SB 227 Primary Care Collaborative Meeting

Wednesday, September 5, 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
Representative David Bentz	David.Bentz@state.de.us
Dr. Nancy Fan	nfanssmith@yahoo.com

Staff:

Juliann Emory	Juliann.Emory@state.de.us
Caitlin Del Collo	Caitlin.DelCollo@state.de.us

Attendees:	**Organization:**
Pam Price	Highmark
Andrew Dahlke	Medical Society of Delaware
Steven Costantino	Dept. of Health & Social Services
Geoff Heathe	Christiana Care Health System
Kiki Evinger	Dept. of Health & Social Services
Debbie Hamilton	Hamilton Goodman Partners
Elizabeth Lewis-Zubaca	Hamilton Goodman Partners
Drew Wilson	Medical Society of Delaware
Susan Conaty-Buck	Delaware Coalition of Nurse Practitioners
Dr. Kara Walker	Dept. of Health & Social Services
Art Jones	Health Management Associates
Lisa Whittemore	Health Management Associates
Jean Glossa	Health Management Associates
Kelly Krinn	Health Management Associates
Richard Henderson	Medical Society of Delaware
Faith Rentz	Department of Human Resources
James Gill	Medical Society of Delaware
Sandi Selzer	Delaware Academy of Family Physicians
Chris Manning	Nemours
Kevin Sheahan	Nemours
Alan Greenglass	Delaware Center for Health Innovation
Wayne Smith	Delaware Healthcare Association
Andy Hegedus	Demosophia

Minutes prepared by Kelly Krinn, Health Management Associates;
Minutes formatted by Caitlin Del Collo, Legislative Assistant

Key Themes:

- Investments in primary care need to support long-term sustainability.
- Supporting primary care is more than just reimbursement, but also includes workforce, technology, integrating care, and outcomes and quality reporting.
- Supporting primary care capacity requires both immediate assistance to help existing practices survive and investing in the workforce pipeline.
- Identify and evaluate evidence and data on investments in primary care and the experiences of other states.
- All stakeholders must be engaged in the ongoing dialogue.

Members of the Collaborative – Rep. Bentz, Sen. Townsend, and Dr. Fan opened the meeting

Sen. Townsend:

- The purpose of these meeting is to facilitate dialogue with stakeholders.

Rep. Bentz:

- The health care industry is facing a multitude of challenges
- One challenge is the trend of primary care doctors leaving small practices for large groups, hospitals, and concierge practices, but Delaware needs more access to primary care not less
- The passed legislation increases reimbursement rates for doctors a little bit and set up this primary care collaborative
- The goal of this process is to build consensus about what we can do to maintain and increase access to primary care

Dr. Fan:

- The scope of this Collaborative goes beyond reimbursement. We also want to consider what can we do to build primary care through workforce, sustainability, integrating behavioral health, women's health.
- The bill sunsets in 3 years, so solutions need to be sustainable in the long term once this Collaborative ends.
- Our goal is to have recommendations in December to share with the HCC, and the HCC sends to General Assembly in January
- DCHI and DHCC was already having a discussion on primary care, starting in the spring. Dr. Greenglass from the primary care workgroup will share some of the ongoing work as background and to help guide further research.

Dr. Greenglass presented the work of the Primary Care Work Group from this year

Dr. Greenglass:

- Primary care is essential to population health.
- Broadly defined it includes physical health as well as oral health and behavioral health
- We held listening sessions with consumers and with providers this summer.
    - Consumers have difficult access, confusing and burdensome insurance and cost

    - Clinicians have financial difficulties, administrative burden. Considering switching to concierge
- These challenges to primary care can be observed across the country.
- Simply adding more money to fee-for-service will help some primary care practices temporarily but won't make a sustainable better system.
- A variety of recommendations coming out of the clinical committee and the work of the primary care workgroup:
    - Improve reimbursement
    - Reduce administrative burden
    - Encourage quality improvement activities
    - Reduce fragmentation and improve communication
    - Facilitate centralized services – primary care, behavioral health integration, dental
    - Provide expertise and facilitation such as after hours or IT
    - Tort reform
    - Financial incentives for new physicians
    - Focus on roles of nurse practitioners, physician assistants, and community health worker
- The primary care provider roundtable
    - Primary care physicians are adopting new practice models
    - New payment models can increase investment in primary care
        - Note that these are long-term investments with a long-term return on investment and moving away from fee-for-service models is assumed
    - An inadequate number of medical students are choosing to enter primary care
        - Nationally, most medical students do not choose primary care. And those attending school in Delaware do not stay in Delaware
    - Physician assistants (PAs) and advanced practice nurses (APNs) face barriers in contributing to the primary care workforce
    - Administrative requirements are a significant burden to primary care providers and they impact productivity, quality of life and practice models
- Consumer roundtable
    - It is difficult for patients to find a new primary care provider.
    - Patients with complex conditions face additional barriers to primary care.
    - Communication with primary care providers is inconsistent.
        - The promise of EHR has not simplified health care for clinicians or consumers.
    - Convenient care options like retail clinics and urgent care centers provide important access but can contribute to fragmented care.
        - Records from these convenient care facilities need to be integrated with primary care to reduce fragmentation.
    - Many consumers fall outside the reach of the traditional health care system.
- Drive diagram
    - Payment design that supports integrated care
    - Simple and integration technology solutions
    - Qualified and accessible workforce
        - We need to understand why people are not going into primary care and not practicing in Delaware.

