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: November 13, 2017

RE: Comments on DHSS "Road to Value" White Paper

Thank you for the invitation to comment on the draft "Delaware's Road to Value" document (the "White Paper"[1]) outlining the Delaware Department of Health and Social Services' (DHSS) health care cost benchmark proposal. On behalf of Christiana Care Health System (CCHS), we respectfully submit this written comment, and welcome the opportunity to discuss our concerns at your earliest opportunity. We hope that addressing these concerns will enable CCHS to proactively partner with the State on pursuing health care policy and spending growth objectives that support access to high quality, affordable health care for all Delawareans.

I. The Cost Trend Data Cited in the White Paper Is Incomplete and Misleading as to Health Care Spending Trends in Delaware

We respectfully submit that the information presented in the Benchmark Summits to date has created a false impression: (1) that Delaware's health care costs are significantly above national trends; and (2) that the primary and root cause of the State's health care budget problems is wasteful spending on hospital care. Setting aside the foundational question of why the State is not focusing more on the primary state budget cost drivers of Medicaid and state employee health care costs, the data

[1] Delaware Department of Health and Social Services (DHSS), *Draft, Delaware's Road to Value*, October 2017, http://dhss.delaware.gov/dhcc/.

upon which the State has been heavily relying to demonstrate health care spending trends has been incomplete and misleading. In fact, our analysis of the same data, and of other publicly available data, reveals that Delaware's per enrollee health care spending is *slightly* higher than the national trend overall, and below national trend for Medicaid and Medicare. The frequently cited data reflecting that Delaware's health care spending growth is the "third highest" in the nation, and that it is "twenty-seven percent higher than the national average" is misleading and incomplete.

The CMS data cited in the White Paper reflects total costs as well as *per enrollee* costs broken down by major payers (Medicaid, Medicare, private insurance). The more accurate metric, per enrollee costs, paints a far less drastic picture than the "third-highest and twenty-seven percent (27%) above national average" statistics that have been summarily referenced and repeatedly cited. As further detailed in Appendix A to this written statement (attached), a detailed review and analysis of the oft-cited 2014 CMS data reflects that the *per enrollee* spending in Delaware is *slightly* higher than the national average for the overall population, and actually *slightly lower* than the national average for Medicare and Medicaid spending.[2]

According to this 2014 data, health care costs in Delaware per enrollee are actually *below* the national average for Medicare and Medicaid, and approximately 5.6% higher for private health insurance per enrollee spending. This downward trend continues to be reflected in more current data. For example, per member per month costs for Medicaid beneficiaries from 2009-2016 increased less than 1 percent per year on average and actually fell in FY16, the most recent year with available data.[3] Additionally, 2016 CMS per capita total cost of care data[4] reflects that Delaware's per capita cost of care was only three percent (3%) higher than the national average, and that the hospital readmission rate in Delaware is below the national average.[5]

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[2] The data detailed in Appendix A to this written comment is based on the 2014 CMS data released in June and cited in the White Paper, including the following link: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-06-14.html.

[3] This is based on supplied to the Delaware Healthcare Association by the Delaware Division of Medicaid and Medical Assistance (DMMA), which reflects that the per member per month costs in the 2009-2016 period increased less than 1 percent per year on average and actually fell in FY16, the most recent year with available data.

[4] CMS, Medicare Chronic Condition Warehouse (2016).

[5] *Id.*

A. The Benchmark Dialogue Continues to Confuse the Concepts of Health Outcomes and Health Care Quality.

In the White Paper, and in prior presentations, Secretary Walker has noted the apparent disconnect between Delaware's health care cost trends and Delaware's health outcomes, impliedly questioning whether we are, in essence, getting what we are paying for in health care in Delaware.[6] Secretary Walker accurately notes Delaware's unique challenges resulting from an "older and sicker" population with "higher rates of chronic disease, in part driven by social determinants including poverty, food insecurity, and violence." The continued association of the "31st in outcomes" statistic with the cost trend data juxtaposes the concepts of health care quality with the concept of adverse health outcomes. The frequent association of Delaware's costs with Delaware's outcomes in the White Paper, and in many of the Summit presentations, creates an impression - intended or not - that the quality and safety of health care provided by Christiana Care and other providers is below some undefined metric of "acceptable" standards of care.

