SB 227 Primary Care Collaborative Meeting

Wednesday, November 28th, 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
Representative David Bentz	David.Bentz@state.de.us

Staff:

Juliann Emory	Juliann.Emory@state.de.us
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Attendees:	**Organization:**
Tyler Blanchard	Aledade
Sarah Schenck	Christiana Care Health Systems
Pam Price	Highmark
Susan Conaty-Buck	Delaware Coalition of Nurse Practitioners
Wayne Smith	Delaware Hospital Association
Kathy Collison	Division of Public Health, DHSS
Faith Rentz	Department of Human Resources
Maggie Bent	Westside Family Healthcare
Dan Elliott	Christiana Care Health Systems
Jim Gill	Medical Society of Delaware
Cheryl Heiks	Webster Consulting
Margaret DeFeo	AmeriHealth Caritas
Alan Greenglass	DCHI
Jennifer Mossna	Highmark
Tom Fitzpatrick	Highmark
Kevin O'Hara	Highmark
Katherine Impellizzeri	Aetna
Chris Morris	Aetna
Elizabeth Staber	Aetna
Andrew Wilson	Medical Society of Delaware/Morris James
Kim Gomes	Byrd Group
Kiki Evinger	DHSS
Emmilyn Lawson	AmeriHealth Caritas

Megan Werner	Westside Family Healthcare
Rose Rivera	La Red Health Center

Introductions and Opening Statements

Aetna

- Chris Morris – VP Network
- Liz Stapper – Market Compliance
- Katherine Palzaeri – Account Executive

AmeriHealth Caritas

- Emily Lawson – Market President
- Margret – COO DE

Highmark

- Tom Fitzpatrick – provider partnerships
- Kevin O'Hara – VB

Highmark opening remarks

- Highmark is actively pursuing value-based reimbursement models
- Highmark is committed to Delaware with nearly 500,000 in the state across all lines of business – commercial and public
- The health insurance business is part of the larger Highmark enterprise – health, vision, dental, stop loss, integrated delivery (8 hospitals and 1,500 physicians)
- Highmark is engaging in key trends:
    - There are evolving customer expectations, and we want consumers to get value out of their health coverage.
    - We have invested in big data, and need to be able to share data with providers
    - We have a growing government business (MA and Medicaid coverage)
    - Highmark is vertically integrated and continuing to expand our IDFS (integrated delivery and financing system) in western Pennsylvania
- Partnerships are critical to Highmark. Highmark has significant provider partnerships across the full continuum of providers, including with the large systems in the state and growing partnerships with primary care providers.
- Highmark's True Performance program is making an impact. Across all states, we have 7,000 physicians involved. It is the second largest risk-based contract in the country with 1.8 million attributed members.
    - In Delaware, we have seen lower emergency department usage and lower readmissions due to the True Performance program.
    - True Performance is continuing to evolve, with the goal of managing the total cost of care.
    - Hospitals and physicians are doing well in quality. Managing total cost of care has been a challenge everywhere.

    - Highmark believes in a robust field deployment strategy. We have invested in data and provider liaisons to provide providers with support and where they can focus their efforts.
    - We have created new data and reporting tools for providers with a focus on making them increasingly user friendly and robust.
    - In the True Performance model, Highmark makes care coordination and lump sum payments (resulting from cost savings) to providers.
- In Delaware, currently 6.4% of Highmark's total medical spending is on primary care.
    - When incentive payments from True Performance are included, and fee schedule adjusted for the January 2019 increases, that share will increase to about 8.5%.

AmeriHealth Caritas

- We do not have the numbers in front of us right now, but our primary care spending does not feel wildly different than what Highmark describes.

Aetna

- Right now, about 60-65% of spending is through value-based payments in Delaware
- The spending on primary care is similar

Dr. Fan

- Other states have targeted achieving 12% primary care spending. We want to know if that target is possible or helpful.

