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GREEN MOUNTAIN CARE BOARD

Determining Primary Care Spend in Vermont

Act 17 of 2019

February 27, 2020

Overview of Charge

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- Identify categories of health care providers and services
- Categories of non-claims payments that are considered primary care
- Total non-claims payments considered health care spending
- Ways in which identified provider types and codes are the same as, or differ from, existing definitions

Process

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Existing Documentation Reviewed

- SIM Working Group
- Universal Primary Care Report
- Medicaid Definition
- GMCB's Total Cost of Care Definition
- Rhode Island Definition and Spend
- Milbank Memorial Fund Report

Stakeholders

- GMCB
- DVHA
- BCBSVT, MVP, Cigna
- VMS
- Vermont Care Partners
- VAHHS
- OneCare
- Bi-State
- Health Care Advocate

4 Meetings

- August 15, 2019
- August 29, 2019
- September 12, 2019
- September 26, 2019

What's In?

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Provider Types (Taxonomies)

- Family practice
- Internal medicine
- Internal medicine (geriatrics)
- Pediatrics
- General practice
- Nurse Practitioner
- Physician Assistant
- Naturopath
- OB/Gyn

Procedure Codes (CPT)

- Office visits
- Encounter payments
- Preventive visits
- Vaccine administration
- Care management
- Chronic care management
- OB/Gyn care
- Nursing facility
- Domiciliary/rest home/custodial care
- Prolonged services
- Mental Health & Substance Use Disorder

What's Different in this Definition* …

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For by and large, the definition is the same but with a few notable differences to inform future definition development including:

- Determining the spend associated with the OB-Gyn (provider type and procedure code);
- Determining the spend associated primary care mental health and substance use disorder spend based on procedure codes for existing provider types.

*From the Green Mountain Care Board existing total cost of care (TCOC) definition

Limitations

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- Nature of data available in VHCURES;
- Interpretation of claims-based and non-claims-based data;
- Difficulty in separating primary care vs. other spending in non-claims-based expenditures;
- Impact of health care reform – prospective payments & the impact on claims analysis;
- Working definition – expect revisions to the definition as this Report is reviewed.

Claims-Based Build Up

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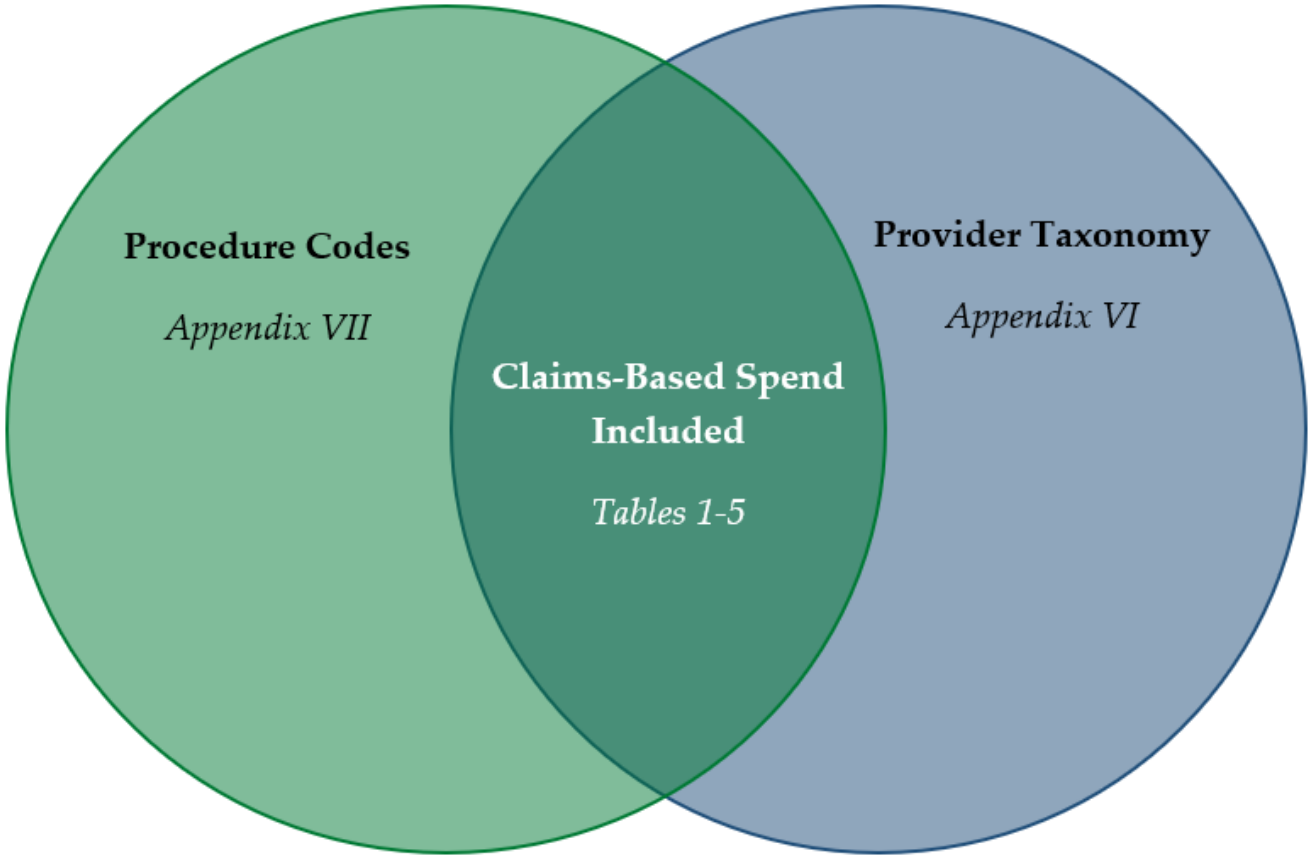

