Healthcare Benchmark Initiative Technical Team

January 25, 2021 Meeting

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Agenda

Time	Topic
4:00 p.m.	I. Call to Order
4:05 p.m.	II. Public Comment
4:15 p.m.	III. Healthcare Benchmark Initiative Updates
4:35 p.m.	IV. Criteria for When to Report Provider Benchmark Performance
4:45 p.m.	V. Stakeholder Engagement Activities
4:50 p.m.	VI. Peterson-Milbank Program for Sustainable Health Costs
4:55 p.m.	VII. Wrap-Up and Next Steps
5:00 p.m.	Adjourn

Call to Order

Public Comment

Healthcare Benchmark Initiative Updates

Pre-Benchmark Measurement

- OHS met with insurers in November to kick off a process for collecting data and performing a pre-benchmark analysis.
- If all goes as planned, pre-benchmark results at the state and market level will be published by the summer of 2021 for CY 2018-2019.
  - *Findings will not be published at the insurer and provider entity levels.*

Finalization of Monitoring Measures to Detect Potential Adverse Consequences from the Cost Growth Benchmark

- OHS received four sets of comments from Technical Team members in reaction to the draft monitoring measure set, which can be found in the spreadsheet distributed with the meeting materials.
- OHS made the following changes to respond to the comments:
  - Stratified analyses, where possible, to highlight differences in performance between commercial and Medicaid payers;
  - Included new analyses to assess...
    - timely access to specialty care (which is a known problem for Medicaid members), and
    - change in out-of-pocket spending by service category (because commercial plan designs may use cost-sharing to disincentivize access to non-preventive services).

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Finalization of Monitoring Measures to Detect Potential Adverse Consequences from the Cost Growth Benchmark

- OHS also modified the plan to:
  - specify which organizations will be responsible for calculating each measure, and
  - include clear timelines for when data will be pulled and analyzed.
- Finally, OHS received significant feedback on how to potentially leverage community health center data to better understand utilization of people who are uninsured.
  - OHS is still evaluating this data source and will update the plan once OHS decides if this is a viable approach.

Primary Care Spend Target

- The Technical Team made recommendations for how payers should increase primary care spending, and asked the Primary Care and Community Health Reforms Work Group to advise on target setting for 2022-24
- The Primary Care and Community Health Reforms Work Group will consider:
  - approaches to achieving increased primary care spending (Q1-Q2)
  - primary care spend targets for 2022-2024 (Q3 – after completion of the pre-benchmark analysis of payer data)

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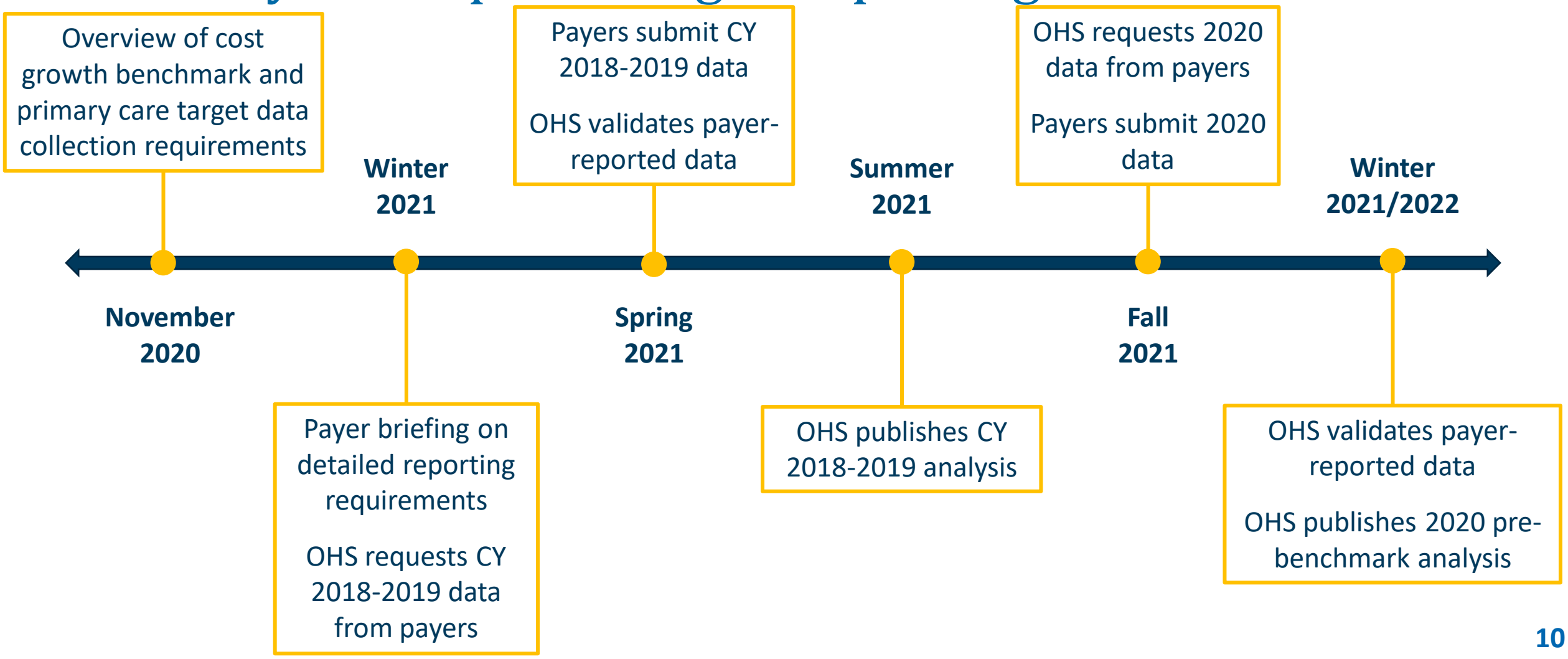
Timeline for Cost Growth Benchmark and Primary Care Spend Target Reporting



