

**DELAWARE HEALTH CARE COMMISSION  
JUNE 2, 2011  
DELDOT ADMINISTRATION BUILDING  
FARMINGTON/FELTON CONFERENCE ROOM  
DOVER**

**MINUTES**

**Commission Members Present:** Bettina Riveros, Chair; Theodore W. Becker, Jr.; Thomas J. Cook, Secretary of Finance; A. Richard Heffron; Rita Landgraf, Secretary, Delaware Health and Social Services; Kathleen S. Matt, PhD; Janice E. Nevin, MD; Dennis Rochford and Fred Townsend

**Commission Members Absent:**

Karen Weldin Stewart, Insurance Commissioner, and Vivian Rapposelli, Secretary, Services for Children, Youth and Their Families

**Staff Attending:** Paula Roy, Executive Director; Marlyn Marvel, Community Relations Officer; Robin Lawrence; Executive Secretary and Linda G. Johnson, Administrative Specialist III

**CALL TO ORDER**

The meeting was called to order at 9:05 a.m. by Bettina Riveros, Commission Chair.

Bettina Riveros welcomed the newest Commission member, Kathleen S. Matt, PhD, Dean of the University of Delaware's College of Health Sciences and head of Health Science Alliance.

**MEETING MINUTES OF FEBRUARY 3, MARCH 3, APRIL 7, and MAY 3, 2011**

The minutes of the February 3, March 3, April 7 and May 3, 2011 meetings, with the addition of Theodore W. Becker, Jr. in attendance at the April 7 meeting, were approved by a vote of the Commissioners, following a motion by Rich Heffron, which was seconded by Tom Cook.

At the May Commission meeting a request was made by a member of the public that a link would be provided on the DHCC web site for comments concerning the decision by Delaware's Insurance Commissioner, Karen Weldin Stewart regarding the medical loss ratio. Ms. Riveros announced that has been done.

**RESEARCH & POLICY DEVELOPMENT**

***Affordable Care Act***

Overview – Center for Medicaid and Medicare Services (CMS) – Nancy O'Connor, Regional Administrator CMS, Region III, U.S. Department of Health and Human Services (this presentation will be made available on the DHCC web site: <http://dhss.delaware.gov/dhss/dhcc/presentations.html>)

**Action Items**

Kathleen S. Matt, PhD, was welcomed as the newest member of the Commission

**Action**  
Commissioner's approved the February 3, March 3, April 7, and May 3, 2011 meeting minutes.

Nancy O'Connor, Regional Administrator CMS, Region III, U.S. Department of Health and Human Services, presented an overview of CMS, the

Ms. Roy introduced Nancy O'Connor, who is responsible for the external affairs operations of the Medicare, Medicaid, and SCHIP programs in the six-state region of Delaware, the District of Columbia, Maryland, Pennsylvania, Virginia and West Virginia. There are more than seven million Medicare, Medicaid and Children's Health Insurance Program beneficiaries and nearly 280,000 providers in the region.

Federal agency that has oversight of the Medicare, Medicaid and Children's Health Insurance Programs

### **The Centers for Medicare & Medicaid Services**

- Federal agency that has oversight of the Medicare, Medicaid, and Children's Health Insurance Program (CHIP).
- Over \$800 billion spent each year on these programs.
  - 19% of the total Federal budget
- Over 100 million beneficiaries
  - Covering 1 in 4 Americans

Over \$800 billion spent each year on these programs- 19% of the total Federal budget

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## **The Business**

### **Medicare**

Annual Expenditure: \$524 Billion in 2010

- Over 4.4 million claims are paid each day to 1.5 million providers worth \$1.1 billion
- Medicare receives almost 19,000 provider enrollment applications every month

Over 100 million beneficiaries - covering 1 in 4 Americans

Medicaid, nationally:

- Over 2.5 Billion claims are paid each year for more than 54 million beneficiaries
- There are 56 State and territory-administered programs

Over 2.5 Billion claims are paid each year for more than 54 million beneficiaries

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## **Strengthening Medicare**

### **Health Care Delivery System Reforms**

- Reforming provider payments by rewarding quality and efficiency
- Investing in patient safety by lowering hospital readmissions and hospital-acquired conditions
- Cracking down on fraud and abuse in Medicare
- Getting the best value for Medicare beneficiaries for DME
- Reducing excessive Medicare payments to insurance companies

There are 56 State and territory administered programs

## Achieving Long Term Savings and Quality Improvement

### Better Health, Better Care, Reduced Costs

- Better coordinated care for individuals enrolled in Medicare and Medicaid
- Expanding Electronic Health Records
- Promoting Prevention
- Center for Medicare and Medicaid Innovation (CMMI)
- Accountable Care Organizations (ACOs)

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### Center for Medicare and Medicaid Innovation

#### Innovation Center Portfolio Criteria

- Greatest potential impact and ability to improve how care is delivered
- Focus on health conditions that offer opportunities to improve care and reduce costs
- Address priority areas in National Quality Strategy
- Reduce disparities of care
- Promote better outcomes and patient-centeredness
- Relevant across diverse geographic areas and states
- Involve major provider types
- Engage broad segments of the delivery system
- Balance short-term and long-term investments
- Structured at a scale and scope consistent with the evidence

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### Pioneer Accountable Care Organization Model

- Accelerated path for mature ACOs
- Accountable for quality, cost and overall care of traditional fee-for-service Medicare beneficiaries
- Request for Applications (RFA)
  - Letter of Intent on or before June 10, 2011.
  - Applications due July 18, 2011.

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### Pioneer ACO

- Works with private payors to improve quality
- Quality Measures
  - Same standards as MSSP
  - Five Domains of Patient Care
  - Details at [http://www.cms.gov/apps/media/fact\\_sheets.asp](http://www.cms.gov/apps/media/fact_sheets.asp)

*Pioneer Accountable Care Organization Model - accountable for quality, cost and overall care of traditional fee-for-service Medicare beneficiaries*

## Pioneer ACOs

### ➤ Eligible Providers

- Group Practice, Networks, Partnerships/Joint Ventures
- By 2012, 50% of primary care providers are MUs of EHR
- Patient Centered
- Beneficiary Enrollment
- > 50% of ACO Revenue from other payers

### ➤ Selection Process/Contract Options

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## The Medicare Shared Savings Program

- Goal is to facilitate coordination and cooperation among providers
  - Designed to improve beneficiary outcomes and increase value of care by:
    - Promoting accountability for the care of Medicare beneficiaries
    - Requiring coordinated care for all Medicare services
    - Encouraging investment in infrastructure and redesigned care processes
- 

## The Medicare Shared Savings Program

### The Proposed Rule

- Includes ACO definition and eligibility requirements
  - One-sided and Two-sided Risk Models
  - 65 Quality Measures
    - Details at [http://www.cms.gov/apps/media/fact\\_sheets.asp](http://www.cms.gov/apps/media/fact_sheets.asp)
  - Retrospectively assigns beneficiaries to an ACO
  - Comment period closes June 6, 2011
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## Advanced Payment ACO

- **Advance Payment ACO Initiative**
    - Seeking public comment by June 17, 2011
    - Access to shared savings up front to build infrastructure
    - ACOs need a plan for funds
    - Advance payments recouped
    - Comments should be e-mailed to [advpayACO@cms.hhs.gov](mailto:advpayACO@cms.hhs.gov)
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Medicare Shared Savings Program (MSSP) - goal is to facilitate coordination and cooperation among providers

## Accelerated Learning Sessions

- **ACO Accelerated Development Learning Sessions**
  - New and emerging ACOS
  - Not a discussion of any CMS ACO programs
- Goal:
  - Understand readiness to become an ACO.
  - Identify goals for achieving the three-part
  - Develop an action plan
- Four sessions
- Information/registrations available at <https://acoregister.rti.org>

Advanced  
Payment ACO  
-  
access to  
shared  
savings up  
front to build  
infrastructure

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### *Thank You*

More information is available at  
[www.innovations.cms.gov](http://www.innovations.cms.gov)  
Questions?  
Suggestions?  
How can we work together?

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### *Discussion*

Dennis Rochford asked if the Pioneer Accountable Care Organization Model is designed for Medicare and Medicaid only or would it have applications over the private market?

Ms. O'Connor responded that the Pioneer ACO model is something CMS is putting out for the Medicare population.

Mr. Rochford also asked if, under the Pioneer model, hospitals, doctors, labs and health care providers come together, receive Medicare and Medicaid funds, provide service to people, assume the risk, and capitalize on the savings and quality of care.

Ms. O'Connor answered that for the Pioneer model, CMS is looking for organizations that are already experienced. The reason CMS is calling the model, 'Pioneer,' is because the organizations have been working in this type of a model for years and are creating the path for others to follow. CMS wants to establish 30 organizations across the countries that are going to improve not only individual health but improve the population health. There are private sector organizations that are using a similar model.

Wayne Smith, representing the hospitals in the State, asked if Ms. O'Connor thinks CMS will make changes to the proposed regulations to address some of the concerns that have been expressed about the proposed regulations. He expressed the opinion that making changes could reignite interest in ACOs.

Ms. O'Connor said CMS has been listening to feedback from organizations regarding its 400 pages of proposed regulations. CMS will review all of the comments received by June 6, then go back to the drawing board and look very hard at the proposals.

Between the Pioneers and the final rule that is issued around the Medicare Shared Savings Program, it is hoped to strike a balance, where there will be a lot of participation on the part of many organizations so that there is a real variety of ACO models to study and move forward with.

Joann Hasse asked a question from the standpoint of a Medicare patient who might be trying to decide whether to participate in an ACO or stay strictly *fee for service*. Many of them do not spend 12 months of the year in one place but may spend 3 months in Florida.

Ms. O'Connor replied this is not an HMO or a Medicare Advantage Plan. Beneficiaries continue to stay *fee for service*. They will be alerted to the fact their physician or hospital is part of an Accountable Care organization and will be asked if their health information data collected can be shared with other providers in the ACO. The beneficiary can opt out of that sharing.

Dr. Ray Sukamar said CMS should listen to the concerns expressed by both large and small organizations, as well as the public before making decisions on the ACO.

Ms. Riveros said the Commission has talked about being an incubator for innovations. We want to be supportive of bringing those innovations to Delaware and asked to continue those discussions with CMS.

**Delaware Public Policy Institute Forum on the Affordable Care Act** – John Taylor, Director (this presentation will be made available on the DHCC web site: <http://dhss.delaware.gov/dhss/dhcc/presentations.html>)

The Delaware Public Policy Institute (DPPI) is a nonprofit, nonpartisan, nongovernmental public policy research organization. Its mission is to conduct research and encourage the study and discussion of public policy issues affecting the citizens of Delaware. The Institute identifies emerging issues that drive Delaware's future public policy agenda.

