PC Collaborative

February 10, 2020

Agenda:

- JHU/Arnold Foundation Presentation
- SEBC Commentary
- DOI Update
- Legislative Update
- Approval of Minutes and Outstanding Items
- Recommendations

Legislative Update:

- SB200 - passed
- SB206 – out of committee

Annual Report Recommendations:

- Report to General Assembly and DHCC – progress and goals
- Defining Operating Procedures: (Line 25 of SS1 for SB116)
  - Proxy representatives may have voting rights and shall be communicated to c-chairs as attending proxy prior to meeting so they may be included in meeting communications and information
  - Term limits: 2 year term with appointment as per SB 116 and SB 206, excluding ex-officio positions
  - Quorum for voting
  - Meeting information and materials to be sent out one week prior to meeting

Rhode Island	Oregon	Delaware	Connecticut
• Each health insurer's annual, actual primary care expenses (direct and indirect) shall be at least 10.7% of annual medical expenses for all insured lines of business • At least 50% of medical payments should be under an alternative payment model, with a minimum downside risk for providers	• Prominent carriers (annual health insurance premium income ≥ $200 million) offering commercial and MA plans, state public employee board plans, and Medicaid CCOs must spend at least 12% of total expenditures for physical and mental health on primary care services by 2023 • If spend less, must document how will increase spending by at least 1% annually	• *Recommendation:* State should mandate payers to progressively increase PC spending to reach percentage milestones that eventually account for 12% of total health care spending (based on RI and OR) • Increase will occur either through 1% point increase per year or within 5 years, whichever is faster • Standard will apply to at least Medicaid, MA, self-insured, fully insured, state employees' health plans • Performance measured by standard definition of primary care spending and total medical spending	• Developing primary care bundled payments that cover office visits, with supplemental bundles that include a PMPM fee to allow practices to hire care managers or invest in HIT, as part of multi-payer model • Multi-payer reform model aims to gradually double revenue stream to primary care providers while maintaining TCC trend through combination of upfront supplemental payments to PC providers who agree to assume risk on controlling TCC
Background: PC spending increased through combination of structural payments (loan repayment, care management fees, and value-based payment opportunities) while hospital rates were capped	*Background:* Primary care spending requirements follow a series of delivery and payment model reforms over the past decade, which had already boosted primary care spending on average to the 12% benchmark	*Background:* State facing acute PC workforce issues, growing health care costs; series of legislative resolutions and EOs focused attention on costs and quality; first state to set health care spending growth target and track quality and health measures	*Background:* Planned investment is strictly in upfront supplemental payment revenue made with the expectation that primary care providers transform practices to offer alternative means of accessing primary care services that are not billable and by using a more extensive care team

Other key features:
• 2010 - OHIC required each insurer to annually increase total commercial medical payments to PC
• Capital investments in PC, including supporting PT and EHR systems, count toward primary care spending
• Each payer must contract with specified share of PC physicians in PCMHs, increasing annually
• To help contain costs, hospital rates are capped at CPIU+1% and ACO total cost of care budgets are capped at CPI-U+1.5%
	Other key features:
	• 2015-2016 - legislation required state to report on percentage of PC spend
	• Analysis includes claim-based and non-claims-based payments
	  ○ Claims-based collected through state's APCD
	  ○ Non-claims based collected through reporting template
	• SB 231- established PC Payment Reform Collaborative, tasked with helping develop and implement the Primary Care Transformation Initiative
		Other key features:
		• PC spend increase should include upfront investment of resources to build infrastructure and capacity, not just increase in FFS rates for PCPs
		• Support/incentives for use of HIT, support for team-based model of care across range of PC setting, value-based incentive payments
		• PC spend requirements should be compatible with state benchmarking process of promoting only sustainable increases in TCC
			Other key features:
			• Building off SIM (thru Jan 2020)
			• Goal: enhance provider performance on shared savings or shared risk arrangements via PC payment reform
			• State priorities: building diverse care teams; expanding patient access to PC via email, home visits, telemedicine; adopting technology with likely ROI; integrating care to better treat behavioral health, address SDOH; developing practice specializations to better treat certain patient subpopulations

- State Office of Financial Management
- Evaluated expenditures for 2018
  - Included copays,deductibles and pharmacy claims for total medical expenditures but not non-claims based expenditures
  - Also used IOM definition of PC and the 4Cs: contact, continuity, comprehensive and coordinated care
  - Calculated narrow and broad definition of providers and services
  - Included commercial, Medicaid, Medicare but not Self-insured, federal and VA benefits
  - 4.4-5.6% with highest in age group <18: 10.4-11.2%

- PC providers: SB 227
  - Family practice, internal medicine, geriatics, pediatrics
  - Physicians, NPs, PAs
- OVBHCD:
  - Use of APCD
  - Specifications:
    - Formulated by OVBHCD with input by PCC>>>?PCC data subcommittee
    - Outpatient and office expenditures
    - ?non –claims payments – aggregated data from payors who are also contributing data to DHIN
    - NO TOPIC RECOMMENDATIONS PROVIDED

