PRIMARY CARE REFORM COLLABORATIVE

JULY 17, 2023

VIRTUAL MEETING- HOUSEKEEPING

- Public- please send your name, email contact, and organization affiliation (if applicable) to elisabeth.massa@delaware.gov or write in the meeting chat box.
- Please keep your computer/phone on mute unless you are making a comment, and if you are not on visual, please identify yourself as well.
- This meeting will be recorded for minutes.

AGENDA

I. Call to Order

II. April 24, 2023, Meeting Minutes Approval

III. Update – Department of Insurance Office of Value-Based Health Care Delivery

IV. Delaware Primary Care Value-Based Payment Model (Health Management Associates)

I. NASEM Survey Summary

II. Strategic Planning

III. Revision of Workgroups

IV. Public Comment

V. Next Meeting

CALL TO ORDER

- Dr. Nancy Fan, Chair
- Senator Brian Townsend, Chair Senate Health & Social Services Committee
- Representative Melissa Minor-Brown, Chair Health & Social Services Committee
- Ted Mermigos, Division of Medicaid and Medical Assistance
- Dr. James Gill, Medical Society of Delaware
- Dr. Rose Kakoza, Delaware Healthcare Association
- Kevin O'Hara, Highmark Delaware
- Steven Costantino (proxy for Secretary DHSS Secretary)
- Commissioner Trinidad Navarro, Department of Insurance
- Faith Rentz, State Benefits Office/DHR
- Deborah Bednar, Aetna
- Maggie Norris-Bent, Westside Family Healthcare
- Vacant, Delaware Nurses Association representative

MINUTES APPROVAL

- Review and approve draft April 24th Meeting Minutes

UPDATE – DEPARTMENT OF INSURANCE OFFICE OF VALUE-BASED HEALTH CARE DELIVERY

Cristine Vogel, MPH, CPHQ
Director, Office of Value-Based Health Care Delivery
Delaware Department of Insurance

Trends in Pharmacy Spending Among Delaware Commercial Fully-Insured 2000-2021

Introduction

- Pharmacy Benefit Managers (PBMs) operate in the middle of the supply chain, with primary functions to negotiate with drug manufacturers and manage prescription drug benefits for health insurers

- The Top 3 PBMs have gained market power
  - Control ~ 80% of the U.S. market
  - Market power helps negotiate prices/rebates but also limits choice
  - Analysis includes DE PBMs with more than 5,000 lives
  - Analysis includes 109,000 commercial fully-insured members in DE
  - Each of these Top 3 PBMs has merged with an insurer
    - **CaremarkPCS/Aetna**
    - **Express Scripts/Cigna**
    - **OptumRx/United HealthCare**

Improving Affordability of Healthcare

In 2021, prescription drug spending paid through members' pharmacy benefit, comprises about **21%** of DE fully-insured commercial total spending

- Spending is expected to increase in coming years as additional costly drugs come to market

The most successful efforts to moderate prescription drug spending aim to ensure patients are prescribed the least costly, most effective option and only when needed

- Comprehensive care management and medication management programs aim at educating patients with chronic conditions about proper usage of medications (most common are diabetes, COPD, and heart disease)
- Patients' inability to afford medications can dramatically impact their health outcomes

Summary of Key Findings

Pharmacy spending increased 5% from 2020 to 2021

- Slightly higher than national trend

Growth in utilization is the driver in spending, prices largely held steady

Specialty brand medications are the driver in Total Spend

- 44% of total pharmacy spending, yet only 1% of the prescriptions filled
- Members paid more than $416 on average for these prescriptions in 2021, nearly 20% higher than the previous year.

Top 10 therapeutic classes comprise of nearly 80% of the spending

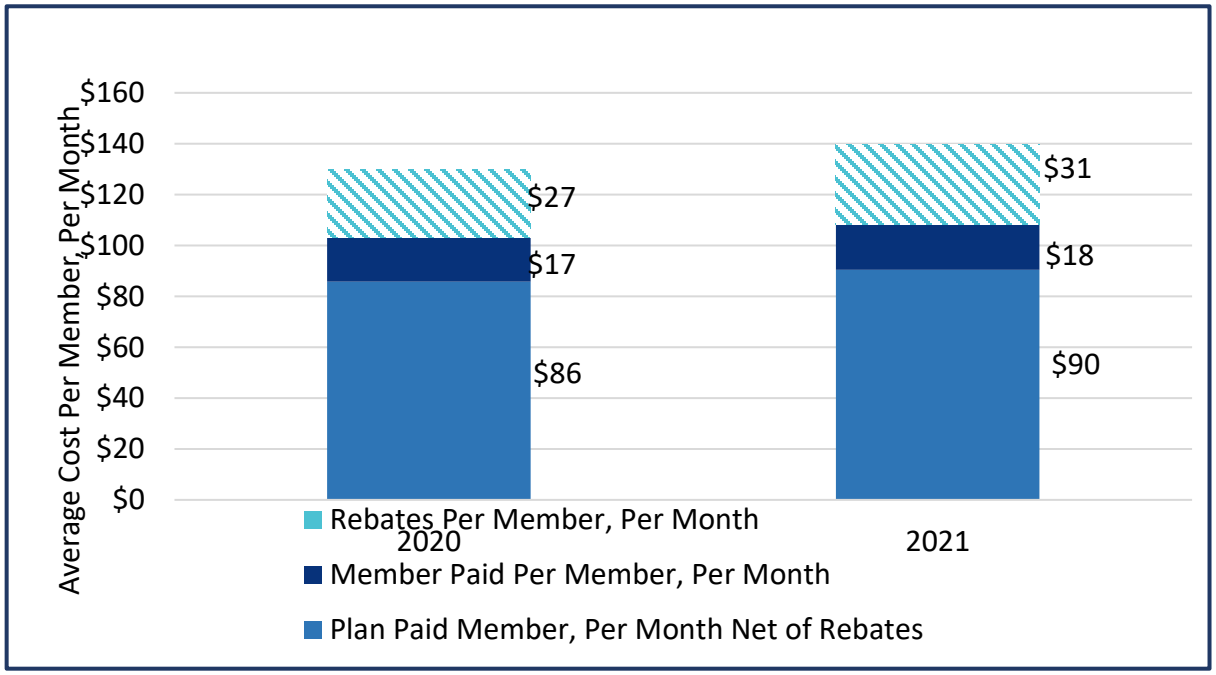
- Nearly 1 in 4 dollars spent on prescriptions among commercially-insured in Delaware was spent on immunological agents in 2021

Total Prescription Drug Spending Rose in 2021

Key Takeaways:

Among Delaware's commercial fully-insured, pharmacy spending increased **5% from 2020 to 2021,** on a per member, per month basis, after subtracting dollars received from rebates.

