CT OHS' Cost Growth Benchmark Unintended Adverse Consequences Measurement Plan

Updated February 2, 2021

I. Summary of Technical Team and Stakeholder Advisory Board's Recommendations

The Technical Team and Stakeholder Advisory Board noted that the cost growth benchmark could possibly result in unintended adverse consequences. This included providers inappropriately reducing access to healthcare services, especially for marginalized populations, and insurers transferring costs to consumers to suppress utilization and spending.

While Massachusetts, the state with the most cost growth benchmark experience, has not documented providers withholding care in response to the benchmark, the Technical Team made a preliminary recommendation to use the Department of Social Services' (DSS) PCMH+ Under-Service Utilization Monitoring Strategy as a starting point for identifying potential under-utilization or inappropriate reductions in access to medically necessary care. OHS' strategy includes tracking preventive care and access measures, similar to DSS, supplemented with additional strategies for measuring unintended adverse consequences based on research and experience in other states. OHS solicited and incorporated feedback from the Technical Team and Stakeholder Advisory Board prior to finalizing this measurement plan.

II. Unintended Adverse Consequences Measurement Plan

There are three main domains of analyses that can measure effects of the cost growth benchmark of concern to the Technical Team and stakeholders, including any unintended consequences that may arise from its implementation: underutilization, impact on marginalized populations, and consumer out-of-pocket spending. Connecticut's ability to implement these measures will depend significantly on time and analytic staff available for this work. This measurement plan will be executed in two phases: measures that OHS will implement immediately given its analytic capabilities and measures that will require developmental activity once OHS decides upon an analytics contractor to support its data use strategy in the next few months.

1. Measures to Implement Immediately

Connecticut currently has the resources to implement the following measures immediately so that a measurement plan is in place when OHS implements the cost growth benchmark. All analyses will compare pre- and post-benchmark implementation periods by market so that OHS can more clearly assess the impact of the benchmark on these indicators. COVID-19 will likely impact performance for several of these measures, so analyses will utilize a two-year baseline performance period from 2019 to 2020. The first measurement period will be calendar year 2021.

A. Underutilization

The following measure recommendations are focused on underutilization of healthcare services due to providers or payers impeding access to care, which is a theoretically possible unintended consequence of the cost growth benchmark. The Technical Team was particularly interested in this type of analysis.

i. One of DSS' strategies for identifying and preventing against underutilization for its Person-centered Medical Home Plus (PCMH+) model is use of **preventive** and **chronic care measures**. The Technical Team appreciated this approach because it facilitates alignment with Medicaid's efforts while also providing a mechanism for identifying whether consumers are receiving medically necessary care.

Commercial plan performance for HEDIS measures, which are widely used in measurement, are easily obtained through NCQA Quality Compass. OHS' contractor, Bailit Health, will pull these data annually for OHS by September 30 of the year following the measurement period.[1] Bailit Health will calculate a statewide weighted average performance for the measures below and annual trend.

There are no Medicaid data for Connecticut, however, in Quality Compass. Therefore, OHS is only selecting measures for Medicaid that DSS is already collecting for its PCMH+ Quality Measure Set.[2] OHS will obtain Medicaid-level data from DSS' PCMH+ website for these measures on an annual basis by December of the year following the measurement period.[3] OHS will calculate the annual trend.

The table outlines the preventive and chronic care measures from NCQA and DSS' PCMH+ Quality Measure Set that are most sensitive to providers restricting care, particularly for vulnerable populations. OHS will assess changes in performance for these measures pre- and post-benchmark implementation.

Measure Name	Medicaid Measure	Commercial Measure
Asthma Medication Ratio	Yes	Yes
Behavioral Health Screening, Ages 1-17	Yes	
Breast Cancer Screening	Yes	Yes
Cervical Cancer Screening	Yes	Yes

---

[1] NCQA releases commercial data through Quality Compass in August the year following the measurement period (e.g., calendar year 2020 data will be released in August 2021).

[2] Of note, OHS included the updated versions of select measures from DSS' PCMH+ Quality Measure Set (e.g., HPV for Female Adolescents is now Immunization for Adolescents – HPV). It did not include measures that were newly added for HEDIS Measurement Year 2020 because OHS will be unable to assess performance for them pre- and post-implementation of the cost growth benchmark.

[3] https://portal.ct.gov/DSS/Health-And-Home-Care/PCMH-Plus. For 2019 data, see: https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/PCMH-Plus/CMC-PCMH-Wave-2-Year-2-QM-and-SS-Webinar-12172020.pdf.

