Cost Growth Benchmark Technical Team Meeting #9
August 27, 2020

OHS
CONNECTICUT
Office *of* Health Strategy

Agenda

Time	Topic
1:00 p.m.	I. Call to Order
1:05 p.m.	II. Review and Approval of Prior Meeting Minutes
1:10 p.m.	III. Public Comment
1:20 p.m.	IV. Stakeholder Advisory Board Feedback
1:40 p.m.	IV. Data Use Strategy
2:40 p.m.	V. Cost Growth Benchmark
3:25 p.m.	VI. Wrap-Up and Next Steps
3:30 p.m.	Adjourn

OHS CONNECTICUT Office of Health Strategy

Approval of August 13, 2020 Meeting Minutes

Public Comment

Stakeholder Advisory Board Feedback Regarding the Primary Care Spend Target

Stakeholder Advisory Board feedback specific to the Primary Care Spend Target: target definitions

1. Recommendation for explicit inclusion of DOs with MDs in primary care provider definition.

2. Reiteration of desire for inclusion of additional provider types and services in the spend target definition:
   - OB/GYN services
     - Specific suggestion for including routine OB/GYN (e.g., pelvic exam) delivered by a PCP
   - Behavioral health services
   - ED services (although the majority opposed this recommendation)

Stakeholder Advisory Board feedback specific to the Primary Care Spend Target: target definitions

3. Recommendation for inclusion of pediatric dental risk assessments (screenings) to parallel inclusion of behavioral health risk assessments.

4. Recommendation for inclusion of pediatric fluoride varnish.

Stakeholder Advisory Board feedback specific to the Primary Care Spend Target: how to increase spending

1. Recommendation to increase spending by:
   - rewarding performance (access, quality)
   - expanding the composition of the primary care team and making more services billable
   - expanding primary care access to populations currently not receiving enough primary care, including those residing in "primary care deserts"

2. Recommendation to be sensitive to not use reduction in specialty spending to increase the share of primary care spending given specialty care access problems resulting from low Medicaid fees.

Data Use Strategy

Recap of data use strategy conversation from August 13th meeting

- At the last meeting, the Technical Team made the following recommendations:
  - Paul Grady and Pat Baker expressed interest in assessing low-value care, and "waste" more broadly, as part of the data use strategy.
  - The Technical Team highlighted the following priority audiences for the data use strategy: provider organizations, policymakers, employers and the public.
- During today's meeting, we will continue our discussion of the data use strategy, including identifying specific analyses OHS should perform, before returning to the cost growth benchmark.

Proposed data use strategy goals

1. Produce **routine analyses that pinpoint leading opportunities to reduce health care spending and health care spending growth** in a manner that will not harm patients, and to **improve quality**.
2. Produce **ad-hoc, one-time analyses in areas of perceived opportunity and that are of specific interest to stakeholders** committed to reducing spending while improving and/or maintaining access and quality.
3. Interpret health care spending analyses and **link findings with recommended actions for the intended audiences** (e.g., providers and provider organizations, employers, policymakers).

OHS CONNECTICUT Office of Health Strategy

Proposed data use strategy goals

- Would the Technical Team like to recommend modification of the proposed data use strategy goals?

Data Use Strategy Guidelines and Analyses to Consider

Proposed guidelines to consider for all analyses

1. Analyses should be stratified by sub-populations that are of interest to stakeholders, including by:
   - insurance coverage (e.g., commercial, Medicaid, Medicare) **(*HCC)**
   - age (e.g., pediatric, adult)
   - provider (e.g., care site, practice, facility, network, system) **(*HCC)**
   - provider specialty
   - presence of chronic conditions
   - race, ethnicity, language and disability status, to the extent possible **(*HCC)**
   - 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
3. Analyses should support comparisons to peer organizations and other benchmarks, and display change over time.

OHS CONNECTICUT Office of Health Strategy

Proposed guidelines to consider for all analyses

- Which of the previously presented guidelines does the Technical Team wish to recommend for the data use strategy?
- Are there any additional guidelines it wishes to recommend?

Potential types of analyses to consider (1 of 2)

- There are multiple categories of analyses the Technical Team can recommend for the data use strategy, including:
  1. cost growth drivers (what is contributing to cost growth?)
  2. cost drivers (what is causing costs to be so high?)
     - wasteful spending, including low-value care and duplicative services
  3. effects of the cost growth benchmark
- In addition, we can look at:
  - What are the respective roles of price, use, service mix/intensity and demographics in cost growth?
  - How does performance vary across providers and regions?
  - How does experience vary by patient population?

Potential types of analyses to consider (2 of 2)

- We exclude quality as a topic for analysis because the Quality Council will consider this topic in the fall. That conversation will include consideration of quality from an equity perspective. **(*HCC)**
- The next group of slides provide examples of analysis of cost growth drivers, cost drivers and impact of a cost growth benchmark. At the end, we will ask you to:
  - Confirm these should be performed
  - Identify others you would like to have performed
  - Recommend prioritization of the analyses

1. Cost growth drivers analyses

- **Cost growth drivers – the leading factors contributing to cost growth over the course of one or more years (*HCC)**
- Analyses can utilize the APCD to support multi-payer analyses that deconstruct the factors (e.g., utilization, price, service mix/intensity, patient demographics, etc.) contributing to longitudinal cost growth.
- These analyses can spotlight cost challenges to the cost growth target, and where providers and policymakers should target priority action.

1. Cost growth drivers analyses: example (1 of 2)

- The Washington Health Alliance has conducted assessments of four factors (i.e., service intensity, unit price, patient demographics, utilization) contributing to cost growth by major service category.
- Mathematica will initially be conducting an assessment of the role of price and utilization on spending growth for OHS.

