Preliminary Recommendations of the Healthcare Cost Growth Benchmark Technical Team

Connecticut Office of Health Strategy

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Executive Summary

On January 22, 2020, Governor Lamont signed Executive Order 5, directing the establishment of a statewide healthcare cost growth benchmark. With the goal of slowing the growth of healthcare spending and making healthcare more affordable for the citizens of Connecticut, Executive Order 5 directs the Office of Health Strategy (OHS) to develop annual healthcare cost growth benchmarks for calendar years (CY) 2021-2025. Once implemented, Connecticut will be the fifth state to have a statewide healthcare cost growth benchmark, joining Massachusetts, Rhode Island, Delaware and Oregon.

Executive Order 5 also requires OHS to implement several additional, related initiatives, including:

- setting targets for increased primary care spending as a percentage of total healthcare spending to reach 10 percent by 2025;
- developing quality benchmarks across all public and private payers beginning in 2022, potentially including clinical quality measures, over- and under-utilization measures, and patient safety measures;
- monitoring and reporting annually on healthcare spending growth across public and private payers, and
- monitoring accountable care organizations and the adoption of alternative payment models.

OHS launched its work on these initiatives in Spring 2020 with the support key deliberating bodies, with the primary advisory body to OHS being the Technical Team. OHS charged the Technical Team with recommending annual cost growth benchmarks across all payers and populations for CYs 2021-2025, and with advising OHS on the best methods for establishing the benchmarks. In so doing, the Technical Team leveraged efforts and learnings of states with existing cost growth benchmarks – notably Massachusetts, Delaware and Rhode Island – and adapted these states' approaches to the Connecticut healthcare landscape. OHS also charged the Technical Team with recommending primary care spending targets across all payers and populations as a share of total healthcare expenditures for CYs 2021-2025, in order to reach a target of 10 percent by 2025. The Technical Team then made preliminary recommendations for a data use strategy intended to produce routine analyses that pinpoint leading opportunities to reduce healthcare spending and healthcare spending growth in a manner that will not harm patients, as well as analyses to assess the benchmark's impact.

Lastly, OHS asked that the Technical Team consider its deliberations and recommendations through the prism of health equity. The Technical Team met 11 times between March and September 2020.

A second advisory body, the Stakeholder Advisory Board, provided input to the Technical Team on the development of the cost growth benchmark and primary care target, as well as the data use strategy. The Board represented a broad group of interested stakeholders, including consumers, consumer advocates, providers, insurers, labor leaders and employer purchasers.

The Stakeholder Advisory Board met six times between May and September 2020, its meetings sequenced so as to provide input to the Technical Team at key decision points.

In fall 2020, OHS will reconvene the Quality Council to begin the process of developing recommendations on quality benchmarks across all public and private payers beginning in Calendar Year 2022. The timing will support alignment with activities specified by Executive Order 6.

This report reflects the results of seven months of research, study and thoughtful deliberation. The recommendations contained herein are considered preliminary; OHS anticipates a subsequent hearing at which time additional input will be gathered on the recommendations. The following paragraphs provide a brief description of the preliminary recommendations, which are described in greater detail in the body of this report.

A. Healthcare Cost Growth Benchmark

The healthcare cost growth benchmark is a targeted annual growth rate that payers, providers and the State should endeavor to stay below. Consistent with the Technical Team's guidance and with input from the Stakeholder Advisory Board, **the benchmark should be based on a calculated and pre-determined blend of the growth in the forecasted per capita potential gross state product (PGSP), and the growth in median income**. This blended benchmark reflects the desire of the Technical Team that healthcare should not grow faster than a forecasted measure of state economic growth *and* that also recognizes the challenges facing Connecticut residents as healthcare costs consume ever greater portions of their income. Recognizing that a benchmark of 2.9 percent may for multiple reasons be difficult for the State, payers and providers to achieve initially, the Technical Team recommended an upward adjustment during the first two years of implementation. Using the blended methodology and the recommended add-on factors during the first two years results in a benchmark value of **3.4 percent for Calendar Year 2021, 3.1 percent for CY 2022, and 2.9 percent for Calendar Years 2023, 2024, and 2025**. The Technical Team also recommended that the methodology and calculation be revisited in the event of a sharp rise in inflation during these years.

B. Primary Care Spending Target

The primary care spending target aims to strengthen Connecticut's primary healthcare services system by establishing a goal for increasing statewide primary care spending as a percentage of total health care expenditures; the target reaches 10 percent by Calendar Year 2025. Research has demonstrated that greater relative investment in primary care leads to better patient outcomes, lower costs, and improved patient experience of care. Like most of the country, Connecticut's healthcare system is largely specialist-oriented. This target is intended to rebalance and strengthen the State's healthcare system by supporting improved primary care delivery. Rhode Island and Oregon have undertaken similar efforts to strengthen primary care delivery, using regulatory and statutory authority to require select payers to increase the percentage of medical spending allocated to primary care. Connecticut's primary care spend target builds upon concurrent work undertaken by the State to measure primary care spending using a consistent methodology in collaboration with other New England states. The Technical

Team noted several challenges to setting a primary care spending target in 2020 given the lack of payer-reported baseline data, shifts in utilization as a result of COVID-19, and the short time frame for payers to achieve increases in primary care spending in 2021. **As a result, the Technical Team supported OHS' recommendation for a conservative target of 5.0 percent for 2021, given the current best estimate of statewide spending on primary care of 4.8 percent.** Moving forward, OHS will develop recommendations with a primary care-focused work group in order to make recommendations for annual primary care spending targets for 2022-2024. As it does so, OHS will consider the guidance offered by the Technical Team during its deliberations for how payers should increase primary care spending.

C. Data Use Strategy

The Governor's Executive Order 5 calls upon OHS to monitor and report "annually on healthcare spending growth across public and private payers." OHS uses the term "data use strategy" to refer to its plan to purposefully leverage state data in order to achieve these objectives. **The technical team recommended that OHS use the State's All-Payer Claims Database (APCD), and other data sources to make sure the aims of the Executive Order are achieved.** By analyzing data, OHS can identify which spending categories warrant greatest attention for "moving the needle" on the cost growth benchmark. **The Technical Team tentatively prioritized the following types of analyses for OHS to perform as part of its data use strategy**:

1) analyses that identify the leading factors contributing to year-over-year health care cost growth (e.g., changes in utilization, price, service mix/intensity, patient demographics);

2) analyses that examine which cost drivers most contribute to total cost of care at a point in time (e.g., specific services, provider types, providers, medical conditions); and

3) analyses of the effects of the cost growth benchmark, including any unintended consequences that may arise from its implementation.

