Cost Growth Benchmark Technical Team
Meeting #8
August 13, 2020

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Agenda

Time	Topic
1:00 p.m.	I. Call to Order
1:05 p.m.	II. Review and Approval of Prior Meeting Minutes
1:10 p.m.	III. Public Comment
1:20 p.m.	IV. Primary Care Spending Target Methodology
2:00 p.m.	V. Data Use Strategy
2:55 p.m.	VI. Wrap-Up and Next Steps
3:00 p.m.	Adjourn

Approval of July 29, 2020 Meeting Minutes

Public Comment

Primary Care Spending Target Methodology

Continued Discussion of Topics from the July 29, 2020 Meeting

Definition of primary care providers and services (1 of 5)

- During the July 29, 2020 meeting, the Technical Team recommended adopting two definitions of primary care providers and services:

  1. a narrower definition for measurement against the primary care spend target and
  2. a broader definition for measurement of primary care spending more comprehensively.

Definition of primary care providers and services (2 of 5)

	Proposed Definition 1: Narrow	**Proposed Definition 2: Broad**
Included Providers (in outpatient settings*)	• **MDs**: Internal Medicine when practicing primary care, Family Medicine, Pediatric and Adolescent Medicine, Geriatric Medicine when practicing primary care • **NPs and PAs**: when practicing primary care	• **MDs**: Internal Medicine when practicing primary care, Family Medicine, Pediatric and Adolescent Medicine, Geriatric Medicine when practicing primary care, OB/GYN and midwifery • **NPs and PAs**: when practicing primary care
Excluded Providers (among others)	• OB/GYN and midwifery • Behavioral health • Emergency room physicians • Naturopathic health care providers	• Behavioral health • Emergency room physician • Naturopathic health care providers

*Including but not limited to private practices, primary care clinics, FQHCs and school-based health centers

**The Technical Team expressed interest in inclusion of integrated behavioral health providers and services in the future.

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Definition of primary care providers and services (3 of 5)

	Proposed Definition 1: Narrow	Proposed Definition 2: Broad
Included Services	• Office or home visits • General medical exams • Routine adult medical and child health exams • Preventive medicine evaluation or counseling • Telehealth visits • Administration and interpretation of health risk assessments • Behavioral health risk assessments, screening and counseling, *if performed by a PCP* • Immunizations • Hospice care	• Office or home visits • General medical exams • Routine adult medical and child health exams • Preventive medicine evaluation or counseling • Telehealth visits • Admin. and interpretation of health risk assessments • Behavioral health risk assessments, screening and counseling, *if performed by a PCP* • Immunizations • Hospice care • <u>Routine primary care and non-specialty gyn. services delivered by OB/GYNs and midwifery</u>
Excluded Services	• <u>Routine primary care and non-specialty gyn. services delivered by OB/GYNs and midwifery</u> • Minor outpatient procedures • Inpatient care • ED care • Nursing facility care • Practice-administered pharmacy	• Minor outpatient procedures • Inpatient care • ED care • Nursing facility care • Practice-administered pharmacy

Definition of primary care providers and services (4 of 5)

- Following the meeting, a member asked the following question:

1. **Is children's preventive dental care included in the list of primary care services?** Preventive dental services, including fluoride varnish for children younger than four, is a pediatric primary care service and is reimbursed by Medicaid and commercial insurers.

   - This service is not explicitly included in the definition. It can, however, be captured if providers are coding preventive dental care using CPT code 99429 (unlisted preventive medicine service). In addition, CPT code 99188 (application of topical fluoride varnish by a physician or other qualified health care professional) can be used to capture for fluoride varnish.

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Definition of primary care providers and services (5 of 5)

- Following the meeting, one member asked the following question:

  2. **Are home visits for newborns, as supported in the Primary Care Modernization project, included in the list of primary care services?**

     - CPT code 99502 (home visit for newborn care and assessment) can be used to capture home visit for newborns.

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Connecticut's definition of primary care providers and services

- **Does the Technical Team support the narrow and broad definitions?**

- **Does the Technical Team wish to include preventive dental care and/or home visits for newborns on the list of primary care services?**

Summary of additional recommendations

- The Technical Team also made the following recommendations during the July 29, 2020 meeting:

  1. Primary care payments:
     - Use **allowed claims** to calculate service-based payments.
     - Adopt **NESCSO's definition for non-service-based payments**, which includes:
       - care management, PCMH infrastructure, pay-for-performance, shared savings distributions, capitation, episode-based payment, EHR/HIT infrastructure, COVID-19 support payments (if feasible) and other (e.g., supplemental workforce payments, loan forgiveness for training providers, flu clinics).

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Summary of additional recommendations

2. Total payments:
   ▫ Adopt the definition of **total spending from the cost growth benchmark**, but **exclude long-term care**.

3. Population:
   ▫ Adopt the population measured for the cost growth benchmark and NESCSO, which includes **in-state residents and all providers (in-state and out-of-state)**.

Summary of additional recommendations

4. Payers:
   - Include commercial and Medicaid payers.
   - Include Medicare.
     - OHS may need to release two primary care spend calculations – an initial one excluding Medicare, and a later one using APCD data including Medicare.
   - Include Veterans Health Administration, **if feasible**.
   - Collect data only for insurers and TPAs that meet a minimum size (TBD).

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Setting the Target

How should OHS set the target?

- There are several key questions to consider when setting the primary care spending target, including:

    1. What is baseline spending, and how does it differ by market?
    2. When calculating the state spending %, should the calculation weight market-specific spending by total market *spending*, or by total market *population*?
    3. At what levels should performance be reported beyond state-level (e.g., insurance market, insurer)?

