



PRIMARY CARE REFORM COLLABORATIVE REPORT 2020



DELAWARE GENERAL ASSEMBLY
STATE OF DELAWARE
411 LEGISLATIVE AVENUE
DOVER, DELAWARE 19901

May 1, 2020

Dear Fellow Delawareans:

Since the last Primary Care Reform Collaborative annual report in January, 2019, the landscape of health care delivery and life in general has been drastically altered. The necessary measures to ensure recovery from the health pandemic that has swept the globe has also paralyzed the normal rhythm and function of every aspect of life. For health care, it has starkly highlighted deficiencies, gaps and disparities but it has also accelerated innovation, partnerships and collaboration, which hopefully will drive the development of successful solutions for the former.

The crisis in primary care, which prompted the passage of SB 227, still exists in the shadow of the overall pandemic. While SB227 has provided a fragile stability for some aspects of primary care, there needs to be much more significant change in how primary care is delivered, including investments to help current practices thrive; enhancements for our existing and future workforce and bending the cost curve with alternative payment models. The expansion of the Primary Care Reform Collaborative invested all stakeholders in what it means for primary care to be foundational to health care delivery in Delaware. Aligning the stakeholders, including payors, providers, employers and the State on how to build primary care beyond survival and through sustainability into a successful “cornerstone” of health care delivery in Delaware will continue to be the bulwark of the Collaborative. The development of the Office of Value Based Health Care Delivery provides an essential framework for data collection, analysis and policy research that is crucial to the development of an overarching primary care policy. How this proceeds in Delaware, post-pandemic, with concerns regarding funding, potential increases in loss of access and the general effect on overall health outcomes is difficult to determine. However, even though the momentum of work has lagged with the pandemic, the stakeholders in the Collaborative are committed to developing and implementing policy recommendations that will improve the delivery of primary care and provide Delaware with adequate, quality access at lower costs.

Sincerely,

Handwritten signature of Senator Bryan Townsend.

Senator Bryan Townsend
Co-Chair

Handwritten signature of Representative David Bentz.

Representative David Bentz
Co-Chair

Handwritten signature of Dr. Nancy Fan.

Dr. Nancy Fan
Co-Chair

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Executive Summary

“Delaware is facing a crisis in its primary care system. Recognizing the need to alleviate the current crisis and forge the sustainability of primary care, SB 227 convened the Primary Care Reform Collaborative” (PCRC)

These are the statements from the opening paragraph of the Executive summary in the first PCRC annual report. The initial impact from SB 227 equalized primary care reimbursement to Medicare levels and provided short term stability to the current environment. However, as alluded to in that January, 2019 report, there would need to be much more robust and meaningful long term investment in primary care to achieve an adequate level of access in Delaware, which may also decrease total health care costs and improve quality. The first report provided high level recommendations and next steps based on a series of presentations and testimony in the latter part of 2018.

Moving forward in 2019, PCRC engaged representatives from all stakeholder groups, including payors, public and commercial; clinicians, health care systems and federally-qualified health care center to start deeper and more deliberative discussions regarding how to translate the recommendations in the annual report into a viable care delivery model with meaningful payment reform. For the first half of the year, there were several meetings focused on what could be feasible options to increase primary care spending and also to drive increased participation in value based payment models. While there were in depth discussions on care coordination, care management, alternative payment models and concepts of accountability and risk by providers, there was a lack of consensus and willingness to promote any one approach for primary care investment. However, there was consistent testimony that it was essential to establish evidence of the current level of primary care spend in Delaware and how it related to a total cost of care. Many of the participants strongly supported the need for this data, both as a benchmark and as an assessment of how much investment increase may be needed to improve the delivery of primary care. Recognizing that there were two needs: 1) an infrastructure to collect and analyze the data; 2) and the need for a continued, sustainable engagement of all stakeholders in this iterative process, SB 116 was sponsored by Senator Townsend and Representative Bentz and passed in June, 2019. This legislation expanded the Collaborative to 17 voting members and established the Office of Value Based Health Care Delivery (OVHCD), under the Department of Insurance. This office would provide the infrastructure to establish affordability standards and collect and analyze data for the assessment of adequate levels of primary care spending. The OVHCD would also establish targets for carrier investment in primary care with recommendations to the Insurance Commissioner and the PCRC regarding appropriate levels of reimbursement rates for primary care.

After the passage of SB116, the expanded Collaborative reconvened in September with the new additional members and the three original members continuing as co-chairs. With the development of the OVHCD, the Collaborative proposed the following definitions as the initial framework for the work of this office.

Primary Care will consist of services within the following specialties and reimbursement for such services when in an outpatient or office setting, exclusive of pharmaceutical, radiological, laboratory or hospital expenditures. The clinicians would be providing general primary care services, exclusive of any areas of specialty, e.g, cardiology, oncology, nephrology:

- Family medicine physicians
- General pediatric physicians
- Geriatric medicine physicians
- Internal medicine physicians
- Nurse practitioners and Physician assistants providing stated general primary care services

The robust discussion around how to measure the level of primary care spending included whether the All Payors Claims Database (APCD), currently under the Delaware Health Information Network (DHIN), would be able to provide accurate claims data on primary care services, given the exclusion of self-insured, large employer plans, which are usually considered as ERISA plans. This was highlighted by the Supreme Court 2016 ruling on *Gobieille vs. Liberty Mutual*, which negated any mandatory data reporting by an ERISA health plan, for inclusion into data collection and analysis of costs of care. However, the Collaborative agreed that the DHIN APCD should be utilized to its maximal benefit and to strongly encourage voluntary reporting by ERISA plans for a more accurate analysis. This voluntary contribution of data could be aggregated data from the third party administrator, aligned with current claims specification in the APCD. There was highlighted a strong need to engage and educate large, self-insured employers about both the benefits of such reporting, as well as plans which may reflect a greater investment in primary care. The most cited benefit to these groups from such investment would be a healthier workforce with possible lower overall health care costs to the employer. ***The Collaborative will develop resources for greater engagement of self-insured, large employer groups to ensure increased voluntary data contribution for determination of spending levels and better understanding of the benefits of a strong primary care.***

Recognizing that there continues to be movement towards more alternative and value based payment models and to encourage higher participation in such payment models, the ***Collaborative recommends to include both claims-based reimbursement and non-claims payments***, which traditionally fall within value based payment models and exclusive of the fee for service claims payments. The non-claims payments would be self-reported aggregated data from payors currently contributing claims data to the APCD, as part of the determination of primary care spending in Delaware. The initial timeframe would be a look back to 2017-2018, which would be for the level of spend for primary care prior to SB227, and then 2019-2021 moving forward from the implementation of SB227.

While there continues to be a lack of consensus regarding the deliberative path necessary to increase investments in primary care, ***the following additional recommendations were agreed upon by the Collaborative:***

1. Re-affirm the basic concept in the first annual report that Primary Care is foundational to health care delivery in Delaware.

2. Practices which demonstrate a team-based or patient-centered medical home-like delivery of care should be eligible for more upfront investment.
3. Initial increases that will flow from the movement to value based care in upfront investments may be tied to an agreed upon definition of “risk” “accountability” and “value”
4. These upfront investments may be in the form of increased payment: per member per month; for care coordination; or as non-claims investments, including but not limited to practice infrastructure and health information technology.

Throughout all of the iterative discussions of 2019, there remains a strong commitment by the expanded Collaborative to the initial goals stated in SB227:

1. Payment reform
2. Value-based care
3. Workforce development and recruitment
4. Directing resources to support and expand primary care access
5. Increasing integrated care, including for women’s and behavioral health
6. Evaluation of system-wide investments into primary care, using claims data obtained from the Delaware Health Care Claims Database

Finally, the Collaborative recognizes that the COVID-19 pandemic, which continues unabated as this report is being discussed and voted upon, has severely strained the healthcare delivery system locally, nationally and internationally. Providers (both individual and hospital/health system) have operated at a level of financial loss during the pandemic which threatens the viability of some providers and will be an ongoing concern. These concerns will infuse the continued work of the Collaborative.

Operations

SB 227 originally defined the Collaborative to consist of:

The Chair of the Health Care Commission
The Chair of the Senate Health, Child and Social Services Committee
The Chair of the House Health and Human Development Committee

During the first half of 2019, the monthly meetings indicated that for sustainable and meaningful engagement of all stakeholders, the Collaborative would benefit from expanding to include such stakeholders. With the passage of SB 116, the number of voting members increased to 17 total with the following:

Primary Care Reform Collaborative Members

Senator Bryan Townsend, Co-Chair	Senate Health & Social Services Committee
Dr. Nancy Fan, Co-Chair	Delaware Healthcare Commission
Representative David Bentz, Co-Chair	House Health & Human Development Committee
Dr. Michael Bradley	Dover Family Physicians/Medical Society of Delaware
Dr. Christine Donohue Henry, MD	Christiana Care/Delaware Healthcare Association
Dr. James Gill	Medical Society of Delaware
John Gooden	MDavis, Inc./DSCC
Steve Groff	Division of Medicaid & Medical Assistance
Dr. Jeffrey Hawtof	Beebe Healthcare/ Delaware Healthcare Association
Leslie Ledogar	Department of Insurance
Christopher Morris	Aetna
Hon. Trinidad Navarro	Department of Insurance
Margaret Norris-Bent	Westside Family Healthcare
Kevin O'Hara	Highmark Delaware
Hon. Kara Odom Walker	Department of Health & Social Services (DHSS)
Faith Rentz	State Benefits Office/DHR
Leslie Verucci	Delaware Nurses Association
Dr. Veronica Wilbur	Next Century Medical Care/ DE Nurses Association

Pending legislation, in the form of SB206, will define all representation on the Collaborative, that is not by virtue of position, as appointments through the Governor's office. The original members of the PCRC, as defined in SB227, are the current co-chairs for the Collaborative.

To provide structure and organization, the members approved the following for operational procedures, as alluded to in SS1 to SB116, line 25:

1. Proxy representatives may have voting rights and shall be communicated to co-chairs as attending proxy prior to meeting so they may be included in meeting communications and information

2. Term limits: 2 year term with appointment as per SB 116 and SB 206, excluding ex-officio positions
3. Quorum for voting
4. Meeting information and materials to be sent out one week prior to meeting
5. An annual report will be made within the first quarter of each year to the Health Care Commission with a progress update and strategic goals.

Discussion

“Primary Care is Foundational to Health Care in Delaware”

The World Health Organization proclaimed in 2018 “that strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people’s physical and mental health, as well as social well-being and that PHC is the cornerstone of a sustainable health system...”¹

This statement reaffirms the value of effective, quality primary care and in the United States, there has been growing evidence of underinvestment in primary care in relation to overall health care spending. A study published in July, 2019 in JAMA Internal Medicine analyzed primary care spending as a proportion of total medical and prescription spending for fee-for-service Medicare beneficiaries. The calculated primary care spend, national, ranged only from 2-4.88%, depending on the definition of the primary care provider.² As states start to recognize this disproportion and the possible negative consequences which may have resulted, e.g., poorer quality of care with poorer health outcomes and increasing total health care spend, more and more states are actively developing health policy, focused on promoting sustainable investments in primary care. Delaware was one of three initial states to pass legislation with such policy. A critical loss of access due to lack of payment reform and stagnant workforce growth, along with increasing health care costs, have driven the impetus for legislation and policy in Delaware. Even since the passage of SB 227, it is becoming increasingly apparent that the instability of maintaining independent primary care practices is leading to a loss of access for Delawareans. The Primary Care Physician survey by the Delaware Department of Health and Social Sciences published in September, 2018, provided statistical evidence of the potential significant loss of primary care workforce in the next 5 years, as practicing physicians retire or move to alternative practice models, such as a concierge practice, which provides greater practice stability but with a much smaller patient population. This is evident as one of the Accountable Care Organizations (ACO) in Delaware reported that since 2017, 5 of their 30 practices have moved to complete or some portion of concierge practice with loss of patient attribution ranging from 11-80%. Any incoming workforce may be outweighed by the factors contributing to this attrition rate. The need to expand the provider workforce has been discussed within the PCRC and there is potential investment for primary care through HB257, which is proposed legislation for a state-sponsored health care provider loan repayment program. Stabilizing and enhancing the current and potential primary care provider workforce is also a mandate of SB227, and the PCRC recognizes this crucial aspect of investment in the delivery of primary care.

Outside of Delaware, since passage of SB 227 in June, 2018, there have been at least 5 other states who have passed legislation forming a primary care collaborative to look at ways to improve primary care investment, recognizing the need for better allocation of resources to improve investments in primary care. As noted in the first annual report, Rhode Island and Oregon have led the way, but in 2019, Colorado, Maine, Vermont, Washington and West

¹ World Health Organization. (2018, Oct). Declaration of Astana. Global Conference on Primary Health Care.

² Reid, R, Danberg, C, Friedberg, M. “Primary Care Spending in the Fee For Service Medicare Population,” JAMA Internal Medicine, July, 2019. 179(7). 977-979.

Virginia all created organizational structures to calculate primary care spending and have started on the path towards determining what is the “right” level of investment for primary care. After engaging in discussions with stakeholders on how to achieve a possible 12% investment in primary care through 2025, ***Delaware recognized the importance of such an infrastructure and moved forward with the development of the Office of Value Based Health Care Delivery (OVBHCD) under SB 116.*** Established under the Department of Insurance, this office will analyze primary care spending in relation to total health spending and provide relevant support for recommendations on what may be a target level of investment in primary care. As Rhode Island and Oregon have demonstrated, organizational structures such as the OVBHCD are essential to providing accurate data research and analysis on an annual basis and necessary for determining long term adjustments in primary care and total health care spending.

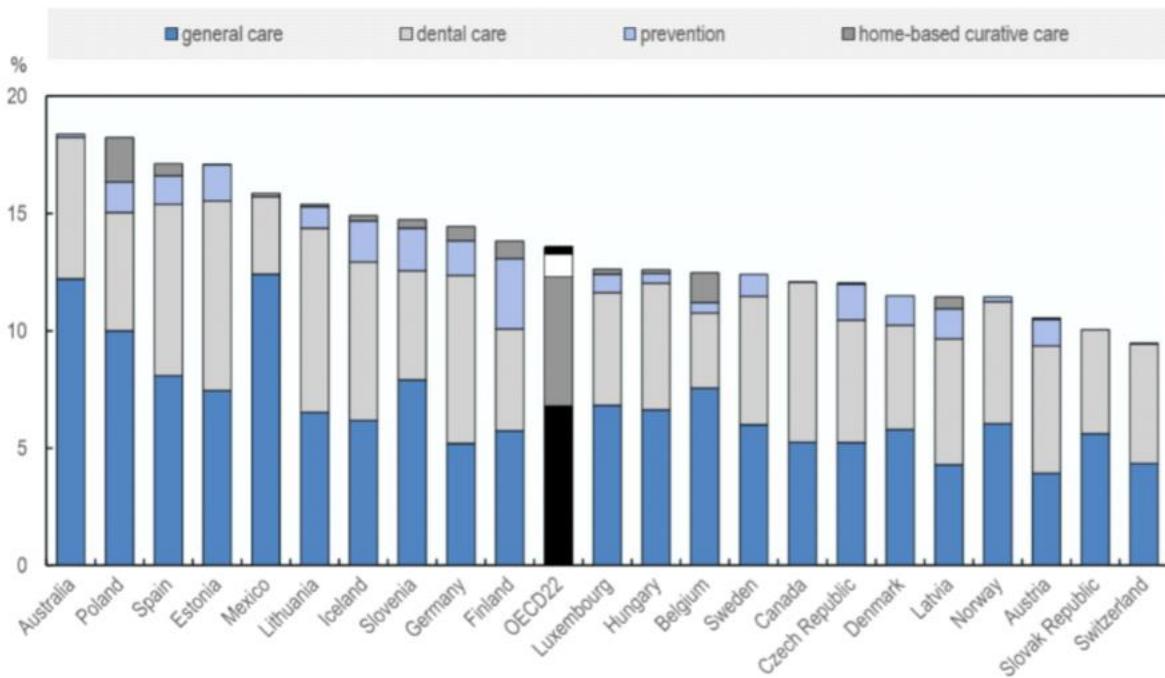
As each state develops its own program, what the “right” answer looks like may be very different for each state. The report “Investing in Primary Care” published in July, 2019 by the Primary Care Collaborative, formerly the Patient Center Primary Care Collaborative (PCPCC), in collaboration with the Robert Graham Center had provided one methodology to standardizing the level of primary care spending throughout 29 states.³ While Delaware was not a participating state, the specialties noted in the definition of primary care for SB277 were also the same ones for the “narrow” definition of “primary care” used in the report. Because this was established in both SB227, and in a large statistical report which analyzed primary care spending, ***the Collaborative affirmed the specialties of internal medicine, family practice, pediatrics and geriatrics for the definition of primary care for Delaware.*** There was a level of discussion regarding the inclusion and impact of behavioral health providers and obstetricians/gynecologists for women’s health, since those specialties often provide “primary care” services to a significant population. However, not only would this fall in the “broad” definition of PC as per the PCPCC report, it would also be exclusive of the definition in SB227. Furthermore, the PCRC recognized that one of the mandates in SB 227 was to develop recommendations regarding the integration of behavioral health and women’s health into traditional primary care. Therefore, the PCRC determined that the narrow definition would be the most useful recommendation to the (OVBHCD) at the current time and to address integration of the other two specialties in the future.

If there is a comparison globally, the Organization for Economic Co-operation and Development (OECD) has been analyzing data regarding primary care for over 15 years. Figure 1 demonstrates the level of primary care spending relative to total health care spending in a sample of countries, with the average level at 14%.⁴

³ PCPCC “Investing in Primary Care: A State Level Analysis” July 2019.

⁴ OECD. (2018, Dec). Focus on spending primary care: first estimates. www.oecd.org/health

Figure 1. Spending on primary care services as share of total health spending among 22 OECD countries, 2016



Source: OECD Health Statistics 2018.

Figure 3. Spending on primary care services as share of total health spending among 22 OECD countries, 2016⁶

While the United States does participate with OECD, it does not contribute data for this particular analysis. A lack of standardization in the calculation of primary care may be a contributing factor as to why the US has been unable to put forth such data as well as an inability to determine a baseline or benchmark for primary care spending. As more states build infrastructure to collect and analyze data specifically for that goal, there may be greater information to support a baseline and benchmark for primary care spending. Since Rhode Island established a 10% and Oregon a 12%, in 2019, Colorado, with its Department of Insurance, chose not to establish a target level but rather incremental increases of 1% per year through 2022.⁵ The initial recommendation from the Delaware PCRC was also for 12% with incremental increases of 1% each year until 12% or 2025. In 2019, there were varying discussions within the expanded Collaborative regarding why 12% may or may not be a suitable benchmark, as well as whether there should be a benchmark at all. While this discussion did not re-affirm the initial 12% recommendation, it was agreed upon that what the “right” level is and how it may be achieved in the complex health care market of Delaware may become clearer with the work and recommendations of the OVBHCD, in collaboration with the PCRC.

⁵ Colorado Primary Care Payment Reform Collaborative Recommendations: First Annual Report, December, 2019.

Investing in Team-based Care or Patient Center Medical Homes as Care Delivery Models

Few discussion regarding the past, present and future of primary care exclude the seminal work of Barbara Starfield. The 2005 publication “Contributions of Primary Care to Health Systems and Health” established the core principles of primary care: First contact access; person, not disease-focused; comprehensive; and coordinated.⁶ These principles have become known as the “4 C’s” – contact, continuity, comprehensive and coordinated. Additionally, variations have been put forth, such as the Agency for Healthcare Research and Quality, which included quality and safety.⁷ These concepts are at the center of a care delivery model such as the patient centered medical home (PCMH). While PCMH incorporates all of these defined values of primary care, it also adds the need for the care to be provided by a personal clinician who directs the care and connects the delivery of such care to payment. The rise of the PCMH model aligns with the move away from volume-based, episodic care that defines the fee-for-service payment model to a broader, more comprehensive, integrated delivery of care with appropriate compensation for such care. The benefits of the PCMH model was noted in the first annual report, with reported results from the BCBS of Michigan PCMH program and Vermont’s initiative to provide a base PMPM for PMCH practices. These programs are in addition to the fact that in Rhode Island, 70% of their primary care practices are in a PCMH model and in Oregon, one of their core organizations is the Patient Centered Primary Care Institute. However, the needed practice transformation to a PCMH can require a significant investment, as does a successful team-based care delivery model, which is less specialty focused. Because of the needed level of investment, this type of care delivery is difficult to achieve in a fee-for-service payment model. Furthermore, there has been marked development of certification and measurement programs regarding the qualifications and outcome metrics of such care delivery models, adding to the cost for a practice to develop one of these types of care models.

During the discussions in the spring regarding different programs which have provided varying levels of payment for care coordination, it was noted that advanced clinical models, such as PCMH, when tied to alternative payment models may have better outcomes in quality and cost. Another report from the PCPCC “Advanced Primary Care: A Key Contributor to Successful ACOs” drew that conclusion after both a literature review of multiple studies and a quantitative analysis. It was noted in the report that as of 2017, up to 49% of all family medicine practices were in a medical home model.⁸ Their analysis concluded that when an ACO had PCMH practices within their network, the ACO performed better in quality and cost outcomes. The report utilized NCQA recognition for the PCMH designation within the ACOs. The PCRC had a fellow from the Robert Graham Center to discuss the report in more detail. Additionally, two fellows from the John Hopkins Bloomberg School of Public Health presented an analysis of various programs which related different care models to alternative payment incentives, specifically upfront investments such as care coordination. The JHU presentation also concluded that pairing a care delivery model with an alternative payment model may improve quality and cost.

⁶ Starfield, Barbara, et al, “Contributions of Primary Care to Health Systems and Health,” The Milbank Quarterly, 2005, V 83(3), 457-502.

⁷ <https://www.ahrq.gov/ncepcr/primary-care-research/workforce-financing/white-paper.html>

⁸ PCPCC “Advanced Primary Care: A Key Contributor to Successful ACOs”, August, 2018.

In Delaware, there had been significant practice transformation for a number of primary care practices to PCMH, reaching NCQA Level 3 designation. However, given the cost of the continued certification, administrative burden and the lack of additional reimbursement for a PCMH model of practice, most of those practices in Delaware have not continued their certification, despite having all the core values of a PCMH. Given this current status, an additional presentation was made to the PCRC regarding the variations in certification and measurement programs for PCMH practices. Several other programs were discussed that might be more cost-effective to practices than NCQA and provide, for payors, a qualitative measure regarding the value of a PCMH practice. Of note, Oregon and New York have developed their own certification for PCMH practices and at least one payor has tied an alternative payment model incentive for PCMH practices. ***There was no conclusion on the part of the PCRC to endorse any one certification process, nor to develop a specific certification process for Delaware. However, there was consensus that there could be greater investment through higher reimbursement or payment incentive, for advanced clinical models, including PCMH or a team based care practice.*** This may be counted towards additional investment in primary care through practice transformation. What does that look like?

Initial Upfront Investments and Alternative Payment Models

This area has proven to be the topic of extensive iterative discussions on the part of the PCRC and also one of the least conclusive. In both the fall of 2018 and the first part of 2019, discussions centered around the specifications of upfront investments. As noted before, there were several presentations specifically regarding the benefits of alternative payment tools, such as payment per member per month or care coordination payments as investments for the sustainability of primary care and to advance to a more comprehensive care delivery model. Most of these discussions occurred during the spring of 2019, prior to the establishment of the expanded PCRC through SB116 and therefore was not voted on as a consensus recommendation. However, during the discussion, there was general consensus between all stakeholders, regarding a list of services, which may be considered essential aspects of care coordination or care management. (*see appendix for meeting February 18, 2019*) The care management described is beyond the traditional definition of “Chronic care management” and reflects services that would qualify as part of a prospective payment to practices for identifiable patients. The JHU presentation provided some common themes from successful models in the analysis: clear goals for outcomes with a vision for the delivery of care; timely and accurate data sharing; risk adjustments in patient panels; prospective payments which are connected to a focused set of metrics and performance based on the “4C’s”; and finally, the use of a multidisciplinary care team.

Since then, there has continued to be robust discussions on how to move practices from fee-for-service to alternative payment models (APMs), which may include some form of prospective payment but may also be associated with a level of downside risk for practices if outcome metrics are not achieved. There was some discussion regarding the forthcoming CMS programs, Primary Care First (PCF) and direct contracting, although the current consensus is that there may be only a low level of engagement of practices in Delaware for PCF due to the concept of a downside risk, even with an upfront flat PMPM payment. Additionally, only larger practices or organizations may have the capacity for direct contracting, which reflects a total cost of care

payment model, given the potential amount of downside risk. Another model discussed during the PCRC meetings was the development of a Medicaid ACO, which has since been put out for application. Given the relative success of the Medicare shared saving ACOs in Delaware, with demonstrated cost savings and increased practice transformation, transitioning to a multi-payer platform would be a reasonable expansion of practices participating in alternative payment models. During one of the meetings focused on funding proposals, a variation on this concept was proposed, which would leverage the ACO infrastructure for blended APM payments to the practices within the ACOs, with varying levels of upfront or incentivized payments and risk. However, while there have been some practices in certain ACOs to contract successfully within other value based payment models and therefore leverage their practice transformation experience, even the largest Medicare ACO in Delaware has not moved beyond the Medicare shared savings APM. Furthermore, while the commercial payors had reported increased uptake in their value-based payment models, as compared to 2018, there was again the concern expressed by all stakeholders represented on the Collaborative, regarding the persistently significant overlay of fee for service as the primary source of payment to practices. The varying levels of readiness for practices with enough practice transformation to participate in APMs impede the overall progression away from FFS but there was no consensus on what may be a recommended “glidepath” that could incorporate sufficient investment balanced with the benefit of cost savings in total health care spending. While there was some consensus among members of the PCRC regarding the need for flexibility for payors and providers, and that the role of the PCRC was not to be prescriptive, there was a lack of consensus in determining recommendations for what would define “sufficient” upfront investment and in what form would that investment be, so that practices could move away from FFS and be successful in value based or alternative payment models.

This last component of “cost” has elicited a wide variety of comments and points of discussion within the PCRC. *The Collaborative continues to support and recommend that while the goal is to increase investment, i.e. spending in primary care, there should not be an increase in the total cost of care.* This is consistent with the goal of the State benchmarking process. However, there is recognition that increasing primary care spending is a “cost” and what recommendations could be made to fund the “cost” has not been agreed upon by the members of the Collaborative. Clearly if practices are able to move towards APMs with some downside risk, there could be greater cost savings and overall decreased total cost of care. But as noted above, this only achievable through a certain amount of upfront or incentivized payments. A presentation by the State Employees Benefits Plan, which has a representative on the PCRC, demonstrated an in-plan analysis of their level of primary care spending compared to other components of their spending costs. The significant disparity was also highlighted by a companion presentation from JHU and Arnold Foundation, which examined for Delaware private price variations for inpatient costs relative to Medicare costs. While this is one perspective regarding other components of health care spending within Delaware, the need to look holistically at health care spending in Delaware and to make appropriate recommendations to support increased investment in primary care will continue to be a crucial aspect of the work of this Collaborative. This will include extensive discussion within the PCRC regarding possible funding proposals from its stakeholder members.

Next Steps

The meetings during 2019 and the early part of 2020 have demonstrated that alignment of payers, providers and all stakeholders on what level of primary care spending is substantial enough for a “sustainable health system,” and what comprises that investment, is both challenging and progressive. The expansion of the Collaborative and the development of the Office of Value Based Health Care Delivery continues to establish the infrastructure to guide the comprehensive policy for primary care reform. While there has been no consensus regarding what would be “acceptable” levels of upfront or prospective investments with what definitions of risk and accountability, there has been some alignment that this is possible within the framework of alternative or value based payment models. There is clearly more movement towards participation in such payment models, but how quickly and how much investment is needed for greater practice transformation to achieve success in non-fee-for-service payment models is difficult to predict. ***Incentivizing practices to move towards a patient-centered medical home or team based care model may require significant resources*** for the practice to develop infrastructure for accurate data analysis for performance and higher investment in multi-care team members. For advanced primary care practices, progressing towards downside risk in an alternative payment model should also be incentivized with prospective payments and not be associated with greater administrative burden. Providing these resources should not be considered an added “cost,” but how that funding is achieved and for what outcomes will continue to present a tension that will pre-occupy the PCRC, as well as infuse potential recommendations from the OVBHCD.

Additionally, there is the continued work in determining primary care spending targets and what target may be warranted, reasonable and feasible. Therefore, to make primary care spending targets warranted and reasonable, ***the PCRC will need to address its role in establishing standards for concepts***, such as “risk”, “accountability” and, most importantly, outcome metrics with alignment of payors and providers. Such metrics clearly will need to be measurable, meaningful and not burdensome. For such targets to be feasible or affordable, ***the PCRC will need to continue to look at the total cost of health care and what components could be more cost saving so that greater spending could be attributed to primary care without increasing the total cost of care***. This should be part of the integration of the work of the PCPR within the broader work of the State and the benchmarking process. The PCRC could leverage the State’s position as both a larger payor and consumer of health care delivery through Medicaid and the State Employees Benefits Plan to progress towards the greater investment in primary care.

Finally, the PCRC has recognized the need for greater engagement with a large segment of health care consumers, in the self-insured, large employer groups. The PCRC recommends that there should be greater resources available to the self-insured, large employer groups regarding the benefits of a strong sustainable primary care and the needed investment to strengthen our current delivery of primary care. ***Additional work in this area could be the development of a subcommittee for learning collaboratives, including representatives from payors, providers and consumers.***

Primary Care Reform Collaborative Appendices

Appendix A
Primary Care Reform Collaborative
Meeting Minutes

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SB 227 Primary Care Collaborative Meeting

Tuesday, February 12, 2019

6:00 p.m.

Medical Society of Delaware

900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

Present:

Senator Bryan Townsend
Dr. Nancy Fan
Representative David Bentz

Email:

Bryan.Townsend@state.de.us
nfanssmith@yahoo.com
David.Bentz@state.de.us

Staff:

Julian Emory
Read Scott

Julian.Emory@state.de.us
Read.Scott@state.de.us

Attendees:

Susan Conaty-Buck
Deborah Zarek
Andrew Wilson
Gary Kirchhof
John Fink, MD
Regina Heffernan
Stephen Cozzo
Christine Donohue Henry, MD
Jamie Clarke
Stephen Groff
Steven Costantino
Charles Jose
Rosa Rivera
Pam Price
Jennifer Mossman
Dan Elliott
Faith Rentz
Sylvia Cantera-Brown
Kim Gomes
Elisabeth Scheneman
Kiki Evinger
Lisa Zimmerman
Maggie Norris Bent
Rose Kakoza

Organization:

Delaware Coalition of Nurse Practitioners
Medical Society of Delaware/Physician
Medical Society of Delaware/Morris James
Highmark
Bayhealth
AmeriHealth Caritas
AmeriHealth Caritas
Christiana Care Health Systems
Nemours
DMMA
DHSS
Robert Graham Center
La Red Health Center
Highmark
Highmark
Christiana Care Health Systems
Department of Human Resources
Delaware Pediatrics
Byrd Group/Medical Society of Delaware
DHSS
DHSS
DHSS
Westside Family Healthcare
Christiana Care Health Systems

Weston Riesselman	Christiana Care Health Systems
Katherine Collison	DHSS/DPH
Kelly Anderson	Johns Hopkins School of Public Health
Jessica Hale	Johns Hopkins School of Public Health
Chris Manning	Nemours
Wayne Smith	Delaware Healthcare Association
Meredith Tweedie	Christiana Care Health Systems
Christine Schultz	Parkowski, Guerke & Swayze
Kelly Krinn	Health Management Associates
Art Jones	Health Management Associates

The meeting was brought to order at 6:00 p.m.

Dr. Deb Zarek, Medical Society of Delaware

- I am an internal medicine physician with private practice. I am representing the primary care doctors in the area.
- It is difficult to get primary care doctors to move to the area because pay is low and new graduates have high loans.
- I am happy about the bill; it is a step in the right direction.
- I am concerned that not all payers are paying the Medicare rates. We need to discuss what happens if these rates are not paid and if there are any consequences.
- Dr. Jim Gill will be joining us later, and he has provided a few additional points. We agree with the Collaborative's goal of increasing primary care spending to 12% of the total health care spend.
- We need a measure of primary care that is standardized and valid. **We will provide a citation for this definition of primary care from Milbank.**
 - Pharmacy costs should not be included in the definition of primary care because that doesn't represent revenue supporting primary care practices.
 - Also not included: Labs, imaging, hospital costs unless provided by primary care physician, facility fees, emergency room, and non-primary care services.
- Even with this definition, 12% spending on primary care is the minimum that should be considered. Colorado has a bill calling for 15% of spending on primary care.
- Not all the primary care spending should be FFS, but FFS is still a large component of our health care reimbursement. It is important to maintain rates at least matching Medicare rates. This requirement from SB227 should expand bill to all Medicaid, MA, and commercial plans.
- Care coordination fees should be included in the 12%. All payers should pay a minimum per member per month (pmpm) fee that is prospective and guaranteed totaling at least \$15-20.
- Primary care providers need to hire nurses and other staff to provide coordinated care. Studies show care coordination care can improve quality and costs.

- Reimbursement for quality and cost savings may be subject to modification, but the care coordination fee must be provided in full in order to ensure primary care practices can operate.

Rep. Bentz

- You are concerned that not all reimbursements have been elevated to Medicare rates. Is that a system or isolated problem?
- We specifically delayed implementation at payer request to make sure they were ready to implement this change. It is disappointing to hear that this is happening given the delay.

Dr. Deb Zarek, Medical Society of Delaware

- There are some that are paying the higher rates and some that are not.
- We can get this information to you.

Sen. Townsend

- The Department of Insurance is not at this meeting, but they will be invited, and they need to be aware of any failure to comply. They met with stakeholders in December to discuss this issue.

Gary Kirchhof, Highmark

- Director of Commercial Contracting at Highmark
- Highmark provided our response to the report.
- First, we believe the patient should be at the center of the solution.
- We believe in a value-based reimbursement (VBR) approach.
- Currently, Highmark spends 8% on primary care, including VBR. We do provide resources and care coordination fees upfront.
- We believe that reimbursement increases should not be done without improvements to quality and lowering the total cost of care. VBR can be useful beyond primary care as well.
- We should look at how we should use physician extenders to shore up primary care access.

Dr. John Fink, Bayhealth

- I am a family physician. I have worked as an employed physician and in private practice. Medical director for the outpatient medical group. I am here representing Dr. Siegelman, CMO and the organization [Bayhealth].
- We want to support role of employed physicians in the network. We are trying to grow the primary care base in Sussex County, filling the needs of the community and playing an important role in recruiting.

- We support this initiative in general. Addressing primary care is not just about reimbursement, but also about reducing the burdens on primary care.
- Value based payment (VBP) can place a burden on independent and employed physicians.

Dr. Nancy Fan

- Regarding increasing primary care spending – are employed physicians counted under hospital or primary care costs? Employed physicians walk a fine line by working for the hospital.

Dr. John Fink, Bayhealth

- Our concept is that whether employed or in private practice, a primary care physician is a primary care provider. The abilities of an employed may be able greater to address acute care spending by leveraging the connections and tools of a health system.
- A primary care physician is still operating as a patient's primary care provider. As a health system, our patient centered medical homes (PCMHs) are set up the same way.

Dr. Nancy Fan

- And you use PCMH as your model for primary care delivery?

Dr. John Fink, Bayhealth

- Yes

Regina Heffernan, AmeriHealth Caritas

- Here representing AmeriHealth Caritas.

Steve Cozzo, AmeriHealth Caritas

- Director, Public Policy
- Amerihealth Caritas is an MCO, entering our second year in Delaware.
- Primary care providers are a cornerstone in our care model. It is important to maintain a robust network in all areas of the state.
- Primary care providers are important resource for us to help our members get the social supports they need.
- We participate in VBP agreements with several providers, but they are all upside risk only. We are exploring opportunities to expand these models to downside risk.
- Our measures are aligned with what the state requires in HEDIS and financial metrics.
- It is important to keep a focus on quality, outcomes, and providing supports outside of financial supports to our providers, so they are able to meet those benchmarks.

Dr. Christine Donohue-Henry, Christiana Care

- CMO of Community Care at Christiana.
- Christiana's goal is to transform ourselves from a health system to a system that delivers health to our community, and primary care is the foundation.
- We have gotten NCQA PCMH designation at all primary care practices recently.
- We are expanding primary care capacity to deliver primary care – we have hired 5 primary care physicians and 15 advanced care providers to join our primary care practices.
- We have done work with our specialty colleagues as well. We need to change the FFS mindset in specialties. How can the PCP talk with specialist to get to the root problem without an official visit?
- We want to share our learnings with our partners both with eBright ACO and the Clinically Integrated Network.
- Primary care should be viewed separately from hospital costs within a health system. Primary care is an investment in the community. The primary care physician has some control of hospital and ED utilization and can make an impact on total cost of care.
- Moving forward, the target was 60% of reimbursement in a VBP structure, but it needs to be a meaningful VBP.
- We want to move to upside and downside risk with total cost of care. We are starting to see progress in our conversations with payers, but anything on the policy side to accelerate that transition would be appreciated.

Dr. Nancy Fan

- When talking about current value-based contracts not being meaningful, is it that the administrative burden inhibits the ROI?

Dr. Christine Donohue-Henry, Christiana Care

- VBP is such a small percentage of the revenue. We are still largely FFS-based and if we want to transform we need to go to total cost of care. We want to move beyond the CPC+ model.
- We are working to build the competencies to get to a total cost of care model.

Dr. Nancy Fan

- CPC+ is offered by CMS, but not currently in Delaware.

Dr. Christine Donohue-Henry, Christiana Care

- Christiana has two practices in New Jersey that participate in the CPC+ model and receive the upfront pmpm payments for resources through that model. CPC+ is a step along the way to a total cost of care model.

Jamie Clark, Nemours

- Executive Director of Value-Based Care at Nemours
- We believe that reimbursement for non-traditional workforce like community health workers (CHW) and case managers will be essential. We also need payment and programs that address social determinants of health. There are not enough resources to address this currently.
- The increased delegation of responsibilities is essential, such as care coordination and case management. We need to know who can be most effective in managing the patient.
- We need to agree on meaningful and actionable measures. Using industry standard of HEDIS is not flexible enough and limited in relevance to children.
- Real-time, actionable data is a concern. We are in upside only contracts. When we move to a risk relationship, we need actionable data.
- We have administrative issues with payers, for instance a new MCO or system migration can be a big problem for the providers.
- We believe VBP is important up to delegated risk. We believe we should be delegated for certain functions. The provider, not the payer, should do the case management and get paid for it. We should take risk on total medical expense and get paid an administrative fee. The payer receives an administrative fee that would be passed to the provider. That administrative fee would not be at risk because taking the provider is taking risk on the medical expense.

Steve Groff, Medicaid Director

- Fundamentally we would be most supportive moving forward in a value-based environment rather than raising FFS.
- That being said, we recognize the need to support primary care because it is a crucial element to getting improved health outcomes.
- One challenge is getting an understanding of what the problems are that we are trying to address. We want to make sure the solutions we are talking about are addressing the specific and unique barriers in Delaware that might not be true in other states.
- Another concern is the readiness to move to risk or total cost of care payment models. We all want to be there eventually, but all at a different point and we need to move as quickly as possible without leaving behind practices.
- Lastly, I share concern about our ability to share and use data.

Dr. Nancy Fan

- Is your concern about using data because it is mostly claims-based, we lack the technical ability to get live data, or the concept of using data as a measure of payment?

Steve Groff, Medicaid Director

- Yes to all.

Steven Constantino, Department of Health and Social Services

- The whole issue of data is that we need data for a lot of reasons. The provider and payer both need quick feedback in a VBP world. Ultimately, we need to make reconciliations and the data needs to reflect the risk for risk corridors or other financial tools.
- There is a disconnect in the definitions we are using. What do you mean by risk – is that simply an incentive payment, is it shared savings – both are FFS? Or is it a prospective payment and taking on the risk of the patient? I would like to get out of this how we define risk.
- The Secretary has talked about moving away from FFS and tying it to high quality and lower cost.
- The thresholds in new MCO contracts are on VBP – the 60% VBP that moves along the taxonomy from FFS to downside risk on population. It is a glide path. Some may think it is too quick or too slow. That will be reviewed each year with MCO.
- Also in the MCO contracts are quality thresholds. These are not just looking at the risk model but also looking at quality. There are also thresholds on certain quality metrics (7 metrics) that put pressure on the system to look at both cost and quality.
- The University of Delaware did do a study on the lack of primary care services in the state and that access issue is a tremendous challenge. There are different reasons people don't go into primary care and we should look at this through a holistic lens because it is not just an impact of the health care system.
- In terms of investments, the Secretary would really like to see these investments tied to models, like PCMH or addressing SDOH.
- Look at other states Rhode Island or Oregon, many of the primary care investments have been tied to new and different models.
- The SIM grant offered mini grants trying to improve the readiness of practices for VBPs.
- At the federal level there will be new models and providers need to be ready to apply for these models and to take on risk. There have been some criticisms that the federal models have been too focused on the shared savings and new models will move toward downside risk.

Dr. Susan Conaty-Buck

- I am representing the nurse practitioners.
- The study from the University of Delaware was only looking at primary care physicians. We will be doing our own study to assess where NPs are practicing in Delaware.
- We have the ability as NPs to practice independently, but we do not have the structure for these providers to get into practice. They do not have the infrastructure and they do not have parity from insurers.
- People would be paid for what they are doing – each service should be paid the same across practices and that is not the case.
- We all want to look at SDOH and we all want an equitable system that allows all providers to provide care.

- The patient should have the right to see who they want to see, but that is not true in Delaware for NPs. We are wasting a resource. We are not supporting a group that wants to work and is facing barriers to practicing independently.
- Those who do best are the ones working in systems – they have more supports, but we need similar support if we want providers to be able to survive outside of these systems.

Dr. Nancy Fan

- Dr. Art Jones from HMA will facilitate. We want to work through these questions stemming from report.
- This will focus on how to move forward on payment reform. There are many other aspects including workforce and access challenges, but this set of meetings pertains to payment reform.
- We might need to come up with some aligned definitions.
- Those at the table will be here for all four meetings. We reached out because we want to hear from these stakeholders. We will be adding DOI and the FQHCs as participants in these meetings. If there are other stakeholders that would be important, please reach out so we can consider them.

Dr. Art Jones, HMA

- The participants affirmed that have a problem with primary care access in Delaware.
- We also consistently heard that there is a combination of lifestyle issues, payment issues, and administrative burden that create barriers to practicing primary care in Delaware.
- Let's move on from defining these problems to consider practical solutions.

Dr. Deb Zarek, Medical Society of Delaware

- I want to make a couple other comments about quality measures. In primary care you are always trying to do your best. The problem with these incentive plans is you get paid after you show that you did something. We are asked to meet all these quality measures, but there is no financial incentive to make sure we can accomplish these goals.
- It's great that Christiana has been able to become PCMH. It is very expensive and not feasible for my private practice to get certified. Furthermore, there is no increase in payment for PCMH certification. I would love for my practice to be a PCMH, but I need the money up front to hire people and get the resources to be a PCMH.

Dr. Art Jones, HMA

- Do we need upfront payments in order to achieve the outcomes we want to see?
- What is the downside of that from a payer perspective?
- If no one has any concerns about upfront payments, then we need to discuss the magnitude.

Steven Constantino, Department of Health and Social Services

- Are insurers paying for PCMHs? Are there contracts for PCMHs?
- I recently saw a map for the Medicaid population showing that there were no contracts with PCMHs. I would like to know on the commercial side, are there any contracts with PCMHs?
- At one time Highmark had a PCMH program, but then the model changed.

Gary Kirchhof, Highmark

- We had a program that provided an incentive for PCMHs. We replaced all incentive programs with True Performance; this program has an upfront payment as a pppm.

Pam Price, Highmark

- The pppm payment is on scale, based on the patient risk.
- For someone young and low risk, the provider might get \$2.50 pppm, and it scales up so someone with chronic care gets \$16 pppm.

Dr. Nancy Fan

- And my understanding is that True Performance is overlaid on FFS. Is there an on ramp away from FFS?

Gary Kirchhof, Highmark

- Yes, there are multiple levels of risk including full risk model. We do not think all providers are ready and so we have a glide path.

Dr. Nancy Fan

- Any practices in the end (total cost of care)?

Gary Kirchhof, Highmark

- No none at the end of that path, but we have practices that are making progress.

Dr. Nancy Fan

- Is there alignment between those with a higher pppm and the practices with more readiness in their delivery model? Are the practices that have been successful PCMHs?

Gary Kirchhof, Highmark

- Not that I'm aware of. We can look across our entire footprint.

Dr. Nancy Fan

- I think this would be a good piece of information for us to have.

Dr. Christine Donohue-Henry, Christiana Care

- It would be helpful to focus specifically from Delaware. The Pennsylvania market is much more advanced.

Gary Kirchhof, Highmark

- Delaware is on the low end of the risk models. We are all in the upside-only models, without downside risk yet.

Dr. Nancy Fan

- From the original meetings, we heard that there has been low uptake of value-based payment models. This might impact the low access and high cost.

Dr. Art Jones, HMA

- What should practice get paid for?
- What do practices need to be able to show in terms of what they invest in and outcomes?

Dr. Jim Gill, Medical Society of Delaware

- I am a family physician working with MSD working with our primary care payment reform committee.
- The AAFP has proposed a new payment model framework. This compartmentalizes the types of payments we need to consider:
 1. Services, office visits and procedures (this may be paid FFS or capitated)
 2. Care coordination fee
 3. Quality of care payment
 4. Utilization and costs payment
- The first two quadrants should not be subject to risk based on quality, but the other two may be.

Dr. Art Jones, HMA

- What accountability should there be for the care coordination fee?
- If I'm the payer, how do I know that this is going to care coordination activities?

Dr. Jim Gill, Medical Society of Delaware

- There could be documentation. Care coordination is a unit of service that is required for primary care.
- The care coordination fee should be \$15-20 pmpm on average. That cannot be subject to risk because a practice must hire staff and do the work regardless.

Dr. Christine Donohue-Henry, Christiana Care

- I agree with Dr. Fan that perhaps we need different models, but maybe limited to 3 or 4 models.

- I think that model Dr. Gill highlights makes sense especially in a private practice world.

Dr. Nancy Fan

- Is this a modular menu?

Dr. Jim Gill, Medical Society of Delaware

- You must pay for the first two, but the other two are more optional based on your goals.

Dr. Christine Donohue-Henry, Christiana Care

- I think the weighting of these quadrants matters – if you want to impact quality and costs you need to emphasize the last two quadrants.

Dr. Nancy Fan

- This is still an overlay on FFS?

Dr. Jim Gill, Medical Society of Delaware

- No, the first quadrant could be completely capitated.
- In quadrants 3 and 4, you could provide nothing, but you will not get great outcomes.

Dr. John Fink, Bayhealth

- CMS provides different models based. Care coordination is ultimately about quality. The more advanced models are available for providers who are willing to take on more risk.
- I think there needs to be a floor for payments, but for increased readiness, practices can be at risk.

Dr. Nancy Fan

- Can provide this fee to multiple different clinical settings?

Dr. Jim Gill, Medical Society of Delaware

- Yes. Some settings might be willing to take on full capitation, but other smaller practices may not be willing to take on a capitated model.

Dr. Christine Donohue-Henry, Christiana Care

- We would not be satisfied with that as the end goal. We believe that we want to move to a total cost of care model.

Dr. Art Jones, HMA

- What is your reaction as a payer? You are providing some care coordination services – so where is your concern for duplication, costs, benchmarks on total cost of care?

Sen. Townsend

- Having silence on issues defeats the purpose of these meetings.
- For those who might not have been here for earlier meetings, these meetings could be used to discuss ways forward that get us to a better place on outcomes and costs and build consensus, but if there is a breakdown in discussions, we will still be moving forward with solutions to address the primary care crisis.

Dr. Art Jones, HMA

- I want to prepare the hospitals to weigh in on this question as more effective care coordination models should reduce ED visits, ambulatory-sensitive admissions and readmissions? We will also want to hear from you next.
- For the payers – increasing spending on primary care through fee for care coordination, what is your concern? What are you looking for in exchange for paying these care coordination fees?

Steve Cozzo, AmeriHealth Caritas

- One thing to keep in mind, we want to make sure in terms of redundancy is that there is one single care coordination entity. This can cause disruptions especially as providers take on risk.
- We also want to ensure that data is available to properly share in a timely, actionable way.
- We are managing for quality and financial benchmarks from the state, so we are concerned about provider readiness.

Dr. Art Jones, HMA

- And also sharing care plans on those complex patients that you have in the plan's care management?

Steve Cozzo, AmeriHealth Caritas

- If feel confident we can share these, but that is not my area of expertise.

Dr. Art Jones, HMA

- Do you have any financial concerns or accountability?

Steve Cozzo, AmeriHealth Caritas

- I think if you are going to put primary care providers at risk, then the risk is the accountability.

Steve Groff, Medicaid Director

- I agree that the risk is a way of keeping providers accountable if we are moving to risk. Dr. Gill's model is a step to total cost of care.
- If we are paying care coordination as a fee for services and there is no way of assessing the impact of the care coordination, then I have some concerns.

Steven Constantino, Department of Health and Social Services

- We have been in a FFS system for 50 years. We still talk about care by code. We are still adding codes to address this problem.
- We also need a definition for care management.
- The care management fee must be tied to something; it must actually reduce ED visits, readmissions, etc. There must be performance metrics tied to it, and you can risk adjust because someone with chronic conditions is not equal to someone without those conditions.
- From a Medicaid point of view, is having a care management code additive or can we link it to changes in health and utilization elsewhere?

Dr. Nancy Fan

- We are talking about this as an upfront investment as a pmpm. A lot of VBP contracts have quality metrics included as a carrot – like shared savings or bonus payments.
- If we agree that care coordination is an upfront investment, then what is the accountability?
- Recognizing that our current data system for performance improvement is poor, should DHIN be involved in these discussions?
- I think I would like us to have some consensus on the framework we want moving forward.
- Payers are speaking for national organizations, but we care about Delaware right now. Can you get buy-in from your organizations? This would help the providers buy-in.
- There is interest in moving to total cost of care, but we do not foresee that in the immediate future.

Steve Cozzo, AmeriHealth Caritas

- I am not the best to speak to specific quality metrics.
- We have a tailored approach to meet the specific market needs.
- We can certainly bring back and discuss Delaware specific solutions

Gary Kirchhof, Highmark

- Today we do not have a measure that outlines the actions required of providers.
- The idea is that pmpm is available for providers to freely use as they need.
- We have transformation consultants and data specialists that are also available to providers

- We focus on upside outcomes.
- I am not prepared to say specifically what we want from care coordination fees.

Dr. Art Jones, HMA

- One concern is that putting extra dollars into care coordination inflates the total cost of care.
- We want to see changes in quality and outcomes. How do you respond to that concern?

Dr. Jim Gill, Medical Society of Delaware

- It is reasonable to put some parameters around care coordination fees.
- Medicare pays a daily SNF fee – that is a care coordination fee. There are some parameters that you must document in your daily work in order to get the care coordination fee.
- There is probably a reasonable way to say that you would document a set of basic activities for the typical patient.
- We need a floor on care coordination fees, maybe there are extra parameters that can increase the care coordination fees.
- And accountability has nothing to do with codes.

Dr. Nancy Fan

- That just sounds like more administrative burden. There needs to be an administrative task taken away if we are adding administrative tasks.

Dr. Art Jones, HMA

- In Connecticut, they simply have to say what they are paying for – like employing staff who are performing the care coordination function.

Dr. Jim Gill, Medical Society of Delaware

- You cannot be at risk for things you cannot control. Primary care providers have no control over hospital costs. But you could get to a place where the primary care community has control. There could be a hospital budget or primary care could set the rates for procedural fees and decides if the hospital gets paid or not.
- No one in primary care should be accountable for cost they cannot control.

Dr. Art Jones, HMA

- From a hospital perspective, what is your response? This would be one way of shifting more of the total health care dollar into primary care, reducing what is available for other services.

Dr. Christine Donohue-Henry, Christiana Care

- We are absolutely preparing for reducing hospital utilization.
- One aspect is care standardization, limiting costs and improving quality.
- We had a definitive effort to standardize and reduce NICU admissions. Following the standard of care and evidence-based guidelines to determine which babies should be in the NICU reducing spending. This is a hit to our bottom line, but we are ready to limit our costs and ED utilization.

Dr. John Fink, Bayhealth

- We are involved in bundled payment initiatives focused on decreasing total cost of care. This is going to benefit the organization and the community. We look at it as an investment in the community.
- We want to grow primary care and we understand the dollars must come from somewhere.

Jamie Clark, Nemours

- We want to make sure we have a track to managing the risk. We would love to have a double digit pmpm care coordination fee, but in our experience we usually have very low pmpm amounts that do not cover the salaries of the care managers.
- We are PCMH at all 12 sites in Delaware.
- We are able to get pmpms, in Pennsylvania where we do not have PCMH, because we can attest to a standard of practice to get the pmpm.
- There are ways for payers to ensure practices are accountable without being a PCMH.

Dr. Nancy Fan

- We have discussed quality outcomes, for instance ED utilization, although these can be difficult to measure.
- Nemours you mentioned you would like to see quality metrics outside of HEDIS. What would that be?

Jamie Clark, Nemours

- It could be a screener for SDOH. There may be other things we are working on that impact total costs like SDOH, which can move costs to a greater extent a basic well child visit.
- We could be more creative to get impactful measures. We are limited to these HEDIS metrics and most are not pediatric-specific.

Dr. Nancy Fan

- It is hard to measure these metrics. Claims measure through codes. For real time data, there is an administrative burden.

- How do new metrics actually fit into this environment? We might have to start with basic metrics.
 - You have 7 metrics in the current MCO contracts – mostly HEDIS measures.
 - True Performance as 12-ish metrics, with the provider selecting their metrics to a certain extent.
- There is diversity in the outcomes and quality metrics.
- We need to consider the reasonable administrative burden in choosing metrics.
- Larger systems might be more able to absorb the burden, but still the providers must do some of the work.

Dr. Christine Donohue-Henry, Christiana Care

- A key part of what we are doing it to prepare for risk is building out the care team.
- It is really important not to throw total cost of care off the table even though there is a glide path.
- We need some up/down risk with a cap or corridor that could expand over time or a model like the ACOs that can choose the level of risk that is appropriate.

Steve Cozzo, AmeriHealth Caritas

- The social determinants directly impact the total cost of care. Medicaid is limited in what we can pay for related to social determinants.
- North Carolina has put together an interesting waiver to consider SDOH. That is a conversation worth having for the health care system and the other support systems.

Dr. Jim Gill, Medical Society of Delaware

- Looking at SDOH are important, but these are not quality metrics.
- We have never measured primary care quality metrics, even though there are good quality measures like the Barbara Starfield metrics. Some of these can be easy to measure like continuity of care and comprehensiveness.
- We need to move away from old HEDIS measures like BMI, which are not measures of primary care.

Dr. Art Jones, HMA

- There are metrics of care coordination. For instance, having a primary care visit after a hospital admission, which we proved reduces readmissions.
- Practices can also look at SDOH to see what factors impact health and costs in their population.
- Summarizing our discussion:
 - One of the ways to invest in primary care is to pay an additional pmpm or fee for PCMH functionality. There was no consensus on the value of certification.
 - If that investment only increases health care spending, it is unsustainable.

- To be successful, there needs to be timely, actionable data to drive the care coordination activities.
- If the patient is being care managed by the plan with a complete care plan, then we need to figure out how to delegate responsibility and share information with clear roles that do not duplicate efforts.
- We need to monitor the impact of care management through quality or other accountability metrics.
- This is one part of a component of a way of managing total cost of care. If effective in reducing the cost, then we will see lower ED utilization and inpatient utilization. As that utilization goes down, the hospital systems need to expect reduced revenue and cannot recover this revenue by increasing prices.

Dr. Christine Donohue-Henry, Christiana Care

- I also heard consensus on having more than one model to meet varying readiness.

Dr. Nancy Fan

- A lot of this discussion is framed around short-term revenue improvements rather than long-term within a total cost of care.

Dr. Christine Donohue-Henry, Christiana Care

- We don't want to wait for everyone in the state to catch up. And we want to bring our partners along in the CIN and ACO.

Sen. Townsend

- We can applaud efforts from different actors, but there is comparing apples and oranges across these different providers.

Steven Constantino, Department of Health and Social Services

- We have not talked about ACOs, but if we are talking about layers of care management, we need to consider what the ACO wants to do.
- North Carolina has some interesting efforts outside of their 1115 waiver, including ACO contracts with BCBSNC, addressing care management and SDOH.
- Currently, Delaware has an RFI in Medicaid that is asking about an MCO / ACO or health system relationship. Primary care is a major piece of that discussion.
- Good primary care can control hospital cost and ED utilization.

Dr. Jim Gill, Medical Society of Delaware

- Obviously, a PCP can control utilization. Our ACO reduced hospital utilization by 12%, but hospital costs went up because prices increased.
- The prices are the problem.

- There is some perception that total cost of care is a higher level of primary care delivery, but there is no evidence that a total cost of care model is better.
- No other country holds any provider accountable for total cost of care, yet their costs are lower and utilization is higher.
- It might be a different way of reimbursing, but the concept that that should be our goal is totally false.

Sen. Townsend

- If you provided the right primary care, but cannot measure the result, then how can be accountable for it?
- There is no doubt that there is a relationship between primary care and other health spending.
- If total cost of care is the end goal for an integrated system, does that make it impossible to be an independent provider?

Steve Cozzo, AmeriHealth Caritas

- From a payer perspective - benchmarking regardless of model, becomes one of the more difficult exercises. The practice location, SDOH, member location, and other circumstances all impacts on the outcome.
- You see some providers and hospitals have penalties for high readmissions, but low mortality, and vice versa. The benchmarking needs be right for success.

Dr. Nancy Fan

- I don't think we are trying to advocate for one model.
- We want models that work best for different primary care practices to reach quality outcomes at a lower cost.
- I'm glad Steven Constantino brought up the ACOs, because there are other models beyond the PCMH.

Dr. Art Jones, HMA

- Homework assignments for the next meeting on Monday February 18th. Come prepared to discuss:
- Primary care providers
 - What type of accountability should be used for care coordination fees? How do we verify that the care coordination fee goes to care coordination?
 - What is the desired impact of care coordination fees? How to we measure that impact? What quality outcomes we should be measuring?
 - How should we create total cost of care guardrails?
- Payers
 - How prepared are we to share actionable and timely patient data and information like care plans to facilitate effective use of care coordination fees?

- If providers are doing care coordination for certain patients, what does that mean for payers who are also doing care coordination?
 - What does it take to offer the full range of alternative payment models?
- All
 - How do we determine a care coordination fee considering the cost of providing care coordination, return on investment, and impact on total cost of care?
 - What alternative payment methodologies including primary care capitation are primary care providers already participating in or ready to participate in?
 - How should we determine provider and payer readiness for alternative payment models?

Dr. Nancy Fan

- Additional homework: identify anyone who is missing at the table who can offer meaningful input.

The meeting was adjourned at 8:00 p.m.

SB 227 Primary Care Collaborative Meeting

**Monday, February 18, 2019
6:00 p.m.**

**Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713**

Meeting Attendance

Collaborative Members:

Present:

Senator Bryan Townsend
Dr. Nancy Fan
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Attendees:

John Fink
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Kathy Collison
Lizzie Lewis Zubaca
Karyn Scout
Kim Gomes
Steven Costantino
Steve Groff
Rebecca Byrd
Lisa Zimmerman
Weston Riesselman
Elizabeth Scheneman
Chris Manning
Shay Scott
Anthony Onugu
Rosa Riviera
Jamie Clarke
Chris Morris
Kathleen Willey
Michael Bradley
Jennifer Mossman
Dr. Jason Hann-Deschaine
Lenaye Lawyer
Faith Rentz

Organization:

Bayhealth Medical Center
Christiana Care Health Systems
Division of Public Health
Hamilton Goodman Partners
AmeriHealth Caritas
Byrd Group/Medical Society of Delaware
Department of Health and Social Services
Division of Medicaid & Medical Assistance
The Byrd Group
Department of Health and Social Services
Christiana Care
Department of Health and Social Services
Nemours
Henrietta Johnson Medical Center
UMACO
La Red Health Center
Nemours
Aetna
Quality Family Physicians
Medical Society of Delaware/MedNet
Highmark DE
MSD/Delaware Pediatrics
ACDE
DHR/Statewide Benefits

Sylvia Canteen-Brown	Delaware Pediatrics
Rose Kakora	Christiana Care
Kiki Evinger	Department of Health and Social Services
Katherine Impellizzer	Aetna
Stephen Cozzo	ACE
Pam Price	Highmark
Susan Conaty	DCNY
Dan Elliot	Christiana Care Health System
Wayne Smith	Delaware Healthcare Association
Mike Wornt	Aetna
Kelly Anderson	Johns Hopkins School of Public Health
Jessica Hale	Johns Hopkins School of Public Health
Kelly Krinn	Health Management Associates
Art Jones	Health Management Associates

Meeting was called to order at 6:00 p.m.

Dr. Fan

- Our first item is the minutes approval. Are there any modifications?

Steven Costantino, Department of Health and Social Services

- I have two corrections.
- The spelling of “Costantino” and on page 17 North Carolina has some interesting efforts coming **out of** their 1115 waiver. Modification, not outside their 1115 waiver.

Dr. Charlie Jose, Graham Center

- I am with the Graham Center at AAFP; we are interested in what Delaware is doing regarding primary care spending.
- We are rolling out a qualitative study where we will be doing key informant interviews in RI, OR, CO, CA – all states who have discussed primary care spending.
- We are interested in talking to payers, providers, and legislators. Our main goal is to understand the process of introducing regulation and legislations.
- We want to set up 30-minute interviews with you to get your perspective and to understand what is unique about Delaware.
- My role is not to advocate for or against regulations. All comments will be anonymous in whatever we publish.

Dr. Fan

- The next point is about consensus items. In the last meeting we agreed:
 - 1) We need to increase investment in primary care in order sustain it.
 - 2) Upfront could be a pathway away from the current system to a value-based model.

- This meeting we were going to focus on care coordination and how we would use it here in Delaware.
- We have support from John Hopkins University. They will be doing a short presentation.

Kelly Anderson, John Hopkins University

- The evidence about paying primary care providers for care coordination.
- We were asked to investigate two questions 1) What is the evidence on the effectiveness of care coordination PMPM payments and 2) Do accountability mechanisms exist to track the effectiveness of care coordination?
- We conclude: A clinical model plus a payment approach to enable the model can lead to improved outcomes
- There are a lot of different approaches to paying primary care providers for care coordination. The real consideration is if they are prospective or retrospective payments and degree of responsibility providers have for quality and cost.

