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Advanced Network Webinar on Cost Growth Benchmark and Quality Benchmarks

Today's Agenda

1. Cost Growth Benchmark Initiative
   a) Introduction and Purpose
   b) Data Collection Overview and Timeline
2. Quality Benchmarks Initiatives
   a) Introduction and Purpose
   b) Data Collection Overview and Timeline
3. Questions

Cost Growth Benchmark Initiative: Introduction and Purpose

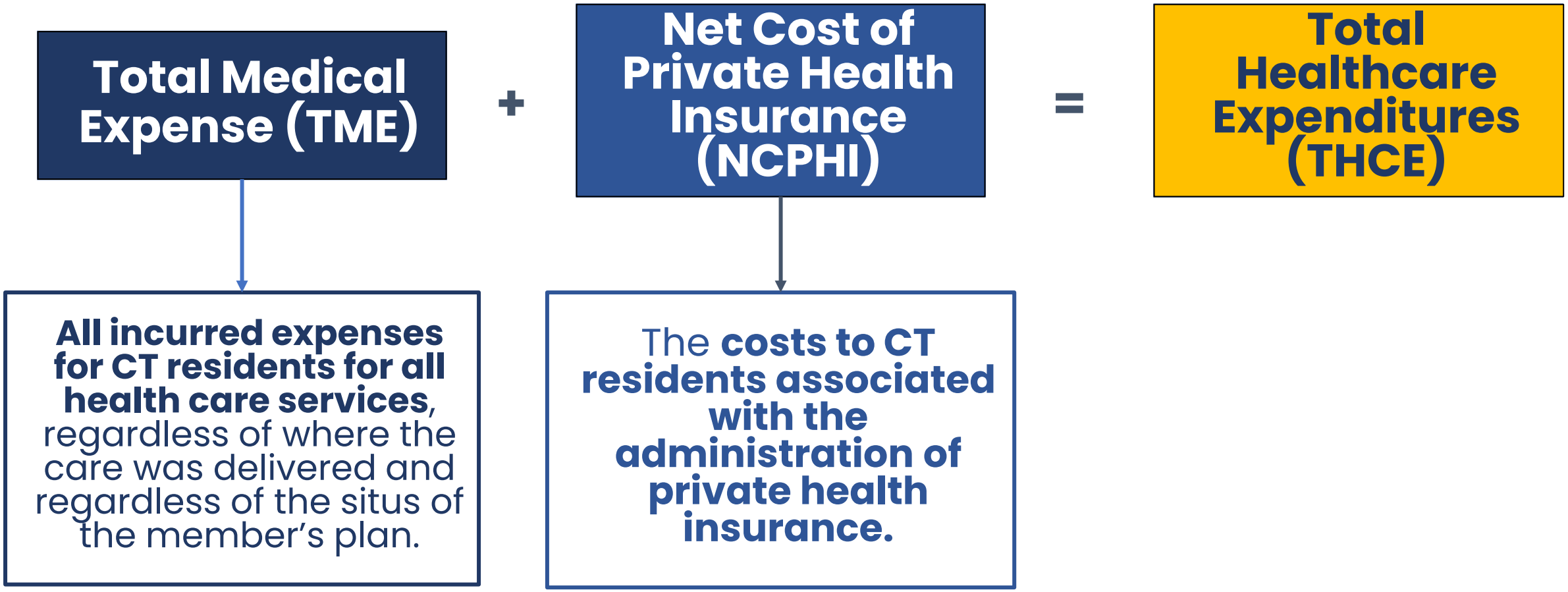
Connecticut's Healthcare Cost Growth Benchmark

Calendar Year	Benchmark Values
2021	3.4%
2022	3.2%
2023	2.9%
2024	**4.0%***
2025	2.9%
2026-2030	2.8%

