Primary Care Reform Collaborative Technical Subcommittee

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Goals for Today

- Gain additional input into key decisions for primary care investment target
- Begin discussion of alternative payment model targets

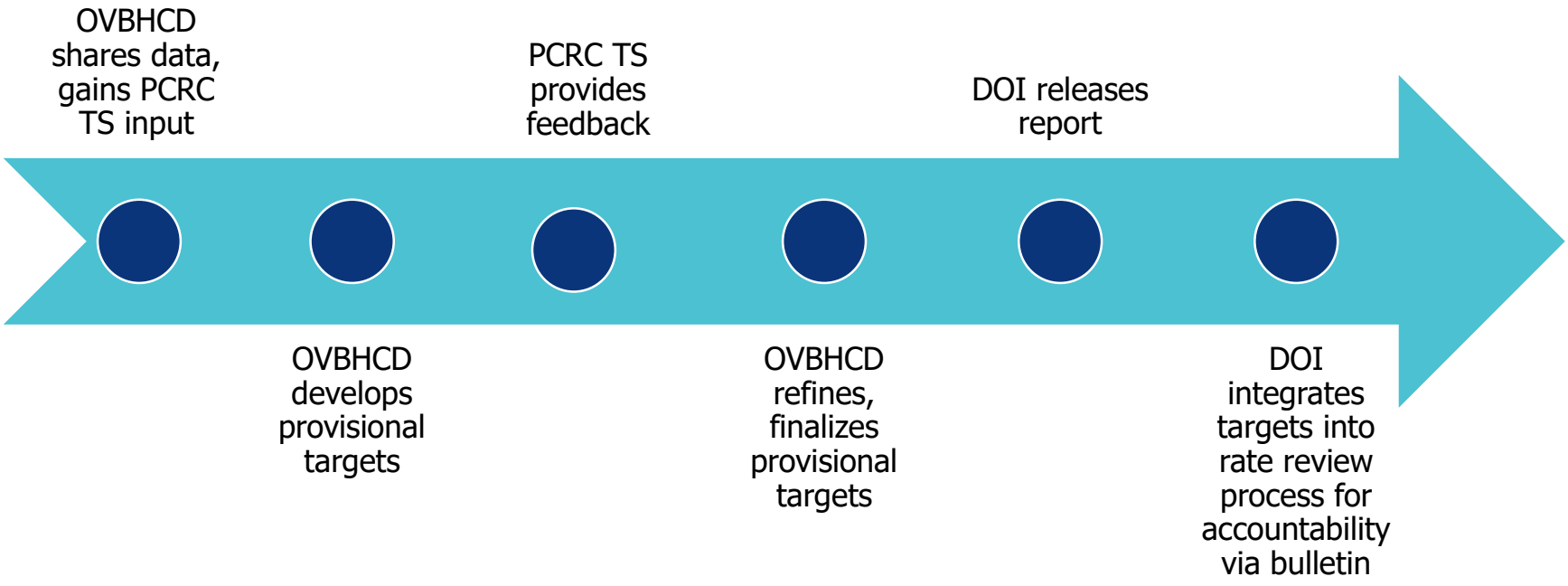
Provisional Affordability Standard Domains (ASD) for Delaware

1. Primary Care Investment Target
2. Provider Rate Review within the Payer Rate Review Process
3. Alternative Payment Model Targets

Integrated with the rate review process for plans under DOI purview

Seeking collaboration and alignment with other payers

Developing Affordability Standard Targets Process



DRAFT DISCUSSION ONLY

We Seek Your Input On:

Primary Care Investment Target:

- Should we include urgent care as a primary care place of service?
- Should we limit the amount of primary care investment coming from "indirect" sources?

Alternative Payment Model Targets:

- What is the right level of specificity, prescriptiveness for the OVBHCD APM targets?
- What is the right pace of increase?
- What is the best unit of measurement (e.g., %TME, attributed lives)?

