CONNECTICUT

Office of Health Strategy Healthcare Benchmark Initiatives

June 25, 2024

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Welcome and Introductions

Agenda

9:30–10:00	Introduction
10:00–10:30	Healthcare Affordability in Connecticut
10:30-11:30	Retail Pharmacy: A Cost Driver for Connecticut's Health System
11:30–11:45	*Break*
11:45–12:45	Cost Growth Benchmark and Primary Care: The Role of Payers
12:45–1:45	*Lunch*
1:45–2:45	Improving Quality Healthcare in Connecticut
2:45–3:15	Primary Care Innovations
3:15–3:30	Conclusion and Next Steps

History of the Healthcare Benchmark

Benchmark Initiatives

Cost Growth Benchmark

Measures the increase in per person, per month spending on healthcare in Connecticut and increases transparency of healthcare costs

Quality Benchmark

Measures healthcare quality with clinical measures

Ensures that cost containment measures are working side by side with quality improvement efforts

Primary Care Spending Target

Seeks to increase the percentage of healthcare dollars spent on primary care

The target increases every year until it reaches the goal of 10% of total healthcare spending by 2025

Connecticut's Healthcare Cost Growth Benchmark

Calendar Year	Benchmark Values
2021	3.4%
2022	3.2%
2023	2.9%
2024	4.0%*
2025	2.9%

*Modified by OHS from 2.9% to account for inflation

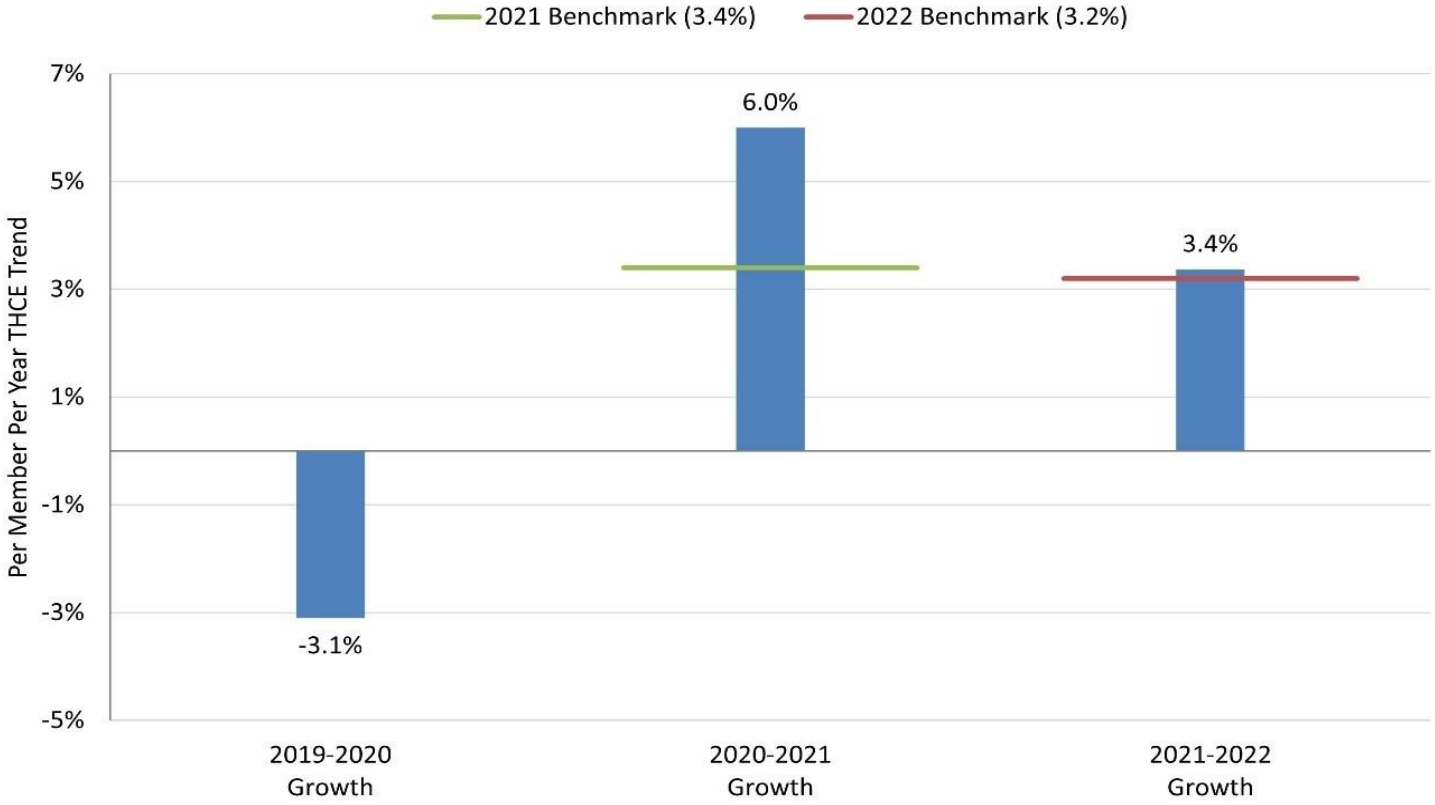
- Connecticut's cost growth benchmark is a target **annual rate-of-growth** for per person healthcare spending.
- The benchmark values are based on a blend of forecasted per capita potential gross state product (PGSP) and forecasted growth in median income.

Understanding Benchmark Programs

- **Not All Spending Growth is Bad**
- **It's About More Than Slowing Growth Rates**

Benchmark Results

Cost Growth Benchmark Results



Data Source: OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS), the Connecticut Department of Social Services (DSS), the Connecticut Department of Correction (DOC), and the Veterans Health Administration (VHA).
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates. Data include the net cost of private health insurance (NCPHI).

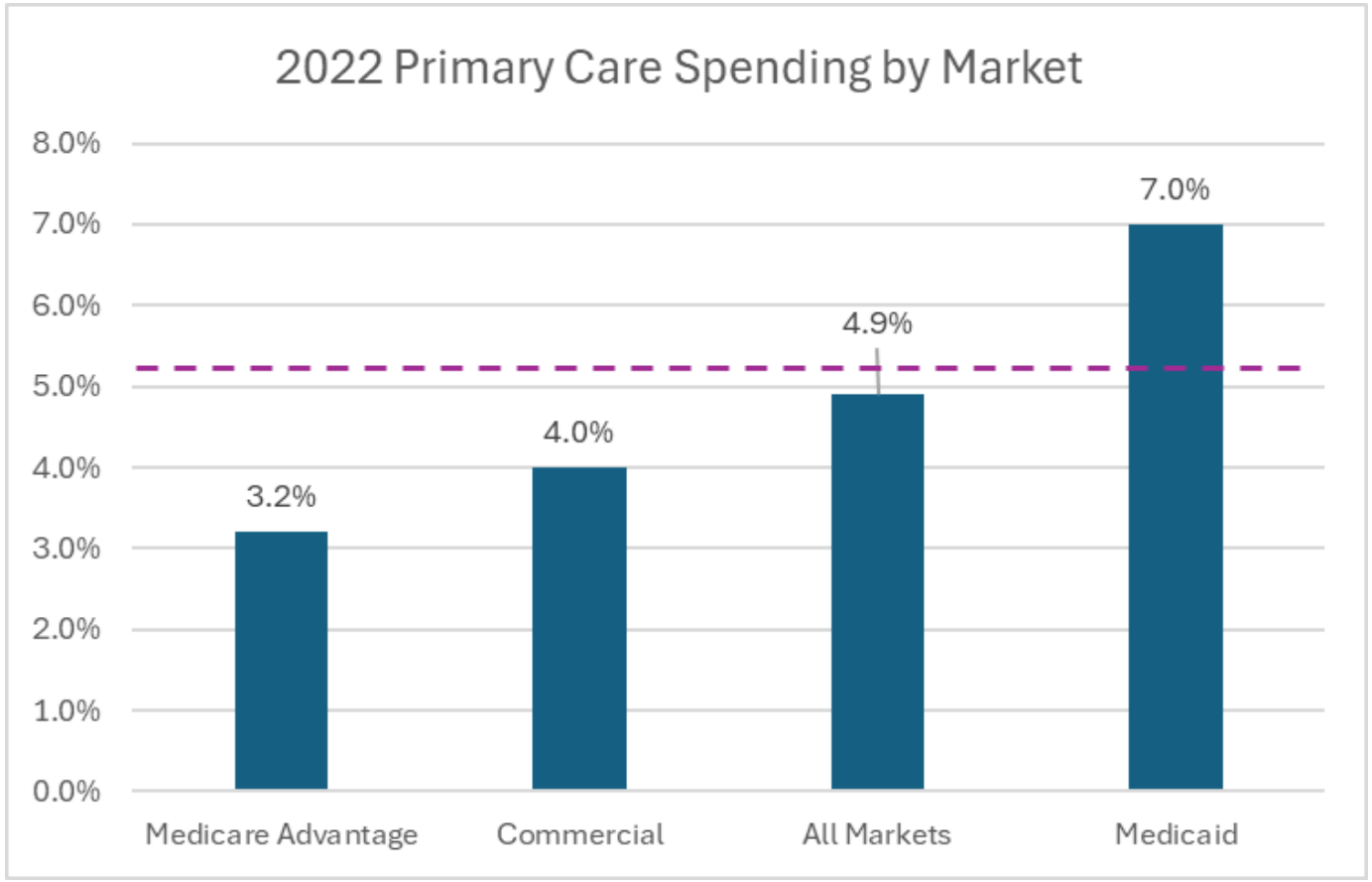
Quality Benchmark Results

	Commercial	Medicare	Medicaid
Asthma Medication Ratio (Ages 5-18)	✓	Not Applicable	✗
Asthma Medication Ratio (Ages 19-64)	✓	Not Applicable	✓
Controlling High Blood Pressure	✓	✓	✓
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: Poor Control	✓	✓	✓

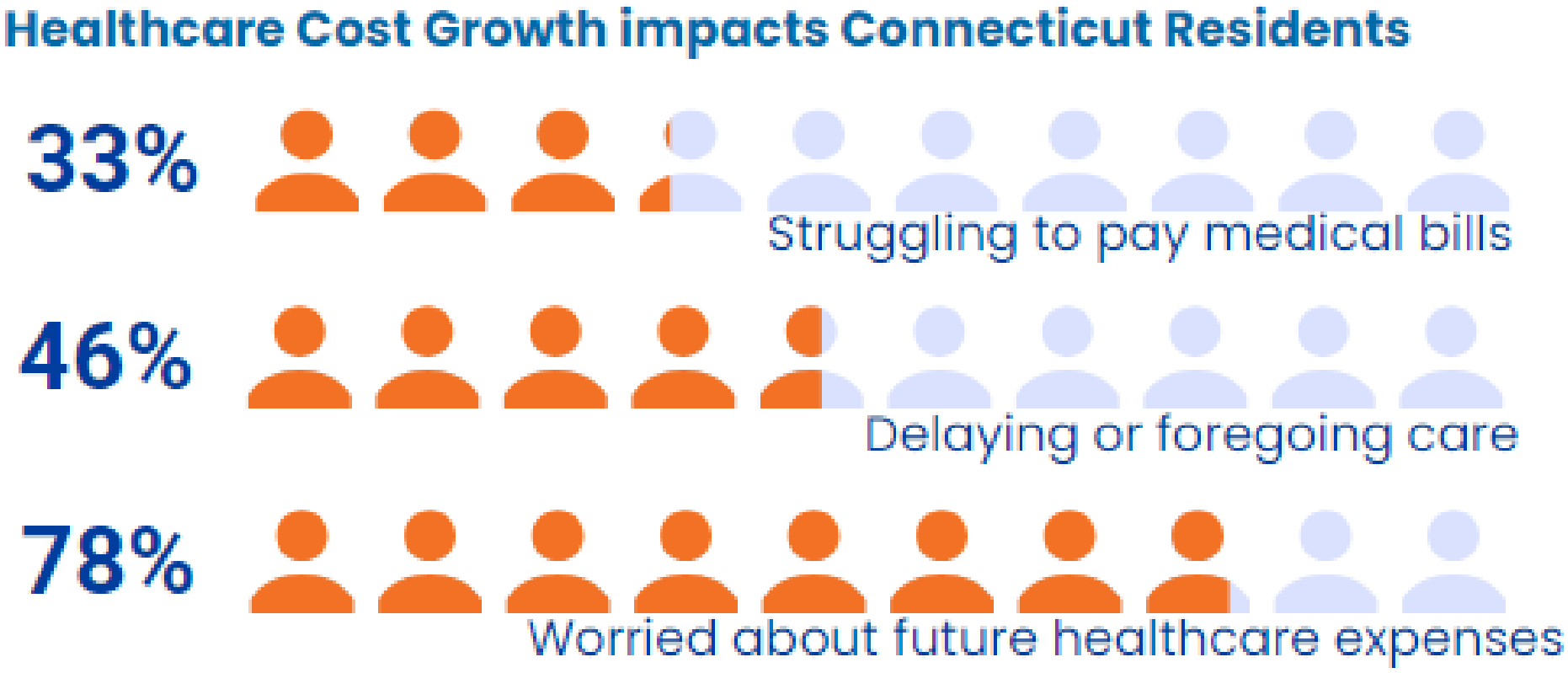
Primary Care Spending Target

- Statewide primary care spending was 4.9%, below the 5.3% target

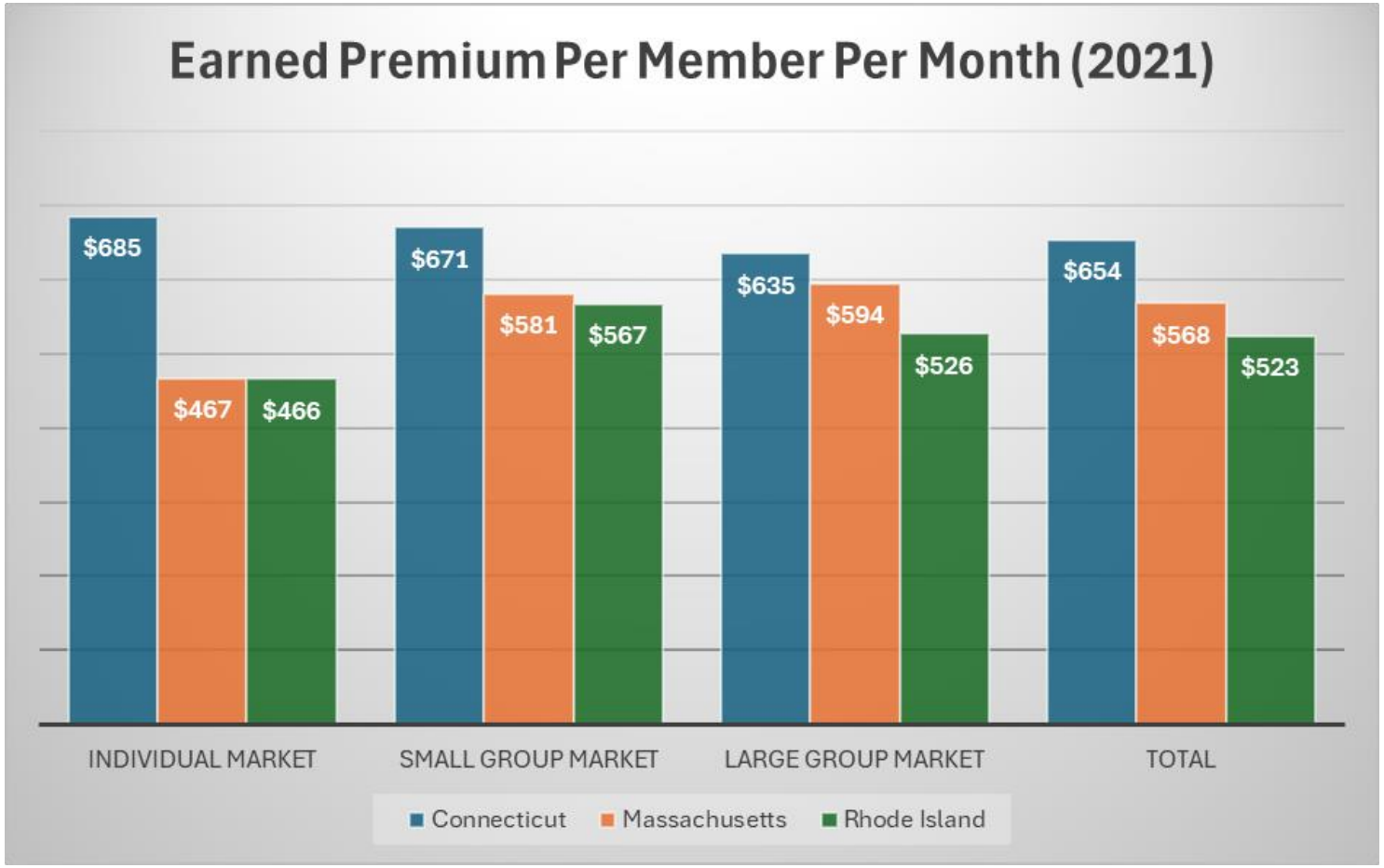
- Statewide, primary care spending increased to $1.05 billion, up from approximately $1 billion in 2021



Why a Cost Growth Benchmark?

