PRIMARY CARE REFORM COLLABORATIVE (PCRC)
Meeting
Monday,
January 22, 2024, 3:00 pm - 5:00 pm
Hybrid (Anchor location DHSS Chapel)

Meeting Attendance and Minutes

Collaborative Members:

Present	Organization
Dr. Nancy Fan, Chair	Delaware Health Care Commission (DHCC)
Kevin Ohara	Highmark Delaware
Deborah Bednar	Aetna
Faith Rentz	State Benefits Office/DHR
Maggie Norris-Bent	Westside Family Healthcare
Christine Vogel (Proxy for Trindade Navarro)	Department of Insurance (DOI)
Dr. Rose Kakoza	Delaware Healthcare Association
Andrew Wilson	Division of Medicaid, and Medical Assistance
Steven Costantino	Division of Health and Social Services
Bryan Townsend	Chair Senate Health social Services
Dr. Micheal Bradley (Proxy for Dr James Gill)	Medical Society of Delaware

Meeting Facilitator: Dr. Nancy Fan

Commission Members Absent: Commissioner Trinidad Navarro *(*Department of Insurance (DOI), Vacant (Delaware Nurses Association), Representative Kerri Evelyn Harris (House Health & Human Development Committee), and Dr. James Gill, Medical Society of Delaware.

Health Care Commission Staff: Dionna Reddy (Public Health Administrator I) and Sheila Saylor (Admin)

Call to Order

Dr. Fan called the meeting to order at approximately 3:05 p.m. A quorum was determined later in the meeting for voting. Dr. Fan asked if you are not identified by a phone number to put your name in the chat. If you are an attendee not on the collaborative, please post your name. If you have any questions or comments, please put them in the chat and we will be monitoring. Please mute yourselves if not presenting.

September 18, 2023, and December 11, 2023, Meeting Minutes Approval

Dr. Fan asked if there were any edits or comments for the September 2023 and December 2023 meeting minutes. Hearing none, a motion was made to approve both sets of minutes by Kevin O'Hara and Rose Kakoza seconded. The minutes were unanimously accepted by PCRC members.

Update – Strategic Planning Work Group

Caitlin Thomas-Henkel along with her colleague Keyan Javadi presented an update for DE PCRC Subcommittee Working Group.

The overview of the project/goals is to complete an environmental scan of the national primary care landscape/state examples of successful primary care models with a focus on authority and governance, primary care cost containment strategy, investments in primary care, and quality measures.

Focus Group Interviews in Delaware and Surveys were conducted with identified external stakeholder focus groups that included Providers, MCOs, and State Representatives. With the information collected, we are in the process of developing recommendations for a 2-year strategic plan, with the final recommendation to be shared at the February meeting.

The individuals representing the state, MCOs, and providers were shared along with the interview questions. The interview questions were designed to understand the perspective of the different focus groups regarding the legislation (SB 120), and how it is working. Getting a sense of the current participation of the payers and the carriers and thoughts about how it is going with the primary care cost containment strategies. We also wanted to know if there are other areas that we should consider in the future.

Some of the key takeaways from the different focus groups were shared.

Provider Group

The takeaways from the Provider Group in terms of strengths were committed chair/co-chairs and that there have been attempts to get representation from various groups on the PCRC. The weakness was little interest in primary care reform. No substantive criteria (e.g., penalties, incentives) to make sure things get implemented. Unclear whether strategies associated with SB 120 will increase access to PCPs. The tactics undertaken by the PCRC do not focus on the entire primary care system (focus on independent practices). The representatives from the various PCP groups may not be the right people. Perceived bias against hospital-employed physicians who provide primary care. The opportunities were to eliminate representation by Medicaid and the state employee group until they agree to participate in SB 120. We need to expand access to primary care (50% of primary care investment targets), PCRC should define the problem they are seeking to solve. Increased transparency between what the PCRC is doing with input from necessary stakeholders. Consider the whole primary care landscape, with attunement to hospital-based primary care practices. Broader application to other commercially run state products like Medicaid MCOs and State Employees. The threat is the lack of Medicaid participation. Payers are not complying with the law. A lack of consensus on what the key issue is that needs to be addressed by the PCRC. The goal and focus of the PCRC are not clear. The strategies and objectives are unclear, and accomplishments are not widely known (no transparency). The most recent strategic planning initiative has not been made public, lacks transparency, and does not have input from all necessary stakeholders. Providers are unaware of how primary care investment is working for DE's primary care system.

MCO Group

The takeaways from the MCO Focus group for strengths were focus and emphasis on primary care. Weaknesses were that access to primary care is a challenge. Need the right metrics to effectively measure primary care access. Long-term impact: disconnect with what PCRC is doing with other health care groups in DE. Some opportunities were to develop structure, goals, and prioritize quality metrics. Better coordination for health-related social needs in the primary care space; MCOs may be able to help. More primary care investment in public health. The threats were that the payers participating have no impact on the Medicaid and Medicare side and need to broaden their scopes to include behavioral health. Little impact in expanding the primary care investment targets into other market segments such as Medicaid and the State Group Health Insurance Plan when only 10% of the population is served in large group plans.

