SB 227 Primary Care Collaborative Meeting

Wednesday, December 12, 2018
4:00 pm
Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

Present:	**Email:**
Senator Bryan Townsend	Bryan.Townsend@state.de.us
Dr. Nancy Fan	nfanssmith@yahoo.com
Representative David Bentz	David.Bentz@state.de.us

Staff:

Juliann Emory	Juliann.Emory@state.de.us
Caitlin Del Collo	Caitlin.DelCollo@state.de.us
Read Scott	Read.Scott@state.de.us

Attendees:	**Organization:**
Tyler Blanchard	Aledade
Pam Price	Highmark
Susan Conaty-Buck	Delaware Coalition of Nurse Practitioners
Dan Elliott	Christiana Care Health Systems
Cheryl Heiks	Webster Consulting
Andrew Dahlke	Medical Society of Delaware
Ray Dotterweich	Christina Care Health Systems
Julie Caynor	Aetna
Nicole Scott	Primary Care LLC
Jennifer Seo	Mental Health Association
Andrew Wilson	Medical Society of Delaware/Morris James
Faith Rentz	Department of Human Resources
Anthony Onugu	United Medical
Ema Ndi	More About You, Inc.
Siobhan Irwin	Brandywine Pediatrics
Veronica Wilbur	Next Century Medical Care
Wayne Smith	Delaware Healthcare Association

The meeting was called to order at 4:00 p.m.

Dr. Irwin

- Brandywine Pediatrics is a large group of general pediatricians and we have pushed to increasingly integrate behavioral health.
- We have a psychologist who is not employed, but embedded in the practice. We share the EHR and discuss patients we refer. We want to get more behavioral health integrated.
- We always have trouble getting behavioral health coverage because many psychologists and psychiatrists have waiting lists because there is so much demand.
- There is more need for primary care providers to do more behavioral health.

Dr. Wilbur

- As a family NP of 25 years, I just started own practice January 2018.
- Concurring with Dr. Irwin regarding the challenges of behavioral health. There are no behavioral health resources, so I do a lot of the behavioral health. Most of my patients have Medicaid.
- I am seeing most of the patients. I have one employee, although she is leaving.
- I have had almost 900 patient visits this year and my employee has had 300 visits.

Nicole Scott

- I have been an NP for 15 years.
- Worked at a had a large outpatient and inpatient practice. Four years ago, Premier Physicians separated, and I started Trinity Medical Associates with a physician.
- I saw how primary care was changing. There was no care because the time pressure of a 15-minute appointment was too great.
- I decided to open own practice and started June 1, 2018. It has been challenging but rewarding.
- On the average, I am seeing 13 patient a day without any marketing. There are new patients calling every day. My goal is not to become humongous; I want to provide good quality care.

Jennifer Seo

- Deputy director of Mental Health Association of Delaware, a statewide nonprofit that does mental health advocacy.

Dr. Conaty-Buck

- I am in practice with the nurse managed primary care center at UDel. The NP practice has 4 practitioners with 8,000 visits per year. The number of visits have increased 25% in

the last couple months as others primary care providers close down. We were one of the few practices taking new patients, but recently had to close to new patients.

- We are also educating the NP graduate students. The clinic at UDel also has PT, nutrition, psych, and a speech and hearing clinic. This is a larger entity that allows us to work with other providers and practice collaboratively.

Dr. Fan

- Starting with the intersection of primary care and behavioral health.
- Both Dr. Irwin and Dr. Wilbur both said a growing component of practice has been behavioral health. Why is this? Do you feel like there is greater need and less access or the need is the same and access is less or more people becoming comfortable with behavioral health in the primary care spectrum?

Dr. Wilbur

- The need for behavioral health is greater, in particular considering the opioid crisis.
- Access is a challenge for Medicaid beneficiaries. Behavioral health providers have 3 to 4 month waiting lists or they don't take Medicaid. Pain management don't take Medicaid. My practice is challenged to provide this care because 90% of my patient population has Medicaid.
- I have 38 years' experience nursing. I think nursing looks at things holistically, we approach things differently.
- When they get out of my realm of expertise and I try to push them out to specialists. But there is either no access or they are not comfortable with other providers.

Dr. Conaty-Buck

- With the Mental Health Coalition, we are getting asked to code for and evaluate behavioral health in exchange for payment. They just started talking about that last week.
- It is important to understand the view of the single practitioners. The challenges of the individual practices are significant. And discussing mental health, we are asking to do more, adding to the things we must do.
- We are barely providing primary care services, to provide suboxone or other behavioral health specific services is too much pressure.

