SB 227 Primary Care Collaborative Meeting

Tuesday, February 12, 2019
6:00 p.m.
Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

Present:	**Email:**
Senator Bryan Townsend	Bryan.Townsend@state.de.us
Dr. Nancy Fan	nfanssmith@yahoo.com
Representative David Bentz	David.Bentz@state.de.us

Staff:

Juliann Emory	Juliann.Emory@state.de.us
Read Scott	Read.Scott@state.de.us

Attendees:	**Organization:**
Susan Conaty-Buck	Delaware Coalition of Nurse Practitioners
Deborah Zarek	Medical Society of Delaware/Physician
Andrew Wilson	Medical Society of Delaware/Morris James
Gary Kirchhof	Highmark
John Fink, MD	Bayhealth
Regina Heffernan	AmeriHealth Caritas
Stephen Cozzo	AmeriHealth Caritas
Christine Donohue Henry, MD	Christiana Care Health Systems
Jamie Clarke	Nemours
Stephen Groff	DMMA
Steven Costantino	DHSS
Charles Jose	Robert Graham Center
Rosa Rivera	La Red Health Center
Pam Price	Highmark
Jennifer Mossman	Highmark
Dan Elliott	Christiana Care Health Systems
Faith Rentz	Department of Human Resources
Sylvia Cantera-Brown	Delaware Pediatrics
Kim Gomes	Byrd Group/Medical Society of Delaware
Elisabeth Scheneman	DHSS
Kiki Evinger	DHSS
Lisa Zimmerman	DHSS
Maggie Norris Bent	Westside Family Healthcare
Rose Kakoza	Christiana Care Health Systems

Weston Riesselman	Christiana Care Health Systems
Katherine Collison	DHSS/DPH
Kelly Anderson	Johns Hopkins School of Public Health
Jessica Hale	Johns Hopkins School of Public Health
Chris Manning	Nemours
Wayne Smith	Delaware Healthcare Association
Meredith Tweedie	Christiana Care Health Systems
Christine Schultz	Parkowski, Guerke & Swayze
Kelly Krinn	Health Management Associates
Art Jones	Health Management Associates

The meeting was brought to order at 6:00 p.m.

Dr. Deb Zarek, Medical Society of Delaware

- I am an internal medicine physician with private practice. I am representing the primary care doctors in the area.
- It is difficult to get primary care doctors to move to the area because pay is low and new graduates have high loans.
- I am happy about the bill; it is a step in the right direction.
- I am concerned that not all payers are paying the Medicare rates. We need to discuss what happens if these rates are not paid and if there are any consequences.
- Dr. Jim Gill will be joining us later, and he has provided a few additional points. We agree with the Collaborative's goal of increasing primary care spending to 12% of the total health care spend.
- We need a measure of primary care that is standardized and valid. **We will provide a citation for this definition of primary care from Milbank.**
    - Pharmacy costs should not be included in the definition of primary care because that doesn't represent revenue supporting primary care practices.
    - Also not included: Labs, imaging, hospital costs unless provided by primary care physician, facility fees, emergency room, and non-primary care services.
- Even with this definition, 12% spending on primary care is the minimum that should be considered. Colorado has a bill calling for 15% of spending on primary care.
- Not all the primary care spending should be FFS, but FFS is still a large component of our health care reimbursement. It is important to maintain rates at least matching Medicare rates. This requirement from SB227 should expand bill to all Medicaid, MA, and commercial plans.
- Care coordination fees should be included in the 12%. All payers should pay a minimum per member per month (pmpm) fee that is prospective and guaranteed totaling at least $15-20.
- Primary care providers need to hire nurses and other staff to provide coordinated care. Studies show care coordination care can improve quality and costs.

- Reimbursement for quality and cost savings may be subject to modification, but the care coordination fee must be provided in full in order to ensure primary care practices can operate.

Rep. Bentz

- You are concerned that not all reimbursements have been elevated to Medicare rates. Is that a system or isolated problem?
- We specifically delayed implementation at payer request to make sure they were ready to implement this change. It is disappointing to hear that this is happening given the delay.

Dr. Deb Zarek, Medical Society of Delaware

- There are some that are paying the higher rates and some that are not.
- We can get this information to you.

Sen. Townsend

- The Department of Insurance is not at this meeting, but they will be invited, and they need to be aware of any failure to comply. They met with stakeholders in December to discuss this issue.

