



PRIMARY CARE COLLABORATIVE REPORT 2019



DELAWARE GENERAL ASSEMBLY
STATE OF DELAWARE
411 LEGISLATIVE AVENUE
DOVER, DELAWARE 19901

January 9, 2019

Dear Fellow Delawareans:

An important step along a critical path—this report is the culmination of an expedited review of the drivers causing the primary care crises in Delaware’s health care arena.

Following the requirements of Senate Bill 227 from the 149th General Assembly, we as the three-person Primary Care Collaborative heard testimony and received input from many of the key stakeholders in Delaware. We also examined frameworks implemented or pursued in other states that have endeavored to address primary care challenges. We did this all against the backdrop of established medical research that shows the importance of sufficient spending on primary care—and against a clear backdrop of insufficient primary care spending in Delaware.

The recommendations found herein are necessarily high-level. The primary health care crisis in Delaware is so real, and the need for action so great, that we chose to conduct our hearings as a series of presentations and Q&As, primarily from various stakeholders right here in Delaware. At this stage of our efforts, and given time pressures, there was limited back-and-forth dialogue among different stakeholders themselves. Ultimately, we did not develop a specific path forward; rather, we have expounded a general framework for what the end-goal of primary care stabilization and reform in Delaware should look like. The next step is to convene stakeholders for the kind of iterative dialogue that can result in finding common ground on the path towards that goal and, when positions diverge, identifying effective resolutions.

To be clear, we know our work is not done. We know we proceed concurrently with the important healthcare benchmarking efforts of Governor Carney’s administration—a separate but related framework. And we know not all sides will agree on all aspects of these challenges. We have included several stakeholder letters in the appendix. Although none were formal members of this Collaborative, we felt it was paramount to have their engagement with the Collaborative. We appreciate their input and acknowledge their important roles in Delaware health care and the importance of their continued involvement as we now proceed to a more intensive, dialogue-driven phase.

The coming weeks and months are critical for Delaware’s health care system. As we move forward, we strive to have continued collaboration with deeper analysis, and bold, patient-focused solutions.

Sincerely,

Handwritten signature of Bryan Townsend in black ink.

Senator Bryan Townsend
Co-Chair

Handwritten signature of David Bentz in black ink.

Representative David Bentz
Co-Chair

Handwritten signature of Nancy Fan in black ink.

Dr. Nancy Fan
Co-Chair

Contents

Executive Summary.....	2
Assessment of Delaware’s Primary Care System.....	3
Potential Solutions.....	6
Recommendations and Next Steps.....	10
Appendices.....	15

Executive Summary

Delaware is facing a crisis in its primary health care system. Currently there is inadequate primary care capacity in Delaware to meet the needs of the population. Approximately one in four residents live in a primary care shortage area.¹ This inadequacy is expected to worsen as the average age of the population increases and there continues to be an increasing deficit between new primary care providers coming into practice compared to the rapid increase in providers leaving or downsizing their practices.

One of the root causes of providers leaving or downsizing their practices is insufficient health care dollars being directed towards primary care. Anecdotally, it is estimated that Delaware spending on primary care is at the lower end of the national US average of 4 to 8% of total health care.² Inadequacy in primary care access is reflected in the fact that Delaware has the 4th highest health care spending in the country but also has below-average health outcomes. Recognizing the need to alleviate the current crisis and forge the sustainability of primary care, SB 227 convened the Primary Care Reform Collaborative (the “Collaborative”). Members of the Collaborative are the chairperson of the Delaware Health Care Commission (currently Dr. Nancy Fan), the Chair of the Senate Health, Children & Social Services Committee (currently Sen. Bryan Townsend), and the Chair of the House Health & Human Development Committee (currently Rep. David Bentz). The Collaborative was tasked with developing annual recommendations to strengthen primary care in Delaware, including in the following areas:

- (1) Payment reform
- (2) Value-based care
- (3) Workforce development and recruitment
- (4) Directing resources to support and expand primary care access
- (5) Increasing integrated care, including for women’s and behavioral health
- (6) Evaluation of system-wide investments into primary care, using claims data obtained from the Delaware Health Care Claims Database

As per the legislative mandate, the Collaborative is to meet and collect input from stakeholders representing the health care and patient community. For this first year, the Collaborative convened six public meetings between September 2018 and December 2018 to discuss the current crisis in primary care and how to proceed with recommendations for the sustainability of primary care.

Specifically, the Collaborative had several meetings with primary care providers practicing across Delaware in small independent practices, health centers (FQHCs), accountable care organizations, large health systems, and multispecialty practices. These providers included physicians and nurse practitioners. Other meetings included representatives from health systems, payors, and consumers, as well as input from other model states that have enacted legislation to strengthen primary care through greater investment.

At these meetings the Collaborative heard extensively about the challenges and problems facing the primary care system in Delaware and stakeholders’ recommendations to address these challenges through enhanced investments in primary care. There was a wide variety of viewpoints from the invited stakeholder attendees and from public comment as reflected in the meeting minutes found in the appendix. The Collaborative took these comments into consideration along with other evidence in formulating a framework and in making the below recommendations. The minutes from the public Collaborative meetings can be found in the appendix.

The common framework, identified by the Collaborative and shared across most stakeholders, consists of the following tenants: (1) ready access to quality primary care is essential for the health of the community and is the foundation for an effective health delivery system; (2) Delaware faces a crisis in primary care access across much of the state; and (3) lack of access to primary care contributes to the high total cost of health care. Although the reasons contributing to the high total cost of care are multi-factorial, the Collaborative recognizes that inadequate access to primary care can shift care to higher acuity and more expensive settings, which may result in delayed detection and inadequate management of medical conditions, worse health outcomes, and higher total cost of care. The Collaborative developed the following recommendations to address these concerns through increased investment by the health care system to improve quality and access to primary care across Delaware. While there currently is some system-wide level of investment, the investment is fragmented and clearly insufficient to have prevented the primary care access crisis facing Delaware.

Recommendations:

1. The State should mandate payers to progressively increase primary care spending to reach percentage milestones that eventually account for 12% of total health care spending. Primary care spending should constitute an investment of these funds to effectively meet the medical, behavioral, and social determinants of health of Delaware's diverse population of patients.
2. The increase in primary care spending should not be strictly an increase in fee-for-service rates. It should include an upfront investment of resources to build and sustain infrastructure and capacity, including use of health information technology, as well as support needed for a team-based model of primary care across the range of Delaware's primary care settings. It also should include value-based incentive payments that reward for high-quality, cost-effective care.
3. It is recognized that increasing investment in primary care does not call for an increase in total cost of health care within Delaware and should be compatible with the State benchmarking process of promoting only sustainable increases in total cost of care. This may result in the need for constraints on increases in other aspects of health care costs.
4. Enforcement of this mandate will occur through legislative statute or a regulatory enforcement authority, whether as a new agency or within an existing agency.
5. The Collaborative will continue to work with stakeholders regarding enhancing participation in value-based payment models, initiatives to increase and sustain primary care workforce, and integrating Women's Health and Behavioral Health within a primary care team model.

Assessment of Delaware's Primary Care System

Statistics and Stakeholder Input

As the Collaborative heard consistently from multiple stakeholders, there is inadequate primary care capacity in Delaware to meet the needs of the population. In Delaware, approximately one in four residents live in a primary care shortage area.³ Despite rising demand, the supply of primary care physicians decreased from 80.3 primary care physicians per 100,000 population in 2008 to 71.4 in 2015.^{4,5} As heard at the public meetings, this shortage of primary care has a direct impact on the ability of individuals to secure a primary care provider who will accept their health coverage and, even when that occurs, to obtain a primary care appointment in a timely manner.

At the public meetings, providers expressed pessimism about future capacity of primary care providers in Delaware, given the current state of education and practice opportunities in Delaware. Looking ahead, the supply of primary care providers is not expected to increase and is likely to worsen. Primary

care physicians are aging into retirement, including choosing early retirement, or choosing to leave practice in Delaware due to the financial challenges of sustaining a practice here. Other physicians are choosing to pursue concierge medicine, which typically involves smaller patient panels. The current workforce pipeline is not going to be able to make up for primary care physician attrition. In Delaware, 40% of ACGME residents or fellows are in primary care training programs (compared to 37% nationwide) but Delaware retains only 28.6% of trainees, which is among the lowest rates nationwide (compared to an average retention of 47.5% nationally).⁶

Physicians and advanced practice nurses (APNs) commented in the meetings that although leveraging APNs and physician assistants (PAs) to the full extent of their clinical training can help to address the shortfall in primary care physician capacity, barriers in training and reimbursement remain. In Delaware, the share of primary care physicians who report use of non-physician providers has increased from 39.6% to 55.9% between 1998 and 2013.⁷ The number of APNs and PAs providing primary care in Delaware has increased from 77.4 per 100,000 in 2013 to 106.5 per 100,000 in 2017^{8,9} but regulatory, reimbursement, and training barriers have hindered broader adoption both in independent practice and in primary care team models.

Stakeholders commented that these workforce trends result from a variety of environmental factors that impact the outlook for primary care providers and adversely influence career decisions by the current and potentially future primary care workforce. Providers operate practices in an uncertain regulatory and financial environment; many understand that independent practice is less feasible than ever. Reimbursement favors specialists, diagnostic and therapeutic procedure, and emergency room and inpatient care. Reimbursement levels do not adequately recognize the value proposition of primary care and have been insufficient to sustain the primary care system. Electronic health record systems, managed care requirements, and reporting requirements inherent in new payment models have increased the administrative burden on providers. Delaware is expected to experience greater demand for primary care services as the population expands and ages. The 65 and older population – who consume more health care services than younger populations – will grow faster than the overall state population.¹⁰ Primary care providers face an increasingly complex patient population as the incidence of chronic conditions has increased over the past decade.¹¹

The consequences of these trends, if not addressed, will be further reductions in access to primary care and preventive services, forcing patients to seek care in more expensive settings with poor continuity of care. As the entry point to the health care system, primary care facilitates access to effective preventive care, early management of health problems, and the reduction of unnecessary or inappropriate specialty care.¹² A wealth of research has demonstrated the relationship between the supply of primary care physicians and improved health outcomes including all-cause mortality, self-reported health status, infant mortality, and low birth weight.¹³ Additionally, a greater supply of primary care physicians is associated with lower total health care expenditures, likely related to better preventive care and lower hospitalization rates.¹⁴ Research has shown that countries that orient their health system toward primary care realize better health outcomes and lower costs than countries that invest less in primary care.¹⁵

The importance of primary care is reflected in the fact that Delaware has among the highest health care spending in the country, but a lower share of which is primary care spending, accompanied by worse than average health outcomes. Delaware had the 4th highest per capita personal health care spending in 2014 (behind the District of Columbia, Massachusetts, and Alaska) – totaling \$10,254 per capita, compared to the U.S. average of \$8,045.¹⁶ In Delaware, approximately one in four residents live in a

primary care shortage area. Anecdotally, Delaware spending on primary care is at the lower end of the national range of state spending of 4 to 8% of total health care spending.¹⁷ Despite spending more on health care, Delaware has below-average health outcomes. According to America's Health Rankings, Delaware is ranked the 31st healthiest state – an improvement from 35th in 2014.¹⁸ Key rankings factors include that Delaware is ranked 48th on infant mortality, 42nd on drug deaths, 41st on physical inactivity, and 39th on low birthweight.¹⁹

Without resetting the course to support the primary care system in Delaware, stakeholders predict that there will be further attrition of the primary care workforce and that Delawareans will face increasingly longer waits for primary care appointments and more difficulty finding a new provider. Primary care providers who are inundated with demand for primary care may knowingly or unknowingly discriminate accepting new patients based on the complexity of the patient or the reimbursement rates of the patient's health coverage. The underutilization of primary care preventive services and reduced time to focus on patient education may lead to an increase in patients with preventable or poorly managed chronic health conditions ultimately needing to seek more expensive acute care. Patients will resort to seeking care in the emergency department or from multiple specialists not attuned to coordinating care with each other or addressing gaps in preventive services. It is likely that the economic productivity and competitiveness of Delaware will be negatively impacted by employee absenteeism, employee presenteeism, and escalating insurance premium costs.

State Efforts at Identifying and Implementing Solutions

The State must take a leadership role in fixing the current crisis; no other stakeholder has taken ownership of the problem, has the breadth of authority to influence the health care system in Delaware, or has the magnitude of budgetary interest in addressing the primary care system and health care spending in general. The State shoulders a large share of the health care costs for residents of Delaware, through Medicaid (which covers nearly 25% of residents), state-sponsored coverage for public employees, and uncompensated care costs.

Other states have been actively addressing their primary care access problems, and their experience informed the Collaborative discussions. Furthermore, these approaches from other states can inform what role Delaware takes in addressing the primary care crisis. Notably, Rhode Island and Oregon have introduced legislative and regulatory mandates to increase primary care spending as a share of total health care spending. Other states, like Connecticut, have taken a lead in multi-payer initiatives involving Medicare and commercially insured populations to adopt advanced alternative payment methodologies through CMMI initiatives such as Comprehensive Primary Care Plus (CPC+), State Innovation Model (SIM) Testing Grants, and the Delivery System Reform Incentive Payment (DSRIP) Program.

Delaware, through its SIM Testing Grant, has established statewide goals aimed at reducing the total health spending trend in our state. Delaware sponsored separate Consumer and Provider Roundtable discussions on June 19, 2018 that have informed these legislative hearings. Through the SIM program, the State has also supported primary care practice transformation for over 100 practices and behavioral health integration for 28 practices. Despite this engagement to date on advancing primary care, the State has not developed concrete proposals to address Delaware's primary care shortage.

Senate Bill 227 is intended to address the need to improve the current status by increasing "investment" in primary care in Delaware with both immediate action as well as solutions for long term

sustainability. In addition to convening the Collaborative by the Delaware Health Care Commission (DHCC), enactment of Senate Bill 227 requires new annual reporting process by the Delaware Health Care Commission to:

- monitor spending on primary care
- measure progress on transitioning from fee-for-service to value-based payment for health care services
- provide oversight for health care workforce development in the state
- evaluate how primary care supports state efforts on meeting its benchmark for controlling total health care spending

Senate Bill 227 requires certain payers to set primary care reimbursement rates at level not less than Medicare rates, as well as requires certain payers to pay chronic care management fees, modeled on Medicare CCM monthly fees.

Potential Solutions

Stakeholder Input

Feedback from the Collaborative Public Meetings highlighted a variety of challenges facing the primary care system. Access to primary care is inadequate, with providers leaving practice, exacerbating the already existing access challenges in the state. The regulatory and financial environment is uncertain and difficult to navigate, particularly for those in small or independent practice. Providers mentioned that this inhibits investment in practice resources and contributes to providers leaving primary care practice in Delaware. The administrative burden on primary care providers also contributes to burnout and means provider time and skills are not used efficiently in caring for patients. The practice environment and financial expectations are also a barrier to new practitioners entering primary care or, for those that do, practicing in Delaware. Primary care providers are also challenged by the complex health needs, behavioral health conditions, and social determinants of health for many of their patients. Providers are generally not reimbursed for the important work of care management, addressing social determinants of health that impact health, or other non-billable patient contact that occurs between office visits.

The consensus among providers and health systems was that team-based care is the future of primary care delivery, but that sufficient reimbursement, including upfront payments supporting practice transformation and monthly payments for care management, was essential to supporting these changes in primary care delivery. New reimbursement models must be flexible enough to account for variations in practice readiness to adopt risk-based models but also ensure practices are accountable, in a way that is not overly burdensome, to the shared goals of improving access and quality of primary care. Providers were also concerned about where the funding for increased primary care would come from – namely, if it would represent new health care spending or shifting other spending. In the long term, providers expected increased spending on primary care to shift spending from low-value to high-value services and help to bend the cost curve, but they also warned that stakeholders should expect an increase in spending in the short term. To increase access to primary care, providers also emphasized that solutions should invest in the workforce pipeline, including financial support and training opportunities that will attract new primary care providers to Delaware.

Evidence from the Literature of the Value of Greater Investment in Primary Care

Research demonstrates the value of primary care access and expenditures on patient outcomes and total health care expenditures. A higher supply of primary care physicians is associated with better health outcomes, including mortality, low birthweight, and self-reported health status.²⁰ Greater supply of primary care physicians is also associated with lower hospital and emergency department utilization.²¹ Areas with a greater supply of primary care physicians per capita also have lower total health care costs, in part due to lower hospital utilization rates and greater utilization of preventive care.²² Researchers estimate that adding one primary care physician per 10,000 people is associated with an average mortality reduction of 5.3 percent.²³ When applied to Delaware, an increase of one primary care physician per 10,000 population translates into 471 potentially averted deaths.²⁴

Countries with stronger primary care systems have lower costs and better outcomes, including lower rates of mortality, hospitalizations for ambulatory care sensitive conditions, and low birthweight.^{25, 26, 27} The U.S. has a weaker primary care system than other countries²⁸ and also spends more than twice as much on health care but experiences worse outcomes on life expectancy and mortality compared to other high-income countries.²⁹

One metric to measure the prominence of primary care in a health system is to identify what share of health care spending constitutes primary care. Due to differences in the definition of primary care and accounting of health care expenditures at a societal level, it is difficult to compare the share of primary care spending across states or countries.³⁰ However, it appears that the United States has lower spending on primary care as a share of total health care expenditures than other countries. On average, 24 OECD countries spend 12% on primary care,³¹ compared to the U.S. average of 4 to 8%.³²

Most primary care is still reimbursed on a fee-for-service (FFS) model that pays providers based on the volume of care they provide rather than the quality or patient outcomes. Value-based payments (VBP) can take a variety of models but share in common a shift in how providers are reimbursed, with greater emphasis on quality or value. VBP models vary greatly depending on the risk a practice is able to assume. Models range from simply adding bonus payments for quality outcomes, to payments with upside shared savings and/or downside shared risk on a FFS chassis, to a capitated payment that fully decouples payment from quantity of visits. Primary care models like patient-centered medical homes (PCMHs) and accountable care organizations (ACOs) have demonstrated the potential of effective primary care to improve health and reduce costs.^{33, 34} These models rely on team-based care to provide greater care management and follow-up to patients but can only be sustained with sufficient VBP models that reimburse practices for work that is typically not reimbursed under a FFS payment system.

Not all PCMH and ACO programs have demonstrated the same amount of success. Practices that have adopted a PCMH model for a longer duration have better outcomes, and practices that treat higher risk patients tend to generate greater savings.³⁵ The BCBS of Michigan PCMH program has been in existence for seven years and is one of the most widespread programs. That PCMH model has generated average cost savings of \$26 PMPM for adults while also improving use of preventive services and decreasing emergency department and hospital utilization.³⁶ Practice transformation that targeted clinical resources to patient needs saved 1.7% over a 26-month program and in particular reduced the total cost of care between \$41 and \$737 PMPM for the most high-risk high cost patients, driven largely by a reduction in inpatient spending.³⁷ In Vermont, after five years PCMHs were associated with \$404 per capita annual savings on health care expenditures, in part driven by lower pharmacy expenditures and slower growth in emergency department expenditures, but also were associated with fewer primary care visits per capita.³⁸ Starting in 2016, Vermont adopted a base fee of \$3 PMPM for PCMHs with potential of an additional \$0.50 PMPM based on quality and utilization metrics.³⁹

Not all efforts to increase primary care spending have resulted in savings. The Comprehensive Primary Care (CPC) initiative, launched in October 2012, was a four-year multi-payer initiative designed to strengthen primary care in seven U.S. regions. Participating providers were paid an upfront population-based care management fee and offered a shared savings opportunity. They were expected to deliver five core primary care functions: (1) Risk-Stratified Care Management; (2) Access and Continuity; (3) Planned Care for Chronic Conditions and Preventive Care; (4) Patient and Caregiver Engagement; and (5) Coordination of Care across the Medical Neighborhood.⁴⁰ Participating practices that used the care management fees to improve their practices resulted in improved care management, access, and coordination of care transitions, and were able to slow the growth in emergency department visits by 2 percent, but were unable to generate savings.⁴¹

Due to the challenges in generating savings by simply providing a care management fee, CMS created the CPC+ program, a five-year advanced primary care medical home model launched in 14 regions in January 2017. CPC+ moves further away from strict fee-for-service reimbursement with a hybrid payment consisting of a prospective per-patient-per month payment and a reduced fee-for-service reimbursement rate. The prospective payment is partially at risk based on performance on quality and efficiency metrics.⁴² CPC+ integrates many lessons learned from CPC, including insights on practice readiness, the progression of care delivery redesign, actionable performance-based incentives, necessary health information technology, and claims data sharing practices. The CPC+ care management fee ranges from \$9 to \$100 PMPM depending on patient risk and provider risk appetite.⁴³

Focusing on primary health care spending can generate health care savings and improve patient outcomes. There are examples outside of Delaware suggesting that increased investment in primary care can improve patient health status and longevity while controlling escalating total health care cost trends.

Evidence from Rhode Island

In Rhode Island, the state has granted the Office of the Health Insurance Commissioner (OHIC) broad authority to impact health care spending through their regulatory oversight of payers. Beginning in 2010, OHIC required each insurer to annually increase their total commercial medical payments to primary care. Capital investments in primary care practices, including supporting practice transformation and EHR systems, count toward primary care spending. Currently, primary care spending must represent at least 10.7% of total commercial medical spending, and at least 50% of medical payments should be under an alternative payment model, with a minimum downside risk for providers. Each payer must also contract with a specified share of primary care physicians in PCMHs, increasing annually. To help contain costs as primary care spending is increasing, hospital rates are capped at CPI-U+1% and ACO total cost of care budgets are capped at CPI-U+1.5%.

Primary care spending as a share of total medical spending has increased from 5.7% in 2008 to 11.5% in 2017, exceeding the target of 10.7%. While primary care spending grew 37.2% between 2008 and 2012, total health expenditures decreased by 14%, resulting from both the increase in primary care spending and hospital and ACO rate caps.⁴⁴

The state has also observed other changes in primary care practice. Rhode Island was the only New England state to increase its supply of PCPs per capita over this period.⁴⁵ Primary care practices report being more confident in their ability to adopt alternative payment models. Over 50% of primary care physicians are practicing in a PCMH. While peer-reviewed research is still forthcoming, initial analyses

show lower ED and inpatient care and lower cost among practices that have transformed compared to those that have not. Primary care investments have helped the development of ACOs; more than 50% of primary care physicians are contracted with ACOs under a total cost of care model. In addition to Medicare ACOs, Rhode Island has five Medicaid ACOs that are contracting with health plans under a shared savings arrangement. Physicians have expressed that their practice is more rewarding, even though their income or practice revenue has not increased substantially.

Evidence from Connecticut

Connecticut is using their State Innovation Model grant to influence payment and delivery reform. The design looks to enhance provider performance on shared savings or shared risk arrangements via payment reform for primary care. While ACO models have expanded in Connecticut, with more than 85% of primary care providers affiliated with an ACO and more than one million beneficiaries attributed to a shared savings model, most are not hitting their minimal savings ratio needed to generate a payment from CMS. The state needed to take additional action beyond shared savings models to generate real change in primary care investment. The state executed on their stakeholder engagement strategy, gathering input from key stakeholders, including ACOs, providers, hospitals, payers, and consumer groups. Connecticut is still in its planning process and is hoping to implement its multi-payer model in 2020.

The state's priorities include: building diverse care teams; expanding the ways patients access primary care including email, home visits, and telemedicine; adopting technology that likely has a return on investment, such as patient monitoring or precision medicine; integrating care to better treat behavioral health conditions and address social determinants of health; and developing practice specializations to better treat certain patient subpopulations. Connecticut is developing new primary care bundled payments that cover office visits with supplemental bundles that include a PMPM fee to allow for practices to hire care managers or invest in health information technology. The primary care bundle would be a revenue neutral solution to allow practices to resolve issues with patients outside of the office, via telephone, or email. The bundles would also help reduce the administrative burden of detailed billing.

Connecticut's multi-payer payment reform model aims to gradually double the revenue stream to primary care providers while maintaining total cost of care trend through a combination of upfront supplemental payments to primary care providers who agree to assuming risk on controlling total cost of care.

Evidence from Oregon

In 2017, Oregon enacted legislation requiring commercial payers, state employee plans, and Coordinated Care Organizations (CCOs) to spend at least 12% of health expenditures on primary care.⁴⁶ The latest data as of plan year 2016 illustrates that, on average, health plans in Oregon met the 12% benchmark, with CCOs spending 15.7% on primary care, commercial payers spending 13.6%, employee and educator plans spending 12.3%, and Medicare Advantage plans spending 11.7%.⁴⁷ Plans that do not meet the target primary care spending will have to provide a plan to increase primary care spending by 1 percentage point per year.⁴⁸

The spending benchmarks are the latest in a series of efforts to strengthen primary care in Oregon. In 2009, Oregon established a PCMH program called Patient Centered Primary Care Home (PCPCH). An evaluation of the PCPCH program found that the top quartile of providers in the program reduced health

expenditures by 4.2% over the initial three year period, with reductions doubling between the first and third years of PCPCH recognition.⁴⁹ A \$1 increase in primary care spending related to the PCPCH program resulted in \$13 in savings in other health care like hospital and emergency department spending.⁵⁰ The average annual increase in primary care spending was 3.1% over three years; that trend progressively increased over time from 2.7% in year one to 6.0% in year three.⁵¹ During the same period, the total cost of care decreased 4.2% on average each year, growing in magnitude over time from -3.5% in year one to 8.6% in year three.⁵²

Some precautions should be taken in seeking to apply the results of Oregon's PCPCH to Delaware. The analysis compared utilization and cost of attributed patients of the highest performing primary care practices in the PCPCH program with a matched cohort of patients from primary care practices that were not participating in PCPCH. No comparison was made to the lower performing PCPCH certified practices. There are systematic differences between the PCPCH and non-PCPCH comparison groups that may have biased the results. The first is that larger practices, often health system employed, were much more likely to pursue PCPCH certification than small independent practices. The second is that 53.7% of the PCPCH attributed individuals were Medicaid beneficiaries compared to only 18.1% of the matched cohort, because the CCOs (Medicaid ACOs implemented in 2012) were encouraged to contract with PCPCHs. Oregon adopted the Medicaid expansion in 2012, which could affect the average disease burden of the attributed population. Many of the newly Medicaid eligible population were previously uninsured, unengaged in primary care, and had undetected and undertreated health conditions, and so part of the observed impact may have been due to incorporating them into usual primary care system of care.

It should be noted that none of the models in Rhode Island, Connecticut, or Oregon have simply increased primary care reimbursement rates. In the case of Rhode Island, primary care spending was increased through a combination of both structural payments, including loan repayment, care management fees, and value-based payment opportunities, while at the same time, hospital rates were capped. In Connecticut, the planned investment is strictly in the upfront supplemental payment revenue made with the expectation that primary care providers transform their practices to offer alternative means of accessing primary care services that are not billable and by using a more extensive care team. In Oregon, the primary care spending requirements follow a series of delivery and payment model reforms over the past decade, which had already boosted primary care spending on average to the 12% benchmark.

Overall, the evidence is encouraging that primary care access has positive effects on population health and overall health care spending. There are numerous examples across the country that demonstrate how new models of care, value-based payment models, and investments in primary care can help bend the cost curve and improve the primary care system. Delaware has a tremendous opportunity to adopt solutions that will address the unique characteristics of the state's health care markets to stem the attrition in primary care capacity, improve access to primary care, and limit the growth in total cost of care.

Recommendations and Next Steps

The Collaborative recommends the following:

- 1. The State should mandate payers to progressively increase primary care spending to reach percentage milestones that eventually account for 12% of total health care spending. The 12% target was set based on the favorable experience of Rhode Island and Oregon as summarized**

in this report. Primary care spending should constitute an investment of these funds to effectively meet the medical, behavioral, and social determinants of health of Delaware's diverse population of patients.

