# Cost Growth Benchmark Technical Team Meeting #7 July 29, 2020



## **Agenda**

<u>Time</u>	<u>Topic</u>
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. Stakeholder Advisory Board Feedback
1:40 p.m.	V. Primary Care Spending Target Methodology
2:55 p.m.	VI. Wrap-Up and Next Steps
3:00 p.m.	Adjourn

## Approval of July 2, 2020 Meeting Minutes

## **Public Comment**

## Follow-up from the July 2, 2020 Meeting

### Revisiting the Cost Growth Benchmark Values (1 of 2)

• During the June 16<sup>th</sup> meeting, you recommended using a **20/80** weighting of Potential Gross State Product and Median Income to set the benchmark value (2.9%) and have it decline over five years to average **2.9%**.

**2021: 3.1%** 

**2021: 3.0%** 

**2023: 2.9%** 

**2024: 2.8%** 

**2025: 2.7%** 

### Revisiting the Cost Growth Benchmark Values (2 of 2)

- During the prior meeting, the Technical Team discussed concern that the cost growth benchmark values may initially be set too low. You then asked to see options which would address the concern.
- Taskforce staff have developed two options for you to consider today and provide feedback.

## Two Options for Alternate Cost Growth Target Values

#### Option 1: Two Values, One Step Base Value is 20/80 PGSP/Median Income

- 2021: **3.4%** (Base Value + 0.5%)
- 2022: **3.4%** (Base Value + 0.5%)
- 2023: **2.9%** (Base Value)
- 2024: **2.9%** (Base Value)
- 2025: **2.9%** (Base Value)

## Option 2: Three Values, Two Steps Base Value is 20/80 PGSP/Median Income

- 2021: **3.4%** (Base Value + 0.5%)
- 2022: **3.2%** (Base Value + 0.3%)
- 2023: **2.9%** (Base Value)
- 2024: **2.9%** (Base Value)
- 2025: **2.9%** (Base Value)

#### **Rationale:**

- Both options continue with the PGSP/Median Income blend that was reaffirmed by most members during the last meeting.
- An upward adjustment to the target value recognizes the concern of some Technical Team and Stakeholder Advisory Board members that initial values (or all values) are too low.
- 3.4% is 70% of the 20-year historical spending in CT which is in line with the initial spending values other states and still aligns with the goal of increased affordability.

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## Revisiting the Cost Growth Benchmark

- The next two Technical Team meetings will be focused on the primary care spend target and the data use strategy.
- The Technical Team will discuss additional details regarding the Cost Growth Benchmark during the August 27<sup>th</sup> meeting.

## Stakeholder Advisory Board Feedback

### Feedback on the primary care spend target (1 of 2)

- Two Stakeholder Advisory Board members shared information about the outcome of two primary care-focused efforts in the State:
  - A state employee union negotiated a requirement that individuals see their PCP in 2011. At the time 40% of employees lacked a PCP. After the first year of implementation, there was no net increase in costs, despite almost 100% of employees developing a PCP relationship. After the second year, there was savings of 6%.
  - In high-performing medical groups that manage spending well, primary care utilization is typically higher than low-performing groups. In addition, these groups also have lower specialty spending.

### Feedback on the primary care spend target (2 of 2)

- The Stakeholder Advisory Board provided feedback on two major questions:
  - 1. Who are primary care providers?
  - 2. How to define total spending?
- We will review their feedback as the Technical Team discusses the same questions during today's meeting.

## **Defining Primary Care**

## What is primary care?

- The definition of primary care can be sub-divided into the following two questions:
  - 1. Who are "primary care providers"?
  - 2. What services are considered "primary care services"?
- This distinction is an important one because primary care physicians and specialists sometimes deliver the same services.

## 1. Who are primary care providers? (1 of 8)

Provider Type	Rhode Island	Oregon	NESCSO
Primary care MD specialties	Yes – family practice, internal medicine, pediatrics, geriatrics	Yes – family medicine, general medicine, pediatrics, preventive medicine	Yes – family medicine, general practice, internal medicine, pediatrics
NPs and PAs	Yes	Yes	Yes
Geriatrics/gerontology	Yes	Yes	Yes
Behavioral health	Yes, but only if accepting the role and fees of a PCP	Yes – psychiatry and general psychiatry	No
OB/GYN and/or midwifery	See "behavioral health"	Yes – OB/GYN	No
Naturopathic health care providers	No	Yes	No

## 1. Who are primary care providers? (2 of 8)

Practice Type	Rhode Island	Oregon	NESCSO
Primary care clinics	No*	Yes	Yes
Federally qualified health centers (FQHCs) and rural health centers (RHCs)	No*	Yes	Yes
School-based health clinics	No*	No	Yes

<sup>\*</sup>Rhode Island does not explicitly include or exclude these practice types. It provides a definition of a primary care practice as a practice of a physician, medical practice, or other medical provider considered by the insured subscriber or dependent to be his or her usual source of care.

