Payer Technical Briefing for the Baseline Health Care Cost Growth Benchmark Submissions

March 31, 2021

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Today’s Webinar

1. Overview of Connecticut’s Health Care Cost Growth Benchmark and Primary Care Spending Target
2. Detailed Review of the Total Medical Expense Data Reporting Requirements
   - Explanation of Definitions and Data Collection Methodology
   - Walk Through of Data Submission Templates
3. Data Reporting, Collection and Validation Process
4. Questions

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Overview of Connecticut’s Cost Growth Benchmark and Primary Care Spend Target Programs

Connecticut's Health Care Cost Growth Benchmark

Calendar Year	Benchmark Values
2021	3.4%
2022	3.2%
2023	2.9%
2024	2.9%
2025	2.9%

Connecticut's cost growth benchmark is an **annual rate-of-growth benchmark for statewide healthcare spending**.

The benchmark values are based on a methodology was developed through an open public process that considered various economic indicators.

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Total Health Care Expenditures

Total Medical Expense (TME) + **Net Cost of Private Health Insurance (NCPHI)** = **Total Healthcare Expenditures (THCE)**

Total Medical Expense (TME): **All incurred expenses for CT residents for all health care services**, regardless of where the care was delivered and regardless of the situs of the member's plan.

Net Cost of Private Health Insurance (NCPHI): The **costs to CT residents associated with the administration of private health insurance.**

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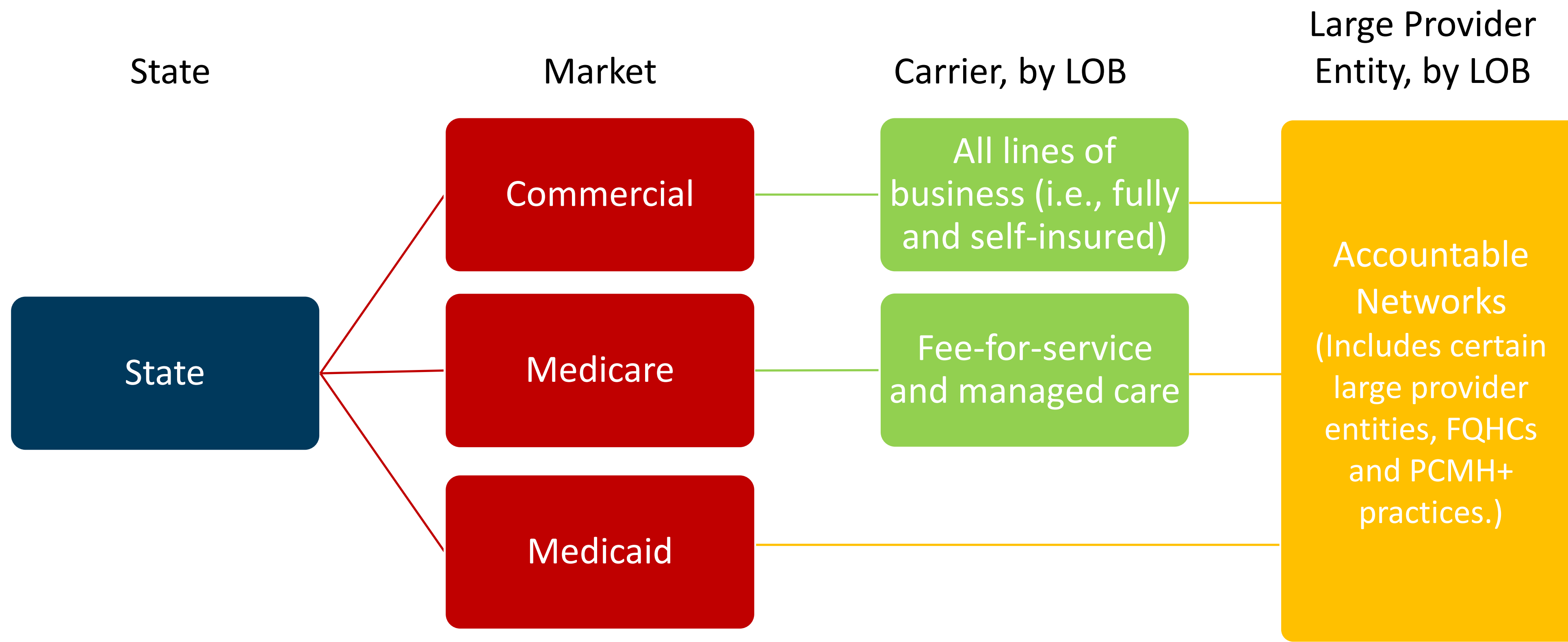
Connecticut's Primary Care Spending Target

