HEALTH MANAGEMENT ASSOCIATES

Delaware Primary Care Reform Collaborative:

Final Report

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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Executive Summary

The Delaware General Assembly passed Senate Bill 120 (SB 120) in 2021 with the goal of continuing to strengthen the primary care system in the state. The Primary Care Reform Collaborative (PCRC) and Office of Value-Based Health Care Delivery (OVBHCD), developed in 2018 and 2019, respectively, have been promoting efforts to reduce costs and increase access to high-quality and cost-efficient healthcare. The PCRC and OVBHCD have engaged Health Management Associates (HMA) to address the goals of SB 120, particularly the considerations for and development of two types of prospective payment investment to providers: the standard quality investment (SQI) and the continual quality investment (CQI).

National Landscape

To inform and guide key elements of prospective payment models, HMA conducted a comprehensive scan of the national landscape, which identified up-to-date research on primary care spending methodologies and payment models in other states. The analysis offers valuable insights into the dynamic activities taking place in the primary care sector to establish quality metrics, alternative payment models (APMs), prospective payments, and quality improvement programs. It also provides an understanding of the present state of primary care, serving as a foundation for informing recommendations, limitations, and best practices related to CQI programs and payment methodologies.

The national scan examined APM models in four states: Colorado, Oregon, Rhode Island, and Maryland. In addition, HMA researched prospective payments and quality improvement programs in New York, Washington, Oregon, Maryland, Mississippi, Rhode Island, Minnesota, and Michigan. The programs identified were models or programs developed by the states or various insurance programs, and this research informed the main categories recommended for using CQI program funds.

Standard Quality Investment

The SQI is a bundled payment for a defined set of services based on a known set of procedure codes. Any services outside the procedure code set will be billed and paid as traditional fee-for-service (FFS) claims. For the beginning stages of SQI, at the direction of the Delaware Health Care Commission (DHCC), HMA's SQI and CQI recommendations apply only to the fully-insured commercial population in Delaware, although expansion of this initiative into other populations is possible in future years. The prospective nature of this payment to providers requires an estimate informed by the historical use of these defined services. HMA worked with the Delaware Health Information Network (DHIN) to receive historical claims data for primary care services to estimate a per member per month (PMPM) prospective payment.

The PMPM estimate depends largely on the chosen attribution logic and panel size (i.e., the number of providers and the number of attributed patients), which have been discussed at previous PCRC meetings. The 2025 projected SQI PMPM should fall between $10 and $30 PMPM. In a case of strong attribution logic, a single provider would deliver all primary care services, and the SQI paid to a provider would be at higher end of the $10–$30 PMPM range (≈$30). On the other hand, with limited attribution, primary care services would likely be performed by more than one provider. Consequently, the same volume of SQI dollars must be allocated to multiple providers, and the prospective SQI PMPM would fall at the lower

end of the range, approximately $10. Due to sample size limitations, instances of smaller panels require more detailed consideration and evaluation based on population and contract details.

Continual Quality Investment

SQI payments are tied to a known set of services and corresponding procedure codes, whereas CQI payments are more generally defined as being used to advance value-based care. Practices can allocate CQI dollars towards several uses, including:

- Integrating social determinants of health (SDOH)
- Behavioral health integration
- Improving care coordination with patient navigators
- Preventative wellness and health literacy
- Technology investments
- Improving medication adherence
- Increased use of patient surveys;
- Infrastructure improvements
- Recruiting, retaining, and training staff

A mechanism for practices to track and report CQI spending consistently and reliably needs to be developed. Since the list of possible uses for CQI is open-ended and non-exhaustive, the spending of CQI dollars by practices should be reviewed to avoid fraud and abuse, and practices should attest that CQI funds have been used appropriately to initiate or enhance value-based care.

Conclusion

An essential aspect of this primary care transformation initiative in Delaware is a statement in SB 120 that by 2025, 11.5 percent of total healthcare spending must be directed toward primary care. *The new SQI and CQI PMPM payments must carefully be balanced with traditional payment models, such as FFS, care management, and other risk settlements to reach the 11.5 percent threshold.* The amounts from the CQI PMPM for advancing value-based care must also be reviewed, as the prospective SQI PMPM payment will vary by attribution and panel size. For example, if a practice were to have a relatively lower SQI PMPM, it may present an opportunity for incentivizing value-based care, and the practice should receive a higher CQI PMPM. Conversely, practices already possessing strong attribution and value-based care should receive higher SQI PMPM payment and a lower CQI PMPM reimbursement. This approach should produce PMPM amounts that allocate payments tailored toward improved effectiveness and efficiency on a practice level and guide carriers to achieve the 11.5 percent threshold.

Introduction

Three different Delaware Senate bills in Delaware are the foundation of the Delaware Enhanced Primary Care Model. In 2018, Senate Bill 227 (SB 227) established the Primary Care Reform Collaborative (PCRC) to develop recommendations for strengthening primary care in Delaware. Senate Substitute 1 for SB 116 in 2019 expanded the PCRC by creating the Office of Value-Based Health Care Delivery (OVBHCD) within the Department of Insurance. The laws aim to reduce healthcare costs by increasing the availability of high-quality, cost-efficient health insurance products that have stable, predictable, and affordable rates. Lastly, the Senate passed Substitute 1 for SB 120 to continue strengthening the primary care system. SB 120 states that by 2025, at least 11.5 percent of the total cost of medical care should be directed toward primary care.

The PCRC has developed workgroups that proposed the concepts of two prospective payments—the Standard Quality Investment (SQI) and the Continual Quality Investment (CQI). Keeping SB 120 in mind, Health Management Associates, Inc. (HMA), has developed recommendations for SQI and CQI and performed a national landscape scan to provide details and comparisons with programs in other states. These recommendations should help the PCRC get closer to achieving the Delaware Enhanced Primary Care Model.

National Landscape

HMA conducted a comprehensive scan of the national landscape in primary care. This research included the review of various state programs and health plan programs to identify and assess the multitude of models and activities being tested and implemented across the healthcare payment landscape. Healthcare systems have increasingly embraced quality improvement initiatives and alternative payment models (APMs) to enhance patient care and improve the utilization of resources. However, the shift toward quality care and implementation of APMs varies, ranging from well-established federal programs to quality initiatives developed through insurance plans. The scan of the national landscape is intended to provide an understanding of the challenges and opportunities in these diverse healthcare settings. The following sections investigate three innovations in the primary care environment: APMs, prospective payment, and quality improvement activities.

Alternative Payment Models

Colorado

Colorado is developing two multi-payer statewide APMs. By 2025, Colorado intends to tie 50 percent of Medicaid payments to a value-based arrangement.

APM 1[1] was implemented in 2016 for primary care providers. The Colorado Department of Health Care Policy & Financing (HCPF), which administers the state's Medicaid program, allocates $50 million, which is authorized by the Colorado General Assembly, for annual investments in primary care medical providers

[1] Colorado Department of Health Care Policy & Financing. Alternative Payment Model 1 (APM 1). 2024. Available at:
Available at: https://hcpf.colorado.gov/alternative-payment-model-1-apm-1. Accessed February 1, 2024.

(PCMPs). The purpose of this program is to provide higher payments to primary care providers that meet quality goals[2].

