

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

Submitted by:



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EXECUTIVE SUMMARY

Section 192 of House Substitute 1 for House Bill 275 required the Secretary of Health and Social Services to report on the progress toward 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 imperative we face as a State, highlight recent stakeholder discussions held, examine the experiences of other states in tackling high health care costs and improving quality, and provide five recommended 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 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 the other Mid-Atlantic States (4.3 percent). As several different metrics and state rankings indicate, we also continue to have a population with a higher prevalence of chronic diseases and other poor health indicators when compared with other states.

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, the Delaware Center for Health Innovation, and the Delaware Health Information Network. Efforts such as developing a “Common Scorecard” of quality metrics and preparing providers for participating in value-based care are chief among those accomplishments, which we will leverage as we move forward.

In addition to building upon the expertise developed through the SIM process, we must recognize that Delaware has made significant investment in transitioning to value-based payment models. Overall, 30 percent of Delawareans are attributed to providers participating in value-based payment models and we are the first state in the country to achieve universal participation of the adult acute care hospitals in the Medicare Shared Savings Program. However, to achieve a greater penetration of value-based payment models, we believe that state government needs to partner with stakeholders to create mechanisms that bolster and further accelerate system transformation. As we consider our next steps, we recognize the importance of building upon this developed expertise to help us achieve reduced health care spending and improved quality.

It is common practice among states to study the strategies employed by other states to address vexing policy problems. We hosted benchmark summit meetings, which were open to the public, to provide a forum for discussion and sharing of information and experience between policy makers, physicians, and health plan leaders from several different states. These experts have reiterated that there is no one right solution, but that it is important to continue on a path forward that is developed by and for Delawareans.

That path forward includes five strategies that we believe will reduce Delaware’s health care cost growth and improve our health outcomes. **First, we recommend the establishment of state health care spending and quality benchmarks.** These benchmarks will bring public attention to the rate of

health care spending growth and quality priorities in Delaware. We propose that responsibility for these benchmarks will rest with the Delaware Health Care Commission, and be used to foster transparency of performance and support progress on payment and delivery system reform within the State.

Second, we recommend analyzing and reporting on variation in health care delivery and costs coupled with making useful data available to providers. If we are to truly transform our health care spending, it is important for us to understand what the sources of cost growth are and where there is unwarranted variation in provider cost and care delivery, including of low-value services and avoidable complications. We plan on leveraging the substantial data that will exist within the new Health Care Claims Database and DHIN to produce a standard set of reports that lend insight, including to factors driving performance relative to cost and quality benchmarks.

Third, in order to create heightened provider accountability for managing health care cost growth and accelerate delivery system reform with the Delaware, we will leverage the State's role as a major health care purchaser to implement aligned Medicaid and state employee total cost of care risk-based contracting utilizing alternative payment methodologies and delivery models that share risk and accountability with providers. We will initiate collaborative discussions with internal State partners, providers and managed care networks to develop strategies for risk-based contracting, drawing upon the 2016 Delaware Center for Health Care Innovation Payment Committee's consensus paper "Outcomes-based payment for population health management" as a starting point.

Fourth, strategies to increase the use of risk-based contracting must be paired with support to providers to ensure they can be successful under such models. We will build upon the effort and resources that have been developed through the SIM process on addressing provider readiness to bear financial risk and provide technical assistance to contractors serving our population through risk-based arrangements. This is especially important to support the large number of small practices and solo practitioners to prepare them to participate in these types of arrangements.

Finally, we recommend focusing upon improving the underlying social and economic issues affecting health outcomes by working with stakeholders to develop and implement a strategy that builds upon prior work and existing resources. We recognize that high health care costs and poor health outcomes are only partially the result of current payment and delivery system design, and that social circumstances, environmental and behavioral factors play a large role in health status. It is of utmost importance that our providers have the capability to serve our Medicaid and other disadvantaged populations and be prepared to address a wide range of socioeconomic risk factors, as well as comparatively high prevalence of mental illness and substance use.

While much has been accomplished within our State in terms of raising awareness of our health care spending and the avenues we can pursue to modify our current trajectory, the importance of accelerating these efforts is now 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 health status 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 total cost of care health care spending benchmark aimed at helping our State have the necessary information to make continued progress toward improving health outcomes and reducing unnecessary health care costs. The Secretary of the Department of Health and Social Services (Department) was 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 health care benchmark. The Department received an extension to December 15, 2017 to submit the report. This extension enabled the Department to incorporate comments received from both submitted comments (see Appendix D) and from in-person stakeholder meetings on the preliminary draft version of this report that was released earlier this month.

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.

2

THE IMPERATIVE TO ACT: RELIANCE ON VOLUME-BASED CARE AND AN UNHEALTHY POPULATION

The providers and payers in Delaware are working hard on providing high quality care and delivering services to an aging population in an ever-changing health care environment. Our providers have adapted to the many changes and reforms developed by the federal government and have proven to be nimble with their ability to respond to these external pressures. While these changes have been significant, it is absolutely necessary to take additional bold steps to improve the value of health care provided to Delawareans.

To highlight the importance of continuing to move forward, in recent months the Department has made a concerted effort to publicly document and demonstrate the challenges of higher than average health care costs in our State, along with a delivery system that continues to be supported by volume-based care instead of value or outcomes-driven care. 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.”* This problem is not unique to Delaware as many states are grappling with these problems and are rapidly developing solutions that fit uniquely within their environment, as we too, are doing.

The most recent and comparable estimates of national and all states’ respective spending from the Centers for Medicare & 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)¹

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%

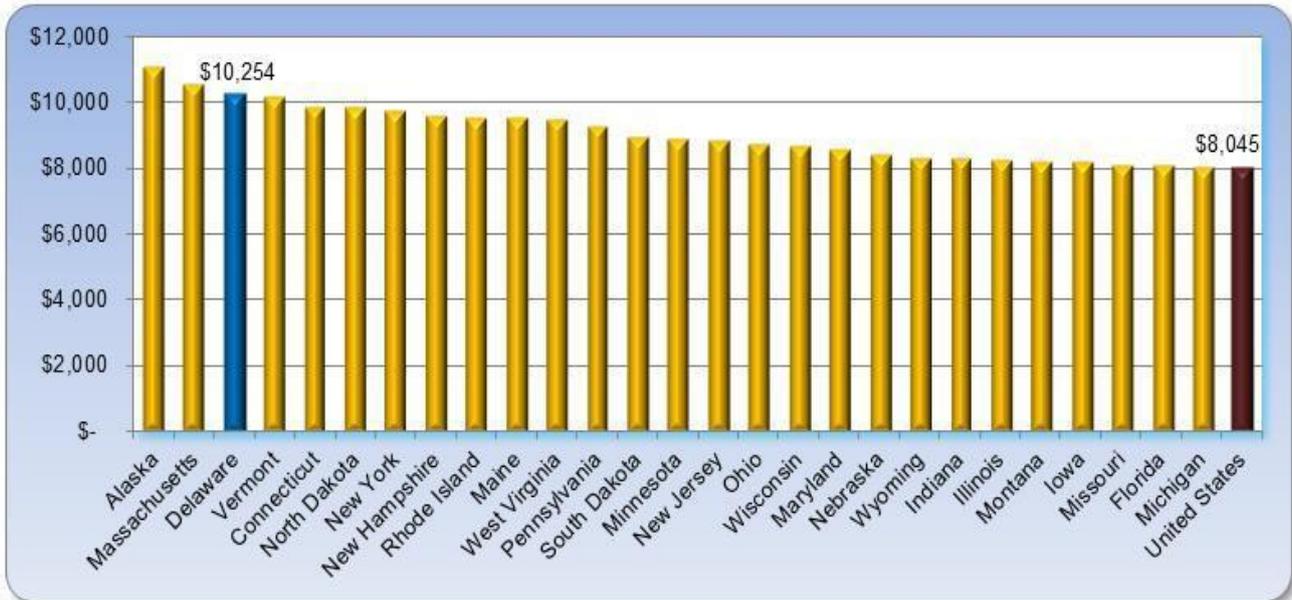
A further review of the CMS expenditure data indicates that each of the major payers/programs in Delaware (e.g., Medicare, Medicaid, private health insurance) have experienced rising health care costs over this 10-year period (see Appendix A, Chart 1). Although this trend is consistent with national 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.