Primary Care Investment Target

Provisional Approach:
Primary Care Investment Target

1. Calculate "direct" and "indirect" primary care spend (FFS & non-FFS) using data from DHIN, benchmark, and rate filings

2. Target incremental increases (e.g. X % of total cost of care) in direct primary care spend for X years, or until X% primary care spend

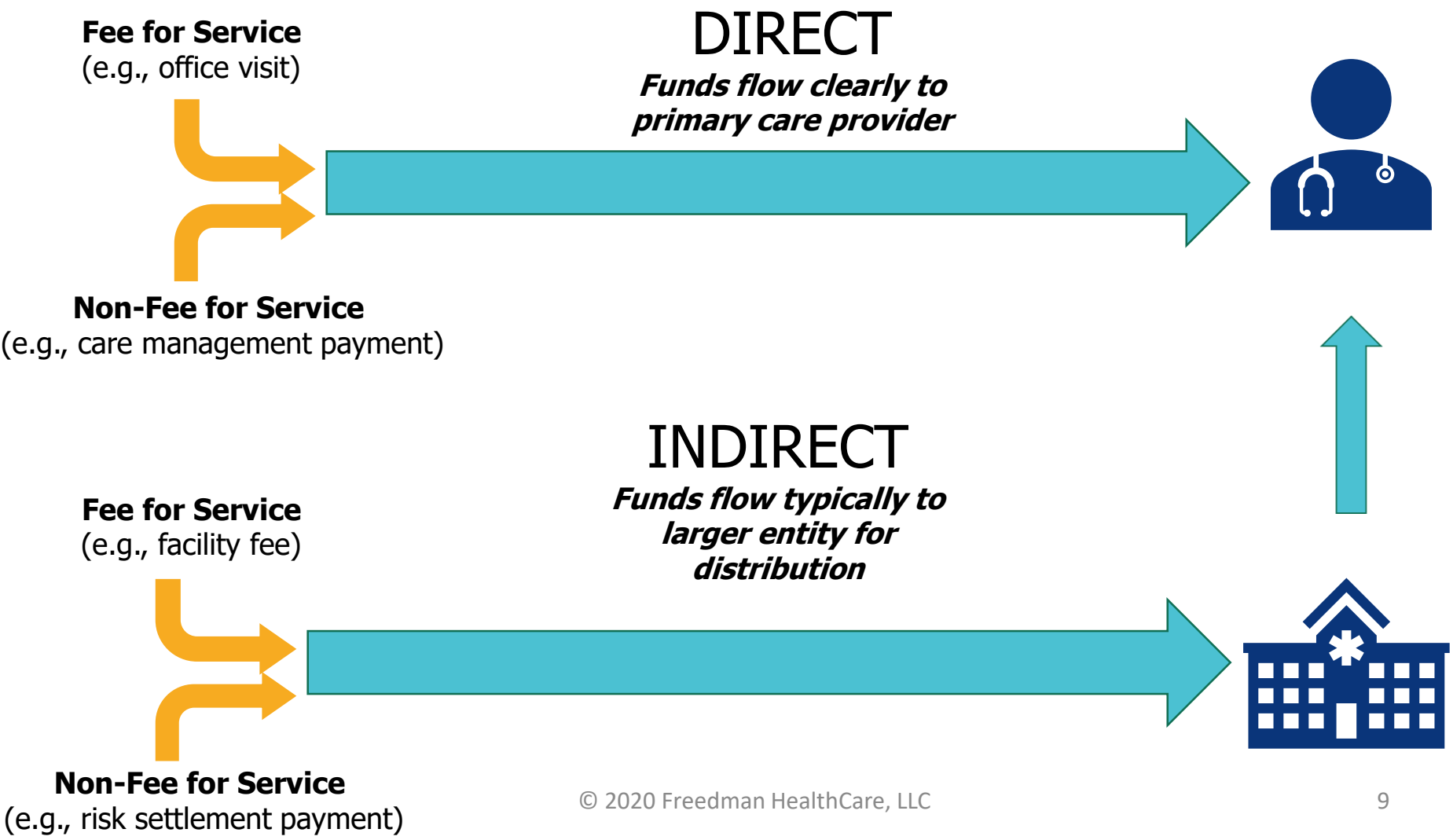
3. Reporting on strategy, programs, accountability augments data

Four Types of Primary Care Investment

1. Direct FFS Payments – ***Wrapping up today***
2. Indirect FFS Payments
3. Direct Non-FFS Payments
4. Indirect Non-FFS Payments

