



Healthcare Cost Growth Benchmark
Steering Committee Meeting

January 27, 2025

"We collaborate, out of a shared concern and responsibility for all Connecticut residents, to develop consensus models that advance equity and consumer affordability of healthcare in our state."

Welcome and Roll Call

Meeting Agenda

<u>Time</u>	<u>Topic</u>
3:00 p.m.	I. Welcome, Roll Call, and Agenda Review
3:05 p.m.	II. Approval of December Meeting Minutes – Vote
3:10 p.m.	III. Update on the Technical Team
3:25 p.m.	IV. Update on AHEAD
3:40 p.m.	V. Overview of OHS' New Analytic Dashboards
4:00 p.m.	VI. Addressing Consolidation in Health Care
4:20 p.m.	VII. 2025 Legislative Agenda
4:50 p.m.	VIII. Public Comment
4:55 p.m.	IX. Wrap-Up and Next Steps
5:00 p.m.	X. Adjournment

Approval of December 16th Meeting Minutes – Vote

Update on the Technical Team

Technical Team Updates

- The Technical Team comprising state and national subject matter experts continues to convene to fulfill its charge.
- The Technical Team has met twice since the last Steering Committee meeting, including just this morning.
 - Much of the discussion to date has been on recommendations for 2026–2030 healthcare cost growth benchmarks.
 - The Technical Team supports continued reporting of Advanced Network spending growth by market.
 - During the meeting this morning, Technical Team members began discussing recommendations for Connecticut’s 2026–2030 primary care spending targets.
- Two additional meetings have been added to the original schedule to ensure sufficient time for discussion.

Setting the 2026–2030 Healthcare Cost Growth Benchmark: General Discussion Points

- Technical Team members have discussed the need for relief for Connecticut residents noting that:
 - The cost of healthcare is already unaffordable, unsustainable, and simply too high.
 - Healthcare costs continue to take up a greater proportion of residents' income.
 - Employers can absorb only so much of an annual increase in premiums before passing on costs to employees.
 - Additional pressure is needed for the system to change and to realize reductions in excess costs.

Setting the 2026–2030 Healthcare Cost Growth Benchmark : Economic Indicator

- The Technical Team considered several indicators for the benchmark and expressed a preference for median household income, a consumer-centric measure.
 - The Technical Team also considered inflation, average annual wage, and Medicare spending trends.
- Technical Team members favor using forecasted values due to volatility in historical trends.
- In addition, Technical Team members acknowledged the need to account for high – and excess – costs already built into the system and for which savings can be realized.
 - For this reason, Team members have discussed an adjustment to the benchmark.

Calculating and Reporting Performance Relative to the Healthcare Cost Growth Benchmark

- Technical Team members have discussed specific components of the current benchmark measurement and recommend that OHS:
 - **Continue to truncate spending.** Some members strongly supported OHS's efforts to examine the current levels to determine if they should be increased.
 - **Continue to use confidence intervals** to assess performance relative to the benchmark.
 - Also, as communicated in the last Steering Committee meeting, Technical Team members recommended that OHS **continue to report age and sex adjusted spending performance** for payers and provider entities.

Discussion: Technical Team

- What reactions do Steering Committee members have to the Technical Team meeting discussions so far?
- Do Steering Committee members wish to provide feedback to OHS to convey to the Technical Team during its next meeting?

Update on AHEAD



Connecticut **AHEAD**

What is the AHEAD Model?

All-Payer Health Equity Approaches and Development Model

CMS, 11-year, Innovation Model

- 6 states are participating (MD, VT, HI, CT, RI, NY)
- Offers:
 - A new multi-payer payment model that can provide hospital financial stability
 - Supports investments in primary care
 - Aims to close disparity gaps, address social needs and link people to community resources

- Model is voluntary

- Holds participating states, hospitals, primary care providers and payers accountable for improving population health
- Statewide accountability targets on cost growth and primary care investment

Connecticut **AHEAD**

Who is eligible to participate in this voluntary model?