HCPF identified three goals for the model:

1. Make long-term, sustainable investments in primary care
2. Reward performance and introduce accountability for outcomes and access to care, while granting flexibility to PCMPs
3. Align with other payment reforms across the delivery system

APM 1 aligns with Centers for Medicare & Medicaid Services (CMS) Core Set Focus Areas: access to primary and preventive care, maternal and perinatal health, care of acute and chronic conditions, dental and oral health services, behavioral health treatment, and experience of care.

Benefits and Limitations of the APM1 Model[3]

Benefits	***Limitations***
• 60% of participating PCMPs in payment year (PY) 2022 reported five or more structural measures that focused on PCMP capacity, systems, and processes that would enable them to provide high-quality care. • The performance data show that most PCMPs participating in the program achieved the 200-point threshold to receive the maximum enhanced rate.	• APM 1 is too broad and cannot drive focused improvements. • Too many measures are included in the APM 1 measure set. • Creates administrative burdens for PCMPs. • Too much variation in the Accepting New Patients structural measure.

APM 2[4] was implemented to support providers by offering additional financial investment, stable revenue, and continuation of the goals set in the APM 1. APM 2 has two main components: (1) partial prospective payments, which provide stable revenue for practices and allow investments in means of care that are

[2] Health Care Payment Learning & Action Network. *AFFORDABILITY TOOLKIT Alternative Payment Models (APM) Fact Sheet April 2021*.; 2021. Available at: https://hcpf.colorado.gov/sites/hcpf/files/Alternative%20Payment%20Model%20Fact%20Sheet.pdf. Accessed February 1, 2024.

[3] Colorado Department of Health Care Policy & Financing. Memo: 2022 Alternative Payment Model 1 for Primary Care Stakeholder Engagement (for Program Year 2023). Available at: https://hcpf.colorado.gov/sites/hcpf/files/Alternative%20Payment%20Methodology%201%20Stakeholder%20Feedback%20Summary%20Memo%202022.pdf. Accessed February 1, 2024.

[4] Colorado Department of Health Care Policy & Financing Alternative Payment Model 2 (APM2). Available at: https://hcpf.colorado.gov/alternative-payment-model-2-apm-2. Accessed February 1, 2024.

not currently rewarded, and (2) incentive payments that allow practices to share in the cost savings derived from enhanced chronic care management.[5]

Benefits and Limitations of the APM 2 Model[6]	
Benefits	***Limitations***
• Revenue stability • Providers select how they want to receive their payments. • Enrolment in value-based purchasing allows providers to share in savings.	• Increased administrative burden. • Providers do not know what percentage of fee for service payments is appropriate to begin with when first participating in the program. • Concerns that PMPM payments do not fit within their current billing and accounting system.

Oregon

The Oregon Health Authority (OHA) developed a value-based payment (VBP) toolkit for coordinated care organizations (CCOs) to ensure that by 2024, at least 70 percent of their payments to providers would be in a VBP model. Oregon's road map identified five objectives for CCOs:[7]

1. Reward the provider's delivery of patient-centered, high-quality care
2. Reward health plan and system performance
3. Align payment reforms with other state and federal efforts
4. Ensure consideration of health disparities and members with complex needs
5. Support the "Triple Aim" of better care, health, and lower costs

CCOs will be required to increase the payment level to hit their annual VBP targets. OHA will use the Health Care Payment Learning & Action Network (HCP-LAN) APM framework to track CCOs' use of VBPs.[8]

[5] Colorado Department of Health Care Policy & Financing APM 2 Investments in Primary Care. Available at: https://hcpf.colorado.gov/sites/hcpf/files/Alternative%20Payment%20Model%202%20Guidebook%202023.pdf. Accessed February 1, 2024.
[6] Colorado Department of Health Care Policy & Financing . An Advocate's Guide to APM2. Available at: https://hcpf.colorado.gov/sites/hcpf/files/Alternative%20Payment%20Model%202%20Guidebook%202023.pdf. Accessed February 1, 2024.
[7] Oregon Health Authority. Oregon's Roadmap to Value-Based Payment. Available at: https://www.oregon.gov/oha/hpa/dsi-tc/pages/value-based-payment.aspx. Accessed February 1, 2024.
[8] Health Care Payment Learning & Action Network. APM Framework. Available at: https://hcp-lan.org/apm-framework/. Accessed February 1, 2024.

CCOs must develop care delivery areas (CDAs) in hospital, maternity, behavioral, children's, and oral healthcare. The framework is based on a gradual expansion of CDA VBP contracts with VBPs from 2020 to 2023, with the expectation that by the end of 2023, VBPs (LAN 2C or higher) would be in place across all five CDAs.

CCOs must use quality metrics identified by the Health Plan Quality Metrics Committee (HPQMC) to ensure quality metrics are aligned. The aligned measure menu includes 57 healthcare quality measures across six domains of services: (1) prevention/early detection; (2) chronic needs and special health needs; (3) acute, episodic, and procedural care; (4) system integration and transformation; (5) patient access and experience; and (6) cost/efficiency.

Benefits and Limitations of Oregon's VBP Road Map Model[9]	
Benefits	***Limitations***
• 15 of 16 CCOs met overall milestones with a statewide average of 50% of total payments occurring in VBP arrangements that qualified for the target. • CCOs, on average, increased infrastructure payments to PCPCHs (patient-centered primary care homes) between 2020 and 2021. • More CCOs reported "total cost of care" agreements, which had the potential to increase provider collaboration. • CCOs continued to develop the capacity to support VBP contracts in their health information technology systems.	• Need to ensure CCOs consistently understand Roadmap requirements for sub-capitated arrangements, quality measures, and enhancement of existing models for CDA requirements. • Important to continue creating opportunities for CCO cross-pollination to share successful models & novel approaches. • Need to work with CCOs to develop best practices for applying health equity goals within VBP strategies. • Additional guidance should be developed on quality measures for specialty services and integrated care.

Rhode Island

The Rhode Island General Assembly created the Office of the Health Insurance Commissioner (OHIC) in 2004 to focus on improving the quality and accessibility of healthcare. The OHIC established a statewide all-payer patient-centered medical home (PCMH) program in 2008 called the Rhode Island Chronic Care Sustainability Initiative, which promotes care for patients with chronic illnesses. The program requires

[9] Oregon Health Authority. VBP Interim Report December 2022.Available at: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP%20Interim%20Report%20December%202022.pdf. Accessed February 1, 2024.

demonstration of practice transformation, implementation of cost management initiatives, and quality performance improvement.[10]

The OHIC-aligned measure sets for primary care include chronic illness, prevention, behavioral health, consumer experience, preventive care, health equity, and social determinants of health.

The Health Care Cost Trends Steering Committee created a Compact to Accelerate Advanced Value-Based Payment Model Adoption in Rhode Island, which developed a set of recommendations for accelerating the adoption of advanced VBP models in April 2022. The committee stated that the FFS payment model incentivizes providing more, rather than higher quality, healthcare services.[11]

Benefits and Limitations of Rhode Island's APM[12][13]	
Benefits	***Limitations***
• State's affordability standards were associated with lower inpatient and outpatient quarterly FFS spending and higher total quarterly non-fee-for-service spending. • Number of Rhode Island primary care physicians per capita increased.	• More than 45% of commercial medical payments are made through an APM, and Medicaid and MA have made similar advances. • Contracts to date significantly emphasized gainsharing. • Approximately 95% of APM payments are based on FFS reimbursement.

