Delaware Health Care Delivery and Cost Advisory Group
Monday, April 16, 2018
1 pm–4 pm
DHSS Herman Holloway Campus — Chapel
1901 North DuPont Highway, New Castle, DE

Advisory Group Members Present:

- Secretary Kara Odom Walker (Chair)
- Michael Jackson
- Dr. Nancy Fan
- Matthew Swanson
- Brenda Lakeman
- Steve Groff
- Dr. Janice Nevin
- Dr. Roy Proujansky
- Dr. James Gill
- Tim Constantine
- Nicholas Moriello
- A. Richard Heffron, Jr.
- David Cutler, PhD

Advisory Group Members Absent: NA

State Staff Present:

- Lieutenant Governor Bethany Hall-Long
- Richard Geisenberger, Secretary of Finance
- Steven Costantino, Director of Health Care Reform and Financing, DHSS
- Molly Magarik, Deputy Secretary, DHSS

Primary Consultants Present:

- Michael Bailit, President, Bailit Health

Meeting time frame:

- The meeting started at 1:02 pm EST and ended at 4:03 pm EST.

I. Welcome and introductions, Secretary Walker:

a. The Secretary thanked the group for their participation and clarified that the purpose of the benchmarks is to increase transparency, not to create a spending cap or penalty or to limit health care.

b. Lieutenant Governor Hall-Long discussed the history of Delaware's health care claims database legislation and efforts on data and transparency.

II. Health Care Spending Benchmark Subcommittee recap, Michael Bailit:

a. The group reviewed highlights from the April 2 Health Care Spending Benchmark Subcommittee, including:
   i. The subcommittee charge, which was the same as that outlined in the Executive Order for the Advisory Group

    ii. Questions considered by the subcommittee, which were the same questions as those reviewed during the first Advisory Group meeting (e.g., What is total health care spending?)
    iii. Questions raised by the Advisory Group during the last meeting

b. The subcommittee recommended the following populations be included in the spending benchmark: Medicare, Medicaid, dual-eligibles and commercially insured and self-insured.

c. The subcommittee also considered the tradeoffs of including other populations, data for which may be difficult to obtain. These populations include veterans and Federal employees covered by VHA, FEHB and TRICARE, prisoners incarcerated by the state and the uninsured (charity care). The subcommittee decided that these populations should be included, unless it is too difficult to obtain the data.

d. On the issue of including uninsured populations, there was discussion on distinguishing between bad debt and charity care and how each is captured in existing health care spending. The following points were initially raised:
    i. Bad debt should not be a spending category. If an individual does not make payments, then the insurance company does not know, so it is difficult to capture the data. In Massachusetts, the state does not subtract bad debt.
    ii. Charity care is paid for through a mark-up of other payers and is already represented in other spending categories. If the goal is to prevent double counting, charity care is already measured through this markup with other payers.

e. The following comments/questions were raised in response specific to the topic of including charity care in the spending definition:
    i. Although it may be difficult to include charity care, the assertion that it is picked up in a mark-up by other payers is not true in Delaware (e.g., commercial pays less than Medicare and Medicaid). It makes sense that charity care is not included in the spending benchmark, but not for the reason that it is included in a mark-up.
    ii. Health care systems in other states have charity care hospitals (e.g., public hospitals/DSH payments), but those do not exist in Delaware. It is important to know the amount of charity care because it reflects the demographics of the state (e.g., poverty, other socioeconomic factors).
    iii. Do hospitals track charity?
    Response: Hospitals reported they were able to track this information.
    iv. Most charity care is provided by hospitals and by federally qualified health centers in the outpatient settings.
    v. Charity care should be included because it is significant and the goal for measuring it should be to find a number that is "good enough."
    vi. Populations included in the spending benchmark should represent areas in which health care improvements can be achieved. The benchmark process appears to be working backwards (e.g., in medicine, the diagnosis determines the treatment, but for this process, it started with the treatment and is working back towards the diagnosis). Additionally, it appears that the spending benchmark will be a spending cap, and assurance is needed to confirm that it is not.