Gary Kirchhof, Highmark

- Director of Commercial Contracting at Highmark
- Highmark provided our response to the report.
- First, we believe the patient should be at the center of the solution.
- We believe in a value-based reimbursement (VBR) approach.
- Currently, Highmark spends 8% on primary care, including VBR. We do provide resources and care coordination fees upfront.
- We believe that reimbursement increases should not be done without improvements to quality and lowering the total cost of care. VBR can be useful beyond primary care as well.
- We should look at how we should use physician extenders to shore up primary care access.

Dr. John Fink, Bayhealth

- I am a family physician. I have worked as an employed physician and in private practice. Medical director for the outpatient medical group. I am here representing Dr. Siegelman, CMO and the organization [Bayhealth].
- We want to support role of employed physicians in the network. We are trying to grow the primary care base in Sussex County, filling the needs of the community and playing an important role in recruiting.

- We support this initiative in general. Addressing primary care is not just about reimbursement, but also about reducing the burdens on primary care.
- Value based payment (VBP) can place a burden on independent and employed physicians.

Dr. Nancy Fan

- Regarding increasing primary care spending – are employed physicians counted under hospital or primary care costs? Employed physicians walk a fine line by working for the hospital.

Dr. John Fink, Bayhealth

- Our concept is that whether employed or in private practice, a primary care physician is a primary care provider. The abilities of an employed may be able greater to address acute care spending by leveraging the connections and tools of a health system.
- A primary care physician is still operating as a patient's primary care provider. As a health system, our patient centered medical homes (PCMHs) are set up the same way.

Dr. Nancy Fan

- And you use PCMH as your model for primary care delivery?

Dr. John Fink, Bayhealth

- Yes

Regina Heffernan, AmeriHealth Caritas

- Here representing AmeriHealth Caritas.

Steve Cozzo, AmeriHealth Caritas

- Director, Public Policy
- Amerihealth Caritas is an MCO, entering our second year in Delaware.
- Primary care providers are a cornerstone in our care model. It is important to maintain a robust network in all areas of the state.
- Primary care providers are important resource for us to help our members get the social supports they need.
- We participate in VBP agreements with several providers, but they are all upside risk only. We are exploring opportunities to expand these models to downside risk.
- Our measures are aligned with what the state requires in HEDIS and financial metrics.
- It is important to keep a focus on quality, outcomes, and providing supports outside of financial supports to our providers, so they are able to meet those benchmarks.

Dr. Christine Donohue-Henry, Christiana Care

- CMO of Community Care at Christiana.
- Christiana's goal is to transform ourselves from a health system to a system that delivers health to our community, and primary care is the foundation.
- We have gotten NCQA PCMH designation at all primary care practices recently.
- We are expanding primary care capacity to deliver primary care – we have hired 5 primary care physicians and 15 advanced care providers to join our primary care practices.
- We have done work with our specialty colleagues as well. We need to change the FFS mindset in specialties. How can the PCP talk with specialist to get to the root problem without an official visit?
- We want to share our learnings with our partners both with eBright ACO and the Clinically Integrated Network.
- Primary care should be viewed separately from hospital costs within a health system. Primary care is an investment in the community. The primary care physician has some control of hospital and ED utilization and can make an impact on total cost of care.
- Moving forward, the target was 60% of reimbursement in a VBP structure, but it needs to be a meaningful VBP.
- We want to move to upside and downside risk with total cost of care. We are starting to see progress in our conversations with payers, but anything on the policy side to accelerate that transition would be appreciated.

Dr. Nancy Fan

- When talking about current value-based contracts not being meaningful, is it that the administrative burden inhibits the ROI?

Dr. Christine Donohue-Henry, Christiana Care

- VBP is such a small percentage of the revenue. We are still largely FFS-based and if we want to transform we need to go to total cost of care. We want to move beyond the CPC+ model.
- We are working to build the competencies to get to a total cost of care model.

Dr. Nancy Fan

- CPC+ is offered by CMS, but not currently in Delaware.

Dr. Christine Donohue-Henry, Christiana Care

- Christiana has two practices in New Jersey that participate in the CPC+ model and receive the upfront pmpm payments for resources through that model. CPC+ is a step along the way to a total cost of care model.

