SB 227 Primary Care Reform Collaborative Meeting

Wednesday, January 8, 2020
5:00 p.m.
Medical Society of Delaware
900 Prides Crossing, Newark, DE 19713

Meeting Attendance

Collaborative Members:

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

Absent:	**Organization:**
Dr. Jeffrey Hawtof	Beebe Healthcare/ Delaware Healthcare Association
Leslie Verucci	Delaware Nurses Association
John Gooden	MDavis, Inc. /DSCC
Margaret Norris-Bent	Westside Family Healthcare
Leslie Ledogar	Department of Insurance
Hon. Kara Odom Walker	Department of Health & Social Services

Staff:

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

Attendees:	**Organization:**
Jamie Clark	Nemours
Elizabeth Staber	Aetna
Kiki Evinger	Department of Health & Social Services
Tyler Blanchard	Aledade

Regina Heffernan	AmeriHealth Caritas Delaware
Katherine Impellizzeri	Aetna
Jennifer Mossman	Highmark DE
Elisabeth Scheneman	Department of Health & Social Services
Pam Price	Highmark
Dr. Susan Conaty-Buck	Delaware Coalition of Nurse Practitioners
Ayanna Harrison	Department of Health and Social Services /DHCC
Sascha Brown	Aetna
Margaret Defeo	AmeriHealth Caritas Delaware
Bill Howard	BDC Health IT
Claudia Kane	DCHI
John Dodd	BDC Health IT
Larry Glazerman, MD	Highmark
Karyn K. Scout	AmeriHealth Caritas Delaware
Sylvia Cat	Delaware Pediatrics
Julane Miller-Armbustic	DCHI
Emmilyn Lawson	AmeriHealth
Paul Speidell	CVS Health/Aetna
Bernard M. Cohen	AmeriHealth Caritas Delaware
Bryan Gordon	Christiana Care
Drew Berenard	AmeriHealth Caritas Delaware
Kevin Leonard	AmeriHealth Caritas Delaware
Lizzie L. Zubaca	Hamilton Goodman Partners, Inc.
Wayne Smith	Delaware Healthcare Association
Shay Scott	Henrietta Johnson Medical
Dr. Muller	Stoney Batter Family Medicine
Kim Gomes	Byrd Group

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

Welcome

The meeting convened at approximately 5:05 p.m. at the Medical Society of Delaware, 900 Pride Crossing, Newark, Delaware 19713. Representative Bentz welcomed all attendees and informed committee members Dr. Fan would arrive shortly. Representative Bentz also shared that the order of the agenda had changed.

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

The meeting began with an update from the Department of Insurance given by Insurance Commissioner Trinidad Navarro. Commissioner Navarro shared that Leslie Ledogar was unable to attend due to a scheduling conflict and instead agreed to come and present an update on the progress to implement the Office of Value Based Health Care Delivery. The Request for Proposal (RFP) was posted on Office of Management and Budget's myMarketPlace Bill Solicitation Directory *http://bids.delaware.gov/* on 11/15/2019. The Department of Insurance reached out to a variety of outlets to ensure that the RFP was widely advertised. Questions were timely received from seven potential bidders. He did not publicly announce the bidders, siting that DOI wants to ensure the process is objective. The Questions and the

Department's responses were timely posted in two documents, which are also available on the Bid Solicitation Directory *http://bids.delaware.gov/bids_detail.asp?i=6037&DOT=N*. The deadline for the submission of the bids was Friday, January 10 at 4:00pm EST. The bid review team will begin their review process on Monday, January 13th. Commissioner Navarro reports that DOI anticipates the review process will be completed within two weeks. Scores will be submitted to him on or before February 10th. Lastly, he reported that his goal is to notify the successful bidder on or before February 19th. He concluded by reporting the current schedule places them ahead of the projected timeline for the completion of the implementation tasks. Commissioner Navarro opened the floor for comments and/or questions.

Introductions

Representative Bentz invited those joining via conference call line to identify themselves. Several individuals on the phone provided their names and affiliations: Wayne Smith, Delaware Healthcare Association, Shay Scott, Henrietta Johnson Medical, Dr. Muller, Stoney Batter Family Medicine, Jaime Clarke, Nemours, Kim Gomes, Byrd/Jones Group and board member Dr. Mike Bradley, Medical Society of Delaware.