## 1. Who are primary care providers? (3 of 8)

- According to a 2017 report from the Oregon Health Authority, approximately 0.4 percent of all claims-based primary care spending was allocated to OB/GYN and psychiatric providers defined as PCPs.\*
  - This percentage appears to be low because a) Oregon adopted a narrow definition of what services delivered by OB/GYNs and psychiatric providers are included in its primary care spending definition, and b) it does not include non-claims payments related to OB/GYN and psychiatric spending.

<sup>\*</sup>Bailit Health calculated a weighted average of claims-based primary care spending allocated to OB/GYN and psychiatric providers defined as PCPs by the primary care spending by market to create a statewide percentage. Source: <a href="https://www.oregon.gov/oha/HPA/ANALYTICS/PCSpendingDocs/2017-Oregon-Primary-Care-Spending-Report-Legislature.pdf">https://www.oregon.gov/oha/HPA/ANALYTICS/PCSpendingDocs/2017-Oregon-Primary-Care-Spending-Report-Legislature.pdf</a>

## 1. Who are primary care providers? (4 of 8)

- During the last meeting, the Technical Team had an extended conversation about whether OB/GYNs should be considered primary care providers.
  - One member of the Technical Team noted that the state health plan experience is that 15 percent of women use an OB/GYN as their primary care provider.
  - We also heard that many women enter the health care system through their OB/GYN relationship, and that OB/GYNs may be a primary source of women's care in underserved communities.

## 1. Who are primary care providers? (5 of 8)

Guidance on OB/GYNs serving as primary care providers:

- The Cleveland Clinic suggests that OB/GYNs can serve as PCPs for women who
  are generally healthy, but not for women with a strong family history of
  disease.\*
- A July 2020 Commonwealth Fund report titled "Transforming Primary Care for Women"\*\* states:
  - "While women often require care from cardiologists, neurologists, ob/gyns, and other specialists, these providers may not have the bandwidth or incentives to comprehensively address broad and intersecting health needs across the life course. Therefore, as women age and experience natural life transitions like menopause, they require the care and attention of a primary health care provider possibly in consultation with other specialists who can monitor their evolving needs and understand emerging patterns that may indicate future health risks."

<sup>\*\*</sup>Source: https://www.commonwealthfund.org/publications/fund-reports/2020/jul/transforming-primary-health-care-women-part-1-framework



<sup>\*</sup>Source: <a href="https://health.clevelandclinic.org/is-it-ok-to-see-your-obgyn-for-primary-care/">https://health.clevelandclinic.org/is-it-ok-to-see-your-obgyn-for-primary-care/</a>

## 1. Who are primary care providers? (6 of 8)

• Other perspectives on defining OB/GYNs as primary care providers:

#### Connecticut precedent:

- The Quality Council decided not to define OB/GYNs as PCPs in 2018.
- Medicaid does not recognize OB/GYNs as PCPs (similar to NCQA and CMS), but the state employee health plan reportedly does.

#### • NESCSO primary care project:

• The New England states participating in the NESCSO study agreed that while many women consider their OB/GYNs to be their PCP, OB/GYNs do not provide the continuum of care, especially for chronic care services, that are included in the commonly accepted definitions of PCPs.

#### • In the literature:

 One 2014 analysis found that PCPs were nearly 2.5 times as likely as OB/GYNs to address problems such as mental health issues, metabolic conditions and circulatory, respiratory, digestive and skin diseases during a preventive gynecological visit.\*



## 1. Who are primary care providers? (7 of 8)

- The Stakeholder Advisory Board provided the following feedback on the topic of including OB/GYNs in the definition of a primary care provider:
  - Several members noted that OB/GYNs and behavioral health providers often serve as PCPs. They worried that excluding these provider types and classifying them as specialists may disincentivize use of OB/GYNs and behavioral health providers.
  - Three members objected to OB/GYNs as PCPs, with one member countering that OB/GYNs are trained as surgeons and cannot provide the continuum of care that a clinician trained to deliver primary care can deliver.

