DELAWARE HEALTH CARE DELIVERY AND COST ADVISORY GROUP

MEETING #1

MARCH 22, 2018

AGENDA

Topic	Time
1. Welcome and Introductions (Secretary Walker)	1:00pm – 1:15pm
2. Review of Open Meeting Law (Monica Horton)	1:15pm – 1:30pm
3. Advisory Group Charge (Michael Bailit)	1:30pm – 1:50pm
4. Cost Growth and Quality Benchmarks (Michael Bailit)	1:50pm – 2:30pm
5. Process for Providing Secretary Walker with Feedback (Michael Bailit)	2:30pm – 2:45pm
6. Topic 1: Total Health Care Spending (Michael Bailit)	2:45pm – 3:15pm
7. Topic 2: Data Sources (Michael Bailit)	3:15pm – 3:30pm
8. Public Comment (Interested Parties)	3:30pm – 3:45pm
9. Wrap-up and Next Steps (Secretary Walker)	3:45pm – 4:00pm

INTRODUCTIONS: THE ADVISORY GROUP (1 OF 2)

Executive Order Appointment	Representative
Secretary of the Department of Health and Social Services	Dr. Kara Odom Walker (Chair)
Director of the Office of Management and Budget	Michael Jackson
Chair of the Delaware Health Care Commission	Dr. Nancy Fan
Chair of the Board of Directors of the Delaware Center for Health Innovation	Matthew Swanson
Director of the State Employee Benefits Office	Brenda Lakeman
Director of the Division of Medicaid and Medical Assistance	Steve Groff

INTRODUCTIONS: THE ADVISORY GROUP (2 OF 2)

Executive Order Appointment	Representative
Health Care System / Hospital Member	Dr. Janice Nevin, Christiana Care Health System
Pediatric Health Care System / Hospital Member	Dr. Roy Proujansky, Nemours/A.I. duPont Hospital for Children
DE Licensed Independent Primary Care Physician	Dr. James Gill, family practice specialist
Insurance Industry Member	Tim Constantine, Highmark
Insurance Brokerage Industry Member	Nicholas Moriello, Health Insurance Associates
Business Community Member	A. Richard Heffron, Jr, Delaware Chamber of Commerce
Health Economist	David Cutler, PhD, Harvard University

INTRODUCTIONS:
STATE STAFF AND CONSULTING TEAM

State Staff	Title
Steven Costantino	Director of Health Care Reform and Financing, DHSS
Ann Kempski	Executive Director, Delaware Health Care Commission
Molly Magarik	Deputy Secretary, DHSS BR2

Primary Consultants	Title
Michael Bailit	President, Bailit Health
Megan Burns	Senior Consultant, Bailit Health
Dianne Heffron	Principal, Mercer
Heather Huff	Principal, Mercer

BR2 Aligned the two tables

Bledsoe, Roxanne, 3/19/2018

DELAWARE OPEN MEETING LAW

MONICA HORTON, DEPUTY ATTORNEY GENERAL

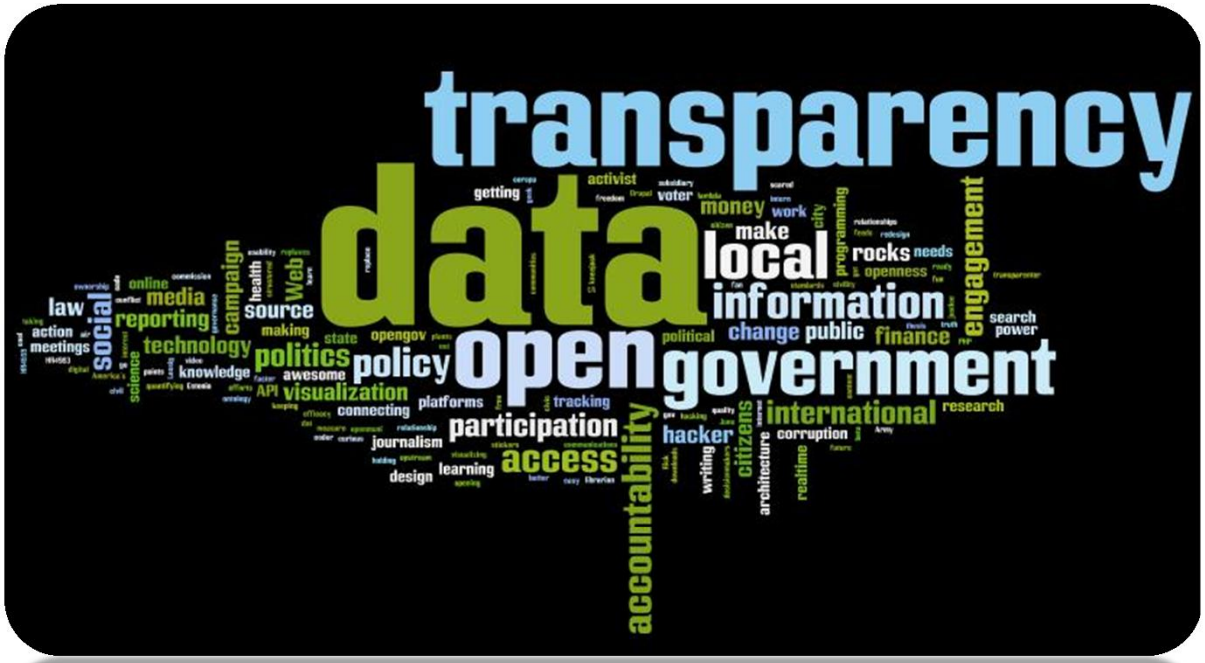
Delaware Freedom of Information Act

— a brief overview

Monica Horton, Esq.
Deputy Attorney General
Health Law Unit

29 *Del. C.* §§10001-10007

Purposes



Purposes


I just wanna say that i think its hecking rediculous that the humans still wont tell us who the good boy is, i demand freedom of information

Does FOIA apply to me?

Public bodies

Meetings

Public records

Health Care Delivery and Cost Advisory Group

- Definitely a public body
- Quorum = 7 members

Public Records

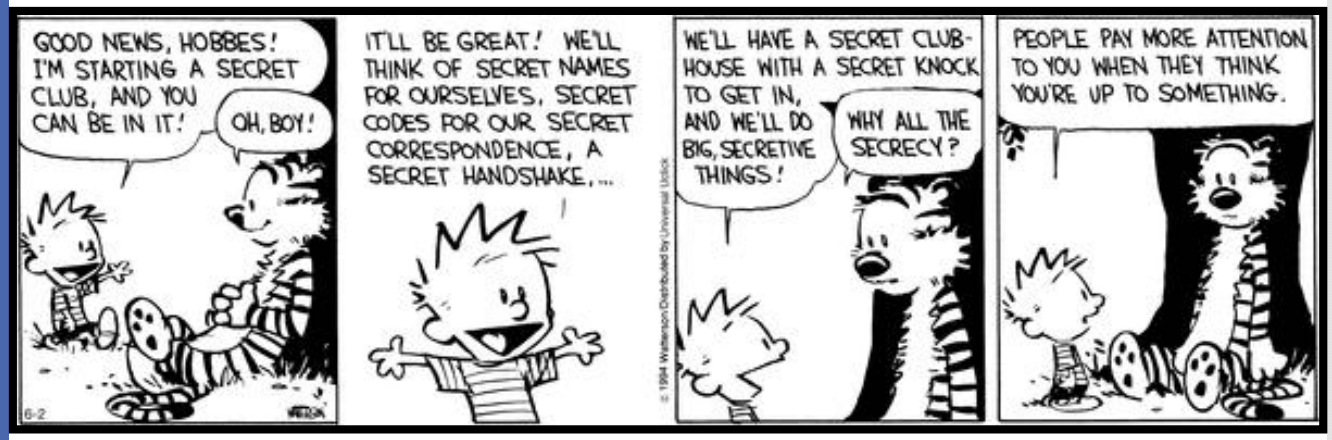
- Definition: “information of any kind, owned, made, used, retained, received, produced, composed, drafted or otherwise compiled or collected, by any public body, relating in any way to public business, or in any way of public interest, or in any way related to public purposes, regardless of the physical form or characteristic by which such information is stored, recorded or reproduced.”

