SB 227 Primary Care Reform Collaborative Meeting

Tuesday, October 21, 2019
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
Leslie Verucci	Delaware Nurses Association
Kevin O'Hara	Highmark DE
Dr. Jim Gill	Medical Society of Delaware
Hon. Trinidad Navarro	Department of Insurance
Dr. Jeffrey Hawtof	Beebe Healthcare/ Delaware Healthcare Association
Dr. Christine Donohue Henry, MD	Christiana Care/Delaware Healthcare Association
John Gooden	MDavis, Inc. /DSCC
Margaret Norris-Bent	Westside Family Healthcare
Dr. Michael Bradley	Dover Family Physicians/Medical Society of Delaware
Chris Morris	Aetna

Absent:	**Organization:**
Hon. Kara Odom Walker	Department of Health & Social Services
Steve Groff	Division of Medicaid & Medical Assistance

Staff:

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

Attendees:	**Organization:**
John Dodd	BDC HealthIT
Liz Staber	Aetna
Kiki Evinger	Department of Health & Social Services
Lizzie L. Zubaca	Hamilton Goodman Partners
Steven Costantino	Department of Health & Social Services
Tyler Blanchard	Aledade
Regina Heffernan	AmeriHealth Caritas Delaware
Kim Gomes	Byrd Group
Avani Virani	Highmark
Lenaye Lawyer	AmeriHealth Caritas Delaware
Daniel Elliott	Christiana Care Health System
Anthony Onegu	United Medical
Shay Scott	Henrietta Johnson Medical Center

Katherine Impellizzeri	Aetna
Jennifer Mossman	Highmark DE
Lisa Zimmerman	Department of Health & Social Services
Jack Schreppler	DCSN
Scott Rosenthal	Rosenthal Chiropractic
Bryan Gordon	Christiana Care Health System
Elisabeth Scheneman	Department of Health & Social Services
Christine Schiltz	Parkowski, Guerke & Swayze
Andrew Wilson	Morris James
Pam Price	Highmark
Ayanna Harrison	Dept. of Health & Social Services/Health Care Commission

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

Introductions

The meeting convened at approximately 5:08 p.m. at the Medical Society of Delaware located at 900 Pride Crossing, Newark, Delaware. Dr. Fan opened with a message of gratitude to the Medical Society of Delaware for allowing the collaborative to use their meeting space. She continued her greeting by introducing newly assigned collaborative members; Mike Bradley representing the Medical Society of Delaware, Jeff Hawtof representing the Delaware Healthcare Association, Kevin O'Hara with Highmark, Chris Morris with Aetna, Maggie Bent with Westside Family Healthcare, and Leslie Ledogar with the Department of Insurance. Special note: Lisa Zimmerman with DHSS/Medicaid attended on behalf of collaborative member Steve Groff and Steven Costantino with DHSS/Secretary's Office, attended on behalf of Sec. Dr. Kara Odom Walker.

Review/Approval of Minutes

Dr. Fan asked the collaborative members if they had any comment on the draft minutes from the Primary Care Reform Collaborative meeting, held on September 17th. Dr. Gill expressed concern about some content of the meeting minutes not accurately capturing concepts discussed. Dr. Fan provided guidance on options members can take to address errors or inconsistences in meeting minutes. She explained that members can recommend edits or comments either before the meeting or during the meeting when calling for a motion to approve. Dr. Gill felt comfortable moving forward with approval. No suggested edits were made at this time. The absence of page numbers was noted. All agreed that page numbers allow members to quickly reference content during discussions. Page numbers will be added to the September minutes and all future meeting minutes. The length of the minutes was discussed and there was a consensus that transcripts were not necessary and a summary of the discussion would be sufficient. Hearing no more comments or call for edits, Dr. Fan motioned for the minutes to be approved. A motion was made and seconded. The motion was carried.

Before transitioning to the next agenda item, Dr. Fan reminded all members to utilize microphones when presenting or commenting.