## 1. Who are primary care providers? (8 of 8)

- The SAB provided the following recommendations:
  - Look at OB/GYN services and identify which are primary care-focused and which are specialty-focused.
  - Consider inclusion of OB/GYN, behavioral health, emergency room and dental providers, as they all can perform primary care-focused services.

### Definition of a primary care provider

 Based on what you just learned, how do you recommend primary care provider be defined?



## 2. Which services are considered "primary care services"? (1 of 4)

• The following tables summarize categories of codes that are included in various definitions of primary care. There may be codelevel differences within the categories that are not highlighted here.

Service Type	Rhode Island	Oregon	NESCSO
Office or home visits	No service restriction	Yes	Yes
General medical exams	(except lab, x-ray and imaging) – uses primary care provider definition only	Yes	Yes
Routine adult medical and child health exams		Yes	Yes
Preventive medicine evaluation or counseling		Yes	Yes
Telehealth visits		Yes	Yes
Admin. and interpretation of health risk assessments		Yes	Yes

## 2. Which services are considered "primary care services"?(2 of 4)

Service Type	Rhode Island	Oregon	NESCSO
Routine obstetric care (excluding delivery and routine gynecological care)	No service restriction	Yes	No
Behavioral health risk assessments, screening and counseling	(except lab, x-ray and imaging) -	Yes	Yes
Minor outpatient procedures	uses primary care provider	No	No
Immunizations (e.g., vaccines and vaccine administration)	definition only	Yes (vaccine and administration)	Yes (administration only)
Inpatient care		No	No
ED care (e.g., suture removal, splinting)		No	No
Nursing facility care		No	No
Hospice care		No	Yes
Practice-administered pharmacy		No	No

## 2. Which services are considered "primary care services"? (3 of 4)

 Oregon and NESCSO both define behavioral health risk assessments, screening and counseling as primary care services, but *only when* they are delivered by a classified PCP. Examples of such codes are included in the table below.

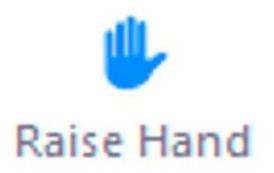
Code	Description
96160-96161	Administration of health risk assessment
99401-99404	Preventive medicine counseling or risk reduction intervention
99406 – 99407	Smoking and tobacco use cessation counseling visit
99408 – 99409	Alcohol or substance abuse screening and brief intervention
99484*	Care management services for behavioral health conditions
99492 – 99494*	Initial and/or subsequent psychiatric collaborative care management
G0396-G0397	Alcohol or substance abuse assessment
G0442-G0444	Annual alcohol screening; brief behavioral counseling for alcohol misuse; annual depression screening

## Stakeholder Advisory Board feedback

- Some Stakeholder Advisory Board members felt that GYN services are primary care services, regardless of who provides them. (These same members also felt that OB/GYNs should be classified as *primary care providers*).
- One Stakeholder Advisory Board member encouraged including routine oral health care in the definition of primary care services.
   She noted that if the State did not wish to crowd the definition of primary care spending, it could create a separate oral health-focused definition.

### Definition of primary care services

 Based on what you just learned, what approach does the Technical Team wish to take to recommend a technical definition of primary care services?



## **Defining Primary Care Payments**

## What constitutes primary care payments?

- The definition of primary care payments can be sub-divided into the following two questions:
  - 1. How does one define "service payments"?
  - 2. How does one define "non-service-based payments"?

## 1. How does one define service payments?

- Rhode Island: payments based on paid medical claims
  - Rationale: health plans have the ability to only control paid amounts
  - <u>Note</u>: Rhode Island modeled historical trends for allowed and paid claims and found that while allowed claims were higher than paid claims, there were no differences in overall trend.
- Oregon: payments based on paid medical claims
  - <u>Rationale</u>: legislators and advocates were focused on plan investments in primary care
- NESCSO: payments based on allowed medical claims
  - Rationale: New England states expressed a preference for allowed amounts

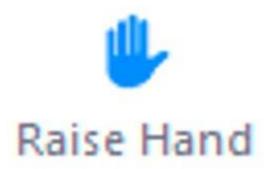


## Advantages and disadvantages of different definitions of service payments

- The advantage of utilizing *paid medical claims* is that it captures the *spending amount which health plans can control*. A spending target focused on paid claims, therefore, can be focused on influencing plan investments in primary care.
- The advantage of utilizing *allowed medical claims* is that it captures total primary care spending. This is important given the sharp rise in consumer cost-sharing in commercial plan designs over the past two decades.

