
DELAWARE HEALTH CARE DELIVERY AND COST ADVISORY GROUP



HEALTH CARE SPENDING BENCHMARK SUBCOMMITTEE
APRIL 2, 2018

AGENDA

Topic	Time
1. Welcome and Introductions (Secretary Walker)	1:00 pm – 1:10 pm
2. Charge of the Subcommittee (Michael Bailit)	1:10 pm – 1:20 pm
3. Total Health Care Spending (Michael Bailit)	1:20 pm – 1:40 pm
4. Data Sources (Michael Bailit)	1:40 pm – 2:10 pm
5. Units of Measurement (Michael Bailit)	2:10 pm – 2:40 pm
6. Break	2:40 pm – 2:50 pm
7. Health Care Spending Benchmark Methodology (Michael Bailit)	2:50 pm – 3:40 pm
8. Public Comment (Interested Parties)	3:40 pm – 3:55 pm
9. Wrap-up and Next Steps (Secretary Walker)	3:55 pm – 4:00 pm



HEALTH CARE SPENDING BENCHMARK SUBCOMMITTEE CHARGE

BACKGROUND

- Governor Carney's Executive Order #19 established an Advisory Group that will provide feedback to the Secretary of the Department of Health and Social Services (DHSS) on:
 - The selection of methodologies to measure and report on the total cost of health care in Delaware, including the data sources that feed into the methodologies, and
 - The establishment of a health care spending growth target, which will become the cost benchmark.
- The Executive Order also calls for additional work related to the quality benchmark and reporting on variation in health care delivery and costs.
- The purpose of this subcommittee is to dig deeper into the methodological issues of the health care spending benchmark and to provide feedback to the Advisory Group as it continues to work through its charge from the Governor.

WHAT WAS THE RATIONALE FOR GOVERNOR CARNEY'S EXECUTIVE ORDER?

- “Enhanced transparency and shared accountability for spending and quality targets can be used to accelerate changes in our health care delivery system, creating benefits for employers, state government, and health care consumers; and
- The establishment, monitoring, and implementation of annual health care cost and quality targets are an appropriate means to monitor and establish accountability for the goal of improved health care quality that bends the health care cost growth curve...”
 - excerpt from Governor Carney's Executive Order #19
- Benchmarks, as envisioned in the Executive Order, are not spending caps.

BACKGROUND

- By agreeing to participate on this subcommittee to the Advisory Group, you are committing to participate in a thoughtful and respectful process to consider the Advisory Group's charge and make recommendations to the Advisory Group.
- We will not discuss the merits of the charge, but only how we can best respond to it.
- The Advisory Group, and therefore this subcommittee, is advisory only. Because both bodies are advisory, there is no requirement that there be full consensus across all members on future recommendations.

HEALTH CARE SPENDING BENCHMARK SUBCOMMITTEE: CHARGE (1 OF 2)

- I. Provide input to the Advisory Group regarding the creation of a health care spending benchmark that will:
 - Utilize a clear and operational definition of total health care spending for Delaware.
 - Make use of currently available data sources, and anticipate the use of new sources should they become available in the future.
 - Be set at the state level, and, as practicable, at the market (commercial, Medicare, Medicaid) insurer, and health system/provider levels.

HEALTH CARE SPENDING BENCHMARK SUBCOMMITTEE: CHARGE (2 OF 2)

2. Provide input to the Advisory Group regarding the creation of a health care spending benchmark that will:
 - Tie a spending growth benchmark to an appropriate economic index.
 - Be established first for ~~use for the first time~~ for Calendar Year 2019, and then annually thereafter
 - Be used in comparative analysis to actual spending following the end of Calendar Year 2019 and annually thereafter.

HEALTH CARE SPENDING BENCHMARK SUBCOMMITTEE: PROCESS

- We are currently scheduled to meet once; additional meetings may be scheduled in May or June depending upon how the Advisory Group's work progresses.
- This subcommittee's feedback will be reported to the Advisory Group on April 16.
- A separate quality benchmark subcommittee is also meeting to address the methodologies of the quality benchmark and will be following a similar process as this subcommittee.



TOPIC I: WHAT IS TOTAL HEALTH CARE SPENDING?

TOTAL HEALTH CARE SPENDING

- The Advisory Group briefly discussed this topic during its first meeting on March 22nd.
- We will start our work today by revisiting the topic.

TOTAL HEALTH CARE SPENDING

- A cost growth benchmark is predicated on understanding total spending on health care. This allows comparison of year-over-year change to the benchmark.
- We therefore need to answer the following questions:
 1. Whose health care spending is being measured?
 - Which populations?
 - Which lines of business?
 2. Exactly what spending should be measured?
 3. Where does the data come from?

TOTAL HEALTH CARE SPENDING

- Ideally, total health care spending would encompass spending on all health care services across the state for all populations. There are challenges to doing so, and therefore strategy options to consider.
- Please note: We are defining “spending” to mean financial outlays by those buying health insurance and/or health care. We are not considering provider or insurer revenues or costs.
- Let’s now consider the questions on the preceding slide one at a time.

TOTAL HEALTH CARE SPENDING: WHICH POPULATIONS?

- Let's assume that Delaware should include as many populations and their associated health care spending as possible to address the Governor's stated aim of creating benefits for employers, state government, and health care consumers through:
 - Enhanced transparency, and
 - Monitoring improved quality that bends the health care cost growth curve.
- With this as a starting point, is there a case to be made for excluding any of the populations on the following slide, assuming for now that necessary data are attainable?

TOTAL HEALTH CARE SPENDING: WHICH POPULATIONS?

- **Medicare**
 - Medicare FFS (Parts A, B, D)
 - Medicare Advantage
- **Medicaid**
- **CHIP**
- **Medicare and Medicaid Dually Eligible**
- **Commercial**
 - Fully-Insured
 - Self-Insured
 - Choose Health Delaware
- **Veterans Health Administration**
- **FEHB**
- **TRICARE**
- **Uninsured**

TOTAL HEALTH CARE SPENDING: EXCLUDED POPULATIONS?

Possible Pros / Cons for Excluding Populations

	Pros	Cons
Medicare	<ul style="list-style-type: none"> • Little state policy influence over Medicare 	<ul style="list-style-type: none"> • Close to 20% of Delawareans are Medicare beneficiaries
Medicaid	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Close to 25% of Delawareans are Medicaid beneficiaries
Medicare and Medicaid Dually Eligible	<ul style="list-style-type: none"> • Less than 3% of the total population are dually eligible 	<ul style="list-style-type: none"> • While a small number, dually eligible beneficiaries incur significant spending
Commercial	<ul style="list-style-type: none"> • Need insurer cooperation • Data limitations may be significant for self-insured 	<ul style="list-style-type: none"> • Largest population within the state

TOTAL HEALTH CARE SPENDING: EXCLUDED POPULATIONS?

Possible Pros / Cons for Excluding Populations

	Pros	Cons
Veterans Health Administration	<ul style="list-style-type: none"> Data may be limited 	<ul style="list-style-type: none"> Veterans make up about 8% of the population of the state.
FEHB	<ul style="list-style-type: none"> Less than 1% of Delawareans are federal employees 	<ul style="list-style-type: none"> None
TRICARE	<ul style="list-style-type: none"> Less than 0.5% of Delawareans are active members of the military 	<ul style="list-style-type: none"> None
Uninsured	<ul style="list-style-type: none"> Data would need to come from providers and is very difficult to estimate 	<ul style="list-style-type: none"> Uninsured residents represent 6% of the population of the state

TOTAL HEALTH CARE SPENDING: WHAT TYPES OF SPENDING?

- Generally there are two sets of spending to be measured:
 1. **Claims-based spending** — Claims-based spending consists of payments made following submission of a specific claim for health care services.
 2. **Non-claims-based spending** — Non-claims-based spending consists of payments not associated with a specific claim (e.g., capitation, pay-for-performance incentive payments).

TOTAL HEALTH CARE SPENDING: CLAIMS-BASED SPENDING

- Typical claims-based spending include:

- Hospital — Inpatient
- Hospital — Outpatient
- Physicians
- Other professionals
- Home health and community health
- Long-term care
- Dental
- Pharmacy
- Durable medical equipment
- Hospice

- Should each of these claim-based spending categories be included?

- Are there any services missing that should be captured in this list?

- An Advisory Group member asked, “Should only payments over which providers and payers have control be included?” How do you evaluate this question?

TOTAL HEALTH CARE SPENDING: CLAIMS-BASED SPENDING EXCLUDED SERVICES?

Possible Pros / Cons for Excluding Services

	Pros	Cons
Hospital Inpatient / Outpatient Services	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Historically the largest source of spending in the health care system
Physician and other professionals	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Largest influencers of cost to the health care system
Home and community health	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Important Provider that will be taking on costs as health care shifts from less expensive sites of care
Long-term care	<ul style="list-style-type: none"> • Primarily a Medicaid-funded service 	<ul style="list-style-type: none"> • Important part of spending in DE as the population ages

TOTAL HEALTH CARE SPENDING: CLAIMS-BASED SPENDING EXCLUDED SERVICES?

Possible Pros / Cons for Excluding Services

	Pros	Cons
Dental	<ul style="list-style-type: none"> • Not covered by commercial insurers as part of health care coverage, nor by Medicare • Data may be difficult to obtain from commercial dental carriers 	<ul style="list-style-type: none"> • Oral health is integral to overall health, and poor oral health can lead to poor general health, which could be costly • Tooth aches are a common reason for ED visits
Pharmacy	<ul style="list-style-type: none"> • High-cost pharmaceuticals and patent-protected drugs new to the market can cause large variation in health care spending year-to-year 	<ul style="list-style-type: none"> • Not including pharmacy would leave out an important piece of the health care cost picture, especially for consumers
DME	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • A substantial source of spending
Hospice	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • A source of spending

MASSACHUSETTS' APPROACH

- Massachusetts' insurers are required to report health care spending on the following:
 - Hospital — Inpatient
 - Hospital — Outpatient
 - Professional physician
 - Professional other — Services provided by licensed practitioners that are not physicians including, community health centers, freestanding ambulatory surgical centers, podiatrists, CRNPs, PT/OT, and more
 - Prescription drugs
 - Other — All other payments generated from claims, including SNF, home health, DME, hearing aids, etc.

TOTAL HEALTH CARE SPENDING: NON-CLAIMS-BASED SPENDING

- Not all health care spending is captured through a claim. There is non-claims spending that should be included. For example:
 - Performance incentive payments;
 - Prospective payments for health care services (e.g., capitation);
 - Payments that support care transformation (e.g., care manager payments);
 - Payments that support provider services (e.g., DSH payments);
 - Prescription drug rebates/discounts;
 - Net cost of private health insurance; and/or
 - Patient cost sharing for eligible populations.
- Is there any reason to not include any of these non-claim-based spending categories?

