
DELAWARE HEALTH CARE DELIVERY AND COST ADVISORY GROUP



MEETING #2
APRIL 16, 2018

AGENDA

Topic	Time
1. Welcome (Secretary Walker)	1:00 pm – 1:10 pm
2. Health Care Spending Benchmark Subcommittee Recap (Michael Bailit)	1:10 pm – 1:45 pm
3. Health Care Spending Benchmark Methodology (Michael Bailit)	1:45 pm – 3:00 pm
4. Break	3:00 pm – 3:10 pm
5. Quality Benchmark Subcommittee Recap (Michael Bailit)	3:10 pm – 3:40 pm
8. Public Comment (Interested Parties)	3:40 pm – 3:55 pm
9. Wrap-up and Next Steps (Secretary Walker)	3:55 pm – 4:00 pm



HEALTH CARE SPENDING BENCHMARK SUBCOMMITTEE RECAP

HEALTH CARE SPENDING BENCHMARK SUBCOMMITTEE: CHARGE (1 OF 2)

1. Provide input to the Advisory Group 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, and
 - Be set at the state level and, as practicable, at the market (commercial, Medicare, Medicaid), insurer and health system/provider levels.

HEALTH CARE SPENDING BENCHMARK SUBCOMMITTEE: CHARGE (2 OF 2)

2. Provide input to the Advisory Group regarding the creation of a health care spending benchmark that will:
 - Tie a spending growth benchmark to an appropriate economic index;
 - Be established first 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.



TOPIC 1:
WHAT IS TOTAL HEALTH CARE SPENDING?

TOTAL HEALTH CARE SPENDING

- The Advisory Group briefly discussed this topic during its first meeting on March 22nd, and the Subcommittee continued the discussion.
- The central questions were:
 1. Whose health care spending is being measured?
 2. Exactly what spending should be measured?

TOTAL HEALTH CARE SPENDING: WHICH POPULATIONS?

- The Subcommittee considered the following population categories and thoughtfully debated some of the challenges in gathering data on certain populations.
- Medicare
 - Medicare FFS (Parts A, B, D)
 - Medicare Advantage
- Medicaid
- CHIP
- Medicare and Medicaid Dually Eligible
- Commercial
 - Fully-Insured
 - Self-Insured
 - Choose Health Delaware
- Veterans Health Administration
- FEHB
- TRICARE
- Uninsured

TOTAL HEALTH CARE SPENDING: WHICH POPULATIONS? FEEDBACK TO THE SECRETARY

- The feedback to the Secretary included:
 - Measure spending for:
 - Medicare
 - Medicaid
 - Dual Eligibles
 - Commercial
 - Consider the trade-offs on complexity of getting data vs. the magnitude of spending for:
 - Veterans and federal employees covered by VHA, FEHB and TRICARE
 - Prisoners incarcerated by the state
 - Uninsured (charity care)

TOTAL HEALTH CARE SPENDING: WHAT TYPES OF SPENDING?

- The Subcommittee reviewed the types of spending in the following broad categories:
 1. Claims-based spending — Claims-based spending consists of payments made following submission of a specific claim for health care services
 - e.g., hospital inpatient / outpatient, professional services, home and community health, long-term care, dental, pharmacy, DME, hospice
 2. Non claims-based spending — Non claims-based spending consists of payments not associated with a specific claim
 - e.g., capitation, pay-for-performance incentive payments, care manager payments, prescription drug rebates, net cost of health insurance, patient cost sharing

TOTAL HEALTH CARE SPENDING: WHAT TYPE OF SPENDING? FEEDBACK TO THE SECRETARY

- Generally speaking, the feedback was to be as inclusive in the types of spending as possible, while making trade-offs to account for data that may be too administratively complex, expensive or not practical to obtain.
- With that caveat, the Subcommittee suggested including:
 - Spending on any claims collected by reporting entity
 - Pharmacy spending net of rebates
 - Net cost of private health insurance
 - Patient cost sharing
 - Spending on carved-out benefits
 - Federal grants that are used to provide direct health care services



TOPIC 2:
FROM WHERE WILL THE DATA FOR THE COST
GROWTH BENCHMARK COME?

FROM WHERE WILL SPENDING DATA COME?

- The Subcommittee considered which entities have and might be best able to provide data.
- Generally, it was felt that insurers have the best data that cannot be provided from the state or federal government.
- The Subcommittee then considered three options:
 1. Asking commercial insurers to provide health care spending calculations voluntarily
 2. Contractually requiring commercial insurers to do so (for those that contract with the State)
 3. Statutorily requiring all health insurers to do so, or at least those with significant size
- The Subcommittee also considered feedback obtained from insurers in advance of the meeting:
 - Insurers should provide the data voluntarily but will want to do so only if other insurers do so.

FROM WHERE WILL SPENDING DATA COME? FEEDBACK TO THE SECRETARY

- Some members of the Subcommittee felt that health plans could be asked to voluntarily report the data.
 - There were concerns that if insurers are asked to submit voluntarily, some plans may not report, thereby limiting the understanding of the state's total health care spending.
- Other members thought that insurers should be statutorily required to submit the data.
 - There were concerns that a mandate would be expensive for health plans based on reported experience with administrative costs incurred to report to the Delaware Health Care Claims Database.



TOPIC 3: UNITS OF MEASUREMENT

UNITS OF MEASUREMENT

- The Executive Order states that the health care spending benchmark will be set at the state level, and as practicable, at the:
 - Market (commercial, Medicare, Medicaid);
 - Insurer, and
 - Health system/provider levels.
- The “as practicable” language applies to assessing performance against the benchmark, rather than setting the benchmark.

UNITS OF MEASUREMENT FEEDBACK TO THE SECRETARY

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



TOPIC 4:
HEALTH CARE SPENDING BENCHMARK
METHODOLOGY

HEALTH CARE SPENDING BENCHMARK METHODOLOGY

- We were unable to address this topic in the Subcommittee meeting.
- This is the last topic, but perhaps the most important, related to the health care spending benchmark.
- The essential question is what will be the benchmark — i.e., the target growth rate?
- There are a number of decisions to make including, will the benchmark be:
 1. Tied to one or more indices of economic growth, inflation or another economic indicator?
 2. Adjusted? (inflated or deflated (+/-) by a certain number of percentage points)
 3. Forecasted, historical or a blend of each?
 4. Based on a multi-year approach (averaging or weighting years) or a single-year approach?
- We'll review each one of these decisions individually.

