REPORT TO GOVERNOR CARNEY ON ESTABLISHING A HEALTH CARE BENCHMARK

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CONTENTS

Executive Summary 3
- A. Health Care Spending Benchmark 3
- B. Health Care Quality Benchmarks 4
- C. Entities Responsible for Setting the Benchmarks and Assessing Performance 4
- D. Variation Analysis 6
- E. Conclusion 6

1. Introduction 7

2. Health Care Spending Benchmark 9
- A. Health Care Spending Benchmark Methodology 9
- B. Methodology for Measuring Spending 11
- C. Process for Obtaining the Spending Data 12

3. Health Care Quality Benchmarks 13
- A. Process for Obtaining the Data to Assess Quality Performance 15

4. Entities Responsible for Setting the Benchmarks and Assessing Performance 16
- A. Setting the Health Care Spending Benchmark 16
- B. Setting the Health Care Quality Benchmarks 17
- C. Assessing Performance Against the Spending and Quality Benchmarks 18
- D. Composition of the Health Care Commission 19

5. Conclusion 23

Appendix A: Quality Measures Suggested by the Advisory Group for Quality Benchmark Development 24

Appendix B: Benchmarks Timeline 26
- A. Long-Range Timeline 26
- B. Annual Timeline 26

Appendix C: Examples of Variation Reports Published by Other States 28

EXECUTIVE SUMMARY

House Joint Resolution 7 (HJR 7), signed in September 2017, tasked the Delaware Department of Health and Social Services (the Department) with the establishment of an annual health care benchmark as a strategy to help address the unsustainable growth in health care spending that was contributing to Delaware's (the State's) deficit. The Department hosted a series of five different health care benchmark summits that provided forums for discussion and the sharing of information and experience from the State and leaders from other states. In December 2017, the Department submitted a report to the General Assembly and to Executive Branch officials describing lessons learned from those summits, an assessment of challenges the State faces and made several recommendations regarding the establishment of a health care spending benchmark. Within that report, the Department also recommended establishing a health care quality benchmark based upon two to five quality measures that would support the twin focus of reduced cost growth and improved quality.

In February 2018, through Executive Order 19, Governor John Carney established an Advisory Group of Delaware health care leaders. The Advisory Group was tasked with advising the Department Secretary on methodologies for the establishment of the health care spending and quality benchmarks and strategies to subsequently assess state, market, insurer and provider performance against those benchmarks.

This report represents the culmination of months of research, study and careful deliberation. Within this report, the Department makes recommendations on the establishment of the health care spending and quality benchmarks.

A. HEALTH CARE SPENDING BENCHMARK

The health care spending benchmark is an annual target growth rate that the State, payers and providers should strive to stay below. Consistent with the Advisory Group's feedback, the Department recommends that the spending benchmark be expressed clearly as a rate using a calculated measure of the per capita potential gross state product (PGSP) growth. The PGSP will be determined in advance of the performance period. The formula to calculate PGSP, which is described within Section 2 of this report, utilizes publicly available information, is easy to calculate and is transparent.

The Department recommends that growth in all in-state and out-of-state health care claims and non-claims-based health care spending for all Delaware residents be measured against the spending benchmark. For the initial performance years, data to support assessing performance should be submitted by insurers and other payers in pre-analyzed fashion, making the assessment against the spending benchmark simple for the State to evaluate and thereby be cost-effective.

B. HEALTH CARE QUALITY BENCHMARKS

The Department recommended in its December legislative report, and Executive Order 19 specified, the creation of two to five quality measures that could be adopted for the purposes of establishing quality benchmarks for the State. As described in Executive Order 19, these quality benchmarks are intended to "monitor and establish accountability for improved health care quality that bends the health care cost growth curve." Within this report, the Department gives options of measures for consideration, including measures that address the following topics, all of which are important to the State:

- Ambulatory care-sensitive condition emergency department (ED) visits;
- Opioid-related overdose deaths and co-prescribed opioid and benzodiazepine prescriptions; and
- Cardiovascular disease prevention.

C. ENTITIES RESPONSIBLE FOR SETTING THE BENCHMARKS AND ASSESSING PERFORMANCE

To operationalize the benchmarks, there are two important functions that need to be established. First, it is necessary to identify the entity responsible for setting the benchmarks. Second, it is necessary to identify the entity responsible for assessing and publicizing performance against the benchmarks and making sure that entity has sufficient resources to do so. In making these recommendations, the Department assessed the roles and functions of the Health Care Commission (HCC), including its current staffing and resources, as well as the Delaware Finance Advisory Committee (DEFAC) and the Delaware Health Information Network (DHIN). In so doing, the Department considered which functions would work best for which entities.

Setting the Health Care Spending Benchmark

The Department recommends that:

1. Governor Carney set the initial health care spending benchmark for calendar year (CY) 2019 (Year 1), with the intention that it remains in place through CY 2023 (Year 5), using the methodology described in Section 2.

   The value of the benchmark may change between CY 2020 and CY 2023 if the proposed, new DEFAC Health Care Spending Benchmark Subcommittee finds the Congressional Budget Office's (CBO's) forecasted inflation rate has changed enough to warrant an update to the benchmark; this is described in the third recommendation below.

2. The methodology be reevaluated and potentially revised after five years of experience. The Department recommends the HCC consider the recommendations made by a new DEFAC Health Care Spending Benchmark Subcommittee and offer the public and interested stakeholders an opportunity to provide input before adopting any changes.

3. DEFAC establish a new subcommittee that is focused specifically on the health care spending benchmark to:

    a. Annually review the inflation component of the PGSP methodology and make recommendations to the HCC regarding whether the forecasted CBO inflation rate component of the PGSP methodology has changed in such a significant way that it would warrant a change in the spending benchmark during Year 2 through Year 5, and if so, how and why the spending benchmark should be modified, and

    b. Review the methodology of the health care spending benchmark in CY 2023 for possible updates or modifications to the methodology for the performance year starting January 1, 2024, and beyond, and make recommendations to the HCC on whether, and, if so, why the spending benchmark methodology should change.

