Attachment 7 Refresh Workgroup
Effective Primary Care
December 5, 2019

Agenda

Time	Topic	Presenter
10am-10:05	◆ Welcome and Introductions	Thai Lee
10:05-10:20	◆ Covered California Proposed Primary Care Expectations for 2022-2024 Refresh ◆ Discussion	Margareta Brandt Lance Lang
10:20-10:50	◆ State of Oregon Investments in Primary Care ◆ Discussion	Jeanene Smith, MD, MPH *Principal, Health Management Associates*
10:50-11:30	◆ Lessons Learned from Large-Scale Practice Transformation: Program and Provider Organization Perspectives ◆ Discussion	Crystal Eubanks *Sr. Manager, Practice Transformation,* *California Quality Collaborative / Pacific Business Group on Health* Aaron Brincko *Hill Physicians*
11:30-12:00	◆ Open Discussion ◆ Next Steps	Lance Lang Margareta Brandt Thai Lee

COVERED CALIFORNIA PROPOSED PRIMARY CARE EXPECTATIONS FOR 2022-2024 REFRESH

EFFECTIVE PRIMARY CARE: APPROACHES 2017-2019

☐ In the current contract, Covered California promotes effective primary care with the following requirements of issuers:

- Ensure that all enrollees either select or be matched with a primary care physician (PCP) within 60 days of enrollment.
- Annually report the number and percent of enrollees who obtain their care in a patient-centered medical home (PCMH).
- Describe a payment strategy that supports primary care physicians in adopting accessible, data-driven, team-based care with accountability for meeting the Triple Aim goals of enhanced quality, improved outcomes and lower costs.

EFFECTIVE PRIMARY CARE: SELECT RESULTS 2017-2019

□ 99% of enrollees were matched with a PCP or clinician in 2018

□ 10 of 11 issuers have *Positive* or *Strong Incentives* for transitioning from volume-based to value-based primary care payment models such as shared savings or population-based payment

□ Patient Centered Medical Home (PCMH)
- Covered California enrollees cared for by PCMH-recognized practices increased from 3% to 11% between 2016 and 2018 (excluding Kaiser); increased from 25% to 40% (including Kaiser).
- Limitations
  □ The formal PCMH recognition programs largely document process improvement without measuring outcomes.
  □ Many advanced primary care practices have not sought formal PCMH recognition.
  □ Covered California is examining alternative approaches to advanced primary care recognition.

HMA RECOMMENDATIONS

□ HMA Suggested Considerations for Covered California
- Covered California should continue to require issuers to contract with providers that meet advanced primary care standards and report on the cost, quality and patient-experience of those enrollees in such practices compared to those who are not.
- Covered California should continue to require issuers to utilize alternative payment models that support advanced primary care and set standards for payment to advanced primary care providers, allowing flexibility to recognize a range of advanced primary care models such as national accreditation or practices that meet standards set by Covered California.

PWC RECOMMENDATIONS

☐ PwC Measures & Benchmark Recommendations for Covered California

- Use QHP national benchmarks reported from QRS.
- For measures that Covered California compares to Quality Compass commercial scores, set QHP benchmark at the 50th, 75th, or 90th percentiles for commercial and Medicaid.
- Recommend Healthcare Effectiveness Data Information Set (HEDIS) measures: Adult Access to Care and Hospitalization for Potentially Preventable Complications; Integrated Healthcare Association (IHA) Align Measure Perform (AMP) measure: Encounter Rate by Service Type.
- Consider analyzing QHP data to develop baseline values:
  - Utilization and expenditure of services
  - Prevalence of diagnoses and comorbid conditions
  - PCP visits per thousand
  - Percent enrollees with PCP or no visit
  - Emergency Department visits and admits with ambulatory care sensitive conditions