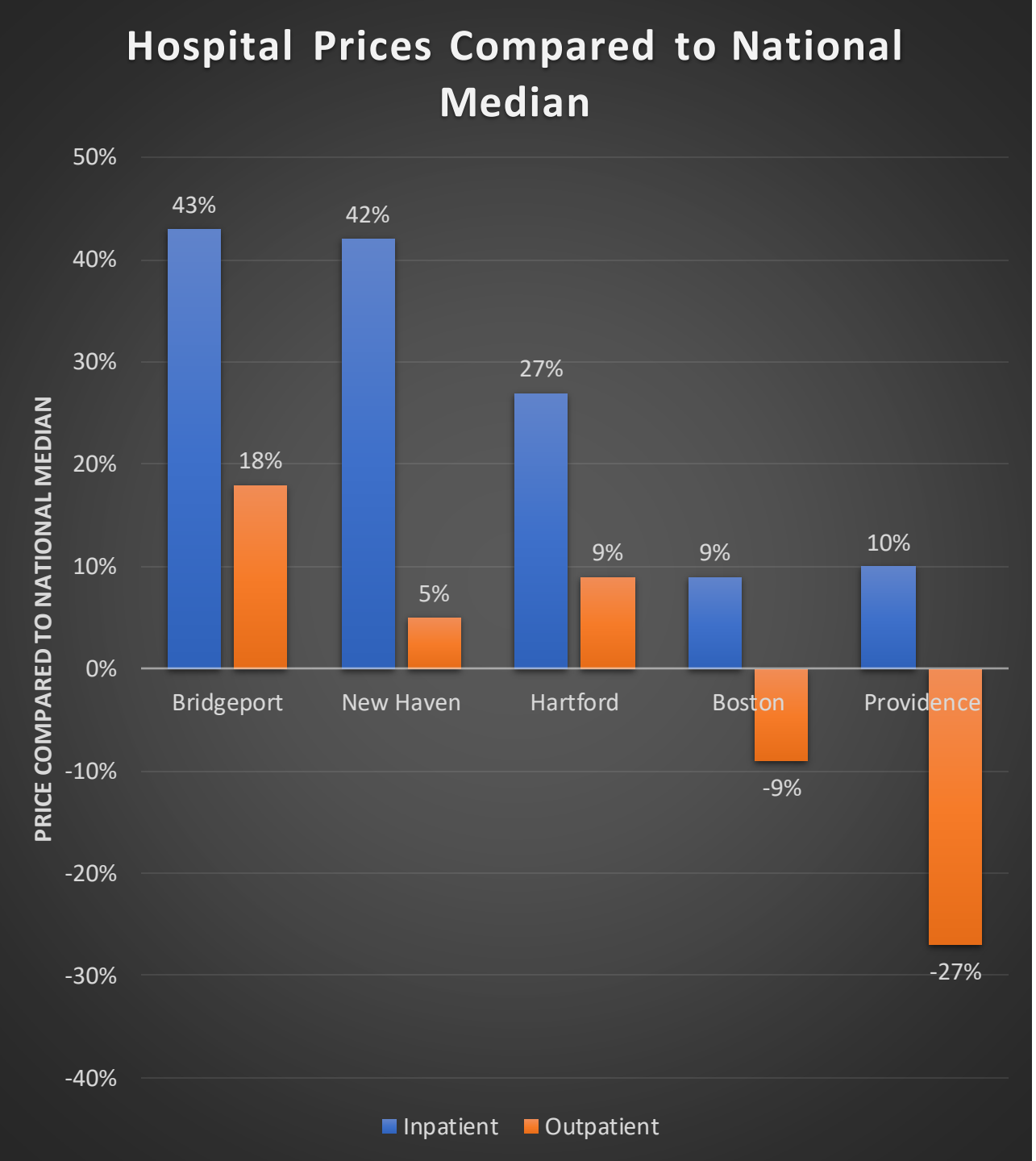


Fully Insured Premiums in Connecticut are Higher Than in Bordering New England States



Source: Federal Medical Loss Ratio Filings summarized by Oliver Wyman for the Rhode Island Office of the Health Insurance Commissioner.

Premiums in Connecticut are higher than in other New England states



Hospital Prices Are Also Higher

- Inpatient and Outpatient Hospital Prices are significantly above national and regional medians

Source: Health Care Cost Institute. Map reflects overall health care prices in 2021 compared to the national median of 183 metropolitan areas in the U.S.

Consumer Testimonial

CT Healthcare Affordability Index

Lisa Manzer, University of Washington

CONNECTICUT

Healthcare Affordability in Connecticut: Challenges and Trends

Presented by Lisa Manzer

June 25, 2024

CENTER FOR WOMEN'S WELFARE
UNIVERSITY of WASHINGTON
School of Social Work

Presentation Outline

- Understanding & Measuring Affordability
- Key Findings between 2019 and 2022
- Why These Changes Occurred
- Broader Impact of Rising Costs
- Challenges Looking Ahead

Understanding Healthcare Affordability

- More than just paying for insurance, it's about securing healthcare without sacrificing other basic needs like housing, food, transportation, and childcare.

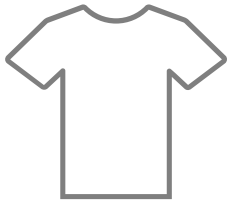
Connecticut Healthcare Affordability Index (CHAI)

Housing

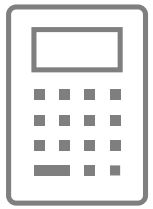
Child Care

Food

Health Care

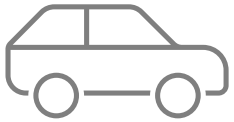


Miscellaneous

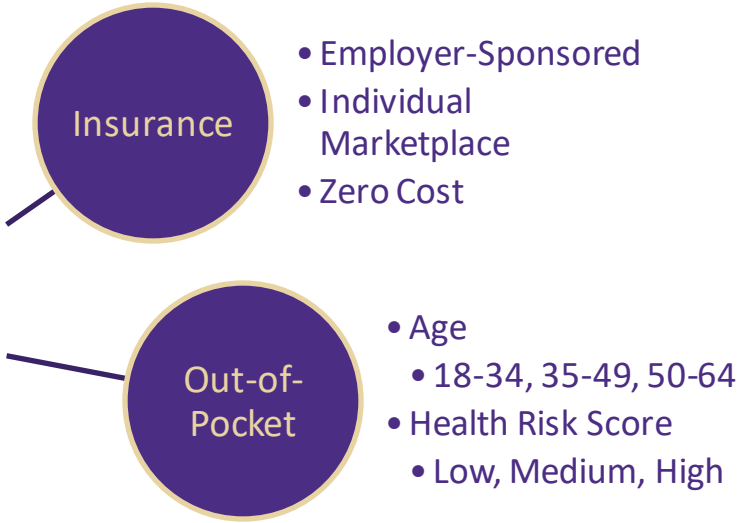


Taxes & Tax Credits

Emergency Savings



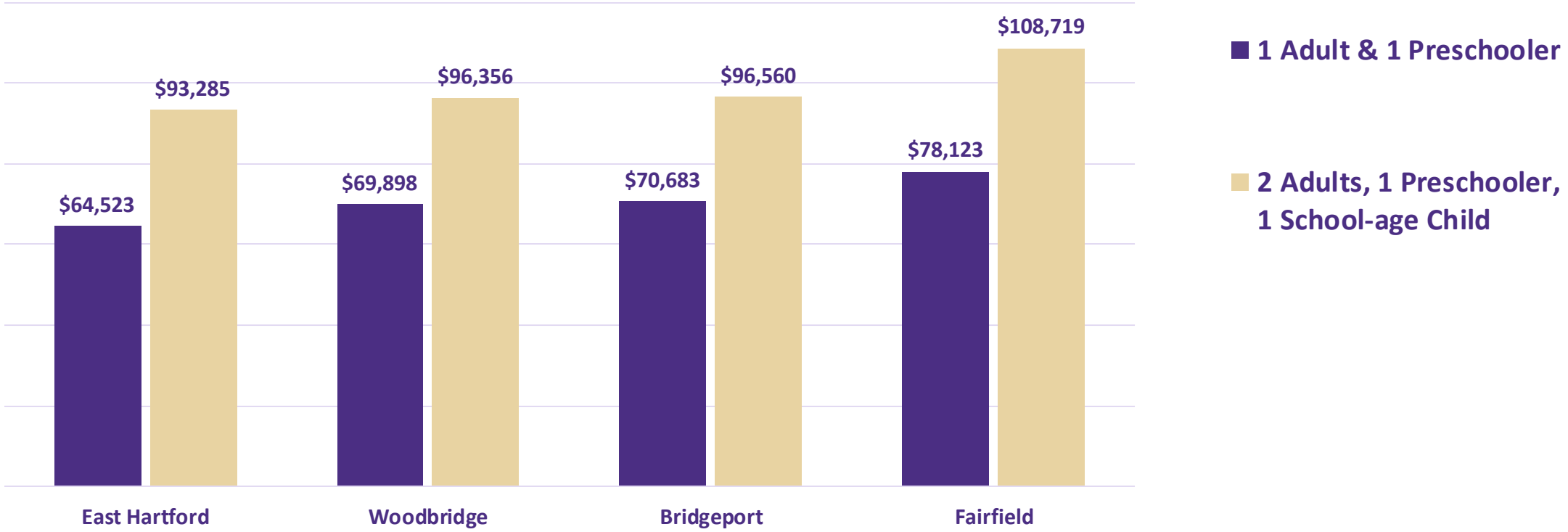
Transportation



The cost of basic needs varies by family type and place

Annual Income Needed to Afford Basic Needs: Connecticut 2022

Employer-sponsored insurance, 35-49 year old adults, low health risk



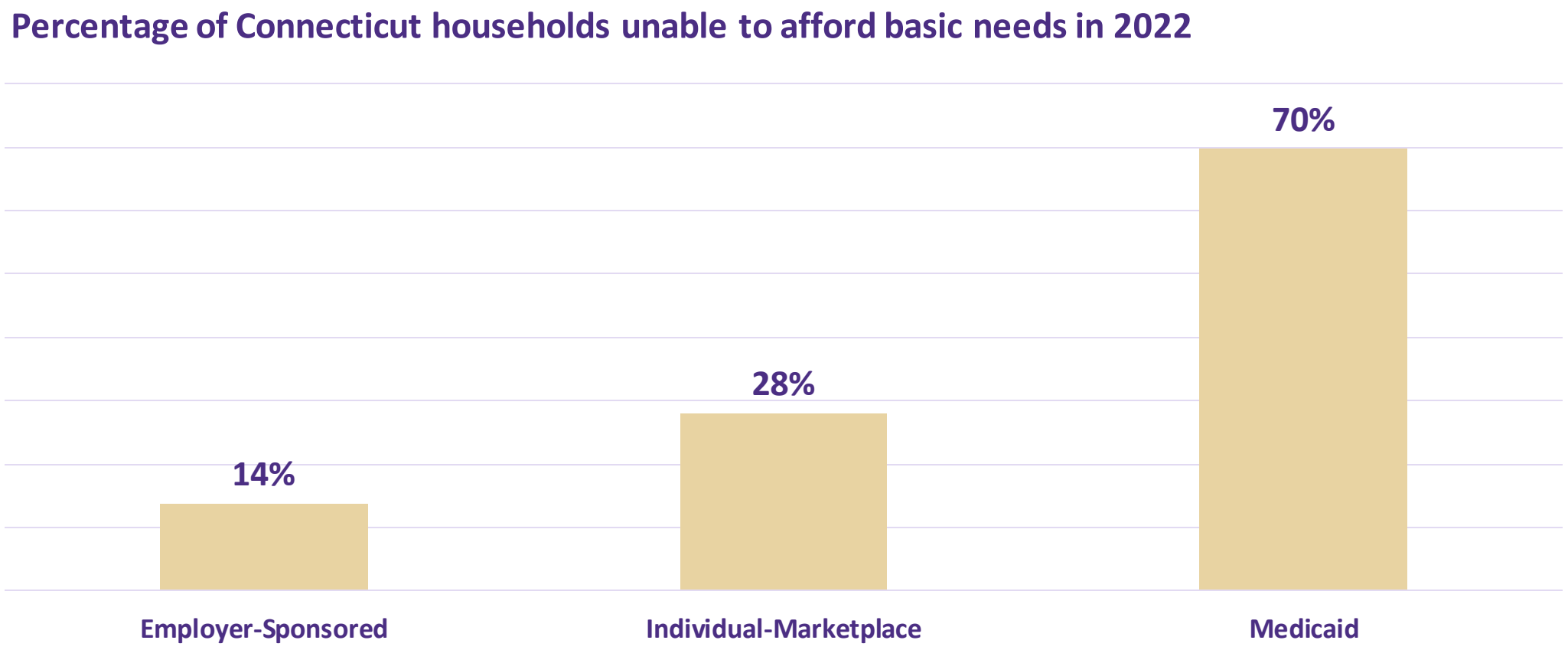
How many can’t afford their basic needs in Connecticut?

300,000 Households

650,000 Individuals

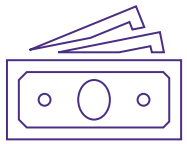
260,000 Children

Affordability by Insurance Type



Healthcare-Specific Affordability

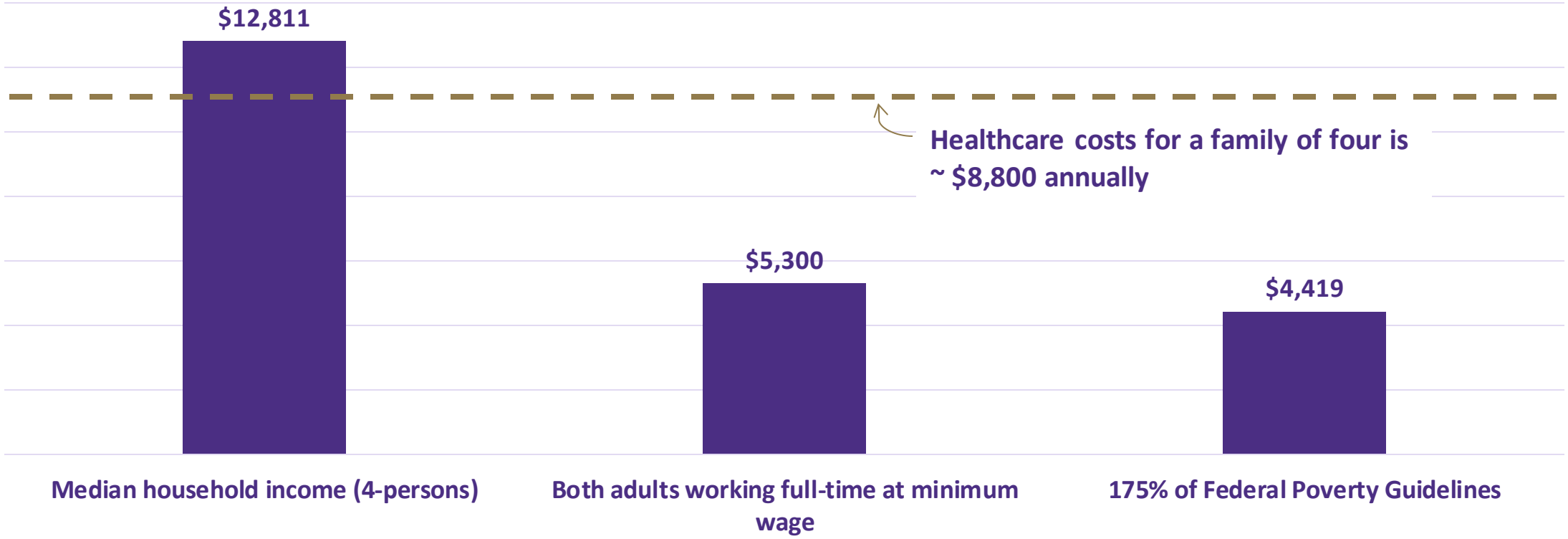
- **The Connecticut healthcare spending target sets a limit on the percentage of income spent on healthcare.**