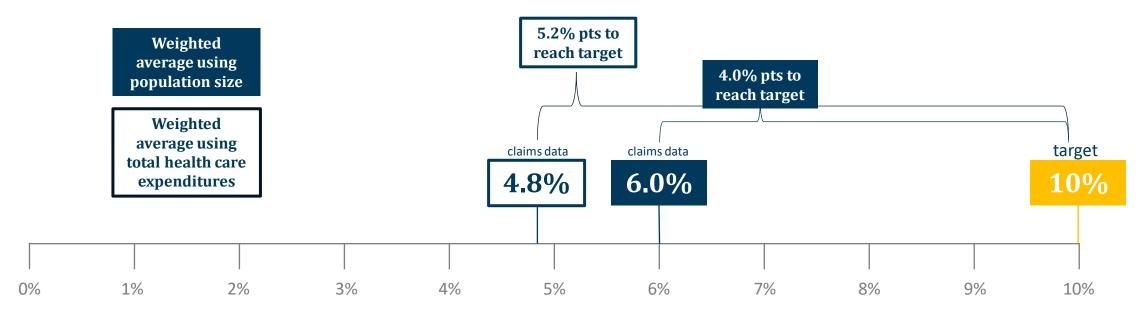# 1. What is baseline spending, and what is baseline spending by market?

- In order to determine how much to increase primary care spending to reach 10 percent, the Technical Team will first need to understand how much it is currently spending.

- The Technical Team will need to identify whether it wishes to utilize historical primary care spending data from the PCPCC, Freedman Healthcare, UConn and/or NESCSO to measure baseline spending.

  - It should choose a source for assessing baseline spending that most aligns with its definition of primary care.
  - We'll revisit the source, and the recommended increments to get to 10%, after the NESCSO analysis is complete.

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2. Should the calculation weight market-specific spending by total market spending or population? (1 of 3)

- The EO calls for statewide spending on primary care to reach 10% of total spending by 2025. Given that primary care spending varies widely based on market, and Connecticut has no influence over traditional Medicare, it may not be feasible for all markets to individually reach the 10% target.

- The design of how Connecticut takes into consideration the size of each market, i.e., by total market spending or population, influences the statewide rate.

2. Should the calculation weight market-specific spending by total market spending or population? (2 of 3)

- As a reminder, spending varies dramatically based on if we calculate a weighted average of total primary care spending in Connecticut by (a) population size and (b) total health care expenditure.

2. Should the calculation weight market-specific spending by total market spending or population? (3 of 3)

- Given this information, **should the calculation of state-level primary care spending be weighted by total market spending or market population?**

3. At what level(s) should performance be reported?

- Once Connecticut collects data for the primary care spending target, it will need to report progress. Possible levels of reporting include:

  - State-level
  - By insurance market (e.g., Medicaid, Medicare, commercial)
  - By insurer
  - By provider organization / health system

At what levels do other states report performance?

Level of Reporting	CT Cost Growth Benchmark	Rhode Island	Oregon
State	Yes	No*	Yes
Insurance Market	Yes	No*	Yes
Insurer	Yes	No*	Yes
Provider Organization / Health System	Yes	No	No

*Rhode Island only presents statewide insurer market and individual insurer results at stakeholder advisory group meetings. It does not otherwise publicly report data.

Example of market-level reporting

Total primary care spending in 2018
Commercial plans, CCOs, Medicare Advantage plans, and PEBB and OEBB plans spent $1.5 billion on primary care out of $11.6 billion of total spending.

Commercial
Primary care spending
$531 million
Total spending
$4.1 billion
Percent primary care
13.0 percent

CCOs
Primary care spending
$519 million
Total spending
$3.4 billion
Percent primary care
15.2 percent

Medicare Advantage
Primary care spending
$300 million
Total spending
$2.9 billion
Percent primary care
10.3 percent

PEBB and OEBB
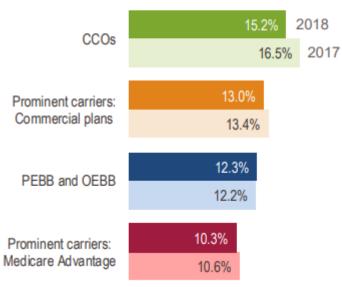Primary care spending
$144 million
Total spending
$1.2 billion
Percent primary care
12.3 percent

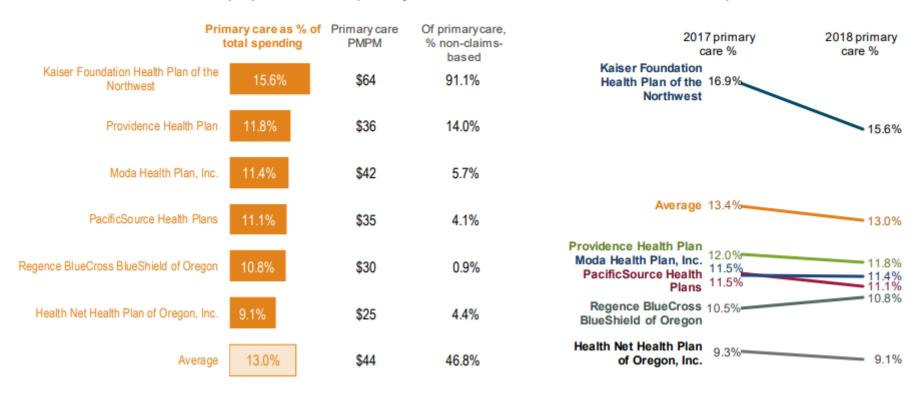**Percentage of total primary care medical spending**
In 2018, CCOs allocated an average of 15.2 percent of total medical spending to primary care. Commercial, Medicare Advantage, and PEBB and OEBB plans allocated an average of 13.0 percent or less of total medical spending to primary care.

	2018	2017
CCOs	15.2%	16.5%
Prominent carriers: Commercial plans	13.0%	13.4%
PEBB and OEBB	12.3%	12.2%
Prominent carriers: Medicare Advantage	10.3%	10.6%

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Example of insurer-level reporting

Primary care spending as a percent of total spending
In 2018, the average spending on primary care for commercial plans was 13 percent. Carriers' spending ranged from $25 to $64 PMPM. For most carriers, the proportion of total primary care that is non-claims-based is less than 6 percent.