Public Records

- Applicable exceptions:
  - Commercial/financial information of a privileged or confidential nature
  - Records specifically exempted from public disclosure by statute or common law

Let's Meet!

Open Meeting requirements



Meetings

Appropriate notice

Posted at the principle office of the public body or at the place where meeting are regularly held

Date, time and place and whether video conferencing will be used

Given at least 7 days before the meeting

Meetings

Voting
Executive Session

- Voting must be public

- Executive Session
  - Discussion of non-public documents

Meetings

Minutes

- Must keep minutes (even during executive session)
  - Posting deadlines
  - Contents:
    - Members present
    - Votes taken
    - Actions agreed upon

Fin

ADVISORY GROUP CHARGE

GOVERNOR CARNEY'S EXECUTIVE ORDER 19

ADVISORY GROUP CHARGE (1 OF 3)

- Governor Carney's Executive Order 19 directs this Advisory Group to:

1. Provide feedback to the Secretary of the Department of Health and Social Services (DHSS) regarding:
   a. the selection of methodologies to measure and report on the total cost of health care in Delaware; including the data that feed into the methodologies, and
   b. the establishment of a health care spending growth target, which will become the cost benchmark for 2019.

ADVISORY GROUP CHARGE (2 OF 3)

2. Determine:
   a. Quality metrics across the health delivery system that will be used to create quality benchmarks for 2019, and
   b. What, if any, changes need to be made to the composition or scope of the Delaware Health Care Commission in order for it to:
      - receive the relevant and necessary data for benchmark calculation,
      - apply the Health Care Commission's adopted benchmark methodology, and
      - update and assess State, market, payer and provider performance relative to the cost and quality benchmarks each year.

ADVISORY GROUP CHARGE (3 OF 3)

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

ADVISORY GROUP CHARGE

- By agreeing to serve on the Advisory Group, you are committing to participate in a thoughtful and respectful process to consider the Advisory Group's charge and make recommendations to the Secretary.
- We will not discuss the merits of the charge, but only how we can best respond to it.
- This body is advisory only. Because the body is advisory, there is no requirement that there be full consensus across all members on future recommendations.
- The scope of work is considerable; in order to facilitate progress staff will prepare content to which you can respond.

COST GROWTH AND QUALITY BENCHMARKS

DEFINITIONS

WHAT ARE THE BENCHMARKS?

DHSS will be establishing two separate types of benchmarks.

1. Spending benchmark: a per annum rate-of-growth target for health care costs in Delaware.
2. Quality benchmarks: annual targets for health care quality performance improvement in Delaware

- The benchmarks are to be established at the state level, and as practical, at the market, insurer and health system/provider levels.
- The spending benchmark is to be tied in some manner to an economic index.
- The quality benchmarks should number between 2 and 5.

ESTABLISHING DELAWARE-SPECIFIC BENCHMARKS

- When creating cost growth and quality benchmarks, it will be important to consider the specific characteristics of Delaware, including:
  - the impact of increased state health care spending on funding of state and local services
  - Delaware's current quality improvement opportunities
  - available data sources
  - state analytic resources

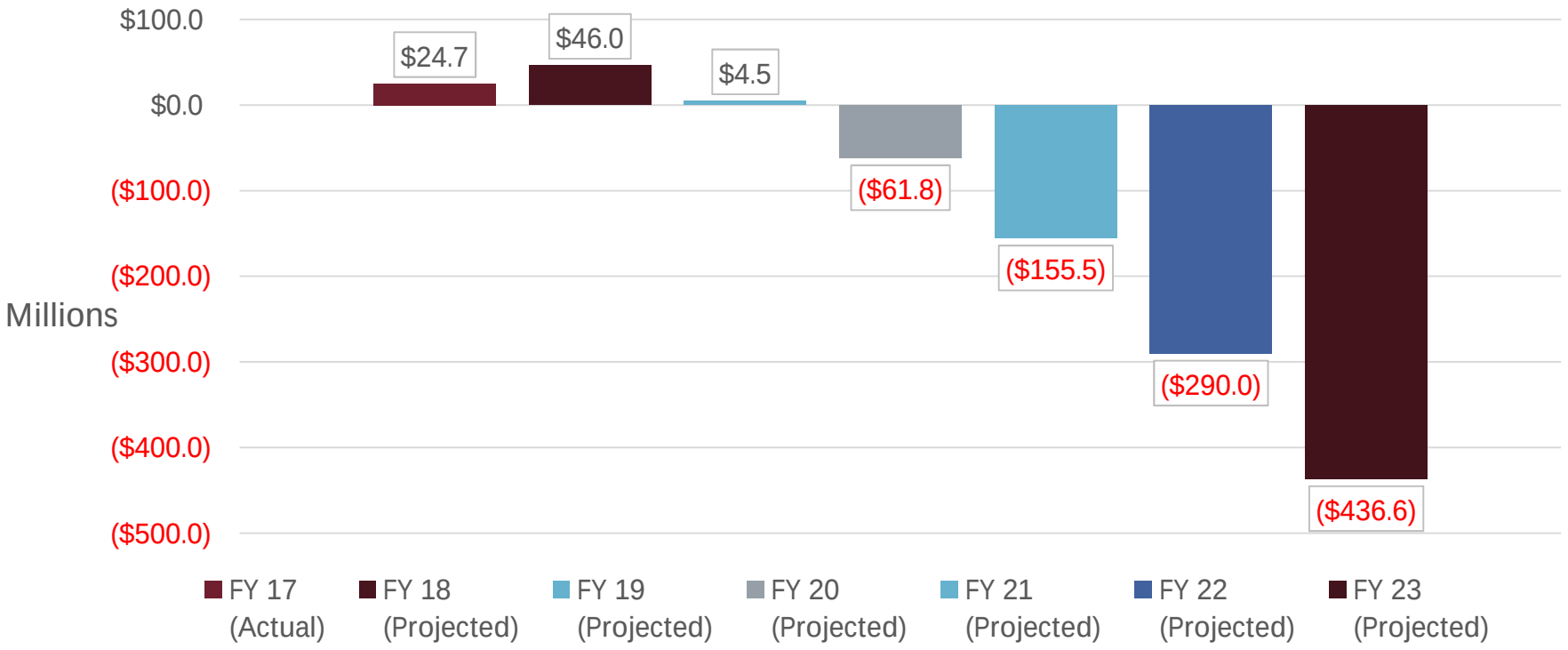
FINANCE SECRETARY GEISENBERGER ON THE IMPACT OF STATE HEALTH CARE SPENDING

- "From 1991 to 2014 (this period includes three recessions – including the Great Recession) per capita healthcare spending increased every single year. This occurred even as per capita income and Gross State Product (GSP) rose and fell with our general economy. This is not sustainable – not for our citizens, not for Delaware businesses, and not for Delaware's budget."