Dr. Wilbur

- My general feeling is that the providers who offer suboxone do it for money.

Dr. Fan

- Right, because medication assisted treatment (MAT) is not necessarily tied to therapy. That is a slippery slope with MAT is that it doesn't address the larger picture of the mental health treatment needed.

Dr. Irwin

- I would say, as a suboxone waiver holder, I do not know many people who provide for insured populations, many do it for cash.

Dr. Fan

- When you imbedded the phycologist, did that help you?

Dr. Irwin

- Our psychologist is more focused on adolescent health.
- We have PhD psychologist who wanted to lease a room. After 3 years she has become more and more integrated. These are her own patients, but we share so much. And the care focuses on family dynamics.
- The children are more comfortable at a place they already know. Same with parents. The follow-up and follow-through is easier.

Dr. Wilbur

- This is true for me too. Many patients don't want to go to another provider, but I don't have the support to do all the behavioral health.
- As an independent provider, I don't hear about some of these programs, grants, or other opportunities. And I don't have the free time to search and stay on top of these opportunities. I want to serve the need I see in patients.

Nicole Scott

- 1 in 2 patients has a behavioral health issue. We are seeing chronic conditions and mental health conditions that are all tied together. In 15 minutes, how do you manage all of this in a patient?
- Behavioral health and mental health issues are one reason I chose to separate myself from a large group because I think integration with a behavioral health specialist is the way to go.

Dr. Irwin

- The need among children is so much greater. These children are stressed out. I am lucky to be in a group with the administration/ backbone to support a lot of this work.
- The nurses know how to schedule based on these conditions – to give me an hour if a child has depression or anxiety.
- We are not officially PCMH. We have a lot of the features, but have not gone through the hoops.

Dr. Fan

- Independent practices cannot become PCMH certified. And hoops are difficult to achieve the official certification, but many practices adopt some of the best practices or achieve the same thing without the certification.

Dr. Conaty-Buck

- When we talked with the insurance companies, they said the payments were flattening. The scary thing is not being able to earn the revenue to support these changes.

Dr. Fan

- Jennifer - do you get a lot of referrals?

Jennifer Seo

- We don't do direct services, but we do get a lot of calls asking for referrals. They are calling because they have tried to find providers and see waiting lists. There are a lot of barriers to doing the research finding someone who is accepting patients in time.
- We refer some individuals to crisis intervention services because they do have a psychiatrist on staff. They may be able to hold the patient over until they can get an appointment.
- We get a lot of calls that trouble finding child psychologists.
- For Medicaid and Medicare the challenges are enhanced.

Dr. Fan

- The amount of investment needed for practitioners to make behavioral health sustainable is difficult to achieve, both on the practice side and in terms of reimbursement.

Dr. Irwin

- There are challenges in access – getting the expertise needed – and in reimbursements, which are not compatible with addressing these conditions in the office.
- Speaking more as a private practice, one thing we deal with being undercut by the big corporations (i.e. Christiana or Nemours). We have more providers joining them because the cost of maintaining independence gets higher and higher, especially with reimbursements flattening.
- It is important for primary care to remain independent. We do operate as a PCMH, although we didn't find the hoops worth it.
- We can remain connected to the patients and provide more consistent, continuous care.

Dr. Conaty-Buck

- There is a difference in the payment. Although we provide the same services, we get lower reimbursement.

- The insurance company may refuse to credential an NP even if they can practice independently in the state. This restricts the choice of a patient.

Dr. Fan

- What additional investments would help you be sustainable?

Dr. Irwin

- We need money up front. We don't have the capital to bring in a full-time behavioral health specialist, see if the codes work, and see if we can make money from this new stream of care.

Dr. Wilbur

- Some little code may be wrong. I just had 20 refusals for AmeriHealth because my EIN number, which they already have, is wrong. Sometimes tell my patients that I don't exist.

Dr. Fan

- Is a care coordination fee or a PMPM?

Dr. Irwin

- Our biggest payer doesn't provide care coordination fees. This would be extremely helpful.
- Any way for us to front cost would be helpful. If the insurance would provide payment in advance, go over the codes together, make sure we know what to bill, and have the payment come off those codes.
- We will have plenty of work for this provider, but we need help to add the capacity up front.

Dr. Conaty-Buck

- We are investing in achieving metrics but the insurance companies need to look at the cost for us to meet the metrics to ensure when we are achieve the metrics we do not experience a net loss.
- The threshold is high and if you don't meet it, the practice gets nothing. Is there a way for smaller to get a scaled payment with money up front?
- What can I pledge up front in return for up front money. Then if I don't do it the payer gets that money back, and if I surpass, we might bet more.