Setting the Health Care Quality Benchmarks

For the chosen quality benchmarks, the Department recommends that the Governor set aspirational benchmarks, along with more incremental annual benchmarks. Having both attainable and aspirational quality benchmarks is important to help maintain provider and insurer focus and motivation, while also aspiring for Delawareans to be the healthiest population in the nation. The Department recommends that the quality benchmarks and their aspirational and incremental targets be reevaluated every three years thereafter to reflect updated priorities and/or improved performance.

The Department recommends that the HCC convene a time-limited advisory group that consists of at least the Department's Divisions of Medicaid and Medical Assistance (DMMA) Public Health (DPH), the Statewide Benefits Office, the Delaware Center for Health Innovation (DCHI) and quality improvement professionals from insurers, medical groups and hospitals to inform the HCC on whether the quality measures should change to reflect new priorities and/or improved performance.

Assessing Performance

The Department recommends that the HCC utilize its existing authority to contract for the appropriate analytical capabilities to receive and analyze the benchmark-related data. The Department recommends data be submitted annually to the HCC. To the extent practical, the Department recommends that, over time, the HCC leverage existing data sources within the DHIN. The HCC should also have the resources to publicize the results of State, market, insurer and large provider performance against the benchmarks and host related forums for public discussion of findings and their implications for system-wide performance improvement activity.

Composition of the Health Care Commission

Executive Order 19 specifically required the Advisory Group to discuss "what, if any, changes need to be made to the composition or scope of the Delaware Health Care Commission" for it to perform the necessary functions related to benchmark setting and performance assessment. The Department

has considered the input from the Advisory Group and believes that some changes are required in order for the HCC to be perceived as a fair and appropriate entity for setting benchmarks and reporting on performance against them. The Department recommends that the composition of the HCC be changed with legislative assent, if necessary, to include one or more insurers as Commissioners, to limit the number of provider seats and to ensure that individuals employed by or contracting with insurer or provider organizations subject to the benchmarks do not chair the HCC, beginning with the appointment of the next chair.

D. VARIATION ANALYSIS

Executive Order 19 specifically requested recommendations on methods for analyzing and reporting on variations in health care delivery and costs in the State at a deeper level than what will be encompassed by the benchmarks' reporting. Analyzing variation in cost and quality will allow the State to further understand the results of State, insurer and provider performance against the benchmarks, and, therefore, identify where specific policies or other solutions may be necessary to help improve cost and quality within the State.

The Department recommends that the HCC contract with the appropriate resources to conduct analyses of the variation of cost and quality in the State's health care delivery system. The Department recommends initially focusing on the variation in costs and quality of high volume, high costs and high-value episodes of care, and the risk-adjusted total medical expense of medical groups of a sufficient size, but the analyses can evolve over time.

Finally, the Department recommends that a regular and ongoing opportunity be created for providers and community partners to use the variation analyses to explore actions addressing identified opportunities for improvement. Engaging providers and stakeholders in regular and ongoing discussion will give the HCC, the State and other interested parties the ability to better understand, evaluate and discuss how Delaware's health care delivery system is evolving over time.

E. CONCLUSION

The State is clearly on the road to value – toward a system that pays for health care based on the outcomes of that care and away from one that pays strictly on the volume of tests, procedures, medications and hospital days provided, regardless of patient outcomes. Over the past year we have taken multiple steps that have culminated with these recommendations for establishing health care spending and quality benchmarks. These benchmarks are a critical means to ensuring transparency and shared accountability for performance. Coupled with analyses of the reasons why spending and quality vary across the State, and why costs are changing and how quality is being impacted, the benchmarks will give the State the ability to improve its health care delivery system, thereby benefiting consumers, private employers, and state and local government. This strategy is practical, operational and carries promise for impact.

1 INTRODUCTION

Following the signing of House Joint Resolution 7 (HJR 7) in September 2017 regarding establishment of an annual health care benchmark, the Department initiated work assessing how best to meet the legislative charge. Beginning that month, the Department hosted a series of five different health care benchmark summits that provided forums for discussion and sharing of information and experience from Delaware leaders and leaders from other states. The Department submitted a report in December 2017, as required by Section 192 of House Substitute 1 for House Bill 275, to the Director of the Office of Management and Budget, the Controller General and the Co-Chairs of the Joint Finance Committee, describing lessons learned from those summits, an assessment of the challenges the State faces, and making several recommendations regarding the establishment of health care spending and quality benchmarks.

Following the legislative report, Executive Order 19 directed the Department to convene an Advisory Group consisting of Delaware health care leaders and key stakeholders. Executive Order 19 directed the Advisory Group to consider establishment of a) a health care spending benchmark, defined as “a health care spending growth target” and b) two to five quality benchmarks, defined as “improvement targets.” The Advisory Group was assembled to advise the Secretary on methodologies for the establishment of the health care spending and quality benchmarks to assess State, market, insurer and provider performance.

The Advisory Group met four times between March 2018 and June 2018. The Department is appreciative of the Advisory Group and its two subcommittees for providing insights and thoughtful suggestions for shaping the State’s benchmark strategy. Their careful consideration of the various benchmark-related topics and issues has informed the Department’s recommendations.

After nine months of research, study and careful deliberation, the Department is pleased to offer Governor Carney recommendations on how to establish the health care spending and quality benchmarks. Within this report the Department recommends:

1. The process for establishing the health care spending and quality benchmarks, including the process for setting the benchmarks for the CY 2019 performance year and for future years;

2. The exact methodology for setting the spending benchmark and offering a short list of recommended measures for defining the health care quality benchmarks;

3. The entities that should be responsible for calculating performance against the benchmarks and publicizing benchmark performance results; and

4. The processes for conducting associated analyses of variation in cost and quality to provide insight into why performance may differ from the benchmarks.

With these benchmark recommendations, the Department is proposing the State's next step on the road to value. The Department believes the health care spending and quality benchmarks are a critical means to transparency and establishing shared accountability for State, insurer and provider performance. With the enhanced transparency and accountability created by the benchmarks, the State will drive measurable positive change in the health care delivery system performance, creating benefits for health care consumers, private employers and state and local government.