- "State revenues going out to fiscal year 2019 and fiscal year 2020 are forecasted to grow at only 2% annually. Meanwhile, employee and retiree healthcare costs, Medicaid and other DHSS-related healthcare costs are rising two to three times that pace. These rising costs along with rising public education costs crowd out every other spending category in state government."

  - Comments to the Health Care Commission, 2-1-18

STATE EMPLOYEE GROUP HEALTH INSURANCE PLAN IS PROJECTED TO BE IN DEFICIT



Projections include a 2% annual premium increase for FY20 - FY23, and savings expected for expanding a site-of-care steerage and Center of Excellence program.

Source: February 26, 2018 SEBC Meeting. Willis Towers Watson

COST GROWTH AND QUALITY BENCHMARKS

THE MASSACHUSETTS EXPERIENCE

EXPERIENCE FROM OTHER STATES CAN BE INFORMATIVE

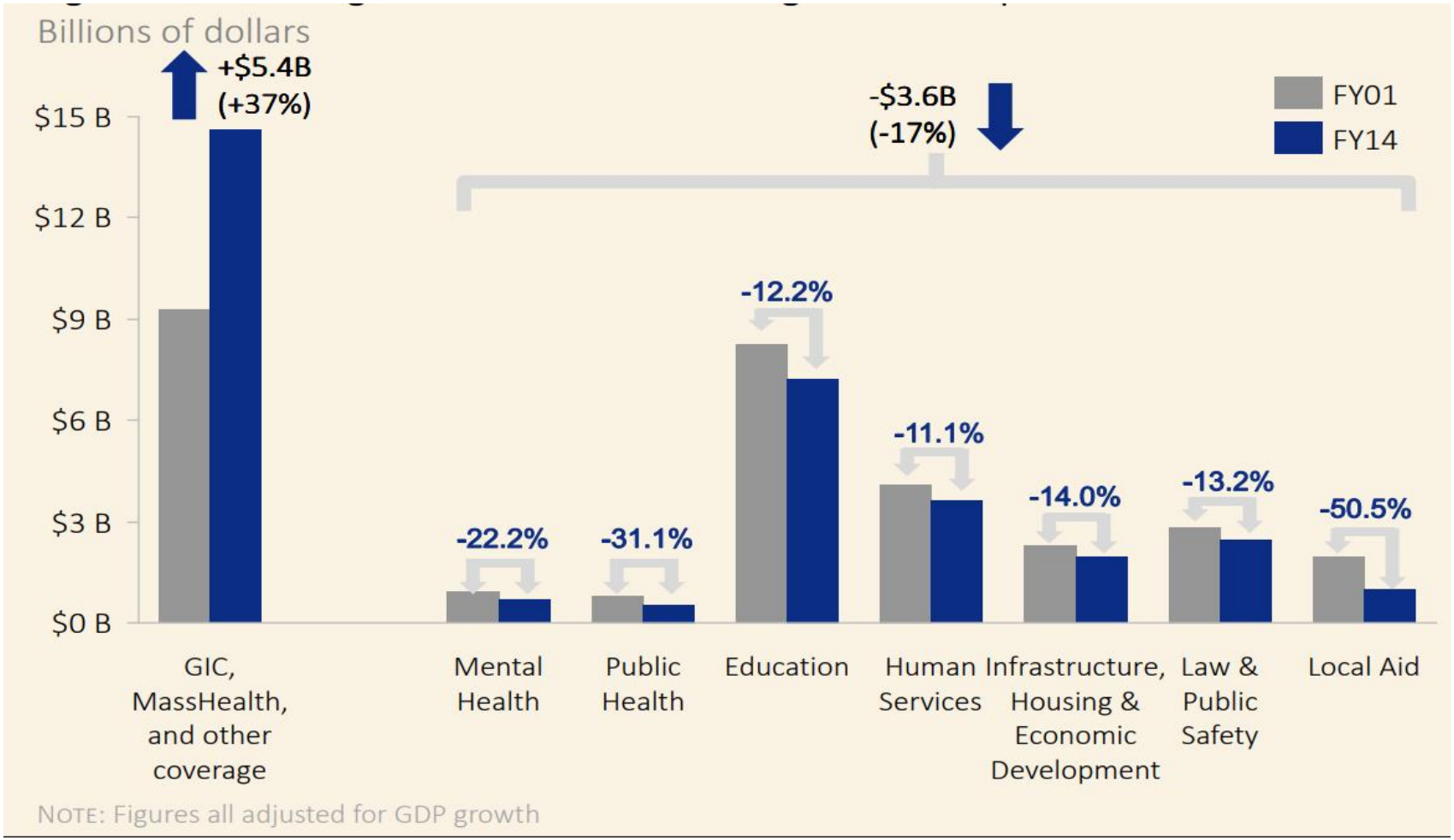
- While Delaware's benchmark approach needs to be designed by and for Delawareans, it will be informative to study how other states have established and applied benchmarks. Doing so will help us identify potential opportunities and pitfalls.
- Massachusetts is the only state that has operationalized a true health care spending benchmark.
- Rhode Island is in the process of establishing both spending and quality benchmarks in parallel with Delaware.
- Maryland and Vermont also have experience with related activity.

MASSACHUSETTS HEALTH CARE SPENDING BENCHMARKS

- Mass. Chapter 224 of the Acts of 2012 created the Health Policy Commission (HPC):
  - a quasi-independent entity that resides within, but not under the control of, the Executive Office for Administration and Finance
  - The HPC was charged with establishing an annual cost growth benchmark and monitoring progress through annual public cost trends hearings

- What was the purpose? To inform the public and to drive behavior change within the delivery system.
  - "To give certainty about how much medical care costs and to lower it from what it otherwise would have been." – Health Policy Commission member

THE IMPACT OF HEALTH CARE SPENDING ON THE MASSACHUSETTS BUDGET, SFY01-SFY14



Source: Health Policy Commission, 2013 Cost Trends Report, data from the Massachusetts Budget and Policy Center

MASSACHUSETTS HEALTH CARE SPENDING BENCHMARKS

- By April 15th of each year, the HPC must set the target growth rate for average total per person medical spending in the state for the next calendar year.
- The health care cost growth benchmark is tied to expected long-term growth in the state's economy—specifically the potential gross state product (PGSP).
- The Secretary of Administration and Finance and the House and Senate Ways and Means Committees must agree on the target by January 15th.

MASSACHUSETTS HEALTH CARE SPENDING BENCHMARKS

- Beginning in 2018, the target changed to PGSP -0.5%. The HPC has some discretion to modify the target (up to PGSP). In 2022, the default target value is set at PGSP and the HPC is able to set the target without restriction.
- The target is primarily intended for state-level use, but…
- …providers and payers are also assessed. Who? By statute…
  - clinics, hospitals, ambulatory surgical centers, physician organizations, accountable care organizations and payers
  - excluding, physician contracting units with a panel of 15,000 or fewer, or which represent providers who collectively receive less than $25M in annual net patient service revenue from carriers