	Primary care as % of total spending	Primary care PMPM	Of primary care, % non-claims-based
Kaiser Foundation Health Plan of the Northwest	15.6%	$64	91.1%
Providence Health Plan	11.8%	$36	14.0%
Moda Health Plan, Inc.	11.4%	$42	5.7%
PacificSource Health Plans	11.1%	$35	4.1%
Regence BlueCross BlueShield of Oregon	10.8%	$30	0.9%
Health Net Health Plan of Oregon, Inc.	9.1%	$25	4.4%
Average	13.0%	$44	46.8%

	2017 primary care %	2018 primary care %
Kaiser Foundation Health Plan of the Northwest	16.9%	15.6%
Average	13.4%	13.0%
Providence Health Plan	12.0%	11.8%
Moda Health Plan, Inc.	11.5%	11.4%
PacificSource Health Plans	11.5%	11.1%
Regence BlueCross BlueShield of Oregon	10.5%	10.8%
Health Net Health Plan of Oregon, Inc.	9.3%	9.1%

Source: https://www.oregon.gov/oha/HPA/ANALYTICS/PCSpendingDocs/2020-Oregon-Primary-Care-Spending-Report-Legislature.pdf

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Connecticut's reporting of performance

- Based on what you just learned, at which levels should Connecticut report performance (e.g., state, insurance market, insurer, provider organization/health system)?

Raise Hand

Complementary Analyses to Understand Primary Care Spending

Which complementary analyses should Connecticut perform?

- In order to better understand trends around primary care spending, OHS will need to identify which complementary analyses it should perform. These analyses will be limited by what data are available.

- Examples of feasible analyses to perform include stratifying spending by:
  - Age
  - Comorbidity (e.g., asthma, diabetes)
  - Geography (e.g., zip code)
  - Insurance category (e.g., commercial, Medicaid, Medicare)

- *OHS at this time is unable to stratify data by disability status (not captured in the APCD) or race and ethnicity (not consistently populated in the APCD), although race could be imputed using public data sources.*

Connecticut's performance of complementary analyses

- Based on what you just learned, what complementary analyses, if any, does the Technical Team recommend?

Raise Hand

Finalizing Data Collection and Analysis

How should data for the target be collected? (1 of 2)

- In order to streamline data collection, the Technical Team should consider embedding collection of primary care spend data with that of other spending data for the cost growth benchmark.

- Because both assessments rely on direct payer submission, payers then could report data for the primary care spend target *and* the cost growth benchmark by submitting one Excel file using one set of standards.

- The Delaware Health Care Commission, for example, has separate columns in its cost growth benchmark submission template where insurers report primary care and non-primary care spending, as demonstrated in the following slide.

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How should data for the target be collected? (2 of 2)

	A	B	C	G	H	M	N	O	P	R	S
	Delaware Health Care Commission										
	Total Medical Expenses Calculation Template										
	Black = Payer-reported data										
	Blue = HCC-calculated data										
			A1	A5	A6	A11	A12	A13	A14	A16	A17
	Large Provider Org Name	Insurance Category Code	Member Months	Claims: Professional, Primary Care	Claims: Professional, Specialty	Non-Claims: Primary Care Incentive Programs	Non-Claims: Incentive Programs, for Services Other Than Primary Care	Non-Claims: Primary Care Capitation	Non-Claims: Capitation, for Services Other Than Primary Care	Non-Claims: Primary Care, Care Management	Non-Claims: Care Management, Other Than for Primary Care

Note: Select columns from the original submission template have been hidden for illustrative purposes.

- **Does the Technical Team agree with combining data collection for the primary care spend target and the cost growth benchmark?**

Source: https://dhss.delaware.gov/dhcc/global.html

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Parameters for How Spend is Increased

Should OHS define parameters for how primary care spending should be increased to meet the target? (1 of 3)

- As with any policy, there is a possibility for unintended consequences that stem from the primary care spending target.

- For example, Rhode Island wanted its target to encourage innovative contracting and payment as well as primary care system investment. It did not want insurers to simply change rates of reimbursement for specific codes in order to meet its target.

- Therefore, it specified insurers could not increase premiums or engage solely in fee service manipulation to meet the primary care spend target.

Should OHS define parameters for how primary care spending should be increased to meet the target? (2 of 3)

- Karen Gee of the Stakeholder Advisory Board expressed interest in Rhode Island's approach and wanted to encourage insurers to utilize value-based incentives in order to increase primary care spending. In addition:
  - Janice Henry noted that Anthem enhances primary care provide rates with payments from its value-based program (based on achievement of quality measures).
  - Rob Kosior stated that in his work, high-performing medical groups that manage spending well typically experience high primary care utilization and lower specialty spending.

Should OHS define parameters for how primary care spending should be increased to meet the target? (3 of 3)

- Given this information, **does the Technical Team have any recommendations on guidance for payers on what they should and/or should not do to meet the primary care spend target?**

- Relatedly, **does the Technical Team envision any actions payers or other stakeholders could take that are contrary to patient or purchaser interest in order to meet the target?**
  - If so, are there any steps Connecticut can take to anticipate and prevent them from occurring?

Introduction to the Data Use Strategy

What is a "data use strategy" anyway?

- We use the term "**data use strategy**" to refer to a plan to purposefully leverage state data in order to achieve state health policy objectives.

- In this instance, we are discussing how to leverage the state's All-Payer Claims Database (APCD), and perhaps other data sources, to make sure the aims of the Governor's Executive Order #5 are achieved.

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Proposed rationale for Connecticut's data use strategy (1 of 2)

- Making progress in reducing cost growth to meet the cost growth benchmark requires information on where **costs are high**, where **costs are growing rapidly** and where **costs are variable**.

- By analyzing data, OHS can shine light on these three areas and identify what spending categories warrant greatest attention for **moving the needle on the cost growth benchmark**.

