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Primary Care Concept Model

State of Delaware
Primary Care Reform Collaborative Meeting

December 21, 2020

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Agenda

01 Context for Primary Care Concept Model Development

02 Three Major Elements of the Primary Care Concept Model

03 Feedback Discussion

04 Next Steps

Delaware Primary Care Environment

The primary care system is struggling under increasing demands and expectations, diminishing economic margins, and increasing workforce attrition compounded by diminishing recruitment of new physicians, nurses and physician assistants into primary care.

Myers et all, AHRQ

Access to Primary Care

Delaware's primary care physician (PCP) workforce cannot meet demand.

Older-Sicker Population

Thirty-second Nationally for obese adults and thirty-sixth in inactivity. Tobacco users, especially during pregnancy.

6% Decline

The number of PCPs in Delaware declined 6% from 2013 to 2018.

Primary Care Shortage Area

Sussex and Kent Counties each meet the federal definition for a primary care shortage area.

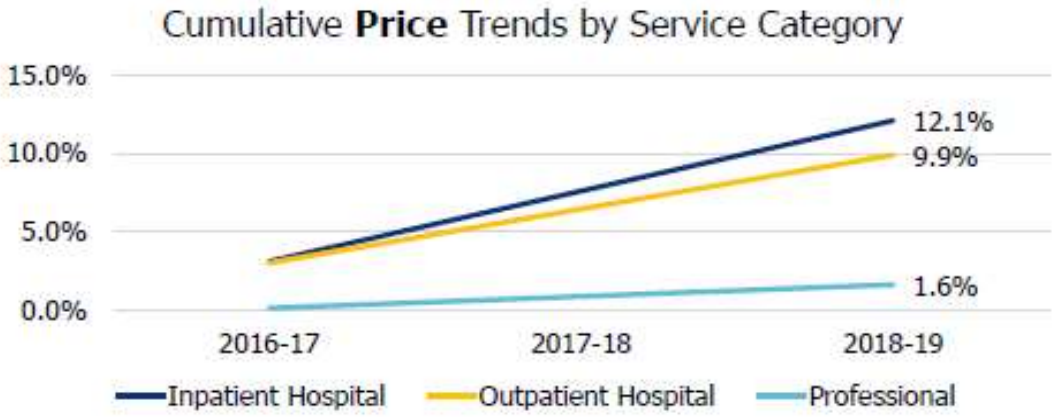
40%

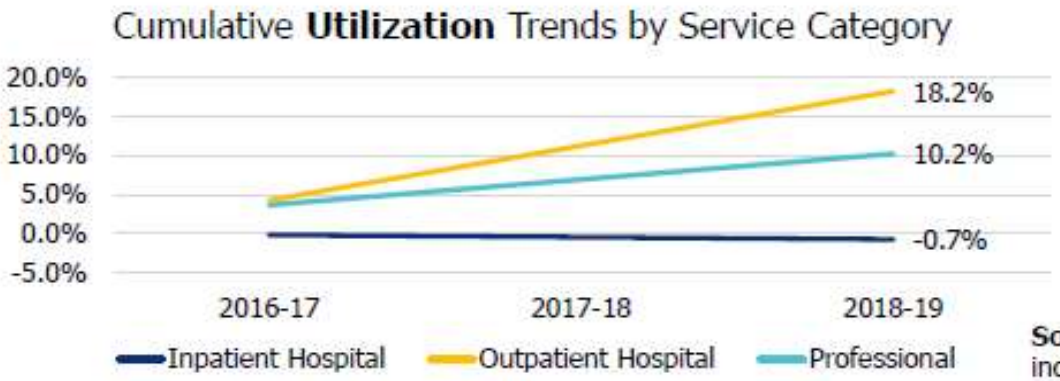
Of Kent County physicians either plan to retire or are unsure if they will be practicing within five years.

Consolidated Market

Health Systems and Insurers

Trends in Price and Utilization





Nationally, research finds increases in health care costs are primarily driven by increases in price.

In Delaware, its both price and utilization.

