Healthcare Cost Growth Benchmark Steering Committee Meeting November 21, 2022

"We collaborate, out of a shared concern and responsibility for all Connecticut residents, to develop consensus models that advance equity and consumer affordability of healthcare in our state."

OHS
CONNECTICUT
Office *of* Health Strategy

Welcome and Roll Call

Welcome New Member!

Christine Marsh, Vice President, Market Access for Boehringer Ingelheim Pharmaceuticals, Inc

Meeting Agenda

Time	Topic
3:00 p.m.	I. Welcome and Roll Call
3:05 p.m.	II. Public Comment
3:10 p.m.	III. Approval of October Meeting Minutes – Vote
3:15 p.m.	IV. Update on Approach to Considering Inflation in Benchmark Assessment
3:20 p.m.	V. Dialogue with Other Benchmark States
4:00 p.m.	VI. Office of the State Comptroller Presentation on Primary Care
4:30 p.m.	VII. Quality Council Activities
4:55 p.m.	VIII. Wrap-Up and Next Steps
5:00 p.m.	IX. Adjournment

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Public Comment

Approval of October 24th Meeting Minutes - Vote

Update on Approach to Considering Inflation in Benchmark Assessment

Update on Approach to Considering Inflation in Benchmark Assessment

- At the October Steering Committee meeting, OHS asked for input on how OHS should consider the rise in inflation on the Cost Growth Benchmark. OHS heard the following perspectives:
  - Some members stated a preference for contextualizing results but making no adjustment to the benchmark.
  - Other members expressed support for creating allowances above the benchmark on a time-limited basis, though there was not agreement among these members on how big such allowances should be.
  - Members generally agreed that if any adjustment is to be made, OHS should determine what criteria need to be met for any similar adjustments to be made in the future.

Update on Approach to Considering Inflation in Benchmark Assessment

- OHS continues to work to finalize its annual inflation review as required by Public Act 22-118, but a final decision has not yet been made on how OHS intends to respond to the rise in inflation.
- OHS is consulting with other cost growth benchmark states to better understand how Connecticut's approach may align with others carrying out similar efforts across the country.
- OHS also welcomes the public to submit additional feedback to Krista Moore at Krista.Moore@ct.gov

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Dialogue with Other Benchmark States

Health Spending Accountability and Transparency in Rhode Island

CORY KING, CHIEF OF STAFF, RHODE ISLAND OFFICE OF THE HEALTH INSURANCE COMMISSIONER

What is OHIC?

The Office of the Health Insurance Commissioner (OHIC) is the state's commercial health insurance policy reform and regulatory enforcement agency. OHIC seeks to improve health care access, affordability, and quality.

OHIC is the principal agency charged with implementing Rhode Island's Health Spending Accountability and Transparency Program which includes the cost growth benchmark and activities to address health care cost growth.