AmeriHealth Caritas

- We have not done the analysis regarding what the right number for primary care spending is.
- It is important to consider other factors like the volume and services that take up a large portion of spending on our Medicaid-specific population. We have a lot of other types of services like long term care, home care, and skilled nursing, that eat up a lot of our spending that are not appropriate for a primary care setting. These are atypical services in other populations, but that we are covering disproportionately. We should that we would need to reconcile how this interacts with a target share of spending on primary care.
- The share of spending depends on your population; this share looks different for Medicaid compared to Medicare or other populations.

Aetna

- We are looking at primary care spending, and the share of spending does vary depending on the programs.
- We have seen the volume and dollars flowing through have increasingly become value-based and we hope to continue to increase value-based payments.
- Delaware is behind eastern Pennsylvania in adoption of value-based payments with 60% vs. 80%.
- Delaware is unique because there are not a lot of acute care health systems. We have seen growth in value-based models though and our goal is to get to 75% over the next 24 months.

Highmark

- The 12% primary care spending from other models – did they address the cost curve

Dr. Fan

- Marie Ganim, the Health Insurance Commissioner in Rhode Island told us that they wanted to increase the total primary care spending over 5 years, recognizing that they might increase costs.

Sen. Townsend

- In Rhode Island, they accepted the premise that spending more on primary care would increase total spending in the immediate term, with the premise that there would be downstream savings.

Highmark

- Another dynamic that we haven't discussed yet is the overall cost in Delaware. Delaware is an outlier with much higher health care costs.
- Most value-based programs have savings attributed back to the provider.
- It is important that we do not lose sight of our customers. We cannot necessarily sell the idea of achieving savings in the long term.

Dr. Fan

- Regarding the timeline to achieve savings, some of the premise of the mandate is that the current investment is making it difficult for providers to see savings down the road.
- With fewer emergency department admissions and other reductions in spending, this savings will come back to everyone.
- With pay-for-value, are you targeting primary care as the biggest bang for the buck?

AmeriHealth Caritas

- As payers, we are trying to understand how the increase in spending will be funded.
- We have to make the case to the customer (typically the state or employer) that the value proposition will benefit them.
- We don't take issue with the premise of increasing primary care spending, but we struggle with where that investment comes from.

Sen. Townsend

- Studies indicate the optimal amount of primary care is higher than what we currently spend, ranging between 12-15%.

AmeriHealth Caritas

- Improved outcomes may stem from increased utilization and higher-value utilization, but I haven't seen anything that shows simply raising the unit cost gives you better health.

Rep. Bentz

- Is there a potential for cost savings?
- To what extent can increasing spending improve access to primary care?
- The idea isn't just spending more but increasing access and seeing greater utilization from more people, not just increasing the unit cost.

Sen. Townsend

- Delaware has among the lowest primary care reimbursement rates in the county. This is a problem that has resulted in a lower supply of primary care physicians.

Highmark

- In the Medicaid space providers in Delaware are making 92% of Medicare (in Pennsylvania that is 54%).

Dr. Fan

- But they also have higher commercial rates in Pennsylvania.
- Returning to the first question, does increasing primary care spending generate savings in the long run or will it not get us a healthier population?

AmeriHealth Caritas

- What is the alternative? Are you proposing we need to increase by more utilization, using FQHCs more?

Sen. Townsend

- Why have not we not optimized how we approach primary care spending?

AmeriHealth Caritas

- Only speaking for Medicaid. Connecting members to primary care providers is a priority. The problem is not finding a provider but finding the member and getting a member to a place where they are comfortable and do not have barriers, like transportation, to seeking primary care.
- We would love for members to take full advantage of primary care services, but there are unique barriers the Medicaid population faces.

Dr. Fan

- At last meeting, FQHCs mentioned that if there were higher care coordination fees they might be able to take care some of those issues that prevent patients from accessing care.

- They might be able to hire care coordinators to connect with patients, but they need financial support for team-based care.
- How do your models pay, a lump sum payment is an upfront investment, then the back-end savings?

