

SB 227 Primary Care Collaborative Meeting

Tuesday, September 17, 2019

5:00 p.m.

**Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713**

Meeting Attendance

Collaborative Members:

Present:

Senator Bryan Townsend
Dr. Nancy Fan
Representative David Bentz

Email:

Bryan.Townsend@delaware.gov
nfanssmith@yahoo.com
David.Bentz@delaware.gov

Staff:

Juliann Emory
Read Scott

Juliann.Emory@delaware.gov
Read.Scott@delaware.gov

Attendees:

Kevin O'Hara
Jennifer Mossman
Lisa Goodman
Andres Wilson
Cydne Teal
Ayanna Harrison
Veronica Wilbur
Mike Gilmartin
Chris Donohue
Rebecca Byrd
Kathleen Willey
Steve Groff
Regina Heffernan
Lisa Zimmerman
Margaret Defeo
Christine Schiltz
Faith Rentz
Susan Conaty-Buck
Leslie Ledogar
Todd Moran
Kiki Evinger
Steven Costantino
Leslie Verucci
Stephanie Myers
Pam Price
Karyn Scout
Lenaye Lawyer

Organization:

Highmark DE
Highmark DE
HGP
Morris James
Christiana Care Health System
Department of Health and Social Services /DHCC
Next Century Medical Care/ Delaware Nurse Association
M. Davis and Sons
Christiana Hospital/Delaware Health Care Association
The Byrd Group
Quality Family Physicians/Medical Society of Delaware
Division of Medicaid and Medical Assistance
AmeriHealth Caritas Delaware
Department of Health and Social Services
AmeriHealth Caritas Delaware
Parkowski, Guerke & Swayze
State Benefits Office/DHR
Delaware Coalition of Nurse Practitioners
Department of Insurance
M. Davis and Sons
Department of Health and Social Services
Department of Health and Social Services
Delaware Nurse Association
AmeriHealth Caritas Delaware
Highmark
AmeriHealth Caritas Delaware
AmeriHealth Caritas Delaware

Jim Gill
Saschen Brown
Elisabeth Scheneman
Wayne Smith
Julie Caynor
Liz Staber
John Fink
Jamie Clark
Anthony Onegu
Kim Gomes
Brian Beachler
Karen Antell

Medical Society of Delaware
Aetna
Department of Health and Social Services
Delaware Healthcare Association
Aetna
Aetna
Bayhealth Medical Center
Nemours
United Medical
Byrd Group
Christiana Care Health System
Christiana Care Health System

Meeting was called to order at 5:08 p.m.

Introductions

Dr. Nancy Fan

- There are new members collaborative we are going to go through and introduce ourselves.
- I am the chair of the Health Care Commission and a full-time OBGYN at St. Francis Healthcare. And So I was named to the collaborative as ex officio from SB227 (<https://legis.delaware.gov/BillDetail/26743>).
- Other introductions around the table:
 - David Bentz, State representative and sponsor of SB227. Serve as chair of the House Health and Human Development Committee
 - Vince Ryan, Department of Insurance
 - Trinidad Navarro, Department of Insurance
 - Faith Rentz, Director Statewide Benefits and Insurance Coverage in the Department of Human Resources representing the State Employee Group Health Plan and State Employee Benefits Committee.
 - Steve Groff, Medicaid Director
 - Steven Costantino, Department of Health and Human Services
 - Chris Donahue, primary care physician and Chief Population Health Officer at Christiana, representing Delaware Health Care Association
 - Jim Gill, family physician in private practice and representing the Medical Society of Delaware
 - Kathy Willey, family physician Hockessin private practice working with the Medical Society
 - Leslie Verucci, Nurse Practitioner in the community sector representing Delaware Nurse Association
 - Veronica Wilbur, Nurse Practitioner and owns a private practice in Claymont area and representing Delaware Nurse Association
- Thank you, everyone, and thank you for being on time and thank you to the Medical Society for allowing us to use their space and their kindness for letting us meet here. Senator Brian Townsend will be here in a few minutes. He is running a few minutes late.
- Senator Bryan Townsend arrived and introduced himself.
 - Bryan Townsend, State Senator South Newark area. Here because primary care is essential to an effective health care system and there is a lot we need to do to make it better in Delaware.

- Housekeeping items:
 - Attendees, please sign in
 - For the members of the collaborative, we will have name tents available at our next meeting. They were not created for this meeting because we have several vacancies (Governor appointees that have not been named yet).
- This is an open public meeting so therefore there will be a public comment at the end of the meeting. There are some in the audience that have attended all of the Primary Care Collaborative meetings and are very familiar with the work that we do, therefore, I might ask for their input on certain topics and items.

Review of Responsibilities

Dr. Nancy Fan

- The purpose of the Collaborative is to address the crisis in primary care services in Delaware that was recognized by our legislators (<https://dhss.delaware.gov/dhcc/files/primarycarecollab.pdf>). SB227 passed the General Assembly in June 2018. The primary purpose as stated in SB227 is to collaborate with the Health Care Commission to strengthen primary care in Delaware. The following are the purposes that we are supposed to reach.
 - Evaluate system-wide investments in primary care partially using the Delaware health care claims database.
 - Discuss payment reform and move payment reform as it pertains to primary care. The goal is to have 60% of all Delaware providers in a value-based payment model by 2021.
 - We talked in the last several sessions about what value-based payment models might look like in other states and what they mean.
 - All the minutes and materials from the PCC meetings through May of this year are on the Health Care Commission website under the [Primary Care Collaborative](#).
- Workforce is another topic, integrated care with women's health and behavioral health, and directing resources to support and expand primary care access.
- We defined Primary care provider, per SB227, as providers in internal medicine, family practice, geriatrics, and pediatrics.
- Relevant when as we discuss defining primary care spend, which is one of the main topics we need to tackle as we move forward.
- [SS1 and SB116](#) passed General Assembly session, two parts expanded the Collaborative. The expansion included people that were already very engaged stakeholders. The purpose of expanding the Collaborative is to mirror some of the work that has been in other states. It provides greater investment versus giving input but having no voting on an actual initiative.
- We established the Office of Value-Based Care and Delivery (OVBCD) under the Department of Insurance (DOI). DOI will provide an update at this meeting.
- The purpose of OVBCD is to provide a transparent process to reduce health care costs. For primary care purposes, establish affordability standards.

- They are to establish targets for carrier investment for robust primary care by 2025. Meaning that the robust primary care should be established by 2025. Establishing the targets, it can be any time during that time along that timeline.
- Annual report of primary care spend in relation to total health care spending.
- They are to make a recommendation to DOI and the PCC regarding appropriate reimbursement for primary care.
- They are collaborating with us and they are collecting data to report on one of the calculated primary care spend in the state. What the carrier compliance is with rates for primary care and the total health care spending with the benchmarking process. I omitted one of the primary legs of SB227, was related to the second component, carrier compliance with rates for primary care SB227 mandating that all reimbursement rates for primary care would be to at least the level of Medicare reimbursement rates. Important when we move forward talking about carrier compliance.
- A JAMA (Journal of American Association) study about what primary care spend was as per fee for service Medicare. This is important because you can use it as a benchmark to establish primary care. It does not help us calculate the rate of primary care spend if that benchmark is very low. The study was an information study. So that's a little bit of the background.