CMS has been listening to feedback from organizations regarding its 400 pages of proposed regulations. CMS will review all of the comments received by June 6, then go back to the drawing board and look very hard at the proposals.

The Delaware Public Policy Institute (DPPI) convened a dialogue of leaders from the public, private and civic sectors on February 1-2, 2011 at the University of Delaware, to share information, exchange views, identify priorities, and formulate recommended strategies for implementation of the Patient Protection and Affordable Care Act (PPACA – Public Law 111-148) for health care delivery in the State of Delaware.

Specifically, the dialogue addressed the following needs:

- Definition and implementation of the medical home concept
- Definition and implementation of Accountable Care Organizations in Delaware
- Consideration of the establishment of Health Care Zones in Delaware
- Readiness for “meaningful use” of health information technology to share medical data and information among providers and with patients
- Assessment of the need for and barriers to development of the medical workforce.

Mr. Taylor summarized the resulting recommendations:

#### *Medical Homes*

- 1) The Patient-Centered Medical Home (PCMH) Demonstration Project Guidelines developed by the Patient-Centered Primary Care Collaborative (PCPCC) should serve as a starting point for defining the medical home concept for purposes of implementation in Delaware. Further, the joint use principles for PCMH as defined by PCPCC should be adopted fully or in part for purposes of implementation in the State.
- 2) The Delaware Health Care Commission should convene a working group to determine in more detail how the medical home concept may be applied more broadly throughout the State, conducting evaluations and developing targeted legislation as appropriate. The group should be constituted to ensure that all essential stakeholders have a voice in the process. The working group should conduct an in-depth study of innovative approaches to establishing incentives, learning from the experiences of other states with circumstances similar to those of Delaware. This proposed working group should be convened by late spring 2011 and have developed a state plan by the end of 2011.

The Delaware Public Policy Institute (DPPI) is a nonprofit, nonpartisan, nongovernmental public policy research organization.

## *Accountable Care Organizations and Health Innovation Zones*

- 1) Accountable Care Organizations (ACOs) should be driven by local hospitals or physician groups.
- 2) The healthcare delivery system needs to shift in emphasis from volume to value, with providers paid by the value of care provided rather than by volume of cases or tests.
- 3) Health care leaders in Delaware must develop a transparent, equitable means of distributing responsibility for the care of high-needs patients among ACOs. At the same time, ACOs must be incentivized to include high-needs population and patients eligible for Medicare and Medicaid.
- 4) Federal regulation must be amended to allow the collaboration among providers necessary for formation and successful functioning of ACOs.
- 5) Significant tort reform must occur to ensure a reasonable degree of immunity for caregivers who adhere to established evidence-based guidelines.
- 6) The Delaware Medical Society, the Delaware Nurses Association, and health care and hospital associations should collaborate to ensure that the best available data (including Medicaid claims information and population health data) are used to inform understanding of the biggest cost drivers in the care of special needs populations, as well as to identify opportunities to better serve those populations.

## *Meaningful Use of Health Information Technology*

- 1) Implementation of the meaningful use concept in Delaware should be guided by the following statement:

*Health care providers in Delaware should be committed to fully adhering to and benefitting from the federal guidelines for meaningful use of health information technology. For implementation to be meaningful, all relevant stakeholders must be involved in using the technology in appropriate ways. Physicians, especially those in private practice, will require substantial support and adaptation of this principle to enable them to meet clinical responsibilities.*

### *Medical Workforce Development*

- 1) Current supply and distribution of the health care workforce should be measured, establishing benchmark data that can be used in projecting and future needs. (This information can be compiled largely by using existing data from the University of Delaware, supplemented by interviews of key hospital personnel).
- 2) Additional state funding should be allocated to the Delaware State Loan Repayment Program by November 2011, and the program should be expanded to include medical residents.
- 3) An increase in residency training in Delaware should be pursued over the next two to four years as a means of building the workforce over time, since physicians tend to practice within fifty miles of where they completed their residency. Special attention must be paid to the downstate areas where practitioners are most needed.
- 4) Legislative action and leadership from the executive branch are needed to increase the scope of practice for nurse practitioners, physician assistants and other caregivers to meet the current and future health care needs of the State.

### *Delaware as a Center for Health Care*

- 1) Leaders in the public, private, and civic sectors in Delaware should collaborate to position the State as a regional and national center for health care innovation. The Delaware Health Care Commission should serve as an incubator and convener for an ongoing series of initiatives aimed at integrating innovation into the process of health care reform, focusing on population-based approaches to preventive health that can improve the health profile of all Delawareans.

### *Discussion*

Paula Roy observed that the initiatives that DPPI recommended for the Health Care Commission are consistent with those that the Commission has identified for itself.

Dennis Rochford asked what would be the follow-up to the report. Would DPPI breakout some of the specific recommendations and bring other people together?

Mr. Taylor responded that some of the things in the report Ms. Riveros has said the Commission is going to do. What DPPI is doing with last year's report on the "*Permitting Process in Delaware for*

*Land Use Development*” is having the facilitator go back to the participants and asking if anybody changed anything. Soon DPPI is going to issue a follow up report on the Permitting Process indicating which recommended changes were and were not made. The same can be done for this report on the Affordable Care Act. The changes are significant and are going to require time to implement. DPPI will allow a year or 16 months and see what changes were made.

Ms. Riveros added that the DPPI event was a great session. They present great opportunities. Many leaders across the State participated and the product is excellent. Rather than “sit on a shelf,” it can guide how the Commission addresses issues moving forward. There are specific take-aways.

With respect to the Patient Centered Medical Home and the recommendation to create a working group, Ms. Riveros has asked Commissioner, Dr. Janice Nevin, newly named Chief Medical Officer of Christiana Care, to lead that group. That activity can start over the summer.

Ms. Riveros asked the Commission members to review the report and identify other areas; Workforce Development may be another one where it could focus attention.

Mr. Taylor said another key is Health Information Technology (HIT). HIT is going to be the linchpin of a truly integrated patient centered health care program in Delaware.

Ms. Riveros added that DHIN is driving forward very strongly. She is a member of its Board and very much engaged. The DHIN is the medical technology infrastructure and is critical. It enables true integration of our health care delivery system so we can take advantage of the most cost effective means of treating people and have a continuity of care and we need to be supportive of that. DHIN is seeking funding through the Bond Bill, but needs self sufficiency moving forward.

In answer to the other portion of Mr. Rochford’s question, Mr. Taylor said the General Assembly needs to be educated about the needs in some of these areas they probably aren’t familiar with. They just don’t know about it and don’t fully understand the complexities of many initiatives and offered to help set up discussions with legislators.

Rich Heffron, who participated in the PPI Forum, said some of the points Mr. Taylor makes are not things that would be ‘nice’ to do - the sense in that room was that if we do not do these things we will not make any positive impact on the health care system. If we don’t have patient centered medical homes; if DHIN doesn’t work; if we

Ms. Riveros has asked Commissioner , Dr. Janice Nevin, newly named Chief Medical Officer of Christiana Care, to lead a working group for defining the medical home concept for purposes of implementation in Delaware.

don't train doctors to be in the right areas where we need them; if we don't take some of the burdens off the doctors and find others ways to treat people, very little change and improvement can be expected. We have a special opportunity because of the size of our state to make a difference. The sense was that if we don't do these things, in 10 or 15 years were going to be in a worse situation than we are now.

As a follow-up, Ms. Riveros requested Dr. Nevin undertake the working group on Patient Centered Medical Homes and will confer with her. Some members have already expressed interest in participating and will be identified and that will be shared with the Commission over the Summer.

Commissioners are asked to indentify other areas where they believe there should be significant follow-up and Workforce Development does seem to be one of them.

Before giving his presentation, Steve Groff, Deputy Director of the Division of Medicaid and Medical Assistance (DMMA) wanted to address the information technology Mr. Taylor was talking about. One aspect of the American Recovery and Reinvestment Act (ARRA) which will be kicking off soon – the section of the law called the *HITECH*. It created incentive funding for both the Medicare and Medicaid Programs for eligible professionals and eligible hospitals which are able to demonstrate meaningful use over time to help offset their costs of purchasing information technology and medical records. DMMA is working with 11 other states in the Medicaid program to create the system needed to coordinate with the national registration in the *Attestation Program* and allow providers in Delaware to enroll and document what they need in order to access that funding. It is hoped to be kicked off in November 2011 and start issuing the incentive payments to providers. DMMA is working with Quality Insights in Delaware, the Regional Extension Center, and its goal is to reach out and work with 1,000 physicians or providers in Delaware to help them understand the technology, and get the technology in place. DMMA and Quality Insights are partnering with the DHIN, which will be integral not only for providers being able to meet meaningful use, but also for DMMA to document providers have satisfied the criteria in order to get those payments.

### ***Exchange Planning***

Update – Steve Groff

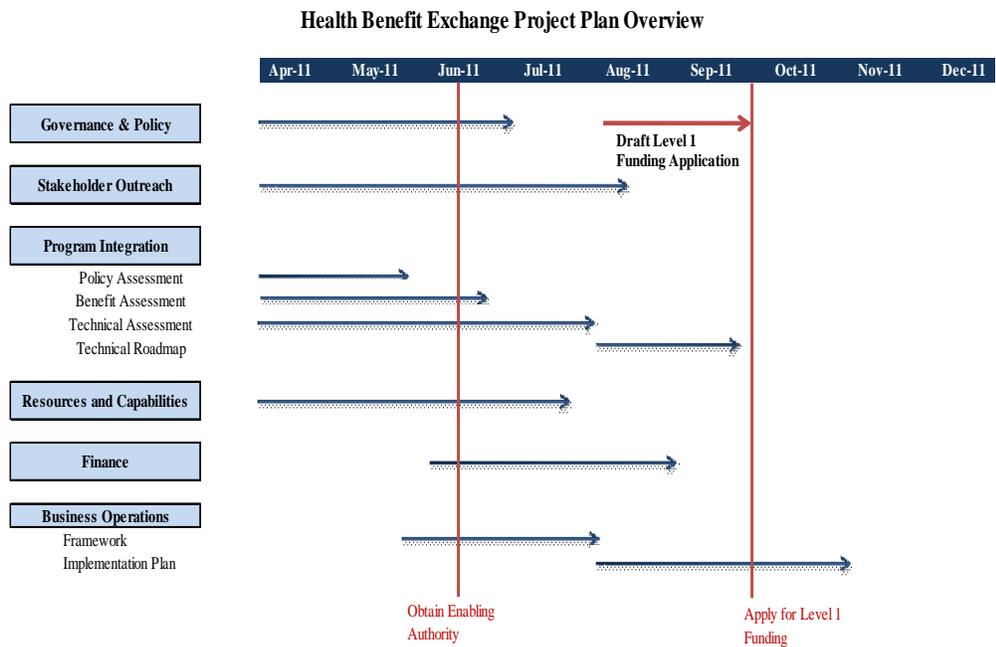
(this presentation will be made available on the DHCC web site:  
<http://dhss.delaware.gov/dhss/dhcc/presentations.html>)

Mr. Groff updated the Commission with progress made in planning for a Delaware Exchange.