- a. This increase will occur either through a 1 percentage point increase per year or within 5 years, whichever is faster.
 - b. This standard will apply to at least Medicaid, MA, self-insured, fully insured, and state employees' health plans.
 - c. Performance will be measured by a standard definition of primary care spending and total medical spending as defined in SB 227.
- 2. The increase in primary care spending should not be strictly an increase in fee-for-service rates. It should include an upfront investment of resources to build and sustain infrastructure and capacity. It also should include value-based incentive payments that reward for high-quality, cost-effective care. It should support a team-based model of primary care across the range of Delaware's primary care settings**
- a. Current efforts to increase value-based payments have not been as successful in Delaware as in other states. Increased upfront investment are essential to encourage broader engagement in VBP.
 - b. The mandate should encourage greater participation in value-based models:
 - i. Increases in primary care spending should be through prioritizing high-value care through a reasonable VBP model with some downside risk that supports the sustainability of small and large primary care practices in the adoption of a team-based care model.
 - ii. The VBP model should include an increased upfront investment, for instance in the form of a sufficient PMPM, that allow practices to obtain essential resources to support a team-based model of care, which requires resources that are not directly reimbursed, including care managers or health IT.
 - iii. The VBP model should represent a net increase in practice revenue, assuming volume and intensity remains stable.
 - c. The mandate should encourage innovative measures to stabilize primary care practices in the short as well as the long term:
 - i. Grant programs funded by the payers for the first five years of the mandate that supports practices, especially those in underserved areas, that require additional funding to enable them to actively participate in VBP models or to address social determinants that impact health. These grants must work toward necessary structural change to support participation in VBP.
 - ii. Other programs that support the primary care workforce pipeline, such as scholarship or loan repayment programs.
- 3. It is recognized that increasing investment in primary care does not call for an increase in total cost of health care within Delaware and should be compatible with the State benchmarking process of promoting only sustainable increases in total cost of care. This may result in the need for constraints on increases in other aspects of health care costs.**
- 4. Enforcement of this mandate will occur through legislation or increased regulatory oversight, assigning enforcement authority to a new or existing agency.**
- a. Stakeholders in Delaware need a framework that ensures sustained implementation to create a predictable environment.
 - b. The implementing authority will ensure the mandate is in alignment with Delaware's benchmarking process and other SIM efforts.

- c. If via regulatory oversight, Delaware will need to create a new office to allow regulatory oversight of plan rates.
 - i. Recognizing the challenge of containing the growth in total cost of care while increasing primary care spending, this regulatory body will assess rates holistically, including specialty and hospital care, with a view to limiting the growth in health care spending and ensuring the sustainability of access across the spectrum of facilities.
 - ii. This regulatory body will also be able to establish a cap on hospital rates to ensure the growth in the total cost of care is limited.
- 5. **The State should convene a representative cross section of stakeholders in 2019 to develop detailed payment models to achieve these recommendations, as well as address increasing and sustaining the primary care workforce.**
 - a. This group will include:
 - i. Providers
 - ii. Health systems
 - iii. Payers
 - iv. Plan sponsors
 - v. Policymakers

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- ¹ [Note: The HRSA-defined primary care shortage areas only account for the supply of primary care physicians, and do not account for non-physician primary care providers.]
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- ² <https://www.delawareonline.com/story/opinion/contributors/2018/05/13/delaware-primary-care-doctors-insurance-reimbursement/603558002/>
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- ³ [Note: The HRSA-defined primary care shortage areas only account for the supply of primary care physicians, and do not account for non-physician primary care providers.]
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- ⁸ <http://www.countyhealthrankings.org/app/delaware/2014/measure/factors/131/data>
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<https://www.pccpc.org/sites/default/files/resources/The%20Patient-Centered%20Medical%20Home%27s%20Impact%20on%20Cost%20and%20Quality%2C%20Annual%20Review%20of%20Evidence%2C%202014-2015.pdf>
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- ²² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/>
- ²³ https://www.jhsph.edu/sebin/m/n/2007_IJHS_Macinko.pdf
- ²⁴ <https://dhss.delaware.gov/dhss/dph/hp/files/mort16.pdf> (Delaware mortality: 8,872 * rate (5.31%))
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Appendices

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:

Senator Bryan Townsend
Representative David Bentz
Dr. Nancy Fan

Email:

Bryan.Townsend@state.de.us
David.Bentz@state.de.us
nfanssmith@yahoo.com

Staff:

Juliann Emory
Caitlin Del Collo

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

Attendees:

Pam Price
Andrew Dahlke
Steven Costantino
Geoff Heathe
Kiki Evinger
Debbie Hamilton
Elizabeth Lewis-Zubaca
Drew Wilson
Susan Conaty-Buck
Dr. Kara Walker
Art Jones
Lisa Whittemore
Jean Glossa
Kelly Krinn
Richard Henderson
Faith Rentz
James Gill
Sandi Selzer
Chris Manning
Kevin Sheahan
Alan Greenglass
Wayne Smith
Andy Hegedus

Organization:

Highmark
Medical Society of Delaware
Dept. of Health & Social Services
Christiana Care Health System
Dept. of Health & Social Services
Hamilton Goodman Partners
Hamilton Goodman Partners
Medical Society of Delaware
Delaware Coalition of Nurse Practitioners
Dept. of Health & Social Services
Health Management Associates
Health Management Associates
Health Management Associates
Health Management Associates
Medical Society of Delaware
Department of Human Resources
Medical Society of Delaware
Delaware Academy of Family Physicians
Nemours
Nemours
Delaware Center for Health Innovation
Delaware Healthcare Association
Demosophia

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.

- 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 complicated 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 there 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.
-

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.

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.

- 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.



PRIMARY CARE COLLABORATIVE

SEPTEMBER 5, 2018

OVERVIEW DR. GREENGLASS

- Address reimbursement for primary care services
- Reduce the administrative burden of practices
- Reduce the fragmentation of the system and improve communication across providers.
- Facilitate centralized services for patients
- Provide expertise and facilitation for clinicians to share
- Institute tort reform to remove the financial and emotional specter of malpractice
- Provide financial incentives for young physicians to enter primary care in DE
- Focus on the roles of nurse practitioners, physician assistants and community health workers



DISCUSSION OF WORK TO DATE

- Provider Roundtable
- Consumer Roundtable
- Driver Diagram
- Practice Transformation
- Behavioral Health Integration





PROVIDER ROUNDTABLE

PROVIDER ROUNDTABLE

- A convening of primary care provider stakeholders to discuss the challenges and opportunities for primary care in Delaware
- June 19, 2018, 5:30-7:30 pm
- Participants were identified and invited by HCC and DCHI
- DCHI facilitated the discussion – gathering information from the participants and from the general audience which included other providers and stakeholders.



ATTENDEES

- Providers and other health system stakeholders including representatives from these organizations:

Represented Organizations

American Cancer Society, Primary Care Systems	Delaware Valley Outcomes Research
American Psychological Association, Center for Psychology and Health	Highmark, Provider Contracting
Christiana Care, Family Medicine	Jefferson School of Medicine (DIMER)
Delaware Academy of Medicine	Mid-Atlantic Family Practice
Delaware Academy of Physician Assistants	Nanticoke Health Services
Delaware Center for Health Innovation	United Medical, Contracting
Delaware Health Care Commission	Westside Family Healthcare



KEY THEMES FROM THE PRIMARY CARE PROVIDER ROUNDTABLE

What we heard:

- Primary care physicians are adopting new practice models
- New payment models can increase investment in primary care
- An inadequate number of medical students are choosing to enter primary care
- 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.



PRIMARY CARE PHYSICIANS ARE ADOPTING NEW PRACTICE MODELS

- PCMH functionality is important, but formal certification* has little value.
 - If certification is required, then it needs to be simpler, less expensive, and financially recognized by payers.
- The trend toward higher patient co-payments and deductibles for primary care services translates into patients wanting all of their issues addressed in a single visit, putting more strain on the primary care provider.
- Primary care physicians who switch to concierge or direct patient care are seeking a model with less administrative burden. This is a primary driver for these physicians.
- The viability of small independent practices is uncertain.



NEW PAYMENT MODELS CAN INCREASE INVESTMENT IN PRIMARY CARE

- Adopting alternative payment models may be a way to increase payments to primary care, but the administrative burden must be minimized.
- Increasing payments in primary care is a long-term investment, although some stakeholders (payers, consumers, employers) want to see short-term returns.
 - *Some roundtable participants advocated for increased FFS payments in the near term. Participants were not in agreement on this issue.*
- In order to engage primary care physicians, value-based payment needs to include a significant upfront PMPM payment.
- Payments for care coordination need to be substantial and should be seen as investments.
- The administrative burden associated with quality metrics has become untenable without clear improvements in patient outcomes or sufficient reimbursement for the additional administrative work.



AN INADEQUATE NUMBER OF MEDICAL STUDENTS ARE CHOOSING TO ENTER PRIMARY CARE

- Students accumulate school debt and are concerned about the financial outlook of entering primary care compared to a higher paying specialty.
- Students entering primary care are looking at health systems or large provider groups as the small independent practice model no longer seems feasible from an economic or quality of life perspective.
- Loan forgiveness programs may incentivize more students to enter primary care.
- To ensure students are prepared to enter primary care, training should incorporate population management under value-based payment models, the business of running a practice, and team-based models of care.
- Foreign medical graduates are a potential source for the primary care workforce, but may lack access to residency programs.



PA'S AND APN'S FACE BARRIERS IN CONTRIBUTING TO THE PRIMARY CARE WORKFORCE

- Physician assistants (PAs) are more likely to work with specialists as it entails a narrower scope of practice.
- PAs find it challenging to find primary care physicians who can afford to hire PAs. Hospital systems seem more inclined to hire APNs.
- PAs are not recognized in Delaware as rendering providers so their services cannot be billed separately. As a result, their contribution to primary care can be overlooked.
- Although lower cost upfront, PAs and APNs may generate more referrals to specialists, increasing overall costs.
- PAs and APNs both would benefit from additional training after graduation, like a residency program, to ensure they are prepared to serve the complexity and diversity seen in primary care practice.
- The residency program at Christiana has been popular and is expanding.



RECOMMENDATIONS OF THE ROUNDTABLE PARTICIPANTS

Primary care physicians are adopting new practice models

- Create a PCMH certification in Delaware that is simpler and less expensive
- Address comprehensive insurance reform that targets the financial liabilities, unpredictability, and burdens that makes running a primary care practice unsustainable

Payment reform can increase investment in primary care

- Increase payments to primary care accounting for the administrative and care coordination work that is required in new models
- Standardize quality metrics across payers and ensure these metrics are clinically meaningful and associated with improving patient health

Few medical students want to enter primary care

- Consider loan repayment for new graduate PC providers to work in HPSA areas
- Provide training in medical school preparing student to run a business
- Increase primary care residency opportunities for foreign medical graduates

PAs and APNs face barriers in contributing to the primary care workforce

- Provide residency training opportunities for PAs and APNs
- Change state law to recognize PAs as “providers”





CONSUMER ROUNDTABLE

CONSUMER ROUNDTABLE

- A convening of consumer advocates to discuss the patient experience when seeking out and engaging with primary care providers
- June 19, 2018, 1:30 – 3:30 pm
- Attendees: A range of consumers, patient advocates, and stakeholders including representatives from:

Represented Organizations

AARP of Delaware	Leukemia and Lymphoma Society
American Cancer Society, Primary Care Systems	Mental Health Association in Delaware
Christiana Care, Patient and Family Centered Care and Resource Management	Wilmington Health Planning Council
Delaware Center for Health Innovation	Patient Advocate
Delaware Health Care Commission	Delaware Division of Vocational Rehabilitation
Health Management Associates	University of Delaware



KEY THEMES: CONSUMER ROUNDTABLE – WHAT WE HEARD:

- 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.
- Convenient care options like retail clinics and urgent care centers provide important access but can contribute to fragmented care.
- Many consumers fall outside the reach of the traditional health care system.



IT IS DIFFICULT FOR PATIENTS TO FIND A NEW PRIMARY CARE PROVIDER

- There is a shortage of primary care providers and geographic disparities in the distribution of providers.
 - Primary care is reimbursed too low to incentivize physicians to stay in practice.
 - APNs can serve as primary care providers.
- Many physicians are leaving practice, retiring, or switching to a concierge model – exacerbating the shortage and forcing more patients to search for a new provider.
- Patients with complex conditions have an even more difficult time finding a primary care provider.



PATIENTS WITH COMPLEX CONDITIONS FACE ADDITIONAL BARRIERS TO PRIMARY CARE

- Patients with mobility impairments lack access to facilities – including basics like scales and exam tables.
- Patients with communications barriers may lack services to ensure they receive appropriately translated care.
- Providers and staff are unsure how to interact with complex patients.
- The burden of coordinating complex care falls to the patient.
- Providers may be unable or unwilling to dedicate uncompensated time to educate themselves on rare complex conditions.



COMMUNICATION WITH PRIMARY CARE PROVIDERS IS INCONSISTENT

- Few primary care providers perform outreach to address gaps in care.
- It can be easier to speak with a provider afterhours than to get through during office hours.
- Most primary care providers have adopted EHRs, but many consumers do not or are not aware they can access their health records.



RETAIL CLINICS AND URGENT CARE CENTERS PROVIDE IMPORTANT ACCESS

- Many consumers are willing to pay more in order to have the convenience of accessing care in this way.
- Records of care are not transferred between retail clinics and primary care providers.
- There is some adoption of telehealth, but barriers include the lack of reimbursement from Medicare.



MANY CONSUMERS FALL OUTSIDE THE REACH OF THE TRADITIONAL HEALTH CARE SYSTEM

- Many people do not normally access health care at traditional sites of delivery.
- There are financial and structural barriers preventing people for accessing health care.
- Providing access to care that meets people where they are – like community centers – may expand access to health care services.
- Accessing mental health care can be an even greater challenge than accessing primary care.



COMMON THEMES FROM ROUNDTABLES

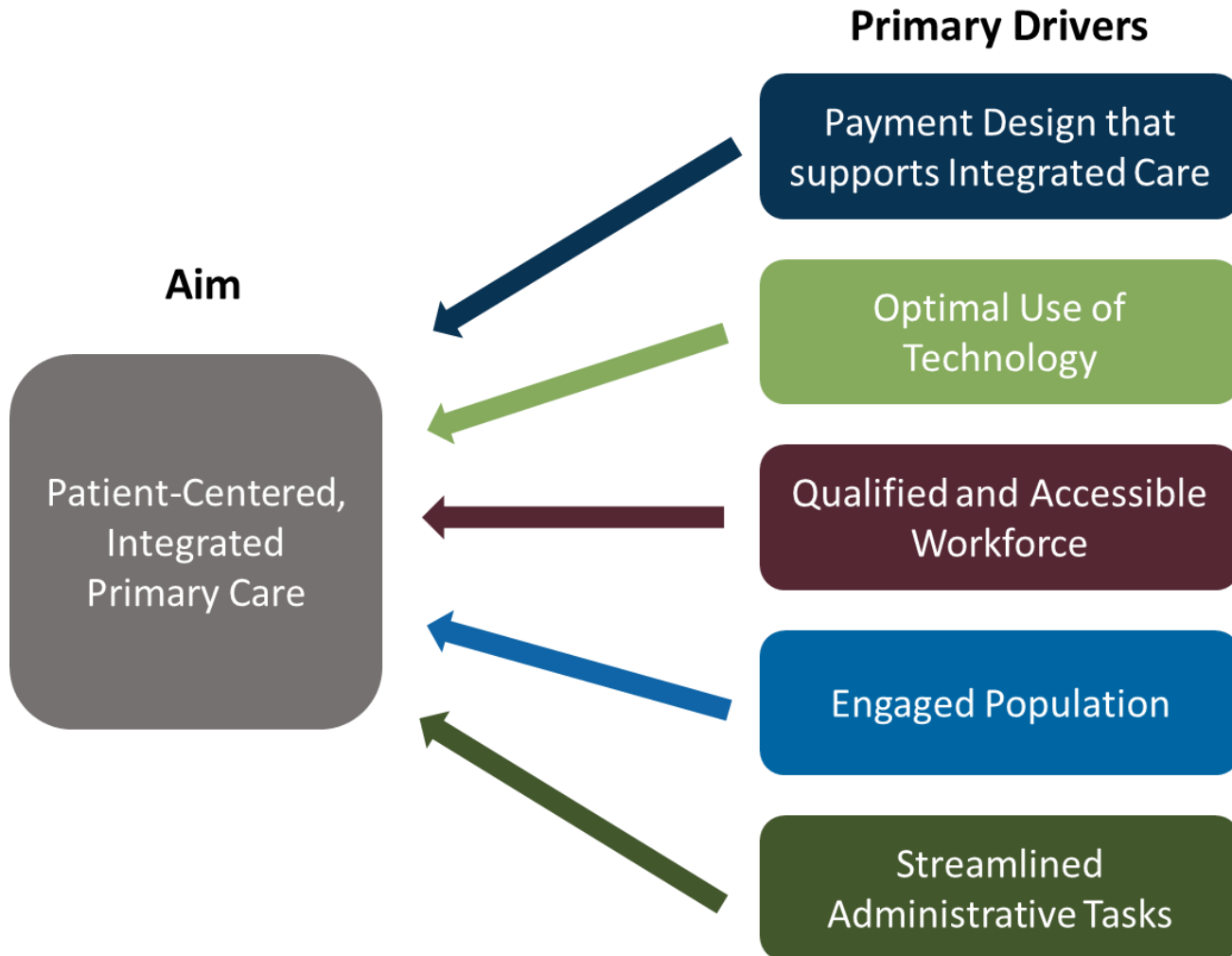
- Pay with models that support primary care
- Reduce administrative burden for PC providers
- Make it easier for people to practice in DE
- Integrate across the health care system
- Enhance the role of PAs & APNs





PRIMARY CARE DRIVER DIAGRAM

DRIVER DIAGRAM





PRACTICE TRANSFORMATION

DELAWARE PRACTICE TRANSFORMATION

- Under Delaware's SIM grant, practice transformation efforts provided practices with customized coaching and technical assistance
- Practice transformation coaching occurred from September 2016 to April 2018
- 112 practices participated encompassing 250 physicians and 100 mid-levels
- The average length of participation was 17.5 months
- Practices made progress on 9 milestones
 - 2016: 4.0 out of 9 on average
 - 2018: 7.4 out of 9 on average
- Reported barriers included:
 - Time and resources to dedicate to PT efforts
 - Adequate staffing
 - Leadership buy-in/ support
 - Leveraging data/ EHRs



PRACTICE TRANSFORMATION MILESTONES

- Participants were expected to make progress toward 9 practice transformation milestones that are representative of the elements of NCQA's PCMH recognition.

Share of Practices who have Passed PT Milestones, April 2018

Milestone 1: Identify 5% of the panel that is at the highest risk and highest priority for care coordination	90.5%
Milestone 2: Provide same-day appointments and/or extended access to care	92.9%
Milestone 3: Implement a process of following-up after patient hospital discharge	86.9%
Milestone 4: Supply voice-to-voice coverage to panel members 24/7	96.4%
Milestone 5: Document sourcing and implementation plan for launching a multi-disciplinary team working with highest-risk patients to develop a care plan	82.1%
Milestone 6: Document plan to reduce emergency room utilization	91.7%
Milestone 7: Implement the process of contacting patients who did not receive appropriate preventive care	84.5%
Milestone 8: Implement a multi-disciplinary team working with highest-risk patients to develop care plans	66.7%
Milestone 9: Document plan for patients with behavioral health care needs	52.4%





BEHAVIORAL HEALTH INTEGRATION

BEHAVIORAL HEALTH INTEGRATION (BHI)

- **BHI work is IN PROGRESS until January 2019**
 - Practices include both primary care and behavioral health/substance use disorder sites and vary in size and complexity of services offered
- The BHI pilot program is divided into two cohorts of practices who receive technical assistance over a six-month period
 - The first cohort - Jan to June 2018 14 practices enrolled
 - The second cohort - July -Dec 2018 28 practices enrolled
 - 28 practices enrolled (all practices from cohort 1 asked to re-enroll)
- **Three tracks:**
 - Fully integrated PC/BH focused on the Collaborative Care model and co-location of services
 - Enhanced referrals- improving referral processes
 - Increasing PC services in BH practices
- Baseline Assessments indicate that 64 percent of the practices will require a high level of transformation efforts to achieve behavioral health/primary care integration



PRACTICE READINESS ASSESSMENT

Evaluation of current BH/PC integration

**Practice/Org
Leadership**
Understanding,
commitment,
involvement

**Practice Team
Commitment**
Awareness,
commitment,
confidence

**Practice
Functions**
e.g., trainings, EHR
sophistication, QI
experience

**Level of
Integration**
In comparison to
chosen track

Screening
Frequency,
intensity and
standardization of
screening

Treatment
Frequency,
intensity, and
standardization of
treatment



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:

Senator Bryan Townsend
Dr. Nancy Fan

Email:

Bryan.Townsend@state.de.us
nfanssmith@yahoo.com

Absent:

Representative David Bentz

David.Bentz@state.de.us

Staff:

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Caitlin Del Collo

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Attendees:

Pam Price
Kevin O'Hara
Stephen Kushner
Andrew Dahlke
Kiki Evinger
Kiara Cole
Susan Conaty-Buck
Dr. Kara Walker
Kelly Krinn
Richard Henderson
Faith Rentz
James Gill
Wayne Smith
Cheryl Heik
Kim Gomes
Kathy Collison
Ron Caviness
Katherine Impellizzeri
Margot Savoy
Adrian Wilson
Deborah Zarek
Dan Elliot

Organization:

Highmark
Highmark
Christiana Care Health Systems
Medical Society of Delaware
Dept. of Health & Social Services
Dept. of Health & Social Services
Delaware Coalition of Nurse Practitioners
Dept. of Health & Social Services
Health Management Associates
Medical Society of Delaware
Department of Human Resources
Medical Society of Delaware
Delaware Healthcare Association
Connections CSP
The Byrd Group
Division of Public Health, DHSS
AETNA
AETNA
Delaware Academy of Family Physicians
Delaware Academy of Family Physicians

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.

Topics for Discussion

Delaware Primary Care Collaborative Meeting Thursday September 27th, 2018

- In your experience, what is the current state of investment in primary care in Delaware?
- 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?
- What is the current state of value-based payments, including as a share of revenue? What obstacles are providers face in adopting existing value-based models?
- What opportunities exist in public policy and in the private sector to improve value-based payments? What value-based models in other states should Delaware consider?
- What structural incentive models or other public policy changes should Delaware consider that would increase the number of recently trained primary care providers? And to what extent should these investments target nurse practitioners, community health workers, and physician assistants?
- What is the magnitude of the potential increase in primary care revenue and how is that potential translating into actual increases in revenue?

SB 227 Primary Care Collaborative Meeting

Wednesday, October 10th, 2018

4:00 pm

Medical Society of Delaware

900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

Present:

Senator Bryan Townsend
Dr. Nancy Fan
Representative David Bentz

Email:

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Attendees:

Andrew Wilson
Dan Elliott
Susan Conaty-Buck
Jean Glossa
Art Jones
Wayne Smith
Andrew Dahlke
Katherine Impellizzeri
Heather Tally
Kara Walker
Caleb Pinder
John Pinder
Jeff Pinder
Pam Price
Leighann Hinkle
Suzanne L.
Kathy Collison

Organization:

Medical Society of Delaware/Morris James
CCHS/eBright ACO
Delaware Coalition of Nurse Practitioners
HMA
HMA
Delaware Hospital Association
Medical Society of Delaware
Aetna
Aetna
DHSS
Student
Student
Parent of Students
Highmark
Department of Human Resources
Highmark
Division of Public Health, DHSS

The meeting was brought to order at 4:04 pm.

Dr. Fan, Sen. Townsend, and Rep. Bentz introduced the guest presenters: Marie Ganim, Health Insurance Commissioner in Rhode Island, and Mark Schaefer, Director of Healthcare Innovation in Connecticut.

Marie Ganim, Health Insurance Commissioner, Rhode Island

- In Rhode Island, health insurance wasn't getting enough attention in the Department of Insurance. Some disruptions in the health insurer market, including insurers leaving the state and harmful business practices spurred the state to action.
- In 2004, the state legislature created the Office of the Health Insurance Commissioner (OHIC) with unique oversight over the health insurance market.
- The OHIC is responsible for:
 - Guarding the solvency of insurers
 - Protecting consumers
 - Encouraging fair treatment of providers
 - Encouraging policies that improve the quality and efficiency of health care service delivery and outcomes
- The responsibility to review and approve rates gives the OHIC broad authority to impact the actions of payers.
- The OHIC has three affordability standards, developed through a transparent and open process with a variety of stakeholders.
 - Care transformation
 - Payment reform
 - Cost growth containment
- In 2008, OHIC began to hold insurers accountable for activities – aligned across payers and identified as community priorities – that will impact the medical cost trend.
- The Health Insurance Advisory Council includes providers, businesses, and consumers, but no insurers. This decision-making body advised OHIC to focus on primary care transformation through four priorities:
 - 1) Expand and improve primary care infrastructure while aligning the insurers so they are working in the same way.
 - 2) Promote adoption of PCMHs. Some payers had already been engaged in this, now all insurers are involved in moving primary care into PCMHs. This model provides extended access and hours, care coordination, and additional services.
 - 3) Promote the adoption of EHRs by physicians. Many independent practices do not have EHR systems, which makes it difficult to hold physicians accountable for care, monitor patient utilization, and track care quality.
 - 4) Implement comprehensive payment reform. The state has tried to embark on a capitated model accounting for patient risk, but the insurers say their systems are not ready to assess the risk and assign patients to practices.

- Beginning in 2010, using regulatory authority, OHIC required each insurer to:
 - Increase their total commercial medical payments to primary care by 1% per year above their 2008 baseline. This was based on the evidence from other countries that spending more on primary care is associated with better health outcomes.
 - Support the expansion of all-payer PCMH. Investments in the all-payer PCMH counted toward the annual spending target for payers. Anti-trust law prevents payers and providers from strategizing together unless facilitated by the state, and the state is still convening these meetings.
 - Invest in the adoption of EHRs by primary care physicians and support the development of the state's Health Information Exchange. These investments also count toward the primary care spending investment.
 - Engage in discussions on comprehensive payment reform and follow the regulatory cap on annual hospital fees for commercial insurance. This regulatory cap started at capping annual increases at CPI-U+2%, then went down to a CPI-U+1% growth cap. This cap applies to fully insured plans, but because these insurers are also administrators for self-funded plans, the cap applies to self-funded plans as well.
- Between 2008 and 2017, primary care spending has increased from 5.7% to 11.5% of total commercial plan medical spending.
 - Each insurer needs to submit a plan of correction if they are unable to meet the annual goal for primary care spending.
 - Insurers propose investments and the OHIC will approve their plans.
 - One insurer invested in community health teams who work to address social determinants of health. The community health teams are staffed by community health workers. The primary care practices linked with these community health teams have a positive view of this investment and appreciate the patient follow-up engagement and service coordination.
 - Another insurer created a pay for performance fund.
 - Overall insurers see the value of these investments. BCBS saw a 2.5 return on their investment in PCMHs.
 - There has been a small increase in the fee-for-service reimbursement for primary care, but most of the investments have been in practice transformation and infrastructure.
- The current Affordability Standards include:
 - Primary care spending must be at least 10.7% of total medical spending.
 - Insurers must have a specified share of primary care physicians in PCMHs, increasing annually.
 - At least 50% of medical payments should be under an alternative payment model, with a minimum downside risk for providers.
 - Hospital rate increase are capped at CPI-U+1%.
 - ACO total cost of care budget increases are capped at CPI-U+1.5%.

- The primary care spending requirement has resulted in care transformation and payment reform:
 - Over 50% of primary care physicians are practicing in a PCMH
 - Primary care investments have helped the development of ACOs, and we have seen that ACOs like working with PCMHs.
 - PCMHs are also using the investment to incorporate new models of care including behavioral health.
 - Primary care practices are more confident in their ability to adopt alternative payment models.
 - More than 50% of primary care physicians are contracted with ACOs under a total cost of care model.
- The previous health insurance commissioner started a public conversation, engaging a wide range of stakeholders across the state. The dialogue was based on evidence demonstrating that primary care investment pays off and used examples across the country to demonstrate options for improving primary care.
- In January, a Health Affairs article will highlight the experience of Rhode Island and the impact of these policy changes in aggregate.
- We have heard from physicians that their practice is more rewarding, even though their income or practice revenue has not increased substantially.

Dr. Fan

- Who are the ACO participants?
- Is there a mandated PMPM requirement?

Marie Ganim

- ACOs most impacted by these state policy changes contract with Medicaid MCOs and commercial payers, though some only contract with Medicaid.
- There is a PMPM recommendation, but it is not mandated by the Health Insurance Commissioner. One of the advisory groups that discusses costs came up with an appropriate PMPM for the practice transformation period and for post-transformation period.