Approval of Minutes

Dr. Nancy Fan

- First order of business is approval of the May meeting minutes. This is the last PCC meeting before the General Assembly closed and the passage of SB116. We have not voted on them because we did not have any other meetings after that.
- Most of you were at the meeting. If you have any modification or comments on what was in the actual minutes we would appreciate that now.
- Any comments from any of the members about the minutes? A quorum is always necessary to vote on anything whether it's an initiative or some recommendation. A quorum is usually nine people. We have a quorum.
- A motion was made for the approval of minutes, the motion was seconded, approval was unanimous
- Next, we have Vince and/or Commissioner Navarro with the DOI update.

Commissioner Trinidad Navarro, Department of Insurance

- The RFP process is nearly complete. We are working on that now. The plan is to share the RFP with Milbank Memorial Fund (Milbank).
- Dr. Walker put us in touch with them. They are not going to apply for the RFP so we are going to have them take a peek at it and see if we have everything we need in there. Sometimes we even make so we can tweak it a little bit, but they are going to offer their insight.
- We are ahead of schedule. That is a good thing. Thanks to Vince and Leslie.
- Leslie Ledogar is our Regulatory Specialist in DOI. She is working on the RFP now.
- The RFP deadline is January 10, 2020, with the anticipated execution of the contract on March 4, 2020. We'd be happy to take any questions if you have any.
- For more information (<https://insurance.delaware.gov/>)

Dr. James Gill, Medical Society of Delaware

- When you say the RFP will help with looking at data and analysis. Is that what you meant?

Commissioner Trinidad Navarro, Department of Insurance

- We do not have the staff at DOI to do this so we going to hire a consultant. That is why we are taking an RFP and showing it to Milbanks to see if there is anything they think we need to add to it. We are going to hire outside contractors to do this.

Dr. James Gill, Medical Society of Delaware

- Recommendation: I talked to the main author from the Graham Center. They said they would be happy to review. His name is Bob Phillips. I can give you the contact if that would be helpful.

Commissioner Trinidad Navarro, Department of Insurance

- Would he be interested in offering their assistance in developing the RFP or would they be interested in applying?

Dr. James Gill, Medical Society of Delaware

- I did not ask specific questions, but guess he would probably be interested in either.

Commissioner Trinidad Navarro, Department of Insurance

- We cannot have conversations with him prior to, if he is interested in applying. That is why it is important to find out. He can reach out to us and then we can clear it out.

Dr. Nancy Fan

- It is the understanding is that the RFP is from the Office of Value Based Healthcare Delivery. Execution of the office within this time so they can have a stand-up office by the deadline of April 1, 2020. They are supposed to be active by April 1, 2020.
- DOI felt for the amount of knowledge, scope of knowledge, and work done they were not sure if they could have the actual staff in place by that time. That is why they using the RFP process to work with a consultant. Is that my understanding?

Commissioner Trinidad Navarro, Department of Insurance

- Yes, we cannot even begin until we hire. We cannot begin until that process is completed through the RFP. We just do not have the staff or the expertise.

Dr. Nancy Fan

- DOI is considered a state structure, they need to have a RFP to have the work completed.

Dr. James Gill, Medical Society of Delaware

- There are very few people in the country who have the expertise.

Commissioner Trinidad Navarro, Department of Insurance

- Milbank still has contact with Rhode Island. This is sort of where we are hoping they do what they did in Rhode Island.

Update on Initiatives Nationally for Primary Care Reform

Dr. Nancy Fan

- Any other comments from the members?
- We are going to do a quick update on what's going on nationally to give us background information. Hopeful this connection will be helpful as they complete the review of the application.
- Some slides are courtesy of Health Management Associates (<https://dhss.delaware.gov/dhcc/files/depcupdate.pdf>). HMA provided infrastructure support in the last year. They worked with the Health Care Commission on parts of the SIM grant.
- When we talk about what is happening nationally, we are talking about payment reform and how primary care payment reform occurs.
- One of the newest topics in Primary Care Capitation (*Slide #2*). This slide has a lot of information. It doesn't necessarily mean we have to talk about it at this very moment. However, we need to look at things that are important for primary care sustainability.
- One of them is improving the predictability of revenue streams for providers.
- What is considered a non-billable workforce and non-billable payment? Meaning non-claims payment, when there is not a claims code that can be attached to a service that is being used within a primary care practice.
- Improving member-centric access to primary care, being able to have greater patient access. That is what brought us here in the first place.
- A lot of primary care reform in the country is centered around the concept of Patient Center Medical. This concept of a payment model has capitation (*Slide #2*). These are some of the components.
- New ideas are being tried out in different areas. I don't like to use the word "reward", but rewarding for outcomes or revenue enhancement potential, aligning other opportunities for shared saving or shared risk.
- We are going to start the federal view of what they have done in the last few years. *Slide #3*
- They had an initial program with ACOs for shared savings and then they came out with a program called CPC Plus which morphed into CPC and then became CPC Plus. The original CPC Plus did not include Delaware.
- There are 14 areas within the country and these were the hallmarks of what was included in the program.
- The initial findings show that there was an increase in alternative care options
- One of the purposes under SB227 is for us to have 60% of our providers in a value-based payment model by 2021.
- I want to make sure we look at all other models that have been able to move along that direction. Not necessary to be successful, just move along that direction.
- They also show that there was a greater behavior health integration and the ability to do some of the non-claims payment work. Such as what happens with the transition between hospital and practices and addressing the social determinants of health.
- Some of what they initially found when they looked back on some of the data from the CPC Plus states.
- Important, because the Center for Medicare and Medicaid Services (CMS) has now come out with a program called [Primary Care First](#) – a track CMS is going to push out for their Medicare patients.
- The CMS lead of Primary Care First/CPC Plus program came to talk to us last week to give our state an idea of the operational aspects of the program.