Ms. Riveros asked the Commission members to review the report and identify other areas; Workforce Development may be another one where it could focus attention

## Health Benefits Exchange | Agenda

- Overview of Project Plan & Milestones
- Key Accomplishments To-Date
- Next Steps - 30-Day Outlook
- Key Decisions
- Small Business Survey Results
- Stakeholder Outreach – DRAFT Schedule for June 2011



## Health Benefits Exchange | Key Accomplishments

*Key Tasks presented 6/16/11*

| Category                           | Key Tasks   | Due Date  | Status   |
|------------------------------------|---|-----------|--|
| Workgroups                         | Organize and define meeting schedule  | 5/9/2011  | ✓ Done   |
| Public Forums                      | Transition Public Forums to PCG facilitation  | 4/28/2011 | ✓ Done   |
|                                    | Develop Small Business Survey*  | 5/15/2011 | ✓ Done   |
| Program Integration                | Develop Benefits Taxonomy   | 4/19/2011 | ✓ Done   |
|                                    | Develop data shell to illustrate key program components   | 4/22/2011 | ✓ Done   |
|                                    | Develop commercial carrier data request   | 5/25/2011 | In Progress - 5/27/11                            |
| Resources & Capabilities           | Prepare overview of core functions/services and responsibilities of Exchange  | 4/28/2011 | ✓ Done   |
| Governance and Administration      | Prepare overview of governance options  | 4/15/2011 | N/A - Structure Determined - Quad State          |
|                                    | Prepare overview of administration options  | 4/28/2011 | ✓ Done   |
|                                    | Identify core functions that can be operated on multi-state level   | 4/28/2011 | ✓ Done   |
| Finance                            | Categorize Exchange services, functions, responsibilities by those that apply to Exchange participants and those that apply across the market | 4/28/2011 | ✓ Done   |
| Technical Infrastructure           | Identify key individuals to participate in As-Is Assessment   | 4/15/2011 | ✓ Done   |
| Business Operations                | None  |           |  |
| Legislative, Policy and Regulatory | Prepare list of statutory/regulatory requirements associated with establishing an exchange  | 5/10/2011 | ✓ Done   |
|                                    | Analysis of NCARC legislation and identify key decisions for DE   | 5/30/2011 | In Progress - 6/14/11                            |
|                                    |   | 6/14/2011 | Policy Regulatory Report DED - Delivered 5/25/11 |

\* Added to workplan based on kickoff discussions.

## Health Benefits Exchange | 30-Day Outlook

| Category                           | Key Tasks  | Due Date  |
|------------------------------------|--|-----------|
| Stakeholder Outreach               | Confirm June Schedule - Public Forums & Targeted Outreach  | 6/10/2011 |
|                                    | Confirm July Schedule - Public Forums & Targeted Outreach  | 6/30/2011 |
| Program Integration                | Distribute Commercial Carrier Data Request, review with carriers, and collect responses  | 7/18/2011 |
| Resources & Capabilities           | Inventory public and private resources that can be leveraged to support the operations of the Exchange and complete gap analysis | 6/20/2011 |
| Governance and Administration      | Prepare Governance and Administration reports - present to Steering Committee  | 6/30/2011 |
| Finance                            | Develop initial financing options and administrative structure to operationalize the Exchange                                    | 7/14/2011 |
| Technical Infrastructure           | Submit Draft "As-Is" Assessment Report   | 5/27/2011 |
|                                    | Initiate "To-Be" Assessment activities   | 6/27/2011 |
| Business Operations                | Prepare basic framework for Exchange implementation and operations   | 7/1/2011  |
| Legislative, Policy and Regulatory | Prepare Policy Regulatory Report and submit to State   | 6/14/2011 |

## Health Benefits Exchange | Key Decisions

- 1) How will the Exchange be governed and administered?
  - Governing Authority
    - Quasi-State Agency ✓
  - Operational Model Options
    - Delaware Only – Internally staffed v. contracted
    - Multi-State – full Multi-State model v. shared back office functions
    - Federal – will still be a state specific risk pool
- 2) One Exchange or Two?
  - One Governing Authority ✓
  - Individual Market
  - Small Group Market
- 3) Infrastructure Options
  - Custom build?
  - Transfer from another State and modify?
  - Contract with Private Exchange and customize?

## Health Benefits Exchange | Small Business Survey Results

Responses Received as of 5-24-2011:

- 76 Surveys completed
- Key Statistics:
  - 60% of Respondents employ less than 10 FTEs
  - 86% of Respondents pay an average wage to employees that is less than \$50,000
  - 68% of Respondents employ 50% or more of their staff on a full-time basis (>30 hrs/wk)
  - 71% of Respondents do not employ seasonal staff
  - 95% of Respondents do not employ foreign students
  - 62% of Respondents employ Delaware residents only; 29% have 1-25% of employees who are non-residents.
  - 67% of Respondents offer their employees some form of health insurance; 90% consider their business "fully insured"
  - 82% of Respondents utilize brokers to make health insurance decisions; 65% are unsure if they will continue to use a broker after the Exchange is implemented
- Top Reasons for offering health insurance to employees
  - Employee recruitment
  - Employee retention

## Health Benefits Exchange | Small Business Survey Results

Summary of Open Ended Question Responses (38 completed):

- What key issue do you believe Delaware must address with regard to the Health Benefit Exchange planning process?
  - Cost/Affordability –to both small businesses and consumers
  - Financial Sustainability
  - Flexibility, choice of benefits and options
  - Education/Communication – making information easy to understand

## Health Benefits Exchange | Stakeholder Outreach Schedule

| June 2011- DRAFT  |  |   |  |   |        |          |
|---|--|---|--|---|--------|----------|
| SUNDAY  | MONDAY   | TUESDAY                                     | WEDNESDAY                                      | THURSDAY  | FRIDAY | SATURDAY |
| <b>Additional Meetings To Be Scheduled In June:</b><br>Targeted Outreach – Advisory Groups and Non-Profit Org.<br>Commercial Caser Meetings<br>Meeting with State of Maryland |  |   | 1  | 2<br>FHC Meeting 8-11a                          | 3      | 4        |
| 5   | 6<br>General HBE Forum<br>1pm – 3pm            | 7<br>General HBE Forum<br>1pm – 3pm         | 8  | 9   | 10     | 11       |
| 12  | 13   | 14  | 15<br>Commercial Market<br>Forum<br>9am – 11am | 16<br>Commercial Market<br>Forum<br>12pm – 2pm  | 17     | 18       |
| 19  | 20   | 21  | 22   | 23  | 24     | 25       |
| 26  | 27<br>Consumer<br>Information<br>2:30 – 4:30pm | 28<br>Consumer<br>Information<br>1:00 – 3pm | 29<br>Medicaid/CHIP<br>Forum<br>2:30 – 4:30pm  | 30<br>Medicaid/CHIP<br>Forum<br>1:00pm – 3:00pm |        |          |

Note: the June 6, 2011 forum has been integrated with the June 7 forum.

Ms. Riveros said Delaware is exploring the options with the private providers to provide some solutions for the Exchange. Delaware is exploring whether it would be a viable option for Delaware to take advantage of the existing capabilities and use it as a foundation for a Delaware front-end Exchange. Even though there are federal funds to build the Exchange, it must be financially self-sufficient

once it is built. We do have to be cautious with spending and conservative with our dollars.

***Approval of Proposed Exchange Governance Structure***

Two documents were distributed to Commissioners – the original and a modified version after review by the Commissioners.

Following is the version with Commission modifications in bolded text.

DELAWARE HEALTH CARE COMMISSION  
DELAWARE HEALTH BENEFIT EXCHANGE

GOVERNANCE STRUCTURE – FINAL VERSION  
As Modified by Health Care Commission  
May 5, 2011  
(changes in **bold** font)

*ORGANIZATIONAL STRUCTURE*

Quasi-state public instrumentality with independent board of directors

PURPOSES OF EXCHANGE

- Facilitate purchase and sale of qualified health plans in individual market
- Assist qualified small employers and facilitate enrollment and purchase of coverage and application for tax credits
- Reduce number of uninsured
- Transparent marketplace for health insurance, consumer education
- Assist Delawareans with access to programs, tax credits, subsidies

*ACTIVITIES OF EXCHANGE*

- Create and administer state-based health insurance exchange
- Assist small employers in facilitating enrollment of employees in health plans
- Make qualified health plans available to individuals and small businesses
- Ensure confidentiality and privacy of patient health care information
- Perform all duties required in the Affordable Care Act, unless the ACA is repealed; held to be unconstitutional or otherwise invalid.

