

STATE OF DELAWARE



**EXECUTIVE DEPARTMENT
DOVER**

**EXECUTIVE ORDER
NUMBER TWENTY-FIVE**

TO: HEADS OF ALL STATE DEPARTMENTS AND AGENCIES

**RE: ESTABLISHING DELAWARE HEALTH CARE SPENDING AND QUALITY
BENCHMARKS**

WHEREAS, Delaware's per capita health care spending consistently ranks in the top ten highest spending states and has historically outpaced economic growth in Delaware; and

WHEREAS, 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

WHEREAS, 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; and

WHEREAS, House Joint Resolution 7 of the 149th General Assembly directed the Secretary of the Department of Health and Social Services (DHSS) to study and plan the means and methods for gathering data to develop an annual growth target of total health care costs in the State of Delaware, known as a "benchmark"; and

WHEREAS, the Health Care Delivery and Cost Advisory Group, established through Executive Order Nineteen, provided the Secretary of DHSS with feedback on: (1) 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; (2) the establishment of a health care spending growth target; (3) the quality metrics across the health care delivery system that will be used to create quality benchmarks; and (4) the system improvements, if any, that can be made to set and evaluate appropriate health care quality benchmarks yearly in Delaware; and

WHEREAS, Senate Bill 236 of the 149th General Assembly, signed by the Governor on June 28, 2018, states that in calculating any statewide, regional or local health care cost calculation target or benchmark program (which program or initiative shall not carry a penalty), the total cost of care calculation, report, study or formulation shall utilize, to the fullest extent practicable, data obtained from the Health Care Claims Database maintained by the Delaware Health Information Network.

NOW, THEREFORE, I JOHN C. CARNEY, by virtue of the authority vested in me as Governor of the State of Delaware, do hereby **DECLARE** and **ORDER** the following:

1. The Delaware Economic and Financial Advisory Council (DEFAC) Health Care Spending Benchmark Subcommittee (hereinafter “Subcommittee”) is hereby established.
2. The Subcommittee shall be responsible for setting the health care spending benchmark for the State of Delaware (hereinafter “Spending Benchmark”) and shall advise DEFAC, the Governor and relevant state agencies on the Spending Benchmark.
 - a. For calendar year 2019, the Spending Benchmark shall be set equivalent to the Benchmark Index submitted to the Governor and General Assembly in December 2018 as established pursuant to Executive Order Twenty-One dated June 30, 2018. For calendar years 2020, 2021, 2022 and 2023, the Spending Benchmark shall be set at 3.5%, 3.25%, 3.0%, and 3.0% per capita spending growth respectively, unless the Subcommittee determines, in its annual review (outlined below) that the Spending Benchmark should be adjusted, using the formula in 2.b.
 - b. The Spending Benchmark shall be the per capita Potential Gross State Product (PGSP) growth rate which shall be calculated as follows:
 - i. The sum of: the expected growth in national labor force productivity; plus the expected growth in Delaware’s civilian labor force; plus the expected national inflation;
 - ii. Minus Delaware’s expected population growth;
 - iii. Plus a transitional market adjustment set at 0.5% for calendar year 2020, 0.25% for calendar year 2021, and 0% for calendar year 2022 and beyond.
3. The Subcommittee shall:
 - a. Review annually all components of the PGSP methodology and recommend to DEFAC for its approval whether the forecasted PGSP growth rate has changed in such a material way that it warrants a change in the Spending Benchmark, and if so, how and why the Spending Benchmark should be modified.
 - b. Review the methodology of the Spending Benchmark periodically for possible updates or modifications to the methodology for the performance year starting January 1, 2024 and beyond, and make recommendations to DEFAC no later than March 2023 and each March thereafter, on whether, and, if so, why the Spending Benchmark methodology and/or the PGSP growth rate should change.
 - c. Provide the public and interested stakeholders an opportunity to provide input and consider their recommendations.

