



December 2023

Measuring Advanced Primary Care in California

Pilot Results and the Path Forward

Introduction: Why Focus on Primary Care?

The United States health care system ranked last in quality, efficiency and outcomes among 11 peer countries in a 2021 research study, despite spending the highest percentage of its gross domestic product on health care¹. Top performing countries consistently invested into primary care and focused on reducing administrative burden for providers. Primary care is the only element of health care where an increased supply is associated with better population health and more equitable outcomes². In the United States, adults who regularly see a primary care physician have 33% lower health care costs and 19% lower odds of dying prematurely than those who see only a specialist³.

Despite these statistics, the power of primary care is hampered by chronic underfunding in the U.S., taking in approximately 4-7% of health care dollars on average. Furthermore, over 65% of California physicians are solo, small or medium-sized providers who feel this the most and tend to have less technology and minimal integration with other functions of care⁴.

In addition, California's health care system is a multi-layered web of health plans, provider organizations and other sources of coverage. This complexity distracts providers from focusing on patient care, as they must invest time and resources to navigate varying requirements, policies and reporting procedures. Primary care practices are particularly burdened by the lack of alignment, which contributes to less joy in work and burnout⁵. The result is a system where patients often experience subpar outcomes.

Getting a Complete View of Primary Care Quality is Challenging

Provider organizations in California vary significantly in size, infrastructure, the number of geographic locations where patients can get care and services offered. Variation in health outcomes across multiple sites or locations can be masked when the clinical performance is aggregated into a single score. Additionally, because provider organizations and practices contract with multiple payers, it is difficult to obtain a comprehensive view of performance across all their patients to understand areas that require improvement.

Until now, a view of health outcomes performance at the granular level of the primary care practice has not existed in California. The Purchaser Business Group on Health (PBGH)'s California Quality Collaborative (CQC) and the Integrated Healthcare Association (IHA) have partnered on a pilot project to do just this, with a focus on identifying where high-quality primary care or advanced primary care is occurring. Another goal of the pilot is revealing where poor primary care outcomes exist and improvement is needed.

What is Advanced Primary Care?

Advanced primary care delivers a better patient experience by ensuring: a care team is easily accessible, patient medical, behavioral, social and other health-adjacent needs are supported and that the high-quality care does not vary based on race, language, age or other variables.

PBGH, CQC and partner stakeholders developed a definition for advanced primary care through [attributes](#) and [measures](#), rooted in a desire to identify and learn from high-performing organizations to improve patient outcomes.

The Advanced Primary Care Measure Set is purposely small and outcomes-focused, contains adult and pediatric measures and avoids redundancy. Where possible, it aligns with existing large-scale measure sets to prevent increasing the reporting burden on providers and includes subdomains designed to emphasize key areas of measurement within primary care delivery. The measure set has been vetted, adjusted and supported by multiple industry groups, including IHA's Technical Measurement Committee and the [California Advanced Primary Care Initiative](#) payer participants, purchaser sponsors and a physician advisory group. The measure set will be revisited annually to ensure alignment with the most relevant measures, adaptability to the system's reporting capabilities and timely consideration of innovative measures that best represent advanced primary care in the evolving health care landscape.

¹ "Mirror Mirror 2021: Reflecting Poorly - Health Care in the US Compared to other High Income Countries", The Commonwealth Fund, <https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly#access>

² National Academies of Sciences, Engineering, and Medicine. 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>

³ "Primary care physicians and specialists as personal physicians. Health care expenditures and mortality experience", PubMed, 1998, <https://pubmed.ncbi.nlm.nih.gov/9722797/>

⁴ "California's Physician Landscape: A Rapidly Changing Market with Limited Data", California Healthcare Foundation (CHCF), *California's Physician Practice Landscape: A Rapidly Changing Market with Limited Data* (chcf.org)

⁵ "Evaluating Value Based Payment in Reducing Administrative Burden", American Academy of Family Physicians (AAFP), October, 2023

What is the Advanced Primary Care Measurement Pilot?

In collaboration with purchasers and health plans, CQC and IHA tested the effectiveness of the Advanced Primary Care Measure Set through a [pilot program conducted at the practice level](#) in California.

Leveraging IHA's comprehensive dataset was the logical first step, as it encompasses statewide claims and eligibility data for a substantial portion of health plans and provider organizations, covering both commercial and Medicare Advantage business lines, as well as some Medi-Cal participation.

The goals of the pilot include:

1. Enable analysis of the Advanced Primary Care measures using IHA's data and measurement process.
2. Test the use of existing data for a new purpose.
3. Gain information on the variation of practice-level performance on Advanced Primary Care in California to inform decision-making for purchasers, plans and system partners.

Goal One: Enable Analysis of the Advanced Primary Care Measure Set

The pilot enables the first comprehensive statewide assessment of clinical outcomes collected at the primary care practice level, combined to collectively indicate that advanced primary care is occurring.

Figure 1: Advanced Primary Care Measure Set

Advanced Primary Care Measure Set
Depression PROMs (phased approach: screening → monitoring → remission) (DSF-E)
Controlling High Blood Pressure* (CBP)
Comprehensive Diabetes Care: HbA1c Poor Control > 9.0%** (HBD)
Comprehensive Diabetes Care: HbA1c Control < 8.0%* (HBD)
Colorectal Cancer Screening* (COL)
Asthma Medication Ratio (AMR)
Childhood Immunization Status: Combination 10* (CIS)
Immunizations for Adolescents: Combination 2 (IMA)
Emergency Department Utilization (EDU)
Acute Hospital Utilization (AHU)
Total Cost of Care using standardized pricing (TCOC)
Patient Experience (CG-CAHPS)

*The National Committee for Quality Assurance (NCQA) and Covered California prioritized these measures to be reported stratified by race and ethnicity, based on wide variation in performance across demographic variables. Additionally, these measures are emphasized in Covered California's [Quality Transformation Initiative](#). CQC and IHA have designated these as equity sensitive measures.

**Both diabetes control measures have been included. Though Diabetes HbA1c Control < 8.0% is the focus of this measurement pilot and other current related work, the plan is to potentially shift to HbA1c Poor Control > 9.0% in future cycles to reflect aligned industry priorities.

Goal Two: Use Existing Data for a New Purpose

Traditionally, IHA's data has been used to report results at the provider organization, plan or geographic level, which are all larger units than primary care practices. As part of this measurement pilot, CQC and IHA formed a technical advisory

group, including experts in health plans, providers and methods. Their expertise guided the development and review of the innovative algorithm to assess health outcomes at the practice level, discussed below.

Figure 2: Practice-Level Algorithm

1. Identify all primary care claims using all services provided by: Family Practitioner, General Practitioner, Internal Medicine, Pediatrics, Nurse Practitioner, Physicians Assistant.
2. Attribute each member to a single provider.
 - Use PCP if available, if not, use NPI from past two years (use most recent NPI if tiebreaker is needed).
3. Map each provider to all relevant practices.
 - Map each rendering NPI to all billing NPIs for which they bill.
 - Map each rendering NPI to other billing NPIs using physical address.
 - Attribute each rendering NPI to a single billing NPI. (Use the "organization" associated in NPPES, otherwise attribute the rendering NPI to the "individual" billing NPI they use most frequently).
4. Select a single practice for each provider.
5. Explore thresholds for practice reporting.

Goal Three: Understand Variation for Decision-Making

A key pilot goal was to uncover what the measure set results at the practice level can tell us about overall advanced primary care performance and variation in California — identifying areas for resource allocation and improvement. Improvement areas identified by low measure score could relate to either data collection and quality, performance, or both.