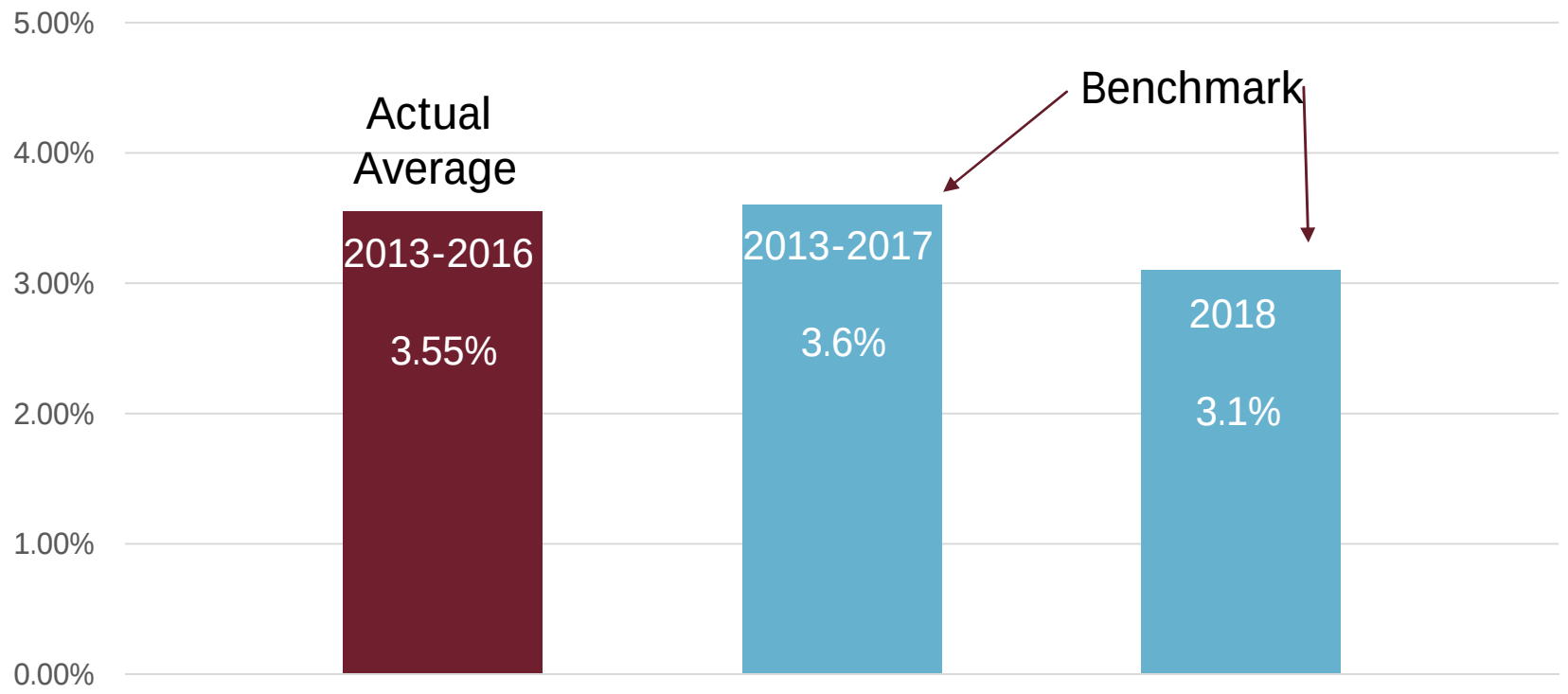
MASSACHUSETTS HEALTH CARE SPENDING BENCHMARKS

- What happens if an organization exceeds the target?
  - The HPC *may* require health care entities that exceed the benchmark to file and implement performance improvement plans.
  - An entity can be fined up to $500,000 for failure to submit, implement, or report on its performance improvement plan.
- What happens if the benchmark strategy doesn't work?
  - "The commission may submit a recommendation for proposed legislation to the joint committee on health care financing if the commission determines that further legislative authority is needed to achieve the health care quality and spending sustainability objectives of this act, assist health care entities with the implementation of performance improvement plans or otherwise ensure compliance with the provisions of this section."

MASSACHUSETTS HEALTH CARE SPENDING BENCHMARKS

- What exactly is Massachusetts measuring?
  - Total health care expenditures (THCE) is a per-capita measure of total state health care spending growth. It has three components:
    - all medical expenses paid to providers by private and public payers, including Medicare and Medicaid
    - all patient cost-sharing amounts (e.g., deductibles and co-payments)
    - the net cost of private health insurance (e.g., administrative expenses and operating margins for commercial payers)

MASSACHUSETTS EXPERIENCE TO DATE



Sources: Center for Health Information and Analysis (CHIA) Performance of the Massachusetts Health Care System Annual Report, September 2017BR6tal Health Care Expenditures from payer-reported data to CHIA and other public sources.

