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# DELAWARE HEALTH CARE DELIVERY AND COST ADVISORY GROUP



ADVISORY GROUP MEETING #3

MAY 22, 2018

# AGENDA

Topic	Time
1. Welcome (Secretary Walker)	9:00 am – 9:05 am
2. Quality Benchmarks (Michael Bailit)	9:05 am – 9:45 am
3. Health Care Spending Benchmark (Michael Bailit)	9:45 am – 10:30 am
4. Benchmark Process and Timelines (Michael Bailit)	10:30 am – 10:50 am
5. Break	10:50 am – 11:00 am
6. Implications for Health Care Commission Composition and Scope (Michael Bailit)	11:00 am – 11:45 am
7. Public Comment (Interested Parties)	11:45 am – 11:55 am
8. Wrap-up and Next Steps (Secretary Walker)	11:55 am – Noon



# QUALITY BENCHMARKS

## QUALITY BENCHMARKS

- We reviewed the suggestions of the Quality Benchmark Subcommittee (the Subcommittee) during our April 16th meeting.
  - The Subcommittee identified criteria for selection of measures to be used for the quality benchmarks. The Advisory Group agreed the criteria were reasonable.
  - The Subcommittee also identified 17 measures and measure concepts for potential benchmark adoption. Advisory Group staff further identified five measures, drawing from the Delaware Common Scorecard.
- At the end of the last meeting, we requested that you each use the resource materials previously distributed to identify the measures you suggest be used for the quality benchmarks.
- Following today's meeting, Advisory Group staff will "score" your suggested measures against the criteria and share the results prior to the next Advisory Group meeting to help you arrive at final suggestions for the two to five quality benchmarks measures.

## REMINDER: MEASURE CRITERIA

### ***Criteria to be Applied to Individual Measures:***

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

### ***Criteria to be Applied to the Measure Set as a Whole:***

1. Representative of pediatric, adult and older adult (Medicare) populations

## SUBCOMMITTEE CANDIDATE MEASURE SUGGESTIONS

1. Access to care composite from CAHPS 5.0H health plan survey
2. Access measure from BRFSS survey
3. Prevention composite: children
4. Prevention composite: adults
5. Potentially preventable hospitalizations
6. Ambulatory care sensitive condition (ACSC) admissions
7. ACSC ED visits
8. Infant mortality rate
9. Overdose death rate
10. Body mass index (BMI)
11. BMI assessment
12. Depression (unspecified)
13. Diabetes (unspecified)
14. Oral health composite
15. Oral health access
16. Timeliness of prenatal care
17. Equity across the studied measures

Note: Ordering reflects timing of suggestions and is not an expression of priority.

## ADDITIONAL STAFF-SUGGESTED MEASURES FOR CONSIDERATION

1. Blood pressure control
2. Hospital readmission rate
3. All-cause unplanned readmissions for diabetes or for multiple chronic conditions
4. Use of opioids:
  - a. At high dosage, or
  - b. From multiple prescribers

## QUALITY MEASURES FEEDBACK FROM HEALTH PLANS

- Advisory Group staff invited the five insurers with the largest enrollment in the state to react to the Subcommittee's suggestions. Two plans have responded. One plan supported all of the measures and measure concepts with the following exceptions:
  - Infant mortality rate – The plan had concerns about how instances [mortality] with no prior history of health risks would be factored into the measurements.
  - Overdose death rate – The plan had concerns about how instances with no prior history of substance abuse would be factored into the measurements.
  - Oral health composite/Oral health access – These services are not covered under health plan contracts.
  - Blood pressure control – This measure may not meet the criteria for being operationally feasible and not burdensome. In the plan's experience, collection of the data needed for measurement tends to be very manual.



## QUALITY MEASURES FEEDBACK FROM HEALTH PLANS

- The second plan specifically recommended the following measures for setting benchmarks:
  - Hospital readmission rate
  - Hospital infection rates
  - All-cause unplanned readmissions for diabetes or for multiple chronic conditions
  - Use of opioids:
    - At high dosage, or
    - From multiple prescribers

## DISCUSSION OF PREFERRED MEASURES FOR QUALITY BENCHMARK USE

- Which two to five measures are you most interested in seeing used as the benchmarks, and why?