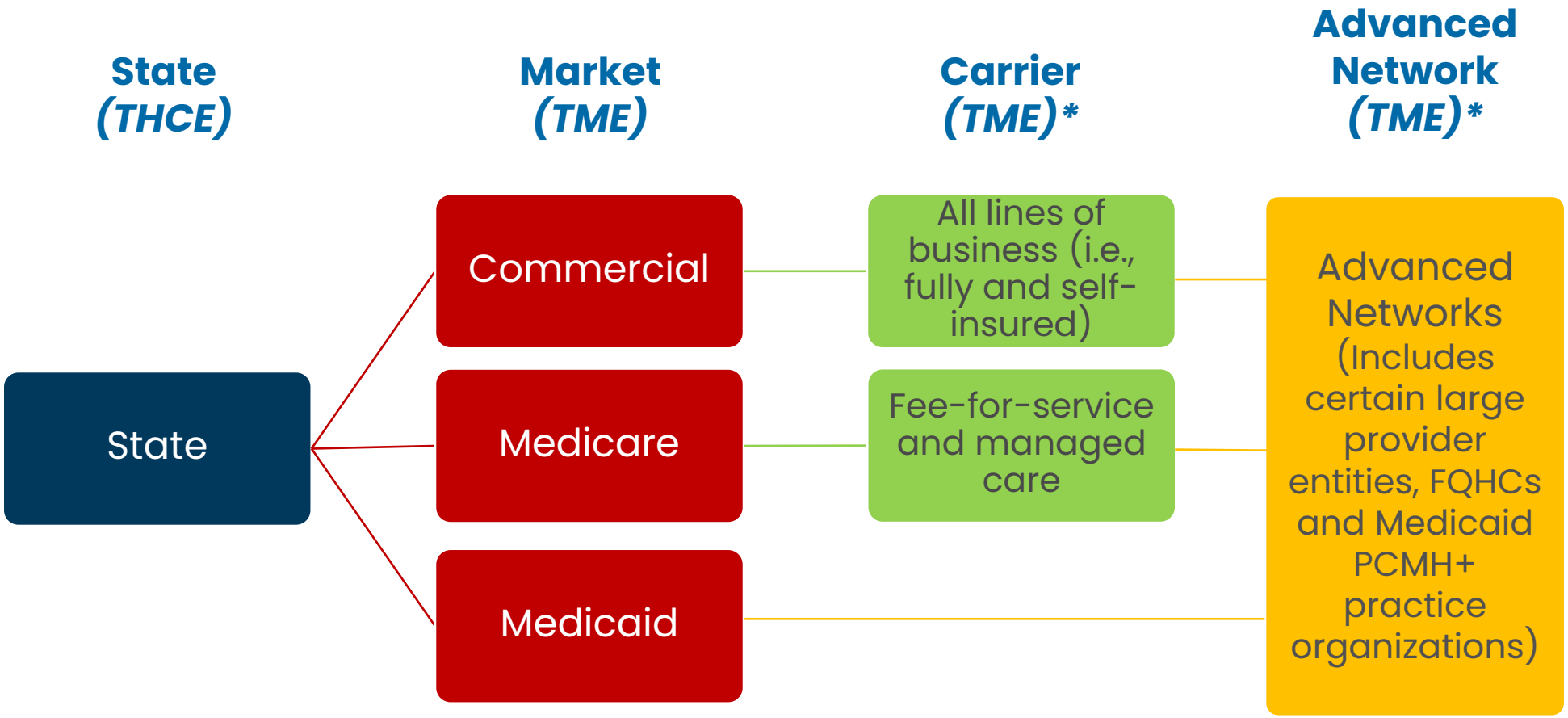
- Connecticut's cost growth benchmark is a target **annual rate-of-growth** for per person healthcare spending.
- The benchmark values are based on a blend of forecasted per capita potential gross state product (PGSP) and forecasted growth in median income.

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

Total Health Care Expenditures



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



**OHS will only publicly report on Carriers 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

Payer*	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.

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	120	First Choice Community Health Centers
103	Connecticut State Medical Society IPA	121	Generations Family Health Center
104	Hartford Healthcare Integrated Care Partners	122	Norwalk Community Health Center
105	NA	123	Optimus Health Care, Inc.
106	Northeast Medical Group	124	Southwest Community Health Center, Inc.
107	Senior Care 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)	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	Wheeler Clinic
113	CIFC Greater Danbury Community Health Center	131	Yale Medicine
114	Community Health and Wellness Center of Greater Torrington	132	InterCommunity Health Care
115	Community Health Center	133	Trinity Health, Inc.
116	Community Health Services	134	Western Connecticut Health Network (WCHN) Physician Hospital Organization
117	Cornell Scott Hill Health Center	**999**	**Members Not Attributed to an Advanced Network**