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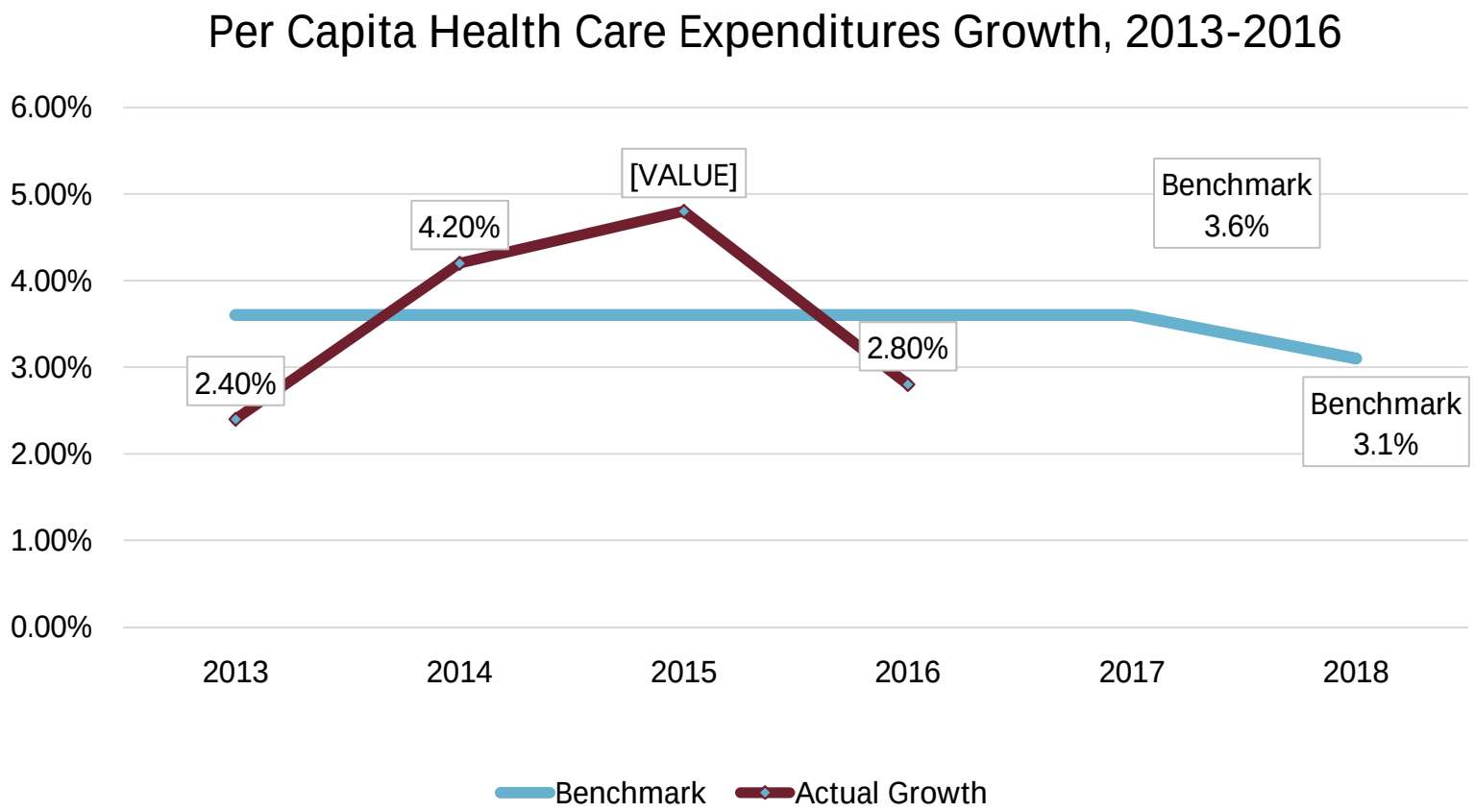
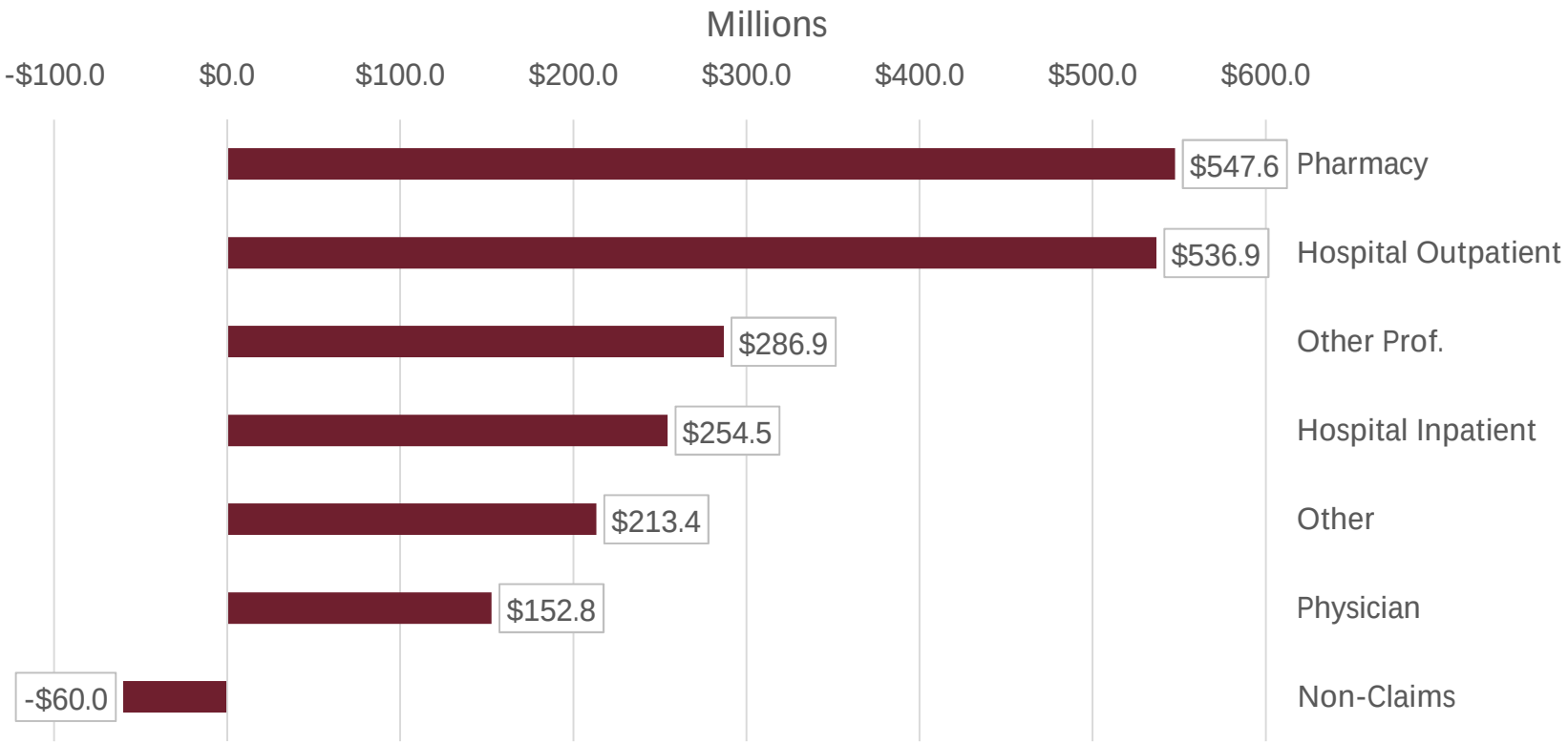
Bledsoe, Roxanne, 3/19/2018

MASSACHUSETTS EXPERIENCE TO DATE



Sources: Center for Health Information and Analysis (CHIA) Performance of the Massachusetts Health Care System Annual Report, September 2017; Total Health Care Expenditures from payer-reported data to CHIA and other public sources.

MASSACHUSETTS EXPERIENCE: LARGEST DRIVERS IN HEALTH CARE COST GROWTH



Change in Health Care Expenditures by Service Category, 2015-2016

Sources: Center for Health Information and Analysis (CHIA) Performance of the Massachusetts Health Care System Annual Report, September 2017; Payer-reported TME (excludes admin & margin) data to CHIA and other public sources.

MASSACHUSETTS EXPERIENCE TO DATE

- Payer and provider rate negotiations are now conducted in light of the 3.6% target. (State Auditor study)
- With an expected utilization increase of about 2%, payers and providers generally agree on annual price increases of about 1.5%. (David Cutler)
- “My sense is that the people who provide care have been very conscientious about trying to lower spending…The law is having an effect.” (Stuart Altman, HPC Chair)
- “The [cost growth benchmark] does mean something. It sets the bar upon which most activities in the health system are judged. It’s more than just a symbol, it’s become an operational component of how our health system works.” (Stuart Altman, HPC Chair)

MASSACHUSETTS EXPERIENCE TO DATE

- Some concerns about the cost growth benchmark in Massachusetts have been raised:

1. GSP is a poor basis for setting a target.
   - There is no correlation between medical spending and state gross domestic product, so why make the linkage? (Archambault *Health Affairs* blog (2013))
   - GSP is a poor proxy for "affordability." (Fuller, RAND)
2. It is unfair to include federal spending over which state actors have no policy influence. (Fuller, RAND)
3. Growth caps lock in historical disparities and inequities in payment.
4. Some health care costs – notably new breakthrough technology costs – but also epidemics (Zika?) and other unforeseen occurrences are beyond the control of providers and insurers.

COST GROWTH AND QUALITY BENCHMARKS

RELATED ACTIVITIES IN MARYLAND AND VERMONT

MARYLAND

- Maryland has been regulating hospital rates under a federal waiver since the 1970s.
- Until recently, however, Maryland did nothing to regulate service volume. As a result, volume grew significantly.
- In 2014, Maryland moved to a hospital global budget model where hospitals could only accrue a budgeted amount of revenue from all payers, with the goal of limiting hospital volume and shifting care to less costly settings.
- Hospital global budgets were effective July 1, 2014.

MARYLAND: HOSPITAL GLOBAL BUDGET

- Brief methodology of the hospital global budget:
  - A global budget is set for each hospital using baseline data from 2013 on its revenue and volume.
  - Each year the budget can be adjusted for:
    - Inflation: estimated growth minus expected productivity gains from growth in hospital costs.
    - Volume adjustment: (1) adjustments based on population demographics; (2) adjustments for changes in market share (only when there are offsetting volume changes at other hospitals in the market); and (3) adjusted from reductions in potentially avoidable utilization.
    - Quality: improved quality can increase the global budget
    - Uncompensated care: historical and projected spending for charity care and bad debt.

