



ANNUAL REVIEW OF CARRIER PROGRESS TOWARDS MEETING AFFORDABILITY STANDARDS



DECEMBER 6, 2021

OFFICE OF VALUE-BASED
HEALTH CARE DELIVERY
DELAWARE DEPARTMENT
OF INSURANCE



Fellow Delawareans -

Effective primary care – including timely and convenient preventive care, chronic condition management, and behavioral health services – is key to improving the quality of healthcare you receive and slowing the growth of related expenses over time.

This year, we worked with the Delaware General Assembly to pass SS 1 for SB 120, a new law that recognizes the benefits of effective primary care and aims to make it more accessible for you. The law now requires commercial health insurance companies to make meaningful increases in primary care investment, limit price increases for hospital and other non-professional services, and improve healthcare value. Many of its concepts were included in our [Office of Value Based Health Care Delivery's inaugural report](#). By implementing the reforms simultaneously, models show that the increases in primary care investment do not result in unsustainable increases in total healthcare costs.

Refocusing Delaware's healthcare system on primary care and improving value requires commitment and collaboration of primary care providers and their care teams, hospitals and health systems, commercial health insurance companies, employers, and even patients like you.

So, where do we begin? We begin here, with this report. The following pages outline where we are now – the baseline we will use to measure our future growth. This data not only reinforces the need for our new law, it shows that there are opportunities for meaningful progress that will improve the physical, mental, and financial health of Delawareans. Moving forward, our Delaware Department of Insurance and its Office of Value-Based Health Care Delivery will develop regulations, measure progress, and provide technical assistance, enforcing the law when necessary.

Commercial health insurance companies will need to begin meeting the requirements of the legislation when they file rates for the 2023 plan year, a process that occurs in 2022. They are working to design programs, adjust agreements with providers and create the framework necessary for success. Healthcare providers have a shared responsibility to fulfill the requirements of the statute. They have frequently communicated a shared interest in improving value and their partnership in this effort is needed in order for it to succeed. Delaware's hospitals and healthcare systems have benefited from significant price increases each year and tend to report strong profitability. While COVID-19 has been challenging, hospitals and health systems have received significant state and federal relief.

In implementing SS 1 for SB 120, we must remember the following:

1) Primary care investment does not, in and of itself, transform primary care.

We look forward to collaborating with the Delaware Health Care Commission and the Primary Care Reform Collaborative as they collaborate with stakeholders to develop the Delaware Primary Care Model, which will provide a roadmap for primary care delivery transformation.

2) Increased primary care investment is unlikely to pay for itself, at least not in the short-term.

SS 1 for SB 120 recognizes this and offsets the increased investment in primary care through savings from limits on price growth for hospital and other non-professional services. In Delaware, prices for hospital services have long outpaced those for physician and other professional services. SS 1 for SB 120 begins to correct this inequity. In the long term, as primary care accessibility grows, the health of Delawareans like you will improve with it, reducing the need for expensive emergency care.

3) Without shared accountability for total cost of care, there is no financial incentive for healthcare provider organizations—particularly those reliant on expensive tests, emergency department visits and hospitalizations—to make the necessary investments in primary care to achieve true care transformation.

With meaningful accountability for total cost, the value of primary care shifts from profit-focused to person-focused by decreasing spending on low-value things, like unnecessary and expensive diagnostic tests. This creates the business case for reducing avoidable utilization of expensive hospital services. We now require commercial health insurance companies to work with healthcare providers to ensure their contracts include meaningful, shared accountability for total cost of care.

Nationally, at least 16 states are working to increase primary care investment and transform primary care delivery. With the passage SS 1 for SB 120, Delaware becomes a leader among them. Working together, we can ensure all Delawareans have access to the high-quality and affordable healthcare they deserve.

Sincerely yours,



TRINIDAD NAVARRO

Delaware Insurance Commissioner



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INTRODUCTION

In late 2020, following intensive stakeholder outreach, an extensive review of data on utilization, cost and access, and a comprehensive literature review and research concerning actions taken by other states, the Delaware Department of Insurance’s (DOI) Office of Value-Based Health Care Delivery (the Office) released, [“Delaware Health Care Affordability Standards: An Integrated Approach to Improve Access, Quality and Value”](#) (the 2020 Report). In the 2020 Report, the Office recommended three Affordability Standards that are designed to work together to create a higher value, more affordable healthcare payment system in Delaware’s commercial health insurance market. When implemented together, the result will be a system that invests in primary care, reins in price growth, and moves a greater portion of the healthcare dollar to meaningful, value-based payment arrangements.

THE THREE STANDARDS ARE



Increase Primary Care Investment



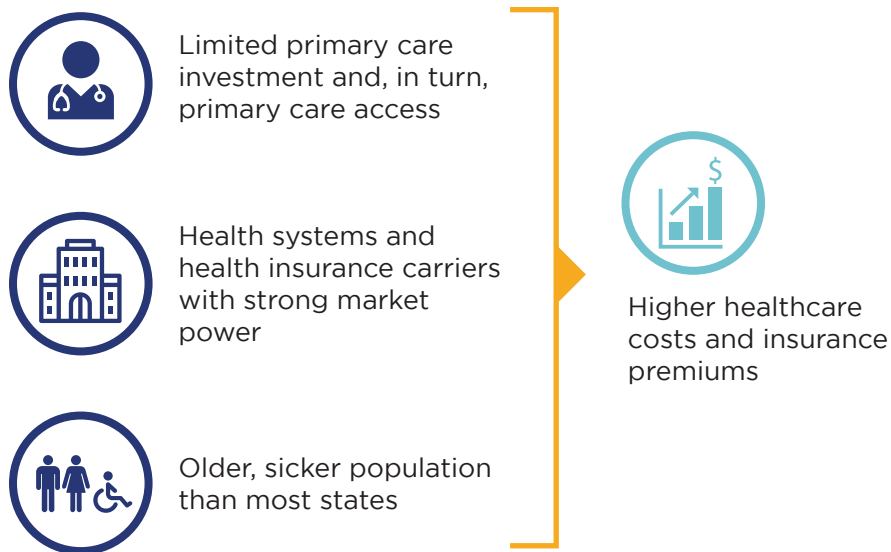
Decrease Unit Price Growth for Certain Services



Expand Alternative Payment Model Adoption

¹ Re-issued Office of Value Based Health Care Delivery (OVBHCD). (2021, February 15).

These Affordability Standards aim to address three challenging forces, all of which are contributing to high health care costs, and as a result, higher health insurance premiums for Delaware’s employers and residents.



Following the release of the 2020 Report, Delaware’s General Assembly passed legislation to require Delaware health insurance carriers achieve the Affordability Standards. This legislation, [SS 1 for SB 120](#), was signed into law in October 2021².

This report is largely based on a template Delaware carriers completed in 2020 and 2021. Carriers submit the template to the Office as part of the carriers’ rate filings. The template also collects data on primary care investment, price trends, utilization trends, and alternative payment model arrangements. It includes information on claims and non-claims spending. In 2020, the purpose of collecting the information using this template was to better understand carriers’ current spending. Beginning in 2021, the purpose shifted to tracking carrier progress toward meeting the Affordability Standards. A copy of a blank template including specifications for completion can be found on the [Office’s website](#).

Data collected by the Office using the template indicate that Delaware health insurance carriers made little progress toward achieving the recommendations included in the Office’s Affordability Standards report. This lack of progress is unsurprising for two reasons: the report’s recommendations were not released until the end of 2020 when providers and payers were still in the midst of the COVID-19 pandemic, and carriers had already finalized rates for 2021. It is also noteworthy that at the time the data were collected, carrier compliance with the Affordability Standards was voluntary.

² Delaware General Assembly. (2021). *Senate Substitute 1 for Senate Bill 120*.

Nevertheless:

1. Primary care investment did not increase as a percent of total cost of care in 2020 and carriers did not expect it to increase in 2021 or 2022.
2. Prices for inpatient and outpatient hospital services increased at a faster rate than in previous years and were expected to continue to increase at this pace in 2021 and 2022.
3. Carriers expanded adoption of alternative payment models, tying a greater percentage of their contracts with providers to value. However, the actual dollars being paid to providers through these models remained minimal, around 1% of total cost of care.

Under newly enacted SS 1 for SB 120, carriers are now required to achieve the Affordability Standards beginning with rate filings submitted in July 2022 for plan year 2023.

To determine the feasibility of achieving these standards, the Office modeled a “what if” scenario based on the requirements of SS 1 for SB 120. Using data provided by the carriers in July 2021, the Office found commercial health insurance carriers could increase primary care investment more than 56% in 2022 to more than \$35 per member, per month, or nearly 7% of total medical expense without increasing growth in total cost of care if they had been subject to the bill’s instruction to limit price growth for non-professional services to Core CPI +1%.

DOI and the Office are in the process of developing regulations to support enforcement of those standards. More information on the carriers’ most recent results, the requirements included in SS 1 for SB 120 and the regulations development process are included in this report. Links to additional reports and bulletins prepared by the Office on primary care investment in Delaware can be found below³:

- 1 [Delaware Primary Care Reimbursement: Evaluating Parity with Medicare Rates](#), discusses findings on carrier compliance with statutory requirements to reimburse at least as much as Medicare for primary care and care management services and provides an analysis of commercial primary care spending reimbursement rates in Delaware.
- 2 [Investment in Comprehensive Primary Care: Unlocking the Savings in Delaware](#), outlines the potential impact on healthcare delivery and cost when increased primary care investment funds high value primary care capabilities.
- 3 [Domestic and Foreign Insurers Bulletin 125](#), informs health care carriers that the Governor signed SS 1 for SB 120 and provides guidance on how to begin planning for implementation.

