

DAVID S. BENTZ
STATE REPRESENTATIVE
18th District



**HOUSE OF REPRESENTATIVES
STATE OF DELAWARE
411 LEGISLATIVE AVENUE
DOVER, DELAWARE 19901**

COMMITTEES
Health & Human Development, Chair
Energy, Vice-Chair
Appropriations
Joint Finance
Labor
Natural Resources

House Health and Human Development Committee Meeting Minutes
June 9, 2021

Chair Bentz called the virtual meeting to order at 1:01 p.m. He stated that the meeting was planned in accordance with HCR 1 and took the roll call of the committee's members. Members present included Reps. Chukwuocha, Johnson, Baumbach, Heffernan, Morrison, Kowalko, Postles, Shupe, Smith, Briggs King and Collins. For a list of guests present, please see the attendance list below.

Chair Bentz introduced **SS1 for SB 120, AN ACT TO AMEND TITLE 16 AND TITLE 18 OF THE DELAWARE CODE, CHAPTER 189, VOLUME 82 OF THE LAWS OF DELAWARE, AND CHAPTER 392, VOLUME 81 OF THE LAWS OF DELAWARE, AS AMENDED BY CHAPTER 141, VOLUME 82 OF THE LAWS OF DELAWARE, RELATING TO PRIMARY CARE SERVICES.**

Chair Bentz, a prime sponsor of the bill, explained that this bill will continue efforts to strengthen primary care in Delaware and was informed by the ongoing work of the Primary Care Collaborative. He stated that the bill's aim is to modernize and improve primary care services by directing the Healthcare Commission to monitor and promote compliance with alternative payment methods that promote value-based care. The bill would also require insurance carriers to spend a certain percentage of its total costs on primary care services, increasing from the current 4 percent level to 11.5 percent by 2025, and empowers the Office of Value-Based Health Care Delivery to monitor compliance with these requirements. Chair Bentz said that the impact of the increased primary care spend would be offset as it limits aggregate unit price growth for inpatient and outpatient medical services over the next four years, and that the bill also makes technical changes to the appointment process for members of the Primary Care Reform Collaborative.

Chair Bentz explained that the Senate Substitute reflected ongoing discussions with stakeholders that continued since the bill's first introduction, and it is mostly technical changes and adjustments that were made to more accurately reflect the intention of the bill and prevent unintended consequences. He highlighted the sunset of sections 5 and 6 of the bill in 2027 which reflects compromise efforts with the State's health systems.

Chair Bentz stated that primary care is a critical part of efforts to reduce long-term costs, however it has been chronically underfunded leading to the current situation. He explained that many constituents have experienced issues with losing a primary care doctor, and that this legislation begins to rectify this issue and is a start towards ensuring all constituents have access to critical primary care services.

Rep. Heffernan shared her strong support of the bill and emphasized that anything done to improve primary care saves money in the long run for the healthcare system and constituents.

Rep. Briggs King asked what other states have implemented similar legislations. Chair Bentz responded that Rhode Island likely has the most similar policy.

Rep. Briggs King inquired about the issue of patient compliance and her concern that there is no accounting for potential noncompliant patients in the quality performance improvement utilized in the bill. She asked how practitioners and hospitals can be held accountable for patient outcomes if the patient is not contributing to their own positive outcome. Chair Bentz shared that the Primary Care Reform Collaborative have been meeting for years to discuss how to move away from the fee-for-service model which bills based on quantity rather than quality.

Chair Bentz introduced Dr. Nancy Fan, Chair of the Health Care Commission, who explained that patient responsibility is multilayered and different patient populations need to be accounted for. She said that there is some onus on the provider to meet the patient where they need to be met so that the patient can be successful in their own care. Dr. Fan explained that value-based care includes programs that are team-based, care coordination, transition of care, and that paying for these

programs and things like reconciliation of medication helps them to be successful. She said that it is very difficult to prioritize these within the current fee-for-service reimbursement model because you must constantly itemize all parts of the care. She shared her personal experience as a practitioner where majority of patients want to be compliant, but it might be very difficult. Dr. Fan stated that being able to help healthcare systems and providers work towards this with their patients is one of the core principals of a comprehensive healthcare delivery system and it should be a core principle of a value-based care system. She explained that one of the goals of Primary Care Collaborative is to continue to work on these details to continue to move forward and find the best ways to improve health outcomes for patients.

Chair Bentz recognized Secretary Molly Magarik, who highlighted the importance of primary care as one of the most trusted roles in healthcare, and the practitioner who can promote the most comprehensive care for their patient which she states is why this legislation is important to validate and invest in this relationship. Secretary Magarik stated that while much of the discussion surrounding this bill has focused on individual primary care practices, the issue is larger than one practice as there has been a chronic underinvestment in primary care across the state. She emphasized the importance of primary care as foundational in the next iteration of healthcare, which is a focus away from a fragmented fee-for-service model that emphasizes testing also known as volume-based healthcare.

