Cost Growth Benchmark Technical Team Meeting #10
September 10, 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.	Cost Growth Benchmark
2:20 p.m.	V.	Primary Care Spend Target
2:40 p.m.	VI.	Data Use Strategy
3:00 p.m.	VII.	Ensuring Program Success
3:25 p.m.	IX.	Wrap-Up and Next Steps
3:30 p.m.	Adjourn	

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Approval of
August 27, 2020 Meeting Minutes

Public Comment

Cost Growth Benchmark

Outstanding Cost Growth Benchmark issues

- The Technical Team previously discussed several items related to the Cost Growth Benchmark that required follow-up research.
- Today we have updates on:
  1. From which insurers data will be requested
  2. How risk-adjustment will be applied
  3. Minimum attribution size for providers
  4. Provider directory options
- Following discussion of these topics, we will have completed discussion of the Cost Growth Benchmark methodology!

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1. Data to support the Cost Growth Benchmark

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

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Recommended payers from which healthcare spending data would be requested

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

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

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2. How should risk adjustment be applied?

- In order to report on payer and provider performance against the Cost Growth Benchmark, cost data will need to be risk adjusted.
- For the Technical Team's purpose, "risk adjustment" is the modification of spending data to reflect changes in the underlying insurer or provider population over the course of the year.
  - The adjustment ensures that assessment of cost growth benchmark attainment considers changes in the underlying health status of the insurer's or provider's served population.

Risk adjustment is only performed at the insurer and provider levels

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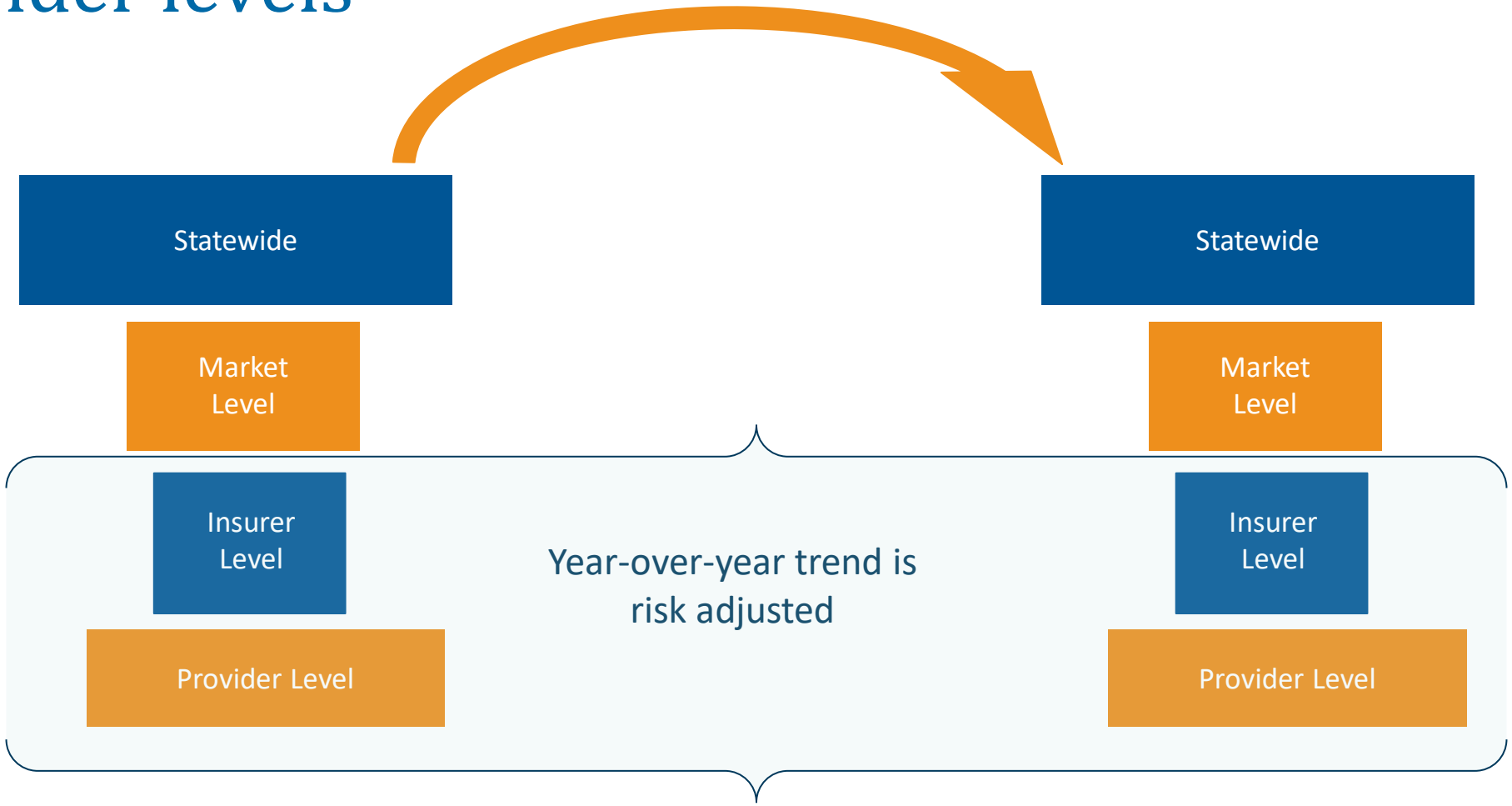
Risk adjustment is only performed at the insurer and provider levels



