Primary Care Reform Collaborative Meeting

Monday, December 21, 2020
5:00-7:00 p.m.
Webex Meeting ID: 173 586 0002, Meeting password: TRdAQ8t3Kt3
Audio/Call-In Number: (408) 418-9388
Access Code: 173 586 0002

Meeting Attendance

Collaborative Members:

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

Absent:	**Organization:**
Dr. Jeffrey Hawtoff	Beebe Healthcare/ Delaware Healthcare Association
John Gooden	MDavis, Inc./DSCC
Mike Gilmartin	MDavis, Inc./DSCC
Margaret Norris-Bent	Westside Family Healthcare

Staff:

Read Scott	Read.Scott@delaware.gov

Attendees:	**Organization:**
Ayanna Harrison	Department of Health and Social Services/DHCC
Bill Howard	BDC – Health
Eunji Elizabeth Staber	Aetna
Elizabeth Lewis	Hamilton Goodman Partners
Dr. Sarah Mullins	Stoney Batter Family Medicine
Elizabeth Staber	Aetna
Tyler Blanchard	Aledade
Mary Jo Condon	Freedman Healthcare
Kim Gomes	Byrd Gomes
Lori Ann Rhodes	Medical Society of Delaware
Lincoln Willis	The Willis Group

Cindy Ward	Mercer
Jill Hutt	Delaware Health Information Network
Dr. Kathleen Willey	Quality Family Physicians PA
Vinayak Sinha	Freedman Healthcare
Lauren Graves	

The meeting was called to order at 5:00 p.m.

Welcome

The meeting convened at approximately 5:06 p.m. via the State of Delaware Webex system https://stateofdelaware.webex.com/stateofdelaware/j.php?MTID=m7302b41fc341d774722a9f8bc0610cfe Dr. Fan welcomed all attendees and reminded them the meeting would be recorded. Members announced their presence as record of attendance. Dr. Fan confirmed that Dr. Susan Conaty-Buck will be serving as proxy for Leslie Verucci, Leslie Ledogar will be serving as proxy for the Insurance Commissioner Navarro. Ms. Ledogar is also representing the Office of Value Based Healthcare Delivery. A quorum was not confirmed. Dr. Fan announced that the approval of the meeting minutes would be postponed until a quorum could be confirmed. Public attendees were asked to submit their name and affiliation to Read Scott via email (Read.Scott@delaware.gov). Attendees were also asked to keep their computers and phones on mute while not making a comment. Dr. Fan briefed members on the meeting agenda and transitioned the meeting to the approval of the October minutes.

Office of Value-based Healthcare Delivery (OVBHCD) Presentation

Dr. Fan invited Mary Jo Condon, Vinayak Sinha, and Leslie Ledogar to share their presentation *Updated Primary Care Investment Model.* Ms. Ledogar reported that OVBHCD has completed the first phase of their important work. They are in the process of publishing the report. She congratulated Freedman Health care and shared that she has enjoyed working with them to complete this excellent work. She assured us that DOI and OVBHCD listened to the concerns that were voiced. The report has been posted on the website and public comments will be accepted at DOI-legal@delaware.gov until January 25, 2021. Ms. Ledogar turned the time over to Ms. Mary Jo Condon.

Mary Jo Condon shared the updated Primary Care Investment Model. She reminded the members that during her last presentation they shared the potential proposed projections for increase in primary care spend. Based on the affordability standard of 1% to 1.5% increase as a percentage of total cost of care each year. CMS recently released their approved fee schedule for Primary Care and all other professions. Ms. Condon reports that updated fee schedules includes one of the most dramatic increases in payments to Primary Care providers. The increase has been estimated at close to 13%. The OVBHCD conducted an analysis incorporating the new fee schedule. She reminded the members of the statute in Senate Bill 227 (SB227) that states commercial carriers must reimburse at least as high as Medicare. This change in Medicare allowed them to update their original model. She points out that the starting point for 2021 of 5%. This is the projection based on that change. They anticipate an increase in their reimbursement able to start a higher rate in 2021. She added that the OVBHCD is aware that 5% is much lower than desired. She reports that they are working with carriers to identify their compliance with SB227 and establish a method for ensuring continued compliance moving forward.

Ms. Condon shared projected annual targets based on the 1% to 1.5% annual increase rate. She reminded the members that the numbers on the slide are only projections. The projections based on an annual increase of 1.5% show that by 2025 the primary care Spend as a percent of total cost of care would reach 11% or approximately $78.00 per member, per month.

