

**IMPACT OF PRIMARY CARE TRANSFORMATION IN PRACTICE:
A POLICY ANALYSIS OF STATE INNOVATION MODELS**

by

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A thesis submitted to the Faculty of the University of Delaware in partial fulfillment
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ABSTRACT

Primary care physicians face challenges with health care delivery, coordination, and cost. These challenges translate into barriers to the access of quality care. For these challenges to be overcome, the current U.S. health care system requires innovative redesign with a new, comprehensive foundation to establish a capable primary care delivery model. However, this type of innovative redesign and transformation of the U.S. health system must be able to meet the needs of an ever-changing patient population and emerging community needs of a longer and sicker living population faced with more chronic health conditions that require team-based care coordination and care management.

This paper will focus on analyzing several policy alternatives that aim to enable primary care transformation by evaluating the effectiveness, efficiency, and equity of these proposed models of health care payment and delivery. Ultimately, the purpose of this paper is to make policy recommendations to relevant stakeholders regarding how to address this policy problem by using these state models of innovative delivery and payment systems as a framework. By analyzing the current health care reforms and two state innovation models, it was determined that although there is no single perfect fit between any of the three policies analyzed, aspects of each alternative that addressed rural health care redesign, health information access, and value-based payment systems will help to improve the access to, engagement with, and quality of health care for all Americans.

Chapter 1

INTRODUCTION

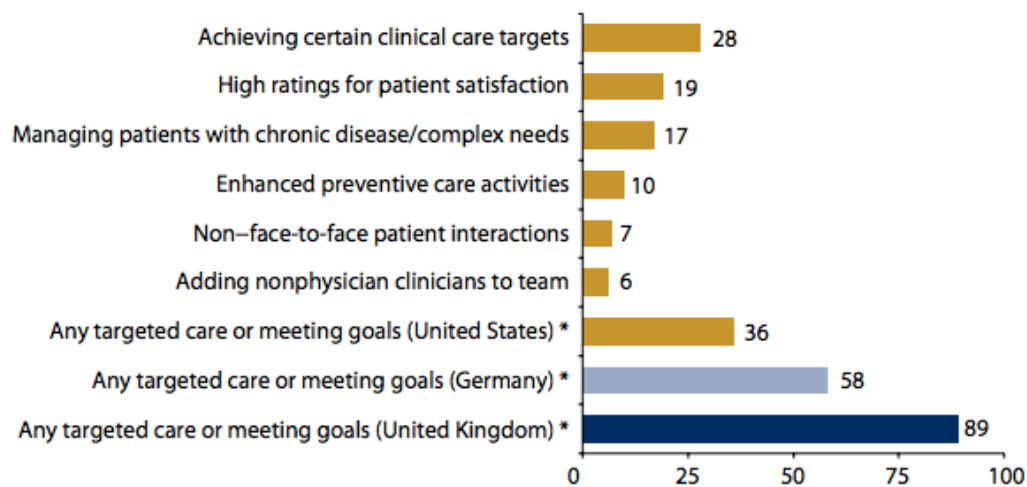
Problem Framework

There is ample evidence that shows that primary care helps prevent illness and death, regardless of whether the care is characterized by supply of primary care physicians, a relationship with a source of primary care, or the receipt of important features of primary care. Primary care, in contrast to specialty care, is associated with a more equitable distribution of health in populations, evidence shows (Starfield et al. 2005). A greater emphasis on primary care can be expected to lower the costs of care, improve health through access to more appropriate services, and reduce the inequities in the population's health. People who have regular access to a primary care physician are more likely than those who do not to receive recommended preventative services and timely care for medical conditions before their conditions become worse and more costly to treat. Among low-income patients, access to primary care is associated with better preventative care, better management of chronic conditions, and reduced mortality. And more generally, in geographic areas where there are higher levels of primary care, mortality rates are lower (Starfield, et al. 2005).

Ultimately, it is obvious that primary care is fundamental to health system performance. However, the health system in the United States has undervalued and underinvested in primary care for decades. This neglect has translated to health care in the U.S. as being poorly coordinated and expensive, which has had negative consequences for both patients and physicians. Patients have difficulties accessing

care, often experiencing extended waits for primary care and difficulty getting primary care after normal office hours without having to go to a hospital emergency room. For example, according to a recent study, one of five chronically ill patients visited the emergency room for care they could have received from their primary care practice because they lacked ready access to care (The Commonwealth Fund, 2011).

Physicians who practice primary care also report many challenges. Primary care providers struggle with having electronic patient records, patient registries, and e-alert systems regarding patient medication, or other office system supports that enable safe, patient-centered care. Moreover, nearly half of primary care physicians work in offices with only one or two practitioners. (Commonwealth Fund, 2011). Coordinating care is often very difficult for PCPs since the vast majority of such small practices are not connected to other ambulatory care providers or hospitals through information systems, so much of a patient's medical records gets lost in translation. Primary care physicians also suffer from an ineffective payment system since there is a systematic underinvestment in primary care that contributes to the growing fragmentation of care. The prevailing fee-for-service system does not adequately pay doctors for time spent with a patient or follow up before or after the next appointment. Rather, it is in favor of procedures like surgeries or medical imaging. But core primary care services, like care coordination or management, and practice infrastructure are sometimes not reimbursed at all. The current payment system also fails to provide PCPs with incentives to improve the quality of care or collaborate in teams with other physicians, a practice associated with better health outcomes for patients (Commonwealth Fund, 2011).



* Can receive financial incentives for any of six: high patient satisfaction ratings, achieve clinical care targets, managing patients with chronic disease/complex needs, enhanced preventive care (includes counseling or group visits), adding nonphysician clinicians to practice and non-face-to-face interactions with patients. Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Figure 1 Percent of U.S. physicians reporting receipt of extra payment based on quality, Commonwealth Fund 2009

Referring to Figure 1, it is evident U.S. primary care doctors report a substantially lower receipt of financial support based on quality in comparison to their colleagues in other countries, so there is no incentive to improve quality of care which in turn hurts patients.

This lack of both financial and infrastructural support, as well as inadequate reimbursement, has led to a general decline in the supply of primary care providers. Additionally, the growing income gap between primary care and other specialties over the past two decades, as well as administrative hassles and high patient loads, all contribute to the decline of primary care providers, nurse practitioners and physician assistants alike. The primary care workforce has severely depleted at a time when the demand for primary care is so high because of a growing population of chronically ill patients who require consistent and coordinated care by primary care providers. Many

studies and findings have come to the same conclusion about access to primary care: greater access leads to better health outcomes, less disparities in outcomes and access, and a decline in overall health care spending.

Over the past decade, the public policy sphere has been introduced to countless legislation to innovate the health care system and address these issues that burden both patients and providers and lead to bad outcomes and rising healthcare costs. This paper addresses policies that plan to achieve the “Triple Aim” of healthcare: to improve the patient experience of care, improve population health, and reduce the per capita cost of health care. However, in order to distinguish these plans and analyze their respective provisions and proposals, three important criteria must be applied and scored against each of these plans. These criteria act as measurable dimensions of objectives, and are used to compare how close different proposed policy alternatives will come to meeting the goals of solving the public problem.

This analysis will use three criteria to evaluate and analyze the policies: effectiveness, efficiency, and equity. Effectiveness in this context is defined as a measure of the implementation, monitoring, and progression of each policy alternatives. Because data and results that stem from these policies are currently unavailable due to the recent and ongoing implementation of these programs, effectiveness will evaluate the extensiveness and focus on implementation that is outlined in these proposals. This includes how these states plan to actually translate and apply these proposals into constructive and influential legislation and infrastructure.

Another measure that will be used in this policy analysis is efficiency, which will essentially be a cost-benefit and financial analysis of these proposals. This will

include weighing short- and long-term investments, the recurrent and one-time payments and the projected savings and generated revenue after these programs are implemented. By conducting a cost-benefit analysis, stakeholders will be able to better distinguish which provisions of these state proposals will cost the most, which will save the most, and which will benefit the most. Ultimately, because one of the goals of the Triple Aim is reduce the per capita cost of health care, it is important to consider if and how such investments in health care transformation and innovation will benefit all stakeholders in the long-term.

Furthermore, it is crucial to also consider if a major healthcare reform is equitable, if it expands access and resources to all patients and providers and whether or not it excludes certain groups relative to their counterparts. After evaluating these reform efforts against these policies, stakeholders at both the federal and state levels will have more information at their disposal to better identify best practices and implement them at all levels.

State Innovation Models Program: Overview

The State Innovation Models (SIM) initiative is a pilot program under the scope of the Affordable Care Act-established Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS). This program is designed to lower costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) while maintaining or even improving the quality of care for beneficiaries. The primary goal of the Affordable Care Act is not only to increase access to health care by expanding health insurance coverage, but to also support innovation in health care delivery and payment aimed at reducing health care costs while also improving patient care and public health.

The State Innovation Models initiative provides federal grants to states to design and test innovative multi-payer health care delivery and payment systems based within their own states. Ultimately, the purpose is to test whether these new models that have the potential to improve care and lower costs in Medicare, Medicaid, and CHIP will produce better results in a state-sponsored plan of a larger health system transformation. In 2012, states submitted SIM proposals that were sponsored and submitted by the Governor's office for a first round of Model Design or Testing awards. These awards are to provide support to states in order to create State Health Care Innovation Plans. These Innovation Plans had to outline the state's proposed approach to system transformation as well as indicate how the state's initiatives would coordinate with or build on other initiatives sponsored by CMS. In early 2013, nearly \$300 million was awarded by the CMMI to 25 states (CMMI 2018). The primary focus of this paper are several states that were granted Model Design awards, specifically Delaware and Pennsylvania. Ultimately, these state innovation plans outline strategies for new delivery and payment models that could help transform the current system and enhance the system made possible under the current policy in place, the Affordable Care Act of 2010.

Chapter 2

CURRENT POLICY

The Patient Protection and Affordable Care Act is a historic legislation that significantly changed healthcare in the United States by making insurance available to almost 50 million more Americans. Its purpose is to lower the federal government's spending on health care while adding \$940 billion to the federal budget over the first 10 years and lowering the budget deficit by \$143 billion over these same 10 years. The ACA has three primary goals: to expand access to affordable health insurance, to expand Medicaid to the working poor, and to change the way medical decisions are made. To work effectively, this policy requires an individual mandate coupled with reform of the private insurance market. There has been tremendous opposition to the ACA, arguing that mandating all U.S. citizens to purchase health care insurance from a private carrier or pay a penalty is unconstitutional. However, the ACA has made considerable strides towards reestablishing primary care as the foundation of U.S. health care delivery. The huge influx of insured individuals creates an urgent need to expand the nation's primary care capacity. The legislation also creates the need for the current healthcare system to transition to more innovative payment models so that the system no longer rewards specialty disease-based and procedurally based care but rather primary and prevention-based care.