HEALTH CARE SPENDING BENCHMARK METHODOLOGY

- Before we delve into the many options to consider, let's recall again why you are advising the Secretary on a methodology for establishing a health care spending benchmark.
- "The establishment, monitoring, and implementation of annual health care cost and quality targets are an appropriate means to *monitor and establish accountability* for the goal of improved health care quality that *bends the health care cost growth curve...*"
 - excerpt from Governor Carney's Executive Order #19
- The spending benchmark, as envisioned in the Executive Order, is not a spending cap.
- Please keep this executive order language in mind as we consider the content on the next several slides.

BEFORE WE START, PART 1 APPROACHES USED IN THREE OTHER STATES

- Massachusetts' use of Potential Gross State Product
- Washington's use of Gross State Product
- Maine's use of a CPI-linked methodology

MASSACHUSETTS' APPROACH

- Massachusetts has set its cost growth benchmark based on the potential gross state product (PGSP).
- First, Massachusetts assumed that output per worker would grow at the same rate as the U.S., but adjusted for projected change in the size of the MA work force. It determined that projected GSP would be 1.6%, using out-year forecasted rates (which are more stable than the near-term forecasted rates).
- Second, it looked at the long-run forecast of inflation, again using out-year forecasted rates. It determined that projected inflation would be 2%.
 - Thus ... potential GSP (1.6%) + Inflation (2%) = 3.6%

WASHINGTON'S APPROACH

- Washington does not have a health care spending benchmark, but it does measure health care spending relative to actual GSP.

MAINE'S APPROACH

- As part of its SIM grant work, Maine developed a voluntary growth target in which ACOs would commit to keeping annual risk-adjusted, aggregate PMPM growth to the target recommended by the Maine Health Management Coalition's Healthcare Cost Workgroup.
- In Year 1, the target was set at the CPI-U for medical care.
- Over the next four years, the target was set between CPI-U for medical care and the CPI-U less food and energy, gradually trending down in Year 5 to general CPI-U less food and energy plus 25% of the difference between the two indices.

BEFORE WE START, PART TWO RECOMMENDED CRITERIA FOR BENCHMARK METHODOLOGY

1. Provide a predictable target
2. Adjust for the effects of changes in inflation
3. Rely on independent, objective data sources
4. Account for significant unexpected events (e.g., Sovaldi)

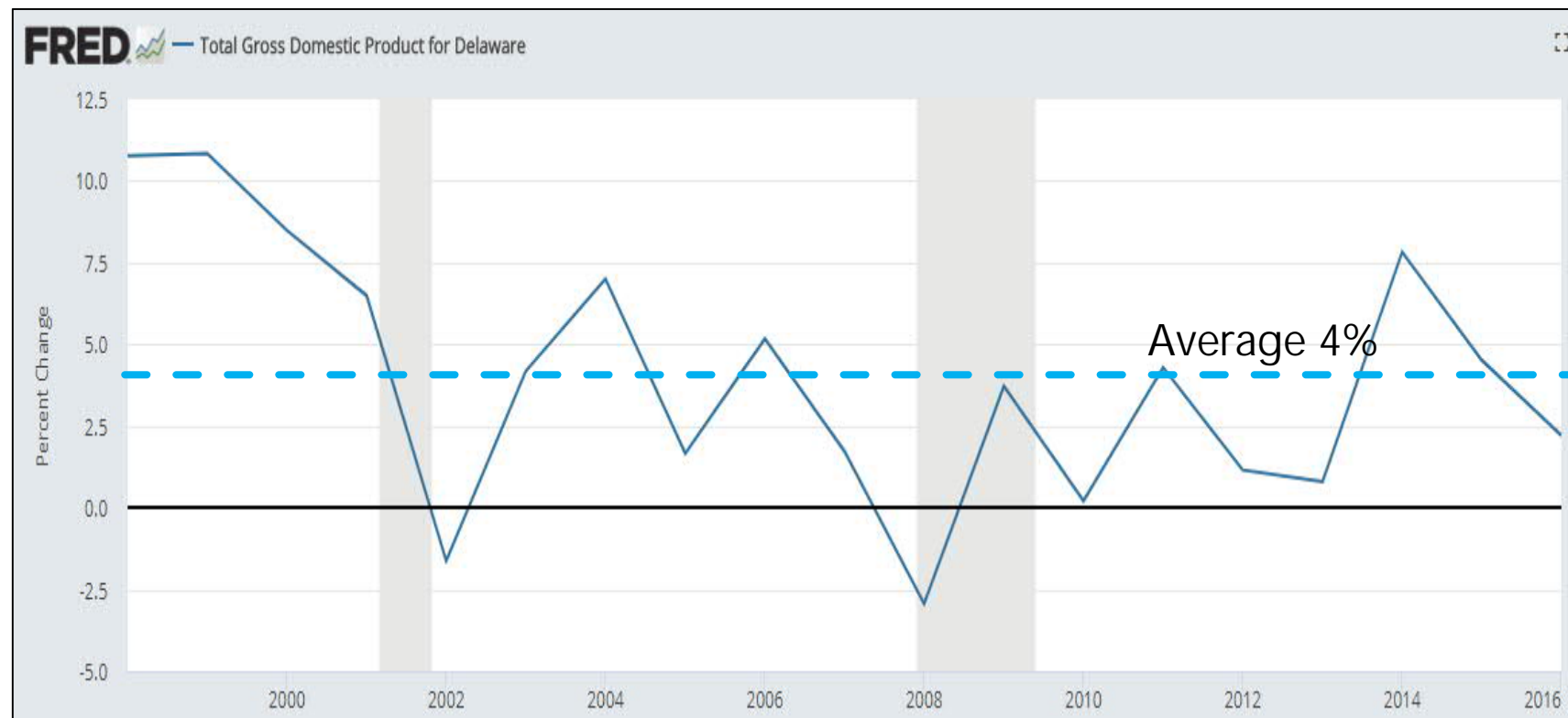
HEALTH CARE SPENDING BENCHMARK: TIED TO ECONOMIC GROWTH, INFLATION OR OTHER RATES?

