SB 227 Primary Care Reform Collaborative Meeting

Monday, February 10, 2020
5:00 p.m.
Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

Present:	**Organization:**
Senator Bryan Townsend, Co-Chair	Senate Health & Social Services Committee
Dr. Nancy Fan, Co-Chair	Delaware Healthcare Commission
Representative David Bentz, Co-Chair	House Health & Human Development Committee
Faith Rentz	State Benefits Office/DHR
Veronica Wilbur	Next Century Medical Care/ Delaware Nurses Association
Kevin O'Hara	Highmark DE
Dr. Jim Gill	Medical Society of Delaware
Dr. Christine Donohue Henry, MD	Christiana Care/Delaware Healthcare Association
Christopher Morris	Aetna
Steve Groff	Division of Medicaid & Medical Assistance
Steven Costantino	DHSS
Dr. Michael Bradley	Dover Family Physicians/Medical Society of Delaware
Dr. Jeffrey Hawtof	Beebe Healthcare/ Delaware Healthcare Association
Margaret Norris-Bent	Westside Family Healthcare
Leslie Ledogar	Department of Insurance

Absent:	**Organization:**
Hon. Kara Odom Walker	Department of Health & Social Services
Mike Gilmartin	MDavis, Inc./DSCC
Leslie Verucci	Delaware Nurses Association
John Gooden	MDavis, Inc./DSCC

Staff:

Juliann Emory	Juliann.Emory@delaware.gov
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Attendees:	**Organization:**
Kent Evans	DCHI
John Dodd	BDC Health IT
Ayanna Harrison	Department of Health and Social Services /DHCC
Jennifer Mossman	Highmark DE
Andrew Wilson	Morris James

Sylvia Canteen-Brown	Delaware Pediatrics
Elisabeth Scheneman	Department of Health & Social Services
Wayne Smith	Delaware Healthcare Association
Matt Swanson	DCHI
Elizabeth L. Zubaca	Hamilton Goodman Partners, Inc.
Chris Manning	Nemours
Claudia Kane	DCHI
Tyler Blanchard	Aledade
Bill Howard	BDC Health IT
Pam Price	Highmark
Bernard M. Cohen	AmeriHealth Caritas Delaware
Anthony Onegu	United Medical (UMACO)
Sascha Brown	Aetna
Kiki Evinger	Department of Health & Social Services
Liz Zimmer	DHSS

The meeting was called to order at 5:05 p.m.

Welcome

The meeting convened at approximately 5:05 p.m. at the Medical Society of Delaware, 900 Pride Crossing, Newark, Delaware 19713. Dr. Fan welcomed all attendees and noted the full agenda. She explained that in efforts to ensure all agenda items were covered the meeting would move right into the first presentation.

JHU/Arnold Foundation Presentation: Inpatient Prices in DE: A Preliminary Analysis of MarketScan and Medicare Cost Report Data

Dr. Fan introduced the first presenter, Dr. Aditi P. Sen. Dr. Sen is a health economist and assistant professor in the Department of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health. Her research addresses the potential of innovative payment and delivery models, as well as insurance design, to improve the quality and value of health care. Dr. Fan yielded the floor to Dr. Sen.

Dr. Sen's presentation titled, "Inpatient Hospital Prices and Margins in Delaware" began with a brief background of the Arnold Ventures project. The project's focus is to support and inform state-level efforts to lower private sector prices. The analytic component sought to demonstrate the extent of price variation across services, geographies, settings and consumers. The study also compared private sector prices to Medicare prices. Dr. Sen added that Medicare prices are transparent and as a result they are used across the country due. These prices can also be utilized when researching Benchmarks. Dr. Sen continued to explain that the study sought to demonstrate practices out-of-network billing, analysis of hospital costs, margins, and community benefit provision.

Dr. Sen reported that the study used three factors when comparing Delaware hospitals to hospitals in other states. The first, was how much more do private insurers in Delaware pay compared to Medicare? The second factor was, are hospital profit margins higher in Delaware than other states? The last factor examined whether or not Delaware hospitals provide more charity care and community benefit services than hospitals in other states.

