State Employees Health Plan Task Force
Haslet Armory, Dover, Delaware 19901
Tuesday, November 17, 2015

The State Employees Health Plan Task Force Committee met on November 17, 2015, at the Haslet Armory, Room 219 in Dover, DE 19901. The following Committee members and guests were present:

Committee Members:
Ann Visalli, Director, OMB, Chairperson
Michael Begatto, AFSCME
JJ Johnson, Representative
Harvey Kenton, Representative
Geoff Klopp, COAD
Dave Lawson, Senate
Harris McDowell, Senate
Mike Morton, CGO
Evelyn Nestlerode, AOC
Bill Oberle, DSTA
Ken Simpler, OST
Jeff Taschner, DSEA
Karen Weldin Stewart, DOI

Guests:
Brian Baker, Cerner
Laura Beck, AOA
Matt Bittle, DE State News
Colin Bonini, Senate
Tom Brackin, DSTA
Lisa Carmean, City of Milford
Jessica Eisenbrey, OMB
Darcell Griffith, Univ of DE
Cheryl Heik, Cozen O'Connor
Kim Hoffman
Carlton Ingram, Aetna
Andrew Kerber, DOJ
Brenda Lakeman, Director, SBO
Omar Masood, OST
Brian Maxwell, Deputy Director, OMB

Guests *(cont'd)*:
Jennifer Mossman, Highmark
Mike North, Aetna
Lisa Porter, SBO
Pamela Price, Highmark
Kimberly Reinagel-Nietubicz, CGO
Faith Rentz, Deputy Director, SBO
Paul Reynolds, DOI
Paula Roy, Roy Associates/DCSN
Christine Schultz, Parkowski, Guerke & Swayze P.A
Daniel Short, Representative
Wayne Smith, DE Healthcare Assn.
Jennifer Vaughn, DOI

Patti Friedman, Aon Hewitt Consulting
Mike Morfe, Aon Hewitt Consulting
Terry Murphy, Bayhealth
Jeffrey Freid, Beebe Health Care
Janice Nevin, CEO, Christina Care Health System
Tom Corrigan, CFO, Christina Care Health System
Staci Vernick, Christina Care Health System
Sarah Nagle, Christina Care Health System
Peg Eitl, Highmark
Rich Pierznik, Highmark
Roy Pnousansky, Nemours

Introductions/Sign In
Director Visalli called the meeting to order at 9:05 a.m. Everyone was reminded to sign in. Introductions were given around the room.

Approval of Minutes
Director Visalli requested a motion to approve the minutes from the November 5, 2015 Task Force meeting. Mike Begatto made the motion and Controller General Morton seconded.

Treasurer Simpler requested more detail from the previous meeting as not fully reflected in the November 5th minutes as to the impact of savings if employees migrated to another plan like the CDH plan.
Mr. Morfe shared that the actuarial value of the plans for PPO and HMO is 90% and 91% and the First State Basic and CDH plans is 86% and 87%. The difference in actuarial value is approximately 4% to 5%. If a member moves from the PPO plan to the CDH plan, they would experience a 4% reduction in their actuarial value. On an average, claims decrease 4% in aggregate and their claims are expected to go down

4% to 5% consistent with the difference in the actuarial value. This is due to the member experiencing a different out-of-pocket cost system which is what drives the claim experience. It is the cost of the claims to the Plan that goes down 4% to 5%. The employee contributions are reduced from 13.25% (PPO) to 5% (CDH) and 4% (First State Basic) which is a decrease of more than 8%. This costs the State more in the premium share costs by 4%. Treasurer Simpler asked how to close this gap. Mr. Morfe responded to first recognize the gap, then if new programs are created, would need to decide what the contributions would be and expect it to be that actuarial difference (fair difference). If everyone is placed in a consumer driven plan, that would change the behavior and may shrink the gap. Design changes or some contribution change would be needed to make up the gap. The reason a surplus is seen right now in the current CDH plan, participants are not representing our population as a whole as this is a select population in both the First State Basic and CDH plans. There is less than 5% in totality enrolled in these two lower option plans.

With no further questions or comments on the minutes, the motion carried to approve the minutes.