 **>**  **= Unaffordable**

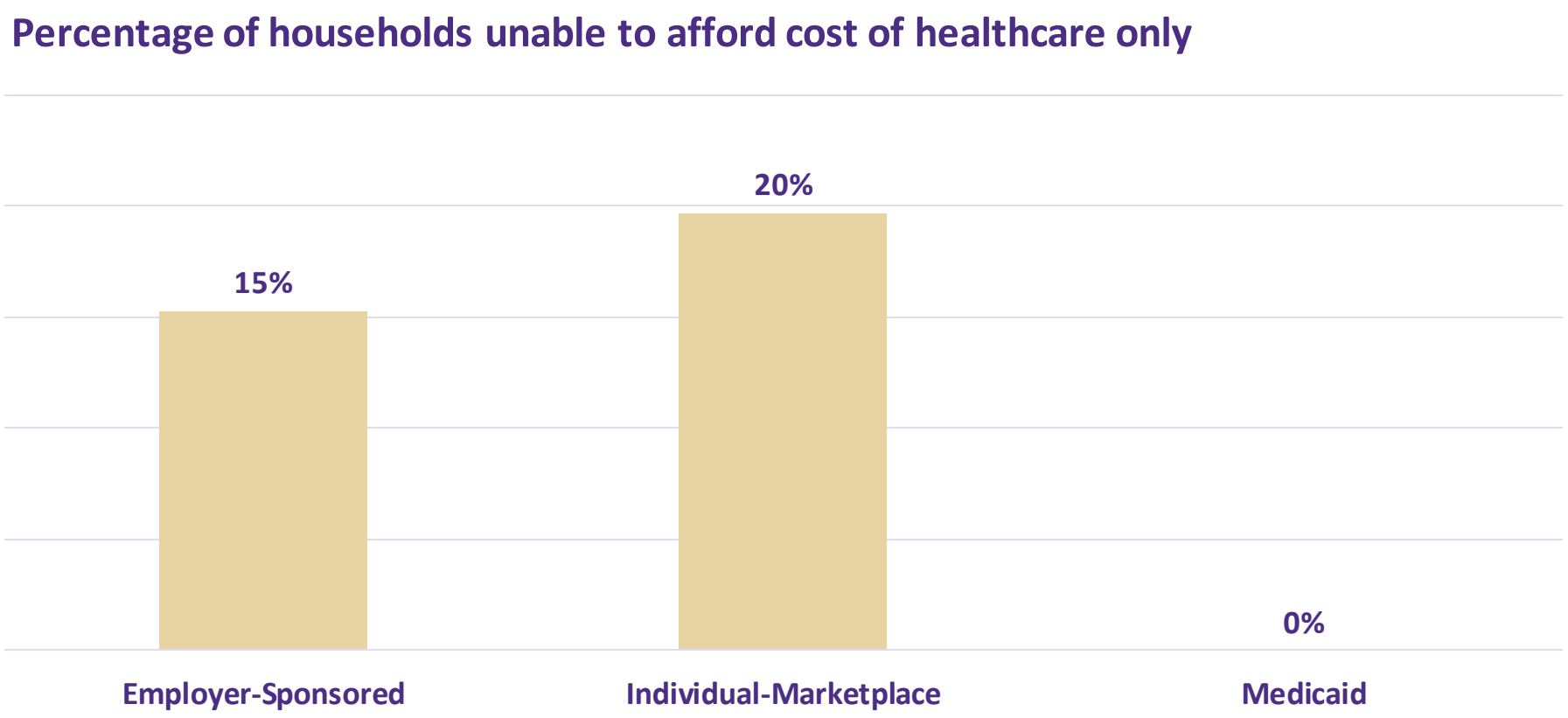
Healthcare is Not Affordable for Households Earning Less than the Median Income

Amount of annual income available for healthcare costs

New Haven Family with Two Adults (35-49, low health risk), One Preschooler, and One School-age Child

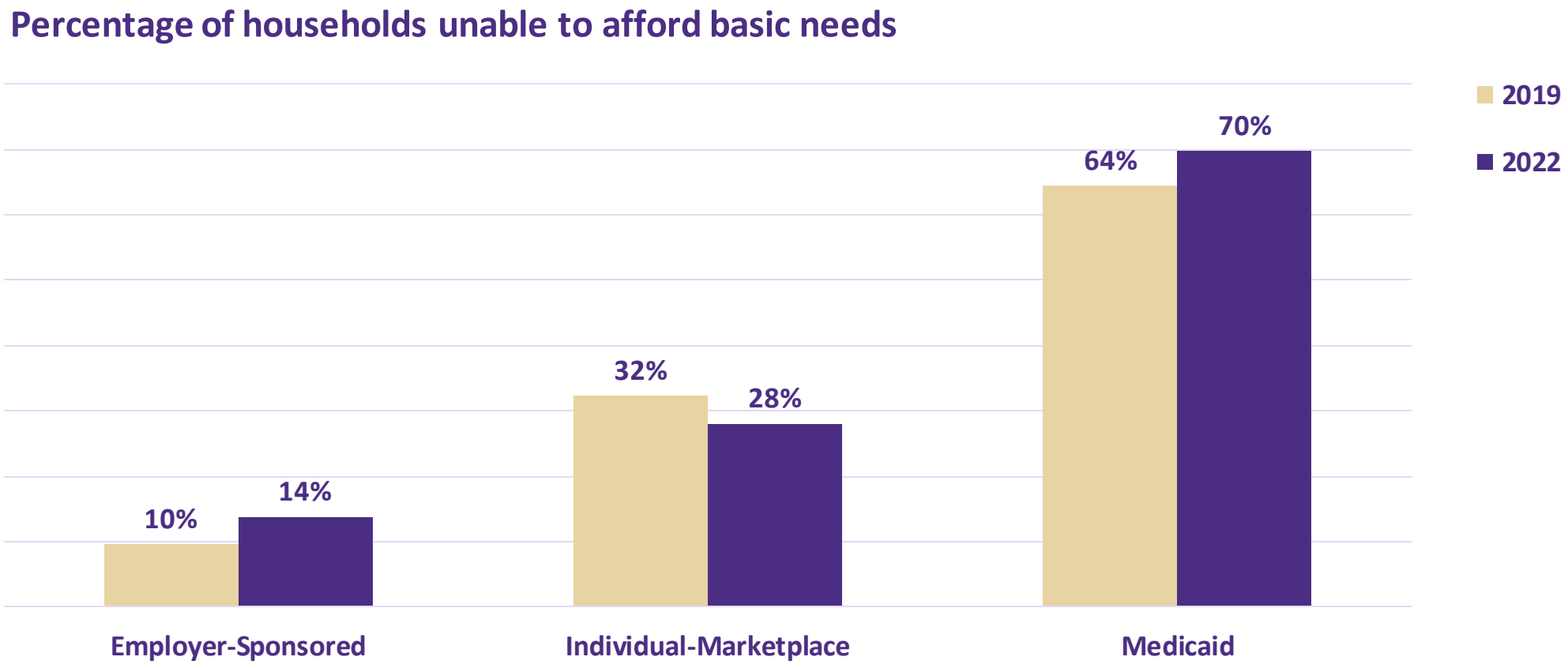


13% of households couldn’t afford their healthcare costs in 2022

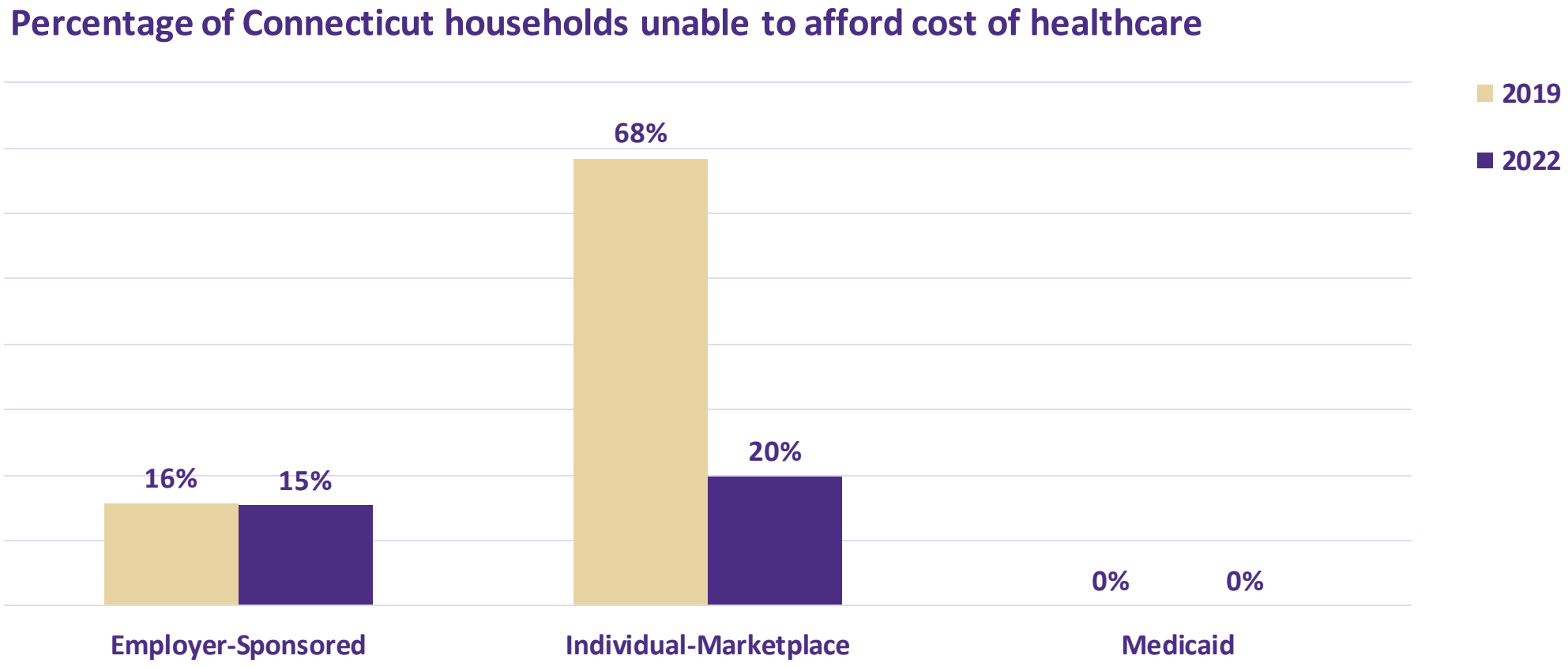


How has affordability changed between 2019 and 2022?

More households are unable to afford basic needs in 2022



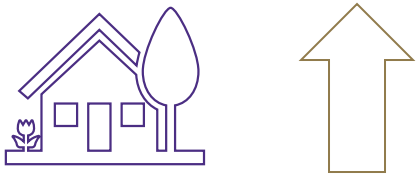
More households are able to afford healthcare in 2022



Why this happened

- Premium decrease in individual marketplace
- The government expanded help for insurance
- Premium increases in employer-sponsored insurance

The cost of basic needs in Connecticut has risen significantly from 2019 to 2022



16%

Rent & Utilities

21%

Childcare

19%

Groceries

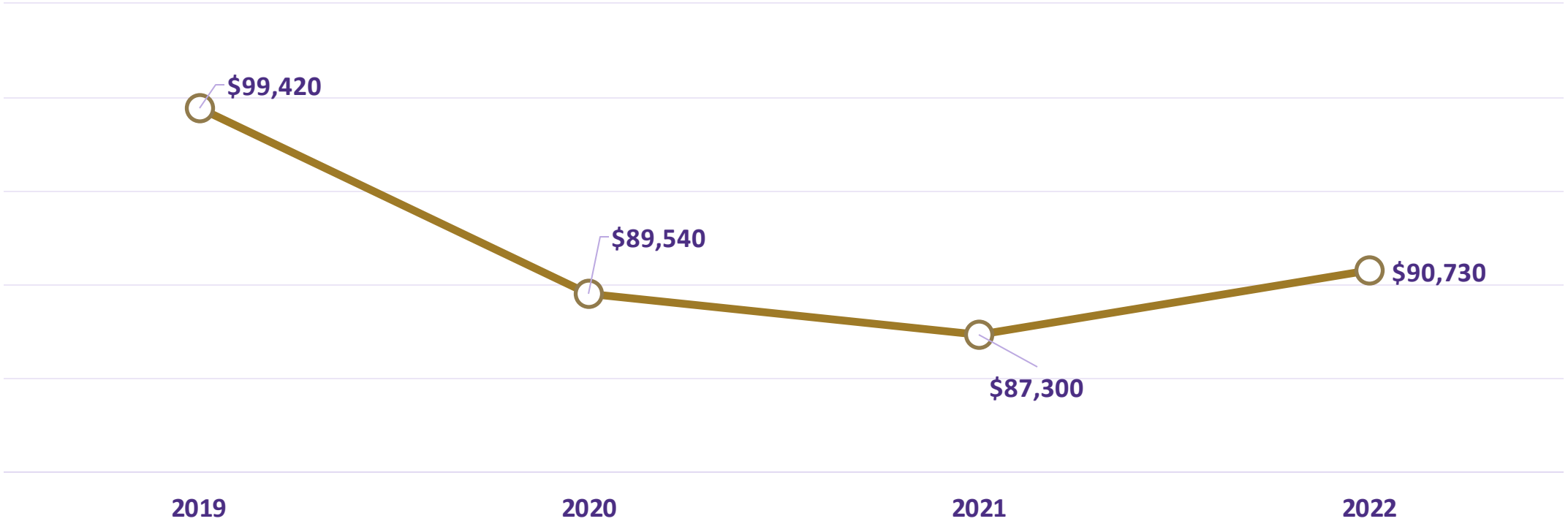
44%

Transportation

Percentage increases for Danbury family with two adults, one preschooler, one school-age child, and one teenager

Median Income decreased between 2019 and 2022

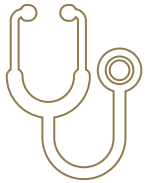
Real Median Household Income in Connecticut (2019-2022)



Source: Federal Reserve Bank of St. Louis calculation of U.S. Census Median Income, 2022 CPI-U-RS Adjusted Dollars, Annual, Not Seasonally Adjusted, https://fred.stlouisfed.org/series/MEHOINUSCTA672N#

Families face tough decisions when incomes don’t keep up with cost of basic needs

OR



OR

OR

Looking ahead

- **Premium tax credit expansion is set to expire in 2025**
- **Without this tax credit many more families will be unable to afford basic needs**

Retail Pharmacy:
A Significant Cost Driver for Connecticut's Health System

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Two Categories of Pharmacy Spending

- **Retail pharmacy** refers to prescription medicines obtained by patients directly from retail pharmacies (e.g., CVS or Walgreens stores)including mail order pharmacies
  - Most of our focus today will be on retail pharmacy.
- **Medical pharmacy** refers to prescriptions administered to patients in providers' offices, hospitals and nursing facilities.

Medical Pharmacy Spending

- Currently, medical pharmacy spending appears in various service categories, although data from Rhode Island suggest that approximately **70%** of medical pharmacy spending is paid to hospital outpatient depts.
- Within the hospital outpatient service category, **administered drugs** was the subcategory with the **second most total commercial spending** in Connecticut in 2022, behind only outpatient surgery. (APCD)
- Commercial payment per administered drug increased **15.4%** in Connecticut from 2021 to 2022. (APCD)

Retail Pharmacy Spending

- We observed in the payer-reported cost growth benchmark data that retail pharmacy was the **#1 driver of 2022 spending growth across all three markets.**
- OHS has conducted follow-up analyses using All-Payer Claims Database (APCD) data to put this observation into the context of longitudinal trends, and to better understand the role of changes in payment per unit vs utilization.
  - As context for the slides that follow, keep in mind that retail pharmacy accounted for approximately **20%** of commercial spending in Connecticut in 2022. (APCD)

Retail Pharmacy: Total Spending Trends

Year	Market	Per Member Per Month (PMPM) Spending	Payment per Unit	Utilization per Thousand
2021-2022 Trend	Commercial	14.1%	7.0%	5.9%
	Medicaid	5.3%	8.9%	-3.6%
	Medicare	14.6%	5.8%	7.7%
Average Annual Trend, 2018-2022	Commercial	6.4%	6.1%	1.8%
	Medicaid	1.9%	5.4%	-2.6%
	Medicare	8.8%	7.2%	3.0%

Source: APCD

Retail Pharmacy: Generic Spending Trends

Year	Market	PMPM Spending	Payment per Unit	Utilization per Thousand
2021-2022 Trend	Commercial	7.7%	-0.4%	7.4%
	Medicaid	-3.0%	0.8%	-2.7%
	Medicare	12.4%	5.8%	6.9%
Average Annual Trend, 2018-2022	Commercial	-0.6%	-1.5%	1.7%
	Medicaid	-5.1%	-1.0%	-2.7%
	Medicare	0.9%	-0.3%	3.1%

Source: APCD

Retail Pharmacy: Brand Spending Trends

Year	Market	PMPM Spending	Payment per Unit	Utilization per Thousand
2021-2022 Trend	Commercial	15.5%	17.4%	-1.1%
	Medicaid	6.4%	18.5%	-9.9%
	Medicare	15.0%	-2.5%	12.7%
Average Annual Trend, 2018-2022	Commercial	8.1%	5.2%	3.4%
	Medicaid	2.9%	8.1%	-4.7%
	Medicare	10.8%	8.3%	2.9%

Source: APCD

Spending Trends by Drug Class

- Two high-spend drug classes have seen rapid growth in spending across all three markets in recent years: **immunosuppressants** and **antineoplastic agents**.
  - Immunosuppressants are drugs used to treat autoimmune diseases and to support organ transplants.
  - Antineoplastic agents are cancer drugs.
- Other drug classes, such as respiratory agents, have also seen rapid growth, but represent a smaller portion of total retail pharmacy spending and thus had a smaller impact on overall retail pharmacy spending growth.
- The following slide illustrates the relative share of 2022 retail pharmacy spending represented by immunosuppressants and antineoplastic agents for each market.

