The State of Delaware

Pre-read for April SEBC Meeting

State Employee Benefits Committee

April 24, 2023

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Overview

- This executive summary is being provided to SEBC members in advance of the April 2023 SEBC meeting to ensure that Committee members have an awareness of several publicly available resources and tools that study provider costs, quality and safety; this is not intended to be an exhaustive list of resources and instead reflects sources of information that have been or will be referenced at future SEBC meetings
- **This material is meant to introduce the SEBC to these resources and provides some basic context for the discussion at the April SEBC meeting**, which will include a presentation by the Office of Value Based Health Care Delivery (OVBHCD) on perspectives related to Delaware's progress with adoption of alternative payment models as well as on 2023 projections related to primary care investment in Delaware
- These topics have previously surfaced during the Committee's recent work to refine the goals of the GHIP Strategic Framework, which includes one goal that is entirely focused on increasing the proportion of GHIP spend through alternative (i.e., value-based) payment models
- Following the April 2023 SEBC meeting, Committee members will receive another pre-read for the May 2023 SEBC meeting that will expand upon the provider cost, quality and safety resources introduced within this document and referenced during the OVBHCD presentation in April
- **The pre-read for the May 2023 SEBC meeting will highlight key findings and takeaways gleaned from these resources that are directly relevant to the GHIP**

National Academy for State Health Policy's (NASHP) Hospital Cost Tool (HCT)

Website	https://tool.nashp.org/
Purpose	• To provide state policymakers and researchers with analytical insights into how much hospitals spend on patient care services, and how such costs relate to the hospital charges (list prices) and actual prices paid by health plans. • HCT dashboard reports on a range of measures for hospital revenue, costs, profitability, and break-even points across over 4,600 hospitals nationwide for the period from 2011 through 2021. • HCT dashboard offers options to view data at the hospital, state, and health system levels.
Data Source(s)	• Underlying dataset includes approximately 60 variables extracted and calculated using data from the national Healthcare Cost Report Information System (HCRIS) as the main data source. Hospitals in this dataset represent approximately 65 million patient discharges and $131 billion hospital net income in the most recent reporting year. • The HCRIS is the Centers for Medicare & Medicaid Services (CMS) system for aggregating cost report information that CMS receives from Medicare-certified institutional (facility) providers via each provider's Medicare Administrative Contractor (MAC). Medicare-certified institutional providers are required by CMS to submit an annual cost report to a MAC. • HCT 2.0 (released November 2022) includes data from Round 4 of the RAND Hospital Price Transparency Study (described further within this document) on aggregate commercial prices for 2018-2020.
Other Comments	• The NASHP HCT uses the same data source as the Johns Hopkins University research[1] reported to the SEBC and its subcommittees in 2019 and 2020 on inpatient hospital prices in Delaware.

All content sourced from NASHP HCT website noted above.

1 For further details on this Johns Hopkins University research, see https://dhr.delaware.gov/benefits/sebc/documents/2019/0408-jhu-de-report.pdf and https://dhr.delaware.gov/benefits/sebc/documents/sub-comm-2020/0213-hospital-prices-margins.pdf.

RAND Hospital Price Transparency Study

Website	https://www.rand.org/health-care/projects/price-transparency/hospital-pricing.html
Purpose	• To provide employers with greater transparency into information on hospital prices that will enable them to monitor the prices negotiated on their behalf, to implement innovative insurance benefit designs, to ensure insurers are negotiating favorable prices and to shop for health care on behalf of their employees. • This study assesses hospital prices paid by employer-sponsored health plans and by Medicare for the same services.
Data Source(s)	• Data collected from self-funded employers and 11 All-Payer Claims Databases (APCDs) over the course of four (4) rounds of this study. Currently, the study is seeking additional employers to participate in Round 5. • Initial round of results was published in 2017 based on data collected from employer participants in the Employers' Forum of Indiana. Subsequent rounds of the study were expanded across other states, achieving national reach by Round 3. • In the most recent round, data sources included $78.8 billion in spending from more than 4,000 hospitals and $2.0 billion from about 4,000 ambulatory surgical centers (ASCs).

Other Comments	• Data for the GHIP and other employer-sponsored plans in Delaware have been included in this study since Round 3 (published in 2020) via submissions by the Delaware Health Information Network (DHIN).
	• Selected general results from this study include:
	  • Employers and private insurers paid more than 2 times what Medicare would have paid for the same services at the same hospitals in 2020.
	  • Prices varied significantly by state. Relative prices in some states (Hawaii, Arkansas, and Washington) were less than 2 times the amount of Medicare prices, while relative prices in 19 states (e.g., Florida, West Virginia, and South Carolina) were more than 3 times that of Medicare.

All content sourced from RAND website noted above.

Kaufman Hall National Hospital Flash Report

Website	https://www.kaufmanhall.com/insights-all?sort=field_publication_date&order=desc&f%5B0%5D=topic%3A976
Purpose	• Provides monthly real-time information about the performance of hospitals nationwide. • Report includes data and analyses across hospital margins, volumes, revenues, and expenses derived from more than 900 U.S. hospitals.
Data Source(s)	• Uses both actual and budget data over the last three years, sampled from more than 900 hospitals on a recurring monthly basis from Syntellis' Axiom™ Comparative Analytics software. • The sample of hospitals for this report is representative of all hospitals in the United States both geographically and by bed size. Additionally, hospitals of all types are represented, from large academic to small critical access. Advanced statistical techniques are used to standardize data, identify and handle outliers, and ensure statistical soundness prior to inclusion in the report.