Secretary Magarik referenced other states who have been successful in moving towards value-based healthcare and explained that they have started with a strong primary care foundation that included individual practices, larger group practices, and healthcare systems. She said that Delaware does not currently have this foundation and cited a report from the Office of Value-Based Health Care Delivery and the Department of Insurance which found that between 4 and 5 percent of total healthcare spending on primary care, while other states farther along than Delaware are spending at least 10 percent of the total budget on primary care. She stated that this bill is an important and concrete step forward towards rebalancing the healthcare delivery system and putting greater investment in primary care. She said that this bill also pushes and asks providers to move away from volume and fragmentation and move towards focusing on individuals and what is needed to address their needs.

Secretary Magarik also explained that because this bill aims to rebalance healthcare spending, it does not create this investment by putting more onto already strained consumers or small businesses. She emphasized that the budget reflects priorities and in order to fulfil their commitment to improving primary care, this investment is needed.

Chair Bentz opened the floor to public comment.

Terence Murphy stated that the bill would place rate restrictions on hospitals to fund the increase in primary care spending and will impact the future provision of money losing healthcare services and impede access to primary care. He said that the bill does not include a description of how primary care will be improved and instead restricts the ability of hospitals to invest in primary care, which he states have been the state's heaviest investors in primary care and serve as a primary care safety net for many Delawareans. Mr. Murphy states that over the past five years over 90 percent of physicians who have started their practice in the Bayhealth service areas in Kent and Sussex counties have been recruited, employed, or supported by Bayhealth. He states that Bayhealth has become a teaching hospital and has invested in the necessary resources to train physicians in Delaware, in addition to opening a new family practice in internal medicine which will be able to provide 50,000 visits annually for Delawareans.

Chris Haas from the Department of Insurance shared that this bill reflects a significant amount of research from stakeholders and the Department of Insurance's Office of Value-Based Healthcare Delivery. She said that Delaware specific data and data from other states with similar programs can be seen in the Office of Value-Based Healthcare's report found at insurance.delaware.gov. Ms. Haas emphasized that the goals of this bill are critical to the State's future and thanked the bill's sponsors for providing appropriate resources for the Department of Insurance to do the work needed to enact the legislation.

Dr. David Krasner, owner of Family Practice Associates, spoke in support of the bill, stating that it has been impossible to recruit new physicians and that they worry about being able to pay the bills. He responded to Bayhealth's concerns by stating that Bayhealth can absorb increasing costs as they are worried about profit while he is concerned about having the funds to pay for electricity and payroll. Dr. Krasner explained that physicians go into family practice primary care earn on average 3.5 million dollars less during their career than other specialists, and which is why it is so hard to recruit physicians for primary care.

Dr. Christine Donohue-Henry of Christiana Care expressed gratitude to the bill's sponsors for their work on the bill. She said that the National Academy of Medicine recently noted that primary care is the foundation of healthcare, and Christiana Care is committed to investing in this area which they have done so through their own employed practices and would like to support independent primary care physicians and advanced practice clinicians in the community as they transition to value-

based care. She stated Christiana Care's support of the bill as they believe it will help increase investment in primary care and encourage participation in alternative payment models to improve health outcomes in the State. They appreciate the Senate Substitute's revisions which consolidate rate, increase limitations, add a sunset provision so that rate caps can be revisited in five years, and exclude behavioral health and substance use disorder services from the rate increase limitations.

Christine Schiltz represented America's Healthcare Plans and shared concerns that health plans must file rates with specific caps for unit growth for nonprofessional services do not allow for flexibility and good jeopardize health plans in Delaware. Ms. Schiltz stated that AHP member companies would prefer if health plans be permitted to work directly with insurance and the Office of Value-Based Healthcare to have flexibility to meet the primary care total cost of care spending mandates without perspective rate caps and without increasing overall spending.

Dr. Sarah Mullins represented an accountable care organization of 34 independent practices across the State and responded to Rep. Briggs King's question saying that they have become experts at counseling patients who struggle with compliance, and they invite the challenge. She stated that they represent 50 percent of the primary care workforce in Delaware and that without investment they will not be able to the transformative work to bring value-based care to Delaware. Dr. Mullins also stated that currently more participants in Delaware residency programs are leaving than staying, and that as long as Delaware is viewed as one of the worst states in the country to practice medicine, they will not be able to reverse this trend.

Dr. David Tam, the President and CEO of Beebe Health, spoke in opposition of the bill. He stated that the legislation will not improve the cost of healthcare in Delaware and will actually reduce access to primary and specialty care services in Sussex County. Dr. Tam stated that in their current financial spectrum Beebe Health has recruited over 60 physicians and providers to Sussex county including 14 primary care services in the past year, which was possible because of the strength and performance of their specialty and hospital services. He explained that the bill will negatively impact Beebe's ability to meet growing healthcare needs in Sussex Care and that his personal experience in the field has shown that you cannot choose one healthcare service over another which this bill does.

