SB 227 Primary Care Reform Collaborative Meeting

Tuesday, November 12, 2019
5:00 p.m.
Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

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

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

Staff:

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

Attendees:	**Organization:**
Jamie Clark	Nemours
Liz Staber	Aetna
Kiki Evinger	Department of Health & Social Services
Tyler Blanchard	Aledade
Regina Heffernan	AmeriHealth Caritas Delaware
Kim Gomes	Byrd Group
Avani Virani	Highmark
Lenaye Lawyer	AmeriHealth Caritas Delaware
Daniel Elliott	Christiana Care Health System
Anthony Onegu	United Medical
Katherine Impellizzeri	Aetna

Jennifer Mossman	Highmark DE
Elisabeth Scheneman	Department of Health & Social Services
Andrew Wilson	Morris James
Pam Price	Highmark
Susan Conaty-Buck	Delaware Coalition of Nurse Practitioners
Lisa Montegna	HighMark BCBSDE
Cydney Teal	Christiana Care Health System
Ayanna Harrison	Department of Health and Social Services /DHCC
Sascha Brown	Aetna
Deb Hamilton	HGP
Margaret Defeo	AmeriHealth Caritas Delaware

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

Introductions

The meeting convened at approximately 5:05 p.m. at the Medical Society of Delaware, 900 Pride Crossing, Newark, Delaware 19713. Representative Bentz welcomed the committee members and informed them Dr. Fan and Senator Townsend would arrive shortly. The floor was opened for introductions. There were two new members present: Mike Gilmartin/MDavis and John Gooden/MDavis. Special note: Elisabeth Scheneman with DHSS/Delaware Health Care Commission attended on behalf of DHSS representatives Sec. Dr. Kara Odom Walker and Steve Groff/Medicaid. Jamie Clark/Nemours was in attendance via conference call line.

Representative Bentz noted that the first item on the agenda is the review and approval of the minutes. This agenda item would be postponed until the arrival of Senator Townsend and Dr. Fan. The meeting would instead begin with a presentation on the Patient-Centered Medical Home (PCMH) Model given by Dr. Jim Gill.

Revisiting the PCMH Model

Dr. Gill opened by raising two questions, “How do we define PCMH?” and “How do we measure to demonstrate value?” His presentation entitled, “Defining and Measuring the Patient-Centered Medical Home” was an adaptation of a presentation prepared for a conference in July 2009. As a result of the original presentation, an article by the same name was published in the Journal of General Medicine in June 2010. A copy of Dr. Gill’s presentation is available at https://dhss.delaware.gov/dhcc/files/pcmhpcc_nov2019.pdf.

Dr. Gill detailed the five principles of Primary Care as accessibility, continuity, comprehensiveness or whole person care, integration/coordination, and family and community-centered care. Dr. Gill added new insight has been given to the importance of including cultural competency as a key element of primary care.

Next, he examined the definition of the PCMH which includes seven basic principles. He stated these principles do not differ from primary care, but instead represent an enhanced structure. The first principle of PCMH is having a personal physician or clinician. Dr. Gill pointed out the original definition only included physician and he emphasized the importance of using the term “clinician”. This distinction allows for the inclusion of advance health care providers (i.e. Nurse practitioners and Physician Assistants) who include primary care services in their practices. The second principle is described as the physician/clinician directed

medical practice. The third principle is a practice that is comprehensive or whole-person orientated. Coordinated care is listed as the fourth principle. This involves care that is coordinated or integrated across the health care system. The fifth is the focus on quality and safety. Sixth is the enhanced access and the seventh principle is the presence of a payment system that recognizes the value of these services.

Dr. Gill described the benefits of primary care, more specifically PCMH models, as: better population health, lower cost, less inequality, and better health care quality. Dr. Gill shared two references with members. One of the referenced articles entitled "Prospects for Rebuilding Primary Care Using The Patient-Centered Medical Home" was provided in the meeting materials.

Dr. Gill continued by sharing the key elements of measuring the PCMH model; measuring primary care principles and measuring new approaches and new technology (EHR and information technology). Dr. Gill shared several caveats when measuring PCMH models. There has been a tendency to overemphasize the technological advances while under-valuing the patient-centered and relationship aspects of primary care. There has also been an expectation that benefits can be seen within one to two years, when in actuality outcomes take between five to ten years.

