OHS CONNECTICUT Office of Health Strategy

Phone: 860.418.7001 www.portal.ct.gov/ohs

TO: Cost Growth Benchmark Technical Team and Stakeholder Advisory Board
FROM: Connecticut Office of Health Strategy (OHS)
DATE: November 13, 2020
RE: Detecting Unintended Adverse Consequences of the Cost Growth Benchmark

I. Introduction

Over the past few months, the Technical Team, Stakeholder Advisory Board and some consumer advocates have raised concerns that a cost growth benchmark may cause providers to reduce provision of necessary healthcare services so as not to exceed the benchmark. This memo provides a brief overview of the Technical Team and Stakeholder Advisory Board's recommendations, outlines OHS' draft strategy for detecting unintended adverse consequences and describes next steps that OHS will take to finalize and implement a measurement strategy.

II. Summary of Technical Team and Stakeholder Advisory Board's Recommendations

The Technical Team and Stakeholder Advisory Board noted that the cost growth benchmark could possibly result in unintended adverse consequences. This included providers inappropriately reducing access to healthcare services, especially for marginalized populations, and insurers transferring costs to consumers to suppress utilization and spending.

While Massachusetts, the state with the most cost growth benchmark experience, has not documented providers withholding care in response to its benchmark, the Technical Team made a preliminary recommendation to use the Department of Social Services' (DSS) PCMH+ Under-Service Utilization Monitoring Strategy as a starting point for identifying potential under-utilization or inappropriate reductions in access to medically necessary care. This strategy includes tracking preventive care and access measures. DSS has acknowledged the limitations of this strategy, including the constraints associated with claims-based measures. In consultation with DSS, OHS has therefore supplemented the PCMH+ Under-Service Utilization Monitoring Strategy with additional recommendations for measuring unintended adverse consequences based on its research.

III. Draft Strategy for Measuring Unintended Adverse Consequences

There are three main domains of analyses that can measure effects of the cost growth benchmark of concern to the Technical Team and stakeholders, including any unintended consequences that may arise from its implementation: underutilization, impact on marginalized populations, and consumer out-of-pocket spending. This memo summarizes

Mailing Address: 450 Capitol Avenue, MS#51OHS, PO Box 340308, Hartford, CT 06134
Physical Address: 450 Capitol Avenue, Hartford, CT 06106

OHS' draft strategy in two phases: measures that OHS is able to implement immediately given its analytic capabilities, and measures that will require developmental activity once OHS decides upon an analytics contractor to support its data use strategy in the next few months.

1. Measures to Implement Immediately

The State currently has the resources to implement the following measures immediately so that a plan for measurement of unintended adverse consequences is in place when the cost growth benchmark is implemented. All measurement will compare pre- and post-benchmark implementation periods by market so that OHS, its advisory bodies and interested stakeholders can more clearly assess the impact of the benchmark on these indicators. COVID-19 will likely impact performance for several of these measures, so OHS will assess data for 2019 as well as 2020 for the baseline performance period for all measures. The first measurement period will be calendar year 2021.

A. Underutilization

The following measure recommendations are focused on underutilization of healthcare services due to providers or payers impeding access to care, which is a theoretically possible unintended consequence of the cost growth benchmark. The Technical Team was particularly interested in this type of analysis.

i. One of DSS' strategies for identifying possible underutilization for its Person-centered Medical Home Plus (PCMH+) model is use of **preventive** and **chronic care measures**. The Technical Team appreciated this approach because it facilitates alignment with Medicaid's efforts while also providing a mechanism for identifying whether consumers are receiving medically necessary care.

Commercial plan performance for HEDIS measures, which are widely used in measurement, are easily obtained through NCQA Quality Compass. OHS will either a) directly obtain these data from NCQA through Quality Compass or b) have a contractor, such as Bailit Health, pull these data annually for OHS. There are no Medicaid data for Connecticut, however, in Quality Compass. Therefore, OHS will only select measures for Medicaid that DSS is already collecting for its PCMH+ Quality Measure Set.[1] DSS reports Medicaid rates for these measures on an annual basis.

