PRIMARY CARE REFORM COLLABORATIVE (PCRC) Meeting
Monday, Sept 18th, 2023 3:00pm - 5:00pm
Hybrid (Anchor location DHSS Chapel)

Meeting Attendance and Minutes

Collaborative Members:

Present	**Organization**
Dr. Nancy Fan, Chair	Delaware Health Care Commission (DHCC)
Senator Bryan Townsend	Chair, Senate Health & Social Services Committee
Dr. James Gill	Medical Society of Delaware
Dr. Rose Kakoza	Delaware Healthcare Association
Kevin O'Hara	Highmark
Steven Costantino *(Proxy for Secretary M. Magarik)*	Department of Health & Social Services (DHSS)
Trinidad Navarro	Department of Insurance (DOI)
Senator Bryan Townsend	Senate Health & Social Services Committee
Deborah Bednar	Aetna
Faith Rentz	State Benefits Office/DHR
Christine Vogel	Proxy for the Department of Insurance /Office of Value Base Health Care Delivery

Meeting Facilitator: Dr. Nancy Fan

Collaborative Members Absent:

Commissioner Trinidad Navarro (Department of Insurance (DOI)) Representative Kerri Evelyn Harris (house health & Human Development Committee), Vacant (Delaware Nurses Association)

Health Care Commission Staff: Elizabeth Massa (Executive Director) and Dionna Reddy (Public Health Administrator I)

Call to Order

Dr. Fan called the meeting to order at approximately 3:06 p.m. Dr. Fan stated that today was the same date and time for the AHEAD webinar which could affect attendance. Dr. Fan asked public attendees to virtually sign-in by placing their name and affiliation in the chat box; public attendees were also informed that they can email this information to dionna.reddy@delaware.gov. Dr. Fan also announced the PCRC has a new vacancy representing the Delaware Nurses Association.

Action Items

Dr. Fan asked if there were any edits or comments for the July 2023 meeting minutes. Hearing none, a motion was made to approve. The minutes were accepted with no comments.

HMA Health Management Associate Presentation

Dr. Fan began the introduction of HMA with a highlighted overview. Dr. Fan described the moving parts to the PCRC as it related to the Delaware Primary Care Delivery Payment Model which is a prospective payment model with hopes to have two components. Those parts include: 1) SQI 2) CQI

The SQI is Standard Quality Investment that will be a bundle payment for specific EMNs. The CQI Is a part of the per-member, per month(PMPM) which will encompass practice transformation to help patient practices move towards a more patient centered value-based practice moving away from fee for service. Dr Fran describes this will probably be a hybrid payment model within this particular payment model. Dr Fran has heard back from the Office of Value-Based Healthcare that some payers would benefit with a structed program that would move some of their practices to a value-based payment model and therefore help them qualify for the primary care spending investment from SB120. Dr Fran has asked consultants from HMA (Health Management Associates) to work on a CQI component. The SQI would try to be as accurate as possible both actuary and with data. Making sure it is calculating the right populations and recognizing SB120 only holds for commercial fully insured payers' practices and patients. Dr Fran introduces HMA to show their recommendations for a prospective payment model, as well as comparison data for other states.

Kyle Edrington, HMA Managing Director, introduces Daniel Nemet, Actuary with HMA who leads the presentation.

Daniel Nemet, HMA, Actuary, gave an overview covering the CQI, background, implementation, and considerations. Nemet describes 2 parts of the analysis that were developed which is the SQI and CQI. Standard Quality Investment and Continual Quality Investment. The State of Delaware, DHCC, PCRC, and OVBHCD focus on triple aim of healthcare:

- Improving quality of care, improving health outcomes, and reducing costs.

Senate Bill 120 promotes primary care by setting two metrics:

- By 2025 60% of Delawareans attributed to VBP models
- Primary care must be at least 10% of total cost of care in 2024 and 11.5% in 2025.

Dr. Michael Bradley, DO, queries the 2nd bulletin regarding SB120 and the assumption that 60% of patients will be in a value-based payment, while presently only 10% of patients are covered by SB 120. How it will be meshed?

Dr Fan references that SB 120 is a legislative mandate with the goal that we have a 60% participation. Part of the goal is how we can optimize the portion of patients that Dr Bradley is referencing, and the second goal is how we can get to the 60%. We will try to work within the legislative mandate as much as we can.