- A primary care spend target evaluates **primary care spending as a percentage of total medical spending**.
- Connecticut is expected to **increase primary care spending as a percentage of total medical spending to 10%** by 2025.
- The primary care spending target for **2021 is 5.0%**. Annual targets for 2022-2024 will be set after OHS collects and analyzes baseline spending data.

Four Levels of Public Reporting of Performance Against the Benchmark and Target



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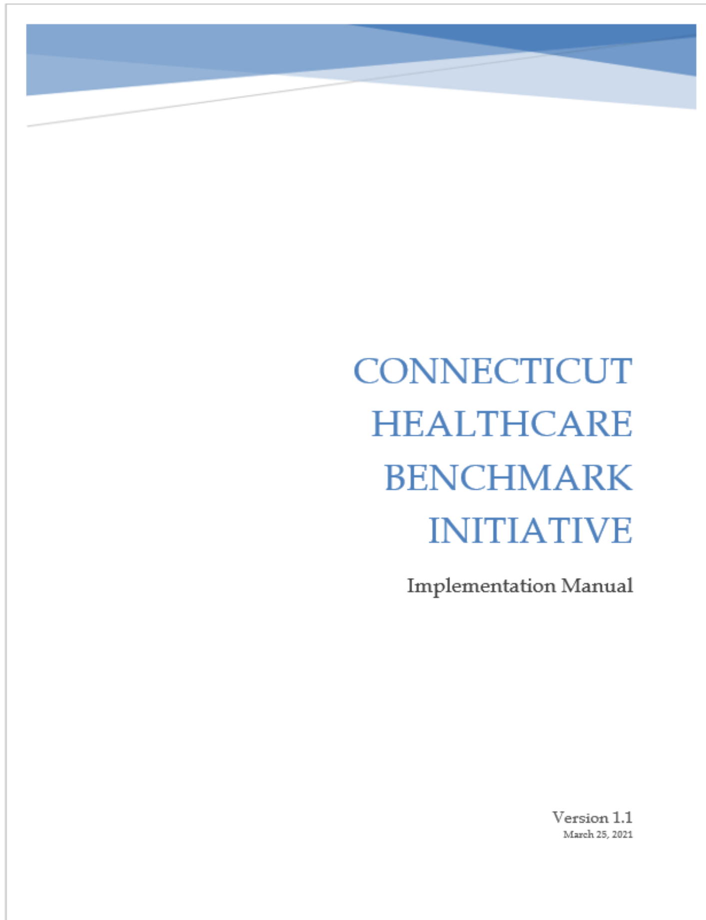
Insurance Carriers Reporting Data to Assess Performance Against the Benchmark and Target

Carrier***	Commercial Fully and Self-Insured	Medicare Managed Care*
Aetna Health & Life	X	X
Anthem	X	X
Cigna	X	
ConnectiCare	X	X
Harvard Pilgrim Health Care	X	
Office of the State Comptroller (OSC)**	X	X
UnitedHealthcare	X	X

* Includes Medicare Advantage Medicare-related expenditures for the Medicare-Medicaid dual eligible individuals. Of note, CMS will provide Medicare FFS spending and prescription-drug spending.
** OSC will submit data for the purposes of measuring OSC's performance relative to the benchmark. OSC's past, current, and future TPAs should still report OSC within their data submission.
*** OHS also collects data from the Centers for Medicare & Medicaid Services and the Department of Health and Social Services for fee-for-service Medicare and Medicaid data.

