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Technical Briefing on Cost Growth Benchmark, Quality Benchmark, and Alternative Payment Model Data Submissions

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. Overview of Connecticut's Alternative Payment Model (APM) Monitoring Initiative
    a. Review of the APM Reporting Requirements
4. 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.

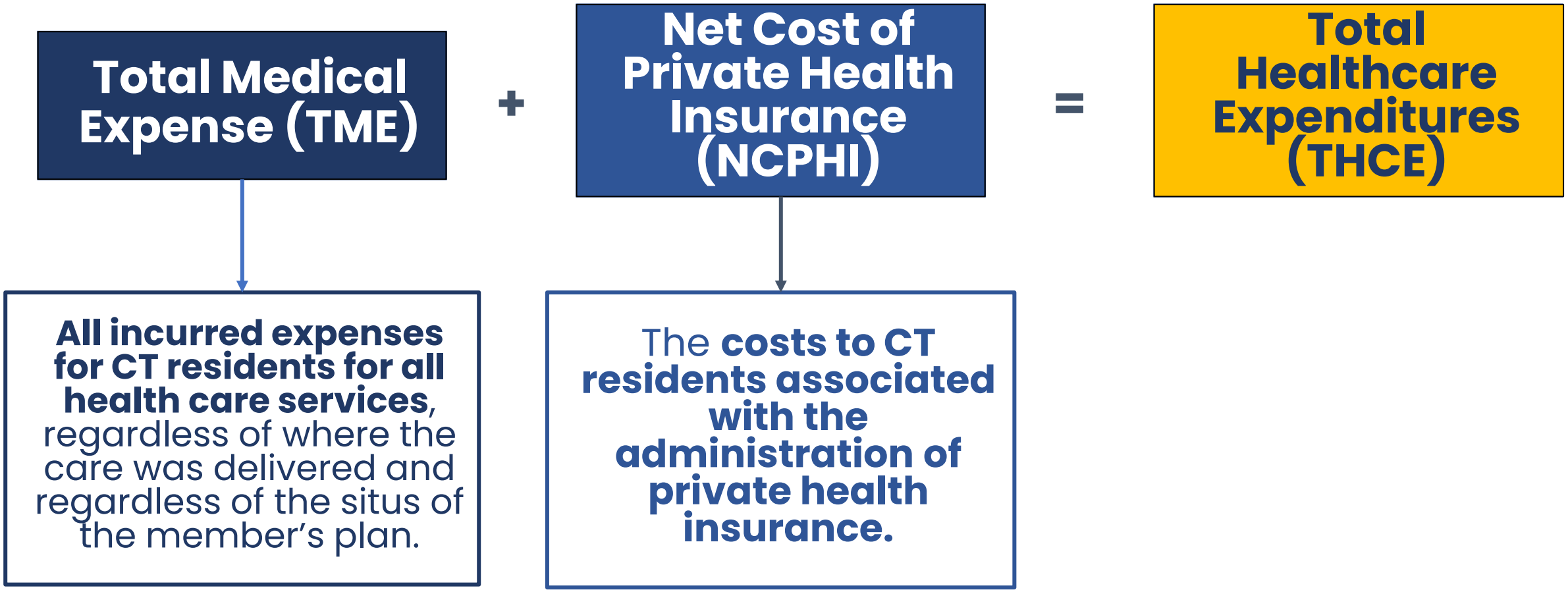
*Note: The 2024 benchmark value was revised upwards from 2.9%, due to the impact of inflation and the COVID-19 pandemic.

Connecticut's Primary Care Spend Target

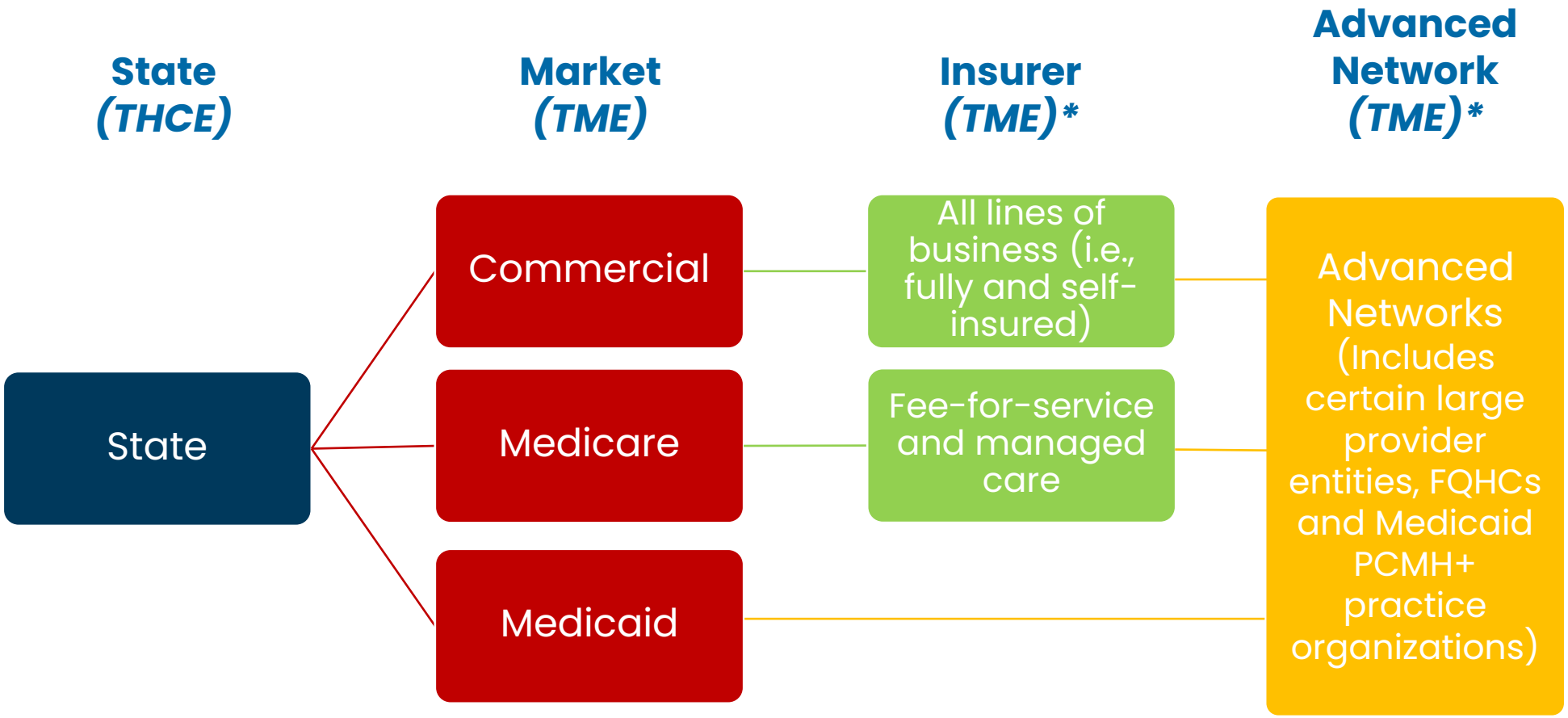
Calendar Year	Target Values
2021	5.0%
2022	5.3%
2023	6.9%
2024	8.5%
2025	10.0%