Highmark Follow-up

Ms. Peg Eitl of Highmark provided additional information as a follow-up from the November 5th meeting regarding hospital spend for FY15. The difference of what Highmark spends for the State of Delaware versus what is spent in Maryland and West Virginia was shown with a Casemix adjusted methodology illustrating what is paid for the same care across the state boarders. Reference was made to the bar graph from the October 22nd meeting showing how the costs compare with the cost of care in Delaware which is about 25% higher than the neighboring states. The first follow-up question is with Highmark's data and what about the State of Delaware and where do our claim dollars actually fall hospital to hospital. The first several slides show a view of the State of Delaware's inpatient spend of $125.5M for FY15, followed by a breakdown for each hospital, other facilities (skilled nursing, psych, substance abuse) and expenses occurred out of state. The same detail was shown for the outpatient spend of $142M for FY15.

Highmark's DRG contracting, employed in Delaware, is a pay for value methodology. This is one of many methods used to contract so that a change in behavior occurs and to get a better handle on how expenses are actually being managed across the State. Only three hospitals have converted over to DRG payments for the commercial business. All of the hospitals use a DRG methodology when interacting with Medicare. Based on a particular diagnosis and care rendered, we are effectively reimbursing the hospital on a case rate basis. In the current methodology, where it is a Fee-for-Service arrangement, the hospital has something called a Charge Master that has a rate attached to everything charged to a patient upon inpatient services (pillow, aspirin, etc). In a Fee-for-Service arrangement, hospitals have the ability to change those fees in our current contract at anytime. Moving to a DRG methodology, shifts some of the responsibility to the hospital by thinking how to manage the care of an individual based on their needs without spending more than or less than needed and not incurring costs at a later time. An analysis of the DRG Reimbursement for the State of Delaware was presented. During a twelve month period, admissions changed from 449 down to 315, even though the average length of stay went up 2.4%, the overall cost per admission decreased 14.1%.

A definition of Cost of Care is effectively whatever Highmark was billed for a member going into the hospital. The DRG levels the playing field. For a patient coming into the hospital, the reimbursement will be the same whether the patient is in the hospital for 2 days and another patient is in the hospital for 4 days for same diagnosis/procedure. It would be the hospital's responsibility to know the difference between patients needing an extra day in order to assure the outcome is the same. The contracting for DRG right now is limited to three hospitals but the overall payment method is the same regardless of what hospital. The patient is not balanced bill. DRG payments started in 2012 but not all hospitals are

participating even now. Senator McDowell asked why the DRG's didn't anchor the spike seen in 2014. Ms. Eitl surmised that the problem goes back to where the care is rendered. The three hospitals participating in the DRG arrangement, do not see as significant volume with the State of Delaware employees as the nonparticipating hospitals. Ms. Lakeman asked to qualify if hospitals are not doing everything under DRG. Ms. Eitl stated the inpatient admission for the three hospitals under DRG are all inclusive. One hospital, Christina Care started moving towards DRG, but they're doing a limited number of DRGs and their experience is not reflected on the chart.

Senator McDowell asked why the State and employees can't pay all the bills and insist on some of these things. Director Visalli responded that is a great question and will be exploring that. This is a shift in a way hospitals and third party administrators do business and it's consistent with the innovation model. It is also the only mechanism that allows hospitals or providers benefit from savings so you can quantify that savings and share in it. If we have a hospital or doctor that is resistant to this model, then the State Employee Benefit Committee (SEBC) will decide how much to exert influence and what is the potential downside. Senator McDowell inquired if all hospitals have a Charge Master (linked to Fee-for-Service) and if different than what the federal government keeps. There are allowable charges by CMS. Hospitals have a Medicare Cost Report that is submitted to CMS to determine reimbursement to each individual hospital.

Ms. Eitl went on to explain the significant difference under a DRG from the 1st year into the 2nd year. The goal is to get the point where it is no longer an opportunity for the hospitals every year to raise prices across their Charge Master that administrators cannot manage. As of January, a fourth hospital has taken a few DRGs with a few more DRGs in July, but this hospital is phasing it in and still billing Fee-for-Service for other services. The first three hospitals adopted the DRG payment method at 100% from the start.

DRGs are not for outpatient services as this model is Ambulatory Payment Category (APC); similar to DRG but for outpatient. In Pennsylvania and West Virginia, Highmark pays all hospitals on a DRG and APC basis. New Jersey has the predominant method for reimbursement for hospital care. Maryland has a different approach they use in putting together a fixed fee schedule.

Mr. Oberle asked if Highmark has done a comparison between DRG and Maryland in cost containment as he is curious to see whether a regulatory scheme was more effective than a DRG approach. Highmark has not compared this and does not do business in the State of Maryland.

