PRIMARY CARE REFORM COLLABORATIVE (PCRC)
Meeting
Monday,
February 12, 2024, 3:00 pm - 5:00 pm
Hybrid (Anchor location DHSS Chapel)

Meeting Attendance and Minutes

Collaborative Members:

Present	Organization
Dr. Nancy Fan, Chair	Delaware Health Care Commission (DHCC)
Kevin Ohara	Highmark Delaware
Deborah Bednar	Aetna
Faith Rentz	State Benefits Office/DHR
Maggie Norris-Bent	Westside Family Healthcare
Christine Vogel (Proxy for Trindade Navarro)	Department of Insurance (DOI)
Dr. Rose Kakoza	Delaware Healthcare Association
Andrew Wilson	Division of Medicaid, and Medical Assistance
Steven Costantino	Division of Health and Social Services
Dr James Gill	Medical Society of Delaware

Meeting Facilitator: Dr. Nancy Fan

Commission Members Absent: Commissioner Trinidad Navarro *(*Department of Insurance (DOI), Vacant (Delaware Nurses Association), Representative Kerri Evelyn Harris (House Health & Human Development Committee), and Bryan Townsend, Chair Senate Health and Social Services

Health Care Commission Staff: Dionna Reddy (Public Health Administrator I), Elisabeth Massa (Exec Director Delaware Health Care Commission), and Sheila Saylor (Admin)

Call to Order

Dr. Fan called the meeting to order at approximately 3:05 p.m. A quorum was determined for voting. Housekeeping items to the public- please send your name, email contact, and organization affiliation (if applicable) to dionna.reddy@delaware.gov or write in the meeting chat box. Please keep your computer/phone on mute unless you are commenting, and if you are not on visual, please identify yourself as well. This meeting will be recorded for minutes.

Review and Approve January 22, 2024, Meeting Minutes Approval

Dr. Fan asked if there were any edits or comments for the January 22, 2024 meeting minutes. Hearing none, a motion was made to approve minutes by Steven Costantino, DHSS and Rose Kakoza, Delaware Healthcare Association seconded. PCRC members unanimously accepted the minutes.

Update – Strategic Planning Work Group - Recommendations

National Academy of Science and Engineering Medicine (NASEM) Statement on Payment Reform
Dr. Fan reviewed the purpose of the Strategic Planning Work Group stating that last year we thought it was a good idea to start having some strategic priorities for the PCRC. We developed a survey based on the National Academy of Sciences, Engineering, and Medicine's statement on payment reform. NASEM did a white paper on primary care reform.

From the results of the survey a statement was developed that everybody agreed should be the overarching vision for the 2024 and 2025 years. It states "Any effort to implement high-quality primary care must begin with a commitment to pay for primary care teams to care for people, not doctors to deliver services. To improve payment for primary care to better meet people's needs, payment should be increased to reflect the outsized benefit primary care has on the health and well-being of society and flexible enough to allow practices to meet the specific needs of the population they serve."

The statement also included that the hybrid reimbursement model (part FFS, part capitated), should pay prospectively for interprofessional, integrated, team members and partnerships with community-based organizations. It should be risk-adjusted for medical and social complexity. Allow for investment in team development, practice transformation resources, and the infrastructure to design, use, and maintain necessary digital technology and align with incentives for measuring and improving outcomes for the patient population assigned to clinicians.

The summary of the survey results was:
If there is an increase in the total cost of care, the cost should not be passed onto the consumer/patient

- 11 responses – 72.7% agree>>>unrealistic

With the information provided by the OVBHCD and through the DHSS Benchmarking and CostAware data, there should be an effort to decrease inpatient costs, even for those health plans not covered under SB120 (Medicaid, self-insured plans)

- 11 responses – 90.9% agree>>> not feasible due to cost factor

If this is a STRONG RECOMMENDATION from the PCRC, should there be a recommendation for an established regulatory body regarding health care systems and their contracted payment schedules with carriers, such as a set schedule for annual increases in service payments, similar to what is in SB120?