- 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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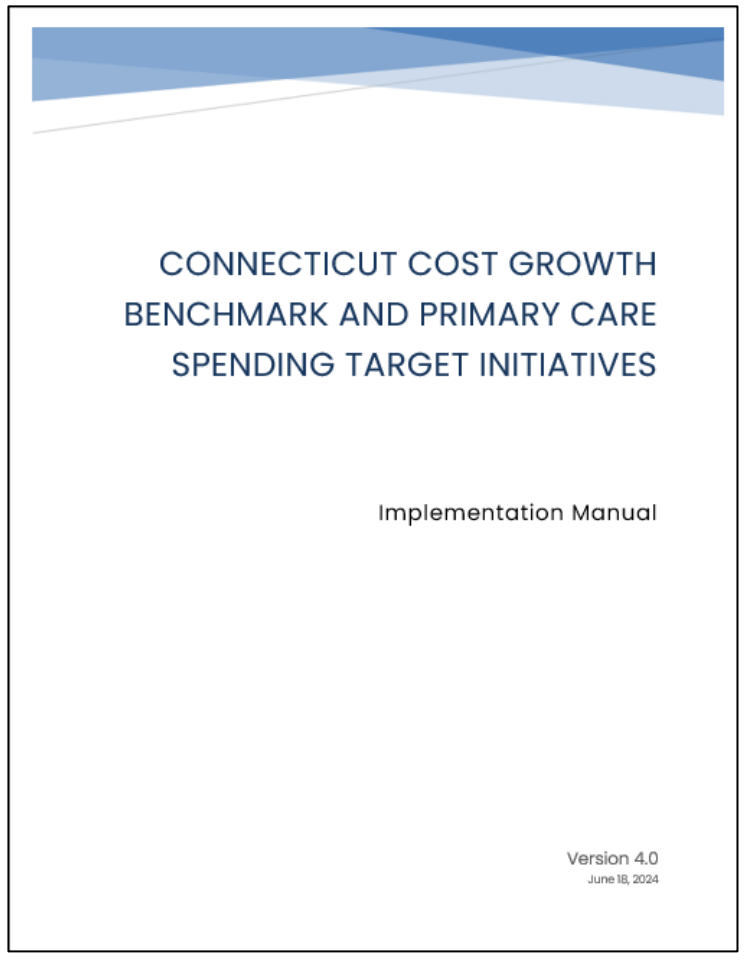
Cost Growth Benchmark and Primary Care Spending Target Implementation Manual



- 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.

Summary of Methodological Updates for 2022-2023 TME Data

1. Added request for payers' **pharmacy rebates for Commercial: Partial Claims** where not available**.**

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

3. Added **guidelines for a new member attribution methodology** utilizing Taxpayer Identification Numbers (TINs) provided by Advanced Networks.

4. **Revised the payer primary care attribution methodology** to include a hierarchical approach and added reporting by hierarchical tier to Total Medical Expense reporting.

Identifying Changes in Implementation Manual

- The Implementation Manual 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

No Changes to Header Tabs

- Carriers should still provide the following information:
  - Reporting period start and end dates
  - Clinical risk adjustment tool, including some description of the underlying methodology
  - Listing of “d/b/a”

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

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 2022-2023

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	117	Cornell Scott Hill Health Center
101	Privia Quality Network of Connecticut (PQN CT) (formerly Community Medical Group) ***[UPDATE]***	118	Fair Haven Community Health Center
102	Connecticut Children's Care Network ***[UPDATE]***	119	Family Centers
103	Connecticut State Medical Society IPA	120	First Choice Community Health Centers
104	Integrated Care Partners	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) ***[UPDATE]***	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 ***[UPDATE]***
109	Southern New England Health Care Organization (aka SOHO Health, Trinity Health of New England ACO, LLC)	126	Starling Physicians
110	Value Care Alliance	127	UConn Medical Group
111	NA* ***[UPDATE]***	128	United Community and Family Services
112	Charter Oak Health Center	129	WestMed Medical Group
113	CIFC Greater Danbury Community Health Center	130	Summit Health (formerly WestMed Medical Group) ***[UPDATE]***
114	Community Health and Wellness Center of Greater Torrington	131	Yale Medicine
115	Community Health Center	999	Members Not Attributed to an Advanced Network
116	Community Health Services		

Advanced Network Tabs

Note: ID 111 (ProHealth) was removed from the 2022-2023 list of Advanced Networks. ***[UPDATE]

Update to Reporting Spending by Advanced Network

- 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.
  - This year's data request will utilize a hierarchal tiered approach (more information on the next slide). ***[UPDATE]***
  - Taxpayer Identification Numbers (TINs) for Advanced Networks will be distributed for attribution purposes. ***[UPDATE]***
- 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 should be reported in aggregate in one row of the TME file (ID 999).

Advanced Network Tabs

Update to Reporting Spending by Advanced Network (Cont'd)

- 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. ***[UPDATE]***

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

Update 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 be asked to report overall spending by Insurance Category Code. ***[UPDATE]***
  - 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

- 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

Clarification 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 ***[CLARIFICATION]*** - 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 manual. ***[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 Implementation Manual ***[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 Implementation Manual ***[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

No Change to Categories of Non-Claims-based Spending to Report

- Carriers should report non-claims-based spending according to the following categories:
  - Prospective Capitation, Global Budget, Case Rate or Episode-based Payments
  - Performance Incentive Payments
  - Payments to Support Population Health and Practice Infrastructure
  - Provider Salaries
  - Recovery
  - Other
  - Total Primary Care Non-Claims Based Payments (*this category is the only category not mutually exclusive from the others*)

Advanced Network Tabs

No Updates to Categories of Non-Claims-Based Spending to Report

- **Prospective Capitation, Global Budget, Case Rate or Episode-Based Payments** *(no change)*: Includes single payments to providers to provider healthcare services over a defined period of time, prospective payments for a comprehensive set of services for a broadly defined population or a defined set of services where certain benefits are carved out, payments made to providers in a given provider organization for a patient receiving a defined set of services for a specific time period, and payments received by providers for a patient receiving a defined set of services for a specific condition across a continuum of care, or care for a specific condition over a specific time period.

- **Performance Incentive Payments** *(no change)*: Includes rewards to providers for achieving quality or cost-saving goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target.

Advanced Network Tabs

No Updates to Categories of Non-Claims-Based Spending to Report

- **Payments to Support Population Health Practice and Infrastructure** *(no change)*: Includes payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs.

- **Provider Salaries** *(no change)*: All payments for salaries of providers who provide healthcare services not otherwise included in other claims and non-claims categories.