Dr Bradley agrees that is something we will have to work with the legislative with.

Dr. Fan adds that there is a small portion/percentage who will not be able to meet their target for primary care spend. Dr Fan states as we increase every single year, we need to be able to offer practices a product that not only help practices enroll in value-based product but also help meet primary care spend.

Dr. Bradley, DO shared his views to the subject and specified that seeing an all-payer system with one quality measure rather than 8-10 that the physicians would have to follow and that someday we will be there.

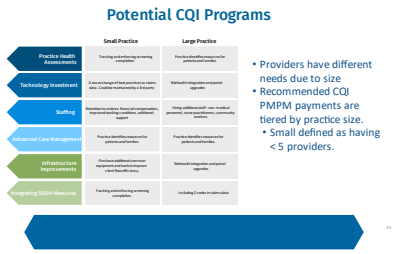
Daniel Nemet, HMA Actuary, added the CQI is going to be a value-based care payment that will help providers by giving them the options to invest in 6 potential categories. The PMPM dollars can be used by providers which will maximize the impact of the dollar.

Dr. Fan shared that the CQI potential uses for continual investments could be used in the following categories: Practice Health Assessments, Technology Investment, Staffing, Advanced Care Management, infrastructure improvement and integrating.

Daniel Nemet, HMA Actuary, reviews the Implementation and Consideration Overview. Nemet provided an overview from the workgroup meeting. The most popular areas identified in which dollars would have the most impact. Responses for CQI Implementation include Care Coordination staff, Information technology/data, Chromic Care Management Staff, Updates to EMR, Infrastructure Upgrades to Improve Client Workflow. Implementation Considerations include:

- A mechanism for reporting the CQI spending needs to be developed.
- CQI PMPM will vary by provider size in the beginning of the program.
- As the program continues other metrics could be introduced to tier the CQI PMPM

Daniel Nemet provides an overview of the Potential CQI Programs. Nemet highlights an example from the list as Technology Investment which could be a small practice who might want to participate in a data exchange, while a larger practice may want to do a Telehealth Integration. Providers have different needs due to size. The recommended CQI PMPM payments are tiered by practice size with small sixes being defined as having < 5 providers.



Daniel Nemet, HMA Actuary, provides an overview of The 2024 Primary Care Scenarios with concrete numbers from HMA's recommendation. The graphs illustrates 5 different scenarios. Which can be viewed on the bottom X Axis. The first yellow block is the same for every scenario which is $28.00 PMPM. There will be things that fall/live outside of these systems. The $28.00 was an estimate from The Office of Value-Based Care which is just setting the baseline. The SQI in blue is a bundle payment based

on procedure codes and HMA is working on the exact PMPM. The focus is on the dashed blue which is the CQI.

- In addition to the size of the practice the range of the CQI will also depend on the practice needs and contracting dynamics.
- CQI can be used by practices to achieve the 10% min requirement.
- By 2025 the 11.5% minimum threshold for primary care spend of TCOC
    - CQI could decrees as SQI payments are increased and investment opportunities are fulfilled.

Dr Michael Bradley, DO asks if the CQI will become larger than the SQI or will it be a standard SQI regardless of how long they are in business?

Mr. Kyle Edrington, HMA Actuary, adds that the intent for the CQI would be a short-term opportunity to direct funding, where it is most appropriate and needed for practices. After 1-3 years the CQI fades away and will allow for more of a traditional payment. Which could possibly be a combination of the SQI and CQI today. For example, if the SQI $30.00 (PMPM) and the CQI is $10.00 we might be pacing towards a future world where the is only one $40.00 payment. The CQI being a short-term opportunity for intervention.

Dr. Fan adds that the 5 scenarios would be 5 different practices. Scenario 1, the advanced practice, that already allotted a build in practice transformation, so they may not need quality investment. In scenario 5, they may have a very low or moderate amount of practice transformation. Which might not have a patient portal, or telehealth, then SQI could be an investment for the primary payment and as they improve their actual value-based delivery.

Kevin Ohara (Highmark) states conceptually it makes sense, but operationally is a huge question. By operationally he adds the ability to facilitate the payments.

Dr. Fan asks what kind of mechanism would you propose for monitoring the CQI?

