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Technical Briefing on Cost Growth Benchmark and Quality Benchmark

Today's Agenda

1. Overview of Connecticut's Health Care Cost Growth Benchmark and Primary Care Spending Target
    a. Review of the Total Medical Expense Data Reporting Requirements
2. Overview of Connecticut's Quality Benchmarks
    a. Review of the Quality Benchmark Data Reporting Requirements
3. Questions

Overview of Connecticut's Cost Growth Benchmark and Primary Care Spend Target Programs

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Connecticut's Healthcare Cost Growth Benchmark

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

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

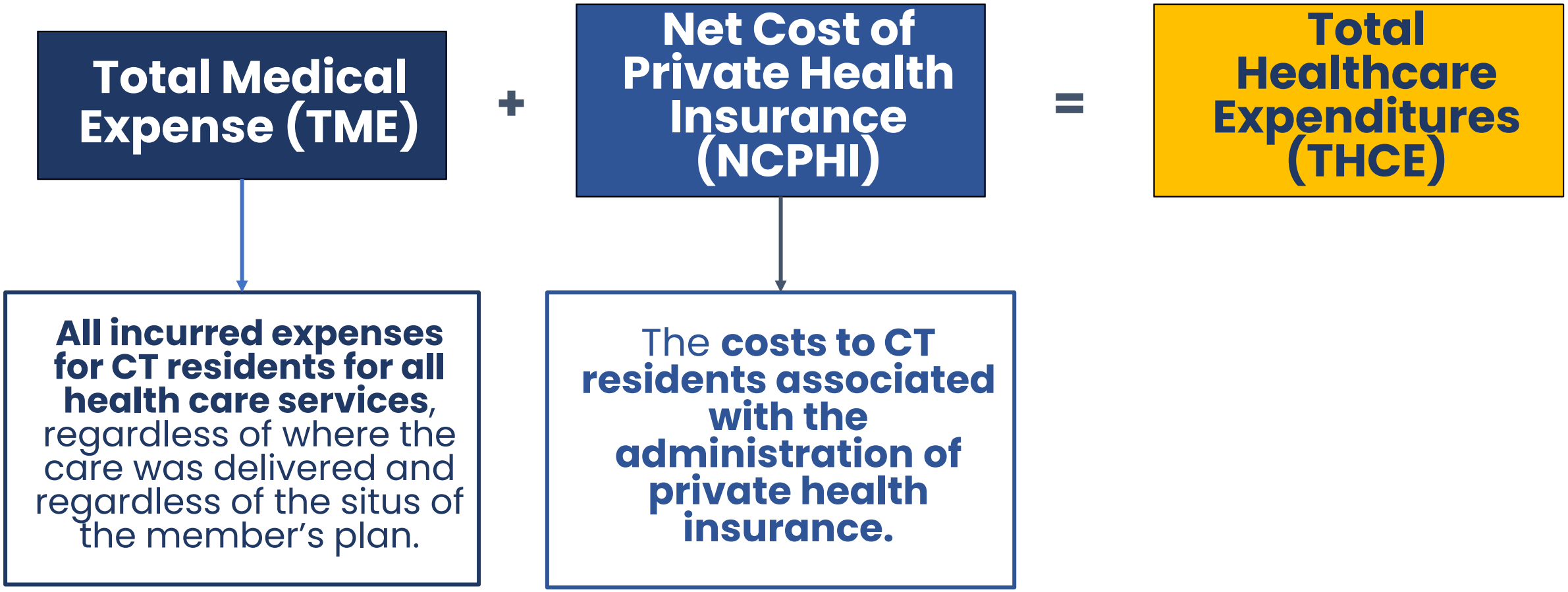
*Note: The 2024 benchmark value was revised upwards from 2.9%, due to the impact of inflation and the COVID-19 pandemic.

Connecticut's Primary Care Spend Target

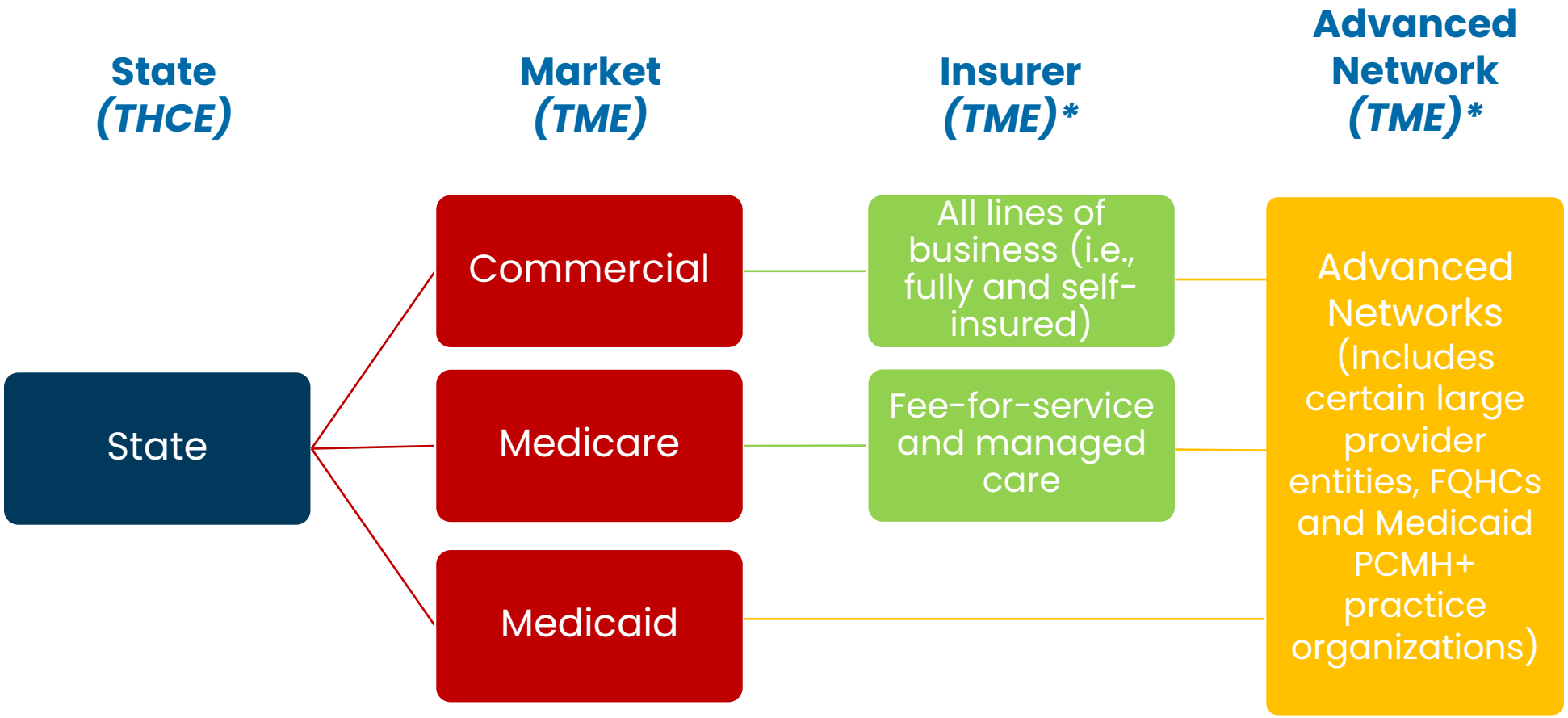
Calendar Year	Target Values
2021	5.0%
2022	5.3%
2023	6.9%
2024	8.5%
2025	10.0%

- Executive Order No. 5 and Connecticut General Statute 19a-754g et. Seq. established a **target to increase primary care spending** to 10 percent of total healthcare expenditures by calendar year 2025.
- The target is intended to rebalance and strengthen Connecticut's healthcare system by supporting improved primary care delivery.