Maryland[14]

Maryland's total cost of care (TCOC) model covers the full continuum of care, building on the previous Maryland all-payer model (MDAPM). The MDAPM was in place from 2014 to 2018 and created hospital all-payer global budgets for Maryland hospitals to limit the growth of total hospital spending per Maryland

[10] Murray R, Delbanco SF, King JS. How Can State Legislation Promote Value in Health Care? Three Innovative Models. Health Affairs Forefront. January 6, 2021. doi: 10.1377/hblog20201222.609656

[11] Office of the Health Insurance Commissioner. RI Health Care Cost Trends Steering Committee, RI Advanced VBP Compact 2022. Available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-04/RI%20Advanced%20VBP%20Compact%202022%2004-20%20FINAL%20%2B%20Signed.pdf. Accessed February 1, 2024.

[12] Baum A, Song Z, Landon BE, Phillips RS, Bitton A, Basu S. Health Care Spending Slowed after Rhode Island Applied Affordability Standards to Commercial Insurers. *Health Affairs*. 2019;38(2):237-245. doi:10.1377/hlthaff.2018.05164

[13] Office of the Health Insurance Commissioner. Rhode Island Health Care Cost Trends Steering Committee. March 22, 2021. Available at:https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/2021/May/Cost-Trends/Meeting-18-Presentation.pdf. Accessed February 1, 2024.

[14] Maryland Health Care Commission. Innovative Value-Based Payment Models. January 21, 2022. Available at: https://mhcc.maryland.gov/mhcc/pages/apc/apc/documents/Innovative_Value_Based_Payment_Models_20220121.pdf. Accessed February 1, 2024.

resident and improve several hospital-focused quality measures. The TCOC model sets a per capita limit on Medicare's total cost of care in Maryland.

The MD TCOC continues to use global budgets but extends its scope past hospitals to statewide improvements in cost and quality outcomes through expanded provider incentives and support. The TCOC model has three main components.

1. Hospital global budgets: Set fixed annual revenue budgets with continuous monitoring by state and federal regulators
2. Care redesign program: Gainsharing between hospitals, hospital-based specialists, and non-hospital providers.
3. Maryland Comprehensive Primary Care Program: Financial support for primary care practitioners who provide care management for high-risk patients

The Maryland Department of Health (MDH) administers the state's Medicaid managed care program, Maryland HealthChoice Program (HealthChoice), with nine participating MCOs in the HealthChoice program.[15]

Benefits and Limitations of the Maryland TCOC Model[16]	
Benefits	***Limitations***
• Substantially reduced rates of all-cause acute care hospital admissions • Moderately reduced total Medicare FFS spending • Improved several quality-of-care measures • Reduced total cost of care spending by $365 million.	• Did not affect patients' ratings of their providers or hospitals. • Increased non-hospital spending substantially in 2021.

[15] Maryland Department of Health. Medicaid Managed Care Organization Value-Based Purchasing Final Report, CY 2020. Available at: https://health.maryland.gov/mmcp/healthchoice/Documents/CY%202020%20VBP%20Report%20Final.pdf. Accessed February 1, 2024.

[16] Rotter J, Calkins K, Stewart K, et al. *Evaluation of the Maryland Total Cost of Care Model: Quantitative-Only Report for the Model's First Three Years (2019 to 2021)*. Mathematica; 2022. https://www.cms.gov/priorities/innovation/data-and-reports/2022/md-tcoc-qor2

Prospective Payments

New York

The Capital District Physician's Health Plan (CDPHP), an independent healthcare insurer in New York State, launched the Enhanced Primary Care (EPC) program in 2008. This medical home model program provides prospective payments for primary care services. Providers also are eligible for performance-based incentives in this program.[17] The health plan has included metrics that provide financial bonuses based on provider performance.[17] CDPHP pays EPC practices on average 50 percent more than FFS practices, with the addition of a possible bonus.

The EPC is designed to deliver on two main goals:[18]

- Practice improvement
    - Ensure members establish and maintain an ongoing relationship with a primary care provider (PCP)
    - Provide members with integrated and comprehensive patient-centered healthcare in a timely and efficient manner
    - Reduce patient churn and allow PCPs to spend more time with higher needs patients
- Payment Reform
    - Replace FFS payments for attributed patients with a value-driven model derived from the PCP's influence on all care
    - Use a risk-based global payment model that could increase PCP compensation by as much as 25 percent over traditional FFS
    - Include performance-based bonuses on achieving targeted quality metrics, increasing potential compensation up to 40 percent over FFS

The EPC Pilot included 12,000 CDPHP member-patients. Each practice in the pilot went through a 12-month transformation program. After the 12-month transformation program, practices received prospective risk-adjusted global payments "in lieu of FFS for attributed member-patients."[18]

The global payment model plus the financial bonus prospectively compensates PCPs based on each patient's level of primary care needs, which allows primary care practices to transform without risking a

[17] Taylor E, Bailit M, Sayles J, Milbank Memorial Fund. *Prospective Payment for Primary Care: Lessons for Future Models*.; 2020. https://www.milbank.org/wp-content/uploads/2020/09/LessonforFutureModels_Bailit_v4.pdf

[18] Pickreign J, Ryan S, Wood E. Enhanced Primary Care Practice and Payment Reform Year Four Program Review. Available at: https://academyhealth.confex.com/academyhealth/2017arm/mediafile/Presentation/Paper18451/Academy%20Health%202017%20%28Pickreign%29%20Final.pdf. Accessed February 15, 2024.

losses in revenue and enables members to receive more efficient and effective care at a lower cost.[18] Providers can earn a bonus of up to $5.32 per member per month by meeting TCOC, HEDIS, and CAHPS measures.[19] Under the EPC payment model, primary care physicians receive a 23 percent increase in reimbursement for codes covered under the capitation arrangement. Practices, however, continue to be paid under a FFS model for services that fall outside the capitation code list. Combined with the 20 percent bonus payments, practices can earn up to 40 percent more under the EPC model than under FFS.[19]

An internal evaluation of the EPC program of 2012−2015 found that the program reduced costs by $19.6 million and that PCPs spent more time with at-risk members. Increased engagement with PCPs was attributed to reduced utilization of resources, including lab, radiology, and prescription services.[20] EPC sites also showed significant improvements in quality measures. Quality scores rose to 77 percent in 2014 from 71 percent in 2010 at EPC sites compared with non-EPC sites, which rose to 68 percent from 64 percent.[20]

Washington

The Washington State Legislature appropriated funding in 2019 to calculate the state's primary care expenditures.[21] Washington is now working to implement a multi-payer primary care VBP model that uses prospective Comprehensive Primary Care Payment to cover myriad services.[22] The model aims to align payment and quality measures across health plans, including Medicaid, public employee, and school employee health plans.[21]

The proposed Washinton Multi-Payer Primary Care Transformation Model includes:[23]

- Comprehensive primary care payment: Fixed PMPM payment for comprehensive primary care services replaces FFS payment
    - Covers physical and behavioral health services such as preventive, acute, and chronic care and care coordination
- Transformation of care fee: Supports primary care transformation.