Next, Dr. Sen reviewed the summary of the initial findings. She reported that in 2017, the private sector price for an inpatient "basket" of common services was 2.41 times the Medicare price in Delaware. This is above the national average price differential of 2.13. The differential between the private and Medicare price for the inpatient basket in DE (2.41) was higher than in neighboring states. She noted that Pennsylvania's differential was 1.91 and Maryland's was a bit lower at 1.35. She continued by sharing that results indicate the median overall hospital margin in Delaware was 11% in 2017, compared to a national median of 3.6%. Hospital profit margins are high in Delaware compared to other states. Lastly Dr. Sen reports hospital-spending (as a percent of expenses) on community benefit as defined by the lower in Delaware at approximately 7%, while the national average for this expense is 9%. A smaller percent of total expenses was spent on charity care and on unreimbursed Medicaid costs among DE hospitals compared to hospitals nationally.

When reviewing the summary of conclusions Dr. Sen reported that Delaware hospitals have profit margins above the national average. The differential between what private insurers are paying and what Medicare pays is higher in DE than in many other states, and higher than in neighboring states. Delaware hospitals provide a smaller percentage of charity care than hospitals in other states (1.1% total expenses compared to 2.0% nationally). Across hospitals, Delaware hospitals spend a smaller proportion of total expenses on uncompensated Medicaid (1.9% compared to 4.1% nationally). It has been debated that this cost is not considered a community benefit, because the state determines the amount of Medicaid payment. However, Dr. Sen pointed out that it is defined as such by the IRS. Dr. Sen also shared that the calculated average is low because of the small number of hospitals (five total) in the Delaware found within IRS data. Two of the five hospitals spend 0%; 1 hospital spends 6.7% total expenses on unreimbursed Medicaid.

The analysis includes data from three sources (private sector, Medicare, and hospital profitable margins/community benefits). MarketScan Commercial Claims database was used to collect private sector data (private prices). This database captures 25-35% of the commercially insured nationally and covers a broad range of insurers. Dr. Sen reports the main limitation of this dataset is cannot see provider level data. Mean dollar amount for the inpatient basket. Hospital Financial Performance data was taken from the Centers for Medicare and Medicaid (CMS), 2017 Medicare Cost report. Lastly data was pulled from the IRS 990 forms to analyze hospital community benefit as a percent of total expenses. Dr. Sen reviewed the data slides pointing out highlights detailed in the summary of findings and summary of conclusions.

Dr. Sen concluded by reviewing Medicare Payment Advisory Commission (MedPAC) examination of the ability of hospitals to accept lower prices. MedPac finds that costs are flexible, and hospitals generally respond by lowering their costs. Dr. Sen suggested members review the appendix provided in their materials and she agreed to answer any questions.

Dr. Fan thanked Dr. Sen for agreeing to come and present this data. Dr. Fan reiterated that one of the mandates of the collaborative to increase the investment into Primary Care without increasing the total cost of spend. She added that it is important for the collaborative to be knowledgeable about where spending is happening in other areas. Dr. Fan transitioned the meeting to the next presenter, Faith Rentz who will provide and overview of the State Employee Benefits Committee initiatives.

A copy of Dr. Sen's presentation is available at https://dhss.delaware.gov/dhcc/files/jhu_de_prices02102020.pdf.

State Employee Benefits Committee Commentary with Faith Rentz

Faith Rentz began her presentation by sharing some details about the State Employee Benefits Committee (SEBC). The committee consists of 9 elected appointed state officials statutorily mandated with the task of managing the benefits administration and the budget for the Sstate Group Healthemployee health pPlans (covering 127,000 covered lives). The gGoals of the Ccommittee includes to provide overview of State Employee Benefits Committee's a focus on value-based contracting and improving access to primary cCare. She reviewed the strategic framework developed three years ago, which includes developing strategies and tactics that are tied to specific goals. There are four components included in the mission of the strategic framework (ensure adequate access to high quality healthcare that produces good outcomes at an affordable cost, promotes healthy lifestyles, and helps them be engaged consumers.) To address adequate access to high quality health care, the group established a goal to include the addition of at least net 1 value-based care delivery (VBCD) model by the end of FY2018. When looking at ensuring affordability the group established a goal to reduce the group GHIP medical prescription drug trend by 2% by the end of FY2020. Lastly, the group set a goal to increase healthy lifestyles and engage consumers by driving membership reenrollment in a consumer-driven or value-based plan exceeding 25% of total population by the end of FY2020.

