



# DEPARTMENT OF HEALTH AND SOCIAL SERVICES (DHSS)

## DELAWARE HEALTH CARE COMMISSION

OVERVIEW OF BENCHMARK TREND REPORT  
CALENDAR YEAR 2019 RESULTS  
AND PROPOSED QUALITY MEASURES

# OVERVIEW

- Background:
  - Health Care Spending Benchmarks
  - Health Care Quality Benchmarks
- Data Collection Methodology
- Data Results
- Proposed Quality Benchmark Measures
- Questions and Public Comment



# HEALTH CARE SPENDING AND QUALITY BENCHMARKS PROGRAM

- In November 2018, Governor Carney signed Executive Order (EO) 25, which laid out a vision for improving the transparency and public health awareness of health care spending and quality
  - Preceded by advice made to the Secretary by the Delaware Health Care Delivery and Cost Advisory Group (Advisory Group) on how to establish a Health Care Benchmarks Program
- The Health Care Cost and Quality Benchmarks program went into effect January 1, 2019
- Governor Carney tasked DHCC with:
  - Setting health care quality benchmarks
  - Advising the Governor and relevant state agencies on quality benchmarks
  - Reviewing the methodology of quality benchmarks in 2022 and every three years thereafter
  - Reporting annually on performance relative to the quality and spending benchmarks
  - Engaging providers and community partners in regular and ongoing forum with the State and with each other to develop strategies to reduce variation in cost and quality and to help the State perform well relative to the benchmarks

# HEALTH CARE SPENDING BENCHMARKS

- The spending benchmark is a target value for the change from the prior year in State level per capita total health care expenditures
  - Formula based on the long-term outlook for population change, inflation, labor force as well as a temporary transitional adjustment factor
- EO 25 established the spending benchmarks for calendar years (CYs) 2019–2023 as follows:
  - CY 2019:3.80%
  - CY 2020:3.50%
  - CY 2021:3.25%
  - CY 2022:3.00%
  - CY 2023:3.00%





# HEALTH CARE QUALITY BENCHMARKS

- EO 25 established annual quality benchmarks for three years (CYs 2019–2021)
  - The Overlapping Opioid and Benzodiazepine measure only had benchmarks applicable to CYs 2020 and 2021, so the same will be applied to the Use of Opioids at a High Dosage.
- Aspirational values assume a longer time horizon (five years)
- Quality measures used for benchmarks:
  - May be retained for multiple years
  - May be added and/or dropped annually
- The benchmark values may change over time



# HEALTH CARE QUALITY BENCHMARKS: PRIORITY AREAS AND MEASURE CATEGORIES

## THREE KEY PRIORITY AREAS



**#1**

Ambulatory care-sensitive  
condition (ACSC) emergency  
department visits



**#2**

Opioid-related overdose  
deaths and co-prescribed  
opioid and benzodiazepine  
prescriptions



**#3**

Cardiovascular disease  
prevention and treatment

## TWO MEASURE CATEGORIES

### Health status measures

Quantify certain  
population-level characteristics

### Health care measures

Quantify performance on health care  
processes or outcomes, and are assessed at  
the State, market, insurer and provider levels

# HEALTH CARE QUALITY BENCHMARKS: HEALTH STATUS MEASURES

HEALTH STATUS MEASURE	SPECIFICATION	CY 2019 BENCHMARK
<b>Adult Obesity</b>	% of adults with body mass index $\geq 30$	30.0%
<b>High School Students Physically Active</b>	% of students with physical activity for $\geq 60$ mins a day on five or more days	44.6%
<b>Opioid-Related Overdose Deaths</b>	# of opioid-related deaths	16.2 deaths per 100,000
<b>Tobacco Use</b>	% of adults who currently smoke	17.1%

# HEALTH CARE QUALITY BENCHMARKS: HEALTH CARE MEASURES

HEALTH CARE MEASURE	SPECIFICATION	CY 2019 BENCHMARK
<b>Concurrent Use of Opioids and Benzodiazepines</b>	% of individuals 18+ with concurrent use of opioids and benzos	TBD
<b>Emergency Department (ED) Utilization</b> (Commercial Market only)	# of ED visits for individuals 18+	190.0 visits per 1,000
<b>Persistence of Beta Blocker Treatment After a Heart Attack</b>	% of individuals 18+ who received beta-blockers for six months after discharge	82.5% Commercial 78.8% Medicaid
<b>Statin Therapy Adherence for Patients With Cardiovascular Disease</b>	% of at-risk individuals who adhered to medication for $\geq$ 80% of treatment period	79.9% Commercial 59.2% Medicaid