Aetna

- Early on, our models are usually upside only and will trend toward downside risk eventually.
- Practices get a fee upfront and upside savings. These are standardized in our models and we are interested in expanding that.

Dr. Fan

- Can you explain why maybe these models haven't expanded more quickly?
- Why are practices leaving or not participating?

Aetna

- Practices need to meet certain thresholds to participate. These are not difficult, but they do need to meet them.
- Many practices are averse to risk. In eastern Pennsylvania practices are less adverse and they have more readiness to take on risk.
- We try to meet practices where they and as they are ready, but that impacts the care coordination payments as well.

Highmark

- We rolled out the True Performance program in 2015. We gave an upfront fee bump to help with building practice infrastructure, then we moved away from fee bumps to care coordination fees.
- Overall, we are making an $83 million investment. Our hope is that the practices who do well invest these dollars in the infrastructure to support the practices.
- We see the glide path in adoption. It isn't as fast as we want it to be, and it is slower in Delaware than in other markets. That difference in adoption is partially due to the lack of competition.
- We are holding primary care providers accountable for the total cost of care, which is a big obligation that they are not ready for. We believe primary care providers are in the best position to manage care. The value-based programs do continue to grow and hopefully, that will continue to grow the share of primary care spending.
- We need savings in total medical cost to get repatriated to the primary care providers.

Dr. Fan

- What about independent practices? Are they able to turn around their practices to achieve cost savings?

Highmark

- West Virginia has had higher reimbursement rates, but also higher total cost of care. We don't necessarily agree with the Rhode Island argument [that higher primary care spending reduces total cost of care] because that doesn't jive with our experience across the board.

Rep. Bentz

- We are just trying to slow the growth in costs, not flatline the costs.

Dr. Fan

- What timeline appropriate? In Rhode Island, they sought to reach 12% in 5 years, but they started at 8%.

Highmark

- If we continue to see the same results on the same trajectory, we can get to 12% there in 5 years. The lump sum savings shared with the primary care providers and the 2019 fee bump are included in that trajectory.

Aetna

- In eastern Pennsylvania, there are larger health systems and a different level of clinical engagement. I don't know if we are at a different level in reimbursement, but the market dynamics vary. The PA practices are more engaged and more likely to meet this target.
- Delaware is an area with fewer independent physicians as well. They are getting purchased by larger systems; they are not leaving practices so much as becoming employed

Rep. Bentz

- What is diagnosis for physicians leaving primary care? We are coming at it from the point of view that primary care isn't as prosperous as other specialties.
- How do we make it more attractive to enter primary care practice in Delaware and to stay?

AmeriHealth Caritas

- I don't know that I would disagree.
- In the Medicaid space, we are shifting our expectations and relying on primary care providers to do more outside of the traditional primary care model that is outside of physicians' expertise and training.
- There are a lot of rules that comes with Medicare and Medicaid which might also play a role in dissatisfaction with primary care practice.

Dr. Fan

- That sounds like general dissatisfaction with the way they have to practice.

AmeriHealth Caritas

- These same issues in eastern Pennsylvania, but they don't have the same capacity challenges as Delaware. These forces are more impactful where there are fewer practices to spread the marginal burden around when one provider leaves practice.

Dr. Fan

- Yes, I agree that the decrease in access increases burden on other practices in Delaware.

Highmark

- We agree with the premise, there is a problem. We see both sides as insurer and provider. This is not specific to Delaware. That is why we partnered with a number of medical schools in an effort to make sure we fill those voids. I don't know that we have an answer for how to convince students to stay in Delaware. We have a scholarship program in place to keep med students in Erie, PA so I'm sure we can in Delaware, but it takes multiple partners to make to happen.

Dr. Fan

- So why can we not provide the care we want to provide? What are we not doing to achieve that?

Highmark

- In Delaware, we have 131 practices engaged in True Performance and we have 37 that are not. We would like to bring those 37 practices into the program or they can make a suggestion to modify the program.
- We cannot simply give fee-for-service rate increases on the prayer that they will reduce costs. We cannot increase the customer's cost and ask them to bet on cost savings.

