DELAWARE PRIMARY CARE REIMBURSEMENT:

Evaluating Parity with Medicare Rates

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OFFICE OF VALUE-BASED
HEALTH CARE DELIVERY

The Problem

Primary care spending in Delaware is low relative to the national average and about half of what is spent in leading states. In 2018, in an effort to quickly increase primary care reimbursement in Delaware, the Legislature passed Senate Bill No. 227 of the 149th General Assembly (SB 227), which requires individual, group, and State employee health insurance plans to reimburse primary care physicians, certified nurse practitioners, physician assistants, and other front-line practitioners for chronic care management and primary care services at no less than the physician rate set by Medicare for the next 3 years (2019, 2020, and 2021).

As part of its enabling legislation, Senate Bill No. 116 of the 150th General Assembly, tasked the Office of Value Based Health Care Delivery (The Office) with evaluating health insurance carrier compliance with SB 227. This document provides an overview of the key findings from that analysis.

In assessing the impact of SB 227, it is important to note that the law only addressed the price of services. Therefore, this analysis only analyzes the prices paid to primary care providers, not total primary care reimbursement, which would include utilization (price multiplied by the number of units of service provided). This is particularly important considering primary care utilization fell precipitously in 2020 due to the COVID-19 pandemic.

Analysis

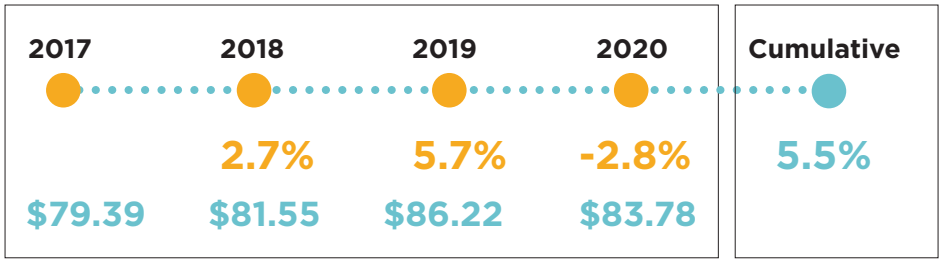
PURPOSE

- Determine whether carriers adjusted reimbursement as necessary to comply with SB 227.
- Analyze the impact of SB 227 on primary care reimbursement.
- Share aggregate results of the analysis with the public.
- Identify instances in which carriers need to further adjust reimbursement policies and procedures to achieve compliance. Share carrier-specific findings with each carrier.
- Continue to work with the carriers to complete necessary adjustments and achieve full compliance.

KEY FINDINGS

1. All carriers reported adjusting their reimbursement processes to comply with the law.
2. Most carriers instructed their claims reimbursement systems to adjust the reimbursement for primary care providers to be at least as much as the Medicare Physician Fee Schedule.
3. For most Current Procedural Terminology (CPT) codes, carriers achieved the requirement to reimburse primary care providers at no less than the physician Medicare rate for primary care services performed in 2019 and 2020.
4. The analysis was based on the 95 CPT codes defined as "primary care services" by the Primary Care Reform Collaborative (PCRC) and the Office in 2020*. These codes are listed in Appendix B. Medicare did not reimburse for **61** of these codes in 2019 and **55** of these codes in 2020, and therefore, the Office had no comparator for these codes. These codes accounted for **23%-26% spending in 2019** and **23%-26% spending in 2020***.
5. Consistent with SB 227, the Office evaluated carrier payments to all primary care providers including physicians, certified nurse practitioners and physician assistants. One carrier excluded mid-level practitioners in its implementation of SB 227 and was instructed to include these practitioners going forward. A full list of the taxonomy codes included in the analysis is provided in Appendix C. Most carriers had applied the fee schedule changes to all providers.
6. Primary care reimbursement for fully insured commercial carriers increased an estimated **5.5% from 2017 to 2020**, on a per service basis, across codes and carriers. This analysis repriced all claims using 2017 utilization to account for changes in the mix of services used each year.