Today's Focus

Direct and Indirect Primary Care Spending



Other States' Primary Care Investment Targets

STATE	TARGET	NOTES
Rhode Island	Investment in primary care should be at least 10.7% of total medical expense	• Of the health insurer's annual Primary Care Expense financial obligation, at least 9.7% of the calculated amount shall be for Direct Primary Care Expenses • Process began in 2010 • "Direct" includes care management, risk settlement patients to PCPs, infrastructure payments, linkages to HIE, BH integration, medical school loan forgiveness
Oregon	Oregon has been working to increase primary care spend for several years and Medicaid and private health insurers operate with a 12% primary care spend target	• Includes psychiatrists, OB-GYN (except delivery) • Includes primary care procedures; not just office visits, care management, vaccinations etc. • Doesn't include Rx in denominator
Colorado	Carriers to increase primary care spend as a percent of total medical expense 1 percentage point per year in 2021, 2022 and report how investments support advanced primary care	• Includes OB-GYN, when "practicing primary care" • Includes BH providers, SUD services in a PCP setting; creates "operational challenges" • Early efforts to measure current CO PCP spend including non-FFS estimate 5.9%- 9.8%, refining process now
Connecticut	The state recently announced a 10% primary care investment target	• CT is in the process of developing the specifications to guide this work

Key Takeaways from Review of Other States' Approaches

- Definitions matter
- Its important to understand absolute dollars available to primary care (PMPM) **and** spending on primary care on as a percent of total spending
- Few states have developed a way to measure all types of primary care investment or reached a robust level of primary care spending

Wrapping Up: Direct, FFS Primary Care Spending

PLACE OF SERVICE CODES INCLUDED:

Place of Service Code(s)	Place of Service Name	Place of Service Description	Traditional or Non-Traditional
11	Office Location	Office Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis	Traditional
71	Public Health Clinic	A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.	Traditional
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.	Traditional
17	**Walk-in Retail Health Clinic**	**A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.**	**Non-Traditional**
20	**Urgent Care Facility**	**Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. (Effective January 1, 2003)**	**Non-Traditional**
02	Telehealth	The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)	Non-Traditional
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.	Non-Traditional

Measuring Indirect, FFS Primary Care Investment

Methodology in development….

1) IDENTIFY PRIMARY CARE OFFICE VISITS: Leverage list of primary care providers and CPT codes from professional services analysis

2) LOOK FOR A "MATCHING" FACILITY FEE: Identify facility charge using revenue code 0510-0519 for the same patient on the same day of service; both visits may have the same claim number

3) CALCULATE SPENDING ON FACILITY FEES ASSOCIATED WITH PRIMARY CARE SERVICES

Collecting Non-FFS Data: Insights from RAND Applied to Delaware

Collecting Data on Non-FFS Payments: A State Summary from RAND

Table 3.1. Summary of State Data Collection Models

State	Agency Collecting Data	Payers Covered	Level of Aggregation	Payment Types[a]	Encounter Data	Primary Care	Frequency of Submission
Rhode Island[b]	Office of the Health Insurance Commissioner	Commercial payers covering more than 10,000 fully insured lives	Total spending by payer for each payment type, with details about payment types	All: grouped by APMs—population-based contracts, APMs—bundled payments, APMs—limited capitation, pay-for-performance, and APMs—other	No	Tracked separately	Twice per year
Vermont	Green Mountain Care Board	Medicaid and commercial payers who participate in the state's ACO model	Total spending aggregated by payment type	Varies by payer	Tracked separately	Not tracked	Annual
Massachusetts	Center for Health Information and Analysis	Commercial (limited to largest plans and those in the exchange), Medicaid Managed Care	Aggregated at ZIP code of residence of covered lives or at level of provider	All; grouped by global budget/payments (full benefits), global budget/payments (partial benefits), limited budget, bundled payments, and other non-FFS based	Tracked separately	Not tracked (under development)	Annual
Oregon[b]	Oregon Health Authority	Commercial and Medicare Advantage payers with at least 5,000 lives, and Medicaid	Total payments by each payment type for each contract, may aggregate across multiple providers	All using modified HCPLAN framework	Tracked separately	Tracked separately, aggregate level by payer	Annual
Colorado	Center for Improving Value in Health Care	Commercial (limited to largest plans), Medicaid, Medicare Advantage	Payments by type aggregated at the level of the billing provider	All using modified HCPLAN framework	Tracked separately	Flag payments for primary care	Annually
California	IHA	Commercial, Medicare Advantage, voluntary submission	Payments attributed to specific patients, not aggregated	Capitation payments (professional, facility, global) collected, working to collect other types of data value-based P4P payments collected at plan level	Yes	Beginning to identify by provider specialty and procedure codes	Annually, transitioning to quarterly

