

Healthcare Cost Growth Benchmark Steering Committee Meeting March 28, 2022

Welcome and Roll Call

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 January 24 th Meeting Minutes – Vote
3:15 p.m.	IV. Proposed Benchmark Methodology Changes
3:45 p.m.	V. APCD Commercial Trend Analysis with Retail Pharmacy Added
3:55 p.m.	VI. Reasons for Commercial Hospital Price Growth
4:45 p.m.	VII. Impact of Urgent Care Utilization on ED Utilization Disparities
4:55 p.m.	VIII. Wrap-Up and Next Steps
5:00 p.m.	IX. Adjournment

Public Comment

Approval of the January 24, 2022 Meeting Minutes - Vote

Proposed Benchmark Methodology Changes

Proposed Benchmark Methodology Changes

- In 2023 OHS will publicly report benchmark performance at the payer and Advanced Network levels for the first time.
- There are strategies we can implement to reduce the chance that random variation plays a significant part in a payer's or provider entity's performance and increase our confidence in benchmark performance assessment.
 - OHS has already adopted the practices of a) performing statistical testing on benchmark performance data and b) only reporting on entities with sufficient population sizes for which performance can be measured reliably.
- Today we will consider a proposal for two additional practices:
 1. Mitigation of the impact of high-cost outliers
 2. Application of risk adjustment

Mitigating the Impact of High-Cost Outliers

- High-cost outliers are members/patients with extremely high levels of annual healthcare spending
 - The members/patients represent real spending that we need to represent in state trend calculations. However...
 - They mostly present randomly in a population.
 - There are limits to how their spending can be influenced due to their complex medical conditions and high-intensity care needs.
 - Payer and provider performance against the benchmark can be significantly influenced by spending on high-cost outliers.

How to Address High-Cost Outliers

- It is common practice in total cost of care contracts to *truncate* expenditures to prevent a small number of members whose health care costs are extremely high from significantly affecting providers' per capita expenditures.
 - Truncation can therefore also serve to prevent the potential adverse impact of providers dropping high-cost members to lower their expenditures.
- Truncation involves capping individual patient annual spending at a high level. For example, that level is often between \$100K and \$150K for commercial population contracts.
- Truncation can be applied to benchmark performance assessment.
 - Spending above the cap can be *excluded* from benchmark performance assessment at the **payer** and **provider** entity levels.
 - Spending above the cap can be *included* in benchmark performance assessment at the **state** and **market** levels.

RI's Experience With High-Cost Outliers

- In RI, analyses showed that high-cost outliers significantly affected performance of provider entities.
 - For one RI ACO, including high-cost outlier spending raised the trend rate by several percentage points for one year.
- The differential treatment of high-cost outliers in the cost growth benchmark program and in TCOC contracts led to confusion and tension around reporting of performance.
- As a result, RI started truncating high-cost outliers beginning with 2022 public reporting of 2020 performance data.
 - NV and WA also recently adopted truncation of high-cost outliers.

Design Recommendation: Truncation of High-Cost Outliers



Does the Steering Committee wish to recommend truncation of high-cost outliers' spending when measuring and reporting payer and Advanced Network benchmark performance?

Applying Risk Adjustment

- Cost growth benchmark states typically risk adjust data to account for possible population changes over time.
 - The composition of a payer's or provider's population may change over the course of a year.
 - Such changes could impact spending growth, e.g., a population that is sicker than a year prior is expected to have higher spending than it would have otherwise.
- Risk adjustment is applied only at the payer and provider entity levels in other states, since population changes are not significant at the market and state levels over the course of one year.

Clinical Risk Adjustment

- *Clinical risk adjustment* is used to assess conditions diagnosed and treated during the performance year to predict spending in the same year.
- Available models use claim and encounter data, such as diagnoses, procedures, and prescription drugs.
 - They do not include medical record information.
- The best risk adjustment models can explain about half of the variation on healthcare spending, and a little more if spending for the highest cost outliers is truncated.*

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

2020 Technical Team Recommendation to OHS

- The predecessor advisory body to OHS on the Healthcare Benchmark Initiative, the Technical Team, made a recommendation in 2020 that OHS adjust for annual changes in payer and Advanced Network population risk by having each payer submit clinical risk scores to OHS when they submit cost growth benchmark data to OHS.
- OHS accepted that recommendation and applied it for the pre-benchmark period reporting in 2021.
- Since that time, analysis in other cost growth benchmark states has made it apparent that the adopted approach is problematic.

