The State of Delaware

GHIP Strategic Framework

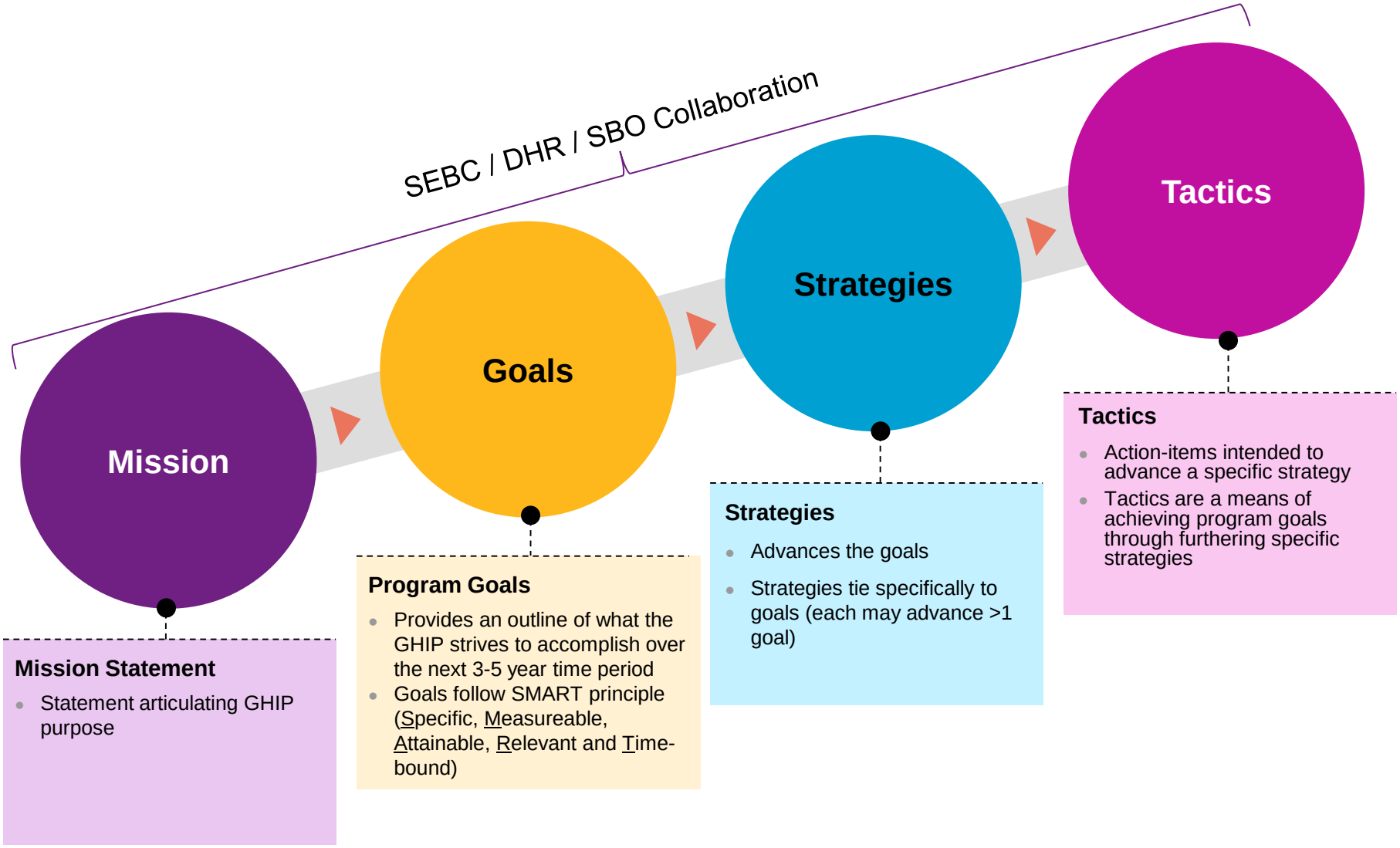
November 16, 2020

Willis Towers Watson

Overview of today's discussion

- Original GHIP strategic framework was approved by the SEBC in December 2016
  - Original goals had various target dates for completion, with the latest being by the end of FY20
  - WTW provided periodic reporting to SEBC on the status of GHIP goal completion
  - SBO developed its strategic plan to operationalize the goals, strategies and tactics cited by the GHIP strategic framework (as well as other priorities designated by DHR)
- In February 2020, the SEBC voted to adopt updated goals, most of which will use FY21 as the baseline year for measurement purposes
- Today's discussion provides a brief summary of the final outcomes from the original GHIP goals as well as an explanation of how the updated GHIP framework and the SBO strategic plan were developed