NOTES:
[a] States were asked about collection of data related to the following payment types: capitation (i.e., full, partial, or professional risk), risk-based contracting payments (e.g., hospital gainsharing, shared savings), bundled/episode-based payments, medical home payments, pay-for-performance, payments for infrastructure expenditures or investment (e.g., HIT incentives), payments for workforce expenditures or investment (e.g., nurse care managers, community health workers, and others).
[b] Oregon and Rhode Island have multiple data collection procedures that may include non-FFS payments; we discuss their more granular methods for accounting for non-FFS payments in this report.

Collecting Data on Non-FFS Payments: Four Recommendations from RAND

1. Develop a single approach for categorizing types of non-FFS payments.

2. Select a common approach for identifying what types of non-FFS payments are considered primary care payments.

3. Define a uniform population or frame for data collection (situs most feasible for payers).

4. Work toward disaggregated data reporting by provider organization and patient zip code, as opposed to cumulative payments from each payer.

Implementing RAND's Recommendations in Delaware – Some Choices

Categorization of types of non-FFS payments

- Health Care Payment Learning & Action Network (HCPLAN)-based system
- State-designed system

Determination of which non-FFS payments are for primary care

- Identify primary care separately or not
- Categorization of payments as for primary care

Population or frame for which data are collected

- State of residence
- Situs of insurance contract – situs refers to the legal location of the insurance contract

Level of aggregation of data reported

- Aggregated across all contracts
- By specific provider contract
- For specific patients or patient groups and provider organizations

Rate Review Template: Primary Care Investment Worksheet

Service categories aligned with the URRT.

Capitation categories breakdown aligned with updated benchmark reporting.

Primary care definition aligned with updated benchmark reporting.

	CY 2017		CY 2018		CY 2019	
	Completed and Incurred ($)	Allowed ($)	Completed and Incurred ($)	Allowed ($)	Completed and Incurred ($)	Allowed ($)
Inpatient Hospital						
Outpatient Hospital						
Professional						
Other Medical						
Capitation						
Primary Care Incentive Programs						
Incentive Programs for Services Other than Primary Care						
Primary Care Capitation						
Capitation for Services Other than Primary Care						
Risk Settlements						
Primary Care, Care Management						
Care Management other than for Primary Care						
Other						
Total Capitation	$0	$0	$0	$0	$0	$0
Prescription Drug						
Total	$0	$0	$0	$0	$0	$0
Primary Care Member Months						

Rate Review Template: Alternative Payment Model Worksheet

Align with LAN categories and subcategories

	2017	2018	2019
Member Months			
Total Medical Expense All Services			
TME PMPM	$0.00	$0.00	$0.00

	2017 Total Medical Expense All Services	2018 Total Medical Expense All Services	2019 Total Medical Expense All Services
LAN Cat 1: Fee For Service - No Link to Quality & Value	$0	$0	$0
LAN Cat 2-A: Payments for Infrastructure & Operations	$0	$0	$0
LAN Cat 2-B: Pay for Reporting	$0	$0	$0
LAN Cat 2-C: Pay for Performance	$0	$0	$0
LAN Cat 3-A: APMs with Shared Savings	$0	$0	$0
LAN Cat 3-B: APMs with Shared Savings and Downside Risk	$0	$0	$0
LAN Cat 4-A: Condition-Specific Population-Based Payment	$0	$0	$0
LAN Cat 4-B: Comprehensive Population-Based Payment	$0	$0	$0
LAN Cat 4-C: Integrated Finance & Delivery System	$0	$0	$0
Total Medical Expense All Services	$0.00	$0.00	$0.00
	CHECK	CHECK	CHECK

Note: This template is for all market segments combined

Return to Primary Care Investment Target

Measuring Non-FFS, Direct Primary Care Investment in Delaware

1) Primary Care Incentive Programs: All payments made to PCPs (as defined for FFS, direct primary care spending) for achievement in specific predefined goals for quality, cost reduction or infrastructure development. Examples include, but are not limited to, pay for performance payments, performance bonuses and EMR/HIT adoption incentive payments.