Mark Schaefer, Director of Healthcare Innovation, Connecticut

- Connecticut is a high health care spending state, like most New England states. Medicaid has been better at containing the growth of expenditures due to the rate control resulting from the switch from managed care to fee-for-service and the PCMH investment.
- Connecticut is using their State Innovation Model grant to influence payment and delivery reform as well as some health IT investment.
- Connecticut is about 1.5 years into SIM implementation; the design work began in 2013 soon after MSSP implementation.

- Commercial payers emulated the MSSP model and ended up coalescing around 15 “Advanced Networks” or primary care based ACOs.
 - More than 85% of primary care providers are affiliated with an ACO.
 - More than a million beneficiaries are attributed to a shared savings model.
 - Commercial payers have worked on quality metric alignment.
- Connecticut has observed limitations of this model. Despite the ACO model and the promise of shared savings, primary care remains largely untransformed and participating practices have seen little or no savings under the MSSP.
- Connecticut has seen ACO investments in closing gaps in care (testing and screening), increased care coordination, and the start of health risk stratification.
- Some of these limitations are because hospital ACOs still mostly use fee-for-service and most physician owned-ACOs don’t have the capital to invest in risk-based models.
- We need to bake-in the investment as part of the new normal and drive improvement in a way that delivers return. Despite our broad participation in MSSP, only one provider earned any shared savings.
- Shared savings was not enough to drive improvements and investments, so the state needed to take additional action.
- Connecticut assessed the research into primary care investment in the U.S. to highlight some possible ways the state could take action.
- The state conducted an analysis on their health expenditures and is working to standardize how researchers define primary care and measure health spending with a consortium of other new England states.
- The state released a report with recommendations for primary care modernization, including goals of:
 - Expanding and diversifying care teams
 - Expanding patient care and support outside of the traditional office visit
 - Double the investment in primary care over five years through more flexible bundled payments
 - Reducing the growth trend in total cost of care
- These goals were built on the foundational assumptions that
 - Participants must be larger groups and systems because small practices don’t have enough resources to make these changes
 - The process must be multi-payer
 - Existing shared savings programs will introduce downside risk
 - Introduce new primary care bundles
- They had a lot of feedback on the report and got positive feedback on the direction of the recommendations.
- Having a stakeholder engagement strategy, the state met with people to gather input on what policies must be included in the transformation plan. Key stakeholders included ACOs, providers, hospitals, payers, and consumer groups.
- A variety of advisory and design groups were engaged throughout the design process.

- The areas of emphasis focus on increasing the ability of primary care to meet patients' needs. These priorities include:
 - Identifying the members of a diverse care team and building these teams through targeted investments.
 - Defining the ways patients should engage with providers including telephone, email, home visits, and telemedicine.
 - Assessing and incorporating technology that provides a return on investment and improves care including patient monitoring, precision medicine, and e-consultation.
 - Integrating and specializing care, for instance integrating behavioral health, connecting patients to social supports, and developing practice specializations to better treat certain patient subpopulations.
- Connecticut is also developing new primary care bundled payments that cover office visits with supplemental bundles that include a PMPM to allow for practices to hire care managers or invest in health information technology.
- The primary care bundle would be a revenue neutral solution to allow practices to resolve issues with patients outside of the office, via telephone or email.
- The bundles would also help reduce the administrative burden of detailed billing.
- For ACOs, the only savings opportunity is to have a lot of sick patients, Connecticut recognizes the need to have solutions that keep people healthy by incorporating evidence-based prevention into primary care.
- Some SIM states are engaged with CMMI in creating a custom demonstration, Connecticut might be able to take advantage of this flexibility which would align Medicare payment approach for MSSP to the state's approach.

Dr. Fan

- These presentations highlight two different approaches and states in two different places in the design and implementation process.

Rep. Bentz

- What were the key components that contributed to the slowdown of health spending growth in Rhode Island? To what extent is it attributed to the primary care spending?

Marie Ganim

- The analysis takes a comprehensive view of the various policy changes. The researchers hesitated to separate out the primary care investment and hospital cap as the specific cause.
- Other researchers have been doing comparisons between those practices participating in the primary care investment and those not. Those practices that have transformed have

lower ED an inpatient care and lower cost. These are not the results of a rigorous research study, but we expect to have that research later.

Rep. Bentz

- Has the hospital rate cap impacted consolidation?

Marie Ganim

- Rhode Island's experience has been no different than that of other states. Smaller community hospitals have struggled, and we are also experiencing market consolidation. We do not think these are not related to the hospital rate cap.
- The cap has been about a 3% increase per year. No one has cited the cap as a problem; they have cited the low Medicaid and Medicare rates as the real problem.

Steven Constantino

- There is a large number of small independent practices in Delaware who do not have capacity to transform. What have you done to address these practices' challenges, for instance sharing services or EHRs.

Mark Schaefer

- It has been a challenge for the ACOs to influence these small practices, not only because they are separate, but also because of the culture at that level.
- We have seen that ACOs develop care management hubs that are assigned to practices and provide support to combined sets of panels of small practices.
- The ACOs are able to digest and analyze data for the small practices.
- It is tough for ACOs to deal with a lot of different EHRs from many different small practices.

Marie Ganim

- We have found that smaller practices want to transform, but they are so busy with patient care that they are unable to spend the time to change. That is where the Collaborative provided facilitators help provide advice and implement changes, provide insight in to what local resources may be shared.
- Some of the most efficient and effective PCMHs are the little practices, but they need help to transform.

Dr. Fan

- Our SIM implemented a practice transformation initiative. Because we could not give SIM funding directly to the practices to assist with transformation, we had four vendors who provided the practice transformation coaching.

- We only had 40% involvement because the practices still found the time to be a burden to adopt the changes and they had extra no resources to make the changes.

Mark Schaefer

- You [in Rhode Island] saw investments in nurse care managers, EHRs, and pay for performance. What other areas have you seen improvements in?

Marie Ganim

- BCBS is funding pharmacists in the practices and behavioral health integration.

Mark Schaefer

- And you said BCBS experienced a 2.5 return on their investment in primary care?

Marie Ganim

- Their analysis was not made public, this research came up as part of the justification in the rate review process. There is a press release outlining this finding though.

Mark Schaefer

- And Rhode Island's PCMH strategy is to use the NCQA certification?

Marie Ganim

- Yes, we have two options, NCQA and a state-level recognition. We are trying to get all through NCQA to reduce the state's burden, but practices find the NCQA recognition to be a financial and administrative burden.

Mark Schaefer

- Connecticut is considering this burden of recognition for practice transformation. It seems it is more valuable for practices to understand how to make the transformation, but sustaining a formal recognition is not necessarily worth the cost.

Dr. Fan

- Connecticut is undergoing these changes as a part of your SIM model. Is there a stated goal for the total spending on primary care?

Mark Schaefer

- Primary care modernization is our sustainability strategy to be launched on the heels of SIM. We have been hobbled by the slow implementation of the APCD which has prevented access to data.

Art Jones

- One concern with the CPC+ advance payment model is practices' concern that they may have to pay back this funding after the fact, preventing them from using this funding on investment in their practices.

Mark Schaefer

- When we talk to CMS, they made clear that any deal would have to have a significant return on investment commitment and requires that providers accept downside risk. They are heading that way with the MSSP.
- In terms of messaging, we have talked about not putting the primary care investments at risk. Our talking points are that this is a standing commitment, but you need upside and downside risk of 2% to participate.
- With market consolidation like the Aetna-CVS merger, you will have beneficiaries who can access convenient care on every corner. Primary care will continue to change even more in response to the changing market.

Art Jones

- How did Connecticut get commercial payers to agree to a CPC+-like model?

Mark Schaefer

- We have had good payer participation in the shared savings model and a willingness to help design. We expect the few largest payers to come to engage and participate going forward since we have developed good relationships.
- We need to share data that illustrates payers can achieve a return on their investment.
- Engagement with the employer advisory group is an important strategy because payers can hide behind the self-funded plans. Having a separate group for self-funded employers helps to identify their concerns and willingness to engage.
- I have never seen a hybrid option of payments (upfront payments combined with a bundled/capitated model) Are there merits to the hybrid model?

Art Jones

- Not that I can see, you end up chasing opposite incentives when you have FFS and capitation in the system.

Marie Ganim

- We are looking at bundled payments for specialists and primary care capitation. Hopefully they are complimentary.

Dr. Fan

- Is Connecticut considering transitioning from fee-for-service to a capitated model directly?

Mark Schaefer

- We are moving to value-based payments including a population-based PMPM that includes office visit revenue as a bundle.
- The CPC had a reduced fee-for-service rate and a population-based component, which is the worst of both worlds because physicians still had to completely document for the fee-for-service component but didn't have the flexibility to provide care as they see best without sacrificing revenue.

Sen. Townsend

- What prevents Connecticut from adopting the strategies implemented in Rhode Island?

Mark Schaefer

- The two most important changes in Rhode Island are the caps to the hospital and ACO benchmark rates. These strategies are difficult politically in Connecticut where the powerful hospital community would oppose capping hospital rate increases.
- Because our Medicaid is fee-for-service, all the market consolidation has not translated to reimbursement increases, but as a result all unit cost increases are being transfer to the commercial sector.
- Regulating the fully insured market is tough because increasing regulations on fully insured plans drives beneficiaries into the self-insured market.

Marie Ganim

- Our hospital and ACO caps are regulations, not state law. It would be very difficult to pass those policies through the legislature.

Sen. Townsend

- You have the power through regulation. What can Delaware do by regulation?

Vince Ryan

- At the Delaware Department of Insurance, we do not have authority to do something like this.

Sec. Walker

- This regulatory authority doesn't exist in DHSS or DOI. The state could consider making changes to the Medicaid market through MCO arrangements, but not more broadly.

Sen. Townsend

- In the next meeting we are planning to have payers and hospitals
- What characteristics about Rhode Island's approach are unpalatable for the Delaware stakeholders?

Marie Ganim

- Delaware and Rhode Island are among the lowest paying state for primary care physicians. Rhode Island has not seen an increase in the income of primary care physicians despite increasing investment in primary care.

Sen. Townsend

- In Rhode Island, this was an overall system goals in Rhode Island and not about specifically improving provider's income.

Dr. Fan

- Which stakeholders' buy in was most important?

Marie Ganim

- In Rhode Island, statewide outreach was very important. The insurers were active and willing to work with us.

Sen. Townsend

- Regulatory authority helps but facilitating conversation and providing an environment for engagement is essential.
- We have heard from insurers that they are on it and its happening but haven't seen the proof.

Marie Ganim

- This is where Rhode Island is with insurers on implementing capitation. We need to declare an implementation date at a certain point. Do they have the capability or not?

Mark Schaefer

- We spent a lot of time listening to stakeholders' frustrations and we made sure to address these key pain points.
- We talk to consumers about community linkages, social determinants, and convenient care.
- The performance including readmissions and chronic care outcomes are concerns, but not really the focus. This doesn't resonate with physicians. Showing physicians what a bad job they are doing isn't something they respond to. What we talk about instead, is how

hard it is for them to do their job and what it takes to get their work done. Physician burnout needs to be in a measure of success.

- We bring consumers and physicians to talk to legislators and other consumers and physicians.
- With the hospitals, it was a discussion about the potential for disruption in the current climate. There are areas where hospitals need to remain competitive and areas where they don't want to spend more resources like diabetes and chronic conditions.
- It makes no sense to have a capitated payment model within capitated Medicaid MCOs. Medicaid is the biggest self-funded product – so we work directly as a self-funded plan and move providers to global budgets outside of the MCOs.
- Consumers push back against MCO capitated because of excess of prior authority in the late 1990s. Consumers mistrust the constraints that result from managed care and the challenge of a physician's fiduciary interest that is not aligned with consumer care.

Delaware Primary Care Collaborative Meeting Topics, October 10, 2018

- What were the challenges facing primary care in your state prior to adopting policies to increase investment in primary care?
- What policies did your state adopt to increase investment in primary care?
 - How did your state agree to target investing 12% of health care spending on primary care?
 - Has spending on primary care increased through reimbursement increases and/or through investment into infrastructure, IT, and workforce?
- How did your state come to consensus on how to increase investment in primary care? Which stakeholders' buy-in has been most essential to successful implementation?
- Did your state increase spending on primary care while controlling the growth in overall health care spending?
- What outcomes have you seen to-date? How have these compared to your expectations?

RHODE ISLAND'S NOVEL EXPERIMENT

REBUILDING PRIMARY CARE FROM THE INSURANCE SIDE*

Delaware Health Care Commission

October 10, 2018

Marie Ganim, PhD

Health Insurance Commissioner

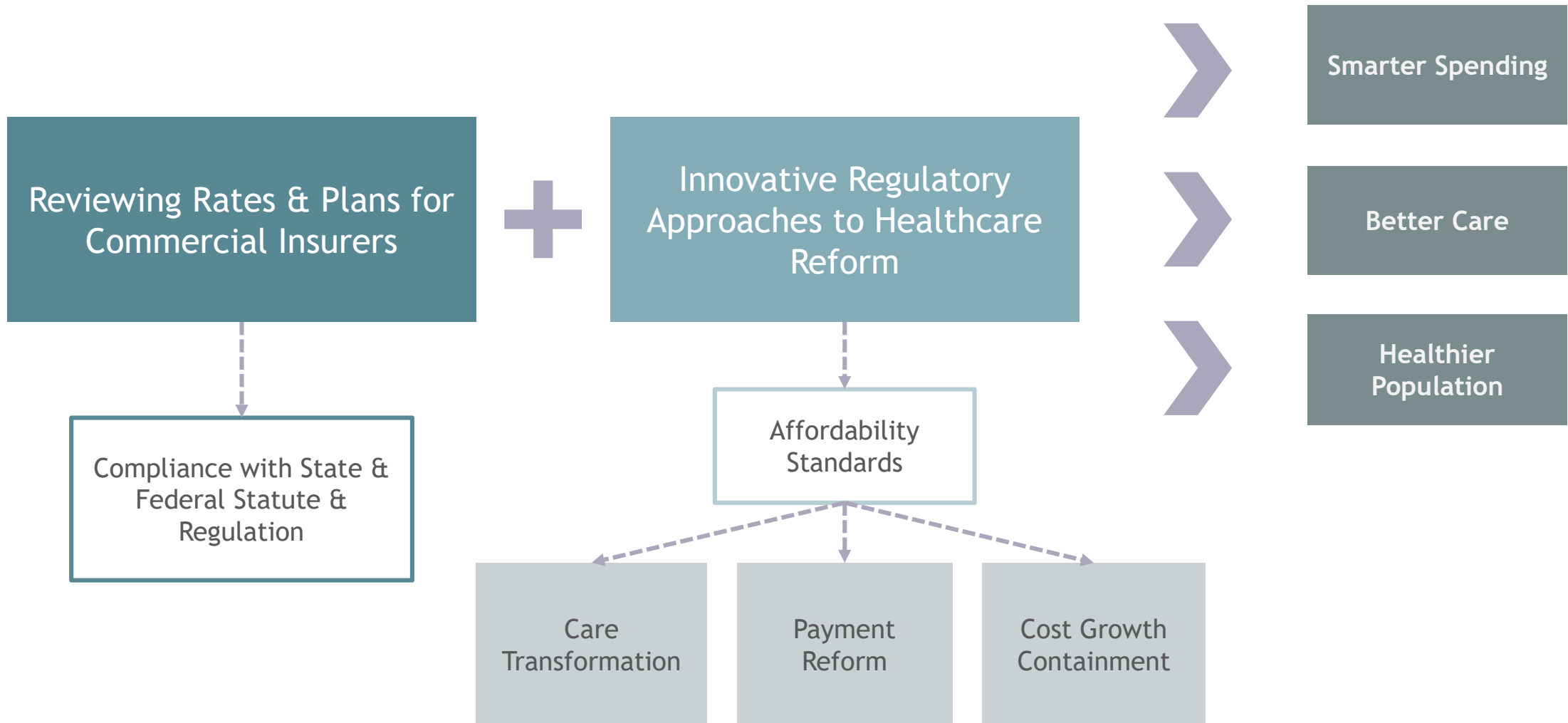
OHIC's Statutory Charge



OHIC was created by the legislature in 2004 with the specific charge to:

- Guard the solvency of insurers
- Protect consumers
- Encourage fair treatment of providers
- Encourage policies that improve the quality and efficiency of health care service delivery and outcomes

OHIC Theory of Action



Insurer Affordability Initiatives & The Role of Regulation

In 2008, OHIC began to hold insurers accountable for implementing policies that improve health care affordability by leveraging the annual rate review process.

Rationale:

1. Insurer activities can affect medical cost trends.
2. Reasonable alignment of policies and actions by insurers is possible and beneficial to achieving systemic goals. Without alignment, insurers' affordability efforts limited by ability and willingness of each insurer to influence change.
3. Communities can identify system priorities in public discussion of trade-offs.

Framing the Affordability Standards

OHIC was advised by its Health Insurance Advisory Council to focus on primary care transformation. Council recommended 4 priorities *to guide insurer action* to advance health care system transformation broadly:

1. Expand and improve the primary care infrastructure
2. Promote the adoption of patient-centered medical homes
3. Promote the adoption of electronic health records by physicians
4. Implement more comprehensive payment reform

These recommendations became regulatory requirements for insurers to follow.

The Affordability Standards

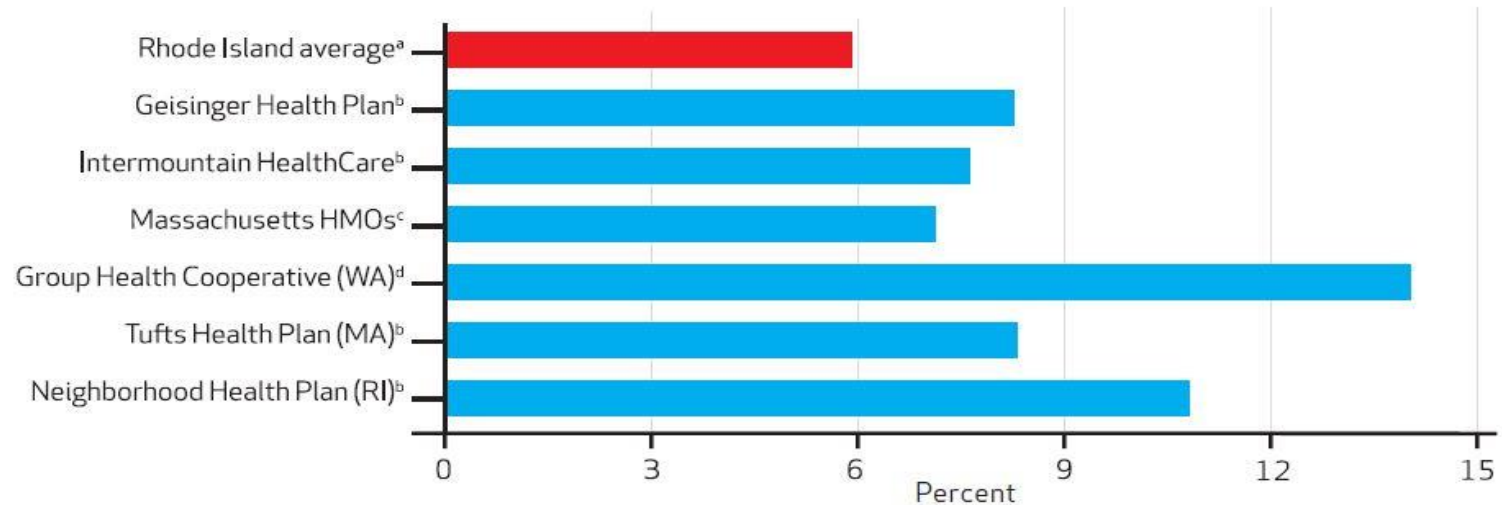
Beginning in 2010, each major insurer was required to:

1. Increase the percentage of total commercial medical payments allocated to primary care by 1% per year above their 2008 baseline, for 5 years;
2. Support expansion of RI's all-payer PCMH program (investments counted toward the annual primary care spend target).
3. Invest in the adoption of electronic medical records by primary care physicians and to support the development of the state's Health Information Exchange (counted toward primary care spend target).
4. Engage in ongoing discussions on comprehensive payment reform; later, included a regulatory cap on annual hospital fee schedule increases for commercial insurance.

The 2008 Primary Care Benchmarking Analysis

EXHIBIT 1

Primary Care Spending As A Percentage Of Total Medical Spending, Rhode Island Average (Baseline) And Benchmarks From Six Large Insurers

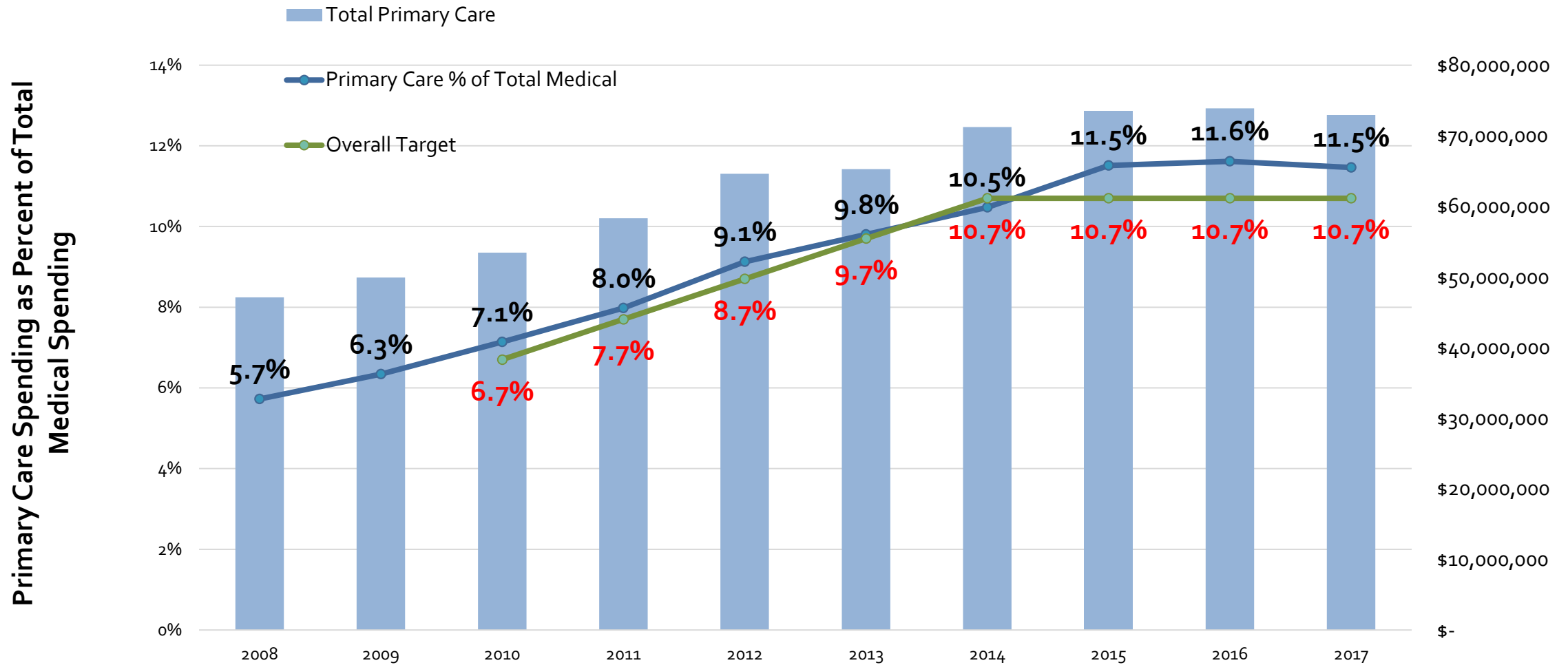


SOURCES Office of the Health Insurance Commissioner, Rhode Island; and various other sources (see below). **NOTES** The Rhode Island average is the mathematical average of the two largest commercial insurers in the state, Blue Cross Blue Shield of Rhode Island and UnitedHealthcare of New England. The Rhode Island target is 10.9 percent, which is the current rate plus five percentage points, as set in affordability standards. ^aPlan-specific spending rates are greatly influenced by membership mix. ^bSource: Self-reported by insurers. ^cSource: Oliver Wyman Study, 2008 Sep, based on commercial, fully insured health maintenance organizations (HMOs) only. Primary care includes obstetrics/gynecology; excludes pay-for-performance. ^dSource: Wagner EH, director of the MacColl Institute for Healthcare Innovation, Center for Health Studies, Group Health Cooperative. Group Health Cooperative is a group-model HMO with owned facilities, like Kaiser Permanente.



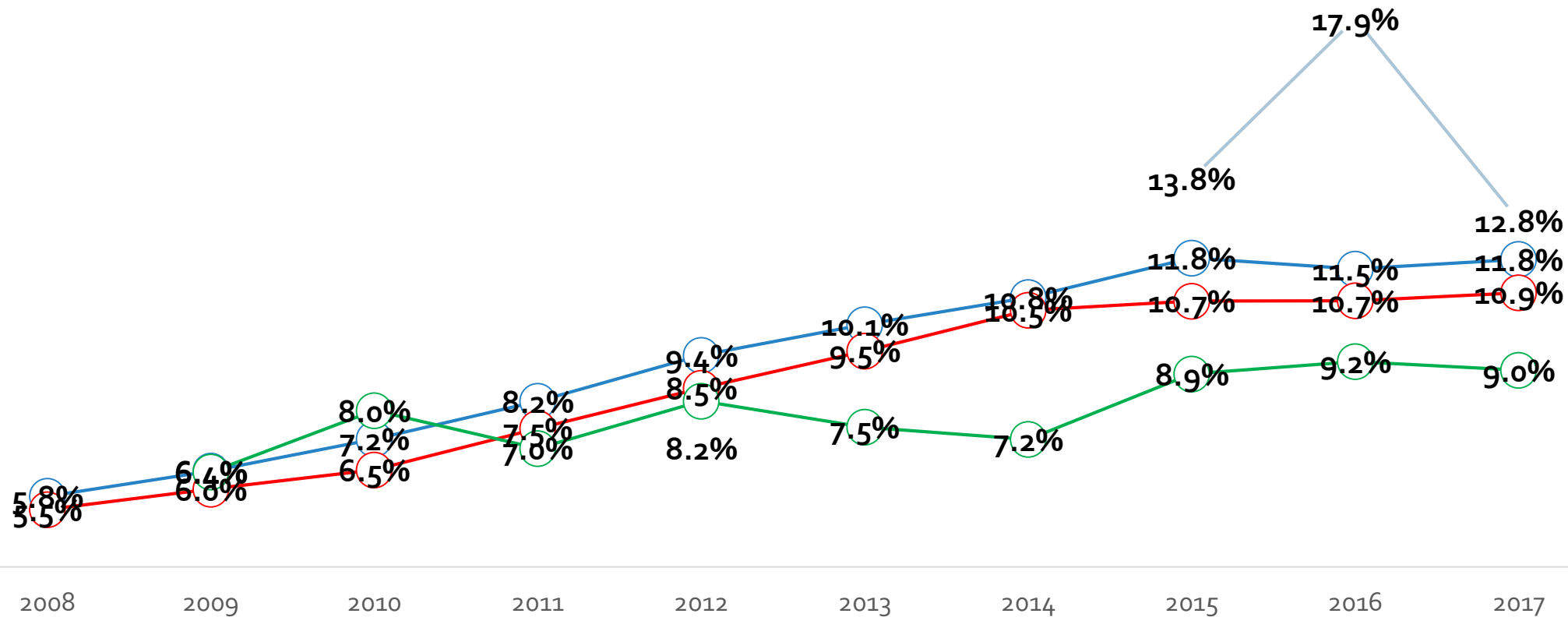
WHAT HAPPENED TO PRIMARY CARE SPENDING IN RHODE ISLAND?

