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DELAWARE HEALTH CARE SPENDING AND QUALITY BENCHMARKS IMPLEMENTATION MANUAL VERSION 1.0

EXECUTIVE SUMMARY

Governor Carney established health care spending and quality benchmarks in Executive Order 25, issued on November 20, 2018. The full implementation manual (herein referred to as manual) contains the technical and operational steps that the Delaware Health Care Commission (DHCC) and the Delaware Economic and Financial Advisory Council (DEFAC) Health Care Spending Benchmark Subcommittee (DEFAC Subcommittee) will need to take to implement Executive Order 25. The full manual contains the methodologies for setting the health care spending and quality benchmarks, and the methodologies for calculating performance against the benchmarks. It also contains the technical specifications for data reporting and collection. This Executive Summary contains the highest level articulation of a very detailed process.

Health Care Spending Benchmark Definition and Methodology

The health care spending benchmark (Spending Benchmark) is the target annual per capita growth rate for Delaware's total health care spending, expressed as the percentage growth from the prior year's per capita spending. The Spending Benchmark is set on a calendar year (CY) basis. The Executive Order set the Spending Benchmarks for CYs 2019–2023 as follows:

- CY 2019: 3.80%
- CY 2020: 3.50%
- CY 2021: 3.25%
- CY 2022: 3.00%
- CY 2023: 3.00%

As specified in Executive Order 25, for CYs 2020–2023, the Spending Benchmark is the forecasted growth in Delaware's per capita potential gross state product (PGSP) plus the following transitional market adjustments (i.e., add-on factors): +0.5% for CY 2020, +0.25% for CY 2021 and +0% for CYs 2022–2023.

Process for Annual Review of Components of PGSP for CYs 2020–2023:
Annually, starting in 2019, the DEFAC Subcommittee is to review all components of the PGSP methodology to determine whether the PGSP growth rate has changed due to large unanticipated economic changes such that it should be recalculated; therefore, changing the value of the Spending Benchmark. To perform this review, the DEFAC Subcommittee should consider the most recently

published values of PGSP and compare them to the values calculated in 2018 and presented in Table 2 in Chapter 2 of the full manual. Prior to making recommendations to DEFAC on whether to utilize a recalculated PGSP using updated forecast figures for the next year's health care spending benchmark, the DEFAC Subcommittee is required to solicit and consider comments from the public and interested stakeholders. Should DEFAC approve use of a recalculated PGSP, and therefore a new Spending Benchmark, Executive Order 25 requires DEFAC to report such changes to the Governor and DHCC no later than May 31 of the year preceding the restated Spending Benchmark. To maintain public awareness and support transparency, the new value of the Spending Benchmark should also be subsequently announced to the public, state agencies, payers and providers no later than July 1 of the year preceding the restated Spending Benchmark.

Process for Annual Review of Spending Benchmark Methodology for CYs 2024 and Beyond:
Per Executive Order 25, no later than March 2023 and each March thereafter, the DEFAC Subcommittee is to review the full methodology for defining the Spending Benchmark. Prior to making recommendations to DEFAC on whether to modify the methodology and/or recalculate PGSP, the DEFAC Subcommittee is to solicit and consider comments from the public and interested stakeholders. The DEFAC Subcommittee should also consider the methodologies and experiences of other states operating health care spending benchmarks, including, but not limited to, Massachusetts and Rhode Island. Whether DEFAC decides on a new methodology and/or a recalculated PGSP, any changes should be announced to the public, state agencies, payers and providers no later than July 1 of the year preceding its implementation.

Methodology for Assessing Performance Against the Spending Benchmark

Executive Order 25 encourages the DHCC to report each year on performance relative to the Spending Benchmark for the state as a whole, for each insurance market (e.g., Medicare, Medicaid, commercial), for individual large payers and for large providers. To do so, DHCC staff and/or DHCC's contractor will need to perform a series of data collection activities and calculations. Chapter 3 of the manual contains the methodology for measuring the growth in health care spending at each level, including which data are necessary to collect and which calculations need to be performed.

Methodology for Measuring Total Health Care Expenditures

To assess changes in the amount of health care spending, the DHCC will need to calculate total health care expenditures (THCE) annually. THCE is the total medical expense (TME)[1] incurred by Delaware residents for all health care benefits/services by all payers reporting to the DHCC, plus the insurers' net cost of private health insurance (NCPHI).[2] The DHCC should measure THCE on an aggregate dollar and per capita basis. The aggregate dollar figure will be for informational purposes only. The change in THCE on a per capita basis will be used to assess performance relative to the Spending Benchmark (see Chapter 3 of the manual).

