# Primary Care Reform Collaborative Meeting

Monday, November 16, 2020
5:00-7:00 p.m.
Webex Meeting ID: 173 586 0002, Meeting password: TRdAQ8t3Kt3
Audio/Call-In Number: (408) 418-9388
Access Code: 173 586 0002

## Meeting Attendance

**Collaborative Members:**

| Present: | Organization: |
|---|---|
| Dr. Nancy Fan, Co-Chair | Delaware Healthcare Commission |
| Senator Bryan Townsend, Co-Chair | Senate Health & Social Services Committee |
| Kevin O'Hara | Highmark Delaware |
| Dr. James Gill | Medical Society of Delaware |
| Sasha Brown | Aetna |
| Steven Costantino (Proxy for Secretary M. Magarik) | Department of Health & Social Services (DHSS) |
| Leslie Ledogar (Proxy for Commissioner Navarro) | Department of Insurance |
| Steve Groff | Division of Medicaid & Medical Assistance |
| Dr. Christine Donohue Henry | Christiana Care/Delaware Healthcare Association |
| Dr. Michael Bradley | Dover Family Physicians/Medical Society of Delaware |
| Dr. Susan Conaty-Buck (Proxy for Leslie Verucci) | Delaware Nurses Association |
| Dr. Veronica Wilbur | Next Century Medical Care/ Delaware Nurses Association |
| Faith Rentz | State Benefits Office/DHR |
| Margaret Norris-Bent | Westside Family Healthcare |

| Absent: | Organization: |
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| Representative David Bentz, Co-Chair | House Health & Human Development Committee |
| Dr. Jeffrey Hawtoff | Beebe Healthcare/ Delaware Healthcare Association |
| John Gooden | MDavis, Inc./DSCC |
| Mike Gilmartin | MDavis, Inc./DSCC |

**Staff:**

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| Read Scott | Read.Scott@delaware.gov |

| Attendees: | Organization: |
|---|---|
| Andrew Sheinen | Cigna |
| Andrew Wineinger | Cigna |
| Ayanna Harrison | Department of Health and Social Services/DHCC |
| Bela Gorman | Gorman Actuarial |
| Bill Howard | BDC – Health |
| Cheryl Mongill | Family Greenhill Medicine |
| Deborah Allen-Brown | AmeriHealth Caritas Delaware |
| Deborah Hamilton | Hamilton Goodman Partners |
| Sara Pletcher | Delaware Diabetes Coalition |
| Eunji Elizabeth Staber | Aetna |
| Elizabeth Lewis | Hamilton Goodman Partners |

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| Pamela Price | Highmark |
| Dr. Sarah Mullins | Stoney Batter Family Medicine |
| Elizabeth Staber | Aetna |
| Katherine Impellizzeri | Aetna |
| Dr. Liz Brown | Department of Health and Social Services |
| Tyler Blanchard | Aledade |
| Mary Jo Condon | Freedman Healthcare |
| Kim Gomes | Byrd Gomes |
| Lisa Zimmerman | Department of Health and Social Services |
| Lori Ann Rhodes | Medical Society of Delaware |
| Mollie Polland | Nemours |
| Claudia Kane | Delaware Center for Health Innovation |
| Bryan Gordon | ChristianaCare |
| Lincoln Willis | The Willis Group |
| Cindy Ward | Mercer |
| Jill Hutt | Delaware Health Information Network |
| Dr. Kathleen Willey | Quality Family Physicians PA |
| Komal Patel | Quality Family Physicians |
| Bruce Landon | Department of Healthcare Policy, Harvard |
| Dr. David Krasner | Family Practice Associates PA |
| Sheila Grant | AARP |
| Selvam | ChristianaCare |
| Vinayak Sinha | Freedman Healthcare |
| Wayne Smith | Delaware Health Associates |
| Tanisha Merced | Department of Health and Social Services |
| J. Freedman | Freedman Healthcare |
| Lauren Graves | |
| Paula Smith | |

**The meeting was called to order at 5:00 p.m.**

**Welcome**

The meeting convened at approximately 5:00 p.m. via the State of Delaware Webex system https://stateofdelaware.webex.com/stateofdelaware/j.php?MTID=m7302b41fc341d774722a9f8bc0610cfe

Dr. Fan welcomed all attendees and reminded them the meeting would be recorded. Members announced their presence as record of attendance. Dr. Fan confirmed that Dr. Susan Conaty-Buck will be serving as proxy for Leslie Verucci, Leslie Ledogar will be serving as proxy for the Insurance Commissioner Navarro. Ms. Ledogar is also representing the Office of Value Based Healthcare Delivery. A quorum was confirmed. Public attendees were asked to submit their name and affiliation to Read Scott via email (Read.Scott@delaware.gov). Attendees were also asked to keep their computers and phones on mute while not making a comment. Dr. Fan briefed members on the meeting agenda and transitioned the meeting to the approval of the October minutes.