Among the policy's many provisions, though, perhaps the least discussed are those reforms directly targeting primary care. The primary care reforms in the ACA include provisions for temporarily increasing Medicare and Medicaid payments to

primary care providers; fostering innovation in the delivery of care, with an emphasis on care models that lead to better health outcomes and patient experiences; enhancing support of primary care providers; and investing in the continued development of the primary care workforce. The goal is to work toward a path to a stronger and more sustainable primary care system that provides expanded access, higher quality and better health outcomes while still reducing health care costs in the future.

The Affordable Care Act has its own strength and weaknesses when analyzing how the policy addresses primary care. First, it reauthorizes programs to support workforce stabilization and expansion in order to allocate federal resources to maintain a well-distributed and balanced workforce that meets local and national needs (Goodson, 2010). It expands primary care residency slots, implementing teaching health centers that are community based and redistributes unused residency positions to primary care. The ACA also provides more incentives to medical students by expanding and improving low-interest student loan programs, scholarships and loan repayments for students who choose primary care as a career (AAFP). Moreover, it established the National Healthcare Workforce Commission to identify barriers limiting workforce production and encourage innovations to address the needs, changes, and other factors of workforce production. However, these programs' congressional funding has been at risk for elimination several times. Their minimal effectiveness is due to medical schools and residency training programs often failing to prioritize workforce needs, negating the importance of educating and training primary care physicians and allied health professionals necessary to fulfill the promise of the ACA.

Another strength of the Affordable Care Act and its provisions targeting primary care is the effort to change payment and financial incentives to promote primary care. The policy provides a bonus to clinicians who participate in Medicare as well as raises reimbursement to providers caring for Medicaid beneficiaries. Ultimately, these provisions provide financial incentives in order to expand access to primary care providers with the goal being more patients with better health outcomes and less disparities within these outcomes, and also to decrease overall health care spending. The Medicare primary care bonus program, whose investments estimate \$3.5 billion, allowed the previously undervalued primary care services provided by clinicians to receive an additional \$2,000 per year from 2011 to 2016 (Commonwealth Fund, 2011).

The Medicaid primary care reimbursement provision addresses the low reimbursement rates in the Medicaid program that have long threatened beneficiaries' access to primary care providers and services. This is due to the lack of incentive for primary care physicians to accept Medicaid patients because of Medicaid fees. But through this Medicaid reimbursement provision as part of the ACA, Medicaid payment rates for primary care physicians have been raised to the level of Medicare payment rates for equivalent services, which is intended to persuade physicians to continue or to start accepting Medicaid as a form of payment. Although this is largely seen as a positive change, it has the potential to be largely ineffective because Medicaid expansion is left to the decision of individual states.

Providing an incentive for patients to obtain preventative care to avoid rising costs of acute and emergency care services is another provision to promote primary care under the ACA. The legislation has three provisions applying to Medicare and

Medicaid beneficiaries as well as the privately insured that include eliminating coinsurance, deductibles, and copayments for approved preventative services and tests. This has been shown to be effective within low-income patients who could, through these provisions, afford and utilize such preventative care that will ultimately prevent them from incurring higher costs and poorer health outcomes in the future. The ACA also adds a new Medicare benefit that makes preventative services more accessible for seniors by covering a free annual wellness visit during which each patient receives a personalized prevention plan (Commonwealth Fund, 2011). By making preventative care more affordable and accessible for both poor and older beneficiaries, the ACA effectively addresses high-risk populations that have consistently had poor health outcomes.

Shifting focus to how the ACA addresses creating more innovative ways to deliver primary care, the major prospect of the legislation is to test and spread the patient-centered medical home model. The patient-centered medical home is a promising model for strengthening primary care – one primary care site that provides patients with timely access to different types of care under one “roof,” partners with patients to manage their health conditions and prevent complications, coordinates all care, and engages in continuous quality improvement. Patients within a medical home have better access to care, are more likely to receive preventative services, and have better management of chronic conditions compared to patients lacking a medical home, according to a growing body of evidence (The Commonwealth Fund, 2011).

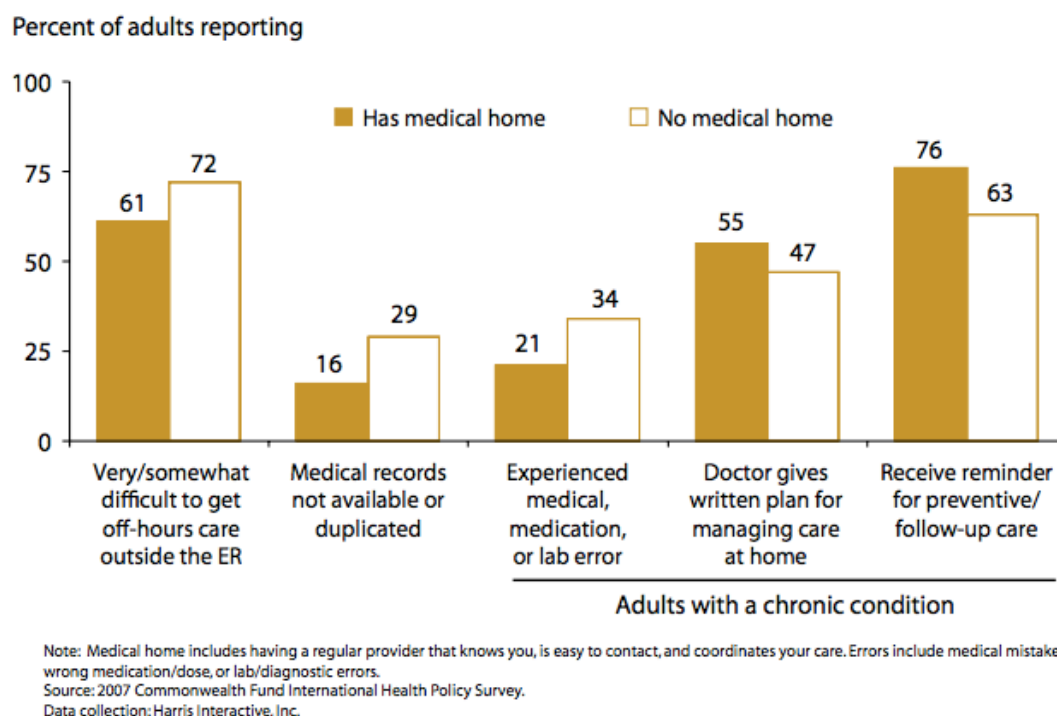


Figure 2 Impact of medical home on quality of care, Commonwealth Fund 2007

According to Figure 2, medical home patients are less likely to go the emergency room, emphasizing the effectiveness of medical home models at cost-saving through reductions in unnecessary hospitalizations and emergency department use.

The ACA plays an important role by advancing the medical home concept and offering all states the option to improve reimbursement of primary care sites designated as “health homes” for Medicaid patients suffering from chronic conditions. These health homes, similar to medical homes, are teams of designated primary care providers and other health care professionals that provide services to eligible patients like comprehensive care management and care coordination. Moreover, the ACA gives states flexibility to design their payment approach in a way that works best for

them. To qualify as a medical home, the ACA specifies that primary care sites need to provide a wide range of services, and it includes provisions designed to help these sites secure the support and infrastructure they need to meet these expectations and function as a medical home.

Another critical component of the Affordable Care Act is its creation of health insurance marketplaces that offer consumers a new, easier way to shop for health insurance. By creating a single streamlined application, and by offering affordability credits and subsidies through these “Qualified Health Plans,” the ACA effectively empowers the consumer to have a choice in their health care, and also drives the market to be more competitive and prices to decrease. Moreover, these private insurance plans must cover 10 “essential health benefits” which expand consumer’s access and entitlement to preventative, primary care services through essential community providers within their networks. This kind of insurance reform protects access to care but also works to control costs, which is important for both patient and provider as it benefits both of these key stakeholders through expanded access to preventative services that will ultimately lead to better care management and better health outcomes.

Overall, the Affordable Care Act as it stands has both promised and accomplished many successful policies and programs that have effectively and efficiently addressed the main issue at hand: tackling the challenges primary care physicians face when addressing care management and coordination that translate into barriers to access and quality of care for patients in the United States. These reform efforts are innovative and comprehensive, such as the provisions that outline more support for the primary care workforce, incentivizing preventative care by expanding

access and eliminating many financial barriers to its access, and transforming primary care delivery. Millions of Medicare and Medicaid beneficiaries will have access to free preventative care services, primary care practitioners who see Medicare and Medicaid patients will receive bonuses or increased payment rates, and more health homes will be available for patients with chronic conditions. The policy benefits both patient and provider, provides incentives for transformative payment models, and also works create

Chapter 3

CHOOSE HEALTH DELAWARE INITIATIVE

Overview

The State of Delaware proposed and was awarded \$2.5 million by the Center for Medicare and Medicaid Innovation to fund their state innovation model coined the “Choose Health Delaware,” a policy reform with the purpose of improving the health of Delawareans and patient experience of care while also working to reduce healthcare costs in the state. The plan’s founders assert that the state’s healthcare system should move toward a more patient-centered, value-oriented, technology-driven, and overall simpler model of care. By 2019, the innovation plan’s main goals to accomplish are to rank Delaware as one of the five healthiest states in the nation, within the top 10% of states in healthcare quality and patient experience, and to reduce healthcare costs by 6%.

The state’s case for change recognizes some major weaknesses in the current healthcare system within the state. The plan identified some of these major weaknesses as the inability to translate resources and ongoing innovation into the current system because of several structural barriers specific to the Delaware health system. The first barrier the prevailing payment model in the state’s health system incentivizes volume rather than quality and value, otherwise known as the fee-for-service payment model. Providers continue to receive a significant portion of payment from “Percent of Charges” reimbursement, basically a model that doesn’t incentivize cost control since provider reimbursements are higher if their costs are higher. A

second barrier is that the current delivery system is very fragmented which makes it difficult to deliver coordinated care for Delawareans. Providers generally lack experience and the scale necessary to invest in team-based coordination, since more than three-quarters of physicians belongs to practices with five or fewer other physicians (DHSS, 2013). The third structural barrier is that our population health approach doesn't integrate public health, health care delivery, and community resources. This approach spreads resources thinly across a broad range of prevention areas, which prevents sustained and focused allocation of resources necessary for such population-level changes.