- Hospitals can participate in Global Budgets
 - Acute care hospitals
 - Children's hospitals (limited to Medicaid and commercial insurance)
- Primary Care practices
 - Independent practices
 - System-owned practices (as long as their affiliate hospital is under a global budget)
 - FQHCs
- Commercial payers (required to have at least one by 2028)

Connecticut AHEAD
Model Components



HOSPITAL GLOBAL BUDGETS
PAYMENT MODEL



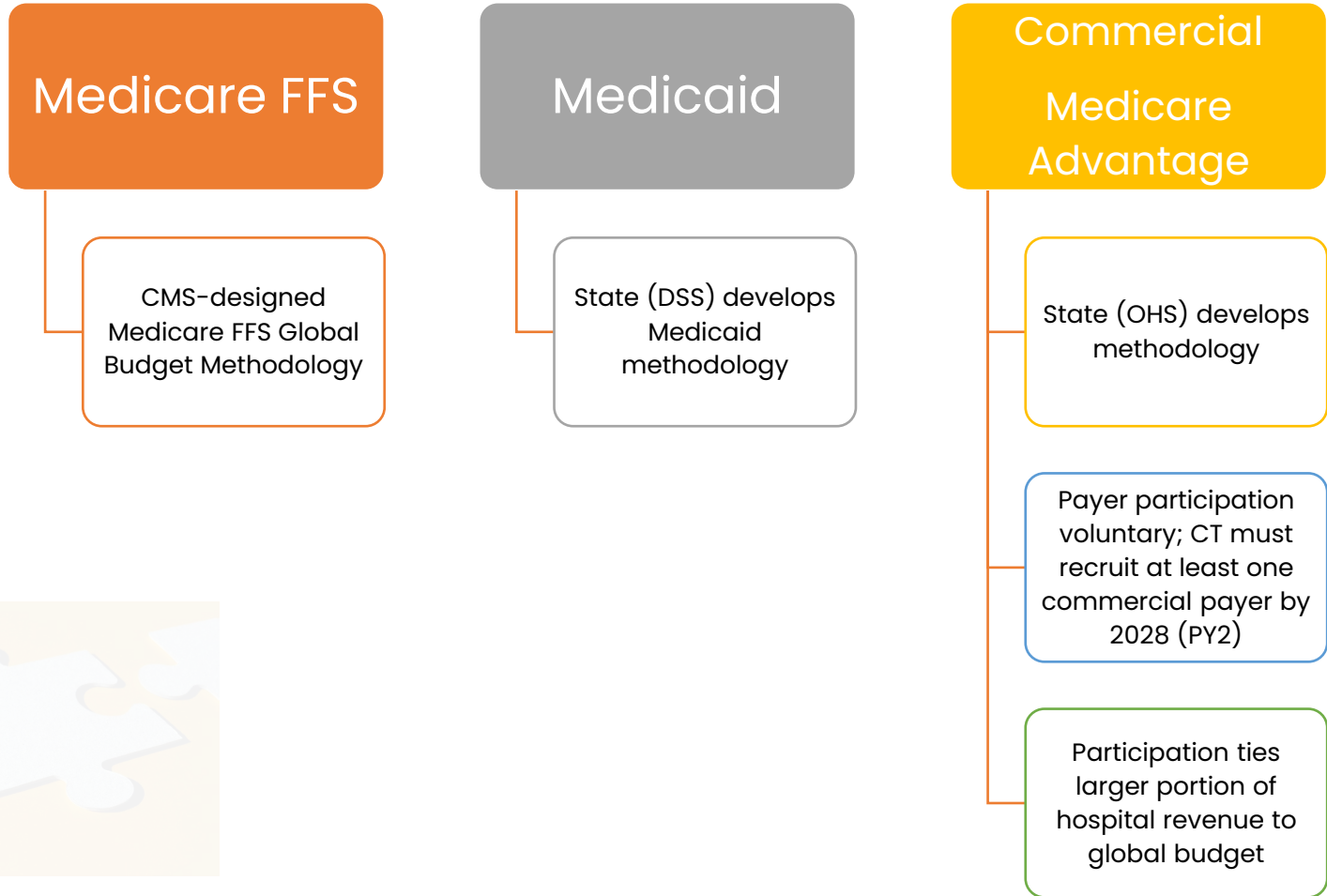
PRIMARY CARE AHEAD
TRANSFORMATION



HEALTH EQUITY

Connecticut **AHEAD**

Hospital Global Budgets by Payer



Connecticut **AHEAD**

Primary Care **AHEAD**

- **Voluntary** participation in this patient-focused model provides prospective, flexible and enhanced payments (Medicare FFS) intended to increase the capacity to deliver advanced primary care services
- Designed to align Medicare with state-led primary care efforts
- Expands whole-person-centered care, care coordination, community connections, behavioral health integration and health-related social needs interventions