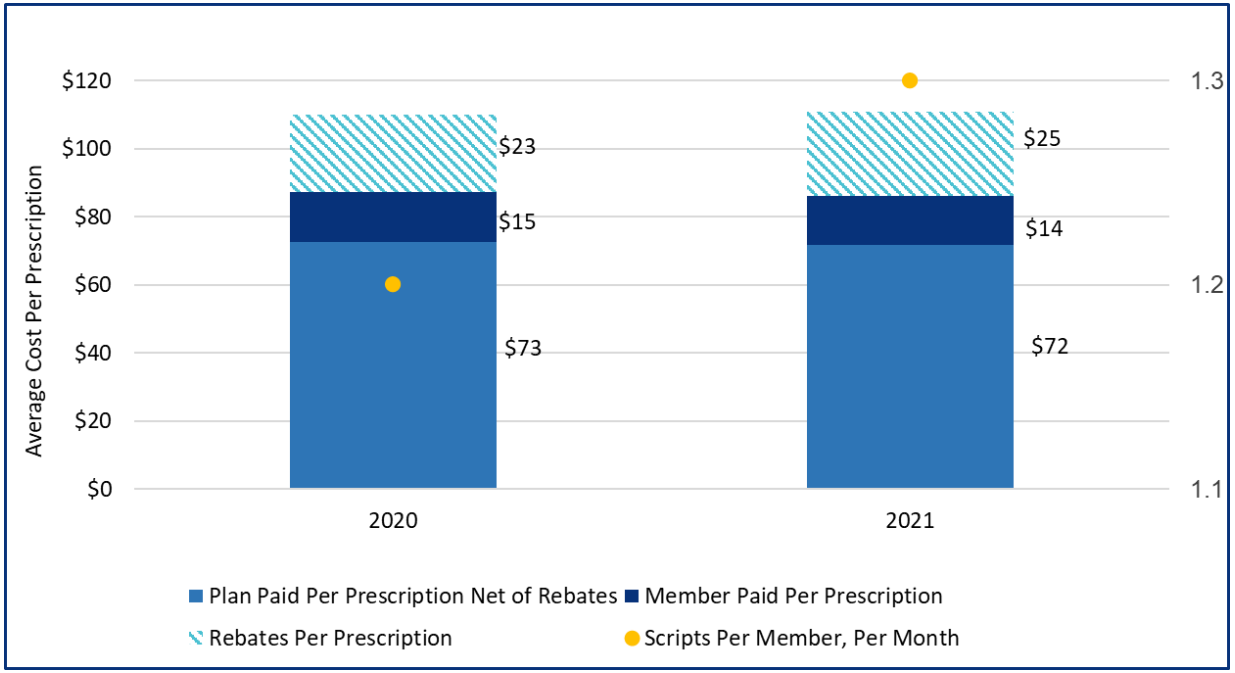
This was **slightly higher than the national trends** reported by Express Scripts Inc. (4%) and Caremark CVS (3.6%).



Cost Per Prescription Held Steady in 2021 While Utilization Increased Post-COVID

Key Takeaways:

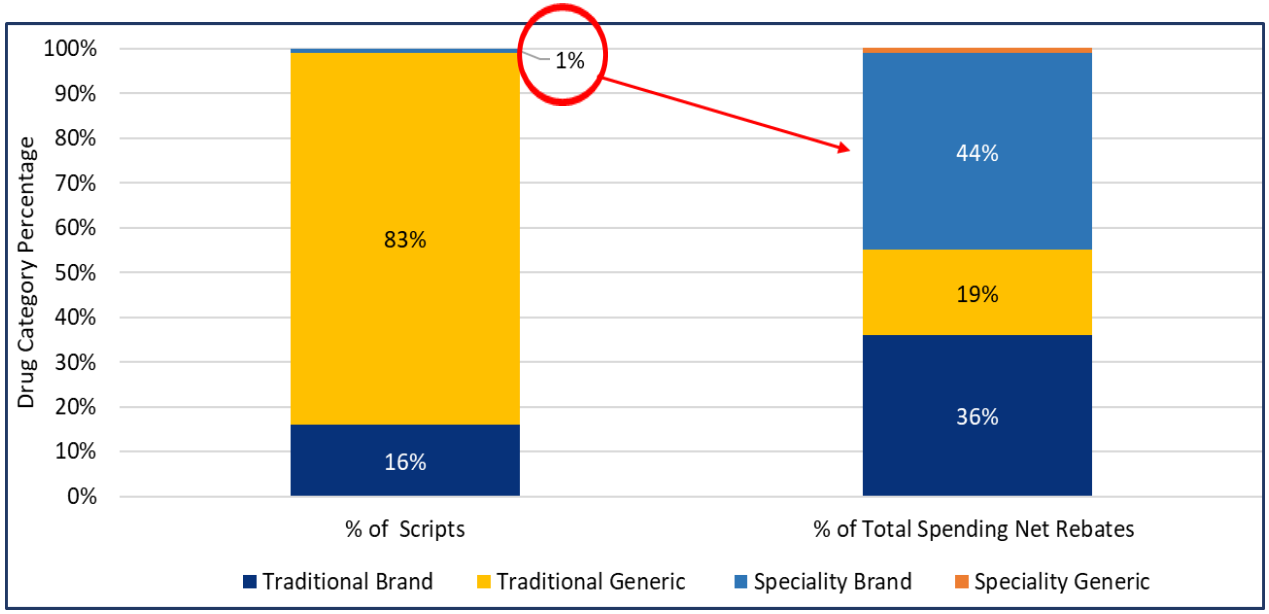
- A **7% increase in utilization** in 2021 drove the increase in total pharmacy spending for fully-insured Delawareans.
- **Average cost per prescription fell 2%,** after subtracting dollars received from rebates.
- **PBMs reported similar trends nationally,** with growth in utilization driving spending as prices largely held steady.