Cost Growth Benchmark Initiative: Data Collection Overview and Timeline

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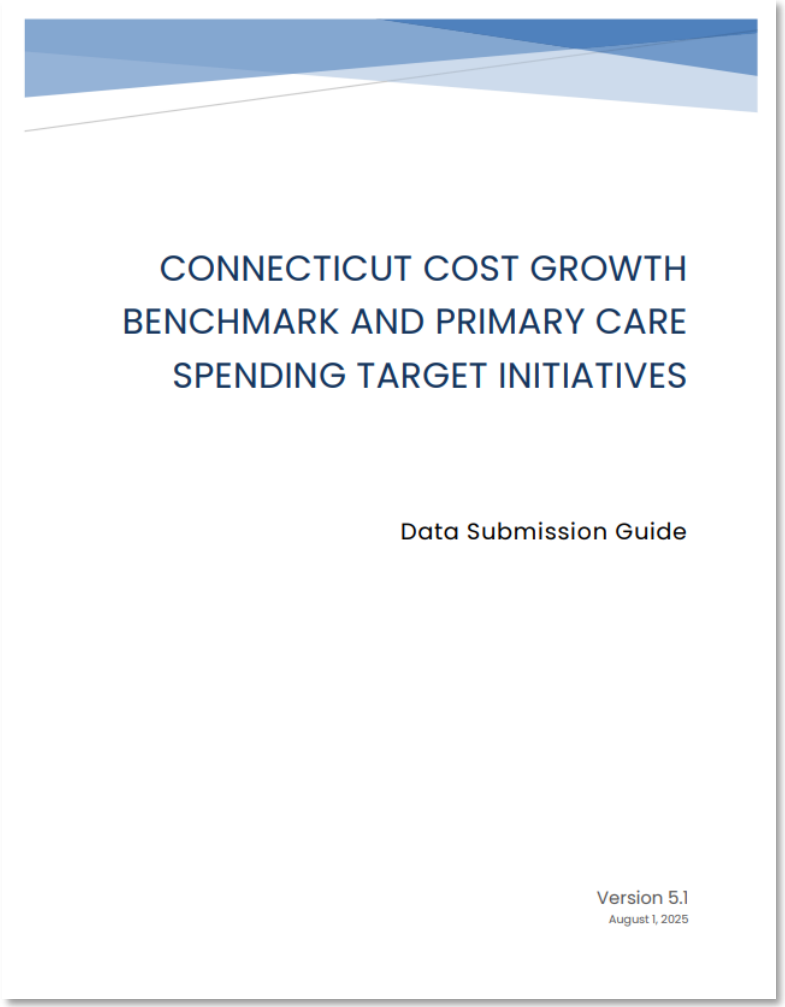
Cost Growth Benchmark and Primary Care Spending Target Data Submission Guide



- 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.
- Guide and data submission templates are posted on OHS' webpage.

Advanced Network Member Attribution (Slide 1 of 2)

- To report spending at the Advanced Network level, members are attributed to a primary care physician (PCPs), and PCPs are attributed to an Advanced Network.
  - Member attribution to Advanced Networks follows the tiered hierarchy approach (described on the next slide).
  - Payers received Taxpayer Identification Numbers (TINs) for Advanced Networks for attribution purposes.
  - Each member may only be attributed through a single methodology to one Advanced Network for a given calendar month.
- All spending on members is reported under the Advanced Network to which the members' PCP is attributed.

Advanced Network Member Attribution (Slide 2 of 2)

- In addition to reporting spending by Insurance Category Code and Advanced Network, the data request included 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.

Taxpayer Identification Numbers (TINs)

