Healthcare Cost Growth Benchmark and Primary Care Target Parameters Adopted by the Office of Health Strategy

Connecticut Office of Health Strategy

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Executive Summary

On January 22, 2020, Governor Lamont signed Executive Order 5 directing the establishment of a statewide healthcare cost growth benchmark. With the goal of slowing the growth of healthcare spending and making healthcare more affordable for the citizens of Connecticut, Executive Order 5 directs the Office of Health Strategy (OHS) to develop annual healthcare cost growth[1] benchmarks for calendar years (CY) 2021-2025. Once implemented, Connecticut will be the fifth state to have a statewide healthcare cost growth benchmark, joining Massachusetts, Rhode Island, Delaware, and Oregon.

Executive Order 5 requires OHS to implement several additional, related initiatives, including:

- setting targets for increased primary care spending as a percentage of total healthcare spending to reach 10 percent by 2025;
- developing quality benchmarks across all public and private payers beginning in 2022, potentially including clinical quality measures, over- and under-utilization measures, and patient safety measures;
- monitoring and reporting annually on healthcare spending growth across public and private payers, and
- monitoring accountable care organizations and the adoption of alternative payment models.

OHS launched its work on these initiatives in Spring 2020. The timing of the launch happened to coincide with the start of the COVID-19 global pandemic. OHS was able to quickly pivot the Technical Team, Stakeholder Advisory Board and other stakeholder meetings to video-based teleconferencing, allowing for a wide array of input into the process. OHS believes that the significant harmful economic impact of COVID-19 has amplified the need to restrain healthcare cost growth. Connecticut residents and businesses need restrained health care cost growth more than ever before.

Throughout the process, OHS was supported by key deliberating bodies, with the primary advisory body to OHS being the Technical Team. OHS charged the Technical Team with recommending annual cost growth benchmarks across all payers and populations for CYs 2021-2025, and with advising OHS on the best methods for establishing the benchmarks. In so doing, the Technical Team leveraged efforts and learnings of states with existing cost growth benchmarks – notably Massachusetts, Delaware, and Rhode Island – and adapted these states' approaches to the Connecticut healthcare landscape. OHS also charged the Technical Team with recommending primary care spending targets across all payers and populations as a share of total healthcare expenditures for CYs 2021-2025, in order to reach a target of 10 percent by 2025. The Technical Team then made preliminary recommendations for a data use strategy intended to produce routine analyses that pinpoint leading opportunities to reduce healthcare

[1] In the context of this report, "cost" and "cost growth" refer to the total spending made by public and private payers to provider organizations, whereas "price", utilized later in this report, refers to the specific reimbursement rates negotiated for services between payers and providers.

spending and healthcare spending growth in a manner that will not harm patients, as well as analyses to assess the benchmark's impact.

Lastly, OHS asked that the Technical Team consider its deliberations and recommendations through the prism of health equity. The Technical Team met 11 times between March and September 2020.

A second advisory body, the Stakeholder Advisory Board, provided input to the Technical Team on the development of the cost growth benchmark and primary care target, as well as the data use strategy. The Board represented a broad group of interested stakeholders, including consumers, consumer advocates, providers, insurers, labor leaders and employer purchasers. The Stakeholder Advisory Board met six times between May and September 2020, its meetings sequenced so as to provide input to the Technical Team at key decision points.

In fall 2020, OHS will reconvene the Quality Council to begin the process of developing recommendations on quality benchmarks across all public and private payers beginning in Calendar Year 2022. The timing will support alignment with activities specified by Executive Order 6.

This report reflects the results of seven months of research, study, and thoughtful deliberation. The recommendations contained herein were developed from the preliminary recommendations made by the Technical Team, consideration of public comment[2] on those recommendations, and input gathered from an informational hearing for legislators held on October 28, 2020.[3] Appendix A contains a listing of organizations and individuals that provided comment on the Technical Team's recommendations.

The following paragraphs provide a brief description of the approach OHS will take to implement Executive Order 5. The approach is described in greater detail in the body of this report.

A. Healthcare Cost Growth Benchmark

The healthcare cost growth benchmark is a targeted annual growth rate that payers, providers, and the State should endeavor to stay below. **The benchmark will be based on a calculated and pre-determined blend of the growth in the per capita potential gross state product (PGSP), which is a forecasted measure of growth in the economy, and the forecasted growth in median income of Connecticut residents**. This blended benchmark reflects the desire of the Technical Team that healthcare spending should not grow faster than a forecasted measure of state economic growth *and* recognition of the challenges facing Connecticut residents as healthcare costs consume ever growing portions of their income, jeopardizing the affordability of health care. Recognizing that a benchmark of 2.9 percent may for multiple reasons be difficult for the State, payers, and providers to achieve initially, the Technical Team recommended an upward adjustment during the first two years of implementation. Using the

[2] OHS received public comment on topics that were unrelated to the directives in Executive Order 5. The Office will take them under consideration as they relate to the Office's other work streams.
[3] Implementing the directives of Executive Order 5 will have no bearing on OHS's ability to complete existing initiatives and priorities.

blended methodology and Technical Team recommended add-on factors during the first two years results in a benchmark value of **3.4 percent for Calendar Year 2021, 3.2 percent for CY 2022, and 2.9 percent for Calendar Years 2023, 2024, and 2025**. The methodology and calculation of the benchmark will be revisited in the event of a sharp rise in inflation during these years. Performance against the benchmark will be measured at the state, payer, insurance market and large provider entity level. The per capita change in spending from one calendar year to the next will be publicly reported by OHS, along with contextual information that may highlight legitimate reasons spending was above or significantly below the benchmark (e.g., COVID-19 or introduction of new orphan drug). There are no regulatory consequences for exceeding the benchmark. The development of a cost growth benchmark is consistent with those adopted by the states of Delaware, Massachusetts, Oregon, and Rhode Island, and those planned by Pennsylvania and Washington.

B. Primary Care Spending Target

The primary care spending target aims to strengthen Connecticut's primary healthcare services system by establishing a goal for increasing statewide primary care spending as a percentage of total healthcare expenditures; the target reaches 10 percent by Calendar Year 2025. Research has demonstrated that greater relative investment in primary care leads to better patient outcomes, lower costs, and improved patient experience of care.[4] Like most of the country, Connecticut's healthcare system is largely specialist-oriented. This target is intended to rebalance and strengthen the State's healthcare system by supporting improved primary care delivery. Rhode Island and Oregon have undertaken similar efforts to strengthen primary care delivery, using regulatory and statutory authority to require select payers to increase the percentage of medical spending allocated to primary care. Connecticut's primary care spend target builds upon concurrent work undertaken by the State to measure primary care spending using a consistent methodology in collaboration with other New England states. The Technical Team noted several challenges to setting a primary care spending target in 2020 given the lack of payer-reported baseline data, shifts in utilization as a result of COVID-19, and the short time frame for payers to achieve increases in primary care spending in 2021. **As a result, OHS will adopt a conservative target of 5.0 percent for 2021, given the current best estimate of statewide spending on primary care of 4.8 percent.**[5] Moving forward, OHS will convene a primary care-focused work group in order to make further recommendations for annual primary care spending targets for 2022-2024 and strategies for investing in primary care that improve access, quality and patient and provider experience. As it does so, OHS will also consider the guidance offered by the Technical Team during its deliberations for how payers should increase primary care spending.

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[4] Starfield B, Shi L, Macinko J. "Contribution of primary care to health systems and health." *Milbank Q.* 2005;83:457–502, and Chernew M, Sabick L, Chandra A, Newhouse J. "Would having more primary care doctors cut health spending growth?" *Health Affairs* (Millwood) 2009; 28(5):1327–35.

[5] OHS calculated a statewide weighted average of current primary care spending by total health care expenditures. Commercial and Medicare data were from UConn and Medicaid data were from Freedman Healthcare and the Department of Social Services. While OHS' best estimate of statewide primary care spending is 4.8 percent, Freedman Healthcare's data suggest that Medicaid primary care spending alone is 9.0 percent.

C. Data Use Strategy

Governor Lamont's Executive Order 5 calls upon OHS to monitor and report "annually on healthcare spending growth across public and private payers." OHS uses the term "data use strategy" to refer to its plan to purposefully leverage state data in order to achieve these objectives. **OHS will use the State's All-Payer Claims Database (APCD), and other data sources (e.g., CHIME hospital data) to make sure the aims of the Executive Order are achieved.** By analyzing data, OHS can identify which spending categories warrant greatest attention for "moving the needle" on the cost growth benchmark. OHS will prioritize **the following types of analyses as part of its data use strategy consistent with the Technical Team's recommendations**:

1) analyses that identify the leading factors contributing to year-over-year healthcare cost growth (e.g., changes in utilization, price, service mix/intensity, patient demographics);

2) analyses that examine which cost drivers most contribute to total cost of care at a point in time (e.g., specific services, provider types, providers, medical conditions); and

3) analyses of the effects of the cost growth benchmark, including any unintended consequences that may arise from its implementation.

