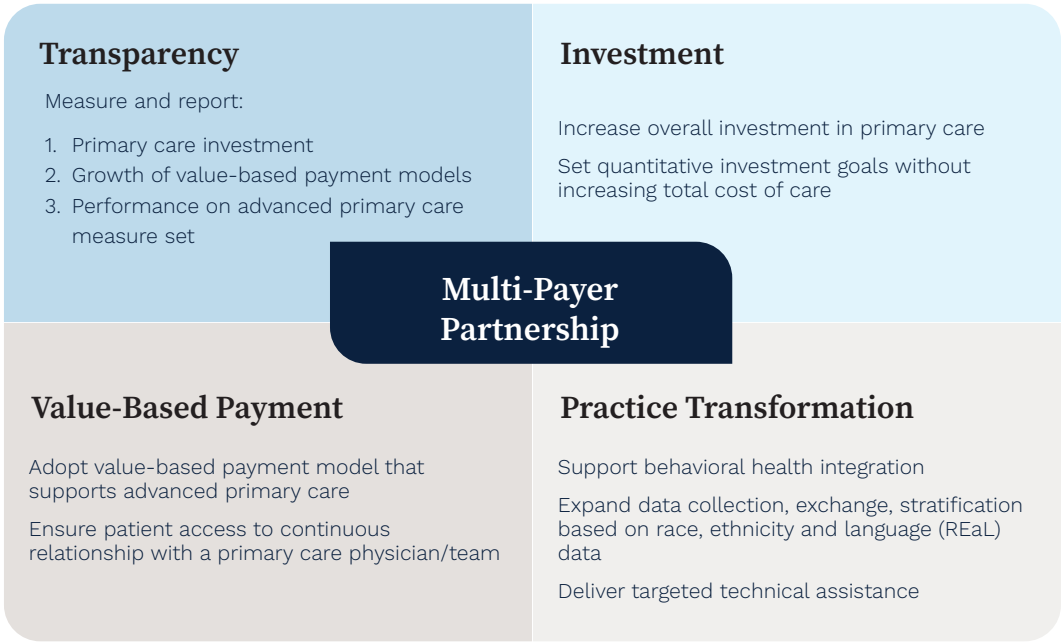
What is the California Advanced Primary Care Initiative?

Convened by the California Quality Collaborative (CQC) and the Integrated Healthcare Association (IHA), the California Advanced Primary Care Initiative is an effort comprised of a group of California-based health care payers — predominantly health plans — who have voluntarily partnered to support providers in strengthening primary care delivery. The group shares a common definition for Advanced Primary Care based on attributes and measures that was collaboratively developed by care providers, health plans and other health system partners.

The initiative is working towards increasing adoption of payment models that provide increased resources, more flexibility and rewards for quality to primary care practices. Due to the range of payers that practices contract with, implementing payment changes collectively has the potential to yield greater positive impact compared to individual plan-driven efforts.



Value-Based Payment

What is Value-Based Payment?

Value-based payments tie health care provider payments to the quality of care delivered. Better outcomes will yield higher payment. These payments are generally designed to be flexible, as they are not tied to delivering specific services. Value-based payment generally holds providers more accountable for improving patient outcomes while also giving them greater flexibility to deliver the right care at the right time.

How is Value-Based Payment Beneficial to Primary Care Physicians?

Providers receiving payment through a fee-for-service (FFS) model are often not compensated for all the work they do. Running a practice and managing the health of a population involves more than interacting directly with patients. Shifting to value-based payment creates flexible revenue for all the additional work clinicians and their team do when not directly engaging with patients, such as hiring and training new staff, chart review, referral research, patient calls, care coordination, process improvement and business administration. Value-based payment also pays more for high-quality outcomes.

Why Are Multiple Plans Paying This Way Together?

There is general agreement on the concept of value-based payment, but what counts as "value" or "high quality" varies. When multiple payers work together to pay primary care providers more using the same criteria, providers can focus on what is most important — providing high-quality patient care — and confusion and administrative burden are reduced. When a larger portion of the patient panel is paid under an aligned value-based model, it enhances value to the provider by increasing the opportunity to earn more based on performance while supporting sustainability.

What is the Impact on Patients?

The overarching goal of value-based payment is to incentivize providers for high-quality performance and equip them with the resources necessary to deliver better patient care — leading to improved outcomes for patients.

Payment Model Demonstration Project Overview

The California Advanced Primary Care Initiative is conducting a one-year demonstration project of the common value-based payment model. The model will be live from January 1, 2025 through December 31, 2025 with a three-month onboarding period in Q4 of 2024. The demonstration project will partner with up to 30 independent primary care practices in California, with the following goals:

- Test the payment model (for more details about all tracks of the payment model, see pages 6-13).
- Build advanced primary care capabilities within participating practices through payment and direct technical assistance, enabling care team success in value-based payment models (for more details about the support for practices, see pages 19-20).
- Improve outcomes for people served by the participating practices.

