CHCF

Primary Care Investment Coordinating Group of California

Strengthening Primary Care

Successful State Innovations: California's Multi-Stakeholder Engagement

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March 23, 2022

California Health Care Foundation

HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

- Private philanthropy
- Dedicated to making meaningful and measurable improvements in health and health care for Californians with low incomes
- Two decades of strategic investments in care models, workforce, and technology innovations

Advancing Primary Care

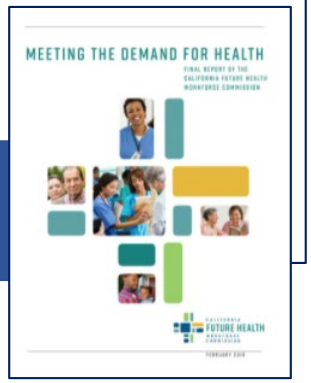
- Launched in 2020, motivated by:
  - Lack of progress on access and quality and reducing disparities, particularly in the Medi-Cal Program, where 80% of enrollees are persons of color
  - Recognition that our piecemeal approach to care transformation was insufficient for widespread change
  - International and domestic evidence: Primary care is the foundation of health and equity
- Our approach:
  1. Invest in the primary care workforce
  2. Increase resources: set and enforce a primary care spending target and align payment models
  3. Build state-specific evidence on the value of primary care
  4. Monitor primary care access; hold leaders accountable

Secret sauce: Multi-stakeholder engagement

Invest in the Primary Care Workforce

- California has a health workforce crisis.
- Critical shortages, maldistribution, record levels of burnout/departures:
  - 7.8 million Californians live in a primary care shortage area
  - 40% of Californians are Latino/x, only 7% of are physicians are Latino/x
- In 2017, the California Future Health Workforce Commission was charged with developing a strategic plan for building the future health workforce of California and identifying practical solutions to address both immediate and longer-term workforce gaps:
  - Leaders from health, labor, education, government, and consumer organizations
  - Emphasis on primary care, behavioral health, and healthy aging
  - 34 recommendations with 10 priority actions
- State-specific roadmap and call to action.

Strategies map to NASEM Recommendations



Results (Three Year Mark)

The state invested over a quarter of the nearly $3 billion recommended by the Commission for its 10 highest-priority recommendations.

California lawmakers:

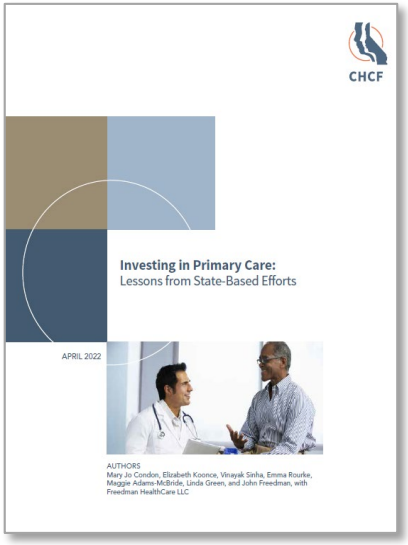
- Expanded scope of practice for nurse practitioners and created several new reimbursable provider types, such as community health workers
- Invested heavily in the mental health workforce, including creating new types of behavioral health positions to care for children and youth
- Made substantial investments in physician residencies, with an emphasis on primary care and psychiatry
- Established the Department of Health Care Access and Information with centralized support for workforce planning and development, including a GME Council

Philanthropy, health system, and education investments:

- California Medical Scholars Program
- University of California System psychiatric and mental health nurse practitioner training program

Increase Resources: Primary Care Spending & Payment Models

- Established the **Primary Care Investment Coordinating Group of California (PICG)**
  - Comprised of public and private health care purchasers, policymakers, analysis and improvement specialists, consumer advocacy organizations, and funders.
  - Goal: Align and coordinate primary care investment strategies and activities.
  - Confirmed guiding principles and **five recommended actions** for increasing primary care resources: Measure and report, set a target, pay for advanced primary care, establish purchaser requirements, track progress.
- Purchaser actions (as of March 2022) – impacting **16 million consumers**:
  - Covered California (marketplace), CalPERS (public employees), Department of Health Care Services (DHCS) (Medi-Cal): Aligned measures for primary care and contract language.
  - Covered California: Required qualified health plans to measure and report on primary care spending (2022); considering spending target and enforcement options.
  - CalPERS: Established requirement for primary care provider matching.
  - DHCS: Made prevention and primary care the foundation of its 5-year quality and equity agenda, will require plan partners to report primary care spending and payments linked to alternative primary care payment models.
  - Purchaser Business Group on Health: Issued a common purchasing agreement for primary care to encourage alignment across large employers and purchasers.
- Health plans engagement: Blue Shield is rolling out a primary care VBP model; additional plans are considering adopting a voluntary primary care spending target.
- State-level action (*proposed*): Office of Health Care Affordability would measure, report, and increase primary care and behavioral health spending (budget proposal and AB 1130, vote expected June 2022).