The Technical Team further emphasized the importance of assessing the benchmark's impact on consumer out-of-pocket spending, noting that the cost growth benchmark will not be wholly successful if consumer spending due to deductibles and co-insurance grows faster than the benchmark. Finally, the Technical Team encouraged OHS to ensure transparency of data and reports for consumers on its website, support consumers in using those reports, and pursue continued consumer engagement in general for all Executive Order 5-related activity.

D. Conclusion

For many Connecticut residents, healthcare has become unaffordable. With implementation of Executive Order 5, OHS is charged with taking a broad approach to rein in healthcare cost growth by establishing a statewide healthcare cost growth benchmark, and ensuring the state prioritizes primary care spending while also establishing statewide quality benchmark measures. There is evidence that cost growth benchmarks and primary care spend targets have had desired impact in other states. With the guidance of its key advisory bodies, OHS is positioned to move forward with implementation of the Executive Order 5 initiatives in

Connecticut to control the rate of cost growth and promote better healthcare quality for all residents.

Background

Connecticut faces an urgent need to slow the growth in healthcare costs. The historical growth rate in healthcare costs in the State is unsustainable, with Connecticut being in the top tier of healthcare spending nationally.[1] In 2014, Connecticut's per capita spending on personal health care was $9,859 – the fifth highest in the nation, outpaced only by Vermont, Delaware, Massachusetts and Alaska. Over the last two decades, annual healthcare spending in Connecticut grew at more than twice the rate of growth in median household income (4.8 percent versus 2.0 percent).[2] Consequently, healthcare has become unaffordable to many Connecticut residents. Since 2000, employer-sponsored insurance premiums in Connecticut have grown two and a half times faster than personal income.

Connecticut's high growth in healthcare costs has numerous harsh effects on healthcare consumers, leading them to delay or avoid necessary care, and defer essential non-healthcare needs. These effects of Connecticut's high healthcare costs are felt by all Connecticut residents, but especially those with low and modest wages. Connecticut has a higher household income distribution inequality than most other states, falling behind only Puerto Rico, the District of Columbia and New York when measuring household income distribution inequality by looking at average income wages across the State. COVID-19 has heightened the strain of cost growth.

To address rising healthcare costs, on January 22, 2020 Governor Lamont signed Executive Order 5 to establish a statewide healthcare cost growth benchmark. The Executive Order directs the Office of Health Strategy (OHS) to develop annual healthcare cost growth benchmarks for calendar years (CY) 2021-2025, and to implement several additional, related initiatives, including:

- setting targets for increased primary care spending as a percentage of total healthcare spending to reach 10 percent by 2025;
- developing quality benchmarks across all public and private payers beginning in 2022, potentially including clinical quality measures, over- and under-utilization measures, and patient safety measures;
- monitoring and reporting annually on healthcare spending growth across public and private payers, and
- monitoring accountable care organizations and the adoption of alternative payment models.

Taken together, these initiatives are meant to slow the growth in healthcare costs in Connecticut while also promoting primary care and strengthening quality of care.

[1]Personal health care spending, per capita, by state. Centers for Medicare and Medicaid Services, State Health Expenditure Accounts, 2014.
[2] Medical Expenditure Survey, Tables D.1 and D.2 for various years.

By establishing a healthcare cost growth benchmark, Connecticut aims to constrain and reduce the dramatic growth in healthcare costs that it has experienced in recent years. Four other states have established cost growth benchmark programs similar to what Connecticut is developing: Massachusetts, Delaware, Rhode Island and Oregon. Each has done so for similar reasons as Connecticut: healthcare is unaffordable for the State and for consumers.

Massachusetts, which has the longest experience of the four states, found that from 2012 to 2018, annual healthcare spending growth averaged 3.38 percent below the state benchmark, and commercial spending growth in Massachusetts has been below the national rate every year since 2013. At the same time, there is no evidence of reduced service use in Massachusetts as a result of benchmark implementation. Since the benchmark has been in place in Massachusetts, inpatient admissions, hospital outpatient visits and emergency department visit have been largely unchanged. Connecticut's implementation of a cost growth benchmark aims to achieve similar results. As in the other four states, the benchmark is not a cap.

Strengthening the State's primary care system can have a notable impact on both healthcare quality and spending. The U.S. healthcare system is largely specialist-oriented. Research has demonstrated that greater relative investment in primary care leads to lower costs, better patient outcomes and improved patient experience of care. States, such as Oregon and Rhode Island, have elected to use primary care to strengthen their healthcare systems by supporting improved primary care delivery (e.g., expanding the primary care team, supporting advanced primary care) and increasing the percentage of total spending allocated towards primary care.

The Governor's charge to increase primary care spending in Connecticut builds upon prior work in Connecticut to strengthen the primary care infrastructure. Previously, OHS convened the Practice Transformation Task Force, which developed advanced medical home standards, provided advice on practice processes, and fostered alignment with other care delivery models in the state. Setting a primary care spending target can help the State not only increase the percentage of total healthcare spending allocated towards primary care, but also provide valuable data on this foundation component of Connecticut's healthcare system.

The Governor's Executive Order also charges OHS to develop quality benchmarks that will apply to all public and private payers beginning in January 2022. Quality benchmarks are annual targets or measures that all public and private payers, providers and the State must work to achieve to improve healthcare quality in the State. They are meant to ensure the maintenance and improvement of healthcare quality as the State implements the cost growth benchmark and the primary care spending target. Connecticut will be the second state to establish statewide quality benchmarks; Delaware has eight quality measures for which it adopted benchmarks in 2019. Quality benchmarks may include clinical quality, utilization, and safety measures. OHS' Quality Council will address the development of a standard set of quality measures for benchmarking purposes beginning in fall 2020. Doing so will allow for the Quality Council to have enough time to make recommendations before implementation for CY 2022 and allow alignment with implementation of Executive Order 6. Several stakeholders expressed disappointment with delaying the start to 2022.

