

Delaware Health Care Delivery and Cost Advisory Group
Wednesday, June 6, 2018
1 pm – 4 pm Eastern
DHSS Herman Holloway Campus — Chapel
1901 North DuPont Highway, New Castle, Delaware

Advisory Group Members Present:

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

Advisory Group Members Absent: NA

State Staff Present:

- Governor John Carney
- Steven Costantino, Director of Health Care Reform and Financing, DHSS
- Molly Magarik, Deputy Secretary, DHSS
- Ann Kempinski, Delaware Health Care Commission

Primary Consultants Present:

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

I. Welcome and introductions (*Secretary Walker*)

- a. The Advisory Group members were reminded of their role and were thanked for their work on the benchmarks. The importance of quality and spending caps in the context of individual wellbeing was reviewed. The Secretary thanked the public on questions and comments submitted to date and encouraged continued feedback.
- b. There was an Advisory Group member request for a deeper conversation, stakeholder engagement and more collaboration on the benchmarks following the completion of the Advisory Group process, including collaboration with DCHI.

II. Quality Benchmarks (*Michael Bailit*)

- a. The last Advisory Group meeting was recapped. At the May 22 meeting, members of the Advisory Group provided suggestions on which measures should potentially be used for defining the quality benchmarks. Advisory Group staff assessed each of the candidate measures for which one or more Advisory Group members expressed interest during that meeting using the Advisory Group's endorsed measure selection criteria.

- b. The following scoring method was developed to compare the measures against the Executive Order requirements. For each measure selection criterion, each measure could receive: 2 points if it met the criterion; 1 point if it somewhat met the criterion; 0 points if the measure did not meet the criterion. A single measure could receive no more than 16 points (eight criteria * two maximum points/criterion).
- c. The following measures received the respective scores based on this criterion: Both prevention composites were defined by NCQA.
- i. 16 points for adult prevention composite (screening for cervical cancer, breast cancer, and colorectal cancer);
 - ii. 16 points for cervical cancer screening;
 - iii. 14 points for children prevention composite (childhood and adolescent immunization status);
 - iv. 13 points for adult BMI assessment;
 - v. 12 points for screening for clinical depression and follow-up plan;
 - vi. 11 points for fluoride varnish application for pediatric patients;
 - vii. 10 points for emergency department (ED) utilization;
 - viii. 10 points for weight assessment and counseling for nutrition and physical activity for children/adolescents (BMI percentile);
 - ix. 10 points for asthma medication ratio;
 - x. 10 points for medication management for people with asthma;
 - xi. 9 points for hospitalization for potentially preventable complications;
 - xii. 8 points for follow-up after ED visit for people with high-risk multiple chronic conditions;
 - xiii. 8 points for access to care composite from CAHPS 5.0 Health Plan Survey (getting needed care);
 - xiv. 7 points for access to care composite from CAHPS 5.0 Health Plan Survey (getting care quickly);
 - xv. 6 points for use of opioids from multiple providers; and
 - xvi. 6 points from 12 month-ending percentage of total deaths due to drug overdose by jurisdiction.
- d. The following questions and comments were raised and the corresponding responses were discussed on the proposed measures:
- i. Both prevention composites (adult and children) were recommended by multiple members.
 - ii. It was noted that depression screening and follow-up is difficult to measure.
 - iii. Concerns about adult BMI assessment and screening for clinical depression and follow-up plan were raised because it is difficult to get follow-up documentation through claims data.
 - iv. Multiple members suggested BMI assessment for a number of reasons (e.g., it is already measured in Medicaid; it is a significant indicator of health in the State).
 - v. Further alignment with the Delaware Common Scorecard was also recommended.
Response: One of the endorsed measure selection criteria was alignment with the scorecard so this is an appreciated reminder.
 - vi. Cervical cancer screening is included in the adult prevention composite so it should not be included in the final recommendations separately.
 - vii. In determining the Common Scorecard measures, screening measures with no follow-up plan were deliberately picked.
 - viii. On the opioid measure, it does not measure quality of care; it measures an outcome.