Response: More information is needed for a “total picture” of the state, and the topics discussed are about understanding data and obtaining better information and data. The spending benchmark is not a spending cap; the benchmark and this process is not changing how Delaware is paying for care or how the state contracts.

f. The group agreed that bad debt should not be included in the spending benchmark.

g. The subcommittee reviewed types of spending to be included in the spending benchmark, including the following: claims-based spending (e.g., hospital inpatient/ outpatient, professional services, home and community health, long-term care, dental, pharmacy, durable medical equipment [DME], hospice) and non-claims-based spending (e.g., capitation, pay-for-performance incentive payments, care manager payments, prescription drug rebates, net cost of health insurance, patient cost sharing).

h. The subcommittee recommended that spending categories should be as inclusive as possible, so long as the data are not too administratively complex, expensive or impractical to obtain. With that caveat, the subcommittee suggested including spending on any claims collected by reporting entity, pharmacy spending net of rebates, net cost of private health insurance, patient cost sharing, spending on carved-out benefits and Federal grants that are used to provide direct health care services. The feasibility of obtaining Federal grant data has not yet been investigated.

i. The following comments/questions were raised, and the corresponding responses were discussed on the topic of types of health care spending as part of the spending benchmark:
    i. Where does capitation fit in?
    Response: Non-claims based spending includes capitation.
    ii. Some employers obtain drug benefits elsewhere, which may come up as third- party liability costs. Some employers are also establishing wellness programs which could expand over time. These costs are not billable, but are significant costs. The types of spending should be as inclusive as possible. How are these costs included in these estimate?
    Response: The feasibility of data collection for this spending will need to be assessed.
    iii. How are employer benefits like Employee Assistance Program benefits captured in the data?
    Response: An estimate for these types of categories can be attempted, but some may be too difficult.
    iv. A *Health Affairs* article on the burden of disease and health spending was referenced. For example, diabetes is a big issue in Delaware, and if there are collective efforts to address diabetes, spending will decrease because of improvements in overall health. How is this being addressed in the benchmark?
    Response: The Advisory Group is responsible for looking at how data can reveal contributors to health care spending in the state. In the June meeting, the Advisory Group will consider how data analysis and how health care spending impacts health outcomes.

j. The subcommittee reviewed where the data will come from, including which entities have and might be best able to provide data. Generally, it was thought that insurers have the best data that cannot be provided from state or Federal government. The subcommittee then considered the following options:
   i. Asking commercial insurers to provide health care spending calculations voluntarily
   ii. Contractually requiring commercial insurers to do so (for those that contract with the State)
   iii. Statutorily requiring all health insurers to do so, or at least those with significant size
   iv. Voluntarily calculations, so long as other insurers provide the information, which was a recommendation from the insurers

k. The subcommittee was split in opinions on voluntarily reporting insurance data.

l. The following comments/questions were raised, and the corresponding responses were discussed on the topic of health insurer data reporting:
   i. What are the current statutory reporting requirements for the Health Care Claims Database and how does that mesh with what we need?
      Response: There is a hole in requirements for non-state employee commercial and self-insured populations.
   ii. If reporting is mandatory, then why is that more expensive than voluntary reporting?
   iii. What is the reporting method in Massachusetts?
      Response: It is mandatory.

m. The subcommittee considered units of measurement. The Executive Order states that the health care spending benchmark will be set at the state level, and as practicable, at the market (commercial, Medicare, Medicaid), insurer and health system/provider levels. The "as practicable" language applies to assessing performance against the benchmark rather than setting the benchmark.

n. To assess performance against the benchmark at the state, insurer and provider levels, the subcommittee recommended the following:
   i. Include Delaware residents, regardless of whether they receive care in or out-of-state
   ii. Exclude out-of-state residents who seek care from Delaware providers in all cases, regardless of the location of their employment

o. The following comments/questions were raised, and the corresponding responses were discussed on the topic of units of measurement:
   i. 10% of active state employees live out of state. It is a concern that this population might not be included.
   ii. It is a concern that the population does not include all those who are receiving care in the State.
   iii. The purpose for choosing this approach was to have a "clean definition" of who should be included.
   iv. How easy is it for the insurers to carve out residents versus non-residents?

Response: Information will be gathered from the insurers on that question, as well as information on what Massachusetts is doing. This information will be brought back to the group for review.

v. It was suggested that the benchmark should measure costs of care over which providers have control.

vi. Out-of-state insurers cannot be asked to report to Delaware on residents who are getting care outside of the State.

p. The group will be provided with a breakout estimate of spending by categories before the next meeting.