1. Economic growth indicators:
 - Delaware GSP
 - Delaware personal income
2. Inflation indicators for the Philadelphia-Camden-Wilmington region:
 - General inflation (Consumer Price Index for urban consumers (CPI-U))
 - CPI-U less food and energy
 - CPI-U less medical care
 - CPI-U medical care
3. Other indicators:
 - Health care employment
 - State population growth (total or age 65+)

LINKING THE BENCHMARK TO ECONOMIC GROWTH

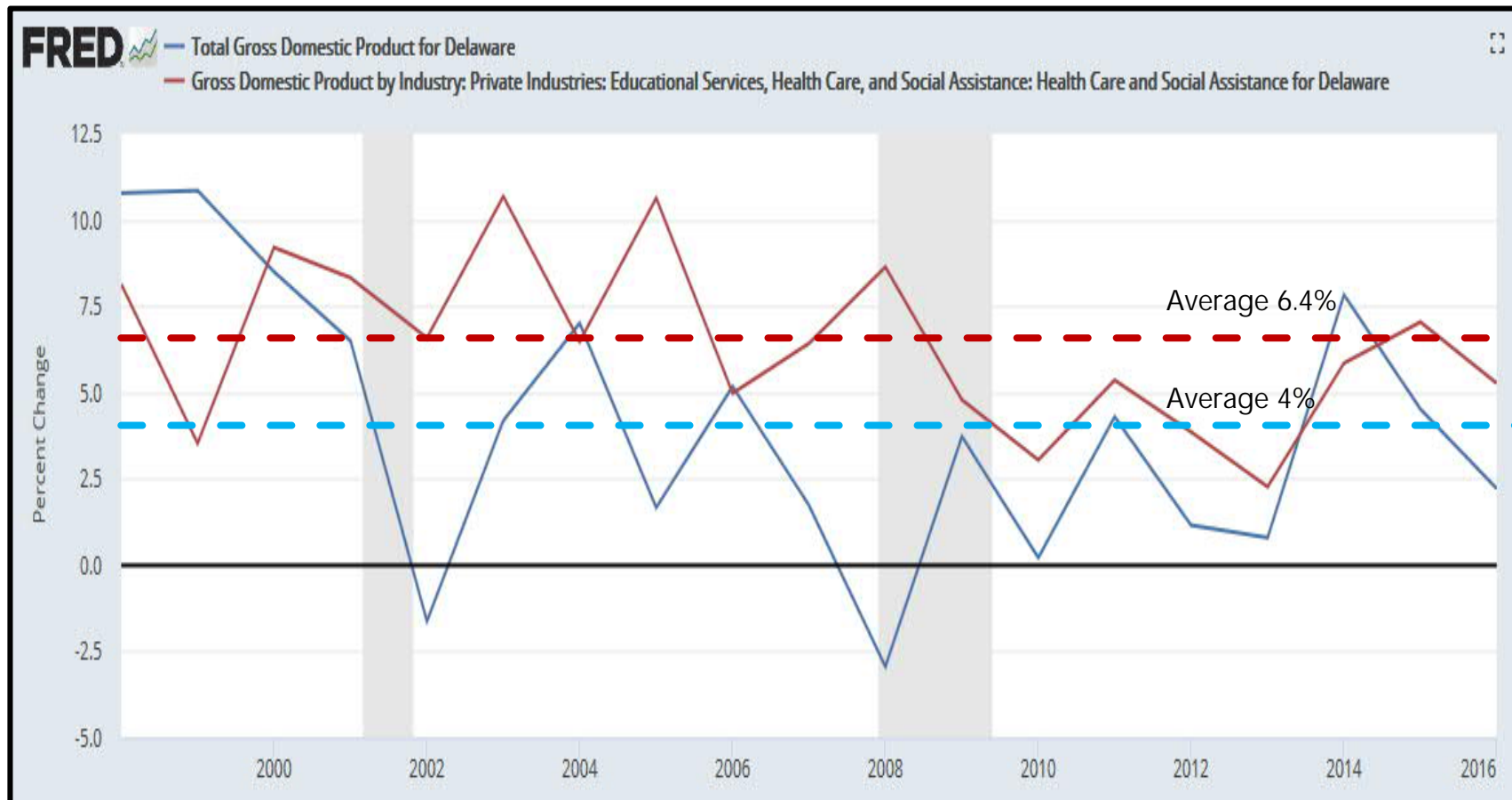
- Generally, if the health care spending benchmark is tied to economic growth, then the benchmark would imply that health care should not grow faster than the economy.
- Measures of Economic Growth:
 - State Gross Domestic Product (GSP): the total value of goods produced and services provided in the state during a defined time period.
 - Personal Income Growth: the total income received by, or on behalf of, all persons from all sources: wages, income derived from owning homes, businesses, from the ownership of financial assets (except realized and unrealized financial gains and losses), government sources (e.g., Social Security benefits) and employer benefits.
 - Wages and salaries account for about half of U.S. personal income.
 - States track personal income growth as a measure of a state's economic trends, as state revenue depends on personal income as does spending on government assistance programs.
- Let's take a look at past rates of economic growth in Delaware, and past and projected rates of economic growth for the U.S.

TOTAL GROSS STATE PRODUCT FOR DELAWARE 1999–2016



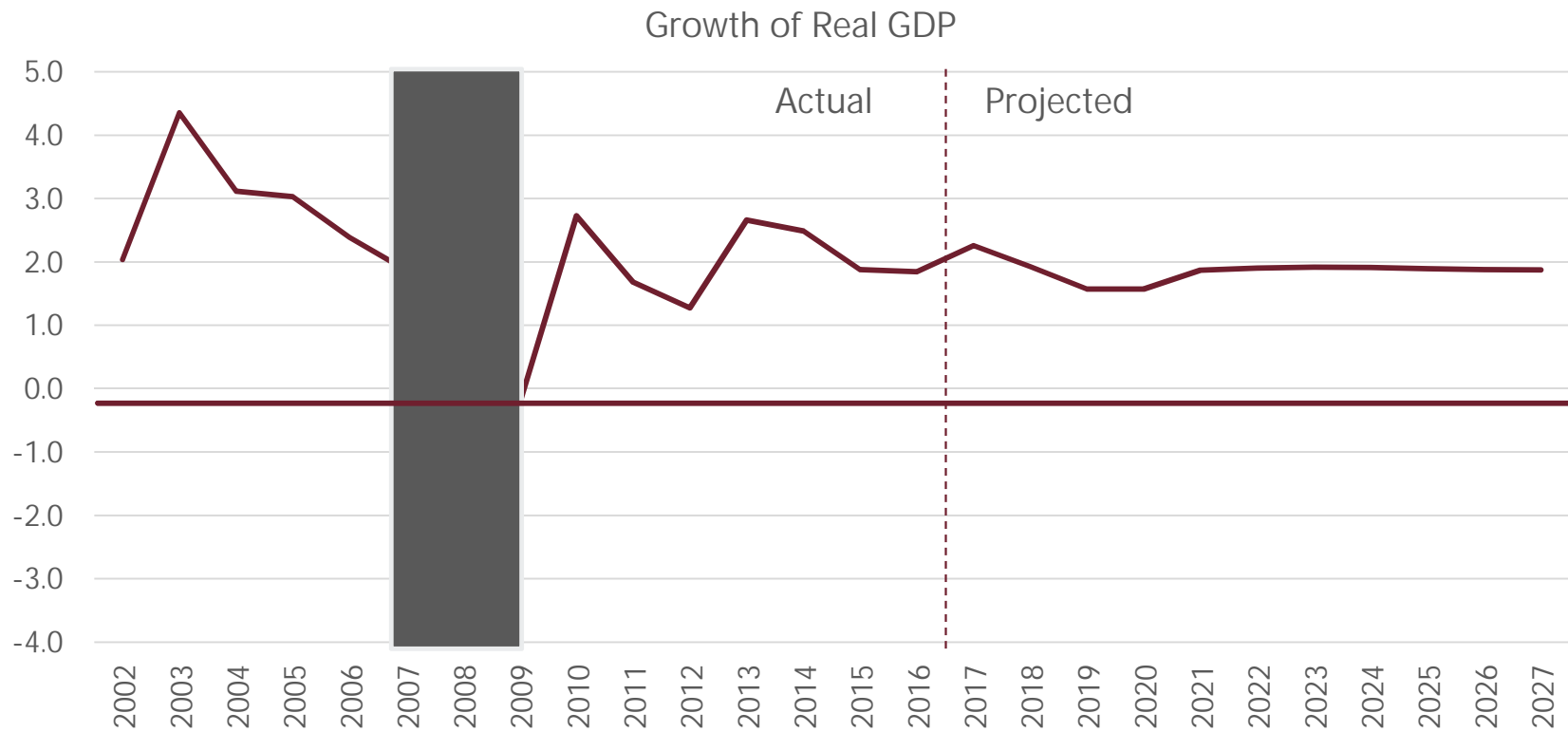
Source: U.S. Bureau of Economic Analysis, Total Gross Domestic Product for Delaware [DENGSP], retrieved from FRED, Federal Reserve Bank of St. Louis; <https://fred.stlouisfed.org/series/DENGSP>, March 20, 2018.