EFFECTIVE PRIMARY CARE: POTENTIAL APPROACHES 2022-2024

| Covered California Goals 2021-2024	Next Steps Under Current Contract	2022-2024 Potential Refresh Elements
• Ensure all enrollees have a primary care clinician as point of access to care delivery and advocate	• Continue to require PCP Matching • Work with issuers to promote value of PCPs to enrollees	• Implement CalHEERS provider directory functionality to support PCP selection at enrollment requiring new data elements from issuers
• Promote "Advanced Primary Care" defined as care that is accessible, data-driven, team-based • Increase the percent of enrollees cared for in Advanced Primary Care	• Collaborate with IHA and CQC to establish and test an outcomes measure set that aligns with national primary care and ACO measures which supports identification and evaluation of Advanced Primary Care at the practice level	• Require use of outcomes measure set for Advanced Primary Care • Require increasing proportion of enrollees cared for by PCPs who meet a target of success on measures
• Payment reform aligned with HCP LAN Level 3 (shared savings) or 4 (population-based payment and capitation) and sufficient to fund hiring a team Note: It is critical that outcomes measurement and payment are linked.	• Promote federal approaches aligned with Covered California expectations such as CPC+ and Primary Care First • Work with CQC and IHA to measure variation in proportion of budget spent on primary care services by plan, provider organization, and ACO • Assess correlation between investment in primary care and outcomes	• Continue to require increasing payment for primary care at LAN Levels 3 and 4 • Require implementation of best practices in payment reform that support Advanced Primary Care models • Require standard reporting for primary care budget and consider establishing targets for budget as proportion of overall health care spend

QUESTIONS?
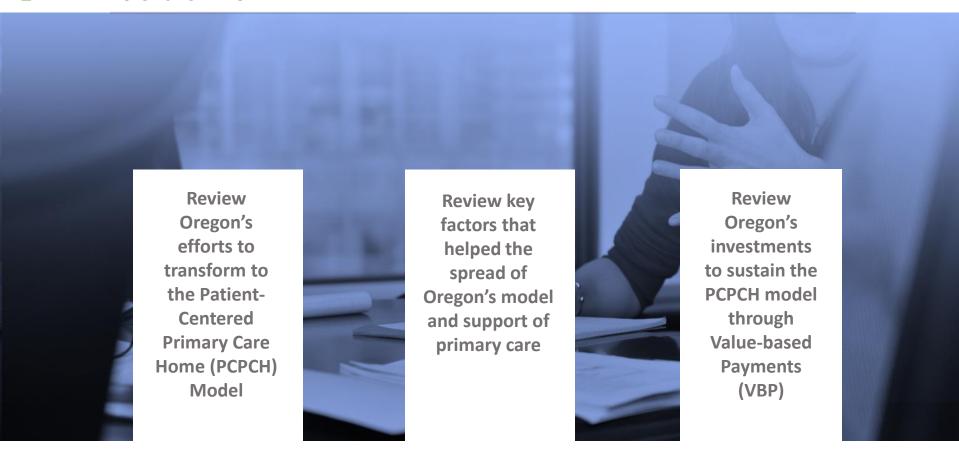
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State of Oregon's Investments in
Primary Care Transformation:
Oregon's Patient Centered Primary Care
Homes (PCPCH)

Jeanene Smith, MD, MPH | Principal

Review Oregon's efforts to transform to the Patient-Centered Primary Care Home (PCPCH) Model

Review key factors that helped the spread of Oregon's model and support of primary care

Review Oregon's investments to sustain the PCPCH model through Value-based Payments (VBP)

OREGON PATIENT-CENTERED PRIMARY CARE HOMES (PCPH)

- Key component of Oregon Health Reform efforts, established in statute in 2009 by the Oregon Legislature

- Further folded into the Coordinated Care Model efforts in 2012, including incentive performance measurements

- The State recognizes clinics as primary care homes and makes sure they meet the PCPCH Standards

- Standards were first set in 2010, updated every 2-3 years.

**Definition:
Oregon Patient-Centered Primary Care Homes**

"….are health care clinics that have been recognized by the Oregon Health Authority for their commitment to providing high quality, patient-centered care.

At its heart, this model of care fosters strong relationships with patients and their families to better care for the whole person.

