Delaware Health Care Delivery and Cost Advisory Group
Thursday, March 22, 2018
1:00 p.m. to 4:00 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
- Cindy Bo (in place of 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:

- Monica Horton, Deputy Attorney General
- Steven Costantino, Director of Health Care Reform and Financing, DHSS
- Ann Kempski, Executive Director, Delaware Health Care Commission
- Molly Magarik, Deputy Secretary, DHSS

Primary Consultants Present:

- Michael Bailit, President, Bailit Health
- Dianne Heffron, Principal, Mercer

I. Welcome and Introductions; Secretary Odom Walker

a. The Advisory Group members and staff introduced themselves and were reminded that this is an open meeting, rules for which will be reviewed by Monica Norton, Deputy Attorney General of the State Department of Justice.
b. Secretary Odom Walker thanked stakeholders, reviewed the need for the health care spending and quality benchmarks, and described the charge of the Advisory Group.

II. Review of Open Meeting Law; Monica Horton, Deputy Attorney General

a. Deputy Attorney General Horton reviewed public meeting rules including the following:
    - Delaware Freedom of Information Act (FOIA), which requires transparency in public meetings, emails and other communication. FOIA applies to Advisory Group meetings because the group is a government-established entity. Generally, all communications are "FOIAable," with the exception of communication with proprietary or personal health information (PHI).

- A quorum of Group members is required for a meeting to commence. A quorum is defined by the State as a simple majority (seven board members in the case of the Advisory Group).
- Notice of Advisory Group meetings is required. Notice must be posted at least seven days in advance of the meeting in a location that is the "principle office of the public body or at the place where meetings are regularly held" and must include the date, time, place and whether video conferencing will be used.
- Meeting minutes are required after each meeting, which must contain information on members present, votes taken, and agreed upon actions.

III. Advisory Group Charge; Michael Bailit

a. General clarifications:
   - The Advisory Group is "advisory" in nature and will not be voting on issues; just processing and reacting to content.
   - "Health care spending growth target" means "cost benchmark."
   - Subcommittees have been added to help advance the work of Advisory Group.

b. The Advisory Group charge is included in the Executive Order, which is to:
   - Provide feedback to the Secretary of the Department of Health and Social Services (DHSS) regarding: the selection of methodologies to measure and report on the total cost of health care in Delaware (including the data that feed into the methodologies); and the establishment of a health care spending growth target, which will become the cost benchmark for 2019.
   - Determine quality metrics across the health delivery system that will be used to create quality benchmarks for 2019, and what, if any, changes need to be made to the composition or scope of the Delaware Health Care Commission in order for it to: receive the relevant and necessary data for benchmark calculation; apply the Health Care Commission's adopted benchmark methodology; and update and assess State, market, payer and provider performance relative to the cost and quality benchmarks each year.
   - Advise the Secretary regarding proposed methods for analyzing and reporting on variation in health care delivery and costs in Delaware.

c. The following questions were asked and corresponding responses were discussed on the Advisory Group's charge:
   - Is the 2019 benchmark timeline tied to the fiscal year or calendar year?
     Response: The Executive Order does not specify, so it should be understood to mean "calendar year."
   - Will the group will be providing feedback or developing the benchmark?
     Response: The Advisory Group will provide feedback on actions that will go into developing the cost and quality benchmarks.
   - Will there be consideration of unintended consequences or lessons learned from other states?
     Response: The Advisory Group will review this and consider how best to address lessons learned from other states.

IV. Cost Growth and Quality Benchmarks; Michael Bailit

a. DHSS will be establishing two benchmarks types (spending benchmark and quality benchmarks). The benchmarks are to be established at the state level, and as practical, at the market, insurer and health system/provider levels.
b. The spending benchmark is to be a per annum rate-of-growth target for health care costs in Delaware. It must be tied to an economic index, but there is not specificity on what index and how it should be tied to the benchmark.
c. The quality benchmarks are to be annual targets for health care quality performance improvement in Delaware. The focus of the quality benchmarks is yet to be determined, but should be on a number scale between 2 and 5.
d. The following questions were asked and corresponding responses were discussed on the spending and quality benchmarks:
    - Health care providers have their own benchmarks; will these be considered?
      Response: Not specifically, but the general goal is to try to gather quality measures currently used in the State (e.g., Common Scorecard, measures used by insurers, etc.).
    - Quality metrics are often confused with health metrics; are the quality metrics under consideration the ones that will be used by providers and health insurers, etc.?
      Response: That appears to be the assumption of the Executive Order, but the Advisory Group may consider population health metrics as part of that work if it wishes to do so.
    - How will health care costs (e.g., pharmaceutical, durable medical equipment, etc.) be considered in the spending benchmark?
      Response: The Advisory Group will discuss these types of issues as part of its charge and work.

