Cost Growth Benchmark Stakeholder Advisory Board Meeting #6 September 16, 2020

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Agenda

Time	Topic
1:00 p.m.	Call to Order
1:05 p.m.	Review and Approval of Prior Meeting Minutes
1:10 p.m.	Public Comment
1:20 p.m.	Follow-up from the Technical Team's September 10th Meeting
1:50 p.m.	Ensuring Success
2:20 p.m.	Reflections
2:55 p.m.	Wrap-Up and Next Steps
3:00 p.m.	Adjourn

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Call to Order and Roll Call

Stakeholder Advisory Board Members

- Vicki Veltri – Office of Health Strategy
- Reginald Eadie – Trinity Health of NE
- Kathy Silard – Stamford Health
- Janice Henry – Anthem BCBS of CT
- Robert Kosior - ConnectiCare
- Richard Searles – Merritt Healthcare Sol.
- Ken Lalime - CHCACT
- Margaret Flinter – Community Health Ctr
- Karen Gee – OptumCare Network of CT
- Marie Smith – UConn School of Pharmacy
- Tekisha Everette – Health Equity Solutions
- Pareesa Charmchi Goodwin – CT Oral Health Initiative
- Howard Forman – Yale University
- Nancy Yedlin – Donaghue Foundation
- Fiona Mohring – Stanley Black and Decker
- Lori Pasqualini – Ability Beyond
- Sal Luciano – CT AFL-CIO
- Hector Glynn – The Village for Fam & Children
- Rick Melita – SEIU CT State Council
- Ted Doolittle – Office of the Healthcare Adv
- Susan Millerick - patient representative
- Kristen Whitney-Daniels - patient represent.
- Jonathan Gonzalez-Cruz - patient represent.
- Jill Zorn - Universal Health Care Foundation

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Review and Approval of Prior Meeting Minutes

Public Comment

Follow-up from the Technical Team's September 10th Meeting

Follow-up from the Technical Team's September 10th Meeting

- During its last meeting, the Technical Team discussed outstanding issues related to the cost growth benchmark and the primary care spend target. We will be discussing the following topics with the Stakeholder Advisory Board today:

<u>Cost growth benchmark:</u>

1. From which insurers will data be requested
2. How risk-adjustment will be applied
3. Minimum attribution size for providers

<u>Primary care target:</u>

4. Setting the target

1. Cost growth benchmark: insurer data requests

- As a reminder, data to support the Cost Growth Benchmark needs to be supplied by payers.
  - Payers are the only source for non-claims payment and self-insured data.
  - All states with cost growth benchmark policies have payers submitting summarized data, including commercial self-insured data, to the state agency responsible for policy implementation.
- Following consultation with the Insurance Department, OHS has recommended that in addition to Traditional Medicare and Medicaid, the insurers listed on the Consumer Report Card on Health Insurance Carriers on Connecticut be requested to submit data to support the Cost Growth Benchmark.

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Recommended payers from which healthcare spending data would be requested

- The Technical Team supported the following list of payers:

Commercial (all product types and all business entities)	Medicare (all product types and all business entities)	Medicaid
Aetna Health & Life	CMS (Traditional Medicare)	Department of Social Services
Anthem	Aetna	
Cigna	Anthem	
ConnectiCare	ConnectiCare	
Harvard Pilgrim Health Care	UnitedHealthcare, Oxford Health and Sierra Health and Life	
UnitedHealthcare and Oxford Health		

*In addition, summary-level data will be obtained from the VA and the CT Department of Corrections.