2022 Retail Pharmacy Spending on Immunosuppressants and Antineoplastic Agents

Drug Class	Market	Total 2022 Spending in the APCD	% of 2022 Retail Pharmacy Spending in the APCD	2022 Spending Rank Among Drug Classes
Immunosuppressants	**Commercial**	$595,677,279	26%	#1
	Medicaid	$262,533,181	15%	#3
	Medicare	$240,385,390	8%	#5
Antineoplastic Agents	**Commercial**	$217,451,390	10%	#4
	Medicaid	$82,673,711	5%	#4
	Medicare	$386,603,888	13%	#2

Source: APCD

Antineoplastic Agents Spending Trends

Year	Market	PMPM Spending	Payment per Unit	Utilization per Thousand
2021-2022 Trend	Commercial	19.4%	11.3%	5.6%
	Medicaid	2.9%	10.5%	-4.3%
	Medicare	15.2%	9.8%	6.4%
Average Annual Trend, 2018-2022	Commercial	14.5%	13.7%	1.9%
	Medicaid	14.7%	18.2%	-0.5%
	Medicare	12.8%	11.7%	3.1%

Source: APCD

Immunosuppressants Spending Trends

Year	Market	PMPM Spending	Payment per Unit	Utilization per Thousand
2021-2022 Trend	Commercial	25.9%	9.1%	15.2%
	Medicaid	22.8%	9.9%	9.1%
	Medicare	27.6%	10.5%	14.7%
Average Annual Trend, 2018-2022	Commercial	21.9%	8.2%	12.1%
	Medicaid	21.4%	9.1%	10.9%
	Medicare	23.3%	9.5%	14.3%

Source: APCD

Retail Pharmacy Spending Trends Summary

1. Retail pharmacy payment per unit has grown across all three markets due to increased payments for brand-name drugs.

2. Spending on *immunosuppressants* and *antineoplastic agents* has driven retail pharmacy spending growth across all three markets.

   - Average annual growth in payment per unit approached or exceeded 10% for both drug categories from 2018-2022.

Retail Pharmacy Spending for Specific Drugs (1 of 3)

- With retail pharmacy being the number one driver of 2022 spending growth across markets, OHS requested that three pharmaceutical companies participate in today's hearing. **None complied.**
- Each invited company manufactures a drug that:
  1. Was among **the top 10 contributors to total commercial spending** in Connecticut in 2022, and
  2. Significantly **increased in price** from 2021 to 2022.
- On the following slide, we will review the data for each drug that OHS identified as "significantly contributing" to health care cost growth in the state in 2022.

Retail Pharmacy Spending for Specific Drugs (2 of 3)

Drug	Manufacturer	Total 2022 Commercial Spending in the APCD	2021-2022 Change in Payment per 30-day Supply
HUMIRA	AbbVie	$130,588,493	6.4%
ENBREL	Amgen	$34,753,283	8.3%
TRIKAFTA	Vertex	$25,313,993	5.8%
OTEZLA	Amgen	$24,635,950	11.2%

- 2021-2022 trend does not account for changes in rebates paid by manufacturers to PBMs. Manufacturers do not share that information with OHS.
- Total commercial market trend for these drugs is much larger, as many self-insured employers do not submit claims to the APCD.
- Medicare, Medicare Advantage plans and Medicaid also cover these drugs.

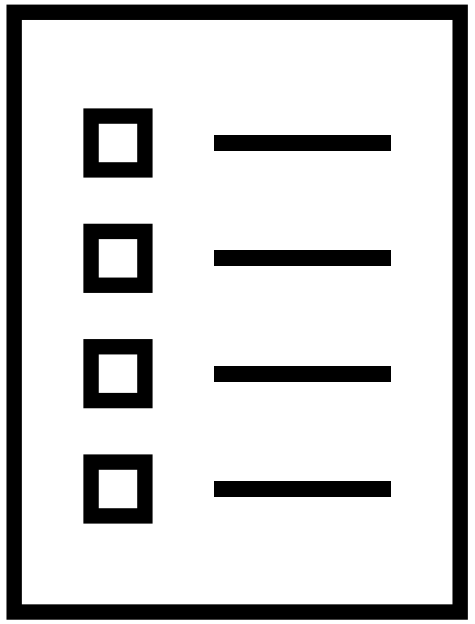
Retail Pharmacy Spending for Specific Drugs (3 of 3)

Drug	Manufacturer	2022 Commercial Payment per 30-day Supply in the APCD
HUMIRA	AbbVie	$7,182
ENBREL	Amgen	$5,752
TRIKAFTA	Vertex	$21,959
OTEZLA	Amgen	$3,723

Optimizing State Plan Pharmacy Benefits

A Strategic Approach to Managing Costs

Joshua Wojcik
Director, Health Policy and Benefits Services Division
Office of the State Comptroller
June 25, 2024



Agenda

- Overview of State Plan Performance relative to Market
  - Principles that undergird the policies driving positive plan performance
- Understanding Pharmacy Benefit Managers (PBMs)
  - PBM Payment Models
  - PBM Contracting
  - Challenges with Current Models
- State Plan Initiatives (Phases 1, 2, and 3)

Overview of State Plan Performance relative to Market

Comparing the performance of the state plan to the All-Payer Claims Database

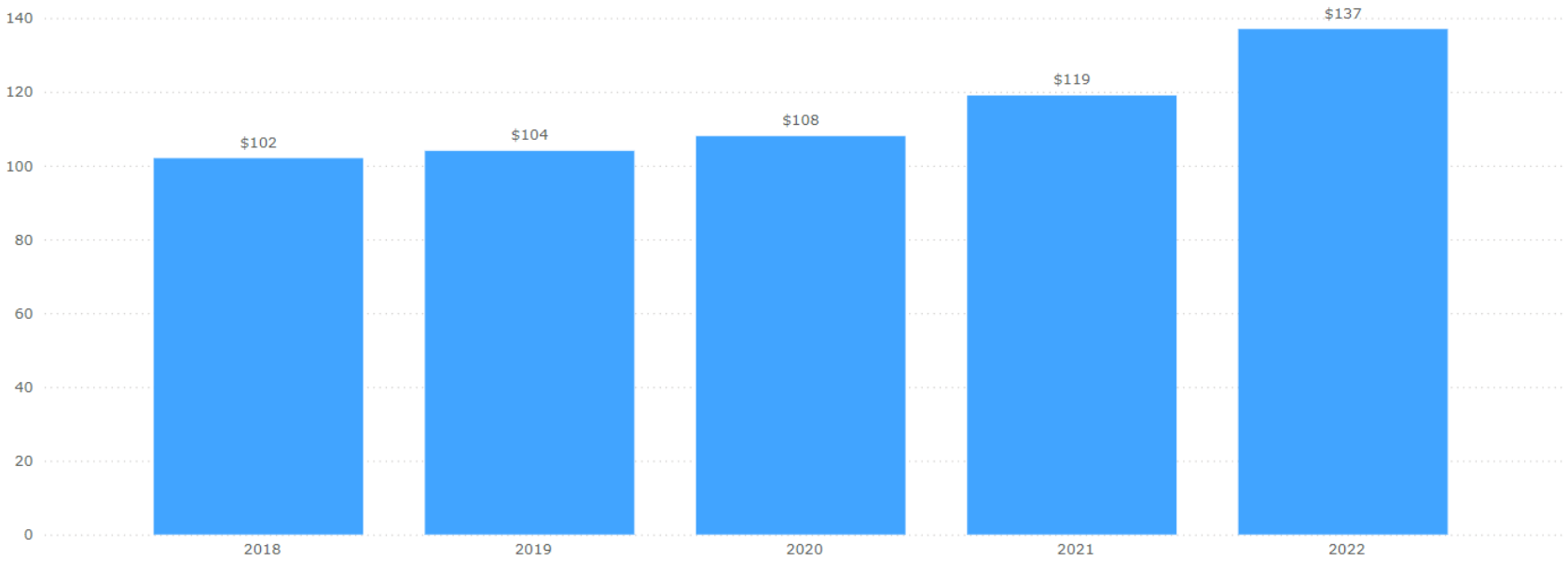
Per Member Per Month Pharmacy Spending (APCD Commercial Market excluding the State Plan)

CONNECTICUT Health Strategy

Retail Pharmacy Overview

Per Member Per Month, Payment Per Unit, and Units Per 1,000 Members

Measure	Market	Submarket	Age group	Gender
Per Member Per Month (PMPM)	COMMERCIAL	Non State Employees	All	All



This table shows average per member per month spending (PMPM), payment per unit (PPU) and units per 1,000 members (UPK) by market, claim category and year for the most recent five years. Annual percent changes for each metric are also included. Optional filters include age group, gender, county, service category and submarket. Results can be sorted by hovering over a column header and clicking on the triangle. Pharmacy spending data do not account for manufacturer rebates. 2020 and 2021 trends are affected by the COVID-19 Public Health Emergency. Medicare FFS data are currently unavailable.

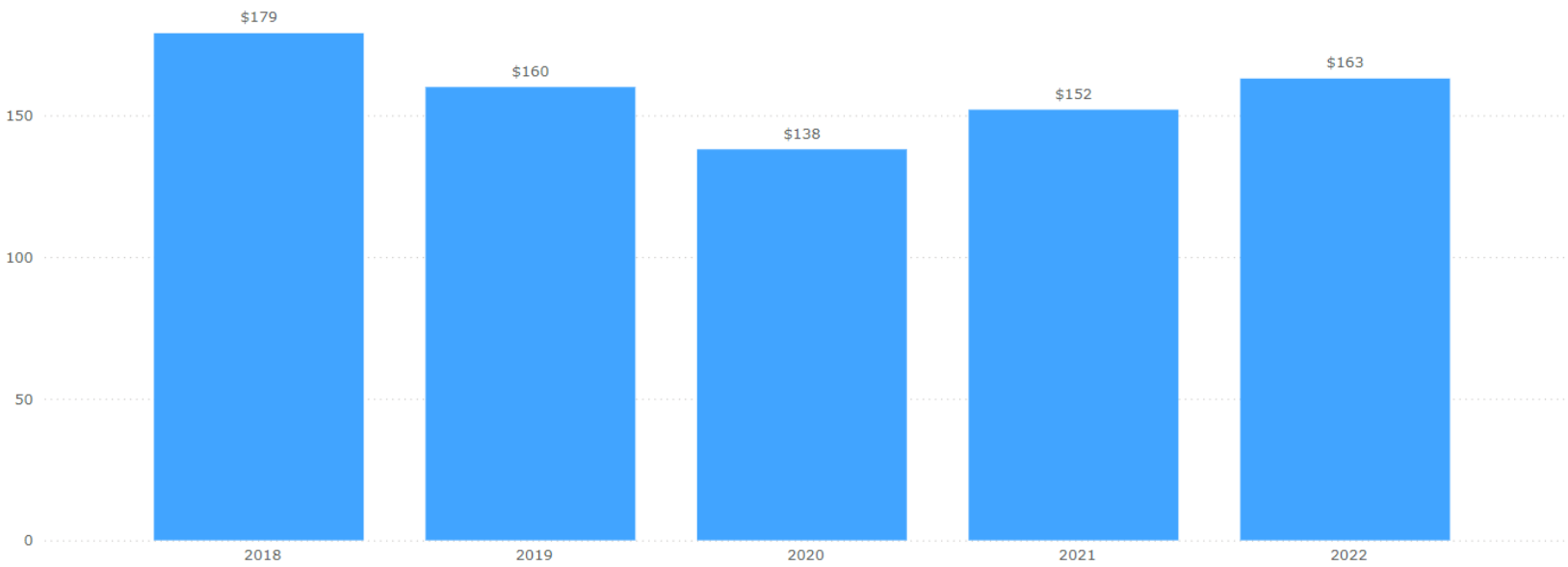
Per Member Per Month Pharmacy Spending (APCD the State Plan)

CONNECTICUT Health Strategy

Retail Pharmacy Overview

Per Member Per Month, Payment Per Unit, and Units Per 1,000 Members

Measure	Market	Submarket	Age group	Gender
Per Member Per Month (PMPM)	COMMERCIAL	State Employees	All	All



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Payment Per Unit Pharmacy Spending
(APCD Commercial Market excluding the State Plan)

This table shows average per member per month spending (PMPM), payment per unit (PPU) and units per 1,000 members (UPK) by market, claim category and year for the most recent five years. Annual percent changes for each metric are also included. Optional filters include age group, gender, county, service category and submarket. Results can be sorted by hovering over a column header and clicking on the triangle. Pharmacy spending data do not account for manufacturer rebates. 2020 and 2021 trends are affected by the COVID-19 Public Health Emergency. Medicare FFS data are currently unavailable.

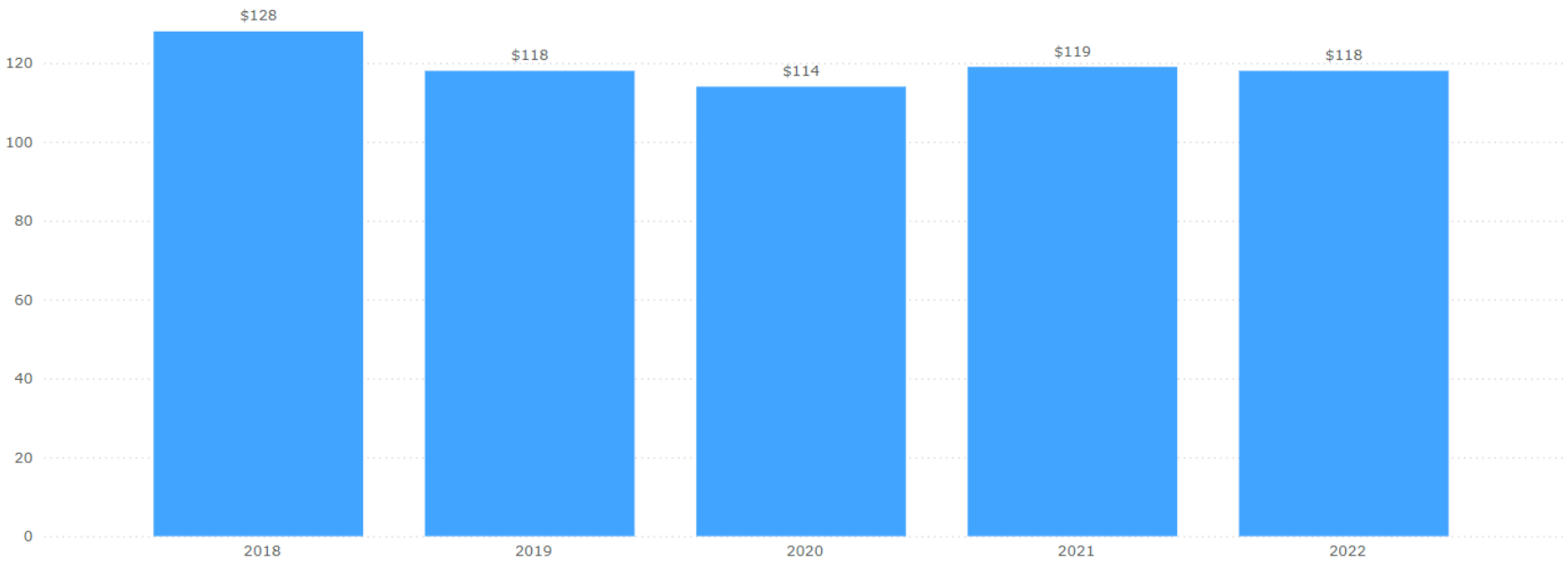
Payment Per Unit Pharmacy Spending (APCD State Plan)

CONNECTICUT Health Strategy

Retail Pharmacy Overview

Per Member Per Month, Payment Per Unit, and Units Per 1,000 Members

Measure	Market	Submarket	Age group	Gender
Payment Per Unit (PPU)	COMMERCIAL	State Employees	All	All



