Patient-Centered
Primary Care
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Primary Care Investment Call

This call will convene a wide range of advocates for greater investment in primary care to discuss state-level legislative advocacy. Participants will share their accomplishments and strategies as well as challenges and obstacles.

Thursday, April 18, 2019
3:00 PM - 4:00 PM ET
(267) 930-4000 Passcode: 740-654-563

I. **Welcome (5 min)** *Ann Greiner, PCPCC*

II. **Introduction and Overarching Comments (5 min)** *Rachel Block, Milbank Memorial Fund*
Chris Adamec, PCPCC

III. **State of Play – Selected Updates (20-30 min)**
   a. CO - Ryan Biehle, Colorado Academy of Family Physicians
   b. OR- Evan Saulino, Clinical Advisor to the Oregon Health Authority
   c. VT - Michele Degree, Green Mountain Care Board
   d. ME - Lisa Letourneau, Maine Department of Health and Human Services
   e. Richard Slusky, NESCO
   f. Shelby King, AAFP

IV. **Other State Activity (10 min)**

V. **Open Discussion (10-20 min)** (Ideas below)
   a. Current state of play & expectations going forward
   b. What tactics and strategies have been most successful
   c. Key allies & influencers
   d. Key infrastructure and variables (PCMH adoption, All-Payer Claims Database, etc.)

VI. **Next Steps!**

As you might have seen in PCPCC's Spring Newsletter, widespread progress towards more investment in primary care has been made nationwide:

- On March 21, 2019 Maine introduced S.P. 421, An Act to Establish Transparency in Primary Health Care Spending. The legislation requires reporting of primary care expenditures, and for the Maine Quality forum to conduct a study on best practices in healthcare spending.

- On March 8, 2019 Colorado introduced legislation HB19-1233 Investments In Primary Care To Reduce Health Costs setting targets for investment in primary care and establishing a primary care payment reform collaborative in the division of insurance in the department of regulatory agencies.

- In March, West Virginia passed SB 641 creating the Primary Care Support Program to provide technical and organizational assistance to community-based primary care services and report on West Virginia Medicaid primary care expenditures as a percentage of total West Virginia Medicaid expenditures.

- On February 11, 2019 Missouri's House of Representatives introduced HB 879 the Primary Care Transparency Act which would establish a primary care payment reform collaborative for the state. The bill was referred to the Committee on Health and Mental Health Policy and a public hearing was hosted on March 11th.

- On January 24, 2019 Vermont introduced legislation increasing the proportion of healthcare spending allocated to primary care. The legislation, S.53 and H.89 proposes to require the Green Mountain Care Board to determine the proportion of healthcare spending currently allocated to primary care, recommend the proportion that should be allocated to primary care going forward, and project the avoided costs that would likely result if that proportion were achieved.

- In January, Hawaii introduced HB 1444 Primary Care Payment Reform Collaborative to establish a task force known as the primary care payment reform collaborative to: a) examine current levels of primary care spending in the state; and b) develop annual recommendations to the legislature to strengthen the primary care system in the state.

- In January, Delaware's Primary Care Reform Collaborative released recommendations to invest more in primary care to meet the medical, behavioral, and social determinants of health of Delaware's diverse patient population. These recommendations, required by the state legislature, have the potential to help transform the healthcare system in Delaware and enhance value, if adopted.

Update: PCPCC 2019 Evidence Report

The 2019 PCPCC Evidence Report will provide context and rationale for efforts to measure and compare primary care investment (or spend) in order to achieve the kind of care envisioned by the Shared Principles.

More specifically, the 2019 report will examine and compare primary care investment at the state level, including sub-analyses of commercial, Medicaid/CHIP and Medicare spend by states. The report will examine primary care investment against key utilization and quality measures, such as ED visits and avoidable hospitalizations.

The data set used in the study is AHRQ's Medical Expenditure Panel Study (MEPS) which will allow for reporting at the national level and for 29 states – including overall and at the commercial, Medicaid/CHIP and Medicare payer levels.

Development of the 2019 PCPCC Evidence Report is well underway with the analytic work completed by the Graham Center and the drafting of the text by both the Graham Center and the PCPCCC in process. The draft will be sent to the following reviewers for their input by April 30th.