Aetna

- It is a leap of faith for plan sponsors. We need to keep the customers on board. They want high quality affordable plans.

Sen. Townsend

- If we know that something is high-value and evidence-based then why are we not invested in it, for instance transportation?

AmeriHealth Caritas

- In order to make the investment the customer also has to buy into that value proposition.
- What can you demonstrate in a landscape where premiums cannot be increased, or our customers will shop for another carrier.

Sen. Townsend

- If we know what works, basic things and low hanging fruit, why can you not insist we do those things? Where is the barrier?

AmeriHealth Caritas

- Most of our premium dollars are spent on essential, high-cost services. If there is more utilization on lower acuity services, you may eventually generate cost savings, but you cannot stop paying for high cost services in the meantime.

Sen. Townsend

- Couldn't we identify the most low hanging fruit?

AmeriHealth Caritas

- Because those essential services are the most expensive and you cannot stop providing them, but that leaves a small pot of money for lower acuity problems

Dr. Fan

- Looking at a public policy perspective, we see an unstable provider workforce, which can over burden the remaining primary care system. How do you help me address that by not blaming the consumer?

AmeriHealth Caritas

- Those dollars need to come from somewhere – the purchaser needs to pay more or other providers need to fewer health care dollars.

Dr. Fan

- The pie is only so big so we either need to make the pie bigger or shift slices.

Highmark

- In the commercial business, the pie is not going to increase.

Dr. Fan

- Oregon, the payers were willing to pay a larger part of the pie because they were expecting a savings overall.
- Everyone wants to bend the cost curve.
- I get at least 5-10% of my patients asking if I can recommend a primary care provider. This is a problem impacting the quality of care.
- With higher upfront investment into primary care, you can increase quality and access?

Highmark

- At some point the equation has to include total cost.

Dr. Fan

- All providers are coming to the understanding that they cannot be risk averse.

Aetna

- You have a limited number of facilities in the state and they are all high cost facilities.
- In Maryland and Pennsylvania, you don't have this problem.

Dr. Fan

- And in West Virginia?

AmeriHealth Caritas

- They have more providers.
- Most other states have moved to bundles for hospitals.

Highmark

- We are trying to balance the cost in Delaware. We are pressured to drive it down. This is a total group effort for primary care providers, specialists, facilities, and payers.
- We need more engagement in a program [True Performance] that we believe will work.
- But we also need more competition; getting 100% participation in True Performance will not work.
- We need to work on getting hospitals engaged on bundled payments and getting score carding done for post-acute providers, so we can drive consumers to the highest quality providers.

Dr. Fan

- Can you see yourselves working with facilities to get that done?

AmeriHealth Caritas

- We are working with facilities every day, but the hospitals are a bigger ship to turn around. Compared to a few years ago, there seems to be more acceptance that changes are inevitable. There is a general understanding that the pricing structure is unsustainable.
- These large organizations need make a lot of changes to get to the value-based models. They have workforces and infrastructures and costs that must change. We have some providers getting 155% of Medicaid. We need to get them off a percent of charge model.

Dr. Fan

- The health systems say they fully embrace value-based programs as well, so we are hearing some dissonance. Where is the disconnect?

Highmark

- The devil is in the details. You ask the hospitals to attack their own revenue to achieve savings in the backend. All the hospitals in Delaware are in some value-based model with us. The maturation of that is not where it needs to be, though.

Aetna

- In Delaware, progress is not even close to other areas. We have fee-for-service rates decreasing in Pennsylvania with increasing engagement in value-based models.
- Here, in Delaware, there are health systems that embrace value-based payments, but not at the expense of fee-for-service increases each year.

Dr. Fan

- When you go to practices that are eligible for a practice that cannot do data analysis or care coordination to be successful.

Highmark

- In our presentation we talked about the liaisons that we deploy to make practices successful. But this is for one payer and that can be disruptive to the practice. Some practices have taken us up and some have not. The most successful practices have an all-payer model.