Consistent with the Technical Team recommendations, OHS will assess the healthcare cost growth benchmark's impact on consumer out-of-pocket spending, noting that the initiative will not be wholly successful if consumer spending due to deductibles and co-insurance grows faster than the benchmark. Finally, OHS commits to ensuring transparency of data and reports for consumers on its website, supporting consumers in using those reports, and pursuing continued consumer engagement in general for all Executive Order 5-related activity.

D. Conclusion

For many Connecticut residents, healthcare has become unaffordable. With implementation of Executive Order 5, OHS is charged with taking a broad approach to rein in healthcare cost growth by establishing a statewide healthcare cost growth benchmark, and ensuring the state prioritizes primary care spending while also establishing statewide quality benchmark measures. There is evidence that cost growth benchmarks and primary care spend targets have had a desired impact in other states. OHS is adopting the recommendations made with the guidance of its key advisory bodies, and is positioned to move forward with implementation of the Executive Order 5 initiatives in Connecticut to control the rate of cost growth and promote better healthcare quality for all residents. OHS will continue to refine the parameters for program implementation on an annual basis in consultation with its advisory bodies, while maintaining as much predictability as possible in benchmarks, targets and associated data requests.

Background

Connecticut faces an urgent need to slow the growth in healthcare costs. The historical growth rate in healthcare costs in the State is unsustainable, with Connecticut being in the top tier of healthcare spending nationally.[6] In 2014, Connecticut's per capita spending on personal health care was $9,859 – the fifth highest in the nation, outpaced only by Vermont, Delaware, Massachusetts and Alaska. Over the last two decades, annual healthcare spending in Connecticut grew at more than twice the rate of growth in median household income (4.8 percent versus 2.0 percent).[7] Consequently, healthcare has become unaffordable to many Connecticut residents and employers. Since 2000, employer-sponsored insurance premiums in Connecticut have grown two and a half times faster than personal income. This growth in premiums and in healthcare costs generally make it difficult for business to compete and thrive in Connecticut, which in turn leads to reduced worker wage growth.

These effects of Connecticut's high healthcare costs are felt by all Connecticut residents, but especially those with low and modest wages. Connecticut has a higher household income distribution inequality than most other states, falling behind only Puerto Rico, the District of Columbia and New York when measuring household income distribution inequality by looking at average income wages across the State.[8] The economic effects of COVID-19 has heightened the strain of cost growth. Connecticut ranks last among all states in terms of personal income growth during the pandemic.[9]

To address rising healthcare costs, on January 22, 2020 Governor Lamont signed Executive Order 5 to establish a statewide healthcare cost growth benchmark. The Executive Order directs the Office of Health Strategy (OHS) to develop annual healthcare cost growth benchmarks for calendar years (CY) 2021-2025, and to implement several additional, related initiatives, including:

- setting targets for increased primary care spending as a percentage of total healthcare spending to reach 10 percent by 2025;
- developing quality benchmarks across all public and private payers beginning in 2022, potentially including clinical quality measures, over- and under-utilization measures, and patient safety measures;
- monitoring and reporting annually on healthcare spending growth across public and private payers, and
- monitoring accountable care organizations and the adoption of alternative payment models.

[6] Personal health care spending, per capita, by state. Centers for Medicare and Medicaid Services, State Health Expenditure Accounts, 2014.
[7] Medical Expenditure Survey, Tables D.1 and D.2 for various years.
[8] US Census Bureau, September 2019.
[9] *The Connecticut Mirror*, "Connecticut ranks last in personal income growth over past year," November 11, 2020.

Taken together, these initiatives are meant to slow the growth in healthcare costs in Connecticut while also promoting primary care and strengthening quality of care.

By establishing a non-punitive healthcare cost growth benchmark, Connecticut aims to constrain and reduce the dramatic growth in healthcare costs that it has experienced in recent years through transparency. Four other states have established cost growth benchmark programs similar to what Connecticut is developing: Massachusetts, Delaware, Rhode Island, and Oregon. Each has done so for similar reasons as Connecticut: healthcare is unaffordable for the State and for consumers.

Massachusetts, which has the longest experience of the four states, found that from 2012 to 2018, annual healthcare spending growth averaged 3.38 percent below the state benchmark, and commercial spending growth in Massachusetts has been below the national rate every year since 2013.[10] At the same time, there is no evidence of reduced service use in Massachusetts as a result of benchmark implementation. Since the benchmark has been in place in Massachusetts, inpatient admissions, hospital outpatient visits and emergency department visits have been largely unchanged.[11] Connecticut's implementation of a cost growth benchmark aims to achieve similar results. As in the other four states, Connecticut's benchmark is not a cap on healthcare spending that would prevent a payer or provider from exceeding the benchmark, or cause a payer or provider to suffer financial penalties for doing so.

Strengthening the State's primary care system can have a notable impact on both healthcare quality and spending. The U.S. healthcare system is largely specialist-oriented. Research has demonstrated that greater relative investment in primary care leads to lower costs, better patient outcomes and improved patient experience of care.[12] States, such as Oregon and Rhode Island, have elected to use primary care to strengthen their healthcare systems by supporting improved primary care delivery (e.g., expanding the primary care team, supporting advanced primary care) and increasing the percentage of total spending allocated towards primary care.

The Governor's charge to increase primary care spending in Connecticut builds upon prior work in Connecticut to strengthen the primary care infrastructure. Previously, OHS convened the Practice Transformation Task Force, which developed advanced medical home standards, provided advice on practice processes, and fostered alignment with other care delivery models in the state. Setting a primary care spending target can help the State not only increase the percentage of total healthcare spending allocated towards primary care, but also provide valuable data on this foundational component of Connecticut's healthcare system. OHS will solicit input from the new Primary Care and Community Health Work Group on which strategies Connecticut should pursue (e.g., increased use of alternative payment models) to meet the target in a way that aligns with existing statewide efforts and improves quality and access.

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[10] Massachusetts Health Policy Commission, 2019 Annual Health Care Cost Trends Report, February 2020.
[11] Kaiser Family Foundation State Health Facts, accessed November 2019.
[12] Starfield B, Shi L, Macinko J. "Contribution of primary care to health systems and health." *Milbank Quarterly* 2005; 83:457–502, and Chernew M, Sabick L, Chandra A, Newhouse J. "Would having more primary care doctors cut health spending growth?" Health Affairs (Millwood) 2009; 28(5):1327–35.

The Governor's Executive Order also charges OHS to develop quality benchmarks that will apply to all public and private payers beginning in January 2022. Quality benchmarks are annual targets or measures that all public and private payers, providers, and the State must work to achieve to improve healthcare quality in the State. They are meant to ensure the maintenance and improvement of healthcare quality as the State implements the cost growth benchmark and the primary care spending target. Connecticut will be the second state to establish statewide quality benchmarks; Delaware has eight quality measures for which it adopted benchmarks in 2019. Quality benchmarks may include clinical quality, utilization, and safety measures. OHS' Quality Council will address the development of a standard set of quality measures for benchmarking purposes beginning in fall 2020. Doing so will allow for the Quality Council to have enough time to make recommendations before implementation for CY 2022 and allow alignment with implementation of Executive Order 6. Several stakeholders expressed disappointment with delaying the start to 2022.

Process for Establishing the Healthcare Benchmarks Initiative

OHS began work on the benchmark in spring 2020 with the support of two appointed advisory bodies, the Technical Team and the Stakeholder Advisory Board. The Technical Team serves as OHS' primary advisory body and includes a mix of state agency executives and external experts who directly engage with OHS on key design and implementation considerations. Meetings of the Technical Team were facilitated by consulting experts from Bailit Health. Appendix B provides a list of Technical Team members. OHS provided opportunity for public comment at all 11 meetings, and the Technical Team heard public comments endorsing the need for primary care reform.

The Technical Team focused on three of OHS' tasks under Executive Order 5:

1. recommending annual cost growth benchmarks across all payers and populations for CYs 2021-2025 by building upon work already undertaken in Connecticut and adapting approaches used by other states;
2. recommending primary care spending targets across all payers and populations as a share of total healthcare expenditures for CYs 2021-2025, to reach a target of 10 percent by 2025, and
3. monitoring and reporting annually on healthcare cost growth across public and private payers.

The Stakeholder Advisory Board provided input and feedback to the Technical Team on the development of the annual healthcare cost growth benchmarks and the primary care target. Stakeholder Advisory Board members represent a cross-section of the Connecticut healthcare landscape, and include consumers, consumer advocates, providers, employer purchasers, labor leaders and insurers. The Stakeholder Advisory Board met monthly during the same time period as the Technical Team. Appendix C provides a list of Stakeholder Advisory Board members.

OHS shared input from each of the Stakeholder Advisory Board's meetings with the Technical Team. OHS sequenced the meetings of these two advisory groups so that the Stakeholder Advisory Board provided input to the Technical Team on each preliminary recommendation, and the Technical Team considered that input and reported back to the Stakeholder Advisory Board on those recommendations, ensuring a feedback loop. As a result of this process, the Technical Team revised its recommendations on numerous occasions.