Primary Care Spending, Total and as Percent of Total Medical Spending, 2008 - 2017



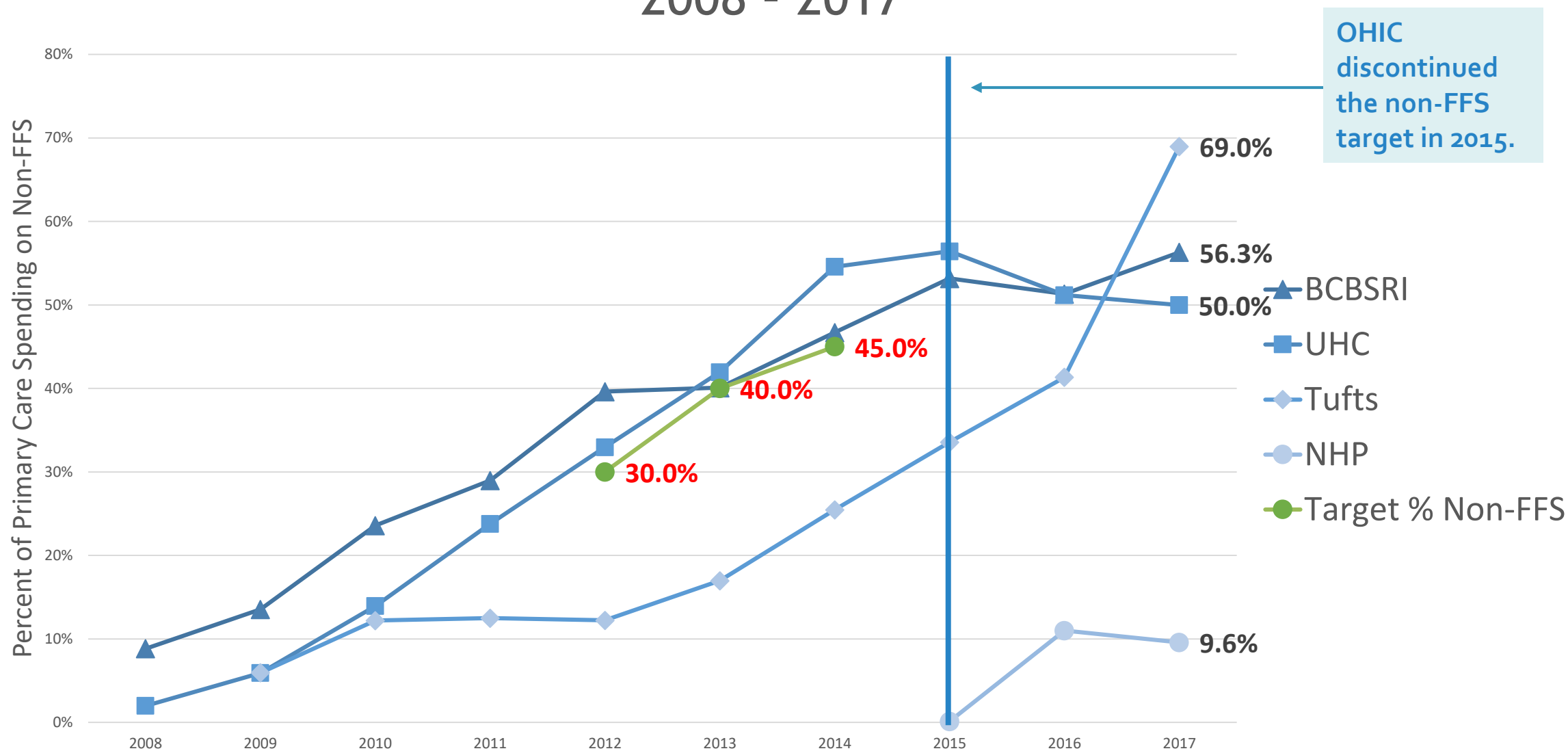
Primary Care Spending as Percent of Total Medical Spending by Insurer, 2008 - 2017

Primary Care as a Percent of Total Medical Spend

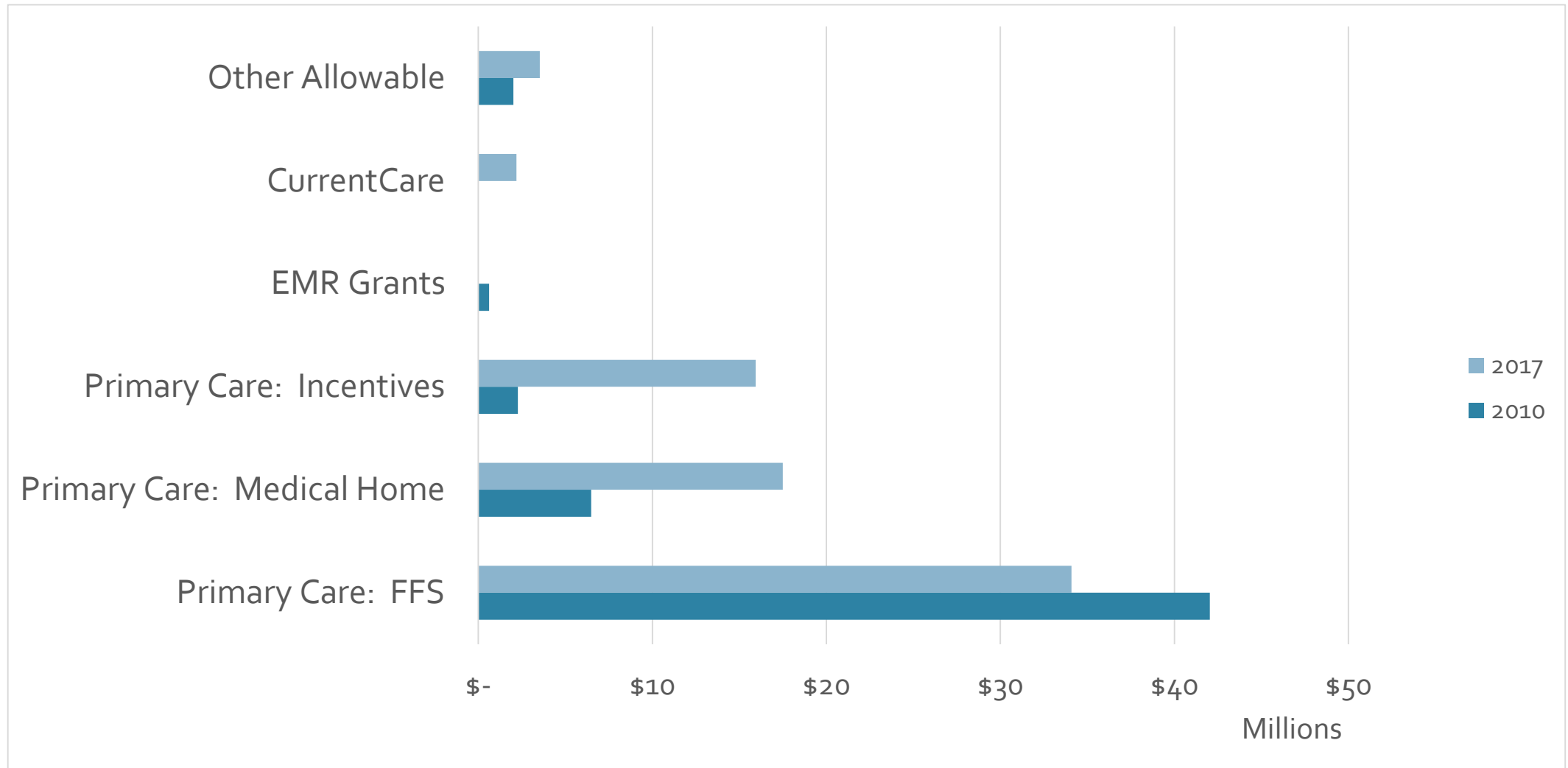


○ BCBSRI ○ UHC ○ Tufts - NHP

Percent of Non-FFS Primary Care Spending by Insurer, 2008 - 2017



Primary Care Spending by Category, 2010 and 2017



The Affordability Standards Today



Care Transformation

- Primary care spending shall be at least 10.7% of total medical spending.
- Insurers shall have a required percentage of PCPs practicing in a PCMH, increasing each year.
- OHIC convenes a Care Transformation Advisory Committee annually.



Payment Reform

- OHIC requires that at least 50% of medical payments should be under an alternative payment model.
- OHIC defines minimum downside risk thresholds in total cost of care contracts.
- OHIC convenes an Alternative Payment Methodology Advisory Committee annually.



Cost Growth Containment

- Hospital rate increases for commercial business shall not exceed CPI-U % plus 1%.
- Accountable Care Organization total cost of care budget increases capped at the CPI-U % increase plus 1.5%.
- Annual Overall Cost Trend Growth Target Planning Underway

Laying the Foundation for Future Transformation

What did the primary care spending requirement accomplish?

Care Transformation

- Over 50% of contracted PCPs are practicing in a PCMH.
- Primary care investments have helped fund the development of ACOs.
- PCMHs are taking on innovative care delivery models, such as integrated behavioral health care.

Payment Reform

- Primary care practices are better positioned to engage in alternative payment models.
- Over 50% of contracted PCPs are engaged in total cost of care contracting through ACOs.

Lessons Learned*

- Use evidence in public conversation to support policy objectives
- Showcase examples of what works
- Adapt to community characteristics— -staying focused on the goal
- Measure before and after intervention; use data transparently
- Adjust policy as needed— -staying focused on the goal
- Use all of the above to set goals and garner support

Questions?

References

*Koller, C. F., Brennan, T. A., & Bailit, M. H. (2010). Rhode Island's Novel Experiment To Rebuild Primary Care From the Insurance Side. *Health Affairs*, 29(5), 941-947.



CONNECTICUT
Office of Health Strategy

Primary Care Modernization and Health Enhancement Communities: Pathways to Better Care and Better Health

Presentation to the Delaware Primary Care Collaborative

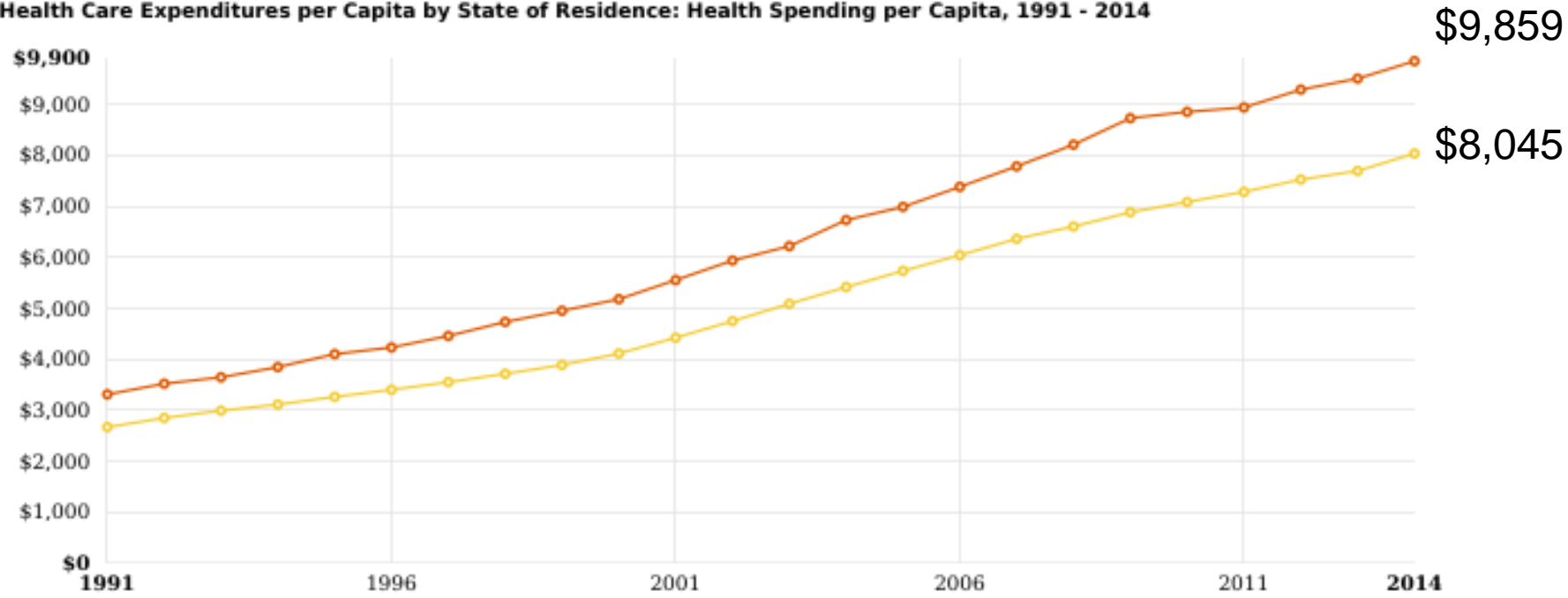
October 10, 2018

Overview

- Discuss CT healthcare reform history and current landscape
- Discuss one of two major design initiatives to promote better care and better health:
Primary Care Modernization
- Share information on a Medicare Multi-payer Demonstration as the vehicle for advancing these reform initiatives

Health Care Spending in Connecticut

Health Care Expenditures per Capita by State of Residence: Health Spending per Capita, 1991 - 2014



- Among Highest Per Capita in the US
- Steeper Increases than Nation

• Health Spending per Capita
■ United States ■ Connecticut

SOURCE: Kaiser Family Foundation's State Health Facts.

Healthcare Reform in Connecticut

- Widespread adoption of the ACO or “shared savings program model”
- More than 85% of Connecticut’s primary care community in ACO arrangement
- SIM achievements
 - 180,000+ Medicaid beneficiaries in PCMH+ shared savings program
 - 1,000,000+ beneficiaries (all payer) attributed under shared savings arrangements
 - Commercial payers 60% aligned on Core Quality Measure Set
 - 125 practices achieved PCMH recognition through SIM
 - 5 provider organizations representing 735 PCPs and 414,174 attributed lives receiving Community and Clinical Integration Program support
 - 14 provider organizations and CBOs negotiating service agreements under Prevention Service Initiative
 - Implementation of information exchange and data analytic solutions underway

Healthcare Reform in Connecticut

- Limitations...

- Primary care remains largely untransformed

- Little or no savings under MSSP

- Limited investments in preventing avoidable illness and injury

The Primary Care System We Need

Primary care's challenges... How we've tried to fix them... What we really need.....

Insufficient coordination and coaching

Ineffective chronic care management

Too little revenue dedicated to primary care, inflexible FFS payment

Limited consumer support between visits

Inconvenient; limited access via phone, email, text = more time away from work, family

Poor integration of mental health and substance use services




Shared "savings" with no downside financial risk

Care coordination, decision support and occasional help navigating the system

Investments in analytics and predictive modeling, closing gaps in care, national telemedicine

ASO or carrier programs to manage chronic conditions, complex cases, care transitions and care gaps

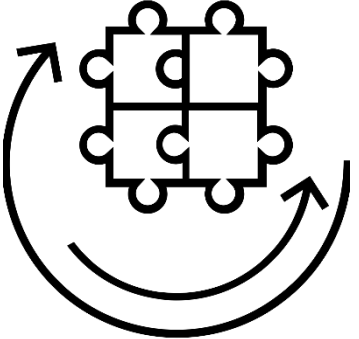


Integrated, expanded care teams that engage patients in their health, identify risks and manage conditions

Technology to keep providers connected with each other and their patients

Convenient, accessible care with options for email, phone, text and virtual visits

Increased investment in primary care; bundled payment; downside risk to drive reductions in total cost of care



Research: Investments in Primary Care Pay Off

Example	Cost Savings	Focus
Iora Health	Reductions in total health care costs of 15% to 20% since 2010	Expanded care teams, integrated behavioral health, patient support
Rhode Island Commercial Health Plan Mandatory Increased Investment in Primary Care	Total spending per capita grew slower in RI than in any other New England state. (0.6% in RI vs. 5.5% in CT)	Primary Care Medical Homes, Accountable Care Organizations, HIT
Boeing Intensive Outpatient Care Program	20% decrease in spending per patient	High-Intensity Primary Care
Proven Health Navigator by Geisinger Health System	1.7 ROI	Primary Care Medical Home
Group Medical Home	\$10.30 per patient per month	Primary Care Medical Home

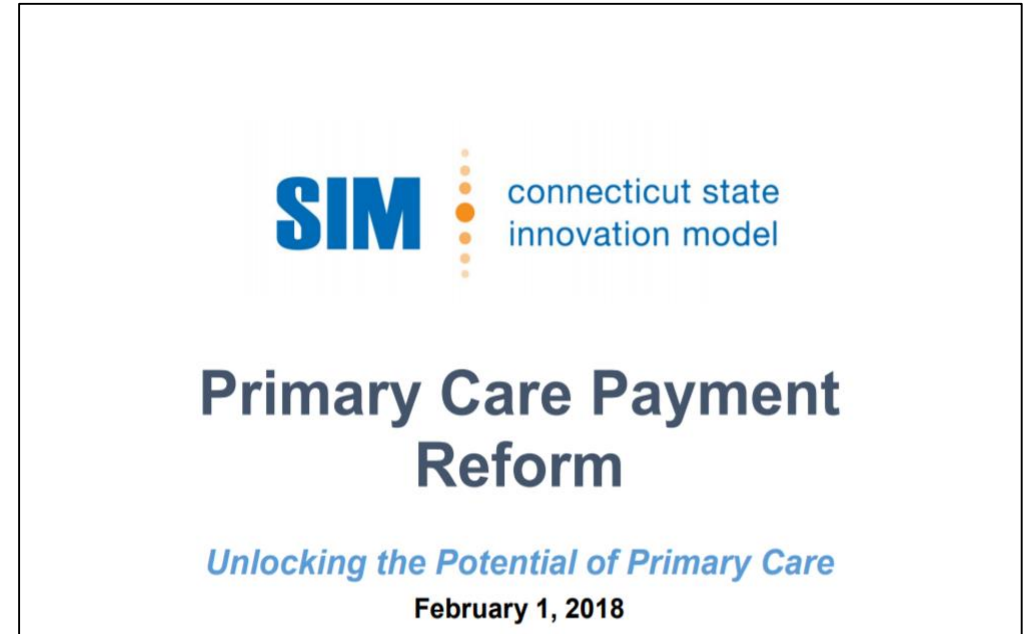
Primary Care Modernization

Design a new model for primary care to:

- Expand and diversify care teams
- Expand patient care and support outside of the traditional office visit
- *Double* investment in primary care over five years through more flexible *bundled* payments
- Reduce trend in total cost of care

Foundational Assumptions for designing model:

- Eligibility limited to practices in Advanced Networks/ACOs/FQHCs
- Multi-payer
- Existing MSSP or other shared savings arrangements remain in place, but model introduces downside risk (*may propose program adjustments*)
- Hybrid, partial or full bundle for primary care services



Support from CT Providers & Consumers

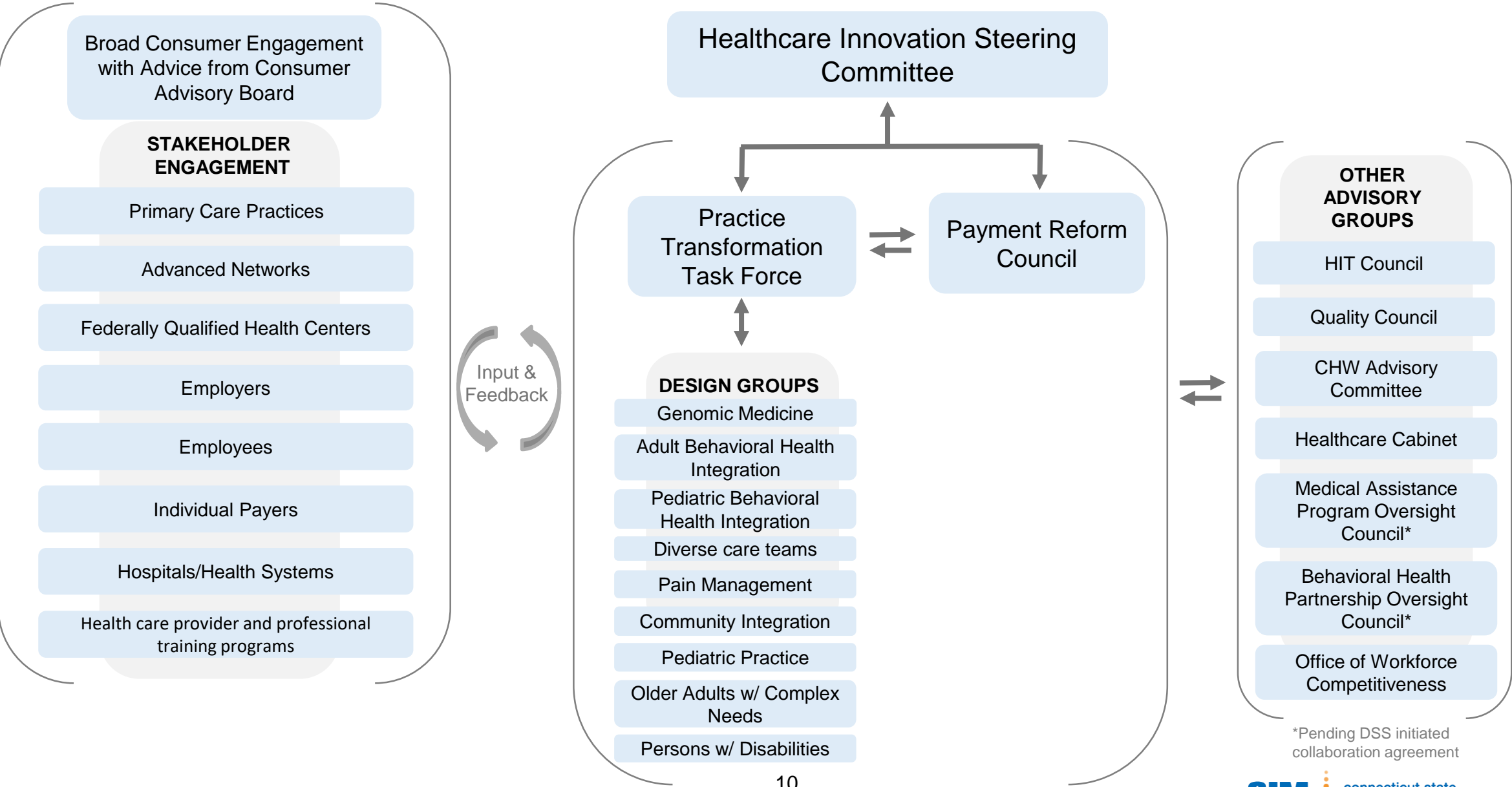
“The changes suggested and recommendations offered are essential to move our state and our nation out of the dismal performance on quality metrics globally that we currently occupy.” - **H. Andrew Selinger, MD, Family Medicine Physician.**

“We need more flexibility in how primary care is paid for so that we can take further strides towards innovative, patient-centered, and interprofessional care.” - **Yale Primary Care Progress.**

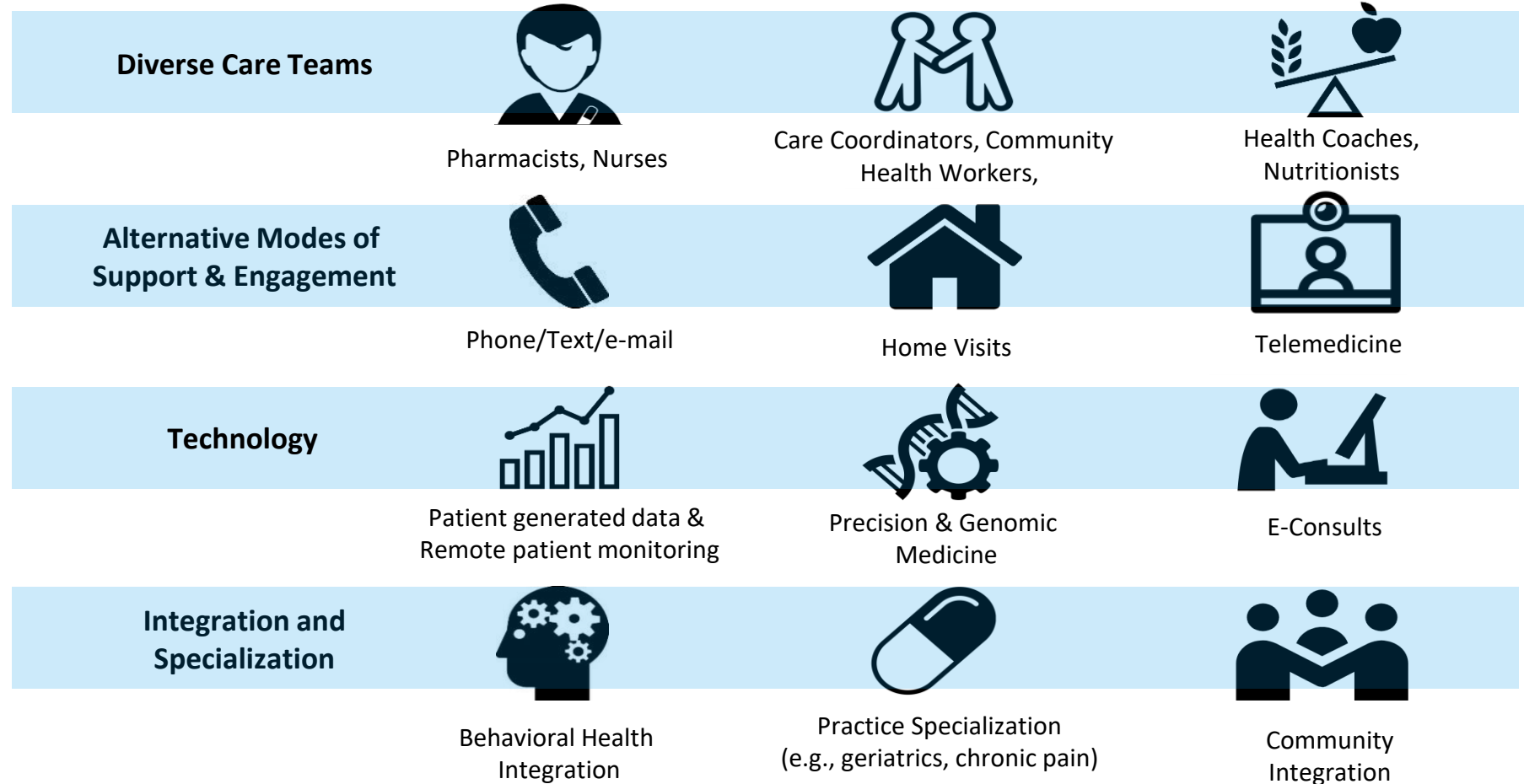
“This draft presents the possibility to rejuvenate and remake primary care in the state of CT. When you think about it, the primary care provider drives the cost of the system down if they have the time needed- we keep patients out of the hospital, same day visits keep patients out of urgent care, and we know our patients so prevent medication interactions or use of medications that a patient has had an adverse effect with.” - **Rebecca Andrews, MD, Governor, CT chapter, American College of Physicians.**

“The Fee-For-Services (FFS) model does not promote the overall health of primary care patients. The FFS model only rewards providers who schedule more patient visits, order more tests, and negotiate higher fees with payers.” - **Theanvy Kuoch, Executive Director of Khmer Health Advocates.**

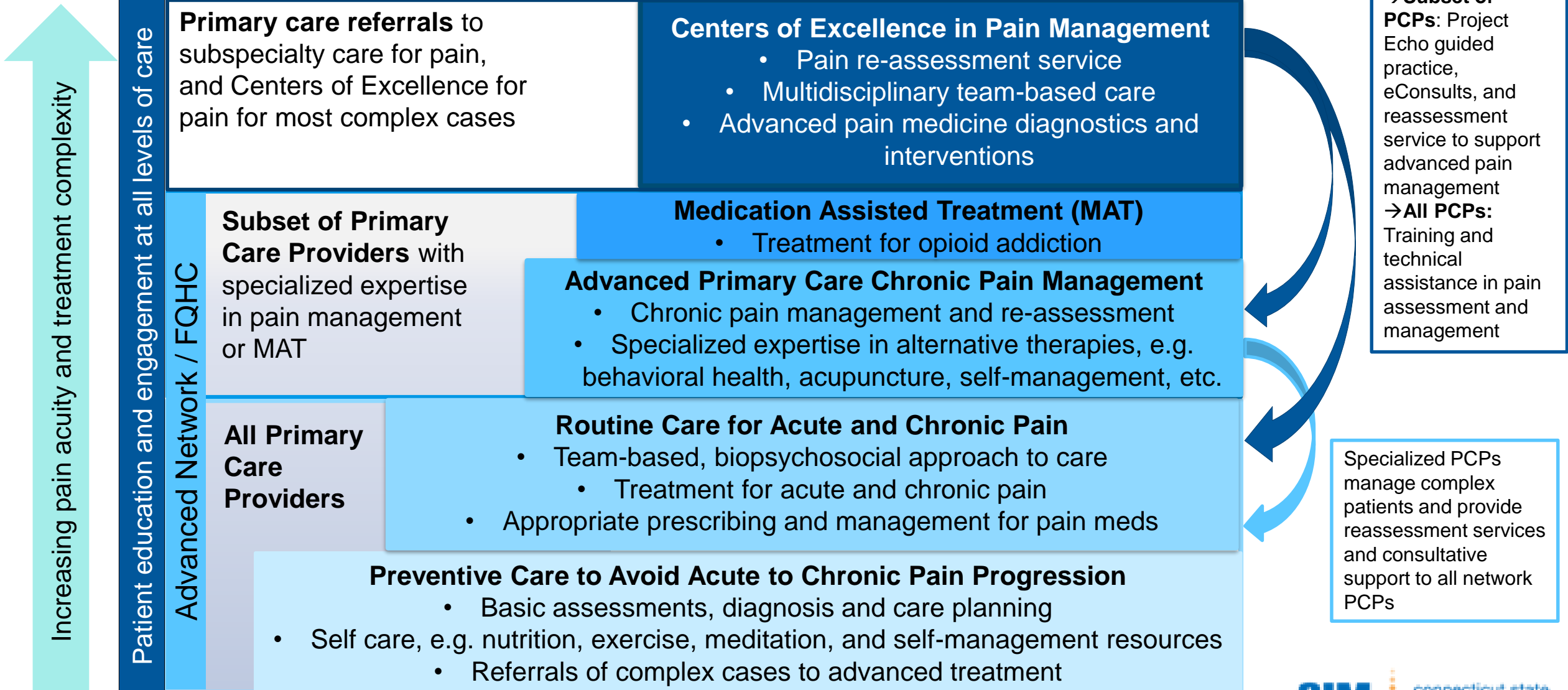
Stakeholder Engagement



Care Delivery Goal: Increase the Ability of Primary Care to Meet Patients' Needs



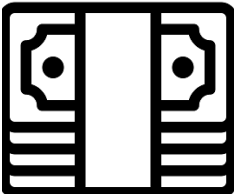
Primary Care Modernization – DRAFT Concept Map for Pain Management



Payment Model Options: Key Questions

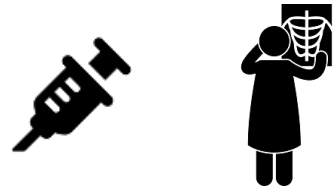
Basic Bundle

- Which services to include?
- Still pay additional, reduced fee for office visits?
- Base off previous experience?