Jamie Clark, Nemours

- Executive Director of Value-Based Care at Nemours
- We believe that reimbursement for non-traditional workforce like community health workers (CHW) and case managers will be essential. We also need payment and programs that address social determinants of health. There are not enough resources to address this currently.
- The increased delegation of responsibilities is essential, such as care coordination and case management. We need to know who can be most effective in managing the patient.
- We need to agree on meaningful and actionable measures. Using industry standard of HEDIS is not flexible enough and limited in relevance to children.
- Real-time, actionable data is a concern. We are in upside only contracts. When we move to a risk relationship, we need actionable data.
- We have administrative issues with payers, for instance a new MCO or system migration can be a big problem for the providers.
- We believe VBP is important up to delegated risk. We believe we should be delegated for certain functions. The provider, not the payer, should do the case management and get paid for it. We should take risk on total medical expense and get paid an administrative fee. The payer receives an administrative fee that would be passed to the provider. That administrative fee would not be at risk because taking the provider is taking risk on the medical expense.

Steve Groff, Medicaid Director

- Fundamentally we would be most supportive moving forward in a value-based environment rather than raising FFS.
- That being said, we recognize the need to support primary care because it is a crucial element to getting improved health outcomes.
- One challenge is getting an understanding of what the problems are that we are trying to address. We want to make sure the solutions we are talking about are addressing the specific and unique barriers in Delaware that might not be true in other states.
- Another concern is the readiness to move to risk or total cost of care payment models. We all want to be there eventually, but all at a different point and we need to move as quickly as possible without leaving behind practices.
- Lastly, I share concern about our ability to share and use data.

Dr. Nancy Fan

- Is your concern about using data because it is mostly claims-based, we lack the technical ability to get live data, or the concept of using data as a measure of payment?

Steve Groff, Medicaid Director

- Yes to all.

Steven Constantino, Department of Health and Social Services

- The whole issue of data is that we need data for a lot of reasons. The provider and payer both need quick feedback in a VBP world. Ultimately, we need to make reconciliations and the data needs to reflect the risk for risk corridors or other financial tools.
- There is a disconnect in the definitions we are using. What do you mean by risk – is that simply an incentive payment, is it shared savings – both are FFS? Or is it a prospective payment and taking on the risk of the patient? I would like to get out of this how we define risk.
- The Secretary has talked about moving away from FFS and tying it to high quality and lower cost.
- The thresholds in new MCO contracts are on VBP – the 60% VBP that moves along the taxonomy from FFS to downside risk on population. It is a glide path. Some may think it is too quick or too slow. That will be reviewed each year with MCO.
- Also in the MCO contracts are quality thresholds. These are not just looking at the risk model but also looking at quality. There are also thresholds on certain quality metrics (7 metrics) that put pressure on the system to look at both cost and quality.
- The University of Delaware did do a study on the lack of primary care services in the state and that access issue is a tremendous challenge. There are different reasons people don't go into primary care and we should look at this through a holistic lens because it is not just an impact of the health care system.
- In terms of investments, the Secretary would really like to see these investments tied to models, like PCMH or addressing SDOH.
- Look at other states Rhode Island or Oregon, many of the primary care investments have been tied to new and different models.
- The SIM grant offered mini grants trying to improve the readiness of practices for VBPs.
- At the federal level there will be new models and providers need to be ready to apply for these models and to take on risk. There have been some criticisms that the federal models have been too focused on the shared savings and new models will move toward downside risk.

Dr. Susan Conaty-Buck

- I am representing the nurse practitioners.
- The study from the University of Delaware was only looking at primary care physicians. We will be doing our own study to assess where NPs are practicing in Delaware.
- We have the ability as NPs to practice independently, but we do not have the structure for these providers to get into practice. They do not have the infrastructure and they do not have parity from insurers.
- People would be paid for what they are doing – each service should be paid the same across practices and that is not the case.
- We all want to look at SDOH and we all want an equitable system that allows all providers to provide care.

- The patient should have the right to see who they want to see, but that is not true in Delaware for NPs. We are wasting a resource. We are not supporting a group that wants to work and is facing barriers to practicing independently.
- Those who do best are the ones working in systems – they have more supports, but we need similar support if we want providers to be able to survive outside of these systems.

Dr. Nancy Fan

- Dr. Art Jones from HMA will facilitate. We want to work through these questions stemming from report.
- This will focus on how to move forward on payment reform. There are many other aspects including workforce and access challenges, but this set of meetings pertains to payment reform.
- We might need to come up with some aligned definitions.
- Those at the table will be here for all four meetings. We reached out because we want to hear from these stakeholders. We will be adding DOI and the FQHCs as participants in these meetings. If there are other stakeholders that would be important, please reach out so we can consider them.