- ix. The asthma medication ratio was recommended.
- x. Multiple members suggested depression screening without the follow-up plan.

III. Variation in Health Care Cost, Utilization, Quality and Patient Experience (Michael Bailit)

- a. Governor John Carney’s Executive Order tasks the Advisory Group with “[advising] the Secretary regarding proposed methods for analyzing and reporting on variations in health care delivery and costs in Delaware.” Variation in health care quality, cost, utilization and patient experience has been reported in multiple ways, including:
 - i. By geography (e.g., county, Hospital Service Area);
 - ii. By provider (e.g., hospital, medical group):
 - 1. Episode of care (e.g., hip/knee replacement)
 - 2. Type of service (e.g., magnetic resonance imaging [MRI], colonoscopy)
 - 3. Patient experience element (e.g., access, personal care)
- b. Many of these examples rely upon claims data, creating a time lag between the service period and the reporting period. Some were devised for provider, payer and policymaker use, but others have been designed for consumer use.
- c. Examples of variation analyses and reporting were reviewed, including geographic variation (Vermont Blueprint for Health, Minnesota Community Measurement, and Center for Improving Value in Health Care (Colorado)) and Provider Variation (Minnesota Community Measurement, Healthier Washington, Center for Improving Value in Health Care (Colorado), and Get Better Maine).
- d. The following specific geographic variation examples were reviewed.
 - i. The Vermont Blueprint for Health is a state-initiated primary care transformation program. It publishes bi-annual Hospital Service Area (HSA) Profiles of health status, health care utilization and quality, reported separately for adults (age 18+) and children (age 1–17). Profile reports are generated at the HSA and statewide average levels using key metrics, including: 1. Expenditures (per capita and by major category of service (e.g., inpatient discharge, ED visit)); and Resource Use Index (to isolate intensity of service use from the effects of price variation); utilization rates (e.g., inpatient discharge, ED visits, advanced imaging); and performance on specific prevention measures (e.g., screenings), many of which align with the State’s ACO strategy. Utilization and expenditure rates are risk-adjusted for demographic and health status differences among the reported populations. Data sources include Vermont’s all-payer claims database (APCD), which includes all covered commercial, Medicaid, and Medicare members attributed to Blueprint practices; also the Blueprint clinical data registry, and the annual Behavioral Risk Factor Surveillance Study (BRFSS). Additional HSA-specific details about the reported rates are included in each profile, for example: Inpatient total expenditures are broken down by inpatient mental health, maternity, surgical and medical for each HSA in its profile and compared with the state. Quality measures that align with the State’s ACO strategy are also reported by commercial, Medicare and Medicaid levels as appropriate. All community profiles are publicly available at: <http://blueprintforhealth.vermont.gov/community-health-profiles>.
 - ii. Minnesota Community Measurement is an independent non-profit organization driven to accelerate the improvement of health by publicly reporting health care information. It collects, analyzes, evaluates and

compares health care quality information from across Minnesota. It reports data about the health of populations (e.g., children), health conditions (e.g., diabetes, asthma), procedures (e.g., heart surgery) and site of care (e.g., clinic, hospital) with the goal of driving improvement. Its *2017 Cost and Utilization Report* includes the following cost information: total cost of care (TCOC), using the Total Cost Index (TCI); average costs for 118 common medical procedures; resource use and prices as context for understanding variations in cost; and statewide, regional and medical group level information. Data sources include 1.5+ million commercially-insured patients (individual and employer-sponsored) from four state health plans.

