MINUTES FROM THE HEALTH POLICY & PLANNING SUBCOMMITTEE
TO THE STATE EMPLOYEE BENEFITS COMMITTEE
NOVEMBER 7, 2019

A meeting of the Health Policy & Planning ("HP&P") Subcommittee to the State Employee Benefits Committee (the "Committee") was held Thursday, November 7, 2019 in the Large Conference Room of the Statewide Benefits Office ("SBO"), 97 Commerce Way, Dover, Delaware 19904

Committee Members Represented or in Attendance:
Director Faith Rentz, SBO, Department of Human Resources ("DHR"), Chair
The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer ("OST")
Ms. Victoria Brennan, Sr. Legislative Analyst, Office of the Controller General ("OCG") (Appointee for CG Morton)
Ms. Molly Magarik, Deputy Secretary, Dept. of Health and Social Services ("DHSS") (Appointee of Sec. Walker)
Mr. Tanner Polce, Policy Director, Office of the Lt. Governor (Appointee of Lt. Governor Hall-Long)
Ms. Judi Schock, Deputy Principal Assistant, Office of Management & Budget ("OMB") (Appointee OMB Dir. Jackson)
Mr. Stuart Snyder, Chief of Staff, Department of Insurance ("DOI") (Appointee of Commissioner Navarro)

Subcommittee Members Not Represented or in Attendance:
Mr. William Oberle, Delaware State Trooper's Association (Appointee of the DSEA, Jeff Taschner)

Others in Attendance:
Mr. Jeff Taschner, Exec. Dir., DSEA, Committee Member
Ms. Leighann Hinkle, Deputy Director, SBO, DHR
Mr. Kevin Fyock, Willis Towers Watson ("WTW")
Ms. Jaclyn Iglesias, WTW
Ms. Christina Bryan, Delaware Healthcare Association
Mr. Justin Fiedler, R-Health
Ms. Katherine Impellizzeri, Aetna
Mr. Walter Mateja, IBM Watson Health
Ms. Jennifer Mossman, Highmark Delaware
Mr. Mason Renier, R-Health
Ms. Paula Roy, Roy Associates
Ms. Martha Sturtevant, Executive Assistant, SBO, DHR
Ms. Elizabeth Zubaca, Hamilton Goodman Partner

CALL TO ORDER
Director Rentz called the meeting to order at 1:02 p.m.

APPROVAL OF MINUTES –DIRECTOR FAITH RENTZ, CHAIR
A MOTION was made by Mr. Polce and seconded by Ms. Brennan to approve the minutes from the combined Subcommittee meeting on September 19, 2019.
MOTION ADOPTED UNANIMOUSLY.

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ, CHAIR
Subcommittee/Committee Updates
The Financial Subcommittee met the morning of November 7, 2019 to review Q1 updates. Updated projections for FY20 and FY21 were reviewed, including modeling of proposed premium rate increases.

Updated projections will be presented to the Committee at the meeting on November 18, 2019. The Committee will also discuss revisions to the Strategic Framework. The Committee is expected to finalize the FY21 budget and any premium rate increases as early as the meeting on February 17, 2020.

Treasurer Davis arrived.

PRIMARY CARE – MRS. JACLYN IGLESIAS, WTW

Options to enhance primary care access being considered by the Subcommittee include, enhancing telemedicine offerings, and contracting with a third-party vendor to add primary care provider options.

The SBO Primary Care Survey results indicated that members are interested in alternative care options. Most survey respondents reside in New Castle County. The free text comments of the survey reflect skepticism over the effectiveness of telemedicine and enhanced kiosks, and concerns over the systemic expense of onsite or near-site clinic options. A further study of either option would be required to fully assess feasibility, timeline and potential cost.

The Subcommittee will meet December 5, 2019 to further define the goals and success measures, the expected financial impact, and timing of governance considerations with each option. The Subcommittee may also interview third-party service providers of telehealth technology and health centers.

Some members who responded to the survey indicated that it was difficult to make an appointment with a primary care physician. However, the sample size of the survey was small and further dialog is needed.