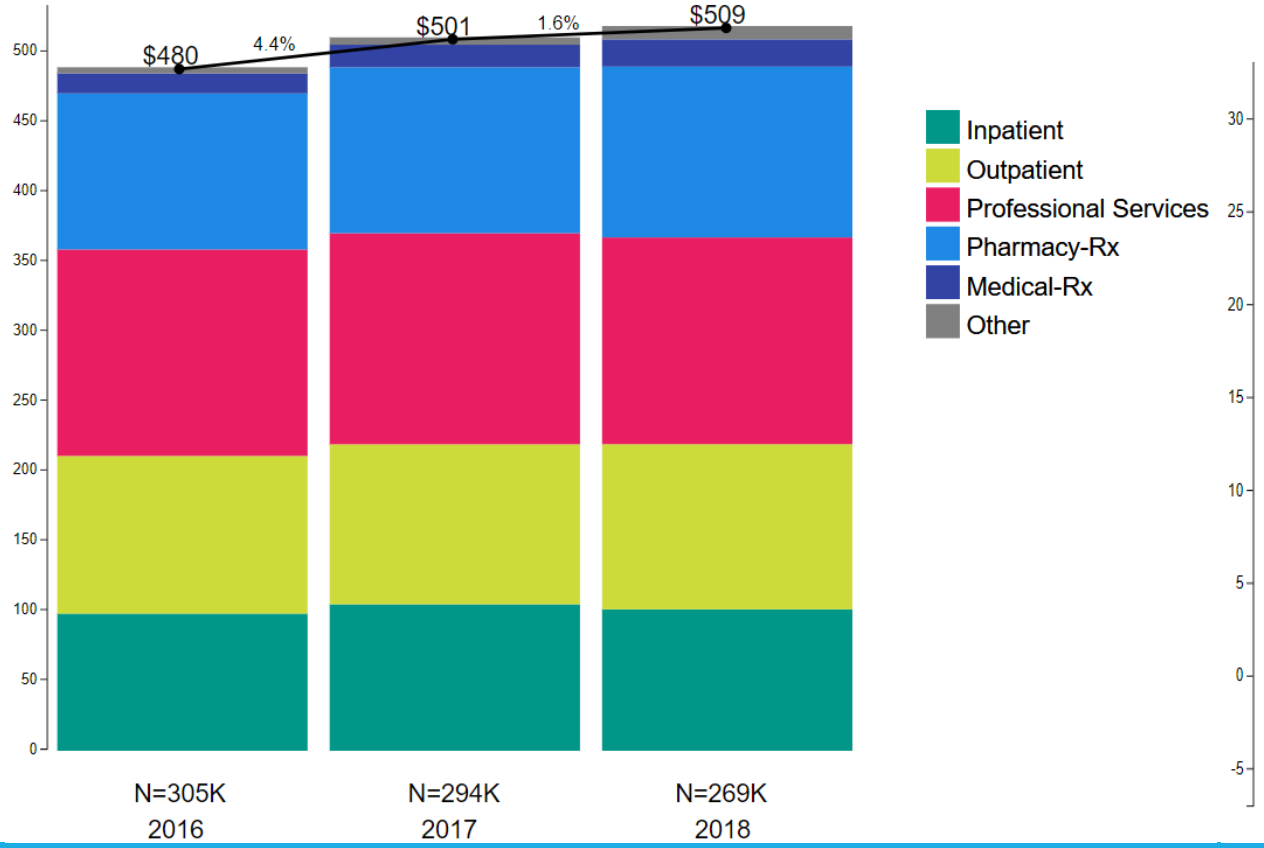
Rhode Island's Model

Case Study

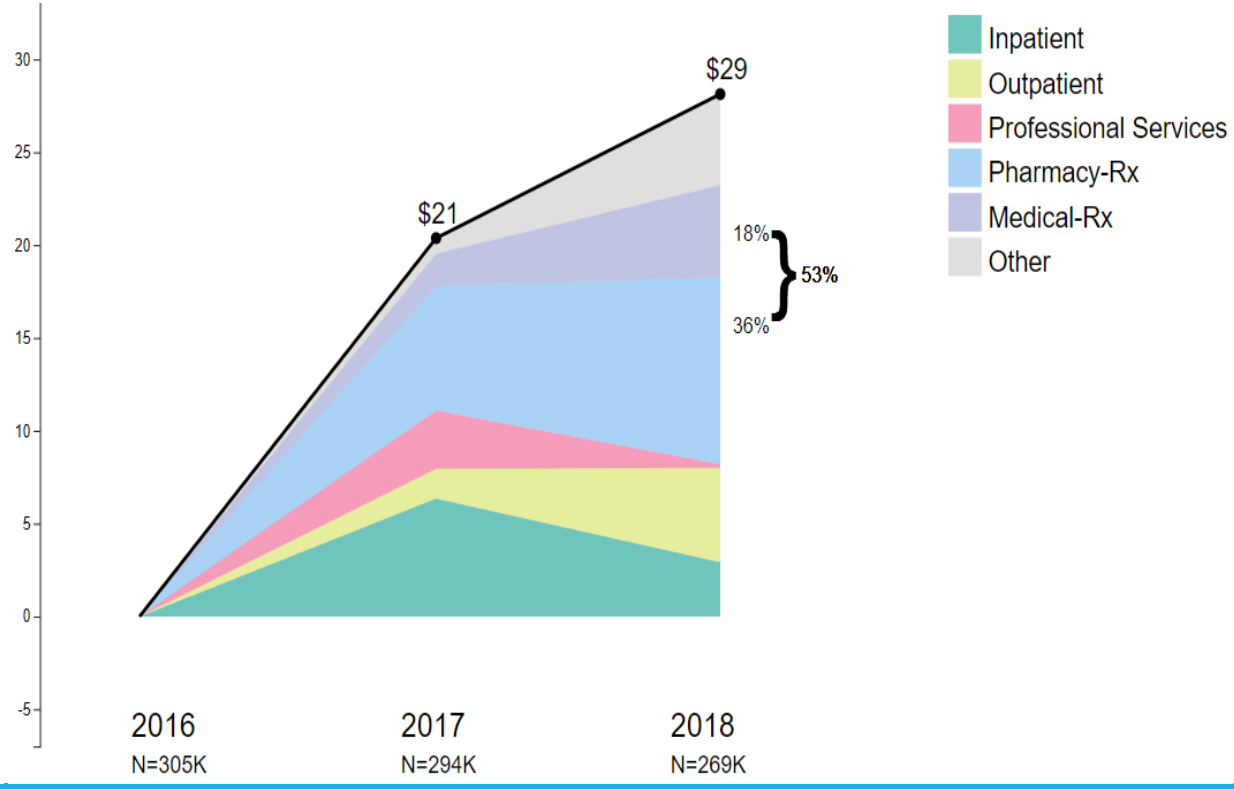
PHARMACEUTICAL SPENDING GROWTH

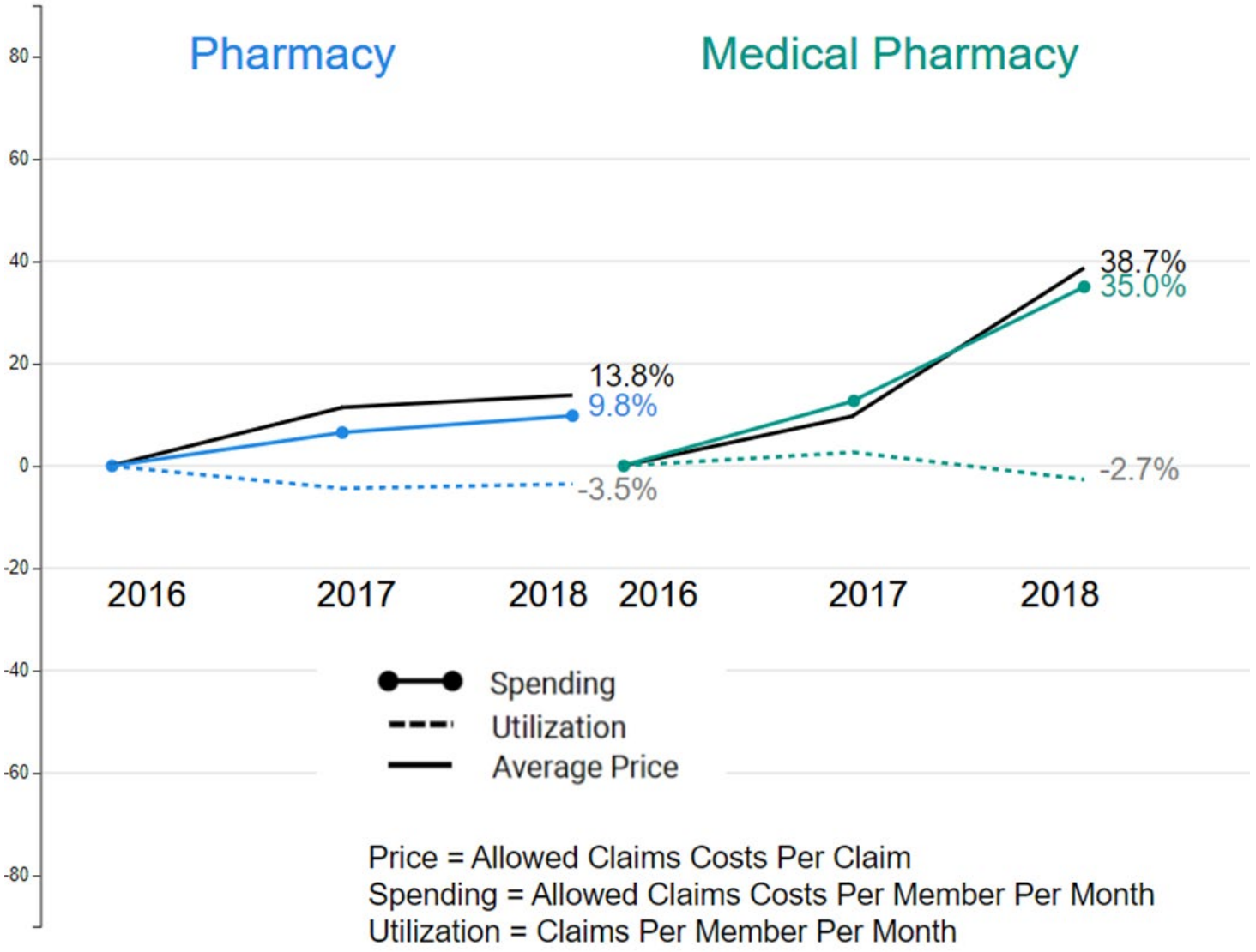
Pharmaceutical Spending Growth

Total PMPM: Commercial Insurance



Cumulative Change in PMPM: Commercial Insurance





Prices drive spending growth

Analysis of claims data from the Rhode Island All-Payer Claims Database pinpointed unit cost as the driver of spending growth over the years 2016 – 2018.

Cost Growth Mitigation Strategies

Public disclosure of cost performance by market participants

Collective actions to address costs: payment reform, legislation, etc.

Prior approval rate review, price growth caps, strategic delivery system investments

Oregon's Health Care Cost Growth Target & Cost Containment Strategies

Connecticut Office of Health Strategy Steering Committee
November 21, 2022
Sarah Bartelmann

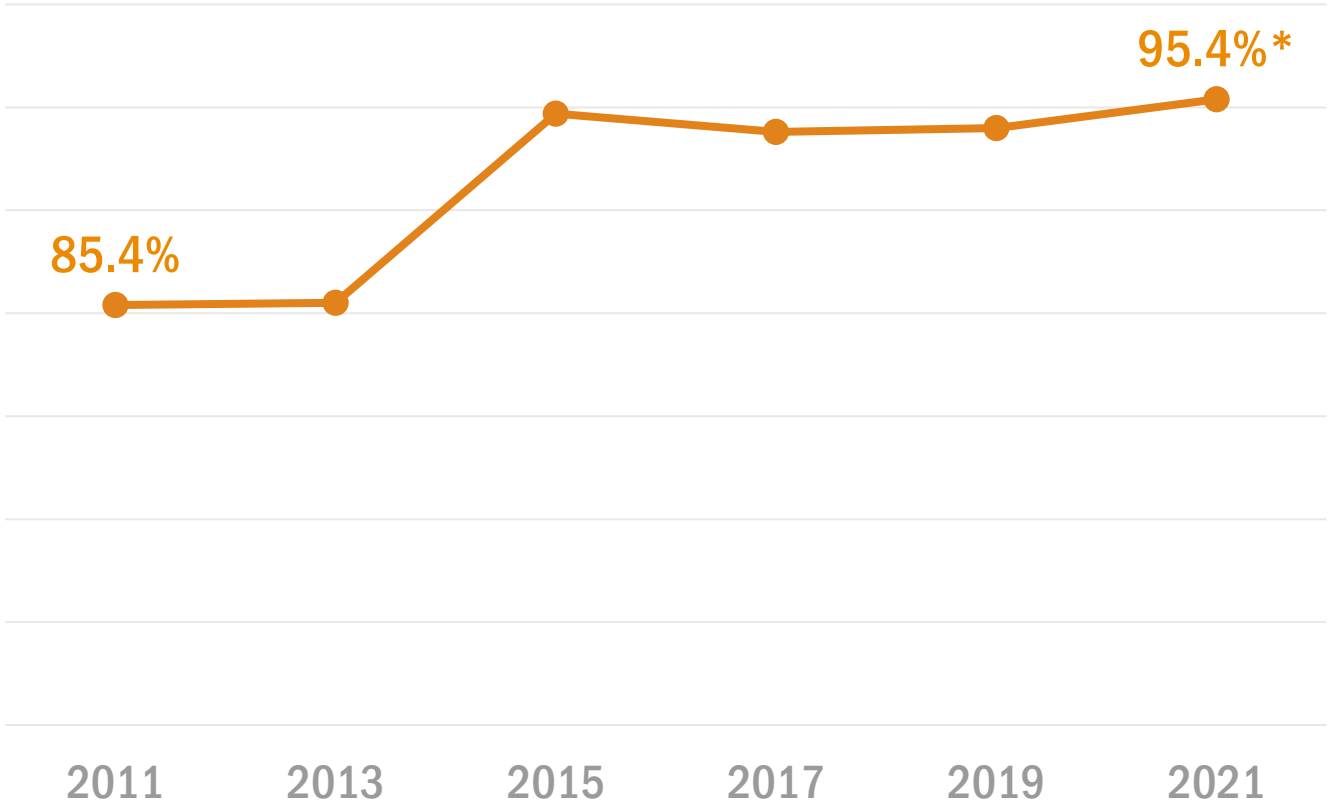
Oregon Health Authority

HEALTH CARE COST GROWTH TARGET

Oregon Landscape

Oregon has made large gains on expanding coverage…

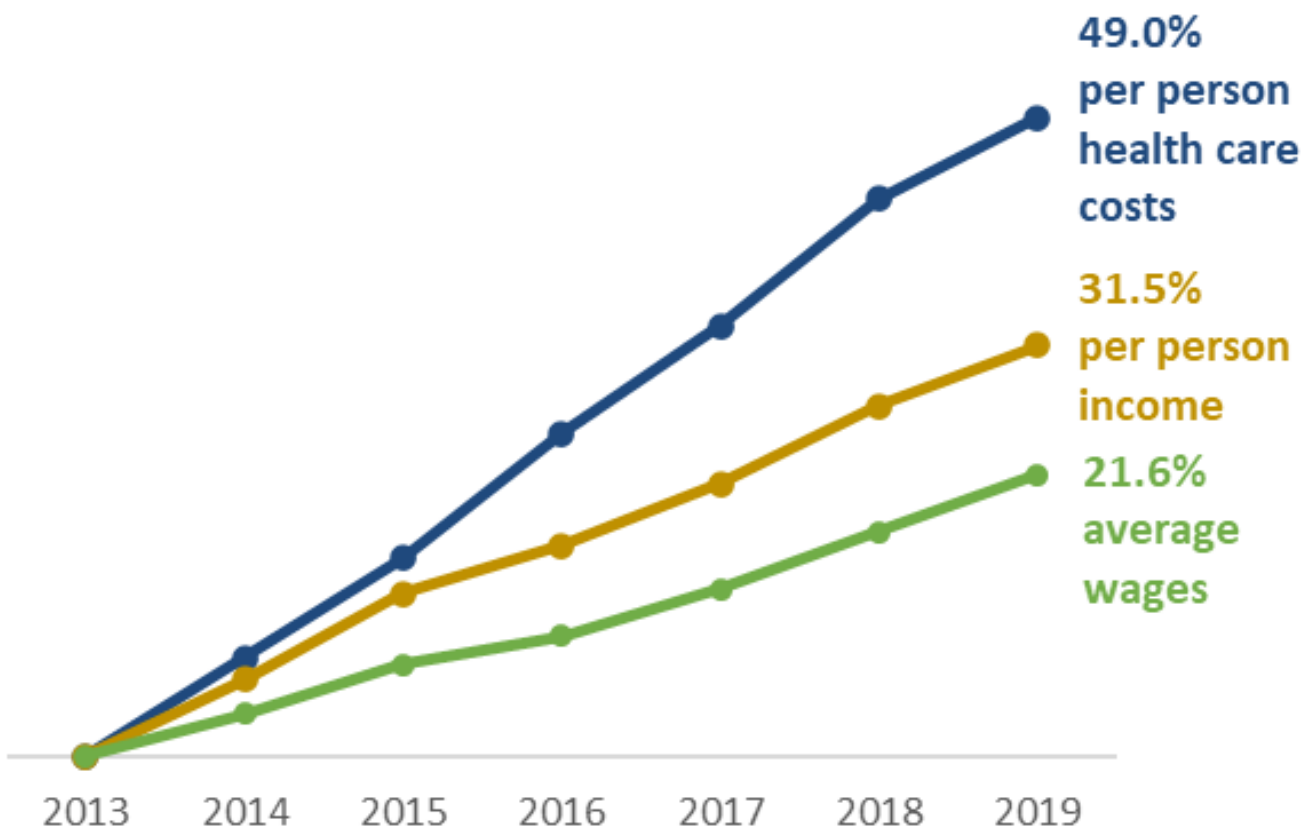
4.27 million people in Oregon; 95% are insured



*Statistically significant difference from the previous year at 90% confidence level.
Source: Oregon Health Insurance Survey

…but from 2013-2019, **health care costs** in Oregon grew faster than **income** and **wages**.

2013-2019 cumulative cost growth in per person health care costs, per person income, and average wages.



Oregon has a robust domestic insurance market

- 15 Medicaid Managed Care Plans
- 26 Medicare Advantage Plans
- 21 Commercial Large Group Plans
- 28 Commercial Individual / Small Group Plans
- Almost 90 self-insured plans (that we know)

Q2 2022 Enrollment Report
https://dfr.oregon.gov/business/reg/reports-data/annual-health-insurance-report/Pages/health-ins-enrollment.aspx

And a varied provider landscape

60 acute care hospitals

Most hospitals are affiliated with or owned by health systems (in 2020, 25% were independent)

28 DRG hospitals

12 Type A hospitals

20 Type B hospitals

Most physicians in the Portland area work for health systems.

In 2016, 39% of Portland metro physicians worked for health systems. In 2018, 71% worked for health systems.

2016

2018

50+ provider orgs included in the cost growth target program

At least 60,000 attributed patient member months within one market (Medicaid, Medicare, Commercial)

Hospital financial and price transparency programs
Hospital community benefit requirements

Value-based payment requirements
Primary care spending requirements

Prescription Drug Price Transparency program
Prescription Drug Affordability Board

Health insurance rate review
Health care merger and acquisition review

Oregon has implemented multiple cost containment strategies over the last decade.