- 10 responses - 90% agree

If a regulatory body is NOT a STRONG RECOMMENDATION, then should the PCRC recommend that those health plans that are not under SB120 contribute to a statewide Primary Care Investment Safety Net, which may cover but is not limited to, costs associated with practice transformation for practices to reach PCMH quality of care; infrastructure costs to establish resource for patients and providers alike regarding primary care access; patient and provider education regarding the benefits of primary care, behavioral health, as well as social determinants of health.

- 10 responses – 70% agree

Those health plans that are not under SB120 should not be required to comply with SB120 or contribute to a statewide Safety Net without access to and an ability to influence the contracted payment schedules in place between health plans and carriers (when such carriers are contractually responsible for providing a network of contracted providers and processing claims for services to the health plan)

Both payers and state agencies should be tasked with educating self-insured entities about the value of primary care not only improves access and quality but also reduces the total cost of care. There should be a database of those payers who do and don't respond with appropriate payments. This should be shared with the physician/provider community as well as well as the public.

The PCRC should recommend telehealth services, which would need to be defined, are included as an essential service of primary care.

- 11 responses – 100% agree

The Delaware Primary Care Delivery Model (aka Value-Based Model) should be incorporated in all health plans, whether through regulation or legislation

- 11 responses – 72.7% agree

The PCRC should recommend that the certification of PCMH level of care not be limited only NCQA certification and can qualify for higher reimbursement if the practice meets certain parameters.

- 11 responses - 54.9% agree; 36.4% not sure – I need to know the qualifying parameters

This was the first phase of what we did to try to establish our strategic priorities. The second phase was having a stakeholder interview with HMA to get a consensus and sentiment about what the PCRC is currently doing and what they feel we should be doing.

Dr. Fan acknowledged the members of HMA who were on the call Gaurav Nagrath, Managing Principal, Keyan Javadi, Consultant, and Caitlin Thomas-Henkel, Principal, and their team, and reviewed what was presented by HMA at the last meeting regarding the interview and the process. Dr. Fan reviewed the timeline for the project and the subcommittee working group members.

Dr. Fan next introduced the PCRC working group takeaways that would be voted on at this meeting.

1. There needs to be a greater effort to decrease inpatient costs; inpatient costs are the highest rise in cost of care
2. PCRC should set goals for where primary care investment is going
3. Expand patient-centered care to look beyond what SB-120 looks at
4. DE needs to find a personalized solution that matches the policies it wants to move forward
5. Specific primary care governance models DE should adopt:
    a. Vermont's Green Mountain Care Board closely resembles what DE hopes to do
6. Develop 3-5 strategic objectives that the PCRC feels passionate about moving forward with

Dr. James Gill, Medical Society of Delaware, asked a question regarding the NASEM statement, "With the information provided by the OVBHCD and through the DHSS Benchmarking and CostAware data, there should be an effort to decrease inpatient costs, even for those health plans not covered under SB120 (Medicaid, self-insured plans) was not feasible due to cost factor." Dr. Gill inquired why decreasing hospital costs is not feasible due to a cost factor.

Dr. Fan stated that it was a general statement, and she thought the concept included plans not currently under SB120. It was not specific to exactly who the cost was directed.

Caitlin Thomas-Henkel from HMA presented each recommendation with feedback and then turned it over to Dr. Fan after each recommendation for a vote.

Recommendation 1: The PCRC should focus on increasing multi-payer participation and buy-in for primary care spending. _9__ Yes __0_ No

Steven Constantino asked for clarification on the recommendation asking if the buy-in was for SB120 or primary care spending. Dr. Fan clarified that it was for primary care spending. Steven Constantino asked if there were any other pathways to increase the investment in primary care since the impact of SB120 impact has been on a very small portion of the population. Dr. Fan stated that we need to invest in a multi-payer environment. The recommendation was put to a vote for commission members only by a show of hands.

Recommendation 2: The PCRC should inform policies that will work on primary care investments, without increasing overall healthcare costs. __8__ Yes No __0___

Dr. James Gill, Medical Society of Delaware commented on the small group in the survey and suggested that the responses be taken with a grain of salt. Dr. Gill also spoke of 2 nuances of concern for him 1) over what timeframe is the recommendation? 2) We cannot hold primary care hostage to hospital lobbying to continue to get dramatic increases in prices.