Dr. James Gill spoke in support of the bill. He highlighted the issue of access which he says is due to poor funding which this bill helps to address. In reference to Rep. Briggs Kings earlier concerns, he explained that the extra funding in the bill goes to paying for care coordination which is what helps patients make lifestyle changes like losing weight or quitting smoking. He also said that Rhode Island was the first to have a program like this, Oregon, Vermont, Connecticut, and Colorado are some of the states that have followed suit. Rhode Island saw dramatic increases in access to care with an 18 percent drop in total cost of care in the first four years, and other states are seeing similar results. Dr. Gill emphasized the urgency of this action as without it more practices will be forced to close, move to concierge, or sell to a hospital system which has been shown to increase costs without any increase in access.

Penny Short of TidalHealth Nanticoke shared the financial struggles they have, particularly during the pandemic. She said that this legislation would cause them to have to reevaluate some of their mission-critical services. She stated that this legislation would impede access and most physicians are looking to join a hospital system rather than an independent practice. She stated that the legislation wrongly assumes rates will increase at a fixed and modest rate which they do not as hospitals cannot control costs like drug pricing or the cost of labor. She expressed the view that rather than capping revenue they should be discussing ways to control utilization of price.

Pamela Price of Highmark and BlueCross BlueShield commented that they appreciate the goal of the legislation, but have concerns that the bill could disrupt the progress made by increasing primary care spend without directly tying it to improvements in progress and cost. She shared additional concerns including that limits on unit price growth for nonprofessional services will likely be insufficient to cover the legislations mandated increase in primary care spending which could lead to increases in premiums, and higher reimbursements for primary care providers may lead to higher member cost sharing. Ms. Price stated that only 30 percent of the market is impacted by this legislation due to the high number of self-funded arrangements meaning it has limited ability to deliver meaningful change while possibly incentivizing small and large fully insured employer groups to migrate to self-funded arrangements. She stated that it is an inherent flaw to set primary care rate spend while prohibiting insurance rates for accounting for overall healthcare costs leading to inadequate rates and market instability.

Dr. Bryan Villar expressed concern about hospitals being targeted in order to pay independent physicians more when hospitals are the primary care safety net. He stated that Bayhealth has designated staff working on recruiting primary care physicians to the state for both independent and employed practices. He explained that Bayhealth and other hospitals pay salaries comparable to surrounding states and take on the administrative burden of dealing with payers, and lose money on these physicians due to the low reimbursements in Delaware and high administrative costs, but do it to maintain primary care services in the communities. Dr. Villar stated that Bayhealth and other hospitals accept Medicaid patients and do not restrict any payer-classes and investing millions into medical students' graduate studies in the hope that they will stay in

Delaware. He further explained that in incentivizing primary care physicians to participate in alternative payment models, Bayhealth requires its primary care doctors to participate in eBrite Accountable Care Organizations and in the Medicare bundled payment programs, while alternative payment models are subject to downside and upside risk.

Dr. Matthew Burday, President of the Medical Society of Delaware, stated that primary care in the State is dying as there are many patients who cannot get in to see their doctor or any doctor. He explained that this bill can only improve the state of primary care and clarified that the money is not going into doctor's pockets but is going towards keep independent practices open. He referenced Secretary Magarik's comments on fragmentation and lack of coordination as a huge problem that will only get worse. He stated that primary care is able to link these different pieces together and urged the committee to release the bill.

After the conclusion of public comment, Chair Bentz stated that to characterize the bill as a vindictive effort against state health systems is inaccurate and does not reflect the conversations that took place within the Primary Care Collaborative which the health systems were a part of. He highlighted the fact that there is not universal opposition to the bill from state health systems, as Christiana Care and Neumors have been supportive. He also stated that it is important to remember that the bill is limited to plans that can be regulated by the state of Delaware, so to assume that the rate caps in the bill will be applied to 100 percent of the reimbursements received by the health systems is also inaccurate.

Chair Bentz emphasized that Delaware is not the only state to have rate caps, and that other states have caps far more aggressive and open ended than what this bill does. He explained that this bill puts a temporary, minor cost control on a very small section of the amount of reimbursements that these health systems get to shift investment into primary care. After the five-year period this bill expires and returns to a system that has hopefully seen a stabilization of primary care and the appropriate balance in order to see the cost benefits of people increasing usage of primary care.

