

# REPORT TO THE DELAWARE GENERAL ASSEMBLY ON ESTABLISHING A HEALTH CARE BENCHMARK

Submitted by:



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*DRAFT REPORT*

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# EXECUTIVE SUMMARY

As required by Section 192 of House Substitute 1 for House Bill 275, this report provides an update on progress towards implementing an all-payer system aimed at improving health outcomes and limiting health care costs in the State. Within this report, we show through different data sources the challenges we face as a State, highlight recent public benchmark summits, summarize experience from other states that have initiated or already implemented reforms, and include several recommendations and strategies for Delaware to move forward.

Based on the most recent national/state data available, on a per capita basis, Delaware has the third highest health care spending in the country, and we are 27 percent higher than the national average. Total personal health care spending in Delaware exceeded \$9.5 billion in 2014, and our 5.7 percent annualized growth rate over the 10-year period from 2004 to 2014 exceeded both the national average (4.9 percent) and other Mid-Atlantic States (4.3 percent). Unfortunately, as several different metrics and state rankings indicate, we are not getting as much value (e.g., improved health outcomes, better population health metrics, higher quality rankings and quality of life) in proportion to our level of spending.

Therefore, the Department has been making a concerted effort to build upon the accomplishments started through our State Innovation Model (SIM), and we value the contributions already made by our partners in the provider community, our hospitals, our local health care leaders and the Delaware Center for Health Innovation. Many stakeholder meetings and summits have already been held with Delaware, as well as regional and national experts to discuss ideas and share experiences. These experts have encouraged us to continue on this road to value and develop a solution that works for Delaware.

Part of this solution involves developing a health care spending benchmark. Creation of a statewide health care spending benchmark will bring more public attention to the rate of health care spending growth in Delaware and further foster payer and provider accountability for managing our health care cost growth. In developing a spending benchmark mechanism, we know there will be many decision-points to address and resolve on an iterative basis with our stakeholders and to do this, we are going to need our own current, relevant and accurate data. Our goal through this process will be to leverage the benchmark to generate desired changes in our health care system.

However, as several experts advised, a spending benchmark alone is likely insufficient to generate the trajectory change we need. Other strategies must be implemented to complement and reinforce the spending benchmark. Not the least of these is developing an oversight/governance authority to manage the data and benchmark. Other states have done this; each in their own unique style and strategy. Delaware will tackle this issue in much the same manner: developing a solution that works for us. This reorganization will support a more integrated and consistent approach to managing

health care cost and promoting statewide improvement in health care quality and population health status.

Moreover, health care spending is not always dependent on a person's health. Social determinants such as environmental factors, access to services, availability of healthy food options, employment opportunities, housing and transportation all play a role, and we need to take steps to better understand and address these issues. Likewise, our health care ecosystem needs a strong and accountable primary care foundation. While significant effort and resources have been expended through the SIM process on addressing provider readiness to bear financial risk, additional support activities will be important if risk-bearing Delaware provider organizations are to operate at the level of best practice entities nationally, including addressing the specific needs of the Medicaid population.

Even though Delaware is a small state, we can do more to leverage our buying power in developing a contracting strategy that is roughly aligned across Medicaid and State employee purchasing, recognizing there are real differences in covered populations and covered services. Current concerns about instability in the health insurance marketplace suggests that we should initially focus on programs/delivery systems that we have more direct control and influence over. We also need to be cognizant of the role Medicare and employer-sponsored insurance offerings have in shaping our health care system and spending levels.

While much has been accomplished within our State in terms of raising awareness of our health care spending crisis and the avenues we can pursue to modify our current trajectory, the importance of accelerating these efforts now is critical. Together, we are moving forward on the road to value to realize the improvements that our health care system can effectuate to slow the growth of health care spending and improve the quality of life for all Delawareans.

# 1

## INTRODUCTION

As required by Section 192 of House Substitute 1 for House Bill 275, this report provides an update on progress towards implementing an all-payer system aimed at improving health outcomes and limiting health care costs in the State. The Secretary of the Department of Health and Social Services (Department) is required to submit to the Director of the Office of Management and Budget, the Controller General and the Co-Chairs of the Joint Finance Committee a report by December 1, 2017 detailing the feasibility of implementing a global health care benchmark.

Within this report, we show through different data sources the challenges we face as a State, highlight recent public benchmark summits, summarize experience from other states that have initiated or already implemented reforms, and include several recommendations and strategies for Delaware to move forward.

While much has been accomplished within our State in terms of raising awareness of our health care spending crisis and the avenues we can pursue to modify our current trajectory, the importance of accelerating these efforts now is critical. Together, we are moving forward on the road to value to realize the improvements that our health care system can effectuate to slow the growth of health care spending and improve the quality of life for all Delawareans.

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## THE CHALLENGE: HIGH SPENDING AND SUB-OPTIMAL OUTCOMES

In recent months, the Department has made a concerted effort to publicly document and demonstrate the challenges, albeit a crisis, in our State’s health care spending and the co-occurring poor quality/health outcomes of our citizens. This should come as no surprise to many readers of this report, as the impetus behind House Joint Resolution 7 (HJR7) was that “*health care spending in Delaware is higher than the national average and has historically outpaced inflation and the State’s economic growth*” and “*it is in the best interest of Delawareans to recognize that public and private health care spending needs to drive greater access to high quality care at lower costs.*” Indeed, the most recent and comparable estimates of all states’ respective spending from the Centers for Medicare and Medicaid Services (CMS) show that total personal health care spending in Delaware exceeded \$9.5 billion in 2014, and the annualized growth rate over the 10-year period from 2004 to 2014 exceeded both the national average and other Mid-Atlantic States as shown in Chart 1:

**Chart 1 – Total Personal Health Care Expenditures (in millions of dollars)<sup>1</sup>**

Region/State of Residence	Total 2004 Expenditures	Total 2014 Expenditures	Average Annual Increase
US Total	\$1,587,994	\$2,562,824	4.9%
Delaware	\$5,498	\$9,587	5.7%
Other Mid-Atlantic States	\$290,541	\$441,624	4.3%

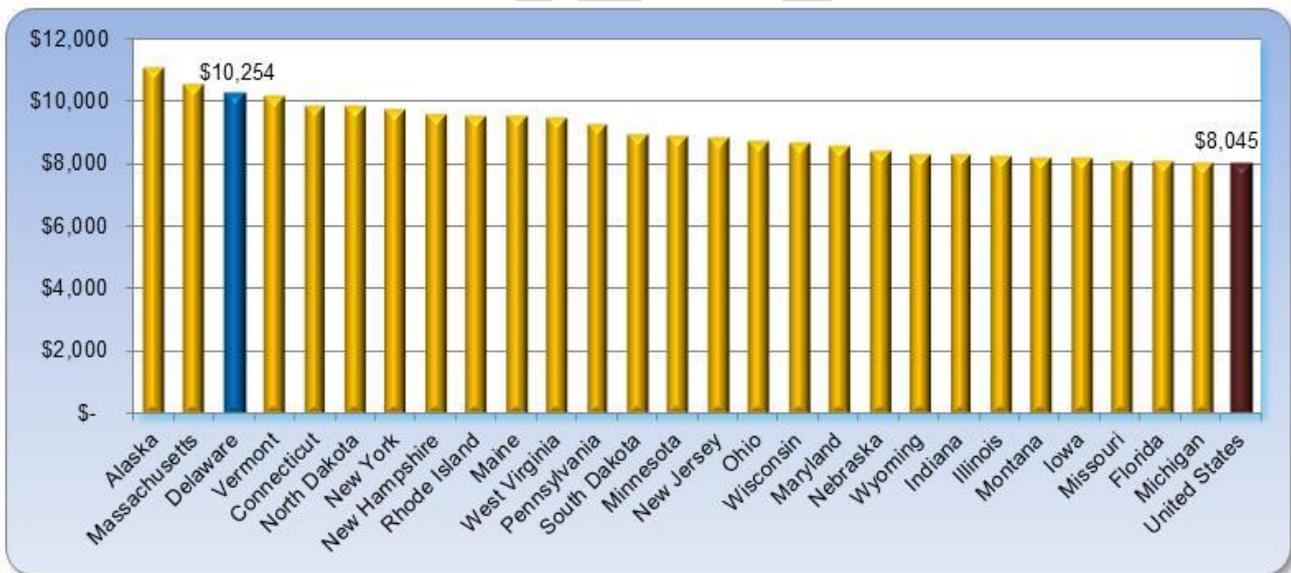
<sup>1</sup> Data from Centers for Medicare & Medicaid Services, Health Expenditures by State of Residence 1991–2014; <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html>.

Other Mid-Atlantic States include Maryland, New Jersey, New York and Pennsylvania.

A further review of the CMS expenditure data indicates that each of the major payers/programs in Delaware (e.g., Medicare, Medicaid, private health insurance) have experienced rising health care costs over this 10-year period (see Appendix A, Chart 1). Although this trend is consistent with national averages, it highlights that this challenge impacts all-payers in Delaware, permeates throughout our State's health care system, and as will be discussed later, impacts our ability to address other societal and fiscal obligations assigned to government. Furthermore, of the approximate \$9.5 billion in total personal health care expenditures in 2014, hospital services compose the single largest segment, 39.8 percent in Delaware. This is slightly higher than the 38.3 percent US average for that same period.<sup>2</sup>

Not only has spending growth been higher in Delaware but, on a per capita basis, personal health care expenditures are high in Delaware relative to other states. As Chart 2 shows, in 2014, Delaware had the third highest per capita health care spending level in the nation at \$10,254. Our spending amount was 27 percent higher than the national average per capita spending level of \$8,045. This is of great concern.

**Chart 2 – Average Per Capita Total Health Care Expenditure Ranking in 2014<sup>3</sup> (limited to states above the national average)**



This relative per capita spending level is not just an anomaly of one or two years; this has been a pattern for a period of many years. Over the past decade, Delaware's average per capita health care spending has consistently been over 20 percent higher than the US average, higher than the

<sup>2</sup> ibid

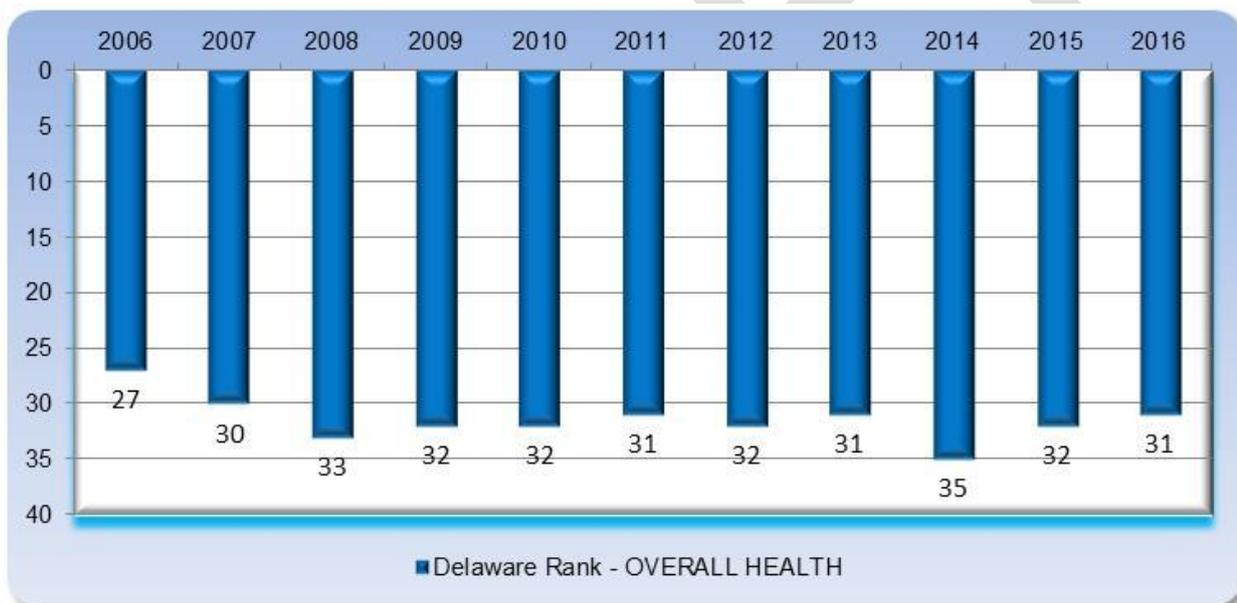
<sup>3</sup> ibid

average of other Mid-Atlantic States, and has been gradually rising against the US average while other Mid-Atlantic States have remained relatively flat (see Appendix A, Chart 2).