Source: Data provided by DE carriers for individual, small group, large group and State Group Health Plan.

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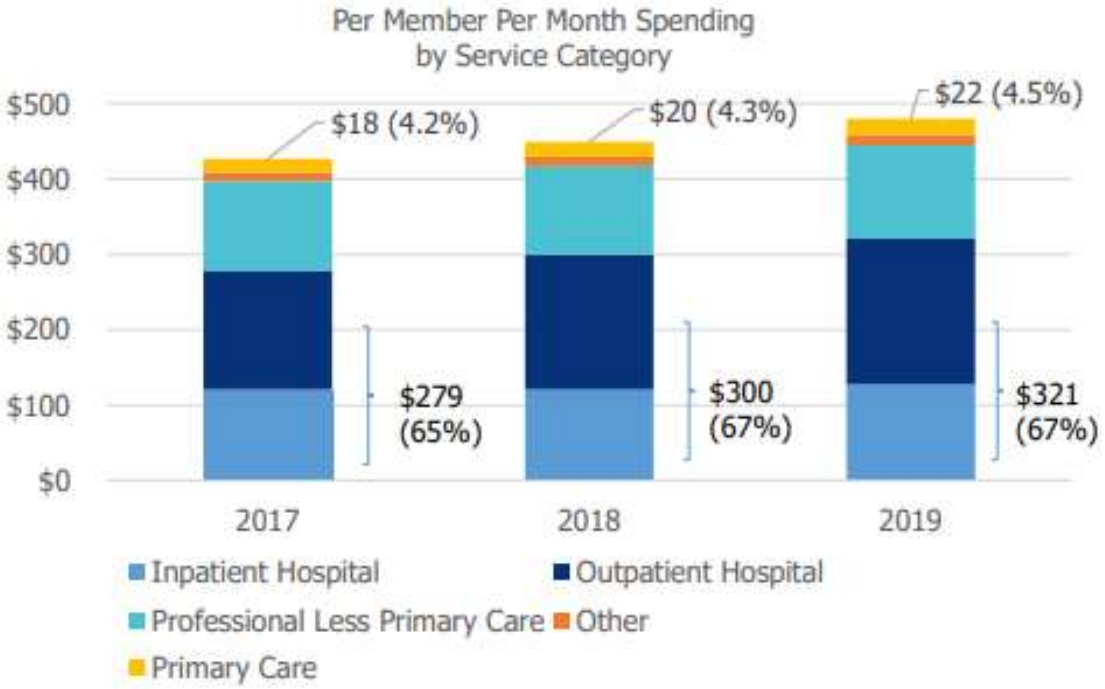
Primary Care Investment, Per Member Per Month



Source: Data provided by DE carriers for individual, small group, large group and State Group Health Plan. PMPM does not include pharmacy spending.

The amount spent on primary care services increased 21% from '17 to '19.