# DATA COLLECTION METHODOLOGY

# COLLECTION OF BENCHMARK SPENDING DATA

- DHCC collected final CY 2018 data and/or first run of CY 2019 data from all payers (e.g., *Aetna, AmeriHealth Caritas, Cigna, Highmark, and United*). CY 2018 data from DMMA and VHA was not restated per the benchmark process. Data sources:

Market/Spending Component	Data Source	Data
Medicare	CMS and Insurers	Summary FFS and managed care, including drug spending and limited pharmacy rebate data (from Insurers only)
Medicaid	DMMA and Insurers	Summary FFS and managed care, including pharmacy rebate data
Commercial	Insurers	Summary medical expenditures, including pharmacy rebate data
Veterans Health Administration	VHA website	Aggregate data from the US Department of Veterans Affairs
Net Cost of Private Health Insurance	Insurer or public reports	Summary level data on revenues and expenses

# COLLECTION OF BENCHMARK SPENDING DATA (CONT'D)

- Insurers were asked to apply the same updated data collection processes for both the restated CY 2018 data and the first submission of CY 2019 data.
- Insurers attested to the accuracy and completeness of their spending data and were given opportunities to review their data. DHCC performed reasonability checks of the data.
- CMS provided Medicare data using their own standard template and processes.
- Note: Due to methodological differences, this data should not be compared to other sources of Delaware spending.



# COLLECTION OF BENCHMARK QUALITY DATA

- Insurers submitted quality data for the CY 2019 performance period:
  - Emergency department utilization
  - Persistent of beta-blocker after a heart attack
  - Statin therapy for patients with cardiovascular disease
- Insurers attested to the accuracy and completeness of their quality data and were given opportunities to review their data. DHCC performed reasonability checks of the data
- Other CY 2019 quality results were obtained from the Centers for Disease Control and Prevention public reports:
  - Adult obesity
  - Tobacco use
  - Opioid-related overdose deaths per 100,000
  - High school students who were physically active (not reported by CDC)

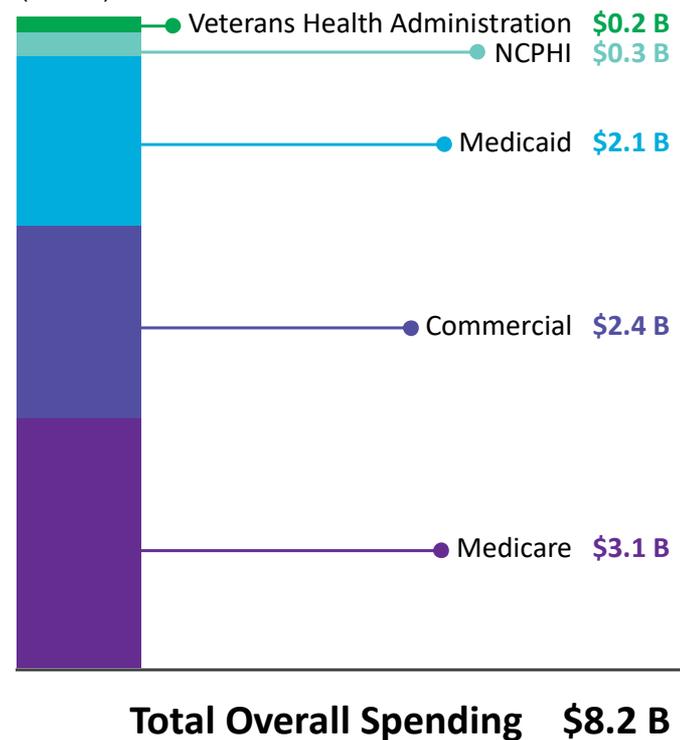


# DATA RESULTS

# TOTAL HEALTH CARE EXPENDITURES

- Total health care expenditures (THCE) went from \$7.6 billion in CY 2018 to \$8.2 billion in CY 2019 an 8.5% increase
- CY 2019 spending by component (similar to CY 2018 spending mix):
  - Medicare (FFS and managed care): 37.3% of spending
  - Commercial (fully and self-insured): 29.8% of spending
  - Medicaid (FFS and managed care): 26.2% of spending
  - Net Cost of Private Health Insurance (NCPHI): 4.2% of spending
  - Veterans Health Administration: 2.5% of spending