Data Used

The Advanced Primary Care Measurement Pilot ran for measurement year 2022 using an IHA dataset comprised of claims, eligibility and limited supplemental clinical data from nearly all the

commercial health plans in California. Two years of data (2021 and 2022) were used for the practice identification and attribution algorithm and further lookback data was used as appropriate for measurement, as defined in the measure specifications.

Results

The Advanced Primary Care Measure Set performance results have been analyzed by some overarching summary views, as well as by individual measure variation.

Figure 3: Summary of Number of Practices Identified that have at Least One Attributed Member, by Practice Type and Average Attributed Membership

Practice Type*	Number of Practices	Average Membership
Total	10,982	681
Adult	7,646	426
Pediatrics	601	876
Mixed	2,735	1,362

* Practice type uses the following criteria:

- **Adult practice:**
>=80% of members are >=18 years old
- **Pediatric practice:**
>=80% of members are <18 years old
- **Mixed practice:** other practices with both adult and pediatric members that fall outside of the ranges above

Summary

A total of 13,055 practices were identified through the practice level algorithm. Of those, 10,982 practices had at least one member attributed and 7,556 practices had at least one reportable measure.

Over half of the practices identified were solo practitioners that did not seem to be affiliated with any other physicians. On average, these solo practitioners had less than 200 commercial

members. The average commercial membership across all practices for the plans in the IHA dataset was 681 members, ranging from one member to more than 300,000 members.

When comparing the physicians affiliated with the identified practices with provider rosters from health plans, over 75% of physicians were mapped to the same practice.

Figure 4: Performance Summary on Individual Measures

Measure	Number of Practices with Sufficient* Denominator	Average Rate	Range	National Commercial 25 th Percentile**	Number of Practices Meeting 25 th Percentile	National Commercial 66 th Percentile**	Number of Practices Meeting 66 th Percentile	National Commercial 90 th Percentile**	Number of Practices Meeting 90 th Percentile
AMR	102	82%	55–95%	81%	51	87%	25	91%	8
CBP	2,372	19%	0–87%	56%	106	67%	27	74%	10
CIS	221	10%	0–58%	45%	5	61%	0	70%	0
COL	4,089	44%	6–94%	52%	923	63%	199	67%	112
HBD1 (<8%)	1,661	39%	0–80%	55%	226	64%	58	69%	19
HBD2 (>9%)	1,661	55%	16–100%	34%	135	25%	23	20%	4
IMA	290	21%	0–76%	26%	104	35%	37	46%	10
AHU	2,468	18 PTMY	0–174 PTMY	26 PTMY	2,070	21 PTMY	1,720	18 PTMY	1,428
EDU	2,462	129 PTMY	19–817 PTMY	146 PTMY	1,769	121 PTMY	1,154	107 PTMY	809
TCOC (std costs)	3,442	\$367 PMPM	\$86–\$1571 PMPM						

*Minimum denominator size of 30 for clinical quality measures and 150 for utilization measures

**Benchmarks are based on the NCQA 2023 Commercial National All LOBs percentiles

Individual Results on Key Measures

All practice-level results from the Advanced Primary Care Measure Set are included in this issue brief. However, four clinical quality measures are highlighted here due to consistent stakeholder input on their high level of importance, equity sensitivity (they tend to exhibit greater variation when stratified by race, ethnicity and language) and their inclusion in Covered California and NCQA quality strategy priorities. Additionally, the two utilization measures and total cost of care measures are shown below. The rest of the Advanced Primary Care Measure Set individual distributions can be found in the Appendix.

Each graph shows the distribution of practice-level performance for those practices that meet a minimum denominator criterion of 30 for clinical quality measures and 150 for utilization and cost measures. Each vertical blue line represents one practice. The three horizontal bars on each graph represent the value of the national commercial all lines of business 25th (orange), 66th (gray) and 90th (yellow) percentiles for each measure.

The table accompanying each measure distribution shows the average rate, range, and number of practices that received a score meeting the 25th, 66th and 90th national commercial percentile benchmarks.

These thresholds were selected for their use in related advanced primary care work. The value-based payment model designed as part of the California Advanced Primary Care Initiative uses these thresholds as cutpoints for financial incentive payments for performance on the Advanced Primary Care Measure Set. In this payment model, improvement incentives can be earned by practices that score between the equivalent of the 25th to 66th national percentiles (based on the Health care Effectiveness Data and Information Set). A higher financial incentive payout can occur for practices attaining a score in the range of the equivalent of the 66th to 90th percentile or above. The California Advanced Primary Care Initiative health plans see the value in gaining a comprehensive view of practice performance on these measures across California to give context for the payment model.

These national percentile thresholds are also used in an Advanced Primary Care Recognition methodology developed to identify practices demonstrating advanced primary care. The methodology identifies two recognition tiers, one for practices meeting the 66th percentile and another for practices meeting the 90th percentile for all measures for which they have results.

