SB 227 Primary Care Collaborative Meeting

Thursday, September 27, 2018
4:00 pm
Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

Present:	**Email:**
Senator Bryan Townsend	Bryan.Townsend@state.de.us
Dr. Nancy Fan	nfanssmith@yahoo.com
Absent:	
Representative David Bentz	David.Bentz@state.de.us
Staff:	
Juliann Emory	Juliann.Emory@state.de.us
Caitlin Del Collo	Caitlin.DelCollo@state.de.us

Attendees:	**Organization:**
Pam Price	Highmark
Kevin O'Hara	Highmark
Stephen Kushner	Christiana Care Health Systems
Andrew Dahlke	Medical Society of Delaware
Kiki Evinger	Dept. of Health & Social Services
Kiara Cole	Dept. of Health & Social Services
Susan Conaty-Buck	Delaware Coalition of Nurse Practitioners
Dr. Kara Walker	Dept. of Health & Social Services
Kelly Krinn	Health Management Associates
Richard Henderson	Medical Society of Delaware
Faith Rentz	Department of Human Resources
James Gill	Medical Society of Delaware
Wayne Smith	Delaware Healthcare Association
Cheryl Heik	Connections CSP
Kim Gomes	The Byrd Group
Kathy Collison	Division of Public Health, DHSS
Ron Caviness	AETNA
Katherine Impellizzeri	AETNA
Margot Savoy	Delaware Academy of Family Physicians
Adrian Wilson	Delaware Academy of Family Physicians
Deborah Zarek	
Dan Elliot	

The meeting began at 4:03 pm.

Dr. Fan and Sen. Townsend invited the guest providers to introduce themselves.

- Dr. Savoy
- Dr. Wilson
- Dr. Gill
- Dr. Zarek
- Dr. Kushner
- Susan Conaty-Buck
- Wayne Smith
- Dr. Henderson
- Dr. Elliot
- Akash Shah

Dr. Fan opened discussion by asking discussants their views on the current state of investment in primary care in Delaware.

Dr. Gill

- We are here because we know investment in primary care a problem, but how bad is it?
- It's very bad. Looking at the share of spending on primary care compared to the rest of the world, the U.S. is very low. The recommendation is to spend 12-16% of health care spending on primary care; in the U.S. is about 6% and in Delaware is at about 4%.
- This low primary care share of spending is linked to higher overall cost and lower quality of care compared to other countries.

Dr. Fan

- How should we increase spending on primary care while controlling the growth in overall health care spending? And what is the timeline for investment and impact?
- We know that improved outcomes will not be immediately apparent.

Dr. Savoy

- In order to achieve these goals, we cannot just tweak the system, we need to overhaul the entire health care system.
- Cuba has better health care because their concept of health care is opposite of the U.S.
- There is a primary care doctor located in every community and care is directed there first. Then patients get escalated to the multi-specialty center and then to the hospitals only as clinically indicated.
- In the U.S., patients often bypass these intermediate steps and initially seek care in the more expensive setting.
- It's also about investing in non-health care problems that impact health including poverty, drug abuse, obesity (food access/exercise access) and other social determinants of health.

Sen. Townsend

- Fundamentally we agree that we need to do something and need to increase spending on primary care services, but we need to get into details about how to make that investment.

Dr. Savoy

- Practices wouldn't have to spend as much if they didn't have to be everything (in particular offering social services) to patients.

Dr. Wilson

- Investment should focus on behavioral health. Primary care practices spend a lot of time and resources on individuals with unmet behavioral health care needs.

Dr. Fan

- If we assume health care spending is a fixed pie, what part are we going to redistribute to increase spending primary care?

Sen. Townsend

- How would you operationalize new resources and how quickly could you adopt changes?

Dr. Gill

- Spending more on primary care does reduce the acceleration of health care spending.
- Depending on what you mean by "value-based payments", that isn't actually the right approach to increase spending. Other countries do not use value-based models.
- Reimbursement should focus on the things that are of the most value.
- For example, Medicare pays for behavioral health coordination and chronic care management. These activities need to be integrated into primary care, and not established as separate entities.
- We can adopt this model – provide a payment that supports these valuable activities and help practices use the payment to implement.
- Pay for these services that are valuable and pay for them upfront, rather than through a "savings" model.