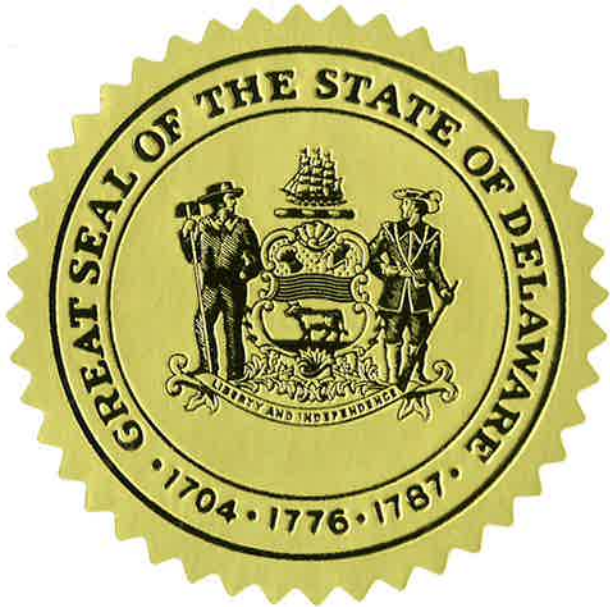
- d. Advise the Governor and DEFAC on current and projected trends in health care and the health care industry, particularly as they affect the expenditures and revenues of the State of Delaware, its citizens, and its major industries.
4. The Subcommittee shall consist of the following:
 - a. A Chair and a Vice-Chair, both of who shall be members of DEFAC and have health care expertise appointed by the DEFAC Chair;
 - b. Three existing members of DEFAC appointed by the DEFAC Chair;
 - c. Two members representing health economists, appointed by the Governor; and
 - d. Two members representing quality improvement experts from two health care systems or hospitals which operate in the state, appointed by the Governor.
 5. All members of the Subcommittee shall be appointed by and serve at the pleasure of the appointing authority. All meetings shall be called by the Chair of the Subcommittee. The Vice-Chair shall chair any meetings of the Subcommittee in the absence of the Chair.
 6. DEFAC shall report no later than May 31 of each year to the Governor and the Delaware Health Care Commission (DHCC) any changes to the Spending Benchmark approved by DEFAC pursuant to Sections 2 and 3 of this Order.
 7. Recognizing the importance of coordination between the Subcommittee and the DHCC in the creation of spending and quality health care benchmarks, and as part of its ongoing efforts to serve as the policy body to advise the Governor and the General Assembly on strategies to promote affordable quality health care to all Delawareans, the DHCC is encouraged to accomplish the following:
 - a. Set health care quality benchmarks for the State of Delaware (hereinafter "Quality Benchmarks") and advise the Governor and relevant state agencies on the Quality Benchmarks. For calendar years 2019 through 2021, the Quality Benchmarks shall be as follows:
 1. Emergency Department Utilization Rate (risk-adjusted rate), as defined by the National Committee for Quality Assurance, measured for commercial populations:
 - a. 2019: 190 visits per 1000
 - b. 2020: 184 visits per 1000
 - c. 2021: 178 visits per 1000
 - d. Aspirational benchmark for longer term attainment: 166 visits per 1000
 2. Opioid-Related Overdose Deaths, as defined by the Centers for Disease Control and Prevention:
 - a. 2019: 16.2 deaths per 100,000
 - b. 2020: 15.5 deaths per 100,000
 - c. 2021: 14.7 deaths per 100,000