- There was an opportunity for providers to ask her what was involved in the program. What were they looking for? How successful could it be?
- I received comments stating that yes, they were happy to hear that you could be in a shared savings ACO and also still apply for the Primary Care First program. They are not exclusive to CMS.
- Unfortunately, they have not come out with their request for application.
- They promise providers that once you have an application, they will do a review to see how successful you could be in the program, if you are qualified, and if you are going to be successful.
- They are giving themselves a two month turn around for every practice, stating you can be up and standing by January 1, 2020.
- “To be determined” when they are going to be able to operationalize this program.
- Delaware is one of the states that was picked for “Primary Care First Track.”
- Geographic Areas (*Slide #5 – Primary Care First Geographic Regions*). It is a 5-year voluntary program. It is based on their Medicare fee-for-service. 70% of the patient revenue must from primary care services. As an OBGYN, I would not be applying. I am not considered a primary care provider under CMS, and this track would not apply to me.
- FQHCs (Federal Qualified Health Centers) are also not eligible because FQHCs receive separate funding for their services, therefore they are not eligible.
- There is a tall primary care payment which is a flat rate payment. There were be a performance-based adjustment. They will calculate out the performance-based adjustment.
- They did release the metric they will use. They are geared towards high-cost metrics such as acute hospital utilization and re-admission. Those are the main ways they are looking for savings within the program.
- Question: If you are in an ACO how does your cost from your ACO affect or apply to what is going on with your PCF total Medicare payment? I don’t have the answer to that.
- Depending on your rate risk assessment for their rates. These are the payments for each and then for every visit that you have beyond what they consider a Professional Population-Based service you will get a flat rate for that particular visit.
- If you have a beneficiary that they consider you before that you are beginning a hundred dollars per member per month and that person tends to come in at least once a week for something else that is into included in the population payment, you technically speaking, still qualify for the \$50.52, technically.
- The Seriously Ill Population track tends to be a higher flat fee payment per member/per month. That was to compensate for the fact that these are greater high-risk patients who obviously should take more time and more services.
- They do not expect a large part of your patient population to be considered seriously ill population. Probably less than 5% (*Slide #8 – Seriously Ill Population*)
- In the same week that we had the CMS come talk to us about Primary Care First, Adam Boehler, former Director of CMMI, spoke with us on a more 30,000 year level about what CMS is trying. He did talk more about direct contracting which is more structure to practices that already take on more of the total cost of care.
- If you are a practice that has difficulty assuming risks they know that is not a track that you can be looking at. They are looking at this for larger organizations. This isn’t something small organizations would be looking at.
- Questions for the Office of Value Based Healthcare Delivery – Are they mining data from the Health Care Claim database? If you are going to be including this kind of Medicare payment spending data on it? I don’t think they are obligated to provide data.
- When we talk about data monitoring and primary care spend within the state we are going to have to recognize that there are certain groups that we are not going to be looking at as accurate of an

assessment unless we have it directly from the payers and then reconciling it with what the practices are saying.

- DOI should be aware that these are factors that we might not be able to account for.

Leslie Ledogar, Department of Insurance

- We put that as part of the description of the duties of the office. That is one of the things that we had asked them to see if they could do.
- When we circulate the draft, please be sure that we wrote that in a way that accurately reflects what your ask is, but I think I did that.

Dr. Nancy Fan

- Milbank will pick up on that.
- They do not foresee a large group of primary care providers being able to do direct contracting model. This is really for larger organizations who will be able to assume a 100% risk or at least a greater risk for total cost of care.
- This is about FQHCs. This is the next model that more and more practices or states being able to use is a capitated FQHC Alternative Payment Model (APM).
- A capitated APM means that they will only receive a certain amount. However, their baseline is always going to be higher than what they have been getting in the past. They receive no less than what they were got under fee for service. What they call pay-for-service.
- They have the potential to have greater revenue depending on their performance.
- These were the other states that have implemented it, have looked at it, that we might be able to have some data from.
- You can see that there are quite a few states who are looking at this as a viable option for their federally qualified health care systems.
- These concepts are important for when we talk about how we are calculating primary care within the state. If you want to talk about who is providing the care...
 - What percentage it is?
 - How many are receiving their payment and under what model?
 - Is very useful for us to be able to determine is that because they have a greater primary care spend?
 - Are they having a greater number of services?
 - Are they getting a great reimbursement and their spend is higher?
- We want to make sure that it is not due to a greater number of services. Right? That is really fee-for-service. We are trying to move away from the volume for fee-for-service. If we find that it is really because they have many more visits versus a great overall spend due to fewer visits but better care, that is one of the variables. We need to know if it is worth our while.
- These are two different types of models that are being approached in other states.
- This study a very good summary.
- This came out in July through three organizations, the Patient Center Primary Care Collaborative, Milbank Memorial Fund, and the Robert Graham Center from the American Association of Family Physicians.
- They did a state-by-state level analysis of what was being spent in primary care, over a certain period.
- Delaware was not one of the states that had contributing data. That is significant to us. I am not sure why.

Commissioner Trinidad Navarro, Department of Insurance

- Too small

Dr. Nancy Fan

- 21 states did not have data.
- They did an aggregate 50 states, but they only looked at 29 states in depth.
- They had two definitions of what primary care was:
 - Primary Care narrow was exactly what SB 227 said. Same providers
 - Primary Care broad included people like OBGYN and behavior health
- When they looked at just outpatient and office-based expenditures. Their average for a narrow definition, nationally is 5.75% with a range of the lowest state was 3.5%, the highest state was 7.6%. They were all well below 10%.
- A lot of their recommendations are great about what to be done at a \$30,000 level. It is what we have been doing.
- We have a PCC, we started talking about data collection, we are defining primary care spend for our state
- One of the things that we would like to see progress beyond this ...
 - What is our primary care spend?
 - What should our optimal primary care spend as a benchmark be?
 - What are we moving toward and how are we moving towards that?
 - Are we moving towards that by investing in different payment models, or different care delivery models, a combination of both?
 - How are we incentivizing providers to be able to do that?
- Those are the tough questions that we want to be able to move forward.
- We have established some of the building blocks with SB227 and SB116 about what's needed to move forward but now we need to do the operational aspects of it.
- This slide shows you what's been going on in other states (*Slide 13, 14 and Page 22*) at a legislative level.
- Essentially it would be Rhode Island, Oregon, us and then the other states that were mentioned. Colorado was soon after us.
- If you look at the descriptions that were provided, most of them have described ...
 - The establishment of a PCC
 - The establishment of metric about how to obtain data, to access primary care spend within in a state
 - The operational aspect of how to access what primary care spend is in relation to their total cost of care spending
- Capturing a lot of the things that we have talked about in the two bills that we have
- These are very broad descriptions. If you look at Oregon – Oregon's is very complex
 - They have a 46 member collaborative. They had a 46 member long before we had a three-person member. They have had in-depth detailed discussions to look at the data, payment model, and practice model
 - They all feed up to one office that then feeds up to the legislature. They have a very different hierarchy then we do.
 - They also have a very different infrastructure.
 - They started with different care delivery models such as care coordination organizations.
 - They were already heavily invested in trying to improve Patient Centered Medical Homes (PCHMs) within their state.
 - When they analyzed the data and realized that PCMH was making a difference in their outcomes for population health. They went back and decided to make that a hallmark of what they wanted to be primary care.
 - How did they want to invest and how did they want to move it?