Dr. Fan

- We have seen practices that make a huge effort, but their returns have been less and less.

Highmark

- We made the upfront investment in fee bumps, this is the investment for transformation and we overpaid for it. Then we moved away from that and gave practices the opportunity to earn that much as they realized cost savings.
- The numbers are the numbers. You get the PMPM at the beginning of the year and at the end of the year you get savings.
- The pushback we get from primary care providers is how can they control utilization from other providers.

AmeriHealth Caritas

- Fees are increasing for other providers, which exacerbates the problem.
- You need a comprehensive solution because there are providers who skew the potential savings because they are increasing costs dramatically.
- You cannot increase the percentage that you are spending in primary care, then you need to address to costs in the other services because spending on those other services costs are outpacing the increases in primary care.

Aetna

- You need to look at the bigger picture. The outliers that spike the costs are in the hospitals.

Sen. Townsend

- What I haven't heard is that we still need to address primary care.

AmeriHealth Caritas

- You can double primary care spending, but if the growth rate of what you are spending on other services continues, then you will never get to 12% primary care spending.
- If the hospital systems every year get price increases between 3-5% and that is an arbitrary number. The unit cost increases in hospitals far exceed the unit cost increases elsewhere.

Dr. Fan

- That is because we have such a small pool of facilities. What do you think about a rate cap like in Maryland?

AmeriHealth Caritas

- I don't know if that works for Delaware, but I don't know enough of the ripple effects of capping rates.

Aetna

- I heard that every few years they are threatening to remove the rate cap in Maryland. And they question whether it is sustainable long term.

Highmark

- The rate setting has been in place since the 1970s. If adopted in Delaware, this would be a seachange.

Dr. Fan

- Nanticoke made a strong argument that the crisis is in rural community hospitals, which is related to the primary care capacity crisis.

AmeriHealth Caritas

- We are all in on value-based payments. The benchmarking and quality metrics that have come out are all important and helpful, but we cannot make these changes quickly. We are throwing a lot of resources at it.
- We are open to suggestions, but we must keep insight that we have to keep afloat.

Dr. Fan

- If we lived in a world where we don't worry about who is paying for it.
- What would be a good investment?

Highmark

- We owe this group some facts.
- We said we haven't seen the same trends providing primary care creates savings, but we will get some real data for the group on how many primary care providers are leaving or moving.
- Anecdotally, we can see that providers are moving to concierge, but that trend has slowed. The vast majority of practices remain contracted with us even after they move to concierge.
- The number of practices purchased is relatively small.
- But we have seen a bubble in western Pennsylvania of moving to concierge, but they were unsuccessful. The vast majority have gone concierge through MDVIP.

Dr. Fan

- Were they leaving practice in western Pennsylvania because they were losing money?

Highmark

- No, the industry is becoming more complex and they though a smaller patient practice would make it easier.

Dr. Fan

- Returning to question 5 regarding the administrative burden – would you be willing to invest in some alignment in outcomes and quality metrics so that primary care providers don't feel like they have too many varied metrics. Could that improve efficiencies and decrease cost?

Highmark

- We are happy to collaborate on work like the Common Scorecard or other metrics.
- If that is a burden that is keeping practices from participating, then we want to address that.

Aetna

- We all focus on similar standardized measures like HEDIS metrics.

Dr. Fan

- Would you also coordinate on DHIN or a health care claims database?

Highmark

- Everyone would be on board, but it is more complicated than it sounds.
- I cannot believe that the menu of quality metrics are that different. Our True Performance metrics are 80% aligned with Common Scorecard.
- It is the modality of looking at these metrics, the input and output that is out of alignment.

Dr. Fan

- Also analyzing the data and allowing provider to see their progress.

Highmark

- The cost metrics would be different due to the underlying cost structures.

AmeriHealth Caritas

- The Medicaid metrics are in the MCO contract.

Rep. Bentz

- You said that some Pennsylvania hospitals are lowering their fee-for-service rates?

