Primary Care in New Jersey: Findings and Recommendations to Support Advanced Primary Care

January 2024

NEW JERSEY HEALTH CARE QUALITY INSTITUTE

Introduction

High-quality primary care is the foundation of a high-performing health system. Access to primary care is associated with lower health care spending, reduced use of emergency departments and hospitalizations, improved health equity, and better population health outcomes over time.[1,2,3] The National Academies of Sciences, Engineering, and Medicine (NASEM) report Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care defines this care as the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities. This type of primary care is also referred to as "Advanced Primary Care." It includes preventative care, the management of chronic conditions, including behavioral health conditions, and a longitudinal perspective on patient health and well-being. Despite these proven benefits, the US health care system chronically underinvests in primary care and has a growing primary care physician shortage.

Policymakers have emphasized the need to strengthen primary care as a key component of improving health care system performance. A major conclusion of the NASEM report was the need to shift towards paying for primary care teams to holistically care for people rather than paying doctors to deliver individual services.[4] The report concluded that fee-for-service (FFS) payment, with its focus on providing and receiving individual billable services, does not support team-based care because it disincentivizes the primary care team from focusing on non-billable services that may have beneficial effects on the health of individuals or a population. The report recommends a shift to hybrid primary care payment models that combine per-member per-month capitation payments with fee-for-service to provide added flexibility for interprofessional care teams to deliver coordinated, whole-person, primary care.

Project Rationale

Developing a state strategy for reforming and supporting Advanced Primary Care requires an understanding of the current primary care workforce, delivery system, payment landscape, and model design. The New Jersey Health Care Quality Institute (Quality Institute) was engaged by the New Jersey Department of Human Services to conduct a market scan of primary care, including alternative payment models ("APM") currently in use in New Jersey. The work included convening a workgroup of stakeholders and subject matter experts to inform the market scan and develop recommendations to support Advanced Primary Care in New Jersey.

Components of Advanced Primary Care

Advanced primary care is patient-centered and comprehensive. Providing such care requires sufficient resources and infrastructure to support effective care teams. In addition to primary care providers, teams may include care managers, social workers, clinical pharmacists, health coaches, behavioral health providers and community health workers. They must be able to serve patients in a variety of settings including medical offices, health care facilities, community settings, and patients' homes. They also need to provide patients with access through a variety of modalities including in person, telephonic and digital. And they need an ability to use data to manage patients' health over time. Traditional fee-for-service payment at current levels is inadequate to support the staffing and technology infrastructure needed to deliver this high-quality team-based care.

The workgroup included health insurance carriers, primary care physicians from private practices, hospital systems, academia, Federally Qualified Health Centers, behavioral health providers, and patient advocates. The Quality Institute conducted interviews and surveys to

collect details on existing payment models and measures used in New Jersey's primary care landscape. The workgroup met regularly throughout the project to consider existing models and measures, share their experiences and challenges, and discuss solutions. Given the project timeline, the workgroup focused on adult primary care in outpatient settings (family medicine, general internal medicine, geriatrics). This report summarizes the market scan key findings and offers recommendations to support and scale Advanced Primary Care in New Jersey.

New Jersey's Primary Care Physician Workforce

There is limited public data available on New Jersey's physician workforce, making it difficult to assess and track primary care physician supply over time. Based on our research, however, there is a shortage of primary care physicians (PCPs) nationwide, and New Jersey is no exception. Slightly less than one-third of practicing physicians in the US are in primary care, compared to half of physicians in the thirty-eight countries in the Organization for Economic Cooperation and Development (OECD). While primary care is also offered by advanced practice providers, such as nurse practitioners and physician assistants, the percentage of patients receiving primary care from a physician varies by state. Residents of New Jersey, compared to other states, rely more on physicians for their primary care.[5]

New Jersey physician survey data for 2023 from the NJ Division of Consumer Affairs, Board of Medical Examiners shows that New Jersey currently has approximately 5,300 primary care physicians (family medicine, general internal medicine, geriatrics) practicing in community settings. This number may be overstated, however, because the data includes physicians practicing in urgent care facilities, which are rapidly opening across the state.[6,7] Even so, the total is lower than previously published numbers on the PCP workforce, (e.g., 8,800 by AAMC or 6,500 by Robert Graham Center).[8,9] Furthermore, of these 5,300, only about half report practicing full time (defined as 32+ hours per week). Moreover, the physician demographic data is incomplete, making it difficult to know the diversity of the PCPs in New Jersey. These limited data and their uncertainties underscore the need for an improved physician survey with publicly available results.