- Look at the two big standards, Rhode Island and Oregon. *(Slide #14)*
- They did have something similar but not exactly the same definition of primary care
 - They had very different spending goals.
 - They had different participation of their payers.
 - But they did have greater participation of their payers on all levels because they include not just their commercial but obviously their state and Oregon did and Medicare, which was kind of important for them.
- When we look at how we want to be able to move forward in defining primary care spend and where are we going to be able to mine data? And then move forward about where our options are to improving that, we need to consider these three top foundational aspects. Variables that we need to define
- Once again we are always talking about the piece of the pie. Essentially the piece of the cake is that you know if you are trying to preserve primary care revenue
 - How move people away from fee-for-service?
 - What is the transition away or do you start offering them a capitated APM? Which is close to the Primary Care First program.
- Then do you put the icing on the cake?
 - Which includes care management fees?
 - Incentives for PCMH program?
 - Pay-for-performance?
 - Shared Savings?
- These are all possibilities that have been tried in other states to varying degrees. The importance of this is for us to recognize we're on the left side of the program right now. How do we move toward the right side with more of the icing on it?
- What elements can we take away from them?
- In the fall of 2018, we got bogged down in the details of what other states have done and trying to pick and choose how we want to be able to move that.
- Now that we have data structure set up we have to move back and decide how are we going to define that and be more deliberative about how or what is our goal for and why is that our goal?
- What part of this "cake" do we build?
- That is what I foresee us doing. I sometimes get the sense when I put stuff up there at these meetings everybody kind of looks like they agree with me but in their head, they are like, "I am not so sure this is going work".
- Voting members on the collaborative need to tell me exactly what you think. We can't go back in January or February and say that we built a cake that nobody is going to be eating any part of it.

Dr. James Gill, Medical Society of Delaware

- Having the CMS Primary Care First model on the table now is actually really helpful because we see huge payer are already doing this.
- It is moving toward the right as you are talking about. *(referencing Slide #15 of presentation)*
- They have a very large care coordination fee which is \$24.00 for the healthiest population and \$175 for the sickest population and those people who are somewhere in between, per month.
- They still pay for visits. I mean you could argue that you want to get rid of that completely but they still pay for visits but at a much lower rate.
- Then the performance, which is probably the part I agree with the least. How they measure performance, but the concept of measuring performance makes sense. The problem is primary care has

very little control over the main thing they are looking at which is hospitalization rates. At least in our area, we don't tend to our own patients. That's relatively small in the scheme of things.

- The general concept makes a lot of sense. It is very consistent with what we have proposed in the previous iterations.
- With the AMPs, that they have a payment model with four quadrants. One quadrant is care coordination, performance, and then payments for services. Think this all makes sense and if we could move toward this and basically mimic what Primacy Care First is doing that would be great.

Dr. Nancy Fan

- What I have heard back from some people that there did not seem to be a lot of interest in doing Primary Care First because there is a potential for a 10 – 20% decrease in revenue.
- It seems to be tailor-made for practices that are already along some level of practice transformation. I don't know if Medicare or if Kevin wants to comment on that, but you have to be able to mine your data.
- You have to have a certain amount of coordinated care structure to be able to be successful.
- You don't have to have this in place to apply for the program, but to be able to have some level of that in place to be successful at it so you are not losing revenue.
- I sense that there is not going to be a high uptake initially.
- I don't think we should sit back and say, "Okay lets' see what providers do." If they sign up for Primary Care First before we decided to move forward with some recommendations of our own.
- I think we should recognize that everything should be done in parallel.
- CMS is working clearly on it in at a glacial speed and on top of which if they are not going to have a lot of high uptake in the beginning then it is not a big end that we are going to be able to say that is a payment model that really works or that is a payment model that is going to sustain and strengthen primary care.
- CMS' goal is to see this be a multi-payer payment model. I don't know what has been discussed at other levels between commercial payers. I know Medicare/Medicaid does their own thing.
- I don't foresee that happening until you get to the critical mass of providers who are able to do it. You have to get through a critical mass of providers who are able to be successful at Primary Care First before they start pushing it.
- ACOs had to get through the critical mass to recognize that they were close to shared savings if not at shared savings before they said alright we are going to use the same resources to try and do true performance versus some other value-based payment model.

Steven Costantino, DHSS

- I think you are right – it is for practices who are on the way or practices that are willing to make major investments.
- The other thing is, it is interesting what you said about the fees, because my understanding that it is not even close to being decided yet.
- In fact, the terms that have been used are kind of general descriptions of what the fee would be, but if you know something that would be interesting to see because of all of the presentations I have seen they have not been very specific of what that fee would be.

- I'd like to see that if you have it.

Dr. Nancy Fan

- Do you mean the flat payment fees?
- Yes, they came out with the flat fees and CMS shared information. However, they still need individual provider practice assessments because it is stratified according to us.
- Yes, you would have 56% in group one and only 25% in group four and 25% in group four pays more per member/per month.

Steven Costantino, DHSS

- The question, first off it is only Medicare. I just want to make that very clear.
- There is a lot of talk around what the uptake will be in these models. They are not mandatory, they are all voluntary.
- I'd just be curious to see what the uptake would be.

Dr. Chris Donohue, Christiana Care Health Systems

- Can I respond just very quickly? Yes, it is just Medicare, but it is interesting to think about if all of our payers in Delaware reimbursed in a model it certain would probably drive that voluntary engagement.

Steven Costantino, DHSS

- At the meeting with CMMI we talked about Medicaid potentially at some point piggybacking on some of these models.
- So now it becomes a multiplayer and hopefully an all-payer.
- I just think that the first Medicare experiment is important. I'm not being cynical, but I have seen so many of these models and the uptake has been very low. Hopefully, the uptake will be...I want to be surprised.

Steve Groff, Medicaid Director

- Back to what Jim was saying, I think that we should look at the Primary Care First less on specifics and like adopting it and more around the principals behind it and the direction that it is trying to take.
- I think it shows promise at least from CMS thinking, around the very things we're talking about in this room. What should go in, what are the primary components of primary care payment methodology which is population-based, capitation so to speak, maintaining the fee-for-service, and then having some type of shared risks or sharing savings that can be earned on top of that. So we were pretty excited when we saw one come out just because we thought it was a positive direction.
- I did speak with people who were happy with our congressional delegation CMS had represented in there as well as and CMMI. CMS is very interested in trying to find ways for Medicaid to align. She indicated that we would be seeing guidance.
- It will be interesting to see because the deal is in the detail, in terms of how well we can align, but I think you are right in order to be successful we need that multi-payer approach but I think we were happy to see.

Dr. Nancy Fan

- My question to a lot of people at the table is there any sort of incentivization? Because there is a built-in incentive to continue fee for service model, right? You get a fee for every time you have that visit that is not based within your population health model.
- I look at prior behavior, right? What drives provider behavior? Currently, we track provider behavior, other than trying to be a good doctor and best practices is if your bottom line is you have to have this many visits for your revenue. How do you move away from that?
- Is that going to be one of the issues with the Primary Care First that we should make sure it doesn't necessarily come at it dis-incentivization in other models within the state if we are looking at them?