Jessica Hale, John Hopkins University

- These tools to pay for coordination are most often leveraged within a broader model for care delivery. Some models include:
- PCMH: which blends FFS and capitation and uses PMPM payments to pay teams of providers for coordination and care management
- CPC+: the most recent CMS model that uses risk-adjusted PMPM fees to prospectively cover all practice expenses over a period of time
- Health Home: coordinates care for high-need and high-cost populations
- ACOs: groups of doctors, hospitals, and other providers who voluntarily coordinate care, adopting a shared savings model
- There are a few common themes we found from successful models:
 - Clear goals for outcomes with a vision for how care will be delivered
 - Timely and accurate data sharing
 - Risk adjustment to account for differences in patient panels
 - Prospective payments to allow practices to make upfront investments
 - Payments connected to a focused set of metrics and performance on the 4 C's (contact, continuity, comprehensiveness, and coordination)
 - Use of multidisciplinary care teams
- We could not find any evidence about PMPM payments alone, as all evidence that examines PMPM coordination fees is evaluated within a broader payment model
- PCMH is where we see the most evidence
- See results vary, NC (large savings reduce admissions) to NJ (not sufficient savings to cover costs and mixed results in health outcomes)
- Context and structure of program matter- each of these states have different PC problems and address it differently through their program
- But PMPM within a PCMH model is being used widely by many states and gaining momentum

- Two other models that use PMPM coordination payments are Health Homes and ACOs
- Health Homes, which as mentioned target complex patients, have care coordination payments that vary by state; Missouri's approach uses a PMPM management fee, which has shown to improve cost and outcome results in Missouri
- Two major ACO programs are the Medicare Shared Savings and the now inactive Pioneer ACO model. While ACOs are continuing to see shared savings and improved outcomes, not all ACOs, as well as CMS, are seeing this translate into reduced costs; but more time will tell as ACOs take on two-sided risk models
- Iora Health is a network of primary care practices that uses fixed and risk-adjusted PMPM amounts and quality targets; their internal reports suggest that their model leads to lower costs and improves some health outcomes
- Michigan uses a fee-for-value program with some reduced spending and quality improvement outcomes

Kelly Anderson, John Hopkins University

- Looking through the evidence of these programs, there is emphasis on getting the right measures. There are well over 100 measures; many metrics come from ARHQ and NQF.
- We saw a variety of different accountability mechanisms.
- CPT codes were commonly used. While this provides documentation there is no deeper understanding of what the activity entails.
- EHRs have a greater ability to capture information, but challenges exist between different EHR systems and with the timely exchange of data.
- Within EHRs there is opportunity to measure process, quality, and costs.
- Care coordination pmpm payments in combination with a model of delivery reform can reduce spending and improve patient outcomes
- Adoption of care coordination pmpm payments is not sufficient to improve care delivery

Dr. Fan

- When you say pmpm payments were not done alone, is that because the upfront component was baked into the payment model or because they created the payment model and decided they needed the upfront investment after the fact?

Kelly Anderson, John Hopkins University

- Not sure. They were adopted simultaneously.

Dr. Fan

- Did the pmpm stay the same or increase over time?

Kelly Anderson, John Hopkins University

- These were shorter evaluations, we did not see changes over time.

Steve Cozzo, AmeriHealth Caritas

- The timing of adoption depends on state circumstances.
- North Carolina looked at pmpm piece first and now are rolling that into managed care. Other states have gone the other direction.

Steven Costantino, Department of Health and Social Services

- I am familiar with the Iora model, revolutionary in terms of PCMH. The care management is engrained in the delivery system; it is not isolated care management.
- Did you look at the types of contracts they had? Was it just a care management fee? Or was the care management actually engrained in the pmpm for the entire population?

Kelly Anderson, John Hopkins University

- Not sure off the top of my head, but we can check.

Jessica Hale, John Hopkins University

- The studies were pretty surface level. We didn't dig into the contracts.

Tom Fitzpatrick, Highmark

- In any of those models, did they have ranges of pmpm?
- Did anyone take the risk-adjusted pmpm approach and pay more for sicker individuals? Are these representative of averages? Or are these flat pmpms paid across the entire attributed population?

Jessica Hale, John Hopkins University

- The model in New York used a risk adjusted pmpm.
- Same with some of the ACOs risk adjusted pmpm amounts.

Tom Fitzpatrick, Highmark

- By line of business, did Medicaid have a different pmpm rates compared to MA or commercial?

Kelly Anderson, John Hopkins University

- Most of the studies were looking at programs within a single payer type.

Dr. Art Jones, HMA

- In Illinois, although with Medicaid, they had different pmpm based on eligibility category – \$2 children, \$3 TANF adults, and \$4 disabled.

Tom Fitzpatrick, Highmark

- Did you see any ranging up to \$20 - \$30?

Jessica Hale, John Hopkins University

- Nothing that high within the subset of research I pulled from, but there has been talk about that in more recent literature.
- Some of the established quality and cost outcomes were based off studies with the smaller pppm amounts.

Dr. Fan

- Is it the case that no studies demonstrate that a high pppm can be successful or we just didn't look at those particular studies?

Jessica Hale, John Hopkins University

- These were just the studies that were most well established. These are the go-to studies for this literature.

Sen. Townsend

- The pppm would adjust for the overall payment method; those example states don't have the level of crisis and dramatically low reimbursement as Delaware.
- In other states, they might achieve savings with a lower pppm.
- Here we have to make sure the resources are there for providers to be successful.

Tom Fitzpatrick, Highmark

- Do we know what the underlying fee schedules in other states are as a percentage of Medicare?

Dr. Art Jones, HMA

- If you go to New York and you look at their health homes program, they have a pppm of \$100 for certain populations within their risk stratification.
- For Medicare there were six RCT studies that looked at complex Medicare patients. The pppms were significant, but that inhibited the ROI even for those seeing significant reductions in ED and hospital use. They all had strictly RN care team models, but they needed to build a less expensive model to get an ROI.

Sen. Townsend

- I am happy to find the data on reimbursement compared to Medicare levels, but I am unaware of other states that have such low reimbursement as Delaware.
- Is a smaller pppm suitable for larger groups because of their economies of scale?

Dr. Mike Bradley, MSD/MEDnet

- Delaware is unique; we are 10 years behind other states like California.
- I think the pppm payment needs to be fit into the fee schedule. The pppm is only one little piece of it. The pppm may be high/low depending on where the rest of the money is coming from regardless of the specific model.

- We have a lots of small practices that don't have a full EMR. We need to do a lot of groundwork in order to ready these practices.
- Don't make a decision regarding the pmpm or model too early.

Dr. Fan

- We need to make a holistic consideration. There a couple of points I thought of seeing these examples:
- What was their workforce projected to be?
- What was the motivation to become early adopters of the pmpm?
- I know New Jersey was not facing a primary care crisis. So were they doing it because they were looking ahead to improve outcomes and cost or were they looking at to sustain primary care?
- We should understand the motivating factor of each state.

Dr. Art Jones, HMA

- Last time we talked about how the state said there was a floor for rates. We decided that we will be moving to APMs. We are focused on the care management fee and next meeting we will consider the payment models including TCOC.

Dr. Jason Hann-Deschaine, MSD

- I am a primary care pediatrician.
- We had a single practitioner who merged his practice into ours because he couldn't find a way forward on his own. He committed a lot of time and money into PCMH certification. He became PCMH certified, but when Blue Cross stopped the ACO program he lost 5% of his revenue. Then he lost another 25% when they stopped their PCMH program.
- The value of certification form Aetna was a couple hundred dollars per quarter.
- United, Cigna, and Medicaid paid nothing to be PCMH certified.
- Overall, he sustained a 30% payout.
- This is a practitioner in solo practice who transformed and essentially had to close down.
- Regarding my practice. We were involved in CCPP quality program through Christiana. They stopped and switched to Aetna as their administrator – which pays below Medicare rates. The state also move over to an Aetna program. We also sustained cuts with the loss of the BCBS ACO and PCMH programs.
- We were already trying to go through a PCMH process and using care management. We did not decide if we were going to become officially certified. We continued with the Highmark Quality Blue program. We see that our practice was the highest performing pediatric providers, but we actually are losing money in that program compared to the previous program. The incentive payment is weighted toward improvement in cost and utilization. We lost on injectable PAD and inpatient costs
- It is discouraging to be scoring high in quality, but be on the verge of financial instability. We are looking at our payments coming in on Wednesday and need to assess if we can pay payroll the next day.

- We are taking on risk just to take on just to stay in practice.
- Debbie Zerak and her husband are sharing as salary trying to pay for providers and a nutritionist.
- I am happy to see SB227 passed and this group convened.
- Currently we have seen low pmpms. We get \$1.97 on average. They cap the members within each risk strata. Only 5% of patients can be high risk, 15%-30% are medium risk, and the rest are low risk. The pmpm is \$16 high risk, \$2 medium risk, and \$1 for low risk.
- I had a patient with a seizure disorder and additional health problems considered a low risk patient. If that is a low risk patient, then I am getting a \$1 per month.
- We are seeing high risk patients, but they are categorized as low risk.
- The other part, we are all talking about taking next steps, but if you look at Aetna, the 2019 fee schedule is 10% lower than last year. They were paying 38% to 85% of Medicare previously, and 30% to 75% currently.
- This is important because they are administering a lot of self-funded plans. Bayhealth, Christiana, Nemours, and the state employees all get coverage through Aetna, in addition to lots of the company plans, but these plans are not paying Medicare rates.
- I would encourage everyone to use their influence to ensure your institutions demonstrate minimal dedication to stabilizing primary care by ensuring your plans pay 100% of Medicare rates.

Dr. Fan

- I appreciate all your comments. What I take away from your experience is if we are going to talk about a delivery model system that has an upfront payment, it cannot be tied to cost or utilization for something you cannot control. And there are services to provide to reach top quality that should be included as part of a quality pmpm.

Dr. Jason Hann-Deschaine, MSD

- Services like: lactation, nutrition, obesity, and after-hours care

Chris Morris, Aetna

- We don't change fee schedule on an annual basis. Payments are based on attributed members.

Tom Fitzpatrick, Highmark

- I appreciate the comments, I would say that Highmark has come into full compliance with SB 227.
- We have changed the program and we change care coordination fees in accordance with how established by CMS.
- Do risk adjustment twice per year through a third party called Fair Risk to establish the risk scores. We pay a pmpm based on risk.

- We do pay for a number of the services you mentioned. We have made a strong push for extended hours on nights and weekends and we pay an extra fee for those services.
- The problem is that we have a cost issue. We have a high-quality network, but people aren't willing to pay just for quality. We have had quality programs for years, but the customers in Delaware and everywhere want to understand the ROI for the programs. We have to have a cost metric, not dissimilar to what CMS has. If there is not a reduction in overall cost of care, then we cannot share that savings back with the PCPs.
- We are happy to continue to work with you and the practice. We will look at how members are stratified. We have different rates for the three different risk levels, and we have different levels for commercial and Medicaid business.
- We did move away from PCMH certification and accreditation because our customers didn't want to pay for it. They want to know how much this program is actually savings.

Sen. Townsend

- In regard to SB 227, we specifically structured January 1, 2019 as the date that would be initiated so there was plenty of time for plans to prepare for implementation. DOI is here today. What are the explanations?

Dr. Art Jones, HMA (Care coordination/care management financial modelling tool distributed)

- Let's define care coordination and care management. We need to move towards a consensus to determine what care management should be. I don't think we can come up with a dollar value here. Our goal is not to come up with a fee, but come up with a process that is fair to set the fee.
- CMS has established 6 core services for its Health Home program – listed in blue.
- CMS does not define the tasks that go under each core service, but I filled in some potential tasks. The issue today is not if we have the list of tasks exactly right, but how the tool can be used to negotiate a reasonable care coordination/management fee from both a cost of delivering the service and a ROI on total cost of care perspective. Anything cell in red can be modified to fit a particular circumstance.
- The idea is that as you negotiate between the provider and plan what is the provider getting paid for?
- I think the tasks will vary by practices and their readiness. First what are the items that any provider does, then what are the tasks that a PCMH does, and what are the care management tasks that go beyond coordination and require a licensed worker.
- This is a tool that helps estimate the costs for providing care coordination services. Providers and payers can determine what is the appropriate formulation of tasks and responsibility for the patient population that will be effective and generate an ROI. What is best done at the provider level and what is best done at the payer level?
- Is there a glide path of increasing responsibility for providers? We cannot afford to have the provider and plan to duplicate services.

- Note that this document is not intended to be accurate in the dollar values or specific tasks, but to provide an approach that providers and payers can work together on. With this tool they can all agree on what is the payer paying for at \$1 pmpm vs \$16 pmpm.

Tom Fitzpatrick, Highmark

- The way we have structured this – whether \$1, \$2.50, or \$16 pmpm – is all based on the activity or the level of engagement that the practice has with our member.
- We are making the assumption that a dollar for a person that is having one or two interactions.
- A high-risk member has many more interactions, so they get a higher pmpm. These are all upfront payments; we never thought that these pay the full amount for care coordination.
- The hope is that all the care coordination will benefit the patient and practice and that the value shows up in the lump sum payments.
- The entire value-based reimbursement is made up of these different parts. This in whole is the payment transformation. The savings from the system will repatriated back to those who are responsible for coordinating the care.

Dr. Fan

- Art has structured what is a care coordination task.
- Health care payment nationally is moving away from FFS. A provider must provide a basic level of care coordination even for the lowest risk patients.
- If you lower that FFS reimbursement and you risk stratify the care coordination pmpm, it will not cover the cost of your original capital investment. You are still providing those services because you still need all these personnel and resources.
- How do we make that transition a lot smoother so they don't just give up practice all together or move to a smaller patient panel under a concierge medicine model?
- We want to talk about these items as the basic minimum of the care coordination.
- The first part of implementing SB227 has not been smooth. We want to make sure that implementation of part two is successful.

Kevin O'Hara, Highmark

- We believe that Highmark is completely compliant with SB 227. If anyone has any issue with that they can come to me directly.

Tom Fitzpatrick, Highmark

- If there is anyone in that room that feels Highmark is not in compliance. We worked on it over the holidays to ensure it was implemented 1/1/2019.
- There is a lot here, in this document. This is a great document to open up the conversation. There are some items here that we need to discuss what needs to be in the plan or provider side.

- This is why we continue to evolve our programs from imbedded care coordinators to virtual models. There is some stuff here like promotion of health education and wellness that we would like to say is part of the plans' role. We just rolled out the Share Care initiative.
- Just seeing this the first time this is a great start. This can serve as the basis to guide the conversation. We should be able to narrow the list to what the provider is expected to do and we should pay for them.

Steven Costantino, Department of Health and Social Services

- As I look at this menu of care management, it would be interesting to know what is at provider level, ACO level, and plan level. It is a pretty comprehensive and intensive list, and there should probably be some mix and matching based on your delivery model.

Dr. Fan

- I want to make sure that the list will be ok applied to every delivery model. It does not have to live within a PCMH or ACO.

Steven Costantino, Department of Health and Social Services

- I want to make a correction. It has been said that Medicaid does not pay for care management. 85% of enrollees are in managed care administered by two plans. Those plans cover care management. It is the 15% of Medicaid beneficiaries still in FFS that do not cover care management.

Dr. Art Jones, HMA

- There will be variation with provider readiness to assume these responsibilities.
- Can we come to consensus in taking this general approach between provider and payer from a cost perspective and ROI perspective?

Dr. Fan

- Anything on this list that should always be on there regardless how much you are paid?

Tom Fitzpatrick, Highmark

- There may be activities that may not be strictly payer/primary care physician related. There are tasks that are part of the medical home – for discharges to post-acute or ED visits.
- There are some things here are not only bidirectional, but that involve the entire care continuum.

Dr. Fan

- So for example for a post-ED visit contact, you would not consider that as part of care management?

Tom Fitzpatrick, Highmark

- I would envision that to be a contact between the primary care practice and the hospital.

Jamie Clark, Nemours

- This is a huge component of what we do as care coordination. We have employees who call patients who go to the ED to convince them to seek care elsewhere.
- We have the DHIN and get the ED data every day.

Dr. Jason Hann-Deschaine, MSD

- We review every ED visit and contact that family and educate them on averting ED utilization.

Dr. Fan

- To clarify, Nemours – although you are a hospital system, what you are referring to is part of the outpatient clinic, right?

Jamie Clark, Nemours

- Yes, this is a task from the primary care side.

Tom Fitzpatrick, Highmark

- I'm not arguing that it is not a part of care coordination. The end result of that is going to be resulting in the cost savings that the practice will get in reducing the cost of care by reducing ED use and readmissions.
- You cannot double pay for those coordination activities.

Dr. John Fink, Bayhealth

- Most of these things on this list are just things we consider good care. If you are fortunate enough to work for a system, the system subsidizes these services. In smaller practices, they might have to cut good care because their revenue has come down.

Dr. Art Jones, HMA

- The pmpm is a cost factor that goes into calculating the savings savings. So if there is a savings, the cost of the pmpm has already been accounted for.

Chris Morris, Aetna

- Is the goal to get to a shared savings with risk associated with it?

Dr. Art Jones, HMA

- Spending money and hoping that there will be shared savings more than a year in the future will not be adequate. The idea is to have up front fees.
- We also have some providers, like Christiana, who want to take on downside risk.

- When you look at the tasks you need to know who is taking downside risk.
- What readiness for people to take on a task and what is their readiness to take on the downside risk?
- We are not looking at one model. There we are looking at a continuum.

Chris Morris, Aetna

- I heard that these will be input into any PCP model.

Dr. Fan

- We want consensus on the tasks that can be used in every delivery model. Across the board providers will know they can get \$x if they offer these services.
- The provider community will want to offer these
- With a decrease in the base fee for service, we want everyone to become stable so they can take additional risk that will develop shared savings.
- It doesn't matter what delivery model you are in, a care coordination fee can improve costs and outcomes. The care coordination fee cannot do it alone.
- We all agree that there are different delivery models.
- We need solutions. We need a very short-term answer – meeting 100% of Medicare
- We need a short-term answer for the next year or two – to help practices ramp up so they can be prepared for true risk.
- There is no one size fits all, but we want consensus on what is care coordination.

Tom Fitzpatrick, Highmark

- One response on your comment that decreasing FFS and increasing care coordination, and that is not the case with Highmark. We have increased the FFS and kept the care coordination fees.
- We are not that far off from the models in the presentation.
- I know we don't want to talk about the rate. I am struggling what to understand how we will figure out the range. I have heard \$30 in previous Collaborative meetings, to the presentation where we will discuss the models

Sen. Townsend

- We are starting from a lower FFS base.
- Your comment raises a good point - definitions are really important.

Kevin O'Hara, Highmark

- Did we get someone to validate the idea that we are starting from a lower base?

Karyn Scout, AmeriHealth Caritas

- We do all the items on this list within the plan. We are working with providers to work out how that care coordination is going to work. We are in our infancy as an MCO here in Delaware. How do we ensure we do not duplicate?

Dr. Art Jones, HMA

- Are you committed to paying a care coordination fee?

Karyn Scout, AmeriHealth Caritas

- We have least data, being in year 1. We are looking with our providers how we can pay care coordination fees.

Dr. Art Jones, HMA

- Do you have a target timeframe?
- We have a real financial crisis and there is an urgency to this.

Karyn Scout, AmeriHealth Caritas

- We don't have a timeframe. We are looking at contract discussions in July with a bigger health system.

Dr. Fan

- The Medicaid contract has VBP targets on a timeline over three years, right?

Steve Groff, Medicaid Director

- Yes. To get to those VBP targets, working with the larger health systems is the quickest way to make gains.
- Related to the infancy of a new plan and mining that data, they still have work to do.

Dr. Fan

- 2018 was your first year and by 2020 you need to offer VBP?

Dr. Art Jones, HMA

- What is expected immediately?

Steve Groff, Medicaid Director

- There are VBP targets in 2018, 2019, and 2020. There is a percentage of overall spend that must be in any VBP and an increasing share of that must be within a TCO model, rather than in pay for performance/bonus type arrangements.
- Other measures, like HEDIS, kick in later. We need the extra time for the lookback to get the data.

Dr. Art Jones

- Are there care management fee expectations in Medicaid?

Steve Groff, Medicaid Director

- I would have to go back and look. There was an expectation several years ago. Care coordination was built into the MCO rate and it was passed along to providers. We got away from that because we believed that that was already becoming engrained in the delivery system and it was no longer necessary to have a direct to care coordination fee.

Dr. Art Jones

- Is Medicaid willing to go take and take a look at this issue?

Steve Groff, Medicaid Director

- I would never rule out, but it was my expectation that this was already going on. I don't think it's necessary for Medicaid to mandate it, but if we discussed that it is not being reimbursed then we can look at it.

Steven Costantino, Department of Health and Social Services

- Medicaid is paying two MCOs. Highmark is paying a care management fee. AmeriHealth is in its infancy, but I would expect that they will be doing the same thing.
- Ultimately the state ends up paying for this. I don't want anyone to assume that the plans are not paying the fee even if Medicaid hasn't stated they must.

Dr. Christine Donohue-Henry, Christiana Care

- Our intention is to go TCOC model. I appreciate the specificity in this document, Art. It has helped us dig in on a deeper level.

Dr. Art Jones, HMA

- Back to the homework questions: an important part of this is access to timely and accurate data. Providers need accurate panels and hospital utilization data. Where are we from a data perspective?

Tom Fitzpatrick, Highmark

- We believe that we have a very robust set of provider reports. We believe we are very prepared.
- As an insurance company we have to set expectations because timely is a relative term, we operate in claims, so it is not point of service data we can share.
- We would offer up a series of workshops for practices to better understand the report and their active participation to improve those reports.
- We have provider contracts, we cannot necessarily share reimbursement allowable rates. There are some restrictions to the data we do share. The reporting and advance analytics we provide have enabled lots of providers to manage their patient populations well.

Dr. Art Jones, HMA

- Does that include Medicaid population as well? Because we heard otherwise even from your own plan this fall that there was a problem with reporting on the panels in Medicaid.

Tom Fitzpatrick, Highmark

- The offer to work with providers applies across all lines of business.
- We had problems with panel reporting in 2018. It was difficult getting our data out through the portal and readily available. Those problems are fixed, but we are prepared to move forward in 2019.

Chris Morris, Aetna

- We provide robust data reporting. The frequency and data varies by model.
- We have over 60% of reimbursement is in a VBP arrangement.
- We have care coordination fees in all VBP models. The member attribution level impacts of these pmpms.
- We are feeding information to an ACO almost daily.

Dr. Fan

- Where does DHIN fit in? They are building a claims database.
- Is it a pathway for more robust CCDs?

Tom Fitzpatrick, Highmark

- We would take the providers advice around that. Highmark has participated in DHIN from the beginning. We are probably not as good at monitoring how productive the DHIN is in data sharing, but we have focused on developing our own set of reporting and analytics.
- If the providers believe that DHIN is the right place to get data, then we will put the resources to DHIN.

Dr. Jason Hann-Deschaine, MSD

- Highmark has a very good PI tool, as a provider you can go into and drill down and get down to the patient level.
- There are still a lot of data issues with Highmark. In the quality program there has been a problem where Health Options cannot connect their data with Blue Cross.
- We have seen no quality data from Health Options. They are having trouble with their systems.
- We do have monthly meetings with our Blue Cross quality representative and she does a great job with us. She works with us and can provide us with useful, custom data.
- All the data is very fragmented. We do not get reliable reports through local hospitals.
- We still cannot see pdfs from DHIN, a problem for several months. The data is inconsistent.
- I am not convinced that the DHIN infrastructure is sufficient for us to integrate and move forward in the quality plans. We spend a lot of time trying to fix the data.
- The states vaccine record is not accurate, and the state is asking us to use our time to go in and fix this.

Kevin O'Hara, Highmark

- The issue of data between plans is universal. Providers not accessing claims from another payer anywhere.
- On the Health Options side, the reporting issue in 2018 has been solved for and we are starting to pushout the reports for 2019. It should look and feel like the data on the commercial side.

Dr. Fan

- Nationally, has there been a solution to the sharing of data as patients move between payers?

Kevin O'Hara, Highmark

- As patients move payer to payer I don't see a universal solution for data collection. We need to start thinking about EMRs and other data schemes.
- If the vaccine record is incomplete, then I don't have that data and I will be asking the provider if that data exists for the provider to get credit.

Dr. Fan

- They just have to reinput it the data.

Tom Fitzpatrick, Highmark

- To answer your question, Pennsylvania and West Virginia do not have anything like the DHIN. We set out in Pennsylvania to try to get a unified clinical connection among all the payers and providers and that did not work.
- To answer your question, that has not been solved anywhere in Highmark's footprint and as far as we know anywhere in the country.

Sen. Townsend

- This is not a trivial issue and a tremendous challenge that should be solved.

Tom Fitzpatrick, Highmark

- Yes, we take data very seriously. We worked as quickly as we could to solve the data issues in DHOP. It should be an aspirational goal of this workgroup.

Dr. Art Jones, HMA

- At what point is there some oversight and accountability, to make sure that there are these negotiations far as care coordination that is based on these criteria?

Dr. Fan

- Is your question who is the oversight body for implementation of any of this?
- We have DOI here – would Vince like to comment?

Tom Fitzpatrick, Highmark

- We have that mechanism today, we negotiate on an entity by entity basis and it has worked well to a certain extent.
- We are happy to engage on the conversation here. If the problem is that our pmpms are not working, then we will engage in those conversations. The pmpm has to be in the context of one of these VBPs that has a shared savings complement.

Vince Ryan, DOI

- As I have discussed with the bill sponsors and MSD, the commissioner is very supportive of the efforts of this group. With respect to administering whatever program and whatever oversight it would entail, if the DOI would be chosen to the body – and the DOI does think we are – we are not staffed with the appropriate people to do the work with the payers and providers. When we decide what these efforts will look like, we hope that there would be some discussion of what additions to the department need to be effective.

Dr. Fan

- Would people feel more comfortable with a sub-division of the DOI, or would it be in the general purpose to implement and enforce pc payment and sustainability
- There has to be some alignment with the benchmarking process.
- Do we feel like the DOI is willing to assume but don't have the bandwidth to do it and do we want someone specifically involved? Or do we want a specific other regulatory body?

Dr. Art Jones, HMA

- Maybe we would put that on the homework

Tom Fitzpatrick, Highmark

- There is not a regulated body in Pennsylvania or West Virginia. We operate independently with all of our provider networks. Everything is a negotiation. We comply with laws and regulations in each state. We do not have a body like that in the other states that regulates our pay for value programs.

Steven Costantino, Department of Health and Social Services

- I don't know that that means if we are simply asking who will regulate care management.
- As someone involved with writing the Rhode Island regulation, it would be good to have a reporting mechanism to know what the spend is on primary care. I don't see that as a very difficult thing for the DOI actuaries to figure out. It has been very hard to figure out how much we spend on primary care; we have heard numbers from 3% to 8%.
- We need to consider if we want to go the regulation route on primary care spending, but no state actually regulates the care coordination part. We are not just talking about the care management aspect.

Dr. Art Jones

- Charlie has been doing some research on the definition of primary care spend.
- The benchmark report came out recently, it is their goal to collect that data, but do not have specifics.

Dr. Charlie Jose, Graham Center

- The Graham Center is working on defining primary care right now as the portion of total health spending. There are different definitions available. There was a recent Milbank Memorial Fund illustrating the different ways to calculate primary care spending.
 - Providers (which for example could include ob/gyn or not), types of services, or where the service is provided.
- We are performing a state-by-state analysis using the MEPS data. This is the most complete source of data on the cost and use of health insurance because it covers 38 states.
- Our deadline is in April and we want to see how states are spending on primary care.
- To put forth recommendations for what a national requirement for primary care spending should be.

Dr. Fan

- Milbank looked at methodology, are you recommending a methodology?

Dr. Charlie Jose, Graham Center

- Happy to pass it along if my supervisors are ok with that.

Dr. Fan

- Within each payer group, do you define primary care spend? This group may not decide on a definition, but we would like to understand how you are thinking about it.
- The suggestion of getting primary care spend reporting is a good idea.

Dr. John Fink, Bayhealth

- Are we looking at spend on primary care outside of patient care – for instance tuition reimbursement?
- Supporting primary care also comes from dollars that doesn't have anything to do with that patient.

Dr. Art Jones, HMA

- We will be discussing increasing primary care spending through advanced (LAN category 3 and 4) APMs next time, and the last meeting we will need to invest in those other items.
- We need to look both short-term and long-term solutions, including recruitment and retention.

Dr. Fan

- Rhode Island allows for a certain share of primary care investment to go to technology or other capital improvements, but they already have a benchmark for spending.

Tom Fitzpatrick, Highmark

- We have a simple method to calculate primary care spending. We look at it as all the providers coded as primary care physicians to identify primary care spending.

Dr. Fan

- If there are certain services or providers that you include or exclude we need to know.

Dr. Mike Bradley, MSD/MEDnet

- Wanted to give you an update on MEDnet. I have been in Delaware for 36 years.
- Physicians are leaving practice due to retirement, entering concierge, or being bought up by health systems.
- With my 6 other partners, our practice has 3 PAs and 20 supporting staff including LPNs. We provide the entire list of care that you have seen there.
- In the 1990s the Medical Society of Delaware formed MEDnet. This is an organization of four different individually-owned physician organizations – one in each of the hospital groups. We are a fully integrated, multispecialty, physician-owned organization.
- Initially we supported individual practice physicians and small groups. We still have over 800 members.
- When the state went to managed care in Medicaid, we became the network for Medicaid. We continued to work with Medicaid; we signed with AmeriHealth.
- 6 to 8 years ago Blue Cross of Delaware came to us to form an ACO. A year or two later Highmark bought Blue Cross of Delaware.
- We were on the verge of providing a full service ACO. Blue Cross was going to integrate our computer systems into one network. We were learning and taking our baby steps.
- With the sale of Blue Cross Delaware to Highmark we came away with no health IT update and we had a 30% increase in E&M coding.
- My practice was the first PCMH level 3 in Delaware. We are now on our 4th re-up of the certification. Blue Cross gave us an extra 25% for being a PCMH. When the plan closed out we had a 30% drop in reimbursement overnight. In their new payment model for 2017, they gathered the data, and in July 2018 we got half our money back due to cost overruns in radiology, pharmacy, and inpatient spending.
- Two years ago, we found a partner, Health EC, a nationally known population management group. We signed our first contract with AmeriHealth.
- We spent money to incentivize our physicians to use the same EHR. We will have live patient information. If patient switched insurance companies, we will know all the information. We don't have to go to the DHIN. We are not competing to drive the DHIN out of existence.
- Physicians in Delaware are ready to move forward. We saw this 10 years ago, but progress was stalled.

- We want the physicians to be in control of one set of quality data metrics. We shouldn't have different sets of quality metrics for different payers.
- We went from 1200 physicians in MEDnet to 800 within the last 5 years.
- We are in a death spiral in the state of Delaware. We need to put money and effort into making the system better.

Dr. Fan

- Any public comment?

Wayne Smith, DHA

- I object to having government decide what primary care should look like and what the reimbursement should be. I think it is contrary to the larger goal of the state's benchmark and TCOC goal. TCOC sets a goal and forces the providers to take more and more risk. They have to come up with a system that makes the most sense. When you start to have pieces of that regulated, you reduce the flexibility of providers to adapt and achieve total cost of care.
- We have concerns in assuming that a legislative or regulatory approach is appropriate for this.

Sen. Townsend

- Government has not been that involved even though government has a critical role evidenced by how much government spends.
- Need the ongoing dialogue with all the stakeholders. Government's role can be bumpers, while providing plenty of room for competition and innovation. We agree that there needs to be significant changes in the health care system right now.

Dr. Art Jones, HMA

- We do have students here, so they will be providing some research at the following meetings.
- At the next meeting we will be looking at APMs categories 3 and 4.
- Providers should be ready to discuss what they are looking for? What are the barriers to you moving forward on category 3 or 4 APMS?
- Payers should be ready to discuss what is your strategic plan to move to advanced models in the delivery system?
- If you have a topic for the group to consider, we will have JHU look at things like tuition reimbursement etc. to strengthen the primary care system.
- Anything else you would like them to research, send them along.

Dr. Fan

- Will also send the homework assignments down.
- Please sign-in - that is how we will pushout all the information.
- Appreciate the Medical Society opening up for us on the holiday.

Meeting was adjourned at 8:00 p.m.

SB 227 Primary Care Collaborative Meeting

Monday, February 25, 2019

6:00 p.m.

Medical Society of Delaware

900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

Present:

Senator Bryan Townsend
Dr. Nancy Fan
Representative David Bentz

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Attendees:

John Fink
Kathy Collison
Karyn Scout
Steven Costantino
Steve Groff
Rebecca Byrd
Lisa Zimmerman
Weston Riesselman
Elizabeth Scheneman
Chris Manning
Rosa Riviera
Jamie Clarke
Chris Morris
Kathleen Willey
Jennifer Mossman
Dr. Jason Hann-Deschaine
Faith Rentz
Sylvia Canteen-Brown
Kiki Evinger
Katherine Impellizzeri
Stephen Cozzo
Pam Price
Susan Conaty-Buck
Wayne Smith

Organization:

Bayhealth Medical Center
Division of Public Health
AmeriHealth Caritas
Department of Health and Social Services
Division of Medicaid & Medical Assistance
The Byrd Group
Department of Health and Social Services
Christiana Care Health Systems
Department of Health and Social Services
Nemours
La Red Health Center
Nemours
Aetna
Quality Family Physicians
Highmark DE
MSD/Delaware Pediatrics
DHR/Statewide Benefits
Delaware Pediatrics
Department of Health and Social Services
Aetna
AmeriHealth Caritas
Highmark
DCNP
Delaware Healthcare Association

Kelly Krinn	Health Management Associates
Art Jones	Health Management Associates
Jennifer Schwartz	Christiana Care Health Systems
Dr. Charlie Jose	Graham Center
Dr. Jeffrey Hawtowf	Beebe
Tom Stephens	Westside Family Healthcare
Kevin O'Hara	Highmark
Todd Graham	Highmark Health Option
Emmilyn Lawson	AmeriHealth Caritas
Christine Schiltz	Parkowski, Guerke & Swayze
Cheryl Heiks	Webster Consulting
Dr. Andrew Dahlke	MSD
Tyler Blanchard	Aledade
Nick Biasotto	MSD
Maggie Bent	Westside Family Healthcare

Meeting was called to order at 6:00 p.m.

Dr. Charlie Jose, Graham Center

- The Graham Center is housed under AAFP, we have editorial independence
- The main question that we are asking is how does primary care do under value-based payment systems?
- The studies in this presentation come from two reports we have produced. The first year we looked at how PCMHs did in terms of cost utilization and quality, and in the second year we looked at ACOs.
- There were three main study types. Some compared to FFS care, some had PCMH-like features, but didn't have the certification compared to FFS care, and last type we looked at PCMHs that were mature and looking at the details of their components.
- This is an overview of these studies in total of 45 included.
- Just because a study is classified as mixed doesn't mean it's bad – that might just mean that the statistical significance wasn't strong enough. Often the sample size is small and that impacts the statistical significance. Mixed results might also be the result of what population.
- A majority of studies were positive or mixed; only a few studies were negative.
 - 1) There are two main themes: 1) Greater cost savings have been observed from more mature PCMHs and 2) Greater cost savings have been observed from higher risk patients.
- There was one study with negative outcomes from a PCMH model, but this study looked at only one study population of breast cancer patients.
- In terms of assessing the cost outcomes, we are talking about cost to the entire system not just the primary care costs.
- Looking at quality, the studies have mixed results. The studies assessing patient satisfaction all trended toward positive.

- Regarding utilization the results were largely mixed. The ED utilization increased in two studies but decreased in 5 studies. Some showed decreased ED utilization, but increased inpatient utilization.
- Overall, the utilization outcomes are not as clear as the cost outcomes.

Dr. Fan

- What was the demographic of the providers in the studies – were they physician-led, team-based, NP-led, etc? This would be useful to understand as we talk about team-based care and access.

Dr. Charlie Jose, Graham Center

- I don't know, but I'll report back.
- Cost and quality trended toward positive, but not uniformly. Practices need time to transform in order to increase cost savings.
- A lot of the ACO evidence is very similar to the PCMH evidence. The greatest improvements were from mature ACOs and among the higher risk patients.
- In one study looking at MSSP ACOs, one-third of ACOs received shared savings. CMS set a difficult benchmark. Physician-led ACOs outperformed hospital ACOs. This makes sense because physician ACOs don't have to worry about the revenue ramifications of avoided ED or hospital utilization.

Dr. Jeffrey Hawtof, Beebe

- ACOs assess costs based on TIN. This would include your cancer centers for instance, and their entire cost falls into the hospital's ACO. This very expensive care falls into the hospital ACO's cost assessment. If that patient was in a primary care only ACO, these costs wouldn't fall into the ACO.

Dr. Charlie Jose, Graham Center

- Much of the evidence was positive.
- The negative study looked at the highest quartile risk of MSSP ACOs. These had more ED visits that led to hospitalizations. This study only looked at primary care, not if they received care from a medical home-like system. This highlights the importance of using an advanced primary care model to generate savings.
- We saw more cost savings if patients were more consistent with primary care physicians. We saw mostly cost savings from lower priced sources of care (60%) vs lower volume (40%). Savings came from preventing hospitalizations and imaging procedures.
- One of the studies had a decrease in utilization by 9%. These outcomes varied by the studies too.

Dr. Jeffrey Hawtof, Beebe

- The cost avoidance was not necessarily calculated the same across these studies, like how a study defines an avoided ED visit. These differences in the avoided cost might translate into different results in the studies.

Dr. Charlie Jose, Graham Center

- That was shown in the MSSP. Previously we were using the benchmarks as counterfactual estimates, which doesn't account for the spending that would have occurred in the absence of this type of program.
- Leadership was responsible for ACO success. We actually did a qualitative study of what makes a PCMH or ACO successful. It came down to accessibility, high value, coordinated services, and collaboration.
- All these are features of the LAN category 3 and 4 forms of delivery.

Dr. Jim Gill, MSD

- There is room for improvement in all types of systems.
- It is actually not true that MSSP biases against hospital systems. You only get shared savings if you decrease your costs, so if your costs are already high you can generate savings easier. Already efficient practices that spend less have a more difficult time generating savings.
- The methodology is changing a bit and moving to include regional cost comparison, not just historical costs.

Dr. Fan

- This tees us up for the APMs LAN category 3 and 4.
- Jessica and Kelly from JHU provided some follow up on the care coordination payments. This document provides further research and drills down a bit in response to some of the questions they received last week.
- If we are going to talk about upfront investment that can fall under LAN category 2. Highmark, your models currently incorporate LAN category 2 elements, correct?

Kevin O'Hara, Highmark

- Yes

Dr. Fan

- How do we get to LAN categories 3 and 4?
- This fall we discussed that Delaware has significantly less uptake of APMs than other states. What are some of the barriers to moving from LAN category 1 to LAN categories 3 or 4?

Dr. Jim Gill, MSD

- We are actually in a LAN category 3 model with our Aledade ACO – type B for Medicare and type A for Highmark and Aetna. We wouldn't have been able to do this without Aledade, they have a fantastic data system and great support. I think we can move to a LAN category 4 model.
- We are the first and only in Delaware to achieve Medicare shared savings.
- There are a lot of barriers to advancing payment models. There is insufficient payment for care coordination. Medicare is the best for care coordination payments, but require a lot of documentation because the payments are paid through chronic care management. The level of administrative work negates the value of the high care coordination

payments. They also apply copays and deductibles that makes no sense to patients or the provider.

- Highmark and Aetna provide lower care coordination payments that don't require much documentation. These care coordination payments cover about 10-15% of the cost to the practice of paying for care coordination. You cannot hire any staff with that level of investment. These payments are also at risk based on quality metrics, which is inappropriate because you cannot take payments back for care coordination.
- One thing recommended is an adequate care coordination fee that is \$15-20 pmpm. That is what is recommended by the most definitive studies from Commonwealth and AHRQ. Also supported some calculations of the costs of having nurses and others to do care coordination. That is the only way you can do care coordination in a sustainable way.

Dr. Fan

- Is one of your barriers data analytics at a provider level?

Dr. Jim Gill, MSD

- The provider needs its own data system. All need the basics, to track the patients and utilization. You need to have that data within the practice in addition to a system level investment.

Dr. Fan

- Beebe and Christiana you have put in the investment yourself at the system level for your practices

Dr. Jeffrey Hawtof, Beebe

- Yes, the systems need to be in place at the practice level, so they can truly impact the health care of the individual. Your EHR typically holds the key to that. The other side of the data is claims-level data.
- If you are going to assume the total cost of care of a patient you are responsible for them no matter where they go, which means we need their claims-level data. We get that pretty well from Medicare already, but getting that same data from insurers quickly is important to allowing me to help my patients.

Jennifer Schwartz, Christiana Care

- What is more challenging than providing data, is providing a meaningful dashboard that resonates with the provider. That is the data that is actionable to a provider. A lot of ACOs and other organizations have worked hard to get to that point.
- At Trinity (NJ), we were a NextGen ACO with downside and upside risk. We were successful all three years I was with Trinity. We assessed our budget and found that we spent \$22 pmpm on the infrastructure to manage the population effectively with downside risk.

Dr. Fan

- Can the payers speak to that? What have you seen in other markets that have put that kind of infrastructure in place? What strategy we could use to advance practices' infrastructure?

Chris Morris, Aetna

- We have seen that in other areas, especially with larger systems with the infrastructure in place.
- With the infrastructure, they were ready to move to the next stage. It is certainly heading to that direction in Delaware, but in other markets in Pennsylvania are ready.

Kevin O'Hara, Highmark

- We have examples of LAN category 3 APMs in Pennsylvania with providers that were already equipped with the ability to manage risk. We have progressed to LAN category 4 with some of those practices.
- The glidepath here in Delaware is all over the place. Some practices have no capabilities and the larger systems are better prepared.
- We have an assessment tool that we use to talk about LAN categories 3 and 4 with providers who are interested. We go through enough data with those practices to evaluate their capabilities and their data needs.

Sen. Townsend

- We understand that different providers are at different stages of readiness, but it sounds like the amounts being payed are still below what the data suggests are needed.
- Regarding the care coordination efforts of payers, are there studies that talk about payers' care coordination efforts?
- Do you do care coordination internally as payers, and if so, what is that investment look like?

Kevin O'Hara, Highmark

- In LAN category 3 and 4 deals, there are other funding streams, beyond care coordination, that allow the provider some contribution for these infrastructure costs, but we do have a standard approach to care coordination for a couple bucks for more well members up to \$15 pmpm for sicker patients. We pay the chronic care codes at Medicare levels.
- We are not just paying care coordination, but we also provide other incentives where we see quality gains and cost savings.

Dr. Fan

- How do you plan to use what you have in place to move providers from LAN category 1 to at least category 2, and from LAN category 2 to 3 when we have people saying they need more to build the infrastructure?

Kevin O'Hara, Highmark

- From a global sense we don't have that strategy in place.

Chris Morris, Aetna

- The goal is to move as many as we can above and beyond, but we don't have a strategy in the place if they don't have the infrastructure already.
- When we are talking about the infrastructure to take on risk, that is beyond the care coordination payment.

Dr. Fan

- The early enablers of PCMH are still struggling and I am trying to figure out why if they really want to move up to LAN categories 3 or 4.

Kevin O'Hara, Highmark

- We are fully able to advance providers that are ready.

Dr. Fan

- How are you helping them get ready?

Steven Costantino, DHSS

- I think there needs to be a realism test. A small practice is not going to take on a lot of risk, and that expectation that a small practice in LAN category 1 or 2 is going to go up to LAN categories 3 or 4 is unrealistic. Any practice can do care coordination, but the expectation that they will take on risk is not realistic.
- I think we need to set some achievable goals. For health systems and ACOs that is where you talk about the continuum of going from LAN category 1 to LAN category 4 or an all-inclusive population-based payment.
- Providing and standardizing that care management payment and tying it to performance is important. But expecting for a small practice to take on this level of risk is not realistic.

Dr. Fan

- For the majority of providers maybe the goal is moving them from a LAN category 1 to 2, and for larger practices, moving to a LAN category 3 or 4.

Steven Costantino, DHSS

- Maybe there are some practices that have matured in the PCMH and can continue on the glidepath.
- Both physicians and hospitals have been in the ACO world for 6 years, and CMS is pushing for more risk. A lot of investments have been made early on in care management, technology, why hasn't there been the ability to piggyback that model into Medicaid and take on an attributed population in Medicaid or in the commercial world?
- What are the barriers to moving to what Vermont did starting with Medicaid when adopted in Medicare and commercial?

Dr. Jeffrey Hawtof, Beebe

- I disagree that a single one or two practice can take on risk. As a practicing family physician, at one point, I had a two-provider practice and grew it to an eight person.
- Two years into our Medicare ACO, we went to Blue Cross for a contract, but they wouldn't give us an ACO contract. Recently things have changed.
- We have four ACOs throughout the state. Joining up with ACO, a small provider can be part of a clinically integrated network (CIN) and can use these tools already built into the ACO.

Steven Costantino, DHSS

- I was talking about a small practice not in an ACO.

Dr. Jeffrey Hawtof, Beebe

- But they could join.

Chris Morris, Aetna

- You want a stable and sizable population in an ACO to mitigate some of the risk and volatility. There is a reason we require a certain attribution level.

Nick Biasotto, MSD

- We recently joined an MSSP. I am happy with the data collection. Why can't the insurers provide a data collection system?

Dr. Jim Gill, MSD

- Just to get back to the model proposed from AAFP this is a LAN category 4 model, it is full risk.
- This model is the capitation covering all your primary care work: preventive care, chronic condition management, care coordination, and also some quality and utilization bonuses.
- This model would work best if practices integrate, but it can still apply to small or large practices. You cannot hold primary care providers responsible for oncologist or other services they do not control.

Nick Biasotto, MSD

- As a PCMH, once a patient became part of an oncologist group, that person became their attributed patient, not mine.

Emmilyn Lawson, AmeriHealth Caritas

- I think there was some discussion last week of Medicaid, which is a little different. A lot of the care management is prescribed by the Medicaid contract. We are required to do a lot of the care coordination tasks mentioned last week.
- As we have discussions with providers, we are using that list to inform what those care coordination fees should look like. We know what we use in terms of resources to provide that care coordination. We stratify the member population and depending on their risk we cover that list with the level of appropriate staff to keep the costs down.

Dr. Fan

- And that is part of the reason I asked Charlie what the team composition was. I know we are using more and more non-physician professionals to drive the teams because we don't have enough physicians.
- We would like to be able to have a consensus that we need to invest more and which tools we will use to do that. Care coordination fees are one tool. We have good data analytics that are not working efficiently for us.
- If you don't have a strategy moving practices out of FFS to build the infrastructure, then what kind of investments can you make?
- The plan sponsors are the ones paying for it. There are some self-funded systems here at the table. We need them to recognize that part of this is the community benefit.
- How to we move practices out of LAN categories 1 and 2? We have already discussed adequate care coordination payments.

Kevin O'Hara, Highmark

- I think I heard that that primary care couldn't have an impact on care they do not control.

Dr. Jim Gill, MSD

- No, we can have an impact, but we cannot get paid based on the decisions of other providers

Kevin O'Hara, Highmark

- Are we divorcing this conversation from how we paid for it? If I was a plan sponsor I would be concerned that everything you are talking about is increasing my costs.

Jennifer Schwartz, Christiana Care

- There is duplication in the care coordination efforts. The payers are required to do certain tasks, and providers duplicate some of those and want to get paid for the duplication. We have to have a meaningful discussion about which entities are best suited to doing care coordination.
- Some payers are inefficient in the outreach because patients don't want to talk to the payer.
- There are only so many dollars in the system. It is unrealistic to think we can add dollars so that everyone can do these tasks. The provider must balance the risk and opportunity with the infrastructure payment they are going to get. The providers have to believe there is a return on investment possible. I have the experience where we saw returns and we could bring checks to providers.

Kevin O'Hara, Highmark

- I have seen this success too, and I agree. The other Delaware reality is that the total cost of care is the third highest in the country.

Sen. Townsend

- That is precisely the reason we need to do this. We all agree this is an issue, and there are some solutions. Then let's do it. It is a complicated conversation and we need to acknowledge the delicate balance that is there.
- We need to make the structural changes in order to get there. We need to have ongoing integrative dialogue to get it right. We don't want to be too strict and stifle innovation. We need to set a framework that people can operate within.
- We need to note when we are identifying problems that we can fix or problems we can do nothing about. I think high cost of care is a reminder of how much money is in the system. Delaware has got the money, it just needs to restructure where it is going.
- If we could agree on the different elements, then let's formalize the process to ensure progress continues.

Dr. Fan

- If we want to talk about a model that would incorporate total cost of care. The total cost of care is being tracked in the state's benchmarking process. In the individual provider context, there is a total cost of care for each patient that is your responsibility. There are systems and ACOs that might be able to reach that level of accountability.

- To answer Kevin's question, where does that money come from, without making the client pay for it?

Rep. Bentz

- The criticism we had over the fall is that we didn't bring a group together to discuss. We need your answers.

Dr. Jim Gill, MSD

- All these studies show that every dollar we invest in primary care you save \$3-5. Savings occurs in months following the investment, so we need money up front.
- We need someone like the payers to put that money up front for a few months or a year.
- We need to be on that same page.
- In New York, providers were getting a \$15 care coordination and got a 5:1 ROI. The return on investment doesn't take 10 years. The Rhode Island initiative saved 4.5% in the first year by increasing primary care up front.

Chris Morris, Aetna

- Did they have targets that they had to meet upfront?

Dr. Jim Gill, MSD

- No, not as far I know.

Tom Stephens, Westside Family Healthcare

- As an FQHC, we play by different rules. We cannot engage in downside risk.
- We have been involved in a lot of initiatives at the state. We have been involved in the SIM grant transformation. On the Clinical Committee, one of the things we recognized with SIM initiative was that we need to pay for care management and care coordination upfront. Practices need this infrastructure and need some upfront payment to get there. Those conversations never happened for whatever reason. We didn't get those payments done and care coordination never happened through the SIM grant.
- Westside had an interaction with UHC when they were a Medicaid MCO. We wanted to do care coordination but couldn't fund it. We got UHC to give us a larger pmpm, sufficient enough that we felt we could begin to build the infrastructure and we hired three care managers. When UHC lost their place in the market, we couldn't follow through to see if there was going to be a benefit. Built into that agreement was that they provided the pmpm as seed money and after a period of time it would face some risk.
- I think there is some middle ground in providing this upfront money. The practices don't have the money. The health systems have money. The payers are the only ones who can make this happen.
- Upfront investment is necessary to move practices ahead. The other requirement is knowledge. We have been able to work with Art Jones recently, and our understanding of APMs has advanced significantly. There are a lot of folks that don't have the ability to make informed decisions or to enter into arrangements.

Steven Costantino, DHSS

- We know the investment works but where does it come from. Is it additive or does it come from within the existing spending?
- If its additive, you are adding to the denominator and you will never get to 12% primary care spending.
- In Rhode Island, they made sure they weren't adding to the denominator. They moved money within the premium to primary care.

Rep. Bentz

- And if you understand that there will be savings?

Steven Costantino, DHSS

- You would have to tie the investment to the savings. That could be the compromise. Then you have to figure out what are the penalties or withholdings for not meeting that criteria.

Rep. Bentz

- In the report, we express that we want to do it within the existing spending, obviously that ruffled some feathers, but we are trying to be conscious of investing without raising premiums.
- What is that middle ground there? We don't want to see a ratchet up of total cost.

Dr. Jeffrey Hawtof, Beebe

- We created two different care coordination models and one worked better. One was centralized model and one was a practice-based model. We found very clearly that a centralized model doesn't work. At the provider level, there are different ways of practicing and different support that they are asking for and were able to reduce the cost of care.
- If you take the money already being used on the insurance side and let care coordination be done by the provider, that would be a more efficient use of spending.

Steve Groff, DMMA Director

- When we talk about the payers, we attribute some more autonomy to their decision-making than we should. Regarding the Medicaid payers, we are talking about the state of Delaware tax payers making that investment. That passes through our organization to the MCOs.
- The state of Delaware is also a major payer though self-employed plans for employees. We need to consider the impacts of our decisions on the state budget and tax payers.
- In 2015, we prioritized care coordination in the MCO contracts, which meant building in very strict requirements for MCOs around levels of staffing and what they have to do to care of the 200,000 members.
- Now we realize that to get where we want to be, we need to push care coordination out to the practice level. We have stuck a lot of requirements and invested heavily and it may not be in the right place. How do we make that transition? It is not just moving the money, because I still have to hold the MCO accountable for the member and they cannot

do that if they will not have levers to pull with the providers. Without that accountability I don't think we will see the savings or even see improved care.

Sen. Townsend

- No one is looking at this as an easy fix, but I think that the key is figuring out the timetable to get this right. We need to have a structure of dialogue and oversight to get this right.
- The two broad topics we need to figure out are provider capacity, including data, and if it is new spending or comes from within the current spending.
- What would be a reasonable timetable? It cannot be a prohibitive challenge that care is expensive.
- I understand the cashflow challenge, but when the savings are proven to be possible, you can identify which patient profiles are the ones most likely to generate immediate cost savings. So why aren't we doing that?

Emmilyn Lawson, AmeriHealth Caritas

- There is a certain level of maturity practices need to achieve those savings. I think the conversation needs to be how do we accelerate that process so that those savings are not two or five years out.
- We can share learning on how to get to those savings. From a payer perspective what is scary is that we cannot simply turn the investment loose with providers. It requires a very careful partnership by all involved to ensure that that timeline to get to savings is short and realized.
- How do we make sure that the savings are realized?

Nick Biasotto, MSD

- Change can be made with the stroke of the pen can be done, as with SB227. We are now being brought up in reimbursement.
- The primary goal is keeping primary care physicians in Delaware.

Dr. Fan

- The preference is not to make this additive.
- I don't like punitive measures, but I do like accountability. To payers, the accountability is cost savings from providers.

Kevin O'Hara, Highmark

- I don't have anyone in the marketplace paying for this. If it isn't additive, then what are the guardrails we are willing to work within.
- We don't know that our payment model is not working yet. It is not yet 3 years old.

Chris Morris, Aetna

- We have to deliver value, and we do have that in some programs. Not all primary care providers are in those programs though.

Dr. Jeffrey Hawtof, Beebe

- Part of the problem is the more successful practices are, the more mature they are. Nothing we can do today will speed that up, unless you pull more into the successful models. If you think of it less like ACO and think of it as a CIN, the payers will contract with the CIN. Now practices have the ability to leverage the experience and readiness of the network.
- We work well with our Aledade doctors; it doesn't matter if they are in our ACO or not. If we all do it right, then we are all happier.
- So I do think we have models where this can be done. The key factor is if we can capture the money already being used for care coordination and move it down to the practice level.

Sen. Townsend

- I understand the payers have their programs, but they are not working.
- Moving forward there needs to be a different approach. Are we talking about broad guidelines with requirements, or are we talking about an approach with specifics?
- We are not on a trajectory to get where we need to be.

Jennifer Schwartz, Christiana Care

- There is not meaningful risk right now for the providers. It changes how you plan, the systems you set up, and how you staff a practice.
- There needs to be some broad parameters on what the levels of risk are meaningful for practices.

Rep. Bentz

- Can we talk about what meaningful risk means?

Jennifer Schwartz, Christiana Care

- That will look different based on the organization.
- The risk that Christiana is willing to take on is different. And that number might be different for Medicare and Medicaid.

Dr. Jim Gill, MSD

- Maybe you guys are coming up with a solution.
- Someone needs to be at risk down the road. You have to be in an integrated entity to be successful. In the future, practices will either be in an independent network, in a system, or they will be concierge. Maybe we can put the money up front, but the ACOs take the risk and part of the payment goes to building the infrastructure.
- Use the money spent on care coordination by payers as upfront spending in the form of \$15 pmpm care coordination fees starting July 1, and hold practices accountable through ACOs. To play you need to be an ACO.
- Solo private practices are not going to take risk.

Dr. Fan

- It doesn't matter what kind of practice you are in to join ACO. You could be PCMH or not.

- In this model is there still room for a smaller practice who doesn't want to join an ACO to get a pmpm, but less than an ACO?

Steve Groff, DMMA Director

- I do take offense that the care coordination from our MCOs does no good. I don't think that's true.
- We do have special populations and I want to know how we protect them if we just ship this out providers. Are providers equipped to handle home modifications for individuals with very specialized needs? We could carve that out.

Dr. Fan

- This conversation is not ended. Next week we will continue this discussion and talk about an implementation entity. The entity is about monitoring and enforcement.
- You should be prepared to discuss what sort of entity you can live with.

Dr. Tom Stephens, Westside Family Healthcare

- The care coordination cannot be done all at the provider level, in particular for a vulnerable population. On the flip side, there are a lot of patients that only want to speak to the provider.
- We need to have these conversations and the flexibility so that it is not one-size-fits-all and automatically all at the practice or payer level.

Dr. Jeffrey Hawtof, Beebe

- Similarly, with MSSP they segmented accountability into four populations with different health needs.
- You can absolutely figure out the most appropriate place to do the care coordination for specific populations.

Public Comment:

Dr. Andrew Dahlke, President of MSD and Beebe Board Member

- I think we have one problem to address and that its data collection. You cannot change bad behavior without it. With MEDnet we don't get the data from AmeriHealth Caritas that we need. We use Health EC to mine the data.
- We will have trouble collecting the data for the APCD.
- I see this as a three-year plan, but until we can get the data to the physicians in a timely manner we cannot change outcomes.

Tyler Blanchard, Aledade

- We work with independent physicians only. We are in the first Medicare ACO in the state to achieve shared savings and we are going to two-sided risk. We collaborate with the other ACOs.
- This problem is urgent. We had a practice that we got to hand a big savings check to, but they moved to a concierge model the next month.
- We have immediate challenges and savings may not enough. And practices just starting today are years away from having a payoff.

- There is technical infrastructure needed. We spend a million dollars each year to operate our infrastructure in Delaware. We are VC backed, so we have a long time horizon to achieve returns.
- We work with those willing to take on risk. We are bankrolling most of the downside risk, and reaching realistic agreements with practices for downside risk they can tolerate.

Rep. Bentz

- You may have noticed we are pushing a bit more at this meeting. We just need to move forward. We were spending more time talking about the problem at the last meeting. We are appreciative of everyone's time.

Dr. Fan

- We are trying to answer a need. We heard that there needs to be more discussion among the stakeholders. We need to invest in primary are. We are getting to the hard questions of where does that money come from.
- If you have information you want to push out that supports your point, please send it to Jules and Read. If you feel there is information that needs some research, let us know that as well.
- For homework for next week, come prepared to continue the discussion from today and to discuss the implementation entity.

Meeting was adjourned at 8:00 p.m.

SB 227: Primary Care Collaborative Meeting

Monday, March 4th, 2019

6:00pm-8:00pm

**Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713**

Meeting Attendance:

Present:

Senator Bryan Townsend
Dr. Nancy Fan
Representative David Bentz

Email:

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David.Bentz@delaware.gov

Staff:

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Attendees:

Katherine Impellizzeri
Kevin O'Hara
Wayne Smith
Vince Ryan
Representative Ray Seigfried
Kathy Collison
Andrew Dahlke
Kim Gomes
Kathleen Willey
Mike Wormt
Margaret Defeo
Rosa Rivera
Susan Conaty
Kristina Thompson
Gary Kirchhof
Anthony Onugu
Kiki Evinger
Dr. Karen Feeney
Sylvia Canteen-Brown
Jennifer Mossman
Liz Stabler
Chris Morris
Steven Costantino
Gary Seigelman
Dr. Christine Donohue-Henry
Karyn Scout
Lizzie Lewis Zubaca

Aetna
Highmark
Delaware Healthcare Association
Department of Insurance
House of Representatives
Division of Public Health
Medical Society of Delaware
Byrd Group
Quality Family Physicians
Aetna
AmeriHealth Caritas
La Red Health Center
Delaware Coalition of Nurse Practitioners
AmeriHealth Caritas
Highmark,
UMACO
Department of Health and Social Services
DCS
Delaware Pediatrics
Highmark
Aetna
Aetna
Department of Health and Social Services
Bayhealth
Christiana Care Health Systems
AmeriHealth Caritas
Hamilton Goodman Partners
Christiana Care Health System

Faith Rentz
Lisa Zimmerman
Pam Price
Jamie Clarke
Steve Groff
Geoff Heath

DHR
DMMA
Highmark
Nemours
DMMA
Christiana Care Health Systems

The meeting was brought to order at 6:00 p.m.

Dr. Fan

- The Collaborative doesn't feel we will come to consensus on everything. The point is to take a deeper dive on these topics. Whatever we can take back as consensus would be useful.

Dr. Art Jones, HMA

- We have agreed that in addition to fee-for-service, we need value-based payment revenue sources
- We talked about three different areas: care management, shared savings to shared risk, and pay for performance
- These models reinforce each other. You can choose to do one of these alone, but we want to move towards an accountable delivery system that includes all three.
- There may be primary care physicians in the market that are not integrated and cannot do shared savings.
- There has to be some possibility for independent physicians to move to value-based payments.

Tom Fitzpatrick, Highmark

- If they are all interrelated isn't there another category of FFS? In that FFS category, I would include the chronic condition and care management fees.

Dr. Art Jones, HMA

- Agreed. This was focused as VBP, but this could be FFS too though.

Steve Costantino, DHSS

- Does it assume everything is under an ACO?

Dr. Art Jones, HMA

- The handout says clinically integrated network; the slide says ACO.
- The assumption is that some integration among providers is necessary to be prepared to take on shared savings or risk effectively.
- Not too many groups have enough attributed population to do shared savings or shared risk within an acceptable degree of impact of statistical variation.

Steve Costantino, DHSS

- If a provider wanted to be a PCMH and not an ACO?

Dr. Art Jones, HMA

- If they had enough attributed lives they could do this alone as a PCMH. Whatever the entity is, they must be big enough to have sufficient attributed lives and the capabilities to manage the total cost of care.

Gary Seigelman, Bayhealth

- Payment is not the only thing that impacts the ability of providers to be successful.
- I have some thoughts on payment models, but there are other burdens like administrative burden.

Dr. Art Jones, HMA

- The administrative burden has come up in other meetings and we recognize that there are also other ways of investing in primary care such as tuition payback programs and support for investment in HIT.

Gary Seigelman, Bayhealth

- Standardizing the quality goals and simplifying the administrative goals.

Dr. Art Jones, HMA

- I think where we do not have total consensus but have agreed on some aspects.
- We will not be able to talk about individual contracts, but what we are trying to do is to agree on some principles so that whether you are the payer or provider group you understand where the other side is coming from and where there is agreement or not.
- Under care management fees, there is an upfront pmpm with task accountability. We have discussed that we do not want duplication of services with clear hand-offs in roles and responsibilities. Whatever the amount, the pmpm should be paid up front and there should be clear accountability.

Dr. Christine Donohue-Henry, Christiana Hospital

- Would there be legislation on the delegation of care management to this entity?

Dr. Nancy Fan

- We don't want to be too prescriptive.
- What we are looking at is what principles you want to agree on to sustain primary care.
- We want to increase primary care spending. And the follow up recommendation is to move to value-based payment models.

Dr. Christine Donohue-Henry, Christiana

- Would the payers also maintain their care management function, in addition to the CIN level?

Dr. Art Jones, HMA

- I think what it comes down to is laying out the tasks and having a conversation about who is most suited to accomplish those tasks.
- Part of that has to do with the population and the entity's capability to do care coordination and care management.
- We would not be prescriptive here, but we would encourage a clear discussion on the tasks.

Karyn Scout, AmeriHealth Caritas

- We are in the Medicaid space and our requirements may look different than those for other populations.
- We might require a higher level of care coordination based on our contracts with the state.

Tom Fitzpatrick, Highmark

- What do you mean by "related to a percent of the premium"?

Dr. Art Jones, HMA

- Before we get to that second bullet, the first bullet means that if it is really a care management fee, the dollars must be used for that particular purpose whether in staffing or other resources for care management.

Tom Fitzpatrick, Highmark

- How is that different from the chronic care management fees?

