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DE PCRC Strategic Plan

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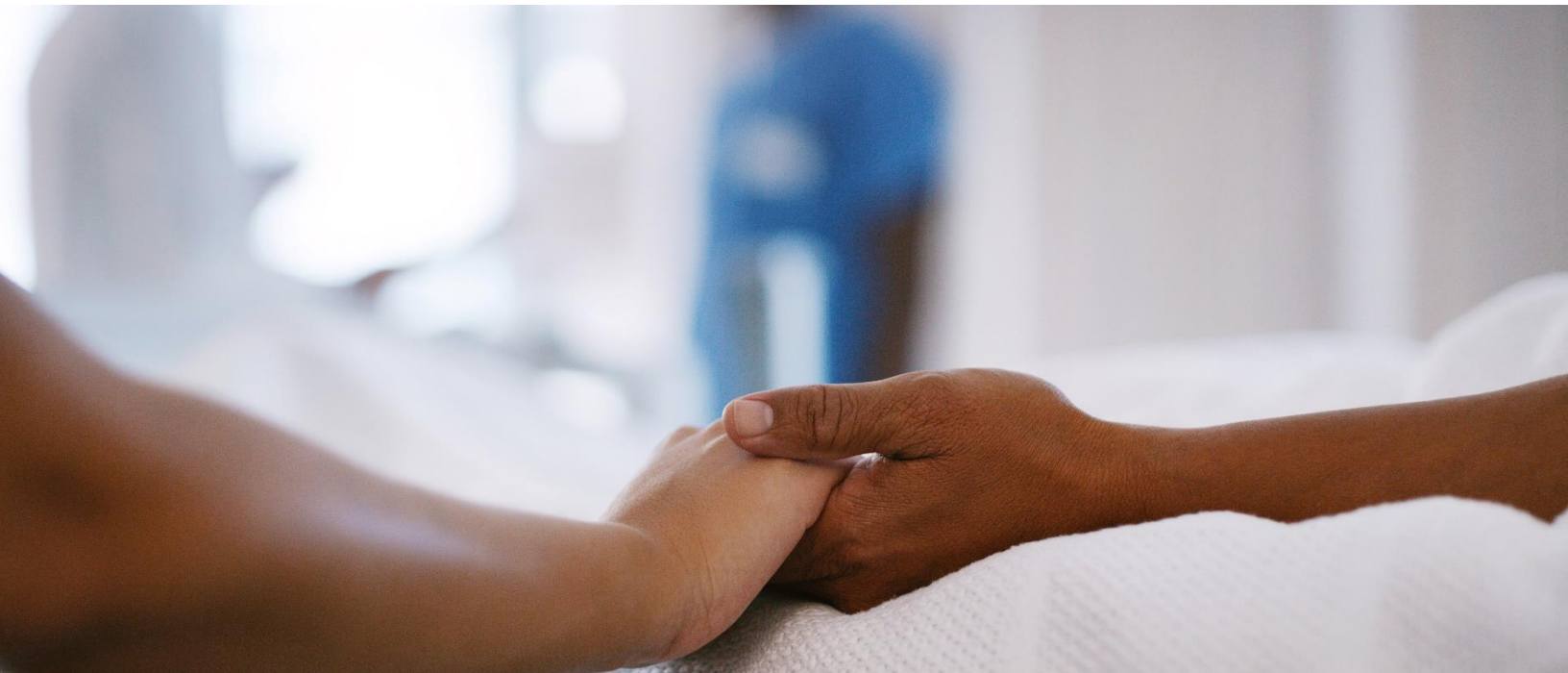

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ACKNOWLEDGEMENTS

This work was made possible with the time and contributions of the Delaware Primary Care Collaborative (PCRC) Working Group, which was led by Nancy Fan, MD, Chair of the PCRC. We also would like to thank the stakeholders that the working group identified, who took the time to participate in interviews to develop this strategic plan.