The NCQA PCMH certification program is widely used and has become the focus when measuring PCMH models. It is used by many health plans and is mostly commonly used in definitions and studies. The NCQA has nine standards and 166 practice-report items. Dr. Gill highlighted the fact that almost half of these items focus on the use of technology with very few measuring coordinating care, continuity of care or care for specific diseases. He also highlighted that only 1% of the measured items focus on continuity of care (one of the four main elements of primary care). It was also noted that several important measures are missing from the NCQA tool. For example, comprehensiveness of care, patient perspective, relationships, mental health, community, population outcomes, and developmental process of transformation.

The discussion shifted to the barriers and cost implications surrounding the use of NCQA certification. The process is expensive and time-intensive. There is a large documentation/administrative burden. Dr. Gill shared that his office achieved level 3 at a cost of between $20,000 and $30,000. Recertification is less expensive but overall cost are high and it was noted that cost may be a barrier for smaller practices. Dr. Gill's office decided not to pursue re-certification.

Dr. Gill shared several alternatives to the NCQA measure. Dr. Gill referenced the article "*Measuring Medical Homes, an evaluation of the tools used to assess the PCMH models*" during this portion of the presentation. This study conducted by Dr. Malouin and Dr. Mertin reviewed tools for their population coverage, format, testing of validity and reliability, and inclusion of the attributes of primary care. The two highest scored instruments were the Primary Care Assessment Tools (PCAT) and Primary Care Assessment Survey (PCAS). The study found that both perform significantly better than the NCQA tool. It was also noted that less than one-tenth of the resources were needed.

Dr. Gill concluded his presentation by sharing that there is strong evidence that PCMH represents enhanced primary care and improves access, outcomes and cost. The NCQA is widely used, common and well-known. It is also very costly, under measures key primary care components or misses them all together. Overall it is

not a strong performer and it is not realistic for practices in Delaware. Dr. Gill closed by emphasizing the need to identify a new certification standard for practices not currently holding NCQA certification.

Dr. Fan stated the purpose of the presentation was to ensure collaborative members share the same concepts and common definitions when discussing PCMH delivery models. She stated PCMH can be used as a care model to enhance primary care in Delaware. She stated certification has been seen as a barrier for some practices attempting to establish a patient-centered medical home. Dr. Fan pointed out that Oregon developed an individual standardized certification and wondered if the collaboration was interested in doing the same. If the committee decided to move forward with developing a standardized tool, ensuring payers are comfortable with the chosen certification strategy would be paramount.

Dr. Bradley shared that his practice achieved level three (PCMH). He reports the cost of this endeavor was approximately $30,000. He stated the first two recertifications were less burdensome. Currently, his practice utilizes the "fast-track" recertification process and they have found it is much easier. He stated the process requires a significant amount of time and effort. Dr. Bradley shared that their office has two to three staff dedicating 100% of their time for processing the documentation of their PCMH claims. The size of their practice allows them to absorb these cost. He admitted this process may not work for all practices in Delaware.

Representative Bentz asked for more information regarding payers discontinuing reimbursements for PCMH claims. Dr. Gill stated it was his understanding the payer determined the model was not producing expected outcomes. Kevin O'Hara reported that the model claims were paid before discontinuing and the decision to discontinue was in part because they did not find cost improvement or efficiencies. Mr. O'Hara also reported there was no indication quality was stronger than non-PCMH practices. He added that the program was terminated but the funds were poured into their current value-based programs.

Kevin O'Hara continued by stating that the discussion of measurement is important because plan sponsors want to know how PCMH models are improving their member's quality and cost. He highlighted that the plan sponsor or employer are the ones paying for these programs. He confirmed the decision to discontinue reimbursement of the plan in question was done across their entire company. Representative Bentz asked other payers in attendance about their findings in regards to the value of PCMH. Chris Morris added that Aetna is still evaluating their programs.

The discussion continued and Dr. Gill shared more information about the NCQA tool. The NCQA measure evaluates quality by applying disease measures. Specific documentation is required to support provider reports. The NCQA collects self-reported data and providers understand supporting documentation may be requested. Practices receive quality measure feedback based on their self-reported data. Recommendations are included. This feedback is aggregated and not broken down by patient.

There was a brief discussion about the difference in the alternate measurements in the literature disseminated. Dr. Gill explained that the first table (Table 3) assesses how well the tools measure the seven primary care attributes. Appendix E provides an overview of the resource intensity of each tool.