Quality Benchmark Development

- In November the Quality Council was briefed on its benchmark recommendation charge.
- In December it began updating its Core Measure Set, after which it will focus on developing Quality Benchmark recommendations.
  - The Quality Benchmarks may include, but will not be limited to, measures in the Core Measure Set.

Data Use Strategy

- Mathematica has delivered its initial data use strategy analysis of cost drivers and cost growth drivers in Connecticut.
  - OHS looks forward to reviewing findings from this analysis with the Technical Team at its February meeting.
  - Prior to that meeting, OHS will meet with a provider stakeholder group to review findings and solicit reactions.
- Reliability of REL data obtained from the Census Bureau's CPS.

Criteria for When to Report Provider Benchmark Performance

Criteria for When to Report Provider Benchmark Performance

- OHS will report individual payer and provider entity performance against the benchmark for 2021 cost growth.
- This reporting will occur in early 2023.
- Today we wish to explore how OHS should make determinations of payer and provider entity performance against the benchmark.
- For this purpose, we ask "*how do we determine when a payer or provider entity has met the benchmark or not*"?

Criteria for When to Report Provider Benchmark Performance

- What is the problem we are trying to solve?
  - Spending and service utilization are subject to **random fluctuations**, particularly in smaller populations.
  - This can impact **statistical confidence** in assessments of payer/provider entity performance against the benchmark.

- OHS could, however, consider adopting requirements similar to what other cost growth benchmark states use.
  - States can set a minimum population size for performance to be reported, and then perform a **simple comparison** of rates.
  - States can set a minimum population size and then apply **statistical analysis parameters**.

Minimum Attributed Lives for Public Reporting of **Payer Performance** in Other States

State	Minimum Enrolled Lives for Public Reporting of Payer Performance
Delaware	None. State requires commercial insurers with the largest market share and Medicaid insurers to report.
Massachusetts	None. State requires commercial insurers with the largest market share and Medicaid insurers to report.
Oregon	Payers and TPAs with at least 5,000 lives in a given market (i.e., Medicaid, Medicare, commercial) will be included in public reporting. All others will be reported in aggregate.
Rhode Island	None. State requires commercial insurers with the largest market share and Medicaid insurers to report.