Coding Completeness and Rising Risk Scores

- The health status of a full population is typically fairly stable between consecutive years because changes in the demographic and health characteristics that might affect an entire population's risk score occur slowly.
- However, clinical risk scores can change annually without changes in the population's underlying risk due to improved documentation of patient condition on claims.

Massachusetts' Experience with Rising Risk Scores

- MA has observed steadily rising risk scores year after year, amounting to an 11.7% increase between 2013 and 2018.
 - MA found that only a small portion of the increase could be explained by demographic trends or changes in disease prevalence.
 - The state's Health Policy Commission now recommends evaluating payer and provider performance based on growth in *unadjusted* spending.
 - NV has since decided to do the same.

Rhode Island's Experience with Rising Risk Scores

- In RI, excluding the duals plans, payer risk scores grew 4.6% from 2018 to 2019.
 - Rising risk scores had the effect of essentially raising the cost growth benchmark value by 3.2%, *doubling* to 6.4% the trend that would meet the cost growth benchmark with an average rising risk score.
 - Consequently, RI decided to only risk-adjust data by age and sex starting with the 2020 performance year.
 - WA has since decided to do the same.

Recent Research on Rising Risk Scores

“During 2013–16 HCC-based risk scores grew faster than CAHPS-based risk scores (2.1 percent versus 0.3 percent annually)...The average gap in risk score growth appears to be the result primarily of HCC coding practices..., suggesting that coding...may account for most of the observed risk score growth for ACO beneficiaries.”

ACCOUNTABLE CARE

By Michael E. Chernew, Jessica Carichner, Jeron Impreso, J. Michael McWilliams, Thomas G. McGuire, Sartaj Alam, Bruce E. Landon, and Mary Beth Landrum

Coding-Driven Changes In Measured Risk In Accountable Care Organizations

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Foundation, Inc.

ABSTRACT Claims data, which form the foundation of risk adjustment in payment for health care services, may reflect efforts to capture more—or more severe—clinical conditions rather than true changes in health status. This can distort payments. We quantify this in the context of Medicare’s accountable care organization (ACO) program by comparing risk scores derived from two different measurement approaches. One approach uses diagnoses coded on claims based on Centers for Medicare and Medicaid Services Hierarchical Condition Categories (HCC), and the other uses self-reported, survey-based health data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). During 2013–16 HCC-based risk scores grew faster than CAHPS-based risk scores (2.1 percent versus 0.3 percent annually), and the gap in HCC- and CAHPS-based risk score growth varied widely across ACOs. The average gap in risk score growth appears to be the result primarily of HCC coding practices rather than poor performance of the CAHPS model, suggesting that coding practices (not necessarily driven by ACO contracts) may account for most of the observed risk score growth for ACO beneficiaries.

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Jeron Impreso is an advisory analyst for Medicaid at Mathematica in Washington, D.C. He was a research associate for health policy, Committee for a Responsible Federal Budget, in Washington, D.C., when this work was conducted. *Health Affairs*

Three Options for Addressing Changing Population Risk

1. Adjust using normalized clinical risk scores.

- Normalization supports recognition of population changes while mitigating overall risk score increases due to coding
- Requires APCD analysis when performed at the payer level.
- Normalization does not remove the provider and plan incentive to increase coding completeness, however.

2. Adjust performance data using age/sex factors only.

- Using clinical risk scores overcompensates for yearly changes in population health status and creates distortion due to claim coding practices.
- Age/sex adjustment will capture the impact of an incrementally aging population, which may be the most significant change affecting population health status over the course of a year.
- Age/sex adjustment will not capture more substantive changes in the health status of a population.

