

Healthcare Cost Growth Benchmark Steering Committee Meeting December 20, 2021

Meeting Agenda

<u>Time</u>	<u>Topic</u>
3:00 p.m.	I. Welcome and Roll Call
3:05 p.m.	II. Public Comment
3:10 p.m.	III. Approval of November 30, 2021 Meeting Minutes – Vote
3:15 p.m.	IV. Approval of 2022 Steering Committee Meeting Schedule – Vote
3:20 p.m.	V. Primary Care Spend Target
3:40 p.m.	VI. Primary Care Roadmap
4:20 p.m.	VII. Quality Benchmarks
4:55 p.m.	VIII. Wrap-Up and Next Steps
5:00 p.m.	IX. Adjournment

Welcome and Roll Call

Public Comment

Approval of the November 30, 2021 Meeting Minutes - Vote

Approval of the 2022 Steering Committee Meeting Schedule - Vote

2022 Steering Committee Meeting Schedule - Vote

- January 24, 2022
- February 28, 2022
- March 28, 2022
- April 25, 2022
- May 23, 2022
- June 27, 2022
- July 25, 2022
- August 22, 2022
- September 19, 2022
- October 24, 2022
- November 21, 2022
- December 19, 2022

Primary Care Spend Target

Overview of the Primary Care Spend Target

- Executive Order #5 (January 2020) established a target to increase primary care spending as a percentage of total healthcare expenditures to 10 percent by calendar year 2025.
 - The target is intended to rebalance and strengthen Connecticut's healthcare system by supporting improved primary care delivery.
- OHS and the predecessor advisory body to this Steering Committee established a definition of primary care spending in 2020 that built upon a methodology established in collaboration with other New England states.

Why Invest In Primary Care?

- Research has demonstrated that greater relative investment in primary care correlated with better patient outcomes, lower costs, and improved patient experience of care.
- CMS, states and private payers have elected to leverage primary care to strengthen healthcare system performance by:
 - supporting improved primary care delivery
 - increasing the percentage of total spending allocated to primary care
- In CT, an analysis by ConnectiCare found that **primary care utilization is typically higher in high-performing medical groups**. These groups manage spending well compared to low-performing groups and have lower specialty spending.

Definition of Primary Care Spending

- **Primary care spending:**
 - **Claims-based spending:** spending for care management; care planning; consultation services; health risk assessments, screenings and counseling; home visits; hospice/home health services; immunization administrations; office visits and preventive medicine and dental care visits.
 - There is a specific code list to calculate claims-based primary care spending.
 - **Non-claims-based spending:** capitation or salaried expenditures, PCMH infrastructure, performance-based payments, risk-based reconciliation, HIT infrastructure, workforce expenditures, COVID-19 support payments.

Definition of Primary Care Spending (Cont'd)