## SETTING QUALITY BENCHMARK VALUES

- Once the quality measures to be used for benchmarking are established, three additional questions need to be answered.
  1. How should the benchmarks be set at the state, insurer and (large) provider level?
    - Best practice level (e.g., national or regional 90<sup>th</sup> percentile), if available?
    - Significant improvement over baseline (e.g., statistically significant, fixed percentage point improvement)?
    - Best practice at the state level if available, but significant improvement at the plan and provider level?
  2. For measures for which available benchmarks are specific to payer lines of business (i.e., commercial, Medicare, Medicaid), should there be:
    - Three separate benchmarks for each measure?
    - A weighted composite benchmark?

## SETTING QUALITY BENCHMARK VALUES (CONT'D)

3. Should the quality benchmarks be set on a single-year or multi-year basis?
  - National reference benchmarks change from year to year, perhaps arguing for a multi-year benchmark.

<b>National Benchmark</b>
<b>88% on HbA1c Control in 2017</b>
<b>90% on HbA1c Control in 2018</b>
  - Performance improvement does not follow a straight-line trend, perhaps arguing for a single-year benchmark.
  
4. When should benchmarks be set for 2019?
  - For HEDIS measures, benchmarks for the prior calendar year become publicly available late summer and early fall.
  - Non-HEDIS benchmarks become available at a range of different dates.



# HEALTH CARE SPENDING BENCHMARKS

## SPENDING BENCHMARK INPUT FROM HEALTH PLANS

- Advisory Group staff invited the five insurers with the largest enrollment in the state to react to the economic index options for setting the benchmark. Two plans have responded. Their input is as follows:
  - One plan recommended utilizing a measure of economic growth, such as State Gross Domestic Product (GDP), to establish the health care spending benchmark, while the other recommended a forecast CPI-U, less food and energy. The latter plan added to its recommendation for forecasted rates that “historical trends are what have gotten us into this situation so we will need to change these.”
  - Other comments:
    - We believe the experience of benchmarks tied to economic growth in other states may provide valuable lessons learned and may prove to be very helpful in guiding our path forward.
    - We believe that it is also important to ensure that any benchmarks that are established have a mechanism for factoring in outliers as the result of new technologies, new treatments and pandemics.
    - [We have] concerns about resolving complexities, which would likely arise from attempting to develop benchmarks based on blended economic factors.

## RECAP OF SPENDING BENCHMARK SUBCOMMITTEE

- On May 7, the Health Care Spending Benchmark Subcommittee reviewed the same content the Advisory Group did on April 16 related to the different types of economic indicators that could be used to set the health care spending benchmark.
- The Subcommittee members agreed the spending benchmark should utilize projected GSP, with an adjustment for change in the percentage of Delaware residents who are over age 65 years.
- The Subcommittee expressed some uncertainty about the basis for projected GSP and suggested that future Advisory Group discussion delve into the methodology to develop comfort with it.

## EXAMPLE FOR DISCUSSION PURPOSES ONLY ESTIMATES OF POTENTIAL GDP GROWTH IN DELAWARE

Category	United States Estimate	Delaware estimate
Potential labor force productivity (output per worker)	1.4%	1.4%
+ Potential labor force	0.4%	-0.3%
+ Expected inflation	2.1%	2.1%
<b>= Nominal potential GDP/GSP</b>	<b>3.9%</b>	<b>3.2%</b>
- Population growth	0.7%	0.5%
<b>= Potential GDP/GSP per capita</b>	<b>3.2%</b>	<b>2.7%</b>

U.S. estimates are from the Congressional Budget Office and Census Bureau, for 2023-28. Delaware estimates are the same, other than growth of potential labor force. (Population projections for Delaware from CDC Wonder.) Additional Delaware adjustment may be required to account for projected growth in labor force participation by seniors and for the impact of growth of the State's elderly population on health care spending.



## ADJUSTING BENCHMARK FOR GROWTH IN POPULATION 65+

- The Subcommittee made a recommendation to adjust the project GSP to reflect the resource utilization made by individuals over 65 years and the growth in this population within Delaware.
- A source for population growth will need to be identified, and then, a methodology for making such adjustment to the projected state product would need to be applied.



## BENCHMARK PROCESS AND TIMELINE

## ADVISORY GROUP'S CHARGE

- “The Advisory Group’s feedback shall be provided to the Secretary of DHSS in the development of benchmark implementation recommendations, per House Joint Resolution 7. The recommendations may include ... a proposed process and timeline for implementing any policy recommendations.”
- We will address process and timeline separately.