III. Health care spending benchmark methodology, Michael Bailit:

a. The topic of the health care spending benchmark methodology (i.e., the basis for the growth rate) was not discussed at the last Advisory Group meeting or at the subcommittee meeting.

b. The essential question is what will be the benchmark? There are a number of decisions to make including, will the benchmark be:

   i. Tied to one or more indices of economic growth, inflation or another economic indicator?
   ii. Adjusted? (inflated or deflated (+/-) by a certain number of percentage points)
   iii. Forecasted, historical or a blend of each?
   iv. Based on a multi-year approach (averaging or weighting years) or a single-year approach?

c. Approaches used in other states include potential gross state product in Massachusetts, gross state product in Washington and a CPI-linked methodology in Maine.

d. Options for the methodology include:

   i. Economic growth indicators (Delaware GSP, Delaware personal income)
   ii. Inflation indicators for the Philadelphia-Camden-Wilmington region (General inflation [Consumer Price Index for urban consumers (CPI-U)], CPI-U less food and energy, CPI-U less medical care, CPI-U medical care).
   iii. Other indicators (Health care employment, state population growth [total or age 65+ years]).

e. In linking the benchmark to economic growth, the benchmark would imply that health care should not grow faster than the economy. Measures of economic growth include:

   i. State gross domestic product: the total value of goods produced and services provided in the state during a defined time period. It is a dynamic figure over time.
   ii. Personal income growth: the total income received by, or on behalf of, all persons from all sources: wages, income derived from owning homes, businesses, from the ownership of financial assets (except realized and unrealized financial gains and losses), government sources (e.g., Social Security benefits) and employer benefits. Wages and salaries account for approximately half of US personal income. States track personal income growth as a measure of a state's economic trends, as state revenue depends on personal income as

does spending on government assistance programs. Personal income growth is volatile.

f. The group reviewed past experience and future projections of economic growth.

g. The following comments/questions were raised, and the corresponding responses were discussed on the GSP and personal income growth:
    i. If the State has an economic downturn, there is less spending on elective/ price-sensitive tests, but it is likely there will be growth in Medicaid and uninsured rates.
    ii. What is the data source for personal income?
    Response: The US Bureau of Economic Analysis, which is "as good as it gets" in terms of estimating personal income data.
    iii. If the benchmark is tied to economic growth, and we already think that we spend too much, then the real question should be how much the State spends, and not how much the spending grows.
    Response: That is an excellent point. The rationale for a benchmark is to at least have a constrained rate of growth over time. How are changing demographics considered? (e.g., Delaware is the fastest growing aging state)
    Response: The group should advise on this topic.
    iv. If the entire health care industry is being held accountable for constraining spending growth, the State should be accountable for economic growth. How is the State held accountable to make that growth happen (e.g., job growth, attract business, viable state economy)?
    Response: It is not the purpose of the benchmark to consider how the State should be held accountable for economic growth. If that is a concern, the GDP may not be a good reference point.
    v. There are concerns about using a volatile measure.
    Response: The prospective measures are less volatile than those looking at past experience. Massachusetts uses prospective forecasts for its measure.

h. The group reviewed linking the benchmark to inflation. Generally, if the health care spending benchmark is tied to inflation, the benchmark would imply that health care should not grow faster than the average rise in consumer-paid prices. Inflation would be measured by a consumer price index, including one of the following:
    i. CPI-Urban, All Items (CPI-U): represents spending for approximately 94% of the total US population of urban or metropolitan areas, including professionals, self-employed, low-income, unemployed and retired. Not included are farmers, people in the Armed Forces and those in institutions (e.g., prisons, mental hospitals).
    ii. CPI-U Less Food and Energy: removes food and energy prices from the calculation, as these prices are typically the most volatile.
    iii. CPI-U Less Medical Care: removes medical care from the calculation, since the health care spending benchmark is focused on medical care.
    iv. CPI-U Medical Care: represents spending only on medical care services (professional, hospital and health insurance) and medical care commodities (Rx, DME) only.

i. The following comments/questions were raised, and the corresponding responses were discussed regarding using a CPI:
    i. There is interest in reducing volatility.
    ii. Is inflation included in GDP?
    Response: It depends on whether it is real or nominal inflation. Inflation is included in nominal GDP.
    iii. Is the benchmark a per capita or a gross number? If per capita, the population factors would create adverse impacts.
    Response: It is a per capita figure, which does not address concerns about an aging population and new drug innovations.
    iv. It was recommended by one participant that a blended CPI be used.

j. The group reviewed the pros and cons of using economic growth versus inflation.

k. The group reviewed other indicators as proxies for health care spending, including population growth (total and 65+ years) and health care employment. The Department of Finance has suggested that these two indicators not be used alone but potentially in conjunction with measures of economic growth or inflation. State population growth is less than 1%.