Process for Making Preliminary Recommendations

OHS began work on the benchmark in Spring 2020 with the support of two appointed advisory bodies, the Technical Team and the Stakeholder Advisory Board. The Technical Team serves as OHS' primary advisory body and includes a mix of state agency executives and external experts who directly engage with OHS on key design and implementation considerations. Meetings of the Technical Team were facilitated by consulting experts from Bailit Health. Appendix A provides a list of Technical Team members and the Team's meeting schedule between March and September 2020. Opportunity for public comment was available at all 11 meetings.

The Technical Team focused on three of OHS' tasks under Executive Order 5:

1. recommending annual cost growth benchmarks across all payers and populations for CYs 2021-2025 by building upon work already undertaken in Connecticut and adapting approaches used by other states;
2. recommending primary care spending targets across all payers and populations as a share of total healthcare expenditures for CYs 2021-2025, to reach a target of 10 percent by 2025, and
3. monitoring and reporting annually on healthcare cost growth across public and private payers.

The Stakeholder Advisory Board provided input and feedback to the Technical Team on the development of the annual healthcare cost growth benchmarks, and the primary care target. Stakeholder Advisory Board members represent a cross-section of the Connecticut healthcare landscape, and include consumers, consumer advocates, providers, employer purchasers, labor leaders and insurers. The Stakeholder Advisory Board met monthly during the same time period as the Technical Team. Appendix B provides a list of Stakeholder Advisory Board members and the Board's meeting schedule.

OHS shared Board input from each of the Stakeholder Advisory Board's meetings with the Technical Team. OHS sequenced the meetings of these two advisory groups so that the Stakeholder Advisory Board provided feedback to the Technical Team on each of its preliminary recommendations, and the Technical Team considered that feedback. As a result of this process, the Technical Team revised its recommendations on numerous occasions.

In addition to obtaining input through the Stakeholder Advisory Board, OHS undertook a vigorous stakeholder engagement effort, more expansive than that used in the other four states. Throughout the spring and summer of 2020, OHS educated other State-convened bodies about the benchmark and target work, and solicited their questions and recommendations. These entities included the OHS Consumer Advisory Council, the Connecticut Health Care Cabinet, the Practice Transformation Task Force, and the Council on Medical Assistance Program Oversight Council ((MAPOC) and legislators. OHS also met with numerous community groups. Each of these occasions provided opportunity for OHS to inform stakeholders on the development of the Executive Order 5 initiatives and gather input. Appendix C provides a list of stakeholder engagement events undertaken by OHS.

OHS is planning to charge the Quality Council to develop the quality benchmarks required by Executive Order 5 with support from OHS and DSS.

Cost Growth Benchmark – Preliminary Recommendations

Executive Order 5 defined the healthcare cost growth benchmark as the per capita sum of all healthcare expenditures in Connecticut from public and private sources for a given calendar year. This section details the preliminary recommendations for establishing the value of the healthcare cost growth benchmark, what spending to measure, and the process for obtaining data to assess performance.

A. Healthcare Cost Growth Benchmark Methodology

The Technical Team established three criteria for selecting an economic indicator that could be used to set a cost growth benchmark. The indicator must: (1) provide a stable and therefore predicable target; (2) rely on independent, objective sources with transparent calculations; and (3) should result in a benchmark value that lowers growth in healthcare spending for consumers, employers and taxpayers.

With input from the Stakeholder Advisory Board, the Technical Team made a preliminary recommendation to base the benchmark on a calculated and pre-determined blend of the **growth in the forecasted per capita potential gross state product (PGSP), and the forecasted growth in median income**, determined in advance of the performance period. The Technical Team wanted to acknowledge that healthcare should not grow faster than a forecasted measure of state economic growth, but recognized the challenges individuals and families experience as healthcare consumes greater portions of their income. Therefore, the Technical Team wanted to create a blended benchmark value that incorporated both of these concepts.

Table 1 below describes the weighted blend of PGSP and median income that the Technical Team preliminarily recommended. In addition, the Technical Team recognized that the weighted methodology's initial value of 2.9% may be difficult for the State's, payers and providers to meet immediately given typical contracting cycles and the effect of COVID-19 on healthcare utilization patterns, and therefore recommended a two-year adjustment to ease into the final target.

Table 1. Cost Growth Benchmark Methodology

Calendar Year	Cost Growth Benchmark Methodology	Add-on Factor
2021	20% PGSP / 80% Median Income	0.5%
2022	20% PGSP / 80% Median Income	0.3%
2023	20% PGSP / 80% Median Income	0.0%
2024	20% PGSP / 80% Median Income	0.0%
2025	20% PGSP / 80% Median Income	0.0%

To calculate the forecasted long-term (2026-2030) per capita PGSP, the Technical Team recommended using the same formula used by Massachusetts, Delaware and Rhode Island:

PGSP = *(expected growth in national labor force productivity + expected growth in the state's labor force + expected national inflation) – expected state population growth*

As calculated by OHS, the forecasted per capita PGSP for Connecticut is 3.7%.

To calculate the forecasted growth in median household income (2026-2030), the Technical Team recommended using the annual growth rate data purchased from IHS Markit by the Connecticut Office of Policy and Management and made available to OHS. The forecasted median household income growth in Connecticut was 2.7%.

Table 2 below presents the Technical Team's preliminary recommendations for the healthcare cost growth benchmark, using the blended formula of the two values listed in Table 1.

Table 2. Cost Growth Benchmark Values 2021-2025

Calendar Year	Cost Growth Benchmark Values
2021	3.4%
2022	3.1%
2023	2.9%
2024	2.9%
2025	2.9%

At least one member questioned starting the cost growth benchmark during the pandemic, but acknowledged the direction of the Executive Order. Finally, the Technical Team made a preliminary recommendation to revisit the healthcare cost growth benchmark's methodology and calculation should there be a sharp rise in inflation between 2021-2025.

B. Methodology for Measuring Healthcare Spending for the Cost Growth Target

Measuring the State's per capita spending on healthcare requires determining whose healthcare spending to measure, and what costs to include in that measurement.

