NOVEMBER 2021

Supporting the Future of Primary Care in California Through Aligned Hybrid Payment Models

A Call to Action

Edith Coakley Stowe, Director
Manatt Health

Megan Ingraham, Director
Manatt Health

Sol Lee, Consultant
Manatt Health

Acknowledgements

Blue Shield of California and Manatt Health thank the health systems, managed care plans, associations and other groups that shared perspectives and reviewed this paper and for their and others' advocacy on this important issue.

About Manatt Health

Manatt Health integrates legal and consulting services to better meet the complex needs of clients across the health care system.

Combining legal excellence, firsthand experience in shaping public policy, sophisticated strategy insight and deep analytic capabilities, we provide uniquely valuable professional services to the full range of health industry players.

Our diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, LLP, and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions and lead health care into the future. For more information, visit https://www.manatt.com/Health or contact:

Edith Coakley Stowe
Director
Manatt Health
202.585.6653
estowe@manatt.com

Megan Ingraham
Director
Manatt Health
415.291.7406
mingraham@manatt.com

Sol Lee
Consultant
Manatt Health
415.291.7438
slee@manatt.com

Table of Contents

Introduction

The vision of primary care as the foundation for all health care is one shared by many who work in and around the U.S. health care system. Patients, policymakers, providers, payers and purchasers generally agree that primary care promotes better health for populations through care that is built on trusted relationships. The National Academies of Sciences, Engineering, and Medicine (NASEM) wrote this year in a major report on primary care that investment in primary care has the power to improve health equity more than investment in any other part of our health care system, as well as to lower total system costs in the long term.[1]

Executive Summary

- Strong primary care is best supported by payment models that make a clear, upfront investment in population health, such as hybrid models.
- Alignment of the approach across multiple payers and purchasers serving the same communities is essential to support better outcomes for all patients.
- Barriers to alignment on hybrid payment models include operational complexity, cost, concerns about anti-competitiveness and a lack of national momentum.
- California can make tangible progress by doubling down on existing alignment efforts, working toward supportive state legislation and standing up tests of the hybrid model that can be scaled over time.

In the past two years, the COVID-19 pandemic has made the gap between vision and reality all too clear. In the spring of 2020, the California Health Care Foundation reported that one-third of California primary care practices felt in danger of permanent closure because of the financial consequences of the pandemic.[2] The COVID-19 experience has brought new calls on the national stage for more aggressive movement on payment reform to support and sustain primary care.[3]

In California, the long-standing existence of capitated payment models can make discussions of payment reform more complex than in other parts of the country. Even experienced policymakers can incorrectly assume that there is less work to do to move toward payment for value in California compared with elsewhere. Yet on the ground, primary care practices in California are still likely to be paid on volume incentives or paid capitated fees by some payers while being paid purely fee-for-service by others. Frequently shifting payment and quality programs can breed skepticism among providers and patient groups about long-term reform.

This paper makes the case for widespread adoption of "hybrid" payment models as an immediate action to support primary care's future in California, and it calls on California payers and purchasers to work together on implementation through strong coalitions that have already been established by the Purchaser Business Group on Health's California Quality Collaborative (CQC), the Integrated Healthcare Association (IHA), and others. The paper was funded by Blue Shield of California as a vehicle for collaboration among a cross-section of key primary care stakeholders in the state. As such, the paper was informed by a series of discussions during the summer of 2021 with a number of those stakeholders, including Acacia Family Medical Group, California Academy of Family Physicians, California Health Care Foundation, California Medical Association, California Primary Care Association, Covered California, the IHA, the PBGH, Scripps Coastal Medical Center, Sharp Community Medical Group and another leading in-state health plan.

Strong Primary Care Is Best Supported by Payment Models With Clear Upfront Investment in Population Health

In the decade following the passing of the Affordable Care Act (ACA), payers in every state, including California, launched new payment models aimed at improving population health, including accountable care organizations (ACOs) and incentives for primary care practices to take on advanced care delivery models known as "patient-centered medical homes."

More recently, a handful of payers and purchasers around the U.S. have taken the payment models a step further into hybrid designs for primary care that **decrease** the level of fees paid on a fee-for-service basis while **increasing** the level of population-based fees, performance-based incentives and overall investment. Under the hybrid model, the level of overall reimbursement that is rolled into the population-based fees can be increased over time, providing a bridge between fee-for-service and payment that is predominantly capitated at the practice level in a way that reflects value to patients.