Perhaps this issue would be of a less critical nature if Delaware’s health care spending levels could be attributed to the State ranking at or near the top of various metrics related to quality, outcomes and overall state health. Unfortunately, in this context, we are not getting as much value (e.g., improved health outcomes, better population health metrics, higher quality rankings and quality of life) in proportion to our level of spending. Therefore, we have an opportunity to not only get a better return on our health care spending investment, but to improve the quality of life for many of our citizens.

According to the data in Charts 3 and 4, Delaware’s overall health ranking has remained approximately 30<sup>th</sup> in terms of overall health and ranks even lower on several specific health measures according to America’s Health Rankings (AHR).<sup>4</sup>

**Chart 3 – AHR’s Delaware State Ranking on Overall Health for the Last 10 Years**



<sup>4</sup> <https://www.americashealthrankings.org/explore/2016-annual-report/measure/Overall/state/DE>

Chart 4 – AHR’s Delaware State Ranking on Select Measures — 2016 Edition<sup>5</sup>

Metric	Value	Delaware State Rank
Drug Deaths (# per 100,000 population)	18.1	39
Obesity (percentage of adults)	29.7%	23
Smoking (percentage of adults)	17.4%	24
<i>All Behaviors (Composite Measure)</i>		<b>27</b>
Dentists (# per 100,000 population)	45.6	47
Primary Care Physicians (# per 100,000 population)	151.4	17
Low Birthweight (percentage of live births)	8.3%	32
Preventable Hospitalizations (discharges per 1,000 Medicare enrollees)	50.2	29
<i>All Clinical Care (Composite Measure)</i>		<b>32</b>
Air Pollution (micrograms of fine particles per cubic meter)	9.5	45
Children in Poverty (percentage of children)	16.3%	18
Infectious Disease (chlamydia, pertussis and salmonella)	0.51	43
<i>All Community &amp; Environment (Composite Measure)</i>		<b>38</b>
Immunizations – Children (% of children age 19 mos to 35 mos)	79.3%	3
Uninsured (% of population)	6.9%	9
Public Health Funding (dollars per person)	\$107	12
<i>Policy (Composite Measure)</i>		<b>7</b>
Cancer Deaths (# per 100,000 population)	198.5	34

<sup>5</sup> ibid

Metric	Value	Delaware State Rank
Cardiovascular Deaths (# per 100,000 population)	247.5	28
Diabetes (percentage of adults)	11.5%	39
Infant Mortality (deaths per 1,000 live births)	6.5	34
<b>All Outcomes (All Outcomes)</b>		<b>34</b>

As stated previously, according to the CMS data, hospital services represents the largest part of our total health care expenditures. This means we should take a closer look at this important segment of our health care system. This is especially relevant when according to the Fall 2017 Hospital Safety Grade<sup>6</sup> rankings by The Leapfrog Group of the six hospitals included in the survey, none of our hospitals received an “A grade”. In fact, Delaware now ranks 49<sup>th</sup> in the country in this Hospital Safety Grade ranking compared to being ranked near the top at 8<sup>th</sup> highest in the Spring 2012 survey (see Appendix A, Chart 3). This concern is reinforced by the fact that three of our six adult care hospitals were penalized by CMS, as it relates to Medicare, in federal fiscal year (FFY) 2017 for high rates of potentially avoidable infections<sup>7</sup> and all six were penalized in FFY 2018 for readmissions<sup>8</sup>.

Our high cost of health care in Delaware<sup>9</sup> also has a “crowd out” impact on other government activities and priorities, as well as on individual income in the form of less disposable income to buy

<sup>6</sup> <http://www.hospitalsafetygrade.org/your-hospitals-safety-grade/state-rankings>. The Leapfrog Hospital Safety Grade uses national performance measures from the Centers for Medicare & Medicaid Services, the Leapfrog Hospital Survey, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, and the American Hospital Association’s Annual Survey and Health Information Technology Supplement. Taken together, those performance measures produce a single letter grade representing a hospital’s overall performance in keeping patients safe from preventable harm and medical errors. The Safety Grade includes 27 measures, all currently in use by national measurement and reporting programs. The Leapfrog Hospital Safety Grade methodology has been peer reviewed and published in the [Journal of Patient Safety](#).

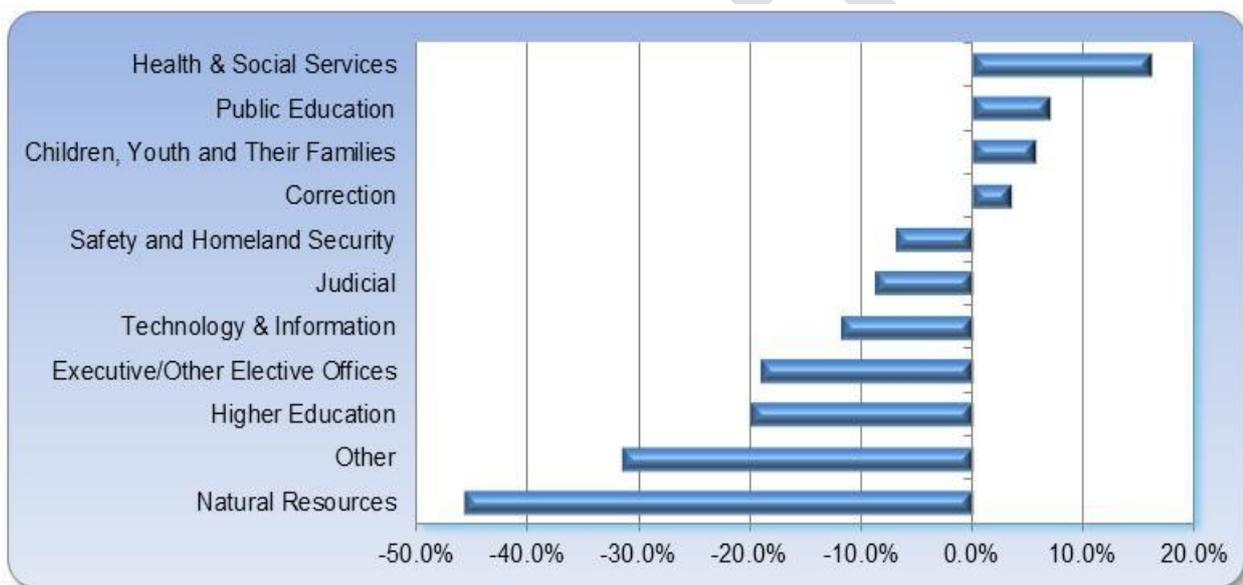
<sup>7</sup> <https://khn.org/news/769-hospitals-penalized-for-patient-safety-in-2017-data-table/> and data available at <https://www.medicare.gov/hospitalcompare/HAC-reduction-program.html>

<sup>8</sup> <https://khn.org/news/under-trump-hospitals-face-same-penalties-embraced-by-obama/>

<sup>9</sup> In fiscal year 2015, State general fund expenditures on Medicaid totaled \$668 million with another \$373 million spent on State employee/retiree health representing approximately 27 percent of all State general fund expenditures. January 29,

goods and services that helps our local economy. Our State government is obligated to perform several important functions, including public safety, promoting economic growth and supporting community well-being (e.g., education, housing, social services, infrastructure). Yet, according to data in the Delaware Fiscal Notebook 2016 Edition,<sup>10</sup> on a per capita basis, total general fund revenues increased at only an annualized 1.1 percent from 2006 to 2016 (see Appendix A, Chart 4), while over this same period, the share of total general fund expenditures on health and social services increased from 25.6 percent in 2006 to 28.7 percent in 2016. As shown below in Chart 5, over this decade, health and social services was the single category with the largest increase in the share of general fund expenditures, +16.0 percent, while most other categories declined.

**Chart 5 – Total Change in Share of General Fund Expenditures from 2006 to 2016<sup>11</sup>**



Similar to our State government expenditures, our citizens have experienced a steady increase in the cost of health care/health insurance relative to their ability to buy other goods and services. Recent news on this issue includes the following which can impact our State’s economic competitiveness and attractiveness for working-age individuals and families:

2016 “Final Report of the Delaware Expenditure Committee” available at <https://omb.delaware.gov/documents/delaware-expenditure-review.pdf>

<sup>10</sup> [https://finance.delaware.gov/publications/fiscal\\_notebook\\_16/front/greetings.shtml](https://finance.delaware.gov/publications/fiscal_notebook_16/front/greetings.shtml)

<sup>11</sup> Ibid. “Other” includes Legislative, Legal, Finance, Transportation, Labor, State and Other. “Other” represents less than four percent of 2016 general fund expenditures.

- Higher costs for premiums and deductibles are likely coming for State government employees. It's just a matter of what those changes will look like. The State Employee Benefits Committee convened Monday to discuss potential increases for the tens of thousands of individuals on a state health care plan. While it did not approve any plan, many options remain on the table. – **April 10, 2017 Delaware State News**<sup>12</sup>
- If these health care spending rates were to continue to increase at this pace, we would price too many Delawareans out of the health care system, put too high a financial burden on employers, and eat up larger and larger portions of the State government budget. We can't afford any of those scenarios. The health care spending benchmark will provide us with the opportunity to transform the way we pay for health care and link that cost to the State's overall economy. The two should go hand in hand. – **Governor Carney at the HJR7 Signing Ceremony**<sup>13</sup>
- Highmark Blue Cross Blue Shield's [the only insurer on Delaware's health care marketplace exchange for 2018] premium prices will rise by 25 percent ... This is the third rate increase Highmark has gotten ... The first year, it received a 25 percent raise and the second year a 32.5 percent raise. It essentially means the policies have doubled in cost during the lifetime of the ACA. – **October 5, 2017 Delawareonline.com**<sup>14</sup>
- Delaware had the 14<sup>th</sup> highest employee contribution amount for employee-plus-one health insurance premiums in 2016 based on the Medical Expenditure Panel Survey (MEPS) Insurance Component. – **Derived from data posted by the Kaiser Family Foundation**<sup>15</sup>
- "...absent additional changes, total costs associated with employee and retiree health insurance will grow from slightly under \$800 million in Fiscal Year 2017 to just over \$1.0 billion in 2020 and just over \$1.2 billion by 2022. The Committee believes that the increases are not sustainable over the next six years." – **Final Report of the Delaware Expenditure Committee, page 50**<sup>16</sup>

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<sup>12</sup> <http://delawarestatenews.net/government/state-employees-facing-higher-health-care-costs/>

