SB 227 Primary Care Collaborative Meeting

Monday, February 18, 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
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Attendees:	**Organization:**
John Fink	Bayhealth Medical Center
Geoff Heath	Christiana Care Health Systems
Kathy Collison	Division of Public Health
Lizzie Lewis Zubaca	Hamilton Goodman Partners
Karyn Scout	AmeriHealth Caritas
Kim Gomes	Byrd Group/Medical Society of Delaware
Steven Costantino	Department of Health and Social Services
Steve Groff	Division of Medicaid & Medical Assistance
Rebecca Byrd	The Byrd Group
Lisa Zimmerman	Department of Health and Social Services
Weston Riesselman	Christiana Care
Elizabeth Scheneman	Department of Health and Social Services
Chris Manning	Nemours
Shay Scott	Henrietta Johnson Medical Center
Anthony Onugu	UMACO
Rosa Riviera	La Red Health Center
Jamie Clarke	Nemours
Chris Morris	Aetna
Kathleen Willey	Quality Family Physicians
Michael Bradley	Medical Society of Delaware/MedNet
Jennifer Mossman	Highmark DE
Dr. Jason Hann-Deschaine	MSD/Delaware Pediatrics
Lenaye Lawyer	ACDE
Faith Rentz	DHR/Statewide Benefits

Sylvia Canteen-Brown	Delaware Pediatrics
Rose Kakora	Christiana Care
Kiki Evinger	Department of Health and Social Services
Katherine Impellizzer	Aetna
Stephen Cozzo	ACE
Pam Price	Highmark
Susan Conaty	DCNY
Dan Elliot	Christiana Care Health System
Wayne Smith	Delaware Healthcare Association
Mike Wornt	Aetna
Kelly Anderson	Johns Hopkins School of Public Health
Jessica Hale	Johns Hopkins School of Public Health
Kelly Krinn	Health Management Associates
Art Jones	Health Management Associates

Meeting was called to order at 6:00 p.m.

Dr. Fan

- Our first item is the minutes approval. Are there any modifications?

Steven Costantino, Department of Health and Social Services

- I have two corrections.
- The spelling of "Costantino" and on page 17 North Carolina has some interesting efforts coming **out of** their 1115 waiver. Modification, not outside their 1115 waiver.

Dr. Charlie Jose, Graham Center

- I am with the Graham Center at AAFP; we are interested in what Delaware is doing regarding primary care spending.
- We are rolling out a qualitative study where we will be doing key informant interviews in RI, OR, CO, CA – all states who have discussed primary care spending.
- We are interested in talking to payers, providers, and legislators. Our main goal is to understand the process of introducing regulation and legislations.
- We want to set up 30-minute interviews with you to get your perspective and to understand what is unique about Delaware.
- My role is not to advocate for or against regulations. All comments will be anonymous in whatever we publish.

Dr. Fan

- The next point is about consensus items. In the last meeting we agreed:
    - 1) We need to increase investment in primary care in order sustain it.
    - 2) Upfront could be a pathway away from the current system to a value-based model.

- This meeting we were going to focus on care coordination and how we would use it here in Delaware.
- We have support from John Hopkins University. They will be doing a short presentation.

Kelly Anderson, John Hopkins University

- The evidence about paying primary care providers for care coordination.
- We were asked to investigate two questions 1) What is the evidence on the effectiveness of care coordination PMPM payments and 2) Do accountability mechanisms exist to track the effectiveness of care coordination?
- We conclude: A clinical model plus a payment approach to enable the model can lead to improved outcomes
- There are a lot of different approaches to paying primary care providers for care coordination. The real consideration is if they are prospective or retrospective payments and degree of responsibility providers have for quality and cost.

Jessica Hale, John Hopkins University

- These tools to pay for coordination are most often leveraged within a broader model for care delivery. Some models include:
- PCMH: which blends FFS and capitation and uses PMPM payments to pay teams of providers for coordination and care management
- CPC+: the most recent CMS model that uses risk-adjusted PMPM fees to prospectively cover all practice expenses over a period of time
- Health Home: coordinates care for high-need and high-cost populations
- ACOs: groups of doctors, hospitals, and other providers who voluntarily coordinate care, adopting a shared savings model
- There are a few common themes we found from successful models:
    - Clear goals for outcomes with a vision for how care will be delivered
    - Timely and accurate data sharing
    - Risk adjustment to account for differences in patient panels
    - Prospective payments to allow practices to make upfront investments
    - Payments connected to a focused set of metrics and performance on the 4 C's (contact, continuity, comprehensiveness, and coordination)
    - Use of multidisciplinary care teams
- We could not find any evidence about PMPM payments alone, as all evidence that examines PMPM coordination fees is evaluated within a broader payment model
- PCMH is where we see the most evidence
- See results vary, NC (large savings reduce admissions) to NJ (not sufficient savings to cover costs and mixed results in health outcomes)
- Context and structure of program matter- each of these states have different PC problems and address it differently through their program
- But PMPM within a PCMH model is being used widely by many states and gaining momentum