Supplemental Bundle

- Paid separately?
- Risk adjusted?



Fee for Service Payments

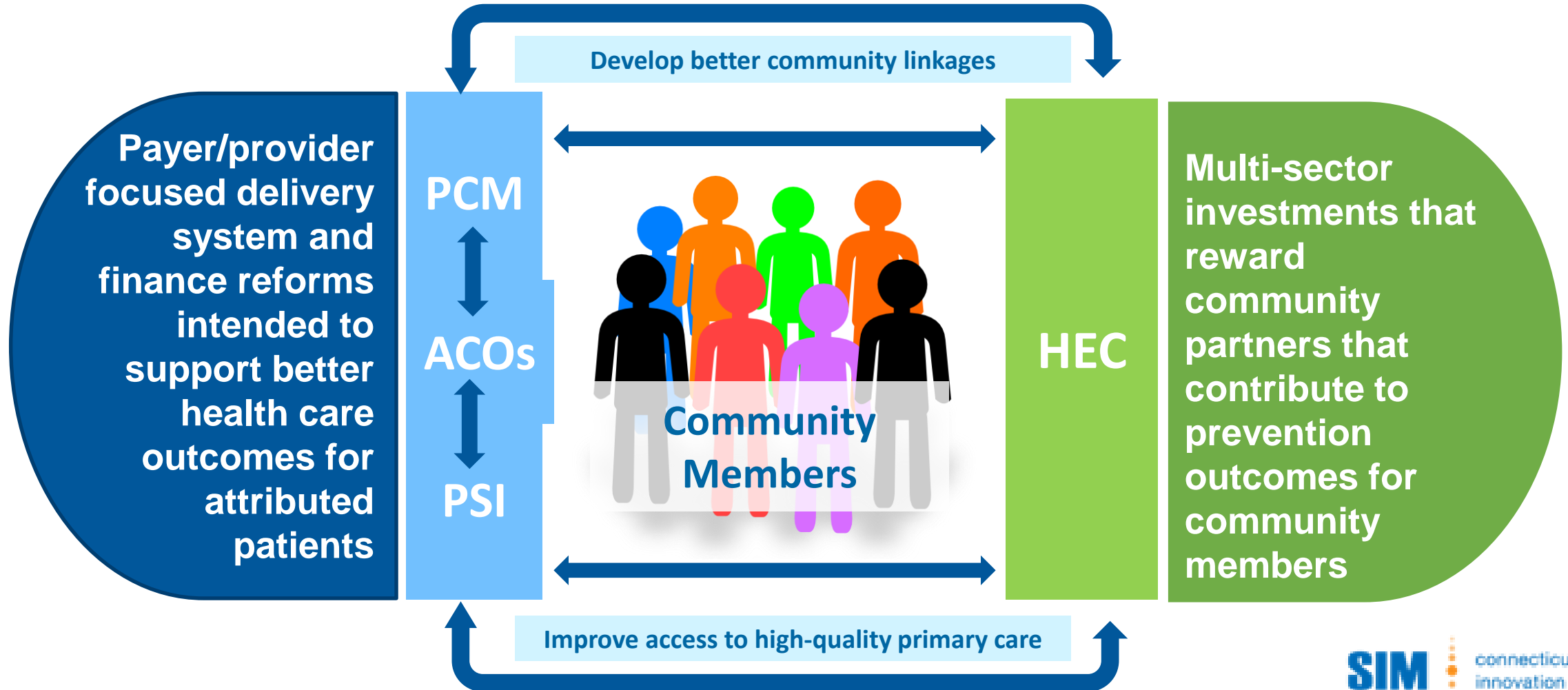
- What services will still be paid fee for service?

MSSP or Other Shared Savings or Downside Model Risk Puts Pressure on Total Cost of Care

- How will patients be attributed to providers?
- How will payments flow to advanced networks and FQHCs?
- How might internal compensation models and patient cost-sharing need to adjust?
- How could these primary care payment options fit into broader shared savings/downside risk programs aimed total cost of care?

Aligned and Complementary Reforms

Connecticut's augmented strategy to incentivize quality and prevention



Reform Goals Require Engagement Across Payers and Providers

Medicare Multi-Payer Demonstration

- A multi-payer demonstration project to improve health, drive efficiency and reduce total cost of care
- Pay for primary care differently by leveraging payment ‘bundles’ to support advanced care delivery
- Create an innovative community-driven model that can encourage investments in community health by monetizing prevention efforts
- In Maryland, Vermont, and Pennsylvania, negotiated agreements with CMS have enabled Medicare investment and participation in model reforms.
- These demonstrations typically:
 - Define how Medicare will invest in the model
 - Constrain Medicare growth compared to a defined baseline
 - Achieve statewide cost growth reductions compared to a defined baseline
- OHS has begun preliminary discussions with CMS about engaging Medicare in our reform effort

Discussion

SB 227 Primary Care Collaborative Meeting

Wednesday, November 7th, 2018

4:00 pm

Medical Society of Delaware

900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

Present:

Dr. Nancy Fan

Email:

nfanssmith@yahoo.com

Absent:

Senator Bryan Townsend¹

Representative David Bentz

Bryan.Townsend@state.de.us

David.Bentz@state.de.us

Staff:

Juliann Emory

Caitlin Del Collo

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Attendees:

Kathy Collison

James Gill

Drew Wilson

Pam Price

Megan Werner

Art Jones

E. Woodford

Cheryl Heiks

Rosa Rivera

Shay Scott

Susan Conaty-Buck

Dr. Christine Donohoe-Henry

Lolita Lopez

Dr. Dan Elliott

Tom Brown

Dr. Bryan Villar

Dr. Gary Siegelman

Organization:

Division of Public Health, DHSS

FMA-Greenhill

Medical Society of Delaware/Morris James

Highmark

Westside Family Healthcare

HMA

DAPA

Connections CSP

La Red Health Center

Henrietta Johnson

Delaware Coalition of Nurse Practitioners

Christiana Care Health Systems

Westside Family Healthcare

eBright ACO

Nanticoke Health Services

Bayhealth

Bayhealth

¹ Senator Townsend was present for the opening of the meeting, but had to leave due to a caucus meeting. Representative Bentz also had a caucus meeting to attend, and therefore did not make this meeting.

The meeting was brought to order at 4:01pm.

Opening remarks from participants

Dr. Christine Donohoe-Henry, CMO – Christiana Care Health Systems

- We have been delivering high quality, but not necessarily high value care.
- We went on a process looking at care delivery and how it needs to change in the future because:
 - Access to primary care providers is extremely limited
 - Significant health disparities exist among ethnic minorities
 - There is a pressing need to decrease costs
 - It is stressful to be primary care clinician especially with EHR and patient visit volume expectations.
- We used a consultant to look at physician need by local geography. Currently patients may wait 2 or 3 months for a new patient appointment.
- Our strategies include:
 - Data is important tool. We need to follow quality metrics and utilization metrics.
 - We have leaned on Carelink CareNow. This is a nurse care management model that provides ongoing care management with social workers and pharmacists as well.
 - We are moving toward one electronic health record – transitioning all practices to the same EHR.
 - We are adopting virtual primary care options for employees and their dependents – via video, calls, and texting.
 - We have co-located and integrated behavioral health into primary care.
 - We have residency recruitment strategy that focuses on doctors who will likely choose to practice primary care and want to support new primary care clinicians.
 - We also have an NP residency transitioning to APC fellowship to support in first 6 months of practice.
- Team-based care:
 - We are also focused on team-based care and moving toward a teamlet model (PCP partnered with an APN within a care team), which include behavioral health and nutrition
 - There will be three teamlets per practice caring for approximately 10k patients.
- Linked specialty
 - We are engaging with specialty providers to repatriate patients who don't need to see specialists as often back into primary care while maintaining the electronic link to those specialists.
 - This helps to improve access to specialist by freeing up appointment times.

Lolita Lopez – Westside Family Healthcare Key point important to FQHCs

- The biggest challenge we have is recruiting and retaining qualified primary care providers to meet the demand.
- In collaboration with Christiana, we now have a residency program that trains at the FQHC site.
 - This has been a successful program. Residents are choosing Christiana for the opportunity to come to an FQHC.
 - They are introduced how to manage social determinants in a continuity setting.
 - We have two residents in each year meaning we have 6 residents at any given time. And we are looking to expand this work.
 - Research shows that doctors practice near where they serve their residency.

- Westside had always had NPs, in fact we were established to be a nurse-managed center. We have found NPs have inconsistent training and students graduate without a lot of primary care training. They need 3 to 6 months of support and training to get them up to speed.
 - We need help supporting APNs and PAs to expand usage of these providers.
- The administrative burden of enhanced care teams and EHR has made it difficult for providers in a community-based practice.
 - We are interested in enhanced payments to help address this challenge.
- We rely heavily on state and federal loan repayment program and would like to see this expanded and enhanced.
- We are always recruiting for primary care providers; we currently have 9 primary care provider vacancies; until we are fully staffed and have capacity, we cannot focus on generating savings in the system because primary care capacity is not sufficient to prevent ED use and sufficiently manage chronic conditions.

Dr. Megan Werner – Westside Family Healthcare

- We want enough primary care providers to take care of the patient population.
- The situation must to be desirable enough for people to want to practice primary care here in Delaware.
- We need to create a system where providers feel supported and can focus on helping patients rather than chasing after administrative work.

Shay Scott – Henrietta Johnson

- Care teams give providers the opportunity to focus on care and step away from the administrative work.
- We find it challenging to have enough primary care providers and are not operating at full capacity due to a PCP shortage. Recruiting APNs and PAs has not been sufficient.
- Our strategy has been to use care coordinators to relieve burden from the provider.
- With the EHR, we find that teaching a provider this new skill has been a burden that impacts our ability to operate at full capacity.

Dr. Dan Elliot – eBright ACO

- As a MSSP ACO, we have employed providers from all the major health systems and 12-15 private practices.
- We do not hire physicians to fill gaps but work to help each of these organizations orient to the value proposition. This includes looking at their own practice model and considering how to improve the value of the care they provide.
- We have a conversation with a group of providers and see that across these geographic areas, all are working to achieve the same ends. We ask - what can we do at scale that is more efficient than we can do individually?
- We have a shared commitment to work together on a few key things such as:
 - Sharing best practices;
 - Sharing investments that take advantage of scale like a data analytics system;
 - A care management program that creates a more supportive environment for PCPs.

- It is complicated work, and everyone must do it individually. These systems and practices are at different stages in adopting best practices. We can help them find the biggest bang for their buck.
- The ACO serves as an aggregator and as a collaborative engine. We help to guide action, assess the situation, and make strategic plans.

Tom Brown – Nanticoke Health Services

- We are a small rural hospital and health system with a service area of about 715,000 residents in the western part of Sussex County. We have a physician group of about 60 physicians. The hospital is financially stressed and threatened with closure.
- The plight of primary care is the same as small community hospitals.
- In rural areas, primary care is strongly linked to the community hospital. The payer mix skews toward public coverage, not private sources. PCPs panels are composed of approximately 60% Medicaid and Medicare covered individuals. That patient mix increases to 83% for the hospital. The commercial share continues to decline.
- Additionally, the population is challenging due to the poor health risks in the population.
- This year alone we have lost 4 out of 30 primary care providers. That is a 15% decrease. We expect to lose another 20% next year. These providers are leaving due to age and financial liability.
- Nanticoke wants to keep independent physicians independent. Having an independent provider leave or seek employment at the hospital is not helpful to sustaining primary care access.
- There is only one primary care group that has hired in the last few years and Nanticoke has financially assisted (within Stark Law rules) in recruiting and hiring these primary care providers.
- We have helped primary care with the ACO. We have a single EHR and help affiliated independent PCPs access to that EHR, which removes a huge burden from independent who wish to join us.
- We don't choose where we locate our physicians in order to gain favorable market share. We want to maintain access.
- We employ 16 primary care physicians and 20 NPs. We have been employing primary care NPs for 8 years. They are treated as providers with their own panel. We also have other NPs under physician supervision. This is intended to relieve the burden on our physicians and our ED.
- By moving ED patients to primary care and keeping them out of the ED, we have saved the state money, although we are not reimbursed well for this success.
- We became PCMH certified. We hired care coordinators who worked with the high-risk patients regardless if the insurer pays for care coordination.
- We have also run a telemedicine behavioral health pilot working with Medicare population in the ACO.
- We participate in the eBright Medicare ACO.
- All these innovations and changes are at a loss to Nanticoke.
- We cross-subsidize the primary care physicians because the level of work does not match up with our reimbursement. We have to find a way to fund the shortfall in the long term.
- Primary care providers need to be paid adequately and appropriately for their role as health care QBs.
- Hospitals and primary care physicians are not all alike. The solution is not monolithic. There is no one public policy that will fix things for all practices. We have different problems and serve different populations. I would rather build a system that is sustainable, not patch the obvious holes in the current system.

Dr. Bryan Villar – Bayhealth

- When I graduated there were no jobs in Wilmington. As foreign grad on an H1 visa, I needed a job. In a small practice, we had 6 residents. Only 2 or 3 of the residents stayed in Delaware. Compensation here is not good so they leave for higher paying states.
- I worked for a private practice. It is a small business, and in a small group it was difficult to sustain our medical insurance. Comparatively, being a hospital resident was better compensated.
- Hospital employment of physicians makes it seem like the hospital is the enemy of the private practice because they are competing for the jobs and talent. In reality, by their ability to offer better salaries and benefits, they are helping to keep primary care physicians in Delaware.
- Bayhealth has sent in application to create internal medicine and family medicine residencies because we know there is a need for primary care doctors. But if other states pay more for primary care, they will not get enough interest.

Dr. Gary Siegelman – Bayhealth

- There are a number of similarities across these organizations.
- The goal is how to bring new providers to the state of Delaware and how to maintain and sustain their practice the once here.
- We applied for a practice transformation grant in 2015 – this was simultaneous with the SIM grant. With this grant from CMS for practice transformation, we provided training in quality improvement, data collection and analytics and practice transformation for 2,400 to 2,500 clinicians. Many of these cohorts of physicians have graduated from practice transformation and are better prepared for care. This included both specialists and primary care physicians.
- We have begun the process to beginning residency training. We plan in July of 2021 to have two programs – family medicine and internal medicine. In the following years we will add emergency medicine and general surgery.
- We think this will add new primary care trainees to the state. We have had preliminary discussions with Westside to work together on training.
- We want to add trainees to the state in the hopes that they will stay in the state.
- You see fewer private practices – we are saying that there is a strong role for private practices, but we recognize that that is not sufficient to sustain the needs of the population. There are very few private practices that are recruiting.
- We have provided forgivable loans to help primary care physicians to enter into private practice, but we have few takers.
- We also brought in two practices in the Milford area – these practices have been in the community for 20 years but couldn't sustain a practice on their own. These practices that we brought in are doing well.
- We participate in the eBright ACO and are doing well on the quality metrics.

Rosa Rivera – La Red Health Center

- We have found that both recruiting and retention are hard, especially when competing with larger groups.
- We are able to use NPs more, but the type of patients seen at FQHCs are very complicated patients, so we are asking NPs to act more like physicians.
- The physicians have an increased workload because they need to mentor and assist NPs.

- The types of patients we see have changed. We have agreed that we need to meet our patients where they are, which increases the cost of operating.
- In Sussex, there are many barriers to patients seeking care, we need to reach out to meet them
- These stressors increase provider burn out. We are using care coordinators to relieve some of the stress.
- FQHCs provide services that we don't get paid for:
 - We provide translators and sometimes must send our translators out with patients to other providers because specialty care practices do not hire their own translators.
 - We also provide transportation to reduce no shows and increase compliance.
- IT is a both blessing and a nightmare. Having access to data is great, but it is a nightmare because it is expensive, requiring staff training and constant maintenance. Payers and governments constantly increase the number of data points they want us to collect. We still struggle to get the reports they want out of the IT system.
- Implementing care coordinators has been great; they help us keep on top us patient prevention and follow up.

Questions

Dr. Fan

- There seem to be some common themes across these organizations.
- Do you see any benefit in trying to push forward investment not just for reimbursement, but direct investment for instance in IT? Would it be helpful for payers to devote a block of money to IT investment? This is one of the strategies begin used in Rhode Island.
- And as we transition away from the current system, how do we build a team-based care model?

Tom Brown – Nanticoke Health Services

- All of our organizations have different ideas to improve care, but implementation is hindered by the uncertainty of the future.

Lolita Lopez – Westside Family Healthcare

- All providers are different. We all have care teams, but they are all a little bit different.
- The work that we do in between visits is not paid for. Even if we have enhanced payment (which FQHCs do get) there is still work between visits that is not reimbursed. Care management would be a good investment from payers.
- I am not sure how you structure it, but that piece of reimbursement is missing.

Dr. Megan Werner – Westside Family Healthcare

- It is no longer possible for physicians or NPs to address all the needs of their patients alone. As a result, we need to rely on care teams, but we are not paid to have care teams support the clinician. These teams provide follow up and medication management, but this is not reimbursed so it is difficult to find a way to pay for it.
- The payment should be flexible to acknowledge that each organization is doing care management differently.

Dr. Fan

- Connecticut is thinking of adopting a primary care bundled payment.
- There are different models of value-based payments. The MSSP ACO model provides a back end payment for value, rather than up front.
- How should value-based payments work?

Dr. Dan Elliot – eBright ACO

- We need upfront investment. We are trying to build smart investments. The issues are consistent across organizations.
- We need investment that pays for care management. This is a shared value across all providers.
- We need to understand what should be purchased at scale and what should be done locally. Then we can direct investment appropriately.
- We need to think through the immediate needs and more strategic investments. The ROI will be much longer than you expect. If you think you are investing in the right thing, you need to avoid placing a timeline on outcomes that is too short and could inhibit or jeopardize the work.

Shay Scott – Henrietta Johnson

- By participating in Aledade's Medicare ACO, we got two care coordinators who have made a huge difference. Figuring out how to pay for that was important, but it has been a great investment. The decision to do this ourselves was tough.
- A grant that supports organizations with flexibility is important – accounting for their unique readiness levels and putting it toward what they need most.

Dr. Fan

- How do you align cost containment with investment?

Dr. Gary Siegelman – Bayhealth

- It may be helpful to have aligned, stepwise goals that link the action and outcome to highlight why change is important.
- One thing that helped us with the practice transformation grant, but the physicians didn't internalize why they should care until the MIPS program provided a specific goal aligned with their practice transformation change.
- Organizations need help with predictability. There were some private insurers who helped the providers become PCMHs, but then that reimbursement was cut. The practices felt that the rug was pulled out from under them.

Rosa Rivera – La Red Health Center

- What is the trade off with this investment? Is it new money or is it a result of reductions elsewhere? We need to be able to put this investment to our most important things – and that probably won't be IT.

- Many services we provide are not reimbursable but make a difference for patients. How can we get paid for these services? All of this costs money. The additional services improve health and make staff happier.

Dr. Megan Werner – Westside Family Healthcare

- It is really important to think about investment in a long-term view. Primary care is the most cost-effective place to provide care, so investment makes our care more efficient in the long term, but not in the short term. I would expect a short-term increase in spending from providing more care, finding conditions, and treating them early. But over the long term it improves health, helps avoid complications, and improves the economy.

Dr. Dan Elliot – eBright ACO

- These concepts are important; we can learn from CPC+ model.
- To put resources in front of someone without accountability for outcomes is a mistake.
- How do we get all providers to participate? We need a glide path that allows for all providers to participate.
- There is a 5-year time horizon to move to downside risk in the Medicare models. This is a precedent that can start a discussion of how fast/how far we can expect adoption.
- The investment needs to be directed, but within a framework that ensures all can benefit from it.

Dr. Fan

- What does value based payment mean to you?

Dr. Dan Elliot – eBright ACO

- Speaking on behalf of Christiana care, our leadership has been interested in moving forward with value-based payments.
- There is an aggressive posture in adopting and making it sustainable.

Tom Brown – Nanticoke Health Services

- We are stewards of the community's assets. When we take risks, it needs to be intelligent. I would like to think that in the next 5 years we have 100% value-based payments and some of that includes downside risk.
- The investment of primary care must be seen in light of the change in primary care payment models.
- Asking about the ROI is not relevant if the bridge is going to fall down. We need to consider ROI from an appropriate baseline.
- We are not going to get value-based payment without physician capacity. Investment cannot only be linked to value-based payments because we need providers and resources.

Dr. Fan

- What do you think about 12% primary care investment as a share of total health care spending?

Tom Brown – Nanticoke Health Services

- That depends on what is measured and included in the numerator.
- We have to devote more resources to primary care, but I am reticent to say a certain number because we need specific details to support a number. Additionally, this is a monolithic fix and not helpful in overhauling the system.

Lolita Lopez – Westside Family Healthcare

- It depends are you taking the additional 9% from somewhere else. Is it a shift or a new investment?
- When I think of ROI, FQHCs offer a big return. There are studies on how much we save particularly for Medicare patients because we have always had care teams and one stop shopping to address the unique needs of our patient.
- For value-based payment, we want measurable quality outcomes, but it is difficult for medically underserve patients because there are many things we cannot impact. We really cannot take on downside risk because there is a limit on how much impact we can have. We can do upside risk.
- We have bundled payments (PPS encounter payment) for a long time, but it has not kept up with expenses and the needs of our patients.
- We want to increase prevention services, but we are not paid for this. Keeping up with the chronic and acute care needs requires so many resources that we cannot focus on the preventive side.

Dr. Fan

- Supporting the workforce continuum has been an important element in this conversation.
- Why does our Delaware attrition rate outpace our ability to support the workforce pipeline?

Dr. Gary Siegelman – Bayhealth

- There is a formula for high cost high utilizers and we need a focused approach to address these people.

Dr. Megan Werner – Westside Family Healthcare

- We need resources to help address social determinants.

Dr. Dan Elliot – eBright ACO

- My concern about spending thresholds is that it becomes like MLRs – a mess, where service categories get re-categorized.
- We need the funding to be directed in a way that is directed by the people who know the real need. We cannot just move money around.
- The institutions are subsidizing primary care. Primary care is not working financially for anyone.
- We care more about where that additional investment goes to rather than how much that investment should be.

Dr. Fan

- We need everyone onboard.
- Everyone has ideas for what is working.
- Our goal in phase one is increase reimbursement within our current model.
- The second phase asks how do we add investment that transforms the system?

Dr. Megan Werner – Westside Family Healthcare

- There is some adding dollars up front, then long-term shifting from low-value to high-value services. The ER spending can be invested in primary care when the people don't rely on the ER as much.
- There is lots of potential in value-based payment models. The question is what is value and to whom?
- The payer wants data for these things that are not clinically meaningful to me or the patient. The smaller your practice the less support you have to deal with this administrative burden.
- We need a common language. There should be accountability, but the burden on the providers to speak the insurers' language is not good.

Rosa Rivera – La Red Health Center

- We are responsible for so many things, but the real impact comes from the patient. The patient plays an important role.

Public comment

Dr. Susan Conaty Buck

- It is unfortunate you have not had any NP practice owners to speak to the Collaborative.
- NPs have a good track record. In Delaware, 100 have the ability to have independent practice, and others can apply for independent practice. Rhode Island and Connecticut both have independent practice. Like all primary care practices, they need support to overcome the same challenges.
- Maryland has been offering a sign on bonus to help establish NPs in their own practices.
- NPs want to practice at the top of their license. In other states, there is recognition that NPs successfully operate solo.
- We need to encourage organizations employing NPs to have them in primary roles, and placing them in places it's hard to get physicians.

Dr. Jim Gill

- I am impressed that everyone here is on the same page that we all need all these types of practices.
- Question about how hospitals can support primary care in ways that has been done in other parts of the county. In other states, a hospital pays the salary of a physician in private practice.

- They charge a part of the practice revenue and the physicians develop a loyalty to the hospital. The primary care physician's salary is small compared to the revenue they generate for the hospital. Would the hospitals here consider this?

Tom Brown – Nanticoke Health Services

- The Stark laws are very prescriptive. Typically you have a 3-year period where you loan the money to the physician. NPs are excluded based in the federal law.
- For an individual physician this program can be a tremendous risk, but for a small group it is easier.
- I used to be able to sell this idea, but now the physician just would rather be hired because of the risk.

Jonathan Kurch

- I am hearing apocalypse and optimism. It strikes me that the system isn't broken but the system is operating exactly as designed.
- The social determinants is a phrase we hear over and over, but most of it has very little to do with physicians and medicine.

Dr. Gary Siegelman – Bayhealth

- I agree that the system is doing what it is designed to do.
- I give a lot of credit to CMS, they have been making significant strides in making changes 5 or 6 years ago. They have tried models to see what works. They have changed reimbursement and goals. The system is changing.

Dr. Dan Elliot – eBright ACO

- The issue is not necessarily whether we should go to risk because no one likes the way things are. The question is how with appropriate guiderails and goals.
- To the social determinants question – I tend to remind that we have a lot of work inside our clinical care that needs to be addressed before we can blame social determinants for adverse outcomes.

Caitlin DelCollo

- There is a lot you don't get reimbursed for, is that because payers make a choice? Is the state authorized to mandate these are reimbursed?

Pam - Highmark

- Telehealth is mandated by the state to be covered with parity to office visits. If it has a code, then it is reimbursed same as an office visit.
- In terms of care coordination, we have a program (True Performance) that pays for care coordination. Our fee for service programs don't have a payment for care coordination.

Dr. Gary Siegelman – Bayhealth

- There are quality metrics hurdles to get care coordination payments.
- Another option would be to gather a population of one payer's members and get a care coordinator from the payer.

Lolita Lopez – Westside Family Healthcare

- It's also different for every payer. Each payer approaches care coordination payments in a different way.