Ms. Condon also shared projections for increases in primary care investment as a percentage of total medical expense (TME) and the resulting increase in total cost of care. She pointed out the calculations are about the same from an annual growth rate perspective as where the State has been in the past.

Steven Costantino shared that CMS recently released their national trends report. He shared that the report was not broken down by state. He shared that nationally there was a 4.2% increase in total cost of care and in some areas the percentage was higher. He asked Ms. Condon what base growth rate was used in their analysis. Ms. Condon reports that the base growth rate changes every year. They collected data from the carriers on what they projected to be increases in all different categories is of care including hospital and pharmacy. She added that they are unable to work within pharmacy right now, but they are hopefully that will change in the future. She reviewed the total medical expense data slide, adding that the projected growth in total medical expense of between 6% to 7% a year. The actuaries are using different various methods to interpret what the spend will be in 2021 and 2022. Ms. Condon stated that it is important to note that this data is not risk adjusted and thus not comparable to the State Benchmarking data. It is also just for the commercial, fully insured carriers and it also included data from State Employee Benefits. Steven Costantino stated that CMS put rate increase within Medicare, and they announced their trends. Ms. Condon added that their actuaries did not incorporate the recent data regarding total trend. They only included the data regarding the fee schedule. The projections are founded on data received by carriers in Delaware making the data specific to State's fully insured market.

Dr. Fan asked if risk adjustment and the non-inclusion of ERISA plans and other plans like Medicaid, would bring that percentage projected growth trend closer to CMS reports or the analysis conducted by the OVBHCD. She added clarification, asking if these variables increase or decrease the projected growth trend? Ms. Condon stated that if you risk adjust data and the population is sicker than average population that it makes the TME percentage decrease. She added that other changes depend on the market as to whether Medicare, Medicaid or Commercial experience growth at a faster rate. Mr. Costantino agreed that it is difficult to estimate. He added that for this reason the Benchmark is valuable because it compares Delaware to Delaware. He also pointed out that CMS does not release state specific data in a timely manner. Ms. Condon shared that Medicaid and Medicare data has not been included in their analysis. She continued to share that the affordability standards are tied to the commercial carriers. While the OVBHCD seeks to align with all carriers in the state, the Department of Insurance only has the ability to regulate and integrate commercial carriers into the model.

Dr. Gill shared that he recently a recent analysis conducted by an ACO, using the participating Primary Care Providers in Delaware using the actual claims history. They found that Medicare funding payment to primary care would go up approximately 5%. This calculation is based on actual changes. The findings of the analysis project a best-case scenario is that spend is up to 4.2%. Ms. Condon commented that she had met with Aledade (Tyler Blanc and Dr. Mullins). Their projections are based on all providers in Delaware versus providers within a specific group. She reminded the members that the results were projections in a time of great uncertainty and based on the data they can access.

Ms. Condon shared a slide that summarized the plans of the OVBHCD. This month they released the Affordability Standard Report. Public comment will be received between December 21st and January 21st. Ms. Condon encouraged members to submit feedback to DOI-legal@delaware.gov. In February, they will publish and post their responses to the public comments. In the first quarter of 2021 they will work with the carriers to assess their compliance with SB227. They also plan to release a bulletin on the Integration with Rate Review in February. Lastly, between February and March they will update the rate filing instructions for the carriers.

Dr. Fan asked if the members had any more questions for Ms. Condon, hearing none she transitioned to the next agenda item.

The full presentation can be viewed on the DHCC website (https://dhss.delaware.gov/dhss/dhcc/files/pcrcovbhcdupdt12172020.pdf).

Mercer Care Delivery Concept Model

Dr. Fan reported that she had been working with Mercer. Mercer's original contract with the State included work to develop a primary care delivery model for Medicaid. Dr. Fan expressed her desire for the PCRC to move forward with developing a Primary Care Model. She reminded the members that one of the components shared by the OVBHCD was the development of a strong practice transformation, alternative payment model and care delivery integration model would provide a foundation that will assist the State with reaching proposed affordability standards. Dr. Fan added that the model is a concept model that includes several elements that have been discussed in the past. This multiplayer model concept moving practices forward into alternative payment model to meet the primary care spend target. She also added that this is a concept model and it is not set in stone. She suggested the members view this as an opportunity to consider what will work for the State.