Three Options for Addressing Changing Population Risk

3. Make no adjustment for changing population risk.

- Using clinical risk scores overcompensates for yearly changes in population health status and creates distortion due to claim coding practices, and the impact of changes in age/sex composition on an annual basis may not be substantive.
- Making no adjustment could disadvantage a plan or provider entity with a large population change over the course of a year.

Design Recommendation: How to Risk Adjust Data



Which of the three options does the Steering Committee wish to recommend for risk-adjustment of cost growth benchmark performance data?

APCD Commercial Trend Analysis with Retail Pharmacy Added

Retail Pharmacy was a Significant Contributor to Commercial Spending Growth Between 2015 and 2019, Pushing Up the All-Services Trend to 5.3% from 4.9%

Service Category	2015		2018		2019		2018-2019 change (%)	Average annual change (%)	Total change (%)	Change in category as percent of total PMPM change
	PMPM	%	PMPM	%	PMPM	%				
All services	\$480.24	100.0	\$565.02	100.0	\$589.13	100.0	4.3	5.3	22.7	100.0
Professional	\$169.69	35.3	\$183.77	32.5	\$188.73	32.0	2.7	2.7	11.2	17.5
Inpatient acute	\$78.57	16.4	\$94.02	16.6	\$98.71	16.8	5.0	5.9	25.6	18.5
Outpatient	\$126.03	26.2	\$151.53	26.8	\$163.82	27.8	8.1	6.8	30.0	34.7
Other	\$5.61	1.2	\$4.87	0.9	\$4.72	0.8	-2.9	-4.1	-15.8	-0.8
ED*	\$27.10	5.6	\$32.76	5.8	\$35.74	6.1	9.1	7.2	31.9	7.9
Pharmacy	\$100.34	20.9	\$130.84	23.2	\$133.14	22.6	1.8	7.6	32.7	30.1

* ED includes both professional and outpatient ED claims if delivered in an ED, and thus overlaps with Professional and Outpatient.

Reasons for Commercial Hospital Price Growth

Reasons for Commercial Hospital Price Growth

- During the November meeting a member asked for a presentation addressing two questions:
 1. **What has been behind hospital price growth?**
 2. **Is cost shifting occurring?**
- These questions are not being asked just in CT. Hospital price growth is an issue across the U.S. For this reason, we summarize national research on the following slides.

FEB 06, 2019

HEALTHCARE FINANCE

Growth in hospital prices outpaces that of physicians by nearly 20 percent, Health Affairs shows

Physician prices have seen a growth trend over the past several years, but between 2007 and 2014, hospital prices outpaced them, according to new research published in *Health Affairs*.

Healthcare Spending Increases

- We know that increases in healthcare spending can result from changes in a mix of factors, including:
 - Price
 - Service intensity
 - Utilization
 - Age
- The Mathematica analysis indicated that **hospital prices** were the main source of inflation in spending in the commercial market between 2015 and 2019. These findings are consistent with national research (Health Care Cost Institute 2020).

