



# CHRISTIANA CARE HEALTH SYSTEM

---

To: Kara Odom Walker, MD, Secretary  
Delaware Department of Health and Social Services  
By Email to: OurHealthDE@state.de.us

From: Christiana Care Health System

Date: December 11, 2017

**RE: Comments on DHSS Preliminary Draft Health Care Spending Benchmark Legislative Report**

---

Thank you for the invitation to comment on the preliminary draft “Health Care Spending Benchmark Legislative Report” dated December 1, 2017 (the “Report”<sup>1</sup>). While this submission summarizes our initial feedback compiled in a relatively compressed timeline, we also appreciate the indication that DHSS will accept further written comments on the final draft Report that DHSS is required to submit to the General Assembly on December 15, 2017, and we look forward to commenting in more detail on the final submission. We also look forward to commenting on the forthcoming revised *Road to Value* White Paper.

**I. The Report reflects the ongoing need to develop a better shared understanding of Delaware’s current health care cost and quality status.**

We respectfully submit that there continues to be a disconnect between the speed at which policy solutions are being developed, and the apparent gap in understanding of the most recent, accurate data reflecting health care quality and costs in Delaware—data that will help to identify genuine opportunities to bend the cost curve. We will not reiterate all of the points made in Christiana Care’s written comments to the “Road to Value” document, but note that the continued citation of the “3<sup>rd</sup> highest” 2014 CMS ranking fails to account for the discrepancies in the 2014 data, including

---

<sup>1</sup> Delaware Department of Health and Social Services (DHSS), *Preliminary Draft, Healthcare Spending Benchmark Legislative Report*, Dec. 1, 2017, <http://dhss.delaware.gov/dhcc/global.html>.

the distinction between aggregate and per capita costs (with aggregate reflecting a higher insured population, Delaware's Medicaid expansion, and the higher degree of general access to care in our state). The state references to per capita spending levels and 27% higher costs are also inexplicable given that Delaware's annual compound growth for Medicare, Medicaid, and commercial payers are below the US average for 1991-2014 (Medicare, Medicaid) and 2001-2014 (commercial) and the FY2014 spending per enrollee is only 4.3%, 1.6% and 5.6% higher, respectively, than the national average during those periods.<sup>2</sup>

The continued reliance on the 2014 CMS data also fails to reflect data from the past three years, which is the time period during which Delaware has made the most significant steps toward adopting value-based payment models. Stating that the stakeholder-led DCHI model has failed to progress at a sufficient pace<sup>3</sup> without fully understanding data trends, including more current data from the past three years, carries a significant risk of developing an incomplete solution for an incorrectly defined problem.<sup>4</sup>

We again raise these concerns and discrepancies in the hope that we can partner together to develop a shared understanding of the data - and a true picture of health care costs – to effectively develop solutions to lower the health care cost trend in Delaware while ensuring access to high quality care for all Delawareans.

**a. The Report cites inaccurate hospital safety metrics, underscoring the need to develop a better shared understanding of reliable data.**

As other comments have noted, the citation of the Leapfrog rankings is very troubling, particularly when the rankings are cited without any accompanying context

---

<sup>2</sup> Data from Centers for Medicare & Medicaid Services, Health Expenditures by State of Residence 1991–2014, Tables 23, 26 and 29; <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.

<sup>3</sup> See Report p. 17 (“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”).

<sup>4</sup> It is also important to make sure there is time to review, as part of developing a shared understanding of the relevant data and potential areas of discrepancy, the different data points submitted by stakeholders in response to the requests to comment on this Report, the White Paper, and other written products of these discussions.

about their significant limitations. It is also troubling that the Report cites<sup>5</sup> the Leapfrog ranking of Delaware hospital safety as a justification for the Report's recommended policy focus on hospital costs, with far less discussion of the role of other system players—including payers, pharmaceutical companies, and non-hospital facilities—as major contributors to the State's rising health care costs.

To be clear, the Leapfrog rankings are aggregate rankings based on a grade point average formula that does not resemble a grade point average calculation formula that one would find in any standard academic setting. In the Leapfrog rankings, the student (or, in this case, state) whose respective hospitals receive one "A" and five "F" grades (a 0.67 GPA on a standard 4.0 scale) generates a higher state ranking than a state with six hospitals that each receive a "B" grade (a 3.0 on the standard 4.0 scale). Leapfrog's unusual methodology has been criticized and discredited in reputable medical journals, which have noted, among other issues, the tendency of the Leapfrog rankings to give the lowest grades to hospitals that treat the sickest patients, as well as high volume hospitals, and hospitals that may not accurately self-report.<sup>6</sup> We are concerned that the draft Report lacks sufficient context to be making these characterizations, and particularly concerned that there was no effort made to contact the hospitals before this harmful and misleading statement about Delaware hospital safety was made in a public document. The Leapfrog statement also did not address the points made in Christiana Care's White Paper comments about all of the other rankings showing high quality and safety of Christiana Care and other institutions in Delaware. Attached as **Appendix A** to this document is additional information on Christiana Care's Leapfrog rankings trends over the past few years (reflecting how minor differences in scoring can account for the difference in grades, which can

---

<sup>5</sup> See Report p. 8 ("As stated previously, according to the CMS data, hospital services represents the largest part of our total health care expenditures. This means we should take a closer look at this important segment of our health care system. This is especially relevant when according to the Fall 2017 Hospital Safety Grade rankings by The Leapfrog Group of the six hospitals included in the survey, none of our hospitals received an 'A grade'").