Specialty Medications Drive Total Spending

Key Takeaways:

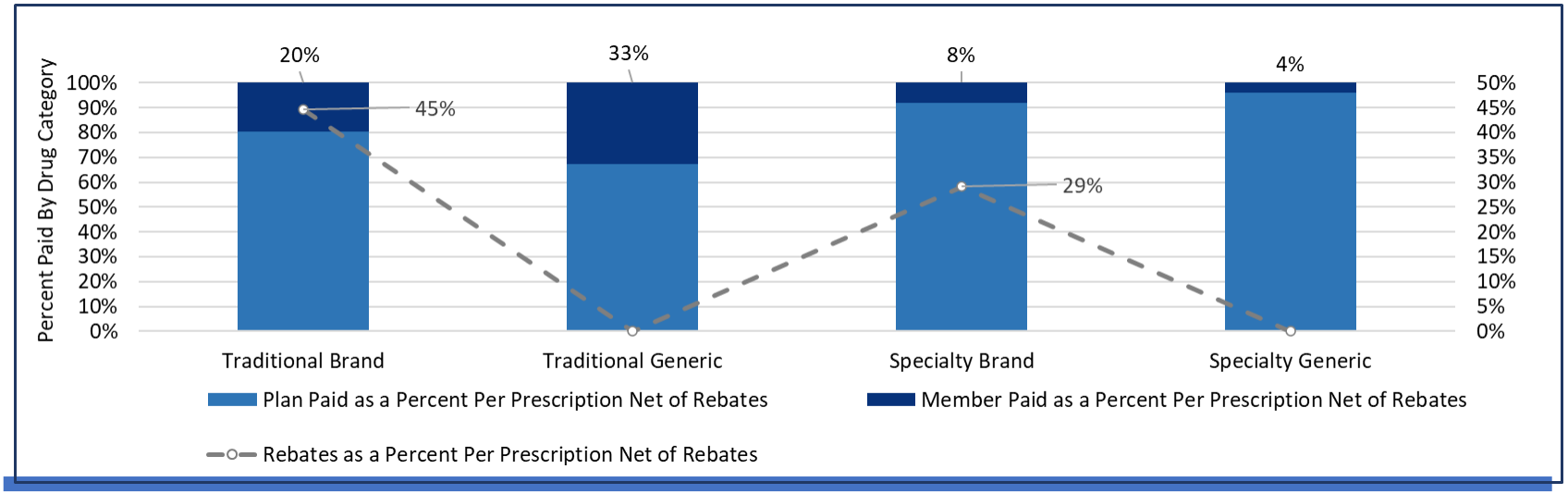
- **Specialty brand medications** comprised **more than 44% of total pharmacy spending** among Delaware's fully-insured in 2021 despite being only 1% of prescriptions filled.
- These medications **cost an average of $5,166 per prescription** after subtracting rebates. **Members paid more than $416** on average for these prescriptions in 2021, nearly 20% higher than the previous year.



Rebates Vary Greatly Depending on Type of Medication

Key Takeaways:

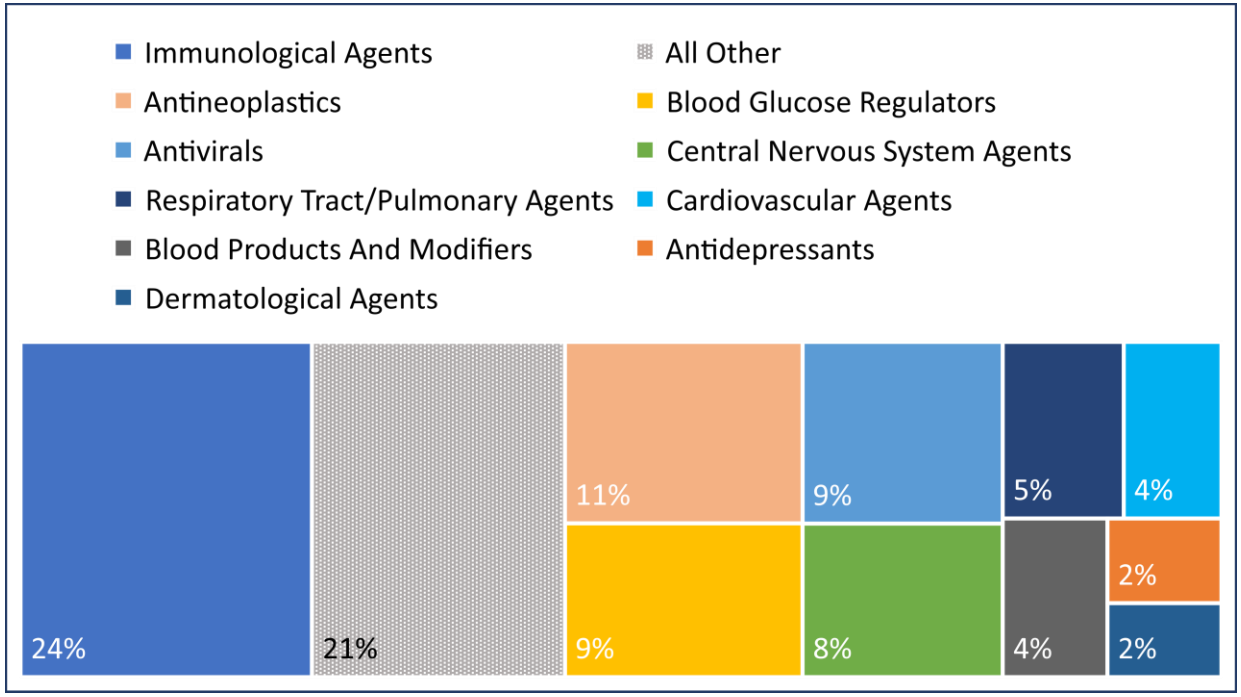
- Across all prescriptions, rebates lowered costs an average of 22% in 2021.
- For some prescriptions, such as certain medications to treat diabetes, the impact was 50% or more.