The State's presentations to date have failed to account for any additional publicly available data about the respective quality and safety of the State's leading health care institutions. Christiana Care, for example, has been repeatedly recognized as a national leader in patient safety and quality by Healthgrades, CareChex Hospital & Health System Quality Ratings, the American College of Surgeons National Surgical Quality Improvement Program and U.S. News & World Report's Best Hospitals rankings. Christiana Care recently earned the John M. Eisenberg Patient Safety and Quality Award, the nation's preeminent recognition for quality and safety in health care, and the Stand Up for Patient Safety Management Award from the National Patient Safety Foundation.

In the most recent Healthgrades ratings, Christiana Care is in the top 2% of hospitals nationally for consistent clinical quality based on an analysis of risk-adjusted mortality and complication rates across a spectrum of inpatient procedures and conditions, and

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[6] For example, in a recent op-ed jointly authored with Governor Carney, Secretary Walker noted that:

> Despite our spending levels, we are not creating a healthier population. In terms of overall health, Delaware ranks 31st in the nation by America's Health Rankings. Studies have shown that patients are not receiving recommended or appropriate care more than 50 percent of the time, according to research published in the New England Journal of Medicine.

The News Journal, Sept. 6, 2017, http://www.delawareonline.com/story/opinion/contributors/2017/09/06/delaware-must-get-control-health-care-spending-gov-carney-and-secretary-walker/638254001/.

in the top 5% of hospitals nationally for overall clinical excellence with comprehensive high-quality care across a spectrum of inpatient procedures and conditions. Christiana Care also was ranked one of the top 100 hospitals in the nation by CareChex in 13 different patient safety measures.

The State's presentations have also failed to define how the Administration will address the social and environmental issues that contribute to poor health outcomes in our community and drive up health care spending. We welcome the opportunity to discuss the need for the state and others to support social services and address the social determinants of health (violence, poverty, food access, etc.) and other issues that cannot be addressed in a clinical setting.

B. The Benchmark Discussions Have Not Acknowledged the State's Progress in Improving Health Outcomes and Health Care Access

The White Paper, as well as the information presented in the Summits to date, also fails to account for the positive attributes of Delaware's health rankings in comparison with other states, and for the progress that we have made in recent years.

For example, the same America's Health Rankings that is cited for the "31st in outcomes" number indicates that Delaware ranks as the 5th best state in childhood immunizations. The report also notes that Delaware ranks 16th highest nationally in cancer deaths --which seems unfavorable unless one considers our historical ranking as one of the top ten worst states for cancer mortality prior to changes in State policy, the relentless commitment and work of the Cancer Consortium, and the ongoing work of the Helen F. Graham Cancer Center and other institutions in Delaware.[7] In fact, the Department of Public Health recently acknowledged this progress, noting in a press release that:

> Cancer screening and early detection have contributed to a continuing decline in Delaware's all-site cancer mortality rate over the past decade, say Delaware Public Health officials. From 1999-2003 to 2009-2013, Delaware's cancer death rate decreased 15 percent, an improvement that was slightly higher than the decline seen nationally (14 percent).[8]

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[7] White Paper p. 7, citing Americas Health Rankings (2016), https://assets.americashealthrankings.org/app/uploads/ahr16-complete-v2.pdf.

[8] Delaware Division of Public Health, *Press Release, Delaware Cancer Mortality Drops Again; Public Health Releases Latest Cancer Report*, Jul. 10, 2017, https://news.delaware.gov/2017/07/10/delaware-cancer-mortality-drops-public-health-releases-latest-cancer-report/.

Christiana Care has made significant progress in recent years in improving health care quality and outcomes, illustrated clearly in our ongoing work to eliminate unnecessary variations in care delivery, identified in the SIM work as a key driver of high health care costs and a critical component of quality care. Christiana Care Health System has been a leader in this important work, as summarized briefly below.[9]

Christiana Care has promulgated the criticality of care standardization to eliminate such variations in care, and we have invested in the infrastructure that supports development, implementation and sustainment of clinical pathways. We have centralized key functions that support this work, including education, communication, data acquisition and analysis, health care delivery science and project management, and we have harnessed the expertise in our clinical leadership, leveraging the clinical governance model to effectively and efficiently introduce care standardization methodologies into practice.