The Technical Team's preliminary recommendation is to measure Total Health Care Expenditures (THCE), (i.e., what is subject to the target) which should be defined as:

(1) the allowed amount of claims-based spending from an insurer to a provider, net of pharmacy rebates;
(2) all patient cost-sharing amounts, including, but not limited to deductibles and copayments, and
(3) the Net Cost of Private Health Insurance (NCPHI).[3]

THCE should include spending on behalf of Connecticut residents who are insured by Medicare, Medicaid or commercial carriers, as well as residents who obtain coverage from self-insured employers, and receive care from any provider in or outside of Connecticut. Spending

[3] Net cost of private health insurance (NCPHI) captures the cost associated with the administration of private health insurance. It is the difference between health premiums earned and benefits incurred. It consists of insurers' costs related to: paying bills, advertising, sales commissions, other administrative costs, premium taxes and other fees. It also includes insurer profits and/or losses.

for out-of-state residents receiving care from in-state providers should be excluded from THCE. THCE should also include spending for Connecticut residents who receive healthcare coverage through the Veterans Health Administration or other military coverage, as well as spending for Connecticut residents incarcerated in a state correctional facility.

The Technical Team and Stakeholder Advisory Board expressed a preference for dental claims by dental insurance carriers to be included in THCE, but after deliberating on the limitations in available data, the lack of health care provider accountability for dental care, and dental insurance being quite limited, the Technical Team opted to exclude spending by dental insurance carriers at this time. The Technical Team expressed preference for revisiting the possibility of including dental claims when and if the data become available through the APCD.

Recognizing that the definition of THCE is limited to individuals with health insurance coverage and that financial burden of healthcare for those without health insurance is high, the Technical Team and Stakeholder Advisory Board requested that OHS conduct supplemental tracking and reporting of costs for uninsured individuals to the extent such data are available.

C. Process for Obtaining Data

Payers will need to submit data to OHS to measure healthcare spending against the benchmark at the State, market, payer and large provider level since payers are the only source for non-claims payments, health care spending for residents whose employers are self-insured, and pharmacy rebates.

To obtain THCE data, the Technical Team agreed that:

1) Payers that the Insurance Department lists on the Consumer Report Card on Health Insurance Carriers in Connecticut should be asked to submit data for their commercial and Medicare product lines,[4] including data from all wholly-owned subsidiaries. These data are intended to be collected using consistent specifications to be developed by OHS (and discussed in the Next Steps section of this report) and will allow for each payer to utilize its own clinical risk-adjustment software.
2) In addition, OHS will need to request Medicare fee-for-service claim payment data from the Centers for Medicare & Medicaid Services (CMS), and Medicaid payment data from the Department of Social Services (DSS).
3) OHS should use publicly available and regularly published data for spending on the Veteran's Health Administration.
4) Finally, OHS will need to request data from the Department of Correction (DOC) for healthcare spending in the State's correctional facilities.

The Technical Team expressed a desire to obtain data from pharmacy benefit managers (PBMs), to the extent possible, and requested that OHS consider how actual data on pharmacy spending

[4] Commercial payers include Aetna Health & Life, Anthem, Cigna, ConnectiCare, Harvard Pilgrim Health Care and UnitedHealthcare and all of the wholly-owned subsidiaries of those companies. Medicare payers, in addition to CMS, include Aetna, Anthem, ConnectiCare, UnitedHealthcare and all of the wholly-owned subsidiaries of those companies. Medicaid includes the Connecticut Department of Social Services.

(as opposed to pharmacy spending estimated by primary payers based on the experience of its membership with pharmacy coverage) and PBM pharmacy rebate data be provided by PBMs.

D. Process for Measuring Performance Against the Benchmark

The Technical Team recommended performance against the target be measured at the **state, payer, market, and large provider entity level**. The per capita change in spending from one calendar year to the next is intended to be publicly reported by OHS, along with contextual information that may highlight legitimate reasons spending was above or significantly below the benchmark (e.g., COVID-19 spending aberrations in 2020 and perhaps in 2021).

To measure and publicly report performance against the benchmark at the provider entity level, it is necessary for OHS to identify which large provider entities should report upon and how large those entities must be in order for their performance to be statistically valid. The Technical Team agreed with staff recommendations that until OHS develops its own provider directory in the Health Information Exchange (HIE), OHS should utilize the provider directory that is being maintained to support the web based HealthScore CT and Quality Scorecard. The Technical Team also agreed with staff suggestions that OHS leverage the empirical model that Oregon is simultaneously building to determine how many primary care patients a provider entity needs to care for, annually, for its performance to be publicly reported. If Oregon is unable to complete its analysis before OHS needs to develop its specifications, the Technical Team agreed with staff recommendations for OHS to continue the research. Further, the Technical Team suggested that OHS consult literature on this topic to inform its final decision.

In order to report on payer and provider performance against the cost growth benchmark, cost data will need to be **risk adjusted**. "Risk adjustment" is the modification of spending data to reflect changes in the health status of the underlying insurer or provider population over the course of the year. The Technical Team recommended that each commercial payer use its own clinical risk adjuster as this would be less administratively burdensome and costly for insurers and research suggests that performance between risk adjusters is relatively minimal. The Technical Team also recommended that commercial payers report which risk adjustment software they use and also its underlying methodology in order to support transparency and understanding.

While there is very limited experience with risk adjusting for social factors and the methodologies for doing so are nascent, the Technical Team, frustrated with current data limitations, strongly recommended that OHS gather social risk data and analyze the relationship between social risk variables and health care spending using APCD data to inform future social risk adjustment of cost growth relative to the cost growth benchmark. It also encouraged use of the State's Health Information Exchange as a potential future source for social risk factor data.

E. Process for Monitoring Unintended Consequences of the Cost Growth Benchmark

Technical Team and Stakeholder Advisory Board members raised concerns that a cost growth benchmark may cause providers to inappropriately reduce healthcare services provided to individuals to stay within the benchmark. While other states with cost growth benchmarks

have not documented such "stinting," the Technical Team made a preliminary recommendation to use DSS's PCMH+ Under-Service Utilization Monitoring Strategy as a starting point for identifying potential under-utilization or inappropriate reductions in access to medically necessary care. This strategy includes tracking preventive and access to care measures. Detection of under-service was also recommended for incorporation into the Data Use Strategy described below.