Connecticut **AHEAD**

AHEAD Health Equity Strategy

1. Establish the Advisory Committee to guide implementation of the model
 - Inform model activities and build partnerships between the state, providers, payers and community
2. Develop a Statewide Health Equity Plan to define and guide Model activities with the goals to:
 - Improve population health
 - Reduce health disparities
3. Incentives to improve quality and reduce disparities
 - Hospital Health Equity Plans
 - Hospital global budgets will be adjusted based on improvements in quality and equity outcomes
 - Advanced primary care (enhanced payments, care integration and coordination)
 - Increase health related social needs screenings/referrals

Connecticut **AHEAD**

Statewide accountability targets / Health Care Benchmark Initiative

AHEAD Requires

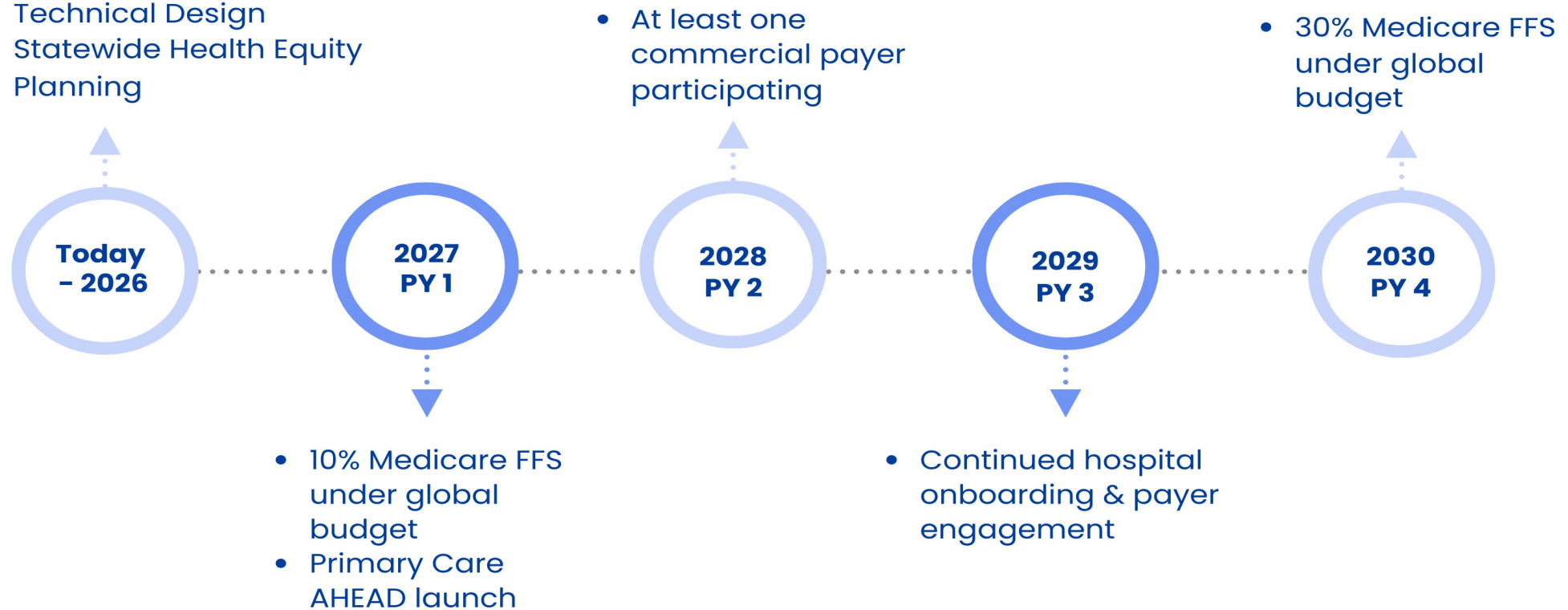
- Statewide TCOC Growth Targets
- Quality and Equity Measures and Targets
- Primary Care Investment Target

