PRIMARY CARE REFORM COLLABORATIVE

DECEMBER 11, 2023

VIRTUAL MEETING- HOUSEKEEPING

- 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 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. Sept 18, 2023, Meeting Minutes Approval
- III. Department of Insurance Office of Value-Based Health Care Delivery- Update
- IV. Primary Care Delivery Model – Update
- V. Ahead Model- Update
- VI. Public Comment
- VII. 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
- Christine Vogel (Proxy for Department of Insurance)

MINUTES APPROVAL

- Review and Approve September 18th 2023 Meeting Minutes

2023 Update of the Primary Care Investment Requirement

Cristine Vogel, MPH, CPHQ
Director, Office of Value-Based Health Care Delivery
December 11, 2023

AGENDA

- 2023 Overview and Update of the Primary Care Investment
- 2024 Affordability Standards Data Submission Update
- Review Next Steps for 2024

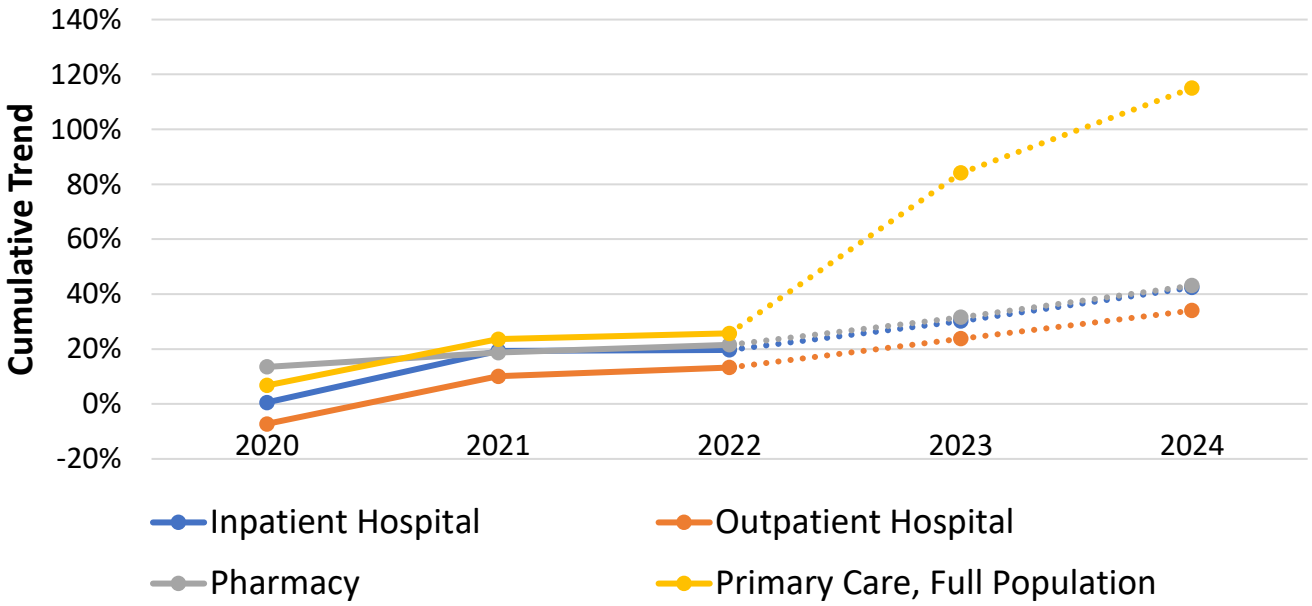
2023 Overview

Market	Aetna	Cigna	Highmark	United HealthCare
Individual	√	--	√	--
Large Group	√	√	√	√
Small Group	--	--	√	√

2023 Highlights:

- Most plans on target to meet the required **8.5%** for the attributed population
- 2023 projections indicate **$42 M** spent on total primary care (full population), this is up from $28.5 M in 2022
- Nearly **$4 M** have been paid out to primary care practices engaged in care transformation, YTD
- Carriers increasing amount of payment associated with risk settlement arrangements which delays investment and compliance evaluation

