Cost Growth Benchmark Technical Team Meeting #5
June 16, 2020

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Agenda

Time	Topic
2:00 p.m.	I. Call to Order
2:05 p.m.	II. Review and Approval of Prior Meeting Minutes
2:10 p.m.	III. Public Comment
2:15 p.m.	IV. Recap of Preliminary Decisions Made to Date
2:20 p.m.	V. Feedback from the Stakeholder Advisory Board
2:40 p.m.	VI. Cost Growth Benchmark Modeling
3:10 p.m.	VII. Reporting on Performance Against the Benchmark
3:55 p.m.	VIII. Wrap-Up and Next Steps
4:00 p.m.	IX. Adjourn

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Approval of June 4, 2020 Meeting Minutes

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Public Comment

Recap of Preliminary Recommendations Made to Date

Recap of Preliminary Recommendations to Date

1. Total Health Care Expenditures (THCE) should be defined as the allowed amount of claims-based spending from payer to provider, all non-claims-based spending from payer to provider, and net cost of private health insurance.
    - THCE should be reported as net of pharmacy rebates.
    - OHS should conduct supplemental tracking and reporting of costs for individuals who are uninsured to the extent OHS determines that such data are available.

Recap of Preliminary Recommendations to Date

2. THCE should be inclusive of 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.
   - THCE should exclude spending for out-of-state residents receiving care from in-state providers.
   - THCE should include spending for Connecticut residents who receive health care coverage through the Veterans Health Administration or other military coverage.
   - THCE should include spending for Connecticut residents incarcerated in a state correctional facility to the extent OHS determines their data are accessible, comparable and replicable.

Feedback from the Stakeholder Advisory Board

Feedback from Stakeholder Advisory Board

- On June 11th, the Stakeholder Advisory Board met for the second time and heard a summary of the key topics discussed during the previous two Technical Team meetings.
- The meeting focused on the definition of Total Health Care Expenditures and the methodology for defining the cost growth benchmark.
- OHS asks the Technical Team to consider the feedback from the Stakeholder Advisory Board when forming its final recommendations to OHS.

Feedback from Stakeholder Advisory Board

- The conversation related to Total Health Care Expenditures largely focused on explaining the definition and answering questions.
- However, clear feedback was given about the need to measure out-of-pocket expenditure growth of Connecticut residents, which cannot be done through the cost growth benchmark itself.
  - We will put this issue in a "parking lot" and circle back to it when we discuss the Data Use Strategy work stream.
- There was also discussion about identifying the cost burden to individuals without insurance. The Stakeholder Advisory Board heard about the challenges in collecting such data.

Feedback from Stakeholder Advisory Board: Cost Growth Benchmark Methodology

- The Stakeholder Advisory Board had a rich discussion on the methodology of the benchmark and reviewed the four economic indicators presented to the Technical Team during the last meeting.
  - GSP/PGSP
  - Median income
  - Average wage
  - CPI-U

Feedback from Stakeholder Advisory Board: Cost Growth Benchmark Methodology

- There was no consensus on which of the four economic indicators to use for benchmarking.
- There was support for all measures, except average wage.
- There was support for composite measures of overall economic growth and personal income, and there was also support for using a "pure" measure.
- The SAB did not have enough time to weigh in on the value of the benchmark.
  - They are considering meeting more frequently than originally planned, or longer, in order to have the time necessary for providing input.

Cost Growth Benchmark Modeling

Reminder: Historical Per Capita Cost Growth in CT's Commercial, Medicare and Medicaid Markets

	Average Annual Growth (time period)
Commercial (UConn SIM Evaluation)	6.6%* (2013-2017)
Commercial (HCCI)	3.9%* (2016-2018)
Medicare	3.5% (2015-2018)
Medicaid	0.3% (2013-2019)

* Differences between the estimates are due to different time periods and sources of data.

Sources: University of Connecticut Center for Population Health, "Connecticut State Innovation Model Final Evaluation Report"; Health Care Cost Institute, "2018 Health Care Cost and Utilization Report"; Centers for Medicare & Medicaid Services Office of Enterprise Data and Analytics; and Connecticut Department of Social Services.

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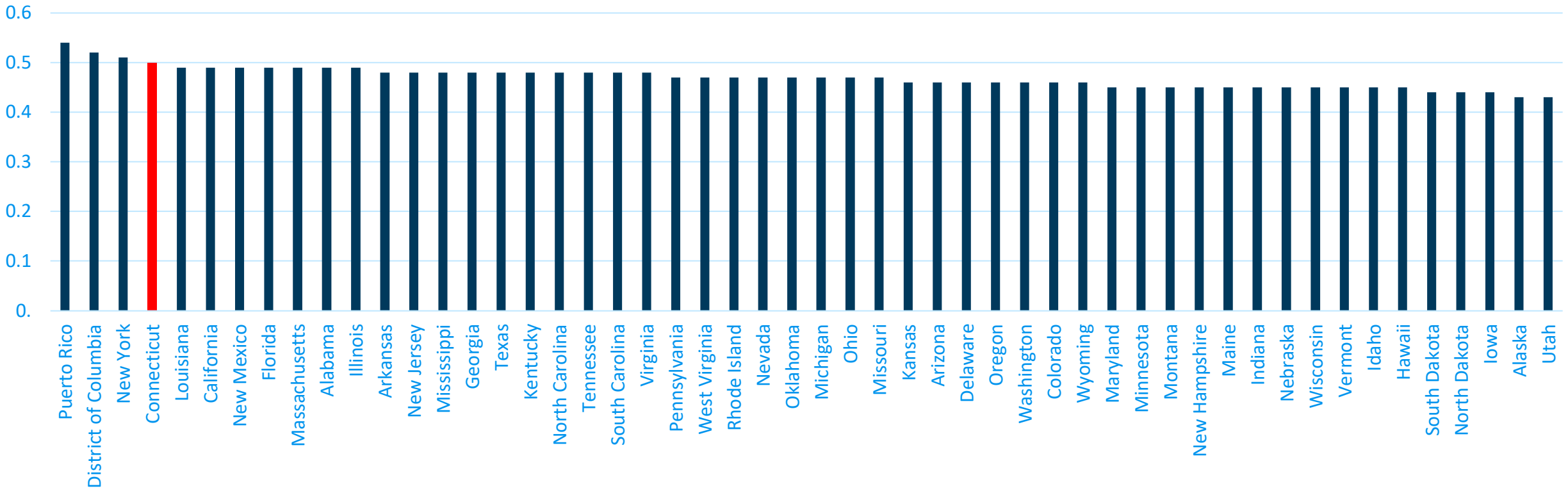
Connecticut has Higher Household Income Distribution Inequality Than Other States (Gini Index, 2018)