2
HEALTH CARE SPENDING BENCHMARK

The health care spending benchmark was defined in Executive Order 19 as an annual growth rate that the State, payers and providers should strive to stay below. This report section addresses the recommended methodology for establishing the value of the spending benchmark, establishing what spending will be measured and the process for obtaining necessary data to assess performance.

A. HEALTH CARE SPENDING BENCHMARK METHODOLOGY

The methodology to calculate the health care spending benchmark should be sound, reasonable, predictable, easy-to-understand and, to the extent possible, be developed in an independent manner. It must also provide a stable cost growth-constraining target against which providers and insurers can plan and contract. In making this recommendation, the Department considered the input from the Advisory Group, the methodologies of other states using benchmark or similar benchmark-like policies, and other Delaware stakeholders.

Recommendation: Consistent with the Advisory Group's feedback, the Department recommends that the spending benchmark be expressed clearly as a rate using a calculated measure of per capita potential gross state product (PGSP) growth, determined in advance of the performance period.

To calculate PGSP growth, the Department recommends the following formula drawing upon publicly available data. This calculation should not require the purchasing of a privately created forecast or employment of an external consultant.

> (Expected growth in national labor force productivity + Expected growth in the Delaware labor force + Expected national inflation) − Expected Delaware population growth = **PGSP** growth

Components *(expressed as a percentage)*	**Forecast** *(expressed as a percentage)*	**Sources**
Expected growth in national labor force productivity	Utilize forecasts that project growth for 5 through 10 years in the future[1]	Congressional Budget Office Budget and Economic Outlook Report (published annually in January)
+ Expected growth in the state civilian labor force	Calculate growth by averaging the forecasted increases of Years 5 through 10 in the future	Delaware Population Consortium Forecasts (published annually in October)
+ Expected national inflation	Utilize the personal consumption expenditure growth for 5 through 10 years in the future	Congressional Budget Office Budget and Economic Outlook Report (published annually in January)
= **Nominal PGSP** growth	N/A	*Calculation*
− Expected state population growth	Calculate growth by averaging the forecasted increases of Years 5 through 10 in the future	Delaware Population Consortium Forecasts (published annually in October)
= **PGSP** growth	N/A	*Calculation*

The output of the calculation will be a value expressed as a percentage (e.g., X.Y%) representing the annual *per capita* health care spending benchmark that health care spending should not exceed. The Department recommends that the spending benchmark be established at the outset for five years and that, annually, only the inflation component of the benchmark be assessed to determine whether the CBO's forecast changed in a substantial way that would warrant a change in the benchmark. The Department anticipates that such spending benchmark adjustments will rarely occur.

The Department notes that the Advisory Group made a specific recommendation to adjust the benchmark upward to account for concerns about an increasing percentage of the State's population over 65 years of age (65+). After careful consideration, the Department recommends against adjusting the benchmark upward to account for this population for several reasons. First, the impact of the growth in the population of individuals 65+ and their associated spending is already included in the baseline. Second, there is a small differential in the growth rate of the overall population and the population of individuals 65+, and it is projected to narrow over time. Third, per capita income tax revenue is projected to decline (in most every state) due to an increase in the aging population, therefore, leaving states with less revenue to spend overall.[2] Finally, doing so would give commercial insurers a higher spending benchmark to meet than warranted given the different demographic composition of a commercially insured population. Therefore, the Department instead recommends performing an analysis of spending by individuals 65+, utilizing a per-member per-month spend and enrollment data, to isolate the effect this population may have on meeting the benchmark and make note of it when annually reporting the results of the benchmark assessment process. Such an approach should be able to isolate whether an increase in that population in a given year accounts for the State exceeding the benchmark.

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[1] It is common for long-range forecasts to be calculated by using assumptions of data that are between five and ten years away from the present.

[2] Felix A and Watkins K. "The impact of an aging U.S. population on state tax revenues." *Economic Review Fourth Quarter 2013.* Federal Reserve Bank of Kansas City.

Rationale: PGSP is a measure of the output of the economy. By using PGSP growth as the benchmark, the State is establishing an expectation that health care spending should no longer grow faster than a forecast of the State's economic growth. Health care spending growing faster than the economy increases the proportion of personal income that is spent on health care for some consumers and decreases the funds available for other public and private investments.

The methodology proposed is a generally accepted methodology for calculating PGSP growth by economists. While it varies from other methodologies used within the State to predict future economic conditions, its purpose is to slow health care spending, not to predict economic growth. Furthermore, the methodology is simple to explain, transparent and easy to calculate using publicly available information, which are all consistent with the goals of establishing a spending benchmark. Finally, the methodology has been employed to some apparent success in Massachusetts.[3]

B. METHODOLOGY FOR MEASURING SPENDING

To measure the State's per capita spending on health care, it is necessary to determine whose health care spending is measured and what costs should be included in that measurement.

Recommendation: Consistent with the Advisory Group's feedback, the Department recommends:

1. Inclusion of health care spending for Delaware residents with Medicaid, state employee/retiree health plans, Medicare, Medicaid and Medicare (i.e., those "dually eligible"), commercial insurance, self-insured insurance coverage, Veterans Health Administration (VHA) and Federal Employees Health Benefits (FEHB); and

2. Inclusion of all in-state and out-of-state health care claims[4] and non-claims-based health care spending. This definition includes spending on any claims collected by a reporting entity, pharmacy spending net of rebates, the net cost of private health insurance,[5] patient cost sharing and spending on carved-out benefits.

Rationale: In order to be effective, the health care spending benchmark must be inclusive of as many large populations and substantive spending as possible. In addition to spending on direct health care services, administrative costs of health insurance, insurer profit and performance incentives paid to providers are examples of costs that are ultimately borne by consumers and employers, and therefore, the Department recommends capturing them as part of the overall spending benchmark. So, too, does the Department recommend inclusion of the significant financial cost-sharing borne by consumers enrolled in most employer-sponsored plans and in traditional Medicare.

