

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

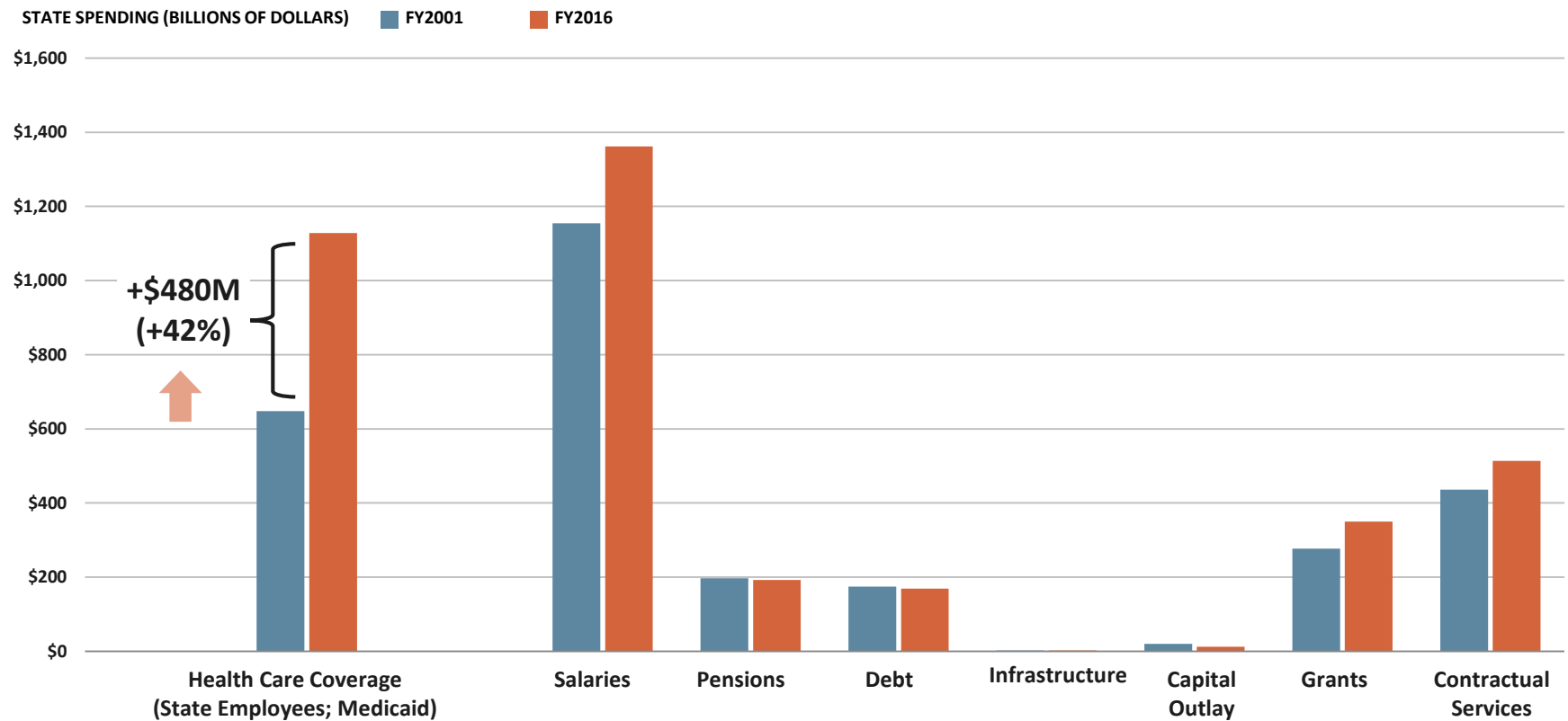


Background on Health Care Spending in Delaware

- 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.

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

DELAWARE STATE BUDGET, FY2010 VS. FY2016



source: Delaware Office of Management and Budget; DEFAC Expenditure Reports; general funds

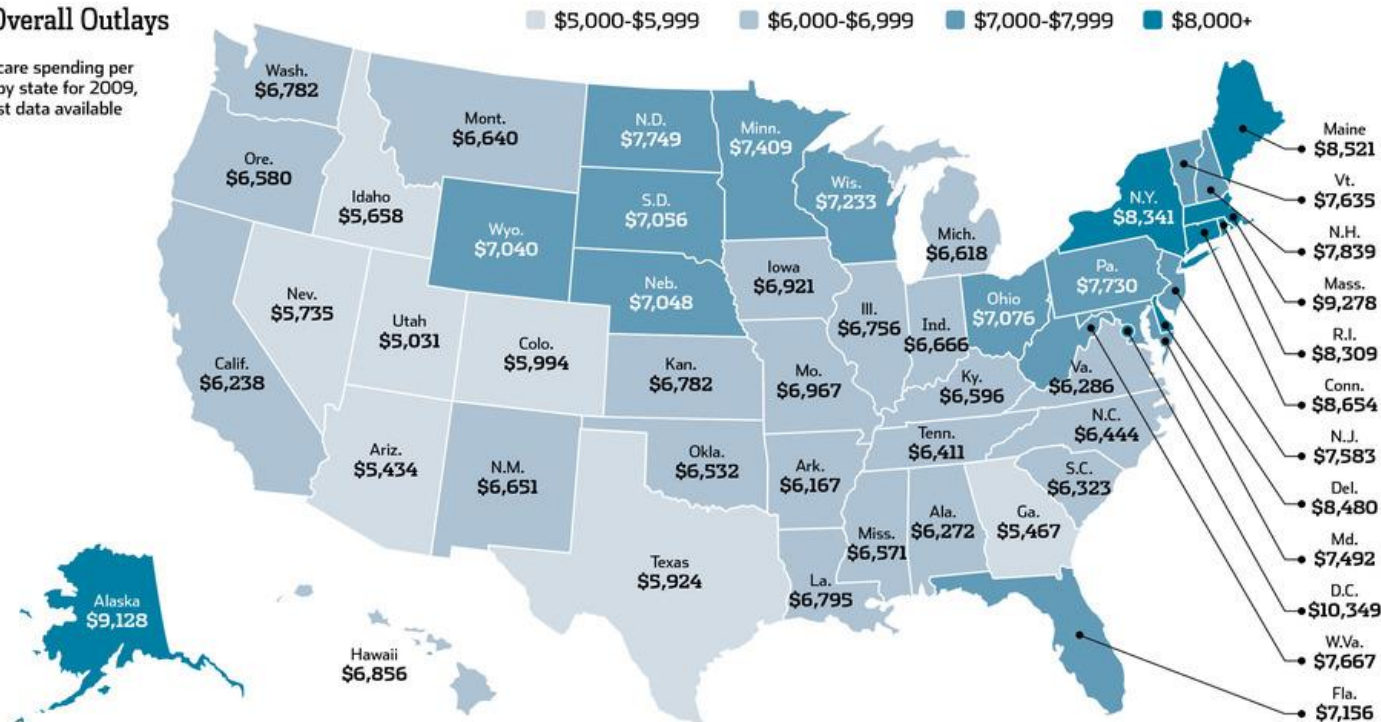
Per Capita Costs in Delaware \$8,480 per person