Furthermore, the authors of this innovation plan assert that these three barriers are exacerbated by operational challenges, related to persistent workforce shortages and gaps across specialties, geographic areas, and skills. They are also exacerbated by limited transparency about quality and cost that continues to hinder the ability of patients and providers to make effective value-based decisions about their care. Moreover, the sustained preference for short-term pilot programs versus designing for longer-term improvements limits the overall impact of the many innovative efforts ongoing in Delaware. These are the reasons as outlined by the authors of the Choose Health Delaware that hinder the ability to translate available resources and ongoing innovation into the system, but present a case for change that many of the provisions and stipulations included in this reform policy will overcome these challenges and barriers in order to achieve the goals that Delaware has set forth for its healthcare system.

More practically, Delaware's current healthcare spending – \$8 million annually – is unsustainable, and is 25% more per capita than the national average

(DHSS 2013). Part of the problem, as identified by authors of Delaware’s SIM, is due to the state’s payer distribution because of higher overall coverage after the state’s Medicaid expansion in 1996 and again in 2014, and the state’s commercial spending per capita that is substantially higher than the national average. Moreover, this greater spending generally has not improved patient experience or health status for the population overall. The health outcomes do not measure up, although there is high quality care in many places and expanded coverage and access.

2010 Health outcomes				
	Delaware	US	Best state	Healthy People 2020
Low birth weight as % of births	8.9%	8.1%	5.7%	7.8%
Infant mortality per 1,000 live births	7.7	6.2	3.8	6
Heart disease deaths per 100,000	175.7	179.1	119.4	NA
Suicide deaths per 100,000	11.3	12.1	7.7	10.2
Cancer deaths per 100,000	185.7	172.8	133.7	160.6

SOURCE: CDC, National Vital Statistics Reports (age adjusted data); cancer deaths includes malignant neoplasms only

Figure 3 National Vital Statistics Report and Health Outcomes (age adjusted rate), CDC 2010

Delaware’s health outcomes in 2010, referring to Figure 3, are worse with higher rates of infant mortality and deaths related to heart disease, suicide, and cancer (CDC, 2010). These statistics are a direct consequence of Delaware’s overall relative unhealthiness. As indicated by the mortality rates, Delaware has a high incidence of

chronic diseases, and is specifically above the U.S. average for many key cardiovascular risk factors

Beyond this quantitative picture of poor health outcomes, Delaware's reported patient experiences of care have been poor. These experiences span across age groups and type of care, and are poor for several reasons. Delaware's current health system lacks coordination and the tools to be patient-focused. Patient accounts also cite administrative complexity with care and report that the "present reimbursement structures discourage efficient coordination of care with a team-based approach" (DHSS, 2013). As one of the three goals of the Triple Aim, patient experience is an important indicator of the effectiveness of transformation initiatives and should also be critically considered when evaluating the efficiency of these proposed models within the framework of a cost-benefit analysis.

Expanding Access to Information

So, what does its plan of action entail? Delaware's plan has several core elements that make up its plan for transformation. First, and arguably the most achievable, is implementing a technology-based patient engagement strategy that provides Delawareans with access to information and resources to take greater accountability for their own health. This element's focus on care coordination for high risk individuals, the elderly and children, who represent almost 15% of the population in greatest need for intensive care coordination has an emphasis on ensuring the integration of both behavioral and medical care so as to concentrate its delivery system on more effective diagnosis and treatment for episodic care to reduce unwarranted variation in care for these high risk populations. If the Delaware healthcare system had one electronic medical record system that both patients and providers across the state

can have easy access to, information can be more effectively communicated between providers and other providers, and between providers and the patient themselves. By providing Delawareans access to information and resources, such as their own patient medical record, test results, medication lists, the populations at higher risk of intermittent care in hospital emergency departments for example will receive better care coordination. These patients will have their own access, granting them more accessibility and awarding them more responsibility and ownership over their own healthcare so that the system will reduce unwarranted variation in care. Ultimately, this can lead to a better patient experience, higher patient engagement, and more effective coordination and management of care – with lower cost to payers.

Patient Engagement

The CHD Initiative also includes a strategy for patient engagement, a critical component of the patient-centered medical home as well as an integral focus of primary care transformation. The plan identifies patient engagement as a means to promote “access to quality affordable health care for all Delawareans” (DHSS 2013). The authors highlight emerging mobile technology for patient access to information that will help consumers compare costs, and will help stakeholders connect with schools and employers to develop peer-based and education-based influencing strategies to evaluate the types of programs Delaware could pursue in the future. The current plan emphasizes the use of technology, engaging community and peer support, outreach and education to empower healthcare consumers with health information and tools. This plan’s approach to rollout will occur over the course of three years, with the introduction of the marketing campaigns and building the new technology

happening within the first year and the introduction and implementation of the new technology continuing over the next two years.

First, the plan includes the provision and adoption of publicly downloadable smartphone apps designed to extend the technology base for patients' health empowerment, access to care, and care coordination. These tools will address personal health promotion, especially with chronic disease self-management and risk reduction behaviors, as well as increase the transparency about the state health care system (DHSS 2013). By utilizing these proposed apps, Delawareans are able to gain easy electronic access to their medical records, and will also have a channel to learn information about risk reduction behaviors, how to make value-conscious health care choices, and how to access health care services in the state. The idea is that, with this additional health promotion information that is now accessible to more people, this could potentially incentivize healthy activity and include the public as a key player of this redeveloped statewide delivery and payment model.

Second, the strategy incorporates the implementation of a "statewide social marketing and education campaign to communicate unified health and health care decision making and utilization messages" (DHSS 2013). This type of marketing will deploy messaging that targets Delaware consumers and communities to inform and empower them to become "fully-participating members of the expanded health care team." More importantly, these messages will highlight the importance of prevention, early detection, and primary care – emphasizing the role of Delawareans as decision-makers and consumers within the context of their own health care as well as within the statewide health care system.

Ultimately, this patient engagement plan hopes to generate cost savings by informing and enabling patients to identify the most appropriate care settings, engage in healthy behaviors and value-based purchasing, and encourage the reduction of unnecessary utilization and the elimination of duplication of services, and ultimately, improving the efficiency of their care and its coordination.

Utilizing Quality Measures

Another core element within Delaware's plan for transformation is the plan to create a simple, common scorecard of provider performance and patient outcome measures, to better evaluate quality relative to cost, and to improve the level of transparency about quality and cost, which was earlier highlighted as an operational challenge that exacerbated barriers within the health system. Additionally, Delaware's plan generally covers a set of shared services and resources the reform hopes to develop in order to support providers, like the creation of clinical guidelines and protocols with a focus on more effective diagnosis and treatment, as well as learning collaboratives and a shared tool for the stratification of care coordination needs. Moreover, the plan hopes to transition outcomes-based payment models across all payers to achieve a goal of 80% of the state's population receiving care through a value-based payment and service delivery model within five years of implementation. This will help address the incentives within the prevailing payment model of volume over quality and value. Lastly, and perhaps the most unique feature of Delaware's plan for transformation, is its blueprint for their coined "Healthy Neighborhoods Model" concept. This model integrates communities with their local care delivery systems in order to better connect community resources with each other. It introduces the Neighborhood Council, comprised of community organizations, employers, and

providers – actors in the healthcare system who lead care coordination in the community and across clinical settings – who share a focus on health, wellness, prevention, and primary care.

Transformative Payment Models

With regards to payment models, the Choose Health Delaware model intends to transition all or most care in the state to outcomes-based payment that “incentivizes both quality and management of total medical expenditures over the next five years” (DHSS 2013). Currently, the health care system in Delaware remains a predominantly fee-for-service (FFS) payment system that promotes incentives for providers to provide a higher volume of care rather than higher value care. There is widespread agreement in the value and need for a shift to an outcomes-based reimbursement system, but many barriers to this new payment model adoption exist within the state’s current system. These barriers include a lack of payer alignment, since past attempts at payment model innovation have affected an insufficient portion of a provider’s payments to encourage the changes needed for care delivery and instead resulted in an increased administrative burden for providers – something that should be avoided. A second barrier persists when trying to scale existing payment system pilot programs due to the diversity in the provider environment, meaning that transformation needs already differ within the system.

Delaware considered two general types of reward structures for outcomes-based payment: pay for value and total cost of care. Both focus on incentivizing quality as well as value. Stakeholders reviewed specific technical design considerations within these two types of structures, such as the pace of roll-out of the new model across the state, level of performance to be rewarded, metrics to be used

for eligibility for participation, as well as member attribution methodology (DHSS 2013). With these considerations, stakeholders ultimately decided on a payment system model that would be the most feasible, and one that also aligns with the goals of the SIM. Ultimately, they decided on a plan for transforming its payment model that is built around a common set of quality measures and accountability for managing per member costs, with the goal of incentivizing value. In the published Choose Health Delaware Initiative, the stakeholders identified the following principles when reviewing options for Delaware's payment model:

1. Population-based as core foundation, with providers assuming accountability for the overall care of their patients (as opposed to just for discrete encounters or individual episodes), with potential for episode and/or other models to be layered on in the future.
2. Multi-payer alignment to support the business case for delivery system transformation, with room for differences in patient populations.
3. Common vision that includes accountability for access, quality, and experience as well as total cost of care.
4. Multiple transition paths to account for differences, structures, and capabilities among providers.
5. Continuous improvement, with established checkpoints during transition.
6. Balanced rules for payment model participation that account for the advantages of scale, clinical integration, and competition.
7. Design for scalability from the outset, even if providers and payers choose to stage rollout for operational or financial reasons.
8. Strive for administrative simplicity while confronting the needs of some payers for administrative consistency with national standards.
9. Plan for the transition costs to some providers (e.g., new capabilities for PCPs, reduced inpatient volume for hospitals).

10. Role for fee-for-service, recognizing that fee-for-service will continue to make sense for some payments.
11. Flexibility, recognizing that providers will make different decisions on organization and risk.
12. Incentives aligned with care for the highest risk patients in a way that prioritizes quality and continuity of care.

The proposed payment model reflects has an overall goal to enable the vast majority of Delawareans to receive their care from providers incentivized by quality and total cost of care. Delaware's goal to maximize inclusiveness and provider participation in these outcomes-based payment models is reflected in the option to begin with the pay-for-value (P4V) model and offering two types of total cost of care arrangements:

Upside only option: Providers continue to be paid fee-for-service for the duration of potentially one year. At the end of this year, providers who meet quality measures and whose risk-adjusted per member costs fall below a benchmark, share a portion of savings. Providers will share in savings that exceed 2-4% minimum savings rate, but with a maximum of 10%.