DELAWARE GSP VS. INDUSTRY-SPECIFIC GSP FOR HEALTH CARE AND SOCIAL ASSISTANCE



Source: U.S. Bureau of Economic Analysis, Gross Domestic Product by Industry: Private Industries: Educational Services, Health Care, and Social Assistance: Health Care and Social Assistance for Delaware [DEHLTHSOCASSNGSP], retrieved from FRED, Federal Reserve Bank of St. Louis; <https://fred.stlouisfed.org/series/DEHLTHSOCASSNGSP>, March 26, 2018.

REAL NATIONAL GROSS DOMESTIC PRODUCT



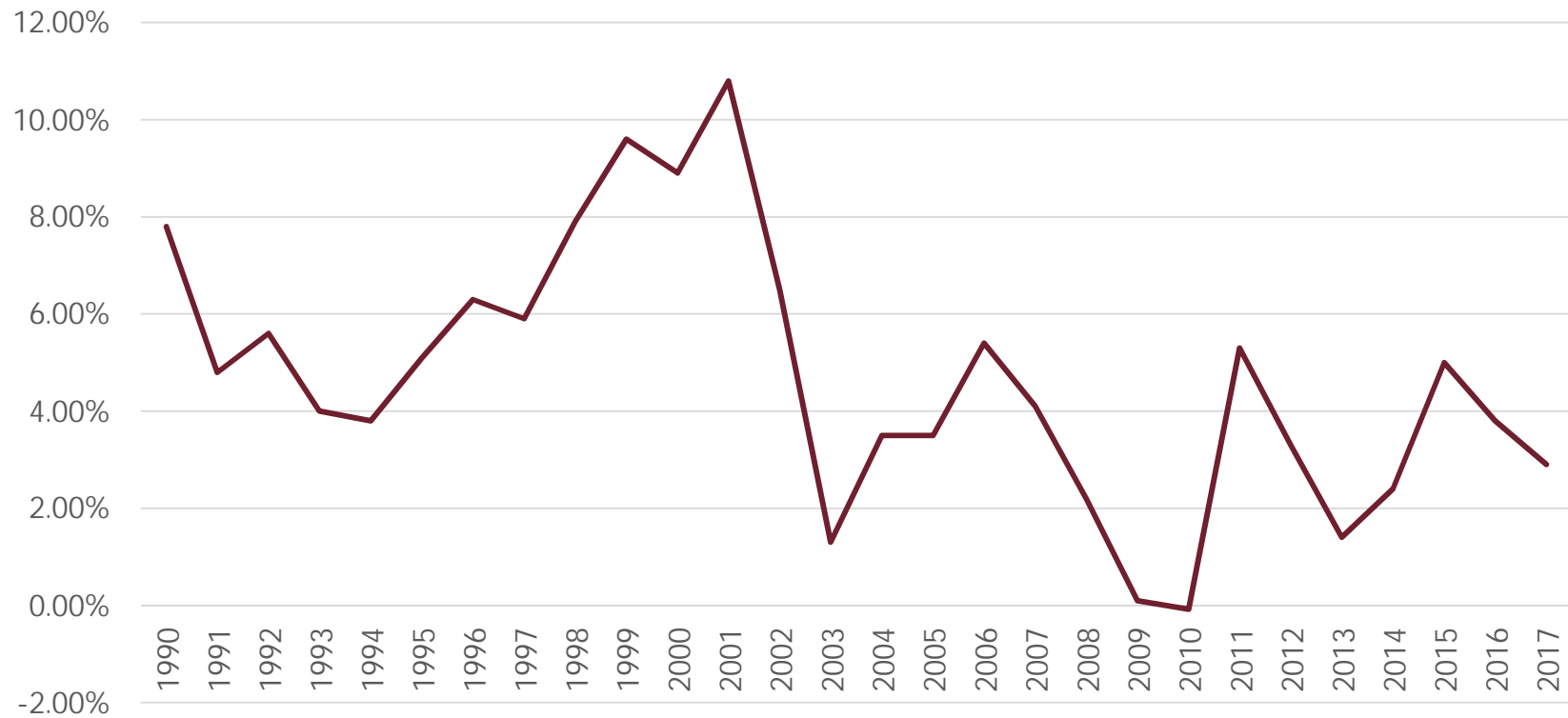
Real GDP is the output of the economy adjusted to remove the effects of inflation.

Shaded area denotes recession period.

Source: Congressional Budget Office; Bureau of Economic Analysis; <https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/reports/52370-supplementaldata.xlsx>

DELAWARE PERSONAL INCOME GROWTH

Annual Change in Personal Income, 1990-2017



Source: Bureau of Economic Analysis

CONSIDERING USE OF ECONOMIC GROWTH FOR SETTING ANNUAL HEALTH CARE SPENDING BENCHMARKS

- Is tying health care spending to state economic growth — past or projected — or past personal income growth a good idea?
 - What would be the rationale for making the linkage to either?
- If it is a good idea, which of these options is preferable and why?
 - State economic growth?
 - State personal income growth?
- If it is a good idea, which of these options is preferable and why?
 - Average of past performance?
 - Projection of future performance?