Measure Name	Medicaid Measure	Commercial Measure
Child and Adolescent Well-Care Visits[4]	Yes	Yes
Chlamydia Screening in Women	Yes	Yes
Colorectal Cancer Screening		Yes
Comprehensive Diabetes Care: Eye Exam	Yes	Yes
Comprehensive Diabetes Care: HbA1c Testing	Yes	Yes
Controlling High Blood Pressure		Yes
Developmental Screening in the First Three Years of Life	Yes	
Oral Evaluation; Dental Services	Yes	
Prenatal and Postpartum Care	Yes	Yes

ii. Another DSS' strategy is to utilize **member experience surveys** to assess member perception of access to care, as well as patient satisfaction with healthcare services and providers. While these are not direct measurements of underutilization, they may help identify patent perception of underutilization that is only captured through a survey. There are two primary sources of data for these assessments: a) the Health Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and b) the Clinician and Group (CG) CAHPS survey. Commercial statewide data for the Health Plan CAHPS measures are available through NCQA Quality Compass.

Similar to II.1.A.i, Bailit Health will pull these data annually for OHS by September 30 of the year following the measurement period and calculate a statewide weighted average and annual trend. OHS will obtain Medicaid-level data from DSS' PCMH+ website for the CG-CAHPS survey items by December of the year following the measurement period.[5]

   a. **Measure #2a**: change in performance for the "Getting Care Quickly" composite, which is the percentage of members who responded "Always" or "Usually" to the questions "In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?" and "In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?" pre- and post-benchmark implementation
   - Level of measurement: statewide rate for commercial plans
   - Data source: Health Plan CAHPS
   - Party accountable for collecting/analyzing data: OHS or its contractor
   - Timeframe: calendar year

---

[4] This measure is new for HEDIS measurement year 2021. It combines Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life with Adolescent Well-Care Visits and adds ages 7-11 to the measure.
[5] https://portal.ct.gov/DSS/Health-And-Home-Care/PCMH-Plus.

b. **Measure #2b**: change in performance on the "Getting Needed Care" composite, which is the percentage of members who responded "Always" or "Usually" to the questions "In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?" and "In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?" pre- and post-benchmark implementation
- Level of measurement: statewide rate for commercial plans
- Data source: Health Plan CAHPS
- Party accountable for collecting/analyzing data: OHS or its contractor
- Timeframe: calendar year

c. **Measure #2c**: change in the percentage of patients who responded "Always" or "Usually" to the question "When you contacted this provider's office to get an appointment for are you needed right away, how often did you get an appointment as soon as you needed?" pre- and post-benchmark implementation
- Level of measurement: Medicaid
- Data source: CG-CAHPS
- Party accountable for collecting/analyzing data: DSS
- Timeframe: calendar year

d. **Measure #2d**: change in the percentage of patients who responded "Always" or "Usually" to the question "When you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?" pre- and post-benchmark implementation
- Level of measurement: Medicaid
- Data source: CG-CAHPS
- Party accountable for collecting/analyzing data: DSS
- Timeframe: calendar year

e. **Measure #2e**: change in the percentage of patients who responded "Always" or "Usually" to the question "How often were you able to get the care you needed from this provider's office during evenings, weekends, or holidays?" pre- and post-benchmark implementation
- Level of measurement: Medicaid
- Data source: CG-CAHPS Supplemental Item Set
- Party accountable for collecting/analyzing data: DSS
- Timeframe: calendar year

f. **Measure #2f**: change in the percentage of patients who responded "Yes" to the question "Did this provider's office give you information about what to do if you needed care during evenings, weekends, or holidays?" pre- and post-benchmark implementation
- Level of measurement: Medicaid
- Data source: CG-CAHPS Supplemental Item Set

