CONNECTICUT HOSPITAL ASSOCIATION

October 15, 2020

Victoria Veltri
Executive Director
Connecticut Office of Health Strategy
P.O. Box 340308
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Hartford, CT 06134

Dear Ms. Veltri,

On behalf of the Connecticut Hospital Association (CHA) please accept the below comments to the Office of Health Strategy's (OHS) Preliminary Recommendations of the Healthcare Cost Growth Benchmark (CGB) Technical Team (Preliminary Recommendations). We appreciate the opportunity to comment on the Preliminary Recommendations and look forward to continuing to work with your office as it continues to implement the requirements of Executive Order No. 5 (EO 5).

CHA is committed to sustaining and improving access to high quality healthcare services for all patients throughout our state. We appreciate that affordability is central to that commitment and as such, we believe that statewide coalescence around a more sustainable growth rate for healthcare expenditures can be an important opportunity to alter the trajectory of healthcare spending in our state.

This work should be undertaken in a collaborative spirit and CHA and its member hospitals are committed to working with the state on the implementation of EO 5 and any future implementing legislation. More specifically, CHA will use the following principles to guide its work on the process for development and implementation of the cost growth benchmarks:

- Preserve and expand access to care
- Memorialize robust stakeholder participation and full transparency in the development of the benchmarks and subsequent periods of evaluation
- Develop spending targets that appropriately reflect and promote healthcare's important role in the state's economy
- Implement a non-punitive assessment and evaluation process
- Define the parameters by which measurement of performance against the benchmark will be determined, including what costs will be excepted
    - Excepted costs should include state spending agreements (i.e., Medicaid rate increases); exceptional circumstances (i.e., public health emergency, novel therapies,

pharmaceutical price increases, financial recovery); and costs not within a provider's control

- Allow for exceptional activities (i.e., service-line expansion)
- Provide that all healthcare spending (physician, hospital, long-term care, pharmaceutical, device, payer, government, etc.) is captured in the benchmark calculation
- Include appropriate adjustment factors (i.e., risk adjustment)
- Accommodate alternative payment models (i.e., risk contracts, shared savings arrangements, etc.)
- Ensure appropriate access to and protections for data and information submitted and used for benchmark purposes

Specific to the Preliminary Recommendations, we offer the following comments.

## Healthcare Cost Growth Benchmark

Annual Spending Target

In setting the annual spending targets, it is imperative that they appropriately reflect and promote healthcare's important role in the state's economy. The state's hospitals and health systems directly employ over 100,000, with more than 200,000 jobs in our state tied to the same.

As the nation and our state dig out of a severe economic downturn, the healthcare sector is going to be an essential part of that recovery.

Unfortunately, the recommendation of the Technical Team undervalues this important role. The recommended benchmark ratio of 80 percent median household income to 20 percent potential gross state product (PGSP) does not appropriately value the healthcare sector's importance to the economy and puts our state's economic recovery at risk. It also dramatically diverges from our neighboring states, Massachusetts and Rhode Island, which have implemented targets successfully and pegged their target rates to PGSP.

The target rate that results from the use of the benchmark ratio, 2.9 percent, is inappropriately low. Only after manual adjustment of the target rates in 2021 (3.4 percent) and 2022 (3.1 percent) do the rates come in closer alignment to an appropriate target rate – one that should be derived from a ratio set at 90 percent PGSP and 10 percent median household income. However, the rates recommended for 2023, 2024, and 2025 (2.9 percent) benefit from no such adjustment and fall well short of being appropriate.

**We recommend that OHS reject the benchmark targets presented in the Preliminary Recommendations and instead adopt target rates derived from a ratio set at 90 percent PGSP and 10 percent median household income.**

Performance Measurement

The Preliminary Recommendations offer only a cursory review of how performance against the benchmark should be implemented. Important details, which we detail below, are left to OHS to determine and implement. We believe further opportunity to comment on these yet-to-be-determined details is essential.

We do note, however, that there is no recommendation that the pharmaceutical industry and its impact on spending be measured as part of implementing the CGB. This is despite the overwhelming influence of drug price increases on healthcare expenditures over the last few years.

For example, according to an American Hospital Association study, *Recent Trends in Hospital Drug Spending and Manufacturer Shortages,* published in January 2019, outpatient drug spending per adjusted admission increased 28.7 percent between fiscal years 2015 and 2017 while inpatient drug spending per admission increased by 9.6 percent during the same period.

Despite its considerable influence on overall healthcare spending, as currently contemplated, the CGB has no direct mechanism for measuring drug spending as a factor in overall spending. **It is a significant deficiency that we believe should be addressed if the CGB is to provide a comprehensive examination of the state's healthcare spending landscape.**

COVID-19

As was described in our June letter to the Governor, since the time the Governor signed EO 5 in January, the COVID-19 pandemic has markedly changed the state's healthcare landscape. Among the pandemic's most profound effects has been a marked reduction in access to and use of medically necessary healthcare services, of all types and in all settings, with consequences for the public's health that are not yet fully understood.

Given these circumstances, it is essential for OHS to specifically outline how it will address the consequences of COVID-19 in its implementation of the benchmark – a critical issue that has not been given appropriate public consideration to this point.

The work to develop and implement the benchmark cannot be completed in a vacuum. Circumstances must inform and impact the process as currently conceived. Of those states that have already created and implemented cost growth benchmarks, it is fair to say that none of them attempted to do so in the midst of an once-in-a-lifetime global health pandemic. We know from our member hospitals and health systems that COVID-19 has created an uncertain and confusing utilization outlook as hospitals and health systems essentially closed their doors to non-urgent services and the public began to avoid necessary care for acute and chronic conditions. Hospitals have seen an increase in the volume of services; however, the outlook remains uncertain with respect to when the use of necessary services will be fully restored.