## PROCESS FOR IMPLEMENTING BENCHMARK POLICY RECOMMENDATIONS

- **Key questions related to process for implementing policy recommendations:**
  1. Who sets the benchmark?
  2. Who assesses performance against the benchmark?
  3. From where do the data for the benchmark come?
  4. How is performance reported?
  5. When setting the benchmark for 2019, should it also be set for one or more additional years?
  
- Who sets and who assesses performance for the benchmark are important questions, but we will address these last as part of a broader discussion related to another Advisory Group charge of examining the scope and composition of the Delaware Health Care Commission. *Hold your thoughts!*

# PROCESS QUESTIONS: FROM WHERE DO DATA TO CALCULATE THE BENCHMARK COME?

- Information sources for the health care spending benchmark:
  - GSP is regularly calculated the U.S. Bureau of Economic Analysis; *potential* GSP, however, is not.
  - There are two methods for determining potential GSP:
    - Calculate the value using publicly available inputs
    - Purchase the value from vendors (Moody's Analytics, Global Insight, HIS Markit)
  - Population growth, including population over age 65 years, is regularly forecast by the CDC and perhaps others.
- Potential sources for the quality benchmarks:
  - NCQA: health plan performance on HEDIS measures
  - CMS: hospital performance
  - CDC: statewide population health measures

## PROCESS QUESTIONS: HOW IS PERFORMANCE REPORTED

- How will state, insurer and provider performance against the benchmark be reported?
  
- There are several options, none of which are mutually exclusive:
  1. Reported to the Delaware Health Care Commission
  2. Reported publicly with press releases, announcements, and online and print publication
  3. Presented to key stakeholder organizations, such as DCHI and GPBGH
  4. Reported through a public hearing process that gives stakeholders and assessed entities an opportunity to showcase their successes and discuss challenges, and to examine underlying contributors to performance.
    - In Massachusetts, the Health Policy Commission annually holds a “Cost Trends” hearing, a two-day public event where health care executives, employers, researchers and government officials discuss the performance of the cost growth benchmark.

## PROCESS QUESTIONS: BENCHMARK SETTING

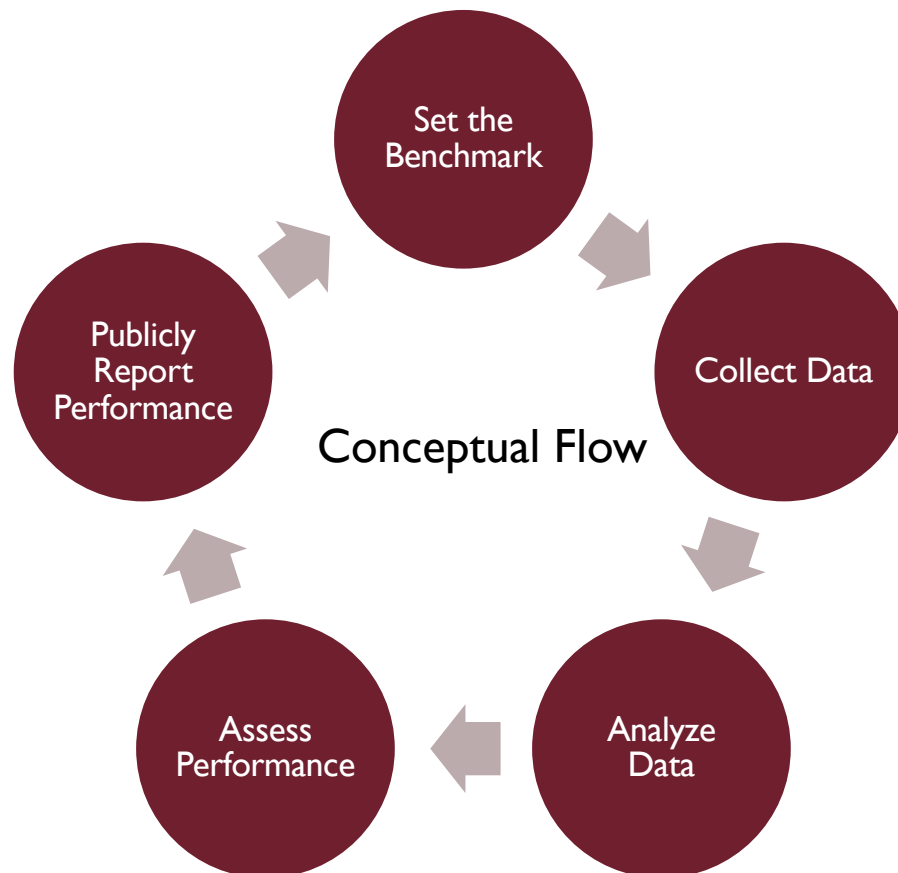
- Benchmarks need to be established for 2019.
- 1. Should the first benchmark cover one or more years? If more, how many?
  - Should the answer be the same for the health care spending and quality benchmarks?
- 2. If the benchmarks are multi-year, should they change over time or be fixed?
  - Would you make the same decision for the health care spending and quality benchmarks?