Department of Insurance Update

Leslie Ledogar from the Department of Insurance (DOI) provided the group with an update on the Office of Value-Based Health Care Delivery request for proposal (RFP). She reported that the RFP has been drafted and reviewed internally. It was then sent to Milbank for an external review. Milbank completed their review and returned the draft making the suggestion to use broader language. Ms. Ledogar explained the DOI was comfortable with the language in question because it was adopted directly from the statute. The RFP will now be reviewed by the Deputy and the Commissioner. Once they have their reviews are complete, the RFP will be submitted to OMB for posting in early November. Commissioner Navarro had no additional comments.

Primary Care Spend

Dr. Fan presented documents acquired by the Department of Insurance from Rhode Island and Oregon. Both templates include guidance on the methodology used in each state. Dr. Fan continued the discussion by providing a review of Oregon's Primary Care Payment Reform activities. Link to the presentation is found here https://dhss.delaware.gov/dhcc/collab.html. Oregon decided their primary care delivery model would begin with the establishment of a patient-centered primary care program. This program was established in 2009 under the Office of Oregon Health Policy and Research. Oregon defined the core attributes of the patient-centered primary care home. They developed uniform quality measures, built from measures that have been accepted nationally. Oregon also developed policies to encourage the retention and growth of their primary care providers.

In 2012 they broadened their approach through the establishment of a Patient-Centered Primary Care Institute. They included behavioral health integration and a learning collaborative to assist with practice transformation and they also included several payment models (CPC, CPC Plus, and Coordinated Care Organizations through Medicaid and a PCMH program through Aetna).

In 2015 and 2016 legislative mandate required Oregon to report primary care spend annually. The mandate included data collection from prominent health insurance carriers with annual health premium incomes of $200 million or more. This reporting included commercial or Medicare Advantage, Health Insurance plans contract by Public Employee Benefits Board, Oregon Educators Benefit Board, and Medicaid Coordinated Care Organizations. There was some discussion on whether or not Delaware carried Medicare Advantage plans. Delaware does currently carries a small amount of Medicare Advantage plans in all three counties.

Oregon's mandate excludes ERISA self-insured plans, prescription drug claims, health care payers not covered under SB231 and health care spending by people who pay out-of-pocket including the non-insured. The mandate also required the Oregon Health Authority to form a Primary Care Payment Reform Collaborative. This collaborative will extend through the year 2027. The goal of this 45 plus member group is to implement and develop the Primary Care Transformation Initiative. Lastly, SB 934 requires carriers and CCO's to allocate 12% of their health care expenditures to primary care by 2023.

The Oregon Office of Health Authority uses claims-based payments on specific provider types for specific services related to primary care. These services included office or home visits, general medical exams, routine medical and child health exams, preventive medicine evaluation or counseling, health risks

assessments, routine obstetric care delivery, reward achievement of quality or cost-savings goals or building a primary care infrastructure and capacity. Non-claims-based payment services included reimbursement for expenses related to adopting health information technology, the addition of supplemental staff or activities, such as practice coaches, patient educators, patient navigators or nurse care managers.

Dr. Fan opened the floor members to discuss the next steps on how the collaborative would like to define primary care spend in Delaware. All members agreed to accept the definition of primary care providers as stated in SB 227. This definition includes providers in the fields of family practice, general internal medicine, general pediatrics and geriatrics. It also includes nurse practitioners and physician assistants working in these fields. At this time the collaborative agreed not to expand to mental health providers who work outside of primary care and do not provide primary care services. Members then shifted their focus to forming a consensus on how to handle claims-based and non-claims-based calculations. The collaborative could choose to adopt methods used by other states. Dr. Fan pointed out that several states separate claims and non-claims services when calculating care spend.

Rhode Island's data management plan was reviewed and it was determined that the document focused on performing the operations of data collection. The fact sheet did, however, outline Rhode Island's use of an all-payers claims database (APCD) to calculate their primary care spend. The Rhode Island APCD is very similar to the system developed in Delaware. Dr. Fan led the discussion on the decision to use an APCD to calculate primary care spend. The issue of the Employment Retirement Income Security Act of 1974 (ERISA) was mentioned. Several members expressed concern over the fact that all data is not fully captured in the APCD due to the ERISA Act. Because ERISA plans are not mandated to contribute data to the APCD, between 40 to 60 percent of the data needed is unavailable.

