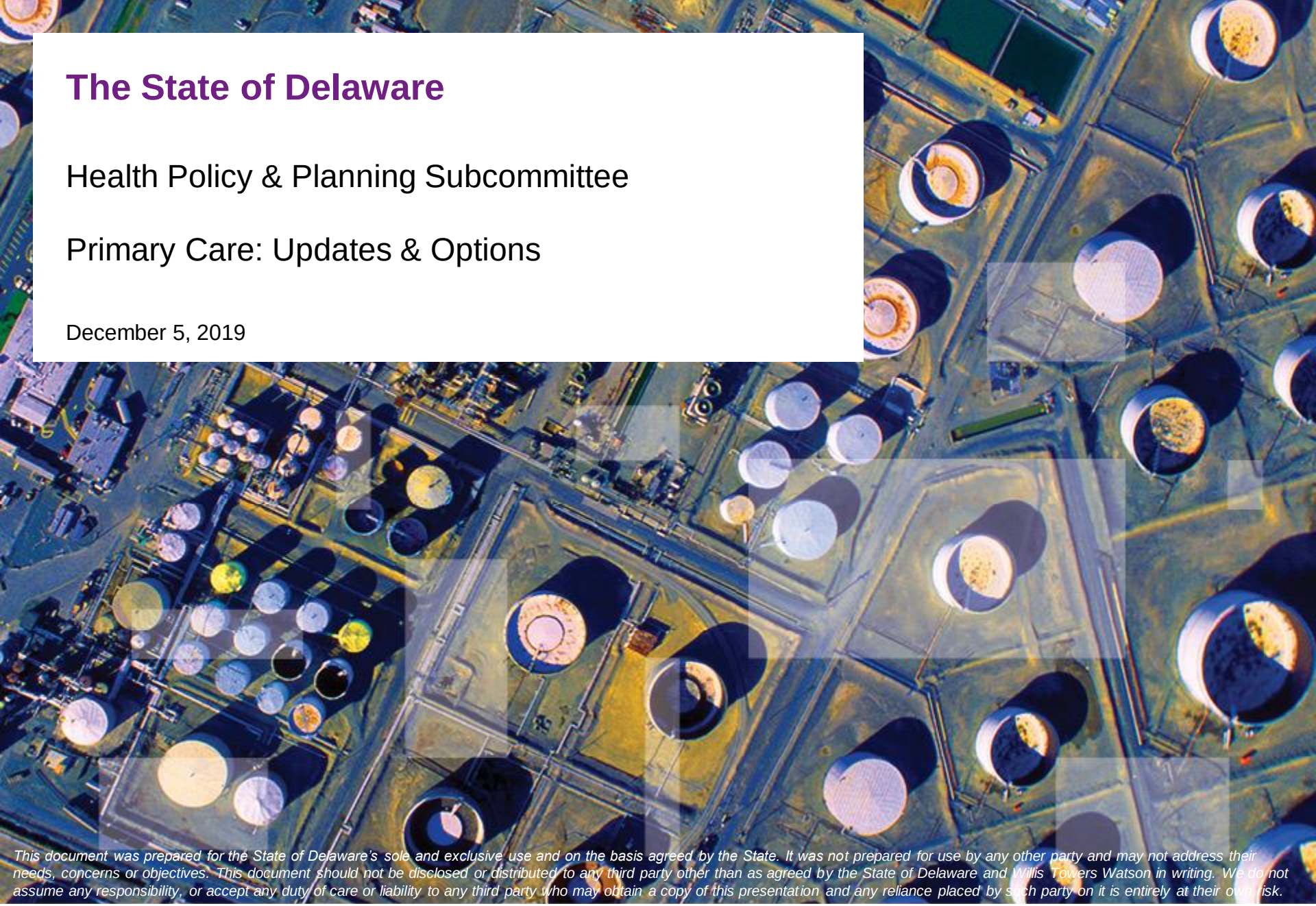
The State of Delaware

Health Policy & Planning Subcommittee

Primary Care: Updates & Options

December 5, 2019



Willis Towers Watson

Today's discussion

- Brief recap – Primary care access in Delaware
- Prior SEBC consideration of third-party primary care providers
  - RFI/RFQ for third-party vendor-provided primary care clinics
  - Considerations for the SEBC – goals and areas for further review
  - Outcomes of this process
- Open discussion on direct / employer-sponsored primary care
- Next steps

