SB 227 Primary Care Collaborative Meeting

Wednesday, October 10th, 2018
4:00 pm
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:**
Andrew Wilson	Medical Society of Delaware/Morris James
Dan Elliott	CCHS/eBright ACO
Susan Conaty-Buck	Delaware Coalition of Nurse Practitioners
Jean Glossa	HMA
Art Jones	HMA
Wayne Smith	Delaware Hospital Association
Andrew Dahlke	Medical Society of Delaware
Katherine Impellizzeri	Aetna
Heather Tally	Aetna
Kara Walker	DHSS
Caleb Pinder	Student
John Pinder	Student
Jeff Pinder	Parent of Students
Pam Price	Highmark
Leighann Hinkle	Department of Human Resources
Suzanne L.	Highmark
Kathy Collison	Division of Public Health, DHSS

The meeting was brought to order at 4:04 pm.

Dr. Fan, Sen. Townsend, and Rep. Bentz introduced the guest presenters: Marie Ganim, Health Insurance Commissioner in Rhode Island, and Mark Schaefer, Director of Healthcare Innovation in Connecticut.

Marie Ganim, Health Insurance Commissioner, Rhode Island

- In Rhode Island, health insurance wasn't getting enough attention in the Department of Insurance. Some disruptions in the health insurer market, including insurers leaving the state and harmful business practices spurred the state to action.
- In 2004, the state legislature created the Office of the Health Insurance Commissioner (OHIC) with unique oversight over the health insurance market.
- The OHIC is responsible for:
    - Guarding the solvency of insurers
    - Protecting consumers
    - Encouraging fair treatment of providers
    - Encouraging policies that improve the quality and efficiency of health care service delivery and outcomes
- The responsibility to review and approve rates gives the OHIC broad authority to impact the actions of payers.
- The OHIC has three affordability standards, developed through a transparent and open process with a variety of stakeholders.
    - Care transformation
    - Payment reform
    - Cost growth containment
- In 2008, OHIC began to hold insurers accountable for activities – aligned across payers and identified as community priorities – that will impact the medical cost trend.
- The Health Insurance Advisory Council includes providers, businesses, and consumers, but no insurers. This decision-making body advised OHIC to focus on primary care transformation through four priorities:
    1) Expand and improve primary care infrastructure while aligning the insurers so they are working in the same way.
    2) Promote adoption of PCMHs. Some payers had already been engaged in this, now all insurers are involved in moving primary care into PCMHs. This model provides extended access and hours, care coordination, and additional services.
    3) Promote the adoption of EHRs by physicians. Many independent practices do not have EHR systems, which makes it difficult to hold physicians accountable for care, monitor patient utilization, and track care quality.
    4) Implement comprehensive payment reform. The state has tried to embark on a capitated model accounting for patient risk, but the insurers say their systems are not ready to assess the risk and assign patients to practices.

- Beginning in 2010, using regulatory authority, OHIC required each insurer to:
    - Increase their total commercial medical payments to primary care by 1% per year above their 2008 baseline. This was based on the evidence from other countries that spending more on primary care is associated with better health outcomes.
    - Support the expansion of all-payer PCMH. Investments in the all-payer PCMH counted toward the annual spending target for payers. Anti-trust law prevents payers and providers from strategizing together unless facilitated by the state, and the state is still convening these meetings.
    - Invest in the adoption of EHRs by primary care physicians and support the development of the state's Health Information Exchange. These investments also count toward the primary care spending investment.
    - Engage in discussions on comprehensive payment reform and follow the regulatory cap on annual hospital fees for commercial insurance. This regulatory cap started at capping annual increases at CPI-U+2%, then went down to a CPI-U+1% growth cap. This cap applies to fully insured plans, but because these insurers are also administrators for self-funded plans, the cap applies to self-funded plans as well.
- Between 2008 and 2017, primary care spending has increased from 5.7% to 11.5% of total commercial plan medical spending.
    - Each insurer needs to submit a plan of correction if they are unable to meet the annual goal for primary care spending.
    - Insurers propose investments and the OHIC will approve their plans.
    - One insurer invested in community health teams who work to address social determinants of health. The community health teams are staffed by community health workers. The primary care practices linked with these community health teams have a positive view of this investment and appreciate the patient follow-up engagement and service coordination.
    - Another insurer created a pay for performance fund.
    - Overall insurers see the value of these investments. BCBS saw a 2.5 return on their investment in PCMHs.
    - There has been a small increase in the fee-for-service reimbursement for primary care, but most of the investments have been in practice transformation and infrastructure.
- The current Affordability Standards include:
    - Primary care spending must be at least 10.7% of total medical spending.
    - Insurers must have a specified share of primary care physicians in PCMHs, increasing annually.
    - At least 50% of medical payments should be under an alternative payment model, with a minimum downside risk for providers.
    - Hospital rate increase are capped at CPI-U+1%.
    - ACO total cost of care budget increases are capped at CPI-U+1.5%.