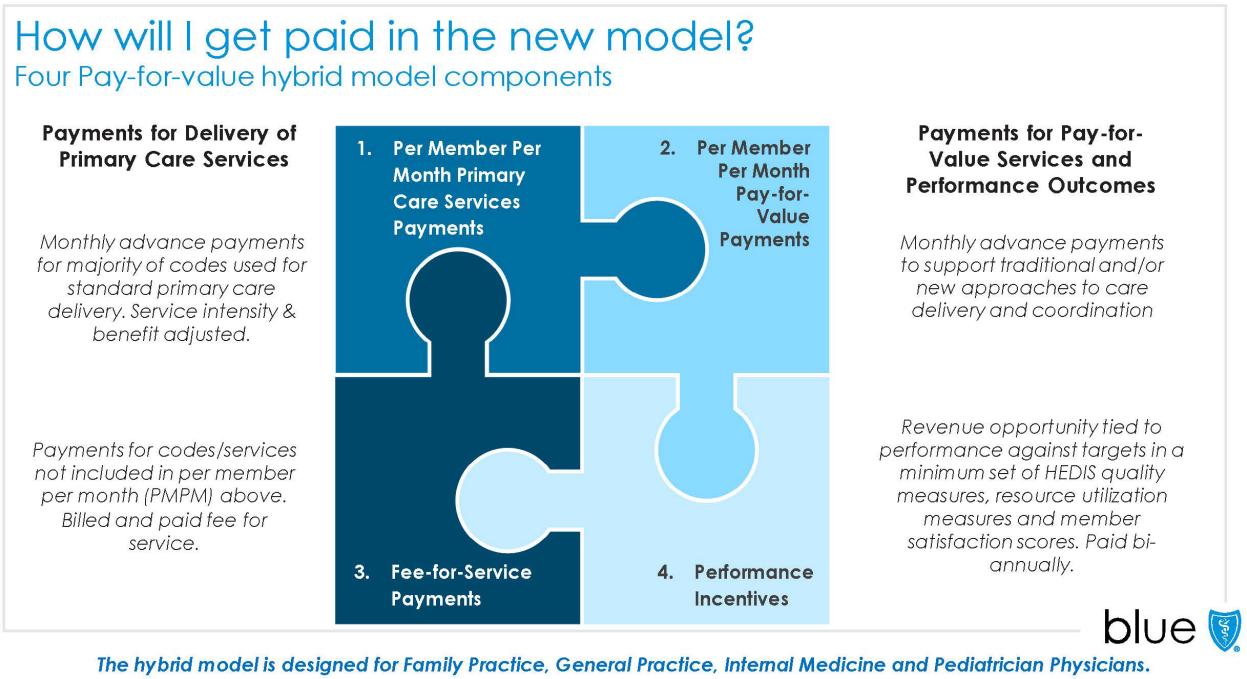
Well-designed hybrid models provide predictable revenue for practices that are tied to the populations they serve while allowing them the opportunity to increase overall revenue when they achieve positive health outcomes for those populations. With revenue largely decoupled from volume—with important exceptions such as immunizations and well-child visits—practices can organize their teams more rationally around patient needs. Hybrid models offer practices the latitude to invest in new services, new staff or improved infrastructure, among other transformative changes. For example, care teams can segment their populations to create different approaches for those with multiple chronic conditions or routine acute care. Practices can design their teams and workflows to serve the needs of their populations, emphasizing telehealth, integrated behavioral health or social determinants of health interventions as needed, and build teams of licensed and nonlicensed care providers to meet these needs. Achieving these goals is impossible under fee-for-service, where practices face limited flexibility and are forced to self-fund many of these nonbillable activities that are needed to best serve their patients.

There is new momentum around hybrid primary care models, hastened by COVID-19 and the report by NASEM earlier this year. NASEM's report—its first review of the sector since 1996—squarely and specifically recommended hybrid payment for primary care as the **default** payment methodology.[4] Meanwhile, a leading group of payers, purchasers and providers formed a national "resiliency collaborative" last year, making public commitments to the expansion of payment models that move further beyond fee-for-service than have been typically tried in recent years, including through hybrid primary care models that provide a meaningful pathway toward value.[5]

NASEM, 2021:

"Public and private payers should shift from a fee for service payment model to hybrid models (part FFS, part capitated, in which clinicians are rewarded for better outcomes and paid per patient, rather than per visit or procedure), making them the default payment method over time."

