RESPONSE TO PUBLIC COMMENTS

The Delaware Department of Insurance Office of Value-Based Healthcare Delivery (the Office) appreciates the thoughtful and thorough comments submitted on its recent report, "**Delaware Health Care Affordability Standards: An Integrated Approach to Improve Access, Quality and Value**" (the Report).

The Office grouped and summarized the comments into subject areas and excerpted relevant quotes from certain comments where those excerpts helped inform the responses. A complete copy of each comment received can be found **here**. Following are the Office's responses to the summarized comments and quotes.

1 Comments related to 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 and on a per member per month basis

ALEDADE, an independent, physician-led accountable care organization (ACO) serving 65,000 Delawareans, reported that data it has collected since its inception support the notion that independent practices often lack financial reserves that would provide financial stability and enable investments in value-based care capabilities. Aledade opined that, "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."

HIGHMARK DELAWARE, a commercial health insurance carrier in Delaware, opined that the statement that, "primary care spending in Delaware is low relative to the national average and about half what is spent in leading states" 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 spending to total spending is skewed relative to actual PCP reimbursement." **HIGHMARK DELAWARE** believes that "the increase in PCP spend, when looked at solely through the lens of a percent of total cost-of-care, does not consider the high spending on inpatient and outpatient care [in Delaware]... Tying PCP spending to total healthcare spending in Delaware and characterizing PCP spend as "low" misrepresents historical PCP spend in Delaware."

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THE OFFICE agrees it is important to evaluate both primary care investment as per member per month (PMPM) amount and as a percentage of total cost of care.

Leveraging both of these views, the report noted, "Primary care spending in Delaware is low relative to the national average and about half of what is spent in leading states." As can be expected, this conclusion falls somewhere between the conclusions of the two commenters. That is because **THE OFFICE** leveraged data from a large variety of sources, including available databases, commercial health insurance carriers, national best practices and the work of the Primary Care Reform Collaborative (PCRC) to present a clear eyed, data-driven review of Delaware's existing healthcare landscape.

Additionally, the conclusions set forth in the Report are derived from stakeholder input and from data on healthcare costs and utilization that **THE OFFICE** collected from two principle sources: 1) a questionnaire specifically designed by **THE OFFICE** to generate the data needed to inform its work and completed by the Delaware health insurance carriers, and 2) data requests from the Delaware Health Information Network Health Care Claims Database (DHIN HCCD), the state All-Payer Claims Database.

The conclusion concerning low primary care spending in Delaware is also supported by work conducted by the national Primary Care Collaborative (PCC), which found primary care spending at 4.4% in Delaware in 2019, compared to an average of 4.8% nationally. Note that the PCC did not include non-claims spending in its calculation, without non-claims spending the national percentage was skewed downward, making it appear as though states with minimal non-claims investment, including Delaware, were closer to the national average than if all spending was included for all states.

Not only did **THE OFFICE** conclude that primary care spending is comparatively low, but it also found that primary care spending as a percentage of total cost of care was also low. This conclusion is also supported from a peer-reviewed perspective. Delaware commercial carriers spent approximately 4.5% of total cost of care on primary care services, which equates to $22 PMPM. Models developed in other states and one published in a peer reviewed journal find investment of $45 or more is necessary to support expanded care teams and other features typically included in leading models of comprehensive primary care delivery.

2 Comment related to Finding 1(c). Prices for physician and other professional services, including primary care services, have increased an average 0.5% a year in recent years compared to an average of 3% to 4% a year for hospital services.

HIGHMARK DELAWARE indicated that for period 2016 to 2019, Delaware PCP spend on a PMPM basis grew more than the aggregate professional spend noted in the Report.

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THE OFFICE notes that it is important to reiterate that Finding 1(c) is focused on increases in prices and not on total spend (which would also include changes in utilization).

3 Comments related to 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 in health insurance premiums.

HIGHMARK DELAWARE commented that "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," further stating that ". . . increased PCP spend, without any consideration for total cost-of-care, would increase premiums and out of pocket costs for Delawareans and employers."