MARYLAND'S "HEALTH CARE SPENDING BENCHMARK"

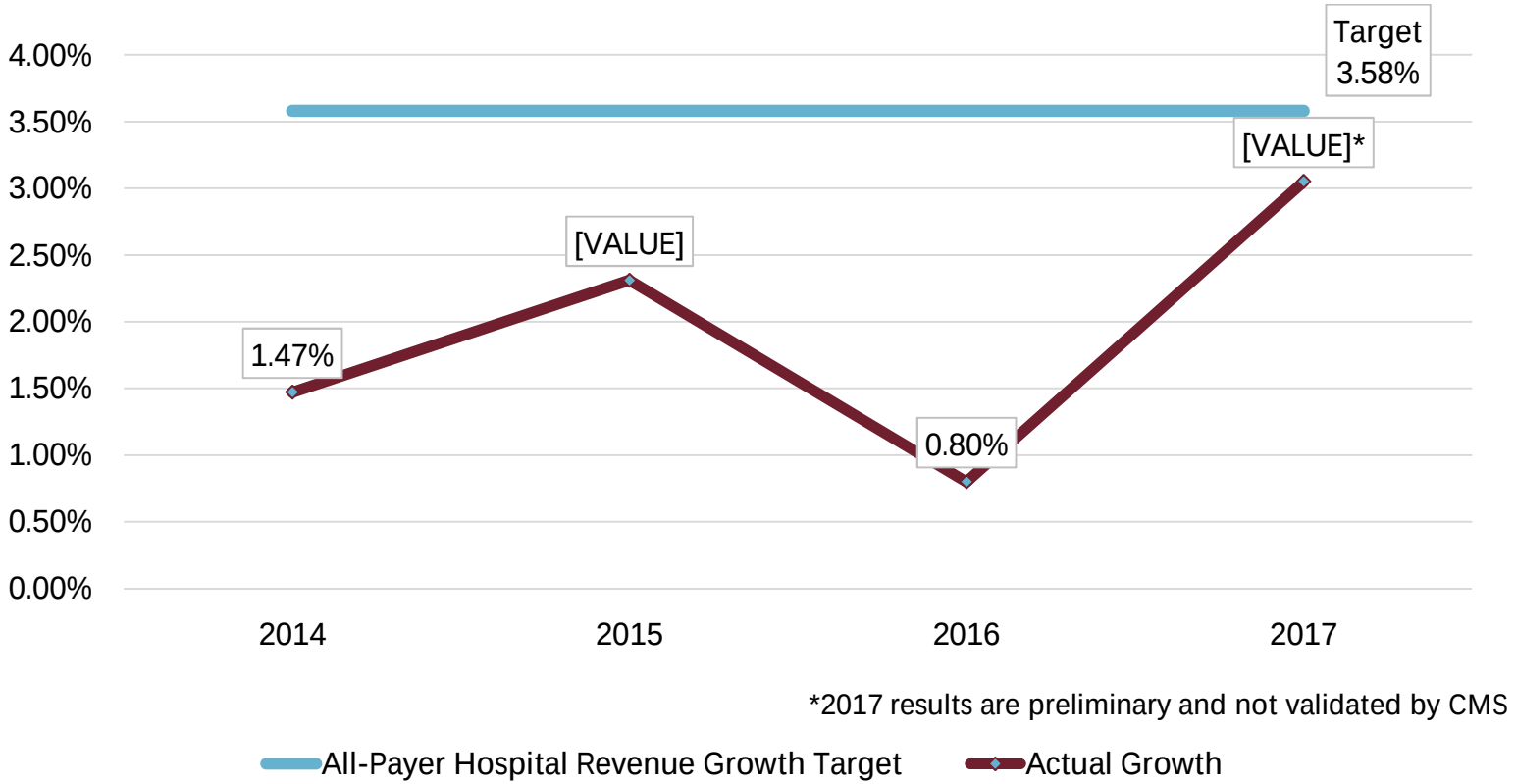
- As part of Maryland's waiver agreement with CMS, the State limited all payer per capita inpatient and outpatient hospital growth to the long-term projected per capita state economic growth (GSP) – 3.58%.
- Medicare also required savings for its Maryland beneficiaries to be a minimum of $330 million over 5 years.
- The agreement also included patient / population centered-measures and targets:
  - Medicare readmission reductions to national average.
  - 30% reduction in preventable conditions over a 5-year period.
  - Quality-related revenue at risk to equal or exceed Medicare programs.

MARYLAND'S "HEALTH CARE SPENDING BENCHMARK"

- There are big consequences if Maryland doesn't meet its goals. If it fails during the five-year performance period, Maryland will have to transition back to the national Medicare payment system.

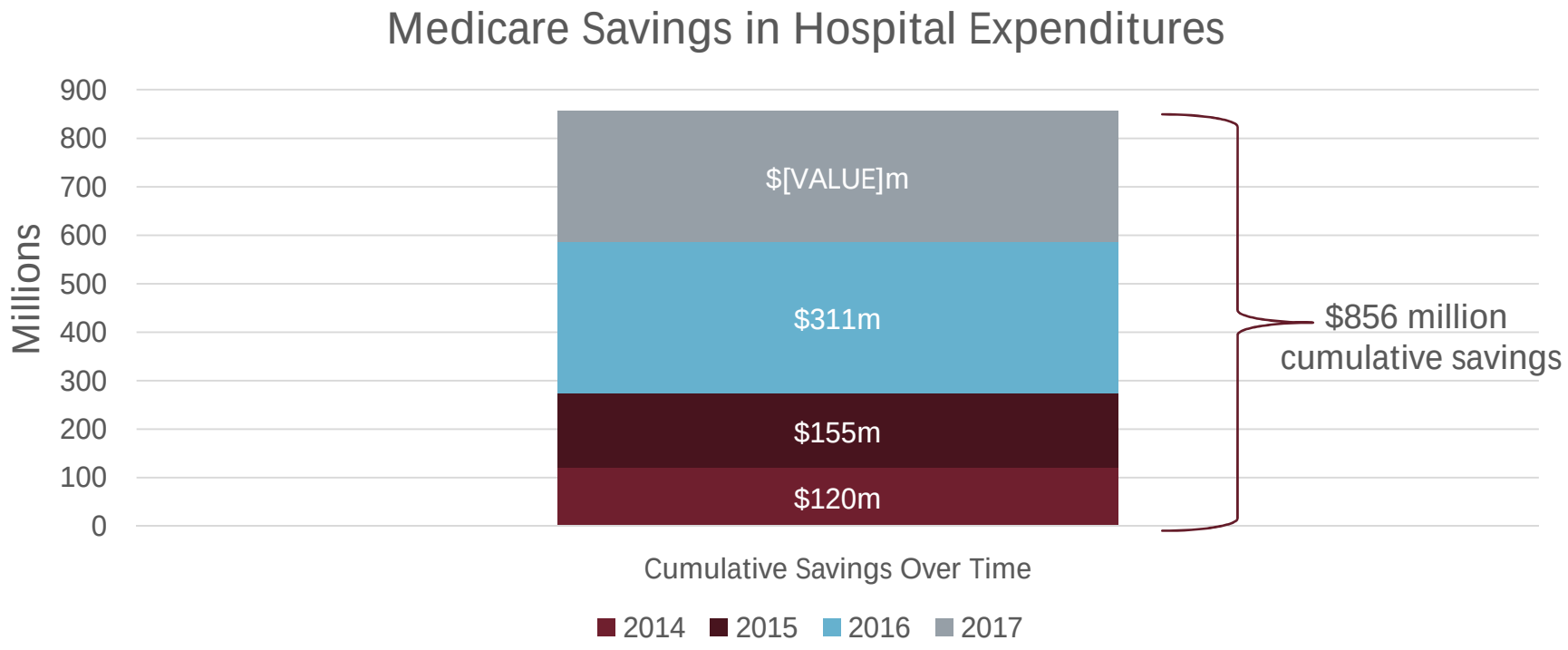
- So how has Maryland done….?