Upside and downside risk sharing: Providers continue to be paid fee-for-service for the duration of potentially one year, similar to the upside only option. At the end of this period, providers who meet the quality measures and whose risk-adjusted member costs fall below a benchmark, will share a portion of savings. However, providers will also bear risk if costs exceed expectations. Providers share in savings that exceed minimum savings rate of 1% with a maximum level of savings or losses of 10% in year 1, and 15% in year 2.

Across all payment models, Delaware's payers will fund provider investments in care coordination. Ultimately, commercial payers may choose to adopt these models for their providers – these merely serve as the starting point models. These models are population-based, and differ in the nature of savings shared and level of

risk. Delaware plans for Medicaid to offer providers these two arrangements, and will invite Medicare to offer similarly structured models.

The goal is to maximize inclusiveness and provider participation in outcomes-based payment models. This plan aligns payers on an overall payment model framework, enabling providers to transition a significant portion of overall payments to a common outcomes-based model. By offering multiple options, the plans enable broad provider participation and also balance flexibility and structure. Choose Health Delaware has identified an overall goal of achieving 80% coverage in new payment models, and it does so by inviting Medicaid, Medicare, and commercial insurers to participate. Delaware Medicaid will introduce the models and Delaware will invite Medicare to introduce similar models. The state's commercial insurers participated in the development of this plan and this complements the transition within the commercial market towards value-based payment. Collectively, these actions will achieve at least the goal of 80% coverage.

Improving Care Coordination

Another important component to consider with Delaware's model when analyzing its impact on primary care transformation is the provisions that address improving care coordination. First, Delaware outlines a strategy to coordinate with statewide health information technology initiatives previously discussed by following a three-part approach. First, the state would build off the current health information exchange network DHIN to connect providers, hospitals and community agencies across the state to increase clinical data exchange between providers to increase continuity of care and integrate statewide public health databases into provider workflow (DHSS 2013). Second, the strategy will use the DHIN interface to create a

multi-payer provider portal for performance reporting and metrics input in order to allow clinical quality measures to be reported to providers and to allow providers to input information and give feedback for standardized metrics. Lastly, the care coordination via health IT strategic initiative also plans to connect the DHIN to the patient engagement strategy to link patient and providers and to help guide care. By doing so, patients will have access to a secure messaging tool as well access to a clinical results delivery system, that will further allow patients to engage directly with providers.

Another approach Delaware's plan to better care coordination is to reach rural providers, small practices, and behavioral health providers. As the plan mentions, broad provider access to patient data relevant for care is an important goal especially within a state that recognizes the fragmentation within care coordination of small practices and rural providers. By incorporating the DHIN adoption efforts with as wide of a base of providers as possible, including rural, small practice, and behavioral health providers, Delaware will be able to expand and facilitate provider access to patient data relevant for care in a secure way. The Delaware plan identifies the existing system of record for all Medicaid claims and payments, known as MMIS, as a functional starting point for this kind of intended statewide data integration approach, and the opportunity to track and measure its functional performance.

Delaware's Workforce

One of the Choose Health Delaware plan's critical goal is to become a "Learning State," to create and actively support interdisciplinary training and retraining. The goals are to achieve "the highest quality health care, the best health outcomes and lower health care costs" by creating "patient-centered, multi-

disciplinary teams delivering integrated and comprehensive care” (DHSS 2013). This vision depends on enabling all health professions to work in coordination, which requires retraining the current workforce and new training programs for the future workforce to learn how to incorporate cooperative communication, critical thinking, and analytical skills along with facility in the use of health IT. Delaware’s plan also recognizes that the “future health care workforce in Delaware will be broader, more diverse, and more geographically distributed” in order to adequately meet the needs of the state’s diverse populations and respond to this expansion of access to health care coverage with a heightened focus on prevention and wellness.

Currently, health care workforce training and education in Delaware and the necessary supporting infrastructure already exists and continues to operate across the state. There are numerous workforce and training systems across the state, like Christiana Care’s Learning Institute comprised of eight virtual centers, its State Loan Repayment program that led to a 400% increase in recruitment and placement of primary care professionals that expanded access to care for 25,000 additional Delawareans, as well as novel training programs at the University of Delaware and participating medical schools and health systems (DHSS 2013). In many respects, the state has a strong health care workforce, but as the plan admits, existing needs remain, citing pressing needs in several specialties and particular geographies.

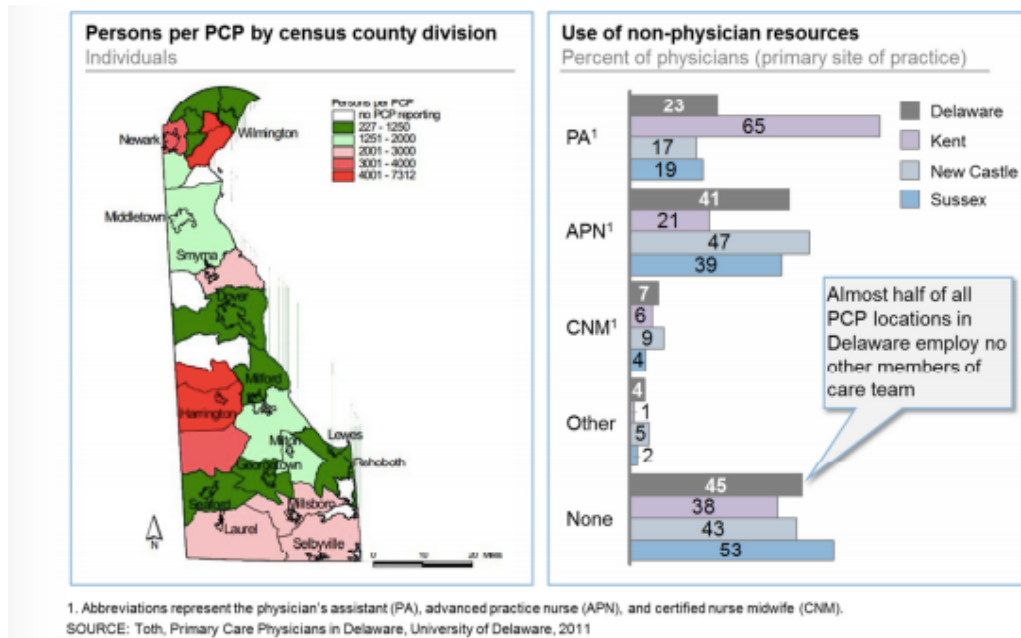


Figure 4 Delaware's Health Professional Shortage Area Across Specialties, University of Delaware 2011

Referring to Figure 4 Delaware's workforce falls below the designation criteria for Health Professional Shortage Area (HPSA) for specialties like primary care providers, and that there is significant variations in involvement of non-physicians within care teams across physician offices. This suggests that nearly have of primary care practices are small and fragmented, employing no other members of the care team. Team members like physician's assistants, advanced practice nurses, and certified nurse midwives are not employed within these private practices; this lack of additional team members has adverse affects on care coordination and a higher administrative burden on physicians.

The Delaware Health Care Commission (DHCC) offered workforce recommendations in its 2012 workforce initiative, identifying several overall

objectives to address existing needs within the workforce. Some of these objectives include supporting and continuing the expansion of Delaware's health IT infrastructure, to support innovative workforce education and training programs, to ensure integrated and supportive practice environments for health care professionals, and lastly, to create and implement comprehensive recruitment strategies.

However, to implement such workforce changes, Delaware has to overcome remaining barriers and close the existing gaps within the workforce. Some of these barriers include limited coordination across training programs and institutions, unclear roles and definitions that make it difficult to communicate about the workforce, and the limited access to training and retraining programs due to lack of individual funding. Furthermore, licensing and credentialing processes remain burdensome, and the workforce efforts remain generally focused on traditional approaches through traditional channels.

Ultimately, Delaware's plan for a "sustainable model for a flexible workforce" depicts care coordination operating across all levels of the system, from within the community all the way to hospitals and care facilities. Care coordinators, like PCPs and community health workers, will play an important role as part of multi-disciplinary teams to promote effective team-based care. To do so, they will require different levels of training based on the setting in which they are providing care – the community or a health care setting. However, once they are properly trained to deliver care within that setting, care coordinators can focus expand the workforce and work with all risk stratifications of Delaware's population, from the highest risk populations to healthy and lower risk populations with a focus on prevention and lowering risk of disease.

Critical Enablers

Choose Health Delaware identifies three “critical enablers,” or key changes that will facilitate the implementation and operation of this reform. First is the industry-leading Delaware Health Information Exchange, a single interface for providers and patients to access health information that “supports care coordination, performance reviews, and patient engagement”(DHSS 2013). This interface is meant to ensure the right information is available at the right time and place in order to promote better, more coordinated, and more team-based care. This is a key component in achieving the first element discussed earlier, the implementation of a technology-based patient engagement strategy. Being able to have one consortium of information across the state is critical, especially for care management and coordination. Second, is the Delaware Center for Health Innovation, a governance structure that would operationalize this transformation, monitor its progress, and make refinements as more data becomes available to identify areas of increased cost, and decreased or no benefit. Ultimately, this key component of the innovation plan is the reassurance of Delaware’s investment in such policy changes, so that this pilot program does not remain a short-term plan but a long-term solution. Delaware’s vision to become a “Learning State” so that this innovation of resources and reforms also translates into the healthcare workforce was previously mentioned as a way to achieve high quality care with an expanded through a refocused workforce. This would give Delaware national recognition for its “innovation and holistic approach to workforce development”(DHSS 2013). This enabler will allow Delaware to create transparency around existing resources to add capacity for new roles within care coordination and health information technology, and to coordinate education and training programs across healthcare-related institutions to make sure the entire workforce receives the

necessary training to be able to practice in teams and as the best in their field. The goal is to render legitimate changes in practice from these policy reforms.

When considering how exactly this innovation model supports primary care practice transformation, it focuses on financially supporting providers who choose to transform their primary care practice, and also funding care coordination. By supporting primary care practice transformation, the innovation model offers transitional financial support and technical assistance to help providers adopt changes within their clinical and operational processes. With care coordination, the plan works to help providers coordinate care between patient's office visits and other encounters within the health system.

Implementation

Translating this strategy into concrete change will no doubt require a concerted effort over several years with sufficient funding. Delaware's plan outlines a set timeframe, resulting capabilities, the budget needed to support these measures, as well as how such a large-scale effort will be governed. The plan's proposed governance model, the Delaware Center for Health Innovation, will serve as a "corporate entity with representatives from both the public and private sector whose purpose is to continue to drive transformation of Delaware's health system, support implementation of the State Health Care Innovation Plan, serve as a continuing forum to bring stakeholders, and ensure an ongoing inclusive and participatory approach to transformation" (DHSS 2013). This type of governance is critical to establish these programs, track their progress, and ensure momentum continues – it's crucial to the long-term success of this work, stakeholders have concluded. The DCHI will establish the Innovation Center Board, composed of four committees of diverse constituencies,

who will all be responsible to track and monitor overall progress. The four committees – the Clinical Committee, Patient Advisory Committee, Workforce Education and Training Committee, and the Healthy Neighborhoods Committee – encompass a broad range of responsibilities to operationalize the resources, represent the interests and perspectives of all players, coordinate workforce training as well as the efforts to improve population health.