Ms. Eitl shared that behavior should change since the hospitals are getting reimbursed on the DRG basis. Highmark took all of the experience in the DRG world, gathered those claims under the fee schedule and reprocessed under the prior arrangement to see what the net would be. In the aggregate, with the three hospitals currently reimbursed by the DRG methodology, the State of Delaware experienced a reduction of costs of $1.5M.

It was noted that each hospital has their own DRG and not the same as the DRG for Medicare. It also factors in the type or level of hospital service (trauma and other service). Treasurer Simpler asked Highmark how they negotiate a DRG process with the hospitals. Mr. Rich Pierznik, who is responsible for the Highmark provider contracting, shared that it usually takes several discussions with the hospital in getting them comfortable with the methodology and how the payments are actually going to work. Some hospitals don't feel any there is any threat to their continuation of the current model and choose to remain paid by fee-for-service.

Mr. Jeff Taschner stated looking at the presentation today, this gives us the amount the State is paying these hospitals and asked how the State of Delaware percentage shown compares to Central Pennsylvania in the Highmark market, similar for the State. If you look at Hospital A (10/22), paying 129% of their benchmark; today paying that hospital $20M – question is that a 129% of the benchmark or is our percentage in relation to Highmark different. Ms. Eitl responded that Highmark set the bar at 100% for Central Pennsylvania and the percentage shown in Delaware is relative to the 100%.

Mr. Taschner asked for an approximate idea of how much of the State's business is subject to the DRGs as Highmark previously stated they are targeting 80% moved to DRG's by 2017. How much do each of those hospitals represent of Highmark's overall business and if Highmark able to achieve that 80% move, what it would mean in the overall cost reductions. Ms. Eitl estimated Highmark is at 21-22% of the State's reimbursements under the DRG methodology where 80% is being processed as Fee-for-Service level for inpatient care only. The majority of outpatient business is fee scheduled base. Mr. Oberle noted that Highmark has limited negotiating power whether with a DRG or APC and would like to explore Metric Based Pricing (MBP). Representative Johnson asked how absolute is the DRG with a hospital and how they justify charging above the rate. Ms. Eitl explained each DRG is negotiated with inlier and outlier language and there may extenuating circumstances in which a hospital could earn more than the set DRG but there has to be medical documentation for those outliers.

Delaware Hospitals Partnering with State Employees to Improve Health & Reduce Costs

Members of various Delaware hospitals shared an analysis of hospital costs in Delaware. Dr. Janice Nevin, President and CEO of Christiana Care started with an overview showing the share of economic activity (GDP) devoted to health care that increased from 7.2% in 1970 to 17.9% in 2009 and 2010. In 2010, $8,402 per person was spent on healthcare. The analysis shows a steep spike in spending on healthcare from age 57. Although high, hospital costs are proportional with 36% of total spend in the United States and 37% of total spend in Delaware is on hospital care. Delaware is one out of five states where hospitals serve as a safety net with no critical access or public indigent hospitals where West Virginia has twenty and Pennsylvania has three. The average weekly wages in Delaware are higher than Pennsylvania and West Virginia. Maryland was not included as their payment model is completely different and difficult when it comes to comparisons with healthcare costs. Dr. Nevin stated they could get this data. Delaware is ranked 24th in hospital costs per day if the critical access hospital costs are removed and has the lowest hospital cost per patient day compared to small East Coast Corridor states. States have the ability to add and mandate coverage and this has been done in Delaware. Each time a benefit is added or mandated, there is a cost to that. There is an advantage in Delaware having nearby hospitals close to home with four in New Castle County, two in Kent County and two in Sussex County. The age and health status directly affect cost of care for State employees. The average age of employees is 47 years old. State employees have a higher proportion of every single chronic condition when compared to the average Delawarean. Chronic diseases are the result of obesity, lack of exercise, poor nutrition, untreated hypertension and diabetes. Delaware is unhealthy being 35th in the country. High-cost patients or 5% of the population have a catastrophic illness or 5 or more chronic conditions which equals about 50% of healthcare spending. The long term investment, if you invest in health and wellness, the 35% of healthy patients and 40% of At-Risk patients, will not reach the top level and fall into the high-cost patient's category. An example was given with a person with diabetes.