- **Recovery** *(no change)*: All payments received from a provider, member/beneficiary or other payer, which were distributed by a payer and then later recouped due to a review, audit or investigations. This field should be reported as a negative number.

Advanced Network Tabs

No Updates to Categories of Non-Claims-Based Spending to Report

- **Other** *(no change)*: All other payments made pursuant to the carrier's contract with a provider not made on the basis of a claim for health care benefits/services and cannot be properly classified elsewhere. For CY 2020, this may also include supportive funds made to providers to support clinical and business operations during the global COVID 19 pandemic.

- **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 should still submit clinical risk scores in the Advanced Network tab so OHS can monitor the impact of the methodological change.

Advanced Network Tabs

No Changes to Truncation of Spending of High-Cost Outliers

- 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	$150,000
2	Medicaid Expenses for Non-Dual Eligible Members	$250,000
3	Commercial: Full Claims	$150,000
4	Commercial: Partial Claims	$150,000
5	Medicare Expenses for Medicare/Medicaid Dual Eligible	$150,000
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible	$250,000

Advanced Network Tabs

No Changes to Truncation of Spending of High-Cost Outliers (Cont'd)

- 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

No Changes to Truncation of Spending of High-Cost Outliers (Cont'd)

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

Example with a $150,000 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 $50,000 while Advanced Network Y's spending above the truncation would be $25,000.
- Since the member cost the payer $375,000 in total, the total dollars above the truncation point for the payer would be $225,000.

Advanced Network Tabs

Update for 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 Implementation Manual. ***[UPDATE]***

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

- 2022-2023 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.

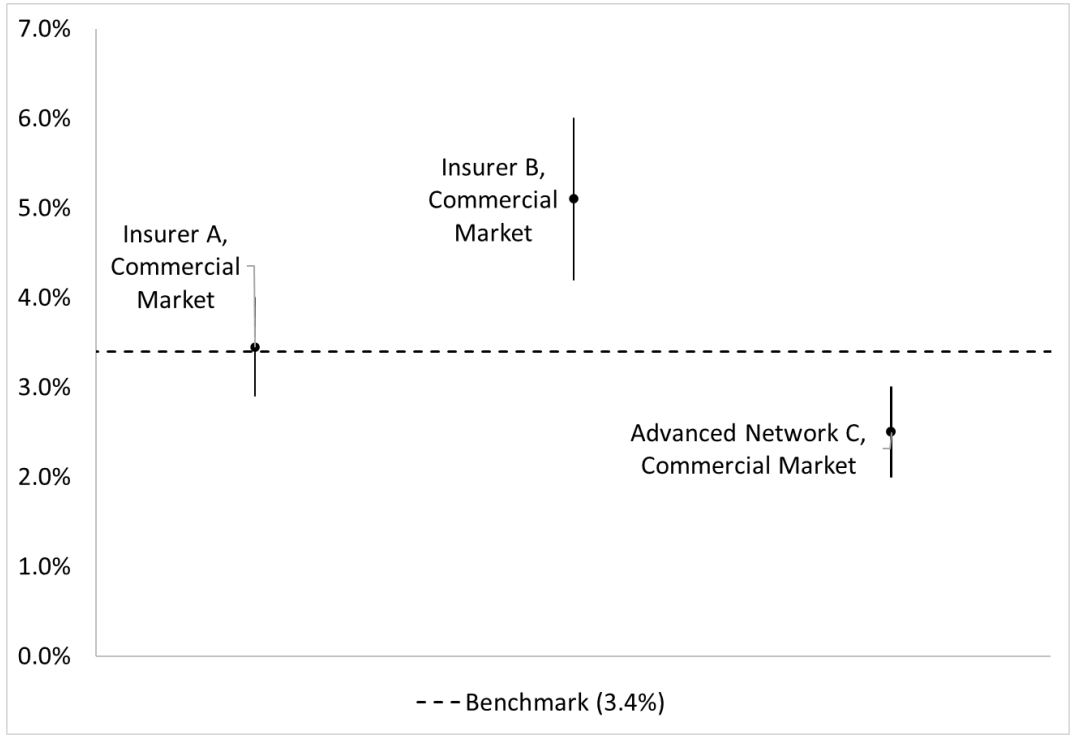
Standard Deviation Tabs

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 Implementation Manual.

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

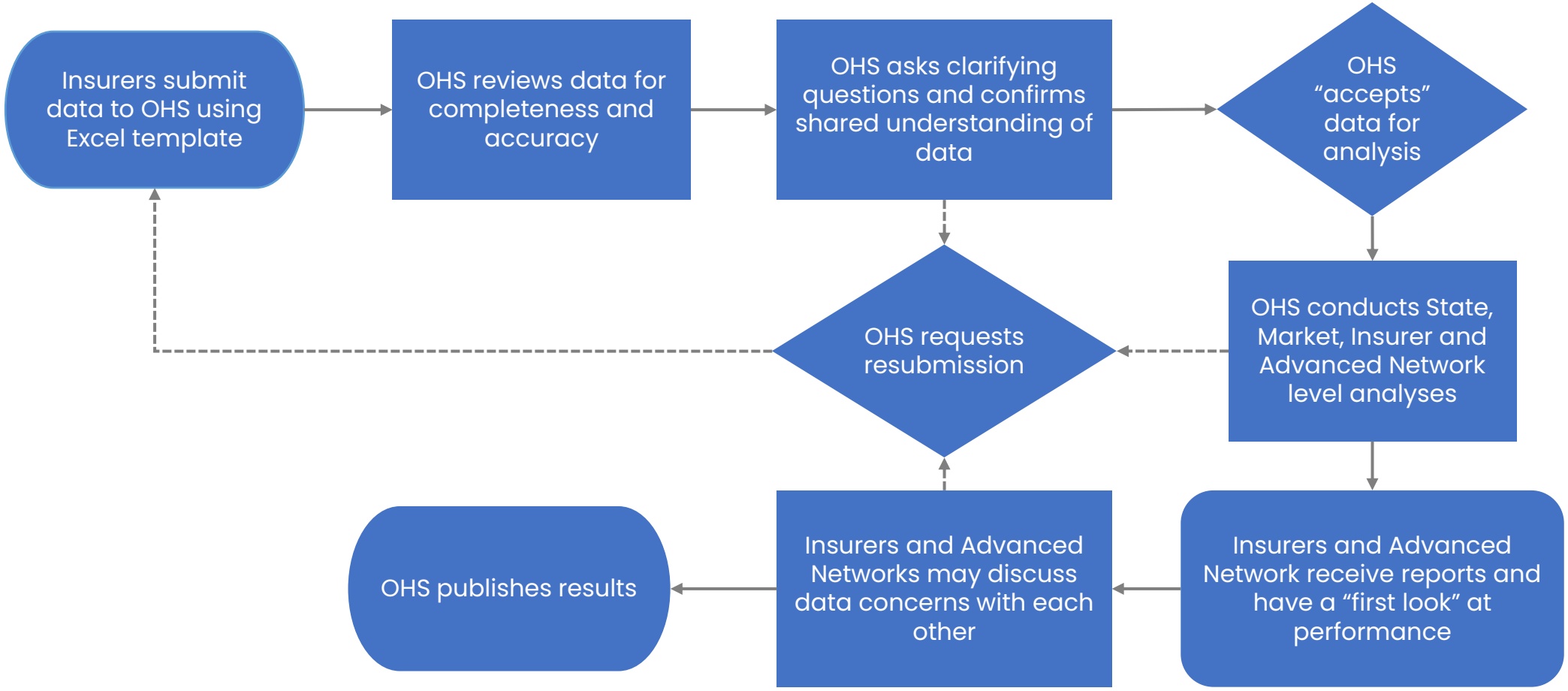
Due Date for Total Medical Expense Data

- This year, OHS is collecting 2022 and 2023 data.
- Data are due to OHS by August 15, 2024.
- 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 Implementation Manual 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.