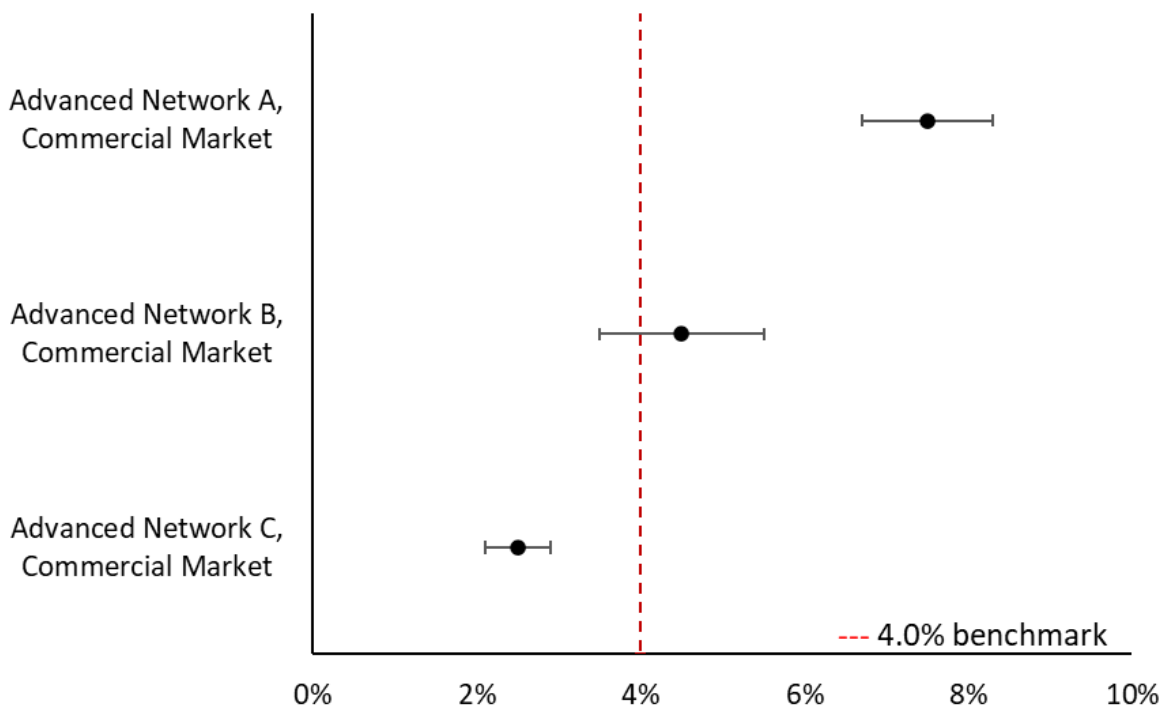
- OHS contacts each Advanced Network early in each calendar year to request the Taxpayer Identification Number(s) (TIN(s)) of their primary care providers for the two prior calendar years.
  - For example, in January 2026, OHS will request TINs for calendar years 2024 and 2025. TINs are provided by market and applicable timeframe.
- OHS follows up with an Advanced Network if any reported TIN overlaps with those of another Advanced Network to remove duplications.
- Guidance provided to payers on the use of TINs can be found in the Cost Growth Benchmark Program's data submission guide: HCBI Guidance for Payers and Providers.

Assessment of Advanced Network Performance Against the Benchmark (Slide 1 of 2)

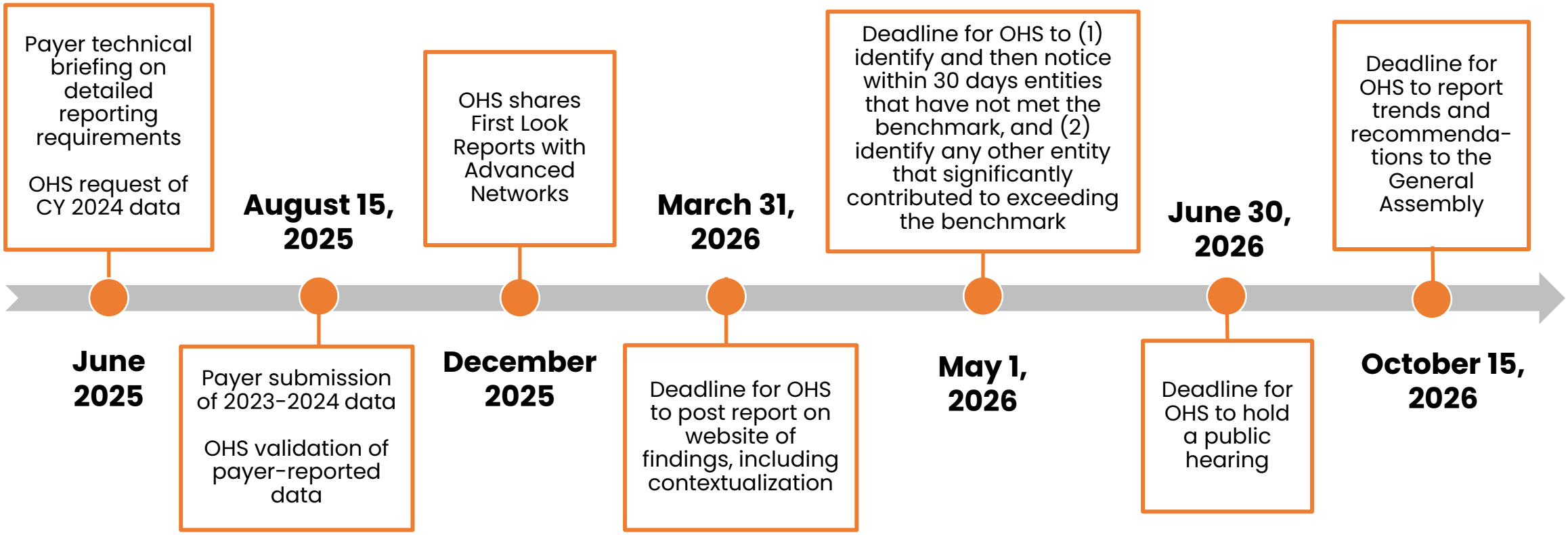
- OHS assesses Advanced Network spending using a per-member-per-month (PMPM) measure.
  - Spending growth is age/sex adjusted for changes in each Advanced Network's attributed patient population's age and sex composition using data provided by payers.
  - Statistical testing is performed to assess Advanced Network performance against the benchmark (more information on next slide).
- OHS publicly reports Advanced Network performance against the benchmark for a given market (e.g., commercial, Medicaid, Medicare) **only if an Advanced Network had more than 60,000 member months (or 5,000 member lives) attributed in both the baseline year and the performance year for that market.**