Total Health Care Expenditures



Four Levels of Public Reporting of Performance Against the Cost Growth Benchmark



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

Payers Reporting Data to Assess Performance Against the Cost Growth Benchmark and Primary Care Spending Target

Carrier*	Commercial Fully and Self-Insured Plans	Medicare Advantage	Medicaid
Aetna Health & Life	X	X	
Anthem	X	X	
Cigna	X		
ConnectiCare	X	X	
Department of Social Services (DSS)			X
Office of the State Comptroller (OSC)**	X	X	
UnitedHealthcare	X	X	
Wellcare		X	

* OHS is also collecting data from the Department of Corrections, the Veteran's Health Administration, and the Centers for Medicare & Medicaid Services.
** OSC will submit data for the purposes of measuring OSC's performance relative to the benchmark. OSC's past, current, and future TPAs should still report OSC within their data submission.

Review of the Total Medical Expense Data Reporting Requirements

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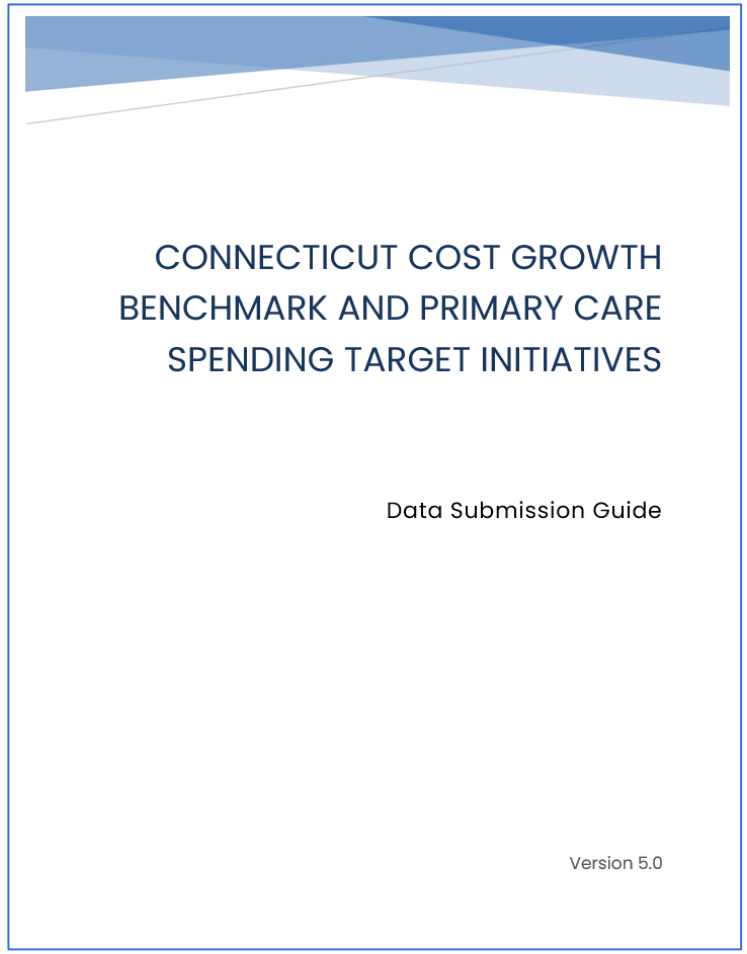
Cost Growth Benchmark and Primary Care Spending Target Data Submission Guide



- Comprehensive document that describes the:
  - Overall initiative;
  - Formulae for developing the healthcare cost growth benchmark and primary care spend target;
  - Methodology for calculating total healthcare spending against the benchmark and primary care spend against the target; and
  - Process for publicly reporting the results.
- Contains data reporting specifications for commercial and Medicare Advantage carriers in Appendix A.
- Guide and data submission templates are posted on OHS' webpage.

Summary of Methodological Updates for 2023–2024 TME Data

1. **Changed document title from "Implementation Manual" to "Data Submission Guide".**

2. **Updated truncation points for the commercial and Medicare markets.**

3. **Updated the list of Advanced Networks.**

4. **Updated guidelines for the member attribution methodology.** Key updates include:

   - OHS will provide unique TINs list for each carrier, by market.
   - Clarified reporting instructions for Advanced Network IDs 100 (Carrier Overall) and 999 (Members not attributed to an Advanced Network).

5. **Removed collection of clinical risk scores.**

Summary of Methodological Updates for 2023-2024 TME Data

6. **Updated non-claims definitions to align with Peterson-Milbank's Consensus Administrative Specifications for Health Care Cost Growth Target Programs.** Key changes include:

    1. Removal of "Non-Claims: Recoveries."
    2. Removal of "Non-Claims: Provider Salaries"
    3. Stratification of "Non-Claims: Performance Incentive Payments into: "Non-Claims: Performance Payments" and "Non-Claims: Shared Savings and Shared Risk Settlements."
    4. Renaming and clarification of other non-claims service categories

7. **Updated code-level definitions of "Claims: Professional, Primary Care" and "Claims: Professional, Primary Care (for Monitoring Purposes)"**

Identifying Changes in Data Submission Guide

- The Data Submission Guide includes call-outs to indicate important updates, major methodological changes, and items of particular interest.

Insurance Carrier TME Reporting Template

Header Tabs	Basic carrier identifying information
Advanced Network Tabs	Total medical expense by Advanced Network and Insurer Carrier Overall, by insurance category code
Pharmacy Rebate Tabs	Pharmacy rebates by insurance category code
Line of Business Enrollment Tab	Detailed line of business enrollment and income from fees of uninsured plans
Standard Deviation Tabs	Data required for creating confidence intervals
Age/Sex Factors Tabs	Spending by age band and by sex, for the purposes of risk adjustment
Mandatory Questions Tab	Attestation on the data accuracy, and checks on assumptions used for reporting the data
Data Validation Tabs	Series of checks to ensure data are consistent

Update to Header Tabs

- Carriers should still provide the following information:
  - Reporting period start and end dates
  - Listing of “d/b/a”

- Payers will not be asked to report clinical risk scores. ***[UPDATE]***

Header Tabs

Updates to List of Advanced Networks

- An **Advanced Network** is an organized group of clinicians that come together for the purposes of contracting, or are an established billing unit that, at a minimum, includes primary care providers, and that collectively, during any given calendar year, has enough attributed lives to participate in total cost of care contracts, even if they are not engaged in a total cost of care contract.
    - Includes validation checks for member months, spending, and truncation
- The next slide provides an updated list of Advanced Networks.

Note: The term “Advanced Network” as used in this manual is equivalent to the term “provider entity” as used in Public Act 22-118

Advanced Network Tabs

Updated List of Advanced Networks for 2023-2024

Advanced Network/Insurer Carrier Org ID	Advanced Network/Insurance Carrier Overall	Advanced Network/Insurer Carrier Org ID	Advanced Network/Insurance Carrier Overall
100	Insurance Carrier Overall	118	Fair Haven Community Health Center
101	Privia Quality Network of Connecticut (PQN CT)	119	Family Centers
102	Connecticut Children's Care Network	120	First Choice Community Health Centers
103	Connecticut State Medical Society IPA	121	Generations Family Health Center
104	Hartford Healthcare Integrated Care Partners ***[UPDATE]***	122	Norwalk Community Health Center
105	NA	123	Optimus Health Care, Inc.
106	Northeast Medical Group	124	Southwest Community Health Center, Inc.
107	OptumCare Network of Connecticut (including ProHealth)	125	Stamford Health Medical Group
108	Prospect Connecticut Medical Foundation Inc. (dba Prospect Medical, Prospect Health Services, Prospect Holdings)	126	Starling Physicians
109	Southern New England Health Care Organization (aka SoNE Health) ***[UPDATE]***	127	UConn Medical Group
110	Value Care Alliance	128	United Community and Family Services
111	NA	129	WestMed Medical Group
112	Charter Oak Health Center	130	Summit Health (now part of Village MD) ***[UPDATE]***
113	CIFC Greater Danbury Community Health Center	131	Yale Medicine
114	Community Health and Wellness Center of Greater Torrington	132	InterCommunity Health Care ***[NEW]***
115	Community Health Center	133	Trinity Health, Inc. ***[NEW]***
116	Community Health Services	134	Western Connecticut Health Network (WCHN) Physician Hospital Organization ***[NEW]***
117	Cornell Scott Hill Health Center	999	Members Not Attributed to an Advanced Network

Advanced Network Tabs

Update to Reporting Spending by Advanced Network (1 of 2)

- To report spending at the Advanced Network level, members will still need to be attributed to a primary care physician (PCPs), and PCPs will need to be attributed to an Advanced Network.
  - Member attribution to Advanced Networks should follow the tiered hierarchy approach (described on the next slide).
  - Taxpayer Identification Numbers (TINs) for Advanced Networks will be distributed for attribution purposes.
- All spending on members will be reported under the Advanced Network to which the members' PCP is attributed.
- Spending for members NOT attributed to an Advanced Network, as well as overall payer spending, should be reported by Attribution Hierarchy Code in the TME file. ***[UPDATE]***

Advanced Network Tabs

Update to Reporting Spending by Advanced Network (2 of 2)

- In addition to reporting spending by Insurance Category Code and Advanced Network, this year's data request will include further stratification by Attribution Hierarchy Code.