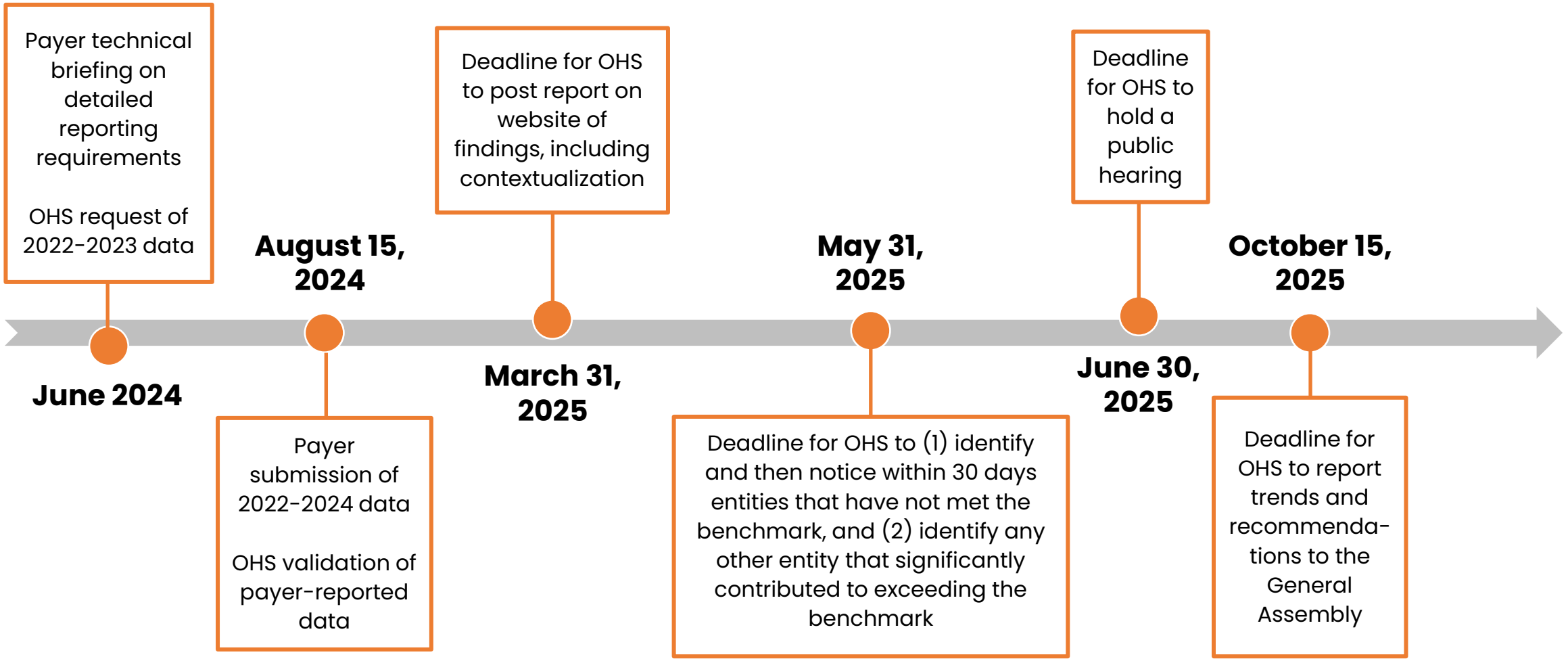
Data Collection, Validation and Reporting Process (Cont'd)



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 Lisa Sementilli (Lisa.Sementilli@ct.gov) and Christopher Romero (cromero@bailit-health.com).

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



Overview of Connecticut's Quality Benchmark Initiative

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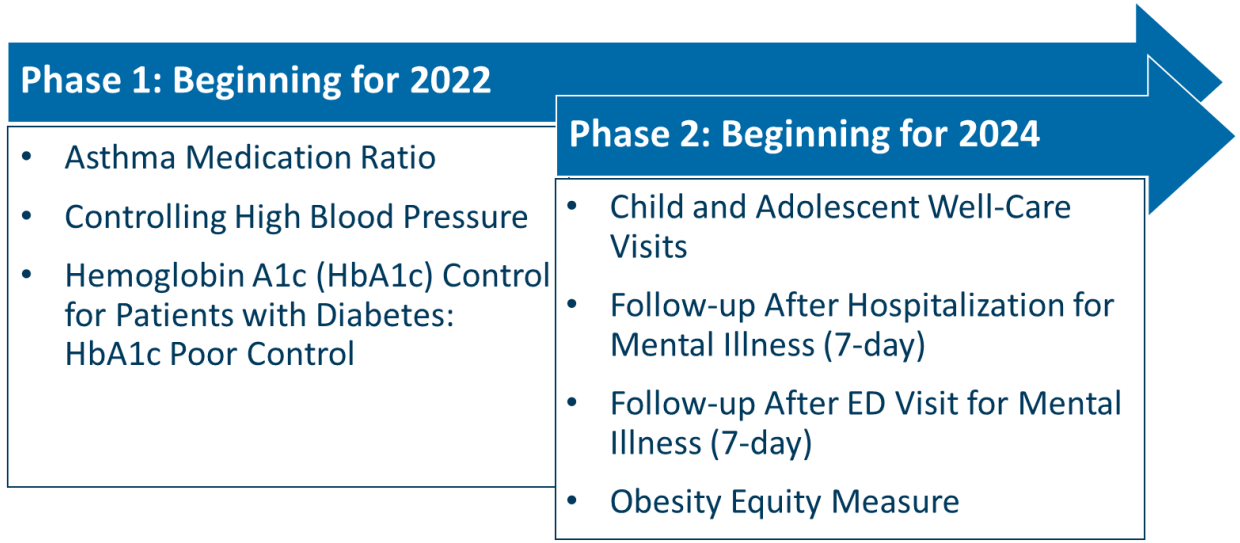
Overview of Connecticut's Quality Benchmarks

- 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

- In 2022 and 2023, OHS requested performance data on the three Phase 1 Quality Benchmark measures.
- In 2024, OHS is requesting 2023 performance data from insurance carriers, again on the three Phase 1 Quality Benchmark Measures.