Representative Bentz continued introductions by asking board members seated around the table to provide their names and affiliations for the record; Representative Bentz, Senator Townsend, Dr. Chris Donahue, Christiana Care/Delaware Health Care Association, Veronica Wilbur, Century Medical Center/Delaware Nursing Association, Dr. Jim Gill, Medical Society of Delaware, Steven Costantino, DHSS, Emmilyn Lawson, President of AmeriHealth Caritas of Delaware, Steve Groff, Medicaid Director/DHSS, Faith Rentz, Kevin O'Hara, HighMark, Chris Morris, Aetna, Mike Gillmartin, MDavis, Inc./DSCC, Commissioner Trinidad Navarro, Department of Insurance, Ayanna Harrison, Delaware Health Care Commission/DHSS (administrative support).

Representative Bentz once again noted that Dr. Fan had a scheduling conflict and would be joining the meeting shortly. At that time, he opened the floor to members who may have questions for the Insurance Commissioner regarding the Office of Value Based Health Care Delivery update. There were no questions or comments and the meeting was moved to the next agenda item to be covered, a presentation entitled "Delaware Medicaid Value Based Purchasing". Representative Bentz yielded the floor to Steve Groff, Medicaid Director/DHSS.

Medicaid/MCO update with Value Based Payment Models and PCMH

Mr. Groff's presentation, "Delaware Medicaid Value Based Purchasing" began with an overview of their approach to intergrating value-based purchasing into their 2018 contracts. He stated 2018 was the first time they explicitly included any value-based purchasing previsions in the managed care contracts. The approach focused on a dual strategy which included a focus on cost savings and quality performance measures. The first being "Quality Performance Measures" (QPM) and the second "Benchmarks for proportion of total spending attritubtable to value based purchasing contracts". Financial penalties will be assessed for failure to meet requirements in either area.

Seven quality measures were selected. Medicaid believes the selected measures address priority areas for the health of Delawareans. These seven included: Diabetes Care, Medication management for people with

asthma Cervical Cancer Screening, Breast Cancer screening, BMI Assessment, Prenatal and postpartum care, 30-day hospital readmission rate.

Next, Mr. Groff highlighted the appendix provided of the Medicaid master settlement agreement. The document outlines the value-based purchasing strategy, defining each QPM and outlining the benchmarks. All quality performance measures, except for the "30-day hospital readmission rate", will focus on HEDIS measures. Benchmarks were set using this methodology. allows Delaware Medicaid to assess their measures against national performance. During the first year of the contract most of the measures are set at the 50th percentile. Nationally some of the measures are set higher than 50th percentile. For value-based purchasing they would like to focus on moving up the continuum toward total risk, however they recognize they need a starting point for MCO providers and their contracted providers. They emphasize "Shared Savings", however their goal is to move into "Bundled/Episodic Payments" and "Risk/Capitation" focused on "Total Cost of Care".

Mr. Groff reported that in 2018 Medicaid set a percentage of total spend that had to be in contracts with their definition of Value Based Purchasing. In 2019, Medicaid will allow all contracts to be in any type of Value Based Purchasing arrangement but the percentage of spend will be increased. As Medicaid moves into 2020- 2022 they plan to continue to increase the percent of total spend that is expected in Value Based Purchasing. However, within this increase benchmarks are set for the percent of contracts that need to be in a bundled or total cost of care arrangement and not simply a shared or risk savings.

Mr. Groff encouraged members to review the document entitled, "Medicaid Managed Care Contracts as Instruments of Payment Reform". This document includes the full contract language (https://dhss.delaware.gov/dhcc/files/hmavbpmedicaid_122019.pdf).

Mr. Groff reported that in December Medicaid issued a proposed regulation around how they will introduce Accountable Care Organizations (ACO) into Medicaid. The implementation goal for this plan is 2021. The proposed regulation authorizes Medicaid to "certify" the application process for ACO to apply to Medicaid program at DMMA. The "certification" will allow Medicaid to ensure ACOs meet their established standards. In 2021, Delaware Medicaid all contracts with Managed Care Organizations to will include language regarding their ability to contract with the Accountable Care Organizations. Mr. Groff opened up the floor for questions or comments.