TOTAL HEALTH CARE SPENDING: NON-CLAIMS-BASED SPENDING

- During the March 22 Advisory Group meeting, questions were raised about additional non-claims-based spending categories. Here are additional categories to be considered by the subcommittee:
 - Correctional health system;
 - Federal grant dollars distributed to providers by state agencies (e.g., mental health, substance use disorder, public health-related services);
 - Federal grant dollars distributed directly to providers (e.g., HRSA funding of FQHCs).

- Should any of these non-claim-based spending categories be included?
- Are there any other services missing that should be captured in the list on the prior slide?

MASSACHUSETTS' APPROACH

- Massachusetts requires the following to be reported:
 - **Non-claims incentive programs:** All payments made to providers for achievement relative to specific pre-defined goals for quality, cost reduction, or infrastructure development (e.g., P4P payments, EMR/HIT adoption incentive payments)
 - **Capitation and risk settlements:** All payments made to providers as a reconciliation of payments made and payments made not on the basis of claims.
 - **Care management:** All payments made to providers for providing care management, utilization review, discharge planning and other care management programs.
 - **Other:** All other payments pursuant to a payer's contract with a provider that were not made on the basis of a claim for a medical services and not classified above, e.g., governmental payer shortfall payments, grants, or surplus payments.

TWO COMPLICATING CIRCUMSTANCES (1 OF 2)

- I. **Carveouts** — Health insurers frequently administer plans with carveouts, most commonly for pharmacy and behavioral health services. Sometimes the carveout vendors contract directly with the self-insured employer.
 - How should Delaware account for such benefit carve-outs?
 - Massachusetts' approach: Payers report partial claims data with respect to their carve-out benefit and the state contracts with an actuary to estimate the health care spending on carved-out services.

TWO COMPLICATING CIRCUMSTANCES (2 OF 2)

2. **Prescription Drug Rebates:** Prescription drug rebates and other price concessions are commonly granted to pharmacy benefit managers and health insurers from drug manufacturers. The effect of these rebates is not clear on health care spending.
 - How should Delaware account for pharmacy rebates?
 - Massachusetts' approach: M.G.L c. 12C requires consideration of the effect of drug rebates and other price concessions in the aggregate on health care spending growth trends.
 - Massachusetts requires payers to report on:
 - Pharmacy expenditures net of rebates,
 - Aggregate prescription drug rebates, and
 - Aggregate pharmacy expenditures (including member cost sharing and excluding rebates).
 - Rebates are reported separately and not part of the benchmark.

TWO COMPLICATING CIRCUMSTANCES

Possible Pros / Cons for Including Carveouts and Prescription Drug Rebates

	Pros	Cons
Carveouts	<ul style="list-style-type: none">• Not doing so would give an incomplete picture of commercial spending	<ul style="list-style-type: none">• If DE adopted MA's approach to estimating carveout spending, it would be an added effort and expense for the State
Prescription Drug Rebates	<ul style="list-style-type: none">• Pharmacy rebates are known to be substantive	<ul style="list-style-type: none">• May be challenging to do• No precedence for including the effect of drug rebates in the total health care cost spending benchmark calculation



TOPIC 2:
FROM WHERE WILL THE DATA FOR THE COST
GROWTH BENCHMARK COME?

WHICH ENTITIES WILL PRODUCE TOTAL HEALTH CARE SPENDING DATA?

- Governor Carney's Advisory Group charge is to advise the Secretary on the selection of methodologies to measure and report on the total cost of health care in Delaware; **including the data that feed into the methodologies.**
- To identify the data that feed into the methodologies, we need to understand:
 1. Which entities have data on total health care spending?
 2. What is the relative effort required for each entity to produce data on total health care spending?
 3. What are the pros and cons for each approach?

FROM WHERE DO THE DATA USED BY MASSACHUSETTS COME?

- The Center for Health Information and Analysis (CHIA) collects data based on its statutory authority from multiple sources that are used to calculate its benchmark.

- **Commercially-Insured Expenditures:**
 - 10 largest commercial payers in Massachusetts
 - Commercial payers offering MassHealth (Medicaid)
 - Medicare Advantage plans

- **Publicly-Insured Expenditures:**
 - CMS (Medicare)
 - MassHealth FFS and MassHealth MCOs
 - Health Safety Net (pays acute care hospitals and community health centers for certain services provided to qualified uninsured and underinsured residents)
 - Medical Security Program (for eligible state unemployment insurance recipients)
 - Veterans Affairs

WHEN IS PERFORMANCE REPORTED IN MASSACHUSETTS?

- The Mass. legislature requires CHIA to report on health care spending relative to the benchmark on September 1 of each year.
- To meet this deadline, the state needed a sufficient amount of time to analyze payer-reported data, and payers needed a long enough claim run-out time period to capture all of the health care spending.
- Therefore, CHIA collects and reports preliminary findings in order to meet the September 1 deadline, and then recalculates the benchmark in a final report a year later.
 - For example, preliminary data for 2017 will be collected in May 2018 (2-3 months of run-out with completion factors and estimates of other anticipated payments (e.g. quality settlements)), and published in September 2018.
 - Final data for 2017 will be collected in May 2019 (14 months of run-out, assumed complete), and published in September 2019.

WHAT OPTIONS DOES DELAWARE HAVE FOR DATA SOURCES?

- There is at present no statute in Delaware requiring insurer data submission exists as in Massachusetts, except for Medicaid MCO and state employee health benefit plan TPA data required for the Delaware Health Care Claims Database.
- This means that additional data, unless there is state action, will have to be submitted voluntarily. What might be the sources for such data?
 - **Medicaid:** DHSS could provide Medicaid FFS spending and enrollment data for non-MCO-covered services.
 - **Medicare:** CMS already provides DHSS with Medicare total cost of care data on a per capita basis that could potentially be used..
 - **Commercial insured:** A small number of insurers represent the majority of the commercial insurance market. Highmark has indicated a willingness to explore voluntary submission. Conversations will need to occur with other carriers.

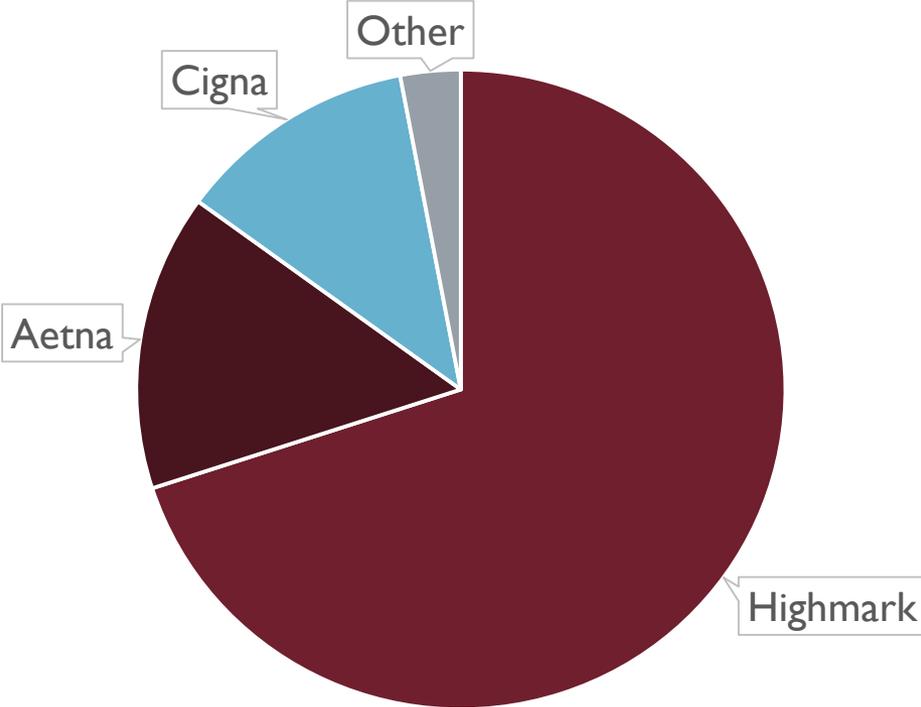
WHAT OPTIONS DOES DELAWARE HAVE FOR DATA SOURCES?

- Special consideration needs to be given to commercial self-insured data.
- The U.S. Supreme Court ruled in *Gobeille vs. Liberty Mutual* that the Employee Retirement Income Security Act (ERISA) invalidates state all-payer claims database (APCD) reporting requirements for self-funded employee health plans.
 - The *Gobeille* decision prohibited states from requiring claim data submission, however, employers can agree to provide them voluntarily.
 - The *Gobeille* decision specifically referred to claims data, and not to summary-level data.
 - Massachusetts' insurers have been amenable to providing self-insured employer data for benchmark purposes because it is provided at a summary level, and not on a claim level as prohibited by *Gobeille*.

WHAT OPTIONS DOES DELAWARE HAVE FOR DATA SOURCES?

- Should Delaware:
 - Ask commercial insurers to provide benchmark calculation data voluntarily?
 - Contractually require that they do so, for those insurers that contract with the state?
 - Statutorily require all health insurers to do so?
- What are the pros and cons of obtaining commercial insurer data from some but not all insurers?
 - Is there a percentage threshold that should be considered for gathering most of the commercial insurance market data?

DELAWARE COMMERCIAL INSURER MARKET SHARE



■ Highmark 70% ■ Aetna 15% ■ Cigna 12% ■ Other 3%

ARE THERE ANY OTHER SOURCES OF COMMERCIAL INSURER SPEND DATA?

- It does not appear so.
- Providers are not in a strong position to submit data for many reasons.
- In the long run, the establishment of a true All-Payer Claims Database (APCD) as exists in other states could assist the State in reporting on the benchmark.
 - Vermont does use its APCD to report on performance against its benchmark.
 - Massachusetts does not use its APCD for performance assessment for ease of use and data validation reasons.