INTRODUCTION

Delaware's Primary Care Reform Collaborative (PCRC) is a legislatively mandated committee designed to strengthen the primary care system in Delaware. Senate Bill (SB 120) lists the goals of the PCRC as follows:

- Direct the Health Care Commission (DHCC) to monitor compliance with value-based care delivery models and develop and monitor compliance with alternative payment methods (APMs) that promote care that ties reimbursement to quality
- Require that rate filings limit aggregate unit price growth for inpatient, outpatient, and other medical services to specific percentage increases over the next four years
- Mandate that insurers spend a certain percentage of their total costs on primary care over the next four years
- Call upon the Office of Value-Based Health Care Delivery to establish mandatory minimums for payment innovations, including APMs, and to annually evaluate whether primary care spending is increasing in compliance with the established mandatory minimums for payment innovations[1]

Health Management Associates (HMA) supported the PCRC in developing an 18-month strategic plan to facilitate the goals above. The sequencing of this process was as follows:

1. Establish a PCRC working group
2. Complete an environmental scan of the national primary care landscape with a focus on:
    a. Authority and governance
    b. Primary care cost containment strategies
    c. Investments in primary care
    d. Quality measures
3. Conduct focus group interviews and surveys with identified stakeholders, including:
    a. Providers
    b. Managed care organizations (MCOs)
    c. State officials
4. Support the PCRC in developing strategic priorities and synthesizing findings to develop a strategic plan.

[1] Delaware General Assembly. Senate Bill 120. Substituted as SS 1 of SB 120. Signed October 1, 2021. Available at: https://legis.delaware.gov/BillDetail/68606. Accessed March 1, 2024.

PROJECT TIMELINE

PCRC WORKING GROUP

In collaboration with the Delaware Health Care Commission (DHCC) Chair, Nancy Fan, MD, a working group was developed to guide the work of developing the strategic and implementation plans and direction, including an assessment of options, collaborative development of goals, formulation of strategic options for each goal, and subsequent adoption of means of moving forward. The PCRC working group monthly for 60−90 minutes to discuss milestones and next steps toward establishing overarching PCRC goals. The process step began with a review of results from a 2021 National Academies of Science, Engineering, and Medicine (NASEM) survey distributed to the PCRC (see Appendix I).

The PCRC working group was composed of the following individuals and was charged with informing the collaborative's strategic priorities.

Name	Affiliation	Role
Dr. Nancy Fan	DHSS	Chair, Delaware Healthcare Commission
Dionna Reddy	DHSS	Public Health Administrator
David Bentz	DHSS	Deputy Director of Healthcare Reform
Laura Knorr	Aetna	Director, Network Management
Kevin O'Hara	Highmark	Director, Network Development

Cristine Vogel	Delaware Dept. of Insurance	Director, Value Based Healthcare Delivery
Tyler Blanchard	Aledade	Market President
Michelle Adams	Westside Family Healthcare	Director, Quality Improvement and Risk Management

Key takeaways from the working group's meeting included:

- The need for a more significant effort to decrease inpatient costs; inpatient costs account for the highest rise in cost of care.
- The PCRC should set goals for allocating the investment in primary care.
- Expand patient-centered care to look beyond SB 120's focus.
- Delaware should find a solution that matches the policies it wants to move forward.
- Develop three to five strategic objectives that the PCRC feels passionate about.

ENVIRONMENTAL SCAN

Our primary care environmental scan reviewed cost containment strategies, primary care investment strategies, and payers that should be included in those strategies across seven states—Connecticut, Maryland, Massachusetts, New Jersey, Oregon, Rhode Island, and Vermont.

In Connecticut, the authority/governance is through the Office of Health Strategy (OHS), which has defined the cost containment strategy as increasing total healthcare spending to 10 percent by 2025 for public and private payers. The primary care investment strategy is to direct OHS to develop annual healthcare cost growth benchmarks for 2021−2025.

Maryland's authority/governance is through the Department of Public Health – Program Management Office. Its containment strategy centers on saving $300 million in annual Medicare spending by the end of 2023. Maryland's primary care investment strategy is through multi-payer, patient-centered medical home programs.

Massachusetts' authority/governance is through the Massachusetts Health Policy Commission, which has a cost containment strategy of increasing primary care spending to approximately 12−15 percent of overall healthcare expenditures by 2029, including commercial insurance payments. The primary care investment strategy centers on a fee-for-service (FFS) model for monthly prospective payment.