Dr. Jim Gill, MSD

- Chronic care management is only for a small subset of the population.
- Care management fees would be for everyone, around \$15-20 per month.
- Chronic care management applies only to individuals with at least 2 chronic conditions and who require the practice to spend 20 minutes in a month on care coordination.

Dr. Art Jones, HMA

- The value has to be taken from two perspectives. It has to be an amount that can reduce total cost of care even after incorporating the cost of the CM fee but also support the cost of doing the service.
- This group is not supposed to dictate a specific value.

Tom Fitzpatrick, Highmark

- The JHU folks had a presentation previously, which showed that the pmpm that generated savings was not \$15-20 dollars.

Dr. Nancy Fan

- That presentation was just an example from other states. They were not prescriptive for Delaware and what works in other states might not work here.
- The number that Dr. Gill is throwing out is his own proposal.
- We want to hear what everyone can do to get to the increased spending in primary care.
- If there is point where the cost of the pmpm cannot support an ROI, then we need to do consider that evidence.
- Tonight we also need to discuss a funding proposal, an oversight body, and other sorts of primary care investments.
- We should all agree that the care management fee is for staffing and infrastructure and not just for chronic care management.
- The pmpm must support the service and provide an ROI.
- We are not going to legislate what the right number is. We will legislate how to increase primary care spending.

Dr. Art Jones, HMA

- For a CPC+ Medicare population, they pay \$15 on a blended rate, but on an average \$800 per month premium. That is 1.8% of premium.
- You have to understand your population and what you are spending. The savings potential depends on the premium costs as well. The care management fee must be proportionate to the health care costs and savings potential.
- If you are going to provide a pmpm, what is the accountability to contain the total cost of care? Develop the shared savings arrangement accounts for the medical and care management costs. The expense for care management is included in the share savings arrangement. The MLR might get adjusted as the administrative cost to the payer changes.
- With pay for performance, we want to choose key metrics. Align the metrics to the provider with the financial incentive of the payer and also align metrics for similar populations across payers as much as possible.

Gary Seigelman, Bayhealth

- This is not a trivial issue. It took us a year and a half to build the CMS metrics in to the EHR with high usability and accuracy and consistently.

Chris Morris, Aetna

- We have standard clinical criteria we use, we just want to ensure that the metrics have enough value to be meaningful.

Kevin O'Hara, Highmark

- We tried to stay as close to the Common Scorecard as possible. For all the measures we have in our program, we can tell you where they came from and we have a 80% compliance with Common Scorecard.

Dr. Fan

- All payers have about 80% compliance with the Scorecard. The difficulty is trying to meet the specifications of each specific plan. That would be a technical discussion on how to make it easier for providers to data mine the metrics and demonstrate that they are meeting the metrics.
- When we are talking about pay for performance, agreeing on the standardization to reduce the administrative burden is an area of savings for the practice.
- That would help enhance pay for performance and uptake.

Dr. Art Jones, HMA

- You have 80% overlap in metrics; can you have a discussion of the 20% other metrics?
- We are not suggesting that there is a certain number of metrics. The total number of metrics needs to be limited to a number that is reasonable for a provider. Metrics will vary by population.
- Providers start their baseline performance at very different places. The providers will look at their benchmark performance and decide they will or will not participate based on if they think they can succeed.
- One strategy is to provide some reward for improvement over baseline and then provide additional rewards for making the goal.

Chris Morris, Aetna

- It is a quality improvement program; if they are hitting a metric and best in class we won't look for improvement.
- The program is very collaborative. We review the metrics with the provider each year.

Dr. Art Jones, HMA

- Does anyone have a problem with the principle?

Tom Fitzpatrick, Highmark

- Is it practice improvement or improvement over the market?
- We believe it should be improvement over the market. If you have a low performing practice, we should not be paying for marginal improvements.

Dr. Art Jones, HMA

- The problem with that approach is that you will not engage them in quality improvements.

Jamie Clarke, Nemours

- Performance has to be measured at the practice level. On appropriate risk adjustment to compare with the market.

- With a unique patient population, we do not always have an appropriate market comparison. We are open to similar children's health systems in other areas, but comparison to the market is difficult in a small state like Delaware.

Dr. Christine Donohue-Henry, Christiana

- Struggling with the clinically integrated network vs the provider level performance.
- The decision of whether you are going to incentivize someone to improve is a discussion for the CIN level that will be implementing the strategy. The CIN would take on the risk and decide how to implement quality improvement.

Margaret Defeo, AmeriHealth Caritas

- It does sometimes take an investment to get a practice back to the median performance.
- It might be worthwhile giving consideration to the practices not getting any incentive and assessing if they would improve with an investment rather than letting them fall out of the program.

Dr. Art Jones, HMA

- The idea is continuous quality improvement. The experience shows that providers assess how likely they will be to succeed. They will not participate if they don't think they can hit the target.

Chris Morris, Aetna

- This is why we have different models.
- We do measure practices against their historic performance. In some models, like in pay for performance, we have greater expectations.

Tom Fitzpatrick, Highmark

- We are having a hard time having a client pay for this program if we are paying out for improvement in a practice that doesn't correlate to cost savings for client.
- How do we square that for agreement?

Dr. Art Jones, HMA

- Sounds like we do not have agreement

Gary Seigelman, Bayhealth

- It is a process. Not sure the details can be worked out. Some of it is selling it to the client. If you want an employer to have a long term strategy, they need to understand that we need to improve the system overall.

Dr. Fan

- If we are going to talk about consensus, we need to be flexible. If we are talking about small practices, the metrics should be against the practice level. For an ACO or ICN, then incentivizing to beat the market might be a better strategy.
- At some point there needs to be a trigger for the payers to say that we have given you a timeline to meet a benchmark and you haven't met that. I think providers are comfortable talking about that.

Steve Costantino, DHSS

- There is a gate and ladder approach. To create a true benchmark with a higher incentive, with smaller incentives for continuous improvements.
- Usually the more you improve the harder it is to improve. You might have a hybrid approach to accommodate both issues.

Dr. Art Jones, HMA

- For the minutes, should we say there is some disagreement on how we reward for improvements?

Tom Fitzpatrick, Highmark

- I think we would like it marked as reward based on practice improvement or market improvement.

Dr. Art Jones, HMA

- If the market improved, and a provider showed some improvement, but didn't get to the market level, should that provider be rewarded?

Tom Fitzpatrick, Highmark

- That is not where we are in agreement
- We would not provide a reward in that case. If the practice didn't move over and above what the market did, either that practice's starting point is too high from a cost perspective or too low from a quality perspective.

Dr. Art Jones, HMA

- Moving onto shared savings to shared risk.
- First, if savings are created, they would be between the CIN and the plan.

Kevin O'Hara, Highmark

- Would the split be 50/50?

Dr. Art Jones, HMA

- The split varies by provider and by year in an agreement. This means that you as a plan will enter into a shared savings moving to shared risk. This is saying that you think it is important to enter into these arrangements.

Gary Seigelman, Bayhealth

- At some point there have to be some parameters. Is it based on amount of risk or the amount of investment?

Dr. Art Jones

- That is part of the negotiation between the plan and provider.
- There are details of a shared savings arrangement that we will not be prescriptive on such as target medical loss ratio.
- There will be an agreement that there is a transition to shared risk over time.

Tom Fitzpatrick, Highmark

- It will depend on the definition of time.
- We have set forward a transition to risk over a 3-5 year period. We have said that for a long time. We cannot afford to have providers in upside only plans forever.

Dr. Art Jones, HMA

- Does the group feel OK on a time of 3-5 years from shared savings to shared risk?

Chris Morris, Aetna

- As long as the risk is within that frame. That really depends on the provider.

Dr. Jim Gill, MSD

- I am mostly just agreeing, assuming that a provider is made whole with the various aspects by paying for these other things. The timeline of 3-5 years is fine.

Tom Fitzpatrick, Highmark

- Doesn't that run counter to the care management expenses as part of the risk pool?
- Those costs would be part of the total cost of care in the shared savings program.

Dr. Jim Gill, MSD

- I am not disagreeing on that. Once you pay for care coordination, it becomes part of the total cost of care. The mechanism by which you pay for care coordination is not through the shared savings.

Dr. Art Jones

- The care management needs to be paid prospectively pmpm. In calculating the shared savings, the care management cost is accounted within the total cost.

Tom Fitzpatrick, Highmark

- Looking at the worst-case scenario, assume we paid \$100k in care management fees but the ACO lost \$100k. When we do the shared savings calculation. Assuming we are in

50/50 arrangement, they will have to pay back \$50k, which is 50% of the care coordination fees.

- We are agreeing to pay care management up front, but we will recoup with losses.

Dr. Art Jones

- Yes, if you are in a shared risk arrangement.

Dr. Fan

- What we are trying to say is that the transition to shared risk is exclusive of the care management fee.
- With a 3-5 year timeline, are you talking about a total cost of care or what level of risk? I think there are areas we could use greater definition.
- You don't have to have all three elements in this slide to do this.
- Your care management fees do not mean you are in a shared savings to shared risk model.

Tom Fitzpatrick, Highmark

- I think we would disagree with that. We cannot pay care coordination fees without realizing savings. We wouldn't agree to pay care management fees on top of chronic condition management codes if there wasn't shared savings and shared risk.

Dr. Christine Donohue-Henry, Christiana

- I think 3 to 5 years is too passive and will not transform care.
- I think we need total cost of care at the CIN level. The money the payers already spend on care management would be provided to CIN in a delegated model. That spending should cover the care management costs.

Dr. Jim Gill, MSD

- I think we are losing the premise. The path is not total cost of care. Shared savings is not the answer.
- Poor primary care in Delaware is the problem. The way to get better primary care is not total cost of care or shared savings. The answer is better care through care coordination and PCMH.
- The current solutions the payers have come up with will not work.

Dr. Christine Donohue-Henry, Christiana

- There is a way to do that and support the primary care physicians and protect them against that risk. The CIN is larger and has the capacity to help support them.

Dr. Jim Gill

- Any model cannot include total cost of care or shared savings up front.
- The pmpm must come first, followed by pay for performance, then shared savings.

Sen. Townsend

- There are things that we need to do, we are missing the point if we are getting distracted by secondary concerns.
- I think your point was this has nothing to do with value-based care necessarily. There are things we need to do to deliver good primary care.
- I hear you say that we are so skeptical that this framework is going to work if that framework is not acknowledging the fundamentals of what we need to provide before we get into measurements, risk, and attribution

Dr. Jim Gill, MSD

- Primary care is valuable. You need to pay for the fundamentals, which includes care coordination, if you want to move to an even better system.

Sen. Townsend

- Risk sharing isn't inappropriate, but the care management piece needs to be considered fundamental and central to good primary care.

Chris Morris, Aetna

- This is why we have a glide path. We look at the care coordination as an investment in year one. We expect to have value though, so they will be at risk eventually.

Dr. Fan

- I don't think there is a lot of disagreement.
- I think the disparate starting points of practices is the difficulty. There are some practices or systems that can do all of this, as long as their care management fee is sufficient.
- We need to have consensus that we need a greater upfront investment in primary care.

Margaret Defeo, AmeriHealth Caritas

- I think I heard from the payers that if they were going to do provide pmpms, by year 3 you need to claw back the care coordination fees for performing worse than the market.
- If we were all investing in care coordination, taking away that little bit of investment away wouldn't be helpful.

Dr. Fan

- I want to hear from Tom and his team about the previous discussions, anything you want to bring forth.

Tom Fitzpatrick, Highmark

- A little bit on my heels hearing that total cost of care cannot be a driver here. That is the whole reason we have been participating and that is the only way it will be sustainable. Otherwise you might as well just go to the clients and ask to increase spending.

- We looked at the savings created through our program. What if we pulled those dollars forward into the next year and set aside for care coordination for the following year.
- The cost savings associated with the program is about \$4 pmpm in the True Performance program. We would look on a pilot basis to add that savings to our existing care coordination fees as an upfront investment to get these practices invested and stabilized in an effort to move to risk. In essence for the first year or two, we would front end load and socialize the savings across all the practices. That is the best way for us to jump start that glide path to risk. This is counter to what we have historically done and what we do in other markets.
- But to not acknowledge total cost of care is not something we can sign up for. We need to reduce total cost of care or we will have a problem.
- We want all practices involved. Hopefully the Collaborative will mandate participation in these programs. We would be willing to do this for all practices. We believe in that middle box of shared savings and risk. We do have parameters for practices to participate currently. The ACO or CIN could help a practice meet the minimum attribution to participate.

Gary Seigelman, Bayhealth

- I think one of the things that is important is that there has been a tremendous amount of investment in population health. That includes investment in people: population health nurses, data analysts, etc
- That infrastructure of the ACO has shown some real improvements; the quality metrics have been high. The ACO has come under the benchmark set by Medicare meaning that Medicare is saving money relative to what they are doing nationally.
- We can leverage this existing infrastructure, not necessarily in a mandated way, but allow practices to participate in the CIN. The CIN can help with the technical challenges of contracting.
- Having a network that you are working in can be a great benefit. This is a model that would provide a great number of benefits.
- You could design how much risk falls to the providers. Most of the risk in the ACO falls to the health system, not the primary care providers.
- This uses an existing infrastructure to address quality and outcomes.
- The assumption is that if you are improving the quality of care, you are flattening the cost curve. If you can do that there are dollars to pay for what the primary care doctor needs to do.
- The payers will save money because the providers will be taking on more risk.
- If there are reductions in utilization per capita there will be savings.

Dr. Fan

- Current ACOs are all Medicare and you are talking about expanding to commercial.
- The incentive to support primary care comes from the infrastructure and cost is already built in a network.

Dr. Jim Gill, MSD

- Current ACOs are not just Medicare. We work with Highmark commercial.

Steve Cosantino, DHSS

- The ACO penetration outside Medicare is minimal. Hence the Medicaid RFI.

Chris Morris, Aetna

- We have two commercial ACOs in Delaware.

Dr. Jim Gill, MSD

- Generally I am in agreement. It probably will work better if clinicians are in CINs.
- The caveat would be that there are some practices that want to do it on their own. We might end up where we need to figure out what to do with the providers who cannot join a CIN. We need every primary care provider in the state, so we cannot ignore anyone.
- As for the funding part – there is money in the system now. Probably need some up-front fees, then the risk would come later. How much later is up for debate.
- The funding is not contingent on risk up front.

Dr. Fan

- NPs as independents should have parity.
- If they have an independent practice within the CIN they do not currently have parity. They assume the same risk and same funding stream and same reimbursement parity with physicians.

Gary Seigelman, Bayhealth

- I personally wouldn't want to speak to that.
- The APRNs are providers and we want them working toward these goals. They also need resources. I'm not sure that parity is an assumption.

Dr. Christine Donohue-Henry, Christiana

- There are structures within that track and measure providers for that clinician's panel. We assume that APRN would be an equal provider in that assessment.

Dr. Fan

- I think a lot of this could dovetail together.

Dr. Jim Gill, MSD

- The medical society also put together a proposal. I have a summary version.
- This is built around the AAFP advanced primary care alternative payment model. This has been approved by PTAC.
- It puts costs into the four quadrants.

- 1) Payment for preventive acute and chronic care
- 2) Care coordination fees
- 3) Performance based payments
- 4) Fee for services items that just don't fit elsewhere
- This is not a total cost of care model .
- The most important points are what level of spending goes into primary care. We need to standardize how we measure that. There is a good report from Milbank that talks about that.
- Right away start the care coordination. The \$15-20 pmpm is supported by studies from Commonwealth and AHRQ. We are happy to discuss the appropriate level and the balance between what it costs to provide and what is feasible.
- In a year or so, build in performance-based measures. We need to move away from HEDIS to other primary care measures, like how much do you do coordination of care, continuity of care.
- Then the risk would be introduced. If you agree to a basic level of risk, you get the basic payment. You cannot take risk if there is no upside. You can be eligible to be at risk if you have an opportunity to get higher measures.
- The shared savings would be the same idea. You should be eligible to get additional money if you share costs. You should be responsible for the cost if you lose money.
- Putting everything into capitation would be a stepwise approach. What gets left over would be high cost.
- We have a lot more details where with how we came up with these numbers.
- The whole thing could be in place January 2022.

Tom Fitzpatrick, Highmark

- Difficult to follow on the phone. We would like to reserve our comments until we have a minute to digest.

Dr. Fan

- We are definitely talking about pay for value, care coordination, shared savings and shared risk.
- These were in all three models.

Kristina Thompson, AmeriHealth Caritas

- Offered to pull together our care coordination model so we have that.

Dr. Art Jones, HMA

- Some of the details we can agree to the principles and the details need to be negotiated between payers and providers.

Steve Costantino, DHSS

- Care coordination can in part be put at risk?

Dr. Jim Gill, MSD

- They can be put at risk based on measurements. It is really important that these metrics are transparent. The data to measure these things need to be available to the provider.

Steve Costantino, DHSS

- What is at risk? Let's say you didn't meet the measures.

Dr. Jim Gill, MSD

- Let's say the basic care coordination fee is \$17 pmpm. Part of that would be at risk if you didn't meet these measures. And you could get more than that as a performance incentive.

Steve Costantino, DHSS

- The only thing at risk is the 15-20? What is not at risk is total cost of care or any of the potential savings?

Dr. Jim Gill, MSD

- That would be part of the shared savings risk. The eventual goal is to get to capitation.

Chris Morris, Aetna

- If you don't deliver value, the entire care management fee is at risk?

Dr. Jim Gill, MSD

- The concept would be that the incentive has to be as great as the risk.
- The care coordination fee isn't something extra. It is a basic payment.

Chris Morris, Aetna

- You could have other cost savings and risks

Tom Fitzpatrick, Highmark

- They really are extra dollars. You don't need care coordination for your low risk patients.
- We are already paying chronic care management fees for your high risk patients. To have a flat dollar amount for everyone is adding extra dollars.

Dr. Jim Gill, MSD

- Everyone needs care coordination. Someone without any health problems still needs care coordination.
- Chronic care management fees don't kick in unless you spend more than 20 mins per month and the patient has 2 chronic conditions.
- There is a misunderstanding that this is something else. We are not getting paid for we have to do and the infrastructure to get this work done.

Dr. Fan

- When we talk about total health care spending, care management is not additive to the total health care dollars already being spent.
- Care coordination fees are a foundational investment. It might seem like additional dollars, but we need to make it not additive. The answer to leveraging primary care investment without making it additive.

Chris Morris, Aetna

- We are not supportive of an additional fee, but we do have care coordination in place where it is an upfront investment. It does become at risk, but not in year one.

Sen. Townsend

- There needs to be some level of agreement of what it takes to get it right.
- What does it take to provide the services we are trying to provide here? If you have the data to back that up, great. Those examples from the last meeting are from states that have different primary care situations, with less crisis.
- So much of the tone of tonight doesn't seem to involve the kind of agreement I thought we would have.
- You have to provide in a primary care context a certain level of service. The initial payments need to be up front and come from somewhere, but the amount can come from savings elsewhere.
- If you agree on a set of services that are needed for different populations, there is a lot of savings available in the system by doing it right. I don't see from the payers a philosophical commitment to the shared incentives and achieving this.

Tom Fitzpatrick, Highmark

- I think your comments are misdirected. We have participated from the beginning. We have talked about our programs' care coordination fees. We are objecting to the amount and the level of these fees. We have shared data to support this. We simply referenced the only piece of data from the JHU. We are happy to look at the evidence supporting higher pmpms. We haven't seen that level of pppm anywhere.
- We put together a proposal to front load care coordination fees, but we cannot do it without savings associated because otherwise we are just increasing total costs. We shared in the first meeting that 70% of our members are attributed to a primary care provider, that is the highest across all our markets. There are engagement issues in all of our footprints.
- The comments are misdirected because we haven't been an impediment to this.

Chris Morris, Aetna

- We want to get primary care providers all involved in one of our models.
- What I am trying to explain that there are complexities. Some of the smaller providers get smaller fees because they cannot take as much risk.

Dr. Kathy Willey, Quality Family Physicians/MSD

- I am a family doctor. I am an NCQA Level 3 medical home. I have 2 years left on my lease and we are closing. I have made it through 20 years of capitation, meaningful use, HIPAA, and the number one reason I am closing is because I cannot tell you what my cost of care is.
- I do great on the quality metrics. Care coordination is done without the physician involved.
- The problem is when I sit down I cannot get an answer for how I can control the external costs. There is not one report that comes in and tells me how to address those costs.
- The care coordination is taking care of the patient when they are not in front of you.
- We cannot get this to work. If we don't invest in this you are going to have a state without primary care doctors.

Rep. Bentz

- That is why we are here. Because we are talking about a business, we lose sight of the customers who are looking to access primary care.
- This was always going to get harder before we have a breakthrough. Some amount of consternation is the sign of a good compromise.

Dr. Fan

- We have not set any more meetings. There is lots of room for discussion.
- My vote is that the three of us will discuss the next direction and where the meeting should be. I want it to include everyone at the roundtable right now. Having your input is very valuable.
- I think you need to think about the original recommendations that we will be building off.
- Oregon and Rhode Island have great ideas, but we need to hear what you are comfortable with in terms of authority and accountability.
- The next steps will be the Collaborative discussing what we have heard so far.

Wayne Smith, DHA

- Talking about giving the authority to cap hospital rates is detrimental to what we are trying to achieve.
- Everyone involved in hospital based primary care knows that they lose millions of dollars. We are the back stop; our primary care providers are in areas where there aren't independent primary care providers.
- The idea of taking money from hospitals is counter to the goals.

The meeting was adjourned at 8:00 p.m.

SB 227: Primary Care Collaborative Meeting

**Thursday, May 9th, 2019
6:00pm-8:00pm
Legislative Hall
411 Legislative Ave, Dover DE 19901**

Meeting Attendance:

Present:

Dr. Nancy Fan
Rep. David Bentz
Senator Bryan Townsend

Email:

nfanssmith@yahoo.com
David.Bentz@delaware.gov
Bryan.Townsend@delaware.gov

Staff:

Julian Emory
Read Scott

Julian.emory@delaware.gov
Read.Scott@delaware.gov

Attendees:

Pam Price	Highmark DE
Susan Conaty	Delaware Coalition of Nurse Practitioners
Wayne Smith	Delaware Healthcare Association
Jennifer Mossman	Highmark DE
Katherine Impellizzeri	Aetna
Kathy Collison	Division of Public Health
Kevin O'Hara	Highmark DE
Lenaye Lawyer	AmeriHealth Caritas
Weston Riesselman	Christiana Care Health System
Bryan Villar	Bayhealth
Chris Morris	Aetna
Vince Ryan	Department of Insurance
Andrew Wilson	Morris James
Shay Scott	Henrietta Johnson Medical Center
Stephanie Myers	AmeriHealth Caritas
Geoff Heath	Christiana Care Health Systems
Daniel Elliot	Christiana Care Health Systems
Nina Figueroa	Department of Human Resources/SBO
James Gill	Medical Society of Delaware
K. Elizabeth Staber	Aetna
Anthony Onugu	United
Joe Bryant	Office of the Governor
Candida Taylor	DAFP
Sylvia Canteen-Brown	Delaware Pediatrics
Regina Heffernan	ACDE
Lizzie Lewis	Hamilton-Goodman Partners
Dr. Cedric Brones	DAFP
Elisabeth Scheneman	DHSS
Jamie Clark	Nemours

The meeting was brought to order at 6:00pm.

Dr. Fan

- Made a motion to approve minutes, Rep. Bentz seconded the motion.
- Moving forward there are recommendations to expand the Primary Care Collaborative
 - Option 1: Expand the board to include stakeholders that have been involved in conversations or
 - Option 2: Create two to three subcommittee under the Department of Insurance who would work under a regulatory body
- Rhode Island, Oregon and Massachusetts are taking efforts to find what works best when addressing Primary Care in their state.

Rep. Bentz

- Expressed interest in hearing feedback from audience.

Kevin O'Hara, Highmark

- Expressed he would like time to share this information with his team prior to providing comments.

Dan Elliot, Christiana Care Health Systems

- Stated next steps depend on the scope of work.

James Gill, Medical Society of Delaware

- Explained he is leaning towards Option 1 due to topics being intertwined.

Wayne Smith, Delaware Healthcare Association

- Shared that his team was able to talk about this information at their latest board meeting.
- Expressed support for Option 1.

Dr. Fan

- Confirmed everyone wanted to be involved regardless of the approach taken.

James Gill, Medical Society of Delaware

- Expressed concerns with voting as a group due to the group's composition.

Dr. Fan

- Agreed composition matters and does not want a large group.
- Asked how the Department of Insurance felt.

Commissioner Navarro, Department of Insurance

- Need more time to digest new information
- Expressed the Department needs more time to digest information, however, they are all in to be a part of this and will need to take steps to evaluate what the Department of Insurance will need in order to contribute and oversee efforts.

Dr. Fan

- Explained this is version one of the legislative draft and the necessity to expand the scope of authority of the Department of Insurance to assist in the Primary Care Collaborative

Senator Townsend

- Explained this is a big step for him and Rep. Bentz to assist in these efforts
- Clarified this would be a shared responsibility of this work with the Department of Insurance

Commissioner Navarro, Department of Insurance

- Expressed the belief that the right place for the Primary Care Collaborative is under the Department of Insurance
- Believed the draft bill is missing pieces as to how things should happen

Rep. Bentz

- Communicated that they want to give the Department of Insurance all the resources they need to do the best work

Dr. Fan

- Recognized the current infrastructure cannot support the work and an expansion is needed.

Senator Townsend

- Stated they will need to get draft legislation finalized by June 30th, including a Fiscal Note for the Joint Finance Committee to review.

Vince Ryan, Department of Insurance

- Explained the Department of Insurance's hiring process, and they would need some time to discuss moving forward with new positions

Dr. Fan

- Stated she would like to have no more than 17 members and encouraged everyone to think about this over the next few days.

Rep. Bentz

- Expressed the notes that were provided on Monday reflect the bill that was released today and therefore we should be able to have more discussions today

James Gill, Medical Society of Delaware

- Showed general support for moving forward and a gradual increase up to 12%

Kevin O'Hara, Highmark

- Concerned with rising cost and the 12% target becoming harder to reach.
- Asked if a component that speaks to shared savings trigger related to total cost should be included in the bill

Dr. Fan

- Clarified that Highmark wants something more deliberate than the collaborative and the state benchmarking process.

Kevin O'Hara, Highmark

- He confirmed and explained other states did more to address cost specifically in their regulations.

Dan Elliot, Christiana Care Health Systems

- Expressed Christiana Care's ongoing commitment to Primary Care and Total Cost of Care Models
- He explained it is important to know what they are trying to accomplish and what the team will look like moving forward.
 - This included defining Primary Care, identifying the regulatory body overseeing the collaborative and developing mechanisms and corrective actions if the increases are not met.
- Expressed concerns that a target percentage may not mean all goals are being met and groups will need time to adjust to find ways that work.

Dr. Fan

- Agreed there will need to be adjustments and everyone must keep in mind the entire vision.
- Explained she believes mandating a concept in flexibility takes away from the collaborative and regulatory components of the group.

Dan Elliot, Christiana Care Health Systems

- Surprised by the lack of numbers and expressed the need to use numbers and data to see where we are and where we may go.

Dr. Fan

- Deliberately did not define Primary Care Spend in the bill. She is curious to know what others are thinking in terms of mandating a number.

James Gill, Medical Society of Delaware

- Agreed creating a definition is critical in how we measure outcomes and track progress.

Dan Elliot, Christiana Care Health Systems

- Restated it is hard to define a number if we do not have a bigger understanding.

Senator Townsend

- Shared they would move forward with regulatory process in legislation.
- June 30th have a framework to share regarding how the Primary Care Collaborative will be comprised and what movement forward would look like

Dr. Fan

- Clarified that we will be working to define Primary Care.
- Encouraged participation so legislators can leave here with next steps.

Chris Morris, Aetna

- Aetna supports Value-Based care and would like to work through the details regarding metrics and how corrective action will occur.

Dr. Fan

- Confirmed this would be the type of concerns that would be worked on in the expansion of the Primary Care Collaborative.
- Emphasized transparency is important when moving forward

Commissioner Navarro, Department of Insurance

- Explained the Department of Insurance has resources for data collection and experience in corrective actions.
- Stated there were a select few areas of concern and may need assistance in understanding certain parts.

Dr. Fan

- Explained the current structure of Primary Care Collaborative does not have enough authority to address concerns.
- Plan to expand authority to other areas and have the ability to deliberately look at areas of concern.

Vince Ryan, Department of Insurance

- Echoed Commissioner Navarro's concern to have a narrower scope of work.
- The Department is happy to collaborate; they just want to make sure that both the Department of Insurance and Collaborative leaders have the same vision.

Senator Townsend

- Discussed including explicit statements in the bill to address the large concerns such as Defining Primary Care before moving forward.

Jamie Clark, Nemours

- Expressed concern that it may take an expanded period to measure changes.

Dr. Fan

- Suggested the DOI think about if they would like to include explicit language to include 'per the recommendations made by the Primary Care Collaborative' rather than stating they would be in collaboration with the Collaborative.
- Expressed the need for guidance in order to work towards the same vision

Dr. Cedric Brones, DAPF

- Asked for clarification if definitions and frameworks will be decided after this.

Dr. Fan

- Clarified this is true and we will be discussing changes after hearing feedback.
- Asked that comments be submitted by the end of the day Monday May 13th, 2019.

Senator Townsend

- Explained the next step is reviewing recommendations and having a bill introduced as soon as possible.

The meeting was adjourned at 7:15pm.

SB 227 Primary Care Collaborative Meeting

Tuesday, September 17, 2019

5:00 p.m.

**Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713**

Meeting Attendance

Collaborative Members:

Present:

Senator Bryan Townsend, Co-Chair
Dr. Nancy Fan, Co-Chair
Representative David Bentz, Co-Chair
Faith Rentz
Veronica Wilbur
Leslie Verucci
Kevin O'Hara
Dr. Jim Gill
Hon. Trinidad Navarro
Steve Groff
Hon. Kara Odom Walker

Organization:

Senate Health & Social Services Committee
Delaware Healthcare Commission
House Health & Human Development Committee
State Benefits Office/DHR
Next Century Medical Care/ Delaware Nurses Association
Delaware Nurses Association
Highmark DE
Medical Society of Delaware
Department of Insurance
Division of Medicaid and Medical Assistance
Department of Health & Social Services

Absent:

Dr. Jeffrey Hawtof
Dr. Christine Donohue Henry, MD
John Gooden
Margaret Norris-Bent
Dr. Michael Bradley
Chris Morris

Organization:

Beebe Healthcare/DHA
Christiana Care Health Systems/DHA
MDavis, Inc./DSCC
Westside Family Healthcare
Dover Family Physicians/Medical Society of Delaware
Aetna

Staff:

Julian Emory
Read Scott

Julian.Emory@delaware.gov

Read.Scott@delaware.gov

Attendees:

Jennifer Mossman
Lisa Goodman
Andres Wilson
Cydney Teal
Ayanna Harrison
Mike Gilmartin
Chris Donohue
Rebecca Byrd
Kathleen Willey
Regina Heffernan
Lisa Zimmerman
Margaret Defeo
Christine Schiltz

Organization:

Highmark DE
HGP
Morris James
Christiana Care Health System
Department of Health and Social Services /DHCC
M. Davis and Sons
Christiana Hospital/Delaware Health Care Association
The Byrd Group
Quality Family Physicians/Medical Society of Delaware
AmeriHealth Caritas Delaware
Department of Health and Social Services
AmeriHealth Caritas Delaware
Parkowski, Guerke & Swayze

Susan Conaty-Buck	Delaware Coalition of Nurse Practitioners
Leslie Ledogar	Department of Insurance
Todd Moran	M. Davis and Sons
Kiki Evinger	Department of Health and Social Services
Steven Costantino	Department of Health and Social Services
Stephanie Myers	AmeriHealth Caritas Delaware
Pam Price	Highmark
Karyn Scout	AmeriHealth Caritas Delaware
Lenaye Lawyer	AmeriHealth Caritas Delaware
Saschen Brown	Aetna
Elisabeth Scheneman	Department of Health and Social Services
Wayne Smith	Delaware Healthcare Association
Julie Caynor	Aetna
Liz Staber	Aetna
John Fink	Bayhealth Medical Center
Jamie Clark	Nemours
Anthony Onegu	United Medical
Kim Gomes	Byrd Group
Brian Beachler	Christiana Care Health System
Karen Antell	Christiana Care Health System

Meeting was called to order at 5:08 p.m.

Introductions

Dr. Nancy Fan

- There are new members collaborative we are going to go through and introduce ourselves.
- I am the chair of the Health Care Commission and a full-time OBGYN at St. Francis Healthcare. And So I was named to the collaborative as ex officio from SB227 (<https://legis.delaware.gov/BillDetail/26743>).
- Other introductions around the table:
 - David Bentz, State representative and sponsor of SB227. Serve as chair of the House Health and Human Development Committee
 - Vince Ryan, Department of Insurance
 - Trinidad Navarro, Department of Insurance
 - Faith Rentz, Director Statewide Benefits and Insurance Coverage in the Department of Human Resources representing the State Employee Group Health Plan and State Employee Benefits Committee.
 - Steve Groff, Medicaid Director
 - Steven Costantino, Department of Health and Human Services
 - Chris Donahue, primary care physician and Chief Population Health Officer at Christiana, representing Delaware Health Care Association
 - Jim Gill, family physician in private practice and representing the Medical Society of Delaware
 - Kathy Willey, family physician Hockessin private practice working with the Medical Society
 - Leslie Verucci, Nurse Practitioner in the community sector representing Delaware Nurse Association

- Veronica Wilbur, Nurse Practitioner and owns a private practice in Claymont area and representing Delaware Nurse Association
- Thank you, everyone, and thank you for being on time and thank you to the Medical Society for allowing us to use their space and their kindness for letting us meet here. Senator Brian Townsend will be here in a few minutes. He is running a few minutes late.
- Senator Bryan Townsend arrived and introduced himself.
 - Bryan Townsend, State Senator South Newark area. Here because primary care is essential to an effective health care system and there is a lot we need to do to make it better in Delaware.
- Housekeeping items:
 - Attendees, please sign in
 - For the members of the collaborative, we will have name tents available at our next meeting. They were not created for this meeting because we have several vacancies (Governor appointees that have not been named yet).
- This is an open public meeting so therefore there will be a public comment at the end of the meeting. There are some in the audience that have attended all of the Primary Care Collaborative meetings and are very familiar with the work that we do, therefore, I might ask for their input on certain topics and items.

Review of Responsibilities

Dr. Nancy Fan

- The purpose of the Collaborative is to address the crisis in primary care services in Delaware that was recognized by our legislators (<https://dhss.delaware.gov/dhcc/files/primarycarecollab.pdf>). SB227 passed the General Assembly in June 2018. The primary purpose as stated in SB227 is to collaborate with the Health Care Commission to strengthen primary care in Delaware. The following are the purposes that we are supposed to reach.
 - Evaluate system-wide investments in primary care partially using the Delaware health care claims database.
 - Discuss payment reform and move payment reform as it pertains to primary care. The goal is to have 60% of all Delaware providers in a value-based payment model by 2021.
 - We talked in the last several sessions about what value-based payment models might look like in other states and what they mean.
 - All the minutes and materials from the PCC meetings through May of this year are on the Health Care Commission website under the [Primary Care Collaborative](#).
- Workforce is another topic, integrated care with women's health and behavioral health, and directing resources to support and expand primary care access.
- We defined Primary care provider, per SB227, as providers in internal medicine, family practice, geriatrics, and pediatrics.
- Relevant when as we discuss defining primary care spend, which is one of the main topics we need to tackle as we move forward.
- [SS1 and SB116](#) passed General Assembly session, two parts expanded the Collaborative. The expansion included people that were already very engaged stakeholders. The purpose of expanding the

- Collaborative is to mirror some of the work that has been in other states. It provides greater investment versus giving input but having no voting on an actual initiative.
- We established the Office of Value-Based Care and Delivery (OVBCD) under the Department of Insurance (DOI). DOI will provide an update at this meeting.
 - The purpose of OVBCD is to provide a transparent process to reduce health care costs. For primary care purposes, establish affordability standards.
 - They are to establish targets for carrier investment for robust primary care by 2025. Meaning that the robust primary care should be established by 2025. Establishing the targets, it can be any time during that time along that timeline.
 - Annual report of primary care spend in relation to total health care spending.
 - They are to make a recommendation to DOI and the PCC regarding appropriate reimbursement for primary care.
 - They are collaborating with us and they are collecting data to report on one of the calculated primary care spend in the state. What the carrier compliance is with rates for primary care and the total health care spending with the benchmarking process. I omitted one of the primary legs of SB227, was related to the second component, carrier compliance with rates for primary care SB227 mandating that all reimbursement rates for primary care would be to at least the level of Medicare reimbursement rates. Important when we move forward talking about carrier compliance.
 - A JAMA (Journal of American Association) study about what primary care spend was as per fee for service Medicare. This is important because you can use it as a benchmark to establish primary care. It does not help us calculate the rate of primary care spend if that benchmark is very low. The study was an information study. So that's a little bit of the background.

Approval of Minutes

Dr. Nancy Fan

- First order of business is approval of the May meeting minutes. This is the last PCC meeting before the General Assembly closed and the passage of SB116. We have not voted on them because we did not have any other meetings after that.
- Most of you were at the meeting. If you have any modification or comments on what was in the actual minutes we would appreciate that now.
- Any comments from any of the members about the minutes? A quorum is always necessary to vote on anything whether it's an initiative or some recommendation. A quorum is usually nine people. We have a quorum.
- A motion was made for the approval of minutes, the motion was seconded, approval was unanimous
- Next, we have Vince and/or Commissioner Navarro with the DOI update.

Commissioner Trinidad Navarro, Department of Insurance

- The RFP process is nearly complete. We are working on that now. The plan is to share the RFP with Milbank Memorial Fund (Milbank).
- Dr. Walker put us in touch with them. They are not going to apply for the RFP so we are going to have them take a peek at it and see if we have everything we need in there. Sometimes we even make so we can tweak it a little bit, but they are going to offer their insight.

- We are ahead of schedule. That is a good thing. Thanks to Vince and Leslie.
- Leslie Ledogar is our Regulatory Specialist in DOI. She is working on the RFP now.
- The RFP deadline is January 10, 2020, with the anticipated execution of the contract on March 4, 2020. We'd be happy to take any questions if you have any.
- For more information (<https://insurance.delaware.gov/>)

Dr. James Gill, Medical Society of Delaware

- When you say the RFP will help with looking at data and analysis. Is that what you meant?

Commissioner Trinidad Navarro, Department of Insurance

- We do not have the staff at DOI to do this so we going to hire a consultant. That is why we are taking an RFP and showing it to Milbanks to see if there is anything they think we need to add to it. We are going to hire outside contractors to do this.

Dr. James Gill, Medical Society of Delaware

- Recommendation: I talked to the main author from the Graham Center. They said they would be happy to review. His name is Bob Phillips. I can give you the contact if that would be helpful.

Commissioner Trinidad Navarro, Department of Insurance

- Would he be interested in offering their assistance in developing the RFP or would they be interested in applying?

Dr. James Gill, Medical Society of Delaware

- I did not ask specific questions, but guess he would probably be interested in either.

Commissioner Trinidad Navarro, Department of Insurance

- We cannot have conversations with him prior to, if he is interested in applying. That is why it is important to find out. He can reach out to us and then we can clear it out.

Dr. Nancy Fan

- It is the understanding is that the RFP is from the Office of Value Based Healthcare Delivery. Execution of the office within this time so they can have a stand-up office by the deadline of April 1, 2020. They are supposed to be active by April 1, 2020.
- DOI felt for the amount of knowledge, scope of knowledge, and work done they were not sure if they could have the actual staff in place by that time. That is why they using the RFP process to work with a consultant. Is that my understanding?

Commissioner Trinidad Navarro, Department of Insurance

- Yes, we cannot even begin until we hire. We cannot begin until that process is completed through the RFP. We just do not have the staff or the expertise.

Dr. Nancy Fan

- DOI is considered a state structure, they need to have a RFP to have the work completed.

Dr. James Gill, Medical Society of Delaware

- There are very few people in the country who have the expertise.

Commissioner Trinidad Navarro, Department of Insurance

- Milbank still has contact with Rhode Island. This is sort of where we are hoping they do what they did in Rhode Island.

Update on Initiatives Nationally for Primary Care Reform

Dr. Nancy Fan

- Any other comments from the members?
- We are going to do a quick update on what's going on nationally to give us background information. Hopeful this connection will be helpful as they complete the review of the application.
- Some slides are courtesy of Health Management Associates (<https://dhss.delaware.gov/dhcc/files/depccupdate.pdf>). HMA provided infrastructure support in the last year. They worked with the Health Care Commission on parts of the SIM grant.
- When we talk about what is happening nationally, we are talking about payment reform and how primary care payment reform occurs.
- One of the newest topics in Primary Care Capitation (*Slide #2*). This slide has a lot of information. It doesn't necessarily mean we have to talk about it at this very moment. However, we need to look at things that are important for primary care sustainability.
- One of them is improving the predictability of revenue streams for providers.
- What is considered a non-billable workforce and non-billable payment? Meaning non-claims payment, when there is not a claims code that can be attached to a service that is being used within a primary care practice.
- Improving member-centric access to primary care, being able to have greater patient access. That is what brought us here in the first place.
- A lot of primary care reform in the country is centered around the concept of Patient Center Medical. This concept of a payment model has capitation (*Slide #2*). These are some of the components.
- New ideas are being tried out in different areas. I don't like to use the word "reward", but rewarding for outcomes or revenue enhancement potential, aligning other opportunities for shared saving or shared risk.
- We are going to start the federal view of what they have done in the last few years. *Slide #3*
- They had an initial program with ACOs for shared savings and then they came out with a program called CPC Plus which morphed into CPC and then became CPC Plus. The original CPC Plus did not include Delaware.
- There are 14 areas within the country and these were the hallmarks of what was included in the program.
- The initial findings show that there was an increase in alternative care options
- One of the purposes under SB227 is for us to have 60% of our providers in a value-based payment model by 2021.
- I want to make sure we look at all other models that have been able to move along that direction. Not necessary to be successful, just move along that direction.
- They also show that there was a greater behavior health integration and the ability to do some of the non-claims payment work. Such as what happens with the transition between hospital and practices and addressing the social determinants of health.
- Some of what they initially found when they looked back on some of the data from the CPC Plus states.

- Important, because the Center for Medicare and Medicaid Services (CMS) has now come out with a program called [Primary Care First](#) – a track CMS is going to push out for their Medicare patients.
- The CMS lead of Primary Care First/CPC Plus program came to talk to us last week to give our state an idea of the operational aspects of the program.
- There was an opportunity for providers to ask her what was involved in the program. What were they looking for? How successful could it be?
- I received comments stating that yes, they were happy to hear that you could be in a shared savings ACO and also still apply for the Primary Care First program. They are not exclusive to CMS.
- Unfortunately, they have not come out with their request for application.
- They promise providers that once you have an application, they will do a review to see how successful you could be in the program, if you are qualified, and if you are going to be successful.
- They are giving themselves a two month turn around for every practice, stating you can be up and standing by January 1, 2020.
- “To be determined” when they are going to be able to operationalize this program.
- Delaware is one of the states that was picked for “Primary Care First Track.”
- Geographic Areas (*Slide #5 – Primary Care First Geographic Regions*). It is a 5-year voluntary program. It is based on their Medicare fee-for-service. 70% of the patient revenue must come from primary care services. As an OBGYN, I would not be applying. I am not considered a primary care provider under CMS, and this track would not apply to me.
- FQHCs (Federal Qualified Health Centers) are also not eligible because FQHCs receive separate funding for their services, therefore they are not eligible.
- There is a tall primary care payment which is a flat rate payment. There will be a performance-based adjustment. They will calculate out the performance-based adjustment.
- They did release the metric they will use. They are geared towards high-cost metrics such as acute hospital utilization and re-admission. Those are the main ways they are looking for savings within the program.
- Question: If you are in an ACO how does your cost from your ACO affect or apply to what is going on with your PCF total Medicare payment? I don’t have the answer to that.
- Depending on your rate risk assessment for their rates. These are the payments for each and then for every visit that you have beyond what they consider a Professional Population-Based service you will get a flat rate for that particular visit.
- If you have a beneficiary that they consider you before that you are beginning a hundred dollars per member per month and that person tends to come in at least once a week for something else that is included in the population payment, you technically speaking, still qualify for the \$50.52, technically.
- The Seriously Ill Population track tends to be a higher flat fee payment per member/per month. That was to compensate for the fact that these are greater high-risk patients who obviously should take more time and more services.
- They do not expect a large part of your patient population to be considered seriously ill population. Probably less than 5% (*Slide #8 – Seriously Ill Population*)
- In the same week that we had the CMS come talk to us about Primary Care First, Adam Boehler, former Director of CMMI, spoke with us on a more 30,000 year level about what CMS is trying. He did talk more about direct contracting which is more structure to practices that already take on more of the total cost of care.
- If you are a practice that has difficulty assuming risks they know that is not a track that you can be looking at. They are looking at this for larger organizations. This isn’t something small organizations would be looking at.

- Questions for the Office of Value Based Healthcare Delivery – Are they mining data from the Health Care Claim database? If you are going to be including this kind of Medicare payment spending data on it? I don't think they are obligated to provide data.
- When we talk about data monitoring and primary care spend within the state we are going to have to recognize that there are certain groups that we are not going to be looking at as accurate of an assessment unless we have it directly from the payers and then reconciling it with what the practices are saying.
- DOI should be aware that these are factors that we might not be able to account for.

Leslie Ledogar, Department of Insurance

- We put that as part of the description of the duties of the office. That is one of the things that we had asked them to see if they could do.
- When we circulate the draft, please be sure that we wrote that in a way that accurately reflects what your ask is, but I think I did that.

Dr. Nancy Fan

- Milbank will pick up on that.
- They do not foresee a large group of primary care providers being able to do direct contracting model. This is really for larger organizations who will be able to assume a 100% risk or at least a greater risk for total cost of care.
- This is about FQHCs. This is the next model that more and more practices or states being able to use is a capitated FQHC Alternative Payment Model (APM).
- A capitated APM means that they will only receive a certain amount. However, their baseline is always going to be higher than what they have been getting in the past. They receive no less than what they were got under fee for service. What they call pay-for-service.
- They have the potential to have greater revenue depending on their performance.
- These were the other states that have implemented it, have looked at it, that we might be able to have some data from.
- You can see that there are quite a few states who are looking at this as a viable option for their federally qualified health care systems.
- These concepts are important for when we talk about how we are calculating primary care within the state. If you want to talk about who is providing the care...
 - What percentage it is?
 - How many are receiving their payment and under what model?
 - Is very useful for us to be able to determine is that because they have a greater primary care spend?
 - Are they having a greater number of services?
 - Are they getting a great reimbursement and their spend is higher?
- We want to make sure that it is not due to a greater number of services. Right? That is really fee-for-service. We are trying to move away from the volume for fee-for-service. If we find that it is really because they have many more visits versus a great overall spend due to fewer visits but better care, that is one of the variables. We need to know if it is worth our while.
- These are two different types of models that are being approached in other states.
- This study a very good summary.
- This came out in July through three organizations, the Patient Center Primary Care Collaborative, Milbank Memorial Fund, and the Robert Graham Center from the American Association of Family Physicians.
- They did a state-by-state level analysis of what was being spent in primary care, over a certain period.

- Delaware was not one of the states that had contributing data. That is significant to us. I am not sure why.

Commissioner Trinidad Navarro, Department of Insurance

- Too small

Dr. Nancy Fan

- 21 states did not have data.
- They did an aggregate 50 states, but they only looked at 29 states in depth.
- They had two definitions of what primary care was:
 - Primary Care narrow was exactly what SB 227 said. Same providers
 - Primary Care broad included people like OBGYN and behavior health
- When they looked at just outpatient and office-based expenditures. Their average for a narrow definition, nationally is 5.75% with a range of the lowest state was 3.5%, the highest state was 7.6%. They were all well below 10%.
- A lot of their recommendations are great about what to be done at a \$30,000 level. It is what we have been doing.
- We have a PCC, we started talking about data collection, we are defining primary care spend for our state
- One of the things that we would like to see progress beyond this ...
 - What is our primary care spend?
 - What should our optimal primary care spend as a benchmark be?
 - What are we moving toward and how are we moving towards that?
 - Are we moving towards that by investing in different payment models, or different care delivery models, a combination of both?
 - How are we incentivizing providers to be able to do that?
- Those are the tough questions that we want to be able to move forward.
- We have established some of the building blocks with SB227 and SB116 about what's needed to move forward but now we need to do the operational aspects of it.
- This slide shows you what's been going on in other states (*Slide 13, 14 and Page 22*) at a legislative level.
- Essentially it would be Rhode Island, Oregon, us and then the other states that were mentioned. Colorado was soon after us.
- If you look at the descriptions that were provided, most of them have described ...
 - The establishment of a PCC
 - The establishment of metric about how to obtain data, to access primary care spend within in a state
 - The operational aspect of how to access what primary care spend is in relation to their total cost of care spending
- Capturing a lot of the things that we have talked about in the two bills that we have
- These are very broad descriptions. If you look at Oregon – Oregon's is very complex
 - They have a 46 member collaborative. They had a 46 member long before we had a three-person member. They have had in-depth detailed discussions to look at the data, payment model, and practice model
 - They all feed up to one office that then feeds up to the legislature. They have a very different hierarchy than we do.
 - They also have a very different infrastructure.
 - They started with different care delivery models such as care coordination organizations.

- They were already heavily invested in trying to improve Patient Centered Medical Homes (PCHMs) within their state.
 - When they analyzed the data and realized that PCMH was making a difference in their outcomes for population health. They went back and decided to make that a hallmark of what they wanted to be primary care.
 - How did they want to invest and how did they want to move it?
- Look at the two big standards, Rhode Island and Oregon. (*Slide #14*)
- They did have something similar but not exactly the same definition of primary care
 - They had very different spending goals.
 - They had different participation of their payers.
 - But they did have greater participation of their payers on all levels because they include not just their commercial but obviously their state and Oregon did and Medicare, which was kind of important for them.
- When we look at how we want to be able to move forward in defining primary care spend and where are we going to be able to mine data? And then move forward about where our options are to improving that, we need to consider these three top foundational aspects. Variables that we need to define
- Once again we are always talking about the piece of the pie. Essentially the piece of the cake is that you know if you are trying to preserve primary care revenue
 - How move people away from fee-for-service?
 - What is the transition away or do you start offering them a capitated APM? Which is close to the Primary Care First program.
- Then do you put the icing on the cake?
 - Which includes care management fees?
 - Incentives for PCMH program?
 - Pay-for-performance?
 - Shared Savings?
- These are all possibilities that have been tried in other states to varying degrees. The importance of this is for us to recognize we're on the left side of the program right now. How do we move toward the right side with more of the icing on it?
- What elements can we take away from them?
- In the fall of 2018, we got bogged down in the details of what other states have done and trying to pick and choose how we want to be able to move that.
- Now that we have data structure set up we have to move back and decide how are we going to define that and be more deliberative about how or what is our goal for and why is that our goal?
- What part of this “cake” do we build?
- That is what I foresee us doing. I sometimes get the sense when I put stuff up there at these meetings everybody kind of looks like they agree with me but in their head, they are like, "I am not so sure this is going work".
- Voting members on the collaborative need to tell me exactly what you think. We can't go back in January or February and say that we built a cake that nobody is going to be eating any part of it.

Dr. James Gill, Medical Society of Delaware

- Having the CMS Primary Care First model on the table now is actually really helpful because we see huge payer are already doing this.
- It is moving toward the right as you are talking about. (*referencing Slide #15 of presentation*)
- They have a very large care coordination fee which is \$24.00 for the healthiest population and \$175 for the sickest population and those people who are somewhere in between, per month.

- They still pay for visits. I mean you could argue that you want to get rid of that completely but they still pay for visits but at a much lower rate.
- Then the performance, which is probably the part I agree with the least. How they measure performance, but the concept of measuring performance makes sense. The problem is primary care has very little control over the main thing they are looking at which is hospitalization rates. At least in our area, we don't tend to our own patients. That's relatively small in the scheme of things.
- The general concept makes a lot of sense. It is very consistent with what we have proposed in the previous iterations.
- With the AMPs, that they have a payment model with four quadrants. One quadrant is care coordination, performance, and then payments for services. Think this all makes sense and if we could move toward this and basically mimic what Primacy Care First is doing that would be great.

Dr. Nancy Fan

- What I have heard back from some people that there did not seem to be a lot of interest in doing Primary Care First because there is a potential for a 10 – 20% decrease in revenue.
- It seems to be tailor-made for practices that are already along some level of practice transformation. I don't know if Medicare or if Kevin wants to comment on that, but you have to be able to mine your data.
- You have to have a certain amount of coordinated care structure to be able to be successful.
- You don't have to have this in place to apply for the program, but to be able to have some level of that in place to be successful at it so you are not losing revenue.
- I sense that there is not going to be a high uptake initially.
- I don't think we should sit back and say, "Okay lets' see what providers do." If they sign up for Primary Care First before we decided to move forward with some recommendations of our own.
- I think we should recognize that everything should be done in parallel.
- CMS is working clearly on it in at a glacial speed and on top of which if they are not going to have a lot of high uptake in the beginning then it is not a big end that we are going to be able to say that is a payment model that really works or that is a payment model that is going to sustain and strengthen primary care.
- CMS' goal is to see this be a multi-payer payment model. I don't know what has been discussed at other levels between commercial payers. I know Medicare/Medicaid does their own thing.
- I don't foresee that happening until you get to the critical mass of providers who are able to do it. You have to get through a critical mass of providers who are able to be successful at Primary Care First before they start pushing it.
- ACOs had to get through the critical mass to recognize that they were close to shared savings if not at shared savings before they said alright we are going to use the same resources to try and do true performance versus some other value-based payment model.

Steven Costantino, DHSS

- I think you are right – it is for practices who are on the way or practices that are willing to make major investments.

- The other thing is, it is interesting what you said about the fees, because my understanding that it is not even close to being decided yet.
- In fact, the terms that have been used are kind of general descriptions of what the fee would be, but if you know something that would be interesting to see because of all of the presentations I have seen they have not been very specific of what that fee would be.
- I'd like to see that if you have it.

Dr. Nancy Fan

- Do you mean the flat payment fees?
- Yes, they came out with the flat fees and CMS shared information. However, they still need individual provider practice assessments because it is stratified according to us.
- Yes, you would have 56% in group one and only 25% in group four and 25% in group four pays more per member/per month.

Steven Costantino, DHSS

- The question, first off it is only Medicare. I just want to make that very clear.
- There is a lot of talk around what the uptake will be in these models. They are not mandatory, they are all voluntary.
- I'd just be curious to see what the uptake would be.

Dr. Chris Donohue, Christiana Care Health Systems

- Can I respond just very quickly? Yes, it is just Medicare, but it is interesting to think about if all of our payers in Delaware reimbursed in a model it certain would probably drive that voluntary engagement.

Steven Costantino, DHSS

- At the meeting with CMMI we talked about Medicaid potentially at some point piggybacking on some of these models.
- So now it becomes a multiplayer and hopefully an all-payer.
- I just think that the first Medicare experiment is important. I'm not being cynical, but I have seen so many of these models and the uptake has been very low. Hopefully, the uptake will be...I want to be surprised.

Steve Groff, Medicaid Director

- Back to what Jim was saying, I think that we should look at the Primary Care First less on specifics and like adopting it and more around the principals behind it and the direction that it is trying to take.
- I think it shows promise at least from CMS thinking, around the very things we're talking about in this room. What should go in, what are the primary components of primary care payment methodology which is population-based, capitation so to speak, maintaining the fee-for-service, and then having some type of shared risks or sharing savings that can be earned on top of that. So we were pretty excited when we saw one come out just because we thought it was a positive direction.
- I did speak with people who were happy with our congressional delegation CMS had represented in there as well as and CMMI. CMS is very interested in trying to find ways for Medicaid to align. She indicated that we would be seeing guidance.

- It will be interesting to see because the deal is in the detail, in terms of how well we can align, but I think you are right in order to be successful we need that multi-payer approach but I think we were happy to see.

Dr. Nancy Fan

- My question to a lot of people at the table is there any sort of incentivization? Because there is a built-in incentive to continue fee for service model, right? You get a fee for every time you have that visit that is not based within your population health model.
- I look at prior behavior, right? What drives provider behavior? Currently, we track provider behavior, other than trying to be a good doctor and best practices is if your bottom line is you have to have this many visits for your revenue. How do you move away from that?
- Is that going to be one of the issues with the Primary Care First that we should make sure it doesn't necessarily come at it dis-incentivization in other models within the state if we are looking at them?

Dr. James Gill, Medical Society of Delaware

- To respond to that, I remember one meeting there was a health economist who was saying the way you should set prices is that doctors should be ambivalent about whether they provide services or not, from a financial point of view.
- You shouldn't lose money for providing a service and you should make money, extra money for providing a service.
- I think there is where Medicare is trying to go. I think that \$50 is maybe a rollout because you are actually, it cost way more for your staff time, than the \$50 you are getting, so you are losing money.
- It doesn't mean argue about the specifics andbut the concept is that it should, you should be I can do this on the phone, my nurse can do it. I can tell my pharmacist to help out with it. I can visit. It doesn't matter. Again, wishing all of the health care systems would move in the room in that direction.
- I think that is the concept
- There are two issues I think and one of the issues is uptake and maybe here are some other reasons that there is not big enthusiasm for uptake.
- Dr. Fan mentioned that uptake at the beginning probably isn't going to be a lot
- There are two main reasons for this. One is we can do it better in the state than Medicare can do it. Medicare is the big battleship that takes forever to turn.
- They are measuring risks about how sick your population was two years ago. Well that doesn't work, right? Because I think, now that you brought up the point, basically said if you do that no one is going to, well actually two components that and you are in a pocket so if you are not, it's not like each patient is a risk, it's your whole population gets a risk
- If you are in risk level two you are not going to want to take anybody who is sick because it going to change nothing in your payment rank.
- It is going to cost me a lot of money to take care of them. You are going to get nothing for that.
- If you move your entire population up to the next level you will get something extra in two years. You will business by then.
- I look at if we are going to do it, we should change that to individual risk scores, not population risk scores and it should be on a three month, your sickness is three months ago not two years ago.

- My guess is that that is one reason people are not going to sign up right now. They are going to say wait a minute my risk at two years, what? We look at ours and we said forget about it. It would not work for us, this year. It may work for us in a year two years.
- That is the reason we can fix those things because we are not Medicare.
- The other thing is hospitalization. Is that the thing we want to pin people on? I'd say probably not, unless, it sounds radical unless the primary care doctor has control over whether that hospitalization gets done and/or paid for. Then maybe yes, but that is probably not going to happen.
- Maybe we want to look at things, again we talk a lot about, and you want your measures to be things that primary care providers can control. Hospitalization is not one of them or they have this much control. So what we do, we do things differently. I think uptake could be high and uptake might be quicker for our program than it will be for Primary Care First Medicare.

Dr. Nancy Fan

- CMS says this is a revenue-neutral program. First of all, this is a federal neutral program. A revenue-neutral program means they are not putting any more money into CMS to help practices achieve this level.
- The second thing is that when we only talk about defining primary care spend we are going to need to talk about what part of that is really that hospital component.
- Currently, to supposedly 60% of all practices, primary care practices, are enrolled in ACO within the state.
- Technically speaking 60% of practices should have the capability to be in a Primary Care First like model because their qualifications are no higher than what they expected for their shared saving ACO. If that is the truth then I am still wondering what the timeline would be then for uptake. It took four years, the whole time of Medicare's shared savings rate for there to be 60% uptake in the state.
- Now Rhode Island has proposed to be 80% within the next three years.
- That is a huge portion of their primary care practices. Eighty percent? That is 8 out of 10 that will be in an ACO. Most of their ACOs are PCHC based ACOs.
- They are not just a practice out there doing their own thing. They are based around a Patient Center Medical Home concept, which is the population health-based concept.
- They should be able to do that with what they have in place regarding levers and investments and being able to show that moving away from fee for service into an ACO could be useful to their practices.
- I don't think we are going to make it. I think I could see us getting to 80% if we are already at 60%. I don't know that it would take for us to get to 80% because I think the biggest thing as the capital investments for the practices that aren't there.
- There are a lot of reasons practices are not in an AOC because they don't have the investment for the basic qualifications. Whether it is mining the data or the infrastructure to do the care coordination. I don't know how we are going to get to that point.
- I am going back to something that Jim said so we can move forward. I think this is useful to DOI. The deadline for the RFP is October 15th, correct?

Vince Ryan

- I believe that the date that DOI is scheduled to submit to OMB is by November 5th, with the Commissioner's final approval on October 29th.
- Our RFP team is submitting that to the commission on October 15th. We would like to have it wrapped up by October 15th.

Dr. Nancy Fan

- Our next meeting is going to be after they would like the information. That would be useful for their RFP if we were able to show that we had defined primary care spend.
- If we are looking at them for data monitoring and data mining and analysis and report. They can't stand up that infrastructure and say, "to be determined." It would be more useful if we define primary care spend for them before we get to that point.
- As we move away this is the basic conversation about what is happening up here. To bring it down to Delaware we need to be able to take certain elements of that and recognize what is going on. My feeling about that is we are not going to wait for Primary Care First or capitated APMs in the FQHCs to drive our primary care sustainability. We need to do other things in the process.
- One of the points that Jim was just talking about was, discussing what goes in our calculation and does that include things like being responsible for the acute care coast (hospital expenditures)?
- In the actual Patient Center, primary care collaborative if you look there's a page on there that compares Oregon, Rhode Island, the Office of Economic Development which is a global one and then a couple of good definitions of primary care.
- Our definition of primary care providers is the narrow definition. I want to make sure that we are all in agreement that we want to stick to that when we talk about how do you define primary care spend.
- When you talk about global organizations like the Office of Economic Development, their definition is much broader and therefore when they define primary care spend for other countries and they say the average is 14%, it is not a direct apple to apple definition.
- We need to consider that when we talking about how we define primary care spend.
- 22 countries out of their 36 participating feed the data for their calculation of what primary care spend is in their country every year for their total cost of care. If their definition is different it affects what their percentage is.
- I don't want us to say, "Okay, because they have all these other services that's why." We still have to look at what we're providing and how much it is. I still think we need to be able to come up with a definition.
- And then within the definition if you all agree that the primary care providers are Internal Medicine, Family Practice, Pediatrics and Geriatrics then we will move from there to talk about exactly what expenditures within those primary care providers need to be defined so that our Office of Value Based Healthcare Delivery will have a starting definition to look at what they are actually mining.
- Dr. Gill and I have talked about claim codes, the actual codes for the claims and if we are looking at the healthcare claims database that is one of our great limiting steps, recognizing that it is all going to be claims-based. If we know who's feeding into the healthcare claims database, has decided that everything that is under Family Practice, under outpatient expenditures, with these claims codes, or what is being put in, at least we know that we will all have apples to apples within each payer.
- I think that is important for our Office of VBHCD

Dr. Chris Donohue, Christiana Care Health Systems

- Nancy, when you say Family Medicine Peds, I am in Geriatrics. Is that the NPs and the PAs that our working within those practices?

Dr. Nancy Fan

- Within SB227 it says all providers.

