



DELAWARE'S HEALTH CARE BENCHMARK

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Delaware's Road to Value

Support **patient-centered, coordinated care.**

Prepare the health provider **workforce and infrastructure.**

Improve health for **special populations.**
Engage **communities.**

Ensure **data-driven performance.**

Pay for Value

Improved Quality and Cost

WHY THE BENCHMARK IS IMPORTANT

- Delaware's per-capita health care costs are **more than 25% above** the U.S. average.
- Delaware's health care spending is expected to more than **double by 2025**.
- Health care costs consume at least **30 percent** of Delaware's state budget.
- Yet, we are **ranked 31st in health outcomes** by America's Health Rankings

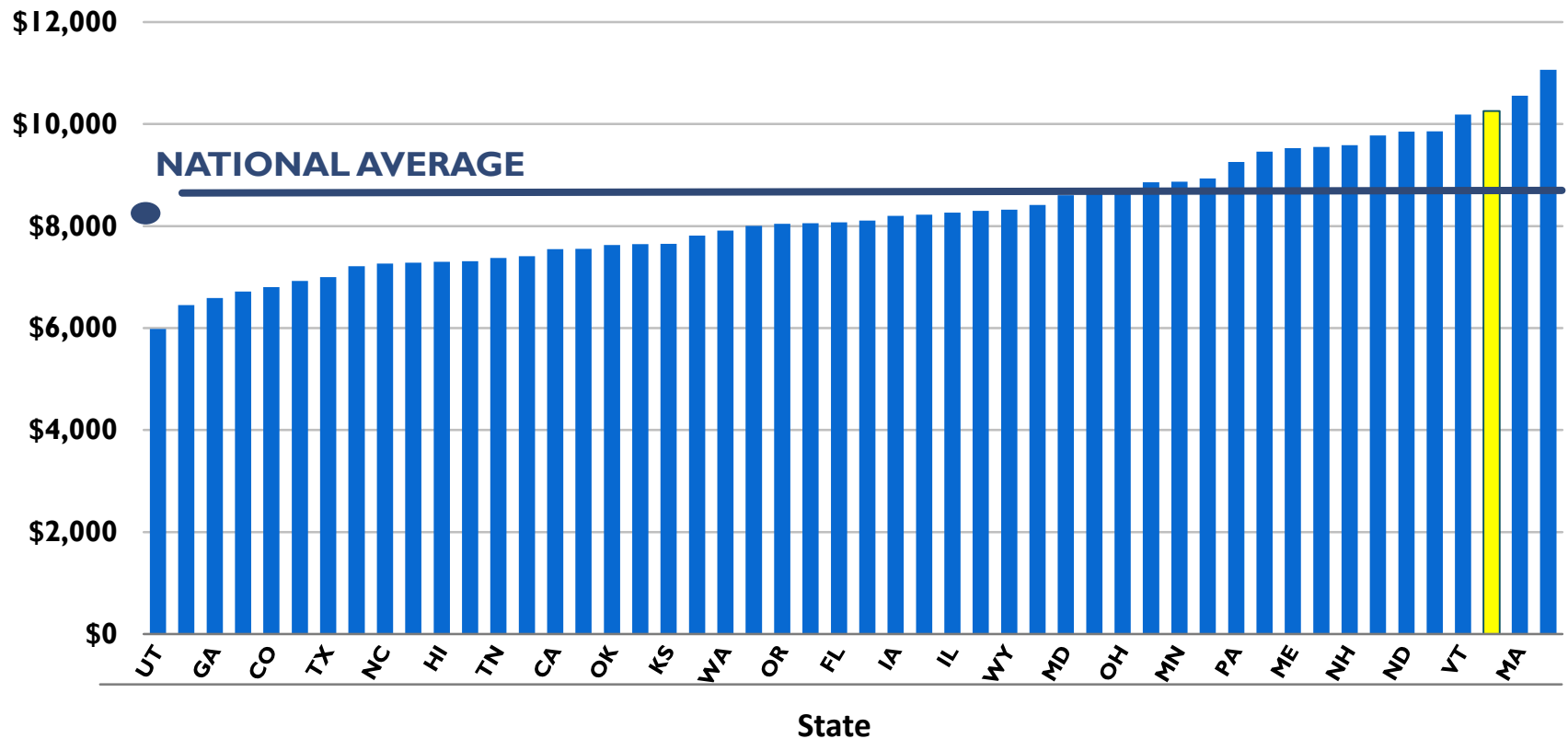


THE HEALTH CARE SPENDING LANDSCAPE



DELAWARE SPENDS MORE ON HEALTH CARE THAN MOST OTHER STATES

PER CAPITA PERSONAL HEALTH CARE EXPENDITURES, 2014

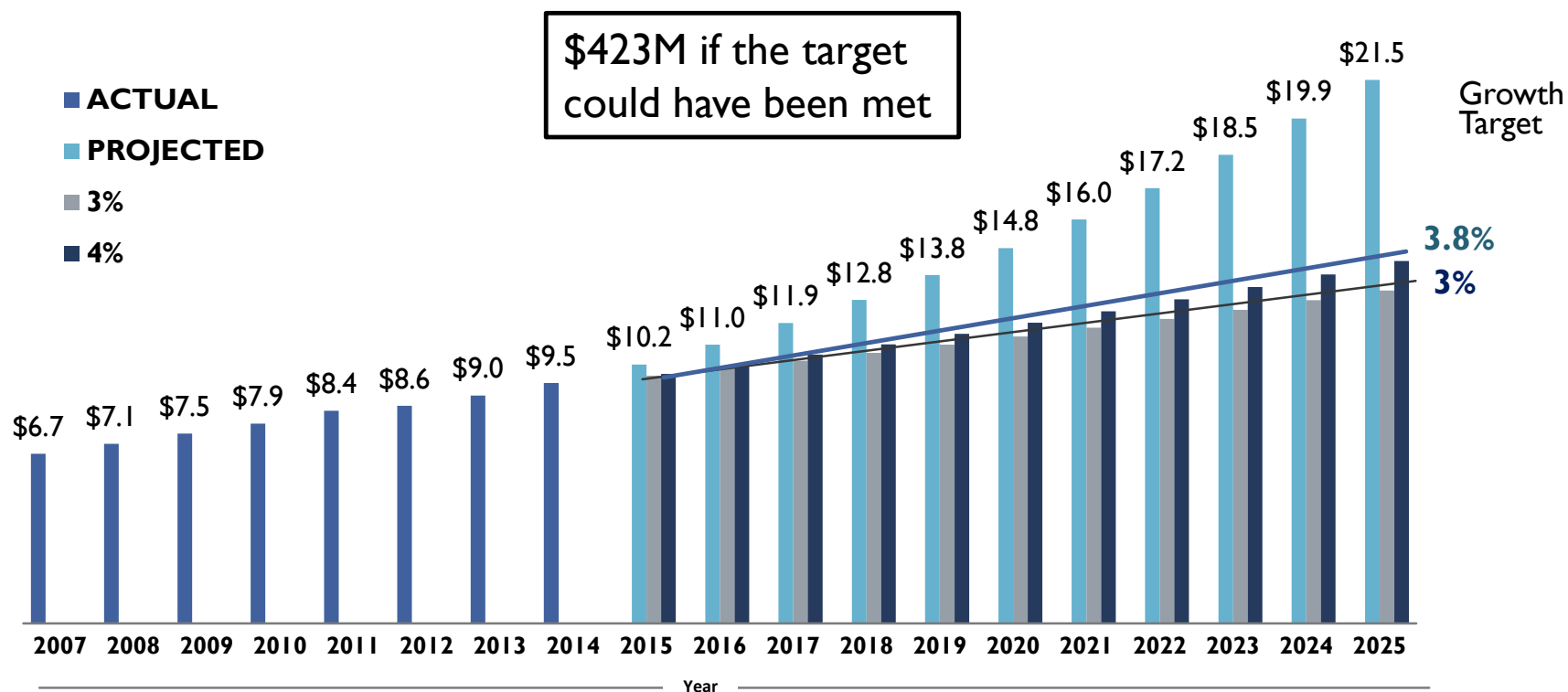


NOTE: District of Columbia is not included.

SOURCE: Centers for Medicare & Medicaid Services, [Health Expenditures by State of Residence](#), CMS, 2017.