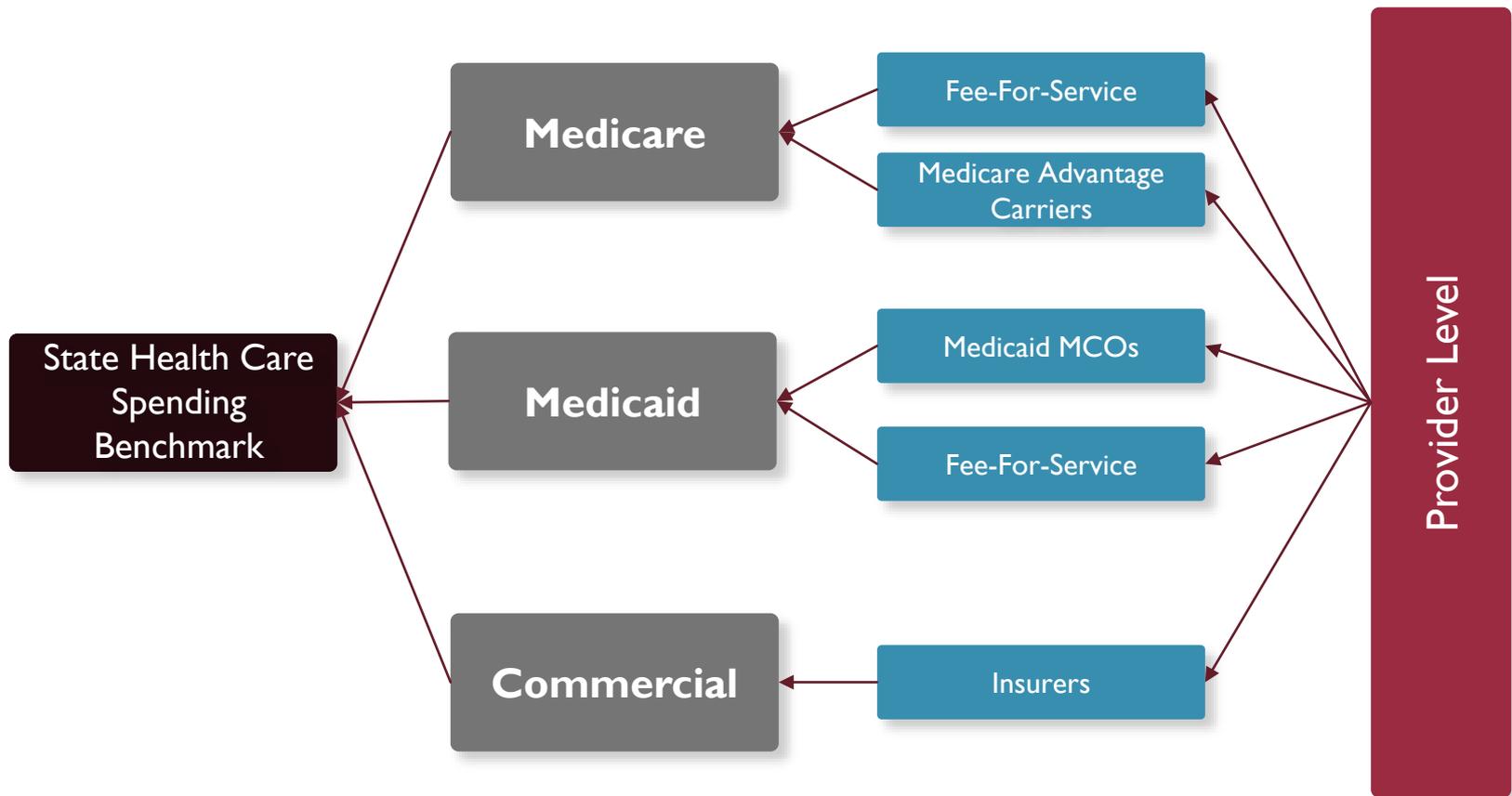


TOPIC 3: UNITS OF MEASUREMENT

UNITS OF MEASUREMENT

- The Executive Order states that the health care spending benchmark will be set at the state level, and, as practicable, at the:
 - Market (commercial, Medicare, Medicaid);
 - Insurer, and
 - Health system/provider levels.
- The “as practicable” language applies to assessing performance against the benchmark, rather than setting the benchmark.

UNITS OF MEASUREMENT



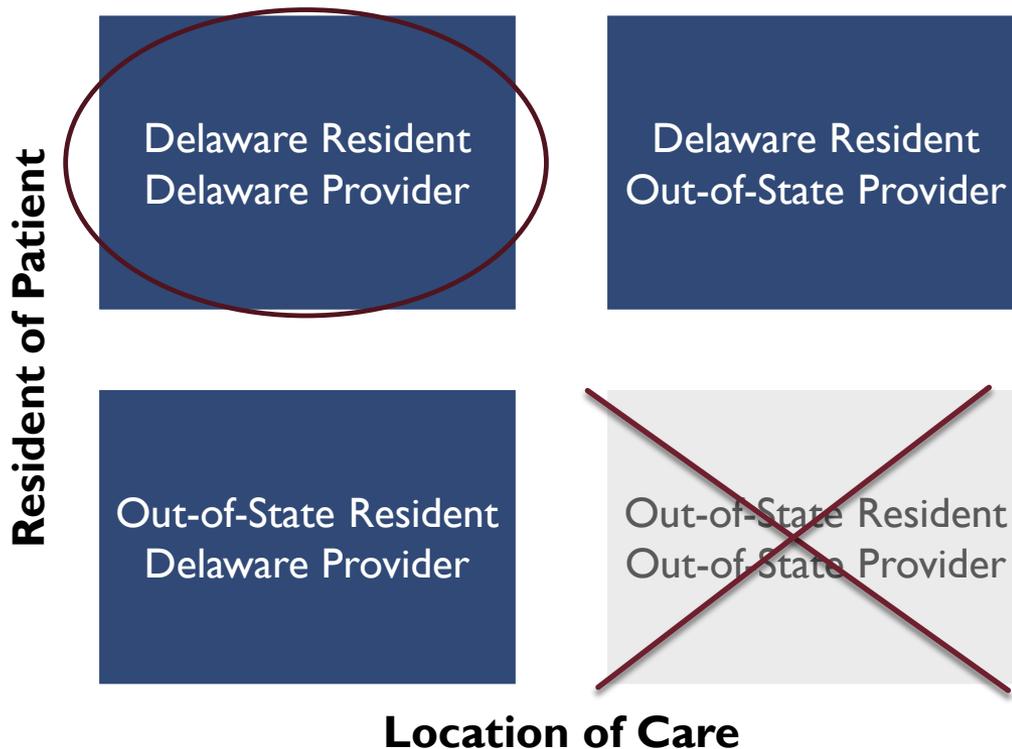
UNITS OF MEASUREMENT: STATE LEVEL

- To report health care spending at the state level there are two decisions to be made:
 1. What is the numerator?
 - What goes into the numerator has been previously addressed when we discussed what should go into total health care spending.
 2. What is the denominator?
 - Two key questions:
 - What is the residence of the patient?
 - What is the location of the care provider?

STATE LEVEL DENOMINATOR: THREE OPTIONS

Resident of Patient	Delaware Resident Delaware Provider	Delaware Resident Out-of-State Provider
	Out-of-State Resident Delaware Provider	Out-of-State Resident Out-of-State Provider
	Location of Care	

STATE LEVEL DENOMINATOR: DELAWARE RESIDENTS CARED FOR BY DELAWARE PROVIDERS



- It's clear that we would want to include Delaware residents who received care from Delaware providers.

STATE LEVEL DENOMINATOR: DELAWARE RESIDENTS CARED FOR BY OUT-OF-STATE PROVIDERS



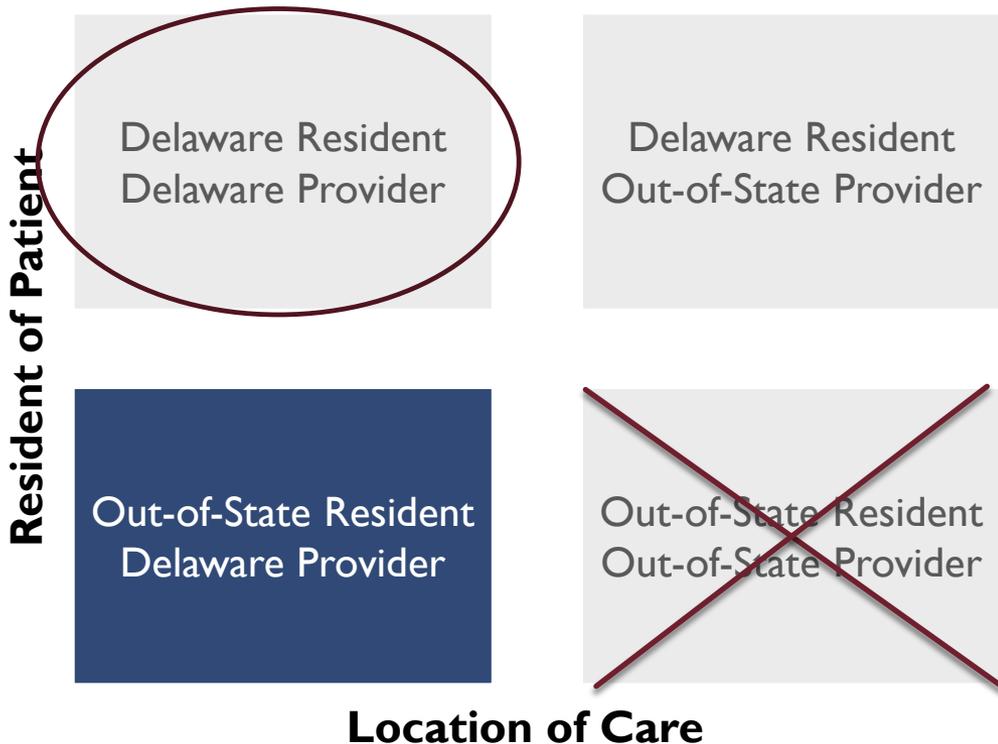
- **Should we include Delaware residents who received care from out-of-state providers?**
- This may be a consideration given the close proximity most residents are to another state.
- If yes, should we include just bordering states? What about “snow birds” who travel to Florida or other parts of the country for part of the year?
- Some health systems and ACOs have affiliation or employed physicians who are practicing in nearby states. Do we include these out-of-state providers if they care for DE residents?

STATE LEVEL DENOMINATOR: DELAWARE RESIDENTS CARED FOR BY OUT-OF-STATE PROVIDERS



- Delaware insurers should not have any difficulty in reporting this data from claims.
- Medicare reports personal health care expenditures by state of provider and by state of residence.
- Massachusetts does **not** include out-of-state providers in its denominator for its cost-growth target, but Massachusetts has much less out-of-state care migration than does Delaware.