[3] "2017 Annual Health Care Cost Trends Report." Massachusetts Health Policy Commission. March 2018. See www.mass.gov/files/documents/2018/03/28/Cost%20Trends%20Report%202017.pdf

[4] Spending on dental and vision would not be included for commercial populations, as those two services are typically considered non-health care services. They would, however, be captured in Medicare and Medicaid spending to the extent the services are a covered benefit.

[5] Net cost of private insurance is the difference between health premiums received by the insurer and the benefits paid out. It therefore includes insurer administrative cost, profit and contribution to reserves.

The Department does recognize that the cost of obtaining data for small populations or small services may be too great and recommends against including data when the benefit of including the information in the benchmark methodology outweighs the cost of obtaining the information. The exact details of the spending (and quality) benchmark methodology and data requirements will be articulated in a technical manual drafted by the Department pending the review and acceptance of these recommendations.

C. PROCESS FOR OBTAINING THE SPENDING DATA

To obtain data for the purposes of creating a baseline and calculating benchmark spending performance, insurers and other payers will need to submit data to the State. The recent passage of Senate Bills 227 and 236 gives the Department additional authority to request claims data from mandatory reporting entities for the purposes of establishing benchmark performance.

Recommendation: For baseline performance (e.g., CY 2017 and CY 2018) and at least performance year 2019 calculations, the Department recommends that the Governor consider appropriate action to clarify Senate Bills (SBs) 227 and 236 to specify insurer responsibility regarding data submissions for the purposes of assessing performance against the benchmark. First, on an interim basis and until the DHIN is able to provide timely and accurate information necessary to assess insurer and provider performance relative to the spending benchmarks, this action should clarify that insurers should submit pre-analyzed data to the HCC. Second, the appropriate action should clarify that insurers must also report non-claims data, such as the net cost of private health insurance and any non-claims payments to providers (e.g., bonuses, incentives, infrastructure payments) or any other non-claims data required for the purposes of assessing performance against the spending benchmark.[6] Finally, the action taken should clarify that data submitted by insurers should include fully- and self-insured populations and the FEHB population for any payers administering the program. Consistent with SB 236, pre-analyzed data submitted to the HCC should be made public by the Department and disclosed at an open meeting of the HCC.

In addition to insurers, the Department will need to formally request data from other sources that do not typically report pre-analyzed data to the State (e.g., Medicare, VHA).

Rationale: On an interim basis, the Department recommends using payer-reported, pre-analyzed data because the DHIN is still establishing the Health Care Claims Database (HCCD). With a well-defined methodology and data request, the Department believes that payers will be able to provide the HCC with pre-analyzed data to support the spending benchmark process. The HCCD is an important tool to use for the purposes of analysis and with recent legislation supporting it; the Department is looking forward to more fully utilizing this resource in the future. When submitting pre-analyzed data, the insurers should explain how the data being submitted relate to the claims data submitted to the DHIN. Again, these data should be publicly reported, per SB 236.

[6] These reporting definitions and templates will be established in the implementation manual created by the Department that will describe the calculations required to perform an assessment against the benchmark.

3
HEALTH CARE QUALITY BENCHMARKS

Executive Order 19 called for the Advisory Group to recommend two to five quality measures that could be adopted for the purpose of establishing quality benchmarks for the State. Executive Order 19 specified that the purpose of the quality (and health care spending) benchmarks is to "monitor and establish accountability for improved health care quality that bends the health care cost growth curve."

The Advisory Group and its Quality Benchmark Subcommittee developed the following eight criteria to evaluate different quality measures:

1. Patient-centered and meaningful to patients;
2. High impact that safeguards public health;
3. Aligned across programs and payers;
4. Presents an opportunity for improvement in Delaware;
5. Actionable by providers;
6. Operationally feasible and not burdensome;
7. Drawn from the Delaware Common Scorecard, if meeting other criteria; and
8. Should have financial impact to bend the State cost curve in the short- or long-term.

The Advisory Group developed a list of 14 measures[7] for the Secretary to consider. With this input, the Department proposes the following quality measures for consideration. These recommended measures draw upon the meet the eight selection criteria in different degrees and take into consideration the State's public health priorities.

The following measures are presented in order of preference by the Department and include a) supporting rationale for their potential use in a quality benchmark strategy and b) whether they were suggested by the Advisory Group.

[7] The 14 measures are listed in **Appendix A**.

The Department's Proposed Quality Measures for Consideration

Measure	Rationale	Relationship to Advisory Group Suggested Measures
1. Ambulatory Care – Sensitive Condition ED Visits	• Improved management of chronic conditions should reduce ED visits and inpatient admissions related to the conditions • Opportunity for improvement:[8] – Commercial rate for ED visits is above the expected level, although below the national average – Medicaid rate for ED visits is not yet publicly available, but will be in the future • Moderate impact and actionable by providers • Potential nearer-term financial impact	Included
2. Two Measures: Opioid-Related Overdose Deaths and Concurrent Use of Opioids and Benzodiazepine	• Addressing opioid use, overdose and mortality is a priority for the State • The overdose death rate measure should be paired with a prescribing measure that is more actionable for insurers and providers • More than 30% of opioid-related deaths nationally involve benzodiazepines[9] • Opportunity for improvement: – Opioid-related overdose death rate is 16th highest in the U.S. and 27% above the national average in the most recent data[10] – Of 16 states participating in enhanced data surveillance, Delaware reported the second-highest percentage change for suspected opioid overdose ED visits, from July 2016 to September 2017[11] – Concurrent use measure: rate not previously calculated for the State • High impact and actionable by providers	Indirect. The Advisory Group suggested the measure Use of Opioids from Multiple Providers, but the Department believes that more opportunity for improvement resides in reducing concurrent opioid and benzodiazepine prescriptions

In addition to the aforementioned quality measures, the Department recommends a measure related to cardiovascular disease prevention. Heart disease is the second leading cause of death in Delaware after cancer, accounting for 23 percent of all deaths in 2016.[12] There are a number of cardiovascular disease prevention measures available for consideration, including the potential for a composite measure. Due to the importance and technical elements of this issue, the Department recommends that a small stakeholder advisory group be convened temporarily to assist the Department in identifying the most appropriate measure(s), taking into account the selection criteria established by

[8] Source: NCQA Quality Compass Benchmarks for Calendar Year 2016

[9] See www.drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids

[10] See www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/delaware-opioid-summary

[11] See https://news.delaware.gov/2018/03/07/delaware-ed-data-shows-increase-opioid-overdoses/

[12] Newman M. "The top causes of death in Delaware: Cancer leads, but drugs, alcohol numbers rising" *The News Journal* May 15, 2018.

the Advisory Group. The Department recommends that the stakeholder group have members consisting of medical and quality measurement experts. The Department recommends this stakeholder group be convened in late summer or fall of 2018 so that the quality benchmarks can be announced before the end of the year.