Leslie Ledogar gave a brief description of the ERISA Act of 1974. ERISA is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans. She also described keys elements of the March 2016 Supreme Court ruling involving Vermont. Over the years the law has put in place guardrails on the collection of data and the regulations related to employee benefits plans, including health plans. As a result, payers cannot be mandated to contribute data to APCD. All participation is voluntary. Rhode Island utilizes a large IT component and they also offer an opt-out option.

Dr. Hawtof pointed out that a considerable amount of time and financial investment has been dedicated to developing our current APCD infrastructure. He asked the group to share the reasons they would not consider using APCD. Dr. Fan asked if the group believed it was worth developing an alternative database. Relying on APCD means data will not capture roughly 50% of the population. Dr. Bradley expressed concern with the ability to extrapolate calculation for 100% of the state spend. Other questions mentioned for discussion included: Are ERISA members healthier? Do they have less cost than non-ERISA members? Lastly, how will these facts affect the primary spend calculation? It was stated that it is possible to utilize aggregate data. This is an option that is used in collecting data for the Benchmark activities. If aggregate data was collected it could be supplemented for the data not captured in the APCD. Kevin O'Hara stated

that conceptually this may be an option but more research would need to be done. Chris Morris agreed that more investigation would be necessary.

After a lengthy discussion, the members agreed APCD is a valuable data source and at present the best available option. Senator Townsend briefly revisited ERISA and the possibility of voluntary disclosure. He continued by asking if state incentives could be implemented to encourage participation. Dr. Fan reminded the group that the purpose of the discussion is to provide the Office of Value-based Payment with recommendations. She presented the group with three options. The first option includes uses the APCD and requesting payers with ERISA plans to voluntarily contribute their claims data (non-aggregate). The second option includes utilizing the APCD and requesting aggregate data from major payers. Dr. Fan pointed out that aggregate data cannot be validated. The third option would be to move forward with the use of APCD, making no attempts to collect ERISA plan data, recognizing that the data will be incomplete.

Before moving forward members revisited the question posed by Dr. Bradley about doubling the data to account for the missing 50% of the population. The concern was raised that Non-ERISA data alone may not provide a representative sample. Additionally, Medicaid and Medicare members may not be as healthy as members who hold plans through their companies. All agreed that doubling final numbers could result in an overestimate of the total primary care spend. It was mentioned that when statistical methods are applied during the analysis of the data, an accurate representative sample can be achieved through the use of stratification and controlling for variables.

At the conclusion of the discussion, Dr. Fan reviewed the three options again. All members agreed unanimously to utilize the APCD, encouraging voluntary participation. A member agreed with this course of action and suggested the collaborative adopt a long term goal to collect ERISA data fully.

The discussion transitioned to determining data collection methods for non-claims-based payments. Dr. Fan asked if the collaborative wanted to request aggregate data from payers. Steven Costantino suggested we ask insurers for the data since it is not included in APCD. He continued to explain the complexities involved in calculating capitated arrangements. He stated that it is possible capitated arrangements include services outside of the definition of primary care. The group agreed to table the topic because Delaware does not have any global capitated rebundled payments for specialty models at this time. A clarification was added that all aggregate data will be accepted. All members agreed.

The next point of business is for the collaboration to decide on the number of years to include in the first report. After some discussion, all members agreed that the first report would include the years of 2017 and 2018. It was unclear whether or not DHIN housed data for both 2017 and 2018. Members agreed to follow up with DHIN directly. A suggestion was made to invite a representative to attend the meetings to provide insight and clarification when necessary.

Dr. Fan called for final comments. There were none, so she closed the primary care spend discussion.

SB 227 Compliance

Dr. Fan introduced the SB 227 compliance discussion by sharing with the group that meetings with individual payers were being scheduled as needed. The meetings are also attended by DOI. They have been mandated to serve as an arbitrator, therefore, they must attend each meeting. To date, the meetings have not produced topics that warrant presentation to the public forum. In the future, presentations will be made in a public forum when deemed necessary.