1. Cost growth drivers analyses: example (2 of 2)

Service	THIS YEAR's Spending (PMPM)	LAST YEAR's Spending (PMPM)	Change (%)	Change (PMPM)	What is contributing to the change in spending? (PMPM): changes in Age/Gender Mix account for:	changes in Service Frequency account for:	changes in Treatment Intensity account for:	changes in Price Level account for:	Total Change in Spending
Pulmonary Edema	$22.90	$21.99	4.2%	$0.92	$0.08	($0.05)	($0.01)	$0.89	$20,612
COPD	$18.99	$17.66	7.5%	$1.33	$0.11	$0.25	$0.44	$0.53	$29,908
Pneumonia	$27.32	$25.40	7.5%	$1.91	$0.17	$0.14	$0.16	$1.43	$43,023
Perc CV Procedures	$26.45	$25.13	5.3%	$1.32	$0.15	$0.03	$0.03	$1.12	$29,756
Circulatory Disorders	$18.88	$18.12	4.2%	$0.76	$0.09	$0.00	$0.01	$0.65	$16,988
Heart Failure	$22.77	$22.31	2.0%	$0.46	$0.06	($0.00)	($0.00)	$0.40	$10,246
Cardiac Arrhythmia	$27.33	$26.51	3.1%	$0.82	$0.09	$0.01	$0.05	$0.66	$18,445
Spinal Fusion	$13.70	$12.88	6.4%	$0.82	$0.06	$0.33	$0.08	$0.35	$18,492
Major Joint Replacement	$16.08	$15.11	6.4%	$0.96	$0.08	$0.14	$0.20	$0.55	$21,706
Cellulitis	$28.26	$25.72	9.9%	$2.54	$0.13	$1.53	$0.01	$0.89	$57,227
Metabolic disorders	$19.26	$17.53	9.9%	$1.73	$0.07	($0.06)	($0.01)	$1.73	$39,006
Urinary Tract Infections	$23.01	$22.55	2.0%	$0.46	$0.03	$0.18	$0.27	($0.01)	$10,355
Septicemia	$10.93	$10.60	3.1%	$0.33	$0.01	$0.12	$0.13	$0.07	$7,377
	$275.87	**$261.51**	**5.5%**	**$14.36**	**$1.13**	**$2.62**	**$1.35**	**$9.27**	**$323,141**
					8%	**18%**	**9%**	**65%**	

Source: Washington Health Alliance. Spending Trend Analysis as presented by Nancy Giunto at the November 14, 2018 Rhode Island Cost Trends Data Use Conference.

OHS CONNECTICUT Office of Health Strategy

2. Cost drivers analyses

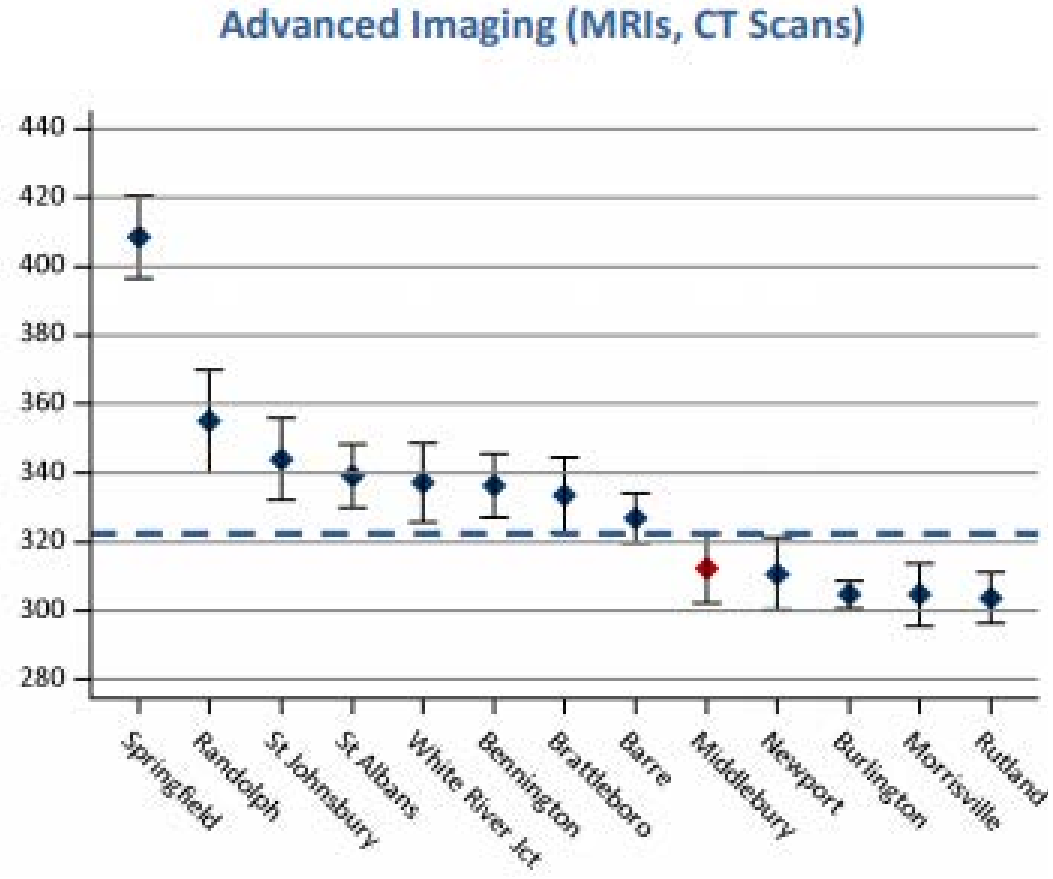
- **Cost drivers – factors that most contribute to the total cost of care for a population of patients**
- There are multiple categories of analyses that fall under cost drivers. In addition to looking at total spending by service, provider and population, it is possible to examine:
  a. Utilization variation
  b. Price and cost variation
  c. Low-value services
  d. Potentially preventable services
  e. Patient demographics

2a. Utilization variation analyses

- **Utilization variation – assess variation in use of services that significantly contribute to total cost of care (*HCC)**
- Analyses can assess to what degree service utilization varies within the state and compared to external benchmarks.
  - There could be a focus on variation within payer by geography and/or by provider, and could be reported by insurer, line of business, geography and provider.
- To the degree possible, analyses should adjust for clinical risk and social risk, and examine utilization in terms of frequency, intensity and site of care.

