



January 25, 2021

Delaware Department of Insurance
Office of Value-Based Health Care Delivery
Attention: Leslie W. Ledogar, Esquire
Director of Office and Legal Special Projects
1351 W North Street, Suite 101
Dover, Delaware 19904

RE: Office of Value-Based Health Care Delivery's ("Office") Report, *An Integrated Approach to Improve Access, Quality and Value*, dated December 18, 2020 ("Report")

Dear Ms. Ledogar:

Highmark BCBSD Inc. ("Highmark Delaware") appreciates the opportunity to provide comments on the above-referenced Report. Below are Highmark Delaware's initial comments to the following findings (each a "Finding") and provisional affordability standards (each a "Standard") and targets (each a "Target") set forth in the Report:

Comments to the Findings

Finding 1: Delaware commercial health insurance carriers' primary care investment will need to increase to support a robust system of primary care by 2025

Finding 1(a): Commercial carriers in Delaware spend less than half as much for primary care services as commercial carriers in leading states, as a percent of total cost-of-care on a per member per month ("PMPM") basis

Comment: Page 4 of the Report states that "primary care spending in Delaware is low relative to the national average and about half what is spent in leading states." This statement is somewhat misleading because it measures primary care spending as a percentage of total healthcare spending and not the actual amounts that insurers are reimbursing primary care providers ("PCPs"). Since overall healthcare spending in Delaware is high, a comparison of PCP spend to total spend is skewed relative to actual PCP reimbursement.

Finding 1(b): Although primary care investment increased more than 20% from 2017 to 2019, its portion of total cost-of-care remained approximately the same during the same period.

Comment: Highmark Delaware appreciates this Finding. The increases in PCP spend, when looked at solely through the lens of total cost-of-care, do not take into account the increased amounts spent on inpatient and outpatient care from

facilities in Delaware. However, this Finding 1(b)- that primary care spending is increasing in Delaware - does support Highmark's comment to Finding 1(a) that tying PCP spending to total healthcare spending in Delaware and characterizing PCP spend as "low" misrepresents historical PCP spend in Delaware.

Finding 1(c): Prices for physician and other professional services, including primary care services, have increased an average .5% a year in recent years compared to an average of 3% to 4% a year for hospital services.

Comment: For period 2016 to 2019, Delaware PCP spend on a PMPM basis grew more than the aggregate professional spend noted. As noted, hospital spend is at 200%+ of Medicare rate. Highmark Delaware is committed to increased PCP spend, but not as the sole solution nor at the expense of overall healthcare spend in Delaware. If total cost-of-care only increases, this cost is born by consumers and employers in terms of premiums and out-of-pocket costs for care. Highmark Delaware believes it is important for payers to incentivize professional providers, including PCPs, to manage the total cost-of-care and the quality of care. This is something Highmark Delaware incorporates into all value based arrangements. Further increases in reimbursement need to tie to an accountability to lower total cost-of-care while increasing quality, otherwise consumers and employers bear the additional costs. Highmark Delaware's True Performance program for primary care physicians includes risk adjusted monthly care coordination fees and incentive payments based on a provider improving performance on nationally-recognized and accepted quality measures as well as lowering the total cost-of-care. Many primary care physicians in Delaware have engaged with Highmark Delaware in this program, including progressing to more advanced gain share reimbursement models.

Finding 1(d): Increasing primary care investment to levels sufficient to support robust primary care—without reducing projected price and utilization growth in other categories—would likely result in unacceptable and unsustainable annual increases in total healthcare spending and increases in health insurance premiums

Comment: Highmark Delaware, as part of the Primary Care Reform Collaborative, did not specify any particular percentage of spend target, citing no concrete plan in the state to hold total cost-of-care in check. We are supportive of additional PCP investment/spend, as long as such investment does not increase overall cost of healthcare spend in Delaware. Additionally, the investment should aim to improve the quality of care provided through quantifiable/measurable outcomes. Further we agree that increased PCP spend, without any consideration for total cost-of-care, would increase premiums and out of pocket costs for Delawareans and employers. We believe that any framework for the healthcare spend

should be reviewed against the quadruple aim in healthcare. The quadruple aim grounds healthcare decisions with the expectation of high-quality outcomes, affordability, and clinician and patient experience.