Dr. Fan

- Are you able to meet the metrics, or are they too high?

Dr. Irwin

- We've been able to meet the value-based metrics.
- The problem is that these metrics appeared without us being aware of the benchmarks and how we were doing though the year. They appeared out of nowhere.
- Our biggest payer has a new practice liaison who has been much better about communicating, and we have gotten more say in what we can accomplish. This has made it more successful for them and for us, because we are working toward things that are important in practice and achievable.

Dr. Fan

- One major trend we see is providers moving into concierge. Is that happening in pediatrics?

Dr. Irwin

- I know that none of the pediatrics have gone to concierge practice. We don't think it's fair to the kids or to the Medicaid beneficiaries. We are likeminded that it isn't a healthy way to practice
- It is where the psychiatrists are going though.
- We have seen that a couple smaller practices have agreed to get bought by larger medical groups. It is too hard to remain productive and profitable.

Dr. Conaty-Buck

- And accessing the insurance company, sometimes the NP practice needs to pay the practice to use their name to get under an agreement with the insurer.

Dr. Fan

- If you are addressing access issues, if we encouraged for team-based care, where instead of volume based, if you had a say in how practice operates would you be more interested in joining a group?

Dr. Conaty-Buck

- It really depends on how the team is structured.

Dr. Wilbur

- It depends on how collaboration is defined.

Dr. Fan

- FQHCs are really pushing the team-based model, especially with NPs and CHWs. Moving outside that particular population would this be possible.
- If you want to stay independent, how do we help you do that?

- I don't think sustainable for 100 practices of 1-2 people, because that is missing a lot of economies of scale, but what about more smaller groups?

Dr. Wilbur

- I am thinking more of consortiums. With team-based I have a vision of a very physician-driven organization and model of care. And I left practice for that reason. I need to collaborate in a truly collegial way. But the team-based models are always physician directed.
- We could make it a consortium of independent NP and physician practitioners that come together and use resources better together.

Dr. Irwin

- We are not allowed to do this though, but this would be really helpful.
- The insurance companies do not allow us to combine or negotiate in a joint way. We cannot discuss contract or negotiate vaccine prices.

Sen. Townsend

- The insurers are barring this. Is it true in all 50 states?

Dr. Fan

- If you have separate tax IDs you cannot purchase together. This is a result of the federal anti-trust laws.

Sen. Townsend

- The antitrust laws prevent small, local collaboration but don't stop large group monopoly concentration?

Dr. Wilbur

- We could still share resources, it doesn't have to be about purchasing. We could share a care coordinator or care management or addressing social determinants.
- I just found out that one of my patients had surgery and no one told me. And now DHIN wants to charge $400 per year to access these records, but I cannot afford that.

Dr. Fan

- Would investment in HIT be helpful?

Dr. Conaty-Buck

- NPs were not included in meaningful use at first. But then they started to allow us, if we met a threshold for Medicaid. As a result, we have been behind with HIT from the beginning, so shared resources here would be good.

Dr. Fan

- And HIT is a barrier for behavioral health integration. I hear the behavioral health are not on EHRs, but there is greater uptake among primary care providers.

Dr. Irwin

- Part of it is getting the provider comfortable. The parents are happy to have us collaborate with their behavioral health providers.

Dr. Fan

- And children may be different adults may have a different concept of behavioral health and sharing information. Some adults object to sharing these mental health diagnoses.
- Do you feel that having investment in behavioral health as part of the 12% primary care investment would be good?

Dr. Irwin

- Yes, and I think this would be a good investment from the payer perspective. Individuals with mental health are not taking care of their chronic conditions. This will keep them out of the emergency room.
- This is an investment that would benefit the payers and the patients, and we can show and track this value.

Dr. Conaty-Buck

- Everyone who works in primary care practice sees this relationship between nutrition, mental health, and primary care.

Jennifer Seo

- The idea if integrated services is appealing because the behavioral health stigma means that many patients may be more comfortable going to a primary care setting.
- Certified peer specialists are people with lived experience in mental health or drug abuse, and get certification with work experience. This is reimbursed through Medicaid. Incorporating into the primary care setting could be beneficial. Those with behavioral health issues or SUD may be willing to talk to the certified peer specialist.
- We have certified peer specialists in Delaware. The Healthy Neighborhoods Taskforce had an internship cohort for a group of peer specialist to get experience and training. We have been able to provide a stipend for the internship.

- It has been pretty successful, and we are hoping to continue. We are trying to create more workforce opportunities for them.
- Private insurance does not pay for certified peer specialists, but Medicaid does. So if we could work on getting them reimbursed in private that would be great.