- iii. Colorado's CIVHC is a public-private entity created to identify and advance initiatives across Colorado that enhance consumers' health care experiences, contain costs and improve the health of Coloradans by creating an efficient, high-quality and transparent health care system. It brings together consumers, providers, payers, businesses and policymakers to work together to improve value across the entire health care system. It is the appointed administrator of the Colorado All-Payer Claims Database (APCD). Using APCD data, CIVHC can assist stakeholders to create new payment models (e.g., bundled payments), and provide analytics to help establish baseline episode costs and quality information. CIVHC uses PROMETHEUS methodology to identify episodes of care by separating typical episode costs from Potentially Avoidable Costs (PACs) and pinpointing opportunities for savings. Its data source is Colorado's APCD. CIVHC analysis of five-year cost trends within each region also point to annual pricing fluctuation. Analysis showed that in some procedures in some regions, prices spike high one year only to drop markedly the following year. Other regions appear to be trending downward for some services while upward for others, and some regions appear to have relatively flat paid amounts over time.
- e. The following questions and comments were raised on geographic variation:
 - i. How is geographic crossover between states accounted for in Vermont data?
Response: It was not accounted for.
 - ii. In Vermont, is data measured at the practice level or clinician level?
Response: At the practice level.
 - iii. In the Minnesota example, what does cost mean?
Response: "Cost" means spending.
 - iv. It is important to measure by episode of care rather than specific services. The goal should be to move to value-based payment.
 - v. Which model has high input from self-insurers?
Response: It varies by state.
- f. The following specific provider variation examples were reviewed:
 - i. Minnesota Community Measurement publishes the average cost of 118 common medical procedures by medical group. Each of these individual procedures can be searched by, and compared across 220 unique medical groups. Average Cost per Procedure (ACP) is based on actual costs, and includes only professional (physician) claims billed directly from the medical group to participating health plans. The data source is commercially insured patients from state payers. Minnesota Community Measurement also publishes health care cost and quality information on the MNHealthScores.org website. The site contains information on the quality of care at hospitals and medical clinics, patient experience and costs, including

average costs of procedures. It is also designed for patients, their families and the public and helps them make educated choices about where to obtain care and what care they should expect. Users can compare providers based on quality, patient experience and cost ratings. Rates are scored against the state average and the state identifies the “Top” scorers as the top 15 clinics or top five medical groups as long as the results are above average. For hospital-acquired conditions, the measure combines results from different measurements into a single rating for the hospital. The rating is converted to a score that compares the hospital to the statewide average. Lower rates may signal better quality (e.g., “lower than average” (better); “higher than average” (worse); “average” (the same)).

- ii. For the Washington Health Alliance’s Healthier Washington Community Checkup, the Community Checkup report includes comparable information about the performance of medical groups, hospitals, health plans and Accountable Communities of Health (ACH) on measures of health care quality, patient experience and cost. It includes results for the State’s Common Measure Set for cost and quality (the 2017 report was the eleventh version). It is intended to help everyone make more informed decisions and to motivate improvement in health care quality and value. The 2017 report includes a “call to action” section describing specific steps different stakeholder groups can take to improve the quality of care in Washington. The report relies on claims and encounter data supplied by health plans, self-insured purchasers, union trusts and the Washington Health Care Authority (which includes the Medicaid agency and state employee benefits program). Data submitted for the report is de-identified and aggregated for reporting purposes. Only medical groups with five or more publicly reportable measures are included. There are separate reports for groups with 15 or more reportable measures and between five and 14 reportable measures. Summary rates are based on how each rate compares to the state rate.
- iii. Provider episodes of care costs outlined in Colorado’s CIVHC reports were reviewed. CIVHC is working on a “Shop for Care” feature for consumers, which will combine price and quality information for common services across select facilities in Colorado. It will be an interactive feature available on the CIVHC website by the end of 2018.
- iv. Get Better Maine is a website administered by the Healthcare Purchaser Alliance of Maine (the Alliance), a non-profit organization with more than 50 members. The Alliance measures and reports health care value to assist employers and their employees in purchasing higher quality, more affordable health care. Reports compare hospitals, ambulatory providers, including adult/pediatric providers, behavioral health providers, and specialty providers (e.g., Ob/Gyn, oncology) and practice groups. Providers are rated on select clinical effectiveness of care (e.g., NCQA recognition for diabetes care), patient experience, and safety, and cost domains. Hospitals are rated on maternity care, patient experience and safety. Data sources vary by provider type and measures. For example, the Alliance developed its own Medication Safety Survey for hospitals. Other data sources include: Leapfrog Hospital Safety Survey; Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Hospital CAHPS; reports from Bridges to Excellence (BTE) that show providers/practices that have received recognition in specific condition categories (e.g., diabetes, hypertension)

