Primary Care Reform Collaborative Meeting

Monday, October 19, 2020
5:00-7:00 p.m.
Webex Meeting ID: 173 976 1051, Meeting password: TRdAQ8t3Kt3
Audio/Call-In Number: (408) 418-9388
Access Code: 173 976 1051

Meeting Attendance

Collaborative Members:

Present:	Organization:
Dr. Nancy Fan, Co-Chair	Delaware Healthcare Commission
Representative David Bentz, Co-Chair	House Health & Human Development Committee
Kevin O'Hara	Highmark Delaware
Dr. James Gill	Medical Society of Delaware
Sasha Brown	Aetna
Steven Costantino (Proxy for Secretary M. Magarik)	Department of Health & Social Services (DHSS)
Leslie Ledogar (Proxy for Commissioner Navarro)	Department of Insurance
Steve Groff	Division of Medicaid & Medical Assistance
Dr. Christine Donohue Henry	Christiana Care/Delaware Healthcare Association
Dr. J. Straight (Proxy for Dr. Michael Bradley)	Dover Family Physicians/Medical Society of Delaware
Mike Gilmartin	MDavis, Inc./DSCC
Dr. Susan Conaty-Buck (Proxy for Leslie Verucci)	Delaware Nurses Association
Dr. Veronica Wilbur	Next Century Medical Care/ Delaware Nurses Association
Faith Rentz	State Benefits Office/DHR

Absent:	Organization:
Senator Bryan Townsend, Co-Chair	Senate Health & Social Services Committee
Dr. Jeffrey Hawtoff	Beebe Healthcare/ Delaware Healthcare Association
Margaret Norris-Bent	Westside Family Healthcare
John Gooden	MDavis, Inc./DSCC

Staff:

Read Scott — Read.Scott@delaware.gov

Attendees:	Organization:
Ayanna Harrison	Department of Health and Social Services/DHCC
Pamela Price	Highmark
Dr. Sarah Mullins	Stoney Batter Family Medicine
Elizabeth Staber	Aetna
Katherine Impellizzeri	Aetna
Tyler Blanchard	Aledade
Jackie Ball	Aetna
Mary Jo Condon	Freedman
Kim Gomes	ByrdGomes
Lisa Zimmerman	Department of Health and Social Services

Michael North	Aetna
Lori Ann Rhodes	Medical Society of Delaware
Mollie Polland	Nemours
Katherine Collison	Division of Public Health, DHSS
Claudia Kane	DCHI
Bryan Gordon	Christiana
Dr. Bernard Cohen	AmeriHealth Caritas
Lincoln Willis	The Willis Group
Jennie Echols	Mercer
Cindy Ward	Mercer
Dr. Bob Monteleone	
Lauren Graves	
R. Rivera	
Julyvette Vazquez	

The meeting was called to order at 5:09 p.m.

Welcome

The meeting convened at 5:09 p.m. via the State of Delaware Webex system
https://stateofdelaware.webex.com/stateofdelaware/j.php?MTID=m7302b41fc341d774722a9f8bc0610cfe
Dr. Fan welcomed all attendees and reminded them the meeting would be recorded. Members announced their presence as record of attendance. A quorum was confirmed. Public attendees were asked to submit their name and affiliation to Read Scott via email (Read.Scott@delaware.gov). Attendees were also asked to keep their computers and phones on mute while not making a comment. Dr. Fan briefed members on the meeting agenda and transitioned the meeting to the approval of the September minutes.

Approval of September 2020 Minutes

Dr. Fan asked the members if they had any comments on the draft minutes from the Primary Care Reform Collaborative meeting, held on September 21, 2020. The following edits were requested: Faith Rentz was present but listed as absent, Steven Costantino should be moved from the attendee list and listed as the Proxy for Secretary Molly Magarik, Leslie Ledogar was listed twice (in attendees and members), and Dr. Gill suggested an edit to a comment made by Dr. Mike Bradley when discussion facility fees for private provider offices. Dr. Fan asked if the members of the collaborative agreed to approve the minutes, understanding the necessary corrections would be made. Steven Costantino made a motion to approve; the motion was seconded by Dr. Jim Gill. The motion to approve was unanimously carried. Approved minutes for the September meeting can be viewed here:
https://dhss.delaware.gov/dhss/dhcc/files/pcrcmtgminutes_09212020.pdf