Dr. Irwin

- That is someone who could do support work like follow up with the patient.

Nicole Scott

- I think a social worker would also be great. I have spent countless hours finding resources to fill social needs for patients, but I don't have the knowledge to do this efficiently.

Dr. Fan

- The FQHCs found that having someone to do coordination for social determinants found that they were providing better care.
- On the other hand, there are behavioral health providers that find a patient with out of control diabetes but cannot find someone to refer to, so this integration must go both ways.
- This is a challenge of solo practice, it is difficult to meet the needs for all these patients.

Dr. Wilbur

- A one stop shop for independent providers to find help and resources for the practice and for the patient.

Ema Edi

- I started as a family NP, then I specialized in mental health and after being in practice for 3 years, I just opened my own clinic. I am now serving ages 5-85. While I specialized in mental health and come across patients with medical challenges. Even with the dual specialty it gets tricky.

Dr. Fan

- Even without marketing, you have full practices. Is that a consequence of physicians leaving adult medicine?
- What do you feel would be an answer to the lack of access?

Nicole Scott

- Making it easier for APNs to obtain the same resources as a physician. For instance, it is challenging to get insurance to collaborate with you and accept you as an independent entity or to get your own malpractice insurance.

- The physicians I worked for previously are supportive. Payers need to keep an open mind and see NPs as an adequate primary care provider.
- AmeriHealth denied me on the basis that I was an NP, despite the fact I am an independent provider and that I had 5,000 different patients in 2 years, that is a problem.

Dr. Conaty-Buck

- She can legally practice in Delaware as an independent practitioner, but an insurance company decided not to allow her in the network.

Dr. Irwin

- Payers decide whether or not to contract with every provider. It is their right at this point.

Ema Edi

- Similarly, under the group practice I was billing under the group NPI. When I went into independent practice, some insurance companies require a collaborative agreement even though the state allows us to practice independently.
- In my specialty for instance, these patients are very committed to you and you are trying to provide a different quality of care to them, but then getting the insurance refusal even though they know you care capable of the work, you just feel marginalized.

Rep. Bentz

- Which companies have done this?

Nicole Scott

- AmeriHealth

Ema Edi

- Aetna

Dr. Fan

- Jennifer, do you get calls for primary care referrals?

Jennifer Seo

- We don't get calls for primary care specifically, mostly for mental health providers, but anecdotally we see people that struggle with finding primary care.

Dr. Wilbur

- I also work at Go Care, and most people seeking care there say that they cannot find a primary care doctor.

Dr. Conaty-Buck

- We trained people who recently got coverage under the ACA to seek care, but now they cannot find it.

Ema Edi

- I refer some patients to a primary care, but they don't have a primary care. I will extend a visit without reimbursement because they will not go to the primary care provider.
- I have been in practice 5 weeks and have 600 patients without advertising.

Dr. Fan

- Is there any unique needs in pediatrics or are there similar challenges across all primary care?

Dr. Irwin

- Both. Pediatrics is specifically different on vaccines. Coordinating vaccine purchases would be important for smaller pediatrics practices.
- The larger systems help and undercut at the same time – for instance with the move to have health care in schools, we get concerned about who is with them. Pediatrics have been proponents of PCMH. School-based care or Go Care undercuts the PCMH approach and continuity of care.
- Our patients have no copay at a place like Go Care and may go there instead solely based on the copay. We lose reimbursement on this as well.

Dr. Fan

- Is there anything else you want to bring to the table on primary care sustainability?

Dr. Irwin

- EHRs are a huge issue, but they are particularly frustrating to independent practices. In a hospital you have many centers and they all must be able to talk. In a small practice everyone can talk without the EHR. The cost of EHRs to get and maintain a good system is not worth it.
- We have had a lot of problems with DHIN recently. The EHRs do not communicate with all the different hospitals or lab providers. We are forced to do the EHR without the benefits of full information.

Dr. Wilbur

- DIHN has good intentions with creating a community record. It seems like not all provider add information.

- Now they want to charge us. They say $400 for DHIN isn't much, but this is one in a series of small monthly costs that are essential to run the practice.

Dr. Conaty-Buck

- And sometimes there are providers who don't recognize the NP as the primary care provider and care coordinator.

Dr. Wilbur

- Bottomline is that we need to communicate better.

Ema Edi

- Before I ventured out on my own, I was in the corrections system. The communication between mental and primary care is essential. Both are treating the same conditions or symptoms without communicating. There are side effects and consequences for the lack of communication.
- The primary care and mental health are treating the same things. We are paying for a EHR that isn't efficient. You ask for data, but don't get it. The patients don't understand what is going on in the background.