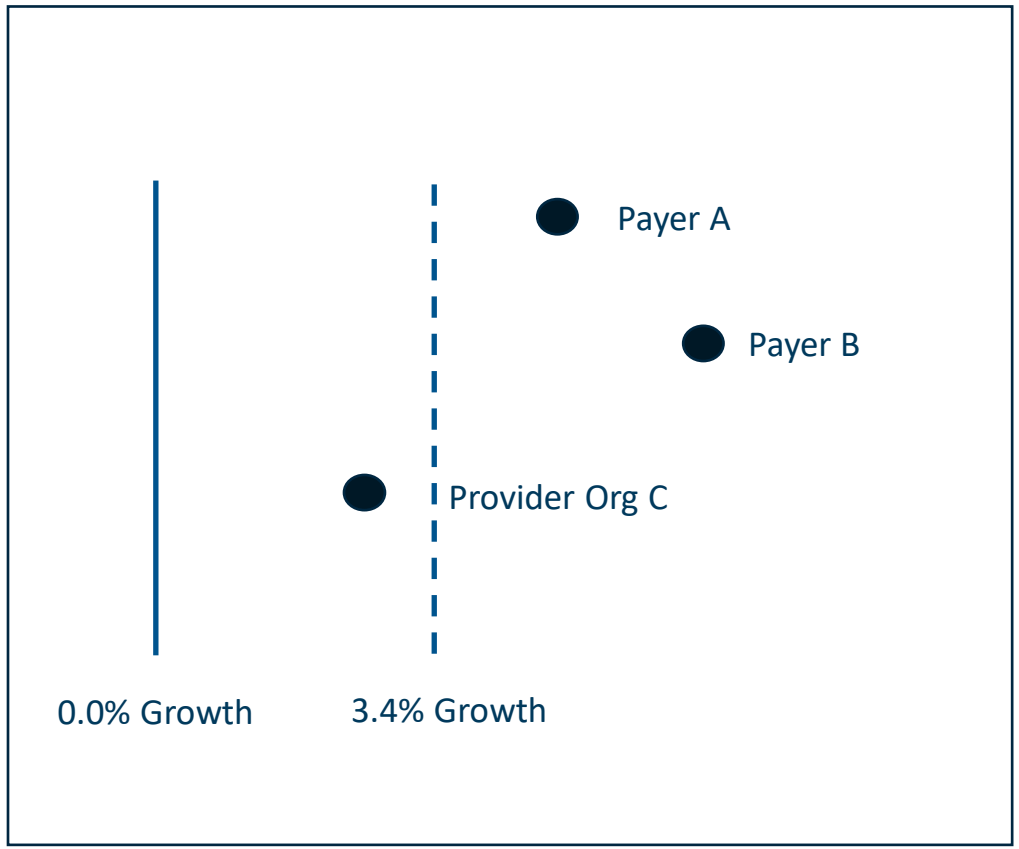
Minimum Attributed Lives for Public Reporting of **Provider Performance** in Other States

State	Minimum Attributed Lives for Public Reporting of Provider Performance
Delaware	By line of business, provider entities that have: • At least 10,000 attributed commercial or Medicaid lives • At least 5,000 attributed Medicare lives
Massachusetts	There is no published standard for public reporting, but the state set a minimum threshold for payer reporting to the state at 3,600 attributed lives
Oregon	Across all markets, provider entities must have at least 10,000 attributed lives
Rhode Island	By line of business, provider entities that have: • At least 10,000 attributed commercial or Medicaid lives • At least 5,000 attributed Medicare lives

Options for Determining Payer and Provider Performance Against the Cost Growth Benchmark

- **Option 1:** Compare payer and provider performance to the cost growth benchmark.
- **Option 2:** Develop an upper and lower bound around payer and provider performance, and compare that range to the cost growth benchmark.
- **Option 3:** Develop an upper and lower bound around the cost growth benchmark and compare payer and provider performance to that range.

