California Health Care Foundation

Primary Care Investment Coordinating Group of California

California Public Purchaser Contract Provisions on Primary Care: Multi-Payer Alignment Drives Investment

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California's largest public purchasers — the Department of Health Care Services (DHCS) for Medi-Cal (15 million enrollment in October 2022[1]), Covered California for marketplace participants (1.7 million enrollment in September 2022[2]), and California Public Employees' Retirement System (CalPERS) for public employees (1.5 million enrollment in January 2022[3]) — collectively negotiate contracts with health plans to provide care to over 18 million Californians. In recent years, DHCS, Covered California, and CalPERS have focused on strengthening and aligning their contract provisions related to primary care measurement, reporting, payment, and investment. Based on information provided by the three public purchasers and a review of contracts in effect in 2023 (Covered California) or going into effect in 2024 (DHCS contract for Medi-Cal managed care plans and CalPERS HMO contract), the table below provides a comparison of select contract provisions, demonstrating the degree of alignment across these large public purchasers. Indeed, the contract provisions are virtually identical in several important areas:

- Reporting on primary care spend
- Consideration of a target or floor for primary care spend
- Reporting on primary care payment models
- Increasing adoption of value-based models for primary care
- Reporting on the payment model for primary care in each health plan's five largest contracted physician organizations

Multi-payer alignment is an essential element in driving primary care investment across the market without increasing the rate of growth of health care costs. Alignment is important both within a market segment (e.g., among Medi-Cal managed care plans) and across segments (e.g., between Medi-Cal and commercial). Multi-payer alignment presents a unified front and collective voice on the importance of and specific approach to creating a primary care–centric health care system; reduces administrative burden and strengthens the signal to providers, compared with proliferating approaches to measurement and payment; and enables transparency and comparability across payers and providers. As the Department of Health Care Access and Information's Office of Health Care Affordability ramps up, the alignment efforts of California's public purchasers can inform efforts to standardize measurement and reporting on primary care spend, set a benchmark for primary care spend as a share of total spend, and increase adoption of value-based models that encourage advanced primary care.

AREA OF FOCUS	PUBLIC PURCHASER CONTRACT WITH PARTICIPATING HEALTH PLANS		
	DHCS (2024)	COVERED CALIFORNIA (2023)	CALPERS (2024 HMO)
Report on primary care spend	Contractor must report on total primary care spend, as defined by the Integrated Healthcare Association (IHA), and the percentage of spend within each Health Care Payment Learning & Action Network alternative payment model (HCP LAN APM) framework category.[4]		
Stratification of reporting on primary care spend	Contractor must stratify the reporting of primary care spend (and primary care spend as a percentage of total spend) by age (children and youth age 0–20, adults age 21+), by race/ethnicity, and as requested by DHCS.		
Consideration of target or floor for primary care spend	Contractor must work with public purchaser (i.e., DHCS, Covered California, or CalPERS) and other stakeholders to analyze the relationship between the percentage of spend for primary care services with performance of the overall delivery system. If the evidence shows that rebalancing to increase primary care spend improves quality or drives lower total cost of care, public purchaser (i.e., DHCS, Covered California, or CalPERS) may set a target or floor for primary care spend in future requirements.		
Report on primary care payment models	Use HCP LAN APM categories and associated subcategories to report on the number and percentage of contracted primary care clinicians paid using each category and subcategory.		
Increase adoption of value-based models for primary care payment	Contractor must adopt and progressively expand the percentage of primary care clinicians paid through the HCP LAN APM categories of population-based payment (category 4) and alternative payment models built on a fee-for-service structure such as shared savings (category 3).		
Payment model for primary care for five largest groups	Contractor must provide a description of the contractor's payment model for its five largest physician groups/medical groups, as defined by the number of providers, and how their primary care clinicians are paid.		
Use, and report on, value-based models, especially for primary care	DHCS encourages contractor to use value-based and alternative payment models to compensate network providers, especially for primary care covered services, in ways that ensure provider accountability for both quality and total cost of care with a focus on population health management. Contractor must monitor, and must report within 90 calendar days of DHCS's request, the number or amount, and percentage, of contractor's members, network providers, and medical expenditures that it makes under such payment models, separately for hospital services, professional services, and other services at a minimum.	Covered California encourages contractor to support its providers through value-based payment models that promote high-quality, affordable, and equitable care to continue to build and strengthen networks based on value. In addition to reporting network payment models using HCP LAN APM categories, contractor will report the percentage of spend within each category and subcategory compared to its overall budget. Contractor shall design and manage its networks based on cost, quality, safety, patient experience, and equity. Contractor shall also report how it meets this requirement and the basis for the selection and review of providers and facilities in networks.	CalPERS encourages contractor to use value-based and alternative payment models to compensate providers, especially for primary care covered services, in ways that ensure provider accountability for both quality and total cost of care with a focus on population health management. Contractor will monitor, and report within 90 calendar days of CalPERS' request, the number or amount, and percentage, of contractor's plan members, participating providers, and medical expenditures that it makes under these payment models, separately for hospital services, professional services, and other services at a minimum.