STATE LEVEL DENOMINATOR: OUT-OF-STATE RESIDENTS CARED FOR BY DELAWARE PROVIDERS

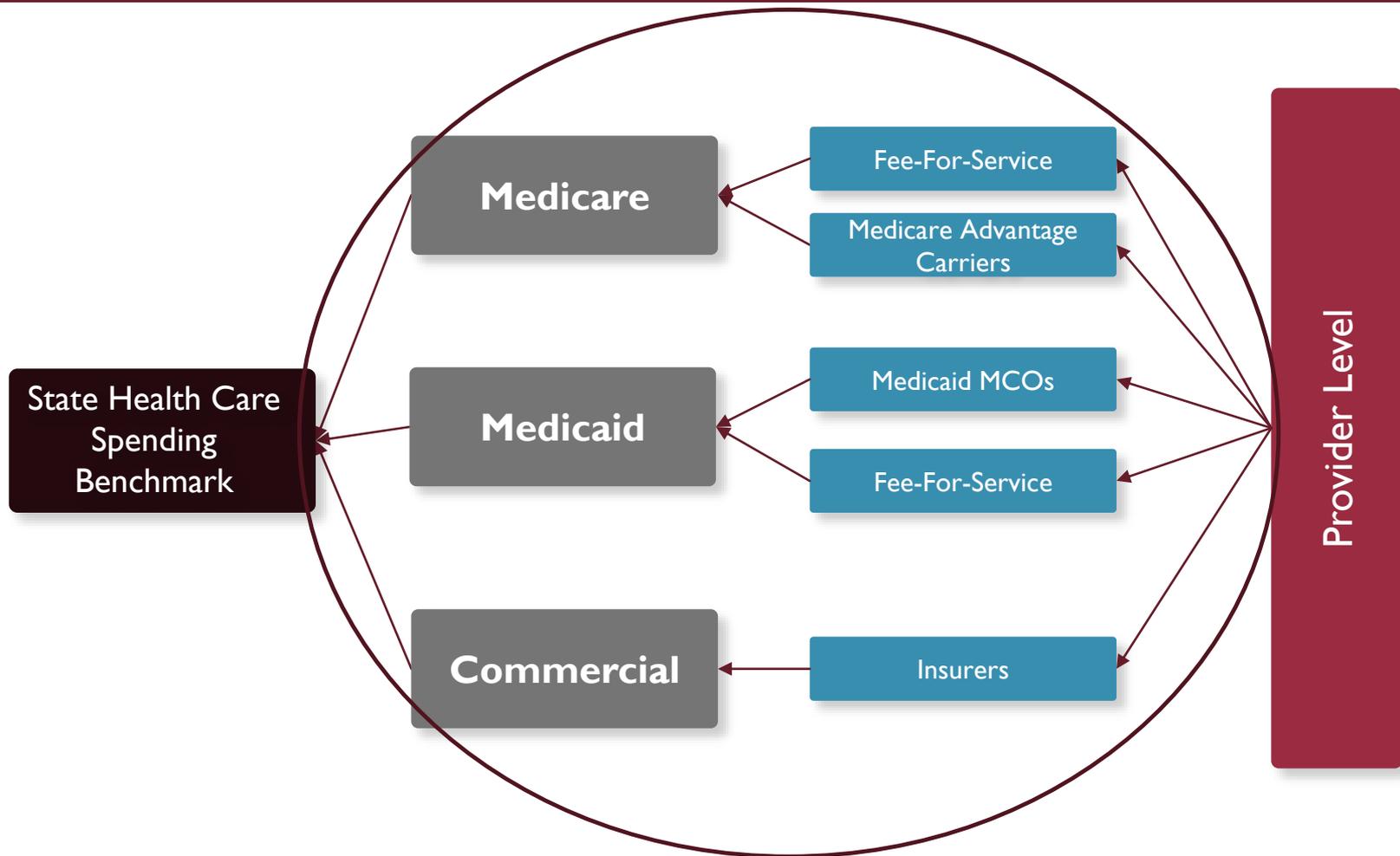


- **Should we include out-of-state residents who receive care by Delaware providers?**
- Because of those close borders, Delaware providers care for non-Delaware residents.
- This might not be challenging for some insurers who have a presence in neighboring states, but may be so for insurers who do not have a large DE market.
- Do we care about this spending since it is not DE spending and DE spending is our focus?

STATE LEVEL DENOMINATOR: ONE LAST DENOMINATOR QUESTION!

- What about employers who pay for health care for employees who don't live in Delaware?
- Does this constitute state spending if neither the patient nor provider resides in Delaware?

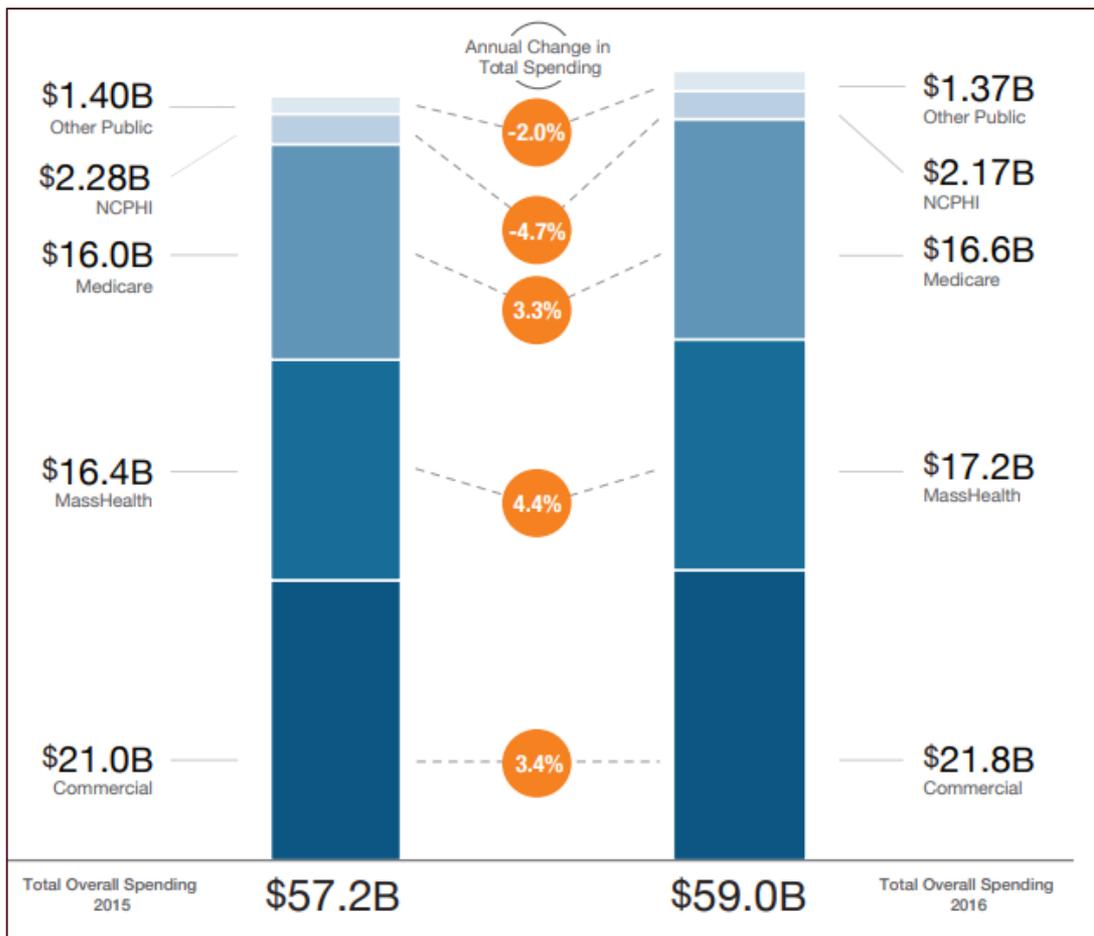
UNITS OF MEASUREMENT: INSURANCE MARKET AND INSURER LEVEL



UNITS OF MEASUREMENT: INSURANCE MARKET AND INSURER

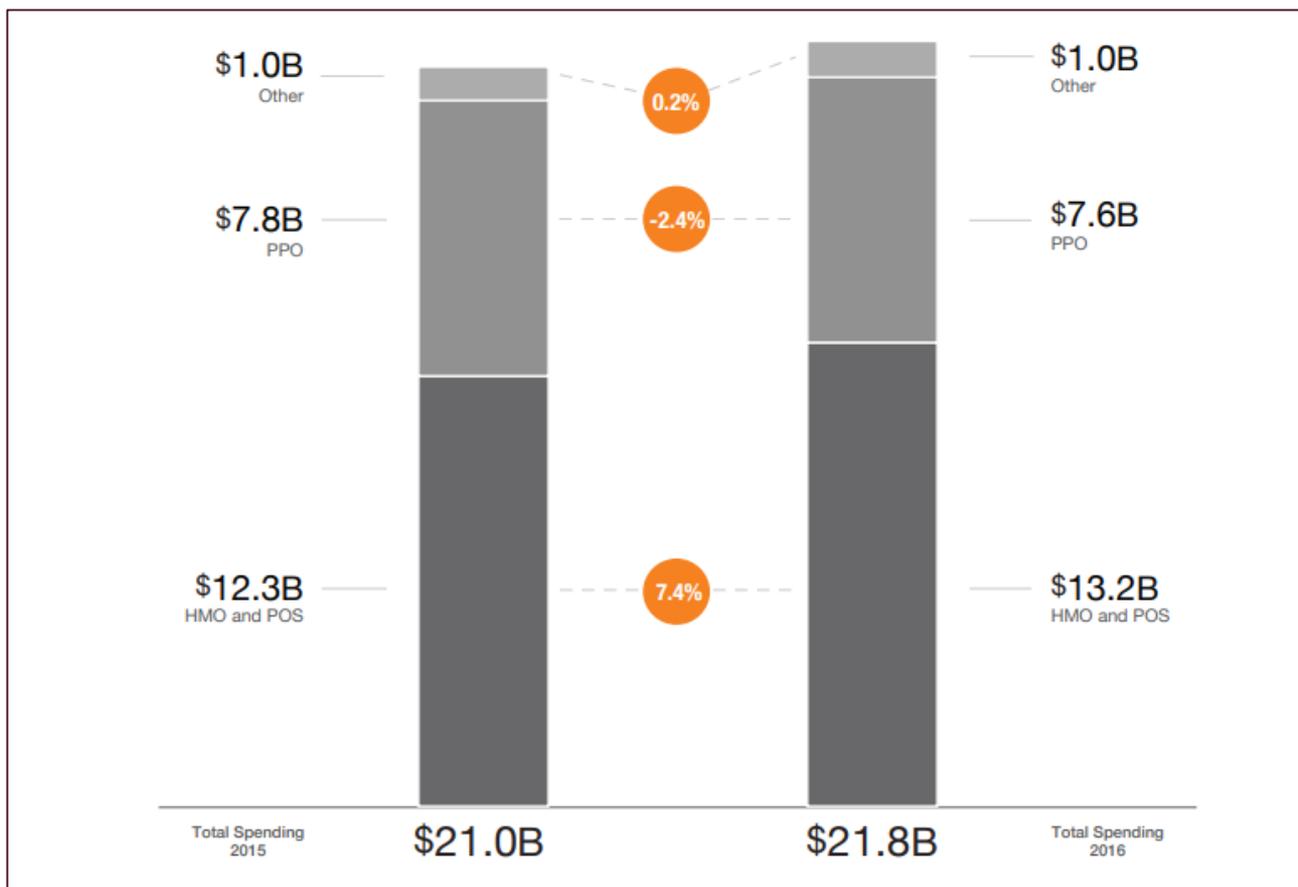
- Reporting at the insurance market and insurer level needs to be addressed by insurance market:
 - **Medicare:** Medicare can provide the State with spending on its FFS population, which is the vast majority of Medicare spending in the State.
 - Should Delaware request data from Medicare Advantage plans, even though they represent a small portion (~10%) of Medicare benefits?
 - **Medicaid:** Should Medicaid report on spending by population group or in solely in aggregate?
 - **Commercial:** There have been several factors to consider with respect to commercial reporting, most of which has been previously discussed.