- **Primary care providers:**

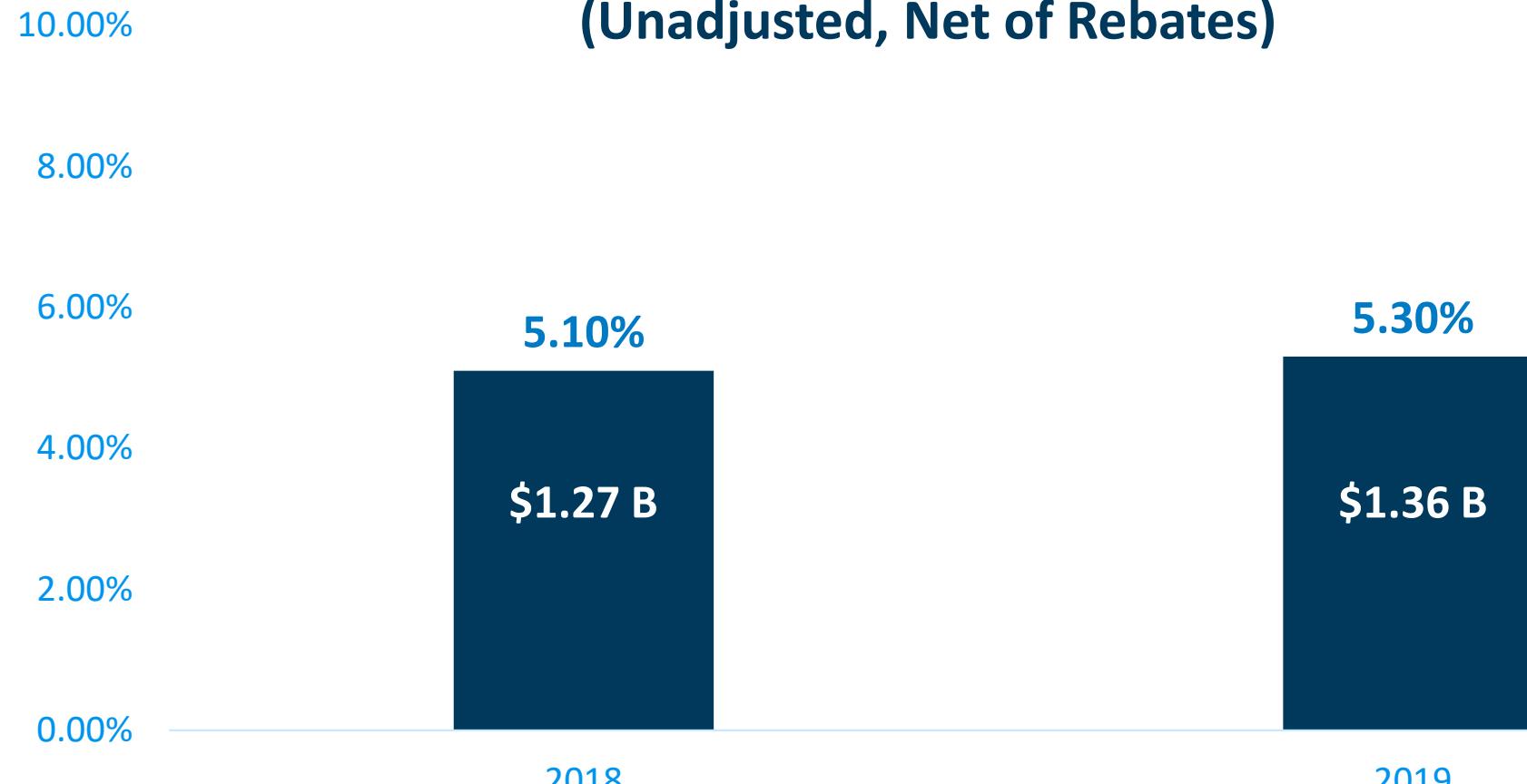
- **MDs and DOs:** geriatric medicine (when practicing primary care), family medicine, internal medicine (when practicing primary care) and pediatric and adolescent medicine.
- **NPs and PAs:** when practicing primary care.
- Of note, OHS is also assessing primary care spending associated with OB/GYNs and midwifery for monitoring purposes.

2018-2019 Baseline Data Analysis

- OHS collected data on 2018-2019 healthcare spending, including primary care spending on the following:
 - six commercial and Medicare Advantage insurers:
 - Aetna Health & Life
 - Anthem
 - Cigna
 - ConnectiCare
 - Harvard Pilgrim
 - UnitedHealthcare
 - Connecticut Department of Social Services (for Medicaid)
 - Centers for Medicare & Medicaid Services (for Medicare)