Top 10 Therapeutic Classes Comprise Nearly 80% of Spending

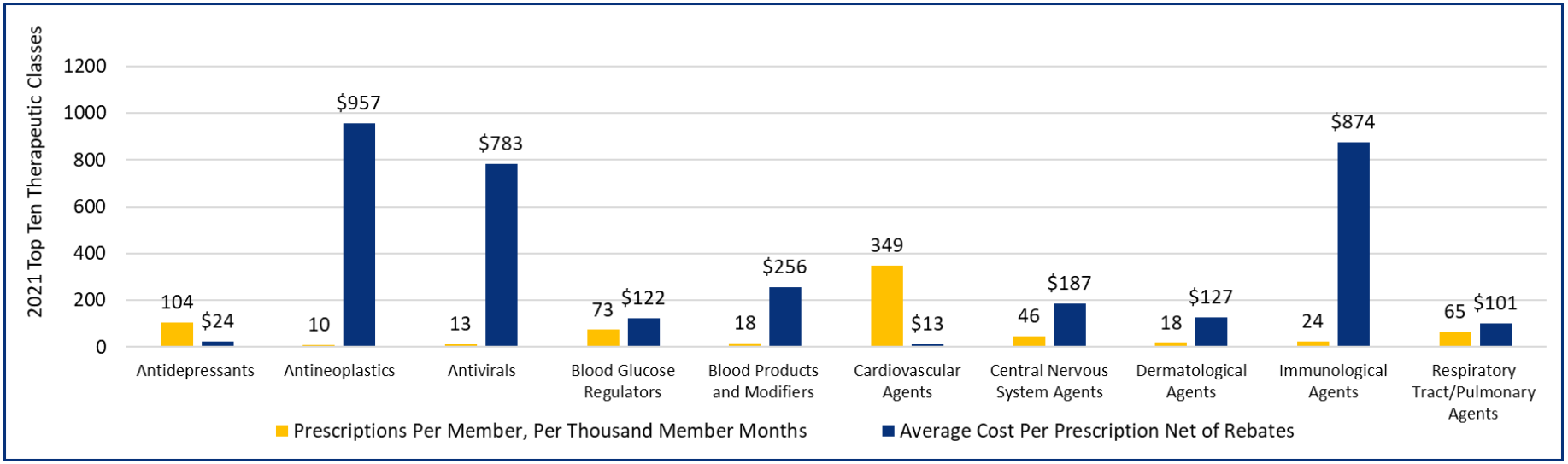
Key Takeaways:

- Immunological agents include cancer treatments and medications to treat Crohn's disease, rheumatoid arthritis and other autoimmune diseases.
- **Nearly one in four dollars spent on prescriptions** among commercially-insured in Delaware **was spent on immunological agents in 2021.**



Utilization, Price or Both Push Therapeutic Classes into Top 10 for Total Spending

Some therapeutic classes have high utilization. Others have high prices. Some have both.



A Look Ahead

- Cost growth likely to hasten
  - Prescription drug spending growth expected to increase in coming years as more specialty drugs come on the market.
  - Nationally, specialty drugs were 55% of Rx spend in 2021, up from 28% in 2011.
- Outsized impact of a few specialty drugs
  - Growth in autoimmune and oncology medications expected to continue; spending on these classes up 459% and 226% respectively since 2011.
  - Biosimilars have yet to achieve promise; some experts believe a tipping point is near
- Continued vertical and horizontal consolidation
  - Helps PBMs secure higher rebates, and complicates market dynamics
  - PBM and retail pharmacy consolidation constricting consumer choice; fewer drugs immediately available at retail

Emerging State Strategies

- In recent years Delaware and a growing number of states have enacted new laws and regulations to constrain costs, make medications more affordable to consumers and encourage good business practices.

- At least nine states now convene Prescription Drug Affordability Boards to support the state in identifying and addressing cost drivers.
  - The role and authority of these Boards vary by state
  - Some seek policy changes across payer types to include those covered by Medicaid, state employee benefits and commercial carriers
  - All allow stakeholders to inform state policy on these particularly complex and evolving topics

Questions and discussion

DELAWARE PRIMARY CARE VALUE-BASED PAYMENT MODEL

Health Management Associates

- Gaurav Nagrath, ScD, MBA

  Managing Principal

- Ainsley Ramsey, MS

  Actuarial Consultant

Delaware Primary Care Value Based Payment Model

July 17th, 2023

Health Management Associates

Agenda

- Introductions
- Value-Based Payments: State Comparison
- CQI in DE: Implementation Considerations
- Discussion
- Conclusion

HMA Team Introduction

Gaurav Nagrath, ScD, MBA
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Research Associate

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Research Associate

Value-Based Payments: State Comparison

Alternative Payment Model (APM) State Comparison

Colorado' Value Based Payments

Alternative Payment Model 1 (APM 1)

- Provide long term, sustainable investments into primary care
- Reward performance & introduce accountability for outcomes and access to care
- Align with other payment reforms

Alternative Payment Model 2 (APM 2)

- Support providers by offering financial investment and stable revenue
- Continuation of goals in APM 1

Oregon's VBP Roadmap

1. Reward the provider's delivery of patient-centered, high-quality care.
2. Reward health plan and system performance.
3. Align payment reforms with other state and federal efforts.
4. Ensure consideration of health disparities and members with complex needs.
5. Support the triple aim of better care, better health, and lower costs.

Rhode Island Advanced Payment Model

Office of the Health Insurance Commissioner (OHIC): improve quality and accessibility to health care

Established Patient-Centered Medical Home Program (PCMH): requires demonstration of practice transformation, implementation of cost management initiatives and quality performance improvement

RI Health Care Cost Trends Steering Committee created "Compact to Accelerate Advanced Value-Based Payment Model"

Maryland Total Cost of Care (TCOC) Model

Hospital Global Budgets: sets fixed annual revenue budgets with continuous monitoring by state and federal regulators.

Care Redesign Program: gainsharing between hospitals, hospital-based specialists, non-hospital providers

Maryland Comprehensive Primary Care Program: Financial support for primary care providers performing care management for high-risk patients

Oregon's VBP Road Map Model (2020-2024)

Regulatory Authority: Oregon Health Authority (OHA)

Oregon Health Authority (OHA) developed a VBP Roadmap that identified five objectives for Coordinated Care Organizations (CCOs):

1. Reward the provider's delivery of patient-centered, high-quality care.
2. Reward health plan and system performance.
3. Align payment reforms with other state and federal efforts.
4. Ensure consideration of health disparities and members with complex needs.
5. Support the triple aim of better care, health, and lower costs.