Dr. Fan explained that the timeframe for our specific area of focus is 2024 and 2025. It doesn't mean that everything will be completed by 2025, this is just our area of focus. Dr. Fan spoke of the strong sentiment within the PCRC on what is happening overall in healthcare and this recommendation reflects how we decide with the action items whether it's cost alone or pricing cost which is a huge driver in healthcare.

Ronald Mezin, Cigna Healthcare, commented that the dilemma economically with this statement is that you are implying that the total healthcare cost is an absolute zero-sum gain which is both economically and clinically untrue. He stated that total medical costs will come down if we improve the quality of care and efficiency and effectiveness of care. Steven Constantino explained that the operative in the recommendation is to inform not act.

Recommendation 3: The PCRC should promote and advocate for quality measures aligned across payers based on the highest cost of care drivers. 7 Yes 1 No 1 Neutral

Dr. Gill felt as though there was a disconnect between the survey results and the focus group. The survey results didn't have anything to do with quality measures but with cost and the focus group dealt with quality and not cost. He felt that with this disconnect the quality measures developed would be inappropriate and focus on things such as utilization that have little direct correlation with primary care.

There was considerable discussion on the wording of the 3rd recommendation and a vote to amend the recommendation to exclude the last part of the recommendation was taken. The recommendation will now read: The PCRC should promote and advocate for quality measures alignment across payers.

7 Yes 1 No 1 Neutral
Motion made to accept an amendment by Steven Constantino and seconded by Dr. Rose Kakoza.

Recommendation 4: The PCRC will develop a more comprehensive communications strategy, such as an annual report, to increase transparency around the vision, goals, and progress of the PCRC.
7 Yes 2 No

Dr. Fan explained that when the PCRC was first enacted there were annual reports in 2018 and 2019 but because of the pandemic and SB116 and SB120 the reports waned. Dr. Fan encouraged the commission that part of their responsibility of being on the PCRC is to return to your organization and help them understand the work that we are doing, discuss initiatives we support, and our strategic priorities.

Recommendation 5: The PCRC should explore a more inclusive strategy across the spectrum (i.e., employed practices, MCOs, etc.) to reflect the needs of all practices within primary care specialties.
7 Yes 1 NO 1 Neutral

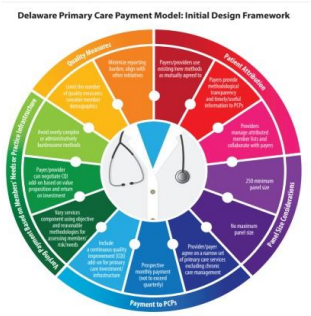
Dr. Fan explained that this recommendation does not specifically have to do with payment reform, it comes from the work of the stakeholder survey done by HMA. This recommendation has to do with the ability of people to participate in what primary care reform looks like and thoughts from groups that feel like it doesn't apply to them, so they don't understand or participate.

Steven Constantino asked what is a primary care investment safety net. Dr. Fan explained that health plans that are not participating in SB120 would contribute to offsetting the total cost of care. Recognize that there are practices that cannot do practice transformation, cannot cover their infrastructure cost, or are limited in their ability to achieve quality measures and we want to help them.

Dr Gill stated that the recommendation could be interpreted in different ways and wondered if we have the right people on the collaborative in terms of primary care if the people on the collaborative aren't engaged or maybe we need people outside of the collaborative. The committee members discussed that the recommendation was not if we have the right composition on the committee, it's about whether or not our strategy is inclusive enough. There was concern that if the committee omitted this recommendation, we might be sending the wrong message to those trying to follow our work. Several committee members agreed, and the recommendation was put to a vote.

Dr Fan commented that all recommendations were passed with different levels of approval but with the majority in agreement. The next step will be how we want to implement these recommendations and what kind of action items we want to come out of that. HMA will be pulling together a summary of all the information provided and recommendations on the feedback that will be shared with everyone.