## Definition of service payments

Do you recommend the definition include paid or allowed payments?



## 2. How does one define non-service-based payments? (1 of 2)

Payment Type	Rhode Island	Oregon	NESCSO
Care management	Yes	Yes	Yes
PCMH infrastructure	Yes	Yes	Yes
Pay-for-performance	Yes	Yes	Yes
Shared savings distributions	Yes	Yes	Yes
Capitation	Yes	Yes (including provider salaries)*	Yes (including provider salaries)*
Episode-based payment	Yes	Yes	Yes
EHR/HIT infrastructure	Yes	Yes	Yes



## 2. How does one define non-service-based payments? (2 of 2)

Payment Type	Rhode Island	Oregon	NESCSO
COVID-19 support payments	TBD	TBD	TBD
Other	Yes (e.g., behavioral health screens in primary care settings, programs aimed to increase the number of primary care physicians)	Yes (supplemental workforce payments, including practice coaches, patient educators, patient navigators or nurse care managers)	Yes (supplemental workforce payments, including practice coaches, patient educators, patient navigators or nurse care managers; loan forgiveness for training providers; flu clinics)

## Definition of non-service-based payments

 Based on what you just learned, how does the Technical Team wish to recommend a definition of non-service-based payments?



## Parallels between the primary care spending target and the cost growth benchmark

- The next three topics discuss how to define total payments, the population, and the payers for the primary care spending target.
- The Technical Team can consider making recommendations that align with those for the cost growth benchmark. Aligning definitions across the target and the benchmark is advantageous because it:
  - greatly reduces reporting burden;
  - allows for select comparisons to be made between the primary care spending target and the cost growth benchmark, and
  - could be viewed as consistent with EO language: "set targets within each annual benchmark for increased primary care spending"
- It may also, however, create non-alignment with other states.

## **Defining Total Payments**

### How does one define total payments?

- The calculation of total payments constitutes the denominator for the primary care spending target calculation. There are a few key spending categories (i.e., prescription drugs, lab and imaging services and dental services) that differ in terms of inclusion among states.
- The Technical Team can choose to recommend the same definition of total payments utilized for the cost growth benchmark (i.e., total medical expenses), or a separate definition.

## What do others include in their definition of <u>total</u> spending?

Spending Category	CT Cost Growth Benchmark	Rhode Island	Oregon	NESCSO
Prescription drugs	Yes (incl. pharmacy rebates)	Yes (pharmacy rebates TBD)*	No	Yes (pharmacy rebates TBD)**
Lab and imaging services	Yes	Yes	Yes	Yes
Dental services	TBD	No	No	No
Vision services	No	No	No	No
Long-term care	Yes	No	No	No (except Skilled Nursing Facility)

<sup>\*</sup>Rhode Island is refining its primary care spending target definition this summer. It will finalize whether to include pharmacy rebates at that time.



<sup>\*\*</sup>NESCSO aims to include pharmacy rebates in its definition of total spending, but will finalize its definition after states submit their initial data in late July 2020.

### Stakeholder Advisory Board feedback

- The Stakeholder Advisory Board was supportive of excluding longterm care from the definition of total spending because it is not covered by all payers and it would be challenging to reach the 10% of target if it were included.
- One Stakeholder Advisory Board member encouraged including oral health care in total spending.

## Advantages and disadvantages of different definitions for total spending

- The benefit of including more categories in total spending makes the calculation of total medical expenses more comprehensive.
  - It also reduces the calculated share of spending going to primary care.
- A narrower definition of total medical expense may be more equitable across payers, as it is limited to service categories that are applicable across multiple markets (e.g., excludes skilled long-term care spending that is concentrated in Medicaid).
  - It also increases the calculated share of spending going to primary care.