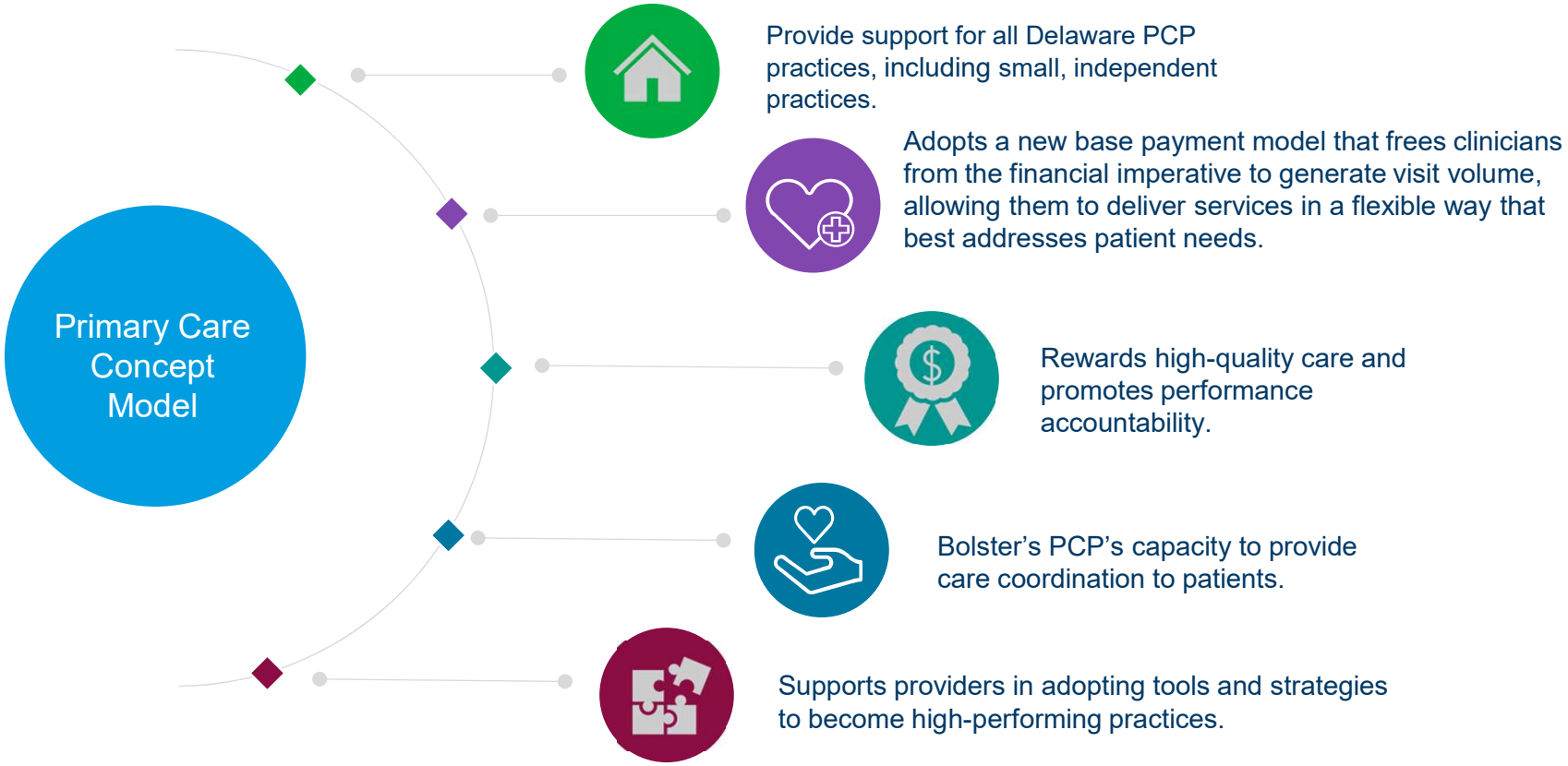
Yet, it barely increased as a percent of total medical expense.

Why?
All other types of spending increased too – about 12% across the three years, excluding pharmacy.

Addressing Senate Bill 277

Senate Bill 277	Concept Model
1. Payment reform	✓
2. Value-based care	✓
3. Workforce and recruitment	✓
4. Directing resources to support and expand primary care access	✓
5. Increasing integrated care (including women's and behavioral health)	✓
6. Evaluation of system-wide investments into primary care, using claims data obtained from the Delaware Health Care Claims Database	

Objectives for Primary Care Concept Model Development



Primary Care Concept Model: Three Elements

1

Alternative payment model

2

Community health teams

3

Care delivery requirements and provider support

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Element 1:

Alternative Payment Model

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Primary Care Concept Model Element #1:
Alternative Payment Model Options

Offers two alternative payment for consideration and discussion, with an intent to adopt just one of them:

Model A:
Primary care prospective payment.

A prospective Per Member Per Month (PMPM) payment for the most common primary care services, regardless of volume of those services.

Model B:
Blended primary care prospective payment.

Relative to Model A, a reduced prospective PMPM payment along with Fee-for-Service (FFS) payment for the same set of commonly delivered services, but at diminished FFS fees.