HIGHMARK DELAWARE emphasized that payers have the obligation to encourage professional providers, including PCPs, to manage the total cost-of-care and the quality of care through quantifiable and measurable outcomes. They opined that the way to avoid having consumers and employers bear the additional costs of further increases in reimbursement would be to ensure accountability to lower total cost-of-care while increasing quality of care. Any framework for healthcare spending should be reviewed against the quadruple aim in healthcare, which grounds healthcare decisions with the expectation of high-quality outcomes, affordability, and clinician and patient experience.

ALEDADE noted that "strong investment in primary care combined with the financial alignment of ACOs creates the greatest opportunity to both expand access and reduce total health care costs for Delawareans. . . . Primary care investment coupled with total cost of care accountability create the greatest alignment with value. . . . We support the inclusion of both targets. We encourage the Office to do what they can this year to pull the 2022 target for primary care 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."

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THE OFFICE appreciates Highmark's cautionary comment concerning potential upward impacts of payment reform on premiums but maintains its position that if all three affordability standards are implemented simultaneously, the impact on premiums should be neutral. **THE OFFICE** agrees that primary care investment in Delaware must increase, with a commensurate decrease in other health care spending, to ensure long term stability of the health care market in Delaware.

THE OFFICE notes that the Affordability Standards were developed to work together to increase primary care spending without increasing growth in total cost of care. **THE OFFICE'S** modeling finds that reductions in unit prices for non-professional services will fund a significant portion of the increased investment, as outlined in Affordability Standard 2. As the commenters point out, the unit price reductions must be combined with moderate decreases in utilization growth, which can be achieved through expanded access to primary care and the incentives provided by total cost of care accountability. Targets for achieving increased total cost of care accountability are outlined in Affordability Standard 3.

Achieving these shared goals simultaneously will require deeper collaboration among carriers and providers. **THE OFFICE** recognizes that most Delaware commercial health insurance carriers have care transformation and alternative payment model programs in place in Delaware and/or other markets. **THE OFFICE** expects carriers will utilize these programs as a guide and adjust them as necessary as they collaborate with providers and multi-stakeholder bodies such as the Primary Care Reform Collaborative to expand enhanced primary care in Delaware. **THE OFFICE** looks forward to facilitating ongoing discussions among stakeholders to help ensure that meaningful progress is achieved.

4 Comments related to Finding 3. Delaware's health systems and health insurance carriers have strong market power

Several commenters expressed concern regarding the impact of Delaware's highly concentrated health insurance carrier and healthcare provider markets.

HIGHMARK DELAWARE wrote that it, "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."

UNITEDHEALTHCARE wrote, "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 Delaware in order to ensure the checks and balances that Delaware residents deserve."

UNITEDHEALTHCARE further noted that, "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."

ALEDADE wrote, "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." They also commented that concierge models "have swept through the state in recent years," which has led to reduced primary care access.

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THE OFFICE agrees that markets require effective competition as well as innovative, collaborative partnerships. **THE OFFICE'S** work in 2021 will include a deeper review of health insurance carrier and healthcare provider market concentration in Delaware. The Department welcomes the opportunity to discuss with interested carriers any opportunities concerning entry/reentry into Delaware's health insurance marketplace and appreciates the comments from its existing carriers regarding opportunities for partnering in new ways and continuing to work collaboratively.

THE OFFICE understands the contract negotiation challenges faced by both physician groups and by carriers in achieving mutually agreeable terms with large health systems and looks forward to helping implement new and creative care delivery models that will hopefully lessen some of these pressures.

5 Comments related to Affordability Standard 1 – Increase Primary Care Investment

HIGHMARK DELAWARE commented that the provisional target of 1% to 1.5% of total cost-of-care each year until 2025 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 went on to comment that it 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 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."

ALEDALE commented that, "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."

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THE OFFICE appreciates the commenters' support of its position that spending on primary care must increase without increasing the total cost of care. **THE OFFICE** appreciates the commenters offering approaches to making this goal a reality and encourages all stakeholders to identify new and innovative ways to address healthcare payment reform.

