CONNECTICUT

Healthcare Cost Growth Benchmark
Technical Team Meeting #5
January 27, 2025

I. Welcome

Meeting Agenda

Time	Topic
10:30 a.m.	I. Welcome
10:30 a.m.-12:20 p.m.	II. Primary Care Spending Target A. Review of Connecticut's primary care spending target initiative B. Current data source used to measure primary care spending C. Defining and calculating primary care spending as percentage of total spending
12:20 p.m.	III. Public Comment
12:25 p.m.	IV. Wrap-Up and Next Steps
12:30 p.m.	V. Adjournment

II. Connecticut's Primary Care Spending Target

Primary Care Spending Target

Technical Team charge: Establish primary care spending targets across all payers and populations as a share of total health care expenditures for CYs 2026-2030

Let's now review Connecticut's primary care spending target initiative.

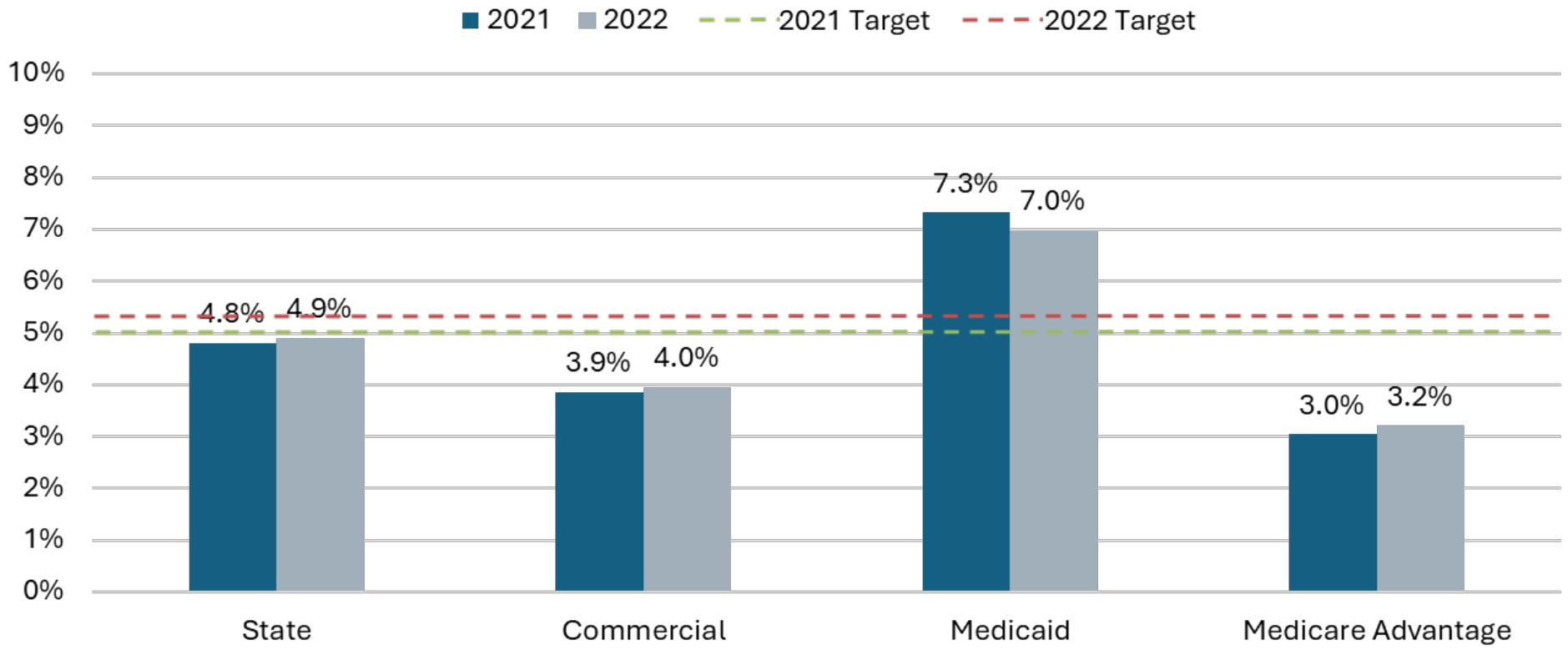
- Current data source used to measure primary care spending
- Experience of other states with primary care spending targets
- Defining and measuring primary care spending as a percentage of total spending