There was a discussion that many millennials prefer urgent care and do not want to utilize a PCP unless required.

R-HEALTH – MR. MASON REINER, R-HEALTH

Data shows that increased access to primary care decreases outpatient visits by 5%, decreases inpatient admissions by 5.5%, decreases emergency room visits by 10%, and decreases surgeries by 7%.

On average, there are approximately 2,500 patients per Primary Care Provider (PCP). On average a PCP on sees 1% of their patient population a day. The Harvard Business Review estimated that it would take 21.5 hours a day for a PCP to deliver all the recommend acute and preventive care to 1% of their patients.

Primary care makes the biggest impact on patients with chronic conditions, however only 9% of PCP's report they have enough time to spend with their patients. On average, doctors spend three hours of administrative work for every hour of patient care.

Primary care is primarily paid on a volume-based, Fee for Service (FFS) reimbursement model that is based on Relative Value Units ("RVUs"). RVUs determine how much a doctor is paid for care provided. RVUs are higher for procedures than patient visits.

There is a growing shortage of PCPs nationally; 79% of physicians report burnout, and more than one-third would not recommend going into medicine. The 2019 Match Report states that of the 8,100 internal medicine positions offered, only 41% were filled by 4th year U.S. medical students. By 2030, the national shortage of PCPs is predicted to be between 14,800 and 49,300.

Replacing FFS with value-based care reimbursement models will help control health care expenses, and reward PCPs for superior care, stewardship, and overall healthcare spend and patient experience.

Onsite and Near Site Clinics

A growing number of employers are pursuing onsite or near site clinics. They offer low-cost care with convenient access. Challenges of offering onsite clinics include the upfront capital costs, low engagement of family members, patient concerns regarding privacy of a "work doctor", and the potential to further fragment care for commuters who prefer to schedule sick visits closer to home.

Ms. Magarik asked if plans that have successfully implemented onsite clinics have high out-of-pocket expenses, noting that GHIP plans are already low cost making it harder to incentivize. Mr. Reiner responded that R-Health

clients cover the spectrum of out-of-pocket costs, but he believes access and a relationship with a doctor who takes time with them becomes the primary driver.

Direct Contracting

Direct contracting with existing regional health networks is an option to leverage existing infrastructure while moving toward value-based care. However even large employer plans account for a small percentage of the network's overall patient panel, making it difficult to customize care for members. Additionally, preferred access may be a violation of carrier contracts.

Telehealth/Telemedicine

Telehealth is an inexpensive option to implement, however adoption rates are low. Telehealth is a good option for acute care. Challenges include no continuity of care, no medical history and limitations in the type of care that can be provided.

Near Home Direct Primary Care

Near Home Direct Primary Care ("DPC") is a network of value-based, relationship-based primary care created within a community. This option has the benefits offered by onsite clinics without fragmenting care and with a better opportunity to engage family members. Benefits include no copays, fewer patients, longer appointments and appointments on nights and weekends. Doctors are capped at one-third of the average patient panel. Participating doctors cannot have any FFS revenue from any other source.

There was a discussion regarding the reimbursement model of R-Health's DPC plan in the State of New Jersey. The state catalyzed the creation of the model. R-Health provided the upfront capital expense to build practices and worked to enroll members in the plan. R-Health is paid Per-Member Per-Month ("PMPM") based on enrollment with an opportunity for shared savings.

Mr. Reiner stated that R-Health is not likely to replicate the New Jersey model again; R-Health was solely responsible for capital costs. He suggested that Delaware begin with strategic locations to build practices, commit to a minimal guarantee of participation, and as enrollment increases the cost PMPM would be scaled.

Mr. Reiner cautioned the Subcommittee that there is no quick fix. He stated that Referenced Based Pricing reduces costs initially, but has long-term consequences, while the R-Health model has an initial spike in cost, but significantly improves the outcomes of chronic conditions over time. The cost PMPM is not tiered or risk adjusted.

