HEALTH WEALTH CAREER

DELAWARE HEALTH CARE

DELIVERY AND COST ADVISORY GROUP SUMMARY

JUNE 25, 2018

State of Delaware

CONTENTS

1 INTRODUCTION

In response to health care spending growth that has historically outpaced Delaware's economic and revenue growth, the Delaware General Assembly passed, and Governor John Carney signed into law on September 7, 2017, House Joint Resolution 7 (HJR 7). HJR 7 authorized and directed the Secretary of the Delaware Department of Health and Social Services (DHSS) to establish a health care benchmark with the underlying commitment to improve health outcomes and quality while addressing transparency and accountability in costs.

The joint resolution directed specific tasks related to the establishment of the health care benchmark. Governor Carney issued Executive Order 19 on February 21, 2018 to establish a Health Care Delivery and Cost Advisory Group (the "Advisory Group") to address some of these specific tasks.[1] Executive Order 19 (full text can be found in **Appendix A**) charged the Advisory Group with advising the Secretary regarding the creation of health care spending and quality benchmarks.

The Advisory Group and supporting subcommittees met a total of seven times between March and June 2018. This report summarizes the work that occurred in those meetings and is organized as follows: Section 2: Advisory Group Purpose and Composition, Section 3: Advisory Group Process, Section 4: Background on Health Care Benchmarks, Section 5: Summary of Feedback on Health Care Spending Benchmark, Section 6: Summary of Feedback on Health Care Quality Benchmarks, Section 7: Summary of Feedback on Process and Timeline for Benchmarks, and Section 8: Summary of Feedback on Methods for Analyzing and Reporting on Variation in Health Care Delivery and Costs.

DHSS requested this report to deliver an accurate representation of feedback provided to the Secretary. This collective feedback will inform the Secretary in her forthcoming recommendations to the Governor.

[1] The Administration has completed other tasks related to establishing health care cost and quality benchmarks per HJR 7 outside of the Advisory Group, such as the recommendations DHSS Secretary Walker made in the December 2017 "Report to the Delaware General Assembly on Establishing a Health Care Benchmark."

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ADVISORY GROUP PURPOSE AND COMPOSITION

In understanding the purpose and objective of the health care spending and quality benchmarks (collectively "the benchmarks"), as directed originally in HJR 7 and in subsequent executive actions and reports since, it is important to reflect on what they are and are not intended to be. The preamble of HJR 7 and Executive Order 19 both aptly summarize broad objectives of the health care benchmarks; that is, to improve health outcomes and quality while addressing transparency and accountability in care costs. The health care spending benchmark is not intended as a cap on spending or limitation of care, or as any other form of a "health care cap". In the interest of further elaborating on the intentions behind the creation of a spending benchmark, the Department released a "Mythbusters" document, which is included in **Appendix B**.

Governor Carney's February 2018 Executive Order 19 was intended to organize and convene a group of stakeholders to advise Secretary Walker on the creation of the benchmarks recommended in her December 2017 report to the General Assembly. Broadly, Executive Order 19 established the Advisory Group to advise the DHSS Secretary on health care spending and quality benchmarks, with the following three charges:

1. To provide feedback to the DHSS Secretary on: i) the selection of methodologies to measure and report on the total cost of health care in Delaware, including the data sources that feed into the methodologies and ii) the establishment of a health care spending growth target which will become the cost benchmark.

2. To determine i) quality metrics across the health delivery system that will be used to create quality benchmarks and ii) 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.

3. To advise the Secretary regarding proposed methods for analyzing and reporting on variations in health care delivery and costs in Delaware.