As the state considers ways to attract and retain PCPs, having accurate, publicly available data on the current health care workforce is a crucial step in designing a health care workforce strategy. One example to emulate is the New Jersey Collaborating Center for Nursing (NJCCN), established by law in 2002, to support development of an adequate nursing workforce.[10] NJCCN receives the New Jersey Board of Nursing (NJBON) nurses license renewal survey information and analyzes it annually to produce workforce supply data reports. The 2023 Nursing Data and Analysis Report includes critical information on educational capacity, workforce supply, workforce demand, and retirement projections.[11] A similar system should be created for collection, analysis, and use of physician licenses. Physicians already fill out mandatory surveys that include data on race and ethnicity, level of education achieved, current employment status, primary employment, position, and additional states where they may be licensed and practice, but the data is not public and has deficiencies. In the future, it should be made publicly available and used to identify shortage areas, estimate workforce supply, create targeted tuition reimbursement and educational opportunities, increase diversity within programs, and shape policy and fiscal decisions.[12]

Finally, supporting Advanced Primary Care, with its improved model of care delivery and payment, should attract more physicians into primary care. Today, unfortunately, fewer medical residents are pursuing primary care specialties. Indeed, a recent JAMA study found that fewer than nine percent of third-year internal medicine residents are interested in careers in primary care.[13] The prohibitive cost of medical education and the reality that primary care physicians earn less than specialists contribute to the lower percentage of medical students pursuing careers in primary care. The average salary for a primary care physician is $255,000 per year, while many specialties earn twice that amount.[14] New Jersey

must make more effort to retain the PCPs it does train. Nationally, while New Jersey ranks high (10th) in the number of total residents/fellows in primary care, it ranks much lower (32nd) in retaining its newly trained physicians.[15]

Background on Payment Models to Support Advanced Primary Care

Payment models are a critical lever influencing care delivery.[16] To adequately support Advanced Primary Care, both the right level of payment and the right method of payment are needed. Starting with the level of payment, the NASEM report explains how the structure of the Medicare physician fee schedule systematically devalues primary care services relative to other services. Many other payers structure their physician payment based on the Medicare physician fee schedule. The share of US health care spending devoted to primary care declined from 6.5% of total health spending in 2002 to 5.4% in 2016.[17] This compares to an average of 7.8% of spending for primary care in 22 OEDC countries.[18] More recent data from 2020 suggest only 4.6% of US health care spending was devoted to primary care.[19] Thus, the NASEM report concludes that primary care in the US is under-resourced – accounting for about 35% of health care visits but only 5% of health care spending. The report calls for a redistribution of funding; calling on the Centers for Medicare and Medicaid Services (CMS) to increase rates for primary care evaluation and management (E&M) codes by 50% and reducing other service rates to maintain budget neutrality.

Several states have enacted legislation or regulations to increase the percentage of total health care spending on primary care. Several other states have enacted primary care spending targets and numerous others have begun requiring payers to report data on primary care spending annually.

The second important aspect of payment for primary care is the method of payment. The NASEM report recommended that payers shift from FFS models to a hybrid model that combines capitation payments and FFS. This more stable model encourages investment in a practice and payment for care that is of value to the patient but may not otherwise be billable because it doesn't generate a specific service or billable code.

Findings on Payment to Support Advanced Primary Care

1. *New Jersey has among the lowest total primary care spending and lowest commercial and Medicaid payment rates in the country.*

New Jersey's primary care spending as a percent of total health spending is one of the lowest in the country. Using the broad definition of primary care, which includes care team members necessary for Advanced Primary Care, New Jersey ranks forty-eight out of fifty states in its investment. **See, Figure 1, Primary Care Spending & FFS Rates.**

Fee-for-service payment rates for primary care are also low compared to other states. NJ Medicaid pays primary care rates that are only about 50% of Medicare rates.[20] Commercial primary care payment rates in New Jersey are on average 93% of Medicare rates compared with the US average of 120% of Medicare. Importantly, there is substantial variation around the average primary care payments with a substantial number of practices paid at 75% of Medicare or less. Our workgroup confirmed these low rates, especially for smaller practices. Work group participants confirmed a growing spread in FFS rates across primary care

Figure 1: Primary Care Spending and Fee for Service Rates Table

Primary Care Spending & FFS Rates	New Jersey	U.S.	NJ - State Rank
2019 Primary Care Spending (%) narrow definition [(1),21]	4.2%	4.6%	30/50
2019 Primary Care Spending (%) broad definition [(1)]	8.6%	11.6%	48/50
2019 Medicaid primary care payments as % of Medicare [(2)]	51%	67%	44/50
2017 Commercial primary care payments as % of Medicare [(3)]	93%	120%	36/37

Sources: [(1)] Milbank Primary Care Scorecard,[22] [(2)] Kaiser Family Foundation,[23] [(3)] Health Care Cost Institute[24]
State rank goes from 1 (highest) to 50 (lowest), except for commercial payments with 37 states reporting.

practices attributable to multiple factors including consolidation or purchase of practices by larger entities with more negotiating power.

Most of the workgroup members, including plans and practices, agreed that FFS primary care rates should be increased. Some plans raised concern over where the additional funding would come from and whether it would lead to growth in premiums. The workgroup agreed that collection and reporting of up-to-date primary care spending data would be beneficial to support such decision-making. Many states have published similar reports. Massachusetts publishes several primary care reports that are good examples.[25, 26]

2. *Despite Primary Care Practice Interest in Advanced Primary Care, Fee-For-Service is still the predominant payment mechanism especially for smaller practices.*

The workgroup agreed that New Jersey is lagging behind other states on APM adoption. The group emphasized that primary care APM are needed to support Advanced Primary Care delivery, especially for independent practices. Practices want to engage in team-based care models, although initial investments in staffing and technology as well as a predictable cash flow are both necessary. One plan shared some results from its survey of practices and its finding that practices reported wanting more assistance from health plans on APM adoption, especially with technology and data use.