Around the Nation

A breakdown of health-care spending state by state

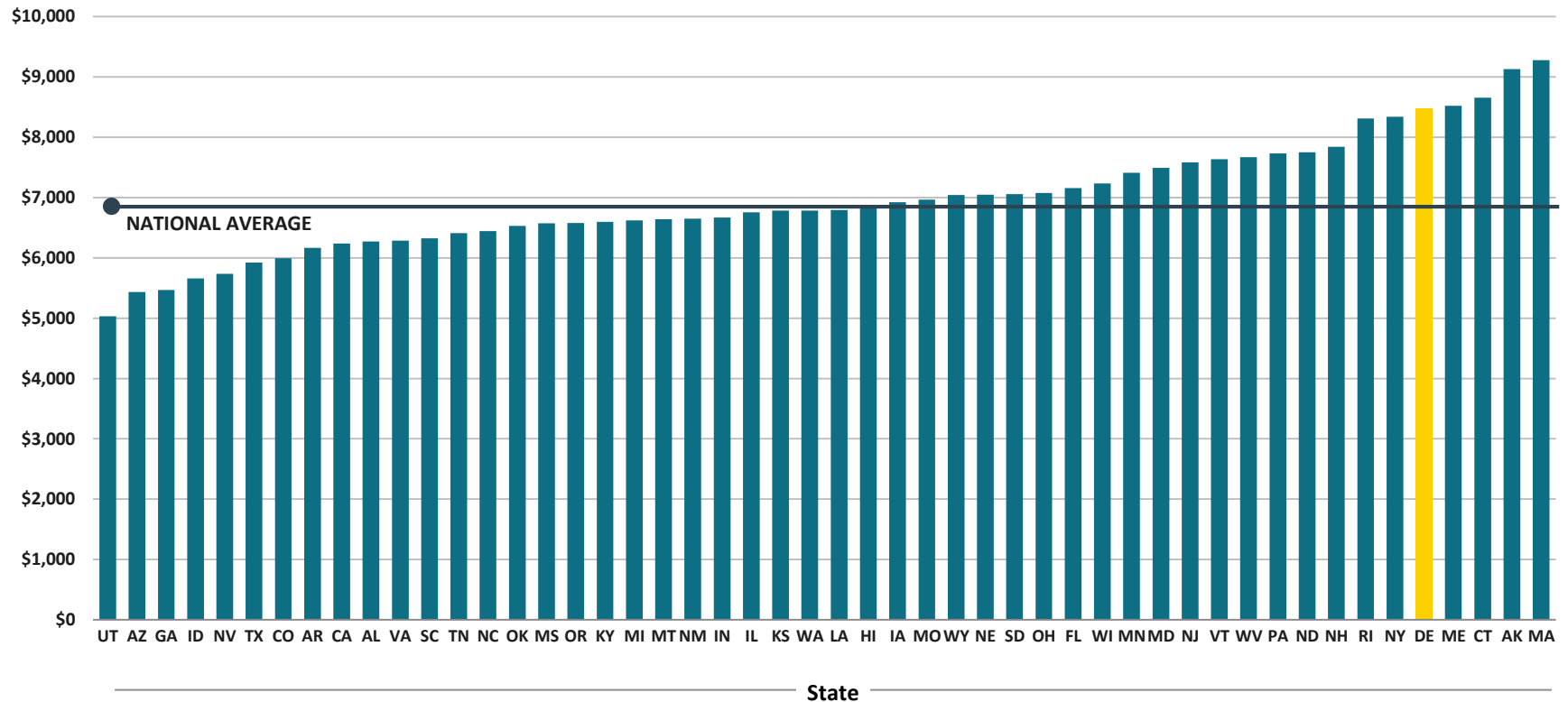
\$ Overall Outlays

Health-care spending per person by state for 2009, the latest data available



Delaware Spends More on Health Care than Most Other States

PER CAPITA PERSONAL HEALTHCARE EXPENDITURES, 2009

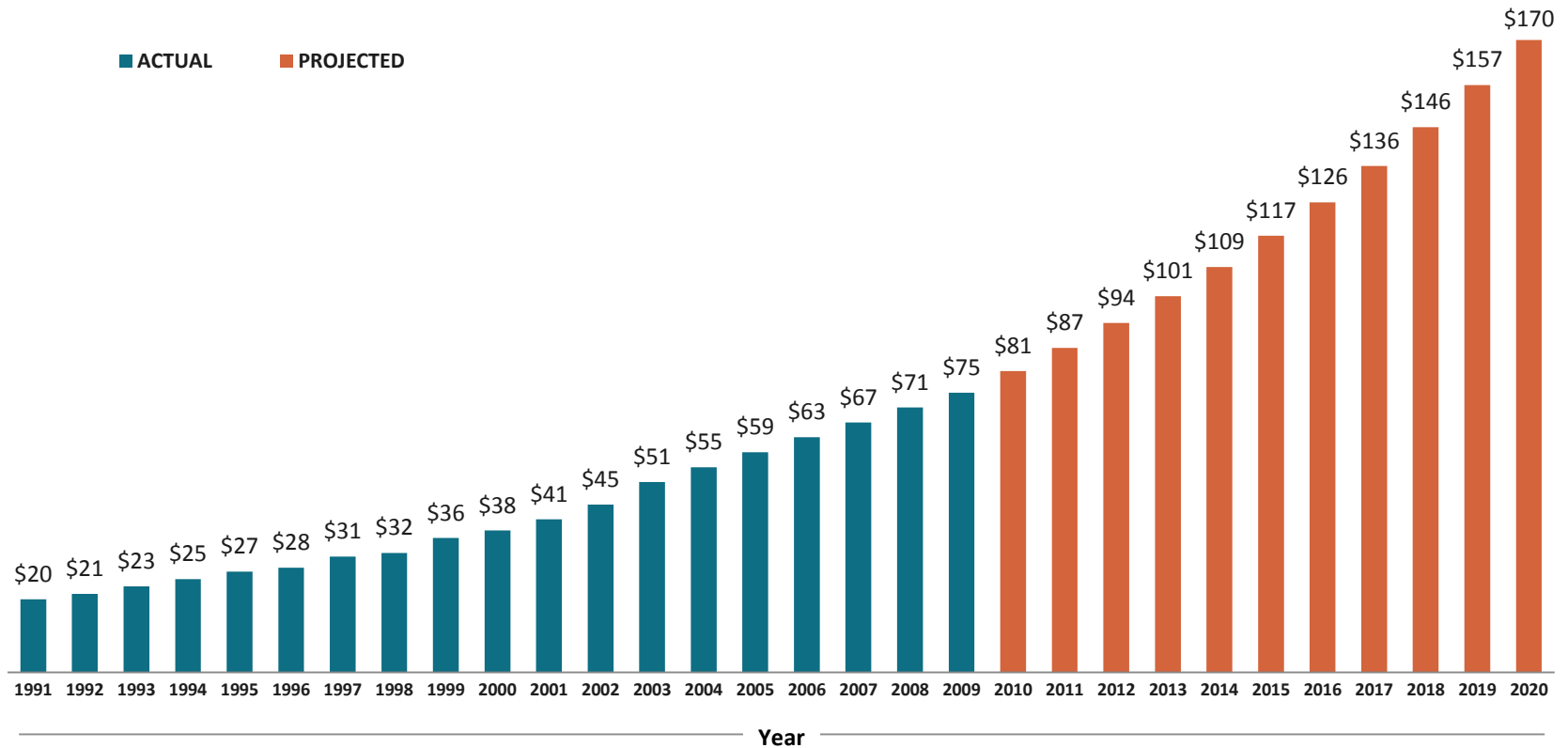


NOTE: District of Columbia is not included.

SOURCE: Centers for Medicare & Medicaid Services, [Health Expenditures by State of Residence](#), CMS, 2011.

