Delaware Health Care Commission Meeting

Thursday, December 7, 2017, at 9:00 a.m.

Del Tech-Terry Campus Corporate Training Center, Rooms 400A&B

100 Campus Drive, Dover, DE

Meeting Attendance

Health Care Commission Members Present:

- Nancy Fan, MD, Chair
- Kara Odom Walker, MD, Secretary
- Rick Geisenberger
- Jan L. Lee, MD
- Theodore W. Becker, Jr.
- Trinidad Navarro
- Edmondo J. Robinson, MD
- Dennis Rochford

Health Care Commission Members Absent:

- Susan A. Cycyk
- Kathleen Matt, PhD
- Richard Heffron

Health Care Commission Staff:

- Ann Kempski, Executive Director
- Eschalla Clarke, Social Services Sr. Administrator
- Kiara Cole, Community Relations Officer
- Marques Johnson, Administrative Specialist III

Meeting Minutes

CALL TO ORDER

Dr. Nancy Fan called the meeting to order at approximately 9:02 a.m.

APPROVAL OF NOVEMBER 2, 2017 MEETING MINUTES

Dr. Nancy Fan requested a vote from present commission members to approve the November 2, 2017, meeting minutes.

- Dr. Edmondo Robinson requested clarification on process of drafting SIM grant for Year 4.
- Ann Kempski suggested that the minutes be updated to clarify that the draft for Year 4 of the SIM grant was created by the Health Care Commission *staff*.

Dr. Nancy Fan suggested that the bullet point be eliminated that Dr. Robinson made reference to. With the exception of eliminating the bullet point, all commissioners present were in favor to carry the motion to approve the November 2, 2017,
meeting minutes, and the meeting minutes were approved unanimously.

APPROVAL OF 2019 QHP STANDARDS

Dr. Nancy Fan acknowledged that there was a quorum and requested a vote from present commission members to approve the 2019 QHP Standards.

- Dr. Nancy Fan opened up the floor for the commission members to ask questions regarding the current state of the 2019 QHP Standards.
- Dr. Edmondo Robinson commented:
    - How are you enforcing the mental health parity and telehealth laws? How are you making sure that the parity law is a reality?
- Department of Insurance representative (Frank) answered:
    - We periodically and randomly review all of the plans and procedures. Usually, it's complaint-driven.
- Dr. Edmondo Robinson replied to Franks comment:
    - As we think about how we deliver care across the entire state we have got to embrace telehealth and address the barriers that come along with it.

Dr. Nancy Fan motioned to the present commissioners to accept the written 2019 QHP Standards. All commissioners were in favor to accept the 2019 QHP Standards. The 2019 QHP Standards were approved.

POLICY DEVELOPMENT ITEMS

Secretary Kara Odom Walker provided an update on the Health Care Spending Benchmark planning.

- Dr. Kara Odom Walker and the DHSS staffed involved are appreciative for all who have taken a look at the **Road to Value** document that describes some principles that have been embraced across what DHSS and DCHI have been doing in the SIM work; and some of the strategic work of the state employee benefits committee.
- DHSS talked about different strategies to achieve some of the overarching principles of moving to value-based payment. We received public comments (the document has been posted to the DHSS website). Some of the public comments that came in were also incorporated into the draft that is due to the Joint Finance Committee (JFC).
    - An extension was granted to DHSS to submit the final draft on December 15, 2017, so that stakeholder feedback could be incorporated.
    - A draft of the public comments has been posted on the DHSS website on how we [DHSS and the state] would implement a benchmark within the state of Delaware.
    - Dr. Kara Odom Walker opened up the door for any additional questions or modifications to be made to the draft that they submit a comment to ourhealthde@state.de.us. If DHSS receives those comments up until December 11th, DHSS will make every effort ensure the comments are posted in the order that they are received.
- Draft report is due on Friday, December 15, 2017
- Final report due on Thursday, March 15, 2018 (UPDATE: December 15th was the final deadline, therefore, there will not be a report due on this date any longer)

Public Comment granted to the Commissioners by Dr. Nancy Fan

Dr. Nancy Fan – I know it sounds complicated and there seems to be a few deadlines – but essentially, if you are looking for the latest draft it can be found here.

