To: Kara Odom Walker, MD, Secretary, Department of Health and Social Services

From: Medical Society of Delaware

Date: November 13, 2017

Re: Comments to "Delaware's Road to Value"

On behalf of the physicians and patients of Delaware, the Medical Society of Delaware (MSD) appreciates the opportunity to provide comments and feedback to the Department of Health and Social Services' (DHSS) "Delaware's Road to Value." The Society supports overarching and bold change to address the health care cost inflation rate and the negative impact it has on public and private sector budgets.

The Society applauds DHSS for moving forward with a purposeful plan which incorporates the "Triple Aim Plus One": improving the health of Delawareans and their patient experience, reducing the cost of care through the benchmarking process, AND decreasing the administrative burden to physicians through meaningful tools, such as a common scorecard.

The "Triple Aim" has been a discussion point for many years, with innumerable policy papers describing in detail many of the tools for addressing the upward trend in costs. Physicians in Delaware have attempted to implement such tools in concerted efforts to bend the cost curve. These include programs such as bundled payments and ACO or ACO-like participation. We urge policymakers and leaders to not shy away from fully implementing policies that have been previously-discussed, but methodically and collaboratively to move from discussion to action through thoughtful deployment of resources.

There is nothing more fundamental to care than connecting a patient to a physician. The creations of systems, development of better tools and procedures, and organization of pools of resources all grow from this foundation. Together, these elements have created the modern health care system which if engaged in concert and in an intentional manner by Delaware's leaders, Delaware can meet its aims.

For its part to-date, the Society and its members have played an active role ensuring access to quality care for Delawareans. For instance, the Voluntary Initiative Program which establishes a patient safety net comprised of volunteer physicians to see under- and un-insured patients has provided care to over 10,000 Delawareans and connected 6,000 of them to nearly 600 primary care physicians.

The Society has also been at the forefront of the Patient-Centered Medical Home (PCMH) model, leading a pilot that was funded by Highmark Delaware from 2013 to 2016. The Society continues to be a leader in helping offices to transform to the PCMH model of care through

programs funded by the State Innovation Models (SIM) grant. Primary care members through practice transformation can achieve the highest NCQA levels.

The Society views these comments as an important step to forward stakeholder engagement which will ultimately lead to legislative and regulatory changes. At such time, the Society endeavors to remain an important partner to be engaged when the ideas are crafted with specificity. The comments here are organized by "Strategy" in the order presented in the DHSS report.

<u>Strategy I</u> - ***Improve Health Care Quality and Cost***

- *Claims vs. Clinical Data* – The All-Payer Claims Database (APCD) is often cited as a potential panacea of information to draw upon while determining the total cost of care. However, claims data is by definition stale. The use of real time clinical data cannot be overstated regarding its usefulness to inform day-to-day practice. It can be used to drill down on localized costs to look for surrogate markers of disadvantaged communities which often require more specialized care with neighborhood-by-neighborhood disparities. These tools can and should be continued to be housed in the Delaware Health Information Network (DHIN) which is constantly innovating in this area.

- *Tracking Cost-Drivers* - All costs have to be looked at, both to account for them in the total cost of care and to track them for future evaluation of impacts as a cost-driver. For instance, pharmaceutical costs, even those in the generic market, can experience sudden and drastic cost inflation. Measuring and accounting for these factors is necessary for an ongoing conversation regarding the total cost of care.

- *Annual vs. Trend Measuring* – Not stated specifically in the report but instead at one of the summits, it was pointed out that benchmarking is not done on a year-to-year basis, but incorporate overall trends to account for economic ups and downs. In a parallel discussion, it is noted that Delaware is currently in a structural economic deficit with few sources of revenue providing funding for the state budget. These sources each have their own sources of volatility within the business- and budget-cycles. Annual measurements and overall trends have to be taken into account and budget shortfalls due to shrinking revenues cannot lead to penalties.

- *Growth Rate Link* – The draft plan suggests tying the benchmark to the "overall economy" of the state. While a rate link is important for this model to succeed, "economic growth" needs further definition as health care costs risk being tied to the economic growth of the state which doesn't reflect cost drivers.