Total Health Spending Will Double from 2009 to 2020

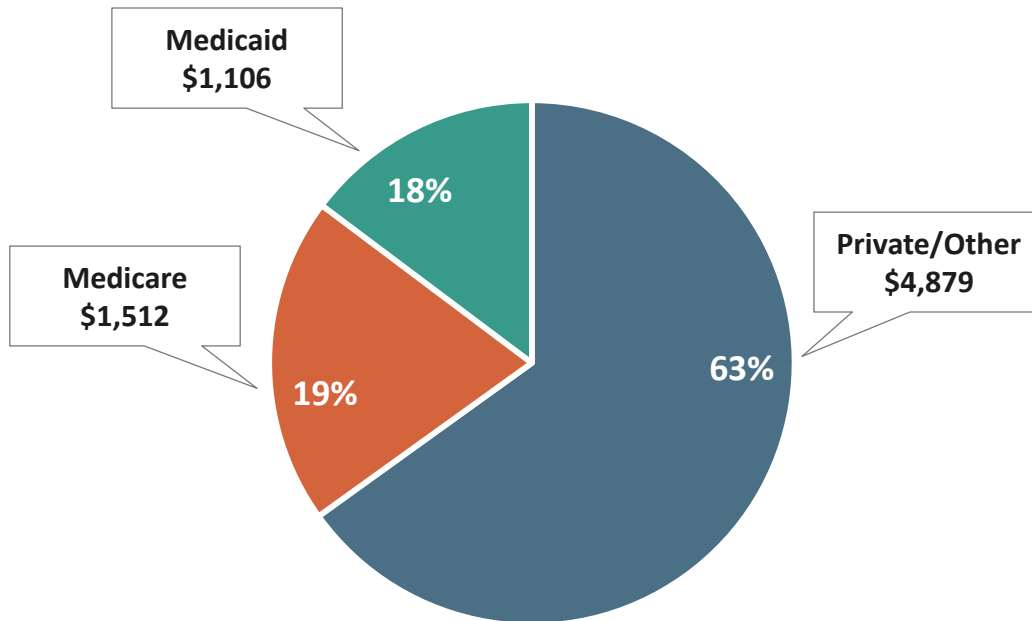
ACTUAL AND PROJECTED DELAWARE TOTAL PERSONAL HEALTH CARE EXPENDITURES, 1991-2020
(BILLIONS OF DOLLARS)



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

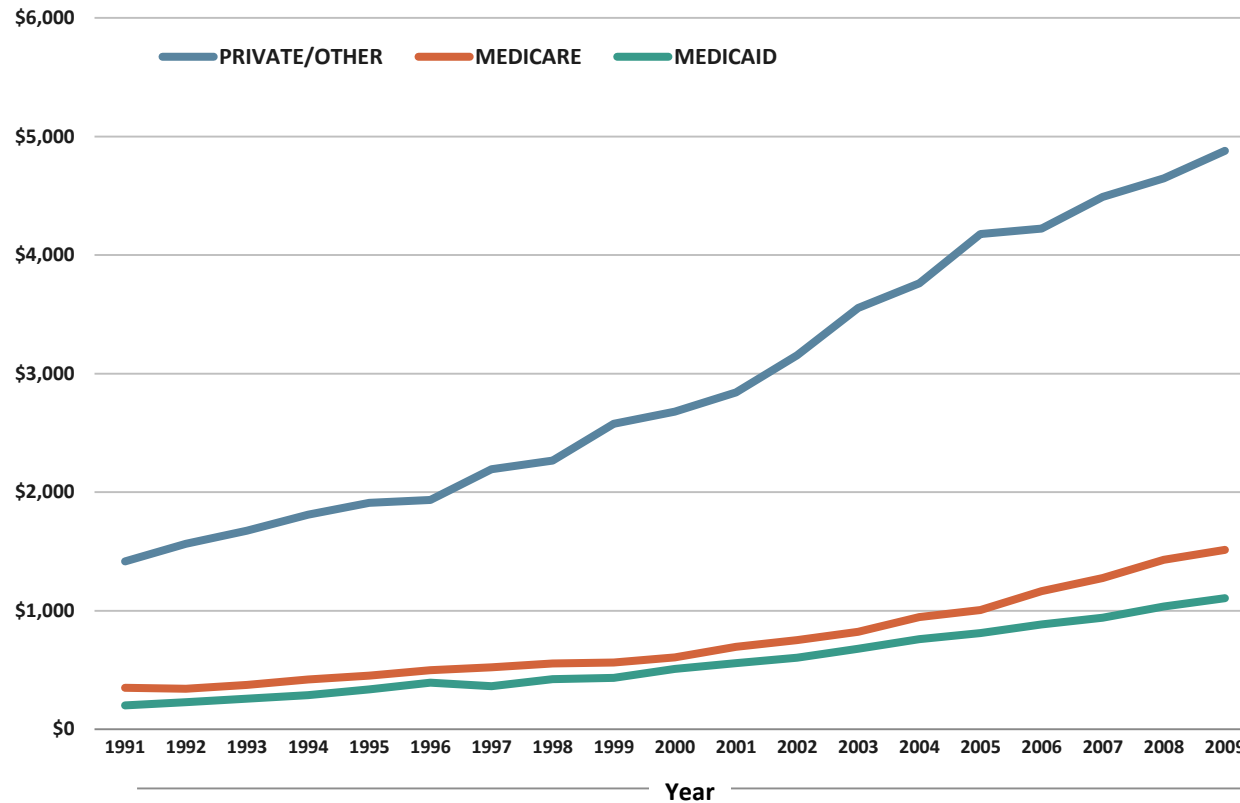
TOTAL PERSONAL HEALTH EXPENDITURES BY PAYER IN DELAWARE, 2009
(MILLIONS OF DOLLARS)



SOURCE: Centers for Medicare & Medicaid Services, [Health Expenditures by State of Residence](#), CMS, 2011.

All Payers in Delaware Have Experienced Significant Spending Growth

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



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

SOURCE: Centers for Medicare & Medicaid Services, [Health Expenditures by State of Residence](#), CMS, 2011.

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:

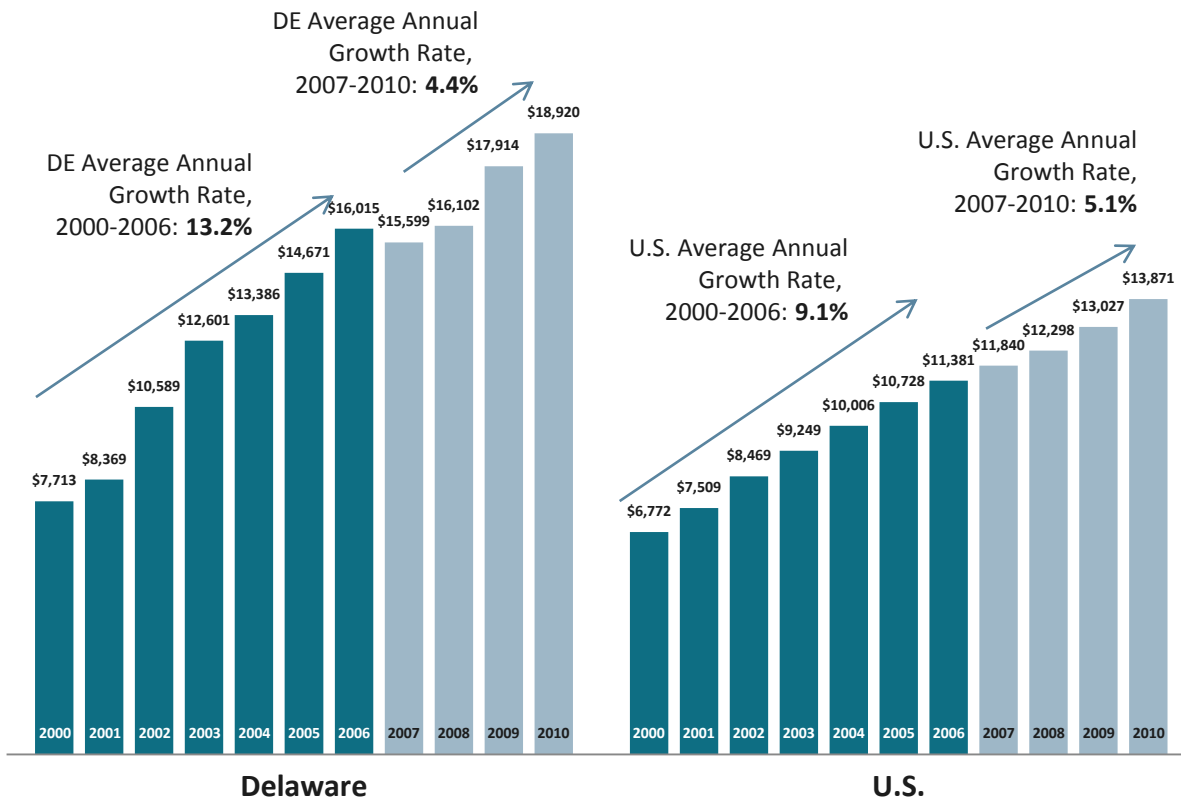
- **Private/Other** average annual growth rate, 1991-2009: **7.7%**
- **Medicare** average annual growth rate, 1991-2009: **8.5%**
- **Medicaid** average annual growth rate, 1991-2009: **10.0%**

Year

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

FAMILY HEALTH INSURANCE PREMIUMS DELAWARE AND THE U.S., 2000-2010



Delaware health insurance premiums have long been higher than the national average. Private premiums have actually grown more slowly than the national average.