6 Comments related to integrating behavioral health into primary care teams.

W. DOUGLAS TYNAN PH.D., ABPP, President Elect of the Delaware Psychological Association, Professor of Pediatrics at Sidney Kimmel Medical College at Thomas Jefferson University and Mental Health Education Coordinator for the American Diabetes Association, discussed the importance of integrating behavioral health into primary care. Dr. Tynan noted the need to add mental health professionals onto primary care teams and articulated his support for including these providers in a comprehensive primary care payment model. He also discussed the need to ensure appropriate training for mental health professionals transitioning to this model of care delivery from a traditional behavioral health counseling framework. He pointed out that, ". . . clear funding for all mental health professions, coupled with training in integrated care, and including mental health in determining quality and outcome goals" could help Delaware achieve the goals established in Report.

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THE OFFICE also agrees that the increased investment should support the standard components of comprehensive primary care including:

- Expanded care teams with access to behavioral health support, care management, patient navigation, and other services to address patients' physical, behavioral and social needs
- Access to care beyond the medical office through phone, text, email, virtual visits, and community-based services
- Increased health information technology infrastructure and data analytical capabilities
- New opportunities to build leadership and teaming skills

THE OFFICE fully supports integration of behavioral healthcare into primary care. The literature finds this integration results in improvements in patient access and outcomes, as well as reductions in the total cost of care for patients with behavioral health conditions. Expanding access to behavioral healthcare, an essential benefit under the Affordable Care Act, also aligns well with State priorities. As an example, Delaware is focused on working across the State and across stakeholders to address the crisis of substance use disorders including opioid addiction. Additionally, this focus on mental and behavioral health comes at a critical time as the isolation, worry and economic challenges of the COVID-19 pandemic drive increases in rates of depression and anxiety. **THE OFFICE** looks forward to continuing to work with the State's providers and payers to ensure Delawareans receive appropriate access to behavioral healthcare.

7 Comments related to the need for increased healthcare access and affordability for underserved communities

CAMP REHOBOTH, a nonprofit community service organization dedicated to creating a positive environment inclusive of all sexual orientations and gender identities in Rehoboth Beach and its related communities, appreciated the candor with which the Office analyzed the status of primary care in Delaware and the integrated approaches the Office proposes to help address this critical problem.

CAMP Rehoboth noted that access to healthcare has proven to be an insurmountable challenge to some members of the LGBTQ community in the form of systemic bias and lack of affordability, particularly to transgender and nonbinary people. CAMP Rehoboth encouraged 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.

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THE OFFICE appreciates the comment and is committed to improving healthcare access and affordability to all Delawareans. **THE OFFICE** looks forward to proactively engaging with CAMP Rehoboth and other community organizations as it proceeds with this important work.

8 Comments related to Affordability Standard 2 - Decrease unit price growth for certain services by requiring that commercial health care insurers' contracts with healthcare providers limit aggregate unit price growth for non-professional services.

UNITEDHEALTHCARE commented that, "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."

HIGHMARK DELAWARE offered its support of Standard #2 generally, but articulated 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 the 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."

HIGHMARK DELAWARE also opined that 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.

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THE OFFICE appreciates that it does not have the authority to interfere in individual payer/provider contract negotiations. However, to the extent that **THE OFFICE** establishes certain requirements, **THE OFFICE** expects that those requirements be implemented. "No progress" will not be an acceptable outcome. Meaningful progress with measurable outcomes must be the end result under the statutory mandate of **THE OFFICE**.

THE OFFICE looks forward to facilitating ongoing discussions among stakeholders, as needed, to help ensure that meaningful progress is achieved.

THE OFFICE will be releasing a Bulletin to provide more details on integration of the affordability standards into the rate review process and will meet with carriers to discuss upon request. **THE OFFICE** expects that achieving the targets will require ongoing, meaningful conversations among carriers, providers, purchasers and as needed, DOI.

9 Comments related to Affordability Standard 3 - Expand Alternative Payment Model (APM) Adoption

UNITEDHEALTHCARE commented that it "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."

UNITEDHEALTHCARE also wrote, "Insurers cannot force providers to enter into APMs" and questioned whether payment reform should include ramifications to providers for not entering into risk-based agreements.