**Approval of October 2020 Minutes**

Dr. Fan asked the members if they had any comments on the draft minutes from the Primary Care Reform Collaborative meeting, held on October 19, 2020. The following edits were requested: Faith Rentz pointed out the mention of the "October" meeting minutes (bottom of page 8) should be updated to "November". Dr. Fan asked if the members of the collaborative agreed to approve the minutes, understanding the necessary corrections would be made. Dr. Jim Gill made a motion to approve; the motion was seconded by Kevin O'Hara. The motion to approve

was unanimously carried. Approved minutes for the October meeting can be viewed here: https://www.dhss.delaware.gov/dhss/dhcc/files/octoberminutes2020.pdf

**Office of Value-based Healthcare Delivery (OVBHCD) Presentation**

Dr. Fan invited Mary Jo Condon, Vinayak Sinha, and Leslie Ledogar to share their progress to identify Affordability Standards. Ms. Condon began her presentation (*Provisional Affordability Standard Targets* - https://dhss.delaware.gov/dhss/dhcc/files/affordablestandard.pdf ) by introducing the members of the OVBHCD team. Ms. Condon is a Senior Consultant at Freedman Healthcare and also the Director of the Office of Value Based Health Care Delivery within the Department of Insurance (DOI). Ledogar greeted the members of the Collaborative and explained that she was the Director of the DOI Office of Legal and Special Projects. Ms. Ledogar thanked the attendees for their time and stated that she looked forward to receiving input from the members and public. Ms. Condon also introduced Dr. John Freedman, the president of Freedman Healthcare, Dr. Bruce Landon, Harvard Professor, Belly Gorman, Gorman Actuarial and Vinayak Sinha, the Project Manager of OVBHCD.

Ms. Condon reviewed the statutory charge given to the OVBHCD: Increase the availability of high quality, cost-efficient health insurance products with stable, predictable, and affordable rates and to establish targets for carrier investment in primary care to support a robust system of primary care by 2025. In order to achieve these goals simultaneously, smaller increases in spending on non-primary care services must be targeted, limiting cost growth in other areas. Ms. Condon stated that the presentation outlines an integrated approach that includes three affordability standards that aim to cover both statutory charges.

Ms. Condon continued by providing some insight on feedback the OVBHCD has received from Delaware's Stakeholder across more than 20 organizations. She thanked everyone on that call that has contributed by lending their time and providing their feedback. She added that feedback received helped shape their work. Ms. Condon reported working closely with DHIN, Delaware's ACPD to collect data on hospital and health plan regulatory and tax filings and data on primary care spending and other type of spending. They also received extensive data from Delaware's health insurance carriers. They investigated multiple sources when possible to confirm findings from one with finding from another. Ms. Condon shared the consistent themes that were identified; Delaware has an older, sicker population, Delaware's health systems and health insurance markets are consolidated, and there is limited access to primary care in the State. Stakeholders noted that these three market forces worked together to lead to high health care premiums and high health care cost growth. OVBHCD spent considerable time analyzing the data and found that their perspective was supported.

The OVBHCD spoke with consumers and consumer advocates. These groups shared that the primary care access was incredibly compromised (i.e. prescription refill delays, patients with chronic conditions that could not get an appointment). This feedback was also consistently shared among primary care providers that were interviewed.

Ms. Condon shared that Delaware is the 4th highest per capita spending in the nation, nationally per capita, the 9th highest in cost growth in per capita spending. OVBHCD was interested to know how this impacts premiums. Delaware is 5th highest average premium in the nation for individual markets, and the 4th highest average premium in the nation for small group markets. She clarified that the data does not reflect the impact of the state reinsurance program, which is expected to help stabilize the health insurance marketplace. The average cost of care for Delaware residents with commercial insurance more than $7,000 in 2019, a 6.4% increase over the previous year. The grow was more than twice as fast as per capita income in the state. Looking ahead, the rate of growth in spending verses the rate of growth in income is not sustainable.