Detailed Review of the Total Medical Expense Data Reporting Requirements

Implementation Manual



- Comprehensive document that describes the:
  - Overall initiative;
  - Formulae for developing the healthcare cost growth benchmark and primary care spend target;
  - Methodology for calculating total healthcare spending against the benchmark and primary care spend against the target; and
  - Process for publicly reporting the results.
- Contains data reporting specifications for commercial and Medicare managed care carriers in Appendix A.

Carrier Reporting Template

Record	Description
Header Record	Basic carrier identifying information
Large Provider Entity Record	Total medical expense by large provider entity, by insurance category code
Pharmacy Rebate Record	Pharmacy rebates by insurance category code
Market Enrollment	Detailed member enrollment by carrier market and income from fees of uninsured plans
Variance Information	Data required for creating confidence intervals
Mandatory Questions	Attestation on the data accuracy, and checks on assumptions used for reporting the data
Data Validation	Series of checks to ensure data are consistent

Basic Carrier Identifying Information

- Each carrier will be assigned an “organization ID”
- Carriers should provide the following information:
  - Reporting period start and end dates
  - Clinical risk adjustment tool, including some description of the underlying methodology
  - Listing of “d/b/a”

Example of Provider Entity Data Reporting

Large Provider Entity	Insurance Category Code	Member Months	Clinical Risk Adjustment Score	Claims: Hospital Inpatient	Claims: Hospital Outpatient	Claims: Professional, Primary Care	Claims: Professional, Specialty	Claims: Professional Other
Sample Provider A	3	205,487	1.59	$32,559,832	$40,765,821	$6,630,127	$16,641,726	$11,821,710
Sample Provider B	4	90,562	1.75	$7,847,784	$5,576,885	$1,783,739	$4,501,854	$2,675,265
Sample Provider C	1	45,962	1.33	$15,476,032	$14,686,812	$4,278,605	$11,758,339	$3,458,896
Sample Provider D	5	65,820	1.70	$2,792,779	$1,085,310	$352,012	$688,323	$656,492
Sample Provider E	3	60,303	1.57	$10,924,413	$22,947,355	$2,457,696	$5,813,743	$5,908,118
Not Attributable*	1	153,023	1.56	$25,264,996	$44,933,676	$5,725,592	$13,934,488	$11,754,523

Large Provider Entity Record

Process for Identifying Large Provider Entities

- To keep reporting manageable, OHS is asking carriers to report on a list of 11 large provider entities.
- This list was developed by:
  - Compiling a list of Accountable Networks, PCMH+ practices and other known large entities in the State.
  - Asking some carriers to identify with which of those organizations they have a total cost of care contract, and which organization serves as the “contracting entity”; and
  - Analyzing the extent of overlap in carriers’ contracting with entities on the original list.
- The list of large provider entities is preliminary, and may change in 2020 and future years after analysis of data.

Large Provider Entity Record

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Listing of Large Provider Entities

Large Provider Entity ID	Large Provider Entity
101	Community Medical Group
102	Connecticut Children’s Medical Center
103	Connecticut State Medical Society IPA
104	Fair Haven Community Health Center (aka Fair Haven Clinic)
105	Integrated Care Partners
106	Medical Professional Services
107	Northeast Medical Group
108	OptumCare Network of Connecticut
109	Prospect Connecticut Medical Foundation, Inc. (dba Prospect Medical, Prospect Health Services, Prospect Holdings)
110	Southern New England Health Care Organizations (aka SOHO Health, Trinity Health of New England ACO, LLC)
111	Value Care Alliance
112	Members Not Attributed to a Large Provider Entity

Large Provider Entity Record

NOTE: List of large provider entities may be revisited in 2020 and future years after analysis of data.

Reporting Spending by Large Provider Entity

- To report spending at the large provider entity level, members will need to be attributed to a primary care physician (PCPs), and PCPs will need to be attributed to a large provider entity.
  - Each carrier should use its methodology to attribute members to a primary care provider.
  - Each carrier will be asked to attribute PCPs to those large provider entities based on existing contractual relationships.
- All spending on members will be reported under the large provider entity to which the members' PCP is attributed.
- Spending for members NOT attributed to a large provider entity should be reported in aggregate in one row of the TME file.