Sen. Townsend

- We see some reactions from others in the room that not everyone agrees that value-based payment models aren't the right approach.
- Your point is that we are not doing the things that we know should be done.
- We know the actions and care that pays off, and we should just do them, rather creating a convoluted system.

Susan Conaty-Buck

- There are two key things where we need investment to improve health: 1) mental health and 2) nutrition/obesity.

Sen. Townsend

- Are there things so fundamental that we can just implement solutions that address key underlying health problems?

Dr. Zarek

- We have a dietitian on staff and lose money on those services because dietitian services are not typically covered. Having a dietitian's services covered would help free up the physician to deliver other care.
- Another area to target is expensive ER overutilization. The payers could lead a primary care campaign to educate patients go to primary care doctor before going to the ER.

Dr. Savoy

- We also need reimbursement for telemedicine, phone triage or app-based interactions, to tell a patient they do or do not need to come in for an in-person visit. This would save everyone's time.

Dr. Fan

- I would rather tell someone about a normal result over the phone, but that is not reimbursed.
- Innovations like telemedicine are great but must be accompanied by shifting the incentives about what, who, and how care is delivered to be more efficient.
- There is definitely savings to be had in the ER, but it is an access issue at the root. The reason people go to urgent care and ERs is because they cannot see their doctor outside of standard business hours.

Dr. Kusher

- Telemedicine is a good concept, but it still stakes my time and I should be reimbursed for that.
- Using a triage nurse frees up the physician's time. This is really paying for team-based care that helps a primary care doctor unload some tasks.

Dr. Fan

- Do you talk about shared resources within the ACO, including nutritionists, social workers, or triage nurses?

Dr. Gill

- We have shared behavioral health coordination and chronic care management because Medicare pays for that service.
- We cannot just share resources that we won't be reimbursed for, like a nutritionist.
- Look at urgent cares in other countries – in the Netherlands, multiple small practices pool resources to provide afterhours access. A nurse on call get the triage first, then send that person to the afterhours clinic, and they all have the shared records. This is potentially something that we could do in or out of an ACO.
- Urgent care centers operating separately from primary care is what is costly and not helpful.

Dr. Savoy

- Many people who go to urgent care still go to see primary care. They want reassurance in the moment, but then want reassurance from someone they trust after the fact.

Dr. Kushner

- The bills are so high at urgent care because they run additional tests. The relationship with a primary care provider matters and impacts health spending.

Akash Shah

- Our ACO has shared resources, including end of life counseling (specific to Medicare population). In deciding what resources to invest in, we ask does the business case for shared resources make sense? We need to get paid for these investments.
- We are in a transition period between fee-for-service and value-based care. There could be a point where fee-for-service doesn't underpin the reimbursement system, then providers can use the health care spending as they see is most valuable.
- Until there is a sufficient transition to reimbursement by capitated or global rates, we still need to ask, will payers pay for things that work?

Dr. Fan

- What is the current state of value-based payments and what obstacles do providers face when adopting existing value-based models?
- What have you seen in other states in adopting value-based payments?

Dr. Henderson

- As a physician who transitioned from a private practice to an employed model, we recently went through contract negotiation where the contract includes no quality metrics, only volume metrics. The contract reflects a FFS models and these contracts determine how physicians practice.

Sen. Townsend

- Years ago we were discussing value-based payments as the future, and this was supposed to be resolved by now.
- We need more primary care spending, but what does it look like – is it capitation, higher fee-for-service reimbursement, or some other model?

Dr. Gill

- The Medicare MSSP ACO model pays on a FFS basis, but focuses on paying for things that are valuable, and if you do a good job you qualify for shared savings.
- In addition to paying for things that are valuable, you can qualify for additional money. It isn't a model where the shared savings is reducing the upfront reimbursement.
- If all payers adopted this Medicare model we would be in better share, though it is not a perfect answer.

Dr. Fan

- Delaware considered the CPC+ program, but the state did not pursue this model. It provides both a prospective upfront payment as well as a shared savings component. The neighboring states that participate are much more stable primary care than Delaware.
- In the private sector, is CPC+ a feasible model?