The Executive Order prescribed the composition of the Advisory Group, with the DHSS Secretary serving as Chair. The Advisory Group consisted of 13 members (see **Appendix C** for Advisory Group membership), including the following executives:

1. The Secretary of DHSS
2. The Director of the Office of Management and Budget
3. The Chair of the Delaware Health Care Commission
4. The Chair of the Board of Directors of the Delaware Center for Health Innovation
5. The Director of the State Employee Benefits Office
6. The Director of the Division of Medicaid and Medical Assistance or a designee appointed by the Secretary of DHSS

And, the following appointments by the Governor:

7. A member representing a health care system or hospital
8. A member representing a pediatric health care system or hospital
9. A Delaware licensed physician who is an independent primary care provider in active practice
10. A representative of the insurance industry
11. A representative of the insurance brokerage industry
12. A representative of the business community who is not operating in the health care, health insurance or insurance brokerage industry
13. A health economist

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ADVISORY GROUP PROCESS

The Executive Order directed a minimum Advisory Group meeting schedule and allowed for the creation of subcommittees. Two subcommittees, the Health Care Spending Benchmark Subcommittee and the Quality Benchmarks Subcommittee, were formed to help in the advisory process. The main charter of both subcommittees was to provide input to the Advisory Group on the respective benchmarks. The Health Care Spending Benchmark Subcommittee and the Quality Benchmarks Subcommittee membership consisted of a mix of Advisory Group members and their designees and can be found in **Appendix D**.

Four Advisory Group and three subcommittee meetings were convened between March and June 2018. For the full list of meetings, see **Appendix E**. In alignment with the charges of the Advisory Group and subcommittees, the meetings were designed as public forums to raise and discuss ideas related to the development of the spending and quality benchmarks and were not intended to result in voting or to drive toward consensus. Members were posed with questions and topics for discussion on the benchmarks and then invited to provide input on various related topics, including benchmark methodology and data sources.

These meetings were public meetings, open for any individuals to attend in person or via Facebook Live. At the conclusion of each meeting, time was reserved for public comment. In addition, written comment was invited to be submitted any time through: ourhealthde@state.de.us. All public comments can be found here: http://dhss.delaware.gov/dhss/dhcc/global.html.

Because there was only one insurer representative on the Advisory Group, Advisory Group staff sought and obtained the input of Delaware's leading insurers in terms of commercial and Medicaid enrollment in addition to public input. Their feedback and input were periodically conveyed during meetings.

State executive branch leadership also participated in meetings and contributed resources to aid in the benchmarks advisory process. For example, Lieutenant Governor Hall-Long participated in the April 16 Advisory Group meeting and discussed the history of Delaware's health care claims database legislation and efforts on data and transparency. In addition, Delaware Department of Finance Secretary Geisenberger and staff participated in Advisory Group meetings and provided the staff supporting the Advisory Group with advice on the development of the health care spending benchmark. Finally, Governor Carney addressed the Advisory Group at the close of its

June 6 meeting, emphasizing the importance of benchmarks as part of the efforts to improve health outcomes, quality, transparency and accountability in the health care costs for Delaware and Delawareans.

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BACKGROUND ON HEALTH CARE BENCHMARKS

Health care benchmarks are a relatively new concept being applied in few other states thus far. This makes Delaware a vanguard, at the forefront of a new strategy to reduce the growth of spending and improve the quality of health care. Massachusetts was the first state to establish a statewide benchmark, specifically a health care spending benchmark, in 2013. Massachusetts set the benchmark equal to the state's potential gross domestic product (3.6%), which is a measure of the long-run growth rate of a state's economy. The public transparency of this benchmark appears to have been successful in helping Massachusetts slow its rate of health care spending below the national trend, and Massachusetts has met the benchmark on average over the four years for which the data have been collected and publicly reported. In 2018, the state lowered the benchmark by 0.5% to further incentivize the slowing of cost growth in the health care system.

Maryland and Vermont have both established health care spending benchmarks in the context of negotiated all-payer agreements with the federal government. As a condition of participation, the federal government required that the health care cost growth rate be limited. In Maryland, the inpatient and outpatient hospital growth has been limited to the state's long-term projected per capita state economic growth (3.58%). In Vermont, the per capita health care spending growth rate for the entire population of Vermont must be limited to 3.5% (figure not tied to economic growth).