In addition to obtaining input through the Stakeholder Advisory Board, OHS undertook a vigorous stakeholder engagement effort, more expansive than that used in the other four states. Throughout the spring and summer of 2020, OHS educated other State-convened bodies about the benchmark and target work, and solicited their questions and recommendations. These entities included the OHS Consumer Advisory Council, the Connecticut Health Care Cabinet, the Practice Transformation Task Force, and the Council on Medical Assistance Program Oversight Council ((MAPOC) and legislators. OHS also met with numerous community groups. Each of these occasions provided opportunity for OHS to inform stakeholders on the development of the Executive Order 5 initiatives and gather input. Appendix D provides a list of stakeholder engagement events undertaken to date by OHS.

OHS published the Technical Team's preliminary recommendations for a four-week public examination and comment period. At the conclusion of the public comment period, OHS had received 24 sets of comments. In addition, OHS held an informational hearing for legislators on October 28, 2020 to review the preliminary recommendations and collect feedback. Feedback received from the Connecticut stakeholder community and legislators was then incorporated into this document.

Finally, with respect to the quality benchmarks, OHS has charged the Quality Council to development recommendations with support from OHS and DSS. Final recommendations for quality benchmarks will be vetted for public feedback and then reconsidered before adoption.

Cost Growth Benchmark

Executive Order 5 defined the healthcare cost growth benchmark as the per capita sum of all healthcare expenditures in Connecticut from public and private sources for a given calendar year. This section details the process for establishing the value of the healthcare cost growth benchmark, what spending to measure, and the process for obtaining data to assess performance.

A. Healthcare Cost Growth Benchmark Methodology

The Technical Team established three criteria for selecting an economic indicator that could be used to set a cost growth benchmark. The indicator must: (1) provide a stable and therefore predictable target; (2) rely on independent, objective sources with transparent calculations; and (3) should result in a benchmark value that lowers growth in healthcare spending for consumers, employers, and taxpayers.

After receiving input from the public, the Stakeholder Advisory Board and legislators, OHS has adopted the recommendations made by the Technical Team to base the benchmark on a

calculated and pre-determined blend of the **growth in the forecasted per capita potential gross state product (PGSP), and the forecasted growth in median income**, calculated in 2020 for calendar years 2021-2025. The Technical Team acknowledged that healthcare spending should not grow faster than a forecasted measure of state economic growth, but recognized the challenges individuals and families experience as healthcare consumes greater portions of their income. Therefore, the Technical Team created a blended benchmark value that incorporated both of these concepts.

Table 1 below describes the weighted blend of PGSP and median income that the Technical Team recommended and OHS has adopted. In addition, the Technical Team recognized that the weighted methodology's initial value of 2.9% may be difficult for the payers, and providers to meet immediately given typical contracting cycles and the effect of COVID-19 on healthcare utilization patterns. OHS agreed with the Technical Team recommendation for a two-year adjustment to ease into the final target.

Table 1. Cost Growth Benchmark Methodology

Calendar Year	Cost Growth Benchmark Methodology	Add-on Factor
2021	20% PGSP / 80% Median Income	0.5%
2022	20% PGSP / 80% Median Income	0.3%
2023	20% PGSP / 80% Median Income	0.0%
2024	20% PGSP / 80% Median Income	0.0%
2025	20% PGSP / 80% Median Income	0.0%

The formula for calculating the forecasted long-term (2026-2030) per capita PGSP is the same used by Massachusetts, Delaware, and Rhode Island:

PGSP = *(expected growth in national labor force productivity + expected growth in the state's labor force + expected national inflation) – expected state population growth*

As calculated by OHS, the forecasted per capita PGSP for Connecticut is **3.7%.**

To calculate the forecasted growth in median household income (2026-2030), the Technical Team recommended using the annual growth rate data purchased from IHS Markit by the Connecticut Office of Policy and Management and made available to OHS. The forecasted median household income growth in Connecticut was **2.7%.**

Table 2 below presents the healthcare cost growth benchmark adopted by OHS, using the blended formula of the two values listed in Table 1.

Table 2. Cost Growth Benchmark Values 2021-2025

Calendar Year	Cost Growth Benchmark Values
2021	3.4%
2022	3.2%
2023	2.9%
2024	2.9%
2025	2.9%

While Massachusetts, Delaware and Rhode Island have utilized PGSP, as previously mentioned, Oregon, like Connecticut, chose a different methodology for its benchmark. Oregon also considered consumer-level indices to ensure affordability is incorporated as an important factor in constraining the rate of cost growth. Regardless of the chosen methodology, the values are generally aligned across states and are comparable to each state's historical health care expenditure growth rate. Table 3 below describes the benchmark values of other states and the benchmark values compared to each state's 20 year health care expenditure growth.

Table 3. Cost Growth Benchmark Values 2021-2025

State	Annual Cost Growth Benchmark Values and Years	Cost Growth Benchmark Values Relative to 20 Year Average Growth of Health Care Expenditures[13]
Connecticut	3.4%-2.9% (2021-2025)	71-60%
Delaware	3.8%-3.0% (2019-2023)[14]	68-54%
Massachusetts	3.1% (2019-2022)[15]	71-61%
Oregon	3.4%-3.0% (2021-2030)[16]	53-50%
Rhode Island	3.2% (2019-2022)	60%

At least one member questioned starting the cost growth benchmark during the pandemic, but acknowledged the direction of the Executive Order. OHS has committed that when publishing data on performance that was impacted by COVID-19, it will provide perspective of the unique circumstances in healthcare spending and utilization patterns that arose as a result and will not penalize payers or provider entities that exceed the benchmark as a result of variation in utilization patterns resulting from the unusual circumstances caused by COVID-19. Finally, OHS will revisit the healthcare cost growth benchmark's methodology and calculation should there be a sharp rise in inflation between 2021and 2025.

B. Methodology for Measuring Healthcare Spending for the Cost Growth Target

Measuring the State's per capita spending on healthcare requires determining whose healthcare spending to measure, and what costs to include in that measurement.

[13] Calculated figure using 20-year average health care expenditure growth as published by the Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group and the National Health expenditures by State of Residence, June 2017.
[14] In Delaware, the cost growth benchmark is PGSP plus a transitional adjustment that varies between 2019 and 2021. Calendar years 2022 and 2023 are the calculated measure of PGSP, which is 3.0%.
[15] In Massachusetts the cost growth benchmark is PGSP minus 0.5% from 2018-2022 unless the Health Policy Commission votes that an adjustment is warranted by a two-thirds majority.
[16] Oregon based its benchmark on historical gross state product and median wage data and in consideration of the growth "cap" in Oregon's Medicaid and publicly purchased insurance programs.

Total Health Care Expenditures (THCE), (i.e., what is subject to the target) is defined as:

(1) all claims-based spending paid to providers by private and public payers, net of pharmacy rebates;
(2) all patient cost-sharing amounts, including, but not limited to deductibles and copayments, and
(3) the Net Cost of Private Health Insurance (NCPHI).[17]

THCE includes spending on behalf of Connecticut residents who are insured by Medicare, Medicaid or commercial carriers, as well as residents who obtain coverage from self-insured employers, and receive care from any provider in or outside of Connecticut, inclusive of those patients who seek care in border states, who may be Connecticut residents but spend part of their time living in another state (i.e., students or "snow-birds"), or those who received care in another state while traveling. Spending for out-of-state residents receiving care from in-state providers is excluded from THCE. THCE also includes spending for Connecticut residents who receive healthcare coverage through the Veterans Health Administration, as well as spending for Connecticut residents incarcerated in a state correctional facility.

The Technical Team and Stakeholder Advisory Board expressed a preference for dental claims by dental insurance carriers to be included in THCE, but after deliberating on the limitations in available data, the lack of healthcare provider accountability for dental care, and dental insurance being quite limited, the Technical Team opted to exclude spending by dental insurance carriers at this time. OHS will revisit the possibility of including dental claims when and if the data become available through the APCD.

Recognizing that the definition of THCE is limited to individuals with health insurance coverage and that financial burden of healthcare for those without health insurance is high, OHS will conduct supplemental tracking and reporting of costs for uninsured individuals, per the request of the Technical Team and Stakeholder Advisory Board, to the extent such data are available.

C. Process for Obtaining Data

Payers will need to submit data to OHS to measure healthcare spending against the benchmark at the State, market, payer and large provider entity level, rather than utilizing the APCD, since payers are the only source for non-claims payments, healthcare spending for residents whose employers are self-insured, and pharmacy rebates.

To obtain THCE data, OHS will:

1) request that payers listed on the Insurance Department Consumer Report Card on Health Insurance Carriers in Connecticut to submit data for their commercial and Medicare product

[17] Net cost of private health insurance (NCPHI) captures the cost associated with the administration of private health insurance. It is the difference between health premiums earned and benefits incurred. It consists of insurers' costs related to: paying bills, advertising, sales commissions, other administrative costs, premium taxes and other fees. It also includes insurer profits and/or losses.

lines,[18] including data from all wholly-owned subsidiaries. These data are intended to be collected using consistent specifications to be developed by OHS (and discussed in the Next Steps section of this report) and will allow for each payer to utilize its own clinical risk-adjustment software;[19]
2) request Medicare fee-for-service claim payment data from the Centers for Medicare & Medicaid Services (CMS), and Medicaid payment data from the Department of Social Services (DSS);
3) use publicly available and regularly published data for spending on the Veteran's Health Administration, and
4) request data from the Department of Correction (DOC) for healthcare spending in the State's correctional facilities.