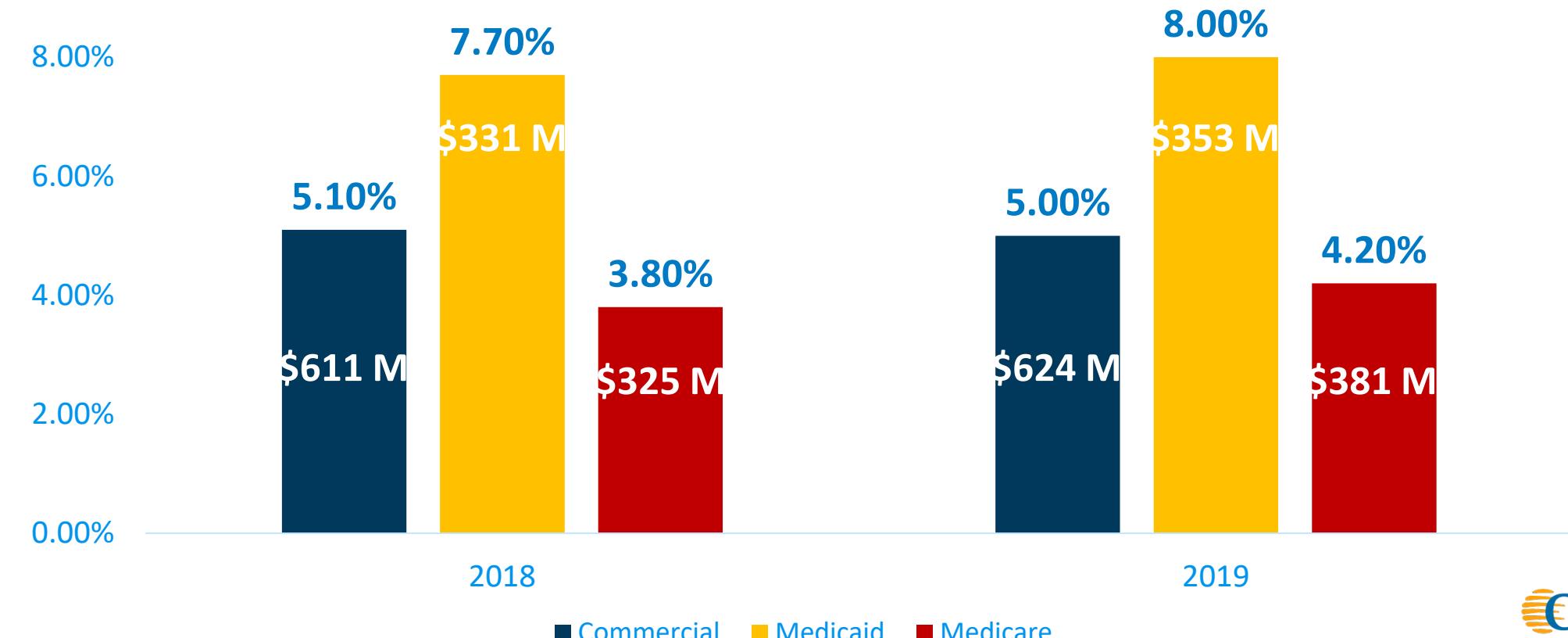
State-Level Primary Care Spending

**Primary Care Spending as a Percentage of Total Spending
(Unadjusted, Net of Rebates)**



Market-Level Primary Care Spending

**Primary Care Spending as a Percentage of Total Spending
(Unadjusted, Net of Rebates)**



Payer-Level Spending

- Commercial carriers

	2018	2019
Primary Care Spending as a Percentage of Total Spending	3.6% - 6.8%	3.5% - 6.7%
PMPM Primary Care Spending	\$21 - \$35	\$21 - \$38

- Medicare Advantage carriers

	2018	2019
Primary Care Spending as a Percentage of Total Spending	5.1% - 7.7%	4.5% - 7.6%
PMPM Primary Care Spending	\$34 - \$89	\$33 - \$84

2022-2024 Primary Care Spend Targets

- The 2022 target will be set at 5.3%, the baseline level calculated for 2019.
- Targets for years 2023-2025 include near-equal annual increases:
 - The targets will be **6.9%**, **8.5%** and **10%** for years 2023-25

Rationale for the targets:

1. Targets must be realistic. December notification of 2022 targets provides short notice to insurers who have already negotiated contracts with primary care organizations for 2022.
2. OHS' primary care program, as defined within the Roadmap for Strengthening and Sustaining Primary Care, won't begin until 2023.
3. The methodology establishing the 2022-2024 targets should be simple to explain.

Primary Care Roadmap

Improving Primary Care: Benefits for Patients



Increased access

Primary care physicians are supported by an expanded care team

More time and attention for individual patients
Convenience of various types of appointments



Whole-person care approach

More time and resources to address social risk factors
Care is delivered in a person-centered manner with the goals of the patient paramount



Focus on prevention and wellness

Improved collaboration across care providers results in early identification and intervention

Improved health and reduced illness burden

Improving Primary Care: Benefits for Practices



More time for patient care

Increased opportunities to understand patient goals and needs
Ability to focus on quality outcomes



Improved professional capabilities

Practice transformation builds practice capabilities around quality and equity improvement, team-based care, care coordination



Multi-payer alignment

Limited number of quality measures across payers reduces administrative burden



Flexibility in practice design and workflow

Services to multiple care modalities to support patient needs
Team-based approach



Predictable financing

Reduces the financial imperative to generate office visits giving practices revenue assurance

Supporting Connecticut's primary care infrastructure (1 of 2)