Figure 5: Controlling High Blood Pressure

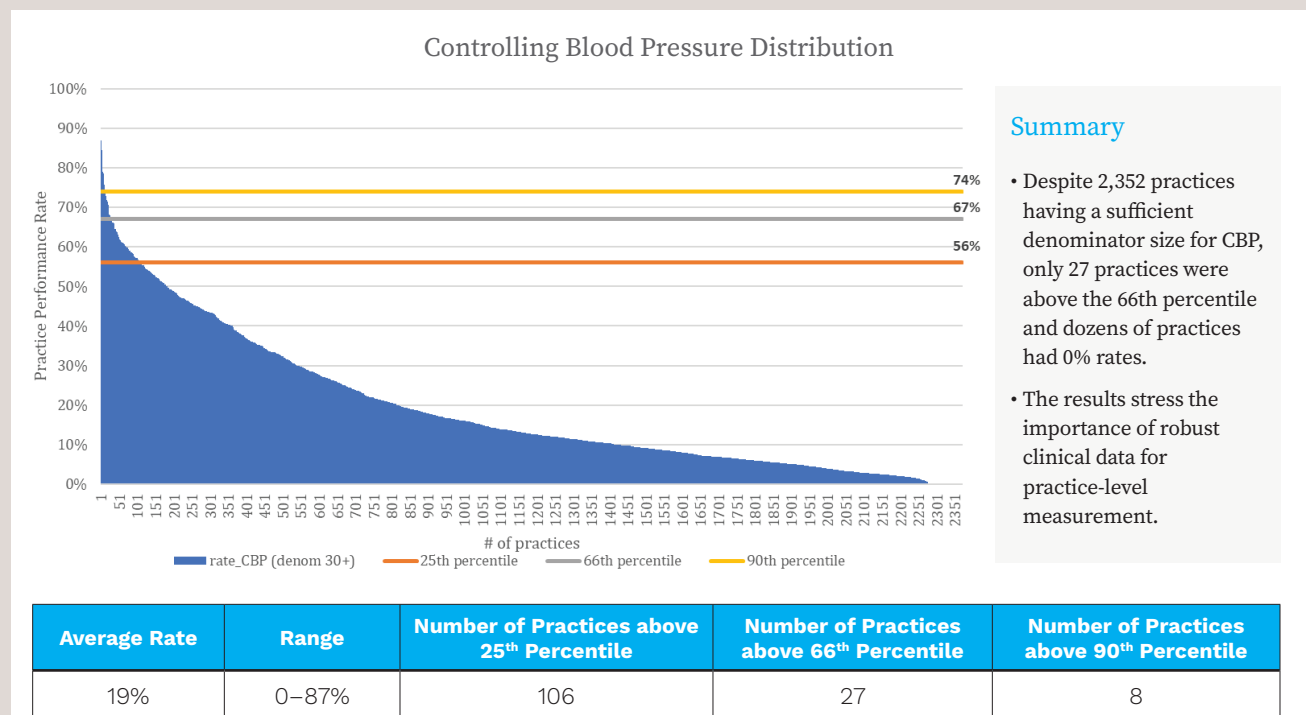


Figure 6: Comprehensive Diabetes Care: HbA1c Control <8.0%

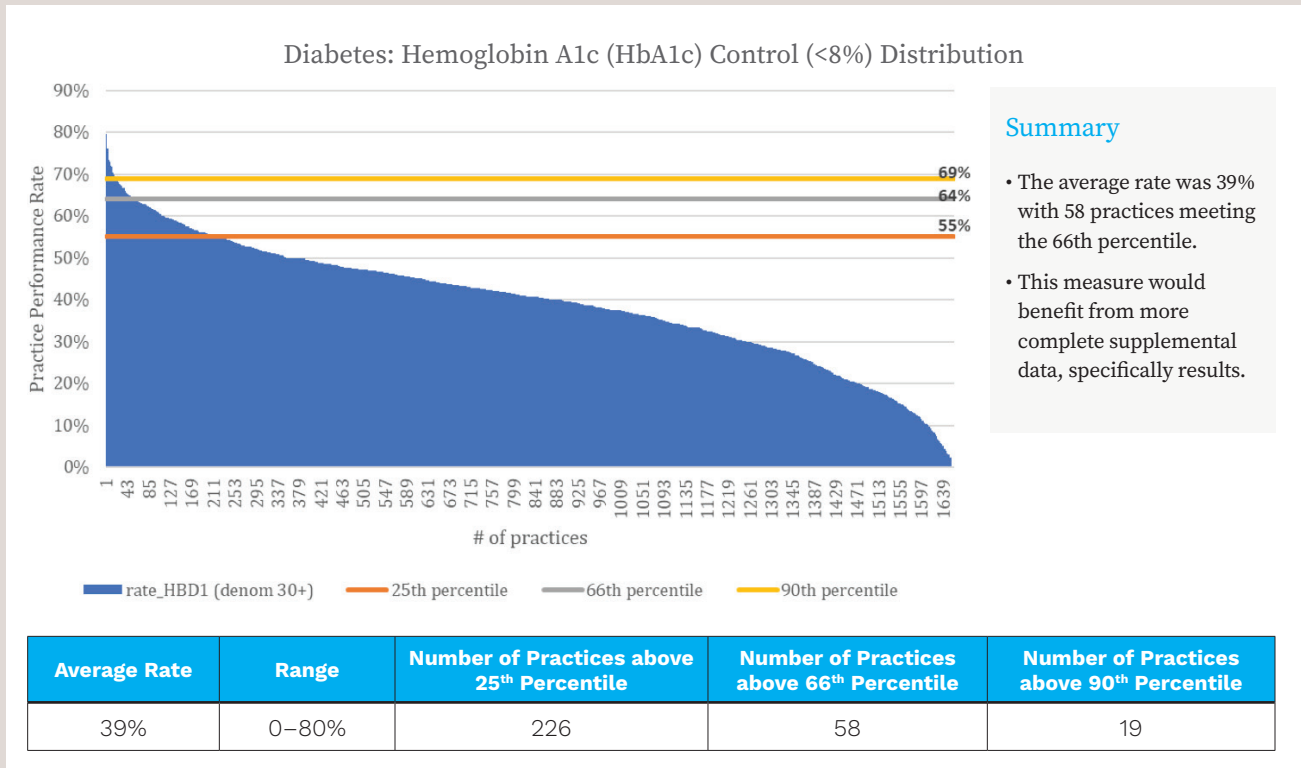


Figure 7: Colorectal Cancer Screening

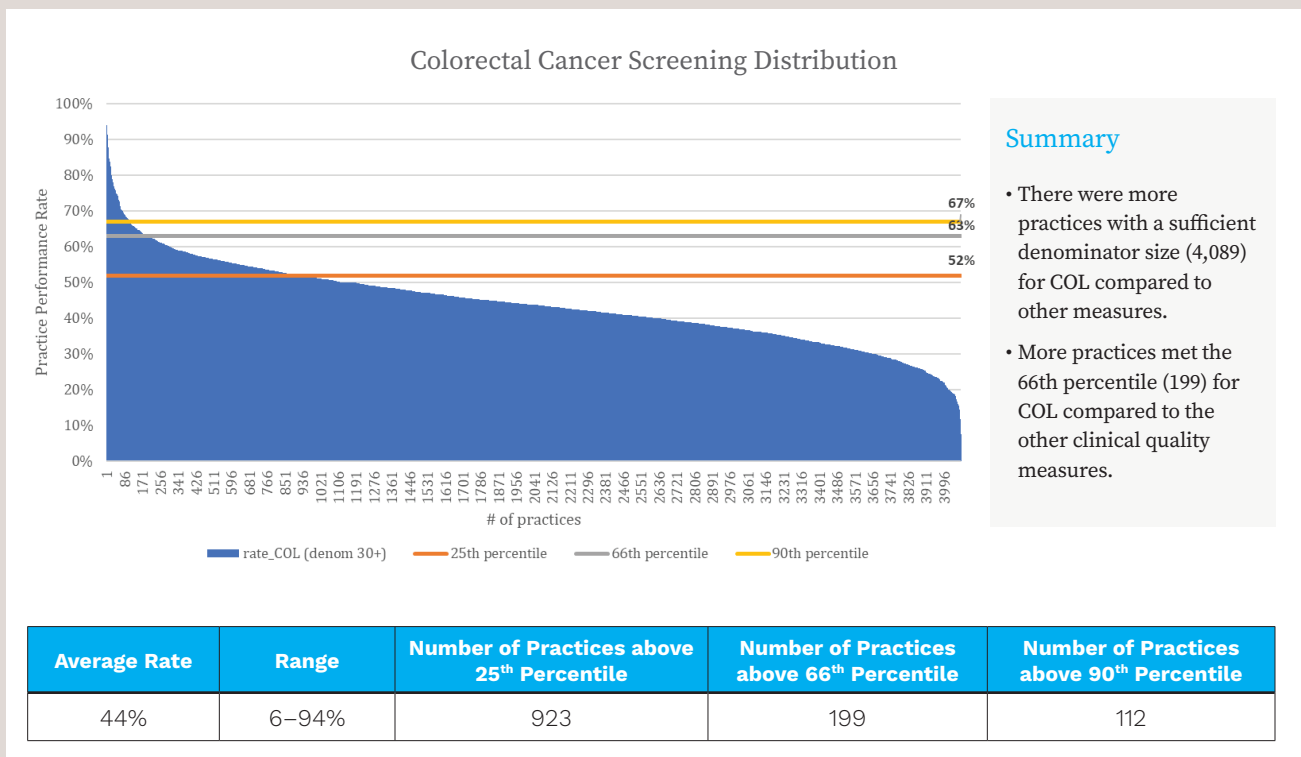


Figure 8: Childhood Immunization Status: Combination 10

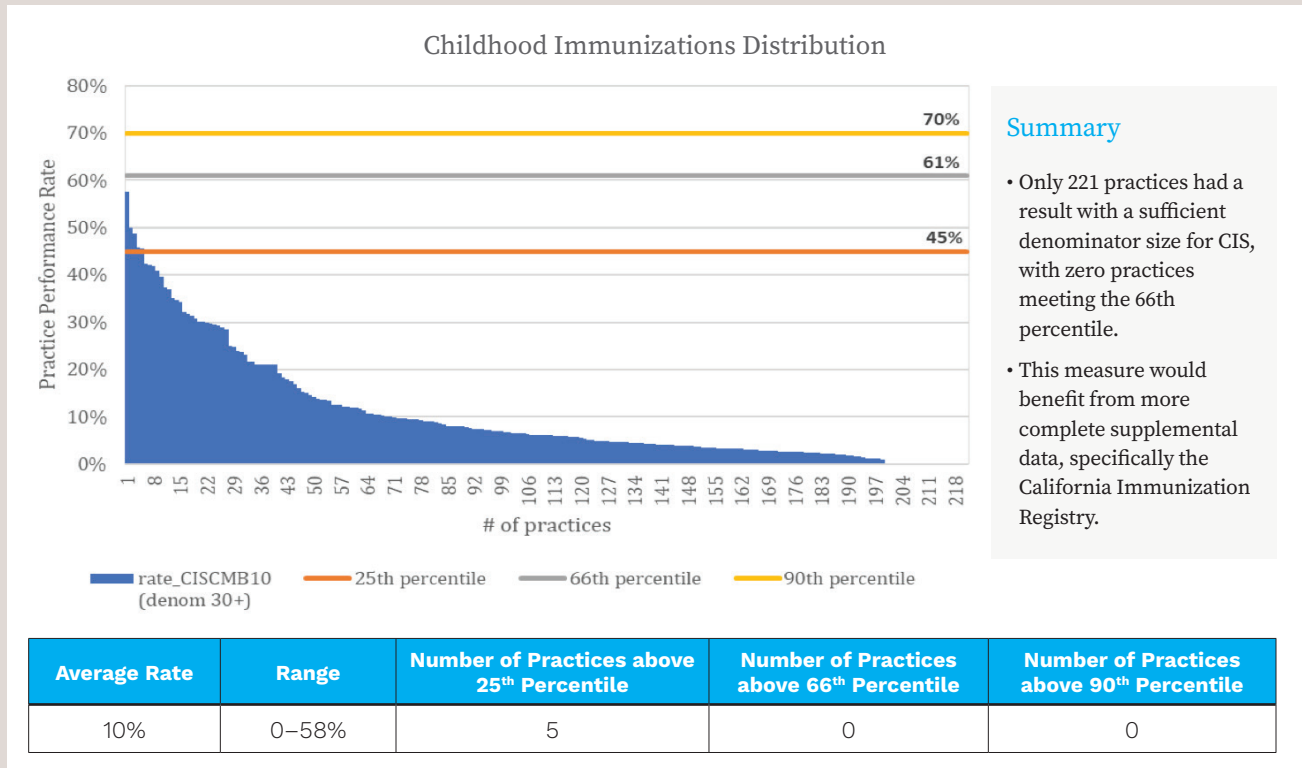


Figure 9: Risk Adjusted Acute Hospital Utilization

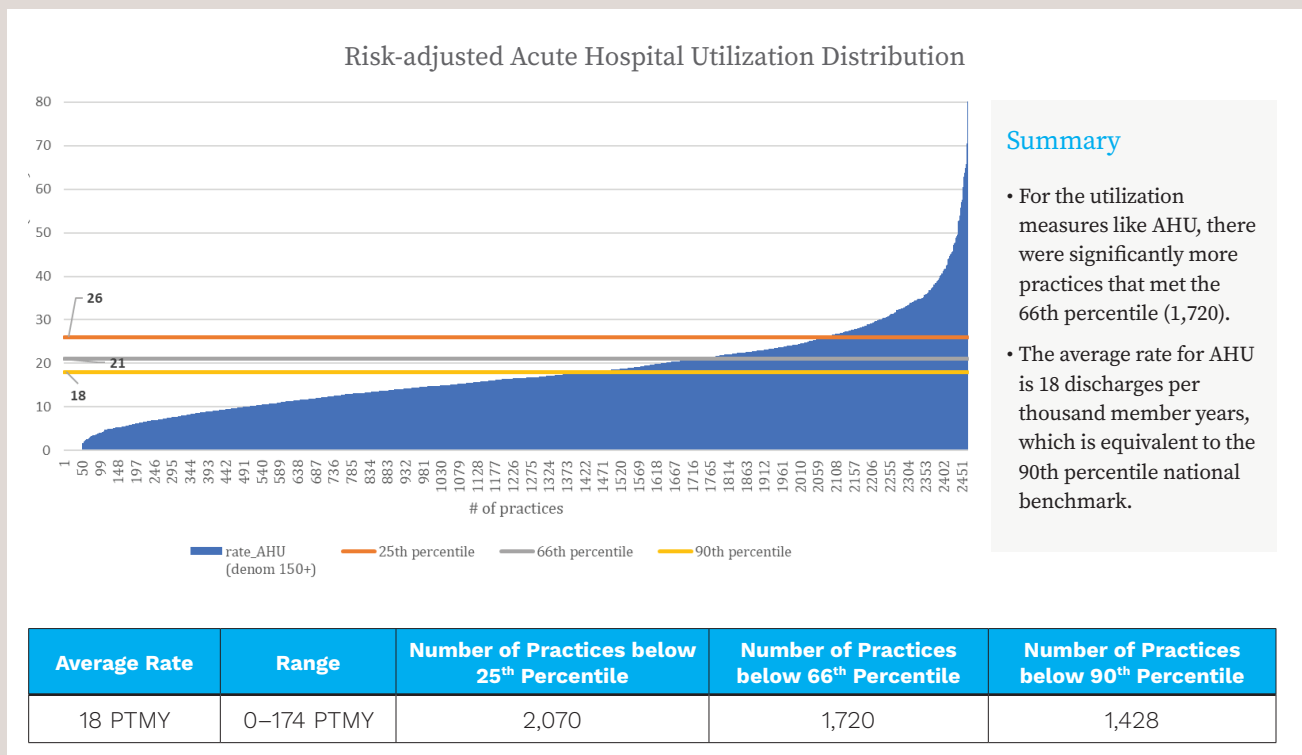


Figure 10: Risk Adjusted Emergency Department Utilization

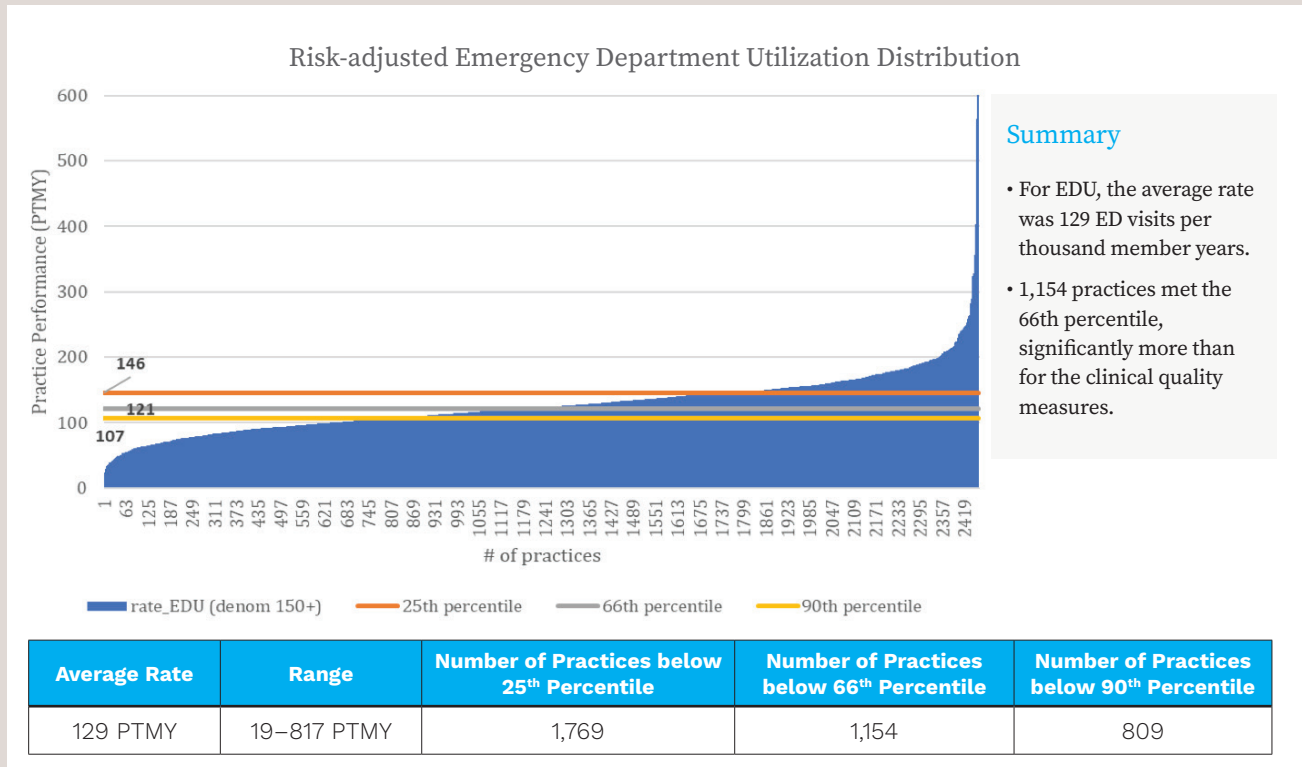
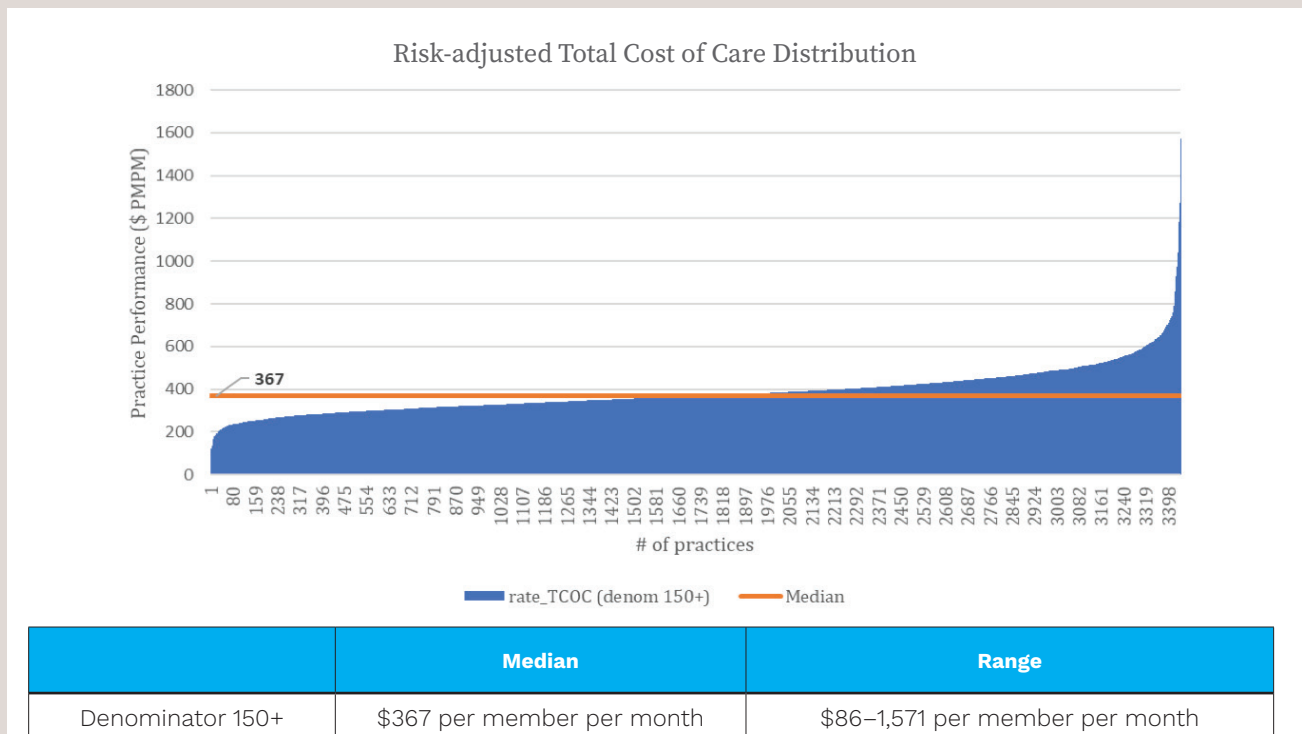


Figure 11: Risk Adjusted Total Cost of Care using Standardized Pricing

This total cost of care measure follows the methodology of the HealthPartners Total Resource Use measure, where a standard fee schedule is applied for each service across all practices. No national benchmarks are available; instead, the median rate and range across all California-based practices is shown. Mean rate was not used due to concern that it would be skewed by outliers.



Discussion

In this pilot, IHA's dataset was successfully used to identify over 10,000 primary care practices and generate results at the practice level on the Advanced Primary Care Measure Set. This process generated several learnings on both practice identification as well as measurement. Below we will delve into the following:

- Addressing low denominator size.
- Increasing data reporting and completeness.