The table below outlines the preventive and chronic care measures that OHS believes are most sensitive to providers restricting care, particularly for vulnerable populations. As mentioned above, OHS will assess changes in performance for these measures pre- and post-benchmark implementation.

[1] Of note, OHS included the updated versions of select measures from DSS' PCMH+ Quality Measure Set (e.g., HPV for Female Adolescents is now Immunization for Adolescents – HPV). It did not include measures that were newly added for HEDIS Measurement Year 2020 because OHS will be unable to assess performance for them pre- and post-implementation of the cost growth benchmark.

Measure Name	Medicaid Measure	Commercial Measure
Asthma Medication Ratio	Yes	Yes
Behavioral Health Screening, Ages 1-17	Yes	
Breast Cancer Screening	Yes	Yes
Cervical Cancer Screening	Yes	Yes
Child and Adolescent Well-Care Visits[2]	Yes	Yes
Chlamydia Screening in Women	Yes	Yes
Colorectal Cancer Screening		Yes
Comprehensive Diabetes Care: Eye Exam	Yes	Yes
Comprehensive Diabetes Care: HbA1c Testing	Yes	Yes
Controlling High Blood Pressure		Yes
Developmental Screening in the First Three Years of Life	Yes	
Oral Evaluation; Dental Services	Yes	
Prenatal and Postpartum Care	Yes	Yes

ii. Another DSS' strategy is to utilize **member experience surveys** to assess member perception of access to care, as well as patient satisfaction with healthcare services and providers. While these are not direct measurements of underutilization, they may help identify patent perception of underutilization that is only captured through a survey. There are two primary sources of data for these assessments: a) the Health Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and b) the Clinician and Group (CG) CAHPS survey. Commercial statewide data for the Health Plan CAHPS measures are available through NCQA Quality Compass. Similar to III.1.A.i, OHS will directly obtain these data from NCQA if it has a Quality Compass license or will have a contractor do so annually. DSS reports Medicaid rates for the CG-CAHPS survey items on an annual basis.

a. **Measure #2a**: change in performance for the "Getting Care Quickly" composite, which is the percentage of members who responded "Always" or "Usually" to the questions "In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?" and "In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?" pre- and post-benchmark implementation

- Level of measurement: statewide rate for commercial plans
- Data source: Health Plan CAHPS
- Party accountable for collecting/analyzing data: OHS or its contractor

[2] This measure is new for HEDIS measurement year 2021. It combines Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life with Adolescent Well-Care Visits and adds ages 7-11 to the measure.

- Timeframe: calendar year

b. **Measure #2b**: change in performance on the "Getting Needed Care" composite, which is the percentage of members who responded "Always" or "Usually" to the questions "In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?" and "In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?" pre- and post-benchmark implementation
   - Level of measurement: statewide rate for commercial plans
   - Data source: Health Plan CAHPS
   - Party accountable for collecting/analyzing data: OHS or its contractor
   - Timeframe: calendar year

c. **Measure #2c**: change in the percentage of patients who responded "Always" or "Usually" to the question "When you contacted this provider's office to get an appointment for are you needed right away, how often did you get an appointment as soon as you needed?" pre- and post-benchmark implementation
   - Level of measurement: Medicaid
   - Data source: CG-CAHPS
   - Party accountable for collecting/analyzing data: DSS
   - Timeframe: calendar year

d. **Measure #2d**: change in the percentage of patients who responded "Always" or "Usually" to the question "When you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?" pre- and post-benchmark implementation
   - Level of measurement: Medicaid
   - Data source: CG-CAHPS
   - Party accountable for collecting/analyzing data: DSS
   - Timeframe: calendar year

e. **Measure #2e**: change in the percentage of patients who responded "Always" or "Usually" to the question "How often were you able to get the care you needed from this provider's office during evenings, weekends, or holidays?" pre- and post-benchmark implementation
   - Level of measurement: Medicaid
   - Data source: CG-CAHPS Supplemental Item Set
   - Party accountable for collecting/analyzing data: DSS
   - Timeframe: calendar year

f. **Measure #2f**: change in the percentage of patients who responded "Yes" to the question "Did this provider's office give you information about what to do if you needed care during evenings, weekends, or holidays?" pre- and post-benchmark implementation
   - Level of measurement: Medicaid