Dr. James Gill, Medical Society of Delaware

- To respond to that, I remember one meeting there was a health economist who was saying the way you should set prices is that doctors should be ambivalent about whether they provide services or not, from a financial point of view.
- You shouldn't lose money for providing a service and you should make money, extra money for providing a service.
- I think there is where Medicare is trying to go. I think that \$50 is maybe a rollout because you are actually, it cost way more for your staff time, than the \$50 you are getting, so you are losing money.
- It doesn't mean argue about the specifics andbut the concept is that it should, you should be I can do this on the phone, my nurse can do it. I can tell my pharmacist to help out with it. I can visit. It doesn't matter. Again, wishing all of the health care systems would move in the room in that direction.
- I think that is the concept
- There are two issues I think and one of the issues is uptake and maybe here are some other reasons that there is not big enthusiasm for uptake.
- Dr. Fan mentioned that uptake at the beginning probably isn't going to be a lot
- There are two main reasons for this. One is we can do it better in the state than Medicare can do it. Medicare is the big battleship that takes forever to turn.
- They are measuring risks about how sick your population was two years ago. Well that doesn't work, right? Because I think, now that you brought up the point, basically said if you do that no one is going to, well actually two components that and you are in a pocket so if you are not, it's not like each patient is a risk, it's your whole population gets a risk
- If you are in risk level two you are not going to want to take anybody who is sick because it going to change nothing in your payment rank.
- It is going to cost me a lot of money to take care of them. You are going to get nothing for that.
- If you move your entire population up to the next level you will get something extra in two years. You will business by then.
- I look at if we are going to do it, we should change that to individual risk scores, not population risk scores and it should be on a three month, your sickness is three months ago not two years ago.
- My guess is that that is one reason people are not going to sign up right now. They are going to say wait a minute my risk at two years, what? We look at ours and we said forget about it. It would not work for us, this year. It may work for us in a year two years.
- That is the reason we can fix those things because we are not Medicare.

- The other thing is hospitalization. Is that the thing we want to pin people on? I'd say probably not, unless, it sounds radical unless the primary care doctor has control over whether that hospitalization gets done and/or paid for. Then maybe yes, but that is probably not going to happen.
- Maybe we want to look at things, again we talk a lot about, and you want your measures to be things that primary care providers can control. Hospitalization is not one of them or they have this much control. So what we do, we do things differently. I think uptake could be high and uptake might be quicker for our program than it will be for Primary Care First Medicare.

Dr. Nancy Fan

- CMS says this is a revenue-neutral program. First of all, this is a federal neutral program. A revenue-neutral program means they are not putting any more money into CMS to help practices achieve this level.
- The second thing is that when we only talk about defining primary care spend we are going to need to talk about what part of that is really that hospital component.
- Currently, to supposedly 60% of all practices, primary care practices, are enrolled in ACO within the state.
- Technically speaking 60% of practices should have the capability to be in a Primary Care First like model because their qualifications are no higher than what they expected for their shared saving ACO. If that is the truth then I am still wondering what the timeline would be then for uptake. It took four years, the whole time of Medicare's shared savings rate for there to be 60% uptake in the state.
- Now Rhode Island has proposed to be 80% within the next three years.
- That is a huge portion of their primary care practices. Eighty percent? That is 8 out of 10 that will be in an ACO. Most of their ACOs are PCHC based ACOs.
- They are not just a practice out there doing their own thing. They are based around a Patient Center Medical Home concept, which is the population health-based concept.
- They should be able to do that with what they have in place regarding levers and investments and being able to show that moving away from fee for service into an ACO could be useful to their practices.
- I don't think we are going to make it. I think I could see us getting to 80% if we are already at 60%. I don't know that it would take for us to get to 80% because I think the biggest thing as the capital investments for the practices that aren't there.
- There are a lot of reasons practices are not in an AOC because they don't have the investment for the basic qualifications. Whether it is mining the data or the infrastructure to do the care coordination. I don't know how we are going to get to that point.
- I am going back to something that Jim said so we can move forward. I think this is useful to DOI. The deadline for the RFP is October 15th, correct?

Vince Ryan

- I believe that the date that DOI is scheduled to submit to OMB is by November 5th, with the Commissioner's final approval on October 29th.
- Our RFP team is submitting that to the commission on October 15th. We would like to have it wrapped up by October 15th.

Dr. Nancy Fan

- Our next meeting is going to be after they would like the information. That would be useful for their RFP if we were able to show that we had defined primary care spend.
- If we are looking at them for data monitoring and data mining and analysis and report. They can't stand up that infrastructure and say, "to be determined." It would be more useful if we define primary care spend for them before we get to that point.
- As we move away this is the basic conversation about what is happening up here. To bring it down to Delaware we need to be able to take certain elements of that and recognize what is going on. My feeling about that is we are not going to wait for Primary Care First or capitated APMs in the FQHCs to drive our primary care sustainability. We need to do other things in the process.
- One of the points that Jim was just talking about was, discussing what goes in our calculation and does that include things like being responsible for the acute care cost (hospital expenditures)?
- In the actual Patient Center, primary care collaborative if you look there's a page on there that compares Oregon, Rhode Island, the Office of Economic Development which is a global one and then a couple of good definitions of primary care.
- Our definition of primary care providers is the narrow definition. I want to make sure that we are all in agreement that we want to stick to that when we talk about how do you define primary care spend.
- When you talk about global organizations like the Office of Economic Development, their definition is much broader and therefore when they define primary care spend for other countries and they say the average is 14%, it is not a direct apple to apple definition.
- We need to consider that when we talking about how we define primary care spend.
- 22 countries out of their 36 participating feed the data for their calculation of what primary care spend is in their country every year for their total cost of care. If their definition is different it affects what their percentage is.
- I don't want us to say, "Okay, because they have all these other services that's why." We still have to look at what we're providing and how much it is. I still think we need to be able to come up with a definition.
- And then within the definition if you all agree that the primary care providers are Internal Medicine, Family Practice, Pediatrics and Geriatrics then we will move from there to talk about exactly what expenditures within those primary care providers need to be defined so that our Office of Value Based Healthcare Delivery will have a starting definition to look at what they are actually mining.
- Dr. Gill and I have talked about claim codes, the actual codes for the claims and if we are looking at the healthcare claims database that is one of our great limiting steps, recognizing that it is all going to be claims-based. If we know who's feeding into the healthcare claims database, has decided that everything that is under Family Practice, under outpatient expenditures, with these claims codes, or what is being put in, at least we know that we will all have apples to apples within each payer.
- I think that is important for our Office of VBHCD

Dr. Chris Donohue, Christiana Care Health Systems

- Nancy, when you say Family Medicine Peds, I am in Geriatrics. Is that the NPs and the PAs that our working within those practices?

Dr. Nancy Fan

- Within SB227 it says all providers.

Kevin O'Hara, Highmark

- Nancy, I just want to add that we put forth, Highmark has put forth some numbers and given that to the collaborative historically and I did some checking and those numbers were based on the narrow definition, and to Christine to your point included NPs and PAs services when performed in a primary care setting, didn't include them obviously when it wasn't.
- My point is that we assumed the narrow definition based on 227 and any numbers that we have quoted thus far...

Dr. Chris Donohue, Christiana Care Health Systems

- I know that the intention of the people around this table is to enhance reimbursement for primary care as we have defined it in this narrow definition, but I am wondering if we're limiting our impact on the community by not including OBGYN or behavioral health in this model.
- I know women's health, in particular, is really challenging for private women's health clinicians to stay in practice and they are certainly addressing primary care needs.