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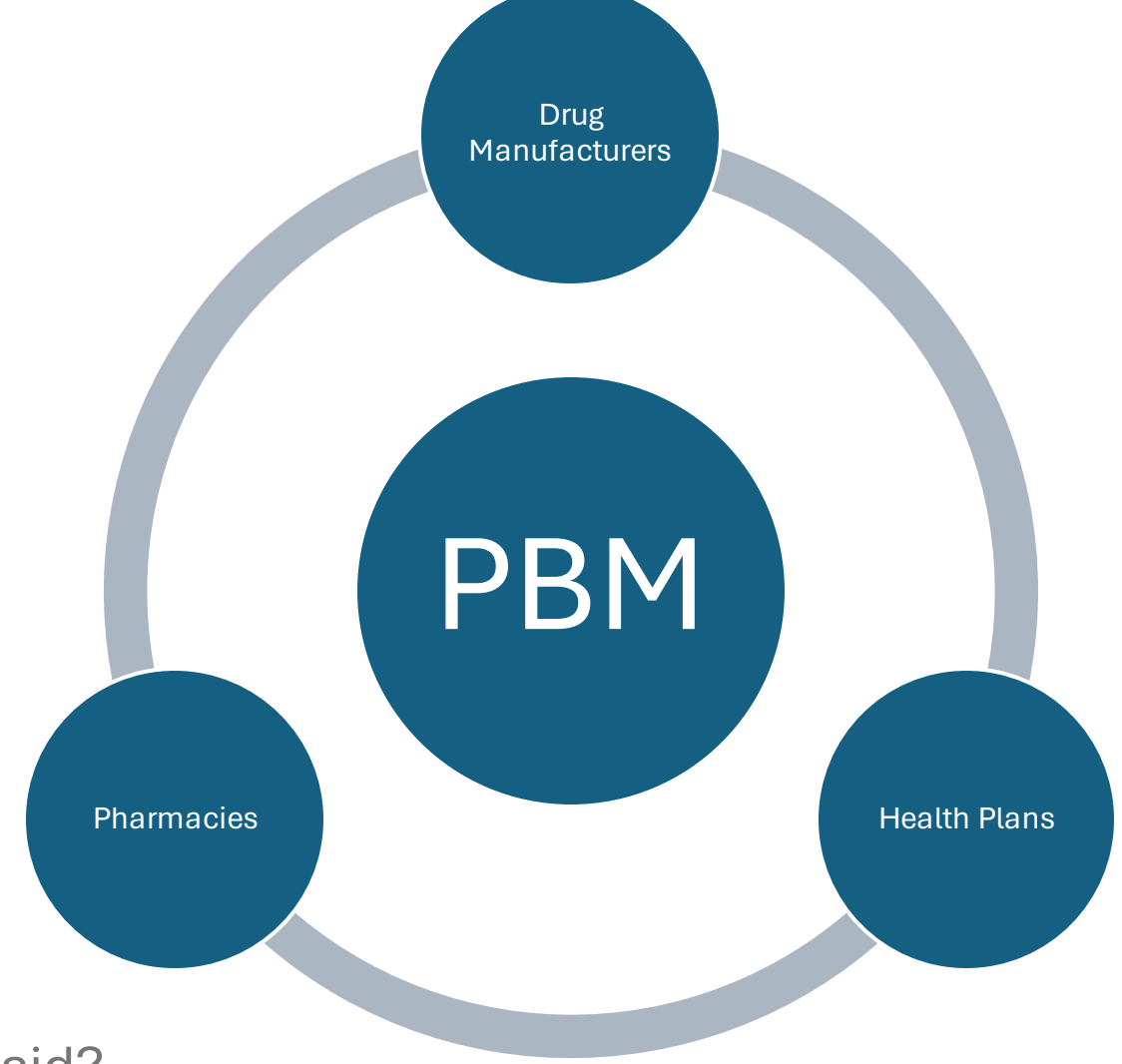
Compound Annual Growth Rate

	Per member per month	Per unit per month
Commercial Market (APCD)*	7.7%	7.4%
State Employee Plan	-2.3%	-2.0%

**APCD commercial market excluding State Employee Plan*

Background –

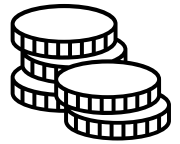
What does a pharmacy benefit manager do?
How does a Pharmacy Benefit Manager get paid?
How do PBMs contract with health plans and pharmacies?
What are the Challenges with the existing model?



What does a Pharmacy Benefit Manager do?

- Contracts with pharmacies to establish a pharmacy network with set reimbursement rate
- Performs utilization management by establishing a formulary of preferred drugs and performing prior authorizations to ensure appropriate use of medications
- Negotiates rebates (post purchase discounts) with drug manufacturers in exchange for preferred formulary placement or limited utilization management
- Administers plan benefit by applying appropriate copay, coinsurance and deductible at the pharmacy counter and ensuring that only covered products are billed to the health plan

How does a Pharmacy Benefit Manager get paid?



- Health Plan relationships with PBM – two models:
  - Spread pricing model– the PBM bills the health plan more than it reimburses network pharmacies for dispensing covered drugs, keeping the difference to cover its administrative costs and profits
  - Transparent model – PBM bills the health plan the same amount it reimburses network pharmacies for dispensing covered drugs and charges and explicit administrative fee to covers its administrative costs and profits
- PBMs may also generate revenue through:
  - Manufacturer revenues that are not defined as rebates (generally rebates are passed through to the health plan)
  - Through wholly owned specialty pharmacies and mail order pharmacies in which the PBMs reimbursement is less than the cost of these pharmacies to procure and dispense covered drugs

How do PBMs contract with health plans and pharmacies – what pricing commitments do they make?

- **Health Plans:** PBM contracts with health plans generally commit the PBM to achieve certain metrics including:
  - discounts off of a list price, usually Average Wholesale Price minus some percentage; and
  - a minimum dollar amount of rebates
- **Pharmacies:** PBM contracts with pharmacies commit the PBM to reimburse pharmacies a certain amount in relation to a list price – again usually AWP, for example a PBM may commit to a pharmacy that it will reimburse generic maintenance drugs in the aggregate at least AWP – 85%

What are the challenges with the existing model?

- Lack of transparency in pass through pricing and hidden manufacturer revenue
- ***It's inflationary***:
  - Encourages PBM to favor drugs with the highest discount off list price and the brand drugs with the highest rebates, rather than the lowest net cost drug or the drug with the highest clinical value
  - Encourages pharmacies to stock drugs with the highest discount off of list price rather than the lowest net cost option
  - Encourages manufactures to inflate their prices as much as possible in order to achieve higher rebates and discounts off list price which are required to preferred by PBMs formulary management and utilization management efforts
- No incentive for PBMs to manage fraud waste and abuse

State Plan Interventions

How did the state plan outperform the market since 2018?

Targeting inefficiencies and committing to following principles:

- Transparency
- Aligning incentives
- Leveraging the states negotiating power to ensure best pricing and information access
- Using data to target interventions

Phase	Time Frame	Focus Area
Phase 1	2019-2023	Transparency, Data Access and Evaluation, Direct Contracting
Phase 2	2023-2025	Aligning Incentives, Targeting Inefficiencies
Phase 3	2025 -	Medical Pharmacy, and Retail Pharmacy Reimbursement

Phase 1: 2019-2023 Transparency, Data Access and Evaluation, Direct Contracting

- Transparent contract with Pharmacy Benefit Manger, with pass through pricing and explicit administrative fees
- Annual market checks to ensure best pricing
- Direct contracting with specialty pharmacies
- Acquisition cost pricing with CVS specialty pharmacy
- Drug costs reported and evaluated net of rebate
- Enhanced oversight of pharmacy network
- Using data analysis to identify opportunities
    - Specialty drugs – leverage manufacturer assistance programs to reduce member and plan costs
    - Generic price variation - Tier generic copays to favor lower cost alternatives within therapeutic class
    - Waste – limit initial fills of maintenance drugs to 30-day supplies

Phase 2: 2023-2025 Aligning Incentives and Targeting Inefficiencies

- Per member per month cost guarantees with pharmacy benefit manager
- Add a third-party formulary advisor with expertise in comparative effectiveness research to identify opportunities to improve the formulary by preferring higher value drugs
- Align incentives with prescribers by including pharmacy in total cost of care value-based arrangements and provide prescribers with information on total prescription costs and clinical value
- Provide clinically appropriate coverage for anti-obesity medication at a sustainable cost through a specified pathway - Flyte

Phase 3: 2025… Medical Pharmacy, and Retail Pharmacy Reimbursement

- Address medical pharmacy
  - Direct infusions to lower cost clinically appropriate site of care
  - Leverage manufacturer assistance to offset plan and member costs
- Leverage bio-similars
- Promote pharmacy reimbursement based on actual acquisition cost rather than discount off of list price

Conclusion

- State Plan experience shows its possible to reduce retail pharmacy costs within the existing system. The key elements to success are:
  - Improving transparency
  - Aligning incentives; and
  - Targeting interventions

Why does pharmacy spending matter?

- High and quickly growing spending on brand name drugs is a **major problem** for the following reasons:

1. Too often Connecticut residents aren't taking prescribed medicines due to cost, thus putting their health, and perhaps their lives, at risk.
   - 23% reported they cut pills in half, skipped doses of medicine or did not fill a prescription per a 2022 survey.[1]

2. Connecticut will not attain its annual cost growth benchmark if spending on drugs grows far in excess of the benchmark rate.

[1] Altarum CHESS survey. Available at https://www.healthcarevaluehub.org/advocate-resources/publications/connecticut-residents-struggle-afford-high-healthcare-costs-worry-about-affording-healthcare-future-support-government-action-ac

Questions?

Break

The Cost Growth Benchmark and Primary Care: The Role of Payors

CONNECTICUT

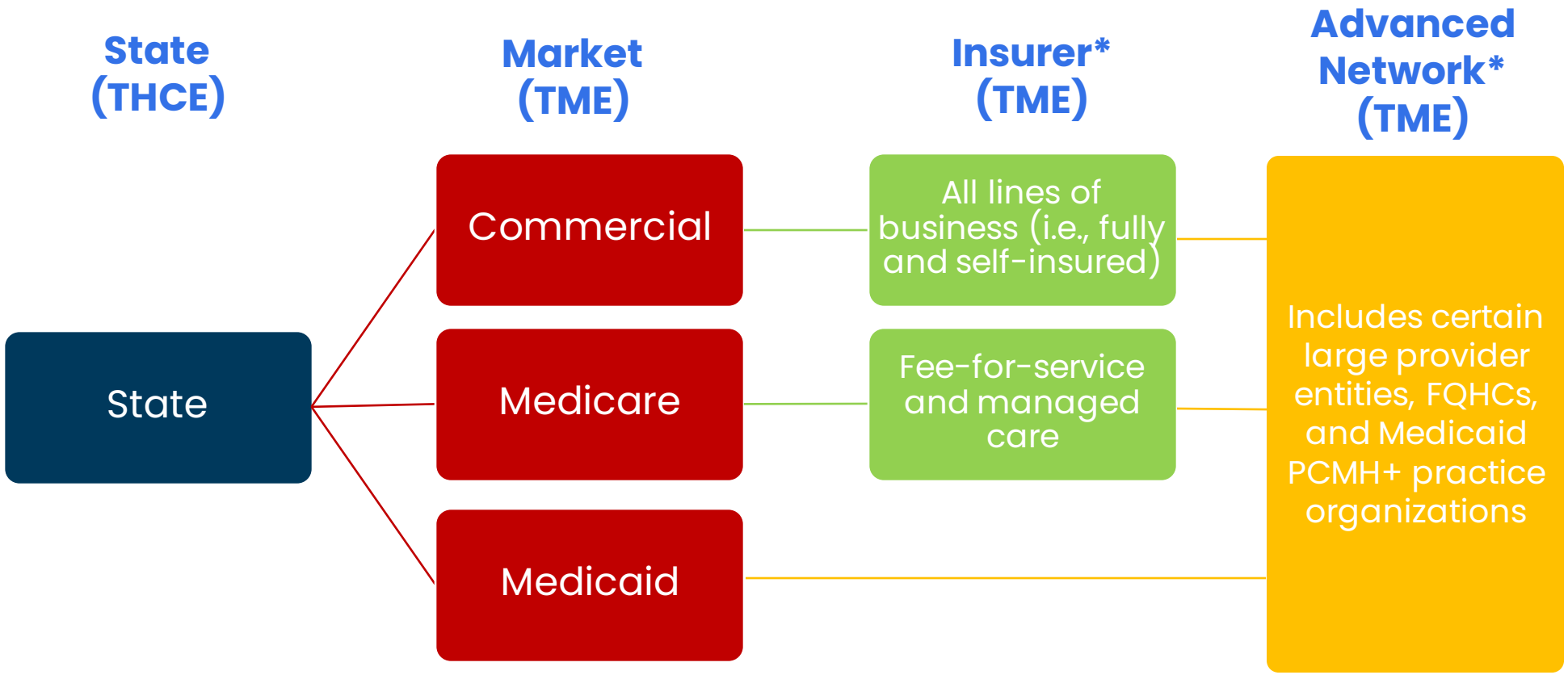
Total Healthcare Expenditures

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

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 health plan

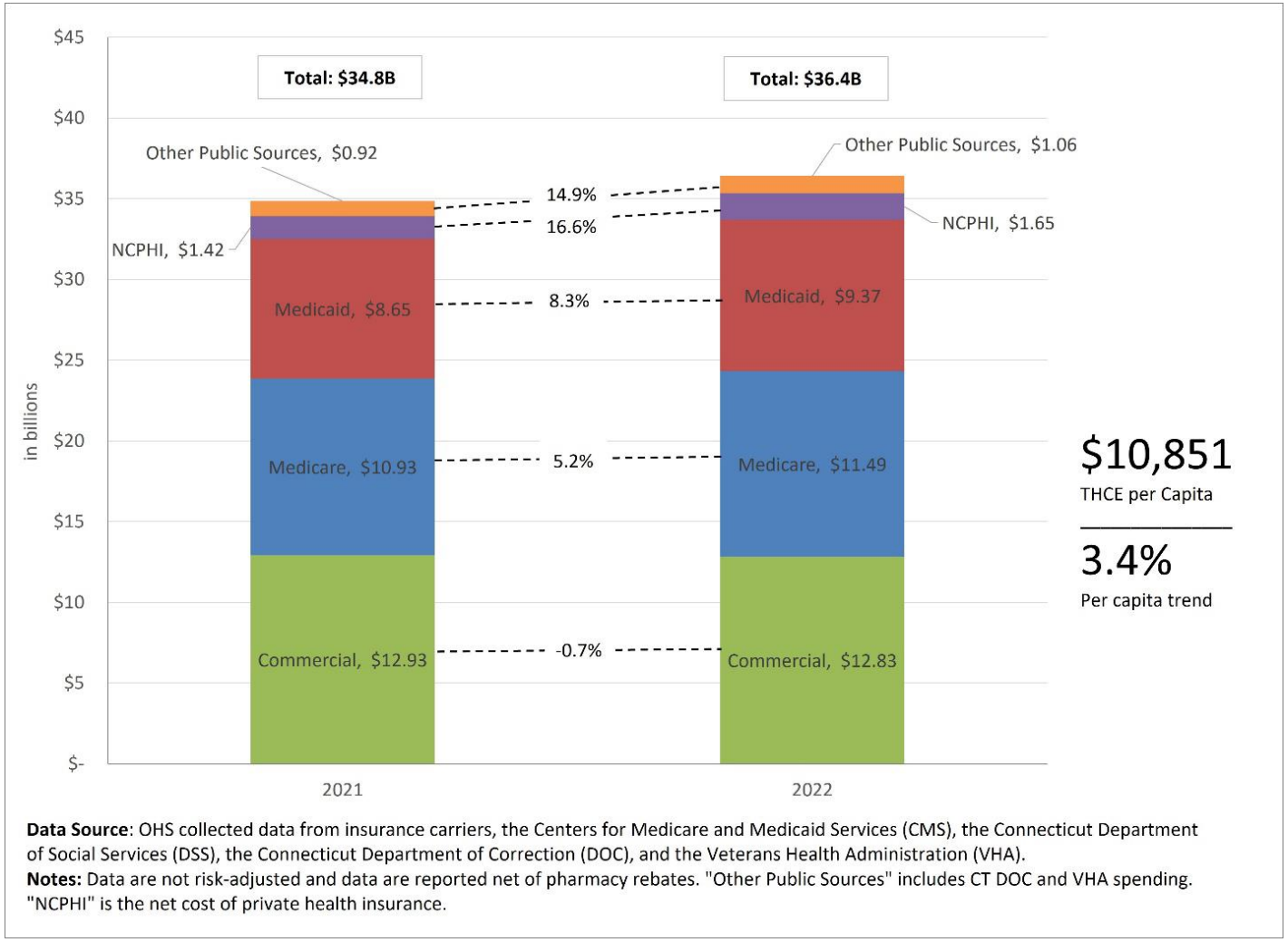
The **costs to CT residents associated with the administration of private health insurance**

Performance Against the Benchmark is Reported at Four Levels



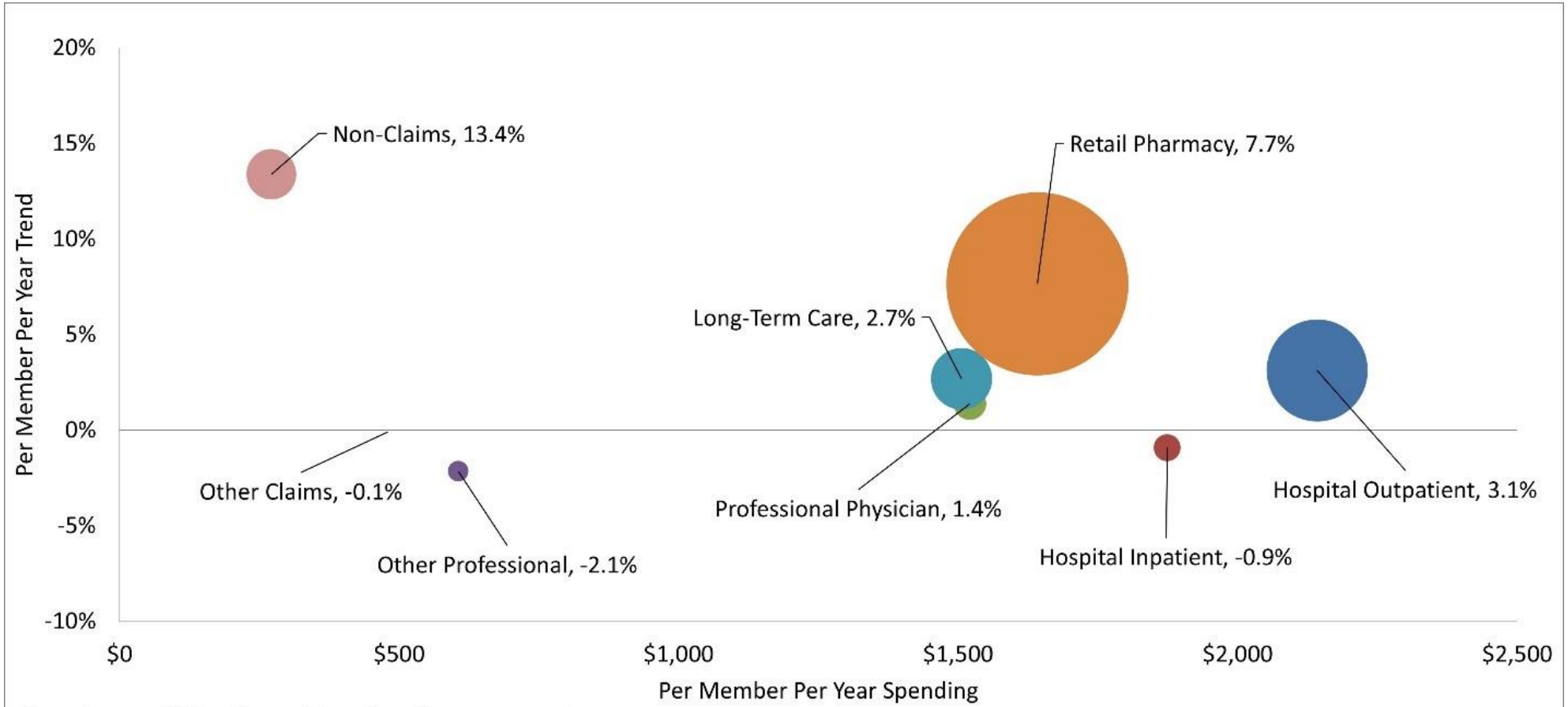
*OHS only publicly reports on Insurers and Advanced Networks with a minimum of 60,000 member months per market.