We interviewed plans participating in the workgroup about the distribution of their covered lives by line of business paid through the payment model categories described herein. We found that FFS is still the predominant payment method for primary care in New Jersey. Some practices receive FFS combined with care management payments and incentive payments for quality, utilization, and risk coding. The most common alternative payment model in New Jersey is shared savings models – primarily in contracts with health systems or management services organizations that contract on behalf of multiple physician practices. In 2022, 17 NJ-based organizations participated in Medicare Shared Saving Program Accountable Care Organizations covering about 40 percent of attribution-eligible beneficiaries in Medicare. A similar proportion of patients could potentially be covered under shared savings arrangements in Medicare Advantage plans. It is more difficult to design an APM for commercially insured patients in markets like New Jersey that do not typically require PCP selection and PCP referrals. This difference makes attribution in these models more difficult to do accurately. The move to aggregator groups that support smaller primary care practices could help New Jersey increase its APM participation rates.

More than 250 primary care practices in New Jersey chose to enter the CMS Primary Care First (PCF) model in 2021 and 2022 – signaling the appeal of hybrid payment models for primary care.[27]

PCF was conceived as a multi-payer model and CMS has invited health plans to participate voluntarily. Humana is the only NJ health plan that participates in PCF.

The use of APM by Medicaid managed care organizations (MCOs) also appears to be limited. Only one MCO provided information about their shared savings model, which covers approximately 179,000 adult lives. The model uses quality measures and shares savings for achieving certain Medical Loss Ratio targets. Other than FFS, the balance of the MCO payments in Medicaid appear to be pay-for-performance quality payments based on achieving HEDIS measures and some modest per-patient per-month care coordination fees. In its most recent Medicaid Quality Report, New Jersey Medicaid reported efforts to develop an APM for Primary Care. New Jersey Medicaid is also participating in a CMS Innovation Center APM called Making Care Primary, which is launching in selected states in 2024.[28]

Recommendations to Support Payments for Advanced Primary Care:

1. The State should raise Medicaid FFS primary care payment rates to the level of Medicare and it should direct Medicaid MCOs to also pay Medicare rates for primary care.

Following the NASEM report's guidance, the Quality Institute, along with many workgroup members across all sectors, encourage the State to increase Medicaid FFS primary care payment rates to be on par with Medicare rates. While Medicare FFS rates and code design could also be improved, it is the system we have today, and using these rates would be a significant improvement for PCPs who agree to participate in the NJ Medicaid program. The current practice of paying these PCPs about half of Medicare FFS rates negatively affect access to primary care for traditionally marginalized groups which have higher levels of participation in Medicaid.[29] Today, because most payments to PCPs are FFS, the low Medicaid FFS rates discourage practices from participating in Medicaid.

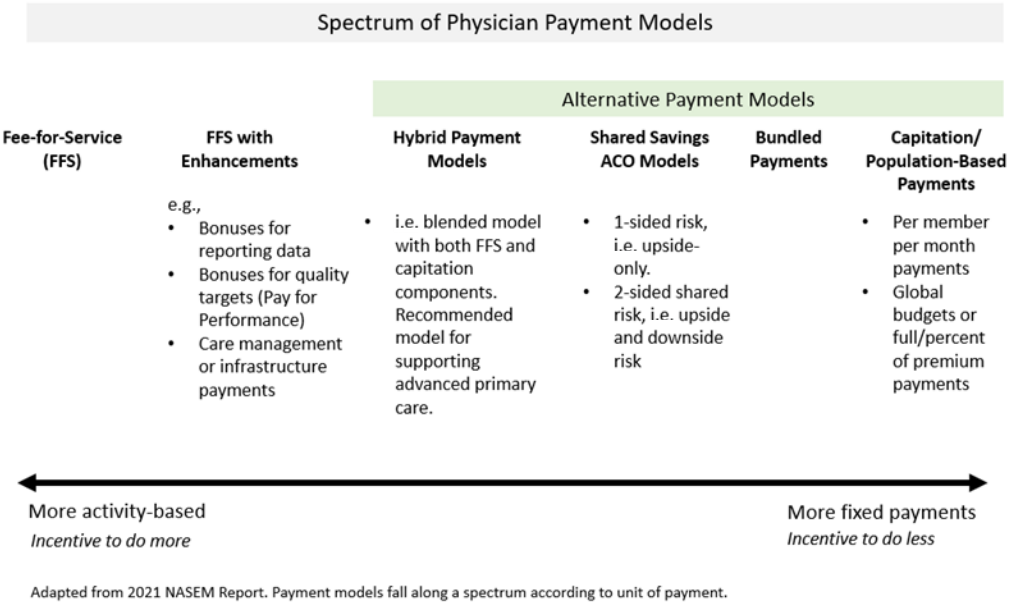
2. The State should take an active role in developing and encouraging Advanced Primary Care in New Jersey.

New Jersey purchases health care through its employees, retiree benefit, and Medicaid programs, where it can set or influence payment rates and design payment models. The State should encourage the development of APM to support Advanced Primary Care (like the CMS Primary Care First model) through its Medicaid contract and State Health Benefit Program (SHBP). Efforts by the State to support or participate in various primary care APM have been sporadic over the past decade. A state led, multi-payer, and multi-stakeholder effort is needed to move the state from mostly FFS models to APM. The models could start out as hybrid (capitation and FFS) payment models to support Advanced Primary Care for New Jersey and then move to more advanced models as laid out in *Figure 2: Spectrum of Physician Payment Models* herein. The Quality Institute and other members of this workgroup stand ready to support this effort. As the largest payer for the most vulnerable populations in the State, New Jersey Medicaid can make an enormous difference by improving primary care quality and access. Similarly, as one of the largest employer-sponsored health benefit programs in the State, SHBP has a vested interest in increasing its focus and investments in Advanced Primary Care for its employees and retirees. This recommendation aligns with those in the 2021 *SHBP Quality and Value Task Force* report. [30]

3. The State should report annually on primary care spending as a percent of total health care spending and on the use of APM.