- d. Aspirational benchmark for longer term attainment: 13.3 deaths per 100,000
- 3. Residents per 1,000 with Overlapping Opioid and Benzodiazepine Prescriptions, as defined by the Pharmacy Quality Alliance, measured for commercial and Medicaid populations:
 - a. 2020, 2021 and aspirational benchmarks to be defined and published by the Secretary of DHSS during 2019
- 4. Adult Obesity, as defined by the Centers for Disease Control and Prevention:
 - a. 2019: 30.0%
 - b. 2020: 29.4%
 - c. 2021: 28.7%
 - d. Aspirational benchmark for longer term attainment: 27.4%
- 5. Adult Tobacco Use, as defined by the Centers for Disease Control and Prevention:
 - a. 2019: 17.1%
 - b. 2020: 16.4%
 - c. 2021: 15.8%
 - d. Aspirational benchmark for longer term attainment: 14.6%
- 6. High School Students Who Were Physically Active, as defined by the Centers for Disease Control and Prevention:
 - a. 2019: 44.6%
 - b. 2020: no survey performed
 - c. 2021: 46.8%
 - d. Aspirational benchmark for longer term attainment: 48.7%
- 7. Statin Therapy for Patients with Cardiovascular Disease – Statin Adherence 80%, as defined by the National Committee for Quality Assurance, measured for commercial and Medicaid populations:
 - a. 2019 (commercial): 79.9%
 - b. 2019 (Medicaid): 59.2%
 - c. 2020 (commercial): 80.5%
 - d. 2020 (Medicaid): 61.5%
 - e. 2021 (commercial): 81.0%
 - f. 2021 (Medicaid): 63.7%
 - g. Aspirational benchmark for longer term attainment (commercial): 82.1%
 - h. Aspirational benchmark for longer term attainment (Medicaid): 68.3%


8. Persistence of Beta-Blocker Treatment After a Heart Attack, as defined by the National Committee for Quality Assurance, measured for commercial and Medicaid populations:
 - a. 2019 (commercial): 82.5%
 - b. 2019 (Medicaid): 78.8%
 - c. 2020 (commercial): 84.9%
 - d. 2020 (Medicaid): 80.1%
 - e. 2021 (commercial): 87.2%
 - f. 2021 (Medicaid): 81.3%
 - g. Aspirational benchmark for longer term attainment (commercial): 91.9%
 - h. Aspirational benchmark for longer term attainment (Medicaid): 83.9%
 - b. Review the methodology of the Quality Benchmarks in 2022, and every three years thereafter, to determine whether changes should be made to the values used to establish the Quality Benchmarks to reflect changes in new population health or health care priority opportunities for improvement, and/or whether the Quality Benchmarks' values should be changed to reflect improved health care performance in the state. Should such determinations be made, the DHCC shall change the values used for the Quality Benchmarks, but only after providing the public and interested stakeholders an opportunity to provide feedback, and considering their recommendations.
 - c. Report annually during the fourth quarter on performance relative to the Spending and Quality Benchmarks during the prior Calendar year, including variation in costs and quality of high-volume, high-cost and high-value episodes of care (identifying the causes of variation, including mix of services used, unit price variation and provision of low-value care) at:
 1. State, health insurance market (e.g., commercial Medicaid, Medicare, Medicare Advantage) and individual payer levels; and
 2. Medical group and accountable care organization (ACO) levels for entities of a sufficient size, using clinical risk adjustment methodologies.
 - d. Engage providers and community partners in a 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 Spending Benchmark and Quality Benchmarks, relying on data and, to the extent practicable, evidence-based solutions to address identified opportunities through the variation analysis.
8. No later than January 31, 2019, the Secretary of DHSS shall publish a technical manual that contains the methodology for the Spending Benchmark and the Quality Benchmarks,

including where to obtain data to calculate the values of the benchmarks and how to assess performance.

This Executive Order shall take effect immediately.

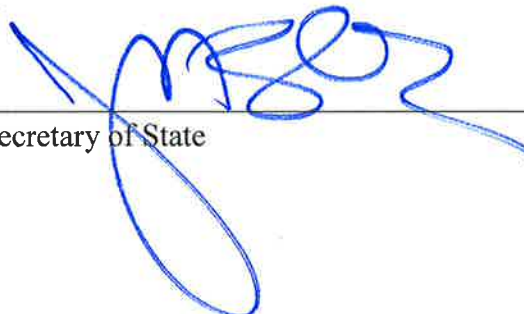


APPROVED this 20th day of November, 2018.



John C. Carney
Governor

ATTEST:



Secretary of State