Primary Care Reform Collaborative Technical Subcommittee Meeting

Thursday, August 13, 2020
9:30-11:00 a.m.
https://us02web.zoom.us/j/82632763612?pwd=ZEJIamkyd1N6WURBNTZQT1BVRi9vUT09
Meeting ID: 826 3276 3612
Password: 493342
Call-In Number: +16468769923

Meeting Attendance

Technical Subcommittee Members:

Present:	**Organization:**
Dr. James Gill	Medical Society of Delaware
Jamie Clarke	Nemours
Lisa Schaffner	Highmark Delaware
Jacqueline Ball	Aetna

Absent:	**Organization:**
Faith Rentz	State Benefits Office/DHR

Staff:	**Organization:**
Leslie Ledogar	Department of Insurance
Mary Jo Condon	Freedman HealthCare
John Freedman	Freedman HealthCare
Vinayak Sinha	Freedman HealthCare

Attendees:	**Organization:**
Ayanna Harrison	Department of Health and Social Services/DHCC
Lincoln Willis	Medical Society of Delaware

The meeting was called to order at 9:33 a.m.

Welcome
The meeting was convened at 9:33 a.m. via web conference. Mary Jo Condon welcomed all members and Vinayak Sinha took a committee member roll call. Jamie Clarke motioned to approve the July meeting minutes, Dr. James Gill seconded. Ms. Condon reviewed the meeting agenda.

Review of Data Analytics Strategy to Inform Affordability Standards Development
Ms. Condon updated the Technical Subcommittee on the different types of data they will consider to provide input into the work of the Office of Value-Based Health Care Delivery. She

discussed that publicly available payer and provider data provided to state and federal regulators, Delaware Health Innovation Network (DHIN) Healthcare Claims Database data, data collected through the Department of Insurance (DOI) questionnaire and rate review process, and the benchmark data would be reviewed as part of determining how to set affordability standard targets. Ms. Condon then reminded the group on the affordability standards being pursued and highlighted the discussion on the primary care investment target as the focus of the day's discussion.

Ms. Condon reviewed the different types of direct and indirect primary care spending and each types fee for service and non-fee for service components as well as the way the DOI questionnaire would be collecting this information. Dr. Gill mentioned that he is most interested in direct primary care spending and that indirect spending may not directly impact primary care. He added that other states' primary care spend targets are generally between 12-15% and sometimes do not include indirect primary care spending. Leslie Ledogar mentioned that it would be important to at least measure the indirect primary care payments to understand how much money flows through the system. Ms. Condon mentioned that although the Office will measure both direct and indirect spending, it has not determined what portion of indirect spending would be included in the primary care investment target. She added that Delaware's statutory definition of primary care providers includes fewer specialties than some other states and therefore we may not expect a primary care investment target of 12-15% and that states typically set targets as 10-12% of total cost of care. Ms. Clarke supported the need for understanding both direct and indirect primary care spending to be able to understand the impact on hospital contracting with payers. Ms. Condon reminded the group that DOI does not intend to recommend how payer-provider contracting should work, but expects that analyses conducted by the Office may help influence these decisions. She also informed the group that DOI was in the process of receiving data from the DHIN for an analysis of facility fees for primary care services and payment rates for primary care services by payer type.

Share Primary Care Spend Analysis Process and Definitions

Ms. Condon mentioned that the primary care spending analysis performed by DHIN for the Health Care Commission/Primary Care Reform Collaborative was performed on professional claims, defined primary care provider specialty according to definitions in Delaware statutes, and considered primary care when a primary care provider performs a primary care service in a primary care place of service. She reviewed the definitions of provider, primary care services and place of service with the group. Ms. Condon discussed how the analysis was performed on a narrow definition of primary care services, aligned with the Milbank Memorial Fund definition, and a broad definition that added additional codes such as care coordination, virtual visits, and vaccine administration. Ms. Clarke pointed out that Federally Qualified Health Center (FQHC) reimbursements were based on cost reports on providing services and asked why there is a need to include their provision of care as they're payments are based on fixed federal Prospect Payment System rates and therefore could not be changed. Ms. Condon said she would look into this further and come back to the group with more information.