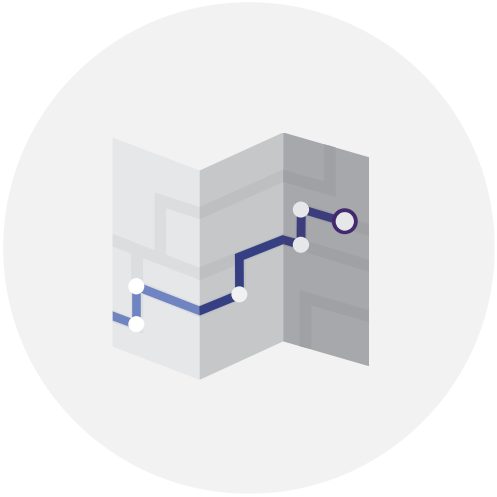
In both Models, FFS payment is retained for those services not included in the prospective payment rate.

Primary Care Concept Model

Key Components

VOLUNTARY

- Practice participation would be voluntary



TARGETS PHASED IN OVER TIME

- Carrier/Managed Care Organization (MCO) goals are phased over time (e.g., first phase focus on practices with 20% of the carrier's managed lives).
- Carrier/MCO could elect to introduce prospective payment-based primary care contracts to practices best positioned for prospective payment success.

CORE CODE SET OF PRIMARY CARE SERVICES

- Model includes a Core Code Set for services, which payers and providers could expand, for inclusion in the prospective PMPM.
- Codes would represent majority of common primary care services, including office visits and telehealth visits.

Primary Care Concept Model

Key Components

Common Measure Set

- Common Measure Set: Model is intended to adopt a limited and aligned measure set that Carriers/MCOs use with all primary care practices.
- Measures are appropriate for the population (e.g., pediatric versus adult) and consistent with other programs to minimize provider reporting burden
- Carriers/MCOs support practices with useful and actionable data

Attribution and Risk Adjustment

- Carriers/MCOs would have an option of attributing patients:
  - to a practice prospectively based on member selection of PCP
  - retrospectively based on member utilization
  - using a hybrid approach
- Patients would be reattributed monthly with updates communicated by Carriers/MCOs to the practices
- Carriers/MCOs would risk adjust their prospective payments to account for variation in the health care conditions of different patient panels, age and gender
- Use of risk adjustment tools specifically for primary care should be explored

Risk Mitigation

- There are some risks associated with a primary care prospective payment
  - Practices may take on more patients than they can realistically care for
  - Practices may reduce use of necessary and appropriate services
- To guard against these risks, the Model will adopt reporting and monitoring standards to identify cases where access is decreasing or there are other signs of stinting on appropriate care

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Element 2:

Community Health Team

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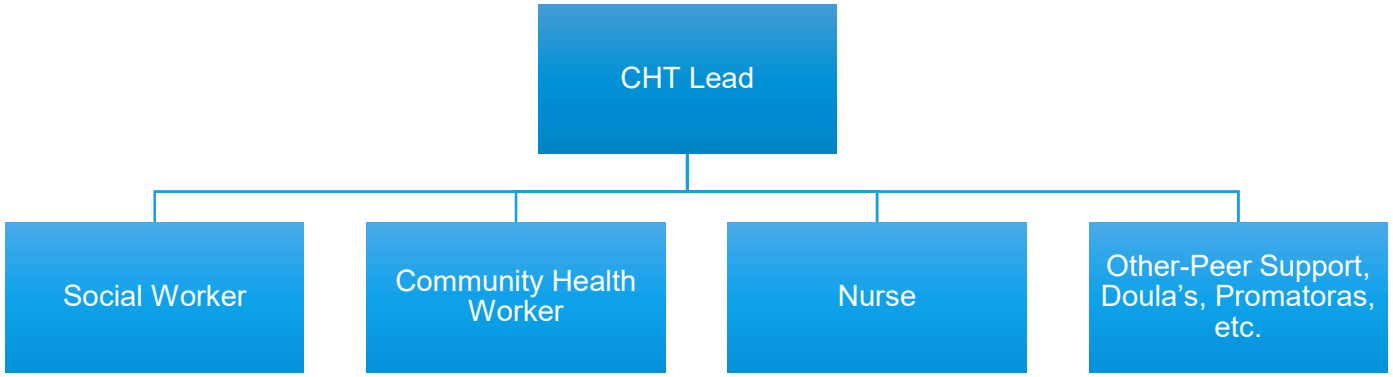
Primary Care Concept Model Element #2:
Community Health Teams (CHTs)