OHS will develop a set of recommended monitoring measures as part of its strategy for monitoring underservice. OHS intends to develop and share these measures with the Technical Team in October.

F. Implementation Timeline

After finalizing these preliminary recommendations, OHS intends to develop an implementation manual that details the healthcare cost growth benchmark methodology, how to obtain data, and data specifications for payers to facilitate consistent reporting. This is discussed in more detail in the Next Steps section of this report. Because data will be reported in aggregate form by payers, the analytic burden on OHS will not be great.

The healthcare cost growth benchmark is intended to start in 2021, which means the change in spending between calendar year 2020 and 2021 will be subject to the benchmark. It takes approximately six months for payers to finalize spending data from previous calendar years. Therefore, public reporting on calendar year 2021 performance will likely not occur until early 2023 to allow OHS enough time to collect, validate and analyze the data. The Technical Team anticipated that 2020 and 2021 spending will likely be significantly impacted by COVID-19. Therefore, the Technical Team made a recommendation to collect baseline data for 2018 and 2019 to identify healthcare spending trends before the pandemic.

Primary Care Spending Target – Preliminary Recommendations

Executive Order 5 specified that by 2025 primary care spending in Connecticut, as a percentage of total health care expenditures, should reach a target of 10 percent. This section describes the preliminary recommendations for how to define primary care spending, obtain data to assess performance, set annual targets to reach 10 percent, analyze primary care spending data, and parameters for how to increase primary care spending.

A. Definition of Primary Care Spending

To reach the 10 percent target for primary care spending, the Technical Team first needed to establish a definition of "primary care spending." The Technical Team expressed interest in measuring primary care spending for measurement against the target established in Executive Order 5, and in assessing primary care spending more comprehensively. For this reason, the Technical Team's preliminarily recommendation was to adopt two definitions of primary care providers and services – a narrow definition and a broader definition. These are described in Tables 3 and 4 below, respectively. The definitions are loosely based off a definition developed by the New England States Consortium Systems Organization (NESCSO), with the addition of

providers and service categories that were of importance to the Technical Team (e.g., OB/GYN and midwifery, pediatric dental risk assessments).

Table 3. Proposed Definitions of Primary Care Providers

	Proposed Definition 1: Narrow	**Proposed Definition 2: Broad**
<u>Included</u> Providers (in outpatient settings[5])	• **MDs and DOs**: 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 and DOs**: 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
<u>Excluded</u> Providers (among others)	• OB/GYN and midwifery • Behavioral health • Emergency room physician • Naturopathic health care provider	• Behavioral health • Emergency room physician • Naturopathic health care provider

Table 4. Proposed Definitions of Primary Care Services

	Proposed Definition 1: Narrow	**Proposed Definition 2: Broad**
<u>Included</u> 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 • Preventive dental care and fluoride varnish • Pediatric dental risk assessments • Home visits for newborns • Routine, non-specialty gyn. services, *if performed by a PCP*	• 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 • Preventive dental care and fluoride varnish • Pediatric dental risk assessments • Home visits for newborns • Routine, non-specialty gyn. services, *if performed by a PCP*

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

	Proposed Definition 1: Narrow	Proposed Definition 2: Broad
		• Routine primary care and non-specialty gynecological. services delivered by OB/GYNs and midwifery
Excluded Services	• Routine primary care and non-specialty gynecological services delivered by OB/GYNs and midwifery • 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

The Technical Team specified that payers should calculate service-based payments, as described above, on an allowed claims basis because it captures total spending on services. Non-service-based payments should include the following categories that NESCSO identified: care management, Patient-Centered Medical Home (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).

Finally, to calculate primary care spending as a percentage of total healthcare expenditures, the Technical Team had to define "total healthcare expenditures." The Technical Team preliminarily recommended aligning the definition of total healthcare expenditures for the primary care spending target with definition used for the cost growth benchmark. It recommended excluding long-term care services, however, because this spending category primarily applies to Medicaid. Excluding long-term care services facilitates better comparisons of primary care spending across commercial, Medicaid and Medicare markets.

B. Process for Obtaining Data

To facilitate alignment with the cost growth benchmark, the Technical Team preliminarily recommended that payers self-report primary care spending data for in-state residents and all providers, along with its cost growth benchmark data submission. As mentioned above, this is because payers are the only source of non-claims payment, self-insured data and pharmacy rebates. The Technical Team recommended that OHS collect data for commercial, Medicaid and Medicare payers in addition to the Veteran's Health Administration and Department of Corrections (DOC). CMS, however, has indicated it does not have the resources to report primary care spending with the cost growth benchmark data. Therefore, OHS may need to release two primary care spending calculations – an initial one excluding Medicare and a later one using Medicare data from the State's All-Payer Claims Database (APCD). OHS continues to explore whether it will be possible to obtain primary care spending data from the Veteran's Health Administration and DOC, as recommended by the Technical Team.

C. Process for Setting Annual Targets

The Executive Order directed the development of a process to calculate statewide spending and set annual targets to achieve the 10 percent target by 2025. The Technical Team recommended calculating statewide spending on primary care by weighting individual insurance markets by total health care expenditures. The Technical Team noted challenges to setting annual targets in 2020 because of the lack of payer-reported baseline data, utilization changes occurring due to COVID-19, and the proximity of the 2021 measurement period limiting payer actions to increase primary care spending in 2021. The Technical Team recommended setting a conservative target of 5.0 percent for 2021, given the current best estimate of statewide spending on primary care was 4.8 percent.[6] The Technical Team also recommended that annual targets for 2022–2024 be set after baseline spending data has been collected from payers and an anticipated OHS-convened, primary care-focused work group considers recommendations that may impact primary care spending. The Technical Team also recommended that OHS report performance against the primary care spending targets at the state, insurance market, insurer, and large provider entity.

D. Analyzing Primary Care Spending Data

The Technical Team highlighted the importance of stratifying primary care spending data to understand current spending trends and identify opportunities for improvement. The future analyses included stratifying by provider/ACO, race/ethnicity, gender, multiple comorbidities, modality (e.g., telehealth, in-person visits) and payment model (e.g., fee-for-service or alternative payment model). These analyses can also help measure any unintended consequences that arise from the primary care spending target.