Kevin O'Hara, Highmark

- Nancy, I just want to add that we put forth, Highmark has put forth some numbers and given that to the collaborative historically and I did some checking and those numbers were based on the narrow definition, and to Christine to your point included NPs and PAs services when performed in a primary care setting, didn't include them obviously when it wasn't.
- My point is that we assumed the narrow definition based on 227 and any numbers that we have quoted thus far...

Dr. Chris Donohue, Christiana Care Health Systems

- I know that the intention of the people around this table is to enhance reimbursement for primary care as we have defined it in this narrow definition, but I am wondering if we're limiting our impact on the community by not including OBGYN or behavioral health in this model.
- I know women's health, in particular, is really challenging for private women's health clinicians to stay in practice and they are certainly addressing primary care needs.

Dr. Nancy Fan

- One of the bullet points within SB227 was integrating women's health and behavioral health within primary care. Hopefully being able to at least address some of that.
- I think since we started on this track of trying to help, to stand up the Office of Value Based Healthcare, I think one of the things we have heard over and over again, was the importance of data.
 - How do we know how much we are spending each year?
 - Where is it coming from?
 - How much do we know, what kind of impact is it having?
- I think that being able to at least compare some apples to apples. Now you are right some of the other states, did use, they included OBGYN to that. We deliberately decided not to include OBGYN in it. You can probably carve out a component of women's health, outpatient women's health which is strictly GYN not including OB because most of OB services are a global payment.
- You cannot carve out individual fee for service concepts within that
- Medicaid does, they are one of the few payers that do.
- There are things in the process that we are working parallel-ly that look at workforce.
- Workforce is one of them.
 - What makes a sustainable workforce?
 - What makes an attractive workforce within the state?
- I know there are other elements, and thank you, Representative Bentz, for [House Bill 257](#), looking at student loan repayment program.

- I think to Kevin's point about what you looked at, I think that the deal in the details because you looked at the specialties we weren't sure exactly how much of the insurances were encompassed in specialties,
 - Did they include lab fees?
 - Did they include radiology fees?
 - Did they include transitional care when they went to skilled nursing?

Kevin O'Hara, Highmark

- Our number was an all-in number, for that practitioner. So we identified the practitioner and put them in PC bucket and then all services were rolled up.
- I agree with you that it is very important to have a common definition of what is being understood.
- I don't want to be in a position to report a number and have another payer report a number based on a different set of
- That is just my point. I'll speak for my organization. I think we have the acumen to be able to report whatever basket of services we want to include, including OB and behavioral health. I was just making the point that we hadn't done that yet.

Dr. James Gill, Medical Society of Delaware

- Important point and that is where some of the other states wanted to stray a bit.
- Which services do you include? When you look at all the studies it is pretty universally agreed that...
- There is some dispute about primary care to include mid-levels or not, some say yes.
- Do you include OBGYN or mental health or not?
- Pretty much everyone agrees you only include services that clinician actually provide in their office. That is not pharmacy, it's not labs, and it's not other tests orders, it's not that patient going to the hospital. It's not anything at all.
- You can see here where they are saying office and outpatient-based services for primary care clinicians.
- You can look at those as well. You can say we're going to have a definition B or a definition C. But I think the key is that our main definition, narrow, are primary care services provided by primary care clinicians. Not things that the primary care has ordered that are not primary care services.
- Oregon, in particular, went astray because some of the insurance companies came back and said we are already at 14% but they are including Hepatitis C drugs and all that stuff.
- They can do that but that is what I am trying to clarify around the table that we are not talking about that, that we are talking about office-based, primary services provided by primary care clinicians, not the things that they order.

Steven Costantino, DHSS

- In Vermont, there is a very robust Primary, PCMH system
- Within those PCMHs and even within primary care offices, the state invested in putting social workers in those offices and behavioral health counselors and so within the practice, pretty much ingrained in the practice was substance use and services as well as behavioral health.
- They have a capitated arrangement, so sometimes it is hard to disentangle the service from that kind of arrangement. That is where it gets a little fuzzy. In terms of the issue of primary care spend.

Dr. Nancy Fan

- Any other comments about what they feel would go into the definition of primary care spend?

Kevin O'Hara, Highmark

- I just want to make sure that when we say primary care spend? We are talking about the spend for primary care, correct?
- I am hearing, total cost of care issues mixed into that? I heard Dr. Gill say we don't want hospital costs. Those sounds like total cost of care or member spend measures, right?

Dr. Nancy Fan

- Correct, we are not including that.

Kevin O'Hara, Highmark

- I just want to make sure that for this conversation we are just talking about primary care spend or what we are spending as a percent of total cost of care perhaps on primary care.

Dr. Nancy Fan

- Correct, I think the purpose of defining primary care spend what services being provided by a primary care provider.
- How we are going to calculate that?
- The data analytics for the office
- Pulling that back out to what is the total cost of care spend, what percentages, exactly,
- Pick a random raw number, 570 million, and then our total health care spend is 1 billion.
- We have to calculate it first and so to be able to that I think that the operational aspect, the technical aspect, will be a challenge within its; self.
- We have to make sure the OVBHCD office, has once again been able to have payers and providers agree that when Highmark is saying this was Dr. Gill's is at – when we de-aggregated it out. I am not saying that is what we should do I am just saying that is what is happening that Dr. Gill is not saying that included "XYZ", which we did not include in our actual definition.
- Or Highmark will be saying to the office actually we included this stuff, isn't that what they are also reconciling with
- We are all on the same page.

Steve Groff, Medicaid Director

- I am trying to figure out, are we just going to ask the payers to report a number based a definition or is there going to be an analysis of data based a definition?

Dr. Nancy Fan

- I pick B.

Steve Groff, Medicaid Director

- The reason I ask is that it is a little less important to me if we are doing B. If we are more inclusive or more expansive in our definition because that data could be broken out and categorized.

- If we want a broad definition or we want to see a bigger picture, we still have the option of choosing a narrow definition down the line because we can drill down into that data.

Dr. Nancy Fan

- So you are looking for more of an itemized database?

Steve Groff, Medicaid Director

- I think the arguments that we are hearing around women's health and behavioral health. I think we would be doing ourselves a disservice not to at least be looking at the data and have some understanding of what that looks like, but that wouldn't necessarily preclude choosing a more narrow definition when it comes to setting benchmarks

Dr. Kathy Willey, Medical Society of Delaware

- Especially in light of all the work that the state is doing in light of the opioid and behavioral health and the enhancement of programs.
- You don't want to take that way from the primary care provider.

Dr. Nancy Fan

- No, you don't, there are a lot of providers that do a lot of that work and don't get reimbursed. Not only do they not get reimbursed they might be reimbursed at an undervalued level for what the work entails. Because it feeds back into the fee-for-service.
- I am going to see the patient ten times and maybe the patient would have the same outcome seeing them five times but the provider has no incentive to be able to do that way other than being a good provider
- I think to Steve's point that if we can come to some sort of definition agreement and this would be very useful to DOI.
- I want to make sure because they will have an RFP out. They will be standing up the office. For them to stand up the office I want them to be able to provide me with accurate data that we can use to move forward with recommendations, right?
 - What should the spend?
 - What are the outcomes?
 - Where is it going?
- To Steven's point if we find out that we have a broader definition then really actual within a practice most of the primary care spend goes to drug maintenance. That is important to know, right? Is that a population health issue? Yes, but to what affect.
- We all agree on who is the primary care provider. We are going to include Nurse Practitioners and Physician's Assistants. That was under the original legislative mandate.
- We won't be broadening the number of primary care providers included within the definition of primary care such as women's health.
- The OECB uses preventative health services. That means places like CVS. They include them for vaccinations. They include any walk-in clinic that provides preventive health services. That is included under their definition of primary care spend.
- I just want to make sure we all agree that is not going to be included.

- Because it is going to be what is defined within a practice.

Dr. Nancy Fan

- I think that is not an office-based expenditure but is certainly an outpatient expenditure versus an acute care expenditure, right?

Steve Groff, Medicaid Director

- Can I explain? Milbank board has specific codes that are included. They do include home visits as well. For example, 992, 201, to 205 preventive services codes, home visit codes and some others. Milbank report 16 that is the reference. When you talk about all office visits and preventive services.

Dr. Nancy Fan

- Yes, I agree. I think it is important to recognize what we are talking about what we all agree to that.

Steven Costantino, DHSS

- I wanted to explain the DHIN question. Health Claims Databases across the country, HBCDs, have two unfortunate issues. Even the best of the country don't include self-insured claims, number one. In most states, I assume have about 40 – 60% self-insured claims. It is a challenge for all payers health claims databases.
- The second issue they don't include non-medical claims. What is a non-medical claim?
- Let's say Jim's practice does a phenomenal job of managing patients. He has an arrangement in an ACO and/or so Medicare pays him or an insurer pays him a million dollars for doing a wonderful job as an incentive payment. That payment is not in the all-pay claims database. Even though it could be taxed with said primary care practices.
- I wanted to clarify what I meant by that when someone mentioned DHIN. It is not that they are not good data it is just there are limitations to all of these data sources. We probably need a combination of looking at a few data sources. What insurers may give you, what DHIN may have and maybe some other sources to validate some of these claims.

Dr. Nancy Fan

- This is one of the challenges when we talk about the benchmarking process, correct?
- One of the challenges with the benchmark process was recognizing that we have a large component of self-payed or self-insured based health care claims, therefore not being captured in Health Care Claims Database.
- We need to recognize that we going to have to all talk the same language.
- If we talk about primary care spend and we talk about total health care spend and we want to talk about what did they are capture and
- What is being all captured under total health care spend does not include non-claims payments and does not include direct contracting for lack of a better word.
- Even though that might go into a total spend in an aggregate term. That is fine. I am okay with that as long as that is what we all agree on.
- If we want to include those variables then we have to find a way that will capture that information that is not currently being captured.

- We can't then just limit it to primary care because if we say we are going to capture non-claims payment just for primary care practices it is going to look a lot larger than it would when all of total health care spend does not include it, correct?
- The whole conversation around the self-insurance is something we do need to address.
- They are large component of what drives our data. How does the office of value-based health care delivery address that?
- I don't know if Leslie looked at that? Did you say you looked at that in the RFP?

Leslie Ledogar, Department of Insurance

- Certainly, we tried to.

Dr. Nancy Fan

- I know you were talked about reconciling with Medicare.

Leslie Ledogar, Department of Insurance

- We need to go back to look at that specific question.

Dr. Nancy Fan

- Does anybody in the collaborative have a better idea of how we can capture that data, from self-insured? I don't want to not use the DHIN.
- The other conversation around the healthcare claims database is that currently by statute there are only four organizations that are allowed to request information from them and a DOI is not one of them.

Dr. Nancy Fan

- If we want to talk about an information base that we already have. Then we are going to have to talk about a different avenue that is going to need to be taken because currently statutory speaking anybody who is not named in it technically has to pay the DHIN to mine the data, to query it. Am I wrong about that?

Steven Costantino, DHSS

- No, I would just say if the Commissioner is talking to Rhode Island it might be worth it to ask them that question. How they are capturing, if they are capturing self-insured data in their percentage?

Dr. Nancy Fan

- If you look at who they have. Those are the actual participating payers. They are the biggest of the health care systems. They did not specifically say that they had self-insured within that payer system.

Steven Costantino, DHSS

- The question is, are they listing them as fully insured companies or are they including them as TPAs?

Dr. Nancy Fan

- It could be Blue Cross might be the only one that is doing all of it.
- If we agreed on the definition of who is a primary care provider.

- We agree we are going to systemically limit this to just outpatient, the only part of outpatient would be home health services.
- Unless there is another outpatient service that everybody feels falls into preventive population health that would need to be included in primary care spend? No
- I am going to just define outpatient services and all office-based expenditures.
- That would be anything from a preventive visit, well visit, vaccinations. I know these are things that are easy claim coded for.

Steve Groff, Medicaid Director

- Vaccinations are not included in Millbank definitions.

Dr. Nancy Fan

- Or they are not one of the claims.

Steve Groff, Medicaid Director

- The things that the physicians orders there not the physician services.

Dr. Nancy Fan

- Some practices do.

Steve Groff, Medicaid Director

- Others don't administer it, it is not medicine.

Kevin O'Hara, Highmark

- I don't want to confuse the issue. If we don't include current incentive fees paid specifically primary care services we are at a level playing field are we good at cost standpoint, right?
- I am not sure that the does a good service because the real picture would include incentive fees. And just saying, those incentive fees are every growing, right?
- Regardless of what the collaborative does. There's organic activity happening out in the marketplace being driven by customers who are paying, that are demanding those incentive fees. I think it is worthy of discussion about whether we should include those things.

Dr. Nancy Fan

- Incentive fees are one of those non-claim payments, correct?

Kevin O'Hara, Highmark

- They are paid outside the claims.

Dr. Nancy Fan

- I think we come back again and we try to capture as much data as we can through something like a claims database.
- Do something like what Steve says – where it's going to be a certain amount of self-reporting with de-aggregating in an itemized fashion? That's for all unit costs, these would be under the claims base and

- for additional services, whether it's behavioral health payment, whether it's an incentivization payment, or whether its other services would be under there.
- Is that something we want to be able to mine? That would be self-reporting.

Dr. Kathy Willey, Medical Society of Delaware

- I am going to say no because the practices that have done better are going to have more than of an achieved incentive.
- When practices are in an incentive-based program there is a maximum that you can collect. It is all based on quality, and cost and measures.
- If we include that there is going to be a level of practices that have achieved it and more, and then there are others that aren't, so I don't think they should be included at all.

Kevin O'Hara, Highmark

- If we are doing those calculations to calculate total spend for a market, for an aggregate number and not for comparative purposes practice to practice, we are not giving credit to activity that is already going on. And that would not be correct.

Dr. Chris Donohue, Christiana Care Health Systems

- It's back to what is the goal? If our goal is to benchmark against other states, then we should do whatever the other states have done. If our goal is to how we are planning for the future certainly we want to take into account these incentive payments in future models because we are imagining that to be a bigger and bigger percentage.

Steven Costantino, DHSS

- It seems the goal is to know how much money primary care is receiving.
- As a percentage of total cost of care
- An incentive payment going to a practice is going to primary care.

Dr. Nancy Fan

- Does that get included into total cost of care?

Steven Costantino, DHSS

- Why wouldn't that be important?

Dr. Nancy Fan

- If we include it, can we de-aggregate it out?

Steven Costantino, DHSS

- We have to worry about the disaggregation because you may lose the self-insured.
- The way we have worked the benchmark process, with the insurers is we have asked for aggregated numbers. Which Massachusetts has done and they have gotten high numbers of self-insurance to participate.
- The benchmark we have been getting very good cooperation from self-insurers because of how we have asked the question.

Steve Groff, Medicaid Director

- The way I phrased it was wrong because I am fine with aggregated data.
- I was hearing we are just going to give you what we want.
- If we are asking them to report it by the level of detail that we want. Even though it is aggregated data. I am ok.

Dr. Nancy Fan

- If Kevin has \$100 to Dr. Gill and \$80 was based on the unit cost of care within a claims base and \$20 was for incentivization that is what you want to look at?
- You don't want just them to say get Dr. Gill got \$100, Dr. Wiley got a \$100. You want to be able to say that out of \$100, the same thing that was the same was the unit cost, population-based preventive health care and then any other variables such as a non-claims payment or other factors,
- For example, Kathy Willey has behavioral health integrated into her practice therefore that gets an extra \$20 - \$30 payment that Dr. Gill's practice doesn't get.

Steve Groff, Medicaid Director

- What is that we want to know? Do we just really want to know one number which is a percent that we are comfortable with or would we like to understand what the primary care spend looks like?
- What types of providers are providing those services?
- What the services are that they are providing? Not at the code level but within categories of service
- Where the services are being provided? I am hearing office elevation and home-based settings.
- Define those major parameters that at the end of the day we have a report that when we read it we can understand where the money is going for primary care? To whom and for what?
- We can generate some ourselves from claims data. Some are non-claims based and I think we could ask for that from health
- So that we understand to what extent if we have made any progress as far as what we call alternative payment for value-based methods
- For the areas that we are not able to generate the data, we may have to ask for the payers to provide aggregate
- As long as we have defined what the end crosstab looks like in a way that everyone understands and can generate the data in a meaningful fashion. That is what I was trying to say.

Vince Ryan, Department of Insurance

- The department started to look at how Oregon and Rhode Island have started to accumulate the data, how they started to call it, how they have organized it and from a data collection standpoint both Oregon and Rhode Island do it very cleanly. that they do aggregate it. It is not like you get a piece of paper with one number on it from a carrier that says they are spending "x" amount.
- Oregon has on its website a very helpful and useful template where the carriers are responsible for doing calculations on an excel spreadsheet which they then submit electronically to the department what their primary care spend is based out of the total cost of care spend. Providing any supporting documentation that they can.

- Rhode Island does something very similar. They go down into traditional primary care physician versus a Nurse Practitioner. Then they do code by code analysis as well.
- If we are going to benchmark Delaware against the other states I imagine Delaware would want to follow something like that.
- The department has, in its possession, both templates and maybe that is something that would be worthwhile to share with the group.
- From an incentive fee standpoint. I think if we are going to legitimately want to get a hard number as to what we are spending on primary care in Delaware. That's the legitimate expense of carriers that are expending on primary care physicians. I think the department would take the position that we would want included in the definition of primary care spend. If I am not mistaken I think incentive fees were included in Oregon and Rhode Island's definitions.

Dr. Fran

- Part of the reason we want to define this is so everyone agrees with what the OVBHCD is looking at.
- If we share the template that you have for Oregon and Rhode Island I think we would like to see that so we can all agree that is something that we would like to see (as in the data mining).
- It would also be useful for you but for us as members this is it how we will define it, this is the metric we will use and this is what we are going to do.
- Now we need to look at the timeline. It is not currently affecting performance and it's not affecting incentive payment.
- Do we want to look at 2015 – 2017 or 2017 – 2019? We don't need this for the RFP, but for the office itself.

Vince Ryan, Department of Insurance

- We need to try to figure out what is the baseline. Ongoing internal discussion, pre-SB227, or post-SB227?

Dr. Nancy Fan

- Yes, pre-SB227, but also think if we can go back (only 2019 will be incomplete) might be a second set we want to look at

Vince Ryan, Department of Insurance

- Department is on the recording stating that we had an understanding prior to SB227 that Delaware spending on primary care is roughly at 3%. We have no idea now what it is post SB227 with the mandated reimbursement increases

Dr. Nancy Fan

- Everyone agrees. Is it okay if we look at the templates and get back to you by the next meeting?
- Will you be able to provide that by the next meeting? We would have a quick discussion.
- I know your deadline is before the next meeting but at least you know where you are starting from.
- We are not reinventing the wheel. We have two models that you could use anyway.
- We have some time, or put it off until the next meeting? What is the timeline? We can discuss this at the next meeting.

- Do we want to look at three years 2015 – 2018, five years 2013 – 2018 or two years?

Kevin O'Hara, Highmark

- If we are going to add members to the collaborative that might have a perspective on this I think we should allay the discussion.

Dr. Nancy Fan

- That makes sense. Three government appointees are not here.
- We also do not know who else will be at the table.
- We will delay voting on a timeline for the OVBHCD until the next meeting.

Senator Townsend

- What are the potential cost implications of looking back five years or two years or three years?
- Does anyone have an idea?

Aetna representative

- Five years is the beginning of, in our world, the BBC if you will, right?
- There is going to be very little, whereas in 2017.
- 2017 and 2018 are really the years that are robust in pre-Senate Bill 227.

Kevin O'Hara, Highmark

- That timeline Senator Townsend, we were cognizant, and we agree with each other around that time.
- If we look at 15 in this market it would be pre-BBR, certainly adoption, 16 would probably be the same, 17 and 18 would be the years that we have some traction and some adoption.
- It is growing every year.
- It is important if we are going to have a relevant conversation about where we started and where we end up, those dates are going to matter.

Senator Townsend

- Just to clarify, the dates matter in the context that you would like to see before then to show the change?

Kevin O'Hara, Highmark

- Yes, I think that would be beneficial to see 15, recognizing at least what is going on in the market during that time.

Senator Townsend

- Are there any operational challenges with saying let's go with 2015 rather than saying let's go with 2017?

Kevin O'Hara, Highmark

- No, we could get around it. I don't pull the data but I think we could get the kind of numbers that you would want to see.

Aetna representative

- We would have to ask. I know we have 2017 and 2018 but I am not sure about 2015 and 2016.

Dr. Nancy Fan

- Incomplete data is incomplete data
- We would have to recognize that we are looking at seven out of the ten apples
- Start off with where were we and then we can compare whether it is post SB227, that would be 2019 – 2021 unless there is a lot of change in the market within this next year and there might be. People may embrace value-based models. CMS gets the ball rolling
- Still may not have the data.
- When you talk about data, there is always that three-month look back delay
- If you are talking about standing up in April 2020, to be able to say you can look at the first quarter of 2020. You are looking at data from the first three quarters of 2019, possibly something from the last quarter of 2019 and nothing from the first quarter of 2020
- The initial data that OVBHCD will give us a report on it established there has been some had work done on it. It would be before SB227 and it would give us an idea of where the movement in the market was at the time.
- We compare where are we now and where do we want to be
- How that breaks out into what the practices are doing.
- There are other pieces of data that we may be able to collect.
- Are we still at 60% ACOs or are we at 55? How many did/did not do PCF? Are we going to be able to collect Medicare data?
- It looks like we have some agenda items for next meeting
- If there are items members want to discuss or present during the next meeting please feel free to bring them up.
- There was a call for Public Comment. There were none
- Next meeting – October 21, 2019, 5:00pm – 7:00pm
- There will be a vote on the minutes at the next meeting.

Meeting adjourned at 6:51 pm

SB 227 Primary Care Reform Collaborative Meeting

Tuesday, October 21, 2019
5:00 p.m.
Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

Present:

Senator Bryan Townsend, Co-Chair
Dr. Nancy Fan, Co-Chair
Representative David Bentz, Co-Chair
Faith Rentz
Veronica Wilbur
Leslie Verucci
Kevin O'Hara
Dr. Jim Gill
Hon. Trinidad Navarro
Dr. Jeffrey Hawtof
Dr. Christine Donohue Henry, MD
John Gooden
Margaret Norris-Bent
Dr. Michael Bradley
Chris Morris

Organization:

Senate Health & Social Services Committee
Delaware Healthcare Commission
House Health & Human Development Committee
State Benefits Office/DHR
Next Century Medical Care/ Delaware Nurses Association
Delaware Nurses Association
Highmark DE
Medical Society of Delaware
Department of Insurance
Beebe Healthcare/ Delaware Healthcare Association
Christiana Care/Delaware Healthcare Association
MDavis, Inc. /DSCC
Westside Family Healthcare
Dover Family Physicians/Medical Society of Delaware
Aetna

Absent:

Hon. Kara Odom Walker
Steve Groff

Organization:

Department of Health & Social Services
Division of Medicaid & Medical Assistance

Staff:

Julian Emory
Read Scott

Julian.Emory@delaware.gov
Read.Scott@delaware.gov

Attendees:

John Dodd
Liz Staber
Kiki Evinger
Lizzie L. Zubaca
Steven Costantino
Tyler Blanchard
Regina Heffernan
Kim Gomes
Avani Virani
Lenaye Lawyer
Daniel Elliott
Anthony Onegu
Shay Scott

Organization:

BDC HealthIT
Aetna
Department of Health & Social Services
Hamilton Goodman Partners
Department of Health & Social Services
Aledade
AmeriHealth Caritas Delaware
Byrd Group
Highmark
AmeriHealth Caritas Delaware
Christiana Care Health System
United Medical
Henrietta Johnson Medical Center

Katherine Impellizzeri	Aetna
Jennifer Mossman	Highmark DE
Lisa Zimmerman	Department of Health & Social Services
Jack Schreppler	DCSN
Scott Rosenthal	Rosenthal Chiropractic
Bryan Gordon	Christiana Care Health System
Elisabeth Scheneman	Department of Health & Social Services
Christine Schiltz	Parkowski, Guerke & Swayze
Andrew Wilson	Morris James
Pam Price	Highmark
Ayanna Harrison	Dept. of Health & Social Services/Health Care Commission

Meeting was called to order at 5:08 p.m.

Introductions

The meeting convened at approximately 5:08 p.m. at the Medical Society of Delaware located at 900 Pride Crossing, Newark, Delaware. Dr. Fan opened with a message of gratitude to the Medical Society of Delaware for allowing the collaborative to use their meeting space. She continued her greeting by introducing newly assigned collaborative members; Mike Bradley representing the Medical Society of Delaware, Jeff Hawtof representing the Delaware Healthcare Association, Kevin O'Hara with Highmark, Chris Morris with Aetna, Maggie Bent with Westside Family Healthcare, and Leslie Ledogar with the Department of Insurance. Special note: Lisa Zimmerman with DHSS/Medicaid attended on behalf of collaborative member Steve Groff and Steven Costantino with DHSS/Secretary's Office, attended on behalf of Sec. Dr. Kara Odom Walker.

Review/Approval of Minutes

Dr. Fan asked the collaborative members if they had any comment on the draft minutes from the Primary Care Reform Collaborative meeting, held on September 17th. Dr. Gill expressed concern about some content of the meeting minutes not accurately capturing concepts discussed. Dr. Fan provided guidance on options members can take to address errors or inconsistencies in meeting minutes. She explained that members can recommend edits or comments either before the meeting or during the meeting when calling for a motion to approve. Dr. Gill felt comfortable moving forward with approval. No suggested edits were made at this time. The absence of page numbers was noted. All agreed that page numbers allow members to quickly reference content during discussions. Page numbers will be added to the September minutes and all future meeting minutes. The length of the minutes was discussed and there was a consensus that transcripts were not necessary and a summary of the discussion would be sufficient. Hearing no more comments or call for edits, Dr. Fan motioned for the minutes to be approved. A motion was made and seconded. The motion was carried.

Before transitioning to the next agenda item, Dr. Fan reminded all members to utilize microphones when presenting or commenting.

Department of Insurance Update

Leslie Ledogar from the Department of Insurance (DOI) provided the group with an update on the Office of Value-Based Health Care Delivery request for proposal (RFP). She reported that the RFP has been drafted and reviewed internally. It was then sent to Milbank for an external review. Milbank completed their review and returned the draft making the suggestion to use broader language. Ms. Ledogar explained the DOI was comfortable with the language in question because it was adopted directly from the statute. The RFP will now be reviewed by the Deputy and the Commissioner. Once they have their reviews are complete, the RFP will be submitted to OMB for posting in early November. Commissioner Navarro had no additional comments.

Primary Care Spend

Dr. Fan presented documents acquired by the Department of Insurance from Rhode Island and Oregon. Both templates include guidance on the methodology used in each state. Dr. Fan continued the discussion by providing a review of Oregon's Primary Care Payment Reform activities. Link to the presentation is found here <https://dhss.delaware.gov/dhcc/collab.html>. Oregon decided their primary care delivery model would begin with the establishment of a patient-centered primary care program. This program was established in 2009 under the Office of Oregon Health Policy and Research. Oregon defined the core attributes of the patient-centered primary care home. They developed uniform quality measures, built from measures that have been accepted nationally. Oregon also developed policies to encourage the retention and growth of their primary care providers.

In 2012 they broadened their approach through the establishment of a Patient-Centered Primary Care Institute. They included behavioral health integration and a learning collaborative to assist with practice transformation and they also included several payment models (CPC, CPC Plus, and Coordinated Care Organizations through Medicaid and a PCMH program through Aetna).

In 2015 and 2016 legislative mandate required Oregon to report primary care spend annually. The mandate included data collection from prominent health insurance carriers with annual health premium incomes of \$200 million or more. This reporting included commercial or Medicare Advantage, Health Insurance plans contract by Public Employee Benefits Board, Oregon Educators Benefit Board, and Medicaid Coordinated Care Organizations. There was some discussion on whether or not Delaware carried Medicare Advantage plans. Delaware does currently carries a small amount of Medicare Advantage plans in all three counties.

Oregon's mandate excludes ERISA self-insured plans, prescription drug claims, health care payers not covered under SB231 and health care spending by people who pay out-of-pocket including the non-insured. The mandate also required the Oregon Health Authority to form a Primary Care Payment Reform Collaborative. This collaborative will extend through the year 2027. The goal of this 45 plus member group is to implement and develop the Primary Care Transformation Initiative. Lastly, SB 934 requires carriers and CCO's to allocate 12% of their health care expenditures to primary care by 2023.

The Oregon Office of Health Authority uses claims-based payments on specific provider types for specific services related to primary care. These services included office or home visits, general medical exams, routine medical and child health exams, preventive medicine evaluation or counseling, health risks

assessments, routine obstetric care delivery, reward achievement of quality or cost-savings goals or building a primary care infrastructure and capacity. Non-claims-based payment services included reimbursement for expenses related to adopting health information technology, the addition of supplemental staff or activities, such as practice coaches, patient educators, patient navigators or nurse care managers.

Dr. Fan opened the floor members to discuss the next steps on how the collaborative would like to define primary care spend in Delaware. All members agreed to accept the definition of primary care providers as stated in SB 227. This definition includes providers in the fields of family practice, general internal medicine, general pediatrics and geriatrics. It also includes nurse practitioners and physician assistants working in these fields. At this time the collaborative agreed not to expand to mental health providers who work outside of primary care and do not provide primary care services. Members then shifted their focus to forming a consensus on how to handle claims-based and non-claims-based calculations. The collaborative could choose to adopt methods used by other states. Dr. Fan pointed out that several states separate claims and non-claims services when calculating care spend.

Rhode Island's data management plan was reviewed and it was determined that the document focused on performing the operations of data collection. The fact sheet did, however, outline Rhode Island's use of an all-payers claims database (APCD) to calculate their primary care spend. The Rhode Island APCD is very similar to the system developed in Delaware. Dr. Fan led the discussion on the decision to use an APCD to calculate primary care spend. The issue of the Employment Retirement Income Security Act of 1974 (ERISA) was mentioned. Several members expressed concern over the fact that all data is not fully captured in the APCD due to the ERISA Act. Because ERISA plans are not mandated to contribute data to the APCD, between 40 to 60 percent of the data needed is unavailable.

Leslie Ledogar gave a brief description of the ERISA Act of 1974. ERISA is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans. She also described keys elements of the March 2016 Supreme Court ruling involving Vermont. Over the years the law has put in place guardrails on the collection of data and the regulations related to employee benefits plans, including health plans. As a result, payers cannot be mandated to contribute data to APCD. All participation is voluntary. Rhode Island utilizes a large IT component and they also offer an opt-out option.

Dr. Hawtof pointed out that a considerable amount of time and financial investment has been dedicated to developing our current APCD infrastructure. He asked the group to share the reasons they would not consider using APCD. Dr. Fan asked if the group believed it was worth developing an alternative database. Relying on APCD means data will not capture roughly 50% of the population. Dr. Bradley expressed concern with the ability to extrapolate calculation for 100% of the state spend. Other questions mentioned for discussion included: Are ERISA members healthier? Do they have less cost than non-ERISA members? Lastly, how will these facts affect the primary spend calculation? It was stated that it is possible to utilize aggregate data. This is an option that is used in collecting data for the Benchmark activities. If aggregate data was collected it could be supplemented for the data not captured in the APCD. Kevin O'Hara stated

that conceptually this may be an option but more research would need to be done. Chris Morris agreed that more investigation would be necessary.

After a lengthy discussion, the members agreed APCD is a valuable data source and at present the best available option. Senator Townsend briefly revisited ERISA and the possibility of voluntary disclosure. He continued by asking if state incentives could be implemented to encourage participation. Dr. Fan reminded the group that the purpose of the discussion is to provide the Office of Value-based Payment with recommendations. She presented the group with three options. The first option includes using the APCD and requesting payers with ERISA plans to voluntarily contribute their claims data (non-aggregate). The second option includes utilizing the APCD and requesting aggregate data from major payers. Dr. Fan pointed out that aggregate data cannot be validated. The third option would be to move forward with the use of APCD, making no attempts to collect ERISA plan data, recognizing that the data will be incomplete.

Before moving forward members revisited the question posed by Dr. Bradley about doubling the data to account for the missing 50% of the population. The concern was raised that Non-ERISA data alone may not provide a representative sample. Additionally, Medicaid and Medicare members may not be as healthy as members who hold plans through their companies. All agreed that doubling final numbers could result in an overestimate of the total primary care spend. It was mentioned that when statistical methods are applied during the analysis of the data, an accurate representative sample can be achieved through the use of stratification and controlling for variables.

At the conclusion of the discussion, Dr. Fan reviewed the three options again. All members agreed unanimously to utilize the APCD, encouraging voluntary participation. A member agreed with this course of action and suggested the collaborative adopt a long term goal to collect ERISA data fully.

The discussion transitioned to determining data collection methods for non-claims-based payments. Dr. Fan asked if the collaborative wanted to request aggregate data from payers. Steven Costantino suggested we ask insurers for the data since it is not included in APCD. He continued to explain the complexities involved in calculating capitated arrangements. He stated that it is possible capitated arrangements include services outside of the definition of primary care. The group agreed to table the topic because Delaware does not have any global capitated rebundled payments for specialty models at this time. A clarification was added that all aggregate data will be accepted. All members agreed.

The next point of business is for the collaboration to decide on the number of years to include in the first report. After some discussion, all members agreed that the first report would include the years of 2017 and 2018. It was unclear whether or not DHIN housed data for both 2017 and 2018. Members agreed to follow up with DHIN directly. A suggestion was made to invite a representative to attend the meetings to provide insight and clarification when necessary.

Dr. Fan called for final comments. There were none, so she closed the primary care spend discussion.

SB 227 Compliance

Dr. Fan introduced the SB 227 compliance discussion by sharing with the group that meetings with individual payers were being scheduled as needed. The meetings are also attended by DOI. They have been mandated to serve as an arbitrator, therefore, they must attend each meeting. To date, the meetings have not produced topics that warrant presentation to the public forum. In the future, presentations will be made in a public forum when deemed necessary.

Dr. Jim Gill reported that the Medical Society of Delaware conducted a survey of Delaware primary care physicians from across the state on the impact of SB 227. In general, physicians report being satisfied with the impact of SB 227. He mentioned that problem areas had been identified by specific types of providers. These issues involve the implementation of the intent of the law, more specifically in reference to chronic care management and items not covered under Medicare.

Kevin O'Hara reports that Highmark believes it is in full compliance. As an insurance company, Highmark has the purview and ability to negotiate rates. However, they are unable to control the coverage or cost share that is provided. Insurers are unable to mitigate these issues because of the Federal Employee Benefit program regulations or protections provided under ERISA. The issues are complex and cannot be easily solved.

Dr. Fan asked the group to brainstorm ideas to gain buy-in from ERISA plans. Members agreed that sharing information about the value of the sustainability and foundation of a health care delivery program could encourage voluntary participation. Members agreed that it would be helpful to have direct communication with these groups however confidentiality regulations prevent insurers from providing this level of detailed information. Promoting the value of this investment and voluntary submission of data through relationships was identified as a possible strategy. However, members were reminded that all activities that involve direct contact would need to be led by Insurers. Dr. Fan encouraged the members to continue to brainstorm solutions to address these barriers. The engagement of these parties is essential to the success of our efforts to develop a primary care delivery model. The success of this model benefits everyone. The APCD only holds a portion of the data. If primary care fails, costs will increase significantly. The collaborative needs to identify a strategy to share this message.

A suggestion was made and accepted to continue this dialogue during the next meeting. It was felt that one of the absent members could provide the group with valuable insight and even poll their peers for additional information. It was agreed that this discussion will be continued in the October meeting.

Senator Townsend revisited the topic of ERISA regulations as it applies to the SB 227 mandates. Kevin O'Hara explained SB 227 only mandates certain populations. ERISA business (administrative services or self-funded business) are not included. Since the mandate does not include these populations, insurers cannot implement cost sharing or chronic care management codes. This would have been seen as manipulating their benefits. Mr. O'Hara continued to explain that insurers can dictate the rates paid to providers but the mandate under SB 227 does not include benefit design. Highmark is paying their ASO clients at the mandated rates. Chris Morris added that Aetna is doing the same. He reports that they are fully compliant and paying providers the mandated rates. He reiterated that while they have updated the rates they cannot

mandate benefits plans. Clients control their own benefit design. Insurers are unable to control the cost-sharing or management codes to certain populations. These are issues that may be causing some providers some frustration.

Senator Townsend led a brief discussion about the March 2016 ERISA Supreme Court ruling. He wondered if the regulations would apply if a third-party possessed aggregated de-identified data. The group was not certain if the regulations would in fact be more lenient if distribution came from a third-party. More investigation would be necessary. All agreed that this topic requires more exploration.

There was no further discussion and the meeting transitioned to the topic of primary care payment models.

Primary Care First Multi-Payor Model

The group discussed the possibility of using primary care first as a transitional model. Dr. Fan reported that the roll out of the Primary Care First has been delayed. She continued the discussion by asking the insurers who were present if they had been involved in discussions to consider adopting a Primary Care First model. An immediate answer was not provided and both insurers reported needing time to investigate. Several members commented on the fact that this model is new to Delaware. The applications are not out yet. The adoption rates are unknown and projections are not high for the first year.

Dr. Fan asked if the ACOs were planning to use the model. Dr. Donahue-Henry reported that the decision to adopt the model will be practice specific or specific to individual health system that is practicing in the ACO. Christiana Care will not direct practices but they are looking into the model. They have made more progress with Primary Care First however they are open to other models, direct contracting models as well. They are waiting for more information to be released. Dr. Fan requested that insurers (Highmark and Aetna) bring an update for the collaborative members about where they are with considering adopting this model as a track to move away from fee-for-service. A member commented that practices may not be taking advantage of this model because it is a smaller percent of the population and if all payers adopted the model Delaware may see a higher uptake. It was also noted that primary care physicians find it difficult to take on additional models because it means they will also take on additional risks.

Defining a Care Delivery Model

Dr. Fan opened the discussion on defining a care delivery model by reminding the members of the strategy used by Oregon. Oregon's primary care delivery model began with the establishment of a Patient-Centered Primary Care Program. Dr. Fan asked the group for their opinions implementing a similar strategy in Delaware. Dr. Fan stressed the importance of implementing measure to achieve the goal to develop a Value-based payment model. Dr. Fan made a request that the group continue to consider avenues for establishing payment reform. She encouraged members to review presentations shared last fall on Care Coordinated payments, PCMH and ACOs. She pointed out that not everyone is an ACO or NCQA qualified and this may present a barrier for practices to become a PCMH. She asked if members were interested in developing a specific type of primary care delivery model. She believes practices are struggling due in part to a lack of infrastructure. Dr. Fan charged the group with defining core objectives. One comment offered stated that a single model could prove to be helpful for practices that have fewer resources and are more naïve. However, the collaborative should keep in mind that there are practices that have already developed a risk-based modeling care coordinated delivery systems. Forcing these more advanced practices to adopt a

model may have a negative impact. After some discussion, the group agreed to focus on establishing a set of principles before defining a prescriptive care delivery model. Additionally, the principles should be easy to measure and not require a lot of resources.

Payment reform mandate will be met through the establishment of the Office of Value-based Health Care. The collaborative has been mandated to move 60% of primary care providers into a value-based payment models by 2021.

Dr. Fan presented the topic of integration of behavioral health and women's health. She focused the discussion on the opinions of the integration of behavioral health, asking for information about models that are currently in place. It was pointed out that outcomes have not been identified. Dr. Fan asked if members were interested in looking at state benefit plans and reminded them of the need to present recommendations to the Office of Value-based Healthcare.

Veronica Wilbur revisited a comment made by Dr. Hawtof concerning independent offices. She pointed out that Nurse Practitioner's with stand-alone offices do not qualify for the ACOs and PCMHs. These practices are not a part of the system but they create value. She charged the members with identifying ways to ensure these practices are involved in the process to develop value-based care delivery systems.

Dr. Hawtof shared that while calculating the primary care spend is important the collaborative should consider conducting a workforce capacity analysis in Sussex County. Currently, the number of primary care providers cannot meet the needs of the population. He stated that using more providers is not solving the problem. In order to address the problem, we must change the way we deliver primary care. He continued by stating the numbers are too large, the growth is too large and there are not enough providers and not enough space. He hoped that future discussions involve what types of primary care models can address these growing issues. Virtual care and other innovative methods should be considered.

After encouraging members to donate blood in light of a severe shortage reported by the Blood bank, Sen. Townsend provided the group with updates regarding questions surrounding ERISA regulations. He shared that he has been in communication with Chamber of Congress member, John Gooden, the President of MDavis. Sen. Townsend believes Mr. Gooden could provide valuable insight regarding ERISA regulations. He also provided the group with updated information he had discovered during the meeting. He learned that the case in Vermont was a TPA. The legal guidance is that states can implement an opt-out model. A state data reporting law could mandate that TPAs have to disclose the data (likely on an aggregate level), however, self-funded plan can still choose not to participate. Behavioral economics data indicates that opt-out versus opt-in models show higher participation rates. He plans to share these thoughts with the John Gooden to gain his opinion as a representative of this specific segment of the marketplace. He will also connect with states that have researched an opt-out model versus an opt-in. Lastly, he plans to contact Delaware Department of Labor Secretary Cerron Cade. During his initial research he learned that the U.S. Department of Labor may be able to collect data from ERISA plans and share it with state level databases. He concluded his update by sharing that there are other possible legal avenues that are worth investigating. He will provide future updates as information is collected.

Public Comment

Dr. Fan opened the floor for public comment. Audience member Jack Shilpfster provided a comment. He shared that he has been involved in health care legislation and regulation in Dover for over 30 years. He agreed to read the March 2016 ruling and offer his opinion. He shared with the group that the two largest ERISA plans in Delaware are the State and New Castle County employees. He assumes these groups may be forthcoming with the data. Private ERISA employers may not be as generous, however the data gathered from the two groups mentioned may provide the collaborative with a large sample of the missing data.

Hearing no other business, Dr. Fan adjourned the meeting at approximately 6:51 p.m.

Next meeting

The next Primary Care Reform Collaborative meeting will be held on Tuesday, November 12, 2019 at the Medical Society of Delaware located at 900 Prides Crossing, Newark, DE 19713, from 5:00 p.m. to 7:00 p.m. p.m.

SB 227 Primary Care Reform Collaborative Meeting

Tuesday, November 12, 2019

5:00 p.m.

Medical Society of Delaware

900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

Present:

Senator Bryan Townsend, Co-Chair
Dr. Nancy Fan, Co-Chair
Representative David Bentz, Co-Chair
Faith Rentz
Veronica Wilbur
Leslie Verucci
Kevin O'Hara
Dr. Jim Gill
Dr. Jeffrey Hawtof
Dr. Christine Donohue Henry, MD
John Gooden
Margaret Norris-Bent
Dr. Michael Bradley
Chris Morris
Leslie Ledogar
Mike Gilmartin

Organization:

Senate Health & Social Services Committee
Delaware Healthcare Commission
House Health & Human Development Committee
State Benefits Office/DHR
Next Century Medical Care/ Delaware Nurses Association
Delaware Nurses Association
Highmark DE
Medical Society of Delaware
Beebe Healthcare/ Delaware Healthcare Association
Christiana Care/Delaware Healthcare Association
MDavis, Inc. /DSCC
Westside Family Healthcare
Dover Family Physicians/Medical Society of Delaware
Aetna
Department of Insurance
MDavis, Inc./DSCC

Absent:

Hon. Kara Odom Walker
Steve Groff
Hon. Trinidad Navarro

Organization:

Department of Health & Social Services
Division of Medicaid & Medical Assistance
Department of Insurance

Staff:

Juliann Emory
Read Scott

Juliann.Emory@delaware.gov
Read.Scott@delaware.gov

Attendees:

Jamie Clark
Liz Staber
Kiki Evinger
Tyler Blanchard
Regina Heffernan
Kim Gomes
Avani Virani
Lenaye Lawyer
Daniel Elliott
Anthony Onegu
Katherine Impellizzeri

Organization:

Nemours
Aetna
Department of Health & Social Services
Aledade
AmeriHealth Caritas Delaware
Byrd Group
Highmark
AmeriHealth Caritas Delaware
Christiana Care Health System
United Medical
Aetna

Jennifer Mossman	Highmark DE
Elisabeth Scheneman	Department of Health & Social Services
Andrew Wilson	Morris James
Pam Price	Highmark
Susan Conaty-Buck	Delaware Coalition of Nurse Practitioners
Lisa Montegna	HighMark BCBSDE
Cydney Teal	Christiana Care Health System
Ayanna Harrison	Department of Health and Social Services /DHCC
Sascha Brown	Aetna
Deb Hamilton	HGP
Margaret Defeo	AmeriHealth Caritas Delaware

The meeting was called to order at 5:05 p.m.

Introductions

The meeting convened at approximately 5:05 p.m. at the Medical Society of Delaware, 900 Pride Crossing, Newark, Delaware 19713. Representative Bentz welcomed the committee members and informed them Dr. Fan and Senator Townsend would arrive shortly. The floor was opened for introductions. There were two new members present: Mike Gilmartin/MDavis and John Gooden/MDavis. Special note: Elisabeth Scheneman with DHSS/Delaware Health Care Commission attended on behalf of DHSS representatives Sec. Dr. Kara Odom Walker and Steve Groff/Medicaid. Jamie Clark/Nemours was in attendance via conference call line.

Representative Bentz noted that the first item on the agenda is the review and approval of the minutes. This agenda item would be postponed until the arrival of Senator Townsend and Dr. Fan. The meeting would instead begin with a presentation on the Patient-Centered Medical Home (PCMH) Model given by Dr. Jim Gill.

Revisiting the PCMH Model

Dr. Gill opened by raising two questions, “How do we define PCMH?” and “How do we measure to demonstrate value?” His presentation entitled, “Defining and Measuring the Patient-Centered Medical Home” was an adaptation of a presentation prepared for a conference in July 2009. As a result of the original presentation, an article by the same name was published in the Journal of General Medicine in June 2010. A copy of Dr. Gill’s presentation is available at https://dhss.delaware.gov/dhcc/files/pcmhpc_nov2019.pdf.

Dr. Gill detailed the five principles of Primary Care as accessibility, continuity, comprehensiveness or whole person care, integration/coordination, and family and community-centered care. Dr. Gill added new insight has been given to the importance of including cultural competency as a key element of primary care.

Next, he examined the definition of the PCMH which includes seven basic principles. He stated these principles do not differ from primary care, but instead represent an enhanced structure. The first principle of PCMH is having a personal physician or clinician. Dr. Gill pointed out the original definition only included physician and he emphasized the importance of using the term “clinician”. This distinction allows for the inclusion of advance health care providers (i.e. Nurse practitioners and Physician Assistants) who include primary care services in their practices. The second principle is described as the physician/clinician directed

medical practice. The third principle is a practice that is comprehensive or whole-person orientated. Coordinated care is listed as the fourth principle. This involves care that is coordinated or integrated across the health care system. The fifth is the focus on quality and safety. Sixth is the enhanced access and the seventh principle is the presence of a payment system that recognizes the value of these services.

Dr. Gill described the benefits of primary care, more specifically PCMH models, as: better population health, lower cost, less inequality, and better health care quality. Dr. Gill shared two references with members. One of the referenced articles entitled “Prospects for Rebuilding Primary Care Using The Patient-Centered Medical Home” was provided in the meeting materials.

Dr. Gill continued by sharing the key elements of measuring the PCMH model; measuring primary care principles and measuring new approaches and new technology (EHR and information technology). Dr. Gill shared several caveats when measuring PCMH models. There has been a tendency to overemphasize the technological advances while under-valuing the patient-centered and relationship aspects of primary care. There has also been an expectation that benefits can be seen within one to two years, when in actuality outcomes take between five to ten years.

The NCQA PCMH certification program is widely used and has become the focus when measuring PCMH models. It is used by many health plans and is mostly commonly used in definitions and studies. The NCQA has nine standards and 166 practice-report items. Dr. Gill highlighted the fact that almost half of these items focus on the use of technology with very few measuring coordinating care, continuity of care or care for specific diseases. He also highlighted that only 1% of the measured items focus on continuity of care (one of the four main elements of primary care). It was also noted that several important measures are missing from the NCQA tool. For example, comprehensiveness of care, patient perspective, relationships, mental health, community, population outcomes, and developmental process of transformation.

The discussion shifted to the barriers and cost implications surrounding the use of NCQA certification. The process is expensive and time-intensive. There is a large documentation/administrative burden. Dr. Gill shared that his office achieved level 3 at a cost of between \$20,000 and \$30,000. Recertification is less expensive but overall cost are high and it was noted that cost may be a barrier for smaller practices. Dr. Gill's office decided not to pursue re-certification.

Dr. Gill shared several alternatives to the NCQA measure. Dr. Gill referenced the article “*Measuring Medical Homes, an evaluation of the tools used to assess the PCMH models*” during this portion of the presentation. This study conducted by Dr. Malouin and Dr. Mertin reviewed tools for their population coverage, format, testing of validity and reliability, and inclusion of the attributes of primary care. The two highest scored instruments were the Primary Care Assessment Tools (PCAT) and Primary Care Assessment Survey (PCAS). The study found that both perform significantly better than the NCQA tool. It was also noted that less than one-tenth of the resources were needed.

Dr. Gill concluded his presentation by sharing that there is strong evidence that PCMH represents enhanced primary care and improves access, outcomes and cost. The NCQA is widely used, common and well-known. It is also very costly, under measures key primary care components or misses them all together. Overall it is

not a strong performer and it is not realistic for practices in Delaware. Dr. Gill closed by emphasizing the need to identify a new certification standard for practices not currently holding NCQA certification.

Dr. Fan stated the purpose of the presentation was to ensure collaborative members share the same concepts and common definitions when discussing PCMH delivery models. She stated PCMH can be used as a care model to enhance primary care in Delaware. She stated certification has been seen as a barrier for some practices attempting to establish a patient-centered medical home. Dr. Fan pointed out that Oregon developed an individual standardized certification and wondered if the collaboration was interested in doing the same. If the committee decided to move forward with developing a standardized tool, ensuring payers are comfortable with the chosen certification strategy would be paramount.

Dr. Bradley shared that his practice achieved level three (PCMH). He reports the cost of this endeavor was approximately \$30,000. He stated the first two recertifications were less burdensome. Currently, his practice utilizes the “fast-track” recertification process and they have found it is much easier. He stated the process requires a significant amount of time and effort. Dr. Bradley shared that their office has two to three staff dedicating 100% of their time for processing the documentation of their PCMH claims. The size of their practice allows them to absorb these cost. He admitted this process may not work for all practices in Delaware.

Representative Bentz asked for more information regarding payers discontinuing reimbursements for PCMH claims. Dr. Gill stated it was his understanding the payer determined the model was not producing expected outcomes. Kevin O’Hara reported that the model claims were paid before discontinuing and the decision to discontinue was in part because they did not find cost improvement or efficiencies. Mr. O’Hara also reported there was no indication quality was stronger than non-PCMH practices. He added that the program was terminated but the funds were poured into their current value-based programs.

Kevin O’Hara continued by stating that the discussion of measurement is important because plan sponsors want to know how PCMH models are improving their member’s quality and cost. He highlighted that the plan sponsor or employer are the ones paying for these programs. He confirmed the decision to discontinue reimbursement of the plan in question was done across their entire company. Representative Bentz asked other payers in attendance about their findings in regards to the value of PCMH. Chris Morris added that Aetna is still evaluating their programs.

The discussion continued and Dr. Gill shared more information about the NCQA tool. The NCQA measure evaluates quality by applying disease measures. Specific documentation is required to support provider reports. The NCQA collects self-reported data and providers understand supporting documentation may be requested. Practices receive quality measure feedback based on their self-reported data.

Recommendations are included. This feedback is aggregated and not broken down by patient.

There was a brief discussion about the difference in the alternate measurements in the literature disseminated. Dr. Gill explained that the first table (Table 3) assesses how well the tools measure the seven primary care attributes. Appendix E provides an overview of the resource intensity of each tool.

Members discussed the prevalence of outcome studies. It was stated that several outcomes studies have been conducted and results have been mixed. In general, studies have shown PCMH attributes are associated with improved quality and improved access and reduced cost.

Dr. Bradley revisited the question raised regarding payers discontinuing reimbursement of PCMH claims. He shared his experience as the president of the Medical Network Management Services of Delaware (MedNet). He explained that Mednet was searching for a delivery model (ACO) and entered into a contract with Blue Cross Blue Shield of Delaware. This partnership was delayed by the merge between Blue Cross Blue Shield of Delaware and Highmark. Their practice was not able to clinically integrate their networks. Their practice lost 25% of their reimbursement resulting in a reduction in their staffing structure. Mednet has entered into a new partnership and they are currently integrating their physicians starting with primary care. They have over 800 in their network over one-third are primary care. They are working towards integrating health information (Electronic Health Records) in their primary care practices.

Dr. Fan highlighted Appendix E (slide 4) of the “Monography Summary” document. This table provides details on various assessment tools used to assess quality and measure performance. PCAS and tools like it are designed to understand the risk characteristics of patient panels. The appendix shared the following data on each assessment tool: date of release, number of questions/pages, length of time to complete, language available and cost of use. Dr. Fan pointed out that while PCAS and PCAT have completion times between 5 to 25 minutes, PPC-PCMH (NCQA) reports taking 40-80 hours to complete. She noted the extensive administrative burden and added that it is likely a barrier for providers.

Dr. Fan added committee members should discuss and define “accountability” and “value”. She raised the following questions: What is value? Is it important to hold practices accountable? What tools will be used to quantify value? She asserted that the tool used by practices should not cost over \$30,000 and take between 40 and 80 hours. In her discussion with various physicians they have listed cost and administrative burden as reasons they have not tried to achieve NCQA.

Dr. Fan asked Chris Morris about Aetna’s PCMH program in Oregon. Morris reported that the program in question was implemented a few years ago. Aetna had programs that were created around value-based care in Oregon. Chris Morris reported the programs Aetna created in Oregon around value-based care met their criteria so the decision was made to continue to move forward in that direction. Dr. Fan reported that Oregon has developed their own certifying body for PCMH. Aetna has increased reimbursement for practices that are recognized as PCMH programs. Chris Morris reported that Aetna has two different levels of PCMH programs depending on the number of attributed members. Both levels include care coordination fees. The larger member/patient volume have gain-share opportunities. The smaller program, built for practices with 25-50 patients, have a care coordination program around NCQA accreditation. There is member/patient criteria level and programs also cannot be in any other value-based program.

Dr. Donahue asked if there was evidence of cost decrease in this model. Chris Morris reports that it is a little too early to attribute a decrease as a result of this program. However, he did report that there has been an increase in the number of providers participating.

Dr. Fan reported that Oregon's first legislation mandated them to have care coordination within their Medicaid program (PCMH) and they had a decrease in cost and increase in access. They had such success that they developed the second and third legislation.

Dr. Gill stated that a large number of PCMH programs are dramatically underfunded. The cost is approximately \$15 to \$20 per patient per month and most reimbursements are approximately \$2. Improved outcomes are often not found in many programs, due to inadequate resources and funding in those programs. He asserted that if the program is funded fully there is dramatic benefit. The group discussed the importance of reviewing the outcomes of fully funded PCMH programs to determine if demonstrated value could be documented. It was suggested that the collaboration review the demonstrated cost savings of CPCI programs because they are similar to a PCHM programs. Several members felt that it was important to obtain a better understanding of the benefits (cost analysis and outcome measures) of these programs before moving forward.

Dr. Fan reported that Trinity Health participated in the ACO Next Generation (Medicare). This program reported savings all three years of participation. The model involves ACOs taking on more financial risk than participants in the Medicare Shared Savings program. The upfront investment was significant at \$22 per payer per month however they were still able to demonstrate cost savings. Dr. Fan suggested the collaboration committee develop standards on measurement alignment that will provide an investment with guardrails. Several members expressed interest in learning more about the ACO NexGen. Dr. Fan shared that discussion details can be found in past collaborative meeting minutes. Note: Discussion on this topic is found in the February 25, 2019 meeting minutes (starting on page 5), located on the Health Care Commission/Primary Care Collaborative webpage: <https://www.dhss.delaware.gov/dhss/dhcc/files/pccmeetingminutes022519.pdf>. Dr. Fan also agreed to contact Jennifer Schwartz (ChristianaCare) and invite her to a future meeting to present her findings. Members agreed a presentation of this type would be helpful.

Members continued to discuss evidence of cost savings. All agreed that currently there is not enough evidence. Dr. Fan suggested the collaborative consider developing a care model that will provide investment with guardrails and build standards around accountability and value. She asserted there is a need to have a standardized measurement tool in place, however it should not include 166 measures.

Kevin O'Hara reports that payers will have a difficult time asking the client/customer to pay for the premiums if there is lack of evidence of cost saving.

Mike Gilmartin reports that employers are willing to share some of the cost if it was known that they would receive better quality care for their employees. He stated that healthy employees are happier and as a result companies benefit. However, he did point out that employers do not wish to lose money. He shared their company became self-insured in 2014 and they are still learning. He continued by stating he believed there is value but the learning curve is steep. It will be necessary to clearly define what we are looking for. There has to be an incentive, perhaps a tax income incentive.

Dr. Fan transitioned the discussion to the review and approval of the October minutes.

Review/Approval of Minutes

Dr. Fan asked the committee members if they had any comment on the draft minutes from the Primary Care Reform Collaborative meeting, held on October 21st. Dr. Fan noted an error on page three. ERISA plans will be continued during the November meeting. Chris Morris requested a change be made to reference to Medicare Advantage (page3). Dr. Gill noted that he sent edits via email prior to the meeting. Read Scott acknowledged receipt of the changes. Seeing no more discussion Dr. Hawtof motioned to approve minutes as amended. Senator Townsend seconded the motion. The motion to approve was unanimously carried. View approved October 21, 2019, meeting minutes here:

<https://dhss.delaware.gov/dhss/dhcc/files/pccmeetingminutes11142019.pdf>.

Update on Value Based Payments

Dr. Fan began the discussion on value-based payments. She stated that a recent report noted that there was a lower uptake in Delaware for participation in value-based payment models as compared to other states. She was interesting in obtaining updated information from payers. She opened the discussion by asking the commercial payers present to answer several questions (Overall total percentage participation, PCMH/PCMH type model participation, number of quality metrics, challenges and measures in place to increase participation, successes, actions if any to increase percentage spend on primary care through value-based models, and last ability to provide Primary Care First track).

Chris Morris reported on behalf of Aetna. He shared that the disparity noted last fall has since narrowed and Delaware is currently at 72% participation in value-based models (50% in primary care alone). He continued his report by sharing that Aetna currently offers 6-7 value-based models. Aetna has been working with practices to find programs that succeed. Quality metrics vary depending on the program. Practices have reported various challenges. Some report experiencing low level of engagement. Others report having difficulty meeting the initial metrics. Challenges can depend on the size of practice and specific criteria requirements. He stated the increase may be due in to the outreach efforts to smaller practices and they also signed contracts with larger health care systems.

Kevin O'Hara reported on behalf of Highmark. He stated they currently have 88% engaged in value-based payment systems with 54% of providers are in advanced customized programs. He reports Highmark builds the programs around the member mix of each practice. The vast majority of their practices have standardized quality metrics (29) however some practices do not qualify or have enough volume and are measuring a much lower number. He reports Highmark's increase in attribution has is a result of the increased activity of Medicaid plans. He also reports Highmark signed contracts with a few larger organizations, aggregators or management companies. These companies aggregate practices that are too small to participate on their own or needed additional support due to lack of resources. Their coordination and clinical support is strong. They have dedicated staff in these areas.

Dr. Fan asked about the ability to transform from a Medicare shared saving program to a multi-payer ACO and if both payers felt their increase was due in part to ACOs moving to multi-payers. Highmark reports that programs are set up with a minimum threshold for membership and a large majority of non-participants were the smaller practices that did not meet the requirements. Adding the aggregators helped them reached the market that was not large enough. Dr. Fan continued the discussion by asking if payers had plans to add Primary Care First track. Kevin O'Hara reports that he has not participated in conversations

about the possibility of adding Primary Care First. He commented on the need to see demonstrated success.

Dr. Donahue with ChristianaCare stated all practices within their health system are engaged in value-based models with some fee-for-service. Chris Morris reported that all of Aetna's programs have fee-for-service. Dr. Hawtof asked what percentage of the programs have downsize risk. Payers reported having programs with both downsize and upside risk.

Dr. Fan transitioned to a discussion to pairing payment models and care delivery models. She reviewed slide 3 of her presentation, focusing on Figure 4. Dr. Fan confirmed that payers have varying participation in each of the value-based payment models. When asked which one was most successful (re: investment and cost). Kevin O'Hara reports that Highmark has analyzed the data tied to their baseline program (True Performance, True Performance Plus and True Performance Advance) and he reports having substantial quality gains and savings. Chris Morris reports that a few of Aetna's value-based programs (complex and pay for performance) have shown some demonstrated value. The group began to examine what determines success. The group agreed that success includes improved quality and reduced cost. With that definition in mind the group began to discuss which model has been more successful. Dr. Fan asked if there was one particular program that had higher participation than the others. Payers report not having data that examines participation rates among providers per available programs.

Dr. Fan continued her presentation with a summary of reoccurring themes she has noted after reviewing several past meeting minutes. She stated several members agreed that the cost savings of a PCMH-like program were greatest with a mature PCMH or higher risk populations. Mature practices have the necessary resources and infrastructure in place. Savings were also associated with the ability to decrease cost associated with high risk populations through reduction in Emergency Department utilization due to management of medication. She continued by sharing important characteristics of PCMH models. The first characteristic is the desire to not add upfront investment into the total cost of care. She clarified that "added" means to increase. Dr. Fan asked the committee the following questions: "Does accountability equal risk?", and "Who assumes the risk, payers or the practice?" The group began to discuss how to build infrastructure. All agreed that the following components were relevant: data, care coordination at practice level, pre-defined targets for outcomes, cost savings and accountability all need to be present. Lastly, Dr. Fan pointed out the need to define the role of established ACOs in the state as the last important characteristic.

Dr. Fan invited Tyler Blanchard from Aledade and Dan Elliot from eBrightHealth to comment on the behalf of ACOs. Dan Elliot reports that eBrightHealth (ACO) has the vast majority (30 of the 45) of PCMH in the state. They currently do not have concierge services. They do have practices that participate in other multiplayer and value-based programs but they currently do not offer support. He continued by stating that Primary Care First is an interesting model. It places risk at primary care practice in a way that is disadvantageous financially to ACOs. He added that Primary Frist changes incentives in an attractive to some of their practices. He stated there is a lot of uncertainty, even with the latest RFP. The program disincentivizes taking care of high-risk patients by risking at the sum or the average across a practice. Lastly, he reported 20% of their practices are strongly considering the Primary Care First model but none have officially confirmed their participation. He added they are moving to Track C in January so there will be

some downsize risk. He concluded his statements by sharing that when practices undergo structural changes it can dramatic and the result of these changes could mean the difference between a windfall or a shortage.