Connecticut's Total Healthcare Expenditures Were $36.4 Billion in 2022



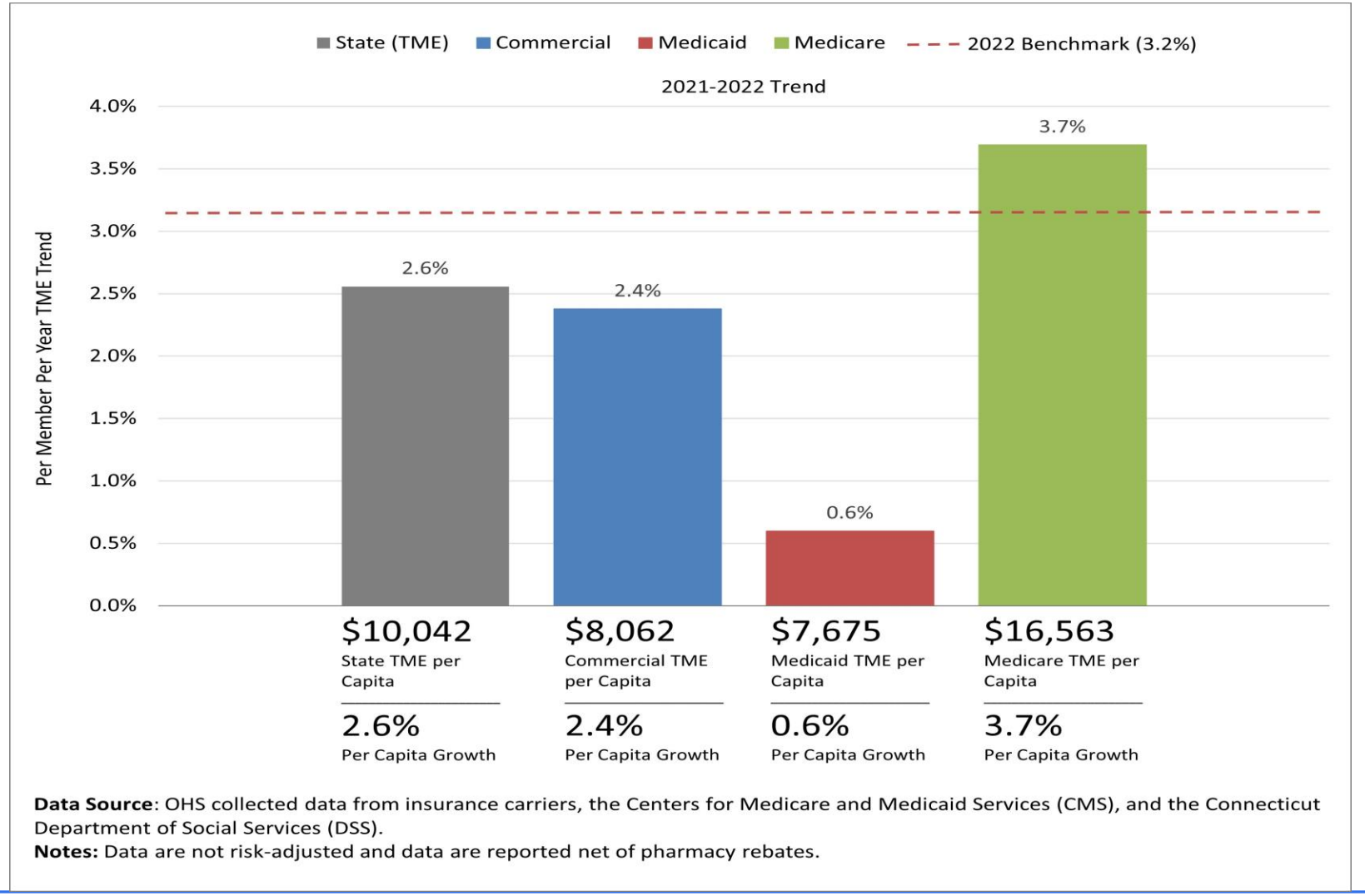
Data Source: OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS), the Connecticut Department of Social Services (DSS), the Connecticut Department of Correction (DOC), and the Veterans Health Administration (VHA).
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates. "Other Public Sources" includes CT DOC and VHA spending. "NCPHI" is the net cost of private health insurance.

Drivers of Statewide Spending Growth



Data Source: OHS collected data from insurance carriers.
Notes: The width of the bubbles represents contribution to trend. Data are not risk-adjusted. Data are reported net of pharmacy rebates. Service category contributions to spending growth varies from year to year.

Total Medical Expense Trends by Market



Data Source: OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS), and the Connecticut Department of Social Services (DSS).
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates.

Primary Care Results

Primary Care Provider Definition for Spending Analysis

- Primary care providers:
  - **MDs and DOs**: Family medicine, pediatric and adolescent medicine, internal medicine (when practicing primary care) and geriatric medicine (when practicing primary care)
  - **NPs and PAs** when practicing primary care

Note: OHS also measures primary care spending associated with OB/GYNs and midwifery for monitoring purposes

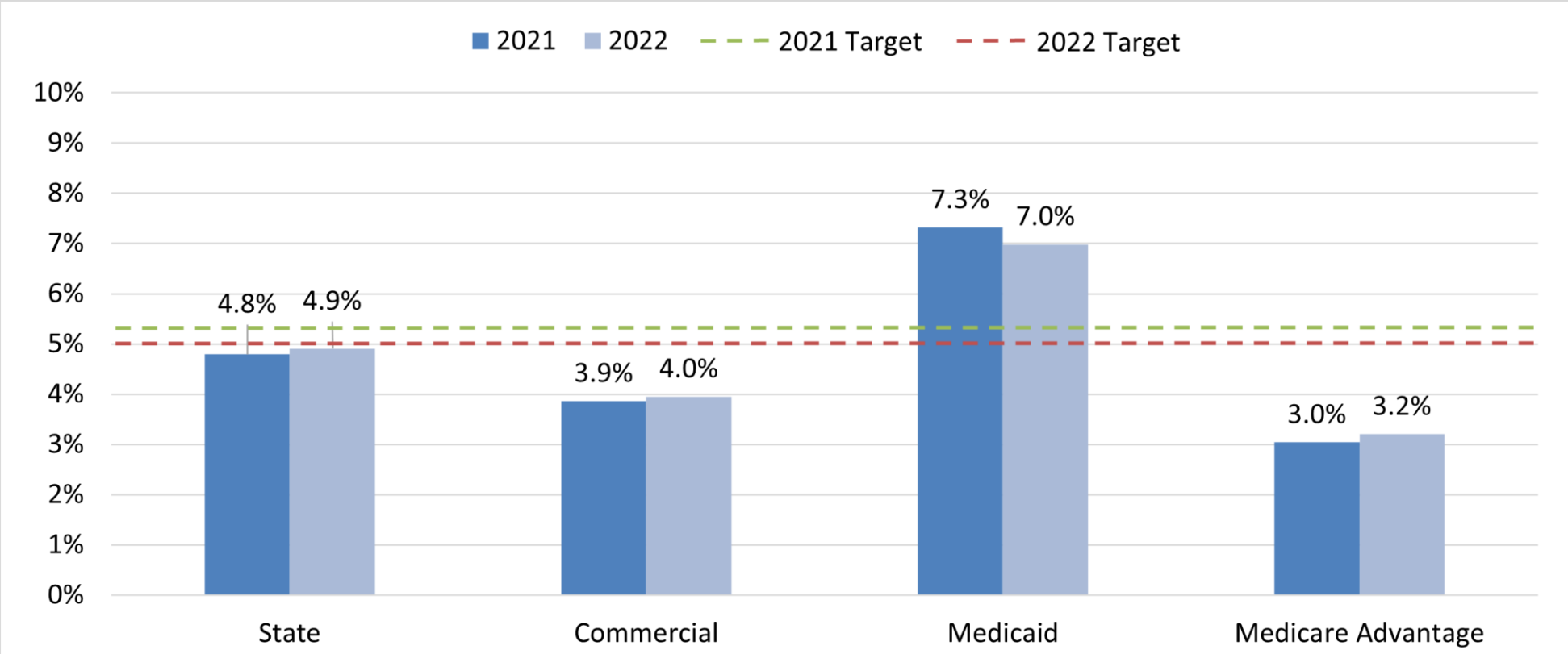
Primary Care Spending Analysis Methodology

- To assess primary care spending at the state, market and payer levels, OHS calculates primary care spending per member per month (PMPM) as a percentage of total medical expenses (TME) PMPM.
- TME for the primary care spending target includes all the spending categories for the cost growth benchmark **except for long-term care** so that calculations across commercial, Medicaid, and Medicare markets are comparable.

Summary of Payer Performance Against the Primary Care Spending Target

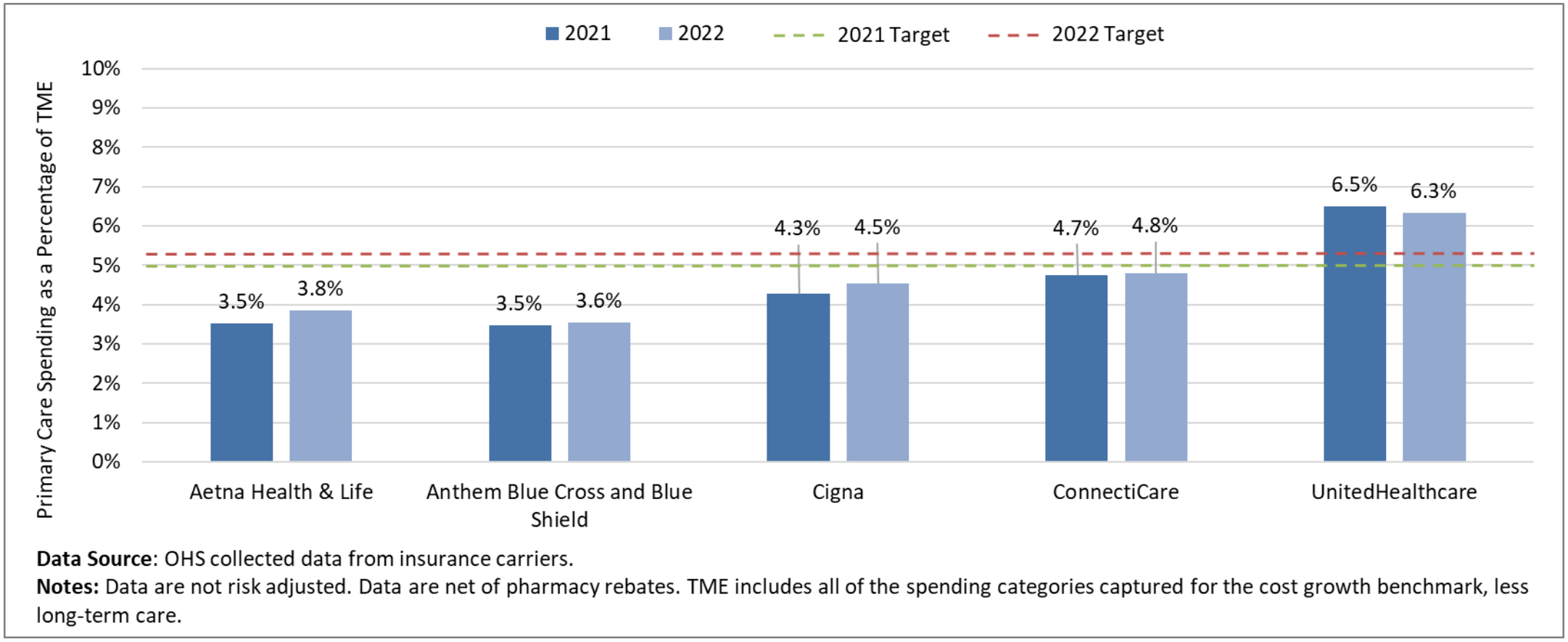
Payer	Commercial	Medicare Advantage
Aetna	Did not meet	Did not meet
Cigna	Did not meet	NA
ConnectiCare	Did not meet	Did not meet
Anthem	Did not meet	Did not meet
UnitedHealthcare	Met	Did not meet

State and Market Performance Against the Primary Care Spending Target



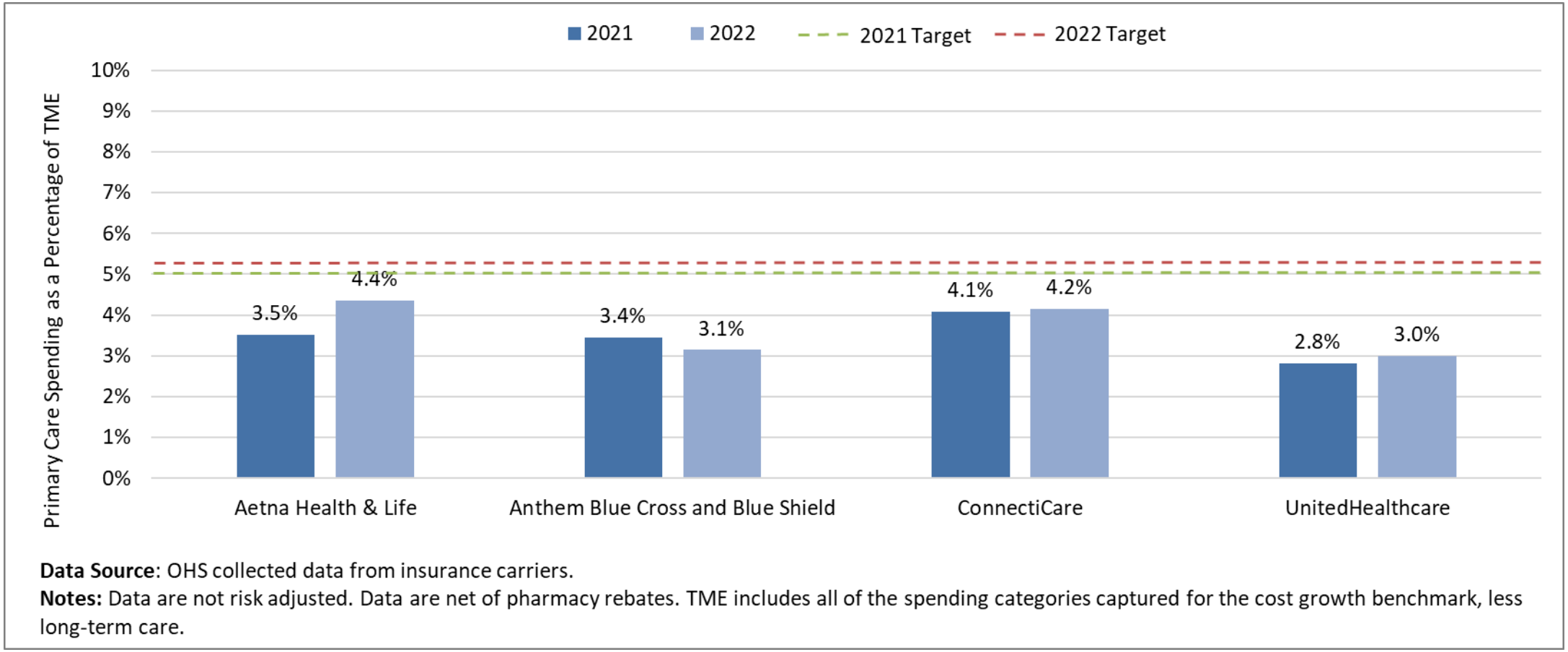
Data Source: OHS collected data from insurance carriers and from the Connecticut Department of Social Services (DSS).
Notes: Data are not risk adjusted. Data are net of pharmacy rebates. Data include commercial, Medicare Advantage and Medicaid FFS spending. TME includes all of the spending categories captured for the cost growth benchmark, less long-term care.