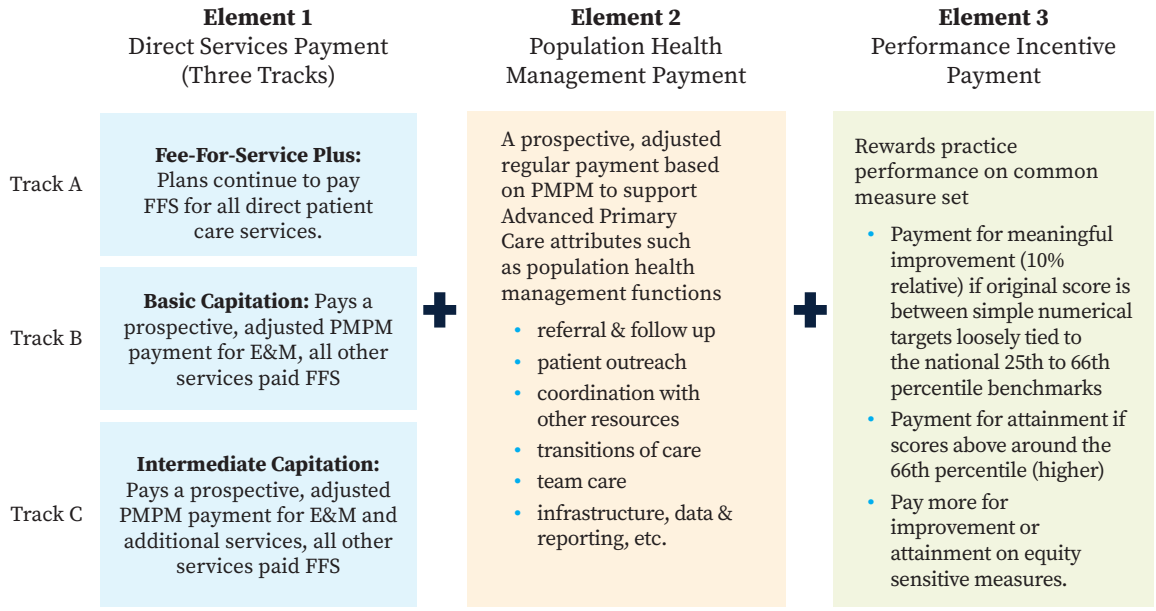
Three health plans — Aetna, Blue Shield of California and Health Net — collaborated to build a framework for a common value-based payment model that enables regular Population Health payments, provides flexibility in how payments are invested, rewards improvement and high performance, and potentially increases total payment. To demonstrate the impact of value based primary care, these health plans are jointly conducting a demonstration project with practices that contract for commercial PPO with at least one of the plans, and ideally multiple plans, that account for a significant portion of the practice's panel. This will enable business and clinical transformation across the whole practice.

By coordinating this demonstration project among shared practices and aggregating resources and technical assistance to practices in one collective approach, the project can demonstrate that collective impact is greater than individual efforts and needed change can be accelerated.

Payment Model Overview

The initiative's payment model aims to increase pay for primary care providers and do so differently, in a manner that invests in primary care in California and promotes value-based care. The payment model includes three elements of payment to participating practices. Together, these three elements of payment are intended to increase revenue to practices, support patient relationships and care coordination, and improve provider satisfaction.

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.



Payment Element 1 tracks B and C and Element 2 will be adjusted for clinical risk and social risk

It is important to note that exact payment amounts may vary by payer, however the structure and measures in the incentive payment will remain the same.

Payment Model Elements

1. Element 1: Direct Services Payment (Three Tracks)
    a. FFS+
    b. Basic Capitation
    c. Hybrid Capitation
2. Element 2: Population Health Management Payment
3. Element 3: Performance Incentive Payment

Element 1: Direct Services Payment

Direct services are all patient care that is billable. The direct services payment includes payment for eligible direct care services for patients. There are three voluntary tracks for direct services payment: A) Fee For Service +, B) Basic Level Capitation Hybrid Model and C) Intermediate Level Capitation Hybrid Model that practices may be able to choose from, depending on health plan offerings and provider preference. It is possible for a practice to participate in more than one track if the practice contracts with multiple health plans, but practices will only participate in one track per health plan.