[19] Alliance of Community Health Plans. Strengthening Primary Care for Patients: Capital District Physicians' Health Plan, Inc. 2013. Available at: https://achp.org/wp-content/uploads/CDPHP-ACHP-Strengthening-Primary-Care-Profile.pdf. Accessed January 18, 2024.
[20] Capital District Physician's Health Plan. CDPHP Enhanced Primary Care (EPC) Initiative. Available at: https://www.cdphp.com/~/media/files/providers/epc/enhanced-primary-care-summary.pdf. Accessed January 18, 2024.
[21] Center for Health Care Strategies. Paying for and Investing in Primary Care in Medicaid: Spotlight on Washington State. Available at: https://www.chcs.org/paying-for-and-investing-in-primary-care-in-medicaid-spotlight-on-washington-state/. Accessed January 18, 2024.
[22] Center for Health Care Strategies. Using Prospective Payment to Support Advanced Primary Care: Opportunities for States. Available at: https://www.chcs.org/using-prospective-payment-to-support-advanced-primary-care-opportunities-for-states/. Accessed January 18, 2024.
[23] Washington State Health Care Authority. Memorandum Of Understanding Among Washington State Health Plans In Support Of Multi-Payer Collaborative Primary Care Reform Work. Available at: https://www.hca.wa.gov/assets/WA-HCA-primary-care-transformation-MOU.pdf. Accessed January 18, 2024.

  - It is aimed at improving care coordination, integration with behavioral health, and care access (e.g., home visits and telehealth)
  - This fee is provided for up to three years based on practices' transformation progress, then transition to Performance Incentive Payment

- Performance Incentive Payment: incentive based on performance on quality and utilization metrics.
  - Incentive payment is prospectively made every quarter according to a tiered PMPM formula based on performance [23]
  - Quality metrics used will be aligned across health plans
  - Measure domains include prevention, chronic care, and behavioral health
  - Total cost of care is tracked but is not yet tied to payment

The Washington Health Care Authority (HCA) is collaborating with state payers and the primary care provider community to develop and implement the new primary care model for the state. HCA and eight other payers signed a memorandum expressing their commitment to implementing the model.[23] Cosigners included: Community Health Plan of WA, Amerigroup of Washington, United Healthcare, Premera Blue Cross, Kaiser Foundation Health Plan of Washington, Molina Healthcare, Regence BlueShield, Washington State Health Care Authority, and Coordinated Care.

Implementation of the model began in January 2023[24] to align payment and incentives across payers. This approach will be tied to measurable value metrics and may include a combination of transformation of care fees, comprehensive payments, and performance-based incentive payments.[24] The HCA Primary Care Measure Set Workgroup approved the following metrics for use in the Washington Common Measure Set:[24]

1. Child and adolescent well-care visit (WCV)
2. Childhood immunization status (CIS) (Combo 10)
3. Breast cancer screening (BCS)
4. Cervical cancer screening (CCS)
5. Colorectal cancer screening (COL)
6. Depression screening and follow up for adolescents and adults (DSF-E)
7. Controlling high blood pressure (CBP)

[24] Washington State Health Care Authority. WA Multi-Payer Primary Care Transformation Model (PCTM). Available at: https://www.hca.wa.gov/assets/program/wa-pct-model-description.pdf. Accessed January 18, 2024.

8. Asthma medication ratio (AMR)

9. Comprehensive diabetes care: Hemoglobin A1c (HbA1c) poor control (>9.0%)

10. Antidepressant medication management (AMM)

11. Follow-up after ED visit for alcohol and other drug abuse of dependence (FUA)

12. Ambulatory Care: Emergency department (ED) visits per 1,000 (AMB) (Medicaid only in HEDIS, but will adapt for use across populations)

Oregon

The Oregon Health Authority's (OHA's) Primary Care Payment Reform Collaborative implemented the Primary Care Transformation Initiative in 2017 to pursue a multi-payer strategy to implement payment reform for primary care services.[17]

The goals of the initiative are:[25]

- Use value-based payment methods that are not paid on a per-claim basis
- Increase investment in primary care
- Facilitate the integration of primary care behavioral and physical healthcare

According to the Primary Care Payment Reform Collaborative's 2022 Progress Report, the model was completed in the first half of 2023, and the Collaborative will now begin supporting implementation. The VBP model for primary puts prospective, capitated payments at the center of the model.

To promote health equity, the VBP model supports screening for health-related social needs (HRSNs) to develop prospective payment, equity-focused quality measures, financial incentives that stratify quality measure performances, and infrastructure payments.[25]

Maryland

In 2019, Maryland launched a multi-payer advanced primary care program, the Maryland Primary Care Program (MDPCP), as part of the state's TCOC All-Payer Model contracted with CMS. MDPCP aims to advance primary care through payment reform and practice support.[17]

Practices can begin on one of two model tracks:[17]

- Track 1: Practices receive Medicare FFS payments, with the expectation that they will transition to Track 2 over time.
- Track 2: Practices receive a portion of their payment prospectively each quarter, with reduced FFS payments. Over time, Track 2 practices increase the portions of payments they receive prospectively.

[25] Oregon Health Authority. Oregon's Primary Care Transformation Initiative 2022 Progress Report. Available at: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/2022-PCPRC-Report.pdf. Accessed January 18, 2024.

In Tracks 1 and 2, practices can receive operational and administrative support and performance-based incentive payments. Track 1 will sunset on December 31, 2023, and the new Track 3 will begin on January 1, 2024. Track 3 increases the TCOC accountability of participating primary care practices by introducing upside and downside risk.[26]

CMS paid each participating practice an average of $163,751 in 2019 to support their transformation efforts, increasing the practice's total revenue by approximately 9 percent.[27] At that time, practices self-reported that they had made progress in the following:

- Extending hours of availability, follow-up rates after hospital discharge
- Expanded care management services to high-risk patients
- Connecting patients with behavioral health supports[27]

In 2021, 524 primary care practices participated in MCPCP.[28]

Quality Programs

Mississippi[29]

Mississippi TrueCare is a not-for-profit Mississippi health maintenance organization. Formed by a coalition of Mississippi's most well-established hospitals and health systems, it serves as the state's only provider-sponsored plan. In 2022, TrueCare received notification that it would be awarded a contract to provide services for the statewide administration of the Mississippi Division of Medicaid Coordinated Care Organization Program. The following proposed programs in this section are outlined in their request for quotation.

TrueCare's Medicaid innovations focus on improving health outcomes, equity, access to care, member engagement, and collaboration with community-based organizations. The Patient-Centered Medical Home program offers financial support through prospective PMPM to cover practice transformation costs. The transformation fund can be used for investments in data-sharing capabilities.