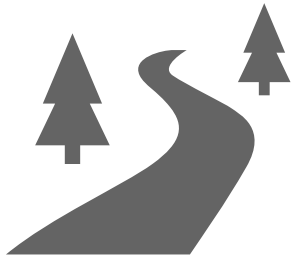
Cost growth target efforts spread statewide

est. 2012	3.4% growth target for federal funds used for Medicaid
est. 2013	3.4% growth target for capitation rates for Medicaid plans
est. 2016	3.4% growth cap for state funds used for Medicaid
est. 2017	3.4% growth cap for public employee health plans
est. 2019	Statewide cost growth target for all payers and providers

https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/Background-The-Health-Care-Cost-Trends-Report-and-Measuring-Medicaid-Cost-Growth-FINAL.pdf

Value-Based Payment

Taking Action: Accelerating the Adoption of Advanced Value-Based Payments (VBP)



VBP Roadmap set targets for Oregon's Medicaid Managed Care Organizations

Cost Growth Target Implementation Committee identified VBP as an initial "taking action" strategy to achieve the target, resulting in…

The VBP Compact, a voluntary, collaborative partnership with payers and providers to accelerate VBP adoption across markets.

More information: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx

The VBP Compact is a voluntary commitment by payers and providers across the state to increase the use of VBP to:

- Lower the rate of cost growth
- Foster health equity
- Improve quality and outcomes

The Compact will increase VBP adoption by:

Expanding innovation

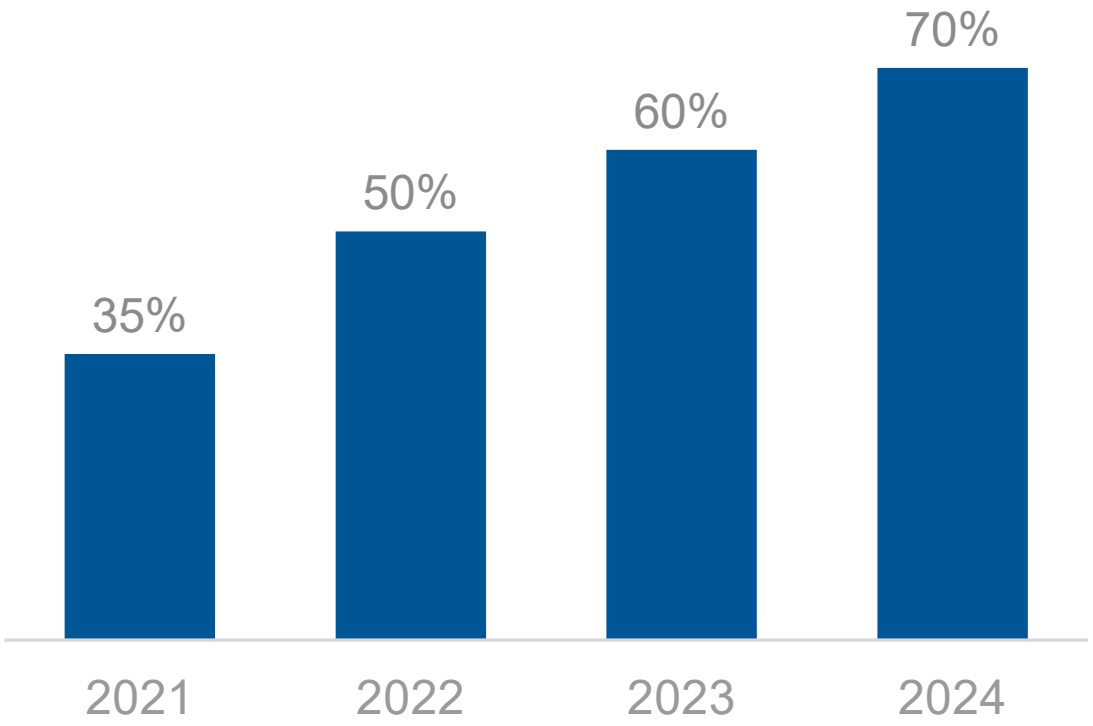
Learning from early adopters

Removing barriers

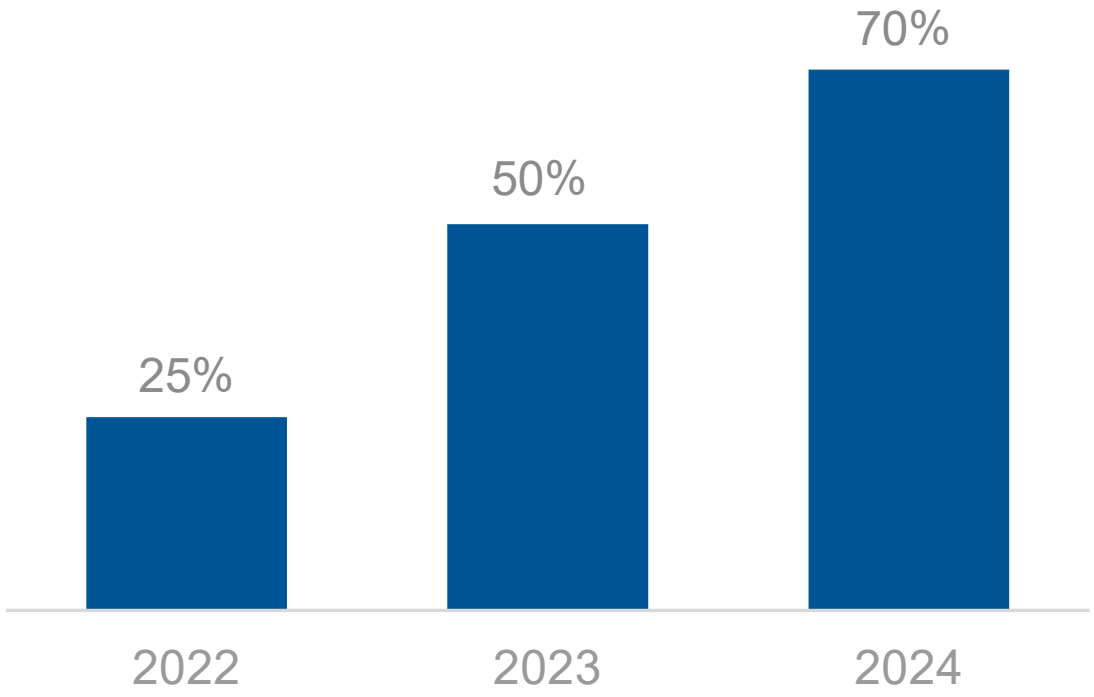
Expanding knowledge & awareness

VBP Compact Targets

All payments under advanced VBP models (shared savings / 3A and higher)



Payments to PCPs and acute care hospitals under advanced VBP models (shared risk / 3B and higher)



46

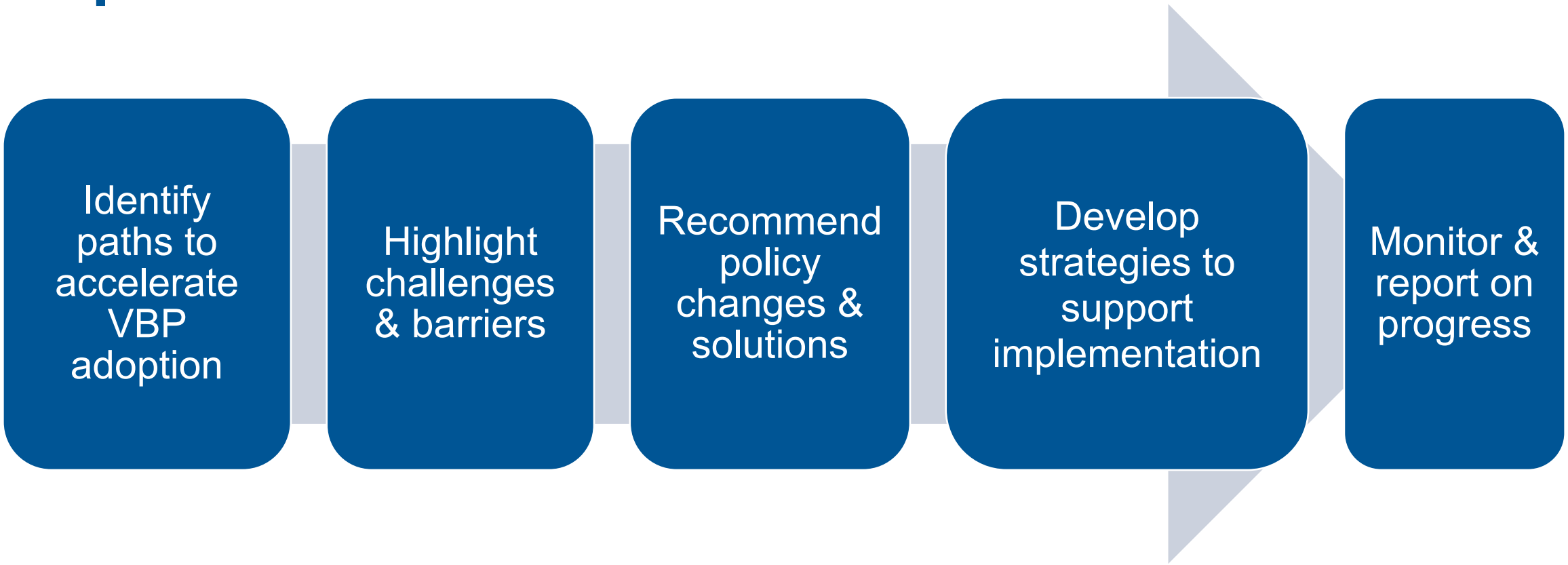
signatories, including commercial payers, Medicaid, Medicare Advantage, health systems and clinics

73%

of Oregonians are represented by Compact signatories

http://www.orhealthleadershipcouncil.org/oregon-value-based-payment-compact/

The VBP Compact Workgroup is charged with ensuring the Compact is successfully implemented



Measuring Progress on VBP Adoption

Oregon is one of the only states to collect data from health insurers about how they pay providers outside of fee-for-service arrangements.