Figure 1. CY 2019 State Total Health Care Expenditures (THCE)

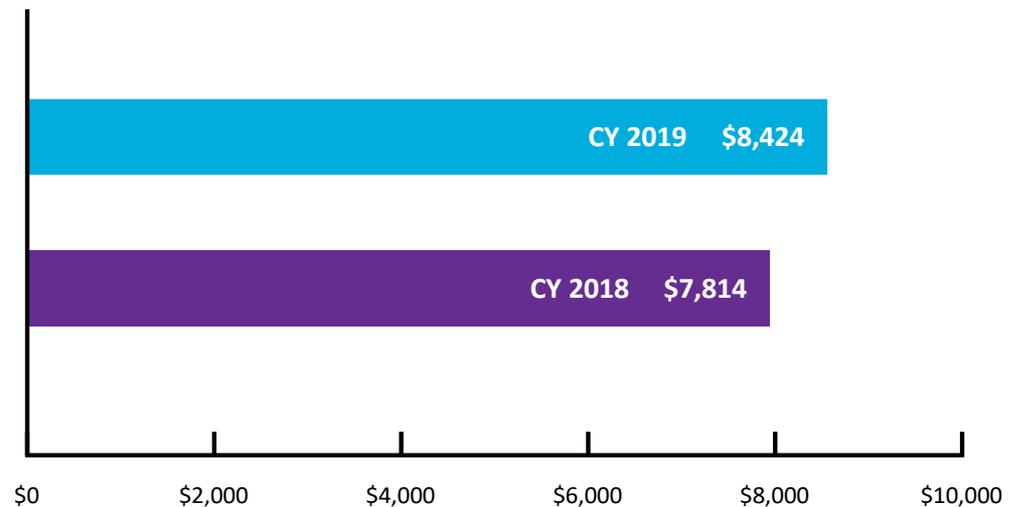


\* Medicare FFS, Medicaid FFS, and Veterans Health Administration does not have NCPHI, so expressed as a percentage of THCE, NCPHI is relatively low.