- Locally-based, multi-disciplinary teams that coordinate care and help manage patients' complex illnesses across providers, settings and systems of care.
- Expand capacity and support a robust primary care system.
- Designed primarily for the use of small, non-hospital-owned primary care practices.

Primary Care Concept Model Element #2:
CHTs

- Centralized community resource that could be deployed to practice sites on an as-needed basis.
- Priority given to small practices that lack the infrastructure and supports to effectively coordinate patient care.
- While ideally funded on a multi-payer basis as in some other states (e.g., Vermont), at least initially any pilot efforts supported by insurers would be coordinated to encourage the development of regional CHTs that work with all interested payers.
- Payment could be on a PMPM basis and risk-adjusted.
- Avoid duplication of effort and minimize patient confusion and provider burden of having to deal with multiple care managers to serve the same patients' care needs.

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Element 3:

Care Delivery and Provider Support

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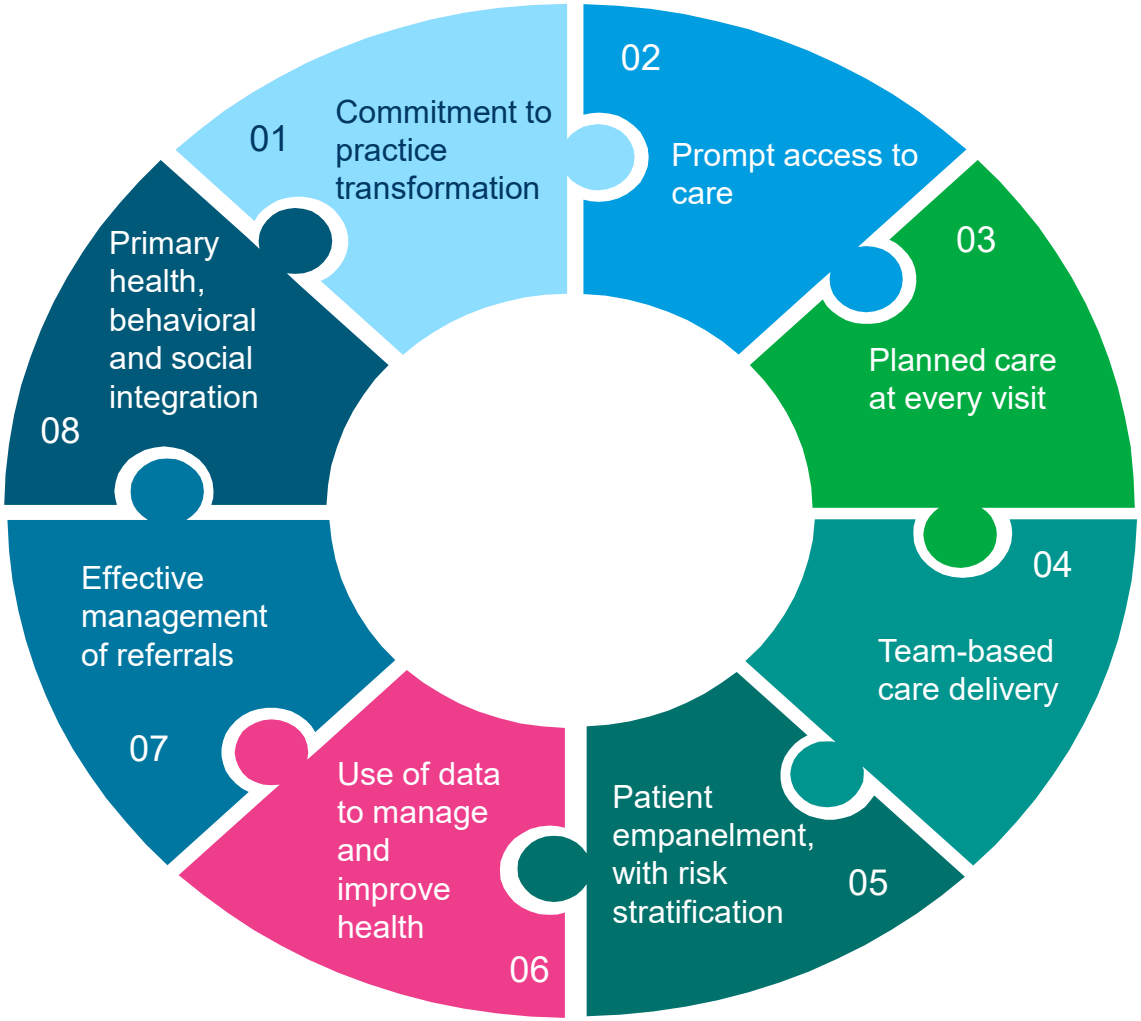
Primary Care Concept Model Element #3:
Transformation Objectives for Primary Care Practices