Ms. Condon reports that they began to research the drivers of the health care cost increase. In most states, increases in health care cost are driven by price. In Delaware, the increase of cost is driven by price and utilization. The older, sicker population may be a contributing factor, compounded by a lack of access to primary care. When these patients are not able to access primary care, they receive care from specialist to treat conditions that could have been addressed within the primary care setting. The result is added cost to the system and unnecessary suffering and reduced quality of life for Delawareans. Ms. Condon also highlighted the drivers associated with price growth, pointing out the differences between hospital services and physicians. There have been double digit increases across the three years for the hospital, while at the same time professional services (primary care, nurse practitioner, etc.) only increasing approximately one-half percent (not even at the rate of inflation). Ms. Condon also shared that feedback from physicians could be categorized as concerned. She added that compared to other states, Delaware residents are more likely to be older, obese/sedentary, and tobacco users.

Ms. Condon discussed their research on the hospital market share in the state. They used the Herfindahl-Hirschman Index (HHI) which is a commonly accepted measure of market concentration. Delaware's HHI is 33.29, which exceeds the 2,500 threshold that is used to define a highly concentrated market. She pointed out that the most states have this same amount of concentration. This does not set Delaware apart from the others, however, when reviewing hospital's percent of discharges within their service areas. The results of their analysis show two systems with over 80%, two around 45% and two at 25%. Ms. Condon invited Dr. Freedman to share his insight on this topic.

Dr. Freedman added that there is a lot of concentration in many markets. Adding that the Depart of Justice categorizes the concentration in levels: moderately concentrated and highly concentrated. Based on his experience with other states, this is an unusually large amount of concentration for any region.

Ms. Condon continued, stating that health plans can feel compelled to accept prices in order to avoid having a major system out of network. Commercial prices for hospital services have gone up considerable while increases for prices in professional services have been almost non-existent. The presentation provided the result of the operating, total or excess margins of Delaware Acute Care Hospitals. She reported that they analyzed hospital spending in Delaware from a variety of perspectives and data sources. They consistently found that hospital spending in Delaware is higher. The best data available suggested Delaware is about 20% above national average on a risk adjusted basis.

The presentation also included data from the RAND report. Commercial prices for hospital-based services in Delaware were 244% to 334% of Medicare. The professional services were only 110% of Medicare. She pointed that this was the lowest differential in the nation.

Stakeholders expressed their belief that the low physician reimbursement rates were contributing to the lack of physicians in the State and poor primary care physician access. A report published by the Department of Health found that Delaware primary care providers declined 6%, between 2013 and 2018. That decrease was coming as the State's population was not only growing but become older. This discrepancy places more stress on the providers practicing in the State. Conversations with physicians indicate practices are closing and the providers that are staying are moving into concierge care. Stakeholders also shared that recruitment efforts are increasingly difficult due to the following: healthcare systems starting primary care residency programs, the lack of a state medical school, the perception of lower income potential and the reality of lower reimbursements rates.

Freedman analyzed data from Delaware healthcare plan carriers for individual, small group, large group and State Group Health Plan to calculate primary care investment in the State. Ms. Condon shared that results from this data source were consistent with data received from DHIN. She added that the definition of primary care investment was

developed by the Primary Care Reform Collaborative Subcommittee and is consistent with the nationally developed definition used by Millbank. There was a small increase of primary care investment as a percent of total cost of care (4.2%, 2017 going up to a half percent in 2019). While primary care spending on PMPM increased, so did all other types of spending. She also pointed out when states look at how they invest in primary care they tie that to a percent of total spending.

The OVBHCD sought to identify a strategy that supports the health insurance carriers with achieving the state health policy goals of reducing total cost of care while increasing primary care investment. Ms. Condon reviewed the three affordability standard targets identified to achieve OVBHCD's statutory goals: primary care investment increases, unit price growth for certain services decreases and alternative payment model adoption expands. She continued to state that increasing primary care investment includes the expansion of access to comprehensive primary care, improvement of care delivery and patient outcomes, and decrease in spending on preventable Emergency Department visit and hospital visits. When these strategies are partnered, primary care spending can be increased with less burden on total cost of care and OVBHCD will be a position to achieve the statutory goals.

