HEALTH CARE COSTS AND SPENDING IN DELAWARE
A Review of the Evidence and Proposed Approach to Payment Reform
June 2017
OVERVIEW

• The Impact of Rising Health Care Costs in Delaware
• Where Health Care Dollars Go
• Drivers of Spending Growth
• Variations in Spending
• Proposed Solution
• Next Step
Background on Health Care Spending in Delaware

- Health care spending per capita in Delaware is higher than the national average. Historically, health care spending has outpaced inflation and the state’s economic growth. Health care costs consume 25% (or approximately 1 billion in FY 2017) of Delaware’s budget. Medicaid cost per capita and the growth in per capita spending have been above the national average. These challenges are not unique to Delaware – affordability is of equal concern to private employer sponsors of Commercial health insurance, as well as some consumer segments who have seen increases in deductibles, copays, and coinsurance.

- Delaware’s demographics and the percentage of our citizens with chronic conditions are key drivers of both spending and poor health outcomes. Delaware’s population is older and is aging faster than the national average – we will be the tenth oldest state by 2025. We are also sicker than the average state, with higher rates of chronic disease, in part driven by social determinants including poverty, food scarcity, and violence. In the most recent publication of America’s Health Rankings, Delaware ranked 31st, exceeding the national average in cancer deaths per capita, cardiovascular deaths per capita, diabetes per capita, infant mortality, and premature death.

- 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. Our hospital systems vary widely in both scale as well as operational efficiency. Primary care and some other physician specialties remain fairly fragmented. Other physician specialties are concentrated. Behavioral health care is in short supply in some parts of the state.

- Increased demand for health care, as well as inefficiencies in the supply of health care, in combination lead to 25% greater historical spend per capita than the U.S. as a whole, which itself has among the highest cost health care systems in the world. While we spend more on care, our investments have not led to better health or outcomes for Delawareans. We spend more than average, not to get better access or higher quality care, but simply to address the challenges of an older and sicker population.

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The Increasing Costs of Health Care Squeeze Out Other Public Spending Priorities

DELAWARE STATE BUDGET, FY2010 VS. FY2016

STATE SPENDING (BILLIONS OF DOLLARS)  
- Health Care Coverage (State Employees; Medicaid)  
- Salaries  
- Pensions  
- Debt  
- Infrastructure  
- Capital Outlay  
- Grants  
- Contractual Services

+$480M (+42%)

SOURCE: Delaware Office of Management and Budget; DEFAC Expenditure Reports; general funds
Per Capita Costs in Delaware $8,480 per person
Delaware Spends More on Health Care than Most Other States

PER CAPITA PERSONAL HEALTHCARE EXPENDITURES, 2009

NOTE: District of Columbia is not included.
Total Health Spending Will Double from 2009 to 2020

ACTUAL AND PROJECTED DELAWARE TOTAL PERSONAL HEALTH CARE EXPENDITURES, 1991-2020
(BILLIONS OF DOLLARS)

SOURCES: Centers for Medicare & Medicaid Services, Health Expenditures by State of Residence, CMS, 2011;
Medicare and Medicaid Account for Nearly 40% of Delaware’s Health Spending

**TOTAL PERSONAL HEALTH EXPENDITURES BY PAYER IN DELAWARE, 2009 (MILLIONS OF DOLLARS)**

- **Medicare** $1,512 (19%)
- **Medicaid** $1,106 (18%)
- **Private/Other** $4,879 (63%)

All Payers in Delaware Have Experienced Significant Spending Growth

These numbers reflect total increases in spending, resulting from both increasing enrollment, especially in Medicaid, and higher per capita spending.

TOTAL PERSONAL HEALTH EXPENDITURES BY PAYER IN DELAWARE, 1991-2009 (MILLIONS OF DOLLARS)

<table>
<thead>
<tr>
<th>Year</th>
<th>PRIVATE/OTHER</th>
<th>MEDICARE</th>
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Total Growth Rates by Payer Have Been Similar Since 1991

Though private spending accounts for the majority of health care costs in Delaware, all types of payers had similar growth rates from 1991 to 2009:

- **Private/Other** average annual growth rate, 1991-2009: **7.7%**
- **Medicare** average annual growth rate, 1991-2009: **8.5%**
- **Medicaid** average annual growth rate, 1991-2009: **10.0%**

*Source: Centers for Medicare & Medicaid Services, Health Expenditures by State of Residence, CMS, 2011.*
ACA Health Reform Did Not Escalate the Trend in Health Care Cost Growth

Delaware health insurance premiums have long been higher than the national average. Private premiums have actually grown more slowly than the national average. With wages stagnant, health care costs consume more of workers’ budgets.