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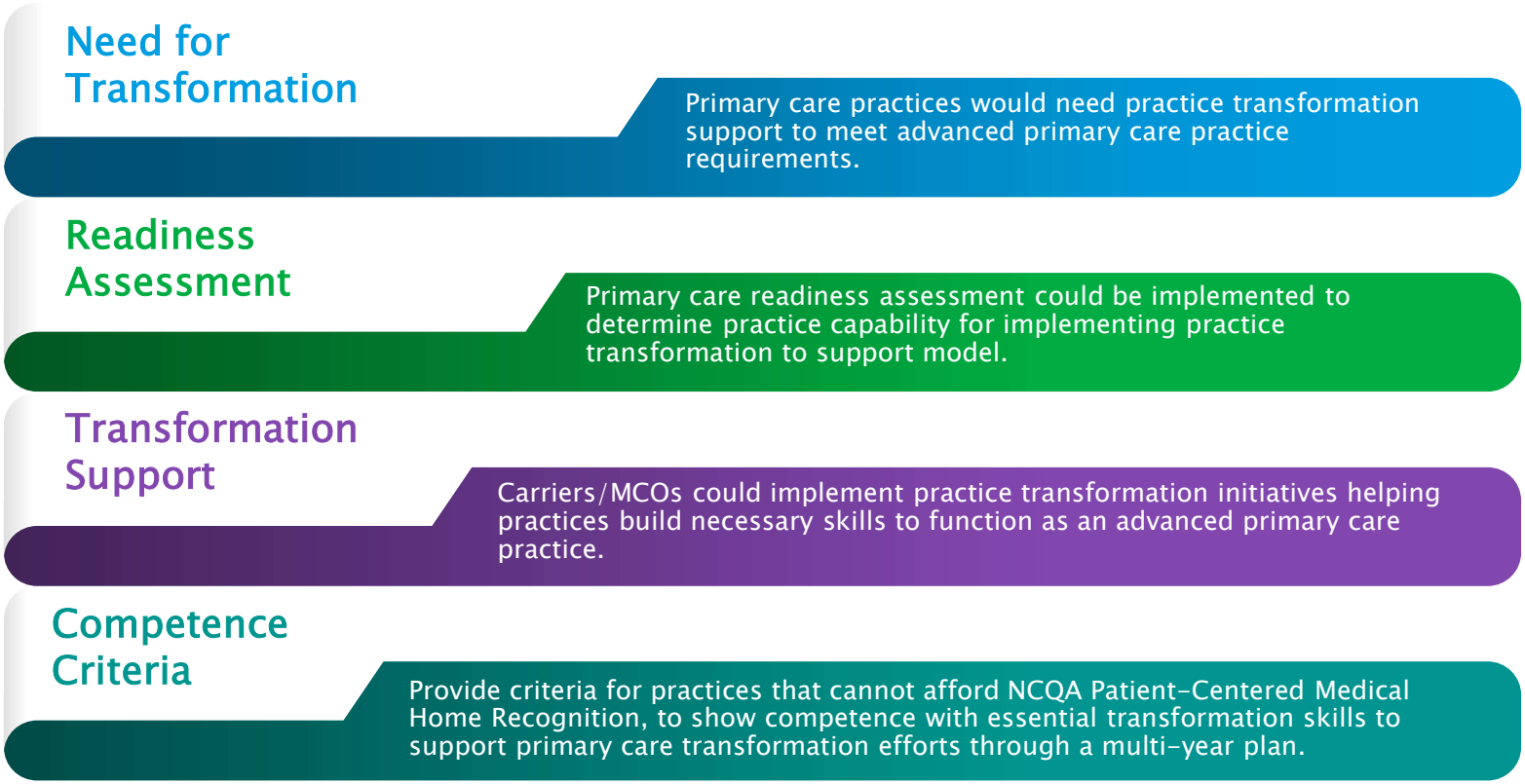