Tier	Description
Tier 1	**Member selection**: Members who were required to select a primary care provider by plan design should be assigned to that primary care provider's organization.
Tier 2	**Contractual arrangement**: Members not included in Tier 1 who were attributed to primary care provider during the measurement period pursuant to a contract between the payer and provider, should be attributed to that primary care provider's organization. For example, if a provider is engaged in a total cost of care arrangement, then the payer may use its attribution model for that contract to attribute members.
Tier 3	**Utilization**: Members not included in Tier 1 or 2 may be attributed to a primary care provider based on the member's utilization, using the payer's own attribution methodology.

Advanced Network Tabs

No Change to TME Data Required in Advanced Network Tab

- In addition to Advanced Network level spending by Insurance Category Code and Attribution Hierarchy Code, Insurance Carriers will continue to be asked to report overall spending by Insurance Category Code.
  - This additional level of reporting will be used for truncation purposes.
  - Carriers should use Advanced Network/Insurance Carrier Overall ID 100 to indicate overall spending by Insurance Category Code.

Advanced Network Tabs

No Change to Reporting TME by Insurance Category Code

- OHS has maintained the mutually exclusive data categories that indicate for what market / line of business the carrier is reporting data.
- Commercial has two categories:
  - Full claims – for when the carrier holds the entire medical benefit and has all of the data.
  - Partial claims – for when the carrier holds part of the benefit, and another part is carved out (e.g., pharmacy or behavioral health). Carriers must estimate partial claims data for which it does not have access.

Advanced Network Tabs

Insurance Category Code	Definition
1	Medicare Managed Care (excluding Medicare/Medicaid Dual Eligibles)
2	Medicaid including CHIP (excluding Medicare/Medicaid Dual Eligibles)
3	Commercial — Full Claims
4	Commercial — Partial Claims
5	Medicare Expenditures for Medicare/Medicaid Dual Eligibles
6	Medicaid Expenditures for Medicare/Medicaid Dual Eligibles
7	Other

No Change to General Parameters for Submitting TME

- Include spending by or on behalf of Connecticut residents regardless of where the care was delivered and the situs of the residents' plan.
- Report spending on allowed claims (i.e., spending covered by payers and out-of-pocket member spending) only when carrier is the primary payer.
  - Do not include premium payments.
- Report spending based on date incurred.

Advanced Network Tabs

No Change to Included and Excluded Policies

Include	Exclude
Commercial Market - Self-insured plans - Short-term health plans - Student health plans - Fully-insured individual and group plans - The State of Connecticut Employee Health Plans - The Federal Employee Health Benefits Program **Medicare Market** - Medicare Advantage Health Maintenance Organization - Preferred Provider Organization - HMO Point of Service - Medicare Medical Savings Account - Private Fee-for-Service - Special Needs Plans	- Accident policy - Disability policy - Hospital indemnity policy - Long-term care insurance - Medicare supplemental insurance (aka Medigap) - Reinsurance policy - Stand-along prescription drug plans - Specific disease policy - Stop-loss plans - Supplemental insurance that pays deductibles, copays or coinsurance - Vision-only insurance - Worker's compensation - Dental-only insurance

Advanced Network Tabs

No Change to Run-Out for Claims Spending

- Allow for a claims run-out or non-claims reconciliation period of at least **180** days after December 31 of the performance year.
  - If necessary, carriers should apply reasonable and appropriate incurred but not reported (IBNR) / incurred but not paid (IBNP) completion factors to each respective TME service category of claims spending.
  - Carriers should apply reasonable and appropriate estimates of non-claims liability to each large provider entity that are expected to be reconciled after the 180-day review period.

Advanced Network Tabs

No Change to Categories of Claims-based Spending to Report

- Carriers should report claims-based spending according to the following categories:
  - Hospital Inpatient
  - Hospital Outpatient
  - Professional: Primary Care (excludes OB/GYN)
  - Professional: Primary Care (for monitoring purposes) (includes OB/GYN)
  - Professional: Specialty
  - Professional: Other
  - Long-term Care
  - Pharmacy
  - Other
- The “Professional: Primary Care” categories have code level definitions in the guide. ***[UPDATE]***

Advanced Network Tabs

Updates to TME Claims Category Definitions

- **Hospital Inpatient** *(no change)*: The TME paid to hospitals for inpatient services, including all room and board and ancillary payments, and payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. Does not include payments made for observation services, for physician services during an inpatient stay that have been billed directly by a physician group practice or an individual physician, and inpatient services at non-hospital facilities.

- **Hospital Outpatient** *(no change)*: The TME paid to hospitals for outpatient services, including payments made for hospital-licensed satellite clinics, emergency room services not resulting in admittance, and observation services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.

Advanced Network Tabs

Updates to TME Claims Category Definitions (Cont'd)

- **Professional, Primary Care** *(code list updated)*: The TME paid to primary care providers delivering care at a primary care site of care generated from claims using the code-level definition in the Data Submission Guide ***[UPDATE]***. *This definition excludes OB/GYN.*
- **Professional, Primary Care (for monitoring purposes)** *(code list updated)*: The TME paid to primary care providers, including OB/GYNs and midwifery, delivering care at a primary care site of care generated from claims using the code-level definition in the Data Submission Guide ***[UPDATE]***.

Advanced Network Tabs

Updates to TME Claims Category Definitions

- **Professional, Specialty** *(no change)*: The TME paid to physicians or physician group practices generated from claims, including services provided by a doctors of medicine or osteopathy in clinical areas other than family medicine, internal medicine, general medicine or pediatric medicine, not defined as primary care in the first primary care definition.
- **Professional, Other** *(no change)*: The TME paid from claims to healthcare providers for services provided by a licensed practitioner other than a physician and is not identified as primary care in the first primary care definition.

Advanced Network Tabs

Updates to TME Claims Category Definitions

- **Pharmacy** *(no change)*: The TME paid from claims to healthcare providers for prescription drugs, biological products or vaccines as defined by the insurance carrier's prescription drug benefit. Pharmacy spending provided under the medical benefit should be attributed to the location in which it was delivered. Medicare Advantage carriers that offer stand-alone prescription drug plans should exclude stand-alone PDP data from their TME. Pharmacy data is to be reported gross of applicable rebates.

Advanced Network Tabs

Updates to TME Claims Category Definitions

- **Long-Term Care** *(no change)*: All TME data from claims to providers for nursing homes and skilled nursing facilities, intermediate care and assisted living facilities, and providers of home- and community-based services, including personal care, homemaker and chore services, home-delivered meal programs, home health services, adult daycare, self-directed personal assistance services, and programs designed to assist individuals with long-term care needs who receive care in their home and community.

- **Other** *(no change)*: All TME paid from claims to healthcare providers for medical services not otherwise included in other categories, including durable medical equipment, facility fees of community health services, freestanding ambulatory surgical center services, freestanding diagnostic facility services, hospice, hearing aid services and optical services.

