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 /PCMH-like 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 non-physician 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

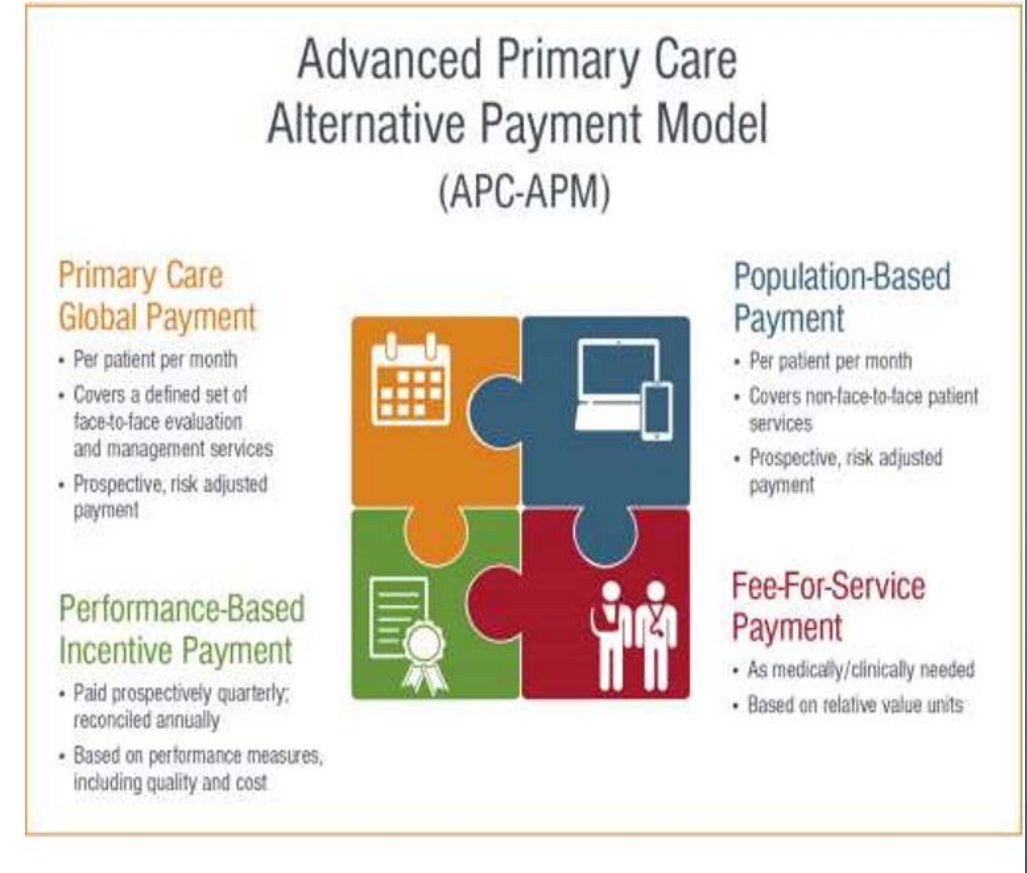
- Reduce spend on hospital inpatient services to the same level in PA
  - Decrease hospital rates by 10% of Medicare rate each year until 190% as that in PA, probably over 5 yrs
  - Overall represent decrease 1% in total spend to be shifted to PC spend