Brief recap – Primary care access in Delaware

- Topic has been subject of ongoing discussion with the SEBC, this Subcommittee and other stakeholder groups statewide
- Among the options for the SEBC to address primary care access were discussed with this Subcommittee at the August and October 2019 meetings, two resonated with the Subcommittee the most:
  a) Enhance telemedicine offerings via advanced technology solutions
  b) Contract with a third-party vendor to add primary care provider options in Delaware
- Further study of either option would be required to fully assess feasibility, timeline and potential cost
  - SEBC previously reviewed similar considerations to those that are currently in play with option (b) in the context of evaluating opportunities to build a primary care clinic in 2017[1]
- Today's discussion will focus on bringing this Subcommittee up to speed on prior SEBC review of considerations surrounding option (b) and the progress made at that time to address questions such as:
  - What would be the goals and success measures of an expanded primary care solution?
  - What are governance considerations?
  - What are the expected costs and savings? Would the State see a return on its investment?
  - How long would implementation take?

1 Summary of RFI results presented to the SEBC: https://dhr.delaware.gov/benefits/sebc/documents/2017/0626-rfi-analysis.pdf

Prior SEBC consideration of third-party primary care providers

RFI/RFQ for third-party vendor-provided primary care clinics

- In the spring of 2017, the SEBC issued a Request for Information and Qualifications ("RFI/RFQ") of interested vendors about the feasibility for statewide employer-sponsored (on-site or near site) clinics
  - Driven by interest in expanding GHIP participants' access to primary care while more closely managing the health of those plan participants
- RFI/RFQ had two primary goals:
  - Provide the SEBC with an understanding of the employer-sponsored clinic marketplace
  - Determine whether the State should continue exploring employer-sponsored health care[1]
- Eleven vendors responded to the RFI/RFQ
  - Reflected a representative sample of the employer-sponsored clinic marketplace

- Activate Healthcare
- CareATC
- CareHere
- Cerner
- HealthStat
- Marathon Health
- OurHealth
- Paladina Health
- Premise Health
- QuadMed
- Vera Whole Health

1 Since Delaware procurement rules require a formal RFP process in order to issue a contract award, a decision to continue exploring employer-sponsored health care would have required the State to issue a formal RFP for a vendor partner.

Topics covered by the RFI/RFQ

Components to offering employer-sponsored healthcare

- Vendors addressed their capabilities for providing the following components of employer-sponsored healthcare within the RFI/RFQ
  - Minimum qualifications and contractual requirements outlined by the SBO
  - **Scope of services**
  - **Hours of operation**
  - **Location**
  - **Patient cost sharing and engagement**
  - Patient experience
  - Patient education
  - **Health center staffing**[1]
  - Clinical quality assurance
  - Health center technology
  - Integration with the State's existing health care vendors
  - Reporting
  - Outcomes
  - Implementation and build-out considerations
  - Start-up and ongoing operating costs
  - Potential savings and ROI
  - Performance guarantees

Highlighted text indicates area for further input by the SEBC

1 While the third-party provider would have final discretion over the staffing requirements, it would consider staffing preferences articulated by the plan sponsor (e.g., a preference for specific provider types, or clinicians with certain credentials or areas of expertise).

Vendor responses to the RFI/RFQ

Considerations for implementation and build-out

- Vendors were asked to comment on the average timeframe of a health center implementation
  - Overall range was 12-30 weeks[1]
  - Variables that most affect the timeline include:
    - Contract review timeframe (and some vendors' unwillingness to commence implementation until the contract has been executed)
    - Requirements of clinic build-out process
- All vendors indicated their willingness to work with an architect of the State's choosing for design of the clinic space and build-out
- Vendors' responses to the level of support they could provide during the build-out process varied, but generally were one of the following:
  - Client (the State) would be responsible for procuring and maintaining clinic space, including working with an architect and general contractor
  - Vendor would partner with the client to procure and maintain clinic space
  - Vendor would be responsible for procuring and maintaining clinic space

1 Note: Lower end of the timeframe does not account for health center build-out.

Vendor responses to the RFI/RFQ

Considerations for operating costs and potential savings

- Vendors were asked to quote on the estimated start-up and ongoing costs associated with a health center
- RFI/RFQ defined key parameters required for the vendors to generate a quote, including eligible population, clinic scope of services, location and hours of operation, member cost sharing and staffing parameters
  - Parameters were heavily caveated as being subject to change in the event that the SEBC decided to move forward with conducting a formal procurement process
- Based on those parameters, vendor-estimated costs for start-up and operating expenses ranged[1] from $4.3m to $22.4m in the first three years; range excludes build-out costs
- Five vendors provided savings estimates as part of their response, but these were not directly comparable across vendors due to variability in the underlying assumptions
  - All 5 vendors caveated these by stating that further analysis of detailed claims data (which was not provided during the RFI/RFQ process) would be required to produce a firm quote
  - Instead, WTW calculated the potential ROI using a consistent set of assumptions and methodology – *3-year ROI range[2]: 0.7x – 3.7x* (net cost of $1.5m to net savings of $13.0m)
  - Remaining vendors declined to estimate savings unless more detailed claims data could be provided
- Responses on the duration of time necessary for a clinic to produce an ROI also varied from <1 to 5 years; is highly dependent on efficiency of clinic staffing model and total build-out cost
  - Shorter ROI duration is usually correlated with more aggressive savings estimates