<sup>6</sup> Smith, Shawna N. PhD\*; Reichert, Heidi A. MA; Ameling, Jessica M. MPH\*; Meddings, Jennifer MD, MSc, *Dissecting Leapfrog: How Well Do Leapfrog Safe Practices Scores Correlate With Hospital Compare Ratings and Penalties, and How Much Do They Matter?* MEDICAL CARE: June 2017 - Volume 55 - Issue 6 - p 606–614, available at: [http://journals.lww.com/lww-medicalcare/Citation/2017/06000/Dissecting\\_Leapfrog\\_How\\_Well\\_Do\\_Leapfrog\\_Safe.10.aspx](http://journals.lww.com/lww-medicalcare/Citation/2017/06000/Dissecting_Leapfrog_How_Well_Do_Leapfrog_Safe.10.aspx). See also *Study Finds Hospital Ranking Flaws*, Rush University, <https://www.rushu.rush.edu/news/study-finds-hospital-ranking-flaws>.

impact an entire state’s “percentage of A grade” ranking), as well as a list of additional quality and safety rankings and awards that presents a more complete picture of the health care that Christiana Care provides to Delawareans.

We appreciate the commitment to ongoing stakeholder dialogue as a critical component of developing the shared understanding that many stakeholders feel has been incomplete in the data and policy proposals released to date.

**II. We should not “teach to the test” in assuming that the benchmark is a necessary or efficient solution to bending the cost curve, and should continue to explore other alternatives for achieving the State’s budgetary and health outcomes goals.**

The stakeholder discussions around the benchmark proposal have generally been based on the premise that the benchmark is the solution around which policies should be developed, without full consideration of whether the benchmark is a necessary or sufficient step to achieving the underlying policy objectives. As the benchmark concept represents a new direction not previously considered in Delaware, it is important to consider the context and timing of the proposal, as well as potential policy implications and alternatives.

**a. The Report Overstates the Degree of Policy Consensus Reflected in HJR 7 and the Benchmark Proposal**

We are deeply concerned about the draft Report’s characterization of the authority vested in the DHSS Secretary in House Joint Resolution No. 7 as a conclusive legislative determination that a benchmark (perhaps with an accompanying governing structure as may be determined by DHSS) will be the primary vehicle for controlling health care costs in Delaware for the foreseeable future. For example, the draft Report notes that “[d]uring the 2017 legislative session, *Delaware decided* that the path forward was to create a health care spending benchmark to provide essential focus and momentum for system transformation.”<sup>7</sup> It is important to keep in mind that HJR7 was introduced at 8:14 p.m., with rules suspended to avoid committee hearings, on what was supposed to be the final evening of the 2017 legislative session, as part of a behind-closed-doors compromise negotiated by legislative leadership to move

---

<sup>7</sup> Report p. 17 (emphasis added).

forward on the state's budget.<sup>8</sup> HJR 7 was the last-minute product of a compromise by legislative leadership that was apparently designed (with support from the Governor's Administration) in part to avoid setting up a public and transparent stakeholder process that was contemplated in Senate Concurrent Resolution Number 36 (which ultimately did not pass). SCR 36 would have established a Health Care Spending Task Force, with stakeholder participation in open meetings, "to produce comprehensive solutions for reducing the cost growth trend in the State's health care spending while promoting and preserving access to high quality, affordable healthcare for all Delawareans."<sup>9</sup> A House Joint Resolution only carries the force of law during the General Assembly during which it is passed.<sup>10</sup> It is not a permanent change to Delaware law, and is more appropriately characterized as authorization to evaluate and plan for a benchmark—with stakeholder input on *whether*, as well as *how*, a proposed benchmark should proceed. If there is, in fact, a true commitment to transparency and collaboration, the option of a full stakeholder process similar to the one contemplated by SCR 36 should be re-examined in the upcoming legislative session.

While we realize that task forces are an imperfect and over-utilized tool in Delaware public policy, the failure to adopt SCR 36 led to an assumption that the benchmark reflected a far greater understanding of Delaware's cost drivers, and of appropriate solutions, than we believe is actually the case based on what has been presented to date. We cannot over-emphasize the critical need to develop a better factual picture of where we currently stand as a state, before we commit to major government restructuring initiatives and potentially significant government control over a far greater degree of health care business operations than has ever been previously contemplated in the State of Delaware.