Large Provider Entity Record

Reporting TME by Insurance Category Code

- Mutually exclusive data categories that indicate for what market / line of business the carrier is reporting data.
- Commercial has two categories:
  - **Full claims** – for when the carrier holds the entire medical benefit and has all of the data.
  - **Partial claims** – for when the carrier holds part of the benefit, and another part is carved out (e.g., pharmacy or behavioral health). Carriers must estimate partial claims data for which it does not have access.

Insurance Category Code	Definition
1	Medicare Managed Care (excluding Medicare/Medicaid Dual Eligibles)
2	Medicaid including CHIP (excluding Medicare/Medicaid Dual Eligibles)
3	Commercial — Full Claims
4	Commercial — Partial Claims
5	Medicare Expenditures for Medicare/Medicaid Dual Eligibles
6	Medicaid Expenditures for Medicare/Medicaid Dual Eligibles
7	Other

Large Provider Entity Record

General Parameters for Submitting TME

- Spending **by or on behalf of Connecticut residents** regardless of where the care was delivered and the situs of the residents' plan
- Spending on **healthcare services/benefits**
  - Vision and dental services are generally excluded, but included only when covered as a medical benefit or are a covered benefit under Medicare

Large Provider Entity Record

Categories of Claims-based Spending to Report

- Carriers should report claims-based spending according to the following categories:
  - Hospital Inpatient
  - Hospital Outpatient
  - Professional: Primary Care (excludes OB/GYN)*
  - Professional: Primary Care (includes OB/GYN)*
  - Professional: Specialty
  - Professional: Other
  - Long-term Care
  - Pharmacy
  - Other

**The "Professional: Primary Care" categories have code level definitions in the manual.*

Large Provider Entity Record

Categories of Claims-Based Spending to Report

- **Hospital inpatient:** The TME paid to hospitals for inpatient services, including all room and board and ancillary payments, and payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. Does not include payments made for observation services, for physician services during an inpatient stay that have been billed directly by a physician group practice or an individual physician, and inpatient services at non-hospital facilities.
- **Hospital outpatient:** The TME paid to hospitals for outpatient services, including payments made for hospital-licensed satellite clinics, emergency room services not resulting in admittance, and observation services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.

Large Provider Entity Record

Categories of Claims-based Spending to Report

- **Professional, Primary Care:** The TME paid to primary care providers generated from claims using code-level definitions as detailed in the implementation manual. *This definition excludes OB/GYN.*
- **Professional, Primary Care (for OHS monitoring purposes):** The TME paid to primary care providers, including OB/GYNs and midwifery, generated from claims using code-level definitions as detailed in the implementation manual.
- **Professional, Specialty:** The TME paid to physicians or physician group practices generated from claims, including services provided by a doctors of medicine or osteopathy in clinical areas other than family medicine, internal medicine, general medicine or pediatric medicine, not defined as primary care in the first primary care definition.

Large Provider Entity Record

Categories of Claims-based Spending to Report

- **Professional, Other:** The TME paid from claims to healthcare providers for services provided by a licensed practitioner other than a physician and is not identified as primary care in the first primary care definition.
- **Pharmacy:** The TME paid from claims to healthcare providers for prescription drugs, biological products or vaccines as defined by the insurance carrier's prescription drug benefit. Pharmacy spending provided under the medical benefit should be attributed to the location in which it was delivered. Medicare Advantage carriers that offer stand-alone prescription drug plans should exclude stand-alone PDP data from their TME. Pharmacy data is to be reported gross of applicable rebates.

Large Provider Entity Record

Categories of Claims-Based Spending to Report

- **Long-Term Care:** All TME data from claims to providers for nursing homes and skilled nursing facilities, intermediate care and assisted living facilities, and providers of home- and community-based services, including personal care, homemaker and chore services, home-delivered meal programs, home health services, adult daycare, self-directed personal assistance services, and programs designed to assist individuals with long-term care needs who receive care in their home and community.
- **Other:** All TME paid from claims to healthcare providers for medical services not otherwise included in other categories, including durable medical equipment, facility fees of community health services, freestanding ambulatory surgical center services, freestanding diagnostic facility services, hospice, hearing aid services and optical services.