Proposed rationale for Connecticut's data use strategy (2 of 2)

While identification of cost growth reduction opportunities should be a priority of the data use strategy, it should not be the only focus.

- Additional analyses should examine **cost growth benchmark impact**. The Technical Team and Stakeholder Advisory Board have already identified the following:
  - identification of any **unintended adverse consequences** of the cost growth benchmark, and
  - assessment of the benchmark's impact on consumer **out-of-pocket spending**.

- Finally, the data use strategy should look at **health disparities** (utilization, cost and quality) and at **quality** more generally.

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Relationship to Past Connecticut Work

- During 2018 the Healthcare Cabinet convened a Cost Containment Data Workgroup. It presented recommendations in March 2019.
  - Pat and Vicki participated on that workgroup.

- The priority recommendations that emerged from that group are integrated within the options set forth in this presentation. They are flagged using the following notation: **(*HCC)**

- The Healthcare Cabinet expressed a desire for this information in response to its Cost Containment Data Workgroup's presentation.

What do other states' data use strategies look like?

- Some of the other states with cost growth benchmarks have developed data use strategies to inform how to achieve their state-specific benchmarks.

- The following slides provides some additional information on the data use strategies for:
  - Massachusetts
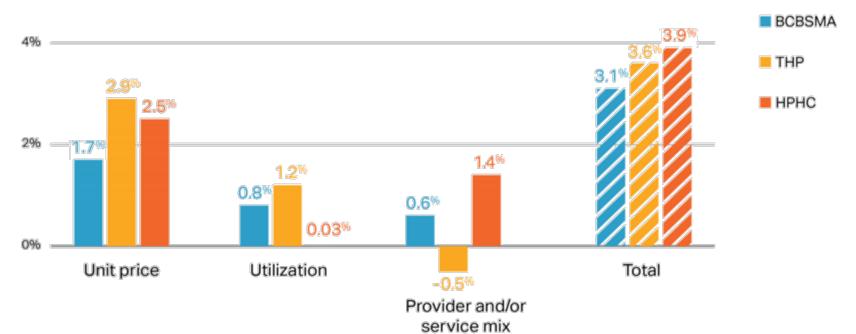 - Rhode Island
  - Oregon

State Examples: Massachusetts

- Massachusetts has been analyzing APCD cost-related data for many years from a number of sources (e.g., APCD, payer-reported total medical expenditures, hospital discharge databases, national health expenditure accounts).

- One of three agencies tasked with monitoring the cost growth benchmark now publishes analyses relative to the benchmark. The agency produces recommendations based on these analyses and convenes a hearing on these analyses annually.

State Examples: Massachusetts

Commercial

Unit price increases continued to drive most of the spending growth among Massachusetts' largest insurers over the past three years.

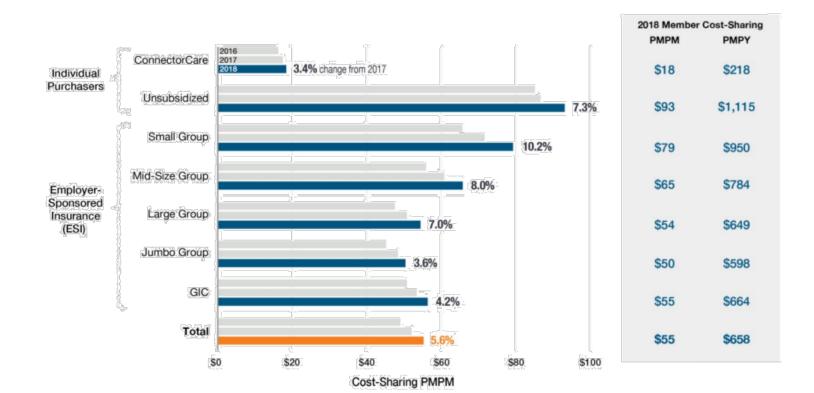Average annual growth in spending by component for top three Massachusetts payers, 2016-2018

Legend:
- BCBSMA
- THP
- HPHC

Unit price: BCBSMA 1.7%, THP 2.9%, HPHC 2.5%
Utilization: BCBSMA 0.8%, THP 1.2%, HPHC 0.03%
Provider and/or service mix: BCBSMA 0.6%, THP -0.5%, HPHC 1.4%
Total: BCBSMA 3.1%, THP 3.6%, HPHC 3.9%

Source: MA HPC Cost Trends Hearing. 2019. https://www.mass.gov/doc/presentation-2019-cost-trends-hearing-day-one/download.

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State Examples: Massachusetts

Commercial Insurance
Cost-Sharing by Market Sector, 2016-2018

Member cost-sharing was higher among unsubsidized individuals and members covered by smaller employers.

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State Examples: Massachusetts

23% of Massachusetts middle-class families spend more than a quarter of all earnings on health care.

Characteristics of middle-class families with employer-sponsored health insurance that spend more than a quarter of earnings on health care (high burden families), 2016-2018 average

A HIGH BURDEN FAMILY IS:

more likely to be non-white — 29.4%

more likely to have a disability or activity limitation — 14.7%

more likely to lack a college degree — 62.9%

more likely to be a single parent — 50.1%

more likely to have worse health — 31.8%

High burden: share of health care spending is greater than 25% of total compensation

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State Examples: Rhode Island

- Rhode Island's data use strategy is currently being implemented to complement its cost growth target.

- To develop its data use strategy, RI hosted a one-day conference to learn about multi-payer claims database analyses in MA, NH, OR, VT and WA, held two provider focus groups to learn about analyses that would be of value to provider organizations, and solicited public input.

- Brown University met with a work group on report design in 2019 & 2020 and will present its first reports in September. These will be precursors of future State-published standard reports.

State Examples: Oregon

- SB 889 established the Oregon Sustainable Cost Growth Target Implementation Committee, which charges the group with taking action to develop a cost growth target.

- SB 889 requires accountability for cost across *all* providers, and not just held to its cost growth benchmark.

- The State's stakeholder advisory body is still developing the data use strategy. It is scheduled to complete that task this fall.