Rep. Ruth Briggs King inquired about a potential difference in dynamics between the hospital systems in the North and more rural South. She explained that some of the rural hospitals lose money for every patient they see, and that those dollars are what they use to add specialty services, buy equipment, and increase quality of services offered. She also suggested that when looking at what other states have done, they look at the entire package of reimbursements beyond just primary care, because other states may have many other insurers providing services. She stated that when considering the efforts Beebe Health, Bayhealth and TidalHealth have made in residency programs to recruit physicians and the loss in funds that comes with providing high-cost services, she does not think this bill as being the fix for everything and has concerns about the ramifications of the rate caps.

Chair Bentz responded that while he understands the potential differences in the North and South, the issues with primary care access in rural parts of the State is directly because of the poor investment in primary care. He stated that the reason doctors say Delaware is a challenging place to work is because of this poor investment in primary care, which this bill helps address. He expressed his appreciation for the investment that hospital systems have made, and he wants to help get more money invested and emphasized that the increased investment is for all primary care, not just independent practices. Chair Bentz explained that creating the collaborative was necessary years ago because of this problem, and these broad steps are needed because the market has failed and currently dollars are just being sucked up by large health systems through hospital costs and squeezing out funding that should go to primary care and preventative care.

Rep. Collins commented that he appreciates what the bill is trying to do and shared that he has not been able to get a physician himself. He stated that despite this, the bill is a price control bill which have been shown to not work as they only create distortion that have to be addressed a short time later.

Chair Bentz responded that they currently do not have any cost controls in place now and they have essentially been writing a blank check to the large health systems in the state with more and more dollars being taken out of primary care and going to high-cost alternatives like hospitalization. He also pointed out that the cataclysmic scenarios being discussed have not materialized in other states with similar legislation.

A motion was made by Rep. Heffernan and seconded by Rep. Morrison to release SS 1 for SB 120 from committee, the motion carried. Yes = 8 (Chair Bentz, Reps. Chukwuocha, Johnson, Baumbach, Heffernan, Morrison, Kowalko, Smith); No = 4 (Reps. Postles, Shupe, Briggs King, Collins); Absent = 3 (Vice Chair Minor-Brown, Reps. Lynn, Hensley). The bill was released from committee with a F=6, M=2, U=1 vote.

Chair Bentz introduced **HB 184, AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO THE NEWBORN SCREENING PROGRAM.**

Chair Bentz, the prime sponsor of the bill, explained that this bill reduces the time frame to obtain a blood specimen from a

newborn from 72 hours to 24 to 48 hours. He recognized witness for the bill, Leah Woodall, from the Department of Public Health (DPH). Ms. Woodall explained that the Newborn Screening Program is the longstanding public health program in operation for over forty years that they have recently began outsourcing in collaboration with A.I. Dupont Children's Hospital who subcontracts for the lab portion of the program with PerkinElmer. She stated that the change from 72 to 24 to 48 hours is already being met by all birthing hospitals, so the bill just makes the formal change to align with what is happening operationally.

Ms. Woodall stated that the bill also requires blood specimens be destroyed once screening and testing is complete, including confirmation of any diagnosis. She explained that the change is because the samples must be stored in a temperature-controlled area, and the current time frame for storage of three years is excessive and not necessary. Ms. Woodall stated that the other changes are to provide abnormal results only to the physician of record, and requires the fees collected from the Newborn Screening Program to go the operating expenses for the program and broadly to support maternal and child health work.

Chair Bentz opened the floor to public comment, there was none.

A motion was made by Reps. Baumbach and Smith and seconded by Rep. Briggs King to release HB 184 from committee, the motion carried. Yes = 11 (Chair Bentz, Reps. Chukwuocha, Johnson, Baumbach, Morrison, Kowalko, Postles, Shupe, Smith, Briggs King, Collins); No = 0; Absent = 4 (Vice Chair Minor-Brown, Reps. Heffernan, Lynn, Hensley). The bill was released from committee with a F=6, M=5, U=0 vote.

Chair Bentz introduced **HB 226, AN ACT TO AMEND TITLES 10 AND 16 OF THE DELAWARE CODE RELATING TO IMMUNITY FROM LIABILITY FOR DONATED FOOD.**

Rep. Spiegelman, a co-prime sponsor of the bill, explained that a few years ago the Sportsmen's Caucus had investigated the Hunters Helping Hunger program and realized that the number of butchers participating had fallen to only three. He said it was determined that the reason for this decrease was due to the liability concerns surrounding donated game meat which resulted in butchers participating in the program needing an additional one million dollars of liability protection. He stated that other states, including Pennsylvania, had liability protections for the donation of all food, including game meat, to nonprofit organizations. Rep. Spiegelman referenced the federal legislation passed in 1996, the Bill Emerson Good Samaritan Food Donation Act, and explained that it has minimal standards states must follow, but that states are allowed to expanded protections beyond this Act.