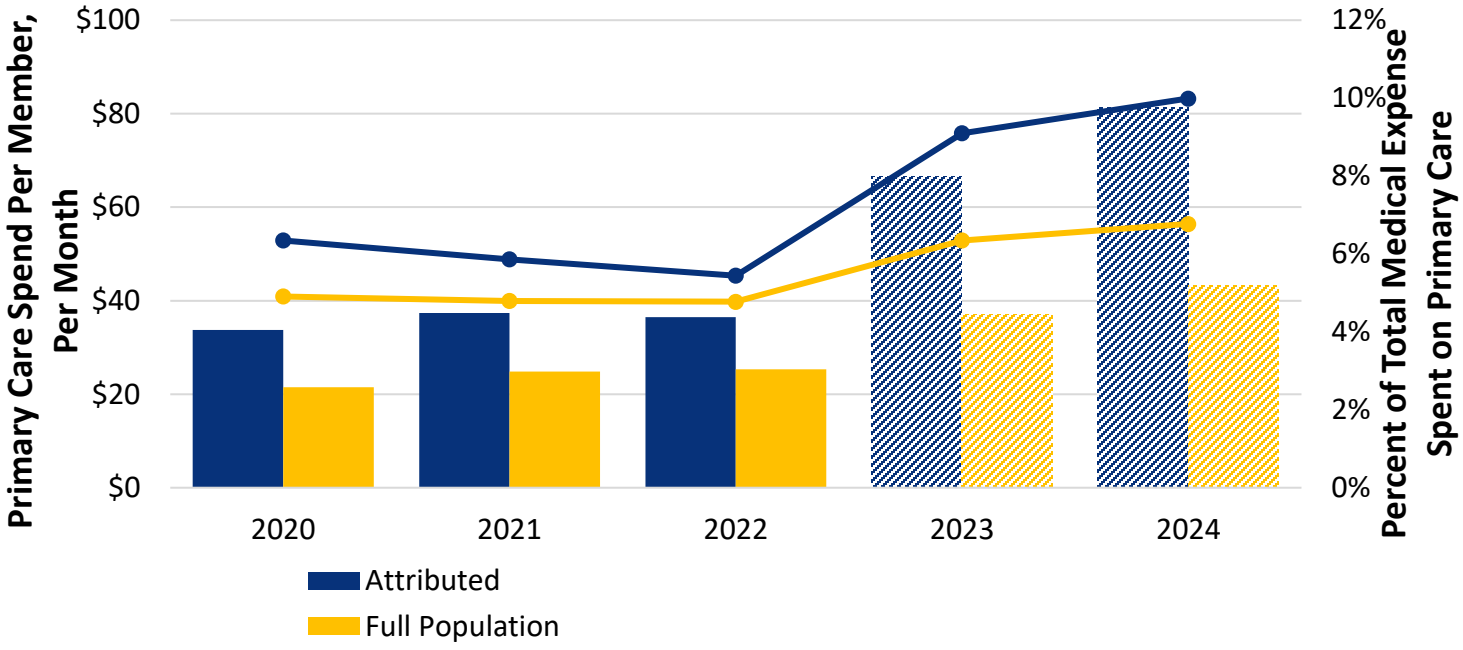
Trends in Fully-Insured Commercial Spending by Service Category, 2020-2024



Key Takeaway:
Among Delaware's fully-insured population, growth in primary care investment is outpacing spending increases in other key service categories including hospital and pharmacy as more of the health care dollar shifts to primary care.

Note: Carrier makeup shifted over the years presented due to new market entrants. Dotted lines reflect projections. Data calculated on a per member, per month basis.

Growth in Primary Care Investment (PMPM) 2020-2024



Note: Carrier makeup shifted over the years presented due to new market entrants. Textured bars and dotted line reflect projections.

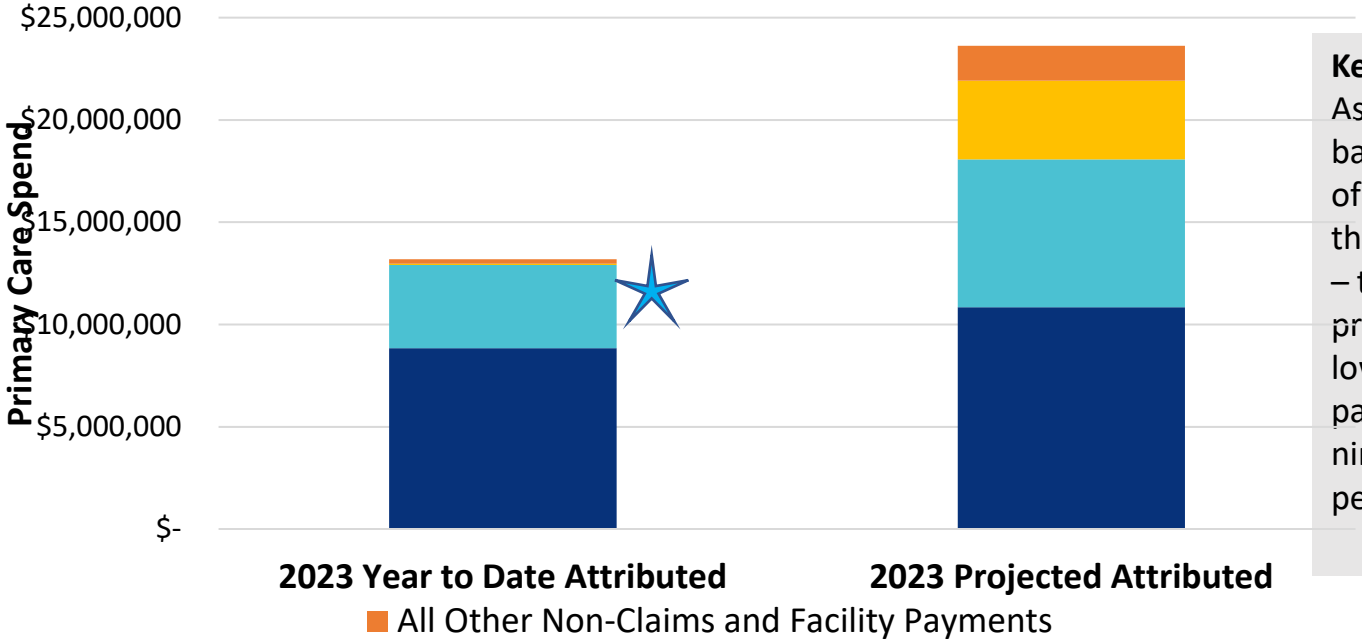
Key Takeaway:
For 2023, the commercial, fully-insured population primary care spending is projected to reach