Connecticut's Data Use Strategy

For whom should analyses be produced?

- In Oregon and Rhode Island, the priority audiences for reports produced through the data use strategy included:
  - Provider organizations
  - Policymakers
  - The public

- Priority was *not* given to the following audiences:
  - Payers: because they already have substantial data on costs
  - Consumers: because repeated research shows that they don't use cost information, even when made available

Proposed data use strategy audience

- Does the Technical Team recommend a focus on provider organizations, policymakers, and the public as the primary audience for analyses produced through the data use strategy, or would it prefer a different approach?

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From where will the data come?

- Data will primarily come from the State's APCD given its breadth of and accessibility to information. Despite the APCD's several gaps, it is a valuable resource to understand healthcare system performance.

- Should OHS wish to leverage other data sources, it can consider the following:
  - voluntary submission of data from different stakeholders (e.g., payers)
  - aggregate spending data collected by the State for the benchmark
  - hospital discharge data – currently collected by OHS
  - national health expenditure data from CMS
  - national survey data (e.g., Medical Expenditure Panel Survey)
  - census data (e.g., American Community Survey)

Who will perform this work?

- Mathematica is performing initial calculations on areas of high costs and cost growth. Some of the Technical Team's recommendations on the data use strategy will be completed by Mathematica.
  - ▫ Mathematica's analyses will begin with those that rely on commercial medical claims, as these are the most actionable analyses at the state level. It will then expand its analyses to include other payers and claim types.
  - ▫ This phased approach provides room for stakeholders to provide additional input on data sources and methods.

- OHS will conduct ongoing and additional analyses that are in the data use strategy but not part of Mathematica's scope of work.

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Proposed data use strategy goals

1. Produce **routine analyses that pinpoint leading opportunities to reduce health care spending and health care spending growth** in a manner that will not harm patients.

2. Produce **ad-hoc, one-time analyses in areas of perceived opportunity and that are of specific interest to stakeholders** committed to reducing spending while improving and/or maintaining access and quality.

3. Interpret health care spending analyses and **link findings with recommended actions for the intended audiences** (e.g., providers and provider organizations, employers, payers and the public).

Proposed data use strategy goals

- Does the Technical Team have any recommendations to modify the proposed data use strategy goals?

Data Use Strategy Guidelines and Analyses to Consider

Guidelines to consider for all analyses

1. Analyses should be stratified by sub-populations that are of interest to stakeholders, including by:
   - insurance coverage (e.g., commercial, Medicaid, Medicare) **(*HCC)**
   - age (e.g., pediatric, adult)
   - provider (e.g., care site, practice, facility, network, system) **(*HCC)**
   - provider specialty
   - presence of chronic conditions
   - race, ethnicity, language and disability status, to the extent data support doing so **(*HCC)**
   - geography (e.g., zip code, town/city, county)

2. Analyses should be structured to produced statistically valid and reliable results

3. Analyses should support comparisons to peer organizations and other benchmarks, and display change over time.

Guidelines to consider for all analyses

- Which of the previously presented guidelines does the Technical Team wish to recommend for the data use strategy?

- Are there any additional guidelines it wishes to recommend?

Types of analyses to consider

- There are multiple categories of analyses the Technical Team can recommend for the data use strategy, including:

  1. cost growth drivers (what contributed to cost growth?)
  2. cost drivers (what is causing costs to be so high?)
  3. cost in the context of population demographics
  4. effects of the cost growth benchmark

- We exclude quality because the Quality Council will consider this topic in the fall. The conversation will include consideration of quality from an equity perspective. **(*HCC)**

- As we consider each category of analysis, we will indicate which will be performed by Mathematica in 2020.

Types of analyses to consider

- Does the Technical Team have any additional categories of analyses it wishes to consider?

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1. Cost growth drivers analyses

- **Cost growth drivers – the leading factors contributing to cost growth over the course of one or more years (*HCC)**

- Analyses can utilize the APCD to support multi-payer analyses that deconstruct the factors (e.g., utilization, price, service intensity, patient characteristics, etc.) contributing to longitudinal cost growth.

- These analyses can spotlight cost challenges to the cost growth target, and where providers and policymakers should target priority action.

1. Cost growth drivers analyses: example (1 of 2)

- The Washington Health Alliance has conducted assessments of four factors (i.e., service intensity, unit price, patient characteristics, utilization) contributing to cost growth by major service category.

- Mathematica will initially be conducting an assessment of the role of price and utilization on spending growth for OHS.

1. Cost growth drivers analyses: example (2 of 2)

	THIS YEAR's Spending (PMPM)	LAST YEAR's Spending (PMPM)	Change (%)	Change (PMPM)	What is contributing to the change in spending? (PMPM)				Total Change in Spending
Service					changes in Age/Gender Mix account for:	changes in Service Frequency account for:	changes in Treatment Intensity account for:	changes in Price Level account for:	
Pulmonary Edema	$22.90	$21.99	4.2%	$0.92	$0.08	($0.05)	($0.01)	$0.89	$20,612
COPD	$18.99	$17.66	7.5%	$1.33	$0.11	$0.25	$0.44	$0.53	$29,908
Pneumonia	$27.32	$25.40	7.5%	$1.91	$0.17	$0.14	$0.16	$1.43	$43,023
Perc CV Procedures	$26.45	$25.13	5.3%	$1.32	$0.15	$0.03	$0.03	$1.12	$29,756
Circulatory Disorders	$18.88	$18.12	4.2%	$0.76	$0.09	$0.00	$0.01	$0.65	$16,988
Heart Failure	$22.77	$22.31	2.0%	$0.46	$0.06	($0.00)	($0.00)	$0.40	$10,246
Cardiac Arrhythmia	$27.33	$26.51	3.1%	$0.82	$0.09	$0.01	$0.05	$0.66	$18,445
Spinal Fusion	$13.70	$12.88	6.4%	$0.82	$0.06	$0.33	$0.08	$0.35	$18,492
Major Joint Replacement	$16.08	$15.11	6.4%	$0.96	$0.08	$0.14	$0.20	$0.55	$21,706
Cellulitis	$28.26	$25.72	9.9%	$2.54	$0.13	$1.53	$0.01	$0.89	$57,227
Metabolic disorders	$19.26	$17.53	9.9%	$1.73	$0.07	($0.06)	($0.01)	$1.73	$39,006
Urinary Tract Infections	$23.01	$22.55	2.0%	$0.46	$0.03	$0.18	$0.27	($0.01)	$10,355
Septicemia	$10.93	$10.60	3.1%	$0.33	$0.01	$0.12	$0.13	$0.07	$7,377
	$275.87	$261.51	5.5%	$14.36	$1.13	$2.62	$1.35	$9.27	$323,141
					8%	18%	9%	65%	