- Dr. Mark Friedberg, RAND
- Dr. Worthe Holt, Humana
- Dr. Ira Klein, Johnson & Johnson
- Dr. Lance Lang, Covered California
- Dr. Bruce Landon, Harvard University/Harvard Center for Primary Care
- Carol Regan, Community Catalyst
- Dr. David Serlin and Dr. Philip Zazove, University of Michigan

The PCPCC expects to release this report in early July. If the necessary funding can be secured, the release will follow a format similar to last year where we invited leading policymakers to discuss the findings at an invitation only briefing that drew approximately 80 participants.

This report builds upon work undertaken by researchers at the Graham Center, American Board of Family Medicine and RAND. Milbank Memorial Fund, which is supporting the PCPCC Report, has been a major funder of this research. The PCPCC will join researchers from these organizations to discuss Primary Care Investment at a session at the Academy Health Research meeting on June 2, 2019.

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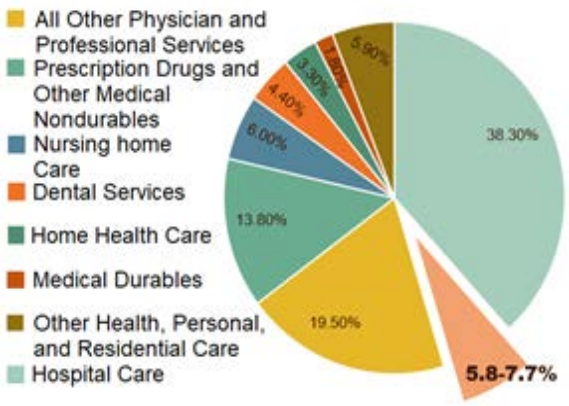
SPENDING FOR PRIMARY CARE

Greater use of primary care is associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality. Despite current high levels of healthcare spending in the United States, the proportion spent on primary care is insufficient. A shift in resources to support greater access to comprehensive, coordinated primary care is imperative to achieving a stronger, higher-performing healthcare system.

What are we spending now?

- Studies indicate that the percentage of total U.S. healthcare spending allocated to primary care ranges between 5.8% and 7.7% and even among high performing health plans, primary care spending varies widely.[i] [ii]

Primary Care Spending



- In the U.S., while we rarely observe a decline in spending on health services, spending on office visits to primary care providers, declined 6% from 2012 to 2016, largely driven by an 18% decline in use of primary care visits. During the same period, spending on specialists increased by 31%.[iii] This shift runs counter to commonly accepted healthcare goals of meeting patient needs in a manner that contains or reduces costs.

What do we lose when we underinvest in primary care?

Underinvestment in primary care gives rise to patient access and workforce issues. A significant financial incentive for physicians and other clinicians to choose other areas of specialty undermines primary care.

<u>Access to Needed Preventative Services</u>:

- As of 2015, only 8% of US adults ages 35 and older had received all high-priority, appropriate clinical preventive services recommended for them. Nearly 5% of adults did not receive any such services. Additional delivery system–level efforts are needed to increase the use of preventive services.[iv]
- Higher primary care Medicaid reimbursement rates improve behavioral health outcomes among enrollees, indicating that primary care is efficient in improving behavioral health outcomes.[v]

<u>Needed Primary Care Workforce:</u>

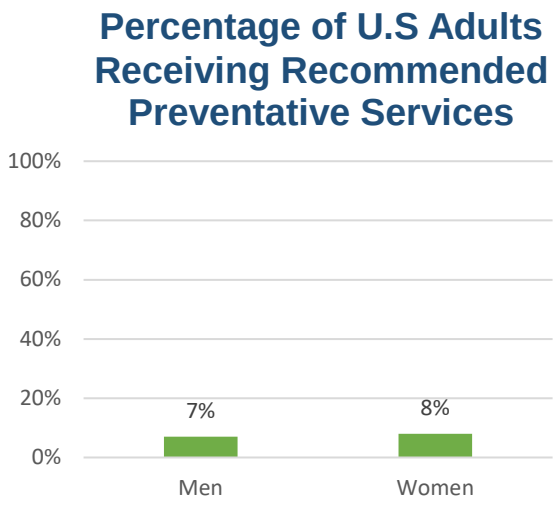
- From 2005 to 2015 primary care physicians as a percentage of total practicing physicians decreased from 44% to 37%.[vi]
- While the number of primary care physician jobs grew by approximately 8% between 2005 and 2015, the number of jobs for specialists grew by approximately six times that amount during the same period, which is due in part to medical students opting for higher paying specialty practices.[vii]

- For those that do become primary care physicians – less than half report that they would choose their same specialty if they could choose again (25%-46% depending on specialty) – likely because of the combination of high patient volume and low reimbursement.[viii]
- Compared with peer countries, the U.S. has fewer primary care clinicians and provides fewer services in the primary care setting.[ix]

What does the evidence indicate we should spend?

