Primary Care Reform Collaborative: PCRC

May 6, 2020

Agenda:

- Approval of Minutes
- ► Member Update re: COVID 19
- ► DOI/OVBHCD Update
- Approval of Technical Subcommittee
- Approval of Annual Report
- ► Future Meetings
- Next Steps
 - Funding proposals
 - ► ERISA subcommittee

COVID UPDATE

- Immediate Lessons learned:
 - Deficiencies in delivery of health care
 - Innovations which may improve the delivery of health care, e.g. Telehealth, expanded team care
- 30000 view immediate analysis of cost to : payors, health care systems, clinicians
- Patient experience
- Any other thoughts?

Technical Subcommittee

- Works directly with OVBHCD and Freedman Healthcare
- One recommendation: total of 5
 - Two payor representatives
 - Two PC clinicians, one hospital based
 - One State, either from DHSS or DMMA
- Similar proposal: total of 5
 - One technical representative (data/actuary) each from Aetna and Highmark
 - A practitioner/clinician from private practice who has the requisite technical expertise
 - A practitioner/clinician from a health system or a rep from a large hospital who has the requisite technical expertise
 - Someone from a large employer/payor such as Statewide Benefits who has the requisite technical expertise

Current Recommendations from Survey:

- Primary Care is foundational to health care delivery in DE
- Practices which demonstrate a team-based or PCMH like delivery of care should have more upfront investment
- Initial increase in upfront investments should be tied to an agreed upon definition of "risk" "accountability" and "value"
 - ▶ Increased PMPM, care coordination payments, non claims payment
- ► ERISA Plans:
 - Provide a Learning collaborative creation of subcommittee
 - Voluntary contribution of data ?aggregated from TPA or specifications in to APCD

Annual Report: Next Steps

- 12% PC spend with incremental one percent per year or within 5 yrs
- Performance measured by standard definition of PC spend
- Increase greater participation in APM with some downside risk in the adoption of team based care models
- Upfront investment for essential resources for team based care model, even if unreimbursable, e.g. care managers and health IT
- Innovative measures to stabilize PC in short and long term, e.g. grant programs
- Alignment with benchmarking process with sustainable increases in health care costs and constraints on other components of health care delivery

- PCRC Vision PC is foundational to health care delivery in DE
- Increased investments tied to risk/accountability>>encourage APMS uptake
- Upfront investments FUNDING
 - Encourage greater adoption of team based /PCMHlike care delivery>>greater reimbursement
 - Care coordination, IT investment, practice transformation ?care managers, non-claims
- OVBHCD recommendations for targets and effect on total cost of care
 - What additional measures need to be recommended
- ERISA plans
 - Mandatory reporting with opt out
 - Learning collaborative subcommittee

Immediate Next Steps for PCRC

- ▶ PC post COVID>>Funding proposals
 - Innovative, flexible and sustainable
- Defining the data driven metrics: value, accountability, risk
- Capacity including addressing lack of parity for BHI and nonphysician clinicians
- DHIN presentation
- ERISA plans subcommittee

Current Comments:

- Determine and monitor outcome measures to evaluate the benefit of increasing PC investment
- Develop a broad "inclusive" definition of Primary care in terms of health care specialties/ professionals
- Assist/Issue to the Insurance Commissioner an annual report on increasing primary care investment
- Use of DHIN to measure PC investment and monitor amount of PC spend with claims and non-claims based payments
- Collaborate with "provider partners" to reallocate funds, on an increasing scale, which have been contributing to a higher cost of care

Current Comments: Increase PC spend without increasing overall health care costs

- Reduce spend on hospital inpatient services to the same level in PA
 - Decrease hospital rates by 10% of Medicare rate each year until 190% as that in PA, probably over 5 yrs
 - Overall represent decrease 1% in total spend to be shifted to PC spend

Current Comments: Increase PC spend without increasing overall health care costs

- Global Reference Based Pricing
 - Montana: 2016>>234% Medicare rates across all service types with \$13.6 m savings/3 yrs
 - Oregon: 2017 legislation effective 2020>>200% Medicare
 - North Carolina: 2019, effective 2020
 - ▶ 155% of Medicare hospital inpatient/200% for critical access hospitals
 - ▶ 200% for hospital outpatient/ 235% for critical access
 - ▶ 160% Medicare for professional services

Past Proposals

AAFP APC-APM

Advanced Primary Care Alternative Payment Model (APC-APM)

Primary Care Global Payment

- · Per patient per month
- Covers a defined set of face-to-face evaluation and management services
- Prospective, risk adjusted payment

Performance-Based Incentive Payment

- Paid prospectively quarterly; reconciled annually
- Based on performance measures, including quality and cost



Population-Based Payment

- · Per patient per month
- Covers non-face-to-face patient services
- Prospective, risk adjusted payment

Fee-For-Service Payment

- · As medically/clinically needed
- · Based on relative value units





CATEGORY 2

FEE FOR SERVICE -LINK TO QUALITY & VALUE

A

Foundational Payments for Infrastructure & Operations

(e.g., care coordination fees and payments for HIT investments)

Pay for Reporting

(e.g., bonuses for reporting data or penalties for not reporting data)

C

Pay-for-Performance

(e.g., bonuses for quality performance)



CATEGORY 3

APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

1

APMs with Shared Savings

(e.g., shared savings with upside risk only)

B

APMs with Shared Savings and Downside Risk

(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

3N

Risk Based Payments

NOT Linked to Quality



CATEGORY 4

POPULATION -BASED PAYMENT

1

Condition-Specific Population-Based Payment

(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)

B

Comprehensive Population-Based Payment

(e.g., global budgets or full/percent of premium payments)

C

Integrated Finance & Delivery System

(e.g., global budgets or full/percent of premium payments in integrated systems)

4N

Capitated Payments NOT Linked to Quality

n.org/workproducts/apm-refresh-whitepaper-final.pdf

PAST PROPOSALS:

Delaware Primary Care Funding Model Proposal

ACO

Proposed Funding Model

3 funding streams:

- Delegated Care Management Fees
- 2. Shared Savings
- 3. Pay for Performance

Care Management

- Upfront PMPM CM Fees with task accountability
 - Used to fund CM staffing and infrastructure
 - Amount related to % premium with both a cost of service and ROI perspective
 - Included as an expense in calculating shared savings/risk pool

Shared Savings to Shared Risk

Health Plan

- Savings split between ACO and Plan
- Transition to Shared Risk over Time
- Stop-loss for high dollar cases
- Risk corridor when transition to risk
- Quality gate
- Guard against price increases eliminating savings from improved utilization

Pay for Performance

- Key measures associated with Plan withhold or quality goals
- Metric choice aligned across payers for similar populations
- Number of metrics allows providers to focus their QI programs
- Improvement and attainment goals achievable

Future Meetings:

- ► THIRD MONDAY OF EACH MONTH:
- **4/6/20**
- **5/6/20**
- **5/18/20**
- ► 6/15/20 (If needed)