Dr. Fan turned the time over to Mercer. The Mercer team introduced themselves. Ms. Elizabeth Collins began the presentation. She shared the presentation would be given by herself, and her colleagues Cindy Ward and Jennie Echols.Ms. Collins reviewed the presentation content. She asked that members hold comments and questions until after they have reviewed all three components. Ms. Collins shared the various issues that Delaware has been facing. Delaware's workforce is unable to meet the demand. Delaware is also 32nd nationally for obese adults and 36th in in activity. There is a 6% decline in primary care physicians from 2013 to 2018. Sussex and Kent Counties have been identified as primary care shortage areas, based on the federal definition. Forty percent of Kent County physicians either plan to retire or are unsure if they will be practicing in the next five years. Lastly, Delaware has a consolidated market for Health systems and Health insurers.

Ms. Collins shared a slide from the Freedman presentation given last month. She stated that nationally the increases in health care cost are primarily driven by increase in price, however, in Delaware price and utilization contribute to the increases. She pointed out that Freedman's analysis showed a much lower investment in primary care. While the amount spent on primary care services increased 21% between 2017 and 2019, there has been little to no movement as a percent of total medical expense (4.2% in 2017, 4.3% in 2018, and 4.5% in 2019.)

Ms. Collins reported the concept model pairs well with items identified in SB227. She continued by shared that both payment reform and value-based care are embedded in the model. Workforce and recruitment are addressed in the concept model. Ms. Collins emphasized the importance of adopting principles that help to recognize the importance of primary care and assist with its sustainability. She added that community health teams will help to ensure independent providers feel supported as well as encourage collaboration between providers and Health systems. Directing resources to support and expand primary care is also embedded within the concept model. Increasing integrated care is also incorporated and larger increases can be made by adopting additional metrics. Ms. Collins added that with the evaluation of system-wide investments into primary care providers will start to see progress by reviewing claims data found in the Delaware Health Care Claims Database.

Ms. Collins reviewed the five objectives of the primary care concept model. The model will adopt a new base payment model that frees clinicians from the financial imperative to generate visit volumes, allowing them to deliver services in a flexible way that best addresses patient needs. High-quality care will be rewarded as it promotes performance accountability. The model will bolster providers capacity to provide care coordination to patients and it

will support providers in adopting tools and strategies to become high-performing practices. Ms. Collins turned the time over to Ms. Cindy Ward.

Ms. Ward reviewed the three elements of the primary care concept model: alternative payment, community health teams and care delivery requirements and provider support. She added that the model has a lot of flexibility and was developed to be customized to fit Delaware's needs. The Alternative Payment Model (APM) element contemplates two different options. In APM, Model A includes a primary care prospective payment which means a per member, per month (PMPM) payment for the most common primary care services, regardless of volume. Model B is a blended primary care prospective payment, meaning a reduced prospective PMPM payment along with fee-for-service (FFS) payment for the same set of commonly delivered services (at a diminished FFS fees.) Both models retain FFS payment for services not included in the prospective payment rate. Ms. Ward shared the key components of element #1: practice participation would be voluntary, targets will be phased in over time, a core code set of primary care services will be included, there will be a common measure set, an attribution and risk adjustment and risk mitigation is also included.

Ms. Ward passed the presentation over to Ms. Collins. Ms. Collins reviewed the concept of Community Health Teams, element #2 within this model. She reported that this element is one of the components that has a lot of opportunity to identify how best to meet the needs in Delaware. This element seeks to establish locally based, multi-disciplinary teams that coordinate care and help manage patients' complex illnesses across providers, setting and systems of care. These teams may include social workers, community health workers, nurses and other peer-support positions like doula's and promatoras. This element will also expand capacity and support a robust primary care system. This element has some flexibility to include centralized community resources, either regionally or at practice sites on an as-needed bases. Mercer has collected funding examples from other similar national models. Having local community health team serve patient care needs across providers could reduce duplication of effort, minimize patient confusion and provider burden.

Ms. Jennie Echols provided an overview of the third element, Care Delivery and Provider Support. She summarized the eight domains of this element. This element will require input from providers and support from carriers and MCOs. The eight domains are reflective of an ideal set a of skills that have been found from literature to be needed for practice transformation. Ms. Echols added that the transition will require a paradigm shift. It is important to recognize that each provider has many levels of readiness, multi-player streams and each patient brings a different type of need (children vs. adults, or specific conditions). She stated that if this is one of the elements that is chosen it will require a lot of thought and development to avoid time consuming or complex types of activities for their practices.