## Connecticut's definition of total spending



- Based on what you just learned, does the Technical Team wish to recommend utilizing the same total spending definition as that in use for the cost growth benchmark, or a different one?
  - If not the cost growth benchmark methodology, does the Technical Team wish to recommend...
    - including total spending for each payer type in the denominator, or exclude Medicaid-only spending?
    - including oral health care, creating a separate definition focused on oral health, or neither?

## **Defining the Population**

## How does one define the population?

• Similar to the cost growth benchmark, the Technical Team must decide how to define the population based on the location of the resident and the provider. There are three viable options:

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**Connecticut Resident Connecticut Provider** 

**Out-of-State Resident Connecticut Provider** 

**Connecticut Resident Out-of-State Provider** 

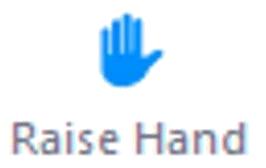
Out-of-State Provider

## How do others define the population?

Resident/Provider Location	CT Cost Growth Benchmark	Rhode Island	Oregon	NESCSO
In-state Resident	Yes	Yes	Yes	Yes
Out-of-state Resident	No	Yes	Yes (only for public employees and educators)	No
In-state Provider	Yes	Yes	Yes	Yes
Out-of-state Provider	Yes	No	Yes (only a few select border areas in WA and ID)	Yes

### Connecticut's definition of the population

- Based on what you just learned, does the Technical Team recommend utilizing the same population definition as that in use for the cost growth benchmark, or a different one?
  - If different, how so?



## **Defining the Payers**

### How does one define which payers to include?

- The definition of which payers to include can be subdivided into the following three questions:
  - 1. Should data be collected for payers other than commercial, Medicaid and Medicare?
  - 2. Should data be collected for Medicare?
  - 3. Should data be collected for all payers, or only payers that meet a minimum size (e.g., covered lives)?

## 1. Should data be collected for payers other than commercial, Medicaid and Medicare?

- The EO calls for measuring primary care spending across public and private payers in the State, although it is likely only feasible to collect data for Medicaid, Medicare and commercial payers.
- The cost growth benchmark is measuring spending for all residents who are covered through Medicaid, Medicare and commercial payers. It also includes coverage through the Veterans Health Administration and potentially state correctional facilities, although it may be challenging to collect primary care data from all of these additional payers.
- Based on what you just learned, does the Technical Team wish to collect data only for include Medicaid, Medicare and commercial payers, or does it wish to include additional payers?
  - If additional payers, which ones?

## 2. Should data be collected for Medicare? (1 of 3)

- The EO calls for including Medicare in the primary care spend target.
- However, CMS has indicated to Bailit Health that it likely does not have the bandwidth to provide Connecticut-specific primary care spending.
- The Technical Team *could* recommend adopting a hybrid data collection approach where commercial and Medicaid data are obtained through payer reporting and Medicare data are obtained through the State APCD.

## 2. Should data be collected for Medicare? (2 of 3)

- However...there are some challenges with this approach:
  - A hybrid data collection method would diverge from the Technical Team's initial recommendation to collect data through payer reporting.
  - Medicare data may not be aligned with payer-reported commercial and Medicaid data due to limitations on what non-claims-based data are available in the APCD.
  - There is a delay in when Medicare data are available in the APCD. Data are uploaded quarterly and are not available until 1.5 years after the quarter has ended (e.g., October-December 2018 data did not become available until June 2020). This is much later than commercial and Medicaid data would become available.

## 2. Should data be collected for Medicare? (3 of 3)

- Not including Medicare in the target may make it more feasible for Connecticut to reach the 10% target issued in the EO.
  - This is because Medicare spends a disproportional amount on nonprimary care services, making its primary care spend as a percentage of total spend substantially lower than other payer types.
- Given this information, does the Technical Team wish to include
   Medicare in the primary care spent target?

## 3. Should data be collected for all payers, or only payers that meet a minimum size?

- An analysis performed by Bailit Health with data provided by Paul Lombardo indicated that a handful of CT insurers and TPAs cover or administer coverage for 96% of all commercially covered lives. This suggests that only including insurers that meet a minimum size may accurately capture primary care spending.
- For this reason, Bailit Health recommends that for both the cost growth benchmark and primary care spend target OHS only collect data for insurers and TPAs that meet a minimum size (to be determined).
- Based on what you just learned, does the Technical Team support this recommendation?