The proposed approach includes setting flexible targets in the three areas (Primary care investment, Unit price growth and Alternative payment model adoption). Ms. Condon continued to share the proposed accountability measures: integrated with rate review for DOI, progress towards each target considered as part of rate review approval and seeking collaboration and alignment with other payers.

Telehealth has contributed to the utilization of care delivery returning to pre-COVID levels. However, this may stall as caseloads begin to rise. This coupled with vaccine costs, has actuaries projecting higher trends in price and utilization in 2020. The presentation also highlighted the impact COVID-19 has had on primary care practices. Primary care providers are willing to move away from reliance on fee-for-service. This has led to an increase in independent practices seeking the stability of a clinically integrated network, accountable care organization or health system. Ms. Condon added that targets will offer flexibility for changing market dynamics, integration into rate review for 2022 and provide multiple opportunities to strengthen primary care investment.

Ms. Condon reviewed the key findings supporting the three affordability standards identified by OVBHCD, starting with primary care investment. Delaware primary care investment is less than 5%, comparted to more than 10% in other states. Commercial prices for primary care and other professional services in Delaware are 10% above Medicare, which is the lowest differential in the nation. Delaware's primary care workforce is shrinking and aging. In recent years the state has experienced a 6% decline in primary care providers and between 30% - 40% and planning to leave in the coming years. Lastly, the state has limited investment to support care management and coordination care. The provisional target for this standard includes the increase of investment of commercial health insurance carriers in primary care by 1% to 1.5% of total medical expense a year until 2025. This will move than double from 2021 to 2025 on a per member, per month basis. It also increases as a percent of total medical expense from 4% to 8% to 10%. It also grows to levels consistent with leading models of comprehensive primary care delivery nationally on a PMPM basis.

Key findings to support Unit Cost Growth Target Development target include historical price increases for hospital services have outpaced price increases for professional services. Delaware has experienced a 3.2% - 3.9% a year increase as compared to the average 0.5%. Delaware hospitals and health systems received commercial reimbursements of 272% to 334%, on average depending on the type of service. Delaware has a high market share. Four of the six adult hospitals had at least 40% of the discharges for their service areas, and two had market share percentages exceeding 80%. The provisional target for this standard includes commercial health insurance carrier's limitation of aggregate unit price growth for non-professional services.

Ms. Condon outlined the HCP-LAN the four categories with the alternative payment model framework (Fee For Service with no link to quality and value, Fee For Service with link quality and value, Alternative Payment Model built on Fee For Services architecture, and Population-based Payment). This framework was developed by CMS along with the HCP-LAN. Carriers are familiar with this national framework, which allows for the use of shared definitions.

Key findings to support the Alternative Payment Model Target Development standard include a Primary Care Reform Collaborative APM target of 60% of Delawareans attributed to "value-based model" by 2021; the State Employee Benefits Committee target of 40% of healthcare spending to be under a Category 3 model and 10% under a Category 4 model by 2022; and movement to a Downside Risk for MSSP. In Delaware, most ACOs currently participating in MSSP are expected move to downside risk in the next few years. The provisional target for this standard includes tying more spending to total cost of care accountability, expanding use of downside risk contracts (within health system ACOs), providing more opportunities for independent providers to participate in pay for performance programs and pilot capitated payments for primary care.

Dr. Bruce Landon mentioned that there would be challenges when moving into a total cost of care model within Delaware's current setting. Their research found that independent physician's group ACOs tend to do better in the program than did independent integrated systems ACOs. He added that this is important to consider in the State because their dominated by hospital systems. He pointed out that independent primary care groups that Aledade are the exception.

Ms. Condon's presentation concluding by stating that the implementation of the three Affordability Standards together allows primary care investment to double with minimal increases in total cost of care growth. She pointed out that this plan would allow for an increase of primary care investment as a percentage of total medical expense faster and higher because of the decrease in the growth of the total cost of care baseline. The TME trend should not be compared to risk-adjusted statewide benchmark. Steps towards the integration with rate review include the submission of the Affordability Standard template as part of rate filing; progress toward achieving standards considered as part of rate determination process; the rate determination is made and the market will conduct exams, audits ad hearings as needed. An annual Affordability Standards report will update standards and discuss progress.

The OVBHCD will complete the Affordability Standards Report in December. The public comment period will be December 15th through January 15th. In February, responses to public comment will be published, along with a bulletin on Integration with Rate review. The Office will update rate filing instructions between February and March.