Connecticut's Primary Care Spending Target

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

- Connecticut's current primary care spending target aims to **increase primary care spending to 10 percent of total healthcare expenditures by 2025**.
- The target is intended to rebalance and strengthen Connecticut's healthcare system by supporting primary care.

State and Market Performance Against the Primary Care Spending Target



Data Source: OHS collected data from insurance carriers and from the Connecticut Department of Social Services (DSS).
Notes: Data are not risk adjusted. Data are net of pharmacy rebates. Data include commercial, Medicare Advantage and Medicaid FFS spending. TME includes all of the spending categories captured for the cost growth benchmark, less long-term care.

Data Source Used to Measure Primary Care Spending in Connecticut

- OHS collects primary care spending data (claims and non-claims) directly from payers as part of the cost growth benchmark data submission process
  - OHS only measures commercial, Medicare Advantage, and Medicaid primary care spending.
  - OHS anticipates collecting primary care spending for Medicare fee-for-service under the new AHEAD model.
- OHS relies on payer data for this effort – not the APCD – in order to obtain non-claims payments, self-insured data, and pharmacy rebates (the latter to net out of the denominator).

Primary Care Spending Targets in Other States

State	Description of Approach	Target Value
California	Payer-specific increase relative to prior year ("improvement"), then an absolute target.	+0.5 to 1 percentage point annually through 2033; 15% by 2034
Connecticut	Absolute targets, increased annually from 2021-2025.	10% in 2025
Colorado	Payer-specific increase relative to prior year.	1% annually
Delaware	Absolute targets, increased annually from 2022-2025.	11.5% in 2025
Oregon	Fixed absolute target.	12%
Rhode Island*	Fixed absolute target.	10% (2025+)

*Proposed rules for a revised target beginning in 2025.
Important note: These states define primary care spending in varying ways, so rates are not comparable.

Calculating Spending on Primary Care

- We will discuss components of the numerator (primary care spending) and denominator (total spending) to determine the percentage of spending allocated to primary care.

1

$$\frac{\text{Primary care service payments (i.e., claims)} + \text{Primary care non-service payments (i.e., non-claims)} = \text{Total primary care spend}}{\text{Total claims-based payments} + \text{Total non-claims-based payments} = \text{Total spending}} \times 100\% \rightarrow \textbf{Primary care spending as a percentage of total spending}$$

What is Primary Care?

- Defining primary care spending for the purposes of setting a spending target involves several key design questions:

    1. Who are “primary care providers”?
    2. What services are considered “primary care services”?
    3. What constitutes “primary care payments”?

- We will review each of these questions and the definitions OHS adopted upon the recommendations of the predecessor Technical Team in 2020.

OHS Current Focus of Primary Care

- OHS uses a "narrow" definition to assess performance relative to the target, as well as a "broad" definition for supplemental analysis.

	Narrow Definition	Broad Definition
Purpose	• **OHS uses this definition to measure performance against the Primary Care Target.** • Focuses on primary care services delivered by traditional primary care specialties. • This definition does *not include OB/GYN or midwifery in its definition of a primary care provider or include services typically performed by them* in the definition of services.	• To more broadly measure primary care spending beyond the Primary Care Target definition, recognizing that many women utilize OB/GYN or midwifery services for primary care. • This definition *includes OB/GYNs and midwives and routine primary care and non-specialty gynecological services they* delivered in the definition.