1. What Causes Hospital Prices to Increase?

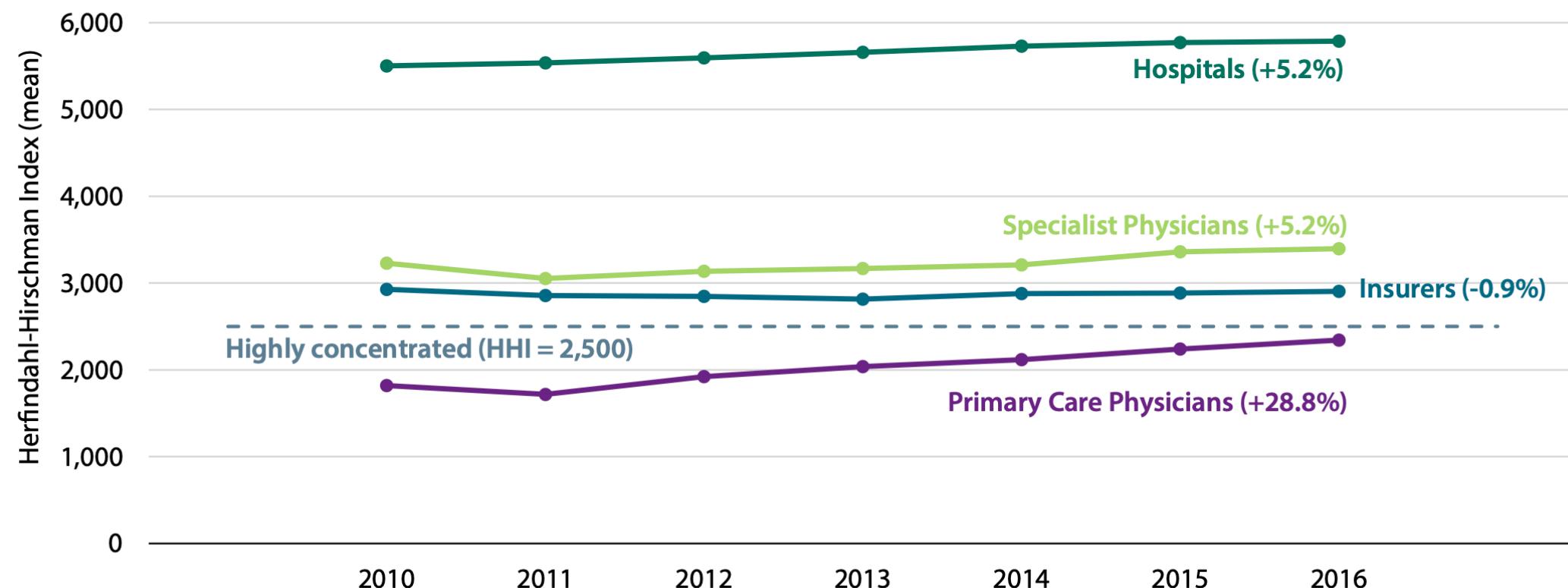
- **Market power has been identified as the leading factor in commercial hospital price growth.**
- Hospital market power can be achieved by one or more of the following:
 - Being the only provider in a geographic area
 - Being a specialty provider (e.g., children's hospitals)
 - Horizontal consolidation and/or vertical consolidation
 - Consumer brand recognition, compelling an insurer to include in network
 - Transactions that mimic consolidation without shifting ownership (e.g., management contracts, joint ventures, long-term leases)

Research Findings That Point to Market Power as the Driving Force of Price Increases

- “Hospital prices are positively associated with indicators of hospital market power” (Cooper et al, 2015)
- Hospitals and doctors who face less competition charge higher prices to private payers, without accompanying gains in efficiency or quality. The same is true for insurance markets. (Gaynor, 2020)
- “The preponderance of evidence suggest that hospital consolidation leads to higher prices.” (MedPAC, 2020)
- Price variations are correlated to market leverage. (MA Attorney General Coakley, 2010)

Hospital Market Concentration Has Been Much Higher Relative to Other Healthcare Providers

Market Concentration for Hospitals, Specialist Physicians, Insurers, and Primary Care Physicians, 2010–16



Source: Fulton, B. D., 2017. "Healthcare Market Concentration Trends In The United States: Evidence And Policy Responses" *Health Affairs*, Vol. 36, No. 9.

Do Hospitals with Market Power Always Appear in Highly Concentrated Markets?

- No. Those with high concentration have significant market power, but it's not a requirement.
- As noted earlier, there are other factors that confer market power.
- In fact, as the next slide shows, a September 2021 *Health Affairs* paper demonstrated that high hospital prices often appear in low concentration markets.

Over Half of Hospitals Offering High Priced IP and OP Services are Located in Unconcentrated-to-Moderately Concentrated Markets

Prevalence of High-Price Hospitals Across Market HHI* Categories

		* <1,500	≥1,500 to ≤2,500	>2,500 to ≤4,000	>4,000	# of hospitals
Inpatient	High price	30.0%	28.4%	24.2%	17.4%	447
	Not high price	27.7%	35.9%	25.1%	11.3%	1,340
	# of hospitals	505	608	445	229	1,787
Outpatient	High price	34.9%	27.5%	24.9%	12.7%	1,273
	Not high price	28.7%	31.1%	27.7%	12.5%	3,816
	# of hospitals	1,541	1,535	1,374	639	5,089

Source: Pany et al. "Regulating Hospital Prices Based on Market Concentration is Likely to Leave High-Price Hospitals Unaffected." *Health Affairs*. September 2021.