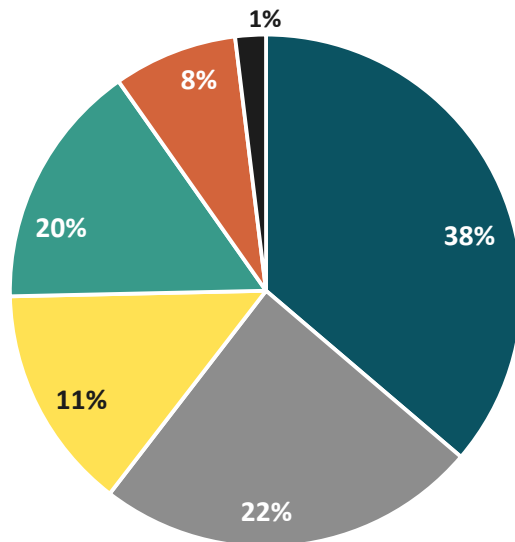
With wages stagnant, health care costs consume more of workers' budgets

NOTE: Data for 2007 is inferred from the average of 2006 and 2008, as data for this year is unavailable.
 source: Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey — Insurance Component*.

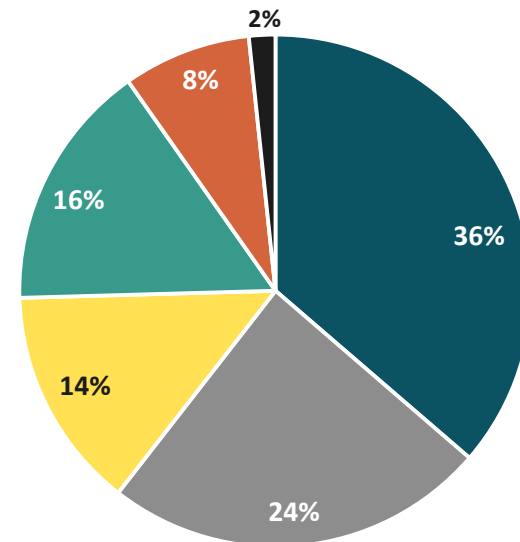
WHERE THE HEALTH CARE DOLLARS GO — SPENDING AND COST GROWTH BY TYPES OF HEALTH CARE SERVICES

The Distribution of Total Spending by Type of Service Is Similar for Delaware and the U.S. as a Whole

DELAWARE PER CAPITA SPENDING BY SERVICE, 2009



UNITED STATES PER CAPITA SPENDING BY SERVICE, 2009

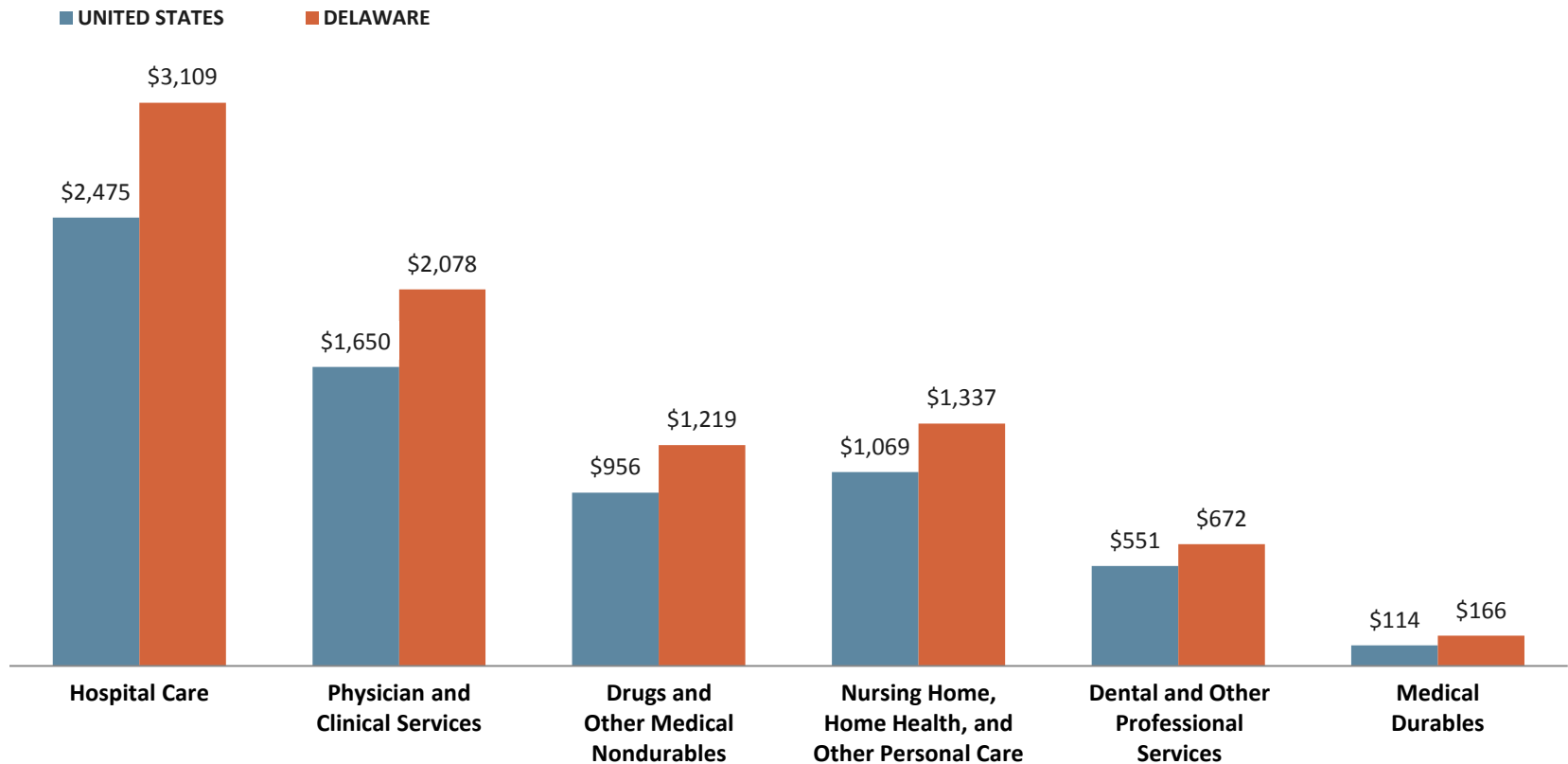


- Hospital Care
- Physician and Clinical Services
- Drugs and Other Medical Nondurables
- Nursing Home, Home Health, and Other Personal Care
- Dental and Other Professional Services
- Medical Durables

source: Centers for Medicare & Medicaid Services, [Health Expenditures by State of Residence](#), CMS, 2011.