Advanced Network Tabs

Updates to Categories of Non-Claims-based Spending to Report

- Carriers should report non-claims-based spending according to the following categories:
  - Payments to Support Population Health and Practice Infrastructure
  - Performance Payments ***[UPDATE]***
  - Shared Savings and Shared Risk Settlements ***[UPDATE]***
  - Capitation and Full Risk Payments ***[UPDATED NAME]***
  - Other
  - Total Primary Care Non-Claims Based Payments (*this category is the only category not mutually exclusive from the others*)

Advanced Network Tabs

Non-Claims Category Crosswalk

Previous Non-Claims Service Categories	Revisions Non-Claims Service Categories
Capitated, Prospective Global Budget, Prospective Case Rate, or Prospective Episode-Based Payments	Renamed to: Capitation and Full Risk Payments
Performance Incentive Payments	Revise and stratify into two categories: • Performance Payments • Shared Savings & Shared Risk Settlements
Payments to Support Population Health and Practice Infrastructure	No change
Provider Salaries	Moved to be captured under 'Other'
Recoveries	Remove; **claims spending should be reported as net of recoveries**
Other	'Provider Salaries' will now be included under 'Other'
Total Primary Care Non-Claims Based Payments	No change

Changes to Categories of Non-Claims-Based Spending to Report

- **Payments to Support Population Health and Practice Infrastructure** *(no change)*: Payments made to support the infrastructure and resources necessary for coordinating care, improving quality, and/or controlling costs. Includes, but is not limited to payments that support a) care management, care coordination, population health, medication reconciliation, b) primary care/behavioral health/social care integration, c) provider electronic health record (EHR)/health information technology (HIT) infrastructure and other provider data analytic payments, and d) patient-centered medical home recognition or practice transformation.

Advanced Network Tabs

Changes to Categories of Non-Claims-Based Spending to Report

- **Performance Payments *[UPDATE]***: Payments made to providers based on their performance on specific metrics, which could be related to quality of care, patient outcomes, or data reporting. Includes pay-for-performance, i.e., payments to reward providers for achieving a set target, and pay-for-reporting, i.e., payments to providers for reporting on a set of metrics, usually to build capacity for pay-for-performance, payments.

Advanced Network Tabs

Changes to Categories of Non-Claims-Based Spending to Report

- **Shared Savings and Shared Risk Settlements *[UPDATE]*:** Financial arrangements where providers are rewarded for achieving cost savings and/or quality goals for a defined set of services over a specific period. Providers may share in the savings generated or bear financial risk if costs exceed expectations. Payments under this category includes shared savings and shared risk settlements a) for fee-for-service episode-based contracts and b) for fee-for-service total cost of care contracts.

Advanced Network Tabs

Changes to Categories of Non-Claims-Based Spending to Report

- **Capitation and Full Risk Payments *[UPDATED NAME]*:** Payments made to providers on a per-patient basis, regardless of the amount of care the patient receives, with the provider assuming full financial risk. All non-claims-based payments for services delivered under the following payment arrangements: a) prospective episode-based payments that include full risk, b) capitation, c) prospective global budget payment with full risk, and d) full risk payments to integrated finance and delivery systems.

Advanced Network Tabs

Changes to Categories of Non-Claims-Based Spending to Report

- **Other *[UPDATE]*:** All other payments made pursuant to the insurer's contract with a provider not made on the basis of a claim for healthcare benefits/services and cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants or other surplus payments. Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME. Includes 'Provider Salaries.'

- **Total Primary Care Non-Claims-Based Payments** *(no change)*: All non-claims-based payments included in the previous six categories that are specifically made to a primary care provider or provider organization.

Advanced Network Tabs

No Changes to Risk Adjustment Methodology

- Carriers should still submit TME data as a non-adjusted value.
- Starting with 2019-2021 TME data, OHS risk-adjusted data by age/sex, rather than by using diagnosis-based risk scores.
- Carriers no longer need to submit clinical risk scores in the Advanced Network tab.

Advanced Network Tabs

Update to Truncation of Spending of High-Cost Outliers (1 of 3)

- Carriers will also submit truncated claims spending and the count of members with claims truncated, using truncation points set for each market.
- Truncation will be applied at the Carrier and Advanced Network levels.

Insurance Category Code	Definition	Per Member Truncation Point
1	Medicare Expenses for Non-Dual Eligible Members	$160,000 ***[UPDATE]***
2	Medicaid Expenses for Non-Dual Eligible Members	$250,000
3	Commercial: Full Claims	$190,000 ***[UPDATE]***
4	Commercial: Partial Claims	$190,000 ***[UPDATE]***
5	Medicare Expenses for Medicare/Medicaid Dual Eligible	$160,000 ***[UPDATE]***
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible	$250,000

Advanced Network Tabs

Update to Truncation of Spending of High-Cost Outliers (2 of 3)

- How to Apply Truncation:
  - Truncation should be applied to individuals' total spending, inclusive of all medical and pharmacy spending.
  - For Carriers reporting Insurance Category Code 4 (Commercial: Partial Claims), the member-level truncation should be applied after estimates of carve-out spending have been made.
  - For members who are attributed to more than one Advanced Network during the year, Carriers should "reset the clock" and calculate truncated spending for the member for each of the Advanced Networks, and for the Carrier as a whole *(see next slide for example).*

Advanced Network Tabs

Update to Truncation of Spending of High-Cost Outliers (3 of 3)

- Example of **"reset the clock" approach** when members are attributed to more than one Advanced Network during the year:

Example with a $160,000 truncation point:

- A member in Insurance Category Code 1 was attributed to Advanced Network X for 8 months with $200,000 in claims.
- The member is then attributed to Advanced Network Y for 4 months with $175,000 in claims.
- Advanced Network X's spending above the truncation would be $40,000 while Advanced Network Y's spending above the truncation would be $15,000.
- Since the member cost the payer $375,000 in total, the total dollars above the truncation point for the payer would be $215,000.

Advanced Network Tabs

No Changes to Pharmacy Rebate Tabs

- OHS will **separately collect medical and retail pharmacy** rebates from each carrier to recognize it as income to the carrier.
  - Data should include PBM rebate guarantee amounts or other PBM rebates transferred to carriers.
  - Insurers should apply IBNR factors to preliminary drug rebate data.
- Pharmacy rebates should be reported as a **negative number**.
- Pharmacy rebate data should exclude stand-alone prescription drug plans.
- Pharmacy rebates for Insurance Category Code 4 (Commercial Partial Claims) should be estimated where not available. Further instructions can be found in the Data Submission Guide.

Pharmacy Rebate Tabs

No Changes to Line of Business Enrollment by Market Tab

Line of Business Category Code	Definition
901	Individual
902	Large group, fully insured
903	Small group, fully insured
904	Self-insured
905	Student market
906	Medicare managed care
908	Medicare/Medicaid duals

- 2023-2024 data all collected in one tab
- The Line of Business Enrollment Tab is the source of some information to compute NCPHI:
  - Member months by line of business; and
  - Income from fees of uninsured plans (applies to self-insured only)
- Only members who are Connecticut residents should be reported in these data

Line of Business Enrollment Tab

No Changes to Standard Deviation Tabs

- Collecting standard deviation for the purposes of statistical testing
- Insurers should still calculate and submit standard deviation data:
  - For each Advanced Network, by market
  - For the Carrier Overall, by market
- Contains check for truncated spending alignment by market

Market Code	Description
1	Medicare (Insurance Category Codes 1 and 5)
2	Medicaid (Insurance Category Codes 2 and 6)
3	Commercial (Insurance Category Codes 3 and 4)

Standard Deviation Tabs

No Changes to Standard Deviation Tabs (Cont'd)

- Reminders about calculating standard deviation data:
  - Carriers should include all members attributed to an Advanced Network, including members with no utilization.
  - Standard deviation should be based on per-member-per-month (PMPM) spending.
  - Carriers should calculate the standard deviation PMPM after partial claims adjustments.
  - Non-claims expenditures should be excluded from the calculation.