Figure 1: Three Potential Tracks for Element One- Direct Services Payment

A. FFS+ Model
Direct Services: All direct services are reimbursed Fee For Service (FFS)

B. Basic Level Capitation Hybrid Model
Direct Services: Evaluation and management services are capitated Per Member Per Month (PMPM), all other services remain FFS

C. Intermediate Level Capitation Hybrid Model
Direct Services: Evaluation and management services and additional services (transitional care management, advance care planning, non-oral drugs, certain small surgeries, some ultrasounds) are capitated PMPM, all other services FFS

Table 1: Capitated Services and CPT Codes – Basic Level Capitation Hybrid Model (B)

Services Covered Under Capitation	Services to be Paid Fee for Service
E&M 992xx	Immunizations 90281–90756, G0008–G0010
Other E&M 99300-99499	Annual well visits 99381–99387, 99391–99397 Home visits Rest home visits SNF
	All other direct, billable services rendered by primary care practice

Table 2: Capitated Services and CPT Codes – Intermediate Level Capitation Hybrid Model (C)

Services Covered Under Capitation	Services to be Paid Fee for Service
E&M 992xx	None
Other E&M 99300-99499	Home Visits, Rest Home Visits, Skilled Nursing Facility (SNF)
Medicine Services 90757-99756, HCPCS – S & Q codes	Echocardiograms, Specimen handling, Inhalation treatment, Filing of inflatable pump, COVID testing, Flu Vaccines, IV tubing, IV infusion, Pap smear, IUDs, Abortion
Temporary HCPCS – G & C Codes	COVID testing
Drugs, non-oral and chemo – HCPCS – J Codes	Ceftriaxone, Progesterone, Asthma-related, Nausea-related, IV Fluid, IUDs, Estradiol, Cortisone, Chemo
Category III – Codes ending in T	None
	All other direct, billable services rendered by primary care practice

This Guide outlines the model's recommended metrics and methodology. Each participating plan will determine whether they will adopt the recommendations or modify them to meet their business needs and any regulatory requirements.

Element 2: Population Health Management Payment

Population health management payment supports population health and care coordination activities and will be paid quarterly to the practice. The payments are based on a PMPM calculation. The population health management payment is additive to payment for direct care services (Element One). The monthly PMPM calculated amount will be adjusted for clinical and social risk based on the methods outlined in this section.

As stated above, the Initiative recommends a potential 30% increase to base payment amongst the three elements, with flexibility for plans to allocate a higher share of the increase in payment to one or more of the elements as they see fit. As a result, the Population Health Management amount may vary slightly from plan to plan while commitment to an overall increase of up to 30% in payment remains aligned.

The initiative recognizes the activities for investment may vary from practice to practice but will require that dollars are put toward strengthening the advanced primary care attributes. Technical assistance coaches will work one-on-one with practices, at no cost to the practice, to assess where these additional funds may be best utilized depending on each unique situation and will be tracking progress via surveys and regular collection tools.

Population Health Management Payment Frequency

The initiative recommends quarterly population health management payouts for the duration of the measurement period of the demonstration project. These quarterly payouts will include payment for the attributed population for each of the three preceding months. Practices may earn the population health management payment as soon as the fourth quarter of 2024 if all of the required onboarding activities listed in the section below titled Technical Assistance – Engagement are completed.

Note that in order to qualify for the monthly population health management payment, the practice must be in compliance with all of the required ongoing activities listed in the section below titled Technical Assistance – Engagement.

Element 3: Performance Incentive Payment

Background

In developing the model for performance incentive payment, the initiative convened a physician workgroup to help create an incentive design that is simple, meaningful, and that reinforces the message that every practice that excels will be rewarded. The initiative is working to move beyond longstanding incentive models based on percentiles within a cohort that force competition among participating practices and instead will put forth numerically simple target scores drawn loosely from national percentiles. This will ensure each practice has the opportunity to succeed for performance on each measure compared to a benchmark that is simple to understand and remember and will not change during the demonstration project. The initiative understands that quality measurement can be a significant undertaking and one of many competing priorities providers must juggle, and it incentivizes improvement on the path to quality performance excellence.

Methodology

Similar to the Population Health Management payment, there is flexibility for plans to allocate a higher share of the overall increase in primary care payment to Element 3: the Performance Incentive than the other two elements. This allows for flexibility while remaining aligned to the overall target of the potential 30% increase in total payment to the participating practices. As a result, the maximum performance incentive amount may vary from plan to plan. The Performance incentive will evaluate Quality, Efficiency, Cost and Patient Experience and incentivize practices that achieve improvement or attainment.

The initiative's performance incentive payment will reward both attainment and improvement, with increasing payment for better performance. There will be a smaller incentive for practices that do not reach the Attainment Threshold (as described below) but demonstrate meaningful improvement.

- The initiative intends to use clinically meaningful levels of performance based on national percentiles as benchmarks, and targets will remain steady for the duration of the demonstration project and ideally going forward.
- The performance incentive will be paid based on performance on the standard primary care measure set listed below. Measure payouts are determined individually by each measure where practice data is available.