E. Parameters for How to Increase Primary Care Spending

Finally, the Technical Team made suggestions for how payers should increase primary care spending. The suggested parameters include:

1. Increase spending (a) in alignment with existing statewide initiatives and policies, (b) through increased utilization of value-based incentives, (c) in a way that provides value[7] and (d) by rewarding performance.
2. Continuously update policies based on incoming data on primary care spending and cost growth.
3. Measure decreased spending elsewhere that is a byproduct of increased primary care spending.
4. Ensure increased access to primary care, especially for populations that are currently not receiving services.

[6] Data from Freedman Healthcare, UConn, the Kaiser Family Foundation and the Department of Social Services suggest that current Connecticut spending on primary care is 4.8 percent.

[7] OHS can define value as improved quality, increased utilization and access and improved outcomes.

5. Enhance how payers and providers deliver primary care, potentially as recommended by the National Alliance of Health Care Purchaser Coalitions recommendations on advancing primary care.[8]

F. Implementation Process and Timeline

As with the healthcare cost growth benchmark, OHS is directed to implement the primary care spending target beginning in 2021. As with total spending, the Technical Team anticipated that 2021 primary care spending will likely be significantly impacted by COVID-19. Therefore, the Technical Team made a recommendation to collect baseline data for 2018 and 2019 to identify primary care spending trends before the pandemic. The timeline and process for payer reporting primary care spend data should be aligned with payer reporting total cost growth data.

Data Use Strategy – Preliminary Recommendations

The data use strategy is a complementary plan that purposefully leverages the State's APCD data to achieve the aims of Executive Order 5. The data use strategy can help identify where costs are high, growing rapidly, and variable. These three variables can identify which spending categories warrant the greatest attention to "move the needle" on the cost growth benchmark. The Technical Team and Stakeholder Advisory Board also expressed interest in leveraging the data use strategy to identify any unintended consequences of the cost growth benchmark, assess the benchmark's impact on consumer out-of-pocket spending and look at the impact of health disparities on utilization, cost and quality. This report section summarizes the preliminary recommendations on priority goals, analyses and audience, the complementary work to be performed by Mathematica, and the timeline and process for implementing the data use strategy.

A. Preliminary Recommendations on Goals and Audience

The Technical Team adopted three priority goals to shape the data use strategy:

1. Produce routine analyses that identify leading opportunities to improve healthcare and invest in higher value care through (1) reduced healthcare spending growth in a manner that will not harm patients, and (2) improved quality.
2. Produce ad-hoc, one-time analyses in areas of perceived opportunity and are of specific interest to stakeholders committed to reducing spending while improving and/or maintaining access and quality.[9]

[8] The complete list of National Alliance of Health Care Purchaser Coalitions' recommendations includes enhanced access for patients, more time with patients, realigned payment methods, organization and infrastructure backbone, behavioral health integration, disciplined focus on health improvement and referral management. For more information, see: https://connect.nationalalliancehealth.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=6ca6ceb5-a85b-0f2d-0a10-21eb7ce3bf69&forceDialog=0.

[9] The Technical Team noted that OHS could develop criteria to prioritize these ad hoc recommendations.

3. Interpret health care spending analyses and link findings with recommended actions for the intended audiences.

The Technical Team then made preliminary recommendations on four priority audiences because of their ability to utilize analysis insights to safely lower health care spending growth: provider organizations, policymakers, employers and the public. The Technical Team also expressed interest in OHS a) ensuring transparency of data and reports for consumers on its website, b) supporting consumer understanding and use of the analyses and c) continuing consumer engagement in all Executive Order 5-related activity.

B. Preliminary Recommendations on Priority Analyses

The Technical Team reviewed and made preliminary recommendations on guidelines to consider all categories of analyses, as well as which specific analyses to prioritize in the data use strategy. Of note, in 2018, the Healthcare Cabinet convened a Cost Containment Data Workgroup. The Healthcare Cabinet's priority recommendations from that group largely align with the Technical Team's preliminary recommendations outlined below.

The Technical Team initially recommended the following guidelines for all analyses:

1. Analyses should be stratified by sub-populations that are of interest to stakeholders, including by:
    a. insurer and insurance coverage (e.g., commercial, Medicaid, Medicare, uninsured)
    b. age (e.g., pediatric, adult)
    c. gender
    d. provider (e.g., care site, practice, facility, network, system)
    e. site of service (e.g., urgent care, emergency department)
    f. provider specialty (e.g., primary care, specialty)
    g. presence of chronic conditions
    h. race, ethnicity, language and disability status, to the extent possible[10]
    i. geography (e.g., zip code, town/city, county)
2. Analyses should be structured to produced statistically valid and reliable results, including through use of risk adjustment and adjusting for social determinants of health where appropriate.[11]
3. Analyses should support comparisons to peer organizations and other benchmarks, and display change over time.

[10] The Technical Team highlighted the limited availability of race, ethnicity, language and disability data across payers. It urged OHS to prioritize improved data collection of these variables, noting that efforts to perform analyses will be limited without such action.

[11] ICD-10 Z codes and social determinants of health data from the American Community Survey may serve as valuable pathways to accomplish this type of analysis. The Technical Team, however, noted the importance of collecting more data, especially non-claims information through the statewide Health Information Exchange, for these analyses.

The Technical Team expressed a preference for making data public to allow stakeholders to replicate and validate analyses as desired. It also urged OHS to take steps to capture and analyze data on the uninsured, including undocumented immigrants.

Finally, the Technical Team tentatively prioritized the following types of analyses for OHS to perform as part of the data use strategy. Appendix D provides more information about the lower-priority analyses of interest to the Technical Team.