Large Provider Entity Record

Additional Specifications for Reporting Claims

- Include **allowed claims** (i.e., spending covered by payers and out-of-pocket member spending) only when carrier is the primary payer
  - Do not include premium payments
- Claims spending should be reported based on the date the service was **incurred**.
- Carriers should allow for a claims run-out period of at least 120 days after December 31 of the performance year.
- If necessary, carriers should apply reasonable and appropriate incurred but not reported (IBNR) / incurred but not paid (IBNP) completion factors to each respective TME service category.

Large Provider Entity Record

Categories of Non-Claims-Based Spending to Report

- Carriers should report non-claims-based spending according to the following categories:
  - Prospective Capitation, Global Budget, Case Rate or Episode-based Payments
  - Performance Incentive Payments
  - Payments to Support Population Health and Practice Infrastructure
  - Provider Salaries
  - Recovery
  - Other
  - Total Primary Care Non-Claims Based Payments *(this category is the only category not mutually exclusive from the others)*

Large Provider Entity Record

Categories of Non-Claims-Based Spending to Report

- **Prospective Capitation, Global Budget, Case Rate or Episode-Based Payments:** Includes single payments to providers to provider healthcare services over a defined period of time, prospective payments for a comprehensive set of services for a broadly defined population or a defined set of services where certain benefits are carved out, payments made to providers in a given provider organization for a patient receiving a defined set of services for a specific time period, and payments received by providers for a patient receiving a defined set of services for a specific condition across a continuum of care, or care for a specific condition over a specific time period.
- **Performance Incentive Payments:** Includes rewards to providers for achieving quality or cost-saving goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target.

Large Provider Entity Record

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Categories of Non-Claims-Based Spending to Report

- **Payments to Support Population Health Practice and Infrastructure:** Includes payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs.
- **Provider Salaries:** All payments for salaries of providers who provide healthcare services not otherwise included in other claims and non-claims categories.
- **Recovery:** All payments received from a provider, member/beneficiary or other payer, which were distributed by a payer and then later recouped due to a review, audit or investigations. This field should be reported as a negative number.

Large Provider Entity Record

Categories of Non-Claims-Based Spending to Report

- **Other:** All other payments made pursuant to the carrier's contract with a provider not made on the basis of a claim for health care benefits/services and cannot be properly classified elsewhere.
- **Total Primary Care Non-Claims-Based Payments:** All non-claims-based payments included in the previous six categories that are specifically made to a primary care provider or provider organization.

Large Provider Entity Record

Additional Specifications for Reporting Non-Claims Payments

- Non-claims payments should be reported based on when the spending was **incurred**.
  - For example, in May 2020, a carrier paid shared savings to a large provider entity based on meeting performance benchmarks in calendar year 2019. Such payment should be reported for 2019.
- Carriers should allow for a non-claims reconciliation period of at least 180 days after December 31 of the performance year to reconcile non-claims payments.
- Carriers should apply reasonable and appropriate estimates of non-claims liability to each large provider entity that are expected to be reconciled after the 180-day review period.

Large Provider Entity Record

Risk Adjustment of Data

- Carriers should submit TME data as a non-adjusted value. However, they should also report provider-level risk scores so OHS can adjust TME based on member clinical risk.
- Payers may choose their own clinical risk adjustment tool and software, but must disclose the tool and underlying methodology with their TME submission.

THCE and TME is Net of Pharmacy Rebates

- OHS will be collecting pharmacy rebate information from each carrier to recognize it as income to the carrier.
- The estimated value of rebates attributed to CT resident members provided by pharmaceutical manufacturers for Rx with dates of fill corresponding to CY reported.
  - This includes PBM rebate guarantee amounts or other PBM rebates transferred to carriers.