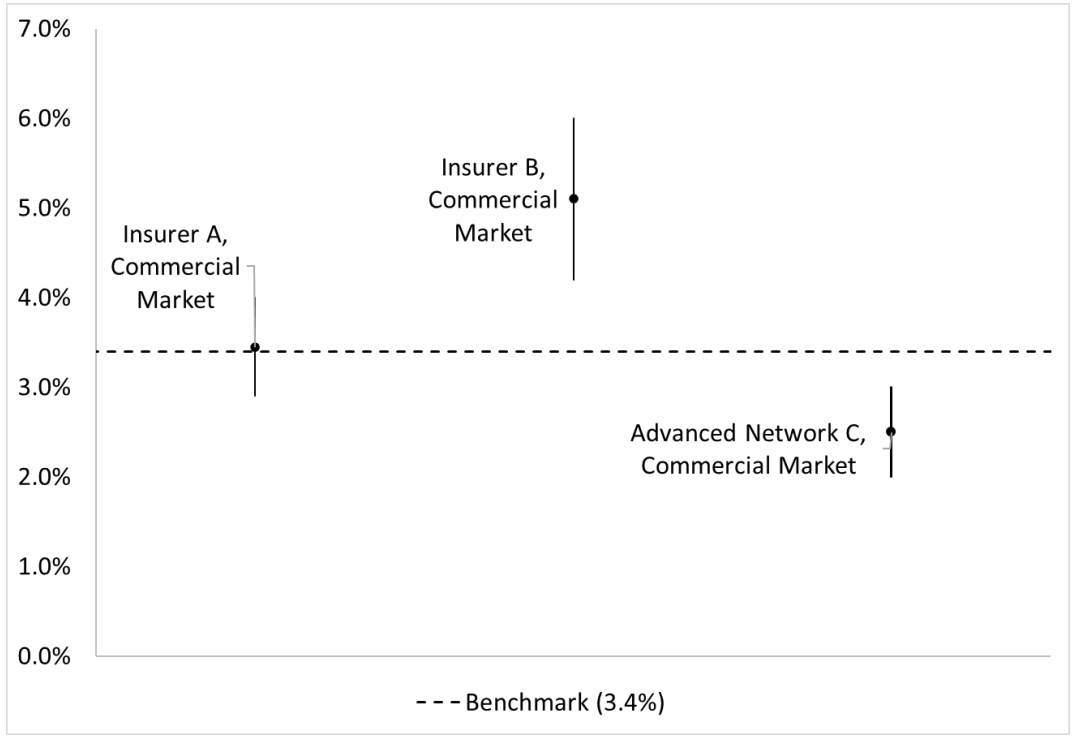
Standard Deviation Tabs

Determining Payer and Provider Entity Performance Against the Benchmark

- OHS uses the standard deviation data to conduct statistical testing to assess carriers' and provider entities' performance against the cost growth benchmark.
- This is done through the development of a "confidence interval" – an upper and lower bound – around each entity's cost growth.
  - A confidence interval is a type of estimate in statistics that shows a possible range of values in which we are fairly sure our true value lies.
  - In practice, it allows OHS to say, "We are 95% confident that the interval between A [lower bound] and B [upper bound] contains the true cost growth for entity C."

Standard Deviation Tabs

How OHS Uses Confidence Intervals to Determine Performance Against the Benchmark



- Performance against the benchmark is determined as follows:
  - Unable to determine performance when upper or lower bound intersects the benchmark (e.g., Insurer A)
  - Benchmark has not been achieved when lower bound is fully over the benchmark (e.g., Insurer B)
  - Benchmark has been achieved when the upper bound is fully below the benchmark (e.g., Advanced Network C)

Standard Deviation Tabs

No Changes to Age/Sex Factor Tabs

- The measurement of Carrier and Advanced Network performance against the Benchmark will be risk-adjusted by age and sex.
- Carriers will need to provide truncated TME data by age/sex bands in the new Age/Sex Factors tabs.
  - Contains check comparing truncated spending + excluded dollars to total spending before truncation

Age Band Code	Description
1	0 to 1 year old
2	2 to 18 years old
3	19 to 39 years old
4	40 to 54 years old
5	55 to 64 years old
6	65 to 74 years old
7	75 to 84 years old
8	85 + years old

Sex Code	Description
1	Female
2	Male

Age/Sex Factors Tabs

Changes to Data Attestation and Mandatory Questions

- Carriers will still attest to the accuracy of the data reported and answer a series of questions designed to ensure that the data reported are consistent with the requirements in the Data Submission Guide.

- New questions have been added regarding the completeness of Advanced Network attribution and non-claims capitation arrangements. ***[UPDATE]***

Mandatory Questions

Pre-Submission Data Validation

- Please review the Data Validation Tabs before submitting data.
- The Data Validation Tabs include:
  - Tables that allow payers to look at per member per month (PMPM) spending on service categories by market, and by Advanced Network by market.
  - Tables that show year-over-year trend data.
  - Checks for alignment across tabs for member months, overall spending, and PMPM spending by market, by service category by market, and by Advanced Network by market.

Data Validation

Data Collection, Validation and Reporting Process

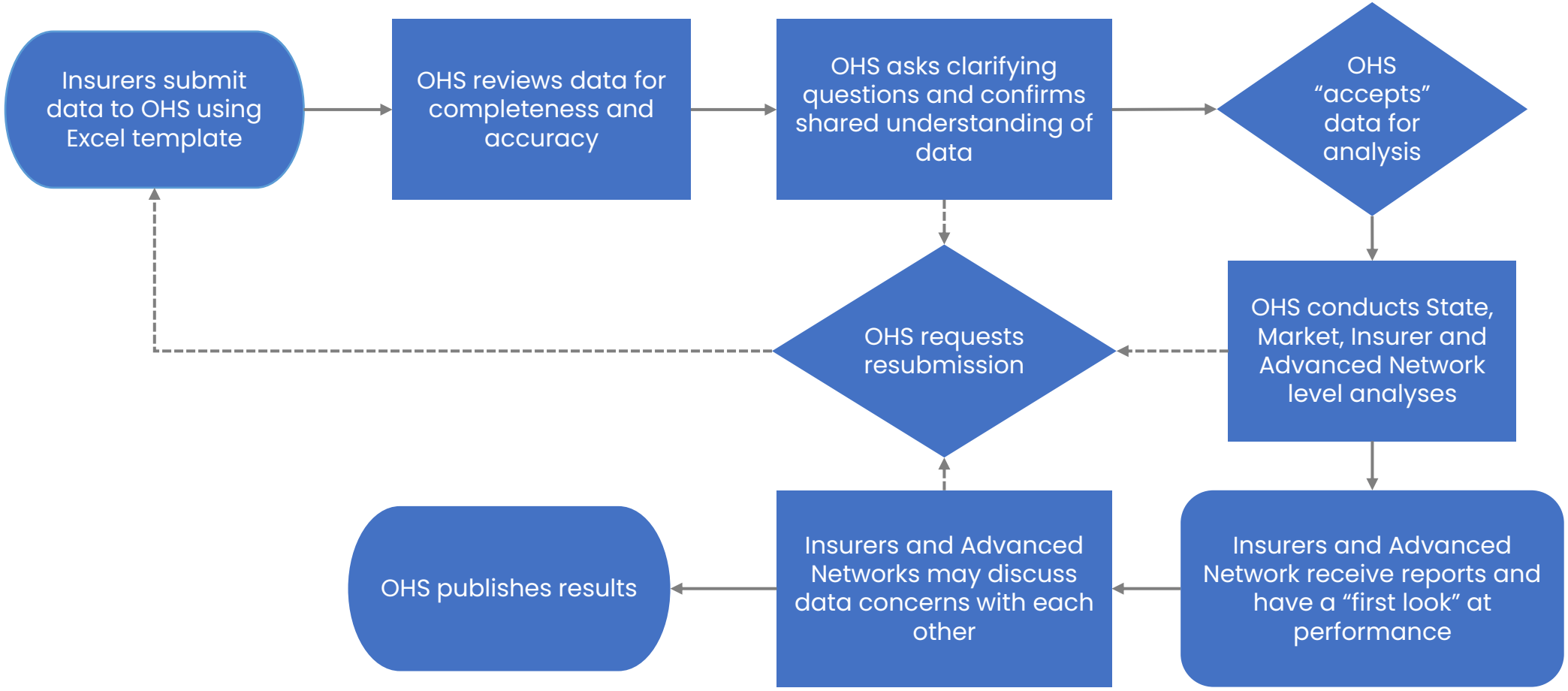
Due Date for Total Medical Expense Data

- This year, OHS is collecting data for CY2023 and CY2024.
- Data are due to OHS by August 15, 2025.
- Electronic files must be submitted through the State's secure file transfer server at https://sft.ct.gov