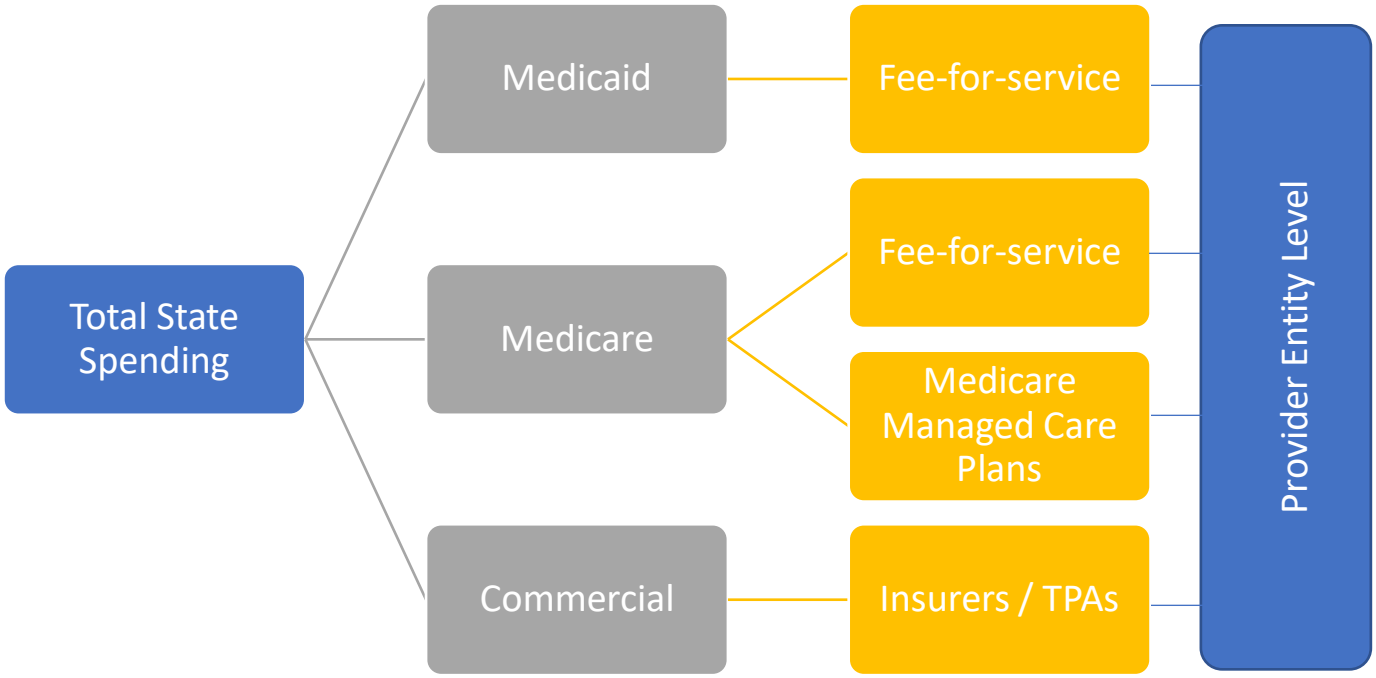
The Technical Team expressed a desire to obtain data from pharmacy benefit managers (PBMs), to the extent possible. However, PBMs are not able to attribute pharmacy spending to a primary care provider in the same manner as primary payers, therefore making the PBM data unusable at the provider entity level. In acknowledgement of this challenge, payers will be asked to submit actual pharmacy spending data and estimated PBM spending based on the experience of members whose pharmacy benefit the insurer covers. While the cost growth benchmark program will be collecting pharmacy rebate data directly from insurers, it will not be able to collect pharmacy rebate data from the PBMs. Instead, the Connecticut Insurance Department will be collecting the aggregate dollar amount of all PBM rebates pursuant to Conn. Gen. Stat. §38a-479ppp (Public Act 18-41). This information can be used to inform the healthcare cost growth benchmark program.

D. Process for Measuring Performance Against the Benchmark

Performance against the benchmark will be measured at the **state, payer, insurance market, and large provider entity level** as shown in Figure 1.

[18] Commercial payers include Aetna Health & Life, Anthem, Cigna, ConnectiCare, Harvard Pilgrim Health Care and UnitedHealthcare and all of the wholly-owned subsidiaries of those companies. Medicare payers, in addition to CMS, include Aetna, Anthem, ConnectiCare, UnitedHealthcare and all of the wholly-owned subsidiaries of those companies. The Medicaid payer is the Connecticut Department of Social Services.
[19] No Protected Health Information (PHI) will be collected through this process.

Figure 1. Benchmark Performance Reporting Levels



The per capita change in spending from one calendar year to the next will be publicly reported by OHS, along with contextual information that may highlight legitimate reasons spending was above or significantly below the benchmark. For example, published data that covers the period of the COVID-19 pandemic will highlight both national and state healthcare utilization and spending experience to put Connecticut-specific payer and large provider entity experience into perspective. Similarly, future events like new market entrants of biologics or orphan drugs, future pandemics or similar unanticipated events that significantly impact healthcare utilization and spending will also be identified (as was the case in Massachusetts when Sovaldi, a hepatitis C treatment, was first approved for use). There will not be regulatory consequences for payers and large provider entities that exceed the benchmark for reasons such as those previously listed.

To measure and publicly report performance against the benchmark at the provider entity level, it is necessary for individual patients to be attributed or assigned to a primary care provider, and those primary care providers to be organized into provider entities large enough for their performance to be statistically valid.[20] Insurers will be asked to utilize their own primary care

[20] For the purposes of the Cost Growth Benchmark, all healthcare spending on behalf of a member, regardless of where the services were received or by whom they were performed, will be attributed to the member's primary care provider. Primary care providers will be attributed to the entity to which the primary care provider belongs, so long as the primary care provider belongs to an entity identified through the provider directory maintained to support the HealthScore CT and Quality Scorecard. The Cost Growth Benchmark performance cannot be reported by individual

attribution methodology to attribute patients to a primary care provider with some broad parameters established in the Implementation Manual by OHS. With respect to organizing primary care providers into larger provider entities, until OHS develops its own provider directory in the Health Information Exchange (HIE), OHS will utilize the provider directory that is being maintained to support the web- based HealthScore CT and Quality Scorecard. In addition, OHS will leverage the empirical model that Oregon is simultaneously building to determine how many attributed patients a provider entity needs to care for, annually, for its performance to be publicly reported. If Oregon is unable to complete its analysis before OHS needs to develop its specifications, OHS will continue the research. Further, OHS will consult with literature on this topic, as suggested by the Technical Team, to inform its final decision.

Public reporting will also include total and per capita spending on key service categories at the state, payer, market, and large provider entity levels. Service categories will be defined in the Implementation Manual and will include but not be limited to hospital inpatient, hospital outpatient, primary care, long-term care, and certain non-claims categories as shown in the examples in Figure 2.

Figure 2. Examples of Cost Growth Benchmark Reporting Categories

In order to report on payer and provider performance against the cost growth benchmark, cost data will need to be risk adjusted. "Risk adjustment" is the modification of spending data to reflect changes in the health status of the underlying insurer or provider population over the course of the year. Each commercial payer will be permitted to use its own clinical risk adjustment tool as this would be less administratively burdensome and costly. Research suggests that performance differences between risk adjustment tools are relatively minimal.[21]

hospital entity unless that entity is identified through the aforementioned provider directory. Performance on hospital cost, quality and utilization, however, can be part of the associated Data Use Strategy, some of which is already collected by OHS and will be utilized in conversations with larger provider entities, as applicable.

[21] Conversation with Arlene Ash, PhD, Professor and Division Chief for Biostatistics and Health Services Research in the Department of Quantitative Health Services at the University of Massachusetts Medical School, May 2020.

OHS will request that commercial payers report which risk adjustment tool they use and the underlying methodology in order to support transparency and understanding.

While there is very limited experience so far with risk adjustment for social factors and the methodologies are early in development, the Technical Team, strongly recommended that OHS gather social risk factor data (e.g., income, education, race and ethnicity, language, housing stability and quality, etc.) and analyze the relationship between social risk variables and health care spending using APCD data to inform future social risk adjustment of cost growth relative to the cost growth benchmark. The Technical Team also encouraged use of the State's Health Information Exchange as a potential future source for social risk factor data.

E. Process for Monitoring Unintended Consequences of the Cost Growth Benchmark

Several members of the Technical Team and Stakeholder Advisory Board raised concerns that a cost growth benchmark may cause providers to inappropriately reduce healthcare services provided to individuals to stay within the benchmark. While other states with cost growth benchmarks have not documented such "stinting," OHS will develop a monitoring approach as part of its Data Use Strategy, using DSS's PCMH+ Under-Service Utilization Monitoring Strategy as a starting point, for identifying potential under-utilization or inappropriate reductions in access to medically necessary care. This strategy will include measures to track preventive and access to care, and detect under-service.

OHS will develop a set of recommended monitoring measures and intends to share them with the Technical Team and Stakeholder Advisory Board in November 2020.