Care standardization is now an accepted and widely applied approach to the design of all of our clinical processes. Christiana Care has developed detailed clinical roadmaps, plans that describe on many levels the best practices, services and procedures to which an individual can expect to be exposed as they journey through a particular episode of care or encounter a specific diagnosis. For each pathway, key outcome metrics have been defined and our teams track progress towards improvements. Examples of improvements in patient care as a direct result of these pathways, include reducing hospital readmission for patients suffering from a heart attack from 9.6% to 5.1%, avoiding admission of infants (born to mothers with a presumptive diagnosis of chorioamnionitis) to the NICU by 81%, and screening 72% of admitted patients for opioid withdrawal and initiating Suboxone treatment for 51.4% of them.

C. Focusing Exclusively on Health Care Costs Ignores Issues of Access

The continued focus on cost and outcomes also fails to acknowledge that Delaware ranks 12th nationally in health care access, according to U.S. News and World Report, which corresponds to the significant decrease in Delaware's uninsured rate that we have witnessed since the implementation of the Affordable Care Act.[10] As Governor Carney noted at the launch of open enrollment for the Health Insurance Marketplace

[9] See Appendix B to this document for additional details.

[10] https://www.usnews.com/news/best-states/rankings/health-care/healthcare-access. (Mass is #1, Vermont #3, Maryland #6, R.I. # 7, Florida #49, Alaska #50). *See Also* DHSS, *Delaware Health Needs Assessment 2015* (Feb. 2017—noting the drop in Delaware's uninsured rate from 10.5% in 2013 to 9.6% in 2014).
http://www.dhss.delaware.gov/dph/hsm/files/depchealthneedsassessment2015.pdf.

on November 1, 2017, Delaware's rate of uninsured moved from more than 10% (2008) to 5.7% (2016), reducing the number of uninsured individuals in our state from more than 100,000 to approximately 50,000.[11]

In fact, the fine print on the same report upon which the "third highest" statement is based contains the following caveats that have not been reflected in the White Paper, nor have they been acknowledged in the benchmark discussions:

"States that have relatively higher levels of personal income per capita, greater percentages of the population enrolled in Medicare or Medicaid, and more healthcare capacity tend to have relatively higher levels of health spending per capita."[12]

The reporters also noted that "States with spending that is higher than the national average tend to be located in the New England, Mideast, Great Lakes, and Plains regions."

Perhaps most significantly, the reporters note that **"[b]y contrast, *states with relatively lower per-capita health spending had relatively high rates of uninsurance.*"**[13] In other words, spending in some states is lower because residents of those states simply cannot access needed health care.

Delaware has a long commitment to expanding access to health insurance coverage and reducing the rate of uninsured individuals in our state. We have made strong progress, enabling more Delawareans to have health insurance coverage, obtain preventive care, effectively manage chronic disease, receive critical care, and improve the health of our population as we continue our journey to better health and health care at a lower cost.

II. The Characterization of Delaware's Reluctant Migration to Value-Based Payment is Inaccurate.

The State's presentations in support of the Benchmark to date have created an impression that the concepts of value-based payment models and risk-bearing

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[11] Press Release, State of Delaware, *Open Enrollment Starts Wednesday for Delaware's Health Insurance Marketplace*, November 1, 2017, https://news.delaware.gov/2017/11/01/open-enrollment-starts-wednesday-for-delawares-health-insurance-marketplace-with-shortened-enrollment-period-delawareans-urged-to-sign-up-early-on-healthcare-gov-and-talk-with-assisters-to-s/.

[12] *Health Spending By State 1991-2014; Measuring Per Capita Spending By Payers and Programs*, Health Affairs, July 2017 vol 36:7, at 1319; http://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0416.

[13] *Id* (emphasis added).

arrangements are new concepts in Delaware, or are not present or being used in the Delaware market. Consequently, the State appears to assume that the delay in embracing full risk-bearing arrangements must be attributed to the provider community's collective ignorance or intransigence regarding the inevitable transformation from fee-for-service to value-based payment models.

While this transformation from fee-for-service to reimbursement based on value and outcomes is a challenging road for providers and payers alike, the journey is one that Christiana Care has embraced for several years. The journey to value requires a relentless commitment to quality care and clinical excellence, innovations in care delivery, developing standards and reducing variations in care, coordinating needs for patients with multiple complex conditions, and understanding and working in partnership with others in our community to address the social determinants of our patients' health outcomes.