Ms. Rentz reports that SEBC contracted with Highmark and Aetna for advanced care management/coordination programs and other value-based care delivery models. She reported that they have implemented programs and changes to drive efficiencies in spend. Ms. Rentz also reported that Group Health Insurance Program (GHIP) has engaged SEBC in discussions regardingof a framework for advanced payment models to understand current Delaware providers' engagement in upside/downside risk sharing arrangements. Ms. Rentz shared details of SEBC's partnerships with Highmark (Enhanced care management program and True Performance) and Aetna (Advanced Care Management/Christiana Care's CareVio program).

Ms. Rentz reports that the medical spend for the year ending in June 20, 2019 was approximately 600 million dollars. She presented the totals for select areas: Physician Outpatient at $69.3M, Other Professional services at $73.3M, Facility Inpatient at $123.1M and Facility Outpatient at $153.5M). Ms. Rentz highlighted that both "Other Professional Services" and "Radiology Outpatient" show significant increases when reviewing trend data (8.4% and 10.2%). Ms. Rentz reports actions taken include participating in the RAND study. RAND is a non-profit organization that collects hospital pricing information from self-insured employers and all-payor claims databases, and hospital pricing information. Results are expected to be released during the first quarter of 2020. She added the GHIPthey are is employing direct provider contracting via SurgeryPlus and providing incentives to members and for utilizing lower cost sites of care, by offering either a low to no co-pay. Ms. Rentz also noted the implementation of a lower co-pay for urgent care or telehealth services. This action was introduced in an efforts to provide other options for members who are unable to reach their primary care provider or those that might consider the ER. Lastly, they continue to evaluate market readiness and options for expanding access to primary care.

Ms. Rentz shared the Alternative Payment Model (APM) framework slide. They are working with the ~~c~~Committee (SEBC) and walked through the model to help the understanding of the framework. She also reports working with Aetna and Highmark in the later half of 2019 to determine where we are currently in the DE marketplace in terms of providers. They also discussed their projections of the movement of providers along the four categories of providers over the next three to five years.

Future work includes updating strategic framework goals and using the APM framework and working towards ~~increasing~~addressing spend in high categories through the advancement of APMs. They plan to increase goals and targets around reducing the spend for the diabetic population. They are attempting to limit the total cost of care at a level commensurate with the Health Care Spending Benchmark. They are also looking into options that suit different demographics to address the changing demographic profile. Lastly, they continue to evaluate the readiness within the state market to provide innovative approaches to reducing total cost of care. They will also explore opportunities to expand access to primary care in the state.

During the January meeting the group voted to give the Statewide B~~b~~enefits ~~o~~Office permission to develop and release a Request for Information (RFI). The RFI will be released in the beginning of the second quarter. The information collected will help promote innovation to decrease total cost of care while not reducing quality. Also, to gain a better understanding of the interest from, and readiness of, the Delaware market to go deeper into more advanced categories of the APM framework. Lastly, they seek to Identify third party providers that could play a role in the Delaware health care marketplace to support the goals of the SEBC. Responses to the RFI will be used to shape the development of the medical TPA RFP, which will kick off internally within the Statewide Benefits Office in ~~January~~ CY2021.

She concluded by sharing next steps which include engaging local provider communities and other stake holders, continue to evaluate other opportunities to drive investments in primary care, and review other data sources for health care provider cost and quality data.

A copy of Ms. Rentz's presentation is available at https://dhss.delaware.gov/dhcc/files/sbo_pccpresntion02102020.pdf

Dr. Fan thanked Ms. Rentz for her presentation. She transitioned the meeting to questions for Dr. Sen from committee members, mentioning questions for Ms. Rentz would follow. Dr. Gill addressed Dr. Sen regarding her choice to limit the hospital services data to include inpatient hospital services only. He also inquired about the comparison of Medicare. He stated that Medicare procedures are generally overvalued with relatively high rates for procedural services.

Dr. Sen thanked Dr. Gill for his question. She stated that collecting accurate outpatient data is difficult as the payments are received from several different payment lines. Medicare includes different rules for bundled services. She added that RAND studies do include this data and their results have indicated Dr. Gill's reference regarding higher thresholds with a lot more variation. She added that their study did not include this data because calculating the Medicare denominator for that ratio on the outpatient side is very complicated. Only about 40% of commercial outpatient claims found could be easily matched to a Medicare price. There are several different payment systems captured in outpatient settings. She continued by

addressing Dr. Gill's second question. She stated that broader conversations are happening among states about the use of Medicare data to establish benchmarks and what services it incentivizes.