Update from The Office of Value-based Healthcare Delivery (OVBHCD) & the Technical Subcommittee

Dr. Fan invited Leslie Ledogar to share updates from the Office of Value Based Health Care and Delivery (OVBHCD). Leslie Ledogar reported that OVBHCD is wrapping up data collection and stakeholder meetings. They will be presenting provisional affordability standards to the Technical Subcommittee in November. This presentation will also be provided during the November Primary Care Reform Collaborative meeting. She continued to report that they plan to release a report for public comment in December. Lastly, Ms. Ledogar shared that a bulletin will be released during the 2021 rate review process announcing the inclusion of targets in the rate review process methodology. Mary Jo Condon agreed with the update and had no additional items to share. Dr. Fan thanked Ms. Ledogar and the OVBHCD for their work.

DRAFT

Dr. Fan announced the two speakers that will be presenting during the meeting (Tyler Blanchard and Dr. Monteleone). They will be representing Aledade ACO and the Delaware Care Collaborative. Before moving into the presentation Dr. Fan shifted the discussion to important events happening within the state. She shared that Delaware Center for Health Innovation (DCHI) will be hosting a Primary Care Virtual Forum on October 22nd, entitled "*The Genie is out of the Bottle: Redesigning Primary Care in a Post-COVID World*". The Forum will focus on moving primary care forward post-COVID and lessons learned from COVID. Various topics covered like gaining a greater understanding of the impact of COVID-19, identifying future implications, and the opportunities presented to establish stronger investment in primary care. Dr. Fan expressed excitement as she shared that to date 150 attendees have registered. She encouraged the attendees to registrar for the event. The two speakers will be Art Jones, Health Management Associates and Jack Westfall of the Robert Graham Center. The second half of the Forum will include a payor panel. Both Sasha Brown and Kevin O'Hara will be two of the panelists who will share their perspective on post-pandemic efforts for payors and providers. Dr. Fan also announced that she will be serving as a facilitator. Attendees were encouraged to view the DCHI workgroup information (https://email.dehealthinnovation.org/?hs_preview=NGzhKhuE-34743779246).

Goal Setting

Dr. Fan transitioned the discussion to goal setting. She explained that agreements have been reached in some areas while others still need to be solidified. The objective of this discussion is to define the role of the Collaborative using SB227 as the framework.

Dr. Fan stated that she would like the Collaborative to build a framework for activities to be completed in Q1 2021. She asked members to identify strategies that will help achieve the identified goals. The group will also need to decide on the type of oversight, legislative or regulatory. Dr. Fan would like the discussion to produce plans the Collaborative could support for either payors or providers for the year 2022.

During past meetings, members of the Collaborative have agreed that stabilizing and promoting primary care is foundation to their role. This concept includes increasing investment in primary care without increasing overall health care cost in Delaware. Supporting the use of value-based care and alternative payment models was listed as a concept the members had discussed in the past. The definition of value-based care and value-based contracting will need to be agreed upon before moving forward. It is also important for members to align goals with the work of the Office of Value Based Health Care and Delivery (OVBHCD)., the office developed through SB116. Dr. Fan asked if all agreed with listing these concepts as part of the role of the Collaborative. Dr. Gill and Dr. Donahue both shared their agreement. Dr. Fan thanked them and opened the floor to other members, asking if any of them would like to elaborate or offer alternative suggestions. There were no further comments.

Dr. Fan reviewed the approaches to affordability presented by Freedman on behalf of the OVBHCD. She pointed out that the Collaborative has spent a lot of time discussing alternative payment models and the adoption of targets. She acknowledged that the Collaborative is waiting for data from the OVBHCD. The data they share will be useful, especially when considering strategies to align with the health care spending benchmark of 3.5%. The work of the Collaborative is tied into the work of the benchmarking process. The members began to discuss the definition of value-based care (advanced primary care). The Medical Society has developed a policy statement that includes four core values that are defining metrics. They have not been discussed in the past and Dr. Fan noted the difference between metrics and that care that we should be striving to achieve. There was some discussion about whether to add "cost" into the definition of value.