2a. Utilization variation analyses: example (1 of 2)

- Vermont calculates risk-adjusted advance imaging utilization per 1,000 members by county, and has demonstrated wide variation across the state.



Source: Vermont Blueprint for Health. Blueprint Hospital Service Area Profile for Middlebury for July 2016-June 2017. Figure 8.

2a. Utilization variation analyses: example (2 of 2)

- Mathematica's initial analyses will focus on variation in frequency of utilization for professional visits and hospital stays. The analysis will be adjusted for the age and gender profile of the population (a rough adjustment for expected health care needs) and can be reported by insurer and line of business.
- Future analyses could focus on variation for low-value and over-utilized services (e.g., imaging), be at finer detailed levels (e.g., DRG-level), be adjusted for the prevalence of and costs associated with chronic conditions among different sub-populations and could be reported by large provider organization.

2b. Price and cost variation

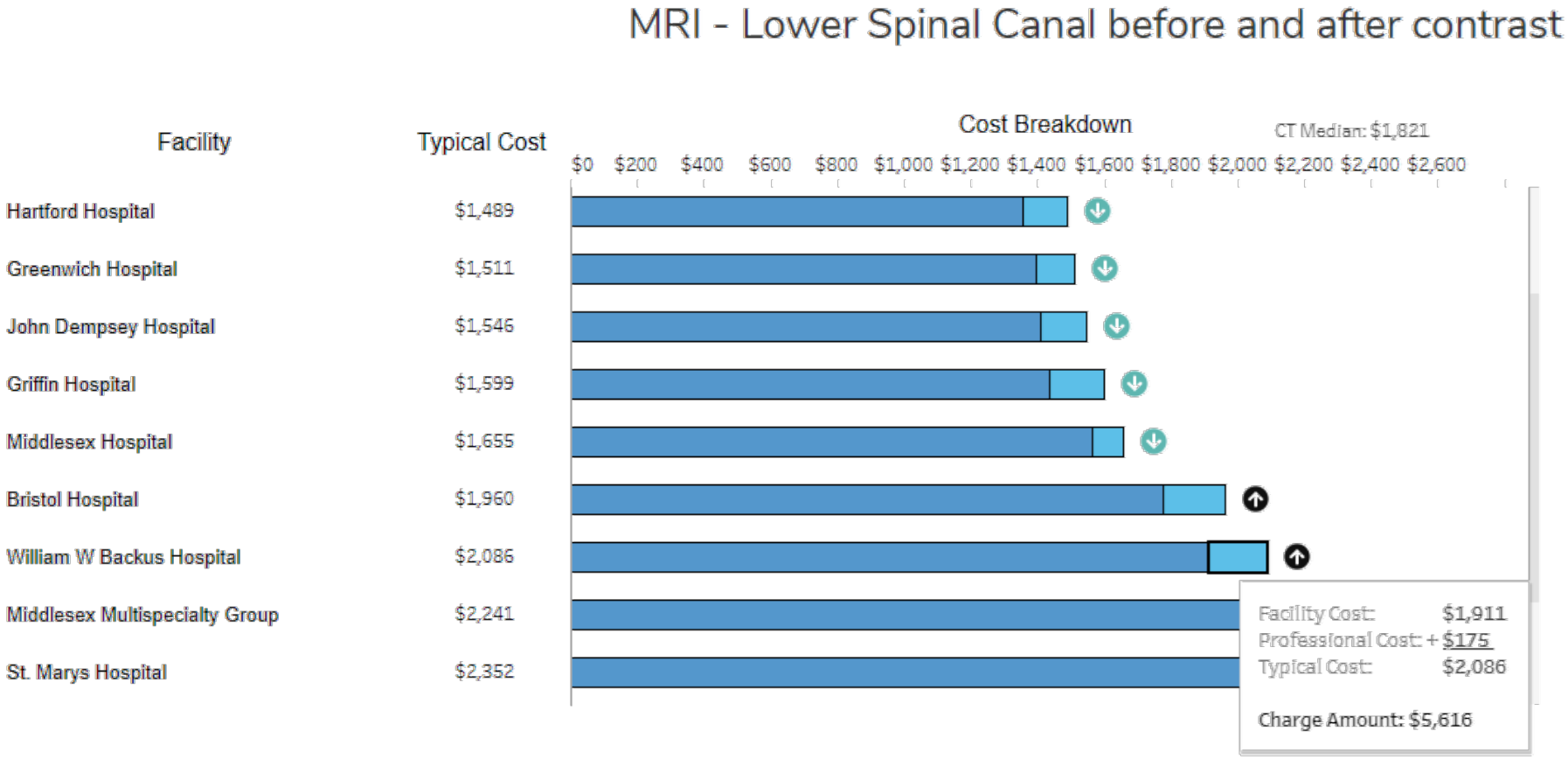
- There are multiple price and cost variation analyses that may be of interest to the Technical Team:
  - By service (price)
  - By episode of care (cost)

2b. Price and cost variation: by service (price)

- **By service (price): assess the variation in the amount providers are paid for a given service**, shedding light on the impact of market power on variation in commercial market prices. **(*HCC)**
  - Analyses focused on variation in provider payments are available through Healthscore CT's Cost Estimator.
  - Future analyses can assess the difference in the change in the number of services versus the change in spending per service, making transparent which services may be driving spending growth.