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. Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control	Insurer; Advanced Network	Insurer; Advanced Network

**Asthma Medication Ratio* is a commercial and Medicaid-only measure.

Review of the Quality Benchmark Reporting Requirements

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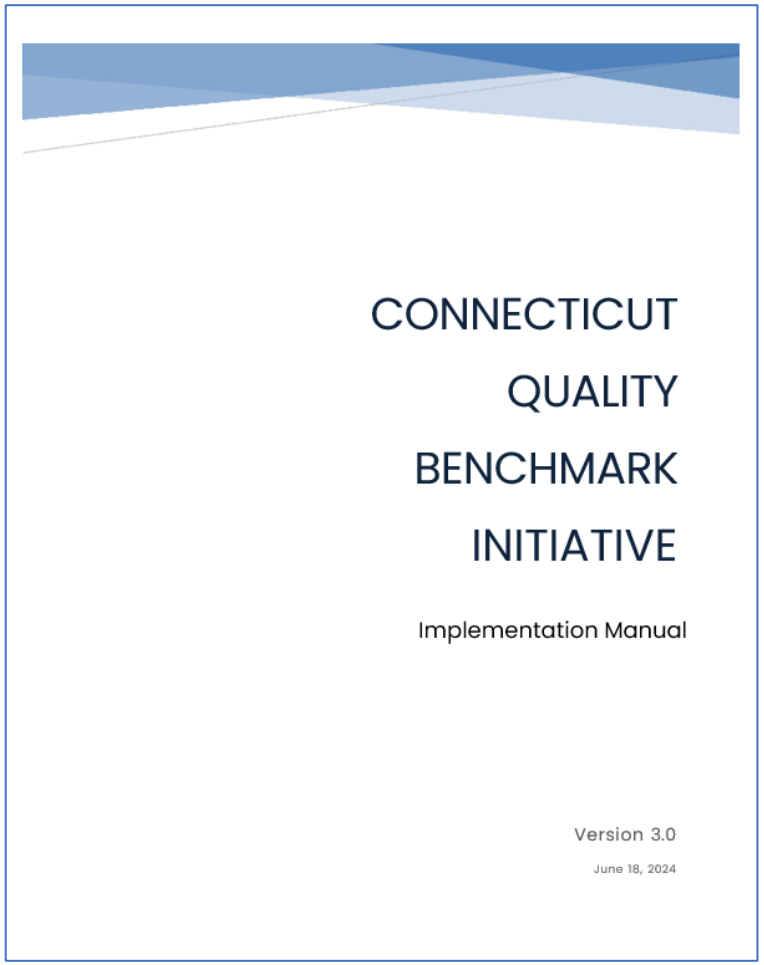
Quality Benchmark Implementation Manual



- 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.
- Manual and data submission template are posted on OHS' webpage.

Identifying Changes in Quality Benchmark Implementation Manual

- The Quality Benchmark Implementation Manual includes call-outs to indicate important updates, major methodological changes, and items of particular interest.

Summary of Changes for CY 2023 Quality Benchmark Data Request

1. **Updated the Quality Benchmark measures and values as follows:**
    - Added interim Quality Benchmark values for 2024 for the Phase 2 Quality Benchmark measures.
    - Modified the 2025 values for the Phase 2 Quality Benchmark measures based on recent Connecticut performance.
    - Added additional monitoring with associated targets for the Obesity Equity Measure.

Summary of Changes for CY 2023 Quality Benchmark Data Request (Cont'd)

1. **Updated the Quality Benchmark measures and values as follows:**
    - Indicated that *HbA1c Control for Patients with Diabetes*: *HbA1c Poor Control* will transition to *Glycemic Status Assessment for Patients with Diabetes (<9.0%)* for the 2024 performance year, in alignment with NCQA's specification changes for this measure.
        - Due to the significant specification changes, *Glycemic Status Assessment for Patients with Diabetes (<9.0%)* will not be reported against a benchmark value for MY 2024. OHS will re-evaluate the 2025 Quality Benchmark value after performance is reported for MY 2024 with the potential to adjust the MY 2025 Quality Benchmark value.

Summary of Changes for CY 2023 Quality Benchmark Data Request (Cont'd)

2. Updated specifications to reflect that insurance carriers should use **NCQA-HEDIS® MY 2023 specifications** for calendar year 2023 performance.

3. Clarified that insurers **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.

4. 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 - 2023	2023 Commercial Quality Benchmark performance at the insurer and Advanced Network levels.
Medicare Advantage - 2023	2023 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 insurance carriers 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.

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)

- The **Advanced Network Organization IDs** are the OHS-assigned IDs for the Advanced Networks that insurance carriers are requested to report on.

Carriers that did not include a Quality Benchmark in contracts with Advanced Networks for MY 2023 need not report MY 2023 performance for the Quality Benchmark. Please note that two of the three Quality Benchmark measures (*Controlling High Blood Pressure* and *Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control)* are Core measures in OHS' Aligned Measure Set, meaning that OHS requests insurers use these measures in all value-based Advanced Network contracts.

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

Reference Tables Tab

Note: ID 111 (ProHealth) was removed from the 2022-2023 list of Advanced Networks. *[UPDATE]

Updates to List of Advanced Networks (Cont'd)

- Insurers 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. ***[CLARIFICATION]***

Reference Tables Tab

Updates to Measure Specifications

- The **Measure Specifications** table includes descriptions, steward, data source, and technical specifications for the Phase 1 Quality Benchmark measures.

Measure	Steward	Data Source	Technical Specifications
Asthma Medication Ratio (ages 5-18 and ages 19-64)	NCQA	Admin	NCQA-HEDIS MY 2023 ***[UPDATE]***
Controlling High Blood Pressure	NCQA	Admin/Clinical Data	NCQA-HEDIS MY 2023 ***[UPDATE]***
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control	NCQA	Admin/Clinical Data	NCQA-HEDIS MY 2023 ***[UPDATE]***

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 2023 for MY 2023 performance).

Commercial/Medicare – 2023 Tabs

No Change 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 relevant Phase 1 Quality Benchmark measures.

    1. *Asthma Medication Ratio*
        - *Ages 5-18*
        - *Ages 19-64*
    2. *Controlling High Blood Pressure*
    3. *Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control*

Commercial/Medicare – 2023 Tabs

No Change to Submission of Numerator and Denominator Data (Cont'd)

- **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 relevant Phase 1 Quality Benchmark measures.

> **Performance for Clinical Data Measures**: For clinical data measures, insurers may calculate performance using a sample rather than the full population. Carriers should not submit performance for clinical data measures calculated using only administrative data. If a carrier submits an administrative-only rate for a clinical data measure, OHS will not use this rate when calculating performance at the state, market, insurer or Advanced Network levels.