Tyler Blanchard from Aledade shared that they began in 2015. Aledade works with independent primary care physicians only. These practices are smaller in size. Currently they are working with 30 practices. In 2017 they achieved shared savings with Medicare. In 2018 they missed shared savings by less than 1%. They have contracts with Aetna and Highmark value-based care across a larger population. They have approximately 50,000 Delawareans in value contracts through their primary care providers. The PCMH has been too costly for practices. There has to be some return to cover the investment. The PCMH programs have mostly lapsed. They may have the infrastructure but lack certification. The difference between a PCMH program and an ACO is more around prescriptive approach verses a more flexible outcome driven approach. In a PCMH program you are checking boxes, while an ACO program is more allowing practices to invest their money in the best way they can care for their population. Concierge has become a growing component. Currently, at least five practices in the ACO use this model, and more are actively pursuing. Smaller practices are able to lessen the burden of having to see at least 30 patients a day. Unfortunately, it leaves patients without access to primary care. It is challenging to aggregate all of the models together. Standardization is difficult because they receive data in different formats. Some payers share claims data. Aledade is integrated in EHR and in the practice management systems and among the practices as well. They have over 50 quality measures. There is not much interest in shrinking the list. Primary Care First is a program that changes the way practices get paid, not more just differently. The intentions are great but difficult to jump into a program when you are unsure of the impact on your business. He reports that Aledade is on two-sided risk with Medicare and they are on the enhanced track (the full risk program). They have plans transition to full-risk with Aetna and they are working with Highmark now.

The group discussed how to incentivize participation in value-based programs. Dr. Gill suggested that the focus remain on metrics and performance over the “4 Cs” (contact, continuity, comprehensiveness, and coordination). He continued by suggesting that the committee move toward with focusing on prospective payments to allow practices to make upfront investments.

There was a lengthy discussion on the intricacies of PCMH and value-based payment models. Dr. Fan and committee members elaborated on the several observations (Primary Care First, practices moving to concierge services, changing the way primary care practices deliver care, and risk management).

The Primary Care First program has several interesting characteristics. The model seeks to reduce cost through the reduction of hospitalizations. One member shared after some analyses their practice decided the Primary Care First model was not worth the investment. Instead their practice focused on Care Coordination. They worked with Skilled Nursing Facilities and they were able to reduce heart failure readmission rates. These rates have been at less than 10% for three quarters in a row.

It was mentioned that cost reduction will not take place until cost attribution to primary care providers is addressed. A comment was made that cost from specialists like radiologist and outpatient laboratories are added to primary care providers overall spend total. Primary care providers have little to no control over

these services but they are attributed to their final numbers. All agreed that addressing this issue would be very beneficial.

One member asserted that changing the way primary care providers deliver care is the key to improving quality and reducing cost. A true transformation includes risk management. Providers must be willing to practice differently. All agreed that some physicians will have no desire to change.

Dr. Fan reminded the members that 10% of practices are moving to concierge services. It was felt that there is a payment pressure. Concierge services decrease access to care for many. She added the collaborative was founded to increase access and decrease cost.

Dr. Fan asked if the committee members could agree on the need for a clinical model with a payment approach that focuses on the “4 Cs” or PCMH. One of the main concerns mentioned was the amount of work involved implementing PCMH programs and the risk that payers will not support the model and providers will not be reimbursed. Several made the point that it is not necessary for all practices to be NCQA certified, another certification approach could be developed in its place. Dr. Fan mentioned that Aetna has a certification tool in place.

Dr. Fan once again asked the members what type of care model can be developed with a payment approach. She pointed out that while other types of care delivery models are not as known, PCMH models have proven outcomes. Literature on PCMH models report better outcomes and improved care. She reminded the committee members that their goal is to increase access for our patients and develop models to increase the sustainability of primary care in the state.

Dr. Fan asserted that the development of a NCQA-like certifying body may remove the barrier some practices are currently facing. She asked if members could agree to that there is a need for a clinical care model that will be supported. She made the request that members consider viable care models and be prepared to discuss during the next meeting in December. She also asked members to think about timely and accurate data sharing. Due to lack of time the committee did not have an opportunity to discuss this topic in depth. Dr. Fan mentioned the success of establishing the Office of Value Based Healthcare.

Lastly, Dr. Fan asked the committee if they felt the mandate to have 60% of primary care practices in value-based care models has been reached. There was some discussion on the terminology used in the bill. Some felt that the definition of provider was not specific. It was decided that they would analyze both numbers. Payers reported that the number of primary care providers participating in value-based models is much higher than all providers. Members agreed to research final numbers in both categories (all providers and primary care providers).

Medicaid is a large payer and next month they will be providing the committee with answers to the questions reviewed by Aetna and Highmark about value-based payment models. They will be present in the December minutes.

There was a brief discussion on the importance of data gathering and data sharing. Dr. Fan reminded the group of the discussion from the October meeting regarding the challenges with access to data from ERISA

plans. Dr. Fan asked that the committee members be prepared to discuss strategies to gain greater engagement for self-insured and private insurers during the next meeting. She highlighted the development of The Office of Value-based care. This office will work on identifying the primary care spend for the state.

A suggestion was made that committee members be provided with a survey that includes the assignments requested by Dr. Fan. Members could submit their answers before the upcoming meeting. Answers could be compiled and disseminated with the meeting materials. Dr. Fan agreed with the idea. Another member asked to have access to the materials that will be reviewed during the meeting well in advance. The member stated having advance review time provides necessary preparation and allows for a more robust discussion. Dr. Fan agreed with this suggestion as well. Her goal has always been to disseminate materials to provide advance review time. She reported having experienced difficulties while attempting to disseminate materials for this meeting. She added that she is committed to sending materials out early in the future.

Public Comment

Dr. Fan opened the floor for public comment.

Hearing no other business, Dr. Fan adjourned the meeting at approximately 6:57 p.m.

Next meeting

The next Primary Care Reform Collaborative meeting will be held on Tuesday, December 10, 2019 at the Medical Society of Delaware located at 900 Prides Crossing, Newark, DE 19713, from 5:00 p.m. to 7:00 p.m.

SB 227 Primary Care Reform Collaborative Meeting

Wednesday, January 8, 2020

5:00 p.m.

Medical Society of Delaware

900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

Present:

Senator Bryan Townsend, Co-Chair
Dr. Nancy Fan, Co-Chair
Representative David Bentz, Co-Chair
Faith Rentz
Veronica Wilbur
Kevin O'Hara
Dr. Jim Gill
Dr. Christine Donohue Henry, MD
Christopher Morris
Mike Gilmartin
Steve Groff
Hon. Trinidad Navarro
Steven Costantino
Dr. Michael Bradley

Organization:

Senate Health & Social Services Committee
Delaware Healthcare Commission
House Health & Human Development Committee
State Benefits Office/DHR
Next Century Medical Care/ Delaware Nurses Association
Highmark DE
Medical Society of Delaware
Christiana Care/Delaware Healthcare Association
Aetna
MDavis, Inc./DSCC
Division of Medicaid & Medical Assistance
Department of Insurance
DHSS
Dover Family Physicians/Medical Society of Delaware

Absent:

Dr. Jeffrey Hawtof
Leslie Verucci
John Gooden
Margaret Norris-Bent
Leslie Ledogar
Hon. Kara Odom Walker

Organization:

Beebe Healthcare/ Delaware Healthcare Association
Delaware Nurses Association
MDavis, Inc. /DSCC
Westside Family Healthcare
Department of Insurance
Department of Health & Social Services

Staff:

Juliann Emory
Read Scott

Juliann.Emory@delaware.gov
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Attendees:

Jamie Clark
Elizabeth Staber
Kiki Evinger
Tyler Blanchard

Organization:

Nemours
Aetna
Department of Health & Social Services
Aledade

Regina Heffernan	AmeriHealth Caritas Delaware
Katherine Impellizzeri	Aetna
Jennifer Mossman	Highmark DE
Elisabeth Scheneman	Department of Health & Social Services
Pam Price	Highmark
Susan Conaty-Buck	Delaware Coalition of Nurse Practitioners
Ayanna Harrison	Department of Health and Social Services /DHCC
Sascha Brown	Aetna
Margaret Defeo	AmeriHealth Caritas Delaware
Bill Howard	BDC Health IT
Claudia Kane	DCHI
John Dodd	BDC Health IT
Larry Glazerman, MD	Highmark
Karyn K. Scout	AmeriHealth Caritas Delaware
Sylvia Cat	Delaware Pediatrics
Julane Miller-Arbustic	DCHI
Emmilyn Lawson	AmeriHealth
Paul Speidell	CVS Health/Aetna
Bernard M. Cohen	AmeriHealth Caritas Delaware
Bryan Gordon	Christiana Care
Drew Berenard	AmeriHealth Caritas Delaware
Kevin Leonard	AmeriHealth Caritas Delaware
Lizzie L. Zubaca	Hamilton Goodman Partners, Inc.
Wayne Smith	Delaware Healthcare Association
Shay Scott	Henrietta Johnson Medical
Dr. Muller	Stoney Batter Family Medicine
Kim Gomes	Byrd Group

The meeting was called to order at 5:05 p.m.

Welcome

The meeting convened at approximately 5:05 p.m. at the Medical Society of Delaware, 900 Pride Crossing, Newark, Delaware 19713. Representative Bentz welcomed all attendees and informed committee members Dr. Fan would arrive shortly. Representative Bentz also shared that the order of the agenda had changed.

Update on Department of Insurance/Office of Value Based Health Care Delivery

The meeting began with an update from the Department of Insurance given by Insurance Commissioner Trinidad Navarro. Commissioner Navarro shared that Leslie Ledogar was unable to attend due to a scheduling conflict and instead agreed to come and present an update on the progress to implement the Office of Value Based Health Care Delivery. The Request for Proposal (RFP) was posted on Office of Management and Budget's myMarketPlace Bill Solicitation Directory <http://bids.delaware.gov/> on 11/15/2019. The Department of Insurance reached out to a variety of outlets to ensure that the RFP was widely advertised. Questions were timely received from seven potential bidders. He did not publicly announce the bidders, siting that DOI wants to ensure the process is objective. The Questions and the

Department's responses were timely posted in two documents, which are also available on the Bid Solicitation Directory http://bids.delaware.gov/bids_detail.asp?i=6037&DOT=N. The deadline for the submission of the bids was Friday, January 10 at 4:00pm EST. The bid review team will begin their review process on Monday, January 13th. Commissioner Navarro reports that DOI anticipates the review process will be completed within two weeks. Scores will be submitted to him on or before February 10th. Lastly, he reported that his goal is to notify the successful bidder on or before February 19th. He concluded by reporting the current schedule places them ahead of the projected timeline for the completion of the implementation tasks. Commissioner Navarro opened the floor for comments and/or questions.

Introductions

Representative Bentz invited those joining via conference call line to identify themselves. Several individuals on the phone provided their names and affiliations: Wayne Smith, Delaware Healthcare Association, Shay Scott, Henrietta Johnson Medical, Dr. Muller, Stoney Batter Family Medicine, Jaime Clarke, Nemours, Kim Gomes, Byrd/Jones Group and board member Dr. Mike Bradley, Medical Society of Delaware.

Representative Bentz continued introductions by asking board members seated around the table to provide their names and affiliations for the record; Representative Bentz, Senator Townsend, Dr. Chris Donahue, Christiana Care/Delaware Health Care Association, Veronica Wilbur, Century Medical Center/Delaware Nursing Association, Dr. Jim Gill, Medical Society of Delaware, Steven Costantino, DHSS, Emmilyn Lawson, President of AmeriHealth Caritas of Delaware, Steve Groff, Medicaid Director/DHSS, Faith Rentz, Kevin O'Hara, HighMark, Chris Morris, Aetna, Mike Gillmartin, MDavis, Inc./DSCC, Commissioner Trinidad Navarro, Department of Insurance, Ayanna Harrison, Delaware Health Care Commission/DHSS (administrative support).

Representative Bentz once again noted that Dr. Fan had a scheduling conflict and would be joining the meeting shortly. At that time, he opened the floor to members who may have questions for the Insurance Commissioner regarding the Office of Value Based Health Care Delivery update. There were no questions or comments and the meeting was moved to the next agenda item to be covered, a presentation entitled "Delaware Medicaid Value Based Purchasing". Representative Bentz yielded the floor to Steve Groff, Medicaid Director/DHSS.

Medicaid/MCO update with Value Based Payment Models and PCMH

Mr. Groff's presentation, "Delaware Medicaid Value Based Purchasing" began with an overview of their approach to integrating value-based purchasing into their 2018 contracts. He stated 2018 was the first time they explicitly included any value-based purchasing provisions in the managed care contracts. The approach focused on a dual strategy which included a focus on cost savings and quality performance measures. The first being "Quality Performance Measures" (QPM) and the second "Benchmarks for proportion of total spending attributable to value based purchasing contracts". Financial penalties will be assessed for failure to meet requirements in either area.

Seven quality measures were selected. Medicaid believes the selected measures address priority areas for the health of Delawareans. These seven included: Diabetes Care, Medication management for people with

asthma Cervical Cancer Screening, Breast Cancer screening, BMI Assessment, Prenatal and postpartum care, 30-day hospital readmission rate.

Next, Mr. Groff highlighted the appendix provided of the Medicaid master settlement agreement. The document outlines the value-based purchasing strategy, defining each QPM and outlining the benchmarks. All quality performance measures, except for the “30-day hospital readmission rate”, will focus on HEDIS measures. Benchmarks were set using this methodology. allows Delaware Medicaid to assess their measures against national performance. During the first year of the contract most of the measures are set at the 50th percentile. Nationally some of the measures are set higher than 50th percentile. For value-based purchasing they would like to focus on moving up the continuum toward total risk, however they recognize they need a starting point for MCO providers and their contracted providers. They emphasize “Shared Savings”, however their goal is to move into “Bundled/Episodic Payments” and “Risk/Capitation” focused on “Total Cost of Care”.

Mr. Groff reported that in 2018 Medicaid set a percentage of total spend that had to be in contracts with their definition of Value Based Purchasing. In 2019, Medicaid will allow all contracts to be in any type of Value Based Purchasing arrangement but the percentage of spend will be increased. As Medicaid moves into 2020- 2022 they plan to continue to increase the percent of total spend that is expected in Value Based Purchasing. However, within this increase benchmarks are set for the percent of contracts that need to be in a bundled or total cost of care arrangement and not simply a shared or risk savings.

Mr. Groff encouraged members to review the document entitled, “Medicaid Managed Care Contracts as Instruments of Payment Reform”. This document includes the full contract language (https://dhss.delaware.gov/dhcc/files/hmavbpmedicaid_122019.pdf).

Mr. Groff reported that in December Medicaid issued a proposed regulation around how they will introduce Accountable Care Organizations (ACO) into Medicaid. The implementation goal for this plan is 2021. The proposed regulation authorizes Medicaid to “certify” the application process for ACO to apply to Medicaid program at DMMA. The “certification” will allow Medicaid to ensure ACOs meet their established standards. In 2021, Delaware Medicaid all contracts with Managed Care Organizations to will include language regarding their ability to contract with the Accountable Care Organizations. Mr. Groff opened up the floor for questions or comments.

Dr. Gill shared that he felt this plan was moving in the wrong direction. He stated that it was his opinion the measures currently used in value-based plans to assess value are inadequate and have little to do with true value. He added that the documentation requirements force providers to focus on specifics that remove their attention from actual good primary care practices. He added that the concept of checking “more boxes” places an administrative burden on providers. He stated that the plan presented mirrored older, inefficient plans.

He continued by encouraging members to abandon this approach and move toward improving access to care, especially primary care. He suggested the group focus on “what is primary care?”, “How do you measure primary care?” and “How do you value that?” He shared that in his opinion providers are leaving primary care because they are held responsible for cost which they do not control. He encouraged the

group to discontinue the use of value-based because it has begun to carry a negative connotation among primary care providers. Dr. Gill stated that even visiting a primary care provider creates value. He encouraged the committee to consider how they will enhance and attract more providers to primary care? Dr. Gill suggested that quality care includes: access to care, continuity, establishing relationships and establishing trust. He concluded by asking members to begin to consider strategies that are focused on access to care and quality of primary care in Delaware. There was some discussion about the agreed upon definition of Primary Care and how the group will measure quality and value.

Mr. Groff stated that it is necessary to measure quality and outcomes when considering any definition of value-based care. He continued by asking Dr. Gill for alternatives to measuring quality based on the four areas that he mentioned.

Dr. Gill referenced a presentation he shared with the committee that provided an overview of how to measure primary care. He stated that measuring primary care includes assessing continuity, comprehensiveness, access and coordination. Additionally, establishing relationships and trust could also be utilized to measure quality. He mentioned that his past presentation included several surveillance methods. Dr. Gill shared that in his opinion HEDIS measures do not measure true quality. The key to quality is access to good primary care. He encouraged the committee to consider strategies to promote primary care. New providers are not choosing primary care and existing providers are leaving. He encouraged the committee to focus on promoting the use of primary care.

Steve Costantino stated that the plan presented by Mr. Groff was an RFP for MCO/ACO relationship. Imbedded in any strong ACO is primary care. He shared that the plan is not a substitute for primary care but a model to fund good primary care. The uptake on this plan will be telling and lessons will be learned. He concluded by emphasizing the plan is not a substitute but a new way to finance a broad range of services including primary care as the “spine”.

Senator Townsend asked that the dialogue be continued during a future meeting. He thanked Mr. Groff for his presentation and introduced Emmilyn Lawson from AmeriHealth Caritas of Delaware as the next presenter.

A copy of Mr. Groff's presentation is available at
https://dhss.delaware.gov/dhcc/files/devaluebsedpurchprescc_01082020.pdf

Assessment of upfront investments by ACOs (tentative)

Dr. Lawson began her presentation by stating the state is not expecting all providers to move to a global payment model. She shared the company's progress from beginning to present. AmeriHealth Caritas went live 1/1/2018. Efforts began with converting letters or intent to contracts and verifying doctors' credentials. The company conducted a large amount of outreach to ensure all members who did not have a provider listed were contacted and assigned a provider. This is a contractual requirement. She shared information about the company's network adequacy requirements and access standards. Test are conducted monthly to assess how long patient wait for an appointment with their assigned provider.

Once they had completed full implementation they launched their Value-B program. They had to aggressively identify partners that were already doing work with value-based programs. AmeriHealth has signed several value-based agreements. They are partnering with ChristianaCare. ChristianaCare is currently taking on risk.

Dr. Lawson shared that while analyzing ChristianaCare data they found there was a disconnect between members enrolled in the program who had not selected a provider and were assigned a provider. A considerable amount of outreach was necessary to ensure members were provided accurate information. Medicaid members do not need report the providers they plan to visit however they are encouraged to share this information. Not having accurate information affects the payment model.

AmeriHealth Delaware expects to continue to evolve their analysis, to uncover barriers that are preventing members from access to care. They are partnering with Nemours to develop a value-based payment model that seeks to address social determinants of health and health inequity.

In 2020, AmeriHealth plans to launch PerformPlus Quality Enhancement Program (QEP) for primary care providers not enrolled in an existing value-based program. Information has been sent to their providers. AmeriHealth also plans to identify opportunities for additional provider/payer collaborations in support of their 2022 targets.

The presentation concluded with a list of lesson learned: The collection of comprehensive data is important to measure the effectiveness of programs; data extraction and interfaces reduce administrative burden for providers and payers; payers and providers need to better leverage DHIN capabilities; Increased reimbursement without improved quality does not reduce total cost of care; payment transformation requires ongoing collaboration between payers and providers; and the quality of provider/payer collaboration is a critical success factor.

A copy of presentation Dr. Lawson's presentation is available online at:
<https://dhss.delaware.gov/dhcc/files/pccacdevbpupdtes.pdf>

Senator Townsend revisited the discussion between Dr. Gill and Mr. Groff. During the discussion it was agreed that the definition of primary care had been decided and agreed upon during past meeting. The definition was established to assist the collaborative with identifying costs that are attributed to primary care, thus calculating primary care spend.

Dr. Gill suggested that the collaborative move toward valuing and measuring primary care not creating reports that become administrative burdens for primary care physicians. Reporting requirements and the attribution of uncontrollable costs (hospital visits, stress tests, etc.) to primary care providers, are a few of the factors that are driving existing care providers away and deterring new providers from joining.

Mr. Groff stated that he did not believe there was a fundamental disagreement. It was his opinion that the two of them were communicating from different perspectives. He apologized and reemphasized that the plans presented can only be successful with strong, quality primary care.

Veronica Wilbur voiced some concern with the continued administrative burden providers are faced. She stated that insurance dictates how providers care for their patients. She reported that she has six and a half pages from a payer that she must complete to receive payment. She continued by thanking Senator Townsend for visiting her practice. She reported is still dealing with same issues they discussed during his visit, however wanted to note that she appreciated his time and concern. As she concluded her statements she mentioned the need for easier access to DHIN. Smaller practices face several obstacles when trying to share or access patient records. Access is costly and larger health systems can afford services, placing smaller practices at a disadvantage. Dr. Fan agreed that DHIN access is an important issue however she suggested it be discussed during another meeting.

Mr. Groff shared that the catalyst for the data requests sent to providers is driven by external requests that his office is mandated to report. He mentioned that all government programs are driven by their Federal counterparts. The reporting requirements are not internally driven. State programs collect the data they are required to report.

Steve Costantino reminded the committee that the plans presented are all voluntary. There are two tracks that have been developed, each with varying risk levels. Unlike Massachusetts, Delaware decided that participation would not be mandated. ACOs have the freedom to apply if they find the plans attractive. He continued by sharing that Total Cost of Care models can be a “best friend” or “worst enemy”. The system of total cost of care can be beneficial if the practice is able to control high end cost and is able to reinvest the money saved. There are other times that benchmarks are not met because they were unable to manage the cost of a high cost in the geographic area or state and as a result they did not gain any savings. In some cases, they experience loss. The market plays a major factor in the success of total cost of care models. He concluded by adding there are only three, all-payer/total cost of care models in the country (VT, PA, and MD). Rhode Island’s model includes primary care spend and they employed an application process with an end date. Delaware felt the first step would be to see if there was an ACO that would be willing to take on this type of model.

Dr. Donahue added that ChristianaCare fully supports moving to a Total Cost of Care model. Their limited exposure to different risk contracts, have motivated them to make infrastructure changes, team-based model that will drive success. She reports that during this fiscal year starting with July they have increased their new patient visits by 60% over the same time last year. Health systems have access to more resources, however within ACO or clinical integrated networks similar resources can also be brought to bear, with a total cost of care on the back end. She encouraged the committee to seek strategies to look at the full picture instead of simply increasing the fee for service renew related to primary care. She cautioned that the later could result in an increase in spending without achieving the desire outcomes.

Dr. Fan stated that while discussion like this (Medicaid MCO/ACO) are beneficial and knowledgeable, the committee is not a consensus driven process. The goal is to come to an alignment about certain areas that can move forward. She cautioned against the committee focusing on creating one solution to solve the system, instead she encouraged the group to focus on identifying core components of a payment model. She revisited the statement made suggesting the committee consider discontinuing the use of the term “value- based”. She agreed that value-based payment should not only reflect quality metrics. She added that the term value-based payment has varying definitions. Once again, Dr. Fan reminded the collaborative

that they have been charged with developing recommendations and identifying the core components of a payment model that can supported within the state.

The discussion shifted back to the presentation provided by AmeriHealth. Dr. Fan asked Dr. Lawson if there was data to support the PerformPlus program's success in other states. Dr. Lawson affirmed that assumption and added that AmeriHealth has similar programs in other states, that are successful. Dr. Lawson noted that the program designed for Delaware is a broader, more general incentive program. AmeriHealth conducts regular data reviews and successful providers are identified and issued immediate incentives. Dr. Lawson added that the incentives are not chosen arbitrarily. They are in alignment with Sec. Walker's guidance. AmeriHealth is also measured and penalized If their membership does not meet quality thresholds.

Dr. Fan asked if the program will transition into a non-fee for service? Dr. Lawson confirmed that PerformPlus is a fee for service program that includes incentives for quality performance (at the back end). Mr. Groff shared that RFP ACO Medicaid plans he presented do not include any administrative burden or extra reporting. Providers will not be expected to complete additional tasks outside of what they were already providing. Medicaid analyzes the data and calculates the incentives internally. Dr. Fan continued the discussion by stating that she agreed with Dr. Gill and Veronica when they express concern with supporting plans that increase the administrative burden of providers.

Dr. Fan asked if Medicaid considered their provider audience and if the intent is to market to more advanced practices. Mr. Groff reported that they recognize that there will be a group of providers that will not want to or be able to participate in the environment. The goal is to stimulate interest to assess if there is capability to form these groups and to incentivize them. Dr. Fan asked if the committee believes they can reach the goal of having 60% of Delawareans in a value-based payment model. She continued to ask if the members felt the goal was unrealistic or necessary, adding that now is the time to make any necessary edits.

Dr. Gill stated the collaborative's goal should be to enhance primary care. He suggested they consider shifting the focus to how to make primary care work instead of developing value-based payment and total cost of care models. Mr. Groff stated that it is not possible to have a conversation about enhancing primary care without addressing costs.

Dr. Bradley shared that he has an advanced primary care practice for over ten years. One of the problems they are facing is obtaining timely meaningful data that will allow them to assess whether they need to implement changes. His practice is in contract with AmeriHealth. They are beginning their third year this month and they did not receive their first-year data dump until November of this year. Providers cannot make improvements until they have the capability to assess their progress by looking at the data. He added that the cost that are attributed to primary care physicians are outside of the control of the primary care. In the past Medicaid patients were required to obtain authorization from their assigned to primary care provider. This process is no longer required. Dr. Bradley encouraged the collaboration to focus on shifting the cost of hospital care, pharmacy benefits and specialist away from primary care. He stated this practice is driving primary care out of business. Insurance companies give providers failing grades because of these costs. Primary Care providers are frustrated.

Dr. Fan concluded this discussion by stating that within the system of health care it is impossible to address issues without talking about costs. She continued by stating that she believes there is a better model, however she doesn't want the collaboration to be weighed down trying to find the "best". She encouraged the collaboration to focus on first developing a "good" model and then move towards the "best".

Primary Care Reform Collaborative Survey Results

Dr. Fan agreed that the issues surrounding cost are important. She suggested they be discussed in future meetings. She continued by reporting that she was pleased with the points that were mentioned in the survey. The discussion transitioned to the survey recently disseminated to collaborative members. Survey results include responses from 14 of the 17 members. The purpose of the survey was twofold; Assess approach to self-insured organizations for data collection to calculate primary care spend with total health care spend and assess the viability of aligning care model with payment reform. The presentation summarizing survey results is available at:

<https://dhss.delaware.gov/dhss/dhcc/files/erisacremodelsrveyreslts.pdf>.

Dr. Fan began by reviewing the first question regarding accessing claim-based data. There was some discussion about strategies to encourage self-insured employers to provide data voluntarily. Financial incentives were mentioned however it would be difficult to secure funding. The group discussed the possibility of legislation and agreed they would face challenges obtaining the support. Survey results from the question show the majority of collaborative members voted for establishing a Learning Collaborative. A Learning Collaborative would allow the self-insured to learn the benefits of the all-payer claims data based or the health care claims database and the sustainability of primary care. Members present agreed to move forward with making the recommendation to establish a Learning Collaborative.

Kevin O'Hara mentioned there would be some difficulties and challenges with getting the right constituents around the table. He suggested that the group include third party administrators, client groups, and representation from the collaborative. Dr. Fan also suggested they consider forming a subcommittee task force that would include representation from the collaborative. She added that it would be necessary to include representation from the payers and individuals who work directly with the self-insured that understand what the needs and deficits.

Steve Costantino asked if the collaborative is interested in the data to go be included into the health care claims database or to be used to calculate primary care spend. If the collaborative wants primary care spend from self-insured, aggregated data can be collected through the benchmarking process. Steven mentioned that the work would be completed by the Health Care Commission. He reported that he had spoken to the consultant completing the work and they were confident they could obtain the data by including the request with the request for benchmark data. Dr. Fan discussed they want to be able to extract the data from the DHIN through the Office of Value Based Health Care Delivery (OVBHCD). She reminded the collaborative that the OVBHCD has been tasked with calculating the primary care spend. Kevin O'Hara agreed to make the request. Dr. Fan reiterated that the request would include the same years that were included in the OVBHCD, years 2017 and 2018.

Dr. Fan stated that the primary care is foundational to a health care delivery system in Delaware. All present agreed. She asked if the collaborative wanted to recommend a clinical care model that supports a value-based payment model. According to the result of the survey the majority agreed. The core value of a patient centered medical home should be the framework that supports a value-based payment model. Members presented agreed that the collaborative is not tied to the NCQA definition framework of what should be in a PCMH. They agreed to embrace core measures (the four C's). The framework does not need 40 quality metrics. 48 to 80 hours of certification and \$10,000.

The discussion transition to the consideration of other care models. Results from the survey show the majority agreed the collaboration should consider other care models, however members did not include recommendations. Dr. Fan stated that team-based care models can be considered a variation of a patient centered medical home. The difference is these models requires infrastructure. She opened the floor for members to discuss other possible care models. Members were asked to prepare brief presentations of alternative care models and prepare to share them with the group. These alternative care models need to have payment models attached. Dr. Fan reminded the members of the need to move forward with a clear recommendation.

Question four was discussed next. This question covered the agreement to develop a NCQA-like certifying body. The results indicate members do not have strong feelings about this topic. Dr. Fan reminded the members of the presentation Dr. Gill provided that included 12 alternative types of NCQA certifications. Dr. Fan stated that this topic would need to be placed on a future agenda and discussed in more detail.

The results for question five indicate the majority agreed with including additional payment incentives for practices with Patient Centered Medical Home (PCMH) like core values and practice infrastructure. Dr. Fan moved to review the results for question eight ("Building a sustainable primary care practice infrastructure...") These results show that the majority of respondents selected "Care coordination payments" when considering mature practices.

There was a brief discussion surround the Primary Care First model. Dr. Fan noted that 41% of respondents strongly agreed with question 6, "Transitioning practices away from fee for service to alternative value-based payment models could include upfront investments with prospective payments and risk-based incentive payments (Primary Care First)." Some expressed concern that there would not be a significant amount of uptake. It was also mentioned that there was very little interest in making Primary Care First into a multi-payer model. Dr. Gill commented that he was surprised by the level of agreement. He questioned whether the payment would be enough. Dr. Fan mentioned that while not perfect, this model should be viewed as a positive step forward. Dr. Gill agreed with that sentiment.

Recommendations for annual report

Before concluding the review of survey results, Dr. Fan asked if members wished to revisit any of the questions or their results or if they were comfortable developing recommendations. She continued by reminding the members that SB227 mandates the development and presentation of annual recommendations. There was some discussion on how the collaborative would present these recommendations. The previous year recommendations were provided in a report format that included a summary of the minutes. Dr. Muller stated that a report, showing the collaborative's progress and future

goals would be a great idea. All members agreed to develop annual recommendations in the format of the report.

Next, Dr. Fan provided a brief overview of Colorado's Primary Care and Payment Reform Collaborative's first annual report (https://dhss.delaware.gov/dhss/dhcc/files/copcpymtrfrmcollabrcpt_121519.pdf). This report was disseminated in meeting materials. Dr. Fan highlighted the collaborative's definition of primary care spend. She asked the members of the committee it consider topics they want to be included in the calculation of Delaware's primary care spend. These recommendations will be shared with the Office of Value Based Health Care Delivery (OVBHCD). Committee members were asked to email top-level topics they recommend be included in primary care spend calculation.

The last slide of Dr. Fan's presentation included the current consensus of the collaboration. She restated the definition of Primary Care providers as stated in SB227: family practice, internal medicine, geriatrics, pediatrics, physicians, Nurse practitioners, and physicians' assistants. The collaborative also reached a consensus on the recommendations for the Office of Value Based Health Care Delivery (OVBHCD). These recommendations included the use of all-payer claims database (DHIN) to calculate the primary care spend. Members also agreed that a presentation from DHIN would be helpful. Dr. Fan agreed to contact DHIN and extend an invitation to present during a future collaborative meeting. The committee also decided to move forward with the development of a Learning Collaborative.

The group discussed how to handle the specifications of the primary care calculations. Dr. Fan mentioned that Washington did not include non-claims data, but Oregon decided to include them. The collaboration has already agreed to exclude pharmacy and hospital cost. Dr. Fan asked if members felt identifying specifications was the work of the collaborative or the work of the OVBHCD. She continued to report that OVBHCD will be staffed by a consultant is due to open in April 2020. Dr. Gill commented that a high level of technical expertise is necessary to complete specifications. He felt that the committee was not equipped with the required skills. He suggested we allow OVBHCD to handle this work. Kevin Ohara agreed that the committee should not develop the specifications, however he asserted that it was the committee's responsibility to obtain a level of understanding and come to a consensus once specifications had been identified. Dr. Fan suggested we develop a subcommittee to attend meetings with OVBHCD and report progress to the larger committee. Dr. Fan asked that members email their recommendations of top-level topics to be included in primary care spend under specifications. She added that members can provide recommendations on any data collection they wanted included.

Steven Costantino asked if the collaboration was willing to accept a calculation of primary care spend based on 40% (self-insured) of the claims data not being included. Dr. Fan stated that the committee had agreed during a previous meeting that data from the Health Care Claims Database (HCCD) would be used to calculate primary care spend. Members were aware that the ERISA/self-insured data would not be included. Dr. Fan continued her comment by stating DHIN reports the missing data a closer to 35%, meaning the final calculation will capture approximately 60%. Steven Costantino suggested a caveat be listed in the report. Dr. Fan agreed that a disclaimer would be added recognizing the data may be incomplete due to the lack of data from particular groups.

Dr. Fan concluded this portion of the discussion by agreeing to prepare a compilation of the submissions from members and present the list during the next meeting for review, discussion and voting. She asked members to submit their recommendations to her in a timely manner.

Review of Minutes and Adoption of Standard Operating Procedures

Dr. Fan mentioned that the minutes had not been reviewed or approved however due to timing she suggested this order of business be addressed during the next meeting. All members present agreed. At this time Dr. Fan brought members attention to Appendix H of Colorado's report (Standard Operating Procedures and Rules of Order, page 77). She asked the committee if they were interested in adopting standard operating procedures. The mandate to form the collaborative did not include guidelines on appointments (length of time, etc.). Members agreed that everyone should carry voting privileges. There was some discussion regarding whether substitutes carry proxy voting rights. All agreed to grant proxy voting rights to assigned substitutes and develop term guidelines. When possible, members will identify their substitutes in advance of the committee meeting by providing their name to the collaborative chair and co-chairs.

Dr. Fan concluded the meeting by suggesting the collaborative adopt a standard meeting date. She noted there may be some conflicts during the legislative season. She suggested disseminating a poll to assist in identifying a consensus on regular day of each month. All members agreed with this plan. There was no further discussion among committee members.

Public Comment

Dr. Fan opened the floor for public comment. Hearing no other business, Dr. Fan adjourned the meeting at approximately 6:57 p.m.

Next meeting

The next Primary Care Reform Collaborative meeting will be held on Monday February 10, 2020, at the Medical Society of Delaware located at 900 Prides Crossing, Newark, DE 19713, from 5:00 p.m. to 7:00 p.m.

SB 227 Primary Care Reform Collaborative Meeting

Monday, February 10, 2020

5:00 p.m.

Medical Society of Delaware

900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

Present:

Senator Bryan Townsend, Co-Chair
Dr. Nancy Fan, Co-Chair
Representative David Bentz, Co-Chair
Faith Rentz
Veronica Wilbur
Kevin O'Hara
Dr. Jim Gill
Dr. Christine Donohue Henry, MD
Christopher Morris
Steve Groff
Steven Costantino
Dr. Michael Bradley
Dr. Jeffrey Hawtof
Margaret Norris-Bent
Leslie Ledogar

Organization:

Senate Health & Social Services Committee
Delaware Healthcare Commission
House Health & Human Development Committee
State Benefits Office/DHR
Next Century Medical Care/ Delaware Nurses Association
Highmark DE
Medical Society of Delaware
Christiana Care/Delaware Healthcare Association
Aetna
Division of Medicaid & Medical Assistance
DHSS
Dover Family Physicians/Medical Society of Delaware
Beebe Healthcare/ Delaware Healthcare Association
Westside Family Healthcare
Department of Insurance

Absent:

Hon. Kara Odom Walker
Mike Gilmartin
Leslie Verucci
John Gooden

Organization:

Department of Health & Social Services
MDavis, Inc./DSCC
Delaware Nurses Association
MDavis, Inc./DSCC

Staff:

Juliann Emory
Read Scott

Juliann.Emory@delaware.gov
Read.Scott@delaware.gov

Attendees:

Kent Evans
John Dodd
Ayanna Harrison
Jennifer Mossman
Andrew Wilson

Organization:

DCHI
BDC Health IT
Department of Health and Social Services /DHCC
Highmark DE
Morris James

Sylvia Canteen-Brown	Delaware Pediatrics
Elisabeth Scheneman	Department of Health & Social Services
Wayne Smith	Delaware Healthcare Association
Matt Swanson	DCHI
Elizabeth L. Zubaca	Hamilton Goodman Partners, Inc.
Chris Manning	Nemours
Claudia Kane	DCHI
Tyler Blanchard	Aledade
Bill Howard	BDC Health IT
Pam Price	Highmark
Bernard M. Cohen	AmeriHealth Caritas Delaware
Anthony Onegu	United Medical (UMACO)
Sascha Brown	Aetna
Kiki Evinger	Department of Health & Social Services
Liz Zimmer	DHSS

The meeting was called to order at 5:05 p.m.

Welcome

The meeting convened at approximately 5:05 p.m. at the Medical Society of Delaware, 900 Pride Crossing, Newark, Delaware 19713. Dr. Fan welcomed all attendees and noted the full agenda. She explained that in efforts to ensure all agenda items were covered the meeting would move right into the first presentation.

JHU/Arnold Foundation Presentation: Inpatient Prices in DE: A Preliminary Analysis of MarketScan and Medicare Cost Report Data

Dr. Fan introduced the first presenter, Dr. Aditi P. Sen. Dr. Sen is a health economist and assistant professor in the Department of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health. Her research addresses the potential of innovative payment and delivery models, as well as insurance design, to improve the quality and value of health care. Dr. Fan yielded the floor to Dr. Sen.

Dr. Sen's presentation titled, "Inpatient Hospital Prices and Margins in Delaware" began with a brief background of the Arnold Ventures project. The project's focus is to support and inform state-level efforts to lower private sector prices. The analytic component sought to demonstrate the extent of price variation across services, geographies, settings and consumers. The study also compared private sector prices to Medicare prices. Dr. Sen added that Medicare prices are transparent and as a result they are used across the country due. These prices can also be utilized when researching Benchmarks. Dr. Sen continued to explain that the study sought to demonstrate practices out-of-network billing, analysis of hospital costs, margins, and community benefit provision.

Dr. Sen reported that the study used three factors when comparing Delaware hospitals to hospitals in other states. The first, was how much more do private insurers in Delaware pay compared to Medicare? The second factor was, are hospital profit margins higher in Delaware than other states? The last factor examined whether or not Delaware hospitals provide more charity care and community benefit services than hospitals in other states.

Next, Dr. Sen reviewed the summary of the initial findings. She reported that in 2017, the private sector price for an inpatient “basket” of common services was 2.41 times the Medicare price in Delaware. This is above the national average price differential of 2.13. The differential between the private and Medicare price for the inpatient basket in DE (2.41) was higher than in neighboring states. She noted that Pennsylvania’s differential was 1.91 and Maryland’s was a bit lower at 1.35. She continued by sharing that results indicate the median overall hospital margin in Delaware was 11% in 2017, compared to a national median of 3.6%. Hospital profit margins are high in Delaware compared to other states. Lastly Dr. Sen reports hospital-spending (as a percent of expenses) on community benefit as defined by the lower in Delaware at approximately 7%, while the national average for this expense is 9%. A smaller percent of total expenses was spent on charity care and on unreimbursed Medicaid costs among DE hospitals compared to hospitals nationally.

When reviewing the summary of conclusions Dr. Sen reported that Delaware hospitals have profit margins above the national average. The differential between what private insurers are paying and what Medicare pays is higher in DE than in many other states, and higher than in neighboring states. Delaware hospitals provide a smaller percentage of charity care than hospitals in other states (1.1% total expenses compared to 2.0% nationally). Across hospitals, Delaware hospitals spend a smaller proportion of total expenses on uncompensated Medicaid (1.9% compared to 4.1% nationally). It has been debated that this cost is not considered a community benefit, because the state determines the amount of Medicaid payment. However, Dr. Sen pointed out that it is defined as such by the IRS. Dr. Sen also shared that the calculated average is low because of the small number of hospitals (five total) in the Delaware found within IRS data. Two of the five hospitals spend 0%; 1 hospital spends 6.7% total expenses on unreimbursed Medicaid.

The analysis includes data from three sources (private sector, Medicare, and hospital profitable margins/community benefits). MarketScan Commercial Claims database was used to collect private sector data (private prices). This database captures 25-35% of the commercially insured nationally and covers a broad range of insurers. Dr. Sen reports the main limitation of this dataset is cannot see provider level data. Mean dollar amount for the inpatient basket. Hospital Financial Performance data was taken from the Centers for Medicare and Medicaid (CMS), 2017 Medicare Cost report. Lastly data was pulled from the IRS 990 forms to analyze hospital community benefit as a percent of total expenses. Dr. Sen reviewed the data slides pointing out highlights detailed in the summary of findings and summary of conclusions.

Dr. Sen concluded by reviewing Medicare Payment Advisory Commission (MedPAC) examination of the ability of hospitals to accept lower prices. MedPac finds that costs are flexible, and hospitals generally respond by lowering their costs. Dr. Sen suggested members review the appendix provided in their materials and she agreed to answer any questions.

Dr. Fan thanked Dr. Sen for agreeing to come and present this data. Dr. Fan reiterated that one of the mandates of the collaborative to increase the investment into Primary Care without increasing the total cost of spend. She added that it is important for the collaborative to be knowledgeable about where spending is happening in other areas. Dr. Fan transitioned the meeting to the next presenter, Faith Rentz who will provide an overview of the State Employee Benefits Committee initiatives.

A copy of Dr. Sen's presentation is available at https://dhss.delaware.gov/dhcc/files/jhu_de_prices02102020.pdf.

State Employee Benefits Committee Commentary with Faith Rentz

Faith Rentz began her presentation by sharing some details about the State Employee Benefits Committee (SEBC). The committee consists of 9 elected appointed state officials statutorily mandated with the task of managing the benefits administration and the budget for the state employee health plans (covering 127,000 covered lives). The goal of the committee is to provide overview of State Employee Benefits Committee's focus on value-based contracting and improving access to primary Care. She reviewed the strategic framework developed three years ago, which includes developing strategies and tactics that are tied to specific goals. There are four components included in the mission of the strategic framework (ensure adequate access to high quality healthcare that produces good outcomes at an affordable cost, promotes healthy lifestyles, and helps them be engaged consumers.) To address adequate access to high quality health care the group establish a goal to include the addition of at least net 1 value-based care delivery (VBCD) model by end of FY2018. When looking at ensuring affordability the group establish a goal reduce the group GHIP medical prescription drug trend by 2% by the end of FY202. Lastly, the group set a goal to increase health lifestyles and engage consumers by driving membership reenrollment in a consumer-driven or value-based plan exceeding 25% of total population by the end of FY2020.

Ms. Rentz reports that SEBC contracted with Highmark and Aetna for advanced care management/coordination programs and other value-based care delivery models. She reported that they have implemented programs and changes to drive efficiencies in spend. Ms. Rentz also reports that Group Health Insurance Program (GHIP) has engaged SEBC in discussions of a framework for advanced payment models to understand current Delaware providers' engagement in upside/downside risk sharing arrangements. Ms. Rentz shared details of SEBC's partnerships with Highmark (Enhanced care management program and True Performance) and Aetna (Advanced Care Management/ChristianaCare's CareVio program).

Ms. Rentz reports that the medical spend for the year ending in June 20, 2019 was approximately 6 million dollars. She presented the totals for select areas: Physician Outpatient at \$69.3, Other Professional services at \$73.3, Facility Inpatient at \$123.1 and Facility Outpatient at \$153.5). Ms. Rentz highlighted that both "Other Professional Services" and "Radiology Outpatient" show significant increases when reviewing trend data (8.4% and 10.2%). Ms. Rentz reports actions taken include participating in the RAND study. RAND is a non-profit organization that collects self-insured employers, all-pay claims database, and hospital pricing information. Results are expected to be released during the first quarter of 2020. She added they are employing direct provider contracting via SurgeryPlus and providing incentives to members for utilizing lower cost sites of care by offering either a low to no co-pay. Ms. Rentz also noted the implementation of a lower co-pay for urgent care or telehealth services. This action was introduced in efforts to provide other options for members who are unable to reach their primary care provider or those that might consider the ER. Lastly, they continue to evaluate market readiness and options for expanding access to primary care.

Ms. Rentz shared the Alternative Payment Model (APM) framework slide. They are working with committee (SEBC) and walked through the model to help the understanding of the framework. She also reports working with Aetna and Highmark in later half of 2019 to determine where we are currently in the DE

marketplace in terms of providers. They also discussed their projections the movement of providers along the four categories of providers over the next three to five years.

Future work includes updating strategic framework goals and using the APM framework and working towards increasing spend in high categories through the advancement of APMs. They plan to increase goals and targets around reducing the spend for diabetic population. They are attempting to limit the total cost of care at a level commensurate with the Health Care Spending Benchmark. They are also looking into options that suit different demographics to address the changing demographic profile. Lastly, they continue to evaluate the readiness within the state market to provide innovative approaches to reducing total cost of care. They will also explore opportunities to expand access to primary care in the state.

During the January meeting the group voted to give the benefits office permission to develop and release a Request for Information (RFI). The RFI will be released in the beginning of the second quarter. The information collected will help promote innovation to decrease total cost of care while not reducing quality. Also, to gain a better understanding of the interest from, and readiness of, the Delaware market to go deeper into more advanced categories of the APM framework. Lastly, they seek to Identify third party providers that could play a role in the Delaware health care marketplace to support the goals of the SEBC. Responses to the RFI will be used to shape the development of the medical TPA RFP, which will kick off internally within the Statewide Benefits Office in January 2021.

She concluded by sharing next steps which include engaging local provider communities and other stakeholders, continue to evaluate other opportunities to drive investments in primary care, and review other data sources for health car provider cost and quality data.

A copy of Ms. Rentz's presentation is available at https://dhss.delaware.gov/dhcc/files/sbo_pccpresntion02102020.pdf

Dr. Fan thanked Ms. Rentz for her presentation. She transitioned the meeting to questions for Dr. Sen from committee members, mentioning questions for Ms. Rentz would follow. Dr. Gill addressed Dr. Sen regarding her choice to limit the hospital services data to include inpatient hospital services only. He also inquired about the comparison of Medicare. He stated that Medicare procedures are generally overvalued with relatively high rates for procedural services.

Dr. Sen thanked Dr. Gill for his question. She stated that collecting accurate outpatient data is difficult as the payments are received from several different payment lines. Medicare includes different rules for bundled services. She added that RAND studies do include this data and their results have indicated Dr. Gill's reference regarding higher thresholds with a lot more variation. She added that their study did not include this data because calculating the Medicare denominator for that ratio on the outpatient side is very complicated. Only about 40% of commercial outpatient claims found could be easily matched to a Medicare price. There are several different payment systems captured in outpatient settings. She continued by addressing Dr. Gill's second question. She stated that broader conversations are happening among states about the use of Medicare data to establish benchmarks and what services it incentivizes.

Veronica Wilbur commented on the increased health care provider mix. She stated that Nurse Practitioners and Physician's Assistants are not allowed to participate individually in value-based payments or ACOs and

their fee-for-service is counted at 15%. Dr. Sen agreed, stating that when you take into account the mix of health care providers, the interaction between pricing and alternate payment models (APM), where there are more or less prevalent, and how many providers and hospital systems are engaged, all of that make pricing difficult.

Dr. Hawtoff inquired about Dr. Sen's choice to utilize data on joint replacements, cesarean section and vaginal delivery when analyzing inpatient private prices. Dr. Sen responded by sharing that deliveries are 25% of all inpatient baskets, nationally. She added that the inpatient basket includes the 15 most frequent hospital services in terms of volume, ranked by Diagnosis Related Group (DRG). She added that the analysis compared pricing not utilization. Dr. Hawtoff also asked Dr. Sen about the choice to use Maryland's Medicare data to compare to Delaware. Maryland's system of reimbursement in Medicare is vastly different than any other state in the country. Dr. Sen answered by sharing that the analysis simply wanted to share Delaware's neighboring states.

Dr. Hawtoff drew Dr. Sen's attention to slide 9, asking for the definition of the term "overall margin". Dr. Hawtoff stated that in his time at Beebe he had not seen an overall margin this large. Dr. Sen responded by sharing that source of this data is collected from Medicare Cost reports. She continued by stating the cost reports do not provide strong detail about how "revenue" is broken down. Dr. Hawtoff was concerned that the data was shared without validating with individual communities. Dr. Sen highlighted that the data submitted could vary by hospital. Details on the data that has been included is not provided. Dr. Hawtoff suggests that given this information this data set may not be the best suited to analyze. Members pointed out that every state has submitted the same data and that the cost reports are submitted by the individual hospital systems. Dr. Hawtoff expressed concern with the accuracy of the data and the use of analysis results to develop policy and decisions. The methodology used to report their data is based on regulations so the difference in their self-reported data and the data presented/shared was concerning.

Dr. Fan suggested the focus be shifted to identifying spend trends and developing strategies to improve them. She added that data is only as accurate as what we collect. She suggested the process be reviewed, tightened and improved instead of questioning the analysis. The data is being collected in the same way for each entity in the analysis. Dr. Fan reminded members that the focus isn't "us" against "them". The focus is to ensure the "patient" receives quality services and improved access to care. She continued by stating that members should work together to develop strategies to assist self-insured, large employers who may want move away from their current spending.

Dr. Donahue with ChristianaCare, shared that the data provided them with the opportunity to improve their care delivery models. She added that closely examining acute hospitalization fee for service rates is a small portion of what needs to be done. She continued by adding that transforming care will begin with discussing value of care and identifying different ways to deliver care. Dr. Donahue mentioned there was some concern with the accuracy of the data. Dr. Donahue pointed out that trends are important, especially trends in community benefit. She also wanted to share that the point of the margin they are shooting for at ChristianaCare will be reinvested in their primary care expansion and infrastructure to support the social care framework. She concluded by emphasizing the importance of maintaining a holistic viewpoint when summarizing results.

Kevin O'Hara with Highmark asked Dr. Sen if the analysis provided some insight for the differences in numbers in Delaware and surrounding states. He asked if the data indicated if demographics or competitive environment were factors. He also asked if the analysis touched on the affordability in Delaware versus the surrounding states.

Dr. Sen responded by sharing that the analysis did not specifically cover affordability in Delaware versus surrounding states. She added that their data does include out of pocket payments and these cost would be the best measure of affordability that they have in their data. If there is interest, additional analyses can be conducted, and the data can be shared with the group.

Kevin O'Hara followed up with a question about the unique delivery system in the state and how it translates in the cost data. Dr. Sen reports that they are doing additional analyses to find an explanation for the price differentials between private and Medicare prices and what factors lead to the variations.

Preliminary data indicates provider landscape may be a factor. Places that have larger hospitals, generally translates into concentrated markets and they tend to have higher price differentials. Areas that have higher Medicaid to Medicare fee indexes have high differentials are also suggestive of negotiation advantage. Dr. Sen reports that the data did not identify clear indicators, and it is difficult to pick up trends with aggregated data. She concluded by emphasizing states typically have a better idea of what is driving costs.

Kevin O'Hara of Highmark pointed out that Maryland's regulations allow hospitals and payers to enter into custom arrangements around procedure types, in efforts to impact utilization and lower costs from the back end. He believes this may be contributing to the variation seen in the Medicare data (35% higher).

Dr. Fan shared that it is her belief that Delaware is regionalized by health care system. Analyses conducted by region may provide insight regarding the impact of reinvestments. Do reinvestments improve access to primary care, behavioral health integration and overall health outcomes for the particular regions?

Dr. Fan highlighted that the primary care spend for the SEBC was documented at 3.8%. She was surprised with this number. She added that the low number could indicate a healthy patient population that doesn't require a lot of investment in primary care, however in her opinion the investment percentage should at least reach 5% for any patient population. She opened the discussion to members with questions for Dr. Sen.

Dr. Mike Bradley of Dover shared with the group that it is his understanding that Kent General Milford recently spent 3 million to build a new hospital. He also added that the hospital system has also purchased several primary care practices throughout the community. As a result, primary care practices have been negatively impacted. He reports that his margin of profit is negative as he is unable to compete with hospital based systems. He has eight providers and he has lost one physician and a physician's assistant who were hired by the hospitals. He shared that he knows of a few physicians that have made this move and they report a higher salary while caring for less patients. He concluded by stating that he does not believe this is increasing access to care. He suspects the funds to pay physicians at higher rates come from inpatient and ancillary services. He also believes these systems are purchasing primary care physicians but not utilizing them as they would if they were independent practitioners.

Before transitioning to questions for Faith Rentz, Dr. Fan asked members if they had any last questions for Dr. Sen. Steve Costantino asked Dr. Sen if the non-patient revenue was included in the cost reports. Dr. Sen answered by stating that this cost is included with "overall".

At this time Dr. Fan asked the members if there were questions for Faith Rentz. Dr. Mike Bradley began the discussion by expressing his disappointment with the total primary care spend for the state employee health benefits (SEB being under 4%). He mentioned his concern with the proposed expansion of primary care access, Ms. Rentz shared during her presentation. The proposal includes an increase in tele-health and work-based clinics. Dr. Bradley suggested these funds be poured into primary care practices so they can provide these services and have the ability to hire more physicians. He also shared that school health-based clinics are great; however, providers have noticed patients do not return to practices. He shared a concern of a similar outcome with the implementation of work-based clinics. Lastly, he stated that he believes every dollar placed into primary care equals a savings of two to three dollars.

Ms. Rentz responded by stating that some of the more recent models they have researched include establishing primary care practices in locations that are convenient to their members. She continued by stating SEBC is hoping the Request for Information (RFI) will allow them the opportunity to work with providers, their insurers and other stakeholders to develop ideas that can be incorporated into a Request for Proposal(RFP) when they bid in 2021 for a Health Management Administration. Dr. Bradley added that primary care providers are undervalued, and private practice physicians may move to hospitals to survive.

Dr. Chris Donahue highlighted the importance of offering a variety of options for consumers. The needs of consumers are diverse. Traditional models of providing primary care in an office may not work for all. Access to primary care via tele-health and within workplaces may be more accessible for some.

Veronica Wilbur shared her concern for the absence of offering a mix of providers like Nurse Practitioners. She stated that Nurse Practitioners are undervalued and underrated and not capitalized on in the state. There are very few Nurse Practitioner practices in the state.

Dr. Hawtoff addressed the members, highlighting the decrease in trends related to facility in-patient and physician inpatient treatments. He shared that BeeBe has experienced significant success with risk-based models. The investments Beebe has placed into care delivery (care coordination) models, have allowed them to create savings in the millions over only a few years. He reports that Beebe has been able to share these savings with insurance companies. He added that Beebe has begun to discuss options with Blue Cross and Aetna to continue work around these care models. He shared that their quality scores are phenomenal, and the reduction in cost is working for everyone. Patients are doing better.

Kevin O'Hara shared that he was very interested in meeting with Dr. Hawtoff to discuss the results around increased quality and decreased cost. Dr. Hawtoff agreed to meet with Mr. O'Hara.

The members of the collaborative spent time discussing the four categories and identifying where practices and hospital systems in the state fit on the spectrum. Dr. Hawtoff reports that BeeBe is currently in the

three range and their goal is to move into category four. Kevin O'Hara reports that Highmark has a few ACOs moving into the 2-3 range, however the vast majority are in the 1 to 2 range.

Steven Costantino mentioned that the framework features current state and future state and includes a bubble chart for free for service. He continued to add that anything three to the left is based on fee for service architecture or fee for service model. Most payments are within the one range. He concluded by stating that there has been movement but the road to value has been a very slow progression.

The members began to discuss the four categories of the care model. Chris Morris of Aetna agreed that their providers are falling within 1 and 2. Steve Groff agreed with Dr Fan's assessment that the RFP with Medicaid would likely move practices from category 1 into category 2. Dr. Fan asked the members if they feel comfortable promoting a PCMH-like program that includes enhanced investments, to assist providers/practices to move from 1 into category 3. She concluded her thought by challenging the collaborative with identifying a source of funding.

Dr. Fan shared a slide from a presentation given by Jennifer Swartz. Ms. Swartz shared that they calculated they spent at \$22 for PMPM for their Trinity ACO to be successful. Dr. Fan invited Tyler Blanchard from Aledade ACO to provide an overview of his organization to the members. Mr. Blanchard reports that their ACO is currently in multiple states and they have been in Delaware for 5 years. The ACO works with 30 independent primary care practices, including Dr. Gill. Mr. Blanchard shared that their central functions are based out of Bethesda, Maryland. They have cost both at the local level and behind the scenes. Mr. Blanchard stated that Aledade spends close to 1 million a year to operate their ACO in Delaware. He pointed out that it is a long-term investment adding that if they do receive shared savings the payment comes the following year. There are also costs to the practices. Mr. Blanchard shared that Dr. Gill's cost are separate and may include: having Health Care Coordinators on staff, making room in his schedule for patients who need a same day appointment, providing risk code training for his team, educating patients on the alternatives to using the Emergency Room, and ensuring phone coverage for patient calls (including weekends).

Dr. Fan asked if Aledade providers offer concierge services. He added that concierge services may have better outcomes and better care delivery model, however she does not believe these services increase access to primary care. Mr. Blanchard responded to Dr. Fan's question about concierge services by sharing that 5 of the 30 Aledade practices have concierge services. He shared that the providers made these decisions on their own and it is a trend in state. He agreed, stating that these providers are caring for 200 patients instead of 2000.

Dr. Donahue pointed out that the Trinity ACO example included Medicare patient population so the \$22 PMPM would not apply to a commercial population. She added that they had 15% of the total medical spend at-risk, this kind of downside risk is a motivator and it forces the investments. Dr. Fan agreed and stated that 15% risk is a high risk for most providers. She added they had 100,000 Medicaid patients which is a very large patient population. She shared this example to illustrate how much it cost to set up this type successful infrastructure.

Dr. Fan asked members to identify a reasonable benchmark. She continued by asking if 2.4% what will be acceptable to the state. Dr. Sen suggested that the collaboration consider setting a reference price for different populations, instead of attempting to impact the entire state population at the same time. Steven Costantino suggested that the collaboration consider setting a benchmark and working through phases over three- or four-year period. Dr. Fan agreed that nothing would be immediate it would have to be three- or five-year plan. She concluded her statement by adding that if there is interest in increasing the investment into primary care, members will need to identify how the funds will be received.

Dr. Fan stated that during the next meeting, committee members will bring proposals and a vote will be taken. She encouraged members to bring concerns or issues to the next meeting.

Dr. Bradley asked the insurers present, if there was a way to reduce outpatient cost paid to hospital-based practices. Kevin O'Hara of Highmark stated that the landscape within the state does not include competing outpatient options. A suggestion was raised to develop regulations on the price of the cost of things like echocardiograms. Dr. Sen reported that Connecticut does have similar regulations. Dr. Fan reminded members that the goal of the collaboration is not to develop regulations for specific procedural. Dr. Sen added that we can recommend regulations but not down to procedures or claim codes.

Dr. Fan reiterated the importance of making decisions and recommendations for next steps. She tasked each member of the collaborative with submitting a proposal that will be reviewed during the meeting scheduled for March 16th. Dr. Fan asked that all proposals be sent to Read Scott by March 6th to allow for review prior to the meeting. Members were asked to submit proposals with recommendations for primary care investment strategies that include the identification of the funding source for the investment. Dr. Fan reminded members of the different approaches that had been mentioned in past meetings when discussing hospital spend. Members discussed using an incremental (over a few years) percentage approach and the use of an absolute benchmark for price differentials (over a few years). She encouraged members to consider other creative approaches. Dr. Fan transitioned the meeting to the review of the minutes.

Review of the November 2019 and January 2020 Minutes

Dr. Fan asked the committee members if they had any comment on the draft minutes from the Primary Care Reform Collaborative meetings, held on November 12, 2019 and January 8, 2020. Hearing no discussion Kevin O'Hara motioned to approve minutes as amended. Dr. Gill seconded the motion. The motion to approve was unanimously carried. View approved November 12, 2019, meeting minutes here: <https://dhss.delaware.gov/dhcc/files/pccmeetingminutes11122019.pdf> View approved January 8, 2020, meeting minutes here: <https://dhss.delaware.gov/dhcc/files/pccmeetingminutes01082020.pdf>

Update on Department of Insurance/Office of Value Based Health Care Delivery

Leslie Ledogar provide a brief update from the Department of Insurance on the progress to implement the Office of Value Based Health Care Delivery. Ms. Ledogar reports that they received five bids from across the nation. She was excited to announce that the evaluation team had completed their reviews and results/scores were submitted to Commissioner Navarro four days in advance of the February 10th deadline. The Commissioner will make the final decision and contact the awardee. The Department will enter into contract negotiation with bidder, if terms can be reached the awardee will become the head of the new

Office of Value Based Health Care Delivery. At that time the other bidders will be notified that they were not successful for this RFP.

Dr. Fan reviewed the decisions made by the collaborative as they relate to the operations of the OVBHCD. The list of primary care providers (Family practice, internal medicine, geriatrics, pediatrics, Physicians, NPs, and PAs) that would be included when calculating primary care spend was reviewed. She stated that during a previous meeting the collaborative agreed specifications would be formulated by OVBHCD with input from the collaborative. The specifications would include outpatient and office expenditures only. She asked if a final decision was made regarding the collection of non-claims payment data. Several members reported the collaborative decided to utilize aggregate data from contributors to the ACPD (DHIN). Dr. Fan continued by asking if topic recommendations about specific areas beyond outpatient office expenditures had been made. Members agreed that no recommendations were made outside of outpatient and office expenditures at this time.

The discussion moved to need or desire to establish a subcommittee to meet with the OVBHCD lead. Ms. Ledogar suggested that the collaboration give the awardee some time to share their plans/approach before sharing our expectations. She reminded the collaborative that the bidders were experts from all over the country. Members agreed to extend an invitation to the newly awarded lead of OVBHCD to present at the April meeting. After the awardee is announced, Dr. Fan agreed to initiate the invitation. All agreed that recommendations will be held until after hearing the plan/approach of the OVBHCD.

Legislative Updates

Dr. Fan reported that Delaware State Senate, 150th General Assembly, Senate Bill No. 200 passed and was just signed today, February 10, 2020, by the Governor today. This is an act to amend the Delaware code relating to the Delaware Health Information Network (DHIN). The bill states that DHIN shall provide access, at no cost, to all claims data reported by the Delaware Health Care Claims Database under this subchapter to the following state agencies for the purposes of public health improvement research and activities: Office of Management and Budget, State Employee Benefits Committee, Division of Public Health, State Council for Persons with Disabilities, Division of Medicaid and Medical Assistance, Department of Insurance, and the Delaware Health Care Commission. Details about SB200 can be found here:

<https://legiscan.com/DE/text/SB200/id/2080563>

Dr. Fan continued her report on Legislative updates by sharing that SB206 is now in the Senate. This bill is an act to revise the appointment process for members of the Primary Care Reform Collaborative who are not members by virtue of position. Under this Act, these members are appointed by a government official to comply with the requirements of the Delaware Constitution. This bill is sponsored by Senator Townsend and co-sponsored by Representative Townsend. On January 29th it was reported out to Committee in Senate with 4 on its merits. Details about SB206 can be found here:

<http://legis.delaware.gov/BillDetail?LegislationId=47988>

Dr. Fan reminded the collaborative of the mandate to submit an annual report to the General Assembly and the Delaware Health Care Commission. The report will include activities and progress of the collaborative and future goals and plans. She reviewed several recommendations that would be included in the report. In line 25 of SS1 for SB116 it states that the collaborative can develop the definition of operating procedures.

