DELAWARE ACADEMY OF FAMILY PHYSICIANS

To:	Kara Odom Walker, MD, MPH, MSHS, Cabinet Secretary Delaware Health and Social Services
From:	Lindsay Ashkenase, MD, President Delaware Academy of Family Physicians
Regarding:	Report to the Delaware General Assembly on Establishing a Health Care Benchmark
Date:	December 11, 2017

This document is in response to the Delaware Health Care Commission's request for comments to the draft Report to the Delaware General Assembly on Establishing a Health Care Benchmark. The comments in this document include input from several members of the Delaware Academy of Family Physicians (DAFP), which represents family medicine physicians across the State of Delaware.

DAFP agrees that the health care problems in Delaware (and the rest of the country) are complex, but that does not mean they require excessively complex solutions. Many of the proposed solutions to date, including some of the solutions coming out of the Delaware SIM project, and perhaps even the "Road to Value" plan are more complex then they need to be and they are not addressing a few very important components. The comments below are aligned to each of the goals of the document, and meant to address the key areas DAFP believes are important to improving the Quadruple Aim in Delaware.

1. **Establish a State Healthcare Benchmark**:

DAFP agrees with a spending benchmark. The 'how' should consist of gathering the stakeholders and allowing them to come up with the ways of achieving the benchmark- which will inevitably involve them asking the state for something as well – e.g., a more agile and responsive payment system, Medicaid paying for community health workers, etc. We must not make the mistake that restricting spending improves quality. If that were the case the cheapest product would always be the best.

Regarding reducing the total cost of care, we can only drive down tertiary health costs if we invest in key social determinants. A simple way would be to engage a state-wide community benefit process which each non-profit health system has to do anyway. By collaborating on this process, each group can choose the 2-3 key social determinants to focus on. This requires no money, simply the will from DHSS (or a partner, like DHSA) to convene a group.

Regarding measuring cost and quality, we must consider health inequities when choosing outcomes and accounting for how they are measured. Disease-focused outcomes along (i.e. A1C poor control) can result in disease focused care rather than whole-person, patient centered care. Outcomes that are being measured must be aligned amongst all payers. The AAFP urges stakeholders to align and harmonize quality measures as part of an overall approach to reducing administrative burden. To accomplish this, the AAFP recommends that using the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure parsimony, alignment, harmonization, and the avoidance of competing quality measures among all payers. In addition, the common scorecard idea has been

developed by DCHI- the State should encourage that work to be refined and 'given teeth' so it can become actionable. DAFP agrees with coordinating on all measures with clear incentives and downsides, and can play a critical role in vetting this, as the single largest group of ambulatory primary care physicians in Delaware.

2. Analyze and Report on Variation in Healthcare Delivery and Cost and Facilitate Data Access for Providers:

Very few states have the benefit of a state-wide Health Information Exchange with the robust data interfaces currently offered by the Delaware Health Information Network (DHIN). Delaware should leverage the DHIN as much as possible to connect hospitals and providers of all types and provide that information in an actionable way to providers across the state. Practice transformation without improved data/information is a waste of time and money.

3. Implement Medicaid and State Employee total cost of care risk-based contracting with Accountable Care Organizations through contracted plans

The AAFP recommends testing the Advanced Primary Care Alternative Payment Model (APC-APM) proposed to CMMI by the AAFP. The APC-APM builds upon CPC Plus (CPC+) and represents another evolutionary step away from fee-for-service (FFS) toward payment for value.

4. Support care transformation and primary care

We need to ensure all Delawareans have access to affordable primary care, and the primary care physician (PCP) should be the first place of contact with the health care system whenever possible. It needs to be easy and affordable to see your PCP. Investment in access to quality primary care drives down long-term spending. Such investment has never occurred in Delaware, either in reimbursements or workforce investment. The DHSS *Primary Care Health Needs Assessment* released in 2016 states that "number of primary care physicians per 100,000 population was 114.3 in 2015, compared to Massachusetts with 206.7 primary care physicians per 100,000 population." Other states have made an investment and have seen results. For example, Rhode Island requires all payers to increase the percent of their spending that goes to primary care by 1% per year in order to get their rates approved by the Insurance Commissioner. That has resulted in nearly a doubling of the primary care spend, increases in primary care physicians, access to care in the state, and dramatic reductions in the growth of health care spending.