    - Need to engage the population in their health beyond just interactions with primary care providers.
        - This includes a public health emphasis.
    - Streamlined administrative tasks to help reduce the expense on administrative work in practices.
        - From the audience: About 15% of one practice's revenue goes to administrative expense.
- Practice transformation work through DCHI was funded by state and federal money
    - Mostly larger groups participated, not too many small practices participated
- Behavioral health integration is currently ongoing.
    - Behavioral health integration has been successful in other states in improving health
    - A good part of primary care costs can be related to behavioral health
    - One of the impediments to this work is getting the payers on board

The session was opened for questions and comments from presenters and attendees

Dr. Fan:

- For background on the work of DCHI and DHCC, the goal of practice transformation was to bring practices up to a certain level where they would be successful with value-based payments. We wanted practices to reach a level similar to NCQA recognition that would qualify practices for care coordination payments.
- Our goal was to get at least 50% of primary care practices in the state enrolled. We did not achieve this because there was no capital investment from the grant to the practices. The practice transformation program provided coaching but could not pay practices them or invest in them.
- We need to recognize this challenge when we discuss investment and total spending in primary care. Getting practices up to team-based care level will require a certain amount of capital investment from the practices themselves.
- Smaller practices are not as able to cover this capital investment, which explains some of the attrition in these small practices without financial support.
- At the Roundtables, attendees raised issues and challenges, but we need to move into data and evidence-based solutions and actions. Or we need Delaware to invest in pilots to generate this evidence.
- The clinical committee asked for PMPM payments a few years ago, but it might be a different conversation now.
- We need to bring payers together around to what kind of PMPM payment would be worthwhile as an investment in primary care.

Rep. Bentz:

- What gives me optimism is that there are a lot of approaches to these problems.
- Where is the investment going to be the most effective?
- Is there an idea as to what is the most important or have the greatest impact?

Dr. Greenglass:

- Investing in the workforce means investing now to develop a future pipeline.

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    - New data will be available soon about clinicians in Delaware. Looking at how many clinicians are going to be retiring soon.
    - In the short term, invest in primary care providers entering school and training.
    - Investment in PAs, NPs, and CHWs will have a more immediate impact on the workforce because they require fewer years of training compared to physicians.
- Stabilizing primary care providers so they do not leave practice is another immediate concern. Many smaller practices cannot remain viable and cannot compete with Christiana Care or other large groups.
- Need to both stabilize those currently practicing and invest in the future workforce.
- Stabilize by helping practices get paid – concerned with both the amount of payment and the format
- Can payers come together, or does it require regulation to ensure a certain reimbursement?
- We hear a lot about value-based payment. This has been a euphemism for creating more work for providers, but it should be focused on changes in quality and outcomes.
    - Practices need money up front, so the provider can invest and improve quality and outcomes.
- For example, with ACOs, around 40% of Delawareans in Medicare are part of an ACO. Many primary care practices have invested time and money in to their ACOs but have not gotten any financial payback.
    - From the audience: We just got the first Medicare payback after years of investment.

Rep. Bentz:

- Some of these solutions you [Dr. Greenglass] covered do seem clear cut as to what course of action may be available. Others are less clear and need more direction on what can be done, like administrative burden and improving communication.

Dr. Greenglass:

- Integrated information on when consumers are seeking care is important for providers.
- DHIN is potentially a wonderful resource. But we cannot expect small practices to pay the fees to get data from DHIN. As a result, these practices don't know when their patients are seeking care elsewhere.
- We can consider how DHIN funded. Is there a way through the state or venture capital that we are not putting the burden on consumers and small practices to make this resource available?
- DCHI also worked to create a common quality scorecard by working with Highmark and Aetna. Ideally, this would function as the common scorecard for all payers. But even though they helped develop, payers will not use it.
- If a provider has patients from many different payers, they are required to keep track of a range of different metrics and many providers just give up. It's too complicate and their EHRs doesn't necessarily keep up with all the variation.
- Why can't we ask the payers (at least those dealing with state-funded coverage sources) that they need to use a common scorecard.
- If the payers don't change voluntarily, then someone needs to do take action to make the change.