DELAWARE'S TOTAL HEALTH SPENDING WILL DOUBLE FROM 2014 TO 2025

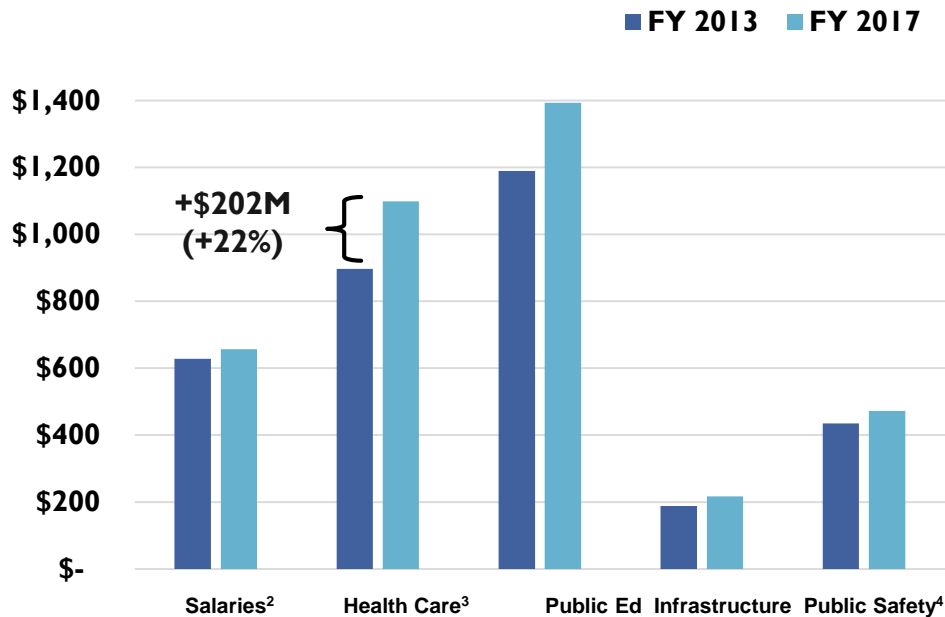
DELAWARE'S ACTUAL AND PROJECTED PERSONAL HEALTH CARE EXPENDITURES, 2007-2025 (BILLIONS OF DOLLARS)



SOURCE: Centers for Medicare & Medicaid Services, *Health Expenditures by State of Residence*, CMS, 2017;

STATE'S INCREASING HEALTH CARE COSTS

DELAWARE GENERAL FUND EXPENDITURES¹, FY2013 VS. FY2017



SOURCE: Delaware Office of Management and Budget; DEFAC Expenditure Reports.

1- Infrastructure funds reported from Transportation Trust Fund expenditures, not General Fund.

2- Salaries are not inclusive of public education salaries.

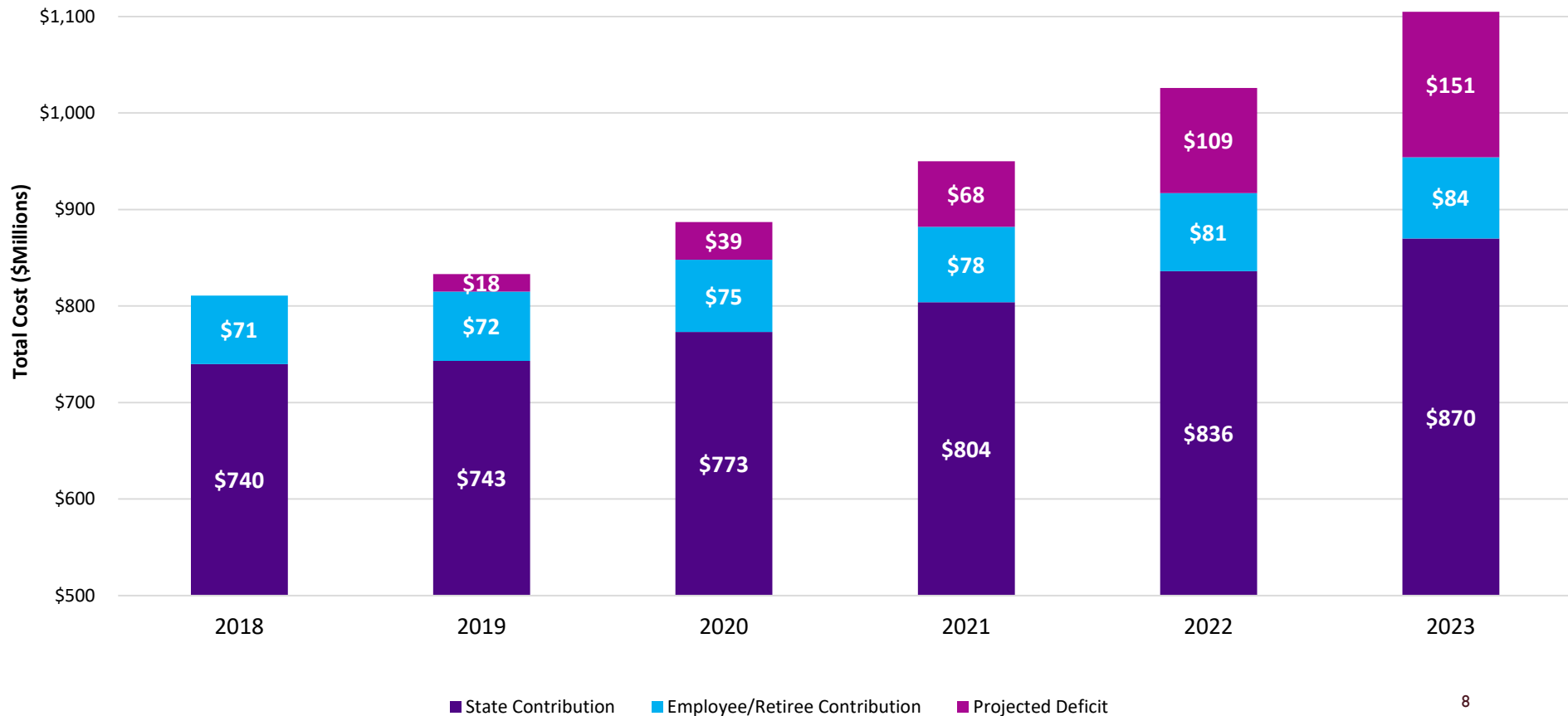
3- Healthcare includes employee health benefit expenditures and Medicaid expenditures.