- *Universal Scorecard* – The first step of the DHSS plan is to ascertain the total cost of care. The very process of doing this is rife with pitfalls, but is indispensable. The Society supports the recommendations in Strategy I for improving health care quality and cost, but how are outcomes measured? HEDIS-type measures of disease-oriented processes may provide a starting point, but a primary care centric model will look to continuity, coordination, comprehensiveness, and access. A universal score card with realistic

metrics agreed upon by all stakeholders is an important guidance for physicians delivering day-to-day care.

Communication and a mutual-willingness to adapt as we move forward is a key component to implementing any change, let alone one of the proposed scope. De-aggregated data is an effective tool in guiding and informing performance which can decrease costs through elimination of unnecessary and sometimes inappropriate practices. Physicians must know if they need to change and physicians want to know this; however, feedback needs to be meaningful.

- *Cost Transparency* – Discussion and evaluation of costs have been hindered for decades not only by a lack of aggregated, reliable information, but also by contract. That is, insurers contractually prevent providers from public or even intra-profession discussion of their negotiated rates. This lack of data transparency is an incredible hindrance to physicians who are trying to help a patient make an informed decision. There is no way to access the costs of what the physician would like to order for the patient, let alone with layers of complication of copays, deductibles, out-of-network charges, and other insurer incentives and disincentives. While sensitivity to patient confusion is important to be cautious of, the reality of this impediment cannot be overlooked.

<u>Strategy II</u> - *Pay for Value*

- *Incremental Transitions* - The Society has and will continue supporting a shift to value-based payment structures. Using a total cost of care benchmark and subsequent growth rate can be an important tool to inform and foster this shift. Of course, such a shift cannot happen overnight. Bridging this gap requires a healthy mix of practical adjustments to the current fee-for-service model, investment in transformation, and a grasp of where the costs currently lie and where we collectively would like them to be.

- *Social Determinants of Health* - The vast majority of what comprises a healthy or unhealthy patient does not occur at the point of contact of the patient and the physician. Much as other large societal systems such as education and criminal justice have concluded: Poverty, violence, education, physical environment, housing, access to healthy foods, and promotion of an active lifestyle all determine the risks of the underlying population of patients. We can and must do more from all of our systems, including health, to coordinate and engage with patients and the population. Examples of these strategies abound, such as a "Housing First" strategy to use Medicaid funding to pay for housing for the homeless and for the inadequately-housed. There must be additional, coordinated public and private sector engagement to address these influencing factors in a meaningful way.

- *Primary Care* – Stated nearly as truism for decades, investment in access to quality primary care drives down long-term spending. Despite agreement, such investment has never occurred in Delaware either in reimbursements or workforce investment. The discrepancies it has led to can be stark: a DHSS *Primary Care Health Needs Assessment*

released in 2016 states that "number of primary care physicians per 100,000 population was 114.3 in 2015, compared to Massachusetts with 206.7 primary care physicians per 100,000 population." Other states have made an investment and have seen results. For example, Rhode Island requires all payers to increase the percent of their spending that goes to primary care by 1% per year in order to get their rates approved by the Insurance Commissioner. That has resulted in nearly a doubling of the primary care spend, increases in primary care physicians, access to care in the state, and dramatic reductions in the growth of health care spending.

How those resources are deployed is equally important. Unrealistically low per member per month payments and over-full patient panels can doom attempts at practice transformation and physician participation.

- *Health Management* – Health management needs more investment. It is through health management that physicians can help patients with the tools they need to address their social determinants of health. Primary care physicians and their often-small practices lack the necessary capital to invest in care coordinators, navigators, behavioral health practitioners, coaches, and other such professionals. The benchmarking process would benefit from the long term investment in supporting this capital investment to primary care physicians.

- *Defensive Medicine* - The Department asserts a consensus that "volume-based payment systems contribute to the health cost growth." Fee-for-service has more than a small role to play in why this is the case, but at no point is there discussion of another risk factor: medical liability. To drive down total cost of care, Delaware needs a meaningful discussion of the standard of care and patient expectations.

  "Medical Liability Reform" has become a divisive term, but there are more innovative and consensus-building approaches to the issue. For instance, medical negligence suits hinge upon a deviation from the standard of care. A standard that can and has "crept" over time, requiring greater utilization and testing. This can be combatted through the creation of localized practitioner guidelines for the top procedures and treatments which can take into account efficacy and cost and can also provide a safe harbor from future suit so long as the care within the guideline was not negligently delivered.