Measure menu includes 57 healthcare quality measures across six domains of service:
(1) prevention/early detection, (2) chronic needs and special health needs, (3) acute, episodic, and procedural care, (4) system integration and transformation, (5) patient access and experience, and (6) cost/efficiency.

Benefits

- 15 of 16 CCOs met overall milestones with a statewide average of 50% of total payments occurring in VBP arrangements that qualified for the target.
- CCOs, on average, increased infrastructure payments to PCPCHs (patient-centered primary care homes) between 2020 and 2021.
- More CCOs reported "total cost of care" agreements, which had the potential to increase provider collaboration.
- CCOs continued to develop the capacity to support VBP contracts in their health information technology systems.

Limitations

- Need to ensure CCOs consistently understand Roadmap requirements for sub-capitated arrangements, quality measures, and enhancement of existing models for CDA requirements.
- Important to continue creating opportunities for CCO cross-pollination to share successful models & novel approaches.
- Need to work with CCOs to develop best practices for applying health equity goals within VBP strategies.
- Additional guidance should be developed on quality measures for specialty services and integrated care.

Colorado's APM 1
(2016-2025)

Regulatory Authority: Department of Health Care Policy & Financing (HCPF)

Main Considerations:

1. Provide long-term, sustainable investments into primary care.
2. Reward performance and introduce accountability for outcomes and access to care while granting flexibility of choice to PCMPs.
3. Align with other payment reforms across the delivery system.

Intends to have 50% of Medicaid payments tied to a value-based arrangement by 2025

APM 1's alignment with CMS Core Set Focus Areas:

- Primary Care Access and Preventative Care
- Maternal and Perinatal Health
- Care of Acute Chronic Conditions
- Dental and Oral Health Services
- Behavioral Health Care
- Experience of Care.

Benefits

- 60% of participating PCMPs in Payment Year (PY) 2022 reported five or more structural measures which focused on PCMPs' capacity, systems, and processes that would enable them to provide high-quality care.
- The performance data shows that most PCMPs participating in the program achieved the 200-point threshold to receive the maximum enhanced rate.

Limitations

- APM 1 is too broad and cannot drive focused improvements.
- Too many measures in the APM 1 measure set.
- Creates administrative burden on PCMPs.
- Too much variation in the Accepting New Patients structural measure.

Colorado' APM 2 (2021-)

Regulatory Authority: Department of Health Care Policy & Financing (HCPF)

Main Considerations:

1. Partial Prospective Payments provide stable revenue for practices and allow investments in means of care that are not currently being rewarded.
2. Incentive Payments which allow for practices to share in the cost savings derived from enhanced chronic care management.

Support providers by offering additional financial investment, stable revenue, and continuation of goals of the APM 1 model.

PCMPs report on 10 quality measures from the APM set: 3 mandatory measures and seven measures selected by the PCMP.

Benefits

- Providers gain revenue stability by receiving per-member, per-month payments
- Providers select the way they want to receive their payments.
- Enrolling in VBP allows providers to share in savings from improved primary and chronic outcomes
- Providers have the flexibility to choose a portion of revenue creating a reliable revenue stream

Limitations

- Increased administrative burden.
- Providers do not know what percentage is appropriate to begin within the program.
- Concerns that per member per month payments do not fit within their current billing and accounting system.

Rhode Island's APM

(2022-2026)

Regulatory Authority: Rhode Island Executive Office of Health and Human Service

Current Framework:

- Current framework is built on the previous FFS payment model which creates a financial rework for increasing the volume of healthcare services.
- Rhode Island Health Care Cost Trends Steering Committee created the "Compact to Accelerate Advanced Value-Based Payment Model Adoption in Rhode Island," which developed a set of recommendations for accelerating the adoption of advanced VBP models in April 2022.

Rhode Island's selected measure set for 2023 includes:

- Core Measure set (chronic illness and prevention)
- Menu Measure Set (chronic illness, preventative care, Health Equity)
- Developmental Measure set (behavioral health, chronic illness, consumer experience, preventive care, and social determinants of health).

Benefits

- States' affordability standards were associated with lower inpatient and outpatient quarterly fee-for-service spending and higher total quarterly non-fee-for-service spending.
- Number of Rhode Island primary care physicians per capita increased.

Limitations

- Over 45% of commercial medical payments are made through an APM, and Medicaid and Medicare Advantage have made similar advances.
- Contracts to date significantly emphasized gainsharing.
- Approximately 95% of APM payments are based on fee-for-service reimbursement.

Maryland's Total Cost of Care Model (2019-2026)

Regulatory Authority: Health Services Cost Review Commission

Main Considerations:

1. Hospital Global Budgets: sets fixed annual revenue budgets with continuous monitoring by state and federal regulators.
2. Care Redesign Program: gainsharing between hospitals, hospital-based specialists, and non-hospital providers.
3. Maryland Comprehensive Primary Care Program: Financial support for primary care providers performing care management for high-risk patients.

Maryland's selected measures criteria:

- Relevance to the HealthChoice core population
- Prevention-oriented to promote optimum health
- Measurable with data availability
- Consistent with CMS Medicaid Core Set or HEDIS performance measures
- Ability of MCOs to achieve quality improvement and positive health outcomes.

Benefits

- Substantially reduced rates of all-cause acute care hospital admissions.
- Moderately reduced total Medicare fee-for-services spending.
- Improved several quality-of-care measures.
- Reduced Total Cost of Care spending by $365 million.

Limitations

- Did not affect patients' ratings of their providers or hospitals.
- Increased non-hospital spending substantially in 2021.

CQI in Delaware: Implementation Considerations

- Continued diligence in attribution monitoring
- Impact on future cost sharing
- CQI Considerations
  - For how long should the CQI be paid?
  - When should the CQI be tied to quality measures?
  - How is compliance ensured regarding use of the CQI payment?
- Other considerations?