Kevin O'Hara suggested cost and efficiency be included in the definition. He added that in regard to quality it is important to ensure the definition is measurable and based on outcomes wherever possible. Dr. Gill commented

DRAFT

that the information on the slide is consistent with the Medical Society's position statement. He agreed, stating that cost is not a problem if primary care is only held responsible for the cost of primary care. Mr. O'Hara provided an alternate viewpoint, stating part of paying for increased investment has be related in a reduction of total cost of care or an increase in efficiency. He was not supportive of limiting cost components in value-based care to primary care only. He asked if other payors wanted to share their opinion. Dr. Fan agreed that other members of the Collaborative should share their thoughts. She asked the Collaborative to discuss and agree on the definition of "comprehensiveness". Discussion highlights:

- The standardized definition of comprehensiveness, which is generally understood to be the scope of areas within health care that provider accepts responsibility for, or the services rendered by the provider.
- The definition of value-based care that used by CMS – Paying for healthcare services that are directly linked to performance, cost, quality and patients experience of care.
- Alternative payment models (subset of value-based care) – achieved through alternative payment models moving away from fee-for-service. These models could include total cost of care models or risk models, moving int the LAN framework
- Cost quality and patients experience are critical in the definition of value-based care
- What models should the Collaborative be considering?
- Total cost should include utilization, efficiencies, specialist cost, outcomes

Dr. Fan asked if the members were comfortable with moving forward with the identification of how to move away from fee-for-service. She shared that other Primary Care Collaboratives have set specific goals (i.e. by 2025 this percentage will be in alternative payment model). She asked the members their goals should include a time frame attached to targets.

There was some concern that all members are not were aligned on the current percent of practices when considering the definition of meaningful value-based care. The suggestion was made to use "driving and supporting practices to value-based care and alternative payment models". Dr. Fan felt it was important for the group to define a specific goal. She added that one of the lessons learned from the pandemic is that fee-for-service is not sustainable for primary care. It was suggested that the Collaborative consider selecting a date to implement a specific plan within Delaware instead of using the transitional approach. Private providers are struggling and will continue to struggle unless something changes. Dr. Fan agreed but highlighted the need to identify concepts that can be supported by all members. She reminded the members that they have spent all summer discussing lessons learned from the pandemic. The outcome that was learned is that fee-for-service is very unstable. Delaware has a stagnant primary care workforce and a higher attrition rate. She encouraged the members to consider being more aggressive an identifying payment models that will pay practices to stay in practice. She would also like to incorporate the concepts of a value-based care. She also mentioned that if we are moving practices away from fee for services that they will not continue to function in the same way they have been. She added that it was important to include parameters about quality and access and cost and efficiency could be added as well. Patient centric should also be included as it is directly related to access. Dr. Fan proposed the inclusion of investment in health information technology within the concept of care transformation. She concluded her comments by highlighting the need to move to the next level by adopting clear definitions. There was some discussion about the need to include access to care as they discuss coordination of care within care transformation.

Steven Costantino shared the link LAN's alternative payment models aspirational goals (https://hcp-lan.org/). He pointed out that the "cost" in their models are not specific to primary care but instead the whole system. He added that there is value in adopting aspirations. It is not necessary to include penalties, there is value in the insight gained on why there are delays in moving into value-based payment. He also mentioned that it was important to ensure all

DRAFT

payors are using the same definitions. LAN has also developed a resiliency document that is very helpful and interesting. Dr. Fan agreed to share the document with the members.

Dr. Fan asserted that her goal is to facilitate movement from the Collaborative to identify aspirational goals and strategies on how to move the health care system towards the aspiration. Members continued to discuss alternative payment models. Dr. Fan asked members to provide feedback on the development of metrics that align multi-payors and demonstrate measurable outcomes from a quality and cost perspective. Faith Rentz shared the activities of the State Employment Benefits Committee regarding the state employment benefit plan. Aspirational goals have been identified using the LAN. Their targets (total medical spend) are set at movement to Category 3 at 40% and Category 4 at 10% by the end of fiscal year 2023. Ms. Rentz added that prospective payments, with risk sharing, are included in Category 3.