- *Pharmaceutical Costs* –Many of the recommendations and actions a state may consider in this area are pre-empted by federal law. However, there are tools remaining. Delaware could follow neighboring Maryland's law which prohibits generic and off-patent prescription drug companies from excessive and not justified increases in the pricing of their drugs. California has taken a multi-prong approach extending from price transparency, regulation of pharmaceutical benefit managers, anti-kickback, and cross-agency purchasing. Dozens of other states are considering permutations of similar strategies.

- *Value Equation* – In furtherance of the Triple Aim, value should not be heavily weighted to decreasing cost. The Society believes in bending the cost curve *and* improving quality

and outcome. To this end, meaningful quality measures which reflect true improvement in health outcomes are deeply important. For instance, if we are looking at quality measures, measuring Hemoglobin A1C without action is insufficient. We must measure coordination, comprehensiveness, and access of care. Physician participation in the development of such meaningful metrics is essential to successful changes in health outcomes.

<u>Strategy III</u> – Support Patient-Centered, Coordinated Care

- *Patient-Centered Medical Homes* – This concept is raised in several locations in the Department draft and the Society shares a view of the importance of this model. The MSD agrees with the joint principles of the PCMH, including physician-led team-based care that is patient-focused, accessible, comprehensive, coordinated, and high-quality. However, the goals of the model face challenges in real-world implementation. This includes payer support. The MSD feels strongly that the 7th principle of the PCMH is critical – *i.e.*, that reimbursement for offices to transform to and sustain the PCMH needs to be adequate. National studies estimate the cost of transformation along the model of the PCMH at $15 PMPM or more, which needs to be the minimum standard for payers in Delaware. Additionally, patient-facing efficiencies, even in fee-for-service, need to be actively sought. For instance, a recognition that delivery of multiple services in the same visit is a virtue from a patient perspective. Items such as there are significant deficits which should be addressed with a benchmarking process.

  We also recognize that primary care is defined by function rather than specialty, and that sometimes patients choose physicians other than the traditional primary care specialties of family medicine, general internal medicine and general pediatrics. We believe that these other specialties can be recognized as a PCMH and reimbursed for that work as long as they fulfill the full PCMH function of high-quality, comprehensive, coordinated and accessible care.

- *All-Payer ACO* –ACO's in Delaware are primarily Medicare ACO's. This model continues to evolve as we see maturation from the Pioneer to Next Generation ACO which offers greater opportunities for providers to participate in risk and reward. MSD remains intrigued over the prospect of an all-payer ACO aligning quality metrics amongst payers to provide a less onerous pathway for physicians to demonstrate value. We look forward to more details on this issue.

<u>Strategy IV</u> – Prepare and Support the Health Provider Workforce and Health Care Infrastructure Needs

- *Physician Burnout* – Data supporting the rapidly increasing rate of physician burnout should be cause of extreme alarm in the health care system. At best burnout leads to early retirement, workforce issues, and practice consolidation and at worst it leads to patient harm. An urgent, concerted, and multi-faceted effort from all involved in the health care system must be made to alleviate these issues.

- *Small-Practice Centric* – Despite system consolidation, a large majority of Delaware's workforce remains in small independent practices. This is a major strength since studies have shown that small practices can improve quality at lower costs. This strength needs to be continued and built upon to ensure access across Delaware's communities while lowering the cost of care. Networks of independent practices can thrive through programs still within the value-based philosophy by using entities such as independent practice ACO's.

- *Medical School* – Delaware has no medical school and as such it yields a two-prong problem. The first is that Delaware students have no natural access to a school to foster their talents, placing them at a professional disadvantage. The second is that there is no nexus for training local students or bringing in students from elsewhere to introduce them to Delaware.

  To remedy to the first problem, the state recently refunded the DIMER program to help provide access for Delaware's students to out-of-state medical schools with in-state preference. This is laudable and necessary. Expansion of the program to other schools and evaluation of models in the area may prove useful. For example, partnerships with schools with a combined or accelerated BA/BS-MD/DO which provides an accelerated track to lower the overall cost of medical education and drive down the debt burden.

  To address the second shortcoming, Delaware through private, public, or a mix of dollars must provide robust incentives to move to Delaware as an early practitioner such as loan repayment programs, requirements to return to Delaware if Delaware supplemented your tuition, and even payment to practice in Delaware. These incentives can extend into other areas of attraction retention as well such as mortgage and business loans with incentives to both retain primary care physicians and also set up transformative independent practices in healthcare provide shortage areas.