Dr. Gill shared that he felt this plan was moving in the wrong direction. He stated that it was his opinion the measures currently used in value-based plans to assess value are inadequate and have little to do with true value. He added that the documentation requirements force providers to focus on specifics that remove their attention from actual good primary care practices. He added that the concept of checking "more boxes" places an administrative burden on providers. He stated that the plan presented mirrored older, inefficient plans.

He continued by encouraging members to abandon this approach and move toward improving access to care, especially primary care. He suggested the group focus on "what is primary care?", "How do you measure primary care?" and "How do you value that?" He shared that in his opinion providers are leaving primary care because they are held responsible for cost which they do not control. He encouraged the

group to discontinue the use of value-based because it has begun to carry a negative connotation among primary care providers. Dr. Gill stated that even visiting a primary care provider creates value. He encouraged the committee to consider how they will enhance and attract more providers to primary care? Dr. Gill suggested that quality care includes: access to care, continuity, establishing relationships and establishing trust. He concluded by asking members to begin to consider strategies that are focused on access to care and quality of primary care in Delaware. There was some discussion about the agreed upon definition of Primary Care and how the group will measure quality and value.

Mr. Groff stated that it is necessary to measure quality and outcomes when considering any definition of value-based care. He continued by asking Dr. Gill for alternatives to measuring quality based on the four areas that he mentioned.

Dr. Gill referenced a presentation he shared with the committee that provided an overview of how to measure primary care. He stated that measuring primary care includes assessing continuity, comprehensiveness, access and coordination. Additionally, establishing relationships and trust could also be utilized to measure quality. He mentioned that his past presentation included several surveillance methods. Dr. Gill shared that in his opinion HEDIS measures do not measure true quality. The key to quality is access to good primary care. He encouraged the committee to consider strategies to promote primary care. New providers are not choosing primary care and existing providers are leaving. He encouraged the committee to focus on promoting the use of primary care.

Steve Costantino stated that the plan presented by Mr. Groff was an RFP for MCO/ACO relationship. Imbedded in any strong ACO is primary care. He shared that the plan is not a substitute for primary care but a model to fund good primary care. The uptake on this plan will be telling and lessons will be learned. He concluded by emphasizing the plan is not a substitute but a new way to finance a broad range of services including primary care as the "spine".

Senator Townsend asked that the dialogue be continued during a future meeting. He thanked Mr. Groff for his presentation and introduced Emmilyn Lawson from AmeriHealth Caritas of Delaware as the next presenter.

A copy of Mr. Groff's presentation is available at
https://dhss.delaware.gov/dhcc/files/devaluebsedpurchprespcc_01082020.pdf

Assessment of upfront investments by ACOs (tentative)

Dr. Lawson began her presentation by stating the state is not expecting all providers to move to a global payment model. She shared the company's progress from beginning to present. AmeriHealth Caritas went live 1/1/2018. Efforts began with converting letters or intent to contracts and verifying doctors' credentials. The company conducted a large amount of outreach to ensure all members who did not have a provider listed were contacted and assigned a provider. This is a contractual requirement. She shared information about the company's network adequacy requirements and access standards. Test are conducted monthly to assess how long patient wait for an appointment with their assigned provider.

Once they had completed full implementation they launched their Value-B program. They had to aggressively identify partners that were already doing work with value-based programs. AmeriHealth has signed several value-based agreements. They are partnering with ChrisitianaCare. ChristianaCare is currently taking on risk.

Dr. Lawson shared that while analyzing ChristianaCare data they found there was a disconnect between members enrolled in the program who had not selected a provider and were assigned a provider. A considerable amount of outreach was necessary to ensure members were provided accurate information. Medicaid members do not need report the providers they plan to visit however they are encouraged to share this information. Not having accurate information affects the payment model.

AmeriHealth Delaware expects to continue to evolve their analysis, to uncover barriers that are preventing members from access to care. They are partnering with Nemours to develop a value-based payment model that seeks to address social determinants of health and health inequity.

