

**DELAWARE HEALTH CARE COMMISSION  
JULY 20, 2005  
DELAWARE TECHNICAL & COMMUNITY COLLEGE  
CONFERENCE CENTER, ROOM 400B**

**Action Item**

**MINUTES**

**Commission Members Present:** John C. Carney, Jr., Chairman; Richard Cordrey, Secretary of Finance; Joseph A. Lieberman, III, MD, MPH; Robert F. Miller, and Dennis Rochford.

**Commission Members Absent:** Matt Denn, Insurance Commissioner; Carol Ann DeSantis, Secretary, Delaware Department of Services for Children, Youth and Their Families; Jacquelyne W. Gorum, DSW; Vincent Meconi, Secretary of Health and Social Services; and Lois Studte, RN.

**Guest Speakers:** Heather Bittner Fagan, MD and James M Gill, MD, MPH, Department of Family & Community Medicine, Christiana Care; Joy Blasier, EDS; and Alice Burton, Director, State Health Policy Group at AcademyHealth.

**Staff Attending:** Paula K. Roy, Executive Director; Brian Reynolds, Intern; Jo Ann Baker, Administrative Specialist III and Robin Lawrence, Secretary.

**CALL TO ORDER**

John C. Carney, Jr., Chairman, called the meeting to order at 9:12 a.m.

**APPROVAL OF JUNE 20, 2005 MINUTES**

Due to the lack of a quorum, approval of the minutes of the June 20, 2005 meeting will be held until the September, 2005 meeting.

**UNINSURED ACTION PLAN  
CHAP**

➤ Evaluation—Drs. Heather Bittner-Fagan and James Gill, Department of Family & Community Medicine, Christiana Care, gave a presentation on CHAP Evaluation 2204/2005. CHAP matches low-income uninsured Delawareans with established health homes. Its goal is to improve health by integrating services, improving access to existing resources and reduce unnecessary emergency department visits and hospitalizations.

This year the evaluation focus was on:

- Health Care outcomes
  - Preventive care measures
  - Hospital utilization (E.R. & hospitalizations)
- Role of CHAP in the Safety Net
  - interaction with Screening for Life program with respect to colon cancer screening (Safety Net Programs)
- Geographical implications

***Action:***

Due to the lack of a quorum, approval of the minutes of the June 20, 2005 meeting will be held until the September, 2005 meeting.

Drs. Heather Bittner Fagan and James Gill gave a presentation on CHAP Evaluation 2204/2005.

- distribution of CHAP enrollees (demand)
- distribution of physicians (supply)

Chairman Carney requested statistics on the value of added services, such as the pharmaceutical discount program, and physical therapy to evaluate how many people received services they would not have received by going to a Federally Qualified Health Center (FQHC).

The data used for the report is from 6/11/2001 to 10/15/2004. The data allowed for a two-group analysis: 6-month continuous enrollment (n=1394) and 1-year continuous enrollment (n=512). Measures used in previous analysis included breast cancer screening (mammogram, breast exam), cervical cancer screening (pap smear), colorectal cancer screening (sigmoidoscopy, blood stool), cholesterol, adult immunizations (Pneumovax, influenza), hospital utilization (ER use and hospitalization).

Baseline is when an individual enrolls in CHAP and fills out the survey about health status. If an individual came into a hospital, health home, or VIP program, they are asked when they had, if ever, a “procedure” (i.e. colonoscopy). These are the people who had procedures prior to being enrolled in CHAP. Follow up would be their re-enrollment and the answers to the same questions.

- All breast cancer screening outcomes improved (breast exams and mammograms).
- Cervical cancer screening also improved from baseline to follow up with the CHAP population.
- Colorectal Cancer screening has tended to increase in both groups (colon/sigmoidoscopy and fecal occult blood). However, this group size is small.
- Cholesterol screening improved in the 6-month group.
- Adult immunizations is also a small group. It tends to increase in most of the measures, especially influenza in the 6-month group. Pneumovax is difficult to measure because it generally occurs in the over-65 population, which falls outside the CHAP target.
- The 6-month group and the one-year group showed a decrease in ER use. Hospitalization appears to have increased. A fairly small number of people are actually hospitalized in the CHAP program. Most of the hospitalizations are for procedures unpreventable by ambulatory care programs (pregnancy, surgery).
- The interaction of CHAP and Screening For Life in regards to colon cancer screening, does not appear to be as strong as hoped. At baseline 21 percent of people coming into CHAP were up to date when Screening for Life didn't cover colon cancer screening. After Screening for Life covered colon cancer screening, 29 percent of people entering CHAP were up to date with their colon

cancer screening. This is a smaller group as these people are 50 years and older. The “N” was different for before and after. These are not the same people – not “before” and “after” CHAP. These people have two programs benefiting them; CHAP and Screening For Life. The increase in utilization is approximately 8 percent for both programs. It was concluded that giving people a regular provider for colon cancer screening was not enough to change behavior. It was enough for a lot of other things but not colon cancer screening. This suggests that a missing piece is to educate people about colon cancer screening and help them navigate through the system.