Several states, including New Jersey, have started to implement cost-growth benchmark programs to improve overall cost transparency, identify and address health care cost drivers, and ensure effective resource allocation.[31, 32] Any report should include

Figure 2: Spectrum of Physician Payment Models



Adapted from 2021 NASEM Report. Payment models fall along a spectrum according to unit of payment.

primary care spending rate by carrier and line of business. This will provide a more complete picture of primary care spending and would enable the State to adopt a multi-year target. In addition, the State should report annually on the use of APM including advanced primary care payment models in New Jersey. The State should collect data on the use of payment methods including the five payment models summarized in Figure 2 herein by carrier and line of business, including the SHBP. These data could be collected through New Jersey's Health Care Affordability, Responsibility, and Transparency (HART) program or alternative mechanisms.[33]

Findings and Recommendations on APM Design to Better Support Advanced Primary Care in New Jersey

Simplifying and aligning quality measurement is a priority for many stakeholders.[34] One practice in the workgroup shared that they have 125 metrics across a dozen contracts, which was a common experience. Fewer and more standardized measures across contracts are needed to make reporting easier. CMS recently released its Universal Foundation measure set as a path forward to streamlining quality measures across CMS programs.[35] The workgroup reviewed these measures, along with existing APM for primary care metrics. The workgroup created a more comprehensive set of meaningful measures that would support Advanced Primary Care and also include certain measures that pragmatically must be kept because of existing CMS requirements on plans. **See Appendix A, Adult Primary Care Core Measure Set for NJ ("NJ Core Measure Set"). See also Appendix B, Comparing the NJ Core Measure Set to other primary care measure sets.** The workgroup endorses the use of the NJ Core Measure Set to support Advanced Primary Care in New Jersey.

Standardizing and Improving the Measures.

Workgroup members from both the health plans and practices agreed that the lack of alignment on measures and focus on measures that do not improve patient care or quality take away from the very essence of primary care --- patient engagement. They agreed that there should be fewer measures within each APM and the focus should be on outcome measures. They acknowledged the need for measure alignment across payers to make reporting easier. They also agreed that once measures are chosen for an APM, they should be kept in place for a reasonable period to enable practices to develop and improve their internal processes. The workgroup suggested 5 years of continuity, except for poor measures which are removed for unsuitability. The group agreed that ideally the measures should connect to what the practices can impact. This limitation, however, is challenging for both plans and practices because of how CMS creates its star ratings and weights certain measures in its models. Unless CMS modifies its models, any New Jersey based APM will have to include some of these more heavily weighted measures even when the plans and practices agree that PCPs cannot significantly impact the measure. To address this challenge, the workgroup agreed that the plans must work to provide the practices with better and more timely data, especially when the action at issue is something that occurs outside of the practice. Finally, the group agreed that measures with low denominators, where one patient can impact the outcome of a year's work, should be avoided.

Risk Adjustment on Measures.

The workgroup discussed which of the measures should be risk adjusted. For efficiency measures including emergency department utilization, and hospital admission rates, there should be risk adjustment for patient medical complexity as well as for socio-economic status and for the social determinants of health of their patients. The medication adherence measure should be risk adjusted based on socio-economic and social determinants of health status.

Data Sharing.

Payers need to play an active supportive role in APM by providing timely data transfers in a standardized format, using a structure like CMS, and moving towards data sharing right into an electronic medical record. All agreed that today's data exchanges and technology platforms are not

where they need to be to support what is being asked of the practices. Receiving pharmacy data is especially important for primary care practices, as is receiving hospital admission, discharge, transfer (ADT) feeds on a timely basis. Payers can also help practices by providing technical support on using the data successfully to engage patients and succeed under APM. Data technology firms and the state Health Information Network and Health Information Exchanges also play a vital role in successful Advanced Primary Care practices. The NJ HIN is not currently meeting the needs of practices working to better integrate care and practice population health.

Measure Targets.

In designing the targets for shared savings or other payments, the workgroup supported a hybrid model that required meeting certain targets on quality or efficiency but also added additional payments for improving year over year. The approach would reward both achievement and attainment and capture those achieving ambitious standards as well as those making improvements in quality. The workgroup also agreed on the criticality of plans and practices meeting regularly to review performance data so that it is meaningful to the PCPs' teams, and they can see how they are being compensated for their work.

Patient-Reported Outcome Measures.

The workgroup agreed on the importance of patient reported outcomes measures. There was a strong consensus that the current patient survey questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) questionnaire do not adequately measure primary care delivery.[36] Unfortunately, however, that is one of the CMS measures used in Medicare and therefore unavoidable unless that changes. The group considered the Person-Centered Primary Care Measure (PCPCM), an NQF-endorsed measure set which will be used in the Making Care Primary pilot launching in New Jersey and seven other states in 2024.[37, 38] The group appreciated that the PCPCM questions get to the value of primary care. PCPCM could be piloted in primary care APM in New Jersey, assuming that the questions can be risk-adjusted for practices with newer physicians and new patients.