Delaware Primary Care Collaborative Questions

November 7, 2018

1. What efforts are you making to stabilize and enhance primary care capacity in the state and what additional measures do you recommend?
2. If we were to pursue a course that resulted in a higher portion of health care spending on primary care, how would you recommend that be accomplished?
 - a. Increased reimbursement rates for primary care services
 - b. New structural payments to primary care such as a supplemental bundled payment being considers in CT or a PCP loan repayment program
 - c. Value-based payment opportunities for primary care providers
3. What is the anticipated impact on your hospital or health system of increasing primary care spending while also bending the curve on total spending on health care services in Delaware and how would you adjust to that different scenario?
4. With regard to the return on investment and amount of investment relative to other primary care investment strategies, what is your perspective on investing in primary care practice transformation, including for example: care team resources, IT investment, the development of community workers through standardized certification programs?

Primary Care at Christiana Care Health System

Christine Donohue-Henry, MD
November 7, 2018



THE CHRISTIANA CARE WAY

We serve our neighbors as respectful, expert, caring partners in their health. We do this by creating innovative, effective, affordable systems of care that our neighbors value.



CHRISTIANA CARE
HEALTH SYSTEM

Why We Need Enhanced Primary Care

- Increase access to care for neighbors
- Eliminate health disparities
- Decrease health care costs within the State
- Enhance caregiver wellbeing

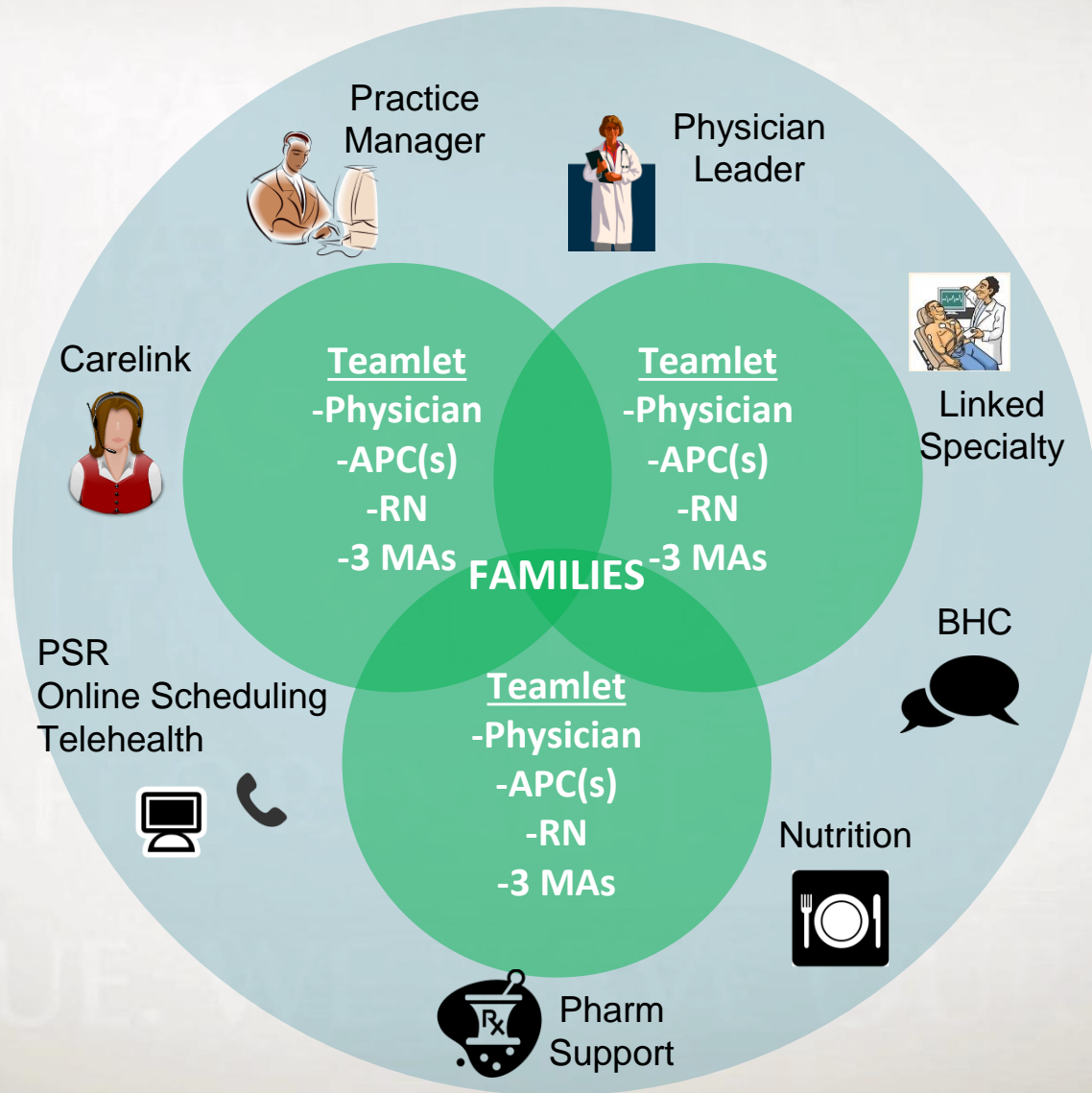
Assessment of Need: Physician Shortage by 2022

Neighborhood	2022 Population	Estimated Physician Need in Zone
New Castle	63,545	38
Lower New Castle County	60,189	26
Bear/Glasgow	136,125	36
City of Wilmington	96,924	5
Claymont	30,513	15
Brandywine (Concord)	46,696	0
Hockessin	25,829	6
Newark	118,441	14

Reimagining Primary Care

- **Team based care**
- **Data to support quality and utilization metrics**
- **Carelink Care Now – RN care management, social work, and pharmacy**
- **ONE Electronic health record**
- **Innovative Models of Care Delivery**
 - **Virtual Primary Care for employees and adult dependents**
 - **Behavioral Health Medical Home**
 - **Telehealth platform**
- **Focused resident recruitment: FM, IM, Med/Peds, Psych**
- **APC Fellowship in Primary Care**

Christiana Care Teamlet Model

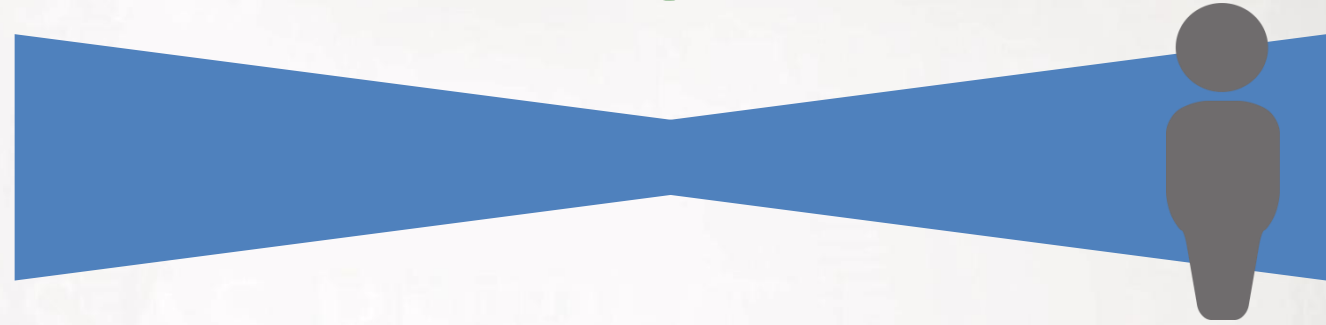


Practices will serve 10,000+ patients

Primary Care and Specialty Integration

Primary
Care
Practice

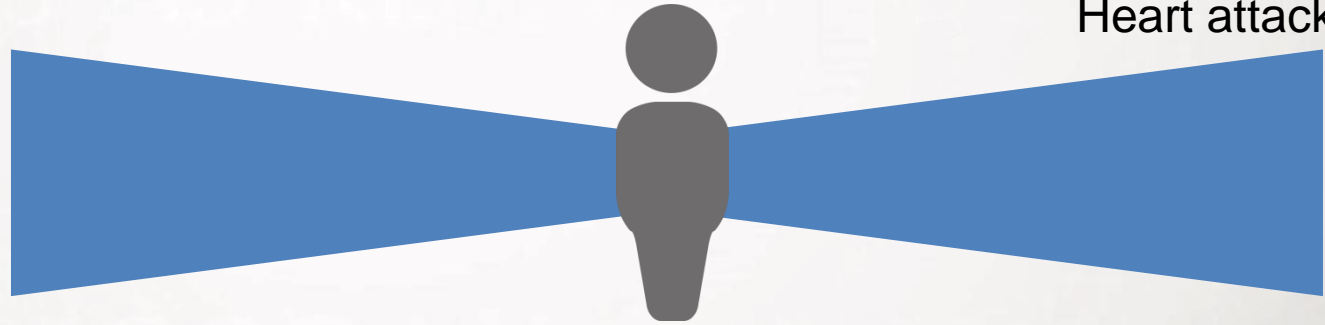
Cardiology
Practice



Heart attack

Primary
Care
Practice

Cardiology
Practice



3 months after heart attack

Primary
Care
Practice

Cardiology
Practice



3 years after heart attack



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:

Senator Bryan Townsend
Dr. Nancy Fan
Representative David Bentz

Email:

Bryan.Townsend@state.de.us
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David.Bentz@state.de.us

Staff:

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Attendees:

Tyler Blanchard
Sarah Schenck
Pam Price
Susan Conaty-Buck
Wayne Smith
Kathy Collison
Faith Rentz
Maggie Bent
Dan Elliott
Jim Gill
Cheryl Heiks
Margaret DeFeo
Alan Greenglass
Jennifer Mossna
Tom Fitzpatrick
Kevin O'Hara
Katherine Impellizzeri
Chris Morris
Elizabeth Staber
Andrew Wilson
Kim Gomes
Kiki Evinger
Emmilyn Lawson

Organization:

Aledade
Christiana Care Health Systems
Highmark
Delaware Coalition of Nurse Practitioners
Delaware Hospital Association
Division of Public Health, DHSS
Department of Human Resources
Westside Family Healthcare
Christiana Care Health Systems
Medical Society of Delaware
Webster Consulting
AmeriHealth Caritas
DCHI
Highmark
Highmark
Highmark
Aetna
Aetna
Aetna
Medical Society of Delaware/Morris James
Byrd Group
DHSS
AmeriHealth Caritas

Megan Werner
Rose Rivera

Westside Family Healthcare
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 country. 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 are 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 overburden 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 thought 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 about 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.

Highmark Delaware Primary Care Collaborative

November 28, 2018

Our Commitment To Delaware

- **Highmark Delaware is the only carrier participating on the Delaware Marketplace and has invested approximately \$50 million in the form of subsidized losses since inception (January 2014).**
- **Serve over 450,000 members across all of these populations**
- **Highmark Delaware developed and implemented a robust Medicaid Managed Care product (DHOP) in 2015 to serve Delawareans and fill a critical void.**
- **Highmark offers the 2nd largest Primary Care focused Risk Based Contract in the country, True Performance, which involves 1.8M attributed members.**
- **Highmark Delaware and its employees have participated actively in the State's SIM & DIN program since their inception.**
- **Highmark Delaware has contributed over \$18,000,000 since 2012 to support over 200 health-related initiatives, programs and organizations within Delaware.**
- **Part of the broader \$18.2B Highmark Health enterprise, which serves 5.2M health plan members and over 24M members through our integrated delivery network, diversified companies and technology solutions business.**

Six trends shaping the market¹ and Highmark's strong position for the future

Trends

Evolving consumer expectations

Big data proliferation

Growing government business

Cross-industry, vertical integration accelerates

The rise of pharmaceutical management

The evolution towards value-based care

Highmark's position

Personalized engagement through data-driven consumerism capabilities and innovative vendor partnerships

Market-leading data and analytic capabilities

Large and influential player in the Medicare, Medicaid and ACA markets

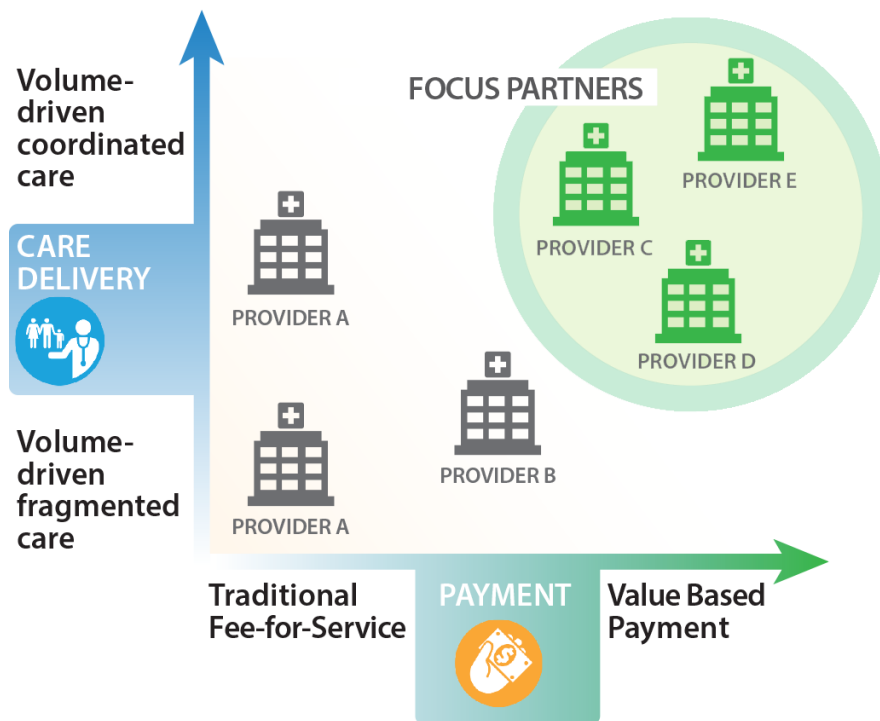
Only Blue integrated delivery and financing system; many large, complex provider partnerships

Proven pharmacy management programs (including specialty drugs) yielding lower trends than leading PBMs

Large, successful VBR programs and enabling capabilities

Provider partnerships are the cornerstone of Highmark's strategy

Aligning care delivery and incentive payments



Highmark's provider partnership strategy

Highmark will jointly develop **value-based programs and products** based on provider readiness and market needs

Focus on keeping providers independent and keeping care local and affordable

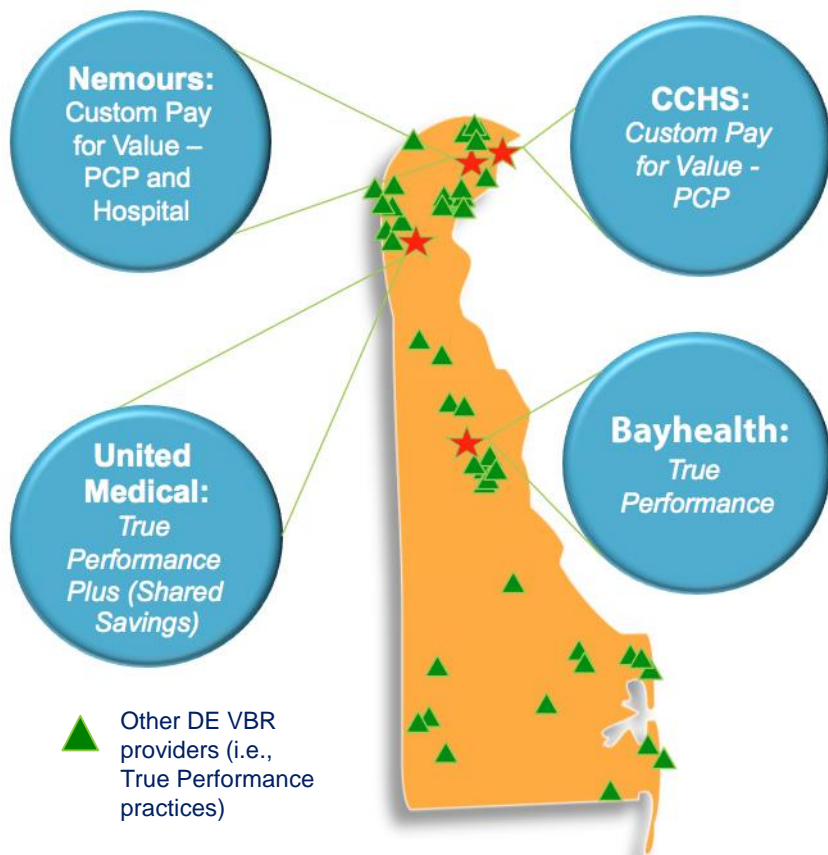
Programs will evolve as providers take on increasing risk for effectively managing care

Ultimately, there **will be winners and losers** as some providers adapt and succeed, while other resist the movement towards value

Moving forward, **we will focus on transforming care delivery** with willing and able partners, rather than with every provider

Highmark, in partnership with other Delaware healthcare providers, has ignited an aggressive agenda forging a new path in care delivery and reimbursement .

Partnership Examples



Delaware VBR Future State

1. Continued focus on aligning incentives at every level of the health care continuum (PCP, Specialists, Hospitals, Post-Acute)
2. Collaboration with State and Local stakeholders on creating & managing a **Spending Benchmark while** rewarding the highest quality outcomes
3. Continued focus on **advancing VBR** in Medicaid, Commercial, and ACA lines of business
4. Introduce quality metrics that **focus on societal and environmental factors of health** to ensure a holistic approach to care delivery
5. Create **member-level incentives** to promote appropriate site of care, intervention, and preventive engagement
6. Intensify focus on **telehealth initiatives** to alleviate access issues and increase efficiency across the continuum
7. Increase **member-level knowledge** of VBR to ensure growth of VBR is supported by all stakeholders
8. Collaborate more with the provider community to develop programs that **center around the patient** and support all parties equitably

True Performance is Making an Impact

TOTAL: 645 contracted entities
1,543 practices
Approximately 1.8 million attributed members

Central Pennsylvania

- 137 entities
- 449 practices
- More than 535,000 members

Western Pennsylvania

- 228 entities
- 558 practices
- More than 690,000 members

West Virginia

- 88 entities
- 264 practices
- More than 200,000 members

NEPA

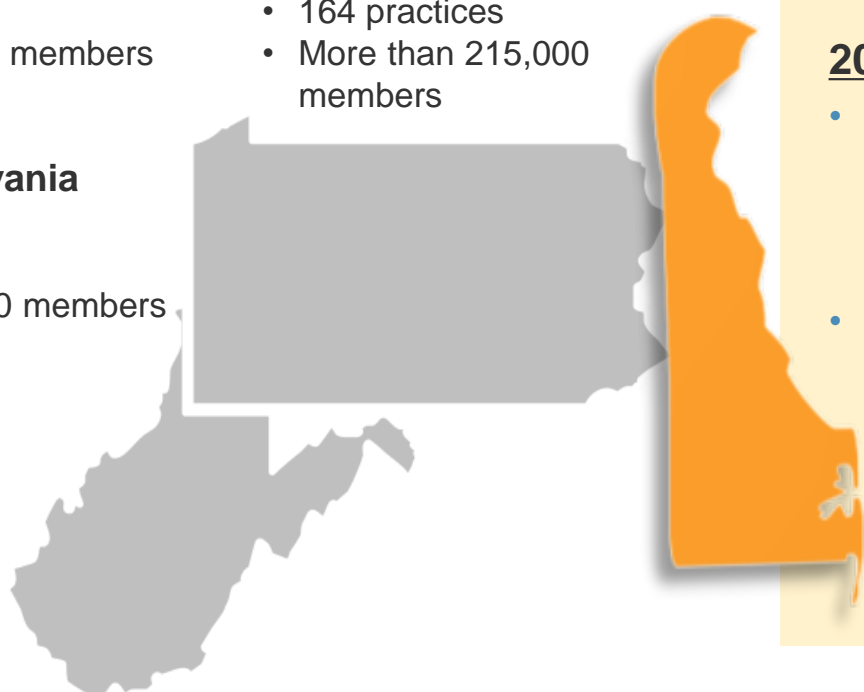
- 110 entities
- 164 practices
- More than 215,000 members

Delaware

- 76 entities
- 131 practices
- 149,557 Commercial members
- 36,537 Medicaid members (Health Options)

2017 DE Results*:

- **10.1% lower ED rates**
 - 22.02 fewer visits/1000 members
 - avg savings of \$1735 per visit
 - ✓ **\$6.4 mil** in savings
- **7.3% lower admission rates**
 - 4.66 fewer admits/1000 members
 - avg savings of \$18,157 per admission
 - ✓ **\$14.3 mil** in savings



DE True Performance and Value Based Activity

- All Delaware hospital providers are currently enrolled in the commercial True Performance program, or a custom VBR arrangement.
- Custom Value Based Reimbursement programs were negotiated with Nemours for both Commercial and Medicaid business.
- There are 37 practices on the target list to add to True Performance for CY2019
- DE hospital providers struggle with TCOC metric but are working aggressively on utilization and pharmacy to impact total cost of care.
- Saint Francis completed the 2017 Quality Blue Program with a perfect score – 1 of only 19 hospitals within Highmark’s entire footprint..
- Meetings continue with all DE hospital systems to finalize 2019 Medicaid Value Based Reimbursement arrangements
- GI Associates (Dover GI practice) has been signed onto a retrospective bundled arrangement

Provider Engagement Team Structure

Provider Account Liaison, Clinical Transformation Consultants and Advanced Analytics Data Analyst

Subject matter experts in True Performance

Meets directly with Providers

Responsible for providers with attribution >500

Responsible for Commercial Adult, Pediatrics and Commercial Senior Populations

Oversees all components of True Performance

True Performance Monthly Reporting:

True Performance Quarterly Reporting:

Collaborates with Practice Administrator, Provider Account Liaison (PAL), and Data Analyst

Strategic Integration for Provider Engagement Team Structure

Population Health Performance Specialist

Subject matter expert in True Performance Plus/Advanced

Engages with strategic partners

Responsible for entities enrolled in advanced VBR programs

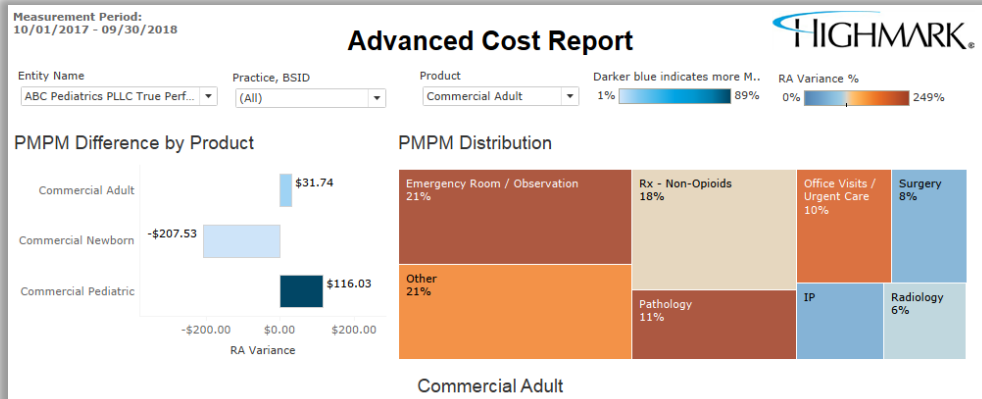
Responsible for Commercial Adult, Pediatrics, Commercial Senior Populations, and Medicare Advantage

Collaboratively develops provider specific strategy to support multi-year cost reduction through the integration of shared savings and shared risk programs

Leverages Highmark resources to support providers in their transition to independently manage the whole patient

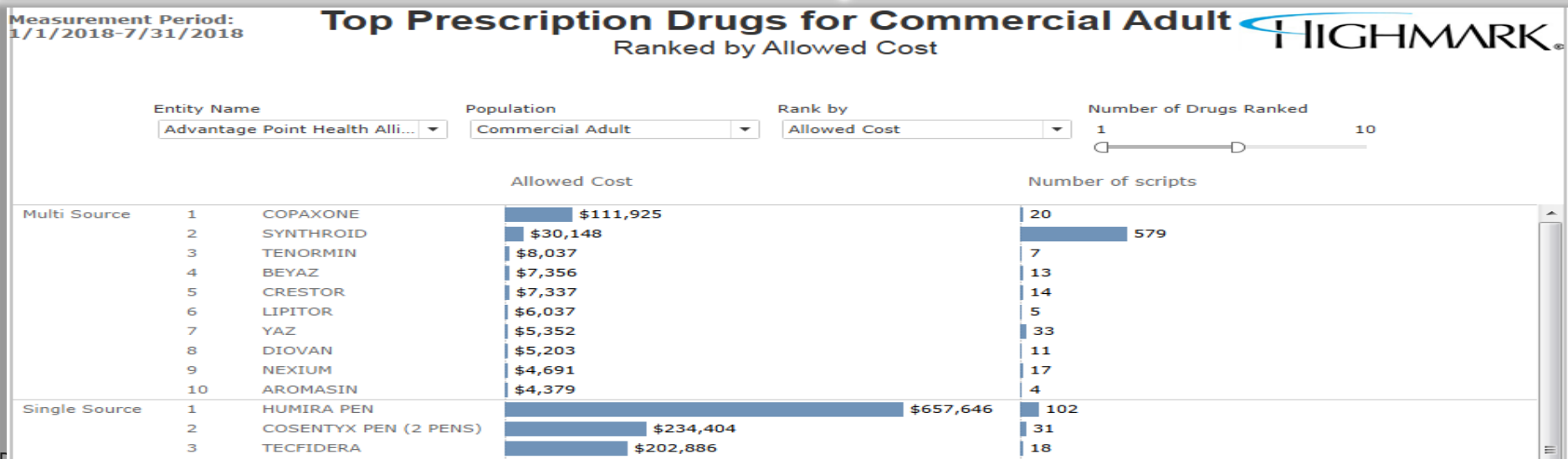
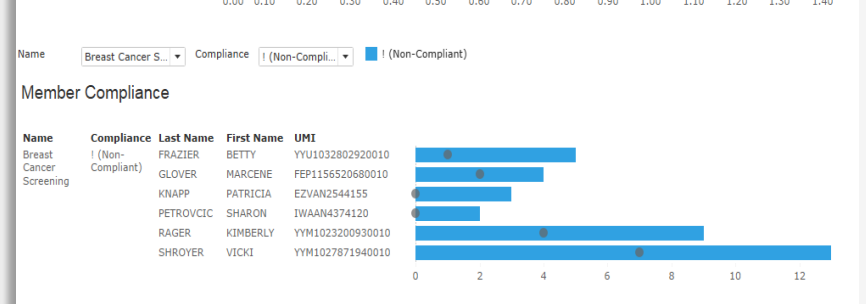
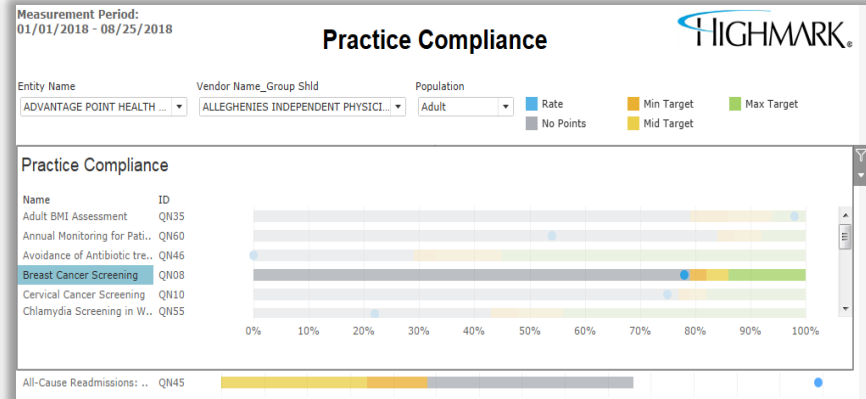
Collaborates closely with Provider Account Liaison (PAL) and CTC teams.