*HHI = Herfindahl-Hirschman Index, a measure of market concentration. The higher the HHI, the more concentrated the market

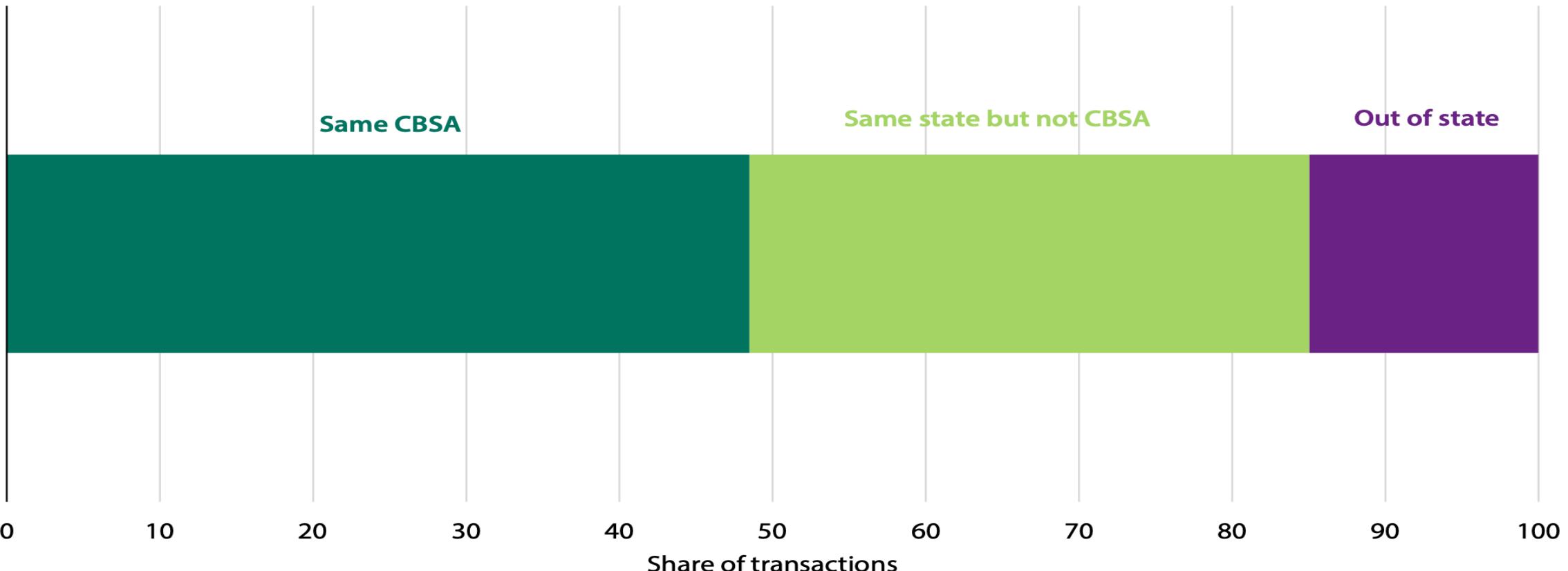


Hospital Consolidation Increases Market Power

- When hospital consolidation is between close competitors, it raises prices by substantial amounts. Research has shown 20-65% price increases after hospital mergers in concentrated markets.
 - The new prices are not a result of a one-time event. They tend to last over time.
- Hospitals that consolidate in different markets can still garner increased prices on the order of 7-17%, taking advantage of multi-state employers who may favor insurance plans with provider networks covering all their employees.

Many Hospital Mergers are Within the Same Cost-Based Statistical Area (CBSA)

Percent of Mergers between Hospitals in the Same Area



Source: Dafny, Ho and Lee 2019

What Has OHS Been Doing About Market Consolidation?