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Cost growth drivers analyses

- Does the Technical Team wish to recommend analyses focused on cost growth drivers in the State's data use strategy?

- If so, are there specific sub-analyses the Technical Team wishes to recommend?

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2. Cost drivers analyses

- **Cost drivers – factors that most contribute to the total cost of care for a population of patients**

- There are multiple categories of analyses that fall under cost drivers. In addition to looking at total spending by service, provider and population, it is possible to examine:

  a. Utilization variation
  b. Price and cost variation
  c. Low-value services
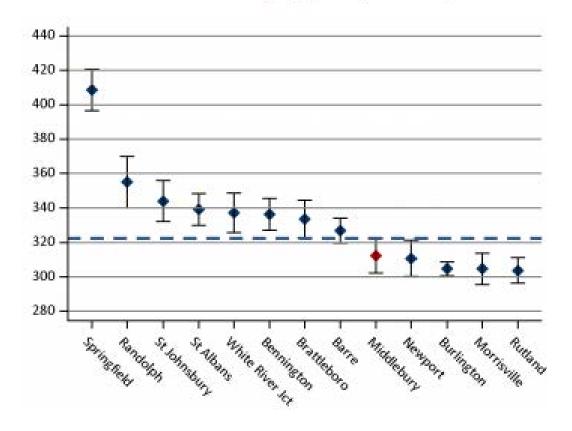 d. Potentially preventable services

2a. Utilization variation analyses

- **Utilization variation – assess variation in use of services that significantly contribute to total cost of care (*HCC)**

- Analyses can assess to what degree service utilization varies within the state and compared to external benchmarks.
  - There could be a focus on variation within payer by geography and/or by provider, and could be reported by insurer, line of business, geography and provider.

- To the degree possible, analyses should adjust for clinical risk and social risk, and examine utilization in terms of frequency, intensity and site of care.

2a. Utilization variation analyses: example (1 of 2)

- Vermont calculates risk-adjusted advance imaging utilization per 1,000 members by county, and has demonstrated wide variation across the state.

Advanced Imaging (MRIs, CT Scans)

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2a. Utilization variation analyses: example (2 of 2)

- Mathematica's initial analyses will focus on variation in frequency of utilization for professional visits and hospital stays. The analysis will be adjusted for the age and gender profile of the population (a rough adjustment for expected health care needs) and can be reported by insurer and line of business.

- Future analyses could focus on variation for low-value and over-utilized services (e.g., imaging), be at finer detailed levels (e.g., DRG-level), be adjusted for the prevalence of and costs associated with chronic conditions among different sub-populations and could be reported by large provider organization.

Cost drivers – utilization variation analyses

- Does the Technical Team wish to recommend analyses focused on utilization variation in the State's data use strategy?

- If so, are there specific sub-analyses the Technical Team wishes to recommend?

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2b. Price and cost variation

- There are multiple price and cost variation analyses that may be of interest to the Technical Team:

  - By service (price)

  - By episode of care (cost)

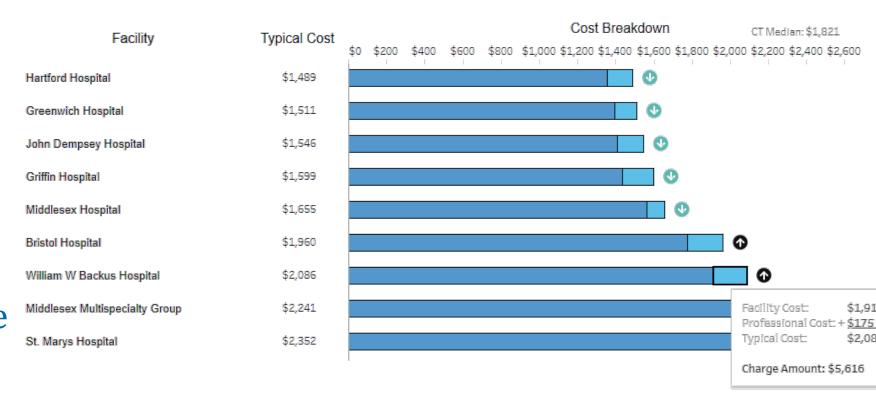 - By out-of-pocket spending (affordability)

2b. Price and cost variation: by service (price)

- **By service (price): assess the variation in the amount providers are paid for a given service**, shedding light on the impact of market power on variation in commercial market prices. **(*HCC)**

  - Analyses focused on variation in provider payments are available through Healthscore CT's Cost Estimator.

  - Future analyses can assess the difference in the change in the number of services versus the change in spending per service, making transparent which services may be driving spending growth.

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2b. Price and cost variation: by service (price) - example

- Healthscore CT's Cost Estimator Tool assesses the paid amounts to Connecticut hospitals and compares hospitals to the statewide median cost.