from either BTE or NCQA; Maine's APCD for Total Cost Index measure (currently includes commercial insurance claims only); provider/practice reporting directly to the Alliance. Ratings are based on three benchmarks: 1. national average; 2. state average; and 3. best practice or top 10% of all hospitals nationally. Ratings are assigned as follows: Low (below all benchmarks); Good (equal to or above 1 benchmark); Better (equal to or above 2 of the 3 benchmarks); and Best (equal to or above all 3 benchmarks).

- g.** The following questions and comments were raised on provider variation:
- i.** A consumer-facing report is recommended.
 - ii.** Are there examples of cost reports as consumer reports?
Response: There are some consumer-facing cost reports.
 - iii.** Have the examples considered how patient behavior has changed?
Response: It's unclear if these examples have tracked changes in patient behavior.
 - iv.** How do consumers know what their out-of-pocket costs are?
Response: It's unclear; that information should be produced by the health plan because they know what the deductibles and copays are.
 - v.** In comparing geographic and provider data, provider data allows for actionable issues. What is actionable about geographic data?
Response: In Vermont, providers collaborate at the community level to work on specific priorities (e.g., health and social services).
- h.** The Advisory Group was asked to consider the following questions in providing feedback to the Secretary:
- i.** Would information like that reported in other states be an asset to efforts in Delaware to improve health system performance? If so, why?
 - ii.** What type of publicly reported information would best support performance improvement in Delaware? Who would use it, and why?
 - iii.** Should the highest priority be placed on reporting quality, utilization, cost or other data (e.g., patient experience)?
 - iv.** Should the highest priority be placed on reporting by geography, provider or payer?
 - v.** What steps would you recommend be taken to develop the functionality to analyze and report on variation in health care delivery and costs in Delaware?
- i.** The following was discussed on the Secretary feedback questions:
- i.** It is recommended that any reports are easy to access and consumer-facing.
 - ii.** For children's hospitals, it may not make sense to have measure comparisons because there's only one. There needs to be some caution with measure comparisons across care sites.
 - iii.** Outcomes should be compared to other organizations in the context of "apples to apples."
 - iv.** It is useful to look at variability. When looking at costs between states, place of care is more important.
 - v.** Geography may be more important, but reports should be practice-specific.
 - vi.** It is recommended that the variation reports should start with geography and should work towards moving to provider-level variability.
 - vii.** In considering ranking costs/spending, quality, and patient experience, there were varied responses. Some placed patient experience as the least important for a variety of reasons (e.g., subjective values on consumer

experience); some stated that patient experience is just as important as the other measures citing that it's part of the Triple Aim. One member stated that for consumer-facing data, the consumer experience is important. There was also discussion that some consumer experience issues drive quality (e.g., ease of appointment scheduling allows patients to better access follow up with care). There was consensus that long-term goals should integrate consumer experience.

- viii. On next steps recommendations, the following was discussed:
 - 1. DHIN should be used as a data source;
 - 2. Efforts that can provide more information to residents (employers, patient, etc.) should be considered because as insurance costs increase and benefits are altered, patients are more exposed to costs, so cost of care transparency becomes more important;
 - 3. The consumer should be kept in mind;
 - 4. Geography variations should be considered;
 - 5. The value-based payment perspective should be considered;
 - 6. Stakeholders should continue to be engaged;
 - 7. New emerging technologies to help improve patient care should be considered (e.g., technologies to steer patients to the most appropriate care sites).