Hospitals are committed to the communities by creating jobs, developing their people, modernizing outdated facilities, building IT infrastructure. Changing the way hospitals are paid from a Fee-for-Service (Number/Volume) to a Value Payment (Health Outcome and Cost) shows hospitals are leading the paradigm shift by reducing hospital admissions, ER visits and high utilization of services. Data shows 35% of ER visits were not emergencies. Hospitals in Delaware are now participating in Accountable Care Organizations (ACO) which holds hospitals accountable for the results offered in healthcare. St. Francis, Christiana Care Health Systems, Bayhealth, Nanticoke and Beebe are participating to work differently with our physicians to be paid for value at the federal level. Director Visalli commented that analysis has been done on the State's chronic conditions as there is a high incidence rate with back injuries, diabetes and other chronic conditions. Mr. Taschner commented that this doesn't explain what the group has heard from Highmark that our adjusted casemix is significantly higher for what people are paying for the same thing and have heard nothing that addresses that. This information of the high prevalence of chronic conditions will be gathered.

Mr. Jeff Freid of Beebe Health Care shared how bundling payments improves care and lowers costs. Care after hospital discharge is a high proportion of costs as shown by CMS data provided by CCHS Finance Dept. 2015. Medicare Advantage is currently underutilized in Delaware. Lower hospital costs can be achieved by care coordination, local patient-centered medical homes focus on care for "super users" of the acute care system, proactively treating substance abuse disorders, new access points (Telehealth), integrating behavioral health into primary care, onsite wellness clinics and wellness incentives. Accountable Care Organizations (ACOs) are groups of doctors, hospitals and other health care providers who provide coordinated care to their Medicare patients. Nationally the population for inpatient admissions per 1,000 population was 120 in 2003 and in 2016 this is expected to be 96. Upon discharge, patients are receiving discharge phone calls to follow-up on transportation, setting up appointments with their PCP to work smarter to reduce admissions and re-admissions. Use of a Clinical Decision Unit for a person coming to the ER, before they get admitted which is a higher cost and care could be managed on an out-patient basis with good results.

Discussion occurred around the topic of an audit of the State's medical and Rx claims, process and findings. Medicare does more retroactive auditing. Mr. Corrigan, CFO of Christiana Care shared there are five levels of the appeal process with Medicare. Dr. Nevin suggested the committee review the Medicare audits and review the principles for a successful audit.

Mr. Taschner asked if the onsite clinics could be translated into cost savings. Dr. Nevin shared on-site wellness clinics have been done with State employees in Colorado and Mexico with immediate healthcare savings. Senator McDowell stated this could be a potential path forward for an effective tool.

Other Business

Ms. Nestlerode suggested to have some of our healthcare experts put forth their top five recommendations.

Director Visalli stated that more dialog in a comprehensive forward thinking fashion needs to occur with the hospitals and how this is accomplished needs to be determined. Aon is prepared to frame up the cost savings ideas during the discussion at the next meeting. There is a Public hearing on December 2, 2015 so that State employees and anyone who wishes has the opportunity to voice their opinion on the work done to date. A final Public hearing on the final report will be scheduled after the report is completed.

Mr. Oberle expressed his concern on the gap and disconnect through this process as what the third party administrators are telling us and what the hospitals are saying.

Senator McDowell asked if the hospitals could present some material to show us how this new value based payment can be used to bend the curve and illustrate with real dollars.

Dr. Nevin stated that their ability to provide specific information is hampered because they don't get the data but would welcome the opportunity to improve healthcare costs.

Mr. Taschner is interested in getting a lot more specifics on their experience in negotiating DRGs such as what's the starting point, is it our current payment rate which we're told is 25% more; understanding how it is addressing what's been called out to the committee by DCHI, Highmark and by Aetna. We need to know more about the experience, the opportunity and potential. It was noted that DRGs are different than metric based pricing.

Treasurer Simpler asked if Aon and others are available for clarity if committee members have any struggle with the amount of data and need interpretation without disrupting any guidelines and to save time during the final meeting.

The final Task Force meeting is scheduled for December 3, 2015 from 9:00 a.m. to 12:00 p.m. at the Delaware State Fire School, Classroom 5 in Dover, DE. A motion to adjourn was requested. Senator McDowell made the motion and Senator Lawson seconded. Motion carried. The meeting adjourned at 12:15 p.m.

Respectfully submitted,

Lisa Porter
Executive Secretary
Statewide Benefits Office, OMB