Gini coefficient measures income inequality by looking at average income rates. A score of 0 would reflect perfect income equality and a score of 1 indicates a society where one person would have all the money and all other people have nothing. Source: US Census Bureau, September 2019

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Cost Growth Benchmark Modeling

- During our last meeting, there was some interest in creating a composite of the economic indicators we presented.
- Staff have therefore developed three models for your consideration.

	Historical ~20-Year Lookback	Forecast (2026-2030)
Gross State Product and Potential Gross State Product	**3.3%** (1999-2019)	**3.7%**
Median Household Income	**2.0%** (2001-2018)	**2.7%**
Average Per Worker Wage	**2.1%** (2001-2018)	**3.5%**
Consumer Price Index	**2.1%** (2001-2019)	**2.4%**

Comparison of Three Models

Model	80% / 20%	50% / 50%	20% / 80%
PGSP / Median Income	3.5%	3.2%	2.9%
CPI / Median Income	2.5%	2.6%	2.6%
PGSP / Average Wage	3.7%	3.6%	3.5%

Historical Growth in Health Care Expenditures in Other States with Cost Growth Benchmarks

	5-Year Average (2010-2014)	10-Year Average (2005-2014)	20-Year Average (1995-2014)	Cost Growth Benchmark
Connecticut	2.4 %	3.9 %	4.8 %	TBD
Massachusetts	3.0 %	4.7 %	5.1 %	3.6 % for 2013-2017 3.1 % for 2018-2022
Delaware	5.1 %	5.7 %	5.6 %	3.8 % for 2019 3.5 % for 2020 3.25 % for 2021 3.0 % for 2022-2023
Rhode Island	2.6 %	3.7 %	5.3 %	3.2 % for 2019-2022
Oregon	5.3 %	5.9 %	5.7 %	3.4 % for 2021-2025 3.0% for 2026-2030

- States started with benchmark values that were 59-70% of their 20-year growth, and dropped those benchmark over time to 52-60%, except for RI which kept a steady benchmark at 60% of the state's 20-year growth.
- Note that the averages reflect data not available to MA when it set its benchmarks.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. National Health Expenditure Data: National Health Expenditures by State of Residence, June 2017.

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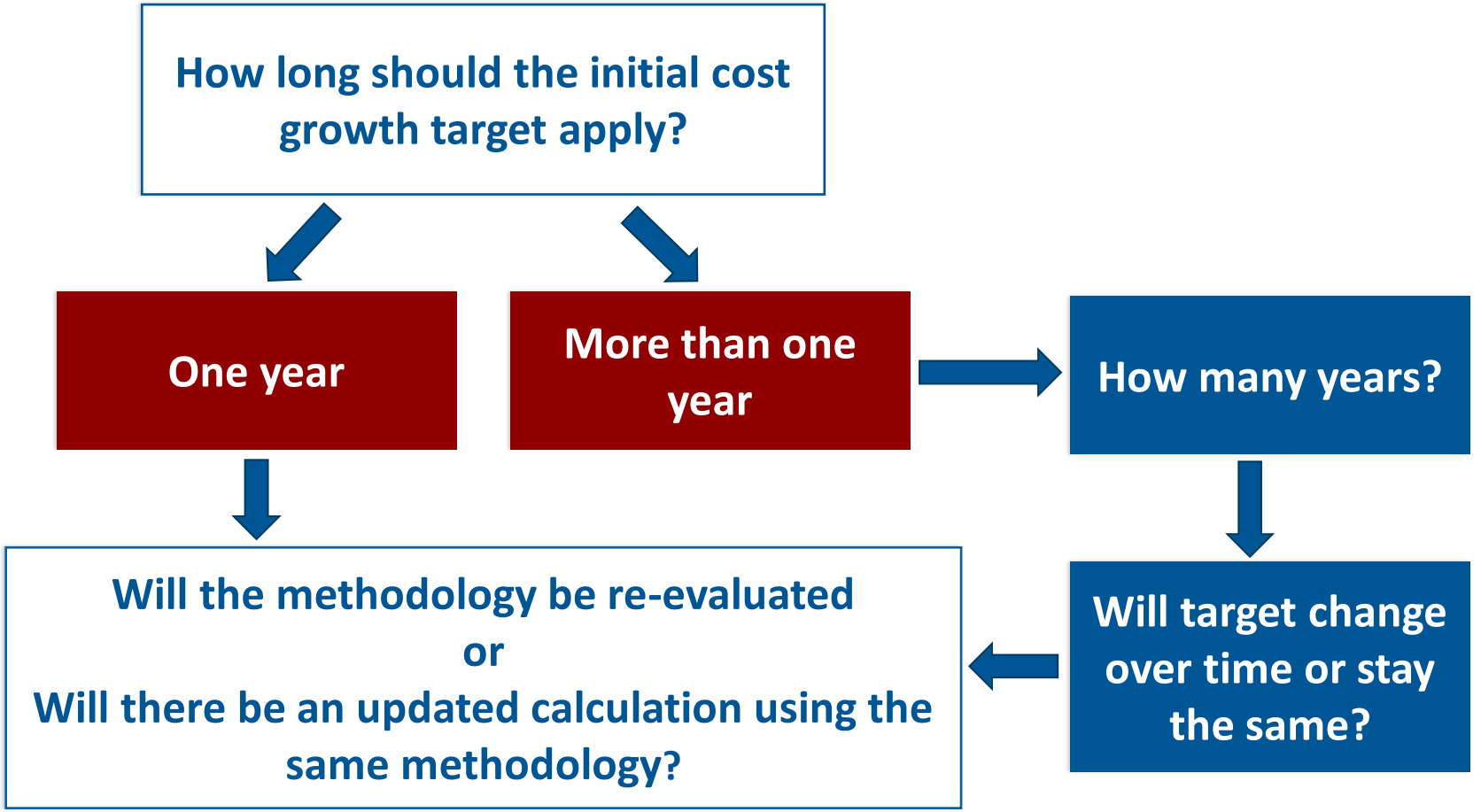
Identifying a Cost Growth Benchmark Methodology and Value