Dr. Art Jones, HMA

- The participants affirmed that have a problem with primary care access in Delaware.
- We also consistently heard that there is a combination of lifestyle issues, payment issues, and administrative burden that create barriers to practicing primary care in Delaware.
- Let's move on from defining these problems to consider practical solutions.

Dr. Deb Zarek, Medical Society of Delaware

- I want to make a couple other comments about quality measures. In primary care you are always trying to do your best. The problem with these incentive plans is you get paid after you show that you did something. We are asked to meet all these quality measures, but there is no financial incentive to make sure we can accomplish these goals.
- It's great that Christiana has been able to become PCMH. It is very expensive and not feasible for my private practice to get certified. Furthermore, there is no increase in payment for PCMH certification. I would love for my practice to be a PCMH, but I need the money up front to hire people and get the resources to be a PCMH.

Dr. Art Jones, HMA

- Do we need upfront payments in order to achieve the outcomes we want to see?
- What is the downside of that from a payer perspective?
- If no one has any concerns about upfront payments, then we need to discuss the magnitude.

Steven Constantino, Department of Health and Social Services

- Are insurers paying for PCMHs? Are there contracts for PCMHs?
- I recently saw a map for the Medicaid population showing that there were no contracts with PCMHs. I would like to know on the commercial side, are there any contracts with PCMHs?
- At one time Highmark had a PCMH program, but then the model changed.

Gary Kirchhof, Highmark

- We had a program that provided an incentive for PCMHs. We replaced all incentive programs with True Performance; this program has an upfront payment as a pmpm.

Pam Price, Highmark

- The pmpm payment is on scale, based on the patient risk.
- For someone young and low risk, the provider might get $2.50 pmpm, and it scales up so someone with chronic care gets $16 pmpm.

Dr. Nancy Fan

- And my understanding is that True Performance is overlaid on FFS. Is there an on ramp away from FFS?

Gary Kirchhof, Highmark

- Yes, there are multiple levels of risk including full risk model. We do not think all providers are ready and so we have a glide path.

Dr. Nancy Fan

- Any practices in the end (total cost of care)?

Gary Kirchhof, Highmark

- No none at the end of that path, but we have practices that are making progress.

Dr. Nancy Fan

- Is there alignment between those with a higher pmpm and the practices with more readiness in their delivery model? Are the practices that have been successful PCMHs?

Gary Kirchhof, Highmark

- Not that I'm aware of. We can look across our entire footprint.

Dr. Nancy Fan

- I think this would be a good piece of information for us to have.

Dr. Christine Donohue-Henry, Christiana Care

- It would be helpful to focus specifically from Delaware. The Pennsylvania market is much more advanced.

Gary Kirchhof, Highmark

- Delaware is on the low end of the risk models. We are all in the upside-only models, without downside risk yet.

Dr. Nancy Fan

- From the original meetings, we heard that there has been low uptake of value-based payment models. This might impact the low access and high cost.

Dr. Art Jones, HMA

- What should practice get paid for?
- What do practices need to be able to show in terms of what they invest in and outcomes?

Dr. Jim Gill, Medical Society of Delaware

- I am a family physician working with MSD working with our primary care payment reform committee.
- The AAFP has proposed a new payment model framework. This compartmentalizes the types of payments we need to consider:
  1. Services, office visits and procedures (this may be paid FFS or capitated)
  2. Care coordination fee
  3. Quality of care payment
  4. Utilization and costs payment
- The first two quadrants should not be subject to risk based on quality, but the other two may be.

Dr. Art Jones, HMA

- What accountability should there be for the care coordination fee?
- If I'm the payer, how do I know that this is going to care coordination activities?

Dr. Jim Gill, Medical Society of Delaware

- There could be documentation. Care coordination is a unit of service that is required for primary care.
- The care coordination fee should be $15-20 pmpm on average. That cannot be subject to risk because a practice must hire staff and do the work regardless.

Dr. Christine Donohue-Henry, Christiana Care

- I agree with Dr. Fan that perhaps we need different models, but maybe limited to 3 or 4 models.

- I think that model Dr. Gill highlights makes sense especially in a private practice world.

Dr. Nancy Fan

- Is this a modular menu?

Dr. Jim Gill, Medical Society of Delaware

- You must pay for the first two, but the other two are more optional based on your goals.