In 2020, AmeriHealth plans to launch PerformPlus Quality Enhancement Program (QEP) for primary care providers not enrolled in an existing value-based program. Information has been sent to their providers. AmeriHealth also plans to identify opportunities for additional provider/payer collaborations in support of their 2022 targets.

The presentation concluded with a list of lesson learned: The collection of comprehensive data is important to measure the effectiveness of programs; data extraction and interfaces reduce administrative burden for providers and payers; payers and providers need to better leverage DHIN capabilities; Increased reimbursement without improved quality does not reduce total cost of care; payment transformation requires ongoing collaboration between payers and providers; and the quality of provider/payer collaboration is a critical success factor.

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

Senator Townsend revisited the discussion between Dr. Gill and Mr. Groff. During the discussion it was agreed that the definition of primary care had been decided and agreed upon during past meeting. The definition was established to assist the collaborative with identifying costs that are attributed to primary care, thus calculating primary care spend.

Dr. Gill suggested that the collaborative move toward valuing and measuring primary care not creating reports that become administrative burdens for primary care physicians. Reporting requirements and the attribution of uncontrollable costs (hospital visits, stress tests, etc.) to primary care providers, are a few f the factors that are driving existing care providers away and deterring new providers from joining.

Mr. Groff stated that he did not believe there was a fundamental disagreement. It was his opinion that the two of them were communicating from different perspectives. He apologized and reemphasized that the plans presented can only be successful with strong, quality primary care.

Veronica Wilbur voiced some concern with the continued administrative burden providers are faced. She stated that insurance dictates how providers care for their patients. She reported that she has six and a half pages from a payer that she must complete to receive payment. She continued by thanking Senator Townsend for visiting her practice. She reported is still dealing with same issues they discussed during his visit, however wanted to note that she appreciated his time and concern. As she concluded her statements she mentioned the need for easier access to DHIN. Smaller practices face several obstacles when trying to share or access patient records. Access is costly and larger health systems can afford services, placing smaller practices at a disadvantage. Dr. Fan agreed that DHIN access is an important issue however she suggested it be discussed during another meeting.

Mr. Groff shared that the catalyst for the data requests sent to providers is driven by external requests that his office is mandated to report. He mentioned that all government programs are driven by their Federal counterparts. The reporting requirements are not internally driven. State programs collect the data they are required to report.

Steve Costantino reminded the committee that the plans presented are all voluntary. There are two tracks that have been developed, each with varying risk levels. Unlike Massachusetts, Delaware decided that participation would not be mandated. ACOs have the freedom to apply if they find the plans attractive. He continued by sharing that Total Cost of Care models can be a "best friend" or "worst enemy". The system of total cost of care can be beneficial if the practice is able to control high end cost and is able to reinvest the money saved. There are other times that benchmarks are not met because they were unable to manage the cost of a high cost in the geographic area or state and as a result they did not gain any savings. In some cases, they experience loss. The market plays a major factor in the success of total cost of care models. He concluded by adding there are only three, all-payer/total cost of care models in the country (VT, PA, and MD). Rhode Island's model includes primary care spend and they employed an application process with an end date. Delaware felt the first step would be to see if there was an ACO that would be willing to take on this type of model.

Dr. Donahue added that ChristianaCare fully supports moving to a Total Cost of Care model. Their limited exposure to different risk contracts, have motivated them to make infrastructure changes, team-based model that will drive success. She reports that during this fiscal year starting with July they have increased their new patient visits by 60% over the same time last year. Health systems have access to more resources, however within ACO or clinical integrated networks similar resources can also be brought to bear, with a total cost of care on the back end. She encouraged the committee to seek strategies to look at the full picture instead of simply increasing the fee for service renew related to primary care. She cautioned that the later could result in an increase in spending without achieving the desire outcomes.

Dr. Fan stated that while discussion like this (Medicaid MCO/ACO) are beneficial and knowledgeable, the committee is not a consensus driven process. The goal is to come to an alignment about certain areas that can moved forward. She cautioned against the committee focusing on creating one solution to solve the system, instead she encouraged the group to focus on identifying core components of a payment model. She revisited the statement made suggesting the committee consider discontinuing the use of the term "value- based". She agreed that value-based payment should not only reflect quality metrics. She added that the term value-based payment has varying definitions. Once again, Dr. Fan reminded the collaborative

that they have been charged with developing recommendations and identifying the core components of a payment model that can supported within the state.