Veronica Wilbur commented on the increased health care provider mix. She stated that Nurse Practitioners and Physician's Assistants are not allowed to participate individually in value-based payments or ACOs and their fee-for-service is counted at 15%. Dr. Sen agreed, stating that when you take into account the mix of health care providers, the interaction between pricing and alternate payment models (APM), where there are more or less prevalent, and how many providers and hospital systems are engaged, all of that make pricing difficult.

Dr. Hawtoff inquired about Dr. Sen's choice to utilize data on joint replacements, cesarean section and vaginal delivery when analyzing inpatient private prices. Dr. Sen responded by sharing that deliveries are 25% of all inpatient baskets, nationally. She added that the inpatient basket includes the 15 most frequent hospital services in terms of volume, ranked by Diagnosis Related Group (DRG). She added that the analysis compared pricing not utilization. Dr. Hawtoff also asked Dr. Sen about the choice to use Maryland's Medicare data to compare to Delaware. Maryland's system of reimbursement in Medicare is vastly different than any other state in the country. Dr. Sen answered by sharing that the analysis simply wanted to share Delaware's neighboring states.

Dr. Hawtoff drew Dr. Sen's attention to slide 9, asking for the definition of the term "overall margin". Dr. Hawtoff stated that in his time at Beebe he had not seen an overall margin this large. Dr. Sen responded by sharing that source of this data is collected from Medicare Cost reports. She continued by stating the cost reports do not provide strong detail about how "revenue" is broken down. Dr. Hawtoff was concerned that the data was shared without validating with individual communities. Dr. Sen highlighted that the data submitted could vary by hospital. Details on the data that has been included is not provided. Dr. Hawtoff suggests that given this information this data set may not be the best suited to analyze. Members pointed out that every state has submitted the same data and that the cost reports are submitted by the individual hospital systems. Dr. Hawtoff expressed concern with the accuracy of the data and the use of analysis results to develop policy and decisions. The methodology used to report their data is based on regulations so the difference in their self-reported data and the data presented/shared was concerning.

Dr. Fan suggested the focus be shifted to identifying spend trends and developing strategies to improve them. She added that data is only as accurate as what we collect. She suggested the process be reviewed, tightened and improved instead of questioning the analysis. The data is being collected in the same way for each entity in the analysis. Dr. Fan reminded members that the focus isn't "us" against "them". The focus is to ensure the "patient" receives quality services and improved access to care. She continued by stating that members should work together to develop strategies to assist self-insured, large employers who may want move away from their current spending.

Dr. Donahue with ChristianaCare, shared that the data provided them with the opportunity to improve their care delivery models. She added that closely examining acute hospitalization fee for service rates is a small portion of what needs to be done. She continued by adding that transforming care will begin with discussing value of care and identifying different ways to deliver care. Dr. Donahue mentioned there was some concern with the accuracy of the data. Dr. Donahue pointed out that trends are important, especially

trends in community benefit. She also wanted to share that the point of the margin they are shooting for at ChristianaCare will be reinvested in their primary care expansion and infrastructure to support the social care framework. She concluded by emphasizing the importance of maintaining a holistic viewpoint when summarizing results.
Kevin O'Hara with Highmark asked Dr. Sen if the analysis provided some insight for the differences in numbers in Delaware and surrounding states. He asked if the data indicated if demographics or competitive environment were factors. He also asked if the analysis touched on the affordability in Delaware versus the surrounding states.

Dr. Sen responded by sharing that the analysis did not specifically cover affordability in Delaware versus surrounding states. She added that their data does include out of pocket payments and these cost would be the best measure of affordability that they have in their data. If there is interest, additional analyses can be conducted, and the data can be shared with the group.

Kevin O'Hara followed up with a question about the unique delivery system in the state and how it translates in the cost data. Dr. Sen reports that they are doing additional analyses to find an explanation for the price differentials between private and Medicare prices and what factors lead to the variations. Preliminary data indicates provider landscape may be a factor. Places that have larger hospitals, generally translates into concentrated markets and they tend to have higher price differentials. Areas that have higher Medicaid to Medicare fee indexes have high differentials are also suggestive of negotiation advantage. Dr. Sen reports that the data did not identify clear indicators, and it is difficult to pick up trends with aggregated data. She concluded by emphasizing states typically have a better idea of what is driving costs.