2b. Price and cost variation: by service (price) - example

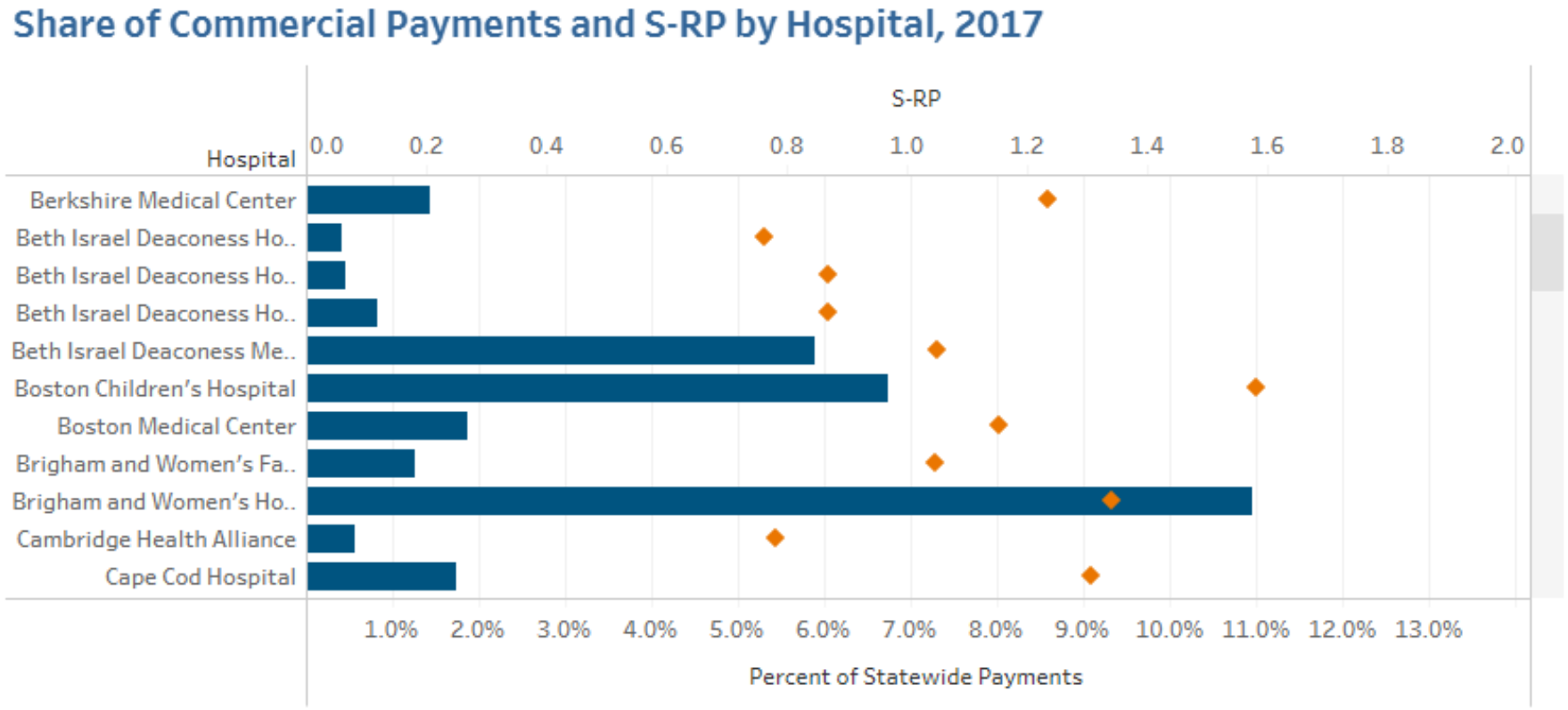
- Healthscore CT's Cost Estimator Tool assesses the paid amounts to Connecticut hospitals and compares hospitals to the statewide median cost.



Source: Healthscore CT https://healthscorect.com/cost-estimator.

2b. Price and cost variation: by service (price) - example

- MA assessed prices at the facility level, using a relative index (S-RP) to show variation.



Source: Provider Variation in the MA Commercial Market (May 2019).
https://public.tableau.com/profile/mass.chia#!/vizhome/ProviderPriceVariationInTheMassachusettsCommercialMarketMay2019/S-RPDashboard

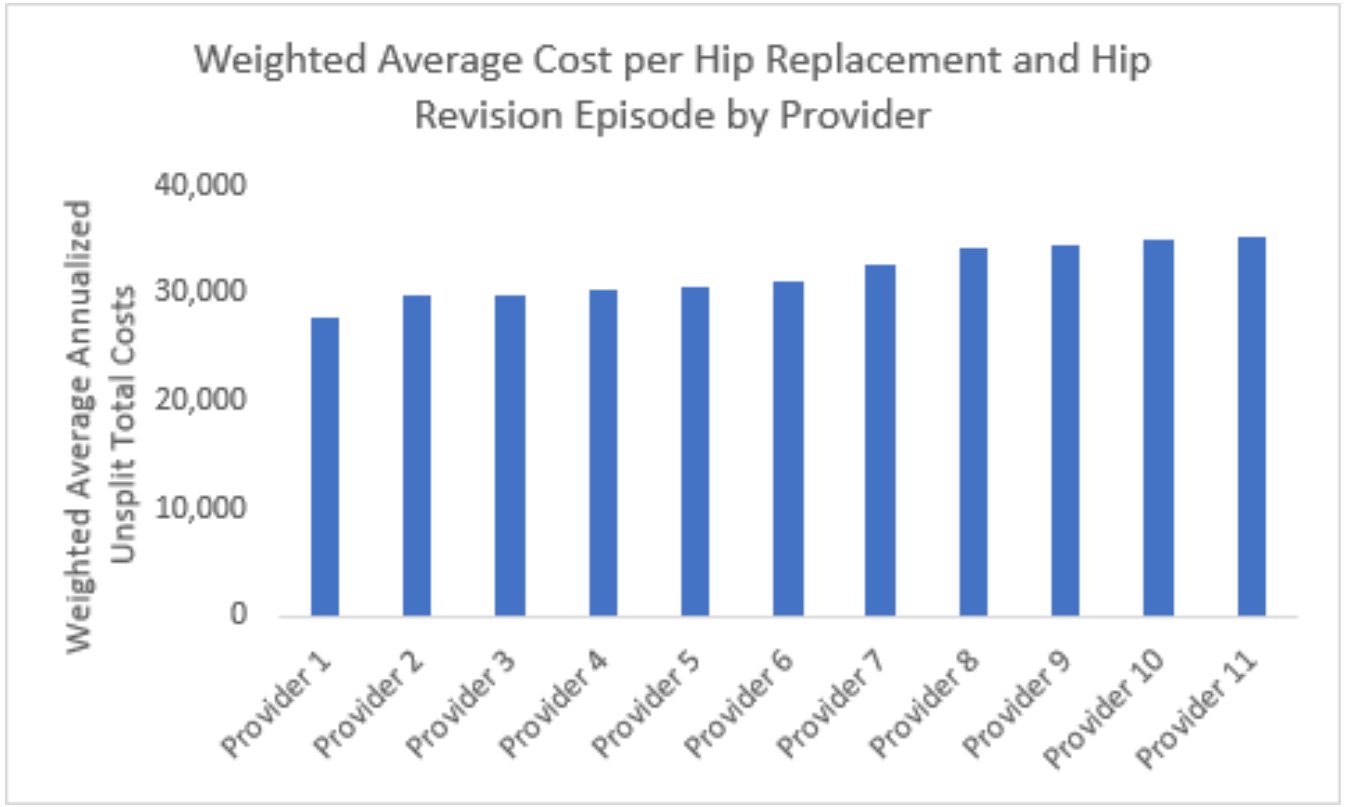
OHS CONNECTICUT Office of Health Strategy