- Primary care across the U.S. and in CT is in trouble. There are multiple indicators:
 - Fewer medical school students entering primary care
 - An aging primary care physician workforce
 - High levels of burnout and dissatisfaction with quality of work life causing clinicians to leave the workforce
 - Connecticut primary care organizations report staff shortages and enormous difficulty in recruitment

Supporting Connecticut's primary care infrastructure (2 of 2)

- Analysis completed by OHS in October 2021 found that:
 - In 2019, only **5.0 percent** of the commercial payments in Connecticut went to primary care. This is below the New England states' mean rate and CT's primary care spending target of 10 percent, and less than half of RI's regulatory commercial insurer standard of 10.7 percent.
- For these reasons, and because primary care is the foundation of our delivery system, Governor Lamont has made sustaining CT's primary care infrastructure a policy priority.

Status of the *Roadmap for Strengthening and Sustaining Primary Care* (1 of 2)

- OHS began work in Spring 2021 with its Primary Care Subgroup to:
 1. Make recommendations for primary care spending targets, as required by Executive Order No. 5.
 2. Design a strategy (the “Roadmap”) to complement the primary care target for more effective and efficient primary care that will better meet the needs of patients and support primary care professionals.



Status of the *Roadmap for Strengthening and Sustaining Primary Care* (2 of 2)

- Learning from the SIM experience, OHS chose to pursue a strategy that is more modest and flexible in scope so that it can be implemented in a timely fashion and achieve the Governor's goals.
- OHS released a draft Roadmap in mid-December, informed by input from the Primary Care Subgroup, for a 30-day public comment. OHS invites your feedback on this document.
- The Roadmap will be finalized once public and stakeholder feedback has been reviewed and considered.

OHS solicited broad input to make sure the Roadmap is feasible, implemented, and successful

OHS engaged a wide array of stakeholders, in addition to those represented on OHS' Primary Care Subgroup:

Consumer Advocates:

- CT Chapter of the National Association of Hispanic Nurses
- Department of Public Health Medical Home Advisory Council
- OHS Consumer Advisory Council
- OHS Community Health Subgroup and Health Enhancement Communities

Providers:

- Bristol Hospital
- Community Health Center Association of CT
- Community Health Center Inc.
- CT State Medical Society – IPA
- Eastern CT Health Network Medical Group
- Hartford HealthCare Integrated Care Partners
- Medical Professional Services
- Northeast Medical Group
- SoNE HEALTH
- Starling Physicians
- Trinity Health of New England Medical Group
- Yale New Haven Health

OHS engaged a wide array of stakeholders, in addition to those represented on OHS' Primary Care Subgroup:

Medical Societies:

- Academy of Family Physicians
- Advanced Practice Registered Nurse Society
- American College of Physicians
- American Academy of Pediatrics

State Agencies:

- Connecticut Insurance Department
- Department of Social Services
- Department of Public Health
- Office of the State Comptroller

Payers:

- Aetna
- Anthem
- Cigna
- ConnectiCare
- Harvard Pilgrim
- UnitedHealthcare

Roadmap strategies for sustainable primary care

The Roadmap initiative is multi-payer:

- Commercial market-focused
- Aligned with Medicaid



Key elements of Roadmap:



Payers will increase primary care spending up to the governor's target and take action to aid implementation of the Roadmap.



Primary care practices that choose to participate in the primary care Roadmap and adopt the prescribed core functions will receive enhanced primary care payments from payers for doing so.



Enhanced payments will go towards improving patient care and implementing high-quality primary care.

Roadmap strategies focus on:

1. Core function expectations of primary care practice teams
2. Resources and supports to help practice teams master the core function expectations
3. Methods to assess and recognize practice team performance
4. Voluntary primary care alternative payment models, beyond fee-for-service (FFS), to reimburse primary care

1. Core function expectations of primary care practice teams

- OHS heard feedback from the Primary Care Subgroup that improved performance and increased accountability of primary care practices should accompany increased investments in primary care.
- In response to OHS direction to consider how the increased investment should be used, the Primary Care Subgroup helped shape 11 core functions foundational to the delivery of high-quality primary care that can be supported by increased investments.
- Following additional stakeholder input, OHS adopted these core functions, described on the next slides.