Rep. Spiegelman stated that this bill provides liability protection for those donating food by changing the standard from simple negligence to gross negligence. He explained that gross negligence is defined as knowingly and purposefully doing something wrong, and that anyone who does this would still be liable for damages caused under this bill. He emphasized that participants in Hunters Helping Hunger, school districts, the Modern Maturity Center, and other organizations that may have a surplus of food will be able to donate food with protections under this bill, whereas they currently have to throw it in the trash wasting thousands of pounds of food.

Rep. Lambert shared that he has been involved with food distribution in the Claymont area where they were able to reach the milestone of one million pounds of fresh food distributed during the pandemic through the Coalition of Churches Food Distribution also known as the Feed Claymont Initiative. He stated that the Islamic mosques, and members of the Indian community faced different roadblocks in being able to donate certain foods. He explained the importance of making sure that all members of the community can donate food in a way that is not as cost prohibitive as going through the FDA and other channels currently available.

Rep. Morrison emphasized the importance of this bill, referencing the need he sees in his district at the Food Bank of Delaware.

Rep. Bennett stated that there may be some comments made by trial lawyers in opposition, but that other states have passed bills like this, some with even greater liability protection than is included in this bill, none of which have had problems. She emphasized the growing issue of food insecurity as prior to the pandemic there were 121 thousand food insecure people in Delaware, which has risen to 171 thousand people.

Rep. Baumbach asked if the bill discusses an individual who is providing a paid service in the process and if they have more or less protection given that they are being paid for the service. Rep. Spiegelman responded that this depends on the service, in the Hunters Helping Hunger program butchers are reimbursed by the state for a certain amount per pound for the venison they use, but in order to participate in the program they need to carry three million dollars of liability insurance rather than just two million and the amount they get back from the state does not cover this increased cost insurance.

Rep. Baumbach stated that he appreciates the problem presented and stated that it can be addressed either by removing the liability from the person who is being paid to process the meat, or by having the state pay more per pound so that the liability insurance is covered and then when there is negligence that may not rise to gross negligence there is protection for the consumer. He stated that he is more comfortable with lines 54 to 57 than with lines 58 to 62, but he appreciates the work Reps. Spiegelman and Bennett have put into the addressing the issue.

Rep. Spiegelman explained that he is sensitive to these concerns, and that Pennsylvania donates more deer than Delaware takes in for any person statewide, and that in the last 17 years where they have had expanded liability protection, they have never had an issue with any donations of tainted meat from the program making the chances Delaware will have a problem astronomically small.

Rep. Baumbach commented that if the chances are that small, the cost for the additional insurance should be pennies.

Chair Bentz opened the floor to public comment, there was none.

A motion was made by Rep. Briggs King, and seconded by Rep. Johnson to release HB 226 from committee, the motion carried. Yes = 10 (Chair Bentz, Reps. Chukwuocha, Johnson, Morrison, Kowalko, Postles, Shupe, Smith, Briggs King, Collins); No = 0; Not Voting = 1 (Baumbach); Absent = 4 (Vice Chair Minor-Brown, Reps. Heffernan, Lynn, Hensley). The bill was released from committee with a F=4, M=7, U=0 vote.

Chair Bentz introduced **HB 222, AN ACT TO AMEND TITLE 16 AND TITLE 18 OF THE DELAWARE CODE RELATING TO CHILDHOOD LEAD POISONING PREVENTION.**

Rep. Lambert, the prime sponsor of the bill, explained that childhood lead poisoning is a serious issue across the state, and that in areas of his district there are many older houses with lead paint. Toddlers start to become mobile at about age 2 which is when they get ahold of these lead chips. Rep. Lambert shared that as an educator he taught his students about the dangers of lead poisoning and how to identify it, and one of his students was in the newspaper for pointing out lead chips her younger brother was about to eat. He stated that he worked closely with the Childhood Lead Poisoning Advisory Committee on this bill and thanked local advocates with Lead Free Delaware including Amy Rowe, Sarah Bucic, Dr. Frank Malone.

Rep. Lambert stated that this bill defines “screening” and “testing” for clarity, mandates screening, defined as a capillary blood test, at or around 12 and 24 months of age, clarifies insurance coverage for the costs of compliance with the Act, and directs the Division of Public Health to report on elevated blood lead levels to the General Assembly annually and to develop regulations to implement and enforce the Act within 12 months of being enacted. He thanked staff at DHSS and DPH for discussing the one issue that was holding up their support of the bill, which was granting school nurses access to universal reporting systems which there will be an amendment to address.

Rep. Briggs King shared that when a similar bill was discussed on the floor a few years ago she had raised objections to language utilized, and that her concerns have been remedied in the language utilized in HB 222.

Dr. James Gill spoke for the Medical Society of Delaware in opposition to the bill stating that while they agree that lead poisoning is a significant issue, but they do not think that doing blood tests on all children is warranted and warned against government intervening in the physician-patient relationship.