- Party accountable for collecting/analyzing data: DSS
- Timeframe: calendar year

   iii.   Another option to assess experience of care among Medicaid members is through **tracking member grievances**, a third DSS strategy. If members are experiencing challenges obtaining timely appointments or feel disrespected by their providers through the PCMH+ program, they can submit a grievance to the State's Administrative Services Organization.[6] While these are not direct assessments of underutilization, they can help identify member perception of underutilization. OHS will obtain Medicaid-level data from DSS' PCMH+ website by December of the year following the measurement period.[7]

      a. **Measure #3a**: change in the number of members filing complaints about no or limited access to a specific provider type per 1,000 member months pre- and post-benchmark implementation
- Level of measurement: provider organization
- Data source: grievance data from the Administrative Services Organization collected at the end of the measurement period
- Party accountable for collecting/analyzing data: DSS
- Timeframe: quarterly, calendar year

      b. **Measure #3b**: change in the number of members filing complaints about delayed access and/or wait time for an appointment (e.g., delay in obtaining appointment, wait time while in office) per 1,000 member months pre- and post-benchmark implementation
- Level of measurement: provider organization
- Data source: grievance data from the Administrative Services Organization collected at the end of the measurement period
- Party accountable for collecting/analyzing data: DSS
- Timeframe: quarterly, calendar year

B. *Consumer Out-of-Pocket Spending*

The cost growth benchmark will not be wholly successful if consumer out-of-pocket spending, including consumer spending due to deductible and co-insurance obligations, grows faster than the benchmark. This has been a problem in Massachusetts. OHS will track changes in consumer out-of-pocket spending, as well as premiums, relative to the benchmark. To begin, it will utilize data from the Current Population Survey (CPS), which collects data annually on the total amount paid in out-of-pocket expenditures and

---

[6] An example of what type of data are available can be found here: https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/PCMH-Plus/2019-August-Member-Complaints.pdf.

[7] https://portal.ct.gov/DSS/Health-And-Home-Care/PCMH-Plus. For 2020 data, see: https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/PCMH-Plus/2020-PCMH-Plus-Member-Complaints-Complaints-Broken-Out-By-Reason-Code-CY-2020.pdf.

premiums by family on an annual basis.[8] It will also look at plan-level out-of-pocket spending using APCD data.

OHS will pull CPS data annually by October of the year following the measurement year.[9] Data are available through the "Annual Social and Economic Supplements" webpage on the U.S. Census Bureau website. OHS and/or its analytic contractor will pull APCD data annually by August of the year following the measurement year.[10]

i. **Measure #B1**: change in the average annual growth in out-of-pocket spending in Connecticut compared to other states pre- and post-benchmark implementation
   - Level of measurement: statewide
   - Data source: CPS
   - Party accountable for collecting/analyzing data: CT OHS
   - Timeframe: calendar year

ii. **Measure #B2**: change in the average annual growth in premiums in Connecticut compared to other states pre- and post-benchmark implementation
   - Level of measurement: statewide
   - Data source: CPS
   - Party accountable for collecting/analyzing data: CT OHS
   - Timeframe: calendar year

iii. **Measure #B3**: change in the average annual growth in out-of-pocket spending by plan pre- and post-benchmark implementation
   - Level of measurement: plan
   - Data source: APCD (i.e., the sum of copays, deductibles and coinsurance divided by the allowed amount)
   - Party accountable for collecting/analyzing data: CT OHS and/or its analytic contractor
   - Timeframe: calendar year

After OHS collects and analyzes data for the above measures, it will convene the Technical Team and Stakeholder Advisory Board to review its findings in the first quarter two years following the measurement year (e.g., 2020 data will be reviewed in the first quarter of 2022). At that time, OHS and its advisory bodies will identify if there are any further analyses OHS should conduct as part of its data use strategy.

2. **Measures Requiring Additional Development**

---

[8] For more information, see: https://www.census.gov/programs-surveys/cps/data.html. The 2020 survey questions and data can be found here: https://www.census.gov/data/datasets/time-series/demo/cps/cps-asec.html.

[9] The Census releases data in September the year following the measurement year (e.g., calendar year 2020 data will be released in September 2021).

[10] Data for calendar year 2020 will not be available until June 2021.

As mentioned previously, Connecticut is limited in its ability to measure unintended adverse consequences of the cost growth benchmark because of its current analytic capabilities and resources. The following measures require additional development and will be implemented after OHS designates an analytics contractor to support its data use strategy. This plan will be updated at that time to include specific timelines and resources for obtaining data to calculate the measures. Measures are organized in three categories: underutilization (continued), consumer out-of-pocket spending (continued) and impact on marginalized populations.

A. *Underutilization (Continued)*

The following additional underutilization measures rely on more sophisticated analyses using plan-reported data.

i. **Anti-stinting measures** can help inform whether providers are limiting access to care to reduce cost growth. These measurements are quantitative assessments that compliment member experience perspectives outlined in section III.1.a.ii. These analyses require provider organizations to report data directly to OHS for an analytics contractor to compare risk scores before and after implementation of the cost growth benchmark. Further, these analyses will assess performance separately for Medicaid and commercial members. Given that OHS has not yet identified analytics contractor to support the Healthcare Benchmark Initiative, it is delaying use of these measures until one has been secured.