MRI - Lower Spinal Canal before and after contrast

Facility	Typical Cost
Hartford Hospital	$1,489
Greenwich Hospital	$1,511
John Dempsey Hospital	$1,546
Griffin Hospital	$1,599
Middlesex Hospital	$1,655
Bristol Hospital	$1,960
William W Backus Hospital	$2,086
Middlesex Multispecialty Group	$2,241
St. Marys Hospital	$2,352

Cost Breakdown — CT Median: $1,821

Facility Cost: $1,911
Professional Cost: + $175
Typical Cost: $2,086

Charge Amount: $5,616

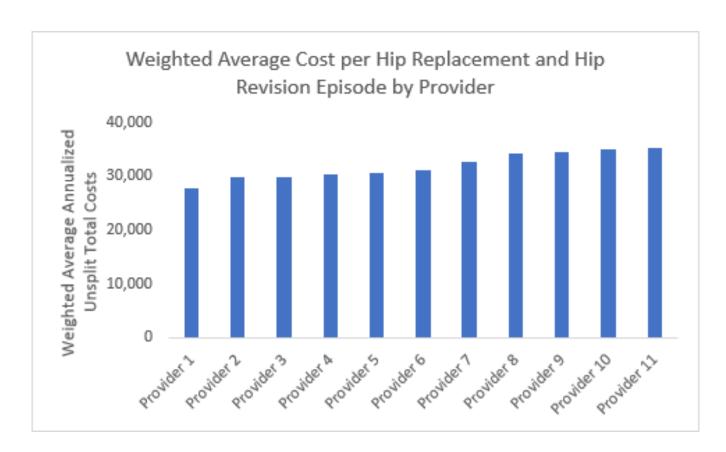# Cost drivers – price variation analyses

- Does the Technical Team wish to recommend analyses focused on price variation in the State's data use strategy?

- If so, are there specific sub-analyses the Technical Team wishes to recommend?

2b. Price and cost variation: by episode of care (cost)

- **By episode of care (cost): assess the variation in aggregate payments across a range of providers for the treatment of an episode of care** (e.g., total hip replacement, treatment of diabetes), which could help providers determine areas to assess potential workflow and process improvement methods to reduce costs

    ▫ Analyses could display the median and range of prices/costs and potential insights into reasons for variation.

    ▫ These analyses are challenging to perform and require special software to do so.

2b. Price and cost variation: by episode of care (cost) - example

- Rhode Island had a contractor assess all costs (e.g., facility, professional inpatient, etc.) associated with individual orthopedic surgeons in 2017, using the state's APCD.

Weighted Average Cost per Hip Replacement and Hip Revision Episode by Provider

Cost drivers – cost variation analyses

- Does the Technical Team wish to recommend analyses focused on cost variation in the State's data use strategy?

- If so, are there specific sub-analyses the Technical Team wishes to recommend?

2b. Price and cost variation: by out-of-pocket spending (affordability)

- **By out-of-pocket spending (affordability): assess the variation in the amount consumers are spending for a given service or episode of care**, thereby providing greater insight into the affordability of health care services **(*HCC)**

  ▫ Analyses could assess variation by geography and/or display the range of out-of-pocket spending. This could highlight specific services and/or regions that policymakers can target for future interventions.

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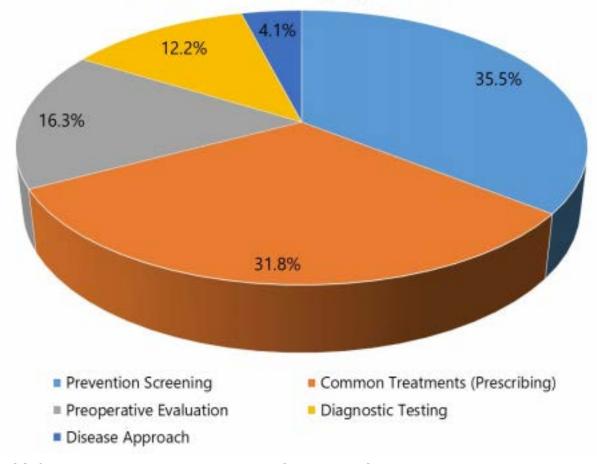
Cost drivers – affordability analyses

- Does the Technical Team wish to recommend analyses focused on affordability in the State's data use strategy?

- If so, are there specific sub-analyses the Technical Team wishes to recommend?

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2c. Low-value services analyses

- **Low-value services – services that produce little-to-no patient benefit and may even result in patient harm (*HCC)**

- Analyses can assess low-value service provision and associated costs using the APCD.
  - Such efforts are in alignment with national and state efforts to avoid unnecessary testing, treatment and procedures (e.g., Choosing Wisely).

- The Oregon Health Leadership Council and Oregon Health Authority assessed the distribution of low-value services by type of service to better inform future interventions focused on reducing low-value care.

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2c. Low-value services analyses: example

Low-value services by type of service

- 35.5% Prevention Screening
- 31.8% Common Treatments (Prescribing)
- 16.3% Preoperative Evaluation
- 12.2% Diagnostic Testing
- 4.1% Disease Approach

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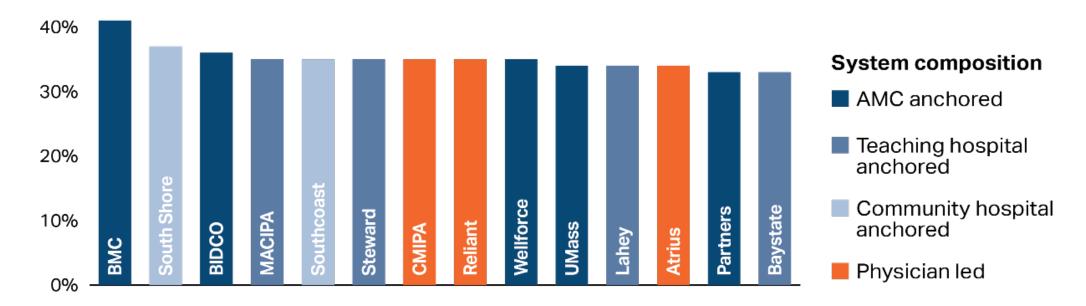
Cost drivers – low-value services analyses

- Does the Technical Team wish to recommend analyses focused on low-value services in the State's data use strategy?