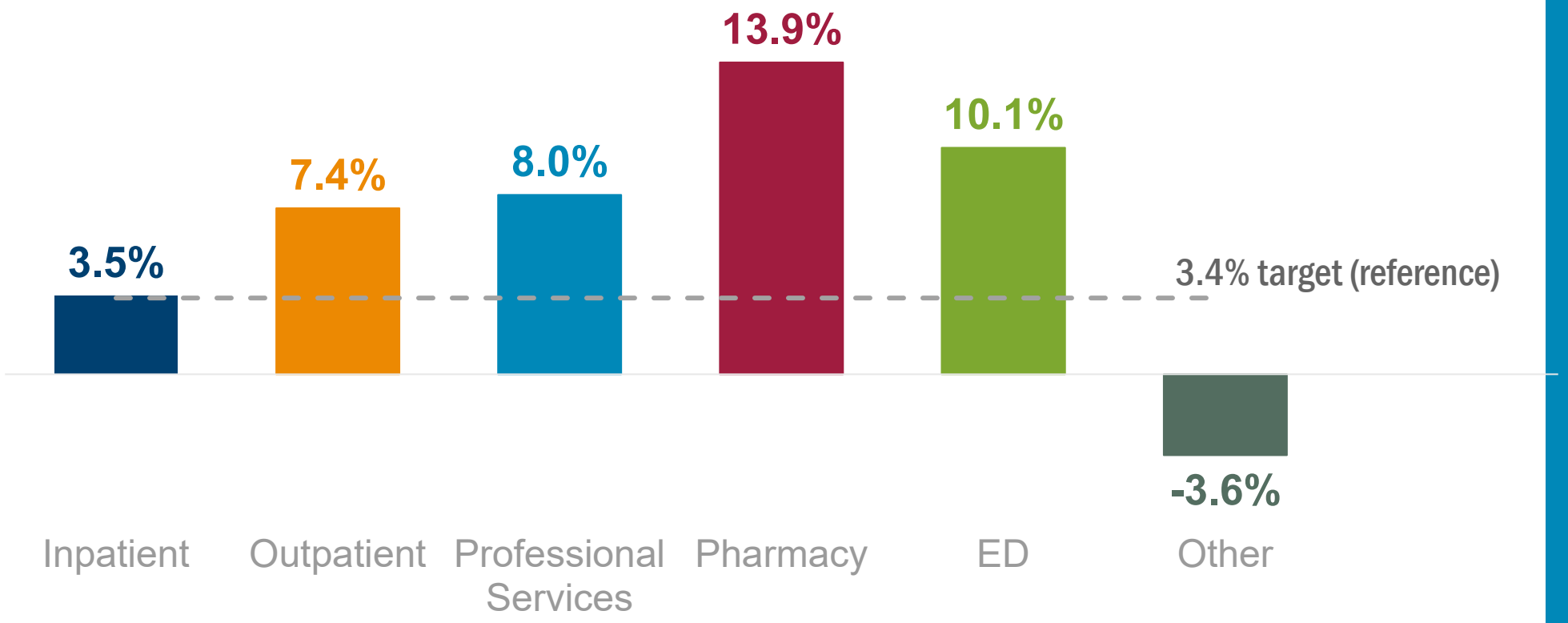
For each market, what is the percentage of dollars in each payment category?

	FFS & Other Payments – No Link to Quality			FFS – Link to Quality				Shared Savings and/or Risk		Population-Based Capitation		
	FFS – No Link to Quality (1)	Risk-Based Payments Not Linked to Quality (3N)	Capitated Payments Not Linked to Quality (4N)	FFS – Link to APM Payments (1A)	Foundational Payments, including PCPCH (2A)	Pay for Reporting (2B)	Pay for Performance (2C)	Shared Savings (3A)	Shared Savings and Risk (3B)	Condition-specific Population-Based Payment (4A)	Comp. Population-Based Payment (4B)	Integrated Finance & Delivery System (4C)
Medicaid CCOs	32%		4%	14%		1%	22%		8%	6%	2%	10%
Medicare Advantage	60%		1%	3%	1%		3%	2%	2%	1%		26%
PEBB/OEBB	53%				2%		4%	6%	10%			25%
Commercial (excluding PEBB/OEBB)	51%		1%	3%	1%		4%	1%	1%			38%

https://go.usa.gov/xuSpV

Pharmacy

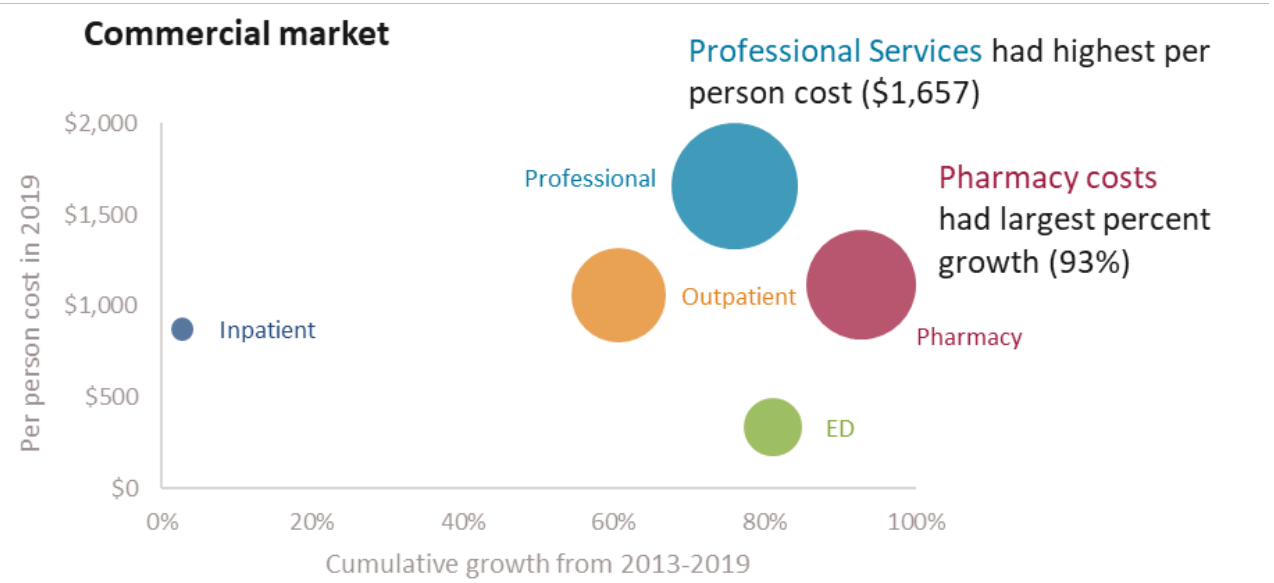
Average annual growth by service category, 2013-2019

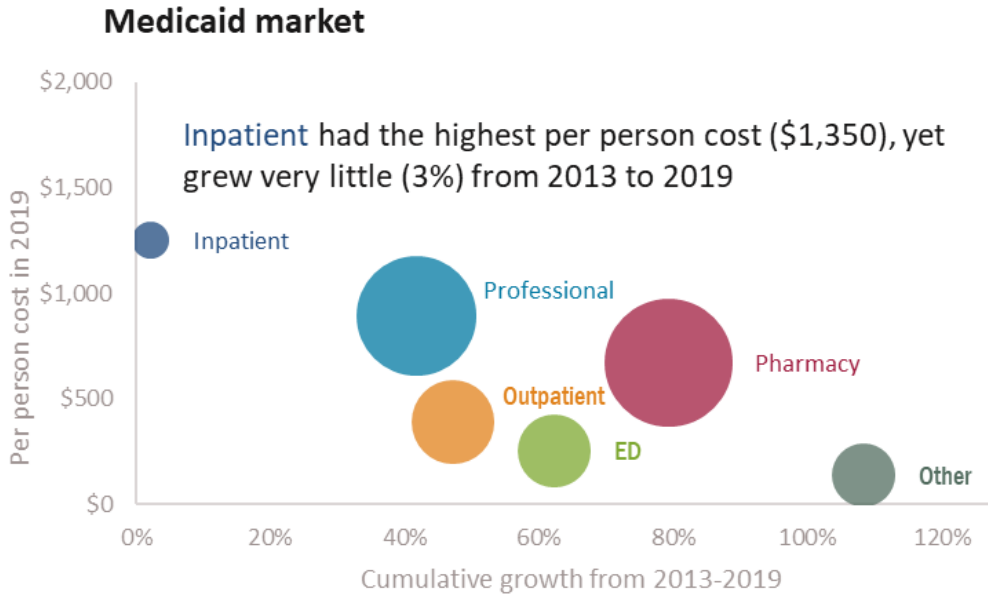


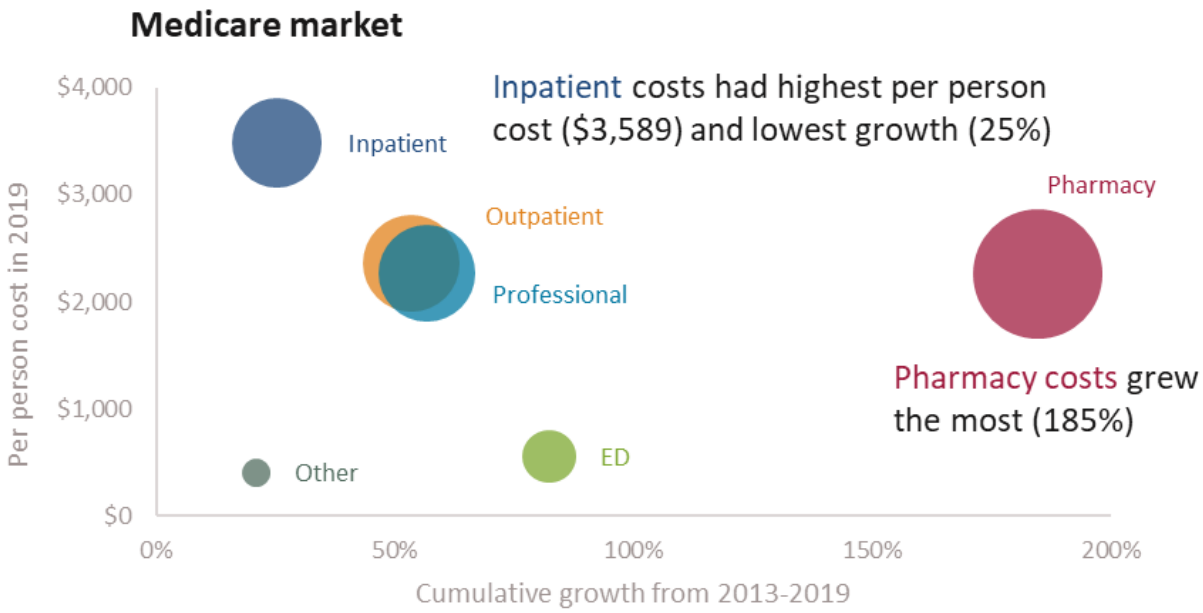
https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/Oregon-Health-Care-Cost-Trends-Report-2013-2019-FINAL.pdf

Pharmacy is a major cost growth driver in Oregon

Pharmacy costs were a main driver of Oregon cost growth between 2013 - 2019, in all 3 markets