Who are “primary care providers”?

- OHS characterizes primary care providers as clinicians who deliver *comprehensive, continuous, routine care*.

Who are "primary care providers"?

	Narrow Definition (adopted by OHS)	Broad Definition
Included Providers (in outpatient settings)*	• MDs and DOs: Internal Medicine when practicing primary care, Family Medicine, Pediatric and Adolescent Medicine, Geriatric Medicine when practicing primary care • NPs and PAs: when practicing primary care	• MDs and DOs: Internal Medicine when practicing primary care, Family Medicine, Pediatric and Adolescent Medicine, Geriatric Medicine when practicing primary care, OB/GYN and midwifery • NPs and PAs: when practicing primary care
Excluded Providers (among others)	• OB/GYN and midwifery • Behavioral health provider • Emergency room physician • Naturopathic health care provider	• Behavioral health provider • Emergency room physician • Naturopathic health care provider

*Including but not limited to private practices, primary care clinics, FQHCs and school-based health centers. Also, telehealth and home visits, as noted in the next slide.

What services are considered "primary care services"? *Included services*

	Narrow Definition (adopted by OHS)	Broad Definition
Included Services	• Office or home visits • General medical exams • Routine adult medical and child health exams • Preventive medicine evaluation or counseling • Telehealth visits • Administration and interpretation of health risk assessments • Behavioral health risk assessments, screening, and counseling, if performed by a PCP • Immunizations • Hospice care • Preventive dental care and fluoride varnish • Pediatric dental risk assessments • Home visits for newborns • Routine, non-specialty gyn. services, if performed by a PCP	• Office or home visits • General medical exams • Routine adult medical and child health exams • Preventive medicine evaluation or counseling • Telehealth visits • Administration and interpretation of health risk assessments • Behavioral health risk assessments, screening, and counseling, if performed by a PCP • Immunizations • Hospice care • Preventive dental care and fluoride varnish • Pediatric dental risk assessments • Home visits for newborns • Routine, non-specialty gyn. services, if performed by a PCP • Routine primary care and non-specialty gynecological. services delivered by OB/GYNs and midwifery

What services are considered "primary care services"? *Excluded services*

	Narrow Definition (adopted by OHS)	Broad Definition
Excluded Services	• Routine primary care and non-specialty gynecological services delivered by OB/GYNs and midwifery • Minor outpatient procedures • Inpatient care • ED care • Urgent care • Nursing facility care • Practice-administered pharmacy	• Minor outpatient procedures • Inpatient care • ED care • Urgent care • Nursing facility care • Practice-administered pharmacy

What constitutes “primary care payments”?

- OHS’ current definition of primary care payments divides this question into two questions:
    1. How to define “service payments”?
    2. How to define “non-service-based payments”?

How to define “service payments”?

- Payments for primary care services can be based on paid medical claims or allowed medical claims.
- Currently, OHS requires payers to calculate primary care service payments using allowed claims to capture both patient out-of-pocket and payer spending.

Option	Rationale
Paid	Captures the ***spending amount which health plans can control***. A spending target focused on paid claims, therefore, can be focused on influencing plan investments in primary care.
Allowed *(OHS adopted)*	Captures **total primary care spending**. This is important given the sharp rise in consumer cost-sharing in commercial plan designs over the past two decades.

How to define “non-service payments”?

- OHS requires that payers report the following non-claims-based payment categories made to a primary care provider:
    1. Prospective capitated, global budget, case rate, or episode-based payments
    2. Performance incentive payments
    3. Payments to support population health / practice infrastructure
    4. Provider salaries
    5. Recovery payments (those made by a payer to a provider and later recouped due to audit, investigation, or other review)
    6. Other, for example, grants or surplus payments, COVID-related support payments

Defining Primary Care Spending: Discussion

- Should OHS amend its definition of primary care for assessing performance relative to the target?
  - *Primary care providers*
  - *Primary care services*
  - *Primary care service payments*
  - *Primary care non-service payments*

Calculating Spending on Primary Care

- Now we will discuss the definition of total spending that will be used for calculating the percent of spend allocated to primary care. We will specifically discuss services included in total spending.