Workgroup Responses for CQI Uses Included:

- Care Coordination Staff
- Information Technology/Data
- Chronic Care Management Staff
- Upgrades to EMR
- Infrastructure Upgrades to Improve Client Workflow

Discussion

Thank you!

Please reach out with questions or concerns.

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Ainsley Ramsey

aramsey@healthmanagement.com

Resources

- Alternative Payment Model 1 (APM 1). https://hcpf.colorado.gov/alternative-payment-model-1-apm-1
- Alternative Payment Methodologies Fact Sheet. https://hcpf.colorado.gov/sites/hcpf/files/Alternative%20Payment%20Model%20Fact%20Sheet.pdf
- Memo: 2022 Alternative Payment Model 1 for Primary Care Stakeholder Engagement (for Program Year 2023). https://hcpf.colorado.gov/sites/hcpf/files/Alternative%20Payment%20Methodology%201%20Stakeholder%20Feedback%20Summary%20Memo%202022.pdf
- Alternative Payment Model 2 (APM2). https://hcpf.colorado.gov/alternative-payment-model-2-apm-2
- APM 2 Investments in Primary Care. https://hcpf.colorado.gov/sites/hcpf/files/Alternative%20Payment%20Model%202%20Guidebook%202023.pdf
- An Advocate's Guide to APM2. https://hcpf.colorado.gov/sites/hcpf/files/Alternative%20Payment%20Model%202%20Advocates%20Guide_0.pdf
- Oregon's Roadmap to Value-Based Payment. https://www.oregon.gov/oha/hpa/dsi-tc/pages/value-based-payment.aspx
- APM Framework https://hcp-lan.org/apm-framework/
- VBP Interim Report December 2022. https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP%20Interim%20Report%20December%202022.pdf
- RI Health Care Cost Trends Steering Committee, RI Advanced VBP Compact 2022. https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-04/RI%20Advanced%20VBP%20Compact%202022%2004-20%20FINAL%20%2B%20Signed.pdf
- How Can State Legislation Promote Value in Health Care? Three Innovative Models. https://www.healthaffairs.org/do/10.1377/forefront.20201222.609656/full/
- Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers. https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05164?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed
- Rhode Island Health Care Cost Trends Steering Committee. https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/2021/May/Cost-Trends/Meeting-18-Presentation.pdf
- Innovative Value-Based Payment Models. https://mhcc.maryland.gov/mhcc/pages/apc/apc/documents/Innovative_Value_Based_Payment_Models_20220121.pdf
- Medicaid Managed Care Organization Value-Based Purchasing Final Report, CY 2020. https://health.maryland.gov/mmcp/healthchoice/Documents/CY%202020%20VBP%20Report%20Final.pdf
- Evaluation of Maryland Total Cost of Care Model. https://innovation.cms.gov/data-and-reports/2022/md-tcoc-qor2
- Value-Based Purchasing Final Report CY 2020. https://health.maryland.gov/mmcp/healthchoice/Documents/CY%202020%20VBP%20Report%20Final.pdf

NASEM SURVEY SUMMARY

- Dr. Nancy Fan, PCRC Chair

NASEM STATEMENT ON PAYMENT REFORM

a. 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.

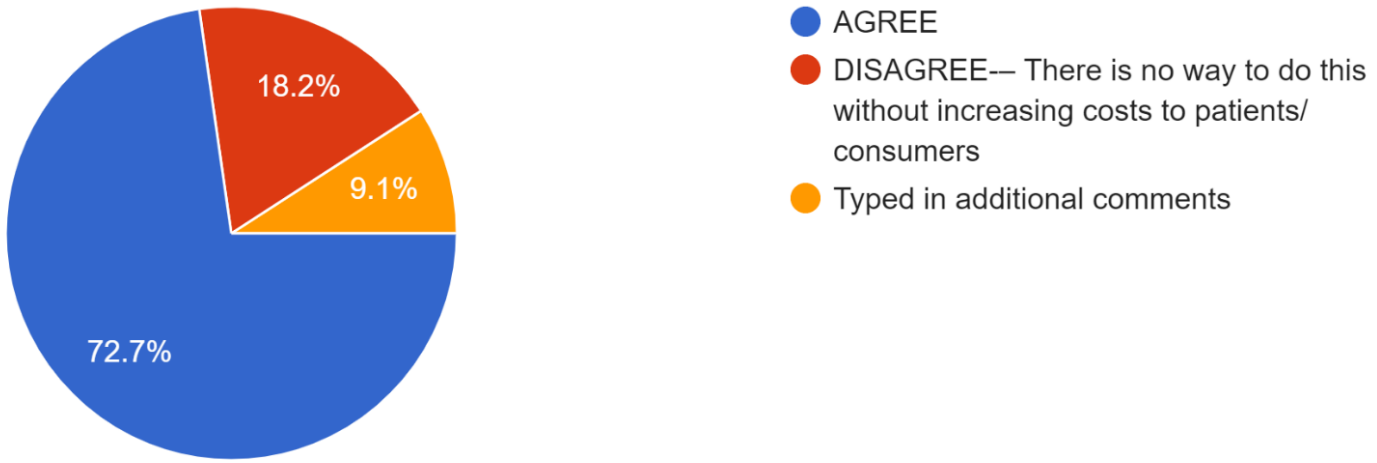
NASEM STATEMENT ON PAYMENT REFORM

b. The hybrid reimbursement model (part FFS, part capitated) should:
   i. • Pay prospectively for interprofessional, integrated, team-based care. This includes incentives for incorporating nonclinician team members and for partnerships with community-based organizations.
   ii. • Be risk-adjusted for medical and social complexity
   iii. • Allow for investment in team development, practice transformation resources, and the infrastructure to design, use, and maintain necessary digital technology; and
   iv. • Align with incentives for measuring and improving outcomes for patient populations assigned to clinicians.