# STATE LEVEL PER CAPITA – CY 2019 VS CY 2018

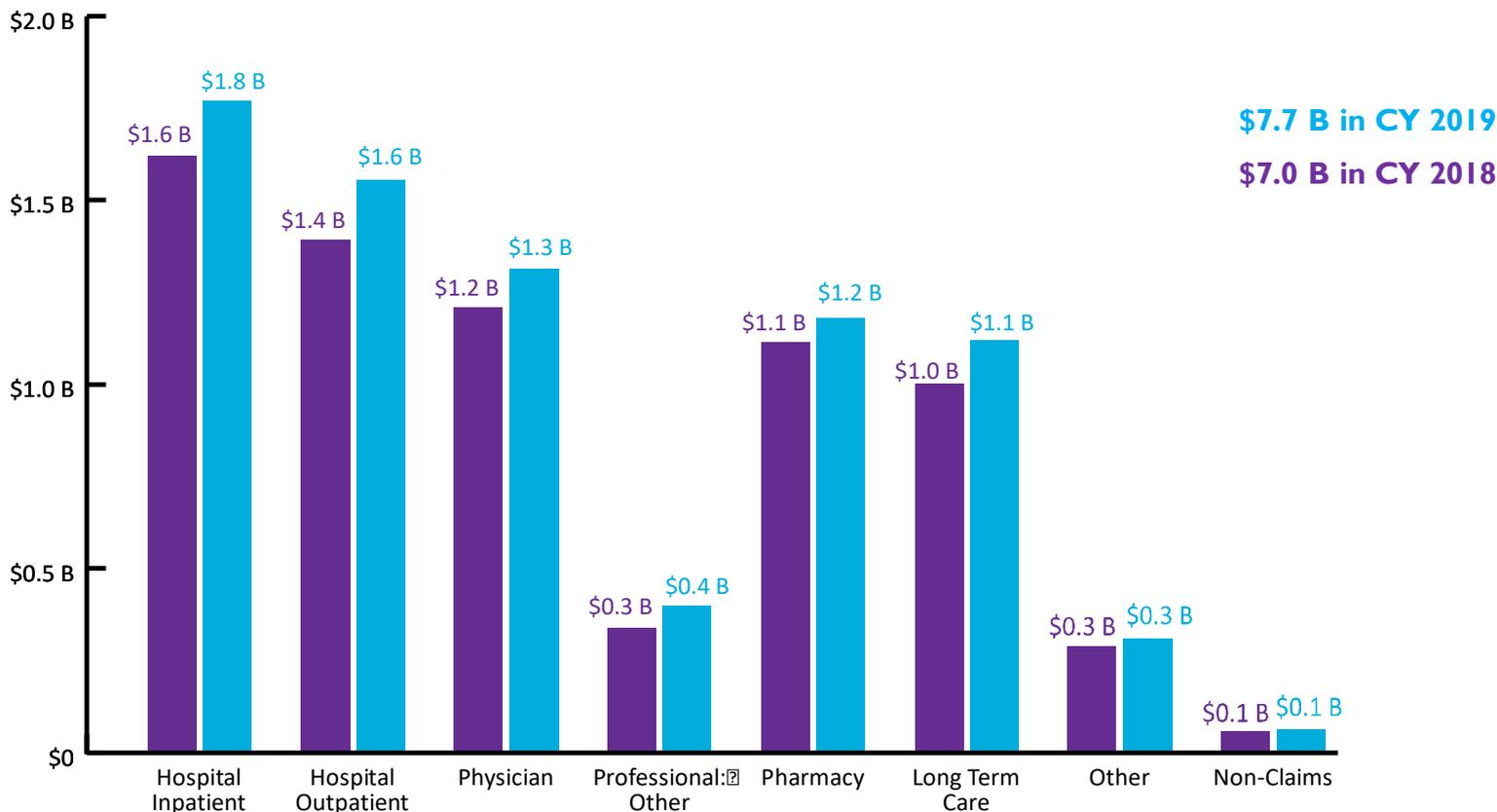
- THCE increased from \$7.6 billion to \$8.2 billion
- Delaware's State population increased from 967,171 to 973,764 or by 0.7%
- THCE per capita increased from \$7,814 to \$8,424
- CY 2019 THCE per capita change was 7.8%
- CY 2019 spending benchmark was 3.8%