Not only has spending growth been higher in Delaware on the whole, but on a per capita basis, personal health care expenditures are high in Delaware relative to nearly all other states. We are also higher than the national average in nearly all service categories (e.g., hospital, physician/clinical services, pharmacy, nursing care facilities); no single category of spending is driving costs in our State. 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 higher than the national average per capita spending level of \$8,045.

¹ 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 – Average Per Capita Total Health Care Expenditure Ranking in 2014² (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 higher than the US average, higher than the 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).

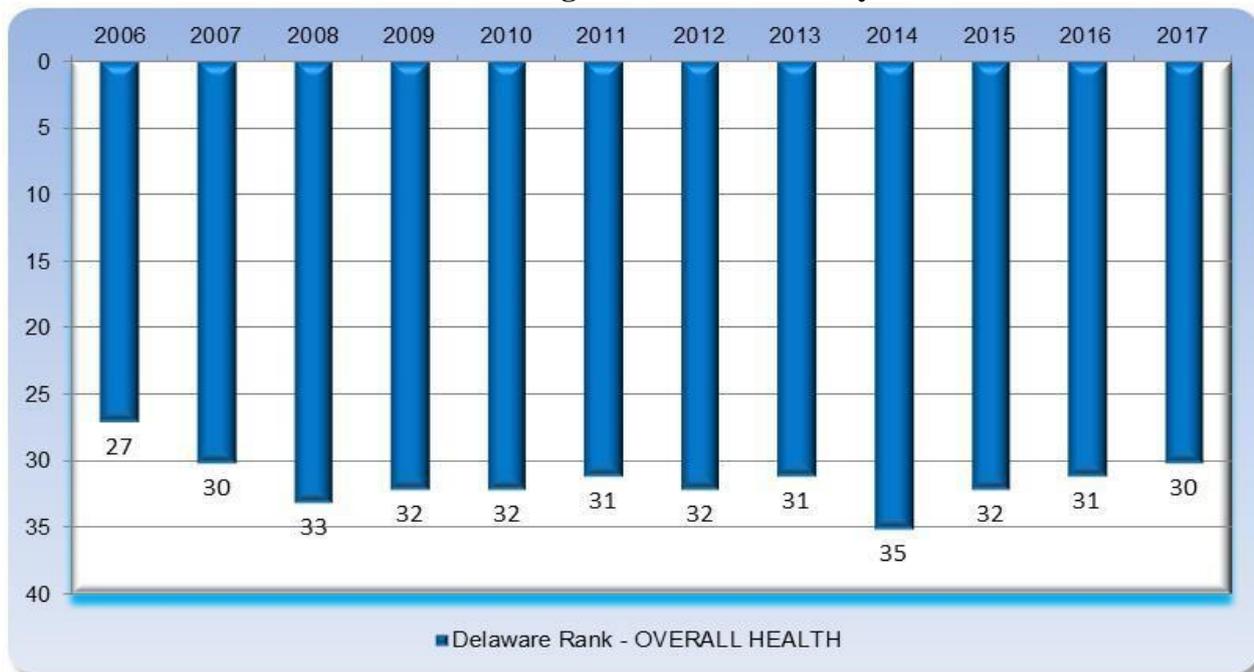
Unfortunately, we not only have high health care costs in Delaware, but we have a population that is behind national averages in terms of health outcomes and overall health status. Additionally, according to US Census Data, our State has a higher percentage of people age 65 and older than the national average — 17.5 percent vs. 15.2 percent. Given that health expenses increase as we age, a larger percentage of seniors in the State creates its own challenges from a spending perspective.

As shown below in Chart 3, Delaware’s overall health ranking has remained approximately 30th in terms of overall health according to America’s Health Rankings (AHR).³ For comparison purposes, for the two states in Chart 2 that are on either side of (i.e., “book-end”) Delaware in terms of having relatively high per capita health expenditures, Massachusetts and Vermont, their respective state rankings on overall health in the 2017 edition were 1st and 3rd.

² Ibid

³ <https://www.americashealthrankings.org/explore/2017-annual-report/state/DE>

Chart 3 – AHR’s Delaware State Ranking on Overall Health by Year



Using the same 2017 AHR report data, a further review of several different measures indicates that while Delaware performed well on a few measures, Immunization-Children and Policy, the more common theme is that Delaware has more opportunity to improve on key health measures. In continuing the comparison of the relatively high per capita expenditure “book-end” states in geographic proximity to Delaware (i.e., the northeast), the rankings of Massachusetts and Vermont are also provided in Chart 4.

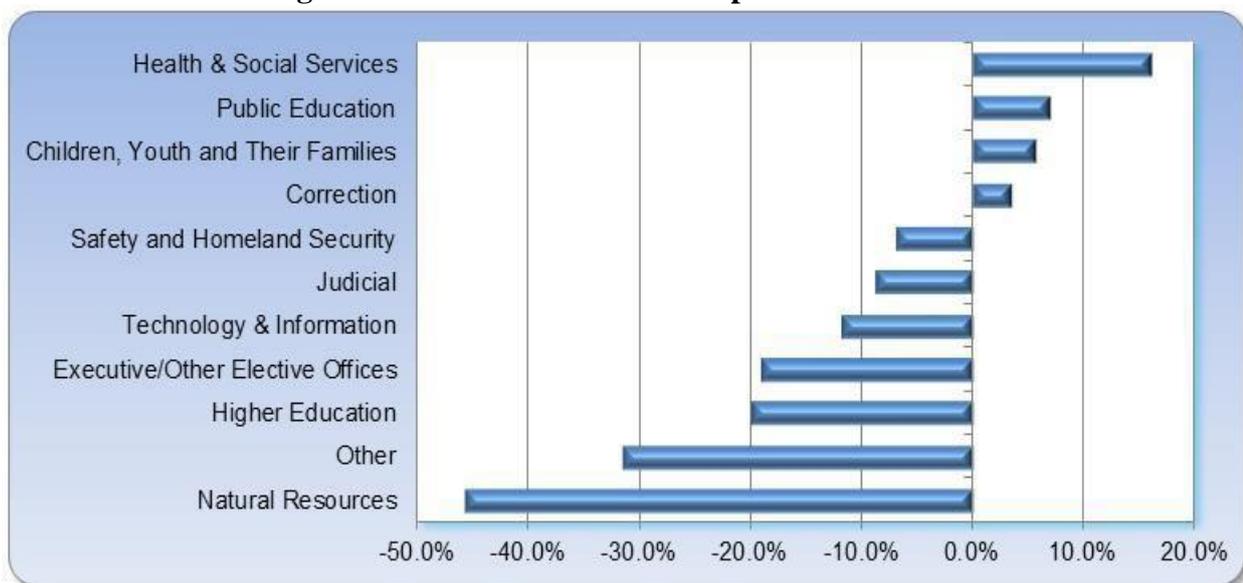
Chart 4 – AHR’s Delaware State Ranking on Select Measures — 2017 Edition⁴