The value-based program offers provider incentives for a variety of quality measures that align with the division's continuous quality improvement goals. Expenses for healthcare quality improvement and healthcare IT are tracked and reported. A survey of the functional areas would be conducted yearly to confirm activities meet the healthcare quality improvement (QI) definitions. Examples of QI activities

[26] Centers for Medicare & Medicaid Services. Maryland Total Cost of Care Model. Available at: https://www.cms.gov/priorities/innovation/innovation-models/md-tccm. Accessed February 1, 2024.
[27] Machta R, Peterson G, Rotter J, et al. Evaluation of the Maryland Total Cost of Care Model: Implementation Report. Mathematica. July 2021. Available at: https://www.mathematica.org/publications/evaluation-of-the-maryland-total-cost-of-care-model-implementation-report. Accessed February 10, 2024.
[28] Centers for Medicare & Medicaid Services. Maryland Total Cost of Care (MD TCOC): Model Evaluation of the First Three Model Years (2019-2021). Available at: https://www.cms.gov/priorities/innovation/data-and-reports/2022/md-tcoc-qor2-aag. Accessed January 5, 2024.
[29] TrueCare. 4.1 Transmittal Letter to Mississippi Division of Medicaid. March 4, 2022. Available at: https://medicaid.ms.gov/wp-content/uploads/2022/08/TrueCare-RFQ-20211210-REDACTED-COPY-03042022.pdf. Accessed January 5, 2024.

include chronic disease management, patient-centered education, and personalized post-discharge counseling.

An evaluation of this program has yet to be conducted.

Rhode Island[30]

The Neighborhood Health Plan of Rhode Island QI Program targets clinical quality of care, member and provider experience, and internal operations to ensure that members have access to high-quality healthcare services. This QI program covers all Neighborhood product lines (Medicaid, Exchange, and Medicare-Medicaid Plan) and offers incentives to providers that achieve improved quality of care.

Neighborhood monitors various performance measures for clinical care and service delivery. The program uses the following sources to guide and inform quality improvement efforts: HEDIS, CAHPS, Qualified Health Plan Enrollee Experience Survey (QHPES), and Medicare Health Outcomes Survey (HOS) results, program evaluations, member and provider experience surveys, claims, utilization data, case management data, and medical records, as well as patient safety data, accessibility, and availability surveys, focus groups, and other data sources. Neighborhood's QI committee, subcommittees, and QI workgroups identify quality improvement areas based on analysis of the data source used.

QI activities include developing and maintaining clinical practice guidelines, disease management and wellness, patient and provider satisfaction surveys, and QI projects.

Minnesota[31]

Minnesota was awarded the State Innovation Model (SIM) testing grant in 2013 from the Center for Medicare and Medicaid Innovation (now known as the CMS Innovation Center). Minnesota used the funds to develop the Minnesota Accountable Health Mode, which is designed to improve patient experience, improve population health, and reduce healthcare costs. The primary drivers of the model include:

- Expansion of e-health
- Improved data analytics across the state's Medicaid accountable care organizations (ACOs)
- Practice transformation to achieve interdisciplinary, integrated care
- Implementation of accountable communities for health
- Alignment of ACO components across payer performance measurements

Minnesota used SIM funding to support the exchange of health information to improve care coordination and quality by providing activities, such as providing education and technical assistance to healthcare professionals on privacy, security, and consent management practices. The SIM funding also supported

[30] Neighborhood Health Plan of Rhode Island. 2023 Quality Improvement Program Description. Available at: https://www.nhpri.org/wp-content/uploads/2023/08/2023-Quality-Improvement-Program-Description-Final.pdf. Accessed January 5, 2024.

[31] Minnesota Department of Human Services. Evaluation of the Minnesota Accountable Health Model. Available at: https://www.leg.mn.gov/docs/2018/other/180336.pdf. Accessed January 5, 2024.

practice transformation by coaching providers to build capacity in patient-centered care teams and hiring staff in emerging professions (community health workers, community paramedics, and dental therapists) to integrate into existing care teams.

The four-year SIM initiative ended in 2017. The model's outcomes included increased HIE vendor capacity, advancement in care coordination model development, and established and achieved clinical process goals. Although SIM funding ended, the model left Minnesota in a well-informed position to continue adding new capabilities and resources to support the state's future QI efforts.

Michigan[32]

The Blue Cross Blue Shield of Michigan (BCBSM) QI program organizes and finances top-of-the-line services to optimize member health status improvement, efficiency, accessibility, and satisfaction. The program applies to BCBSM PPO commercial and marketplace products.

The quality program includes a physician group incentive program, which allows physicians across the state to collaborate on initiatives that offer incentives based on performance improvement and program metrics. In 2021, more than 40 physician organizations participated, representing approximately 20,000 primary and specialty care physicians.

The QI program activities are designed to monitor the quality and safety to identify areas for improvement. The clinical quality committee approved the quality improvement activities. Examples of programs used include behavioral health surveys, virtual well-being programs for members, weight management, tobacco cessation, and preventive care initiatives.

National Landscape Takeaways and Limitations

The various programs we reviewed in the national scan led to valuable insights regarding existing programs and practices, allowing us to identify common themes and limitations. The scan is a key step toward informing and guiding future models aimed at moving toward value-based care and payment.

Key Takeaways

The APM models share similar categories in their measurement alignments, emphasizing areas such as chronic disease management, behavioral health integration, patient experience of care, preventive care, and patient access to care. Prospective payment models reviewed have a focus on patient-centered care. These models, characterized by PMPM for primary care services, are designed to align healthcare incentives to provide comprehensive patient-centered healthcare and patient management. The goal of incentivizing providers and practices to prioritize patient needs over volume encourages greater investments in primary care to promote better outcomes. Furthermore, they provide support for practice transformation, allowing primary care providers to adapt to the evolving needs of their patient populations.

[32] Blue Cross Blue Shield of Michigan. Quality Improvement Program Description. Available at: https://www.bcbsm.com/content/dam/public/Common/Documents/commercial-ppo-quality-improvement-program-description-2022.pdf. Accessed January 5, 2024.

Numerous programs across the three areas reviewed (APMs, prospective payments, quality programs) feature financial incentives by attaining a certain performance on measures. The incentives are designed to encourage practices and healthcare providers to improve the quality of care they deliver.

Likewise, quality improvement programs showcase similar activities, including investment in practice transformation, healthcare information technology, staffing, advanced care management, infrastructure improvements, chronic disease management, patient-centered education, care coordination, expansion of e-health, behavioral health integration, and SDOH assessments.

Limitations

Several limitations in the national scan are important to note, starting with the lack of research on CQI payments in other primary care payment models. Therefore, our national scan identified categories for CQI payments through quality improvement programs in insurance health plans and other state programs. This approach can introduce some uncertainty regarding the suitability and relevance of the identified categories. Future research should be dedicated to exploring CQI payments within various payment models.

In addition, some programs and models identified may not be directly applicable because of the lack of multiplayer involvement. Furthermore, some programs have limited evaluation or implementation guides because they are newer or the information has been made publicly available, which made it difficult to reach definitive conclusions.

Lastly, several limitations are evident in this research concerning the specific characteristics of the programs reviewed. Differences in regulatory authorities and funding mechanisms restrict the broader applicability of certain programs to different healthcare settings. The Maryland Primary Care Program, for instance, is a state-sponsored program with a longstanding global budgeting model. Maryland also has federal contractual arrangements, which places it in a unique regulatory environment and limits the generalizability of the state's findings.

Moreover, specific programs, such as the Oregon Primary Transformation initiative, are legislatively mandated, instigating specific requirements and limiting flexibility in the state's payment model.

These limitations should be considered when interpreting the implications of the research findings and their applicability to different healthcare settings or payment structures.

Standard Quality Investment

The SQI provides a prospective bundled payment for a defined set of services based on a known set of procedure codes, listed in Figure 1. These procedure codes represent some of the most common primary care services, and any codes not listed can be billed as traditional FFS claims. This set of procedure codes was recommended by the PCRC and form the basis for all future analyses.

