HMA

HEALTH MANAGEMENT ASSOCIATES

Delaware Primary Care Reform Collaborative:

Final Report - DRAFT

PRESENTED TO

DELAWARE HEALTH CARE COMMISSION

FEBRUARY 8, 2024

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

[Background]

In 2021, Delaware passed legislation for Senate Bill 120 (SB120) with the goal of continuing to strengthen the primary healthcare 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 healthcare costs while increasing the availability of high quality and cost-efficient care. The PCRC and OVBHCD have been working with Health Management Associates (HMA) to address some of the goals of SB120, particularly the considerations for and development of two types of prospective payments to providers: the standard quality investment (SQI) and the continual quality investment (SQI) payments.

[National Landscape]

To help inform and guide key elements of prospective payments for the Delaware Enhanced Primary Care Model, HMA conducted a comprehensive environmental scan that identified up-to-date research for primary care spending methodologies and payment models in other states. The analysis offers valuable insight into the dynamic landscape in the primary care sector around quality metrics, alternative payment models (APMs), prospective payments, and examples of quality improvement programs. It also provides an understanding of the present status of primary care, serving as a foundation for informing recommendations, limitations, and best practices related to CQI programs and payment methodologies.

The environmental scan examined APM models in four states: Colorado, Oregon, Rhode Island, and Maryland. In addition, HMA researched prospective payments and quality improvement program models in New York, Washington, Oregon, Maryland, Mississippi, Rhode Island, Minnesota, and Michigan. The programs identified were models or programs developed by the state or various insurance programs, and this research informed the main categories recommended for uses of 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 of the procedure code set will be billed and paid as traditional fee-for-service (FFS) claims. The prospective nature of this payment to providers requires an estimate informed by historical utilization of these defined services. HMA worked with the Delaware Health Information Network (DHIN) to receive historical claims data for primary care services used to estimate a per-member-per-month (PMPM) prospective payment.

The PMPM estimate significantly depends on the chosen attribution logic and panel size (i.e., the number of providers and the number of attributed patients), both of which have been topics discussed at previous PCRC meetings. The SQI PMPM should fall between $10 and $30 PMPM. In a case of strong attribution logic, all primary care services would be performed by a single provider, and the SQI paid to a provider would be on at higher end of the $10-$30 range, around $30 PMPM. On the other hand, with limited attribution, primary services would likely be performed by more than one provider; this means the same

volume of SQI dollars must be allocated to multiple providers, and the prospective SQI PMPM could be on at the lower end of the $10-$30 range, about $10. Due to sample size limitations, instances of smaller panels require more detailed consideration and must be evaluated based on population and contract details.

[Continual Quality Investment]

Whereas SQI payments are tied to a known set of services and corresponding procedure codes, CQI payments are more generally defined as being used for advancing practices' value-based care. Practices can allocate CQI dollars towards several uses, including but not limited to:

- 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; and
- Recruiting, retaining, and training staff.

A mechanism for practices to track and report CQI spend 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 should be reviewed to avoid fraud and abuse. Practices will attest that CQI funds have been used appropriately to initiate or enhance value-based care.

[Conclusion]

An important aspect of this primary care transformation initiative in Delaware is a statement in SB120 that by 2025, 11.5% of total healthcare spending must be utilized on primary care. The new SQI and CQI PMPMs must carefully be balanced with traditional payments like FFS, care management, and other risk settlements such that the 11.5% threshold can be reached. The CQI PMPM used for advancing practices' value-based care must also be reviewed, as the prospective SQI PMPM will vary by attribution and panel size. For example, if a practice were to have a relatively lower SQI PMPM, this may present an opportunity for growing value-based care, and this practice should receive a higher CQI PMPM. Conversely, practices already possessing strong attribution and value-based care should receive a higher SQI PMPM and a lower CQI PMPM. This approach should produce PMPM amounts that allocate payments tailored to be most effective and efficient on a practice level and should also achieve the 11.5% threshold.