Pharmacy Rebate Record

Member Months by Market

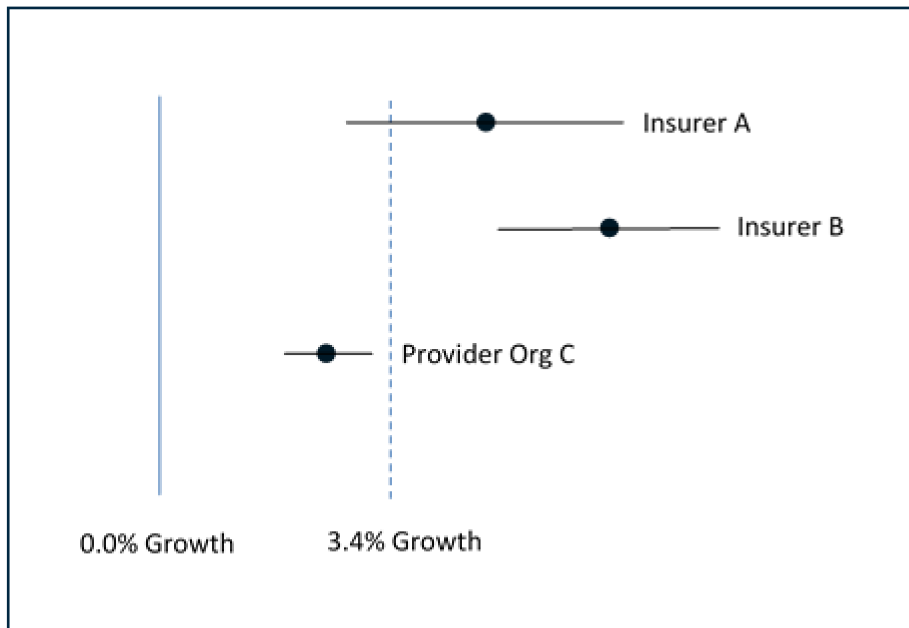
- The Market Enrollment Tab will be the source of some information to compute NCPHI:
  - Member months by market; and
  - Income from fees of uninsured plans (applies to self-insured only)
- Only members who are Connecticut residents should be reported in these data

Market Enrollment Category Code	Definition
901	Individual
902	Large group, fully insured
903	Small group, fully insured
904	Self-insured
905	Student market
906	Medicare managed care
907	Medicaid/CHIP managed care
908	Medicare/Medicaid duals

Determining Payer and Provider Entity Performance Against the Benchmark

- OHS intends to conduct statistical testing to assess carriers' and provider entities' performance against the cost growth benchmark.
- This will be done through the development of a "confidence interval" – an upper and lower bound – around each entity's cost growth.
  - A confidence interval is a type of estimate in statistics that shows a possible range of values in which we are fairly sure our true value lies.
  - In practice, it allows OHS to say, "We are 95% confident that the interval between A [lower bound] and B [upper bound] contains the true cost growth for entity C."

How OHS Will Use Confidence Intervals to Determine Performance Against the Benchmark



Note: Figure is not to scale

- Performance against the benchmark will be determined as follows:
- Benchmark has been achieved when the upper bound is fully below the benchmark (e.g., Provider Org C)
- Unable to determine performance when upper or lower bound intersects the benchmark (e.g., Insurer A)
- Benchmark has not been achieved when lower bound is fully over the benchmark (e.g., Insurer B)

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Data Needed to Develop Confidence Intervals

- Carriers will need to provide variance information:
  - by line of business for the carrier overall
  - by line of business for each large provider entity
- Line of business is defined as follows:
  - **Medicare:** includes Medicare managed care, and Medicare expenditures for Medicare/Medicaid dual eligible
  - **Commercial:** includes full claims and partial claims populations
- Each individual member should be included in calculation of variance, regardless of whether the member has any paid claims.
- Variance data should be based on the adjusted partial claim population data.

Data Attestation and Mandatory Questions

- Payers must attest to the accuracy of the data reported.
- Payers must answer a series of questions designed to ensure that assumptions used for reporting data are consistent with the requirements outlined in the Implementation Manual, including questions on:
  - Clinical risk adjustment
  - Population included
  - Reporting of Total Medical Expense data
  - Reporting of pharmacy data
  - Reporting of variance data

Mandatory Questions

Pre-Submission Data Validation

- Be sure to review the Data Validation Tab before submitting data!
- The Data Validation Tab includes:
  - A series of checks for inconsistencies in the data.
  - Tables that allow payers to look at per member per month (PMPM) spending on service categories by market, and by large provider entity by market.