1. Do any of the three models resonate with you? If so, why?
2. If not, do you prefer to go back to using a one of the previously discussed economic indicators?
3. Have you considered stakeholder feedback when forming your recommendation?

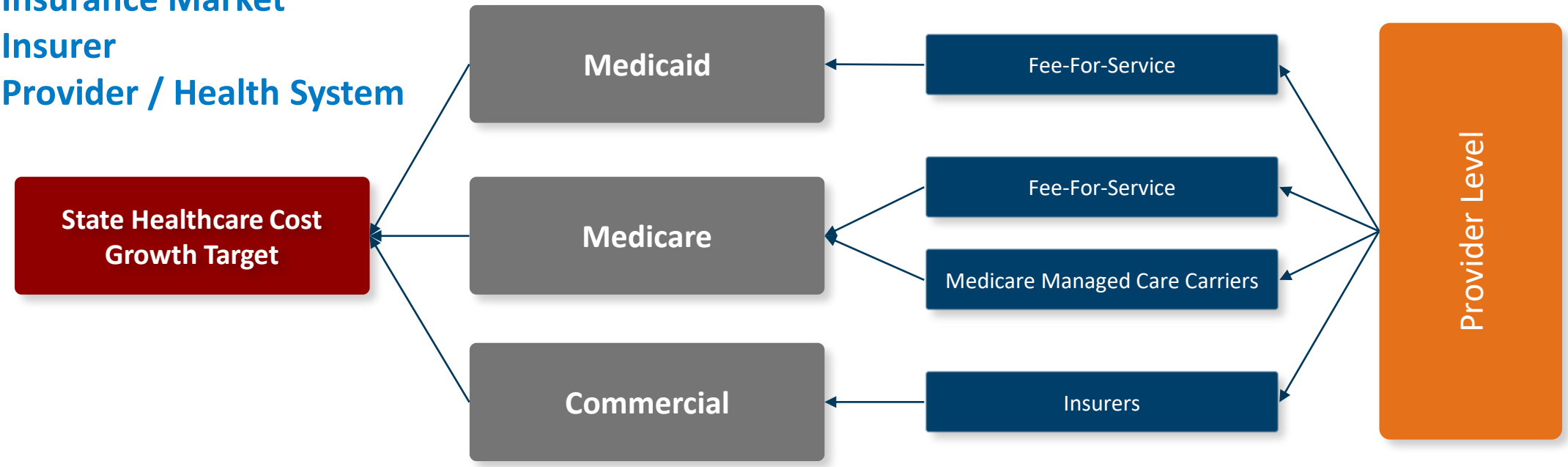
Should the Benchmark be Adjusted?



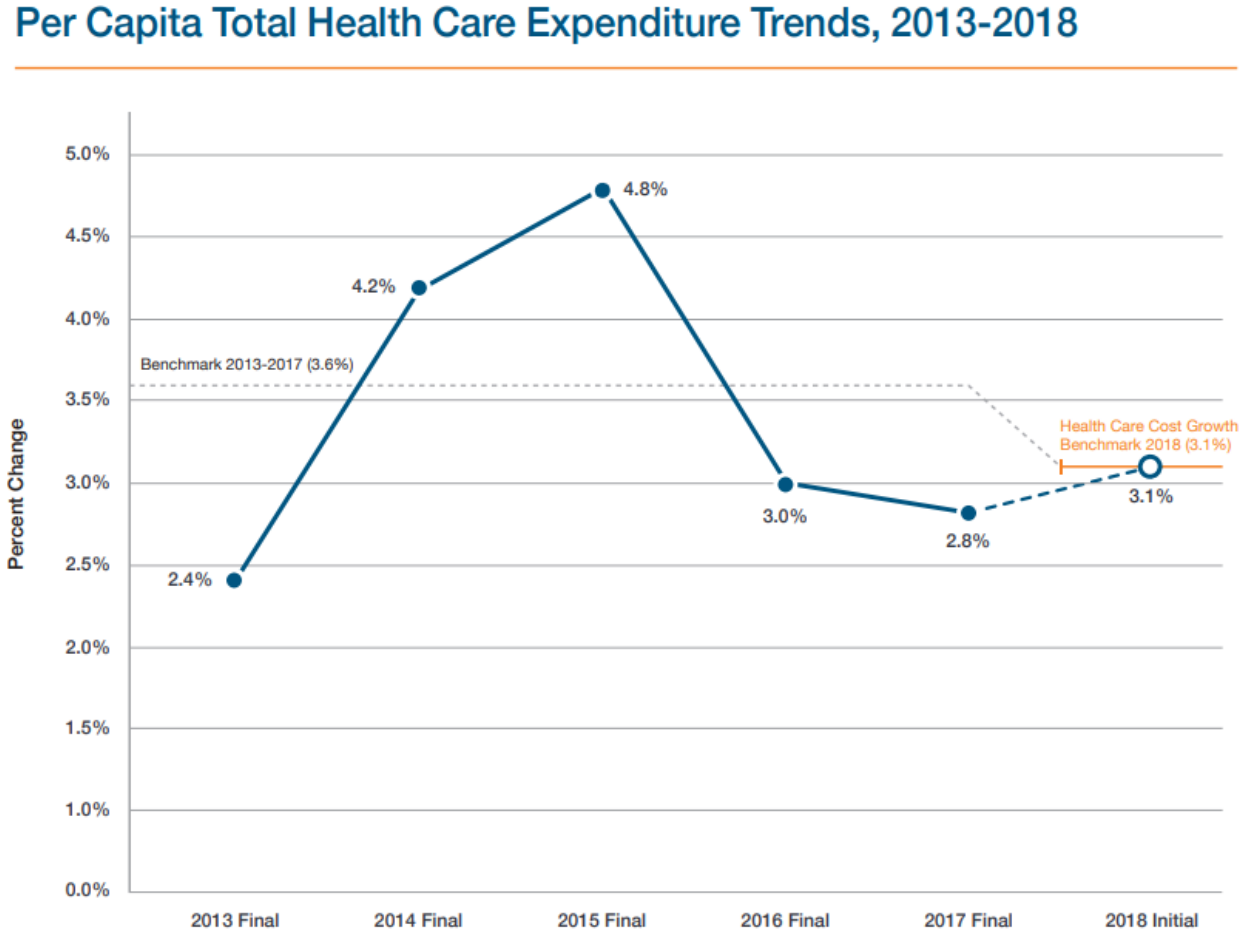
Reporting on Performance Against the Benchmark