2b. Price and cost variation: by episode of care (cost)

- **By episode of care (cost): assess the variation in aggregate payments across a range of providers for the treatment of an episode of care** (e.g., total hip replacement, treatment of diabetes), which could help providers determine areas to assess potential workflow and process improvement methods to reduce costs
  - Analyses could display the median value and the range of prices/costs, and offer potential insights into reasons for variation.
  - These analyses are challenging to perform and require special software to do so.

2b. Price and cost variation: by episode of care (cost) - example

- Rhode Island had a contractor assess all costs (e.g., facility, professional inpatient, etc.) associated with multiple episodes of care in 2017, using the state's APCD.



Source: Altarum analysis for RI OHIC. 2017.

OHS CONNECTICUT Office of Health Strategy

2b. Price and cost variation: by episode of care (cost) - example

Savings Opportunity

Reduction in average episode costs and PACs from shifting all providers to high performance levels.

	High Performing Providers			All Other Providers			Total Savings/Reduction	
	# Providers	Total $	PAC Rate	# Providers	Total $	PAC Rate	Total $	PAC Rate
Commercial							***$48,748,764***	
Gall Bladder Surgery	4	$10,267	29%	10	$11,877	37%	$1,193,394	-21%
Knee Replacemnt	3	$27,674	19%	7	$31,172	26%	$2,441,710	-26%
Hysterectomy	1	$9,619	23%	8	$15,326	48%	$3,652,501	-52%
Vaginal Delivery	2	$9,312	26%	10	$11,276	34%	$5,585,549	-25%
Asthma	62	$1,641	22%	83	$2,367	35%	$3,373,150	-36%
CAD	10	$2,908	23%	16	$5,121	34%	$1,387,714	-32%
Hypertension	216	$1,283	18%	279	$1,819	28%	$13,082,991	-35%
GERD	98	$1,237	11%	117	$1,894	20%	$5,479,886	-44%
Low Back Pain	60	$1,083	13%	94	$2,128	20%	$4,777,613	-37%
Diabetes	62	$4,035	36%	95	$5,780	53%	$7,774,256	-32%
Medicaid							***$16,871,210***	
Asthma	59	$1,749	33%	82	$2,554	48%	$4,435,735	-30%
COPD	7	$3,655	47%	16	$5,444	56%	$1,924,084	-17%
Hypertension	107	$1,463	34%	148	$2,215	46%	$6,630,969	-26%
Diabetes	30	$4,719	56%	59	$6,376	73%	$3,880,422	-23%