Dr. Jonathan Miller, a pediatrician and Medical Director of Value-Based Care at Neumors Children’s Hospital and Chair of the Childhood Lead Poisoning Advisory Committee. He highlighted that lead poisoning causes permanent, irreversible brain damage and that identifying children with this problem is crucial. He explained that while the American Academy of Pediatrics (AAP) previously recommended routine screening at one and two years old for everyone and then changed this to only in high-risk areas, 70 percent of housing in Delaware are considered high-risk, and of those who are not included many are on Medicaid where it is also recommended to do testing at one and two years old. He also stated that it is important to consider the forty-three additional recommendations made by the Lead Poisoning Advisory Committee that include prevention strategies.

Dr. Frank Malone spoke in support of the bill and explained that this bill would bring Delaware in line with majority of the Northeast states. He stated that the permanent diminishing of intellectual capacity from lead poisoning is entirely preventable and mandated universal screening is necessary for primary prevention and removing sources of lead exposure in the State.

Dr. Shirley Klein shared ten reasons why two-year-olds should be tested for lead poisoning; screening at age two will catch

those who missed the one year screen, some children who did not have an elevated blood level at age one will at age two, 70 percent of children in Delaware live in zip codes with a high risk of exposure, screening questionnaires are not useful at predicting which children are at higher risk and need screening, Medicaid requires screening at ages one and two and 38 percent of children under 6 in Delaware have Medicaid, most other states in the region require lead screening at ages one and two with some also requiring it at ages three and five, two-year-olds are more likely to be iron deficient than one-year-olds and children who are iron deficient absorb lead more easily, it is cheaper and easier to prevent lead poisoning than treatment does not prevent damage, waiting until kindergarten is too late as most brain development happens before age 3, and the fact that it is impossible to remove lead from all contaminated buildings.

Kelly Coffey of Delaware PTA shared the organization's dedication to addressing the issue of childhood poisoning and highlighted that a simple finger prick and three-minute wait is all that is required to rule out exposure to lead, and that approximately 300 children are identified with elevated blood levels each year in Delaware. Ms. Coffey stated that each day taking substantive action to identify lead poisoning is delayed, additional at-risk children miss out on the essential services already available with federal funds and the lead is not being removed from their environment. She emphasized that children are dynamic individuals who play in different houses and outdoor areas that may be contaminated.

Diane Frentzel of Delaware Readiness Teams spoke in support of the bill, emphasizing that no amount of lead exposure is safe and that it is critical to screen for lead at 12 and 24 months so that early intervention can take place. She highlighted the difficulty families have in identifying lead.

A motion was made by Rep. Johnson and seconded by Rep. Baumbach to release HB 222 from committee; motion carried. Yes = 10 (Chair Bentz, Reps. Chukwuocha, Johnson, Baumbach, Morrison, Kowalko, Postles, Smith, Briggs King, Collins); No = 0; Absent = 5 (Vice Chair Minor-Brown, Reps. Heffernan, Lynn, Shupe, Hensley). The bill was released from committee with a F=6, M=5, U=0 vote.

Chair Bentz adjourned the meeting at 2:40 p.m.

Respectfully submitted,
Chelsea Chatterton

Speaker List:

- Rep. Spiegelman
- Rep. Bennett
- Rep. Lambert
- Dr. Nancy Fan (Healthcare Commission)
- Secretary Molly Magarik
- Terrance Murphy (Bayhealth)
- Chris Haas (Department of Insurance)
- Dr. David Krasner (Family Practice Associates)
- Dr. Christine Donohue-Henry (Christianacare)
- Christine Shiltz (America's Healthcare Plans)
- Dr. Sarah Mullins
- Dr. David Tam (Beebe Health)
- Dr. James Gill
- Penny Short (TitalHealth Nanticoke)
- Pamela Price (Highmark and BlueCross BlueShield)
- Dr. Bryan Villar
- Dr. Matthew Burday
- Leah Woodall (Department of Public Health)
- Dr. James Gill (Medical Society of Delaware)
- Dr. Jonathan Miller (Neumors, Childhood Lead Poisoning Advisory Committee)
- Dr. Frank Malone
- Dr. Shirley Klein
- Kelly Coffey (Delaware PTA)
- Diane Frentzel (Delaware Readiness Teams)

June 9, 2021

Representative David Bentz
House Health & Human Development Committee
Delaware General Assembly
Legislative Hall
411 Legislative Avenue
Dover, DE 19901

Re: SS 1 to Senate Bill 120 – Primary Care Legislation

Dear Chairman Bentz,

On behalf of AHIP and its members, we appreciate the opportunity to offer comments on Senate Bill 120 amended by SS 1 (SS1) regarding reimbursement guidelines of primary care providers within the Delaware health care system.