- Two other models that use PMPM coordination payments are Health Homes and ACOs
- Health Homes, which as mentioned target complex patients, have care coordination payments that vary by state; Missouri's approach uses a PMPM management fee, which has shown to improve cost and outcome results in Missouri
- Two major ACO programs are the Medicare Shared Savings and the now inactive Pioneer ACO model. While ACOs are continuing to see shared savings and improved outcomes, not all ACOs, as well as CMS, are seeing this translate into reduced costs; but more time will tell as ACOs take on two-sided risk models
- Iora Health is a network of primary care practices that uses fixed and risk-adjusted PMPM amounts and quality targets; their internal reports suggest that their model to lower costs and improves some health outcomes
- Michigan uses a fee-for-value program with some reduced spending and quality improvement outcomes

Kelly Anderson, John Hopkins University

- Looking through the evidence of these programs, there is emphasis on getting the right measures. There are well over 100 measures; many metrics come from ARHQ and NQF.
- We saw a variety of different accountability mechanisms.
- CPT codes were commonly used. While this provides documentation there is no deeper understanding of what the activity entails.
- EHRs have a greater ability to capture information, but challenges exist between different EHR systems and with the timely exchange of data.
- Within EHRs there is opportunity to measure process, quality, and costs.
- Care coordination pmpm payments in combination with a model of delivery reform can reduce spending and improve patient outcomes
- Adoption of care coordination pmpm payments is not sufficient to improve care delivery

Dr. Fan

- When you say pmpm payments were not done alone, is that because the upfront component was baked into the payment model or because they created the payment model and decided they needed the upfront investment after the fact?

Kelly Anderson, John Hopkins University

- Not sure. They were adopted simultaneously.

Dr. Fan

- Did the pmpm stay the same or increase over time?

Kelly Anderson, John Hopkins University

- These were shorter evaluations, we did not seeing changes over time.

Steve Cozzo, AmeriHealth Caritas

- The timing of adoption depends on state circumstances.
- North Carolina looked at pmpm piece first and now are rolling that into managed care. Other states have gone the other direction.

Steven Costantino, Department of Health and Social Services

- I am familiar with the Iora model, revolutionary in terms of PCMH. The care management is engrained in the delivery system; it is not isolated care management.
- Did you look at the types of contracts they had? Was it just a care management fee? Or was the care management actually engrained in the pmpm for the entire population?

Kelly Anderson, John Hopkins University

- Not sure off the top of my head, but we can check.

Jessica Hale, John Hopkins University

- The studies were pretty surface level. We didn't dig into the contracts.

Tom Fitzpatrick, Highmark

- In any of those models, did they have ranges of pmpm?
- Did anyone take the risk-adjusted pmpm approach and pay more for sicker individuals? Are these representative of averages? Or are these flat pmpms paid across the entire attributed population?

Jessica Hale, John Hopkins University

- The model in New York used a risk adjusted pmpm.
- Same with some of the ACOs risk adjusted pmpm amounts.

Tom Fitzpatrick, Highmark

- By line of business, did Medicaid have a different pmpm rates compared to MA or commercial?

Kelly Anderson, John Hopkins University

- Most of the studies were looking at programs within a single payer type.

Dr. Art Jones, HMA

- In Illinois, although with Medicaid, they had different pmpm based on eligibility category – $2 children, $3 TANF adults, and $4 disabled.

Tom Fitzpatrick, Highmark

- Did you see any ranging up to $20 - $30?

Jessica Hale, John Hopkins University

- Nothing that high within the subset of research I pulled from, but there has been talk about that in more recent literature.
- Some of the established quality and cost outcomes were based off studies with the smaller pmpm amounts.

Dr. Fan

- Is it the case that no studies demonstrate that a high pmpm can be successful or we just didn't look at those particular studies?

Jessica Hale, John Hopkins University

- These were just the studies that were most well established. These are the go-to studies for this literature.

Sen. Townsend

- The pmpm would adjust for the overall payment method; those example states don't have the level of crisis and dramatically low reimbursement as Delaware.
- In other states, they might achieve savings with a lower pmpm.
- Here we have to make sure the resources are there for providers to be successful.

Tom Fitzpatrick, Highmark

- Do we know what the underlying fee schedules in other states are as a percentage of Medicare?