Primary care homes reduce costs and improve care by catching problems early, focusing on prevention, wellness, and managing chronic conditions"
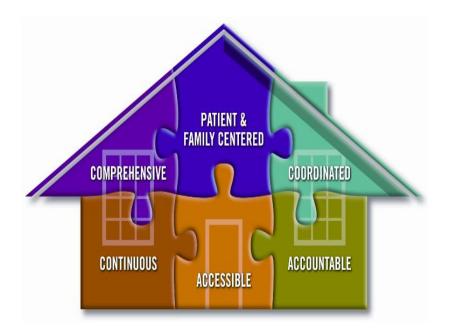
Approximately ¾ of all Oregonians get their care at a PCPCH

- First developed in 2010

- Regularly updated by a volunteer multi-stakeholder Standards Advisory Committee

- Six core attributes, each with specific standards and measures

- Eleven "Must Pass" measures all clinics must meet

- Five Tiers of recognition based on which measures a clinic meets

- Enhanced focus on children and behavioral health on past updates

- Current update looking at dental integration and social determinants of health
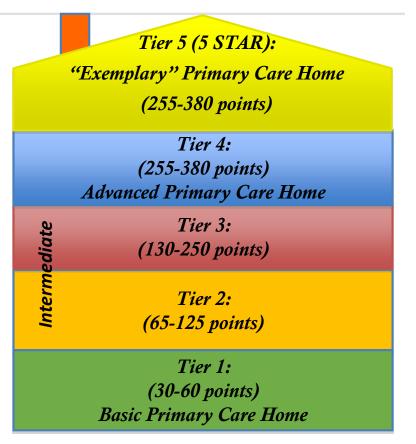
The Core Attributes of Primary Care Homes

Oregon PCPH Program: Now 5 Different Tiers of "Home-ness"
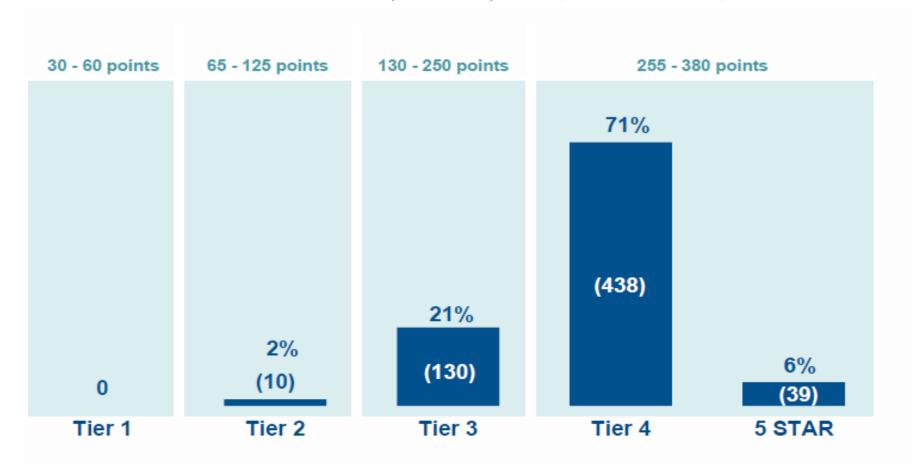
Tiered levels of recognition
- Used for payments by Medicaid CCOs and health plans
- Tiers reflect basic to more advanced primary care home functions
- Initially only 3 Tiers, expanded to 5 Tiers based on overall points score

Alignment with NCQA PCMH Standards:
- Oregon's Standards initially more focused on outcomes than NCQA's older process focus (2008 version)
- Newest (2017) NCQA Standards now very similar to PCPCH
- Clinics get credit under Oregon's program for NCQA recognition, with possible 1-2 additional things they must complete/demonstrate

Tier 5 (5 STAR):
"Exemplary" Primary Care Home
(255-380 points)

Tier 4:
(255-380 points)
Advanced Primary Care Home

Tier 3:
(130-250 points)

Tier 2:
(65-125 points)

Tier 1:
(30-60 points)
Basic Primary Care Home

Intermediate

PCPCH distribution by tier and points (as of June 2019)

30 - 60 points	65 - 125 points	130 - 250 points	255 - 380 points	
0	2% (10)	21% (130)	71% (438)	6% (39)
Tier 1	Tier 2	Tier 3	Tier 4	5 STAR

Oregon PCPH Program: Practice Recognition Process

- Voluntary with no fees to the clinics

- Recognition based on fulfilling Oregon's PCPCH Standards

- On-line attestation recognition application

- Small state staff in the Oregon Health Authority's Transformation Center oversee the recognition process