The discussion shifted back to the presentation provided by AmeriHealth. Dr. Fan asked Dr. Lawson if there was data to support the PerformPlus program's success in other states. Dr. Lawson affirmed that assumption and added that AmeriHealth has similar programs in other states, that are successful. Dr. Lawson noted that the program designed for Delaware is a broader, more general incentive program. AmeriHealth conducts regular data reviews and successful providers are identified and issued immediate incentives. Dr. Lawson added that the incentives are not chosen arbitrarily. They are in alignment with Sec. Walker's guidance. AmeriHealth is also measured and penalized If their membership does not meet quality thresholds.

Dr. Fan asked if the program will transition into a non-fee for service? Dr. Lawson confirmed that PerformPlus is a fee for service program that includes incentives for quality performance (at the back end). Mr. Groff shared that RFP ACO Medicaid plans he presented do not include any administrative burden or extra reporting. Providers will not be expected to complete additional tasks outside of what they were already providing. Medicaid analyzes the data and calculates the incentives internally. Dr. Fan continued the discussion by stating that she agreed with Dr. Gill and Veronica when they express concern with supporting plans that increase the administrative burden of providers.

Dr. Fan asked if Medicaid considered their provider audience and if the intent is to market to more advanced practices. Mr. Groff reported that they recognize that there will be a group of providers that will not want to or be able to participate in the environment. The goal is to stimulate interest to assess if there is capability to form these groups and to incentivize them. Dr. Fan asked if the committee believes they can reach the goal of having 60% of Delawareans in a value-based payment model. She continued to ask if the members felt the goal was unrealistic or necessary, adding that now is the time to make any necessary edits.

Dr. Gill stated the collaborative's goal should be to enhance primary care. He suggested they consider shifting the focus to how to make primary care work instead of developing value-based payment and total cost of care models. Mr. Groff stated that it is not possible to have a conversation about enhancing primary care without addressing costs.

Dr. Bradley shared that he has an advanced primary care practice for over ten years. One of the problems they are facing is obtaining timely meaningful data that will allow them to assess whether they need to implement changes. His practice is in contract with AmeriHealth. They are beginning their third year this month and they did not receive their first-year data dump until November of this year. Providers cannot make improvements until they have the capability to assess their progress by looking at the data. He added that the cost that are attributed to primary care physicians are outside of the control of the primary care. In the past Medicaid patients were required to obtain authorization from their assigned to primary care provider. This process is no longer required. Dr. Bradley encouraged the collaboration to focus on shifting the cost of hospital care, pharmacy benefits and specialist away from primary care. He stated this practice is driving primary care out of business. Insurance companies give providers failing grades because of these costs. Primary Care providers are frustrated.

Dr. Fan concluded this discussion by stating that within the system of health care it is impossible to address issues without talking about costs. She continued by stating that she believes there is a better model, however she doesn't want the collaboration to be weighed down trying to find the "best". She encouraged the collaboration to focus on first developing a "good" model and then move towards the "best".

Primary Care Reform Collaborative Survey Results

Dr. Fan agreed that the issues surrounding cost are important. She suggested they be discussed in future meetings. She continued by reporting that she was pleased with the points that were mentioned in the survey. The discussion transitioned to the survey recently disseminated to collaborative members. Survey results include responses from 14 of the 17 members. The purpose of the survey was twofold; Assess approach to self-insured organizations for data collection to calculate primary care spend with total health care spend and assess the viability of aligning care model with payment reform. The presentation summarizing survey results is available at: https://dhss.delaware.gov/dhss/dhcc/files/erisacremodelsrveyreslts.pdf.

Dr. Fan began by reviewing the first question regarding accessing claim-based data. There was some discussion about strategies to encourage self-insured employers to provide data voluntarily. Financial incentives were mentioned however it would be difficult to secure funding. The group discussed the possibility of legislation and agreed they would face challenges obtaining the support. Survey results from the question show the majority of collaborative members voted for establishing a Learning Collaborative. A Learning Collaborative would allow the self-insured to learn the benefits of the all-payer claims data based or the health care claims database and the sustainability of primary care. Members present agreed to move forward with making the recommendation to establish a Learning Collaborative.