OHS has been taking the following actions within existing Certificate of Need (CON) laws to address consolidation:

- Administration of the CON requirements
- Application of future price caps put on mergers and acquisitions
- Requirements for negotiations with individual hospitals and not systems
- Banned IP and OP facility fees in CON transactions
- Added conditions on transactions to increase hospital systems' investments in community benefits
- Communicated concerns with gaps in CON laws to executive and legislative branches and the Attorney General's office
- Assembled physician practice work group to make recommendations re: vertical acquisitions and related acquisitions in outpatient space that affect market power
- Made recommendations re: acquisitions that affect market power based on continuous review of provider group acquisitions.

Internal OHS analyses have suggested that price conditions may be having the intended mitigating impact on high commercial price growth for affected hospitals.

2. Do Hospitals Negotiate Higher Prices to Make Up for Low Public Payer Rates (i.e., Cost Shift)?

- “**Hospital cost shifting**” is defined as hospitals charging private payers more in response to shortfalls in public payments. That hospitals charge one payer more because it received less (relative to costs or trend) from another is widely believed. (Frakt, 2011)
- Are low public payer rates a problem for hospitals? *Certainly*. A higher share of hospital revenue from Medicaid has been associated with increased odds of hospital financial distress. (Enumah, 2021)
 - Does this mean that low public payer rates drive the rate of commercial hospital price growth?
No.

Do Hospitals Negotiate Higher Prices to Make Up for Low Public Payer Rates (i.e., Cost Shift)?

- Reviews of empirical evidence and other studies have repeatedly failed to find substantial evidence that cost shifting exists. (Wu, 2010; Frakt, 2011; Dranove et al, 2017, RAND, 2020)
- **“...the preponderance of the evidence suggests that hospitals do not engage in cost shifting. Moreover, the idea of cost shifting is inconsistent with economic theory: If hospitals could charge private payers more, it is unclear why they would do so only after payment cuts from public payers.”** (Congressional Budget Office, 2022)

Do Hospitals Negotiate Higher Prices to Make Up for Low Public Payer Rates (i.e., Cost Shift)?

- “If hospitals were able to cost shift, then hospitals with larger shares of Medicare and Medicaid patients (for whom prices are relatively low) would be paid relatively high prices by commercial insurers. However, **CBO’s analysis of data for more than 1,500 hospitals indicates a weak cross-sectional relationship between commercial insurers’ average prices for a hospital’s inpatient and outpatient services during the 2016–2018 period and the percentage of Medicare and Medicaid patients among the hospital’s discharges.**” (Congressional Budget Office, 2022)

Do Hospitals Negotiate Higher Prices to Make Up for Low Public Payer Rates (i.e., Cost Shift)?

- What hospitals may do (as do many other businesses in various industries) is *price discriminate*. Meaning, they charge one payer (or customer) more than another for the same set of services up to what the market will bear.
- Price discrimination is not the same as cost shifting.
- “Cost shifts are driven by strategic hospital decisions, not by shortfalls from public insurance.” (CO Dept of Health Care Financing and Policy, 2020)
- “...hospitals that get paid more or have a better payer mix tend to spend more and cost more.” (CT hospital CEO, 2022)

Do Hospitals Negotiate Higher Prices to Make Up for Low Public Payer Rates (i.e., Cost Shift)?

- The empirical literature finds that to the extent cost shifting has occurred at all, it is at a low rate. Instead, the vast majority of public payers' shortfalls are accommodated by *cost cutting*, not *cost shifting*. (Frakt, 2011)
- MedPAC has shown that the ability or willingness of hospitals to control their operating costs is directly related to the level of negotiating power they face from both public and private payers in a given market. When hospitals have more power, they are less likely to control costs. (Catalyst for Payment Reform, 2017)

Do Hospitals Negotiate Higher Prices to Make Up for Low Public Payer Rates (i.e., Cost Shift)?

Percentage of Payments from Private Payers in 2019	Average Annual Percent Change in Payments per CMAD 2016-2019
<50% private pay hospitals (median)	4.30%
≥50% private pay hospitals (median)	6.92%

- This table shows that CT hospitals receiving a greater proportion of payments from private payers had higher growth in payments per CMAD than those more dependent on public payers.
- If there was a “cost shift,” those with fewer private pay patients would have had *faster* growing payments per CMAD, not *slower* growing payments.