- A randomly-selected percentage of PCPCHs get state oversight/site visits, and a clinic must have a site visit if applying for Tier 5

- Site visits, while regulatory to audit the self-attestation, are also structured to promote education and sharing best practices; the program team include a provider as much as possible who has gone thru the process themselves to bring a peer perspective

- The state's recognition program staff and a collaborative community entity have provided technical assistance to the clinics; on-line modules are updated and available for each of the Standards

Core Attribute 1: Access to Care
"Health care team, be there when we need you"
Examples:

*Must Pass

- Standard 1.B-After Hours Access
- Standard 1.C-Telephone and Electronic Access*
- Standard 1.D-Same Day Access

Core Attribute 2: Accountability
"Take responsibility for making sure we receive the best possible care"
Examples:

- Standard 2.A-Performance and Clinical Quality"*
- Standard 2.C- Patient and Family Involvement in Quality of Improvement

Core Attribute 3: Comprehensive Whole-person Care
"Provide or help us get the health care, information, and services we need"
Examples:

- Standard 3.C – Behavioral Health Services*
- Standard 3.D- Comprehensive Health Assessment and Intervention

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<u>**Core Attribute 4: Continuity**</u>   *Must Pass

"Be our partner over time in caring for us"

Examples:

- Standard 4.B - Personal Clinician Continuity*
- Standard 4.E - Specialized Care Setting Transitions*

<u>**Core Attribute 5: Coordination and Integration**</u>

"Help us navigate the health care system to get the care we need in a safe and timely way"

Examples:

- Standard 5.A - Population Data Management
- Standard 5.C - Complex Care Coordination
- Standard 5.E - Referral & Specialty Care Coordination

<u>**Core Attribute 6: Person & Family Centered Care**</u>

"Recognize that we are the most important part of the care team and that we are ultimately responsible for our overall health and wellness "

Examples:

- Standard 6.A – Language/Cultural Interpretation*
- Standard 6.C – Experience of Care*

Metrics are required as one of the must-pass Standards

Core Attribute 2: Accountability

Standard 2.A- Performance and Clinical Quality

- The program provides a list of quality measures in the TA guide, which includes a core and menu set of metrics
- Data needs to be submitted with application, is verified at site visit, including raw data used to calculate the selected quality measures
- Clinics decide which of the metrics they will address

The requirements are:

- **2.A.0:** *Tracks* 1 quality metric from core or menu set

- **2.A.2**. *Tracks and reports* on 2 measures from core and 1 measure from the menu set

- **2.A.3**. *Tracks, reports and meets benchmark* on 2 measures from core and one measure from the menu set

Oregon PCPH Program: Includes Behavioral Health Integration

- The legislature, via SB 832 (2015), directed the state to set a clearer framework defining **physical and behavioral health integration**

- The PCPCH Standards Advisory Committee in their 2015 update recommended significant revisions to Standard 3.C Behavioral Health Services:

  - PCPCHs are required to **routinely screen for mental health, substance use** and developmental conditions at the lowest points level

  - **Co-location** was added as an option (3.C.2)

  - A new measure was added with higher points for full **integration** of behavioral health (3.C.3)

- The Committee also developed a **behavioral health home model framework** for integration of physical health services *into* behavioral health care settings:

  - Same six core attributes as the PCPCH model

  - Standards & measures specific to providing **both** physical and behavioral health services

  - Aligns with state expectations for the CCBHC model (Oregon has 23 sites)

COORDINATED CARE ORGANIZATION

Local accountability for health and resource allocation

Standards for safe and effective care

Integration and coordination of benefits and services

Global budget indexed sustainable growth

PATIENT & FAMILY CENTERED

COMPREHENSIVE

COORDINATED

CONTINUOUS

ACCESSIBLE

ACCOUNTABLE

- Early in development in 2010, the state, thru a Section 2703 of the Affordable Care Act (Health Homes) State Plan Amendment used 90:10 federal match to pay tiered monthly PMPM care management fees for 2 years

- After the Medicaid CCOs started in 2012, PCPCH enrollment was designated as **an incentive metric for CCOs qualifying for performance payments**

- PCPCH enrollment was also adopted as **a metric for public employee and school district state-purchased plans**