1. **Cost growth drivers** are the leading factors contributing to cost growth over the course of one or more years. These analyses deconstruct the factors (e.g., utilization, price, service mix/intensity, patient demographics, etc.) contributing to longitudinal cost growth.
2. **Cost drivers** are factors that most contribute to the total cost of care for a population of patients at a specific point in time. Cost drivers can be specific categories of services, provider types, providers, and medical conditions. There are multiple categories of analyses that can be employed to understand cost drivers, three of which were preliminarily prioritized by the Technical Team.
    a. **Utilization variation** assesses differences in use of services that significantly contribute to total cost of care. They can assess to what degree service utilization varies within the state and compared to external benchmarks.
    b. **Price variation** analyses look at the variation in the amount providers are paid for a given service, shedding light on the impact of market power on commercial market prices.
    c. **Cost variation** analyses assess the variation in aggregate payments across a range of providers for the treatment of episodes of care (e.g., total hip replacement, treatment of diabetes). The Technical Team expressed special interest in how episode cost variation in Connecticut is impacted by potentially avoidable complications, including healthcare-acquired infections.
3. As referenced earlier, the Technical Team expressed interest in measuring the **effects of the cost growth benchmark**, including any unintended consequences that may arise from its implementation.
    a. **Underutilization** of healthcare services, as a result of providers or payers impeding access to care, is a possible unintended consequence of the cost growth benchmark. The Technical Team was particularly interested in this type of analysis. There are a few ways OHS could assess underutilization, comparing pre and post-benchmark implementation time periods, by insurance market.
        i. One of DSS' strategies for identifying and preventing against underutilization for PCMH+ model is use of **preventive** and **access to care measures** (e.g., well-visit measures, preventive screening measures, routine diabetic care, follow-up care measures). The Technical Team appreciated this approach because it facilitates alignment with Medicaid's efforts while also providing a mechanism for identifying whether consumers are receiving medically-necessary care.

ii. **"Cold spotting"** analyses can identify which cities, towns and neighborhoods have consumers that are underutilizing necessary services.
iii. **Anti-stinting measures** (e.g., availability of appointments, "cherry picking," and "lemon dropping") can help inform whether providers are limiting access to care to reduce cost growth.[12]

b. Effects of the cost growth benchmark in terms of **impact on marginalized populations**, was important to the Technical Team and Stakeholder Advisory Board. This can be assessed by stratifying the previously discussed analyses by income, race/ethnicity, geography, disability status and select social determinants of health (SDOH) factors.
c. The cost growth benchmark will not be wholly successful if **consumer out-of-pocket spending**, including consumer spending due to deductible and co-insurance obligations, grows faster than the benchmark. This has been a problem in Massachusetts. OHS can track changes in consumer out-of-pocket spending, as well as premiums, relative to the benchmark.

C. Complementary Work by Mathematica and Timeline

In the short-term, OHS sub-contractor Mathematica will perform certain analyses focused on areas of high costs and high cost growth that are included in the proposed data use strategy. OHS' goals for this work are to:

1. provide analytics that help establish trust in the APCD data;
2. identify an initial set of cost drivers;
3. identify opportunities to reduce costs and cost growth without harming patients, and
4. create room for stakeholders to provide input before OHS moves forward with the larger data use strategy.

Mathematica's analyses will focus on annual changes and average annual changes in spending (including total spending, per member per month spending, spending by service category or chronic condition and out-of-pocket spending) and utilization.[13] Analyses will be stratified by payer, age, gender and region, and will also be adjusted for age and gender. Mathematica will first analyze commercial medical claims, and then will move on to Medicaid and Medicare.

Mathematica will complete the initial work by the end of 2020.

[12] Potential measures include: (a) assessing whether practices are adhering to basic requirements for office hours and/or the availability of appointments, (b) assessing whether newly enrolled patients are healthier and/or have fewer comorbid conditions with lower healthcare costs, i.e., "cherry picking" and (c) assessing practice population risk score and/or scores of patients that left the practice, as practices may drop patients with more costly care needs.

[13] If there is additional time, Mathematica will also assess avoidable hospitalizations and low-value services.

D. Implementation Process and Timeline

After Mathematica concludes its work, OHS will need to develop detailed specifications for the analyses recommended by the Technical Team. For example, it will need to identify the services on which each set of analyses will focus. The Technical Team expressed a preference for assessing differentiated services (e.g., colonoscopy, MRI, joint replacement, OB care) when looking at utilization, price, and cost. OHS will also need to identify the timeframe for publishing these analyses. The Technical Team preliminarily recommended that analyses be produced on a bi-annual basis. Finally, OHS will need to develop a process for performing analyses, producing reports and sharing data with its priority audiences. Of note, the technical Team recommended that OHS produce regular reports as well as ad hoc analyses. For example, one ad hoc report of interest to the Technical Team would assess the impact of ambulatory surgical centers on cost growth, utilization and access and whether these variables differ based on how far away a center is from the main hospital.

The Technical Team did not define a timeline for this work, so OHS will need to develop a plan and timeline for advancing the data use strategy going forward.

E. Ensuring Success

The Technical Team offered a range of recommendations to ensure the success of Connecticut's cost growth benchmark, including the following:

- Continue to emphasize the importance of data transparency and ongoing communications.
- Ensure the benchmark does not have the unintended consequence of limiting access by means of the underservice measurement and monitoring strategy described earlier in this report.
- Avoid punitive consequences for providers during initial years of implementation.
- Consider a thoughtful definition of success.
- Direct the Primary Care Work Group to recommend an approach for implementation of a standard that consumers must select a primary care physician when they enroll in health insurance coverage, taking into concern the challenges that such a standard might pose for some individuals and providers.

OHS will continue to work with both the Technical Team and the Stakeholder Advisory Board to ensure the successful implementation of all initiatives it is charged with implementing under Executive Order #5.

Next Steps

A. Public Hearing to Finalize Recommendations

OHS intends to pursue a fall 2020 hearing to review these recommendations in order to inform their finalization and steps to implement them in the months ahead.

B. Quality Benchmarks

The Quality Council will be reconvened in the fall of 2020 in order to begin the process of developing recommendations on quality benchmarks across all public and private payers beginning in CY 2022.

C. Implementation Manual with Data Specifications for the Cost Growth Benchmark and Primary Care Spending Target

Once these preliminary recommendations have been finalized after the aforementioned public hearing, OHS will develop an implementation manual detailing the process for implementing the healthcare spending benchmark and primary care spending targets. This will include the methodology for the healthcare cost growth benchmark and primary care spending targets, including how OHS will calculate each and the sources of data used. It will also contain detailed specifications for insurers to use when submitting data to OHS. For the primary care spending target, those detailed specifications will leverage, where appropriate, NESCSO's work in this area. Finally, the manual will also include information for how to consolidate payer-reported data for reporting at the state, market, insurer and large provider entity levels (as applicable to the benchmark or target).

Future editions of the manual will also contain details on how to operationalize the quality benchmarks.