Dr. Jan Lee comment

- The final draft that will be going to the JFC, will it be posted anywhere for us to see prior to when it goes to the JFC?

Secretary Kara Odom Walker

- If I understand your question it's when will the December 15th report be posted [to the DHSS website]?
    - We're taking comments until December 11; I do not think a version will be posted before the December 15th deadline. We will post it on December 15th and then address as many comments as possible with the acknowledgment that we will probably need to revise the report again.

Secretary Rick Geisenberger

- You do not want to post a report to the Joint Finance Committee or the governor online before you submit it to the Joint Finance Committee or the governor. So, that final version she's [Secretary Kara Odom Walker] going to have to give to the JFC or she can do it simultaneously but you cannot do it before. Or they [the JFC or governor] will say, *how come you sent it to the public before you sent it to us?*

UPDATE: ACA MARKETPLACE

Ann Kempski, Executive Director, provided a brief update on the future of the Affordable Care Act as well as where policies stand with the new federal administration.

- I'm sure that most people in this room know that the deadline for enrollment is December 15th. We want to get the word out there. Also, this is a time of uncertainty federally around the Affordable Care Act.
    - We will take more time at the January meeting. By that time, I am sure we will know where some big policy questions stand around the future of the individual mandate and some other issues.

Commissioner Trinidad Navarro provided an update on the current state of the Marketplace.

- DOI consulted with Highmark last week and as of last week (week of November 27, 2017) and about 8,400 people signed up. Which is good and bad because we only have a week left.
    - We [DOI] have received calls from individuals who have been assisted by Westside Family Health and Chapman.
    - I have been notified that with Chapman it is a 3-day wait that they are so overwhelmed with calls that they are unable to support the volume of calls that have been coming through.
        - Westside Family Health representative commented that there is not a 3-day wait. Westside has a little bit more capacity than Chapman does.
    - The issue that many applicants are running into is that 80-90% of the enrollment is easy – completing the rest of the application is a bit more challenging because of the technical assistance needed by navigators to complete the application.
    - Navarro spoke to Senator Carper's office and Highmark the week of November 27th because of concerns that the DOI will run out of time. We [DOI] told the folks to sign up early and to sign up often. We do know that things were going great the first couple of weeks, however, people are going to wait too long.
        - Senator Carper's office wants to see if we can extend the sign-up period and extend the deadline for consumers.
        - DOI consulted with Highmark to make sure this is something that they could do.
            - DOI met with Highmark on December 5, 2017, and they [Highmark] indicated that extended the enrollment period would be an issue. But they were committed to doing what they need to do.
    - Both are onboard – we just do not know what the Federal government is going to do
    - Highmark was cross walking Aetna patients. We did not know that that was going to happen
    - We will not know the total confirmed numbers for the enrollment period is over – the 8,400 number was confirmed the week of November 27th – Navarro is assuming that the number is much higher

- **Public Comment granted to the Commissioners and then to the public**
    - Commissioner Trinidad Navarro
        - Do you have a delay or are you able to see folks right away?
    - Representative from Westside family health
        - We have not been experiencing a 3-day delay [like Chapman has] but for the most part, we are open. We have been staying open for the weekend and the evenings
            - We have 10 people that are bilingual which also helps with expediting the process of assisting consumers

Rick Geisenberger

- In the individual tax bill – the mandate is eliminated is that effective for 2018 or 2019?
    - Answer: 2019 – keeping it in effect through 2018
- Commissioner Trinidad Navarro
    - One of the factors when Highmark requested their refiling was that CSR's would not be included and that the individual mandate would have been repealed. We guessed right, but we would have time.
    - The fact that we were able to negotiate a 35% decrease, Delaware faired really well compared to most states

Public Comments

Nick Moriello

- Some of the concerns that you have heard in the delays, we are experiencing in the broker community
- Fewer agents and brokers that there were in prior years – it's a similar delay in a week or more delay
    - The last-minute folks are not in that delay – capacity will be an issue

Dr. Nancy Fan

- Is the lack of capacity due to lack of funding or lack of interest regarding the ACA?