Assessment of Advanced Network Performance Against the Benchmark (Slide 2 of 2)

- A confidence interval is constructed around each Advanced Network's spending using statistical data submitted by payers.
  - If the lower bound of the confidence interval exceeds the benchmark, the entity is determined to have exceeded the benchmark. (A)
  - If the upper bound is below the benchmark, the entity is considered to have met the benchmark. (C)
  - If the benchmark value falls within the confidence interval, the entity's performance relative to the benchmark cannot be determined. (B)



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



Advanced Network First Look Reports

- Advanced Networks will receive a First Look report in mid-December.
  - These contain data on Advanced Network performance against the benchmark by market, attributed members by market, and service category contributions to spending growth.
  - This year, OHS will also include information on an Advanced Network's spending by attribution hierarchy tier.
- Please note that data contained in "First Look" reports **may differ** from data received from payers in medical cost reports.
  - Factors that contribute to these differences: the exclusion of members in self-funded plans by some payers, the exclusion of non-Connecticut residents, and the inclusion of members attributed through utilization.
- If Advanced Networks have **questions about payer-reported data**, OHS encourages them to reach out directly to their payer representatives. OHS will provide contacts for payer personnel involved in the cost growth benchmark reporting.
  - If Advanced Networks would like support in their communications with payers, OHS can serve as a point of contact and facilitate conversations between Advanced Networks and payers.

Questions?

- Questions about the cost growth benchmark initiative should be directed to Patty Blodgett (patricia.blodgett@ct.gov) and Christopher Romero (cromero@bailit-health.com).

Quality Benchmarks Initiative: Introduction and Purpose

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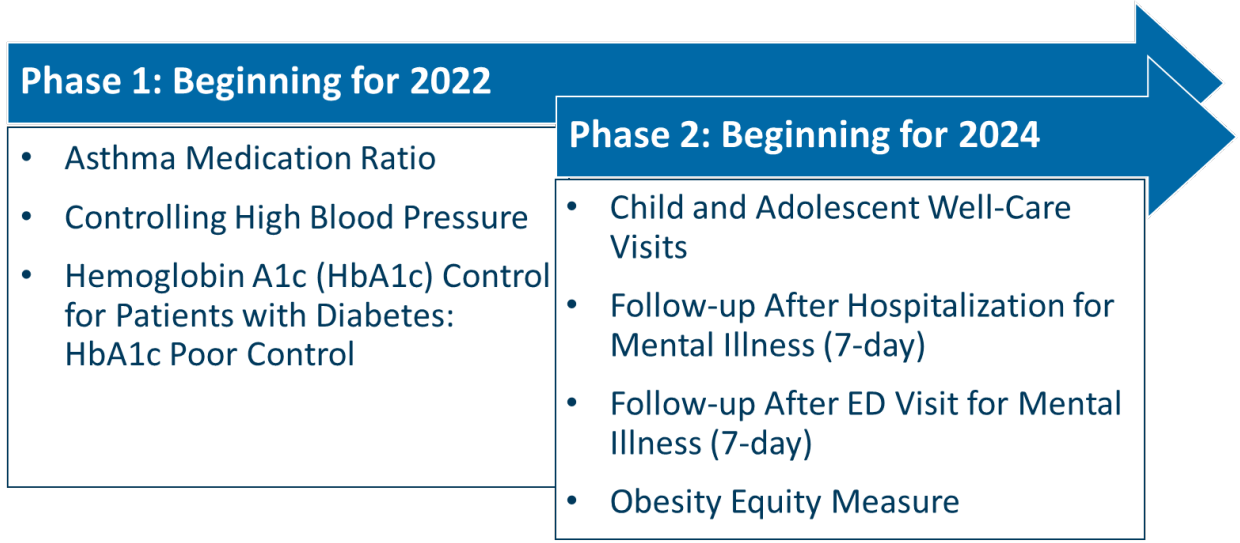
Overview of Connecticut's Quality Benchmarks