Metric	Delaware Value	Delaware State Rank	Massachusetts State Rank	Vermont State Rank
Drug Deaths (# per 100,000 population)	20.0	40	38	25
Obesity (percentage of adults)	30.7%	27	2	12
Smoking (percentage of adults)	17.7%	27	5	23
<i>All Behaviors (Composite Measure)</i>		<i>30</i>	<i>3</i>	<i>10</i>
Dentists (# per 100,000 population)	44.3	47	1	21
Primary Care Physicians (# per 100,000 population)	156.7	18	2	11
Low Birthweight (percentage of live births)	9.3%	44	19	7
Preventable Hospitalizations (discharges per 1,000 Medicare enrollees)	47.2	23	37	11
<i>All Clinical Care (Composite Measure)</i>		<i>36</i>	<i>1</i>	<i>6</i>
Air Pollution (micrograms of fine particles per cubic meter)	9.1	43	10	3
Children in Poverty (percentage of children)	16.9%	24	5	8
Infectious Disease (chlamydia, pertussis and salmonella)	-0.213	18	9	4
<i>All Community & Environment (Composite Measure)</i>		<i>34</i>	<i>3</i>	<i>2</i>
Immunizations – Children (% of children age 19 mos to 35 mos)	78.1%	4	1	9
Uninsured (% of population)	5.8%	11	1	2
Public Health Funding (dollars per person)	\$107	14	13	8
<i>Policy (Composite Measure)</i>		<i>5</i>	<i>1</i>	<i>2</i>
Cancer Deaths (# per 100,000 population)	197.2	33	18	27
Cardiovascular Deaths (# per 100,000 population)	250.7	28	3	16
Diabetes (percentage of adults)	10.6%	27	14	7
Infant Mortality (deaths per 1,000 live births)	7.9	48	2	5
<i>All Outcomes (All Outcomes)</i>		<i>34</i>	<i>9</i>	<i>14</i>

⁴ ibid

Our high cost of health care in Delaware⁵ 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 goods and services that helps our local economy. Our State government is obligated to perform several important functions, including public safety, promoting economic growth, providing primary and secondary education and supporting community well-being (e.g., housing, social services, and infrastructure). Yet, according to data in the Delaware Fiscal Notebook 2016 Edition,⁶ 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 3), 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 a result, 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 2016⁷



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:

- 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

⁵ 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, 2016 “Final Report of the Delaware Expenditure Committee” available at <https://omb.delaware.gov/documents/delaware-expenditure-review.pdf>

⁶ https://finance.delaware.gov/publications/fiscal_notebook_16/front/greetings.shtml

⁷ Ibid. “Other” includes Legislative, Legal, Finance, Transportation, Labor, State and Other. “Other” represents less than four percent of 2016 general fund expenditures.

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**⁸

- 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**⁹
- 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 Affordable Care Act (ACA). – **October 5, 2017 Delawareonline.com**¹⁰
- Delaware had the 14th 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**¹¹
- "...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**¹²
- 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 Goods¹³.

⁸ <http://delawarestatenews.net/government/state-employees-facing-higher-health-care-costs/>

⁹ <https://news.delaware.gov/2017/09/07/benchmark/>

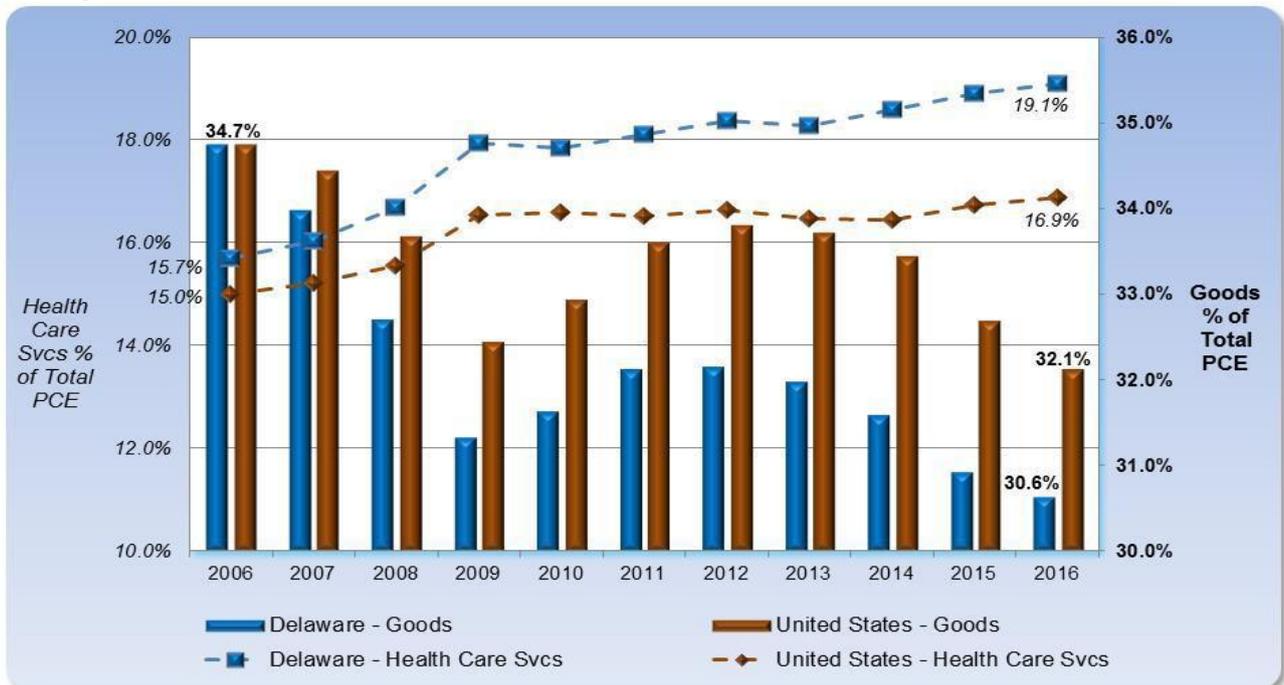
¹⁰ <http://www.delawareonline.com/story/news/health/2017/10/05/highmarks-obamacare-policies-rise-25-percent-delaware/732278001/>

¹¹ <https://www.kff.org/other/state-indicator/employee-plus-one-coverage/?dataView=0¤tTimeframe=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%22colId%22:%22Employee%20Contribution%22,%22sort%22:%22desc%22%7D>

¹² See reference #9

¹³ www.bea.gov, Total Personal Consumption Expenditures (PCE) by State (millions of dollars)

Chart 6 – Percent of Total PCE on Health Care Services versus Good — 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 11.3 percent and a little less than the 13.4 percent average of other Mid-Atlantic States (see Appendix A, Chart 4).
- 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 5)

3

EXAMPLES AND LESSONS FROM OTHER STATES

A. SUMMARY OF BENCHMARK SUMMIT MEETINGS

It is common practice among states to study the strategies employed by other states to address vexing policy problems. For this reason, 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 toward reducing health care costs.
- 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.

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.¹⁴ 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 expenditures¹⁵ 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*,¹⁶ reported at annual hearings¹⁷ and in consultants' conversations with providers and insurers that the cost growth benchmark has become a starting point for insurer and provider negotiations.