Nick Moriello

- Broker capacity is due to compensation reductions that have happened in the last several years – fewer and fewer agents remain
- The condensed enrollment has taken a greater toll than we anticipated
    - Which overlaps with the Medicare enrollment which ends today (December 7, 2017)

Commissioner Trinidad Navarro

- With respect to agents/brokers, he [Nick Moriello] said it very nicely – the decreased compensation – there is **no** compensation – there isn't any incentive for navigators to help consumers

Nick Moriello

- Going into 2017 it got reduced to zero; going into 2018 there was a little increase but not by that much

Jill Fredel

- Update regarding a report that CMS released of the snapshot of enrollment – December 2nd there were about 8,846
    - About 7% above where we were this time last year
- The bulk of enrollments came a week before December 15th and a week after December 15th
- Nationally, experts are expecting Delaware to be down by 20% in the number of enrollees

Nick Moriello

- For the folks who are in line right now, for the folks who are not receiving tax credits the increase that they are experiencing (25%) and they do not get to talk to someone right away
    - Some of those folks might just step out of market and the may be the lowest cost consumers

DHSS SUBSTANCE ABUSE USE DISORDER SERVICES STRATEGIC PLAN

Dr. Karyl Rattay presents on the substance abuse strategic plan (see PowerPoint slides here).

- Dr. Rattay presented in March regarding the opioid crisis broadly. The state has been working very hard on improving the quality of life and elevating the crisis in the state of Delaware
    - New director for the Division of Substance Abuse – Elizabeth Romero
    - Emily Neural – leading the planning efforts in the Public Health Division
- Much of the early drivers of this epidemic were prescription drugs. As this crisis has evolved many individuals have started using heroin which then led to the illicit use of the drug Fentanyl
- The Division of Public Health began convening across state gov't in May 2017
    - DHSS
    - Kids Department
    - Homeland Security
    - Dept. State DPT
    - Dept. of Corrections
- Balanced Scorecard Map (slide 4)
    - Helps communicate the strategy
    - Visually appealing and easy to understand
    - Helps to use data and to hold everyone accountable
    - Used daily; incorporated into every work that is done
- Within the strategy map there contain ovals (or bubbles) they are objectives
    - Measures and initiatives and plans
    - Insight Vision – a software that is used frequently in the Division of Public Health that helps bring everything together
- Where are we at now?
    - We have had about 50 meetings
    - Initiatives have been identified by its priority
- Six Groups that have been broken down into objectives
    - Health Status Outcomes – which improved by:
    - Implementation – projects, services, actions to improve health, which are made more effective by:
    - Learning & Process – policy & plan, evaluation, health status monitoring, research, which are made more effective by:
    - Assets – financial & non-financial resources, engaged community members & partners, competent workforce
- Treatment
    - Engage people in treatment
    - Outpatient treatment has increased significantly

  - Keeps track of bed availability
  - Residential treatment

- Comment from Elizabeth Romero
  - A quality improvement process to verify the bed slots and as of yesterday, December 6, 2017, all slots were accurate as far as bed count
  - We're [Substance Abuse Division] also going to dig deeper as to why people are not choosing certain facilities – people are not wanting a slot that is available
- Comment from Dr. Jan Lee
  - You showed that there were slots available but there are 69 on a waiting list – could you expand on that?
- Dr. Karyl Rattay
  - There are places that people do not want to go we believe. There are places that have a better reputation than others.
- Dr. Jan Lee
  - So, what you're saying is that there is a waiting list for a specific facility rather than a waiting list for the next available slot?
- Dr. Karyl Rattay
  - To some degree, yes.
- Comment from the audience
  - Is some of that issue transportation?
- Dr. Karyl Rattay
  - It is, yes. It's geographic as well.

- Stakeholder perceptions
  - Clients are still unsure of how to access the treatment that they need – communication networks are siloed

Public Comment

Dr. Kara Odom Walker

- I just wanted to commend Dr. Rattay for putting into action such a heavy lift. It is a full departmental effort to align all of our funding and resources and people power. Thank you for pulling this together. We have reached out to as many individuals who can help us with aligning our Medicaid policies; looking at prior authorizations; thinking about how our 1115 waiver process can facilitate the transition to a more coordinated system because it does require alignment of what is happening in all systems. What's happening in inpatient care and out-patient care and primary care. I just want to say thank you and for anyone in the audience who has helped facilitate this initiative, I just want to say thank you.