- Re-assessing performance recognition.
- Missing results unable to be included for this cycle (patient experience and demographic data stratification).

Addressing Low Denominator Size

Some measures in the set, particularly the pediatric measures, had a small percentage of practices with a denominator size that met the industry standard of 30 patients for clinical quality measures and 150 patients for utilization and cost. There are different ways to address this low denominator size issue. First, the denominator size requirement could be reduced to allow more practices to meet the requirement. This approach would require finding the right balance of measurement reliability for a smaller denominator, with the number of practices that have a useable result. Below are other considerations.

Increase the Population Included for Measurement

One way to address the low denominator size issue is to increase the population included. The Advanced Primary Care Measurement Pilot was based on results using data from non-Kaiser Permanente commercial plans only. Many of the practices measured also likely care for Medicare and Medi-Cal members. Data from Medicare Advantage plans and Medi-Cal Managed Care plans could also be included in measurement to expand the population and increase denominator size. Because of the differences across commercial, Medicare and Medi-Cal populations, case-mix

adjustment should be considered when combining performance across these populations. Increasing the population size would also help support valid samples sizes in stratification of results across race, ethnicity, language, and other variables in future cycles, which is crucial to understanding and mitigating disparities in outcomes and care.

Adjust the Practice-Level Algorithm

Another way to address the low denominator size issue is to consider changes to the practice identification algorithm. The IHA dataset only included National Provider Identifier (NPI). Most plans in California indicated that they use Tax Identification Number (TIN) to contract with practices. A comparison of health plan practice rosters with the practices identified by the claims algorithm based on NPI used in the measurement pilot revealed that a single organization often has multiple NPIs and that combining these NPIs produces a larger unit that is closer to the TIN-identified practice.

Reconsider Restrictive Technical Specifications

The technical specifications on some of the measures greatly restricted the patient pool. For example, many of the people with asthma do not meet the eligible population criteria for the Asthma Medication Ratio (AMR) measure, which requires (1) at least four asthma medication dispensing events, (2) a utilization threshold that can be met several ways involving emergency department, inpatient, outpatient, medication or a combination, and (3) continuous enrollment for two years. When these criteria are applied, most practices do not have 30 attributed members who meet the criteria.