Oregon: In 2009, Oregon 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

¹⁴ 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.

¹⁵ 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).

¹⁶ www.bostonglobe.com/business/2016/09/07/health-care-spending-mass-again-exceeds-target/7HvYRD1RGxeJAe3nFTsIEL/story.html

¹⁷ www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/annual-cost-trends-hearing/2016/

- 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 trends.¹⁸ 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.

C. 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

¹⁸ Vermont All-Payer ACO Model Fact Sheet. <https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/>

- 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.

4

FIVE STRATEGIES TO REDUCE DELAWARE HEALTH CARE COST GROWTH AND IMPROVE HEALTH OUTCOMES

A. ESTABLISH STATE HEALTH CARE SPENDING AND QUALITY BENCHMARKS

Three years ago, CMS awarded Delaware a State Innovation Model (SIM) grant to achieve five state-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, the Legislature directed study and planning toward implementation of a health care spending benchmark to provide essential focus and momentum for system transformation. The Department recommends that the health care spending benchmark be complemented with a small number (e.g., three to five) health care quality benchmarks to support a twin focus on cost and quality. Additionally, the Department proposes that responsibility for the benchmarks will rest with the Delaware Health Care Commission, after passage of enabling legislation and/or regulations.

Rationale: Creation of a statewide health care spending benchmark will bring public attention to the rate of health care spending growth in Delaware, as will quality benchmarks bring focus to important quality priorities. A spending benchmark will also foster transparency of payer and provider performance of managing health care cost growth. Such transparency should inform and support progress on payment and delivery system reform within the State.

Delaware precedence: In 1977, Delaware created the Delaware Economic and Financial Advisory Council (DEFAC) for providing objective, non-partisan guidance to the Governor, his or her cabinet, and the General Assembly on current and future revenue and expenditure projections for the State. DEFAC projections have become the foundation for any economic analysis in Delaware, and DEFAC is a trusted and almost-universally accepted source of economic information.

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.¹⁹

Other states have since adopted health care spending benchmarks in the form of agreements with CMS. Vermont²⁰ 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 2018.²¹ Cost growth benchmark conversations have been ongoing in Rhode Island.²²

Implementation steps: The Department has identified the following specific process for benchmark design and implementation.

1. *Convene a stakeholder body to advise State design of the benchmark methodology, prior to legislative enactment of the benchmarks.* 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.
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 and stakeholder body will draw upon precedence and lessons from other states, since there is not an analogous process in Delaware. 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.²³
4. *Identify top state quality improvement priorities and associated measures.* With many quality improvement opportunities and hundreds of available quality measures, it will be necessary to identify those opportunities of highest importance to Delaware. It will also be important to confirm that validated measures exist, ideally with external-to-Delaware benchmarks that can inform performance assessment.

¹⁹ Cutler D. “The Massachusetts Target on Medical Spending Growth” *NEJM Catalyst*, May 6, 2016.

²⁰ <https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/>.

²¹ <https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/>

²² Salit R. “R.I. task force calls for limits on health care spending” *Providence Journal*, December 1, 2015.

²³ Brown EF and King J. “The Consequences of *Gobeille v. Liberty Mutual* for Health Care Cost Control” *Health Affairs Blog* March 10, 2016.

5. *Identify the source(s) of data and analytic resources.* The calculation of a health care spending benchmark needs well-defined, complete and accurate data sources and analytic resources to assess health care spending. Ideally, the Department will be able to leverage the Delaware Health Care Claims Database²⁴, currently under development by the Delaware Health Information Network (DHIN), as a data source and use a similar approach as the Delaware Economic and Financial Advisory Committee to examine data and trends. So, too, will data sources will need to be identified for the quality benchmarks. The DHIN may serve as a source for these data as well. It will be necessary to identify resources to perform the types of analyses required to support the benchmarks. Delaware payers will need to provide the data necessary to report on the cost and quality benchmarks.
6. *Determine units of measurement.* There will be multiple policy decisions before the benchmarks can be put into place. The first involves the units of measurement. In addition to statewide measurement of total cost of care and quality indicators, the State could measure costs per enrollee for Medicare, Medicaid, state employee/retiree health plans, and commercial insurers. Additionally, large health systems, medical groups and ACOs also appear to be natural units of measurement, which is the current practice in Massachusetts.
7. *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., health economists, actuaries) who should annually advise the State on benchmark setting.
8. *Link spending benchmark and quality benchmark performance.* While establishing the health care spending benchmark is a top priority, the Department will explore with stakeholders how to appropriately supplement the spending benchmark with a limited, but critical 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 DHIN, the Delaware Center for Health Innovation's (DCHI) Clinical Committee, and State payers, Delaware is now producing a "Common Scorecard" of quality metrics. Selected Scorecard measures could serve as a quality benchmark companion to a cost benchmark.
9. *Amend statutory authority for the Delaware Health Care Commission (DHCC) to clarify sources for the data to determine the benchmark, allow publishing of the benchmark, and maintenance of necessary analytic resources.* Such statutory authority will confirm the Legislature's desire to have benchmarks produced on an ongoing basis, and ensure that the adequate and necessary data and technical expertise is available to the Delaware Health Care Commission and the DHIN.

²⁴ 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 #5, baseline total cost of care will be calculated at the State level and at the applicable unit-of-measurement level (Step #6). Having completed this task, the selected economic index (Step #7) will be applied as a multiplier to the baseline calculation to establish the benchmark for the State. A similar process, but without applying an economic index multiplier, will be needed for the health care quality benchmarks targeted at leading health care and health improvement priorities.
11. *Identify additional strategies to support the benchmark.* After the experience of calculating and reporting on the benchmarks, the Delaware Health Care Commission will identify additional strategies to support the benchmark and its ability to help improve the performance of the Delaware health care system.

B. 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 cost²⁵ and care delivery, including of low-value services and avoidable complications. Transparency of this information is required for delivery system improvement and provider performance accountability and should be an adjunct to the benchmarking process if policy makers are to receive the most benefit from the benchmark analysis.

Supporting evidence: Analysis of cost and quality variation was critical to motivating and informing Massachusetts' reforms²⁶ 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 DHIN's clinical data. Best practice nationally, such as the MyHealth Access Network²⁷ in Oklahoma and the Michigan Health Data Collaborative²⁸, integrates claim and clinical data for reporting purposes.

²⁵ 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.).

²⁶ "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

²⁷ <http://myhealthaccess.net/>

²⁸ <https://www.michigandatacollaborative.org/>

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, care where equally effective lower cost alternatives exist, and care that is proven to produce little benefit or harm) and comparing cost and quality for standard episodes of care, including both procedural and non-procedural care. Nationally, initiatives like Choosing Wisely²⁹ and Smart Care California³⁰ 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.³¹ These analyses must be timely and will need to be available to the public so that providers can make use of them.

C. IMPLEMENT MEDICAID AND STATE EMPLOYEE TOTAL COST OF CARE RISK-BASED CONTRACTING UTILIZING ALTERNATIVE PAYMENT METHODOLOGIES AND DELIVERY MODELS THAT SHARE RISK AND ACCOUNTABILITY WITH PROVIDERS

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.³² 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).³³ 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 third-party administrator for employee benefits and interested providers in discussions regarding how best to implement risk-based contracting strategies with providers through the State’s contractors. The discussion will draw upon the 2016 DCHI Payment Committee’s consensus paper “Outcomes-based payment for population health management,”³⁴ and its design principles for total cost of care contracts, as a starting point.