Option 1: Compare Payer and Provider Performance to the Cost Growth Benchmark



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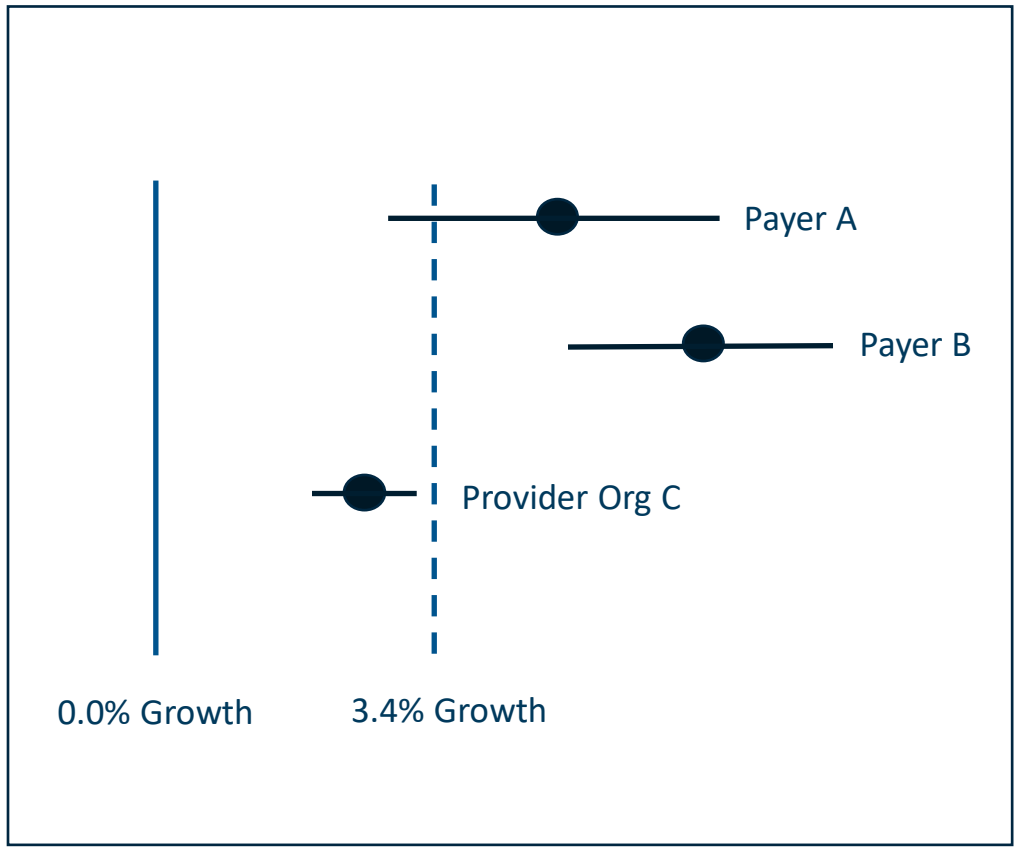
Performance against the benchmark would be determined as follows:

- Benchmark has been achieved when measured performance is at or below the benchmark value.
- Benchmark has not been achieved when measured performance is above the benchmark value.

Option 2: Develop an Upper and Lower Bound Around Payer and Provider Performance



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Performance against the benchmark would be determined as follows:

- Benchmark has been achieved when the upper bound is fully below the benchmark
- Unable to determine performance when upper or lower bound intersects the benchmark
- Benchmark has not been achieved when lower bound is fully over the benchmark

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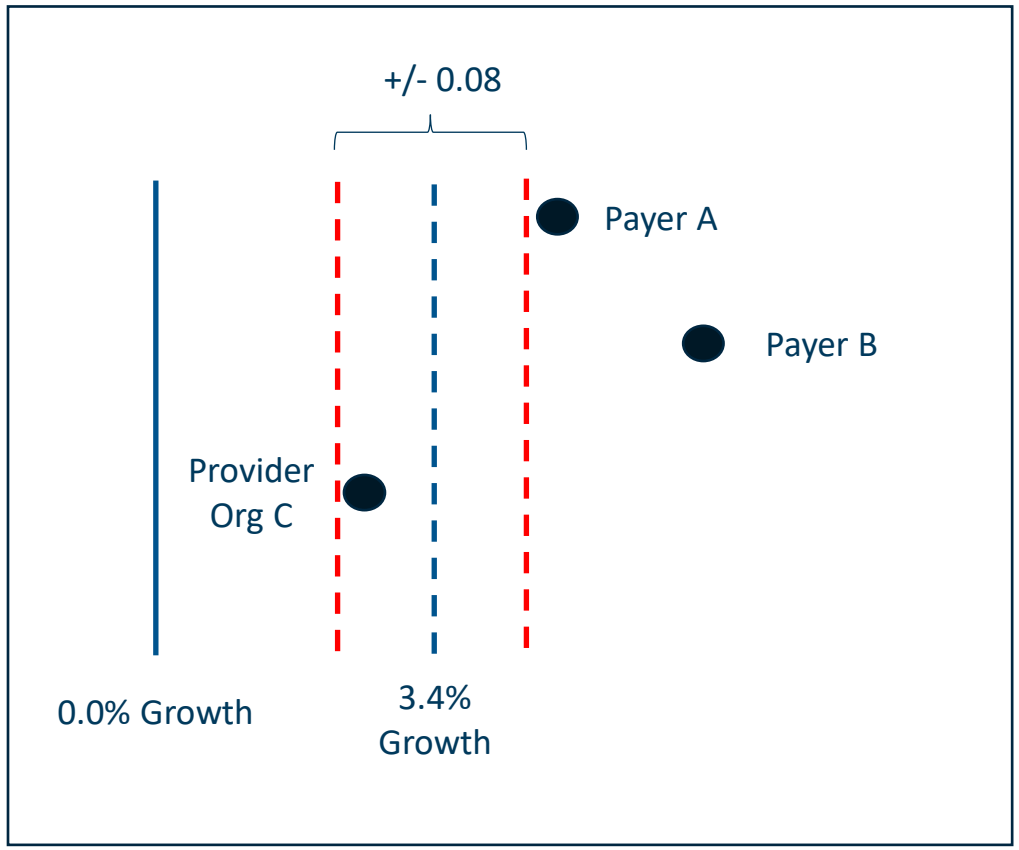
What the Confidence Interval Tells Us