Ms. Echols stated that practices should complete a readiness status and progress report. This allows practices to internally target the activities and changes that need to be undertaken to achieve success. She also pointed out that the support needs to target the processes that will help them achieve the targets so they can achieve the incentives. This will motivate practices to more forward with their transformation. Ms. Echols also shared their estimated timeframe for implementation, sharing that Mercer initially estimated four years for practices to meet requirements in all eight domains. It is necessary to obtain input from practices and examine readiness to best estimate timelines. Without obtaining this baseline data it would be difficult to estimate an actual implementation timeline. There are many lessons learned from other states that have initiated these transformation models of primary care. The literature states that it is necessary for an ongoing process for a continuing dialogue through a primary care leadership group or committee or learning collaboration.

Ms. Echols encouraged members to review the appendices at the end of the presentation (https://dhss.delaware.gov/dhss/dhcc/files/pcrcmtgprst122120.pdf) that include draft CPT codes, primary care first quality measures, and additional quality measures. She concluded the presentation and opened the meeting for questions and/or comments.

A question was asked about the PMPM coverage. Ms. Echols reported that the PMPM is based off the bundled payment of traditional primary care services. She added that the framework could adjusted to include a broader more total cost of care payment. Dr. Mike Bradley reported that the Medical Society's model closely resembles this model. He also shared that his practice took three to five years to implement their transformation. Dr. Gill stated the proposal is feasible and practices will need help to make it work and make it sustainable. He emphasized the fact that because primary care is so underfunded, the proposal should start with a higher base target and his recommendation is 12% of Total Spend. The group discussed the how to customize the model to meet Delaware's needs. Ms. Echols stated that the first part of the process will be to establish a framework and concept. Step two would be to identify health goals and the next steps includes selecting the measures meet the needs of the State.

Dr. Fan reminded the members that the model is conceptual, and the framework is flexible. The goal of the Collaborative is to put forth a recommendation to the Health Care Commission or for possible legislative mandate. She encouraged the members to focus on identifying the driving metrics for the reason for the quality code. Dr. Fan reiterated the need to agree on definitions for the terminology that is being used in the discussions. The following definitions were discussed:

- Bundled Payment represents a prospective payment for primary care services/capitation.
- Global Capitation/Total Cost of Care includes downside risk that incorporates harder elements
- Primary Care Global Payment (Model A) – Capitation model for primary care services

There was a question asking for clarification on Model A would not be more costly than Model B, Ms. Echols agrees that Model B would be budget neutral. The discussion moved to the cost of the model and identifying where the funds will come from. Mr. O'Hara asked if Mercer contemplated expanded use of virtual solutions for primary care. Ms. Echols reports that they looked at using telehealth as a method to provide primary care services. This method has been included as reimbursable.

The members discussed issues related to identifying funding for the increased investment into primary care. Mr. Costantino commented that the current system is increasing at an unsustainable level. He asked how we reallocate versus add affordability standards. He emphasized the need to pay for the investment that drive down the cost of care. Dr. Bradley suggested that funding that is currently spent on hospital care can be reallocated to primary care. Mr. O'Hara added that as an industry they had abandoned capitation. He shared that it was not popular at the provider level. He reported that there were some gatekeeper aspects that were rejected by the consumer. He agreed with the Mercer presentation and trendlines describing inpatient and outpatient costs and reallocating 2% from these buckets and redirecting those funds into primary care. He commented that reallocation will be difficult given the market forces and there will be no easy way to negotiate the unit cost down. Sasha Brown shared Aetna's experience with capitation. She reported that Aetna currently uses capitation in Delaware, and they have recently discussed whether or not to increase capitation across the entire state. Ms. Brown added that the PMPM is based on age and sex. Mr. Steven Groff asked how the group planned to address total cost of care, how risks will be introduced and where will the funding come from. Dr. Gill asked members to remember that an increase in primary care will decrease spend in other places. Mr. O'Hara asked Dr. Gill to clarify earlier statements surrounding primary care providers being held accountable for hospital spend. He asked how an increase in primary care could equal a decrease in total cost of care if providers are unable to impact these costs. Dr. Gill provided some clarification by explaining that while primary care providers should not be held responsibility for the cost of inpatient and

outpatient cost, primary care services can impact and decrease these costs. He added that the state of Oregon experienced a decrease in total cost of care when they increased primary care investment.

Dr. Fan stated that next steps will include identifying funding for the model. She agreed with Mr. Costantino's comments that this model does not address total cost of care or funding. She reminded the members that Mercer's presentation is a care delivery concept model.

Mr. Costantino mentioned that several tools have been developed to mitigate risk to providers. Dr. Donahue-Henry commented that she supports the concept of capitation and accountability. She suggested an implementation approach that included leveraging the existing ACOs to ensure increased success. Dr. Fan agreed with the suggestions of incorporating current infrastructure. Veronica Wilbur stated that the model is attractive to her as a private practitioner. She added that utilizing the available tools have proven to be time consuming. Practices want to be transformative but there are several barriers. She concluded by emphasizing the importance of including the entire provider population versus just focusing on the needs of independent providers and hospital providers.