- Public Employees Benefit Board (PEBB) also directed the health plans to **set lower co-pays** for members using a recognized PCPCH as part of the benefit design

- The federal initiatives, Comprehensive Primary Care Initiative (CPC & CPC+ initiatives) brought in other commercial payers and Medicare for value-based payment for 150 clinics, expecting all the sites to move to PCPCH recognition. Those payments are wrapping up this year

Oregon's PCPCHs: Additional Support for PCPCHs and Primary Care

- Oregon implemented an **APM in FQHC's** in 2013; started with 3 centers, has expanded to 10; intended to support PCPCH efforts in the centers

- Initial legislation (SB 231 in 2015) passed by the Legislature to **report spending on primary care**; continued regular reporting required

- **Primary Care Payment Reform Collaborative**: A multi-stakeholder group that first came to an agreement to support the PCPCH model of primary care, more recently directed by Senate Bill 934 (2017) to collaborate on initiatives to increase investment in primary care and improve reimbursement methods

- SB 934 (2017) was passed and **required that 12% of premium to be directed to primary care for both public and private plans by 2023.** The most recent Feb 2019 report found:

  - **Medicaid CCOs averaged 13.4% (range 9.2 to 23.8%)**

  - **Public Employees and School District Benefit Boards' plans are at 12.2% (ranged 11-16%)**

  - **Medicare Advantage at 10.6% (range 4 - 23%)**

  - **Commercial carriers average 13.4 % (range 6.7 - 16.9%)**

Oregon's PCPCHs: Additional Support for PCPCHs and Primary Care - MEDICAID

- The state's Medicaid program's new January 2020 contracts, known as "CCO 2.0" have a focus on increased value-based payment, behavioral health integration and to focus on social determinants of health and equity by the coordinated care organizations.

- State is asking also to see new or expanded VBP in hospital, maternity, children's care, behavioral health and oral health care; still expect PCPCH support

- CCOs must annually increase the level of payments to their providers that are value-based:

  - In 2020: no less than **20%** in LAN Category 2C (Pay for performance) or higher

  - By 2021 – no less than **35%** in LAN Category 2C (Pay for Performance) or higher

  - By 2022 - no less than **50%** in LAN Category 2C (Pay for Performance) or higher

  - By 2023 – no less than **60%** in LAN Category 2C *and* to begin **no less than 20% in LAN 3B** (Shared Savings and Downside Risk) or higher

  - By 2024 – no less than **70%** in LAN 2C ((Pay for Performance) **and** begin **no less than 25% in LAN 3B (Shared Savings and Downside Risk)** or higher

PCPCH's have reduced overall healthcare costs

From study by Portland State researchers:

Gelmon, S et al (2016, September). Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Findings Final Report to the Oregon Health Authority.

Available at: http://www.oregon.gov/OHA/HPA/CSI-PCPCH/Documents/PCPCH-Program-Implementation-Report-Final-Sept-2016.pdf

Using the All-Payer Database, study found:

Reduced total spend by $13/month, increasing longer a clinic was a PCPCH across both public and private payers

$13 in savings is in other services such as specialty care, ED and inpatient care for every $1 increase in primary care spend in a PCPCH

Saved $240 million over the first 3 years (some of it pre-Medicaid's CCOs)

RESOURCES TO HELP TRANSFORM AND SUSTAIN CHANGE

Source: Oregon's Patient Centered Primary Care Institute - http://www.pcpci.org/

Oregon PCPCH Program: Weblinks to more information

PCPCH program website: https://www.oregon.gov/oha/hpa/dsi-pcpch/Pages/index.aspx

- PCPCH Standards 2017 Criteria Technical Assistance guide (new 2019 update in progress): https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/TA-Guide.pdf

- PCPCH Standards Advisory Committee and their Reports (see the 2015 Committee report for Behavioral Health update & Integration framework) https://www.oregon.gov/oha/HPA/dsi-pcpch/Pages/SAC.aspx

Recognition Information for Oregon Payers (includes info on payers supporting PCPCH)
- https://www.oregon.gov/oha/HPA/dsi-pcpch/Pages/Recognition-Oregon-Payers.aspx

Oregon's Primary Care Transformation Initiative: 2018 Progress Report
- https://www.oregon.gov/oha/HPA/dsi-tc/SB231%20Meeting%20Docs/PCPRC2018Report-1.28.19.pdf

PCPCH Resources and Technical Assistance with links to additional resources:
- https://www.oregon.gov/oha/HPA/dsi-pcpch/Pages/Resources-Technical-Assistance.aspx
- Training modules: http://www.pcpci.org/online-modules-2017-pcpch-standards

- These early years are laying the groundwork

- Oregon's goal is an innovative, outcome focused, patient-centered, and resource effective health system.