New Jersey's authority/governance model is through the Governor's Office of Health Care Affordability and Transparency. Its cost containment strategy centers on decreasing annual growth in healthcare costs, currently at a rate of 3.2 percent, including Medicaid payments. The primary care investment strategy is to set benchmark performance criteria and conduct a cost-driver analysis.

The Oregon Primary Care Reform Collaborative, which has developed a cost containment strategy of increasing investment in primary care and tracking spending allocated to primary care carriers, the

Public Employees Benefits Board, the Oregon Employees Benefits Board, and coordinated care organizations, including multi-payers, Medicaid, and commercial payers. The collaborative's primary care investment strategy is through a patient-centered primary care home (PCPCH).

Rhode Island's Office of the Health Insurance Commissioner (OHIC) has created a cost containment strategy of directing 9.7 percent of total healthcare spending to direct primary care through multi-payer, Medicaid, and commercial payer systems, similar to Oregon. The state is also similar to Oregon in that its primary care investment strategy is through the use of patient-centered medical homes, as well as an APM.

Vermont has a unique quasi-government entity called the Green Mountain Care Board. The cost containment strategy the board has outlined calls for tracking healthcare spending in 2018−2023 and keeping the average increase in costs at 3.5−4.3 percent through commercial insurance, Medicaid, and Medicare payments. The primary care investment strategy is a per member per month approach.

The table below summarizes of the key findings from all seven states included in the environmental scan:

State	Authority/ Governance	Cost Containment	Payers Included	Primary Care Investment Strategy	Aligned Quality Measures
CT	Office of Health Strategy (OHS)	Cap Total healthcare spending at 10% by 2025	Public and private payers	Directs OHS to develop annual healthcare cost growth benchmarks for calendar years (CY) 2021−2025	Yes – mix of HEDIS • Hypertension • HbA1c
MD	Department. of Public Health – Program Management Office	Saving $300 million in annual total Medicare spending by the end of 2023	Medicaid, Medicare	Multi-payer patient-centered medical home program	Yes – mix of HEDIS • Hypertension • HA1c
MA	Massachusetts Health Policy Commission	Increase primary care spending approximately 12−15% of	Commercial	FFS to a monthly prospective payment	Yes – mix of HEDIS • Hypertension • HbA1c

		overall healthcare expenditures by 2029			
NJ	Governor's Office of Health Care Affordability and Transparency	Decrease how much health care costs grow each year (3.2% value)	Medicaid	Set benchmark performance criteria and conduct a cost-driver analysis	Yes – HEDIS, CAHPS • Hypertension • HbA1c
OR	Oregon Primary Care Reform Collaborative	Increase investment in primary care. Track spending allocated to primary care carriers, PEBB, OEBB, and (CCOs)	Multi-payer, Medicaid, commercial	Patient-centered Primary Care Home (PCPCH)	Utilization • Hypertension • HbA1c
RI	Office of the Health Insurance Commissioner (OHIC)	At least 9.7% of total healthcare spending must go toward direct primary care spending	Multi-payer, Medicaid, Commercial	Alternative payment model; PCMH	Yes – mix of HEDIS • Hypertension • HbA1c
VT	Green Mountain Care Board	Track healthcare spending between 2018−2023 to keep avg. increase in costs between 3.5−4.3%.	Commercial, Medicaid, Medicare	Per Member-Per Month (PMPM)	Yes – mix of HEDIS • Hypertension • HbA1c

STAKEHOLDER INTERVIEWS AND KEY FINDINGS

For stakeholder interviews, we contacted to 15 participants from various backgrounds, including providers, MCOs, and state officials. We conducted six virtual interviews, six individuals provided written responses, and three participants responded to our request. The table below provides a details about all 15 potential participants along with their affiliation and category they corresponded to (provider, MCO, or state):

