PRIMARY CARE REFORM COLLABORATIVE (PCRC) Meeting

Monday, January 10th, 2022
5:00pm-7:00pm
Virtual WebEX Meeting

Meeting Attendance and Minutes

Collaborative Members:

Present	**Organization**
Dr. Nancy Fan, Co-Chair	Delaware Health Care Commission (DHCC)
Representative David Bentz, Co-Chair	House Health & Human Development Committee
Dr. James Gill	Medical Society of Delaware
Dr. Rita Meadows	Delaware Nurses Association
Dr. Rose Kakoza	Delaware Healthcare Association
Deborah Bednar	Aetna
Kevin O'Hara	Highmark
Steven Costantino *(Proxy for Secretary M. Magarik)*	Department of Health & Social Services (DHSS)
Mary Jo Condon *(Proxy for Commissioner Navarro)*	Department of Insurance (DOI)
Steve Groff	Division of Medicaid & Medical Assistance
Faith Rentz	State Benefits Office/DHR
Maggie Norris-Bent	Westside Family Healthcare

Meeting Facilitator: Dr. Nancy Fan (Co-Chair)

Commission Members Absent: Senator Sarah McBride *(Future Proxy will be Senator Bryan Townsend: Co-Chair)*

Health Care Commission Staff: Elisabeth Massa (Executive Director), Stephanie Hartos (Public Health Administrator 1)

CALL TO ORDER

Dr. Fan called the meeting to order at approximately 5:04 p.m. via WebEx. It was determined a quorum was present. Dr. Fan asked public attendees to virtually sign-in by placing their name and affiliation in the chat box; public attendees were also informed through the chat that they can email this information to stephanie.hartos@delaware.gov.

INTRODUCTIONS

Dr. Fan began with introductions from DHCC staff members. It was noted that Senator Townsend will be serving as the Proxy Representative for Senator McBride on this commission and will be present in future meetings. All other collaborative members were present, including Steven Costantino (the Proxy for Secretary Magarik) and Mary Jo Condon (temporary Proxy for Commissioner Navarro). All commission members gave brief introductions about themselves and the organizations they represented.

PCRC Role

Dr. Fan began with a brief overview of SS1 for SB120. SS1 for SB120 is a broad mandate for DHCC, with specific focus to the PCRC in sections 1-3. Responsibilities of the PCRC are to mandate the uptake and compliance of primary care providers with value-based payment models, review and incorporate Office of Value Based Health Care Delivery (OVBHCD) spend and affordability standards, solicit reports from payers, hospitals, and acute healthcare facilities regarding quality and practice transformation of alternative payment models (APM), increase overall participation in APM, and reward primary care services which address health disparities and social determinants of health. The goal is to attribute 60% of the Delaware population to value-based payment models by 2025. SS1 for SB120 also provides information on how the collaborative should be structured, the roles of the members, and appointment guidelines.

Office of Value Based Health Care Delivery

The next presentation was from Mary Jo Condon, a senior consultant with Freedman Healthcare and the Director of OVBHCD. In 2019, SB116 directed the Department of Insurance (DOI) to create the OVBHCD with the goal of reducing health care costs by increasing the availability of high-quality, cost-effective health insurance products with stable, predictable, and affordable rates. A focus was placed on increasing the investment in primary care without increasing the total cost of care. SS1 for SB120 expanded the authority of OVBHCD to support the department with implementing rate filing provisions and to develop regulations to define affordability standards.

Ms. Condon discussed the recent works of OVBHCD. Findings showed that primary care investment has not seen any substantial change in increased spending over the last five years. The OVBHCD also evaluated carrier's compliance with Medicare Parity (SB227) and found most carriers were largely compliant. Research was done on anticipated savings with a value-based care model, and these findings, along with other recent work from the OVBHCD can be found at Office of Value Based Health Care Delivery (OVBHCD) - Delaware Department of Insurance - State of Delaware.

Carriers are expected to comply with primary care investment standards that are enacted by SS1 for SB120. See the rate filing percentages below for the minimum primary care spend over the next four years, as well as the projection for primary care investment through 2027.