SS1 proposes that by 2025, a health plan must spend at least 11.5% of its overall health care spending on primary care. It requires movement towards value-based reimbursement contracting and expands the Department of Insurance's regulatory authority over inpatient hospital and other nonprofessional and medical services rates. While on the surface, these cost-cutting mechanisms seem appropriate, mandating specific reimbursement levels for any type of provider negates the advances Delaware has achieved shifting to a quality and value-based focused health care system.

The legislation does not consider the great progress Delaware has made with strengthening its healthcare system and innovative steps on fully implementing value-based care so that quality, access, and the promotion of patient-centered care remain the focal point for the state. The Department of Insurance, through its Office of Value-Based Health Care Delivery, is working with all health plans in the state to increase value-based health care and provide greater investment in primary care services. Therefore, proposing a cost shift from other providers and facilities within the health care system would negate the value-based care healthcare system altogether.

The principle of cost-shifting, mandatory rate caps, and required specified reimbursement rates is not based on market-driven ideals but instead requires rate regulation, favoring primary care providers over other provider groups. Specifically, Section 2503 of the legislation requires that health plans must file rates with specific caps on unit growth prices for non-professional services. These services are defined to include inpatient hospital facility services, outpatient hospital facility services, and other medical services such as non-capitated ambulance, home health care, durable medical equipment, prosthetics, and supplies.

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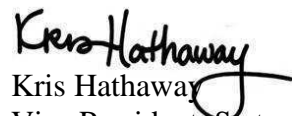
Additionally, Section 3342 mandates that health plans shall spend at least a certain amount of their overall cost of care on primary care, resulting in spending of at least 11.5% of overall care spending by 2025. Specific payments made to one type of provider do not allow for flexibility should it be required. Such questions should be asked - what if a separate public health crisis arises and we need to spend more on a certain specialist, or what if more allocations need to be made on the treatment of behavioral health or substance abuse treatment? What if these spending limitations cause actuarial soundness issues within a company? There is no flexibility included in the legislation and could jeopardize the financial soundness of a health plan in the state, particularly given the expansive list of facilities and services subject to the rate limitation.

We support the work undertaken by the Department of Insurance's Office of Value-Based Health Care Delivery to work with plans to invest in primary care and more alternative payment models. We believe the legislation should allow this work to continue under the regulation of the Department of Insurance. Only a few states have mandated specified rate benchmarks, and for those that have, they have not placed the specific percentages in statute, they give the state's Department of Insurance oversight to determine adequate numbers.

The proposed legislation would only apply to those fully insured commercial plans and those individual plans in the state marketplace, which account for approximately 30% of the health insurance marketplace in Delaware. It exempts the state employee plan and Medicaid plans and would not apply to those self-insured plans governed by ERISA. We are not certain how imposing these requirements on 30% of the insurance marketplace will assist primary care providers. We believe the focus of primary care reform in Delaware should build on the work that has occurred on moving to value-based reimbursement while providing financial support to independent practitioners perhaps by utilizing funding from the federal American Rescue Plan.

Thank you for the opportunity to provide feedback on this proposed regulation. If you have any questions or concerns regarding our feedback and would like to discuss the matter further, please contact me at khathaway@ahip.org or by phone at (202)-870-4468.

Sincerely,



Kris Hathaway
Vice President, State Affairs
America's Health Insurance Plans

cc: Members of the House Health and Human Development Committee

America's Health Insurance (AHIP) is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to

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market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.



SENT VIA EMAIL:

June 9th, 2021

TO: Members of the Delaware House Health & Human Development Committee

RE: SS1 to SB 120 Relating to Primary Care Services

Dear Members of the House Health & Human Development Committee,

On behalf of Highmark Blue Cross Blue Shield Delaware ("Highmark Delaware"), I want to thank you for the opportunity to offer comments on SS1 to SB 120 relating to primary care services.

At Highmark Delaware we appreciate the goal of SS1 to SB 120 of ensuring adequate investment in primary health care structures and services. Highmark Delaware has been keenly focused on delivering value-based reimbursement in both hospital and private primary care settings. While well-intentioned, we have concerns that SS1 to SB120 could disrupt the progress we have made to date by increasing primary care spend without directly tying it to improvements in both quality and cost, two critical components of any VBR contract. Other concerns include but are not limited to the following:

- The limits on unit price growth for non-professional services will likely be insufficient to cover the legislation's mandated increases in primary care spend which could lead to increases in premiums.
- Higher reimbursement to PCPs may also lead to higher member cost sharing, particularly where a member's cost share for the service is based on a percentage of the rate charged by the provider.
- Because only 30% of the market is impacted by this legislation due to the already high number of self-funded arrangements, SS1 to SB120 has limited ability to deliver any meaningful change while possibly incenting small and large fully insured employer groups to migrate to self-funded arrangements.
- We believe it is an inherent flaw to set a primary care rate spend while prohibiting insurance rates from accounting for overall health care costs. Such a prohibition has the potential to result in inadequate rates, leading to market instability.
- SS1 to SB 120 could have the unintended consequence of decreasing Medicaid members' access to primary care. It has been estimated that less than a third of independent primary care doctors accept Medicaid patients. Because Medicaid is not covered in this bill, it could further disincentivize primary care providers from accepting the lower Medicaid reimbursement rate for this vulnerable population.