Components of the GHIP strategic framework



Mission Statement

- Statement articulating GHIP purpose

Program Goals

- Provides an outline of what the GHIP strives to accomplish over the next 3-5 year time period
- Goals follow SMART principle (Specific, Measureable, Attainable, Relevant and Time-bound)

Strategies

- Advances the goals
- Strategies tie specifically to goals (each may advance >1 goal)

Tactics

- Action-items intended to advance a specific strategy
- Tactics are a means of achieving program goals through furthering specific strategies

Original GHIP goals – approved by SEBC in December 2016

Tied to the GHIP mission statement

Mission Statement:	***Goals:***
Offer State of Delaware employees, retirees and their dependents ***adequate access*** *to* ***high quality healthcare that produces good outcomes…***	○ Addition of at least net 1 value-based care delivery (VBCD) model by end of FY2018
at an ***affordable cost****…*	○ Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020[1]
promotes ***healthy lifestyles,*** *and helps them be* ***engaged consumers.***	○ GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020[2]

[1] Gross trend is inclusive of total increase to GHIP medical plan costs (both "employer" and "employee") and will be measured from a baseline average trend of 6% (based on a blend of the State's actual experience and Willis Towers Watson market data).

[2] Note: To drive enrollment at this level, the State will need to make plan design and employee contribution changes that may require changes to the Delaware Code.

Progress toward completion of original GHIP goals and pathway to new goal development

Goal: Addition of at least net 1 value-based care delivery (VBCD) model by end of FY2018

FY18 Result

Met through introduction of AIM[1] HMO model with CareVio risk sharing arrangement

- Since this original GHIP goal was established, there have been gradual shifts at the national level in:
  - Medical providers' willingness to opt into value-based contracting arrangements with commercial insurance carriers
  - Plan sponsors' interest in steering plan participants to high quality providers, which tend to also be more willing to enter into value-based contracts
  - Efforts to standardize the framework of provider payment models that are alternatives to fee-for-service reimbursement

[1] AIM = Alternative Innovation Model.

Progress toward completion of original GHIP goals and pathway to new goal development

Goal: Addition of at least net 1 value-based care delivery (VBCD) model by end of FY2018 (continued)

- At the local level, interest in provider adoption of alternative payment models in Delaware also grew
  - SEBC continued to receive periodic updates on Highmark and Aetna efforts to contract with medical providers via alternative payment models
  - Broader use of the Health Care Payment Learning & Action Network's Alternative Payment Model (APM) Framework to track progress toward payment reform
  - Opportunity to align updated strategic framework with this construct

New goal established February 2020:

Using the APM Framework and FY2021 medical spend as a baseline[1], increase GHIP spend through advanced APMs[2] to be at least the following by the end of FY2023 (as % of total spend):

- Category 3: 40%
- Category 4: 10%

1 Estimated FY21 baseline medical spend in advanced APMs: Category 3 – 17%, Category 4 – 0%. Based on GHIP-specific data provided by Highmark and Aetna.
2 Defined by the APM Framework as Category 3 and Category 4 models.

Progress toward completion of original GHIP goals and pathway to new goal development

Goal: Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020[1]

SBO strategic plan incorporates the same goal

FY20 Result

Met – Compared to a baseline average trend[1] of 6%, the annual increase in GHIP gross claims[2] per member for FY16-FY20 was:

- 2.7% (includes favorable impact of COVID-19 due to deferred care)
- 3.9% (excludes Q4 FY20, when favorable impact of COVID-19 was realized)

- Throughout FY19 and FY20, increased attention was paid to GHIP cost increases for specific categories of services
  - Significant annual increases in facility costs and in specialty drugs dispensed through the medical plan (i.e., through a provider's office or at a medical facility)
  - *Examples:* change in cost per member per month for FY20 compared to FY19:
    - Inpatient admissions, medical (non-surgical) reasons: +14.4%
    - Specialty drugs, dispensed through medical plan in outpatient setting: +88.5%

[1] Gross trend is inclusive of total increase to GHIP medical plan costs (both "employer" and "employee") and will be measured from a baseline average trend of 6% (based on a blend of the State's actual experience and Willis Towers Watson market data).

2 Observed trend captures gross medical and prescription drug claims per member and excludes pharmacy rebates and Employer Group Waiver Plan (EGWP) payments.