Includes hospitals and physicians with 10+ episodes

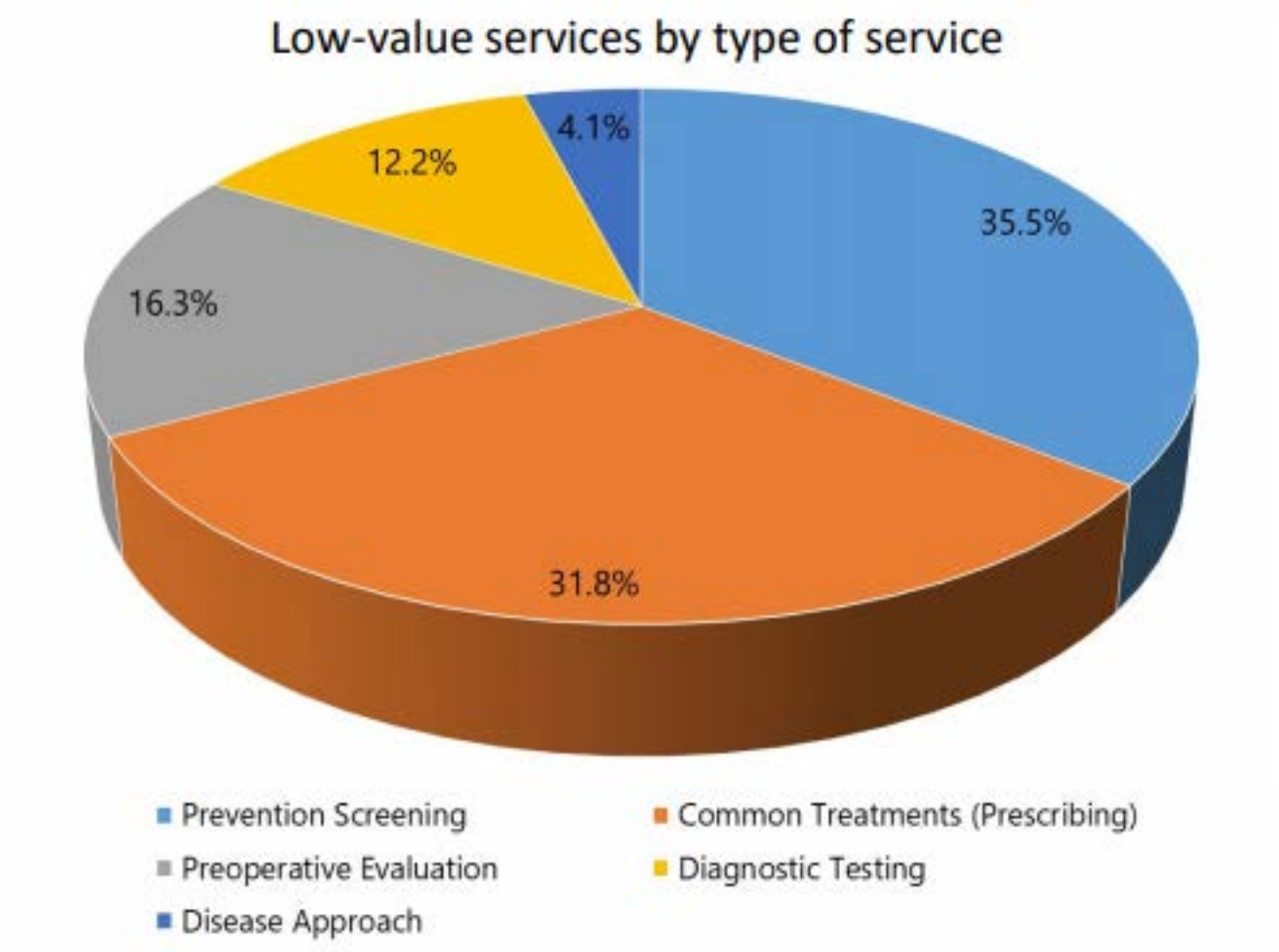
32

Source: June 2018 presentation by Altarum to RI OHIC.

2c. Low-value services analyses

- **Low-value services – services that produce little-to-no patient benefit and may even result in patient harm (*HCC)**
- Analyses can assess low-value service provision and associated costs using the APCD.
  - Such efforts are in alignment with national and state efforts to avoid unnecessary testing, treatment and procedures (e.g., Choosing Wisely).
- The Oregon Health Leadership Council and Oregon Health Authority recently assessed the distribution of low-value services by type of service to better inform future interventions focused on reducing low-value care.

2c. Low-value services analyses: example



Source: OHLC and OHA. 2020. Better Health for Oregonians: Opportunities to Reduce Low-Value Care. http://www.orhealthleadershipcouncil.org/wp-content/uploads/2020/07/Oregon-Low-Value-Care-Report-Final-July-2020.pdf.

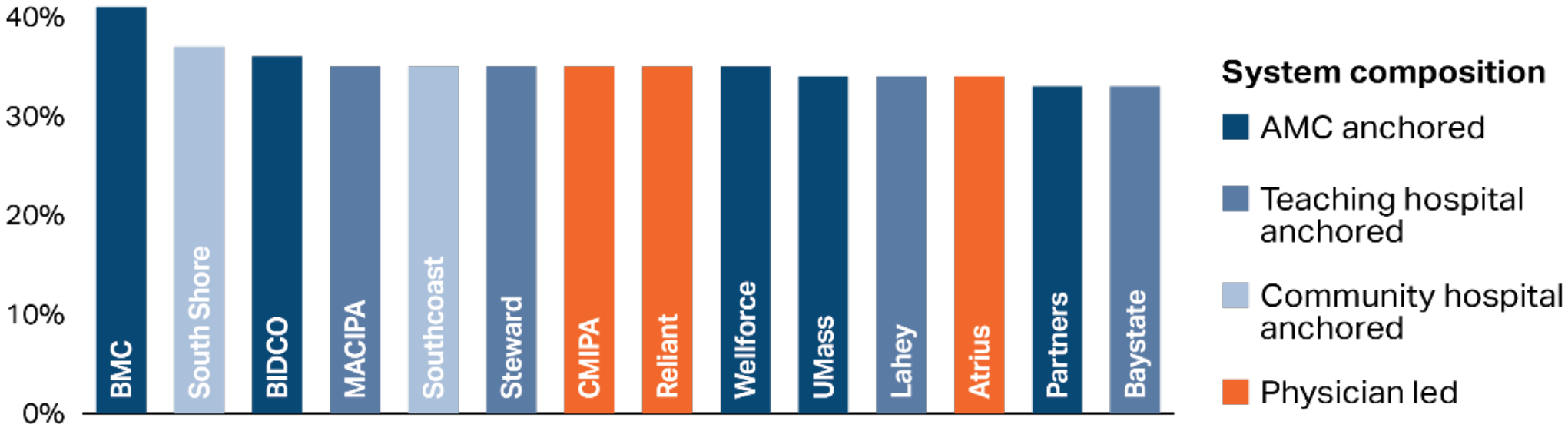
OHS CONNECTICUT Office of Health Strategy

2d. Potentially preventable services analyses

- **Potentially preventable services – acute care services that could perhaps have been avoided through more effective or efficient provision of ambulatory services (*HCC)**
  - Analyses can assess the frequency of potentially preventable services (e.g., variation in avoidable ED use) using the APCD to shed light on areas for performance improvement.
  - They can begin by focusing on variation by geographic areas and then, as possible, by provider groups.

2d. Potentially preventable services analyses: example

- The Massachusetts Health Policy Commission analyzes risk- and demographic-adjusted avoidable ED use by health system.



Source: MA HPC. Avoidable ED Visits as presented by David Auerbach at the November 14, 2018 Rhode Island Cost Trends Data Use Conference. Risk and demographic-adjusted by system composition.

OHS CONNECTICUT Office of Health Strategy

2e. Population demographics analyses

- Population demographics analyses can focus on the prevalence of and spending by chronic conditions and various social determinants of health (SDOH).
  - Analyses require integration of 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).
  - Analyses can highlight communities of highest social risk. They can help providers better understand their populations and proactively serve them holistically.
  - Further, "hot spotting" analyses could help providers target particularly high-risk communities and neighborhoods within their service area.