NASEM SURVEY SUMMARY

2. If there is an increase in total cost of care, the cost should not be passed onto patients/consumers.

11 responses

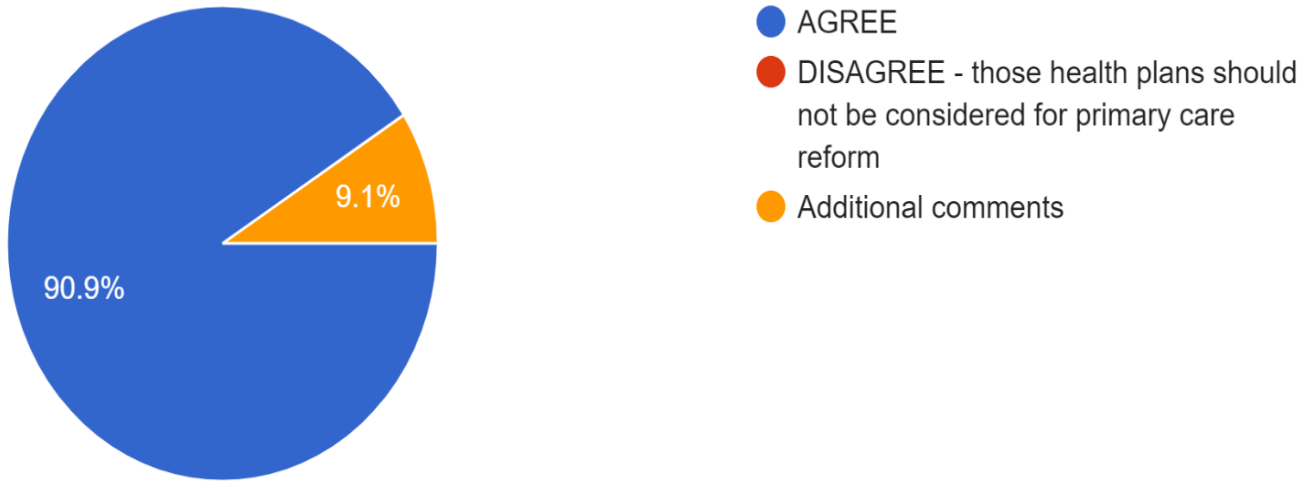


- ONLY BECAUSE IT IS UNREALISTIC TO ASSUME OR MANDATE THESE COSTS WOULD NOT BE PASSED ONTO PATIENTS/CONSUMER

NASEM SURVEY SUMMARY

3. With the information provided by the OVBHCD and through the DHSS Benchmarking and Costaware data, there should be an effort to decre...covered under SB120 (Medicaid, self-insured plans)

11 responses



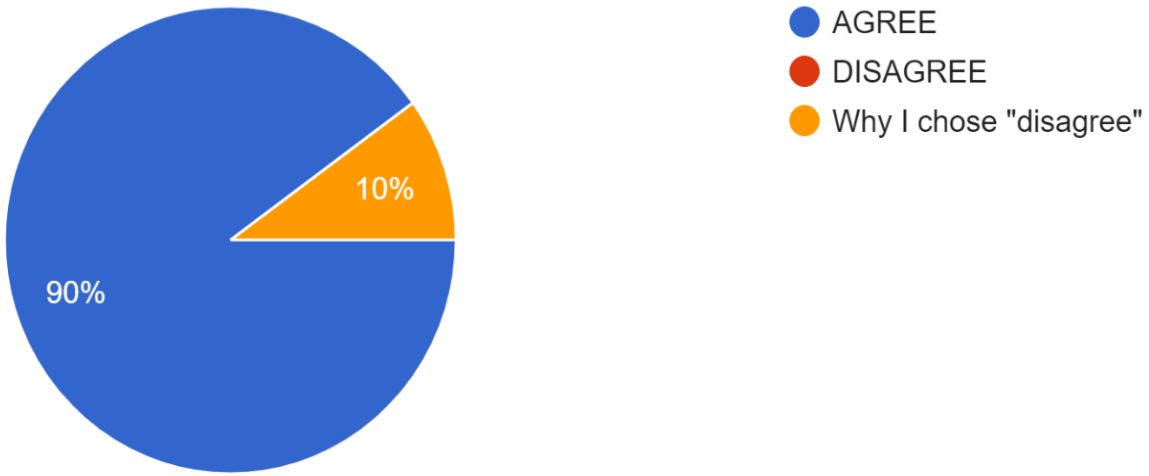
NASEM SURVEY SUMMARY

- While hospital costs are out of control (both inpatient and outpatient hospital costs), and government should be involved in getting that under control, that's not what the PCRC is about. The PCRC is about Primary Care Reform.
- Due to the Cost factor

NASEM SURVEY SUMMARY

4. If #3 is a STRONG RECOMMENDATION from the PCRC, should there be a recommendation for an established regulatory body regarding health car...s in service payments, similar to what is in SB120?

10 responses

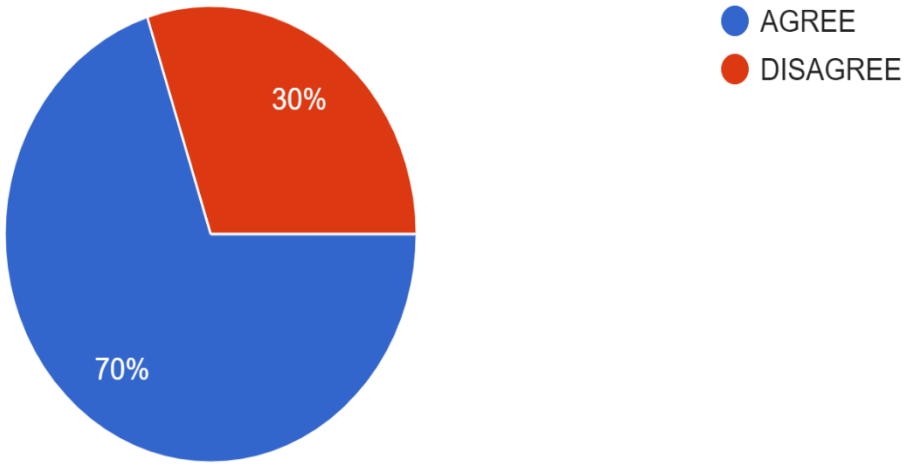


PLACE BETWEEN HEALTH CARE SYSTEMS AND CARRIERS TO PAYORS (MEDICAID, SELF-INSURED PLANS)

NASEM SURVEY SUMMARY

5. If #4 is NOT a STRONG RECOMMENDATION, then should the PCRC recommend that those health plans which are not under SB120 contribute to a stat...l health, as well as social determinants of health.