A. PROCESS FOR OBTAINING THE DATA TO ASSESS QUALITY PERFORMANCE

Data on quality measure performance can be obtained from multiple sources. Ultimately, the quality measures that are selected to serve as the benchmarks will determine the best source of the required data.

Recommendation: To the extent practical, the Department recommends leveraging existing sources of data to assess performance against the quality benchmarks. The Department also recommends balancing the data collection process with the ability to report performance at the State, market, insurer and possibly provider level.

It is possible that appropriations to the HCC will be required to access data submitted to health care accreditation organizations, such as the National Committee for Quality Assurance (NCQA), if that health care accreditation organization proves to be the best source for data for certain quality benchmarks. A contracted analytic vendor may also be able to provide such information.

Rationale: Delaware providers are already reporting performance data to the Department, DHIN, NCQA, the Centers for Medicare & Medicaid Services (CMS) and insurers. Consistent with the Advisory Group’s feedback, utilizing existing sources where possible would not increase the reporting burden on payers and providers. However, data may be needed from providers for the purposes of reporting performance at the provider group level that may not be currently reported to one of the aforementioned resources. Careful consideration should be made between the potential reporting burden on providers and the desire to report performance at the provider group level.

4

ENTITIES RESPONSIBLE FOR SETTING THE BENCHMARKS AND ASSESSING PERFORMANCE

To operationalize the benchmarks, there are two important functions that need to be established. First, it is necessary to identify the entity responsible for setting the benchmarks. Second, it is necessary to identify the entity responsible for assessing and publicizing performance against the benchmarks and making sure that entity has sufficient resources to do so. In making these recommendations, the Department assessed the roles and functions of the HCC, including its current staffing and resources, as well as the DEFAC and the DHIN. In so doing, the Department considered which functions would work best for which entities.

A. SETTING THE HEALTH CARE SPENDING BENCHMARK

Recommendation: The Department recommends three steps for setting the health care spending benchmark.

1. Governor Carney set the initial health care spending benchmark for CY 2019 (Year 1), with the intention that it remains in place through CY 2023 (Year 5), using the methodology described in Section 2.

   The value of the benchmark may change between CY 2020 and CY 2023 if the proposed, new DEFAC Health Care Spending Benchmark Subcommittee finds the CBO's forecasted inflation rate to have changed enough to warrant an update to the benchmark; this is described in the third recommendation below.

2. The methodology should be reevaluated and potentially revised after five years of experience. (A chart depicting the recommended timeline is provided in Appendix B.) The Department recommends the HCC consider the recommendations made by the DEFAC Health Care Spending Benchmark Subcommittee and provide the public and interested stakeholders an opportunity to provide input before adopting any changes.

3. Finally, DEFAC should establish a new subcommittee that is focused specifically on the health care spending benchmark comprised of a subset of existing DEFAC members and include at least three qualified economists. The DEFAC Health Care Spending Benchmark Subcommittee should be given the responsibility to:

   a. Annually review the inflation component of the PGSP methodology and recommend to the HCC whether the forecasted CBO inflation rate that is part of the PGSP methodology has changed in such a significant way that it would warrant a change in the spending benchmark during Year 2 through Year 5, and if so, how and why the spending benchmark should be modified, and

b. Review the methodology of the health care spending benchmark in CY 2023 for possible updates or modifications to the methodology for the performance year starting January 1, 2024, and beyond, and make recommendations to the HCC on whether, and, if so, why the spending benchmark methodology should change.

Rationale: Given DEFAC's expertise and experience in establishing a benchmark for the purposes of budget setting, the Department believes that the recommended subcommittee, with qualified economists, would be the best entity to annually review the inflation component of the health care spending benchmark methodology. Utilizing DEFAC reinforces the goal of linking health care spending to the State's economic growth.

B. SETTING THE HEALTH CARE QUALITY BENCHMARKS

Unlike the health care spending benchmark, which is focused solely on a single per capita measure of health care spending, the quality benchmarks will address multiple topics with a goal of achieving improved performance over time. In addition, whereas the health care spending benchmark is expected to remain static for each five-year performance period, the quality benchmarks may change over time should performance on the benchmarks improve and/or State improvement priorities change.

Recommendation: The Department recommends that Governor Carney set the initial quality benchmarks. Moreover, consistent with Advisory Group suggestion, the Department recommends that for each quality measure selected for benchmark application, an aspirational benchmark value be established along with a more incremental annual benchmark value. The annual benchmark value should be defined as: a) a fixed improvement or percentage improvement from prior year performance (e.g., two or three percentage point improvement per year) or b) achievement of the aspirational benchmark rate.

Further, both aspirational and annual benchmark values for each quality benchmark measure should be informed by consideration of national performance data (e.g., 90th percentile performance among health plans) and baseline Delaware performance at the State, insurer and/or provider levels, as available. Separate quality benchmark values should be established for commercial and Medicaid populations, when possible, if the benchmark measure pertains to a health outcome (as opposed to a process of care).

Rationale: It is important that quality benchmark values be both attainable or providers and insurers may lose motivation to attain them, and aspirational so that Delaware can strive to have one of the healthiest populations in the U.S., with our population receiving the best, most appropriate and cost-effective care. Because variation on quality varies at the insurer and provider levels, it is helpful to have benchmarks that provide motivation for lower performers and recognition of high achievement for the very best performers. Even if small annual improvements are not statistically meaningful, if repeated over multiple years they will become meaningful. Finally, the use of separate

benchmark values for different key population groups recognizes multiple research findings that social determinants of health associated with poverty negatively influence health outcomes.