Approval of November 2020 Minutes

Dr. Fan asked the members if they had any comments on the draft minutes from the Primary Care Reform Collaborative meeting, held on November 16, 2020. Steven Costantino made a motion to approve; the motion was seconded by Kevin O'Hara. The motion to approve was unanimously carried. Approved minutes for the November meeting can be viewed here: https://dhss.delaware.gov/dhss/dhcc/files/pcrcmtgminutes111620.pdf

Care/Practice Transformation

Dr. Fan led a discussion on the next steps for the Collaborative. There are several decisions that need to be made. She asked if members had comments on how to establish funding and how to align these efforts with the State Benchmarks. She continued to ask the members how information from OVBHCD affordability standards and RAND report to establish funding. Dr. Fan added that aligning with the benchmarking process is important, however members should be mindful of the purpose of the process, which is to allow the State to be informed on spending trends within healthcare and to track these trends to ensure improvements are being made. She encouraged the members to vote on a recommended target. Representative Bentz shared his appreciation for the work that has taken place thus far, however he stressed the importance of action taking place this year. Senator Townsend charged the Collaborative with identifying specific steps to move forward for the immediate future. Providers are moving into concierge services and there is an urgent demand (from stakeholders) for a solution.

Dr. Fan summarized the recommendations from the OVBHCD: start at 5% in 2021, increase by 1%, target will reach 9% by 2024 or start at 5% and implement an annual increase by 1.5% - target will reach 11% by 2024. She added that there are three caveats:

1. The model is based on voluntary increase in primary care investment
2. The model involves commercially funded payors and State Employment Benefits (no ERISA)
3. Members should recognize downward pressure on other components will come in 2022 (in order to fund the 1.5% increase for making sure the total cost of sending isn't out of proportions).

Members continued to discuss the target investment rate. Dr. Fan shared that the Medical Society's recommendation is to increase the investment to 10- 12%, with specific descriptions of prospective payments. She added that it had been shared by providers that most cannot wait until 2022 to receive the increase. Dr. Gill emphasized the importance of the urgency of the matter. He did not feel the increase should be dependent on the increase within

Medicare. A portion of the Medical Society's proposal includes reimbursement of care coordination services. He stated that 12% is consistent with national guidelines and 10 – 14% should be our goal and it should not be lowered even if total cost of care is higher. Mr. O'Hara shared that assigning a particular number could be difficult and may not be the best strategy. Total cost of care must be addressed, along with an explanation of the spending in primary care in order for a solution to be established. Dr. Bradley shared that primary care services have been undervalued for many years and he was in favor with increasing the investment to 12% within 3 to 5 years. He added that most physicians coming out of training are going into specialties and not moving into primary care. He agreed that it is imperative that movement to increase the investment take place this year. Dr. Fan agreed with the urgency but also shared that fee schedules have been set and budgets have been set and making major changes may be difficult for payors. Dr. Gill shared that it was his understanding payors have additional funds from this year put aside due to decrease in payments. Members continued to discuss the desired increase primary care investment target.

Dr. Fan called for last comments on the OVBHCD's recommendations to begin at 5% and increase annual either by 1% or 1.5%. Dr. Fan asked members agreed on the timeline. She highlighted three elements that need to be discussed further: activities for 2021, aligning with the benchmark process, affordability standards establishing funding for the primary care investment. Leslie Ledogar provided some clarification on the OVBHCD recommendations. She shared that the OVBHCD recommendations do not suggestion primary care increase happens alone but rather increase while downward pressure is on inpatient and large hospital spend. She also added all three things need to happen at the same time (increase primary care investment, the implementation of alternative payment models and decrease hospital spend). Mr. O'Hara thank Ms. Ledogar for her comments, and he added that Highmark is largely supportive of the three pillars she identified. Dr. Fan acknowledged the time and stated that the conversation will continue in the January meeting.

Dr. Fan reviewed the 2021 meeting schedule. She shared the next two meeting dates fall on holidays; therefore, January and February meetings will move to the fourth week (January 25th and February 22nd). The meetings will resume their normal schedule in March.

Public Comment

Dr. Fan called for public comments. Hearing no comments or other business, the meeting was adjourned at approximately 7:05p.m.

Next meeting

The next Primary Care Reform Collaborative meeting will be held on ***Monday January 25, 2021***.