Statewide quality benchmarks have not been established in other states in the public way in which Delaware is currently contemplating doing so. However, some states (like Maryland and Vermont) do have quality targets they must meet as part of all-payer agreements with the federal government, and states are often holding insurers and providers accountable for quality benchmarks through their purchasing requirements. Delaware is the first state to publicly take steps toward creating statewide quality benchmarks.

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SUMMARY OF FEEDBACK ON HEALTH CARE SPENDING BENCHMARK

The Advisory Group and the Health Care Spending Subcommittee (the Subcommittee) were asked to provide feedback on how the health care spending benchmark would be set and how performance against the benchmark would be measured. Each advisory body was given a brief introduction and education on each topic, and they were informed of various economic measures and potential economic models that could help serve to calculate the Delaware benchmark. There was thoughtful discussion, specific details of which can be found in the meeting summaries posted here: http://dhss.delaware.gov/dhss/dhcc/global.html.

The following provides a summary of the feedback provided to the Secretary:

- *Whose health care spending is being measured?* To determine exactly whose health care spending should be measured, the Advisory Group and the Subcommittee considered several broad populations of individuals by coverage category. **There was general agreement that health care spending on at least Medicaid, the Delaware state employee/retiree health plans, Medicare, Dual Eligible (Medicare and Medicaid) and commercial insured and self-insured populations be included.** Other populations, such as Veterans Health Administration, Federal Employee Health Benefits, TRICARE (health insurance for uniformed service members, retirees and their families), prisoners incarcerated by the State and the uninsured, needed further consideration of the trade-offs between associated spending and administrative effort to obtain required data. Where data can be obtained and is important to providing the fullest picture possible of health care spending in Delaware, the advisory bodies agreed they should be included.

- *What spending should be measured?* To determine exactly what health care costs should be measured, the Advisory Group and the Subcommittee considered both claims-based and non-claims-based spending. First, the advisory bodies considered the pros and cons of including and excluding certain claims-based services that are particularly high cost or difficult to predict or contain, including pharmacy. **There was general agreement that all claims-based and non-claims-based spending categories be included in the benchmark methodology if the data are obtainable.** The group recognized that some spending might be more difficult to include based on availability of data, but suggested that the methodology should be as inclusive as practical. This includes spending on any claims collected by reporting entity, pharmacy

spending net of rebates, net cost of private health insurance[2], patient cost sharing, spending on carved-out benefits and, if possible, federal grants that are used to fund provision of direct health care services. The advisory bodies also specifically debated whether charity care and bad debt should be included in the methodology and determined that, if practical, charity care should be included as reported by hospitals. There were concerns expressed around bad debt and whether it should be included, but the group did not coalesce around a final determination.

- *Where does the data come from?* The advisory bodies recognized there are a limited number of publicly available health care spending data sources outside of state government and agreed that a Delaware all-payer claims database would be a desirable and helpful future data source. **For the short run, the advisory bodies discussed health insurers submitting data and were of split opinion on whether the insurers should be voluntarily asked or mandatorily required to submit the data required to calculate performance against the benchmark**. With regard to data for self-insured employed populations, the advisory bodies learned that insurers are able to provide summary level data for the purposes of measuring performance against the benchmark and that the Supreme Court decision *Gobeille v. Liberty Mutual,* which limits what self-insured data can be required by the state, is understood elsewhere as applicable to claims-level data.

- *What should be the residency status of the measured population?* The Executive Order states that the health care spending benchmark will be set at the state level, and, as practicable, at the market, insurer and health system/provider levels. To report health care spending at the state level, the advisory bodies needed to consider what the residence of the individual receiving health care was and what the location of the provider delivering care was, as health care spending occurs by Delaware residents inside and outside of Delaware, and within Delaware by Delaware residents and residents of other states or countries. **There was consensus that the spending benchmark should cover in state and out-of-state spending for Delaware state residents only and not include out-of-state residents who seek care from Delaware providers.** However, the question of how to handle State employees and retirees who do not live in Delaware was raised and left open for further considerations given that spending's impact on the State's budget each year.