- Data source: CG-CAHPS Supplemental Item Set
- Party accountable for collecting/analyzing data: DSS
- Timeframe: calendar year

iii. Another option to assess experience of care among Medicaid members is through **tracking member grievances**, a third DSS strategy. If members are experiencing challenges obtaining timely appointments or feel disrespected by their providers through the PCMH+ program, they can submit a grievance to the State's Administrative Services Organization.[3] While these are not direct assessments of underutilization, they can help identify member perception of underutilization. Of note, this measure is applicable only for Medicaid members, as there is not a directly analogous process in place for commercial members.

a. **Measure #3a**: change in the number of members filing complaints about no or limited access to a specific provider type per 1,000 member months pre- and post-benchmark implementation
- Level of measurement: provider organization
- Data source: grievance data from the Administrative Services Organization collected at the end of the measurement period
- Party accountable for collecting/analyzing data: DSS
- Timeframe: quarterly, calendar year

b. **Measure #3b**: change in the number of members filing complaints about delayed access and/or wait time for an appointment (e.g., delay in obtaining appointment, wait time why in office) per 1,000 member months pre- and post-benchmark implementation
- Level of measurement: provider organization
- Data source: grievance data from the Administrative Services Organization collected at the end of the measurement period
- Party accountable for collecting/analyzing data: DSS
- Timeframe: quarterly, calendar year

B. Consumer Out-of-Pocket Spending

The cost growth benchmark will not be wholly successful if consumer out-of-pocket spending, including consumer spending due to deductible and co-insurance obligations, grows faster than the benchmark. This has been a problem in Massachusetts, where consumers costs have grown faster than the cost growth benchmark. While this pattern is driven by employer benefit design decisions, at least in theory, if cost growth is restrained employers will have less reason to shift growing costs to their employees and dependents in the form of increased cost-sharing.

[3] An example of what type of data are available can be found here: https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/PCMH-Plus/2019-August-Member-Complaints.pdf.

OHS will track changes in consumer out-of-pocket spending, as well as premiums, relative to the benchmark. To begin, it will utilize data from the Current Population Survey (CPS), which collects data annually on the total amount paid in out-of-pocket expenditures and premiums by family on an annual basis.[4] It will also look at plan-level out-of-pocket spending using APCD data.

i. **Measure #B1**: change in the average annual growth in out-of-pocket spending in Connecticut compared to other states pre- and post-benchmark implementation
   - Level of measurement: statewide
   - Data source: CPS
   - Party accountable for collecting/analyzing data: CT OHS
   - Timeframe: calendar year

ii. **Measure #B2**: change in the average annual growth in premiums in Connecticut compared to other states pre- and post-benchmark implementation
   - Level of measurement: statewide
   - Data source: CPS
   - Party accountable for collecting/analyzing data: CT OHS
   - Timeframe: calendar year

iii. **Measure #B3**: change in the average annual growth in out-of-pocket spending by plan pre- and post-benchmark implementation
   - Level of measurement: plan
   - Data source: APCD (i.e., the sum of copays, deductibles and coinsurance divided by the allowed amount)
   - Party accountable for collecting/analyzing data: CT OHS and/or its analytic contractor
   - Timeframe: calendar year

2. Measures Requiring Additional Development

As mentioned previously, OHS is limited in its ability to measure unintended adverse consequences of the cost growth benchmark because of its current analytic capabilities and resources. The following measures require additional development and will be implemented after OHS designates an analytics contractor to support its data use strategy. Measures are organized in three categories: underutilization (continued), consumer out-of-pocket spending (continued) and impact on marginalized populations.