Primary care is a great investment for a high-performing health system. Research shows that greater use of primary care is associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality.[x]

- Within the U.S., healthcare markets with a larger percentage of primary care physicians (PCPs) have lower spending and higher quality of care.[xi]
- Internationally, almost all developed countries have a higher ratio of primary care to specialty spending than the U.S. and enjoy lower costs and higher life expectancy. For example, in Great Britain, primary care services constitute 12% of overall health care spending, and primary care serves as the "source of 80% of all interactions between patients and the physician."[xii]
- The current U.S. health care system does not adequately support the medical home team model of delivery. Leading researchers suggest that doubling primary care financing to 10–12% of total health care spending, would be likely to pay for itself, through resulting reductions in overall health spending.[xiii]



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[iii] *2016 Health Care Cost and Utilization Report A review of trends in health care spending, utilization (p. 14, Rep.). (2018). Health Care Cost Institute.*

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[vi] *Sanborn, B. J. (n.d.). Shift in physician workforce towards specialists fuels primary care shortage, potential spending growth. https://www.healthcarefinancenews.com/news/shift-physician-workforce-towards-specialists-fuels-primary-care-shortage-potential-spending*

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[xii] *Koller, C. F. Measuring Primary Care Health Care Spending*

[xiii] *Phillips, R. L., & Bazemore, A. W. (2010, May). Primary Care And Why It Matters For U.S. Health System Reform. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0020*

Consensus Recommendations on Increasing Primary Care Investment

Estimates indicate that that the percentage of total U.S. healthcare spending on primary care ranges between 5.8[i] and 7.7 percent[ii], with wide variation. The highest-performing systems, both domestically and internationally, invest a much higher percentage of total healthcare spending in primary care, which is associated with improved health outcomes and lower costs.[iii]

Rhode Island[iv] and Oregon[v] built successful state-level initiatives to drive additional resources to strong primary care and other states are considering similar action.[vi] PCPCC encourages this work as well as health plan, employer, and federal government efforts to promote increased investment in primary care that supports high-value, patient-centered, and community-engaged primary care.

PCPCC has developed consensus recommendations to support such initiatives. The recommendations build upon the model of care outlined in the Shared Principles of Primary Care, which is our guiding vision endorsed by nearly 300 organizations.

Consensus Recommendations

Define the Challenge

Primary care investment should be tracked and reported through a standardized measure. Long-term, systemic change demands a system that ensures a standardized measurement at the health plan level across all payers to track and publicly report primary care investment. This data is essential to demonstrate that increases in investment lead to improved quality.

Engage Stakeholders

Primary care investment should include broad stakeholder engagement and participation representing all parts of the community and healthcare delivery system. Broad participation is critical to sustainability and requires strategies that will:

- ✓ Convene diverse voices to shape priorities around primary care investment, including consumers, primary care and specialist clinicians, regulators, heath plans, employers, community organizations, and others.
- ✓ Facilitate a continued dialogue between stakeholders that supports and engages in best practices between participants as they work to increase primary care investment while not increasing total cost of care.[vii]
- ✓ Empower consumers through education about healthcare and the value of primary care.

Set Clear Goals

Additional primary care investment should strengthen the ability of primary care to achieve the quadruple aim through targeted strategies that support unmet needs. Policymakers should emphasize strategies that will:

- ✓ Empower clinicians to focus on health and community outcomes such as empowering consumers, strengthening access in underserved areas, increasing coordination with community partners, and integrating behavioral health services.
- ✓ Support investments in both human assets and infrastructure that strengthens team-based primary care including; care managers, counselors, financing capital that modernizes primary care facilities, better care team integration, and support for tools that strengthen care delivery such as health information exchange.
- ✓ Allow clinicians to focus on the most appropriate outcomes without being hindered by excessive, unnecessary, or redundant documentation.