By granting one central team quasi-official authority as the leading body for this innovation in the state, and by holding this team accountable for the progress, efficiency, and effectiveness of each area within its oversight, Delaware has the appropriate tools to ensure the implementation of such long-term transformation. When considering the overall timeline of this transformation, Delaware’s vision to transform the payment system is a plan that will take place over the next five years, and establishes “checkpoints” for the development of the remaining aspects of the plan. The Delaware Center for Health Innovation will hold the primary responsibility for refining these checkpoints as the plan progresses and incorporates new stakeholder feedback over time.

Chapter 4

HEALTH INNOVATION IN PENNSYLVANIA

Overview

The State of Pennsylvania was also granted a \$3 million award by the Center for Medicare and Medicaid Innovation as one of 38 total awardees in the State Innovation Models Initiative, along with Delaware. Their comprehensive plan, the Health Innovation in Pennsylvania (HIP) plan, addresses health care delivery system transformation, value-based payment systems, expanded use of health IT, and improving population health and workforce development across the state. The HIP plan focuses on three primary strategies as stated in its executive summary: “1) to accelerate the transition from volume- to value-based payment models, 2) to achieve price and quality transparency; and 3) to redesign rural health care delivery” (HIP 2016). For each strategic priority area, specific initiatives were identified that will enable the state to meet these goals as well as the Triple Aim: better care, smarter spending, and healthier people.

As part of the HIP’s primary strategies, the state plans to join federal efforts to increase the percentage of health care spending in value-based payments with a four-year goal. In order to achieve this goal, the strategy includes both advanced primary care and episode-based payment models. These approaches have been pursued before in other states with positive results, but the distinctiveness in PA’s approach is that it emphasizes building on existing work within the state and identifying targeted areas where model development and deployment can be accelerated. Another primary

strategy of the HIP is its focus on several transparency initiatives like consumer health literacy, “shoppable” care for commodities, and shoppable care for episodes. These initiatives’ primary focus is on improving transparency for PA consumers but will also benefit other “end-users” such as providers, payers, and policymakers (HIP 2016). The last primary strategy is the state’s rural health redesign through the expansion of tele-health services and utilization of community health workers to ultimately elevate the health status of those living outside densely population urban centers currently experiences less or fragmented access to care. These initiatives help improve access to high quality health care for those living in rural areas of the state. In order to enable these strategies, the HIP includes transforming the health care delivery system as well as technology initiatives to develop a centralized Health Information Exchange among other initiatives.

The current health of Pennsylvania’s 12.8 million residential population is outlined in the State Health Assessment 2014 report released by the Department of Health outlining the health status, factors that contribute to health issues and resources that can be utilized to address health improvement. The health status of Pennsylvania’s residents is comparable to the rest of the nation, including the issues they face such as obesity, smoking, teen pregnancy, diabetes, and untreated mental health conditions. However, there are significant disparities in health status and access by race, ethnicity, and geography in Pennsylvania.

Table 1.2 Selected Measures of Health Status and Health Access by Race/Ethnicity in Pennsylvania Compared to the United States, 2011-2012¹¹

Share of respondents reporting that they:	Pennsylvania			United States		
	White	Black	Hispanic	White	Black	Hispanic
Have a fair or poor general health	16%	25%	22%	16%	23%	26%
Are overweight or obese	65%	70%	69%	63%	73%	68%
Smoke	20%	28%	26%	19%	20%	14%
Have frequent mental distress	34%	41%	43%	33%	36%	34%
Have no usual source of care	12%	20%	30%	18%	26%	41%
Have not had a checkup in the past 2 years	17%	10%	16%	17%	11%	22%
Data may not sum to 100% due to rounding and data restrictions. Data for Whites and Blacks exclude Hispanics.						

Figure 5 Measures of Health Status and Health Access by Race/Ethnicity in Pennsylvania Compared to the U.S. from 2011-2012, HIP 2016

Figure 5 highlights selected measures of health status and access of Pennsylvanians of different races compared to the national averages in the United States. One glaring disparity is the inequitable access to usual source of care in PA, with blacks and Hispanics in the state reporting not having a usual source of care at twice and three times higher rate than whites, respectively (KFF 2016). Over forty percent of both Hispanics and blacks report having frequent mental distress compared to 34% of whites, and both groups are also more likely to smoke than whites. One in four black residents report being in fair or poor general health compared to 16% of white residents who report the same (KFF 2016). Pennsylvania residents also experience health disparities based on geography, specifically those living in rural communities who are more likely to have unmet health needs and poor access to care. For example, the Pennsylvania DOH reported in 2012 that residents in rural communities had higher rates for cancer, obesity, heart disease, and diabetes. The central goal in the HIP's

pursuit of delivery system transformation is to eliminate these disparities in health status or access to health care services that are based on living in Pennsylvania, or where they live in the state.

The current payment system in Pennsylvania is predominantly private insurance, with more than half of state residents covered by employer-sponsored insurance and non-group coverage. Another third of residents are covered by public insurance – Medicaid (17%) and/or Medicare (15%) (HIP 2016). Eight percent of Pennsylvanians remain uninsured. Total health care spending for all coverages types and services in the state is 13.4% higher than the national averages, and Medicaid spending alone accounts for 30% of the state's total budget (CMS 2012).

Pennsylvania's fractured payer landscape is due largely to the diverse health insurance market including numerous small and large group carriers as well as individual carriers. Moreover, the state's health care market overall expenditures keeps growing by an annual rate of 5.7%, which contributes to PA's per capita health care spending that is 13% higher than the average U.S. per capita spending level (HIP 2016). There are various drivers of growth in health care expenditures, including incentives to perform more care due to a fee-for-service system, fragmented care, a larger aging population, increasing rates of chronic diseases, and overuse and underuse of care.

Current initiatives for health improvement in Pennsylvania have laid the critical groundwork for health care delivery system transformation, notably the policies targeting workforce development and framework development for a health information exchange (HIE) database. Pennsylvania's DOH currently operates multiple programs to train the health care workforce and support health care professionals both administratively and financially. The state-adopted HIE supports better data exchange

and works to improve health care delivery and outcomes by enabling the secure exchange of electronic health information.

Value-based Payment Models

Pennsylvania aims to accelerate its ongoing shift from volume to value-based payment models for both public and commercial payers in order to curb the rising health care costs the state has been experiencing exponentially over the past decade. The rising costs affect an increasing share of the state's budget, employer costs, and consumer pocket books. Overall, health care spending represents 37% of per capita income (HIP 2016). The state's four-year goal to shift the payment mechanism from a fee-for-service to a value-based model will include both population-based and episode-based payment models.

Population-based payment models, such as advanced primary care, incentivizes proactive manage care and are most effective when one provider – the primary care provider – acts as the central coordinator across patients' needs. Advanced primary care models emphasizes this team approach to primary care delivery to create better efficiency and collaboration across providers to meet patients' health care and social needs.

Episode-based payment, otherwise known as bundled payments, incentivize actively managed episodic care by utilizing evidence-based practices to reduce variation in care, improve quality, and lower costs. This could address up to 50-70% of costs, according to a study of Ohio's similar payment model implementation (HIP 2016). With episode-based payments, a single provider – the Principal Accountable Provider (PAP) – is responsible for managing the episodes for both quality and cost efficiency, and may bring other providers into the episode as necessary to care for the

patient. The PAP leads the team and is responsible for driving improvements and results with value-based payments. These episodes of care, according to HIP stakeholders, provide an opportunity for a multi-payer approach in Pennsylvania, more work needs to be done to establish common definitions and an infrastructure for implementation to develop these models more broadly throughout the state.

One big advantage to incorporating both episode-based and population-based payment models is that they are complementary in addressing health costs spent during a defined period of time as well as in a patient's lifetime. Population-based models provide a structure to manage total cost of care and overall health outcomes, with an emphasis on chronic conditions and prevention. The models encourage care coordination of PCPs, community health workers, and other providers who work with patients across the health continuum to keep them healthier overall and thus avoiding spending on unnecessary services. Episodic-based models further address health care spending in ways that are not already addressed by the population-based models. Specifically, bundling payments across providers during episodes of care leads to better quality and cost transparency, and incentivizes team-based care to manage an episode from beginning to end. Specialists who manage episodes can provide valuable information for PCPs involved in population-based models about how to improve total cost of care and quality, and can also be mobilized to coordinate care to ensure patients receive optimal care while reducing wasteful or duplication of services. Using this approach of incorporating both types of payment models as a transition from fee-for-service models, the state can improve quality for the majority of health care activity and spending while reducing costs.

As previously noted, Pennsylvania plans to build upon existing initiatives in order to implement these payment model transitions. The population-based models are already well underway, and the HIP works to address the critical need and largest opportunity for impact to drive standardized definitions and measures for advanced primary care. These models are underway in PA and have had significant momentum, and several programs that have piloted this payment model have reported positive outcomes including “cost savings, fewer emergency department visits, and improved health, access, prevention, and patient/provider satisfaction” (HIP 2016). Given this progress along with increasing interest in expanding the use of this payment model in more programs, the HIP aims to work with insurers on their implementation and formulating a common set of quality measures. Overall, the HIP plan pursues multi-payer episode-based payments and creates common elements of the episode approach across all payers.

Price and Quality Transparency

For stakeholders to effectively implement any type of new or refined payment models, price and quality transparency efforts are critical. The HIP plan identifies four objectives to achieve such transparency:

1. Performance transparency – patients, providers, employers and other stakeholders must have clear understanding of cost and quality performance
2. “Shoppable” care transparency – patients are empowered and enabled to make value-conscious decisions around their care choices
3. Rewarding value – a level of transparency enables innovative payment models to reward providers for patient outcomes and cost-effectiveness

4. Consumer behavior change – consumers are better informed about the impact of their behaviors on their individual health

The HIP plan also identifies several challenges and gaps, such as the growing need to leverage data to improve transparency driven by the increasing demand from consumers to understand quality and out-of-pocket cost. Based on these recommendations, the state plans to work with stakeholders to improve consumer health literacy, support broad primary care transparency for all data users by streamlining and standardizing PCP reporting requirements, and enabling “shoppable” care transparency. After the initial stages of implementation, the state will continue to drive the development of a commodity transparency tool. Ultimately, these plans will streamline the transition to value-based payments and make price and quality transparency a priority within this transition.