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Options for risk adjustment approach

There are two ways to perform clinical risk adjustment:

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

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

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Risk adjustment for social factors

- The duties of the Cost Growth Benchmark Technical Team, per ARTICLE II, Section I.H of its bylaws, include the following:
  - *Recommend risk adjustment that includes social risk.*
- There is growing interest nationally in applying social risk factor adjustment to healthcare payments.
- However, there is *very* limited experience with risk adjusting for social factors; methodologies for doing so are nascent.
  - It does not appear that there is yet a means to wide application of social risk factor adjustment in CT, although there is clear potential for the future.
- Staff recommend against social risk adjustment to cost growth benchmark performance calculations, and revisiting the topic in the future.

3. What is a "sufficient population size" to measure provider performance against the benchmark?

- To report on healthcare spending at the provider level, the provider needs to be sufficiently large to help dampen any "noise" in the data, and reduce the chance that random variation played a part in its performance.
- While payers and providers contract on a shared savings or shared risk basis for as few as 3,000 attributed lives, statistical analysis reveals that random variation will impact cost performance assessments at that population size, and much larger populations.*

* McCall N and Peikes D. "Tricky Problems with Small Numbers" Robert Wood Johnson Foundation, Princeton, NJ, 2016.

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

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

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

- Oregon is developing an empirical model to use as the basis for setting a minimum population size(s) for publicly reporting data. Project staff suggest that Connecticut wait for the results of this analysis before making a decision on this topic.
  - Should Oregon not be able to complete its work for some reason, project staff recommend that Connecticut work to develop an empirical basis for establishing a minimum population for which to report on large provider entities.
- **Is waiting for Oregon to complete its analysis, or having Connecticut continue analysis from Oregon's prior work (if needed), an acceptable approach?**

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4. How to identify large provider entities

- Technical Team members may recall that on June 16th it discussed the concept of organizing individual providers into larger provider entities for the purposes of reporting.

- Staff presented four options:
  1. Leverage the work that UConn has been performing in support of HealthScore CT and the Quality Scorecard
  2. Leverage Medicaid's provider files
  3. Await the development of OHS's provider directory
  4. Utilize existing payer total cost of care contracts

Project staff recommendations

- Until OHS's provider directory is developed, project staff recommend utilizing the work performed by UConn to support HealthScore CT and the Quality Scorecard.
- Project staff make this recommendation because:
  - The Medicaid provider directory is updated too infrequently (2-5 years).
  - Physicians participating in total cost of care contracts will vary across payers thereby, potentially leading to "granny smith apples to golden delicious apples" comparisons.
  - The OHS provider directory will not be ready for a few more years.
- **Does the Technical Team support this recommendation?**

*Traditional Medicare (Medicare FFS) data cannot be organized by provider entity.