2e. Population demographics analyses: example

- The Massachusetts Health Policy Commission includes patient demographic analyses in its ACO reports.

	Risk score	Zip-code income	Area deprivation index	% over 55	% Self-insured	% Female
Atrius	.96	$83,284	76.7	26%	52%	56.4%
BMC	.89	$63,319	88.5	20%	52%	54.2%
Lahey	1.05	$85,677	77.8	31%	43%	51.7%
MACIPA	.94	$85,615	70.1	28%	47%	53.5%
Partners	1.03	$86,017	76.6	29%	44%	55.5%
Southcoast	1.09	$59,721	97.6	30%	50%	51.4%
Steward	1.05	$70,131	90.1	30%	48%	52.4%
All physician-led	.96	$81,723	80.2	25.8%	47.8%	55.3%
All other hospital-anchored	1.02	$74,485	86.6	29.8%	45.7%	52.6%
All AMC-anchored	1.02	$81,646	80.7	28.3%	44.5%	53.7%

Source: MA HPC. Patient Demographics as presented by David Auerbach at the November 14, 2018 Rhode Island Cost Trends Data Use Conference

OHS CONNECTICUT Office of Health Strategy

3. Effects of the cost growth benchmark analyses

- The Technical Team and Stakeholder Advisory Board have expressed interest in measuring the effects, including any unintended consequences, that may result from the cost growth benchmark.
- Both entities were particularly focused on measuring:
  a. underutilization,
  b. affordability, including for uninsured populations, and
  c. the impact on marginalized populations.

3a. Underutilization analyses

- While there is no evidence of this occurring in MA, the cost growth benchmark *could* lead providers to impede access to health care
- To assess underutilization **(*HCC)**, the State could measure:
  - preventive and access-to-care measures (e.g., well-visit measures),
  - patient self-reported access to and quality of care (e.g., patient surveys) and/or
  - trends in utilization and costs for specific services that may be most impacted (e.g., specialty services).
- The State could leverage its quality benchmark strategy to capture some of these measures.

3b. Affordability analyses

- Reductions in cost growth will not necessarily produce reduced out-of-pocket consumer spending, because employers may change benefit design, consumers may change plan selection and/or providers may increase charges to the uninsured. It is therefore valuable to track out-of-pocket spending as an indication of affordability (premium growth being another). **(*HCC)**
- Measures of affordability could include assessing change in out-of-pocket spending over time.

3c. Impact on marginalized populations analyses

- Finally, it is important for the State to identify how the cost growth benchmark is impacting sub-populations, especially marginalized populations, as well as the overall population.
- To monitor this impact, Connecticut could stratify the previously discussed analyses by race and ethnicity, geography, disability status and select SDOH factors, as described in the population demographics analyses section.
  - Data are not always available in the APCD, however, so the State will need to look to additional data sources to find this information.

Data Use Strategy: Which Analyses to Prioritize?

- **Cost Growth Driver** (change over time) **and Cost Driver** (point in time)
  - Utilization Variation
  - Price Variation
  - Cost Variation
  - Low-value Services
  - Potentially Preventable Services
  - Patient Demographics
- **Effects of the Cost Growth Benchmark**
  - Underutilization
  - Affordability
  - Marginalized Populations

- **After considering the options**
  - √ Confirm they should be performed
  - √ Identify others you would like to have performed
  - √ Recommend prioritization of the analyses

OHS CONNECTICUT Office of Health Strategy

Stakeholder Advisory Board Feedback Regarding the Data Use Strategy

Stakeholder Advisory Board feedback specific to the Data Use Strategy

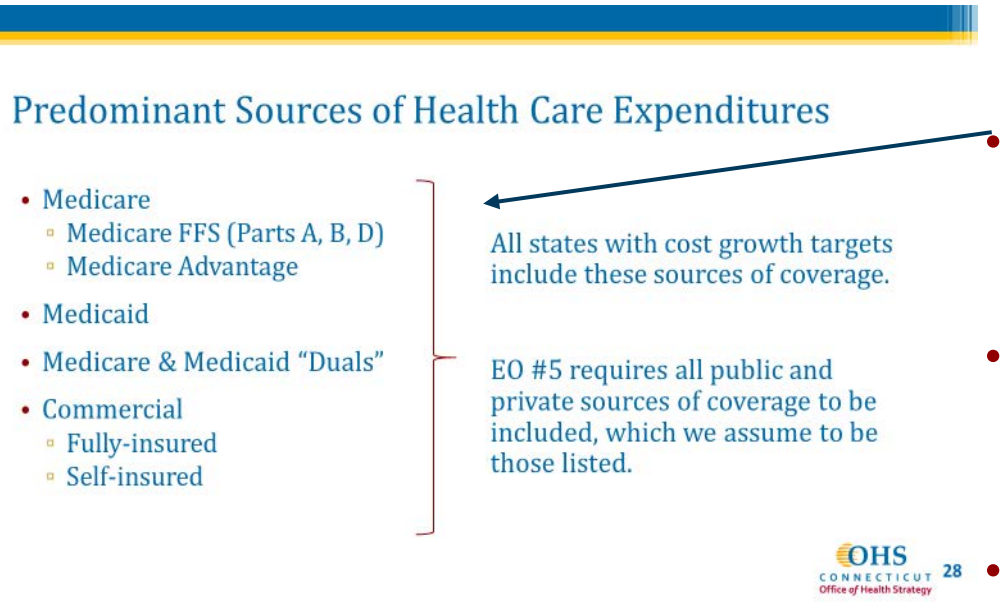
- Don't message that the first proposed goal of producing reports is to reduce health care spending and spending growth. The goal is really to improve health care and invest in higher value health care.
- Add utilization of risk-adjusted analyses, where appropriate, to the guidelines.
- Stratify analyses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

Cost Growth Benchmark

Outstanding Cost Growth Benchmark issues

- There were several items related to the Cost Growth Benchmark that required follow-up and research following prior meeting discussion.
- Today we have updates on:
  - Ability to collect data from the Department of Corrections
  - Implications for collecting data from stand-alone dental insurance carriers
- Remaining outstanding topics specific to the Cost Growth Benchmark will be discussed in September.