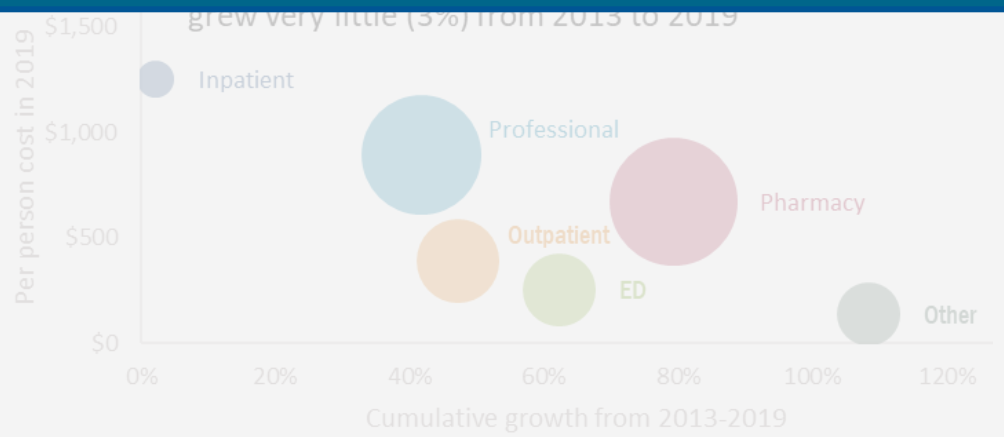


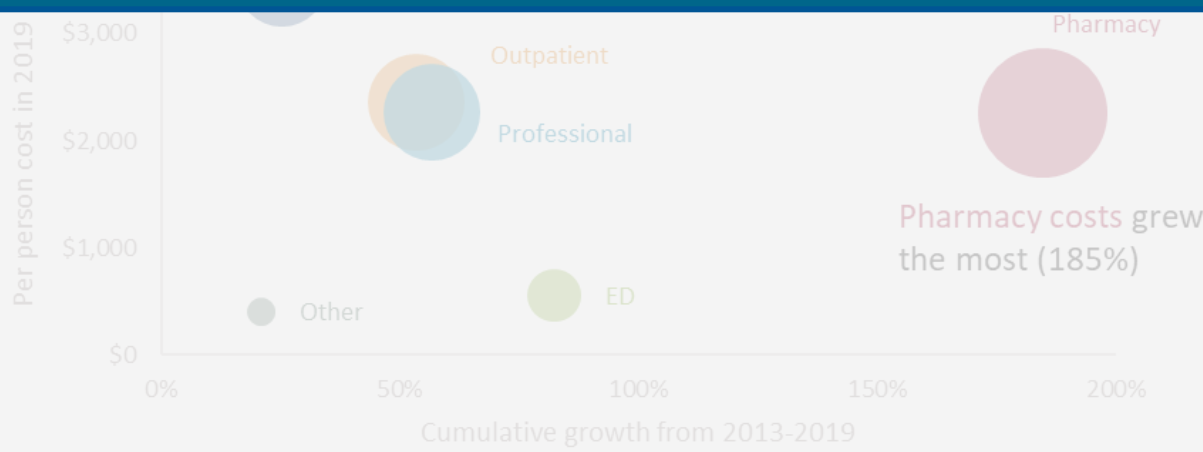




Pharmacy costs were a main driver of Oregon cost growth between 2013 - 2019, in all 3 markets

However,… this pharmacy cost analysis does not include rebates





Transparency & Affordability Review

- Prescription Drug Affordability Board (PDAB)
- Prescription Drug Price Transparency Program

Pharmacy Benefit Manager (PBM) Regulation

- Prohibited gag clauses
- Prohibited PBMs from requiring mail order pharmacies

Cost Sharing

- Capped member cost-sharing for insulin

Medicaid Specific Strategies

- Preferred Drug List
- Sovereign States Drug Consortium
- Medication Therapy Management

Existing pharmacy cost containment strategies in Oregon

ArrayRx

Mission: To provide high-value pharmacy solutions overseen and administered by states' public sector purchasers of prescription drugs where transparency and stewardship of tax dollars is the highest priority.

Vision: To be the most trusted pharmacy solutions provider in the industry.

Created for states, by states

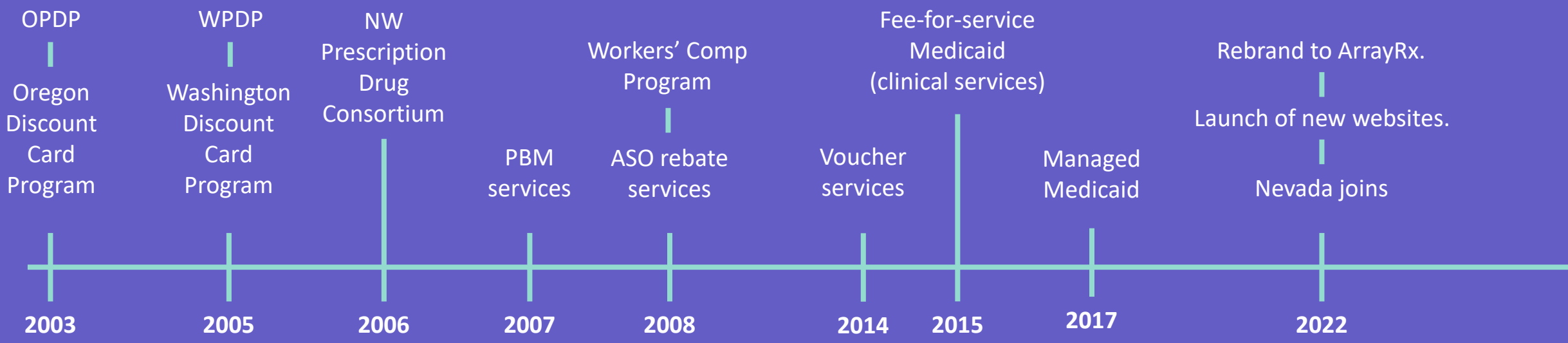
OPDP Oregon Prescription Drug Program

Washington Prescription Drug Program

Northwest Prescription Drug Consortium

Integrating Solutions for Best Value

ArrayRx



ArrayRx

Created for states, by states

- An inter-state agreement between the States of Oregon, Washington, and Nevada.
- Intended to meet the pharmacy needs for public entities where stewardship of tax dollars is our highest priority.
- Overseen by a team of experienced public officials with over 100 years of experience in pharmacy supply chain and pharmacy benefit management and contracting.
- Available to public sector entities and municipalities nationally.

ArrayRx

ArrayRx Services

PBM Services

ASO Rebate Services

Medicaid Programs

Voucher Programs

Discount Card

Group Purchasing Org Services

For More Information

ArrayRxSolutions.com
ArrayRxCard.com

Heidi Murphy, Operations Manager
Heidi.R.Murphy@dhsoha.state.or.us

Trevor Douglass, Director
Trevor.Douglass@dhsoha.state.or.us

- Prescription Drug Price Transparency Program – annual report and public hearing in December
- Prescription Drug Affordability Board – annual report and legislative recommendations in December
- Cost Growth Target Advisory Committee to review PDAB recommendations in January
    - May endorse or select additional strategies / policies at that time

Next Steps

For More Information

Email:

HealthCare.CostTarget@oha.oregon.gov

sarah.e.bartelmann@oha.oregon.gov

Website:

https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx

Office of the State Comptroller Presentation on Primary Care

State Employee Plan Primary Care Initiative Pilot

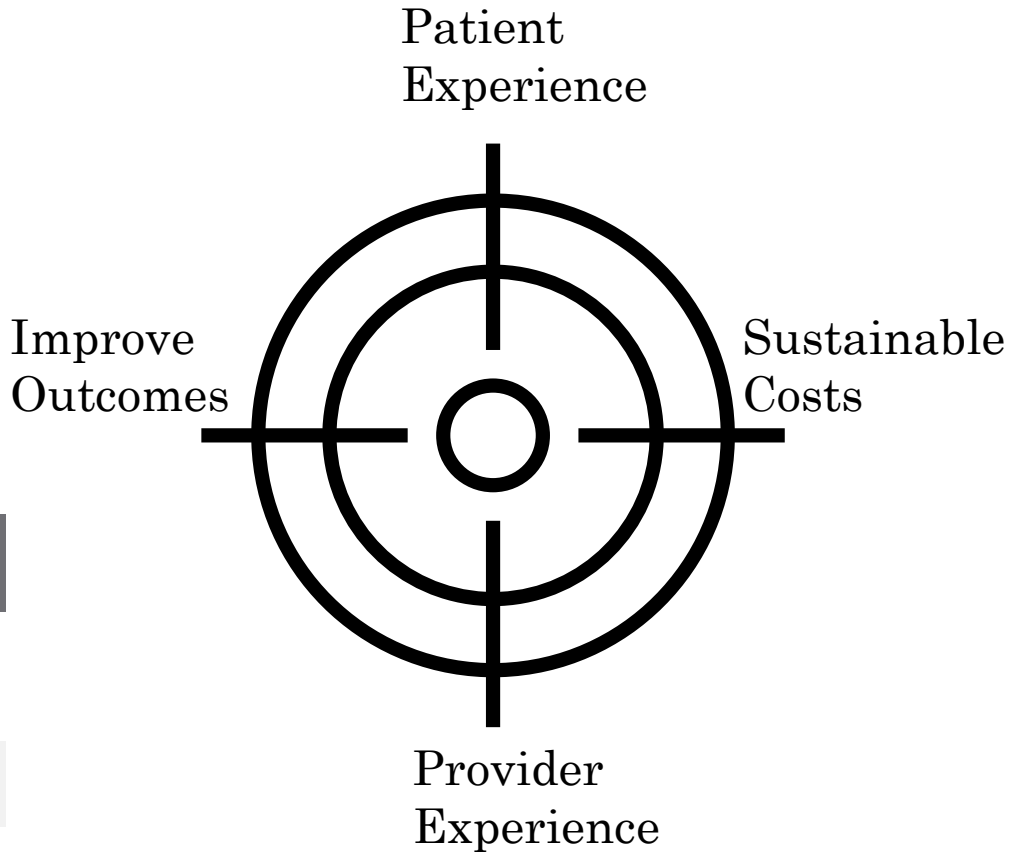
Presentation to the Healthcare Cost Growth Benchmark Steering Committee

Joshua Wojcik
Director, Health Policy and Benefits Division
Office of the State Comptroller

November 21, 2022

Aligning with Statewide Policy Goals

- Managing healthcare cost growth
- Increasing expenditures on primary care
- Standardizing quality measures

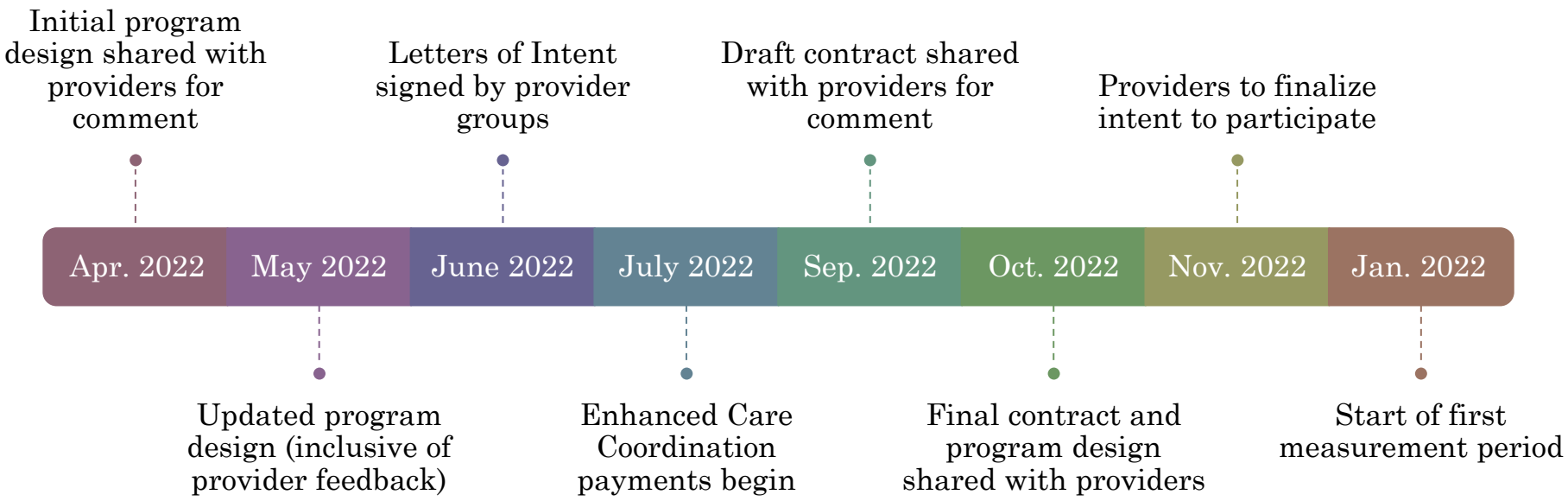


Statewide Goals		
Calendar Year	Health Care Cost Growth Benchmark	Primary Care Spend
2023	2.9%	6.9%
2024	2.9%	8.4%
2025	2.9%	10.0%