Finding 3: Delaware’s health systems and health insurance carriers have strong market power

Comment: Highmark Delaware recognizes its strong presence in the market and the strong presence of the health systems, and this speaks to the need for partnerships and new ways of doing things collaboratively in value based arrangements which would improve the experiences of the patients and providers while increasing the quality, positively impacting the outcomes, and ultimately lowering the cost-of-care.

Finding 5: Pairing increases in primary care investment with other reforms allows states to maximize improvements in care delivery and value

Comment: Highmark Delaware is supportive of increased PCP investment provided such an increase would result in overall cost savings and improved quality of care. Such investment should create savings for the consumers and employers.

Comments to the Standards and Targets

Standard #1: Increase Primary Care Investment

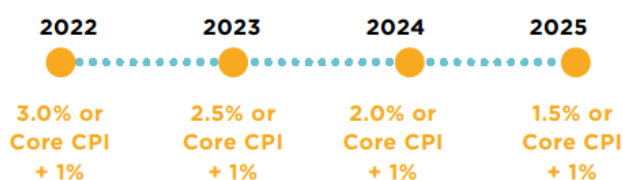
Provisional Target: Commercial health insurance carriers will increase investments in primary care, as defined by the Office, by 1% to 1.5% of total cost-of-care each year until 2025.

Comment: This Target involves four (4) years of annualized increases of 22.5% to 29.7%, including an increase in the first year of 27.3-38.3% (based on the PMPMs in Exhibit 9). This is significantly higher than Consumer Price Index (“CPI”) and annual health care trends and will contribute to higher overall costs of care in Delaware ultimately born by the citizens and employers within the state. Highmark Delaware is supportive of increased primary care investment provided that it does not contribute to an increase in the total cost-of-care. Additionally, any added investment should be tied to quality and cost reduction metrics via value-based reimbursement (“VBR”) contracting. We are not supportive of a specified percentage of increased spend if there is no control of total cost-of-care, as any percentage measurement will only contribute to increased total cost-of-care. PCP investment should be measured as growth in actual PMPM costs. PCP spending should be tied to *actual* savings in care in other categories so that total cost-of-care in the state does not increase as a result of these specified increases in PCP spend.

Standard #2: Decrease Unit Price Growth for Certain Services

Provisional Target: Through their contracts with healthcare providers, commercial health insurance carriers will limit aggregate unit price growth for non-professional services according to Exhibit 11 below. Non-professional services will be defined as those categorized as “Inpatient Hospital,” “Outpatient Hospital,” and “Other Medical Services” in the Unified Rate Review Template (URRT), see Appendix 2: Benefit Categories in the URRT. These categories do not include professional services.

EXHIBIT 11: Provisional Target Will Be the Greater of the Following



“Other Medical Services” is defined in Appendix 2 as “[N]on-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services, and other services.”

The Report indicates that payers will submit information on historical and prospective price increases to DOI and the Office annually via a template contemplated as part of the rate review process and indicates progress toward achieving the price growth Target will inform but not determine DOI’s rate review decision. See Report, at 31.

Comment: Highmark Delaware is supportive of Standard #2 generally but has concerns related to its impact on the DOI’s rate review decision given that unit price growth is dependent on other factors beyond Highmark Delaware’s control. The Report does not provide any level of detail related to how progress toward achieving the price growth Target will impact the rate review. Therefore, Highmark Delaware is unable to support this aspect of the Target without additional information and requests that the Office provide guidance on how a payer’s progress toward achieving the price growth Target will impact the rate review.

Additionally, the limiting of unit price growth for non-professional services will be dependent upon collaboration and partnership between payers and providers resulting in value based care arrangements. Without this collaboration and commitment of payers together with providers to achieve the price growth Target, payers will not make meaningful progress alone, and in turn may be penalized by way of the rate review process. Highmark Delaware requests that this Office explore ways to assist all stakeholders in collaboration for achieving the price growth Target.

Furthermore, the Report's Target for limiting of unit price growth for non-professional services will be insufficient to cover the Report's Target increase in primary care investment. In addition, annual expenditures for non-professional services are influenced by many other factors beyond unit price growth such as utilization and technology. Provider contracts are multi-year and will need to be adjusted over time. Implementing changes will require long-term planning. Like primary care, investment in these services and others also need to improve quality while controlling cost.