NOTE: Data for 2007 is inferred from the average of 2006 and 2008, as data for this year is unavailable.
WHERE THE HEALTH CARE DOLLARS GO — SPENDING AND COST GROWTH BY TYPES OF HEALTH CARE SERVICES
The Distribution of Total Spending by Type of Service Is Similar for Delaware and the U.S. as a Whole
Per Person Spending in Delaware Is Higher than the National Average in Every Category of Service

United States and Delaware Per Capita Spending by Service, 2009

- **Hospital Care**: $3,109 (United States), $2,475 (Delaware)
- **Physician and Clinical Services**: $2,078 (United States), $1,650 (Delaware)
- **Drugs and Other Medical Nondurables**: $1,219 (United States), $956 (Delaware)
- **Nursing Home, Home Health, and Other Personal Care**: $1,337 (United States), $1,069 (Delaware)
- **Dental and Other Professional Services**: $672 (United States), $551 (Delaware)
- **Medical Durables**: $114 (United States), $166 (Delaware)

Spending on Hospitals and Nursing Homes Makes Up the Majority of the Difference Between Delaware and the U.S.

CONTRIBUTION TO DIFFERENCE IN DE AND U.S. SPENDING BY SERVICE, 2009

- Hospital Care: 41.8%
- Physician and Clinical Services: 17.4%
- Drugs and Other Medical Nondurables: 3.1%
- Medical Durables: 0.2%
- Dental and Other Professional Services: 6.2%
- Nursing Home, Home Health, and Other Personal Care: 31.3%

DRIVERS OF COST GROWTH IN DELAWARE
UTILIZATION: Delaware Residents Use the Emergency Room Slightly More than U.S. Residents Overall

HOSPITAL EMERGENCY ROOM VISITS PER CAPITA IN DELAWARE AND IN THE U.S. OVERALL, 2009 (ADMISSIONS PER 1,000 RESIDENTS)

Delaware: 491
U.S.: 440

DIFFERENCE: 11%

SOURCES: Kaiser State Health Facts, with data from the American Hospital Association Annual Survey and U.S. Census.
UTILIZATION: Adjusting for Age, Sex, and Race, Medicare Beneficiaries in the Last Two Years of Life Are Slightly Above Average for Use of Inpatient Hospital Care

HOSPITAL CARE INDEX FOR BENEFICIARIES IN THE LAST TWO YEARS OF LIFE, BY STATE, 2003-2007

NOTE: The Hospital Care Intensity Index is computed by comparing each hospital’s utilization rate, which is based on the number of days patients spend in the hospital and the number of times they visit a physician, with the national average and adjusting for age, sex, race, and severity of illness.

PROVIDER AND SERVICE MIX: Delaware is above average for all States in Total Physicians and Specialists Per Capita

Delaware has more physicians per capita, and also more specialists per capita, than many other states. Research finds that regions with more total physicians tend to spend more on health care than other regions, and that states with a higher proportion of specialists also tend to spend more on health care.

SPECIALISTS AS A SHARE OF ALL PHYSICIANS BY STATE, 2006 (PHYSICIANS PER 100,000)

NOTE: Physician counts are estimated from rates and population and are not exact. DC is excluded.

Moving forward with global health care benchmark
Current situation

- Health care costs consume ~25% of DE’s state budget, with significant current year deficit
- Total Delaware Medicaid spending was ~$2.0B in Fiscal Year 2015, with ~$1.2B coming from federal government
- DE’s average Medicaid Per Member Per Year (PMPYs) and growth trends are above the national average for most eligibility categories
- DE State health purchasing currently accounts for nearly twice as many lives as many other states
- DE’s individual marketplace received ~$90M in federal support (subsidies and cost sharing reductions)