D. Refinement of the Data Use Strategy and Process for Report Development

Mathematica will share its code with OHS staff at the conclusion of its work. OHS and any contractors it chooses to use for this work will build off Mathematica's code to produce ongoing and ad hoc reports, as specified above. As mentioned earlier, OHS will develop detailed specifications for the data use strategy as well as a process for performing analyses, producing reports and sharing data with its priority audiences.

OHS will also need to establish a body to provide guidance on the routine development and publication of these reports. The Technical Team emphasized the importance of including stakeholders and consumers in this body to ensure they have a voice. This includes identifying which analyses and designs are effective to report, advising on any refinements, discussing ad hoc analyses that can be of value, and discussing methodological considerations for each analysis (e.g., statistical validity). This body will also review findings prior to publication and discuss the implications and possible activities that can result from the findings (e.g., collaborative quality improvement efforts, use of regulatory levers, introduction of legislation). Finally, this body will work with OHS to recommend and facilitate public hearings, in addition to public reporting, to share findings and/or facilitate discussion around key questions.

E. Development of Ongoing Advisory Body(ies) and Stakeholder Engagement Processes through Implementation

OHS extends its gratitude to the members of its two key advisory bodies, the Technical Team and Stakeholder Advisory Board, for their dedicated service and thoughtful guidance. OHS intends to continue working with these two advisory bodies on an ongoing basis moving forward. The continued guidance of these two groups will be an important source of input as

the OHS completes implementation of the benchmark, and undertakes implementation of the primary care spend target and quality benchmarks.

As part of its overall emphasis on transparency, OHS will conduct annual hearings and publish reports that shine a spotlight on the main drivers of healthcare cost growth in Connecticut. These activities will help foster public understanding and trust in the cost growth benchmark and related initiatives. OHS has learned from Massachusetts' experience, where the State has done exceptionally well in publishing detailed, trusted reports on its healthcare cost growth benchmark experience, and then letting those reports "speak for themselves." OHS will focus on doing the same: good public reporting and clear, objective communication of Connecticut's experience with the healthcare cost growth and quality benchmarks, and primary care spend targets.

OHS will need to continue to engage not only the public at large, but also stakeholder groups, most especially providers on an ongoing basis so as to continue informing them about these initiatives. OHS will ensure that as it educates and communicates to stakeholder groups, it will articulate both the "why" of these initiatives as well as their potential benefits to Connecticut residents. Communications will need to be clear and not overwhelm audiences with unnecessary detail.

Appendices

Appendix A: Technical Team

Vicki Veltri, Office of Health Strategy (Chair)

Paul Grady, Connecticut Business Group on Health (Vice Chair)

Rebecca Andrews, American College of Physicians, Connecticut Chapter

Patricia Baker, Connecticut Health Foundation (retired)

Zack Cooper, Yale University

Judy Dowd, Office of Policy and Management

Angela Harris, Phillips Metropolitan CME Church

Paul Lombardo, Connecticut Insurance Department

Kate McEvoy, Department of Social Services

Luis Pérez, Mental Health Connecticut, Inc.

Rae-Ellen Roy, Office of the State Comptroller

More information may be found at: https://portal.ct.gov/OHS/Pages/Cost-Growth-Benchmark-Technical-Team

Appendix B: Stakeholder Advisory Board

Vicki Veltri, Office of Health Strategy (Chair)

Ted Doolittle, Healthcare Advocate, Office of the Healthcare Advocate

Reginald Eadie, Trinity Health of New England

Tekisha Everette, Health Equity Solutions

Pareesa Charmchi Goodwin, Connecticut Oral Health Initiative

Margaret Flinter, Community Health Center, Inc.

Karen Gee, OptumCare Network of Connecticut

Hector Glynn, The Village for Families and Children

Jonathan Gonzalez-Cruz, patient representative

Howard Forman, Yale University

Janice Henry, Anthem Blue Cross and Blue Shield of CT

Rob Kosior, ConnectiCare

Ken Lalime, Community Health Center Association of Connecticut

Sal Luciano, Connecticut AFL-CIO

Rick Melita, SEIU Connecticut State Council

Susan Millerick, patient representative

Fiona Mohring, Stanley Black & Decker

Lori Pasqualini, Ability Beyond

Richard Searles, Merritt Healthcare Solutions

Kathy Silard, Stamford Health

Marie Smith, UConn School of Pharmacy

Kristen Whitney-Daniels, patient representative

Nancy Yedlin, Donaghue Foundation

Jill Zorn, Universal Health Care Foundation

More information may be found at: https://portal.ct.gov/OHS/Pages/Cost-Growth-Benchmark-Stakeholder-Advisory-Board

Appendix C: Stakeholder Engagement

Webinar presentations:

- Connecticut Council on Developmental Services
- Ministerial Health Fellowship
- OHS Consumer Advisory Council
- State Health Improvement Planning Coalition (SHIP) Maternal, Infant and Child Health Action Team

Meetings:

- Connecticut Health Care Cabinet
- Connecticut Hospital Association
- Council on Medical Assistance Program Oversight (MAPOC)
- Monthly calls with legislators

Outreach conversations:

- Congregations Organized for a New Connecticut (CONECT)
- Keep the Promise Coalition

Appendix D: Data Use Strategy Analyses

The Technical Team also expressed interest in the following analyses, and prioritized them for development as part of a second wave of analyses:

1. **Low-value services** produce little-to-no patient benefit and may even result in patient harm. Analyses can assess provision of, and costs associated with, low-value services, which alignment with national and state efforts to avoid unnecessary testing, treatment and procedures (e.g., Choosing Wisely).
2. **Potentially preventable services** are acute care services that could have perhaps been avoided through more effective or efficient provision of ambulatory services. Analyses can assess the frequency of potentially preventable services, shedding light on areas for performance improvement.
3. **Patient demographics** analyses can focus on the prevalence of and spending by chronic conditions and various SDOH. These require integrating 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). They can highlight communities of highest social risk and help providers better understand how to serve their populations more holistically and proactively.
4. Assessment of the impact of the cost growth benchmark on the **affordability** of health care services. For example, consumers may realize increase out-of-pocket spending if employers change benefit design, and if consumers change plan selection. Another potential affordability analysis could look to change in premium growth over time.