Name	Affiliation	Focus Group
James Gill, MD, MPH	DE Medical Society and PCRC member	Provider
Kristin Dwyers	Nemours	Provider
James Trumble	Tidal Health	Provider
William Chasanov, MD	Beebe Hospital (leads the value-based reimbursement and contract efforts)	Provider
Megan Werner, MD	Westside Health (FQHC)	Provider
Rose Kakoza, MD	Christiana Care (in charge of Medicaid ACO) and PCRC member	Provider
Sara Mullins, MD	Aledade (Senior Medical Director)	Provider
Dan Elliott, MD	Delaware First Health (Medical Director); family practice physician/Advanced primary care	MCO
Christopher Wheelock, MD	Highmark Health	MCO
Emmilyn Lawson	Market President/CEO with AmeriHealth Caritas Delaware	MCO
Cari Miller	DHIN	State
Nichole Moxley	Chief, Health Planning and Resources Management, Division of Public Health	State

Faith Rentz	Director, Statewide Benefits and Insurance Coverage	State
Steven Costantino	State of Delaware	State
David Bentz	State of Delaware	State

HMA asked all stakeholders a series of eight questions, regardless of their affiliations. Below are the questions we asked:

1. **As you reflect on SB 120 and its intent to increase access to primary care, control costs, and drive outcomes:**
    a. What is working well?
    b. Where does it fall short?
    c. You are not that familiar with it (share some information related to SB 120)
2. **How familiar are you with the PCRC and its goals? If unfamiliar, move on.**
    a. What are some of the PCRC strengths and weaknesses?
    b. Can you identify some opportunities that the PCRC should consider?
3. **Currently, the payers participating are those carriers offering commercial fully insured plans, which represent about 10 percent of the population (e.g., Aetna, Cigna, Highmark, and United HealthCare).**
    a. Are you aware of how the primary care investment is working for Delaware's primary care system?
    b. Do you think it is working well or not?
    c. Please expand on your response above
4. **What are your thoughts (advantages/disadvantages) about expanding the primary care investment targets into other market segments such as Medicaid and the State Group Health Insurance Plan?**
    a. What would be the impact (positive/negative) of expanding into more market segments?
    b. Are there specific market segments (e.g., state employees, Medicaid) that you think should be prioritized?
5. **Increasing primary care investment is one of the critical elements to reach the stated goals (above); however, it must be coupled with cost-savings, there is a "price growth limit" for hospital services that the carriers are required to be in compliance.**
    a. Are there specific primary care investment strategies you think the PCRC should pursue?
6. **What are some strategies for Delaware to take to achieve primary care cost containment?**
7. **Has the current price growth limit worked well or not, explain? Are there other strategies that should be considered?**
8. **Do you have additional topics or areas that we did not discuss that you would like to share?**

A SWOT (strengths, weaknesses, opportunities, and threats) analysis was conducted for each group. Below is what each focus group (providers, MCOs, state) conducted based on strengths, weaknesses, opportunities, and threats related to the PCRC:

Provider Focus Group

Strengths	Weaknesses
• Committed chair/co-chairs • Attempts have been made to get representation from various groups on the PCRC	• Little interest in primary care reform. • No substantive criteria (e.g., penalties, incentives) to make sure things get implemented. • Unclear whether strategies associated with SB 120 will increase access to PCPs. • PCRC tactics do not focus on the entire primary care system (focus on independent practices). • Representatives from the various PCP groups may not be the right people. • Perceived bias against hospital-employed physicians who provide primary care
Opportunities	**Threats**
• Eliminate representation by Medicaid and the state employee group until they agree to participate in SB 120. • Need to expand access to primary care (50% of primary care investment targets). • PCRC should define the problem it is seeking to solve. • Increased transparency in what the PCRC is doing, with input from necessary stakeholders. • Consider the whole primary care landscape, with attunement to hospital-based primary care practices. • Broader application to other commercially run state products like Medicaid MCOs and State Employees.	• Lack of Medicaid participation. • Payers are not complying with the law. • A lack of consensus on what the key issue is that the PCRC needs to address. • The goal and focus of the PCRC is unclear. The strategies and objectives are unclear, and accomplishments are not widely known (no transparency). • The most recent strategic planning initiative has not been made public, lacks transparency, and does not have input from all necessary stakeholders. • Providers unaware of how primary care investment is working for DE's primary care system

MCO Focus Group

Strengths	Weaknesses
• Focus and emphasis on primary care	• Access to primary care is a challenge. • Need the right metrics to effectively measure primary care access. • Long-term impact: disconnect with what PCRC is doing with other healthcare groups in DE.
Opportunities	**Threats**
• Develop structure, goals, and prioritize quality metrics • Better coordination with health-related social needs in the primary care space; MCOs may be able to help • More primary care investment in public health	• The payers participating have no impact on the Medicaid and Medicare side and need to broaden their scopes to include behavioral health. • Little impact in expanding the primary care investment targets into other market segments such as Medicaid and the State Group Health Insurance Plan, when only 10% of the population is served in large group plans.