1. Core function expectations of primary care practice teams

1. Care delivery is centered around what matters to the patient, developing **trusted relationships** with patients, making them feel heard and listened to, and instilling person-centered practices from the front desk to post-visit follow-up.
2. Care delivery is **team-based**, with the practice team consisting of a range of clinicians and non-clinicians, working with the patient, all with defined responsibilities that are clear to the patient and support the patient and the practice to the full extent of training and credentials.
3. Practice teams formally **designate a lead clinician** for each patient. That person fosters a continuous, longitudinal relationship. A lead clinician is a designated medical professional within a practice team who holds lead responsibility for an individual patient relationship e.g., a physician or APRN.

1. Core function expectations of primary care practice teams

4. Practice teams coordinate care for its patients between visits and across the continuum of care. To support such work, the practice team includes a) **qualified, embedded clinical care management personnel** to support patients with chronic conditions and disabilities and patients experiencing transitions of care, and b) **embedded non-clinical care coordination personnel** to connect all patients with community supports to address social factors that influence health, and work with families and other caregivers.
5. **Behavioral health** is integrated into the practice team through a) mental health clinicians who are members of the practice and provide assessment, brief treatment and referral, and b) through screening and referral for substance use treatment.

1. Core function expectations of primary care practice teams

6. Practice teams deliver “**planned care**” at every visit, including reviewing the patient’s medical record prior to the visit and addressing all identified issues during the visit.
7. Care is easily **accessible and prompt**, using multiple care modalities, including in-person, electronic and virtual visits, and including time outside of traditional work hours. Care is accessible to persons with disabilities and is **culturally and linguistically competent**.
8. Care delivery follows **evidence-based** guidelines for prevention, health promotion and chronic illness care, supported by electronic health record (EHR) clinical decision support.

1. Core function expectations of primary care practice teams

9. Practices **engage and support** patients in healthy living and in management of chronic conditions.
10. The practice team **utilizes patient information in conjunction with data** from an EHR when utilized by the practice, HIE, pharmacies and payers to identify patient care needs, monitor change over time, and **inform targeted quality and equity improvement** activity, including design and implementation of quality improvement plans.
11. The practice team identifies **social factors that influence the health** of its patients and is knowledgeable about **community resources** that can address social needs.

2. Resources and supports to help practice teams master the core function expectations

- OHS will support practices in implementing and mastering the 11 core functions through a blend of supports:
 - Practice coaches
 - Learning collaborative



2. Resources and supports to help practice teams master the core function expectations

1. Practice coaches are primarily provided by an OHS-contracted third party(ies).

- Because practices are required to demonstrate commitment to the mastery of all 11 core functions to qualify for enhanced payments, practices will be offered access to practice coaching to help them master the 11 functions.
- Some practice teams may elect to receive coaching from a commercial insurer or its own resources.
 - Practice coaches must demonstrate a commitment to and plan for addressing all 11 core functions.
- Practice teams must demonstrate mastery of the core functions to the satisfaction of OHS.

2. Resources and supports to help practice teams master the core function expectations
2. **A learning collaborative is provided by an OHS-contracted third party(ies).**
 - Participation is voluntary and offered to all practices seeking or that have already obtained OHS practice team recognition.
 - Learning collaboratives are organized around care of children and adolescents and care of adults.
 - The learning collaborative is contingent on state funding.

3. Methods to assess and recognize practice team performance

- In response to commercial insurers who sought to understand how practices would use increased primary care investments, the Roadmap describes methods for OHS to assess and recognize practice team performance on the adoption of the 11 core functions.
- There are two pathways for practices to become an OHS-recognized practice:
 1. Practices currently recognized by NCQA as a PCMH, including all DSS PCMH+ recognized practices, qualify for recognition with some limited additional requirements.
 2. Practices not recognized by NCQA or that were recognized but let the recognition lapse can seek OHS recognition.

3. Methods to assess and recognize practice team performance



- All OHS-recognized practice teams must renew OHS recognition every two years.
- Practices may opt out of the OHS recognition process and forego enhanced payments specified by the primary care spend target.

Image courtesy of the National Academies of Science, Engineering, Medicine:
Implementing High-Quality Primary Care

4. Voluntary primary care alternative payment models, beyond FFS, to reimburse primary care

- To support team-based care and balance interest from practices that want to move away from FFS, OHS asks insurers to make a **value-based prospective primary care payment model** available to interested practices, while permitting continued FFS payments to others.
 - Primary care practices are prospectively paid a fixed PMPM fee for most primary care services in lieu of FFS payments.
 - Does not preclude other aligned primary care alternative payment models.
- Practices are eligible for enhanced payments so long as they are seeking or have obtained OHS-recognition for mastery of the 11 core functions.