Dr. Christine Donohue-Henry, Christiana Care

- I think the weighting of these quadrants matters – if you want to impact quality and costs you need to emphasize the last two quadrants.

Dr. Nancy Fan

- This is still an overlay on FFS?

Dr. Jim Gill, Medical Society of Delaware

- No, the first quadrant could be completely capitated.
- In quadrants 3 and 4, you could provide nothing, but you will not get great outcomes.

Dr. John Fink, Bayhealth

- CMS provides different models based. Care coordination is ultimately about quality. The more advanced models are available for providers who are willing to take on more risk.
- I think there needs to be a floor for payments, but for increased readiness, practices can be at risk.

Dr. Nancy Fan

- Can provide this fee to multiple different clinical settings?

Dr. Jim Gill, Medical Society of Delaware

- Yes. Some settings might be willing to take on full capitation, but other smaller practices may not be willing to take on a capitated model.

Dr. Christine Donohue-Henry, Christiana Care

- We would not be satisfied with that as the end goal. We believe that we want to move to a total cost of care model.

Dr. Art Jones, HMA

- What is your reaction as a payer? You are providing some care coordination services – so where is your concern for duplation, costs, benchmarks on total cost of care?

Sen. Townsend

- Having silence on issues defeats the purpose of these meetings.
- For those who might not have been here for earlier meetings, these meetings could be used to discuss ways forward that get us to a better place on outcomes and costs and build consensus, but if there is a breakdown in discussions, we will still be moving forward with solutions to address the primary care crisis.

Dr. Art Jones, HMA

- I want to prepare the hospitals to weigh in on this question as more effective care coordination models should reduce ED visits, ambulatory-sensitive admissions and readmissions? We will also want to hear from you next.
- For the payers – increasing spending on primary care through fee for care coordination, what is your concern? What are you looking for in exchange for paying these care coordination fees?

Steve Cozzo, AmeriHealth Caritas

- One thing to keep in mind, we want to make sure in terms of redundancy is that there is one single care coordination entity. This can cause disruptions especially as providers take on risk.
- We also want to ensure that data is available to properly share in a timely, actionable way.
- We are managing for quality and financial benchmarks from the state, so we are concerned about provider readiness.

Dr. Art Jones, HMA

- And also sharing care plans on those complex patients that you have in the plan's care management?

Steve Cozzo, AmeriHealth Caritas

- If feel confident we can share these, but that is not my area of expertise.

Dr. Art Jones, HMA

- Do you have any financial concerns or accountability?

Steve Cozzo, AmeriHealth Caritas

- I think if you are going to put primary care providers at risk, then the risk is the accountability.

Steve Groff, Medicaid Director

- I agree that the risk is a way of keeping providers accountable if we are moving to risk. Dr. Gill's model is a step to total cost of care.
- If we are paying care coordination as a fee for services and there is no way of assessing the impact of the care coordination, then I have some concerns.

Steven Constantino, Department of Health and Social Services

- We have been in a FFS system for 50 years. We still talk about care by code. We are still adding codes to address this problem.
- We also need a definition for care management.
- The care management fee must be tied to something; it must actually reduce ED visits, readmissions, etc. There must be performance metrics tied to it, and you can risk adjust because someone with chronic conditions is not equal to someone without those conditions.
- From a Medicaid point of view, is having a care management code additive or can we link it to changes in health and utilization elsewhere?

Dr. Nancy Fan

- We are talking about this as an upfront investment as a pmpm. A lot of VBP contracts have quality metrics included as a carrot – like shared savings or bonus payments.
- If we agree that care coordination is an upfront investment, then what is the accountability?
- Recognizing that our current data system for performance improvement is poor, should DHIN be involved in these discussions?
- I think I would like us to have some consensus on the framework we want moving forward.
- Payers are speaking for national organizations, but we care about Delaware right now. Can you get buy-in from your organizations? This would help the providers buy-in.
- There is interest in moving to total cost of care, but we do not foresee that in the immediate future.

Steve Cozzo, AmeriHealth Caritas

- I am not the best to speak to specific quality metrics.
- We have a tailored approach to meet the specific market needs.
- We can certainly bring back and discuss Delaware specific solutions

Gary Kirchhof, Highmark

- Today we do not have a measure that outlines the actions required of providers.
- The idea is that pmpm is available for providers to freely use as they need.
- We have transformation consultants and data specialists that are also available to providers

- We focus on upside outcomes.
- I am not prepared to say specifically what we want from care coordination fees.