- If so, are there specific sub-analyses the Technical Team wishes to recommend?

2d. Potentially preventable services analyses

- **Potentially preventable services – acute care services that could perhaps have been avoided through more effective or efficient provision of ambulatory services (*HCC)**

  - Analyses can assess the frequency of potentially preventable services (e.g., variation in avoidable ED use) using the APCD to shed light on areas for performance improvement.

  - They can begin by focusing on variation by geographic areas and then, as possible, by provider groups.

2d. Potentially preventable services analyses: example

- The Massachusetts Health Policy Commission analyzes risk- and demographic-adjusted avoidable ED use by health system.

Cost drivers – potentially preventable services analyses

- Does the Technical Team wish to recommend analyses focused on potentially preventable services in the State's data use strategy?

- If so, are there specific sub-analyses the Technical Team wishes to recommend?

3. Population demographics analyses

- Population demographics analyses can focus on the prevalence of and spending by chronic conditions and various social determinants of health (SDOH).

  - Analyses require integration of APCD data with other public data sets (e.g., American Community Survey) that capture patient demographics (e.g., race, ethnicity, language) and SDOH information (e.g., housing status, income).

  - Analyses can highlight communities of highest social risk. They can help providers better understand their populations and proactively serve them holistically.

  - Further, "hot spotting" analyses could help providers target particularly high-risk communities and neighborhoods within their service area.

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3. Population demographics analyses: example

- The Massachusetts Health Policy Commission includes patient demographic analyses in its ACO reports.

	Risk score	Zip-code income	Area deprivation index	% over 55	% Self-insured	% Female
Atrius	.96	$83,284	76.7	26%	52%	56.4%
BMC	.89	$63,319	88.5	20%	52%	54.2%
Lahey	1.05	$85,677	77.8	31%	43%	51.7%
MACIPA	.94	$85,615	70.1	28%	47%	53.5%
Partners	1.03	$86,017	76.6	29%	44%	55.5%
Southcoast	1.09	$59,721	97.6	30%	50%	51.4%
Steward	1.05	$70,131	90.1	30%	48%	52.4%
All physician-led	.96	$81,723	80.2	25.8%	47.8%	55.3%
All other hospital-anchored	1.02	$74,485	86.6	29.8%	45.7%	52.6%
All AMC-anchored	1.02	$81,646	80.7	28.3%	44.5%	53.7%

Source: MA HPC. Patient Demographics as presented by David Auerbach at the November 14, 2018 Rhode Island Cost Trends Data Use Conference

Cost drivers – patient demographic analyses

- Does the Technical Team wish to recommend analyses focused on patient demographics in the State's data use strategy?

- If so, are there specific sub-analyses the Technical Team wishes to recommend?

4. Effects of the cost growth benchmark analyses

- The Technical Team and Stakeholder Advisory Board have expressed interest in measuring the effects, including any unintended consequences, that may result from the cost growth benchmark.

- Both entities were particularly focused on measuring:

  a. underutilization,
  b. affordability, including for uninsured populations, and
  c. the impact on marginalized populations.

4a. Underutilization analyses

- While there is no evidence of this occurring in MA, the cost growth benchmark *could* lead providers to impede access to health care

- To assess underutilization **(*HCC)**, the State could measure:
  - preventive and access-to-care measures (e.g., well visit measures),
  - patient self-reported access to and quality of care (e.g., patient surveys) and/or
  - trends in utilization and costs for specific services that may be most impacted (e.g., specialty services).

- The State could leverage its quality benchmark strategy to capture some of these measures.

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Effects of the cost growth benchmark – underutilization analyses

- Does the Technical Team wish to recommend analyses focused on underutilization in the State's data use strategy?

- If so, are there specific sub-analyses the Technical Team wishes to recommend?

4b. Affordability analyses

- Reductions in cost growth will not necessarily produce reduced out-of-pocket consumer spending, because employers may change benefit design, consumers may change plan selection and/or providers may increase charges to the uninsured. It is therefore valuable to track out-of-pocket spending as an indication of affordability (premium growth being another). **(*HCC)**

- Measures of affordability could include assessing:
    - change in out-of-pocket spending over time, and/or
    - change in costs for uninsured population.

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Effects of the cost growth benchmark – affordability analyses

- Does the Technical Team wish to recommend analyses focused on affordability (other than what is included under cost driver analyses) in the State's data use strategy?

- If so, are there specific sub-analyses the Technical Team wishes to recommend?

4c. Impact on marginalized populations analyses

- Finally, it is important for the State to identify how the cost growth benchmark is impacting sub-populations, especially marginalized populations, as well as the overall population.

- To monitor this impact, Connecticut could stratify the previously discussed analyses by race and ethnicity, geography, disability status and select SDOH factors, as described in the population demographics analyses section.
  - Data are not always available in the APCD, however, so the State will need to look to additional data sources to find this information.

Effects of the cost growth benchmark – marginalized population analyses

- Does the Technical Team wish to recommend analyses focused on the impact on marginalized populations (other than what is included under the population demographics analyses) in the State's data use strategy?

- If so, are there specific sub-analyses the Technical Team wishes to recommend?

Effects of the cost growth benchmark – other analyses

- Are there any other analyses the Technical Team wishes to recommend to track the effects of the cost growth benchmark?

Wrap-up & Next Steps

Next Steps

- Mathematica will conduct the initial analyses of health care cost and cost growth drivers as part of the initial cost growth benchmark work using the State APCD and select additional sources.

- In the long term, OHS will utilize these analyses to drive future standard reports.

Next Meeting: August 27, 2020

- At the next meeting, we will conclude our initial discussion of the **data use strategy**.

- We will also return to our discussion of the **cost growth benchmark** to consider some remaining questions.

Meeting Schedule

Meeting #	Date	Time
9	Thursday, August 27	1-3pm
10	Thursday, September 10	2-4pm
11	Thursday, September 24	1-3pm