- 9% of total medical expense for patients attributed to a primary care provider in care transformation, and
- 6% for the full population

2023 Year to Date, Payment Data

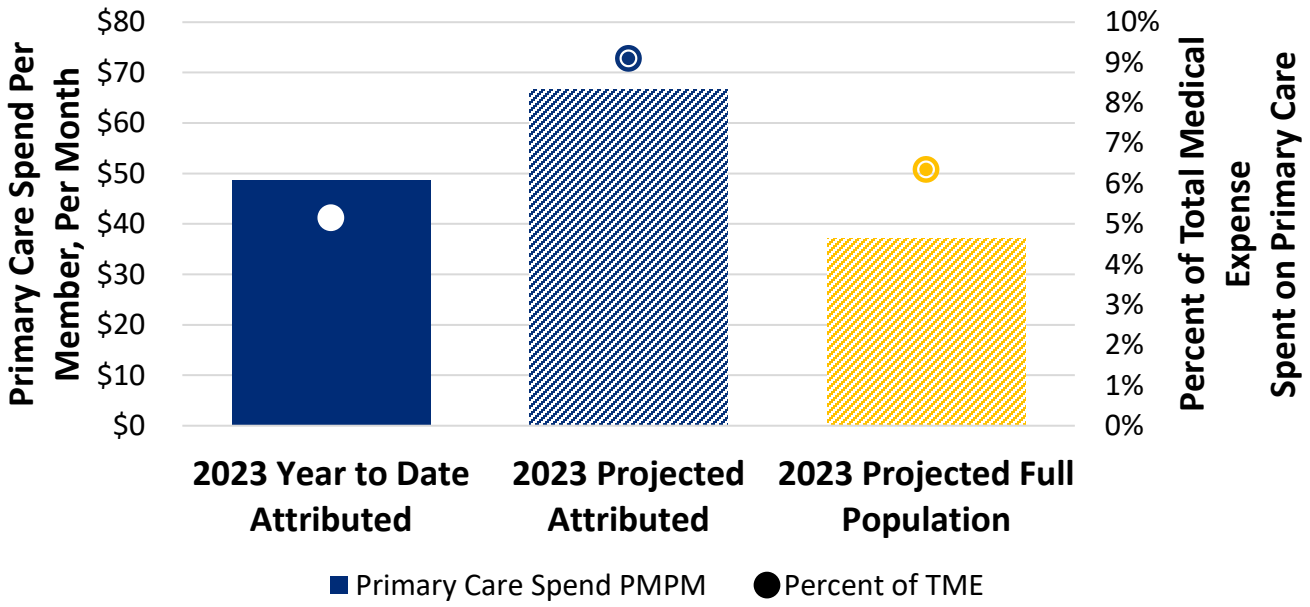
- Year-to-Date, actual payment data was collected from Carriers in November 2023
- Enables the OVBHCD to track “actual” progress toward the target, and does not rely solely on projections
- Amounts already paid generally reflect Care Coordination/Care Management prospective payments

Attributed Primary Care Spend by Component, 2023 Year to Date and Projected



Key Takeaway:
As more providers move to value-based payment, a growing portion of primary care investment is paid through risk settlement payments – the shared savings that providers receive when costs are lower than expected. These payments are typically made six to nine months after the performance period.

Primary Care Investment by Population, 2023 Year to Date and Projected



Key Takeaway:
Year to Date payments already made to providers, in aggregate, are nearly $50 PMPM for the attributed population.