Average Cost Per Service and Trends for Primary Care Services, 2017 – 2020



7. Primary care reimbursement, on a per service basis, decreased slightly across carriers from 2019 to 2020*. This decrease appears to be driven by small decreases in some carriers' fees for certain high volume primary care CPT codes including certain office visit codes. Many of these codes were among those that are not reimbursed by Medicare and therefore, they had no minimum required fee.

*Due to timing of data collection, 2020 data includes only the first, second and third quarters.

8. The Office analysis found some opportunities for the carriers to improve their processes. Each carrier has been notified in writing of any codes in which they were below the Medicare Fee Schedule. Carriers will have 60 days to achieve full compliance. More on the Office approach can be found in Appendix A.

9. Across all carriers, the potential total primary care "under reimbursement" was approximately **0.5% – 0.9%** of primary care investment in 2019. In 2020, the potential "under reimbursement" was **0.8% - 1.7%** of primary care investment*. The total amount of potential under reimbursement is estimated to be between **$130,000 - $260,000** across both years. Note this under investment only reflects commercial individual, small group and fully insured large group plans. The range is provided because one carrier noted it paid a separate facility fee for some primary care services but did not provide information on how frequently these facility fees were paid. When a facility fee is paid, Medicare pays a lower fee for the professional component of the service.

10. The Office did not request carriers provide reimbursement data by provider. Therefore, the Office did not calculate the impact on any individual provider or provider organization.

11. An initial analysis of Delaware Health Information Network (DHIN) data, in which the Office estimated a potential under reimbursement of 5% to 10% of primary care investment has proven to be high. Reasons for the discrepancy include:

    a. The populations in the initial DHIN analysis and this study were not the same. The DHIN analysis was based on Delaware residents, regardless of where they received primary care services. The data supplied by carriers for this study only included reimbursements to Delaware providers.

    b. The DHIN analysis included claims with a modifier signaling multiple services were provided in a single day. When this occurs, each service is discounted to account for the efficiencies and to reduce incentives to provide unnecessary care.

    c. The DHIN analysis included claims in which the payer was secondary and therefore, not responsible for the full reimbursement.

    d. Both analyses may have included partial reimbursements for certain services, including only the professional component of a reimbursement when a separate facility fee was also paid.

12. The Office then requested the DHIN data by carrier and clarified technical specifications to obtain a more "apples to apples" comparison.

    a. After addressing the discrepancies listed above, the potential under reimbursement fell to approximately 2.5% in 2019 and 2.9% in 2020.

    b. The DHIN team then performed a detailed analysis of the CPT codes with the greatest under reimbursement. It found most claims were paid at least the Medicare Fee Schedule but not all.

    c. In some cases, the under reimbursement appeared to be caused by confusion over changing rules around reimbursement for virtual services due to the pandemic.

    d. In other cases, it was unclear whether the under reimbursement was in error or the result of the business rules sometimes applied to the fee schedule that result in a lower payment.

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*Due to timing of data collection, 2020 data includes only the first, second and third quarters.

Looking Ahead

Increasing primary care investment in Delaware is an important policy goal and SB 227 offered primary care providers a way to immediately receive some level of increased reimbursement. However, a policy tied solely to fee-for-service reimbursement and in particular, Medicare fee-for-service reimbursement, has limitations including the following:

- Commercial health insurance carriers and Medicare cover different populations with different healthcare needs. As such, commercial and Medicare fee schedules do not cover identical services and use different codes for certain services resulting in no reimbursement threshold or comparator for **23-26%** of spend in each year.
- Without a target for total primary care reimbursement, carriers can offset reimbursement increases for some services with decreases for others.
- Business rules sometimes discount the actual reimbursement to be lower than the fee schedule. The complexity of these business rules makes it difficult for providers to know whether the lower reimbursement complies with the statute.
- Requiring increases in fee-for-service reimbursement conflicts with efforts to move primary care to more flexible reimbursement models including care management fees and primary care capitation. With more flexible reimbursement, primary care providers can expand patients' access to virtual care and to a wider range of care team members, including pharmacists, behavioral health clinicians and care coordinators.