Kevin O'Hara (Highmark) adds that similarly Highmark is currently having the same conversations. They went with an attestation model for two reasons.

1) A rush to get the money into the marketplace.
2) They are internally having the same question about how to evaluate where the dollars are going and how the dollars are used.

Kevin Ohara (Highmark) adds that as a payer, they are struggling with what the projections would look like.

Dr. Michael Bradley, D0. adds that this is like a captivate model which is a good concept to work with. He believes that most physicians can stand behind it. He added that a way to look at the attestation is what they have done with the medical society with blueprints and the donation to the medical society for primary care is a checklist. He stated that based on the quality measures that they must meet with the insurance companies he suggests that we make it as simple as possible.

Dr. Fan asks Deborah Bednar to add her comments from Aetna regarding the feasibility or mechanism for monitoring.

Deborah Bednar (Aetna) echoes Kevin Ohara regarding the research and how to pay it. Deborah Bednar also asks why does the fee for service not increase?

Dr. Fan states it's not the complete but more a prospective payment. Within the SQI there is a limited number ~~of EMN's~~ of E&Ms. It doesn't include well visit, or vaccination visits. So it would be a hybrid but there is a fee for service component along with a prospecting payment component. Dr Fan adds this is only the prospecting payment component. The SQI component will be worked on at a later point.

Kyle Edrington HMA – added that this is largely hypothetically but the main point is that the CQI and SQI are tools to create promote better care, resources, infrastructure, but also be a lever to be pulled to achieve that 10, or 11 % threshold as it moves to future years.

Maggie Norris Bent, Westside Family Healthcare- adds the feasibility is there. She also likes how the model is laid out. Maggie Noris Bent echoes Dr Bradley with the attestation being great for the first year. She further inputs that perhaps doing some requirements similarly to grant funding. She stated that quarterly could be too cumbersome maybe twice a year.

Kevin O'Hara, Highmark, asked if the concept contemplated the element of risk adjustment.

Dr. Fan stated that not for the first year. She added it may not be possible to add risk adjustment to the CQI because it is prospective payment.

Kevin O'Hara , Highmark questioned if later down the road if the goal is to stabilize overall spend and increase the percentage of overall care.

Dr Fan stated that it would be open to discussion at the collaborative. If they see that the firs year is attestation because practices need to be able to see how they can spend the CQI dollars instead of being held to a goal or measurement.

Gaurav Nagrath, HMA Managing Principal – gives a brief overview of state comparisons. He begins with Maryland. Maryland Primary Care Program (MPCP) modified to fit into the framework of TCOC model. Advanced primary care goals are to help the state manage health of high-risk individuals, reduce unnecessary hospital utilization, and provide preventative care.

Christine from Office of Value-Based Health Care asked what portion of those incentive payments are funded by CMS like Medicare fee for service. In addition, if this is an all-payers program.

Gaurav Nagrath, HMA Managing Principal stated that the playbook was developed in partnership with CMS and the Maryland Primary care management office. Maryland Primary Care Program (MPCP) modified to fit into the framework of TCOC model. Advanced primary care goals are to help the state manage health of high-risk individuals, reduce unnecessary hospital utilization, and provide preventative care. MDPCP Strategic Investments to reduce costs and improve outcomes Statewide include:

- Access & Continuity
- Care Management
- Comprehensiveness & Coordination
- Beneficiary & Caregiver Experience

- Planned Care for Health Outcomes

Gaurav Nagrath, HMA Managing principal, states that Mississippi is a new model. Nagarth mentions that Mississippi TrueCare is a Coordinated Care Organization committed to changing the trajectory of Mississippi's healthcare system. Expenditures on quality improvement activities related to health care quality improvement and health care information technology (HIT) are individually identifiable, tracked and reported. Innovative proposed programs are focused on improving health outcomes, equity, access to care, member engagement and collaboration with CBOs.