Standard #3: Expand Alternative Payment Model ("APM") Adoption

Provisional Target: A minimum of 50% of total cost-of-care will be tied to an APM contract that meets the HCP-LAN Category 3 definition by 2023, with a minimum of 25% of total cost-of-care covered by an APM contract that meets the definition of Category 3B. Total cost-of-care accountability may not be the right fit for all PCPs. Delaware carriers will provide more opportunities for independent providers to participate in pay for performance programs to increase investment in high value services. Commercial health insurance carriers will also explore new ways to pilot and implement capitated payments for primary care and other services and report to the Office on the success and lessons learned of those programs.

Comment: Highmark Delaware is supportive of this standard – our True Performance programs meets the standards set forth in HCP-LAN Category 3a. We continue to work aggressively with our clinically integrated network providers along with health systems to migrate to risk based VBR contracts. Additionally, we are supportive of movement toward capitation models, as long such arrangements improve quality and reduce costs. Please note that any implementation of expanded or more sophisticated VBR models takes time as it occurs over the course of many months.

Additional Comments

Highmark Delaware appreciates the need to invest in primary care services while also addressing the total cost-of-care. We cannot address primary care alone. Value based arrangements require collaboration and partnerships with payers and providers across the continuum of care aimed at improving the experiences of patients and providers while increasing quality and decreasing the total cost-of-care. Highmark Delaware works towards these partnerships on behalf of all whom we serve as part of our core mission and vision.

Highmark Delaware believes the Office should allow for sufficient lead time and ample notice to payers regarding final data template requirements, particularly if the data

collection process is incorporated into the rate filing review process. Data collection fields should be limited to those data elements needed to directly support the Standards and measurement of the Targets.

Thank you again for the opportunity to provide comments to the Report.

Sincerely,

A handwritten signature in cursive script that reads "Nicholas Moriello".

Nicholas A. Moriello, R.H.U.

President

Highmark BCBSD Inc.



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January 26, 2021

Delaware Health Care Affordability Standards: An Integrated Approach to Improve Access, Quality and Value

CAMP Rehoboth appreciates the opportunity to comment on the Department of Insurance's Office of Value Based Health Care Delivery report, "Delaware Health Care Affordability Standards: An Integrated Approach to Improve Access, Quality and Value." We particularly support the Department's efforts to encourage expansion of primary care access and affordability in Delaware.

CAMP Rehoboth is a 501(c)(3) nonprofit community service organization dedicated to creating a positive environment inclusive of all sexual orientations and gender identities in Rehoboth Beach Delaware and its related communities. We seek to promote cooperation and understanding among all people, as we work to build a safer community with room for all. CAMP Rehoboth has a deep and enduring commitment to the health of LGBTQ Delawareans, as evidenced by the depth and breadth of our Health & Wellness Programs, including Sexual Health Counseling, HIV and STI Testing, Health Testing and Flu Shots, Health/Wellness Programs for 55+, HIV Prevention at 5 sites, advice about PrEP, Support Groups, and Grief Counseling. Further, CAMP Youth UP program connects LGBTQ+ youth and families to information and community-based resources as well as providing advocacy, support, and health and wellness education to youth impacted by bullying, abuse, and harassment.

In our experience, access to affordable care has proven to be an insurmountable challenge to members of the LGBTQ community on a number of levels. All too often, members of the LGBTQ community experience systemic bias in terms of access to quality medical care, and assuming access can be achieved, healthcare is often not affordable. Access and affordability are particularly challenging to transgender and nonbinary members of our community, including those Delawareans who are in transition.

Accordingly, CAMP Rehoboth appreciates the candor with which the Department analyzes the status of primary care in Delaware and the integrated approaches the Department proposes to help address this critical problem. We encourage the Department to include a special focus on healthcare access and affordability to LGBTQ Delawareans in its implementation of the report's recommendations, because of the special challenges that members of the LGBTQ community face that are in addition to the challenges faced by the non-LGBTQ community.

We look forward to partnering with the Department as it moves forward with this important work.

Sincerely,

A handwritten signature in black ink, appearing to read "David Mariner", written over a white background.

David Mariner

Executive Director, CAMP Rehoboth

Aledade

Dear Commissioner Navarro and Office of Value-Based Health Care Delivery Leadership Team,

Years of underfunding primary care relative to other payers and other states cannot be reversed by just catching up to other states and Medicare. Delaware must commit to leading primary care investment to correct the past. Strong investment in primary care combined with the financial alignment of accountable care organizations (ACOs) creates the greatest opportunity to both expand access and reduce total health care costs for Delawareans.