The Benchmark Summit presentations to date have not acknowledged the progress made to date. 2016 CMS data reflects that approximately fifty percent of the Medicare (FFS) population statewide is attributed to a Delaware shared savings Accountable Care Organization. As the state is aware, providers statewide have demonstrated willingness to expand our participation in risk-based contracts in partnership with payers.

The Benchmark Summit presentations also have not examined the reasons for Delaware's challenges in moving to value-based payment models, including factors that may be beyond the State's ability (separately or together with the payer and provider community) to control. As one of many examples, in a recent Request for Information, CMS noted its receipt of "feedback from the healthcare provider community on the extensive and lengthy process that is required for a model to qualify as an Advanced [Alternative Payment Model],"[14] and noted the need to streamline the process and make additional data available to providers." We welcome the opportunity to have a more detailed conversation with the DHSS leadership team about the progress we have made, within our own organization and in partnership with the eBrightHealth Accountable Care Organization, in moving to risk-bearing value based payment models. We also welcome further discussions around potential opportunities to eliminate some of the structural barriers that we have encountered to date.

[14] CMS, *RFI, Innovation Center New Direction*, Oct. 2017, p. 3; https://innovation.cms.gov/Files/x/newdirection-rfi.pdf.

III. While We Support Finding New Opportunities to Reduce the State's Healthcare Costs, We Do Not Support a Benchmark Based on a "Massachusetts Model" or "Vermont Model" Approach.

While we support the general concept of consolidating some of the state's existing health care policy silos, we oppose the creation of an authority substantially similar to the Massachusetts Health Policy Commission or the Vermont Green Mountain Care Board.

In Massachusetts, the Health Policy Commission has an annual budget of over $10 million and began with approximately 60 full-time employees. Beyond the fundamental structural questions about the number of full-time employees and the cost of creating and maintaining a benchmark oversight and healthcare policy board, we are particularly concerned about the potential for considerable "mission and scope creep" that could easily result from the creation of a large, expensive government oversight authority with expansive jurisdiction over all aspects of the State's health care economy.

This potential is particularly evident in legislation that was introduced in late October, and passed the Massachusetts Senate last week[15], to give even more sweeping State regulatory authority over health care administration to the Massachusetts Health Policy Commission (which already has unprecedented authority to review hospital budgets and subpoena written and oral testimony about health care industry costs). We question the value in creating a vastly expensive government bureaucracy, particularly when the onus for such creation is based upon potentially inaccurate and misleading assumptions about the progress we have made to date through far less draconian measures.

Subject to confirmation of specific details, we would likely support a benchmark or other initiative specific to Medicaid spending, and welcome the opportunity to work with the State on more visionary and innovative proposals for its Medicaid Section 1115 and/or Section 1915 waivers targeting Delaware's most acute areas of need.

We have an opportunity to implement best practices statewide in a coordinated approach reflecting our shared concerns about the unrelenting impact of the opioid epidemic on individuals and families across our state, the opportunity to address disparities in infant mortality rates, and our shared responsibility – in partnership with other health care providers – to care for children with complex medical conditions and ensure their smooth transition to adulthood.

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[15] Katie Lannan, *Mass. Senate Passes Sweeping Health Care Reform Bill,* Nov. 10, 2017, http://www.wbur.org/commonhealth/2017/11/10/mass-senate-health-care-reform-bill.

We look forward to collaborating with DHSS and the state to advance the health of all Delawareans in a thoughtful, deliberate, and transparent manner that ensures continued access to high quality health care services for all Delawareans, including the needs of the most vulnerable members of our community.

Appendix A

All Payers Average Annual % Growth (1991-2014)	National	Delaware
Total Personal Health Care Expenditures	6.0%	7.2%

Medicare

2014 Medicare Spending Per Enrollee	National	Delaware
Delaware's Medicare Spending is **4.3%** higher than the national spending.	$10,986	$11,460

Medicare Personal Health Care Expenditures Average Annual % Growth (1991-2014)	National	Delaware
Total Expenditures	7.2%	7.9%
Per Enrollee Expenditures	5.2%	4.8%

Medicaid

2014 Medicaid Spending Per Enrollee	National	Delaware
Delaware's Medicaid Spending per enrollee is **1.6%** higher than the national spending.	$6,815	$6,921