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[1] TME consists of all payments for medical expenses for the Delaware resident population.
[2] NCPHI measures the costs to Delaware residents associated with the administration of private health insurance (including Medicare Advantage and Medicaid Managed Care). It is defined as the difference between health premiums earned and benefits incurred and consists of insurers' costs of paying bills, advertising, sales commissions and other administrative costs, premium taxes and profits or losses.

Data Sources for THCE

Data for THCE comes from several sources. DHCC will request data about all lines of business from the largest insurers in the state during the performance period.[3] Other sources include the Centers for Medicare & Medicaid Services, the Division of Medicaid and Medical Assistance and the US Department of Veterans Affairs. The full specification of the insurer data request and other sources of data appear in the appendices of the manual.

Public Reporting of Spending Benchmark Performance

To publicly report on performance against the Spending Benchmark, the DHCC should report at the statewide level with several "drill-down" analyses. Table 1 outlines the minimum levels at which DHCC should publicly report performance.

TABLE 1: LEVELS AT WHICH PUBLIC REPORTING OF PERFORMANCE AGAINST SPENDING BENCHMARK SHOULD OCCUR

LEVEL	REPORTING DETAIL
State level	• Aggregate spending and per capita • Compare per capita rate of change against benchmark
Commercial market	• Aggregate spending and per-member per-month (PMPY) • Compare PMPY rate of change against benchmark
Medicare market	• Aggregate spending and PMPY • Compare PMPY rate of change against benchmark
Medicaid market	• Aggregate spending and PMPY • Compare PMPY rate of change against benchmark
Insurer level (e.g., Highmark, AmeriHealth), by line of business (including Medicare Advantage, Medicare fee-for-service and Medicaid managed care organization)	• PMPY • Compare PMPY rate of change against benchmark
Large provider group	• PMPY; however, a more limited set of spending data than reported elsewhere

[3] As of 2018, these were Aetna, AmeriHealth Caritas, Cigna, Highmark Blue Cross Blue Shield Delaware and UnitedHealthcare. This may evolve over time, and the manual will describe how to determine which insurer should be required to report.

Reporting TME by Service Category
The data specifications for payers will allow data to be reported by major service category. By analyzing service category spending, the DHCC will be able to understand the scale of changes in individual service categories and the share of spending changes that are attributable to each service category. The individual service categories that should be assessed include:

- Hospital inpatient
- Hospital outpatient
- Professional physician (primary care)
- Professional physician (specialty care)
- Professional other
- Long-term care
- Retail pharmacy (including separately identifiable pharmacy rebate values)

Reporting TME by Large Provider
Annually, the DHCC should report, by line of business, on the health-status-adjusted TME for large providers that meet the following criteria:

- A minimum of 5,000 Medicare lives with an individual payer for one or more lines of business
- A minimum of 10,000 Medicaid or commercial lives with an individual payer for one or more lines of business

Because many Delaware primary care providers have a small number of patients who can be attributed to them, public reporting of spending data on all primary care providers is not appropriate due to the effects of random variation that commonly occurs in health care spending with small populations. In order to report on primary care providers, DHCC should ask each of the insurers to submit data to DHCC on the number of members attributed to each insurer's 10 largest contracts and report on those providers if they meet the aforementioned thresholds.

Insurers will be required to submit health status-adjusted and non-adjusted data. TME should be adjusted based on health status using insurer-reported health status (risk) adjustment tools. Because these tools will likely vary from insurer to insurer, it is not possible to compare or combine health status-adjusted TME data across insurers for public reporting purposes.

Given the small size of many Delaware providers, prior to reporting data in 2020, DHCC should consult with a statistician regarding how to report large provider data with proper statistical interpretation.

Timeline for Measuring and Reporting the Health Care Spending Benchmark
Executive Order 25 calls for the DHCC to publish THCE statistics in the fourth quarter of each calendar year following the respective reporting/data year. To the extent practicable, the DHCC should publish the THCE statistics close to the beginning of the fourth quarter. DHCC should anticipate that the first year of reporting may involve a longer timeline and higher start-up costs due to the time required to process questions, develop reporting templates, create data exhibits and resolve unanticipated issues. A complete timeline appears in the full manual as Attachment 4.

Health Care Quality Benchmarks

Delaware has established health care quality benchmark values intended to foster accountability at multiple levels (i.e., state, insurer, provider) for improved health status and health care quality in the State. There are eight quality measures for which Delaware has adopted quality benchmarks for the years 2019 through 2021. The full specifications of each measure appear in the complete manual. These measures fall into two categories:

1. **Health status measures:** These measures quantify certain population-level characteristics of Delaware residents.

2. **Health care measures:** These measures quantify performance on health care processes or outcomes. Performance is assessed at the provider, health insurer, insurance market and State levels.