About the Aledade Delaware ACO

Aledade helps independent primary care practices make the transition from fee-for-service payment to new models based on patient quality and outcomes. Aledade partners with about 800 practices in 31 states, but has the longest relationship with its Delaware practices which formed the first Aledade ACO in 2015. In Delaware, Aledade partners with 35 practices which jointly manage total cost of care for approximately 65,000 Delawareans covered by Medicare, Medicare Advantage, Commercial, and Medicaid payers. These Delawareans jointly incur more than half a billion dollars of medical spend in the state annually.

Challenges Faced by Primary Care

Aledade makes significant investments to operate each Accountable Care Organization, including population health technology, analytics, governance and staffing that can surpass \$1M per year. Practice success heavily depends on practices also making their own investments that result in improved access, timely patient outreach, and higher quality of care. When we began to work with practices to bolster these capabilities in Delaware, it was clear that independent practices were lacking financial reserves that would provide financial stability and enable investments in value-based care capabilities. One practice shared that they had to skip 6 pay checks to their physicians over the previous year so that they could afford to pay their staff. Another physician had borrowed against their personal residence to make payroll. It was astounding that practices with full patient care schedules were struggling to break even. This was happening before the COVID-19 pandemic began. The root of the issue was inadequate fee for service payment from the state's commercial payers which were paying 65% to- 85% of Medicare rates at the time. In most states, commercial payers pay at rates well above government payers.

The downstream costs of under-investment in independent primary care are real. Independent primary care providers, [who have been found in research studies to be more effective than employed physicians at reducing unnecessary spend in the health care system](#), struggle to compete with health systems when recruiting providers and staff. Health care consolidation in the state has put pressure on small doctors to sell their practices to the dominant health system in order to capture the higher fee schedule revenue the system has been able to negotiate through market power. In 2020, one ACO partner practice sold one of their sites to a health system in Millsboro to avoid perpetual inability to break even. Concierge models, like MDVIP, have swept through the state in recent years, which increase revenue to the primary care provider at the expense of the patient. This model has led to reduced primary care access for all except the wealthiest Delawareans (MDVIP allows a maximum of 600 patients per physician

and charges patients more than \$1600 per year on top of what their health insurance reimburses).

Progress to Date

Aledade has made strides in helping practices maximize revenue opportunities by focusing on delivery of wellness and preventive services that are proven to reduce overall health care costs downstream. By focusing on Annual Wellness Visits, Transitional Care Management visits, and telephone and office visits for high-risk, high-utilizing patients, revenue at the average Aledade practice increases 15% after joining our network. But most important, these practices are earning the largest Medicare shared savings payments of any ACO in the state (nearly \$6.4M was paid to 22 Aledade partners in Delaware for their 2019 Medicare MSSP performance) through reductions in unnecessary ER utilization, reduced readmissions, and preventive care on steroids.

Creating a Statewide Solution

Investment in primary care should not be based on market power of large health systems or Aledade's fundraising capacity. Investment in primary care should be foundational to the healthcare ecosystem in Delaware. Investment coupled with accountability create the greatest alignment with value. As the Office seeks to require primary care investment, it is crucial to also target commercial and Medicaid growth in alternative payment models. We support the inclusion of both targets. We encourage the Office to do what they can this year to pull the 2022 target for investment and 2023 target of APM adoption into 2021 and 2022 respectively. Just like planting a tree, the best time to start was yesterday, but the next best time is today.

Additionally, we would encourage the Office to not be prescriptive about what form that the primary care investment takes. Higher fee for service rates, primary care capitation, care coordination PMPMs, and upfront direct investments have all shown to make a difference. Experimentation by both providers and payers on the approach should be encouraged while coupled with robust information collection about how each approach is working. Transparency without the burden of rigid models is key. Total cost of care models like MSSP have [outperformed](#) all other APMs. The simplicity of total cost of care accountability is paramount - complex value programs can hamper adoption. Measures to ensure quality are both needed, but should be kept to a minimum. Just as in primary care investment has a floor, the Office should create a floor under APM design that ensures equitable payer/provider splits in APMs as well.