4- Public safety expenditures include expenditures by DSHS, DOC, and Youth Rehabilitative Services (DSCYF)

- During this same time frame, General Fund revenue collection has grown by just 7.6%.
- Health care costs now account for about **30% of the state's budget**.
- **Crowds out necessary investments in:**
 - Education
 - Public Safety
 - Infrastructure
 - Salaries

DELAWARE'S EMPLOYEE AND RETIREE HEALTH CARE COST PROJECTIONS

Group Health Insurance Plan Projected Cost



HEALTH CARE SPENDING BENCHMARK



Delaware's Benchmark Timeline

Summits (Fall 2017)

6



To explore the benchmark concept with stakeholders

Advisory Council Meetings (early 2018)

7



To discuss parameters for spending and quality benchmarks

Governor's Executive Order (November 2018)

#25

Sets 8 quality benchmarks for 2019 and authorizes state financial council to set spending benchmark

Spending Benchmark Set (December 2018)

3.8%



Delaware Financial and Advisory Council sets spending benchmark for 2019 at 3.8%

Monitoring (2019)

Delaware Health Care Commission tracks spending and quality benchmarks

HEALTH CARE SPENDING BENCHMARK

Mythbusters

House Joint Resolution 7 granted authority to the Department of Health and Social Services to study and plan for a health care spending benchmark. There has been some confusion about what the benchmark is and what it is intended to do. The following clarifies any misperceptions.

MYTH: The benchmark is a cap on spending.

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

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

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

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

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

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

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

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

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

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

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

Send any comments, questions, or concerns to ourhealthde@state.de.us.
Read more about the benchmark at ChooseHealthDE.com.



ChooseHealth
DELAWARE
Improving the state of health

RECAP OF THE BENCHMARKS



Result of legislative impetus, many months of public meetings, interactive discussions and evaluation of other states that took similar action. For more information: <https://dhss.delaware.gov/dhcc/global.html>



Governor Carney's Executive Order 25 (Nov 2018) established the benchmarks. Available at: <https://governor.delaware.gov/executive-orders/eo25/>
Some opportunity for Benchmarks to change over time, in prescribed situations.



The first performance year of the spending and quality benchmarks will be calendar year 2019. First public reports on performance will be fall 2020.

- Benchmarks are set at State level, but performance is reported on at multiple levels.

ANTICIPATED TIMELINE

Tasks	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Receive data from insurers											
Collect data from non-insurers (VHA, DMMA, etc.)											
Create data validation tool											
Validate data and follow-up with insurers											
Create and announce new quality benchmark for opioid and benzo Rx measure											
Analyze TME and quality data											
Create draft public report templates (for 2020 and beyond)											
Publish limited report on CY 2018 baseline data											
Develop strategic plan for stakeholder engagement											
Edit implementation manual and insurer data submission request											

HEALTH CARE SPENDING BENCHMARK: DEFAC SUBCOMMITTEE

The membership of the Subcommittee will include:

- A Chair and Vice-Chair, both of whom shall be members of DEFAC and have health care expertise. Appointed by the DEFAC Chair.
- 3 existing members of DEFAC appointed by the DEFAC Chair.
- 2 members representing health economists, appointed by the Governor.
- 2 members representing quality improvement experts from 2 health care systems or hospitals, which operate in the state, appointed by the Governor.