In California, Blue Shield of California unveiled its Primary Care Pay-for-Value Hybrid Payment Model earlier this year, having accelerated development and scale due to the impact of COVID-19 on independent practices. The model, which Blue Shield is rolling out in its fully insured preferred provider organization (PPO) line of business and will be expanding it to its other lines of business in future years, follows the NASEM recommendations by reimbursing through a mixture of traditional fee-for-service and per member per month (PMPM) payments. Under the model, the PMPM primary care service payments are based on expected service patterns and utilization for the average size of the practice population, and payments are adjusted monthly to account for expected utilization differences based on gender, age and health conditions. In addition to this predictable base, Blue Shield makes a "pay for value PMPM payment" for each attributed PPO member to further support a broad range of care coordination activities, such as proactive outreach to patients and families, coordination with specialists and labs, and medication reconciliation and review. A "performance incentive" element—paid biannually—allows practices to earn additional revenue based on population outcomes. Blue Shield is working closely with early-adopter practices to refine how the population-based fee is adjusted so that it accurately reflects the patient panel and practices can predict how the model will operate, and then plan their budgets accordingly. Small practices trying the new model report that the predictable cash flow built into the model allows them to return to practicing medicine the way they set out to at the outset of their careers. They also express optimism that the spread of this style of payment will even help U.S. medical students see primary care as a more viable career than they do today.



The hybrid model is designed for Family Practice, General Practice, Internal Medicine and Pediatrician Physicians.

The Value of Harnessing Alignment Across Multiple Payers

Under the vision of primary care as the foundation of all health care, primary care is a public good with greater value than the sum of its parts. Primary care providers offer the best care at the lowest cost to all when they can take a practice-wide approach to care that is as payer-agnostic as possible. Practices are also most likely to adopt and succeed in a value-based payment environment when a critical mass of their patient panels are included in value-based payment arrangements. Researchers at Harvard Medical School conducted a "microsimulation" of primary care practices under different payment arrangements and found that capitated payments allowed practices both to profit financially and shift their working practices to non-visit forms of care, but only once a "tipping point" of 63% of annual capitated payments paid was reached.[6,7] Without sufficient alignment across payers in California, many practices will remain reliant on fee-for-service and be unable to benefit from the flexibility afforded by hybrid models' prospective population-based payments. To progress toward more hybrid models that work for California primary care practices, payers and purchasers can and should work on the following priorities:

1. Aligned Measures

The CQC's five 'Attributes of Advanced Primary Care':

1. Person- and Family-Centered
2. High Value
3. Team-Based and Collaborative
4. Accessible
5. Coordinated and Integrated

A core goal of quality measurement and reporting is to focus providers on improving key outcomes. On the ground, however, a typical primary care practice can be held accountable to dozens of different performance measures. While measure choices by payers are often grounded in the needs of subpopulations (for example, children or elderly patients), practices can experience this as an unmanageable set of standards that cannot be tracked or comprehensively understood by the care team. Breaking this impasse takes leadership from leading payers and purchasers acting as a group. Fortunately, significant progress has already been made in California. The CQC has been working since 2019 to create a unified measure set for supporting high-quality, high-value "advanced" primary care, employing a multistakeholder process that included purchasers, health plans, providers and patients. The resulting set of twelve measures, which itself was based on pre-existing state and national measures, is able to be implemented across populations and payer types and can be clearly cross-walked to a set of agreed-upon Attributes of Advanced Primary Care.[8] Wide adoption of this measure set in California, whether or not as part of hybrid models, will help practices maintain focus and decrease low-value administration of multiple measure sets. Covered California and CalPERS are leading the way by piloting the measure set with their contracted health plans in 2022.[9]

2. Aligned Data Sharing Approaches

Strong primary care practices use multiple data sources to guide care. While much of that data resides in the practice's own electronic health records, data about the care patients received outside of the four walls of the practice can be equally or more important. It must be transmitted to the care team through payers' claims data, through health information exchanges with other providers or a combination of the two. Newer payment models, such as the hybrid primary care approach, require integration of data from multiple sources to accomplish risk adjustment of the population-based payments that better reflects clinical reality. Payers and purchasers in a region can work together in a number of ways to help practices understand their patient panels in as payer-agnostic a fashion as possible. In many regions, payers and purchasers have established long-term, joint investment in a neutral third party to aggregate and report information to a network of practices. Even if such a structure does not exist, payers and purchasers can make joint decisions on file formats and periodicity of reporting to ease the burden on practices.