*POWERS GRANTED TO THE EXCHANGE*

- Enter into contracts with

- ✓ Sufficient third parties
- ✓ Local governments
- ✓ Government agencies
- Employ non-state employees – exempt from Merit rules, Procurement rules and rules governing the disposal of state owned material
- Establish non-appropriated special fund to receive gifts, donations, grants and other sources of funding
- Establish reasonable fees or charges for providing its services

#### *EXCHANGE BOARD COMPOSITION*

- 11 members
- members appointed by Governor
- 1 member appointed by President Pro Tempore of Senate
- 1 member appointed by Speaker of the House of Representatives
- 4 ex-officio members (voting – members by virtue of position in state government)
  - Secretary, Health & Social Services
  - Director, Office of Management and Budget
  - Insurance Commissioner
  - Controller General

#### *EXCHANGE BOARD QUALIFICATIONS*

- 1 or more of the following:
  - ✓ Expertise in individual or small group market
  - ✓ Expertise in health care administration, health care financing or health information technology
  - ✓ Expertise in administration of health care delivery systems
  - ✓ Experience as a consumer who would benefit from Exchange
  - ✓ Experience in small business
- Appointing authorities consider:
  - ✓ Areas of expertise collectively represented on Board
  - ✓ Represent a range of skills, knowledge, experience, geographic and stakeholder perspectives
- May not hold elective office or be state or municipal employee (except ex-officios)
- No affiliation with health insurer (employee, consultant, member of the board, ownership interest)

#### *EXCHANGE BOARD OPERATIONS*

- Elect Chair and vice-chair – 1 year terms with option for re-election
- Board terms – 3 years

- Vacancies filled by same appointing authority
- Meet at least once per quarter – more often if necessary
- No voting by proxy, **except for ex-officio members**
- Authority to appoint subcommittees and advisory committees on relevant issues within scope of board

#### *BOARD REQUIREMENTS*

- Adopt by-laws
- Written fiscal and operational report to Governor and General Assembly June 30 and Dec 31 each year
- Public report by December 31 annually summarizing activities and contributions of Exchange to Delawareans
- Annual audit functions and operations
- Submit all reports required by federal law
- Define “qualified health plan” for Delaware if federal law repealed, held unconstitutional or otherwise invalid
- **Meetings and relevant documents subject to the Freedom of Information Act.**

#### *BOARD AUTHORITY*

- Adopt regulations to carry out powers of Exchange
- Prepare special reports concerning Exchange to Governor and General Assembly
- Contract for professional, technical and operational services
- **Hire outside counsel**

#### *OTHER BOARD ACTIVITIES*

- Appoint Executive Director
  - Is responsible to Board
  - Have experience in administration of health care or health insurance
  - Executive Director may appoint other staff – exempt from merit rules
  - Board approves staffing plans presented by Executive Director, but does not manage day-to-day operations**
- With DHSS ensure Exchange coordinates with Medicaid, CHIP and any other applicable state or local public program – create single point of entry
- **Coordinate with the Delaware Health Information Network in relevant areas and ensure that activities of the Exchange and the DHIN support each other.**
- Assure that DHSS, Insurance Department and any other relevant state agency work with Exchange, provide support to Exchange, including entering into inter-agency agreements

- Authority to enter into agreement with other states for shared operational support
- **Authority to enter into agreements with private entities for operational support.**

*ROLE OF EXCHANGE AND DEPARTMENT OF INSURANCE*

Clarify that no Exchange action is construed to preempt or supersede authority of Insurance Commissioner.

Mr. Heffron recommended that it be made clear an ex-officio's designated proxy has expertise and is an active participant rather than having a different designee every month. Ms. Riveros said language can be added strengthening that process.

**Action**

Ted Becker made a motion to approve the proposed Exchange Governance Structure as modified by the Health Care Commission and Rich Heffron's comments with relation to the ex-officio's proxy. Secretary Rita Landgraf seconded the motion. After a voice vote, the motion carried.

**Medicaid Health Homes Under the Affordable Care Act – Steve Groff**

Mr. Groff pointed out the Affordable Care Act is much more than just the Exchanges – it addresses quality of care; payment reform; service delivery reforms.

Health Homes for Enrollees with Chronic Conditions

Affordable Care Act Section 2703

- Effective Date: January 1, 2011
- Eligible Populations
  - Individuals eligible under the Medicaid State Plan (or waiver) who have at least two chronic conditions, one chronic condition and at risk for another, or one serious and persistent mental health condition
  - Chronic conditions include: mental health condition, substance abuse disorder, asthma, diabetes, heart disease, overweight (BMI over 25). This list may be expanded – currently considering HIV/AIDS.
- Service Definitions – comprehensive and timely high quality services, including the following health home services provided by designated health home providers or health teams
  - Comprehensive care management
  - Care coordination and health promotion
  - Comprehensive transitional care from inpatient to other settings, including appropriate follow up

**Action**

The Commission approved the proposed Exchange Governance Structure as modified by the DHCC and with added comments.

- Individual and family support, which includes authorized representatives
  - Referral to community and social support services, if relevant
  - The use of health information technology to link services, as feasible and appropriate
- Enhanced FMAP – FMAP for health home services shall be 90% for the first eight fiscal quarters that a State Plan Amendment (SPA) is in effect.
- Provider Arrangements
    - Designated Providers: physicians, clinical practices or clinical group practices, rural health clinics, community health centers, community mental health centers, home health agencies, others (including pediatricians, gynecologists, and obstetricians)
    - Team of Health Care Professionals: physicians and other professionals that may include a nurse care coordinator, nutritionist, social worker, behavioral health professional, or other professionals. May operate in a variety of ways (free standing, virtual, hospital or clinic based).
    - Health Team: to be defined by DHHS Secretary but should be interdisciplinary, inter-professional team and must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, doctors of chiropractic, licensed alternative medicine practitioners, and physicians' assistants.
- Planning Activities in Delaware
    - A workgroup including representatives from the Division of Medicaid and Medical Assistance, Medicaid Managed Care Organization (MCOs), Division of Public Health, Division of Substance Abuse and Mental Health and Nemours has been formed and continues to explore the new ACA state plan option to provide coordinated care through a health home for individuals with chronic conditions.
    - A data subgroup researched which populations would best be served following the guidelines proposed under the grant. Data collection showed that the following chronic conditions proved to be where efforts could be best focused:
      - Diabetes
      - Respiratory Conditions (Chronic Obstructive Pulmonary Disease, Asthma)
      - Cardiac Diseases (Coronary Artery Disease, Myocardial Infarctions, Hypertension)
      - Behavioral Health
    - Providers and Stakeholders have also been identified and will be included in ongoing planning activities. There are

significant data collection and reporting requirements, including avoidable hospital readmissions, cost savings, emergency room visits, quality measurements, patient outcomes, etc. associated with this program.

## **HEALTH PROFESSIONAL WORKFORCE DEVELOPMENT**

### ***State Loan Repayment Program Funding Updates***

The Loan Repayment Program has the following funds available for distribution:

- \$ 67,214 available in State DIDER funds through June 30, 2011
- \$ 65,000 available in State DIMER funds through June 30, 2011
- \$ 54,771 available in FY 10 federal matching funds through August 31, 2011
- \$ 17,500 available in FY 11 federal matching funds through August 31, 2011
- \$100,000 available in ARRA federal matching funds through September 29, 2011

### **State Loan Repayment Program Award Recommendations**

#### DIDER Loan Repayment Awards

The Loan Repayment Review Committee and the DIDER Board of Directors made the following recommendations:

*Syamack Ganjavian, DDS –new applicant - previously on HOLD*  
Be awarded \$37,214, for a two year contract to practice at Crescent Dental in Wilmington.

*Andrea Hunter, DMD – continuation contract – previously on HOLD*  
Be awarded \$15,000 for an additional one year extension of her contract to practice at Diamond State Dentistry in Milford.

*Adam Sydell, DMD - continuation contract*  
Be awarded loan repayment in the amount of \$15,000 for an additional one year extension of his contract to practice at Mercer Dental Associates in Dover.

#### DIMER Loan Repayment Awards

The Loan Repayment Review Committee and DIMER Board of Directors made the following recommendations:

*Gina Amorosa, DO - continuation contract-previously placed on hold*  
Dr. Gina Amorosa be awarded loan repayment in the amount of \$20,000 (\$10,000 state funds plus \$10,000 federal funds) for an additional one year extension of her contract to practice at Nemours Pediatrics in Wilmington.

*Cedric T. Barnes, DO – new applicant*

Be awarded \$10,000 for a two year contract to practice at the Southern Delaware Medical Group in Milford.

*Ian Baxter, DO – previously awarded 2 year contract*

Be awarded \$20,000 (\$10,000 State funds plus \$10,000 Federal funds) for an additional two year contract to practice at Nanticoke Women's Health Center in Seaford.

*David K. Brown – new applicant*

Be awarded \$20,000 for a two year contract to practice at the Center for Pediatric and Adolescent Medicine in Dover.

*Carmelo DiSalvo, MD - continuation contract-previously on HOLD*

Be awarded \$5,000 for an additional one year extension of his contract to practice at Mid-Atlantic Family Practice in Lewes.

*Sherin Ibrahim, DO - previously awarded but contract not executed*

Be awarded \$5,000 for a two year contract to practice at the Pearl Clinic in Millsboro.

*Jemine Wayman, CNW - continuation contract-previously on HOLD*

Be awarded loan repayment in the amount of \$5,000 for an additional one year extension of her contract to practice at Dedicated to Women in Dover.

The Loan Repayment Committee and DIMER Board recommended that:

*Scott Hammer, MD*, not be awarded loan repayment, given that he previously received a DIMER grant/loan of \$86,770 from the State.

*Kenny Vu, MD*, not be awarded additional funds, given that he was awarded a \$6,000 one year extension in 2009 which he did not accept.

*Mark N. Wilkinson, MD*, not be awarded loan repayment, as gastroenterology is not an approved specialty.

**Action**

Dr. Janice Nevin made a motion to approve the recommendations of the State Loan Repayment Review Committee and the DIDER and DIMER Boards of Directors. Dennis Rochford seconded the motion, which carried after a voice vote.

**Action**

The Commission approved the recommendations of the State Loan Repayment Review Committee and the DIDER and DIMER Boards of Directors.

**Proposed Change in State Loan Repayment Program Guidance**

One of the requirements of the State Loan Repayment Program is that the practice site be located in a Health Professional Shortage Area (HPSA). The State follows the Federal guidelines for HPSAs, which are designated by the U.S. Health and Human Services, Health Resources and Services Administration (HRSA).

Upon deliberation, the DIDER and DIMER Boards agreed that state operated facilities, by their very nature, serve underserved populations, regardless of where the facility is physically located. By only considering geographic location, some facilities might be eligible to have loan repayment recipients practicing within their walls, while others would not.

The DIDER Board believed that providing dental services to residents in state owned or operated facilities is in fact meeting the spirit of the program, and recommend amending the program guidance to permit this.

The DIMER Board agreed in concept with the recommendation and noted that, at some point in the future, a similar situation could arise for health professionals eligible to receive loan repayment awards made under DIMER.

**Action**

Dennis Rochford made a motion to amend the existing State Loan Repayment guidance to allow state loan repayment recipients to provide services for patients in state owned or operated facilities or institutions. Since this recommendation falls outside of Federal definitions, State only dollars would be awarded in the cases where the geographic location of the facility is outside of a Federally designated Health Professional Shortage Area (HPSA). Thomas Cook seconded the motion. After a voice vote, the motion carried.

**Authority for DHCC Staff to Act Upon the Special Award for Pediatric Dentist(s)**

Delaware State Dental Director, Dr. Greg McClure, applied for and was awarded a two year, \$200,000.00 (\$100,000.00 each year) federal grant to fund a pediatric dentist in an underserved area of Delaware (Lower Kent or Sussex Counties). A proviso of the award is that the State disburses \$40,000.00 in the DIDER program in each of the grant years (2011 and 2012), which it has done for 2011. One hundred thousand dollars of the grant must be spent by August 31, 2011.