- Drs. Bittner-Fagan and Gill discussed the geography of CHAP. Their findings, along with the entire presentation, can be found on the DHCC website at [www.state.de.us/dhcc](http://www.state.de.us/dhcc).
  - In summary CHAP improves health outcomes, preventive services and decreases emergency department utilization. Some exceptions appear to be colon cancer screening and immunizations. CHAP and Screening For Life together still leave colon cancer screening sub-optimal. Finally the distribution of physicians in the CHAP program mirrors the need of CHAP enrollees.
  - It was recommended that the CHAP evaluation move toward disease management and do more analysis in matching supply and demand with geo-mapping. It appears as though CHAP is doing well in this area.
  - The new CHAP model would include disease management based on age of population, obesity, smoking and hypertension and measure the ability of the program to help a vulnerable population navigate the health system (health literacy).
- Restructure Fiscal Year 2006 – Paula Roy led commissioners through proposed CHAP restructuring.

#### OUR CHARGE

- Make a difference with CHAP – better care
- Get input from CHAP partners on strengthening the program

#### OUR PROPOSAL

- Program restructure to better achieve desired outcomes
- Budget Neutral \$1.250

#### KEY NEW COMPONENTS

##### *Customer Service – intake*

Screen & enroll

CHAP or other programs

Referral to other existing programs

WIC

Screening for Life

DPAP-Delaware Prescription Assistance Program

Veterans Administration

Paula Roy led commissioners through proposed CHAP restructuring.

## Medicaid

### Administer Health Risk Assessment

Pre-determine any special health needs

Increased marketing of program

Enhanced provider relations activities (increase activities to market the program so more people know about the program. Second, enhanced outreach to CHAP providers for the dual purpose of assuring understanding of how CHAP operates and allow early detection of program operation problems.

### *Disease Management/Health Promotion and Benefits*

Clinical Case Manager interprets Health Risk Assessment

– Targeted mailings/ etc. on issues specific to patient's general needs

Focus: Literacy and culturally appropriate information

Assignment to health home

Stepped up referral to sub-specialty and ancillary care

Radiology

Physical Therapy

Result:

- Patient arrives at health home with Health Risk Assessment in place.
- Physician helped by already having some baseline health information, upon which to form a care plan
- Patient is aware of other ancillary resources available through CHAP

### *Community Resource People (on the ground)*

Focus on outreach, enabling services

Translation, “navigation”, education, referral to CHAP

## IMPACT OF CHANGES

### *What stays the same?*

Partners and network – assuming response to RFP's

Screening and Referral

Other programs

Enhanced CHAP services

Focus on health home and primary care

### *What Changes?*

New Health Risk Assessment

Development of care plan in consultation with physician

Greater culturally appropriate consumer/health education

More systematic coordination with existing programs

Enhanced provider relations

Deeper evaluation dimension focusing on health and care management

Increased focus on community based resources (on the ground activity)

## FY 2006 PROGRAM GOALS

- Enrollment in available coverage
- Coordinated use of existing programs and resources in a

- better way
- Regular source of primary care and easy access to other health services
- Most vulnerable population equipped with better health system navigation skills, better understanding of prevention
- Linkage to a health home for improved health status

Betsy Wheeler emphasized that the eligibility function in and of itself has much more depth than simply eligibility enrollment. It is, in fact, the nucleus of the CHAP system. Customer service will have a more active role with provider relations.

Paula Roy told the Commission that between now and September 30, 2005 RFPs need to be drafted, submitted, and contract work needs to be complete.

A concrete plan should be in place by the September, 2005 DHCC monthly meeting.

Dr. Gill explained that the function of the “care coordinator” at the health home who does the health appraisal, will screen out the patients who are there for the “sore throat, etc.” vs. the people who have a health problem that needs to be tracked. The time, money, and energy would be spent with that person or persons in the health home tracking and giving service to those people and not continuing to do re-assessment and re-appraisals of the healthy people as to whether or not they got their mammogram.