Recommendation: After the initial three years of the quality benchmarks, and every three years thereafter, the HCC should convene a time-limited advisory group that consists of at least DMMA, the Department's Division of Public Health (DPH), the Statewide Benefits Office, the Delaware Center for Health Innovation (DCHI) and quality improvement professionals from two insurers, two medical groups and two hospitals to inform the HCC on whether the quality measures should change to reflect new or updated priorities or whether the target values for the existing measures should change to reflect improved performance on the quality benchmark measures. The HCC should provide the public and interested stakeholders an opportunity to provide input before adopting changes.

Rationale: To allow providers and insurers time to generate improved performance, it makes sense to wait for three years to revisit the quality benchmarks to determine if performance has sufficiently improved to reset the annual and aspirational values for the existing quality benchmark measures or to replace some or all of the measures due to a change in the State's health improvement priorities or comparatively greater opportunities for improvement in other important areas.

C. ASSESSING PERFORMANCE AGAINST THE SPENDING AND QUALITY BENCHMARKS

Recommendation: For the health care spending and quality benchmarks, the HCC should be given the resources to contract with appropriate analytical contractors to assess performance utilizing, to the extent possible, DHIN-supplied data, payer-reported data and other sources, as necessary. Depending on the capabilities of potential contractors, the same contractor may or may not be able to support the HCC with both the spending and quality benchmarks.

Finally, the HCC should also have the resources to publicize the results of State, market, insurer and large provider performance against the spending and quality benchmarks, and host related forums for public discussion of findings and their implications for system-wide performance improvement activity.

Rationale: The Department's recommendations on the benchmark methodologies and the process to assess performance have been made with consideration of limited State resources to effectuate this strategy. Nonetheless, some appropriation will need to be made to support the HCC in contracting with analysts who could receive and interpret benchmark data. Resources would need to be identified to establish staffing and/or consultant and technical expertise to support these efforts.

As noted previously, should these recommendations be accepted, the Department will create a technical manual that will describe the process for assessing performance against the benchmarks, including what data will be used to calculate performance.

D. COMPOSITION OF THE HEALTH CARE COMMISSION

Executive Order 19 specifically required the Advisory Group to discuss “what, if any, changes need to be made to the composition or scope of the Delaware Health Care Commission” for it to perform the necessary functions related to benchmark setting and performance assessment. The Department has considered the input from the Advisory Group and believes that some changes are required in order for the HCC to be perceived as a fair and appropriate entity for setting benchmarks and reporting on performance against them.

Recommendation: The composition of the HCC should change with legislative assent, if necessary, to include one or more insurers as Commissioners, limit the number of provider seats and ensure that individuals employed by or contracting with insurer or provider organizations subject to the benchmarks do not chair the Commission beginning with the appointment of the next chair.

Rationale: The benchmarks are not meant to be punitive, but they are meant to raise awareness on spending and quality and provide transparency should cost growth be high or quality performance low. Most, but not all, of the Advisory Group members believe that Delaware is too small a state to find individuals with expertise in health care who would not be subject to the benchmark to serve on the HCC. The Department acknowledges the legitimacy of this assessment, but is also concerned that there may be a conflict of interest created if insurers and providers subject to the benchmarks heavily influence their definition.[13]

For this reason, the Department recommends that individuals representing or serving as contractors to organizations whose performance will be measured against the benchmarks should not have the authority to oversee changes to the benchmark methodology. Specifically, the Department recommends that the statute governing the composition of the HCC explicitly limit the number of seats that may be filled by providers to no more than three and that one or more insurers be added to the HCC to achieve a more balanced representation of stakeholders. Further, beginning at the conclusion of the current chair’s term, the Department recommends that the HCC should not have insurers or providers chairing the HCC or any HCC-organized committees, subcommittees or work groups tasked with making recommendations specific to the benchmarks.

[13] No providers or insurers subject to the Massachusetts health care spending benchmark are involved in voting on the benchmark value.

5
VARIATION ANALYSIS

Executive Order 19 specifically requested recommendations on methods for analyzing and reporting on variations in health care delivery and costs in Delaware at a deeper level than what will be encompassed by the benchmarks' reporting. Analyzing variation in cost and quality will allow the State to further understand the results of State, insurer and provider performance against the benchmarks, and therefore, identify where specific policies or other solutions may be necessary to help improve the costs and quality within our State.

Recommendation: The Department recommends that the HCC contract with the appropriate resources to conduct analyses of the variation of cost and quality in Delaware's health care delivery system. The focus of these analyses should be for a) policy makers, insurers, providers and consumers to understand the differences in cost and quality of care and the reasons those differences may exist, and b) to understand what may be driving overall performance on the benchmarks, especially if the benchmarks are not met.

The Department recommends initially focusing on the variation in costs and quality of high volume, high costs and high-value episodes of care, and the risk-adjusted total medical expense of medical groups of a sufficient size, but the analyses can evolve over time. Similar analyses performed in other states show that the following episodes of care have great opportunity for improvement in terms of costs and quality in both the commercial and Medicaid populations:

- Coronary artery disease;
- Diabetes;
- Depression and anxiety;
- Hypertension; and
- Maternity care.

When assessing variation within episodes of care, the analysis should specifically identify the variation at the provider group level, and identify what might be driving the variation, including mix of services used (e.g., whether one provider group used a high-cost drug when an equally effective lower-cost drug was available), unit price and provision of low-value care (e.g., care that may be unnecessary, potentially harmful or lacks evidence of effectiveness).

While the Department recommends that the DHIN supply the data to support these variation analyses, the HCC should contract with an external contractor to complete the applicable analyses.[14] The initial analysis could be performed using State employee or Medicaid claims data only until such time as other payer claims data is more fully available from the DHIN. Since recent legislation mandates the reporting of claims to the Health Care Claims Database by fully insured commercial plans, the contractor also could include a single payer's commercial data as a proxy for all fully insured and self-insured commercial data. It is possible that this recommended variation analysis and the assessment of performance against the benchmarks will utilize separate data sources, but that is unlikely to be problematic.