Table 3: Advanced Primary Care Measure Set

Standard California Primary Care Standard Measure Set	Measure Type	Source/ Benchmark Source	Adult/ Pediatric
Asthma Medication Ratio (AMR)	Quality	NCQA	Both
Breast Cancer Screening (BCS-E)	Quality	NCQA	Adult
Childhood Immunization Status: Combination 10* (CIS)	Quality	NCQA	Pediatric
Colorectal Cancer Screening* (COL-E)	Quality	NCQA	Adult
Controlling High Blood Pressure* (CBP)	Quality	NCQA	Adult
Depression Screening and Follow-Up (DSF-E) Phased approach: screening → monitoring → remission	Quality	NCQA	Both
Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD)	Quality	NCQA	Adult
Immunizations for Adolescents: Combination 2 (IMA)	Quality	NCQA	Pediatric
Acute Hospital Utilization (AHU)	Utilization	NCQA/IHA Atlas	Adult
Emergency Department Utilization (EDU)	Utilization	NCQA/IHA Atlas	Adult
Total Cost of Care using standardized pricing (TCOC)	Cost	Health Partners/ CA Advanced Primary Care Initiative	Both
Tracking Measures To be tracked for informational purposes only, not eligible for incentive			
Child and Adolescent Well-Care Visits (WCV)	Quality	NCQA	Pediatric
Depression Remission or Response for Adolescents and Adults (DRR-E)*	Quality	NCQA	Both
Glycemic Status Assessment for Patients with Diabetes <8.0%* (GSD)	Quality	NCQA	Adult
Pharmacotherapy for Opioid Disorder (POD)	Quality	NCQA	Both
Prenatal and Postpartum Care (PPC)	Quality	NCQA	Adult
Well Child Visits in the First 30 Months of Life (W30)	Quality	NCQA	Pediatric

* The National Committee for Quality Assurance (NCQA) and Covered California are requiring these measures to be reported stratified by race and ethnicity, because they tend to be equity sensitive. This means they exhibit a greater range of performance when stratified across demographic variables. Additionally, these measures are emphasized in Covered California's Quality Transformation Initiative (QTI). This version of the payment model demonstration project will not be evaluating based on stratified scores for race and ethnicity.
** All utilization and cost measures will be risk adjusted

As the table above illustrates, there are eleven total measures included in the Advanced Primary Care measure set and eligible for the performance incentive. Please note there are also six measures that will be tracked for informational purposes only that will not be eligible for the incentive. Variance on the number of measures applicable at each practice for the incentive depends on the type of practice and the population for which each measure applies. For Mixed Practices, or practices that serve both adult and pediatric populations, all measures apply. For Adult practices, there are nine measures and for Pediatric practices, there are five measures.

Along with guidelines for both attainment and improvement in this section, there is a table included in both the attainment and improvement sections that models out the proportion of the maximum total incentive amount for each of the applicable measures for the three types of practice (Mixed/Adult/Pediatric). For example, for a pediatric practice that has five applicable measures, each measure will be worth a larger proportion of the total incentive amount than a mixed practice where there are eleven measures. The intention is that each practice, regardless of the type of population they serve, is eligible for the maximum incentive amount set by each payer.

Measure weighting will be applied as follows if a practice has valid results for at least half of the measures for their practice type, the practice is eligible for the full incentive amount possible set by each plan and the measures will be weighted accordingly to total 100%. If a practice has valid results for less than half the measures applicable for their practice type, they are eligible for 50% of the financial incentive maximum amount set by each plan and each measure will be weighted accordingly to total 50%.

In order to be considered a valid result, a measure denominator of 20 or greater is required for “Adult” and “Both” quality measures and a denominator of 10 or greater is required for “Pediatric” quality measures. To be considered a valid result for Utilization and Cost measures, a measure denominator of 150 member years or 1800 member months is required for “Adult”, “Pediatric” and “Both”.

It is also important to note that Non-QTI measures are consistently worth about two-thirds of QTI measures in an effort to emphasize the importance of equity sensitive measurement.

A practice's performance on each measure will fall into one of three categories: 1. score is ineligible for an incentive as it does not meet the Minimum Performance Threshold score, 2. score meets the Minimum Performance Threshold but does not meet or exceed the Attainment Threshold and is eligible for an improvement incentive, or 3. score meets the Attainment Threshold and is eligible for an attainment incentive.

Incentive Payment Frequency

The initiative recommends one incentive payout for the duration of the measurement period of the demonstration project, approximately five months after the measurement period has closed to allow for three months of data runout to be submitted and incorporated. The incentive payout would be made in approximately May 2026 based on the measurement period from January 1, 2025 through December 31, 2025.

Element 3: Performance Incentive Payment: Improvement Incentive

The performance-based incentive payment will reward improvement within the Improvement Range from the Minimum Performance Threshold which loosely aligns with the national 25th percentile (from the National Committee for Quality Assurance) for all lines of business up to the Attainment Threshold which aligns loosely with the national 66.7th percentile.