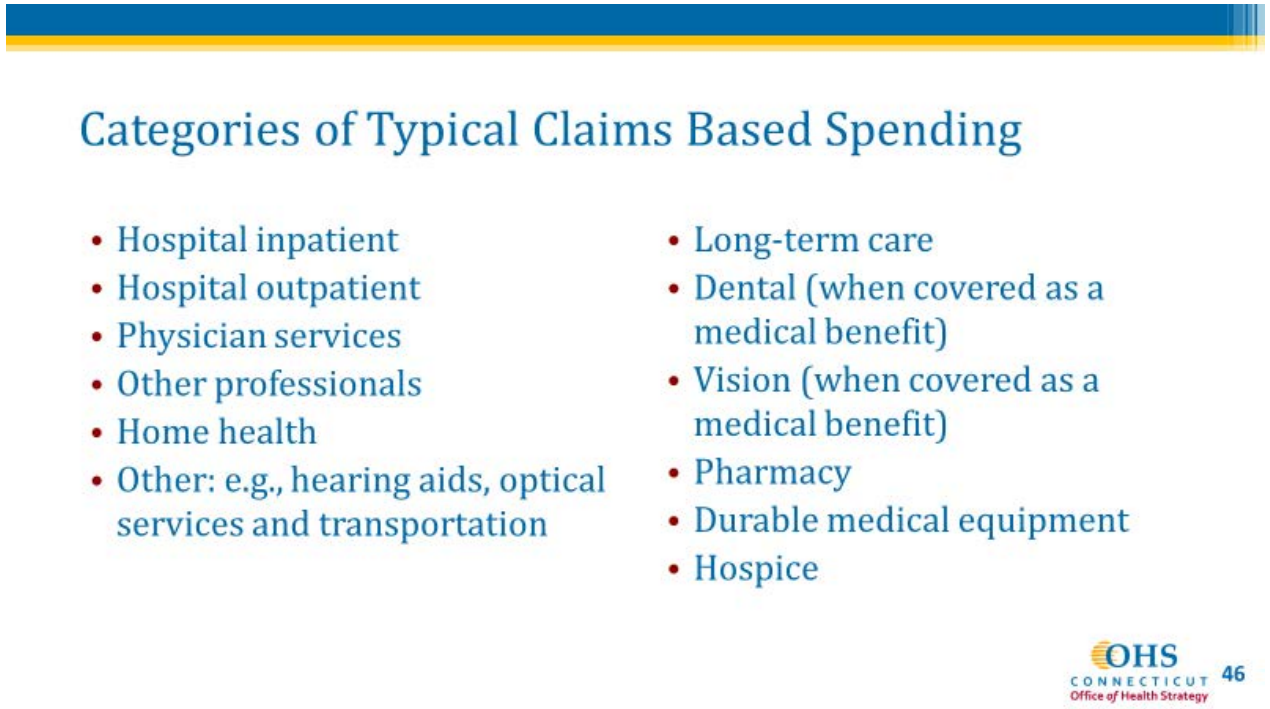
Total Health Care Expenditures for whom?



- During our May 19th meeting we discussed which populations should would be included in the measurement of Total Health Care Expenditures.
- The Technical Team recommended including all predominant sources of health care expenditures, plus spending for CT residents who receive health care coverage through the VHA.
- **The outstanding question was whether health care spending for individuals incarcerated in state correctional facilities could be included.**
- **OHS has determined that data after FY 2019 are accessible, comparable and that collection of data can be replicated over time.**
- **Does the Technical Team wish to recommend spending data on corrections be included?**

OHS CONNECTICUT Office of Health Strategy

What is included in Total Health Care Expenditures?



- During our May 19th meeting we discussed which types of spending would be collected.
- The recommendation was to include all claims-based and non-claims spending from health insurance carriers.
- However, some Technical Team members, and subsequently some Stakeholder Advisory Board members, requested exploration of the idea of adding spending by dental insurance carriers.

Dental care in the Cost Growth Benchmark

- Some spending on dental services is included in the cost growth benchmark because of the varying ways dental care is covered under medical insurance.
- Without collecting data on spending within dental-only insurance policies, the following is included in the benchmark:
  - Comprehensive dental services for HUSKY Health members, and children receiving insurance through Marketplace products
  - Dental services included in any commercial medical benefit, e.g., some hospital-performed surgical procedures
  - Emergency complicated dental procedures covered under Part A
  - Dental services that are optionally covered by Medicare Part C (Medicare Advantage) plans
- When these data are collected for Cost Growth benchmark purposes, they will not be separately identified as a "service category"

OHS CONNECTICUT Office of Health Strategy

Include spending by dental insurance carriers in the Cost Growth Benchmark?

Advantages of Inclusion	Disadvantages of Inclusion
• CT could track aggregate growth in spending on dental services offered by dental insurance.	• Dental insurance coverage is limited and growth in spending would not account for all spending on dental care, or for services not covered and paid out-of-pocket.
• Incorporating spending by dental carriers may help to bridge the historical dental-medical divide.	• Dental claims cannot be attributed to a primary care provider, therefore, there will be a lack of accountability to any provider entity.
	• There are 24 dental insurance carriers in the individual and group market Connecticut. This makes gathering data in a consistent way costly and laborious. Dental insurer reporting compliance is also uncertain.

Wrap-up & Next Steps

Next Steps

- Mathematica will conduct the initial analyses of health care cost and cost growth drivers as part of the initial cost growth benchmark work using the State APCD and select additional sources.
- Bailit Health will begin to write up all of the recommendations made by the Technical Team in anticipation of a report to be shared prior to the final meeting on September 24th.

Next Meeting: September 10, 2020

- We will discuss outstanding issues related to the Cost Growth benchmark and Primary Care Spend Target, as well as explore how to ensure the Cost Growth Benchmark program's success.