Data for the variation analyses should be no more than three years old, leverage existing sources and, to the extent possible, cover multiple years of experience. The Department also recommends the HCC (and its contractor) be able to report on risk-adjusted total medical expenses of different medical/provider groups of a sufficient size. [15] The specific details for accounting for risk differences are beyond the scope of this report, but the Department acknowledges that the characteristics of the member/patient population can impact spending and quality measures at the provider level.

Finally, the Department recommends that a regular and ongoing opportunity be created for providers and community partners to use the variation analyses to explore actions addressing identified opportunities for improvement. Engaging providers and stakeholders in regular and ongoing discussion will give the HCC, the State and other interested parties the ability to better understand, evaluate and discuss how Delaware's health care delivery system is evolving over time.
This regular and ongoing forum should, to the extent possible, be informed by data and evidence-based solutions to address identified opportunities through the variation analysis.

Rationale: Coupled with the benchmarks, an analysis of variation will give the State the ability to understand the drivers behind the pace and composition of spending growth and quality performance, as well as the reasons behind observed performance variation. By conducting such analyses and then creating a regular and ongoing forum for providers and community partners to strategize and act upon ways to improve, the State, insurers and providers will be able to better understand what policies may be necessary to affect continued improvement of the value of Delawareans' health care dollar.

While, the Advisory Group expressed interest in focusing on giving consumers additional tools to make health care decisions based on transparent cost and quality data, research has repeatedly shown that consumers often do not use such transparency tools, and when they occasionally do, it is more often used for purposes of personal budget planning.[16] Therefore, the Department recommends that

[14] This external organization could also be contracted to measure performance against the health care spending benchmark using raw claims data from the DHIN, but such an approach could be prohibitively expensive and still require plans to submit additional data, as described in Section 2 of this report.

[15] Further analysis should be performed to determine how large a medical group must be for assessing the variation in total medical expense.

[16] Mehotra A, Chernew ME, and Sinaiko AD. "Promise and Reality of Price Transparency" *N Engl J Med* 2018; 378:1348-1354; Desai S, Hatfield LA, Hicks AL, Chernew ME, Mehrotra A. "Association Between Availability of a Price Transparency Tool and Outpatient Spending" *JAMA*. 2016; 315(17):1874–1881 and "Show me the Money: Why Transparency for Patients is Good for Providers, Too." www.accenture.com/t20171020T194802Z__w__/us-en/_acnmedia/PDF-64/Accenture-Health-Show-Me-The-Money.pdf#zoom=50

cost and quality variation reports not focus exclusively on consumers, but also on policymakers, insurers and providers too. The effect of having transparent cost and quality information in an easy-to-use format, like the examples cited in **Appendix C**, might also motivate providers to improve their cost and quality on the specific services being measured.

6
CONCLUSION

Delaware is clearly on the road to value-based health care and, over the year, has taken multiple steps that have culminated with these recommendations for establishing health care spending and quality benchmarks. These benchmarks are a critical means to transparency and shared accountability for performance. Coupled with analyses of the reasons why spending and quality vary across the State, and why costs are changing and how quality is being impacted, the benchmarks will give the State the ability to improve the health care delivery system, thereby benefiting consumers, private employers, and state and local government. This strategy is practical, operational and carries promise for impact.