Recommendations:

- Remove the specific requirements of and limitations on insurance rate filings from the legislation to allow the DOI to use actuarial standards and adjust appropriately during unforeseen events, such as a pandemic.
- Make the primary care spend targets rather than mandates.
- Enact and fully fund the primary care student loan repayment program (HB 48 w/ HA1).

Highmark Delaware appreciates the need to invest in primary care services while also addressing the total cost-of-care. We cannot address primary care alone. Value based arrangements require collaboration and partnerships with payers and providers across the continuum of care aimed at improving the experiences of patients and providers while increasing quality and decreasing the total cost-of-care. Highmark Delaware works towards these partnerships on behalf of all whom we serve as part of our core mission and vision.

Sincerely,

Pamela V. Price
Senior Government Affairs Representative
Highmark Delaware
800 Delaware Ave
Suite 953
Wilmington, DE 19801
302 421-2172



June 9, 2021

Comments on SS 1 for SB 120; Relating to Primary Care Services

Chairman Bentz and all members of the House Health Committee:

My name is Dr. Chris Donahue-Henry, and I am the Chief Population Health Officer for ChristianaCare. Thank you for the opportunity to provide comments on Senate Substitute 1 for Senate Bill 120, relating to primary care services in Delaware. I'd also like to specifically thank Senator Townsend and Representative Bentz for their hard work and leadership on this bill. We truly appreciate your focus on this critical issue.

As a family physician, I know the importance of primary care as a fundamental cornerstone to individual and family health. As the National Academy of Medicine recently noted "primary care is the foundation of health care." At ChristianaCare, we are deeply committed to expanding access to high-quality primary care services in Delaware. We have made significant investment in this area and continue to seek opportunities to provide additional resources and support to independent primary care physicians in the community as they transition to value-based care. That's also why we support this legislation.

We believe this bill will help to increase investments in primary care services and incentivize participation in alternative payment models, thus improving both access and quality of primary care in Delaware. In particular, we appreciate the substitute bill's revisions which consolidate rate increase limitations, add a sunset provision to allow us to revisit rate caps in five years, and exclude behavioral health and substance use disorder services from rate increase limitations. Especially at a time when those services are needed most.

We strongly believe that SS 1 for SB 120 will have a positive impact on primary care services and help improve health outcomes for Delawareans statewide. Thank you again for the opportunity to provide comments on this legislation here today. We hope you will consider supporting this bill and advocate for its passage.



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**Testimony on Childhood Lead Poisoning
Before the House Committee on Health & Human Development
June 9, 2021**

Thank you for the opportunity to present views of the League of Women Voters on Childhood Lead Poisoning. My name is Sandy Spence. I am representing the LWV of Delaware and am also honored to serve as a public member of the Childhood Lead Poisoning Advisory Committee.

A League position on early intervention for children at risk adopted in 1994 seeks early intervention and prevention measures that are effective in helping children reach their full potential.

No level of lead is safe. It is a significant factor in preventing children from reaching their potential. As stated in the Advisory Committee's Annual Report submitted recently:

"Lead is a neurotoxin, causing permanent and irreversible damage to the human body. The human body does not require lead for any function. Once entering the bloodstream, lead finds its way to the brain, kidneys, and bones. Even low levels of lead in the body correlate to a lower IQ, reduce ability to pay attention, and impair academic achievement."

Delaware's children and those in other East Coast states experience higher than average lead poisoning due to the number of old housing units that are the primary source of childhood lead poisoning. Yet, we are one of only two states in the East Coast that provides no state funding for childhood lead poisoning prevention or remediation.

In 2019 the League advocated, unsuccessfully, for a bill in this Committee to require testing of Children at age 2 in addition to the current required age 1. We have also testified at the Joint Finance Committee for funding for the purchase of additional machines to facilitate increased testing. We also support lowering the current level of 10 micrograms per deciliter of lead in children's blood to 5 micrograms per deciliter, as recommended by the Centers for Disease Control and other recognized authorities.

Delaware's children have waited long enough for attention to this major issue. We urge you to release HB 222 and seek its enactment and funding needed for this program.

For additional details on this issue go to the legis.delaware.gov link to task forces, find Childhood Lead Advisory Committee, scroll to the bottom and find out 2021 Annual Report. There you will see all the recommendations to date.