³ Office of Value-Based Health Care Delivery (OVBHCD). (2021, May 11).; Office of Value-Based Health Care Delivery (OVBHCD). (2021, September 09)..



AFFORDABILITY STANDARD 1: INCREASE PRIMARY CARE INVESTMENT

RECOMMENDATION FROM 2020 REPORT:

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.

SS 1 FOR SB 120 REQUIREMENT:

Increase primary care investment to 7% of total medical expense in 2022, and according to a defined schedule thereafter.

**In 2019 investment in primary care was 4.5% of total medical expense without pharmacy.*

Primary Care Investment Analysis

Delaware commercial health insurance carriers' investment in primary care remained about half of that in leading states in 2020, showing no improvement over previous years⁴. Delaware commercial carriers spent approximately 4.6% of total medical expense, excluding retail pharmacy costs, on primary care services in 2020 as shown in Figure 1. This equals approximately \$21 per member, per month, consistent with data reported for 2018 and 2019.

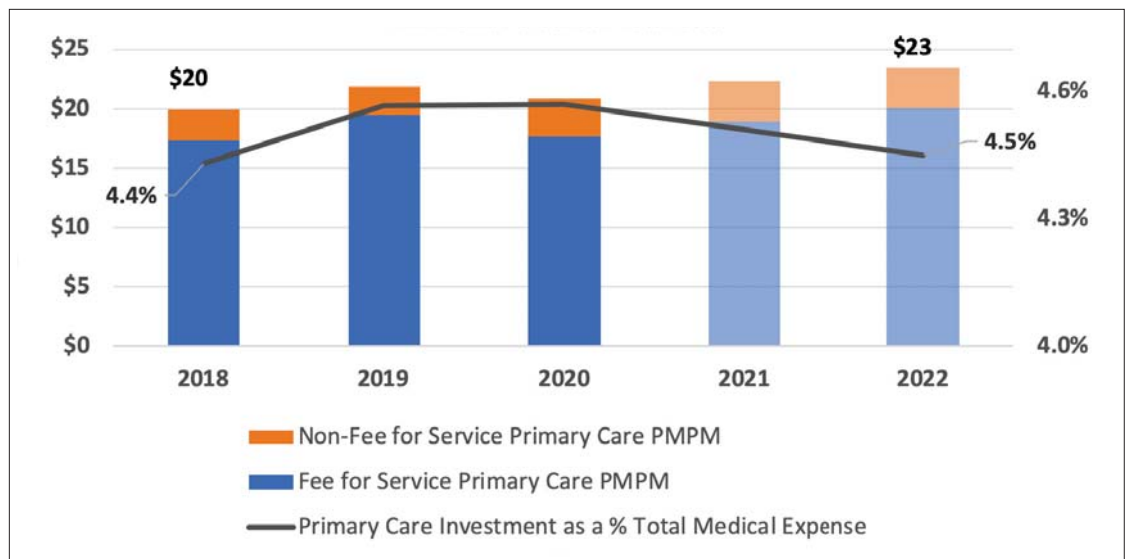
⁴ Office of Value-Based Health Care Delivery Questionnaire (2020).

Although per member, per month primary care spending fell slightly in 2020, total medical expense also declined as providers temporarily shut down routine services during the initial months of the COVID-19 pandemic. As a result, primary care spending as a percent of total cost of care did not change. The lack of progress was not surprising given patients' limited access to routine and elective care during the COVID-19 pandemic. Nationally, [total health spending](#), including pharmacy, was 1.5% lower for the 12 months ending December 2020 compared to the same period in 2019⁵. In Delaware, the drop was steeper. Total medical expense declined 4.8%, excluding pharmacy. Sharp drops in utilization of outpatient services and physician services led the decline nationally and in Delaware.

Notwithstanding the primary care spending decline just discussed, primary care and other providers' revenue were buoyed by Delaware emergency orders and other policies that increased telehealth access. These policies, enacted early in the pandemic, were later solidified through passage of [HB 160, the Telehealth Access Preservation and Modernization Act of 2021](#)⁶. This bill was signed into law in June 2021, and allows for the use of telemedicine services by residents even without an initial in-person visit and allows appointments to occur through the use of audio-only technologies, see also DOI's [telehealth bulletin](#). Relief provided to hospitals and health systems is discussed on [page 20](#).

**FIGURE 1:
Primary Care
Investment in
Delaware, 2018-2022
(Projected): PMPM and
Percent of Total Cost**

Source: Delaware carrier template submissions to the Office. Data reflects commercial fully insured and State Group Health Plan.



*Columns with a transparent color represent projections.

The Office cross checked its analysis of fully-insured and State Group Health Plan template submissions with data reported by the carriers to the [Delaware Health Information Network \(DHIN\) Health Care Claims Database](#)⁷ and found that its analysis aligns with the DHIN data. Figure 2 below shows nearly identical rates of primary care spending as a percent of total medical expense, excluding pharmacy costs, for commercial plans when non-claims payments are excluded. The DHIN data set

⁵ Cox, C., Amin, K., & Kamal, R. (2021, March 22).

⁶ Delaware General Assembly. (2021). *House Bill 160*.

⁷ Delaware Health Information Network (DHIN). *DHIN HCCD Analytics Portal*.

does not include non-claims payments. Therefore, the Office also calculated payments excluding non-claims payments for comparison to DHIN. The DHIN data set also provides insight into primary care investment of other payer types as shown in Figure 2.

**FIGURE 2:
Primary Care
Spending as a
Percentage of
Total Cost of Care**

OVBHCD		DHIN			
2020					2019
Commercial including non-claims payments	Commercial excluding non-claims payments	Commercial excluding non-claims payments	Medicaid	Medicare Advantage	Medicare FFS
4.6%	3.9%	3.7%	6.3%	3.4%	4.3%

* Medicare fee-for-service data is provided for 2019 as it is the most current data DHIN has received for this population.

The difference between Medicaid and other DHIN-reported payer categories is likely, in large part, due to the age mix of the population. Children tend to have higher primary care spending and lower total cost of care than other age groups. Therefore, their primary care spending as a percent of total cost of care tends to be higher. Medicaid includes more children as a percent of its total population than other payer types. Also, Medicare tends to have a lower primary care investment percentage because the total cost of care is higher than other payers as Medicare enrollees tend to consume far more services due to their age and health status.

Statutory Requirement to Increase Primary Care Investment

In late 2020, the [Office recommended](#) Delaware commercial carriers increase primary care investment by 1% to 1.5% of total cost of care each year from 4.5% in 2020⁸. The Office based the recommendation on research showing Delaware had:

- Low primary care investment compared to leading states
- Low reimbursement for primary care and other professional services compared to providers nationally and compared to hospital services
- A shrinking and aging primary care workforce
- Limited investment in flexible primary care payments to support care management and other high value services

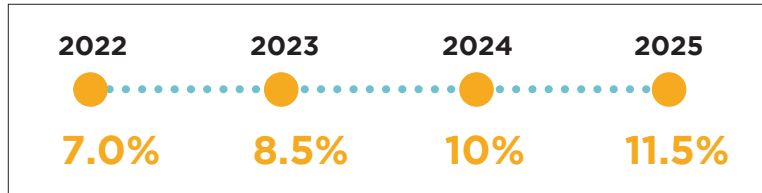
Building on that recommendation, [SS 1 for SB 120](#) now requires that Delaware commercial carriers spend 7% of total medical expense, excluding pharmacy costs, on primary care as part of their 2022 rate filings and gradually increase that percentage according to the defined schedule shown on the following page, until reaching 11.5% as part of their 2025 rating filings⁹. The Office expects that investment of 7% total medical expense in 2022 will equal approximately \$40 PMPM, based on current projections.

⁸ Office of Value-Based Health Care Delivery (OVBHCD). (2021, February 15).

⁹ Delaware General Assembly. (2021). *Senate Substitute 1 for Senate Bill 120*.