Because the Delaware Health Care Commission does not customarily meet in July or August, the Commission staff is seeking approval to

**Action**

The Commission approved amending the existing State Loan Repayment guidance to allow state loan repayment recipients to provide services for patients in state owned or operated facilities or institutions. Professional Shortage Area (HPSA), using State funds only.

act upon awarding those funds should action be necessary during that time frame.

**Action**

Rita Landgraf made a motion to grant authority to the DHCC Staff to act upon the Special Award for Pediatric Dentist(s), which was seconded by Dr. Nevin. The motion carried after a voice vote.

**UNINSURED ACTION PLAN**

**Community Healthcare Access Program (CHAP) and Screening For Life(SFL)**

Ms. Riveros said that continued progress has been made on the integration of CHAP and Screening for Life. Blending these programs will realize efficiencies with unified, single administrative overhead, improving patient care and program delivery. In the Governor's Recommended Budget, the Uninsured Action Plan, which is the source of the funding for the Community Healthcare Access Program (CHAP), has been moved to the Division of Public Health. The other issues will not need to be addressed because the contracts will be transferred to Public Health.

Jill Rogers reported to the Commission that there have been discussions with Federally Qualified Health Centers (beginning with Westside Family Health), hospitals, the Health Care Association and others about their needs as the transition happens. The overall goal is that services on the ground to clients remain as smooth as possible. There is no need for any changes in the way those services are provided. Ms. Rogers is grateful to the Healthcare Association for identifying two critical issues that they want to make sure got incorporated into the transition: web based access for care coordinators and hospital staff and continuation of the current system until Screening For Life IT carries out all of the functions that are covered in CHAP.

Ted Becker asked Ms. Rogers what she sees as the IT timeline. She believes it will be in the Fall. It will depend upon how significant the technical issues are. It is important to make sure that whatever functionality the users of the system need is incorporated.

Dr. Ray Sukumar commented that Delaware Screening For Life was recognized nationally as being the best.

**Reports to the Delaware Health Care Commission**

Reports were provided to the Commissioners in the meeting materials from Christiana Care Health System, as required by the DIDER MOU; Temple University Kornberg School of Dentistry as required by the DIDER MOU and Christiana Care Health System as required by the DIMER MOU.

**Action**

The Commission granted the DHCC staff authority to act Upon the Special Award for Pediatric Dentist(s).

*Public Comment*

Debbie Hamilton, representing constituents in hospitals and patient advocacy groups in the State, said there needs to be formalized stakeholder public input mechanisms into the Exchange planning and Ms. Roy pointed out that was one of the requirements of an Exchange.

Lolita Lopez, President and CEO of Westside Family Healthcare, wanted to update the public attendees and the Commission with progress on opening a health center in Kent County. Ms. Lopez said Delmarva Rural Ministries and Kent Community Health Center are closing as of June 12. Westside Family Healthcare is working with HRSA and Delmarva Rural Ministries to close the gap in care and it looks as though Westside will be able to provide primary care service on a part time basis on June 13. Westside will be locating to a permanent facility around August 1 and will keep everyone informed of that progress. Ms. Lopez thanked Dr. Karyl Rattay and the Division of Public Health for the opportunity to get the word out about continued services.

Ms. Riveros encouraged everyone to look at the issue briefs being generated by Public Consulting Group, with the Delaware Health and Social Services and the Health Care Commission, in order to address the issues with respect to the Exchange.

The federal government – US HHS is very receptive to receiving input from states. Delaware should take the opportunity to influence areas of importance.

If there are comments about the Medical Loss Ratio issue, a link will be posted on the DHCC web site to do so.

**NEXT MEETING**

The next meeting of the Delaware Health Care Commission is 9:00 a.m. on September 1, 2011, at the Department of Transportation Administration Building, First Floor, Farmington /Felton Conference Room, 800 Bay Road, Dover.

**ADJOURN**

The meeting adjourned at 11:10 a.m.

**NEXT MEETING**

The next meeting of the Delaware Health Care Commission is 9:00 a.m. on September 1, 2011, at the Department of Transportation Administration Building, First Floor, Farmington /Felton Conference Room, 800 Bay Road, Dover.

## **GUESTS**

|                         |  |
|-------------------------|--|
| Thomas G. Bastholm, OD  | Delaware Optometric Association                  |
| Anthony J. Brazen, D.O. | DHSS/DMMA  |
| Judy Chaconas           | DHSS/DPH   |
| Jeanne Chiquone         | American Cancer Society                          |
| J'Aime Conrod           | Pfizer   |
| Barbara DeBastiani      | Wheeler and Associates                           |
| Tom Ferry               |  |
| Dr. JoAnn Fields        | Family Practice Physician                        |
| Dr. Robert Frelick      | Medical Society of Delaware                      |
| Steve Groff             | DHSS/Division of Medicaid and Medical Assistance |
| Debbie Hamilton         | Cozen O'Connor                                   |
| Joann Hasse             | League of Women Voters                           |
| Cheryl Heiks            | Cozen O'Connor                                   |
| Connie Hughes           | DelARF   |
| Jon Kirch               | American Heart Association/American Stroke Assn. |
| Lolita Lopez            | Westside Family Health                           |
| George Meldrum          | Nemours  |
| Melissa Bishop-Murphy   | Pfizer   |
| Linda Nemes             | Department of Insurance                          |
| Sarah Noonan            | Westside Family Health                           |
| Sheila Nutter           | Hewlett Packard                                  |
| Brian Olson             | La Red Health Center                             |
| Brian Posey             | AARP   |
| Nitin Rao               | DPS  |
| Jill Rogers             | DHSS/Division of Public Health                   |
| Christine Schultz       | Parkowski, Guerke & Swayze                       |
| Wayne Smith             | Delaware Healthcare Association                  |
| Ray Sukamar             | DPS  |
| Mark Thompson           | Medical Society of Delaware                      |
| Kay Wasno               | Hewlett Packard                                  |
| Betsy Wheeler           | Wheeler and Associates                           |

**Dialogue on Healthcare Reform Implementation in Delaware  
February 1- 2, 2011  
Newark, Delaware**

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The Delaware Public Policy Institute (DPPI) is a nonprofit, nonpartisan, nongovernmental public policy research organization. Its mission is to conduct research and encourage the study and discussion of public policy issues affecting the citizens of Delaware. The Institute identifies emerging issues that drive Delaware's future public policy agenda.

This report was prepared for DPPI by Brad Sperber and Johanna Raquet of The Keystone Center ([www.keystone.org](http://www.keystone.org)), a nonprofit that has been helping public, private, and civic-sector leaders solve complex problems and advance good public policy since 1975. Keystone relies on its independence, commitment to good science and skills in designing and leading consensus-building processes to establish new partnerships, reduce conflict, and produce policy agreements.

Funding for the Dialogue on Healthcare Reform Implementation in Delaware and for this report was provided by DPPI and Christiana Care Health Systems.

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## **Executive Summary**

The Delaware Public Policy Institute (DPPI) convened a dialogue of leaders from the public, private and civic sectors to consider the implications of the Patient Protection and Affordable Care Act (PPACA – Public Law 111-148) for healthcare delivery in the State of Delaware.<sup>1</sup> Stakeholders representing a diversity of sectors, disciplines and perspectives gathered on February 1-2, 2011 at the University of Delaware to share information, exchange views, identify priorities, and formulate recommended strategies for implementation of the healthcare reform legislation.

The aims of the PPACA include increasing the accountability of insurance companies, lowering healthcare costs, providing more healthcare choices, and enhancing the quality of healthcare for all Americans. However, many details of how best to interpret and implement many key elements are left to the discretion of states, creating a need for coordination of efforts and interests among key stakeholders to ensure effective and efficient operationalization of the reform package.

The dialogue endeavored to ensure strong familiarity among key Delaware stakeholders with key elements of the legislation, assess how the State is currently positioned to implement those elements, consider how implementation should proceed in the context of healthcare delivery in Delaware, and consider whether and how healthcare delivery in the State can be transformed into a preventive model. The dialogue focused on the present content of the PPACA – the law as it currently exists and how it should be implemented in Delaware – rather than how it might have been configured or might evolve in the future.

Specifically, the dialogue addressed the following needs:

- Definition and implementation of the medical home concept
- Definition and implementation of Accountable Care Organizations in Delaware
- Consideration of the establishment of Healthcare Innovation Zones in Delaware
- Readiness for “meaningful use” of health information technology to share medical data and information among providers and with patients
- Assessment of the need for and barriers to development of the medical workforce.

The participants included medical professionals, executives of medical centers, patient advocates, educators, organized labor, representatives of special needs populations, employers (both large and small businesses), and state officials. The Attendee List accompanies this report as Appendix A.

This report, developed by the meeting’s facilitators, summarizes the key discussion points from the dialogue. The document intends to accurately represent participating stakeholders’ observations and joint recommendations, although participants were not asked to endorse this report as written.

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<sup>1</sup> <http://docs.house.gov/energycommerce/ppacacon.pdf>.

## **Summary of Recommendations**

### *Medical Homes*

- 1) The Patient-Centered Medical Home (PCMH) Demonstration Project Guidelines developed by the Patient-Centered Primary Care Collaborative (PCPCC) should serve as a starting point for defining the medical home concept for purposes of implementation in Delaware. Further, the joint use principles for PCMH as defined by PCPCC should be adopted fully or in part for purposes of implementation in the State.
- 2) The Delaware Health Care Commission should convene a working group to determine in more detail how the medical home concept may be applied more broadly throughout the State, conducting evaluations and developing targeted legislation as appropriate. The group should be constituted to ensure that all essential stakeholders have a voice in the process. The working group should conduct an in-depth study of innovative approaches to establishing incentives, learning from the experiences of other states with circumstances similar to those of Delaware. This proposed working group should be convened by late spring 2011 and have developed a state plan by the end of 2011.

### *Accountable Care Organizations and Health Innovation Zones*

- 1) Accountable Care Organizations (ACOs) should be driven by local hospitals or physician groups.
- 2) The healthcare delivery system needs to shift in emphasis from volume to value, with providers paid by the value of care provided rather than by volume of cases or tests.
- 3) Healthcare leaders in Delaware must develop a transparent, equitable means of distributing responsibility for the care of high-needs patients among ACOs. At the same time, ACOs must be incentivized to include high-needs population and patients eligible for Medicare and Medicaid.
- 4) Federal regulation must be amended to allow the collaboration among providers necessary for formation and successful functioning of ACOs.
- 5) Significant tort reform must occur to ensure a reasonable degree of immunity for caregivers who adhere to established evidence-based guidelines.
- 6) The Delaware Medical Society, the Delaware Nurses Association, and healthcare and hospital associations should collaborate to ensure that the best available data (including Medicaid claims information and population health data) are used to inform understanding of the biggest cost drivers in the care of special needs populations, as well as to identify opportunities to better serve those populations.