The population for AMR illuminates the importance of reevaluating regularly to ensure measures are assessing the population impacted and what is most important.

Increasing Data Reporting and Completeness

Below are suggestions to make quality measure reporting easier at the point of care, as well as ways to enhance data completeness for projects that build a comprehensive data view across a provider or practice, such as the Advanced Primary Care Measurement Pilot.

Build Infrastructure at the Point of Care for Reporting

Some measures do not have many data points because they are challenging to track and report without infrastructure to support them, such as the Depression Screening and Follow Up measure. There were zero patients in the Advanced Primary Care Measurement Pilot data who met numerator criteria for this measure, based on the available data. The national mean rates in the commercial population for this measure according to NCQA indicate that 2.1% of patients were given a screening and 69.1% of patients with a positive screen were referred for follow-up. These numbers indicate either incredibly low performance or data collection and reporting challenges exist nationally as well.

In addition, primary care providers are often the entry point and “catch all” for the health system. They do many things that they may not have time to report, especially if the reporting is cumbersome and is not reimbursed, as is often the case for depression screening. Having reporting infrastructure at the point of care is essential for efficiently meeting reporting requirements. The implementation grants available through the new California Data Exchange Framework could help build necessary infrastructure.

Gather Supplemental Data from Health Plans

IHA has built a process for regularly collecting supplemental data from health plans, such as lab tests and results, blood pressure readings, information from the California Immunization Registry and historical data for measure exclusions. Health plans vary in their ability to report this data and IHA is working with plans to strengthen their supplemental data submission for the next cycle of measurement.

Promote Current Procedural Terminology Category II (CPT II) Codes

Developed by the American Medical Association, Current Procedural Terminology Category II (CPT II) codes can be used by providers to report results from tests or procedures such as blood pressure control or diabetes HbA1c level. This eliminates the need for chart abstraction, minimizing the administrative burden on physicians and other health care professionals.

CPT II codes are billed in the procedure code field just as CPT I codes are reported. CPT II codes do not have a fee schedule associated with them and are not a substitute for CPT I, but a supplement. Payers and providers have an opportunity to increase awareness and promote adoption of these codes.

Utilize Common Reporting Platforms

A primary care practice may need to log into multiple platforms to report and view data and results for their different payer contracts, often creating cumbersome operational workflows that cause administrative burden and can limit use. This unnecessary complexity can pull providers away from valuable time with their patients, leading to a diminished sense of joy in practicing medicine. Payers can alleviate some of this burden by working together to streamline reporting through a common platform. When payers align and agree to common measures and a common reporting platform, it signals to practices they have a partner in the reporting process that cares about their needs. In addition, a common reporting platform may be able to access data from electronic health records which will reduce reporting burden while improving data completeness for reporting clinical quality measures.

Performance Recognition Reassessment

As noted above, CQC, IHA, the health plans participating in the California Advanced Primary Care Initiative and the sponsoring purchasers developed Advanced Primary Care Recognition criteria to highlight practices that were demonstrating advanced

primary care. Two tiers of recognition were defined: the first tier for consistently scoring above the 66th percentile on each measure and a higher tier for consistently scoring above the 90th percentile on each measure. To build in room for missing measures (e.g., not penalizing a practice that did not have enough children to have a reliable score for Childhood Immunization Status), a practice would need results for at least half of the equity measures (Controlling Blood Pressure, Childhood Immunization Status, Colorectal Cancer Screening, Comprehensive Diabetes Care: HbA1c Control < 8.0%) and results for at least half of the other measures in the Advanced Primary Care Measure Set.

After applying the Advanced Primary Care Recognition criteria, no practices achieved either recognition tier. Even with this result, the organizations that developed the criteria still believed that the methodology was appropriate and that changes were not needed. They recommended focusing on ways to increase practice size and ways to improve data completeness and accurate reporting.

Missing Results that Should Have Been Included

Reporting challenges exist that prevented patient experience data and demographic stratification from being incorporated into the Advanced Primary Care Measurement Pilot. These challenges are outlined below.

Patient Experience

Patient experience is universally agreed upon to be a crucial measure in provider performance, which is why it is a designated domain within the Advanced Primary Care Measure Set. The most widely used industry collection tool is the Consumer Assessment of Healthcare Providers and Systems (CAHPS). However, this survey has consistently received feedback from stakeholders that it is long and

burdensome, resulting in lower than desired response rates and results that lack robustness. This type of consumer survey could benefit from a more granular assessment to gain insight into patient experience with a specific provider or team, however, it would require a much more extensive sample size and cost to obtain reliable results at the practice level.

CAHPS data collected by PBGH at the provider organization level has not been collected in a way that would allow disaggregation down to the practice level. As a result, patient experience was not included in the Advanced Primary Care Measurement Pilot. After extensive research and discussion, there is currently no identified alternative patient experience measure to test in 2024; however, exploration in this area will continue.

Demographic Data Stratification

We all share the quality and cost burden from adverse health outcomes resulting from inequities in care delivery. Bringing disparities in outcomes to light is crucial for improvement in this area. Demographic data on race, ethnicity, and social drivers of health should be regularly collected and applied to clinical quality and utilization measures.

CQC and IHA explored the possibility of stratifying practice-level results in the Advanced Primary Care Measurement Pilot across race, ethnicity, and language and determined there was not enough self-reported demographic data in the IHA dataset to do so. Feedback from advocates and stakeholders indicated that inputting demographic data for the pilot would not be helpful enough to be valuable and could distract from the more critical goal of collecting better self-reported demographic data. Stratifying the data would further reduce patient numbers, exacerbating the existing issue of small sample sizes. This underscores the need to increase the proportion of patient data included for each practice.

The Path Forward

Advanced Primary Care Measure Set

CQC, IHA and stakeholders have built an annual process for updating the Advanced Primary Care Measure Set. This involves CQC and IHA drafting a proposal for changes in August once refreshed results on the Advanced Primary Care Measure Set are available and large California purchasers are assessing updates. A process for stakeholder review will occur between August and October when any proposed revisions will be shared for feedback from various groups, including IHA’s Technical Measurement Committee, state purchasers and provider trade associations. The CQC Steering Committee will

approve final changes to the measure set and any measures to test for future inclusion.

Changes are considered based on feasibility of assessing the measure at the practice level, if it is measuring what is actually important, alignment with other sets and existing reporting, if there are better, more innovative measures that could be substituted in, and how much value the measure adds to the overall set in terms of understanding primary care strength.

Figure 12: The 2024 Advanced Primary Care Measure Set Updates

	Measure	Acronym	Rationale
Remove	Concurrent Use of Opioids and Benzodiazepines	COB	Appropriate under certain circumstances which are hard to carve out
Add	Breast Cancer Screening**	BCS	Disparities sensitive women’s health measure
	Diabetes HbA1c Control <8%	HBD	This measure is tied to health plan financial implications in the Covered California QT1 contract, until a benchmark for poor control exists
Test	Pharmacotherapy for Opioid Use Disorder*	POD	Could replace COB as a patient safety measure
	Well-Child Visits in the First 30 Months of Life**	W30	CIS had small number challenges; this could be another way of measuring pediatric performance
	Child and Adolescent Well-Care Visits**	WCV	
	Prenatal and Postpartum Care**	PPC	Disparities sensitive women’s health measure

* *Managed Care Accountability Set (MCAS) measure (Medi-Cal)*

** *Department of Managed Health Care Health Equity and Quality set measure and DMHC and MCAS Measure*

To test a measure in the set above means the measure will be included in analysis the following year to see how it performs at the practice level. If determined to be of value, the measure can be included formally the following year. “Test” measures will not be included for payment incentives in the California Advanced Primary Care Initiative payment model until formally voted into the measure set.