Measures focused on proactively selecting healthier/more adherent patients, i.e., "cherry picking"

a. **Measure #4a**: change in the ratio of average risk score of patients attributed during the measurement year and the existing patient population attributed to the provider organization for the measurement year prior to the implementation of the cost growth benchmark, stratified by coverage type[11]
- Level of measurement: provider organization
- Data source: APCD data analyzed using risk adjustment software or plan-reported data using a specified Excel template
- Party accountable for collecting/analyzing data: OHS and/or its analytic contractor
- Timeframe: calendar year

---

[11] If the risk scores of a provider organization's new patients are significantly better than the risk scores of the population prior to the implementation of the cost growth benchmark, it may indicate cherry-picking. This measure requires use of a risk-adjustment program that produces a risk score, which may not be available at all provider organizations. In addition, the measure may not always be indicative of cherry-picking, as there are several reasons as to why a provider organization might have or attract healthier patients (e.g., community, provider-type, referrals, relationship to hospital or academic medical center).

Measures focused on dropping patients that are less healthy/more complicated, i.e., "lemon dropping"

    b. **Measure #4b**: change in the ratio of the average risk score of the provider organization's patients who attributed to a different provider organization within the same geographic region during the measurement year and the provider organization's patients who remained with the organization during the measurement year, stratified by coverage type, pre- and post-benchmark implementation[12]

- Level of measurement: provider organization
- Data source: APCD data analyzed using risk adjustment software or plan-reported data using a specified Excel template
- Party accountable for collecting/analyzing data: OHS and/or its analytic contractor
- Timeframe: calendar year

ii. **Timely access to specialty care** is a known problem for Medicaid members. OHS will measure whether there is a change in utilization of specialty care pre- and post-benchmark implementation. Connecticut's APCD does have a field that captures the rendering provider's specialty taxonomy code. As of April 2020, this field, on average, was being completed 84 percent of the time. Of note, the field is not populated for the billing, pharmacy or prescribing provider.

    a. **Measure #5a**: change in utilization pre- and post-benchmark implementation by provider specialty and coverage type

- Level of measurement: provider organization
- Data source: APCD data
- Party accountable for collecting/analyzing data: OHS and/or its analytic contractor
- Timeframe: calendar year

B. *Consumer Out-of-pocket Spending (Continued)*

OHS will evaluate the impact of the cost growth benchmark on out-of-pocket spending at the statewide or plan level today using data from the CPS and APCD, respectively. OHS, however, aims to also evaluate out-of-pocket spending trends for preventive services separately for non-preventive services, due to the potential impact of cost-sharing on utilization in commercial plan designs. To conduct this analysis, OHS will need to

---

[12] If the risk score of a provider organization's patients that enroll if a different provider organization in the same geographic region are significantly higher than those who remain with the organization, it may indicate lemon-dropping. This measure requires use of a risk-adjustment program that produces a risk score, which may not be available at all provider organization. In addition, the measure may not always be indicative of lemon-dropping, as there are several reasons as to why a patient may leave the organization (e.g., the new practice may have expertise in their chronic condition, patient may be dissatisfied with the organization's care for reasons unrelated to their risk score).

perform more sophisticated analyses using its APCD. Further, to assess premiums at the plan level, OHS will need to request these data directly from plans.

iv. **Measure #B4**: change in the average annual growth in out-of-pocket spending by plan and service category pre- and post-benchmark implementation
- Level of measurement: plan
- Data source: APCD (i.e., the sum of copays, deductibles and coinsurance divided by the allowed amount)
- Party accountable for collecting/analyzing data: OHS and/or its analytic contractor
- Timeframe: calendar year

v. **Measure #B5**: change in the average annual growth in premiums pre- and post-benchmark implementation
- Level of measurement: plan
- Data source: plan-reported data using a specified Excel template
- Party accountable for collecting/analyzing data: OHS and/or its analytic contractor
- Timeframe: calendar year

C. Impact on Marginalized Populations

The Technical Team and Stakeholder Advisory Board expressed interest in assessing the effects of the cost growth benchmark on marginalized populations. Based on stakeholder input, this can include stratifying utilization and spending data based on income, insurance status, race/ethnicity, social risk factors and zip code. OHS will combine several of these variables to focus on specific vulnerable populations, such as combining geography, income and race/ethnicity to assess communities of color in the lowest-income zip codes. The table below summarizes the variables OHS will include in its analysis, the data source for the variables, and notes on what types of analyses OHS will perform.