Members discussed the prevalence of outcome studies. It was stated that several outcomes studies have been conducted and results have been mixed. In general, studies have shown PCMH attributes are associated with improved quality and improved access and reduced cost.

Dr. Bradley revisited the question raised regarding payers discontinuing reimbursement of PCMH claims. He shared his experience as the president of the Medical Network Management Services of Delaware (MedNet). He explained that Mednet was searching for a delivery model (ACO) and entered into a contract with Blue Cross Blue Shield of Delaware. This partnership was delayed by the merge between Blue Cross Blue Shield of Delaware and Highmark. Their practice was not able to clinically integrate their networks. Their practice lost 25% of their reimbursement resulting in a reduction in their staffing structure. Mednet has entered into a new partnership and they are currently integrating their physicians starting with primary care. They have over 800 in their network over one-third are primary care. They are working towards integrating health information (Electronic Health Records) in their primary care practices.

Dr. Fan highlighted Appendix E (slide 4) of the "Monography Summary" document. This table provides details on various assessment tools used to assess quality and measure performance. PCAS and tools like it are designed to understand the risk characteristics of patient panels. The appendix shared the following data on each assessment tool: date of release, number of questions/pages, length of time to complete, language available and cost of use. Dr. Fan pointed out that while PCAS and PCAT have completion times between 5 to 25 minutes, PPC-PCMH (NCQA) reports taking 40-80 hours to complete. She noted the extensive administrative burden and added that it is likely a barrier for providers.

Dr. Fan added committee members should discuss and define "accountability" and "value". She raised the following questions: What is value? It is important to hold practices accountable? What tools will be used to quantify value? She asserted that the tool used by practices should not cost over $30,000 and take between 40 and 80 hours. In her discussion with varous physicians they have listed cost and administrative burden as reasons they have not tried to achieve NCQA.

Dr. Fan asked Chris Morris about Aetna's PCMH program in Oregon. Morris reported that the program in question was implemented a few years ago. Aetna had programs that were created around value-based care in Oregon. Chris Morris reported the programs Aetna created in Oregon around value-based care met their criteria so the decision was made to continue to move forward in that direction. Dr. Fan reported that Oregon has developed their own certifying body for PCMH. Aetna has increased reimbursement for practices that are recognized as PCMH programs. Chris Morris reported that Aetna has two different levels of PCMH programs depending on the number of attributed members. Both levels include care coordination fees. The larger member/patient volume have gain-share opportunities. The smaller program, built for practices with 25-50 patients, have a care coordination program around NCQA accreditation. There is member/patient criteria level and programs also cannot be in any other value-based program.

Dr. Donahue asked if there was evidence of cost decrease in this model. Chris Morris reports that it is a little too early to attribute a decrease as a result of this program. However, he did report that there has been an increase in the number of providers participating.

Dr. Fan reported that Oregon's first legislation mandated them to have care coordination within their Medicaid program (PCMH) and they had a decrease in cost and increase in access. They had such success that they developed the second and third legislation.

Dr. Gill stated that a large number of PCMH programs are dramatically underfunded. The cost is approximately $15 to $20 per patient per month and most reimbursements are approximately $2. Improved outcomes are often not found in many programs, due to inadequate resources and funding in those programs. He asserted that if the program is funded fully there is dramatic benefit. The group discussed the importance of reviewing the outcomes of fully funded PCMH programs to determine if demonstrated value could be documented. It was suggested that the collaboration review the demonstrated cost savings of CPCI programs because they are similar to a PCHM programs. Several members felt that it was important to obtain a better understanding of the benefits (cost analysis and outcome measures) of these programs before moving forward.

Dr. Fan reported that Trinity Health participated in the ACO Next Generation (Medicare). This program reported savings all three years of participation. The model involves ACOs taking on more financial risk than participants in the Medicare Shared Savings program. The upfront investment was significant at $22 per payer per month however they were still able to demonstrate cost savings. Dr. Fan suggested the collaboration committee develop standards on measurement alignment that will provide an investment with guardrails. Several members expressed interest in learning more about the ACO NexGen. Dr. Fan shared that discussion details can be found in past collaborative meeting minutes. Note: Discussion on this topic is found in the February 25, 2019 meeting minutes (starting on *page 5*), located on the Health Care Commission/Primary Care Collaborative webpage: https://www.dhss.delaware.gov/dhss/dhcc/files/pccmeetingminutes022519.pdf. Dr. Fan also agreed to contact Jennifer Schwartz (ChristianaCare) and invite her to a future meeting to present her findings. Members agreed a presentation of this type would be helpful.