Figure 2. State Level THCE – Per Capita



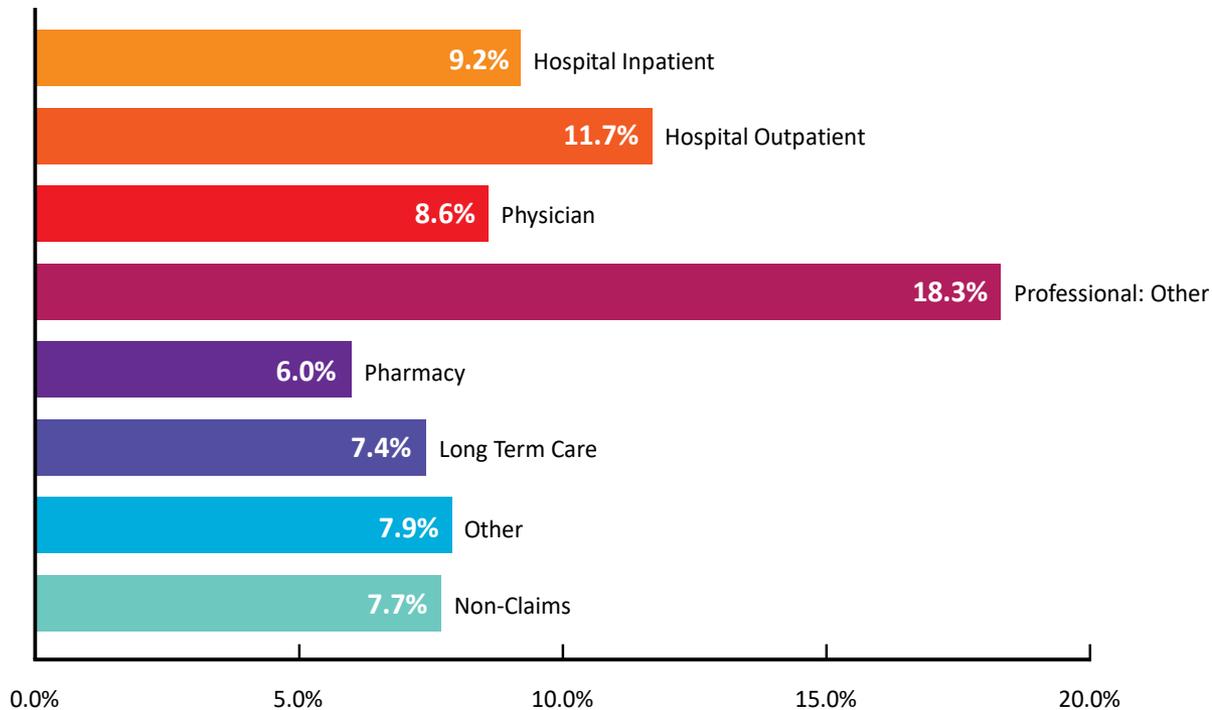
# TOTAL MEDICAL EXPENSE (TME) BY SERVICE CATEGORY – CY 2019 VS CY 2018 DATA

Figure 3. State Level TME by Service Category (excluding VHA) in Billions



# CHANGE IN TME BY SERVICE CATEGORY

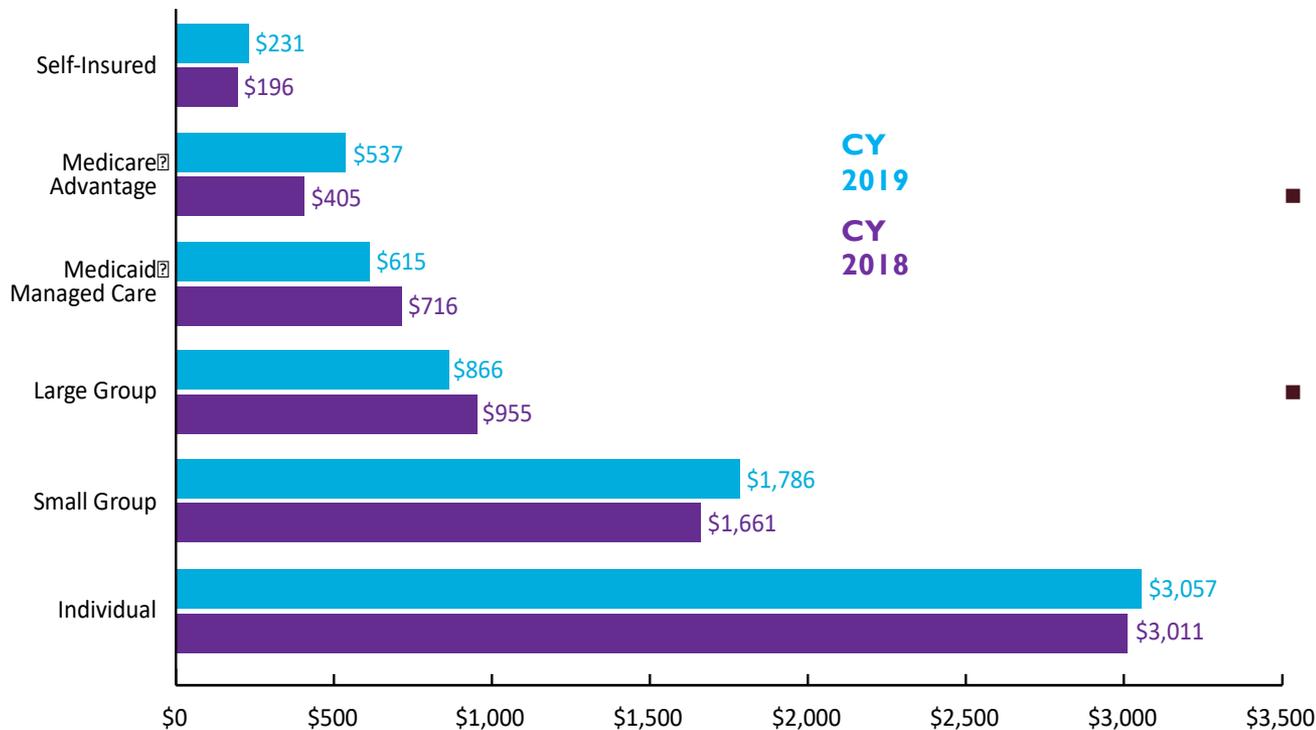
Figure 4. CY 2019 Change in State Level TME by Service Category (excluding VHA)