Align Payment

Primary care investment should be implemented through payment models that align incentives across participants, including consumers. Policymakers should support existing and new models that will:

- ✓ Support investments to strengthen primary care though existing but under-resourced models shown to improve value, such as patient-centered medical homes (PCMH).[viii] Leverage these investments to accelerate movement away from fee-for-service to value-based payment.
- ✓ Align public and private payers at the state or payment program level. Aligned payments are much more likely to have a transformative impact on the delivery system because the signals are clear and consistent.

Evaluate Outcomes

Primary care investment should be evidence-based with appropriate outcome evaluation. Policymakers should allocate new resources to support practices and programs that advance progress toward regular reporting of outcomes including patient-reported outcomes, clinical outcomes, and impact on costs to the health system (acknowledging that development of primary care outcome measures is needed).

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[ii] Christopher F. Koller and Dhruv Khullar. (2017). Primary Care Spending Rate — A Lever for Encouraging Investment in Primary Care. New England Journal of Medicine.

[iii] Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of Primary Care to Health Systems and Health. Milbank Quarterly

[iv] Koller, 2017.

[v] Primary Care Spending in Oregon-A Report to the Oregon State Legislature (Feb 2018) Oregon Health Authority.

[vi] *Similar legislation introduced in California, Colorado, and Delaware in 2018.*

[vii] *Total cost of care measures also need further development and refinement.*

[viii] The Impact of Primary Care Practice Transformation on Cost, Quality, and Utilization. (2017) Patient-Centered Primary Care Collaborative.

RESEARCH LETTER

Primary Care Spending in the Fee-for-Service Medicare Population

Greater health system orientation toward primary care is associated with higher quality, better outcomes, and lower costs.[1,2] Recent payment and delivery system reforms emphasize investment in primary care,[3] but resources presently devoted to primary care have not been estimated nationally.[4,5] In this study, we calculated primary care spending as a proportion of total spending among Medicare fee-for-service beneficiaries and describe variation by beneficiary characteristics and by state.

Methods | We analyzed spending for all Medicare beneficiaries 65 years or older with 12 months of Parts A and B fee-for-service medical coverage and Part D prescription coverage in 2015. We used the Master Beneficiary Summary File (MBSF) Base segment (enrollment and demographic data), MBSF Cost and Utilization segment (total medical and prescription spending), and MBSF Chronic Conditions segment (27 chronic conditions); Carrier File (professional claims) and Outpatient File (professional claims absent from the Carrier File including critical access hospitals, rural health centers, federally qualified health centers, and electing teaching amendment hospitals); and Medicare Data on Provider Practice and Specialty File (practitioner characteristics). This study was approved by the RAND Corporation Human Subjects Protection Committee with waiver of informed consent for analysis of deidentified data.

We measured primary care spending by using narrow and broad definitions of primary care practitioners (PCPs) and primary care services.[5] The narrow PCP definition included family practice, internal medicine, pediatric medicine, and general practice; the broad PCP definition also included nurse practitioners, physician assistants, geriatric medicine, and gynecology. Both definitions excluded hospitalists.

The narrow primary care services definition included Healthcare Common Procedure Coding System codes on professional claims, including evaluation and management visits, preventive visits, care transition or coordination services, and in-office preventive services, screening, and counseling; the broad definition included all professional services billed by PCPs. We excluded facility fees for outpatient primary care services billed in the Car-

Table. Patient Characteristics and Primary Care Spending Among Fee-for-Service Medicare Beneficiaries in 2015

Characteristic	Primary Care Practitioner Definition, %			
	Narrow[a]		Broad[b]	
	Narrow Primary Care Services[c]	All Professional Services	Narrow Primary Care Services[c]	All Professional Services
Age, y				
65-69	2.28	3.92	2.92	5.15
70-74	2.28	3.97	2.86	5.12
75-79	2.19	3.90	2.71	4.96
80-84	2.03	3.73	2.52	4.71
>85	1.76	3.38	2.24	4.34
Sex				
Male	2.15	3.87	2.60	4.82
Female	2.11	3.74	2.72	4.92
Race/ethnicity[d]				
White	2.13	3.82	2.70	4.96
Black	1.76	3.28	2.21	4.15
Asian	3.04	4.73	3.35	5.30
Hispanic	2.18	3.70	2.57	4.42
North American Native	1.51	3.02	2.16	4.23
Other	2.61	4.25	2.99	4.99
Unknown	2.61	4.27	3.14	5.31
Dually eligible for Medicare and Medicaid				
Yes	1.64	3.23	2.16	4.23
No	2.32	4.02	2.88	5.14