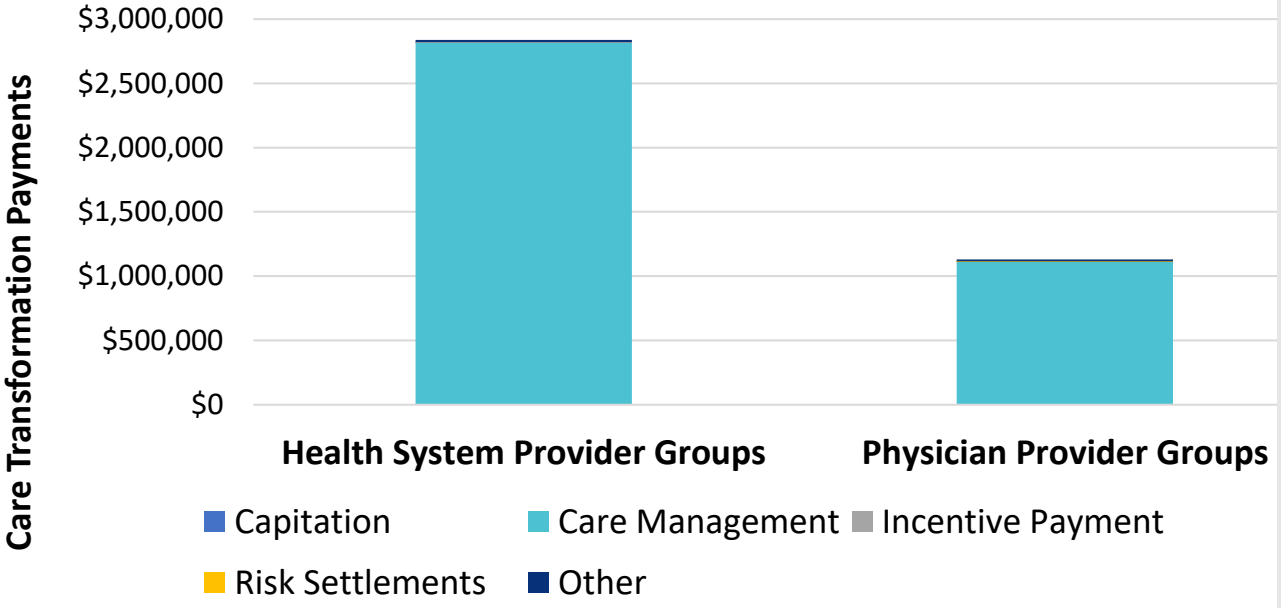
2023 projections, for the attributed population are about $65 PMPM.

Note: Carrier makeup shifted over the years presented due to new market entrants. Textured bars reflect 2023 projections.

2023 Year to Date, Provider Data

- Provider organization data was reported by each carrier based on their value-based contracts
- Payments represent paid out amounts from January - October of 2023
- Payment amounts were categorized to fit into one of two categories:
  - Health system provider groups
  - Physician provider groups (contains ACO/CIN)
- Carriers gravitated their value-based contracts with provider groups that likely had some infrastructure in place to implement care transformation activities

Care Transformation Payments Paid to Health System and Physician Provider Groups, 2023 Year to Date



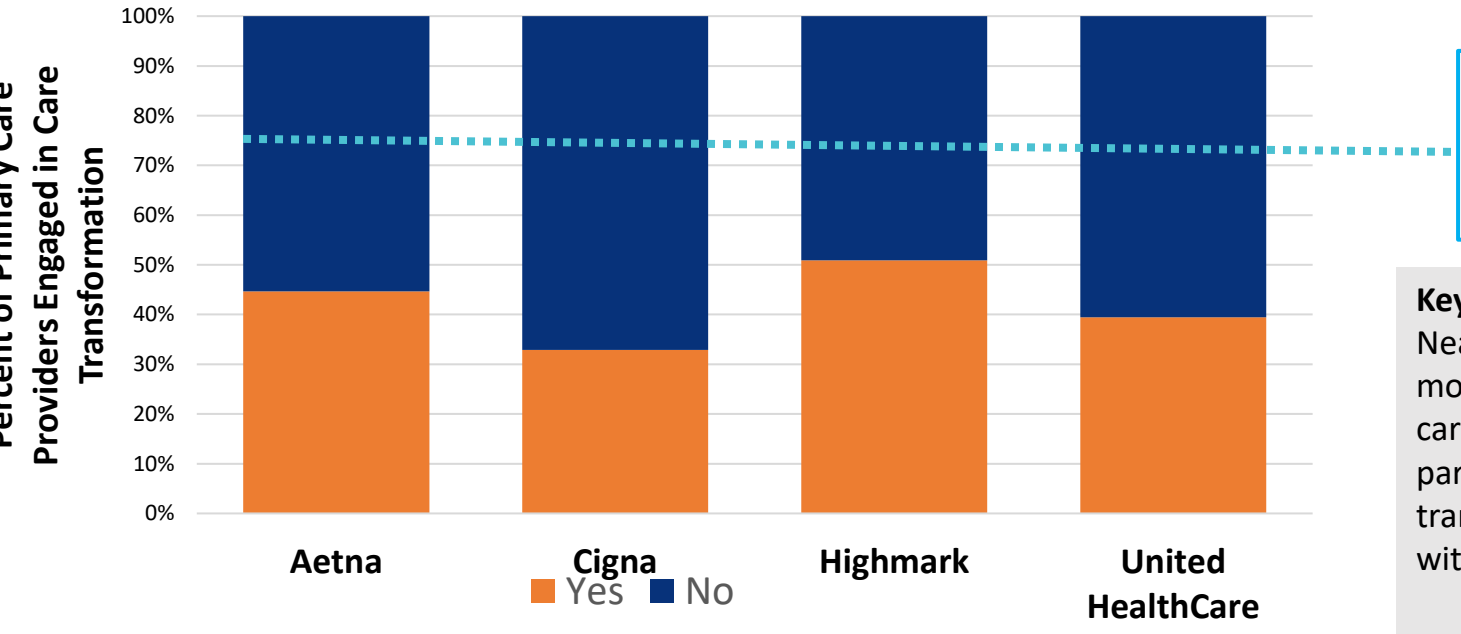
Key Takeaway:
Nearly 40% of Delaware primary care providers reported in carrier data, were affiliated in some way with a health system.