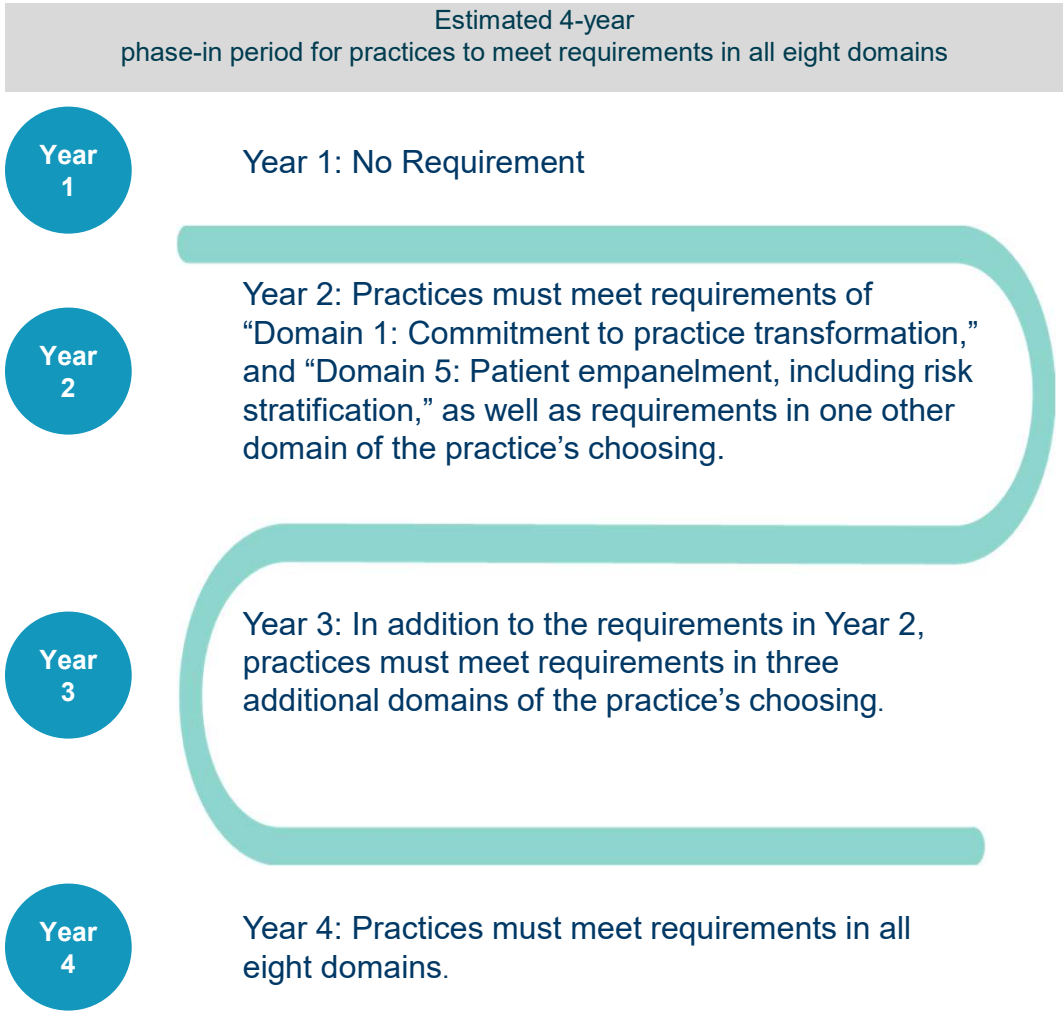
Primary Care Concept Model Element #3:
Care Delivery Requirements and Support



