Delaware Center for Health Innovation (DCHI) Clinical Committee
Compiled Comments on Delaware's Road to Value
November 13th, 2017

Submitted on behalf of DCHI Executive Director Julane Miller-Armbrister and DCHI Clinical Committee Co-Chairs Dr. Nancy Fan and Dr. Alan Greenglass

Comment #1

After thinking more regarding the practice transformation funding, I think we may have to be a bit more patient. I'm not sure where else the funding would be used if we don't continue the practice transformation funds. I'm hearing some positive effects from the ACO practices who are working with our practice liasons who were trained in practice transformation by HealthTeamWorks. It makes sense to me to consider moving the funding into a train the trainer model. Perhaps some practice managers could be considered for the training. This way people who are embedded permanently in the practices or in the ACOs can benefit.

Comment #2

- Strategy II: Pay for Value—"The State of DE and all payers ***should*** continue to refine the primary care-based health care homes to provide incentives for care coordination and better health outcomes."
    - The word ***should*** will not achieve the necessary change we are looking for. We have tried for years to get payers to provide adequate PMPM to cover the costs of care coordination, navigators, coaches, behavioral health, etc., all to no avail. I believe that legislative action is the necessary next step to ensure that the primary care workforce can afford to run their practices efficiently enough to provide the needed value of true population health care. Unrealistic PMPM will doom our attempts at practice transformation. Payer investment in primary care will ensure successful ACOs and give the best potential on bending the cost curve.

- Delaware's Progress on Payment Reform, paragraph 3—"Despite this progress, many primary care providers in smaller practices have not yet chosen to participate in value-based models."
    - Other than doctors who are nearing retirement and therefore don't have any incentive to transform their practices, the rest of these small practice doctors do not have the capital to invest in care coordinators, navigators, behavioral health practitioners, coaches, etc. Payment reform would undoubtedly push the needle much further to the right.

- II. Overview of Implementation Plan—1) "Ensure that Delawareans have choice and the information needed to make better health care decisions."
    - The doctors, themselves, do not have enough information to help their patients make informed decisions. We have little to no idea what anything we order costs the patient. Total charges, billable charges, copays, deductibles, out of plan issues, donut holes, etc., are too complicated for even someone with an advanced degree to figure out.

- II. Overview of Implementation Plan—3) "Support primary care infrastructure…."

    - How? Without adequate reimbursement, primary care cannot do the heavy lift required for population health.

- Relationships Between Strategies for Value-Based Health Care-- "For all of the strategies, the strategies are not siloed as independent strategies, but are interconnected and essential for one another to work."
    - Unfortunately, there is one strategy which has been omitted from this report (and it was also absent from the Affordable Care Act); tort reform. If a practitioner is following evidence-based guidelines, then they should be immune from malpractice suits which occur when there is a bad outcome. Tort reform could help decrease unnecessary tests and referrals, as well as bend the cost curve by minimizing frivolous and/or unjustified lawsuits. If the Administration and the General Assembly are serious about bending the cost curve, tort reform must be a part of the equation.

- Relationships Between Strategies for Value-Based Health Care-- "Finally, it is important to reorient the payment system to support prevention efforts rather than visits and illness."
    - I would include chronic disease management in the equation. I would also support payment modifiers to adjust for social determinants, e.g., by zip code or other surrogate markers of disadvantaged populations. [this is addressed, in part, in "Prepare for increased need for safety net providers."

- Strategy V: Improve Health for Special Populations—
    - I would include a robust network for home visits for the frail and elderly (along with adequate reimbursement for this highly complex and vulnerable population). Christiana Care's Independence at Home demonstration project has significantly decreased total cost of care, ED utilization, inpatient readmissions, patient satisfaction, and more. Any program which decreases the use of SNFs and ECFs will help bend the curve and improve patient satisfaction, allowing more people to "age in place." Increased utilization of palliative care and hospice also promises the same.

- Strategy V: Improve Health for Special Populations—"… and trauma-informed, school-linked mental health supports for children."
    - Several of the CCHS-run School-Based Health Centers have already piloted such programs, with intention to expand the number of schools and students this year.

- Use patient-centered medical homes approaches to support prison re-entry populations
    - Currently, Medicaid stops when a person is incarcerated. When they are released from prison, they must re-enroll in Medicaid. This creates unnecessary barriers to care, unless the prisoner and/or the prison medical staff are proactive. We also need much better access to behavioral care, since so many people in this population have mental health disorder, including substance abuse/addiction.