Dr. Nancy Fan

- There was mention of the concept of choice and the waiting list for facilities. How much of that is driven by financial resources on the consumer side? Do they not have any concerns about finding a facility because they cannot pay for it?

Dr. Karyl Rattay

- That's a great question. It's not a one size fits all. Interestingly, those patients who have the greatest issues are those who are privately insured. So, here in Delaware, Medicaid is really a frontrunner to help support access to treatment. Division of Substance Abuse and Mental Health (DSAMH) has gone in parallel of step-by-step with Medicaid for those who are uninsured and underinsured. And so, it really tends to be those who are privately insured that have the greatest challenges with accessing services.

Dr. Nancy Fan

- For the Insurance Commissioner – as far as the working committee on non-opioid pain management – is one of the primary goals to find reimbursement for people who opt for non-opioid management? Or for providers/prescribers who want to be able to offer their services? I mean, is that one of the priorities?

Commissioner Trinidad Navarro

- Yes. It's Senator Hansen's bill. It's an alternative treatment, to provide coverage with regards to acupuncture or to essentially ensure funding for that type of treatment – or even chiropractic care. Other treatments and other ways to manage pain before drugs. It's something that we've been working on for several months now.

Dr. Karyl Rattay

- So, with it goes certainly reimbursement coverage, and there's also a really important educational component, too. All those in the health care system can have a better understanding that opioids are not effective for chronic pain management and other modalities are more effective.
- It's also important that the public be aware of that as well – we're a pill-taking society

Dr. Nancy Fan

- I know from the health provider side – at least two health systems who have independently started having in-health care system training for their providers on non-opioid pain management; more specifically pre-surgically. Because we allotted people's first exposure to opioids whether it's something as simple as teenagers ACL repair or childbirth (apparently childbirth is a painful process). Some people get pain management after birth. So, I think that there are some individual programs being demonstrated. I would love to see them, not just being scopeable for the rest of the state but also being coordinated so that the providers get the same information and same concepts. I [Dr. Fan] think that is going on, but it's hard to see that.

Tom Stephens (Chief Medical Officer for Westside Family Healthcare)

- When you [Dr. Rattay] mentioned the Centers for Excellence, it sounded like you were really focusing on the hospitals as those Centers for Excellence and I would just ask that you include the Federally Qualified Health Centers (FQHC) in that first wave as you are looking at that. There is a lot of work that is being done. In fact, we've [Westside Family] got consultants from the state to work on the behavioral health integration. I [Tom] think that the place for this treatment for many patients is best done in primary care. We have a high-risk population and I'd really like to see our FQHC's be those Centers of Excellence so people can get it [treatment] in the location where they feel most comfortable. It sounds like part of the Centers for Excellence idea focuses on providing those resources to help develop those and I would argue that those hospital systems don't need those resources nearly as much as FQHC's. That's just a plea for keeping us [FQHC's] in mind when making headway with that.

Dr. Edmondo Robinson

- I disagree with that [with the comment that Tom Stephens made].

Dr. Lynn Fahey

- From a substance abuse provider perspective, ditto. Absolutely. As a second clientele who are coming to the treatment facilities that don't access primary care. They very well could. We [FQHC's] want to be included in that Centers for Excellence and could benefit from those resources.

Dr. Karyl Rattay

- Clearly, I need to clarify something. I think I communicated this [the presentation] in a confusing way. So, the Centers of Excellence are opioid treatment providers. So, the Centers for Excellence need to be able to provide Methadone, Vivitrol, and Buprenorphine. A variety of different entities can become opioid treatment providers. I was not thinking that hospitals were Centers for Excellence, but they could become.
- When I mentioned hospitals, what I really was emphasizing was the opportunity to engage people in treatment from the hospitals. The Centers for Excellence then are the engagers, if you will. I don't know if any of you have heard or seen Terry Horton speak on the high prevalence of admissions and long-term expensive admissions they're seeing related to IV drug usage. Endocarditis, Sepsis, Osteomyelitis – they are seeing a lot of people who are ending up 6-8 weeks in-patient care. It has historically been a missed opportunity for treatment engagement.
    - Engaging people who are in-patient, post-partum, as well as, people who are in the emergency department (ED) who have overdosed or just pain seeking whatever.