Investing in Primary Care: Lessons from State Based Efforts (April 2022)

Freedman HealthCare scanned 17 states and a dozen private purchasers committed to increasing primary care resources and identified three mechanisms to drive investment:

✓ Transparency
✓ Contracting
✓ Regulatory

Build State-Specific Evidence for Primary Care

- Primary care has not received the attention it deserves:
  - Policymakers
  - Health system leaders
  - Consumers
- Developed a fact base on primary care spending in California to inform decisionmakers:
  - Studies on the relationship between primary care spending, quality, patient experience, utilization, and total cost of care
  - Results of consumer poll demonstrating the value of having a primary care provider: fewer negative experiences, better access and engagement, more positive health behaviors
- Communications and consumer engagement:
  - "Primary Care Matters" (website, April 2022)

"Primary care is a common good, which makes the strength and quality of the country's primary care services a public concern."

2021, National Academies of Sciences, Engineering, and Medicine (NASEM)

Assure Accountability

- Monitor primary care access and hold Medi-Cal accountable
  - Survey consumers
  - Monitor network adequacy
  - Track and compare plan performance
  - Highlight disparities
  - Engage partners

In 2015, there were 39 primary care physicians (FTEs) participating in Medi-Cal per 100,000 enrollees, well below the state's own standards (50) and COGME guidelines (60).

Key takeaways for states:

1. Look for evidence, apply lessons
2. Engage stakeholders
3. Set expectations and send clear signals
4. Make the case relevant to your state's priorities
5. Hold leaders accountable

Examples of Federal government policy steps to help California (and other states) further strengthen primary care

Area	Federal Government Policy Step
Workforce	• Reform graduate medical education financing. • Move primary care training out of hospitals and into communities. • Finance and support interdisciplinary training. • Make the Health Resources and Services Administration's (HRSA's) teaching health center program permanent.
Primary care investment	• Set a Medicare target for primary care spending; provide resources and encouragement to state Medicaid programs to follow suit. • Ensure Medicare participates in state-led efforts to measure, monitor, and increase primary care spending. • Reinstate federal support for primary care practice improvement; focus resources on private/independent practices, rural practices (all types), and in primary care shortage areas. • Allow states more flexibility in Centers for Medicare & Medicaid Services Innovation Center models.
State-specific evidence	• Embrace the National Academies of Sciences, Engineering, and Medicine primary care scorecard recommendation; support nested state scorecards that reflect state priorities (e.g., language concordance). • Fund the Agency for Healthcare Research and Quality to conduct primary care research that recognizes variations in state-specific needs and policy. • Align primary care data definitions and measures across payers and markets (Uniform Data System, Healthcare Effectiveness Data and Information Set, etc.).
Accountability	• Support state efforts to monitor and address disparities within Medicaid and between Medicaid and other insured populations. • Establish common methodology for measuring network adequacy for primary care. • Enforce Early and Periodic Screening, Diagnostic and Treatment provisions.