Sensitivity table of potential cost savings

<table>
<thead>
<tr>
<th>Savings from percent cost reduction</th>
<th>$M</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1%</td>
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<tr>
<td>Funding base</td>
<td></td>
</tr>
<tr>
<td>State Medicaid funding</td>
<td></td>
</tr>
<tr>
<td>($788M)</td>
<td>8</td>
</tr>
<tr>
<td>State funding for State employees</td>
<td></td>
</tr>
<tr>
<td>($762M)</td>
<td>8</td>
</tr>
<tr>
<td>Total State health care spending</td>
<td>80</td>
</tr>
<tr>
<td>($8B)</td>
<td></td>
</tr>
</tbody>
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1 Health and Human Services accounted for 28.6% of expenditures in FY2015 (DE Expenditure Review Committee report); 2 Budget presentation FY 2017
3 MACPAC; 4 FY2013 (MACPAC); 5 2000-2011 for full benefit enrollees only (KFF)
6 ASPE reports monthly funding amount, which are annualized using a factor of 11.33 average member months (2015 MLR Report)
7 2015 (MACPAC); Medicaid spend breakdown by eligibility category in FY2011 is as follows: 14% aged, 32% individuals with disabilities, 35% adult, and 20% children (KFF)
8 Estimated for FY2017 by multiplying average PEPY by # of enrolled employees (FY17 Q1 Quarterly Financial Report)
9 Growth trend for individuals with disabilities is below national average

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Total Health Spending Will Double from 2009 to 2020

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SOURCES: Centers for Medicare & Medicaid Services, Health Expenditures by State of Residence, CMS, 2011;
### Considerations for level of impact across models

<table>
<thead>
<tr>
<th>Percent of healthcare spending</th>
<th>Potential impact in success case</th>
<th>Factors affecting level of impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total cost of care</strong></td>
<td>60-70% of Medicaid* 90-100% of Medicare and Commercial</td>
<td>50-150 basis points of trend mitigation</td>
</tr>
<tr>
<td><strong>Bundled payments</strong></td>
<td>20-40% of spend in top 10-30 episodes of care</td>
<td>200-400 basis points of trend mitigation for included spend</td>
</tr>
<tr>
<td><strong>Special needs</strong></td>
<td>30-40% of Medicaid*</td>
<td>0-200 basis points of trend mitigation</td>
</tr>
</tbody>
</table>

*Assumes that supportive care is excluded from Total Cost of Care model in initial years, and addressed through complementary model for special needs populations*
### Examples of Payment Reform Models

<table>
<thead>
<tr>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
</table>
| **Total cost of care**                                                     | ▪ Massachusetts  
▪ New York  
▪ Vermont  
▪ Medicare Shared Savings  
▪ NextGen Medicare ACO |
| **Bundled payments**                                                       | ▪ Arkansas  
▪ Ohio  
▪ Tennessee  
▪ BPCI  
▪ CJR |
| **Special needs models**                                                   | ▪ Iowa  
▪ Massachusetts  
▪ Missouri  
▪ Tennessee |

Accountability for the quality and cost of an episode of care for either a chronic condition, an acute exacerbation, or an acute procedure.
Delaware’s Progress on Voluntary Adoption of Value Based Payment Reform

- After receiving federal grant monies through the Centers for Medicare and Medicaid’s State Innovation Model (SIM) project, Delaware has made a significant investment in transitioning to value-based payment models. Value based payment models enable collaboration between providers and health systems in addition to allowing a greater focus on keeping people healthy through improving primary care. This is vastly different than the traditional Fee for Service model that aligns payment for services with volume, regardless of patient outcomes and whether the overall population of the state is getting healthier.

- The State has supported these changes from a policy perspective by setting the expectation for Medicaid Managed Care Organizations (MCOs) and State Employee/Retiree Third-party administrators to offer and promote the adoption of value-based models.

- Currently, nearly 40% of primary care practices have participated in primary care practice transformation funded by the federal grant. Delaware recently became the first state in the country to achieve universal participation of our adult acute care hospitals in the Medicare Shared Savings Program. Some of these hospital systems as well as other physicians-led Accountable Care Organizations have recently begun to expand their participation into the Commercial segment as well. Overall, 30% of Delawareans are attributed to providers participating in value-based payment models.

- Despite this progress, many primary care providers in smaller practices have not yet chosen to participate in value-based models, and even for larger health systems the change to value based payments can be expensive requiring retraining of providers, paying for services not reimbursed under the Fee for Service model, and making investments in health IT or other infrastructure to support value. In Delaware we may already be seeing the limitations of a purely voluntary adoption model for payment reform.
**Case study: Massachusetts payment reform (1/2)**

Massachusetts is restructuring its MassHealth (Medicaid) program through an 1115 waiver to support health care delivery system reforms enabled by significant federal investment.