OHS parameters for any primary care alternative payment model to maximize overall success and ensure patients are not harmed

Common parameters require insurers to:

1. **Risk adjust payments** to account for variation in the health care conditions of different patient panels and for age and gender.
2. Provide **prospective notification** of those patients for whom they are receiving capitated payment.
3. Carefully **monitor practice behavior** to identify cases where access is decreasing or there are other signs of stinting on care or adverse impact.
4. Adopt for universal primary care contractual use an **aligned set of quality measures** that include equity-focused measures.
5. Offer and make payment related to **substantial quality incentives**.
6. Supply providers with **timely, high-quality data** to allow more effective management of their patient panel and their revenue under a capitated arrangement.

Structural barriers to high-quality primary care

- The Roadmap development process highlighted many barriers to high-quality primary care that cannot be solved by the Roadmap alone but are important to raise.
- Many barriers have current or planned actions underway:
 1. Current primary care payment models
 2. Access to primary care
 3. Practice administrative requirements
 4. Technology
 5. Primary care workforce

Roadmap implementation plan

- The Roadmap describes who is responsible for what actions by when over a two-year period to successfully implement the Roadmap.
 - Primary actors include OHS, commercial insurers, and primary care practices.
- Planning activities begin in 2022, with practice **implementation starting in 2023**.
 - Planning will include development of operational guidance for core functions, payment parameters, and reporting requirements for insurers and practices.



Quality Benchmarks

Overview of the Quality Benchmarks

- Executive Order #5 charges the Quality Council with developing healthcare quality benchmarks to become effective on January 1, 2022. The benchmarks:
 - shall ensure the **maintenance and improvement of healthcare quality**;
 - shall be applied across all **public and private payers**, and
 - *may include clinical quality, over- and under-utilization and patient safety measures.*
- Connecticut will be the second state to have quality benchmarks.
 - Delaware was the first state – it established quality benchmarks in 2019.

Overview of the Quality Benchmarks (Cont'd)

- The Quality Council recommended two types of measures for the Quality Benchmarks:
 - **health status measures**, which quantify certain population-level characteristics of CT residents (e.g., statewide obesity rate) and are assessed at the state level
 - **healthcare measures**, which quantify performance on healthcare processes or outcomes and are assessed at the state, market, insurer and provider levels (e.g., OHS' Core Measure Set measures)

Overview of the Quality Council

- OHS looked to its Quality Council to provide feedback on the Quality Benchmarks, including:

Consumer Advocates

- CT Center for Patient Safety
- CT Health Foundation
- Three consumer representatives

Payers

- Anthem
- Cigna
- ConnectiCare
- UnitedHealthcare

State Agencies

- Dept. of Mental Health and Addiction Services
- Dept. of Public Health

Providers

- Cardiology Associates of New Haven
- Community Health Center of CT
- Community Medical Group
- CT Hospital Association
- Eastern CT Health Network / Quinnipiac
- First Choice Health Centers
- Stamford Health
- Trinity Health of New England
- Yale, Yale New Haven Health, Yale New Haven Hospital

- Dept. of Social Services
- Office of the State Comptroller

Tentative Quality Benchmark Measures

Phase 1: Beginning for 2022

- Asthma Medication Ratio
- Controlling High Blood Pressure
- Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control

Phase 2: Beginning for 2024

- Child and Adolescent Well-Care Visits
- Follow-up After ED Visit for Mental Illness (7-day)
- Follow-up After Hospitalization for Mental Illness (7-day)
- Obesity Equity Measure*

*Performance for this measure will only be assessed at the state level (and not by market).

Quality Benchmarks Values

- OHS will set **separate Quality Benchmark values** for each measure for the **commercial** market, **Medicaid** market, and **Medicare Advantage** market for 2025.
 - *Obesity Equity Measure* will only have one statewide value.
- Phase 1 measures will also have **interim annual targets** (for 2022, 2023, and 2024).
 - OHS and the Quality Council recommend keeping the 2022 Benchmark value for Phase 1 measures the same value as the baseline rate. They recognize that it is unlikely that there will be notable improvement towards the Benchmark values for Phase 1 Quality Benchmarks in 2022 because the Benchmarks are being finalized just before the start of the measurement year.