Dr. Art Jones, HMA

- If you go to New York and you look at their health homes program, they have a pmpm of $100 for certain populations within their risk stratification.
- For Medicare there were six RCT studies that looked a complex Medicare patients. The pmpms were significant, but that inhibited the ROI even for those seeing significant reductions in ED and hospital use. They all had strictly RN care team models, but they needed to build a less expensive model to get an ROI.

Sen. Townsend

- I am happy to find the data on reimbursement compared to Medicare levels, but I am unaware of other states that have such low reimbursement as Delaware.
- Is a smaller pmpm suitable for larger groups because of their economies of scale?

Dr. Mike Bradley, MSD/MEDnet

- Delaware is unique; we are 10 years behind other states like California.
- I think the pmpm payment needs to be fit into the fee schedule. The pmpm is only one little piece of it. The pmpm may be high/low depending on where the rest of the money is coming from regardless of the specific model.

- We have a lots of small practices that don't have a full EMR. We need to do a lot of groundwork in order to ready these practices.
- Don't make a decision regarding the pmpm or model too early.

Dr. Fan

- We need to make a holistic consideration. There a couple of points I thought of seeing these examples:
- What was their workforce projected to be?
- What was the motivation to become early adopters of the pmpm?
- I know New Jersey was not facing a primary care crisis. So were they doing it because they were looking ahead to improve outcomes and cost or were they looking at to sustain primary care?
- We should understand the motivating factor of each state.

Dr. Art Jones, HMA

- Last time we talked about how the state said there was a floor for rates. We decided that we will be moving to APMs. We are focused on the care management fee and next meeting we will consider the payment models including TCOC.

Dr. Jason Hann-Deschaine, MSD

- I am a primary care pediatrician.
- We had a single practitioner who merged his practice into ours because he couldn't find a way forward on his own. He committed a lot of time and money into PCMH certification. He became PCMH certified, but when Blue Cross stopped the ACO program he lost 5% of his revenue. Then he lost another 25% when they stopped their PCMH program.
- The value of certification form Aetna was a couple hundred dollars per quarter.
- United, Cigna, and Medicaid paid nothing to be PCMH certified.
- Overall, he sustained a 30% paycut.
- This is a practitioner in solo practice who transformed and essentially had to close down.
- Regarding my practice. We were involved in CCPP quality program through Christiana. They stopped and switched to Aetna as their administrator – which pays below Medicare rates. The state also move over to an Aetna program. We also sustained cuts with the loss of the BCBS ACO and PCMH programs.
- We were already trying to go through a PCMH process and using care management. We did not decide if we were going to become officially certified. We continued with the Highmark Quality Blue program. We see that our practice was the highest performing pediatric providers, but we actually are losing money in that program compared to the previous program. The incentive payment is weighted toward improvement in cost and utilization. We lost on injectable PAD and inpatient costs
- It is discouraging to be scoring high in quality, but be on the verge of financial instability. We are looking at our payments coming in on Wednesday and need to assess if we can pay payroll the next day.

- We are taking on risk just to take on just to stay in practice.
- Debbie Zerak and her husband are sharing as salary trying to pay for providers and a nutritionist.
- I am happy to see SB227 passed and this group convened.
- Currently we have seen low pmpms. We get $1.97 on average. They cap the members within each risk strata. Only 5% of patients can be high risk, 15%-30% are medium risk, and the rest are low risk. The pmpm is $16 high risk, $2 medium risk, and $1 for low risk.
- I had a patient with a seizure disorder and additional health problems considered a low risk patient. If that is a low risk patient, then I am getting a $1 per month.
- We are seeing high risk patients, but they are categorized as low risk.
- The other part, we are all talking about taking next steps, but if you look at Aetna, the 2019 fee schedule is 10% lower than last year. They were paying 38% to 85% of Medicare previously, and 30% to 75% currently.
- This is important because they are administering a lot of self-funded plans. Bayhealth, Christiana, Nemours, and the state employees all get coverage through Aetna, in addition to lots of the company plans, but these plans are not paying Medicare rates.
- I would encourage everyone to use their influence to ensure your institutions demonstrate minimal dedication to stabilizing primary care by ensuring your plans pay 100% of Medicare rates.

Dr. Fan

- I appreciate all your comments. What I take away from your experience is if we are going to talk about a delivery model system that has an upfront payment, it cannot be tied to cost or utilization for something you cannot control. And there are services to provide to reach top quality that should be included as part of a quality pmpm.

Dr. Jason Hann-Deschaine, MSD

- Services like: lactation, nutrition, obesity, and after-hours care

Chris Morris, Aetna

- We don’t change fee schedule on an annual basis. Payments are based on attributed members.