- 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 (Slide 1 of 2)

- In 2025, OHS requested 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 (Slide 2 of 2)

- In 2025, OHS requested 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

Quality Benchmarks Initiative: Data Collection Overview and Timeline

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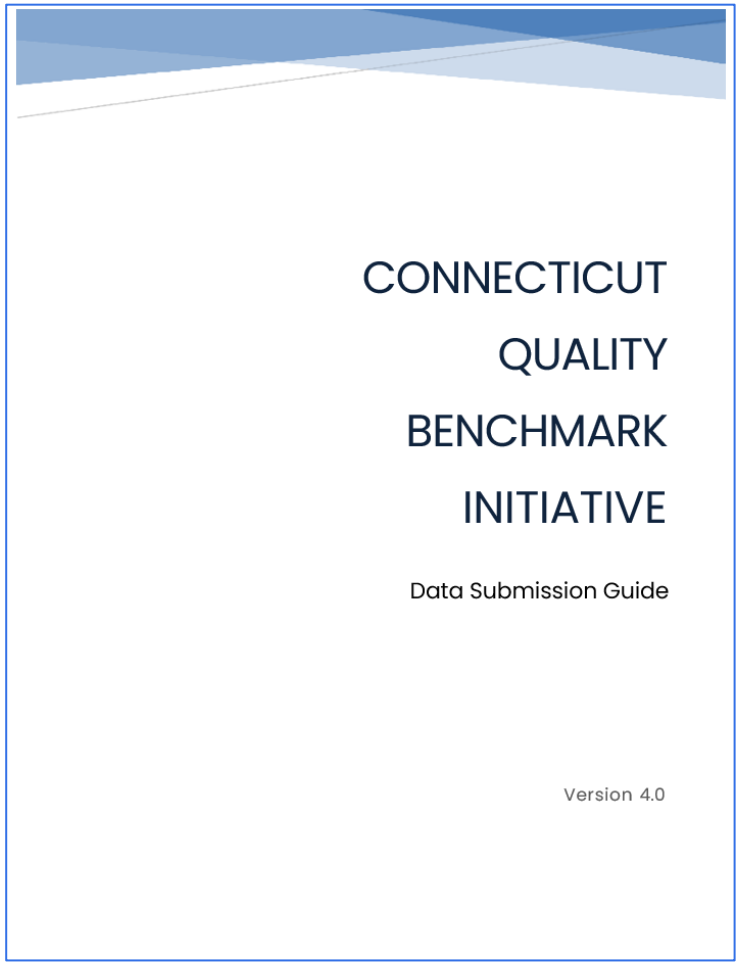
Quality Benchmark Data Submission Guide



- Comprehensive document that describes the:
  - overall initiative;
  - process for selecting, reviewing and updating Quality Benchmark measures and values.
- Contains the data reporting specifications used by commercial and Medicare Advantage carriers in Appendix A and for DSS in Appendix B.
- The data submission guide can be found on OHS' webpage.

Summary of Changes for CY 2024 Quality Benchmarks

1. All references to *HbA1c Control for Patients with Diabetes*: *HbA1c Poor Control* have been changed 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.

2. **Phase 2** Quality Benchmarks will be assessed for the first time for CY 2024.

3. As a point of clarification, OHS noted that Quality Benchmark performance rates are rounded to the nearest decimal point.

4. Some Advanced Network names and organizational IDs have been updated.

Key Notes for Advanced Networks (Slide 1 of 2)

- Payers are asked to only report Advanced Network-level performance for a Quality Benchmark measure **if the measure was included in the payer's contract with an Advanced Network for the given performance year.**

- For clinical data measures, payers are asked **not to submit** performance for clinical data measures calculated using **only administrative data** (i.e., without supplemental clinical data).
  - OHS conducts reasonable checks and omits any payer-submitted data where Advanced Network performance appears too poor to include clinical data.