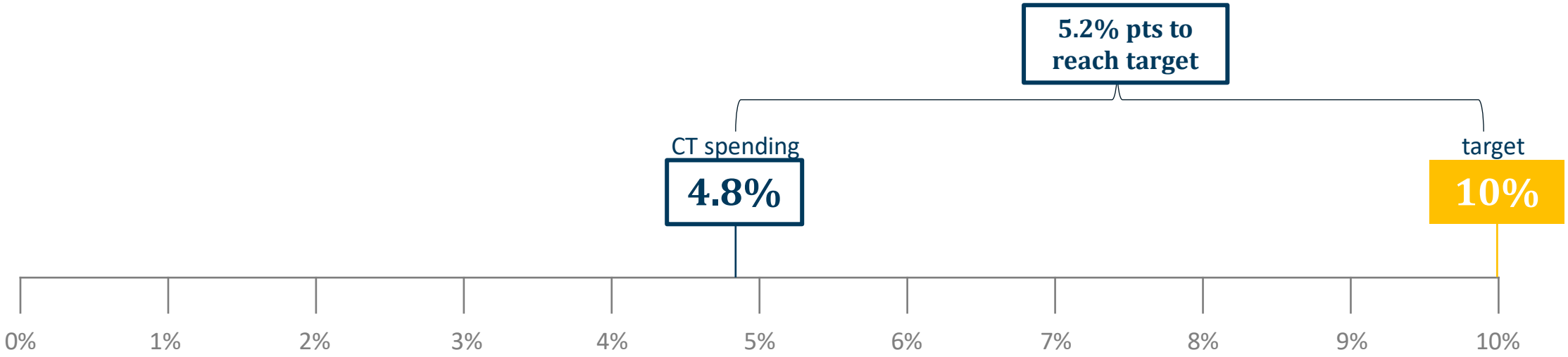
Primary Care Spend Target

Outstanding primary care spend target issues

- In August, the Technical Team initially recommended deferring setting the primary care spend target to the primary care-focused work group.
- OHS now believes there will not be enough time for the primary care work group to perform the necessary work to inform target selection.
- OHS therefore proposes the following strategy:
  - Set a conservative target for 2021 based on currently available data.
  - Defer setting targets for 2022-2024 to a future work group once payer-submitted data are available.

Setting the target (1 of 2)

- As a reminder, the Technical Team previously recommended calculating a statewide weighted average of total primary care spending using total healthcare expenditures.



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

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Setting the target (2 of 2)

- Therefore, OHS recommends **setting the 2021 primary care spend target at 5.0%** for the following reasons:

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

What is the primary care spend target?

1. Do you have any feedback on OHS' revised process for setting the targets for 2021-2025?
2. Do you have any feedback on the proposed target for 2021?

Data Use Strategy

Stakeholder Advisory Board feedback specific to the Data Use Strategy

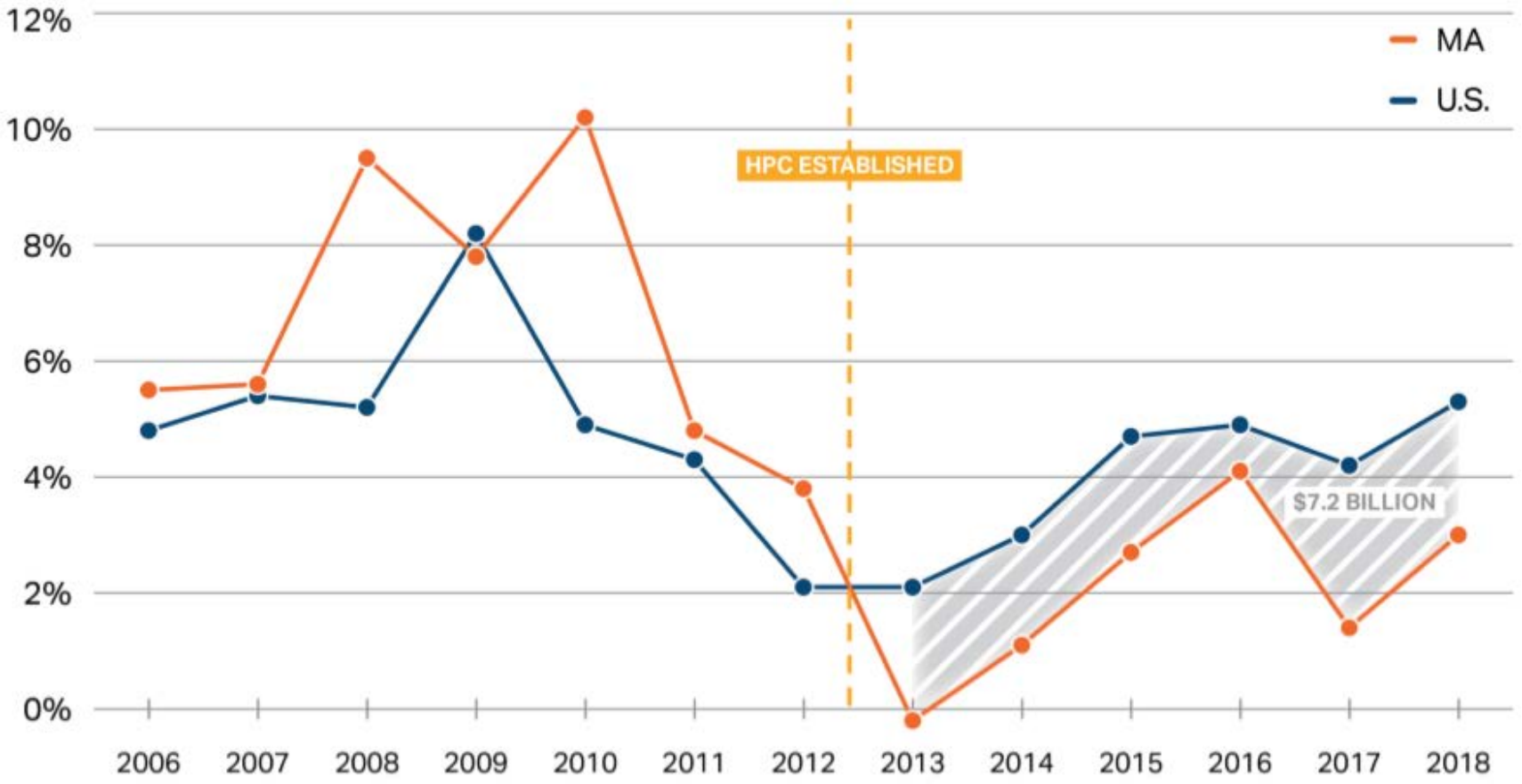
- Don't message that the first proposed goal of producing reports is to reduce health care spending and spending growth. The goal is really to improve health care and invest in higher value health care.
- Add utilization of risk-adjusted analyses, where appropriate, to the guidelines.
- Stratify analyses by gender.
- Conduct episode-based analysis, if possible.
- Look at site of service as a variable when analyzing cost growth drivers.
- Grant all stakeholders access to analytics to replicate and validate information.
- Capture and analyze data on the uninsured and undocumented immigrants.
- Start thinking about how stakeholders and consumers will have say into issues such as how ad hoc analyses will be prioritized, how to provide access to data, etc.