Update- Delaware Primary Care Value-Based Payment Model
Dr. Fan would like for the commission to come up with a name for the payment model and she reviewed the original work from HMA on the color when and the measures from the quality metrics group on the measures we would be adopting. We are trying to keep quality measures to 10 or less to reduce the administrative burden for each practice. There will be a pediatric subset as their measures may be different.



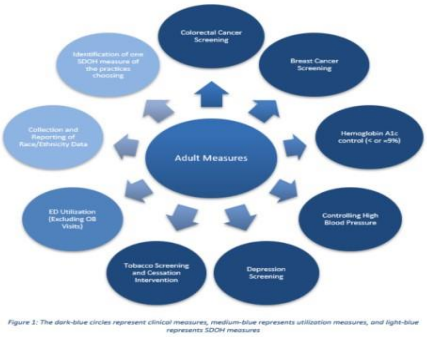
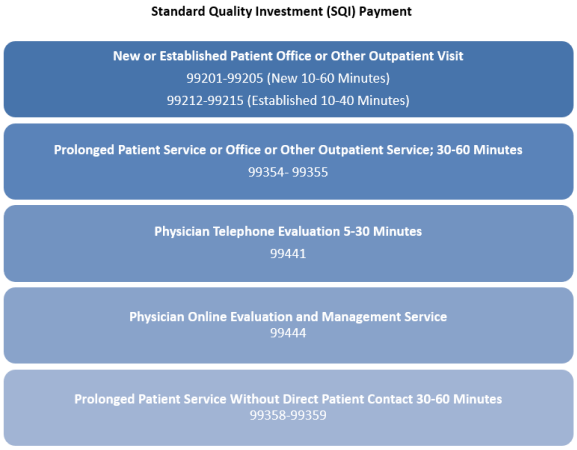


Figure 1: The dark-blue circles represent clinical measures, medium-blue represents utilization measures, and light-blue represents SDOH measures

SQI and CQI Methodology

Standard Quality Investment (SQI)
Continual Quality Improvement (CQI)

Kyle Edington, Managing Director HMA, provided some details on previously presented data from the DHIN on bundled procedure codes provided by primary care providers for fully insured populations resulting in PMPM payments.



The payment model can differ between assigned and attributed members and is dependent on the delivery model which varies if the data is collected on all potential providers or providers rendering the procedure codes listed. This is important because of the contract details between the payer and the PCP.

Some healthcare attribution considerations are that implementing SQI requires continued conversations around PCP attribution. SQI PMPM will vary significantly depending on whether all care is included or only care from attributed PCPs. DHIN data reflects only primary care visits.

Ronald Mezin, Cigna asked for clarification on the context of the information. Dr. Fan provided a high-level explanation saying the data being presented is to inform a recommendation for a prospective payment model that will include a flat rate that includes the specific procedure codes we talked about.

Dr. Gill asked for clarification on is this data collected if it is what has been paid or what should be paid. Kyle Edington answered that it was both because the main thing we are trying to answer is when you bundle these procedure codes in one payment and have a prospective capitation rate what is a realistic

expectation for the payment on a PMPM basis.

Kyle Edington presented an SQI calculation from the model where only the PCP provides care.

SQI Calculation

	Historical						Projected	
	2017	2018	2019	2020	2021	2022	2024	2025
Number of Visits	99,734	106,453	123,802	97,846	105,338	121,774		
Number of Members using SQI Procedure Codes	59,733	64,277	74,388	63,165	68,189	76,553		
Visits per Utilizer	1.67	1.66	1.66	1.55	1.54	1.59		
Visits per Covered Life	0.70	0.74	0.88	0.74	0.78	0.83		
Number of Fully Insured Lives	142,221	144,513	140,360	131,541	134,365	146,938	149,000	151,000
Paid Dollars for SQI Procedure Codes	$5,511,236	$6,204,045	$8,071,708	$6,776,397	$8,593,733	$10,234,187	$11,954,131	$13,568,339
Trend							12%	12%
SQI PMPM	$ 3.69	$ 4.09	$ 5.48	$ 4.91	$ 6.09	$ 6.63	$ 9.32	$ 10.44

SQI recommendation depends on attribution logic and panel size. These topics have been part of previous PCRC discussions and are pending formal definition. Generally, the SQI PMPM should be expected to be between $10 and $30 PMPM. A large panel with a stronger attribution implementation should be around $30. A large panel with a more limited attribution implementation could be as low as $10. Smaller panels require additional consideration specific to each population and contract.