AREA OF FOCUS	PUBLIC PURCHASER CONTRACT WITH PARTICIPATING HEALTH PLANS		
	DHCS (2024)	COVERED CALIFORNIA (2023)	CALPERS (2024 HMO)
Primary care physician matching (selection or assignment)	Contractor must ensure that each member has an assigned PCP who is available and physically present at the service location for sufficient time to ensure access and appointments for the assigned member when medically required. If the member does not select a PCP within 30 calendar days of the effective date of enrollment, contractor shall assign that member to a PCP and notify the member and the assigned PCP no later than 40 calendar days after the member's enrollment.	All plan members must select or are provisionally assigned to a PCP within 60 days of enrollment. Contractor must report the number and percentage of enrollees who select a PCP, and the number and percentage of enrollees who are assigned to a PCP. When assigning a PCP, contractor will use commercially reasonable efforts to assign a PCP consistent with a plan member's stated language, ethnic and cultural preferences, geographic accessibility, existing family member assignments, and any prior PCP relationship.	
Advanced primary care measure set (California Quality Collaborative)		Contractor will implement a measure set that includes quality and cost-driving utilization measures for advanced primary care to assess the prevalence of high-quality advanced primary care practices within contractor's provider network. Contractor will submit data to IHA for use in the advanced primary care measure set.	

Notes:
In some cases, language is summarized or minor distinctions in contract language are not reflected. *HMO* is health maintenance organization. *PCP* is primary care provider (the term used by DHCS and CalPERS); Covered California uses the term primary care clinician.

Sources:
DHCS contract language for 2024 is available at "Event Details: Medi-Cal Managed Care Plans (RFP 20-10029)," Cal eProcure, accessed April 11, 2023. Click on "View Event Package," download the "RFP_Main" zip file, select Exhibits > Primary Operations Contract, and view "3-Primary Contract Exh A Att III SOW.pdf." For primary care spending/APM language, see Section 3.3 (pp. 111–112); for primary care assignment requirements, see Section 5.2.1 (p. 252).

Covered California contract language for 2023 is available at *Attachment 1 to Covered California 2023-2025 Individual Market QHP Issuer Contract: Advancing Equity, Quality, and Value* (PDF), Covered California, August 1, 2022, including health plan requirements for quality, equity, and value. The primary care payment and spend requirements are in Article 4.01.3 Payment to Support Advanced Primary Care (p. 26).

CalPERS contract language for 2024 is public but is not yet available via link to a contract document; CalPERS provided the relevant excerpts.

Author

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Endnotes

1 *Medi-Cal Monthly Eligible Fast Facts (date represented: October 2022)* (PDF), California Department of Health Care Services, January 2023.

2 *Covered California Active Member Profile (coverage month: Sep 2022)* (Excel file), Covered California, January 18, 2023.

3 *Health Benefits: Facts at a Glance for Fiscal Year 2021-22* (PDF), CalPERS, January 2022.

4 *Alternative Payment Models: The APM Framework* (PDF), Health Care Payment Learning & Action Network, refreshed 2017.