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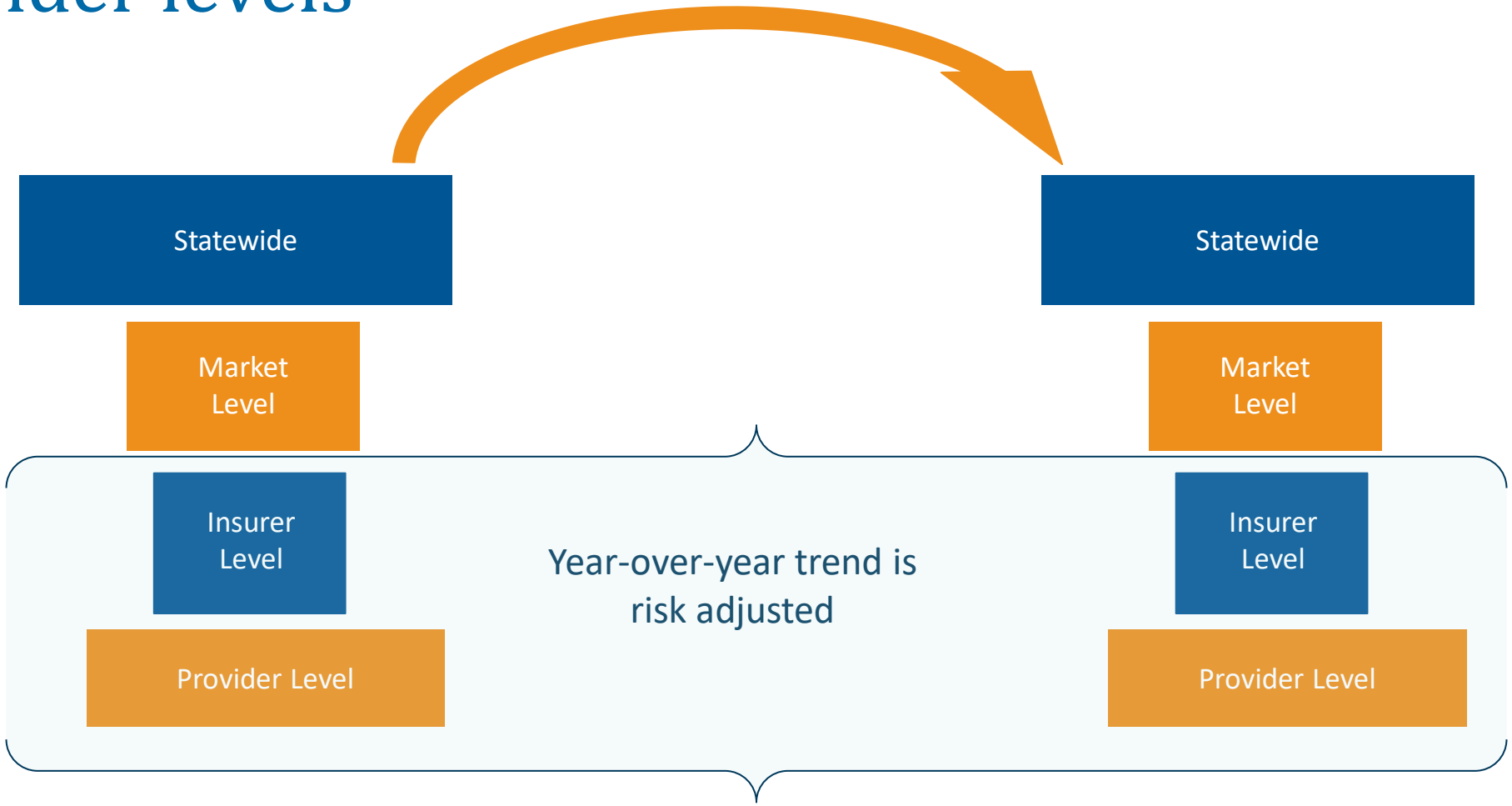
2. Cost growth benchmark: risk adjustment

- In order to report on payer and provider performance against the Cost Growth Benchmark, cost data will need to be risk adjusted.

- For the Technical Team's purpose, "risk adjustment" is the modification of spending data to reflect changes in the underlying insurer or provider population over the course of the year.
  - The adjustment ensures that assessment of cost growth benchmark attainment considers changes in the underlying health status of the insurer's or provider's served population.