2) Primary Care Capitation: All payments made to PCPs (as defined for FFS, primary care spending) made not on the basis of claims (i.e., capitated amount). Amounts reported as capitation should not include any incentive or performance bonuses paid separately and can be separately reported as Non-Claims: Incentive Program. These payments are typically made monthly for the care of assign beneficiaries.

3) Primary Care, Care Management: All payments made to PCPs (as defined for FFS, primary care spending) for providing care management, utilization review and discharge planning.

Definitions consistent with DE Benchmark process

Data collected via rate review template

Measuring Non-FFS, Indirect Primary Care Investment in Delaware

The Challenge:

While payers will provide information in the rate review template on shared savings, risk settlement and global capitation payments, we have no visibility into how those payments are shared within the organization.

Two Potential Options:

1. Exclude these dollars completely

2. Apportion a small percentage of these payments as "primary care spending" similar to Rhode Island's approach for "indirect primary care spend"

Alternative Payment Model Target

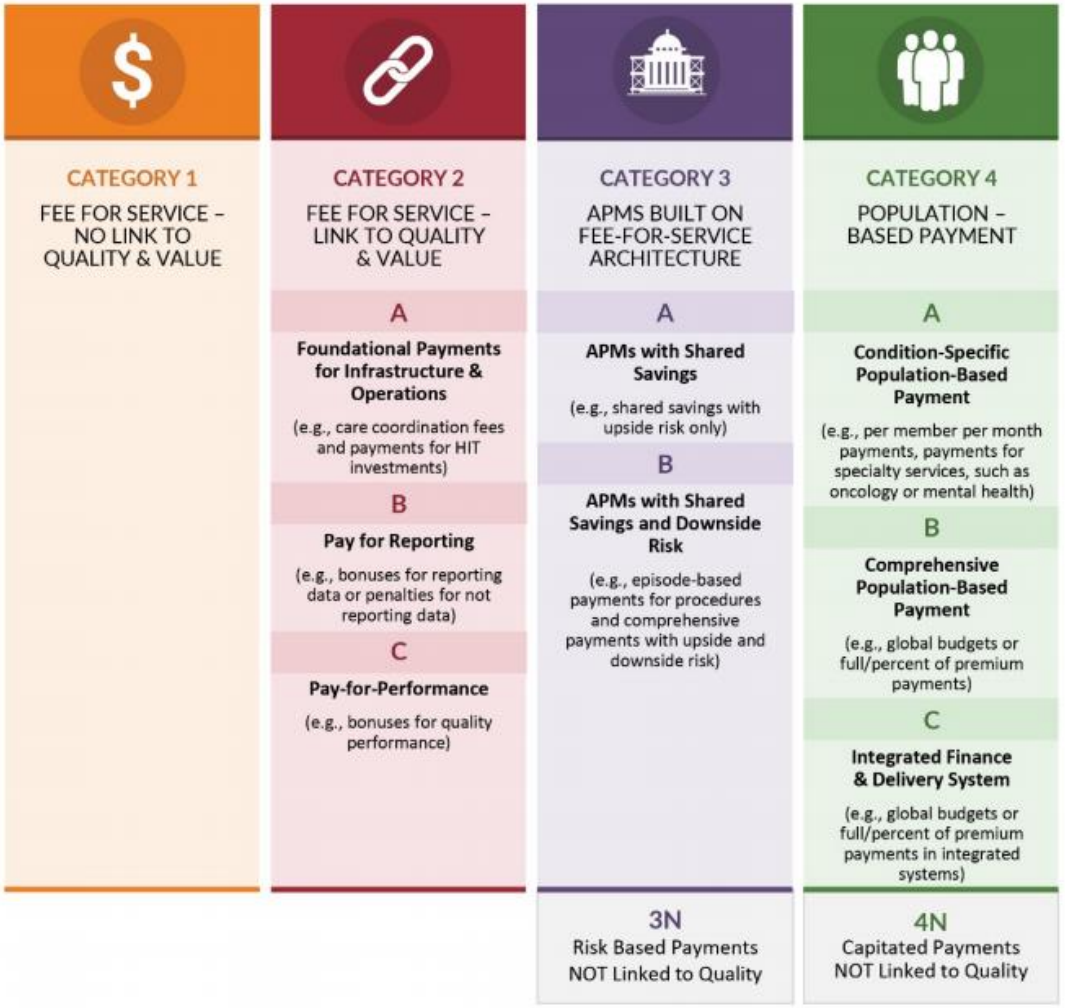
Estimates of APM Activity in DE

- Primary Care Reform Collaborative
- Delaware Center for Health Innovation
- DOI OVBHCD