Performance Reporting Against the Benchmark Is Applied at Four Levels

1. State
2. Insurance Market
3. Insurer
4. Provider / Health System



Massachusetts Reports on Total Health Care Expenditure Trends at the State Level



Source: Annual Report on the Performance of the Massachusetts Health Care System: 2019. MA Center for Health Information and Analysis.

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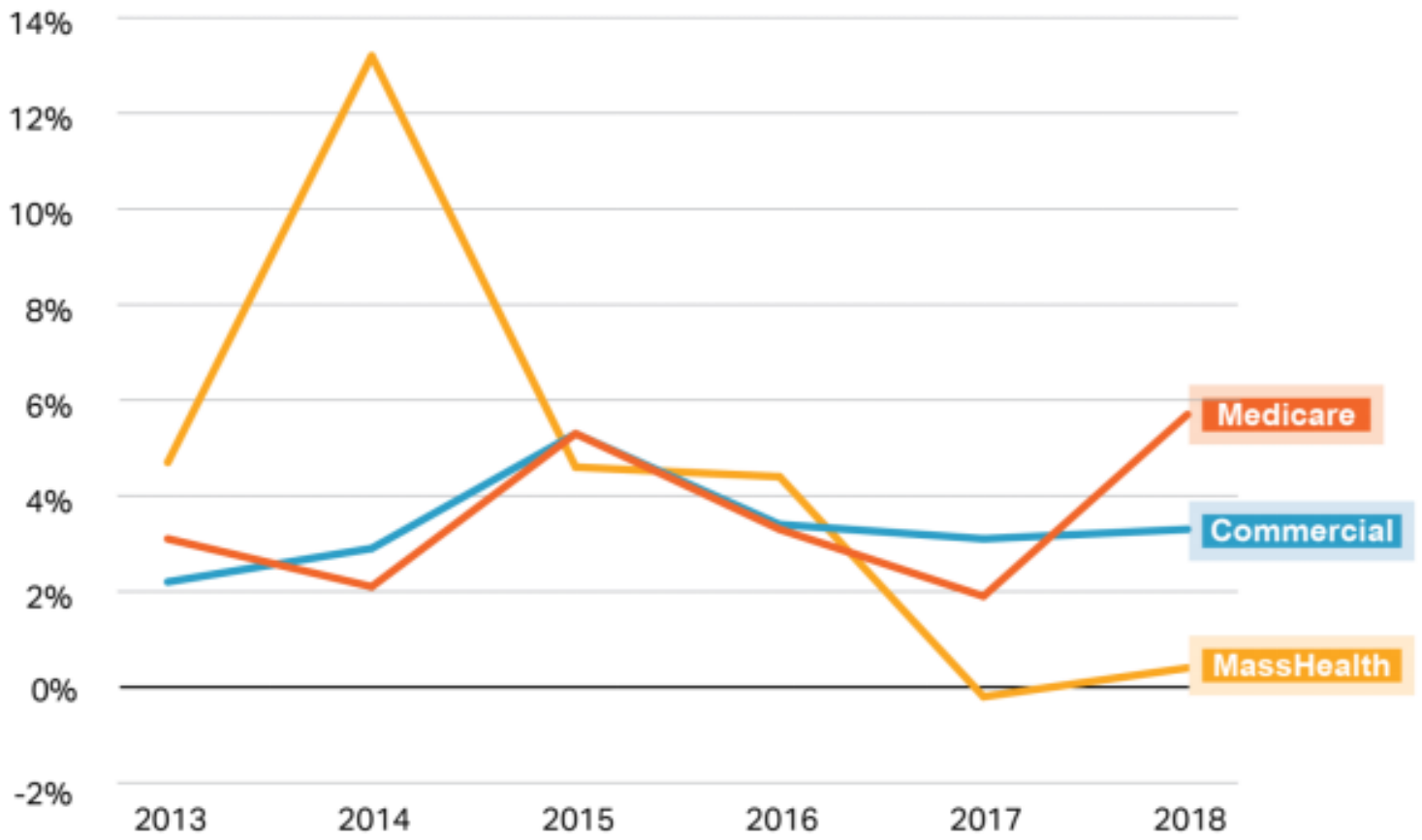
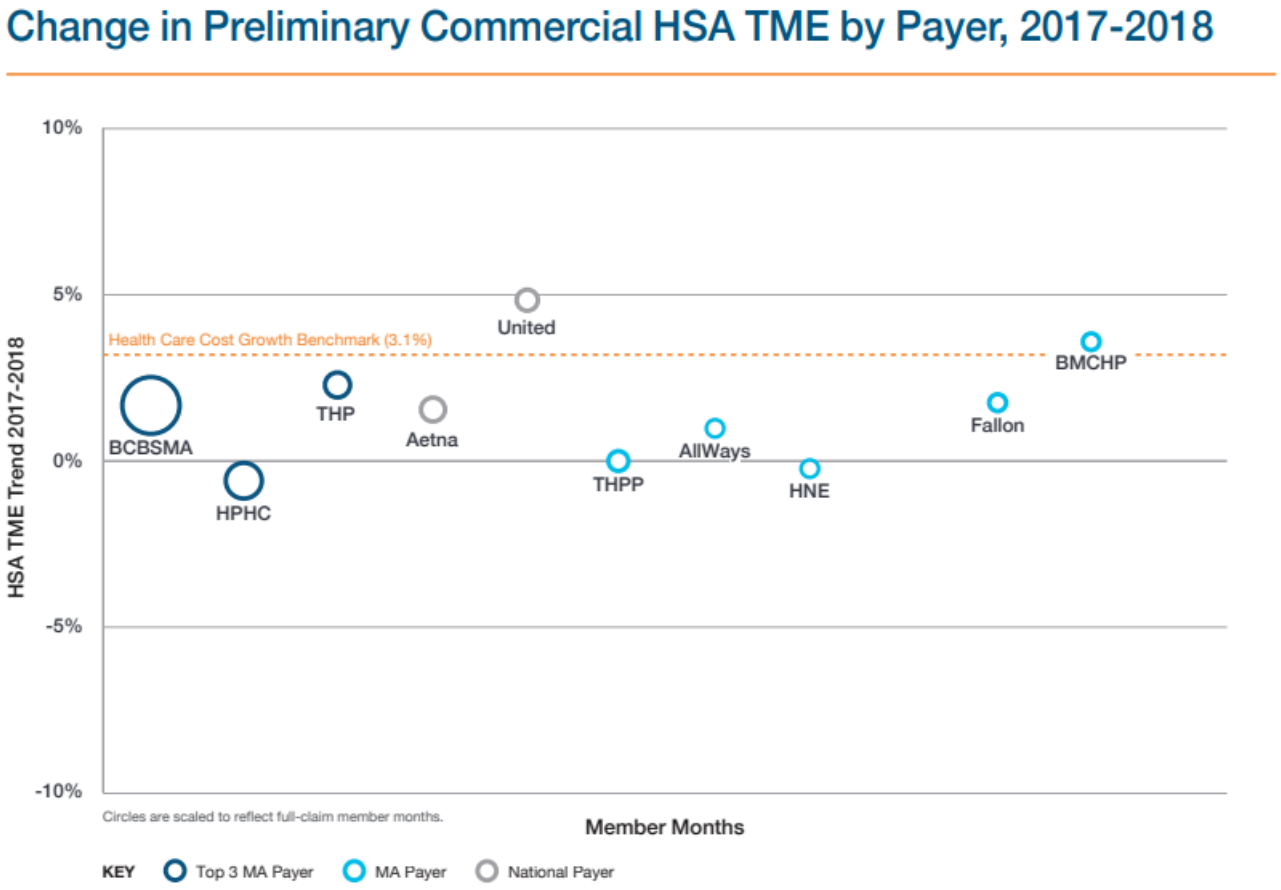
Massachusetts Reports on Annual Spending Growth by Major Sector