Improvement Incentive Guidelines

- If a practice's performance is within the Improvement Range, it is recommended the practice receive a payment if their performance closes at least 10% of the gap between their own baseline performance and the Attainment Gold Standard (roughly the national 90th percentile).
- The amount does not vary based on how much improvement the practice makes or where their current year performance falls in the Improvement Range.

Table 4: Performance-Based Improvement Incentive Model

					Mixed Practice	Pediatric Practice	Adult Practice
Measure	**Adult/ Pediatric**	**Improvement Range**	**Attainment Gold Standard**	**Improvement Needed to Earn Incentive**	**% of Total Incentive**	**% of Total Incentive**	**% of Total Incentive**
Asthma Medication Ratio (AMR)	Both	81-87	91	10% gap closure	3.5%	7.5%	4.0%
Breast Cancer Screening (BCS-E)	Adult	70-76	80	10% gap closure	3.5%	NA	4.0%
Childhood Immunization Immunization Status Combo 10 (CIS)	Pediatric	45-61	71	10% gap closure	5.0%	11.0%	NA
Colorectal Cancer Screening (COL-E)	Adult	52-63	67	10% gap closure	5.0%	NA	6.0%
Controlling High Blood Pressure (CBP)	Adult	56-67	74	10% gap closure	5.0%	NA	6.0%
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	Both	Screening: 0-1 Follow-Up: 65-81	Screening: 11 Follow-Up: 87	10% gap closure	3.5%	7.5%	4.0%
Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD)	Adult	34-25	20	10% gap closure	5.0%	NA	6.0%
Immunizations for Adolescents Combo 2 (IMA)	Pediatric	26-35	46	10% gap closure	3.5%	7.5%	NA
Acute Hospital Utilization – Total Acute (AHU)	Adult	26-21	18	10% gap closure	3.5%	NA	4.0%
Emergency Department Utilization (EDU)	Adult	149-124	110	10% gap closure	3.5%	NA	4.0%
Total Cost of Care using standard pricing (TCOC)	Both	432-339	283	10% gap closure	3.5%	7.5%	4.0%

*For the DSF-E measure, practices will be measured against thresholds for both depression screening and follow-up on positive screen. Performance for depression screening and follow-up on positive screen will be worth 50% each for the measure PMPM.

It is important to note that exact payment amounts may vary by payer, however the structure and measures in the incentive payment will remain the same.

Element 3: Performance Incentive Payment: Attainment Incentive

If the practice's performance reaches the Attainment Threshold for a measure, the practice is eligible for an attainment incentive and is no longer eligible for an improvement incentive.

Attainment Incentive Guidelines

- If the practice's performance meets the Attainment Threshold for the measure, the practice will receive a recommended base, depending on whether it is a QTI measure, and incrementally more the closer they are to the Attainment Gold Standard.
- If the practice's performance meets the Attainment Gold Standard for a measure, the practice will receive the full Gold Standard amount for that measure, with higher amounts given to equity sensitive measures.
- The recommended total maximum PMPM across all measures and including both attainment and improvement is as much as 15% increase to base payment.

Table 5: Attainment Incentive

				Mixed Practice		Pediatric Practice		Adult practice	
Measure	**Adult/ Pediatric**	**Attainment Threshold**	**Attainment Gold Standard**	**Threshold % of Total Incentive**	**Gold Standard % of Total Incentive**	**Thresh-old % of Total Incentive**	**Gold Standard % of Total Incentive**	**Thresh-old % of Total Incentive**	**Gold Standard % of Total Incentive**
Asthma Medication Ratio (AMR)	Both	87	91	5.0%	8.0%	11.0%	18.0%	6.0%	9.75%
Breast Cancer Screening (BCS-E)	Adult	76	80	5.0%	8.0%	NA	NA	6.0%	9.75%
Childhood Immunization Immunization Status Combo 10 (CIS)	Pediatric	61	71	7.5%	11.0%	16.5%	28.0%	NA	NA
Colorectal Cancer Screening (COL-E)	Adult	63	67	7.5%	11.0%	NA	NA	9.0%	14.0%
Controlling High Blood Pressure (CBP)	Adult	67	74	7.5%	11.0%	NA	NA	9.0%	14.0%
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	Both	Screening: 1 Follow-Up: 81	Screening: 11 Follow-Up: 87	5.0%	8.0%	11.0%	18.0%	6.0%	9.75%
Glycemic Status Assessment for Patients with Diabetes >9.0 (GSD)	Adult	25	20	7.5%	11.0%	NA	NA	9.0%	14.0%
Immunizations for Adolescents Combo 2 (IMA)	Pediatric	35	46	5.0%	8.0%	11.0%	18.0%	NA	NA
Acute Hospital Utilization – Total Acute (AHU)	Adult	21	18	5.0%	8.0%	NA	NA	6.0%	9.75%
Emergency Department Utilization (EDU)	Adult	124	110	5.0%	8.0%	NA	NA	6.0%	9.75%
Total Cost of Care using standard pricing (TCOC)	Both	339	283	5.0%	8.0%	11.0%	18.0%	6.0%	9.75%

*For the DSF-E measure, practices will be measured against thresholds for both depression screening and follow-up on positive screen Performance for depression screening and follow-up on positive screen will be worth 50% each for the measure PMPM.