Commercial Market Benchmark Values: Phase 1 Measures

Quality Benchmark Measure	2022 Value	2023 Value	2024 Value	2025 Value	2025 Value Reference Source
Asthma Medication Ratio (Ages 5-18)	79%	81%	83%	86%	Between the national commercial 50 th and 7 th percentiles
Asthma Medication Ratio (Ages 19-64)	78%	80%	82%	85%	National commercial 90 th percentile
Controlling High Blood Pressure	61%	63%	65%	68%	Between the New England commercial 50 th and 75 th percentiles
HbA1c Control for Patients with Diabetes: HbA1c >9%*	27%	26%	25%	23%	Between the national commercial 75 th and 90 th percentiles

The annual change in Benchmark values may not be even due to rounding.

*A lower rate indicates higher performance.

Commercial Market Benchmark Values: Phase 2 Measures

Quality Benchmark Measure	Baseline Rate	2025 Value	2025 Value Reference Source
Child and Adolescent Well-Care Visits	TBD	TBD	TBD – will be set in winter / spring 2023
Follow-up After ED Visit for Mental Illness (7-Day)	60%	71%	New England commercial 75 th percentile
Follow-up After Hospitalization for Mental Illness (7-Day)	56%	65%	New England commercial 90 th percentile

Medicaid Market Benchmark Values: Phase 1 Measures

Quality Benchmark Measure	2022 Value	2023 Value	2024 Value	2025 Value	2025 Value Reference Source
Asthma Medication Ratio (Ages 5-18)	66%	68%	70%	73%	Between the National Medicaid 50 th and 75 th percentiles
Asthma Medication Ratio (Ages 19-64)	63%	65%	67%	70%	Between the National Medicaid 75 th and 90 th percentiles
Controlling High Blood Pressure	61%	63%	65%	68%	National Medicaid 75 th percentile
HbA1c Control for Patients with Diabetes: HbA1c >9%*	37%	36%	35%	33%	National Medicaid 75 th percentile

The annual change in Benchmark values may not be even due to rounding.

*A lower rate indicates higher performance.

Medicaid Market Benchmark Values: Phase 2 Measures

Quality Benchmark Measure	Baseline Rate	2025 Value	2025 Value Reference Source
Child and Adolescent Well-Care Visits	TBD	TBD	TBD – will be set in winter / spring 2023
Follow-up After ED Visit for Mental Illness (7-Day)	50%	65%	National Medicaid 90 th percentile
Follow-up After Hospitalization for Mental Illness (7-Day)	48%	55%	New England Medicaid 90 th percentile

Medicare Advantage Market Benchmark Values

Quality Benchmark Measure	2022 Value	2023 Value	2024 Value	2025 Value	2025 Value Reference Source
Controlling High Blood Pressure	73%	75%	77%	80%	National Medicare Advantage 75 th percentile
HbA1c Control for Patients with Diabetes: HbA1c >9%*	20%	18%	16%	15%	National Medicare Advantage 90 th percentile

The annual change in Benchmark values may not be even due to rounding.

*A lower rate indicates higher performance.

Statewide Market Benchmark Values

Quality Benchmark Measure	Baseline Rate	2025 Value	2025 Value Reference Source
<p>Obesity Equity Measure</p> <p><i>the difference in the obesity rates of the White, non-Hispanic and Black, non-Hispanic race/ethnicity populations</i></p>	17	10	2019 Behavioral Risk Factor Surveillance System

Strategies to Generate Action on the Quality Benchmarks

- Does the Steering Committee have recommendations on how to generate focused attention and improvement activity on the Quality Benchmarks?
- As a reminder...

Phase 1 Measures

- Asthma Medication Ratio
- Controlling High Blood Pressure
- Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control

Phase 2 Measures

- Child and Adolescent Well-Care Visits
- Follow-up After ED Visit for Mental Illness (7-day)
- Follow-up After Hospitalization for Mental Illness (7-day)
- Obesity Equity Measure

Wrap-Up and Next Steps

Wrap-Up and Next Steps

- The next meeting will be held on **January 24th** from 3-5:00 p.m.
 - OHS is currently planning to present pre-benchmark cost growth trend data for 2018-19.
 - We'll also have follow-up conversation regarding:
 - Stakeholder Advisory Board input;
 - reasons for high rates of commercial hospital price growth, 2015-19;
 - potential strategies to address commercial cost growth drivers, and
 - additional analysis relating to ED utilization disparity.

Adjournment