Redesigning Rural Health

For the 1.8 million Pennsylvanians who live in rural areas, there exist several challenges that impact access, cost, and quality of care. Access to care is often limited in rural areas, and many rural providers struggle financially which also jeopardizes access to care. Even hospitals in rural Pennsylvania operate within negative margins and are at risk to fail without a sustainable business model, according the HIP plan (2016). In many cases, rural health providers are central to communities located in medically underserved areas or areas with shortages of health professionals, so if they close, access to health care would have to transition to urban centers which are often higher cost and less convenient. In addition to the risk to access, quality of care is also impacted. Often, rural hospitals have sub-scale service lines that pose a risk of “lower quality when a minimum threshold of procedures is not performed on a consistent

basis” (HIP 2016). For example, 48% of stroke patients admitted to rural emergency received the necessary drug over 3 hours after the stroke, compared to only 14% of stroke patients in non-rural hospitals (CMMS 2017). Moreover, economic challenges also affect rural health care in Pennsylvania. Specifically, many recent value-based payment model innovations in Pennsylvania have engaged few rural hospitals and clinics and have failed to be implemented within rural health systems.

To overcome these health care access, quality, and economic challenges, the HIP plan works to ensure better health and care for rural residents by following several broad initiatives. One of these initiatives is focusing health care delivery system transformation for rural community on ways to improve access to care by removing barriers to tele-health and expanding access to oral and behavioral health providers. Another initiative is to work in conjunction with the CMMI and payers to develop “predictable revenue streams for hospitals to enable them to transform how they deliver care to better match the needs of the local population” (HIP 2016). A value-based, multi-payer payment model for rural hospitals would replace the current fee-for-service model that is failing rural hospitals because hospital volume has declined in rural areas.

Health Care Delivery System Transformation Plan

Another strategy for health innovation Pennsylvania addresses in its SIM. The HIP plan centers on improving access to care by utilizing tele-health services, data collection and analysis, and expanding workforce capacity. Care collaboration and patient engagement are also considered important aspects of health care delivery transformation to PA stakeholders. The advancement of care collaboration and patient

engagement require improving technology and building awareness of the entire care team to deliver high-performing, patient-centered care.

Currently, Pennsylvania has many initiatives in progress to accomplish this transformation, including streamlined data collection processes and health professional education. Its plan is to apply several strategies to build on these existing initiatives, like integrating behavioral and mental health with primary care, expanding tele-health capacity, and building a more robust health care workforce. First, Pennsylvania plans to create a public health gateway through an e-health partnership authority and the state's Department of Human Services. This would be a streamlined way for providers and existing regional health information organizations to connect and submit reportable public health data, which will pool resources to collect, store and analyze reportable health information and increase productivity that will save money. Secondly, the Department of Health in the State of Pennsylvania will work utilize existing programs within its jurisdiction to improve the distribution of the health care workforce to meet the needs of medically underserved populations. In the future, the plan will also work to integrate behavioral and mental health with primary care in order to enhance the capacity of primary care, expand the workforce, and will remove barriers to co-location of providers. The plan will also expand tele-health capacity, as previously mentioned, to help leverage a poorly distributed provider workforce and increase access to services in underserved areas.

Health Information Technology Plan

As previously mentioned, Pennsylvania has existing healthcare technology initiatives and has long invested state and federal resources in building statewide health information technology functionality and capacity. Substantial infrastructure

exists to support a functional health information exchange, and many providers and hospitals are already utilizing electronic health records (EHR) system. According to the U.S. Department of Health and Human Services Office of the National Coordinator for Health IT, 53% of hospitals, including rural hospitals, have adopted basic EHRs, however, only 42% of providers have adopted at least basic EHRs (HIP 2016). Adoption of EHRs is not universal – rural hospitals, long-term care providers, behavioral health providers, and social services agencies lag in EHR adoption because some of these institutions do not have the same incentives to do so through federal funding. Innovative funding and infrastructure support options is important to promote the integration and operability of clinical information systems. For these reasons, expanding the statewide health information exchange, supporting price and quality transparency, and enhancing the use of tele-health technologies are primary objectives of the HIP plan for health information technology.

Workforce Development Strategy

Retention and recruitment of a diverse health care workforce across Pennsylvania, particularly in underserved areas, has proved to be challenging. This often leaves many Pennsylvanians without access to the care they need, so the state must work to ensure there is an adequately sized and competently trained workforce so that residents are not disadvantaged because of where they live. The state has developed workforce development strategies supported by state agencies as well the private sector to address this need.

Currently, Pennsylvania has a higher physician-to-patient ratio than the U.S. average, but the disproportionate distribution of physicians still leaves many residents without access to health care services (HIP 2016). Pennsylvania is home to more than

a hundred Health Professional Shortage Areas and Medically Underserved Areas due to an inadequate workforce. The state is also home to nine medical school programs and innovative teaching centers, but the availability of these programs and the growing number of professionals trained in these programs have not been reflected in the retention rates. Physician shortages have to be addressed with more than just simply expanding medical and health training. It must also target financial support for primary health care practitioners to make this profession more appealing and to help build the physician workforce across specialties and geographies.

Ongoing workforce development efforts in Pennsylvania are expanding and enhancing as part of the HIP initiative. Several initiatives currently working to increase providers in underserved areas include developing and monitoring primary care resources, participating in waiver programs for physicians, as well as administering statewide community-based health care programs. However, in the future, stakeholders recognize that with shortages, an aging workforce, an increase of people seeking care due to increased insurance coverage, as well as a changing health care landscape, Pennsylvania must be innovative in its workforce planning. They recognize that the state will achieve a more efficient health care system by building and maintaining a workforce that is trained in care coordination, data sharing, value-based payments and team-based care.

One unique component of the workforce redesign strategy is the utilization of community health workers as a core building block to creating a coordinated and efficient health care system and expanding workforce capacity for patients who face chronic illness and/or socially disadvantaged conditions. CHWs can play a big role in improving quality and reducing costs, and with more awareness and recognition to the

profession, as well as support training and development opportunities, the state can operationalize CHWs to improve care collaboration and coordination across care providers. Moreover, the HIP plan also strategizes a way to integrate behavioral and mental health with primary care, which stakeholders recognize already comes with several challenges such as infrastructure and capacity building. However, with this kind of integration, care coordination could improve to ensure that behavioral and mental health providers are clinically integrated.

Chapter 5

CRITERIA ANALYSIS DISCUSSION

As part of the policy analysis, it's crucial to evaluate the policy alternative against several criteria; in this case, the policy alternatives will be evaluated based on their effectiveness, efficiency, and equity as previously defined in Chapter 1. Effectiveness, in this context, can be defined as a measure of the implementation of the provisions within the state proposals. Evaluations of "high effectiveness" translate to the feasibility of the plan and its inclusion of a well-contextualized plan for implementation, whereas "low effectiveness" translates to infeasibility and disengagement of stakeholders and drivers of action. Efficiency will be evaluated using a cost-benefit analysis, weighing short- and long-term investments to the projected savings and revenue. Evaluations of "high efficiency" are if a plan is low-cost with increased benefit when looking at its financial analysis. A "low efficiency" evaluation translates to a plan which costs are too high without considerable benefit. Equity measures and evaluates the degree of disproportionate impact on some social groups. A "high equity" evaluation translates to the plan does not exclude certain groups, specifically groups based on geography, race, gender, social class, or wealth, but rather expands their access to quality care equitably to their counterparts. This also includes an equitable expansion of resources across all providers as well as payers. A "low equity" evaluation translates to a plan that does not expand equitable access to quality health care and does not expand resources to all providers and payers.

Table 1 Criteria Analysis for Current and Alternative Policies

	ACA	Delaware	Pennsylvania
Effectiveness	Moderate	Moderate	High
Efficiency	Moderate	High	Moderate
Equity	Low	High	Moderate

Effectiveness

Affordable Care Act 2010

The effectiveness of the Affordable Care Act is due to several of its initiatives, specifically the implementation of major technological systems to payment systems, and streamlining both the enrollment and renewal processes and increasing administrative effectiveness of Medicaid. The level of impact after its passage is considerable, decreasing the number of uninsured individuals but not by as much as originally predicted. By 2015, there were still 35 million individuals without insurance, with only 15 million fewer uninsured individuals since 2010. There are few indications that the ACA has had its intended impact on cost of care and access to it – two of the three principles of the Triple Aim. Total health expenditures have returned to pre-recession rates, but that demonstrates that there hasn't been a bend in the cost curve. For many who have gained insurance coverage, they haven't been successful at gaining access to affordable care because they are still paying premiums for plans that do not meet their needs. The ACA's health coverage policy does not focus on enlisting market forces to lower costs rather but merely just subsidizes costs. Physicians' opinion on whether they believe the ACA is a good option and vehicle for healthcare

reform, according the 2014 Survey of America's Physician conducted by the Physician's Foundation, the majority of the physicians surveyed answered they'd give the ACA a grade of "C" (Health Policy Gateway, 2018).

However, the ACA's provision for tax credits to the middle class, those below 400% of the poverty level, and its expansion of Medicaid to 138% of the federal poverty level provides coverage to millions more Americans. It also allows for young adults to stay or be added to their parent's plan up to age 26. The reform also gives Medicare beneficiaries a 55% percent discount on prescription drugs (Amadeo, 2018). Moreover, the ACA transforms health care delivery as well, especially through Medicare and Medicaid programs, to prioritize a comprehensive approach through Accountable Care Organizations. Ultimately, though the ACA has expanded coverage and access to millions of Americans, it has not achieved its expected and predicted success and therefore has been scaled as having moderate effectiveness.

Choose Health Delaware

The "drivers of action" for each stakeholder are specific incentives for each stakeholder that will help to ensure the commitment of various stakeholders to work together through this health transformation. This greatly improves the effectiveness of this plan, since stakeholders experience greater accountability and benefit from transforming healthcare and improving the health of Delawareans.

Individuals, in their role as patients, clients, consumers, and caregivers, will find a health care system more centered on their care and will be sensitive not only to their health outcomes but also the costs they will pay and the experiences they will have. This type of transformation will produce a system that is simpler and higher quality that will expand access, preserve choice, and improve affordability, which will

have the tools to engage and take greater accountability in managing their own health. Clinicians – primary care doctors and specialists – will be aided in providing the type of coordinated care that’s usually not feasible in small practitioner settings. They will be given the opportunity to share in the financial benefits of managing and limiting costs as they improve the health of Delawareans. They will preserve their independence and benefits from administrative simplicity through multi-payer participation, but will also come together to take accountability for improving quality and better managing costs through these different proposed payment models. For payers, such as commercial payers, this plan relieves the pressure to raise rates and premiums for consumers and provides an opportunity to offer more affordable coverage options. For payers that are employers, this plan will support a healthier workforce and support affordability of health care coverage. For public payers, this plan supports long-term fiscal viability of government health programs like Medicare and Medicaid. Lastly, taxpayers can benefit from this approach because it emphasizes sustainability and responsibility in that it enables high quality care for Delawareans but also directs the State towards long-term sustainability.