- An upper and lower bound – or "confidence interval" – is a type of estimate in statistics that shows a possible **range of values** in which we are fairly sure our **true value** lies.
- In practice, it allows us to make the following statement:
  - *We are XX% confident that the interval between A [lower bound] and B [upper bound] contains the true cost growth for entity C.*
- The confidence interval is influenced by the confidence level, the number of cases or observations, and the spread of costs associated with those cases.

Option 3: Develop and Upper and Lower Bound Around the Cost Growth Benchmark



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Performance against the benchmark would be determined as follows:

- Benchmark has been achieved when measured performance is below the benchmark value's lower bound.
- Unable to determine when measured performance is within the benchmark value's lower and upper bound bounds.
- Benchmark has not been achieved when measured performance is above the benchmark value's upper bound.

Comparison of Three Options for Determining Performance Against the Benchmark

Option	Advantages	Disadvantages
1) **Compare Payer and Provider Performance to Benchmark Value**	• Does not require additional data collection or analysis. • Methodology is understandable to the general public.	• Not statistically rigorous and could produce inaccurate findings.
2) **Develop Upper and Lower Bound Around Payer and Provider Performance**	• Rigorous and provides a strong level of confidence around the determination of whether an entity has or has not met the benchmark.	• Requires additional data collection from payers. • Requires some additional OHS resources to calculate confidence intervals and conduct statistical significance testing. • Methodology may not be understandable to the general public.
3) **Develop Upper and Lower Bound Around the Cost Growth Benchmark**	• Does not require additional data collection. • Work to determine "confidence intervals" around the benchmark is minimal.	• While less risk than with Option #1 to produce inaccurate assessments, less accurate than Option #2.

What do the other states do?

- Oregon will use Option #2, developing an upper and lower bound (confidence interval) around payer and provider performance.
- All of the other states are using Option #1, making simple comparisons to the benchmark value.

Stakeholder Engagement Activities

Stakeholder Engagement in 2021

- In 2021, OHS is planning to continue with stakeholder engagement, with a focus on seeking the input of consumers – especially Black, Indigenous, and People of Color (BIPOC) communities.
- OHS will work with community and civic organizations to conduct educational events and gather input on the Healthcare Benchmark Initiative.
- OHS will continue to provide briefings to legislators, MAPOC, hospitals, payers, providers, employers, and other stakeholders.
- OHS will engage stakeholders in examining factors that are driving healthcare cost growth in order to inform strategies that will support the success of Connecticut's Healthcare Benchmark Initiative.

Peterson-Milbank Program for Sustainable Health Costs

Additional Updates

CT has begun receiving technical assistance as a participant in the Peterson-Milbank Program for Sustainable Health Costs.

- This will provide two years of funding and technical assistance.
- So far, Oregon is the other state accepted into the program. Up to three additional participating states will be accepted in the next month.

Wrap-Up & Next Steps

Next Steps

- OHS has scheduled monthly meetings of the Technical Team for January through June.
  - The next Technical Team meeting takes place February 25th.
- Meetings of the Stakeholder Advisory Board are scheduled for every-other-month for February through June.
  - The next Board meeting takes place February 10th.
- Advisory body meetings will continue throughout 2021.


THANK
YOU