Commercial/Medicare – 2023 Tabs

No Changes to Mandatory Questions Tab

- Carriers will input contact information and answer a series of questions designed to ensure that the data reported are consistent with the requirements in the Implementation Manual.

Mandatory Questions

No Changes 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.
- 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 2023 data.
- Data are due to OHS by August 15, 2024.
- Electronic files must be submitted through the State's secure file transfer server at https://sft.ct.gov

Data Collection, Validation and Reporting Process

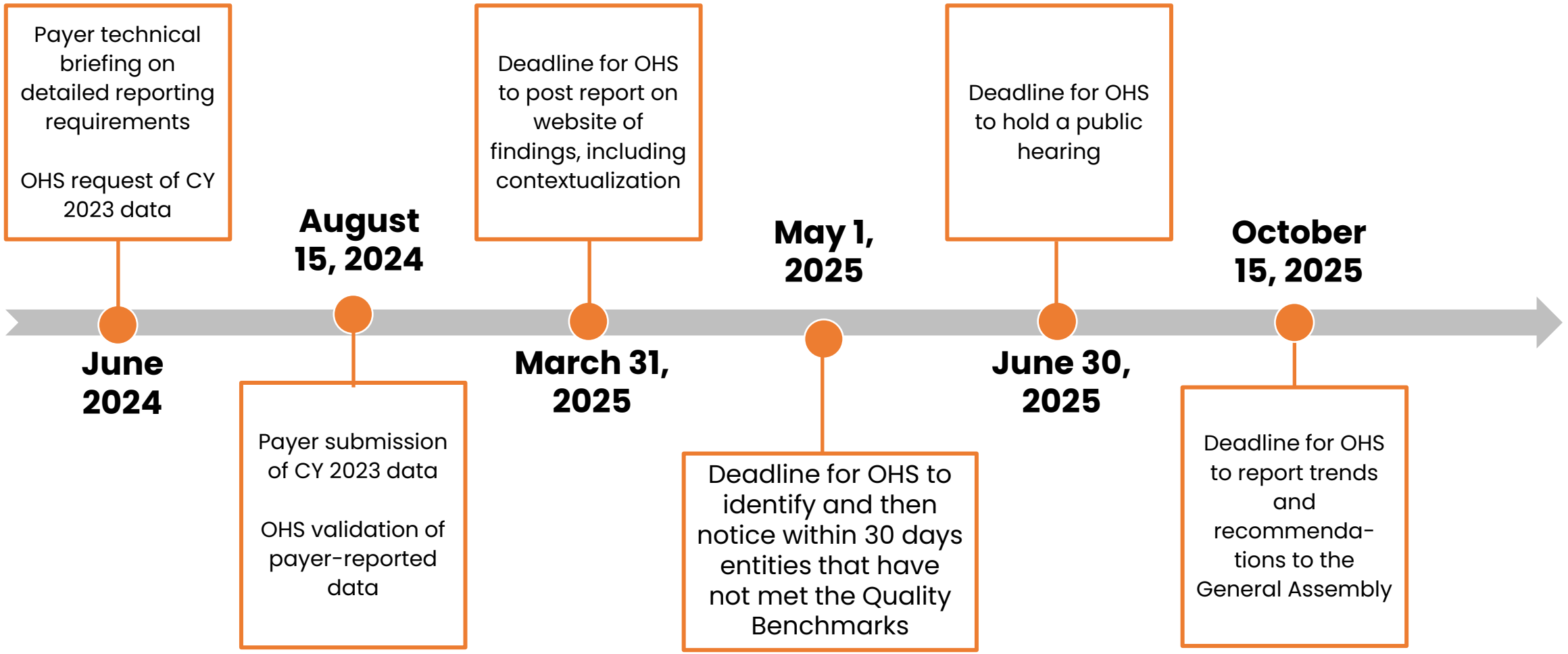
- Similar to the Cost Growth Benchmark data collection process, OHS will work with payers to validate Quality Benchmark performance data. Payers can expect to hear from OHS:
    1. After the initial data submission to ensure data were submitted using specifications outlined in the Implementation Manual; 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 2023 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

- Carriers 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 Hanna Nagy (hanna.nagy@ct.gov) and Matt Reynolds (mreynolds@bailit-health.com).

APM Data Request Background

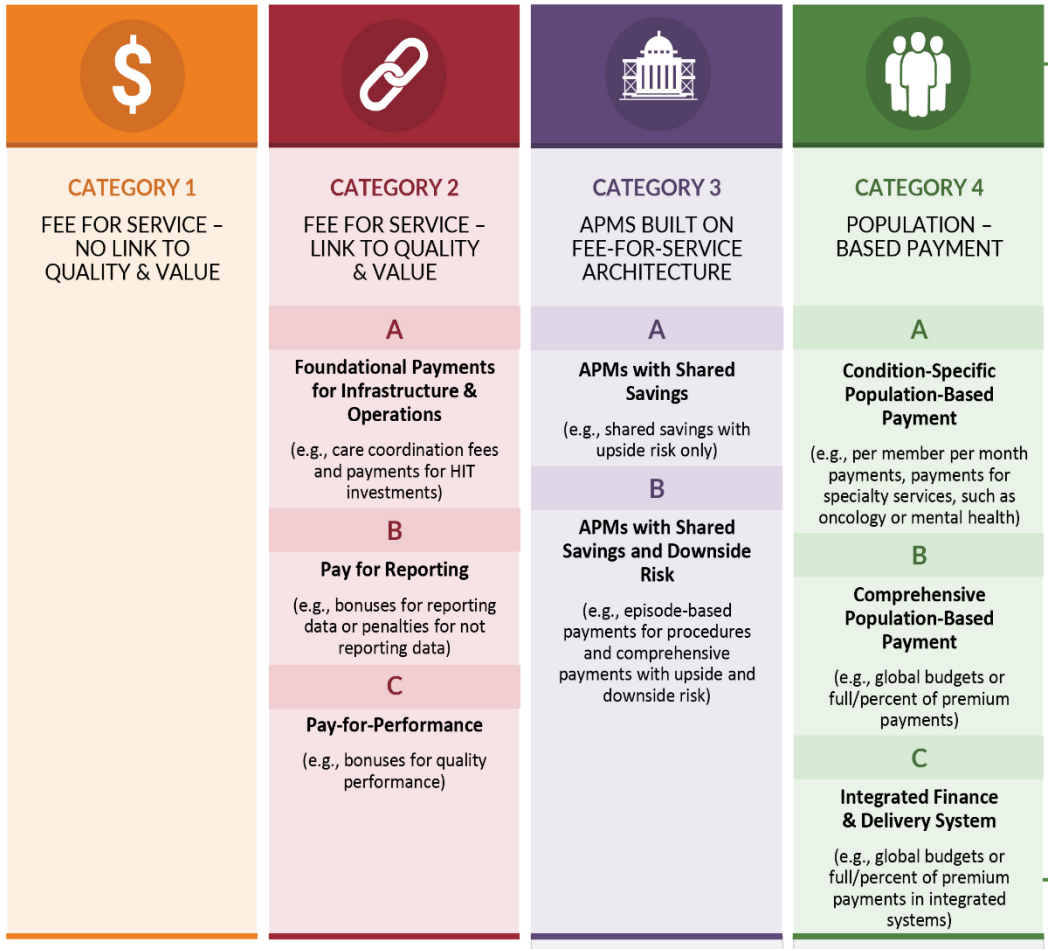
APM Data Request Background

- In 2020, Governor Lamont signed Executive Order No. 5 directing OHS to monitor the adoption of alternative payment methodologies (APMs) in Connecticut. In 2022, Connecticut General Statute 19a-754g et. Seq. codified Executive Order No. 5 into law.
- In 2023, OHS collected data from Connecticut payers on APM adoption for the first time. In 2024, OHS will again collect data from Connecticut payers on APM adoption.