States with the most successful approaches to improving primary care quality and access do so through policies that increase primary care investment, expand use of value-based payments for primary care and other services, and identify opportunities to reduce total cost of care. As discussed in its recent report, Delaware Health Care Affordability Standards: An Integrated Approach to Improve Access, Quality and Value, the Office will be integrating targets to achieve these goals for the fully-insured commercial market as part of its 2021 rate review process. The Office will continue to monitor carriers' compliance with Senate Bill 227 in 2022 or until the legislation sunsets. It looks forward to continuing to work with the Legislature and PCRC to strengthen this and other efforts to increase primary care investment.

Appendix A: Compliance Evaluation Methodology

DATA COLLECTION

An interrogatory was sent to each Delaware health insurer (Aetna, Cigna, Highmark, Optimum Choice, and UnitedHealthcare) in the fully insured commercial market. The interrogatory consisted of three sections. The first section requested actual allowed claims and utilization by primary care CPT code. Data was collected for 95 CPT codes for CY 2017, 2018, 2019, and 2020. These were the same 95 CPT codes that the Office and the PCRC previously used to measure primary care investment in Delaware. From these data, an average reimbursement per service was calculated for each CPT code: (Total Allowed Claims/Utilization). The second section requested the actual primary care fee schedule for the same 95 CPT codes. A minimum fee and a maximum fee were requested for each year from 2017 through 2021. The third section consisted of a notes and questions section.

METHODOLOGY FOR ANALYSIS

The examination focused on CY 2019 and CY 2020 data; however, 2017 and 2018 data were reviewed for consistency. The analysis consisted of two "tests" to understand whether an insurer complied with the statutory requirement that reimbursement rates for chronic care management and primary care services be at or above the Medicare Fee Schedule.

Test #1 "Fee Schedule Test": For each insurer, the actual fee schedule was compared to the Medicare Fee Schedule. If the minimum fee was greater than the Medicare Fee Schedule, then the fee for this CPT code would "pass." If the minimum fee was less than the Medicare Fee Schedule, then the fee for this CPT code would "fail." After reviewing responses of many of the insurers, it appears that this test is not foolproof as many insurers built in "manual overrides" in their claims processing to ensure that reimbursement would meet the state requirements.

Test #2 "Reimbursement Test": For each insurer, an average payment per service was calculated for each of the 95 CPT codes. Then this payment per service was compared to the fee reported in the applicable Medicare Fee Schedule. If the payment per service for a CPT code was greater than the fee listed in the Medicare Fee schedule, the payment for that code "passed." If the payment per service was less than the Medicare Fee schedule, then the payment for that code "failed." The shortcoming of this test is that the test analyzes averages. For those codes that passed, there may be payments within the code that failed. This test may have "false passes." However, all the fails are "true fails," i.e. if the average payment per service is lower than the Medicare Fee Schedule then there must have been payments made that were lower than the Medicare Fee Schedule. For carriers that provided facility and non-facility fee schedules, additional tests were performed. Finally, the Medicare Fee Schedule does not include fees for all 95 codes requested. In these instances, a judgement on pass or fail was not made. Many insurers responded that reimbursement was imputed using the resource-based relative value scale (RBRVS) for these codes or their standard fee schedule.

COMPLIANCE

The Office analysis found some opportunities for the carriers to improve their processes. Each carrier has been notified in writing of any codes in which they were below the Medicare Fee Schedule. Carriers will have 60 days to achieve full compliance.