It is important to note that exact payment amounts may vary by payer, however the structure and measures in the incentive payment will remain the same.

Risk Adjustment

Element 1 (Track B and C) capitation payments and Element 2 population health management payments will be adjusted for clinical severity and social risk. The initiative seeks to align with the National Academies report on primary care and recognizes that different patients will need different levels of primary care based on their unique medical situation, demographic area and other variables.

Clinical Risk

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 utilizing the factors listed below. For potential future use, the initiative will continue to explore the value of developing a more nuanced approach to adjustment that includes clinical diagnoses.

Table: Age/Gender Factors for the Payment Model Demonstration

Age Range	Female	Male	Unknown or Not Disclosed
0-2	1.2169	1.3273	1.2721
2-6	0.9539	1.0363	0.9951
6-18	0.6673	0.6815	0.6744
18-25	0.7072	0.5180	0.6126
25-30	0.8752	0.7227	0.7989
30-35	0.9232	0.8043	0.8637
35-40	0.9758	0.8214	0.8986
40-45	1.0358	0.8777	0.9568
45-50	1.1309	0.9370	1.0339
50-55	1.2196	1.0251	1.1224
55-60	1.2702	1.1465	1.2084
60-65	1.3670	1.2617	1.3143
65+	1.6814	1.5546	1.6180

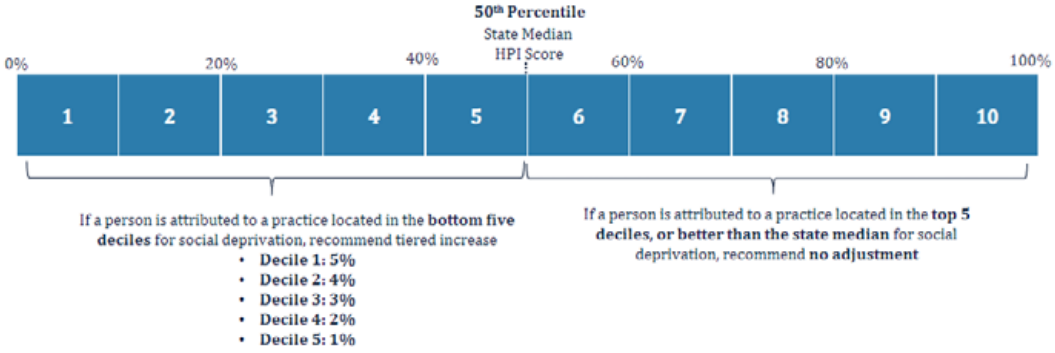
Social Risk

The initiative will use the California Healthy Places Index (HPI) to adjust payments for both direct service capitation and population health management payment. HPI was selected as the superior index, as it is a California-specific index and includes additional data sources on top of the American Community Survey commonly used in other indices.

Direct service capitation and population health management payments will be adjusted upwards only for populations lower than the California state median HPI score. HPI scores will be calculated based on practice location and every practice will be attributed to a decile. If the practice is located in the bottom five deciles for social deprivation, the recommended tiered increase is 5% upwards adjustment for the lowest decile, 4% for the second lowest decile, 3% for the third decile, 2% for the fourth decile, and 1% for the fifth decile. If the practice is located in the top five deciles, or better than the state median for social deprivation, the Initiative recommends no adjustment.

Although the additional payment for social risk is expected to increase a small amount overall, the initiative believes that incorporating a person's social environment into the primary care payment model through social risk adjustment is a step toward whole-person, integrated care.

Figure 2: Recommended HPI Adjustment Index



Attribution

Attribution will either be performed by the plan according to a plan's own attribution methodology and provided to the initiative each month or alternatively, the initiative will run a common methodology for plans who choose this route.

If the common methodology is chosen, membership attribution will be done utilizing claims data and will map each member to one practice and then one primary care provider. Each participating practice of the initiative will have a panel of attributed members that will be updated monthly.

Common Methodology

Members will be attributed to a single practice and then to a provider in that practice. For Commercial PPO and EPO, attribution will be strictly claims-based. For Commercial HMO and Medicare Advantage, preference will be given to a primary care provider selected by a member or matched by a plan and reported in the eligibility file. If a member has selected or been matched to a PCP they will be attributed to their selected/matched PCP. In the absence of a selected/matched PCP, claims-based attribution will be run.