MASSACHUSETTS REPORTS ON SPENDING AT THE INSURANCE MARKET LEVEL

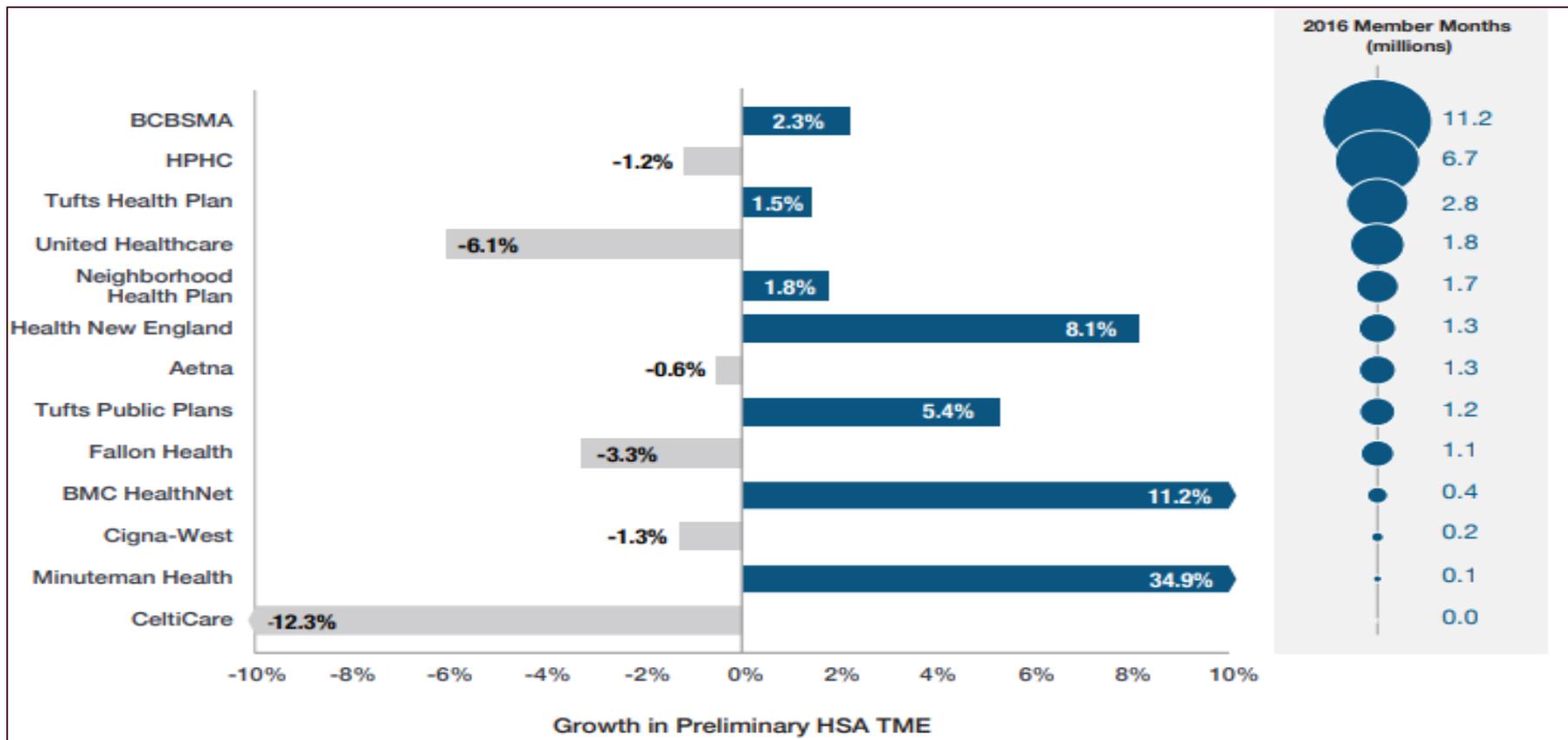


Source: Center for Health Information and Analysis (CHIA) Performance of the Massachusetts Health Care System Annual Report, September 2017

MASSACHUSETTS REPORTS ON SPENDING BY PRODUCT TYPES WITHIN INSURANCE MARKETS



MASSACHUSETTS MEASURES TOTAL MEDICAL EXPENSE GROWTH BY INSURER



UNITS OF MEASUREMENT: PROVIDER

- In order to publish health care spending growth by provider, there are four questions that we must address.
 1. How will patients be attributed to providers?
 2. What types of providers should be included?
 3. How many attributed patients must a provider have for its health care spending growth rate to be calculated?
 4. Does the difference in clinical risk across providers or changes in clinical risk attributed to one provider get adjusted, and if so, how?

PATIENT ATTRIBUTION: WHY IT'S IMPORTANT

- Performance against the benchmark needs to be reported on a per capita basis because doing so takes into account the three driving factors of health care growth: price, volume and service mix.
- To report on a per capita basis, the spending of patients/members needs to be attributed to one provider.
- Before we discuss which providers' performance should be reported, we must first consider how patients could be attributed to any given provider.

PATIENT ATTRIBUTION: TWO APPROACHES

1. Patients can be attributed using a common patient attribution methodology, where insurers work together to agree upon a methodology and apply it to this process.
 - Pro: This would increase comparability across insurers.
 - Con: This could add a layer of complexity to the process as insurers would need to agree upon a methodology, and then apply it to their data.
2. Patients can be attributed using each payer's own attribution methodology employed with their value-based payment contracts or for other purposes.
 - Pro: This would make reporting easier for insurers.
 - Con: The variation in methodology could might produce inconsistent results.

MASSACHUSETTS' APPROACH TO PATIENT ATTRIBUTION

- Massachusetts has developed a four-step patient attribution process.
 1. Insurers first attribute spending by Massachusetts members who are required to select a primary care provider by plan design.
 2. Then, by members who were attributed during the reporting year to a PCP, pursuant to a contract between the payer and provider for financial or quality performance.
 3. Next, on members attributed to a PCP by the payer's own attribution methodology.
 4. Finally, members not attributable to a PCP are reported to CHIA at the insurer and level (and not at the provider level).
- Note: MA law requires that “to the maximum extent possible [carriers] shall attribute every member to a primary care provider.”

PATIENT ATTRIBUTION: WHAT TYPES OF PROVIDERS SHOULD BE INCLUDED?

- Now that we've discussed possible ways of attributing patients, we need to apply that to provider types to answer the question: which provider types will have their performance assessed against a benchmark?
- Options include:
 - ACOs
 - Health systems
 - IPAs
 - Medical groups with primary care, including FQHCs

PATIENT ATTRIBUTION: WHAT TYPES OF PROVIDERS SHOULD BE INCLUDED?

PROVIDER TYPE	PROS	CONS
ACOs	<ul style="list-style-type: none">• Patients are already attributed to ACOs for the purposes of their contracts• Significant ACO development is underway	<ul style="list-style-type: none">• None identified
Health Systems	<ul style="list-style-type: none">• Health systems are the principle organizers of care in Delaware	<ul style="list-style-type: none">• Some of the hospitals could lack sufficient volume for meaningful measurement

PATIENT ATTRIBUTION: WHAT TYPES OF PROVIDERS SHOULD BE INCLUDED?

PROVIDER TYPE	PROS	CONS
Medical groups with primary care, including FQHCs	<ul style="list-style-type: none">• Patients can be attributed fairly easily, especially within HMO products	<ul style="list-style-type: none">• Only the largest practices would meet minimum volume thresholds
IPAs	<ul style="list-style-type: none">• Significant number of DE physicians belong to IPAs	<ul style="list-style-type: none">• IPAs may not be mutually exclusive from ACO—this warrants analysis

MASSACHUSETTS' APPROACH

- Massachusetts publicly reports on health care spending relative to the benchmark by provider organization with a certain volume (to be discussed momentarily).
- Massachusetts reports performance relative to the benchmark for the 10 largest provider organizations.
- For other groups that still meet volume thresholds, CHIA confidentially reports to the Health Policy Commission any provider that is above the benchmark, for one or more payers, so that the Health Policy Commission may conduct further analysis.

HOW MANY ATTRIBUTED PATIENTS MUST A PROVIDER HAVE FOR ITS HEALTH CARE SPENDING GROWTH RATE TO BE CALCULATED?

- To report on health care spending at the provider level, the provider needs to be sufficiently large enough to help dampen any “noise” in the data, and reduce the chance that random variation played a part in its performance.
- What should the minimum patient volume be for providers who will have their performance measured against the benchmark?

MASSACHUSETTS PROVIDER SIZE

- Insurers calculate and report by physician groups for which the insurer has 36,000 Massachusetts resident member months.
- Member months:
 - 12 member months is the equivalent of one member year, so 36,000 member months is equivalent to 3,000 member years.
- Insurers report data at the physician group level and at the physician group's parent organization level (if applicable).
- Insurers report data in aggregate at the insurer level only for contracted physician practices with fewer than 36,000 member months.

RISK ADJUSTMENT APPROACH

- If providers are going to have members and their expense attributed to them, differences in clinical risk should be considered.
- There are two ways in which risk adjustment might be done.
- Each insurer can use its own risk adjuster.
- Insurers use a common risk adjuster.