SS 1 FOR SB 120 STATUTORY REQUIREMENT

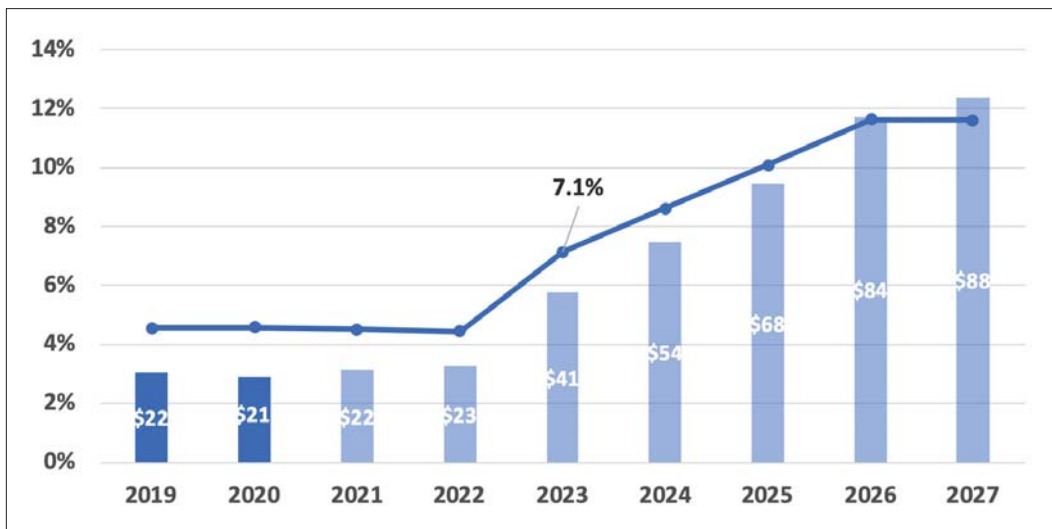
Commercial health insurance carriers will increase investments in primary care, as defined by the Office, according to the schedule below. Note the year below refers to the rate filing year. The increase will take effect the following year.



As shown in Figure 3, the Office estimates primary care investment would nearly double from 2022 to 2023 and then continue to gradually increase until reaching 11.5% or a projected \$84 per member, per month. The Office expects primary care investment will remain at these levels to support care delivery in future years.

FIGURE 3:
Impact of SS1 for SB 120 on Primary Care Investment in Delaware 2019-2027 (Projected): PMPM and Percent of Total Cost

Source: Delaware carrier template submissions to the Office. Data reflects commercial fully insured and State Group Health Plan.



*Columns with a transparent color represent projections.

Implementing Increased Primary Care Investment

SS 1 for SB 120 charges the Department with ensuring that commercial health insurance carriers increase primary care investment with the intent that increased primary care investment will foster more comprehensive primary care delivery and access, thereby resulting in less downstream spending on specialty and hospital care¹⁰. Therefore, in parallel, the law directs the Primary Care Reform Collaborative (PCRC) to develop a Delaware Primary Care Model that will increase participation in value-based models of primary care with quality and performance metrics and incent use of primary care services that are designed to reduce health disparities and address social determinants of health.

¹⁰ Delaware General Assembly. (2021). *Senate Substitute 1 for Senate Bill 120*.

The Department and the PCRC will continue to work closely together to ensure alignment of the care model with the investment requirements. In September 2021, the Office published [“Investment in Primary Care: Unlocking Savings in Delaware”](#) which used the latest research and data from the DHIN to estimate the impact of comprehensive, high-quality primary care on health care costs and utilization¹¹. The Office’s report leveraged primary care capabilities identified by the PCRC as foundational components of advanced primary care in Delaware.

POTENTIAL PRIMARY CARE CONCEPT MODEL FEATURES PROPOSED BY PRIMARY CARE REFORM COLLABORATIVE IN 2020¹²

The features proposed by the PCRC in 2020 include:

- Team-based care
- Prompt access to care
- Planned care at every visit
- Patient empanelment, including risk stratification
- Active use of data
- Integration of primary health care with behavioral health and social services
- Effective management of tests and specialists referrals

As Delaware refines its vision for primary care delivery, the Office anticipates working with the PCRC to determine whether the features identified in 2020 remain relevant and whether additional features should be added.

DEFINING PRIMARY CARE

The Office’s current definition of primary care investment was developed with the input of a technical subcommittee of the PCRC. It aligns well with the “narrow” definition described in the 2017 Milbank Memorial Fund report, [“Standardizing the Measurement of Commercial Health Plan Primary Care Spending¹³,”](#) which is largely a list of certain fee-for-service and provider taxonomy codes.

Delaware’s current definition of primary care investment also includes certain non-fee-for-service payments paid to primary care providers as incentive payments, capitated payments, or to deliver care management services. These non-fee-for-service categories are aligned with those captured by the [Delaware Health Care Spending Benchmark¹⁴](#). At the time of its development in 2019, the methodology reflected the prevailing models of primary care delivery in the Delaware.

However, as the expectations for care delivery and investment increase, the Office will need to evaluate how best to reflect those changes in its measurement strategy. For example, Delaware’s current primary care definition does not include services and expenses built into the PCRC’s vision for primary care transformation such as services related to integrated behavioral health or identifying and addressing social needs.

¹¹ Office of Value-Based Health Care Delivery (OVBHCD). (2021, September 09).

¹² Mercer. (Presented 2020, December 21).

¹³ Bailit, M., Friedberg, M., Huoy, M. (2017, July 25).

¹⁴ Delaware Health Care Commission. (2019).

With a growing acknowledgment that behavioral health integration should be a core capability of advanced primary care, states have begun discussions about expanding definitions of fee-for-service and non-fee-for-service payments for behavioral health services. Unfortunately, states have yet to coalesce around a consensus definition. That said, most states include assessment and screening services provided by primary care clinicians in the measurement of primary care. Oregon includes psychiatric-provided behavioral health services for children and adolescents.

The current definition also does not capture any costs to support health information technology, infrastructure development, or technical assistance to support care transformation activities. Colorado, Massachusetts, and Rhode Island include these expenses in their definitions.

ALIGNED WITH CARE DELIVERY GOALS

Currently [Colorado](#) and [Rhode Island](#) require health insurance carriers to meet specific primary care investment goals¹⁵. [Oregon](#) has had a target for several years and beginning in 2023 will require commercial carriers, state employee benefit plans, and Medicaid CCOs to spend 12% of the healthcare dollar on primary care¹⁶. These increased levels of investment are accompanied by specific care delivery goals such as integrating care for physical, behavioral and social needs. Providers are actively engaged in efforts to transform primary care delivery and earn additional payments by demonstrating progress toward a set of shared goals.

In consultation with stakeholders and informed by the PCRC model, the Office will determine whether Delaware primary care providers will need to offer specific, additional care delivery capabilities or meet other requirements to be eligible for increased investment.

Full technical specifications for the current Delaware primary care definition are provided on the [Office's website](#). More information on expected changes in care delivery is discussed in the Office's 2021 report, "[Investment in Comprehensive Primary Care: Unlocking the Savings in Delaware](#)."¹⁷

¹⁵ Colorado Primary Care Payment Reform Collaborative. (2020, December 15).; Office of the Insurance Commissioner (OHIC)- Rhode Island. (2019, December).

¹⁶ Oregon Health Authority. (2020, February).

¹⁷ Office of Value-Based Health Care Delivery (OVBHCD). (2021, September 09).

Office's Role in Supporting Implementation

- Collaborate with the PCRC to develop its Delaware Primary Care Model and to determine how to incorporate its priorities into the Office's measurement strategy
- Determine whether the Office's current definition of primary care needs to be refined to reflect changing care delivery expectations. For example, should the definition include:
 - > Behavioral health services provided in the primary care setting
 - > Primary care services provided at urgent care centers or through commercial telehealth vendors
 - > A portion of the carrier-provider risk settlement payments
 - > Dollars spent to support primary care providers in care delivery transformation such as money spent on technical assistance, infrastructure or health information technology
- Determine whether primary care providers will need to offer specific care delivery capabilities (e.g., expanded care teams, telemedicine, integrated behavioral health) or meet other requirements to be eligible for the full increased investment

Additional Market Context

NATIONAL PERSPECTIVE

At least a dozen states have announced a goal to increase primary care investment and have begun measurement efforts. Passage of SS 1 for SB 120 makes Delaware a leader among them. States' shared interest in increasing primary care investment is founded in evidence. Increased numbers of primary care providers are associated with improvements in health and decreases in mortality. Increased investment in primary care is also associated with lower rates of emergency department visits and hospital admissions¹⁸.

The [National Academies of Sciences, Engineering and Medicine](#) convened a consensus committee in January 2020 to develop recommendations for implementing high quality primary care¹⁹. Describing high-quality primary care as “the foundation of a robust health care system” and “an essential element for improving the health of the U.S. population,” they offered five recommendations:

1. Pay for primary care teams to care for people, not doctors to deliver services.
2. Ensure that high-quality primary care is available to every individual and family in every community.
3. Train primary care teams where people live and work.
4. Design information technology that serves the patient, family, and interprofessional care team.
5. Ensure that high-quality primary care is implemented in the United States.

¹⁸ National Academies of Sciences, Engineering, and Medicine (NASEM). (2021).

¹⁹ National Academies of Sciences, Engineering, and Medicine (NASEM). (2021).

²⁰ Maryland Department of Health. *Maryland Primary Care Program*.

²¹ Care Transformation Collaborative Rhode Island (CTC-RI). Rhode Island.

SUPPORTING THE TRANSITION

Supporting practices in successfully transitioning to advanced primary care including developing the capabilities identified by the PCRC will take time and resources. Recognizing this, states have deployed various approaches to offer hands on care team support and technical assistance. In Maryland, [Care Transformation Organizations](#) (CTOs) are entities that hire and manage interdisciplinary care management teams capable of providing a wide array of care coordination services²⁰. Providers pay the care transformation organization a percentage of their care management fees and delegate certain care management functions to the CTO.