- Hospital (inpatient + outpatient) spending increased by 10.4%
- Physician spending increased 8.6%
- Pharmacy spending increased 6.0%
- Professional Other spending increased the most, but is a small piece of TME

# SPENDING ON THE NET COST OF PRIVATE HEALTH INSURANCE (NCPHI)\*

Figure 5. Estimated PMPY NCPHI by Insurance Segment



- Total NCPHI was estimated at \$341 million in CY 2019 a decrease of 3.4%
- Weighted average per member per year (PMPY) NCPHI amount across markets was \$604
- PMPY differs by market segment, from \$3,057 for the commercial individual market to \$231 for the self-insured market in CY 2019

\*NCPHI is the cost to Delaware residents associated with the administration of private health insurance (e.g., insurer over-head, staff salaries, advertising, sales commissions, other administrative costs, premium taxes, and profits/losses). It is the difference between health premiums earned and benefits incurred.



# QUALITY MEASURE RESULTS

QUALITY MEASURE	CY 2019 Benchmark	CY 2019 Results	Notes
Adult Obesity	30.0%	34.4%	Lower result/score is better
Adult Tobacco Use	17.1%	15.9%	Lower result/score is better
Opioid-related Overdose Deaths	16.2 deaths per 100,000	43.0 deaths per 100,000	Lower result/score is better
Emergency Department Utilization	190.0 visits per 1,000 (Commercial only)	193.2 visits per 1,000	Lower result/score is better
Persistence of Beta-Blocker Treatment after a Heart Attack	82.5% Commercial 78.8% Medicaid	93.9% Commercial 73.5% Medicaid	Higher result/score is better
Statin Therapy for Patients With Cardiovascular Disease – Statin Adherence 80%	79.9% Commercial 59.2% Medicaid	83.5% Commercial 65.1% Medicaid	Higher result/score is better



# PROPOSED QUALITY BENCHMARK MEASURES

## CY 2022–2024 CYCLE



# REVIEW OF CURRENT MEASURES

- EO 25 requires DHCC to review the quality measures for the next cycle (i.e., starting with CY 2022) and every three years thereafter
- DHCC's recommendations:
  - Retire two measures
    - “High school students who were physically active”
    - “Tobacco use” measures are being recommended for retirement,
    - Rationale: *Data availability limitations and usefulness of the data in supporting positive change*
  - Maintain six measures
    - Use of Opioids at a High Dosage
    - Opioid-Related Overdose Death
    - Emergency Department Utilization
    - Adult Obesity
    - Persistence of Beta-Blocker Treatment after a Heart Attack
    - Statin Therapy for Patients with Cardiovascular Disease – Statin Adherence 80%





# PROPOSED QUALITY MEASURES (CY 2022 – 2024)

- Proposed Quality Measures for CY 2022–2024
  - Maintain six of the eight from the CY 2019–2021 cycle
  - Adopt four new measures
    - Three focused on cancer screenings
    - One measure focused on dental services
  - New annual benchmarks will need to be developed for all quality measures





# BREAST CANCER SCREENING

## Measure Description

- Women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years.

## Rationale

- Alignment with “Choose Health Delaware” initiatives as prevention is a priority for Delaware/Delaware Health and Social Services (DHSS).
- Delaware Community Health Needs Assessment – identified cancer prevention as a need.

## Market

- Commercial Market and Medicaid Market.
- Medicaid fee for service program excluded.



# COLORECTAL CANCER SCREENING

Measure Description	<ul style="list-style-type: none"><li>• Adults 50–75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every five years, colonoscopy every 10 years, computed tomography colonography every five years, stool DNA test every three years.<sup>1</sup></li></ul>
Rationale	<ul style="list-style-type: none"><li>• Alignment with “Choose Health Delaware” initiatives as prevention is a priority for Delaware/Delaware Health and Social Services (DHSS).</li><li>• Delaware Community Health Needs Assessment – identified cancer prevention as a need.</li></ul>
Market	<ul style="list-style-type: none"><li>• Commercial Market and Medicaid Market.</li><li>• Medicaid fee for service program excluded.</li></ul>

<sup>1</sup>Source: NCQA HEDIS® 2020 Measure Set



# CERVICAL CANCER SCREENING

## Measure Description

- Women screened for cervical cancer using any of the following criteria:
  - Ages 21–64, cervical cytology performed within the last three years.
  - Ages 30–64, cervical high-risk human papillomavirus testing performed within the last five years.
  - Ages 30–64, cervical cytology/high-risk human papillomavirus co-testing within the last five years.<sup>1</sup>

## Rationale

- Alignment with “Choose Health Delaware” initiatives as prevention is a priority for Delaware/Delaware Health and Social Services (DHSS).
- Delaware Community Health Needs Assessment identified cancer prevention as a priority.
- Delaware is below target on indicators related to cervical cancer screenings, incidence, and age-adjusted death rate.