Dr. Nancy Fan

- One of the bullet points within SB227 was integrating women's health and behavioral health within primary care. Hopefully being able to at least address some of that.
- I think since we started on this track of trying to help, to stand up the Office of Value Based Healthcare, I think one of the things we have heard over and over again, was the importance of data.
 - How do we know how much we are spending each year?
 - Where is it coming from?
 - How much do we know, what kind of impact is it having?
- I think that being able to at least compare some apples to apples. Now you are right some of the other states, did use, they included OBGYN to that. We deliberately decided not to include OBGYN in it. You can probably carve out a component of women's health, outpatient women's health which is strictly GYN not including OB because most of OB services are a global payment.
- You cannot carve out individual fee for service concepts within that
- Medicaid does, they are one of the few payers that do.
- There are things in the process that we are working parallel-ly that look at workforce.
- Workforce is one of them.
 - What makes a sustainable workforce?
 - What makes an attractive workforce within the state?
- I know there are other elements, and thank you, Representative Bentz, for [House Bill 257](#), looking at student loan repayment program.
- I think to Kevin's point about what you looked at, I think that the deal in the details because you looked at the specialties we weren't sure exactly how much of the insurances were encompassed in specialties,
 - Did they include lab fees?

- Did they include radiology fees?
- Did they include transitional care when they went to skilled nursing?

Kevin O'Hara, Highmark

- Our number was an all-in number, for that practitioner. So we identified the practitioner and put them in PC bucket and then all services were rolled up.
- I agree with you that it is very important to have a common definition of what is being understood.
- I don't want to be in a position to report a number and have another payer report a number based on a different set of
- That is just my point. I'll speak for my organization. I think we have the acumen to be able to report whatever basket of services we want to include, including OB and behavioral health. I was just making the point that we hadn't done that yet.

Dr. James Gill, Medical Society of Delaware

- Important point and that is where some of the other states wanted to stray a bit.
- Which services do you include? When you look at all the studies it is pretty universally agreed that...
- There is some dispute about primary care to include mid-levels or not, some say yes.
- Do you include OBGYN or mental health or not?
- Pretty much everyone agrees you only include services that clinician actually provide in their office. That is not pharmacy, it's not labs, and it's not other tests orders, it's not that patient going to the hospital. It's not anything at all.
- You can see here where they are saying office and outpatient-based services for primary care clinicians.
- You can look at those as well. You can say we're going to have a definition B or a definition C. But I think the key is that our main definition, narrow, are primary care services provided by primary care clinicians. Not things that the primary care has ordered that are not primary care services.
- Oregon, in particular, went astray because some of the insurance companies came back and said we are already at 14% but they are including Hepatitis C drugs and all that stuff.
- They can do that but that is what I am trying to clarify around the table that we are not talking about that, that we are talking about office-based, primary services provided by primary care clinicians, not the things that they order.

Steven Costantino, DHSS

- In Vermont, there is a very robust Primary, PCMH system
- Within those PCMHs and even within primary care offices, the state invested in putting social workers in those offices and behavioral health counselors and so within the practice, pretty much ingrained in the practice was substance use and services as well as behavioral health.
- They have a capitated arrangement, so sometimes it is hard to disentangle the service from that kind of arrangement. That is where it gets a little fuzzy. In terms of the issue of primary care spend.

Dr. Nancy Fan

- Any other comments about what they feel would go into the definition of primary care spend?

Kevin O'Hara, Highmark

- I just want to make sure that when we say primary care spend? We are talking about the spend for primary care, correct?
- I am hearing, total cost of care issues mixed into that? I heard Dr. Gill say we don't want hospital costs. Those sounds like total cost of care or member spend measures, right?

Dr. Nancy Fan

- Correct, we are not including that.

Kevin O'Hara, Highmark

- I just want to make sure that for this conversation we are just talking about primary care spend or what we are spending as a percent of total cost of care perhaps on primary care.

Dr. Nancy Fan

- Correct, I think the purpose of defining primary care spend what services being provided by a primary care provider.
- How we are going to calculate that?
- The data analytics for the office
- Pulling that back out to what is the total cost of care spend, what percentages, exactly,
- Pick a random raw number, 570 million, and then our total health care spend is 1 billion.
- We have to calculate it first and so to be able to that I think that the operational aspect, the technical aspect, will be a challenge within its; self.
- We have to make sure the OVBHCD office, has once again been able to have payers and providers agree that when Highmark is saying this was Dr. Gill's is at – when we de-aggregated it out. I am not saying that is what we should do I am just saying that is what is happening that Dr. Gill is not saying that included "XYZ", which we did not include in our actual definition.
- Or Highmark will be saying to the office actually we included this stuff, isn't that what they are also reconciling with
- We are all on the same page.

Steve Groff, Medicaid Director

- I am trying to figure out, are we just going to ask the payers to report a number based a definition or is there going to be an analysis of data based a definition?

Dr. Nancy Fan

- I pick B.

Steve Groff, Medicaid Director

- The reason I ask is that it is a little less important to me if we are doing B. If we are more inclusive or more expansive in our definition because that data could be broken out and categorized.
- If we want a broad definition or we want to see a bigger picture, we still have the option of choosing a narrow definition down the line because we can drill down into that data.

Dr. Nancy Fan

- So you are looking for more of an itemized database?

Steve Groff, Medicaid Director

- I think the arguments that we are hearing around women's health and behavioral health. I think we would be doing ourselves a disservice not to at least be looking at the data and have some understanding of what that looks like, but that wouldn't necessarily preclude choosing a more narrow definition when it comes to setting benchmarks

Dr. Kathy Willey, Medical Society of Delaware

- Especially in light of all the work that the state is doing in light of the opioid and behavioral health and the enhancement of programs.
- You don't want to take that way from the primary care provider.

Dr. Nancy Fan

- No, you don't, there are a lot of providers that do a lot of that work and don't get reimbursed. Not only do they not get reimburse they might be reimbursed at an undervalued level for what the work entails. Because it feeds back into the fee-for-service.
- I am going to see the patient ten times and maybe the patient would have the same outcome seeing them five times but the provider has no incentive to be able to do that way other than being a good provider
- I think to Steve's point that if we can come to some sort of definition agreement and this would be very useful to DOI.
- I want to make sure because they will have an RFP out. They will be standing up the office. For them to stand up the office I want them to be able to provide me with accurate data that we can use to move forward with recommendations, right?
 - What should the spend?
 - What are the outcomes?
 - Where is it going?
- To Steven's point if we find out that we have a broader definition then really actual within a practice most of the primary care spend go to drug maintenance. That is important to know, right? Is that a population health issue? Yes, but to what affect.
- We all agree on who is the primary care provider. We are going to include Nurse Practitioners and Physician's Assistants. That was under the original legislative mandate.
- We won't be broadening the number of primary care providers included within the definition of primary care such as women's health.
- The OECB uses preventative health services. That means places like CVS. They include them for vaccinations. They include any walk-in clinic that provides preventive health services. That is included under their definition of primary care spend.
- I just want to make sure we all agree that is not going to be included.
- Because it is going to be what is defined within a practice.

Dr. Nancy Fan

- I think that is not an office-based expenditure but is certainly an outpatient expenditure versus an acute care expenditure, right?