Sincerely,

Tyler Blanchard
ACO Executive Director, Aledade

On Behalf of Aledade Delaware Primary Care Provider Partners:

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Susan Parks, FNP-BC

Jennifer Shade, NP

Delaware Care Collaboration

Good morning,

I am writing to comment regarding the Healthcare Affordability Standards Report. There is a section that states that physician led ACOs tend to be more successful. I have an objection to that general comment being in this document in Delaware. Most of the admissions and the costs of inpatient care for the Delaware Care Collaboration are not at St. Francis. Some hospital ACOs cover service areas well beyond the catchment area for a specific hospital. Here is the paragraph:

"Physician-led ACOs tend to be more successful. It is often easier for them to reduce spending on acute inpatient care, post-acute care, home health care initiated on an outpatient basis, and outpatient care in hospital-owned settings, all of which contribute to reductions in total spending. For hospital-led ACOs, the conflicting incentives can be challenging. They provide a range of care for patients who are not covered by their ACO contracts and can lose substantial fee-for-service revenue if they are unable to focus reductions in utilization on ACO-covered patients. Physician-led ACOs have stronger incentives to limit utilization because they do not lose revenue when they reduce unnecessary hospitalizations or outpatient hospital procedures and imaging for any patient, regardless of whether that patient is covered by an ACO contract."

I do not believe that it is easier for physician led ACOs to reduce spending on post-acute care and home health care. Actually, hospital based ACOs have closer relationships and more influence over SNFs as hospitals are the largest referral source for SNFs. Home health care is often a less expensive alternative to SNF care and provides more touch points for patients to minimize ER utilization, so reducing home health care costs is sometimes counterproductive.

My suggestion is to change this paragraph to

"Physician-led ACOs and hospital-based ACOs where most of the inpatient spend is outside of their own health system tend to be more successful. For hospital-led ACOs where the majority of the spend is within their own system, the conflicting incentives can be challenging. They can lose substantial fee-for-service revenue if they are unable to focus reductions in utilization on ACO-covered patients. Hospital-led ACOs have a greater capacity to reduce SNF costs and length of stay as hospitals have greater influence to refer patients to SNFs with higher quality and lower costs due to the number of SNF referrals that come from hospitals. Physician-led ACOs have stronger incentives to limit utilization because they do not lose revenue when they reduce unnecessary hospitalizations, hospital procedures and imaging within their own health system, regardless of whether that patient is covered by an ACO contract ."

Thank you for your consideration and your time.

Sincerely,

Robert A. Monteleone, M.D.

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Dr. W Douglas Tynan Ph.D., ABPP

Overall this report captures the major issues that have been discussed on the national level and proposes specific recommendations that can be implemented in Delaware. Key is support of physician led primary care practices. As we know, in areas where care has become concentrated within medical centers costs increase, and I think additional referrals to specialists increase.

In my previous work as the Director of Integrated Health Care for the American Psychological Association, I am familiar with efforts in many states. I applaud the reference to the Oregon CCO models which fully integrate health and mental health. What is unique to Oregon, payment went from fee for service to Fee for service plus payment for quality and outcome model. They included ALL mental health professionals in the payment - psychology, social work, licensed counselors, LMFT AND also authorized payment for intern services for all of those professions. As a result training programs increased, the number of available staff increased, and as current work shows in Oregon, Colorado, Missouri and Virginia in several projects - when you meet the mental health needs in the primary care clinic, medical costs are reduced significantly. I would be happy to share those papers with you if there is interest. The key is providing a range of mental health services, not just psychiatric consultation. A number of programs do very well with Primary Care Behavioral Health which is very much structured like an Employee Assistance Program - brief screening, 3-4 session intervention and then referral out only if needed. This is quite different than psychiatric consultation.

In summary the one addition I would make is clear funding for all mental health professions, coupled with training in integrated care (there is a very good video on demand online program through Univ of Massachusetts Dept Family Practice), and including mental health in determining quality and outcome goals. I think that could help us to the goals established.

--

W. Douglas Tynan Ph.D., ABPP
President Elect Delaware Psychological Association
Professor of Pediatrics, Sidney Kimmel Medical College
Thomas Jefferson University

Mental Health Education Coordinator
American Diabetes Association

UnitedHealthcare

UnitedHealthcare is grateful for the opportunity to provide comments on the Delaware Healthcare Affordability Standards published December 18, 2020. Based on our experience with affordability requirements in other states, and our national experience in the healthcare marketplace, we offer the following comments.