Dr. Gill expressed disagreement with the methodology because the codes are not primary care CPT codes and only a third of the CPT codes are going to be used by PCPs and determining if the contract is locked down or not is completely irrelevant. Dr. Fan reminded everyone that the committee approved the codes a while ago. The reason they were approved is if we want to talk about comprehensive care and we want to be able to pay for providers to provide comprehensive care they should get a flat prospective payment. Dr Fan stated that this is a hybrid model and a subset of the actual payment a provider would receive. Dr. Gill acknowledged that he didn't disagree with the historical data but that the calculation shows payment to primary care is woefully inadequate and the data is showing us that it is much worse than we thought. Dr. Fan clarified that there is a portion of the payment that will not change regardless, and the rest of the payment model is what we are looking at.

Dr. Michael Bradley stated that the services he provides daily are included in the codes selected, so what additional payments would he receive? Christine Vogel, Department of Insurance (DOI) stated that this payment model would be in addition to any capitation funds. Kyle Edington stated several fee-for-service codes such as care management will continue to be paid outside of SQI and CQI. Also, CQI and SQI are short-term tools in the toolbox that enable you to not only pay for a bundled capitation rate on those procedure codes but also develop new appropriate interventions that complement things that have been done before. CQI and SQI are not one-size-fits-all.

Dr Fan stated that if the PCRC wants to adjust the thinking behind this model based on the data that's been provided we will have to go back to the drawing board and regress a little bit. Dr. Fan asked for a comfort level with the payment model based on these principles representing a certain amount of fee-for-service codes that are now going to be a prospective payment, a certain amount that we'll have for practice transformation if needed, and you will still have the fee for service payment for other activities that is what we are moving towards as long as we can define that prospective payment. Dr. Fan stated that it is difficult to have a specific number for the payment mainly because of attribution and panel size. The PCRC is trying to move the model only for primary care providers.

Christine Vogel expressed her concern with the hybrid package because she wanted to know where care management dollars would come from since that is the majority of the investment trend. Dr. Fan stated that her understanding is the base won't change even if we add this layer of prospective payment to it.

Dr. Fan tabled the remainder of the presentation due to the time.

Dr. Fan stated that she needed members to decide where they want to go with the payment model because we have been working on this for a year and a half and we missed one health plan year and will miss another if we don't stand something up.

Conclusion

The next PCRC meeting is scheduled for Monday, March 18, 2024, from 3:00-5:00 pm. This meeting will be hybrid.

Anchor Location:
The Chapel
Herman M. Holloway Sr. Health and Social Services Campus
1901 N. DuPont Highway
New Castle, DE 19720

PUBLIC COMMENT

No public comments.

Meeting Adjourned at 5:22 PM

Public Meeting Attendees 2/12/2024

Ainsley Ramsey	Health Management Assoc.
Bria Greenlee	
Brian Frazee	
Caitlin Henkel	Health Management Assoc.
Chris Haas	
Christopher Morris	Aetna
Daniel Nemet	Health Management Assoc.
David Bentz	DHSS
David Tyler	
Dr Sarah Mullins	
Gaurav Nagrath	Health Management Associates
Jason Lotus	Cigna
Jennifer Moyer	Aetna
Kristin Dwyer	Nemours
Kyle Edrington	HMA
Laura Brooks	

Laura Knorr	Aetna
Lauren Graves	Christianacare
Lincoln Willis	
Lisa Gruss	Medical Society Delaware
Lori Ann Rhoads	
Michael Bradley	
Nehath Sheriff	
Pamela Price	
Ronald Mezin	Cigna Healthcare
Stephanie Hartos	
Suzanne I. Lufadeju	
William Albanese	Atracare