Behavioral Health Measures.

The workgroup looked at which Behavioral Health measures are currently used in Primary Care APM today. The members of the group who are behavioral health providers suggested that the measures are inadequate. Yet, all recognize that today, access to behavioral health care is exceedingly difficult and not something that will be fixed by adding more screening and referral measures when sources for care are limited. Thus, as a preliminary step, the workgroup recommends taking immediate steps to eliminate state based regulatory and payment barriers to patients accessing behavioral health care.

Today, the measure commonly included in the APM is screening for depression and referral. But when patients screen positive for behavioral health needs, the practices need to take the critical, time intensive and time sensitive next steps of finding a mental health provider to meet with the patient and evaluate them including assessing their needs for therapy and/or medication and set up referrals and follow-ups. Some FQHCs and hospital owned or affiliated practices are in a better position because the practice may be an ambulatory facility with the ability to provide and bill for integrated behavioral health. Other larger or hospital owned practices described absorbing these costs because it is part of their non-profit mission or because it helps them in their Accountable Care Organization (ACO) contracts. But for independent practices, having integrated behavioral health or finding places to refer their patients is a struggle. Today, two barriers to behavioral health care could be removed in New Jersey. First, for patients covered by NJ Medicaid, the State could allow Licensed Clinical Social Workers (LCSWs) practicing independently and outside of an ambulatory care facility, to bill for seeing patients. Second, the State should create an integrated facility license, which would allow one license rather than three, for ambulatory care facilities to provide primary and behavioral health

care. Making these regulatory changes would immediately increase access to behavioral health, enabling PCPs to screen and either treat their patients within their facility or have someone to refer their patients to for care. As these issues are addressed, there are additional behavioral health measures in the CMS Adult Core Measure Set for States that should be added to the proposed New Jersey Adult Core Measure Set, especially because CMS will be requiring State Medicaid programs to report on more behavioral health measures.[39]

Collecting and Using Data on Demographics and Social Determinants of Health.

The workgroup agreed that collecting demographic data on Race, Ethnicity and Language (REaL) and Sexual Orientation and Gender Identity (SOGI), as well as screening patients for social determinants of health (SDOH), is important. Improving collection of this data aligns with CMS as they move to advance health equity. The group suggested that these activities be treated as "pay for reporting" as a first step. Group members expressed the need for clear, nationally standardized definitions for these data. They also need training for their entire organizations and their patients as to why the data is being collected, how to ask for it, and how to explain how it will be used and protected. This process must be done in a culturally sensitive manner, ideally where there is a trusted relationship. The government and payers must play an active role in defining the data, as well as designing and funding training and communication materials.

Conclusion

In summary, our findings indicate that in New Jersey:

- Primary Care Physicians are interested in moving away from Fee-for-service (FFS) models to APM such as Advanced Primary Care models which deliver team-based care, which is higher quality, more comprehensive care. Advanced Primary Care requires greater financial support and investment.
- Limited physician workforce data points to an inadequate number of primary care physicians for the population of New Jersey. New Jersey lacks good data on the diversity among those primary care physicians compared to the demographic makeup of the state. Better and publicly available data is needed to make fiscal and policy decisions to support a strong, diverse future primary care workforce.
- The state spends less than most other states on primary care as a percentage of total health care expenditure; FFS primary care rates in Medicaid are at the low end in the United States, at about fifty percent of Medicare rates.[40] Commercial payment rates are amongst the lowest in the country, and less than Medicare on average.[41]
- FFS is still the predominant payment mechanism, especially for smaller physician groups. To support Advanced Primary Care, greater use of hybrid payment models that combine capitation and FFS payment is needed. In the meantime, FFS payment rates for primary care should be increased.
- Payers use too many different measures with different specifications in their APM; delivered on different platforms through differing reports. The reports are not timely enough. More standardization of reports and measures is needed with a focus on a limited set of outcomes measures. A NJ Core Measure Set is suggested.
- Practices need greater support from payers, data technology vendors, and the state to receive and meaningfully use timely data to successfully operate in APM and improve their patients' quality of care. Despite years of federal and state funding, the NJ HIN is not supporting the transfers of data and interoperability that is needed in population health.
- While some larger practices and FQHCs have been able to integrate primary and behavioral health services, there remain significant licensing and payment barriers which add to widespread access issues for behavioral health.