Figure 1. SQI Procedure Codes

In developing a recommendation for the SQI PMPM, HMA relied upon historical data to project future costs of the relevant procedure codes. DHIN provided five years (2017−2022) of historical data reflecting the following:

- Utilization, including the number of visits
- Paid amounts, including those paid by the member and by insurance
- The number of members in Delaware with fully-insured commercial insurance coverage

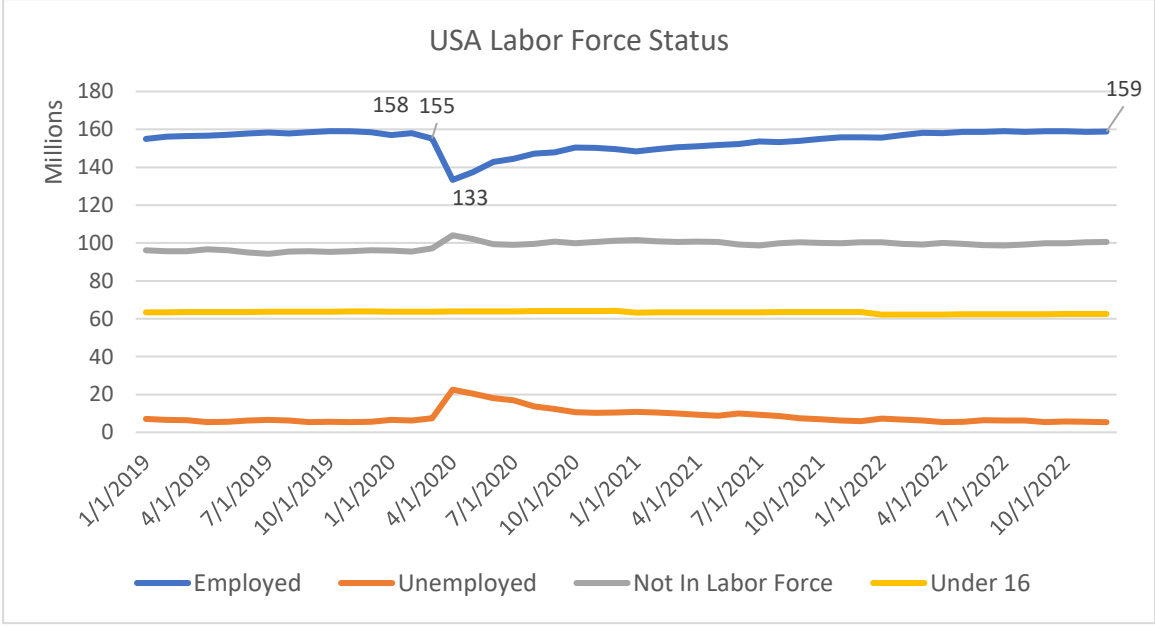
These data were used first to calculate historical PMPMs by dividing the total claims dollars for the defined procedure codes by the total number of eligible fully-insured people, and these historical PMPMs were then the basis for future PMPM projections.

An accurate reflection of historical experience is essential for the integrity of future projections. When reviewing the data provided to determine the most appropriate historical time period, HMA observed a decrease in utilization, membership, and paid claims in 2020 as a result of the COVID-19 pandemic. Consequently, 2020 historical experience was a poor candidate for developing 2025 projections, as the decreased volumes observed during that time would not be expected to continue through 2025. In some

instances, acuity adjustments to the data could be a valuable tool to compensate for the dampened utilization and member volumes; however, census data from US Bureau of Labor Statistics' Current Population Surveys (CPS) showed that in 2022, healthcare services returned to pre-pandemic levels and could be used as a base period for projections.

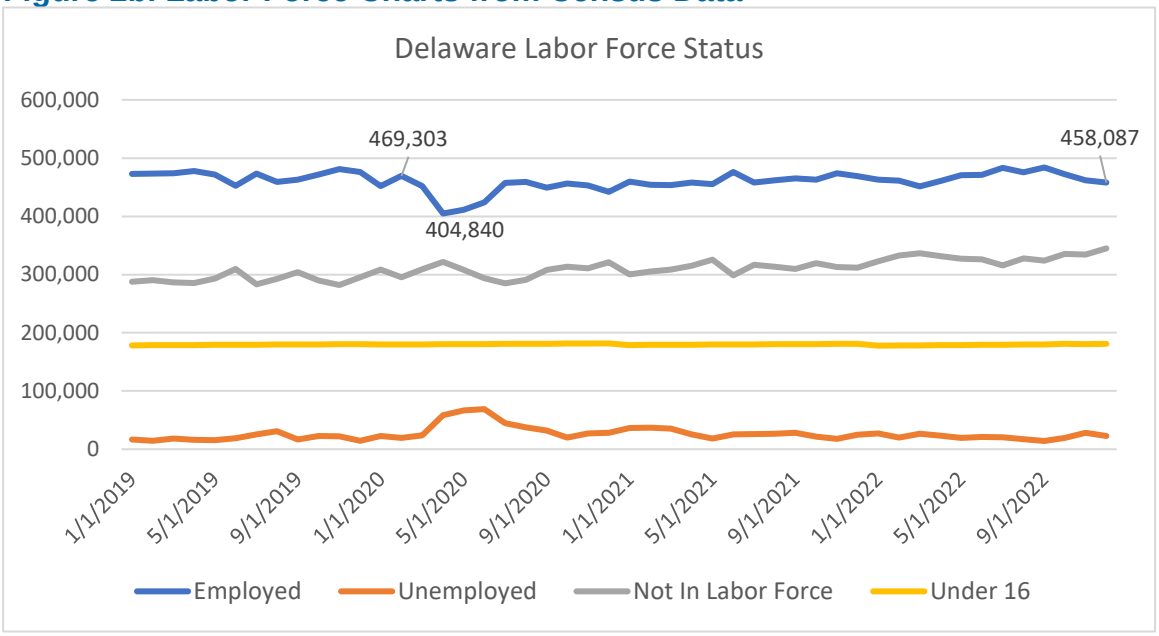
The membership volume decrease observed in 2020 was likely the result of the large job market loss in that year. In the United States, approximately 25 million jobs were lost because of the pandemic, a 16 percent decrease in the labor force, and it took more than two years to return to pre-pandemic levels (see Figure 2). In Delaware specifically, approximately 65,000 jobs (14% decrease, see Figure 2b) were lost because of the pandemic, and loss of work translated in the loss of employer-sponsored insurance for many people.

Figure 2a. Labor Force Charts from Census Data for United States



Source: CPS basic monthly reports from data.census.gov

Figure 2b. Labor Force Charts from Census Data



Source: CPS basic monthly reports from data.census.gov

Since the scope of this estimate is only for people who have fully-insured coverage through commercial plans (i.e., excluding self-funded and state employees' insurance), HMA expected to see significantly fewer lives reported in the DHIN data than the amount of employed lives shown in the census data. The table below summarizes the membership-related data provided by DHIN and confirms HMA's expectation.

Table 1. Count of Fully-insured Lives from DHIN

Eligibility Year	Amount of Fully Insured Lives
2017	142,221
2018	144,513
2019	140,360
2020	131,541
2021	134,365
2022	146,938
Source: DHIN data request on 10/25/2023	

HMA deemed DHIN's membership data to be reasonable based on the census data and because not all workers have fully-insured coverage through commercial insurance plans.