Tom Fitzpatrick, Highmark

- I appreciate the comments, I would say that Highmark has come into full compliance with SB 227.
- We have changed the program and we change care coordination fees in accordance with how established by CMS.
- Do risk adjustment twice per year through a third party called Fair Risk to establish the risk scores. We pay a pmpm based on risk.

- We do pay for a number of the services you mentioned. We have made a strong push for extended hours on nights and weekends and we pay an extra fee for those services.
- The problem is that we have a cost issue. We have a high-quality network, but people aren't willing to pay just for quality. We have had quality programs for years, but the customers in Delaware and everywhere want to understand the ROI for the programs. We have to have a cost metric, not dissimilar to what CMS has. If there is not a reduction in overall cost of care, then we cannot share that savings back with the PCPs.
- We are happy to continue to work with you and the practice. We will look at how members are stratified. We have different rates for the three different risk levels, and we have different levels for commercial and Medicaid business.
- We did move away from PCMH certification and accreditation because our customers didn't want to pay for it. They want to know how much this program is actually savings.

Sen. Townsend

- In regard to SB 227, we specifically structured January 1, 2019 as the date that would be initiated so there was plenty of time for plans to prepare for implementation. DOI is here today. What are the explanations?

Dr. Art Jones, HMA (Care coordination/care management financial modelling tool distributed)

- Let's define care coordination and care management. We need to move towards a consensus to determine what care management should be. I don't think we can come up with a dollar value here. Our goal is not to come up with a fee, but come up with a process that is fair to set the fee.
- CMS has established 6 core services for its Health Home program – listed in blue.
- CMS does not define the tasks that go under each core service, but I filled in some potential tasks. The issue today is not if we have the list of tasks exactly right, but how the tool can be used to negotiate a reasonable care coordination/management fee from both a cost of delivering the service and a ROI on total cost of care perspective. Anything cell in red can be modified to fit a particular circumstance.
- The idea is that as you negotiate between the provider and plan what is the provider getting paid for?
- I think the tasks will vary by practices and their readiness. First what are the items that any provider does, then what are the tasks that a PCMH does, and what are the care management tasks that go beyond coordination and require a licensed worker.
- This is a tool that helps estimate the costs for providing care coordination services. Providers and payers can determine what is the appropriate formulation of tasks and responsibility for the patient population that will be effective and generate an ROI. What is best done at the provider level and what is best done at the payer level?
- Is there a glide path of increasing responsibility for providers? We cannot afford to have the provider and plan to duplicate services.

- Note that this document is not intended to be accurate in the dollar values or specific tasks, but to provide an approach that providers and payers can work together on. With this tool they can all agree on what is the payer paying for at $1 pmpm vs $16 pmpm.

Tom Fitzpatrick, Highmark

- The way we have structured this – whether $1, $2.50, or $16 pmpm – is all based on the activity or the level of engagement that the practice has with our member.
- We are making the assumption that a dollar for a person that is having one or two interactions.
- A high-risk member has many more interactions, so they get a higher pmpm. These are all upfront payments; we never thought that these pay the full amount for care coordination.
- The hope is that all the care coordination will benefit the patient and practice and that the value shows up in the lump sum payments.
- The entire value-based reimbursement is made up of these different parts. This in whole is the payment transformation. The savings from the system will repatriated back to those who are responsible for coordinating the care.

Dr. Fan

- Art has structured what is a care coordination task.
- Health care payment nationally is moving away from FFS. A provider must provide a basic level of care coordination even for the lowest risk patients.
- If you lower that FFS reimbursement and you risk stratify the care coordination pmpm, it will not cover the cost of your original capital investment. You are still providing those services because you still need all these personnel and resources.
- How do we make that transition a lot smoother so they don't just give up practice all together or move to a smaller patient panel under a concierge medicine model?
- We want to talk about these items as the basic minimum of the care coordination.
- The first part of implementing SB227 has not been smooth. We want to make sure that implementation of part two is successful.

Kevin O'Hara, Highmark

- We believe that Highmark is completely compliant with SB 227. If anyone has any issue with that they can come to me directly.

Tom Fitzpatrick, Highmark

- If there is anyone in that room that feels Highmark is not in compliance. We worked on it over the holidays to ensure it was implemented 1/1/2019.
- There is a lot here, in this document. This is a great document to open up the conversation. There are some items here that we need to discuss what needs to be in the plan or provider side.

- This is why we continue to evolve our programs from imbedded care coordinators to virtual models. There is some stuff here like promotion of health education and wellness that we would like to say is part of the plans' role. We just rolled out the Share Care initiative.
- Just seeing this the first time this is a great start. This can serve as the basis to guide the conversation. We should be able to narrow the list to what the provider is expected to do and we should pay for them.