Enhanced, Tableau-based visuals



PMPM Detail

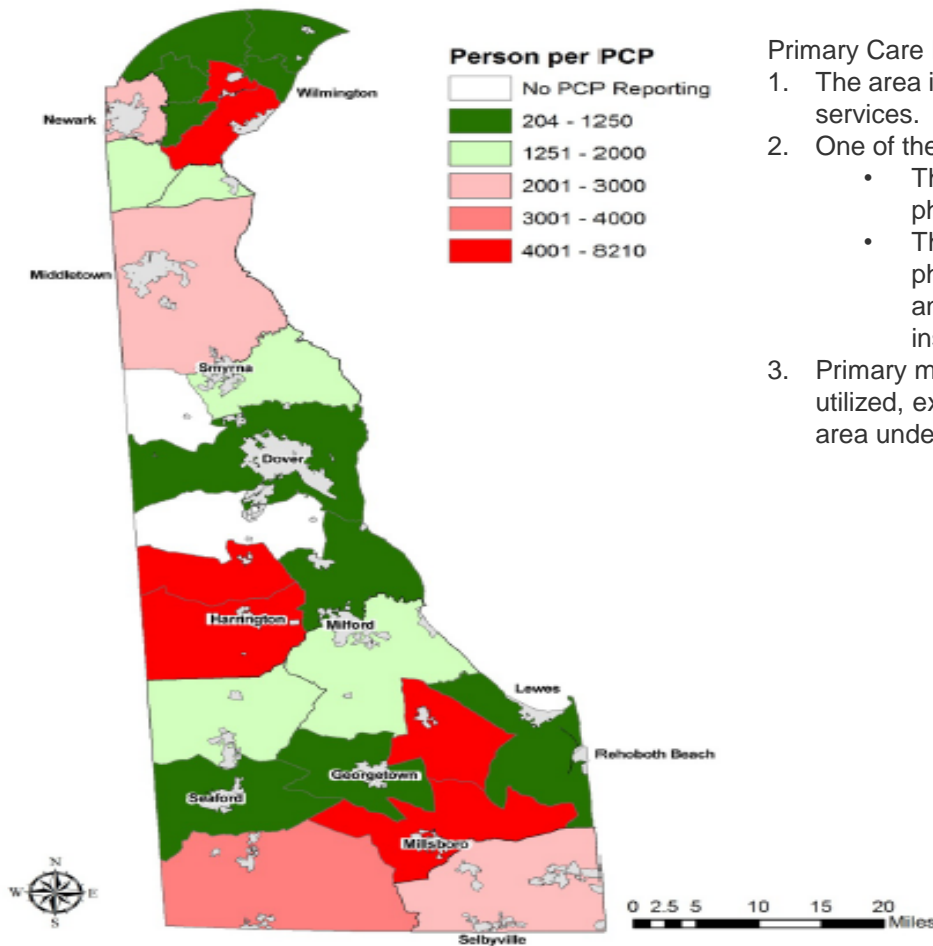
	RA Variance \$	RA Variance %	Diff due to Cost %	Diff due to Util %	Practice PMPM	Practice Util/1000	Mkt PMPM
Practice Total	\$31.74	111	114	98	\$314.08	26,248	\$811.29
Pathology	\$20.02	249	137	182	\$33.50	1,998	\$38.41
Emergency Room / Observati...	\$38.39	247	131	189	\$64.54	549	\$74.53
Office Visits / Urgent Care	\$15.47	198	104	190	\$31.21	3,376	\$44.85
Other	\$24.35	161	89	180	\$64.46	5,613	\$114.31
Rx - Non-Opioids	\$1.91	103	107	96	\$57.58	13,158	\$165.22
Radiology	-\$1.59	92	109	85	\$18.09	732	\$56.09
Surgery	-\$26.96	48	87	55	\$25.04	380	\$148.18
IP Non-Maternity	-\$25.51	43	203	21	\$19.37	84	\$127.90
Rx - Opioids	-\$1.07	6	103	6	\$0.07	190	\$3.38
Injectables / Chemo	-\$11.65	2	86	2	\$0.23	169	\$33.86
Post-Acute Care	-\$1.59	0			\$0.00	0	\$4.54



Primary Care Needs in Delaware

Delaware Primary Care Health Needs Assessment 2015

Figure 19. Number of Persons per Primary Care Physicians, in Delaware, by census county division, 2013



Primary Care Designated Shortages if these criteria are met:

1. The area is a rational area for the delivery of primary medical care services.
2. One of the following conditions prevails within the area:
 - The area has a population to full-time-equivalent primary care physician ratio of at least 3,500:1.
 - The area has a population to full-time-equivalent primary care physician ratio of less than 3,500:1 but greater than 3,000:1 and has unusually high needs for primary care services or insufficient capacity of existing primary care providers.
3. Primary medical care professionals in contiguous areas are over utilized, excessively distant, or inaccessible to the population of the area under consideration.



Next Steps:

- **Continue discussions** with Delaware health systems and large medical groups to accelerate the migration to value-based reimbursement for both Medicaid and Commercial business.
- **Continue partnering** with Delaware health systems and medical groups to become Blue Cross Blue Shield Centers of Excellence.
- **Will remain focused** on our customers through the provision of access to high-quality, cost-effective health care and the tools and programs to help improve overall health



SB 227 Primary Care Collaborative Meeting

Wednesday, December 12, 2018

4:00 pm

Medical Society of Delaware

900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

Present:

Senator Bryan Townsend
Dr. Nancy Fan
Representative David Bentz

Email:

Bryan.Townsend@state.de.us
nfanssmith@yahoo.com
David.Bentz@state.de.us

Staff:

Juliann Emory
Caitlin Del Collo
Read Scott

Juliann.Emory@state.de.us
Caitlin.DelCollo@state.de.us
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Attendees:

Tyler Blanchard
Pam Price
Susan Conaty-Buck
Dan Elliott
Cheryl Heiks
Andrew Dahlke
Ray Dotterweich
Julie Caynor
Nicole Scott
Jennifer Seo
Andrew Wilson
Faith Rentz
Anthony Onugu
Ema Ndi
Siobhan Irwin
Veronica Wilbur
Wayne Smith

Organization:

Aledade
Highmark
Delaware Coalition of Nurse Practitioners
Christiana Care Health Systems
Webster Consulting
Medical Society of Delaware
Christina Care Health Systems
Aetna
Primary Care LLC
Mental Health Association
Medical Society of Delaware/Morris James
Department of Human Resources
United Medical
More About You, Inc.
Brandywine Pediatrics
Next Century Medical Care
Delaware Healthcare Association

The meeting was called to order at 4:00 p.m.

Dr. Irwin

- Brandywine Pediatrics is a large group of general pediatricians and we have pushed to increasingly integrate behavioral health.
- We have a psychologist who is not employed, but embedded in the practice. We share the EHR and discuss patients we refer. We want to get more behavioral health integrated.
- We always have trouble getting behavioral health coverage because many psychologists and psychiatrists have waiting lists because there is so much demand.
- There is more need for primary care providers to do more behavioral health.

Dr. Wilbur

- As a family NP of 25 years, I just started own practice January 2018.
- Concurring with Dr. Irwin regarding the challenges of behavioral health. There are no behavioral health resources, so I do a lot of the behavioral health. Most of my patients have Medicaid.
- I am seeing most of the patients. I have one employee, although she is leaving.
- I have had almost 900 patient visits this year and my employee has had 300 visits.

Nicole Scott

- I have been an NP for 15 years.
- Worked at a had a large outpatient and inpatient practice. Four years ago, Premier Physicians separated, and I started Trinity Medical Associates with a physician.
- I saw how primary care was changing. There was no care because the time pressure of a 15-minute appointment was too great.
- I decided to open own practice and started June 1, 2018. It has been challenging but rewarding.
- On the average, I am seeing 13 patient a day without any marketing. There are new patients calling every day. My goal is not to become humongous; I want to provide good quality care.

Jennifer Seo

- Deputy director of Mental Health Association of Delaware, a statewide nonprofit that does mental health advocacy.

Dr. Conaty-Buck

- I am in practice with the nurse managed primary care center at UDel. The NP practice has 4 practitioners with 8,000 visits per year. The number of visits have increased 25% in

the last couple months as others primary care providers close down. We were one of the few practices taking new patients, but recently had to close to new patients.

- We are also educating the NP graduate students. The clinic at UDel also has PT, nutrition, psych, and a speech and hearing clinic. This is a larger entity that allows us to work with other providers and practice collaboratively.

Dr. Fan

- Starting with the intersection of primary care and behavioral health.
- Both Dr. Irwin and Dr. Wilbur both said a growing component of practice has been behavioral health. Why is this? Do you feel like there is greater need and less access or the need is the same and access is less or more people becoming comfortable with behavioral health in the primary care spectrum?

Dr. Wilbur

- The need for behavioral health is greater, in particular considering the opioid crisis.
- Access is a challenge for Medicaid beneficiaries. Behavioral health providers have 3 to 4 month waiting lists or they don't take Medicaid. Pain management don't take Medicaid. My practice is challenged to provide this care because 90% of my patient population has Medicaid.
- I have 38 years' experience nursing. I think nursing looks at things holistically, we approach things differently.
- When they get out of my realm of expertise and I try to push them out to specialists. But there is either no access or they are not comfortable with other providers.

Dr. Conaty-Buck

- With the Mental Health Coalition, we are getting asked to code for and evaluate behavioral health in exchange for payment. They just started talking about that last week.
- It is important to understand the view of the single practitioners. The challenges of the individual practices are significant. And discussing mental health, we are asking to do more, adding to the things we must do.
- We are barely providing primary care services, to provide suboxone or other behavioral health specific services is too much pressure.

Dr. Wilbur

- My general feeling is that the providers who offer suboxone do it for money.

Dr. Fan

- Right, because medication assisted treatment (MAT) is not necessarily tied to therapy. That is a slippery slope with MAT is that it doesn't address the larger picture of the mental health treatment needed.

Dr. Irwin

- I would say, as a suboxone waiver holder, I do not know many people who provide for insured populations, many do it for cash.

Dr. Fan

- When you imbedded the phycologist, did that help you?

Dr. Irwin

- Our psychologist is more focused on adolescent health.
- We have PhD psychologist who wanted to lease a room. After 3 years she has become more and more integrated. These are her own patients, but we share so much. And the care focuses on family dynamics.
- The children are more comfortable at a place they already know. Same with parents. The follow-up and follow-through is easier.

Dr. Wilbur

- This is true for me too. Many patients don't want to go to another provider, but I don't have the support to do all the behavioral health.
- As an independent provider, I don't hear about some of these programs, grants, or other opportunities. And I don't have the free time to search and stay on top of these opportunities. I want to serve the need I see in patients.

Nicole Scott

- 1 in 2 patients has a behavioral health issue. We are seeing chronic conditions and mental health conditions that are all tied together. In 15 minutes, how do you manage all of this in a patient?
- Behavioral health and mental health issues are one reason I chose to separate myself from a large group because I think integration with a behavioral health specialist is the way to go.

Dr. Irwin

- The need among children is so much greater. These children are stressed out. I am lucky to be in a group with the administration/ backbone to support a lot of this work.
- The nurses know how to schedule based on these conditions – to give me an hour if a child has depression or anxiety.
- We are not officially PCMH. We have a lot of the features, but have not gone through the hoops.

Dr. Fan

- Independent practices cannot become PCMH certified. And hoops are difficult to achieve the official certification, but many practices adopt some of the best practices or achieve the same thing without the certification.

Dr. Conaty-Buck

- When we talked with the insurance companies, they said the payments were flattening. The scary thing is not being able to earn the revenue to support these changes.

Dr. Fan

- Jennifer - do you get a lot of referrals?

Jennifer Seo

- We don't do direct services, but we do get a lot of calls asking for referrals. They are calling because they have tried to find providers and see waiting lists. There are a lot of barriers to doing the research finding someone who is accepting patients in time.
- We refer some individuals to crisis intervention services because they do have a psychiatrist on staff. They may be able to hold the patient over until they can get an appointment.
- We get a lot of calls that trouble finding child psychologists.
- For Medicaid and Medicare the challenges are enhanced.

Dr. Fan

- The amount of investment needed for practitioners to make behavioral health sustainable is difficult to achieve, both on the practice side and in terms of reimbursement.

Dr. Irwin

- There are challenges in access – getting the expertise needed – and in reimbursements, which are not compatible with addressing these conditions in the office.
- Speaking more as a private practice, one thing we deal with being undercut by the big corporations (i.e. Christiana or Nemours). We have more providers joining them because the cost of maintaining independence gets higher and higher, especially with reimbursements flattening.
- It is important for primary care to remain independent. We do operate as a PCMH, although we didn't find the hoops worth it.
- We can remain connected to the patients and provide more consistent, continuous care.

Dr. Conaty-Buck

- There is a difference in the payment. Although we provide the same services, we get lower reimbursement.

- The insurance company may refuse to credential an NP even if they can practice independently in the state. This restricts the choice of a patient.

Dr. Fan

- What additional investments would help you be sustainable?

Dr. Irwin

- We need money up front. We don't have the capital to bring in a full-time behavioral health specialist, see if the codes work, and see if we can make money from this new stream of care.

Dr. Wilbur

- Some little code may be wrong. I just had 20 refusals for AmeriHealth because my EIN number, which they already have, is wrong. Sometimes tell my patients that I don't exist.

Dr. Fan

- Is a care coordination fee or a PMPM?

Dr. Irwin

- Our biggest payer doesn't provide care coordination fees. This would be extremely helpful.
- Any way for us to front cost would be helpful. If the insurance would provide payment in advance, go over the codes together, make sure we know what to bill, and have the payment come off those codes.
- We will have plenty of work for this provider, but we need help to add the capacity up front.

Dr. Conaty-Buck

- We are investing in achieving metrics but the insurance companies need to look at the cost for us to meet the metrics to ensure when we achieve the metrics we do not experience a net loss.
- The threshold is high and if you don't meet it, the practice gets nothing. Is there a way for smaller to get a scaled payment with money up front?
- What can I pledge up front in return for up front money. Then if I don't do it the payer gets that money back, and if I surpass, we might bet more.

Dr. Fan

- Are you able to meet the metrics, or are they too high?

Dr. Irwin

- We've been able to meet the value-based metrics.
- The problem is that these metrics appeared without us being aware of the benchmarks and how we were doing though the year. They appeared out of nowhere.
- Our biggest payer has a new practice liaison who has been much better about communicating, and we have gotten more say in what we can accomplish. This has made it more successful for them and for us, because we are working toward things that are important in practice and achievable.

Dr. Fan

- One major trend we see is providers moving into concierge. Is that happening in pediatrics?

Dr. Irwin

- I know that none of the pediatrics have gone to concierge practice. We don't think it's fair to the kids or to the Medicaid beneficiaries. We are likeminded that it isn't a healthy way to practice
- It is where the psychiatrists are going though.
- We have seen that a couple smaller practices have agreed to get bought by larger medical groups. It is too hard to remain productive and profitable.

Dr. Conaty-Buck

- And accessing the insurance company, sometimes the NP practice needs to pay the practice to use their name to get under an agreement with the insurer.

Dr. Fan

- If you are addressing access issues, if we encouraged for team-based care, where instead of volume based, if you had a say in how practice operates would you be more interested in joining a group?

Dr. Conaty-Buck

- It really depends on how the team is structured.

Dr. Wilbur

- It depends on how collaboration is defined.

Dr. Fan

- FQHCs are really pushing the team-based model, especially with NPs and CHWs. Moving outside that particular population would this be possible.
- If you want to stay independent, how do we help you do that?

- I don't think sustainable for 100 practices of 1-2 people, because that is missing a lot of economies of scale, but what about more smaller groups?

Dr. Wilbur

- I am thinking more of consortiums. With team-based I have a vision of a very physician-driven organization and model of care. And I left practice for that reason. I need to collaborate in a truly collegial way. But the team-based models are always physician directed.
- We could make it a consortium of independent NP and physician practitioners that come together and use resources better together.

Dr. Irwin

- We are not allowed to do this though, but this would be really helpful.
- The insurance companies do not allow us to combine or negotiate in a joint way. We cannot discuss contract or negotiate vaccine prices.

Sen. Townsend

- The insurers are barring this. Is it true in all 50 states?

Dr. Fan

- If you have separate tax IDs you cannot purchase together. This is a result of the federal anti-trust laws.

Sen. Townsend

- The antitrust laws prevent small, local collaboration but don't stop large group monopoly concentration?

Dr. Wilbur

- We could still share resources, it doesn't have to be about purchasing. We could share a care coordinator or care management or addressing social determinants.
- I just found out that one of my patients had surgery and no one told me. And now DHIN wants to charge \$400 per year to access these records, but I cannot afford that.

Dr. Fan

- Would investment in HIT be helpful?

Dr. Conaty-Buck

- NPs were not included in meaningful use at first. But then they started to allow us, if we met a threshold for Medicaid. As a result, we have been behind with HIT from the beginning, so shared resources here would be good.

Dr. Fan

- And HIT is a barrier for behavioral health integration. I hear the behavioral health are not on EHRs, but there is greater uptake among primary care providers.

Dr. Irwin

- Part of it is getting the provider comfortable. The parents are happy to have us collaborate with their behavioral health providers.

Dr. Fan

- And children may be different adults may have a different concept of behavioral health and sharing information. Some adults object to sharing these mental health diagnoses.
- Do you feel that having investment in behavioral health as part of the 12% primary care investment would be good?

Dr. Irwin

- Yes, and I think this would be a good investment from the payer perspective. Individuals with mental health are not taking care of their chronic conditions. This will keep them out of the emergency room.
- This is an investment that would benefit the payers and the patients, and we can show and track this value.

Dr. Conaty-Buck

- Everyone who works in primary care practice sees this relationship between nutrition, mental health, and primary care.

Jennifer Seo

- The idea if integrated services is appealing because the behavioral health stigma means that many patients may be more comfortable going to a primary care setting.
- Certified peer specialists are people with lived experience in mental health or drug abuse, and get certification with work experience. This is reimbursed through Medicaid. Incorporating into the primary care setting could be beneficial. Those with behavioral health issues or SUD may be willing to talk to the certified peer specialist.
- We have certified peer specialists in Delaware. The Healthy Neighborhoods Taskforce had an internship cohort for a group of peer specialist to get experience and training. We have been able to provide a stipend for the internship.

- It has been pretty successful, and we are hoping to continue. We are trying to create more workforce opportunities for them.
- Private insurance does not pay for certified peer specialists, but Medicaid does. So if we could work on getting them reimbursed in private that would be great.

Dr. Irwin

- That is someone who could do support work like follow up with the patient.

Nicole Scott

- I think a social worker would also be great. I have spent countless hours finding resources to fill social needs for patients, but I don't have the knowledge to do this efficiently.

Dr. Fan

- The FQHCs found that having someone to do coordination for social determinants found that they were providing better care.
- On the other hand, there are behavioral health providers that find a patient with out of control diabetes but cannot find someone to refer to, so this integration must go both ways.
- This is a challenge of solo practice, it is difficult to meet the needs for all these patients.

Dr. Wilbur

- A one stop shop for independent providers to find help and resources for the practice and for the patient.

Ema Edi

- I started as a family NP, then I specialized in mental health and after being in practice for 3 years, I just opened my own clinic. I am now serving ages 5-85. While I specialized in mental health and come across patients with medical challenges. Even with the dual specialty it gets tricky.

Dr. Fan

- Even without marketing, you have full practices. Is that a consequence of physicians leaving adult medicine?
- What do you feel would be an answer to the lack of access?

Nicole Scott

- Making it easier for APNs to obtain the same resources as a physician. For instance, it is challenging to get insurance to collaborate with you and accept you as an independent entity or to get your own malpractice insurance.

- The physicians I worked for previously are supportive. Payers need to keep an open mind and see NPs as an adequate primary care provider.
- AmeriHealth denied me on the basis that I was an NP, despite the fact I am an independent provider and that I had 5,000 different patients in 2 years, that is a problem.

Dr. Conaty-Buck

- She can legally practice in Delaware as an independent practitioner, but an insurance company decided not to allow her in the network.

Dr. Irwin

- Payers decide whether or not to contract with every provider. It is their right at this point.

Ema Edi

- Similarly, under the group practice I was billing under the group NPI. When I went into independent practice, some insurance companies require a collaborative agreement even though the state allows us to practice independently.
- In my specialty for instance, these patients are very committed to you and you are trying to provide a different quality of care to them, but then getting the insurance refusal even though they know you care capable of the work, you just feel marginalized.

Rep. Bentz

- Which companies have done this?

Nicole Scott

- AmeriHealth

Ema Edi

- Aetna

Dr. Fan

- Jennifer, do you get calls for primary care referrals?

Jennifer Seo

- We don't get calls for primary care specifically, mostly for mental health providers, but anecdotally we see people that struggle with finding primary care.

Dr. Wilbur

- I also work at Go Care, and most people seeking care there say that they cannot find a primary care doctor.

Dr. Conaty-Buck

- We trained people who recently got coverage under the ACA to seek care, but now they cannot find it.

Emma Edi

- I refer some patients to a primary care, but they don't have a primary care. I will extend a visit without reimbursement because they will not go to the primary care provider.
- I have been in practice 5 weeks and have 600 patients without advertising.

Dr. Fan

- Is there any unique needs in pediatrics or are there similar challenges across all primary care?

Dr. Irwin

- Both. Pediatrics is specifically different on vaccines. Coordinating vaccine purchases would be important for smaller pediatrics practices.
- The larger systems help and undercut at the same time – for instance with the move to have health care in schools, we get concerned about who is with them. Pediatrics have been proponents of PCMH. School-based care or Go Care undercuts the PCMH approach and continuity of care.
- Our patients have no copay at a place like Go Care and may go there instead solely based on the copay. We lose reimbursement on this as well.

Dr. Fan

- Is there anything else you want to bring to the table on primary care sustainability?

Dr. Irwin

- EHRs are a huge issue, but they are particularly frustrating to independent practices. In a hospital you have many centers and they all must be able to talk. In a small practice everyone can talk without the EHR. The cost of EHRs to get and maintain a good system is not worth it.
- We have had a lot of problems with DHIN recently. The EHRs do not communicate with all the different hospitals or lab providers. We are forced to do the EHR without the benefits of full information.

Dr. Wilbur

- DIHN has good intentions with creating a community record. It seems like not all provider add information.

- Now they want to charge us. They say \$400 for DHIN isn't much, but this is one in a series of small monthly costs that are essential to run the practice.

Dr. Conaty-Buck

- And sometimes there are providers who don't recognize the NP as the primary care provider and care coordinator.

Dr. Wilbur

- Bottomline is that we need to communicate better.

Ema Edi

- Before I ventured out on my own, I was in the corrections system. The communication between mental and primary care is essential. Both are treating the same conditions or symptoms without communicating. There are side effects and consequences for the lack of communication.
- The primary care and mental health are treating the same things. We are paying for a EHR that isn't efficient. You ask for data, but don't get it. The patients don't understand what is going on in the background.

Rep. Bentz

- Does DHIN charge different amount depending on the size of the practice?

Dr. Conaty-Buck

- It looks at the number of patients.

Rep. Bentz

- What is the range of monthly cost for DHIN?

Dr. Fan

- There are different costs to different services. If you contribute CCBs, there is a cost to that. The hospitals do that. The costs are by practice site.

Sen. Townsend

- I am surprised this is the first time I've heard of DIHN problems during all these sessions.

Dr. Wilbur

- DIHN had been absorbing cost, so the fees are now in place.

- It is critical sometimes to hear about what happens to my patients. And other providers would benefit from the information I can provide on the patient as well.
- I would invite anyone to come spend a day in my practice to see what the rules and regulations are and how it impacts the practice.

Dr. Conaty-Buck

- CMS had two specialists follow us around when looking at administrative burden and they were shocked.
- One of the things facing us is supporting the independent practice. The large hospital practices which can support a sophisticated infrastructure. How are we making sure that there are different choices, so the patients can find the right provider for them, accessible at different levels. We need to provide support for the small practices to continue to exist.

Dr. Fan

- Large practices donate lots of resources at their own cost to support primary care, but smaller do not have the margins to do that. We want the patients to be able to see the provider they want. Keeping the patient at the center is essential.
- One of the hardest questions I get is “I need a new primary care provider” because they trust me.

Dr. Irwin

- Take the solo/small out of this. There are still share challenges. Behavioral health is really important so why at larger clinics are they not integrating behavioral health? Because it is not considered important in the reimbursement.
- We have challenges in primary care where we are responsible for the specialist and patient decisions. We get the burden of handling it on the primary care end, rather than on the side of the specialist or emergency room.

Dr. Fan

- You are assuming the risk and not getting the value.

Dr. Wilbur

- I have patients who don't want to go back to specific providers. But they have few choices outside of those providers.

Dr. Conaty-Buck

- It isn't us vs them – NP vs physician. Each of us have different talents and abilities.
- The NPs are not trying to takeover or attack physicians. The intention is to allow us to practice effectively and provide good patient care.

Dr. Fan

- We want to keep the patient first and recognize that we have an access problem in Delaware.

Dr. Conaty-Buck

- At the university we train mental health NPs. We are seeing a number of NPs going back to get the specialization. These folks have jobs 6 months to a year before they graduate. But many are being lured to other states with offers of greater salary, benefits, and independence.
- If you want to build a strong workforce it's not all about money, but you have to look at the equity and their career outlook.
- Now most NPs get doctorates which requires additional cost and schooling.

Dr. Fan

- In terms of maintaining the current workforce, have you had any new pediatricians?

Dr. Irwin

- We have not had much turn over. We have been very stable.

Public Comment

Wayne Smith

- I run the Delaware Healthcare Association. We have an access problem in Delaware. Primary care is the key to good health and Delaware hospitals are fully on board with making sure we have a robust primary care system.
- We have a statement responding to the payers' discussion at the last meeting that discussed hospital costs.
- We are fully behind VBP reform and hospitals are leading the way in Delaware. The hospitals advocated for the addition of the DHCC tracking value-based contracts with the goal of reaching 60%.
- There is a lack of competition among health insurers is a significant issue. Of the 50 states, Delaware has the second worst competitive environment. The lack of competition among health insurers mean they are not compelled to develop VBP. It is the economic and political environment that determines VBP adoption, not the willingness of the hospitals. The political environment has been positive with the 60% VBP goal. But the economic environment is challenging with the lack of competition.
- All general acute care hospitals are in the Medicare ACOs and are moving toward statewide integrated networks. The payers have had no engagement in these initiatives. And no insurers have proposed anything similar to the Medicare ACO programs.

- The lack of prayer competition has been a key force in driving independent to joining hospital systems due to high administrative costs. They cannot do patient care when they are doing managed care work. Hospitals can take up some of this burden for primary care providers.
- We are fully behind payment reform and believe hospitals are leading the way.

Cheryl Hikes

- I represent Delaware Health Information Network. I am not able to share information on their pricing, but I can ask them to come and share information for follow-up if you like.

Dr. Fan

- We will have a draft report with the recommendations that will be circulated then presented publicly on the January 2nd. This will be a public meeting.

Sen. Townsend

- If you sign-in, we will circulate the draft report. Then on January 2, we finalize and approve.

The meeting was adjourned at 6:00 p.m.

Topics for Discussion

Delaware Primary Care Collaborative Meeting Thursday December 12, 2018

Nurse Practitioner Questions

1. What unique challenges do nurse practitioners face in primary care practice in Delaware compared to other primary care practitioners that could be addressed through increased investment in primary care?
2. How effective are the existing value-based payment programs offered by payers in Delaware in supporting your delivery of high value primary care?
3. Beyond enhanced revenue potential, what other barriers to practicing in Delaware do nurse practitioners face and how should those be addressed?
4. How do you recommend that we both enhance financial support of primary care providers in Delaware while assuring accountability for controlling total cost of health care inflationary trend at rate that society has deemed necessary? Do you have any specific payment reform models to recommend?

Primary Care/BH

1. What portion of your primary care patients have a behavioral health condition? How has this impacted your primary care practice? Are you able to find timely referral sources for your patients with behavioral health conditions?
2. What are the barriers to addressing more behavioral health within your primary care practice?
3. How could additional investment in primary care help PCPs/pediatricians address more behavioral health within the medical home?

Pediatrics:

1. Pediatrics was the original group who designed and championed the PCMH model. Is your practice a PCMH model? Would further investment in primary care, from the state, be helpful to support practices to become PCMHs and would that impact cost/quality/outcomes?
2. Are you participating in any VPB programs *such as True Performance*? If so, how has the program impacted your approach to meeting quality metrics and managing total cost of care of your patients, including newborns?

Consumers:

1. What has been your experience, of that of your members, in finding access to primary care practices?
2. What could your PCP do to better address your preventative and chronic medical conditions?