In this area, too, California already has strengths on which to build. The IHA's "Align. Measure. Perform." (AMP) program has long aggregated results across plans when measuring provider organization performance for incentive payments and public reporting. Fourteen health plans and more than 200 provider organizations participate in AMP, covering more than 13 million Californians.[10] AMP has included cost results along with quality for the past decade; although at this time, AMP aggregates information at the level of larger health organizations, not at the level of each primary care practice. More recently, California passed legislation to enable a new approach to data sharing called the Health Care Payments Data (HPD) Program, for which the IHA will provide the infrastructure in partnership with OnPoint Health Data. The HPD Program is scheduled to go live in 2023 and will be an all-payer claims database with multiple use cases, including making information on health care spending more publicly available.[11] HPD Program implementation promises to support the accelerated rollout of the hybrid primary care payment model by collecting and organizing information about the impact of alternative payment models (APMs) across payers and purchasers.[12]

3. Aligned Hybrid Payment Structure for Primary Care

When practices are paid multiple ways under multiple contracts, operating a business becomes unnecessarily complicated. The behaviors that the payment models are designed to incent can even be in direct conflict with one another. It takes multiple payers willing to invest and pay upfront population-based fees in a similar fashion to be able to create and sustain services such as dedicated care managers, pharmacists for medication reconciliation, telehealth, remote monitoring and integrated behavioral health. Actions by one payer are not enough. States and regions around the country have evolved governance structures to make sure there is momentum across payers for value-based payment. For example, earlier this year, the Oregon Health Leadership Council adopted the "Oregon Value-based Payment Compact," a voluntary commitment by a diverse set of payers and providers to adopt and scale value-based payments, including for primary care practices.[13]

Again, California already has strong existing work to build on and extend. In 2022, the CQC will pilot the use of its aligned measure set across multiple payers and purchasers, and the PBGH has been engaging purchasers on principles for reforming payment for advanced primary care, including through a new "Common Purchaser Agreement."[14] Aligned with these principles, the IHA has been facilitating discussions for nearly a year to explore the development of a standard hybrid primary care payment

model to be available for voluntary adoption by its providers with health plans. Finally, and significantly, California has also been a selected testing ground for the federally led Primary Care First payment model since the beginning of 2021. Under Primary Care First, traditional Medicare pays participating practices under a hybrid model, consisting of a population-based fee plus a performance-based element, with supplementary fee-for-service payments. So far, participation is on a modest scale, with Humana and the AIDS Healthcare Foundation participating with traditional Medicare. Blue Shield will join the initiative in 2022. Over time, the model could provide additional momentum for alignment with the hybrid approach.

Barriers to Scale and Spread of Value-Based Primary Care Payments in California

Following NASEM's recommendations, all payers and purchasers in California should swiftly move to a hybrid model for primary care payment. However, at least three major barriers exist that must be overcome.

Barrier 1: Operations and Cost

Operationally, payment systems are set up either for fee-for-service payments or for global capitation payments. Value-based payment models, including the hybrid primary care approach, require different operational processes, including continuous adjustment of payments using data flowing back and forth with practices. Constant communication with providers by a dedicated team is essential to refine the model over time. Even within health plans, new levels of coordination across lines of business are required in order to create an enterprise approach to the new payment models. Additionally, intersections with other existing APMs, such as ACOs, can further complicate the work. Payers and purchasers should not expect the cost of the hybrid approach—either the total reimbursement to practices or the associated operational costs—to be lower than the status quo in the short term. Rather, the incremental added cost and effort should be understood as an investment in better care for better outcomes as well as a more rewarding role for primary care teams. This way of thinking about cost requires leadership within and across organizations to take a longer-term view of value.