Per Person Spending in Delaware Is Higher than the National Average in Every Category of Service

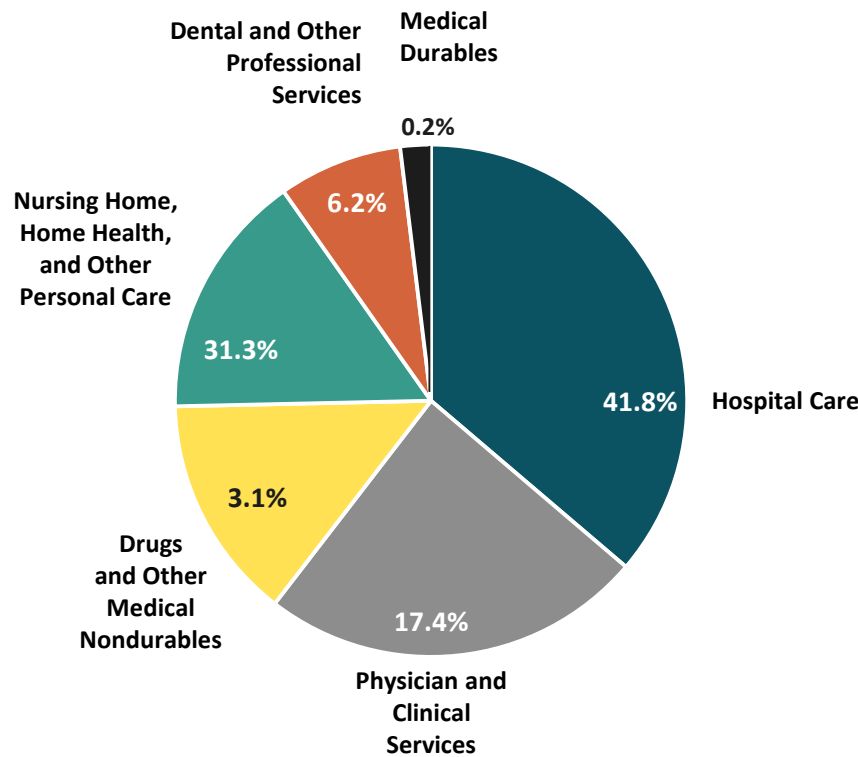
UNITED STATES AND DELAWARE PER CAPITA SPENDING BY SERVICE, 2009



SOURCE: Centers for Medicare & Medicaid Services, [Health Expenditures by State of Residence](#), CMS, 2011.

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

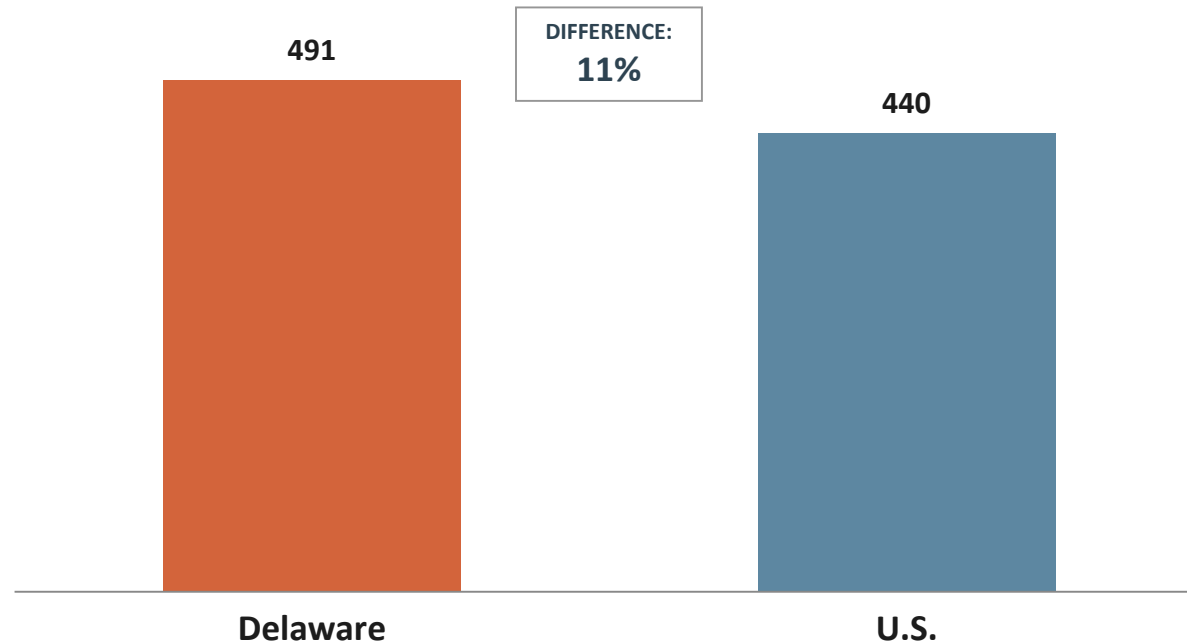


source: Centers for Medicare & Medicaid Services, [Health Expenditures by State of Residence](#), CMS, 2011.

DRIVERS OF COST GROWTH IN DELAWARE

UTILIZATION: Delaware Residents Use the Emergency Room Slightly More than U.S. Residents Overall

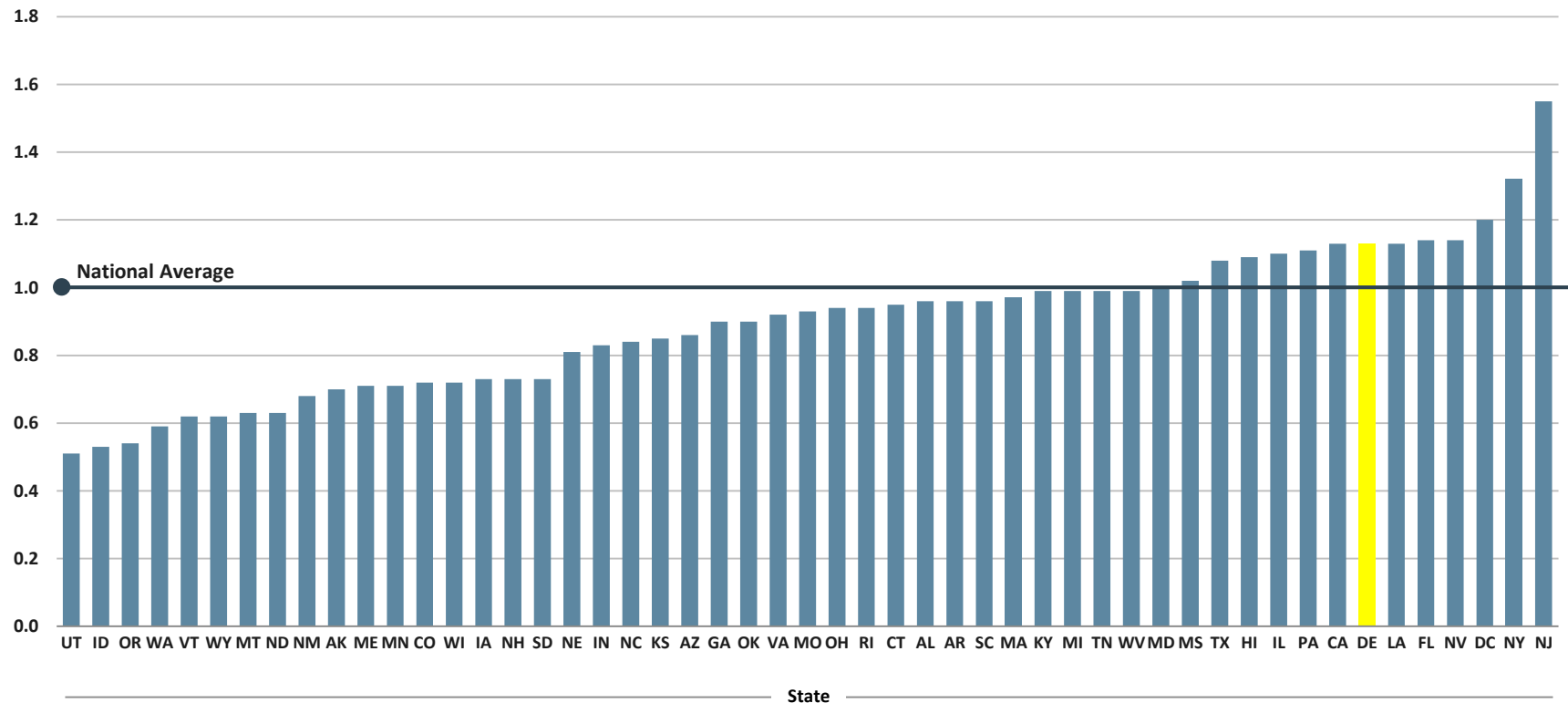
HOSPITAL EMERGENCY ROOM VISITS PER CAPITA IN DELAWARE AND IN THE U.S. OVERALL, 2009
(ADMISSIONS PER 1,000 RESIDENTS)