[4] For more information, see: https://www.census.gov/programs-surveys/cps/data.html. The 2020 survey questions and data can be found here: https://www.census.gov/data/datasets/time-series/demo/cps/cps-asec.html.

A. Underutilization (Continued)

The following additional underutilization measures rely on more sophisticated analyses using plan-reported data.

i. **Anti-stinting measures** can help inform whether providers are limiting access to care to reduce cost growth. These measurements are quantitative assessments that compliment member experience perspectives outlined in section III.1.a.ii. These analyses will require provider organizations to report data directly to OHS for an analytics contractor to compare risk scores before and after implementation of the cost growth benchmark. Given that OHS does not currently have an analytics contractor, it is delaying use of these measures.

Measures focused on proactively selecting healthier/more adherent patients, i.e., "cherry picking"

a. **Measure #5a**: change in the ratio of average risk score of patients attributed during the measurement year and the existing patient population attributed to the provider organization for the measurement year prior to the implementation of the cost growth benchmark[5]
   - Level of measurement: provider organization
   - Data source: APCD data analyzed using risk adjustment software or plan-reported data using a specified Excel template
   - Party accountable for collecting/analyzing data: OHS and/or its analytic contractor
   - Timeframe: calendar year

Measures focused on dropping patients that are less healthy/more complicated, i.e., "lemon dropping"

b. **Measure #5b**: change in the ratio of the average risk score of the provider organization's patients who attributed to a different provider organization within the same geographic region during the measurement year and the provider organization's patients who remained with the organization during the measurement year pre- and post-benchmark implementation [6]

[5] If the risk scores of a provider organization's new patients are significantly better than the risk scores of the population prior to the implementation of the cost growth benchmark, it may indicate cherry-picking. This measure requires use of a risk-adjustment program that produces a risk score, which may not be available at all provider organizations. In addition, the measure may not always be indicative of cherry-picking, as there are several reasons as to why a provider organization might have or attract healthier patients (e.g., community, provider-type, referrals, relationship to hospital or academic medical center).

[6] If the risk score of a provider organization's patients that enroll if a different provider organization in the same geographic region are significantly higher than those who remain with the organization, it may indicate lemon-dropping. This measure requires use of a risk-adjustment program that produces

- Level of measurement: provider organization
- Data source: APCD data analyzed using risk adjustment software or plan-reported data using a specified Excel template
- Party accountable for collecting/analyzing data: OHS and/or its analytic contractor
- Timeframe: calendar year

B. Consumer Out-of-pocket Spending (Continued)

OHS will evaluate the impact of the cost growth benchmark on out-of-pocket spending at the statewide or plan level immediately using data from the CPS and APCD, respectively. To assess premiums at the plan level, however, OHS needs to request these data directly from plans.

iv. **Measure #B4**: change in the average annual growth in premiums pre- and post-benchmark implementation

- Level of measurement: plan
- Data source: plan-reported data using a specified Excel template
- Party accountable for collecting/analyzing data: OHS and/or its analytic contractor
- Timeframe: calendar year

C. Impact on Marginalized Populations

The Technical Team and Stakeholder Advisory Board expressed interest in assessing the effects of the cost growth benchmark on marginalized populations. Based on stakeholder input, this can include stratifying utilization and spending data based on income, insurance status, race/ethnicity, social risk factors and zip code. OHS will combine several of these variables to focus on specific vulnerable populations, such as combining geography, income and race/ethnicity to assess communities of color in the lowest-income zip codes.

The table that follows summarizes the variables OHS will include in its analysis, the data source for the variables, and notes on what types of analyses OHS will perform.

---

a risk score, which may not be available at all provider organization. In addition, the measure may not always be indicative of lemon-dropping, as there are several reasons as to why a patient may leave the organization (e.g., the new practice may have expertise in their chronic condition, patient may be dissatisfied with the organization's care for reasons unrelated to their risk score).