Steve Groff, Medicaid Director

- Can I explain? Milbank board has specific codes that are included. They do include home visits as well. For example, 992, 201, to 205 preventive services codes, home visit codes and some others. Milbank report 16 that is the reference. When you talk about all office visits and preventive services.

Dr. Nancy Fan

- Yes, I agree. I think it is important to recognize what we are talking about what we all agree to that.

Steven Costantino, DHSS

- I wanted to explain the DHIN question. Health Claims Databases across the country, HBCDs, have two unfortunate issues. Even the best of the country don't include self-insured claims, number one. In most states, I assume have about 40 – 60% self-insured claims. It is a challenge for all payers health claims databases.
- The second issue they don't include non-medical claims. What is a non-medical claim?
- Let's say Jim's practice does a phenomenal job of managing patients. He has an arrangement in an ACO and/or so Medicare pays him or an insurer pays him a million dollars for doing a wonderful job as an incentive payment. That payment is not in the all-pay claims database. Even though it could be taxed with said primary care practices.
- I wanted to clarify what I meant by that when someone mentioned DHIN. It is not that they are not good data it is just there are limitations to all of these data sources. We probably need a combination of looking at a few data sources. What insurers may give you, what DHIN may have and maybe some other sources to validate some of these claims.

Dr. Nancy Fan

- This is one of the challenges when we talk about the benchmarking process, correct?
- One of the challenges with the benchmark process was recognizing that we have a large component of self-paid or self-insured based health care claims, therefore not being captured in Health Care Claims Database.
- We need to recognize that we going to have to all talk the same language.
- If we talk about primary care spend and we talk about total health care spend and we want to talk about what did they are capture and
- What is being all captured under total health care spend does not include non-claims payments and does not include direct contracting for lack of a better word.
- Even though that might go into a total spend in an aggregate term. That is fine. I am okay with that as long as that is what we all agree on.
- If we want to include those variables then we have to find a way that will capture that information that is not currently being captured.
- We can't then just limit it to primary care because if we say we are going to capture non-claims payment just for primary care practices it is to going to look a lot larger than it would when all of total health care spend does not include it, correct?

- The whole conversation around the self-insurance is something we do need to address.
- They are large component of what drives our data. How does the office of value-based health care delivery address that?
- I don't know if Leslie looked at that? Did you say you looked at that in the RFP?

Leslie Ledogar, Department of Insurance

- Certainly, we tried to.

Dr. Nancy Fan

- I know you were talked about reconciling with Medicare.

Leslie Ledogar, Department of Insurance

- We need to go back to look at that specific question.

Dr. Nancy Fan

- Does anybody in the collaborative have a better idea of how we can capture that data, from self-insured? I don't want to not use the DHIN.
- The other conversation around the healthcare claims database is that currently by statute there are only four organizations that are allowed to request information from them and a DOI is not one of them.

Dr. Nancy Fan

- If we want to talk about an information base that we already have. Then we are going to have to talk about a different avenue that is going to need to be taken because currently statutory speaking anybody who is not named in it technically has to pay the DHIN to mine the data, to query it. Am I wrong about that?

Steven Costantino, DHSS

- No, I would just say if the Commissioner is talking to Rhode Island it might be worth it to ask them that question. How they are capturing, if they are capturing self-insured data in their percentage?

Dr. Nancy Fan

- If you look at who they have. Those are the actual participating payers. They are the biggest of the health care systems. They did not specifically say that they had self-insured within that payer system.

Steven Costantino, DHSS

- The question is, are they listing them as fully insured companies or are they including them as TPAs?

Dr. Nancy Fan

- It could be Blue Cross might be the only one that is doing all of it.
- If we agreed on the definition of who is a primary care provider.
- We agree we are going to systemically limit this to just outpatient, the only part of outpatient would be home health services.

- Unless there is another outpatient service that everybody feels falls into preventive population health that would need to be included in primary care spend? No
- I am going to just define outpatient services and all office-based expenditures.
- That would be anything from a preventive visit, well visit, vaccinations. I know these are things that are easy claim coded for.

Steve Groff, Medicaid Director

- Vaccinations are not included in Millbank definitions.

Dr. Nancy Fan

- Or they are not one of the claims.

Steve Groff, Medicaid Director

- The things that the physicians orders there not the physician services.

Dr. Nancy Fan

- Some practices do.

Steve Groff, Medicaid Director

- Others don't administer it, it is not medicine.

Kevin O'Hara, Highmark

- I don't want to confuse the issue. If we don't include current incentive fees paid specifically primary care services we are at a level playing field are we good at cost standpoint, right?
- I am not sure that the does a good service because the real picture would include incentive fees. And just saying, those incentive fees are every growing, right?
- Regardless of what the collaborative does. There's organic activity happening out in the marketplace being driven by customers who are paying, that are demanding those incentive fees. I think it is worthy of discussion about whether we should include those things.

Dr. Nancy Fan

- Incentive fees are one of those non-claim payments, correct?

Kevin O'Hara, Highmark

- They are paid outside the claims.

Dr. Nancy Fan

- I think we come back again and we try to capture as much data as we can through something like a claims database.
- Do something like what Steve says – where it's going to be a certain amount of self-reporting with de-aggregating in an itemized fashion? That's for all unit costs, these would be under the claims base and for additional services, whether it behavioral health payment, whether it's an incentivization payment, or whether its other services would be under there.
- Is that something we want to be able to mine? That would be self-reporting.

Dr. Kathy Willey, Medical Society of Delaware

- I am going to say no because the practices that have done better are going to have more than of an achieved incentive.
- When practices are in an incentive-based program there is a maximum that you can collect. It is all based on quality, and cost and measures.
- If we include that there is going to be a level of practices that have achieved it and more, and then there are others that aren't, so I don't think they should be included at all.

Kevin O'Hara, Highmark

- If we are doing those calculations to calculate total spend for a market, for an aggregate number and not for comparative purposes practice to practice, we are not giving credit to activity that is already going on. And that would not be correct.

Dr. Chris Donohue, Christiana Care Health Systems

- It's back to what is the goal? If our goal is to benchmark against other states, then we should do whatever the other states have done. If our goal is to how we are planning for the future certainly we want to take into account these incentive payments in future models because we are imagining that to be a bigger and bigger percentage.

Steven Costantino, DHSS

- It seems the goal is to know how much money primary care is receiving.
- As a percentage of total cost of care
- An incentive payment going to a practice is going to primary care.

Dr. Nancy Fan

- Does that get included into total cost of care?

Steven Costantino, DHSS

- Why wouldn't that be important?

Dr. Nancy Fan

- If we include it, can we de-aggregate it out?

Steven Costantino, DHSS

- We have to worry about the disaggregation because you may lose the self-insured.
- The way we have worked the benchmark process, with the insurers is we have asked for aggregated numbers. Which Massachusetts has done and they have gotten high numbers of self-insurance to participate.
- The benchmark we have been getting very good cooperation from self-insurers because of how we have asked the question.

Steve Groff, Medicaid Director

- The way I phrased it was wrong because I am fine with aggregated data.

- I was hearing we are just going to give you what we want.
- If we are asking them to report it by the level of detail that we want. Even though it is aggregated data. I am ok.