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

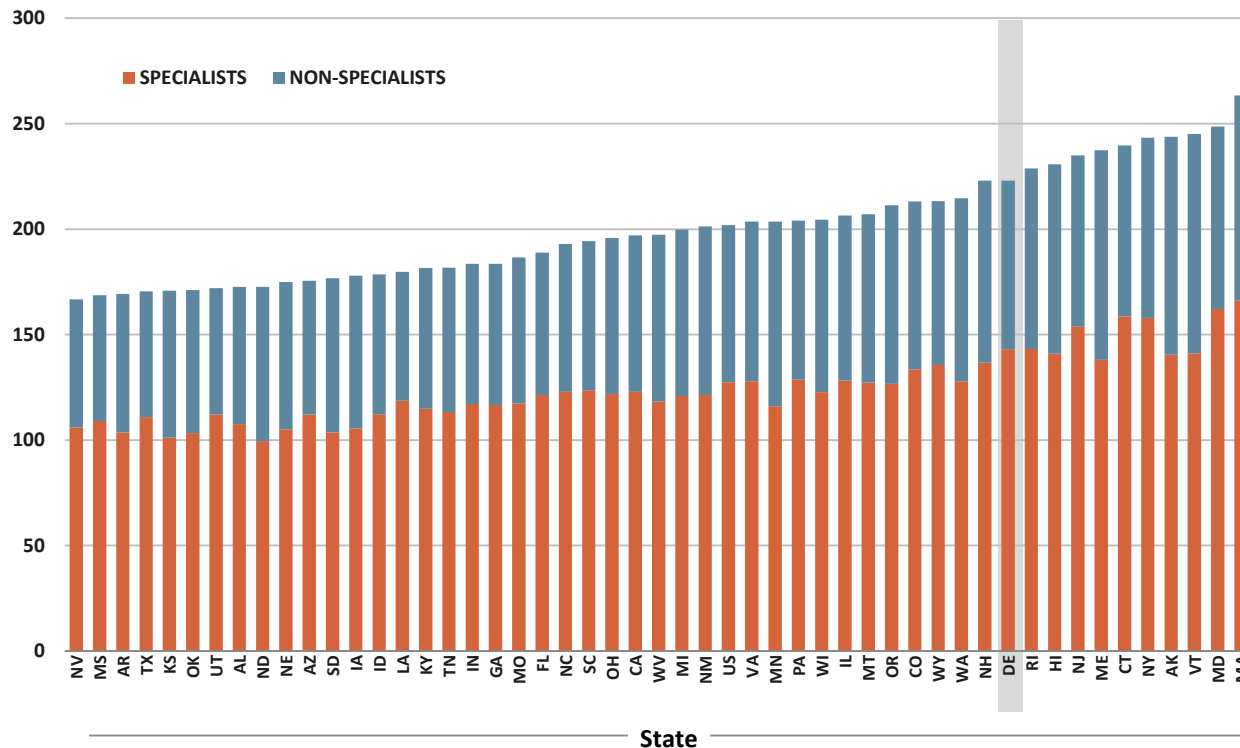


NOTE: The Hospital Care Intensity Index is computed by comparing each hospital's utilization rate, which is based on the number of days patients spend in the hospital and the number of times they visit a physician, with the national average and adjusting for age, sex, race, and severity of illness.

SOURCE: Dartmouth Atlas of Health Care.

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

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



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.

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

SOURCES: Physicians per capita data from Dartmouth Atlas. Evidence for relationship between more physicians and higher spending from Fisher, E.S., et. al., "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, Feb. 18, 2003.

Moving forward with global health care benchmark

Current situation

- Health care costs consume ~25%¹ 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 government³
- DE’s average Medicaid Per Member Per Year (PMPYs) and growth trends are above the national average for most eligibility categories^{7,9}
- 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

	Savings from percent cost reduction		
	\$M		
Funding base	1%	3%	5%
State Medicaid funding (\$788M) ⁷	8	23	39
State funding for State employees (\$762M) ⁸	8	23	38
Total State health care spending (\$8B)	80	240	400

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)

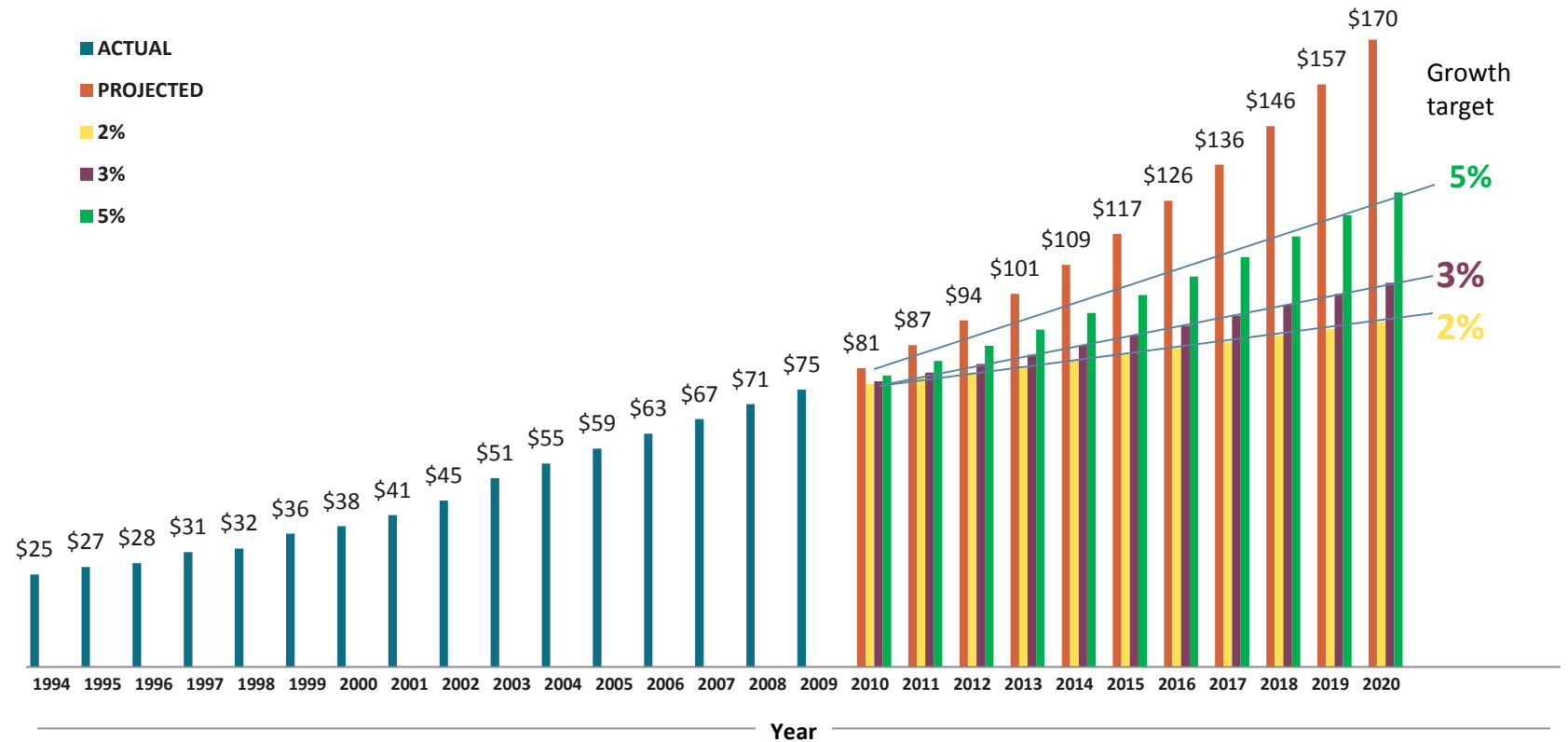
7 2015 (MACPAC); Medicaid spend breakdown by eligibility category in FY2011 is as follows: 14% aged, 32% individuals with disabilities, 35% adult, and 20% children (KFF)