Commercial Payers' Performance Against the Primary Care Spending Target



Data Source: OHS collected data from insurance carriers.
Notes: Data are not risk adjusted. Data are net of pharmacy rebates. TME includes all of the spending categories captured for the cost growth benchmark, less long-term care.

Medicare Advantage Payers' Performance Against the Primary Care Spending Target



Data Source: OHS collected data from insurance carriers.
Notes: Data are not risk adjusted. Data are net of pharmacy rebates. TME includes all of the spending categories captured for the cost growth benchmark, less long-term care.

Takeaway Observations

- Connecticut fell short of the 5.3% primary care spending target in 2022 with only a modest increase from 2021.
- Payers in the Commercial and Medicare markets will need to make significant strides for Connecticut to meet the 10% target in 2025.

Questions?

The Cost Growth Benchmark – Primary Care and the Role of Payors

Christopher F. Koller, Milbank Memorial Fund, Moderator

- **Anthem Blue Cross and Blue Shield of Connecticut** (Wendy Polsinelli, RVP, Connecticut Provider Solutions; Christine Etzel, Director of Strategic Provider Collaboration
- **Aetna** (Duncan Stuart, Vice President, New England Regional Market)

Lunch

Quality Benchmark Results

Quality Benchmarks by Market

Quality Benchmark Measure	2022 Quality Benchmark Value			
	Preferred Performance	Commercial	Medicare Advantage	Medicaid
Asthma Medication Ratio (Ages 5-18)	Higher	79.0%	--	66.0%
Asthma Medication Ratio (Ages 19-64)	Higher	78.0%	--	63.0%
Controlling High Blood Pressure	Higher	61.0%	73.0%	61.0%
HbA1c Control for Patients with Diabetes: HbA1c Poor Control*	Lower	27.0%	20.0%	37.0%

Quality Benchmark Analysis Limitations

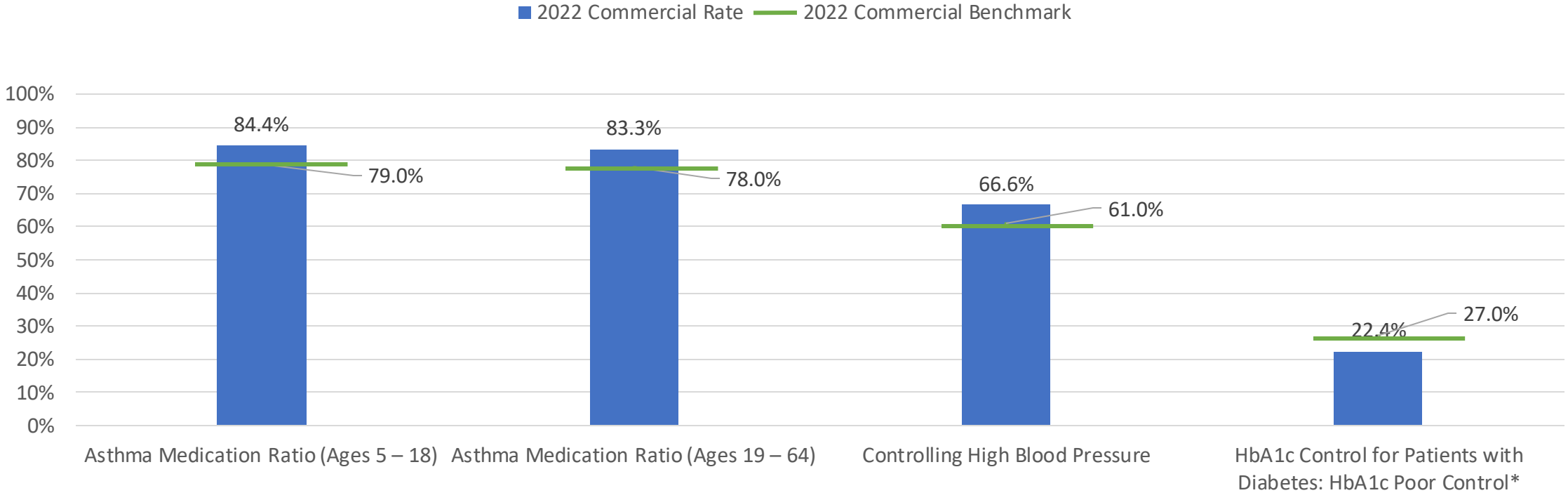
- ***Controlling High Blood Pressure*** *and* ***HbA1c Control for Patients with Diabetes: HbA1c Poor Control*** require both claims and clinical data to calculate
  - Insurers were not able to report Quality Benchmark performance data for many Advanced Networks for these measures
  - Where insurers did report Advanced Network data for these measures, the reported population did not always meet minimally acceptable denominator threshold
- Two insurers, Elevance and UnitedHealthcare, did not submit complete quality performance data to OHS at the provider entity level, and thus these data were not included in OHS' analysis

Quality Benchmark Results

Statewide, by Market

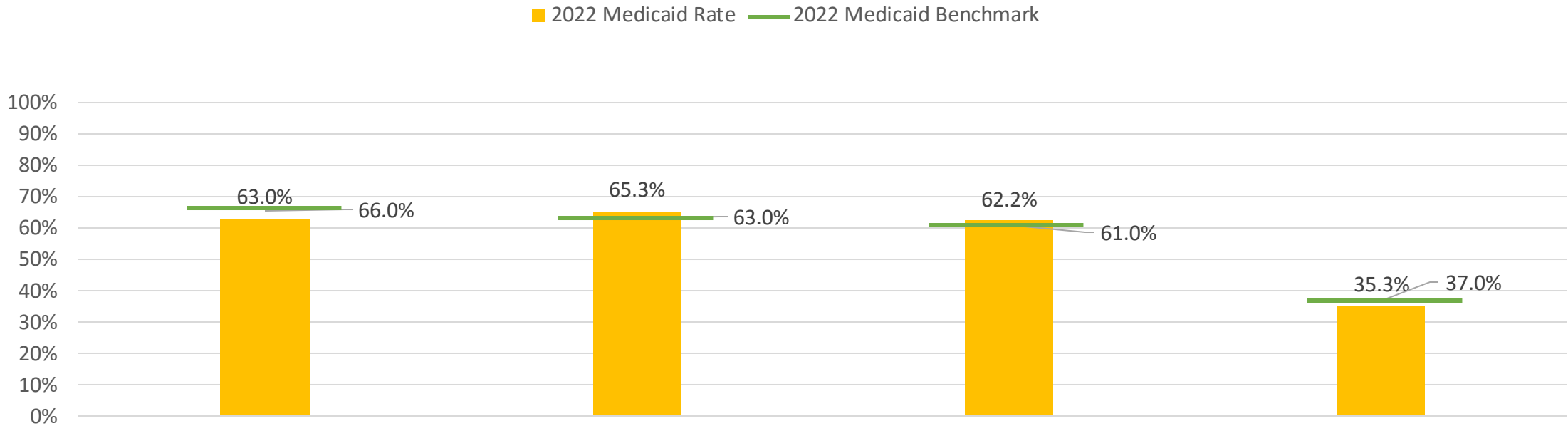
	Commercial	Medicare	Medicaid
Asthma Medication Ratio (Ages 5-18)	✓	Not Applicable	✗
Asthma Medication Ratio (Ages 19-64)	✓	Not Applicable	✓
Controlling High Blood Pressure	✓	✓	✓
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: Poor Control	✓	✓	✓

Statewide Commercial Quality Benchmark Performance



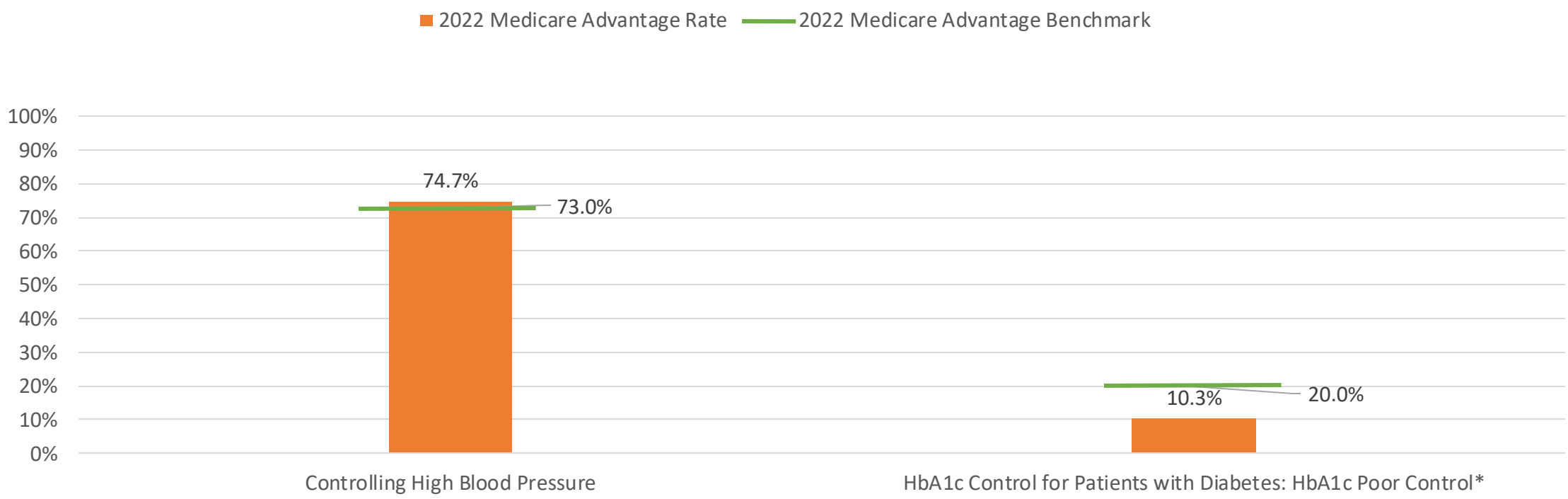
*A lower performance rate indicates better performance for HbA1c Poor Control.
Data Source: OHS collected performance data from insurance carriers.
Notes: Commercial performance is a weighted average of insurer performance, using commercial member months from OHS' cost growth benchmark data request.

Statewide Medicaid Quality Benchmark Performance



*A lower performance rate indicates better performance for HbA1c Poor Control.
Data Source: OHS collected performance data from the Department of Social Services (DSS).
Notes: Medicaid performance includes HUSKY A/B, HUSKY C, and HUSKY D but excludes Medicare/Medicaid dual eligible members. Medicaid performance for the hybrid measures (Controlling High Blood Pressure and HbA1c Poor Control) are a weighted average of HUSKY A/B, HUSKY C and HUSKY D.

Statewide Medicare Advantage Quality Benchmark Performance



*A lower performance rate indicates better performance for HbA1c Poor Control.
Data Source: OHS collected performance data from insurance carriers.
Notes: Medicare Advantage performance is a weighted average of insurer performance, using Medicare Advantage member months from OHS' cost growth benchmark data request.

Commercial Payers' Quality Benchmark Performance

Payer	Asthma Medication Ratio, Ages 5-18 Benchmark: 79.0%	Asthma Medication Ratio, Ages 19-64 Benchmark: 78.0%	Controlling High Blood Pressure Benchmark: 61.0%	HbA1c Poor Control* Benchmark: 27.0%
Aetna	80.4%	85.0%	56.2%	19.8%
Cigna	87.4%	87.7%	67.9%	29.4%
ConnectiCare	89.1%	89.7%	72.3%	28.3%
Elevance	85.1%	82.0%	67.2%	19.7%
UnitedHealthcare	81.8%	77.1%	72.2%	22.2%

*A lower rate indicates better performance for HbA1c Poor Control

Medicare Advantage Payers' Quality Benchmark Performance

Payer	Controlling High Blood Pressure Benchmark: 73.0%	HbA1c Poor Control* Benchmark: 20.0%
Aetna	74.3%	10.0%
ConnectiCare	79.6%	17.8%
Elevance	64.7%	27.3%
UnitedHealthcare	75.5%	7.1%

*A lower rate indicates better performance for HbA1c Poor Control

Advanced Network Quality Benchmark Performance

- OHS also analyzed Advanced Network performance on the three Phase 1 Quality Benchmark Measures
- Performance results can be found in OHS published 2024 Quality Benchmarks report

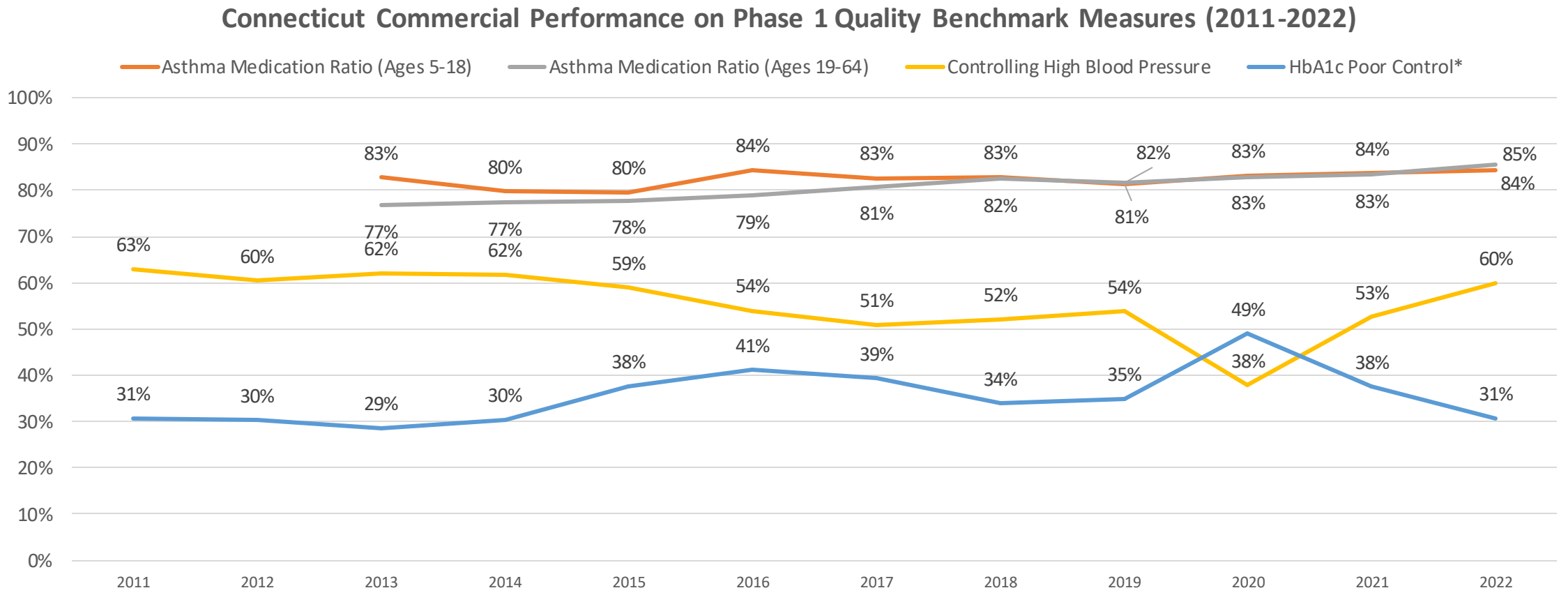
Takeaway Observations

- At the market and payer levels, performance was strong for *Asthma Medication Ratio* and *Controlling High Blood Pressure* and opportunity for improvement exists for *HbA1c Poor Control*
- There was substantial variation across Advanced Networks on these measures, especially for *Controlling High Blood Pressure* and *HbA1c Poor Control*
  - The challenges OHS encountered with collecting complete and valid data underscores the need for:
    - For insurers to integrate quality benchmark measures into value-based contracts with Advanced Networks, and
    - To collect the requisite clinical data to accurately report performance against the Quality Benchmark Values

Longitudinal Quality Benchmark Performance

- The following slides present longitudinal CT commercial performance for the Phase 1 and Phase 2 Quality Benchmark measures using data from NCQA's Quality Compass database.
  - OHS does not have access to comparable data for the Medicare Advantage or Medicaid markets.
  - Performance rates were calculated as flat average and not weighted by insurer enrollment.

Longitudinal Quality Benchmark Performance



*A lower performance rate indicates better performance for *HbA1 Poor Control.*
Data Source: NCQA Quality Compass (product years 2012-2023)
Notes: Commercial performance includes all lines of business. NCQA did not publish performance for Asthma Medication Ratio until 2013.

Questions?