General comment

UnitedHealthcare is supportive of payment reform and the continued move toward alternative payment models. UnitedHealthcare also shares the belief that payment models must evolve to incorporate greater downside risk in order to fully leverage payment reform. We caution, however, that speed in moving toward these goals does not guarantee success, nor does imposing these additional regulatory requirements on all plans regardless of their membership in Delaware. One size does not fit all. For capitation arrangements to be successful a large volume of membership is needed. Also, health plans with smaller memberships bear a greater burden and are impacted to a greater extent by additional regulatory burdens and their attendant cost. The increased regulatory requirements and added cost of these requirements may stifle competition, resulting in some carriers leaving the fully insured market in Delaware.

One solution we strongly suggest is to impose affordability requirements on plans with larger memberships, as Rhode Island has done. Under 230 RICR 020-30-4, carriers must “employ delivery system reform and payment reform strategies to enhance cost effective utilization of appropriate services” if the plan has greater than ten thousand (10,000) covered lives under insurance plans issued in Rhode Island. The risk sharing contract requirements do not apply until a carrier has at least 10,000 attributable lives under a contract. Additional requirements must be met when 20,000 lives are reached, and again when 30,000 attributable lives are reached.

Affordability Standard #1

Increase primary care investment and expand alternative payment model adoption by PCPs, in order to support comprehensive care teams, provide care beyond the office walls and improve patients’ access to care management, care coordination and disease prevention services. The target is to have commercial health insurers increase investments in primary care by 1% to 1.5% of total cost of care (TCOC) each year until 2025.

Comment:

Primary care transformation requires the ability and willingness of providers to participate in any such efforts. UnitedHealthcare is supportive of investments in primary care but a plan should be developed that allows the program to be self-sustaining and not a separate revenue stream. Requiring commercial health insurers to increase investments in primary care, without a program to require additional accountability on the part of primary care providers, may increase costs without the expected results. For example, Rhode Island has tied investment in primary care to the establishment and sustainment of PCMH’s. This approach, along with clear accountability to primary care groups to proactively engage DE residents in primary care, should be a requirement.

Affordability Standard #2

Decrease unit price growth for certain services to offer regulatory guidance to support a better functioning market; allow for additional investment in primary care services; help reduce the impact of

that increased investment on TCOC. The proposal will achieve this by requiring that commercial health care insurers' contracts with healthcare providers limit aggregate unit price growth for non-professional services.

Comment:

United is supportive of the payment reform actions. Requiring that commercial health care insurers' contracts with healthcare providers limit aggregate unit price growth for non-professional services could limit the ability of carriers to be competitive. In order to address the disparity in hospital rates, disparity across payors should also be addressed. An alternative approach would be to take steps to level the playing field in terms of provider competition and thereby increase competition. The findings in the Health Care Affordability Standards Report specific to the increase in spend related to hospital services (thereby decreasing the primary care spend as a percentage of the overall total) illustrate the challenges commercial insurers face with large health system conglomerates that demand large rate increases to stay in-network. It is imperative that competition between commercial insurers as well as health systems be heightened in DE in order to ensure the checks and balances that DE residents deserve.

What is being proposed will also impact not only insured business but also self-insured business, due to systems constraints and the way in which provider contracts are structured. We recommend that large employers based in DE, that offer self-insured plans to their members, also be part of this conversation. These requirements will significantly impact the way in which the employers' health care dollars are spent and could impact the business climate in the state.

Affordability Standard #3

Expand Alternative Payment Model (APM) adoption. A minimum of 50% of TCOC will be tied to an APM contract that meets the HCP-LAN Category 3 definition by 2023, with a minimum of 25% of TCOC covered by an APM contract meeting the definition of Category 3B. Because TCOC accountability is not right for all PCPs, DE carriers will provide more ways for independent providers to participate in pay for performance programs to increase investment in high value services. Commercial health insurers will also explore new ways to implement capitated payments for PCPs and other services and report to the Office on the successes/lessons learned of those programs.

Comment:

UnitedHealthcare has and will continue to provide providers with incentive programs that include APMs. But while UnitedHealthcare is supportive of moving to APM, if providers are reluctant to do so we have limited opportunity to increase risk based agreements and new APMs that require provider support and collaboration. We agree risk sharing may be the next evolution in payment reform, but Insurers cannot force providers to enter into APMs. This is a concern on behalf of insurers and providers when the attributed population is not sufficient to support a total cost of care program, due to the fluctuation in data attributed to such low population. Actions should also be taken to address these issues with providers. What are the ramifications to providers for not entering into such agreements?

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