SHARED GOAL: Standardized approach (LAN) to measure impact of APMs on DE market

PRIMARY DIFFERENCES: Unit of measurement, other technical specifications

HCPLAN Framework



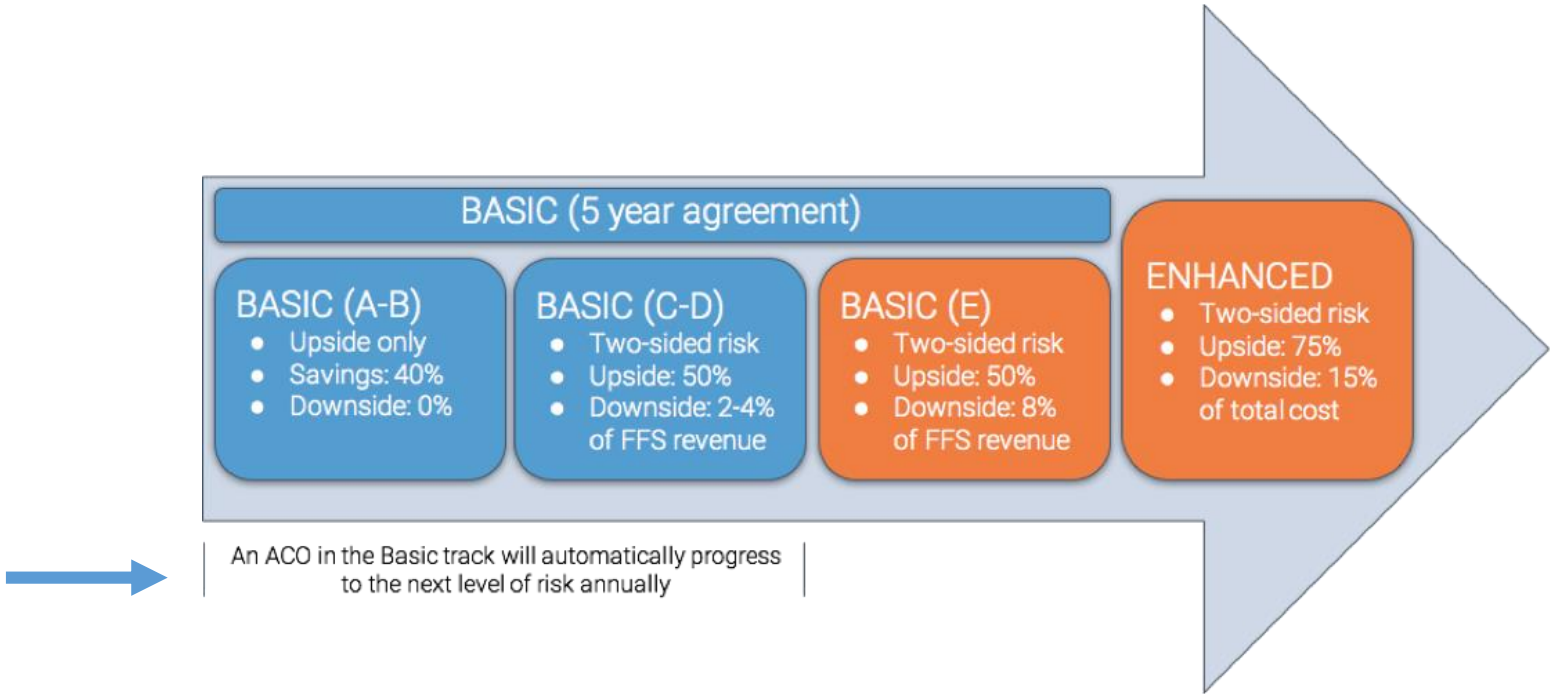
Early Findings on DE Commercial APMs

- APMs (of some sort) likely exceed 60% of TME; target was 60% of Delawareans attributed to some sort of APM
- Very little flowing through downside or capitation; Highmark reported less than 5% in both categories combined
- General interest in moving to downside faster; concern that all providers are not ready; differing opinions on movement to capitation for primary care, even among providers well-positioned to succeed
- Interest in allowing providers who desire the ability to remain independent i.e. not join an integrated delivery system well positioned to take on risk
- Less clarity on accountability, particularly for providers not in downside risk arrangements

Early Findings on DE Medicare APMs

- Generally good performance in MSSP, movement along the continuum to risk but slow
- 2nd highest enrollment nationally in MSSP (as % eligible); historically low enrollment in DE MA plans
- Little interest in PCF and DC, for different reasons
- Consensus that it takes time to learn and aligned incentives to achieve real success with population health management

Early Findings on DE Medicare APMs



Track	BASIC					ENHANCED
	Level A (upside only)	*Level B (upside only)*	*Level C (two sided)*	*Level D (two sided)*	*Level E (two-sided; Advanced APM)*	*Years 1-5 (two-sided; Advanced APM)*