Although the annual quality benchmarks have been defined for three years at the outset, the corresponding aspirational values assume a longer time horizon (five years). Annual quality benchmark values were determined by comparing baseline data to the aspirational value and dividing by five, with the annual quality benchmark value being adjusted annually by the quotient. Resulting values were rounded to one decimal point.

MEASURE AND MEASURE STEWARD	ASPIRATIONAL QUALITY BENCHMARK	BENCHMARK SOURCE(S)
Health State Measures		
Adult obesity (CDD)	27.4%	75th percentile (all states, 2016 Behavioral Risk Factor Surveillance System, CDC)
High school students who were physically active (CDC)	48.7%	75th percentile (all states, 2017 Youth Risk Behavior Survey, CDC)
Opioid-related overdose deaths (CDC)	13.3 per 100,000 (state population)	50th percentile (all states, 2016, CDC)
Tobacco use (CDC)	14.6%	75th percentile (all states, 2016 Behavioral Risk Factor Surveillance System, CDC)

MEASURE AND MEASURE STEWARD	ASPIRATIONAL QUALITY BENCHMARK	BENCHMARK SOURCE(S)
Health Care Measures		
Concurrent use of opioids and benzodiazepines (PQA)	TBD[4] (commercial and Medicaid)	Analysis of insurer-generated baseline data for CY 2018
Emergency department utilization (EDU) (NCQA-HEDIS, modified[5])	165.9 per 1,000 risk-standardized rate (commercial)	75th percentile (national, commercial all lines of business, 2017, NCQA 2018 Quality Compass)
Persistence of beta-blocker treatment after a heart attack (NCQA-HEDIS)	91.9% (commercial) 83.9% (Medicaid)	90th percentile (national, commercial all lines of business, 2017, NCQA 2018 Quality Compass) 75th percentile (national, Medicaid HMO, 2017, NCQA 2018 Quality Compass)
Statin therapy for patients with cardiovascular disease – statin adherence 80% (NCQA-HEDIS)	82.1% (commercial) 68.3% (Medicaid)	90th percentile (national, commercial all lines of business, 2017, NCQA 2018 Quality Compass) 75th percentile (national, Medicaid HMO, 2017, NCQA 2018 Quality Compass)

Calculating Performance Against the Benchmark

Annually, by September 30 of the reporting year, DHCC staff should complete calculation of performance against the quality benchmarks for the measurement year for all measures except for opioid-related overdose deaths. Performance against the quality benchmark for opioid-related overdose deaths should be calculated by February 1 in the second calendar year following the reporting year. Performance should be calculated at the state, market, insurer and/or provider level depending on the measure. Performance equal to or above the annual benchmark value indicates that the quality benchmark has been met. Performance below the annual quality benchmark indicates that the annual quality benchmark has not been met. The levels at which performance should be calculated are outlined below. Data sources are italicized.

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[4] The State will gather baseline performance data from Delaware insurers during CY2019 in order to set annual and aspirational benchmarks for 2020 and 2021.
[5] Rather than use the HEDIS observed-to-expected ratio, NCQA recommended and Delaware has adopted use of a risk-standardized rate for the quality benchmark.

MEASURE	STATE AND MARKET			INSURER		PROVIDER	
	Overall	Commercial	Medicaid	Commercial	Medicaid	Commercial	Medicaid
Health Status Measures							
Adult obesity	X *CDC*						
High school students who were physically active*	X *CDC*						
Tobacco use	X *CDC*						
Opioid-related overdose deaths	X *CDC*						
Health Care Measures							
Concurrent use of opioids and benzodiazepines		X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*
Emergency department utilization		X *Insurer*		X *Insurer*		X *Insurer*	
Persistence of beta-blocker treatment after a heart attack		X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*
Statin therapy for patients with cardiovascular disease – statin adherence 80%		X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*

Updating the Quality Benchmarks

The DHCC should review the quality benchmark methodology in 2021, and every three years thereafter, to determine whether changes should be made to the quality benchmark measures, the values used to

establish the quality benchmarks to reflect changes in new population health or health care priority opportunities for improvement, and/or whether the quality benchmarks values should be changed to reflect improved health care performance in the state. Should the DHCC identify appropriate changes, the DHCC should make such changes to measures and/or to benchmark values used for the quality benchmarks only after providing the public and interested stakeholders an opportunity to provide feedback and after considering their recommendations.

Timeline

The Quality Benchmark implementation timeline will require the DHCC to request and/or receive data throughout the year. The full timeline and associated activities appear in the full manual.

Conclusion

Delaware is the second state in the country to establish a health care spending benchmark and the first to establish health care quality benchmarks. The accompanying manual outlines the methodology for establishing the benchmarks and reporting performance against them, as well as, the detailed specifications required for the DHCC and DEFAC to implement these benchmarks.