Appendix B: Primary Care Codes and Medicare Fee Schedule

PROCEDURE CODE	MEDICARE SHORT DESCRIPTION	MEDICARE FEE SCHEDULE 2020	MEDICARE FEE SCHEDULE 2019
90460	Im admin 1st/only component	$14.65	$17.22
90461	Im admin each addl component	$13.18	$13.19
90471	Immunization admin	$14.65	$17.22
90472	Immunization admin each add	$13.18	$13.19
90473	Immune admin oral/nasal	$14.65	$17.22
90474	Immune admin oral/nasal addl	$13.18	$13.19
90649	Hpv Vaccine 4 Valent Im	not available	not available
90658	Flu Vaccine 3 Yrs & > Im	not available	not available
90670	Pneumococcal Vacc 13 Val Im	not available	not available
90686	Flu Vac No Prsv 4 Val 3 Yrs+	not available	not available
90688	Flu Vacc 4 Val 3 Yrs Plus Im	not available	not available
90715	Tdap Vaccine >7 Im	not available	not available
90732	Pneumococcal Vaccine	not available	not available
98966	Hc pro phone call 5-10 min	$14.61	not available
98967	Hc pro phone call 11-20 min	$28.47	not available
98968	Hc pro phone call 21-30 min	$41.60	not available
98969	Online service by hc pro	not available	not available
99201	Office/outpatient visit new	$47.28	$47.35
99202	Office/outpatient visit new	$78.36	$78.84
99203	Office/outpatient visit new	$110.89	$111.90
99204	Office/outpatient visit new	$169.30	$169.74
99205	Office/outpatient visit new	$213.86	$174.04
99211	Office/outpatient visit est	$23.85	$23.46
99212	Office/outpatient visit est	$46.91	$46.58
99213	Office/outpatient visit est	$77.23	$76.59

PROCEDURE CODE	MEDICARE SHORT DESCRIPTION	MEDICARE FEE SCHEDULE 2020	MEDICARE FEE SCHEDULE 2019
99214	Office/outpatient visit est	$111.95	$112.09
99215	Office/outpatient visit est	$150.31	$150.20
99241	Office consultation	not available	not available
99242	Office consultation	not available	not available
99243	Office consultation	not available	not available
99244	Office consultation	not available	not available
99245	Office consultation	not available	not available
99324	Domicil/r-home visit new pat	$56.20	$57.10
99325	Domicil/r-home visit new pat	$81.72	$82.70
99326	Domicil/r-home visit new pat	$142.29	$143.43
99327	Domicil/r-home visit new pat	$191.22	$192.50
99328	Domicil/r-home visit new pat	$226.26	$226.52
99334	Domicil/r-home visit est pat	$62.07	$62.22
99335	Domicil/r-home visit est pat	$98.20	$98.07
99336	Domicil/r-home visit est pat	$138.70	$139.83
99337	Domicil/r-home visit est pat	$200.00	$200.20
99339	Domicil/r-home care supervis	not available	not available
99340	Domicil/r-home care supervis	not available	not available
99341	Home visit new patient	$56.20	$57.10
99342	Home visit new patient	$80.62	$82.37
99343	Home visit new patient	$132.40	$134.33
99344	Home visit new patient	$187.95	$188.13
99345	Home visit new patient	$228.84	$228.76
99347	Home visit est patient	$56.21	$57.11
99348	Home visit est patient	$86.49	$86.76
99349	Home visit est patient	$132.50	$133.24
99350	Home visit est patient	$184.69	$184.87
99354	Prolong e&m/psyctx serv o/p	$133.61	$125.90
99355	Prolong e&m/psyctx serv o/p	$101.49	$102.49
99358	Prolong service w/o contact	$114.94	$115.31
99359	Prolong serv w/o contact add	$56.21	$55.64
99381	Init pm e/m new pat infant	not available	not available
99382	Init pm e/m new pat 1-4 yrs	not available	not available
99383	Prev visit new age 5-11	not available	not available
99384	Prev visit new age 12-17	not available	not available