### *Meaningful Use of Health Information Technology*

- 1) Implementation of the meaningful use concept in Delaware should be guided by the following statement:

*Healthcare providers in Delaware should be committed to fully adhering to and benefitting from the federal guidelines for meaningful use of health information technology. For implementation to be meaningful, all relevant stakeholders must be involved in using the technology in appropriate ways. Physicians, especially those in private practice, will require substantial support and adaptation of this principle to enable them to meet clinical responsibilities.*

### *Medical Workforce Development*

- 1) Current supply and distribution of the healthcare workforce should be measured, establishing benchmark data that can be used in projecting and future needs. (This information can be compiled largely by using existing data from the University of Delaware, supplemented by interviews of key hospital personnel.)
- 2) Additional state funding should be allocated to the Delaware State Loan Repayment Program by November 2011, and the program should be expanded to include medical residents.
- 3) An increase in residency training in Delaware should be pursued over the next two to four years as a means of building the workforce over time, since physicians tend to practice within fifty miles of where they completed their residency. Special attention must be paid to the downstate areas where practitioners are most needed.
- 4) Legislative action and leadership from the executive branch are needed to increase the scope of practice for nurse practitioners, physician assistants and other caregivers to meet the current and future healthcare needs of the State.

### *Delaware as a Center for Healthcare Innovation*

- 1) Leaders in the public, private, and civic sectors in Delaware should collaborate to position the State as a regional and national center for healthcare innovation. The Delaware Health Care Commission should serve as an incubator and convenor for an ongoing series of initiatives aimed at integrating innovation into the process of healthcare reform, focusing on population-based approaches to preventive health that can improve the health profile of all Delawareans.

## Introduction

### Background

Healthcare spending in the United States (U.S.) is among the highest of all industrial countries, accounting for 16.2 % of the country's Gross Domestic Product. Costs have risen steadily for several years, from \$253 billion in 1980 to \$2.3 trillion in 2008, outpacing both inflation and the growth in national income.<sup>2</sup> Despite this investment, concerns persist about health outcomes and affordability of and access to quality care. A 2007 study by the National Association of Community Health Centers and the Robert Graham Center found that 56 million Americans – most of whom have health insurance – lack ready access to primary care.<sup>3</sup> Many Americans (at least half, according to some research) are not receiving the care they need, with a disproportionate burden borne by minorities and the poor.

On March 23, 2010, President Obama signed comprehensive national health reform into law in the form of the Patient Protection and Affordable Care Act (PPACA, Public Law 111-148).<sup>4</sup> The aims of this legislation include:

- Increasing the accountability of insurance companies;
- Lowering healthcare costs;
- Providing more healthcare choices; and
- Enhancing the quality of healthcare for all Americans.

The Congressional Budget Office estimated that implementation of the PPACA (in tandem with the Health Care and Education Reconciliation Act of 2010 – H.R. 4872) will equate to significant cost savings. Their estimate included a reduction of the deficit by \$143 billion over the first 10 years and by \$1.2 trillion in the second. The reform package is also expected to reduce the number of uninsured by upwards of 32 million<sup>5</sup>

While the fundamental provisions of the legislation are mandatory, details of how best to interpret and implement many key elements are left to the discretion of states. To many stakeholders of the U.S. healthcare system, passage of the PPACA constitutes a paradigm shift in patient care (and in the delivery of that care) requiring thoughtful consideration of how to ensure full realization of the opportunities it affords, as well as how to navigate the complexities it presents. More narrowly and pragmatically, there is a need for coordination of efforts and interests to make efficient and effective use of Federal resources dedicated to implementation of the reform mandates.

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<sup>2</sup> Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, *National Health Care Expenditures Data*, January 2010.

<sup>3</sup> National Association of Community Health Centers, The Robert Graham Center, and Health Link, *Access Granted: The Primary Care Payoff*, August 2007.

<sup>4</sup> <http://docs.house.gov/energycommerce/ppacacon.pdf>.

<sup>5</sup> <http://www.cbo.gov/publications/collections/health.cfm>, accessed on March 11, 2011.

## **The Dialogue**

The Delaware Public Policy Institute (DPPI) convened a dialogue of leaders from the public, private and civic sectors to consider the implications of this recent legislation for the State of Delaware. Stakeholders gathered on February 1-2, 2011 at the University of Delaware to share information, exchange views, identify priorities, and begin development of promising strategies.

### *Objective and scope*

The chief goal of this dialogue was to ascertain how healthcare delivery in Delaware should evolve in light of the PPACA. Specifically the dialogue aimed to:

- Ensure strong familiarity among key stakeholders with key elements of the national legislation, especially those pertaining to healthcare delivery;
- Assess how Delaware is currently positioned vis-à-vis implementation of the prescribed reform;
- Consider how implementation of reform should proceed in the context of healthcare delivery in Delaware; and
- Consider whether and how healthcare delivery in Delaware can be transformed into a preventive model.

Through pre-meeting discussions with stakeholders, the facilitators identified five substantive topics as priority areas of inquiry for the dialogue:

- Definition and implementation of the medical home concept
- Definition and implementation of Accountable Care Organizations in Delaware
- Consideration of the establishment of Healthcare Innovation Zones in Delaware
- Readiness for “meaningful use” of health information technology to share medical data and information among providers and with patients
- Assessment of the need for and barriers to development of the medical workforce.

The dialogue focused squarely on the present content of the PPACA – the law as it currently exists and how it should be implemented in Delaware. Questions of what the Federal legislation might or should have contained, as well as about whether and how the act might be amended going forward, were outside the purview of discussion.

### *Participants*

DPPI assembled a robust group of participants, striving for diversity in professional sector and discipline, subject matter expertise, geographical location, and demographics, as well as the ability to characterize the interests of and be influential among key constituencies (e.g., professional peers, a region or community). The participants included medical professionals, executives of medical centers, patient advocates, educators, organized labor, representatives of special needs populations, employers (both large and small businesses), and state officials. Several other key stakeholders were invited to observe the dialogue but did not participate actively in plenary discussion. The Attendee List accompanies this report as Appendix A.

The Keystone Center ([www.keystone.org](http://www.keystone.org)) provided a facilitation team to assist with designing the agenda, moderating discussion in a fair and impartial manner, and to draft this report.

### *The dialogue process*

The meeting commenced with presentations by Federal government representatives in order to provide participants with a shared foundation of knowledge regarding the implications of the PPACA for the State, and what potential opportunities are available as a result of the legislation. Dialogue participants were briefed by Joanne Corte Grossi, Regional Director, US Department of Health and Human Services, Region III, on key components of the legislation as it pertains to delivery of healthcare. Nancy O'Connor, Regional Administrator for the Centers for Medicare & Medicaid Services (CMS), provided an overview of the provisions of the Act that CMS is implementing and their status and potential impact on the states.

Following the background presentations, the dialogue group delved into extensive discussion – in plenary and small group settings – of the major issue areas noted above. In the course of deliberation, participating stakeholders also identified a need and opportunity for the State of Delaware to position itself more firmly as a regional and national leader in healthcare innovation.

Consensus (defined as the absence of significant dissent) was sought during the discussion, but was not considered essential to a successful outcome since differences in perspective, value or interpretation can also be important information for purposes of making policy and crafting public health strategy. However, the recommendations contained in this report are the product of consensus or, at minimum, enjoyed the support of a strong majority of participants.

The meeting agenda accompanies this report as Appendix B.

### *This report*

Audiences for the recommendations contained in this report include (but are not limited to) the Delaware Department of Health and Social Services, the Delaware Health Care Commission, medical centers, doctors and other medical professionals, small and large employers (or state and local chambers of commerce), patient and consumer advocacy groups, and elected officials.

This report serves as a summary of discussion during the meeting, capturing key discussion points, major bodies of opinion, and agreements. The document does not attribute statements or viewpoints to specific individuals.

The report was developed by the meeting's facilitators. Meeting participants should be understood as important contributors to the discussion; the observations and recommendations presented in these pages are the product of their deliberation. However, participants have not been asked to endorse this report as written.

## Recommendations

### Medical Homes

The medical home is an approach to providing primary care services that is team-based, whole-person, comprehensive, ongoing and coordinated patient-centered care. The “patient-centered medical home” model establishes teams that comprehensively attend to multiple needs of patients, aiming to provide more coordinated care, promote prevention and reduce health care costs. The American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics and the American Osteopathic Association have jointly defined the medical home as “a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for providing all the patient’s health care needs and, when needed, arranges for appropriate care with other qualified physicians.”<sup>67</sup>

Participants articulated a vision for comprehensive healthcare in Delaware in which all patients should have access to quality healthcare that is coordinated, comprehensive, integrated, preventive, interactive, and affordable both to the patient and to the community. Implementation of the medical home concept provides a means of realizing this overarching vision. The medical home constitutes an approach to providing organized healthcare that can improve quality and reduce cost by centering on the patient’s needs. Participating stakeholders noted that such coordination of care will be beneficial to patients by reducing confusion and increasing access.

In order to qualify for funding opportunities that may be available or become available, the State needs to adopt a more comprehensive, coordinated approach to patient centered medical care. Coordinated care is the “wave of the future” and Delaware must prepare to be competitive in funding opportunities.

Participants recommended that the Patient Centered Medical Home (PCMH) Demonstration Project Guidelines (<http://www.pcpcc.net/content/guidelines-patient-centered-medical-home-pcmh-demonstration-projects>) developed by the Patient-Centered Primary Care Collaborative (PCPCC) ([www.pcpcc.net](http://www.pcpcc.net)) serve as a starting point for defining the medical home concept for purposes of implementation in Delaware. Participating stakeholders further recommended that the joint use principles for PCMH as defined by PCPCC be adopted fully or in part for purposes of implementation in the State.

The participant group expressed strong concern about the lack of an adequate workforce to provide the level of care needed in this new medical home model. Participants observed that existing professional boundaries need to be reorganized to better meet the needs of patients. The group also acknowledged the need for a patient’s medical home to shift in many cases based on health status and on the current reality of a shortage of primary care practitioners.

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<sup>6</sup> Association of Maternal and Child Health Programs, *Health Reform: What’s in it to Promote the Medical Home?* October 2010, [www.amchp.org](http://www.amchp.org), accessed on March 14, 2011.

<sup>7</sup> <http://www.pcpcc.net/>, accessed on March 14, 2011.