PROVIDER TYPE	PROS	CONS
Each insurer uses its own risk adjuster	<ul style="list-style-type: none">• Administratively less complex	<ul style="list-style-type: none">• Provider spending growth rates can't be compared against each other as easily since how clinical risk is adjusted for is different
A common risk adjuster is used	<ul style="list-style-type: none">• There are publicly available risk adjusters that could be used (HCCs)	<ul style="list-style-type: none">• Administratively more complex

MASSACHUSETTS: EACH INSURER USES ITS OWN RISK ADJUSTER

Payer	Risk Adjustment Tool and Version		
	2014 Final	2015 Final	2016 Preliminary
Aetna Inc.	Ingenix ERG Retrospective v8.2.116	Ingenix ERG Retrospective v8.2.130	Ingenix ERG Retrospective v8.2.130
Blue Cross Blue Shield of Massachusetts	DxCG Version 4.2	DxCG Version 4.2	DxCG Version 4.2
BMC HealthNet Plan	DxCG 4.3.1	DxCG 4.3.1	DxCG 4.3.1
Celticare Health Plan of Massachusetts	Optum Impact Pro V7 & V8	Optum Impact Pro V7 & V8	Optum Impact Pro V7 & V8
Cigna Health and Life Ins. Co. (EAST)**	ERG INGENIX 7.5	ERG INGENIX 7.5 & 8.3	ERG INGENIX 8.3
Cigna Health and Life Insurance Company (CHLIC)	MedAssets Refined DRG Grouper RDRG r24	MedAssets Refined DRG Grouper RDRG r24	MedAssets Refined DRG Grouper RDRG r24
Fallon Health	Optum IIRP v4.1	Optum IIRP v4.1	Optum IIRP v4.1
Harvard Pilgrim Health Care	DxCG 4.1 model 18	DxCG 4.1 model 18	DxCG 4.1 model 18
Health New England	MARA 2.2.4.0	MARA 3.8	MARA 3.8
Health Plans Inc. (Harvard Pilgrim Health Care)	DxCG 5.0 model 18	DxCG 5.0 model 18	DxCG 5.0 model 18
Minuteman Health, Inc.	Federal HCC Risk Adjustment 2015	Federal HCC Risk Adjustment 2015	Federal HCC Risk Adjustment 2015
Neighborhood Health Plan	DxCG 5.1	DxCG 5.1	DxCG 5.1
Tufts Health Public Plans, Inc. (Network Health LLC)	DxCG Intelligence 4 GUI 4.2.0	DxCG Intelligence 4 GUI 4.2.0	DxCG Intelligence 4 GUI 4.2.0
Tufts Health Plan***	DxCG 5.0	DxCG 5.0	DxCG 5.0
Tufts Medicare Advantage	CMS Monthly Membership Report	CMS Monthly Membership Report	CMS Monthly Membership Report
UniCare Life and Health Insurance Company	DxCG 4.1.0	DxCG 4.1.0	DxCG 4.1.0
UnitedHealthcare	Symmetry Episode Risk Grouper 8.3	Symmetry Episode Risk Grouper 8.3	Symmetry Episode Risk Grouper 8.3
United Medicare Advantage	2007 CMS-HCC & CMS Monthly Membership Report	2007 CMS-HCC & CMS Monthly Membership Report	2007 CMS-HCC & CMS Monthly Membership Report



TOPIC 4:
HEALTH CARE SPENDING BENCHMARK
METHODOLOGY

HEALTH CARE SPENDING BENCHMARK METHODOLOGY

- The last topic, but perhaps the most important, is what will be the benchmark, i.e., the target growth rate?
- There are a number of decisions to make including, will the benchmark be:
 1. Tied to economic growth, inflation or another economic indicator?
 2. Adjusted? (inflated or deflated (+/-) by a certain number of percentage points)
 3. Forecasted, historical or a blend of each?
 4. Based on a multi-year approach (averaging, or weighting years) or a single-year approach?
- We'll review each one of these decisions individually.

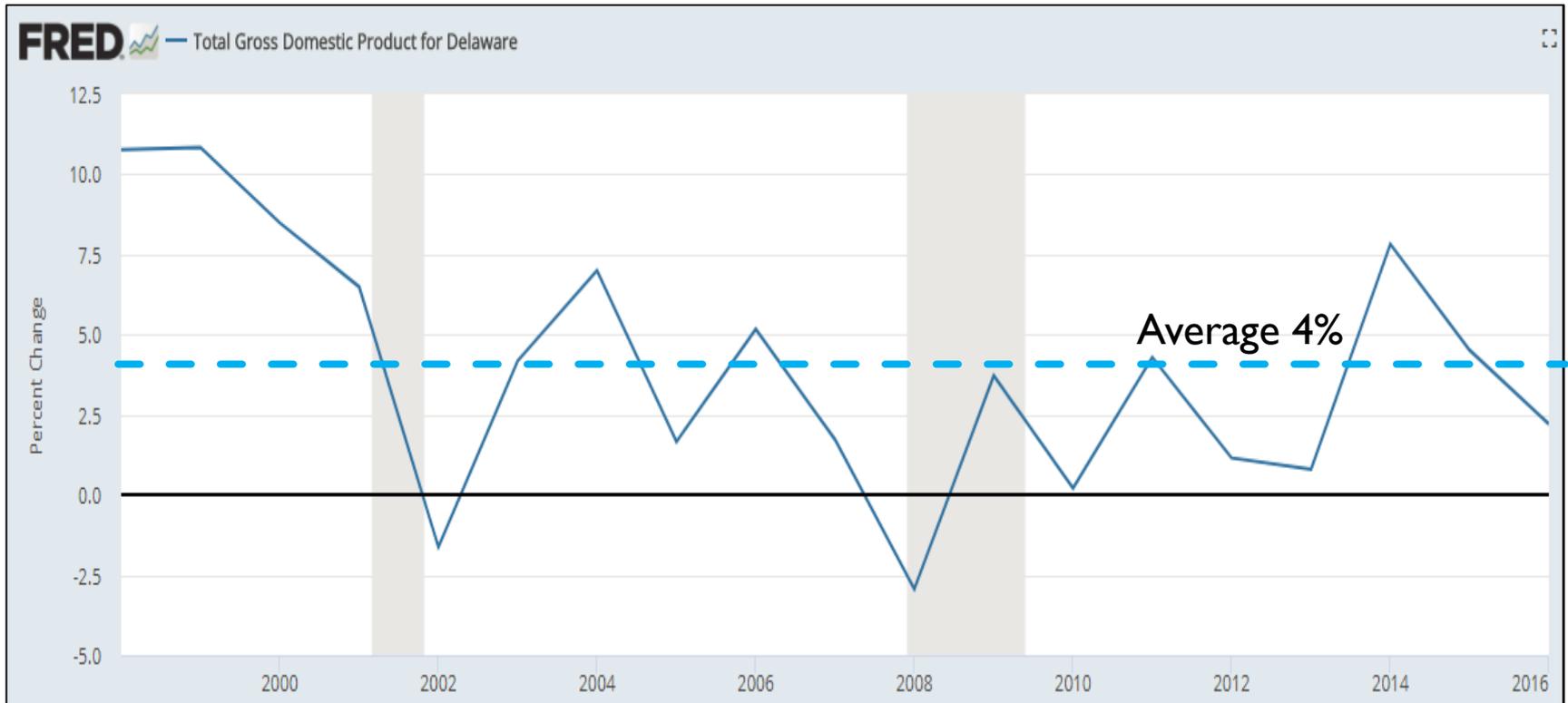
BENCHMARK: TIED TO ECONOMIC GROWTH OR INFLATION?

1. Economic growth indicators:
 - Delaware GSP
2. Inflation indicators for the Philadelphia-Camden-Wilmington region:
 - General inflation (Consumer Price Index (CPI))
 - CPI less food and energy
 - CPI medical care
 - Implicit price deflator for state and local government purchases

LINKING THE BENCHMARK TO ECONOMIC GROWTH

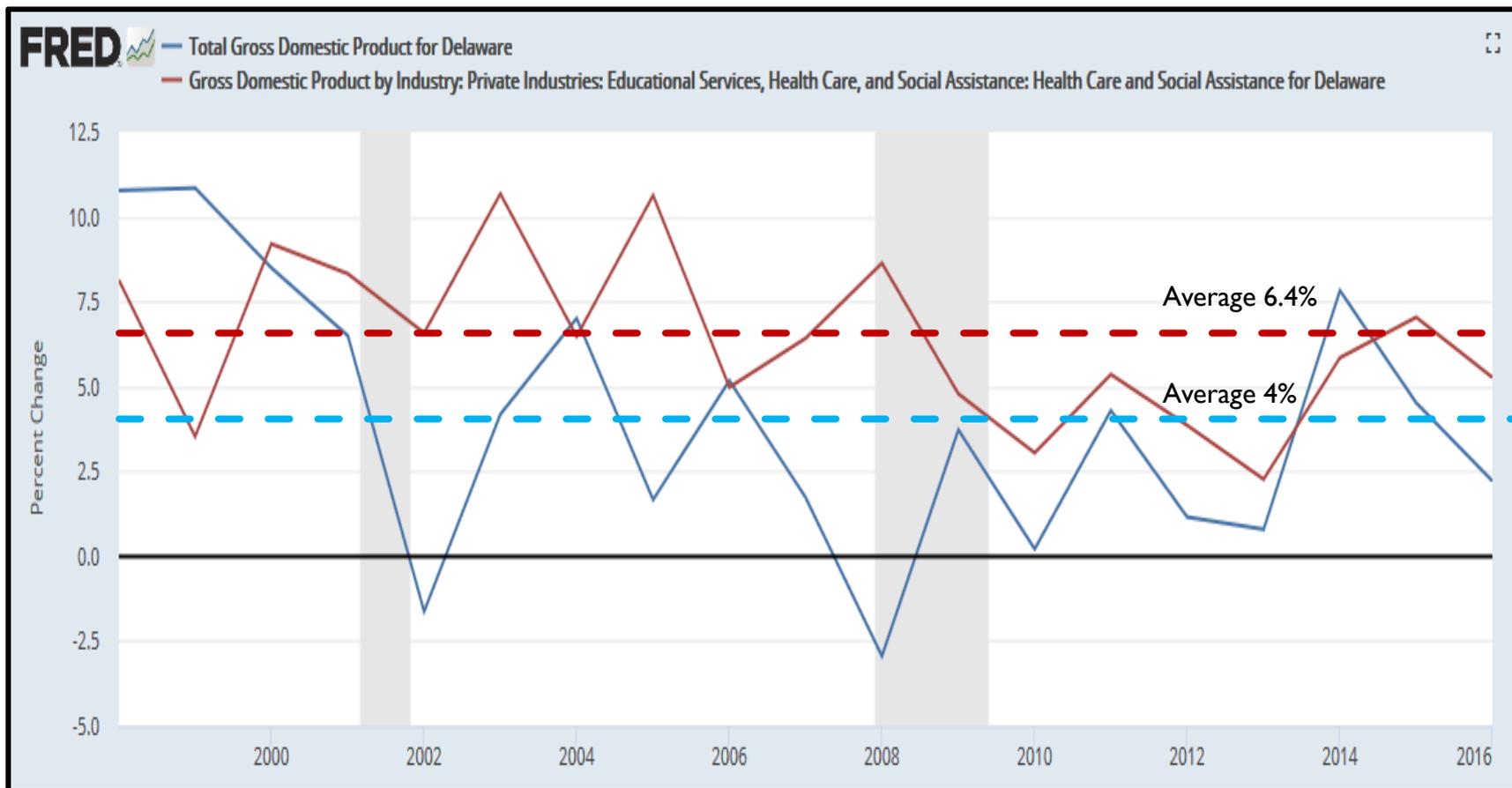
- Generally, if the health care spending benchmark is tied to economic growth, then the benchmark would imply that health care should not grow faster than the economy.
- How might economic growth be measured?
- **State Gross Domestic Product (GSP):** the total value of goods produced and services provided in the state during a defined time period.