Dr. Art Jones, HMA

- One concern is that putting extra dollars into care coordination inflates the total cost of care.
- We want to see changes in quality and outcomes. How do you respond to that concern?

Dr. Jim Gill, Medical Society of Delaware

- It is reasonable to put some parameters around care coordination fees.
- Medicare pays a daily SNF fee – that is a care coordination fee. There are some parameters that you must document in your daily work in order to get the care coordination fee.
- There is probably a reasonable way to say that you would document a set of basic activities for the typical patient.
- We need a floor on care coordination fees, maybe there are extra parameters that can increase the care coordination fees.
- And accountability has nothing to do with codes.

Dr. Nancy Fan

- That just sounds like more administrative burden. There needs to be an administrative task taken away if we are adding administrative tasks.

Dr. Art Jones, HMA

- In Connecticut, they simply have to say what they are paying for – like employing staff who are performing the care coordination function.

Dr. Jim Gill, Medical Society of Delaware

- You cannot be at risk for things you cannot control. Primary care providers have no control over hospital costs. But you could get to a place where the primary care community has control. There could be a hospital budget or primary care could set the rates for procedural fees and decides if the hospital gets paid or not.
- No one in primary care should be accountable for cost they cannot control.

Dr. Art Jones, HMA

- From a hospital perspective, what is your response? This would be one way of shifting more of the total health care dollar into primary care, reducing what is available for other services.

Dr. Christine Donohue-Henry, Christiana Care

- We are absolutely preparing for reducing hospital utilization.
- One aspect is care standardization, limiting costs and improving quality.
- We had a definitive effort to standardize and reduce NICU admissions. Following the standard of care and evidence-based guidelines to determine which babies should be in the NICU reducing spending. This is a hit to our bottom line, but we are ready to limit our costs and ED utilization.

Dr. John Fink, Bayhealth

- We are involved in bundled payment initiatives focused on decreasing total cost of care. This is going to benefit the organization and the community. We look at it as an investment in the community.
- We want to grow primary care and we understand the dollars must come from somewhere.

Jamie Clark, Nemours

- We want to make sure we have a track to managing the risk. We would love to have a double digit pmpm care coordination fee, but in our experience we usually have very low pmpm amounts that do not cover the salaries of the care managers.
- We are PCMH at all 12 sites in Delaware.
- We are able to get pmpms, in Pennsylvania where we do not have PCMH, because we can attest to a standard of practice to get the pmpm.
- There are ways for payers to ensure practices are accountable without being a PCMH.

Dr. Nancy Fan

- We have discussed quality outcomes, for instance ED utilization, although these can be difficult to measure.
- Nemours you mentioned you would like to see quality metrics outside of HEDIS. What would that be?

Jamie Clark, Nemours

- It could be a screener for SDOH. There may be other things we are working on that impact total costs like SDOH, which can move costs to a greater extent a basic well child visit.
- We could be more creative to get impactful measures. We are limited to these HEDIS metrics and most are not pediatric-specific.

Dr. Nancy Fan

- It is hard to measure these metrics. Claims measure through codes. For real time data, there is an administrative burden.

- How do new metrics actually fit into this environment? We might have to start with basic metrics.
    - You have 7 metrics in the current MCO contracts – mostly HEDIS measures.
    - True Performance as 12-ish metrics, with the provider selecting their metrics to a certain extent.
- There is diversity in the outcomes and quality metrics.
- We need to consider the reasonable administrative burden in choosing metrics.
- Larger systems might be more able to absorb the burden, but still the providers must do some of the work.

Dr. Christine Donohue-Henry, Christiana Care

- A key part of what we are doing it to prepare for risk is building out the care team.
- It is really important not to throw total cost of care off the table even though there is a glide path.
- We need some up/down risk with a cap or corridor that could expand over time or a model like the ACOs that can choose the level of risk that is appropriate.

Steve Cozzo, AmeriHealth Caritas

- The social determinants directly impact the total cost of care. Medicaid is limited in what we can pay for related to social determinants.
- North Carolina has put together an interesting waiver to consider SDOH. That is a conversation worth having for the health care system and the other support systems.

Dr. Jim Gill, Medical Society of Delaware

- Looking at SDOH are important, but these are not quality metrics.
- We have never measured primary care quality metrics, even though there are good quality measures like the Barbara Starfield metrics. Some of these can be easy to measure like continuity of care and comprehensiveness.
- We need to move away from old HEDIS measures like BMI, which are not measures of primary care.