---

<sup>8</sup> See also A. Kimberly Hoffman, Joshua H. Meyeroff, Andrew B. Wilson, *Delaware Healthcare Industry Update: July 18 2017*, <https://www.morrisjames.com/blogs-morris-james-de-jure-delaware-healthcare-industry-update-july-2017>

"Addressing these costs became a major point of negotiation between the various budget factions. Ideas on exactly how to address the issue were many, as shown by competing task force resolutions: HCR49 (Wilson) and SCR36 (Townsend) and House Joint Resolution 7 (Longhurst). Rather than move forward on a delineated task force, the legislature opted to instead pass HJR 7 which empowers the Department of Health and Social Services to undergo a process of benchmarking the cost of care in consultation with the many health stakeholders in the state."

<sup>9</sup><https://legis.delaware.gov/json/BillDetail/GenerateHtmlDocument?legislationId=26119&legislationTypeId=3&docTypeId=2&legislationName=SCR36>

<sup>10</sup> See DELAWARE LEGISLATIVE DRAFTING MANUAL Ch. 5 § 1 (2015) p. 51 ("Resolutions are legislative vehicles that enable the General Assembly to express itself rather than to amend the Code... A resolution is effective only during the existence of the General Assembly which promulgates it. Thus, a resolution purporting to take effect during a future General Assembly or to continue the spending or appropriating of money in subsequent General Assemblies is expressing only a desire, with no authority to enforce compliance.")

We also need to thoroughly consider the potentially negative consequences for Delawareans of the implementation of the current DHSS proposal without a more accurate understanding of our current status. These potential consequences include compromising continued access to high quality services (especially for at-risk populations), threatening continued Medicaid eligibility and benefits, and ensuring that Delaware has sufficient health care providers to meet the needs of our population, including those serving the Medicaid population. Additionally, as noted in the draft Report, nearly 70,000 Delawareans are employed in the health and social services industry and health care services are presently a major and growing segment of the Delaware economy, especially given the influx of retirees to Delaware.

**b. The “necessary complementary strategies to the benchmark” identified in the draft Report should perhaps be the primary focus of State policy leaders, as opposed to the Benchmark itself.**

The “necessary complementary strategies” identified in Section 5 of the draft Report appear, at least based upon our initial review, to be more appropriately described as potential primary areas of policy focus for the State, as opposed to focusing the time and resources that will be needed to compile data and establish a supporting infrastructure to implement a benchmark, particularly the following (on which we will comment in more detail in response to the final Report):

- “Develop an aligned contracting strategy ... across Medicaid and State employee purchasing, recognizing real differences in covered populations and covered services... we should initially focus on programs/delivery systems that we have more direct control and influence over.” (Report p. 23)
- “Convene a stakeholder body to develop a strategy [on social determinants of health] (Report p. 26)

**Conclusion**

While we have different ideas about some of the policy and data points, no one disputes the State’s need to address rising health care costs, nor do we dispute the need to better align our health care delivery system to the acute health care and social support needs of many Delawareans. We are committed to caring for our community, improving the health of the populations we serve, and ensuring continued access to high quality health care that our neighbors value. We look forward to further opportunities to collaborate with the State and other health care stakeholders on appropriate and realistic paths forward.

## Appendix A

# Leapfrog Hospital Safety Grade: Fall 2017



## Healthgrades - Clinical Quality Awards

100 Best Hospital awards are given in 11 specialty areas to the hospitals in the top 5% or 10% of the nation. There must be at least 100 hospitals in the top 10% for an award to be made.

### 2018, 2017, 2016 America's 100 Best Hospitals for:

- **Gastrointestinal Care Award** – superior outcomes (mortality & complications) in bowel obstruction treatment, colorectal surgeries, gallbladder removal, esophageal/stomach surgeries, treatment of gastrointestinal bleeds, pancreatitis treatment and small intestine surgeries.
- **General Surgery Award** – superior outcomes (mortality & complications) in bowel obstruction treatment, colorectal surgeries, gallbladder removal, esophageal/stomach surgeries and small intestine surgeries.
- **Joint Replacement Award** – superior outcomes (complications) in knee and hip replacement.
- **Orthopedic Surgery Award** – superior outcomes (complications) in back & neck surgery, spinal fusion, hip fracture treatment, total hip & total knee replacement
- **Pulmonary Care Award** – superior outcomes (mortality) in treating chronic obstructive pulmonary disease (COPD) and pneumonia.
- **Spine Surgery Award** - superior outcomes (complications) in back & neck surgery and spinal fusion.
- **Stroke Care Award** – superior outcomes (mortality) in care and treatment of stroke.
- **Cranial Neurosurgery Excellence Award** – superior outcomes (mortality) for cranial neurosurgery.
- **Critical Care Excellence Award** – superior outcomes (mortality) in pulmonary embolism treatment, respiratory system failure treatment, sepsis treatment and treatment of diabetic emergencies.
- **Neurosciences Excellence Award** – superior outcomes (mortality) stroke care and neurosurgery.