Also an effectiveness criteria of this plan lies within the monitoring and evaluation of the implementation and its overall impact on each element of the Triple Aim.

	Goal	Metric
High-level goals: The Triple Aim	▪ Improved outcomes	▪ Basket of HEDIS measures
	▪ Enhanced experience	▪ Net promoter score
	▪ Health	▪ Chronic disease burden, prevalence of Behavioral Health conditions
	▪ Reduced cost	▪ TME trend vs historical and baseline trend
Initiative-based indicators	▪ Payment	▪ Covered lives and % of population of total cost model ▪ Covered lives and % of population of P4V model
	▪ Metrics	▪ % of patients with care plans (target 10%)
	▪ Shared resources and services	▪ % of practices using 1+ shared service or resource
	▪ DHIN	▪ % of practices using bidirectional payer-provider portal
	▪ Healthy Neighborhoods	▪ % of population covered by a Healthy Neighborhood ▪ Wellness and screening rates
	▪ Policy response	▪ Governance structure stood up and active participation in governance
	▪ Workforce	▪ Number of care coordinators vs. number required

Figure 6 Preliminary Measures of Evaluation and Effectiveness in Delaware, DHSS 2013

In Figure 6, Delaware’s plan provides a list of preliminary measures for evaluation (DHSS 2013), including the goal of the Triple Aim and initiative-based indicators with their corresponding metric. These measures are to be reviewed quarterly by the Delaware Innovation Center Board who is responsible for making adjustments if necessary. The Innovation Center will publish progress against these metrics regularly and will make data available to stakeholders so that transparency will be maintained within the evaluation process.

Overall, with the metrics used to measure and evaluate the implementation and progress of the plan, as well as the incentives provided to stakeholders to ensure

transformation and swift implementation, Choose Health Delaware scores as having a moderate effectiveness. It does not score a high effectiveness mostly because of its top-down and heavy-handed bureaucratic approach. With such an approach, the tendency will be reduce incentives to increase productivity. By aligning the incentives of doctors and patients, as well as payers and taxpayers, Delaware could work to incentivize problem-solving, cost-cutting, innovative behavior by those closest to the problem.







Health Innovation in Pennsylvania


Similar to how the Choose Health Delaware innovation plan was evaluated, the Health Innovation in Pennsylvania plan also has its own unique characteristics that meet the effectiveness criteria. The plan also identifies its own drivers of action for each of its stakeholders, on whom the success of these initiatives relies heavily on the ongoing participation. Individuals, who also act as the patients and consumers, will benefit directly from improved economics and better overall health outcomes. For providers, this ongoing innovation is also of material interest to the provider community. The quality improvement and increased transparency anticipated would further the mission of health care across the spectrum. For employers and other payers, this kind of innovation has the potential to directly impact the productivity of the employer's workforce as well as their spending on health care. Therefore, employers and other payers have the incentive to spend less for improved health outcomes by participating in these pilot programs to transform the health care delivery system. Such transformation will allow payers to create value and realize gains for themselves. Similar to the Delaware plan, Pennsylvania's plan provides the same incentive for participation to all the stakeholders to ensure and maximize success. The HIP plan

also includes ways the state will continue to engage a wide range of stakeholders throughout the implementation phase through while the state's primary role will be as a convener to bring stakeholders together to advance initiatives.


Moreover, HIP's unique plan for monitoring and evaluation for the initiatives in each work group area allows stakeholders use metrics that are most relevant, actionable, and readily available in order to track progress and monitor innovation across the state. The plan includes the state's Catalyst for Payment Reform that created a value-based payment scorecard that will involve surveying commercial payers and aggregating data the state will use as a baseline for measuring future progress and as a baseline for price and quality transparency. Ongoing evaluation of population health by collecting data to support evaluation needs will also be a crucial part of the progress monitoring to measure changes in health outcomes as these programs and initiatives are implemented.

Much of HIP's effectiveness stems from the utilization of existing programs and resources that already have measurable outcomes which will serve as the foundation for many of its new initiatives, and will also expand and be further implemented. Examples of the existing capacity and efforts include the State Health Improvement Plan that will be integrated with this Health Innovation in Pennsylvania plan since both SHIP and HIP could link reports and data sources to foster collaboration on best methods for sustainable funding, expanding access to services, and supporting community collaborative efforts and health literacy to ultimately target population health needs and resources.


Health Priority 2: Primary care and preventive services		
Goal 1: Improve access to primary care services for Pennsylvanians.		
Objective 1.1: Reduce the number of federally designated Geographic and Population Health Professional Shortage Areas (HPSA) by 3 percent by December 2020:		
• Primary Care: from 45 to 43	44 in 2016 ⁸	
• Dental: from 61 to 59	60 in 2016 ⁹	
• Mental Health: from 26 to 25	26 in 2016 ¹⁰	
Goal 2: Increase the number of Pennsylvania residents receiving preventive health care services.		
Objective 2.1: Increase the percent of providers that report the administration of all immunizations into the State Immunization Information System to 100 percent by December 2020.	[Deleted in 2016 on recommendation of the task force]	
Objective 2.2: Reduce the eight-month provisional enrollment period for children to receive all required school immunizations by December 2020.	Final rule published	
Objective 2.3: For youth ages 1 to 20 years old who are enrolled in Medicaid with at least 90 days of continuous eligibility, increase the percentage who have had a preventive dental service in the past year from 41 percent in FFY 2014 to 47 percent by December 2020.	43 percent in 2015 ¹¹	
Goal 3: Improve health literacy (i.e., the capacity to obtain, process and understand basic health information and services needed for informed health decision-making) of Pennsylvania residents.		
Objective 3.1 Establish a method of determining the health literacy of Pennsylvania residents by December 2020.	Under development	




Goal achieved




Making progress



No change



Negative progress



Not reported

Figure 7 Primary Care and Preventative Services Health Priority, Pennsylvania DOH 2017

Referring to Figure 7, Pennsylvania is well on its way to make progress and achieve its goals within improving access to primary care, increasing the number of residents receiving preventative health care, and improving health literacy (DOH 2017). By integrating existing programs and initiatives with the HIP, success in implementation

and improvement of health outcomes can only be furthered and resources can be shared across the initiatives to ultimately make both initiatives more effective.

Efficiency

Affordable Care Act 2010

There is great estimated cost savings projected by the ACA with its successful implementation, which will and has since affected millions of Americans. Considering the effect of Medicaid expansion on state budgets alone, the Urban Institute estimates \$14 billion in net state spending, calculated from a project spending of \$80 billion and savings of \$66 billion (Buettgens, Dorn and Carroll, 2011). Overall, the ACA's effect on state and federal budgets is projected to increase federal spending from \$704 billion to \$743 billion, but is also projected to increase state savings from \$92 billion to \$129 billion. Although there would be considerable state and regional variation in these costs and savings, by significantly reducing the uninsured population, the ACA will still roughly halve spending on uncompensated care, and the federal government will save between \$39 and \$78 billion (Beuttgens, Dorn and Carroll, 2011). Ultimately, federal spending will increase due to the various provisions that will provide federal subsidies for insurance coverage and increased federal spending and investments on initiatives within the Affordable Care Act. This is because more than half of the substantial increase in insurance coverage under the ACA would come from increased enrollment in Medicaid, and so the federal government will pay a substantially higher share of previously ineligible enrollees' costs. Federal share of costs for these newly eligible enrollees will decline over the years, but the ACA also contains many provisions that substitute federal spending for state spending leading to savings for

states. So, state spending is projected to decrease, and state spending is projected to increase between 2014 and 2019. These spending and saving figures led to rating the ACA as moderately efficient.

Choose Health Delaware

Currently, Delaware's spending on healthcare estimates to be \$8 billion annually, including more than \$5 billion for those on Medicaid, Medicare and commercial health insurance, with the biggest percent of total spent on commercial users because of its considerably larger population than the Medicare and Medicaid population (DHSS 2013). These costs are projected to grow due to the demographic growth, medical inflation and new technology. Total spending on medical expenditures excluding out-of-pocket costs is projected to grow from \$5.5 billion to approximately \$10.5 billion over the next 10 years if nothing is changed (DHSS 2013).

Choose Health Delaware predicts a high level of impact based on four factors: potential gross impact over time, participation of payers and providers in new payment model, recurrent spending on care coordination and shared savings, and one time investments in transformation. Combining these four factors predicts a net savings of \$676 million annually, dispersed between Medicaid, Medicare, and commercial payer types. Figure 8, however, includes the savings net of recurrent costs, but prior to fixed investments (DHSS 2013).

Gross impact	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Savings (\$M)	—	19	76	157	284	442	593	686	744	796	852
Impact as % of Spend for participants	—	0%	1%	3%	4%	6%	6%	6%	6%	6%	6%
Recurrent costs (\$M)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Care coordination fees	—	30	39	49	58	65	74	84	91	98	106
Shared savings	—	1	19	45	75	109	115	85	48	23	13
Fixed investments (\$M)	2014	2015	2016	2017	2018	2019 ¹	2020 ¹	2021 ¹	2022 ¹	2023 ¹	2024 ¹
Transformation support	2.9	2.3	1.5	0.8	0.6	3.0	3.0	3.0	3.0	3.0	3.0
Delivery system	3.0	10.8	10.0	10.0	4.0	—	—	—	—	—	—
Population health	2.0	4.8	4.2	2.4	1.8	—	—	—	—	—	—
Payment	3.0	1.5	1.5	0.8	0.6	—	—	—	—	—	—
Data & analytics	4.0	14.0	13.6	11.8	11.2	4.0	4.0	4.0	4.0	4.0	4.0
Workforce	1.2	2.9	2.9	2.3	2.3	—	—	—	—	—	—
Policy	0.8	0.8	0.8	0.4	0.4	—	—	—	—	—	—
Net Savings	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Total (\$M)	(17)	(50)	(17)	35	130	258	393	515	615	678	729
Percent of baseline	-0.3%	-0.9%	-0.3%	0.5%	1.9%	3.5%	4.9%	6.0%	6.7%	6.9%	6.9%

¹ Estimate for 2019-2024 is for in-kind support that may spread across multiple areas of focus depending on need; included in transformation support for simplicity
NOTE: Corrected for typographical error on 4/28/14

Figure 8 Projections of Savings in Delaware After Choose Health Delaware Implementation, DHSS 2013

Delaware's plan targets areas of prime focus, or categories in which the state could incur savings based on a systematic review of evidence, such as unnecessary services, inefficiently delivered services, and missed prevention opportunities. Combined, these categories represent potential impact of 15.8% in savings that are being actively pursued. Moreover, participation in the new payment and delivery models will add to the level of impact over a five-year period. Delaware assume that the total cost of care models will achieve 9% gross savings, whereas the P4V models will achieve only 3% gross savings (DHSS 2013). This is because the total cost of care

model provides a much stronger incentive for providers and will therefore deliver more impact.