Advanced Primary Care Measurement and Potential Payment Model Demonstration Project

CQC and IHA plan to re-run the Advanced Primary Care Recognition that was developed in 2023, and assess if supplemental data, state grants to support connection to the Data Exchange Framework, momentum toward value-based payment in the state, and other efforts are enough to yield more practices receiving the recognition. In addition, CQC and IHA will continue to consider denominators lower than 30 to increase the number of measures available for each practice.

CQC and IHA will also consider refinements to the practice identification algorithm. In addition to rolling up to organization name or TIN level, the order of attribution may be changed. California Advanced Primary Care Initiative health plans determined that attribution to a practice should take precedence, followed by attribution to a physician within the practice. This would help ensure alignment with payment to a practice and allow a physician to belong to multiple practices, which more closely reflects reality.

The California Advanced Primary Care Initiative health plans are exploring a payment model demonstration project in Southern California and the Central Valley, that would pay incentives to practices based on performance on this measure set. In addition, the project would include tailored technical assistance for each practice and access and training on a common platform to report results across each plan and reduce administrative burden.

Figure 13: Recommended Changes for Next Year and for a Potential Statewide Program

Issue	Actions for Refinement
Small Denominators	Explore ways to incorporate more populations into the dataset, expanding to include the complete IHA dataset across payer types and other plans that were unable to be included this round
	Consider denominators less than 30 patients
Missing data	Enhance supplemental data additions from health plans and explore use of CPT II codes by providers
	Improve data exchange (e.g., common reporting platform, support through Data Exchange Framework)
Defining a Practice	Practice level algorithm: shift from patient to provider to practice, to patient to practice to provider. This ensures practice attribution supports consistency with contracting and allow PCPs to belong to more than one practice.

Actions to Improve Data Collection and Performance

The Advanced Primary Care Measurement Pilot represents a large enough sample of California claims data to illuminate several key takeaways on what the California delivery system needs:

1. Expansion of clinical data exchange capability: Better infrastructure for clinical data reporting at the point of care will enable providers to represent their true performance, both for their own improvement tracking, and for increased visibility across the system for decision making. Part of improving infrastructure involves payers and purchasers acknowledging the daily lived experience of care teams managing many platforms, reporting streams and sets of requirements, and helping align to alleviate that administrative burden.
2. Comprehensive views of performance at the point of care across payers, products and populations: Interoperability of systems, standard data specifications, and alignment of formats and initiatives across multiple payers, state agencies, purchasers, and/or improvement organizations will facilitate this type of comprehensive performance reporting. Larger populations for measure assessment and improvement tracking will also support stratification across demographic variables and uncover disparities for disparity reduction.
3. Performance improvement: From the data we do have, not one practice scored above the 66th national percentile on half or more of the measures. Though it is clear that data is missing, in particular for controlling high blood pressure, depression screening, and childhood immunizations, there is enough of a performance sample to see that there is significant opportunity for improvement.
4. Support for the delivery system to do 1-3: The reality of a physician's and team's day to day, especially on the ground at a small practice that does not have leverage to negotiate high rates, can be challenging and chaotic. Physicians at solo, small, and medium sized practices, who make up over 65% of practicing physicians in California, need additional resources such as shared tools, technical assistance, and team support to shift processes, adopt systems, and take on the practice transformation that is needed to achieve sustained improvement and joy in work.

Each organization type in our health system can help move the needle toward the above goals, in the short, medium and long term.

Figure 14: Actions to Improve Data Exchange and Quality Outcomes, by Organization Type

Payers (Health Plans and Provider Organizations)
Invest more into primary care through value-based payment in a way that is flexible and guarantees revenue. Move away from volume-based payment which is a known root cause of administrative burden ^{iv} .
Support aligned measurement to reduce reporting burden.
Participate in alignment projects to pool resources for more point of care support for practice transformation, reporting, and tracking. (e.g., the California Advanced Primary Care Initiative).
Encourage uptake of CPT II codes that simplify quality measure reporting. Adjust systems to be able to accept the codes, spread awareness and train providers, support system shifts to enable reporting.
California State Agencies and Center for Medicare and Medicaid
Support measure alignment , by including a small amount of the right measures in contracts and programs.
Support testing of new measures or innovative, easier ways of reporting an existing measure.
Fund practice transformation grants to support providers to be able to enhance data reporting and clinical data exchange.
Support data exchange across providers and payers. (e.g., the California Data Exchange Framework will assist with more efficient and complete reporting to support more effective performance improvement efforts.)
Support comprehensive databases that can be used to measure performance, understand health trends, and support policy and program decision making. (e.g., the Health Care Payments Data (HPD) program is an all-payer claims database in California that collects claim and encounter data as submitted from California payers and will be used to inform policy decisions, reduce health care costs and disparities.)
Data Aggregators and Exchange Platforms
Make decisions that support interoperability and combining data views with other platforms and systems.
Be affordable to avoid equity in access issues.
Accrediting Organizations and Measure Stewards
Build or be open to adjusting technical specifications to be as inclusive in population size as possible (e.g., through age, eligibility criteria) to strengthen practice level measure results and demographic stratification.
Trade Associations
For each item listed above, find ways to encourage member participation and support , whether it is through membership incentives, advocacy, work group participation or other means.
<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> Short-Term Actions (Could initiate in ~two years or less) </div> <div style="text-align: center;"> Medium to Long-Term Actions (Could initiate in ~three or more years) </div> </div>

^{iv} "Evaluating Value Based Payment in Reducing Administrative Burden", AAFP, 2023, ValueBasedPayment-ElationHealth-Report.pdf

The California health system has a large problem to solve but can view this as an opportunity to be creative. No one organization is going to solve this on its own and it will require multiple efforts in tandem, many of which are listed above.

Given the current measure universe, the Advanced Primary Care Measure Set includes the right measures to focus on with the intention that it will continue to evolve in a way that promotes innovation and measures what truly counts in delivering high-quality primary care.

Seeing comprehensive performance is the first step in identifying where improvement is needed, and California has a strong head start through the use of the IHA dataset to measure performance at various levels within the health care system. Subsequent efforts will focus on continuing to enhance the data available for performance measurement through collecting supplemental clinical data, accessing data from electronic health records, and implementing a common reporting platform to provide actionable information to providers to support performance improvement.

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About the Purchaser Business Group on Health (PBGH)

Purchaser Business Group on Health (PBGH) is a nonprofit coalition representing nearly 40 private employers and public entities across the U.S. that collectively spend \$350 billion annually purchasing health care services for more than 21 million Americans and their families. PBGH has a 30-year track record of incubating new, disruptive operational programs in partnership with large employers and other health care purchasers. Our initiatives are designed to test innovative methods and scale successful approaches that lower health care costs and increase quality across the U.S.

About the California Quality Collaborative (CQC)

California Quality Collaborative (CQC), a program of PBGH, is 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.

About the Integrated Healthcare Association (IHA)

At Integrated Healthcare Association (IHA), we bring the health care 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 health care system work better for everyone. We provide insights that help the health care 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 health care. 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 health care system works.

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Appendix

Below are distributions for the rest of the Advanced Primary Care Measure Set results.

Note: Results are shown for the two industry standard measures that assess diabetes control. CQC and IHA recognize the redundancy but have analyzed and are including both until the industry completes a shift toward one and retires the other. California and national momentum appears to be moving toward keeping poor control yet some existing large-scale contracts include good control until poor control has benchmarks.