Appendix A - Adult Primary Care Core Measure Set for New Jersey ("NJ Core Measure Set")

Domain	Description and Developer/Measure Number
Wellness and Prevention	**Colorectal cancer screening (COL)** Percentage of adults 45-75 year who were screened for COL. (NCQA) **Breast cancer screening (BCS)** – Percentage of women 50-74 year who had a mammogram within last 27 months. (NCQA) (CMS #93) **Cervical cancer screening (CCS and CCS-E)** Percentage of women 21-64 year who were screened. (CMS #124) and (NQF #0032)
Chronic Conditions	**Diabetes Hemoglobin A1c Poor Control** for Patients with Diabetes (HBD) Percentage of adults 18-75 year with diabetes (1 and 2) whose HbA1c1 was under poor control during the measurement year (>9%). (measure is reverse scored) (CMS/MSSP/PCF/NCQA) (CMS#204) (note - risk adjusted for the SDS of your practice's population if possible) **Controlling for High Blood Pressure (CBP)** Percentage of adults 18-85 year with diagnosis of hypertension whose BP was adequately controlled during year. (less than 140/90) (NCQA) (CMS#167) **Plus** - Recommend adding **"Target BP"*** and include payment enhancement for % of patients using and practice reporting it. **Medication Adherence for diabetes, hypertension, cholesterol** (NCQA) (use only for QI and reporting until better data sharing of pharmacy established)
Patient Experience	**PCPCM:** (pilot for reporting only and pay bonus to higher scoring physicians/practices) (PCPCM PRO-PM 3568)
Behavorial Health	**Screening for depression and follow-up** plan. Screening for depression for ages 12+ at encounter or 14 days prior and if positive follow up plan w/in 2 days. (CMS-ACO-eCQM #134) (CMS#672)
Patient-Centered Care	**Advance Care Planning (ACP)** Percentage of adults 66-80 year with advanced illness, frailty, or receiving palliative care, and adults 81+ who had ACP during the measurement year. (NCQA)

Efficiency	**Emergency Department Utilization (EDU)** For adults 18 years of age and older, the risk adjusted ratio of observed to expected emergency department (ED) visits during the measurement year. (NCQA) **Acute Hospital Utilization (AHU)** For adults 18 years of age and older, the risk adjusted ratio of observed to expected acute inpatient and observation stay discharges during the measurement year. (NCQA)
Equity	**Social Need Screening and Intervention (SNS-E)** – The percentage of patients who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive. (NCQA) (For reporting only)

**For more information on this evidence based program see: https://targetbp.org/.*

Appendix B - Comparison Chart – NJ Core Measure Set vs CMS Sets for Primary Care Models

Name of Model & Measure Domains	NJ Adult Primary	CMS Universal Foundation	Primary Care FIrst	Making Care Primary
Wellness & Prevention	Colorectal Cancer Screening	Y (139)	Y	Y
	Breast Cancer Screening	Y (93)	N	N
	Cervical Cancer Screening	N	N	N
Chronic Conditions	Controlling high blood pressure*[1]	Y (167)	Y	Y
	Hemoglobin A1c poor control (greater than 9%) (risk adjust for SDS)	Y (204)	Y	Y
	Med Adherence for diabetes, hypertension, cholesterol*[2]	N	N	N
Patient Experience	PCPCM (#3568)*[3]	N	N	Y
Patient-Centered Care	Advance Care Planning (MIPS CQM)	N	Y	N
Behavorial Health	Screening for depression & follow-up (CMS #672 and eCQM #134)	Y	N	Y

Name of Model & Measure Domains	NJ Adult Primary	CMS Universal Foundation	Primary Care FIrst	Making Care Primary
Efficiency	ED Utilization, risk adjusted ratio observed vs expected (NCQA)	N/A	N/A	Y
	Acute Hosp Utilization. Risk adjusted ratio observed vs expected (NCQA)	N/A	N/A	N
Equity	Social Needs Screening and Intervention (NCQA)*[4]	Y	N	Y

[1]Add a trial of TargetBP and include payment enhancement for percentage of eligible patients using it and practice reporting the data.
[2]Use for quality improvement and reporting only, not payment, until pharmacy data sharing improved.
[3]Use on trial basis and pay bonus for high marks. Look to risk adjust for newer practices and physicians. Test specific questions.
[4]Use for reporting only and pay for time for practice to collect and report.

Workgroup Members

These recommendations represent the collective ideas of a multi-stakeholder group, and each individual contributing organization may not endorse every recommendation.

Michael Ruiz de Somocurcio
Chief Network and Operations Officer
Aetna, NY/NJ

Michele Fronckiewicz
ACO Executive Director
Aledade

Michelle Alkhalaileh, LPC
Chief Information Officer
CarePlus

Kumar Dharmarajan, MD, MBA
Chief Scientific Officer and Associate CMO
Clover Health

Jamie Reedy, MD, MPH
Chief Population Health Officer & SVP, Health Solutions
Horizon Blue Cross Blue Shield of NJ

Robert Zorowitz, MD, MBA, CMD
Regional VP, Health Services, NE Region
Humana

Roy Leitstein
CEO
Legacy Treatment Services

Tom Dwyer
Market President
Navvis Healthcare

Cathy Rowe, DrPH
Executive Director
NJAAW

Alfred F. Tallia, MD, MPH
Professor and Chair
Department of Family Medicine and Community Health
Rutgers Robert Wood Johnson Medical School

Ashish D. Parikh, MD
Chief Population Health Officer
VillageMD-Summit Health

Harmeet Bassi, MD, CPHQ
Medical Director, Quality
VillageMD-Summit Health

Thomas McCarrick, MD, MBI
Managing Partner, CMO, CMIO
Vanguard Medical Group

Melissa Mothersil
Transformation and QI Manager
Vanguard Health Solutions

Mary F. Campagnolo, MD, MBA, FAAFP
Medical Director
Virtua Health
Board Member
New Jersey Health Care Quality Institute

Vikranta Sharma, MD
Medical Dir of Hospice and Palliative Care
VNA Health Group

Support for this project was provided by the New Jersey Department of Human Services. The views expressed here do not necessarily reflect the views of the Department.