What Does All of This Mean?

1. Market power is the driving force behind high growth in hospital prices.
2. Market power can be achieved through multiple means, including consolidation.
 - Hospital consolidations have received increased scrutiny, so more research has been conducted on its effects than on other means. Hospital consolidation drives prices upward in the short term and effects persist in the long term.
 - Many policymakers are now addressing vertical acquisitions and capital spending as issues that contribute to market power and higher prices.
3. The act of cost shifting isn't borne out in the literature as the reason for high hospital prices. Cost cutting has been proven to be the tool used to respond to low government payer rates.



Sample of Evidence: Provider Consolidation Leads to Higher Prices

Study	Major Findings
Zack Cooper et al. (2019)	Among 366 U.S hospital mergers and acquisitions between 2007-2011, prices increased by over 6 percent when the merging hospitals were geographically close, but not when the hospitals were geographically distant.
Leemore Dafny et al. (2019)	Between 1996-2012, within-state hospital mergers yielded price increases of 7-9% for acquiring hospitals. There were no significant increase for out-of-state acquisitions.
Matthew Lewis and Kevin Pflum (2017)	From 2000-2010 prices at hospital acquired by out-of-market systems increase by about 17% more than unacquired, stand-alone hospitals and confirm that out-of-market mergers result in a relaxation of competition, the prices of nearby competitors to acquired hospitals increase by around 8%
Daniel Austin and Laurence Baker (2015)	Vertical consolidation increases hospital prices paid by private insurers. From 2001 to 2007, a one-standard deviation increase in the market share of hospitals that owned physician practices was associated with significant increase in prices and spending of 2-3 percent.
Cory Capps and David Dranove (2004)	Consolidation enabled hospitals to increase prices in three of four markets studied.

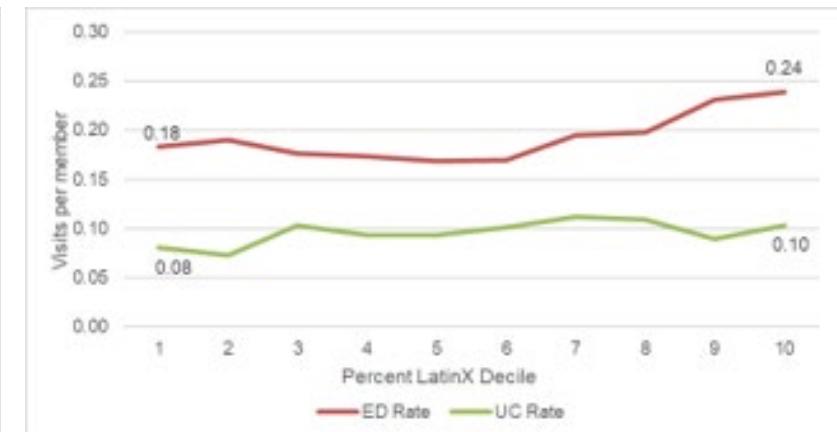
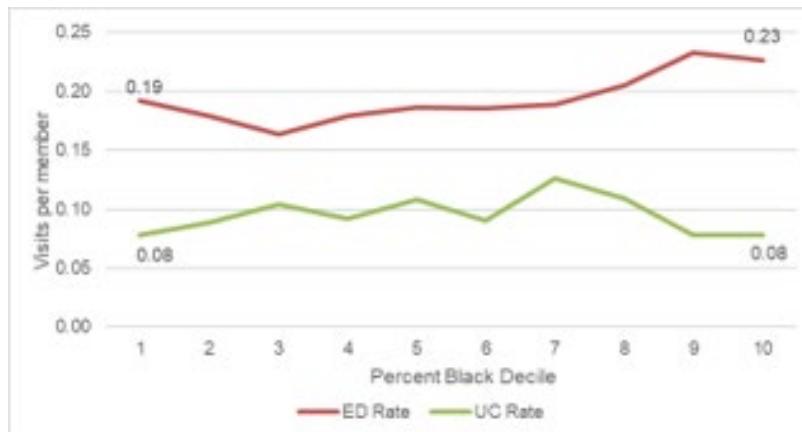
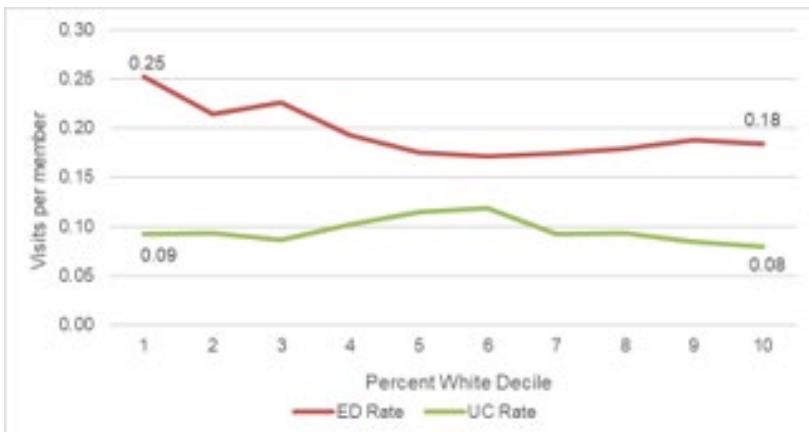
Impact of Urgent Care Utilization on ED Utilization Disparities