Source: Annual Report on the Performance of the Massachusetts Health Care System: 2019. MA Center for Health Information and Analysis.

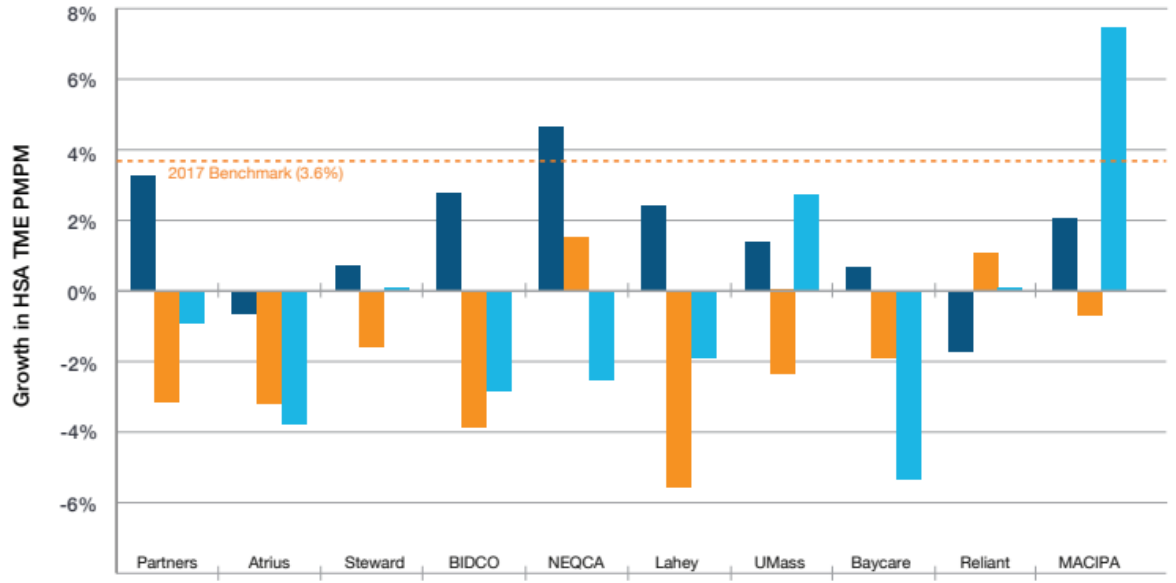
Massachusetts Reports on Total Medical Expense Growth by Insurer



Source: Annual Report on the Performance of the Massachusetts Health Care System: 2019. MA Center for Health Information and Analysis.