V. Experiences with benchmarks in other states; Michael Bailit and David Cutler

a. Massachusetts
    - Massachusetts is only state that has operationalized a spending benchmark; it has not established quality benchmarks.
    - Health care spending in the state was growing faster than other costs, which prompted the benchmark.
    - The benchmark is rooted in state law and tied to a specific economic growth index, the Potential Gross State Product (PGSP), which is set once per year. The reason for choosing this index is that in considering how to stabilize health care spending relative to the state budget, Massachusetts decided the benchmark should be linked to projected growth in state revenue. This helps address fluctuations in state economic growth. In 2018, the benchmark is PGSP minus 0.5%.
    - Providers of a certain size are assessed relative to the benchmark; smaller providers are excluded.
    - There are limited consequences if benchmarks are not met; the law allows for a performance improvement plan, but that has never happened.
    - Concerns about the Massachusetts cost growth benchmark include: 1. PGSP is a poor basis for setting a target because there is no correlation between medical spending and state gross domestic product; 2. It is unfair to include federal spending over which state actors have no policy influence; 3. Growth caps lock

in historical disparities and inequities in payment; and 4. some health care costs are beyond the control of providers and insurers (e.g., Zika outbreak or hepatitis C drugs).

b. The following questions were asked and corresponding responses were discussed on the Massachusetts example:
    - Does Massachusetts's index adjust for population composition (e.g., growth, age)?
      Response: Population factors are baked into the baseline.
    - Are urgent care centers excluded from the in Massachusetts's benchmark?
      Response: Most attention is paid to aggregate health care spending and there is hesitation to attribute spending to one sector.
    - How are patient costs assessed post-hospitalization (e.g., long-term care)?
      Response: The State looks at systematic patterns instead of particular sectors (e.g., contracts associated with particular provider).
    - Is there a separate body on the provider side that regulates rates?
      Response: No.
    - Is there transparency in developing the benchmark?
      Response: Yes, everything is public.
    - Is self-insured included in measure?
      Response: Generally, yes (states can't require plans to provide information).
    - How is spending on community health (e.g., prevention) accounted for?
      Response: Payments are measured by looking at all payments to providers (e.g., from insurers, Medicaid, etc.), which may include such expenditures.
    - Are there unintended consequences (e.g., health system consolidation)?
      Response: Other issues are pushing consolidation. The biggest issue with that is with disparity in reimbursement across providers; lowest paid providers are most threatened to consolidate.
    - Small business premiums are increasing 11-12%, but state government spending is flat; is this accurate?
      Response: Yes, generally accurate.
    - There is no mechanism for payment for critical access care; how is that factored in to overall costs?
    - Response: The State legislature has provided funding for uncompensated care.

c. Maryland
    - Maryland has recently established statewide growth targets.
    - Maryland has been regulating hospital rates under a federal waiver since the 1970s. However, volume was not regulated and grew as a result.
    - In 2014, Maryland moved to a hospital global budget model where hospitals could only accrue a budgeted amount of revenue from all payers, with the goal of limiting hospital volume and shifting care to less costly settings.
    - CMS can remove Maryland's waiver authority if the statewide growth target of 3.58% is not met
    - The State has come in under target for hospital spending growth.

d. Vermont

- Vermont recently established statewide growth targets.
- In 2017 Vermont entered into an all-payer ACO model with Medicare, Medicaid (under an 1115 waiver), commercial payers and the state's sole ACO. The model anticipates providing care to 70 percent of all Vermont residents and 90 percent of all Vermont Medicare beneficiaries by 2022.
- Targets associated with the agreement include: Per capita health care expenditure growth rate for all payers is limited to 3.5%; Medicare per capita growth for Vermont Medicare beneficiaries is limited to 0.1-0.2 percentage points below that of projected national Medicare growth; quality targets were set for substance use disorder, suicides, care of chronic conditions, and access to care.
- The model excludes retail pharmacy, but commercial payer contracts are said to include it.
- The model allows for corrective action plan if measures aren't met; however, the biggest threat is Medicare "pulling out of the deal."

e. The following questions were asked and corresponding responses were discussed on the Vermont example:
   - Why did Vermont choose the ACO model?
     Response: State dynamics are largely responsible (e.g., there is an active legislature and providers feared legislative action that would limit their autonomy, the culture of Vermont allowed the State to constructively partner with providers, and there was retrenchment after failure of the governor's proposed single payer system, among other state factors).
   - The Vermont experience seems more collaborative than the MA example. Did the benchmark in VT address variation in pricing between providers?
     Response: VT did not have a great deal of variation in pricing prior to benchmark activity..

f. Rhode Island
   - Rhode Island is developing health care spending and quality benchmarks.