Medicaid Personal Health Care Expenditures Average Annual % Growth (1991-2014)	National	Delaware
Total Expenditures	7.3%	9.2%
Per Enrollee Expenditures	3.0%	2.3%

Private Health Insurance

2014 Private Health Insurance Personal Health Care Spending Per Enrollee	National	Delaware
Delaware's Private Health Insurance Spending is **5.6%** higher than the national spending.	$4,551	$4,806

Private Health Insurance Personal Health Care Expenditures Average Annual % Growth (2001-2014)	National	Delaware
Total Expenditures	5.3%	4.5%
Per Enrollee Expenditures	5.6%	4.6%

Appendix B

W. Edwards Deming said that "Uncontrolled variation is the enemy of quality." Healthcare is increasingly recognizing the relationship between reducing variation and improving outcomes.

As a leader in identifying and then reducing unwarranted variation in care, Christiana Care has promulgated the criticality of care standardization and invested in the infrastructure that supports development, implementation and sustainment of clinical pathways. We have centralized key functions that support this work, including education, communication, data acquisition and analysis, health care delivery science and project management – and we have harnessed the expertise in our clinical leadership through a clinical governance model.

Care standardization is now an accepted and widely applied approach to the design of all of our clinical processes. Christiana Care has developed numerous well established, detailed clinical roadmaps, plans that describe on many levels the best practices, services and procedures to which an individual can expect to be exposed as they journey through a particular episode of care or encounter a specific diagnosis.

For each pathway, key outcome metrics have been defined and our teams track progress towards improvements on a dashboard. Pathways are modified through application of rapid cycle process improvement methods.

The following are some specific examples of measurable improvements that have occurred as a direct outcome of clinical process changes defined in these pathways.

The Heart and Vascular Service Line implemented a pathway that supports the optimal care of patients experiencing a specific variant of acute coronary syndrome (a heart attack). Processes were standardized based on available best evidence. Adherence to the pathway reduced variations in clinical care.

As a result of pathway implementation, we have seen the following improvements:

- 30% reduction in the time from arrival in the Emergency Department to the key diagnostic first blood test is drawn
- Increase in best evidence medication adherence during hospitalization from 87% to 92%

- Decrease in 30 day readmission rate from 9.6% to 5.1%

The Behavioral Health Service Line implemented an opioid withdrawal pathway in recognition of the variability in screening, identifying and caring for patients with active opioid withdrawal across inpatient settings.

As a result of pathway implementation, we have seen:

- 72% of admitted patients are now screened for opioid withdrawal
- 92.5% of patients found to be at risk for opioid withdrawal have a complete Clinical Opioid Withdrawal Scale (COWS) assessment completed
- 51.5% of patients found to be in opioid withdrawal receive Suboxone for treatment

The Women's and Children's Service Line implemented a pathway for full term newborns (greater than 35 weeks gestation) who are born to mothers with a presumptive diagnosis of chorioamnionitis. At baseline, all of these babies were admitted to the NICU, blood cultures were drawn and antibiotic therapy initiated. The pathway introduced a standard, evidence based assessment of these babies that allowed for more rational assignment to the appropriate level of care.

As a result of pathway implementation, we have seen:

- 81% of babies born to a mother with a fever avoided a NICU admission (only 6% of those babies ultimately required NICU admission)
- Only 29% of newborns in this group required blood cultures
- Only 20% of newborns in this group received antibiotics
- Percentage of babies in this group who were successfully breastfed increased from 5% to 44%

The Surgical Services Service Line implemented a pathway for patients requiring complex hernia repair, a procedure for patients with prior failed hernia repair that require extensive reconstruction. These patients often have attendant co-morbidities and are high risk for surgical and postoperative complications.

As a result of pathway implementation, we have seen:

- Length of stay reduced from 9.6 to 7.2 days
- Readmission rate reduced from 54% to 10%
- Postoperative infection rate reduced from 57% to 10%

The Neurosciences Service Line introduced a pathway to serve adult patients who come to the Emergency Department with a documented seizure that is deemed "uncomplicated." At baseline, many of these patients were lost to follow up in the ambulatory setting with a neurologist.

As a result of pathway implementation, we have seen:

- 78% increase in neurologist involvement in patient care
- 71% decrease in patients lost to follow up
- 98% of pathway patients are contacted by an outpatient neurologist after discharge