- *What should be the methodology for setting the benchmark rate?* The advisory bodies considered different indices of economic growth and inflation, and indicators that could potentially adjust economic growth or inflation, such as population growth (total and over 65 years) and health care employment. After much discussion, the Health Care Spending

[2] Net cost of private insurance is the difference between health premiums received by the insurer and the benefits paid out.

Subcommittee (which reviewed this topic after the Advisory Group had already done so) agreed the benchmark should meet the following four criteria: (1) be a predictable target, (2) adjust for the effects of changes in inflation, (3) rely on independent, objective data sources and (4) account for significant events. The Subcommittee leaned towards utilizing the annual change in the per capita measure of potential Delaware gross state product (GSP), expressed as a percent, with some adjustment for growth in the population over age 65 years. The Advisory Group agreed that a prospective economic measure should be the basis for the benchmark versus a retrospective one, and mostly agreed that there should be an adjustment for growth in the population over age 65 years There were no objections raised to the concept of a potential Delaware GSP, and the Advisory Group did not have an opinion on whether the projected GSP should be calculated by state staff or purchased from an outside vendor. Ultimately, the Advisory Group agreed that the most important factor was transparency in methodology and ease of calculation.

6

SUMMARY OF FEEDBACK ON HEALTH CARE QUALITY BENCHMARKS

The Advisory Group and the Health Care Quality Benchmarks Subcommittee (the Quality Subcommittee) were asked to provide feedback on which two to five high-priority health care measures should be used to establish the quality benchmarks, the methodology for establishing the quality benchmarks and sources for supporting data.

What are the criteria for choosing measures? The Advisory Group and the Quality Subcommittee established criteria for choosing the benchmarks. These criteria were selected to focus on measures that were the most important to Delaware and appropriate for benchmark use.

The following eight criteria were established:

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
8. Should have financial impact in the short- or long-term

In addition, the Advisory Group and the Quality Subcommittee wanted the two to five measures to be representative of pediatric, adult and older adult (Medicare) populations, and set multi-year goals with measures that are retained over that timeframe.

- ***What are the top two to five State quality improvement priorities?*** The Advisory Group reviewed more than 20 measures that were collected through discussions with the Health Care Quality Subcommittee, Advisory Group staff, health insurers and within the Advisory Group itself. Of those measures, one or more Advisory Group members expressed interest in sixteen. The sixteen measures were then scored by Advisory Group staff to determine how the measures aligned with the criteria the Advisory Group established, and then were presented for consideration. The Advisory Group did not come to a final determination on the measures that should be used for the quality benchmarks, but did express interest in a number of measures, listed below in Table 1.

Table 1. Measures of Interest to One or More Advisory Group Members

MEASURE NAME
Prevention Composite: Adults • Cervical Cancer Screening • Breast Cancer Screening • Colorectal Cancer Screening
Prevention Composite: Children • Childhood Immunization Status • Immunizations for Adolescents
Adult BMI Assessment
Screening for Clinical Depression
Fluoride Varnish Application for Pediatric Patients
Ambulatory Care – Sensitive Condition (ACSC) ED Visits
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (BMI Percentile)
Asthma Medication Ratio
Medication Management for People with Asthma

MEASURE NAME
ACSC Admissions – Hospitalization for Potentially Preventable Complications
ACSC ED Visits – Follow-up After ED Visit for People with High-Risk Multiple Chronic Conditions
Access to Care Composite from CAHPS 5.0H Health Plan Survey – Getting Needed Care
Access to Care Composite from CAHPS 5.0H Health Plan Survey – Getting Care Quickly
Use of Opioids from Multiple Providers

The Advisory Group agreed to recommend against any measure regarding opioid death rates because it is too difficult for providers to impact the measure. It should also be noted that over the course of several meetings, there was repeated interest in an access measure, and the group reviewed the type of access measures suggested from the CAHPS 5.0 Health Plan Survey for future consideration.