Dr. Art Jones, HMA

- There are metrics of care coordination. For instance, having a primary care visit after a hospital admission, which we proved reduces readmissions.
- Practices can also look at SDOH to see what factors impact health and costs in their population.
- Summarizing our discussion:
    - One of the ways to invest in primary care is to pay an additional pmpm or fee for PCMH functionality. There was no consensus on the value of certification.
    - If that investment only increases health care spending, it is unsustainable.

- To be successful, there needs to be timely, actionable data to drive the care coordination activities.
- If the patient is being care managed by the plan with a complete care plan, then we need to figure out how to delegate responsibility and share information with clear roles that do not duplicate efforts.
- We need to monitor the impact of care management through quality or other accountability metrics.
- This is one part of a component of a way of managing total cost of care. If effective in reducing the cost, then we will see lower ED utilization and inpatient utilization. As that utilization goes down, the hospital systems need to expect reduced revenue and cannot recover this revenue by increasing prices.

Dr. Christine Donohue-Henry, Christiana Care

- I also heard consensus on having more than one model to meet varying readiness.

Dr. Nancy Fan

- A lot of this discussion is framed around short-term revenue improvements rather than long-term within a total cost of care.

Dr. Christine Donohue-Henry, Christiana Care

- We don't want to wait for everyone in the state to catch up. And we want to bring our partners along in the CIN and ACO.

Sen. Townsend

- We can applaud efforts from different actors, but there is comparing apples and oranges across these different providers.

Steven Constantino, Department of Health and Social Services

- We have not talked about ACOs, but if we are talking about layers of care management, we need to consider what the ACO wants to do.
- North Carolina has some interesting efforts outside of their 1115 waiver, including ACO contracts with BCBSNC, addressing care management and SDOH.
- Currently, Delaware has an RFI in Medicaid that is asking about an MCO / ACO or health system relationship. Primary care is a major piece of that discussion.
- Good primary care can control hospital cost and ED utilization.

Dr. Jim Gill, Medical Society of Delaware

- Obviously, a PCP can control utilization. Our ACO reduced hospital utilization by 12%, but hospital costs went up because prices increased.
- The prices are the problem.

- There is some perception that total cost of care is a higher level of primary care delivery, but there is no evidence that a total cost of care model is better.
- No other country holds any provider accountable for total cost of care, yet their costs are lower and utilization is higher.
- It might be a different way of reimbursing, but the concept that that should be our goal is totally false.

Sen. Townsend

- If you provided the right primary care, but cannot measure the result, then how can be accountable for it?
- There is no doubt that there is a relationship between primary care and other health spending.
- If total cost of care is the end goal for an integrated system, does that make it impossible to be an independent provider?

Steve Cozzo, AmeriHealth Caritas

- From a payer perspective - benchmarking regardless of model, becomes one of the more difficult exercises. The practice location, SDOH, member location, and other circumstances all impacts on the outcome.
- You see some providers and hospitals have penalties for high readmissions, but low mortality, and vice versa. The benchmarking needs be right for success.

Dr. Nancy Fan

- I don't think we are trying to advocate for one model.
- We want models that work best for different primary care practices to reach quality outcomes at a lower cost.
- I'm glad Steven Constantino brought up the ACOs, because there are other models beyond the PCMH.

Dr. Art Jones, HMA

- Homework assignments for the next meeting on Monday February 18th. Come prepared to discuss:
- Primary care providers
    - What type of accountability should be used for care coordination fees? How do we verify that the care coordination fee goes to care coordination?
    - What is the desired impact of care coordination fees? How to we measure that impact? What quality outcomes we should be measuring?
    - How should we create total cost of care guardrails?
- Payers
    - How prepared are we to share actionable and timely patient data and information like care plans to facilitate effective use of care coordination fees?

    - If providers are doing care coordination for certain patients, what does that mean for payers who are also doing care coordination?
    - What does it take to offer the full range of alternative payment models?
- All
    - How do we determine a care coordination fee considering the cost of providing care coordination, return on investment, and impact on total cost of care?
    - What alternative payment methodologies including primary care capitation are primary care providers already participating in or ready to participate in?
    - How should we determine provider and payer readiness for alternative payment models?

Dr. Nancy Fan

- Additional homework: identify anyone who is missing at the table who can offer meaningful input.

The meeting was adjourned at 8:00 p.m.