Delaware Health Information Network (DHIN) UPDATE

Dr. Jan Lee presented a DHIN update (see PowerPoint slides)

- The last update at the HCC was in April 2017.
    - A lot of what's going on is more the same – but an update will be provided on where each of the activities currently stands
- DHIN's Core Services
    - **Clinical Results Delivery**
        - EHR integration
        - Inbox on provider web portal
        - Autoprint
            - Ubiquitous across the state of Delaware
            - The number of practices enrolled in DHIN exceeds the number of practices that are in Delaware – there are practices that are enrolled in DHIN that are out of state
                - Maryland
                - Pennsylvania
                - New Jersey
    - **Community Health Record (CHR)**
        - Longitudinal patient record crossing time, geography and care settings
    - Additional Services
        - Public Health Reporting (ELR, Syndromic Surveillance, Immunization, newborn hearing screening
        - Care Summary Exchange

        - Medication History
        - Image Sharing
        - Specimen location for research
        - **Event Notification Service**
        - DMOST Registry (in progress)
        - Analytics/Reporting Service
        - Fraud Detection
        - **Common Provider Scorecard**
        - **Patient Portal/PHR**
        - **Health Care Claims Database** (in progress)
            - *Note: DHIN is transitioning to new vendor partners for these services.*
- Lowering the Cost of Care
    - Nominal cost savings per test: $250
    - Potential annual savings across the state: $5,979,864
- Supporting Care Coordination
    - Supported "events" include:
        - Hospital or emergency department (ED) admissions or discharges
        - SNF admission or discharges
        - Telehealth encounter
        - Walk-in clinic visit
        - Receipt of a Care Summary
        - The conclusion of a couple of different grants that DHIN has been awarded – the chart on slide 6 of the PowerPoint presentation – shows the cost of care for lab tests and imaging tests
        - Another aspect of the SIM work is improving on care coordination – one of the activities that DHIN is doing in support of that is the notification service
    - Event is defined as any patient that has been admitted or discharged from a hospital or ED
        - The more of this information that is included in the Community Health Record (CHR) lowers the rate of reordering tests that have already been completed.
        - If a patient living in Delaware has a Delaware zip code is seen in a hospital through a five-state region, except for Pennsylvania, DHIN can provide a notification that that event occurred.
        - Solid evidence concludes that early follow-up after a hospital discharge improves compliance with a care plan and reduces the risk of readmission. Knowing that the event happens increases the chances of early follow-up
    - DHIN does not have the ability to show a copy of the event happened, but it is coming soon.
        - Right now, they have to look at the CHR to identify these events happened per patient

Configuration Options

- Events to be notified
- Channel for sending notifications (SFTP drop of CSV file, message into HER, web portal)

How it Works:

- Subscriber provides roster of patients (or "auto-subscribe)
- Incoming ADTs are compared to that roster
- A "match" generates a notification that an "event" occurred

On the Horizon:

- Notification of abnormal labs
- Care Summary transmission

- Event Notification
  - 87.3K notifications in Sept. 2017
  - 2-13% from out-of-state sources
  - 2-8% from urgent care/walk
    - Notifications to Payers
      - 466,289 patients enrolled through a payer
    - Notification to Practices
      - 266,035 patients enrolled in a practice

Growth in Data Senders Enriches Both CHR and ENS

- "Traditional" Data Senders
  - Hospitals – 100%+
  - Laboratories - ~100%
  - Imaging Groups - ~95%
- End Users
  - Ambulatory/ED/Inpatient providers – 100%+
  - FQHCs – 100%
  - School clinics – 100%
  - Behavioral Health – 47%
  - State agencies
- New Data Senders
  - Walk-in/Urgent Care Clinics – 7
  - Telehealth Providers – 2
  - Ambulatory Practices – 135
  - Nursing Homes – 5
  - Other State HIEs – 5
  - Sleep Center – 1
  - Dialysis Center – 1
- The numbers with the +plus sign signify that there are providers/hospitals out of state that submit their data (Maryland)