Kevin O'Hara mentioned there would be some difficulties and challenges with getting the right constituents around the table. He suggested that the group include third party administrators, client groups, and representation from the collaborative. Dr. Fan also suggested they consider forming a subcommittee task force that would include representation from the collaborative. She added that it would be necessary to include representation from the payers and individuals who work directly with the self-insured that understand what the needs and deficits.

Steve Costantino asked if the collaborative is interested in the data to go be included into the health care claims database or to be used to calculate primary care spend. If the collaborative wants primary care spend from self-insured, aggregated data can be collected through the benchmarking process. Steven mentioned that the work would be completed by the Health Care Commission. He reported that he had spoken to the consultant completing the work and they were confident they could obtain the data by including the request with the request for benchmark data. Dr. Fan discussed they want to be able to extract the data from the DHIN through the Office of Value Based Health Care Delivery (OVBHCD). She reminded the collaborative that the OVBHCD has been tasked with calculating the primary care spend. Kevin O'Hara agreed to make the request. Dr. Fan reiterated that the request would include the same years that were included in the OVBHCD, years 2017 and 2018.

Dr. Fan stated that the primary care is foundational to a health care delivery system in Delaware. All present agreed. She asked if the collaborative wanted to recommend a clinical care model that supports a value-based payment model. According to the result of the survey the majority agreed. The core value of a patient centered medical home should be the framework that supports a value-based payment model. Members presented agreed that the collaborative is not tied to the NCQA definition framework of what should be in a PCMH. They agreed to embrace core measures (the four C's). The framework does not need 40 quality metrics. 48 to 80 hours of certification and $10,000.

The discussion transition to the consideration of other care models. Results from the survey show the majority agreed the collaboration should consider other care models, however members did not include recommendations. Dr. Fan stated that team-based care models can be considered a variation of a patient centered medical home. The difference is these models requires infrastructure. She opened the floor for members to discuss other possible care models. Members were asked to prepare brief presentations of alternative care models and prepare to share them with the group. These alternative care models need to have payment models attached. Dr. Fan reminded the members of the need to move forward with a clear recommendation.

Question four was discussed next. This question covered the agreement to develop a NCQA-like certifying body. The results indicate members do not have strong feelings about this topic. Dr. Fan reminded the members of the presentation Dr. Gill provided that included 12 alternative types of NCQA certifications. Dr. Fan stated that this topic would need to be placed on a future agenda and discussed in more detail.

The results for question five indicate the majority agreed with including additional payment incentives for practices with Patient Centered Medical Home (PCMH) like core values and practice infrastructure. Dr. Fan moved to review the results for question eight ("Building a sustainable primary care practice infrastructure...".) These results show that the majority of respondents selected "Care coordination payments" when considering mature practices.

There was a brief discussion surround the Primary Care First model. Dr. Fan noted that 41% of respondents strongly agreed with question 6, "Transitioning practices away from fee for service to alternative value-based payment models could include upfront investments with prospective payments and risk-based incentive payments (Primary Care First)." Some expressed concern that there would not be a significant amount of uptake. It was also mentioned that there was very little interest in making Primary Care First into a multi-payer model. Dr. Gill commented that he was surprised by the level of agreement. He questioned whether the payment would be enough. Dr. Fan mentioned that while not perfect, this model should be viewed as a positive step forward. Dr. Gill agreed with that sentiment.

Recommendations for annual report

Before concluding the review of survey results, Dr. Fan asked if members wished to revisit any of the questions or their results or if they were comfortable developing recommendations. She continued by reminding the members that SB227 mandates the development and presentation of annual recommendations. There was some discussion on how the collaborative would present these recommendations. The previous year recommendations were provided in a report format that included a summary of the minutes. Dr. Muller stated that a report, showing the collaborative's progress and future

goals would be a great idea. All members agreed to develop annual recommendations in the format of the report.