IV. Follow-up Items (*Michael Bailit*)

- a. The Group reviewed health care spending by category. To better understand what categories of spending should be included in the benchmark, the Advisory Group asked in a past meeting for an analysis on health care spending across Delaware. An analysis was performed and data were collected from a variety of sources. Some data were estimated using the best available information, others were available through publicly available sources, such as the Division of Insurance filings, or through HRSA. The three biggest spending categories are Medicare, Medicaid managed care, and commercial. Charity care estimates are understated, but are still small in context of other spending. It was clarified that Medicaid spending includes long-term care costs.
- b. The Group reviewed inclusion of non-Delaware residing state employees. When discussing which populations to include in the health care spending benchmark, there was discussion about the approximately 10% of active Delaware state employees who do not reside in the State, and whether to capture their spending. Massachusetts limits the populations included to be Massachusetts residents, regardless of whether they are employed in the state or not. Health insurers did not respond with information regarding the feasibility of collecting such data, but two did respond with their preference to not include non-Delaware residents in the calculation of the benchmark for simplicity. One insurer also recommended restricting the measure to health care spending with Delaware providers.
- c. The following questions and comments on inclusion of non-Delaware residing state employees were discussed:
 - i. It was recommended that the benchmarks only consider Delaware residents.
 - ii. An issue about large employers employing many out-of-state residents was raised with this approach.
 - iii. Another point was raised that any quality efforts will have wider benefits.
 - iv. Most care costs are determined by factors other than care (e.g., social determinants of health, genetics, etc.) and actions by providers only have a portion of the impact on costs.

V. Final Report (*Michael Bailit*)

- a. In advance of this meeting, the Advisory Group received a draft of the Group's report to the Secretary. The draft report is a collection of the feedback and advice on the benchmarks collected during the meetings of the Advisory Group (4) and its subcommittees (3). A final draft will be provided to Advisory Group members on June 13, 2018. It will include a summary of today's proceedings. At that point, Advisory Group members will be asked for feedback in writing that will be incorporated in the final report. Secretary Walker will provide instructions via email on how to submit written comments and the due date. Written comments should be submitted to ourhealthDE@state.de.us by June 18, 2018.
- b. One member suggested that on pg. 11 of the draft, the issue of "who should set the benchmark" should be added. A request was presented on behalf of Tim Constantine that insurance representation should be included in the group setting the benchmarks.

VI. Public Comment (*Interested Parties*)

- a. One public comment was received described as follows. There was general appreciation of the benchmark work. However, quality should be defined and there is concern that consumers are not represented in the meeting. Quality of care should be consistent regardless of source of care. Quality of care and quality of choice is not equal. It's important that in measuring quality, consumer treatment should be considered. Benchmarks should consider the overall wellbeing of the individual. Transparency for consumers should also be supported and additional input from consumers is needed.

VII. Wrap up and next steps (*Secretary Walker*)

- a. The Secretary thanked the Group members for their efforts and described the following next steps.
- b. Following the submission of the report summarizing the work of the Advisory Group, the Secretary will take additional steps to devise a benchmark implementation plan that will be informed by the Advisory Group's work. In addition, the Secretary will review the Advisory Group report and implementation planning steps with legislative leadership. It is the Governor's intent that the benchmarks will be implemented starting January 1, 2019. While the work of the Advisory Group ends today, the Secretary will continue to seek public input through multiple channels.
- c. One member expressed appreciation for being part of the Group and made requests that stakeholders be included in the process moving forward and for more specificity on next steps.

VIII. Remarks from Governor Carney

- a. Governor Carney thanked the Advisory Group for its efforts and recounted the need for the benchmarks. These remarks are summarized as follows. Health care costs are increasingly impacting the State budget (health care costs are growing at 22% and State revenue is growing at 7%), which is unsustainable. At the federal level, the Medicare Trustees recently reported Medicare insolvency three years sooner than projected last year. The solution is to address health care in a systemic way that does not sacrifice quality. A general goal is to figure out how much the State spends on care and where it is spent. The Group will continue to be part of the dialogues.