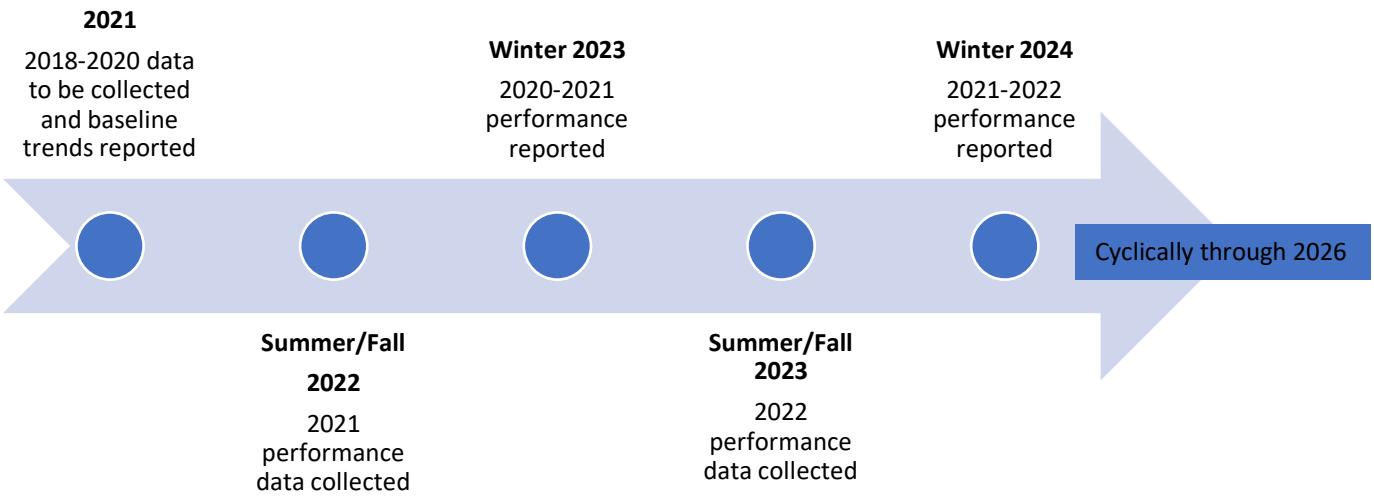
F. Implementation Timeline

Prior to the end of 2020, OHS will develop an implementation manual that details the healthcare cost growth benchmark methodology, how to obtain data, and data specifications for payers to facilitate consistent reporting. This is discussed in more detail in the Next Steps section of this report. Because data will be reported in aggregate form by payers, the analytic burden on OHS will not be great.

The healthcare cost growth benchmark is intended to become effective in 2021, which means the change in spending between calendar year 2020 and 2021 will be subject to the benchmark.[22] It takes approximately six months for payers to finalize spending data from previous calendar years. Therefore, public reporting on calendar year 2021 performance will likely not occur until early 2023 to allow OHS enough time to collect, validate and analyze the data as seen in Figure 4 below. The Technical Team anticipated that 2020 and 2021 spending will likely be significantly impacted by COVID-19. OHS will collect baseline data for 2018 and 2019 to identify healthcare spending trends before the pandemic.

[22] OHS acknowledges that some payer and provider contracts for CY 2021 were signed in advance of the publication of this final report and that associated negotiated rate increases could have exceeded the cost growth benchmark.

Figure 4. Benchmark Performance Reporting Timeline



Primary Care Spending Target

Executive Order 5 specified that by 2025 primary care spending in Connecticut, as a percentage of total health care expenditures, should reach a target of 10 percent. This section describes the recommendations for defining primary care spending, obtaining data to assess performance, setting annual targets to reach 10 percent, analyzing primary care spending data, and parameters for how to increase primary care spending.

A. Definition of Primary Care Spending

To reach the 10 percent target for primary care spending, the Technical Team first needed to establish a definition of "primary care spending." The Technical Team expressed interest in measuring primary care spending for measurement in two ways. The first definition, i.e., the "narrow" definition, focuses on tracking investment in primary care services that are delivered by traditional primary care specialties. OHS will use this definition to assess statewide spending against the target established in Executive Order 5. The second definition, i.e., the "broad" definition, also includes primary care-focused services delivered by OB/GYNs and midwifery. Approximately 15 percent of women, especially those that are generally healthy, reportedly use an OB/GYN as their primary care provider and the Technical Team did not

want to lose sight of this.[23,24] At the same time, OB/GYNs do not provide the same breadth of services as traditional primary care specialties and therefore the Technical Team did not think they should be included in the narrow definition of primary care spending. Public comment also highlighted advantages and disadvantages associated with having a narrow and broad definition of primary care spending. The purpose of the narrow and broad definitions of primary care spending can be found in Table 4 below.

Table 4. Purpose of Narrow and Broad Definitions of Primary Care Spending

	Narrow Definition	Broad Definition
Purpose	• To measure performance against the Primary Care Target. 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 and includes those providers and routine primary care and non-specialty gynecological services delivered by OB/GYNs and midwifery in the definition.

OHS decided to adhere to the Technical Team's recommendation, which was informed by the Stakeholder Advisory Board's input, to adopt two definitions of primary care providers and services – a narrow definition and a broad definition. This decision reflects the overall position of the public comments received on the primary care spending target. These definitions of primary care providers and services are described in Tables 5 and 6 below, respectively. The definitions are loosely based off a definition developed by the New England States Consortium Systems Organization (NESCSO), with the addition of providers and service categories that were of importance to the Technical Team with the advice of the Stakeholder Advisory Board (e.g., OB/GYN and midwifery, pediatric dental risk assessments).

Table 5. Definitions of Primary Care Providers

	Definition 1: Narrow	Definition 2: Broad
Included Providers (in	• **MDs and DOs**: Internal Medicine when practicing primary care, Family Medicine, Pediatric and Adolescent	• **MDs and DOs**: Internal Medicine when practicing primary care, Family Medicine, Pediatric and Adolescent Medicine, Geriatric Medicine when

[23] Rae-Ellen Roy, Assistant Director of the Health Policy and Benefits Division at the Connecticut Office of the State Comptroller, reported that 15 percent of women covered under the health plan use their OB/GYN providers as their primary care physician during the July 2, 2020 Technical Team meeting.
[24] Cleveland Clinic. "Why an OB/GYN Should Not Be Your Only Doctor." September 18, 2018. Accessed November 5, 2020. https://health.clevelandclinic.org/why-an-ob-gyn-should-not-be-your-only-doctor/, and Zephyrin, L., Suennen, L., Viswanathan, P., Augenstein, J. and Bachrach, D. "Transforming Primary Health Care for Women – Part 1: A Framework for Addressing Gaps and Barriers." The Commonwealth Fund. July 16, 2020. Accessed November 5, 2020. https://www.commonwealthfund.org/publications/fund-reports/2020/jul/transforming-primary-health-care-women-part-1-framework.

outpatient settings[25])	Medicine, Geriatric Medicine when practicing primary care • **NPs and PAs**: when practicing primary care	practicing primary care, OB/GYN and midwifery • **NPs and PAs**: when practicing primary care
<u>Excluded</u> Providers (among others)	• OB/GYN and midwifery • Behavioral health • Emergency room physician • Naturopathic health care provider	• Behavioral health • Emergency room physician • Naturopathic health care provider

Table 6. Definitions of Primary Care Services

	Definition 1: Narrow	**Definition 2: Broad**
<u>Included</u> 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
<u>Excluded</u> Services	• Routine primary care and non-specialty gynecological services delivered by OB/GYNs and midwifery • Minor outpatient procedures • Inpatient care • ED care • Nursing facility care • Practice-administered pharmacy	• Minor outpatient procedures • Inpatient care • ED care • Nursing facility care • Practice-administered pharmacy

[25] Including but not limited to private practices, primary care clinics, FQHCs and school-based health centers

Payers will be requested to calculate service-based payments, as described above, on an allowed claims basis because it captures both patient out-of-pocket and payer spending on services. Non-service-based payments should include the following categories that NESCSO identified: capitation or salaried expenditures, Patient-Centered Medical Home (PCMH) infrastructure, performance-based payments, risk-based reconciliation, HIT infrastructure, workforce expenditures, COVID-19 support payments (if feasible) and other (e.g., loan forgiveness for training providers, flu clinics).[26]

Finally, to calculate primary care spending as a percentage of total healthcare expenditures, the Technical Team had to define "total healthcare expenditures." The Technical Team recommended and OHS agrees with aligning the definition of total healthcare expenditures for the primary care spending target with the definition used for the cost growth benchmark. It recommended – and OHS agrees with - excluding long-term care services, however, because this spending category primarily applies to Medicaid. Excluding long-term care services facilitates better comparisons of primary care spending across commercial, Medicaid and Medicare markets.

B. Process for Obtaining Data

To facilitate alignment with the cost growth benchmark, payers will be requested to report primary care spending data for in-state residents and all providers, along with their cost growth benchmark data submissions. As mentioned above, OHS will not utilize the APCD for this data because payers are the only source of non-claims payment, self-insured data, and pharmacy rebates. To measure spending across the payers, OHS will collect data for commercial, Medicaid and Medicare payers in addition to the Veteran's Health Administration and Department of Correction (DOC). CMS, however, has indicated it does not have the resources to report primary care spending with the cost growth benchmark data. Therefore, OHS may need to release two primary care spending calculations – an initial one excluding Medicare and a later one using Medicare data from the State's APCD. In addition, OHS explored whether it was possible to obtain primary care spending data from the Veteran's Health Administration and DOC. It was unable to confirm the ability of the Veteran's Health Administration to report primary care spending data, however, it did confirm that DOC would be able to provide these data.