The primary goal of tracking total dollars paid through APMs is to monitor the progress of healthcare organizations in shifting from traditional fee-for-service payment models to more value-based approaches.

APM Data Request Background (Cont'd)

- OHS' APM tracking methodology is based on the Health Care Payment Learning Action Network (HCP-LAN) Framework, which categorizes payment models into four major categories.
- OHS data collection methodology is based on the LAN's APM Measurement Survey.



Review of the APM Data Reporting Requirements

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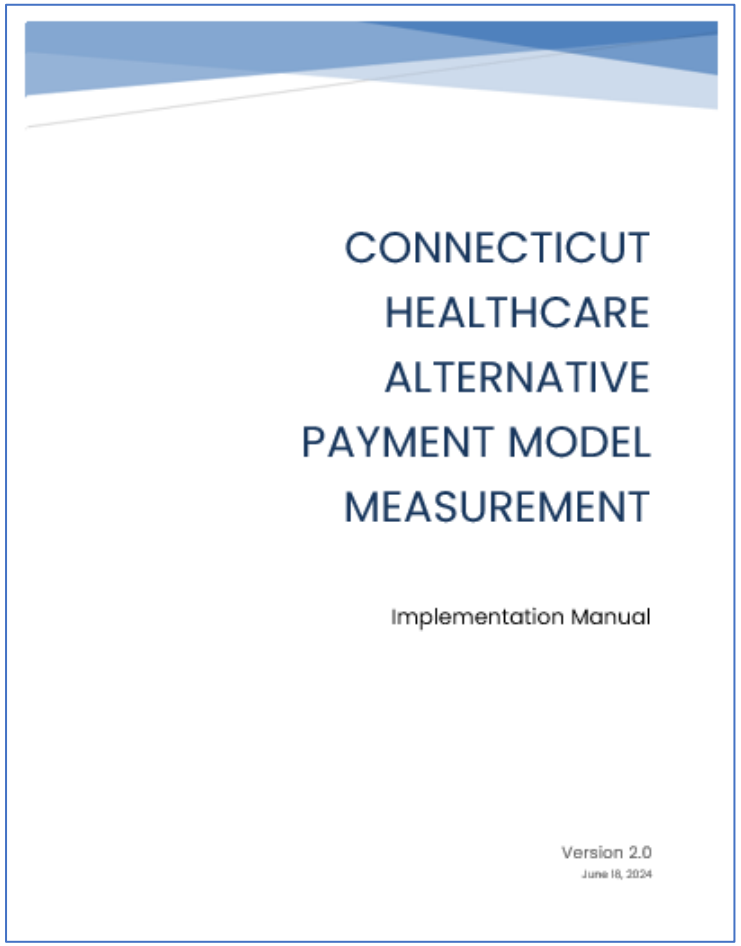
APM Implementation Manual



- Comprehensive document that describes the:
  - Overall initiative;
  - Definitions of APM categories;
  - Process for publicly reporting APM adoption.
- Contains data reporting specifications for commercial and Medicare Advantage carriers in Appendix A.
- Implementation manual and data submission template are posted on OHS' webpage.

Identifying Changes in APM Implementation Manual

- The APM Implementation Manual includes call-outs to indicate important updates, major methodological changes, and items of particular interest.

Summary of Changes for CY 2023 APM Data

1. Clarified that payments that could be categorized in **HCP-LAN's 3N and 4N categories should be reported in Category 1** (legacy payments), because they are not linked to quality.

2. **Updated the payment period definition** to reflect that, if necessary, plans may deviate from OHS' calendar year payment period specification and submit for the most recent 12-month period; however, plans must indicate the start and end dates of the payment period in their data submission.

3. Clarified that if a payer does not engage in value-based contracting with a given provider type, the payer should **still include that provider's spending in the plan's total expenditures** (denominator).

Insurance Carrier APM Reporting Template

General Information	Collects background information about data submission.
Commercial Payments	Collects numerator and denominator values by HCP-LAN category for the commercial market.
Commercial Covered Lives	Collects plan members attributed to CT providers participating in APMs by HCP-LAN category for the commercial market.
Medicare Payments	Collects numerator and denominator values by HCP-LAN category for the Medicare Advantage market.
Medicare Covered Lives	Collects plan members attributed to CT providers participating in APMs by HCP-LAN category for the Medicare Advantage market.
Definitions	Includes relevant definitions for terms used in the submission template.
LAN APM Framework	Includes a figure depicting APM categories according to the LAN framework.

No Change to General Information Tab

- Carriers should provide the following information:
  - Contact information;
  - Markets in which the health plan operated during the payment period (commercial and/or Medicare Advantage); and
  - Total number of members covered by the insurance carrier by market (commercial and/or Medicare Advantage) during the payment period.

General Information Tab

No Change to Commercial and Medicare Payments Tabs

- Carriers should provide:
  - **Denominator Value:** Total dollars paid to providers (in and out of network) for commercial or Medicare Advantage members in the specified payment period; and
  - **Numerator Values:** Total dollars paid to providers operating under a commercial or Medicare Advantage contract(s) that includes one or more APMs.
- Commercial and Medicare payments are collected in separate tabs.

Commercial/Medicare Payments Tabs

Clarification for APM Category 1

Category #	Category Name	Category Description
Category 1*	**Fee-for-service payments with no link to quality**	These payments utilize traditional FFS payments (i.e., payments made for units of service) that are not adjusted to account for infrastructure investments, provider reporting of quality data, or for provider performance on cost and quality metrics. Diagnosis-related group payments (DRGs) that are not linked to quality are in Category 1.