Dr. Gill commented that the main problem is that Primary Care is underfunded. Increasing the funding dramatically is the primary goal. How payment is structured is secondary. The straw man is being set up as moving away from fee-for-service, but the discussion should be around what is the accountability. He believes it is important to set the 12% goal. He stated that the members agree on the need to increase access to care, care coordination, value-based care, moving from fee-for-service and being responsible for cost. The problem is who is accountable for which cost. LAN is referring to the larger health care system. The larger health care system could be held accountable for total cost. ACO's that have some leverage over whether patients are hospitalized may be held accountable for hospitalization cost. The issue begins when individual doctors or small offices are held responsible for things they cannot control. He agreed that this discussion is too detailed to have within this setting, but he wanted to share the general concept of being responsible for total cost is something you do for a large health system not an induvial doctor. He encouraged the Collaborative to focus on how much funding is the crux of the issue and secondly, what level of system is being considered when discussing accountability.

Dr. Fan followed Dr. Gills comments by adding that the underfunding of primary care is extremely important, however she believes the desired outcome should be the sustainability of primary care. She reiterated the fact that fee-for-service is not sustainable for primary care. She asked if other members wanted to provide additional comments. She also asked if members agree that the Collaborative should be defining quality by outcomes. Mr. Costantino agreed with Dr. Fan and added that historically primary care has been underfunded. The challenge is identifying a strategy to make the investment while moving the alignment of incentives away from fee-for-service.

Dr. Fan asked the Collaborative if developing an aspirational goal is possible and if so, should the focus also include identifying a strategy to help us reach the goal. She mentioned the breakdown of fee-for-service within the LAN 3 and LAN 4 categories and asked if the Collaborative should be focused on defining similar models. Mr. O'Hara agreed with the setting of an aspirational goal, but he mentioned some concern on whether members could reach a common model. He believes there is value in defining what it may look like but added that payors may have difficulty moving their programs towards a consistent Delaware focused set a metrics.

Dr. Fan commented that she used the Maryland example because it is aspirational and prescriptive. Dr. Susan Conaty-Buck pointed out that the Maryland model includes a suite of tools that allow small practices the same opportunities as the larger system. She added that this addition is equitable and makes it a strong competent of the model. Mr. O'Hara mentioned the Maryland model was comprehensive program, but it is against the backdrop of the state's system as a whole. Both Dr. Fan and Dr. Conaty-Buck commented that it was an investment infrastructure that supported clinicians over time.

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Comment via Webex Chat box
Steve Costantino - https://hcp-lan.org/workproducts/apm-figure-3-final.pdf

Dr. Fan stated they will need to decide on an aspirational goal. She encouraged members to reach out to her between meetings. She recognized that it may be uncomfortable for some members to share in the larger group. She stated that she was confident that members could agree on a common feature of models that we believe will be most successful. She asked if members could agree on a timeline tonight. There was some discussion about if it is the role of the group to align metrics. There was a suggestion to create a subcommittee to work on this task. Dr. Gill shared that he agrees with Mr. Costantino, that aspirations of value-based care can be made as long as it comes with dramatic increase in primary care with a specific amount.

Dr. Fan mentioned that the OVBHCD will help with the identification of primary care targets. This work is essential to the establishment of health policy for practice transformation. She concluded by asking members if they could support an alternative payment model that included a large portion of capitated payments with other smaller features. She recognized this would be skipping over LAN 2 into an advance LAN 3 with a built-in concept of measurable outcomes and defined risks involved with the payment model. She added that if Delaware had 10% of the current practices leave, it would make a significant impact on the state's ability to have a functional health care delivery system.

Dr. Fan introduced Tyler Blanchard from Aledade to share his perspective on what the key areas that helped them with culture change and practice transformation for their providers and how did they obtain buy-in. Tyler introduced himself sharing that he is the Executive Director for Aledade Maryland and Delaware Markets. Aledade saved a little over 18 million dollars in 2019. The physicians took home 6.4 billion dollars in bonuses in the past few weeks. Mr. Blanchard reported that Aledade achieved a quality score of 92.4%. He excitedly shared that this was the first time they paid a million dollars or more to a practice. Aledade reduced Emergency Department utilization by 9%. They experienced close to 10% reduction in inpatient utilization and 14.6% improvement in Primary Care utilization. More than half of the practices they work with in Delaware are solo physician practices.