Massachusetts Reports on Change in Total Medical Expense at the Provider Level

Change in Final Managing Physician Group Commercial HSA TME, 2016-2017



	Partners	Atrius	Steward	BIDCO	NEQCA	Lahey	UMass	Baycare	Reliant	MACIPA
BCBSMA, HPHC, and THP Share of Group's Managed Member Months	91.0%	90.0%	85.7%	79.5%	93.1%	90.3%	80.8%	45.1%	62.1%	88.9%
Total Managed Member Months in 2017	3.1M	2.3M	2.2M	1.5M	1.4M	1.1M	1.0M	1.0M	0.7M	0.4M

Key ■ BCBSMA ■ HPHC ■ THP

Source: Annual Report on the Performance of the Massachusetts Health Care System: 2019. MA Center for Health Information and Analysis.

Key Questions for Reporting at the Provider Level

- To report healthcare spending growth by provider, there are four questions that we must address:
  1. How should providers be organized into larger entities (for the purposes of reporting)?
  2. How should Connecticut residents be attributed to reporting providers?
  3. What is a "sufficient population size" to measure provider performance against the benchmark?
  4. How should risk adjustment be applied?
- These questions are technical in nature. We will walk you through the associated major issues and ask you to provide input to OHS on three of the four questions today.

1. How Should Providers Be Organized into Larger Entities (for the Purpose of Reporting)?

- To report data, payers need technical instructions on how to organize providers.
- One approach is to have a provider directory where individual physician NPI numbers are associated with larger organizations. (MA uses this approach)
  - Several states use Tax ID Numbers (TINs) to assist with linking individual physicians to their affiliated entities but do not include TINs in the directory
  - NPIs alone provide an unreliable view of the number of organizations represented in a provider directory
- An alternative is to organize providers by total cost of care contracts applied to ACOs. (RI uses this approach)

Massachusetts Matches NPIs to Physician Groups

	A	B	C
1	NPI Number	OrgID	TME Physician Group
2	1033171749	10910	Acton Medical Associates
3	1043292360	10910	Acton Medical Associates
4	1053302158	10910	Acton Medical Associates
5	1184690505	10910	Acton Medical Associates
6	1447365408	10910	Acton Medical Associates
7	1538170774	10910	Acton Medical Associates
8	1588861660	10910	Acton Medical Associates
9	1922205020	10910	Acton Medical Associates
10	1124019765	10995	Affiliated Pediatric Practices (APP)
11	1164412839	10995	Affiliated Pediatric Practices (APP)
12	1245221019	10995	Affiliated Pediatric Practices (APP)
13	1356332985	10995	Affiliated Pediatric Practices (APP)
14	1396736161	10995	Affiliated Pediatric Practices (APP)
15	1497748834	10995	Affiliated Pediatric Practices (APP)
16	1528059128	10995	Affiliated Pediatric Practices (APP)
17	1568664795	10995	Affiliated Pediatric Practices (APP)
18	1578554713	10995	Affiliated Pediatric Practices (APP)
19	1679835011	10995	Affiliated Pediatric Practices (APP)
20	1881685485	10995	Affiliated Pediatric Practices (APP)
21	1891909305	10995	Affiliated Pediatric Practices (APP)
22	1922061878	10995	Affiliated Pediatric Practices (APP)
23	1215305040	11764	Allied Pediatrics of Greater Brockton, Inc.
24	1780849943	11764	Allied Pediatrics of Greater Brockton, Inc.
25	1942301239	11764	Allied Pediatrics of Greater Brockton, Inc.
26	1003044272	9995	Atrius Health
27	1003939703	9995	Atrius Health
28	1013975457	9995	Atrius Health
29	1023074366	9995	Atrius Health

- MA created a provider mapping of individual NPI numbers to physician groups.
- Patients are attributed to an individual clinician by their NPI number.
- Then insurers report at the physician group level.

Rhode Island Identifies the Largest ACOs

- Total cost of care contracts require a listing of which individual primary care clinicians belong to an ACO.
- RI identified the commercial and Medicaid ACOs in the state.
- Insurers identify the individual physicians "underneath" those ACOs, consistent with their own total cost of care contracts.

ACO/AE Organization	Identification Number for TME Reporting
Blackstone Valley Community Health Care	101
Coastal Medical	102
Integra Community Care Network	103
Integrated Healthcare Partners	104
Lifespan	105
Providence Community Health Centers	106
Prospect CharterCARE	107
Members Not Attributed to an ACO/AE	108

What are Options for Connecticut?

- Unlike Massachusetts, Connecticut does not currently have a provider directory that can be used to organize providers for the purpose of reporting.
  - OHS is embarking with UConn on the development of a provider directory now, so this may be a resource for future analysis.
- One option is to leverage Medicaid's provider files that link individual providers to provider groups, but it may not capture some large provider organizations that don't contract with Medicaid.
- Another option is to leverage work that UConn has been performing in support of HealthScore CT and the Quality Scorecard.

Work Performed for CT's Quality Scorecard Could Serve as the Basis for Identifying Providers for Reporting

- The Quality Scorecard assesses performance of "advanced networks," which are provider organizations that are accountable for a patient population.
- The Scorecard uses a two-step process that attributes patients to providers and providers to medical groups.