²⁹ www.choosingwisely.org/

³⁰ www.iha.org/our-work/insights/smart-care-california

³¹ <http://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/Episodes/HowtoReadYourReport.pdf>

³² Kahneman, D. & Tversky, A. (1992). "Advances in Prospect Theory: Cumulative Representation of Uncertainty". *Journal of Risk and Uncertainty*. 5 (4): 297–323.

³³ 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.

³⁴ www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Consensus-Paper-On-Outcomes-BasedPayment.pdf

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 2016.³⁵
 - b. Consider how best to align with Medicare’s ACO and federal Medicare and CHIP Reauthorization Act (MACRA) 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 percent 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 value-based 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. If done under the parameters set forth in MACRA, such a contracting strategy could increase Delaware’s providers’ ability to receive additional funds from Medicare.
 - 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.

D. SUPPORT CARE TRANSFORMATION AND PRIMARY CARE

Rationale: Placing financial and clinical responsibility for cost containment and quality on entities like ACOs will prove unsuccessful if providers lack the tools to transform care delivery. While

³⁵ www.youtube.com/watch?v=vD2GiY1EtzE

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 provider organizations are to operate at the level of best practice entities nationally, including addressing the specific needs of disadvantaged populations.

Supporting evidence: Providers face significant challenges in assuming clinical and financial responsibility for population health and total cost of care.³⁶ 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, Oregon³⁷ 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.*³⁸ During 2016 and 2017, the State contracted with practice transformation vendors³⁹ to support primary care providers across Delaware to transform their practices. Four vendors have supported practice transformation and have engaged one-third of the primary care clinicians in the State. As a complement to practice transformation, another vendor provided a learning and re-learning curriculum for practitioners seeking to develop the skills and capabilities required to coordinate care effectively. The State paused these activities while we worked with our stakeholders to develop the recommendations outlined in this report. We believe there is opportunity to reinvest and expand these activities that were started under SIM to engage additional providers, including more primary care providers and to add specialty care providers. This is especially important to support the large number of small practices and solo practitioners to prepare them to participate in risk-based arrangements.
2. *Provide technical support specific to providers serving the Medicaid population.* Delaware's largest health systems have experience serving the Medicare population under ACO contracts. They have been developing core functions, including population health management, data analytics and quality improvement programs for this purpose.⁴⁰ However, employed and Medicaid populations have differing needs, challenges and opportunities for improvement and thus require distinctive strategies (e.g., integrating behavioral health care).

³⁶ Pearl R. "The 4 Biggest Obstacles ACOs Face" *Forbes*, August 14, 2014.

³⁷ The Oregon Health Authority operates a transformation center expressly for this purpose. See www.transformationcenter.org. Other states, including Massachusetts, Minnesota and Vermont have provided technical assistance to risk-assuming providers through technical assistance and grants.

³⁸ 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.

³⁹ The vendors include MedAllies, Remedy Healthcare Consulting, the New Jersey Academy of Family Physicians and the Medical Society of Delaware/HealthTeamWorks.

⁴⁰ <https://christianacare.org/forphysicians/qualitypartners/>, www.bayhealth.org/physicianalliance, www.umusa.net/umaco-for-patients.html#whatisACO, www.aledade.com/de/ and www.decarecollaboration.com/.

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

Rationale: High health care costs and poor health outcomes 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.⁴¹ Delaware providers have identified social and environmental health factors as a priority topic for attention. This is true for Medicaid and other disadvantaged populations, where our contractors need 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.⁴² Ironically, Delaware has been limited in the past in investing in these services because high health care spending has pre-empted (i.e., “crowded-out”) the ability to fully invest in these very areas which could reduce our health care spending in a positive and rewarding cycle. Potential thus exists for Delaware to re-balance over time our finite resources to create a more sustainable, diverse and robust system of care and supports.

Supporting evidence: Increasing evidence points to the impact that strengthened social and environmental supports — and especially housing — have on health care spending.⁴³ States, including Iowa, Michigan, Massachusetts,⁴⁴ California, Minnesota, Vermont and Washington, are giving attention to social determinants in their payment and delivery reforms and/or through cross-sector collaborations called Accountable Communities for Health (ACH).⁴⁵ Provider organizations nationally are increasingly also addressing social determinants of health.⁴⁶

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 initiative⁴⁷) and current provider activity.

⁴¹ 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.

⁴² Bailit M and Waldman B. “Safety-Net Provider ACOs: Considerations for State Medicaid Purchasers” Robert Wood Johnson Foundation, Princeton, NJ, January 2016.

⁴³ 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.

⁴⁴ 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.

⁴⁵ “Using Medicaid Levers to Support Health Care Partnerships with Community-Based Organizations” Partnership for Health Outcomes Fact Sheet, October 2017.

⁴⁶ Hussein T and Collins M. “The Community Cure for Health Care” *Stanford Social Innovation Review* July 21, 2016.

⁴⁷ 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.

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. *Empower 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. The focal point of this work continues to be the DCHI Healthy Neighborhoods' initiative because it involves both public, private, and non-profits leaders, along with key community leaders. Topics should continue to 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.
4. *Continue focus on educational and economic opportunities.* Given the impact of social determinants on the health of Delawareans, efforts in Delaware that drive quality education for all, educational attainment, and the creation of jobs that pay a living wage will be key to helping combat high health care costs and ensuring that all Delawareans are able to be healthy and prosperous throughout their lives.

5

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 and responded to 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:

- **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 DCHI 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.
- **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 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. Strategies for accelerating payment reform and developing health care benchmarks must consider these special populations in developing an effective measure.

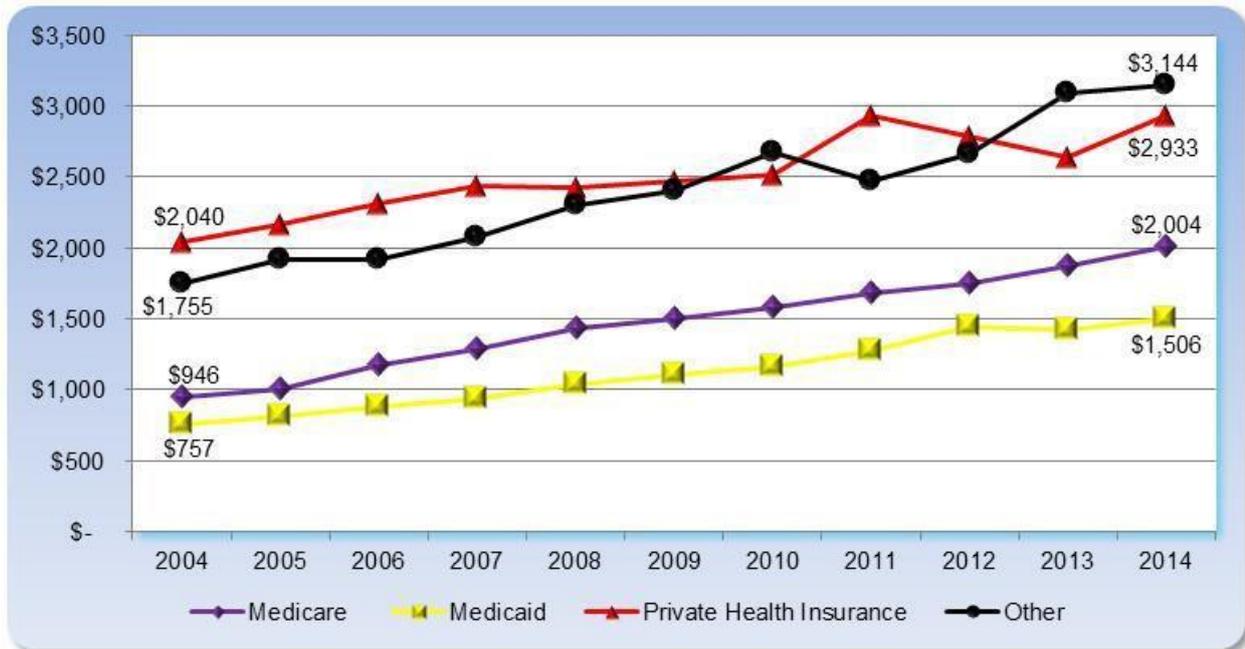
- **Consider the factors that make Delaware unique:** Delaware’s demographics and population health are key drivers of both spending and growth in spending. Delaware’s population is older and is aging faster than the national average, forecasted to be the tenth oldest state by 2025.⁴⁸ Additionally, Delaware 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.
- **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, to ensure that adequate providers exist to support the population’s health needs. It may be time to consider whether the small number of providers in the pipeline is due to a gap in investment, or whether it is time to focus investment 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, especially those who are trained in addiction medicine.
- **Do not forget small towns and rural areas:** The physician landscape is fairly fragmented; and over 75 percent of physicians (and almost 80 percent of primary care physicians) are in practices of five physicians or fewer, creating challenges for implementing value-based payment arrangements. 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.