Primary Care Investment: Increases as a Percent of Total Spend

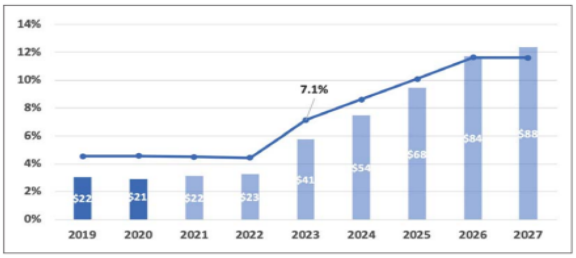
HIGHLIGHTS OF SS 1 FOR SB 120 AND RELATED REGULATIONS

Rate Filing Year	Plan Year	Minimum % Total Cost of Medical Care Spent on Primary Care
2022	2023	7%
2023	2024	8.5%
2024	2025	10%
2025	2026	11.5%

Primary Care Investment: Projections Under SS 1 for SB 120

FIGURE 3: Impact of SS1 for SB 120 on Primary Care Investment in Delaware 2019-2027 (Projected): PMPM and Percent of Total Cost

Source: Delaware carrier template submissions to the Office. Data reflects commercial fully insured and State Group Health Plan.



*Columns with a transparent color represent projections.

As Ms. Condon was reviewing opportunities for savings with new primary care models, Maggie Norris Bent from Westside Family Healthcare suggested reviewing The Joint Commission Primary Care Medical Home at Primary Care Medical Home | The Joint Commission, which focuses on transformation in various levels of care. Ms. Condon said they will review that program.

Ms. Condon stated that Freedman Healthcare also collected data on the Delaware health care market and found that hospital prices were increasing much more quickly than other professional medical services. Beginning in 2017, professional prices were increasing approximately .5% annually, while hospital prices were increasing 3-5% annually. This led to the addition of Limits to SB120 on aggregated price growth for non-professional services (including inpatient hospital and outpatient hospital services). More information on exact Limits can be found in SS1 for SB120.

The last leg of primary care reform stated in SS1 for SB120 focuses on alternative payment model adoption. One option is a new reimbursement framework; this has been seen to increase efficiency and

transparency among health care systems and can address the complexity of percent of charges reimbursement. Additional discussions have taken place regarding shared savings and shared savings towards downside risk with larger carriers, such as Highmark.

It is noted that SS1 for SB120 calls for rate filing provisions to sunset on January 1st, 2027. However, the OVBHCD has been given explicit authority to implement affordability standards, including cost growth limits and APM's, which is a provision that does not sunset. This will allow for more long-term transformation in Delaware's health care market. Compliance to these standards will be monitored by the OVBHCD.

Dr. Gill responded to the presentation by speaking from a medical community standpoint. They agree with a large majority of what Freedman/OVBHCD presented but do have an issue with the timing of the implementation. Delaying for an additional year can cause serious problems. The timing of SB120 was very specific to increase primary care spending beginning in 2022, not 2023. Dr. Gill stated that primary care offices are "hanging on by their fingernails" and many have already closed. These offices were expecting help in 2022 and cannot continue to wait. They propose that we keep the timing in the regulation the same as the timing in the bill (SB120). They understand the rate filings may be difficult to implement with carriers in 2022, however carriers knew this was coming and should have prepared appropriately. Dr. Gill suggested that the payers still provide the funding even if the insurance department cannot force them to do so. He also suggests that the primary care payment in 2023 remains at 8.5% as stated in SB120 as they have ample time to prepare. These recommendations will be provided to the DOI in a formal written comment.

Ms. Condon responded that a formal response will be provided in the public comment process. As for now, carriers are already working on how they can increase primary care spending. The Medicare Parity requirement is also still in place, though many people agree that is not enough.

Leslie Ledogar with DOI also responded to Dr. Gill that updating this primary care spend to 8.5% for 2023 would involve an additional 30-day public comment period, which could result in more delay.