Rep. Bentz

- Does DHIN charge different amount depending on the size of the practice?

Dr. Conaty-Buck

- It looks at the number of patients.

Rep. Bentz

- What is the range of monthly cost for DHIN?

Dr. Fan

- There are different costs to different services. If you contribute CCBs, there is a cost to that. The hospitals do that. The costs are by practice site.

Sen. Townsend

- I am surprised this is the first time I've heard of DIHN problems during all these sessions.

Dr. Wilbur

- DIHN had been absorbing cost, so the fees are now in place.

- It is critical sometimes to hear about what happens to my patients. And other providers would benefit from the information I can provide on the patient as well.
- I would invite anyone to come spend a day in my practice to see what the rules and regulations are and how it impacts the practice.

Dr. Conaty-Buck

- CMS had two specialists follow us around when looking at administrative burden and they were shocked.
- One of the things facing us is supporting the independent practice. The large hospital practices which can support a sophisticated infrastructure. How are we making sure that there are different choices, so the patients can find the right provider for them, accessible at different levels. We need to provide support for the small practices to continue to exist.

Dr. Fan

- Large practices donate lots of resources at their own cost to support primary care, but smaller do not have the margins to do that. We want the patients to be able to see the provider they want. Keeping the patient at the center is essential.
- One of the hardest questions I get is "I need a new primary care provider" because they trust me.

Dr. Irwin

- Take the solo/small out of this. There are still share challenges. Behavioral health is really important so why at larger clinics are they not integrating behavioral health? Because it is not considered important in the reimbursement.
- We have challenges in primary care where we are responsible for the specialist and patient decisions. We get the burden of handling it on the primary care end, rather than on the side of the specialist or emergency room.

Dr. Fan

- You are assuming the risk and not getting the value.

Dr. Wilbur

- I have patients who don't want to go back to specific providers. But they have few choices outside of those providers.

Dr. Conaty-Buck

- It isn't us vs them – NP vs physician. Each of us have different talents and abilities.
- The NPs are not trying to takeover or attack physicians. The intention is to allow us to practice effectively and provide good patient care.

Dr. Fan

- We want to keep the patient first and recognize that we have an access problem in Delaware.

Dr. Conaty-Buck

- At the university we train mental health NPs. We are seeing a number of NPs going back to get the specialization. These folks have jobs 6 months to a year before they graduate. But many are being lured to other states with offers of greater salary, benefits, and independence.
- If you want to build a strong workforce it's not all about money, but you have to look at the equity and their career outlook.
- Now most NPs get doctorates which requires additional cost and schooling.

Dr. Fan

- In terms of maintaining the current workforce, have you had any new pediatricians?

Dr. Irwin

- We have not had much turn over. We have been very stable.

Public Comment

Wayne Smith

- I run the Delaware Healthcare Association. We have an access problem in Delaware. Primary care is the key to good health and Delaware hospitals are fully on board with making sure we have a robust primary care system.
- We have a statement responding to the payers' discussion at the last meeting that discussed hospital costs.
- We are fully behind VBP reform and hospitals are leading the way in Delaware. The hospitals advocated for the addition of the DHCC tracking value-based contracts with the goal of reaching 60%.
- There is a lack of competition among health insurers is a significant issue. Of the 50 states, Delaware has the second worst competitive environment. The lack of competition among health insurers mean they are not compelled to develop VBP. It is the economic and political environment that determines VBP adoption, not the willingness of the hospitals. The political environment has been positive with the 60% VBP goal. But the economic environment is challenging with the lack of competition.
- All general acute care hospitals are in the Medicare ACOs and are moving toward statewide integrated networks. The payers have had no engagement in these initiatives. And no insurers have proposed anything similar to the Medicare ACO programs.

- The lack of prayer competition has been a key force in driving independent to joining hospital systems due to high administrative costs. The cannot do patient care when they are doing managed care work. Hospitals can take up some of this burden for primary care providers.
- We are fully behind payment reform and believe hospitals are leading the way.

Cheryl Hikes

- I represent Delaware Health Information Network. I am not able to share information on their pricing, but I can ask them to come and share information for follow-up if you like.

Dr. Fan

- We will have a draft report with the recommendations that will be circulated then presented publicly on the January 2nd. This will be a public meeting.

Sen. Townsend

- If you sign-in, we will circulate the draft report. Then on January 2, we finalize and approve.

The meeting was adjourned at 6:00 p.m.