MARYLAND RESULTS



Source: Health Services Cost Review Commission: Budget Analysis, February 22, 2018

MARYLAND RESULTS



*2017 results are preliminary and not validated by CMS, 2017 figures are only through October 2017

Source: Health Services Cost Review Commission: Budget Analysis, February 22, 2018

VERMONT

- In 2017 Vermont entered into an all-payer ACO model with Medicare, Medicaid (under an 1115 waiver), commercial payers and the state's sole ACO. The model anticipates providing care to 70 percent of all Vermont residents and 90 percent of all Vermont Medicare beneficiaries by 2022.
- There are several targets associated with this agreement:
  - Per capita health care expenditure growth rate for all payers is limited to 3.5%.
  - Medicare per capita growth for Vermont Medicare beneficiaries is limited to 0.1-0.2 percentage points below that of projected national Medicare growth.
  - Quality targets set for substance use disorder, suicides, care of chronic conditions, and access to care.

VERMONT'S PER CAPITA HEALTH CARE EXPENDITURE GROWTH RATE

- Modeled off the Medicare Next Generation ACO model.
- Medicaid contracts directly with the ACO on a shared risk basis (no Medicaid MCOs in VT).
- Dominant commercial insurer (> 80% market share) also contracted with the ACO.
- The growth is calculated as the compound annual growth rate over the five performance years of the agreement (2018-2022).
- The growth calculation is limited to expenditures on targeted services.

Sources: Fact Sheet – Vermont All-Payer ACO Model All-Payer Growth Financial Target, April 2017 and working knowledge of Vermont

VERMONT'S TARGETED SERVICES

Payer	Included Services	Excluded Services
Medicare	Medicare Parts A and B	Medicare Part D (retail Rx)
Medicaid	Most medical services Mental health paid for by the Medicaid agency Long-term institutional services (2021-2022)	Retail Rx Dental care Medicaid HCBS Medicaid mental health and substance abuse services funded by other state agencies Long-term institutional services (2018-2020)
Commercial	Most medical services	Retail Rx Dental care
Self-Insured	Most medical services	Retail Rx Dental care

Source: Fact Sheet – Vermont All-Payer ACO Model All-Payer Growth Financial Target, April 2017

VERMONT'S ALL-PAYER GROWTH FINANCIAL TARGET

- While the goal for spending is 3.5%, there is some flexibility for unanticipated factors, including changes in Medicare law or local health or economic shocks.
- If Vermont's spending is over 4.3%, then Vermont is required to submit and implement a corrective action plan to get back on track.
- The ACO ensures financial target compliance by delegating significant risk to the participating hospitals in the form of a prospectively defined budget for total cost of care in the hospital's service area.

Sources: Fact Sheet – Vermont All-Payer ACO Model All-Payer Growth Financial Target, April 2017 and ACO state filing.

DISCUSSION

WHAT LESSONS SHOULD WE DRAW FROM THESE OTHER STATES?

PROCESS FOR DEVELOPING FEEDBACK FOR THE DHSS SECRETARY

PLAN FOR DISCUSSING SPENDING AND QUALITY BENCHMARKS IN FUTURE MEETINGS

- Separate subcommittees of this Advisory Group have been established to address the cost growth and quality benchmarks separately.
- Each subcommittee will provide feedback on key methodological considerations for the two benchmarks.
- Each subcommittee will report out to the Advisory Group for further discussion.
- Advisory Group members have been invited to participate in the two subcommittees, and may send a designee:
  - The designee should be well-acquainted with the Advisory Group's charge and have considered the content of this meeting.

HEALTH CARE SPENDING BENCHMARK COMMITTEE CHARGE

- Advise the Secretary 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;
  - 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.

QUALITY BENCHMARK COMMITTEE CHARGE

- 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;
  - Utilize measures that have been endorsed by the National Quality Form, 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 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.

PROPOSED PLAN FOR DISCUSSING COST AND QUALITY BENCHMARKS AT FUTURE MEETINGS

- We will present key questions for consideration by providing background information and context.
- We will record the feedback received for the Secretary.
- Feedback will also be recorded in meeting summaries available after each meeting.
- The Advisory Group's feedback will assist DHSS and the Health Care Commission in developing its methodology for the health care cost growth and quality benchmarks.

PROCESS FOR PUBLIC ENGAGEMENT

- As is customary, at the conclusion of each meeting there will be time reserved for public comment. Any interested parties in attendance may provide feedback.
- We will also ask for feedback on specific topics and key questions by posting requests at http://dhss.delaware.gov/dhcc/global.html and accepting feedback through ourhealthde@state.de.us.
- In addition, Secretary Walker will engage with interested stakeholders through other public forums.
- Finally, Advisory Group staff will seek input from external content experts.

TIMELINE FOR FUTURE MEETINGS

	Mar	Apr	May	Jun
Advisory Group		April 16 1pm-4pm	May 22 9am-12pm	June 6 1pm-4pm
Cost Growth Benchmark Committee		April 2 1pm-4pm		
Quality Benchmark Committee		April 2 9am-12pm		
Final Recommendations				June Date TBD

TOPIC 1:
WHAT IS TOTAL HEALTH CARE SPENDING?

TOTAL HEALTH CARE SPENDING

- A cost growth benchmark is predicated on understanding what the total spending is on health care to be able to compare year-over-year change to the benchmark.
- We therefore need to answer the following questions:

1. Whose health care spending is being measured?
2. Exactly what costs should be measured?
3. Where do the data come from?

TOTAL HEALTH CARE SPENDING

- Ideally, total health care spending would encompass spending on *all* health care services across the state for *all* populations. There are some challenges to this and strategy options to consider.
- Key questions:
  - Which populations?
  - Which lines of business?
  - What costs?
  - What time period?
- We'll address these one by one today, and then continue in future subcommittee and Advisory Group meetings.

TOTAL HEALTH CARE SPENDING: WHICH POPULATIONS?

- To get a full picture of total health care spending in Delaware, it would be important to gather cost data for as many populations as possible. Alternative approaches could be considered, however.

- When thinking about the populations to be included in the benchmark, there will be some data considerations for us to ponder. We will address those questions separately, yet systematically, in an upcoming meeting.

- Today, let's focus on which covered populations you think should be considered in the benchmark.

TOTAL HEALTH CARE SPENDING: WHICH POPULATIONS?

- Medicare
  - Medicare FFS (Parts A, B, D)
  - Medicare Advantage
- Medicaid
  - Chronic Renal Disease Program
  - Children's Community Alternative Disability Program
- Medicare and Medicaid Dually Eligible
- Commercial
  - Fully-Insured
  - Self-Insured
  - Choose Health Delaware
- Veterans Health Administration
- FEHB
- TRICARE
- Uninsured

Data access will inform who can be included.

Are there any other populations the Secretary should consider for inclusion?

TOTAL HEALTH CARE SPENDING: WHICH POPULATIONS?

§ Are there any populations that should be excluded?

Possible Pros / Cons for Excluding Populations		
	Pros	Cons
Medicare	• Little state policy influence over Medicare.	• Close to 20% of Delawareans are Medicare beneficiaries.
Medicaid	• None	• Close to 25% of Delawareans are Medicaid beneficiaries.
Medicare and Medicaid Dually Eligible	• Less than 3% of the total population are dually eligible.	• While a small number, dually eligible beneficiaries incur significant costs.
Commercial	• Need insurer cooperation • Data limitations may be significant for self-insured.	• Largest population within the state.