Primary Care Initiative Pilot Key Features

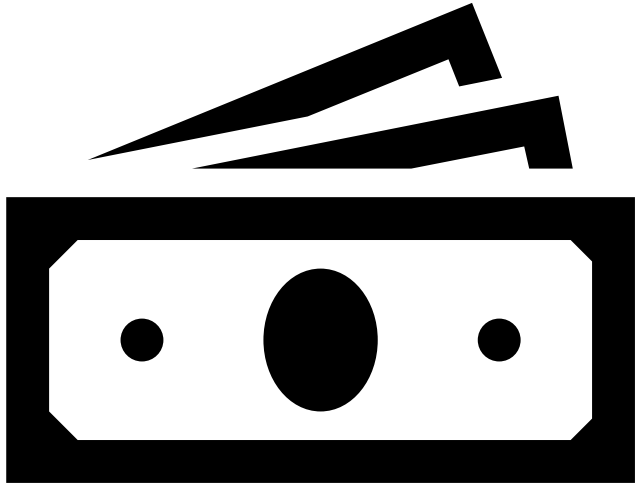
- Significantly Increase Per Member Per Month Care Coordination Fees
- Require additional resources be used to improve competencies in the 11 focus areas established by the Office of Health Strategies Primary Care Roadmap
- Quality bonus for performance on the OHS Quality Council Core Measure Set
- Accountability through:
  - shared risk on total cost of care;
  - annual reporting; and
  - OHS recognition (when available)
- Provide robust staffing and reporting support to assist participating providers in identifying and leveraging opportunities for care improvement and cost savings

Implementation Timeline



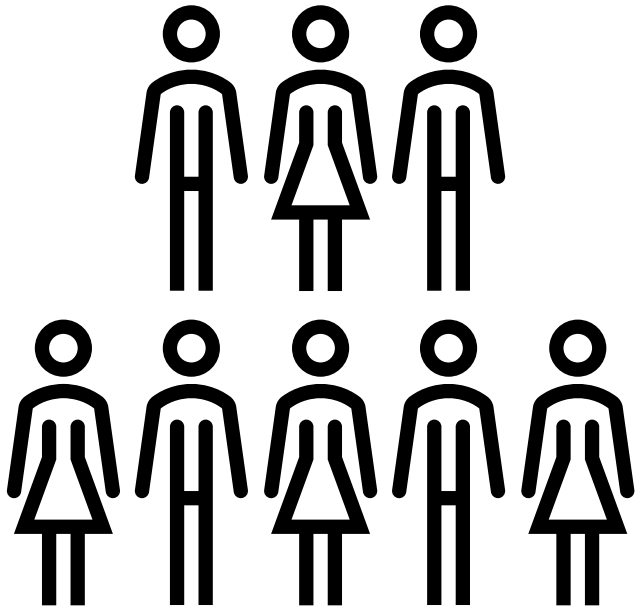
Care Coordination Fees

- Enhanced Care Coordination Fees (CCF) $12 PMPM
- Risk Adjusted
- Enhanced CCF is in addition to any current CCF paid by Anthem on behalf of state membership
- CCF is not at risk and is exempt from total cost of care calculations
- CCF may increase in measurement years 2 and 3 to meet statewide primary care expenditure goals - dependent on available funds



Attribution

- Attribution to be identified using Anthem's current attribution methodology.
- Attribution will be fixed for the measurement period based upon membership attribution as of April 1st of the current measurement period.
- Attributed members to be informed of the PCP/Provider they have been assigned to prior to the start of the measurement period. Members will be asked to contact Anthem Member Services if a correction is needed.



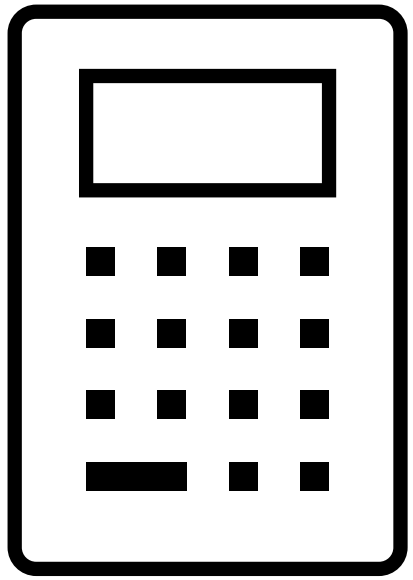
Total Cost of Care Targets Trend

- Annul Prospective Trend Targets
  - Measurement year 1 = 5%
  - Measurement year 2 = 4%
  - Measurement year 3 = 2.9%
- Trend targets adjust in concert with changes to the health care cost growth benchmark (e.g. 1% increase benchmark = 1% increase in trend target)
- Retrospective trend adjustments applied when actual trend is:
  - >6% or <4%.

  The trend adjustment is a one-to-one adjustment for trend above or below thresholds

Total Cost of Care Targets Baseline

- Prior year experience is phased into Total Cost of Care (TCC) Targets
- Total Cost of Care (TCC) Target Calculations
  - CY 2023 = CY 2022 actual TCC x 1.05
  - CY 2024 = (CY 2023 TCC Target + CY 2023 actual TCC)/2 x 1.04;
  - CY 2025 = (CY 2023 TCC Target x CY 2024 final target trend + CY 2023 actual TCC x CY 2024 final target trend + CY 2024 actual TCC)/3 x 1.029



Risk Options						
Groups with 3,000 – 6,000 attributed lives*						
Category	Year 1		Year 2		Year 3	
Options	Option 1	Option 2	Option 1	Option 2	Option 1	Option 2
Upside Shared Savings Potential	25%	35%	30%	40%	35%	50%
Downside Shared Loss Potential	10%	20%	20%	30%	35%	50%
Upside Cap %	1%	1.5%	1.5%	2%	1.5%	2%
Downside Cap %	1%	1.5%	1.5%	2%	1.5%	2%
Groups with 5,000 or more attributed lives						
Category	Year 1		Year 2		Year 3	
Options	Option 1	Option 2	Option 1	Option 2	Option 1	Option 2
Upside Shared Savings Potential	35%	45%	40%	50%	50%	50%
Downside Shared Loss Potential	20%	30%	30%	50%	50%	50%
Upside Cap %	1.5%	2%	2%	2% or 4%	2%	4%
Downside Cap %	1.5%	2%	2%	2% or 4%	2%	4%

Multiple Risk Options to Meet Provider Needs

<u>Exemptions</u>

- Expenditures above $175,000 for an attributed member
- Transplant members

Quality Bonus +

A quality bonus approximately equal to $3 PMPM will be paid for performance on quality measures from the Office of Health Strategy's standard measure set.

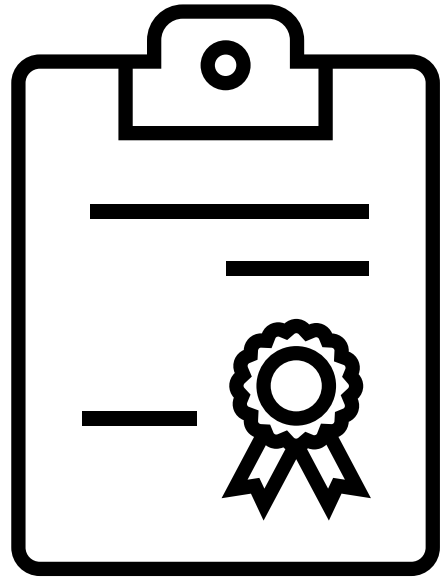
Quality bonus to be proportionally adjusted based upon quality score achieved.

<u>Excess Quality Bonus Pool</u>

Unrealized bonus funds to be equally distributed to groups meeting highest quartile of quality scores as additional bonus payment

OHS Recognition Requirements

- Providers commit that the following percentage of attributed lives be served by OHS recognized practices:
  - End of measurement first measurement year following the availability of the OHS recognition program = 50%
  - End of measurement first measurement year following the availability of the OHS recognition program = 75%
  - End of measurement first measurement year following the availability of the OHS recognition program = 100%
- Providers also required to report to OSC annually on how CCF payments were invested to improve competency on 11 core function areas

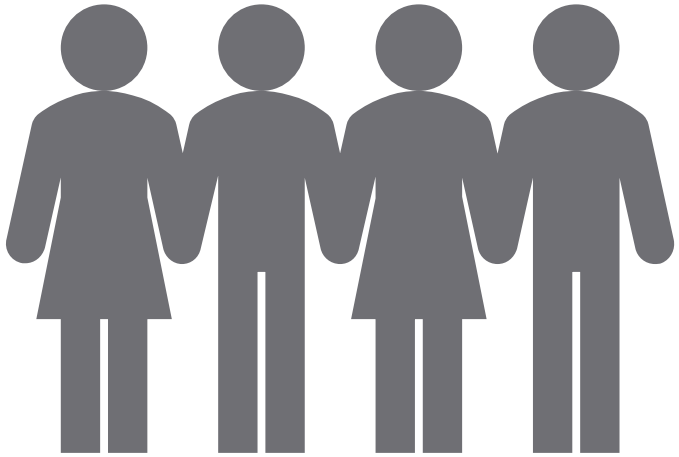


The Payer as a Partner

- Dedicated analytics and clinical staff
- Plan design that aligns with program goals
- Provider feedback in program design
- Central resource for all plan care management and other programing for both members and providers

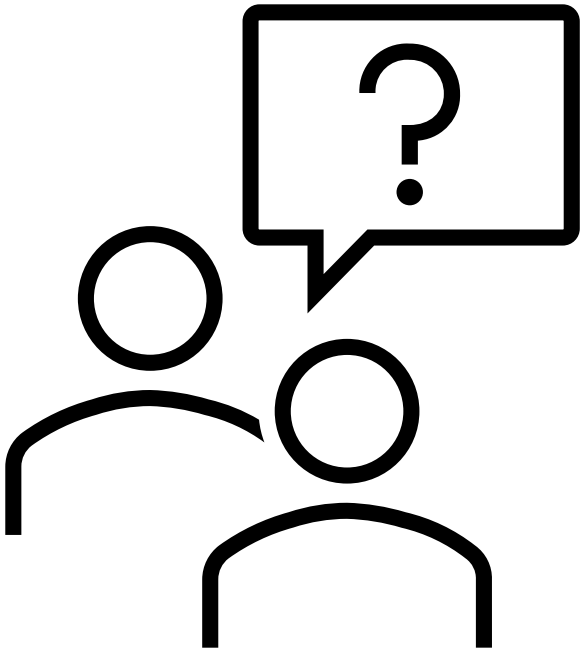
Pilot Participation

- 9 Provider Groups signed Letter of Intent covering 100,000 attributed members



Continued State Support

- OHS Quality Council – Maintain and update Core measure set and benchmarks
- OHS Recognition – Provides confidence additional care coordination dollars are being invested with purpose; necessary to expand payments beyond groups large enough to take risk
- Cost Growth Benchmark – Regular review to ensure benchmark aligns with current economic conditions
- State supported technical resources to help provider groups expand their capabilities and learn best practices (learning collaborative and technical assistance)



Questions

Thank You

Quality Council Activities

Quality Council Responsibilities

CT Aligned Measure Set

- Recommend a set of clinical quality, patient safety, consumer experience, and over-and under-utilization measures from which OHS requests insurers select measures for use in **value-based contracts with Advanced Networks**

Quality Benchmarks

- Recommend **annual measures and target values** that all public and private **payers, providers and the State** should work to achieve to improve healthcare quality in Connecticut

Members of the Quality Council include healthcare providers, health insurance experts, patient advocates, consumer representatives, state agencies and other experts from across the healthcare and related sectors in Connecticut.