Dr. Fan opened the discussion up for comments from the members of the Collaborative. Dr. Gill expressed his gratitude to the OVBHCD for the excellent presentation. He commented that while some information was known (hospital costs are high in Delaware, primary care spend is low), he was not aware of how low spending was for overall professional services. Low investment not only impacts primary care but independent practices within the State. Payment reform needs to happen now to avoid the loss of practices going out of business. He added that the investment is starting out too low and stated that 2020 was devasting to primary care and if the investment will be even lower than before, there will be no primary care left to save. Primary care offices are continuing to go out of business and the State will not have anywhere to send patients. He concluded by stating that asking providers to wait two or three years is unacceptable.

He recommends that a significate care coordination payment be added at $10-$12 dollars per patient per months. This addition would increase the investment to 5.5% - 6%. He asserted that the 4% increase would be devastating for practices. He also does not agree with stopping at 8%. He mentioned policies that state limits should not be set under 10% regardless of total spend. He argued that the higher the spend, the higher the primary care spend needs to be. The more spend that happens in non-primary care spend, the more primary care will be needed. He closed by encouraging the Collaborative to consider his proposals to add a care coordination fee. Dr. Fan pointed out that because we are in November of 2020, what we can do for 2021 is limited. Ms. Condon responded by agreeing that there are some limitations due to the time of year. She assured Dr. Gill that the Office is in the process of ensuring that carriers are in compliance with SB227. She believes this is the first step. She added that this may lead to some faster increases. She also highlighted hat these targets will be reviewed and refined annually. There is nothing to suggest they could not go beyond 8%. The Office felt it was important to start somewhere. She concluded her response by acknowledging how difficult things have been for primary care this year.

Dr. Fan asked if the 4% total spend includes CMS's new the fee schedule. Ms. Condon responded by sharing that the carrier's projections were provided while the CMS schedule was in draft form, they may not have fully incorporated that into their projects. She agreed to follow up with carriers to confirm. Dr. Fan encouraged members to note that these are only projections and CMS has changed their fee schedule and if commercial payers are in compliance, we may not project 4% even though our total cost of care may increase at a different rate. Looking at it from raw numbers it looks concerning that we are starting at 4%. She pointed out that the landscape is not as fixed as could be assumed. She also wondered how the Medicaid ACO will affect the total cost of spend, adding that if the total cost of spend decreases the percentage of primary care spend will increase.

Dr. Veronica Wilbur asked about Medicaid's role, stating that a lot of the slides refer to commercial carriers. She pointed out that 60% of her cliental is Medicaid. Ms. Condon responded by sharing that nurse practitioners would be included into the definition of primary care providers so any increases given to physician providers of primary care would also come to Nurse Practitioners, Physician's Assistances and primary care providers. She continued by pointing out that the Office resides within the Department of Insurance and they regulate commercial carriers and do not have oversight over Medicaid, however they appreciate the partnership and have tried to stay in close contact to ensure there is alignment. Steve Groff added that their goal is to be in alignment, and they hope to move forward with the OVBHCD. He added that while there is no direct oversight, they are subject to the provisions. Mr. Groff continued by sharing that there is need to work in concert to ensure success of the delivery system reform. Steven Costantino added that Medicaid has included value and quality in their contracts with carriers. The model to care initiated in Medicaid is primary care centric model that aligns with OVBHCD work. There was some discussion regarding limiting the primary care spend at 8%. If the total cost of spend is decreased, the 8% might represent a higher number because the larger spend has gone down. The consensus was to start moving in the right direction, reviewing regularly and adjusting as needed.

Kevin O'Hara agreed that total cost of care needed to be addressed to work towards ending the curve. If not, it will make difficult to achieve a larger investment in primary care. He appreciated the presentation of the landscape of care delivery as it relates to other parts of the world. He added that the proposed affordability standards make sense. Sasha Brown agreed with Mr. O'Hara, stating that it was nice to see that what we know is validated. She also spoke to the various initiatives mentioned that could be put into place. She was interested in hearing more about the Consumer Price Index (CPI). She asked if it was index CPI or Medical CPI. Ms. Condon confirmed that it was core CPI, excluding food and energy. The purpose was to demonstrate (similar to Rhode Island) that we can't increase cost in health care and not be cognizant of the impact on consumers and families. Ms. Brown also asked if the Office reviewed the dollars flowing through capitation or capitation overall. Ms. Condon reports that there is very

little capitation in Delaware at this time and they were very interested in hearing from carriers as they further define and develop plans around capitation.