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

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;

Considerations for level of impact across models

	Percent of health-care spending	Potential impact in success case	Factors affecting level of impact
Total cost of care	<ul style="list-style-type: none"> 60-70% of Medicaid* 90-100% of Medicare and Commercial 	<ul style="list-style-type: none"> 50-150 basis points of trend mitigation 	<ul style="list-style-type: none"> Level of provider commitment (e.g., level of upside and/or risk) Execution effectiveness Pricing
Bundled payments	<ul style="list-style-type: none"> 20-40% of spend in top 10-30 episodes of care 	<ul style="list-style-type: none"> 200-400 basis points of trend mitigation for included spend 	<ul style="list-style-type: none"> Degree of provider competition Execution effectiveness Pricing
Special needs	<ul style="list-style-type: none"> 30-40% of Medicaid* 	<ul style="list-style-type: none"> 0-200 basis points of trend mitigation 	<ul style="list-style-type: none"> Mix of institutional care vs. home and community-based care Execution effectiveness Pricing

*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

	Description	Examples
Total cost of care	Accountability for the quality and total cost of care for a broad population of patients	<ul style="list-style-type: none">▪ Massachusetts▪ New York▪ Vermont▪ Medicare Shared Savings▪ NextGen Medicare ACO
Bundled payments	Accountability for the quality and cost of an episode of care for either a chronic condition, an acute exacerbation, or an acute procedure	<ul style="list-style-type: none">▪ Arkansas▪ Ohio▪ Tennessee▪ BPCI▪ CJR
Special needs models	Accountability for the quality and cost of supportive services for populations with severe mental illness, intellectual, developmental, or physical disabilities	<ul style="list-style-type: none">▪ Iowa▪ Massachusetts▪ Missouri▪ Tennessee

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



Stakeholder participation

- 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
- Providers**
 - 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

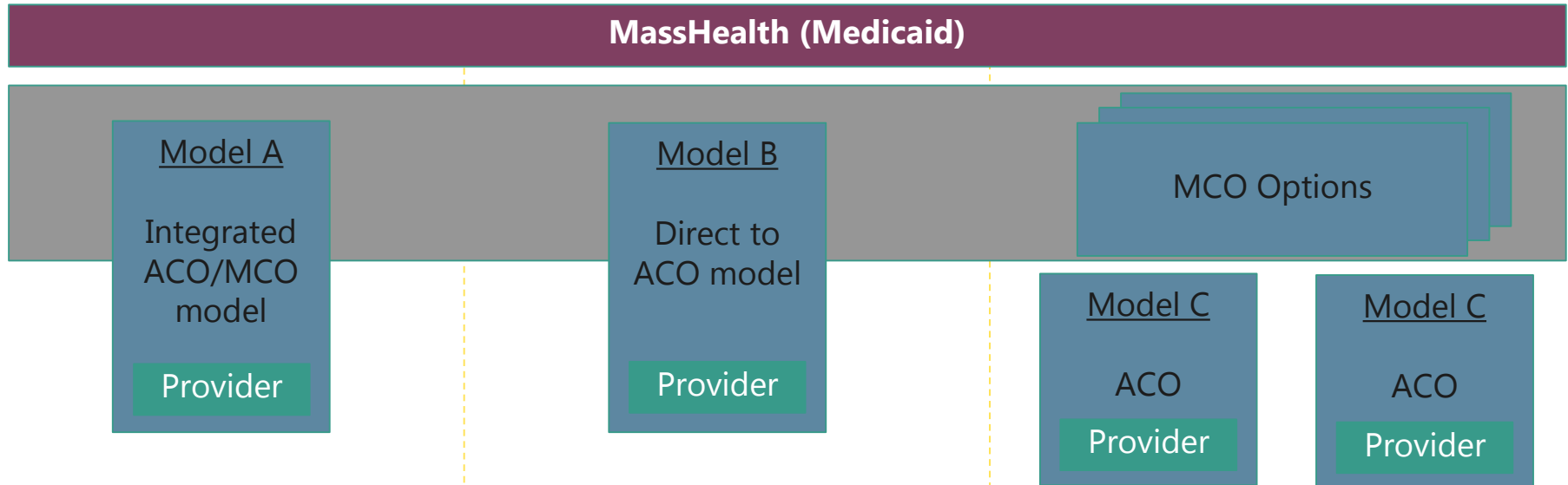


Regulatory & contractual authorities

- 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



Case study: Massachusetts payment reform (2/2)



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

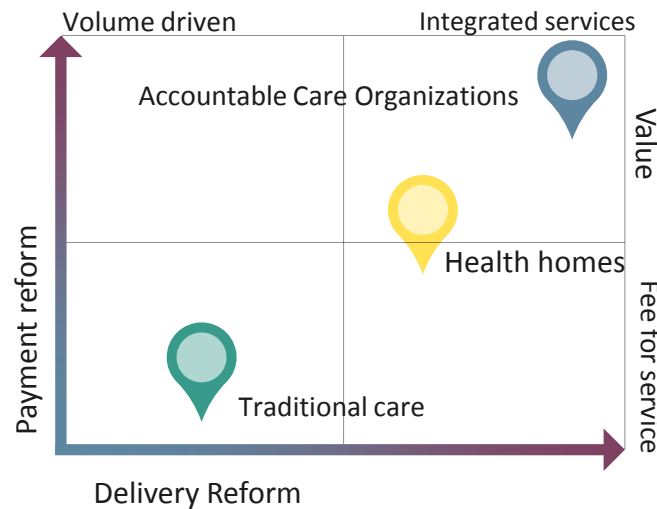
- ACO provider contracts directly with MassHealth
- Based on MassHealth network
- ACO may have provider partnerships for referrals and care coordination
- Advanced model with two-sided performance (not insurance) risk