⁴⁸ Defined by percent of population over age 65. U.S. Census Bureau, Population Division, Interim State Population Projections, 2005

APPENDIX A

SUPPLEMENTAL CHART PACK

CHART 1 – GROWTH IN TOTAL DELAWARE PERSONAL HEALTH CARE EXPENDITURES BY PAYER/PROGRAM (IN MILLIONS OF DOLLARS) ⁴⁹



⁴⁹ 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 ⁵⁰

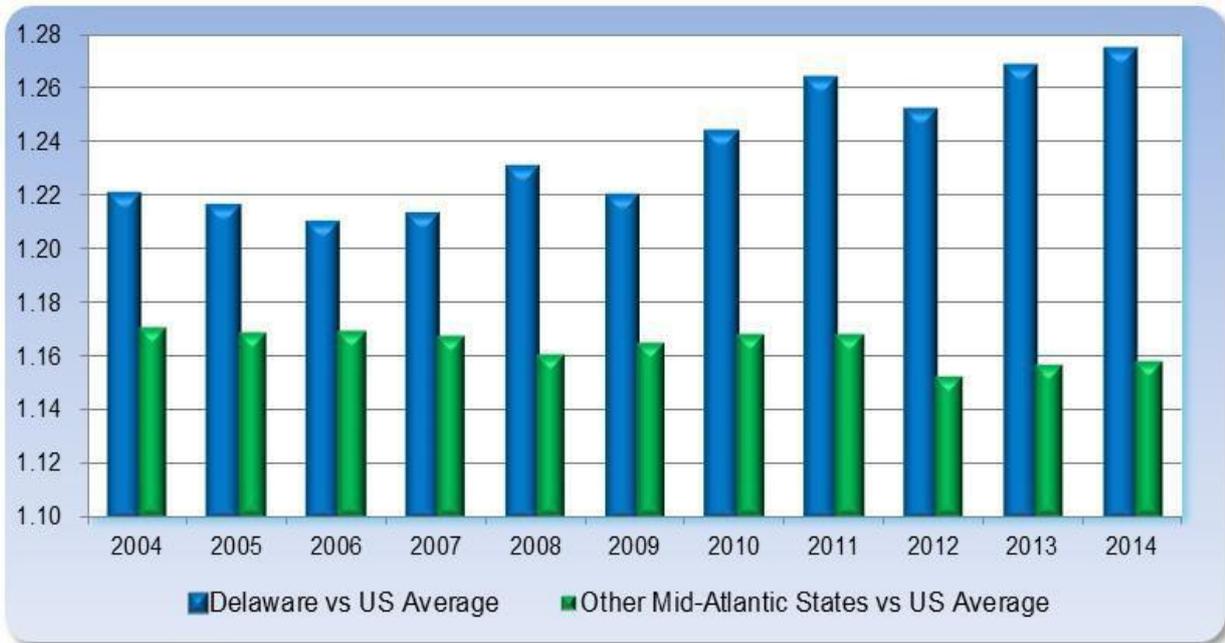
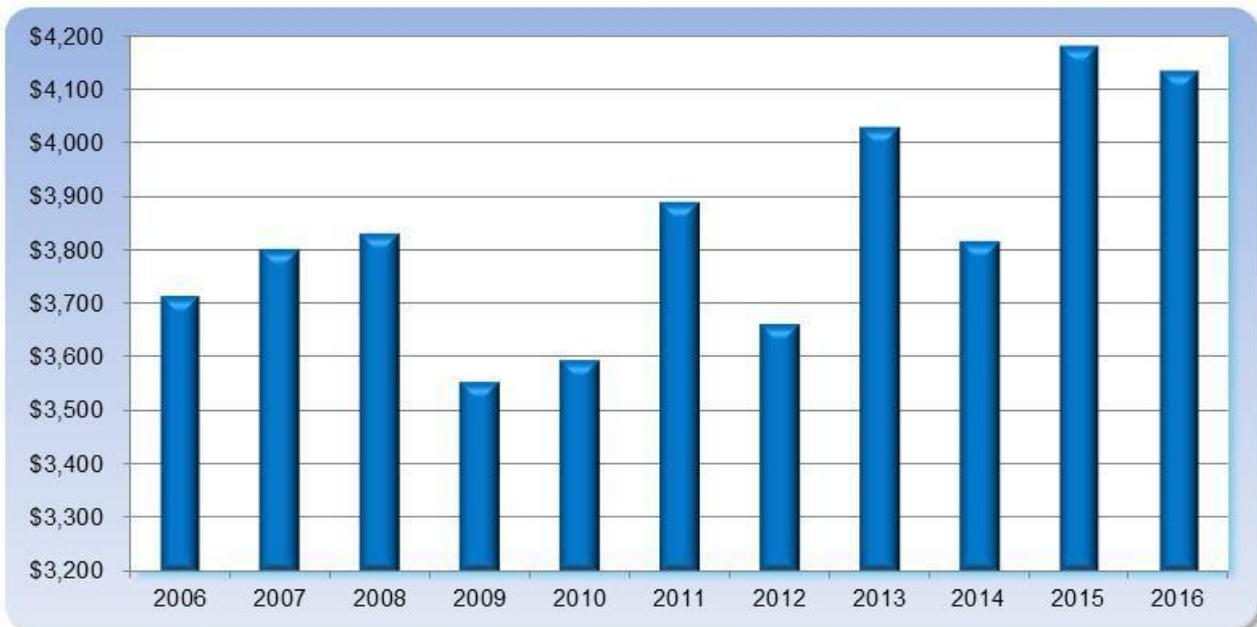


CHART 3 – PER CAPITA DELAWARE GENERAL FUND REVENUES (NOT ADJUSTED FOR INFLATION) ⁵¹



⁵⁰ Ibid.