Dr. Mike Bradley commented that the presentation has confirmed what we know, hospital care is too high, primary care spend it too low. He reported that he has given notice to his practice associates that he will be retiring in September of 2021. He added that actions are not taken soon, many other providers will be going out of business. He also reported that providers within hospital systems are paid more and see less patients. He reiterated the importance of reducing hospital reimbursements and using the funds to reinvigorate primary care spending. He mentioned that he is the president and chairmen for MedNet. They have over 850 physicians with close to 250 primary care providers in their network. He reported that MedNet has tried to break into obtaining contracts with carriers to no avail. They have successfully worked with AmeriHealth and they have significantly reduced their cost. He is hopeful that they will receive some shared savings. He believes MedNet would be a good pilot project for the state to look at providing another access to providing primary care services outside of hospital-based practices and outside of other ACOs. He is confident they could help carriers to reduce cost. He asked if the modeling projections shared showing a decrease in total medical expense, are related to COVID-19. He urged the Collaborative to consider all the recommendations presented by the OVBHCD. Ms. Condon added that the OVBHCD is moving forward with the 2022 rate review process and they are interested in aligning with partners. She also mentioned SB227 and the importance of ensuring carriers are keeping pace with increases in primary care and this is another way that an increase in primary care investment can happen before 2022.

Dr. Fan reviewed the three targets that are proposed by OVBHCD. She continued to point out that the Collaborative will have primary ownership of the lead on the alternative payment model adoption. Members have full autonomy to develop the model. Together they can determine how things will look at the clinical level, how things will be developed and if there should be a capitation pilot program (identified goal to increase investment by a certain percent within the first year, etc.). Members will also work together to identify the amount of downside risk and other components of the APM. She concluded her comments by cautioning the members to be mindful of the changing landscape.

Dr. Fan invited Nemours and ChristianaCare to speak to the provisional targets presented. Dr. Donahue reported that ChristianaCare has been moving towards value. They have been transitioning and planning their response. She also reported that 65% of their business is related to government payers. They are moving forward with their ACO and now their Medicaid ACO application. They are strongly committed to price transparency. She shared that they consider themselves as partners with the Collaborative in these efforts. She expressed her excitement to see that the Collaborative has a solid direction forward. She stated that she believes the APMs are an important piece of the model (total cost of care accountability as well as an increase in rates to primary care providers).

Jaime Clark, Nemours stated that they are committed to progressing to an alternative payment methodology, including shared risks. Ms. Clarke asked the group to consider addressing issues around timeliness of the discussions with payers. The process is taking extended amounts of time. Providers need timely access to data. There is a willingness to collaborative however, there needs to be a deeper collaboration and timeliness of information sharing, allow informed decision to be made. Ms. Clarke shared that she is the Executive Director of the Delaware Children's Health Network, a pediatric CNI in the state. She asserted that they are committed to increasing access and reimbursement to primary care. She added that they strongly believe there needs to be accountability among the primary care practices surrounding the expectations of care coordination and care management. If primary care providers are receiving increased reimbursements, there should be an understood level of expectations and accountability. She added that not all practices provide the same level or possess the capacity to provide the same level of service. She added that as Nemours contemplates risks in 2021, one of the factors they consider is the

amount of time and back and forth it has taken to access data and provide that data to their actuaries to assist them with making informed decisions. In the past it has been challenging. She stressed the importance of holding the payers accountable for releasing the data as quickly as possible. Dr. Fan agreed and added that measuring accountability can be difficult technical aspect to have timeline information. She thanked Ms. Clarke and Dr. Donahue for their insight and feedback.

Dr. Fan highlighted several areas that will be discussed during the December meeting. Members were asked to come prepared to vote on/discuss the following:

1. The adoption of a path forward and decisions regarding Practice Transformation
2. Where to start the primary care investment rate? Do members want to begin with a higher primary care investment rate?
3. Is the corporation of the unit price growth into the rate review system is appropriate or "enough"?
4. What are the aspirational goals for the amount of percentage increases (Goal setting of % of practices in VBM/LAN 3)?
5. Core components of Value Based Care. Defining Value Based Care>>Advanced Primary Care