A clinical model plus a payment approach to enable the model can lead to improved outcomes

- Common elements of successful models include:
  - – 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

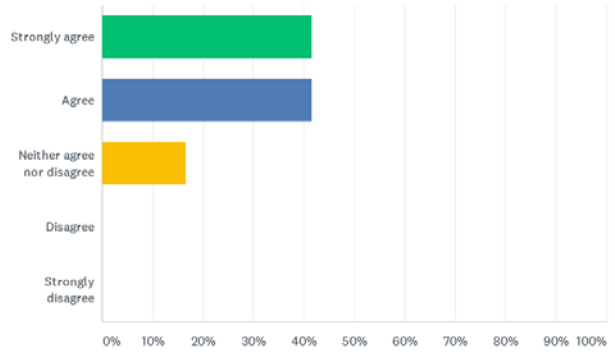
Previous Comments: This past Spring

- Value of PCMH:Total Cost savings was greatest with mature PCMH or higher risk populations
- important characteristics:
  - upfront investment without being additive to total cost
  - Accountability=risk
  - Building of infrastructure: data; care coordination at practice level; pre-defined targets for outcomes, cost savings, accountability
  - Role of established ACOS in state

Delaware Primary Care Collaborative

Q6 Please indicate the rate in which you agree with this statement : "To transition practices away from FFS to alternative value based payment models could include both upfront investments with prospective payments and risk based incentive payments (Primary Care First model)"

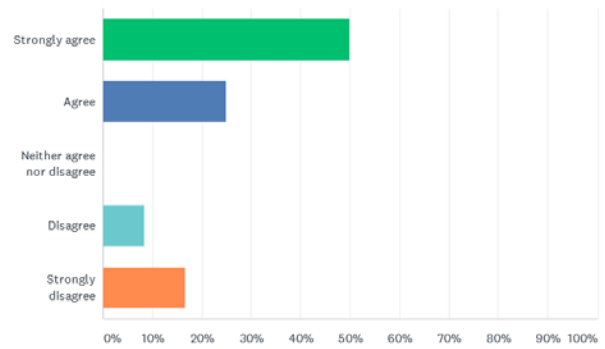
Answered: 12 Skipped: 0



Delaware Primary Care Collaborative

Q7 Please indicate the rate in which you agree with this statement: "Increased prospective payments should be tied to risk and value based payment models"

Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	50.00%	6

Trinity Health ACO

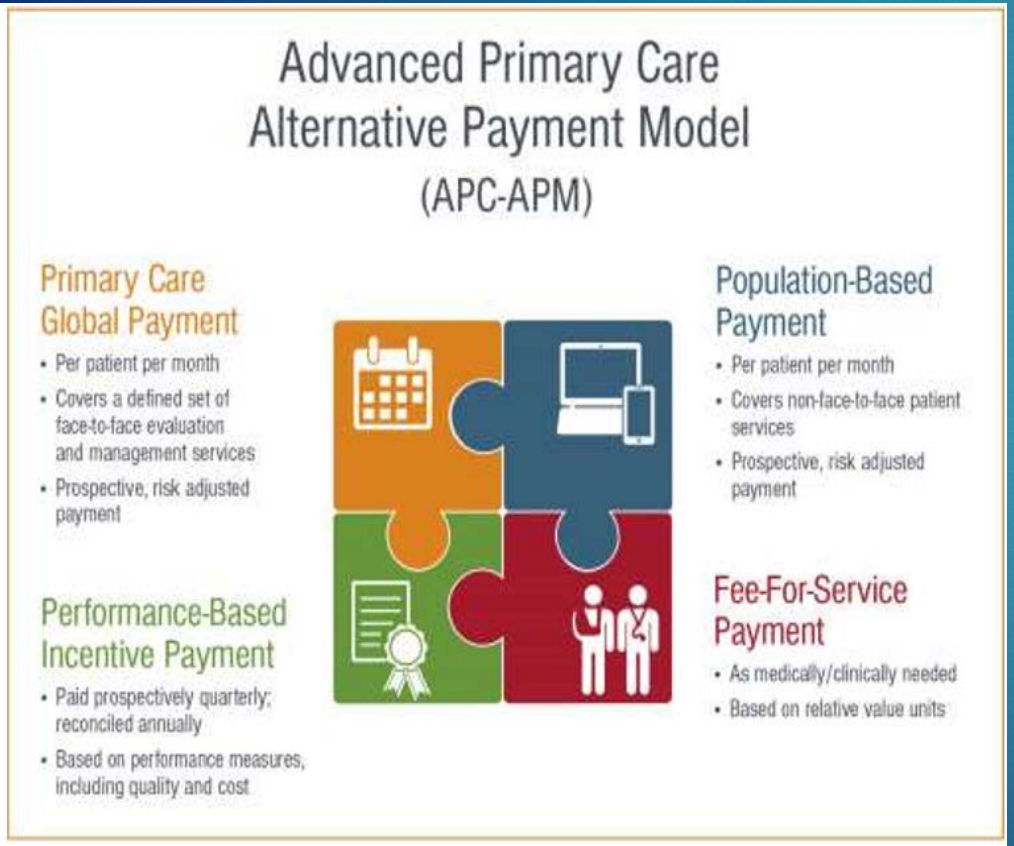
- Next Generation ACO with upside and downside risk
- Included patients from health systems and private groups in Illinois, Michigan, New Jersey, and Ohio
- 100K Medicare patients with up to 15% of medical spend at risk
- Centralized team that provided actuarial support and data analytics at the system level
- Local teams responsible for care management, social work, care coordination, clinician engagement, and leadership
- Expectation that local group spent $22 PMPM on the infrastructure above