The group also recommended that the Delaware Health Care Commission (DHCC) convene a working group to determine in more detail how the medical home concept may be applied more broadly throughout the State. The working group should be constituted to ensure that all relevant stakeholders have a voice in the process. The working group should conduct an in-depth study of innovative approaches to establishing incentives, conducting evaluations and developing targeted legislation. Special consideration should be given to models of medical homes in Vermont, Rhode Island, Maine, Maryland, Pennsylvania, and other states that may closely align with Delaware’s unique circumstances.

The proposed working group should be convened by late spring 2011 and a state plan developed by the end of 2011. Many participants acknowledged the ambitious nature of this timeframe, and also noted challenges in financing a robust medical home system. Participants generally agreed, however, on the importance of proceeding expeditiously and in coordinated fashion.

### **Accountable Care Organizations and Healthcare Innovation Zones**

Provisions for the creation of Accountable Care Organizations (ACOs) appears in Section 3022 of PPACA under “shared savings program” and authorizes the Center for Medicare and Medicaid Services (CMS) to create an ACO program no later than January 1, 2012. Though CMS has not announced an official definition of ACOs as of this writing, the concept is widely defined as “a group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get.” Payment is tied to achieving health care quality goals and outcomes that result in cost savings.<sup>8</sup> The law provides for incentives for physicians to join ACOs. Such collaboratives intend to provide enhanced coordinated care by improving quality, preventing illness and disease, and reducing hospital admissions, thereby reducing costs in the healthcare system.

For purposes of implementation in Delaware, the group defined the ACO as an *organized collaborative of multiple providers assuming joint accountability for improving healthcare quality and slowing the growth of healthcare costs*. The ACO is a means of driving improvement in the coordination and efficient delivery of healthcare, while enhancing the quality of that care through joint responsibility. An ACO should encompass the full spectrum of care including acute care, well care and chronic care.

#### *Roles, governance, and operations*

Participants agreed that such a collaborative should be driven by local hospitals or physician groups, and typically organized by proximity. Each ACO should be responsible for establishing a system of governance to build, implement and maintain an appropriate business model, including by-laws, a fee structure, a payment structure, and a distribution system.

It is essential to establish the willingness of payors – both public and private – to participate in the shared savings system offered by the ACO concept. Start-up funding from payors would

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<sup>8</sup> <http://www.healthcare.gov/glossary/a/accountable>, accessed on March 14, 2011; and Harold D. Miller, “How To Create an Accountable care Organization,” Center for Healthcare Quality and Payment Reform, September 2009.

facilitate the initial formation and implementation of the collaboratives. Payor organizations will need to monitor and report out on the performance of ACOs to ensure that progress can be tracked and incentivized.

### *Patient-centered care*

A variety of models are likely to emerge throughout the State of Delaware, but in all cases the well-being and safety of patients should serve as the highest goal of all member providers. The current healthcare delivery system needs to shift from volume to value, with providers paid by the value of care provided rather than by volume of cases or tests. In an ACO, providers should therefore be accountable for the patient's health outcomes. Payment structures should take patient satisfaction into account, with that satisfaction worded and weighted in a way that does not penalize those who care for high-risk populations.

Healthcare leaders in Delaware must devise a transparent means for distributing the responsibility for caring for high-needs patients among ACOs, to ensure that those patients receive the best care possible and to ensure that the responsibility for that care is shared equitably. Participants suggested development of a case mix index encompassing key medical and socioeconomic factors to inform such decisions.

A successfully structured and managed ACO should ensure patients receive the needed care in the appropriate setting. Shifting to a focus on outpatient care minimizes the degree to which patients enter (or re-enter) facility-based care prematurely, thereby making more efficient use of resources, fostering a sense of independence, and reducing exposure to healthcare-associated infections.

### *Legal and regulatory reform*

Successful implementation of needed reforms in healthcare delivery in Delaware will require legal and regulatory changes, which must be pursued collaboratively by payors, providers, the business community, trial lawyers, and hospitals.

The number of ACOs that actually emerge in Delaware will depend in part on whether anti-trust restrictions can be redefined. Federal regulation must be amended to provide a "safe harbor" that allows more collaboration (for purposes of ACOs specifically) among providers. Such changes to the status quo are especially important given the size and market circumstances of Delaware; providers must be attracted from elsewhere. Without regulatory and legislative changes – which must be approved by CMS – ACOs either will not form or will not operate successfully, with the needed impacts.

Participants also noted significant tort reform as a high priority, while acknowledging that support for the needed changes must be cultivated over time. For the ACO concept to achieve the benefits envisioned, a legal framework must support immunity for caregivers that follow established evidence-based guidelines.

### *Healthcare Innovation Zones*

The concept of the Healthcare Innovation Zone (HIZ) was developed by the Association of American Medical Colleges (AAMC) in recognition of the vital importance of healthcare education and research in the development of the culture of medical practice. HIZs combine change in the structure of healthcare delivery systems with an educational and research agenda designed to facilitate and sustain that change. Functionally, the group defined HIZs as Accountable Care Organizations which incorporate the education of healthcare professionals and research on the effectiveness of the ACO in serving the community.

The establishment of the Delaware Health Sciences Alliance (University of Delaware, Christiana Care Health System, AI DuPont/Nemours, and Thomas Jefferson University) together with the collegial relationships among healthcare providers in the State offers a unique opportunity to test the effectiveness of the HIZ concept. Several organizations in the State (i.e., BayHealth, Christiana Care) have been instrumental in the development of the concept.

As a point of focus, participants suggested implementation of HIZs should be utilized as an opportunity to foster care of high-needs populations or those eligible for Medicare and/or Medicaid. Available Federal funding should be pursued to incentivize ACOs to include such populations. At the same time, existing data (including Medicaid claims data and population health data) must be mined to improve understanding of the biggest cost drivers of special needs populations, identifying opportunities to better serve those populations.

Participating stakeholders recommended that the Delaware Medical Society, the Delaware Nurses Association, and healthcare and hospital associations collaborate to ensure that such data guides the strategy, leading to positive health outcomes.

### **Meaningful Use of Health Information Technology**

As part of the American Recovery and Reinvestment Act of 2009, the Health Information Technology Economic and Clinical Health Act (HITECH) was enacted. This law authorized incentives payments for providers as well as funding to build national infrastructure for the adoption of the Electronic Medical Record (EMR), and established the goal of “meaningful use” of EMR. Together with the passage of the ACA, these measures are intended to facilitate better management healthcare costs, and improved quality resulting in improved patient health outcomes.<sup>9</sup>

The dialogue explored questions of how aggressively and legalistically meaningful use of Health Information Technology (HIT) should be pursued in Delaware. Participants shared the assumption that approximately 20% of practitioners in the State currently use Electronic Medical Records (EMR), and agreed that the use of EMR needs to increase statewide significantly.

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<sup>9</sup> <http://healthit.hhs.gov>, accessed on March 15, 2011.

State officials expressed interest in the government serving as a partner to support the implementation and enhancement of HIT in the State. The State is coordinating the Delaware Health Information Network (DHIN), a communication system that is available to healthcare providers throughout Delaware. The DHIN will apply the latest technology with security practices to make it possible for physicians, hospitals, and laboratories to deliver and access critical healthcare for patients. The DHIN will aid the effort to achieve eventual development of a fully integrated system by saving time, improving care, enhancing privacy and reducing cost.

The group concluded that overall costs of healthcare delivery can be reduced with the implementation of meaningful use of health information technology throughout the State. However, the group stressed the importance of participation by all healthcare practitioners in all settings for this effort to be successful. Increased participation will result in more beneficial communication among practitioners and therefore more comprehensive care to patients. Barriers to participation include financing, although Federal funding is available to offset some of the cost of implementation. Physicians close to retirement age seem least likely to implement these changes because of the high upfront costs of implementation, including training.

Participants developed the following statement as guidance for implementation of the meaningful use concept in the State:

*Healthcare providers in Delaware should be committed to fully adhering to and benefitting from the federal guidelines for meaningful use of health information technology. For implementation to be meaningful, all relevant stakeholders must be involved in using the technology in appropriate ways. Physicians, especially those in private practice, will require substantial support and adaptation of this principle to enable them to meet clinical responsibilities.*

While the statement stresses widespread use, its flexibility should allow for greater adaptation and therefore implementation.

Discussion focused on the need to communicate to practitioners – not only practical information about use of the DHIN, but also the business case for participation. It was acknowledged that different marketing tools may be needed for different medical settings and types of practitioners, to make the appeal for EMR and participation in the DHIN. Participants proposed that the Health Science Alliance add research on cost savings to its research agenda.

## **Medical Workforce Development**

Participating stakeholders articulated a goal of assuring that a high-quality healthcare workforce exists to meet the needs of a diverse and changing population in Delaware. Ensuring a workforce of caregivers that is adequate in number – and sufficiently trained and resourced – must become a top priority of leaders in government, education, and the healthcare community.

Current supply and distribution of the healthcare workforce should be measured, thereby establishing benchmark data, and future needs must be projected. This information can be

compiled largely by using existing data from the University of Delaware, supplemented by interviews of key hospital personnel.

Recommended strategies for developing the needed workforce include expanding assistance with student debt, increasing residency training, redefining the scope of practice for some types of caregivers, identifying new ways of providing long-term care, and incentivizing students to enter primary care practice.

### *Student debt*

Ensuring adequate financial support for the education of future caregivers is an essential step. The group recommended that additional state funding be secured for the Delaware State Loan Repayment Program, and that the program be expanded to include medical residents. Efforts should focus on targeted professional areas as part of a broader strategy to allow all practitioners (doctors, nurses, physician assistants, etc.) to work at the top of their skill level.

It is hoped that the State legislature and the governor will consider this need as a budget priority, with a goal of authorizing the needed funds. The Delaware Health Care Commission (HCC) should continue to provide oversight, and the Medical Society of Delaware should support and advocate for the needed changes.

### *Residency training*

An increase in residency training in Delaware should be pursued over the next two to four years as a valuable means of building the workforce over time. (Physicians tend to practice within fifty miles of where they completed their residency.) Special attention must be paid to the downstate areas where practitioners are most needed.

Team and residency training need to be incorporated and applied to all healthcare professionals. Hospitals and the Health Sciences Alliance (HSA) can be leaders in promoting this development. The number of training and clinical positions must increase commensurately, as well as the administrative capabilities to handle the additional residents.

### *Scope of practice*

It will be necessary to increase the scope of practice for nurse practitioners, physician assistants and other caregivers to meet the current and future healthcare needs of the State. This will require legislative action and leadership from the executive branch in order gain political momentum and eventual passage.

The issue of liability and patient privacy related to the role of volunteers in providing care will also need to be addressed.

### *Long-term care*

The current number of long-term care providers in Delaware cannot meet the growing need within the system of healthcare delivery. Participants recommended the encouragement of alternatives to long-term care (such as home care) to help aid in the reduction of costs by avoiding multiple (and sometimes premature) hospital visits.