(continued)

Table. Patient Characteristics and Primary Care Spending Among Fee-for-Service Medicare Beneficiaries in 2015 (continued)

Characteristic	Primary Care Practitioner Definition, %			
	Narrow[a]		Broad[b]	
	Narrow Primary Care Services[c]	All Professional Services	Narrow Primary Care Services[c]	All Professional Services
Chronic conditions				
Acute myocardial infarction	1.30	2.90	1.66	3.70
Alzheimer disease	1.40	2.99	1.99	4.11
Alzheimer disease and related disorders or senile dementia	1.40	3.02	1.90	4.03
Atrial fibrillation	1.54	3.15	1.95	4.04
Cataract	2.07	3.74	2.61	4.81
Chronic kidney disease	1.53	3.11	1.94	3.99
Chronic obstructive pulmonary disease	1.66	3.32	2.12	4.25
Congestive heart failure	1.49	3.09	1.90	3.95
Diabetes	1.91	3.55	2.37	4.47
Glaucoma	2.06	3.66	2.56	4.65
Hip or pelvic fracture	1.08	2.54	1.46	3.41
Ischemic heart disease	1.79	3.40	2.24	4.33
Depression	1.73	3.33	2.28	4.41
Osteoporosis	1.88	3.54	2.40	4.59
Rheumatoid arthritis or osteoarthritis	1.97	3.61	2.49	4.68
Stroke or transient ischemic attack	1.55	3.19	1.99	4.10
Cancer				
Breast	1.75	3.20	2.27	4.23
Colorectal	1.48	3.06	1.86	3.89
Prostate	1.85	3.41	2.23	4.28
Lung	1.12	2.49	1.42	3.18
Endometrial	1.54	3.00	2.10	4.19
Anemia	1.76	3.35	2.22	4.31
Asthma	1.66	3.32	2.11	4.26
Hyperlipidemia	2.13	3.80	2.66	4.86
Benign prostatic hyperplasia	2.04	3.76	2.46	4.67
Hypertension	2.06	3.71	2.58	4.75
Hypothyroidism	1.98	3.64	2.51	4.68
Primary care spending				
Per beneficiary, $	308.32	550.62	387.79	708.23
Fraction of total medical and prescription spending[e]	2.12	3.79	2.67	4.88

[a] Includes family practice, internal medicine, pediatric medicine, and general practice.

[b] Includes family practice, internal medicine, pediatric medicine, general practice, nurse practitioner, physician assistant, geriatric medicine, and gynecology.

[c] Includes Healthcare Common Procedure Coding System codes on professional claims including evaluation and management visits, preventive visits, care transition or coordination services, and in-office preventive services, screening, and counseling.

[d] All race/ethnicity variables in this analysis are from the Master Beneficiary Summary File (variable name BENE_RACE_CD).

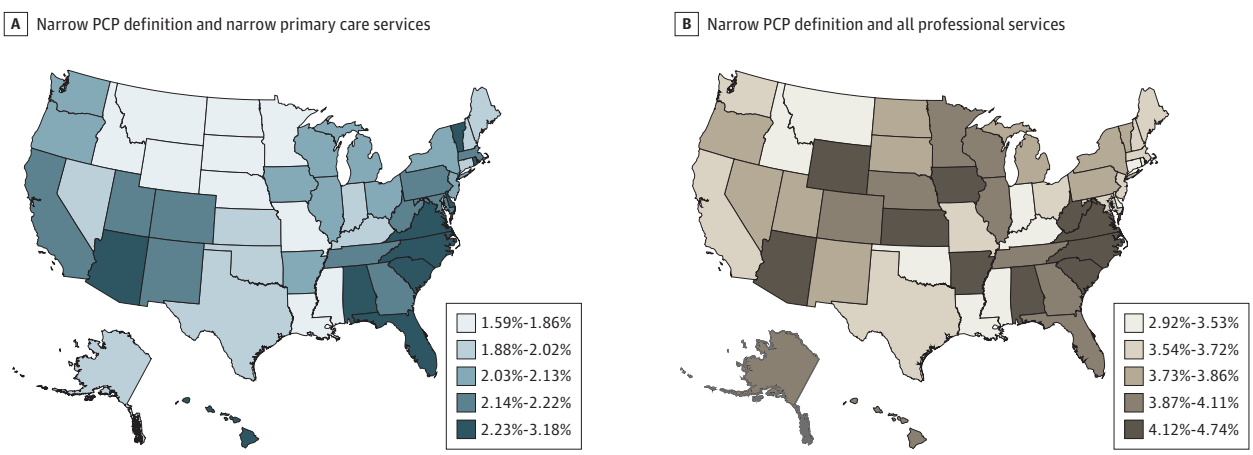
[e] In 2015, for the selected population, mean per capita total medical and prescription spending was $14 519 ($11 596 in medical spending and $2913 in prescription spending).