Risk adjustment is only performed at the insurer and provider levels



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Options for risk adjustment approach (1 of 2)

There are two ways to perform clinical risk adjustment:

Method	Pros	Cons
1. Each insurer uses its own risk adjuster (if using payer-reported data)*	• Administratively less complex	• It was previously thought that combining risk adjusted data across payers could not be done, but research suggests that the performance variation between risk adjusters is relatively minimal
2. Use a common risk adjuster	• There are publicly available risk adjusters that could be used (e.g., HCCs) • Provider experience could be compared across insurers	• Administratively more complex because payers currently use many different risk adjustment products

*All other cost growth benchmark states are using this approach.

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Options for risk adjustment approach (2 of 2)

- The Technical Team supported Option 1 because it is much more likely to secure payer buy-in and the State can likely still compare findings across payers that use different tools.
- It recommended requiring payers to report which risk adjustment tool it used and which version of the tool with their data submissions.

Social risk adjustment

- The Technical Team also discussed social risk adjustment. There are no established methods yet for performing this type of adjustment, and commercial payers nationally are not currently doing so. The Technical Team recommended not applying social risk adjustment to cost growth benchmark performance.
- The Technical Team did, however, strongly urge the State to adjust for social risk as part of the data use strategy.

3. Cost growth benchmark: minimum attribution size

- To report on healthcare spending at the provider level, the provider needs to be sufficiently large to help dampen any “noise” in the data and reduce the chance that random variation played a part in its performance.
- Statistical analysis reveals that random variation will impact cost performance assessments unless populations are quite large.

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Minimum number of attributed lives for provider-level reporting in DE, MA, RI and OR (1 of 2)

- States have chosen 3,000-10,000 lives as their minimum population size.
- Massachusetts is the only state to have reported performance publicly. While it chose 3,000 as the minimum for *collecting data*, it is reporting on provider entities that are much larger. It has not publicly stated a minimum for *reporting data*.
- DE and RI are just now collecting data on their first performance period. They intend to report at 5,000 lives (Medicare) and 10,000 lives (commercial and Medicaid).
  - Overall, Medicare is a statistically more stable population in terms of change in costs over time than commercial and Medicaid, which is why the Medicare threshold is lower.

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Minimum number of attributed lives for provider-level reporting in DE, MA, RI and OR (2 of 2)

- Oregon is developing an empirical model to use as the basis for setting a minimum population size(s) for publicly reporting data. Project staff and the Technical Team suggest that Connecticut wait for the results of this analysis before making a decision on this topic.
  - Should Oregon not be able to complete its work for some reason, project staff and the Technical Team recommend that Connecticut work to develop an empirical basis for establishing a minimum population for which to report on large provider entities.

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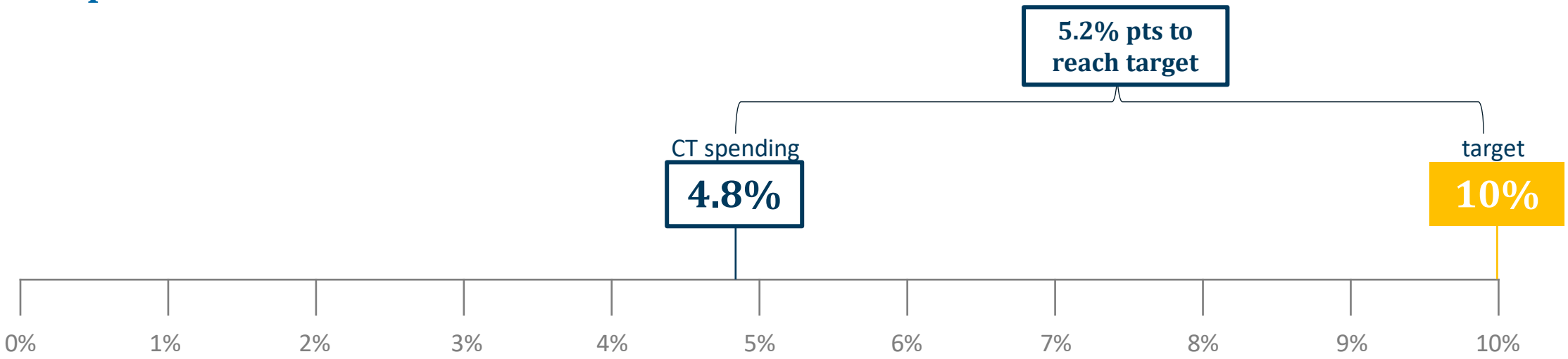
Does the Stakeholder Advisory Board have any feedback on these three cost growth benchmark topics?