Mr. Blanchard shared their details about their practice transformation process. Aledade assists practices with identifying strategies and developing goals. He added that there is a focus around what they call Core 4 (ER reduction, transition care management, access and wellness and risk). He attributes the frequent meetings with practices this to their success, sharing that the meetings are monthly. Meeting topics include physician best practices, data review and barrier removal. They have staff who help improve workflow. They also offer training on population health tools and data and provide quality gap closure lists. He shared that there is a heavy focus on fostering relationships of trust with their practices. Their practice transformation specialist are workflow experts, trainers of their system and they have other experts on staff including from the EHR team, coding and billing team, non-Medicare performance team, and others as needed. Aledade also holds monthly board meetings that are well attended. Every practice has a seat on the board. They review high level data, measuring practices and comparing them to each other. They also hold monthly clinical calls, where directors speak with physicians directly. They showcase data, discuss issues and offer solutions. In the past they have held in-person retreats two times a year (pre-COVID). They hold monthly CME National Rounds, giving physician's the opportunity to obtain additional education. Attendance is recorded at each meeting and is factored into payout shared savings. They develop toolkits and cheat sheets. They send postcards and contact high-risk patients during the holidays, to remind them to refill medications, see their primary care doctor. They also share their 24/7 phone number in case they need care when practices are closed. They measure practice satisfaction. If they find physician satisfaction is low, they implement plans in place to address issues. He concluded his comments by sharing that their Net Promoter Score (NPS) is 72. He attributes this to the support Aledade provided to practices during the pandemic. Mr. Blanchard introduced the

next speaker, Dr. Mullins, an Aledade Regional Director and a practicing physician. Dr. Mullins stated that while she is a Regional Director, she planned to share the perspective of a participating practice. They joined Aledade in 2014. They currently have 25 employees, 4 physicians and 3 Nurse Practitioners and a concierge physician within the practice. She shared the impact the practice experienced after a 10% drop in their physician's population. They have worked closely with their practice transformation specialist over the years. It is a heavy presence of data analysis. Physicians are provided summary cards for each patient. They information on these cards includes stats on last mammogram, risk score, last Emergency Room visit, number of well visits and how much their spend is at the hospital system level. They could not do this level of analysis on their own, as an independent practice. The Practice Transformation Representatives also work closely with the administrative staff. They provide guidance on which patients should be called proactively to bring them in for preventative care services. Aledade has provided five contracts over the payors (Commercial payors, Medicaid, Medicare) to ensure the same work can be provided across multi-payors. Their practice did well during the pandemic due to the diverse revenue (per-member-per month payments and shared savings payments). Physician coaching and peer support are also meaningful components of models that have high potential in Delaware.

Dr. Veronica Wilbur mentioned (via chat box) that there are providers, such as Nurse Practitioners who are blocked from being a part of some of these systems. She encouraged the members to consider strategies to ensure they have an opportunity to be included.

Dr. Fan thanked Dr. Mullins and then turned the time over to Dr. Bob Monteleone, Medical Director of the Delaware Care Collaboration. He shared that one of the big practice transformations is identifying high-risk patients and targeting them to get them into primary care and avoid hospitalization. He added that he learned early that he could not control Emergency room visits independently, it is only possible with the support of an ACO team (Practice Transformation Specialist, Care Managers, and Practice Liaisons). Cost savings analysis indicate that two main areas hold their largest savings. The first is transitional care management (patients leaving hospital within two days and being scheduled for an appointment within a week). They received a 5-million-dollar savings within their total cost of care. He also mentioned that they had great success with reducing length of stay. The Skilled Nursing Facility (SNF) length of stay was also another main area they experienced savings. He accredits this success with partnership with Social Workers that assisted the families with placements. Every patient is connected with the SNF by the Social Workers. This was helpful, especially during the pandemic, as it became very difficult to transfer patients. High-risk reports include Emergency Room visits. This report also includes patients that are not just high-risk but also patients within a frailty index (patients most frail, most likely to have poor health outcomes). He shared that he enjoys the work, adding that physicians experience a sense of satisfaction as they note the higher quality scores, the impact on health and cost outcomes, and the increased connections with patients. Another valuable service provided includes the calls from Case Managers. He reported receiving anecdotal data from patients that they have enjoyed receiving the calls. Some have even called to ask why the calls have stopped. The data analytics received from an ACO could not be done by a private practice alone. He concluded by adding that ACO support allows physicians to gain a perspective of practicing on a systematic level.