Kevin O'Hara of Highmark pointed out that Maryland's regulations allow hospitals and payers to enter into custom arrangements around procedure types, in efforts to impact utilization and lower costs from the back end. He believes this may be contributing to the variation seen in the Medicare data (35% higher).

Dr. Fan shared that it is her belief that Delaware is regionalized by health care system. Analyses conducted by region may provide insight regarding the impact of reinvestments. Do reinvestments improve access to primary care, behavioral health integration and overall health outcomes for the particular regions?

Dr. Fan highlighted that the primary care spend for the SEBC was documented at 3.8%. She was surprised with this number. She added that the low number could indicate a healthy patient population that doesn't require a lot of investment in primary care, however in her opinion the investment percentage should at least reach 5% for any patient population. She opened the discussion to members with questions for Dr. Sen.

Dr. Mike Bradley of Dover shared with the group that it is his understanding that Kent General Milford recently spent 3 million to build a new hospital. He also added that the hospital system has also purchased several primary care practices throughout the community. As a result, primary care practices have been negatively impacted. He reports that his margin of profit is negative as he is unable to compete with hospital based systems. He has eight providers and he has lost one physician and a physician's assistant who were hired by the hospitals. He shared that he knows of a few physicians that have made this move

and they report a higher salary while caring for less patients. He concluded by stating that he does not believe this is increasing access to care. He suspects the funds to pay physicians at higher rates come from inpatient and ancillary services. He also believes these systems are purchasing primary care physicians but not utilizing them as they would if they were independent practitioners.

Before transitioning to questions for Faith Rentz, Dr. Fan asked members if they had any last questions for Dr. Sen. Steve Costantino asked Dr. Sen if the non-patient revenue was included in the cost reports. Dr. Sen answered by stating that this cost is included with "overall".

At this time Dr. Fan asked the members if there were questions for Faith Rentz. Dr. Mike Bradley began the discussion by expressing his disappointment with the total primary care spend for the state employee health benefits (SEB being under 4%). He mentioned his concern with the proposed expansion of primary care access, Ms. Rentz shared during her presentation. The proposal includes an increase in tele-health and work-based clinics. Dr. Bradley suggested these funds be poured into primary care practices so they can provide these services and have the ability to hire more physicians. He also shared that school health-based clinics are great; however, providers have noticed patients do not return to practices. He shared a concern of a similar outcome with the implementation of work-based clinics. Lastly, he stated that he believes every dollar placed into primary care equals a savings of two to three dollars.

Ms. Rentz responded by stating that some of the more recent models they have researched include establishing primary care practices in locations that are convenient to their members. She continued by stating SEBC is hoping the Request for Information (RFI) will allow them the opportunity to work with providers, their insurers and other stakeholders to develop ideas that can be incorporated into a Request for Proposal(RFP) when they bid in 2021 for a Health Management Administration. Dr. Bradley added that primary care providers are undervalued, and private practice physicians may move to hospitals to survive.

Dr. Chris Donahue highlighted the importance of offering a variety of options for consumers. The needs of consumers are diverse. Traditional models of providing primary care in an office may not work for all. Access to primary care via tele-health and within workplaces may be more accessible for some.

Veronica Wilbur shared her concern for the absence of offering a mix of providers like Nurse Practitioners. She stated that Nurse Practitioners are undervalued and underrated and not capitalized on in the state. There are very few Nurse Practitioner practices in the state.

Dr. Hawtoff addressed the members, highlighting the decrease in trends related to facility in-patient and physician inpatient treatments. He shared that BeeBe has experienced significant success with risk-based models. The investments Beebe has placed into care delivery (care coordination) models, have allowed them to create savings in the millions over only a few years. He reports that Beebe has been able to share these savings with insurance companies. He added that Beebe has begun to discuss options with Blue Cross and Aetna to continue work around these care models. He shared that their quality scores are phenomenal, and the reduction in cost is working for everyone. Patients are doing better.

Kevin O'Hara shared that he was very interested in meeting with Dr. Hawtoff to discuss the results around increased quality and decreased cost. Dr. Hawtoff agreed to meet with Mr. O'Hara.