This demand obliges leaders in Delaware (policy-makers, medical professionals, employers, patient advocates, etc.) to consider new ways of practicing and providing patient care, such as telemedicine and tele-monitoring. A supplemental workforce may also become necessary. A supervised non-medical workforce can emerge as a new type of caregiver, although social stigmas must be addressed via public education in order for this strategy to be successful.

Pursuant to ensuring an adequate qualified workforce and considering alternative venues for and means of care, payment reform may be needed to support the needed transition. Involvement and action by the HCC, Delaware Department of Health and Social Services (DHSS) and advocacy groups such as the AARP will be vital to the success of advancing long-term care.

### *Incentives for primary care*

The current system does not sufficiently incentivize medical students to select a professional focus on primary care. Recommended strategies for encouraging residents to enter primary care practice in Delaware include inclusion in loan repayment programs (as noted above), and better marketing of the quality of life and competitive pay that Delaware offers.

More significantly, the State should initiate a longer-term transition toward a preventive model of primary care – a shift involving private employers. Such a shift, requiring initial investment and a change in provider culture, should be supported and promoted by third party payors, provider organizations, and State government.

## **Delaware as a Center for Healthcare Innovation**

Stakeholders expressed the need to articulate and build toward an expansive vision of the health of Delawareans in the future as the system of healthcare delivery evolves due to legislative reform and other drivers. Dialogue participants discussed the need to look beyond traditional pathways for providing care, fostering a state-wide culture of catalyzing innovative ideas to provide care to the next generation. Deliberations focused on developing Delaware as a regional and/or national leader in innovation. Given its compact size, diverse population, geographical proximity to major centers of education and policy (e.g., New York City, Philadelphia, and Washington, DC), collaborative nature, and well-developed relationships with the public sector, Delaware is uniquely positioned to become a showcase for innovation in healthcare.

The Delaware Health Care Commission could serve as an incubator and convenor for initiatives aimed at integrating innovation into the process of healthcare reform. Such efforts should focus on population-based approaches to preventive health, with an end goal of improving the health of all Delawareans. Topics to consider include obesity, clean air, and use of technology. Projects should learn from existing successful models for innovating and lowering costs, consider the potential roles of non-traditional caregivers (e.g., social workers, community-based organizations, and faith-based organizations), and showcase relevant research being conducted in Delaware. Increased collaboration among key stakeholders will be necessary to attract funding for such initiatives.

### *Proposed focus on reduction in chronic disease*

As an example of such an initiative, participants proposed development of a comprehensive, population-based approach to reducing incidence of chronic disease – including obesity – prevalent in Delaware. A cross-sector focus on prevention would serve as an innovative approach to cost containment and reduction in the healthcare system. This program could foster the needed paradigm shift toward preventive, patient-centered care articulated in the PPACA, by providing support for individuals to assume greater personal responsibility for their health. The initiative could build on successes and incorporate lessons from various models within the State and around the country such as Farm to School programs and Florida’s Healthy 100 program, which promote healthy eating and active living as part of obesity and chronic disease prevention.

Participants acknowledged that a “culture of health” needs to be created in the State and that cultural change takes time. The program should be piloted in the Medicaid population and then more widely implemented, with incentives to fully engage participants. A statewide marketing campaign will be needed to enlist all stakeholders in this effort at all levels and in all settings. Potential components could include:

- Financial incentives for healthy decision-making by patients/consumers
- Worksite wellness
- Community health coaches (provided to those who are high utilizers of the healthcare system)
- Campaign to “right-size” meals, addressing the problem of excessive portion size (especially in away-from-home settings)
- Effort to ensure affordability of healthy foods, especially for underserved populations

Funding sources for the program could include grants from private foundations, support from Federal agencies (such as the Centers for Medicare and Medicaid Services), and/or taxation of sugared beverages.

## **Next Steps**

Participants considered how best to advance this body of recommendations. The Delaware Health Care Commission ([www.dhss.delaware.gov/dhss/dhcc](http://www.dhss.delaware.gov/dhss/dhcc)) is charged by the State General Assembly with developing a pathway to basic, affordable healthcare for all Delawareans, and

will continue its efforts to engage stakeholder in the implementation of the PPACA throughout the State pursuant to achieving comprehensive, patient-centered care. The Commission is uniquely positioned to engage interactively with stakeholders from all sectors while coordinating progress toward the needed action steps.

More broadly, participants in this dialogue, along with their counterparts throughout the State, must work together to catalyze the shift to a new model of healthcare delivery in Delaware that emphasizes quality over volume.

***Appendix A: Attendee List***

Dialogue on Healthcare Reform Implementation in Delaware  
February 1- 2, 2011  
Newark, Delaware

***Attendee List***

***Participants***

|   |  |
|---|--|
| Ted Becker<br>The Inn at Canal Square<br>Delaware Health Care Commission              | Jim Lafferty<br>Executive Director<br>Mental Health Association of Delaware      |
| Dr. David Bercaw<br>President<br>Medical Society of Delaware                          | Secretary Rita Landgraf<br>Delaware Department of Health and Social<br>Services  |
| Bob Bird<br>Owner<br>Home Instead   | Dr. Robert Laskowski<br>CEO<br>Christiana Care Health System                     |
| Dr. Curt Blacklock  | Lolita A. Lopez<br>President and CEO<br>Westside Family Healthcare.              |
| Tim Constantine<br>President and CEO<br>Blue Cross Blue Shield of Delaware            | Kathy Matt<br>Dean<br>College of Health Sciences<br>University of Delaware       |
| Robert Dayton<br>President<br>Delaware Bioscience Association                         | Brian McGlinchey<br>Director, Government Affairs<br>Laborers International Union |
| Mark DiMaio<br>Senior Director<br>Delaware Public Policy Institute                    | Terrence M. Murphy<br>President and CEO<br>Bayhealth, Inc.                       |
| Richard Heffron<br>Senior Vice President<br>Delaware State Chamber of. Commerce       | Bonnie Osgood<br>President<br>Delaware Nurses Association                        |
| Bill Kirk<br>Vice President and General Counsel<br>Blue Cross Blue Shield of Delaware |  |

Dr. Karyl Rattay  
Director  
Delaware Division of Public Health  
Delaware Department of Health and Social  
Services

Bettina Riveros  
Chair  
Delaware Health Care Commission

Brian S. Olson  
CEO  
La Red Health Center

Steve Silver  
Managing Member  
Onix Group

John H. Taylor, Jr.  
Executive Director  
Delaware Public Policy Institute

Michelle Taylor  
President and CEO  
United Way of Delaware

***Speakers***

Joanne Grossi  
Director  
U.S. Department of Health and Human  
Services Region III

Nancy O'Connor  
Regional Administrator  
Centers for Medicare and Medicaid Services

***Invited Observers***

Sarah Carmody  
Executive Director, Delaware Nurses  
Association

Karen Day  
Executive Director  
US Public Policy  
AstraZeneca

Marsha Gilmore  
Vice President  
Strategy & Planning  
Christiana Care Health System

Colleen Kempf  
Senior Manager  
State Health Policy  
AstraZeneca

Mark Meister  
Executive Director  
Medical Society of Delaware

Paula Roy  
Executive Director  
Delaware Health Care Commission

Dr. Alan Greenglass  
Senior Vice President  
Medical Group  
Christiana Care Health System

Wayne Smith  
President and CEO  
Delaware Healthcare Association

***Facilitators***

Johanna Raquet  
Associate Mediator and Facilitator  
The Keystone Center

Brad Sperber  
Senior Mediator and Facilitator  
The Keystone Center

## **Appendix B: Meeting Agenda**

### Dialogue on Healthcare Reform Implementation in Delaware February 1- 2, 2011 Newark, Delaware

#### **Agenda**

#### **Meeting objectives**

The dialogue seeks to understand how healthcare delivery in Delaware should evolve in light of the Patient Protection and Affordable Care Act. Specifically, this meeting aims to:

- A) Ensure strong familiarity with key elements of the national legislation, especially those pertaining to healthcare delivery;
- B) Assess how Delaware is currently positioned vis-à-vis implementation of the prescribed reform;
- C) Consider how implementation of reform should proceed in the context of healthcare delivery in Delaware; and
- D) Consider whether and how healthcare delivery in Delaware can be transformed into a preventive model.

#### **Day 1 – February 1<sup>st</sup>**

**8:15 a.m.**      **Room open, coffee available**

**9:00**            **Opening**

- Welcome and review of meeting objectives – *John Taylor, Executive Director, Delaware Public Policy Institute*
- Meeting overview – *Brad Sperber, Senior Associate, The Keystone Center*
  - Introductions
  - Review of agenda
  - Introduction of protocols for the meeting

**9:45**            **Overview of the Patient Protection and Affordable Care Act**

- Presentation of key components of healthcare reform legislation as it pertains to delivery of healthcare – *Joanne Grossi, Regional Director, U.S. Department of Health and Human Services Region 3*
- Q&A and discussion

**10:30**          **Break**

**10:45**            **Continuation of legislation overview**

**11:30**            **Opportunities for federal funding to support reform implementation**

- Presentation regarding current and future opportunities to secure federal resources for implementation efforts in Delaware – *Nancy O'Connor, Regional Administrator, Centers for Medicare and Medicaid Services*
- Q&A and discussion

**12:15 p.m.**    **Lunch**

**12:45**            **Medical homes**

- Consideration of how best to define and implement the medical home concept

**2:15**             **Accountable care in Delaware**

- Consideration of how to define and implement “Accountable Care Organizations” in Delaware

**3:45**             **Break**

**4:00**             **Healthcare innovation**

- Consideration of how to define and implement Healthcare Innovation Zones in Delaware

**5:15**             **Recap of Day 1, preview of Day 2**

**5:30**             **Adjourn**

## **Day 2 – February 2<sup>nd</sup>**

**8:00 a.m.**      **Room open; coffee available**

**8:30**             **Welcome, overview of the day**

**8:45**             **Meaningful use**

- Readiness for “meaningful use” of health information technology to share medical data and information among providers and with patients

**9:45**            **Assessing the need for and barriers to development of the medical work force**

**10:45**            **Break**

**11:00**            **Breakout discussions**

- Small groups will form around the five substantive topic areas to identify priority strategies for implementation

**12:30 p.m.**    **Lunch**

**1:00**            **Reports from breakout discussions**

- Brief reports from breakout groups
- Plenary discussion of priority strategies

**2:15**            **Closing**

- Follow-up to this meeting
- Identifying the contributions key stakeholders can make

**3:00**            **Adjourn**