State Focus Group

Strengths	Weaknesses
• Representation on PCRC from most stakeholders	• Falls under too large an umbrella; reimbursement model is inadequate • Access is not improving; need to step back and look at SB 120 in the context of the larger DE landscape • Only a small portion of stakeholders are actively engaged

Opportunities	Threats
• Need to understand the population they are trying to serve and where they currently are to prioritize market segments • Listen to providers and offer incentives to improve outcomes • Need representation from across the state	• Not seeing the results/impact of the payers participating that are those carriers offering commercial fully insured plans (only early conversations for VBP arrangements)

KEY DECISIONS

After the stakeholder interviews were completed, results from the 2021 NASEM survey and the environmental scan were presented, the PCRC working group arrived at five strategic objectives. HMA presented these objectives to the PCRC for a vote. All five recommendations passed and are highlighted below.

Recommendation #1

The PCRC should focus on increasing multi-payer participation and buy-in for primary care spending. – **PASSED (9/9)**

- 9 – yes
- 0 – no
- 0 - abstain

Recommendation #2

The PCRC should inform policies that will incentivize primary care investments without increasing overall healthcare costs. **– PASSED (9/9)**

- 9 – yes
- 0 – no
- 0 – abstain

Recommendation #3

The PCRC should promote and advocate for quality measures alignment across payers. – **PASSED (8/9)**

- 8 – yes
- 1 – no
- 0 - abstain

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 – **PASSED (9/9)**

- 9 – yes
- 0 – no
- 0 - abstain

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. – **PASSED (8/9)**

- 8 – yes
- 1 – no
- 0 – no

CONCLUSION

The five strategic recommendations from the PCRC, listed in the Key Decisions section of this report, will support Delaware in addressing the legislatively mandated goals to strengthen primary care across the state. Though work still needs to be done, these strategic priorities will help pave a path forward for the coming year(s).

APPENDIX

Appendix I.

Delaware Primary Care Reform Collaborative Summary Survey

1. The PCRC agrees with the goals of the NASEM as provided in the email.
    - ( ) AGREE
    - ( ) DISAGREE
    - ( ) Other - please type in comment to either Agree or Disagree

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

    - ( ) AGREE
    - ( ) DISAGREE-– There is no way to do this without increasing costs to patients/consumers
    - ( ) Typed in additional comments

3. With the information provided by the Office of Value Based Health Care Delivery (OVBHCD) and through the Delaware Health and Social Services Benchmarking and Costaware data, there should be an effort to decrease inpatient costs, even for those health plans not covered under SB 120 (Medicaid, self-insured plans)

    - ( ) AGREE
    - ( ) DISAGREE - those health plans should not be considered for primary care reform
    - ( ) Additional comments

4. If #3 is a STRONG RECOMMENDATION from the PCRC, should there be a recommendation for an established regulatory body regarding healthcare 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?

    - ( ) AGREE
    - ( ) DISAGREE
    - ( ) Why I chose "disagree"

5. If #4 is NOT a STRONG RECOMMENDATION, then should the PCRC recommend that those health plans that are not under SB 120 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 PMCH quality of care; infrastructure costs to establish resource for patients and providers alike regarding primary care access; and patient and provider education regarding the benefits of primary care, behavioral health, as well as social determinants of health.

- ( ) AGREE
- ( ) DISAGREE

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

- ( ) AGREE
- ( ) DISAGREE
- ( ) COMMENTS

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

- ( ) AGREE
- ( ) DISAGREE

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.

- ( ) AGREE
- ( ) DISAGREE
- ( ) NOT SURE - I NEED TO KNOW THE QUALIFYING PARAMETERS