The Quality Institute partnered with the Institute for Accountable Care (IAC), an independent, non-profit research institute that supports organizations navigating value-based payment and care delivery, to develop this report.

The New Jersey Health Care Quality Institute is a multi-stakeholder non-profit organization whose mission is to improve the safety, quality, and affordability of health care for everyone. Learn more at www.njhcqi.org.

Footnotes

[1] Yalda Jabbarpour, MD, Ann Greiner, MCP, Anuradha Jetty, MPH, Megan Coffman, MS, Charles Jose, MD Stephen Petterson, PhD, Karen Pivaral, Robert Phillips, MD, MSPH, Andrew Bazemore, MD, MPH, Alyssa Neumann Kane, Patient-Centered Primary Care Collaborative, Robert Graham Center, 2019 https://thepcc.org/sites/default/files/resources/pcmh_evidence_report_2019_0.pdf
[2] Shi, L. 2012. *The Impact of Primary Care: A Focused Review*. Scientifica 2012:432892.
[3] Bitton, A., H. L. Ratcliffe, J. H. Veillard, D. H. Kress, S. Barkley, M. Kimball, F. Secci, E. Wong, L. Basu, C. Taylor, J. Bayona, H. Wang, G. Lagomarsino, and L. R. Hirschhorn. Primary health care as a foundation for strengthening health systems in low- and middle-income countries. Journal of General Internal Medicine 32(5):566–571, 2017.
[4] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Implementing High-Quality Primary Care; Linda McCauley, Robert L. Phillips, Jr., Marc Meisnere, and Sarah K. Robinson, Editors, 2021, https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care.
[5] FAIR Health, *A Window into Primary Care*, March 15,2023, https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/A%20Window%20into%20Primary%20Care%20-%20A%20FAIR%20Health%20White%20Paper.pdf
[6] Allan Baumgarten, Developments in Convenient Care in New Jersey and the Impact of the COVID-19 Pandemic, September 29, 2022, https://allanbaumgarten.com/wp-content/uploads/2023/01/Revised-NJ-Convenient-Care-Update.pdf.
[7] Scott Fallon, NorthJersey.com, Retail medicine: Explosion of Urgent Care Centers in NJ changes health care landscape, November 2, 2023, https://www.northjersey.com/story/news/health/2023/11/02/explosion-of-urgent-care-centers-in-nj-changes-health-care-landscape-american-family-care/71328112007/.
[8] Association of American Medical Colleges, State Physician Workforce Data Report, 2021, https://www.aamc.org/data-reports/workforce/data/2021-state-profiles.
[9] Stephen Petterson, Elizabeth Wilkinson, A.C. Kessler, Courtney Stone, Andrew Bazemore. The State of Primary Care Physician Workforce. Washington, D.C.: The Robert Graham Center, 2018, https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/phys-workforce/New-Jersey.pdf.
[10] New Jersey Collaborating Center for Nursing, 2023, https://njccn.org/.
[11] Edna Cadmus PhD, RN, NEA-BC, FAAN, Pamela B. de Cordova, PhD, RN-BC, Susan Weaver, PhD, RN, CRNI, NEA-BC, Arun Ravichandran, MS, Zifan Li, MS, Maria Zamora, CPA, Nicole Thomas, Zohar Hasson, BA, New Jersey Collaborating Center for Nursing. (2023). Nursing data and analysis. Newark, NJ; NJCCN, https://njccn.org/wp-content/uploads/2023/01/2023-Data-Report_Revised2-20-2022.pdf.
[12] New Jersey Health Care Quality Institute, *Implementing the Action Plan A Guidance Document to Recruit, Train, and Retain a Resilient and Diverse Health Care Workforce for New Jersey*, July 27, 2022, https://www.njhcqi.org/wp-content/uploads/2022/07/Guidance_Implementing-the-Action-Plan-for-Diverse-Healthcare-Workforce_2022.pdf.
[13] Neha Paralkar, MD, Nancy LaVine, MD, Saoirse Ryan, BA, Rosemarie Conigliaro, MD, Jason Ehrlich, MD, Aisha Khan, MD, Lauren Block, MD, MPH, Career Plans of Internal Medicine Residents From 2019 to 2021, August 28, 2023, https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2808652.
[14] Katie Adams, Nurse Practitioners' Starting Salaries Are Rising Faster Than Those of Primary Care Physicians, August 17, 2023, https://medcitynews.com/2023/08/physician-salary-nurse-healthcare-cvs-walgreens-amazon/.
[15] Association of American Medical Colleges (AAMC), *State Physician Workforce Report*, 2021, https://www.aamc.org/data-reports/workforce/data/2021-state-profiles.
[16] Aledade Policy Team, *Minimum Primary Care Spend: A Framework for Sustained Investment*, October 3, 2023, https://resources.aledade.com/primary-care-advocacy/minimum-primary-care-spend-a-framework-for-sustained-investment/.
[17] Martin, S., R. L. Phillips, Jr., S. Petterson, Z. Levin, and A. W. Bazemore. *Primary Care Spending in the United States*, 2002–2016. JAMA Internal Medicine. 2020.
[18] OECD, *Deriving Preliminary Estimates of Primary Care Spending Under the SHA 2011 Framework*. Paris, France: Organisation for Economic Co-operation and Development. 2019.
[19] Yalda Jabbarpour, Stephen Petterson, Anuradha Jetty, AND Hoon Byun, Robert Graham Center, *The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care*, February, 2023, https://www.milbank.org/publications/health-of-us-primary-care-a-baseline-scorecard/.
[20] Kaiser Family Foundation (KFF), Medicaid-to-Medicare Fee Index, 2019, https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[21] Ann Kempski, MS, Adviser, Primary Care Collaborative Ann Greiner, MCP, President and CEO, *Primary Care Collaborative, Primary Care Spending: High Stakes, Low Investment*, December, 2020, https://thepcc.org/sites/default/files/resources/PCC_Primary_Care_Spending_2020.pdf.
[22] Millbank Memorial Fund, *The Health of US Primary Care Baseline Scorecard Data Dashboard*, February 2023, https://www.milbank.org/primary-care-scorecard/.
[23] Kaiser Family Foundation (KFF), Medicaid-to-Medicare Fee Index, 2019, https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/.
[24] Bill Johnson, Kevin Kennedy, Daniel Kurowski, Aaron Bloschichak, Elianna Clayton, Jean Fuglesten Biniek, Katie Martin, Comparing Commercial and Medicare Professional Service Prices, August 13, 2020, https://healthcostinstitute.org/hcci-