Ms. Condon provided reviewed the list of primary care places of service. Ms. Clarke mentioned that primary care provided at certain places of service, such as urgent care clinics or walk-in retail health clinics, do not always have payments flowing to primary care providers. Jacqueline Ball mentioned that urgent care spending does not go to primary care providers and that although walk-in retail health clinics do not manage primary care panels, there is primary care service provision and spending captured at those sites of service. Dr. Gill mentioned that the inclusion of these two sites of service may distort primary care spending analyses. Ms. Condon acknowledged that it would be important to understand how much spending is done at these sites of service and discuss further with the group. Ms. Condon added that consumers view place of service differently as their focus is on where they are able to access primary care services and retail clinics and urgent care facilities are these sites for some consumers. The consumers would not be concerned about who is responsible for them as members of a panel. Ms. Condon mentioned that these payments are important to acknowledge and that for providers managing primary care panels payers and the state compensate them through various other arrangements, such as risk settlements. Ms. Condon added that most states include these sites of service in their definition of primary care and that if these were not included in Delaware, we might expect a lower investment target. Dr. John Freedman concluded that both methods are correct and that if we want to calculate what primary care spending is going to providers managing primary care panels, then we should exclude these sites of service, but that if we want to understand what the state is paying for primary care services, then we should include these sites. A number of technical subcommittee members agreed with this statement.

Review Results of PCRC Analysis of Primary Care Professional Claims

Ms. Condon presented the results of the analysis. She highlighted that commercial primary care spending without the inclusion of pharmacy spending in the total cost of care was 5.6% in 2019, with the inclusion of pharmacy spending it is approximately 3.5% of total cost of care. Ms. Clarke asked whether typical state targets of 10-12% primary care spending as a percentage of total cost of care include pharmacy. Ms. Condon replied that pharmacy is typically included and that states that set targets closer to 12% typically also include behavioral health services and services performed by OB/GYNs. Dr. Gill added that even though most states may set targets around 10-12% that doesn't mean that amount of spending is adequate, he mentioned that other countries spend more than that and that Delaware should consider targets that are robust.

Ms. Condon reviewed results on a per-member-per-month basis and noted considerable increases in the commercial market. She then explained that although there were significant increases in dollar value spending, the increases in spending as a percent of total cost of care were less significant due to high increases in other service categories as well. Ms. Condon highlighted that spending on primary care for adult females was higher than adult males and that analysis also showed that primary care spending was nearly identical for male and female children and seniors. Ms. Condon displayed results that showed that per-member-per-month spending differences between the narrow and broad definitions was not significant and mentioned that In future analyses, we should consider eliminating the narrow and broad categories or group like services together. Ms. Condon reviewed results on who provided primary care services and

whether care was provided in Delaware or out of state. As Ms. Condon displayed results on spending by place of service, she highlighted how low spending in retail clinics and urgent care facilities was and whether this was helpful in determining if they should be included in analyses and the investment target. Ms. Clarke replied that she would like continue to track the difference as analyses are conducted. Ms. Condon agreed that the data should be displayed by place of service to continue to track this spending, particularly as a lot of primary care was delivered as telehealth this year due to the COVID-19 pandemic. Ms. Ledogar asked the group what bodies urgent care facilities and retail clinics are accountable to for the care they provide. Ms. Clarke replied that they are generally privately owned and the Nemours discusses with payers how they keep urgent care centers accountable and that is varied by center. Ms. Ball added that retail clinics are required to communicate provision of care with primary care providers to ensure an appropriate continuum of care. Dr. Gill mentioned that the communication may not impact quality of care provided at the clinic and that there aren't bodies that oversee quality of care provided. Dr. Freedman added that these facilities are inspected during credentialing, that payers have the opportunity to hold them accountable and that Departments of Public Health often do as well. Ms. Ledogar asked Technical Subcommittee members to bring any other questions on the results of this analysis to the Office's attention after they have reviewed results with their organizations.

Discuss How Primary Care spend Analysis Will Inform Development of Affordability Standards

Ms. Condon highlighted next steps in the primary care spend analyses including the data coming through DOI's questionnaire to payers, the DHIN, and including all direct and indirect payments. She reminded the Technical Subcommittee that the Office was to set targets for incremental increases in primary care to achieve a robust primary care system by 2025. Ms. Condon mentioned that increases are typically around 1% of total cost of care a year and that the group would need to consider guidelines on what portion of the increased investment can flow through indirect primary care payments once the data was analyzed. Ms. Ledogar highlighted that the proposed 2021 Medicare Physician Fee Schedule drastically increased reimbursement rates for primary care and asked the group whether they had feedback since in Delaware commercial fully-insured plans are required to reimburse at or above Medicare rates for primary care and chronic care services. Dr. Gill mentioned that this was directionally positive, but that it may not have a significant quantitative impact. Ms. Clarke asked whether this change would apply to commercial self-insured plans and Ms. Ledogar mentioned it would not. Dr. Gill added that Highmark and Aetna have applied an office payment for primary care across all plans, but that the amount was lower for chronic care.

Ms. Condon thanked the group for the lively discussion and brought to their attention that the next meeting was scheduled for September 1st.

Public Comment

Hearing no comments or other business, the meeting was adjourned at 10:52 a.m.