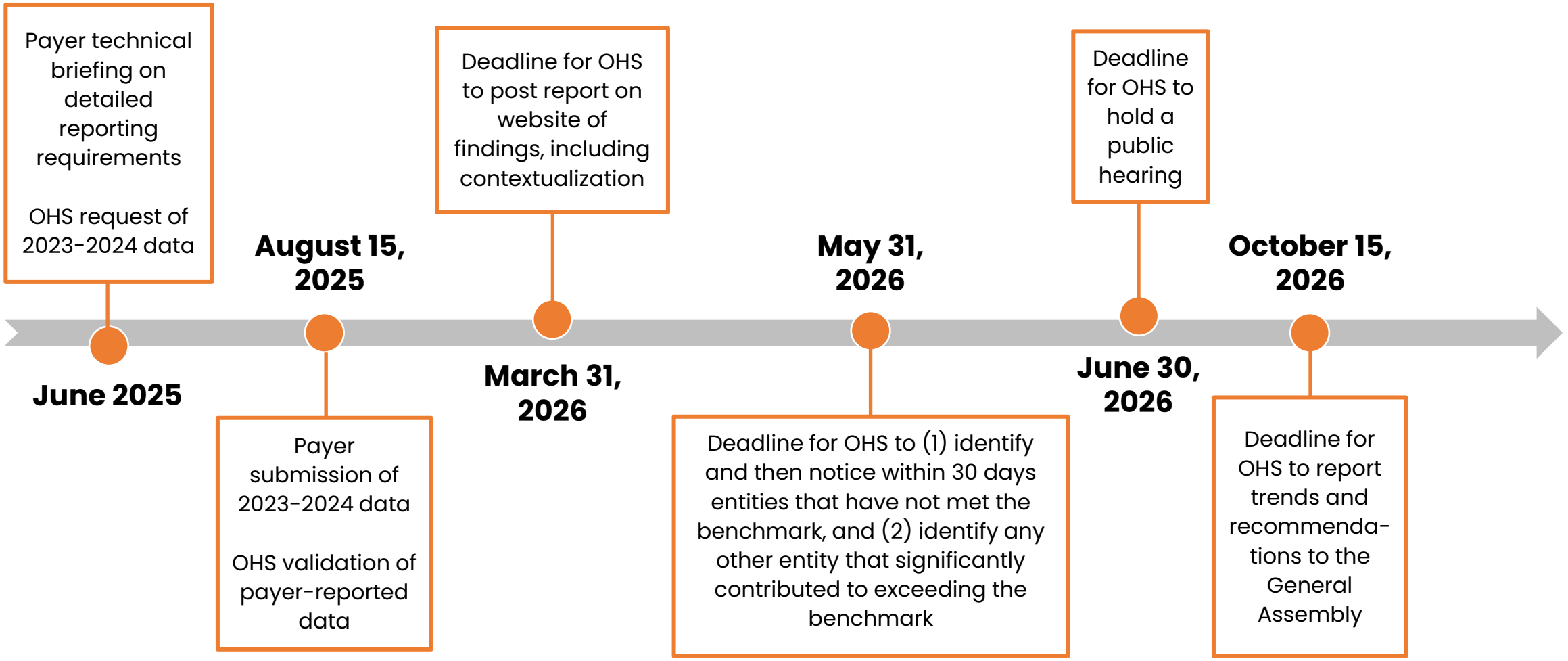
Data Collection, Validation and Reporting Process

- Similar to previous data collection cycles, OHS will work with payers to validate TME and primary care spending data. Payers can expect to hear from OHS:
    1. After the initial data submission to ensure data were submitted using specifications outlined in the Data Submission Guide and to review initial PMPM spending and trend by service category; and
    2. Once OHS aggregates payer and Advanced Network data to review payer data prior to publication.

Data Collection, Validation and Reporting Process (Cont'd)



Cost Growth Benchmark and Primary Care Spending Data Collection and Reporting Timeline



Office Hours

- Bailit Health and OHS will contact each insurance carrier to set up a time to answer questions and offer individualized guidance.
  - To coordinate additional sessions, please email Christopher Romero (cromero@bailit-health.com).
- Questions about the cost growth benchmark data request should be directed to Patty Blodgett (Patricia.Blodgett@ct.gov) and Christopher Romero (cromero@bailit-health.com).

Overview of Connecticut's Quality Benchmark Initiative

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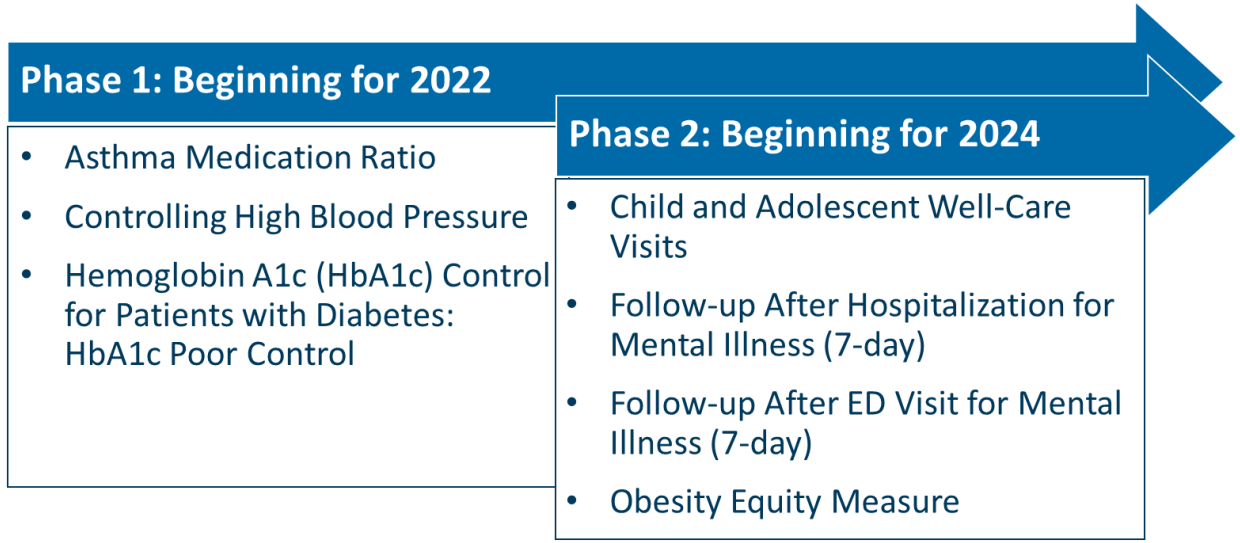
Overview of Connecticut's Quality Benchmarks

- In 2020, Governor Lamont signed Executive Order No. 5 directing OHS to develop annual Quality Benchmarks for CY 2022-2025.
- In 2021, OHS selected seven Quality Benchmark measures and Benchmark values for phased implementation, with guidance from the OHS Quality Council.
- In 2022, Connecticut General Statute 19a-754g et. Seq. codified Executive Order No. 5 into law and created new Quality Benchmark reporting requirements.



Quality Benchmark Data Request (1 of 2)

- In 2025, OHS is requesting 2024 performance data from payers for:
  - the three Phase 1 Quality Benchmark Measures, and
  - the three Phase 2 Quality Benchmark Measures **for the first time**.