Other Comments	• Findings from the March 2023 report[1] include:
	  • An emerging “new normal” in terms of hospital margins: down -1.1% from January to February, continuing an 8-month trend of decreasing month-to-month margins compared to the last three years. Report suggests that relatively flat margins are likely to continue in near future given external economic factors
	  • Volume of care remains relatively steady, while outpatient care is a driver of revenue based on patient preferences which began during the pandemic
	  • Cost of goods and services are increasing (due to inflation and cost pressure) faster than labor expenses (which may indicate less reliance on contract labor)

All content sourced from Kaufman Hall website noted above.

1 Source: https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-march-2023

Primary Care Collaborative's State Primary Care Investment Hub

Website	https://www.pcpcc.org/primary-care-investment
Purpose	• The Primary Care Collaborative (PCC) is a not-for-profit multi-stakeholder membership organization and dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home. • Founded in 2006, the PCC's mission is to unify and engage diverse stakeholders in promoting policies and sharing best practices that support the growth of high-performing primary care that treats the whole person.
Data Source(s)	• The State Primary Care Investment Hub is a repository of information on actions that various states have taken related to legislation or regulations to measure, benchmark, and ultimately increase levels of investment in primary care. • Hub contains tools and interactive maps that allow users to filter on specific states to view information about legislative efforts and investment initiatives; also contains a "Health of Primary Care" scorecard created by the Milbank Memorial Fund, which is a foundation focused on improving population health and health equity with an emphasis on state health policy. • Sourced from various state public websites and information from other participating public and private organizations.
Other Comments	• The PCC also runs a State Primary Care Investment Workgroup that convenes executive member organizations and state leaders from across the country to discuss current trends in state legislation and regulations related to primary care investment on a quarterly basis. • Delaware's efforts to pass the Primary Care law (formerly known as SS1 for SB120 prior to adoption) and recent reports from the Delaware OVBHCD are highlighted on the PCC's State Primary Care Investment Hub.

All content sourced from PCC website noted above.
Further details about the Milbank Memorial Fund are available at https://www.milbank.org/about/.

Georgetown University research on state employee health plan cost containment initiatives

Website	https://sehpcostcontainment.chir.georgetown.edu/
Purpose	• Georgetown University's Center on Health Insurance Reforms fielded a survey between September 15 and December 7, 2020 to collect data on State Employee Health Plan (SEHP) organizational structure and benefits. • SEHP administrators were asked to identify the primary cost drivers for their plans, any cost containment initiatives implemented in the last three years, barriers to implementation of those initiatives, and any documented cost savings resulting from those initiatives.
Data Source(s)	• Self-reported information from forty-seven (47) states responded to the survey. Responses were not received from Arkansas, District of Columbia, Maryland, or South Dakota. • Website contains an interactive map that allows users to drill down into survey results by state with information on various components on the eligible population, health plan options and cost containment initiatives at play for each state. • A report on this research was published in 2022 and is available here: https://georgetown.app.box.com/s/qljs9kpo467k3ahpaap7gqya5byzulgr
Other Comments	• Findings from this survey were included in recent discussions with the SEBC Health Policy & Planning and Financial Subcommittees about other state efforts related to direct contracting with health systems and other providers. See materials from the November 2022 combined Subcommittee meeting here: https://dhr.delaware.gov/benefits/sebc/documents/sub-comm-2022/1117-fy24-planning.pdf

All content sourced from Georgetown University website noted above.

Leapfrog Hospital Survey and Hospital Safety Grade Reports

Website	https://www.hospitalsafetygrade.org/
Purpose	• Founded in 2000 by large employers and other purchasers, The Leapfrog Group is a national nonprofit organization driving a movement for “giant leaps forward” in the quality and safety of American health care. • The Leapfrog Hospital Survey collects and reports hospital performance, empowering purchasers to find the highest-value care and providing consumers with information to make informed decisions. • The Leapfrog Hospital Safety Grade, Leapfrog’s other main initiative, assigns letter grades to hospitals based on their record of patient safety, helping consumers protect themselves and their families from errors, injuries, accidents, and infections.
Data Source(s)	• The Leapfrog Hospital Survey is an annual voluntary survey in which Leapfrog asks hospitals to report quality and safety data and then publicly reports that information by hospital. • The Leapfrog Hospital Safety Grade is a letter grade Leapfrog bi-annually assigns to all general hospitals in the United States, whether or not they report to the Hospital Survey. • If a hospital does not report to the Hospital Survey, the Safety Grade uses publicly available data from numerous secondary sources. The majority of data used to calculate the Safety Grade comes from the Centers for Medicare and Medicaid Services. • Most recent Hospital Safety grades were released in November 2022. Measures include how well hospitals protect patients from preventable medical errors, accidents, injuries, and infections.
Other Comments	• An analysis[1] by The Leapfrog Group of data across the Hospital Safety Grade’s history suggests improvement in patient safety over time. • Thirty percent of hospitals received an "A," 28% received a "B," 36% received a "C," 6% received a "D," and 1% received an "F.” • The top ten states with the highest percentages of "A" hospitals are New Hampshire, Virginia, Utah, Colorado, Idaho, New Jersey, North Carolina, Maine, Pennsylvania, and Florida. • There were no “A” hospitals in the District of Columbia, North Dakota, or Vermont.

All content sourced from the Leapfrog Group’s website noted above.

1 Source: https://www.leapfroggroup.org/sites/default/files/Files/Safety%20Grade%2010-year%20Trends%20Table_Final.pdf