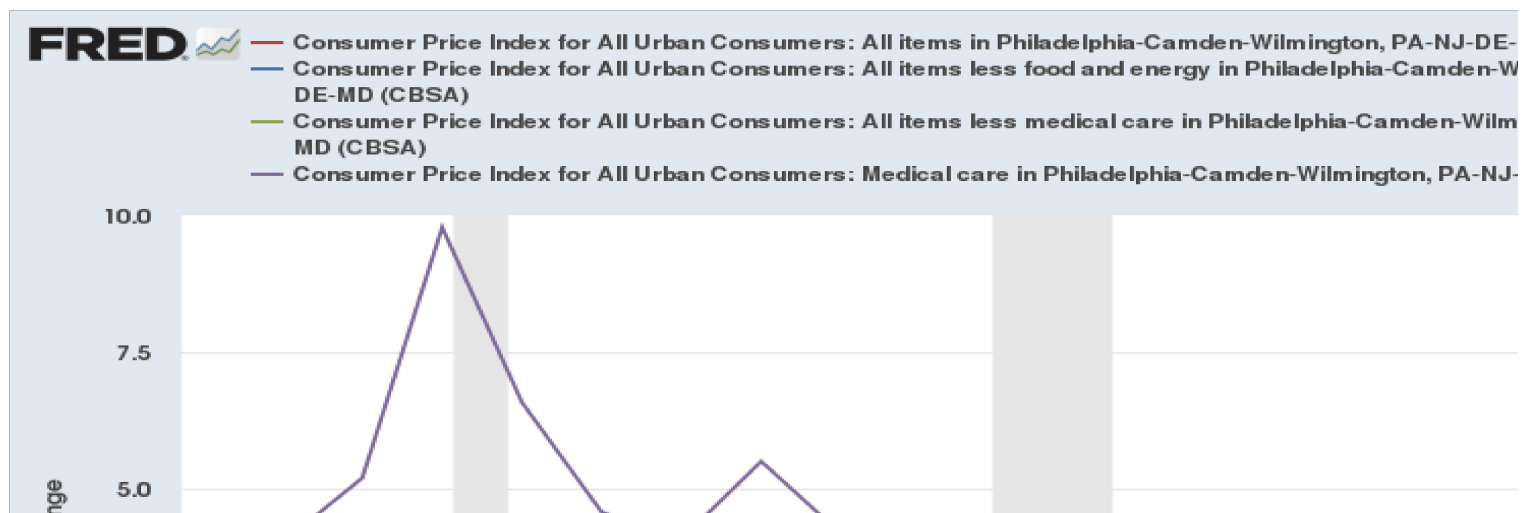
LINKING THE BENCHMARK TO INFLATION

- Generally, if the health care spending benchmark is tied to inflation, then the benchmark would imply that health care should not grow faster than the average rise in consumer-paid prices.
- How might inflation be measured?
- Consumer Price Index: an index of the variation in prices paid by typical consumers for retail goods and other items. Specifically for food, clothing, shelter, fuel, transportation, medical care, prescription drugs and other goods and services that people buy for day-to-day living.

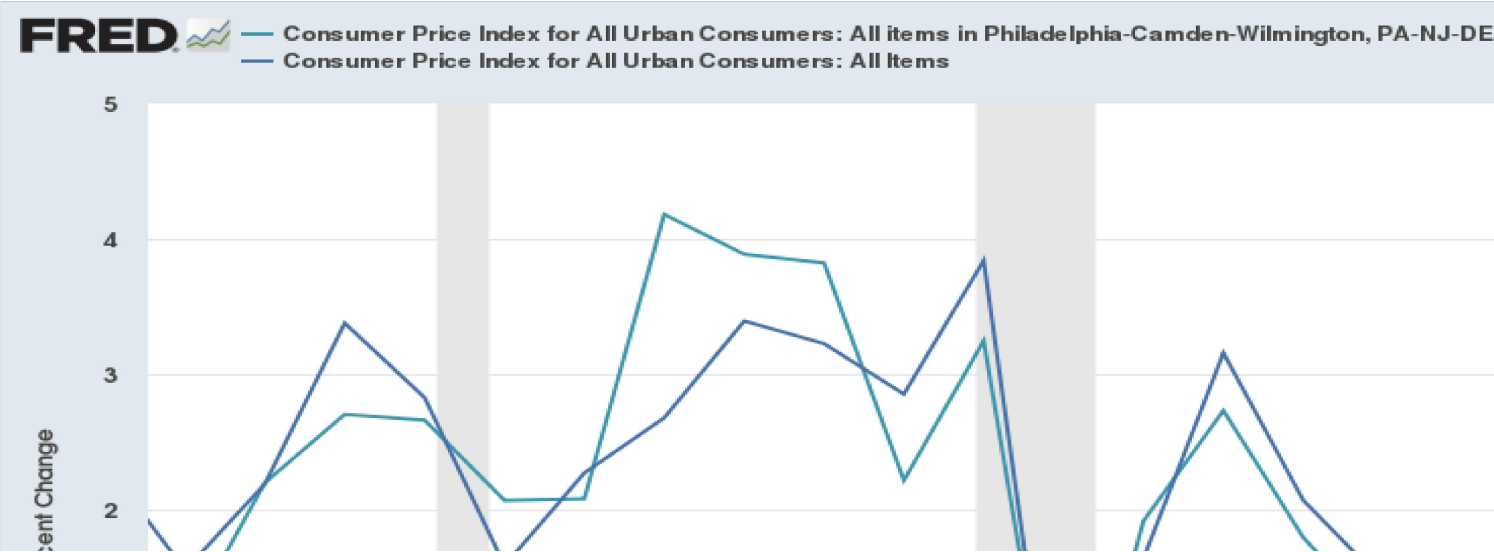
CONSUMER PRICE INDEX: FOUR OPTIONS

- CPI-Urban, All Items (CPI-U): represents spending for about 94% of the total U.S. population of urban or metropolitan areas, including professionals, self-employed, low-income, unemployed and retired. Not included are farmers, people in the Armed Forces and those in institutions (e.g., prisons, mental hospitals).
- CPI-U Less Food and Energy: removes food and energy prices from the calculation, as these prices are typically the most volatile.
- CPI-U Less Medical Care: removes medical care from the calculation, since the health care spending benchmark is focused on medical care.
- CPI-U Medical Care: represents spending only on medical care services (professional, hospital and health insurance) and medical care commodities (Rx, DME) only.