[26] Capitation or salaried expenditures include capitation and/or salaried arrangements with primary care providers or other providers not billed or captured through claims. PCMH infrastructure includes practice-level payments for the provision of comprehensive primary care services, payments based upon PCMH recognition or payments for participation in proprietary or other multi-payer medical home or specialty care practice initiatives. Performance-based payments include bonus incentive payments to a provider for meeting predetermined baseline or target of medical service use. Risk-based reconciliation includes risk-based payments to primary care providers or practices that are not billed or otherwise captured through claims. HIT infrastructure includes payments for health information technology structural changes at a primary care practice, such as electronic records and data reporting capacity from those records. Workforce expenditures include payments or expenses for supplemental staff or activities integrated into the primary care practice (e.g., practice coaches, patient educators, patient navigators, nurse care managers). Other includes any non-claims-based expenditures to support primary care practices, such as investments in loan forgiveness for training providers, flu clinics, rewards for provider reporting.

C. Process for Setting Annual Targets

The Executive Order directed the development of a process to calculate statewide spending and set annual targets to achieve the 10 percent target by 2025. To calculate statewide spending on primary care, the Technical Team recommended creating a weighted average by multiplying each insurance market's percentage of spending on primary care by its total market share based on total health care expenditures. The Technical Team noted challenges to setting annual targets in 2020 because of the lack of payer-reported baseline data, utilization changes occurring due to COVID-19, and the proximity of the 2021 measurement period limiting payer actions to increase primary care spending in 2021. In addition, it hesitated to adopt annual targets without first identifying parameters for how spend should be increased. It recommended adopting a conservative target for 2020 and deferred setting annual targets until it could solicit input from the Primary Care and Community Health Work Group on what strategies Connecticut stakeholders should take to increase primary care spend. This would impact how quickly spend should increase on an annual basis to reach the five-year target. OHS adopts these recommendations and the initial primary care target will be a conservative target of 5.0 percent for 2021, given the current best estimate of statewide spending on primary care is 4.8 percent.[27] Annual targets for 2022–2024 will be set after baseline spending data has been collected from payers and the OHS-convened, Primary Care Work Group considers recommendations that may impact primary care spending. Performance against the primary care spending targets will be reported at the state, insurance market, insurer, and large provider entity.

D. Analyzing Primary Care Spending Data

The Technical Team highlighted the importance of stratifying primary care spending data to understand current spending trends and identify opportunities for improvement. Future analyses will include stratifying by provider/accountable care organization (ACO), race/ethnicity, gender, multiple comorbidities, modality (e.g., telehealth, in-person visits) and payment model (e.g., fee-for-service or alternative payment model). These analyses can also help measure any unintended consequences that arise from the primary care spending target.

E. Parameters for How to Increase Primary Care Spending by Payers

Finally, the Technical Team made suggestions for how payers should increase primary care spending. These suggestions will be considered by OHS and include:

1. Increase spending (a) in alignment with existing statewide initiatives and policies, (b) through increased utilization of value-based incentives, (c) in a way that provides value[28] and (d) by rewarding performance.
2. Continuously update policies based on incoming data on primary care spending and cost growth.

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[27] OHS calculated a statewide weighted average of current primary care spending by total health care expenditures. Commercial and Medicare data were form UConn and Medicaid data were from Freedman Healthcare and the Department of Social Services. While OHS' best estimate of statewide primary care spending is 4.8 percent, Freedman Healthcare's data suggest that Medicaid primary care spending alone is 9.0 percent.

[28] OHS can define value as improved quality, increased utilization or primary care and access to care, and improved outcomes.

3. Measure decreased spending elsewhere that is a byproduct of increased primary care spending.
4. Ensure increased access to primary care, especially for populations that are currently not receiving services.
5. Enhance how payers and providers deliver primary care, potentially as recommended by the National Alliance of Health Care Purchaser Coalitions recommendations on advancing primary care.[29]

F. Implementation Process and Timeline

OHS is directed to implement the primary care spending target beginning in 2021 per Executive Order 5. As with total spending, OHS acknowledges that 2021 primary care spending will likely be significantly impacted by COVID-19. OHS will collect baseline data for 2018 and 2019 to identify primary care spending trends before the pandemic. The timeline and process for payer reporting primary care spend data should be aligned with payer reporting total healthcare cost growth data.

Data Use Strategy

The data use strategy is a complementary plan to the cost growth benchmark that purposefully leverages the State's APCD data to achieve the aims of Executive Order 5. The data use strategy can help identify where costs are high, where they are growing rapidly, and where they are variable. These three approaches can identify which spending categories warrant the greatest attention to "move the needle" on the cost growth benchmark. The Technical Team and Stakeholder Advisory Board expressed interest in leveraging the data use strategy to identify any unintended consequences of the cost growth benchmark, assess the benchmark's impact on consumer out-of-pocket spending and examine the impact of health disparities on utilization, cost and quality. This report section summarizes the recommendations on priority goals, analyses and audience, the complementary work to be performed by Mathematica, OHS' sub-contractor for data analytics, and the timeline and process for implementing the data use strategy.

A. Data Use Strategy Goals and Audience

The Technical Team adopted three priority goals to shape the data use strategy:

1. Produce routine analyses that identify leading opportunities to improve healthcare and invest in higher value care through (1) reduced healthcare spending growth in a manner that will not harm patients, and (2) improved quality.

[29] The complete list of National Alliance of Health Care Purchaser Coalitions' recommendations includes enhanced access for patients, more time with patients, realigned payment methods, organization and infrastructure backbone, behavioral health integration, disciplined focus on health improvement and referral management. For more information, see: https://connect.nationalalliancehealth.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=6ca6ceb5-a85b-0f2d-0a10-21eb7ce3bf69&forceDialog=0.

2. Produce ad-hoc, one-time analyses in areas of perceived opportunity and are of specific interest to stakeholders committed to reducing spending while improving and/or maintaining access and quality.[30]
3. Interpret health care spending analyses and link findings with recommended actions for the intended audiences.

Based on the Technical Team's recommendations, OHS commits to a) ensure transparency of data and reports for consumers on its website, b) support consumer understanding and use of the analyses and c) continue consumer engagement in all Executive Order 5-related activity.

B. Priority Analyses

The Technical Team reviewed and made final recommendations on guidelines to consider all categories of analyses, as well as which specific analyses to prioritize in the data use strategy. Of note, the Healthcare Cabinet convened a Cost Containment Data Workgroup whose 2019 priority recommendations largely align with the Technical Team's recommendations. They were adopted by OHS and are outlined below.

Guidelines for all analyses include:

1. Analyses should be stratified by sub-populations that are of interest to stakeholders, including by:
    a. insurer and insurance coverage (e.g., commercial, Medicaid, Medicare, uninsured)
    b. age (e.g., pediatric, adult)
    c. gender
    d. provider (e.g., care site, practice, facility, network, system)
    e. site of service (e.g., urgent care, emergency department)
    f. provider specialty (e.g., primary care, specialty)
    g. presence of chronic conditions
    h. race, ethnicity, language, and disability status, to the extent possible[31]
    i. geography (e.g., zip code, town/city, county)
2. Analyses should be structured to produce statistically valid and reliable results, including through use of risk adjustment, and adjusting for social determinants of health where appropriate.[32]
3. Analyses should support comparisons to peer organizations and other benchmarks, and display change over time.

[30] The Technical Team noted that OHS could develop criteria to prioritize these ad hoc recommendations.
[31] The Technical Team highlighted the limited availability of race, ethnicity, language and disability data across payers. It urged OHS to prioritize improved data collection of these variables, noting that efforts to perform analyses will be limited without such action.
[32] ICD-10 Z codes and social determinants of health data from the American Community Survey may serve as valuable pathways to accomplish this type of analysis. The Technical Team, however, noted the importance of collecting more data, especially non-claims information through the statewide Health Information Exchange, for these analyses.

The Technical Team recommended making data public to allow stakeholders to replicate and validate analyses as desired, and OHS commits to doing so. OHS will take steps to capture and analyze data on the uninsured, including undocumented immigrants, to the extent possible.

The following types of analyses will be prioritized by OHS to perform as part of the data use strategy. Appendix E provides more information about the other analyses also of interest to the Technical Team.