### Massachusetts' Approach

Year	Benchmark
2013-2017	PGSP
2018-2022	PGSP – 0.5%
2023 and beyond	PGSP or another value, at the discretion of the Health Policy Commission

# TIMELINE FOR IMPLEMENTING BENCHMARK POLICY RECOMMENDATIONS

- What is the timeline for implementing the benchmark in 2019 and ongoing?





# COST AND QUALITY BENCHMARK TIMELINE

2019

- January
  - January 1: Year 1 begins
- November
  - November 1: Year 2 cost and quality benchmarks announced
- December
  - December 31: Year 1 ends

2020

- January
  - January 1: Year 2 begins
- August
  - August 1: Data from Year 1 (2019) is received and performance review begins
- October
  - October 1: Year 1 performance announced
- November
  - November 1: Year 3 cost and quality benchmarks announced
- December
  - December 31: Year 2 ends

2021

- January
  - January 1: Year 3 begins
- December
  - December 31: Year 3 ends

Does this timeline seem reasonable and appropriate?



# IMPLICATIONS FOR HEALTH CARE COMMISSION COMPOSITION AND SCOPE

## ADVISORY GROUP CHARGE

- The Advisory Group is to provide feedback on “what, if any, changes need to be made to the composition or scope of the Delaware Health Care Commission in order for it to:
  - a. receive the relevant and necessary data for benchmark calculation
  - b. apply the Health Care Commission’s adopted benchmark methodology, and
  - c. update and assess State, market, payer and provider performance relative to the cost and quality benchmarks each year.”

## ADVISORY GROUP CHARGE

- The Advisory Group charge does not address what person or which body is to set the benchmarks. We invite the Advisory Group to consider this as well, however.
- Therefore, please consider the following questions during the balance of today's discussion:
  1. Who or what body should set the health care spending and quality benchmarks for the state?
  2. Is the current composition of the Health Care Commission appropriate for it to *annually assess performance* relative to the benchmarks?

## DELAWARE HEALTH CARE COMMISSION

- Created in 1990 to be a public/private entity that balances executive and legislative branches of government with the private sector.
  - Currently, the HCC is housed within the Department of Health and Social Services.
- The Commission is authorized to conduct pilot projects to test methods for catalyzing private sector activities that will help the State meet its health care needs.
- Currently, the Commission fulfills several roles:
  - Administration of Delaware Institute of Medical Education and Research (DIMER) and Delaware Institute for Dental Education and Research (DIDER) funds
  - Administration of the Delaware Health Resources Board (HRB) Certificate of Public Review (CPR)
  - Establishment of the Qualified Health Plan standards
- The HCC has 6 FTEs, though none with the analytical skills required to assess performance relative to the benchmark.

## COMMISSIONERS FOR THE HEALTH CARE COMMISSION

Commissioner	Current Position / Title
Dr. Nancy Fan (Chair)	Board-Certified OB/GYN
Dr. Kara Odom Walker	Secretary of the Department of Health and Social Services
Theodore Becker, Jr.	Mayor, City of Lewes
Josette Manning	Secretary of the Department of Services for Children, Youth and Their Families
Trinidad Navarro	Insurance Commissioner
Dennis Rochford	President, Maritime Exchange for the Delaware River and Bay
Dr. Edmondo Robinson	Senior Vice President and Executive Director, Wilmington Hospital
Dr. Jan Lee	President and CEO, Delaware Health Information Network
Dr. Kathleen Matt	Dean, College of Health Sciences, University of Delaware
Rick Geisenberger	Secretary of the Department of Finance
Rich Heffron	President, Delaware State Chamber of Commerce