Census data served as a benchmark for the DHIN data's membership volumes, but a similar reasonableness check was infeasible for the utilization and claims volume portions of the DHIN data. Ideally, detailed claims data for the number of visits and paid amounts for each relevant procedure code

would serve this purpose, but these data are unavailable. Nonetheless, the number of visits (i.e., utilization) and paid claims cost information provided in DHIN's data aligned with the membership patterns previously described, allowing HMA to deem that portion of the data as acceptable for use in this report.

Though these high-level checks allowed HMA to proceed with analyses, it was impossible to conduct a thorough audit, and HMA relied on the underlying DHIN data as appropriate and accurate.

As previously mentioned, the number of eligible people with fully insured coverage serves as the denominator in the SQI PMPM calculation. The distinction between utilizing members and eligible members is essential to properly compute the SQI because it could affect the integrity of the denominator. Historical claims represent members who *utilized* services, but *eligible* members represent the SQI target population. Therefore, to accurately develop the SQI PMPM, the historical claims data (i.e., the numerator) must be divided by the entire population of eligible individuals with fully insured coverage, regardless of whether they actually used any services. This key difference is illustrated in the gray section of **Table 2** below, where the number of visits is less than the number of eligible members. The number of visits reflects a subset of the eligible membership—utilizing membership.

The rows in white show the historical number of fully insured lives, paid dollars for SQI procedure codes, and the resulting historical and trended PMPM. Trend assumptions were blended from a sample of historical trends provided to HMA from the OVBHCD.

Table 2. Historical and Projected SQI Calculations

SQI Calculation	Historical						Projected	
	2017	2018	2019	2020	2021	2022	2024	2025
# of Visits	99,734	106,453	123,802	97,846	105,338	121,774		
# of Fully Insured Lives	142,221	144,513	140,360	131,541	134,365	146,938	149,000	151,000
SQI Proc Codes Paid $	$5,511,236	$6,204,045	$8,071,708	$6,776,397	$8,593,733	$10,234,187	$11,954,131	$13,568,339
Trend							12%	12%
SQI PMPM	$3.69	$4.09	$5.48	$4.91	$6.09	$6.63	$9.32	$10.44

As the calculation above shows, the projected SQI amount is approximately $10 PMPM; however, HMA's recommendation for the SQI PMPM is $10–$30 PMPM. This difference is because of the nature of attribution logic and panel size. In order to recommend a framework that could work for a variety of providers and health plans, attribution and panel size must be incorporated.

Many fully-insured health plans require members to have one primary care doctor to promote consistent, efficient, and cost-effective healthcare, although transitions to new or other primary care doctors still occur. A system in which providers are reimbursed with a prospective PMPM amount for services rendered need a consistent mechanism for appropriately paying providers for the member care. This mechanism could also account for member transitions between different primary care doctors, ensuring providers are reimbursed for each member served in a reasonable manner. For example, if a member visits one primary care doctor in March and a different one in June, a consistent and defined approach should be taken to decide how and when each of the two primary care practitioners can receive reimbursement.

This mechanism for assigning members to their corresponding providers is called attribution. There are many different forms of attribution logic, and each has its own benefits and obstacles. HMA recognizes the impracticality of a "perfect" attribution approach and does not recommend any particular attribution logic. More generally, however, the strictness of a chosen attribution approach will affect where a provider's PMPM reimbursement may fall within HMA's recommended $10–$30 range. If a stronger, stricter attribution approach were applied, all primary care services for a member would likely be attributed to a single provider, and the entirety of the SQI PMPM would be paid to that sole provider. The reimbursement amount would then fall on the higher end of the $10–$30 range, approximately $30 PMPM. Conversely, a limited attribution approach would allow the flexibility for a member to receive primary care services from more than one provider, and the claims payments for each member would be allocated to each provider. As a result, each provider's monthly reimbursement would reflect a share of the SQI PMPM and would fall on the lower end of the $10–$30 range. It should be noted that smaller-scale practices could be more strongly affected by a chosen attribution approach because of sample size limitations. HMA recommends that instances of smaller panel size be given more consideration and be evaluated based on specific population and contract details.

The recommended framework for SQI does not vary the PMPM amount based on age, gender, geography, or member acuity. The PCRC could consider incorporating these factors at a later date to improve the accuracy of future PMPM estimates and provider payments. HMA explored these ideas in our recommendations; however, DHCC and the PCRC decided to keep the SQI PMPM structure simple in the initial years to promote implementation and comprehension. Stratifying the SQI PMPM this way would require more granular data and analysis, and the additional detail involved in such an exercise would complicate business operations and implementation.

Continual Quality Investment

The CQI is intended for building out the primary care infrastructure to advance and empower providers to succeed in a value-based framework. Like the SQI, the CQI is expected to be paid to providers prospectively; unlike the SQI, however, it is not tied to a set of procedure codes, but rather is an additional payment to providers on top of the SQI. Practices can allocate CQI dollars toward several uses, which are broadly defined as including the categories and examples in Figure 3a and 3b.