Members continued to discuss evidence of cost savings. All agreed that currently there is not enough evidence. Dr. Fan suggested the collaborative consider developing a care model that will provide investment with guardrails and build standards around accountability and value. She asserted there is a need to have a standardized measurement tool in place, however it should not include 166 measures.

Kevin O'Hara reports that payers will have a difficult time asking the client/customer to pay for the premiums if there is lack of evidence of cost saving.

Mike Gilmartin reports that employers are willing to share some of the cost if it was known that they would receive better quality care for their employees. He stated that healthy employees are happier and as a result companies benefit. However, he did point out that employers do not wish to lose money. He shared their company became self-insured in 2014 and they are still learning. He continued by stating he believed there is value but the learning curve is steep. It will be necessary to clearly define what we are looking for. There has to be an incentive, perhaps a tax income incentive.

Dr. Fan transitioned the discussion to the review and approval of the October minutes.

Review/Approval of Minutes

Dr. Fan asked the committee members if they had any comment on the draft minutes from the Primary Care Reform Collaborative meeting, held on October 21st. Dr. Fan noted an error on page three. ERISA plans will be continued during the November meeting. Chris Morris requested a change be made to reference to Medicare Advantage (page3). Dr. Gill noted that he sent edits via email prior to the meeting. Read Scott acknowledged receipt of the changes. Seeing no more discussion Dr. Hawtof motioned to approve minutes as amended. Senator Townsend seconded the motion. The motion to approve was unanimously carried. View approved October 21, 2019, meeting minutes here: https://dhss.delaware.gov/dhss/dhcc/files/pccmeetingminutes11142019.pdf.

Update on Value Based Payments

Dr. Fan began the discussion on value-based payments. She stated that a recent report noted that there was a lower uptake in Delaware for participation in value-based payment models as compared to other states. She was interesting in obtaining updated information from payers. She opened the discussion by asking the commercial payers present to answer several questions (Overall total percentage participation, PCMH/PCMH type model participation, number of quality metrics, challenges and measures in place to increase participation, successes, actions if any to increase percentage spend on primary care through value-based models, and last ability to provide Primary Care First track).

Chris Morris reported on behalf of Aetna. He shared that the disparity noted last fall has since narrowed and Delaware is currently at 72% participation in value-based models (50% in primary care alone). He continued his report by sharing that Aetna currently offers 6-7 value-based models. Aetna has been working with practices to find programs that succeed. Quality metrics vary depending on the program. Practices have reported various challenges. Some report experiencing low level of engagement. Others report having difficulty meeting the initial metrics. Challenges can depend on the size of practice and specific criteria requirements. He stated the increase may be due in to the outreach efforts to smaller practices and they also signed contracts with larger health care systems.

Kevin O'Hara reported on behalf of Highmark. He stated they currently have 88% engaged in value-based payment systems with 54% of providers are in advanced customized programs. He reports Highmark builds the programs around the member mix of each practice. The vast majority of their practices have standardized quality metrics (29) however some practices do not qualify or have enough volume and are measuring a much lower number. He reports Highmark's increase in attribution has is a result of the increased activity of Medicaid plans. He also reports Highmark signed contracts with a few larger organizations, aggregators or management companies. These companies aggregate practices that are too small to participate on their own or needed additional support due to lack of resources. Their coordination and clinical support is strong. They have dedicated staff in these areas.

Dr. Fan asked about the ability to transform from a Medicare shared saving program to a multi-payer ACO and if both payers felt their increase was due in part to ACOs moving to multi-payers. Highmark reports that programs are set up with a minimum threshold for membership and a large majority of non-participants were the smaller practices that did not meet the requirements. Adding the aggregators helped them reached the market that was not large enough. Dr. Fan continued the discussion by asking if payers had plans to add Primary Care First track. Kevin O'Hara reports that he has not participated in conversations

about the possibility of adding Primary Care First. He commented on the need to see demonstrated success.

Dr. Donahue with ChristianaCare stated all practices within their health system are engaged in value-based models with some fee-for-service. Chris Morris reported that all of Aetna's programs have fee-for-service. Dr. Hawtof asked what percentage of the programs have downsize risk. Payers reported having programs with both downsize and upside risk.