IMPLEMENTATION MANUAL



Executive Order 25 directed the Department of Health and Social Services (DHSS) to create a **manual** that contains the methodology for the Spending Benchmark and the Quality Benchmarks including where to obtain data to calculate the values of the benchmarks and how to assess performance.

https://dhss.delaware.gov/dhss/files/insurertechbriefng_05162019.pdf



HEALTH CARE SPENDING BENCHMARK

- Provides guidance to restrain growth in health care costs to growth of the State's economy
- Equal to the budget Benchmark Index for CY 2019 established under Executive Order 21 (*based on near term measures of growth in DE personal income, DE population, and inflation in state and local government expenditures*). Now 3.8%
- Thereafter, set by Executive Order 25 at:

2020	2021	2022	2023
3.50%	3.25%	3.00%	3.00%

- Based on the growth of potential gross state product (PGSP) per capita, the long-term sustainable growth rate of the State's economy



PGSP METHODOLOGY

- Per capita Potential Gross State Product (PGSP) is calculated based on average annual long-term expected growth rates (*) as follows:
 - National labor force productivity + Delaware's civilian labor force + National inflation
 - Minus: Delaware's expected population growth
 - Plus: A transitional market adjustment of:
 - 0.5% (2020)
 - 0.25% (2021)
 - 0.0% (2022 and beyond)

(*) *Forecast Years 6 through 10 (CY2024 to CY 2028)*



HEALTH CARE BENCHMARKS: WHAT'S NEXT?

- **By May 31st of each year:** DEFAC will report to the Governor and the Health Care Commission on any changes to the spending benchmark approved by DEFAC.
- **4th quarter of each year:** HCC will report on the performance relative to the spending and quality benchmarks.
- **Ongoing:** HCC will engage providers and community partners in discussion – with the State and each other – about how to reduce variation in cost and quality, and to help the State perform well relative to each benchmark.



Note: Delaware Economic Financial Advisory Committee (DEFAC)
Health Care Commission (HCC)



HEALTH CARE QUALITY BENCHMARKS



HEALTH CARE QUALITY BENCHMARKS

HEALTH STATUS MEASURE	SPECIFICATION	CY 2019 BENCHMARK
Adult Obesity	% of adults with body mass index ≥ 30	30.0%
High School Students Physically Active	% of students with physical activity for ≥ 60 mins a day on five or more days	44.6%
Opioid-related Overdose Deaths	# of opioid-related deaths	16.2 deaths per 100,000
Tobacco Use	% of adults who currently smoke	17.1%

HEALTH CARE MEASURE	SPECIFICATION	CY 2019 BENCHMARK
Concurrent Use of Opioids and Benzodiazepines	% of individuals age 18 and older with concurrent use of opioids and benzos	TBD
Emergency Department (ED) Utilization (Commercial Market only)	# of ED visits for individuals age 18 and older	190 visits per 1,000
Persistence of Beta Blocker Treatment After a Heart Attack	% of individuals age 18 and older who received beta-blockers for 6 months after discharge	82.5% Commercial 78.8% Medicaid
Statin Therapy Adherence for Patients with Cardiovascular Disease	% of at-risk individuals who adhered to medication for $\geq 80\%$ of treatment period	79.9% Commercial 59.2% Medicaid



LINKING STATE EMPLOYEE BENEFITS COMMITTEE AND THE BENCHMARK

With statewide growth trends and quality targets in place, the State Employee Benefits Committee (SEBC) can use these targets as guidelines to develop specific growth trends and quality targets

- Embedded in contracts
- Updated strategic planning targets
- Prioritize benefits design around primary care, emergency department utilization, opioid use, cardiovascular disease prevention
- Consider tobacco cessation, obesity management and cholesterol targets for specific state employees



ADDITIONAL STRATEGIES TO MOVE TO VALUE

- Explore **hospital global budgeting** for rural hospitals
- Included Value based and quality thresholds in our MCO contracts
- Released an **RFI for Medicaid ACO and adult dental coverage**
- Work with **Federally Qualified Health Centers** on alternative payment arrangement model
- Explore **pediatric ACO models** and alternative payment arrangements
- Update **substance abuse payment** to include value based payment
- Support **primary care investments** and monitor primary care spend



Thank You And Questions

Please contact me with any further questions:

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