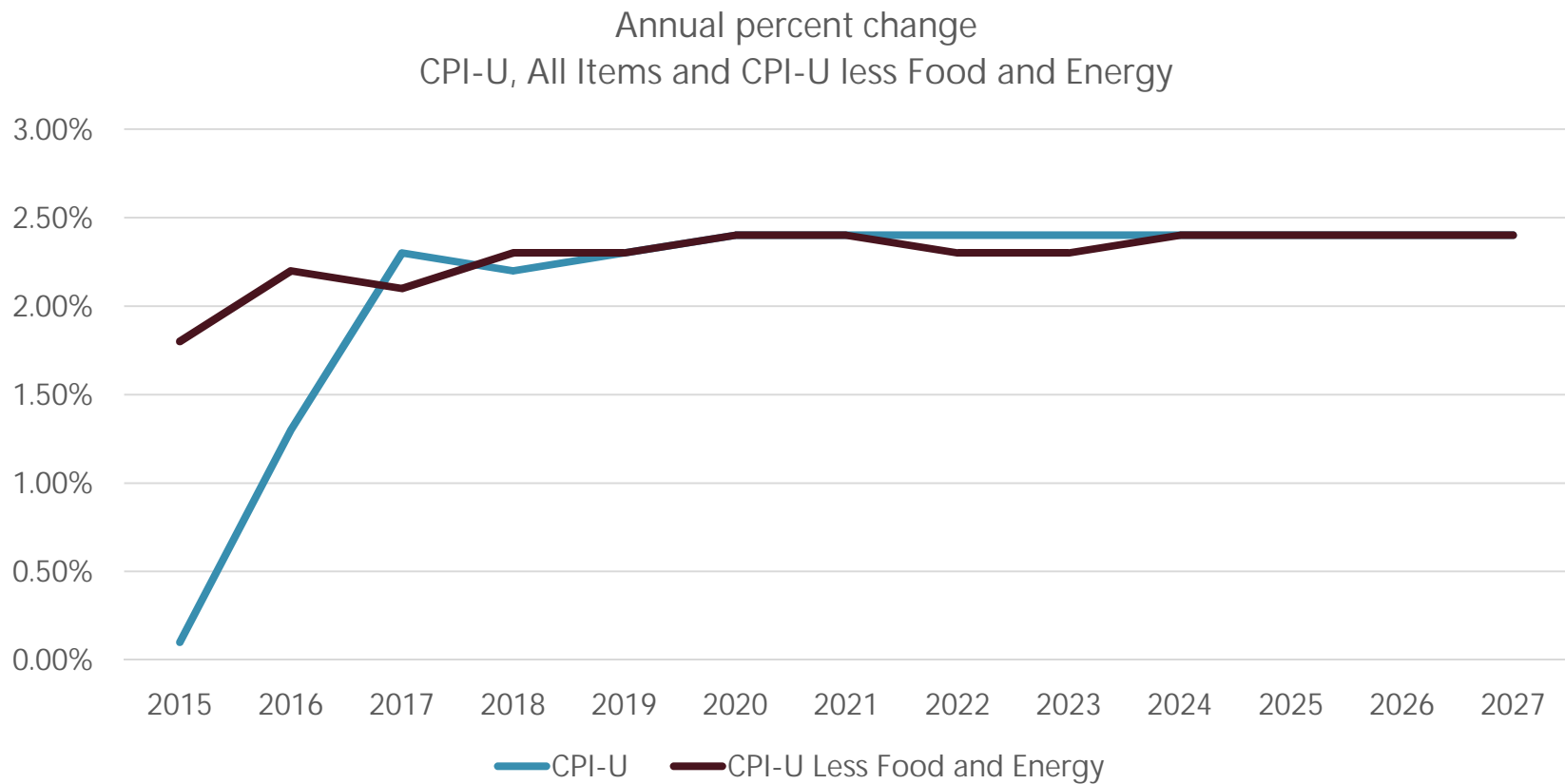
CONSUMER PRICE INDEX: THE FOUR OPTIONS



CONSUMER PRICE INDEX



NATIONAL CONSUMER PRICE INDEX: HISTORICAL AND FORECAST



Source: CBO An Update to the Budget and Economic Outlook: 2017 to 2027 www.cbo.gov/publication/52801

CONSIDERING USE OF INFLATION FOR SETTING ANNUAL HEALTH CARE SPENDING BENCHMARKS

- Is tying health care spending to consumer price growth — past or projected — a good idea?
 - What would be the rationale for making the linkage to CPI?
- If it is a good idea, which of these options is preferable and why?
 - CPI-Urban (CPI-U), all items?
 - CPI-U, less food and energy?
 - CPI-U, less medical care?
 - CPI medical care?
- If it is a good idea, which of these options is preferable and why?
 - Average of past performance?
 - Projection of future performance?