## Market

- Commercial Market and Medicaid Market.
- Medicaid fee for service program excluded.



# PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES

## Measure Description

- Percentage of individuals ages 1–20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period.<sup>1</sup>

## Rationale

- The *Percentage of Eligibles Who Received Preventive Dental Services* measure is a preventative measure, which aligns with Delaware's focus on prevention and access to healthcare services.

## Market

- Medicaid Market (fee for service and/or managed care).

# NEXT STEPS

- At the conclusion of this meeting the following will be posted on DHCC website:
  - Benchmark Trend Report, “*Calendar Year 2019 Results: Benchmark Trend Report*”
  - Today’s Presentation slides, “*Overview of Benchmark Trend Report Calendar Year 2019 Results and proposed quality measures*”
  - Proposed Quality Measures summary document, “*Quality Benchmarks Newly Proposed Measures — March 2021*”
- DHCC is accepting written public comments at [DHCC@delaware.gov](mailto:DHCC@delaware.gov)
  - Comments will be publicly posted on the DHCC website at <https://dhss.delaware.gov/dhcc/global.html>
  - Please send comments by Friday, April 9, 2021



# THANK YOU!

For more information about the health care spending benchmark, visit:  
<https://dhss.delaware.gov/dhcc/global.html>



## Questions?





# APPENDIX

# GLOSSARY OF KEY TERMS

- **Allowed Amount:** The amount the payer paid plus any member cost sharing for a claim. Allowed amount is the basis for measuring the claims component of medical expenses for purposes of the benchmark spending data.
- **Insurer:** A private health insurance company that offers one or more of the following, commercial insurance, Medicare managed care products and/or are Medicaid/Children's Health Insurance Program (CHIP) managed care organization products.
- **Market:** The highest level of categorization of the health insurance market. For example, Medicare and Medicare managed care are collectively referred to as the "Medicare market." Medicaid/CHIP FFS and Medicaid/CHIP MCO managed care are collectively referred to as the "Medicaid market." Individual, self-insured, small and large group markets and student health insurance are collectively referred to as the "Commercial market."
- **Payer:** A term used to refer collectively to all entities submitting data to DHCC.
- **Total Health Care Expenditures (THCE):** The total medical expense (TME) incurred by Delaware residents for all health care benefits/services by all payers reporting to the DHCC plus insurers' NCPHI.
- **Total Health Care Expenditures Per Capita:** THCE (as defined above) divided by Delaware's total state population.
- **Total Medical Expense (TME):** The total claims and non-claims medical expense incurred by Delaware residents for all health care benefits/services as reported by payers submitting data to the DHCC.

# PRIMARY CARE DEFINITION: CY 2019 & 2018

- For consistency and to avoid confusion to benchmark data contributors, the DHCC used the same definition of primary care that was developed in early 2020 by the Delaware Department of Insurance (DOI) in its efforts to evaluate health care affordability within the State.
  - Taxonomy = 207Q00000X, 207QA0505X, 207QG0300X, 208D00000X, 207R00000X, 207RG0300X, 208000000X, 363L00000X, 363LA2200X, 363LP0200X, 363A00000X, 363AM0700X, 363LF0000X, 363LG0600X, or 363LP2300X.

AND

- Place of Service = 11, 71, 50, 17, 20, 02, or 12.

AND

- Procedure Code = 90460-90461, 90471-90474, 98966, 98967, 98968, 98969, 99201-99205, 99211-99215, 99241-99245, 99339-99340, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99354-99355, 99358, 99359, 99381-99385, 99386-99387, 99391-99395, 99396-99397, 99401-99404, 99406-99409, 99411-99412, 99420, 99429, 99441, 99442, 99443, G2010, 99444, 99495-99496, G0008, G0009, G0402, G0438-G0439, G0444, G0463, G0502-G0507, S9117, T1015, 99492-99494, 99483, 99487, 99489, 99490, G0506, G0511, G0467, G0468, or G0010.