Steven Costantino, Department of Health and Social Services

- As I look at this menu of care management, it would be interesting to know what is at provider level, ACO level, and plan level. It is a pretty comprehensive and intensive list, and there should probably be some mix and matching based on your delivery model.

Dr. Fan

- I want to make sure that the list will be ok applied to every delivery model. It does not have to live within a PCMH or ACO.

Steven Costantino, Department of Health and Social Services

- I want to make a correction. It has been said that Medicaid does not pay for care management. 85% of enrollees are in managed care administered by two plans. Those plans cover care management. It is the 15% of Medicaid beneficiaries still in FFS that do not cover care management.

Dr. Art Jones, HMA

- There will be variation with provider readiness to assume these responsibilities.
- Can we come to consensus in taking this general approach between provider and payer from a cost perspective and ROI perspective?

Dr. Fan

- Anything on this list that should always be on there regardless how much you are paid?

Tom Fitzpatrick, Highmark

- There may be activities that may not be strictly payer/primary care physician related. There are tasks that are part of the medical home – for discharges to post-acute or ED visits.
- There are some things here are not only bidirectional, but that involve the entire care continuum.

Dr. Fan

- So for example for a post-ED visit contact, you would not consider that as part of care management?

Tom Fitzpatrick, Highmark

- I would envision that to be a contact between the primary care practice and the hospital.

Jamie Clark, Nemours

- This is a huge component of what we do as care coordination. We have employees who call patients who go to the ED to convince them to seek care elsewhere.
- We have the DHIN and get the ED data every day.

Dr. Jason Hann-Deschaine, MSD

- We review every ED visit and contact that family and educate them on averting ED utilization.

Dr. Fan

- To clarify, Nemours – although you are a hospital system, what you are referring to is part of the outpatient clinic, right?

Jamie Clark, Nemours

- Yes, this is a task from the primary care side.

Tom Fitzpatrick, Highmark

- I'm not arguing that it is not a part of care coordination. The end result of that is going to be resulting in the cost savings that the practice will get in reducing the cost of care by reducing ED use and readmissions.
- You cannot double pay for those coordination activities.

Dr. John Fink, Bayhealth

- Most of these things on this list are just things we consider good care. If you are fortunate enough to work for a system, the system subsidizes these services. In smaller practices, they might have to cut good care because their revenue has come down.

Dr. Art Jones, HMA

- The pmpm is a cost factor that goes into calculating the savings savings. So if there is a savings, the cost of the pmpm has already been accounted for.

Chris Morris, Aetna

- Is the goal to get to a shared savings with risk associated with it?

Dr. Art Jones, HMA

- Spending money and hoping that there will be shared savings more than a year in the future will not be adequate. The idea is to have up front fees.
- We also have some providers, like Christiana, who want to take on downside risk.

- When you look at the tasks you need to know who is taking downside risk.
- What readiness for people to take on a task and what is their readiness to take on the downside risk?
- We are not looking at one model. There we are looking at a continuum.

Chris Morris, Aetna

- I heard that these will be input into any PCP model.

Dr. Fan

- We want consensus on the tasks that can be used in every delivery model. Across the board providers will know they can get $x if they offer these services.
- The provider community will want to offer these
- With a decrease in the base fee for service, we want everyone to become stable so they can take additional risk that will develop shared savings.
- It doesn't matter what delivery model you are in, a care coordination fee can improve costs and outcomes. The care coordination fee cannot do it alone.
- We all agree that there are different delivery models.
- We need solutions. We need a very short-term answer – meeting 100% of Medicare
- We need a short-term answer for the next year or two – to help practices ramp up so they can be prepared for true risk.
- There is no one size fits all, but we want consensus on what is care coordination.

Tom Fitzpatrick, Highmark

- One response on you comment that decreasing FFS and increasing care coordination, and that is not the case with Highmark. We have increased the FFS and kept the care coordination fees.
- We are not that far off from the models in the presentation.
- I know we don't want to talk about the rate. I am struggling what to understand how we will figure out the range. I have heard $30 in previous Collaborative meetings, to the presentation where we will discuss the models

Sen. Townsend

- We are starting from a lower FFS base.
- Your comment raises a good point - definitions are really important.

Kevin O'Hara, Highmark

- Did we get someone to validate the idea that we are starting from a lower base?

Karyn Scout, AmeriHealth Caritas

- We do all the items on this list within the plan. We are working with providers to work out how that care coordination is going to work. We are in our infancy as an MCO here in Delaware. How do we ensure we do not duplicate?

Dr. Art Jones, HMA

- Are you committed to paying a care coordination fee?