Advanced Networks*
Community Medical Group
Day Kimball Healthcare
Eastern Connecticut Health Network
Griffin Health
Hartford HealthCare
Medical Professional Services
Middlesex Hospital
Pediatric Healthcare Associates
ProHealth Physicians
Saint Francis Hospital and Medical Center
Saint Mary's Hospital
Soundview Medical Associates
ST. Vincent Medical Center
Stamford Health
Starling Physicians
Waterbury Health / Alliance
Western Connecticut Health Network
Westmed Medical Group
Yale Medicine
Yale New Haven Health

UConn's Process for Identifying Advanced Networks

- An "advanced network" is any provider that has a value-based payment contract, including pay-for-performance contracts.
- Networks were determined through the following means:
  1. Participation in Medicare Accountable Care Organization (ACO) programs.
  2. Identifying well-recognized and branded providers.
  3. Feedback from SIM and the Quality Council.
- Provider lists are then sent to the advanced networks for confirmation.
- Network updates are conducted at the end of each calendar year.
- This methodology does not apply to FQHCs, which are considered as standalone organizations.

How Should Providers Be Organized into Larger Entities (for the Purpose of Reporting)?

1. Based on existing payer total cost of care contracts?
2. Using the Quality Scorecard methodology for identifying advanced networks?
3. Another suggested method?

2. How Will Residents Be Attributed to These Providers?

- Residents need to be "attached" to a provider for the costs incurred by that resident to be "attributed" ("assigned") to a provider.
- Attribution is performed routinely by insurers for value-based contracts when providers are held accountable for quality and/or the cost of care.
- Insurers also attribute patients to providers for their own internal analyses. Some states and quality improvement organizations do the same.

What is Attribution in the Context of Reporting on the Cost Growth Benchmark?

- Being attributed to a provider for the purpose of analyses does not mean that:
  - the Connecticut resident was required to see that provider; or
  - the provider delivered all of the care the patient received.
- Attribution is used, however, to indicate that a provider had a caregiving relationship with a patient and the provider helped to direct the patient's care in some manner.

Resident Attribution: Two Approaches

Method	Pros	Cons
• Residents are attributed using a **common patient attribution methodology**, where payers work together to agree upon the methodology (such as the PCMH + or Quality Scorecard attribution methodologies) and apply it to this process.	• Supports potential comparisons of provider performance across insurers.	• Could add a layer of complexity to the process.
• Residents are attributed using each **payer's own attribution methodology** employed with its value-based payment contracts or for other purposes.	• Makes reporting easier for insurers.	• Variation in methodology would produce inconsistent results and not support provider comparisons across insurers.

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Resident Attribution Approach in DE, MA and RI

Delaware, Massachusetts and Rhode Island have all taken a similar approach, leaving the **exact methodology up to each reporting insurer.** All three states are using a primary care attribution model.

1. Insurers attribute spending by state resident members to a primary care provider based on which primary care provider was selected by plan design.
2. Then, remaining members are attributed to a primary care provider pursuant to a contract between the payer and provider for financial or quality performance.
3. Finally, members are attributed to a PCP by the payer's own attribution methodology (that does not encompass steps 1 or 2) that the insurer may use for any other purpose.

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How Should Residents Be Attributed to Provider Entities?

1. Using a common attribution methodology to be developed and agreed upon by a separate advisory body?
2. Using payers' own attribution methods?

3. What Is a "Sufficient Population Size" to Measure Provider Performance Against the Benchmark?

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

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

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4. How Should Risk Adjustment Be Applied?

- The duties of the Cost Growth Benchmark Technical Team, per ARTICLE II, Section I.H of its bylaws, include the following:

  Recommend risk adjustment that includes social risk

- For the Technical Team's purpose, "risk adjustment" is the modification of spending data to reflect changes in the underlying insurer or provider population over the course of the year.

Why Is Risk Adjustment Needed?

- The composition of a payer's or provider's population – including its clinical and social risk profile – may change over the course of a year.
  - Such changes will have an impact on spending growth, e.g., a population that is sicker than a year prior is expected to have higher spending than it would have otherwise.
- Without risk adjustment, an evaluation of performance relative to the cost growth benchmark could produce inaccurate results.

Risk Adjustment Models

- Available risk adjustment models use data elements found in claim encounter records, such as diagnoses, procedures and prescription drugs.
  - They do not include information from medical records, e.g., clinical indicators of severity, measures of prior use, lifestyle or supplemental demographic information.
- The best risk adjustment models can explain about half of the variation on health care spending, and a little more if spending for the highest cost outliers is truncated (capped).*

*Accuracy of Claims-Based Risk Scoring Models, Society of Actuaries, October 2016.

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Risk Adjustment Is Only Performed at the Insurer and Provider Level