Aetna

- Yes, that is true because they are lowering FFS rates and volume and they are taking more in value-based payments. They are on a glidepath to shift increasingly to value-based models.

Highmark

- I assume they feel the potential is enough that they are willing to forgo that fee-for-service.

Rep. Bentz

- Are they getting that savings?

Aetna

- Yes, they do analyses beforehand to see potential. We meet with them monthly to help see their progress.

AmeriHealth Caritas

- How long did it take to get them to that place?

Aetna

- They have been in these arrangements for 3 to 4 years, at minimum. Not just in P4P too, they are further up the spectrum of value-based models.
- They are also looking at co-branded products to get market share. We don't see that in Delaware. There is a lack of opportunity regarding the contracted network.

Public Comment

Susan Conaty-Buck

- Have any of you looked at what the practice gets net of what they pay out for all the things they need to spend on?

Highmark

- We know that for our own integrated practice. We can say it is margin accretive. We don't know the cost structures for other practices.

Susan Conaty-Buck

- We talk about people staying in the state – there are perceived stressors to practice in the state.
- They have to be in a place where they feel comfortable and confident that they will have a job. We need to fix the baseline before we can get people to stay.

Megan Warner

- We participate in the Highmark program. There are things that could make the value-based payment work better for us.
- We need an adequate upfront fee to support the team-based care. We need enough money to get the team supported.
- The payments need to be transparent – what do we need to achieve and how do we get there?
- We know where we are with the Highmark commercial patients, but we don't know about the Highmark Medicaid patients.
- There needs to be predictable and stable funding source, so we can invest in resources in a way that works for our budget.
- The solution cannot be monolithic because all practices are different.
- The goals need to be achievable. If you don't hit each metric you get nothing.
- Even with upside only, if we hire care coordinators that is a risk that we are taking on.
- Goals need to be attainable in getting data to you. We only communicate through claims. The system requires clinicians to do administrative work or we need to hire more people – neither is efficient. Going forward we are looking forward to working together. We would love to see a same playing field across all the payers, so we don't think of our patients as their payers. I want all this to be consolidated and aligned.

Highmark

- This is all good feedback.
- We will continue to evolve these programs we have had some reporting glitches due to a system migration that took forever to complete. We want to be as transparent as possible. We would probably make an improvement by moving away from a pass/fail grading.
- We started in a self-reporting metrics, but thought that was a burden, so we moved to a claims-based program so that it would help eliminate the burden.

Susan Conaty-Buck

- The bump in fees at the start of the program went to everyone?

Highmark

- It went to every practice that had signed up. It is not available to practices starting the program now.

Susan Conaty-Buck

- That doesn't provide any investment to help practices get a running start.

Highmark

- It was not for a lack of offering. We can have that discussion about what the practices who did not take up the program in the beginning need to adopt the program now.

Dr. Fan

- Can you send quality metrics and performance based on live data, not on claims data?
- Outcomes-based data is possible rather than a claims-based. Claims data has deficiencies, including a 90-day delay for some.

Highmark

- We are working with a handful of hospital-based practices where we have bidirectional feeds, but not here in Delaware.
- All we can do is report on claims-based data until we get bidirectional.

Aetna

- Depending on the model, we have increased the frequency of data exchange, we are moving in that direction abut I don't think that will change soon in Delaware.

AmeriHealth Caritas

- Don't think we have that elsewhere. We do have some bi-directional in some larger practices.

Art Jones

- Delaware is a high cost state – how much is explained by price or utilization?

AmeriHealth Caritas

- For us in Medicaid, the majority of our spending goes to more atypical services for the population.

Highmark

- The lion's share of the increase is unit cost. It is a combination both including inappropriate utilization, waste. But the lion's share of the driver is the unit cost.

Art Jones

- We are stable on hospital utilization?

Highmark

- My gut tells me that unit price is driving the higher cost.

Aetna

- The underlying unit cost is driving costs in Delaware compared to Pennsylvania.