- The primary care spending requirement has resulted in care transformation and payment reform:
    - Over 50% of primary care physicians are practicing in a PCMH
    - Primary care investments have helped the development of ACOs, and we have seen that ACOs like working with PCMHs.
    - PCMHs are also using the investment to incorporate new models of care including behavioral health.
    - Primary care practices are more confident in their ability to adopt alternative payment models.
    - More than 50% of primary care physicians are contracted with ACOs under a total cost of care model.
- The previous health insurance commissioner started a public conversation, engaging a wide range of stakeholders across the state. The dialogue was based on evidence demonstrating that primary care investment pays off and used examples across the country to demonstrate options for improving primary care.
- In January, a Health Affairs article will highlight the experience of Rhode Island and the impact of these policy changes in aggregate.
- We have heard from physicians that their practice is more rewarding, even though their income or practice revenue has not increased substantially.

Dr. Fan

- Who are the ACO participants?
- Is there a mandated PMPM requirement?

Marie Ganim

- ACOs most impacted by these state policy changes contract with Medicaid MCOs and commercial payers, though some only contract with Medicaid.
- There is a PMPM recommendation, but it is not mandated by the Health Insurance Commissioner. One of the advisory groups that discusses costs came up with an appropriate PMPM for the practice transformation period and for post-transformation period.

Mark Schaefer, Director of Healthcare Innovation, Connecticut

- Connecticut is a high health care spending state, like most New England states. Medicaid has been better at containing the growth of expenditures due to the rate control resulting from the switch from managed care to fee-for-service and the PCMH investment.
- Connecticut is using their State Innovation Model grant to influence payment and delivery reform as well as some health IT investment.
- Connecticut is about 1.5 years into SIM implementation; the design work began in 2013 soon after MSSP implementation.

    - Commercial payers emulated the MSSP model and ended up coalescing around 15 “Advanced Networks” or primary care based ACOs.
    - More than 85% of primary care providers are affiliated with an ACO.
    - More than a million beneficiaries are attributed to a shared savings model.
    - Commercial payers have worked on quality metric alignment.
- Connecticut has observed limitations of this model. Despite the ACO model and the promise of shared savings, primary care remains largely untransformed and participating practices have seen little or no savings under the MSSP.
- Connecticut has seen ACO investments in closing gaps in care (testing and screening), increased care coordination, and the start of health risk stratification.
- Some of these limitations are because hospital ACOs still mostly use fee-for-service and most physician owned-ACOs don’t have the capital to invest in risk-based models.
- We need to bake-in the investment as part of the new normal and drive improvement in a way that delivers return. Despite our broad participation in MSSP, only one provider earned any shared savings.
- Shared savings was not enough to drive improvements and investments, so the state needed to take additional action.
- Connecticut assessed the research into primary care investment in the U.S. to highlight some possible ways the state could take action.
- The state conducted an analysis on their health expenditures and is working to standardize how researchers define primary care and measure health spending with a consortium of other new England states.
- The state released a report with recommendations for primary care modernization, including goals of:
    - Expanding and diversifying care teams
    - Expanding patient care and support outside of the traditional office visit
    - Double the investment in primary care over five years through more flexible bundled payments
    - Reducing the growth trend in total cost of care
- These goals were built on the foundational assumptions that
    - Participants must be larger groups and systems because small practices don’t have enough resources to make these changes
    - The process must be multi-payer
    - Existing shared savings programs will introduce downside risk
    - Introduce new primary care bundles
- They had a lot of feedback on the report and got positive feedback on the direction of the recommendations.
- Having a stakeholder engagement strategy, the state met with people to gather input on what policies must be included in the transformation plan. Key stakeholders included ACOs, providers, hospitals, payers, and consumer groups.
- A variety of advisory and design groups were engaged throughout the design process.