Appendix A: California Efforts to Boost Primary Care

- **Blue Shield of California** adopted a primary care pay-for-value hybrid payment model in 2021, beginning with its preferred provider organization (PPO) products. The hybrid model includes four components: (1) population-based payment (per-member per-month, or PMPM) for primary care services; (2) population-based payment (PMPM) for "value services and performance outcomes;" (3) fee-for-service (FFS) payments for services not included in the PMPM rate; and (4) performance incentives for quality, utilization, and patient experience.
- Focus on primary care and preventive services is a theme in the 2022 Comprehensive Quality Strategy released by the **California Department of Health Care Services (DHCS)**, which manages Medi-Cal (California's Medicaid program). Additionally, DHCS is planning to launch an alternative payment methodology for Federally Qualified Health Centers (FQHCs). If approved by the Centers for Medicare & Medicaid Services, FQHC payment modernization would provide FQHCs with prospective payment and greater flexibility to provide whole-person primary care services, including alternative workforce models, home visits, and virtual care.
- The **California Quality Collaborative (CQC)**, a program of the Purchaser Business Group on Health (PBGH), and the Integrated Healthcare Association (IHA) have been working with system partners since 2019 to develop shared standards of advanced primary care, including common definitions of primary care practice attributes, a performance measure set, practice attribution methodology, and a value-based hybrid payment model.
- In 2022, **Covered California** and the **California Public Employees' Retirement System (CalPERS)** are requiring contracting health plans to participate in a pilot project conducted by CQC and IHA to measure advanced primary care based on the standard measure set. The results of the pilot will inform future contractual requirements related to primary care.
- **Covered California**'s 2022 contract with participating health plans includes a requirement to measure and report on primary care payment (see Attachment 7, Article 7.04). Contracting plans must report on primary care clinicians and spend using the Health Care Payment Learning & Action Network alternative payment model categories.
- Medi-Cal's CalAIM is a multiyear initiative to move to a whole-person, population-health approach to care delivery. It includes key roles for primary care to help identify and address patients' needs, including physical, behavioral, and social needs, and connect them to appropriate services.
- **PBGH**, whose members include Covered California (California's marketplace) and CalPERS, created the Health Value Index, a set of key performance indicators that reflects the priorities of its large-employer and public-purchaser members in communicating with contracted health plans. The focused measure set includes primary care spending as a percentage of the total cost of care, with the goal of ensuring adequate investment in primary care to meet patient needs. Details are available in the September 2021 Summary Findings.
- **PBGH** has incorporated the shared attributes and measure set into its *Employer Health Plan Common Purchasing Agreement for Advanced Primary Care*, outlining eight principles that purchasers can incorporate into their contracts with health plans.

Appendix B: Primary Care Investment Coordinating Group (PICG)

Members

- **Palav Babaria, MD,** *Chief Quality Officer and Deputy Director of Quality and Population Health Management,* California Department of Health Care Services
- **Rachel Block,** *Program Officer,* Milbank Memorial Fund
- **Alice Hm. Chen, MD, MPH,** *Chief Medical Officer,* Covered California
- **Crystal Eubanks, MS,** *Senior Director, Care Redesign and the California Quality Collaborative,* Purchaser Business Group on Health
- **Julia Logan, MD,** *Chief Medical Officer,* California Public Employees' Retirement System
- **Elizabeth Mitchell,** *President & CEO*, Purchaser Business Group on Health
- **Vishaal Pegany, MPH, MPP,** *Assistant Secretary*, California Health and Human Services Agency*
- **Kathryn Phillips, MPH,** *Senior Program Officer*, California Health Care Foundation
- **Lisa Dulsky Watkins, MD**, *Director, Multipayer Primary Care Network*, Milbank Memorial Fund
- **Anthony Wright,** *Executive Director*, Health Access
- **Dolores Yanagihara, MPH,** *Vice President, Strategic Initiatives*, Integrated Healthcare Association

Staff

- **Jill Yegian, PhD,** Yegian Health Insights, *Project Director*
- **Lance Lang, MD,** *Clinical Advisor*

*While CHHSA is represented on the PICG as an active participant and the recommended actions align with the Agency's vision for strengthening primary care in California's health care system, the recommendations of the PICG have not been approved or endorsed by the California Health and Human Services Agency.

PICG Guiding Principles

1. Access to high-quality primary care is critical for improving population health outcomes, reducing disparities, and slowing health care cost growth.

2. Primary care is under resourced and requires increased investment.

3. Payment for primary care should be sufficient to support the adoption and maintenance of advanced primary care attributes, including the ability to assess and address patients' behavioral health and social needs.

4. Payment for primary care should shift from volume (fee-for-service) to value (prospective, outcome-based, population-based).

5. Multi-payer alignment on primary care investment, measurement, and payment are essential to strengthening primary care.

PICG Recommended Actions

1. **Measure and Report PC Spending**: All payers should participate in measurement and public reporting on the percentage of total medical expenditures spent on primary care. Measurement of primary care spending, including non-claims spending, should be standardized to the extent feasible.

2. **Set a Target**: A floor and/or target for primary care spending as a percent of total medical care expenditures should be set to stimulate adequate investment in primary care services by all payers and plans.

3. **Pay for Advanced Primary Care**: All payers should adopt payment models that support advanced primary care. Based on evidence of impact and aligning with the NASEM recommendation, priority should be given to models that include three components: payment for direct patient care using a mix of risk-adjusted capitation and fee-for service, population-based payment to support population health management, and performance-based payment based on common measures.

4. **Establish Purchaser Requirements**: All purchasers should evaluate benefit design and provider networks, and incorporate contractual requirements such as primary care provider assignment, with the goal of creating and communicating a primary care-centric delivery system.

5. **Track Progress**: The impact of increased primary care spending should be measured. California stakeholders should regularly compile and disseminate an implementation scorecard to track progress and report on impact.