Advisory Group members expressed a desire to identify measures for which subsequent "drill-down" analysis could be performed to better understand variation in care.

What should be the methodology for setting the benchmark values? The Advisory Group spent time discussing how to establish the benchmark value, regardless of what measures were chosen. There was a general belief that the quality benchmarks should have two values: (1) a short-term goal of incremental improvement year-over-year based on past performance that might also be specific to the population (i.e., Medicaid, Medicare, commercial) and (2) a long-term goal that is aspirational in nature, informed by a regional or national benchmark. The Advisory Group members agreed that the benchmark for the long-term goal should be a weighted composite that takes into account all populations, even though there may be performance differences among the populations.

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SUMMARY OF FEEDBACK ON PROCESS AND TIMELINE FOR THE BENCHMARKS

The Advisory Group was asked to provide feedback on the process for establishing the timeline for the benchmarks. The Advisory Group considered the overall timing of when the benchmarks would be announced and the cadence at which data would be collected, analyzed and then reported upon. They also contemplated how performance relative to the benchmarks would be publicized, and who would have the responsibility for setting and updating the benchmarks. The following represents their feedback.

- *When should the benchmarks be set?* The Advisory Group contemplated the timing of when the benchmark values would be set and announced. For the 2019 benchmarks, the Advisory Group thought that fall 2018 was a reasonable timeframe for the health care spending and quality benchmarks to be announced, recognizing that the most recent data to establish a baseline for the quality benchmarks will not be obtained until early fall. The Advisory Group agreed that annually thereafter, the benchmark values could be reassessed and modified, and the performance be announced in the fall of subsequent years.

- *How should performance relative to the benchmarks be made public?* The Advisory Group reviewed several options for how performance against the benchmark should be shared. There was agreement that performance results should be shared with the Health Care Commission and that there be a public forum to discuss findings and for providers and insurers to be given the option to present their work relative to the benchmark during that meeting or meetings. There was also agreement that the results should be transparent to the public and conveyed to members of the General Assembly and other interested health care stakeholders (e.g., the Chamber of Commerce).

- *Who should set the benchmark?* The Advisory Group was asked whether the Health Care Commission or another State agency/body should set the benchmark. To inform their opinions, the Advisory Group learned of independent policymaking bodies that operate in Massachusetts and Vermont. The Advisory Group generally agreed that the Health Care Commission, with its current membership, should set the benchmarks. There was some discussion about whether the body that establishes the benchmarks should be devoid of individuals with conflict of interest or the perception of conflict of interest. The Advisory Group had general agreement that in Delaware, given the small size of the state, there are few individuals who have the expertise to

set the benchmarks and who do not at least have a tangential connection to the existing health delivery system. Most believed that the connection to the health care delivery system should not prevent an individual from participating in the body that will be assigned the responsibility to manage the benchmark process, but there was concern voiced regarding the benchmarks being defined by those whose performance will be measured and reported as part of the benchmark process. Finally, a couple Advisory Group members recommended that if the Health Care Commission were to be given the responsibility to establish the benchmarks, insurers would need to be represented on the Commission.

- *Does the Health Care Commission have the resources to support the benchmark process?* The Advisory Group was provided with information on the Health Care Commission's current roles, responsibilities and staffing, and determined that additional resources will be necessary for the Health Care Commission to set the benchmark and analyze and report on its results. The Advisory Group suggested three approaches for adding additional resources: (1) additional staff could be added to the Health Care Commission, (2) the Delaware Health Information Network or (3) the State could hire a health care consulting firm to support the work.