2022 Quality Council Activities

- In 2022, the Quality Council has accomplished the following:
  1. Measured and reported insurer and DSS fidelity to the 2022 Aligned Measure Set
  2. Finalized the 2023 Aligned Measure Set and created new Core and Menu measure categories
  3. Identified strategies to improve Quality Benchmark performance and began implementing the priority strategies
- We will discuss these activities in greater detail on the following slides.

1. Fidelity to the 2022 Aligned Measure Set (1 of 3)

- OHS' annual Quality Council Insurer Survey captures measures in use by payers in value-based contracts with Advanced Networks.*
- The 2022 survey assessed:
  - **Measures in use** in contracts effective beginning on or after January 1, 2022
  - Whether the measures had **Pay-for-Performance or Pay-for-Reporting** status in contracts
  - **Number of contracts** in which measures were used
  - Payer **stratification** of measures by race, ethnicity and/or language
  - Measures with **modified specifications** and **homegrown measures**

***Advanced Networks** are defined by OHS as entities that are or could be engaged in a total cost of care contract with one or more payers.

OHS CONNECTICUT Office *of* Health Strategy

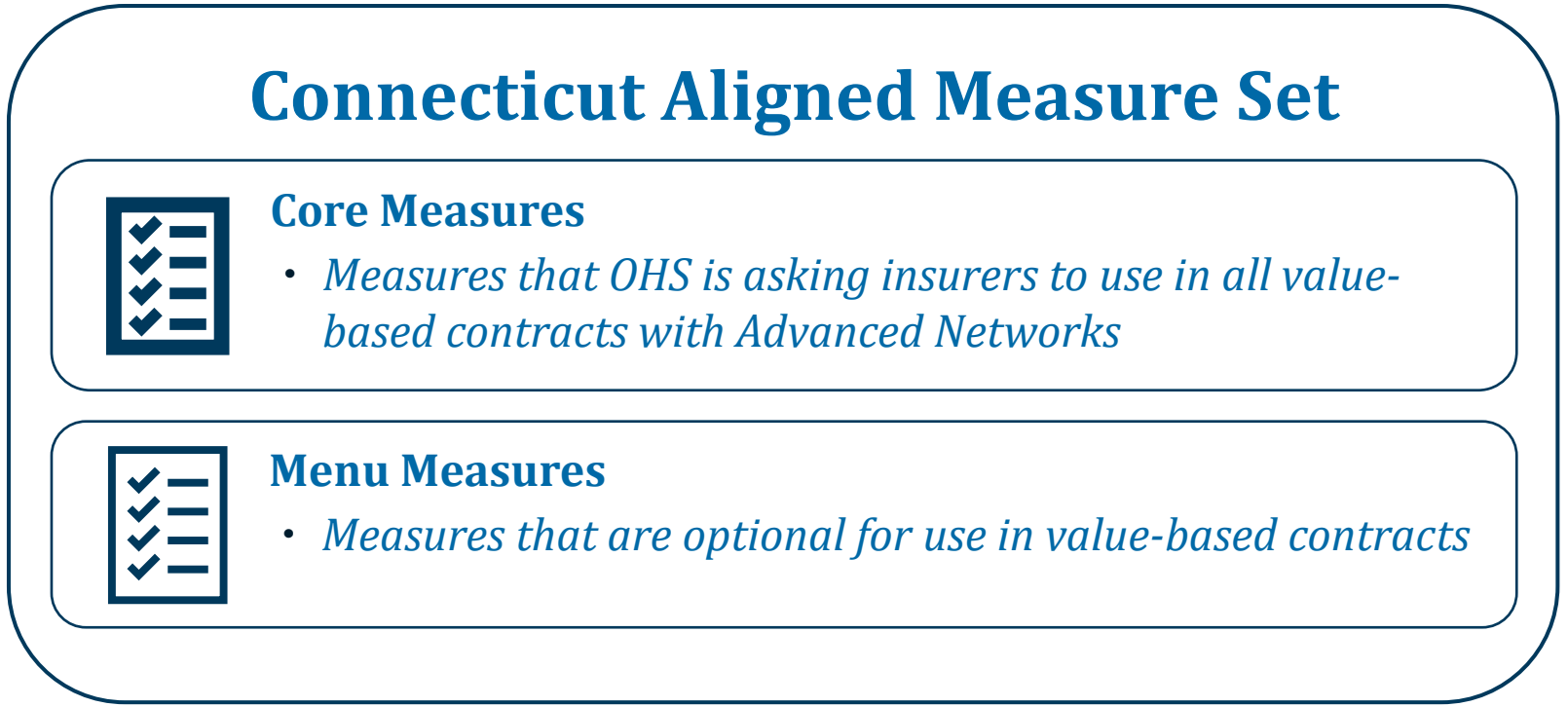
1. Fidelity to the 2022 Aligned Measure Set (2 of 3)

- Using data from the 2022 Insurer Survey, OHS used the formula below to calculate each insurer's Aligned Measure Set fidelity score.
  - **Note**: The assessment only considered quality measures that would be considered for inclusion in the Aligned Measure Set (e.g., excluded hospital-focused measures, prescription drug-focused measures, Medicare Advantage-focused measures).

$$\textbf{\textit{Aligned Measure Set Fidelity Score}} = \frac{\textit{Number of instances Aligned Measure Set measures were used by the insurer in contracts}}{\textit{Sum of instances any measures (Aligned Measure Set measures or otherwise) were used by the insurer in contracts}}$$

2. 2023 Aligned Measure Set (1 of 2)

- In 2022, the Quality Council updated the Aligned Measure Set for 2023 contracts, including by adopting a "true" Core Measure Set.



2. 2023 Aligned Measure Set (2 of 2)

1. Asthma Medication Ratio
2. Behavioral Health Screening*
3. Breast Cancer Screening
4. Cervical Cancer Screening
5. **Child and Adolescent Well-Care Visits**
6. Chlamydia Screening in Women
7. Colorectal Cancer Screening
8. Concurrent Use of Opioid and Benzodiazepines
9. **Controlling High Blood Pressure**
10. Developmental Screening in the First Three Years of Life
11. Eye Exam for Patients with Diabetes
12. **Follow-Up After Emergency Department Visit for Mental Illness (7-Day)**
13. Follow-Up After for Children Prescribed ADHD Medication
14. Follow-Up After Hospitalization for Mental Illness (7-Day)
15. **Health Equity Measure**
16. **Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control (>9%)**
17. Immunizations for Adolescents (Combo 2)
18. Kidney Health Evaluation for Patients with Diabetes
19. Metabolic Monitoring for Children and Adolescents
20. PCMH CAHPS Survey
21. **Plan All-Cause Readmission**
22. **Prenatal and Postpartum Care**
23. Screening for Depression and Follow-Up
24. Social Determinants of Health Screening
25. Substance Use Assessment in Primary Care
26. Transitions of Care
27. Use of Pharmacotherapy for Opioid Use Disorder
28. Well-Child Visits in the First 30 Months of Life

*Medicaid-only measure
Core Measures are in bold

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3. Strategies to Improve Performance on Quality Benchmark Measures (1 of 9)

- In 2020, Governor Lamont signed Executive Order No. 5 directing OHS to develop annual Quality Benchmarks for CY 2022-2025. In 2022, Public Act 22-118 codified Executive Order No. 5 into law and created new Quality Benchmark reporting requirements.
- In 2021, OHS selected seven Quality Benchmark measures and Benchmark values for phased implementation, per the Quality Council's recommendation.

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 Hospitalization for Mental Illness (7-day)
- Follow-up After ED Visit for Mental Illness (7-day)
- Obesity Equity Measure

3. Strategies to Improve Performance on Quality Benchmark Measures (2 of 9)

- In 2022, the Quality Council recommended OHS prioritize six strategies to improve performance on the Quality Benchmarks.

Strategies to Improve Performance on Quality Benchmarks
1. Create a true set of "core measures", including the Quality Benchmark Measures as Core Measures.
2. Have the Office of the State Comptroller (OSC) adopt the Quality Benchmarks in its contracts.
3. Public reporting of Advanced Network and payer performance on the Quality Benchmarks annually with Cost Growth Benchmark performance.
4. Public recognition of providers and payers that are performing well and/or demonstrating improvement on the Quality Benchmarks.
5. Partner with other agencies on a PR and education campaign.
6. Create a toolkit to give to provider organizations.

3. Strategies to Improve Performance on Quality Benchmark Measures (3 of 9)

Strategy #1: Create a true set of "core measures", including the Quality Benchmark Measures as Core Measures.

Activities

- ☑ The Quality Council will annually update measures in the Core Measure Set and notify insurers and providers.
- ☑ OHS will annually conduct a measure use survey to determine fidelity to the Core Measure Set.*
- ☑ OHS will annually share fidelity scores with insurers and then report fidelity scores to the Quality Council and Healthcare Benchmark Initiative Steering Committee.*

*In 2022, OHS reported insurer fidelity to the 2022 Aligned Measure Set. In 2023, OHS will report fidelity to the true set of Core Measures in the 2023 Aligned Measure Set.

3. Strategies to Improve Performance on Quality Benchmark Measures (4 of 9)

Strategy #2: Have the Office of the State Comptroller (OSC) adopt the Quality Benchmarks in its contracts.

Activities

- ☑ OHS will meet with OSC annually to discuss alignment with Quality Benchmarks, including sharing measure specifications and how to obtain benchmark data.

3. Strategies to Improve Performance on Quality Benchmark Measures (5 of 9)

Strategy #3: Public reporting of Advanced Network and payer performance on the Quality Benchmarks annually with Cost Growth Benchmark performance

Activities

- ☑ OHS will annually prepare data submission instructions and reporting template.
- ☐ Payers will annually report on Quality Benchmark performance at the payer and Advanced Network level.
- ☐ OHS will annually validate, analyze, and report on Advanced Network and payer performance to the Quality Council.