Barrier 2: Competition Concerns

U.S. health care is competitive for both payers and providers, both of which understand that they must not discuss prices with one another. A culture of concern about anticompetitive activities can spill over into a reticence to discuss payment models even in a general way. Even within work on value-based payment models, the search for differentiators by product or carrier can often lead to additional churn rather than value for patients.[15] Fortunately, California has a strong foundation of competitors working together to address industry pain points through the CQC, the IHA and others in a spirit of "co-opetition."[16] Through the detailed work that has already been done on quality and model attributes, these "tables" have already developed a culture of information sharing that builds value across competitors without crossing into pricing or other legally sensitive subject matter. Making a joint commitment to the implementation of hybrid models for primary care would work within those same established parameters to produce value

across populations. As multiple payers roll out similar models, a shared, unrelentingly practical focus on how to improve the models over time will add up to progress for the broader population in California.

Barrier 3: Not Enough National Momentum

While the federal government has often led the way in implementing major tests of payment change for primary care since the ACA, the status quo has not moved significantly: The vast majority of U.S. primary care practices are still being paid purely fee-for-service for their patients covered by traditional Medicare. Barriers to wholesale payment reform of the Medicare program include its system of relative value units to value services as well as outdated operational infrastructure for making payments outside the traditional fee-for-service pathway. For state Medicaid programs around the country, the progress has been slower still, with less than 25% of all Medicaid payments tied to APMs that move beyond pay for performance,[17] despite federal guidance that encourages states to accelerate the adoption of new payment models, including for primary care.

States cannot wait for a national impetus to act, although federal activities will undoubtedly accelerate change in states and localities. There are promising signs in the California state legislature. Proposals were recently considered—and are expected to be taken up again next year—to establish a new statewide framework for measuring and pushing up total health care spend on primary care and behavioral health through a new Office of Affordability, following a strategy pursued in recent years by other states, including Rhode Island, Delaware, Colorado and Oregon. Blue Shield is supportive of such measures. Other legislative proposals could advance the implementation of hybrid models, such as S.B. 402, sponsored by the California Academy of Family Physicians, which would establish a state-run "Multipayer Payment Reform Collaborative" to pilot hybrid payment for certain primary care practices. Meanwhile, as a purchaser, California has begun to take a more proactive role in payment reform. Covered California recently updated its requirements so that it specifically measures and incents the deployment of primary care payment models that include a significant population-based element,[18] and its health plans must pilot the CQC's Advanced Primary Care Measure Set. In Medi-Cal, the CalAIM[19] reforms that will go live in 2022 will help bolster primary care revenue and capacity building by allowing providers to take on new roles as providers of longitudinal care management (known as "enhanced care management" or ECM), and Medi-Cal plans can combine a hybrid primary care approach with ECM payment. California can make progress even as federal solutions are still awaited.

A Call to Action

California has the right elements in place to rapidly expand hybrid payment for primary care in the next few years. To make meaningful progress, the health care sector must work together in the following areas:

Call to Action		
1. Payers and Purchasers: Double Down on Alignment at Existing 'Tables.'	**2. State Government: Make a Commitment to Primary Care Payment Reform.**	**3. Payers, Purchasers, Providers and Patient Groups: Launch Pilots, Refine and Scale.**
• Through existing modes of collaboration and building on significant work already done, payers and purchasers should accelerate work on payment for advanced primary care, focusing on hybrid models that combine stable population-based payments, performance incentives and reduced fee-for-service payments. • Following this year's NASEM recommendations, these groups can and should set explicit targets for how such models will become the default mode of payment, with a focus on common measure sets and effective data exchange.	• California should continue to use its levers as a purchaser through Covered California, CalPERS and Medi-Cal to promote value-based payments for primary care in general and, where possible, the hybrid model specifically. • California can help the market make progress through legislation. The state should adopt the recent proposals for an Office of Affordability that would monitor and set benchmarks for the proportion of total spending to be directed to primary and behavioral health care.	• Payers and purchasers should proceed with testing models that implement the CQC's common quality metrics. • Blue Shield and other payers and purchasers should test the hybrid model, starting on a small scale with committed early-adopter practices. • Primary Care First is a promising medium for testing the hybrid model alongside traditional Medicare. More payers may consider joining the test over time.

[1] "Implementing High-Quality Primary Care," NASEM, 2021. Available at https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care.