Dr. Jim Gill reported that the Medical Society of Delaware conducted a survey of Delaware primary care physicians from across the state on the impact of SB 227. In general, physicians report being satisfied with the impact of SB 227. He mentioned that problem areas had been identified by specific types of providers. These issues involve the implementation of the intent of the law, more specifically in reference to chronic care management and items not covered under Medicare.

Kevin O'Hara reports that Highmark believes it is in full compliance. As an insurance company, Highmark has the purview and ability to negotiate rates. However, they are unable to control the coverage or cost share that is provided. Insurers are unable to mitigate these issues because of the Federal Employee Benefit program regulations or protections provided under ERISA. The issues are complex and cannot be easily solved.

Dr. Fan asked the group to brainstorm ideas to gain buy-in from ERISA plans. Members agreed that sharing information about the value of the sustainability and foundation of a health care delivery program could encourage voluntary participation. Members agreed that it would be helpful to have direct communication with these groups however confidentiality regulations prevent insurers from providing this level of detailed information. Promoting the value of this investment and voluntary submission of data through relationships was identified as a possible strategy. However, members were reminded that all activities that involve direct contact would need to be led by Insurers. Dr. Fan encouraged the members to continue to brainstorm solutions to address these barriers. The engagement of these parties is essential to the success of our efforts to develop a primary care delivery model. The success of this model benefits everyone. The APCD only holds a portion of the data. If primary care fails, costs will increase significantly. The collaborative needs to identify a strategy to share this message.

A suggestion was made and accepted to continue this dialogue during the next meeting. It was felt that one of the absent members could provide the group with valuable insight and even poll their peers for additional information. It was agreed that this discussion will be continued in the October meeting.

Senator Townsend revisited the topic of ERISA regulations as it applies to the SB 227 mandates. Kevin O'Hara explained SB 227 only mandates certain populations. ERISA business (administrative services or self-funded business) are not included. Since the mandate does not include these populations, insurers cannot implement cost sharing or chronic care management codes. This would been seen as manipulating their benefits. Mr. O'Hara continued to explain that insurers can dictate the rates paid to providers but the mandate under SB 227 does not include benefit design. Highmark is paying their ASO clients at the mandated rates. Chris Morris added that Aetna is doing the same. He reports that they are fully compliant and paying providers the mandated rates. He reiterated that while they have updated the rates they cannot

mandate benefits plans. Clients control their own benefit design. Insurers are unable to control the cost-sharing or management codes to certain populations. These are issues that may be causing some providers some frustration.

Senator Townsend led a brief discussion about the March 2016 ERISA Supreme Court ruling. He wondered if the regulations would apply if a third-party possessed aggregated de-identified data. The group was not certain if the regulations would in fact be more lenient if distribution came from a third-party. More investigation would be necessary. All agreed that this topic requires more exploration.
There was no further discussion and the meeting transitioned to the topic of primary care payment models.

Primary Care First Multi-Payor Model

The group discussed the possibility of using primary care first as a transitional model. Dr. Fan reported that the role out of the Primary Care First has been delayed. She continued the discussion by asking the insurers who were present if they had been involved in discussions to consider adopting a Primary Care First model. An immediate answer was not provided and both insurers reported needing time to investigate. Several members commented on the fact that this model is new to Delaware. The applications are not out yet. The adoption rates are unknown and projections are not high for the first year.

Dr. Fan asked if the ACOs were planning to use the model. Dr. Donahue-Henry reported that the decision to adopt the model will be practice specific or specific to individual health system that is practicing in the ACO. Christiana Care will not direct practices but they are looking into the model. They have made more progress with Primary Care First however they are open to other models, direct contracting models as well. They are waiting for more information to be released. Dr. Fan requested that insurers (Highmark and Aetna) bring an update for the collaborative members about where they are with considering adopting this model as a track to move away from fee-for-service. A member commented that practices may not be taking advantage of this model because it is a smaller percent of the population and if all payers adopted the model Delaware may see a higher uptake. It was also noted that primary care physicians find it difficult to take on additional models because it means they will also take on additional risks.