The members of the collaborative spent time discussing the four categories and identifying where practices and hospital systems in the state fit on the spectrum. Dr. Hawtoff reports that BeeBe is currently in the three range and their goal is to move into category four. Kevin O'Hara reports that Highmark has a few ACOs moving into the 2-3 range, however the vast majority are in the 1 to 2 range.

Steven Costantino mentioned that the framework features current state and future state and includes a bubble chart for free for service. He continued to add that anything three to the left is based on fee for service architecture or fee for service model. Most payments are within the one range. He concluded by stating that there has been movement but the road to value has been a very slow progression.

The members began to discuss the four categories of the care model. Chris Morris of Aetna agreed that their providers are falling within 1 and 2. Steve Groff agreed with Dr Fan's assessment that the RFP with Medicaid would likely move practices from category 1 into category 2. Dr. Fan asked the members if they feel comfortable promoting a PCMH-like program that includes enhanced investments, to assist providers/practices to move from 1 into category 3. She concluded her thought by challenging the collaborative with identifying a source of funding.

Dr. Fan shared a slide from a presentation given by Jennifer Swatrz. Ms. Swatrz shared that they calculated they spent at $22 for PMPM for their Trinity ACO to be successful. Dr. Fan invited Tyler Blanchard from Aledade ACO to provide an overview of his organization to the members. Mr. Blanchard reports that their ACO is currently in multiple states and they have been in Delaware for 5 years. The ACO works with 30 independent primary care practices, including Dr. Gill. Mr. Blanchard shared that their central functions are based out of Bethesda, Maryland. They have cost both at the local level and behind the scenes. Mr. Blanchard stated that Aledade spends close to 1 million a year to operate their ACO in Delaware. He pointed out that it is a long-term investment adding that if they do receive shared savings the payment comes the following year. There are also costs to the practices. Mr. Blanchard shared that Dr. Gill's cost are separate and may include: having Health Care Coordinators on staff, making room in his schedule for patients who need a same day appointment, providing risk code training for his team, educating patients on the alternatives to using the Emergency Room, and ensuring phone coverage for patient calls (including weekends).

Dr. Fan asked if Aledade providers offer concierge services. He added that concierge services may have better outcomes and better care delivery model, however she does not believe these services increase access to primary care. Mr. Blanchard responded to Dr. Fan's question about concierge services by sharing that 5 of the 30 Aledade practices have concierge services. He shared that the providers made these decisions on their own and it is a trend in state. He agreed, stating that these providers are caring for 200 patients instead of 2000.

Dr. Donahue pointed out that the Trinity ACO example included Medicare patient population so the $22 PMPM would not apply to a commercial population. She added that they had 15% of the total medical spend at-risk, this kind of downside risk is a motivator and it forces the investments. Dr. Fan agreed and stated that 15% risk is a high risk for most providers. She added they had 100,000 Medicaid patients which

is a very large patient population. She shared this example to illustrate how much it cost to set up this type successful infrastructure.

Dr. Fan asked members to identify a reasonable benchmark. She continued by asking if 2.4% what will be acceptable to the state. Dr. Sen suggested that the collaboration consider setting a reference price for different populations, instead of attempting to impact the entire state population at the same time. Steven Costantino suggested that the collaboration consider setting a benchmark and working through phases over three- or four-year period. Dr. Fan agreed that nothing would be immediate it would have to be three- or five-year plan. She concluded her statement by adding that if there is interest in increasing the investment into primary care, members will need to identify how the funds will be received.

Dr. Fan stated that during the next meeting, committee members will bring proposals and a vote will be taken. She encouraged members to bring concerns or issues to the next meeting.

Dr. Bradley asked the insurers present, if there was a way to reduce outpatient cost paid to hospital-based practices. Kevin O'Hara of Highmark stated that the landscape within the state does not include competing outpatient options. A suggestion was raised to develop regulations on the price of the cost of things like echocardiograms. Dr. Sen reported that Connecticut does have similar regulations. Dr. Fan reminded members that the goal of the collaboration is not to develop regulations for specific procedural. Dr. Sen added that we can recommend regulations but not down to procedures or claim codes.