<sup>13</sup> <https://news.delaware.gov/2017/09/07/benchmark/>

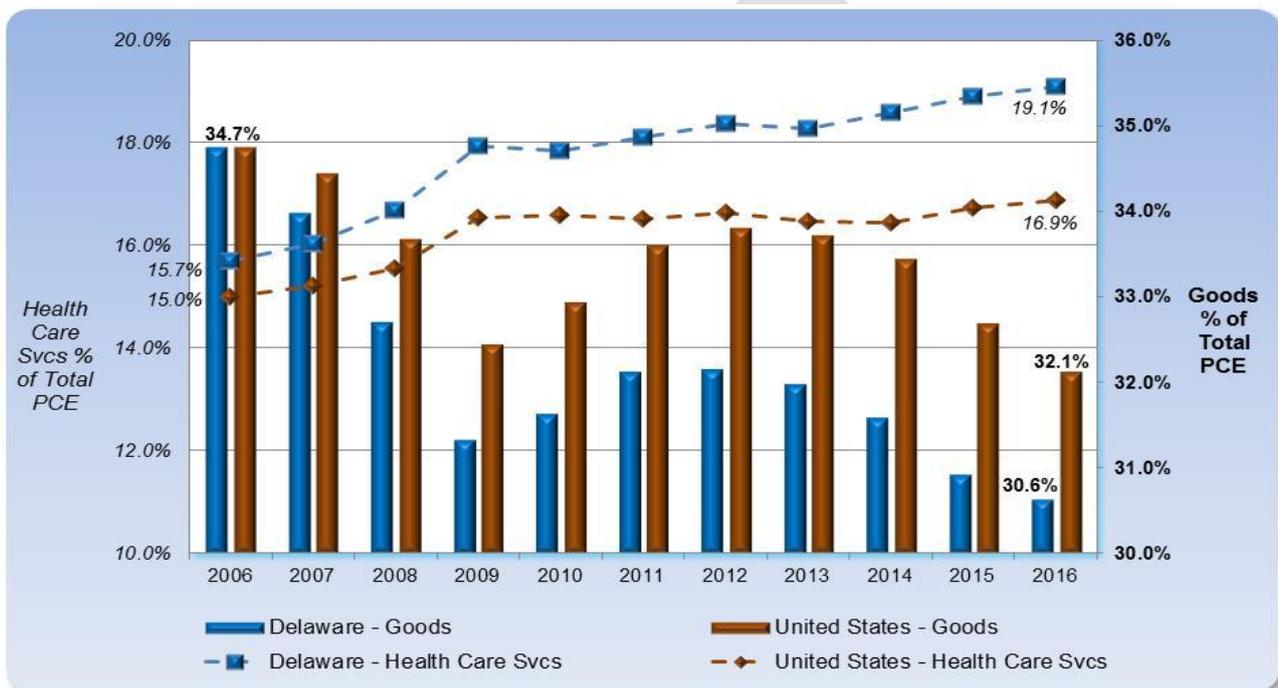
<sup>14</sup> <http://www.delawareonline.com/story/news/health/2017/10/05/highmarks-obamacare-policies-rise-25-percent-delaware/732278001/>

<sup>15</sup> <https://www.kff.org/other/state-indicator/employee-plus-one-coverage/?dataView=0&currentTimeframe=0&selectedDistributions=employee-contribution&selectedRows=%7B%22states%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22collId%22:%22Employee%20Contribution%22,%22sort%22:%22desc%22%7D>

<sup>16</sup> See reference #9

- As shown below in Chart 6, according to personal consumption expenditures (PCE) from the federal Bureau of Economic Analysis (BEA), from 2006 to 2016, in Delaware the percentage of total PCE on Health Care Services (dashed line) increased over 21 percent — going from 15.7 percent to 19.1 percent of total PCE. While over the same time period the percentage spent on Goods (vertical bar) declined by nearly 12 percent — decreasing from 34.7 percent to 30.6 percent of total PCE. These figures are significantly higher than the national average change of over 12 percent increase on Health Care Services and a near 8 percent decrease on Goods<sup>17</sup>.

**Chart 6 – Percent of Total PCE on Health Care Services versus Goods — Delaware and US Average**



It is also important to note how large and integral our health care system is to our State's overall economy and economic activity. As one speaker commented at our health care summits, "health care is big business". We need to be cognizant of this fact as we proceed down the road to value that health care in general is a major segment of our economy. The following points encapsulate this issue by comparing Delaware to the US and other Mid-Atlantic States on two key economic indicators from the BEA:

- In 2016, of our State's 576,620 total employment (number of jobs), 12.9 percent were in the Health Care and Social Services industry. This is higher than the national average of

<sup>17</sup> [www.bea.gov](http://www.bea.gov). Total Personal Consumption Expenditures (PCE) by State (millions of dollars)

11.3 percent and a little less than the 13.4 percent average of other Mid-Atlantic States (see Appendix A, Chart 5).

- In 2016, of our State's near \$45.5 billion in total personal income, 10.3 percent or almost \$4.7 billion came from the Health Care and Social Services industry. This is higher than both the national average of 8.0 percent and the 8.4 percent average of other Mid-Atlantic States (see Appendix A, Chart 6)

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# 3

## EXAMPLES AND LESSONS FROM OTHER STATES

### SUMMARY OF BENCHMARK SUMMIT MEETINGS

Beginning on September 7, 2017, the Department hosted a series of five different health care benchmark summits that were open to the public. These benchmark summits provided a forum for discussion and sharing of information and experience between our guest speaker/presenters and all attendees. In-person attendance was high, around 100 people at each meeting, with additional attendance via live Facebook streaming and subsequent views of the recorded videos (available on the Department of Health and Social Services [DHSS] homepage, Facebook and/or YouTube).

In addition to local Delaware health care leaders, invited guest speakers included well-known/key individuals from several different states, including California, Massachusetts, Oregon, Pennsylvania, Rhode Island and Vermont. Speakers included physicians, state senators, health plan leaders and health commission board members. Each summit focused on a different key topic with each guest speaker discussing their specific experiences, challenges and accomplishments, offering suggestions on key points Delaware should consider and taking time to respond to ad hoc questions from the audience. The five benchmark summits held were:

- September 7, 2017 “Establishing the Benchmark”
- September 22, 2017 “Provider/Hospital Leadership”
- September 25, 2017 “Legal/Regulatory Issues”
- October 18, 2017 “Data Analytics (Total Cost of Care)”
- November 2, 2017 “Governance/Authority (Total Cost of Care)”

Over the course of all five benchmark summits, a few common themes resonated from the guest speakers as follows:

- Delaware was applauded for taking action to address our high level of health care spending. No guest speaker offered any regrets for the actions their state had taken on their respective road.

- There is no single way to do this and it will not be easy, but we were encouraged to keep moving. Speakers advised that we need to determine what will work for Delaware.
- Providers, such as primary care physicians and hospitals, need to help drive change and move away from the status quo.
- Should Delaware wish to create a new oversight entity (e.g., the Health Policy Commission in Massachusetts) or leverage an existing governmental or quasi-governmental entity, speakers strongly supported two key characteristics: transparency and independence.

A more complete summary of each benchmark summit, including highlights from speakers, is included in Appendix B.

## CHARACTERISTICS OF STATE EFFORTS TO TRANSFORM PAYMENT AND CARE DELIVERY AND TO CONTAIN COSTS IN MASSACHUSETTS, OREGON AND VERMONT

**Massachusetts:** Massachusetts has a long history of health care reform efforts, stemming from an active legislature and several governors who have made health care reform a top priority.<sup>18</sup> One of the most recent influential pieces of legislation made several key changes to state policy — most notably, it established a cost growth target for total health care expenditures<sup>19</sup> by which state plans and providers are measured and held accountable through principles of transparency.

The cost growth benchmark has been in place — and set by the legislature at 3.6 percent — since 2013. Over the four years it has been in place thus far, the state has averaged 3.55 percent growth with some variability year-over-year due to increases in prescription drugs costs and an increase in Medicaid enrollment. In 2018, the legislation mandated the benchmark be lowered to 3.1 percent, unless the independent Health Policy Commission (described in the next section below) voted to increase it. The measuring and reporting of this cost growth, while providing mixed results on a year-to-year basis, also brought increased awareness on cost to the state. It has been reported in the *Boston Globe*,<sup>20</sup> reported at annual hearings<sup>21</sup> and in consultants' conversations with providers

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<sup>18</sup> One of the most significant changes in Massachusetts was the passage of Chapter 58 in 2006 — the landmark legislation that created insurance mandates and a statewide health insurance case — after which the federal Affordable Care Act was modeled.

<sup>19</sup> Total health care expenditure is a measure that includes all medical expenses paid to providers by private and public payers, all patient cost-sharing amounts (e.g., deductibles, co-pays), and net cost of private insurance (e.g., administrative expenses and operating margins for commercial payers).

<sup>20</sup> [www.bostonglobe.com/business/2016/09/07/health-care-spending-mass-again-exceeds-target/7HvYRD1RGxeJAe3nFTsIEL/story.html](http://www.bostonglobe.com/business/2016/09/07/health-care-spending-mass-again-exceeds-target/7HvYRD1RGxeJAe3nFTsIEL/story.html)

and insurers that the cost growth benchmark has become a starting point for insurer and provider negotiations.

**Oregon:** Oregon has created a consolidated state agency, the Oregon Health Authority (Authority), responsible for overseeing all state health policy development and purchasing strategies. The Authority has pursued three key transformation and cost containment strategies:

- Patient-centered medical homes
- Incorporating evidence into Medicaid and state employee plan health care coverage policies
- Creating coordinated care organizations (CCOs), a network of health care providers that agree to work together within their local community to serve Medicaid beneficiaries

Each CCO is responsible for providing services within a specific geographic area and must implement a coordinated care model that incorporates best practices to manage and coordinate care. CCOs, by contract, must also pursue payment models that reward outcomes and improved health based on performance measures, transparency in price and quality data. CCOs receive a global budget with a fixed rate of per capita growth at 3.4 percent per year, consistent with 10-year projections on state revenue growth. CCO performance has consistently shown improvements in quality measures.

**Vermont:** Vermont has pursued several reform efforts, most recently led by the state's policy-making body — the Green Mountain Care Board (GMCB). The GMCB has been successful in reducing cost growth and driving innovation. In 2015, through aggressive review of hospital budgets, the GMCB limited system-wide and per-hospital net patient revenue to its target of 3.5 percent. It has also worked with multiple stakeholders to negotiate the terms of a statewide accountable care organization (ACO) payment and delivery system model, which is the backbone of Vermont's CMS All-Payer Model.

The GMCB was very influential in the groundbreaking all-payer single ACO model that began January 1, 2017. The All-Payer ACO model was born out of the GMCB's testing of an ACO shared savings pilot program (the [Vermont Shared Savings Program](#)) between 2014 and 2016 and collaboration with the existing successful patient-centered medical home program ([Blueprint for Health](#)). One single ACO contracts with Medicare, Medicaid and commercial insurers and has agreed to limit the overall per capita health care expenditure growth to a 3.5 percent benchmark and will limit the Medicare per capita health care expenditure growth to be below projected growth

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<sup>21</sup> [www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/annual-cost-trends-hearing/2016/](http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/annual-cost-trends-hearing/2016/)

trends.<sup>22</sup> Although participation in the All-Payer ACO model is voluntary for providers, the GMCB has the regulatory authority to determine the payment rules for providers that are not part of the single ACO and will continue to exercise regulatory oversight for hospital budgets and commercial insurance rates.

## LESSONS LEARNED FROM MASSACHUSETTS, OREGON AND VERMONT

Massachusetts, Oregon and Vermont have leveraged their significant purchasing and regulatory power to reform their health care systems to reduce the burden of health care expenditure on taxpayers, employers and consumers. Key lessons learned from these three states include:

- Health care cost and quality data are a necessary support foundation for state policy making
- Aligning state strategies across state purchasing and regulatory agencies can drive broader change in the marketplace

The experience of these states in developing effective cost containment strategies indicates that multiple factors contribute to the success. A key to success is the political will among all stakeholders to focus on a common goal and engage in difficult decision-making that involves all parties. Coming to agreement requires the willingness to break from the status quo and to take risks on new strategies. It also requires strong, committed leadership from the legislature, the governor and from executive branch agency staff.