Defining a Care Delivery Model

Dr. Fan opened the discussion on defining a care delivery model by reminding the members of the strategy used by Oregon. Oregon's primary care delivery model began with the establishment of a Patient-Centered Primary Care Program. Dr. Fan asked the group for their opinions implementing a similar strategy in Delaware. Dr. Fan stressed the importance of implementing measure to achieve the goal to develop a Value-based payment model. Dr. Fan made a request that the group continue to consider avenues for establishing payment reform. She encouraged members to review presentations shared last fall on Care Coordinated payments, PCMH and ACOs. She pointed out that not everyone is an ACO or NCQA qualified and this may present a barrier for practices to become a PCMH. She asked if members were interested in developing a specific type of primary care delivery model. She believes practices are struggling due in part to a lack of infrastructure. Dr. Fan charged the group with defining core objectives. One comment offered stated that a single model could prove to be helpful for practices that have fewer resources and are more naïve. However, the collaborative should keep in mind that there are practices that have already developed a risk-based modeling care coordinated delivery systems. Forcing these more advanced practices to adopt a

model may have a negative impact. After some discussion, the group agreed to focus on establishing a set of principles before defining a prescriptive care delivery model. Additionally, the principles should be easy to measure and not require a lot of resources.

Payment reform mandate will be met through the establishment of the Office of Value-based Health Care. The collaborative has been mandated to move 60% of primary care providers into a value-based payment models by 2021.

Dr. Fan presented the topic of integration of behavioral health and women's health. She focused the discussion on the opinions of the integration of behavioral health, asking for information about models that are currently in place. It was point out that outcomes been not been identified. Dr. Fan asked if members were interested in looking at state benefit plans and reminded them of the need to present recommendations to the Office of Value-based Healthcare.

Veronica Wilbur revisited a comment made by Dr. Hawtof concerning independent offices. She pointed out that Nurse Practitioner's with stand-alone offices do not qualify for the ACOs and PCMHs. These practices are not a part of the system but they create value. She charged the members with identifying ways to ensure these practices are involved in the process to develop value-based care delivery systems.

Dr. Hawtof shared that while calculating the primary care spend is important the collaborative should consider conducting a workforce capacity analysis in Sussex County. Currently, the number of primary care providers cannot meet the needs of the population. He stated that using more providers is not solving the problem. In order to address the problem, we must change the way we deliver primary care. He continued by stating the numbers are too large, the growth is too large and there are not enough providers and not enough space. He hoped that future discussions involve what types of primary care models can address these growing issues. Virtual care and other innovative methods should be considered.

After encouraging members to donate blood in light of a severe shortage reported by the Blood bank, Sen. Townsend provided the group with updates regarding questions surrounding ERISA regulations. He shared that he has been in communication with Chamber of Congress member, John Gooden, the President of MDavis. Sen. Townsend believes Mr. Gooden could provide valuable insight regarding ERISA regulations. He also provided the group with updated information he had discovered during the meeting. He learned that the case in Vermont was a TPA. The legal guidance is that states can implement an opt-out model. A state data reporting law could mandate that TPAs have to disclose the data (likely on an aggregate level), however, self-funded plan can still choose not to participate. Behavioral economics data indicates that opt-out verses opt-in models show higher participation rates. He plans to share these thoughts with the John Gooden to gain his opinion as a representative of this specific segment of the marketplace. He will also connect with states that have researched an opt-out model verse an opt-in. Lastly, he plans to contact Delaware Department of Labor Secretary Cerron Cade. During his initial research he learned that the U.S. Department of Labor may be able to collect data from ERISA plans and share it with state level databases. He concluded his update by sharing that there are other possible legal avenues that are worth investigating. He will provide future updates as information is collected.

Public Comment

Dr. Fan opened the floor for public comment. Audience member Jack Shilpfter provided a comment. He shared that he has been in involved in health care legislation and regulation in Dover for over 30 years. He agreed to read the March 2016 ruling and offer his opinion. He shared with the group that the two largest ERISA plans in Delaware are the State and New Castle County employees. He assumes these groups may be forthcoming with the data. Private ERISA employers may not be as generous, however the data gathered from the two groups mentioned may provide the collaborative with a large sample of the missing data.

Hearing no other business, Dr. Fan adjourned the meeting at approximately 6:51 p.m.

Next meeting

The next Primary Care Reform Collaborative meeting will be held on Tuesday, November 12, 2019 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.