rier File and did not include services ordered but not performed directly by PCPs (eg, tests and medications).

We measured primary care spending as a percentage of total medical and prescription spending nationally, by beneficiary characteristics, and by state. Statistical analyses were performed using SAS software, version 9.4 (SAS Institute). Results were reported as 2015 US dollars and Spearman correlation coefficients. We reported 2-tailed $P < .05$ as statistically significant.

Results | Among 16 244 803 beneficiaries, primary care represented 2.12% of total medical and prescription spending for the narrow definitions of PCPs and primary care services and 4.88% for the broad definitions (**Table**). For all definitions, pri-

Figure. Primary Care Spending as a Proportion of Total Medical and Prescription Spending Among Fee-for-Service Medicare Beneficiaries



Definitions of primary care practitioner (PCP) and primary care services are given in the Methods section.

mary care spending percentages were lower among beneficiaries who were older (eg, 1.76% for beneficiaries 85 years or older vs 2.12% for all beneficiaries, using the narrow definition), black (1.76%) or North American Native (1.51%), dually eligible for Medicare and Medicaid (1.64%), and who had chronic medical conditions (except hyperlipidemia). Primary care spending percentages varied by state (**Figure**), from 1.59% in North Dakota to 3.18% in Hawaii for the narrow health care provider and service definitions and from 2.92% in the District of Columbia to 4.74% in Iowa for the narrow health care provider and broad service definition. States' primary care spending percentages were not significantly correlated with per capita PCP headcounts[6] (Spearman correlation coefficients 0.10 [P = .47] and −0.07 [P = .61], respectively).

Discussion | Primary care spending represented a small percentage of total fee-for-service Medicare spending and varied substantially across populations and states. Primary care spending percentages were lower among medically complex populations and were not correlated with state-level PCP headcounts, which suggests that headcounts might mismeasure primary care investment. Our estimates of primary care spending percentages in Medicare were lower than previous estimates among a convenience sample of commercial insurers, states, and other countries[4,5]; these comparisons were confounded by differences in patient age, payer type, and other factors.

One limitation of this study is that our broader definitions of primary care spending may have included nonprimary care services delivered by PCPs, while our narrower definitions of primary care services may have excluded some PCPs or primary care services.

The optimal percentage of Medicare spending for primary care is unclear. Future research should evaluate effects on quality or outcomes of state efforts (eg, Rhode Island and Oregon) to institute minimum primary care spending percentages.[4] Our estimates may constitute reference points for future policies across the United States.

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Author Contributions: Dr Reid had full access to all the data in the study and takes responsibility for the integrity of the data analysis.
Concept and design: Reid, Friedberg.
Acquisition, analysis, or interpretation of data: All authors.
Drafting of the manuscript: Reid.
Critical revision of the manuscript for important intellectual content: Damberg, Friedberg.
Statistical analysis: Reid.
Obtained funding: All authors.
Supervision: Friedberg.

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Disclaimer: The content and opinions expressed in this publication are solely the responsibility of the authors and do not reflect the official position of the Agency for Healthcare Research and Quality or the US Department of Health & Human Services.

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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,

Senator Bryan Townsend
Co-Chair

Representative David Bentz
Co-Chair

Dr. Nancy Fan
Co-Chair

Contents

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 countries[28] 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

[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.]
https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry&rs:Format=PDF
[2] https://www.delawareonline.com/story/opinion/contributors/2018/05/13/delaware-primary-care-doctors-insurance-reimbursement/603558002/
https://www.pcpcc.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
[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.]
https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry&rs:Format=PDF
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