- The areas of emphasis focus on increasing the ability of primary care to meet patients' needs. These priorities include:
    - Identifying the members of a diverse care team and building these teams through targeted investments.
    - Defining the ways patients should engage with providers including telephone, email, home visits, and telemedicine.
    - Assessing and incorporating technology that provides a return on investment and improves care including patient monitoring, precision medicine, and e-consultation.
    - Integrating and specializing care, for instance integrating behavioral health, connecting patients to social supports, and developing practice specializations to better treat certain patient subpopulations.
- Connecticut is also developing new primary care bundled payments that cover office visits with supplemental bundles that include a PMPM to allow for practices to hire care managers or invest in health information technology.
- The primary care bundle would be a revenue neutral solution to allow practices to resolve issues with patients outside of the office, via telephone or email.
- The bundles would also help reduce the administrative burden of detailed billing.
- For ACOs, the only savings opportunity is to have a lot of sick patients, Connecticut recognizes the need to have solutions that keep people healthy by incorporating evidence-based prevention into primary care.
- Some SIM states are engaged with CMMI in creating a custom demonstration, Connecticut might be able to take advantage of this flexibility which would align Medicare payment approach for MSSP to the state's approach.

Dr. Fan

- These presentations highlight two different approaches and states in two different places in the design and implementation process.

Rep. Bentz

- What were the key components that contributed to the slowdown of health spending growth in Rhode Island? To what extent is it attributed to the primary care spending?

Marie Ganim

- The analysis takes a comprehensive view of the various policy changes. The researchers hesitated to separate out the primary care investment and hospital cap as the specific cause.
- Other researchers have been doing comparisons between those practices participating in the primary care investment and those not. Those practices that have transformed have

lower ED an inpatient care and lower cost. These are not the results of a rigorous research study, but we expect to have that research later.

Rep. Bentz

- Has the hospital rate cap impacted consolidation?

Marie Ganim

- Rhode Island's experience has been no different than that of other states. Smaller community hospitals have struggled, and we are also experiencing market consolidation. We do not think these are not related to the hospital rate cap.
- The cap has been about a 3% increase per year. No one has cited the cap as a problem; they have cited the low Medicaid and Medicare rates as the real problem.

Steven Constantino

- There is a large number of small independent practices in Delaware who do not have capacity to transform. What have you done to address these practices' challenges, for instance sharing services or EHRs.

Mark Schaefer

- It has been a challenge for the ACOs to influence these small practices, not only because they are separate, but also because of the culture at that level.
- We have seen that ACOs develop care management hubs that are assigned to practices and provide support to combined sets of panels of small practices.
- The ACOs are able to digest and analyze data for the small practices.
- It is tough for ACOs to deal with a lot of different EHRs from many different small practices.

Marie Ganim

- We have found that smaller practices want to transform, but they are so busy with patient care that they are unable to spend the time to change. That is where the Collaborative provided facilitators help provide advice and implement changes, provide insight in to what local resources may be shared.
- Some of the most efficient and effective PCMHs are the little practices, but they need help to transform.

Dr. Fan

- Our SIM implemented a practice transformation initiative. Because we could not give SIM funding directly to the practices to assist with transformation, we had four vendors who provided the practice transformation coaching.

- We only had 40% involvement because the practices still found the time to be a burden to adopt the changes and they had extra no resources to make the changes.

Mark Schaefer

- You [in Rhode Island] saw investments in nurse care mangers, EHRs, and pay for performance. What other areas have you seen improvements in?

Marie Ganim

- BCBS is funding pharmacists in the practices and behavioral health integration.

Mark Schaefer

- And you said BCBS experienced a 2.5 return on their investment in primary care?

Marie Ganim

- Their analysis was not made public, this research came up as part of the justification in the rate review process. There is a press release outlining this finding though.

Mark Schaefer

- And Rhode Island's PCMH strategy is to use the NCQA certification?

Marie Ganim

- Yes, we have two options, NCQA and a state-level recognition. We are trying to get all through NCQA to reduce the state's burden, but practices find the NCQA recognition to be a financial and administrative burden.

Mark Schaefer

- Connecticut is considering this burden of recognition for practice transformation. It seems it is more valuable for practices to understand how to make the transformation, but sustaining a formal recognition is not necessarily worth the cost.

Dr. Fan

- Connecticut is undergoing these changes as a part of your SIM model. Is there a stated goal for the total spending on primary care?

Mark Schaefer

- Primary care modernization is our sustainability strategy to be launched on the heels of SIM. We have been hobbled by the slow implementation of the APCD which has prevented access to data.

Art Jones

- One concern with the CPC+ advance payment model is practices' concern that they may have to pay back this funding after the fact, preventing them from using this funding on investment in their practices.

Mark Schaefer

- When we talk to CMS, they made clear that any deal would have to have a significant return on investment commitment and requires that providers accept downside risk. They are heading that way with the MSSP.
- In terms of messaging, we have talked about not putting the primary care investments at risk. Our talking points are that this is a standing commitment, but you need upside and downside risk of 2% to participate.
- With market consolidation like the Aetna-CVS merger, you will have beneficiaries who can access convenient care on every corner. Primary care will continue to change even more in response to the changing market.