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<sup>22</sup> Vermont All-Payer ACO Model Fact Sheet. <https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/>

# 4

## THE FIRST PRIORITY FOR STATE ACTION: ESTABLISH A STATE HEALTH CARE SPENDING BENCHMARK

### ESTABLISH A STATE HEALTH CARE SPENDING BENCHMARK

Three years ago, CMS awarded Delaware a five-year State Innovation Model (SIM) grant to achieve five stated-defined objectives, one of which was to engage payers to move health care payment to a pay-for-value model based on total cost of care budgeting. Since that time, and following considerable intensive stakeholder work, it has become apparent that there are limits to the scope and pace of progress through voluntary adoption of payment and delivery reform by payers and providers. In states that have initiated or implemented reform, state government and stakeholders have collaborated to create mechanisms that bolster and accelerate system transformation. During the 2017 legislative session, Delaware decided that the path forward was to create a health care spending benchmark to provide essential focus and momentum for system transformation.

**Rationale:** Creation of a statewide health care spending benchmark will bring public attention to the rate of health care spending growth in Delaware. A spending benchmark will also further foster payer and provider accountability for managing health care cost growth. Such accountability should accelerate payment and delivery system reform within the State.

**Supporting evidence:** Massachusetts is one state with positive, but limited, experience with a cost growth benchmark. Massachusetts Chapter 224 of the Acts of 2012 directed the establishment of an annual cost growth benchmark and monitoring progress through annual cost trends hearings. Reflecting on this process, one state Health Policy Commission member reported, *“It has put a spotlight on the growth of health care spending in Massachusetts and that is a good thing.”* The first target was set for 2013. For 2013–2017, the benchmark has been defined as the potential gross state product (PGSP). For 2018, it becomes the PGSP less 0.5 percent, unless the Health Policy Commission approves a different target. Although experience has varied from year-to-year, the average of the first four years has been 0.05 percentage points lower than the target. In addition, insurers and providers report that the target has become the starting point for contract negotiations. Early evaluation work also suggests a positive impact on state spending growth.<sup>23</sup>

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<sup>23</sup> Cutler D. “The Massachusetts Target on Medical Spending Growth” *NEJM Catalyst*, May 6, 2016.

Other states have since adopted health care spending benchmarks in the form of agreements with CMS. Vermont<sup>24</sup> targets all-payer per capita annual spending growth over five years at 3.5 percent. Maryland is currently developing a proposal for a new model based on a Medicare total per capita cost of care test to begin after 2018.<sup>25</sup> Cost growth benchmark conversations have been ongoing in Rhode Island.<sup>26</sup>

**Implementation steps:** Implementation steps will build upon the preceding SIM stakeholder work, the Department's recent benchmark summit meetings and our October working paper titled "The Road to Value."<sup>27</sup> The Department will continue to iteratively involve stakeholders in developing a responsible and effective health care spending benchmark mechanism that will generate desired change. The Department has identified the following specific process for benchmark design and implementation.

1. *Convene a stakeholder body to advise State design of the methodology.* This will be a stakeholder advisory body of reasonable and manageable size with balanced representation of consumers, employer purchasers, health care providers, insurers, economist(s) and State agency staff.
2. *Continue to solicit broad public input.* Public communication and engagement should not be limited to the select group participating as members of the stakeholder advisory body. The Department will share details on benchmark-related work on an ongoing and iterative basis using web, email and in-person outreach to do so.
3. *Define "Total Cost of Care."* The first step for the State will be to define "Total Cost of Care" for benchmark definition. To facilitate this and other work, the Department will draw upon precedence and lessons from other states. Decisions will need to be made on services and populations, including the significant population of individuals covered by employer self-funded plans for which the State cannot mandate data reporting.<sup>28</sup>
4. *Identify the source(s) of data and analytic resources.* The calculation of performance relative to a benchmark needs well-defined, complete and accurate data sources and analytic resources to assess benchmark achievement. Ideally, the Department will be able to leverage the Delaware

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<sup>24</sup> <https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/>.

<sup>25</sup> <https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/>

<sup>26</sup> Salit R. "R.I. task force calls for limits on health care spending" Providence Journal, December 1, 2015.

<sup>27</sup> The working paper lays out a vision for more person-centered, coordinated care for Delawareans and provides seven strategies to employ to achieve better outcomes at a more sustainable cost to all health care payers. The thoughtful public comments received in response to the working paper are listed in Appendix C.

<sup>28</sup> Brown EF and King J. "The Consequences Of Gobeille v. Liberty Mutual For Health Care Cost Control" Health Affairs Blog March 10, 2016.

Health Care Claims Database<sup>29</sup> as a data source. It will be necessary to identify resources to perform the types of analyses required to support the benchmark.

5. *Determine units of measurement and accountability.* There will be multiple policy decisions before the cost spending benchmark can be put into place. The first is for which entities performance will be assessed. In addition to statewide measurement, Medicare, Medicaid and commercial insurers appear to be natural units of measurement and accountability, as do large health systems, medical groups and ACOs. This is the current practice in Massachusetts.
6. *Define a method for benchmark setting.* Health care spending benchmarks are often set using an economic index on a per capita basis. The Department and its stakeholder advisory group will consider options, including measures of State domestic product growth and inflation. Other states have employed one or the other of these general methods. In addition, consideration will be given to the type(s) of technical expert(s) (e.g., economists) who should annually advise the State on benchmark setting.
7. *Consider supplementing the spending benchmark with quality benchmarks.* While establishing the health care spending benchmark is a top priority, the Department will explore with stakeholders possibly supplementing the spending benchmark with a limited number of health care quality benchmarks targeted at leading health care and health improvement priorities in Delaware. Under the SIM grant, and with the important help of the Delaware Health Information Network (DHIN), the Delaware Center for Health Innovation's Clinical Committee, and state payers, Delaware is now producing a "Common Scorecard" of quality metrics. The Scorecard may inform discussions regarding possible quality benchmark companions to a cost benchmark.
8. *Identify accountability implications.* The most challenging and potentially impactful benchmark policy decision will be deciding upon the implications of meeting and not meeting the benchmark in a given year for an entity subject to the benchmark (see #5 units of measurement and accountability above). The accountability implications could potentially vary over a multi-year time frame.
9. *Identify statutory authority for applying benchmark accountability consequences.* Depending upon the decision reached above in Step #7 regarding accountability implications, it may be necessary for the legislature to give statutory authority and/or reallocate current resources to an existing, new governmental or quasi-governmental body to take action. If authority is to be given to a new body, there will be a need for an associated governance structure. Legislation will then need to be drafted.

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<sup>29</sup> The HCCD was created by statute, pursuant to 16 Del.C. Ch. 103, Subchapter II, under the purview of DHIN, to achieve the "Triple Aim" of the State's ongoing health care innovation efforts: (1) improved health; (2) health care quality and experience; and (3) affordability for all Delawareans. The HCCD is created and maintained by the Delaware Health Information Network (DHIN), to facilitate data driven, evidence-based improvements in access, quality and cost of healthcare, and to promote and improve the public health through increased transparency of accurate claims data and information. <http://regulations.delaware.gov/register/july2017/proposed/21%20DE%20Reg%209%2007-01-17.htm>.

10. *Calculate baseline total cost of care performance and establish benchmark(s) for total spend and/or per capita spend.* Utilizing the data and analytic resources addressed above in Step #4, baseline total cost of care will be calculated at the State level and at the applicable unit-of-accountability level (Step #5). Having completed this task, the selected economic index (Step #6) will be applied as a multiplier to the baseline calculation to establish the benchmark for the State. Also, depending upon the resolution of Step #7, potentially establish health care quality benchmarks targeted at leading health care and health improvement priorities.

## ANALYZE AND REPORT ON VARIATION IN HEALTH CARE DELIVERY AND COST AND FACILITATE DATA ACCESS FOR PROVIDERS

**Rationale:** Cost containment is dependent upon understanding the sources of cost growth and the reduction of unwarranted variation in provider cost<sup>30</sup> and care delivery, including of low-value services and avoidable complications. Transparency and benchmarking of this information is required for delivery system improvement and provider performance accountability.

**Supporting evidence:** Analysis of cost and quality variation was critical to motivating and informing Massachusetts' reforms<sup>31</sup> and is a cornerstone of most delivery system performance improvement efforts.

### **Implementation steps:**

1. *Define a standard set of reports that support the benchmark.* Delaware policymakers and providers will need a standard set of reports to understand trends underlying the benchmark calculation. If the State, a payer or a provider exceeds the benchmark, there will be a need to know whether increases in unit cost or service volume drove cost, and for which services, conditions and in which geographies cost growth was highest and lowest. The Health Care Claims Database should provide the data to support this analysis, with supplementation from the Delaware Health Information Network's (DHIN's) clinical data. Best practice nationally, such as the MyHealth Access Network in Oklahoma and the Michigan Health Data Collaborative, integrates claim and clinical data for reporting purposes.
2. *Identify sources of regional and provider care variation.* A critical method for driving out low-value care and eliminating unwarranted variation is to empower Delaware providers with information that highlights such opportunities across the State. This can be performed using DHIN claims and clinical data for highlighting examples of low-value care delivery (i.e., care not supported by evidence) and comparing cost and quality for standard episodes of care, including both procedural and non-procedural care. Nationally, initiatives like Choosing

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<sup>30</sup> This is inclusive of the total cost of care for a provider's attributed patient population, or the total cost of care associated with the delivery of an episode of service (e.g., management of a patient with diabetes, provision of maternity care, etc.).

<sup>31</sup> "Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 118G, § 6½(b): Report for Annual Public Hearing" Massachusetts Attorney General, March 16, 2010

Wisely<sup>32</sup> and Smart Care California<sup>33</sup> target low-value care reduction, while the states of Arkansas, New York, Ohio and Tennessee have invested in episode of care measurement and produce reports for providers.<sup>34</sup> These analyses must be timely and will need to be available to the public so that providers can make use of them.

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<sup>32</sup> [www.choosingwisely.org/](http://www.choosingwisely.org/)

<sup>33</sup> [www.iha.org/our-work/insights/smart-care-california](http://www.iha.org/our-work/insights/smart-care-california)

<sup>34</sup> <http://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/Episodes/HowtoReadYourReport.pdf>

# 5

## NECESSARY COMPLEMENTARY STRATEGIES TO THE BENCHMARK

### IMPLEMENT MEDICAID AND STATE EMPLOYEE TOTAL COST OF CARE RISK-BASED CONTRACTING WITH ACCOUNTABLE CARE ORGANIZATIONS THROUGH CONTRACTED PLANS

**Rationale:** Create heightened provider accountability for managing health care cost growth. Such accountability should accelerate delivery system reform within the State.

**Supporting evidence:** Experience in multiple states has revealed that downside risk assumption is necessary for true care delivery transformation. “Upside” shared savings arrangements do not motivate transformative change because loss aversion is many times more motivating than opportunity for gain.<sup>35</sup> Thanks to the leadership of Delaware’s hospitals, Delaware providers are positioned to take this step with nearly 50 percent of primary care providers and all health systems now participating in one or more ACOs or clinically integrated networks (CINs).<sup>36</sup> While contract requirements for our Medicaid managed care plans have employed value-based payment targets, it is necessary to now move forward more boldly.

#### **Implementation steps:**

1. *Initiate collaborative discussions.* Working in partnership with the Department of Human Resources (DHR) Statewide Benefits Office, the Department will collaborate with Medicaid managed care plans, the State’s administrator for employee benefits and interested providers in discussions regarding how best to implement risk-based contracting through the State’s contractors with providers. The discussion will draw upon the 2016 Delaware Center for Healthcare Innovation (DCHI) Payment Committee’s consensus paper “Outcomes-based

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<sup>35</sup> Kahneman, D. & Tversky, A. (1992). "Advances in prospect theory: Cumulative representation of uncertainty". *Journal of Risk and Uncertainty*. 5 (4): 297–323.