Dr. Fan asked how buy-in is obtained from practices to participate in practice transformation. Dr. Monteleone, shared that he believes sharing the payouts achieved in the past have helped. Showing the success over time, is proof that the investments will payout. There was continued discussion on how practices have been engaged. Dr. Mullins shared that she encouraged her practice to become involved by sharing the 2018 CMS goal to ensure 30% spend is not fee-for-service. There was some discussion on whether primary care providers be responsible for total cost of care. Some felt that the results presented by both speakers show that primary care providers can drive total cost of care. Dr. Monteleone commented that full-risk models could close a practice down if they did not succeed. He mentioned that this type of model would need to be supported by a health care system. He added that he is working

on a proposal that includes incentives for practices that are willing to take on more risk; increased risk would lead to increased payout. Mr. Costantino also shared that some practices use a phased in approach. He agrees that primary care can affect total cost of care but there would need to be ACO involvement (transformation investments) as opposed to a solo practice outside of this system.

<u>Comments via Webex Chat box</u>
Dr. Veronica Wilbur

- Without being in an ACO we are held to the same issues of discharge --- How can individual practices be included in the same principles of action towards a version of VBC?
- Can we speak to other providers within the system beyond the physicians?
- Case management exists within the two Medicaid products, but they do not collaborate well with my practice. I have a high-risk population.
- Case management exists within the two Medicaid products, but they do not collaborate well with my practice. I have a high-risk population.

Mr. Blanchard responded by sharing that attribution process, stating that the patient enters into an ACO by being seen by a physician or by Nurse Practitioner or Physician's Assistant that is billing to an MD or MO. He added that these rules are led by the payors. Kevin O'Hara also added that attribution is driven by provider selection or claims data. He added that this was an issue that could be explored. It becomes problematic when you start to attribute cost of nontraditional services because they may receive multiple attributions for the same member. Dr. Fan suggested that members identify possible strategies to offer nontraditional health care providers avenues to participate in value-based care and payment models. She added that the workforce is stagnant and if the goal is to increase access and sustain workforce, the Collaborative will need to consider how Delaware can attract and sustain these providers. She concluded by reminding the members that before the pandemic, five years from 2018 the state expects a 10% decrease in workforce.

<u>Comments via Webex Chat box</u>
Dr. Veronica Wilbur

- Exactly about expanding the work force!!! I have my own practice of 650 patients

Dr. Fan thanked Tyler Blanchard and Dr. Monteleone. She asked members to come to the next meeting prepared by reading the following reports and considering the comments/questions:

- Rand Report
  - What does this mean with regard to the cost drivers in Delaware?
  - How can we find funding for investment in primary care?
- Maryland Primary Care Program
  - What components seem feasible for Delaware?
  - How this information can shape our funding conversation and components of value-based
- Capitated Alternative Payment
  - Can we promote a model to align payers to invest in primary care and move more practices away from fee for service?
- Question: Do we want an additional subcommittee to focus on aligning metrics? Should the Technical Subcommittee take care of this?
- Each Collaborative member should submit a proposal (example: 30% in value-based care model, 20% fee for service, 80% capitated, by 2025).

Dr. Fan called for comments or questions, hearing none she reviewed the plan for the upcoming meetings. She reported that in November members will be defining value-based care and defining approaches to affordability standards and oversight. There will also be discussion regarding recommendations to achieve primary care spend

targets and value-based alternative care models. Lastly, she shared that the October meeting would include a presentation from the Office of Value Based Health Care Delivery. Their presentation will include preliminary findings from their analysis. The meetings will continue to be held on the third Monday of every month (11/16/2020, 12/16/2020, and 1/18/2021).

Public Comment

Dr. Fan called for any additional public comments. Hearing no comments or other business, the meeting was adjourned at approximately 6:32p.m.

Next meeting

The next Primary Care Reform Collaborative meeting will be held on ***Monday November 16, 2020***.

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