Variable	Data Source	Notes
Geography	APCD	Focus on zip codes that are most vulnerable, which OHS defines as those with the greatest poverty rates. Based on initial data from the Census, this will include zips codes for the following cities and towns that have more than 20 percent of persons in poverty: Bridgeport, Hartford, New Britain, New Haven, New London, Storrs, Thompsonville, Waterbury, Willimantic and Winsted.[7]
Income	ACS	Focus on communities that are in poverty (see above).
Insurance status	APCD	Focus on Medicaid.[8]
Race/ethnicity	ACS	Focus on communities of color.
Social risk factors	ACS	Focus on communities with food (i.e. food stamp or SNAP recipient)[9], housing (i.e., housing units without running water, a stove and or a refrigerator)[10] and transportation (i.e. no cars)[11] needs as these are the health-related social needs that are most commonly identified by Medicaid and Medicare members.[12]

One primary challenge with stratifying these analyses is that it is not feasible to link data from various sources. For example, preventive and chronic care measures obtained through NCQA Quality Compass as outlined in section III.1.A.i are unable to be linked with any of the variables mentioned in the above table. APCD data can only be linked to the ACS using zip code data. Plan-reported data are not easily linked with APCD and ACS data.

Given the challenges associated with obtaining these data and the analytic capabilities required to perform these analyses, OHS will to implement the following measures after

[7] For more information, see: https://www.census.gov/quickfacts/fact/map/CT/IPE120219.
[8] Stakeholder groups also expressed interest in capturing the uninsured population. However, there is no straightforward way to capture spending for this population for the types of analyses Connecticut wishes to perform at this time.
[9] For more information, see: https://www.census.gov/acs/www/about/why-we-ask-each-question/food-stamps/.
[10] Limited access to these facilities can serve as a proxy for low housing quality. For more information, see: https://www.census.gov/acs/www/about/why-we-ask-each-question/plumbing/.
[11] Not having a car can serve as a proxy for having limited access to adequate transportation. We understand that these numbers may be inflated, however, because some individuals in a city may not need a car. For more information see: https://www.census.gov/acs/www/about/why-we-ask-each-question/vehicles/.
[12] For more information, see: https://innovation.cms.gov/media/document/ahc-fact-sheet-2020-prelim-findings.

1) it hires an analytic contractor to support its data use strategy and 2) demonstrates that it is able to accurately implement measures outlined in section III.1 in the short-term.

i. **Measure #C1**: for communities of color in the lowest income zip codes, an assessment of the change in utilization for the following select services: behavioral health, inpatient hospital, outpatient hospital, prescription drugs and preventive care pre- and post-benchmark implementation
   - Level of measurement: zip codes for select cities
   - Data source: APCD utilization data linked to ACS race/ethnicity data
   - Party accountable for collecting/analyzing data: OHS and/or its analytic contractor
   - Timeframe: calendar year

ii. **Measure #C2**: measure C1, stratified by insurance market
   - Level of measurement: zip codes for select cities
   - Data source: APCD utilization and insurance market data linked to ACS race/ethnicity data
   - Party accountable for collecting/analyzing data: OHS and/or its analytic contractor
   - Timeframe: calendar year

iii. **Measure #C3**: measure C1, stratified by social risk factors
   - Level of measurement: zip codes for select cities
   - Data source: APCD utilization and insurance market data linked to ACS race/ethnicity and social risk factor data
   - Party accountable for collecting/analyzing data: OHS and/or its analytic contractor
   - Timeframe: calendar year

IV. Next Steps

Once OHS finalizes a proposed measurement strategy with input from the Technical Team and the Stakeholder Advisory Board, it will develop a timeline and work plan that outlines how OHS will obtain data, perform each analysis and report its findings. OHS acknowledges that this strategy may reveal unexpected trends that require further exploration, such as significant changes in utilization patterns. Therefore, OHS will also develop a process for conducting ad hoc analyses to better understand such unexpected trends as part of Connecticut's data use strategy.

OHS hopes you find this memo to be helpful and look forward to discussing these topics with you during the November 17th meeting of the Technical Team and Stakeholder Advisory Board.