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

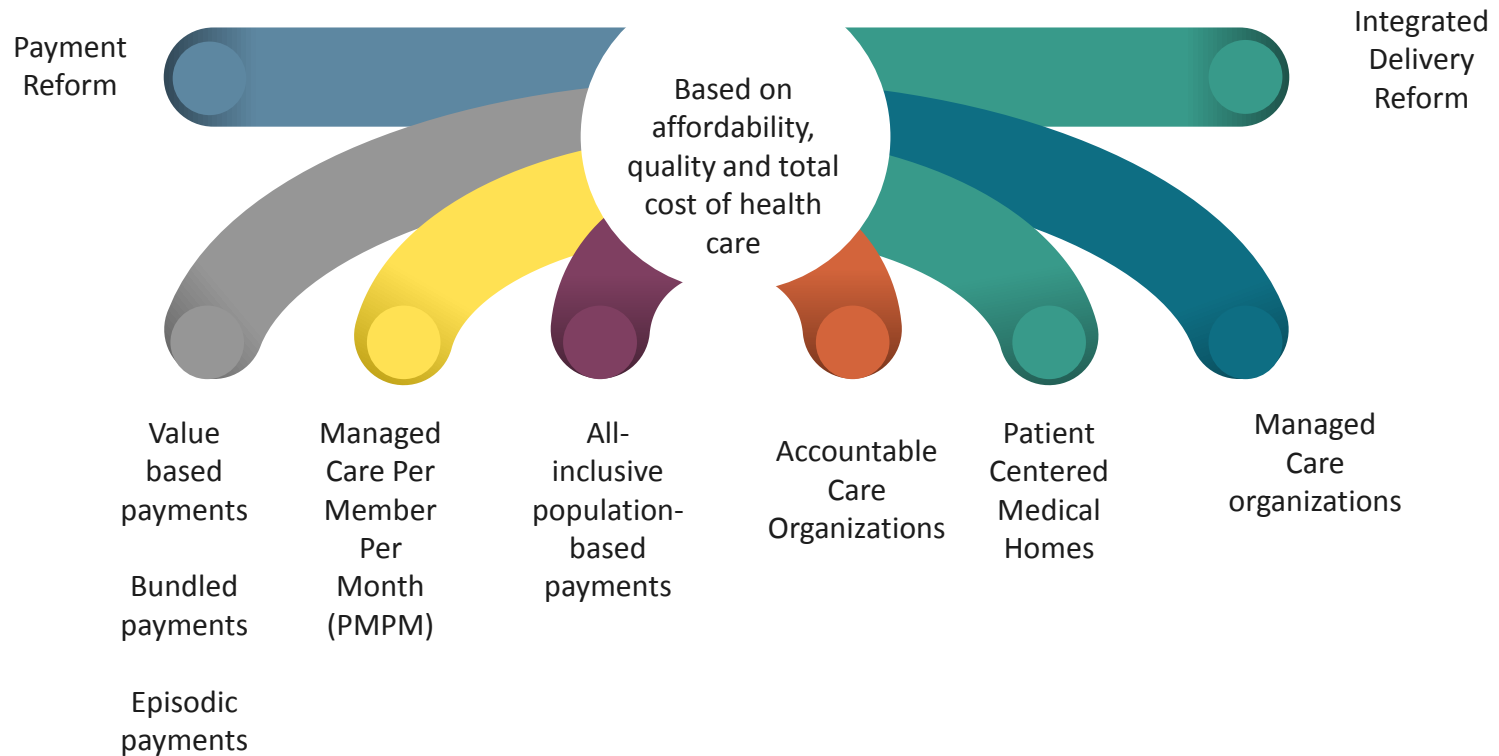
An on-ramp to improved patient-centered care, quality and cost



Key Measures

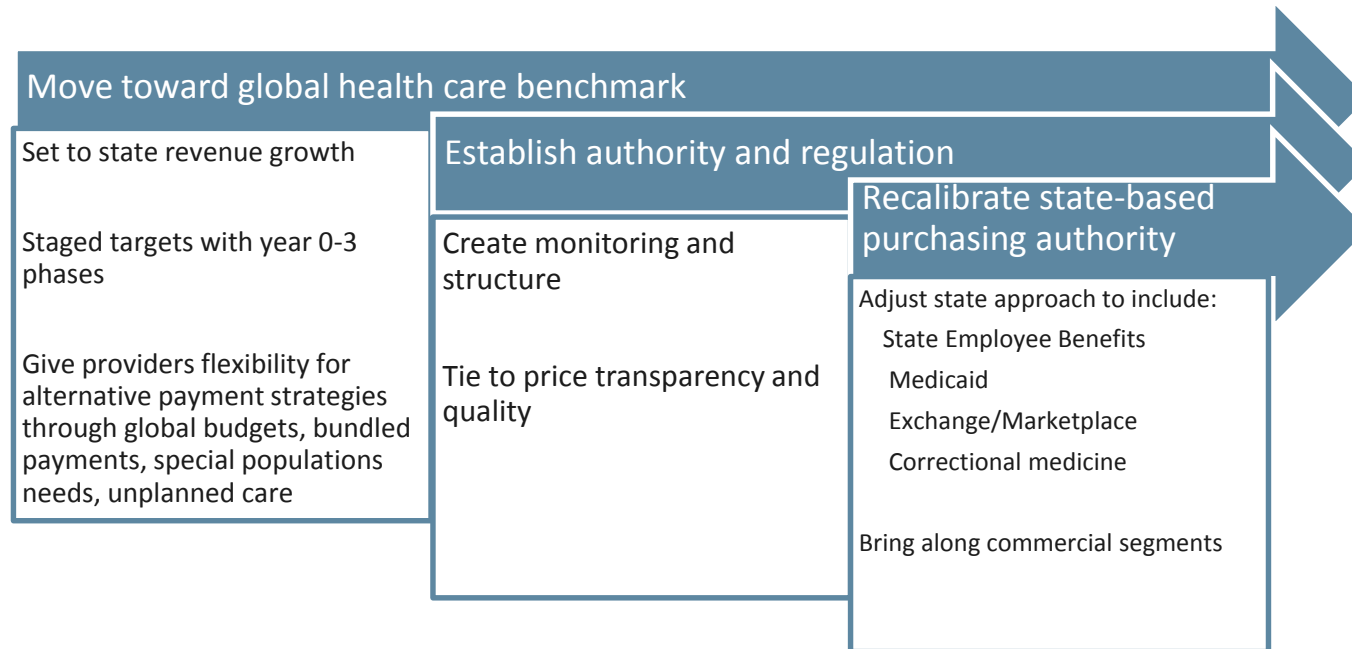
- A All payer claims data
- B Quality
- C Integration
- D Affordability

Global Health Care Benchmark



Stages to Reduce Health Care Costs in Delaware

Proposed approach



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

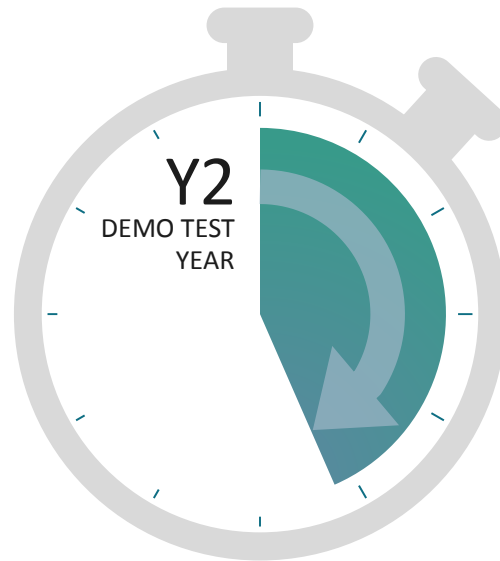
- Publish the common scorecard with cost and health outcomes
- Fully adopt value-based payment reform
- Integrated behavioral and primary care
- Improve long-term care
- Align the scope of practice needs with community needs (community health workers, nurse practitioners, behavioral health workers)

IMPLEMENTATION PLAN

PHASED APPROACH TO GLOBAL HEALTH CARE BENCHMARK

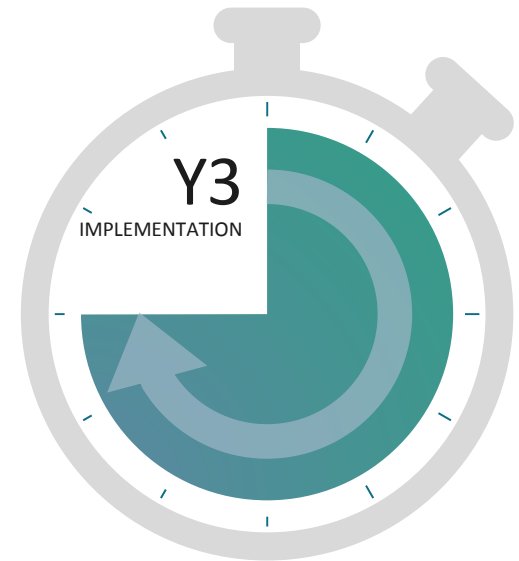


ESTABLISH LEGISLATION FOR GLOBAL HEALTH CARE BENCHMARK



FOCUS ON PLANNING YEAR TO DETERMINE MODELS ACROSS MEDICAID, STATE EMPLOYEES/RETIREES AND FULLY INSURED

ESTABLISH THE AUTHORITY AND PERFORMANCE MANAGEMENT APPROACH



ALL ASPECTS OF THE IMPLEMENTATION ARE IN EFFECT

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)