Goal for the End State

- Consumers can access all of their health data across geography, time and care settings through a single login – they see the same data their provider sees
  - An existing patient portal can call data from the DHIN data repository via API
  - A practice without a portal can us a practice-branded instance of the PHR (must be sending CCDs to DHIN in order for patient to see the practice's data)
  - A DHIN-branded instance of the PHR will be provided for patients with no other exception

In Summary

- DHIN is fulfilling its statutory purpose
- The value of DHIN grows with increasing participation
- Ideally, all participants should both receive and contribute value
- DHIN is an important tool in achieving the "Triple Aim" of better care, healthier people and lower costs
- Technology is an enabler, not an end in itself…

- …But you can't do transformation without technology
- DHIN stands ready to provide additional tools and services as demand dictates and funding enables

COMMON SCORECARD UPDATE

Ann Kempski, Executive Director

- So, the common scorecard was referenced by Dr. Lee. This was a common consensus of a lot of stakeholders. A scorecard is a group of healthcare metrics. It is a SIM-supported project as it relates to transparency. The commission partnered with DHIN in making this a reality.

    - There has been great collaboration. The notion of the scorecard was that we had to start somewhere and then it would evolve over time. We have data out of the common scorecard – it will help with practice improvement and where we stand as a state.

- HCC staff would like the permission from the commissioners to roll the scorecard up and prepare for public release. Time will be set aside for the January meeting and making sure that the public understands any limitations.

- Other states are benchmarking themselves, such as Oregon. It is a great way to see where we are going over time.

UPDATE: SIM SPONSORED ACTIVITY

Ann Kempski update on year 4 of the SIM grant

- Many of you know that HCC has a multi-year contract with CMMI. The SIM work has faced delays on the state and federal level due to transitions of new leadership and limitations on how money can be spent.
    - HCC submitted a 'No Cost Extension' to extend year 3 grant money to buy us a bit of time due to a slow procurement process slowed down some of our activities this year. In particular the Health Neighborhoods, behavioral health and payment reform activities. As a result, we have not been able to complete some of our year 3 activities as quickly as we would have liked.
    - Our federal partners have strongly recommended that we instead apply for our year 4 funds to get the ball rolling. The deadline to submit will be in early January.
    - Year 4 allotment is $5.6 million
    - HCC staff does not know how year 3 will close out, but we anticipate some carry over funds will be available in Year 4.

Health Management Associates

Nancy Jaeckels Kamp, Managing Principal, Project Lead

- What we're starting out on with the integration – HCC had proposed in the original SIM – creating different pilots in the different levels
    - Primary care services being put into behavioral health clinics
    - Behavioral health built into primary care practices

- There about **five** practices that have applied and we have about six to eight more that HMA has spoken to within the last week that have expressed their interest.
- HMA will be offering multi-levels of technical assistance (TA)
- All of this activity will be supported by process improvement data sets and the scorecard as a benchmark.

Lisa Whittemore

- Things completed so far:
    - A kick-off webinar with about 30 participants – HMA has sent the applications
    - HMA met with the board members at the clinical committee for DCHI
    - Beginning to plan site visits in January and learning collaborative for February

Liddy Garcia-Brunuel

- HMA Team had created phased approach in order to select fiscal agent and begin disbursement of mini-grants
    - Phase I: Hosting Listening sessions (in progress)
    - Phase II: Final Health Neighborhoods Model Rolled Out (December 15, 2017)
    - Phase III: Fiscal Agent Selected (January 15, 2018)

Kristen McIntosh

- Statewide Fiscal Agent
    - Fiscal agent will disburse funds directly to Neighborhood Initiatives
- 3-Step Mini-Grant Disbursement
    - Complete Readiness Assessment
    - Present to statewide sounding board to obtain support and ensure sustainability
    - Obtain Local Council approval
- Statewide Consortium
    - Shared learning, community-level data, sustainability, policy

Public Comment

Dr. Edmondo Robinson

- What is the function of the statewide fiscal agent?

Liddy Garcia-Bunuel

- They simply are the holder of the funds and disburse the funds when requested by the HCC.

The meeting was adjourned by Dr. Nancy Fan at 12:30 p.m.