# of DE ACOs*		3	1		1	2

Other States' APM Targets

STATE	TARGET	NOTES:
Rhode Island	• 50% of insured medical payments to APMs, risk-based contracting targets and minimum downside risk standards that increase over time will be released • Prospective payment for primary care required by January 2021	• Very specific in approach, some of which remains under development • Important to note evolution over time; this did not occur overnight
Colorado	Carriers to move at least 50% of applicable medical expense to APMs by 2023 or face DOI performance improvement plan	• Specifics are in development; workgroup paused due to COVID-19
Oregon	By 2024, no less than 70 percent of each CCO's provider payments must be in the form of a VBP in LAN Category 2C (Pay for Performance) or higher, and at least 25 percent of the CCO's provider payments should include downside risk (fall within LAN Category 3B or higher).	• State developed a PCRC and is participating in CPC Plus to encourage payment innovations among other payers

Considerations for a DE target

- Should OVBHCD targets align with targets already in place at SBO, Medicaid?
- What is the right level of specificity, prescriptiveness?
- What is the right pace of increase?
- What is the best unit of measurement?

Next Steps

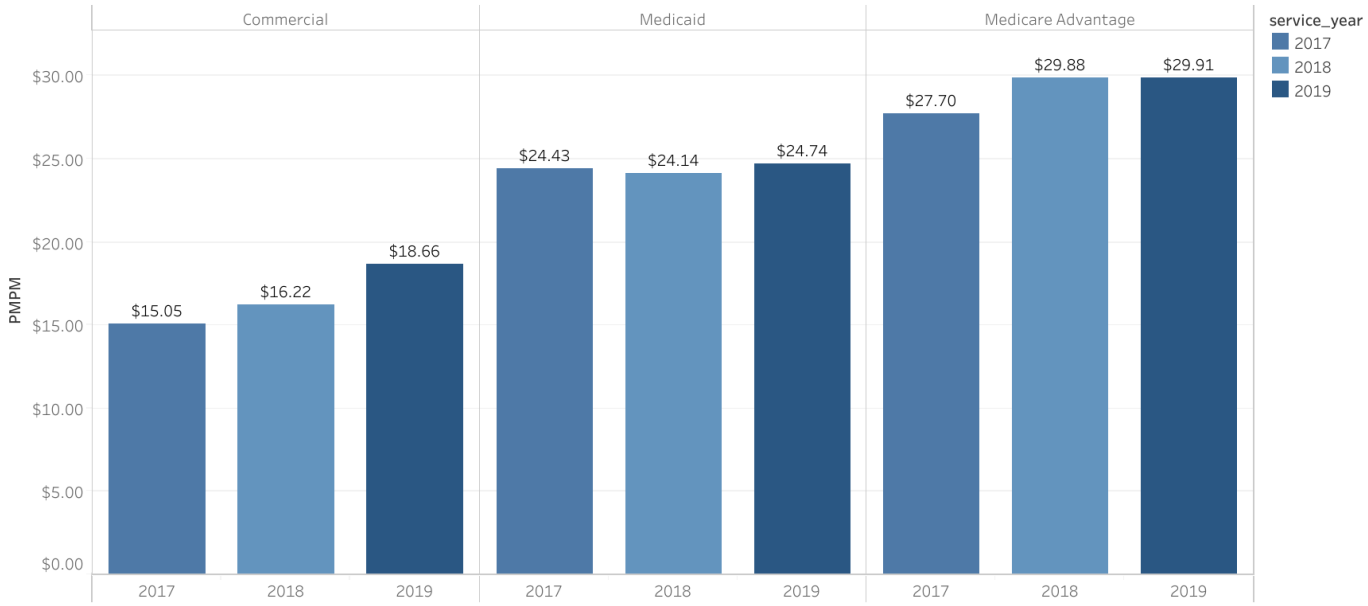
- Complete primary care facility fee analysis
- Gather data from DHIN, DOI templates
- Develop provisional targets for affordability standards and discuss with stakeholders
- Determine opportunities for alignment with other payers
- Release report and draft regulations