In Rhode Island, the [Care Transformation Collaborative of Rhode Island](#) (CTC-RI) is a statewide, non-profit health improvement collaborative with a mission to lead primary care transformation in the state²¹. Health insurance carriers fund CTC-RI to provide technical assistance, convene stakeholders and help direct care transformation activities. Health insurance carriers can fulfill a portion of the primary care investment obligation through financial support of CTC-RI. More information on primary care transformation can be found on page 30.





AFFORDABILITY STANDARD 2: DECREASE UNIT PRICE GROWTH FOR CERTAIN SERVICES

RECOMMENDATION FROM 2020 REPORT:

Limit aggregate unit price growth for nonprofessional services to the greater of Core CPI + 1% or 3% for rates filed in 2022, 2.5% for rates filed in 2023 and 2% for rates filed in 2024, and 1.5% for rates filed in 2025.

SS 1 FOR SB 120 REQUIREMENT:

Limit aggregate unit price growth for nonprofessional services to the greater of Core CPI + 1% or 3% for rates filed in 2022, 2.5% for rates filed in 2023 and 2% for rates filed in 2024, 2025 and 2026.

Price and Utilization Analysis

PRICE

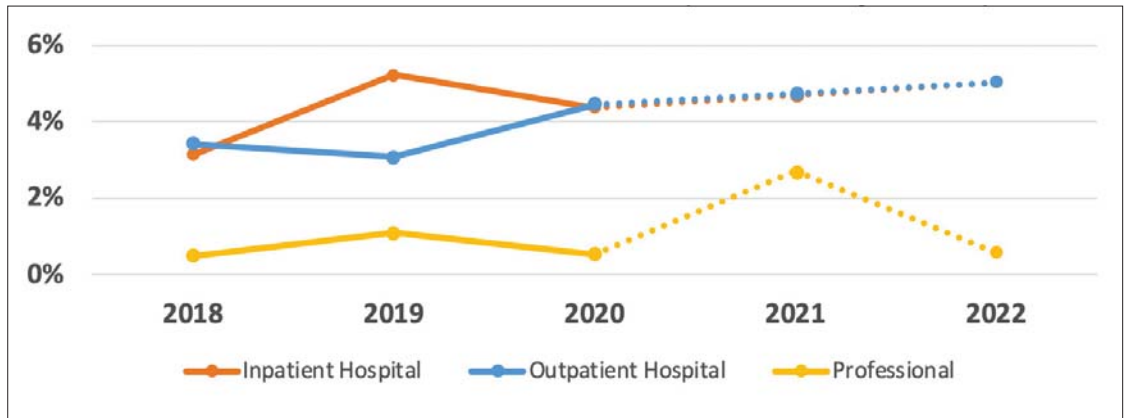
Since 2018, commercial prices for inpatient and outpatient hospital services in Delaware each increased an average of 3% to 5% per year, each year, according to the most recent data provided by the carriers, as shown in Figure 4. In their reports to the Office, carriers report price trends, defined as changes in their negotiated rates or fee schedules, and utilization trends. Utilization trends include the number of services provided as well as the impact of changes in mix of services, or when patients are using more intensive or costly services than in the past. Most recently, in 2020,

hospitals and health systems received average price increases of 4.4% for inpatient services and 4.5% for outpatient services. Meanwhile, commercial prices for physician and other professional services increased 0.5%. These trends were consistent with data reported by the carriers in 2021.

UTILIZATION

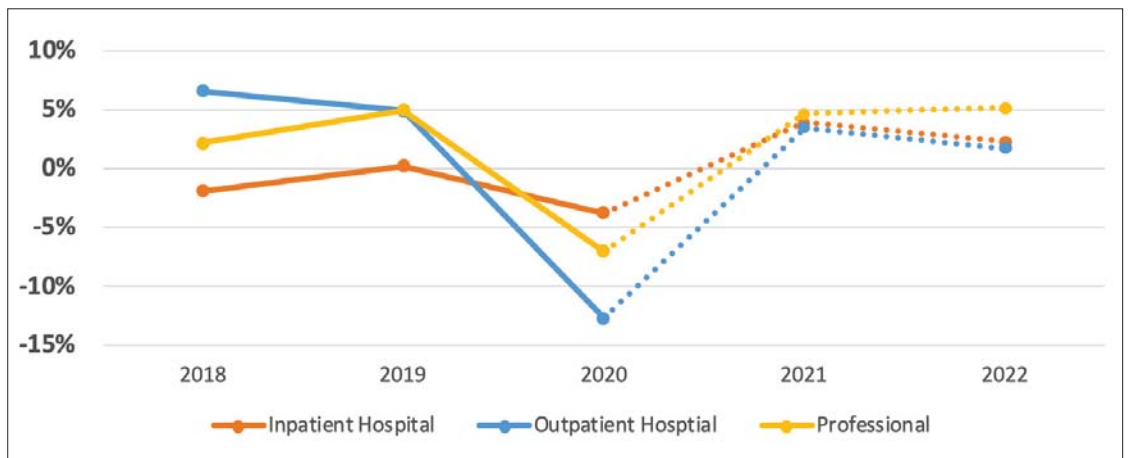
Due to the COVID-19 pandemic, Delaware hospitals showed a steep decline in utilization in 2020, which carriers expected would rebound in 2021. It is possible the rebound will not be as robust as expected due to variants.

**FIGURE 4:
Delaware Price
Trends 2018-2022
(Projected)**



**FIGURE 5:
Delaware
Utilization Trends
2018-2022
(Projected)**

Source: Delaware carrier template submissions to the Office. Data reflects commercial fully insured and State Group Health



*Dotted lines reflect projections.

Statutory Requirement to Limit Aggregate Unit Price Growth for Non-Professional Services

Data referenced on page 15 was submitted prior to the passage of SS 1 for SB 120. At that time, carriers indicated that they did not plan to limit price increases for inpatient or outpatient hospital services. However, beginning with rate filings submitted in 2022, SS 1 for SB 120 prohibits health insurance carriers from filing rates with price increases for non-professional services that exceed the schedule as shown below.

SS 1 FOR SB 120 STATUTORY REQUIREMENT

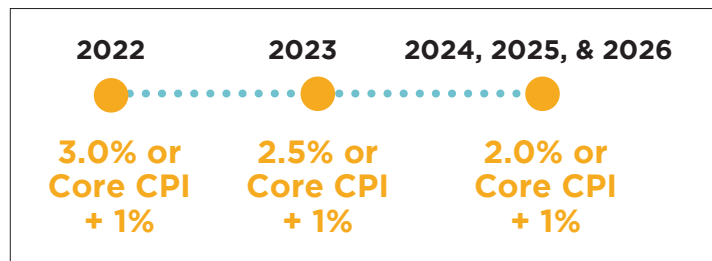
Through their contracts with healthcare providers, commercial health insurance carriers will limit aggregate unit price growth for non-professional services according to the schedule below. Non-professional services will be defined as those categorized as “Inpatient Hospital,” “Outpatient Hospital,” and “Other Medical Services” in the Unified Rate Review Template (URRT).

These categories do not include professional services.

The “Core CPI” is the Consumer Price Index for All Urban Consumers: All Items Less Food & Energy. Developed by the US Bureau of Labor Statistics, it is a widely used aggregate of prices paid by urban consumers for a typical basket of goods. It excludes food and energy because food and energy have very volatile prices.

Note: The years referenced below reflect the rate filing year. The limit will take effect the following year.

Statutory Requirements Will Be the Greater of the Following



Implementing Limits on Aggregate Unit Price Growth for Non-Professional Services

Similar to the primary care investment requirement, DOI will implement this component of SS 1 for SB 120. Payers already submit information on historical and prospective price increases to DOI and the Office annually via a template completed as part of the rate review process. The Office is currently meeting with stakeholders in preparation for creating necessary regulations and policies regarding enforcement.

MARKET POWER

Payers, employers and other stakeholders report Delaware hospitals' market power makes it difficult to effectively negotiate sustainable increases in prices across hospital services, resulting in fewer dollars available to pay physicians and higher health insurance costs for Delawareans. In its 2020 report, the Office substantiated this concern with data showing two of the state's six applicable hospitals controlled more than 82% of the discharges for their service area, another two controlled more than 40% and the last two controlled more than 20%.

SS 1 for SB 120 changes this dynamic by offering health insurance carriers more leverage to refuse to accept price increases in conflict with the statutory requirement since carriers will not be able to include those price increases in their rate filings. More than a decade ago, Rhode Island began limiting hospital price growth to Core CPI +1. In 2018, an analysis published in [Health Affairs](#) found the policy successfully decreased total healthcare spending more than 8% compared to a control group from 2007 to 2016²². Rhode Island commercial carriers reinvested a portion of the savings in primary care. Quality measure results improved or were unchanged.

Office's Role in Supporting Implementation

- Develop a methodology to support using Core CPI + 1% to establish a limit on price increases for hospital inpatient, hospital outpatient, and other medical services.
 - > Develop a lookback period for the Core CPI that creates stability and predictability
 - > Provide additional context on definitions for each service category based on the definitions in the Centers for Medicare and Medicaid Services [Unified Rate Review Template](#) and guidance in the statute.

²² Baum, A., et al. (2019, February).

²³ White, C. (2018).