10 responses



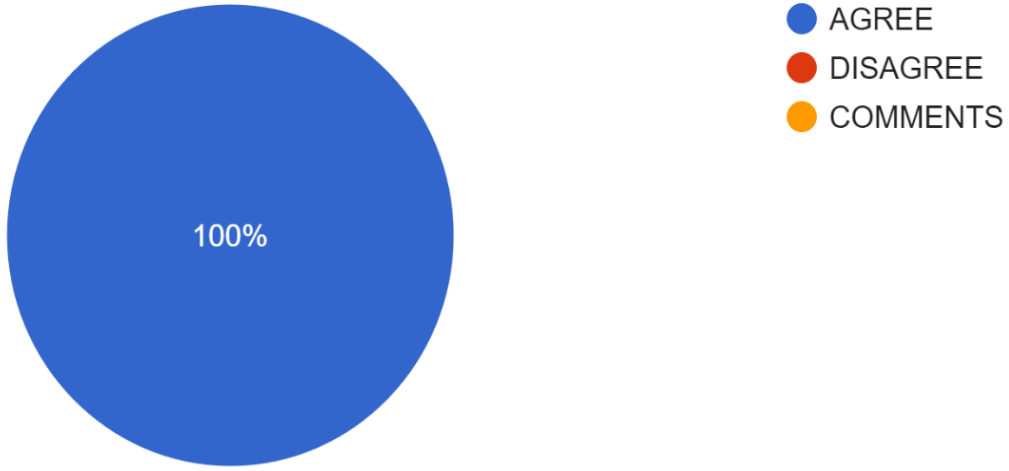
NASEM SURVEY SUMMARY

- Those health plans which 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, and the fact that paying more for primary care not only improves access and quality but also reduces total cost of care. There should be a database of those payers that do and don't respond with appropriate payments. This should be shared with the physician/provider community as well as well as the public.

NASEM SURVEY SUMMARY

6. The PCRC should recommend that telehealth services, which would need to be defined, be included as essential services of primary care?

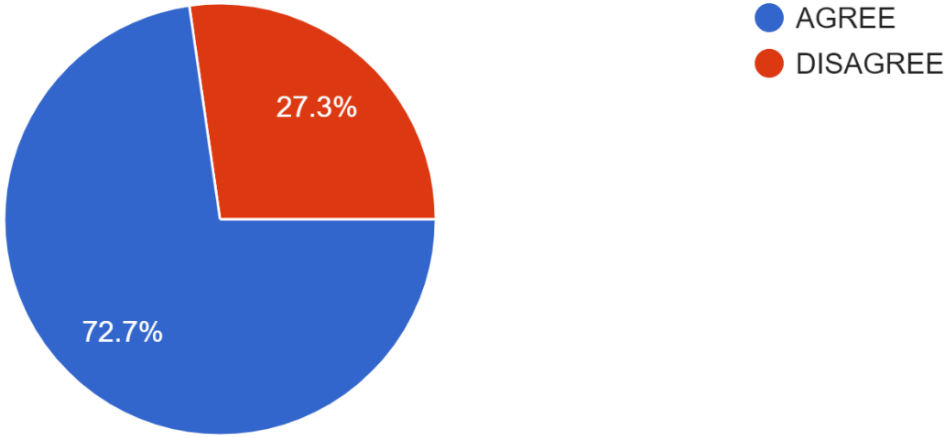
11 responses



NASEM SURVEY SUMMARY

7. The Delaware Primary Care Delivery Model should be incorporated into all health plan options, whether through regulation or legislation.

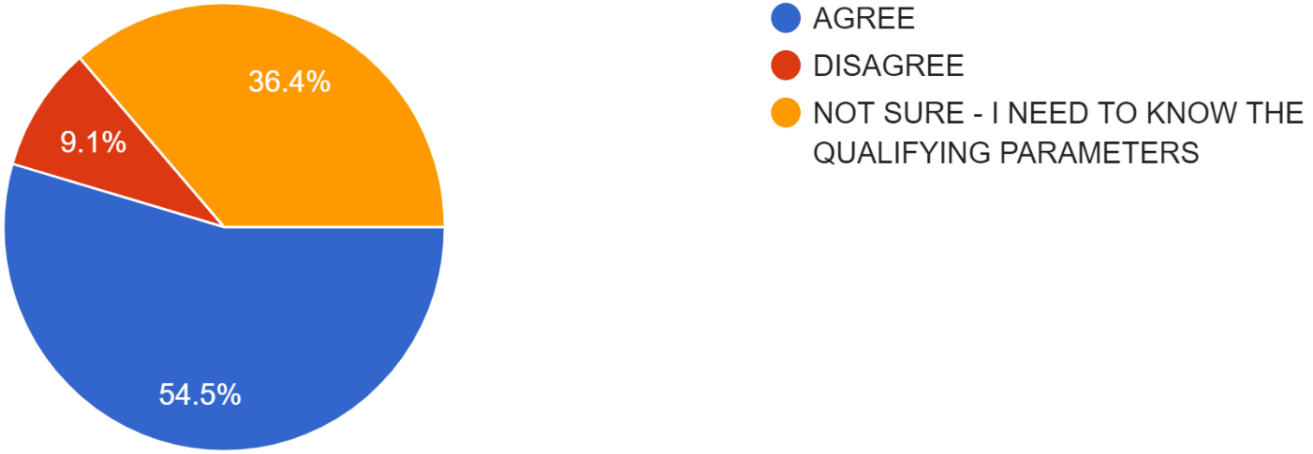
11 responses



NASEM SURVEY SUMMARY

8. 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



STRATEGIC PLANNING

- Planning Committee:
  - 3 members, Chair, and HMA consultant
  - Priorities/Goals for 2024

REVISION OF WORKGROUPS

- Current PCRC Workgroups
  1. Payment and Attribution
  2. Care Coordination
  3. Quality Measures and Benchmarks

PUBLIC COMMENT

NEXT MEETING

Primary Care Reform Collaborative Meeting

Monday, September 18, 2023

3:00 p.m. – 5:00 p.m.

Anchor Location:

The Chapel

Herman M. Holloway Sr. Health and Social Services Campus

1901 N. DuPont Highway

New Castle, DE 19720