Health System provider groups received approximately 70% of care transformation payments, $2.8 million, YTD.

Physician Provider Group received $1.1 million, YTD. ACOs are counted in this category.

Note: One of the carriers only has one contract, therefore 100% of its health system providers are receiving care transformation payments.
Providers deemed affiliated with an organization if it contracted on their behalf.

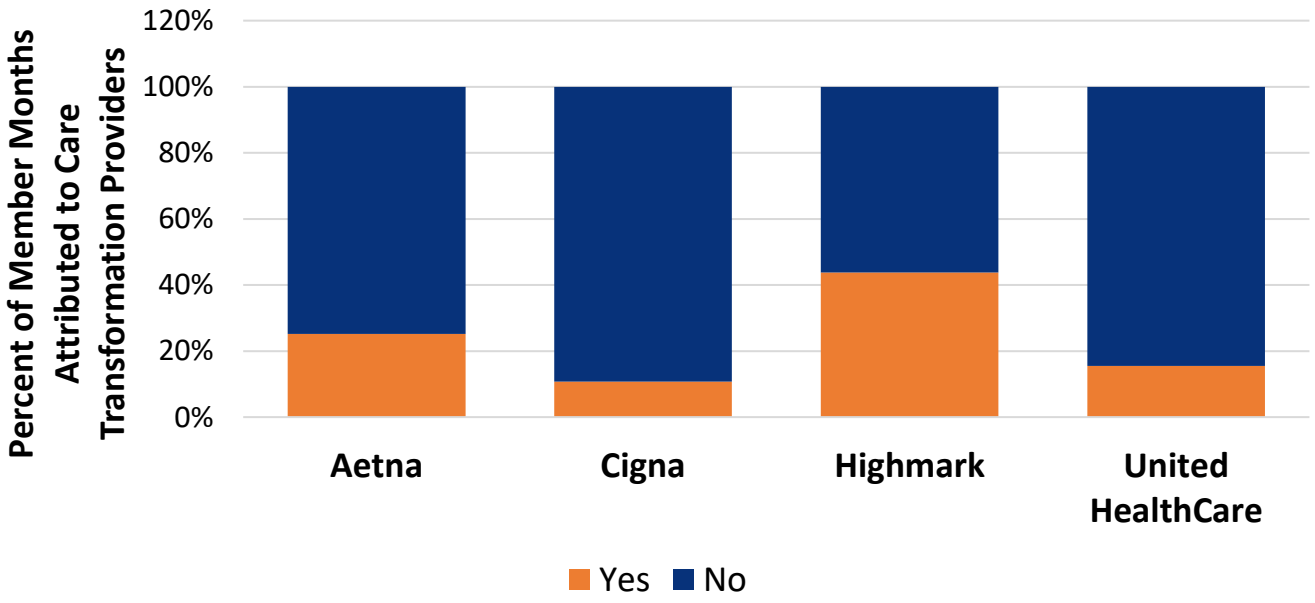
Primary Care Providers in Care Transformation 2023 Year To Date



Carriers must reach 75% of providers in care transformation by 2025

Key Takeaway:
Nearly 800 of Delaware's more than 1,500 primary care providers are now participating in a care transformation program with at least one carrier.

Members Attributed to Primary Care Providers in Care Transformation, 2023 Year To Date



Key Takeaway:

Carriers have had more difficulty achieving significant percentages of members attributed to these providers.

Collaborating with carriers and providers to increase these attribution percentages will be a focus for the Office in 2024.

2024 Affordability Standards Data Submission

2024 Highlights:

- Affordability Standards Data Submissions were due in June 2023 and September 2023.
- Most carriers plan to be on target reaching primary care investment of 10% in plan year 2024.
- Carriers are increasing amount of non-claims payment associated with risk settlement arrangements.

Looking Forward to 2024 …

- Continue to track 2023 primary care investment to ensure compliance with the 8.5% target.
- In April 2024, OVBHCD will request another round of Year to Date, actual data.
- Work with new carriers (AmeriHealth and AmBetterHealth) and the data submission template.
- Collaborate with carriers and providers to assist with improving attribution.
- Collaborate with carriers and providers to determine meaningful measures associated with primary care quality and value.