The DAFP supports the joint principles of the PCMH, including physician-led team-based care that is comprehensive, coordinated, accessible and high-quality. This requires payer support, which is the 7th principle of the PCMH – *i.e.*, that reimbursement for offices to transform to and sustain the PCMH needs to be adequate. National studies estimate the cost of transformation along the model of the PCMH at $15-17 PMPM, which should be the standard for payers in Delaware.

While there has been a steady move toward consolidation of practices into hospital systems and other large systems, the majority of Delaware's workforce remains in small independent practices. This is a strength since studies have shown that small practices can improve quality at lower costs. There is certainly room for all types of practices in Delaware, and both private and system-based practices have strengths. But since small independent practices are a major driver of lower costs as well as access to care, we do not want to see further erosion of this model. Therefore, it is important that any statewide

reform ensures support for independent and system-based practices. This includes requiring payers to pay independent practices at the same rate as they pay system-based practices. It also may include support of independent practice ACOs and/or IPAs, which can assist practices in providing value-based care and keeping up with increasing regulations and requirements.

Pay primary care physicians (board certified in family medicine or internal medicine) more appropriately for providing primary care services by creating a primary care physician modifier that significantly increases payment for E&M services performed by primary care physicians and/or significantly increases per-member per-month payments (total increase needs to be substantial - in the range of 50 to 75% above current rates). And, those payments need to be paid up front for work done - not in the future or as a promise for attaining certain measures. This will accomplish three things: 1) allow primary care physicians to spend more time actually caring for patients and provide more services which will reduce unnecessary referrals to specialist (both of which will, as we all know and studies have proven, in and of itself, reduce costs); 2) drive more residents into those two specialties because they will have the potential to earn more for the work they do; and therefore, 3) ensure there are more primary care physicians so that all patients have access to one.

5. Address underlying social and environmental issues affecting health outcomes and partially ameliorate them with appropriate strategies

The social determinants of health cannot be overstated when considering health care costs. We need safe neighborhoods with low levels of violence, access to healthy foods, education etc. to have healthy patients. We know having patient-centered teams including nurses, social work, health care navigators and pharmacists work, but it is practically very difficult to get these teams in small practices, and even in health system practices due to up-front costs. We really need to think about upstream determinants that create these special populations- low health literacy, access to healthy food, safety of neighborhoods. Family docs are in tune with these needs and want to make changes, they just need the resources.

Improve integration of community-based initiatives and primary care providers to create an extension of primary care focused on prevention, wellness and social determinants of health. Incentivize primary care providers to work closely with and build tight referral networks with community-based programs, which are currently unknown and underutilized by primary care physicians. Create a local or regional, community-based healthcare atmosphere where primary care providers, specialists and community-based resources break down silos and truly work together as a medical neighborhood to not only care for ill patients, but promote proactive prevention, wellness and behavioral health among residents in that region. Including poverty, violence, education, housing, and access to healthy foods all determine the health of patients even more so than medical care. We should do more to improve these social determinants so as to improve the health of patients and the population. Some examples use health care dollars to support social determinants, such as a “Housing First” strategy to use Medicaid funding to pay for housing for the homeless and for the inadequately-housed.

6. Redesign executive branch functions and state purchasing strategies to manage healthcare cost and quality more effectively

The new entity should draw on best practices elsewhere, but be unique to Delaware. Vermont’s Green Mountain Care board is one such example. Second, engaging with DE’s health systems to buy in to this ahead of time is going to be critical.