Figure 3a. Potential Purposes and Integration of CQI Programs

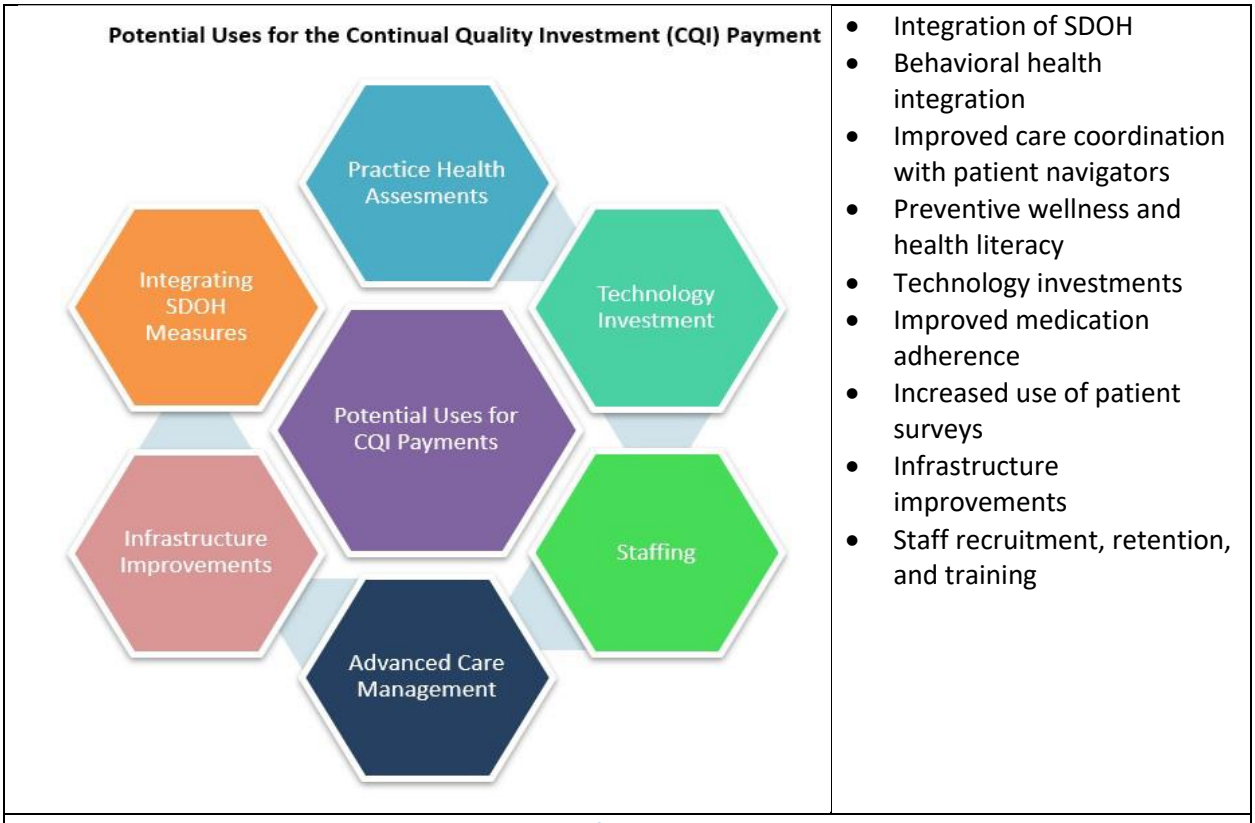
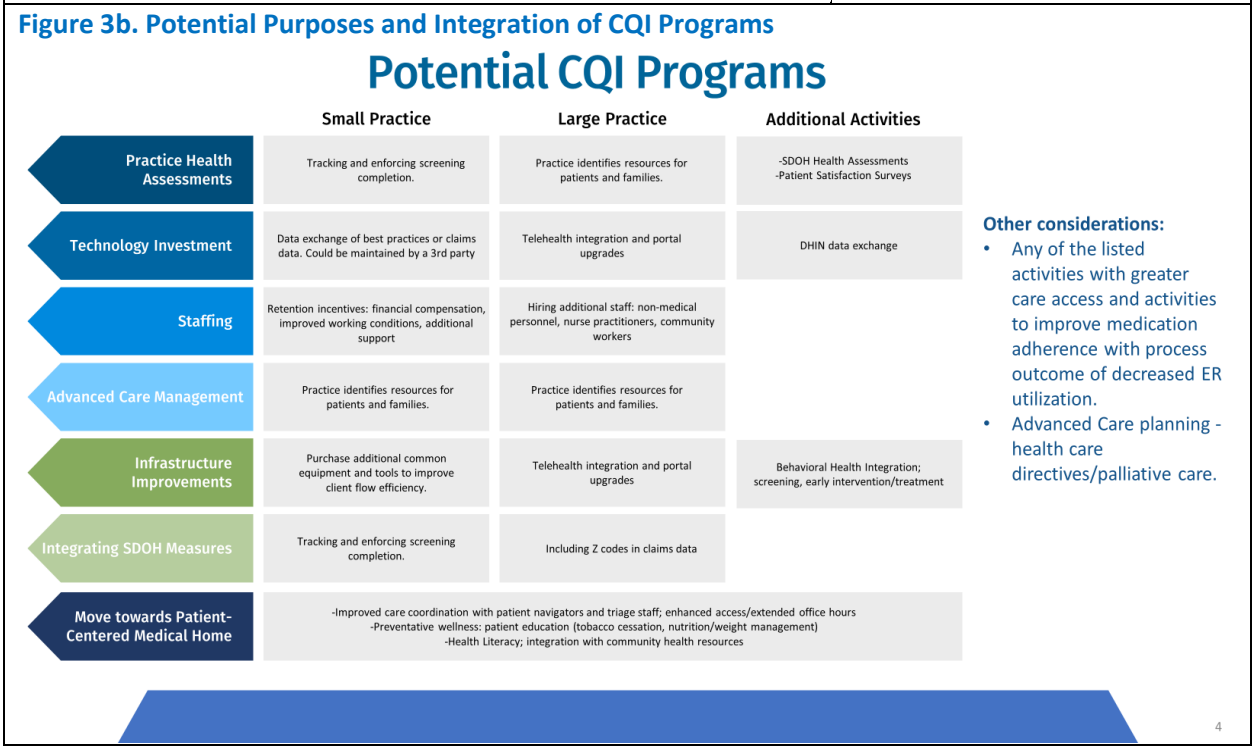


Figure 3b. Potential Purposes and Integration of CQI Programs



HMA's recommendation for the CQI PMPM is a range dependent on panel size, the degree to which practices' value-based care efforts are satisfactory, and the expected annual amount of the total cost of care. Another important aspect of the Delaware Enhanced Primary Care Model is a provision in SB 120 that by 2025, 11.5 percent of total healthcare spending must be allocated to primary care. Depending on the estimated total cost of care, the CQI can be leveraged to close gaps between estimated primary care spending and the requirement for 11.5 percent of the total cost of care. Due to the variety of CQI uses and provider mix, the CQI prospective payment should be evaluated based on need and available provider information.

The panel size of a practice is a driver of the CQI amount because of the broad description of allowable uses of CQI funds and the diversity in practice size and infrastructure in Delaware. For example, a smaller practice struggling with staff acquisition and retention might use CQI funding to make infrastructure or equipment improvements or recruit, retain, and train staff. On the other hand, a larger practice struggling with proper management of a large patient population might use the CQI funding to improve care coordination or make technology investments. In general, practices already using advanced value-based care techniques will have less of a need for the CQI funding, as it is intended, than practices earlier on in progression towards upholding a successful value-based framework.

In addition to affecting the computation of the CQI PMPM payment amount, compliance and monitoring standards are essential for successful implementation of the recommended framework. The broad guidance for allowable CQI uses, in conjunction with the anticipated variance in use of CQI funds by different practices, warrants a defined system for documenting, tracking, and approving the use of CQI funds in each practice to minimize fraud and abuse. This system could include a requirement for regular reporting of CQI fund use by practices, as well as a requirement of attestation from practices that CQI funds have been spent for their allowed purposes.

Recommendations

HMA recommends the following considerations and implementations for the Delaware Enhanced Primary Care Model.

- Potential CQI program categories should include practice health assessments, technology investments, staffing, advanced care management, infrastructure improvements, integration of SDOH measures, movement toward the patient-centered medical home.
- Prospective payments incentivize providers and practices to prioritize patient needs over volume encouraging greater investments in primary care to promote greater outcomes.
- The 2025 SQI PMPM should be $10−$30 based on panel size and attribution adherence.
- The 2025 CQI PMPM should be based on panel size, development of value-based care, and the estimated percentage of primary care spending out of the total cost of care.
- Keeping the SQI and CQI PMPMs in the beginning of the program sample aims to promote adoption, but in future years varying the PMPMs by age, gender, geography, or member acuity could improve accuracy.

- A system to track and report uses of CQI should be developed to ensure proper spending.

Conclusions

As reflected in the scan of the national landscape, CQI, and SQI, Delaware has an opportunity to create a system that assures people that they will receive high-quality and cost-efficient care. The development of the CQI and SQI payments in the primary care environment enhances access to quality care and promotes sustainable care delivery. The promotion of patient well-being supports not only patients, but also healthcare providers, staffing, and infrastructure. This framework models advancements in value-based care, increases primary care investments, decreases administrative burden, and promotes practice transformation.