1 Factors contributing to cost variability: scope of services, staffing, equipment/IT costs, vendor-specific administrative fee for corporate oversight and profit.
2 ROI was calculated by WTW using vendor savings estimates to ensure a consistent methodology was used across all vendors; ROI excludes build-out cost estimates.

Third-party vendor provider of primary care clinics

Considerations for the SEBC

- The SEBC's decision on how to proceed with the evaluation of employer-sponsored clinic vendors rested on several factors, including:
  - The current budgetary environment of the State of Delaware
  - The Committee's comfort level with the average duration of time required for a health center to produce an ROI
  - Whether a reasonable level of employee engagement can be expected
  - Determination of the initial location for the potential health center
  - The requirement to provide up-front funding for space build-out and ongoing operating costs
  - Whether the vendors can meet the minimum requirements (contractual, technological, risk management) for doing business with the State
- In light of these considerations, further dialogue on this topic with the SEBC was tabled until December 2017

On-site / Near-site health centers – considerations

- Results of the RFI were presented to the SEBC on June 26, 2017; further discussion of employer-sponsored clinics with the SEBC did not take place until the December 11, 2017, at which the exhibit below was presented

Areas to address

Goals and operating parameters

Determine the following:

- Health center goals, and how success will be measured
- Eligible population
- Scope of services
- Staffing preferences
- Location(s) and hours of operation
- Member cost sharing

Initial draft goals and success measurements were presented at 1/22/18 SEBC meeting

Source of funding

One of the following must happen:

- State Legislature appropriates funding for a clinic
- State Legislature grants SEBC the authority to use GHIP funds to finance health center start-up and operations

Oversight

Determine ownership of health center vendor oversight:

- SEBC?
- Department of Human Resources?
- OMB – Division of Facilities Management?
- Another agency within the Executive Branch?

Proposed employer-sponsored health care goals and success measures

Based on SEBC feedback and consistent with GHIP strategic framework

Proposed goals

Expand Access to Care

With focus on primary care, prevention and wellness, with selected specialty care as needed

Improve Quality of Care

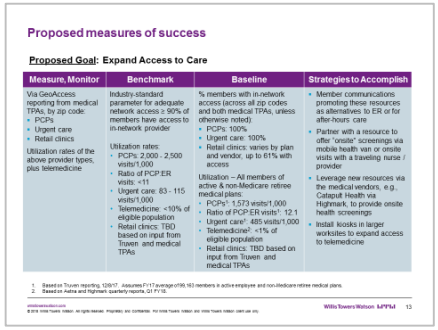
Directly through the health center and indirectly via referrals to high performing providers

Reduce Total Cost of Care

Through improved health of the covered population, and through redirection of care from expensive, suboptimal and inappropriate settings, when clinically appropriate

*Success measures**

For each goal, highlights key metrics to monitor, suggested benchmarks, baseline measures based on actual GHIP data, and additional strategies to accomplish the same goal