8

SUMMARY OF FEEDBACK ON METHODS FOR ANALYZING AND REPORTING ON VARIATION IN HEALTH CARE DELIVERY AND COSTS

The Advisory Group was tasked with "[advising] the Secretary regarding proposed methods for analyzing and reporting on variations in health care delivery and costs in Delaware." To provide such feedback, the Advisory Group was given an overview of how different states and organizations are collecting data and presenting analyses on variation in performance by geography and provider. Efforts in other states include a mix of reports for payer, provider and policymaker use, and other reports designed for consumer use. The Advisory Group reviewed examples of performance variation measurement involving cost, service utilization, clinical quality and patient experience, and agreed that generating data on variation in cost and quality to inform health system performance improvement would be an asset to Delawareans. Multiple members of the Advisory Group specifically supported starting with variation on cost and quality reported at the geographic level as a means for beginning to understand where there are opportunities for improvement. There was some concern that any variation analysis adequately account for the differences in population risk so that providers that care for the highest risk patients are not inappropriately compared to providers that care for predominately lower risk patients. Other sentiments conveyed by the Advisory Group included the following:

- Consumers should be able to have information regarding cost and quality that could help inform their health care decision-making.
- Some felt that assessing variation in consumer experience should be a top priority, noting that some hospitals already voluntarily publicize such data. Other Advisory Group members thought that cost and quality data would initially be more actionable and should, therefore, be a higher priority.
- If cost variation is analyzed, it should be done at the episode-of-care level rather than at the service unit level.
- If variation data are reported for consumer use, they should ideally integrate cost and quality data in one report.
- The Delaware Health Information Network should provide the analysis of performance variation.

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CONCLUSION

Delaware is establishing health care spending and quality benchmarks as a means to transparently convey the performance of the health care system in the state. To inform development of the benchmarks, Governor Carney created an Advisory Group to provide feedback to Secretary Walker on specific topics relative to benchmark methodology. Over four months, from March 2018 to June 2018, the Advisory Group and subcommittees engaged in thoughtful discussion and provided feedback on how spending and quality benchmarks could be established by the Governor. This report memorializes the summary feedback provided by the Advisory Group members and will be used to inform the State on the establishment of the benchmarks.

APPENDIX A

EXECUTIVE ORDER 19

WHEREAS, Delaware is committed to improving the health of Delawareans and improving patient-centered health care quality in the state, and has previously undertaken steps to try to address health care spending, most recently through the work of the Delaware Center for Health Innovation; and

WHEREAS, Delaware's per capita health care spending consistently ranks in the top ten highest spending states, and has historically outpaced economic growth in Delaware; and

WHEREAS, it is in the best interest of Delawareans to recognize that public and private health care spending must lead to high-quality health care at lower costs; and

WHEREAS, enhanced transparency and shared accountability for spending and quality targets can be used to accelerate changes in our health care delivery system, creating benefits for employers, state government, and health care consumers; and

WHEREAS, 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; and

WHEREAS, House Joint Resolution 7 directed the Secretary of the Department of Health and Social Services to study and plan the means and methods for gathering data to develop an annual growth target of total health care costs in the State of Delaware, otherwise known as a "benchmark," including selecting methodologies, determining sources of data, and collecting actuarial certification.

NOW, THEREFORE, I, JOHN C. CARNEY, by virtue of the authority vested in me as Governor of the State of Delaware, do hereby DECLARE and ORDER the following:

1. The Health Care Delivery and Cost Advisory Group (the "Advisory Group") is hereby established.

2. The Advisory Group:

    a. shall provide feedback to the Secretary of the Department of Health and Social Services (DHSS) regarding (1) the selection of methodologies to measure and report

on the total cost of health care in Delaware, including the data sources that feed into the methodologies, and (2) the establishment of a health care spending growth target, which will become the cost benchmark; and

b. shall determine (1) quality metrics across the health delivery system that will be used to create quality benchmarks, and (2) 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.