<sup>36</sup> ACOs and CINs are provider affiliations created to contract with payers for managing the health and cost of care for defined populations of patients, typically as determined by patient primary care provider affiliation.

payment for population health management,"<sup>37</sup> and its design principles for total cost of care contracts, as a starting point.

2. *Develop an aligned contracting strategy.* The Departments will design a collaborative, risk-based contracting strategy that is roughly aligned across Medicaid and State employee purchasing, recognizing real differences in covered populations and covered services. In addition, the Department will assess the feasibility of creating a parallel future requirement of qualified health plans in the health insurance marketplace. Near-term implementation is not advisable given the current instability of that market. The Department will also take the following related steps:
  - a. Through alignment, simplify messaging and incentives to providers. For example, the Departments may apply an aligned measure set across contracts, building from the 19-measure primary care Common Scorecard measures adopted in the State in 2016.<sup>38</sup>
  - b. Consider how best to align with Medicare's ACO program designs to further streamline ACO and network provider expectations across other payers. Medicare is the primary payer for almost 170,000 Delawareans — or more than 15% of the population — but Medicare accounts for a much higher proportion of total spending. Providers are highly sensitive to changes in Medicare payment and coverage rules. Alignment with Medicare will therefore simplify the change process for providers.
  - c. Consider whether and if so, upon which schedule, to introduce the full array of Medicaid covered services to the ACO contracts. (Massachusetts and Vermont have each elected to pursue phased population and covered service implementation, e.g., long-term services and supports, in year 3.)
  - d. Develop a multi-year plan to introduce and increase downside risk over time, while building in important protections to ensure access and quality are not compromised, and providers are protected from high-cost outlier patients and whether they serve a sicker-than-average population.
  - e. Identify the key capabilities that contracting risk-bearing providers will need to possess, and ensure that they are addressed in health plan and plan administrator provider contract solicitations and contracts.
3. *Partner with contracted health plan and plan administrator partners to complete the design process and implement.* Following the design process, the Departments (DHSS and DHR) will work with respective contractors to move the design process to implementation.

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<sup>37</sup> [www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Consensus-Paper-On-Outcomes-BasedPayment.pdf](http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Consensus-Paper-On-Outcomes-BasedPayment.pdf)

<sup>38</sup> [www.youtube.com/watch?v=vD2GiYIEtZE](http://www.youtube.com/watch?v=vD2GiYIEtZE)

## SUPPORT CARE TRANSFORMATION AND PRIMARY CARE

**Rationale:** Placing financial and clinical responsibility for cost containment and quality on ACOs will prove unsuccessful if providers lack the tools to transform care delivery. While significant effort and resources have been expended through the SIM process on addressing provider readiness to bear financial risk (e.g., promoting adoption of models that integrate care for high-risk individuals who account for 50 percent of costs), additional support activities will be important if risk-bearing Delaware provider organizations are to operate at the level of best practice entities nationally, including addressing the specific needs of the Medicaid population.

**Supporting evidence:** Providers face significant challenges in assuming clinical and financial responsibility for population health and total cost of care.<sup>39</sup> While Delaware's health systems have been participating in the Medicare ACO program and preparing for assumption of downside risk, and SIM dollars have been invested in strengthening the primary care infrastructure of Delaware, there are added challenges when assuming some financial risk sharing. Other states, including Massachusetts, Minnesota, Oregon<sup>40</sup> and Vermont, among others, have provided technical assistance and/or funding to help risk-bearing providers develop skills and capacity with a focus on those serving the Medicaid population.

### **Implementation steps:**

1. *Expand upon prior and current SIM transformation support activity.*<sup>41</sup> During 2016 and 2017, the State contracted with practice transformation vendors<sup>42</sup> to support primary care providers across Delaware to transform their practices. Four vendors are supporting practice transformation and have engaged one-third of the primary care clinicians in the State. As a complement to practice transformation, another vendor is providing a learning and re-learning curriculum for practitioners seeking to develop the skills and capabilities required to coordinate care effectively. There is opportunity to expand these activities to engage additional providers, including more primary care providers and to add specialty care providers.

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<sup>39</sup> Pearl R. "The 4 Biggest Obstacles ACOs Face" Forbes, August 14, 2014.

<sup>40</sup> The Oregon Health Authority operates a transformation center expressly for this purpose. See [www.transformationcenter.org](http://www.transformationcenter.org). Other states, including Massachusetts, Minnesota and Vermont have provided technical assistance to risk-assuming providers through technical assistance and grants.

<sup>41</sup> Other prior and ongoing transformation support activity has included development of a consensus paper with a shared perspective on the definition and core elements of care coordination, promoting adoption of electronic records by behavioral health providers and supporting new models of integrated care between primary care and behavioral health providers.

<sup>42</sup> The vendors include MedAllies, Remedy Healthcare Consulting, the New Jersey Academy of Family Physicians and the Medical Society of Delaware/HealthTeamWorks.

2. *Provide technical support specific to ACOs serving the Medicaid population.* Delaware's largest health systems have ACO experience serving the Medicare population. They have been developing core functions, including population health management, data analytics and quality improvement programs for this purpose.<sup>43</sup> However, employed and Medicaid populations have distinct needs and require distinctive strategies. This is especially true for the Medicaid population, where ACOs need to be prepared to address a wide range of socioeconomic risk factors (e.g., instable housing, food insecurity and transportation limitations), comparatively high prevalence of mental illness and substance use, and safety net providers that are not positioned to make large infrastructure investments to manage population health.<sup>44</sup>

## ADDRESS UNDERLYING SOCIAL AND ENVIRONMENTAL ISSUES AFFECTING HEALTH OUTCOMES AND PARTIALLY AMELIORATE THEM WITH APPROPRIATE STRATEGIES

**Rationale:** High health care costs in Delaware are only partially the result of current payment and delivery system design and the way in which care is provided. Estimates suggest that no more than 20 percent of health status is the result of medical care. Social circumstances, in contrast, are estimated to have an impact twice as great. When combined, social, environmental and behavioral factors may account for 80 percent of health status.<sup>45</sup> Delaware providers have identified social and environmental health factors as a priority topic for attention. Ironically, Delaware has been limited in the past in investing in these services because high health care spending has pre-empted the ability to fully invest in these very areas.

**Supporting evidence:** Increasing evidence points to the impact that strengthened social and environmental supports — and especially housing — have on health care spending.<sup>46</sup> States, including Massachusetts,<sup>47</sup> California, Iowa, Michigan, Minnesota, Vermont and Washington, are giving attention to social determinants in their payment and delivery reforms and/or through

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<sup>43</sup> <https://christianacare.org/forphysicians/qualitypartners/>, [www.bayhealth.org/physicianalliance](http://www.bayhealth.org/physicianalliance), [www.umusa.net/umaco-for-patients.html#whatisACO](http://www.umusa.net/umaco-for-patients.html#whatisACO), [www.aledade.com/de/](http://www.aledade.com/de/) and [www.decarecollaboration.com/](http://www.decarecollaboration.com/).

<sup>44</sup> Bailit M and Waldman B. "Safety-Net Provider ACOs: Considerations for State Medicaid Purchasers" Robert Wood Johnson Foundation, Princeton, NJ, January 2016.

<sup>45</sup> Booske B et al. "Different Perspectives for Assigning Weights to Determinants of Health." County Health Rankings Working Paper. University of Wisconsin Population Health Institute, Madison, WI, 2010.

<sup>46</sup> Berkowitz SA et al. "Supplemental Nutrition Assistance Program (SNAP) Participation and Health Care Expenditures Among Low-Income Adults" *JAMA Intern Med.* 2017;177(11):1642-1649 and Butler S. Matthew DB and Cabello M. "Re-balancing medical and social spending to promote health: Increasing state flexibility to improve health through housing" Brookings Blog, February 15, 2017.

<sup>47</sup> Lloyd J and Hefflin K. "Massachusetts' Medicaid ACO Makes a Unique Commitment to Addressing Social Determinants of Health" Center for Health Care Strategies Blog, December 19, 2016.

cross-sector collaborations called Accountable Communities for Health (ACH).<sup>48</sup> Provider organizations nationally are increasingly also addressing social determinants of health.<sup>49</sup>

**Required steps to address underlying social and economic issues affecting health outcomes:**

1. *Understanding prior work and existing resources in Delaware, research evidence and innovative practices.* Any effort needs to begin with a consideration of prior and existing efforts (e.g., the Department of Health’s development of its Health Equity Guide for Public Health Practitioners and Partners in 2015, the SIM Healthy Neighborhoods initiative<sup>50</sup>) and current provider activity. In addition, understanding the research on the relationship of social determinants, health and health spending is necessary, as is understanding innovative practices within the State and across the country.
2. *Convene a stakeholder body to develop a strategy.* With no clear blueprint on how best to address social determinants of health, a collaborative effort of an interdisciplinary team of stakeholders from within the health and social service sectors will be needed. Topics will include, but not be limited to, screening for social determinants of health, linkages with community social service providers, prioritized interventions and customizing approaches for children, adults and linguistic and cultural minorities.
3. *Design and implement pilot projects.* It may be of value to pilot multiple approaches across Delaware once the design work is complete. If so, health care and social services providers will be invited to participate with any other appropriate partners.

**REDESIGN EXECUTIVE BRANCH FUNCTIONS AND STATE PURCHASING STRATEGIES TO MANAGE HEALTH CARE COST AND QUALITY MORE EFFECTIVELY**

**Rationale:** Delaware has struggled to constrain health care cost growth. Current agency organization and State regulatory functions need modification to increase effectiveness.

**Supporting evidence:** Massachusetts, Oregon, Vermont and Washington all reorganized state government in different ways to bring heightened focus and increased effectiveness to state health

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<sup>48</sup> “Using Medicaid Levers to Support Health Care Partnerships with Community-Based Organizations” Partnership for Health Outcomes Fact Sheet, October 2017.

<sup>49</sup> Hussein T and Collins M. “The Community Cure for Health Care” Stanford Social Innovation Review July 21, 2016.

<sup>50</sup> Healthy Neighborhoods are local communities that come together to harness the collective resources of all organizations in their community to design and implement locally tailored solutions to some of the state’s most pressing health needs. For more information, see [www.dehealthinnovation.org/healthy-neighborhoods](http://www.dehealthinnovation.org/healthy-neighborhoods).

care purchasing and policy. It appears that multiple approaches are viable to achieve a common aim. Delaware needs to adopt a strategy that is the best fit for Delaware.

**Required steps to redesign executive branch functions to manage health care cost and quality more effectively:**

1. *Design a Delaware Health Authority.* Informed by the alternative structures employed to manage state health care spending in leading states, the Department will initiate a process to design a Delaware Health Authority that will combine state government health functions currently spread across multiple agencies. This reorganization will support a more integrated and consistent approach to managing our health care cost and promoting statewide improvement in health care quality and population health status. The Authority will be modeled off of those operated by Oregon and Washington, but will also draw lessons from innovative executive branch structures in Massachusetts and Vermont. While the Delaware Health Authority will borrow ideas from these states, it will be customized for and responsive to the needs of Delaware. The design and function of the Delaware Health Authority will be informed by conversations with stakeholders, state agency staff and legislators. While the design of the Delaware Health Authority will only emerge after these conversations, the Department recommends that it possess certain characteristics, including:

- An appointed health policy board with responsibility for policy-making and oversight
- Integration of all state health care purchasing activity, including Medicaid, public employee benefits and Choose Health Delaware
- Responsibility for public health, mental health and substance use services
- Responsibility for state health data functions

Having completed this task, the Department will assess the likelihood of success in Delaware, the statutory changes that would be required to adopt the model and the administrative cost implications of such a change.