- Primary care is the foundation, and PCMH/PCPCH model is the key

- Value-based purchasing can be key to PCMH/PCPCH sustainability

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HMA

QUESTIONS?

Lessons Learned from Large-Scale Practice Transformation:

Program and Provider Organization Perspectives from the Practice Transformation Initiative

- Crystal Eubanks, CQC   ceubanks@calquality.org
- Aaron Brincko, Hill Physicians   Aaron.Brincko@hpmg.com

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Practice Transformation Initiative Lessons Learned and Resources

- Webinar - December 10th, 12-1pm
  - Registration Link
- Available @ www.calquality.org
  - Digital Resource Library
  - Reports
    - Lessons in Scaling Transformation
    - Improvement Coaching: What Matters Most in Transformation
  - Case Studies
    - Medical Foundation
    - IPA

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What did large-scale practice transformation look like?

Transforming Clinical Practice Initiative – CMS

PBGH/CQC's Practice Transformation Initiative

2015-2019

Network Characteristics

Cohort	Medical Foundation	IPA/ MSO	FQHC/ Health Plan
Organizations	3	8	2
Clinicians	847	3061	550
Practices	98	1276	90
Practice Size	8.6	2.4	6.1
Lives	1.18M	0.93M	0.91M
Payer Mix			
Commercial	50%	52%	11%
Medicare	12%	27%	5%
Medicaid	0%	12%	58%
Other	38%	9%	27%

Organization Cohorts
- Medical Foundations
- FQHC Consortium/Health Plan
- IPA/MSO

Aligning VBP Measures for Practices

	PTI Measure Set	NQF ID	QPP	Medicare Stars	Medicaid Core Set
Clinical Outcomes	Controlling Blood Pressure for People with Hypertension	0018	✓	✓	
	Asthma Medication Ratio (0-64)	1800			✓
	Diabetes: Two HbA1c Tests	0057			✓
	Diabetes: HbA1c Poor Control > 9.0%	0059	✓	✓	
	Diabetes: HbA1c Control < 8.0%	0575			✓
	Diabetes: Eye Exam	0055	✓	✓	✓
	Diabetes: Nephropathy	0062	✓	✓	
	Controlling Blood Pressure for People with Diabetes	0061			
	Cervical Cancer Screening	0032	✓		✓
Utilization	Cervical Cancer Overscreening Overuse: Low Back Pain Screening	0052	✓		
	Emergency Department Visits Inpatient Bed Days				
	Patient Feedback Quarterly			✓	

Technical Assistance

Practice Coaching

Peer Network for Sharing and Learning

Focused Trainings

Local Master Coach Development

Improvement Advising

Bi-weekly, transitioning to monthly

Peer Sharing & Learning

In-person = Quarterly

Virtual - Monthly

Knowledge and Skills Trainings

In-person = Quarterly

Virtual - Monthly

Data Infrastructure

PTI
Learning
Collaborative

Build data analytics capabilities

What was achieved?

Patients Impacted

Health Outcomes

Diabetes
- **40,000** patients improved HbA1c control
- **9,700** patients improved blood pressure control

Hypertension
- **9,700** patients improved blood pressure control

Reduce Unnecessary Hospital Use

Inpatient Bed Days
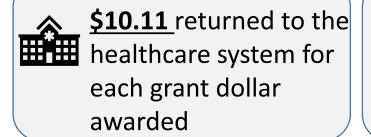- **47,000** avoided bed days