Members discussed R-Health implementations among similar employers. Mr. Reiner responded that the primary catalysts for adopting the DPC model include reducing long-term costs, improving PCP access and improved long-term health. DPC membership should be voluntary and offered as an alternative to PCP options available through a healthcare plan. There was a low adoption rate in plans where membership was not voluntary. In New Jersey the initiative was strongly supported by the state's public sector unions.

There was a discussion regarding the challenges of adopting/implementing of a DPC model. Members do not like changes to their healthcare plans. There is a belief that lower costs equal lower benefits. It is important to communicate that lower costs are vital to long-term plan sustainability. Scaling the network effectively requires a large employer or a group of employers. As the DPC model scales up, the infrastructure must be scaled appropriately to support and maintain quality of care.

Communication to doctors is also pivotal to a successful adoption. Doctors under contract with, or owned by, a health system are not eligible to participate.

As doctors have more time with patients, PCPs more effectively evaluate for behavioral health. Virtual behavioral health consults are a valuable resource for PCPs. Patients often prefer telemedicine for behavioral health.

Members reviewed the clinical impact of the State of New Jersey's DPC. PCP engagement is more than four-times the national average. 93% of urgent risk members reduced their health risk quotient. 61% of members with high cholesterol have reduced their cholesterol. 51% of members with diabetes moved from uncontrolled to controlled. 43% of members diagnosed with obesity have decreased their BMI. 83% of members with hypertension have controlled blood pressure.

R-Health's HIPAA compliant phone app can be utilized to send secure messages, schedule appointments or a virtual visit. More than 40% of NJ employee members have virtual interactions compared to a 0.52% telemedicine adoption rate. Member satisfaction is 92.7% for R-Health compared to 12% for the national insurance average.

Members discussed the competitors of a DPC model. Mr. Reiner stated that advanced primary care provider organizations and not concierge models are the competitors. He added that DPC differs from concierge as most concierge doctors utilize a FFS model with access fees that are more than double R-Health's PMPM.

Successful implementation requires coordinated communication, strong data integration with Third Party Administrators, a multi-year investment, a robust data & technology platform, and clinical collaboration and oversite.

Ms. Magarik queried whether DPC doctors continue to treat members who switch to Medicare. Mr. Reiner responded that it is illegal for a doctor to treat a Medicare patient without billing Medicare. DPC doctors cannot participate in a FFS model (Medicare), but can treat patients under Medicare Advantage.

Mr. Reiner added that another benefit of the DPC plan design is that members can enroll at any time in the year independent of plan selection.

Mr. Polce left the meeting.

OPIOID MANAGEMENT INITIATIVES – DIRECTOR RENTZ

Express Scripts

As part of the contractual arrangement with Express Scripts there is per-member contract allowance set up for communications, outreach and technology projects during the term of the contract. There is a use-or-lose balance of $800K remaining. The Advance Opioid Management benefit being offered by Express Scripts will spend down the balance at no additional cost.

Members queried possible expenses or alternate program options available. There are no other foreseeable expenses or optional programs that would expend the balance within the remaining 18 months of the contract.

SBO recognizes the importance of opioid management but expressed concern over cost of program. SBO committed to negotiating more flexibility in the use of any future contract allowance. Implementation of the program provides the opportunity to evaluate the success of the program for consideration in future contracts.

Ms. Magarik inquired about the option to set triggers that proactively dispense Naloxone nasal spray. Ms. Rentz responded the Advanced Opioid Management program incorporates outreach/dispensing of Naloxone for high risk members. She added that Express Scripts has stated that they will not customize the benefit.

Director Rentz invited the Subcommittee to support a recommendation to adopt the Advanced Opioid Management program with a flexible implementation date that allows pending projects to be fully funded and the remaining allowance to be expended with no additional funding. The Subcommittee supported the recommendation.

OTHER BUSINESS

No new business.

PUBLIC COMMENT
No public comment.

ADJOURNMENT
A MOTION was made by Ms. Magarik and seconded by Ms. Brennan to adjourn the meeting at 3:04 p.m.
MOTION ADOPTED UNANIMOUSLY:

Respectfully submitted,

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Martha Sturtevant, Statewide Benefits Office, Department of Human Resources
Recorder, Statewide Employee Benefits Committee