3. The Advisory Group shall consist of the following members:

a. The Secretary of DHSS, who shall serve as Chair;

b. The Director of the Office of Management and Budget;

c. The Chair of the Delaware Health Care Commission;

d. The Chair of the Board of Directors of the Delaware Center for Health Innovation;

e. The Director of the State Employee Benefits Office;

f. The Director of the Division of Medicaid and Medical Assistance (DMMA), or a designee appointed by the Secretary of DHSS;

g. One member representing a health care system or hospital, appointed by the Governor;

h. One member representing a pediatric health care system or hospital, appointed by the Governor;

i. One Delaware licensed physician who is an independent primary care provider in active practice, appointed by the Governor;

j. One representative of the insurance industry, appointed by the Governor;

k. One representative of the insurance brokerage industry, appointed by the Governor;

l. One representative of the business community, who is not operating in the health care, health insurance or insurance brokerage industry, appointed by the Governor; and

m. One health economist, appointed by the Governor.

4. Members serving by virtue of position may appoint a designee to serve in their stead and at their pleasure, except as provided above.

5. The Chair may invite persons who are not members of the Advisory Group to facilitate and support the work of the Group.

6. The Advisory Group may establish subcommittees with members appointed by the Group to focus on specific subject areas or issues.

7. The Advisory Group shall convene at least once in each of March, April, and May and shall, over the course of its existence, perform at least the following tasks:

    a. Advise the Secretary regarding the creation of a health care spending benchmark that will:

        - use 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.

    b. 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;
        - use measures that have been endorsed by the National Quality Forum, 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 for Calendar Year 2019, and then annually thereafter; and
- Be used in comparative analysis to actual performance following the end of Calendar Year 2019 and annually thereafter.

c. Advise the Secretary regarding proposed methods for analyzing and reporting on variations in health care delivery and costs in Delaware.

8. 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. policy recommendations regarding any of the proposed items before the Advisory Group;

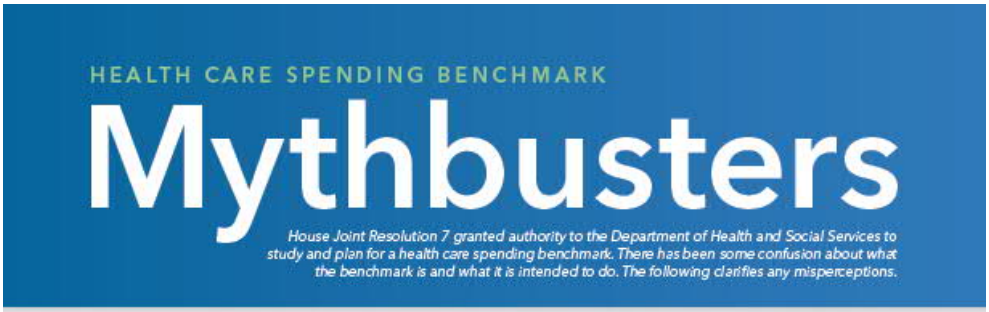
    b. the features essential to the success of any recommended benchmarks or reporting of variations in health care costs or delivery; and

    c. a proposed process and timeline for implementing any policy recommendation.

The Advisory Group shall dissolve on June 30, 2018, unless reconstituted by further executive order.

APPENDIX B

HEALTH CARE SPENDING BENCHMARK MYTHBUSTERS



MYTH: The benchmark is a cap on spending.

REALITY: The benchmark is not a cap on spending. It is a target for health care spending growth. By increasing transparency and the dialogue about total health care spending, we can identify opportunities for cost and quality improvement.

MYTH: Under the cost and quality benchmarks, health care providers will be penalized for not meeting targets.

REALITY: The state will not penalize health care providers for not meeting a cost or quality benchmark. Both benchmarks will allow us – across the health care spectrum in Delaware – to take stock of where we stand.