*Payments that could be categorized in HCP-LAN's 3N and 4N categories should be reported in Category 1 (legacy payments), because they are not linked to quality. ***[CLARIFICATION]***

Commercial/Medicare Payments Tabs

No Change to APM Category 2

Category #	Category Name	Category Description
Category 2	**Fee-for-service payments linked to quality***	These payments utilize traditional FFS payments (i.e., payments made for units of service) but these payments are subsequently adjusted for infrastructure investments to improve care or clinical services, based on whether providers report quality data, or based on how well providers perform on cost and quality metrics. • **2A –** Foundational Payments for Infrastructure and Operations to improve care delivery such as care coordination fees and payments for HIT investments. • **2B –** Pay for Reporting: Bonus payments/rewards for reporting on specified quality measures, including those paid in DRG systems. • **2C –** Pay for Performance: Bonus payment/rewards, or penalties as applicable, for performance on cost and quality measures.

* Whereas LAN only requests payments in Categories 2A and 2C in its annual survey (and not 2B), OHS is requesting payments in Categories 2A, 2B and 2C.

Commercial/Medicare Payments Tabs

No Change to APM Category 3

Category #	Category Name	Category Description
Category 3	**APMs built on fee-for-service architecture** (excludes risk-based payments that are NOT linked to quality)	APMs built on FFS architecture while providing mechanisms for effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account, payments are based on cost (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. • **3A** – APMs with upside gain sharing based on a budget target ("shared savings") • **3B** – APMs with upside gain sharing and with downside risk sharing based on a budget target ("shared risk")

Commercial/Medicare Payments Tabs

No Change to APM Category 4

Category #	Category Name	Category Description
Category 4	**Population-based payment** (excludes capitated payment models that are NOT linked to quality)	These payments are structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a defined scope of practice, a comprehensive collection of care or a highly integrated finance and delivery system. These models hold providers accountable for meeting quality and, increasingly, person-centered care goals for a population of patients or members. • **4A** – Condition-specific population-based payments • **4B** – Comprehensive population-based payments - full or % of premium population-based payment • **4C** – Integrated finance and delivery system

Commercial/Medicare Payments Tabs

Updated Payment Period Guidance

- The **12-month calendar year period** applicable to the specified APM report, (e.g., CY 2023: January 1 - December 31, 2023).

OHS' payment period definition differs from the LAN's annual survey specifications, which allow insurance carriers to report payment information for the calendar year *or* the most current 12-month period.

[UPDATE] **If necessary, plans may deviate from OHS' calendar year payment period specification and submit for the most recent 12-month period; however, plans must indicate the start and end dates of the payment period in their data submission.**

Commercial/Medicare Payments Tabs

Updated Payment Period Guidance (Cont'd)

- Carriers should use a **"date of payment"** approach, where only actual payments to providers between January 1st and December 31st are reported in the APM Data Submission Template.
  - Carriers should not estimate payments that providers may receive in the following payment period(s) related to APM arrangements or dates of service within the reporting year.

OHS' "date of payment" approach for APM reporting differs from OHS' Cost Growth Benchmark data specifications, which request that insurance carriers submit allowed amounts on an incurred basis (not paid basis).

Commercial/Medicare Payments Tabs

Updated Payment Period Guidance (Cont'd)

- Carriers should only count an APM payment arrangement for the time-period in which it was effective.

Example of How to Handle Payments when APM Arrangement becomes Effective mid-Payment Period

If an APM payment arrangement became effective with a provider beginning April 1st of a payment period, the insurance carrier should include the pro-rated portion of the contract between April 1st and December 31st of the reporting year.

The portion of the contract paid between January 1st and March 31st should not be included in that particular APM model reporting.

Commercial/Medicare Payments Tabs

No Change to Insurance Policies to Include/Exclude

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) - Stand-alone 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

Commercial/Medicare Payments Tabs

Clarification on Guidance on Providers to Include/Exclude

- Carriers should **include** payments for all Connecticut health care providers for whom there is healthcare spending. This includes:
  - *Physicians, hospitals and other traditional health care providers*
  - *Behavioral health*
  - *Durable medical equipment (DME)*
  - *Pharmacy*
- If a payer does not engage in value-based contracting with a given provider type, the payer should still **include** that provider's spending in the plan's total expenditures (denominator). ***[CLARIFICATION]***
- Carriers should **exclude** spending for dental and vision policies, but not spending for dental and vision medical coverage services.

Commercial/Medicare Payments Tabs

No Change to Guidance on Providers Participating in Multiple APMs

- In cases where a provider participates in multiple APMs, carriers should allocate the payment amounts to the **"highest" APM category**.

Example of Allocating Payment Amounts to the "Highest" APM Category

If a provider has a shared savings contract with a health plan and is also eligible for performance bonuses for meeting quality measure performance targets (P4P), the health plan would report the fee-for-service claims, shared savings payments (if any), and the P4P dollars in the shared savings subcategory (Category 3).

Commercial/Medicare Payments Tabs

No Change to Commercial and Medicare Covered Lives Tabs

- Carriers should provide:
  - Total covered lives for the payment period; and
  - Total members attributed, aligned, assigned, or empaneled to a Connecticut primary care physician (PCP), primary care group (PCG), or a non-PCP (i.e., specialist) participating in a total cost of care (TCOC) accountable care APM of six months or longer in the payment period.
- Commercial and Medicare covered lives are collected in separate tabs.

Commercial/Medicare Covered Lives Tabs

No Change to Commercial and Medicare Covered Lives Tabs (Cont'd)

For members attributed to a PCP or PCG	Please list **the total number of health plan members by line of business and by APM Category** who are attributed/aligned/assigned/empaneled to a **primary care physician (PCP) or primary care group (PCG)** participating in a total cost of care (TCOC) **Category 3 or Category 4** accountable care APM of six months or longer in CY 2023.
For members attributed to non-PCPs (specialists)	Please list the **total number of health plan members by line of business and by APM Category** who are attributed/aligned/assigned/empaneled to a **non-PCP (i.e., specialist)** provider participating in a TCOC **Category 3 or Category 4** accountable care APM of six months or longer in CY 2023.

Commercial/Medicare Covered Lives Tabs

Update to Public Reporting of APM Adoption

- **Payments**: OHS will report APM adoption for CY 2023 at the market and payer levels (commercial, Medicare Advantage, Medicaid) for each APM category. ***[PAYER-LEVEL REPORTING IS NEW]***
  - At the market and payer level, OHS will report the percentage of payments made through each of the APM categories and subcategories.
  - At the market level, OHS will report payments in each category as a whole (e.g., Category 2 in total) and each subcategory (e.g., Categories 2A, 2B and 2C separately).
- **Covered Lives:** OHS will use payer-submitted membership data to report the percentage of members covered under Category 3 and 4 accountable care APMs for each market in CY 2023 at the market and payer levels. ***[PAYER-LEVEL REPORTING IS NEW]***

Due Date for APM Data

- This year, OHS is collecting 2023 data.
- Data are due to OHS by August 15, 2024.
- Electronic files must be submitted through the State's secure file transfer server at https://sft.ct.gov

Questions

- Carriers may use Cost Growth Benchmark office hours to discuss APM data questions or arrange a separate date/time to meet.
- Any additional questions should be directed to Lisa Sementilli (lisa.sementilli@ct.gov) and Christopher Romero (cromero@bailit-health.com).