## SIMILAR ENTITIES IN OTHER STATES

- When determining whether the Delaware Health Care Commission is comprised of the right staff and commissioners, and whether their scope can accommodate the setting of the benchmark and measuring performance, it is helpful to review how other independent state health policy-making entities operate.
- These states have independent health care policy-making entities:
  - Vermont (Green Mountain Care Board)
  - Massachusetts (Health Policy Commission)

## VERMONT GREEN MOUNTAIN CARE BOARD

- The Green Mountain Care Board is responsible for approving ACO and hospital budgets, and for approving health insurance rates.
- Independent group of five Vermonters, who, with their staff, are charged with ensuring that changes in the health system improve quality while stabilizing costs.
- Members are nominated by a broad-based committee and appointed by the Governor.
- Members include:
  - Small business owner and former legislator (chair)
  - Corporate public and private finance professional
  - Professor of economics
  - Former Director of Health Care Reform for a past governor
  - Formerly appointed official in Administration, Finance and Tax
  - Attorney with health care experience in primary care and pharmaceutical industry



# MASSACHUSETTS HEALTH POLICY COMMISSION

- The Health Policy Commission is “an independent public entity not subject to the supervision and control of any other executive office, department, commission, board ... or political subdivision of the Commonwealth.”
- Four main functions:
  - Set the health care cost growth benchmark and hold providers responsible
  - Change the delivery system to be more efficient
  - Make payments to support the new health care delivery models
  - Improve market performance
- The Board has an advisory council of 30+ individuals that have diverse health care experience and support the agency by providing:
  - Input toward HPC policies
  - Feedback on investment priorities
  - A forum for direct communication to interested stakeholders

## MASSACHUSETTS HEALTH POLICY COMMISSION (CONT'D)

- State statute dictates the professional experience each commissioner must have. It does not specifically limit the commissioners from having a conflict of interest, but it has not appointed a member with a conflict of interest, thus far.
  1. Secretary of Administration and Finance
  2. Secretary of Health and Human Services
  3. One member, designated as chairperson, with demonstrated expertise in health care delivery, health care management at a senior level or health care finance and administration, including payment methodologies
  4. One member with demonstrated expertise in the development and utilization of innovative medical technologies and treatments for patient care
  5. One member who is a primary care physician
  6. One member with expertise in health care consumer advocacy

## MASSACHUSETTS HEALTH POLICY COMMISSION (CONT'D)

7. One member with expertise in behavioral health, substance use disorder and mental health services
8. One member who is a health economist (David Cutler)
9. One member with demonstrated expertise in representing the health care workforce as a leader in a labor organization
10. One member with demonstrated expertise as a purchaser of health insurance representing business management or health benefits administration
11. One member with demonstrated expertise in health plan administration and finance

## WHO SHOULD SET THE BENCHMARK?

- Proposed principles for the entity or individual setting the benchmarks:
  1. Content knowledge in quality measurement and health care economics
  2. Informed by interested stakeholders and the public
  3. No conflict of interest (that is, no private organization that is subject to the benchmark should be responsible for setting benchmarks)
  
- What do you think of these principles? What other principles might be adopted?

# OPTIONS FOR SETTING AND ASSESSING PERFORMANCE AGAINST THE BENCHMARK

## ■ **Immediate Term (2019)**

- Health Care Commission
- Executive branch leadership

## ■ **Longer Term (2020 and beyond)**

- Health Care Commission, with composition modifications to meet previously discussed criteria
- Executive branch leadership
- Another existing entity or a to-be-formed entity



## PUBLIC COMMENT



## WRAP-UP AND NEXT STEPS

## UPCOMING ADVISORY GROUP ACTIVITIES

- There is one remaining Advisory Group meeting:
  - June 6, 2018
- In addition to wrapping up topics from this meeting, the Advisory Group has one final topic to address:
  - Proposed methods for analyzing and reporting on variations in health care delivery and cost in Delaware.
- A report with the Advisory Group's feedback will be presented to the Secretary by the end of June:
  - A draft will be shared with the Advisory Group at the June 6, 2018, meeting for comment
  - A subsequent draft will be shared shortly after the June 6, 2018, meeting for final comment.