Karyn Scout, AmeriHealth Caritas

- We have least data, being in year 1. We are looking with our providers how we can pay care coordination fees.

Dr. Art Jones, HMA

- Do you have a target timeframe?
- We have a real financial crisis and there is an urgency to this.

Karyn Scout, AmeriHealth Caritas

- We don't have a timeframe. We are looking at contract discussions in July with a bigger health system.

Dr. Fan

- The Medicaid contract has VBP targets on a timeline over three years, right?

Steve Groff, Medicaid Director

- Yes. To get to those VBP targets, working with the larger health systems is the quickest way to make gains.
- Related to the infancy of a new plan and mining that data, they still have work to do.

Dr. Fan

- 2018 was your first year and by 2020 you need to offer VBP?

Dr. Art Jones, HMA

- What is expected immediately?

Steve Groff, Medicaid Director

- There are VBP targets in 2018, 2019, and 2020. There is a percentage of overall spend that must be in any VBP and an increasing share of that must be within a TCOC model, rather than in pay for performance/bonus type arrangements.
- Other measures, like HEDIS, kick in later. We need the extra time for the lookback to get the data.

Dr. Art Jones

- Are there care management fee expectations in Medicaid?

Steve Groff, Medicaid Director

- I would have to go back and look. There was an expectation several years ago. Care coordination was built into the MCO rate and it was passed along to providers. We got away from that because we believed that that was already becoming engrained in the delivery system and it was no longer necessary to have a direct to care coordination fee.

Dr. Art Jones

- Is Medicaid willing to go take and take a look at this issue?

Steve Groff, Medicaid Director

- I would never rule out, but it was my expectation that this was already going on. I don't think it's necessary for Medicaid to mandate it, but if we discussed that it is not being reimbursed then we can look at it.

Steven Costantino, Department of Health and Social Services

- Medicaid is paying two MCOs. Highmark is paying a care management fee. AmeriHealth is in its infancy, but I would expect that they will be doing the same thing.
- Ultimately the state ends up paying for this. I don't want anyone to assume that the plans are not paying the fee even if Medicaid hasn't stated they must.

Dr. Christine Donohue-Henry, Christiana Care

- Our intention is to go TCOC model. I appreciate the specificity in this document, Art. It has helped us dig in on a deeper level.

Dr. Art Jones, HMA

- Back to the homework questions: an important part of this is access to timely and accurate data. Providers need accurate panels and hospital utilization data. Where are we from a data perspective?

Tom Fitzpatrick, Highmark

- We believe that we have a very robust set of provider reports. We believe we are very prepared.
- As an insurance company we have to set expectations because timely is a relative term, we operate in claims, so it is not point of service data we can share.
- We would offer up a series of workshops for practices to better understand the report and their active participation to improve those reports.
- We have provider contracts, we cannot necessarily share reimbursement allowable rates. There are some restrictions to the data we do share. The reporting and advance analytics we provide have enabled lots of providers to manage their patient populations well.

Dr. Art Jones, HMA

- Does that include Medicaid population as well? Because we heard otherwise even from your own plan this fall that there was a problem with reporting on the panels in Medicaid.

Tom Fitzpatrick, Highmark

- The offer to work with providers applies across all lines of business.
- We had problems with panel reporting in 2018. It was difficult getting our data out through the portal and readily available. Those problems are fixed, but we are prepared to move forward in 2019.

Chris Morris, Aetna

- We provide robust data reporting. The frequency and data varies by model.
- We have over 60% of reimbursement is in a VBP arrangement.
- We have care coordination fees in all VBP models. The member attribution level impacts of these pmpms.
- We are feeding information to an ACO almost daily.

Dr. Fan

- Where does DHIN fit in? They are building a claims database.
- Is it a pathway for more robust CCDs?

Tom Fitzpatrick, Highmark

- We would take the providers advice around that. Highmark has participated in DHIN from the beginning. We are probably not as good at monitoring how productive the DHIN is in data sharing, but we have focused on developing our own set of reporting and analytics.
- If the providers believe that DHIN is the right place to get data, then we will put the resources to DHIN.

Dr. Jason Hann-Deschaine, MSD

- Highmark has a very good PI tool, as a provider you can go into and drill down and get down to the patient level.
- There are still a lot of data issues with Highmark. In the quality program there has been a problem where Health Options cannot connect their data with Blue Cross.
- We have seen no quality data from Health Options. They are having trouble with their systems.
- We do have monthly meetings with our Blue Cross quality representative and she does a great job with us. She works with us and can provide us with useful, custom data.
- All the data is very fragmented. We do not get reliable reports through local hospitals.
- We still cannot see pdfs from DHIN, a problem for several months. The data is inconsistent.
- I am not convinced that the DHIN infrastructure is sufficient for us to integrate and move forward in the quality plans. We spend a lot of time trying to fix the data.
- The states vaccine record is not accurate, and the state is asking us to use our time to go in and fix this.