CT already has under the HCBI

- Cost Growth Benchmark
- Quality Benchmarks
- Primary Care Spending Target

Connecticut **AHEAD**

- Pre-implementation
- Stakeholder engagement
- Global Budget Technical Design
- Statewide Health Equity Planning



Overview of OHS' New Analytic Dashboards

Overview of OHS' New Analytic Dashboards (1 of 7)

- OHS recently created a new "Healthcare Benchmark Data Transparency" page on its website, which you can find [here](#).
- The page includes information and links to additional documents that clarify the differences between cost growth benchmark data and data from the All-Payer Claims Database (APCD), as well as how OHS uses the different data sources.
- In addition, the page includes links to three interactive dashboards that allow stakeholders and members of the public to review healthcare spending trends based on **data from the state's APCD**.

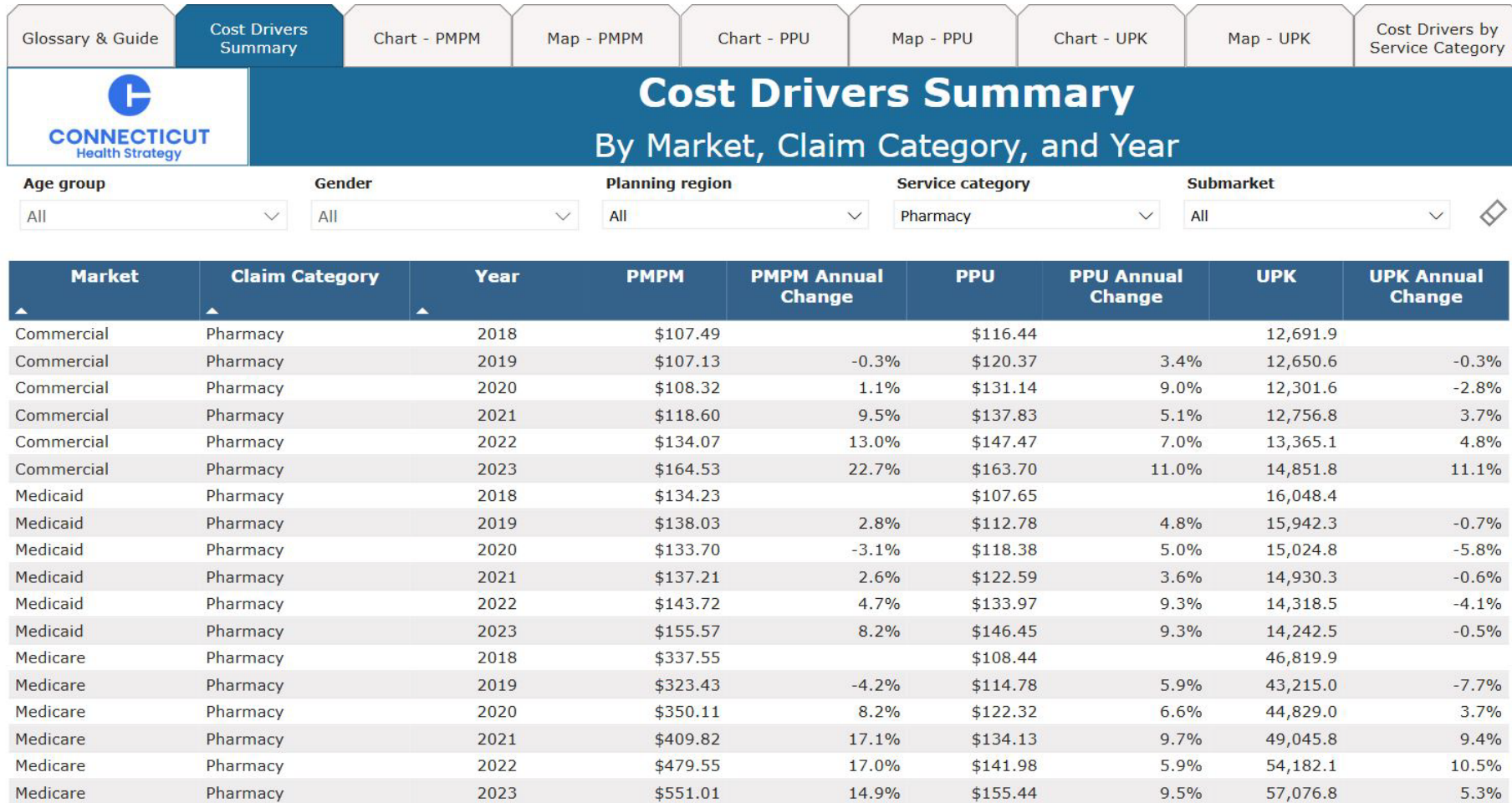
Overview of OHS' New Analytic Dashboards (2 of 7)