➤ Enrollment Statistics – Joy Blaiser, EDS

Joy Blaiser, from EDS, the current enrollment broker, is the “keeper of the numbers.” The period covered in the report is July 1, 2004 – May 11, 2005. This is not a complete-year set but certain trends can be identified.

- From 7/1/04-5/11/05 2643 new CHAP applications were received with 1508 enrollments.
- Clients who were denied Medicaid called CHAP to find a physician.
- Many clients already had an existing health home, largely because they had been enrolled in Medicaid, but enrolled in CHAP because they were no longer eligible for Medicaid. Those clients were referred to the VIP II coordinators.
- Twenty-eight percent of new applicants chose VIP as their health home; 23 percent came into the program through care coordinators at Beebe Hospital; Westside Health saw 14 percent of new applications received; 8 percent through Henrietta Johnson Medical Center; 7 percent through Claymont; 5 percent through LaRed; 4 percent from Wilmington Hospital; 4 percent from Christiana; 3 percent each from Kent and Milford; and 1 percent from Delmarva Rural Ministries.

Joy Blaiser, EDS, gave a report on statistics of CHAP enrollment from the period of 7/1/04 through 5/11/05.

- The average age of applicants was 39 for males and 37 for females. The average age of all applicants last year was 36.
- The ratio of enrollment of “citizens” was lower than the ratio for “non-citizens.” There were 1776 citizens to apply and 48 percent were enrolled. Many times these applicants were eligible for other benefits (Medicaid, etc.)
- There were 856 “non-citizen” to apply and 76 percent were enrolled into CHAP. Again, some applicants were eligible for Medicaid.
- Many applicants were not eligible for CHAP due to having other insurance (Medicaid, employee benefits); 13 percent were over income; 15 percent refused to apply for Medicaid (did not return information or follow up). If a Medicaid application is not completed they will not be enrolled in CHAP. Only 7 percent were not interested in CHAP.
- Other types of insurance, such as Medicare or employee benefits insurance, are not tracked.
- New enrollments 7/1/04 through 5/11/05 had 21.8 percent black, 34.2 percent white, 3.4 percent Asian/Pacific Island, 0.3 percent Native American/Alaskan, 0.1 percent refused, 0.3 percent blank, 0.1 percent didn’t know and 39.9 percent other. Previous data (6/30/04) the “other” category made up almost 58 percent of the enrollment, 23.31 percent white, 16.98 percent black, 0.08 percent American Indian/Alaskan, 1.69 percent Asian/Pacific Islander and 0.05 percent refused. There has been a shift in the number of applications submitted and consequently enrolled from people who consider themselves part of the “other” category. Part of this trend is due to fewer applications submitted by Community Health Centers in this last year, up to 5/11/05.
- The percent of CHAP enrollments, by county from 7/1/04 through 5/11/05 were New Castle County with 51.42 percent – 1307 applied, 672 enrolled; Kent County with 55.91 percent – 313 applied, 175 enrolled; and Sussex County with 64.61 percent – 1023 applied, 661 enrolled.

The CHAP Progress Report is available online at [www.state.de.us/dhcc](http://www.state.de.us/dhcc).

➤ Children’s Health Insurance Program (CHIP) Expansion Overview

Alice Burton spoke about issues and questions to consider in implementing SCHIP Expansion to Parents.

1. Public (Medicaid/SCHIP) Coverage of Parents
  - a. States can already cover parents under Medicaid without a waiver
  - b. Delaware already has an 1115 waiver for adults under Medicaid, which includes parents and childless adults
  - c. States are interested in SCHIP waivers to cover

Alice Burton spoke on issues and questions to consider for a SCHIP expansion to parents.

parents so that they can receive enhanced federal matching funds available under SCHIP (65 percent match vs. 50 percent match under Medicaid)

2. SCHIP Financing
  - a. Each state receives a federal allotment under SCHIP. This is the amount of federal funds available for states to pay for their SCHIP program.
    - i. States have a limited time to spend the allotment before they lose funds
    - ii. In the past unused allotments have been redistributed to other states who over spent their allotments
  - b. Delaware has under-spent its allotment. It is still spending funds from 2001 and 2002.
3. Federal approval needed
  - a. 1115 waiver allows states to ask CMS permission to change federal rules (in this case need to waive limit of SCHIP eligibility to children)
  - b. Traditional 1115 waiver or Health Insurance Flexibility and Accountability (HIFA) Initiative are options
  - c. HIFA is intended to create a simpler process for states proposing to implement creative ideas to cover the uninsured. HIFA requires:
    - i. State-wide program
    - ii. Expansion of coverage
    - iii. Coordination with the private sector
  - d. Timeliness of CMS review uncertain
    - i. Some states have received SCHIP waivers to cover parents, possibly setting precedent for Delaware's proposal
4. Next steps
  - a. Finalize cost estimate (data on the number of people potentially eligible in the State at the 35 percent match).
  - b. Determine how much of the federal SCHIP allotment is really available and how long Delaware has to spend the funds before losing them.
  - c. Determine which federal authority would be most beneficial for Delaware to pursue (1115 or HIFA waiver). States sometimes submit a short concept paper to CMS to seek their staff level guidance on which federal authority is best. This should take into consideration:
    - i. Whether Delaware wants to consider coordinating expansion with private insurance.
    - ii. Whether there are issues that might impact Delaware's current 1115 waiver.