Impact of Urgent Care Utilization on ED Utilization Disparities

- During the November Steering Committee meeting we reviewed data that indicated significant disparities in commercial ED utilization based on income and race.
- In January, we reviewed the results of the first of two follow-up analyses requested by the Steering Committee.
 - That analysis found that adjusting for age and sex almost completely eliminated the disparities.
 - There remains a question about what the findings would have been if Black and Hispanic populations were analyzed separately.
- Today we will review the second analysis, looking at the impact of urgent care utilization.

Impact of Urgent Care Utilization on ED Utilization Disparities

- Urgent care utilization does not appear to vary much based on race (as defined in this analysis), but ED utilization does.



What Else Did We Learn About Urgent Care Utilization?

- It grew a lot over 2015-2019, increasing about 30 percent from 2015, with the sharpest increase from 2015 to 2016.
- By 2019, the commercial urgent care rate was about half the ED rate.

Year	ED visit rate	UC visit rate
2015	0.206	0.073
2016	0.209	0.088
2017	0.206	0.100
2018	0.190	0.093
2019	0.190	0.097

Urgent Care (UC) Visit Rates Varied by County

- Rates in Fairfield and Hartford Counties were three times the rate in Windham County.
- County-level UC visits rates were negatively correlated with ED visit rates ($r=-.89$, $p<.01$).

County	ED visit rate (2019)	UC visit rate (2019)
Fairfield	0.16	0.12
Hartford	0.18	0.12
Tolland	0.21	0.10
Litchfield	0.19	0.10
Middlesex	0.18	0.08
New Haven	0.22	0.06
New London	0.23	0.06
Windham	0.26	0.04

In 2019, UC Visit Rates Decreased as ED Visit Rates Increased by Zip Code, County, and Income Decile.

- No significant correlation observed when comparing rates across race deciles

Dimension	Correlation (r)	n	p
Zip code	-0.35	278	<0.00*
County	-0.89	8	<0.00*
Income Decile	-0.79	10	<0.00*
Percent Black Decile	-0.44	10	0.10
Percent Hispanic/Latino Decile	0.10	10	0.61
Percent White Decile	-0.36	10	0.15

Between 2015 and 2019, Increases in the UC Visit Rate were Associated with Decreases in the ED Visit Rate in the Same Zip Codes.

- On average, a 1-point rise in the UC visit rate in a zip code in a year was associated with a .08-point drop in the ED visit rate in that zip code in that year.
 - The relationship was statistically significant ($p<.01$).
- **For example, an annual increase of 12.2 urgent care visits per 100 members was associated with an annual decrease of 1 ED visit per 100 members.**
- These findings were based on a linear regression with controls for zip code, year, and demographic change.

Wrap-Up and Next Steps

Wrap-Up and Next Steps

- The next meeting will be held on **Monday, April 25th** from 3–5:00 p.m.