TOTAL GROSS STATE PRODUCT FOR DELAWARE 1999–2016



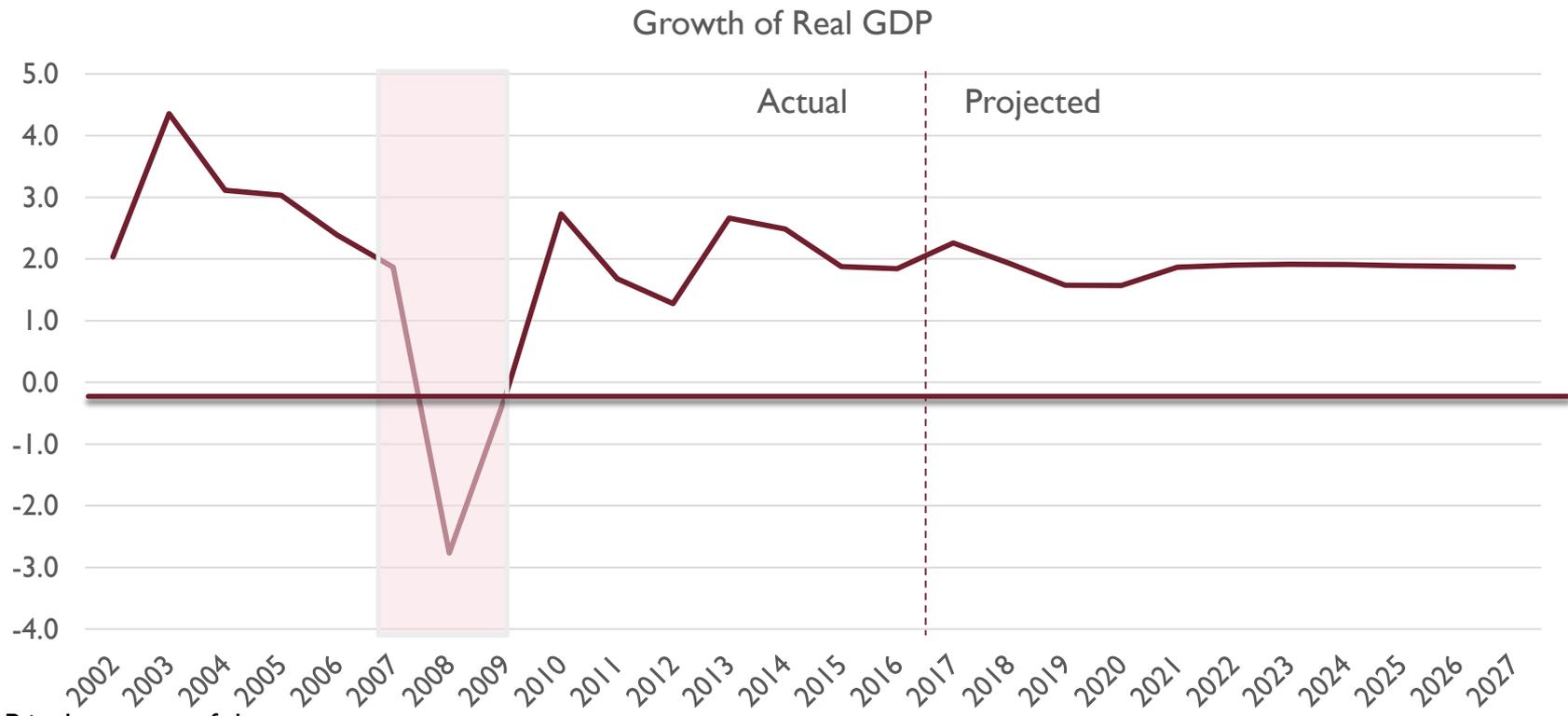
Source: U.S. Bureau of Economic Analysis, Total Gross Domestic Product for Delaware [DENGSP], retrieved from FRED, Federal Reserve Bank of St. Louis; <https://fred.stlouisfed.org/series/DENGSP>, March 20, 2018.

DELAWARE GSP VS. INDUSTRY-SPECIFIC GSP FOR HEALTH CARE AND SOCIAL ASSISTANCE



Source: U.S. Bureau of Economic Analysis, Gross Domestic Product by Industry: Private Industries: Educational Services, Health Care, and Social Assistance: Health Care and Social Assistance for Delaware [DEHLTHSOCASSNGSP], retrieved from FRED, Federal Reserve Bank of St. Louis; <https://fred.stlouisfed.org/series/DEHLTHSOCASSNGSP>, March 26, 2018.

NATIONAL GROSS DOMESTIC PRODUCT



Real GDP is the output of the economy adjusted to remove the effects of inflation.

Shaded area denotes recession period

Source: Congressional Budget Office; Bureau of Economic Analysis; <https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/reports/52370-supplementaldata.xlsx>

LINKING THE BENCHMARK TO INFLATION

- Generally, if the health care spending benchmark is tied to inflation, then the benchmark would imply that health care should not grow faster than average consumer-paid prices rise.
- How might inflation be measured?
- **Consumer Price Index:** an index of the variation in prices paid by typical consumers for retail goods and other items. Specifically for food, clothing, shelter, fuel, transportation, medical care, prescription drugs, and other goods and services that people buy for day-to-day living.

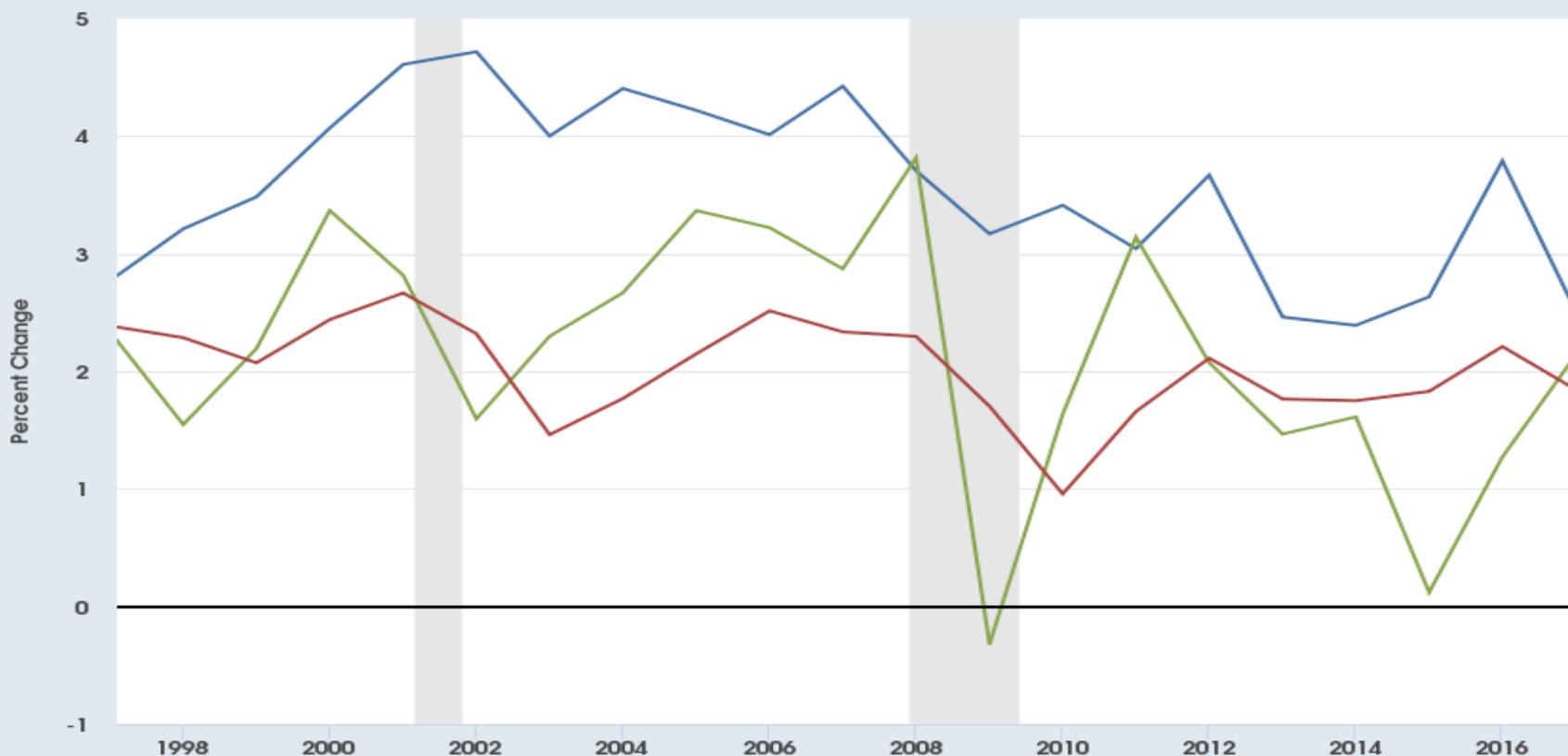
CONSUMER PRICE INDEX: THREE OPTIONS

- **CPI-Urban, All Items (CPI-U):** represents spending for about 93% of the total US population of urban or metropolitan areas, including professionals, self-employed, low-income, unemployed and retired. Not included are farmers, people in the Armed Forces, and those in institutions (e.g., prisons, mental hospitals).
- **CPI-U Less Food and Energy:** removes food and energy prices from the calculation as these prices are typically the most volatile.
- **CPI-U Medical Care:** represents spending only on medical care services (professional, hospital and health insurance) and medical care commodities (Rx, DME) only.