Dr. Nancy Fan

- If Kevin has \$100 to Dr. Gill and \$80 was based on the unit cost of care within a claims base and \$20 was for incentivization that is what you want to look at?
- You don't want just them to say get Dr. Gill got \$100, Dr. Wiley got a \$100. You want to be able to say that out of \$100, the same thing that was the same was the unit cost, population-based preventive health care and then any other variables such as a non-claims payment or other factors,
- For example, Kathy Willey has behavioral health integrated into her practice therefore that gets an extra \$20 - \$30 payment that Dr. Gill's practice doesn't get.

Steve Groff, Medicaid Director

- What is that we want to know? Do we just really want to know one number which is a percent that we are comfortable with or would we like to understand what the primary care spend looks like?
- What types of providers are providing those services?
- What the services are that they are providing? Not at the code level but within categories of service
- Where the services are being provided? I am hearing office elevation and home-based settings.
- Define those major parameters that at the end of the day we have a report that when we read it we can understand where the money is going for primary care? To whom and for what?
- We can generate some ourselves from claims data. Some are non-claims based and I think we could ask for that from health
- So that we understand to what extent if we have made any progress as far as what we call alternative payment for value-based methods
- For the areas that we are not able to generate the data, we may have to ask for the payers to provide aggregate
- As long as we have defined what the end crosstab looks like in a way that everyone understands and can generate the data in a meaningful fashion. That is what I was trying to say.

Vince Ryan, Department of Insurance

- The department started to look at how Oregon and Rhode Island have started to accumulate the data, how they started to call it, how they have organized it and from a data collection standpoint both Oregon and Rhode Island do it very cleanly. that they do aggregate it. It is not like you get a piece of paper with one number on it from a carrier that says they are spending "x" amount.
- Oregon has on its website a very helpful and useful template where the carriers are responsible for doing calculations on an excel spreadsheet which they then submit electronically to the department what their primary care spend is based out of the total cost of care spend. Providing any supporting documentation that they can.
- Rhode Island does something very similar. They go down into traditional primary care physician versus a Nurse Practitioner. Then they do code by code analysis as well.
- If we are going to benchmark Delaware against the other states I imagine Delaware would want to follow something like that.

- The department has, in its possession, both templates and maybe that is something that would be worthwhile to share with the group.
- From an incentive fee standpoint. I think if we are going to legitimately want to get a hard number as to what we are spending on primary care in Delaware. That's the legitimate expense of carriers that are expending on primary care physicians. I think the department would take the position that we would want included in the definition of primary care spend. If I am not mistaken I think incentive fees were included in Oregon and Rhode Island's definitions.

Dr. Fran

- Part of the reason we want to define this is so everyone agrees with what the OVBHCD is looking at.
- If we share the template that you have for Oregon and Rhode Island I think we would like to see that so we can all agree that is something that we would like to see (as in the data mining).
- It would also be useful for you but for us as members this is it how we will define it, this is the metric we will use and this is what we are going to do.
- Now we need to look at the timeline. It is not currently affecting performance and it's not affecting incentive payment.
- Do we want to look at 2015 – 2017 or 2017 – 2019? We don't need this for the RFP, but for the office itself.

Vince Ryan, Department of Insurance

- We need to try to figure out what is the baseline. Ongoing internal discussion, pre-SB227, or post-SB227?

Dr. Nancy Fan

- Yes, pre-SB227, but also think if we can go back (only 2019 will be incomplete) might be a second set we want to look at

Vince Ryan, Department of Insurance

- Department is on the recording stating that we had an understanding prior to SB227 that Delaware spending on primary care is roughly at 3%. We have no idea now what it is post SB227 with the mandated reimbursement increases

Dr. Nancy Fan

- Everyone agrees. Is it okay if we look at the templates and get back to you by the next meeting?
- Will you be able to provide that by the next meeting? We would have a quick discussion.
- I know your deadline is before the next meeting but at least you know where you are starting from.
- We are not reinventing the wheel. We have two models that you could use anyway.
- We have some time, or put it off until the next meeting? What is the timeline? We can discuss this at the next meeting.
- Do we want to look at three years 2015 – 2018, five years 2013 – 2018 or two years?

Kevin O'Hara, Highmark

- If we are going to add members to the collaborative that might have a perspective on this I think we should allay the discussion.

Dr. Nancy Fan

- That makes sense. Three government appointees are not here.
- We also do not know who else will be at the table.
- We will delay voting on a timeline for the OVBHCD until the next meeting.

Senator Townsend

- What are the potential cost implications of looking back five years or two years or three years?
- Does anyone have an idea?

Aetna representative

- Five years is the beginning of, in our world, the BBC if you will, right?
- There is going to be very little, whereas in 2017.
- 2017 and 2018 are really the years that are robust in pre-Senate Bill 227.

Kevin O'Hara, Highmark

- That timeline Senator Townsend, we were cognizant, and we agree with each other around that time.
- If we look at 15 in this market it would be pre-BBR, certainly adoption, 16 would probably be the same, 17 and 18 would be the years that we have some traction and some adoption.
- It is growing every year.
- It is important if we are going to have a relevant conversation about where we started and where we end up, those dates are going to matter.

Senator Townsend

- Just to clarify, the dates matter in the context that you would like to see before then to show the change?

Kevin O'Hara, Highmark

- Yes, I think that would be beneficial to see 15, recognizing at least what is going on in the market during that time.

Senator Townsend

- Are there any operational challenges with saying let's go with 2015 rather than saying let's go with 2017?

Kevin O'Hara, Highmark

- No, we could get around it. I don't pull the data but I think we could get the kind of numbers that you would want to see.

Aetna representative

- We would have to ask. I know we have 2017 and 2018 but I am not sure about 2015 and 2016.

Dr. Nancy Fan

- Incomplete data is incomplete data
- We would have to recognize that we are looking at seven out of the ten apples
- Start off with where were we and then we can compare whether it is post SB227, that would be 2019 – 2021 unless there is a lot of change in the market within this next year and there might be. People may embrace value-based models. CMS gets the ball rolling
- Still may not have the data.
- When you talk about data, there is always that three-month look back delay
- If you are talking about standing up in April 2020, to be able to say you can look at the first quarter of 2020. You are looking at data from the first three quarters of 2019, possibly something from the last quarter of 2019 and nothing from the first quarter of 2020
- The initial data that OVBHCD will give us a report on it established there has been some had work done on it. It would be before SB227 and it would give us an idea of where the movement in the market was at the time.
- We compare where are we now and where do we want to be
- How that breaks out into what the practices are doing.
- There are other pieces of data that we may be able to collect.
- Are we still at 60% ACOs or are we at 55? How many did/did not do PCF? Are we going to be able to collect Medicare data?
- It looks like we have some agenda items for next meeting
- If there are items members want to discuss or present during the next meeting please feel free to bring them up.
- There was a call for Public Comment. There were none
- Next meeting – October 21, 2019, 5:00pm – 7:00pm
- There will be a vote on the minutes at the next meeting.

Meeting adjourned at 6:51 pm