Primary Care Concept Model Element #3:
Phased Transformation Process

To reduce the burden associated with requiring NCQA recognition, practices would complete a self-assessment to evaluate progress on each domain on which the practice is actively working, and readiness to undertake activities in other domains.



Appendix 1
Primary Care Concept Model – Draft CPT Code List

New or Established Patient Office or Other Outpatient Visit		99201–99205, 99211–99215
Prolonged Patient Service or Office or Other Outpatient Service		99354–99355
New or Established Patient Prevention and Wellness		99381–99387, 99391–99397
Urinalysis		81000–81003, 81005, 81015, 81020,
Electrocardiogram		93000, 93005, 93010, 93040, 93268, 93270, 93272, G0403–G0405
Consultation		99241–99245
Codes otherwise bundled into the office visit	Telephone and online E&M Collection, blood Measure blood oxygen level	98966–98969, 99441–99444, 36415–36416, 94760–94761
Services typically not performed by a PCP or subject to overuse.	Removal of skin lesions, skin tags, Nail trim, debridement, Intralesional injection	11056, 11200–11201, 11719–11721, 11900–11901

Appendix 2: Primary Care First Quality Measures

Practices in **Risk Groups 3-4** and practices accepting SIP patients are evaluated on a different set of quality measures than Risk Groups 1-2.

Measure Title	Model Years
Advance Care Plan (MIPS CQM measure) *(also used for Practice Risk Groups 1-2)*	Years 1-5
Total Per Capita Cost (MIPS claims measure)	Years 1-5
CAHPS® (beneficiary survey)	Years 2-5 (but administered in Year 1)
24/7 Access to a Practitioner (beneficiary survey)	Years 3-5
Days at Home (claims measure)	Years 3-5

Appendix 2: Primary Care First Quality Measures

The following measures for **Practice Risk Groups 1-2** will inform performance-based adjustments and assessment of quality of care delivered.

Measure Type	Measure Title	Model Years
Utilization Measure for Performance-Based Adjustment Calculation (Calculated Quarterly)	**Acute Hospital Utilization** (AHU) (HEDIS measure)	Years 1-5
Quality Gateway (Calculated Annually)	**Patient Experience of Care Survey** (CAHPS® with supplemental items)	Year 2-5
	Diabetes: Hemoglobin A1c (HbA1c) **Poor Control** (>9%) (eCQM)	
	Controlling High Blood Pressure (eCQM)	
	Advance Care Plan (MIPS CQM measure)	
	Colorectal Cancer Screening (eCQM)	

Practices in Risk Groups 3-4 and practices accepting SIP patients are evaluated on a different set of quality measures— see the next slide for details.

Appendix 2: Additional Sample Quality Measures

Measure
Well-child visits in the first 15-months of life: Six or More (HEDIS)
Well-child visits in the third, fourth, fifth and sixth years of life (HEDIS)
Adolescent well care visits (HEDIS)
Breast Cancer Screening (HEDIS)
Cervical Cancer Screening (HEDIS)
Asthma Medication Ratio (HEDIS)

Thoughts and Discussion

Services provided by Mercer Health & Benefits LLC.