Key Notes for Advanced Networks (Slide 2 of 2)

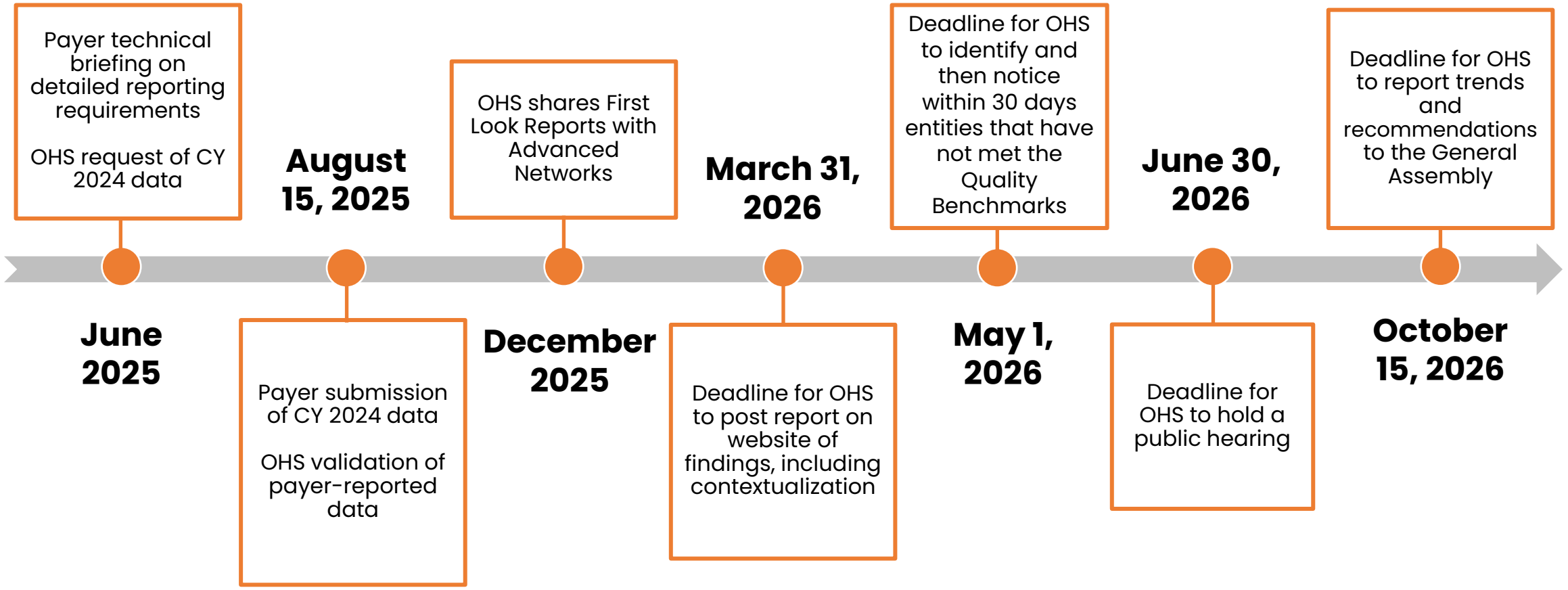
- OHS will **not report** Advanced Network-level performance for **measures with denominators less than 30** (after aggregating data across insurers), consistent with NCQA's minimum denominator size for its Effectiveness of Care measures.

- Unlike for the Cost Growth Benchmark, Quality Benchmark data may include **all patients** attributed to an Advanced Network, including those who reside outside of Connecticut.

Data Collection, Validation and Reporting Process

- Similar to the Cost Growth Benchmark data collection process, OHS works with payers and providers to validate Quality Benchmark performance data. This includes:
    1. Follow-up with payers after the initial data submission to ensure data were submitted using specifications outlined in the Data Submission Guide; and
    2. Pre-publication payer and provider review of performance results following data aggregation and analysis.

Quality Benchmark Data Collection and Reporting Timeline



Questions

- ANs may email OHS with questions and/or to arrange a date/time to meet.
- Emails should be directed to Lisa Sementilli (lisa.sementilli@ct.gov) and Matt Reynolds (mreynolds@bailit-health.com).