As we have seen in other states, cost growth benchmarks are designed to be durable enough to accommodate unpredictable, one-time spending irregularities. However, that durability is built off a well-understood and data-backed cost and utilization base period.

**It is incumbent, therefore, that as Connecticut's process for building the benchmark continues, there is explicit instruction to detail the steps that will be taken to account for the anomalous situation that COVID-19 has created, seek stakeholder feedback on those steps, and incorporate them into the final product.**

Implementation

We appreciate OHS's work to include stakeholders in the implementation of EO 5, including the inclusion of hospital and health system representatives on the Stakeholder Advisory Board. In keeping with an open and transparent process, we encourage OHS to take further steps to obtain additional public comment and feedback, most specifically as it develops implementation guidance. The opportunity to provide comment on the details related to how OHS will implement and measure the CBG is paramount to its long-term success. **As such, merely issuing an implementation manual, as is contemplated in the Preliminary Recommendations, without an opportunity to review and comment, is not sufficient to ensure a successful implementation of the program.**

There are a number of critical, outstanding questions that deserve public review, scrutiny and comment. Among those that deserve additional specificity:

- Implementation of the assessment and evaluation process,
- Defining the parameters, including excepted spending, by which measurement of performance against the benchmark will be determined, and
- Appropriate protections for data and information submitted and used for benchmark purposes.

## Primary Care Spending Targets

Definition of Primary Care Spending

EO 5 requires ten percent of total spending to be attributed to primary care by 2025. OHS sets forth a central aim of using the increased investment to promote **advanced primary care**. If the definition adopted for the purpose of meeting the target does not include the components of advanced primary care, payers will focus on investments that fall within a more narrow definition. Conversely, **payers may reduce investments** in advanced primary care outside of the scope of the narrow definition because they get no credit for making such investments relative to the target.

The narrow definition is at odds with the National Alliance of Healthcare Purchaser Coalitions, which OHS cites as a point of reference. This definition is also at odds with the recommendations of the Patient Centered Primary Care Collaborative, and the recommendations of OHS's own Practice Transformation Task Force in support of primary care modernization.

Unfortunately, the Preliminary Recommendations appear to take an overly narrow view of the types of providers and services that should be counted for purposes of meeting the target, especially community health workers and other the individuals that enable the provision of team-based care. **At a minimum, the definition should include integrated behavioral health, which is widely viewed as an essential element of advanced primary care by the National Alliance of Healthcare Purchaser Coalitions, Patient Centered Primary Care Collaborative, and the OHS Practice Transformation Task Force.**

The use of a definition consistent with the above recommendations will spur investments in advanced primary care that are aligned with this definition and it will enable better quality care, better healthcare outcomes, and reductions in avoidable use and associated costs.

Measuring Attainment of Target

As was discussed at length during discussion at the Stakeholder Advisory Board, how and where many Connecticut residents receive their primary care is instructive to how attainment of the target is measured in the future.

Connecticut continues to suffer from a lack of primary care providers. This scarcity, however, is not evenly experienced. Our state's low-income residents often find it more difficult to find a regular source of primary care. The uneven access results in use of the hospital emergency department or urgent care clinics for irregular primary care access. **As the Preliminary Recommendations do not recognize these primary care services towards attainment of the target, it is important that OHS consider attainment to the 10 percent goal at various levels – including how communities without sufficient access today, see improved access between now and 2025.**

Annual Targets

The Preliminary Recommendations devotes considerable attention to the number of difficulties in setting a primary care spending target for 2021. Given the considerable work left to be done in this area, including, finalizing the definitions of primary care provider and primary care services, collecting and analyzing data for purposes of setting a primary care spending baseline, and determining how attainment of targets will be measured, we recommend that no target be set for 2021.

**Instead, OHS should continue the process for finalizing these important details with an eye to setting a more carefully crafted target for 2022. Declining to set an annual target for 2021, will likely have no impact on the larger goal of attaining primary care spending of 10 percent of all spending by 2025.**

## Data Strategy/Data Transparency

Data transparency is essential to the credibility of the implementation of the CGB. **We strongly urge OHS to provide stakeholders with access to the data being used to apply the benchmark *and* implement the OHS Data Strategy.**

The opportunity to replicate and cross-validate OHS findings will enhance the collaborative approach that OHS seeks and will provide important transparency into the process. Moreover, stakeholder led analyses will enhance the value of the overall effort by substantially broadening the scope of analyses that may be undertaken and the insights that may be drawn by independent analysts with unique and experience informed perspectives.

**General Comment**

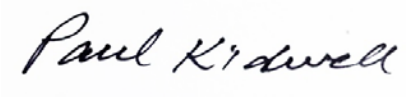
As we noted earlier, healthcare affordability is central to the state's interest in implementing the CGB. We share the desire to ensure that all our state's residents have access to the healthcare services they need, when they need them. It is with this in mind that we note the benefits of the CGB for patients will only go so far.

While a critical review of spending is valuable, equally valuable is a review of the roadblocks patients experience in accessing care – including insurance designs, such as high-deductible health plans, which may put needed care out of reach.

We look forward to remaining engaged in the process to implement the CGB but more broadly in the ongoing work of improving access to healthcare for our patients. We appreciate the opportunity to comment on the Preliminary Recommendations, and look forward to additional opportunities to provide comment on CGB implementation guidance.

Thank you for your consideration.

Sincerely,



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