## **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?

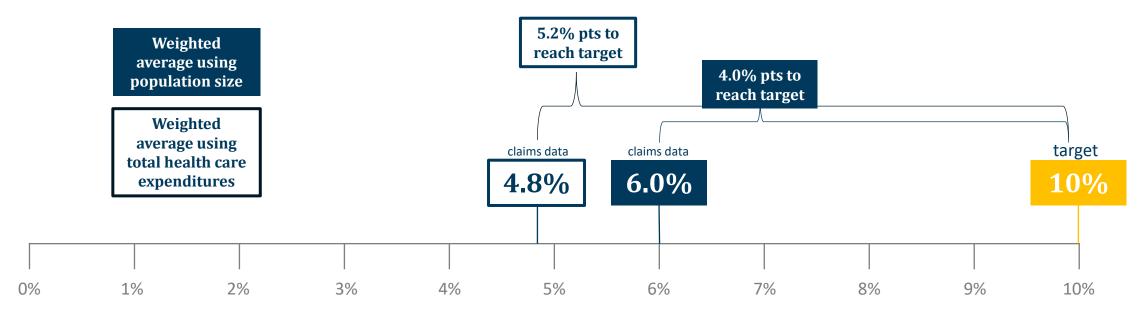
- In order to determine how much to increase primary care spending to reach 10 percent, the Technical Team will first need to understand how much it is currently spending.
- The Technical Team will need to identify whether it wishes to utilize historical primary care spending data from the PCPCC, Freedman 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.

## 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

<sup>\*</sup>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** 

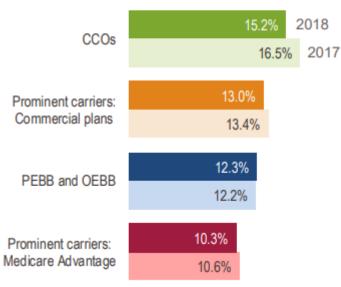
\$1.2 billion

Percent primary care

12.3 percent

#### Percentage of total primary care medical spending

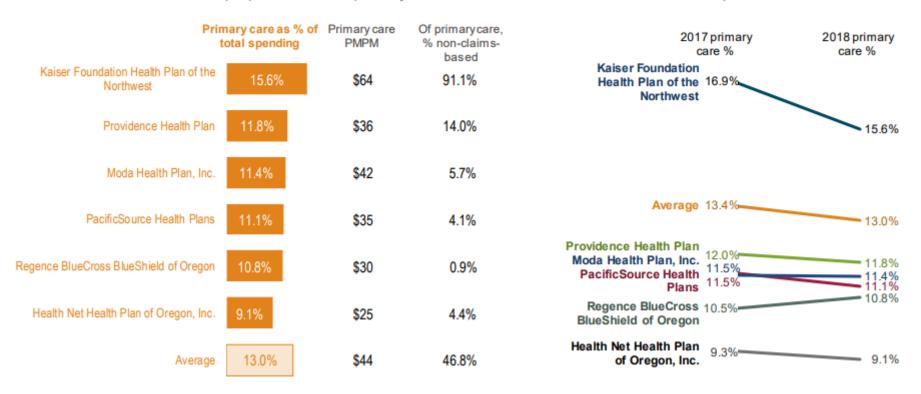
In 2018, CCOs allocated an average of 15.2 percent of total medical spending to primary care. Commercial, Medicare Advantage, and PEBB and OEBB plans allocated an average of 13.0 percent or less of total medical spending to primary care.



### 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.



### 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)?



# 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).

### Connecticut's performance of complementary analyses

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



## 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.

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

Α	В	С	G	Н	М	N	0	Р	R	S
Delaware Health Care	Commission					_				
Total Medical Expense	s Calculation Template						Note: S	elect colum	ns from the	2
Black = Payer-reported	l data					original submission template have		WO		
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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

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

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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?

## Wrap-Up & Next Steps

### Next Meeting: August 13, 2020

- At the next meeting, we will begin our discussion of a **data use strategy** to help identify (1) where costs are high, (2) where costs are growing rapidly and (3) where costs are variable.
- By analyzing data through a data use strategy, OHS can shine light on these areas and identify what spending categories have the greatest chance of moving the needle on the cost growth benchmark.

## Meeting Schedule

Meeting #	Date	Time
8	Thursday, August 13	1-3pm
9	Thursday, August 27	1-3pm
10	Thursday, September 24	1-3pm