l. The group reviewed a mixed weighted approach. The Department of Finance has suggested that a weighted mix of measures could be used to more fully capture inflation drivers, cost drivers and population growth. The Department is not suggesting a specific formula but trying to put out a concept similar to one considered by the Delaware Economic and Financial Advisory Council. By using measures reported by the Bureau of Labor Statistics, there is no debate on data sources.

m. The following comments/questions were raised, and the corresponding responses were discussed on using a mixed weighted approach:
    i. Costs (in terms of who is paying, e.g., consumer payer, etc.) should be clarified. There are concerns regarding commoditizing health, and the benchmark should consider how to ensure that people who need care will receive it and how to grow primary care.
    Response: The Advisory Group is responsible for considering what concepts should be included in the benchmark, and affordability for consumers could be a consideration.
    ii. How would change in service need be measured?
    Response: There could be a clinical risk adjustment.
    iii. A goal is to better identify costs, and there is no right answer. The group should look to something reasonable that has as little volatility as possible. Using multiple indices to create a benchmark slide may do this.
    iv. It was requested that lessons learned from other states be added to the agenda and that a consumer stakeholder voice be considered.
    Response: The mandate for the Advisory Group is explicit in the Executive Order. There have been numerous public sessions where public input was solicited on lessons learned from other states.

n. The group was asked to consider the proposed indices further. The indices will be reviewed with the Subcommittee on May 7.

IV. Quality Benchmark Subcommittee recap, Michael Bailit:

a. The Quality Benchmark Subcommittee met on April 2 to discuss measure selection criteria, candidate measures, benchmark methodology and patient attribution.

b. The subcommittee made the following recommendations on the quality benchmark criteria to be applied to the individual measures:
   i. Patient-centered and meaningful to patients
   ii. High impact that safeguards public health
   iii. Aligned across programs and with other payers
   iv. Presents an opportunity for improvement in Delaware
   v. Actionable by providers
   vi. Operationally feasible and not burdensome
   vii. Drawn from the Common Scorecard, if meeting other criteria (with dissent)
   viii. Should have financial impact in the short or long term (with dissent)

c. The subcommittee made the following recommendations on the quality benchmark criteria to be applied to the measure set as a whole:
   i. Representative of pediatric, adult and older adult (Medicare) populations

d. The group agreed that these are reasonable criteria.

e. The subcommittee made the following recommendations on candidate measures:
   i. Access to care composite from CAHPS 5.0H health plan survey
   ii. Access measure from BRFSS survey
   iii. Prevention composite: children
   iv. Prevention composite: adults
   v. Potentially preventable hospitalizations
   vi. Ambulatory Care-Sensitive Condition (ACSC) admissions
   vii. ACSC emergency room visits
   viii. Infant mortality rate
   ix. Overdose death rate
   x. BMI
   xi. BMI assessment
   xii. Depression (unspecified)
   xiii. Diabetes (unspecified)
   xiv. Oral health composite
   xv. Oral health access
   xvi. Timeliness of prenatal care
   xvii. Equity across the studied measures

f. Four additional candidate measures were suggested by Advisory Group consultants and staff, including:
   i. Blood pressure control
   ii. Hospital readmission rate
   iii. All-cause unplanned readmissions for diabetes or for multiple chronic conditions
   iv. Use of opioids at high dosage or from multiple prescribers

g. The group was reminded that the Executive Order calls for only two to five measures for quality benchmarks; the list of proposed measures should be narrowed down to a smaller set.

h. The following comments/questions were raised, and the corresponding responses were discussed on quality candidate measures:
    i. It is difficult to recommend if the group does not know how the measures are going to be used, including time frame considerations.
    Response: The subcommittee recommended multi-year goal setting with measures that will be retained over that time frame.
    ii. Measures that are more global and less specific should be chosen.
    iii. The group should focus on specific health outcomes that define Delaware's health care rankings, and then quality measures should be pulled in based on that.
    iv. Some metrics are process measures; some are outcomes measures.
    v. There are concerns that consumer input is not being considered.

i. The group was asked to review the proposed candidate measures, identify those of greatest interest for benchmark adoption and come up with additional measure recommendations, if desired, for consideration at the next meeting.

j. The group will resume the quality benchmark discussion at the next meeting.

V. Public comment:

a. Pat Michael from the Developmental Disabilities Council read and submitted a written statement. The statement conveyed Pat's perspective that the health care system does not account for those with disability needs (e.g., access to care, accommodations, transportation, community care, etc.) and this benchmark process should account for those needs.

VI. Wrap up and next steps, Secretary Walker:

a. The Secretary thanked everyone for their input and participation and informed the group that if there are questions, to reach out.