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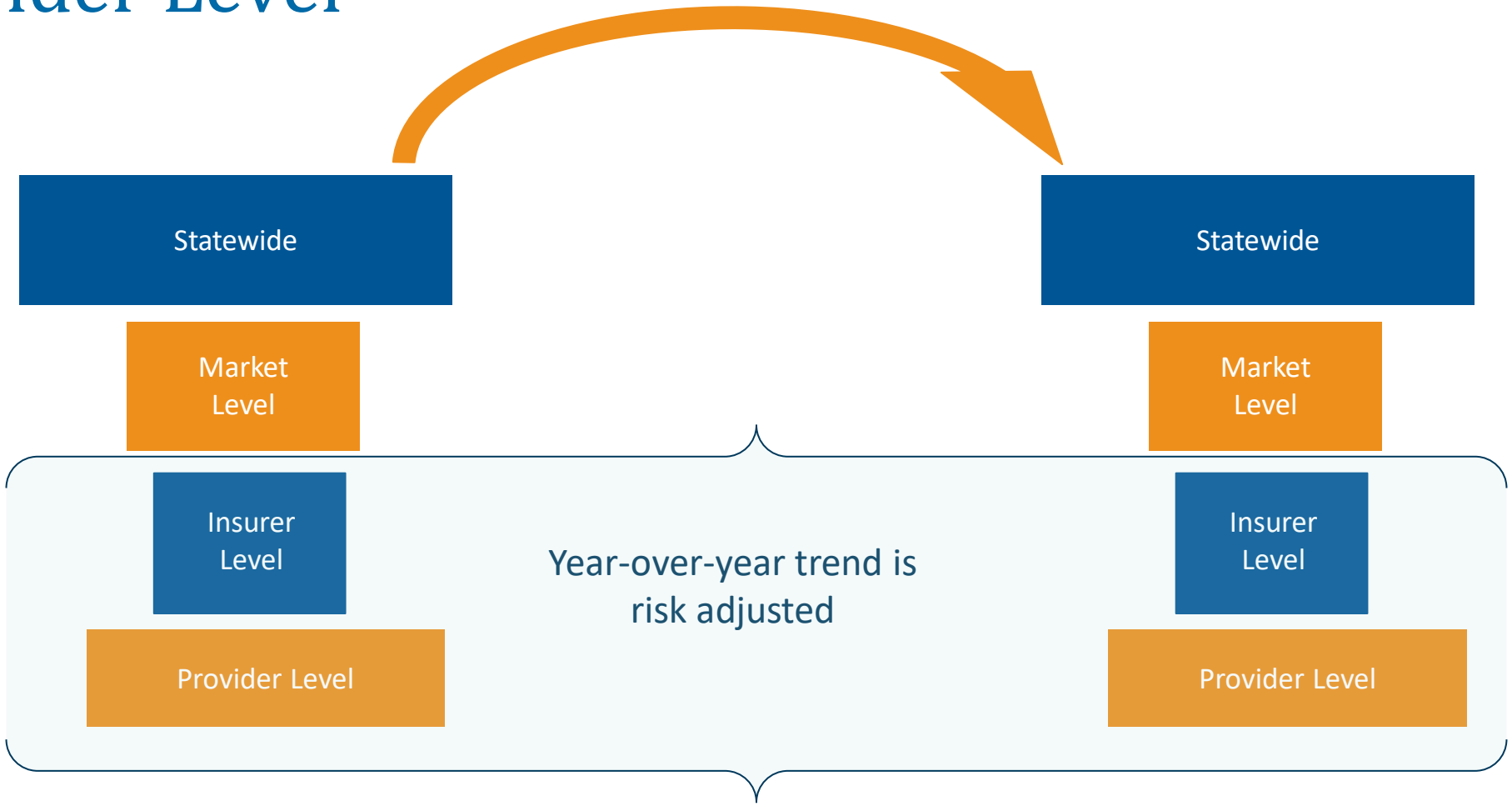
Risk Adjustment Is Only Performed at the Insurer and Provider Level



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Other States' Approach to Risk Adjustment

- Other states with cost growth benchmarks adjust cost growth trend data to reflect changes in the population.
  - Insurers are instructed to generate risk scores using whatever product they license. States then use the scores to make the adjustments.
- For Massachusetts, in 2016 insurers used at least 11 organizations that had produced at least 40 different risk adjustment software models.

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Risk Adjustment Approach

There are two ways to perform clinical risk adjustment:

Method	Pros	Cons
1. Each insurer uses its own risk adjuster (if using payer-reported data)	• Administratively less complex	• Provider spending growth rates can't be compared across insurers because clinical risk adjustment varies
2. Use a common risk adjuster	• There are publicly available risk adjusters that could be used (e.g., HCCs) • Provider experience could be compared across insurers	• Administratively more complex - if using payer-reported data

How Should Connecticut Address Clinical Risk Adjustment?

1. Adopt a single risk-adjustment methodology?
2. Have each payer use its own methodology?

Risk Adjustment for Social Factors

- There is growing interest nationally in applying social risk factor adjustment to health care payments
- However, there is *very* limited experience with risk adjusting for social factors; methodologies for doing so are nascent.
  - It does not appear that there is yet a means to wide application of social risk factor adjustment in CT, although there is clear potential for the future.
- State strategies to adjust for social risk factors in payment and / or quality improvement policies are evolving.

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Risk Adjustment for Social Factors

1. Payment Adjustments: Massachusetts and Minnesota incorporate social factor risk adjustment into payments to MCOs (MA) and ACOs (MA & MN)
   - Massachusetts Medicaid (MassHealth) has been exploring how SDOH and medical complexity combined help to predict health care costs
     - Modeling adds SDOH predictors, including unstable housing and a "neighborhood stress score," a composite measure of financial and economic stress, to clinical risk adjustment (DxCG)
   - Minnesota adjusts ACG scores for homelessness or past incarceration (adults); child protection (children)
     - Adjustments are combined with other risk factors, including SMI and SUD

Risk Adjustment for Social Factors

2. Quality: Massachusetts is also developing and testing risk adjustment for social factors for Medicaid ACO quality measures
   - Found largest SDOH contributor to risk adjustment is home insecurity/homelessness
3. Care Coordination: Medicaid programs in Minnesota, Oregon and Washington, are exploring ways to assess medical and social complexity to stratify pediatric populations
   - Seek to identify factors that are predictive of a high-cost event
   - Recommend tiers to deliver targeted care coordination services (MN, WA) or design care management programs (OR)

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Given the State of the Art for Social Risk Adjustment, How Should Connecticut Address Social Risk Adjustment for the Cost Growth Benchmark?

Wrap-Up & Next Steps

Next Meeting: July 2, 2020

- At our next meeting, we will begin our discussions on the primary care target, beginning first with a review of other states' targets.

Meeting Schedule

Meeting #	Date	Time
6	Thursday, July 2	1-3pm
7	Wednesday, July 29	1-3pm
8	Thursday, August 13	1-3pm
9	Thursday, August 27	1-3pm
10	Thursday, September 24	1-3pm

Appendix: Stakeholder Engagement

- CONECT
- SHIP
- Ministerial Health Fellowship
- Keep the Promise Coalition
- Cross Disability Lifespan Alliance