Dr. Fan called comments, mentioning the numerous messages added in the chat box. She invited Wayne Smith to share his thoughts and ask his questions. Mr. Wayne asked if there was data on what the actual per capita dollars for primary care spend in Delaware versus other states. He suspects that Delaware may be spending more dollars than other states that have a higher share of a lower cost. Ms. Condon reviewed the data presented and highlighted the per capita spending for primary care services in 2019 was $22. When compared to nationally published research, the OVBHCD found that the calculation of $22 is less than half on a PMPM basis. Mr. Smith clarified that his question is more specifically, where does the $22 PMPM rank across the states. Ms. Condon shared that primary care spending is not calculated across states. Mr. Smith highlighted that Delaware is being compared to an ideal, which may be where we want to go but he also added that Delaware may be in the middle of the pack, which may work for our state. Dr. Bruce Landon added that if you look at the prices paid commercially in Delaware, they are at the level of 110% of Medicare, which is much lower than other parts of the country. Ms. Condon agreed and shared that data from RAND report shows that for professional services, commercial prices are the lowest compared to Medicare of any state in the nation. Dr. Fan added that if Delaware is in fact in the middle of the pack, is not helping Delaware citizens or providers. She continued to encourage members to look at outcomes as well as number of dollars. If the dollars in the lower numbers and to still equates to poor outcomes, then they need to be addressed. She thanked Mr. Smith for his question and insight.

Dr. Krasner shared that he appreciates the hard work. He also shared his perspective from the front lines. His practice is in an underserved area and he has had a difficult time recruiting. He has relied on mid-level providers, adding that his most recent hire is 68 years old and close to retirement. Medical students are following the money due to the large number of student loans they leave. He stated that in order to change the narrative and attract/incentivize providers to practice in the state, Delaware needs to pay the providers more. He asked Senator Brian Townsend if there were plans to develop legislation to address these issues. He stated that insurance companies have been unable to negotiate lower fees and hospitals have incentives to make more money. He asserted that it will take a decision by the legislature to force the issue. The more you pay towards primary care, the better quality you receive and at a lower cost. It will take some bold measures to finally do what needs to be done. Waiting until 2022 to increase the rates to 12% is risky. He added that having primary care shoulder the burden of hospital care costs is unacceptable. A primary care doctor makes $3.5 million less over his/her career than other specialists. The only way we will attract primary care workers is to pay more.

Dr. Wiley agreed with Dr. Krasner. She wanted to share her perspective from the private sector. She stated that conversations regarding timing of retirement have increased since the inception of the Collaboration. She asked how the funds from the increased investment would be allocated. In order to care for patients, it takes a provider, mid-level provider, an assistant, a nurse, two medical assistants and a front desk (a team). She asserted that the funds are not coming directly to the provider, they are used to support the team members need to care for patients.

Dr. Fan thanked Dr. Krasner and Dr. Wiley for their comments. She remined the members to come prepared to discuss the items she listed earlier. She also added that Mercer would be presenting a Primary Care Model during the December meeting. She stated that Dr. Wiley's points demonstrate the need to define where the money will be allocated. She added that Dr. Krasner's comments are a strong reminder that the collaborative should ensure there is continued work to identity strategies to assist primary care providers to be sustainable.

Dr. Fan asked members to review the following readings in preparation for the December meeting:

- JAMA Intern Med. Published online November 16, 2020 (shared by Dr. Gill)
  *Changes in Health Care Use and Outcomes After Turnover in Primary Care*
  Adrienne H. Sabety, PhD1; Anupam B. Jena, MD, PhD2,3,4; Michael L. Barnett, MD, MS5,6
  Author Affiliations Article Information
- RAND report
- Maryland PCP Program

Before closing Dr. Fan invited the two co-chairs to make comments or remarks. Senator Townsend shared his support for Dr. Krasner. He added that it was his hope that there would be more forward movement. He shared his desire to develop legislation in 2021 that we addressed the issues mentioned. He closed by reassuming Dr. Krasner that his passion was noted and not lost on him. He stated that he understood swift action is needed and he plans to do his best to ensure improvements are made.

**Public Comment**

Dr. Fan thanked the members and public participants for their time and commitment to the goals of the collaborative. Dr. Fan reminded the attendees of the importance to adhere to the guidelines surrounding gatherings for the holiday. She encouraged everyone to be safe and called for final public comments. Hearing no comments or other business, the meeting was adjourned at approximately 6:58p.m.

**Next meeting**

The next Primary Care Reform Collaborative meeting will be held on ***Monday December 21, 2020***.