PRIMARY CARE DELIVERY MODEL UPDATE

- Dr Nancy Fan, PCRC Chair

Delaware Primary Care Value Based Payment Model

December 11, 2023

Health Management Associates

Agenda

- Open Discussion
  - CQI
  - State Scan

Previously presented materials included as Appendix for reference

HMA Team Introduction

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CQI Discussion

Questions and Comments - Primary Care Reform Collaborative Members

WHAT CQI PAYMENTS SHOULD BE USED FOR – GENERAL PRINCIPLES:

1. Care Coordination.

   This includes staff (nurses, nurse/medical assistants, clerical support staff)

   Also includes infrastructure (tools, supplies, management)

2. IT/EMR

   This includes EMR infrastructure, esp ability to identify, track and report quality measures

   Also includes personnel to implement, train and track IT

3. SDOH

   Identify patients with socioeconomic needs

   Connect patients with resources

   Important that practices are NOT expected to add additional administrative burden of collecting SDOH data. This should be done by payers, using current administrative data (e.g., addresses translated to SDOH measures

HOW DETAILS OF CQI USE AND PAYMENTS SHOULD BE DETERMINED

1. Practice-specific: Most of the CQI should be used by practices to best fit the needs of its population, rather than proscribed.

2. To the extent that guidelines will be determined by the PCRC, the committee determining that must include those who know best – the practices. So whether it is the Strategic Planning Committee or other committee, that group should include representation from independent practices – at least one physician owner/leader and one administrator/manager from independent practices.

3. Payment for CQI must flow directly to these practices via their TIN, (whether independent practice, hospital-owned, or other) following the patients and physicians/clinicians to whom the patients are attributed.

State Comparisons

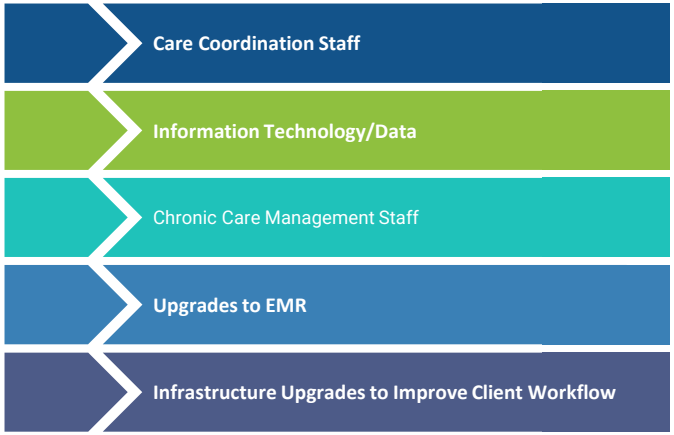
Questions and Comments - Primary Care Reform Collaborative Members

Appendices

Appendix 1 – CQI Information

CQI in Delaware: Implementation Considerations

Workgroup Responses for CQI Implementation:



Implementation Considerations:

- A mechanism for reporting the CQI spent 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.