Results – Claims-based Build up

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Table 1: Primary Care Claims-Based Spending by Payer

PRIMARY CARE ALL VHCURES – CLAIMS-BASED ONLY	COMMERCIAL	MEDICAID	MEDICARE [15]	TOTAL
2018				
PRIMARY CARE COSTS	$59,030,340.85	$45,310,641.10	$52,500,234.99	**$156,841,216.94**
PRIMARY CARE COSTS PMPY	$291.59	$337.32	$430.08	**$341.82**
PRIMARY CARE COSTS PERCENT OF TOTAL	5.4%	12.3%	4.4%	**5.9%**

Table 2: OB/GYN Claims-Based Spending by Payer

OB/GYN ALL VHCURES – CLAIMS-BASED ONLY	COMMERCIAL	MEDICAID	MEDICARE	TOTAL
2018				
PRIMARY CARE COSTS[16]	$2,722,484.38	$445,597.38	$573,443.13	**$3,741,524.89**
PRIMARY CARE COSTS PMPY	$13.45	$3.32	$4.70	**$8.15**
PRIMARY CARE COSTS PERCENT OF TOTAL	0.2%	0.1%	0.0%	**0.1%**

Table 3: Mental Health and Substance Use Disorder Claims-Based Spending by Payer

MENTAL HEALTH AND SUBSTANCE USE DISORDER ALL VHCURES – CLAIMS-BASED ONLY	COMMERCIAL	MEDICAID	MEDICARE	TOTAL
2018				
PRIMARY CARE COSTS	$26,885,552.86	$36,070,371.47	$13,368,196.57	**$76,324,120.90**
PRIMARY CARE COSTS PMPY	$132.80	$268.53	$109.51	**$166.34**
PRIMARY CARE COSTS PERCENT OF TOTAL	2.5%	9.8%	1.1%	**2.9%**

Reported Spending Results – Claims-Based Only

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PRIMARY CARE, OB/GYN, MENTAL HEALTH AND SUBSTANCE USE DISORDER TOTAL All VHCURES – CLAIMS-BASED ONLY	Commercial	Medicaid	Medicare	Total
2018				
Primary Care Costs	$88,638,378.09	$81,826,609.95	$66,441,874.69	**$236,906,862.73**
Primary Care Costs PMPY	$437.84	$609.17	$544.30	**$516.32**
Primary Care Costs Percent of Total	8.1%	22.3%	5.5%	**8.9%**

Non-Claims Build Up

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What's In?

- Commercial: CHT and PCMH Payments
- Medicaid: CHT, PCMH, WHI & 80% of Spoke Payments
- Medicare: CHT, PCMH and SASH

What's Out?

- Capacity payments to Designated Agencies ($16,183,090)
- Medicaid Prospective Payments ($69,941,022)

Reported Spending Results

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COMBINED SPEND CLAIMS & NON-CLAIMS	Commercial	Medicaid	Medicare	Total
2018				
Primary Care Claims Costs (A) – from table 4	$88,638,378.09	$81,826,609.95	$66,441,874.69	**$236,906,862.73**
Primary Care Non-Claims Costs (B)	$15,696,378.00[15]	$12,170,605.09[16]	$7,776,760.00[17]	**$34,734,647.09**
Statewide Claims-Based TCOC (C)	$1,124,513,841.06	$374,502,572.49	$1,129,993,016.00	**$2,629,009,429.55**
Statewide Non-Claims-Based Costs (D)	$14,787,281.00[18]	$13,111,840.13	$13,345,337.00	**$42,153,555.13**
Primary Care Costs Percent of TCOC (A+B/C+D)	9.2%	24.3%	6.5%	**10.2%**

Board's Relevant Regulatory Responsibilities

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- ACO Regulation & Rule 5.000
  - Payer contract review
  - Population health program review
  - Pilot program review (i.e. CPR pilot for independent primary care practices)
- QHP Rates
  - Minimal impact (~70,000 lives)
- Rate Setting Authority
  - Existing; has not been exercised – not funded or staffed

Key Takeaways

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- The stakeholder working group achieved consensus for a definition of primary care that met participant's expectations and conveyed broad understanding, and was in alignment with the Milbank Memorial Fund report;
- Use of that definition resulted in a calculation of Total Primary Care Spend (Claims-based and Non-Claims-based) of 10.2% for primary care in 2018 but percentages both differed by payer and were calculated with data limitations necessary for consideration prior to any conclusions being developed;
- Claims-based primary care spend was 8.9% in 2018 but percentages both differed by payer and were calculated with data limitations necessary for consideration prior to any conclusions being developed;
- Approximately $86 million in prospective capitated payments for primary care and acute services are not included due to data limitations that do not allow the authors to quantify the proportion of primary care spending with sufficient accuracy at this time but form a key component for future analysis;
- A consistent methodology for reporting and analyzing "would have paid" or "shadow" claims across providers and payers is needed to more precisely determine the proportion of health care spending allocated to primary care; and
- Increasing primary care spending could be accomplished through modifications to a fee-for-service system, through payment reform, or a combination of the two