Ensuring Program Success

Cost Growth Targets in Massachusetts Appear to Have Had a Positive Impact

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

Massachusetts' Cost Growth Benchmark Experience



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

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

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

Observers' Assessment of the MA Benchmark Program's Impact

- "Payer and provider rate negotiations are now conducted in light of the 3.6% target."
  —*State Auditor study*
- "With an expected utilization increase of about 2%, payers and providers generally agree on annual price increases of about 1.5%."
  —*David Cutler, HPC member*
- "The [cost growth benchmark] does mean something… It's more than just a symbol, it becomes an operational component of how our health system works."
  —*Stuart Altman, HPC Chair*

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What Are the Factors that Contributed to the Success of a Cost Growth Target Program in Massachusetts?

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

Tools to Put a Spotlight on Healthcare Cost Growth

- The MA Health Policy Commission holds an **annual hearing** to review healthcare cost trends that it conducts with the Office of the Attorney General, and can compel healthcare entities to testify publicly on factors driving their cost growth.
- The Health Policy Commission Board can require a healthcare entity to submit a **performance improvement plan** and be subject to ongoing monitoring (but has never done so!).
- These tools appear to have "spotlight effect" that helps to restrain market behavior, perhaps because entities wish to avoid public shaming that could result from being questions in a public hearing or from being required to submit a performance improvement plan.

SOURCE: L. Waugh and D. McCarthy, "How the Massachusetts Health Policy Commission Is Fostering a Statewide Commitment to Contain Health Care Spending Growth," The Commonwealth Fund, March 5, 2020.

How Can We Ensure the Cost Growth Benchmark's Success in Connecticut?

1. To what extent do the factors that contributed to success in Massachusetts exist in Connecticut?
2. What steps need to be taken in Connecticut that respond to Connecticut's specific environment and could facilitate the cost growth benchmark program's success?

Ensuring Primary Care Spend Target Success

- Only OR and RI have primary care spend targets, and their application is narrower in terms of affected payers and is also in regulation (RI) and statute (OR).

- What steps should CT take to ensure this strategy is successful?

Ensuring Data Use Strategy Success

- If CT only implements benchmarks and targets, but doesn't perform and publicly report analysis to understand what is driving underlying trends, the benchmarks and targets may be less likely to be achieved.

- What steps should CT take to ensure this strategy is successful?

Wrap-up & Next Steps

Next Meeting: September 24, 2020

- Discuss a draft report summarizing Technical Team recommendations.
- Review the final input of the Stakeholder Advisory Board for possible report incorporation.
- Reflect on the Technical Team process.

Meeting Schedule

Meeting #	Date	Time
11	Thursday, September 24	1-3pm