State Focus Group

The takeaway from the State Focus Group for strengths was representation on PCRC from most stakeholders. The weaknesses were that SB 120 falls under too large of an umbrella – the reimbursement model is not good. Access is not getting better; we need to step back and look at SB 120 in the context of the larger DE landscape. Only a small portion of stakeholders are actively engaged. The opportunities were that we needed to understand the population we are trying to serve and where to currently prioritize market segments. Listen to providers and offer incentives to improve outcomes. We need representation from across the state. The threats were that we are not seeing the results/impact of the payers participating which are those carriers offering commercial fully insured plans (Only early conversations for VBP arrangements).

Next Caitlin Thomas-Henkel along with her colleague Keyan Javadi reviewed the Primary Care Environmental scan and key findings from Connecticut, Maryland, New Jersey, Oregon, Rhode Island, and Vermont which have advanced primary care cost containment models.

ENVIRONMENTAL SCAN KEY FINDINGS

State	Authority/Governance	Cost Containment	Payers Included	Primary Care Investment Strategy	Aligned Quality Measures
CT	Office of Health Strategy(OHS)	Total healthcare spending to 10% by 2025	Public and private payers	Directs OHS to develop annual healthcare cost growth benchmarks for calendar years (CY) 20212025	Yes – mix of HEDIS • Hypertension • HbA1c
MD	Dept. of Public Health – Program Management Office	Saving $300 million in annual total Medicare spending by the end of 2023	Medicaid, Medicare	Multi-payer patient-centered medical home program	Yes – mix of HEDIS • Hypertension • HA1c
MA	Massachusetts Health Policy Commission	Increasing primary care spending to about 12 to 15% of overall health care expenditures by 2029.	Commercial	Fee-for-service to a monthly prospective payment	Yes – mix of HEDIS • Hypertension • HbA1c
NJ	Governor's Office of Health Care Affordability and Transparency	Decrease how much health care costs grow each year (3.2% value)	Medicaid	Set benchmark performance criteria and conduct a cost-driver analysis	Yes – HEDIS, CAHPS • Hypertension • HbA1c
OR	Oregon Primary Care Reform Collaborative	Increase investment in primary care. Track spending allocated to primary care carriers, PEBB, OEBB and Coordinated Care Organizations (CCOs)	Multi-payer, Medicaid, Commercial	Patient-centered Primary Care Home (PCPCH)	Utilization • Hypertension • HbA1c
RI	Office of the Health Insurance Commissioner(OHIC)	At least 9.7% of total health care spending must go towards direct primary care spending	Multi-payer, Medicaid, Commercial	Alternative payment model PCMH	Yes – mix of HEDIS • Hypertension • HbA1c
VT	Green Mountain Care Board	Track healthcare spending between 2018 2023, to keep avg. increase in costs between 3.5% to 4.3%.	Commercial, Medicaid, Medicare	Per Member-Per Month (PMPM)	Yes – mix of HEDIS • Hypertension • HbA1c

Dr Fan added some additional comments that there is only a very small proportion of primary care receiving primary care reform. The subcommittee's decision was that were needed a broader touch

than the members on the committee. The stakeholders are not members to help us form strategic priorities. Dr. Fan expressed how the environmental scan looked and what other states have done to successfully increase their primary care investment and how they go about achieving success. These achievements should be looked at as low-hanging fruit for investment.

Dr. Fan clarified that should SB 120 sunset, the committee will still be in force because we were founded under SB 227 and we are a standing collaborative. Also, the committee should be ready to vote on the recommendations at the next meeting as well as priorities for 2024 and 2025. Dr. Fan then reviewed the voting process and who could vote with proxies.

Dr. Fan asked if PCRC wanted the survey results presented at the next meeting and hearing no objections the results will be presented. She reminded everyone that the presentation slides will be available on the website.

Update- Delaware Primary Care Value-Based Payment Model

Health Management Associates, Gaurav Nagrath, Daniel Nemet, and Berkley Powell presented an overview of 8 state programs with their prospective payment models and examples of program activities.

New York: Enhanced Primary Care (EPC)
Capital District Physician's Health Plan (CDPHP)

New York is a multi-payer model, including Medicaid MCOs, Medicare Advantage and commercial payors. CDPHP is a physician-founded, community-based, not-for-profit health plan. Providers earn bonus PMPM by meeting efficiency (total cost of care), quality (HEDIS), and patient experience (CG-CAHPS) measures (retrospective). EPC Model includes commonly used codes and analyzes codes submitted (E&M Visits, physician office labs, etc.). Supports practice transformation at the administrative and clinical levels to improve access to care, health IT capabilities, and coordination of care. It is limited because the program is through a not-for-profit health plan that is not statewide. Bonus payments are based on meeting targeted quality metrics. There is a 12-month transformation program after that practices will begin to receive global payments vs FFS.