2. *Identify best practices in value-based purchasing and compare them to current practice within DHSS and DHR.* Considerable work has been done nationally to examine best practices in state value-based purchasing.<sup>51</sup> The Departments will conduct a comparative analysis to see where

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<sup>51</sup> Dyer M and Waldman B. "Value-Based Purchasing for Managed Care Procurements: A Toolkit for State Medicaid Agencies" Robert Wood Johnson Foundation, Princeton, NJ, October 18, 2017; Burns M, Waldman B and Taylor E. "The Role of State Medicaid Programs in Improving the Value of the Health Care System" National Association of Medicaid Directors, Washington, DC, March 24, 2016, and Slen J, Bailit M and Houy M. "Value-Based Purchasing and Consumer

gaps may exist between current and best practice, and then pursue changes in policy, practice and staffing (as necessary) where current gaps may exist.

3. *Engage stakeholders in discussion of alternative executive branch structures specific to health care policy and purchasing.* Any potential change in executive branch structures should not be taken lightly given the impact on our State government and those who interact with it. The Governor's Office, State Legislature, the Department and other executive branch agencies, as appropriate, will share the analysis and draft recommendations with the public for questions and comments before finalizing recommendations.

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# 6

## SPECIAL CONSIDERATIONS CONVEYED BY DELAWAREANS

As we develop a State health care spending benchmark and identify complementary transformative strategies for health care delivery and payment reform in Delaware, we understand that there are unique circumstances in Delaware that must be considered as part of the process. During the course of multiple public summits, town halls, and smaller meetings with stakeholders, the Department heard some recurrent themes. In addition, we received specific comments and recommendations to the Road to Value draft working paper (see Appendix C). Some of the considerations that must be considered throughout this process include:

- **Consider the factors that make Delaware unique:** Delaware’s demographics and population health are key drivers of both spending and growth in spending. Delaware’s population is older and is aging faster than the national average, forecasted to be the tenth oldest state by 2025.<sup>52</sup> Additionally, Delaware stretches from an urban and suburban environment in the north through to a rural environment south of the canal and, in particular, in the southwestern corner of the State. Inherent within this geographic and demographic variation there are significant differences in the density of health care provision.
- **Build on expertise and stakeholder work to date:** As discussed earlier in this report, Delaware has been engaged in an effort to transform our health system for several years. Our goal is improving the health of Delawareans, improving the patient experience of care, reducing per capita health care costs and enhancing provider experience — the Triple Aim Plus One. The Delaware Center for Health Innovation has led key aspects of our SIM efforts, coordinating with the DHIN and collaborated with the Department. These joint efforts have resulted in the coming together of our health care community, including consumers, clinicians, community health centers, health systems, payers and the State to articulate a plan for how we can meet the challenges we face together. This engagement creates a foundation for the next phase of transformation in Delaware health care delivery.

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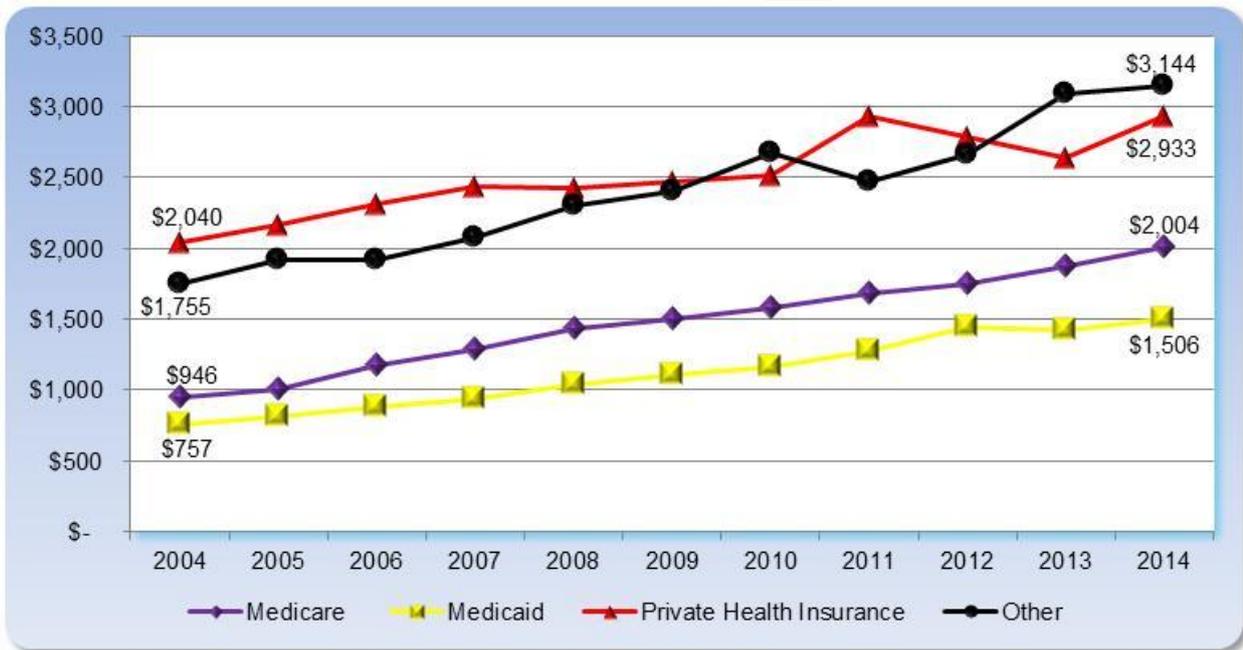
<sup>52</sup> Defined by percent of population over age 65. U.S. Census Bureau, Population Division, Interim State Population Projections, 2005

- Consider the strengths of our health care delivery system:** Delaware has made a significant investment in transitioning to value-based payment models as a result of ongoing efforts through SIM and the Medicare ACO models. Overall, 30 percent of Delawareans are attributed to providers participating in value-based payment models. Delaware is the first state in the country to achieve universal participation of the adult acute care hospitals in the Medicare Shared Savings Program. Some of these hospital systems, as well as other physician-led ACOs, have recently begun to expand their participation into the commercial segment as well. The DHIN is the State's health information exchange (HIE) and provides a system that can facilitate improved communication within the health care community, improved efficiency and elimination of redundant testing, monitoring of population health and community health, ultimately, leading to the reduction of health care costs.
- Consider where we have shortages, not enough capacity and market concentration:** The hospital landscape is more concentrated in Delaware than in most other markets, with just six acute care hospital systems across the State, with most populations relying on a single hospital for their care. Fewer competing providers per region often means less choice for consumers and fewer options for referring providers. The State has invested in funding to support its educational pipeline. It may be time to consider whether the pipeline is the gap in investment or whether it is time to focus on providers who will stay and work in the State, particularly in underserved communities and rural areas downstate. Additionally, it may be time to reconsider the requirement for dental residency, as many states are moving away from this requirement. Finally, the mental health and geriatrics workforce is in need of a major boost in those who are trained in addiction medicine.
- Consider needs of special populations:** There are approximately 22,000 dual-eligible individuals (who are enrolled in both Medicaid and Medicare) in Delaware. The State serves 7,000 Delawareans with serious and persistent mental illness (SPMI), who receive care through Medicaid and Delaware Division of Substance Abuse and Mental Health programs. The Division of Developmental Disability Services serves approximately 3,700 Delawareans with intellectual disabilities, autism and Asperger's, including 900 individuals with intellectual and developmental disabilities living outside of the family home whose care is funded through a 1915(c) Home- and Community-Based Services (HCBS) waiver program.
- Do not forget small towns and rural areas:** The physician landscape is fairly fragmented; over 75 percent of physicians (and almost 80 percent of primary care physicians) are in practices of five physicians or fewer. Advance practice nurses practice pursuant to a collaborative agreement with a physician. On some measures, the health care workforce meets or exceeds national measures, but the workforce is concentrated in certain geographies, leaving some regions of the State with significant workforce shortages in key segments (e.g., behavioral health and dental care). Strategies for accelerating payment reform and developing a health care benchmark must consider these market parameters in developing an effective measure.

# APPENDIX A

## SUPPLEMENTAL CHART PACK

CHART 1 – GROWTH IN TOTAL DELAWARE PERSONAL HEALTH CARE EXPENDITURES BY PAYER/PROGRAM (IN MILLIONS OF DOLLARS) <sup>53</sup>



<sup>53</sup> Data from Centers for Medicare & Medicaid Services, Health Expenditures by State of Residence 1991–2014; <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html>.

Other Mid-Atlantic States include Maryland, New Jersey, New York and Pennsylvania.