4. Primary care target: setting the target

- The Technical Team previously recommended calculating a statewide weighted average of total primary care spending using total healthcare expenditures.



Source: Bailit Health analysis using data from the Freedman Healthcare analysis, the UConn SIM evaluation report, the Kaiser Family Foundation Health Insurance coverage estimates for 2018 and CT DSS Medicaid spending estimates.

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Recommendation for the 2021 target

- Therefore, the Technical Team recommended **setting the conservative 2021 primary care spend target at 5.0%** for the following reasons:
  1. OHS does not yet have baseline data from payers to identify current primary care spending. The 4.8% in the previous slide is our best estimate for current spending.
  2. COVID-19 has significantly impacted primary care utilization in 2020, which is likely to continue into early 2021, at the very least.
  3. The 2021 measurement period will begin in a few months, which does not give payers and providers much advanced notice of the target, nor time to talk action to increase primary care spending as a percentage of total spending.

Recommendation for the 2022-2024 targets

- The Technical Team recommended deferring setting targets for 2022-2024 to an OHS-convened Work Group focused on primary care after baseline payer-reported data are available.

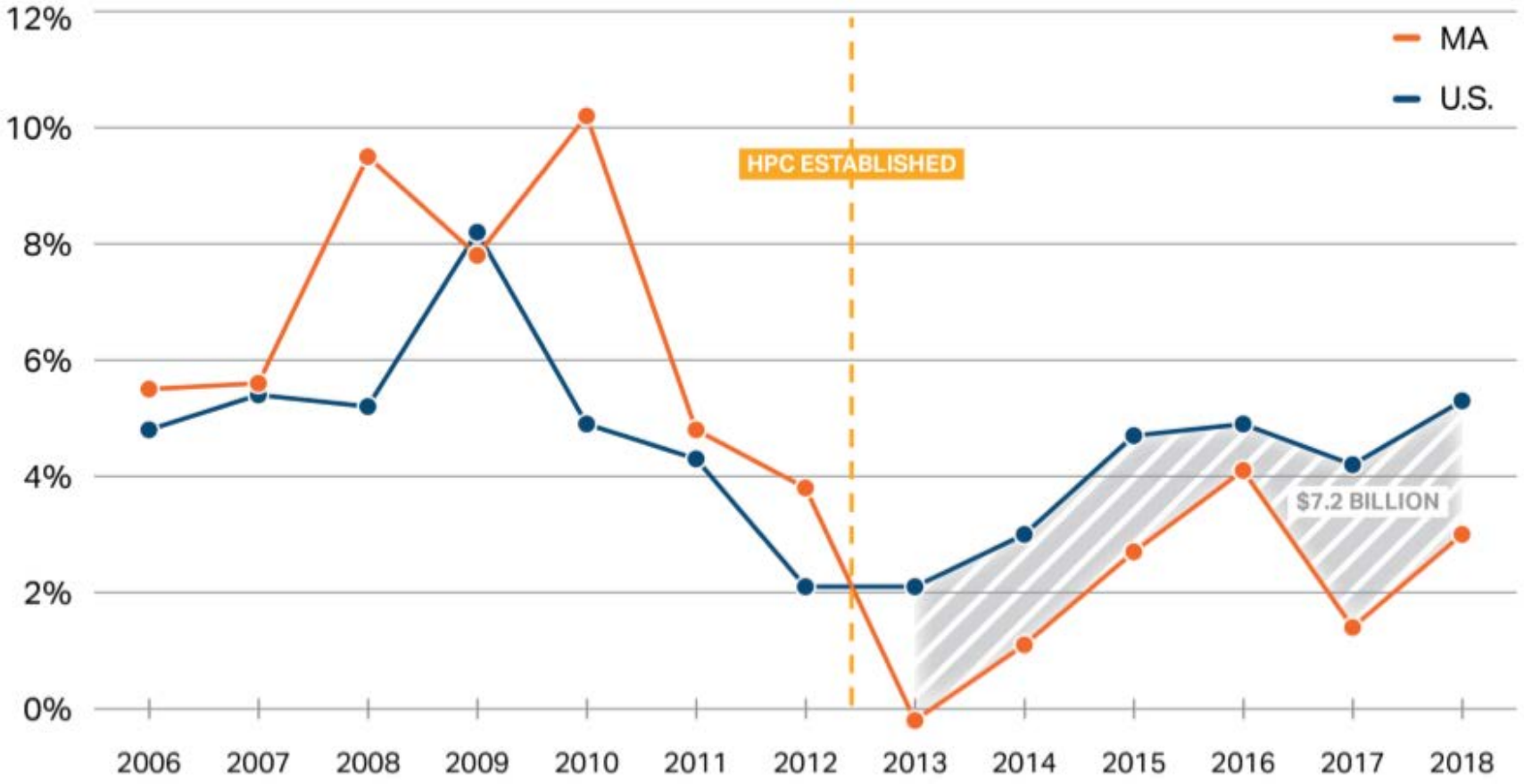
Does the Stakeholder Advisory Board have any feedback on the proposed primary care spend target for 2021 and the proposed methodology for 2022-2024?