Improving Quality Healthcare in CT:

Bradley Richards, MD, Chief Medical Officer, CT Dept. of Social Services, Moderator

- **Rohit Bhalla, MD, Stamford Health**
- **David Krol, MD, CT Children's Network**
- **Benjamin Oldfield, Fair Haven Community Health Center**

• Primary Care
• Innovations

- Connecticut Healthcare Benchmarks
- Informational Hearing
- June 25, 2024

- Al Kurose MD
- President & COO
- Nuvance Health Medical
- Practice

Today's Agenda

1. Lessons from the Rhode Island Experience
2. How One ACO in RI Improved Performance
3. Current Challenges in Primary Care
4. How Do We Invest in Primary Care To Improve Access, Quality and Cost Trend?

Please raise your hand with questions as we go!

My Background

PCP in East Providence, RI 1991-2011

CEO, Coastal Medical, 2008-2022

SVP Primary Care & Pop Health, Lifespan ‘21-’23

Work on payment reform & healthcare policy

Today is my 90th day at Nuvance

Lessons from RI's Investment in Primary Care

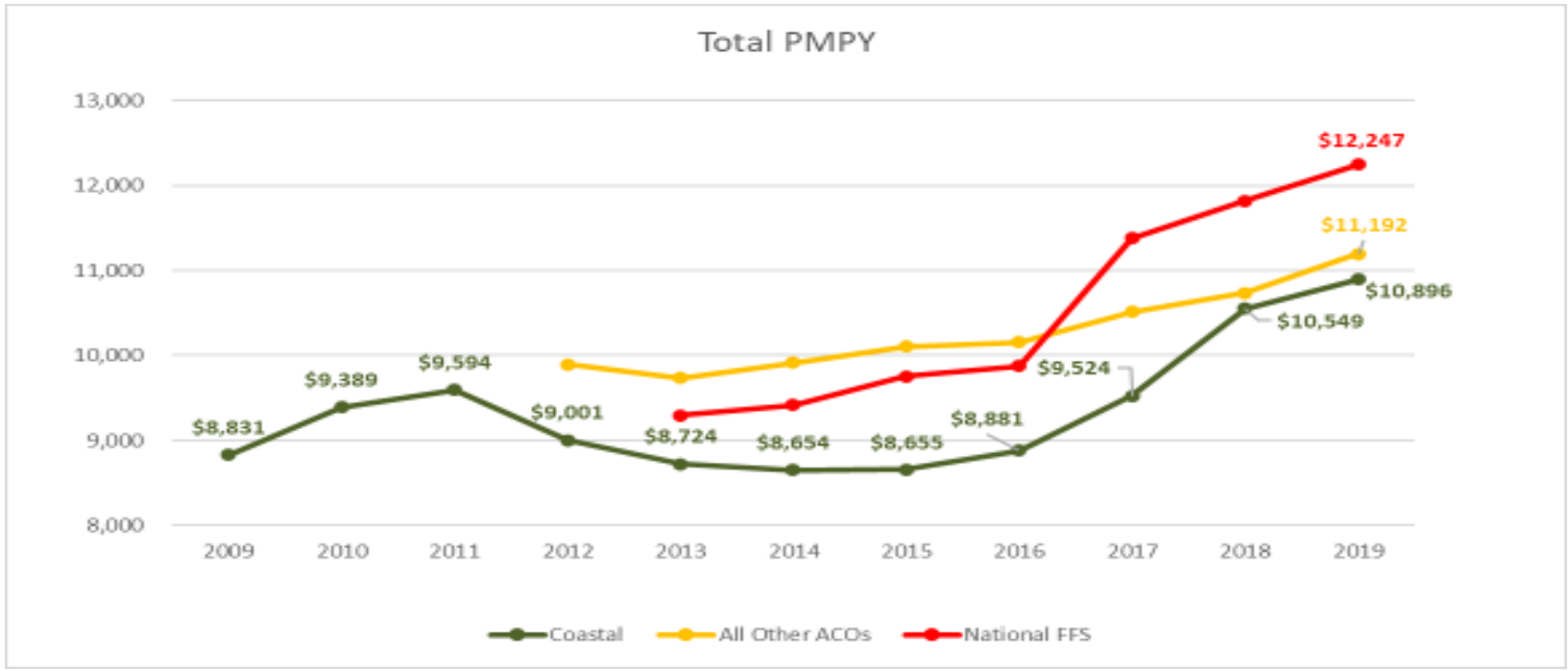
Collaboration of payers, providers & regulators was crucial.

Value-based payment drove emergence of high performing ACO's.

Value-based care moved past a tipping point when payment models were translated into physician compensation.

The state convened a primary care transformation collaborative that kept payers, providers, & regulators together at the table.

Breaking the cost curve

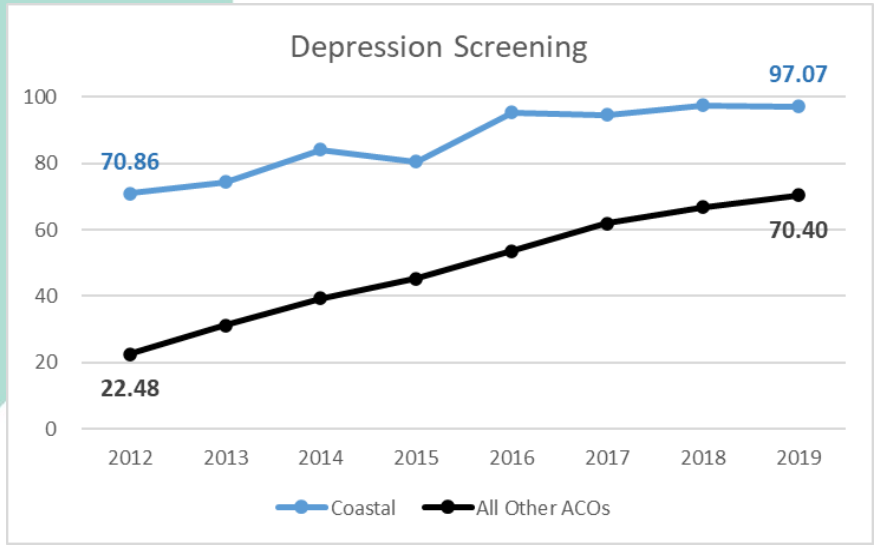


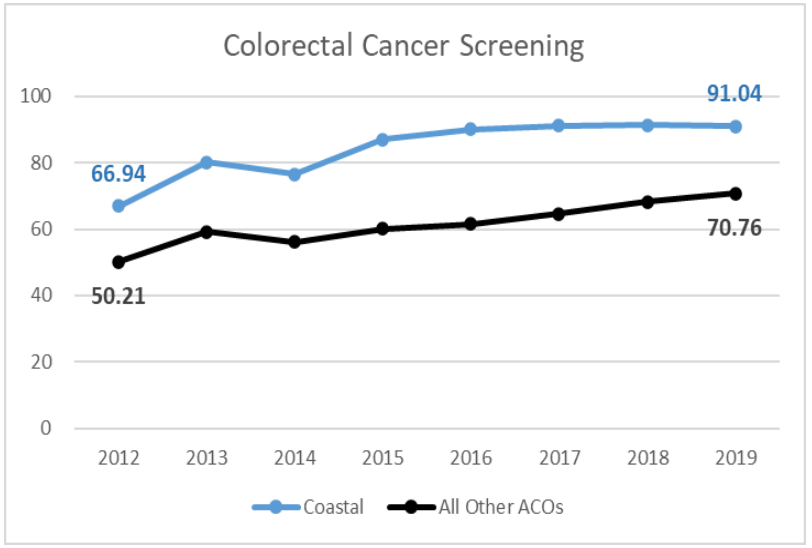
* 2017 National FFS method changed to assignable beneficiaries

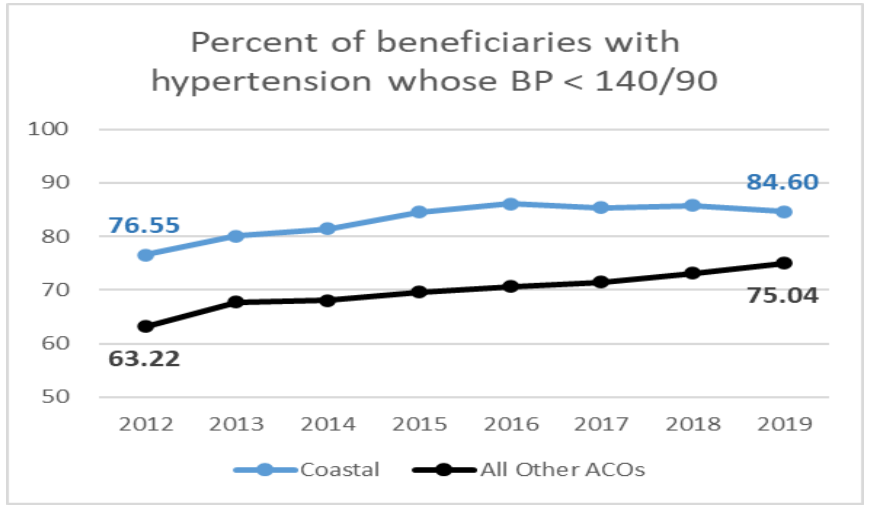
* 2018 attribution method changed to prospective attribution, which caused some large increases

* 2017/2018 Coastal Medical PMPY increased due to CPC+ payments included in spend

Fig. 1. *Breaking the Cost Curve*, 2019, courtesy of Coastal Medical







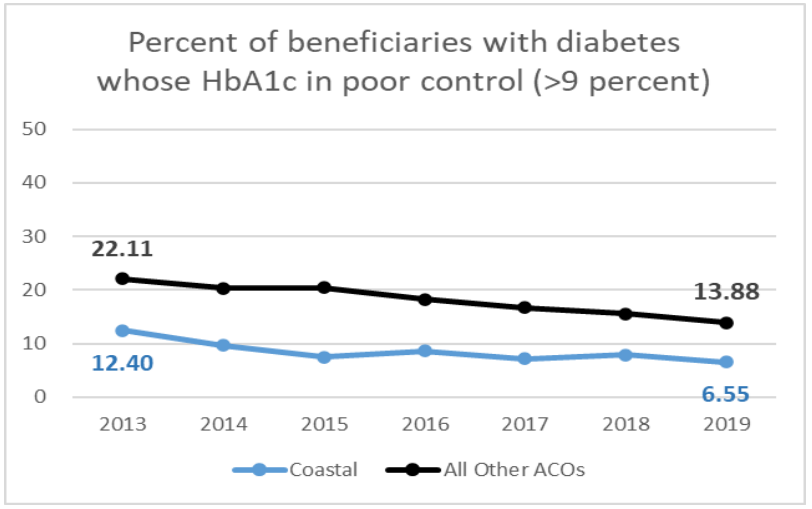


Fig. 2. Health Screening and Control of Chronic Conditions, 2019, courtesy of Coastal Medical

How?…VBP Enabled Programs That Drove Performance

Coastal365 urgent primary care clinics nights, weekends, and holidays
Disease management programs: CHF, COPD, DM & HTN
Care management: high-risk patient panels; rounding in hospitals & SNF's
Transitions of Care Team: Outreach post discharge from hospital, ED, & SNF
Clinical pharmacy: Rx refill, prior authorizations, antibiotic & narcotic stewardship, disease management, home visit team
Integrated behavioral health
Navigators, social workers
Non-operative musculoskeletal health program
Multidisciplinary home visit program
Palliative care and hospice in partnership with preferred provider

We Have a Numbers Problem That is Going to Get Worse

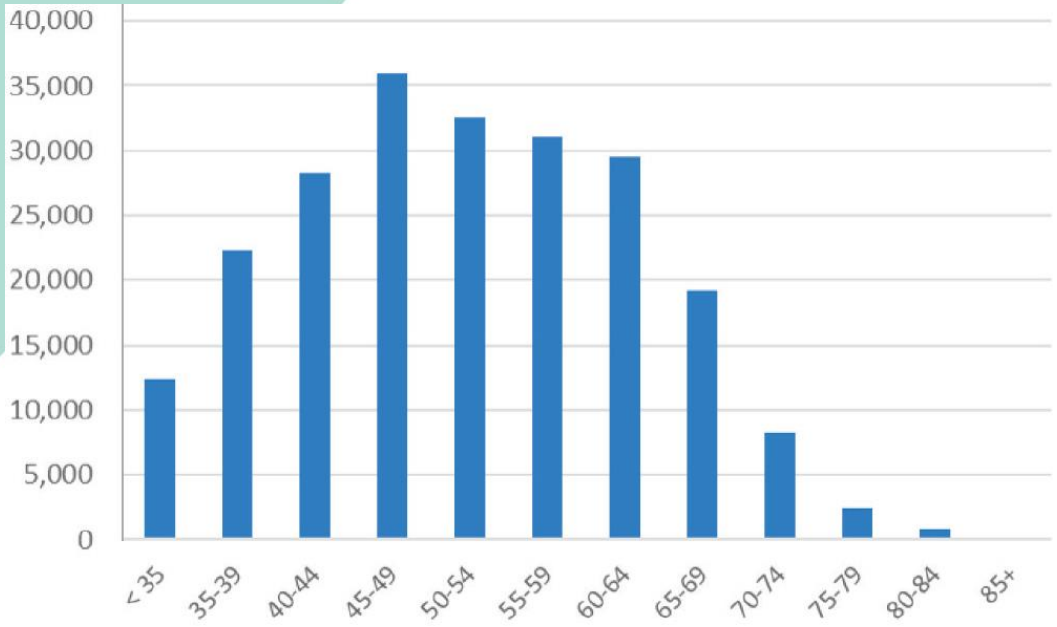
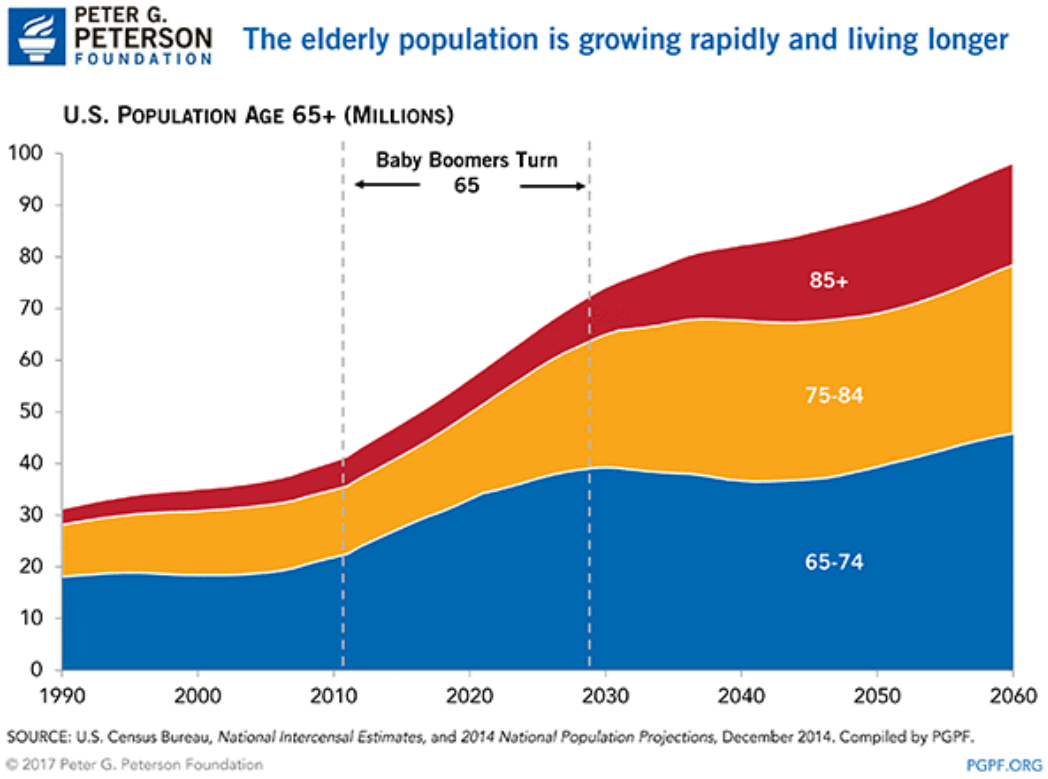


Fig. 3. Age distribution of US primary care physicians, from 2021 NASEM Report. Original source: Peterson, et al., 2018



Since we know what's coming, shouldn't we be more proactive?

How Should We Transform the Delivery of Primary Care?

Primary Care Practice Model

More team-based care, larger panels, fewer PCP visits
More APP's & expanded scope of practice for nurses and pharmacists
CHW's, navigators, nutritionists, SW, pharmacy tech's, upskilled MA's

Organizational Support

Centralized clinical programs
Centralized administrative programs
VBC analytics

Setting Expectations

Working at top of license becomes imperative as the numbers problem worsens
For patients, past norms and expectations aren't going to be sustainable

How Should We Change How We Pay for Primary Care?

Payment Model

Pay more for quality
Pay more for infrastructure support
Pilot primary care capitation
Adjust risk expectations based on current state & ***provider investment risk***

Compensation Model

Dial down volume-based incentives
Dial up incentives based on risk adj. panel size, quality, pt. experience, and TCOC

Questions?

Thanks!

Contact Info:

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George.Kurose@NuvanceHealth.org
M 475-237-0914 (text message preferred to start)

Conclusion/Next Steps

Thank you

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CONNECTICUT