Primary Care Model- Mercer

Mercer Government, a contractor team currently working with DHCC and the PCRC, presented information on the Primary Care (PC) Concept Model. Liz Collins began with a six-phase, 365-day action plan that described the process of PC Model development and what steps the PCRC needs to take to move from planning to approval. Main objectives of the PC Concept Model are to provide support for Delaware PCP practices, adopt a new base payment model to assist primary care providers, reward high-quality care that promotes accountability, boost PCP capacity to provide care coordination to patients, and support providers as they are adopting these strategies. The PC Concept Model for Delaware has three main elements:

- **Alternative Payment Model (APM)**- Mercer has been reviewing two models for this APM- Prospective Payment and Blended Prospective Payment.
- **Community Health Teams-** These community health teams are meant to be locally based, multi-disciplinary teams who coordinate care and help manager patients across providers, settings, and systems of care. They will support a robust primary care system and expand current capacity without duplicating efforts.
- **Care Delivery Requirements with Provider Support-** Practices will need a plan for transformation to identify what their needs are; a readiness assessment can take place to determine capability of implementation. Carriers and MCO's could implement practice transformation initiatives to assist in the advancing of these practices, and criteria will be provided to show competence with essential transformation skills and to support primary care efforts through a multi-year plan.

WebEx Chat Box:

from Kevin OHara to everyone:

How would the community health teams be deployed - shared by practices? within practices?

from Steven Costantino to everyone:

An example of this is in VT

https://blueprintforhealth.vermont.gov/about-blueprint/blueprint-community-health-teams

from MCondon to everyone

May also want to look at the Maryland Care Transformation Organization model

Ms. Collins also stated this will be discussed further in the feedback section.

Fred Gibison, Senior Consultant with Mercer Government, re-iterated that this is just a framework and that it is flexible. Development will occur within determined subcommittees over the course of the year.

Cindy Ward (Mercer) stated that they had met with multiple stakeholders regarding this PC concept model (including ACO's and Health Plans) and shared their feedback. For the APM, a care coordination fee, as well as some sort of mix of PMPM and Fee-For-Service is desired amongst most providers. Transparency in total cost of care, upfront capital investment, incentives, and risk adjustment within the PMPM were also desired. For community health teams, flexibility and support within this concept are wanted by many providers due to differences in practice size, team ownership discussions, and resources. Additional feedback was provided regarding quality measures, workforce development, and data collection/analysis.

Dr. Gill made a comment that Community Teams would work better if they were centered more in the practice, as opposed to having individuals from outside of the practice, as they know their own needs, resources, etc. best. Dr. Gill also mentioned that practices will likely need help moving towards better models, not because they do not know what needs to be done, but because they do not have the resources to do it alone.

Dr. Fan moved into the topic of Subcommittees. The role of the PCRC is to develop a new PC Model that is specific to Delaware with the goal of many practices choosing to use this model as their APM. In order to efficiently develop this model for transformational primary care, three (3) subcommittees are being developed under the PCRC to focus on specific elements of the model. The three initial subcommittees are: Payment and Attribution, Quality Measures and Benchmarks, and Care Coordination. Two possible future subcommittees may be Practice Transformation Support and Data and Information Sharing.

Scott Banken (Mercer) stated that having these three initial subcommittees are due to the fact that having a smaller group of people who are subject matter experts can be more productive than having the entire PCRC trying to work through every aspect. The goal is to have 5-7 subject matter experts on each subcommittee, and nominations can be sent to stephanie.hartos@delaware.gov by February 1st, 2022. Nominees do not have to be PCRC members.

Dr. fan stared that the goal is to have these subcommittees formalized by the next meeting on February 14th. We want to be able to present this PC Model to payers and providers while they are determining what health plans they will be putting out for 2023.

ACTION ITEM: SUBCOMMITTEE APPROVAL

Dr. Fan asked the collaborative to approve the three proposed subcommittees. Dr. Gill motioned to accept the three proposed subcommittees as well as the two future subcommittees.

Dr. Kakoza wanted to acknowledge that Christiana Care had just activated “Crisis Level” due to Covid-19 and other health systems are doing the same. Dr. Kakoza suggested that these subcommittees wait until March or another time to get through the current crisis as attention is being focused to maintaining care standards.