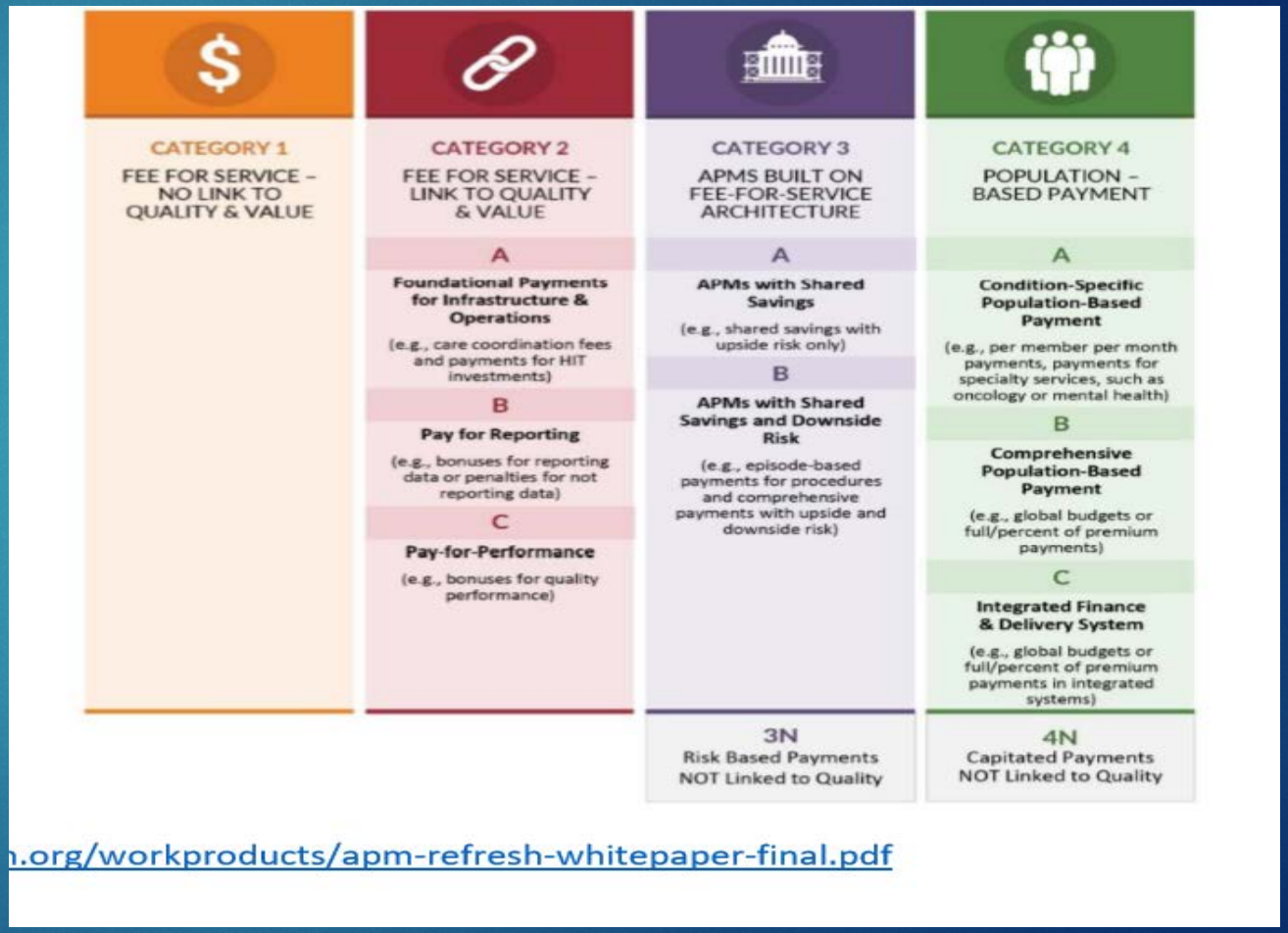
Current Comments: Increase PC spend without increasing overall health care costs

- 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





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

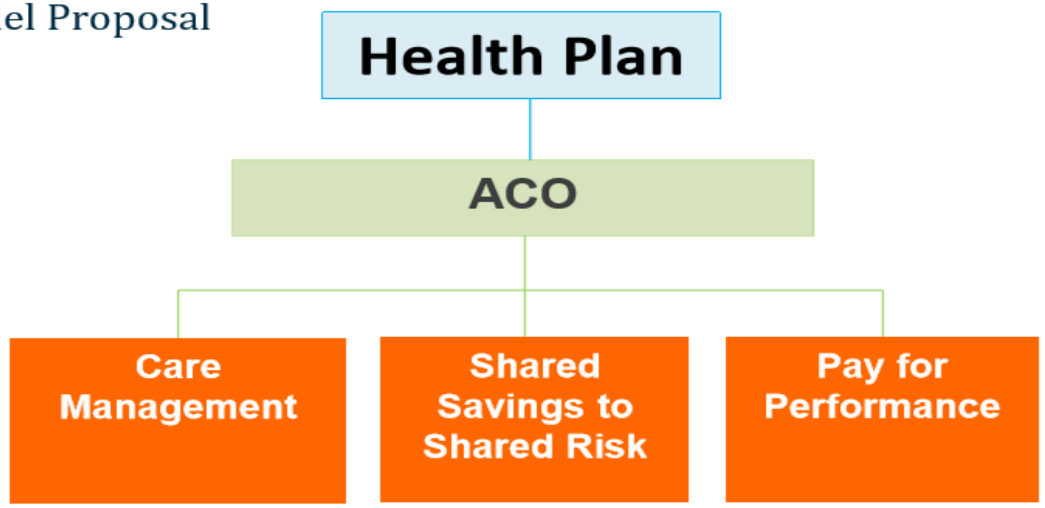
PAST PROPOSALS:

Delaware Primary Care Funding Model Proposal

Proposed Funding Model

3 funding streams:

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



- 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

- 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

- 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)