Figure 15: Comprehensive Diabetes Care: HbA1c Poor Control > 9.0%

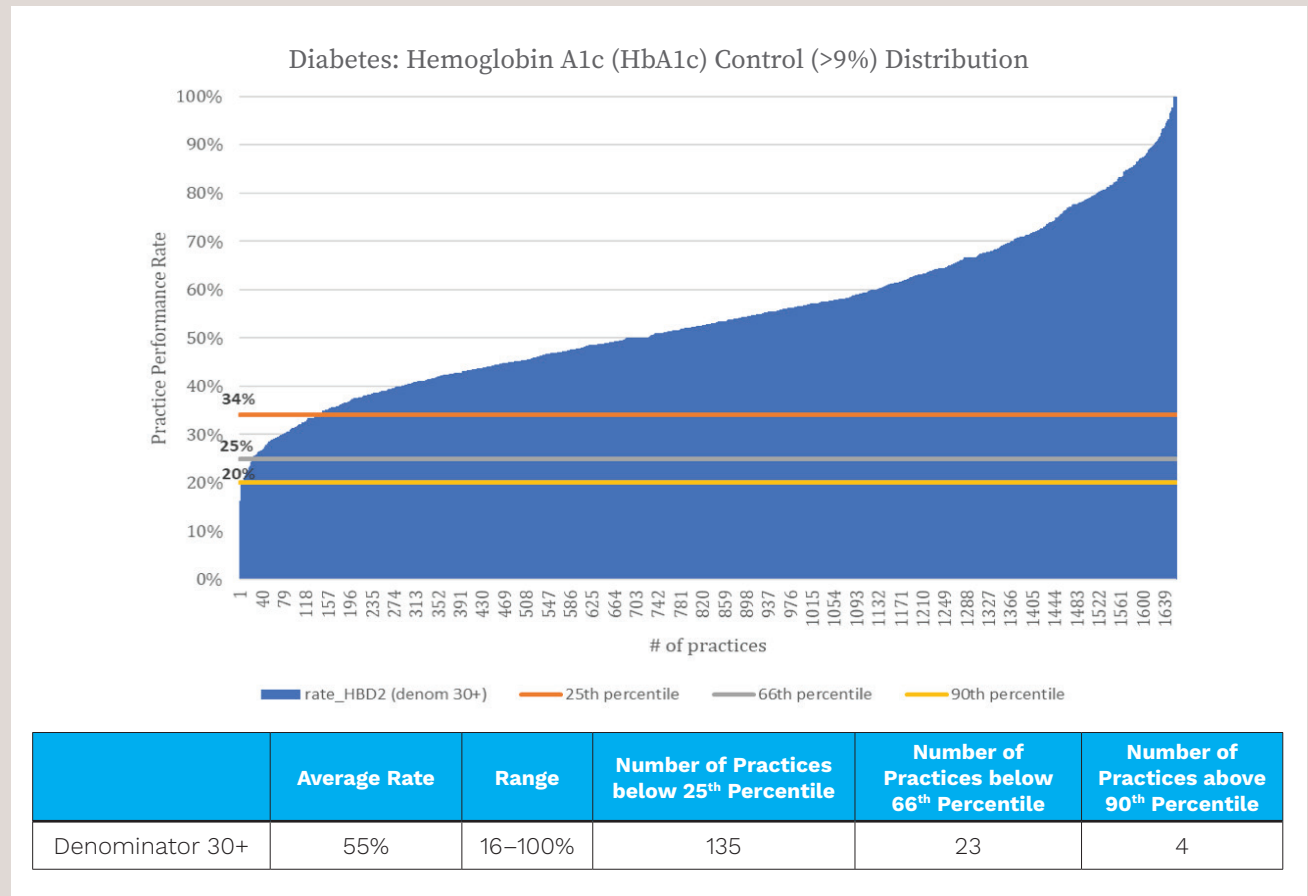


Figure 16: Asthma Medication Ratio

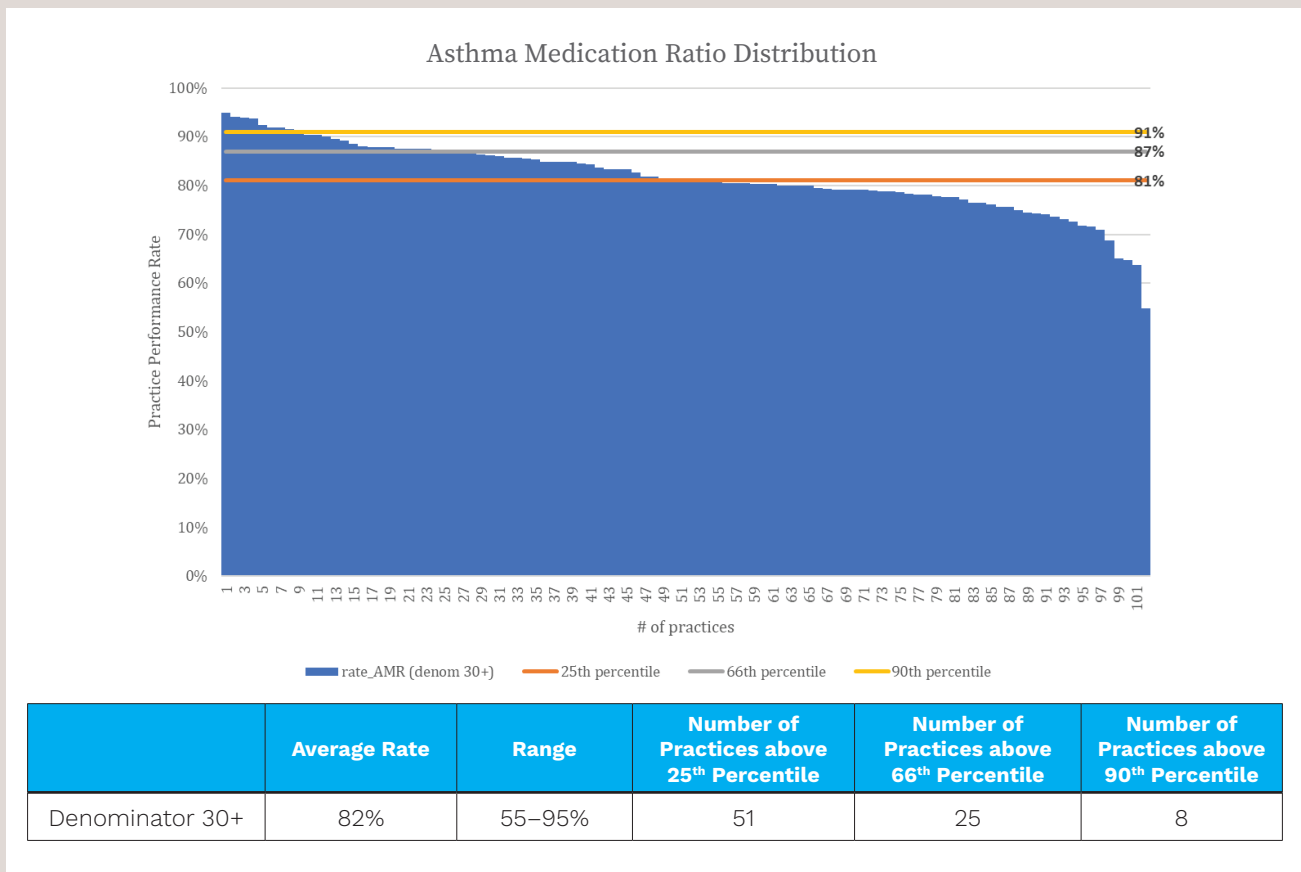


Figure 17: Immunizations for Adolescents: Combination 2