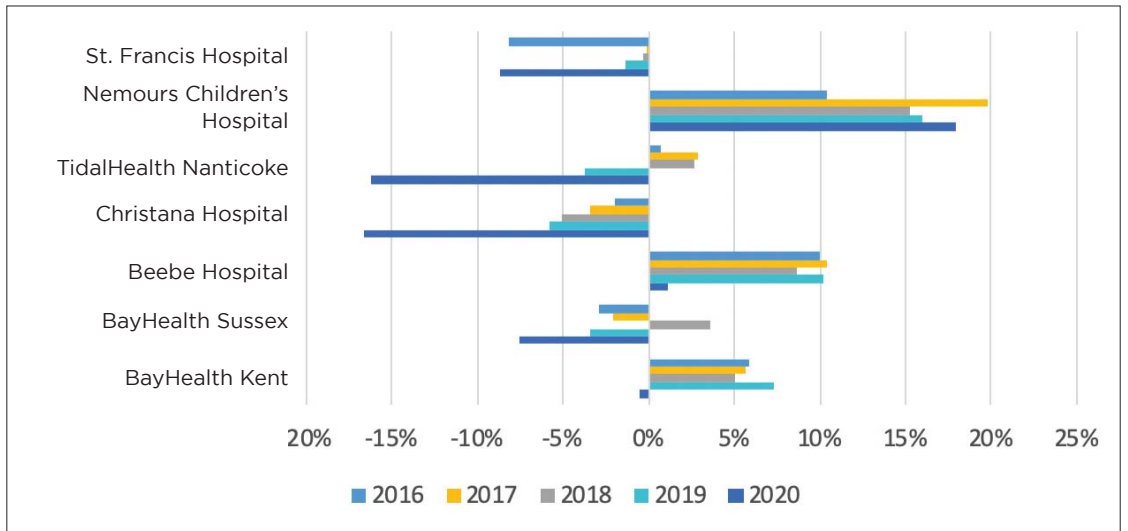


Additional Market Context

HOSPITAL FINANCES

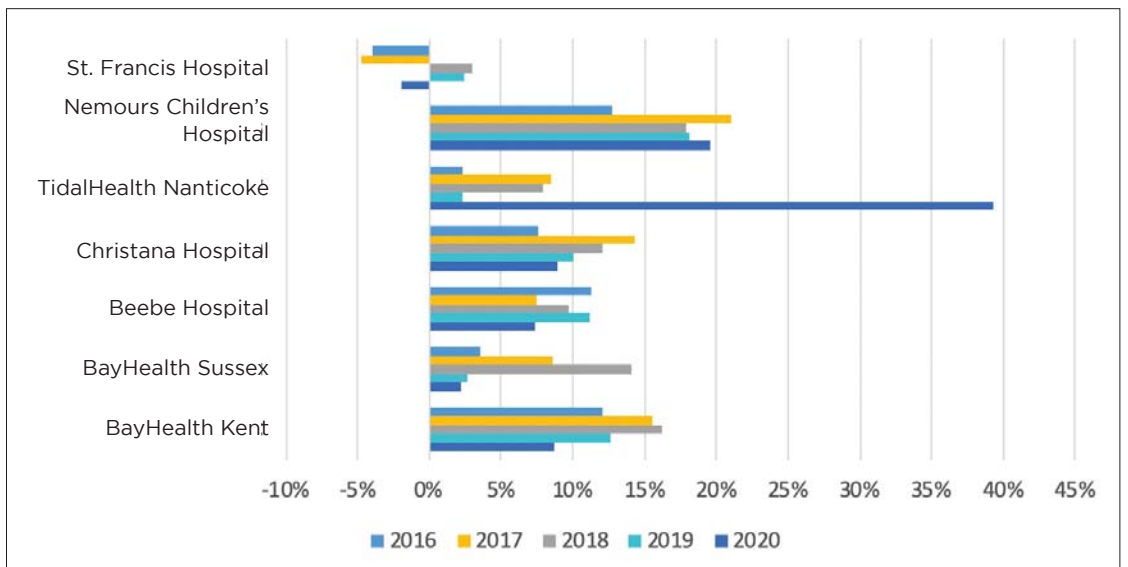
Due to the pandemic, hospitals showed a decline in revenues and net income from patient care in 2020. For 2020, five of Delaware's [seven hospitals reported](#) a negative margin when only revenues from patient care were included, as shown in Figure 6, which is based on the hospitals' CMS Medicare Cost Reports and compiled by the RAND Corporation²³.

FIGURE 6:
Operating Margins
Including Only
Patient Care
Revenue



However, [when all revenues were included](#), all hospitals except St. Francis Hospital in Wilmington reported positive results for the year, as shown in Figure 7²⁴. St. Francis was the only hospital to have any losses in the past five years.

FIGURE 7:
Total Margin
Including All
Revenue

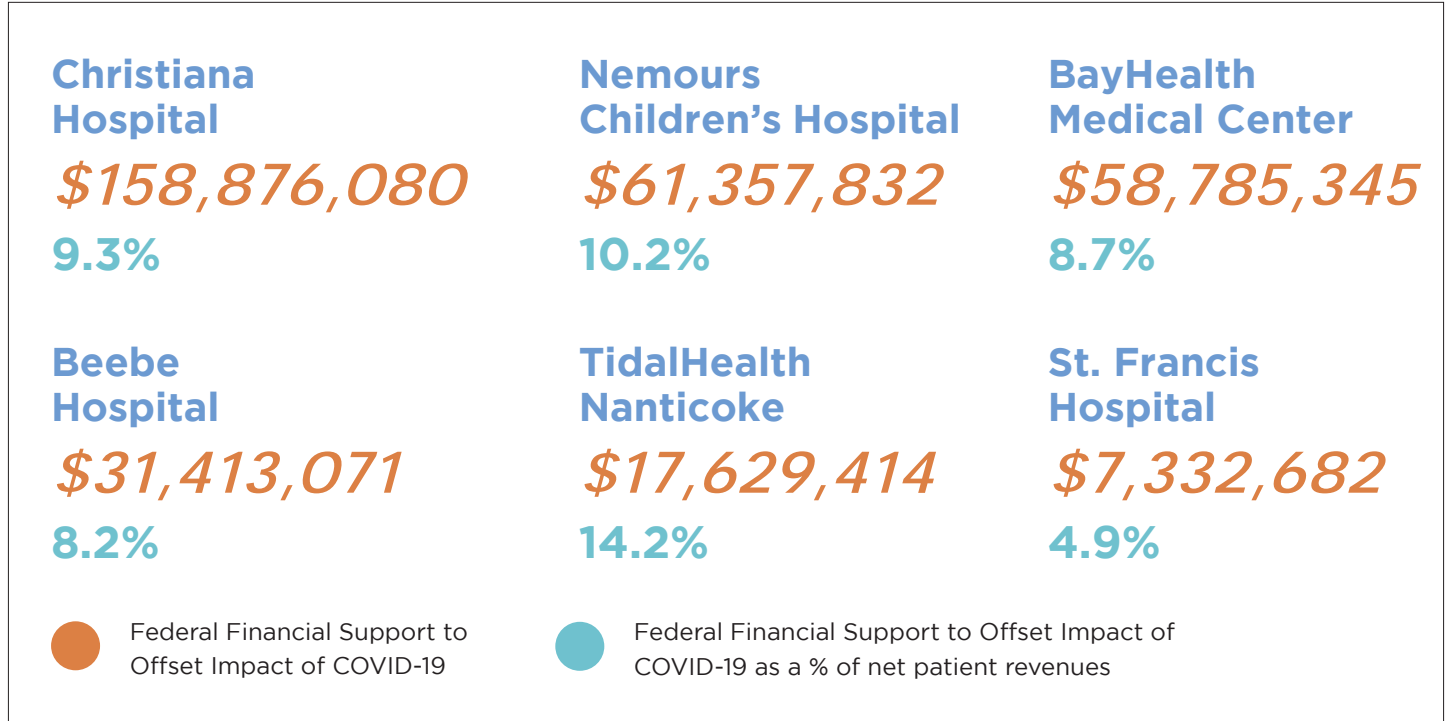


*Nanticoke merged with Peninsula Regional Medical Group in 2020 and is now named TidalHealth.

²⁴ White, C. (2018).

Federal COVID-19 support for each of the hospitals as of September 2021 is provided in Figure 8. Relief dollars are continuing to flow in. Gov. John Carney announced in October that the state is putting more than \$75 million of its American Rescue Plan funding toward helping hospitals and healthcare facilities recruit and retain frontline staff.

FIGURE 8: Federal Financial Support to Delaware Hospitals, April 2020 - Sept 2021



DATA LIMITATIONS

Currently available public data on hospital and health system finances for 2020 should be treated with caution for the following reasons:

- 1 Data is based on hospitals, [CMS Cost Reports](#) for the 2020 fiscal year. In Delaware, hospitals' 2020 fiscal year would include revenue and expenses from July 2019 through June 2020, thus capturing only a portion of the pandemic²⁵.
- 2 Though hospitals began receiving [federal support](#) through the Coronavirus Aid, Relief, & Economic Security (CARES) Act in April, they have continued to receive federal support on a rolling basis through several programs including the Paycheck Protection Program and Health Care Enhancement Act (PPHCEA), and the Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act²⁶. As of September 2021, these programs had provided \$178 billion for relief funds to hospitals and other healthcare providers nationally. This funding is intended to support healthcare-related expenses or lost revenue attributable to COVID-19 and does not need to be repaid.
- 3 Further, guidance on how to report Provider Relief Fund (PRF) and other COVID-19-related financial benefits was not provided until August 2020 and thus there may be variation in how hospitals and health systems reported this data.