Art Jones

- How did Connecticut get commercial payers to agree to a CPC+-like model?

Mark Schaefer

- We have had good payer participation in the shared savings model and a willingness to help design. We expect the few largest payers to come to engage and participate going forward since we have developed good relationships.
- We need to share data that illustrates payers can achieve a return on their investment.
- Engagement with the employer advisory group is an important strategy because payers can hide behind the self-funded plans. Having a separate group for self-funded employers helps to identify their concerns and willingness to engage.
- I have never seen a hybrid option of payments (upfront payments combined with a bundled/capitated model) Are there merits to the hybrid model?

Art Jones

- Not that I can see, you end up chasing opposite incentives when you have FFS and capitation in the system.

Marie Ganim

- We are looking at bundled payments for specialists and primary care capitation. Hopefully they are complimentary.

Dr. Fan

- Is Connecticut considering transitioning from fee-for-service to a capitated model directly?

Mark Schaefer

- We are moving to value-based payments including a population-based PMPM that includes office visit revenue as a bundle.
- The CPC had a reduced fee-for-service rate and a population-based component, which is the worst of both worlds because physicians still had to completely document for the fee-for-service component but didn't have the flexibility to provide care as they see best without sacrificing revenue.

Sen. Townsend

- What prevents Connecticut from adopting the strategies implemented in Rhode Island?

Mark Schaefer

- The two most important changes in Rhode Island are the caps to the hospital and ACO benchmark rates. These strategies are difficult politically in Connecticut where the powerful hospital community would oppose capping hospital rate increases.
- Because our Medicaid is fee-for-service, all the market consolidation has not translated to reimbursement increases, but as a result all unit cost increases are being transfer to the commercial sector.
- Regulating the fully insured market is tough because increasing regulations on fully insured plans drives beneficiaries into the self-insured market.

Marie Ganim

- Our hospital and ACO caps are regulations, not state law. It would be very difficult to pass those policies through the legislature.

Sen. Townsend

- You have the power through regulation. What can Delaware do by regulation?

Vince Ryan

- At the Delaware Department of Insurance, we do not have authority to do something like this.

Sec. Walker

- This regulatory authority doesn't exist in DHSS or DOI. The state could consider making changes to the Medicaid market through MCO arrangements, but not more broadly.

Sen. Townsend

- In the next meeting we are planning to have payers and hospitals
- What characteristics about Rhode Island's approach are unpalatable for the Delaware stakeholders?

Marie Ganim

- Delaware and Rhode Island are among the lowest paying state for primary care physicians. Rhode Island has not seen an increase in the income of primary care physicians despite increasing investment in primary care.

Sen. Townsend

- In Rhode Island, this was an overall system goals in Rhode Island and not about specifically improving provider's income.

Dr. Fan

- Which stakeholders' buy in was most important?

Marie Ganim

- In Rhode Island, statewide outreach was very important. The insurers were active and willing to work with us.

Sen. Townsend

- Regulatory authority helps but facilitating conversation and providing an environment for engagement is essential.
- We have heard from insurers that they are on it and its happening but haven't seen the proof.

Marie Ganim

- This is where Rhode Island is with insurers on implementing capitation. We need to declare an implementation date at a certain point. Do they have the capability or not?

Mark Schaefer

- We spent a lot of time listening to stakeholders' frustrations and we made sure to address these key pain points.
- We talk to consumers about community linkages, social determinants, and convenient care.
- The performance including readmissions and chronic care outcomes are concerns, but not really the focus. This doesn't resonate with physicians. Showing physicians what a bad job they are doing isn't something they respond to. What we talk about instead, is how

hard it is for them to do their job and what it takes to get their work done. Physician burnout needs to be in a measure of success.

- We bring consumers and physicians to talk to legislators and other consumers and physicians.
- With the hospitals, it was a discussion about the potential for disruption in the current climate. There are areas where hospitals need to remain competitive and areas where they don't want to spend more resources like diabetes and chronic conditions.
- It makes no sense to have a capitated payment model within capitated Medicaid MCOs. Medicaid is the biggest self-funded product – so we work directly as a self-funded plan and move providers to global budgets outside of the MCOs.
- Consumers push back against MCO capitated because of excess of prior authority in the late 1990s. Consumers mistrust the constraints that result from managed care and the challenge of a physician's fiduciary interest that is not aligned with consumer care.