Kevin O'Hara, Highmark

- The issue of data between plans is universal. Providers not accessing claims from another payer anywhere.
- On the Health Options side, the reporting issue in 2018 has been solved for and we are staring to pushout the reports for 2019 It should look and feel like the data on the commercial side.

Dr. Fan

- Nationally, has there been a solution to the sharing of data as patients move between payers?

Kevin O'Hara, Highmark

- As patients move payer to payer I don't see a universal solution for data collection. We need to start thinking about EMRs and other data schemes.
- If the vaccine record is incomplete, then I don't have that data and I will be asking the provider if that data exists for the provider to get credit.

Dr. Fan

- They just have to reinput it the data.

Tom Fitzpatrick, Highmark

- To answer your question, Pennsylvania and West Virginia do not have anything like the DHIN. We set out in Pennsylvania to try to get a unified clinical connection among all the payers and providers and that did not work.
- To answer your question, that has not been solved anywhere in Highmark's footprint and as far as we know anywhere in the country.

Sen. Townsend

- This is not a trivial issue and a tremendous challenge that should be solved.

Tom Fitzpatrick, Highmark

- Yes, we take data very seriously. We worked as quickly as we could to solve the data issues in DHOP. It should be an aspirational goal of this workgroup.

Dr. Art Jones, HMA

- At what point is there some oversight and accountability, to make sure that there are these negotiations far as care coordination that is based on these criteria?

Dr. Fan

- Is your question who is the oversight body for implementation of any of this?
- We have DOI here – would Vince like to comment?

Tom Fitzpatrick, Highmark

- We have that mechanism today, we negotiate on an entity by entity basis and it has worked well to a certain extent.
- We are happy to engage on the conversation here. If the problem is that our pmpms are not working, then we will engage in those conversations. The pmpm has to be in the context of one of these VBPs that has a shared savings complement.

Vince Ryan, DOI

- As I have discussed with the bill sponsors and MSD, the commissioner is very supportive of the efforts of this group. With respect to administering whatever program and whatever oversight it would entail, if the DOI would be chosen to the body – and the DOI does think we are – we are not staffed with the appropriate people to do the work with the payers and providers. When we decide what these efforts will look like, we hope that there would be some discussion of what additions to the department need to be effective.

Dr. Fan

- Would people feel more comfortable with a sub-division of the DOI, or would it be in the general purpose to implement and enforce pc payment and sustainability
- There has to be some alignment with the benchmarking process.
- Do we feel like the DOI is willing to assume but don't have the bandwidth to do it and do we want someone specifically involved? Or do we want a specific other regulatory body?

Dr. Art Jones, HMA

- Maybe we would put that on the homework

Tom Fitzpatrick, Highmark

- There is not a regulated body in Pennsylvania or West Virginia. We operate independently with all of our provider networks. Everything is a negotiation. We comply with laws and regulations in each state. We do not have a body like that in the other states that regulates our pay for value programs.

Steven Costantino, Department of Health and Social Services

- I don't know that that means if we are simply asking who will regulate care management.
- As someone involved with writing the Rhode Island regulation, it would be good to have a reporting mechanism to know what the spend is on primary care. I don't see that as a very difficult thing for the DOI actuaries to figure out. It has been very hard to figure out how much we spend on primary care; we have heard numbers from 3% to 8%.
- We need to consider if we want to go the regulation route on primary care spending, but no state actually regulates the care coordination part. We are not just talking about the care management aspect.

Dr. Art Jones

- Charlie has been doing some research on the definition of primary care spend.
- The benchmark report came out recently, it is their goal to collect that data, but do not have specifics.

Dr. Charlie Jose, Graham Center

- The Graham Center is working on defining primary care right now as the portion of total health spending. There are different definitions available. There was a recent Milbank Memorial Fund illustrating the different ways to calculate primary care spending.
    - Providers (which for example could include ob/gyn or not), types of services, or where the service is provided.
- We are preforming a state-by-state analysis using the MEPS data. This is the most complete source of data on the cost and use of health insurance because it covers 38 states.
- Our deadline is in April and we want to see how states are spending on primary care.
- To put forth recommendations for what a national requirement for primary care spending should be.

Dr. Fan

- Milbank looked at methodology, are you recommending a methodology?

Dr. Charlie Jose, Graham Center

- Happy to pass it along if my supervisors are ok with that.