⁵¹ https://finance.delaware.gov/publications/fiscal_notebook_16/front/greetings.shtml

CHART 4 – PERCENT OF TOTAL EMPLOYMENT IN HEALTH CARE AND SOCIAL SERVICES INDUSTRY⁵²

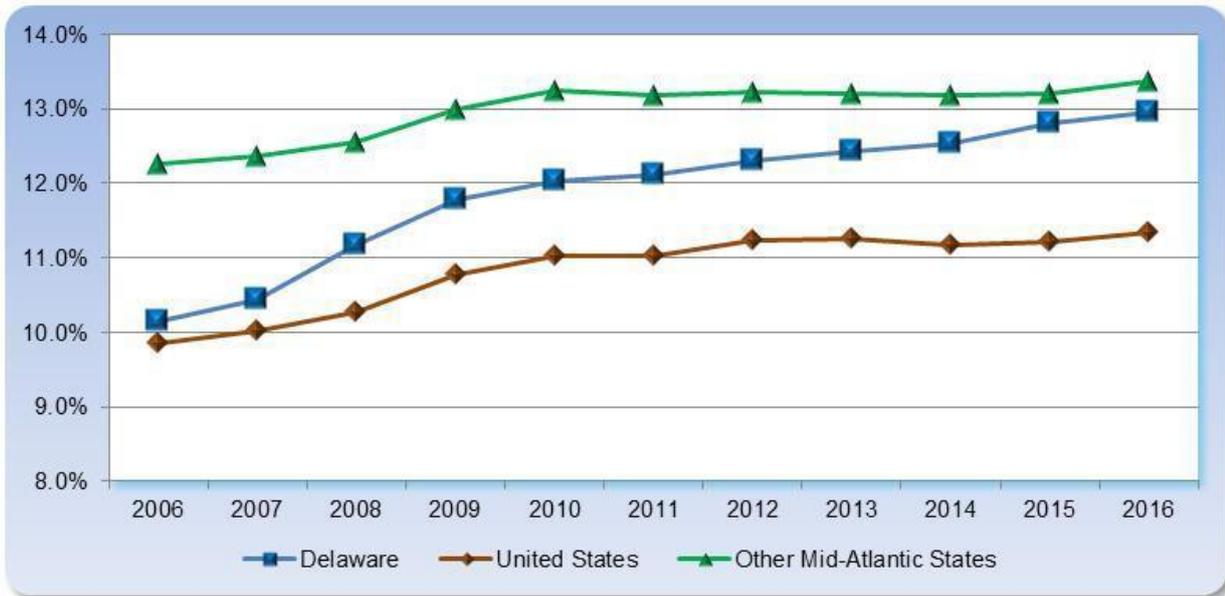
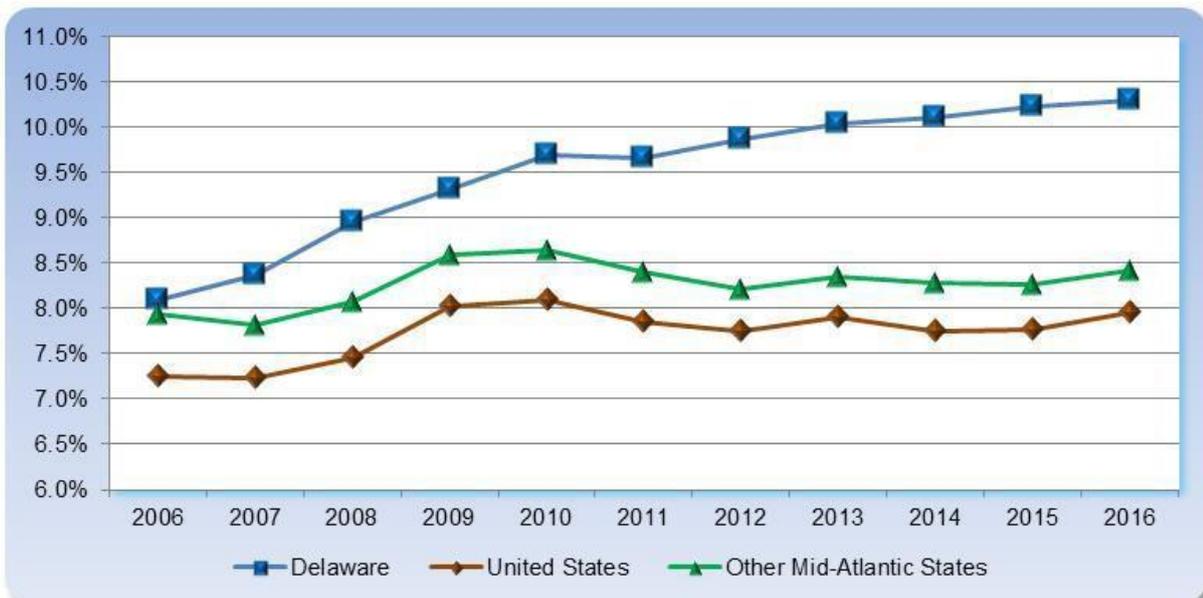


CHART 5 – PERCENT OF TOTAL PERSONAL INCOME FROM HEALTH CARE AND SOCIAL SERVICES INDUSTRY⁵³



⁵² Bureau of Economic Analysis, SA25N Data, <https://www.bea.gov/itable/iTable.cfm?ReqID=70&step=1#reqid=70&step=1&isuri=1>

⁵³ 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 Pravis 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: **Matt Swanson (DCHI)**
- **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 the closing date for comments on the Road to Value paper which was November 13, 2017. These comments are available at: <http://dhss.delaware.gov/dhss/valuecomments.html>.

The Department’s response to these comments is available at: <http://dhss.delaware.gov/dhcc/files/roadtovalue.pdf> and the updated version of the Road to Value paper is available at: <http://dhss.delaware.gov/dhcc/files/delawareroadtovalue.pdf>

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
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

APPENDIX D

DRAFT BENCHMARK LEGISLATIVE REPORT COMMENTS

The following table provides a list of comments received and posted on the Department’s website as of the closing date for comments on the draft benchmark legislative report which was December 11, 2017. These comments are available at:

<http://dhss.delaware.gov/dhss/dhcc/legislativereport.html>

Comments By	Submitted Date
Christiana Care Health System	12/11/2017
Timothy E. Gibbs, MPH	12/11/2017
Highmark Delaware	12/11/2017
Medical Society of Delaware	12/11/2017
Debbie Hamilton, Hamilton Goodman Partners LLC	12/11/2017
Delaware Academy of Family Physicians	12/11/2017
Erin J. Goldner, Person in Long-Term Recovery from Opioids and Alcohol	12/11/2017
Deborah Zarek, MD, FACP	12/08/2017
Robert Ferber, MD Seaford, Delaware	12/08/2017
Jonathan M. Kirch, Government Relations Director, Delaware and Philadelphia State and Local Advocacy	12/08/2017

Additionally, on Tuesday, December 5, 2017, the Department held a series of stakeholder meetings to solicit in-person feedback on the draft version of the report. The following table lists individuals invited and whether they attended.