Progress toward completion of original GHIP goals and pathway to new goal development

Goal: Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020

- Further attention drawn to facility costs through research conducted by Johns Hopkins University on inpatient hospital prices and margins in Delaware, and the RAND Corporation's study of health care prices paid by private health plans relative to Medicare
- Opportunity to take a targeted approach to managing future cost increases, *and* link to the Delaware Health Care Spending Benchmark

New goal established February 2020:

Limit total cost of care inflation for GHIP participants at a level commensurate with the Health Care Spending Benchmark[1] by the end of FY2023 by focusing on specific components, which are inclusive of, but not limited to:

- Outpatient facility costs
- Inpatient facility costs
- Pharmaceutical costs

1 Currently pegged at 3.8% for 2019.

Progress toward completion of original GHIP goals and pathway to new goal development

Goal: Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020

- At the same time, focus on managing diabetes disease burden was expanding statewide
  - Health Care Spending Benchmark includes diabetes management as a key component to managing population health across Delaware
  - Enactment of HB203 implemented new joint reporting requirements by Delaware Division of Public Health, Division of Medicare & Medicaid, and the Statewide Benefits Office
- For the GHIP, diabetes is consistently a top cost driver and occurs at a higher rate than in other commercially insured populations
  - Diabetes was the most expensive episode of care in FY19 ($45.2M net paid for medical/Rx claims, with a PEPM trend of +18.4%)
  - Average annual increase in cost associated with diabetics, FY17-FY20: 7.2%
- GHIP offers targeted programs to help members with a diagnosis of diabetes (Livongo) or those with metabolic syndrome (diabetes prevention programs through Retrofit and the YMCA)

Progress toward completion of original GHIP goals and pathway to new goal development

Goal: Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020

- Opportunity to address the GHIP's top clinical condition cost driver, while also synchronizing efforts with broader public health initiatives in Delaware

New goal established February 2020:

Reduction of GHIP diabetic cost per-member-per-month (PMPM) by 8% by the end of FY2023[1], using FY2021 spend as a baseline

SBO strategic plan incorporates the same goal, with a modified timeline

- Goal was previously incorporated into SBO strategic plan during the 2018 calendar year
- Target for goal completion in the SBO plan was the end of FY2020; with the addition of the above goal into the GHIP strategic framework, the SBO plan will continue to track progress toward this goal through at least the end of FY2023
- Baseline average annual cost increase for diabetic members from FY17-FY20: 7.2%

1 Estimated reduction in diabetic member cost for FY21 is approximately 1.5% ($0.7m).

Progress toward completion of original GHIP goals and pathway to new goal development

Goal: GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020[1]

FY20 Result

Met – 29% of active employees and non-Medicare pensioners were enrolled in the CDH Gold plan (a consumer-driven option) and the AIM HMO plan (a value-based[2] option) as of June 2020.

- The intention of this goal was to encourage greater member engagement in their health and health care usage
  - Offering and encouraging enrollment in consumer-driven health plans is one tactic that other plan sponsors have utilized to encourage member engagement
  - Value-based plans, in which members are directed to use higher quality, cost efficient providers, are another approach that some plan sponsors have used
- Recently, the emphasis on driving GHIP member engagement has shifted away from encouraging greater member engagement through a consumer-driven plan to increasing member education and benefits literacy to motivate members to play a greater role in their own health care

1 Note: To drive enrollment at this level, the State will need to make plan design and employee contribution changes that may require changes to the Delaware Code.
2 Considered to be a value-based plan option at the time this goal was under development. The definition of a "value-based" plan has evolved since this time to encompass APMs.

Progress toward completion of original GHIP goals and pathway to new goal development

Goal: GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020

- In support of the focus on empowering members to make informed decisions about their health and care utilization, there is opportunity to leverage the wide variety of member engagement tools available in the marketplace

New goal established February 2020:

In light of the GHIP's changing demographic profile, strive for an incremental increase in unique users utilizing a specific point-of-enrollment and/or point-of-care engagement platform/consumerism tool[1] by at least 5% annually

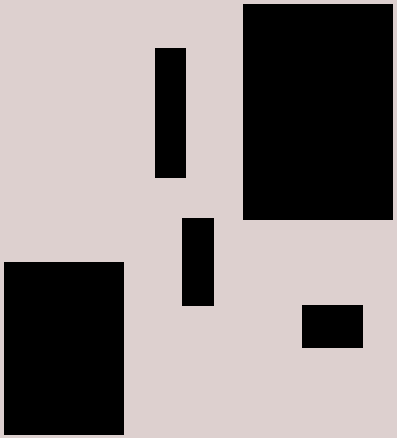
SBO strategic plan incorporates the same goal

1 Through FY2021, this tool will continue to be administered under the purview of the SBO. Post-FY2021, selection of a specific engagement platform / consumerism tool will be at the discretion of the SEBC.

Next steps

- Progress towards the updated goals will continue to be monitored and will continue be reported to the SEBC on a periodic basis

Appendix



GHIP mission statement

Core concepts defined

Offer State of Delaware employees, retirees and their dependents adequate access to high quality healthcare that produces good outcomes at an affordable cost, promotes healthy lifestyles, and helps them be engaged consumers.