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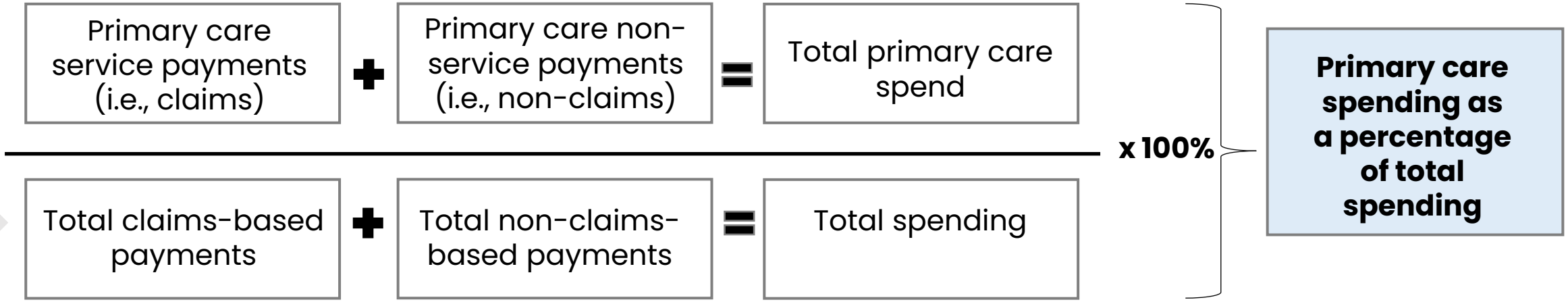

How OHS Measures Total Healthcare Expenditures (THCE): Recap

- THCE includes spending on behalf of ***Connecticut residents who***:
  - have health insurance coverage through Medicare, Medicaid, commercial carriers (fully-insured and self-insured), Veterans Health Administration, or state correctional facilities, and
  - receive care from *any provider in or outside of Connecticut*.*
- When calculating *statewide per capita spending*, OHS uses the covered lives figures reported by payers.

**Spending for out-of-state residents receiving care from in-state providers is excluded from THCE.*

Defining Total Healthcare Spending for Primary Care Percent Calculation

- OHS has mostly aligned the definition of total spending with the cost growth benchmark definition of total medical expenses *(THCE less net cost of private health insurance).*
- **OHS excludes long-term care services from the denominator** to calculate percent spending on primary care.
  - This spending category primarily applies to Medicaid.
  - Removing this spending from the denominator facilitates better comparisons of primary care spending across markets.
- Other services OHS considered excluding when setting the initial primary care spending targets but chose not to: **prescription drugs, lab and imaging services, and oral health services**.

Advantages and disadvantages of different definitions for total spending

- The benefit of including more categories in total spending makes the calculation more comprehensive.
  - It also reduces the calculated share of spending going to primary care.
- A narrower definition of total spending may be more equitable across payers, as it is limited to service categories that are applicable across markets (e.g., excludes long-term care spending that is concentrated in Medicaid).
  - It also increases the calculated share of spending going to primary care.

Total Healthcare Spending: Discussion

- Should OHS amend its definition of total spending for the purposes of calculating the percent of spending in primary care?
  - *Include / exclude LTSS, as OHS currently does*
  - *Other services for inclusion / exclusion*

III. Public Comment

IV. Wrap-Up and Next Steps

Wrap-Up and Next Steps

- The next meeting is scheduled for February 18th.
- During the next meeting we will return to discussion of recommendations of the cost growth benchmark and whether to adjust for primary care spending. We will also wrap up discussion of recommendations for Connecticut's primary care spending target.

V. Adjourn

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