²⁵ White, C. (2018).

²⁶ Health Resources & Services Administration (HRSA). (2021, June).

HOSPITAL QUALITY AND PATIENT EXPERIENCE

Research finds that high hospital prices do not equal high quality or high patient experience scores. CMS assigns an [Overall Hospital Quality Star Rating](#) (Overall Star Rating) to each hospital in the nation, which summarizes the hospital's performance on dozens of measures of quality across five domains 1) Mortality 2) Safety of Care 3) Readmission 4) Patient Experience and 5) Timely & Effective Care²⁷. The CMS Overall Star Rating methodology was developed in partnership with national experts in healthcare quality and measurement and stakeholders representing those who provide care, those who receive care and those who pay for care. The goal of the Overall Star Rating is to offer consumers a simple overall rating generated by combining multiple dimensions of quality into a single summary score. Some of the data included in the score reflects care provided to patients with coverage through Medicare and Medicaid. Other data, including the patient experience scores, reflects care provided to all adult patients regardless of payer type. An Overall Star Rating is not available for care provided at pediatric hospitals. The highest rating a hospital can receive in either of these measures is five stars; [more information on the methodology for the Overall Star Rating program is available here](#)²⁸.

As shown below, 2021 Overall Star Ratings for hospitals in Delaware were varied with four hospitals joining approximately 30% of the nation's hospitals in receiving four stars and two hospitals joining 20% of the nation's hospitals in receiving two stars. All of Delaware's hospitals received three stars from patients reporting their experience of care, except St. Francis Hospital which received two stars.

CHARITY CARE AND COMMUNITY INVESTMENT

In 2020, [The Lown Institute](#), a nonpartisan healthcare think tank, began publishing comparative data on hospitals' charity care and community investment²⁹. All Delaware hospitals ranked by Lown received a single star for charity care spending. Two Delaware hospitals performed better on Lown's community investment metric which also includes investments in local non-profits, health clinics and other activities that provide community benefit. Delaware hospitals ranked 34th among the 50 states in providing charity care to patients, according to a 2020 report by North Dakota Department of Insurance³⁰.

	CMS Overall Star Rating	CMS Patient Survey Ratings	Lown Charity Care Spending	Lown Community Investment
BayHealth Kent	★★	★★★★	★	★★★★★
BayHealth Sussex	★★★★★	★★★★	n/a	n/a
Beebe Hospital	★★★★★	★★★★	★	★★★★★
Christiana Hospital	★★★★★	★★★★	★	★
St. Francis Hospital	★★	★★★	★	★
TidalHealth Nanticoke	★★★★★	★★★★	★	★

**Highest rating for all categories is five stars.*

²⁷ Centers for Medicare & Medicaid Services (CMS). (2021). *Five-Star Quality Rating System*.

²⁸ Centers for Medicare & Medicaid Services (CMS). (2021). *Methodology Resources*.

²⁹ Lown Institute. Massachusetts.

³⁰ Horizon Government Affairs (2020).

PRICE TRANSPARENCY

The [Federal Hospital Price Transparency final rule](#) went into effect on January 1, 2020. It requires all hospitals operating in the United States to provide “clear, accessible pricing information online³¹.” The rule requires hospitals to provide two types of information.

- ① Machine Readable File: Single machine-readable digital file containing the following standard charges for all items and services provided by the hospital: gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges.
- ② Consumer-friendly Display of Shoppable Services: Display of at least 300 “shoppable services” (or as many as the hospital provides if less than 300) that a health care consumer can schedule in advance. Must contain plain language descriptions of the services and group them with ancillary services, and provide the discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges.

The table below provides information on Delaware hospitals’ compliance based on a recent review of their websites by the Office. Non-compliance with the Federal Hospital Price Transparency rule can result CMS issuing hospitals a Corrective Action Plan and a civil monetary fine of up to \$300 per day.

Website Contained

	Gross Charges	Discounted Cash Prices	Payer-specific Negotiated Charges	De-identified minimum and maximum negotiated charges
BayHealth Kent and Sussex	✓	Not Found	Not Found	✓
Beebe Hospital	✓	✓	Not Found*	✓
Christiana Hospital	✓	✓	✓	✓
Nemours Children’s Hospital	Not Found	Not Found	Not Found	Not Found
St. Francis Hospital	✓	✓	Not Found*	✓
TidalHealth Nanticoke	✓	✓	Not Found	✓

* *Beebe Hospital and St. Francis Hospital provided a “derived contracted rate” across all payers*

³¹ Centers for Medicare & Medicaid Services (CMS). (2021). *Hospital Price Transparency*.



AFFORDABILITY STANDARD 3: EXPAND ALTERNATIVE PAYMENT MODEL ADOPTION

RECOMMENDATION FROM 2020 REPORT:

Carriers will tie a minimum of 50% of total cost of care to an alternative payment model (APM) contract that meets the Health Care Payment Learning and Action Network (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.

SS 1 FOR SB 120 REQUIREMENT:

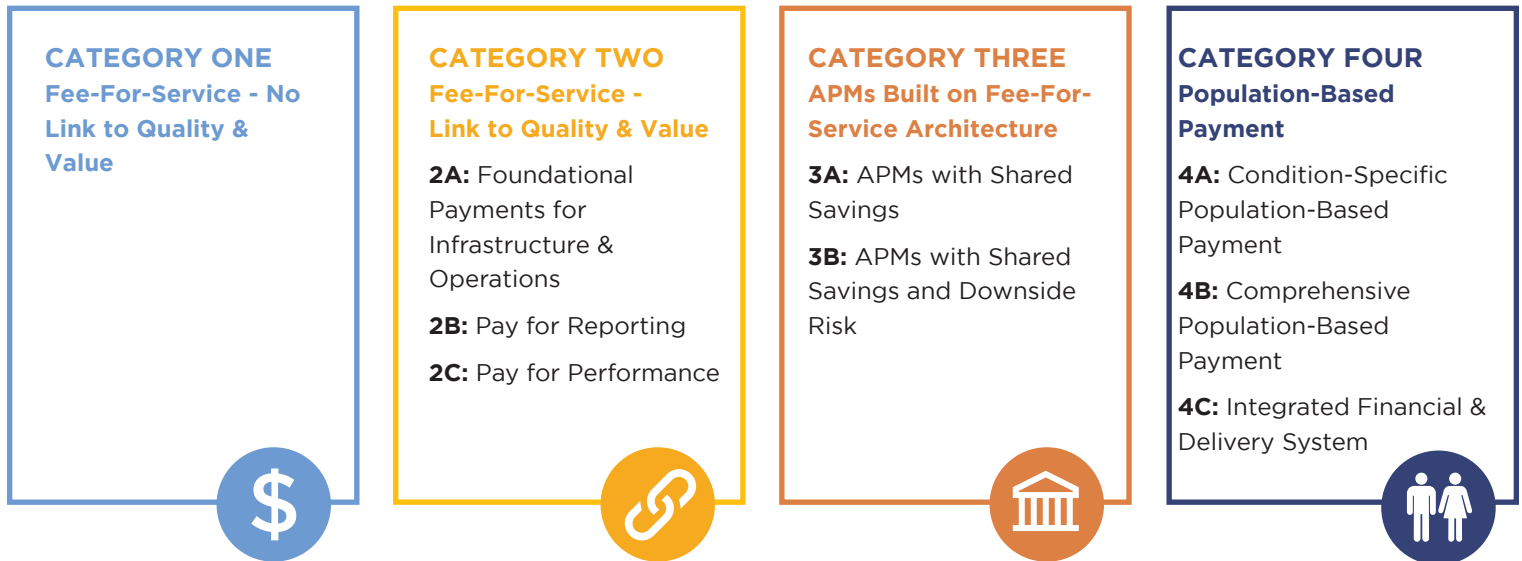
Carriers with more than 10,000 fully-insured lives in Delaware must tie more than 50% of total cost of care to an alternative payment model contract that meets the HCP-LAN Category 3 definition for shared savings or shared savings with downside risk by 2023, with a minimum of 25% total cost of care covered by an alternative payment model contract that meets the definition of HCP-LAN Category 3B, contracts with downside risk and shared savings.

Alternative Payment Model Adoption Analysis

APMs aim to improve healthcare value by offering providers more ability to be paid based on the quality of care they provide versus solely the volume of care they provide. APMs can apply to a specific clinical condition, a care episode, or a population. HCP-LAN is a group of representatives of government and private

payers and purchasers, provider organizations and the research community who come together to help develop a national framework and strategy to guide APM adoption. One effort of the HCP-LAN has been to establish a common vocabulary and approach to categorizing payment models that helps stakeholders track progress related to payment reform. HCP-LAN APM categories are described in Figure 9.