During the last meeting members agreed proxy representatives will have voting rights. Attendance of a proxy must be communicated to co-chairs prior to meeting so they may be included in meeting communication and information. Term limits as described in SB116 and SB206 are limited to two years with appointment. This excludes ex-officio positions. All agreed a quorum (10 of 17) is necessary for voting. Lastly, meeting information and materials will be disseminated to members one week prior to each meeting date.

Recommendations resulting from survey results

Dr. Fan presented current recommendations based on the survey results:

- Primary care is the foundational to health care delivery in DE
- Practices which demonstrate a team based or PCMH like delivery of care should have more upfront investment
- Initial increase in upfront investments should be tied to an agreed upon definition of “risk” and “value” as well as overall cost saving benchmark
 - Increased PMPM, care coordination payments, non-claims payment
- ERISA Plans:
 - Provide a Learning collaborative – creation of subcommittee
 - Voluntary contribution of data -request aggregated from TPA or specifications in to APCD

Dr. Fan summarized by stating that the results from survey indicate the majority agreed that upfront investment is a good way to help patient center medical homes or team based like practices transition to a value and risk based incentive payment like Primary Care First Model and that increased prospective payments should be tied to risk and value based payment models. She added next steps should be to identify the last set of recommendations about where the funding should come from. She called for discussion and stated that if members had any questions or opposition now would be the time to share. If members had no comment the recommendations would be included in the annual report as shown.

Dr. Gill stated that he did not believe the collaborative agreed that upfront investments would be tied to overall cost savings benchmarks. It was his belief that group agreed that value would be tied to accountability, primarily tied to the “Four Cs”. Several members disagreed. Dr. Fan agreed to revise the statement by including risk and value based and accountability. Dr. Fan asked if there were additional comments. Kevin O’Hara suggested upfront investments in primary care should be linked to increase in quality and decrease in cost. Dr. Fan reminded him that this discussion was focused on recommendations that resulted from the survey. At that time, Dr. Fan opened the floor for public comment.

Public Comment

Wayne Smith, Health Care Alliance addressed the collaborative by raising his concerns regarding progress being driven by agreements to studies and suggestions with questionable data. He continued his comments by addressing the calculation reported by the State Benefits Office that indicated state employees spend 3.8% on primary care. He shared that Willis Tower Watson has found that state employees tend to be older and less healthy than the general population. He suggests that this calculation does not provide a clear picture, adding that a per capita comparison of 50-year-old state employees versus the entire 50-year-old population would be a more accurate representation.

He also mentioned concern with Dr. Sen's use of Maryland data as a comparison and pointed out that the Maryland's use of a unique waiver system. He shared results from an article published this year that reports Maryland's Medicare rates are 40% higher than other states. This rate disparity will show lower rates. His calculations show Medicare Maryland with \$5,277 and Delaware at \$3,762. He stated he did not believe the basket of services used in the Dr. Sen's study, capture the complete picture. Mr. Smith also mentioned several issues with comparing Pennsylvania data with Delaware. He concluded by stating that in his opinion the collaborative did not have enough high quality, uniform, comparative data to support benchmark proposals that will change the relative investments in primary care versus non-primary care.

Dr. Fan thanked Mr. Smith for his comments. She asked if anyone from the public had additional comments. There were no none.

Dr. Fan reviewed the upcoming meeting dates with the group. The meetings will be held on the third Monday of each month, ending in May. A June date has been scheduled; however, this meeting may not be necessary. She concluded by reminding members that next meeting agenda will include the review of proposals, concluding with a vote and decision made for recommendations to be presented in the annual report.

Hearing no other business, Dr. Fan adjourned the meeting at approximately 7:00 p.m.

Next meeting

The next Primary Care Reform Collaborative meeting will be held on Monday March 16, 2020, at the Medical Society of Delaware located at 900 Prides Crossing, Newark, DE 19713, from 5:00 p.m. to 7:00 p.m.

Appendix B
Primary Care Reform Collaborative
Meeting Materials

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Paying Primary Care Providers for Care Coordination: *Considerations and Evidence from Other States*

Kelly Anderson, MPP
Jessica Hale

February 18, 2019

Overview

- **What is the evidence on the effectiveness of care coordination PMPM payments?**
 - Care coordination PMPM payments have been shown to reduce costs and improve quality when partnered with a model for care delivery
- **Do accountability mechanisms exist to track the effectiveness of care coordination?**
 - Yes, there are more than 100 published measures
 - Mechanisms include CPT codes, EHR documentation, and process, cost, and quality measures
- **We conclude: A clinical model plus a payment approach to enable the model can lead to improved outcomes**

What are approaches to pay primary care providers for care coordination?^{1,2}

- **Per member per month (PMPM):** Payment to providers, in this case intended to cover care coordination services not covered under traditional reimbursement for clinical services
- **Pay for performance (P4P):** bonus payment given to providers if they meet agreed-upon quality performance measures or improve performance (on top of FFS to incentivize quality)
- **Traditional capitation:** Prospective payments that are independent of visit volume and can support paying for all care both inside and outside of a traditional visit, often using risk adjustment and quality measures to mitigate the risk of inappropriate underutilization of services

1. Gold, S. B., & Park, B. J. (2016). *Effective payment for primary care an annotated bibliography*. () Washington, DC: Starfield Summit. Retrieved from https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/StarfieldSummit%20Annotated%20Bibliography_Payment-FIN.pdf

2. Park, B., Gold, S. B., Bazemore, A., & Liaw, W. (2018). How evolving united states payment models influence primary care and its impact on the quadruple aim. *Journal of the American Board of Family Medicine : JABFM*, 31(4), 588-604. doi:10.3122/jabfm.2018.04.170388 [doi]

What are approaches to pay primary care providers for care coordination?^{1,2}

- **Shared Savings:** Providers held accountable for the quality, cost, and experience of care of an assigned population. If costs are below set financial targets, the providers get to keep some of the savings
- **Total Cost of Care (TCOC):** Provides a risk-adjusted payment to an entity that is responsible for the full range of medical services (hospital and outpatient) for their patient panel. In some models the responsible party is the hospital, in other models a provider group or ACO may be assigned responsibility. Reductions to TCOC occur through using patient-centered care teams and primary care enhancements

1. Gold, S. B., & Park, B. J. (2016). *Effective payment for primary care an annotated bibliography*. () Washington, DC: Starfield Summit. Retrieved from https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/StarfieldSummit%20Annotated%20Bibliography_Payment-FIN.pdf
2. Park, B., Gold, S. B., Bazemore, A., & Liaw, W. (2018). How evolving united states payment models influence primary care and its impact on the quadruple aim. *Journal of the American Board of Family Medicine : JABFM*, 31(4), 588-604. doi:10.3122/jabfm.2018.04.170388 [doi]

Payment reform can leverage these payment tools in combination with a model for care delivery^{1,2}

- Examples of payment models include:
 1. Patient centered medical home (PCMH)
 2. Comprehensive Primary Care Plus (CPC+)
 3. Health Home
 4. Accountable Care Organizations (ACOs)
- Common elements of successful models include:
 - Clear goals for outcomes with a vision for how care will be delivered
 - Timely and accurate data sharing
 - Risk adjustment to account for differences in patient panels
 - Prospective payments to allow practices to make upfront investments
 - Payments connected to a focused set of metrics and performance on the 4 C's (contact, continuity, comprehensiveness, and coordination)
 - Use of multidisciplinary care teams

1. Gold, S. B., & Park, B. J. (2016). *Effective payment for primary care an annotated bibliography*. () Washington, DC: Starfield Summit. Retrieved from https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/StarfieldSummit%20Annotated%20Bibliography_Payment-FIN.pdf

2. Park, B., Gold, S. B., Bazemore, A., & Liaw, W. (2018). How evolving united states payment models influence primary care and its impact on the quadruple aim. *Journal of the American Board of Family Medicine : JABFM*, 31(4), 588-604. doi:10.3122/jabfm.2018.04.170388 [doi]

What is the evidence on the effectiveness of care coordination PMPM payments in Patient Centered Medical Homes?

Outcome	Evidence by State Program
Costs	<ul style="list-style-type: none">North Carolina (\$3 PMPM for care management and \$2.50 for medical home activities)¹: \$184 million in savings and 7.87% relative PMPM savingsIllinois (PMPM management fees and bonus payments)²: annual savings of 6.5-8.6% with \$1.46 billion Medicaid savings; inpatient costs declined by 30.3% but outpatient costs roseNew Jersey (\$3-\$5 PMPM care coordination fee with optional performance bonus)³: patient costs decreased but not enough to cover PCMH programNew York (payments use 63% as a risk-adjusted base, 27% as bonus, and 10% FFS)⁴: one model finds a 6-8% reduction in health care spending growth
Quality & Utilization	<ul style="list-style-type: none">North Carolina (\$3 PMPM for care management and \$2.50 for medical home activities)¹: the rate of inpatient admissions declined from 420 per thousand per year to 384 per thousand per year from 2007 to 2011Illinois (PMPM management fees and bonus payments)²: quality improved across all metrics but one (metrics included cervical cancer screening, colonoscopy, and diabetes)New Jersey (\$3-\$5 PMPM care coordination fee with optional performance bonus)³: mixed results on quality measures and no change in utilization

1. Fillmore, H., DuBard, C. A., Ritter, G. A., & Jackson, C. T. (2014). Health care savings with the patient-centered medical home: Community care of north carolina's experience. *Population Health Management*, 17(3), 141-148. doi:10.1089/pop.2013.0055 [doi]
2. Phillips, R. L., Jr., Han, M., Petterson, S. M., Makaroff, L. A., & Liaw, W. R. (2014). Cost, utilization, and quality of care: An evaluation of illinois' medicaid primary care case management program. *Annals of Family Medicine*, 12(5), 408-417. doi:10.1370/afm.1690 [doi]
3. Patel, U. B., Rathjen, C., & Rubin, E. (2012). Horizon's patient-centered medical home program shows practices need much more than payment changes to transform. *Health Affairs*, 31(9), 2018-2027. doi:10.1377/hlthaff.2012.0392
4. Vats, S., Ash, A. S., & Ellis, R. P. (2013). Bending the cost curve? results from a comprehensive primary care payment pilot. *Medical Care*, 51(11), 964-969. doi:10.1097/MLR.0b013e3182a97bdc [doi]

What is the evidence on the effectiveness of care coordination PMPM payments in Health Homes & ACOs?

Outcome	Evidence by State Program: Health Homes ¹
Costs	<ul style="list-style-type: none">Missouri (care coordination for complex patients): \$5.7 million saved from reduce hospitalizations, \$2 million saved in Medicaid, and \$148 PMPM saved on average
Quality & Utilization	<ul style="list-style-type: none">Missouri (care coordination for complex patients): hospital admissions reduced by 5.9% and ED use by 9.7% per 1,000 enrollees as well as improvements in blood sugar, cholesterol, and blood pressure levels
Outcome	Evidence by State Program: ACOs ²
Costs	<ul style="list-style-type: none">Medicare Shared Savings Program (risk-adjusted PMPM and bonus payments): ACOs earning shared savings is increasing (24% in 2013 to 30% in 2015), with \$429 million in total program savings in 2015Pioneer ACO (higher shared savings and risk with prospective PMPM option): Six of the 12 ACOs qualified for shared savings and one repaid losses in 2014
Quality & Utilization	<ul style="list-style-type: none">Medicare Shared Savings Program (risk-adjusted PMPM and bonus payments): 84% of quality measures were improved in both 2014 and 2015Pioneer ACO (higher shared savings and risk with prospective PMPM option): quality scores increased on average, from 87% in 2014 to 92% in 2015

1. MO HealthNet. (2014). Missouri primary care health homes: interim evaluation review summary. Jefferson City, MO: MO HealthNet. Retrieved from https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/mo_healthnet_primary_care_hh_interim_evaluation_report_summary.pdf
2. Kocot, S. L., & White, R. (2016). Medicare ACOs: Incremental progress, but performance varies. Retrieved from <https://www.healthaffairs.org/do/10.1377/hblog20160921.056715/full/>

What is the evidence on the effectiveness of care coordination PMPM payments in other models?

Outcome	Evidence by State Program
Costs	<ul style="list-style-type: none">Iora Health (receives fixed, risk-adjusted PMPM from payers and incorporates additional payments for meeting quality or use targets)¹: One Iora case study reports a 12.3% decrease in expendituresMichigan (fee-for-value (P4P program) incentivizing coordination, quality, and low costs)²: 1.1% lower spending for adult participations and 5.1% lower for children
Quality & Utilization	<ul style="list-style-type: none">Iora Health (receives fixed, risk-adjusted PMPM from payers and incorporates additional payments for meeting quality or use targets)¹: Iora reports ER visits reduced by 48% and by 41% for inpatient admissions; also improvements in blood pressureMichigan (fee-for-value (P4P program) incentivizing coordination, quality, and low costs)²: quality maintained or improved for 11 of 14 measures

1. Fernandopulle, R. (2013). Learning to fly: Building de novo medical home practices to improve experience, outcomes, and affordability. *The Journal of Ambulatory Care Management*, 36(2), 121-125. doi:10.1097/JAC.0b013e3182871fac [doi]
2. Lemak, C. H., Nahra, T. A., Cohen, G. R., Erb, N. D., Paustian, M. L., Share, D., & Hirth, R. A. (2015). Michigan's fee-for-value physician incentive program reduces spending and improves quality in primary care. *Health Affairs (Project Hope)*, 34(4), 645-652. doi:10.1377/hlthaff.2014.0426 [doi]

What accountability mechanisms exist to track the effectiveness of care coordination?

- In 2014, AHRQ published a Care Coordination Measure Atlas (https://www.ahrq.gov/sites/default/files/publications/files/ccm_atlas.pdf)
- In 2013, Schultz et al identified care coordination 96 measures, many of which focus on communication and information transfer (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3651252/pdf/1472-6963-13-119.pdf>)
- The National Quality Forum maintains an online repository of endorsed quality measures

What accountability mechanisms exist to track the effectiveness of care coordination?

Mechanism	Implementation	Challenges
CPT codes	Billing codes exist for care coordination activities	<ul style="list-style-type: none">Do not provide information about how care coordination is achieving model of care (value)
EHR documentation	Allows more flexible tracking of care coordination activities	<ul style="list-style-type: none">Independent practices may not have sufficient EHR capabilities¹
Process measures	May be calculated using claims, EHR, or survey data	<ul style="list-style-type: none">May increase provider documentation time With numerous measures available, may be difficult to gather consensus on best process measures
Quality measures	Select quality measures in alignment with model of care	<ul style="list-style-type: none">Measures may need to vary by practice and patient populationMeasures outcome rather than care coordination actions
Cost Measures	Select utilization measures in alignment with model of care	<ul style="list-style-type: none">Measures may need to vary by practice and patient populationMeasures outcome rather than care coordination actions

1. Townsend, B., Bentz, D., & Fan, N. (2019). *Primary care collaborative report 2019*. (). Dover, DE: Delaware General Assembly. Retrieved from <https://www.pcpcc.org/sites/default/files/resources/Collaborative%20Report%20-%20January%202019.pdf>

What are the key takeaways from the evidence?

- Care coordination per member per month (PMPM) payments in combination with a model of delivery reform can reduce spending and improve patient outcomes
- Adoption of care coordination PMPM payments is not sufficient to improve care delivery
 - Clinical model + payment approach to enable the model ⇒ improved outcomes

Care Coordination and Care Management Tasks

Steven Constantino made a good point in the discussion of 02122019 of the importance of defining care coordination and care management. That is particularly important if we are to recommend paying PCPs for these services. One standard we could use is that established for Health Homes by CMS under Section 2703 of the Patient Protection and Affordable Care Act. It broadly identifies health home services as including comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up from inpatient to other settings; patient and family support; and referral to community and support services. Although there are no federal regulations that define these core components, some tasks that could be included under each are listed for each.

Comprehensive Care Management

- Identifying individuals potentially eligible to receive care management services; although this responsibility often lies predominantly with either the Medicaid agency or the managed care health plans through claims, primary care practices (PCP) may identify individuals missed through that screening process and should refer them for consideration to the entity responsible for final eligibility determination;
- Engaging individuals and families with explanation as to the benefits of participation in care management; although responsibility for enrollment may also rest with the Medicaid agency or health plan, the PCP often can capitalize on existing trusting relationship with the individual to explain the benefit of care management services and facility enrollment;
- Completing a comprehensive assessment of the individual's physical health, behavioral health, and social needs;
- Developing a single, integrated, person-centered care plan that reflects input from the entire health care team including the individual and family;
- Developing a communication plan to ensure routine information exchange among the full care team (including the enrollee, pertinent family members, care givers, care manager, PCP, BH provider, and specialist) as well as with any health plan care manager involved with the individual;
- Implementing the care plan;
- Monitoring the care plan to assess the individual's progress, barriers to care, and services provided relative to the desired outcomes and goals; modifying the care plan as appropriate.

2. Care Coordination

- Working with the health plan to identify gaps in preventive services and chronic disease management;
- Providing assistance with obtaining health care services including making appointments; facilitating communication between the PCP and specialists to enhance patient safety and reduce unnecessary duplication of services;
- Facilitating transportation as needed to those appointments;

- Accompanying the enrollee to the appointment if necessary;
- Validating that services were received and facilitating rescheduling when appointments are missed;
- Tracking tests and referrals with necessary follow-up;
- Performing medication management and reconciliation;
- Coordinating prevention, management, and stabilization of crises, including post-crisis follow-up care;
- Making referrals to community, social, and recovery supports as clinically indicated.

3. Comprehensive Transitional Care

- Developing arrangements with inpatient facilities, emergency departments and residential facilities for prompt notification of admission and discharge;
- Participating in discharge planning including developing coordinated, comprehensive discharge plans and/or transition plans and arranging timely ambulatory follow-up appointments with the PCP, BH provider and/or appropriate specialist;
- Timely and appropriate follow-up with the enrollee post-discharge;
- Facilitating timely transmission of clinical information.

4. Health Promotion

- Providing health education about wellness and health lifestyle choices;
- Referring individuals and families to evidence based wellness programs;
- Providing condition-specific education to promote self-management skills;
- Connecting individuals and families to peer supports as clinically appropriate.

5. Referral to Community and Social Support Services

- Identifying and providing referrals to community, social or recovery support services including legal assistance and housing;
- Providing assistance in making appointments, facilitating transportation, validating that service was received, and completing any follow-up.

6. Individual and Family Support Services

- Providing access and availability of services to the individual, family, and care team;
- Supporting the delivery of person-centered care;
- Performing outreach and advocacy for the individual and family to obtain needed resources;
- Educating the individual and family on self-management techniques;
- Facilitating individual and family engagement in care planning and providing access to clinical information and the care plan;
- Referring individuals and family members to community/social/recovery supports.

Delaware Primary Care Collaborative – February 12, 2019

Participants should be prepared to discuss, and back up their position with evidence where possible, the following questions:

Primary care providers

- What type of accountability should be used for care coordination fees? How do we verify that the care coordination fee goes to care coordination?
- What is the desired impact of care coordination fees? How to we measure that impact? What quality outcomes we should be measuring?
- How should we create total cost of care guardrails?

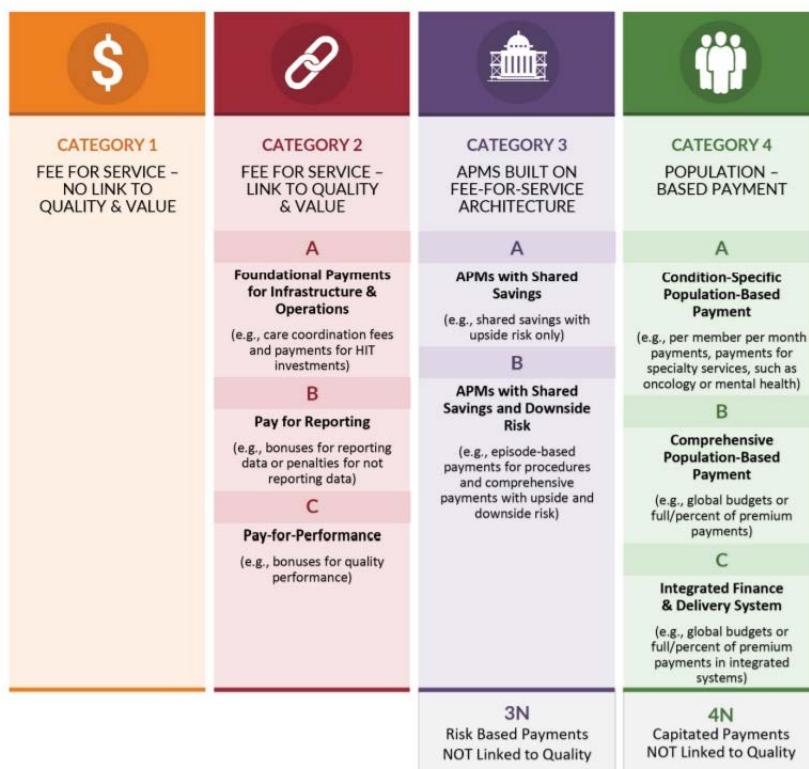
Payers

- How prepared are we to share actionable and timely patient data and information like care plans to facilitate effective use of care coordination fees?
- If providers are doing care coordination for certain patients, what does that mean for payers who are also doing care coordination?
- What does it take to offer the full range of alternative payment models?

All

- How do we determine a care coordination fee considering the cost of providing care coordination, return on investment, and impact on total cost of care?
- What alternative payment methodologies (*see the APM Framework below*) including primary care capitation are primary care providers already participating in or ready to participate in?
- How should we determine provider and payer readiness for alternative payment models?

Figure 4: The Updated APM Framework



Source: <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>

CARE MANAGEMENT TASK ASSIGNMENT MODELLING

Choose care management tasks

"PCMH" refers to PCP with more advanced capacity for care coordination/care management functions

Assign task to PCP CC, PCHM CC or PCMH CM

Assume tasks assigned to PCP CC would be done by PCMH and are additive

Assume health plan CC or CM would perform tasks in absence of PCP or PCMH unable or unwilling to assume responsibility

Allocate tasks by risk stratification

Estimate time per task

Estimate frequency of task by risk category

Estimate product category mix (in this example by Medicaid eligibility)

Insert ED visit rates from historical data

Insert hospitalization rates from historical data

Estimate salary and benefit expense based on local market rates

Modify assumptions from perspective of cost of delivering services and budget neutrality in terms of anticipated % of premium savings

All values in red should be modified to fit the specific patient population

Care Coordination Tasks	Time allocated (hours)	Frequency per year		PCP Care Coordinator hrs/yr		PCMH Care Coordinator hrs/yr		PCMH Care Manager hrs/yr		Health Plan	
		increased low risk	high risk/ Hale elig	increased low risk	high risk/ Hale elig	increased low risk	high risk/ Hale elig	increased low risk	high risk/ Hale elig	increased low risk	high risk/ Hale elig
Onboarding new members within 30 days of enrollment to schedule a PCP appointment	0.5	0.5	0.5	0.5	0.25	0.25	0.25				
Outreach to members who have not been seen by the PCP in the previous twelve months	0.25	0.25	0.25	0.25	0.0625	0.0625	0.0625				
Initial or annual health risk screen (includes PHQ, assumes multiple attempts are sometimes required)	0.5	1	1	1				0.5	0.5	0.5	
Assist with making appointments; facilitating communication with specialists	0.5	0.5	1	1	0.25	0.5	0.5				
Outreach to close gaps in care	0.5	1	2	2	0.5	1	1				
Facilitating transportation to medical appointments as needed	0.5	0.05	0.2	1				0.025	0.1	0.5	
Health Promotion Tasks											
Providing health education about wellness and healthy lifestyle choices	0.5	1	1	1	0.5	0.5	0.5				
Referring individuals and families to wellness programs	0.5	0.1	0.2	0.3	0.05	0.1	0.15				
Providing condition-specific education to promote self-management skills	0.5	0.1	0.5	0.75					0.05	0.25	0.375
Connecting individuals and families to peer supports as clinically appropriate	0.5	0	0.1	0.25					0	0.05	0.125

Referral to Community and Social Support											
Services											
Identifying and providing referrals to community/social/recovery supports	0.25	0.5	1	2			0.125	0.25	0.5		
Assist in making appointments, facilitating transportation	0.25	0.25	0.5	1			0.0625	0.125	0.25		
Validating service was received and completing follow-up	0.25		1	2			0	0.25	0.5		
Individual and Family Support Services											
Performing outreach and advocacy for the individual and family to obtain needed resources	1	0	0.05	0.1			0	0.05	0.1		
Educating the individuals and family on self-management techniques	1	0	1	1					0	1	1
Care Management Tasks											
Outreach and enrollment in care management	0.5	0	1	1			0	0.5	0.5		
Comprehensive risk assessment and initial/major revision of care plan	1.5	0	1	2					0	1.5	3
Telephonic care plan review and implementation	0.5	0	2	8					0	1	4
Face-to-face care plan update and implementation	0.5	0	1	2					0	0.5	1
Disease management/health coaching	0.5	0	3	6					0	1.5	3
Transitional Care											
Post-ED visit contact	0.25	0	0	0							
Outreach to members with four or more emergency department visits in the previous six months	1	0	0.1	0.3					0	0.1	0.3
Post-hospitalization transition of care (low risk)	1	0.07	0	0	0.07						
Post-hospitalization transition of care (rising and high risk)	4	0	0.25	1.5					1	6	
Hours PMPY					1.68	2.41	2.46	0.71	1.78	2.85	0.05
Hours PMPY including PCP CC								2.40	4.19	5.31	6.90
											18.80
Percentage of TANF/CHIP members	80.0%	95.0%	4.0%	1.0%							
Percentage of Medicaid expansion members	15.0%	90.0%	5.0%	5.0%							
Percentage of SPD members	5.0%	70.0%	15.0%	15.0%							
MCO Blend	100.0%	93.00%	4.70%	2.30%	100.0%						
Blended hospitalizations PMPY		0.07	0.25	1.50							
Total hospitalizations/1000/per year		66.3	11.75	34.50							
Estimated hospital admits/1000/per year											
TANF/CHIP	75	60									

Medicaid expansion	200	30
SPD	450	23
Blended		113

	Total	low risk	increased r high risk/ Hale elig	
PCP Care coordinator	173	156	11	6
PCMH Care coordinator	261	223	20	19
Care manager	80	5	32	43

Non-Contact Time
(Downtime/Inefficiencies/other tasks) **20%**

	Case Load	Case Load/FTE	Salary and benefits/y	
			ear	PMPM
PCP Care Coordinator		849	\$50,000	\$4.91
PCMH Care Coordinator		563	\$50,000	\$7.40
Care Manager		1833	\$85,000	\$3.87
PCMH Team				\$11.27

Working hours/year **1840**

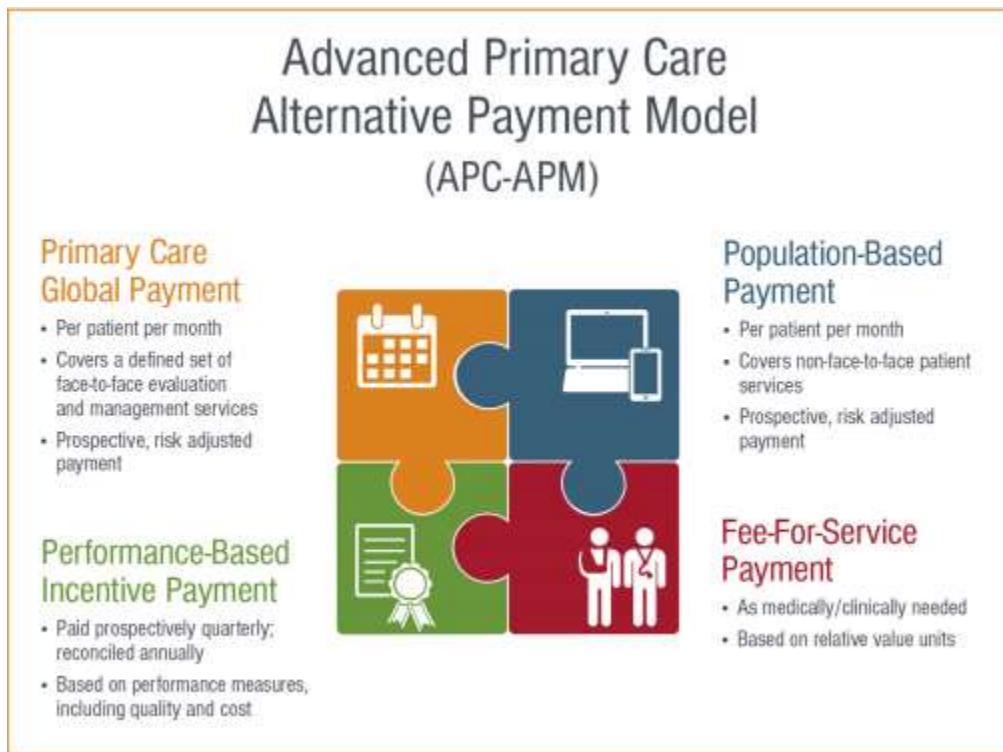
	Total	low risk	increased r high risk/ Hale elig	
Care Coordinator	849	789	40	20
Care Coordinator hours spent	1472	1328	96	48
Care Manager	1833	1704	86	42
Care Manager hours spent	1472	85	594	792

Premium TANF/CHIP PMPM*	\$200
Premium Medicaid Expansion	\$400
Premium SPD PMPM*	\$1,000
Blended Premium PMPM*	\$270

CM Expense as % premium **4.2%**

Proposed “Value-Based” Model for Primary Care Collaborative

Presented at March 4, 2019 Primary Care Collaborative Meeting



Proposed Independent Model – based on AAFP’s APC-APM

The AAFP’s Advanced Primary Care – Advanced Payment Model (APC-APM) was proposed to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and recommended by them to CMS about a year ago.

It assumes practices can attest to the basic functions of advanced primary care, as defined in the joint principles of the patient-centered medical home (PCMH); this includes sufficient care coordination, per-member-per-month, as previously supplied to the Collaborative.

As one may see, the model is divided into four quadrants. The long-term goal would as shown in the schematic, specifically:

1. Quadrant one (orange): global capitation for most face-to-face services (acute, chronic and preventive visits in the office).
2. Quadrant two (blue): global capitation for non face-to-face services, specifically care coordination.



3. Quadrant three (green): Performance-based incentives, which will include bonuses for quality/utilization/cost metrics, or reduction of care-coordination payments if minimal standards are not met.
4. Quadrant four (red): Fee-for-service payments for services not included in quadrants one and two (e.g., office procedures and testing, immunizations, hospital visits and services, etc).

A key remains an overall measure that the aggregate payments for all four quadrants, globally totaling by insurer 12 percent of each's total health care spend. Currently, this is estimated at \$10,700 per person per year in the United States.

Of course, measuring the primary care spend would need to be and given to an objective source and standardized. We recommend the Department of Insurance, after a proper investment in the staff necessary in their discretion to oversee such a process. We also would continue to recommend using the standardized measures developed and published by David Balint, *et. al.* in the Milbank-funded study. If primary care definitions are expanded beyond the traditional definition of primary care (family medicine, primary care internal medicine, primary care pediatrics), then the total spend measure for primary care would need to be increased. Within the AAFP model, this does not preclude that payments could be adjusted based on patient risk.

The timeline would assume this would be in place by January 2022 as per the specifications of SB 227.

We would recommend a step-wise approach to adopting this model:

1. Begin monthly prospective PMPM care coordination payments, as shown in the blue quadrant of the APC-APM. This should be in the range of \$15-20 PMPM, but we have again previously provided a general sketch for this calculation. Overall, this range is what was found to be required by the definitive national studies (Commonwealth Fund and AHRQ) and what is paid in CMS's CPCI. It is also justified by our calculations.

However, critical to moving forward as care coordination is a threshold item, we need to agree on what is "base" PMPM. That is, the cost of doing the PMPM as defined in our calculations. Whatever that base is, payments cannot go below that number until a "risk-based model" is put into place where the practice is willing to take risk and the payer offers an "upside" that is greater than the downside risk. This will be described below under quadrant three. Note that the



AAFP recommends that these payments not be subject to quality, utilization or cost benchmarks since there is already an inherent “risk” in accepting a PMPM since it may cost you more for many patients but you don’t get paid more.

Care coordination payments would begin immediately.

2. Begin performance-based incentive payments (quadrant 3/green). In the AAFP model, this is where quality incentives come in, as well as bonuses for meeting cost and utilization measures. This is where payments can be adjusted up for meeting performance measures, or adjusted down for not meeting minimal benchmarks (*i.e.*, implementing “risk”).

For this risk-based model, it would likely be ACO’s assuming the risk rather than the practices themselves, since practices cannot afford to hire care coordinators and then not get paid for their cost, based on lower quality/utilization results. However, individual practices that want to take on risk could also participate.

That said, if any risk is assumed, there would need to also have meaningful “upside gain” for performance beyond performance measures.

By way of example, assuming a baseline of \$17 PMPM. Then the baseline is \$17, but if you are willing to accept risk, your payment would be: \$19 PMPM for minimal measures (perhaps “copper star”), \$24 PMPM for “silver star” and \$28 PMPM for “gold star”.

Then if the metrics go below copper, you get less than the \$17 PMPM, maybe down to \$13 PMPM. But that \$4 PMPM cut could be borne by a larger entity such as the ACO, since the practice will have already invested the \$17 PMPM for the staff and other overhead for conducting care coordination.

Metrics for determining copper/silver/gold should be determined by a group of clinical experts. But as a start we could consider:

1. 1-2 measures on primary care quality (*e.g.*, access, coordination)
2. 1-2 measures that are modified from HEDIS, in a way that looks at physician performance, not patient performance (*e.g.*, was a mammogram **ordered**)
3. 1 measure of patient satisfaction
4. 1 measure of utilization (perhaps emergency department utilization, but since practices currently have little control over whether patients go to the



ED, we might consider making clinicians responsible ONLY if the payer requires our approval to go to the ED).

An important point is that these measures should not require any additional administrative work from practices, understanding that additional work would unintentionally increase the overhead necessary for the delivery of the services themselves. An unnecessary cost-driver. Any measures that cannot be obtained from current claims or electronic data should not be included in a set of metrics until such automated measurement is feasible. Also note that while the AAFP's graphic says performance based incentives should be "paid prospectively quarterly, reconciled annually", the current AAFP thinking is that it may be better to just pay these retrospectively, in order to avoid the "clawback" phenomenon, which can be very damaging to practices.

Another important point is that the measurements need to be "transparent." That is, the rules are published and clear to everyone. The data upon which the measures are made are made available to the ACOs (and individual practices) for confirmation of validity.

As to risk adjusting, care coordination payments will be adjusted for patient illness (*i.e.*, case-mix). Again, we need to determine how to do this without requiring burdensome tasks such as submitting codes to achieve HCC scores.

Regarding timeline, this might be able to be put in 12-18 months from the start.

3. Performance incentives for cost, or shared savings. This can be upside or both upside/downside (it cannot be downside only, *i.e.*, reducing payments if cost benchmarks are not met). Doing appropriate shared savings will require much more attention and time to be able to measure and control costs appropriately. It will require dovetailing with the state's benchmarking process. Assuming procedure costs inside of facilities, including urgent care and medical aid units, that are outside of the primary care's discretion and control are decoupled from the risk, it may be reasonable to start the process sooner than the benchmarking process is complete. We would estimate this might be implemented in eighteen months to two years.



Performance incentives can also include incentives for the characteristics of the practice. *E.g.*, practices that achieve a higher level of sophistication (perhaps PCMH level 3) could get higher care-coordination payments given the same case-mix.

Important to note here that PCMH certification should not be based mainly on NCQA, which are too burdensome and costly, and are not well aligned with the principles of the PCMH. We should develop our own PCMH-certification process that is easier and more aligned with the principles of the PCMH.

Part of the shift at this point is also to move APC-APM quadrant 1 payments to capitation. This will require a lot of preparation. The general thinking is that it will include the main primary care services – acute, chronic and preventive care visits. But it will not include special procedures (*e.g.*, minor surgery, casting/splinting, higher level testing) or items for which there is a high cost of purchasing supplies (*e.g.*, immunizations). Nor will it include services outside of the office such as hospital visits. All of these will remain in quadrant 4. Moving things from quadrant 4 to quadrant 1 might be a stepwise approach, as determined by other policies such as PCP direction of patient care between settings. Eventually even these payments could be at “risk”. But again, if at risk, the payments need to be higher to create balance and the risk should be where it can be borne, likely an ACO. Of course, this ACO would also get a compensatory cut of the higher payments.

We would assume that fully changing to capitation would not be in place for a matter of two to three years.

Overall, ACOs are likely going to be critical components in achieving these goals. Practices will be much more successful if they band together with the help of these ACOs which will be relied upon to assume risks. Also critical is the use of data systems and usable data that are wed to the metrics and measurements a practice is placed under.

We must also remember two other critical components that are not often mentioned.

First, we need to be cautious to safeguard independent specialty care. As the goal herein, in part, is to direct spending to where the patients and ultimately all citizens see the best use health dollar investments, independent specialty care is a virtue and cost-saving to the system as well. As primary care is given better tools to coordinate patient care, evaluate care through data, and lower high-cost setting utilization, the link between these two independent settings should and must only grow stronger. The savings achieved through this close relationship will

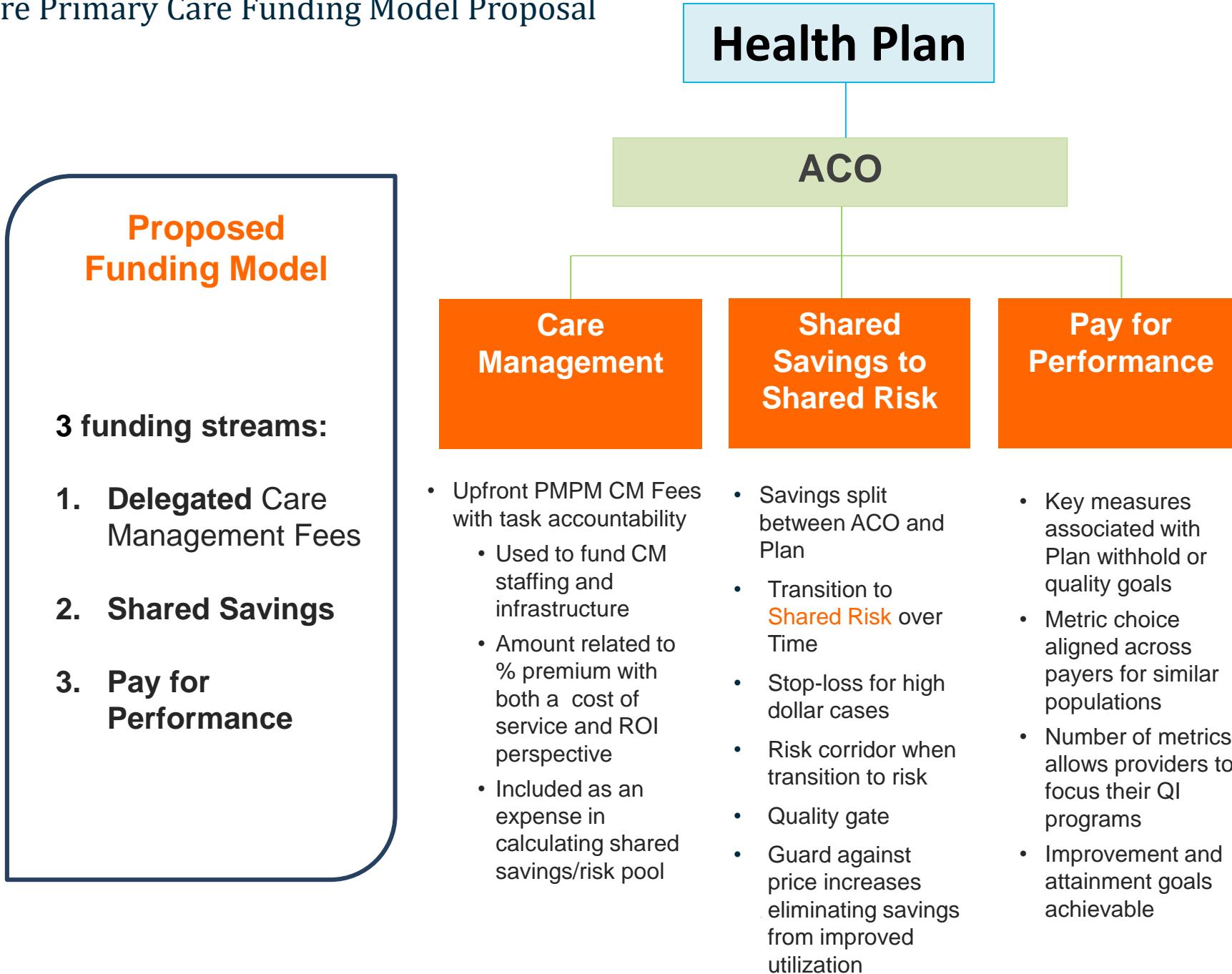


Medical Society of Delaware
LEADING THE WAY TO A HEALTHY DELAWARE

benefit the patient and the system. Losing sight of that could potentially undermine the benchmark goal of bending the global cost curve.

Second, there will always be practices, hopefully in drastically-shrinking numbers as opportunities to grow through processes created herein and through the collaborative's work open, that, for a variety of reasons, may not be able to avail themselves. Likely as they are winding down or are unable to take on substantial risk. These practices will continue to have value and will continue to have little bargaining power in the market. We suggest continued discussions on how best to ensure they are not unintentionally left behind.

We remain grateful to the Collaborative for all of its hard work and diligence. We are thankful to the stakeholders for their additional input. Thank you for including our voice.





DE Primary Care Collaborative

March 4, 2019

SB 227

- ▶ Collaborate with DHCC to strengthen PC in DE
- ▶ Evaluate system wide investments in PC using DE HCCD
- ▶ Payment Reform
- ▶ Value based payment models 60% by 2021
- ▶ Workforce
- ▶ Integrated Care
- ▶ Directing resources to support and expand PC access
- ▶ PCP: internal medicine, family practice, geriatrics, pediatrics

SS1 to SB 116

Expanded Collaborative

- ▶ Chair, DHCC; Chair Senate; Chair House
- ▶ MSD - 2
- ▶ DNA – 2
- ▶ DHA – 2
- ▶ DOI – Insurance Commissioner
- ▶ Insurers – 2 appointed by Governor
- ▶ Secretary, DHSS
- ▶ Director, DMMA
- ▶ Chair, State Employees Benefits Plan
- ▶ FQHC – appointed by Governor
- ▶ Self-insurer employer – DE Chamber of Commerce

Office of Value Based Health Care Delivery

- ▶ Reduce HC costs
- ▶ Establish Affordability Standards
- ▶ Establish targets for carrier investment for robust PC 2025
- ▶ Annual report on PC spend in relation to total HC spend
- ▶ Make recommendations to DOI and PCC for appropriate reimbursement for PC
- ▶ Collect data and report:
 - ▶ Calculate PC spend
 - ▶ Carrier compliance with rates for PC
 - ▶ Total HC spending within benchmarking process

HEALTH MANAGEMENT ASSOCIATES

National Trends in Payment for Primary Care Services

DE Primary Care Collaborative

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W W W . H E A L T H M A N A G E M E N T . C O M

■ WHAT'S THE ATTRACTION OF PRIMARY CARE CAPITATION?

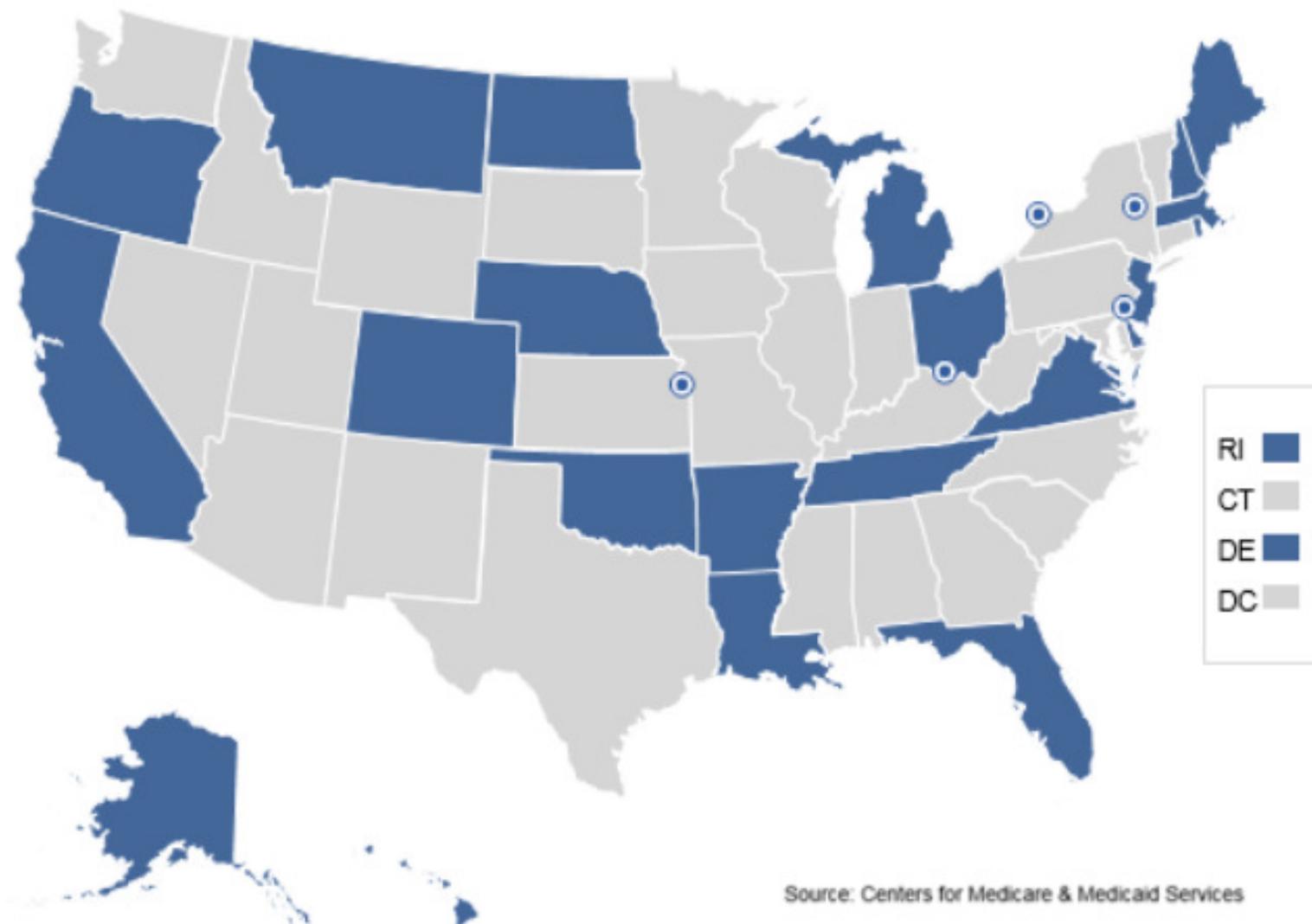
- + Improve predictability of revenue stream and cash flow
- + Movement away from strict reliance on face-to-face visits as payment
- + Support practice transformation including use of a broader “non-billable” workforce
- + Improve member-centric access to primary care
- + Will enhance market competitiveness
- + Facilitate care for a larger population via larger PCP panel sizes without increasing that PCP’s visit volumes
- + Reward for outcomes; revenue enhancement potential
- + Align with any opportunity for shares savings and/or shared risk for the cost of health care services beyond primary care

- + 5 year program started in 2017 in 14 areas around the country
- + CM fee risk based + prospective performance-based quality incentive + Medicare fee schedule
 - + Strict FFS – track 1
 - + Lower FFS + quarterly comprehensive primary care fee
- + Initial findings:
 - + Increase in alternative care options, behavioral health integration, hospital follow-up rates, and addressing social determinants of health

PRIMARY CARE FIRST (PCF)

- + 5-year voluntary program
- + Aligns with Triple Aim
- + Medicare FFS
- + 70% patient revenue from primary care
- + Two tracks:
 - + PCF Model
 - + PCF High Needs Population Model
- + FQHCs are NOT eligible

PRIMARY CARE FIRST GEOGRAPHIC REGIONS



Source: Centers for Medicare & Medicaid Services

PCF TOTAL MEDICARE PAYMENT

Total primary care payment

Professional
Population-Based
Payment

Flat Primary Care
Visit Fee



Performance-based adjustment

Opportunity for practices to **increase revenue by up to 50%** of their total primary care payment based on key performance measures, including acute hospital utilization (AHU).

- 1 National adjustment
- 2 Cohort adjustment
- 3 Continuous improvement adjustment

Source: <https://innovation.cms.gov/Files/slides/pcf-info-webinar-series-slides.pdf>

TOTAL PRIMARY CARE PAYMENT

Professional Population-Based Payment

Payment for service in or outside of the office, adjusted for practices caring for higher risk populations. This payment is the same for all patients within a practice.

Practice Risk Group	Payment <i>Per beneficiary per month</i>
Group 1 (lowest average HCC)	\$24
Group 2	\$28
Group 3	\$45
Group 4	\$100
Group 5 (highest average HCC)	\$175



Flat Primary Care Visit Fee

Flat payment for face-to-face treatment that reduces billing and revenue cycle burden

\$50.52

per face-to-face patient encounter

Adjusted for geography

These payments allow practices to:

- ✓ Easily predict payments for face-to-face care
- ✓ Spend less time on claims processing and more time with patients

Source: <https://innovation.cms.gov/Files/slides/pcf-info-webinar-series-slides.pdf>

SERIOUSLY ILL POPULATION

- + Providers meeting relevant care capability can opt to be assigned SIP without a PCP
- + Payments
 - + First time visit = \$325
 - + Monthly payments = \$275
 - + Flat fee primary care visit = \$50
 - + Quality payment = up to \$50

CMS DIRECT CONTRACTING MODEL

Professional Population-based Payment

- + ACO structure with Participants and Preferred Providers defined at the TIN/NPI level
- + 50% shared savings/shared losses with CMS
- + Primary Care Capitation equal to 7% of total cost of care for enhanced primary care services

Global Population-based Payment

- + ACO structure with Participants and Preferred Providers defined at the TIN/NPI level
- + 100% risk
- + Choice between Total Care Capitation or Primary Care Capitation

CAPITATED FQHC APM ELEMENTS

- + FQHCs receive no less than what they would have under PPS
- + FQHCs retain the right to opt in and out of the APM
- + Current payment relationships can remain in place (wrap flow of payments from Medicaid agency directly or as pass through the health plans)
- + No recoupment under the APM; reconciliation payment only if required to assure at least PPS equivalency
- + Prospective adjustment can be based on performance on quality metrics

STATUS OF THE CAPITATED FQHC APM APPROACH IN OTHER STATES

- + Illinois implemented 2001 – 2013 without filing a State Plan amendment
- + Oregon 2012
- + Washington State 2017
- + Other initiatives:
 - + Negotiations on hold: California
 - + New York, Connecticut, Colorado, Illinois, Iowa, New York, Michigan: in the planning phase

Investing in Primary Care

A STATE-LEVEL ANALYSIS

Summary:

Across 29 states, using outpatient and office based expenditures, narrow definition which is the same as DE had an average of 5.7% with range of 3.5-7.6%



the legislation or executive orders. See pcbcc.org/legislation.

CO	HB 19-1233 (2019) establishes a multistakeholder primary care payment reform collaborative in the Division of Insurance of the Colorado Department of Regulatory Agencies. It also requires the insurance commissioner to establish affordability standards for premiums, with added targets for carrier investments in primary care. Additionally, it requires the Colorado Department of Health Care Policy and Financing and carriers that offer health benefit plans to state employees to set targets for investment in primary care.
DE	SB 277 (2018) promotes the use of primary care by: <ul style="list-style-type: none">• Creating a multistakeholder Primary Care Reform Collaborative under the Delaware Health Care Commission• Requiring all health insurance providers to participate in the Delaware Health Care Claims Database• Requiring individual, group, and state employee insurance plans to reimburse primary care clinicians at no less than the physician Medicare rate for three years
ME	Introduced in 2019, "An Act to Establish Transparency in Primary Health Care Spending" requires insurers to report primary care expenditures to the Maine Health Data Organization and requires the Maine Quality Forum to use this data to report annually to the Department of Health and Human Services and the legislature the percentage of total medical expenditures paid for primary care.
OR	SB 934 (2017) requires coordinated care organizations, the Public Employees' Benefit Board, and the Oregon Educators Benefit Board to spend at least 12% of total medical expenditures on primary care by January 1, 2023. It also requires the Department of Consumer and Business Services to establish requirements for carriers to submit plans for increasing spending on primary care as a percentage of total medical expenditures if the carrier is spending less than 12% of total medical expenditures.
RI	S 770 (2011) created the Care Transformation Collaborative. From 2009 to 2014, Rhode Island regulators required commercial insurers to raise their primary care spending rate by one percentage point per year (using strategies other than increasing fee-for-service rates) as a condition of having their rates approved. The state measured and increased its primary care spending from 5.7% in 2008 to 9.1% in 2012. Over this same period, total health care expenditures fell by 14%. Rhode Island achieved its target of 10.7% by 2014.

RI	S 770 (2011) created the Care Transformation Collaborative. From 2009 to 2014, Rhode Island regulators required commercial insurers to raise their primary care spending rate by one percentage point per year (using strategies other than increasing fee-for-service rates) as a condition of having their rates approved. The state measured and increased its primary care spending from 5.7% in 2008 to 9.1% in 2012. Over this same period, total health care expenditures fell by 14%. Rhode Island achieved its target of 10.7% by 2014.
VT	SB 53 (2019) requires the Green Mountain Care Board to determine the proportion of health care spending currently allocated to primary care, recommend the proportion that should be allocated to primary care going forward, and project the avoided costs that would likely result if that proportion was achieved. It also directs certain payers to provide a plan for achieving the level of primary care spend that is recommended by the board.
WA	In 2019, Washington appropriated \$110,000 for fiscal year 2020 that is provided solely for the Office of Financial Management to determine annual primary care medical expenditures in the state, by insurance carrier, in total and as a percentage of total medical expenditure. Where feasible, this determination must also be broken down by relevant characteristics. The determination must be made in consultation with statewide primary care provider organizations using the state's all-payer claims database and other existing data.
WV	SB 641 (2019) creates the Primary Care Support Program to provide technical and organizational assistance to community-based primary care services and to report on West Virginia Medicaid primary care expenditures as a percentage of total West Virginia Medicaid expenditures.

TABLE 3.1

Comparison of Rhode Island and Oregon

Each state has a different definition for what constitutes primary care and different primary care investment goals.

	Rhode Island	Oregon
Primary Care Definition	All payments to family physicians, internists, pediatricians, and affiliated advanced practice providers AND payments for approved "common good" services (health information technology, loan repayment, and practice transformation)	All payments for selected services to family physicians, general medicine physicians, pediatricians, OB/GYNs, psychiatrists, geriatricians, physician assistants, nurse practitioners, naturopaths, and homeopaths ¹
Primary Care Spend Goal	10.7% by 2014	12% by 2023
Participating Payers	Commercial: Blue Cross Blue Shield, UnitedHealthcare, Tufts	Prominent carriers ² CCOs Medicare PEBB/OEBB

CHOOSING A PRIMARY CARE REIMBURSEMENT MODEL THAT FACILITATES ADDITIONAL REVENUE

Preserving PCP Revenue:
Fee-for-service
PPS or Capitated
APM?



- Icing on the Cake**
- CM fee
 - PCMH
 - P4P
 - Shared savings
 - Partial capitation for non-PCP services

A bigger piece of the cake
(market share)

Letters

RESEARCH LETTER

Primary Care Spending in the Fee-for-Service Medicare Population

Greater health system orientation toward primary care is associated with higher quality, better outcomes, and lower costs.^{1,2} Recent payment and delivery system reforms emphasize investment in primary care,³ but resources presently devoted to primary care have not been estimated nationally.^{4,5} In this study, we calculated primary care spending as a proportion of total spending among Medicare fee-for-service beneficiaries and describe variation by beneficiary characteristics and by state.

Methods | We analyzed spending for all Medicare beneficiaries 65 years or older with 12 months of Parts A and B fee-for-service medical coverage and Part D prescription coverage in 2015. We used the Master Beneficiary Summary File (MBSF) Base segment (enrollment and demographic data), MBSF Cost and Utilization segment (total medical and prescription spending), and MBSF Chronic Conditions segment (27 chronic con-

ditions); Carrier File (professional claims) and Outpatient File (professional claims absent from the Carrier File including critical access hospitals, rural health centers, federally qualified health centers, and electing teaching amendment hospitals); and Medicare Data on Provider Practice and Specialty File (practitioner characteristics). This study was approved by the RAND Corporation Human Subjects Protection Committee with waiver of informed consent for analysis of deidentified data.

We measured primary care spending by using narrow and broad definitions of primary care practitioners (PCPs) and primary care services.⁵ The narrow PCP definition included family practice, internal medicine, pediatric medicine, and general practice; the broad PCP definition also included nurse practitioners, physician assistants, geriatric medicine, and gynecology. Both definitions excluded hospitalists.

The narrow primary care services definition included Healthcare Common Procedure Coding System codes on professional claims, including evaluation and management visits, preventive visits, care transition or coordination services, and in-office preventive services, screening, and counseling; the broad definition included all professional services billed

Table. Patient Characteristics and Primary Care Spending Among Fee-for-Service Medicare Beneficiaries in 2015

Characteristic	Primary Care Practitioner Definition, %			
	Narrow ^a		Broad ^b	
	Narrow Primary Care Services ^c	All Professional Services	Narrow Primary Care Services ^c	All Professional Services
Age, y				
65-69	2.28	3.92	2.92	5.15
70-74	2.28	3.97	2.86	5.12
75-79	2.19	3.90	2.71	4.96
80-84	2.03	3.73	2.52	4.71
>85	1.76	3.38	2.24	4.34
Sex				
Male	2.15	3.87	2.60	4.82
Female	2.11	3.74	2.72	4.92
Race/ethnicity ^d				
White	2.13	3.82	2.70	4.96
Black	1.76	3.28	2.21	4.15
Asian	3.04	4.73	3.35	5.30
Hispanic	2.18	3.70	2.57	4.42
North American Native	1.51	3.02	2.16	4.23
Other	2.61	4.25	2.99	4.99
Unknown	2.61	4.27	3.14	5.31
Dually eligible for Medicare and Medicaid				
Yes	1.64	3.23	2.16	4.23
No	2.32	4.02	2.88	5.14

(continued)

Table. Patient Characteristics and Primary Care Spending Among Fee-for-Service Medicare Beneficiaries in 2015 (continued)

Characteristic	Primary Care Practitioner Definition, %			
	Narrow ^a		Broad ^b	
	Narrow Primary Care Services ^c	All Professional Services	Narrow Primary Care Services ^c	All Professional Services
Chronic conditions				
Acute myocardial infarction	1.30	2.90	1.66	3.70
Alzheimer disease	1.40	2.99	1.99	4.11
Alzheimer disease and related disorders or senile dementia	1.40	3.02	1.90	4.03
Atrial fibrillation	1.54	3.15	1.95	4.04
Cataract	2.07	3.74	2.61	4.81
Chronic kidney disease	1.53	3.11	1.94	3.99
Chronic obstructive pulmonary disease	1.66	3.32	2.12	4.25
Congestive heart failure	1.49	3.09	1.90	3.95
Diabetes	1.91	3.55	2.37	4.47
Glaucoma	2.06	3.66	2.56	4.65
Hip or pelvic fracture	1.08	2.54	1.46	3.41
Ischemic heart disease	1.79	3.40	2.24	4.33
Depression	1.73	3.33	2.28	4.41
Osteoporosis	1.88	3.54	2.40	4.59
Rheumatoid arthritis or osteoarthritis	1.97	3.61	2.49	4.68
Stroke or transient ischemic attack	1.55	3.19	1.99	4.10
Cancer				
Breast	1.75	3.20	2.27	4.23
Colorectal	1.48	3.06	1.86	3.89
Prostate	1.85	3.41	2.23	4.28
Lung	1.12	2.49	1.42	3.18
Endometrial	1.54	3.00	2.10	4.19
Anemia	1.76	3.35	2.22	4.31
Asthma	1.66	3.32	2.11	4.26
Hyperlipidemia	2.13	3.80	2.66	4.86
Benign prostatic hyperplasia	2.04	3.76	2.46	4.67
Hypertension	2.06	3.71	2.58	4.75
Hypothyroidism	1.98	3.64	2.51	4.68
Primary care spending				
Per beneficiary, \$	308.32	550.62	387.79	708.23
Fraction of total medical and prescription spending ^e	2.12	3.79	2.67	4.88

^a Includes family practice, internal medicine, pediatric medicine, and general practice.

^b Includes family practice, internal medicine, pediatric medicine, general practice, nurse practitioner, physician assistant, geriatric medicine, and gynecology.

^c Includes Healthcare Common Procedure Coding System codes on professional claims including evaluation and management visits, preventive visits, care

transition or coordination services, and in-office preventive services, screening, and counseling.

^d All race/ethnicity variables in this analysis are from the Master Beneficiary Summary File (variable name BENE_RACE_CD).

^e In 2015, for the selected population, mean per capita total medical and prescription spending was \$14 519 (\$11 596 in medical spending and \$2913 in prescription spending).

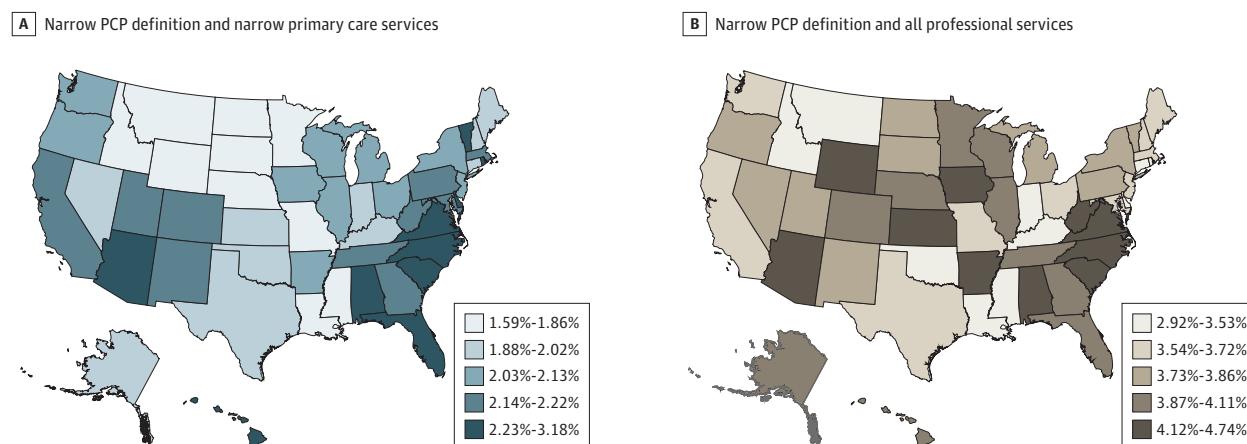
by PCPs. We excluded facility fees for outpatient primary care services billed in the Carrier File and did not include services ordered but not performed directly by PCPs (eg, tests and medications).

We measured primary care spending as a percentage of total medical and prescription spending nationally, by beneficiary characteristics, and by state. Statistical analyses were

performed using SAS software, version 9.4 (SAS Institute). Results were reported as 2015 US dollars and Spearman correlation coefficients. We reported 2-tailed $P < .05$ as statistically significant.