Quality Benchmark Measure	Levels of Data Collection	
	Commercial	Medicare Advantage
1. **Asthma Medication Ratio**	Insurer; Advanced Network	NA
2. **Controlling High Blood Pressure**	Insurer; Advanced Network	Insurer; Advanced Network
3. **Glycemic Status for Patients with Diabetes > 9.0%**	Insurer; Advanced Network	Insurer; Advanced Network
4. **Child and Adolescent Well-Care Visits**	Insurer; Advanced Network	NA
5. **Follow-Up After ED Visit for Mental Illness (7-day)**	Insurer; Advanced Network	NA
6. **Follow-Up After Hospitalization for Mental Illness (7-day)**	Insurer; Advanced Network	NA

Quality Benchmark Data Request (1 of 2)

- In 2025, OHS is requesting 2024 performance data from payers for:
  - the three Phase 1 Quality Benchmark Measures, and
  - the three Phase 2 Quality Benchmark Measures **for the first time**.

Quality Benchmark Measure	Levels of Data Collection
	Medicaid
1. Asthma Medication Ratio	Market; Advanced Network
2. Controlling High Blood Pressure	Market
3. Glycemic Status for Patients with Diabetes > 9.0%	Market
4. Child and Adolescent Well-Care Visits	Market; Advanced Network
5. Follow-Up After ED Visit for Mental Illness (7-day)	Market; Advanced Network
6. Follow-Up After Hospitalization for Mental Illness (7-day)	Market; Advanced Network

Review of the Quality Benchmark Reporting Requirements

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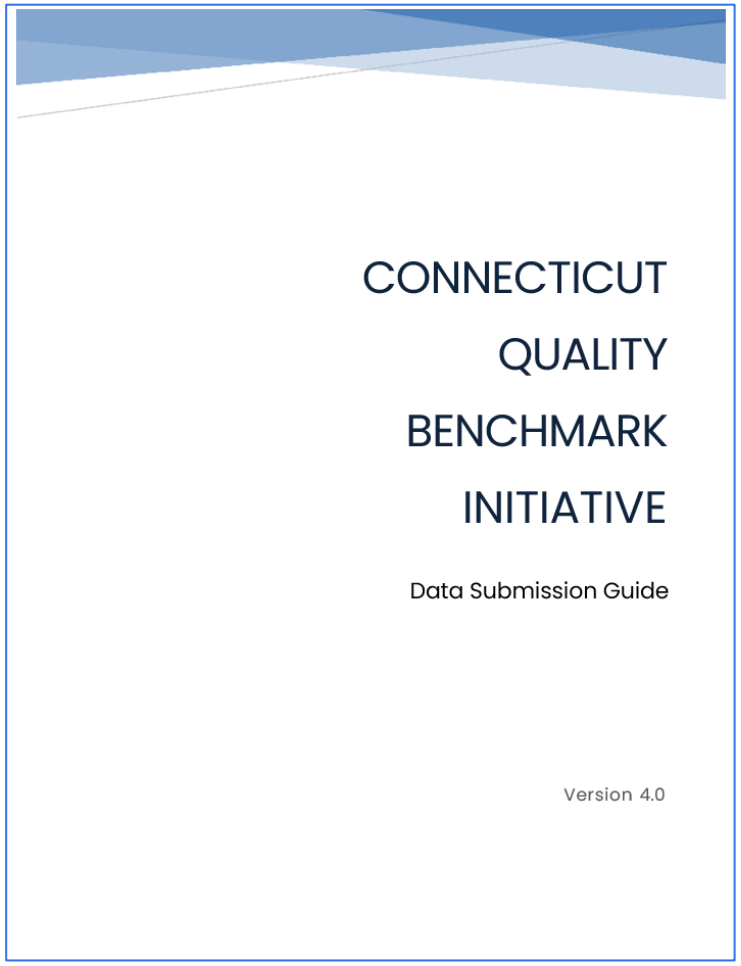
Quality Benchmark Data Submission Guide



- Comprehensive document that describes the:
  - overall initiative;
  - process for selecting, reviewing and updating Quality Benchmark measures and values.
- Contains data reporting specifications for commercial and Medicare Advantage carriers in Appendix A and for DSS in Appendix B.
- Guide and data submission template are posted on OHS' webpage.

Summary of Changes for CY 2024 Quality Benchmark Data Request

1. **Updated the Quality Benchmark measures and values as follows:**
    - Changed all references to *HbA1c Control for Patients with Diabetes*: *HbA1c Poor Control* to *Glycemic Status Assessment for Patients with Diabetes*: *Glycemic Status > 9.0%* in alignment with NCQA's specification changes for this measure for the 2024 performance year.
    - Added Phase 2 Quality Benchmarks, which will be assessed for the first time for CY 2024.
    - Noted that due to significant specification changes from NCQA for MY 2025, *Follow-Up After Emergency Department Visit for Mental Illness (7-day) and Follow-Up After Hospitalization for Mental Illness (7-day)* will not be reported against a benchmark value for MY 2025.

Summary of Changes for CY 2024 Quality Benchmark Data Request (Cont'd)

2. Updated specifications to reflect that payers should use **NCQA-HEDIS® MY 2024 specifications** for calendar year 2024 performance.

3. Clarified that for clinical data measures, if payers calculate performance using a sample rather than the full population, they should **explain how they determined the sample**.

4. Clarified that Quality Benchmark performance rates are **rounded to the nearest decimal point**.

5. Updated **Advanced Network names and organizational IDs.**

Insurance Carrier Quality Benchmark Reporting Template

Contents	List and description of tabs in carrier reporting template.
Reference Tables	Tables with Insurer Org IDs, Advanced Network Org IDs and measure specification summary.
Commercial - 2024	2024 Commercial Quality Benchmark performance at the insurer and Advanced Network levels.
Medicare Advantage - 2024	2024 Medicare Advantage Quality Benchmark performance at the insurer and Advanced Network levels.
Mandatory Questions	Basic carrier identifying information and checks on assumptions used for reporting the data.
Validation by Market	Summary tables that use insurer-level data to flag potentially aberrant rates and/or numerators and denominators.
Validation by Advanced Network	Summary tables that use Advanced Network-level data to flag potentially aberrant rates and/or numerators and denominators.

No Change to Insurance Carrier Organizations Required to Report Quality Benchmark Data

- The **Insurance Carrier Organizational IDs** are the OHS-assigned IDs for the carriers submitting the reporting template.

Carrier	Organizational ID	Commercial Fully and Self-Insured	Medicare Managed Care
Aetna Health & Life	201	X	X
Anthem	202	X	X
Cigna	203	X	
ConnectiCare	204	X	X
UnitedHealthcare	206	X	X
Wellcare	208		X

Reference Tables Tab

Updates to List of Advanced Networks

- The **Advanced Network Organization IDs** are the OHS-assigned IDs for the Advanced Networks that payers are requested to report on.
  - An **Advanced Network** is defined as an organized group of clinicians that come together for the purposes of contracting, or are an established billing unit that, at a minimum, includes primary care providers, and that collectively, during any given calendar year, has enough attributed lives to participate in total cost of care contracts, even if they are not engaged in a total cost of care contract.

Payers that **did not include a Quality Benchmark in contracts** with a given Advanced Network for MY 2024 **need not report MY 2024 performance** for that measure for that Advanced Network.

Note: The term "Advanced Network" as used in this manual is equivalent to the term "provider entity" as used in Connecticut General Statute 19a-754g et. Seq.