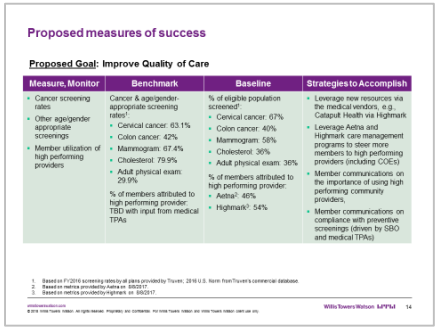


Proposed measures of success

Proposed Goal: Expand Access to Care

Measure, Monitor	Benchmark	Baseline	Strategies to Accomplish
Via GeoAccess reporting from medical TPAs, by zip code: • PCPs • Urgent care • Retail clinics Utilization rates of the above provider types, plus telemedicine	Industry-standard parameter for adequate network access ≥ 90% of members have access to in-network provider Utilization rates: • PCPs: 2,000 - 2,500 visits/1,000 • Ratio of PCP:ER visits: <11 • Urgent care: 83 - 115 visits/1,000 • Telemedicine: <10% of eligible population • Retail clinics: TBD based on input from Truven and medical TPAs	% members with in-network access (across all zip codes and both medical TPAs, unless otherwise noted): • PCPs: 100% • Urgent care: 100% • Retail clinics: varies by plan and vendor, up to 61% with access Utilization – All members of active & non-Medicare retiree medical plans: • PCPs[1]: 1,573 visits/1,000 • Ratio of PCP:ER visits[1]: 12:1 • Urgent care[2]: 485 visits/1,000 • Telemedicine[2]: <1% of eligible population • Retail clinics: TBD based on input from Truven and medical TPAs	• Member communications promoting these resources as alternatives to ER or for after-hours care • Partner with a resource to offer "onsite" screenings via mobile health van or onsite visits with a traveling nurse / provider • Leverage new resources via the medical vendors, e.g., Catapult Health via Highmark, to provide onsite health screenings • Install kiosks in larger worksites to expand access to telemedicine

1. Based on Truven reporting, 12/6/17. Assumes FY17 average of 99,163 members in active-employee and non-Medicare retiree medical plans.
2. Based on Aetna and Highmark quarterly reports, Q1 FY'18.

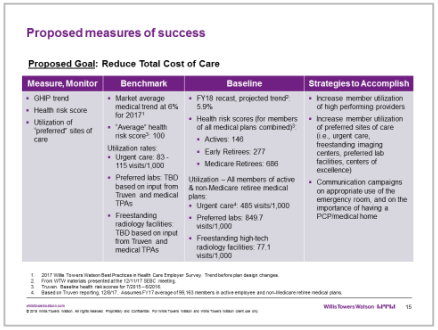


Proposed measures of success

Proposed Goal: Improve Quality of Care

Measure, Monitor	Benchmark	Baseline	Strategies to Accomplish
• Cancer screening rates • Other age/gender appropriate screenings • Member utilization of high performing providers	Cancer & age/gender-appropriate screening rates[1] • Cervical cancer: 63.1% • Colon cancer: 42% • Mammogram: 67.4% • Cholesterol: 79.9% • Adult physical exam: 29.9% % of members attributed to high performing provider: TBD with input from medical TPAs	% of eligible population screened[2] • Cervical cancer: 67% • Colon cancer: 40% • Mammogram: 58% • Cholesterol: 36% • Adult physical exam: 36% % of members attributed to high performing provider: • Aetna[3]: 46% • Highmark[3]: 54%	• Leverage new resources via the medical vendors, e.g., Catapult Health via Highmark • Leverage Aetna and Highmark care management programs to steer more members to high performing providers (including COEs) • Member communications on the importance of using high performing community providers, • Member communications on compliance with preventive screenings (driven by SBO and medical TPAs)

1. Based on FY2016 screening rates by all plans provided by Truven; 2016 U.S. Norm from Truven's commercial database.
2. Based on metrics provided by Aetna in 9/8/2017.
3. Based on metrics provided by Highmark on 9/8/2017.



Proposed measures of success

Proposed Goal: Reduce Total Cost of Care

Measure, Monitor	Benchmark	Baseline	Strategies to Accomplish
• GHIP trend • Health risk score • Utilization of "preferred" sites of care	• Market average medical trend at 6% for 2017[1] • "Average" health risk score[2]: 100 Utilization rates: • Urgent care: 83 - 115 visits/1,000 • Preferred labs: TBD based on input from Truven and medical TPAs • Freestanding radiology facilities: TBD based on input from Truven and medical TPAs	• FY18 recast, projected trend[3]: 5.9% • Health risk scores (for members of all medical plans combined)[4]: • Actives: 1.46 • Early Retirees: 277 • Medicare Retirees: 686 Utilization – All members of active & non-Medicare retiree medical plans: • Urgent care[4]: 485 visits/1,000 • Preferred labs: 849.7 visits/1,000 • Freestanding high-tech radiology facilities: 77.1 visits/1,000	• Increase member utilization of high performing providers • Increase member utilization of preferred sites of care (i.e., urgent care, freestanding imaging centers, preferred lab facilities, centers of excellence) • Communication campaigns on appropriate use of the emergency room, and on the importance of having a PCP/medical home

1. 2017 Willis Towers Watson Best Practices in Health Care Employer Survey. Trend before plan design changes.
2. From WTW materials presented at the 12/11/17 SEBC meeting.
3. Truven. Baseline health risk scores for 7/2015 – 6/2016.
4. Based on Truven reporting, 12/6/17. Assumes FY17 average of 99,163 members in active-employee and non-Medicare retiree medical plans.