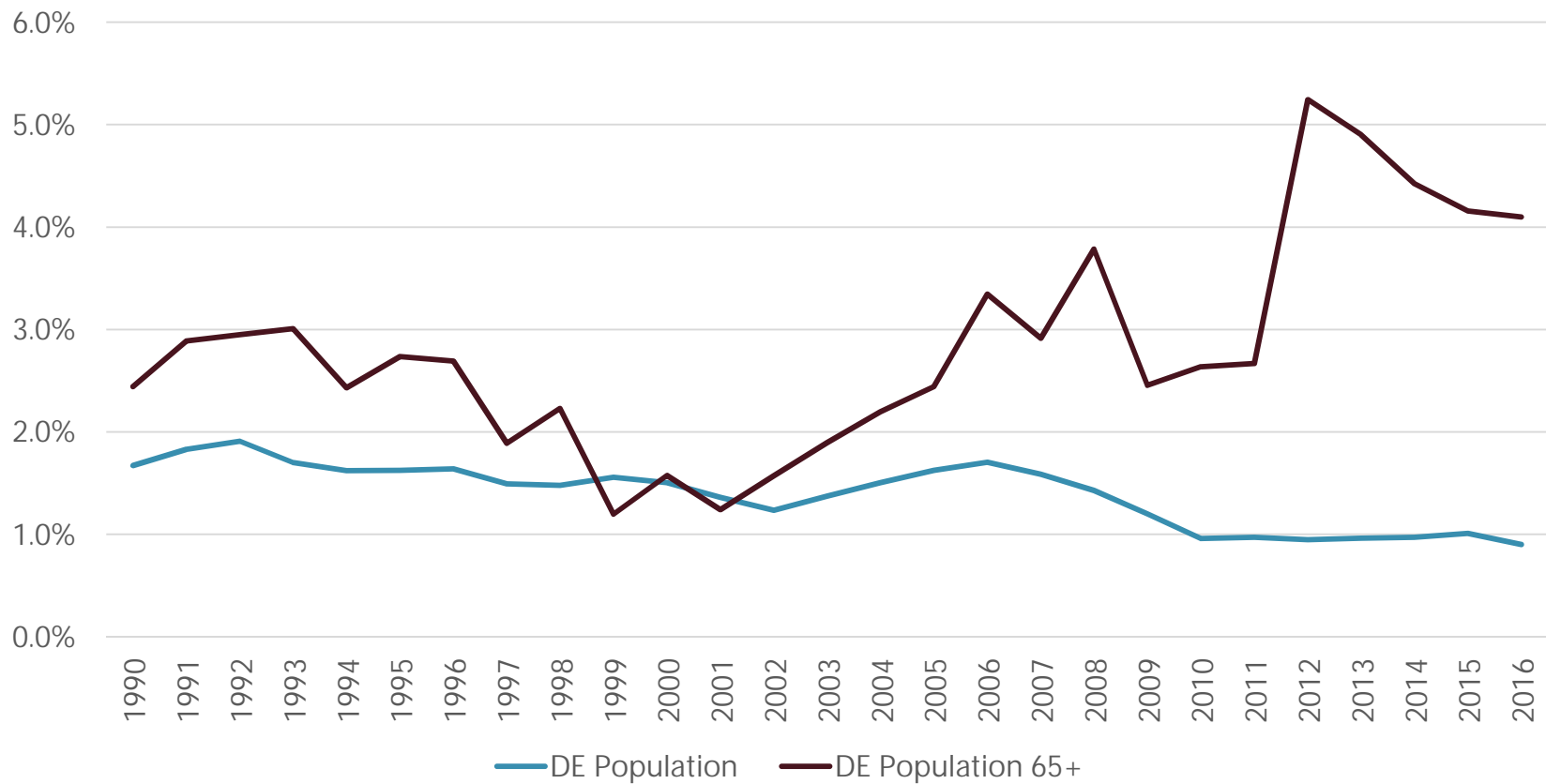
ECONOMIC GROWTH VS. INFLATION

ECONOMIC INDICATOR	PROS	CONS
Gross State Product	<ul style="list-style-type: none"> Sets expectation that health care shouldn't grow faster than the rest of the economy 	<ul style="list-style-type: none"> Consumers view health care cost as any other cost Doesn't address high degree of waste in current spending
Personal Income	<ul style="list-style-type: none"> Sets expectation that health care shouldn't grow more than personal income – a more consumer-centric concept than GSP. 	<ul style="list-style-type: none"> Similar to Gross State Product Does not capture all sources of personal income, e.g., capital gains
Consumer Price Index All Items	<ul style="list-style-type: none"> Sets expectation that health care shouldn't grow faster than other consumer costs 	<ul style="list-style-type: none"> Assesses health care on price only and does not consider service volume
Consumer Price Index Less Food and Energy	<ul style="list-style-type: none"> Same strengths as CPI All Items but much more stable 	<ul style="list-style-type: none"> Does not capture the significant effects of food and energy on consumer cost
Consumer Price Index Medical Care	<ul style="list-style-type: none"> More generous to health care payers and providers, recognizing that, historically, health care cost growth has greatly exceeded CPI 	<ul style="list-style-type: none"> Use of this index would make the benchmark methodology self-referencing Does less to reduce spending on health care services based on historical experience

OTHER INDICATORS AS PROXIES FOR HEALTH CARE DEMAND

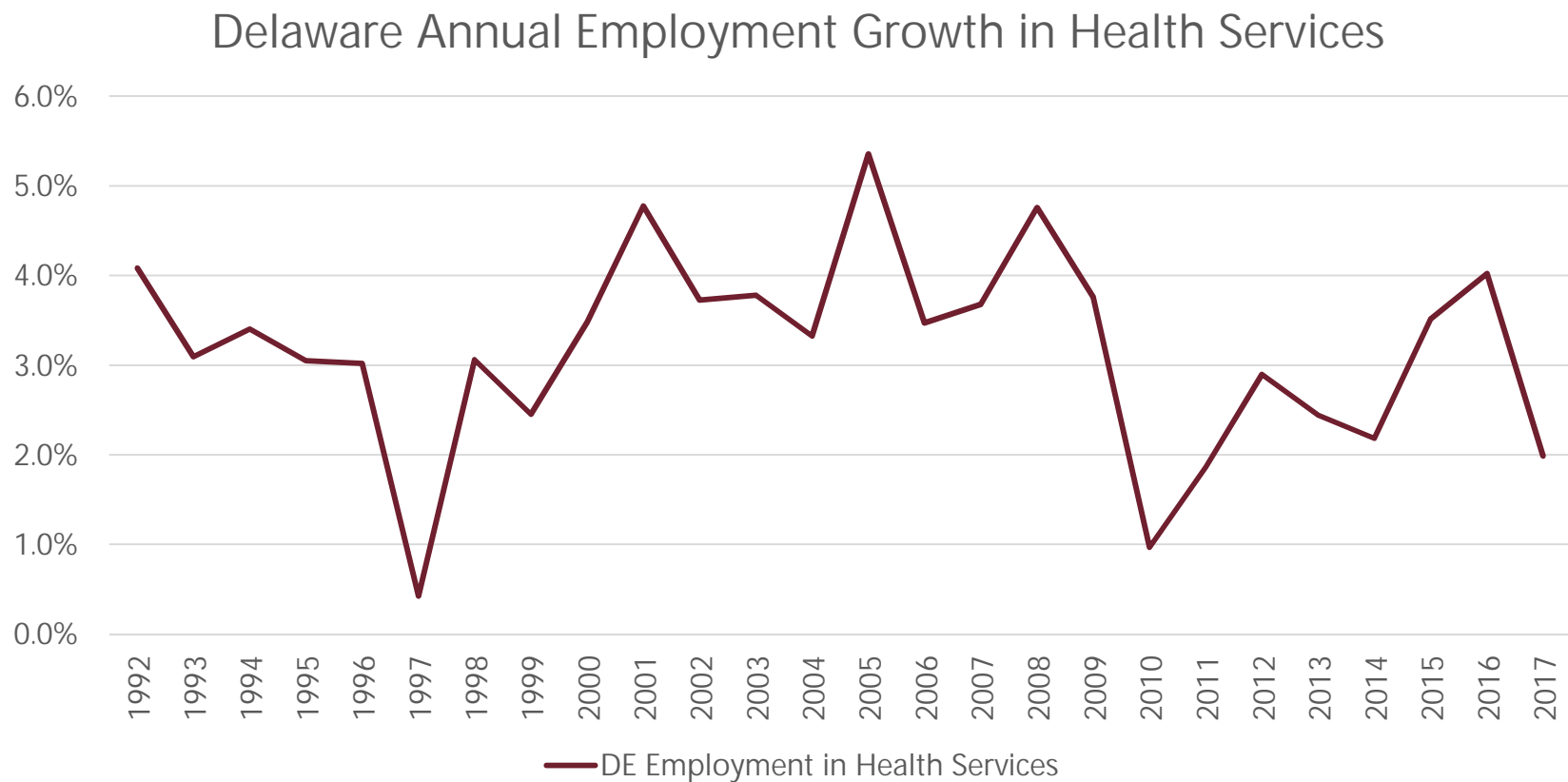
- The Department of Finance has identified two proxies indicators that may estimate the demand for health care services.
 1. Population growth (total and 65+)
 2. Health care employment
- The Department has suggested that these two indicators not be used alone, but potentially in conjunction with measures of economic growth or inflation.