[2] "COVID-19 Tracking Poll: One-Third of California Primary Care Doctors Worry Their Practices Won't Survive," California Health Care Foundation, May 2020. Available at https://www.chcf.org/blog/covid-19-tracking-poll-one-third-california-primary-care-doctors-worry-their-practices-wont-survive/.

[3] "The LAN Healthcare Resiliency Collaborative," Health Care Payment Learning & Action Network (HCP-LAN). Available at https://hcp-lan.org/resiliency-collaborative/framework/. Accessed Aug. 2021.

[4] "High-Quality Primary Care Should Be Available to Every Individual in the U.S., Says New Report; Payment Reform, Telehealth Expansion, State and Federal Policy Changes Recommended," NASEM, May 2021. Available at https://www.nationalacademies.org/news/2021/05/high-quality-primary-care-should-be-available-to-every-individual-in-the-u-s-says-new-report-payment-reform-telehealth-expansion-state-and-federal-policy-changes-recommended.

[5] "The LAN Healthcare Resiliency Collaborative," HCP-LAN. Available at https://hcp-lan.org/resiliency-collaborative/framework/. Accessed Aug. 2021.

[6] "High Levels Of Capitation Payments Needed To Shift Primary Care Toward Proactive Team And Nonvisit Care," Health Affairs, Sept. 2017. Available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0367.

[7] This principle has attracted enough attention that the incoming Centers for Medicare & Medicaid Services administrator placed the issue of multipayer alignment prominently in a recent statement of priorities for payment reform in the Biden administration:

"Innovation At The Centers For Medicare And Medicaid Services: A Vision For The Next 10 Years," Health Affairs, Aug. 2021. Available at https://www.healthaffairs.org/do/10.1377/hblog20210812.211558/full/.

[8] "Advanced Primary Care Measure Set: Alignment with Attributes," PBGH and CQC, Jun. 2021. Available at https://www.pbgh.org/wp-content/uploads/2021/06/CQC-Standards-SlidesFINAL.pdf.

[9] "Covered California, CalPERS and Purchaser Business Group on Health to Launch Sweeping Quality Improvement Project to Modernize Primary Care for Californians," PBGH, Sept. 2021. Available at https://www.pbgh.org/covered-california-calpers-and-purchaser-business-group-on-health-to-launch-sweeping-quality-improvement-project-to-modernize-primary-care-for-californians/.

[10] "Align. Measure. Perform.," IHA. Available at https://iha.org/performance-measurement/amp-program/. Accessed Sept. 2021.

[11] "HPD Program Advisory Committee," California Department of Health Care Access and Information (HCAI). Available at https://hcai.ca.gov/data-and-reports/cost-transparency/hpd-program-advisory-committee/. Accessed Sept. 2021.

[12] "Health Care Payments Data," HCAI. Available at https://hcai.ca.gov/data-and-reports/cost-transparency/healthcare-payments/. Accessed Sept. 2021.

[13] "Oregon Value-based Payment Compact," Oregon Health Leadership Council. Available at http://orhealthleadershipcouncil.org/oregon-value-based-payment-compact/. Accessed Sept. 2021.

[14] "Employer Health Plan Common Purchasing Agreement for Advanced Primary Care," PBGH, Oct. 2021. Available at https://www.pbgh.org/wp-content/uploads/2021/10/PBGH-Common-Purchaser-Agreement.pdf.

[15] Dr. Alice Chen, Covered California, remarks as part of "Implementing High-Quality Primary Care in California: A Policy Roundtable," Mathematica Policy Research, Sept. 2021. Available at https://www.mathematica.org/events/implementing-high-quality-primary-care-in-california-a-policy-roundtable.

[16] "The Rules of Co-opetition," Harvard Business Review, Feb. 2021. Available at https://hbr.org/2021/01/the-rules-of-co-opetition.

[17] "APM Measurement Effort," 2019, HCP-LAN. Available at https://hcp-lan.org/workproducts/apm-infographic-2019.pdf.

[18] "Draft Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy," Covered California, Feb. 2021. Available at https://hbex.coveredca.com/stakeholders/plan-management/library/Attachment-7-2022-Draft-Jan-2021_Clean.pdf.

[19] "California Advancing and Innovating Medi-Cal," California Department of Health Care Services. Available at https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx. Accessed Aug. 2021.