*Further details in Appendix.

SEBC consideration of third-party primary care providers

Outcomes

- While there appeared to be general agreement among the SEBC to the proposed goals and success measures for onsite or near-site primary care, the topic was tabled for further dialogue due to other more pressing priorities that the Committee was focused on addressing
- The Committee did not address the following key decision points, which remain outstanding:
  - Other important operating parameters, such as the clinical scope of services and staffing preferences
  - Source(s) of funding
  - Oversight

Direct / Employer-sponsored primary care

Open discussion with Health Policy & Planning Subcommittee

- What are Subcommittee members' questions about direct / employer-sponsored primary care?
- How does this option fit into the goals and other priorities of the GHIP[1] and SBO strategic frameworks?
- How much interest is there in continuing to explore this option for expanding access to primary care vs. further exploring advanced telehealth technology?

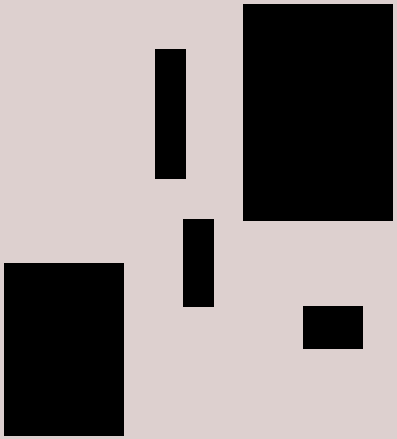
1 See Appendix for GHIP Strategic Framework mission statement and goals.

Next steps

- Use Subcommittee feedback obtained during today's discussion to drive further direction on further discussion of direct / employer-sponsored primary care
- Consider further evaluation of options for expanding access to advanced telehealth technology, including potentially interviewing other vendors and third-party service providers of telehealth technology

Appendix

Proposed success measures for an employer-sponsored clinic



Proposed measures of success – employer-sponsored clinics

Proposed Goal: Expand Access to Care

Measure, Monitor	Benchmark	Baseline	Strategies to Accomplish
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Proposed measures of success – employer-sponsored clinics

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3. Based on metrics provided by Highmark on 8/8/2017.

Proposed measures of success – employer-sponsored clinics

Proposed Goal: Reduce Total Cost of Care

Measure, Monitor	Benchmark	Baseline	Strategies to Accomplish

▪ GHIP trend
▪ Health risk score
▪ Utilization of "preferred" sites of care
	▪ Market average medical trend at 6% for 2017[1]
	▪ "Average" health risk score[3]: 100
	Utilization rates:
	▪ Urgent care: 83 - 115 visits/1,000
	▪ Preferred labs: TBD based on input from Truven and medical TPAs
	▪ Freestanding radiology facilities: TBD based on input from Truven and medical TPAs
		▪ FY18 recast, projected trend[2]: 5.9%
		▪ Health risk scores (for members of all medical plans combined)[3]:
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		  ▪ Early Retirees: 277
		  ▪ Medicare Retirees: 686
		Utilization – All members of active & non-Medicare retiree medical plans:
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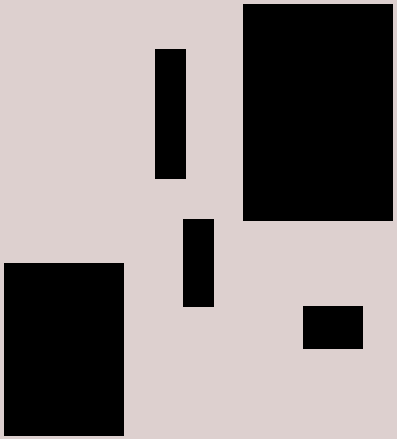
Appendix

GHIP Strategic Framework –
Mission statement and goals



GHIP goals – approved by SEBC

Tied to the GHIP mission statement

Mission Statement:

Offer State of Delaware employees, retirees and their dependents ***adequate access*** *to* ***high quality healthcare that produces good outcomes…***

at an ***affordable cost****…*

promotes ***healthy lifestyles,*** *and helps them be* ***engaged consumers.***

Goals:

- Addition of at least net 1 value-based care delivery (VBCD) model by end of FY2018
- Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020[1]
- GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020[2]

[1] Gross trend is inclusive of total increase to GHIP medical plan costs (both "employer" and "employee") and will be measured from a baseline average trend of 6% (based on a blend of the State's actual experience and Willis Towers Watson market data).

[2] Note: To drive enrollment at this level, the State will need to make plan design and employee contribution changes that may require changes to the Delaware Code.