MYTH: The ultimate goal of the benchmark is for the state to set rates.

REALITY: The benchmark has not been created to set rates. While the ultimate goal is to move toward value-based health care, the benchmark focuses solely on information transparency.

MYTH: The benchmark will reduce health care providers' reimbursement rates and their income.

REALITY: The benchmark process will not change contracting, or decrease reimbursement rates or a practice's revenues. It will create transparency so that we may understand where our health dollars are going and provide up-to-date data to determine the total cost of health care spending.

MYTH: Under the benchmark, health care providers will be singled out for differences in cost and quality.

REALITY: The reporting will not examine individual or small-practice variation in cost or quality. The benchmark is focused on total cost of expenditures in the state. Reporting will be at the system level and may look at large organizations, such as accountable care organizations, but not at small, individual practices.

MYTH: The benchmark will require health care providers to spend a lot of time gathering reports about their billing.

REALITY: There will be no report that health care providers or office staff have to fill out. Providers and their office staff will not spend additional time providing data to help measure the total cost of care. The information likely will come from health insurance claims.

Send any comments, questions, or concerns to: ourhealthde@state.de.us.
Read more about the benchmark at: https://www.choosehealthde.com/Health-Care-Spending-Benchmark.

ChooseHealth DELAWARE
Improving the state of health

APPENDIX C

ADVISORY GROUP MEMBERSHIP

- Kara Odom Walker, MD, MPH, MSHS, Department of Health and Social Services (Chair)
- Regina Mitchell, Office of Management and Budget
- Nancy Fan, MD, Delaware Health Care Commission
- Matthew Swanson, Delaware Center for Health Innovation
- Brenda Lakeman, State Employee Benefits Office
- Stephen Groff, Division of Medicaid and Medical Assistance
- Janice Nevin, MD, MPH, Christiana Care Health Systems
- Roy Proujansky, MD, Nemours/AI duPont Hospital for Children
- James Gill, MD, MPH, family medicine specialist
- Tim Constantine, Highmark Delaware
- Nicholas Moriello, Health Insurance Associates
- Richard Heffron, Jr., Delaware State Chamber of Commerce
- David Cutler, PhD, Harvard University

APPENDIX D

SUBCOMMITTEE MEMBERSHIP

Health Care Spending Benchmark Subcommittee Membership

- Tim Constantine, Highmark Delaware
- Nancy Fan, MD, Delaware Health Care Commission
- Tom Corrigan, Christiana Care Health System
- Ryan Forman, Nemours/AI duPont Hospital for Children
- Regina Mitchell, Office of Management and Budget
- Nicholas Moriello, Health Insurance Associates
- Tom Brown, Delaware Center for Health Innovation
- James Gill, MD, MPH, family medicine specialist
- Richard Heffron, Jr., Delaware State Chamber of Commerce
- Faith Rentz, Statewide Benefits Office
- Lisa Zimmerman, Division of Medicaid and Medical Assistance

Health Care Quality Benchmarks Subcommittee Membership

- Tim Constantine, Highmark Delaware
- Nancy Fan, MD, Delaware Health Care Commission
- Sharon Anderson, Christiana Care Health System
- Jamie Clarke, Nemours/AI duPont Hospital for Children

- Alan Greenglass, MD, Delaware Center for Health Innovation
- James Gill, MD, MPH, family medicine specialist
- Faith Rentz, Statewide Benefits Office
- Elizabeth Brown, MD, Division of Medicaid and Medical Assistance

APPENDIX E

ADVISORY GROUP AND SUBCOMMITTEE GROUP SCHEDULE

ADVISORY GROUP

March 22, 2018

April 16, 2018

May 22, 2018

June 6, 2018

HEALTH CARE SPENDING BENCHMARK SUBCOMMITTEE

April 2, 2018

May 7, 2018

HEALTH CARE QUALITY BENCHMARKS SUBCOMMITTEE

April 2, 2018

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