FIGURE 9: HCP-LAN Alternative Payment Model Categories



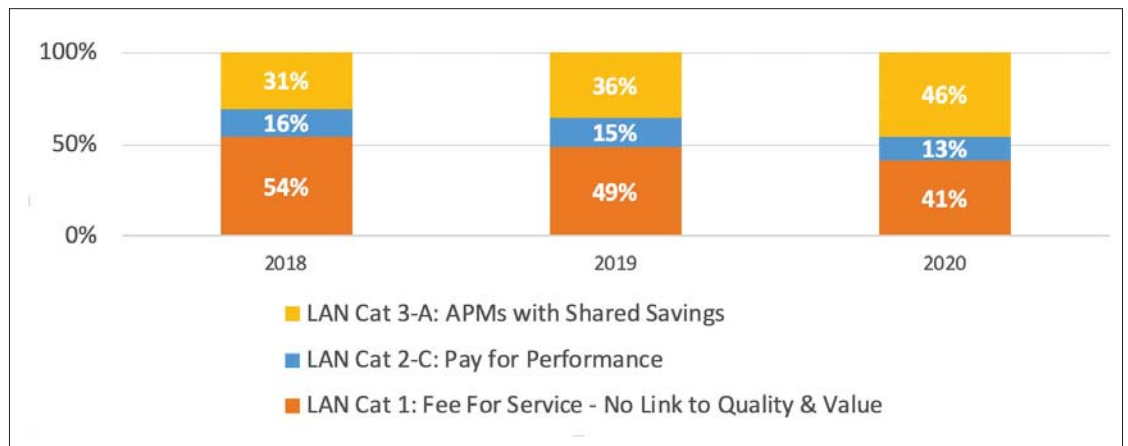
The Office measures carriers progress toward alternative payment model adoption using two methodologies.

ALTERNATIVE PAYMENT MODEL MEASUREMENT METHODOLOGY 1

The first method measures the proportion of a carrier’s fully-insured and State Group Health Plan total healthcare spending that qualify as different categories of value-based payment. For this method, carriers identify the HCP-LAN category that best suits each of their provider contracts. Then, they report the percentage of healthcare spending that falls into each HCP-LAN category as displayed in Figure 10.

FIGURE 10: Percent of Delaware Health Insurance Carriers Spend Tied to Contracts that Meet Certain HCP-LAN Categories (Carrier Reported, 2018-2020)

Source: Delaware carrier template submissions to the Office. Data reflects commercial fully insured and State Group Health Plan.



ALTERNATIVE PAYMENT MODEL METHODOLOGY 2

The second method measures non-fee-for-service payments to providers. These payments include capitation, payments for care management services, performance incentives and shared savings, which are defined to align with the Delaware Healthcare Spending Benchmark categories. Under this method, the Office aggregates payments reported in these categories by health insurance carriers. Data indicate that these payments have hovered around 1% of total cost of care, excluding pharmacy costs, since 2018. Increasing these types of more flexible payments, particularly to primary care providers, will be critical to support the care delivery transformation envisioned.

Statutory Requirement to Expand Alternative Payment Model Adoption

The SS 1 for SB 120 requirement regarding expanding use of APMs is focused on two types of APMs, Category 3A Shared Savings and Category 3B Shared Savings with Downside Risk. Shared savings is a type of value-based payment or alternative payment model that offers provider entities, typically accountable care organizations led by health systems or large groups of physicians, the opportunity to receive a portion of savings if a population of patients health care costs are less than expected. Similar to shared savings, contracts with downside risk also allow providers to share in savings. However, these contracts also require providers to pay back losses if the population of patients they care for cost more than expected.

As shown in Figure 10, Delaware carriers now report that 46% of their total healthcare dollars for fully-insured plans and the State Group Health Plan are tied to contracts that offer providers a share of the savings if their patients cost less than expected, known as HCP-LAN Category 3A. This level of APM adoption would nearly meet the SS 1 for SB 120 requirement of 50% for fully-insured plans.

Delaware carriers reported no healthcare spending for fully-insured plans or the State Group Health Plan that would qualify as HCP-LAN Category 3B. Carriers with more than 10,000 fully insured lives in Delaware have until their rate filings in 2023 to demonstrate 25% of their total of their total fully-insured spend is associated with contracts that includes downside risk.

As noted above, this requirement is limited to carriers with 10,000 fully insured Delaware lives. Therefore, at this time, it only applies to Highmark Blue Cross Blue Shield Delaware. Restricting this requirement to carriers with a minimum number of lives helps to ensure providers have a sufficient portion of their patient panel covered by the payer for implementing a new program to be worth the time, effort and cost. It also helps ensure the provider had enough patients covered by the carrier so that performance could be reliably measured and has actuarial stability.

SS 1 FOR SB 120 STATUTORY REQUIREMENT:

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.

Implementing Expansion of Alternative Payment Model Adoption

Though Delaware health insurance carriers already report the percentage of their contracts by HCP-LAN category, the Office has not provided detailed technical specifications to determine which category the carrier should use for a specific program. Rather, the Office has asked carriers to use their best judgment based on their knowledge of the program and the categories. As the reporting evolves from measuring progress toward a voluntary target to compliance with a statutory requirement, the Office will be developing a set of minimum risk requirements that define whether a contract qualifies as having shared savings and shared savings with downside risk.

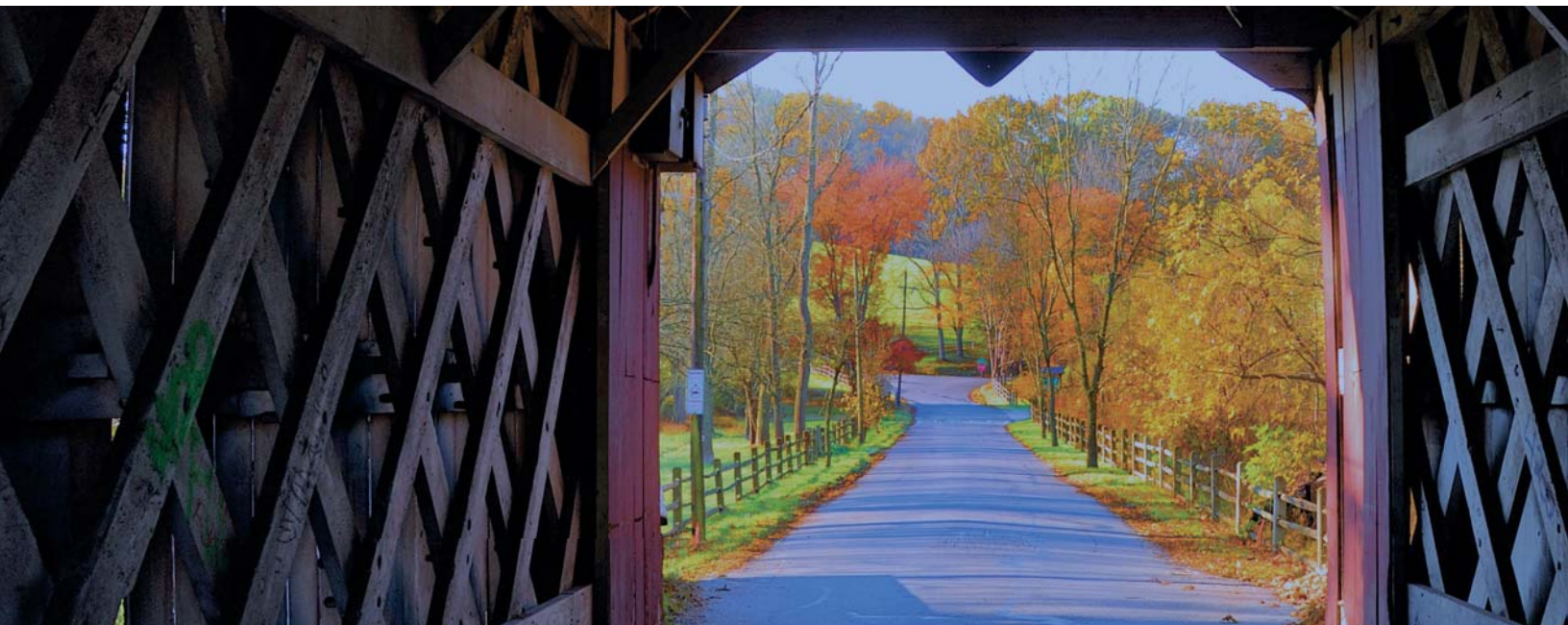
In addition to the Office's role in measuring carrier compliance with the requirements above, SS 1 for SB 120 also requires the [Delaware Health Care Commission](#) (HCC) to develop and monitor compliance with APMs that promote value-based care³². The Office looks forward to working closely with the HCC to ensure alignment across these enforcement activities so that Delaware payers and providers have clear and consistent direction regarding the State's priorities and requirements for value-based payment.

Office's Role in Supporting Implementation

- Develop minimum risk requirements for contracts to qualify as LAN Cat 3-A: APMs with Shared Savings and LAN Cat 3-B: APMs with Shared Savings and Downside Risk
- Continue to build collaborative approaches with the Health Care Commission to support its statutory requirement to develop and monitor compliance with value-based care delivery models.

³² Delaware Health Care Commission. *What is the Delaware Health Care Commission?*

³³ Office of Value-Based Health Care Delivery (OVBHCD). (2021, February 15).