Claims-based attribution will determine the primary care practice and provider that has been seen most frequently and recently for primary care services over the past 24-month period. Primary care is defined by a combination of provider specialty, place of service and specific services. The definition will be aligned with the Office of Health Care Affordability (OHCA). See pages 8-9 of this OHCA document for more information.

Common Reporting Platform

The initiative will use Cozeva as its common reporting platform. Access to the Cozeva platform will be available to all practices participating in the demonstration project. Cozeva requires only one login to view data on patients across plans. The intention is to create a seamless experience for practices and provide them with actionable information related to performance on the incentive measures for payout. Cozeva will provide plan-specific and aggregated performance results reporting to practices and identify member-specific care gaps. Projected incentive payments will also be displayed and updated with each data refresh. Practices will receive training from Cozeva and ongoing support on the platform through the technical assistance described below.

Technical Assistance

Practices contracting for any version of the initiative's common value-based payment model will engage in technical assistance to support performance improvement. Technical assistance services are provided by the California Quality Collaborative (CQC), a nonprofit regional health care improvement program of the Purchaser Business Group on Health. CQC has been serving ambulatory care practices across California for more than twenty years.

Technical assistance will include evidence-based support through a combination of on-demand virtual learning resources and personalized guidance from an improvement advisor who interacts with practices in bimonthly virtual coaching sessions and remains available to address questions and offer support throughout the duration of the demonstration project. The improvement advisor will partner with the practice to understand needs and opportunities, set goals, guide improvement efforts and track progress. In addition, participating practices will meet together each quarter to exchange learnings, provide peer support for overcoming challenges and celebrate achievements.

Curriculum

The foundation of the technical assistance program will focus on concepts from evidence-based frameworks and best practices, including:

- Model for Improvement
  A widely used framework from the Institute for Healthcare Improvement for developing, testing and implementing changes leading to improvement.
- 10 Building Blocks of High-Performing Primary Care
  A roadmap to identify foundational capabilities and implement these 'building blocks,' which include practice-level advanced primary care capabilities like engaged leadership, data-driven improvement, team-based care and population management. CQC has developed webinars on the 10 Building Blocks of Primary Care.
- Practice Transformation Initiative
  An assessment, change package and curriculum developed by CQC and used across more than 2,000 California primary care practices to guide transformation efforts and improve care and health outcomes.

Engagement

Required Onboarding Activities

Completion of the following activities is required by December 31, 2024 for the practice to earn the population health management payment for the fourth quarter of 2024. Practices that join later will still need to complete these required onboarding activities, but will not be eligible for the fourth quarter population health management payment.

1. **Welcome Email:** Confirm receipt and review onboarding materials.
2. **Onboarding Meetings:** Participate in up to five (5) virtual onboarding meetings with CQC improvement advisor.
3. **Learning Resources:** Review materials on billing, coding and quality measures.
4. **Business Associate Agreement (BAA):** Sign and submit the BAA with the CQC improvement advisor.
5. **Implementation Milestone Assessment Tool (IMAT):** Complete baseline IMAT.
6. **Practice Improvement Plan (PIP):** Work with CQC improvement advisor to develop a PIP, prioritizing improvement areas and designating team members.
7. **Coaching Sessions:** Schedule regular meetings for the practice's improvement team with the CQC improvement advisor.

Required Ongoing Activities

Completion of the following activities each month is required for the practice to earn the population health management payment for that month.