Dr. Elliot

- CPC+ gives you money to invest up front in things that the collective wisdom has deemed valuable, including care coordination and practice infrastructure.
- On the back end, there are shared savings and quality-based incentives.
- For savings, there is a question with regard to how much the primary care physician can actually move the lever and produce savings, but the key element is the upfront money to make investments and improvements in the practice.
- Medicare's quality metrics feel more relevant than a lot of the private payers' metrics. We need to figure out what quality metrics get closest to the concept of what is valuable.

Dr. Zarek

- With value-based payments, the payments need to be enough to make it worthwhile for the doctor.
- Even the Medicare ACO payments, the amount of time and staff put into it does not quite make sense for the pay off.

Sen. Townsend

- You need your baseline and incentive payments to be appropriately balanced, with a focus on a sufficient baseline payment.

Dr. Fan

- Within your ACO, did you invest more than you were doing previously, and did you see commiserate outcomes for your level of investment?

Dr. Gill

- We put in too much investment for the potential shared savings pool, and there is no guarantee you will receive anything.

Dr. Elliot

- We put a significant investment in infrastructure and we have no chance of getting return on this investment under the MSSP. Despite this, we made this investment because it is the right thing to do and we need to change the way care is delivered.

Sen. Townsend

- Anecdotes and examples are important, and we need to hear from other stakeholders as well as consider the experiences of other states, but we need to move into specific solutions and steps.
- If it is a fixed amount of money, what is the shift in where health care dollars are spent, and how do we need to achieve this – regulatory, statutory, contract negotiations?

Dr. Savoy

- Doesn't matter what model, if you pay enough for the right thing. The current system pays for doing, not for thinking. Doesn't matter if value-based or FFS, but payments need to pay the provider to achieve the right end, rather than to focus on other endpoints. For example, if you are paying me to get the HbA1c to a specific level as opposed to improving your life, these are two different strategies for caring for someone.
- In moving the spending around, we cannot move it to the patient. Shifting costs back to patient prevents people from getting care.
- By providing first dollar coverage for preventive care services, the ACA has had a great impact in encouraging people to seek preventive care as these services are free to them.

Dr. Zarek

- Primary care physicians are so far underpaid and all we want is to be paid a fair amount. Payers pay specialists much more. Why are specialists making so much?
- No new physicians will enter primary care because they get paid so much less than specialists.

Sen. Townsend

- We need to make sure we have solutions that slow attrition in current primary care physicians and also keep in mind ways to establish a sustained pipeline into the profession.
- The current disparities in pay and profits cannot be explained by simple market forces. But discussing the redistribution of the health care spending is a politically sensitive topic.
- Is it shifting money among providers or from those making the most profits?

Dr. Elliot

- It's amazing what happens when there is a total cost of care model shared among providers. The more people you put under a collective responsibility, more people will react to that.
- By including specialists in these total cost of care programs, they can make tradeoffs between fee-for-service revenue and performance-based incentives.
- Providers can also consider the cost of health care through the eyes of a business owner, which many are concerned about as they employ those working in their practices. This can again place a collective responsibility view on the health care system.

Sen. Townsend

- I have heard from specialists in context of this discussion who do not want to see patients that they shouldn't have to see from a clinical necessity perspective. For good physicians there will be no shortage of people to see.
- We've inflated the specialist side of the market and deflated the primary care side. There is going to be a shift.
- Where are we going to have these conversations?

Dr. Savoy

- As a group, we had a conversation about how often you need to see people with diabetes. Sending more patients to primary care for managing diabetes and sending them to endocrinologist only for clinical complications or failure to reach adequate control helped to reduce the number of appointments with the endocrinologist and the overall system worked well together.

Dr. Fan

- There is opportunity for discussion among our medical profession and increasing collaboration between primary care and specialists.

Dr. Gill

- Talking about specialists and primary care, it's important to broaden this further. The team-based approach is critical, and it must be paid for sufficiently. It is not just about primary care and specialist physicians, but we also need to consider PAs, NPs, nurses, care coordinators.