Programs to Support the Division's Quality-Based Initiatives include:

- Value-Based Purchasing
- Patient-Centered Medical Homes
- Social Determinants of Health
- Value-Added Benefits
- Performance Improvement Projects
- Health Literacy
- Telehealth
- Use of Technology

The Rhode Island state comparison. Nagarth mentions Neighborhood Health Plan of Rhode Island Quality Improvement (QI) Program ensure that members have access to high quality health care services. Neighborhood's Continuous Quality Improvement (CQI) approach emphasizes the use of "Plan Do Study Act". Neighborhood's CQI efforts support the core principles of: Leadership Driven, Costumer Focused, Employee Empowerment/Involvement, Result-Based Decision-Making.
Quality Improvement Activities:

- HEDIS Measures and CAHPS Survey Results
- Care Management Member Satisfaction Survey
- Provider Satisfaction Survey
- Clinical Practice Guidelines
- Disease Management and Wellness
- Peer Review Activity
- Actions to Address Quality of Care Complaints
- Quality Improvement Projects
- Chronic Care Improvement Programs
- Activities to Improve Patient Safety
- Objectives to Enhance Service to a Culturally Diverse Membership and Members with Complex Health Needs
- Population Health Management Strategy
- Annual Evaluation and Work Plan Development

Gaurav Nagrath, HMA Managing Principal, also provided an overview of The Minnesota Accountable Health Model as part of the State Innovation Models (SIM) initiative sponsored by CMS. Five primary drivers, which most activities are organized: Expansion of e-health, Improved data analytics across the state's Medicaid Accountable Care Organizations (ACOs), Practice transformation to achieve

interdisciplinary, integrated care, Implementation of Accountable Communities for Health (ACHs), and Alignment of ACO components across payers related to performance measurements.

Gaurav Nagrath, HMA Managing Principal overviews Michigan Blue Cross Blue Shield Quality Improvement Program. The goal of the Michigan CQI program is to organize and finance top of the line services to help optimize member health status improvement, efficiency, accessibility, and satisfaction. Across all BCBS service lines Blue Cross embraces the Institute of Healthcare Improvement's Triple Aim framework by, improving the health of the population, improving the patient experience of care including quality and satisfaction and reducing or at least controlling the per capita cost of care.

Dr Fan questions if Minnesota is a all-payers program. Gaurav Nagrath states that it is Medicaid. Dr. Fan asks if they are all prospective payment programs. Gaurav will get back to the PCRC with a list of state by state.

Cristine Vogel, Director of The Office of Value Based Health Care Delivery, provides an update from The Office of Value Based Health Care Delivery. Cristine Vogel states that they are reviewing standardized data from June and that next month they will review projections for 2024. Moving forward the goal would be to provide information on how they are tracking information for 2023. One of the main focuses is that carriers are also compliant. Making sure that physicians practices understand that the payments are identified in a way that physicians feel comfortable making sure their patients are being attributed and fully insured. The data that is collected quarterly is provider level as a state. How can we facilitate their involvement in practicing in a value-based contract.

Dr. Fan discusses the All Payer Health Equity Approaches and Development (AHEAD Model) Centers for Medicare & Medicaid Services (CMS) announced a new voluntary state total cost of care model – the States Advancing All-Payer Health Equity Approaches and Development ("States Advancing AHEAD" or "AHEAD Model"). Under AHEAD, participating states will be better equipped to promote health equity, increase access to primary care services, set health care expenditures on a more sustainable trajectory, and lower health care costs for patients. CMS will issue awards to up to eight states. States selected to participate in AHEAD will have the opportunity to receive up to $12 million from CMS to support implementation. The first Notice of Funding Opportunity (NOFO) application period will be released in late fall 2023. States have 90 calendar days to apply for a cooperative agreement award during this first application period. The second NOFO application period is anticipated to open in Spring 2024 with a 60-day application period.

Conclusion

The December 11, 2023 PCRC meeting will be hybrid. The meeting location and Links will be posted to the public calendar.

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

Public Comment

No Public comment

Public Meeting attendees

Loria Ann Rhoads	Medical Society Delaware
Suzanne Lufadeju	VP Network Development & Contracting Delaware First Health
Cari Miller	Lab Corp
Gaurav Nagrath	Health Management Associates
Daniel Nemet	Health Management Associates
Ainsley Ramsey	Health Management Associates
Anthony Onugu	United Medical, LLC.
Tyler Blanchard	Aledade ACO
Cristine Vogel	Department of Insurance
David Bentz	DHSS
Mike Pellin	Aetna
Alessandra Campbell	Health Management Associates
Angel Pannell	Highmark
Dr. Sarah Mullins	Aledade ACO
Lauren Knorr	Aetna
Kristin Dwyer	Nemours