UNITEDHEALTHCARE further suggested that for capitation arrangements to be successful, a large volume of membership is needed. It suggested that Delaware implement the graduated model adopted by Rhode Island in which "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. 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." See 230 RICR 020-30-4.

HIGHMARK DELAWARE offered its support of the third affordability standard, stating that, "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."

HIGHMARK DELAWARE commented that 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.

ALEDALE suggested that the Office should not be prescriptive about what form that the alternative payment models take, opining that, "The simplicity of total cost of care accountability is paramount - complex value programs can hamper adoption. . . ."

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THE OFFICE agrees that "one size" or one alternative payment model does not work for all health insurance carriers or all healthcare providers and that speed does not equate to success. However, the Office is mindful of its statutory mandate to move forward, and that commercial health insurance carriers in Delaware are required to comply with the Delaware Insurance Code.

THE OFFICE notes that Affordability Standard 3 includes layers of targets. It developed these layers of targets to reflect the varying needs of different provider organizations.

- A minimum of 50% of total cost of care will be tied to an alternative payment model contract that meets the HCP-LAN Category 3 definition by 2023, with a minimum of 25% of total cost of care covered by an alternative payment model contract that meets the definition of Category 3B.
- More opportunities for independent providers to participate in pay for performance programs to increase investment in high value services.
- Pilot and implement capitated payments for primary care and other services and report to the Office on the successes and lessons learned of those programs.

10 Comments related to coordination with other payer types and payment programs

ALEDADE commented that, "Total cost of care models like the Medicare Shared Savings Program have outperformed all other APMs" and that, "As the Office seeks to require primary care investment, it is crucial to also target commercial and Medicaid growth in alternative payment models."

UNITEDHEALTHCARE opined that, "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."

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THE OFFICE agrees that the most benefit can be achieved when health insurers and health plan administrators (third party administrators or TPAs) coordinate payment mechanisms to ensure collaboration and continuity. That said, the Office's jurisdiction is limited under the Insurance Code to health insurance carriers and plans operating in the fully insured space.

Nevertheless, **THE OFFICE** encourages Delaware health insurers to move swiftly to educate their self-insured clients about the opportunities of value-based payment and work diligently to expand their programs from the fully insured market to self-insured clients. This will allow all patients and employers with all types of commercial coverage to benefit from the improvements in quality and value that can come from well-designed alternative payment models. Further, alternative payment models promote greater alignment of financial incentives across providers' patient panels.

Additionally, **THE OFFICE** is committed to cultivating its collaboration with the Department of Health and Social Services and its Division of Medicaid and Medical Assistance on alternative payment models, and to continuing to work closely with the PCRC to reach all members of the healthcare community.

11 Comments related to the role of hospital-owned accountable care organizations (ACOs) in reducing avoidable utilization, particularly when the utilization is not occurring at their own facilities.

DR. ROBERT MONTELEONE, MD Medical Director, Delaware Care Collaboration, wrote, "There is a section [in the Report] 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. . . . Some hospital ACOs cover service areas well beyond the catchment area for a specific hospital. . . . Hospital-led ACOs have a greater capacity to reduce skilled-nursing facility costs and length of stay as hospitals have greater influence to refer patients to skilled nursing facilities (SNFs) with higher quality and lower costs due to the number of skilled nursing facility referrals that come from hospitals."

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THE OFFICE notes that nationally, results on the Medicare Shared Savings Program (MSSP) consistently find physician-led or low-revenue ACOs tend to perform better than hospital-led or high-revenue ACOs. Similarly, in Delaware, all the ACOs that produced savings were low-revenue ACOs in 2018 and 2019, the most recent years available.

THE OFFICE appreciates that Delaware Care Collaboration (DCC) has had success in reducing its number of skilled nursing facility days. It looks forward to learning more about how DCC has achieved these improvements.

THE OFFICE agrees that all ACOs have the ability to address avoidable utilization and costs. **THE OFFICE** supports an expansion of total cost of care accountability contracts that offer providers the aligned financial incentives necessary to support this important work.