Dr. Fan:

- What we hope to achieve is coming up with a plan for increasing spending in primary care that would help decrease overall health spend, but also increase sustainability.

Dr. Greenglass:

- A two-pronged strategy to sustainable primary care access: 1) ensure that small practices can survive; and 2) make Delaware hospitable to new primary care providers.

Dr. Fan:

- If discussing ramping up primary care spending, we need to include investments in practices themselves, but also in the other aspects of the driver diagram.

Dr. Greenglass:

- Changing primary care delivery requires time and money up front and to-date we have asked the small practices to pay the costs of this change.
- Globally, the U.S. spends more on health care, so the is money there. Support for primary care must come from somewhere else in the system.

Sen. Townsend:

- There has been a great breadth and depth of experience and efforts to date. We don't want to duplicate what others are doing.
- The discussion today has been focused on the reality of what primary care providers experience.
- Thinking about it from the perspective of moving toward the 12% benchmark primary care spending in the legislation, what do we need to move from dialogue to data and operationalizable solutions.

Dr. Fan:

- Related to the 12% of health care spending on primary care – what does that mean and what is our goal for that spending?
- Consider the work in Rhode Island and Vermont.

Wayne Smith, Delaware Healthcare Association [Attendee]:

- We haven't yet discussed the aspect of the legislation that allows HCC to create a system so that we reach 60% value-based payments by 2020.
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Sen. Townsend:

- Everyone is kind of assuming that additional funding for primary care is all through value-based care in some definition.
- One challenge in achieving this goal is dealing with the churn in payers and practices.

Pam Price, Highmark [Attendee]:

- We [Highmark] want to work with everyone on this. As a payer a lot of the changes must include Highmark and we will be an active participant in these discussions.

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Sen. Townsend:

- In an earlier meeting, there was some discussion of provider frustration with payment models.

Dr. Fan

- Highmark operates in other states.
- How do you promote primary care in other states?
- Is there some research/data that Highmark could share based on these different experiences and strategies?

Pam Price, Highmark [Attendee]:

- I have been in discussions where we compare what is going on in other states. Some programs are more successful in Pennsylvania.

Susan Conaty-Buck, Delaware Coalition of Nurse Practitioners [Attendee]:

- I was in the first group doing practice transformation.
- There are so many different parts of the system that need to be addressed. We need to look at this at each step of the way to identify and address barriers to change.
- Where are the other payers? While a number of us work with Highmark, we also work with other payers and we need all those payers to be engaged.
- This is a multi-faceted problem. We need to look at everyone involved.
- I do like looking at other states to identify what is successful.
- I work training primary care practitioners and all they hear is death, depression, and don't work in primary care. We need to take steps to make this an acceptable environment, so they can work successfully.

James Gill, Medical Society of Delaware [Attendee]:

- Our goal is to figure out how to fix this problem for the long term. But is important not to lose sight of the short term.
- The situation is urgent. Practices are currently going to go out of business. Part of this legislation is hoping to stem the bleeding, but that's not being accomplished quite yet. This group needs to ensure that this happens.
- If a practice doesn't have a new contract with the payer in the next couple months they may consider the uncertainty to be too much and close practice. It is critical for small practices to rates and plan for their future.

Sen. Townsend:

- The bill wasn't signed until last week, and rates are not effective until January 1st.
- If there is reason to believe that law isn't going to be complied with that's an issue.
- Complying with a January 1 effective date is the minimum legal obligation, but a payer could give notice on the rates as soon as possible.

Pam Price, Highmark [Attendee]:

- Highmark wants to contract with any willing provider.

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- But Highmark isn't contracting with the Aledade ACO. Is this the specific issue that Dr. Gill is referencing?

Sen. Townsend:

- The question is will there be compliance with the mandated rates by January 1st, and give a clear indication to providers of those rates before that date?

Pam Price, Highmark [Attendee]:

- Provider relations is constantly in contact and in negotiation with providers.
- We are still seeking clarity on a number of questions within the bill.
- Furthermore, we need to invest time to change our system to be compliant. We cannot flip a switch and make this change.
- We are concerned that we will be ready for January 1st. I don't think we are in any position to roll out changes earlier.

Sen. Townsend:

- It's not that you need to flip the switch early. Just that you need to give an indication of what that change will be so providers can plan prospectively.