Delaware will also incur recurrent spending as well as one-time investments. Recurrent spending on care coordination and shared savings are required to achieve these savings. Explicit care coordination fees cover the need for new delivery models that coordinate the care of complex patients, and these costs were calculated through a care coordination cost assumption for Medicaid, Medicare, and commercial costs. One-time investments in transformation are non-recurrent costs such as new investments in IT, investment in practice transformation, investment in workforce, and financial support to complete and implement the supporting initiatives. For these reasons, Delaware was evaluated as having a high efficiency because of its growing savings as opposed to spending. By 2024, the recurrent costs of coordinate fees and shared savings total to \$119 million, and fixed investments will total to just \$7 million since many of the fixed investments are one-time costs (DHSS 2013). However, by 2024, the net savings will total to \$729 million.

Overall, Delaware's potential to save is over \$700 million annually, with an investment up to \$190 million annually to recurrent costs and \$160 million in one-time fixed costs over the 10-year period.

Health Innovation in Pennsylvania

When evaluating the HIP plan's financial analysis, it's important to note the financial and economic goals that the plan hoped to achieve. Because spending on healthcare in Pennsylvania is higher than the U.S. average, at 17% compared to 14.5% for the United States overall, smarter health care spending is identified as a key objective of the plan. Pennsylvania's total health care spending is projected to increase

from \$97 billion in 2009 to \$180 billion by 2021 if conditions remain unchanged, according to the latest data provided by National Health Expenditure (CMS, 2009).

However, by changing the way people pay for health care, avoid waste, and decrease the rate of medical inflation by adopting value-based payment models, the state could generate significant savings by implementing both the episode-based and advanced primary care payment models. Though the HIP plan doesn't include specific projected figures of savings, unlike Delaware's plan, Pennsylvania has identified total medical cost savings of each its proposed payment models. The programs involved with the APC model are projected to see anywhere between 2-7.9% of total healthcare cost savings. Because the HIP plan did not identify specific figures, it is hard to say whether or not the plan is projected to be efficient by using a cost-benefit analysis, so the plan scores a moderate efficiency in the evaluative criteria.

Equity

Affordable Care Act 2010

The Affordable Care Act, as a starkly redistribute law, preserves and creates a variety of horizontal and vertical inequities. With its provision for tax subsidies for private health insurance, those with employer-sponsored insurance and non-group coverage are treated differently, favoring those who obtain their coverage within the ACA's marketplace by providing much higher subsidies than those who have access to "affordable" employer-sponsored insurance. Those with low incomes get much higher subsidies if they purchase their insurance through the marketplace than if they had employer-sponsored coverage, and conversely, those with higher incomes generally get higher subsidies via ESI than within the marketplace. Moreover, the

employer mandate and individual “affordability firewall” forces many households facing burdensome premiums to ESI to also not qualify for subsidies for purchasing coverage in the ACA marketplace (Health Policy Gateway, 2010). The ACA also allows the opportunity to consider the equity of how its benefits are distributed. By eliminating the ability to be denied health coverage due to pre-existing conditions, and by provisioning essential health benefits to be required under all insurance plans, the ACA essentially equitably expands the same benefits to everyone, avoiding discriminating against any specific groups. Ultimately, there exists “relative” equity that still only warrants a low equity rating when evaluating against the outlined criteria.

Choose Health Delaware

Delaware’s SIM plan’s focus on Healthy Neighborhoods as a way to transform the state’s approach to population health is a critical element to leveraging resources for health equity. This program provides resources for individual communities to identify their community-specific health needs through targeted interventions. This kind of increased focus and shift toward more prevention-oriented and integrated systems of care create opportunities to advance health equity. By creating a more inclusive and comprehensive health system that better addresses the entire continuum of health determinants, especially the upstream social conditions that give rise to the downstream delivery of care, Delaware’s plan can achieve health equity. By engaging such upstream strategies for community health, improving living conditions and creating healthy communities, this plan does well to disperse access to care across all populations in Delaware, and also expands resources to all providers and payers. Upstream strategies like the Healthy Neighborhoods program addresses the social

needs of patients, and providers will be able to address the challenges their patients face with improved care coordination and ability to practice culturally competent care. Because Delaware's plan offers a program model to specifically address increasing health equity and access across all groups without any exclusion, Choose Health Delaware was rated as highly equitable in this criteria analysis.

Health Innovation in Pennsylvania

Much of how this plan addresses equity is within the context of its redesign of rural health. Because Pennsylvania faces unique challenges that impact access, cost, and quality of care for the nearly 2 million of Pennsylvanians who live in rural areas, this redesign is a major component of the innovation model's expansion of access and resources for both patients and providers. By equalizing quality outcomes and costs between urban and rural hospitals, the state can strategize to ensure better health and better care for rural residents as well as the other residents. The healthcare delivery system transformation for rural communities includes the utilization of existing programs in the rural areas while also monitoring their progress so that those living in these medically underserved or underinvested communities will not fall behind again but instead progress forward in their health outcomes.

Chapter 6

POLICY RECOMMENDATIONS

With all of this information compiled, explained, and evaluated, the next critical component is the subsequent recommendations that can be made to federal and state-level stakeholders. There are three major recommendations that can be made, that are feasible and supported by evidence to be beneficial to all stakeholders. First, a recommendation will be made regarding a best practice payment model, and then recommendations will also be made regarding increase health information access and growing the workforce.

All four payment-model reform efforts have strong aspects, and together, a combination of their different components can be complementary in strengthening the value-based payment model transition altogether. Pennsylvania’s episode-based payment can be used to reduce waste and inefficiency, gives involved providers an incentive to coordinate their activities, eliminate unnecessary services, and avoid complications – ultimately improving quality of care. However, it will be important to better define what an episode-of-care is. This payment system model is better than other payment reforms because it includes a “limited warranty” where both hospital and physician have a financial and quality incentive to improve (IOM, 2010). However, this episode-based payment system would work together with Delaware’s proposed total cost of care payment model. Because episode-based payment models alone do not encourage preventing episodes of care from occurring in the first place, incorporating Choose Health Delaware’s total cost of care model will help to prevent

episodes and to encourage use of high-value services. Comprehensive care payment systems are designed to solve this problem because they support better care management of chronic diseases and encourages use of higher-value services for treatment by providing physicians with the resources and incentive to engage in shared decision making with their patients. This model also avoids penalizing providers for treating sicker patients so more patients will have access to PCPs and will therefore have more access to care coordination and care management to ultimately improve health outcomes.

In order to make health information timely, accessible, accurate, and understandable to make it beneficial and useful to consumers and providers, stakeholders must build the integrity of health information. By expanding access to health information, patients will assume more responsibility for their own care, and the prevalence of initiation of remote monitoring and mobile health applications by the patients will also increase. Making health information readily available to patients, investing in health information technology, will allow patients and their caregivers an expectation that this information will be reviewed and utilized in healthcare decision making, and will enable collaboration, communication, and transparency. By supporting the implementation, dissemination, and utilization of health information and technology, stakeholders will be address patient engagement and care coordination as well. Patients require access to good quality, evidence-based information so they can take an active part in decisions about their health care, and providers require access to good quality, consolidated information to facilitate team-based coordination with reduced administrative burdens. More specifically, Pennsylvania's initiative for a public health gateway, to establish an e-health

partnership as well as expanding existing health information technology initiatives is the better practice to consider implementing.

Lastly, growing and supporting the primary care workforce will require maximizing the current workforce and transforming more states into “learning states” to build on the existing work of the medical academic institutions but also implement a more innovative approach to health professional training in primary care and behavioral health. Delaware’s plan outlined its goal to become a “learning state” as a goal to become a national leader in workforce innovation and development. More specifically, by become a “learning state,” stakeholders can create transparency around existing resource to add capacity for new roles and coordinate education and training programs across institutions to ensure that the entire workforce receives training needed to practice in teams at the top of their license. Subsequently, this will depend on all of the health professions working in coordination and therefore involves retraining the current workforce and new training programs for the future workforce. By redesigning the future healthcare workforce to become broader, more diverse, and more geographically distributed – as Pennsylvania’s plan highlights with its innovation of the rural healthcare workforce – stakeholders will facilitate the expansion of access to health care. Within Pennsylvania’s plan, too, is a component of growing the workforce that can be critical in the overall effort. By placing value in innovating rural health delivery and supporting rural health providers, stakeholders will also be able to reach communities located in medically underserved or health professional shortage areas. By doing so, providers across all geographic areas will receive support and their patient population will receive increased access to care.

CONCLUSION

In consideration of these findings and the subsequent policy recommendations, it is important to note that no single model is perfect or translatable across all states. Though these alternatives present with strong redesigns of the current payment system, work to expand health information access and promote patient engagement, as well as help to grow and strengthen the workforce, the proposed policy recommendations are for best practice models and work to address the challenges patients and their primary care providers face within the health care system in its current state. By focusing on the value of reforming the health care system, especially the rural health care system, and surrounding all delivery and payment reform efforts around patients and their PCPs, stakeholders will be able to move toward achieving the goals of the Triple Aim. Such policy changes will help to transform the organization and delivery of primary care to achieve high quality, accessible, and efficient health care for all Americans, in addition to meeting the needs of a changing patient population with emerging community needs.

By analyzing each of these policy models using the three criteria – effectiveness, efficiency, and equity – it was concluded that the two innovative models supplemented the Affordable Care Act in order to further address the barriers to primary care identified in this paper. Furthermore, this paper has identified ways in which primary care transformation plays an integral role in the efforts to better organize and coordinate patient care by becoming more patient-service oriented and providing effective care to lead to better patient outcomes. By transforming payment and delivery models, by furthering the efforts to increase access to primary care as well as the availability of it, and by supporting primary care providers by giving them

the resources to provide quality and efficient care, the Affordable Care Act's initial policy goals will be realized and even broadened.

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