DEPT. OF FINANCE PROXIES FOR HEALTH CARE DEMAND: POPULATION GROWTH (TOTAL AND 65+)



Source: US Census Bureau

DEPT. OF FINANCE PROXIES FOR HEALTH CARE DEMAND: DE EMPLOYMENT GROWTH IN HEALTH SERVICES



Source: Bureau of Labor Statistics, Current Employment Statistics

USING MULTIPLE INDICES TO CREATE A BENCHMARK

- The Department of Finance has suggested that a weighted mix of measures could be used to more fully capture inflation drivers, cost drivers and population growth.
- The Committee on Budgets has been looking at the following multi-component index as a means of forecasting state budget growth:
 - 1/2 personal income growth
 - 1/2 (consumer price index + population growth)

Over the last 3 years, this formula has yielded a rate of 2.62% and over the last 20 years, a rate of 3.90%.

- The Department of Finance has noted that, specifically to the health care benchmark, the following weighted mix of measures could be a possibility:
 - 1/4 personal income growth
 - 1/4 on consumer price index
 - 1/4 on population growth for individuals 65+
 - 1/4 on growth in health care employment

Over the last 3 years, this formula has yielded a rate of 3.01% and over the last 20 years, a rate of 3.16%.

BENCHMARK COMPARISONS

	Consumer Price Index-Less Food and Energy	Delaware GSP	Dept. of Finance Possible Hybrid Approach
3-year average	1.93%	4.85%	3.01%
5-year average	1.93%	3.29%	2.89%
10-year average	1.86%	2.35%	2.70%
20-year average	2.01%	4.02%	3.16%
Projected	2.40%	4.30%*	N/A

*Since projected DE GSP was not available, we used, as a proxy, national real GDP forecast (1.9%) plus CPI-U (2.4%).

ADDITIONAL QUESTIONS TO CONSIDER

- Now that we have had an initial discussion of economic indicators, we need to address some related questions:
 - Will the economic indicator(s) be adjusted (inflated or deflated (+/-) by a certain number of percentage points)?
 - Will it/they be based on a multi-year approach (averaging or weighting years) or a single-year approach?



QUALITY BENCHMARK SUBCOMMITTEE RECAP

QUALITY BENCHMARK SUBCOMMITTEE: CHARGE (1 OF 2)

1. Provide input to the Advisory Group regarding the creation of 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 from recognized measure developers, such as the National Committee for Quality Assurance (NCQA), or that have been endorsed by the National Quality Forum (NQF);
 - Make use of currently available data sources, and
 - Be set at the state level and, as practicable, at the market (commercial, Medicare, Medicaid), insurer and health system/provider levels.

QUALITY BENCHMARK SUBCOMMITTEE: CHARGE (2 OF 2)

2. Provide input to the Advisory Group regarding the creation of a quality benchmark that will:
 - 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.

QUALITY SUBCOMMITTEE DISCUSSION TOPICS

1. Measure selection criteria
2. Candidate measures
3. Benchmark methodology
4. Patient attribution

CRITERIA FOR SELECTION OF MEASURES TO BE USED FOR QUALITY BENCHMARKS

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 (*with dissent*)
8. Should have financial impact in the short or long term (*with dissent*)

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

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

CANDIDATE MEASURE IDENTIFICATION

- Subcommittee members were provided with the following documents to inform their thinking on candidate measures:
 1. List of measures found in the following measure sets:
 - Common Scorecard
 - Medicaid MCO contracts
 - Highmark value-based provider contracts
 - Medicare Share Savings Program and Next Generation ACO contracts
 2. Performance of Delaware commercial and Medicaid plans relative to national benchmarks on Common Scorecard measures found in the HEDIS measure set

CANDIDATE MEASURE ELIGIBILITY CRITERIA

- During the March 22nd Advisory Group meeting, a member asked whether measures of population health status (e.g., BMI) were candidates for the quality benchmarks.
 - The wording of the Executive Order suggests that measures of population health status should only be considered to the extent that they are viewed by the Advisory Group as indicators of health care system performance for accountability purposes.
- Some Subcommittee members opted to suggest measures of population health status.
- Other Subcommittee members opted to suggest measures of health care quality, some drawn from measures already in use in the state and others not.
- While the measures were proposed for consideration after the discussion of measure selection criteria, not all of the measures met most of the criteria.
 - Advisory Group staff will score measures for their fit with the Advisory Group's suggested measure selection criteria following today's meeting.

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. 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

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

BENCHMARK METHODOLOGY

- Subcommittee members conveyed the following thoughts on how to set benchmark values for 2019 once the measures have been selected:
 - Set long-term goals for each of the measures, and then, also set annual targets for year-over-year progress.
 - Keep the benchmarks in place for several years.
 - Define the benchmark value in terms of the State's ranking relative to other states (with a goal of improving the ranking over time).
 - Where baseline data are available on state performance, look at multiple years' worth of data to inform the benchmark.
 - Consider having no benchmark the first year, and treat the first year as a planning year.

PATIENT ATTRIBUTION

- While not a planned discussion topic, one Subcommittee participant wished to share thoughts on how patients should be attributed, in particular, to provider organizations:
 - Only attribute patient to provider organizations if the patient has been seen by that organization.
 - All payers should use the same algorithm.
- The meeting participants appeared to support these two ideas, but also, seemed resigned to the limited likelihood that payers would agree to utilize the same attribution algorithm.



PUBLIC COMMENT





WRAP-UP AND NEXT STEPS