Dr. Fan agreed with this statement but stated that Covid has “taken up all of the air in the room” for the past 20 months as it should, but that we need to keep moving or the work will not get done. Dr. Fan stated that Dr. Kakoza’s point is very well taken but still feels we can go ahead with the ask. If nominees are unavailable, this can be restructured based on need.

Dr. Fan asked the collaborative if there were any objections to the three subcommittees and the format of these committees that had been proposed. There was no response, so the three subcommittees were approved. Dr. Fan then asked if there were any proposals for additional subcommittees; none were provided.

CONCLUSION

Dr. Fan went through a brief history of DHCC and the SIM Grant. This work has been discussed in Delaware previously, but there is a new level of need, along with more incentives and APM's to where a new level of change can occur.

The schedule for future meetings was discussed and is available on the PCRC website: - Delaware Health and Social Services - State of Delaware.

Dr. Fan opened the meeting for public comment.

The next meeting will take place on February 14th from 3:00-5:00pm.

PUBLIC COMMENT

Dr. Mark Glassner, a practicing Family Medicine Physician, invoked an early public comment at approximately 5:10pm. Dr. Glassner had assisted with the passing of Senate Bill 120 and expressed concern regarding the delay of implementation for assistance regarding Delaware primary care practice. Dr. Glassner stated that many primary care facilities in the state are closing, going out of business, or moving to a more privatized version of care. As more PCP's are retiring, primary care may not exist over time as there is extreme difficulty in bringing in new primary care physicians due to the rates of payment being so low compared to neighboring states. Dr. Glassner has 5,000 patients who will need a new provider once he retires and wants them to go to a provider who is being paid reasonably.

Dr. Sarah Mullins, the Medical Director of a Maryland ACO and Delaware's Physician-lead ACO, stated that Delaware is very far behind other states when it comes to value-based care. The timeline set by Mercer needs to be expedited as primary care practices depend on it. Private offices are ready to take on that work, they just need reinforcements.

Dr. David Krasner, a practicing Family Medicine Physician, stated that he heard of two primary care practices that are thinking of closing or selling to the hospital system, which has higher costs and lower quality of care. Time is wasting and it is frustrating to hear that payers are being awarded another year to put off this implementation. Dr. Krasner urged to not let payers delay as it is difficult bringing primary care practitioners to the state and that they cannot compete with the hospitals.

Public Meeting Attendees

Lori Ann Rhoads	Medical Society of Delaware
Pam Price	Highmark BCBS
Joe Fitzgerald	Fitzgerald Consulting, Inc., Highmark
Nicole Freedman	Morris James
Tyler Blanchard	Aledade ACO
Megan Richards	Aetna
Mike Pellin	Aetna
Dr. Sarah Mullins	Aledade ACO
Fred Gibison Jr.	Mercer
Meredith Stewart Tweedie	ChristianaCare
Maureen Hensley-Quinn	NASHP
John Bartholomew	NASHP
Lizzie Lewis	302 Strategies
Dr. David Krasner	Family Medicine Practitioner
Dr. John Freedman	Freedman Healthcare
Sandeep Mann	
Beste Kuru	United Medical, LLC
Dr. Bruce Landon	Harvard Medical School
Dr. Mark Glassner	Glassner Family Practice, LLC
Leslie Ledogar	DOI
Cindy Ward	Mercer
Jaclyn Iglesias	Willis Towers Watson
Christine Schiltz	PGS Legal
Katherine Impellizzeri	Aetna
Scott Banken	Mercer
Dr. Nicholas Biasotto	Family Medicine Practitioner
Michael North	Aetna
Esther Mays	Mercer
Dr. Abimbola Osunyele Osunkoya	Bayhealth Medical Center
Dr. David Donohue	Progressive Health Of Delaware
Liz Collins	Mercer
Vinayak Sinha	Freedman Healthcare
Joseph Fitzgerald	Fitzgerald Consulting, Inc.
Megan Richards	Aetna