Dr. Fan

- Within each payer group, do you define primary care spend? This group may not decide on a definition, but we would like to understand how you are thinking about it.
- The suggestion of getting primary care spend reporting is a good idea.

Dr. John Fink, Bayhealth

- Are we looking at spend on primary care outside of patient care – for instance tuition reimbursement?
- Supporting primary care also comes from dollars that doesn't have anything to do with that patient.

Dr. Art Jones, HMA

- We will be discussing increasing primary care spending through advanced (LAN category 3 and 4) APMs next time, and the last meeting we will need to invest in those other items.
- We need to look both short-term and long-term solutions, including recruitment and retention.

Dr. Fan

- Rhode Island allows for a certain share of primary care investment to go to technology or other capital improvements, but they already have a benchmark for spending.

Tom Fitzpatrick, Highmark

- We have a simple method to calculate primary care spending. We look at it as all the providers coded as primary care physicians to identify primary care spending.

Dr. Fan

- If there are certain services or providers that you include or exclude we need to know.

Dr. Mike Bradley, MSD/MEDnet

- Wanted to give you an update on MEDnet. I have been in Delaware for 36 years.
- Physicians are leaving practice due to retirement, entering concierge, or being bought up by health systems.
- With my 6 other partners, our practice has 3 PAs and 20 supporting staff including LPNs. We provide the entire list of care that you have seen there.
- In the 1990s the Medical Society of Delaware formed MEDnet. This is an organization of four different individually-owned physician organizations – one in each of the hospital groups. We are a fully integrated, multispecialty, physician-owned organization.
- Initially we supported individual practice physicians and small groups. We still have over 800 members.
- When the state went to managed care in Medicaid, we became the network for Medicaid. We continued to work with Medicaid; we signed with AmeriHealth.
- 6 to 8 years ago Blue Cross of Delaware came to us to form an ACO. A year or two later Highmark bought Blue Cross of Delaware.
- We were on the verge of providing a full service ACO. Blue Cross was going to integrate our computer systems into one network. We were learning and taking our baby steps.
- With the sale of Blue Cross Delaware to Highmark we came away with no health IT update and we had a 30% increase in E&M coding.
- My practice was the first PCMH level 3 in Delaware. We are now on our 4th re-up of the certification. Blue Cross gave us an extra 25% for being a PCMH. When the plan closed out we had a 30% drop in reimbursement overnight. In their new payment model for 2017, they gathered the data, and in July 2018 we got half our money back due to cost overruns in radiology, pharmacy, and inpatient spending.
- Two years ago, we found a partner, Health EC, a nationally known population management group. We signed our first contract with AmeriHealth.
- We spent money to incentivize our physicians to use the same EHR. We will have live patient information. If patient switched insurance companies, we will know all the information. We don't have to go to the DHIN. We are not competing to drive the DHIN out of existence.
- Physicians in Delaware are ready to move forward. We saw this 10 years ago, but progress was stalled.

- We want the physicians to be in control of one set of quality data metrics. We shouldn't have different sets of quality metrics for different payers.
- We went from 1200 physicians in MEDnet to 800 within the last 5 years.
- We are in a death spiral in the state of Delaware. We need to put money and effort into making the system better.

Dr. Fan

- Any public comment?

Wayne Smith, DHA

- I object to having government decide what primary care should look like and what the reimbursement should be. I think it is contrary to the larger goal of the state's benchmark and TCOC goal. TCOC sets a goal and forces the providers to take more and more risk. They have to come up with a system that makes the most sense. When you start to have pieces of that regulated, you reduce the flexibility of providers to adapt and achieve total cost of care.
- We have concerns in assuming that a legislative or regulatory approach is appropriate for this.

Sen. Townsend

- Government has not been that involved even though government has a critical role evidenced by how much government spends.
- Need the ongoing dialogue with all the stakeholders. Government's role can be bumpers, while providing plenty of room for competition and innovation. We agree that there needs to be significant changes in the health care system right now.

Dr. Art Jones, HMA

- We do have students here, so they will be providing some research at the following meetings.
- At the next meeting we will be looking at APMs categories 3 and 4.
- Providers should be ready to discuss what they are looking for? What are the barriers to you moving forward on category 3 or 4 APMS?
- Payers should be ready to discuss what is your strategic plan to move to advanced models in the delivery system?
- If you have a topic for the group to consider, we will have JHU look at thing like tuition reimbursement etc. to strengthen the primary care system.
- Anything else you would like to them to research, send them along.

Dr. Fan

- Will also send the homework assignments down.
- Please sign-in - that is how we will pushout all the information.
- Appreciate the Medical Society opening up for us on the holiday.

Meeting was adjourned at 8:00 p.m.