VI. Process for Providing Secretary Walker with Feedback; Michael Bailit

a. Subcommittee meeting logistics
   - Subcommittee discussions will be reported out at the next monthly meeting.
   - If a member is sending a designee, it's requested that he or she review past meeting information.

b. It is the Health Care Spending Benchmark Committee charge to advise the Secretary regarding the creation of a health care spending benchmark that will:
   - Utilize a clear and operational definition of total health care spending for Delaware;
   - Make use of currently available data sources, and anticipate the use of new sources should they become available in the future;
   - Be set at the state level, and, as practicable, at the market (commercial, Medicare, Medicaid) insurer, and health system/provider levels;
   - Tie a spending growth benchmark to an appropriate economic index;

- Be established for use for the first time for Calendar Year 2019, and then annually thereafter; and
- Be used in comparative analysis to actual spending following the end of Calendar Year 2019 and annually thereafter.

c. It is the Quality Benchmark Committee charge to advise the Secretary regarding health care quality benchmarks that will:
    - Target improvement for no fewer than two and no more than five health care quality improvement priorities for Delaware;
    - Utilize measures that have been endorsed by the National Quality Form, the National Committee for Quality Assurance or comparable national bodies;
    - Make use of currently available data sources;
    - Be set at the state level, and, as practicable, at the market (commercial, Medicare, Medicaid), insurer, and health system/provider levels;
    - Inform benchmark selection by consideration of publicly available benchmark data for the selected measures from the National Committee for Quality Assurance, the Centers for Medicare and Medicaid Services or comparable national bodies;
    - Be established for use for the first time in Calendar Year 2019, and then annually thereafter; and
    - Be used in comparative analysis to actual performance following the end of the Calendar Year 2019 and annually thereafter.

d. Proposed plan for discussing cost and quality benchmarks at future meetings
    - Advisory Group staff will present key questions for consideration by providing background information and context.
    - DHSS will record the feedback received for the Secretary.
    - Feedback will also be recorded in meeting summaries available after each meeting.
    - The Advisory Group's feedback will assist DHSS and the Health Care Commission in developing its methodology for the health care cost growth and quality benchmarks.

e. Process for public engagement
    - At the conclusion of each meeting, there will be time reserved for public comment. Any interested parties in attendance may provide feedback.
    - The State will also ask for feedback on specific topics and key questions by posting requests at http://dhss.delaware.gov/dhcc/global.html and accepting feedback through ourhealthde@state.de.us.
    - Secretary Walker will engage with interested stakeholders through other public forums.
    - Advisory Group staff will seek input from external content experts.

f. The following question was asked and the corresponding response discussed:
    - Will there be transparency with data sources?
      Response: Yes.

VII. Topic 1: Total Health Care Spending; Michael Bailit

a. To define health care spending, the following questions need to be answered:

- Whose health care spending is being measured (e.g., which populations), including the following:
  - Medicare (Medicare FFS (Parts A, B, D), Medicare Advantage)
  - Medicaid (Chronic Renal Disease Program, Children's Community, Alternative Disability Program)
  - Medicare and Medicaid Dually Eligible
  - Commercial (Fully-Insured, Self-Insured, Choose Health Delaware
  - Veterans Health Administration
  - FEHB
  - TRICARE
  - Uninsured

  Comments and questions on proposed populations:
  - Chronic Renal Disease Program not a Medicaid program.
  - Children's Community, Alternative Disability Program could be seen differently than LTSS.
  - "Look alike" program missing from list (cancer treatment program).
  - Should grant programs (e.g., SAMHSA) be included?
  - It's difficult to respond and advise on the topics without having the information ahead of time.
  - Commercial insurers must be included.

- Exactly what costs should be measured?
  - Typical claims-based costs include (refer to handout for definitions):
  - Hospital inpatient
  - Hospital outpatient
  - Physicians
  - Other professionals
  - Home health and community health
  - Long-term care
  - Dental
  - Pharmacy
  - Durable medical equipment
  - Hospice

  Comments and questions on proposed costs:
  - It's difficult to respond and advise on the topics without having the information ahead of time.
  - The State should focus on individual and family access to care.
  - Should the cost of employer-sponsored coverage paid for in Delaware to those who do not live in Delaware be included in these calculations? In Massachusetts, costs were defined for residents only.

VIII. Public Comment

a. Two public comments were provided:

- Substance use disorder treatment and payment for those treatments should be considered in these discussions; and, corrections health expenditures should be included in data.
- Questions were raised about how NIH grants and ACO costs are included in these discussions.

IX. Wrap-up and Next Steps

a. The plan is to spend future meetings discussing pros and cons of issues related to the benchmarks.
b. For future meetings, materials to be discussed will be provided in advance.