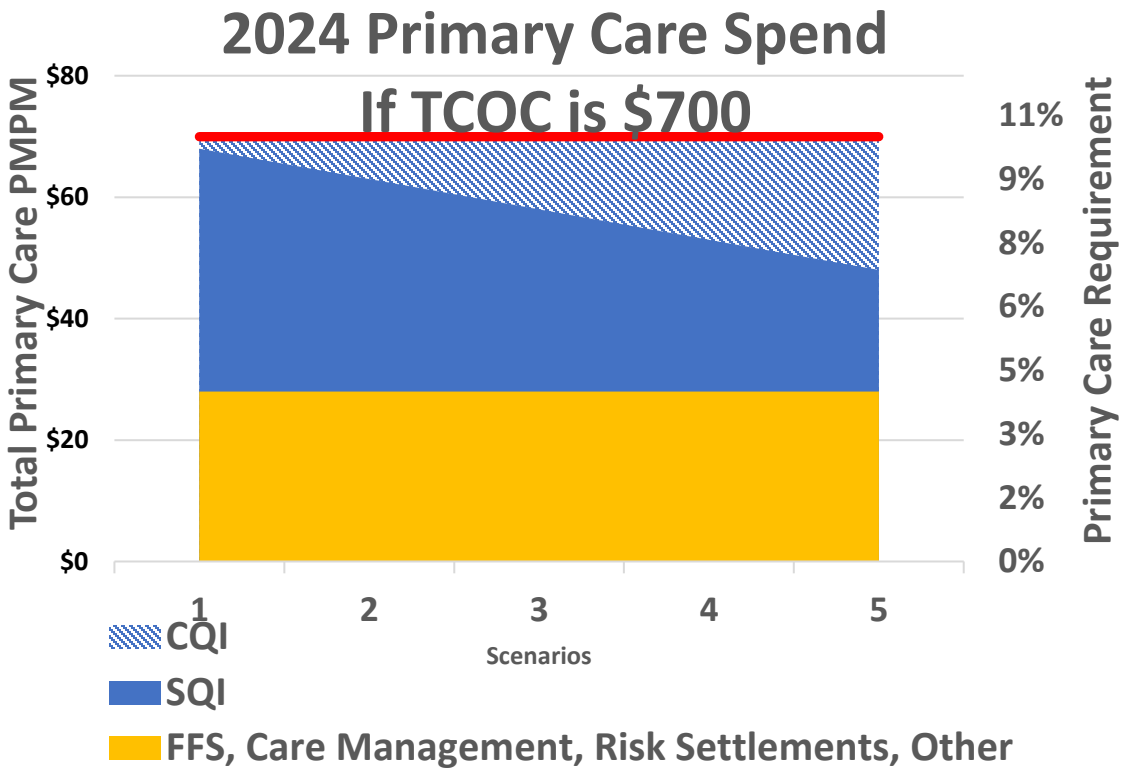
Potential CQI Programs

	Small Practice	Large Practice
Practice Health Assessments	Tracking and enforcing screening completion.	Practice identifies resources for patients and families.
Technology Investment	Data exchange of best practices or claims data. Could be maintained by a 3rd party	Telehealth integration and portal upgrades
Staffing	Retention incentives: financial compensation, improved working conditions, additional support	Hiring additional staff: non-medical personnel, nurse practitioners, community workers
Advanced Care Management	Practice identifies resources for patients and families.	Practice identifies resources for patients and families.
Infrastructure Improvements	Purchase additional common equipment and tools to improve client flow efficiency.	Telehealth integration and portal upgrades
Integrating SDOH Measures	Tracking and enforcing screening completion.	Including Z codes in claims data

- Providers have different needs due to size
- Recommended CQI PMPM payments are tiered by practice size.
  - Small defined as having < 5 providers.

2024 Primary Care Scenarios

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



Appendix 2 – State Scan

New York

Medical Home Model – Enhanced Primary Care (EPC)

The development of the EPC initiative comprises of two main goals:

1. Practice Reform
   - Ensure members establish and maintain an ongoing relationship with a primary care provider (PCP).
   - Provide members with integrated and comprehensive patient-centered healthcare in a timely and efficient manner.
   - Reduce patient churn and allow PCPs to spend more time with needier patients.
2. Payment Reform
   - Replace FFS payments for attributed patients with a value-driven model derived from the PCP's influence on all care.
   - Use a unique risk-based global payment model that could increase PCP compensation by as much as 25% over traditional fee-for-service (FFS).
   - Include performance-based bonuses on achieving targeted quality metrics, increasing potential compensation up to 40% over FFS.

Program:

- A prospective payment model for primary care services
- Providers are also qualified for performance-based incentives
- The health plan has included metrics that provide financial bonuses based on providers' performance
- The global payment model plus the financial bonus prospectively compensates PCPs based on each patient's level of primary care needed.
- This allows primary care practices to transform without risking loss in revenue and allows members to receive more efficient and quality care at a lower cost.

Washington

Washington Multi-Payer Primary Care Transformation Model

1. Comprehensive Primary Care Payment: fixed per member per month (PMPM) payment for comprehensive primary care services, replacing FFS payment.
    - Covers physical and behavioral health services such as preventive, acute, and chronic care and care coordination.
2. Transformation of Care Fee: aimed to support primary care transformation.
    - Aimed to improve care coordination, integration with behavioral health, and care access (ex: home visits and telehealth).
    - This fee is provided for up to three years based on practices' transformation progress, then transition to Performance Incentive Payment.
3. Performance Incentive Payment: incentive based on performance on quality and utilization metrics.
    - Incentive payment prospectively every quarter according to a tiered PMPM formula based on performance.
    - Quality metrics used will be aligned across health plans.
    - Measure domains include prevention, chronic care, and behavioral health.
    - Total cost of care is tracked but is not tied to payment currently.

Program:

- Developed in 2019, Washington is currently working to implement a multi-payer primary care VBP model that uses prospective Comprehensive Primary Care Payment to cover a range of services.
- The model aims to align payment and quality measures across health plans, including Medicaid, public employee, and school employee health plans
- Washington Health Care Authority and eight other payers signed a memorandum with their commitment to implement the model. Implementation of the Model began in January 2023.