Dr. Fan reiterated the importance of making decisions and recommendations for next steps. She tasked each member of the collaborative with submitting a proposal that will be reviewed during the meeting scheduled for March 16th. Dr. Fan asked that all proposals be sent to Read Scott by March 6th to allow for review prior to the meeting. Members were asked to submit proposals with recommendations for primary care investment strategies that include the identification of the funding source for the investment. Dr. Fan reminded members of the different approaches that had been mentioned in past meetings when discussing hospital spend. Members discussed using an incremental (over a few years) percentage approach and the use of an absolute benchmark for price differentials (over a few years). She encouraged members to consider other creative approaches. Dr. Fan transitioned the meeting to the review of the minutes.

Review of the November 2019 and January 2020 Minutes

Dr. Fan asked the committee members if they had any comment on the draft minutes from the Primary Care Reform Collaborative meetings, held on November 12, 2019 and January 8, 2020. Hearing no discussion Kevin O'Hara motioned to approve minutes as amended. Dr. Gill seconded the motion. The motion to approve was unanimously carried. View approved November 12, 2019, meeting minutes here: https://dhss.delaware.gov/dhcc/files/pccmeetingminutes11122019.pdf View approved January 8, 2020, meeting minutes here: https://dhss.delaware.gov/dhcc/files/pccmeetingminutes01082020.pdf

Update on Department of Insurance/Office of Value Based Health Care Delivery

Leslie Ledogar provide a brief update from the Department of Insurance on the progress to implement the Office of Value Based Health Care Delivery. Ms. Ledogar reports that they received five bids from across the nation. She was excited to announce that the evaluation team had completed their reviews and results/scores were submitted to Commissioner Navarro four days in advance of the February 10th deadline.

The Commissioner will make the final decision and contact the awardee. The Department will enter into contract negotiation with bidder, if terms can be reached the awardee will become the head of the new Office of Value Based Health Care Delivery. At that time the other bidders will be notified that they were not successful for this RFP.

Dr. Fan reviewed the decisions made by the collaborative as they relate to the operations of the OVBHCD. The list of primary care providers (Family practice, internal medicine, geriatrics, pediatrics, Physicians, NPs, and PAs) that would be included when calculating primary care spend was reviewed. She stated that during a previous meeting the collaborative agreed specifications would be formulated by OVBHCD with input from the collaborative. The specifications would include outpatient and office expenditures only. She asked if a final decision was made regarding the collection of non-claims payment data. Several members reported the collaborative decided to utilize aggregate data from contributors to the ACPD (DHIN). Dr. Fan continued by asking if topic recommendations about specific areas beyond outpatient office expenditures had been made. Members agreed that no recommendations were made outside of outpatient and office expenditures at this time.

The discussion moved to need or desire to establish a subcommittee to meet with the OVBHCD lead. Ms. Ledogar suggested that the collaboration give the awardee some time to share their plans/approach before sharing our expectations. She reminded the collaborative that the bidders were experts from all over the country. Members agreed to extend an invitation to the newly awarded lead of OVBHCD to present at the April meeting. After the awardee is announced, Dr. Fan agreed to initiate the invitation. All agreed that recommendations will be held until after hearing the plan/approach of the OVBHCD.

Legislative Updates

Dr. Fan reported that Delaware State Senate, 150th General Assembly, Senate Bill No. 200 passed and was just signed today, February 10, 2020, by the Governor today. This is an act to amend the Delaware code relating to the Delaware Health Information Network (DHIN). The bill states that DHIN shall provide access, at no cost, to all claims data reported by the Delaware Health Care Claims Database under this subchapter to the following state agencies for the purposes of public health improvement research and activities: Office of Management and Budget, State Employee Benefits Committee, Division of Public Health, State Council for Persons with Disabilities, Division of Medicaid and Medical Assistance, Department of Insurance, and the Delaware Health Care Commission. Details about SB200 can be found here: https://legiscan.com/DE/text/SB200/id/2080563

Dr. Fan continued her report on Legislative updates by sharing that SB206 is now in the Senate. This bill is an act to revise the appointment process for members of the Primary Care Reform Collaborative who are not members by virtue of position. Under this Act, these members are appointed by a government official to comply with the requirements of the Delaware Constitution. This bill is sponsored by Senator Townsend and co-sponsored by Representative Townsend. On January 29th it was reported out to Committee in Senate wit 4 on its merits. Details about SB206 can be found here: http://legis.delaware.gov/BillDetail?LegislationId=47988