Sen. Townsend

- And hospitals could encourage team-based care depending on the incentives they have through reimbursement.

Dr. Fan

- How do we incorporate other professionals in primary care? What kind of investment should we make in these other providers?
- ACOs encourage these team-based models, but what private sector or public policy investments should we make?
- The number of NPs in training and in primary care practice is increasing much faster than the number of physicians.

Dr. Henderson

- We have no data on PAs because they do not have a NPI that allows them to bill for their services which documents the care they are performing. We need to decide what the care team looks like and document their contributions fully.

Dr. Zarek

- We have two NPs and one PA; their contributions are valuable to our practice. I would be happy to expand with NPs and PAs, but the financial incentive is not there to open a second practice staffed largely with NPs and PAs.
- They can take care of patients just as well as doctors and they should be utilized more.
- For PAs, they need a physician on staff, but we cannot hire them because we lose money on them.

Dr. Fan

- If you cannot capture that PAs are providing care, then their contribution isn't visible and reimbursed.

Susan Conaty-Buck

- NPs can open their own practices, but they aren't because they aren't paid enough to open practices and they are not staying in Delaware but choosing to practice in other states.

Sen. Townsend

- It sounds like the same forces are at play for NPs and physicians in primary care.
- We are not interested in carving out just the doctors and not addressing NPs.

Dr. Savoy

- Physicians do not like being called "providers" grouped with other levels of providers. This is one feature that turns physicians off coming to a state that calls physicians "providers".

Susan Conaty-Buck

- NPs find being referred to as "midlevel providers" is offensive also.

Dr. Zarek

- Creating a primary care residency track for physicians at Christiana would be helpful.
- In addition, we need some incentive to stay in Delaware, for instance help with student loans.

Sen. Townsend

- Yes, we need to have solutions addressing the payment piece and the workforce pipeline.

Dr. Savoy

- PAs and NPs are expensive still. Community health workers (CHW) get overlooked. They can provide face to face interactions that don't require a clinical provider.

Dr. Fan

- DCHI looked at CHWs recently. One of the sticking points is standardizing training and licensing, determining what is the basic qualification and what kind of work can they do.
- Will we be increasing overall health care spending or shifting spending between parts of the health care system?

Dr. Gill

- Long-term investing in primary care will reduce total spending.
- We might spend more in the short term, but I would just assume you are going to increase spending in the first few years.
- In Rhode Island, they decreased their total health costs in the first year.

Dr. Fan

- One example is the eBright ACO who made a huge investment up front. The CPC+ model makes that upfront investment as well. The assumption is that savings will follow in the future.

Dr. Kusher

- Will the increase result in better quality care? Will family physicians be more satisfied?

Dr. Savoy

- We don't want to do what happened with the ACA where we pretended it wasn't going to cost money and when it did cost money the policy was threatened.
- We should be optimistic you can save money because there are clear populations that would benefit. But we should sell the policy up front as costing money in the early years to help ensure support in the long term.

Akash Shah

- It's not about reducing spending, it's about bending the cost curve and slowing the growth in spending to match economic growth.
- Whose costs are we talking about – public sector or private sector risk?
- These are costs already being incurred by private practices and borne without reimbursement.
- There is evidence for bending the cost curve in the Aledade ACO. While it took 3 years to achieve savings, we able to identify low-hanging fruit. For all three years we were making progress, it just took 3 years to get to a statistically relevant level of savings in order to be paid a portion of those savings.

Dr. Fan

- There are independent practices who cannot make this investment on their own – these are the group that are leaving practice quickly. There are still a significant number of independent practices and these are the practices that we see the greatest attrition among.
- If we assume the primary care investment equals spending and we assume that spending will increase, then hopefully this increased spending will help to build infrastructure and stabilize small practices.

Dr. Elliot

- Whenever talking about calculating shared savings, the raw numbers are adjusted using an algorithm that incorporates based on disease burden, inflation and other factors. It can be easy to talk about global risk and shared savings, but keep in mind the black box approach to these calculations is a huge part of success or failure.
- Medicare has gone a great job with the MSSP, but the black box decreases transparency, so practices are not able to predict what they will actually get in terms of savings.

The meeting adjourned at 5:33 pm.