CONSUMER PRICE INDEX: THREE OPTIONS

FRED

- Consumer Price Index for All Urban Consumers: Medical Care
- Consumer Price Index for All Urban Consumers: All Items
- Consumer Price Index for All Urban Consumers: All Items Less Food and Energy



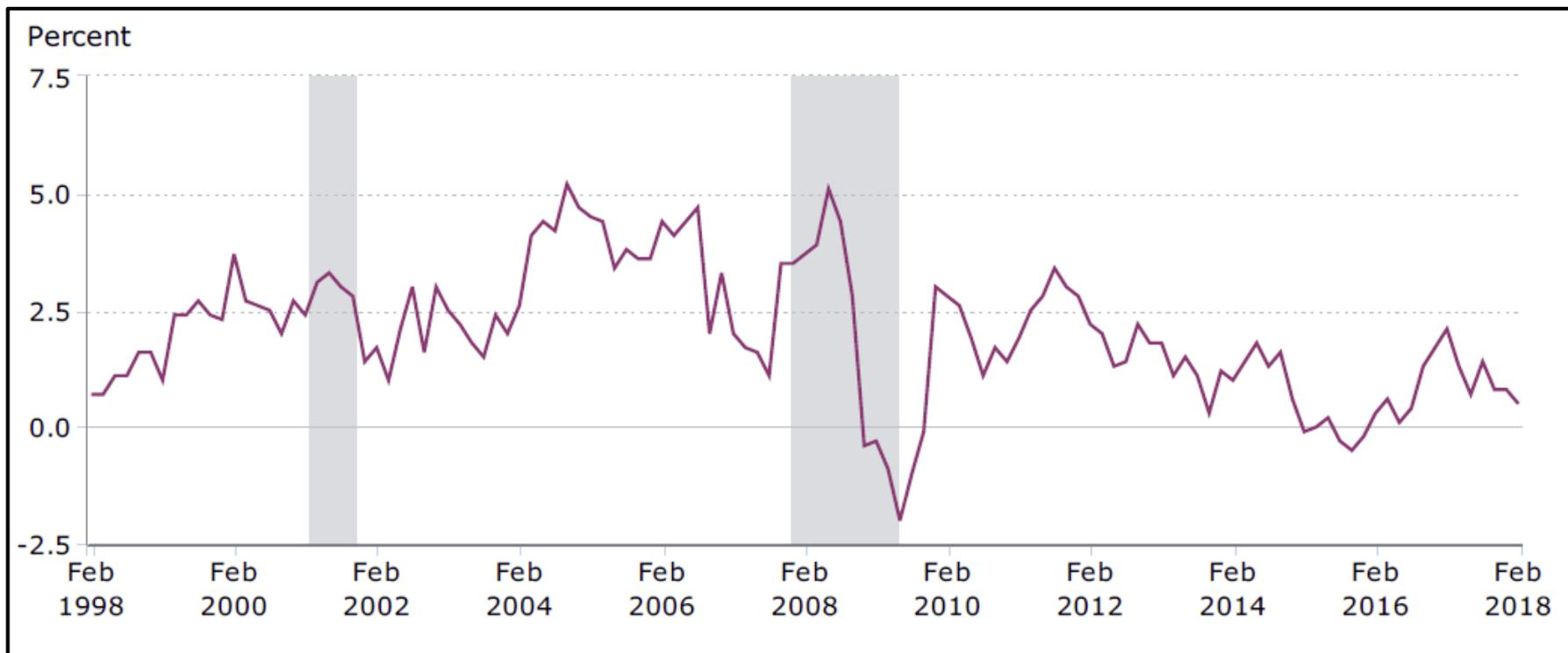
Shaded areas indicate U.S. recessions

Source: U.S. Bureau of Labor Statistics

[myf.fred/g/jdmc](https://myf.fred.stlouisfed.org/g/jdmc)

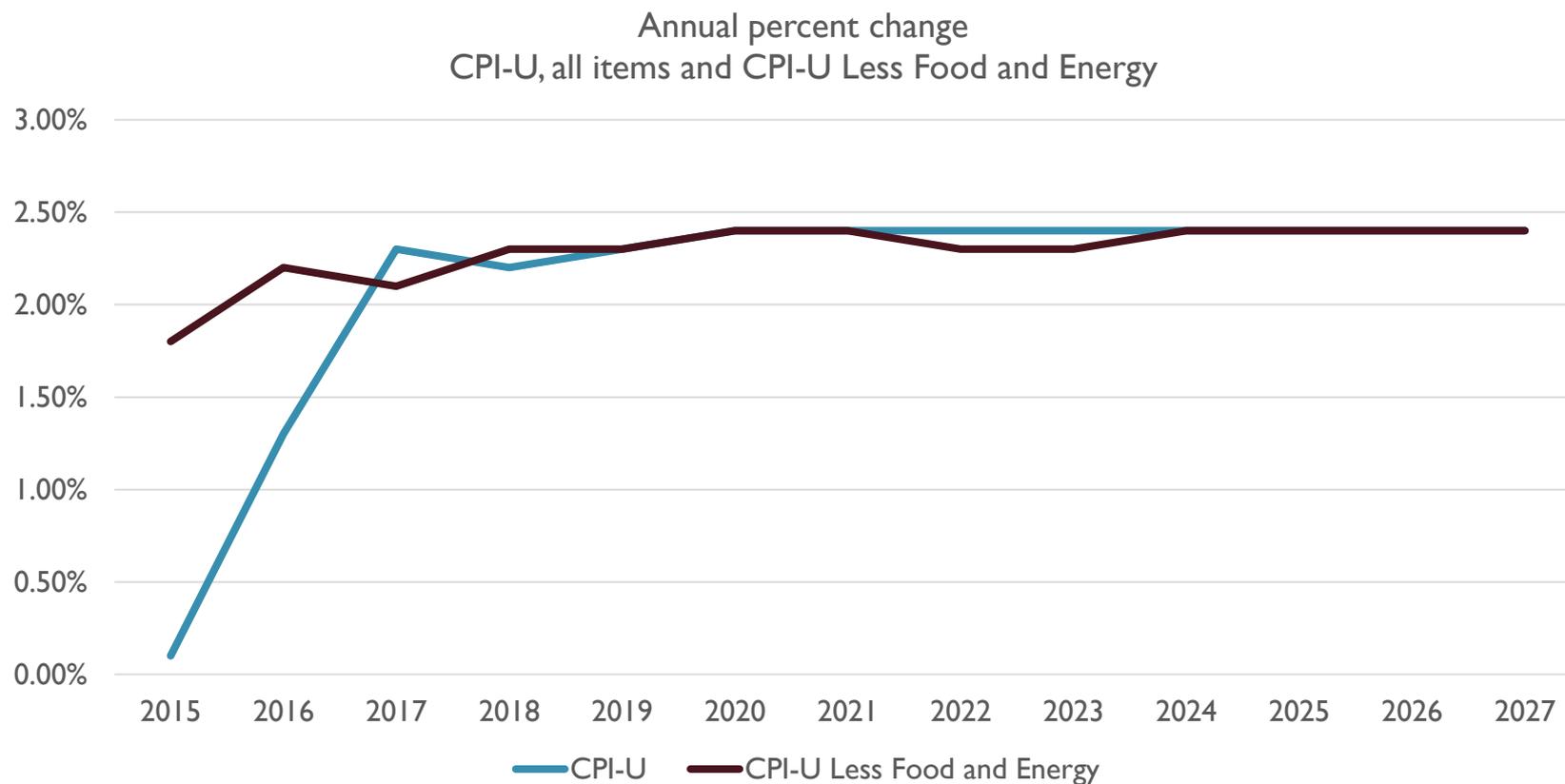
CONSUMER PRICE INDEX

12-month percentage change, CPI, all items, not seasonally adjusted
Philadelphia-Camden-Wilmington



Shaded area represents recession periods
Source: U.S. Bureau of Labor Statistics

NATIONAL CONSUMER PRICE INDEX HISTORICAL AND FORECAST



Source: CBO An Update to the Budget and Economic Outlook: 2017 to 2027 www.cbo.gov/publication/52801

ECONOMIC GROWTH VS. INFLATION

ECONOMIC INDICATOR	PROS	CONS
Gross State Product	<ul style="list-style-type: none"> Looks at health care as part of the economy 	<ul style="list-style-type: none"> Consumers view health care cost as any other cost Volatile
Consumer Price Index All Items	<ul style="list-style-type: none"> Represents the costs of consumer experience 	<ul style="list-style-type: none"> Volatile
Consumer Price Index Less Food and Energy	<ul style="list-style-type: none"> Likely the most stable of all CPI indices Represents most costs that consumers experience 	<ul style="list-style-type: none"> Does not capture the effects of food and energy on consumer cost
Consumer Price Index Medical Care	<ul style="list-style-type: none"> Can focus health care cost growth on price alone, bringing focus to efficiency in delivery 	<ul style="list-style-type: none"> Use of this index is self-referencing Does less to reduce spending on health care services based on historical experience

ADDITIONAL DECISIONS TO BE MADE

- Now that we have discussed the economic indicators, we need to determine a number of related factors:
 - Will the economic indicator be adjusted (inflated or deflated (+/-) by a certain number of percentage points)?
 - Will it be the forecasted, historical or a blend of each?
 - Will it be based on a multi-year approach (averaging, or weighting years) or a single-year approach?

MASSACHUSETTS' APPROACH

- Massachusetts has set its cost growth benchmark based on the prospective gross state product (PGSP).
- First, Massachusetts assumed that output per worker would grow at the same rate as the U.S., but adjusted for projected change in the size of the MA work force. It determined that projected GSP would be 1.6%, using out-year forecasted rates (which are more stable than the near term forecasted rates).
- Second, it looked at the long-run forecast of inflation, again using out-year forecasted rates. It determined that projected inflation would be 2%.
 - Thus...Prospective GSP (1.6%) + Inflation (2%) = 3.6%

MAINE'S APPROACH

- As part of its SIM grant work, Maine considered creating a voluntary growth target in which payers and ACOs would commit to keeping annual risk-adjusted, aggregate PMPM growth to the target recommended by the Maine Health Management Coalition's Healthcare Cost Workgroup.
- In Year 1, the target was to be set at the CPI-U for medical care.
- Over the next four years, the target was to be set between CPI-U for medical care and the CPI-U less food and energy, gradually trending down in Year 5 to general CPI-U less food and energy plus 25% of the difference between the two indices.
- The program was never implemented.



PUBLIC COMMENT



WRAP-UP AND NEXT STEPS