Results | Among 16 244 803 beneficiaries, primary care represented 2.12% of total medical and prescription spending for

Figure. Primary Care Spending as a Proportion of Total Medical and Prescription Spending Among Fee-for-Service Medicare Beneficiaries



Definitions of primary care practitioner (PCP) and primary care services are given in the Methods section.

the narrow definitions of PCPs and primary care services and 4.88% for the broad definitions (Table). For all definitions, primary care spending percentages were lower among beneficiaries who were older (eg, 1.76% for beneficiaries 85 years or older vs 2.12% for all beneficiaries, using the narrow definition), black (1.76%) or North American Native (1.51%), dually eligible for Medicare and Medicaid (1.64%), and who had chronic medical conditions (except hyperlipidemia). Primary care spending percentages varied by state (Figure), from 1.59% in North Dakota to 3.18% in Hawaii for the narrow health care provider and service definitions and from 2.92% in the District of Columbia to 4.74% in Iowa for the narrow health care provider and broad service definition. States' primary care spending percentages were not significantly correlated with per capita PCP headcounts⁶ (Spearman correlation coefficients 0.10 [$P = .47$] and -0.07 [$P = .61$], respectively).

Discussion | Primary care spending represented a small percentage of total fee-for-service Medicare spending and varied substantially across populations and states. Primary care spending percentages were lower among medically complex populations and were not correlated with state-level PCP headcounts, which suggests that headcounts might mismeasure primary care investment. Our estimates of primary care spending percentages in Medicare were lower than previous estimates among a convenience sample of commercial insurers, states, and other countries^{4,5}; these comparisons were confounded by differences in patient age, payer type, and other factors.

One limitation of this study is that our broader definitions of primary care spending may have included nonprimary care services delivered by PCPs, while our narrower definitions of primary care services may have excluded some PCPs or primary care services.

The optimal percentage of Medicare spending for primary care is unclear. Future research should evaluate effects on quality or outcomes of state efforts (eg, Rhode Island and Oregon) to institute minimum primary care spending

percentages.⁴ Our estimates may constitute reference points for future policies across the United States.

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Author Contributions: Dr Reid had full access to all the data in the study and takes responsibility for the integrity of the data analysis.

Concept and design: Reid, Friedberg.

Acquisition, analysis, or interpretation of data: All authors.

Drafting of the manuscript: Reid.

Critical revision of the manuscript for important intellectual content: Damberg, Friedberg.

Statistical analysis: Reid.

Obtained funding: All authors.

Supervision: Friedberg.

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Disclaimer: The content and opinions expressed in this publication are solely the responsibility of the authors and do not reflect the official position of the Agency for Healthcare Research and Quality or the US Department of Health & Human Services.

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6. US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce. Area Health Resources Files (AHRF) 2015-2016. Rockville, MD. <https://data.hrsa.gov/topics/health-workforce/ahrf>. Accessed March 5, 2019.

Use of Opioid Overdose Deaths Reported in One State's Criminal Justice, Hospital, and Prescription Databases to Identify Risk of Opioid Fatalities

The United States is in the midst of an opioid overdose epidemic, with 45 000 opioid overdose deaths in 2017, most involving fentanyl and heroin.¹ The President's Commission on Combating Drug Addiction and the Opioid Crisis has recommended data integration between state-based prescription drug monitoring programs and other systems to identify individuals who are at an elevated risk of overdose.² Linking prescription drug monitoring program data with other large databases can provide insight into how different service systems could have reached many individuals who fatally overdosed and how risk rates for each subgroup compare with statewide means.

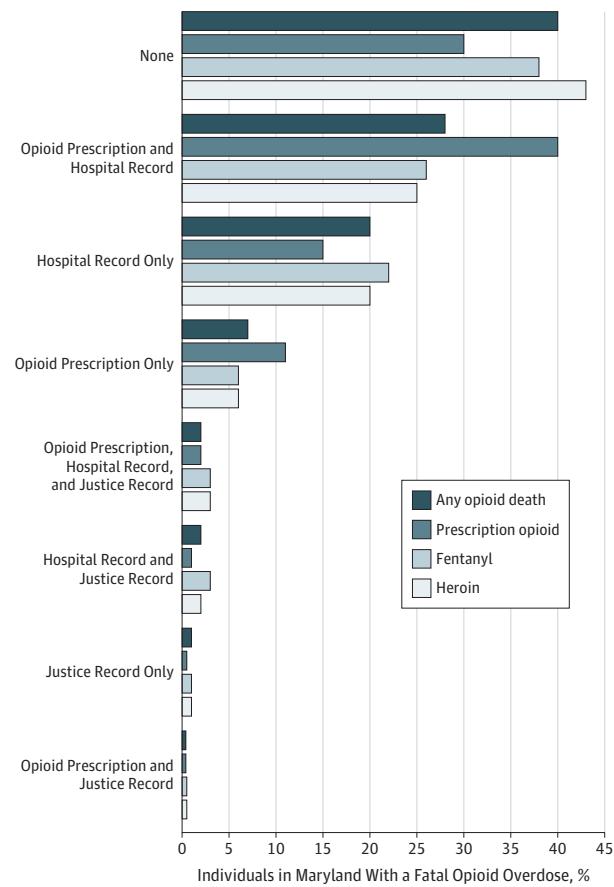
Methods | We identified Maryland residents with at least 1 record in 2015-2016 in any of 3 state-level data sets: opioid prescriptions in the prescription drug monitoring program data ($n = 1740\ 332$), inpatient hospitalization or emergency department visits in the Health Services Cost Review Commission data ($n = 2\ 047\ 397$), or at least 1 record for an adjudicated arrest, incarceration, or community supervision record (parole or probation) related to a property or drug offense in the Department of Public Safety and Correctional Services data ($n = 42\ 925$). These data were linked with opioid overdose death records (intentional and unintentional) from the Office of the Chief Medical Examiner ($n = 2902$), which could be separated into deaths involving heroin ($n = 1938$), fentanyl ($n = 1452$), and/or prescription opioids ($n = 765$) (numbers do not sum to 2902, as multiple types of opioids could be in-

volved in a death). Data were linked and deidentified through a health information exchange that maintains a sharing agreement with the Maryland Department of Health by using a validated algorithm.³ The study was approved by the institutional review boards at the Johns Hopkins School of Public Health and the Maryland Department of Health.

We described the proportion of individuals with a fatal opioid overdose who previously appeared in 1 or more of the above-described data sets. In addition, we compared the overdose death rate across each combination of data sources. All analyses were performed using STATA/MP, version 15 (StataCorp).

Results | Most individuals with fatal opioid overdose events appeared in at least 1 of the 3 data sets between 2015 and 2016 (Figure 1): 27.7% had opioid prescriptions and hospital records, 19.7% had hospital records only, 7.1% had opioid prescriptions only, and 5.9% had criminal justice records (either alone or in combination with clinical records). A total of 39.6% of individuals with fatal overdoses could not be linked with records in any

Figure 1. Percent of Persons With a Fatal Opioid Overdose Found Within Data Source in Maryland, 2015-2016



Persons experiencing fatal overdoses in 2015-2016 in Maryland who had opioid prescriptions, hospital records, and/or criminal justice records prior to overdose, separated by type of opioid death. More information on opioid prescriptions, hospital records, and justice records can be found in the Methods section.



Oregon Primary Care Payment Reform Collaborative

NANCY FAN, MD

OCTOBER 21, 2019

Patient Centered Primary Care Program

(courtesy Patient Centered PC Collaborative)

- ▶ Established 2009
- ▶ Define core attributes of the patient centered primary care home;
- ▶ Establish a simple and uniform process to identify patient centered primary care homes that meet the core attributes defined by the Office;
- ▶ Develop uniform quality measures that build from nationally accepted measures and allow for standard measurement of patient centered primary care home performance; and
- ▶ Develop policies that encourage the retention of, and the growth in the numbers of, primary care providers.
- ▶ Established to help practices with CPC, CCO and Health Homes

Patient Centered Primary Care Program

- ▶ Broadened in 2012 with the establishment of the Patient Centered Primary Care Institute
- ▶ to help practice transformation, including behavioral health integration support, and learning collaboratives with expert network
- ▶ Had multiple payment models:
 - ▶ CPC, CPC Plus
 - ▶ Coordinated Care Organizations through Medicaid
 - ▶ Aetna PCMH program

Patient Centered Primary Care Program

<p>Chapter 602 of the 2011 Oregon Laws</p> <p>This law established the Oregon Integrated and Coordinated Health Care Delivery System. It requires the Oregon Health Authority (OHA) to establish standards for using PCPCHs within Coordinated Care Organizations (CCO) and requires CCOs to implement PCPCHs to the extent possible.</p>	Enacted 2011
<p>Chapter 595 of the 2009 Oregon Laws</p> <p>The legislation established the Patient Centered Primary Care Home (PCPCH) Program by the Office for Oregon Health Policy and Research. This law created a learning collaborative to assist practices in developing the infrastructure for PCPCH. The law also allowed for changes in payment for practices who provide care in medical homes including payment for interpretive services and rewards for improvements in health quality.</p>	Enacted 2009
<p>Oregon Senate Bill 934 - Relating to payments for primary care; creating new provisions; and amending ORS 514A.005</p> <p>Requires coordinated care organization, Public Employees' Benefit Board and Oregon Educators Benefit Board to spend at least 12 percent of total medical expenditures on primary care by January 1, 2023.</p> <p>Requires Department of Consumer and Business Services to establish requirements for carrier to submit plan for increasing spending on primary care as percentage of total medical expenditures if carrier is spending less than 12 percent of total medical expenditures. Extends sunset on Primary Care Transformation Initiative.</p>	Enacted 2017
<p>PASSED - Effective date, January 1, 2018.</p>	
<p>SB 765 A: Relating to Primary Care</p> <p>Modifies definitions of "primary care" and "total medical expenditures" for purpose of reports on spending for primary care by insurance carriers, Public Employees' Benefit Board, Oregon Educators Benefit Board and coordinated care organizations.</p> <p>Requires all carriers, providing specified health insurance Public Employees' Benefit Board, Oregon Educators Benefit Board and coordinated care organizations to report on spending anticipated in upcoming year on primary care, and on use of alternative payment methodologies for reimbursing costs of primary care and on</p>	Pending 2019

Primary Care Payment Reform Collaborative

(report to the Oregon Legislature, Feb, 2019)

- ▶ Established 2015 and 2016 by legislative mandate for reporting of annual primary care spending. The spending included:
 - ▶ Prominent carriers, defined as health insurance carriers with annual health premium income of \$200 million or more. These carriers may offer commercial or Medicare Advantage plans.
 - Health insurance plans contracted by the Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB)
 - Medicaid coordinated care organizations (CCOs)
 - ▶ It excludes:
 - ERISA self-insured plans
 - Prescription drug claims
 - Health care payers not covered by SB 231, and
 - Health care spending by people who pay out-of-pocket including people without insurance.

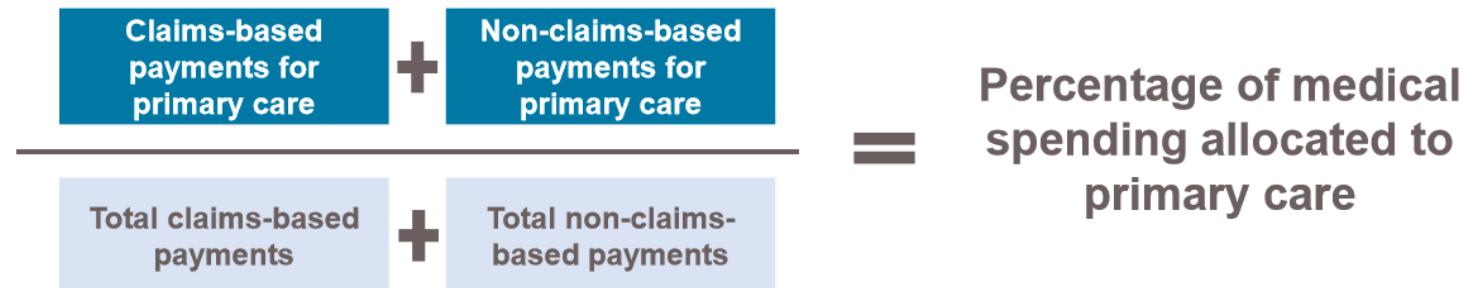
Primary Care Payment Reform Collaborative

- ▶ In addition to reporting on spending allocated to primary care, SB 231 requires OHA to convene a Primary Care Payment Reform Collaborative. The collaborative is an advisory group tasked with helping OHA develop and implement the Primary Care Transformation Initiative to strengthen Oregon's primary care system. Senate Bill 934 (2017) extends the collaborative through 2027.
- ▶ SB 934 also requires health insurance carriers and CCOs to allocate at least 12 percent of their health care expenditures to primary care, by 2023.

Primary Care Payment Reform Collaborative

- ▶ Claims-based payments: Payments to health care providers for services reported on health care claims. As reflected in statute, OHA uses claims based on specific provider types and for specific services related to primary care. Information about claims-based payments made by Oregon's major health care payers is available from OHA's All Payer All Claims Data Reporting Program (APAC).
- ▶ • Non-claims-based payments: Payments to health care providers intended to:
 - ▶ o Motivate efficient care delivery o
 - ▶ Reward achievement of quality or cost-savings goals, and
 - ▶ o Build primary care infrastructure and capacity.

drugs.



Claims-based payments

Payments to primary care providers and practices:

Primary care providers

- Physicians specializing in primary care, including family medicine, general medicine, obstetrics and gynecology, pediatrics, general psychiatry, and geriatric medicine
- Naturopathic providers
- Physicians' assistants, and
- Nurse practitioners

For primary care services:

- Office or home visits
- General medical exams
- Routine medical and child health exams
- Preventive medicine evaluation or counseling

Primary care practices

- Primary care clinics
- Federally qualified health centers (FQHCs), and
- Rural health centers

- Health risk assessments
- Routine obstetric care, including delivery, and
- Other preventive medicine

Non-claims-based payments

Payments to primary care providers and practices:

- Capitation payments and provider salaries
- Risk-based payments
- Payments for patient-centered primary care home or patient-centered medical home recognition
- Payments to reward achievement of quality or cost-savings goals
- Payments aimed at developing capacity to improve care for a defined population of patients, such as patients with chronic conditions
- Payments to help providers adopt health information technology, such as electronic health records
- Payments or expenses for supplemental staff or activities, such as practice coaches, patient educators, patient navigators or nurse care managers

Defining and Measuring the Patient-Centered Medical Home

James M. Gill, MD, MPH
DE Primary Care Collaborative
November 12, 2019

Adapted from:

The PCMH: Setting a Policy Agenda
July 27, 2009 Washington, DC

Kurt C. Stange, MD, PhD

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William L. Miller, MD, MA

Carlos R. Jaén, MD, PhD

Benjamin F. Crabtree, PhD

Susan A. Flocke, PhD

James M. Gill, MD, MPH



Stange KC, Nutting PA, Miller WL, et al. Defining and measuring the patient-centered medical home. Journal of General Internal Medicine. 2010 Jun;25(6):601-12.

Summary

- Primary care leads to health benefits
- Patient Centered Medical Home (PCMH)
 - Advanced primary care
 - Enhanced benefits
- How to measure the PCMH
- NCQA PCMH Tool: pros and cons
- Alternatives to NCQA

Principles of Primary Care

- **First Contact Care:** Access
- **Longitudinality:** Continuity over Lifespan
- **Comprehensiveness:** Whole Person
- **Coordination:** Integration with rest of health care system
- **Family and Community Centered**

Starfield B. Primary Care Concept, Evaluation and Policy. 1st ed. New York: Oxford University Press; 1992

Principles of PCMH

- Personal physician (clinician)
- Physician-directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality & safety
- Enhanced access
- Payment recognizes added value

Joint principles of the patient-centered medical home. Accessed at:
www.medicalhomeinfo.org/Joint%20Statement.pdf.

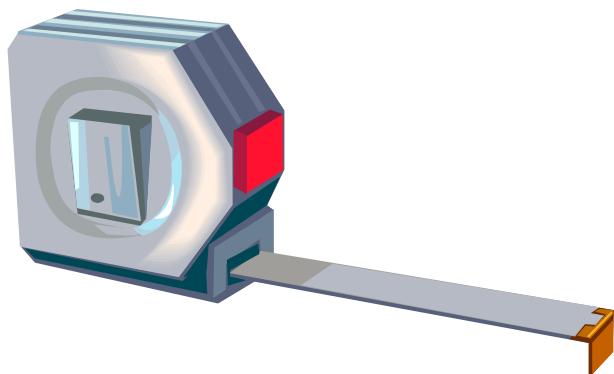
Benefits of Primary Care/PCMH

- Better population health
- Lower cost
- Less inequality
- Better health care quality
- PCMH shown to enhance benefits of Primary Care

Starfield B, Shi LY, Macinko J. Contribution of primary care to health systems and health. *Milbank Q.* 2005;83(3):457-502.

Landon BE, Gill JM, Antonelli RC, Rich EC. Prospects for rebuilding primary care using the patient-centered medical home. *Health Affairs.* 2010 May;29(5):827-34

Principles for Measuring the PCMH



- 1. Primary care principles**
- 2. New technology & approaches**
 - Caveats:
 - Tendency to over-emphasize instrumental/technical aspects
 - Tendency to under-value relationship and patient-centered aspects
 - Tendency to expect benefits too soon: Outcomes take 5-10 years
 - Great potential for unintended consequences if not careful

NCQA Measure

- Most common and well-known measure
 - Used by many health plans
 - Most common definition in studies
- **9 Standards:**
 - Access and communication
 - Patient tracking and registries
 - Care management
 - Patient self-management support
 - Electronic prescribing
 - Test tracking
 - Referral tracking
 - Performance reporting and improvement
 - Advanced electronic communications

NCQA Measure – 166 practice-report items

46% Use of information technology

14% Care for 3 specific chronic diseases

13% Systems for coordinating care

9% Processes for accessibility

5% Performance reporting

4% Tools for organizing clinical data

2% Use of non-physician staff

2% Collection of data on patient experience

1% Preventive service delivery

1% Continuity of care

1% Patient communication preferences

O'Malley AS, Peikes D, Ginsburg PB. Qualifying a Physician Practice as a Medical Home Policy Perspective: Insights into Health Policy Issues. No. 1 December, 2008. Available at:

<http://www.hschange.com/CONTENT/1030/#ib1>

What's Missing?

- Comprehensiveness of care
- Patient perspective
- Relationships/Trust
- Mental health
- Neighborhood/Community
- Longitudinal person & population outcomes
- Developmental process of transformation

Nutting PA, Miller WL, Crabtree BF, Jaén CR, Stewart EE, Stange KC. Initial lessons from the first national demonstration project on practice transformation to a patient-centered medical home. *Ann Fam Med.* 2009;254-26.

Biggest Problem with NCQA Measure

- Enormously time and resource-intensive
- Extremely costly
- Our office achieved level 3 PCMH – at a cost of \$20-30K
- That is the reason most small offices do not pursue NCQA certification
- Re-certification is somewhat less expensive (but still very time consuming and expensive)
- Our office decided not to pursue re-certification
- NCQA not realistic for Delaware

Alternatives to NCQA Measure

- Primary Care Assessment Tools (PCAT)
 - Developed at Johns Hopkins by Starfield, et. al.
- Primary Care Assessment Survey (PCAS)
 - Developed by Dana Safran, ScD
- PCAT and PCAS perform better than NCQA-PCMH
- Require <10% of the resources of NCQA-PCMH

Measuring Medical Homes: Tools to Evaluate the Pediatric Patient- and Family-Centered Medical Home. Rebecca A. Malouin, PhD, MPH, and Sarah L. Merten, MPH. Accessed at: https://medicalhomeinfo.aap.org/tools-resources/Documents/Monograph_FINAL_Sept2010.pdf

Measuring Medical Homes

Tools to Evaluate the Pediatric Patient-
and Family-Centered Medical Home

Rebecca A. Malouin, PhD, MPH
and Sarah L. Merten, MPH

Department of Pediatrics and Human Development
College of Human Medicine
Michigan State University

were included in the tool.

TABLE 3. PEDIATRIC MEDICAL HOME ATTRIBUTES OF AVAILABLE TOOLS

Tool	Accessible	Family Centered	Continuous	Comprehensive	Coordinated	Compassionate	Culturally Effective
CAHPS Child Primary Care Questionnaire 2.0	-	++	+	++	++	+	+
CPCI	-	++	+	++	++	+	-
FCCT	++	++	+	+	++	++	++
MHI	-	++	+	-	++	-	+
MHFI	++	++	+	-	++	+	+
MHQI	-	++	+	++	++	-	++
MPOC - 56	-	++	++	++	++	++	-
MPOC - 20	-	++	+	++	++	++	-
PCAS	++	++	++	++	++	++	+
PCAS - Short Form	+	++	+	++	++	++	-
PCAT - Child Expanded Tool	+	++	++	++	++	++	++
PCAT - Child Short Tool	+	++	+	++	++	+	++
PHDS	-	++	+	++	+	++	++
PPC-PCMH	+	++	+	+	++	-	++
P3C	+	++	+	++	++	+	+
YAHCS	-	++	-	+	-	+	+

- No elements from the AAP Desirable Characteristics of a Medical Home included in attribute

+ if at least one element from AAP Desirable Characteristics of a Medical Home included in attribute

++ if more than one element from AAP Desirable Characteristics of a Medical Home included in attribute

Appendix E. Tools At-a-Glance Table

TOOL NAME	DATE OF ORIGINAL RELEASE	NUMBER OF ITEMS/ QUESTIONS	NUMBER OF PAGES	LENGTH OF TIME TO COMPLETE	LANGUAGE AVAILABLE	TYPE(S) OF RESPONDENT		FORMAT FOR COMPLETION		COST FOR USE
						PHYSICAL	CINICIAN	PARENT/FAMILY	SELF-ADMIN	
CAHPS® C&G	Child Primary Care 1.0	2006	37 (additional 64 supplemental)	11	15-20 minutes	English & Spanish		X	X	X
	Child Primary Care 2.0 (beta)	2008	54 (additional 24 supplemental)	15	20-25 minutes			X	X	None. Permission required
CPCI		1996	52	2	15 minutes	English		X	X	None. Permission required
Family-Centered Care Self Assessment Tools	Family Version	October	98	8	15-20 minutes	English		X	X	None.
	Provider Version	2008	105	8	15-20 minutes		X		X	
MHI	MHI		25	11	15-20 minutes	English	X	X	X	None. Permission required
	MHFI	2001	38	3	15-20 minutes	English & Spanish		X	X	
	MHI-Short Version		10	4	5-10 minutes	English	X	X	X	Sharing of data requested.
MHIQ		April 2008	9 modules of 13-30 questions	Web-based	Minimum of 15 minutes/module; average time-to-completion of 2-4 hours	English	X	X	X	None. Free registration is required.
MPOC	MPOC-56	November 1995	56	6	15-20 minutes	English, French, Dutch, German, Finnish, Swedish		X	X	None. Permission required. The MPOC-SP will be sent to you electronically.
	MPOC-20	1999	20	3	5-10 minutes	English		X	X	
	MPOC-SP	1998	27	4	10-15 minutes	English	X	X	X	
PCAS	Full Version	1994	51	19	7-15 minutes (self-admin) or 15-20 minutes (interviewer-admin)	English		X	X	X
	Short Version	2000	23	7				X	X	X
PCAT Child		1998	121	14	20-25 minutes	English, Spanish, French		X	X	X
PCAT Child		1998	68	11	10-15 minutes		X	X	X	

PCAS	Full Version	1994	51	19	7-15 minutes (self-admin) or 15-20 minutes (interviewer-admin)	English	X	X	X	None. Permission required
	Short Version	2000	23	7	5-10 minutes		X	X	X	
PCAT	PCAT Child	1998	121	14	20-25 minutes	English, Spanish, French, Catalan, Portuguese, Korean & Mandarin Chinese (both People's Republic of China & Taiwan)	X	X	X	None. Permission required
	PCAT Child Short Version	1998	68	11	10-15 minutes		X	X	X	
	PCAT Provider	1998	153	14	20-25 minutes		X		X	
	PCAT Provider Short Version	1998	70	10	10-15 minutes		X		X	
	PCAT Facility	1998	153	14	20-25 minutes		X		X	
	PCAT Facility Short Version	1998	70	10	10-15 minutes		X		X	
PHDS	Full Version	1999	61	15	15-18 minutes	English, Spanish	X	X (mail)		None. Tool is copyrighted, but non-proprietary. Available at no charge. Permission required.
	PHDS-PLUS	2001	128	N/A	12-15 minutes		X		X (telephone)	
	Pro-PHDS	2002	21	4	5 minutes		X	X (mail/in office)		
	Online PHDS	2008	Maximum of 66 questions - users can pick specific sections	Web-based	10-15 minutes **			X (online)		
	ProPHDS-5	2008	5	Web-based	3-5 minutes		X	X (online)		
PPC-PCMHTM		2008	166	Web-based	40-80 hours	English	X	X	X	\$80 to access for 1-4 users
P3C		2001	23	1	5-10 min	English, Spanish, Vietnamese & Tagalog		X	X	None. Permission required
YAHCS		1999	56	7	10-15 minutes	English & Spanish		X	X	None. Permission required

**Users can choose to complete only specific sections, thereby shortening the survey length

Trinity Health ACO

- Next Generation ACO with upside and downside risk
- Included patients from health systems and private groups in Illinois, Michigan, New Jersey, and Ohio
- 100K Medicare patients with up to 15% of medical spend at risk
- Centralized team that provided actuarial support and data analytics at the system level
- Local teams responsible for care management, social work, care coordination, clinician engagement, and leadership
- Expectation that local group spent \$22 PMPM on the infrastructure above

Delaware Medicaid Value Based Purchasing

*Primary Care Reform Collaborative
January 8, 2020*



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Medicaid & Medical Assistance

2018 Managed Care Contracts Driving Value Based Purchasing

Dual Strategy

- Quality Performance Measures
- Benchmarks for proportion of total spending attributable to value based purchasing contracts

Financial penalties for failure to meet requirements in either area

2018 Managed Care Contracts Driving Value Based Purchasing

Quality Performance Measures

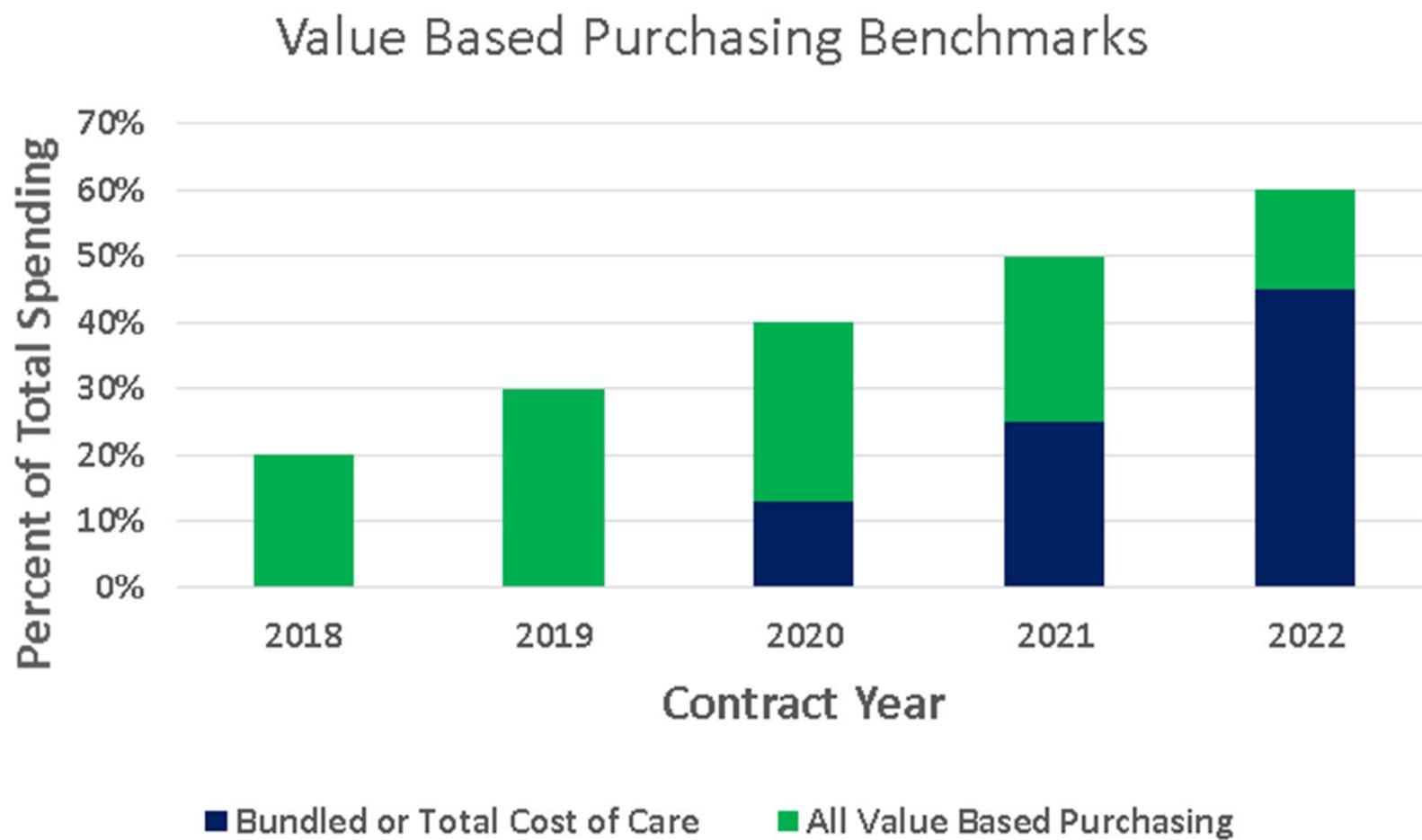
- Diabetes Care
- Medication management for people with asthma
- Cervical Cancer Screening
- Breast Cancer screening
- BMI Assessment
- Prenatal and postpartum care
- 30-day hospital readmission rate

2018 Managed Care Contracts Driving Value Based Purchasing

Value Based Purchasing

- Shared Savings: offers providers a percentage of any realized net savings – upside risk.
- Bundled/Episodic Payments: provider receives a lump sum for all health services delivered for a single episode of care.
- Risk/Capitation/Total Cost of Care: contractor and provider share the financial risk for a defined population – upside and downside risk.

2018 Managed Care Contracts Driving Value Based Purchasing



Delaware Value-Based Programs

Primary Care Collaborative Update



Delaware Health Care Delivery Reform

DHSS Moves Medicaid Managed Care Contracts to Value-Based Purchasing to Accelerate Health Care Delivery Reforms

Delaware's health care delivery system, Department of Health and Social Services (DHSS) Secretary Dr. Kara Odom Walker announced today that DHSS has entered into a value-based purchasing care initiative through contracts in its Medicaid Managed Care Program. This initiative applies to all managed care organizations participating in the Delaware Medicaid program.

Beyond accelerating reforms, Secretary Walker said the purpose of the agreement is to transition the system away from traditional fee-for-service, volume-based care to a system that focuses on rewarding and incentivizing improved patient outcomes, value, quality improvements and reduced expenditures. DHSS seeks to align the incentives of the managed care organizations, providers and members through innovative value-based strategies.

Delaware Health and Social Services | Office of the Governor Date Posted: Thursday, January 25, 2018

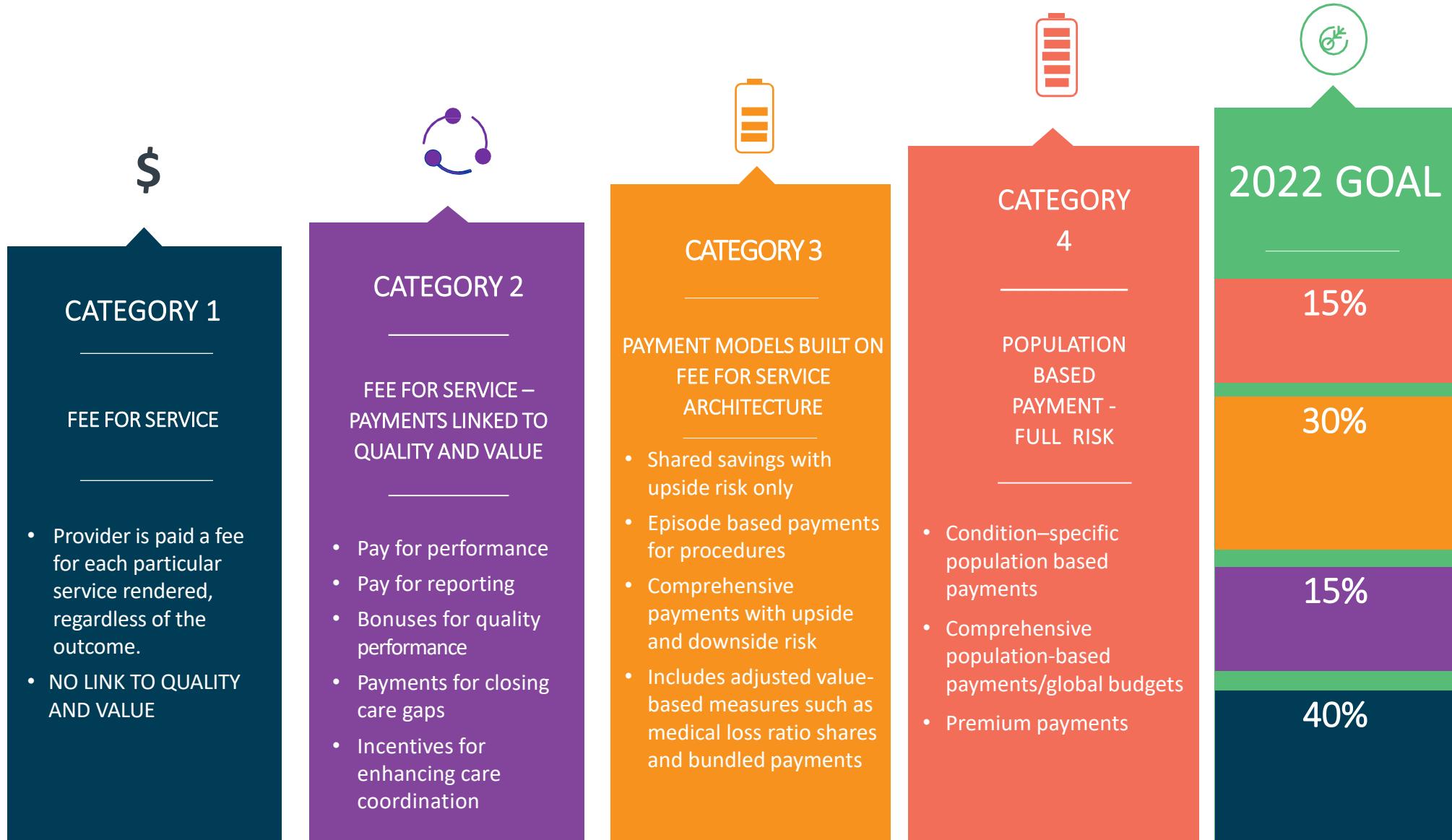
Medicaid MCO Requirements

“The purpose of this initiative is to accelerate the implementation of reforms/innovation within Delaware’s health care delivery system to migrate the system away from traditional fee-for-service (FFS)/volume-based care to a system that focuses on rewarding and incentivizing improved outcomes, value, quality improvement and reduced expenditures.”

Delaware Health and Social Services | Medicaid Managed Care Master Services Agreement

1. MCO contract requirements were implemented effective 1/1/2018 requiring MCOs to meet or exceed seven specific quality thresholds and to achieve value-based contracting threshold targets.
2. The value-based contracting thresholds increase each year to reach a minimum 60% of all medical/service expenditures for all populations by 2022. 3/4 of the 60% must be from combination of: shared savings; bundled/episodic payments; risk/capitation/total cost of care; or other innovative payment arrangements approved by the state.
3. Significant penalties will be assessed for each year of non-compliance; no additional funding was added to MCO rates for these new requirements.

Alternative Payment Model Continuum



Source: Adapted from AmeriHealth Caritas

AmeriHealth Caritas Delaware Implementation Plan

2018 ACDE Year 1 Meet or Exceed 10% threshold level	2019 ACDE Year 2 Meet or Exceed 20% threshold level	2020 ACDE Year 3 Meet or Exceed 40% threshold level
<ul style="list-style-type: none">• Health Plan Go Live 1/1/18!!!• Convert all LOAs to fully executed contracts• Complete credentialing of provider network• Outreach to members and providers to create PCP assignments for all transitioned members• Implement targeted Value-Based Programs based on shared savings• Meet state VBP contract requirements• Establish quality baselines• 499 Primary Care Physicians• 236 Specialists	<ul style="list-style-type: none">• Evaluate 2018 results and adjust programs as needed• Begin automation of data exchanges (i.e., DHIN, i2i, Carelink)• Incorporate partial risk arrangements into new or existing contracts• Launch Specialty Value-Based Programs (i.e., FQHC, Home Health, BH)• Identify additional internal quality interventions to support provider initiatives and close care gaps• Identify opportunities for additional provider/payer collaboration in support of 2022 targets• 555 Primary Care Physicians• 300 Specialists	<ul style="list-style-type: none">• Evaluate 2019 results and adjust programs as needed• Ongoing analysis to validate member auto-assignment vs. utilization• Identify additional internal quality interventions to support provider initiatives and close care gaps• Continue automation of data exchanges• Launch PerformPlus Quality Enhancement Program (QEP) for PCPs not enrolled in an existing VBP• Continue to transition Shared Savings Contracts to Partial/Full Risk Arrangements as appropriate• Identify opportunities for additional provider/payer collaboration in support of 2022 targets

Source: Adapted from AmeriHealth Caritas

2020 PerformPlus Quality Enhancement Program

- The PerformPlus Quality Enhancement Program is designed by AmeriHealth Caritas to link the fee-for-service payment model to quality and value.
- The Quality Enhancement Program model is built on the idea that receiving the right care at the right time in the right setting can improve health outcomes. It is a foundational alternative payment model and is intended to be an introduction in the evolution toward pay-for-performance reimbursement structures.
- The program measures are tailored to align with the state's Medicaid quality and aim to increase the use of preventive services.
- All primary care physician groups with greater than or equal to at least 50 ACDE member panels not already participating in an ACDE value-based program are eligible to participate and may receive financial rewards for accurate data reporting and exemplary quality performance.

Lessons Learned

- Many adjustments to our criteria needed to be made along the way due to immature data as a new health plan.
- Data extractions and interfaces greatly reduce administrative burden for providers and payers.
- Payers and providers need to better leverage DHIN capabilities.
- Increased reimbursement without improved quality does not reduce total cost of care.
- Payment transformation is a journey which requires ongoing provider/payer collaboration to achieve better outcomes.
- The quality of provider/payer collaboration is a critical success factor.

More than
35 YEARS
of making
care the heart
of our work.

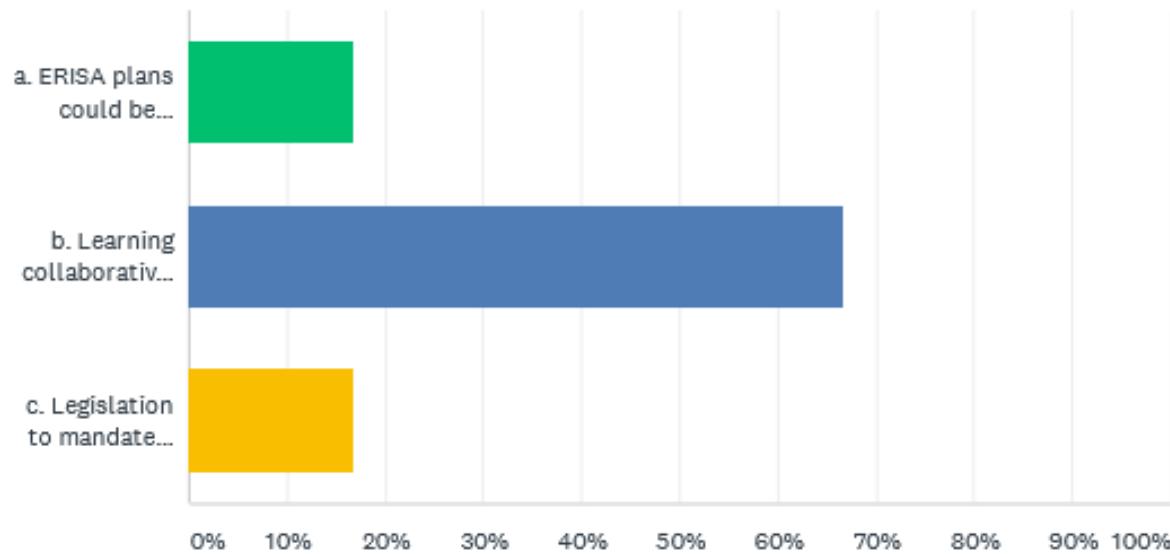




Care Model and Certification Survey Results

Q1 The Collaborative has discussed that accessing claim based data from ERISA plans is a challenge. Without ERISA plan data, the all claims database will be incomplete. Please select the answer that you believe is the best approach. If you believe all of the items need to be considered, please indicate it in your comments.

Answered: 12 Skipped: 0



ANSWER CHOICES		RESPONSES
a. ERISA plans could be financially incentivized to submit data to the APCD		16.67% 2
b. Learning collaborative to educate self-insured organizations regarding the goal of sustaining primary care and the use of the APCD		66.67% 8
c. Legislation to mandate submission of data to APCD		16.67% 2
TOTAL		12
#	COMMENTS (OPTIONAL):	DATE
1	Based upon the Supreme Court case from VT, it doesn't sound like this can be mandated.	12/31/2019 2:30 PM
2	We suggest that ERISA-applicable plans be encouraged to contribute data to ensure that the database is as complete as possible, and for the good of the overall project. We look forward to hearing how the successful bidder for the Director of the Office of Value Based Health Care Delivery has tackled this issue in her/his experience with health care innovation.	12/30/2019 3:42 PM
3	Education on the goal of sustaining primary care is not needed. Just the use of the APCD.	12/25/2019 2:18 PM
4	Incentivized by the state or insurance companies.	12/23/2019 1:27 PM
5	In the end, legislation may be necessary, but the collaborative approach should start with education and hopefully cooperative care. However, given ERISA is a federal mandate, I am not sure that the states can do anything to get the data.	12/22/2019 3:26 PM

Q2 Please include any general comments related to the APCD and ERISA plans.

Answered: 5 Skipped: 7

#	RESPONSES	DATE
1	Inclusion of ERISA plans should be pursued but we should be prepared to move forward regardless of their participation.	12/30/2019 9:33 PM
2	Understanding the interface between ERISA-regulated plans and DOI-regulated plans is important to moving the APCD discussion forward.	12/30/2019 3:42 PM
3	A well-developed value-proposition could be successful in getting ERISA plans to participate in the APCD.	12/27/2019 2:06 PM
4	Who are the largest self insured organizations in Delaware? The State? U of D? Can insurance carriers provide us with this information.	12/23/2019 1:27 PM
5	Business, as usual, is not an option - open access (to appropriate practitioners) of the information is critical to success.	12/22/2019 3:26 PM

Q3 Please include any general comments related to the work completed by Primary Care Collaborative here.

Answered: 3 Skipped: 9

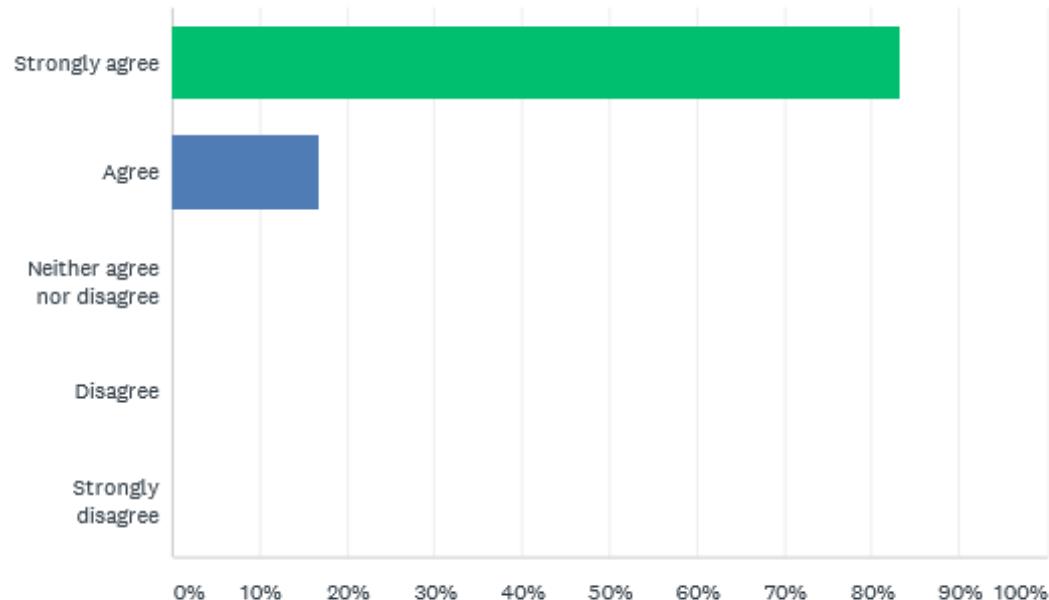
#	RESPONSES	DATE
1	The Commissioner is please to be a member of the PCC and looks forward to contributing on a going forward basis.	12/30/2019 3:42 PM
2	Heading in the right direction.	12/23/2019 1:27 PM
3	I would question the inclusion of cultural diversity in the group - how do our initiatives dovetail with the Delaware SHIP goals, and is that important? We need to maintain the forefront that this is about patient care. There are too many regulations now; let's not make the mistake of fixing a problem with a problem. DHIN is a perfect example of not sharing information yet charging a lot for the limited-service to struggling practitioners.	12/22/2019 3:26 PM



ERISA and APCD Survey Results

**Q1 Please indicate the rate in which you agree with this statement:
"Primary Care is foundational to health care delivery in Delaware"**

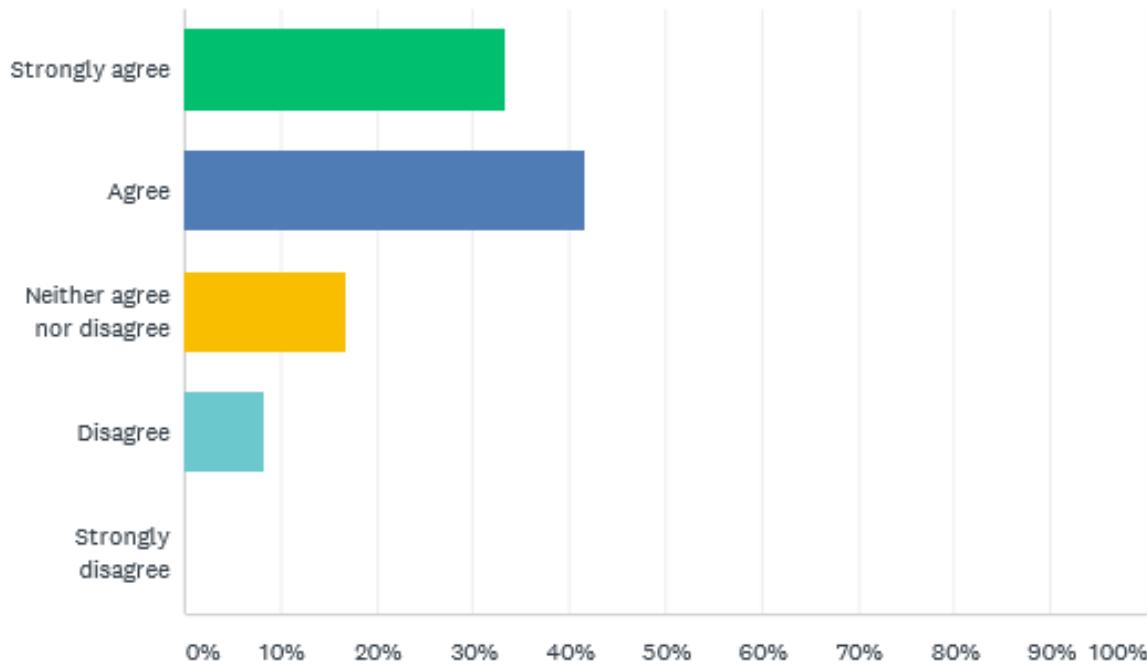
Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	83.33%	10
Agree	16.67%	2
Neither agree nor disagree	0.00%	0
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		12

Q2 Please indicate the rate in which you agree with this statement: "The core values of the Patient Center Medical Home should be the framework that support valued based payment."

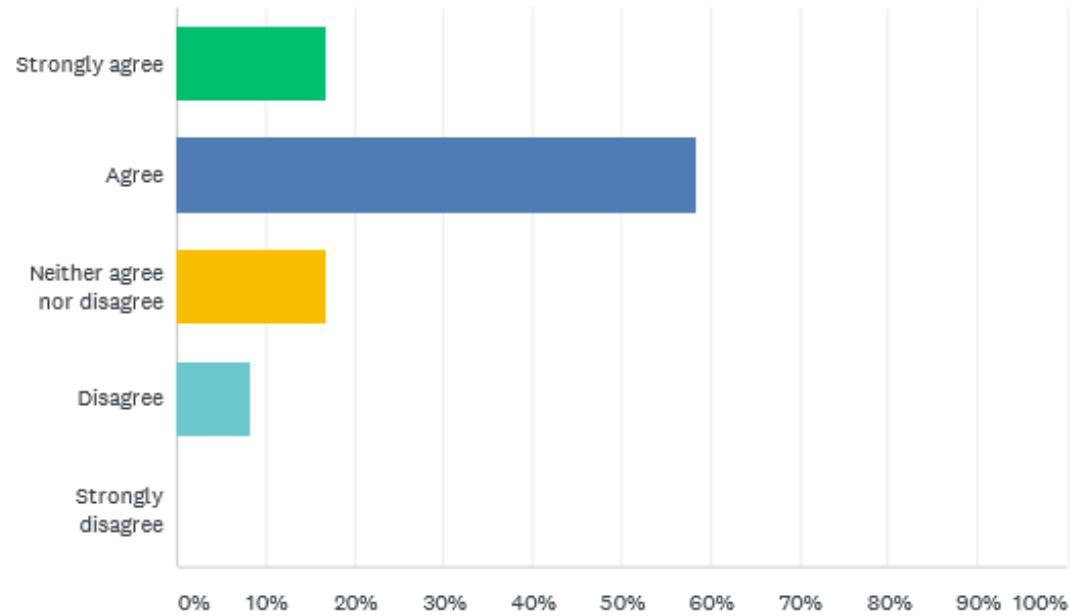
Answered: 12 Skipped: 0



ANSWER CHOICES		RESPONSES	
Strongly agree		33.33%	4
Agree		41.67%	5
Neither agree nor disagree		16.67%	2
Disagree		8.33%	1
Strongly disagree		0.00%	0
TOTAL			12
#	COMMENTS (OPTIONAL):	DATE	
1	we should make sure that we consider variations of the PCMH, including the Joint Commission Primary Care Medical Home accreditation.	1/5/2020 2:21 AM	
2	There needs to be a consideration for ALL healthcare providers to create a team. The meaning here is that independent practices still exist but are often excluded from many aspects of PCMH principles. We all want to provide the best care, no one provider is better than the whole as long as the team is inclusive and NOT related to a physical location or entity.	12/21/2019 10:47 PM	

Q3 Please indicate the rate in which you agree with this statement: "Other care models than PCMH type should be considered"

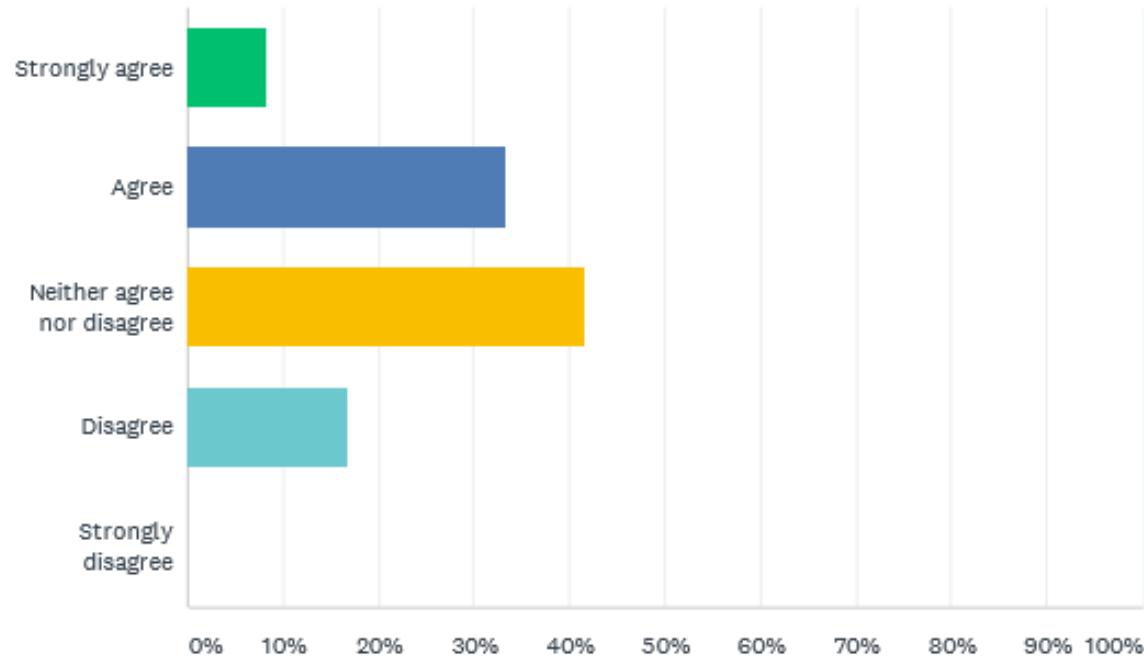
Answered: 12 Skipped: 0



ANSWER CHOICES		RESPONSES	
Strongly agree		16.67%	2
Agree		58.33%	7
Neither agree nor disagree		16.67%	2
Disagree		8.33%	1
Strongly disagree		0.00%	0
TOTAL			12
#	COMMENTS (OPTIONAL):	DATE	
1	Other models of care may better address the components discussed above, we need to take the location out and create virtual teams that allow patient choice in their care.	12/21/2019 10:47 PM	

**Q4 Please indicate the rate in which you agree with this statement:
"Delaware should develop a NCQA-like certifying body."**

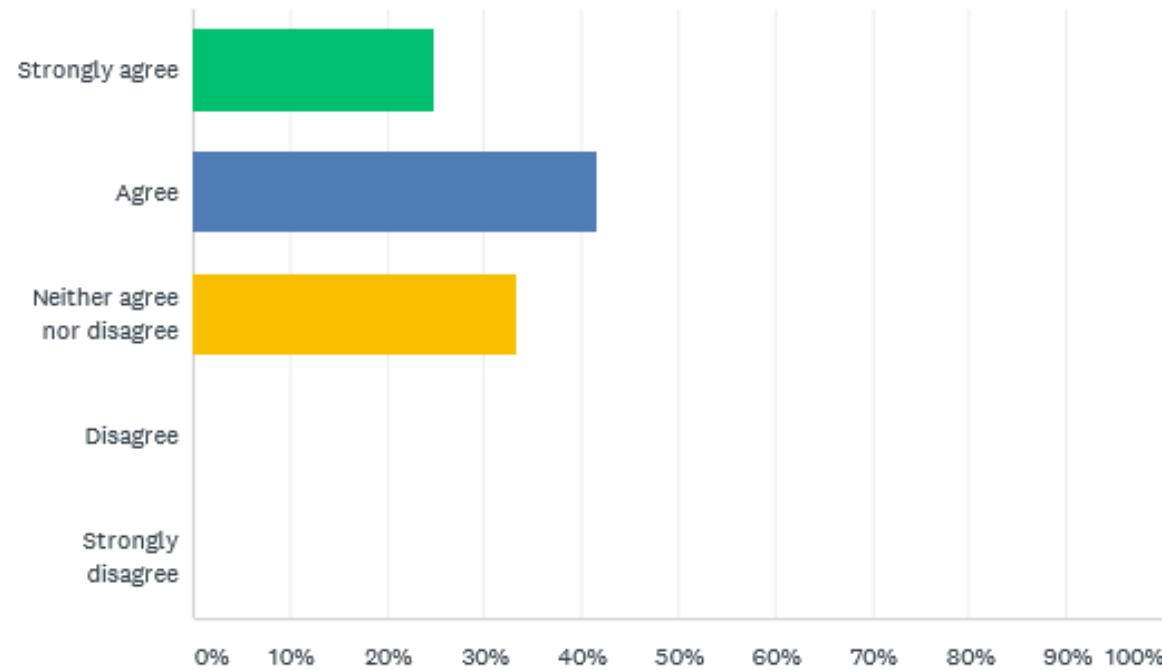
Answered: 12 Skipped: 0



ANSWER CHOICES		RESPONSES	
Strongly agree		8.33%	1
Agree		33.33%	4
Neither agree nor disagree		41.67%	5
Disagree		16.67%	2
Strongly disagree		0.00%	0
TOTAL			12
#	COMMENTS (OPTIONAL):	DATE	
1	While I believe it would be important to have a Delaware-specific certifying body, we do need to consider what it would take to sustain this effort in the future. Perhaps its more of a certification review board.	1/5/2020 2:21 AM	
2	Maybe in the future, but I don't think we are even close to creating an entity like NCQA before we consider the implications for all practitioners.	12/21/2019 10:47 PM	

Q5 Please indicate the rate in which you agree with this statement:
"Additional payment incentives could be adopted for practices with PCMH-like core values and practice infrastructure"

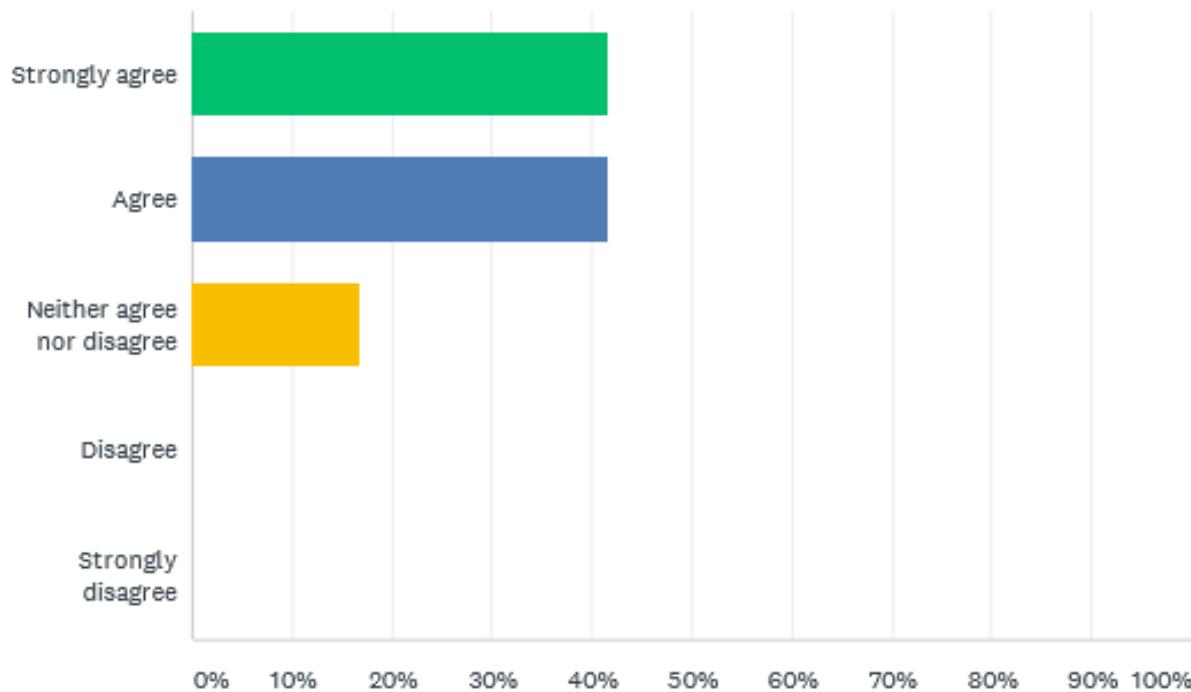
Answered: 12 Skipped: 0



ANSWER CHOICES		RESPONSES	
Strongly agree		25.00%	3
Agree		41.67%	5
Neither agree nor disagree		33.33%	4
Disagree		0.00%	0
Strongly disagree		0.00%	0
TOTAL			12
#	COMMENTS (OPTIONAL):	DATE	
1	If there is additional reimbursement, base it on the quality of care, not the 'numbers' of patients treated.	12/21/2019 10:47 PM	

Q6 Please indicate the rate in which you agree with this statement : "To transition practices away from FFS to alternative value based payment models could include both upfront investments with prospective payments and risk based incentive payments (Primary Care First model)"

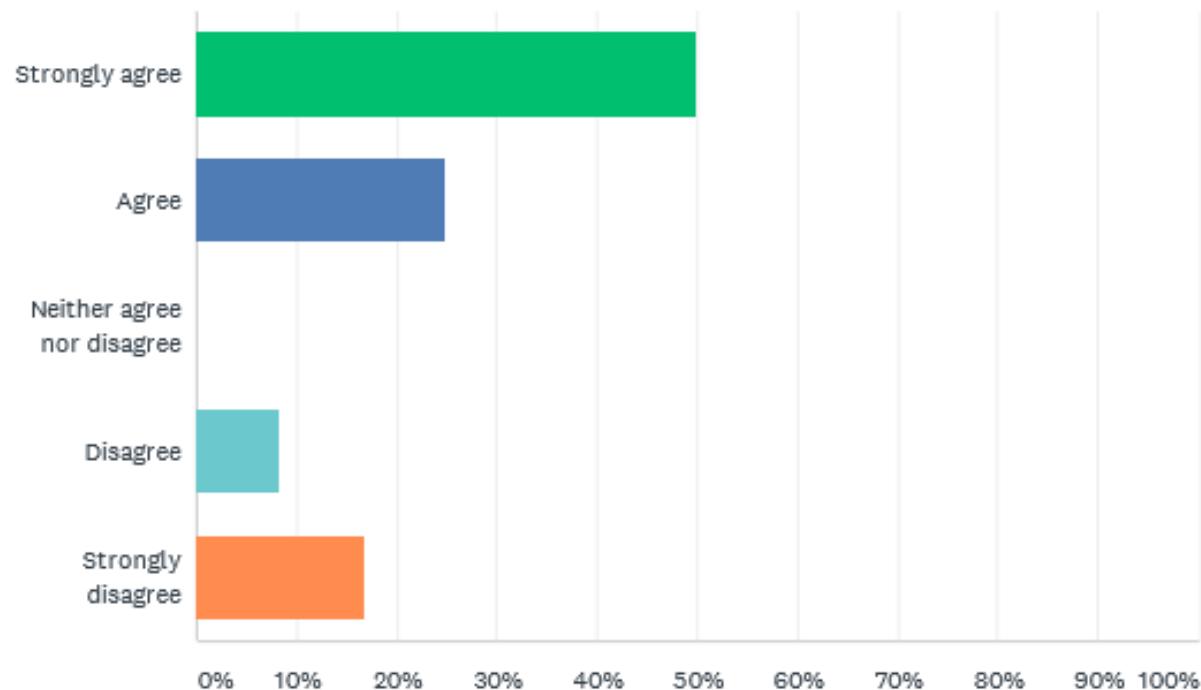
Answered: 12 Skipped: 0



ANSWER CHOICES		RESPONSES	
Strongly agree		41.67%	5
Agree		41.67%	5
Neither agree nor disagree		16.67%	2
Disagree		0.00%	0
Strongly disagree		0.00%	0
TOTAL			12
#	COMMENTS (OPTIONAL):	DATE	
1	This model seems to be more appropriate to include all types of practitioners and sites.	12/21/2019 10:47 PM	

Q7 Please indicate the rate in which you agree with this statement:
"Increased prospective payments should be tied to risk and value based payment models"

Answered: 12 Skipped: 0

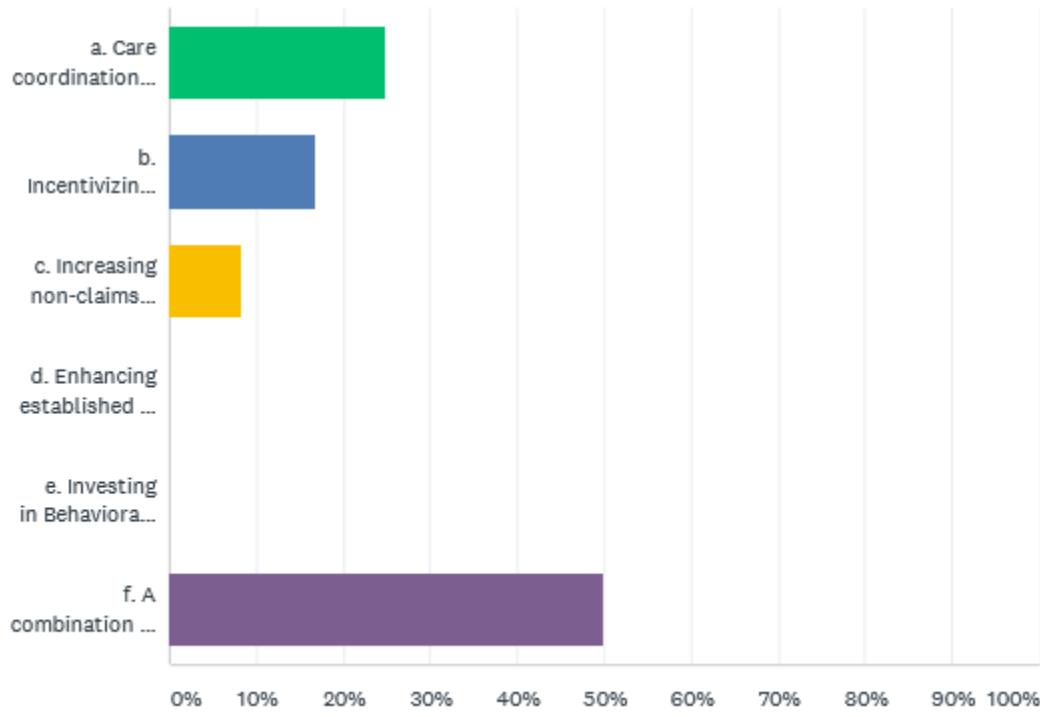


ANSWER CHOICES	RESPONSES
Strongly agree	50.00% 6
Agree	25.00% 3
Neither agree nor disagree	0.00% 0
Disagree	8.33% 1
Strongly disagree	16.67% 2
TOTAL	12

#	COMMENTS (OPTIONAL):	DATE
1	This is only makes sense if the practice can take on risk. FQHCs are prohibited from taking on downside risk.	1/5/2020 2:21 AM
2	Until we have a fair system of reimbursement, I would not agree with this statement. As independent primary care and new at that, we are in no position to accept risk unless included in the care team (doesn't occur right now)	12/21/2019 10:47 PM
3	Not until the second or more likely third year of any program	12/21/2019 2:26 PM

Q8 Building a sustainable primary care practice infrastructure that drives value and accountability is critical. For a practice that is mature and has implemented elements of a patient centered medical home, where should the investment in primary care be allocated? Select the best answer. We have included a comment field to add comments, if you feel it is necessary.