PROCEDURE CODE	MEDICARE SHORT DESCRIPTION	MEDICARE FEE SCHEDULE 2020	MEDICARE FEE SCHEDULE 2019
99385	Prev visit new age 18-39	not available	not available
99386	Prev visit new age 40-64	not available	not available
99387	Init pm e/m new pat 65+ yrs	not available	not available
99391	Per pm reeval est pat infant	not available	not available
99392	Prev visit est age 1-4	not available	not available
99393	Prev visit est age 5-11	not available	not available
99394	Prev visit est age 12-17	not available	not available
99395	Prev visit est age 18-39	not available	not available
99396	Prev visit est age 40-64	not available	not available
99397	Per pm reeval est pat 65+ yr	not available	not available
99401	Preventive counseling indiv	not available	not available
99402	Preventive counseling indiv	not available	not available
99403	Preventive counseling indiv	not available	not available
99404	Preventive counseling indiv	not available	not available
99406	Behav chng smoking 3-10 min	$15.72	$15.39
99407	Behav chng smoking > 10 min	$29.95	$29.31
99408	Audit/dast 15-30 min	not available	not available
99409	Audit/dast over 30 min	not available	not available
99411	Preventive counseling group	not available	not available
99412	Preventive counseling group	not available	not available
99420	Health Risk Assessment Test	not available	not available
99429	Unlisted preventive service	not available	not available
99441	Phone e/m phys/qhp 5-10 min	$46.91	not available
99442	Phone e/m phys/qhp 11-20 min	$77.23	not available
99443	Phone E/M By Phys 21-30 Min	$111.95	not available
99444	Online e/m by phys/qhp	not available	not available
99483	Assmt & care pln pt cog imp	$268.98	$268.20
99487	Cmplx chron care w/o pt vsit	$93.79	$94.53
99489	Cmplx chron care addl 30 min	$45.42	$47.27
99490	Chron care mgmt srvc 20 min	$42.78	$42.85
99492	1st psyc collab care mgmt	$159.37	$164.92
99493	Sbsq psyc collab care mgmt	$128.14	$131.54
99494	1st/sbsq psyc collab care	$64.78	$68.13
99495	Trans care mgmt 14 day disch	$190.34	$169.22
99496	Trans care mgmt 7 day disch	$251.48	$238.84

PROCEDURE CODE	MEDICARE SHORT DESCRIPTION	MEDICARE FEE SCHEDULE 2020	MEDICARE FEE SCHEDULE 2019
G0008	Admin influenza virus vac	not available	not available
G0009	Admin pneumococcal vaccine	not available	not available
G0010	Admin hepatitis b vaccine	not available	not available
G0402	Initial preventive exam	$170.77	$171.72
G0438	Ppps, initial visit	$175.19	$177.27
G0439	Ppps, subseq visit	$118.95	$120.17
G0444	Depression screen annual	$18.70	$18.69
G0463	Hospital outpt clinic visit	not available	not available
G0467	Fqhc visit, estab pt	not available	not available
G0468	Fqhc visit, ippe or awv	not available	not available
G0502	Init psych collaborative care, first 70 minutes	not available	not available
G0503	Subseq psych collaborative care, first 60 minutes	not available	not available
G0504	Init or subseq psych collab, additional 30 minutes	not available	not available
G0505	Cognition and functional assessment	not available	not available
G0506	Comp asses care plan ccm svc	$64.38	$64.47
G0507	Care mgmt serv for behavioral health, 20 minutes	not available	not available
G0511	Ccm/bhi by rhc/fqhc 20min mo	not available	not available
S9083	Global Fee Urgent Care Centers	not available	not available
S9117	Back to School Visit	not available	not available
T1015	All inclusive clinic visits	not available	not available

Appendix C: Primary Care Provider Taxonomy

TAXONOMY CODE	DESCRIPTION
207Q00000X	Family Medicine
207QA0505X	Adult Medicine
207QG0300X	Geriatric Medicine (Family Medicine)
208D00000X	General Practice
207R00000X	Internal Medicine
207RG0300X	Geriatric Medicine (Internal Medicine)
208000000X	Pediatric Medicine
363L00000X	Nurse Practitioner
363LA2200X	Adult Health Nurse Practitioner
363LP0200X	Pediatric Nurse Practitioner
363A00000X	Physician Assistant
363AM0700X	Medical Physician Assistant
363LF0000X	Family Nurse Practitioner
363LG0600X	Gerontology Nurse Practitioner
363LP2300X	Primary Care Nurse Practitioner