When CHIP is expanded to parents, not only will there be an increase in involvement with parents, but more children will be enrolled.

## **PROJECT UPDATES**

Paula Roy introduced Brian Reynolds, an intern from the University of Delaware, who is working for the Health Care Commission for the summer to implement State Loan Repayment Program changes approved in April 2005.

### ➤ Delaware State Loan Repayment Program

The State Loan Repayment Program changes include: expansion of the number of specialties that are eligible for funding under the program, and development of a marketing strategy that will target these new professions for recruitment; and the possibility of eliminating the tax stipend for physicians and dentists placed at federally qualifying HPSA sites is under exploration. Other states have been contacted to learn how they are addressing new federal tax rules. Our goal is to expand the number of sites eligible to receive federal funding within the program's guidelines. The staff is also exploring new evaluation criteria for applicants. Most activities should be complete by the end of the summer.

### ➤ Information & Technology - DHIN

#### Technical and Operational Planning

DHIN's Technical and Operational Planning contractor, HCIC, has conducted 75 individual and group interviews as the basis for the DHIN technical infrastructure and architecture design. Additionally, eight technical surveys were received and analyzed to determine commonalities and potential interface and data exchange standards. DHIN stakeholders surveyed and interviewed included: physicians, hospital representatives, consumers, pharmacies, insurers, business leaders, and state and federal government representatives. Preliminary findings of the survey and interview process have identified five functional areas that may be implemented by DHIN in the short-term that will maximize value to users. On June 30, 2005 – HCIC delivered a "Technical Infrastructure Assessment" report and the architecture design document is due July 31, 2005.

Additional deliverables include:

August 31, 2005 - Requirements Definition

October 31, 2005 – Advanced Planning Document

September 30, 2005 – Cost-Benefit Analysis

October 31, 2005 -Sustainability Plan

#### Funding

On June 17, 2005, DHIN received follow up questions from the Agency for Healthcare Research Quality (AHRQ) regarding DHIN's response to the RFP entitled "Delaware Health Information Network HIT Demonstration." Answers to the questions were submitted on July 1, 2005. A single award is anticipated for a

Paula Roy updated the Commission on State Loan Repayment activities and introduced Brian Reynolds, an intern working for the DHCC.

Robert Miller, Chair of the Delaware Health Information Network updated Commissioners on DHIN activities.

period of five years. If awarded the contract, DHIN will receive \$700,000 for year one and \$1,000,000 each for the remaining four years.

### Board of Directors

A nominating committee of the DHIN Board of Directors recommended the following members to Board leadership positions, which will comprise the DHIN Executive Committee:

Chair: Robert Miller, DHCC representative

Vice Chair: Joseph M. Letnaunchyn, Delaware Healthcare Association

Secretary: William E. Kirk, III, Esq., Blue Cross Blue Shield of Delaware

Additional Executive Committee Members (4): Joann Hasse, consumer representative; Joseph A. Lieberman, III, MD, MPH, DHCC representative; Mark Meister, Medical Society of Delaware; and the DE State Chamber of Commerce appointee (TBA)

These appointments will be voted on at the next Board meeting on September 27, 2005.

The nominated Executive Committee met for the first time, in an unofficial capacity, in June and has begun to develop DHIN Board operating procedures. Additionally, the Executive Committee is reviewing the current DHIN advisory committee structure and will make recommendations to the Board regarding the role and composition of DHIN committees.

The Management Team, which has overseen DHIN activities to day, will be folded into the Executive Committee. The Executive Committee will assume responsibility for the “day to day” activities and will take to the Board the major decision-making actions. In turn these decisions will flow to the Commission.

The vision is that there will be five (5) subcommittees. They will include: the Technical Committee, the one that is active and operating for the development of the DHIN’s system, which is chaired by Edward Ratledge; the Consumer Advisory Committee; a Finance Committee; a Provider Committee; and a Payer/Employer Committee. These committees will do their work, bring the results back to the Executive Committee, and final decisions will be made by the Board.