- *Residency Programs* – Another access point for new physicians to move to Delaware is through expanded downstate residency programs through the hospital systems or FQHCs.

- *Telehealth* – As the report notes, telehealth can be implemented in several forms and fashions to better the health of Delawareans. However, it can also be used as a workforce access tool, particularly, but not exclusively to address specialty shortages. MSD supports the use of telehealth and building in-state networks which can be assembled to embed and integrate services into the primary care setting. As a supplement if-needed, physicians such as psychiatrists can be recruited from across the country, perhaps even while in residency, to see Delaware patients. Licensure can be provided at no-cost by the state for additional incentive in such case.

  Related, the state should re-examine joining the Interstate Licensure Compact as this can be a barrier to telemedicine use for Delaware patients by physicians located outside of the state and vice versa. At this moment, Maryland and Pennsylvania are considering joining. Many Delaware patients commonly seek services in neighboring states and the licensure barriers can expose physicians following the continuity of care to unnecessary legal risk.

<u>Strategy V</u> – Improve Health for Special Populations

- *Targeted Care* – The Society agrees that health spending is not equally distributed, but instead is targeted to persons with the most need. The "Road to Value" cites a few such at-risk populations such as maternal/child health, the disability community, re-entry, and behavioral health. Thinking big and holistically with these populations can lead to making strides towards the triple aim, but auditing for small changes in policies can yield immediate results. For instance, Medicaid coverage is terminated at the time of incarceration. MSD suggests removing administrative barriers around Medicaid coverage during re-entry into the community after incarceration.

  Additionally, as Medicaid covers telemedicine at certain sites, Society physician members are willing to provide services to the prison population through telemedicine. This would result in cost savings for transportation, hazard pay, and smooth re-integration into the health system with an established physician post-incarceration.

- *Aging Care, Aging in Place, and Palliative Care* – Delaware's retirement community is growing and the population across the nation is aging. A robust network for home visits for the frail and elderly along with adequate reimbursement for this highly complex and vulnerable population is necessary for increased cost effectiveness, rather than an investment in more brick and mortal facilities. Programs which facilitate collaboration and transition from the hospital setting to physician practices significantly decrease total cost of care, emergency department utilization, inpatient readmissions, patient satisfaction, and more. Any program which decreases the use of skilled nursing facilities and extended care facilities will help bend the curve and improve patient satisfaction, allowing more people to "age in place." Similar results can be seen in palliative care and hospice.

- *Trauma* – It is important that the discussion not be limited to "physical" trauma, but to recognize there are other types of trauma. Families and bystanders to trauma experience adverse health effects, as has been noted in the Wilmington CDC work. Trauma can also extend for social determinants such as food deserts, racial disparity, and the ongoing exposure to these situations that create a decreased wellness state. Partnership with the education system may provide important wrap-strategies for youth.

<u>Strategy VI</u> – Engage Communities

- *Patient Engagement* –In creating a system that is prepared to provide wrap-around services for a population to address social determinants of health, it is essential that the population be engaged to be aware of these changes. The Society welcomes an opportunity to learn about community health care teams and participate in efforts to inform and educate Delawareans.

- *Data Use* – While how, where, and when data is used is pervasive in the benchmark discussion, it should be reiterated that real time data can and should underpin population engagement. Looking for factors which identify at-risk populations, their risk factors, and properly deploying resources before risks come to fruition will further the Triple Aim.

<u>Strategy VII</u> – Ensure Data-Driven Performance

- *Data Requirements* – For any data to be useful to a practicing physician, it must have the following attributes: real time, meaningful, accurate, and actionable. Among this, the data must be specific to the providers, not just their practice, to provide a picture of where they stand to their similarly-situated peers. Information and best practices can be disseminated using the competitive nature of the marketplace. Ultimately, for any data to be useful, it must provide feedback to physicians and cannot sit in confidential databases. To reiterate, physician participation in the development of such meaningful metrics is essential to successful changes in health outcomes.

<u>Closing Thoughts</u>

The Society anticipates that this benchmarking process and feasibility plan will become more defined through additional engagement. To this end, the Society strongly supports active outreach by the State for engagement of physicians in all practice settings. This means a Governance structure that is robust for all stakeholders. As the practice of medicine stems from the physician, change must stem from engaging physicians. To attain this, physicians should be essential members of any committees, councils, or boards which will develop, implement, and sustain the benchmarking process.