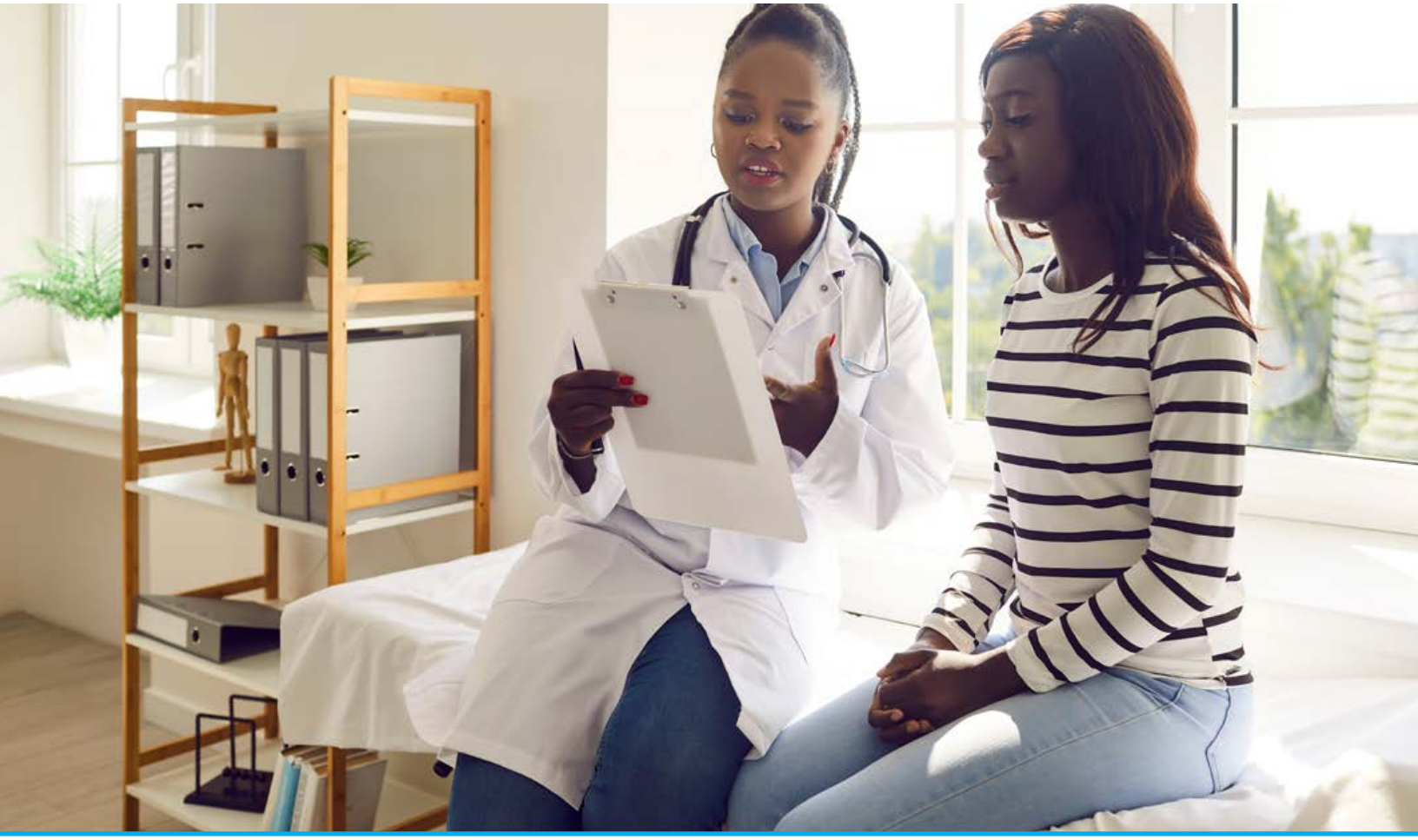
8. **Work Plan:** Develop a work plan for the Practice Improvement Plan and make monthly progress on implementing the plan. Coaching Sessions: Participate in two (2) individual coaching sessions each month.
    - If practice lead cannot attend, a new meeting must be scheduled.
    - The CQC improvement advisor will determine the length and content of the sessions based on the specific needs of the provider.
    - Sessions will focus on implementing the PIP and how the population health management payment is being used.
9. **Learning Webinars:** Join and contribute to quarterly learning webinars and complete any related offline learning activities in advance.
10. **IMAT:** Complete mid-point IMAT in June 2025 and final IMAT in December 2025, which will assess scored progress on milestones across nine domains — project planning, patient/family engagement, workforce, health IT, clinical/care model, financing data/reporting, sustainability and health equity.

Support and Resources

In addition to learning practice-level change concepts, participants will have access to skill-building trainings such as improvement coaching, motivational interviewing and patient and family engagement techniques.

Participating practices will receive a range of technical assistance from CQC to support quality improvement and advanced primary care capabilities. In turn, each practice will work directly with their assigned improvement advisor to tailor, test, implement and scale the quality improvement recommendations.

The technical assistance will focus on strategies that build upon and enhance existing practice capabilities and relationships with participating practices. Practices will leave the program with deeper insight into their practices and an improved ability to support their quality improvement work.



About the California Quality Collaborative (CQC)

California Quality Collaborative (CQC), a program of PBGH, is a health care improvement program dedicated to helping 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, the state and purchasers to align goals and take action to improve the value of health care for Californians.

Visit pbgh.org/program/california-quality-collaborative to learn more.

About the Integrated Healthcare Association (IHA)

At Integrated Healthcare Association (IHA), we bring the healthcare community together to solve industry-wide challenges that stand in the way of high-value, equitable care. As a non-profit industry association, we use objective data, our decades of expertise, and our unique role as a trusted facilitator to make the healthcare system work better for everyone. We provide insights that help the healthcare system continuously improve. We build new tools that simplify how the industry works together. And we provide a forum for cross-industry leaders—through our board and our programs—to have honest conversations that guide the future of healthcare. Because we envision a future where people get the best possible care at an affordable price. Where providers can focus on delivering care, health plans can focus on serving their customers, and purchasers feel confident they're getting value for their money. A future where the healthcare system works.

Visit iha.org/who-we-are to learn more.

Contact us to learn how you can get involved: lpetersen@pbgh.org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