An organizational chart will be provided to the Health Care Commission upon completion. Active participation is encouraged. The meetings will be open to everyone to build understanding and consensus of DHIN.

### **OTHER BUSINESS**

- Judy Chaconas resigned from the DHCC the last week of June. She is now Director of the Bureau of Health Planning and Resources Management for the Division of

Public Health. In her new role, Judy will continue to be in contact with various programs that intersect with DHCC, i.e. Health Resources Board; J-1 Visa program which works very closely with the State Loan Repayment Program; Nursing Implementation Committee; and the Delaware Workforce Center Committee. First-round interviews for a replacement have begun.

- Three pieces of Legislation affecting the Health Care Commission were passed in the General Assembly.
  - Legislation that specifically authorizes the Division of Professional Regulation to share specific professional licensee information with the Division of Public Health and the Health Care Commission for research purposes. This is important in that some reports that the DHCC has produced and co-produced with the Division of Public Health in the past (Physicians in Delaware, Dentists in Delaware, Specialty Physicians, etc) were produced based on surveys sent to the licensee list from Division of Professional Regulation. By sharing information the list will be helpful in obtaining the needed information. This legislation passed the House but is still in Senate.
  - A task force to review and evaluate healthcare associated infections (hospital acquired infections) was established . The Commission is named as a member.
  - A resolution that reconstitutes the Medical Liability Insurance Task Force was passed. It requires an update to the General Assembly on the progress being made per recommendations issued in 2003.

Commissioner Dennis Rochford requested an update on the three bills and whatever legislation may have been introduced for the Statewide Health Insurance Pool, Worker’s Compensation, and the Medical Malpractice.

In response, Chairman Carney stated that there has been epilogue language inserted in the budget that essentially requires the Budget Office to oversee additional actuarial analysis on a statewide purchasing pool. There was some concern among legislators about entering into a new financial commitment without more specifics in terms of the structure of the pool and the costs associated with establishing, operating and subsidizing it. Two recommendations are requested: the Statewide Purchasing Pool and the expansion of CHIP. The language stipulates that “said study shall include, but not limited to,

Judy Chaconas resigned and is now working for the Division of Public Health.

Legislation affecting the DHCC include:

- 1) authorizing the Division of Professional Regulation to share licensing information with the Division of Public Health and the Delaware Health Care Commission.
- 2) A task force to review and evaluate healthcare associated infections
- 3) Reconstitution of the Medical Liability Insurance Task Force

separate proposals submitted by each of the following agencies – The Delaware Health Care Commission and Health and Social Services. In the epilogue language, the results need to be submitted to the Governor and Joint Finance Committee by December 1, 2005. This timing will allow consideration by the Governor for her recommended budget.

### **PUBLIC COMMENT**

Dr. Robert Frelick asked about:

- Proportion of people in CHAP that are racial minorities
- How many parents have limited education
- Whether CHAP Health Risk Assessments can be subject to a HIPAA waiver so they can become part of the DHIN.

Rita Marocco expressed concern that the proposed CHAP Health Risk Assessment not replace the physician. She congratulated progress on the DHIN.

### **NEXT MEETING**

The next meeting of the Delaware Health Care Commission will be held at 9:00 a.m. on **THURSDAY, SEPTEMBER 1, 2005 in Room 400B** at the Delaware Technical and Community College Conference Center, Dover.

### **ADJOURN**

The meeting adjourned at 11:15 a.m.

## GUESTS ATTENDING

Jack Akester, Consumer Advocate  
Helen Arthur, Division of Public Health  
Anthony J. Brazen, D.O., Division of Social Services, Medicaid  
Lynn Depa, Delmarva Sleep Diagnostics  
Robert Frelick, MD, Medical Society of Delaware  
B. Michael Herman, Coventry Health Care of Delaware  
Imburgia, Cathy, Creative Communications  
Barbara Jackson, EDS  
Lolita Lopez, Westside Health Center  
Rita Maroco, National Alliance for the Mentally Ill – Delaware  
Linda Nemes, Department of Insurance  
Brian Olson, La Red Health Center  
Jeff Owens, AFLAC  
Gina Perez, Advances In Management  
Suzanne Raab Long, Delaware Healthcare Association  
Faith Rentz, State of Delaware Budget Office  
Albert Shields, Office of the Lt. Governor  
Diane Treacy, Planned Parenthood of Delaware  
Kay Wasua, EDS  
Betsy Wheeler, Management Concepts, Inc.