CHART 2 – RATIO OF PER CAPITA HEALTH CARE SPENDING TO US AVERAGE <sup>54</sup>

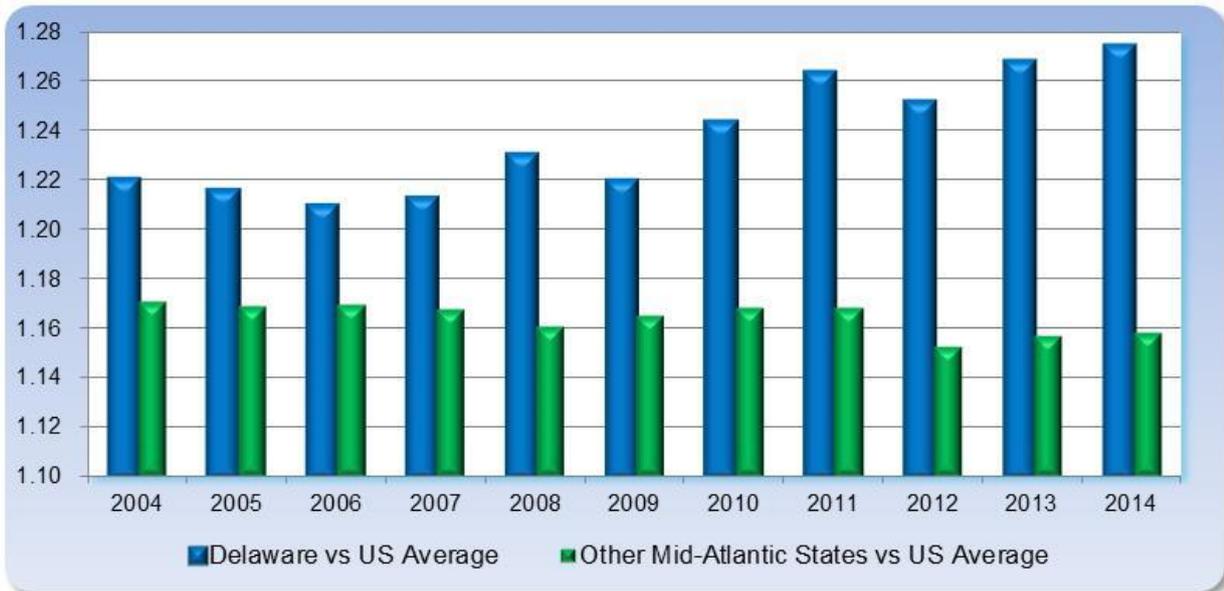


CHART 3 – FALL 2017 STATE RANKINGS OF HOSPITAL SAFETY GRADES — THE LEAPFROG GROUP <sup>55</sup>

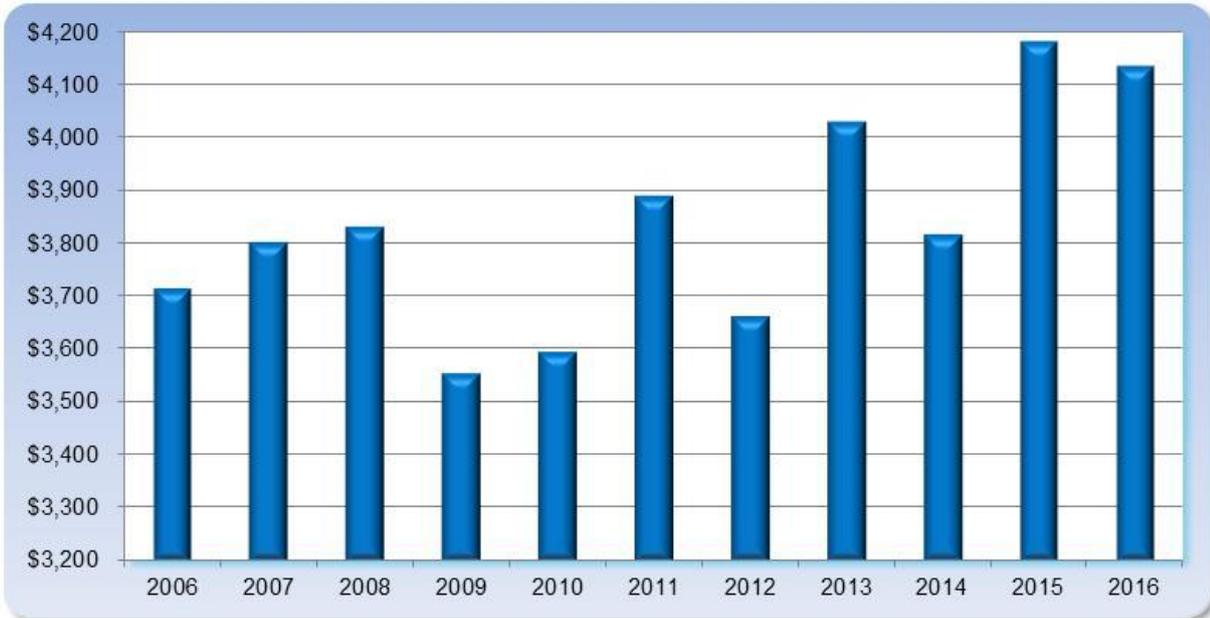
RANK	STATE	Total # of Hospitals Scored	Total # of A Hospitals	Percent of A Hospitals	Spring 2012 State Ranking
1	Rhode Island	7	5	71.4%	50
2	Maine	16	11	68.8%	2
3	Hawaii	12	8	66.7%	36
4	Idaho	11	7	63.6%	19
5	Virginia	68	41	60.3%	7
6	Wisconsin	56	33	58.9%	44
7	Massachusetts	60	34	56.7%	1
8	Oregon	32	16	50.0%	48
9	Ohio	110	51	46.4%	15
10	Colorado	39	18	46.2%	27
11	New Jersey	68	30	44.1%	14
12	North Carolina	78	34	43.6%	29
13	South Carolina	46	19	41.3%	11
14	Utah	22	9	40.9%	32
15	Kansas	31	12	38.7%	39

<sup>54</sup> Ibid.

<sup>55</sup> <http://www.hospitalsafetygrade.org/your-hospitals-safety-grade/state-rankings>

RANK	STATE	Total # of Hospitals Scored	Total # of A Hospitals	Percent of A Hospitals	Spring 2012 State Ranking
16	New Hampshire	13	5	38.5%	19
17	Montana	8	3	37.5%	16
17	South Dakota	8	3	37.5%	29
19	Texas	210	77	36.7%	24
20	New Mexico	15	5	33.3%	32
20	Mississippi	33	11	33.3%	34
22	Missouri	58	18	31.0%	47
23	Indiana	59	18	31.0%	18
24	Florida	174	53	30.5%	12
25	Pennsylvania	126	38	30.2%	22
26	Illinois	111	33	29.7%	4
27	Minnesota	34	10	29.4%	9
27	Louisiana	51	15	29.4%	25
29	Tennessee	63	18	28.6%	5
30	Connecticut	25	7	28.0%	43
31	California	265	74	27.9%	10
32	Oklahoma	40	11	27.5%	46
33	Iowa	33	9	27.3%	23
34	Kentucky	50	13	26.0%	28
35	Washington	44	11	25.0%	13
36	Michigan	77	19	24.7%	6
37	Arizona	47	10	21.3%	31
38	Vermont	5	1	20.0%	3
38	Alaska	5	1	20.0%	17
40	Georgia	74	14	18.9%	36
41	Arkansas	28	5	17.9%	48
42	Alabama	49	7	14.3%	41
42	Wyoming	7	1	14.3%	19
44	Nebraska	16	2	12.5%	35
44	West Virginia	24	3	12.5%	45
46	Nevada	19	1	5.3%	26
47	New York	142	7	4.9%	40
48	Maryland	44	1	2.3%	Not graded
49	Delaware	6	0	0.0%	8
49	District of Columbia	7	0	0.0%	42
49	North Dakota	6	0	0.0%	36

CHART 4 – PER CAPITA DELAWARE GENERAL FUND REVENUES (NOT ADJUSTED FOR INFLATION)<sup>56</sup>

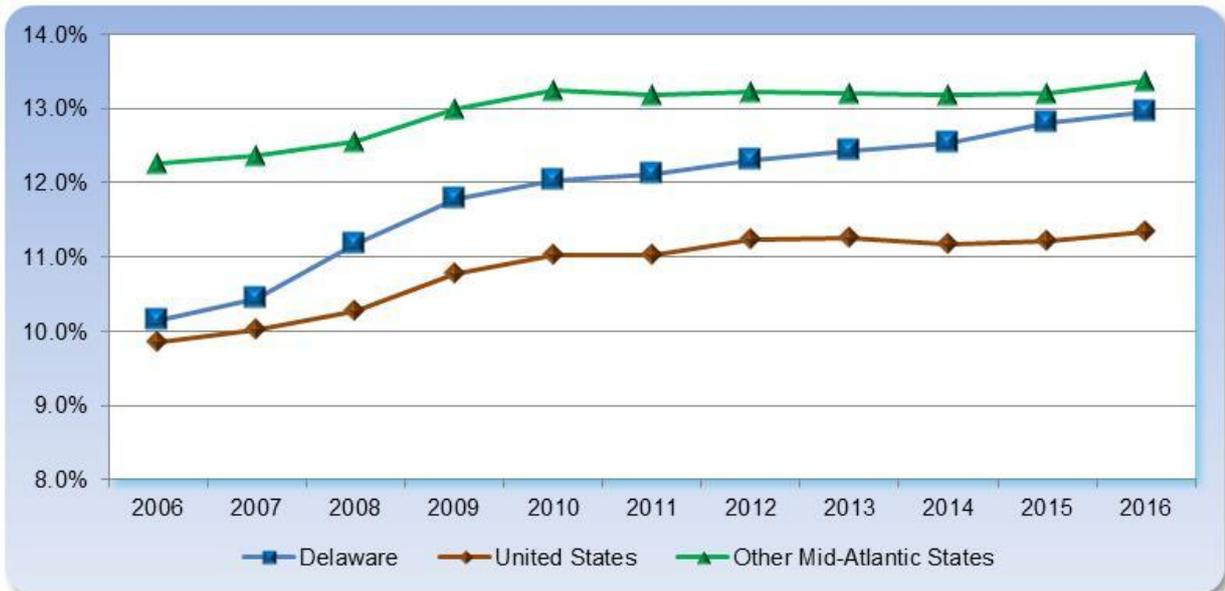


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<sup>56</sup> [https://finance.delaware.gov/publications/fiscal\\_notebook\\_16/front/greetings.shtml](https://finance.delaware.gov/publications/fiscal_notebook_16/front/greetings.shtml)

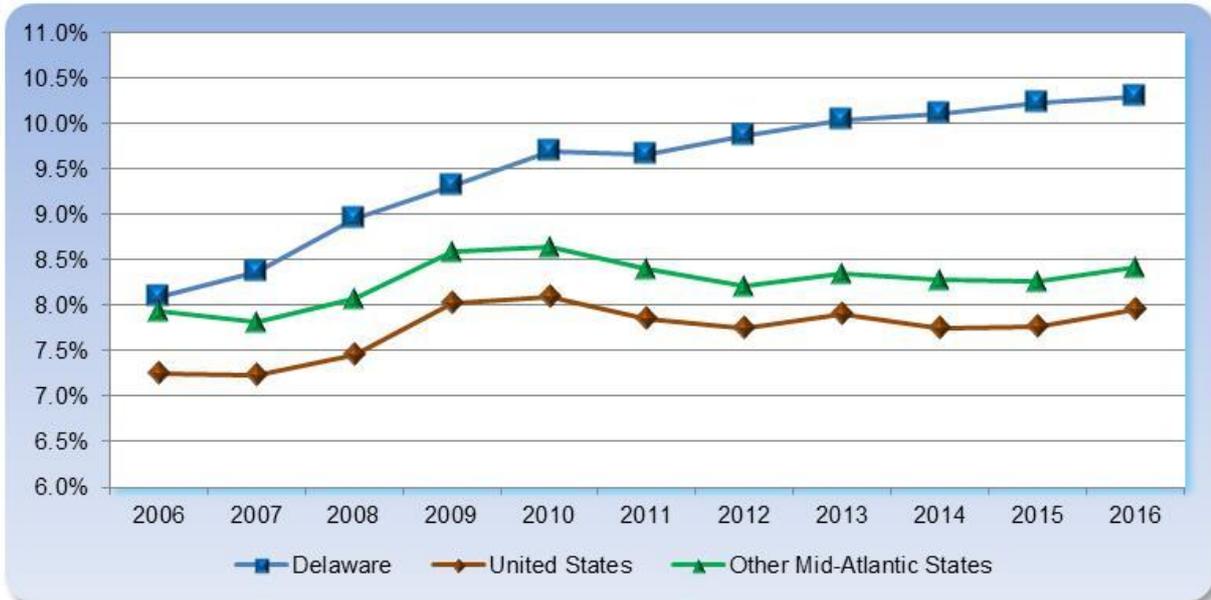
CHART 5 – PERCENT OF TOTAL EMPLOYMENT IN HEALTH CARE AND SOCIAL SERVICES INDUSTRY<sup>57</sup>



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<sup>57</sup> Bureau of Economic Analysis, SA25N Data,  
<https://www.bea.gov/itable/iTable.cfm?ReqID=70&step=1#reqid=70&step=1&isuri=1>

CHART 6 – PERCENT OF TOTAL PERSONAL INCOME FROM HEALTH CARE AND SOCIAL SERVICES INDUSTRY<sup>58</sup>



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<sup>58</sup> Bureau of Economic Analysis, SA5N Data,  
<https://www.bea.gov/itable/iTable.cfm?ReqID=70&step=1#reqid=70&step=1&isuri=1>

# APPENDIX B

## DETAILED SUMMARY OF BENCHMARK SUMMITS

### SUMMIT #1 – SEPTEMBER 7, 2017 “ESTABLISHING THE BENCHMARK”

- Host/Moderator: **Delaware Center for Health Innovation**
- **The Impact of Rising Healthcare Costs and Options for Delaware**
  - Speaker/Presenter: **Ezekiel J. Emanuel, MD, PhD of the University of Pennsylvania Department of Medical Ethics and Health Policy**
- **Creating Value and Lowering Costs: Perspectives from a Delaware ACO**
  - Speaker/Presenter: **Farzad Mostashari, MD, ScM of Aledade Inc**
- **Convening Stakeholders and Employers for Payment Reform: Massachusetts Experience**
  - Speaker/Presenter: **Audrey Shelto, MMHS of Blue Cross Blue Shield of Massachusetts Foundation**
- **Considering Economic Evaluation and Data-Driven Policy Analysis: A View from Vermont’s Approach**
  - Speaker/Presenter: **Christine Eibner of RAND Corporation**