Emergency Department Visits
- **17,000** avoided ED visits

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Return on Investment

Cost Savings

$186 Million in
Total Cost Savings

$10.11 returned to the healthcare system for each grant dollar awarded
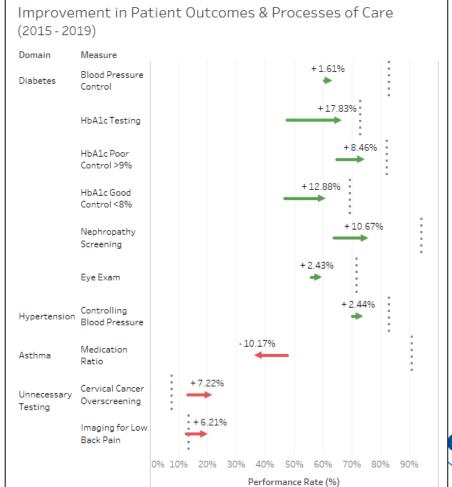
$42,000 saved per enrolled clinician

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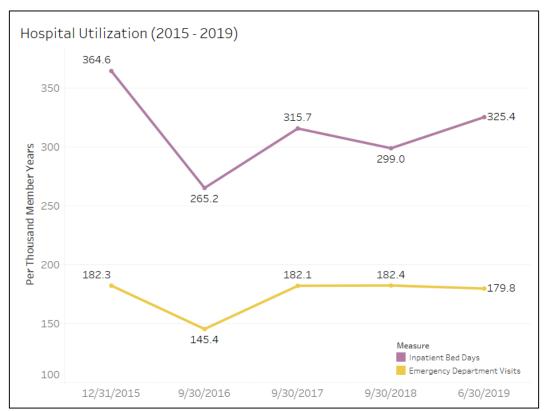
Network Performance

9 of 13 provider organizations improved over 4 years

Improvement in Patient Outcomes & Processes of Care (2015 - 2019)

Domain	Measure	Performance Rate (%)
Diabetes	Blood Pressure Control	+1.61%
	HbA1c Testing	+17.83%
	HbA1c Poor Control >9%	+8.46%
	HbA1c Good Control <8%	+12.88%
	Nephropathy Screening	+10.67%
	Eye Exam	+2.43%
Hypertension	Controlling Blood Pressure	+2.44%
Asthma	Medication Ratio	-10.17%
Unnecessary Testing	Cervical Cancer Overscreening	+7.22%
	Imaging for Low Back Pain	+6.21%

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Hospital Utilization

Hospital Utilization (2015 - 2019)
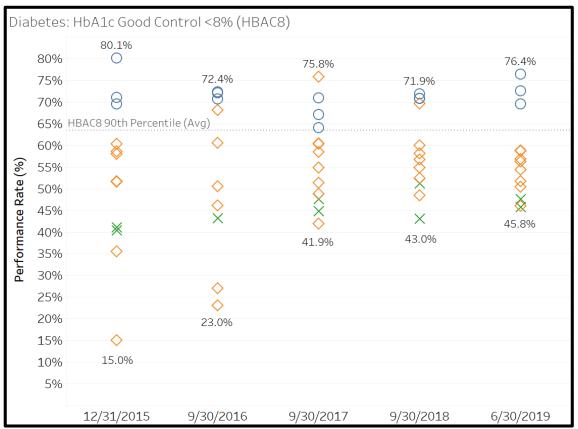
Reduced Variation across Network

Large reduction in performance differences across program participants

Range:
65.1% (12/31/15);
30.6% (06/30/19)

What changes were most impactful?

PRACTICE ASSESSMENT TOOL

  Every 6 months

  Assessed progress on process improvements

  Available online at PTI Resource Library

CQC
California Quality Collaborative

Practice Transformation
Initiative
DRIVER DIAGRAM

AIM:
To measurably improve **quality** of care while
decreasing **cost** for
4 million Californians
by working with
4,800 clinicians across
16 Provider Organizations in a
Practice Transformation Network.