Ensuring Success

Cost growth targets in Massachusetts appear to have had a positive impact

- **Massachusetts established a healthcare cost growth target in 2012.**
- Since that time, annual all-payer healthcare spending growth has averaged the cost growth target level of growth, and has been below the U.S. average every year.
- The impact appears to be most pronounced in commercial spending, where spending growth had historically been highest.

Massachusetts' cost growth benchmark experience



From 2012 to 2018, annual healthcare spending growth averaged 3.38%, below the state benchmark.

Commercial spending growth in Massachusetts has been below the national rate every year since 2013.

Notes: U.S. data includes Massachusetts.
Sources: CMS National Healthcare Expenditure Accounts, Personal Health Care Expenditures Data (U.S. 2014-2018) ; CMS State Healthcare Expenditure Accounts (U.S. 2000-2014 and MA 2000-2014); CHIA Annual Report THCE Databooks (MA 2014-2018).

What are the factors that contributed to the success of a cost growth target program in Massachusetts?

- After extensive **negative press** regarding provider market power and high prices driving cost growth, and **legislative attention** on health care costs, providers were ready to be responsive to accountability measures.
- To help control rising healthcare costs, there was **wide adoption of total cost of care contracts** across the state – which easily translate to a cost growth benchmark.
- **Annual hearings and reports** put a "spotlight" on the main drivers of healthcare cost growth provided strong incentives to keep cost increases down.

The Technical Team's perspective

- The Technical Team highlighted the importance of **data transparency** and a **strong communications strategy** when ensuring success of the cost growth benchmark.
- It further recommended:
  - holding annual hearings,
  - obtaining buy-in from stakeholder groups, especially providers, and
  - articulating clearly the benefit and purpose of the benchmark (e.g., conveying that the benchmark is not attempting to cut cost as the expense of quality).

How can we ensure the cost growth benchmark's success in Connecticut?

1. To what extent do the factors that contributed to success in Massachusetts exist in Connecticut?
2. What other conditions exist in Connecticut that could facilitate the cost growth benchmark program's success?

Reflections (1 of 2)

- We appreciate the time provided and thoughtfulness of the Stakeholder Advisory Board over these last six months.
- We hope to take some time today to reflect on this process and the future of the cost growth benchmark, the primary care spend target and the data use strategy.

Reflections (2 of 2)

1. For what are you most appreciative from this process, and for what do you have regret?

2. What do you most hope will happen as a result of your participation on this Board?

Wrap-Up & Next Steps


THANK
YOU