| Risk model | New delivery system reform features three risk models:  
|            |  
|            | - Model A: integrated MCO-ACO model with full insurance risk responsibility  
|            | - Model B: direct State-ACO contracting model with two-sided risk sharing  
|            | - Model C: MCO-ACO contracting model with two-sided risk sharing  
| Payers     | New MCO contracts (expected 2017) will require Medicaid MCOs (6 in MA) to participate in and support one or more of the three ACO models  
| Stakeholder participation | ACOS may voluntarily participate, with Delivery System Reform Incentive Program (DSRIP) funding made available only to participating providers  
| Patients   | Patients are attributed by the MCOs to participating ACOs through the patients’ selected primary care physician  
| Regulatory & contractual authorities | MassHealth existing 1115 waiver renewal used as an opportunity for payment reform  
|            | Relies heavily upon MCOs in the State to create and administer ACO models  
|            | State offers $1.8B in DSRIP funding for participating ACOs to invest in infrastructure, care coordination, and BH/LTSS partnerships  

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### Case study: Massachusetts payment reform (2/2)

#### MassHealth (Medicaid)

<table>
<thead>
<tr>
<th>Model A: Integrated ACO/MCO</th>
<th>Model B: Direct to ACO</th>
<th>Model C: MCO-Administered model</th>
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</thead>
<tbody>
<tr>
<td><strong>Provider</strong></td>
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**Model A: Integrated ACO/MCO**
- Fully integrated: an ACO joins with an MCO to provide full range of services
- Risk-adjusted, prospective capitation rate
- ACO/MCO entity takes on full insurance risk

**Model B: Direct to ACO**
- ACO provider contracts directly with MassHealth
- Based on MassHealth network
- ACO may have provider partnerships for referrals and care coordination
- Advanced model with two-sided performance (not insurance) risk

**Model C: MCO-Administered model**
- ACOs contract and work with MCOs
- MCOs play larger role to support population health management
- Various levels of risk; all include two-sided performance (not insurance) risk
AFFORDABILITY AND QUALITY TARGET
An on-ramp to improved patient-centered care, quality and cost

Key Measures
A. All payer claims data
B. Quality
C. Integration
D. Affordability

Graph showing:
- Volume driven vs. Integrated services
- Payment reform vs. Delivery Reform
- Traditional care vs. Health homes
- Accountable Care Organizations vs. All payer claims data

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Global Health Care Benchmark

- Value based payments
- Bundled payments
- Episodic payments
- Managed Care Per Member Per Month (PMPM)
- All-inclusive population-based payments
- Accountable Care Organizations
- Patient Centered Medical Homes
- Managed Care organizations

Based on affordability, quality and total cost of health care

Integrated Delivery Reform

Payment Reform

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Stages to Reduce Health Care Costs in Delaware
Proposed approach

Move toward global health care benchmark
- Set to state revenue growth
- Staged targets with year 0-3 phases
- Give providers flexibility for alternative payment strategies through global budgets, bundled payments, special populations needs, unplanned care

Establish authority and regulation
- Create monitoring and structure
- Tie to price transparency and quality

Recalibrate state-based purchasing authority
- Adjust state approach to include: State Employee Benefits, Medicaid, Exchange/Marketplace, Correctional medicine
- Bring along commercial segments
# Moving toward innovative strategies

## Payment Strategies
- Cost growth goal
- Implement bundled payments for all payers and global budgets
- Finalize all-payer claims database and price transparency
- Consider reference pricing/cost monitoring

## Access issues
- Expand community-based strategies
- Combat addiction to prescription drugs and heroin
- Expand telehealth up and down state
- Decreased unplanned care

## Quality improvement
- Publish the common scorecard with cost and health outcomes
- Fully adopt value-based payment reform
- Integrated behavioral and primary care
- Improve long-term care
- Align the scope of practice needs with community needs (community health workers, nurse practitioners, behavioral health workers)
IMPLEMENTATION PLAN
PHASED APPROACH TO GLOBAL HEALTH CARE BENCHMARK

Y1
PLANNING YEAR
ESTABLISH LEGISLATION FOR GLOBAL HEALTH CARE BENCHMARK

Y2
DEMO TEST YEAR
FOCUS ON PLANNING YEAR TO DETERMINE MODELS ACROSS MEDICAID, STATE EMPLOYEES/RETIREES AND FULLY INSURED
ESTABLISH THE AUTHORITY AND PERFORMANCE MANAGEMENT APPROACH

Y3
IMPLEMENTATION
ALL ASPECTS OF THE IMPLEMENTATION ARE IN EFFECT

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Next steps

- Work with stakeholders on initial legislation
- Establish phases and infrastructure to move the conversation from what to how
- Use state authority to revise 1115 and 1332 waivers (Medicaid and Exchange/Marketplace, respectively)