Reference Tables Tab

Updates to List of Advanced Networks (Cont'd)

Advanced Network Org ID	Advanced Network	Advanced Network Org ID	Advanced Network
101	Privia Quality Network of Connecticut (PQN CT) (formerly Community Medical Group)	118	Fair Haven Community Health Center
102	Connecticut Children's Care Network	119	Family Centers
103	Connecticut State Medical Society IPA	120	First Choice Community Health Centers
104	Hartford Healthcare Integrated Care Partners ***[UPDATE]***	121	Generations Family Health Center
105	NA	122	Norwalk Community Health Center
106	Northeast Medical Group	123	Optimus Health Care, Inc.
107	OptumCare Network of Connecticut (including ProHealth)	124	Southwest Community Health Center, Inc.
108	Prospect Connecticut Medical Foundation Inc. (dba Prospect Medical, Prospect Health Services, Prospect Holdings)	125	Stamford Health Medical Group
109	Southern New England Health Care Organization (aka SoNE Health) ***[UPDATE]***	126	Starling Physicians
110	Value Care Alliance	127	UConn Medical Group
111	NA	128	United Community and Family Services
112	Charter Oak Health Center	129	Summit Health (part of VillageMD) ***[UPDATE]***
113	CIFC Greater Danbury Community Health Center	130	Wheeler Clinic
114	Community Health and Wellness Center of Greater Torrington	131	Yale Medicine
115	Community Health Center	132	InterCommunity Health Care ***[NEW]***
116	Community Health Services	133	Trinity Health, Inc. ***[NEW]***
117	Cornell Scott Hill Health Center	134	Western Connecticut Health Network (WCHN) Physician Hospital Organization ***[NEW]***

Reference Tables Tab

Updates to List of Advanced Networks (Cont'd)

- Payers should not use OHS' TIN-based definition of Advanced Networks that is to be employed for reporting of Cost Growth Benchmark performance unless the TIN-based definition aligns with the insurer's value-based contract with the Advanced Network. ***[REMINDER]***

Reference Tables Tab

No Change to Performance Period Guidance

- **Performance Period Beginning and Ending Dates**: The dates for the beginning and ending of the period represented by the reported data.
  - OHS requests that payers submit data for the performance year **beginning January 1 and ending December 31** to remain consistent with the Healthcare Cost Growth Benchmark and the payer measurement period reporting to NCQA.

> **Carriers with contracts that do not align with the calendar year** should still submit performance but indicate performance period start and end dates in their data submission. If the performance period bridges the calendar year, carriers should use the contract period that ended in the calendar year being requested (e.g., the period ending in 2024 for MY 2024 performance).

Commercial/Medicare – 2024 Tabs

Update to Submission of Numerator and Denominator Data

- **Numerator and Denominator Data:** Commercial and Medicare Advantage numerator and denominator data at the insurance carrier and Advanced Network levels following the specifications for the Quality Benchmark measures.
  - These tabs were only updated to incorporate the Phase 2 Quality Benchmark measures and new Advanced Networks.

Commercial/Medicare – 2024 Tabs

Update to Mandatory Questions Tab

- Carriers will now be asked to indicate whether the data submitted for *Controlling High Blood Pressure* and *Glycemic Status Assessment for Patients with Diabetes: Glycemic Status > 9.0%* represent the full population or a sample, and if a sample is used, carriers should indicate how the sample(s) was determined. **[NEW]**
  - Carriers should not submit performance for clinical data measures calculated using only administrative data.

Mandatory Questions

Update to Data Validation Tabs

- The **Validation by Market** and **Validation by Advanced Network** tabs use data submitted in the Commercial and Medicare Advantage tabs to summarize performance and flag potentially aberrant rates and numerator/denominators.
  - These tabs were only updated to incorporate the Phase 2 measures and new Advanced Networks.
- Be sure to review the Data Validation Tabs before submitting data.

Note: The data validation tabs will not populate unless the Insurer Org ID has been correctly inputted in the Mandatory Questions tab.

Data Validation Tabs

Data Collection, Validation and Reporting Process

Due Date for Quality Benchmark Data

- This year, OHS is collecting 2024 data.
- Data are due to OHS by August 15, 2025.
- Electronic files must be submitted through the State's secure file transfer server at https://sft.ct.gov

Data Collection, Validation and Reporting Process

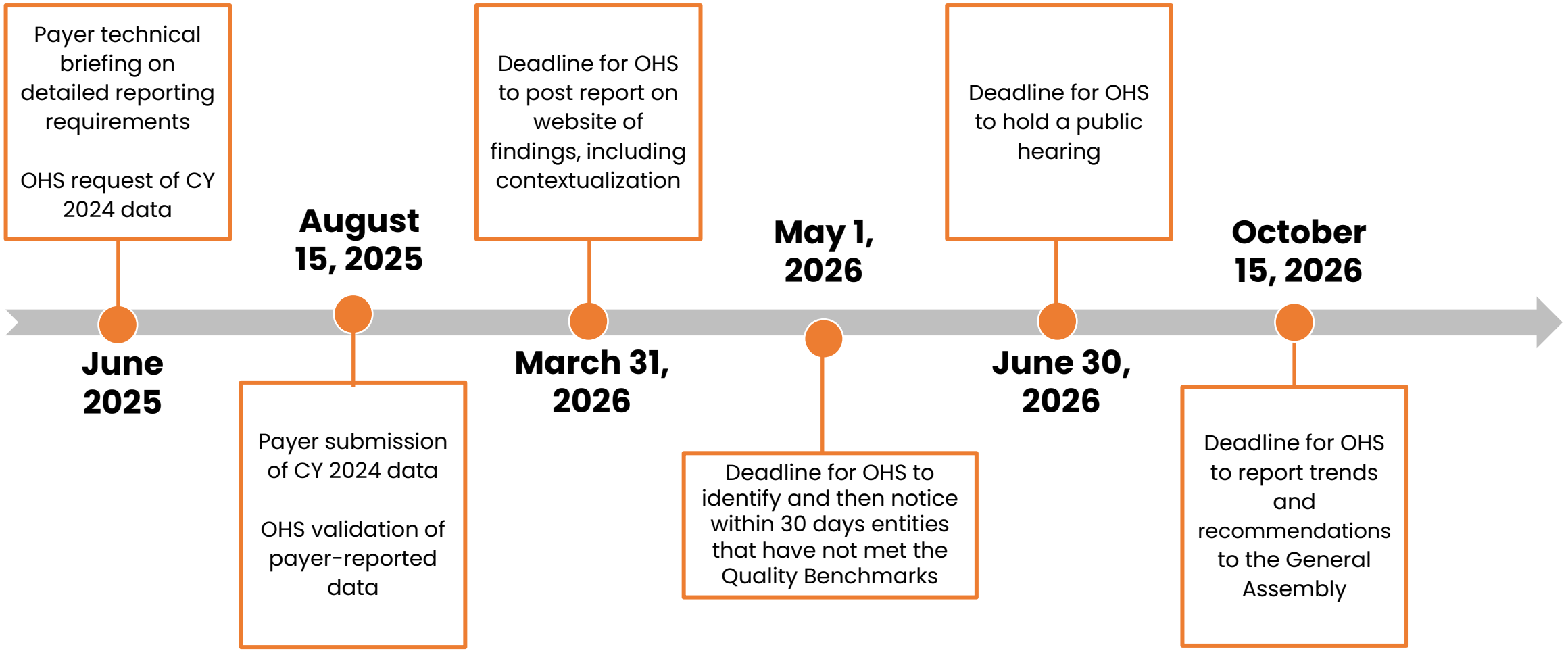
- Similar to the Cost Growth Benchmark data collection process, OHS will work with payers to validate Quality Benchmark performance data. Payers can expect to hear from OHS:
    1. After the initial data submission to ensure data were submitted using specifications outlined in the Data Submission Guide; and
    2. Once OHS aggregates payer and Advanced Network data to review payer data prior to publication.

Data Collection, Validation and Reporting Process (Cont'd)

- For 2024 Quality Benchmark performance data, OHS will once again report performance at the **market, insurer and Advanced Network** levels, following a specific timeline as required by Connecticut General Statute 19a-754g et. Seq.(see following slide).

- **Minimum Denominator Size for Public Reporting:** At the insurer and Advanced Network-levels, OHS will not report performance for measures with denominators less than 30 (less than 30 aggregated across insurers for Advanced Network performance), consistent with NCQA's minimum denominator size for its Effectiveness of Care measures.

Quality Benchmark Data Collection and Reporting Timeline



Questions

- Payers may use cost growth benchmark office hours to discuss Quality Benchmark questions or arrange a separate date/time to meet.
- Any additional questions should be directed to Lisa Sementilli (lisa.sementilli@ct.gov) and Matt Reynolds (mreynolds@bailit-health.com).