Additional Market Context

The focus on moving to value-based payment is well-aligned with other Delaware payers. Similar to the requirements of SS 1 for SB 120, the State Group Health Plan continues to work with its insurers to move to APMs. The Delaware Division of Medicaid and Medical Assistance (DMMA) is partnering with its managed care organizations to develop similar agreements on payments flowing through value-based care models with Delaware ACOs³³.

Delaware also has one of the nation's highest percentages of Medicare beneficiaries participating in the Medicare Shared Savings Program. Delaware providers continue to outperform their national peers. Four of Delaware's eight ACOs, which care for about 75% of the state's Medicare beneficiaries enrolled in an ACO, generated savings for Medicare in 2020 and all of these ACOs generated sufficient savings to earn some of it for themselves, an average of \$332 per enrollee. Four of the eight Delaware ACOs also have arrangements with Medicare in which they have to pay back money if patients cost significantly more than expected. None had to do so in 2020³⁴.

Delaware providers' experience in public payer programs will give this data meaningful context as they expand their total cost of care accountability contracts with commercial health plans. It will be important to understand their lessons learned and consider implications for their contracts with commercial carriers. Further, the high proportion of the Delaware providers participating in MSSP Pathways suggests that it may be an important framework for Delaware commercial carriers to consider as they build and refine their own similar programs.

³⁴ Centers for Medicare & Medicaid Services (CMS). (2021, August).





LOOKING AHEAD

With the signing of SS 1 for SB 120, the Office has turned to developing regulations as directed by statute. These regulations will focus on updating the definition of primary care to align with care delivery expectations of a Delaware Primary Care Model, care delivery requirements for eligibility to meet increased investment, guidance on the methodology used to limit price increases for hospital inpatient, outpatient and other medical services, and minimum risk requirements for alternative payment model contracts. The Office will continue to meet with stakeholders to obtain their input in ongoing discussions, collaboration with the PCRC and through public comment.

A first step for the Office is to identify opportunities to provide additional guidance for carriers as they begin to implement statutory requirements. The Office looks forward to working with stakeholders to gain their input on these regulations over the coming months. Once these regulations are in place, the Office will provide technical assistance to commercial health insurance carriers to support their implementation of the statute and regulations and continue to work in unison with the Health Care Commission to measure and report on Delaware's compliance with SS 1 for SB 120.

Through increased primary care investment, the development of a Delaware Primary Care Model, loan repayment and training programs focused on the next generation of clinicians and a robust health information technology infrastructure, Delaware is poised to stride forward and demonstrate a new and highly effective approach to resourcing and delivering primary care services to its residents.

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Primary Care Transformation: Case Studies in Implementation

Care Transformation Organizations in Maryland

Care Transformation Organizations, part of the Maryland Primary Care Program, are entities that hire and manage interdisciplinary care teams capable of providing a wide array of care coordination services. Smaller primary care practices and medical groups can purchase the services of a CTO, allowing them to offer patients advanced primary care efficiently and without requiring they join an accountable care organization (ACO) or become employed by a hospital system. Participating providers have several options to enhance primary care delivery including those listed below.¹

COLLABORATIVE CARE MODEL

- Universal screening for behavioral health conditions and social needs
- A care registry to identify and track patient risks, needs and priorities
- Assessment and treatment through counseling with a behavioralist
- Medication management with a clinician
- Referrals as needed to psychiatry and addiction specialists
- Regular care team huddles to discuss high risk patients and identify quality improvement opportunities

CARE MANAGEMENT TRACKS

Track One:

Access to a complex care manager per 2,000 attributed lives responsibilities include:

- Coordinates episodic and longitudinal care management for rising- and high-risk patients. Patients may be identified based on risk stratification, screenings and primary care clinician referrals.
- Collaborates with primary care providers and other care team members to develop and monitor comprehensive individualized care plans
- Provides patient education and self-management support, including follow-up during care setting transitions
- Uploads care alerts and care plans into CRISP, a health information exchange system
- Coordinates access to interdisciplinary team for consults on complex patient cases (e.g., pharmacy, dietitian, social work, diabetes educator, respiratory therapy)

¹ Maryland Department of Health. (2019).

Track Two:

Services described above as well as:

- Pharmacist conducts comprehensive medication management for rising- and high-risk patients, including assessing the patient's medication therapy and developing and initiating an action plan to address risks and offer potential alternatives
- A Community Health Worker provides support to rising- and high-risk patients, including assisting with patient activation and self-management support outside of the clinic and managing community-based social service referrals and follow-up

CARE COORDINATION

A certified LPN or medical assistant supports patient panel management, including:

- Developing and maintaining a disease registry, identifying patients in need of outreach to complete health screenings and close care gaps
- Daily monitoring of alerts for hospital and emergency department discharges, providing monthly list of "high-risk" algorithm-identified patients for clinician review and risk stratification
- Telephonic outreach to enroll patients identified for care management, and behavioral health
- Identifying potential patients for comprehensive medication management and advanced illness management and providing patient referrals to education and self-management resources, and community and social service resources²

² Maryland Department of Health. (2019).



Coordinated Care Organizations in Oregon

[Coordinated Care Organization's](#) (CCO) are networks of health care providers who work together to serve the physical and behavioral health needs of patients across Oregon, particularly those on Medicaid. The goal of the CCOs is to prevent and manage chronic conditions and social determinants of health to improve outcomes and reduce hospital admissions and trips to the emergency room.³

SUMMARY OF CARE DELIVERY INNOVATION

Health Share Oregon is a CCO in Oregon that [implemented innovative primary care delivery practices](#) including:

- Emergency department guides to assist patients with non-emergent needs who might be better served at a more efficient care site
- **Standard Transitions:** A program uses discharge summaries embedded in hospitals' electronic health record systems to develop work flows to assist patient transfers and follow
- **C-Train:** A programs that helps patients who are typically high utilizers of care efficiently and effectively move from the inpatient setting to outpatient settings
- **Intensive Transitions Teams:** Support patients from a psychiatric hospital admission to outpatient care including crisis support
- **Interdisciplinary Community Care Teams (ICCTs):** Outreach workers embedded into care teams to assist a particular population with accessing and navigating additional resources and information
- **911 Service Coordination Program** with social workers on staff who provide additional case management with emergency responders .

³ Oregon Health Authority. (n.d.).



Community Health Teams in Rhode Island

In Rhode Island, Community Health Teams (CHT) have been implemented through multiple modes including Patient-Centered Medical Homes (PCMH), general primary care practices, independent payers, and Accountable Care Organizations (ACO).⁴ CHT aim to increase referrals, service, and intervention to high-risk patients in Rhode Island. They serve as a bridge to the addressing the social determinants of health for patients and closing gaps in health inequities. Community health workers and behavioral health providers connect patients with high needs to help them navigate additional resources and limit to improve outcomes. The goal is to connect people with community-based resources to address needs before they become a crisis.

⁴ Rajotte. (2016).



FIGURE 1: Implementing Comprehensive Primary Care

Capabilities	Improved Condition Management due to Integrated Behavioral Health	Reduced Use of Emergency Department and Urgent Care for Minor, Acute Needs AND Reductions in Ambulatory Care Sensitive Condition (ACSC) Admissions and Emergency Department Visits			Increased Use of Lower Cost Sites of Service
Intervention/ Model	Behavioral Health Integration	Care Management/ Coordination	Community Health Teams	Interdisciplinary Community Care Teams (ICCTs)	Primary Care Redesign
Additional Care Team Members	<ul style="list-style-type: none"> • A psychologist • Licensed independent social worker • Care Manager/Care Coordinator • Consultant Dietitian/Nutritionist • Health Educator 	<ul style="list-style-type: none"> • Clinical Nurse Specialist or Nurse Practitioner, Physician (MD or DO), Physician Assistant • Behavioral Health/ Social Worker • Care Manager/Care Coordinator • Consultant Dietitian/ Nutritionist • Health Educator • Laboratory/Radiology Technician • Licensed Practical Nurse (LPN), Medical Assistant Other Health Staff • Pharmacist/Pharmacy Technician • Physical/Respiratory Therapist • Practice Supervisor/ Practice Manager • Quality Improvement Specialist • Receptionist/ Appointing Registered Nurse (RN) 	<ul style="list-style-type: none"> • Community-Based Licensed Health Professionals (pharmacist, nutritionists) • Community Health Workers (including Peer Support Specialists) 	<ul style="list-style-type: none"> • Community Outreach Specialists 	<ul style="list-style-type: none"> • Medical Assistants
Example of where support for coordination comes from	<ul style="list-style-type: none"> • Care Transformation Organizations (CTO) • Patient Centered Medical Home (PCMH) 	<ul style="list-style-type: none"> • CTO • PCMH • CCO • Accountable Care Organization 	<ul style="list-style-type: none"> • PCMH • Accountable Care Organization (ACO) 	<ul style="list-style-type: none"> • Coordinated Care Organizations (CCO's) 	<ul style="list-style-type: none"> • University Health Systems • Primary Care Practices
Focus on improving:	Increased access to mental and behavioral health through integrated care for primary care patients	Increases patient satisfaction, improves patient outcomes, reduces costs	To better support high-risk and high-cost patients with complex behavioral and social health needs	Support to high-use patients to help them build health literacy, address psychosocial needs, and overcome barriers to health	Reduce provider burnout and moving toward the quadruple aim

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