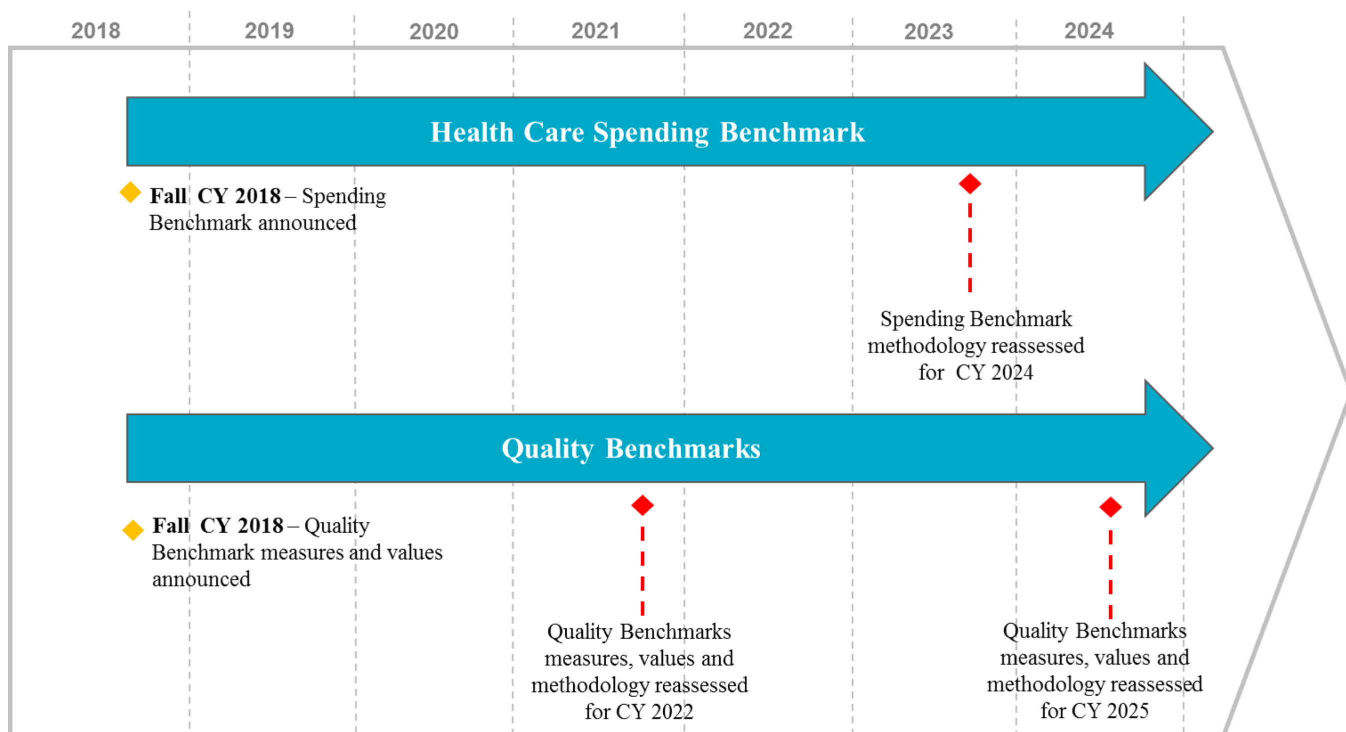
Appendix A

QUALITY MEASURES SUGGESTED BY THE ADVISORY GROUP FOR QUALITY BENCHMARK DEVELOPMENT

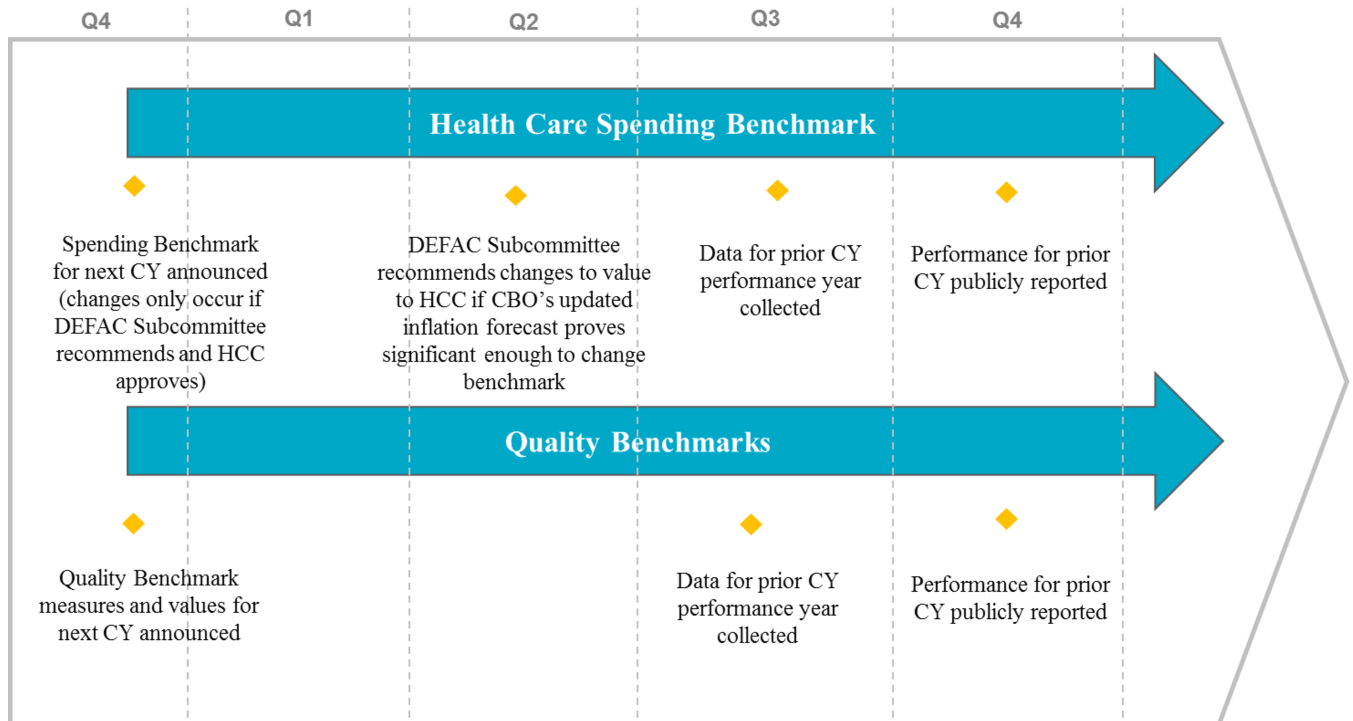
Measure Name
1. Prevention Composite: Adults: – Cervical Cancer Screening – Breast Cancer Screening – Colorectal Cancer Screening
2. Prevention Composite: Children: – Childhood Immunization Status – Immunizations for Adolescents
3. Adult Body Mass Index (BMI) Assessment
4. Screening for Clinical Depression
5. Fluoride Varnish Application for Pediatric Patients
6. Ambulatory Care-Sensitive Condition (ACSC) ED Visits
7. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI Percentile)
8. Asthma Medication Ratio
9. Medication Management for People with Asthma
10. ACSC Admissions – Hospitalization for Potentially Preventable Complications
11. ACSC ED Visits – Follow-up After ED Visit for People with High-Risk Multiple Chronic Conditions
12. Access to Care Composite from CAHPS 5.0H Health Plan Survey – Getting Needed Care
13. Access to Care Composite from CAHPS 5.0H Health Plan Survey – Getting Care Quickly
14. Use of Opioids from Multiple Providers

Appendix B
BENCHMARKS TIMELINE

A. LONG-RANGE TIMELINE



B. ANNUAL TIMELINE



Appendix C

EXAMPLES OF VARIATION REPORTS PUBLISHED IN OTHER STATES

Colorado (Center for Improving Value in Health Care (CIVHC)):

- CIVHC reports on episodes-of-care highlighting the differences in the delivery of care that are expected (typical) and care that might be unwarranted (potentially avoidable complications). www.civhc.org/shop-for-care/

Minnesota (Minnesota Community Measurement (MNCM)):

- MNCM publishes total cost of care and the average cost of 118 common medical procedures by medical group. www.mnhealthscores.org/

Vermont (Blueprint for Health):

- Bi-annually publishes hospital service area profiles of the health status, health care utilization and outcomes for adults and children. Key metrics include expenditures (per capita and by major category of spending), resource use index, utilization rates and performance on specific quality measures. http://blueprintforhealth.vermont.gov/community-health-profiles