Dr. Fan reminded the collaborative of the mandate to submit an annual report to the General Assembly and the Delaware Health Care Commission. The report will include activities and progress of the collaborative

and future goals and plans. She reviewed several recommendations that would be included in the report. In line 25 of SS1 for SB116 it states that the collaborative can develop the definition of operating procedures. During the last meeting members agreed proxy representatives will have voting rights. Attendance of a proxy must be communicated to co-chairs prior to meeting so they may be included in meeting communication and information. Term limits as described in SB116 and SB206 are limited to two years with appointment. This excludes ex-officio positions. All agreed a quorum (10 of 17) is necessary for voting. Lastly, meeting information and materials will be disseminated to members one week prior to each meeting date.

Recommendations resulting from survey results

Dr. Fan presented current recommendations based on the survey results:

- Primary care is the foundational to health care delivery in DE
- Practices which demonstrate a team based or PCMH like delivery of care should have more upfront investment
- Initial increase in upfront investments should be tied to an agreed upon definition of "risk" and "value" as well as overall cost saving benchmark
    - Increased PMPM, care coordination payments, non-claims payment
- ERISA Plans:
    - Provide a Learning collaborative – creation of subcommittee
    - Voluntary contribution of data -request aggregated from TPA or specifications in to APCD

Dr. Fan summarized by stating that the results from survey indicate the majority agreed that upfront investment is a good way to help patient center medical homes or team based like practices transition to a value and risk based incentive payment like Primary Care First Model and that increased prospective payments should be tied to risk and value based payment models. She added next steps should be to identity the last set of recommendations about where the funding should come from. She called for discussion and stated that if members had any questions or opposition now would be the time to share. If members had no comment the recommendations would be included in the annual report as shown.

Dr. Gill stated that he did not believe the collaborative agreed that upfront investments would be tied to overall cost savings benchmarks. It was his belief that group agreed that value would be tied to accountability, primarily tied to the "Four Cs". Several members disagreed. Dr. Fan agreed to revise the statement by including risk and value based and accountability. Dr. Fan asked if there were additional comments. Kevin O'Hara suggested upfront investments in primary care should be linked to increase in quality and decrease in cost. Dr. Fan reminded him that this discussion was focused on recommendations that resulted from the survey. At that time, Dr. Fan opened the floor for public comment.

Public Comment

Wayne Smith, Health Care Alliance addressed the collaborative by raising his concerns regarding progress being driven by agreements to studies and suggestions with questionable data. He continued his comments by addressing the calculation reported by the State Benefits Office that indicated state employees spend 3.8% on primary care. He shared that Willis Tower Watson has found that state employees tend to be older and less healthy than the general population. He suggests that this calculation does not provide a clear

picture, adding that a per capita comparison of 50-year-old state employees versus the entire 50-year-old population would be a more accurate representation.
He also mentioned concern with Dr. Sen's use of Maryland data as a comparison and pointed out that the Maryland's use of a unique waiver system. He shared results from an article published this year that reports Maryland's Medicare rates are 40% higher than other states. This rate disparity will show lower rates. His calculations show Medicare Maryland with $5,277 and Delaware at $3,762. He stated he did not believe the basket of services used in the Dr. Sen's study, capture the complete picture. Mr. Smith also mentioned several issues with comparing Pennsylvania data with Delaware. He concluded by stating that in his opinion the collaborative did not have enough high quality, uniform, comparative data to support benchmark proposals that will change the relative investments in primary care versus non-primary care.

Dr. Fan thanked Mr. Smith for his comments. She asked if the anyone from the public had additional comments. There were no none.

Dr. Fan reviewed the upcoming meeting dates with the group. The meetings will be held on the third Monday of each month, ending in May. A June date has been scheduled; however, this meeting may not be necessary. She concluded by reminding members that next meeting agenda will include the review of proposals, concluding with a vote and decision made for recommendations to be presented in the annual report.

Hearing no other business, Dr. Fan adjourned the meeting at approximately 7:00 p.m.

Next meeting
The next Primary Care Reform Collaborative meeting will be held on Monday March 16, 2020, at the Medical Society of Delaware located at 900 Prides Crossing, Newark, DE 19713, from 5:00 p.m. to 7:00 p.m. p.m.