1. **Cost growth drivers** are the leading factors contributing to cost growth over the course of one or more years. These analyses deconstruct the factors [e.g., utilization, price, service mix/intensity (e.g., cost or quantity of services used to treat any one given condition), patient demographics, etc.] contributing to longitudinal cost growth.
2. **Cost drivers** are factors that most contribute to the total cost of care for a population of patients at a specific point in time. Cost drivers can be specific categories of services, provider types, providers, and medical conditions. There are multiple categories of analyses that can be employed to understand cost drivers, three of which were preliminarily prioritized by the Technical Team.
    a. **Utilization variation** assesses differences in use of services that significantly contribute to total cost of care. They can assess to what degree service utilization varies within the state and compared to external benchmarks.
    b. **Price variation** analyses look at the variation in the amount providers are paid for a given service, shedding light on the impact of market power on commercial market prices.
    c. **Cost variation** analyses assess the variation in aggregate payments across a range of providers for the treatment of episodes of care (e.g., total hip replacement, treatment of diabetes). The Technical Team expressed special interest in how episode cost variation in Connecticut is impacted by potentially avoidable complications, including healthcare-acquired infections.
3. As referenced earlier, the Technical Team expressed interest in measuring the **effects of the cost growth benchmark**, including any unintended consequences that may arise from its implementation.
    a. **Underutilization** of healthcare services, as a result of providers or payers impeding access to care, is a possible unintended consequence of the cost growth benchmark. The Technical Team was particularly interested in this type of analysis. There are a few ways OHS could assess underutilization, comparing pre and post-benchmark implementation time periods, by insurance market.
        i. One of DSS' strategies for identifying and preventing against underutilization for PCMH+ model is use of **preventive** and **access to care measures** (e.g., well-visit measures, preventive screening measures, routine diabetic care, follow-up care measures). The Technical Team appreciated this approach because it facilitates alignment with Medicaid's efforts while also providing a mechanism for identifying whether consumers are receiving medically-necessary care.

ii. **"Cold spotting"** analyses can identify which cities, towns and neighborhoods have consumers that are underutilizing necessary services.
iii. **Anti-stinting measures** (e.g., availability of appointments, "cherry picking," and "lemon dropping") can help inform whether providers are limiting access to care to reduce cost growth.[33]

b. Effects of the cost growth benchmark in terms of **impact on marginalized populations**, was important to the Technical Team and Stakeholder Advisory Board. This can be assessed by stratifying the previously discussed analyses by income, race/ethnicity, geography, disability status and select social determinants of health (SDOH) factors.
c. The cost growth benchmark will not be wholly successful if **consumer out-of-pocket spending**, including consumer spending due to deductible and co-insurance obligations, grows faster than the benchmark. This has been a problem in Massachusetts. OHS can track changes in consumer out-of-pocket spending, as well as premiums, relative to the benchmark.

C. Complementary Work by Mathematica and Timeline

In the short-term, OHS' data analytics contractor Mathematica will perform certain analyses focused on areas of high costs and high cost growth that are included in the proposed data use strategy. OHS' goals for this work are to:

1. provide analytics that help establish trust in the APCD data;
2. identify an initial set of cost drivers;
3. identify opportunities to reduce costs and cost growth without harming patients, and
4. create room for stakeholders to provide input before OHS moves forward with the larger data use strategy.

Mathematica's analyses will focus on annual changes and average annual changes in spending (including total spending, per member per month spending, spending by service category or chronic condition and out-of-pocket spending) and utilization.[34] Analyses will be stratified by payer, age, gender and region, and will also be adjusted for age and gender. Mathematica will first analyze commercial medical claims, and then will move on to Medicaid and Medicare should time and resources allow.

Mathematica will complete the initial work by the end of 2020.

D. Implementation Process and Timeline

After Mathematica concludes its work, OHS will develop detailed specifications for the analyses recommended by the Technical Team. For example, it will identify the services on which each

[33] Potential measures include: (a) assessing whether practices are adhering to basic requirements for office hours and/or the availability of appointments, (b) assessing whether newly enrolled patients are healthier and/or have fewer comorbid conditions with lower healthcare costs, i.e., "cherry picking" and (c) assessing practice population risk score and/or scores of patients that left the practice, as practices may drop patients with more costly care needs.
[34] If there is additional time, Mathematica will also assess avoidable hospitalizations and low-value services.

set of analyses will focus. OHS will assess differentiated services (e.g., colonoscopy, MRI, joint replacement, OB care) when looking at utilization, price, and cost. OHS will identify the timeframe for publishing these analyses on a bi-annual basis. Finally, OHS will develop a process for performing analyses, producing reports, and sharing data with its priority audiences. Of note, the Technical Team recommended that OHS produce regular reports as well as ad hoc analyses. For example, one ad hoc report of interest to the Technical Team would assess the impact of ambulatory surgical centers on cost growth, utilization, and access and whether these variables differ based on how far away a center is from the main hospital.

OHS will develop a plan and timeline for advancing the data use strategy going forward.

E. Ensuring Success

The Technical Team offered a range of recommendations to ensure the success of Connecticut's cost growth benchmark and primary care target. OHS will work to implement the following:

- Continue to emphasize the importance of data transparency and ongoing communications.
- Ensure the benchmark does not have the unintended consequence of limiting access by means of the underservice measurement and monitoring strategy described earlier in this report.
- Avoid punitive consequences for providers during initial years of implementation.
- Consider a thoughtful definition of success.
- Direct the Primary Care Work Group to recommend an approach for implementation of a standard that consumers must select a primary care provider when they enroll in health insurance coverage, taking into concern the challenges that such a standard might pose for some individuals and providers.

OHS will also explore the potential applicability and usability of its new Healthcare Affordability Index when fully developed to test the impact of the cost growth benchmark and will continue to work with both the Technical Team and the Stakeholder Advisory Board to ensure the successful implementation of all initiatives it is charged with implementing under Executive Order #5.

Next Steps

A. Quality Benchmarks

The Quality Council will reconvene in the fall of 2020 in order to begin the process of developing recommendations on quality benchmarks across all public and private payers beginning in CY 2022.

B. Implementation Manual with Data Specifications for the Cost Growth Benchmark and Primary Care Spending Target

OHS will develop an implementation manual prior to the end of 2020 detailing the process for implementing the healthcare spending benchmark and primary care spending targets. OHS intends to develop these specifications to collect CY 2018 and CY 2019 data sufficiently in advance of requesting the data. This will include the methodology for the healthcare cost

growth benchmark and primary care spending targets, including how OHS will calculate each and the sources of data used. It will also contain detailed specifications for insurers to use when submitting data to OHS. For the primary care spending target, those detailed specifications will leverage, where appropriate, NESCSO's work in this area. Finally, the manual will also include information for how to consolidate payer-reported data for reporting at the state, market, insurer, and large provider entity levels (as applicable to the benchmark or target).

OHS intends to develop specifications that will be updated on an annual basis, but will work to avoid large methodological changes year-to-year that would cause undue administrative burden on reporting payers or create confusion for providers. Future editions of the manual will also contain details on how to operationalize the quality benchmarks.

C. Refinement of the Data Use Strategy and Process for Report Development

Mathematica will share its code with OHS staff at the conclusion of its work. OHS and any contractor(s) it chooses to use for this work will build off Mathematica's code to produce ongoing and ad hoc reports, as specified above. As mentioned earlier, OHS will develop detailed specifications for the data use strategy as well as a process for performing analyses, producing reports, and sharing data with its priority audiences.

D. Development of Ongoing Advisory Body(ies) and Stakeholder Engagement Processes through Implementation

OHS extends its utmost gratitude to the members of its two key advisory bodies, the Technical Team and Stakeholder Advisory Board, for their dedicated service and thoughtful guidance. OHS intends to continue working with these two advisory bodies on an ongoing basis. The continued guidance of these two groups will be an important source of input as the OHS completes implementation of the healthcare cost growth benchmark, and undertakes implementation of the primary care spend target and quality benchmarks.

OHS will establish a body to provide guidance on the routine development and publication of these reports. The Technical Team emphasized the importance of including stakeholders and consumers in this body to ensure they have a voice. This includes identifying which analyses and designs are effective to report, advising on any refinements, discussing ad hoc analyses that can be of value, and discussing methodological considerations for each analysis (e.g., measure validity). This body will also review findings prior to publication and discuss the implications and possible activities that can result from the findings (e.g., collaborative quality improvement efforts, use of regulatory levers, introduction of legislation).

As part of its overall emphasis on transparency, OHS will conduct annual hearings and publish reports that shine a spotlight on the main drivers of healthcare cost growth in Connecticut. These activities will help foster public understanding and trust in the cost growth benchmark and related initiatives. OHS has learned from Massachusetts' experience, where the State has done exceptionally well in publishing detailed, trusted reports on its healthcare cost growth benchmark experience, and then letting those reports "speak for themselves." OHS will focus on doing the same: good public reporting and clear, objective communication of Connecticut's

experience with the healthcare cost growth and quality benchmarks, and primary care spend targets.

OHS will continue to engage not only the public at large, but also stakeholder groups, on an ongoing basis so as to continue informing them about these initiatives. OHS will ensure that as it educates and communicates to stakeholder groups, it will articulate both the "why" of these initiatives as well as their potential benefits to Connecticut residents. Communications will need to be clear and not overwhelm audiences with unnecessary detail.

Appendices

Appendix A: Public Comment

The OHS received public comments from the following individuals and organizations. All public comments may be viewed on the OHS website. Some of the commenters listed below submitted multiple letters or were co-signers.