Core Concept	Definition
Adequate access	Access to various types of healthcare providers that meets generally accepted industry standards (e.g., *x* number of *y* PCPs, specialists, hospitals within *z* miles of GHIP participant's home zip code).
High quality healthcare that produces good outcomes	Healthcare that meets nationally recognized standards of care established by various governmental and non-governmental health care organizations (e.g., AHRQ, NCQA, The Leapfrog Group).[1]
Affordable cost	Annual health care cost trend that is lower than national average for both GHIP participants and the State. For GHIP participants, at minimum, medical plans meet the minimum value and affordability requirements under PPACA; cost reflects both out-of-pocket cost sharing via plan features and employee payroll contributions. For the State, program costs are monitored and budgeted to promote greater fiscal certainty.
Healthy lifestyles	Combination of behaviors that reduce health risk factors, including regular exercise, proper nutrition, avoidance of tobacco, moderation of alcohol use, preventive care, and active management of chronic conditions.
Engaged consumers	GHIP members who have taken ownership of their health by using all available resources provided by the State (e.g., provider cost/quality data, SBO consumerism website and online training course) to make informed decisions on how, where and when they seek care.

[1] AHRQ = Agency for Healthcare Research and Quality, a Federal agency within the U.S. Department of Health and Human Services (HHS).
NCQA = National Committee for Quality Assurance, a 501(c)(3) not-for-profit organization.
The Leapfrog Group is a nonprofit watchdog organization and a national advocate of hospital transparency in cost, quality and safety data to support informed decision-making among healthcare consumers.

Health Care Payment Learning & Action Network

- Launched by the US Department of Health and Human Services (HHS)
- Public-private partnership established to accelerate transition in the healthcare system from a fee-for-service payment model to ones that pay providers for quality care, improved health, and lower costs
- Established the Alternative Payment Model (APM) Framework to track progress toward payment reform

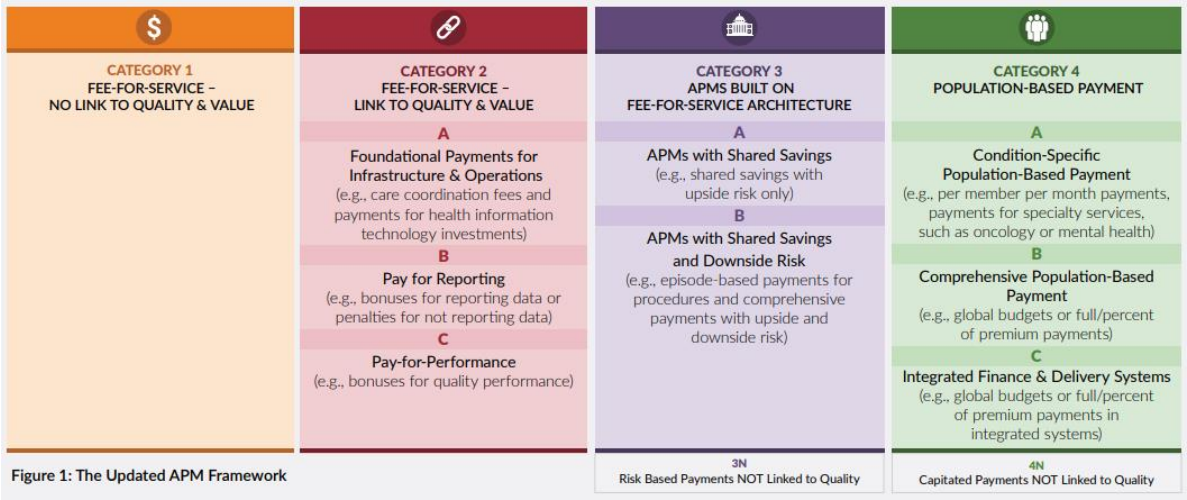


Figure 1: The Updated APM Framework

As payments move away from fee-for-service and towards pay-for-value…

Total cost of care ↓

Quality of care ↑

Source: https://hcp-lan.org/

Health Care Payment Learning & Action Network

Healthcare Resiliency Collaborative

- ***Purpose: "***to articulate and commit to the most important short and long term actions that can be taken to achieve resiliency in the health care system"

- Brought to light by financial stress created by COVID-19 on providers that are paid primarily on a fee-for-service basis

- Supports HCP-LAN vision "to create a health care system that is responsive and resilient to events such as the unprecedented COVID-19 public health emergency (PHE) and achieves better patient experience, outcomes, equity, quality, appropriateness, affordability and accessibility at reduced total cost of care– not just a system that recovers to previous models of care and payment."

- Involves payer-provider collaboration to shift payments from fee-for-service to "effective" APMs built around population-based payments and two-sided risk sharing

- Developed a framework for key short- and long-term actions by payers, providers and multi-stakeholder groups to promote "more resilient, effective APMs"

Source: https://hcp-lan.org/resiliency-collaborative/framework/