TOTAL HEALTH CARE SPENDING: WHICH POPULATIONS?

§ Are there any populations that should be excluded?

Possible Pros / Cons for Excluding Populations		
	Pros	Cons
Veterans Health Administration	• Data may be limited	• Veterans make up about 8% of the population of the state.
FEHB	• Less than 1% of Delawareans are federal employees.	• None
TRICARE	• Less than 0.5% of Delawareans are active members of the military.	• None
Uninsured	• Data would need to come from providers and is very difficult to estimate.	• Uninsured residents represent 6% of the population of the state.

TOTAL HEALTH CARE SPENDING: WHAT COSTS?

- Generally there are two sets of costs to be measured: claims-based costs and non-claims-based costs.
- Claims-based costs are payments made on the basis of a specific claim for health care services.
- Non-claims-based costs are payments not associated with a specific claim (e.g., capitation and P4P).

TOTAL HEALTH CARE SPENDING: CLAIMS-BASED COSTS

- Typical claims-based costs include (refer to handout for definitions):
  - Hospital inpatient
  - Hospital outpatient
  - Physicians
  - Other professionals
  - Home health and community health
  - Long-term care
  - Dental
  - Pharmacy
  - Durable medical equipment
  - Hospice
- Are there any services missing that should be captured in this list?

TOTAL HEALTH CARE SPENDING: CLAIMS-BASED COSTS

§ Are there any services that should be excluded?

Possible Pros / Cons for Excluding Services		
	Pros	Cons
Hospital Inpatient / Outpatient Services	• None	• Largest costs in health care system
Physician and other professionals	• None	• Largest influencers of cost to the health care system
Home and community health	• None	• Important provider that will be taking on costs as health care shifts from less expensive sites of care.
Long-term care	• Primarily a Medicaid-funded service.	• Important part of costs in DE as the population ages.

TOTAL HEALTH CARE SPENDING: CLAIMS-BASED COSTS

§ Are there any services that should be excluded?

Possible Pros / Cons for Excluding Services		
	Pros	Cons
Dental	• Not covered by commercial insurers as part of health care coverage, nor by Medicare. • Data may be difficult to obtain from commercial dental carriers.	• Oral health is integral to overall health, and poor oral health can lead to poor general health, which could be costly. • Tooth aches are a common reason for ED visits
Pharmacy	• High cost pharmaceuticals and patent protected drugs new to the market can cause large variation in health care spending year to year.	• Not including pharmacy would leave out an important piece of the health care cost picture, especially for consumers.
DME	• None	• A substantial source of spending.
Hospice	• None	• A source of spending.

TOTAL HEALTH CARE SPENDING: NON-CLAIMS-BASED COSTS

- Not all health care spending is captured through a claim. There are some non-claims costs that could be considered. For example (refer to handout for definitions):
  - Performance incentive payments
  - Prospective payments for health care services (e.g., capitation)
  - Payments that support care transformation (e.g., care manager payments)
  - Payments that support provider services (e.g., DSH payments)
  - Prescription drug rebates / discounts
  - Net-cost of private health insurance
  - Patient cost sharing for eligible populations

- Are there any other costs missing that should be captured in this list?
- Are there any costs you think should be excluded?

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

WHICH ENTITIES WILL PRODUCE TOTAL HEALTH CARE SPENDING DATA?

- Governor Carney's charge was that this group advise the Secretary on the selection of methodologies to measure and report on the total cost of health care in Delaware; including the data that feed into the methodologies.
- To identify the data that feed into the methodologies, we need to understand:

1. Which entities have data on total health care spending?
2. What is the relative effort required for each entity to produce data on total health care spending?
3. What are the pros and cons for each approach?

FROM WHERE DO THE DATA USED BY MASSACHUSETTS COME?

- The Center for Health Information and Analysis (CHIA) collects data based on its statutory authority from multiple sources that are used to calculate its benchmark.
  - Commercially-Insured Expenditures
    - 10 largest commercial payers in Massachusetts
    - Commercial payers offering MassHealth (Medicaid)
    - Commonwealth Care MCO plans
    - Medicare Advantage plans
  - Publicly-Insured Expenditures
    - CMS (Medicare)
    - MassHealth FFS and MassHealth MCOs
    - Health Safety Net
    - Medical Security Program
    - Veterans Affairs

FROM WHERE DO THE DATA USED BY MASSACHUSETTS COME?

- Each payer provides CHIA with aggregate data with up to four months of claims runout, along with claims completion and settlement estimates.
  - The Mass. legislature requires CHIA to report on the state's progress toward the benchmark on September 1 of each year. This led CHIA to not wait for the close of the year, or permit a longer claims run-out time period (often, 6 months).
- Annually, CHIA updates its prior year's benchmark calculation with up to 16 months of claims runout and settlements.

WHAT OPTIONS DOES DELAWARE HAVE FOR DATA SOURCES?

- There is at present no statute requiring data submission as exists in Massachusetts, except for Medicaid MCO and state employee health benefit plan TPA data required for the Delaware Health Care Claims Database.
- This means that additional data, unless there is state action, will have to be submitted voluntarily. What might be the sources for such data?
  - Medicaid: DHSS could provide Medicaid FFS spending and enrollment data for non-MCO-covered services
  - Medicare: CMS already provides DHSS with Medicare total cost of care data on a per capita basis that could potentially be used.
  - Commercial insured: A small number of insurers represent the majority of the commercial insurance market. Highmark has indicated a willingness to explore voluntary submission. Conversations will need to occur with other carriers.

WHAT OPTIONS DOES DELAWARE HAVE FOR DATA SOURCES? (CONT'D)

- This means that additional data, unless there is state action, will have to be submitted voluntarily. What might be the sources for such data?
  - Commercial self-insured: The same small number of insurers serve the commercial self-insured market and they can submit summary level data on the benchmark.
    - The *Gobeille vs. Liberty Mutual* specifically refers to claims data, not summary level data.
- A policy option to consider is to increase statutory authority to collect data and not have the data submitted on a voluntary basis.

COULD OTHER ENTITIES IN DELAWARE PROVIDE DATA?

- At this point, we don't think so.
- Why? Providers are not in a strong position to submit data:
  - If the methodology calls for patient cost sharing, providers do not have that information.
  - Providers have charge data, but charges don't accurately reflect costs.
- It would be far easier for the State to accept data from few sources (payers) than from providers.
- In the long run, the establishment of a true All-Payer Claims Database (APCD) as exists in other states could assist the State in reporting on the benchmark.
  - Vermont is using its APCD to report on performance against its benchmark.
  - Massachusetts does *not* use its APCD for performance assessment for ease of use and data validation reasons.

COULD OTHER ENTITIES PROVIDE DATA?

- What, if any, challenges or problems do you see with the state using payer-reported data to calculate the benchmark?
- Is it reasonable to rely on voluntary efforts by commercial insurers to provide commercial market data?
- What should be done to facilitate acquisition of self-insured market data?
- Is our logic about providers not being able to submit data sound?

PUBLIC COMMENT PERIOD

NEXT MEETINGS

Quality Benchmark Subcommittee

April 2, 2018

9am-12pm

DHSS Herman Holloway Campus – Chapel

Cost Growth Benchmark Subcommittee

April 2, 2018

1pm-4pm

DHSS Herman Holloway Campus – Chapel

Advisory Group

April 16, 2018

1pm-4pm

DHSS Herman Holloway Campus – Chapel