Next, Dr. Fan provided a brief overview of Colorado's Primary Care and Payment Reform Collaborative's first annual report (https://dhss.delaware.gov/dhss/dhcc/files/copcpymtrfrmcollabrecrpt_121519.pdf). This report was disseminated in meeting materials. Dr. Fan highlighted the collaborative's definition of primary care spend. She asked the members of the committee it consider topics they want to be included in the calculation of Delaware's primary care spend. These recommendations will be shared with the Office of Value Based Health Care Delivery (OVBHCD). Committee members were asked to email top-level topics they recommend be included in primary care spend calculation.

The last slide of Dr. Fan's presentation included the current consensus of the collaboration. She restated the definition of Primary Care providers as stated in SB227: family practice, internal medicine, geriatrics, pediatrics, physicians, Nurse practitioners, and physicians' assistants. The collaborative also reached a consensus on the recommendations for the Office of Value Based Health Care Delivery (OVBHCD). These recommendations included the use of all-payer claims database (DHIN) to calculate the primary care spend. Members also agreed that a presentation from DHIN would be helpful. Dr. Fan agreed to contact DHIN and extend an invitation to present during a future collaborative meeting. The committee also decided to move forward with the development of a Learning Collaborative.

The group discussed how to handle the specifications of the primary care calculations. Dr. Fan mentioned that Washington did not include non-claims data, but Oregon decided to include them. The collaboration has already agreed to exclude pharmacy and hospital cost. Dr. Fan asked if members felt identifying specifications was the work of the collaborative or the work of the OVBHCD. She continued to report that OVBHCD will be staffed by a consultant is due to open in April 2020. Dr. Gill commented that a high level of technical expertise is necessary to complete specifications. He felt that the committee was not equipped with the required skills. He suggested we allow OVBHCD to handle this work. Kevin Ohara agreed that the committee should not develop the specifications, however he asserted that it was the committee's responsibility to obtain a level of understanding and come to a consensus once specifications had been identified. Dr. Fan suggested we develop a subcommittee to attend meetings with OVBHCD and report progress to the larger committee. Dr. Fan asked that members email their recommendations of top-level topics to be included in primary care spend under specifications. She added that members can provide recommendations on any data collection they wanted included.

Steven Costantino asked if the collaboration was willing to accept a calculation of primary care spend based on 40% (self-insured) of the claims data not being included. Dr. Fan stated that the committee had agreed during a previous meeting that data from the Health Care Claims Database (HCCD) would be used to calculate primary care spend. Members were aware that the ERISA/self-insured data would not be included. Dr. Fan continued her comment by stating DHIN reports the missing data a closer to 35%, meaning the final calculation will capture approximately 60%. Steven Costantino suggested a caveat be listed in the report. Dr. Fan agreed that a disclaimer would be added recognizing the data may be incomplete due to the lack of data from particular groups.

Dr. Fan concluded this portion of the discussion by agreeing to prepare a compilation of the submissions from members and present the list during the next meeting for review, discussion and voting. She asked members to submit their recommendations to her in a timely manner.

Review of Minutes and Adoption of Standard Operating Procedures

Dr. Fan mentioned that the minutes had not been reviewed or approved however due to timing she suggested this order of business be addressed during the next meeting. All members present agreed. At this time Dr. Fan brought members attention to Appendix H of Colorado's report (Standard Operating Procedures and Rules of Order, page 77). She asked the committee is they were interested in adopting standard operating procedures. The mandate to form the collaborative did not include guidelines on appointments (length of time, etc.). Members agreed that everyone should carry voting privileges. There was some discussion regarding whether substitutes carry proxy voting rights. All agreed to grant proxy voting rights to assigned substitutes and develop term guidelines. When possible, members will identify their substitutes in advance of the committee meeting by providing their name to the collaborative chair and co-chairs.

Dr. Fan concluded the meeting by suggesting the collaborative adopt a standard meeting date. She noted there may be some conflicts during the legislative season. She suggested disseminating a poll to assist in identifying a consensus on regular day of each month. All members agreed with this plan. There was no further discussion among committee members.

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 Monday February 10, 2020, at the Medical Society of Delaware located at 900 Prides Crossing, Newark, DE 19713, from 5:00 p.m. to 7:00 p.m. p.m.