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

Payment Redesign

Payment Incentives in the MDPCP

Practices – Track 1/Track 2

Care Management Fee	Performance-Based Incentive Payment	Underlying Payment Structure
• $6-$100 Per Beneficiary, Per Month (PBPM) ➢ Tiered payments based on acuity/risk tier of patients in practice including $50/$100 to support patients with complex needs, dementia, and behavioral health diagnoses • Timing: Paid prospectively on a quarterly basis, not subject to repayment	• Up to a $2.50/$4.00 PBPM payment opportunity • Must meet quality and utilization metrics to keep incentive payment • Timing: Paid prospectively on an annual basis, subject to repayment if benchmarks are not met	• Track 1: Standard FFS • Track 2: Comprehensive Primary Care Payment (CPCP) - Partial pre-payment of historical E&M volume with 10% bonus • Timing: Track 1: FFS; Track 2: prospective

40 *MSSP ACO practices do not receive the Performance-Based Incentive Payment*
Potential for additional bonuses via AAPM Status under MACRA Law

MARYLAND Department of Health

Source: Improving Quality and Preparing for the Maryland Primary Care Program

MDPCP Strategic Investments to reduce costs and improve outcomes Statewide:

- Access & Continuity
- Care Management
- Comprehensiveness & Coordination
- Beneficiary & Caregiver Experience
- Planned Care for Health Outcomes

HEART Payment

$110 PMPM payment offered and is not tied to performance on quality or utilization measures. Funds are used to enhance care performance specifically addressing SDOH.

Payments can be used for some of the following services:

- Providing trainings: implicit bias or cultural competency
- Implementing social needs assessment screening as part of the EHR, or substance abuse screening
- Data collection efforts on SDOH
- Facilitate housing navigation and support
- Address barriers such as transportation

Mississippi

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

Figure 4.2.2.8_A: HCQI Expense Categories

A survey with the functional areas is conducted annually to ensure accuracy and to confirm activities meet the definition of HCQI expenses.

1	2	3	4	5
Improve Health Outcomes	**Prevent Hospital Readmissions**	**Improve Patient Safety & Reduce Medical Errors**	**Implement Wellness & Health Promotion**	**HIT Expenses for Health Care Quality Improvements**
° Case management ° Care coordination ° Chronic disease management ° Quality reporting & documentation ° Accreditation fees directly related to quality of care activities	° Patient-centered education & counseling ° Personalized post discharge counseling ° Quality reporting related to hospital readmission ° Comprehensive discharge planning	° Activities to lower the risk of facility-acquired infections ° Activities to identify & encourage evidence-based medicine ° Prospective prescription drug Utlization Review aimed at identifying potential adverse drug interactions	° Public health education campaigns ° Quality reporting & related documentation ° Coaching or education programs ° Wellness assessments	° Health Information Technology (HIT) expenditures that are attributable to the programs listed here

MS_MSCAN20_4.2.2.8_HCQI Expense Categories_2

Source: True Care Technical Qualification (Blind Evaluation)

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:

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

Rhode Island

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

Source: Neighborhood Health Plan of Rhode Island 2020 Quality Improvement Program Description

Minnesota

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)
- Alignment of ACO components across payers related to performance measurements

Programs:

- Practice transformation investments: provided coaching and TA to providers in building capacity in centered care teams
- HIE/HIT: education and technical assistance on privacy and consent management practices
- Expansion of e-health capabilities such as advancements in EHR systems and advancements in other health information technologies

Outcomes:

- Increased Statewide HIE Vendor Capacity
- Advancement in Care Coordination Model Development
- Established and Achieved Clinical Process Goals

Source: Evaluation of the Minnesota Accountable Health Model

Michigan

Blue Cross Blue Shield Quality Improvement Program

- Goal of the 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:
  - Improving the health of the population
  - Improving the patient experience of care including quality and satisfaction
  - Reducing or at least controlling the per capita cost of care

Programs:

- Behavioral Health Surveys
- Tobacco Cession Coaching Program
- Weight management and nutrition information through bcbsm.com
- Virtual well-being program: virtual webinars
- Enterprise-wide provider directory: can be used by members to compare providers, skill sets, and costs.
- Mail reminders for preventative care services or automated telephone reminders

Source: 2022 Blue Cross Blue Shield of Michigan Quality Improvement Program Description

Thank you!

Please reach out with questions or concerns.

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Daniel Nemet, ASA, MAAA

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Resources

1. https://mhcc.maryland.gov/mhcc/pages/apc/apc/documents/FQHC_Webinar_20191209.pdf
2. https://medicaid.ms.gov/wp-content/uploads/2022/08/TrueCare-RFQ-20211210-REDACTED-COPY-03042022.pdf
3. 2022 Blue Cross Blue Shield of Michigan Quality Improvement Program Description (bcbsm.com)
4. htthttps://health.maryland.gov/mdpcp/Documents/MDPCP_HEART_Payment_Playbook.pdfps://www.cms.gov/priorities
5. https://www.nhpri.org/wp-content/uploads/2020/08/2020-Quality-Improvement-Program-Description-Final.pdfinnovation
6. https://www.leg.mn.gov/docs/2018/other/180336.pdfmedia

AHEAD MODEL UPDATE

- Dr Nancy Fan, PCRC Chair

PUBLIC COMMENT

NEXT MEETING

Primary Care Reform Collaborative Meeting

Monday, January 22, 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

THANK YOU