Variable	Data Source	Notes
Geography	APCD	Focus on zip codes that are most vulnerable, which are defined as those with the greatest poverty rates. Based on initial data from the Census, this will include zips codes for the following cities and towns that have more than 20 percent of persons in poverty: Bridgeport, Hartford, New Britain, New Haven, New London, Storrs, Thompsonville, Waterbury, Willimantic and Winsted.[13]
Income	ACS	Focus on communities that are in poverty (see above).

---

[13] For more information, see: https://www.census.gov/quickfacts/fact/map/CT/IPE120219.

Variable	Data Source	Notes
Insurance status	APCD	Focus on Medicaid.[14]
Race/ethnicity	ACS	Focus on communities of color.[15]
Social risk factors	ACS	Focus on communities with food (i.e. food stamp or SNAP recipient)[16], housing (i.e., housing units without running water, a stove and or a refrigerator)[17] and transportation (i.e. no cars)[18] needs as these are the health-related social needs that are most commonly identified by Medicaid and Medicare members.[19]

One primary challenge with stratifying these analyses is that it is not feasible to link data from various sources. For example, OHS is unable to link preventive and chronic care measures obtained through NCQA Quality Compass as outlined in section II.1.A.i with any of the variables mentioned in the above table. It can only link APCD data to ACS data using zip codes. Further, OHS cannot easily link plan-reported data with APCD and ACS data.

Given the challenges associated with obtaining these data and the analytic capabilities required to perform these analyses, OHS will implement the following measures after 1) it hires an analytic contractor to support its data use strategy and 2) demonstrates that it is able to accurately implement measures outlined in section II.1 in the short-term.

---

[14] Stakeholder groups also expressed interest in capturing the uninsured population. However, there is no straightforward way to capture spending for this population for the types of analyses Connecticut wishes to perform at this time.

[15] The Technical Team and Stakeholder Advisory Board expressed concern about whether race/ethnicity data from the ACS was representative. The ACS, like any survey, is subject to error, but it is the most valid and reliable source of demographic data at the local level that is readily available. The ACS continues to achieve higher response rates than any other federal survey because of its data collection methodology and mandatory response. Further, it makes many efforts to contact individuals who historically have lower response rates to minimize the bias that would occur if individuals who do not respond are systematically different from those who do. It also utilizes a weighting strategy to adjust for higher rates of non-response among some demographic groups. Finally, the ACS routinely publishes data on sample size and data quality that OHS and/or its analytic contractor can consult prior to utilizing these data.

[16] For more information, see: https://www.census.gov/acs/www/about/why-we-ask-each-question/food-stamps/.

[17] Limited access to these facilities can serve as a proxy for low housing quality. For more information, see: https://www.census.gov/acs/www/about/why-we-ask-each-question/plumbing/.

[18] Not having a car can serve as a proxy for having limited access to adequate transportation. We understand that these numbers may be inflated, however, because some individuals in a city may not need a car. For more information see: https://www.census.gov/acs/www/about/why-we-ask-each-question/vehicles/.

[19] For more information, see: https://innovation.cms.gov/media/document/ahc-fact-sheet-2020-prelim-findings.

i. **Measure #C1**: for communities of color in the lowest income zip codes, an assessment of the change in utilization for the following select services: behavioral health, inpatient hospital, outpatient hospital, prescription drugs and preventive care pre- and post-benchmark implementation
- Level of measurement: zip codes for select cities
- Data source: APCD utilization data linked to ACS race/ethnicity data
- Party accountable for collecting/analyzing data: OHS and/or its analytic contractor
- Timeframe: calendar year

ii. **Measure #C2**: measure C1, stratified by insurance market
- Level of measurement: zip codes for select cities
- Data source: APCD utilization and insurance market data linked to ACS race/ethnicity data
- Party accountable for collecting/analyzing data: OHS and/or its analytic contractor
- Timeframe: calendar year

iii. **Measure #C3**: measure C1, stratified by social risk factors
- Level of measurement: zip codes for select cities
- Data source: APCD utilization and insurance market data linked to ACS race/ethnicity and social risk factor data
- Party accountable for collecting/analyzing data: OHS and/or its analytic contractor
- Timeframe: calendar year