Washington Multi-Payer Primary Care Transformation Model (PCTM)
Washington Health Care Authority (HCA)

Washington multi-Payer Collaborative Members Amerigroup, Community Health Plan of Washington, Coordinated Care, Kaiser Permanente, Molina Healthcare, PacificSource, Premera, Regence, UnitedHealthcare, Washington State Health Care Authority. Fixed PMPM payment for comprehensive primary care services, replacing FFS payment. Transformation of care fee provides examples of programs that aim to improve care coordination, integration with behavioral health, and care access (ex: home visits and telehealth)· Incentive payment prospectively according to tiered PMPM formula based on performance. Aligned measurement set among payers. Limitations for Implementation are phased implementation began in January 2023. Payment depends on the practice certification level. Includes Medicaid. HCA interested in aligning with Medicare model principles.

Oregon Primary Care Transformation Initiative
Oregon Health Authority (OHA)

The goal of the initiative is to use value-based payment methods that are not paid on a per-claim basis for an Increased investment in primary care. Also to facilitate the integration of primary care behavioral and physical healthcare. Oregon has a legislative mandate to include Medicaid, CPC + programs, and

Medicare.

Maryland Primary Care Program (MPCP)
Maryland Department of Health
Advanced primary care goals are to help the state manage the health of high-risk individuals, reduce unnecessary hospital utilization, and provide preventative care. MDPCP's strategic investments to reduce costs and improve outcomes include statewide access and continuity, care management, comprehensiveness and coordination, beneficiary and caregiver experience, and planned care for health outcomes.

Mississippi
TrueCare
Mississippi TrueCare is for Medicaid only and is not multi-payor model. TrueCare is a coordinated care organization committed to changing the trajectory of Mississippi's healthcare system. Innovative proposed programs are focused on improving health outcomes, equity, access to care, member engagement, and collaboration with CBOs. Expenditures on quality improvement activities related to healthcare quality improvement and healthcare information technology (HIT) are individually identifiable, tracked, and reported.

Rhode Island
Neighborhood Health Plan of Rhode Island Quality Improvement Program
The Neighborhood Health Plan of Rhode Island Quality Improvement (QI) Program ensures that members have access to high-quality healthcare services. Neighborhood's Continuous Quality Improvement (CQI) approach emphasizes the use of "Plan Do Study Act". Neighborhood's CQI efforts support the core principles of being leadership-driven, customer-focused, employee empowerment/involvement, and result-based decision-making.

Minnesota Accountable Health Model
State Innovation Models (SIM) initiative sponsored by CMS
The five primary drivers, which most activities are organized are expansion of e-health, improved data analytics across the state's Medicaid Accountable Care Organizations (ACOs), practice transformation to achieve interdisciplinary, integrated care, implementation of accountable communities for health (ACHs), and alignment of ACO components across payers related to performance measurements. The outcomes are increased statewide HIE vendor capacity, advancement in care coordination model development, and established and achieved clinical process goals.

Michigan
Blue Cross Blue Shield Quality Improvement Program
This is a retrospective payment model. The goal of the Quality improvement program is to organize and finance top-of-the-line services to help optimize member health status improvement, efficiency, accessibility, and satisfaction across all BCBS service lines. Blue Cross embraces the Institute of Healthcare Improvement's Triple Aim framework, which is improving the health of the population, improving the patient experience of care including quality and satisfaction, and reducing or at least controlling the per capita cost of care.

The collaborative asked several questions regarding attribution and outcome data for these initiatives. HMA response is that some of these programs are too early to have any data yet and it was noted that outcome data for any value-based payment model has been difficult to collect and analyze.

Conclusion

The next PCRC meeting is scheduled for Monday, February 12, 2024, from 3:00-5:00 pm. This meeting will be virtual.

PUBLIC COMMENT

No public comments.

Meeting Adjourned at 4:30 PM

Public Meeting Attendees

Ainsley Ramsey	Health Management Assoc.
Alicia Palombo	CVS
Alison Birzon	
Andrew Harner	
Berkley Powell	
Bria Greenlee	
Brian Frazee	
Caitlin Henkel	Health Management Assoc.
Christina Bryan DHA	
Corinne Armann	
Daniel Nemet	Health Management Assoc.
David Bentz	DHSS
Dr Sarah Mullins	
Gaurav Nagrath	Health Management Associates
Jason Lotus	Cigna
Jennifer Moyer	Aetna
Keyan Javadi	Health Management Assoc.
Linda Micai-Manning	
Kirsti Ryan	
Kristin Dwyer	Nemours
Laura Brooks	
Laura Knorr	Aetna
Lauren Graves	Christianacare
Lincoln Willis	
Lisa Gruss	Medical Society Delaware
Lori Ann Rhoads	
Megan Williams	
Mike Pellin	
Nichole Moxley	
Ronald Mezin	
Stephanie Hartos	
Tyler Blanchard	Aledade