3. Strategies to Improve Performance on Quality Benchmark Measures (6 of 9)

Strategy #3: Public reporting of Advanced Network and payer performance on the Quality Benchmarks annually with Cost Growth Benchmark performance.

3. Strategies to Improve Performance on Quality Benchmark Measures (7 of 9)

Strategy #4: Public recognition of providers and payers that are performing well and/or demonstrating improvement on the Quality Benchmarks

Activities

- ❑ OHS will determine appropriate public recognition of providers and payers performing well and/or demonstrating improvement.
- ❑ OHS will annually determine which payers and providers are performing well/demonstrating improvement.

3. Strategies to Improve Performance on Quality Benchmark Measures (8 of 9)

Strategy #5: Partner with other agencies on an education campaign (including a webinar series)

Activities

- ❑ OHS will host a webinar with subject matter experts on each Quality Benchmark measure.
- ❑ OHS will create communication materials about the Quality Benchmarks and partner with agencies to coordinate dissemination.

3. Strategies to Improve Performance on Quality Benchmark Measures (9 of 9)

Strategy #6: Create a toolkit to give to provider organizations

Activities/Updates

- ☑ OHS will conduct research into external resources and best practices for each Quality Benchmark measure.
- ☐ OHS will develop a toolkit with resources and best practices for each Quality Benchmark measure.
- ☐ OHS will develop and implement a dissemination strategy for the toolkit.

Wrap-Up and Next Steps

Wrap-Up and Next Steps

- The next Steering Committee meeting will be held virtually on Monday, **December 19th** from 3–5:00 p.m.

State Employee Plan Primary Care Initiative Pilot

Appendix

Care Delivery Requirements (OHS)

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.

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. “Embedded” refers to staff who are dedicated to specific practices. They may be physically located full or part-time at the practice site or should the practice site not afford sufficient physical space, physically located elsewhere.*

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.*

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.

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.

Quality Program Detail

Quality Measures

- Quality measures will align with those established by the OHS Quality Council
- All contracts will include all Core Measures (7 for 2023)
- Other measures may be added through mutual agreement from the Menu Measure Set
- All Core and Menu measures focused or broadly applicable to pediatrics will be included for groups with a significant pediatric population.
- Measures will only be included in measurement periods in which Anthem can calculate and report on them. Thus, a more limited set will be applied in year 1 with additional measures applying in years 2 and 3. (See table on next slide)
- A minimum of 30 cases for each measure will be required for the measure to be scored

Quality Bonus

- Groups will receive a composite quality score. The composite score will represent the percentage of the $3 bonus each group is eligible to receive.
- Composite Score Calculations for each measure:
  - Meeting the OHS benchmark (if one exists): 1 pt.
  - Showing year over year improvement on the measure: 1 pt.
  - Percentile rank on measure: up to 2 pts. (see chart)
  - Scores are normalized as a percentage of total available points for each measure (pts/maximum pts) to determine a final score for each measure
  - Scores for all applicable measures are averaged
  - The resultant average percentage is the final composite score and is multiplied by the $3 (the maximum base bonus) to determine final base bonus
  - See example on next slide

Percentile Performance	Points
Below 10th	0
10th	0
20th	0
30th	0.6
40th	0.8
50th	1
60th	1.4
70th	1.6
80th	2
90th	2

	Performance			Points			Calculation			
Measure	**Rate**	**2023 Benchmark**	**YOY Improvement (Y/N)**	**Performance Percentile Decile**	**2023 Benchmark**	**YOY Improvement**	**Performance Percentile Decile**	**Points Earned**	**Points Available**	**Normalized Score**
Plan all-cause readmission	5%	NA	Y	80th	NA	1	2.00	3	3.00	100%
Controlling High Blood Pressure	65%	0.63	Y	70th	1	1	1.60	4	4.00	90%
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control (>9%)	28%	0.27	Y	50th	-	1	1.00	2.00	4.00	50%
Child and Adolescent Well-care Visits	85%	NA	N	70th	NA	-	1.60	1.60	3.00	53%
							Total Composite Score (average of normalized scores):			**73%**
							PMPM Quality Bonus Amount ($3 x composite score):			**$2.20**

Quality Bonus Sample Calculation

Excess Quality Bonus Pool

- Excess Bonus Pool – Any unearned bonus dollars will go toward the Excess Quality Bonus Pool. For example, a group earns $2.50 per attributed member, $0.50 per attributed member will go toward the Excess Quality Bonus Pool.

- The bonus pool will be split into a general bonus and pediatric bonus. Quality bonus pool dedicated to pediatrics will be calculated as follows:
  - The number of members under 21 attributed to groups in the program with pediatric measures divided by the total number of members attributed to all groups participating in the program. The resultant percentage will then be multiplied by the total available dollars in the Excess Quality Bonus Pool to determine the amount dedicated to the pediatric portion of the pool. The remaining dollars will be allocated to the general portion of the Excess Quality Bonus Pool.

- For the general bonus, groups with the highest overall composite scores for the basic bonus will be eligible for the Excess Quality Bonus. For the pediatric bonus, groups with highest composite scores on pediatric measures will be eligible for the bonus.

- Groups scoring in the highest quartile will share the Excess Quality Bonus Pool equally on a per attributed member basis.

2023 Core Measures

Core Measures	Available in CY 2022	Available in CY 2023	Pediatric Measure	Benchmark Measure Phase 1	Benchmark Measure Phase 2
Plan all-cause readmission	x				
Controlling High Blood Pressure		x		x	
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control (>9%)	x			x	
Child and Adolescent Well-care Visits	x		x		x
Prenatal and Postpartum Care		x			
Follow-up After Emergency Department Visit for Mental Illness (7-Day)		x			x
Health Equity Measure1		x			

Menu Measures

Menu Measures	Available in CY 2022	Available in CY 2023	Pediatric Measure	Benchmark Measure Phase 1	Benchmark Measure Phase 2
PCMH CAHPS Survey					
Transitions of Care2					
Breast Cancer Screening3	x				
Cervical Cancer Screening	x				
Chlamydia Screening in Women	x				
Colorectal Cancer Screening		x			
Immunizations for Adolescents (Combo 2)		x	x		
Developmental Screening in the First Three Years of Life			x		
Well-Child Visits in the First 30 Months of Life	x		x		
Screening for Depression and Follow-up Plan		x			
Asthma Medication Ratio	x		x	x	
Eye Exam for Patients with Diabetes					
Follow-up Care for Children Prescribed ADHD Medication			x		
Metabolic Monitoring for Children and Adolescents on Antipsychotics (Medicaid only)3			x		
Follow-up After Hospitalization for Mental Illness (7-Day)		x			x
Substance Use Assessment in Primary Care					
Concurrent Use of Opioids and Benzodiazepines		x			
Use of Pharmacotherapy for Opioid Use Disorder					
Social Determinants of Health Screening5					

Table 2: Commercial Quality Benchmark Values

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source
Phase 1 Measures				
Asthma Medication Ratio (Ages 5 – 18)	79%	81%	83%	86% Between the national commercial 50th and 75th percentiles
Asthma Medication Ratio (Ages 19 – 64)	78%	80%	82%	85% National commercial 90th percentile
Controlling High Blood Pressure	61%	63%	65%	68% Between the New England commercial 50th and 75th percentiles
HbA1c Control for Patients with Diabetes: HbA1c Poor Control[3]	27%	26%	25%	23% Between the national commercial 75th and 90th percentiles
Phase 2 Measures				
Child and Adolescent Well-Care Visits	TBD[4]	TBD	TBD	TBD
Follow-up After ED Visit for Mental Illness (7-day)	60%	N/A	N/A	75% Between the New England commercial 75th and 90th percentiles
Follow-up After Hospitalization Visit for Mental Illness (7-day)	56%	N/A	N/A	63% Between the New England commercial 75th and 90th percentiles

Benchmarks

Note: Child and Adolescent Well- Care Visits will be set by the Quality Council in 2023

Quality Council Appendix

Commercial Market Benchmark Values: Phase 1 Measures

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source	Percentage Point Improvement
Asthma Medication Ratio (Ages 5-18)	79%	81%	83%	86% *Between the national commercial 50th and 75th percentiles*	Overall: 7% Annual: 2%
Asthma Medication Ratio (Ages 19-64)	78%	80%	82%	85% *National commercial 90th percentile*	Overall: 7% Annual: 2%
Controlling High Blood Pressure	61%	63%	65%	68% *Between the New England commercial 50th and 75th percentiles*	Overall: 7% Annual: 2%
HbA1c Control for Patients with Diabetes: HbA1c >9%*	27%	26%	25%	23% *Between the national commercial 75th and 90th percentiles*	Overall: 4% Annual: 1%

The annual change in Benchmark values may not be even due to rounding.
*A lower rate indicates higher performance.

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Commercial Market Benchmark Values: Phase 2 Measures

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source	Percentage Point Improvement
Child and Adolescent Well-Care Visits	TBD	TBD	TBD	TBD	TBD
Follow-up After ED Visit for Mental Illness (7-Day)	60%	N/A	N/A	75% *Between the New England commercial 75th and 90th percentiles*	Overall: 15%
Follow-up After Hospitalization for Mental Illness (7-Day)	56%	N/A	N/A	63% *Between the New England commercial 75th and 90th percentiles*	Overall: 7%

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

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Medicaid Market Benchmark Values: Phase 1 Measures

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source	Percentage Point Improvement
Asthma Medication Ratio (Ages 5-18)	66%	68%	70%	73% *Between the national Medicaid 50th and 75th percentiles*	Overall: 7% Annual: 2%
Asthma Medication Ratio (Ages 19-64)	63%	65%	67%	70% *Between the national Medicaid 75th and 90th percentiles*	Overall: 7% Annual: 2%
Controlling High Blood Pressure	61%	63%	65%	68% *National Medicaid 75th percentile*	Overall: 7% Annual: 2%
HbA1c Control for Patients with Diabetes: HbA1c >9%*	37%	36%	35%	33% *National Medicaid 75th percentile*	Overall: 4% Annual: 1%

The annual change in Benchmark values may not be even due to rounding.
*A lower rate indicates higher performance.

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Medicaid Market Benchmark Values: Phase 2 Measures

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source	Percentage Point Improvement
Child and Adolescent Well-Care Visits	TBD	TBD	TBD	TBD	TBD
Follow-up After ED Visit for Mental Illness (7-Day)	50%	N/A	N/A	65% *National Medicaid 90th percentile*	Overall: 15%
Follow-up After Hospitalization for Mental Illness (7-Day)	48%	N/A	N/A	55% *New England Medicaid 90th percentile*	Overall: 7%

Medicare Advantage Market Benchmark Values

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source	Percentage Point Improvement
Controlling High Blood Pressure	73%	75%	77%	80% *National Medicare Advantage 75th percentile*	Overall: 7% Annual: 2%
HbA1c Control for Patients with Diabetes: HbA1c >9%*	20%	18%	16%	15% *National Medicare Advantage 75th percentile*	Overall: 5% Annual: 2%

The annual change in Benchmark values may not be even due to rounding.
*A lower rate indicates higher performance.

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Statewide Benchmark Values

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source	Percentage Point Improvement
Obesity Equity Measure *the ratio of the White, non-Hispanic obesity rate and Black, non-Hispanic obesity rate*	1.65	N/A	N/A	1.33 *National ratio*	Overall: 0.32