Answered: 12 Skipped: 0

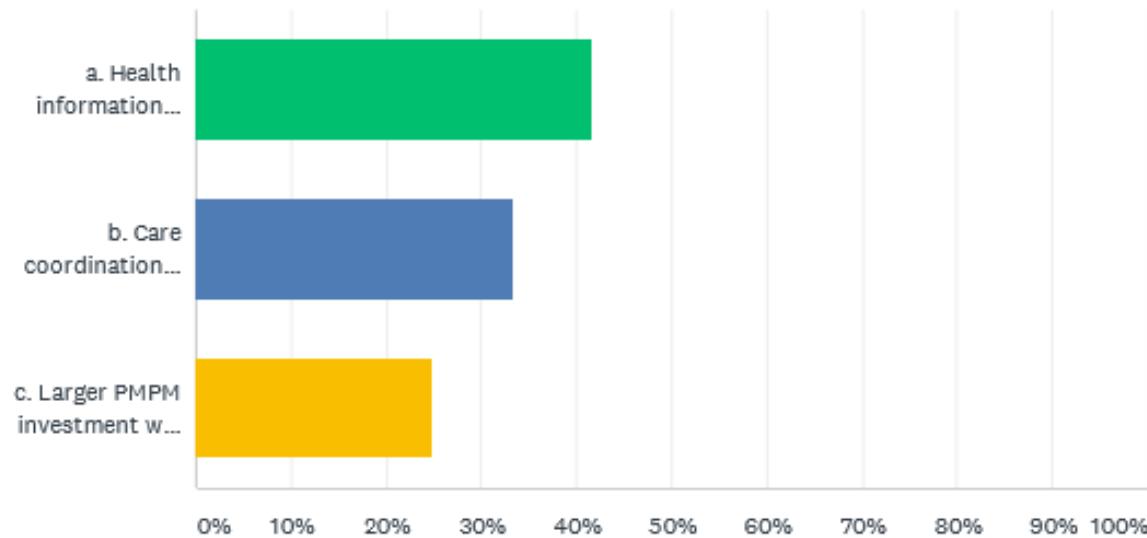


ANSWER CHOICES	RESPONSES	
a. Care coordination payments	25.00%	3
b. Incentivizing practices towards risk-based value payment models with upfront investment, e.g. greater PMPM but needs to meet a cost-saving benchmark	16.67%	2
c. Increasing non-claims payments	8.33%	1
d. Enhancing established HIT for greater interoperability	0.00%	0
e. Investing in Behavioral Health integration with bundled payments	0.00%	0
f. A combination of a/b/c with the practice at risk if does not meet an established cost saving benchmark	50.00%	6
TOTAL	12	

#	COMMENTS (OPTIONAL):	DATE
1	option e should also be considered	12/27/2019 2:04 PM
2	I would pick A and D...without interoperability, getting quality data is onerous on practices.	12/22/2019 1:54 PM
3	Answered the question as a 'non-mature' primary care	12/21/2019 10:47 PM

Q9 Building a sustainable primary care practice infrastructure that drives value and accountability is critical. For a practice that has NOT implemented elements of patient center medical home, where should the investment in primary care be allocated? Select the best answer. We have included a comment field to add comments, if you feel it is necessary.

Answered: 12 Skipped: 0



ANSWER CHOICES		RESPONSES	
a.	Health information technology, e.g. EHR, use of DHIN	41.67%	5
b.	Care coordination payments	33.33%	4
c.	Larger PMPM investment with focus on established chronic disease protocols; use of innovative staff with community health workers or expanded social work, behavioral health or transitional care staff	25.00%	3
TOTAL		12	
#	COMMENTS (OPTIONAL):	DATE	
1	In other practices that have demonstrated their commitment to value based care.	12/31/2019 2:18 PM	
2	similar to q8, a & b also important and should be considered. Depending upon practice, a & b could be best answer	12/27/2019 2:04 PM	
3	The access to additional care team members is essential to proceeding with patient-centered care.	12/21/2019 10:47 PM	
4	None of the above	12/20/2019 7:26 PM	

Q10 Please answer the following questions related to risk and value. (1) In value based payment models, does accountability equal risk?; and (2) who should assume risk - the insurance payers, primary care practices, or both? Please explain.

Answered: 8 Skipped: 4

#	RESPONSES	DATE
1	1) I think what you mean by this question is whether primary care practices being accountable for good care "counts" as risk, as opposed to requiring financial risk. If this is the question, then the answer is yes. 2) Similarly, I'm not quite sure where this question is going. If you are asking who should be accountable, then I think primary care should be accountable for the things that primary care can be accountable for - providing high-quality, accessible, continuous and coordinated care. They should not be accountable for things they have little or no control over, i.e., overutilization and/or cost of care for things that other doctors or institutions provide. It has always perplexed me that we are so focused on holding primary care docs accountable for costs, while those who are responsible for the high cost and over-utilization (i.e., hospitals, proceduralists and some specialists) have essentially no accountability. This is the core reason for our poor and expensive health care system. We need to fully fund primary care, which will improve quality and reduce cost. If we want to reduce cost further, then we need to stop over-paying for hospital and procedural services	1/3/2020 9:11 PM
2	Accountability should be commensurate with risk —ie, a primary care practice alone would have difficulty controlling total costs of care, so risk should be mitigated. However, primary care can control inpatient/ED utilization and could be at risk for that measure, similar to primary care first model	12/31/2019 2:18 PM
3	1. No 2. Both	12/30/2019 9:31 PM
4	1. accountability is a component of risk; 2. both	12/27/2019 2:04 PM
5	1. Accountability does not equal risk. This is the reason why healthcare spend is going up. The system needs to also be accountable to each other. As a profession we need to be BOTH cost conscious and quality conscious 2. Both ... as in #1 EVERYONE has to be accountable to our patients and assume risk.	12/22/2019 1:54 PM

6	1) No, accountability does not equal risk -- practices can be accountable, but why should they assume the risk for social determinants beyond their control. An example is using surrogate markers for diabetes, where the practitioner has to take accountability for an outcome where the patient is not adherent. 2) Whom should assume the risk - that is a hard question - if the allotment of appropriate resources to primary care exist, then co-assumption of risk is necessary, but how about risk from the patient side? Once again, there is a huge piece missing in addressing the social determinants of care.	12/21/2019 10:47 PM
7	Both if appropriate for the Primary Care Practice	12/20/2019 7:26 PM
8	collaboration between both- insurance carries need to demonstrate value to their plan sponsors who are funding these arrangements so PCPs need to have reimbursement tied to delivering value	12/20/2019 7:05 PM



PC Collaborative

January 8.2020

Business:

- ▶ Approval of Minutes
- ▶ Discussion of Standard Operating Procedures:
 - ▶ CO PCPRC 2019 Annual Report – Appendix H
 - ▶ Recommendations and reports: SB 227 “annual”
 - ▶ Appointments are from SB116
 - ▶ Member terms: ? 2 years for two terms
 - ▶ Absences and Use of Proxy:
 - ▶ Full voting privileges
 - ▶ Prior notification to Staff for meeting purposes

MEDICAID/MCO UPDATE:

- ▶ Medicaid ACO RFP
- ▶ HMA VBP MEDICAID MCOs:
 - ▶ DE on page 21-22
 - ▶ Comments on focus areas: Maternity, Pharmacy, Behavioral Health, social determinants; quality metrics; provider support and care management – DE has data sharing under provider support (pg 76)
- ▶ Update on VBPM and PCMH:
 - ▶ Total overall percentage participation
 - ▶ How many are in PCMH/ PCMH type models
 - ▶ Number of quality metrics
 - ▶ Challenges>>what measures are in place to increase participation
 - ▶ Successes>>have you deliberately increased percentage spend on PC through VBM
 - ▶ Ability to provide a PCF-like track

CO Primary Care and Payment Reform Collaborative

- ▶ Legislatively mandated under HB19-1233 under DOI – sunset 2025
- ▶ Mission: developing strategies for increased investments in primary care that deliver the right care in the right place at the right time
- ▶ CO GA envisions a highly functional health system built on the foundation of a robust PC system
- ▶ Uses a definition of Primary Care from Institute of Medicine but includes narrow and broad definition of PCP
- ▶ Appendix D – data analysis
- ▶ Appendix H – Operations of Collaborative
- ▶ Appendix L – comparison to other states (next slide)

Rhode Island	Oregon	Delaware	Connecticut
<ul style="list-style-type: none"> Each health insurer's annual, actual primary care expenses (direct and indirect) shall be at least 10.7% of annual medical expenses for all insured lines of business At least 50% of medical payments should be under an alternative payment model, with a minimum downside risk for providers 	<ul style="list-style-type: none"> Prominent carriers (annual health insurance premium income \geq \$200 million) offering commercial and MA plans, state public employee board plans, and Medicaid CCOs must spend at least 12% of total expenditures for physical and mental health on primary care services by 2023 If spend less, must document how will increase spending by at least 1% annually 	<ul style="list-style-type: none"> <i>Recommendation:</i> State should mandate payers to progressively increase PC spending to reach percentage milestones that eventually account for 12% of total health care spending (based on RI and OR) Increase will occur either through 1% point increase per year or within 5 years, whichever is faster Standard will apply to at least Medicaid, MA, self-insured, fully insured, state employees' health plans Performance measured by standard definition of primary care spending and total medical spending 	<ul style="list-style-type: none"> Developing primary care bundled payments that cover office visits, with supplemental bundles that include a PMPM fee to allow practices to hire care managers or invest in HIT, as part of multi-payer model Multi-payer reform model aims to gradually double revenue stream to primary care providers while maintaining TCC trend through combination of upfront supplemental payments to PC providers who agree to assume risk on controlling TCC
<p><u>Background:</u> PC spending increased through combination of structural payments (loan repayment, care management fees, and value-based payment opportunities) while hospital rates were capped</p>	<p><u>Background:</u> Primary care spending requirements follow a series of delivery and payment model reforms over the past decade, which had already boosted primary care spending on average to the 12% benchmark</p>	<p><u>Background:</u> State facing acute PC workforce issues, growing health care costs; series of legislative resolutions and EO focused attention on costs and quality; first state to set health care spending growth target and track quality and health measures</p>	<p><u>Background:</u> Planned investment is strictly in upfront supplemental payment revenue made with the expectation that primary care providers transform practices to offer alternative means of accessing primary care services that are not billable and by using a more extensive care team</p>
<p><u>Other key features:</u></p> <ul style="list-style-type: none"> 2010 - OHIC required each insurer to annually increase total commercial medical payments to PC Capital investments in PC, including supporting PT and EHR systems, count toward primary care spending Each payer must contract with specified share of PC physicians in PCMHs, increasing annually To help contain costs, hospital rates are capped at CPIU+1% and ACO total cost of care budgets are capped at CPI-U+1.5% 	<p><u>Other key features:</u></p> <ul style="list-style-type: none"> 2015-2016 - legislation required state to report on percentage of PC spend Analysis includes claim-based and non-claims-based payments <ul style="list-style-type: none"> Claims-based collected through state's APCD Non-claims based collected through reporting template SB 231- established PC Payment Reform Collaborative, tasked with helping develop and implement the Primary Care Transformation Initiative 	<p><u>Other key features:</u></p> <ul style="list-style-type: none"> PC spend increase should include upfront investment of resources to build infrastructure and capacity, not just increase in FFS rates for PCPs Support/incentives for use of HIT, support for team-based model of care across range of PC setting, value-based incentive payments PC spend requirements should be compatible with state benchmarking process of promoting only sustainable increases in TCC 	<p><u>Other key features:</u></p> <ul style="list-style-type: none"> Building off SIM (thru Jan 2020) Goal: enhance provider performance on shared savings or shared risk arrangements via PC payment reform State priorities: building diverse care teams; expanding patient access to PC via email, home visits, telemedicine; adopting technology with likely ROI; integrating care to better treat behavioral health, address SDOH; developing practice specializations to better treat certain patient subpopulations

Washington State PC Expenditures Report, December, 2019

- ▶ State Office of Financial Management
- ▶ Additional commentary re: non claims investments, PCMH, provider incentives, workforce
- ▶ Evaluated expenditures for 2018
 - ▶ Included copays, deductibles and pharmacy claims for total medical expenditures but not non-claims based expenditures
 - ▶ Also used IOM definition of PC and the 4Cs: contact, continuity, comprehensive and coordinated care
 - ▶ Calculated narrow and broad definition of providers and services
 - ▶ Included commercial, Medicaid, Medicare but not Self-insured, federal and VA benefits
 - ▶ 4.4-5.6% with highest in age group <18: 10.4-11.2%



UPFRONT INVESTMENTS ACO

Summary of Survey:

- ▶ 14 of 17 respondents (12 listed; one sent in)
- ▶ Majority vs Consensus
- ▶ Purpose:
 - ▶ Assess approach to self-insured organizations for data collection to calculate PC spend with total health care spend
 - ▶ Assess viability of aligning care model with payment reform

A clinical model plus a payment approach to enable the model can lead to improved outcomes

- ▶ Common elements of successful models include:
 - ▶ – Clear goals for outcomes with a vision for how care will be delivered
 - ▶ – Timely and accurate data sharing
 - ▶ – Risk adjustment to account for differences in patient panels
 - ▶ – Prospective payments to allow practices to make upfront investments
 - ▶ – Payments connected to a focused set of metrics and performance on the 4 C's (contact, continuity, comprehensiveness, and coordination)
 - ▶ Use of multidisciplinary care teams

Past Proposals

AAFP APC-APM

Advanced Primary Care Alternative Payment Model (APC-APM)

Primary Care Global Payment

- Per patient per month
- Covers a defined set of face-to-face evaluation and management services
- Prospective, risk adjusted payment



Performance-Based Incentive Payment

- Paid prospectively quarterly, reconciled annually
- Based on performance measures, including quality and cost

Population-Based Payment

- Per patient per month
- Covers non-face-to-face patient services
- Prospective, risk adjusted payment

Fee-For-Service Payment

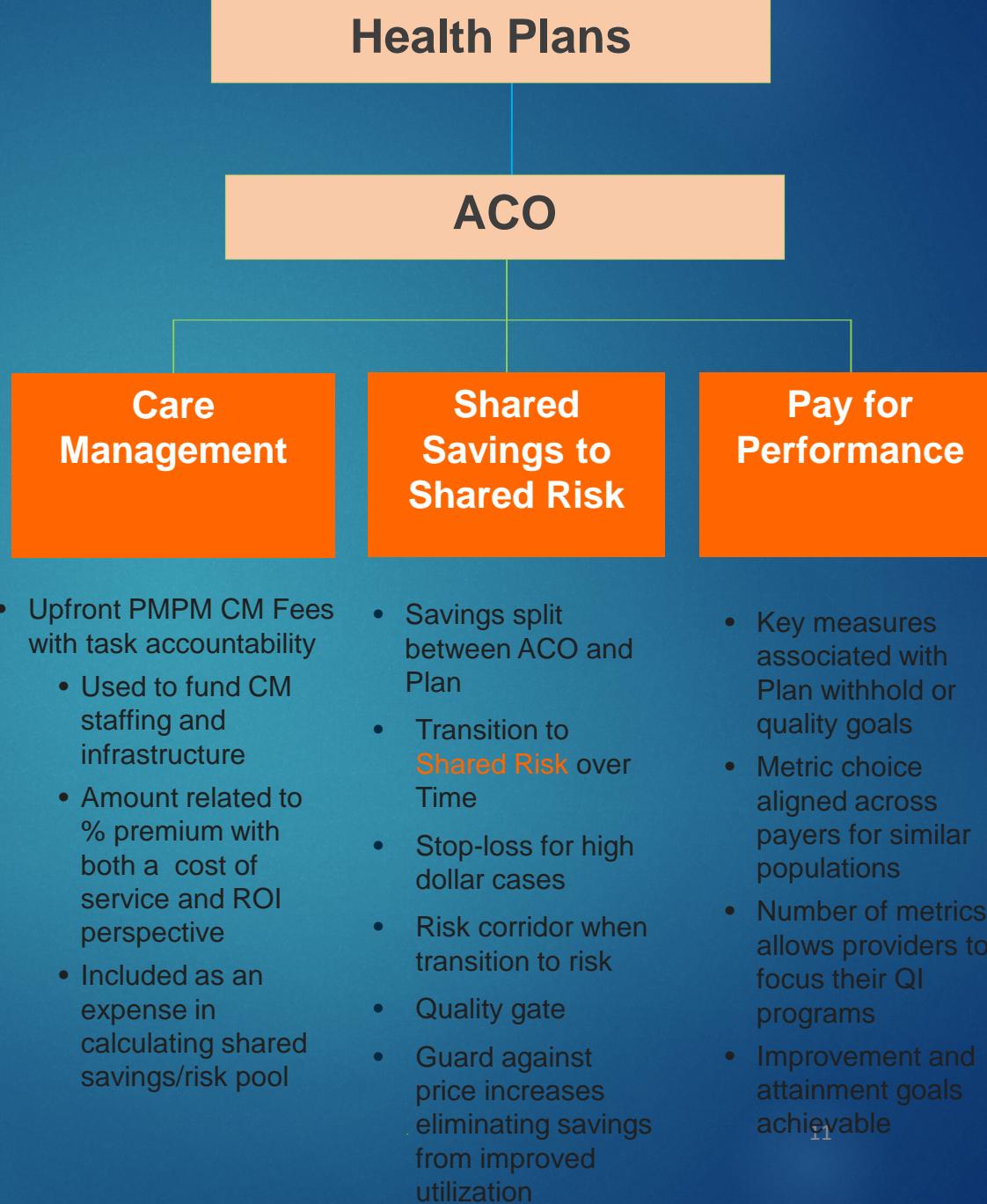
- As medically/clinically needed
- Based on relative value units

Figure 4: The Updated APM Framework

\$	🔗	🏛️	👤
CATEGORY 1 FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	CATEGORY 2 FEE FOR SERVICE – LINK TO QUALITY & VALUE	CATEGORY 3 APMs BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION – BASED PAYMENT
A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)	A APMs with Shared Savings (e.g., shared savings with upside risk only)	A APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	A Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	B Pay-for-Performance (e.g., bonuses for quality performance)	B Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)	B Integrated Finance & Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)
C Risk Based Payments NOT Linked to Quality	3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality	

Source: <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>

Proposed Funding Model



Previous Comments: This past Spring

- ▶ Value of PCMH: Total Cost savings was greatest with mature PCMH or higher risk populations
- ▶ important characteristics:
 - ▶ upfront investment without being additive to total cost
 - ▶ Accountability=risk
 - ▶ Building of infrastructure: data; care coordination at practice level; pre-defined targets for outcomes, cost savings, accountability
 - ▶ Role of established ACOS in state

Current Consensus:

- ▶ PC providers: as stated in SB 227
 - ▶ Family practice, internal medicine, geriatrics, pediatrics
 - ▶ Physicians, NPs, PAs
- ▶ Recommendations to OVBHCD:
 - ▶ Use of APCD – DHIN presentation?
 - ▶ Mandating TPA to disclose aggregate data (10/21) with opt out option vs learning collaborative from survey
 - ▶ Specifications:



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Inpatient Hospital Prices and Margins in Delaware

Primary Care Reform Collaborative
Aditi P. Sen
Johns Hopkins Bloomberg School of Public Health
February 10, 2020

JHU Project Background

- ▶ Background: Arnold Ventures project to support and inform state-level efforts to lower private sector prices
- ▶ Could encompass a range of policy approaches, including reference pricing, global budgets, public option pricing, out-of-network price regulation, etc.
- ▶ Analytic component:
 - ▶ Demonstrate the extent of price variation across services, geographies, settings, and consumers (e.g., by plan type)
 - ▶ Compare private sector prices to Medicare prices
 - ▶ Demonstrate extent of practices such as out-of-network billing
 - ▶ Analysis of hospital costs, margins, community benefit provision

Today

- ▶ We compared Delaware hospitals to hospitals in other states. We examined three factors:
- ▶ How much more do private insurers in Delaware pay compared to Medicare?
 - ▶ Private insurers pay more than double what Medicare pays for hospital services in most states
- ▶ Are hospital profit margins higher in Delaware than other states?
- ▶ Do Delaware hospitals provide more charity care and community benefit services than hospitals in other states?

Summary of Initial Findings

- ▶ In 2017, the private sector price for an inpatient “basket” of common services was 2.41 times the Medicare price in Delaware. This is above the national average price differential of 2.13.
- ▶ The differential between the private and Medicare price for the inpatient basket in DE (2.41) was higher than in neighboring states, e.g., PA (1.91) and MD (1.35).
- ▶ Median overall hospital margin in Delaware was 11% in 2017, compared to a national median of 3.6%. Hospital profit margins are high in Delaware compared to other states.
- ▶ As a percent of total expenses, hospital-level spending on community benefits as defined by the IRS was lower in DE (6.96%) than the national average (9.28%). A smaller percent of total expenses was spent on charity care and on unreimbursed Medicaid costs among DE hospitals compared to hospitals nationally.

Summary of Conclusions

- ▶ Delaware hospitals have profit margins significantly above the national average.
- ▶ The differential between what private insurers are paying and what Medicare pays is higher in DE than in many other states, and higher than in neighboring states.
- ▶ Delaware hospitals provide a smaller percentage of charity care than hospitals in other states (1.1% total expenses compared to 2.0% nationally).
- ▶ Across hospitals, Delaware hospitals spend a smaller proportion of total expenses on uncompensated Medicaid (1.9% compared to 4.1% nationally), which we do not consider to be a community benefit because the state determines the amount of Medicaid payment. However, the average is low because 2 of the 5 hospitals spend 0%; 1 hospital spends 6.7% total expenses on unreimbursed Medicaid.



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Detailed Data

Private prices in Delaware vs surrounding states, 2017

	DE		PA		MD	
	Mean \$	Private: Medicare ratio	Mean \$	Private: Medicare ratio	Mean \$	Private: Medicare ratio
Inpatient Basket	9,068	2.41	7,778	1.91	7,125	1.35
Joint Replacement	35,616	2.47	27,794	1.98	25,689	1.32
Cesarean Section	16,719	2.59	15,186	1.78	13,853	1.29
Vaginal Delivery	12,883	2.33	11,420	1.94	11,684	1.38

Private price variation within Delaware, 2017

	State Mean	Dover	Wilmington	Salisbury	Ratio Max to Min MSA
Inpatient Basket	9,068	9,154	9,062	7,788	1.18
Hip Replacement	35,721	35,920	35,584	30,672	1.17
Knee Replacement	35,619	39,350	35,672	40,517	1.14
Cesarean Section	16,719	16,974	17,243	16,075	1.07
Vaginal Delivery	12,883	12,961	12,961	11,261	1.15



Delaware Hospital Margins Analysis, 2017

Operating margin is for just patient care

Overall margin is for all services the hospital provides

	Overall Margin	Operating Margin
BEEBE MEDICAL CENTER	9.8%	8.7%
CHRISTIANA CARE HEALTH SYSTEM	14.5%	-5.1%
KENT GENERAL HOSPITAL	15.2%	5.0%
MILFORD MEMORIAL HOSPITAL	13.0%	3.6%
NANTICOKE MEMORIAL HOSPITAL	8.3%	2.7%
ST. FRANCIS HOSPITAL WILMINGTON	3.1%	-0.3%
U.S median (1Q,3Q)	3.6% (-2.7%, 10.6%)	-2.6% (-11.6%, 5.6%)

Centers for Medicare and Medicaid Services (CMS) Medicare cost reports 2017

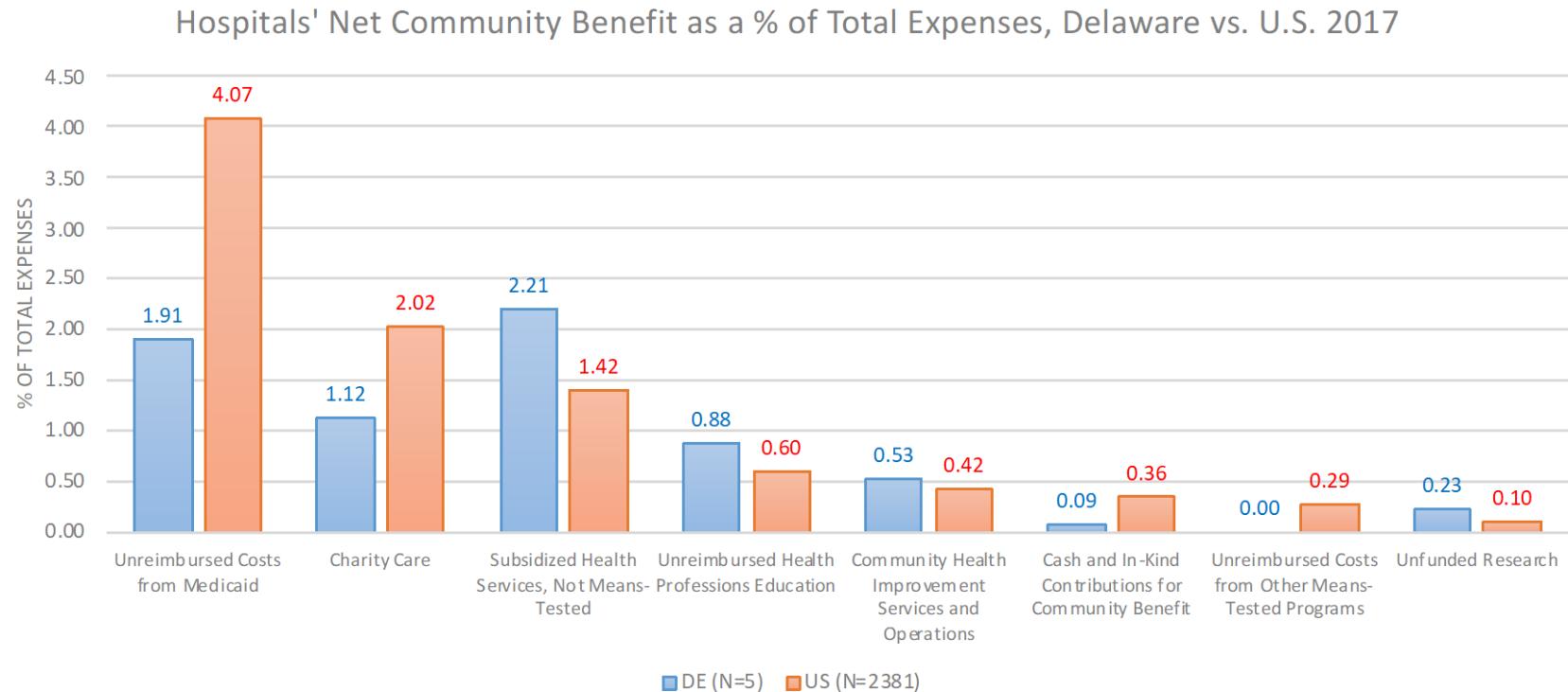
<https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/>

https://atlasdata.dartmouth.edu/static/supp_research_data/

Delaware Hospital Overall Margin 2011-16

	2011	2012	2013	2014	2015	2016
BEEBE MEDICAL CENTER	2.7	5.3	9.1	9.2	11.5	7
CHRISTIANA CARE HEALTH SYSTEM	8.1	13.1	15.4	10.3	8.3	17
KENT GENERAL HOSPITAL	5.9	18.4	18.5	8.7	5.9	17
MILFORD MEMORIAL HOSPITAL				3.6	-3.3	10
NANTICOKE MEMORIAL HOSPITAL	8.7	9.3	15.3	11.6	2.3	9
ST. FRANCIS HOSPITAL WILMINGTON	1.3	1.4	15.9	-2	-4.2	-5
NATIONAL	4.4	5.5	5.1	5.2	4.7	4.3

Delaware hospital community benefit as a % of total expenses



Hospital Costs: How Do Hospitals Respond to Lower Prices?

- ▶ We examined what the Medicare Payment Advisory Commission (MedPAC) has said about the ability of hospitals to accept lower prices
- ▶ Hospital costs are **flexible and hospitals respond by lowering their costs**
 - ▶ “Hospitals under financial pressure tend to have lower costs. High pressure equals low cost. Low pressure equals high cost.”
 - ▶ “Costs do vary in response to financial pressure and low margins on Medicare patients can result from a high cost structure that has developed in reaction to high private payers rates.”
 - ▶ “Lack of pressure is more common in markets where a few providers dominate and have negotiating leverage over payers.”

Appendix

Data, Methods and Background Information



Data: MarketScan Commercial Claims Was Used To Compare Medicare and Private Sector Prices

- ▶ Private-sector health data from approximately 350 insurers
- ▶ Captures person-specific clinical utilization, expenditures, and enrollment across settings
- ▶ Includes active employees, early retirees, COBRA continuees and dependents insured by employer-sponsored plans
- ▶ Large nationally representative sample
- ▶ High-quality and reliable coding

MarketScan analysis sample

- ▶ **MarketScan sample:** Individuals age 18-64 with an inpatient admission that occurred within the state of DE from 2012-2017
- ▶ **Main outcome:** Spending on market basket of 15 services, spending for select services

Year	Total Mkt Sample	Inpatient Mkt Sample
2012	135,020	7,247
2013	128,983	6,834
2014	136,957	6,845
2015	132,887	6,085
2016	124,048	6,424
2017	68,725	3,809

Hospitals' Financial Performance

- ▶ We used 2017 Medicare cost reports to examine the operational profitability and financial viability of hospitals
- ▶ Operational profitability = Operating Margin
= Operating net income / Net patient revenue
How much money do hospitals make from patient services?
- ▶ Financial viability = Overall Margin
= Overall net income / Net patient revenue
How much money do hospitals make from ALL activities?

Creating the inpatient “basket”

- ▶ The basket includes the 15 most frequent hospital services, ranked by Diagnosis Related Group (DRG)
- ▶ Removes variation due to volume
- ▶ These 15 DRGs represent a significant amount of health care – 46% of total admissions and 37% of total spending.
- ▶ Example DRGs include: Vaginal delivery w/o complicating condition (CC), Major joint replacement or reattachment of lower extremity w/o major complicating condition (MCC), Cesarean section w/o CC/MCC, Cesarean section w CC/MCC, Spinal fusion except cervical w/o MCC, PTCA.

Creating the inpatient “basket”

<u>15 Most Frequent DRGs</u>	<u>Average DRG Price</u>	<u>X</u>	<u>Proportion Adm</u>	<u>Summation</u>
Vaginal Delivery w/o CC	\$11,082		.1393	
Major joint replacement or reattachment of lower extremity w/o MCC	\$32,850		.0451	
Cesarean section w/o CC/MCC	\$15,180		.0451	
.				
.				
PTCA	\$36,871		.0090	

15 DRG Market Basket

Identifying inpatient procedures

Procedure	Age	DRG
Joint Replacement	45-64	470
Cesarean Section	25-34	766
Vaginal Delivery	25-34	775



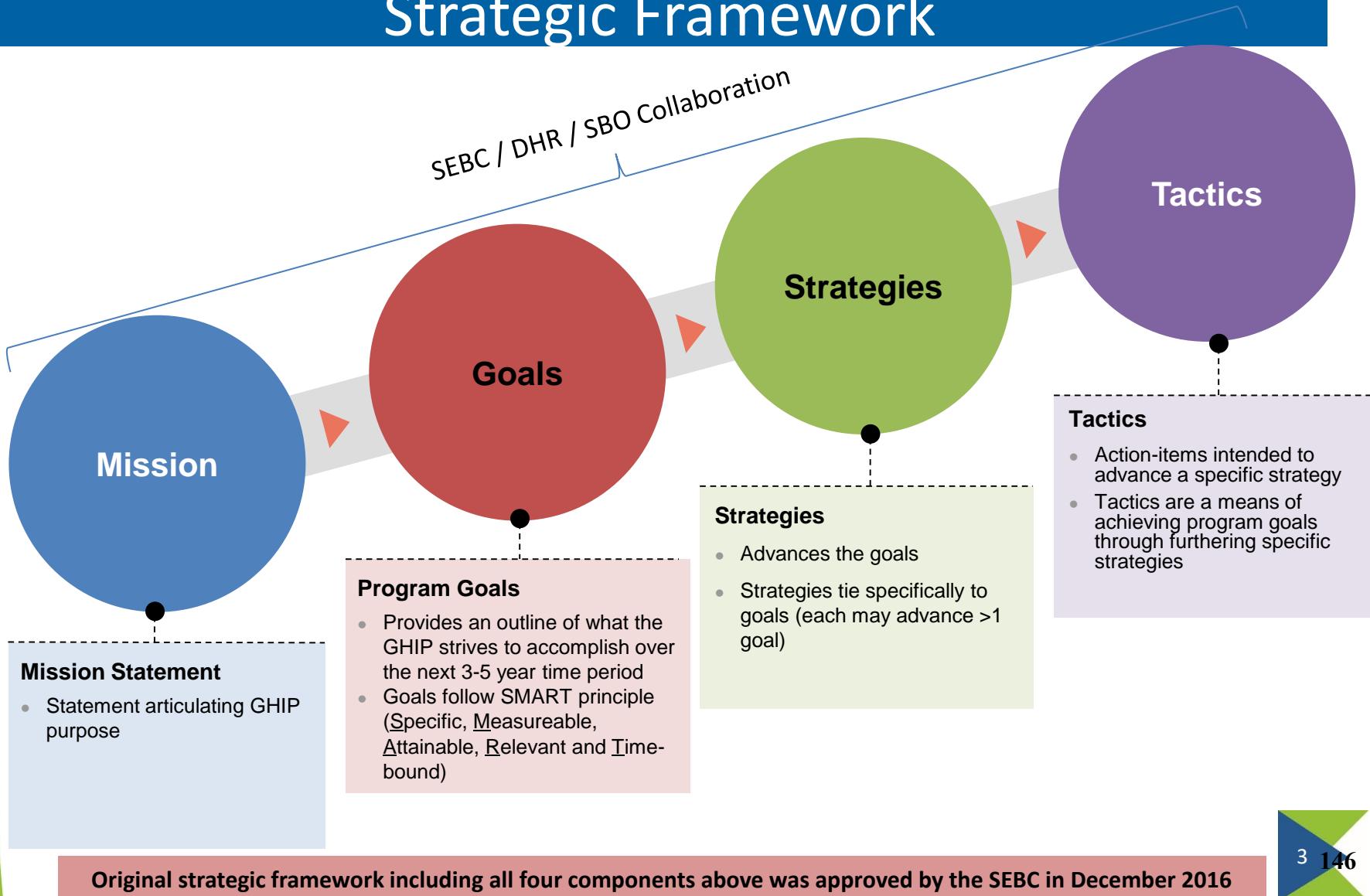
State Employee Benefits Committee Initiatives
Faith Rentz, Director
Statewide Benefits Office
February 10, 2020

Today's Discussion

Goal: Provide overview of State Employee Benefits Committee's focus on value-based contracting and improving access to primary care

- Overview of GHIP strategic framework
- Recent initiatives – 2017 – 2019
- Future plans – 2020+

Components of the Group Health Insurance Program (GHIP) Strategic Framework



GHIP Mission Statement

Offer State of Delaware employees, retirees and their dependents adequate access to high quality healthcare that produces good outcomes at an affordable cost, promotes healthy lifestyles, and helps them be engaged consumers.

Approved by the SEBC in December 2016

GHIP Goals

- Tied to the GHIP mission statement

Mission Statement:

*Offer State of Delaware employees, retirees and their dependents **adequate access to high quality healthcare that produces good outcomes...***

*at an **affordable cost...***

*promotes **healthy lifestyles**, and helps them be **engaged consumers**.*



Original Goals:

- Addition of at least net 1 value-based care delivery (VBCD) model by end of FY2018
- Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020
- GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020



Recent Initiatives: 2017 – 2019

- Contracted with State Group Health plan's medical TPAs, Highmark and Aetna, for advanced care management/coordination programs and other value-based care delivery models
- Based on continued measurement of GHIP medical spend, implemented programs and changes to drive efficiencies in spend
- Engaged SEBC in discussions of an framework for advanced payment models to understand current Delaware providers' engagement in upside/downside risk sharing arrangements

State Group Health Plan Contracts

Highmark

- Enhanced care management program provides clinical advocacy, navigation support and assistance with closing gaps in care
 - Performance guarantees based on member engagement, clinical outcomes and trend
- True Performance program promotes payment-for-value delivered by primary care physicians via shared savings arrangements
- Limited availability of other value-based care models in Delaware for commercially insured population
 - Other models (e.g., accountable care organizations) exist in Pennsylvania and other surrounding states

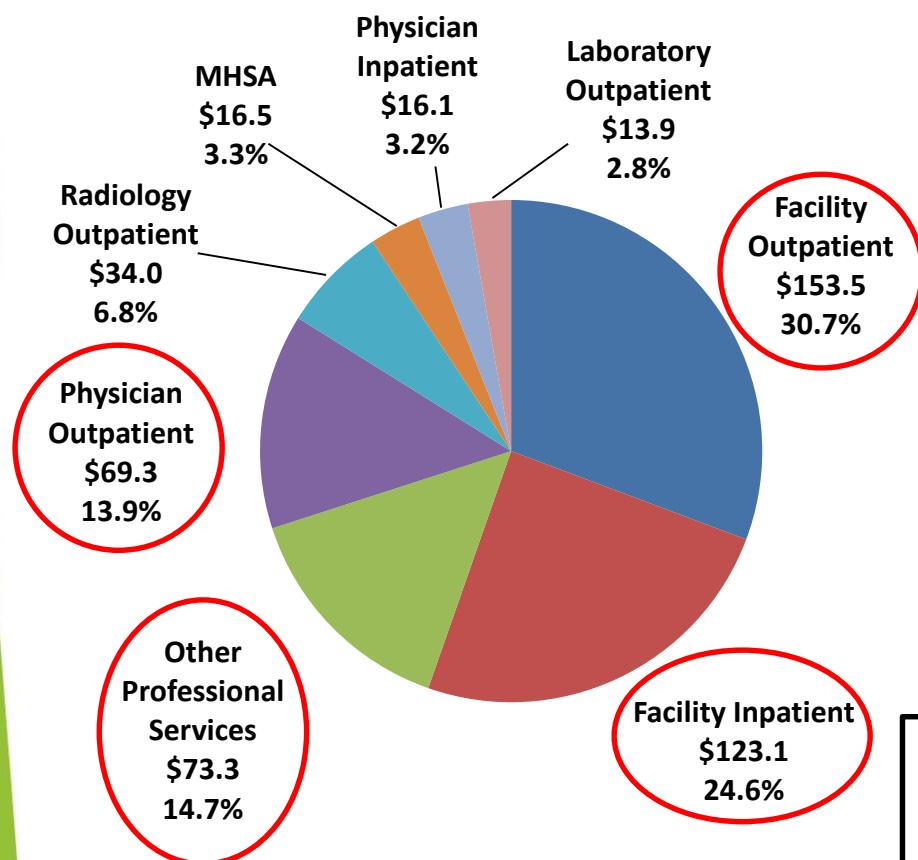
Aetna

- Advanced care management and primary care coordination for HMO in partnership with ChristianaCare's CareVio program
 - Includes financial risk-sharing with CareVio for managing population health and reducing trend
- Contract also includes bundled payments for select services with local hospital system
- Other value-based care models in Delaware are limited to patient-centered medical homes with primary care providers

Other Actions Taken to Drive Efficiencies in GHIP Spend

GHIP net payments for service category groups, medical costs only (\$millions)

Delaware payroll groups only; includes active employees, non-Medicare retirees and Medicare retirees and their dependents
Incurred July 1, 2018 – June 30, 2019



Trend PEPM	
Facility Outpatient	4.6%
Facility Inpatient	-0.6%
Other Professional Services	8.4%
Physician Outpatient	4.0%
Radiology Outpatient	10.2%
MHSA	3.1%
Physician Inpatient	-1.4%
Laboratory Outpatient	3.0%

= top areas of concern

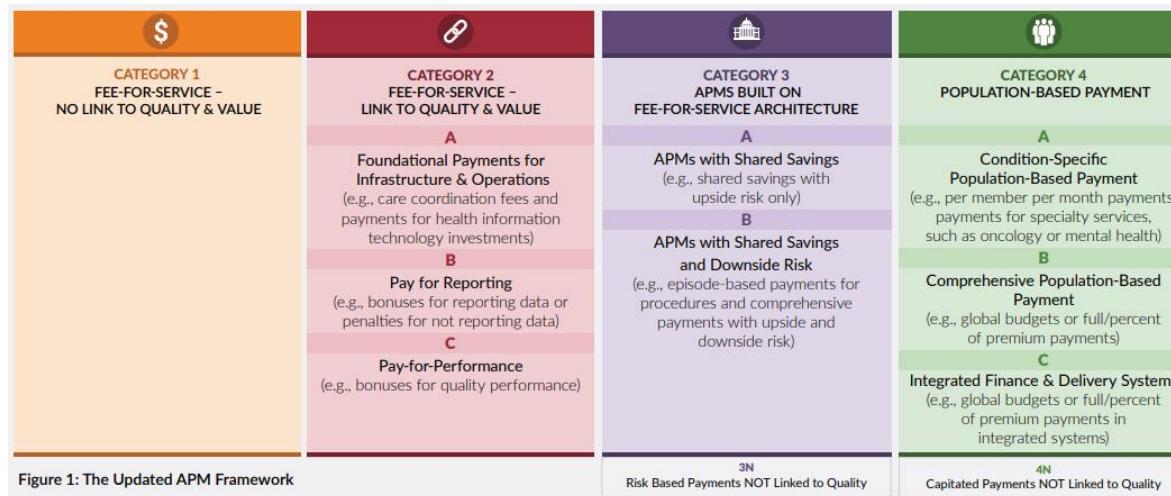
Primary Care only (conservative estimate) \$19.0 (3.8%)

Actions taken:

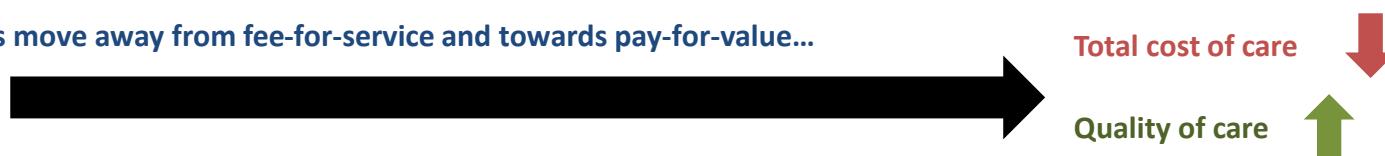
- Participation in RAND study
- Direct provider contracting via SurgeryPlus surgeons of excellence
- Greater steerage toward lower cost/higher quality sites of care
- Evaluating market readiness to move further into advanced APMs
- Evaluating options for expanding access to primary care

Alternative Payment Model (APM) Framework

- Established to track progress toward payment reform, and developed by the Health Care Payment Learning & Action Network (LAN) (launched by US Department of Health and Human Services)



As payments move away from fee-for-service and towards pay-for-value...



Overview of provider contracting provided to SEBC on 8/26/19 defined APMS using the above framework as a guide

Future Work of the SEBC: 2020+

- Revisions to GHIP strategic framework goals, with the following themes:
 - Using the APM framework to increase GHIP spend through advanced APMs (Category 3 and 4 models)
 - Reduction in GHIP diabetic member cost per-member-per-month
 - Limit total cost of care inflation for GHIP participants at a level commensurate with the Health Care Spending Benchmark by focusing on specific components, inclusive but not limited to inpatient and outpatient facility costs and pharmaceutical costs
 - In light of the GHIP’s changing demographic profile, strive for incremental annual increase in unique users of a specific “point-of-enrollment” and/or “point-of-care” engagement platform or consumerism tool
- Evaluating readiness of Delaware market to provide innovative approaches to reducing GHIP total cost of care
- Exploring opportunities to expand access to primary care in Delaware

Health Care Stakeholder Request for Information (RFI)

- Request for information from providers and other health care stakeholders to gather best practices in cooperative approaches and innovative solutions to reducing the total cost of care for the GHIP
- Interest in gaining a better understanding of provider partnerships and opportunities within the market to implement more advanced APMs
 - Focus on capabilities to help the SEBC promote innovation around reduction in total cost of care, without sacrificing quality of care
 - Understand ability for providers/other stakeholders to operate as a standalone solution

Health Care Stakeholder Request for Information (RFI)

Goals

1. Gather best practices in cooperative approaches and innovative solutions to reducing the total cost of care for the GHIP
 2. Gain a better understanding of the interest from, and readiness of, the Delaware market to go deeper into more advanced categories of the APM framework
 3. Identify third party providers that could play a role in the Delaware health care marketplace to support the goals of the SEBC
-
- Responses to the RFI will be used to shape the development of the medical TPA RFP, which will kick off internally within the Statewide Benefits Office in January 2021

Expanding Primary Care Access in Delaware

- Topic is currently being explored by the Health Policy & Planning Subcommittee of the State Employee Benefits Committee, including review of:
 - Research on access to primary care in Delaware and efforts by the Primary Care Collaborative
 - GHIP member utilization of primary care providers
 - Results from SBO survey of GHIP members' preferences, access to and use of primary care providers
 - Considerations associated with potential options for addressing primary care access, two of which resonated most strongly with Subcommittee members:
 - Enhance telemedicine offerings via advanced technology solutions
 - Contract with a third-party vendor to add primary care provider options in Delaware
 - In-person presentations by several third-party providers of primary care services and/or telehealth technology: R-Health, Cerner, American Well
- Further discussion of this topic will continue with the Subcommittee into the foreseeable future
- Responses to the health care stakeholder RFI may further inform this discussion

Next Steps

- Engage the local provider community and other health care stakeholders in exploring ways to drive innovation and reduce GHIP total cost of care
- Continue evaluating other opportunities to drive further investments in primary care
- Ongoing review of other data sources for health care provider cost and quality data, e.g., Delaware Health Information Network (DHIN)
 - Further participation by other self-funded employers voluntarily providing their claim data to the DHIN would enhance the robustness of the dataset

Thank You



Phone: 1-800-489-8933

Email: benefits@delaware.gov

Website: de.gov/statewidebenefits



PC Collaborative

February 10, 2020

Agenda:

- ▶ JHU/Arnold Foundation Presentation
- ▶ SEBC Commentary
- ▶ DOI Update
- ▶ Legislative Update
- ▶ Approval of Minutes and Outstanding Items
- ▶ Recommendations

Legislative Update:

- ▶ SB200 - passed
- ▶ SB206 - out of committee

Annual Report Recommendations:

- ▶ Report to General Assembly and DHCC – progress and goals
- ▶ Defining Operating Procedures: (Line 25 of SS1 for SB116)
 - ▶ Proxy representatives may have voting rights and shall be communicated to c-chairs as attending proxy prior to meeting so they may be included in meeting communications and information
 - ▶ Term limits: 2 year term with appointment as per SB 116 and SB 206, excluding ex-officio positions
 - ▶ Quorum for voting
 - ▶ Meeting information and materials to be sent out one week prior to meeting

Rhode Island	Oregon	Delaware	Connecticut
<ul style="list-style-type: none"> Each health insurer's annual, actual primary care expenses (direct and indirect) shall be at least 10.7% of annual medical expenses for all insured lines of business At least 50% of medical payments should be under an alternative payment model, with a minimum downside risk for providers 	<ul style="list-style-type: none"> Prominent carriers (annual health insurance premium income \geq \$200 million) offering commercial and MA plans, state public employee board plans, and Medicaid CCOs must spend at least 12% of total expenditures for physical and mental health on primary care services by 2023 If spend less, must document how will increase spending by at least 1% annually 	<ul style="list-style-type: none"> <i>Recommendation:</i> State should mandate payers to progressively increase PC spending to reach percentage milestones that eventually account for 12% of total health care spending (based on RI and OR) Increase will occur either through 1% point increase per year or within 5 years, whichever is faster Standard will apply to at least Medicaid, MA, self-insured, fully insured, state employees' health plans Performance measured by standard definition of primary care spending and total medical spending 	<ul style="list-style-type: none"> Developing primary care bundled payments that cover office visits, with supplemental bundles that include a PMPM fee to allow practices to hire care managers or invest in HIT, as part of multi-payer model Multi-payer reform model aims to gradually double revenue stream to primary care providers while maintaining TCC trend through combination of upfront supplemental payments to PC providers who agree to assume risk on controlling TCC
<p><u>Background:</u> PC spending increased through combination of structural payments (loan repayment, care management fees, and value-based payment opportunities) while hospital rates were capped</p>	<p><u>Background:</u> Primary care spending requirements follow a series of delivery and payment model reforms over the past decade, which had already boosted primary care spending on average to the 12% benchmark</p>	<p><u>Background:</u> State facing acute PC workforce issues, growing health care costs; series of legislative resolutions and EOs focused attention on costs and quality; first state to set health care spending growth target and track quality and health measures</p>	<p><u>Background:</u> Planned investment is strictly in upfront supplemental payment revenue made with the expectation that primary care providers transform practices to offer alternative means of accessing primary care services that are not billable and by using a more extensive care team</p>
<p><u>Other key features:</u></p> <ul style="list-style-type: none"> 2010 - OHIC required each insurer to annually increase total commercial medical payments to PC Capital investments in PC, including supporting PT and EHR systems, count toward primary care spending Each payer must contract with specified share of PC physicians in PCMHs, increasing annually To help contain costs, hospital rates are capped at CPIU+1% and ACO total cost of care budgets are capped at CPI-U+1.5% 	<p><u>Other key features:</u></p> <ul style="list-style-type: none"> 2015-2016 - legislation required state to report on percentage of PC spend Analysis includes claim-based and non-claims-based payments <ul style="list-style-type: none"> Claims-based collected through state's APCD Non-claims based collected through reporting template SB 231- established PC Payment Reform Collaborative, tasked with helping develop and implement the Primary Care Transformation Initiative 	<p><u>Other key features:</u></p> <ul style="list-style-type: none"> PC spend increase should include upfront investment of resources to build infrastructure and capacity, not just increase in FFS rates for PCPs Support/incentives for use of HIT, support for team-based model of care across range of PC setting, value-based incentive payments PC spend requirements should be compatible with state benchmarking process of promoting only sustainable increases in TCC 	<p><u>Other key features:</u></p> <ul style="list-style-type: none"> Building off SIM (thru Jan 2020) Goal: enhance provider performance on shared savings or shared risk arrangements via PC payment reform State priorities: building diverse care teams; expanding patient access to PC via email, home visits, telemedicine; adopting technology with likely ROI; integrating care to better treat behavioral health, address SDOH; developing practice specializations to better treat certain patient subpopulations

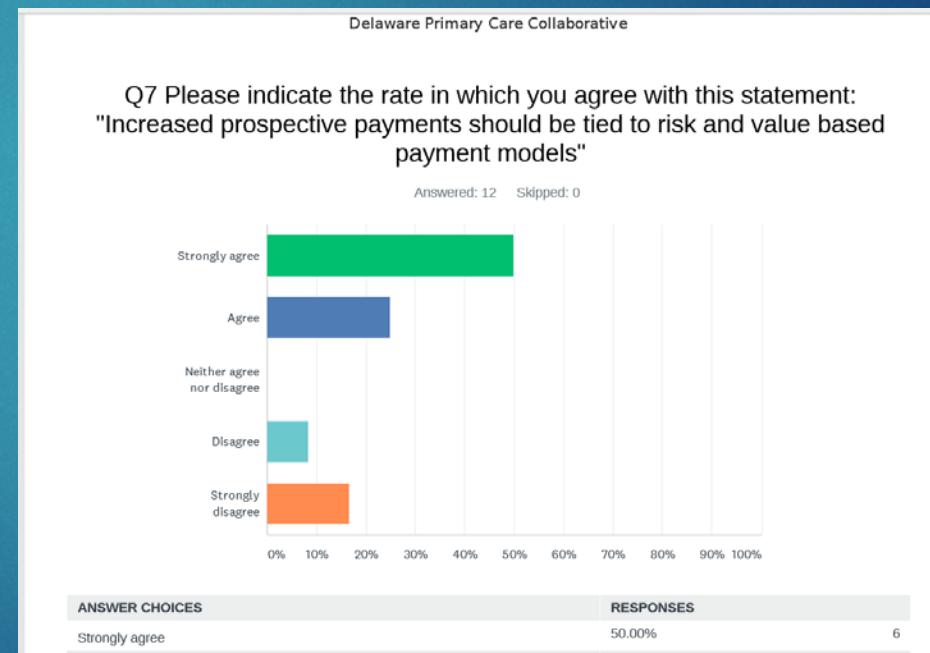
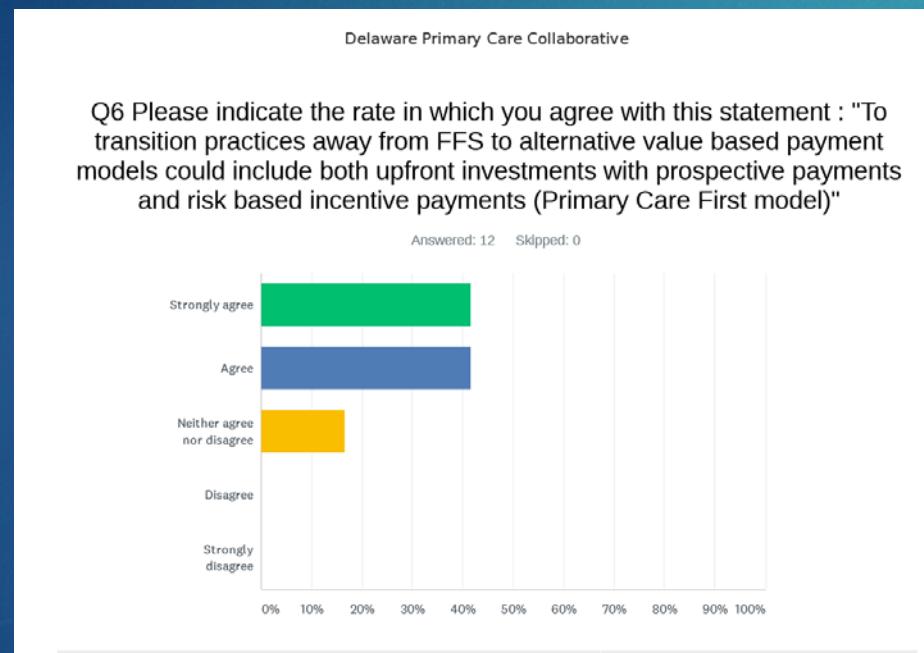
- ▶ State Office of Financial Management
- ▶ Evaluated expenditures for 2018
 - ▶ Included copays, deductibles and pharmacy claims for total medical expenditures but not non-claims based expenditures
 - ▶ Also used IOM definition of PC and the 4Cs: contact, continuity, comprehensive and coordinated care
 - ▶ Calculated narrow and broad definition of providers and services
 - ▶ Included commercial, Medicaid, Medicare but not Self-insured, federal and VA benefits
 - ▶ 4.4-5.6% with highest in age group <18: 10.4-11.2%
- ▶ PC providers: SB 227
 - ▶ Family practice, internal medicine, geriatrics, pediatrics
 - ▶ Physicians, NPs, PAs
- ▶ OVBHCD:
 - ▶ Use of APCD
 - ▶ Specifications:
 - ▶ Formulated by OVBHCD with input by PCC>>>?PCC data subcommittee
 - ▶ Outpatient and office expenditures
 - ▶ ?non -claims payments – aggregated data from payors who are also contributing data to DHIN
 - ▶ NO TOPIC RECOMMENDATIONS PROVIDED

A clinical model plus a payment approach to enable the model can lead to improved outcomes

- ▶ Common elements of successful models include:
 - ▶ – Clear goals for outcomes with a vision for how care will be delivered
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- ▶ important characteristics:
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 - ▶ Accountability=risk
 - ▶ Building of infrastructure: data; care coordination at practice level; pre-defined targets for outcomes, cost savings, accountability
 - ▶ Role of established ACOS in state



Trinity Health ACO

- ▶ Next Generation ACO with upside and downside risk
- ▶ Included patients from health systems and private groups in Illinois, Michigan, New Jersey, and Ohio
- ▶ 100K Medicare patients with up to 15% of medical spend at risk
- ▶ Centralized team that provided actuarial support and data analytics at the system level
- ▶ Local teams responsible for care management, social work, care coordination, clinician engagement, and leadership
- ▶ Expectation that local group spent \$22 PMPM on the infrastructure above

Current Recommendations from Survey:

- ▶ Primary Care is foundational to health care delivery in DE
- ▶ Practices which demonstrate a team-based or PCMH like delivery of care should have more upfront investment
- ▶ Initial increase in upfront investments should be tied to an agreed upon definition of “risk” and “value” as well as overall cost saving benchmark
 - ▶ Increased PMPM, care coordination payments, non claims payment
- ▶ ERISA Plans:
 - ▶ Provide a Learning collaborative – creation of subcommittee
 - ▶ Voluntary contribution of data - ?aggregated from TPA or specifications in to APCD

Past Proposals

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- Based on relative value units

Figure 4: The Updated APM Framework

CATEGORY 1 FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	CATEGORY 2 FEE FOR SERVICE – LINK TO QUALITY & VALUE	CATEGORY 3 APMs BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION – BASED PAYMENT
A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)	A APMs with Shared Savings (e.g., shared savings with upside risk only)	A APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	A Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	B Pay-for-Performance (e.g., bonuses for quality performance)	B Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)	B Integrated Finance & Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)
C Pay-for-Performance (e.g., bonuses for quality performance)	3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality	

Source: <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>

Proposed Funding Model

Health Plans

ACO

Care Management

Shared Savings to Shared Risk

Pay for Performance

- Upfront PMPM CM Fees with task accountability
 - Used to fund CM staffing and infrastructure
 - Amount related to % premium with both a cost of service and ROI perspective
 - Included as an expense in calculating shared savings/risk pool
- Savings split between ACO and Plan
 - Transition to **Shared Risk** over Time
 - Stop-loss for high dollar cases
 - Risk corridor when transition to risk
 - Quality gate
 - Guard against price increases eliminating savings from improved utilization
- Key measures associated with Plan withhold or quality goals
 - Metric choice aligned across payers for similar populations
 - Number of metrics allows providers to focus their QI programs
 - Improvement and attainment goals achievable

Future Meetings:

- ▶ THIRD MONDAY OF EACH MONTH:
- ▶ 3/16/20
- ▶ 4/20/20
- ▶ 5/18/20
- ▶ 6/15/20 (If needed)

Links to External Meeting Materials

Primary Care Reform Collaborative Meeting – September 17, 2019

Investing in Primary Care: A State Level Analysis

<https://dhss.delaware.gov/dhcc/files/investfullreport.pdf>

Primary Care Reform Collaborative Meeting – November 12, 2019

Defining and Measuring the Patient-Centered Medical Home

https://dhss.delaware.gov/dhcc/files/pcmhpcc11606_2010_1291.pdf

Prospects for Rebuilding Primary Care Using the Patient-Centered Medical Home

<https://dhss.delaware.gov/dhcc/files/landongillhlthaffrs2010.pdf>

Advanced Primary Care: A Key Contributor to Successful ACOs

<https://dhss.delaware.gov/dhcc/files/pcpevidencerp2018.pdf>

Primary Care Reform Collaborative Meeting – January 8, 2020

Medicaid Managed Care Contracts as Instruments of Payment Reform

https://dhss.delaware.gov/dhcc/files/hmavbpmedicaid_122019.pdf

Primary Care Expenditures Summary of current primary care expenditures and investment in Washington

<https://dhss.delaware.gov/dhcc/files/wapcexpendituresrpt2019.pdf>