Invitee	Organization	Attended?
Ann Phillips	Delaware Family Voices	
Barry Dahlloff	Christiana Care Health System	Y
Beth Mineo	UD Center for Disabilities Studies	
Bettina Riveros	Christiana Care Health System	Y
Bob Chadwick	Acting President NCCo Chamber	
Brenda Lakeman	State Employee Health	
Cathy McKay	Connections	
Cindy Bo	Nemours	Y
Dave Ricci	St. Francis Medical Center	
Debbie Hamilton	Pharma Task Force/Chronic Disease	Y

Invitee	Organization	Attended?
Dr. James Gill	American Academy of Family Physicians	Y
Dr. Jane Lee	DHIN	Y
Dr. Janice Nevin	Christiana Care Health System	Y
Dr. Nancy Fan	Delaware Health Care Commission	Y
Dr. Prayus Tailor	Delaware Medical Society	Y
Dr. Roy Proujansky	Nemours AI duPont Hospital	Y
Elizabeth Romero	DSAMH	
Emily Vera Coggin	Mental Health Association in Delaware	Y
Jeff Taschner	Del State Education Assn	
Jeffrey Fried	CEO of Beebe Healthcare	Y
John McNeal	State Council of Persons with Disabilities	Y
Josh Thomas	NAMI Delaware	
Judy Diogo	President of Central Delaware Chamber of Commerce	
Julane Miller-Armbrister	DCHI	Y
Kathy Janvier	Delaware Tech	
Ken Sklenar	Easterseals	Y
Lindsay Ashkenase	Delaware Association of Family Physicians	Y
Lolita Lopez	Westside Family Healthcare	Y
Lynn Fahey	Brandywine Counseling	
Mark Thompson	Medical Society of Delaware	Y
Mary Finn	St. Francis Hospital	Y
Matt Swanson	DCHI	Y
Meredith Tweedle	Christiana Care Health System	Y
Mike Begatto	Delaware Public Employees AFSCME	
Mike Jackson	OMB	
Mike Matthews	Delaware State Education Association	
Pat Maichle	Developmental Disabilities Council	
Paul Kempkinski	Nemours AI duPont Hospital	
Rep. David Bentz	Chairman, DE House Health & Human Development Committee	
Rep. Melanie Smith	JFC Co-Chair	
Rich Heffron	Delaware State Chamber	
Rita Landgraf	UD College of Health Sciences	Y

Invitee	Organization	Attended?
Sen. Bryan Townsend	Chairman, DE Senate Health, Children & Social Services Committee	
Sen. Harris McDowell	JFC Co-Chair	
Sheila Grant	AARP Delaware	
Steve Rose	Nanticoke Memorial Hospital	Y
Susan Conaty-Buck	President-Elect Nurse Practitioners	Y
Terri Hancharick	Governor's Commission	Y
Terry Murphy	President and CEO of Bayhealth	Y
Thomas Cook	Ability Network of Delaware	Y
Timothy E. Gibbs	Delaware Academy of Medicine/DE Public Health Association	N
Tom Brown	Nanticoke Memorial Hospital	Y
Verna Hensley	Easterseals	Y
Wayne Smith	Delaware Healthcare Association	Y
Yrene Waldron	Delaware Health Care Facilities Association	Y

APPENDIX E

GLOSSARY OF TERMS

- **Accountable Care Organization (ACO):** A general term for a type of health care entity, not a payment method. ACOs are provider-led organizations of groups of doctors, hospitals, and/or other health care providers who come together voluntarily to provide coordinated health care services to their patients. ACOs are often paid using value-based payment strategies or a combination of value- and volume-based payment strategies and can be stand-alone entities or operate in collaboration with an MCO.
- **All-Payer:** A term used to broadly describe a health care purchasing strategy/methodology where all payers such as Medicare, Medicaid, commercial insurers and private insurers participate/pursue similar purchasing goals/strategies.
- **Centers for Medicare & Medicaid Services (CMS):** The Centers for Medicare & Medicaid Services is a federal agency that is part of the U.S. Department of Health and Human Services. CMS oversees many healthcare programs including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.
- **Economic Index:** An economic index is a statistical measure of changes in a representative group of individual data points. These data points may be derived from any number of market-based sources, including company performance, prices, productivity, and employment.
- **Episodic/Episode of Care Payment:** A payment strategy for which health care providers are paid an overall sum for all services to treat a given condition, or, to provide a given treatment (e.g., knee-surgery with follow-up care, pregnancy/birth) over a defined period of time, rather than being paid for each individual treatment, test or procedure. Comparable terms include global payment, package pricing, case rate or bundled payment.
- **Downside Risk:** A reference to a payment strategy where the provider shares, participates in or has accountability for losses/excess costs. While payment strategies may contain a mix of upside and downside risk, a provider has the financial risk associated with losses when it has taken on downside risk.
- **Health Care Marketplace/Exchange:** Another term for the Health Insurance Marketplace, a service available in every state that helps individuals, families, and small businesses shop for and enroll in affordable medical insurance. The Marketplace is accessible through websites, call centers, and in-person assistance.
- **Health Care Quality Benchmark:** A targeted level of performance on measures of quality process and outcomes.

- **Health Care Spending Benchmark:** A per capita growth target on the total cost of care for a defined population.
- **Managed Care Organization (MCO):** A general term for a health care management entity, which can be formed by a provider/hospital group or other legal business entity that manages/coordinates the care of enrolled members and establishes a network of providers which the MCO pays per negotiated contracts. MCOs are often risk-bearing entities that receive a capitation (fixed) payment for fulfilling their contractual obligations. Payment to an MCO can include value-based elements as well.
- **Medical Expenditure Panel Survey (MEPS):** The Medical Expenditure Panel Survey (MEPS) is a set of large-scale surveys of families and individuals, their medical providers, and employers across the United States.
- **Patient-Centered Medical Home (PCMH):** A health care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.
- **Per Capita:** Means “per person”. For example, in a calculation the numerator (e.g., dollars) is divided by total number of people to express dollars on a per capita basis.
- **Risk:** The uncertainty of future events and how events can determine or influence the potential for a positive or negative outcome.
- **Shared Savings:** A payment strategy where the payer (e.g., insurer) and provider share in a percentage of the difference (i.e., savings) between the forecasted and actual cost of care. This refers to a payment strategy where payer and provider share only if savings occur (i.e., upside risk only). If actual costs are higher than expected, no sharing applies, but the provider is not accountable for the overages. Shared savings arrangements often incorporate quality/outcome measures as a condition for a provider to receive any shared savings payment, or to adjust the amount of savings a provider is eligible to receive.
- **Social Determinants of Health/Socioeconomic Factors:** Factors or conditions related to where a person is born, lives, works and ages. Factors like these can impact the amount of health care needs, health quality or health outcomes a person experiences. Includes factors such as education, provider availability/access to care, employment status, income, living conditions, food access, transportation, violence, health literacy, social support systems and language.
- **Total Cost of Care:** A numerical value for a defined set of health care services that will take into consideration all defined costs (e.g., payments to providers, deductibles, copays). Typically includes all services such as hospital care, professional care, pharmaceuticals, medical equipment, behavioral health care, long term care and other services for a specific population group or individual.

- **Value-Based Care/Value/Value-Based Payment:** A general reference to a health care payment method that links provider reimbursement to improved performance/outcomes. This can include bundled/episodic payments, shared savings, capitation or other forms of payment. Payment is linked to, dependent on or has an element related to quality/outcome measures and often times also linked to cost performance.
- **Upside Risk:** A reference to a payment strategy where the provider shares, participates in or has accountability for gains/savings. While payment strategies may contain a mix of upside and downside risk, a provider has the financial risk associated with gains when it has taken on upside risk.
- **Volume-Based Care/Fee-For-Service:** A general reference to a health care payment method where providers are reimbursed based on the number (i.e., volume) of services (e.g., tests, days, visits) rendered. The more services rendered the more providers are paid. Often used to describe fee-for-service payment processes which do not typically factor in any quality/outcome measures in determining payment amount.