Dr. Fan transitioned to a discussion to pairing payment models and care delivery models. She reviewed slide 3 of her presentation, focusing on Figure 4. Dr. Fan confirmed that payers have varying participation in each of the value-based payment models. When asked which one was most successful (re: investment and cost). Kevin O'Hara reports that Highmark has analyzed the data tied to their baseline program (True Performance, True Performance Plus and True Performance Advance) and he reports having substantial quality gains and savings. Chris Morris reports that a few of Aetna's value-based programs (complex and pay for performance) have shown some demonstrated value. The group began to examine what determines success. The group agreed that success includes improved quality and reduced cost. With that definition in mind the group began to discuss which model has been more successful. Dr. Fan asked if there was one particular program that had higher participation than the others. Payers report not having data that examines participation rates among providers per available programs.

Dr. Fan continued her presentation with a summary of reoccurring themes she has noted after reviewing several past meeting minutes. She stated several members agreed that the cost savings of a PCMH-like program were greatest with a mature PCMH or higher risk populations. Mature practices have the necessary resources and infrastructure in place. Savings were also associated with the ability to decrease cost associated with high risk populations through reduction in Emergency Department utilization due to management of medication. She continued by sharing important characteristics of PCMH models. The first characteristic is the desire to not add upfront investment into the total cost of care. She clarified that "added" means to increase. Dr. Fan asked the committee the following questions: "Does accountability equal risk?', and "Who assumes the risk, payers or the practice?" The group began to discuss how to build infrastructure. All agreed that the following components were relevant: data, care coordination at practice level, pre-defined targets for outcomes, cost savings and accountability all need to be present. Lastly, Dr. Fan pointed out the need to define the role of established ACOs in the state as the last important characteristic.

Dr. Fan invited Tyler Blanchard from Aledade and Dan Elliot from eBrightHealth to comment on the behalf of ACOs. Dan Elliot reports that eBrightHealth (ACO) has the vast majority (30 of the 45) of PCMH in the state. They currently do not have concierge services. They do have practices that participate in other multiplayer and value-based programs but they currently do not offer support. He continued by stating that Primary Care First is an interesting model. It places risk at primary care practice in a way that is disadvantageous financially to ACOs. He added that Primary Frist changes incentives in an attractive to some of their practices. He stated there is a lot of uncertainty, even with the latest RFP. The program dis-incentivizes taking care of high-risk patients by risking at the sum or the average across a practice. Lastly, he reported 20% of their practices are strongly considering the Primary Care First model but none have officially confirmed their participation. He added they are moving to Track C in January so there will be

some downsize risk. He concluded his statements by sharing that when practices undergo structural changes it can dramatic and the result of these changes could mean the difference between a windfall or a shortage.

Tyler Blanchard from Aledade shared that they began in 2015. Aledade works with independent primary care physicians only. These practices are smaller in size. Currently they are working with 30 practices. In 2017 they achieved shared savings with Medicare. In 2018 they missed shared savings by less than 1%. They have contracts with Aetna and Highmark value-based care across a larger population. They have approximately 50,000 Delawareans in value contracts through their primary care providers. The PCMH has been too costly for practices. There has to be some return to cover the investment. The PCMH programs have mostly lapsed. They may have the infrastructure but lack certification. The difference between a PCMH program and an ACO is more around prescriptive approach verses a more flexible outcome driven approach. In a PCMH program you are checking boxes, while an ACO program is more allowing practices to invest their money in the best way they can care for their population. Concierge has become a growing component. Currently, at least five practices in the ACO use this model, and more are actively pursuing. Smaller practices are able to lessen the burden of having to see at least 30 patients a day. Unfortunately, it leaves patients without access to primary care. It is challenging to aggregate all of the models together. Standardization is difficult because they receive data in different formats. Some payers share claims data. Aledade is integrated in EHR and in the practice management systems and among the practices as well. They have over 50 quality measures. There is not much interest in shrinking the list. Primary Care First is a program that changes the way practices get paid, not more just differently. The intentions are great but difficult to jump into a program when you are unsure of the impact on your business. He reports that Aledade is on two-sided risk with Medicare and they are on the enhanced track (the full risk program). They have plans transition to full-risk with Aetna and they are working with Highmark now.

The group discussed how to incentivize participation in value-based programs. Dr. Gill suggested that the focus remain on metrics and performance over the “4 Cs” (contact, continuity, comprehensiveness, and coordination). He continued by suggesting that the committee move toward with focusing on prospective payments to allow practices to make upfront investments.