- Charlie Conway, Access Independence
- Nancy Alisberg
- Anthem
- Carmen R Correa-Rios, Center for Disability Rights
- Judith Stein, Center for Medicare Advocacy
- Supriyo Chatterjee
- Connecticut Association of Health Plans
- Elaine Burns, Connecticut Brain Injury Support Network
- Ann Pratt, Connecticut Citizen Action Group
- Melissa Marshall, Connecticut Cross Disability Lifespan Alliance
- Peaches Quinn, Connecticut Coalition on Aging
- Connecticut Health Foundation
- Ellen Andrews, Connecticut Health Policy Project
- Connecticut Hospital Association
- Connecticut Legal Services
- Sharon J. Heddle, Disabilities Network of Eastern CT
- Kathy Flaherty, Connecticut Legal Rights Project
- Karen Roseman, Connecticut State Independent Living Council
- Bob Joondeph, Disability Rights CT
- Greater Hartford Legal Aid
- Hartford HealthCare
- Gaye Hyre, Patient Advocate
- Eileen Healy, Independence Northwest, Inc.
- Jacklyn Pinney, Independence Unlimited
- Susan Israel, MD
- Doris Maldonado, Keep The Promise Coalition

- Elaine M. Kolb, Disability Rights Activist
- Velandy Manohar, MD
- Suzi Craig, Mental Health Connecticut
- Middlesex Health
- Moving to Value Alliance
- Stephen Wanczyk-Karp, National Association of Social Workers-CT
- New Haven Legal Assistance Association
- Wei Ng
- Nuvance Health
- Office of the Healthcare Advocate
- Josie Torres, People First
- Radiological Society of Connecticut
- Stamford Health
- Win Evarts, The ARC Connecticut, Inc.
- Trinity Health of New England
- Universal Health Care Foundation
- Wellville
- Yale New Haven Health System

Appendix B: Technical Team

Vicki Veltri, Office of Health Strategy (Chair)

Paul Grady, Connecticut Business Group on Health (Vice Chair)

Rebecca Andrews, American College of Physicians, Connecticut Chapter

Patricia Baker, Connecticut Health Foundation (retired)

Zack Cooper, Yale University

Judy Dowd, Office of Policy and Management

Angela Harris, Phillips Metropolitan CME Church

Paul Lombardo, Connecticut Insurance Department

Kate McEvoy, Department of Social Services

Luis Pérez, Mental Health Connecticut, Inc.

Rae-Ellen Roy, Office of the State Comptroller

More information may be found at: https://portal.ct.gov/OHS/Pages/Cost-Growth-Benchmark-Technical-Team

Appendix C: Stakeholder Advisory Board

Vicki Veltri, Office of Health Strategy (Chair)

Ted Doolittle, Healthcare Advocate, Office of the Healthcare Advocate

Reginald Eadie, Trinity Health of New England

Tekisha Everette, Health Equity Solutions

Pareesa Charmchi Goodwin, Connecticut Oral Health Initiative

Margaret Flinter, Community Health Center, Inc.

Karen Gee, OptumCare Network of Connecticut

Hector Glynn, The Village for Families and Children

Jonathan Gonzalez-Cruz, patient representative

Howard Forman, Yale University

Janice Henry, Anthem Blue Cross and Blue Shield of CT

Rob Kosior, ConnectiCare

Ken Lalime, Community Health Center Association of Connecticut

Sal Luciano, Connecticut AFL-CIO

Rick Melita, SEIU Connecticut State Council

Susan Millerick, patient representative

Fiona Mohring, Stanley Black & Decker

Lori Pasqualini, Ability Beyond

Richard Searles, Merritt Healthcare Solutions

Kathy Silard, Stamford Health

Marie Smith, UConn School of Pharmacy

Kristen Whitney-Daniels, patient representative

Nancy Yedlin, Donaghue Foundation

Jill Zorn, Universal Health Care Foundation

More information may be found at: https://portal.ct.gov/OHS/Pages/Cost-Growth-Benchmark-Stakeholder-Advisory-Board

Appendix D: Stakeholder Engagement

Webinar presentations:

- Connecticut Council on Developmental Services
- Ministerial Health Fellowship
- OHS Consumer Advisory Council
- State Health Improvement Planning Coalition (SHIP) Maternal, Infant and Child Health Action Team

Meetings:

- Connecticut Health Care Cabinet
- Connecticut Hospital Association
- Council on Medical Assistance Program Oversight (MAPOC)
- Monthly calls with legislators
- October 2020 informational hearing for legislators

Outreach conversations:

- Congregations Organized for a New Connecticut (CONECT)
- Keep the Promise Coalition

Appendix D: Data Use Strategy Analyses

The Technical Team recommended the following analyses, prioritized for development as part of a second wave of analyses:

1. **Low-value services** produce little-to-no patient benefit and may even result in patient harm. Analyses can assess provision of, and costs associated with, low-value services, which alignment with national and state efforts to avoid unnecessary testing, treatment, and procedures (e.g., Choosing Wisely).
2. **Potentially preventable services** are acute care services that could have perhaps been avoided through more effective or efficient provision of ambulatory services. Analyses can assess the frequency of potentially preventable services, shedding light on areas for performance improvement.
3. **Patient demographics** analyses can focus on the prevalence of and spending by chronic conditions and various SDOH. These require integrating APCD data with other public data sets (e.g., American Community Survey) that capture patient demographics (e.g., race, ethnicity, language) and SDOH information (e.g., housing status, income). They can highlight communities of highest social risk and help providers better understand how to serve their populations more holistically and proactively.
4. Assessment of the impact of the cost growth benchmark on the **affordability** of health care services. For example, consumers may realize increase out-of-pocket spending if employers change benefit design, and if consumers change plan selection. Another potential affordability analysis could look to change in premium growth over time.

Appendix E: Executive Order No. 5

STATE OF CONNECTICUT

BY HIS EXCELLENCY

NED LAMONT

EXECUTIVE ORDER NO. 5

WHEREAS, health care costs continue to grow in Connecticut at a rate that outpaces the growth of the Connecticut and regional economies; and

WHEREAS, the rate of growth of health care costs impacts the ability of individuals and consumers to afford needed health care services and other necessary expenses; and

WHEREAS, health care costs generally can affect the desirability of Connecticut as a business location; and

WHEREAS, the growth of health care expenditures affects the state's budget; and

WHEREAS, disparities in health care outcomes persist in Connecticut among people of color, LGBTQ+ individuals, and other demographic factors; and

WHEREAS, Connecticut must address the challenge posed by health care costs for all residents of Connecticut, regardless of payer and provider; and

WHEREAS, Connecticut needs to improve health outcomes while reducing the rate of growth of health care costs; and

WHEREAS, the state's Office of Health Strategy (OHS), pursuant to Section 19a-754a of the Connecticut General Statutes (CGS), is responsible for developing and implementing a comprehensive and cohesive health care vision for the state, including, but not limited to, a coordinated state health care cost containment strategy; and

WHEREAS, OHS is responsible for convening forums and meetings with state government and external stakeholders, including, but not limited to, the Connecticut Health Insurance Exchange, to discuss health care issues designed to develop effective health care cost and quality strategies; and

WHEREAS, the Department of Social Services is the single state agency charged with administering the Medicaid program for the State of Connecticut; and

WHEREAS, the Connecticut Insurance Department is charged with overseeing the regulation of fully-insured health plans in the State of Connecticut;

NOW, THEREFORE, I, NED LAMONT, Governor of the State of Connecticut, by virtue of the authority vested in me by the Constitution and the laws of the State of Connecticut, do hereby **ORDER AND DIRECT:**

1. The Executive Director of OHS, consistent with her statutory authority, shall monitor health care spending growth across all public and private payers and populations in Connecticut, report annually to the Governor on such growth, and, by December 2020, develop annual health care cost growth benchmarks.

2. The Executive Director of OHS shall develop such initial annual benchmarks for calendar years 2021 through 2025.

3. The Executive Director, pursuant to her statutory authority under CGS Section 4-8, shall convene a Connecticut Cost Benchmark Technical Advisory Board to assist her in developing such benchmarks. The members of such Technical Advisory Board shall be named within the next thirty days and include the Secretary of the Office of Policy and Management and the Commissioners of the Department of Social Services and the Insurance Department, or their designees, and representatives of health care stakeholders.

4. Such health care cost growth benchmarks shall be based on total health care expenditures, defined as the per capita sum of all health care expenditures in this state from public and private sources for a given calendar year.

5. Such health care cost growth benchmarks shall account for current primary care spending and set targets within each annual benchmark for increased primary care spending as a percentage of total health care expenditures to reach a target of 10% by calendar year 2025.

6. To ensure the maintenance and improvement of health care quality, the Executive Director of OHS, with the input and assistance of the Commissioners of the Social Services, Public Health, and Insurance, shall use the existing OHS Quality Council to assist in the development of quality benchmarks across all public and private payers beginning in calendar year 2022. Such quality benchmarks may include clinical quality measures, under- and over-utilization measures, and patient safety measures.

7. The Executive Director shall continue to monitor the development of accountable care organizations and the adoption of alternative payment methodologies in the State of Connecticut.

8. The Executive Director may make recommendations for legislation to fulfill the purposes of this order.

This order shall take effect immediately.

Dated at Middletown, Connecticut, this 22nd day of January, 2020.

Ned Lamont
Governor

By His Excellency's Command

Denise W. Merrill
Secretary of the State