SB 227 Primary Care Collaborative Meeting

Wednesday, January 2, 2019

4:00 pm

Medical Society of Delaware

900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

Present:

Senator Bryan Townsend
Dr. Nancy Fan
Representative David Bentz

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Attendees:

Pam Price
Steven Costantino
Molly Magarik
Drew Wilson
Secretary Kara Walker
Cheryl Heiks
Stacey Schiller
Lizzie Lewis Zubaca
Wayne Smith
Katherine Impellizzeri
Christine Schiltz
Elisabeth Scheneman
Jan Lee

Organization:

Highmark
DHSS
DHSS
Morris James/ MSD
DHSS
Webster Consulting
DHIN
HGP
DHA
Aetna
Parkowski Guerke & Swayze
DHSS
DHIN

The meeting was called to order at 4:00 p.m.

As a follow up to questions about DHIN at the last Collaborative meeting, Dr. Jan Lee, CEO of DHIN gave the following presentation.

- DHIN is a statutory entity. DHIN has a broad mandate to promote the design implementation, operation, and maintenance of facilities for the public and private use of health care information. DHIN is the state sanctioned provider of health information exchange (HIE) services.
- DHIN has the power to establish and collect user fees but has avoided charging user fees for a long time.
- Early on, DHIN searched for a funding model. Starting in 2006, DHIN received federal from AHRQ and state funding based on a dollar-for-dollar private match.
- Based on survey feedback about the demand for services, DHIN established an electronic results delivery service. Subsequently, in 2009, DHIN added the community health record, which is a searchable longitudinal health record.
- In 2010, DHIN was reorganized to function within a more traditional, self-sustaining corporate model, moving away from the cost recovery model. Goals included creating value for payers to bring them in as participants and saturating the market to capture more data. DHIN have received no capital funding from the state since 2012.
- Currently, DHIN offers 20 service lines. This includes the results delivery and the community health record.
- The funding has shifted from largely state and federal funding to largely data senders, and payers. Medicaid and state employee health plans were required to participate and support DHIN (an indirect state payment). Data senders include the 6 Delaware hospitals, 3 Maryland hospitals, many labs, and most imaging centers in Delaware. Providers are a very small portion of the funding (about 3%) as of 2016.
- DHIN's pricing guiding principles:
 - All who receive value from DHIN should help support DHIN
 - Support can be both financial and non-financial
 - Fees should be proportional to the value received
- State funding sources and mandated costs:
 - Public Health reimburses DHIN for the cost of infrastructure for Public Health programs (pass through costs).
 - DMMA (Medicaid), SEBC (state employee health plans), and QHPs (ACA Exchange plans) required payers to support DHIN.
 - DHIN used to receive legal support from the state, but now must have their own in-house counsel.
 - DTI now requires DHIN to carry cyber insurance.
- Data senders pay all costs associated with delivering results. DHIN does not charge providers to receive clinical results.
- Ambulatory Providers:

- Hospitals have been pushing for ambulatory practices to bear some of the costs.
- FY2019 is the first year DHIN has charged ambulatory practices for access to the community health record. This cost is approximately \$1.50 per business day for a practice to access records via DHIN. If the practice agrees to send data to DHIN, that fee is cut in half.
- There are eight different service bundle options available. The community health record is \$400 per year. Additional services such as event notification or using PHR as their patient portal increases the ambulatory provider fee.
- The utilization of the community health record continues to grow.

Rep. Bentz

- At the last meeting I was inquiring if the fee model is flat or accounts for utilization. Is there a way to make it more affordable for those who use DHIN less compared to high utilizers? In particular, a model accounting for small practices who would access it less compared to larger practices with more providers?

Dr. Lee

- We started here because we didn't think this would be cost prohibitive, but also knowing that there would be some practices that would refuse to pay anything, no matter how low.
- We want to finish the year with this model and reevaluate going forward.

Dr. Jones, HMA

- This tool and additional services such as real time alerts of hospital registrations and discharges become increasingly useful for providers that are participating in an advanced alternative payment model that incent for better management of the total cost of care.

Dr. Fan

- When you move to a value-based program, practices should be able to show the advantage of accessing a tool like this. Whether it is an investment in your own infrastructure or reimbursed through a PMPM, practices will want to understand the value they can generate by using these tools.
- New payment models represent a new horizon for DHIN and can inform the role DHIN plays in the health system transformation moving forward.
- DHIN will need to demonstrate its value proposition in the new health care environment.

Dr. Lee

- DHIN reevaluates the pricing structure each year. In May we come out with the projected for the coming fiscal year.
- Hospitals have a tier model based on the value of data they send, ranging from \$0.24 and \$0.34 per record sent.

- We have an annual report to the General Assembly and the Governor containing this financial information.

Sen. Townsend

- For the hospitals what is the range of fees in aggregate?

Dr. Lee

- Christiana is the largest contributor, contributing over \$1 million annually, followed by Bayhealth which contributed about \$1 million.
- DHIN's total annual budget is around \$8 million.

Dr. Fan

- Moving on to the report – is there anything we need to highlight for discussion?

Sen. Townsend

- Apologies for delay in getting it out later than anticipated. We had hoped to have this out several days ago. The content should not surprise anyone. The format is not final, but the hope is that the content is now completed.
- The outstanding issue is how to proceed, following up in the legislative context or exploring the bounds of this Collaborative which is established in statute. This report provides a path for legislative and non-statutory authority.

Dr. Fan

- Going through the way the report was structured. First, we have the executive summary, which provides a high-level overview of the content of the report.
- The report includes the content of the Collaborative meetings. It became clear during those meetings that payment reform was the most urgent issue, even though the SB227 had other areas the Collaborative must address during these three years. All these other topics, like workforce, dovetailed with the payment reform recommendations.
- We tried to illustrate that we heard from many different groups. It seemed evident that while there have been initiatives to address primary care, not everyone is aligned and moving in the same direction. Also, efforts are not moving as quickly as everyone would like. We heard that if we don't address these problems urgently we will have a real crisis.
- This is not a consensus report – it doesn't reflect everyone's opinions from those who attended the stakeholder sessions. We wanted to move it forward and offer recommendations that would increase investment in primary care and keep it sustainable.
- Foundationally, we all agree that primary care is essential to a better health care system and there is evidence that maintaining the primary care workforce saves lives and money.
- I would appreciate it if people would read through the report.

- The minutes from all of the stakeholder meetings in this process will all be added as an appendix and are available on the website. I want to point out that there is more content in the body of the report than what is just in the executive summary, in particular the evidence base for the recommendations.

Sen. Townsend

- We could have organized this differently, but we took this approach to be concise and prescriptive in the interest of moving the discussion forward and towards action.
- This report is not meant to reference every single thing we discussed in these meetings.

Dr. Fan

- Next, this report goes to HCC and the General Assembly.
- In time we will focus on other topics outlined in SB227, including workforce and behavioral health.
- This report is the jumping off point to start addressing the most pressing needs. I heard repeatedly that we must recognize that the primary care system is not sustainable and decreasing in access. This report starts to address how to relieve some of that immediately and address other topics down the road.
- We also heard from other states that none of this gets done in a year.

Rep. Bentz

- The executive summary lays out in the quickest terms what we learned from this process. The document is not meant to reflect a general consensus, but rather what the Collaborative took from this series of meetings and our conclusions of what a good path forward would be.
- Nothing should be surprising in terms of the content and recommendations. These recommendations are supported by what we heard in terms of the problems and possible solutions. The evidence also provides additional support for the recommendations.
- The frequency of these meeting will reduce in the coming months.

Sen. Townsend

- Part of the challenge is that this turned into a dialogue from a different stakeholder each week but didn't allow for a dynamic conversation across stakeholders.
- Moving forward, the Collaborative can facilitate additional open dialogue in an iterative way, even concurrently with the legislative process. One of the big opportunities for us is to simply provide an opportunity for iterative debate dialogue. We also want to ensure the stakeholders are willing to continue to participate – whether this dialogue continues privately or publicly.

Dr. Fan

- Since this was our first session of the Collaborative we were more prescriptive with format, but we are open to feedback on how to move forward including venues formats, topics, etc.

Public comment:

Wayne Smith

- This report has only been available for a couple hours, but I have had a couple minutes to note a few comments.
- What is the process of this document?

Dr. Fan

- The initial idea was to have a draft at this meeting to present to the HCC and the General Assembly on the 8th.

Sen. Townsend

- This is different from a taskforce that requires consensus. We want to have it finalized today. As a disclaimer, this report does not represent the consensus of all the groups we heard from throughout the Collaborative meetings.

Dr. Fan

- Would it be good to have a comment section at the end of the report, like a letter comment or reaction?

Sen. Townsend

- I would rather do a disclaimer that this doesn't present the views of all these stakeholders. Other taskforces have a minority report or dissenting comment letter about how they feel about the issue. This is a different process though.

Wayne Smith

- My concern is that it represents your consensus opinions (the three Collaborative members).
- There are some major recommendations that are big surprises.
- You call for hospital rate caps, which is well beyond the scope of SB227.
- You have a mandate to investigate the progress to value-based payments (VBPs). Adding rate caps destroys the negotiation process that is essential to moving to VBPs.
- Talking about rate caps contradicts the Secretary's statement that the benchmark process does not include rate caps.

- The only other thing I would mention is that hospitals pay a lot to support primary care. In particular for smaller hospitals, if rates are capped you provide impediment to supporting primary care.
- The rate cap is a dramatic recommendation, beyond the scope of SB227, and contradictory to supporting value-based payments.

Rep. Bentz

- I don't think it is beyond the scope of our mandate. We are investigating the merits of 12% investment in primary care and how this fits into the benchmark, which is intended to keep the growth within the range sent by the administration.
- The idea of considering total cost controls when you are proposing increasing payments to a primary care is within the scope of this Collaborative.
- Again – this is not intended to be a consensus document. This is us (the three of the Collaborative) taking the information we got and informing how we think the state should proceed.

Wayne Smith

- My concern is that this is your consensus. You had limited input, and the process didn't allow a back and forth among stakeholders, rather it was more a cataloging of the concerns of different stakeholders. There was little time for investigation. We did not ascertain if the testimony was accurate or evidence-based.

Sen. Townsend

- In the report, we are asking for a consideration of a rate cap. Our point is not that this is a hard and fast solution, but that a rate cap is a tool to be considered and fleshed out in the broader context of increased primary care investment.
- This is to be teed up in the continued dialogue about how much, if, and when to address these issues. There is no legislation out there to put this into action immediately.
- This is related to value-based payment. We need additional analysis and discussion.
- This represents an acknowledgment of the broader issue of total health care spending.

Dr. Fan

- We all recognize that there are other topics that need a deeper dive, including value-based payments.
- Regarding the benchmarking process, it is not a process where they are setting or adding rate caps. If out of the Collaborative process, the legislative or regulatory body decides that this needs to be used as a tool, that body might consider and implement the rate caps.
- We recognize that we need to talk about the total health care spending and the unsustainable growth in health care spending.

- If we are asking for an increase in primary care spending here, then we need to also consider the total cost.
- None of us are shying away from the concept of rate caps, but this is not the end all be all and we don't expect everyone to agree with us.

Pam Price

- As a citizen, rather than Highmark, in the future I would suggest bringing the different stakeholders together and set the agenda for discussion. There was a lot of learning during this Collaborative, but we need open dialogue in order to do the deeper dive. I was left wanting further answers. There was none of that back and forth, but with increased discussion, we could get closer to the truth and discuss discrepancies.

Dr. Fan

- A more discussive atmosphere would be good. Everyone has their own source of truth and aligning those viewpoints might not be possible.

Sen. Townsend

- We can and should be able to sort out a lot in a discussive meetings. We would need to channel the discussion and identify the right representatives of stakeholders. This needs to occur outside of a legislative context due to the time requirements.
- The Collaborative is able to call additional meetings apart from what is legally mandated.
- I hope people would come to the table with the information they need to make their case.

Rep. Bentz

- There is a lot of merit to proceeding with open dialogue about different ideas.
- Regarding the report, I don't know how much a set up like that would change the report.

Sen. Townsend

- Inherent in the cost mandate, there are a lot of structural and systemic features that we should get into in more detail, but that doesn't necessarily change our views.
- We are a crisis level, so we wanted to get this report out. We need to work on this now.
- We need to have these tough conversations now and figure out how to address this issue.

Christine Schiltz

- The Health Care Commission meeting is tomorrow at 9am. Will this be presented tomorrow to the HCC?

Dr. Fan

- The update to the HCC will be that we drafted a report and it will go to the HCC and the General Assembly.
- The HCC will all get a copy, but the intention was not to have another public discussion on the report at tomorrow's meeting.

Sen. Townsend

- And this will not be finalized to deliver at the HCC meeting tomorrow. It will be a few days to package it up.

Dr. Fan

- I am open to having an appendix of comments and responses in light of the fact that we did not have time for people to see this.

Sen. Townsend

- Provide us your comments by 2pm Monday, January 7th.
- There is no legislation teed up. There will need to be legislation in order to make any changes.
- There are a lot of issues to work through, and we want to work with all the key stakeholders to get this done.

Dr. Fan

- The final draft will include an appendix with the minutes and presentations as well as comment letters. The document will be released publicly – specifically for the HCC and the General Assembly.

Sen. Townsend

- We will solicit input about what these upcoming meetings should look like.
- We will figure out when, how, and with whom these meetings will occur. We need additional discussion of these issues.



January 7, 2019

Wayne A. Smith
President & CEO

**Delaware Healthcare Association
Primary Care Collaborative Submission for Final Report**

Dear Senator Townsend, Representative Bentz, and Dr. Fan:

*Alfred I. duPont Hospital
for Children*
Roy Proutjansky, MD,
Chief Executive of
Nemours Delaware
Valley Operations

Thank you for the opportunity to comment on the draft report (the “Report”) of the Primary Care Collaborative that was circulated for stakeholder input late last week. I respectfully submit this comment letter on behalf of the members of the Delaware Healthcare Association (“DHA”).

Bayhealth
Terry Murphy,
President & CEO

As DHA noted in last year’s legislative debates about the primary care legislation, we agree that a robust system of primary care is the lynchpin of a high value health care delivery system for the neighbors we serve. Access to primary care increases health and saves money.

Beebe Healthcare
Jeffrey M. Fried
President & CEO

*Christiana Care Health
System*
Janice E. Nevin, M.D.
MPH
President & CEO

A core mission of the hospital and health systems that serve all of Delaware is the maintenance of a robust primary care network in service of local communities. Delaware health systems are the backstop to ensuring primary care exists for those we serve. Delaware health systems invest significant resources to recruit, maintain and support primary care service providers that in many cases would not exist in certain locals absent health system support. As we also noted in last year’s discussions about the proposed primary care legislation, our emergency rooms are the health care setting of last resort for patients whose physicians have retired or converted to concierge practices. DHA members are investing heavily in primary care infrastructure to alleviate the current shortages.

Nanticoke Health Services
Steven A. Rose, RN, MN
President & CEO

St. Francis Healthcare
Daniel Sinnott
President & CEO

*Delaware Healthcare
Association*
Wayne A. Smith
President & CEO

The availability of primary care is a national issue and has national causes. Local influences in Delaware also contribute to the current environment. These local influences are important, but one cannot ignore major factors such as the rise of specialists and subspecialists to address ever more complex and sophisticated treatment and the low number of new primary care physicians being trained. To the extent the presentations to the Collaborative addressed causes, there was little focus on national trends. Also unexplored during this process were ways in which primary care is being delivered beyond traditional avenues such as via virtual visits, walk-in clinics, and the growing utilization of telemedicine in the continuum of care.

A significant assumption of this report is that the Delaware issue with primary care providers is a direct result of how primary care physicians are paid here. This is held out as the sole cause of the decreasing number of physicians in Delaware. Based on direct experience with the recruitment and deployment of primary care providers, Delaware hospitals and health systems and other recruiters know that the issues with primary care acquisition and supply

are multi-faceted, and, as described above, national as well as local in nature.

There is no exploration in this Report of why we have a smaller percentage of healthcare spending going to primary care other than reimbursement. Questions such as, *Is the actual pay of Delaware primary care physician's less than the national or regional average?*, and, *Are the rates paid by Medicaid and commercial less here than other similar locations?*, would be important to answer before contemplating action. An assessment of the success or failure of the significant SIM grant monies used to support primary care transformation “for over 100 practices” would also be important as well as regulatory, reimbursement, and training barriers that have hindered broader deployment of advance practice registered nurses and physician assistants as seen in other states.

Data collection and assessment were not a part of this process. While the opinions and qualitative observations provided by those who presented at the Collaborative's meetings are certainly important inputs in framing the issue, an examination of local and national data regarding primary care acquisition, deployment and maintenance was largely absent from the proceedings. Understanding of the scope of the problem and the opportunities available for action would be significantly increased were quantitative assessment and analysis undertaken.

While we fully agree that a well-resourced primary care system is critical for a high-value health care delivery system in Delaware, DHA members are very concerned about the nature of the recommendations outlined in the draft Report. Our concerns are briefly outlined below, and we look forward to further opportunities to provide input and feedback on these recommendations.

(1) A hospital cost cap will ultimately reduce access to health care for Delawareans.

Our fundamental concern is that imposing a cap on hospital rates in order to fund higher insurance payments to primary care providers will ultimately *reduce* access to health care services for Delawareans—including primary care services.

The proposal to cap hospital rates is precisely the type of cost cap that was soundly rejected in the 2017 Congressional proposals to “Repeal and Replace” the Affordable Care Act with a Medicaid system that imposed per-capita caps on the cost of health care services for Medicaid beneficiaries. A cost cap is a blunt instrument that fails to account for significant structural issues in the health care system at the federal and individual state levels. For example, Delaware is one of only three states that CMS has classified as “all-urban” (meaning there are no small, rural hospitals as federally defined), accounting for the fact that Delaware health systems are competing for physicians, nurses and other health care delivery professionals with large health system employers in neighboring cities and states (including Philadelphia and Baltimore).

Hospitals lose millions of dollars annually in recruiting and then supporting primary care providers for those networks that are the access point for many underserved Delawareans. Delawareans who would otherwise have very limited primary care options they could easily or affordably access. A cap on hospital rates would reduce the money needed to underwrite the losses incurred by our non-profit hospitals in ensuring primary care where it otherwise would not exist.

(2) The recommendations outlined in the Report reflect the need for additional data and stakeholder input.

At the outset, and with no disrespect to the considerable time and effort expended by the Collaborative Co-Chairs, the Primary Care Collaborative was structured in a way that limited the opportunities to work toward sustainable systemic solutions. No work groups of stakeholders met collaboratively to discuss ways to better ensure access to primary care. Sessions were a series of discrete meetings where stakeholders (physicians, nurse practitioners, hospitals, insurers) singularly described the primary care environment as they saw it and put forth to a greater or lesser degree suggestions to address concerns with the existing system. These meetings were augmented by a few outside presenters who shared experiences from other states – states with very different health environments than found in Delaware.

What was missing, perhaps in large part due to the very compressed time window required by SB 227 for initial recommendations, was the collaborative back and forth that is the important feature of stakeholder member task forces. Dialogues among stakeholders are the best way to identify common approaches that might actually address the issue and avoid unintended consequences.

In addition, and as further outlined below, SB 227 contemplated that data from the Delaware Health Care Claims Database (HCCD) would inform the dialogue and discussions about the primary care delivery system in Delaware, including providing the baseline data about primary care spending that has been conspicuously absent in the State’s ongoing policy discussions.

(3) Imposing an arbitrary cost cap on hospital and health care services will undermine the State’s goals to move to value-based payment in health care delivery.

Senate Bill 227 – the law that produced this Primary Care Collaborative also directed the Delaware Health Care Commission to take the opportunity to measure and facilitate reaching a goal of having at least 60% of Delawareans attributed to meaningful value-based payment models by 2021. Value Based Contracting is the national trend and practice in changing a broken fee-for service payment system to one that incentivizes high quality and economy in delivery of health care. It also incentivizes a robust primary care component in order to treat on the front end those ailments that grow ever costlier if left alone. However, Value Based Contracting requires a playing field where insurers and providers can negotiate freely toward sustainable value based contracting models. Artificially set or capped rates by the state would destroy the environment in which productive value-based negotiations could take place and severely limit the ability of one or both sides in the negotiations to arrive at mutually agreeable and sustainable Value Based payment models.

This report contradicts the Administration’s Benchmark assertions and statements that a Benchmark is not a cap on spending. Secretary Kara Walker emphatically and repeatedly made this point during last spring’s Advisory Panel meetings on the Benchmark in her “Myth Busters” document.

This report also advocates changes in payment and mandates that were laid on the table during the legislative process that produced SB 227. Critical parts of SB 227 have a three-year duration. This three-year period will only be eight days old at the release of this report. The Health Care Commission has yet to even begin the measurement process of accretion in the market toward the 2021 goal of 60% coverage of patient lives by value-based contracts.

Clearly this report is an opinion document by a small group of governmental officials and not the product of a stakeholder process. The unintended consequences of the report's recommendations risk lessening the provision of primary care services in areas where it is hard to attract physicians and nurse practitioners without hospitals underwriting losses in primary care. The recommendations run counter to the Administration's stated position that the Benchmark is not rate setting or rate capping. This report also would severely distort the effort undertaken in SB 227 to drive greater support for primary care by encouraging a significant increase in patient lives covered by value-based contracts.

SUGGESTED PATH FORWARD.

The best opportunity to identify the scope of the primary care issue, contributing factors, and workable action plans would be to include stakeholders and those with experience and expertise in a discussion and search for recommendations. The issue of primary care support is complex and multi-faceted, and it is a subset of the complex and multi-faceted issues relating to health care delivery in a system defined by high value.

We propose the convening of a stakeholder and experience work group that would include providers, payers (commercial and governmental), and the public. This group would undertake a systematic examination of the issue and work towards recommendations that can move towards the goal of serving a robust primary care system for all Delawareans with a minimum of disruptive and unintentional consequences.

All who read this report will recognize such a suggested workgroup as the time-honored path toward meaningful and effective change in Delaware. It should be deployed in pursuit of the objective of maintaining a robust system of primary care for the health of those we serve.

Sincerely,



Wayne A. Smith
President and CEO

Thank you for the opportunity to comment on the draft final report of the Primary Care Collaborative. Highmark Delaware believes that this collaborative can be an effective resource in transforming the way in which care is delivered, reimbursed, and evaluated. We are concerned, however, that we and other members of the collaborative have not been allotted an opportunity to contribute to the drafting of the final report or afforded sufficient time to review, analyze and offer constructive feedback to the report. Further, without looking at the entire continuum of health care delivery, from pre-acute services to post- acute care, we will continue to struggle to find the right solutions to providing affordable, accessible care to the residents of the state of Delaware.

We offer the following immediate observations. As we continue to review and analyze the final draft report, we hope to provide additional comments to the committee. :

- Patients are the ones that pay for health care. Whether it be individuals enrolled in individual policies paying both premiums and cost sharing or group customers offering benefits to employees sharing the cost of premiums, it is health care consumers that pay for the services. We need to develop and recommend solutions that keep the patient at the center of the solution.
- Rate setting promotes and perpetuates a fee for service reimbursement methodology. The market should move towards, adopt or offer value based reimbursement methods which will encourage the health care market to more appropriately balance spending allocations, but most importantly, lower the cost of healthcare while providing better outcomes.
- Highmark Delaware recommends not mandating a specific rate or percentage of spend in a specific category but rather work off the benchmarks already established and develop a strategy to reach that goal.
- Highmark Delaware agrees that promoting and expanding primary care services is a critical success factor to lower health care costs and as we have demonstrated through our actions, Highmark Delaware is committed to placing the primary care physician at the center of managing the patients' health. Our True Performance program promotes effective and efficient use of primary care services, provides human resources and technical support to the practices and provides a real and sustainable financial reward for demonstrating measurable outcomes that provide the patient with appropriate quality, cost management and experience. Our True Performance program already provides exactly what the Committee is recommending: "...upfront payments..." to build and sustain an appropriate infrastructure and "...value based incentives that reward high-quality, cost effective care." Our True Performance program currently has over 1.8M attributed members and over 1,500 primary care practices.
- Highmark Delaware fully supports the recommendation that any solution should encourage greater participation in value-based models. Highmark Delaware has been highly successful in developing, with willing and engaged provider partners, value based reimbursement models and is a leader in this space.
- The use of down-side risk is an important element of any value based reimbursement program, but care must be taken to not force risk on providers who do not have the capability to manage

downside risk. In our experience, very few providers are currently prepared to appropriately and successfully manage down side risk. Providers must be assessed for their ability and then bridged via other value based programs into risk to ensure viability of the providers and the program. Highmark has been successful in implementing down-side risk programs with providers that are prepared for managing a population and a population of enough size to minimize routine variability.

- The critical piece that is missing from the report is that true engagement by all providers in the health care continuum, especially hospitals and health systems, is needed for these programs to take effect in Delaware.
- The committee needs to look closely at the cost of care that is being provided by the hospitals and health systems in the State. These costs remain a significant factor in Delaware's overall cost of care. The committee should develop recommendations for hospitals and health systems to invest in primary care.
- Increasing payments without tying those increases to quality outcomes and total cost of care improvements/reductions will only serve to increase care costs; while patients will continue to struggle with access and availability to good quality and appropriate care. Any mandate of additional payments or specific rates must be offset by savings through more efficient, effective and quality driven care.
- The report and recommendations places the responsibility and solutions primarily on payers on behalf of the individuals and businesses that pay for care. The solutions must be a collaborative effort that recognizes this as a community problem. Focusing only on Primary Care and on fee for service reimbursement will only exasperate the problem, not generate solutions. Putting new costs directly on the payers will only force consumers/patients to pay more for services.

Additionally, Highmark DE would like to share the following metrics to help inform this discussion,.

- 90% of Highmark members in each county in the state will have at least 1 PCP and 1 of each of the specialists/providers available within 20 miles urban/suburban and within 45 miles rural in any other county.
- There were 0 provider gaps identified specific to PCP's for our products.
- There were 0 provider gaps identified specific to specialists for our products.
- There were no member complaints related to practitioner availability for this population.
- As of June 2018 89.4% of PCPs in our network have open panels.
- 100% of Pediatricians in our network have open panels.

Highmark Delaware is the only carrier investing in the marketplace, and has contributed over \$18,000,000 since 2012 to support Delaware health-related initiatives. Highmark Delaware remains committed to promoting effective, outcomes based health care.



LEADING THE WAY TO A HEALTHY DELAWARE

January 7, 2019

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PAST PRESIDENT

MARK B. THOMPSON
EXECUTIVE DIRECTOR

Primary Care Collaborative
411 Legislative Ave.
Dover, DE 19901

Re: 2019 Primary Care Collaborative Draft Report

Dear Rep. Bentz, Sen. Townsend & Dr. Fan:

On behalf of the Medical Society of Delaware we are writing to supply supplemental comments to your draft 2018 report. We are grateful for your time and attention to what we know is a fundamental and increasingly-urgent problem in Delaware, but equally an opportunity: our primary care infrastructure.

While many of our comments and cautions were contained in previously-submitted documents for the collaborative's consideration, in response to your draft we appreciate the opportunity to reiterate some of them here.

First, we cannot caution enough how "risk" is allocated in the primary care setting. Delaware arrived at its current crisis in part because primary care reimbursement was deflated to 65-85% of Medicare on what we feel was substantially a pretense of risk. It is clear that there is a floor for sufficient reimbursement for a practice not only to grow, but to simply exist. Delawareans receive the biggest "upside" when primary care is robust and recommendations must be implement to grow, not to punish.

Second, key to the path forward to ensure resources are flowing where needed are strong definitions. We are particularly sensitive to the pressure and expectations on Delaware's insurers for successful implementation of many of the recommendations. Under pressure and with limited pathways to provide adequate networks, Delaware insurers and the Insurance Commission, or related oversight body, will need the tools and guidelines, which are provided by robust definitions, necessary to carry through with the recommendations' intent.

Third, and related to the second, healthcare is often spoken of as the three legs of a stool: workforce, facilities, and payers. We would be remiss if we did not put on the record that while this conversation has properly focused on the importance of independent primary care, independent specialty care is also a deeply important pathway for Delawareans' access to quality and efficient care. We urge a vigilance that the percent increase to the primary care spend not result in creation of a new crisis in independent specialty care. They similarly lack bargaining power in the healthcare marketplace that led to the primary care crisis.

Lastly, as recommendation five in the report suggests, we urge the collaborative to continue to convene stakeholders and to take ideas to action as quickly as possible.

Sincerely,

Andrew Dahlke, MD
President