originals-dropdown/all-hcci-reports/comparing-commercial-and-medicare-professional-service-prices.
[25] Center for Health Information and Analysis, *Massachusetts Primary Care Expenditures*, October 2023, https://www.chiamass.gov/assets/docs/r/pubs/2023/Primary-Care-Expenditures-Report-2023.pdf.
[26] Center for Health Information and Analysis, *Massachusetts Primary Care Expenditures*, October 2023, https://www.chiamass.gov/assets/docs/r/pubs/2023/MA-PC-Dashboard-2023.pdf.
[27] Centers for Medicare and Medicaid Services, *Primary Care First Model Options*, https://www.cms.gov/priorities/innovation/innovation-models/primary-care-first-model-options.
[28] New Jersey Division of Medical Assistance and Health Services, *Quality Strategy*, July 26, 2022, https://www.nj.gov/humanservices/dmahs/news/NJ_DMAHS_Quality_Strategy_2022.pdf.
[29] Medicaid and CHIP Payment and Access Commission (MACPAC). 2019. *Physician Acceptance of New Medicaid Patients: New Findings*. Washington, DC: MACPAC. https://www.macpac.gov/publication/physician-acceptance-of-new-medicaidpatients-new-findings/.
[30] State Health Benefits Quality and Value Task Force, *Improving Healthcare Outcomes and Managing Costs*, May 10, 2021, https://nj.gov/governor/docs/TaskForce_FinalReport.pdf.
[31] New Jersey Health Care Affordability, Responsibility, and Transparency (HART) program, 2021, https://www.cshp.rutgers.edu/content/nj-benchmark-program.
[32] Joel Ario, Managing Director Manatt Health Strategies Kevin McAvey, Director Manatt Health Strategies Amy Zhan, *Consultant Manatt Health Strategies, State Benchmarking Models Promising Practices to Understand and Address Health Care Cost Growth*, June 2021, https://www.manatt.com/Manatt/media/Documents/Articles/RWJF_State-Benchmarking-Models_June-2021_i_FOR-WEB.pdf.
[33] New Jersey Health Care Affordability, Responsibility, and Transparency (HART) program, 2021, https://www.cshp.rutgers.edu/content/nj-benchmark-program.
[34] Isabella Rubin, Joshua Israel, *The Case For Aligning Quality Measurement*, December 5, 2022, https://www.healthaffairs.org/content/forefront/case-aligning-quality-measurement.
[35] Centers for Medicare and Medicaid Services, *Aligning Quality Measures Across CMS - the Universal Foundation*, September 6, 2023, https://www.cms.gov/aligning-quality-measures-across-cms-universal-foundation.
[36] Centers for Medicare and Medicaid Services, *Consumer Assessment of Healthcare Providers & Systems (CAHPS)*, September 6, 2023, https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems.
[37] The Larry A. Green Center, *The Person-Centered Primary Care Measure (PCPCM)*, https://www.green-center.org/pcpcm.
[38] Centers for Medicare and Medicaid Services, *Making Care Primary (MCP) Model*, June 8, 2023, https://www.cms.gov/priorities/innovation/innovation-models/making-care-primary.
[39] Centers for Medicare and Medicaid Services, *CMS Releases Proposed Rule to Improve Medicaid & CHIP Quality Reporting Across States*, August 18, 2022, https://www.cms.gov/newsroom/press-releases/cms-releases-proposed-rule-improve-medicaid-chip-quality-reporting-across-states.
[40] Kaiser Family Foundation (KFF), *Medicaid-to-Medicare Fee Index*, 2019, https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/.
[41] Bill Johnson, Kevin Kennedy, Daniel Kurowski, Aaron Bloschichak, Elianna Clayton, Jean Fuglesten Biniek, Katie Martin, *Comparing Commercial and Medicare Professional Service Prices*, August 13, 2020, https://healthcostinstitute.org/hcci-originals-dropdown/all-hcci-reports/comparing-commercial-and-medicare-professional-service-prices.