There was a lengthy discussion on the intricacies of PCMH and value-based payment models. Dr. Fan and committee members elaborated on the several observations (Primary Care First, practices moving to concierge services, changing the way primary care practices deliver care, and risk management).

The Primary Care First program has several interesting characteristics. The model seeks to reduce cost through the reduction of hospitalizations. One member shared after some analyses their practice decided the Primary Care First model was not worth the investment. Instead their practice focused on Care Coordination. They worked with Skilled Nursing Facilities and they were able to reduce heart failure readmission rates. These rates have been at less than 10% for three quarters in a row.

It was mentioned that cost reduction will not take place until cost attribution to primary care providers is addressed. A comment was made that cost from specialists like radiologist and outpatient laboratories are added to primary care providers overall spend total. Primary care providers have little to no control over

these services but they are attributed to their final numbers. All agreed that addressing this issue would be very beneficial.

One member asserted that changing the way primary care providers deliver care is the key to improving quality and reducing cost. A true transformation includes risk management. Providers must be willing to practice differently. All agreed that some physicians will have no desire to change.

Dr. Fan reminded the members that 10% of practices are moving to concierge services. It was felt that there is a payment pressure. Concierge services decrease access to care for many. She added the collaborative was founded to increase access and decrease cost.

Dr. Fan asked if the committee members could agree on the need for a clinical model with a payment approach that focuses on the "4 Cs" or PCMH. One of the main concerns mentioned was the amount of work involved implementing PCMH programs and the risk that payers will not support the model and providers will not be reimbursed. Several made the point that it is not necessary for all practices to be NCQA certified, another certification approach could be developed in its place. Dr. Fan mentioned that Aetna has a certification tool in place.

Dr. Fan once again asked the members what type of care model can be developed with a payment approach. She pointed out that while other types of care delivery models are not as known, PCMH models have proven outcomes. Literature on PCMH models report better outcomes and improved care. She reminded the committee members that their goal is to increase access for our patients and develop models to increase the sustainability of primary care in the state.

Dr. Fan asserted that the development of a NCQA-like certifying body may remove the barrier some practices are currently facing. She asked if members could agree to that there is a need for a clinical care model that will be supported. She made the request that members consider viable care models and be prepared to discuss during the next meeting in December. She also asked members to think about timely and accurate data sharing. Due to lack of time the committee did not have an opportunity to discuss this topic in depth. Dr. Fan mentioned the success of establishing the Office of Value Based Healthcare.

Lastly, Dr. Fan asked the committee if they felt the mandate to have 60% of primary care practices in value-based care models has been reached. There was some discussion on the terminology used in the bill. Some felt that the definition of provider was not specific. It was decided that they would analyze both numbers. Payers reported that the number of primary care providers participating in value-based models is much higher than all providers. Members agreed to research final numbers in both categories (all providers and primary care providers).

Medicaid is a large payer and next month they will be providing the committee with answers to the questions reviewed by Aetna and Highmark about value-based payment models. They will be present in the December minutes.

There was a brief discussion on the importance of data gathering and data sharing. Dr. Fan reminded the group of the discussion from the October meeting regarding the challenges with access to data from ERISA

plans. Dr. Fan asked that the committee members be prepared to discuss strategies to gain greater engagement for self-insured and private insurers during the next meeting. She highlighted the development of The Office of Value-based care. This office will work on identifying the primary care spend for the state.

A suggestion was made that committee members be provided with a survey that includes the assignments requested by Dr. Fan. Members could submit their answers before the upcoming meeting. Answers could be compiled and disseminated with the meeting materials. Dr. Fan agreed with the idea. Another member asked to have access to the materials that will be reviewed during the meeting well in advance. The member stated having advance review time provides necessary preparation and allows for a more robust discussion. Dr. Fan agreed with this suggestion as well. Her goal has always been to disseminate materials to provide advance review time. She reported having experienced difficulties while attempting to disseminate materials for this meeting. She added that she is committed to sending materials out early in the future.

Public Comment

Dr. Fan opened the floor for public comment.

Hearing no other business, Dr. Fan adjourned the meeting at approximately 6:57 p.m.

Next meeting

The next Primary Care Reform Collaborative meeting will be held on Tuesday, December 10, 2019 at the Medical Society of Delaware located at 900 Prides Crossing, Newark, DE 19713, from 5:00 p.m. to 7:00 p.m. p.m.