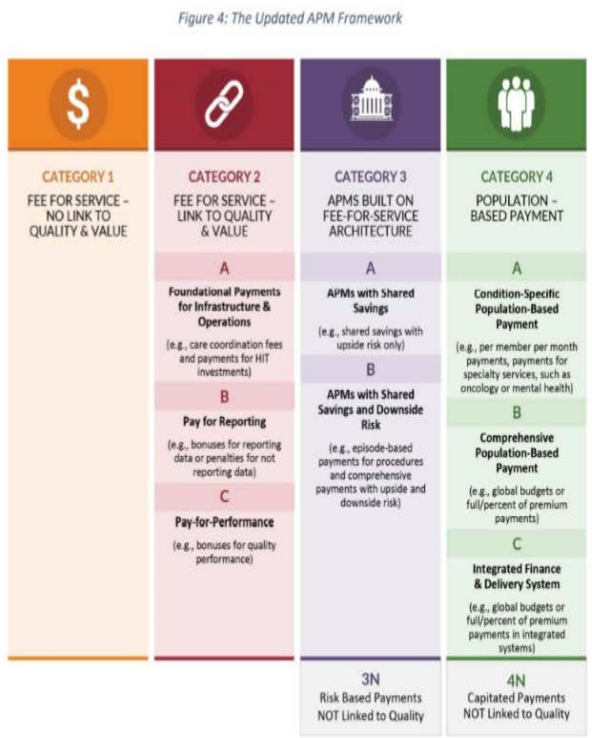
Current Recommendations from Survey:

- 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” and “value” as well as overall cost saving benchmark
  - 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

Past Proposals

AAFP APC-APM



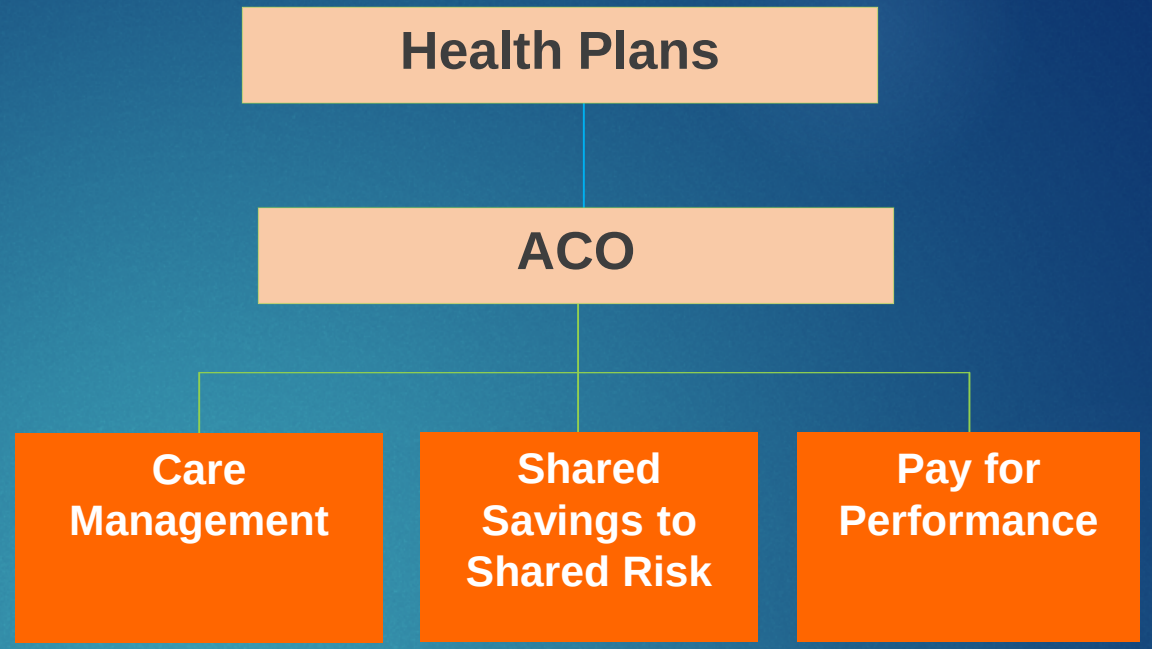


Source: http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

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:
- 3/16/20
- 4/20/20
- 5/18/20
- 6/15/20 (If needed)