Appendix

FFS Primary Care Professional Services, as % of TME

	DHIN Commercial 2017-2019	SBO Primary Care Spend Analysis 2018-2019	Milbank, PCP A, primary care service only, PPO plans
With Rx in denominator →	**3.5%-3.6%**	**3.8%**	**4.3%** (3.0-5.4)

FFS Primary Care Professional Services, as PMPM



Commercial payers increased fee for service spending on primary care professional services 24% from 2017 to 2019.

HCPLAN Definitions

LAN Category 1 - Fee For Service: Payment models classified in Category 1 utilize traditional FFS payments (i.e., payments made for units of service) that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor provider performance on cost and quality metrics. Additionally, it is important to note that diagnosis related groups (DRGs) that are not linked to quality and value are classified in Category 1.

LAN Category 2A - Fee for Service Linked to Quality & Value - Foundational Payments for Infrastructure & Operations: Payments placed into Category 2A involve payments for infrastructure investments that can improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on quality metrics.

LAN Category 2B - Fee for Service Linked to Quality & Value - Pay for Reporting: Payments placed into Category 2B provide positive or negative incentives to report quality data to the health plan and/or to the public.

LAN Category 2C - Fee for Service Linked to Quality & Value - Pay for Performance: Payments are placed into Category 2C if they reward providers that perform well on quality metrics and/or penalize providers that do not perform well, thus providing a significant linkage between payment and quality. Note that a contract with pay-for-performance that affects the future fee-for-service base payment would be categorized in Category 2C.

HCPLAN Definitions

LAN Category 3A - APMs Built on Fee-For-Service Architecture - APMs with Shared Savings: In Category 3A, providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. However, providers do not need to compensate payers for a portion of the losses that result when cost or utilization targets are not met. If a plan operates an APM where a physician group, primary care physician, or other physician is held responsible for ALL of the attributed member's health care spending, including outpatient, inpatient, specialists, pharmacy, out-of- network, etc., all of the dollars associated with the attributed members can be included.

LAN Category 3B - APMs Built on Fee-For-Service Architecture - APMs with Shared Savings and Downside Risk: In Category 3B, providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. Additionally, payers recoup from providers a portion of the losses that result when cost or utilization targets are not met. If a plan operates an APM where a physician group, primary care physician, or other physician is held responsible for ALL of the attributed member's health care spending, including outpatient, inpatient, specialists, pharmacy, out-of- network, etc., all of the dollars associated with the attributed members can be included.

LAN Category 4A - Population-Based Payment - Condition-Specific Population-Based Payment: Category 4A includes bundled payments for the comprehensive treatment of specific conditions.

HCPLAN Definitions

LAN Category 4B - Population-Based Payment - Comprehensive Population-Based Payment: Payments in Category 4B are prospective and population-based, and they cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct.

LAN Category 4C - Population-Based Payment - Integrated Finance & Delivery System: Payments in Category 4C also cover comprehensive care, but unlike Category 4B payments, they move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization.