

Attachment A

**RESOLUTION
of the
SHBP Plan Design Committee**

**Direct Primary Care Medical Home Pilot Program
& Related Issues**

BE IT RESOLVED THAT –

The New Jersey State Health Benefits Program (“SHBP”) Plan Design Committee (“PDC”) hereby establishes a Direct Primary Care Medical Home (DPCMH) Pilot Program and directs that the Pilot Program be implemented with commencement of care to participating public employees and dependents beginning in the first quarter of calendar year 2016.

Definition – A participating Direct Primary Care Medical Home shall be a primary care practice that assumes contractual responsibility for providing comprehensive primary care services, including preventive care, episodic sick care and basic urgent care, disease management medication management, basic procedures, health and wellness coaching, immunizations, and lab draws/collections, as well as coordination of comprehensive specialist, hospital, and outpatient services. Participation should include active employees, early retirees and their dependents.

The Direct Primary Care Medical Home is compensated for direct delivery and coordination of overall patient care to enrolled members with a capitated Per Member, Per Month (PMPM) fee. Enrolled members pay no cost-sharing (no copays, deductibles, or coinsurance) for these medical services. A detailed description of Direct Primary Care Medical Home specifications and standards is provided in Appendix 1 to this Resolution.

Pilot: Direct Primary Care Medical Homes shall be established in pilot regions across the State based on member participation.

“Pilot” Size - Establish a minimum participation rate to be measured at the end of year 1 and at 18 months to ensure a statistically relevant population. Further, maximum participation should be dictated by market considerations (supply and demand for DPCMH services). The 12 month minimum participation benchmark will be 10,000 enrollees and the 18 month benchmark will be 18,000. Failure to reach these benchmarks shall not be grounds for early termination of the Pilot Program. Rather, the goal of these benchmarks is to determine, if the benchmarks are not being met, why they are not, so that the PDC can suggest changes to increase beneficiary participation.

Eligibility of Plan Beneficiaries: The DPCMH shall be offered as a primary care provider option available to active employees, early retirees not covered by Medicare and their dependents in all SHBP health plans, except the Horizon and Aetna HMO Plans. [NOTE: If an Exclusive Provider Organization (“EPO”) or similar narrow network plan design should be offered by either Horizon or Aetna as a health plan choice, the DPCMH shall also be included as a primary care provider option to those who elect to participate in the EPO or narrow network health plan.]

Voluntary Enrollment: Enrollment of eligible SHBP members in the DPCMH Pilot Program shall be voluntary on a first come, first served basis depending on physician participation and panel limitations. Eligible plan members may enroll (opt in) or dis-enroll (opt out) at their sole discretion at any time during the plan year.

Horizon BC/BS and Aetna Cooperation: The SHBP Plan Design Committee expects the cooperation of Horizon Blue Cross Blue Shield of New Jersey (“Horizon”) and Aetna in implementing and administering the Direct Primary Care Medical Home Pilot Program.

Initial Commencement of Care Delivery: By no later than the end of the first quarter (March 31, 2016) delivery of DPCMH care to enrolled SHBP participants shall commence.

Scaling of DPCMH Care Delivery Capacity in the Pilot Regions – Before the date of initial commencement of care delivery in the pilot regions, Horizon and Aetna shall present for review by the PDC its plan for scaling capacity to deliver DPCMH care within 12 months following the date of initial commencement of care delivery in each of the pilot regions.

Selection of DPCMH Providers: Horizon and Aetna currently have participating providers in a PCMH program, which unlike Direct Primary Care, relies on physician fee-for-service reimbursement for provision of primary care services. At the discretion of Horizon and Aetna, these providers can be utilized in the DPCMH pilot to the extent of their willingness and capacity to deliver care in accordance with the DPCMH specifications and standards in Appendix 1 of this Resolution. Further Horizon and Aetna agree to contract with, qualified and experienced DPCMH provider(s) currently not within their networks subject to appropriate contractual amendment if necessary. In order to achieve the goal of including such provider(s) in the initial launch period before March 31, 2016 in each of the pilot regions, Horizon and Aetna shall make a demonstrably good faith effort to execute contract agreement(s) with one or more qualified and experienced DPCMH providers by August 1, 2015. The execution of Horizon and Aetna contract(s) with qualified DPCMH provider(s) shall not limit Horizon or Aetna from exercising their discretion to contract with additional qualified DPCMH providers to scale delivery of DPCMH care following commencement of care delivery in the pilot regions. The term “qualified DPCMH provider” as used in this paragraph, refers to a provider who has the capacity and willingness to deliver care in accordance with the specifications and standards in Appendix 1 of this Resolution.

Duration and Evaluation of the DPCMH Pilot Program: The DPCMH Pilot Program shall continue for a period of three years following commencement of Direct Primary Care Medical Home care delivery to SHBP members in the pilot regions. Based on data from the first two years of care delivery experience, utilizing an independent third party, the SHBP PDC shall evaluate the savings and

clinical performance of the DPCMH Pilot Program as described in Appendix 2 to this Resolution and determine whether to:

- a) terminate the Pilot Program following expiration of the three-year pilot period, or
- b) extend the Pilot Program for a period of time to be determined by the SHBP Design Committee,

The DPCMH Pilot Program will sunset after year three unless the PDC agrees to extend through a positive vote.

Measuring program success and satisfaction during the first three years – Labor, in conjunction with the Division, Horizon and Aetna will develop a survey or conduct focus groups each six months to ascertain awareness of the program among unenrolled union members, so that the PDC can suggest changes in marketing and education efforts to increase participation. Similarly, the Net Promoter Score will be utilized to measure enrolled DPCMH satisfaction with the program. Any costs of developing and implementing such surveys or focus groups will be borne by the Division. Horizon and Aetna should survey the providers at their expense to gather similar feedback.

Education Plan – Labor, insurance carriers and the State shall coordinate efforts to educate SHBP beneficiaries about the DPCMH Program. All members are afforded an equal opportunity to participate in the Pilot Program on a first come first serve basis, as set for above. However, nothing in this paragraph shall be interpreted to limit, in any way, union education of their own members about the DPCMH Program either on their own or in concert with others and nothing herein shall imply a recommendation of the DPCMH by any particular union. Participating DPCMH providers will be expected to participate in union member education efforts.

Ongoing Adjustments – This Resolution provides the basic tenets of the DPCMH. However, it is reasonable to assume that adjustments to the program to improve participation, improve qualitative results and maximize the outcomes as intended may be necessary. As such, it is resolved that a sub-committee made up of equal participation of labor and management is created to review data and results during the three year pilot. The sub-committee shall have the authority to modify the program if the sub-committee deems it to be necessary, subject to the advice and consent of the full PDC. Division staff, third party evaluators, DPCMH providers, Aetna and Horizon will be expected to provide all quantitative and qualitative feedback required or requested by the sub-committee in order to determine if any changes are necessary. The PDC co-chairs will nominate the sub-committee members. The first meeting of the sub-committee will take place no later than 6/1/16.

Financial Considerations: Risk-sharing is designed to minimize the unexpected possibility that SHBP total costs of care would be increased, rather than reduced, by the DPCMH pilot program. To mitigate exposure to such risk, special preference shall be given in selection of DPCMH vendors who are willing to assume financial risk for meeting savings performance standards. Alternative risk sharing mechanisms that would be acceptable in the pilot program include the following:

- a) The DPCMH vendor will guarantee an average rate of growth in total costs of care for enrolled DPCMH patients that is less than 100% of the projected rate of growth in total costs of care for all SHBP medical care utilizers, based on the historical SHBP trend, for the first two program years (2016 and 2017). If the rate of total cost growth for enrolled DPCMH patients exceeds the guaranteed rate of growth, which will be less than 100% of projected, historical trend-based rate, then the provider will be required to repay the excess costs to the SHBP up to the total of all PMPM fees paid by the SHBP to that vendor during the first two years of the program.
 - b) The DPCMH vendor will assume risk for reducing the total cost of care, upfront, by offering reduced PMPM fee rates to SHBP enrollees. The vendor may recoup some portion of forgone PMPM fee revenues by sharing with SHBP in some portion of savings (reduced total costs of care) for DPCMH enrollees.
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- c) Reasonable alternative financing proposals by prospective vendors will be brought to the PDC subcommittee for consideration.

Enrollment Design and Provider Payment: The member enrollment and details for triggering the provider payments will be further developed by the PDC sub-committee.

IN WITNESS THEREOF, THIS RESOLUTION (WHICH INCORPORATES APPENDICES 1, 2 AND 3, BELOW) IS HEREBY APPROVED AND ADOPTED BY THE NEW JERSEY STATE HEALTH BENEFITS PROGRAM PLAN DESIGN COMMITTEE.

 SHBP Plan Design Comm Co –Chair (print)

 SHBP Plan Design Committee Chair (signature) date

 SHBP Plan Design Comm Co–Chair (print)

 SHBP Plan Design Comm Co–Chair (signature) date

Appendix 1 – DPCMH Specifications and Standards

To qualify for participation in the DPCMH Pilot Program, a Direct Primary Care Medical Home must meet and adhere to the following care delivery specifications and standards:

A. The Medical Practice

- 1) The Direct Primary Care Medical Home will provide comprehensive primary care services, including preventive care, episodic sick care and basic urgent care, chronic disease management, medication management, basic procedures, health and wellness coaching, immunizations, and laboratory draws and collections on location at the medical home location(s), as well as coordination of comprehensive specialist, hospital, and outpatient services delivered, as medically appropriate, to enrolled participants by their personal primary care physicians. The medical services will be provided by the Direct Primary Care Medical Home shall include, but not be limited to the following:

Primary & Preventive Care

- Basic vision/hearing screening
- Biometric screening
- Blood pressure screening
- Chronic disease management
- Comprehensive physical exams
- Coordination with other providers (e.g., specialists, hospitals)
- Episodic sick care
- Fitness & nutrition coaching
- Health risk assessment
- Lifestyle & risk-reduction coaching
- Medication management
- Urgent care
- Individualized Care Plans
- Screening and diagnostic imaging (note: recommended but not required)

Treatments & Procedures

- Basic splinting
- Basic wound care
- Ear wax removal
- EKG
- Ingrown toenail removal
- Nebulizer treatment
- Peak flow testing
- Skin biopsy (lab not included)
- Skin cyst removal

Skin tag & wart removal (cryo)
Stitches
Suture / staple removal

Labs

Blood draws & sample collection
Hemoglobin A1C
Lung function screening (spirometry; lab not included)
Pregnancy test
Standard annual lab test
Stool blood test (FOBT)
Strep throat test

Immunizations

Flu vaccine (3 shot series)
Hepatitis A (2 shot series)
Hepatitis B (3 shot series)
HPV (human papilloma virus)
Meningococcal
MMR (measles, mumps, rubella)
Varicella (chicken pox)
Pneumovax
TD (tetanus, diphtheria, booster)
Tdap (tetanus, diphtheria, pertussis)
Zoster (shingles)

- 2) The Direct Primary Care Medical Home will offer each enrollee an accountable personal primary care physician (and a choice of such physicians, if there is more than one participating primary care doctor) who will be responsible for coordinating their patients' care across all care settings, overseeing transitions in care between settings, and minimizing the risk of gaps in care for their patients.
- 3) The Direct Primary Care Medical Home will provide enrollees same day or next day urgent care appointments with, and direct telephone and electronic access 24 hours a day and 7 days a week access to, their personal primary care physicians. In the unusual case where direct access is temporarily impossible, patients will be able to access a practice-based on-call primary care physician or nurse practitioner who is working under direction of the patient's personal physician.
- 4) Patient panels for participating DPCMH primary care physicians will not exceed 1,000 SHBP patients per physician.

- 5) DPCMH primary care physicians will conduct initial comprehensive physical examinations for each of their patients and follow-up comprehensive examinations at a frequency that is medically appropriate. Working with their patients, DPCMH physicians will develop customized personal health plans designed to achieve compliance with recommended clinical best-practice standards for disease prevention and management, meet individual patient health needs, and reflect patients' individual lifestyle preferences.
- 6) At a minimum, the DPCMH health IT system will enable secure electronic medical record keeping, user-friendly, patient access to personal medical records, population health management tools, including a disease registry, clinical performance and outcomes reporting, secure patient-provider email communications, online scheduling of appointments, and patient access to health education resources.
- 7) To the extent allowed by New Jersey law, each DPCMH will maintain a supply of the most commonly prescribed generic medications from which DPCMH primary care physicians may dispense, at cost (i.e. without markup), medications they prescribe to their patients.

B. Optimization of Downstream Care

- 1) *PCP Responsibility for Care Coordination* – The patients' primary care providers will be responsible for coordinating their patients' care across all care settings, overseeing transitions in care between settings, and minimizing the risk of gaps in care for their patients. When referrals are medically appropriate, or elected by the patient, regardless of physician referral, the patient's primary care physician will provide the patient's medical records to the downstream provider (specialist, hospital, or other outpatient care provider, as appropriate), brief the downstream provider on the specific reasons for the patient referral, and specify questions to be answered or medical issues to be resolved. Whenever possible, ongoing collaboration between the patient's primary care provider and the downstream provider will be established.
- 2) *Referral Management* - Protocols between primary care providers and high-value secondary and tertiary providers will be in place to facilitate care coordination and help ensure patients return to care provided by the DPCMH primary care physician as soon as is clinically appropriate.
- 3) *High-Value Referrals* - The Direct Primary Care Medical Home will utilize transparency tools, Horizon and Aetna ASO network provider quality and price data, patient satisfaction data, and measures of secondary and tertiary provider willingness and ability to coordinate care with the patient's primary care provider in order to develop and continuously update a list of preferred, high-quality, competitively priced *in-network* specialists, hospital centers of excellence, and other service providers, when such referrals are medically appropriate or elected by the

patient, regardless of physician referral.

- 4) *No Gatekeeping*- Direct Primary Care Medical Home physicians will recommend clinical referrals to high-value secondary or tertiary providers. However, Direct Primary Care Medical Home physicians will not restrict patient choice of providers or limit access to providers to which patients otherwise have access in their selected SHBP health plans.

C. Alignment of Financial Incentives

- 1) *No Patient Out-of-Pocket Cost-Sharing for Direct Primary Care Medical Home Services* - For enrolled SHBP members, there shall be no out-of-pocket cost-sharing in the form of patient copays, deductibles, or co-insurance for the expanded scope of primary care and comprehensive care coordination services provided by the Direct Primary Care Medical Home. Existing plan co-pays, deductibles, or co-insurance for downstream specialists remain in effect.
- 2) *Compensation of DPCMH Primary Care Physicians* - Compensation paid by Direct Primary Care Medical Homes to their participating primary care physicians may include components such as a defined salary, a portion of Medical Home PMPM revenues, clinical outcomes-based compensation bonuses, and bonuses based on patient satisfaction levels. However, participating primary care physicians may *not* receive payment based on any fee-for-service reimbursement income from any source.
- 3) *Compensation to the DPCMH* - Participating Direct Primary Care Medical Homes shall be compensated for delivery and coordination of comprehensive medical care services with monthly payment of a per-member-per month ("PMPM") fee for each eligible beneficiary who opts to enroll in a participating Direct Primary Care Medical Home for as long as each beneficiary remains enrolled in the DPCMH primary care option. Such payment shall be administered by Horizon and Aetna in accordance with a contractually agreed to PMPM fee schedule.
- 4) *Non-Utilization* - If an eligible SHBP beneficiary who opts to enroll in a participating Direct Primary Care Medical Home and engages the physician, but does not utilize any medical services of the Direct Primary Care Medical Home during the ensuing 12 month period, SHBP's obligation to pay further PMPM fees for that beneficiary may be suspended until the patient re-engages in care from his/her Direct Primary Care Medical Home provider.
- 5) *Risk/Gain Sharing* - Compensation in the form of PMPM fees may be supplemented by risk and gains (savings) sharing. Special preference shall be given in selection of DPCMH providers who are willing and able to do so.

- 6) Direct Primary Care Medical Homes shall not be entitled to receive any fee-for-service reimbursements.

NOTE: It should be made clear that the specifications and standards for participation of a primary care practice in the DPCMH Pilot Program do not, in and of themselves, prohibit a multi-physician primary care practice from earning fee-for-service revenues as an Aetna or Horizon PCMH operator, or otherwise, while also operating a qualified Direct Primary Care Medical Home in this DPCMH Pilot Program. To operate concurrently as a DPCMH provider in the Pilot Program and as a PCMH provider, for example, the medical practice would need only to dedicate one or more primary care physicians to practicing exclusively in the DPCMH model, provide the support required to enable the dedicated DPCMH physicians to meet the high expected standards of patient access and care quality, and comport the specifications and standards for DPCMH care articulated in this Resolution, including the physician compensation specifications in paragraph C.2 the DPCMH compensation specifications in paragraphs C.3 through 6, above. Subject to these terms, it is allowable for a multi-physician primary care practice to separately earn both PMPM fees and fee-for-service or other revenues through supporting concurrent operation of a qualified Direct Primary Care Medical Home alongside a PCMH or other practice model delivering care to separate and distinct patient panels.

- 7) *Payment for Hospital, Specialist, and Other Outpatient Services* - Care delivered outside of the Direct Primary Care Medical Home setting by specialists, hospitals, and other outpatient service providers will be paid for in accordance with current plan administrators' payment methods.
- 8) *Capacity to Scale* – Convenience of patient access is promoted by establishing networks of relatively small, advanced primary care health centers at conveniently accessible locations in or near communities where significant concentrations of public workers and their families live and work. The cost of leasing, construction and refitting of commercial spaces suitable for the advanced primary care locations will be borne entirely by the DPCMH provider(s). Therefore, in selecting prospective PCMH providers for the Pilot Program, substantial weight should be given to their capacity to establish and scale networks of advanced primary care facilities as demand for DPCMH care grows among SHBP members.
- 9) *Integration of Public Employee Health and Wellness Incentives* – DPCMH primary care physicians may integrate any employment-based health and wellness incentives that are offered by SHBP or New Jersey State, county, or municipal employers into their patients' personal health plans.
- 10) The Direct Primary Care Medical Home may not be owned, managed, or otherwise dominated by a hospital, insurer, or an ACO.

D. Care Quality Measurement –To facilitate comparisons with non-pilot baseline metrics, the DPCMH care quality and patient satisfaction metrics should be aligned to the extent possible with the SHBP plan administrator’s established PCMH metrics and also metrics for other SHBC plans. Where established PCMH metrics are not included, also, in the list below, they should be added. Where the SHBP plan administrator’s currently utilized PCMH metrics fail to include the DPCMH metrics listed below, the SHBP plan administrator’s battery of metrics should be broadened to include the below-listed care quality and patient satisfaction measurements. These adjustments will facilitate an ample spectrum of key comparisons between provider performance among in-network PCMHs, other non-Pilot providers and the Pilot Program DPCMHs.

1) Participating Direct Primary Care Medical Homes will continuously monitor care quality in accordance with a standardized set of care quality and patient satisfaction measurements. At a minimum, such care quality measurements will include the following groups of metrics:

Group 1: Patient Engagement - % of patients who have completed a –

- a. comprehensive annual physical examination and adopted an individualized care plan
- b. The NJ Well program (% of eligible)
- c. face-to-face visit with the patient’s personal primary care physician
- d. follow-up contact with personal primary care physician after a referral

Group 2: Prevention – % of patients who have received age/gender appropriate diagnostic screenings, including --

- a. cervical Cancer screening
- b. breast Cancer screening
- c. colorectal Cancer screening

Group 3: Chronic Disease Management - % of –

- a. Diabetic patients who have HbA1C Screening
- b. Diabetic patients with HbA1C <9
- c. Diabetic patients with HbA1C <7
- d. Diabetic patients who have LDL-C Screening
- e. Diabetic patients with LDL-C<100
- f. Hypertensive Patients with blood pressure<140/90

Group 3a: Chronic Disease Management – SHBP Plan Design Committee may specify any similar metrics it deems appropriate to evaluate quality of care provided by participating Direct Primary Care Medical Homes for members with

chronic diseases that are most prevalent and associated with the highest health care costs among the SHBP patient population.

Group 4: Patient Satisfaction - Participating Direct Primary Care Medical Homes will periodically assess patient satisfaction through patient surveys that include, at a minimum, the Net Promoter Score.

- 2) Direct Primary Care Medical Homes will contrast their care quality performance to that of the most recent HEDIS commercial health maintenance organization (HMO) averages and present their findings on a schedule prescribed by the SHBP Plan Design Committee.
- 3) The DPCMHs will apply the evaluation metrics above to evaluation and continuous improvement of health and patient satisfaction outcomes.

Appendix 2 – SHBP Evaluation of the Pilot Program

- A. After a period of two years following commencement of DPCMH care delivery in the pilot regions, the SHBP Plan Design Committee shall apply the appropriate evaluation metrics to evaluate the clinical performance of the DPCMH Pilot Program, as a whole. This evaluation shall include measurement and comparison of the clinical performance of the participating DPCMH providers. In addition, the SHBP Plan Design Committee shall evaluate the savings performance of the DPCMH pilot program, as a whole. This evaluation shall include comparison of savings generated by the respective DPCMH providers.
- B. If several DPCMH providers are selected to participate in the DPCMH Pilot Program, the SHBP Plan Design Committees may, at its sole discretion, authorize formation of a DPCMH Learning Collaborative to evaluate and disseminate best DPCMH practices for increasing the value of care delivered to SHBP beneficiaries. In such case, the SHBP Plan Design Committee may hire a consultant to coordinate the work of the DPCMH Learning Collaborative.
- C. An independent third party evaluation firm will be contracted by the Division and report to the Plan Design Committee.
- D. During the roll out period of the Pilot, the SHBP Plan Design Committee will receive at least quarterly reports from participating DPCMH providers, the Division, Aetna and Horizon. The PDC shall receive all data necessary to evaluate the efficacy of the pilot. This includes survey results, census data, third party evaluations, plans and progress for scaling the DPCMH implementation and any other

relevant information not prohibited from review by the full PDC by HIPPA or other applicable patient confidentiality regulations. Such determination is at the sole discretion of the Division Director on the advice of the Attorney General's Office.

Appendix 3 – General Purpose of this Resolution

The objectives of this resolution are as follows:

- A. Reduce overall growth in the cost of health care for the SHBP and their beneficiary employees, with nominal, if any, additional commitment of state resources
- B. Improve care quality, convenience of access, and SHBP beneficiary satisfaction with their care
- C. Offer NJ public employees and their families choices of advanced Direct Primary Care Medical Home care delivery options designed to:
 - 1) optimize delivery of high-quality, evidence-based healthcare in the most cost-effective settings (with emphasis on effective prevention and management of chronic disease),
 - 2) prioritize patient-centered delivery of comprehensive health care that is responsive to the individual needs and preferences of patients,
 - 3) align patient and provider incentives to improve patient health outcomes and maximize the value of patient care,
 - 4) assign accountable primary care providers with direct responsibility for delivering and coordinating quality health care across all care settings, while preserving patient choice of providers,
 - 5) guarantee quick (same/next day) access to urgent care appointments and 24 hour, 7 day a week online and telephone access to patients' personal primary care physicians who are responsible for direct provision and coordination of their patients' overall health care,
 - 6) identify and continuously update a list of high-value specialist and hospital in-network providers to serve as a preferred referral network for DPCMH physicians,
 - 7) eliminate public employee and dependent cost-sharing (i.e. copays, coinsurance, and deductibles) for an expanded scope of advanced primary care services, and
 - 8) locate conveniently accessible advanced primary care health centers in or near communities where public employees and their dependents live and work.

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