Measurements: Quality & cost improvements demonstrated by an average of 15% improvement across a set of indicators for:
- *Diabetes, hypertension & asthma management*
- *ED & hospital utilization*
- *Back pain imaging*
- *Cervical cancer screening*
- *Patient feedback*

Practice Assessment Tool
Phase of Transformation towards APM

#s 1-9: CMS Change Package drivers that align with 10 Building Blocks

Primary Drivers

Secondary Drivers

1. Leadership & Vision
- Leaders at all levels
- Org/practice-wide vision
- Measurable goals and objectives

2. Data
- Data systems that collect information related to measures
- Actionable data displays, regularly updated data
- Data shared widely

3. Empanelment
- Each patient linked to PCP/care team
- Panel size standards and measurement

4. Team-Based Care
- Other health care professionals part of team
- Standing orders for uncomplicated patients
- Dyads/teamlets within practices
- Co-location
- Daily huddles

Clinical Guidelines
- Clinician training/education on evidence-based clinical guidelines for specific chronic illnesses
- Standard work flows by patient diagnosis

5. Patient Engagement
- Shared decision-making
- Agenda-setting
- Patient satisfaction data

6. Population Health
- Health coaching for subset of patients
- Panel stratification
- Panel management
- Complex care management

7. Continuity
- Tracking of continuity measures
- Support of practice staff for continuity

8. Access
- Collecting and tracking data for 3NA
- Accommodating patient preference for seeing own provider vs same day access

9. Coordination
- Automatic notification of hospital discharge or ED visit
- Care/referral coordinator
- Maximization of specialist referrals; diagnostics secured in advance

Staff Vitality & Joy in Work
Aligning Financial Incentives for Improvement / Sustainable Business Operations

Highest Capabilities by Project End

Network Final Score 0-3 (Avg.)

	Hospital Follow-Up (M.13)	2.54
	Phone Access (M.17)	2.44
	Risk Management Processes (M.9)	2.42
	Medical Neighborhood (M.12)	2.38
	Care Management of High-Risk Patients (M.10)	2.36

Most Improved Capabilities

	Improvement (Avg.)	Final Score (Avg.)
QI Capability (M.20)	1.04	1.99
Practice Aims (M.18)	1.02	2.17
Care Management of High-Risk Patients (M.10)	0.91	2.36
Shared Decision Making (M.4)	0.72	2.04
Risk Management Processes (M.9)	0.72	2.42

What are the implications for future application?

FUTURE DIRECTIONS

GROUP DISCUSSION

1. **Primary Care Fundamentals:** 3-year program beginning in 2020 for 1,500 clinicians in the Central Valley, Inland Empire, and Imperial County to improve outcomes for Californians with chronic conditions, specifically asthma & diabetes.

2. **Behavioral Health Integration**: An improvement collaborative to improve access and outcomes in primary care settings, scheduled for launch in late 2020.

3. **Centers for Medicare and Medicaid Services Clinician Quality Improvement Contractor (CQIC)**: Proposal submitted in August 2019 for state-wide transformation effort among 5000+ primary/specialty care clinicians across commercial and safety net systems over a 5-year period, across chronic disease, hospital utilization, and behavioral health measures.

Cal HIVE

Health. Impact. Value. Engagement.

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Advanced Primary Care Designation

An increasing number of health plans and purchasers in California are interested in recognizing and ultimately rewarding primary care practices adopting processes known to deliver more value to patients and payers – higher quality at lower cost of care.

As health plans, such as Blue Shield of California, and purchasers, such as Covered California, begin to develop programs to change payments for practices qualified as Advanced Primary care sites, the market runs the risk that variation in service expectations, measures and evaluation criteria will create burden and confusion at the practice and PO level.

Therefore, we propose a multi-stakeholder process to:

- Establish a common definition of Advanced Primary Care – Define the attributes or processes known, through literature or experience, to deliver both higher quality and lower total cost of care,

- Align on a common set of measures for external assessment of advanced primary care practices, and

- Define common contract language acceptable to practices, POs and plans and purchasers. *(insert anti-trust language)*

We aim for common definitions and measures to be applicable across all lines of business. Contract language and terms may vary between capitated, FFS and ACO products.

QUESTIONS?

OPEN DISCUSSION

NEXT STEPS

- Proposed Attachment 7 Refresh Workgroup 2020 dates
  - January ??
  - February 6
  - March 5
  - April 2
  - May 7
  - June 4

- Proposed Topics – (in depth discussions and analysis of QHP contract language)
  - Health Equity
  - Primary Care
  - Behavioral Health
  - Networks Based on Value
  - Promotion of Integrated Delivery Systems & ACOs
  - Data Sharing & Analytics