Data Reporting, Collection and Validation Process

Due Date for Pre-Benchmark Data

- For this round, OHS is collecting 2018 and 2019 pre-benchmark data.
- Data are due to OHS by **May 28, 2021.**
- Electronic files must be submitted through the State's secure file transer server at https://sft.ct.gov

Data Reporting, Validation and Collection Process

OHS will work with payers to validate TME and primary care spend data. Payers can expect to hear from OHS:

1. After the initial data submission to ensure data were submitted using specifications outlined in the Implementation Manual and to review initial PMPM spending and trend by service category; and
2. Once OHS aggregates payer and large provider entity data to review payer data prior to publication.

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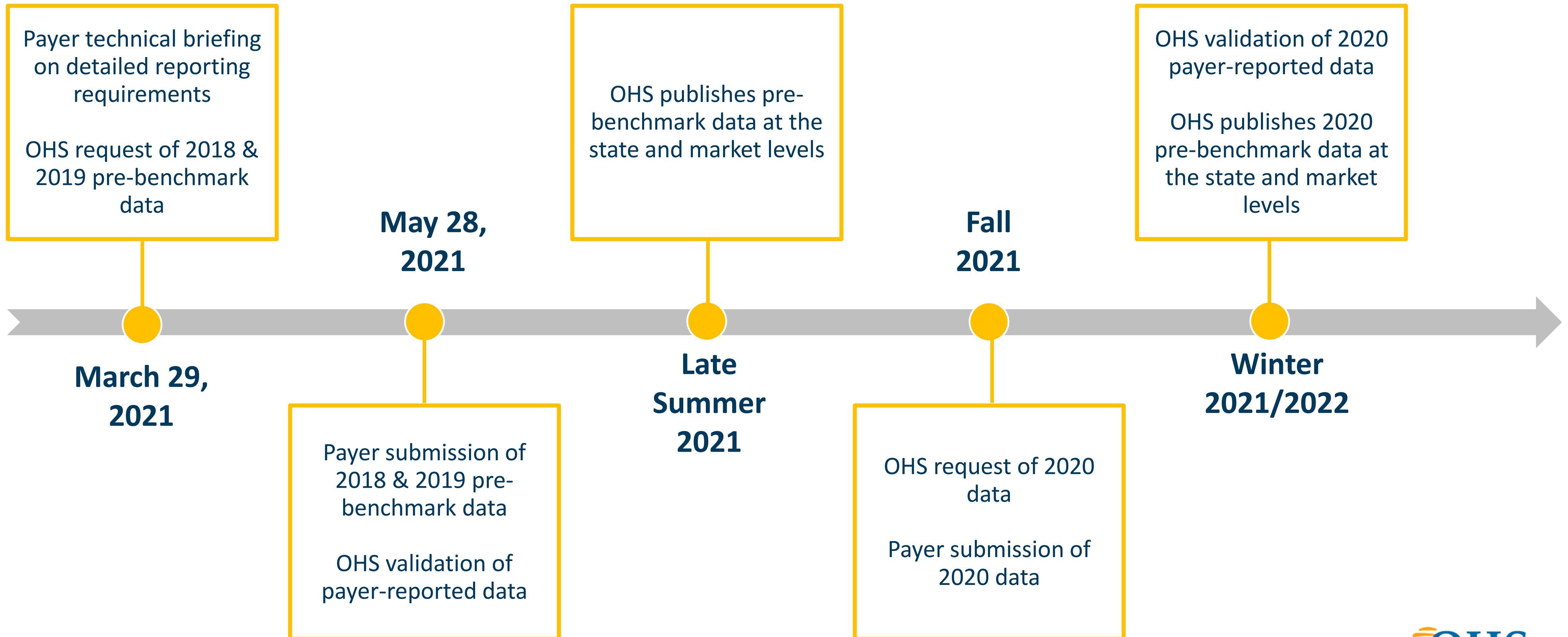
Data Collection and Reporting Timeline



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