### Highlights from the Summit:

- This was the inaugural Delaware health care summit.
- Obviously, Delaware wants to be a national leader in transforming health care; big drivers of waste in health care are unnecessary services, inefficiently delivered care and pricing failures; generally start to see a return on investment after three years; we are way too hospital-focused in this country; a large part of what we need to do is invest in social determinants of health; one of the single biggest investments that any government could make is early childhood interventions – **Ezekiel J. Emanuel, MD, PhD**
- Aledade is a physician-based ACO, and Delaware was our first signed contract; it was the vision of the group of independent primary care physicians in Delaware that has been our touchstone as we have grown; physicians are the quarterback to lead and be accountable; primary care access is about actually being available to the patients when they really need you; our rate of ER visits that leads to hospitalization is down 12.8 percent; in our third year, our primary visit rate is up and readmissions are down; need to be able to speak with confidence that this is not cheaper care, this is better care – **Farzad Mostashari, MD, ScM**
- There was a realization that millions were being spent on disorganized and disjointed care that could be repurposed; we knew there were going to be thorny details down the road, but we knew this was something we can and should do – **Audrey Shelto, MMHS**

## SUMMIT #2 – SEPTEMBER 22, 2017 “PROVIDER/HOSPITAL LEADERSHIP”

- Host/Moderator: **Delaware Hospital Association and Medical Society of Delaware**
- **Transforming Care Delivery in an Era of Complexity**
  - Speaker/Presenter: **Nirav R. Shah, MD, MPH of Kaiser Permanente Southern California**
- **My Journey Through The World Of Healthcare Cost**
  - Speaker/Presenter: **Dr. Norvell Coots of Holy Cross Health/Maryland Region of Trinity Health**
- **Lessons from 6 Years as a Primary Care-Driven ACO**
  - Speaker/Presenter: **Al Kurose, MD, MBA, FACP of Coastal Medical (Rhode Island)**
- **Pediatric Accountable Care: Population Health and Value-Based Financing**
  - Speaker/Presenter: **Colleen A. Kraft, MD, FAAP of the American Academy of Pediatrics**
- **The Impact of Chronic Disease on Health Care Costs in Delaware**
  - Speaker/Presenter: **Sharon L. Anderson, RN, BSN, MS, FACHE of Christiana Care CareLink/Christiana Care Health System**

### Highlights from the Summit:

- All five speakers spoke about a range of experiences to an audience of over 100 in-person attendees and many more on line – **Secretary Walker**
- In complicated systems, standardization is innovation and variation is the enemy; it is everyone’s job to speak up about health care processes/patient needs; starting with what is common creates considerable opportunity to raise the bar; shared consciousness and empowered execution is what we need in health care to get the next order of magnitude of improvement – **Nirav R. Shah, MD, MPH**
- Coastal Medical is a primary care-driven/physician-owned ACO; we had a bunch of the pieces, so we took the initiative to help drive transformation and the best care to reduce total cost of care; we took an “all-in” strategy, not just a toe in the water; we lead with engaging the primary care physicians and their advanced medical homes; being a first-mover had an advantage of elevating our position within the marketplace that we were just not primary care docs but leaders in our community – **Al Kurose, MD, MBA, FACP**
- Maryland hospitals are now taking responsibility for total cost of care; had to explain to Trinity [ownership] that growth is bad and it is good we are seeing less patients in the ER; drive care out of the inpatient sphere and back out into the community; we did not have to negotiate [hospital] payment rates with any payer, but budgets are fixed which can impact ability to invest in new technologies; we are all responsible for the same community for the care, so it is best to cut down artificial barriers between our system of care; as hospitals do not fear quality and cost savings reforms, it is up to us as leaders to do it – **Norvell Coots, MD**
- If you do not have a healthy child, you will continue to repeat the cycle of an unhealthy adult; if you do not have data that is correct, your doctors are not going to believe it; population health

principles show that we can see reducing high-cost care and optimizing the health of our kids at the same time – **Colleen A. Kraft, MD, FAAP**

- The top 5 percent of the US population drive 50 percent of health care spend, and they have one thing in common: multiple-chronic diseases; chronic disease is the leading cause of death in Delaware; we need to focus on chronic disease prevention, detection and reduction; if we are going to lower cost, we need to improve health, and this is a heavy lift; It is a different system we have to create, in Delaware; we are small enough to do it – **Sharon L. Anderson, RN, BSN, MS, FACHE**

### SUMMIT #3 – SEPTEMBER 25, 2017 “LEGAL/REGULATORY ISSUES”

- Host/Moderator: **Delaware State Senator Bryan Townsend**
- **Driving Change with the Health Care Spending Benchmark: Delaware’s Road to Value**
  - Speaker/Presenter: **Secretary Kara Odom Walker, MD, MPH, MSHS of the Delaware Department of Health and Human Services**
- **The Role in States in Limiting The Growth of Healthcare Spending: The Massachusetts Story...**
  - Speaker/Presenter: **Stuart H. Altman, PhD of The Heller School for Social Policy and Management, Brandeis University**
  - Speaker/Presenter: **Massachusetts State Senator Richard T. Moore**

#### Highlights from the Summit:

- It was important to hear that Massachusetts had patients, consumers and employers coming together to talk about how to create a benchmark; when health care costs consume at least 30 percent of the state budget, we really do need to think about things in a different way – **Secretary Walker**
- This is one of the most important issues to tackle, as the fiscal implication alone of the inequities in our health care system issue holds back other progress in Delaware – **Delaware State Senator Bryan Townsend**
- States are where things are really going to get done/happen; really important for Delaware to look at total health system spending, not just Medicaid; you will need an entity/organization whose governance is independent, but interconnected; in Massachusetts, the Health Policy Commission (11 members) reviews all increases that exceed the benchmark to find out why and ask why do you need to spend more and can there be a plan developed to get down to the benchmark; we can penalize and publicize if groups exceed the benchmark; our big physician groups are committed voluntarily to moving towards medical homes; recently, every major group/hospital, other than the physicians, wanted a 3.1 benchmark for 2018 – **Stuart H. Altman, PhD**
- The benchmark is only possible or achievable if you do other things in the health care system in dealing with disparities, scope of practice, looking at medical loss ratios, possibly insurance reform – **Massachusetts State Senator Richard T. Moore**

## SUMMIT #4 – OCTOBER 18, 2017 “DATA ANALYTICS (TOTAL COST OF CARE)”

- Host/Moderator: **Delaware Health Information Network (DHIN)**
- **The Future: Redefining Health Care Systems and Improving Health**
  - Speaker/Presenter: **Robert H. Brook, MD, ScD of RAND Corporation**
- **Vendor’s View: Data Platforms and Analytics**
  - Speaker/Presenter: **Arielle Mir, MPA of NUNA**
- **Using Data to Drive Change**
  - Speaker/Presenter: **Craig Jones, MD of Privis Health and Office of the National Coordinator for Health Information Technology**
- **Total Cost of Care Measurement and All-Payer Claims Databases**
  - Speaker/Presenter: **John Freedman, MD, MBA of Freedman Healthcare**
- **Data Analytics & Total Cost of Care**
  - Speaker/Presenter: **Karen Tseng, JD of the Massachusetts Attorney General’s Office**

### Highlights from the Summit:

- Whole day was spent discussing how Delaware can better use data and outcomes in a transparent way to inform total cost of care and paying for value not just volume – **Secretary Walker**
- Delaware needs to find a vision; the people of Delaware need to buy into this with the government and health professionals in a community participatory way; must be both a “bottom up and top down” movement – **Robert H. Brook, MD, ScD**
- Stakeholders who submit data to these types of repositories are also data consumers and stand to benefit from this type of shared resource – **Arielle Mir, MPA**
- How Delaware assembles the rules that allow the use of an all-payer claims database will determine its value; Delaware has an opportunity to do this right – **Craig Jones, MD**
- An all-payer claims data is an aggregation of big data file and, at its core, consists of three things: eligibility data, claims records and provider files; and allows for very diverse, flexible and sophisticated examination of the health care system and spending – **John Freedman, MD, MBA**
- Since the 1990s, Massachusetts was on a steady journey of health care reform which resulted in the ability to establish a spending benchmark; the benchmark was not an end unto itself, but a tool in our toolkit across our broader imperative; our state legislature gave the AG office the unique ability to use subpoena to compel payers and providers to submit data to support market examinations and monitor health care trends and release information out for stakeholder consumption – **Karen Tseng, JD**

## SUMMIT #5 – NOVEMBER 2, 2017 “GOVERNANCE/AUTHORITY (TOTAL COST OF CARE)”

- Host/Moderator: **Medical Society of Delaware**
- **Key Considerations in the Creation of Green Mountain Care Board in Vermont**
  - Speaker/Presenter: **Mark Larson Vice President of Policy at the Center for Health Care Strategies**
- **Introduction to the Massachusetts Health Policy Commission**
  - Speaker/Presenter: **David Seltz, Executive Director, Massachusetts Health Policy Commission**
- **The Oregon Health Authority: Governance, Authority and One State’s Path to Quality Affordable Healthcare for All**
  - Speaker/Presenter: **Dr. Bruce Goldberg, Senior Associate Director Oregon Rural Practice Based Research Network**

### Highlights from the Summit:

- The health care spending benchmark is a goal to lower spending and a tool to monitor total health care costs through enhanced transparency and increased efficiencies – **Matthew Swanson**
- Role of the Green Mountain Care Board included regulation, innovation and evaluation; we thought a lot about at what point does policy want to be separate from the regulator and at what point together; we pushed back on Board representation of certain individuals, as we had some prior history with representative Boards getting bogged down to a point of inefficiency, we really wanted to maintain an independent Board to make decisions in the best interest of Vermonters and be responsible for looking at the whole, not representing some specific entity; in selecting members, we drew from the trusted judicial nomination process; independence matters; openness of the process is an essential asset but is resource intensive – **Mark Larson**
- There is no one right way to do this; states are a laboratory and tailor it to your state; our health care cost growth benchmark was the organizing principle of our entire effort; two state agencies were established, CHIA (data hub) and HPC (policy hub); CHIA was made through repurposing existing state resources/assets, but HPC was created from scratch; really important for us to have an independent board that does not represent one single stakeholder/segment; HPC Board consisted of areas of expertise, but appointees required to take a broader view for the benefit of all of Massachusetts; our four core strategies are research/report, convene, watchdog and partner; health care is big business, and this effort is hard and needs to be done thoughtfully – **David Seltz**
- There is no perfect structure for governance; Oregon Health Authority was borne out of a belief we could do better and harness the state’s purchasing power; no magic number for our 9 Health Policy Board members (5 VT and 11 MA); two-year time frame to do transition; you need some authority, but influence is key; payment reform is critical to help drive value – **Bruce Goldberg, MD**

# APPENDIX C

## ROAD TO VALUE PUBLIC COMMENTS

The following table provides a list of comments received and posted on the Department's website as of November 30, 2017. Available at: <http://dhss.delaware.gov/dhss/valuecomments.html>

Comments By	Submitted Date
Delaware Coalition of Nurse Practitioners	11/13/2017
John Dodd	11/13/2017
Delta Dental of Delaware	11/13/2017
UD Partnership for Healthy Communities	11/13/2017
Musculoskeletal Care	11/13/2017
Marianne Carter	11/13/2017
Medical Society of Delaware	11/13/2017
Delaware Center for Health Innovation (DCHI) Clinical Committee	11/13/2017
Emergency Medicine Coalition Of Delaware	11/13/2017
Christiana Care Health System	11/13/2017
Delaware Healthcare Association	11/13/2017
Ashley Panichelli MD	11/12/2017
Erin Goldner	11/12/2017
Joann Hasse	11/09/2017

<b>Comments By</b>	<b>Submitted Date</b>
Kristine Thurston Toppe	11/09/2017
John Walsh	11/08/2017
Teresa LoPorto	11/07/2017
Erin Goldner	11/07/2017
Mark S. Borer	11/07/2017
Vincent Carr	11/07/2017
Jan Lee	11/06/2017
Mike Bio	11/04/2017
Michael Dejos, PharmD, BCPS	10/27/2017

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