- The three dashboards include data on:
 - Drivers of healthcare spending ("**Cost Drivers Dashboard**")
 - Hospital spending ("**Hospital Cost Tool Dashboard**")
 - Retail pharmacy spending ("**Retail Pharmacy Tool Dashboard**")
- We will review each dashboard in greater detail on the following slides.
- Corresponding "Technical Notes" on the methodologies employed to create each dashboard are also available on the [data transparency webpage](#).

Overview of OHS' New Analytic Dashboards (3 of 7)

- The "**Cost Drivers Dashboard**" allows users to view medical and pharmacy spending trends in Connecticut between 2018–2023.
 - The dashboard also shows the contributions of utilization and payment per unit to observed spending trends.
- Data can also be sorted by:
 - Market
 - Service category
 - Zip code

Overview of OHS' New Analytic Dashboards (4 of 7)



This table shows average per member per month spending (PMPM), price per unit (PPU) and units per 1,000 members (UPK) by market, claim category and year for the most recent six years. Annual percent changes for each metric are also included. Optional filters include age group, gender, planning region, service category and submarket. Results can be sorted by hovering over a column header and clicking on the triangle. Pharmacy spending data do not account for manufacturer rebates.

The image to the left is a screenshot of the Cost Drivers Dashboard to provide an example of its functionality.

In the image, the "Cost Drivers Summary" tab is filtered to show pharmacy spending trends for each market.

More granular pharmacy data can be gleaned from the Retail Pharmacy Tool Dashboard.

Overview of OHS' New Analytic Dashboards (5 of 7)

- The "**Hospital Cost Tool Dashboard**" allows users to view each Connecticut hospital's commercial inpatient and outpatient spending trends between 2018–2023.
 - The dashboard also shows the contributions of utilization and payment per unit to observed spending trends.
- The Hospital Cost Tool Dashboard also allows users to look at spending trends (by hospital) for specific services as well as for broader procedure categories.

Overview of OHS' New Analytic Dashboards (6 of 7)

Glossary and Guide | Population Age and Gender Distribution | All Services: Annual Trends | All Services: Annual and Cumulative Trends | **Select Services: Annual and Cumulative Trends** | PPU and Utilization Trends for Select Services | Procedure Category Drilldown

CONNECTICUT
Health Strategy

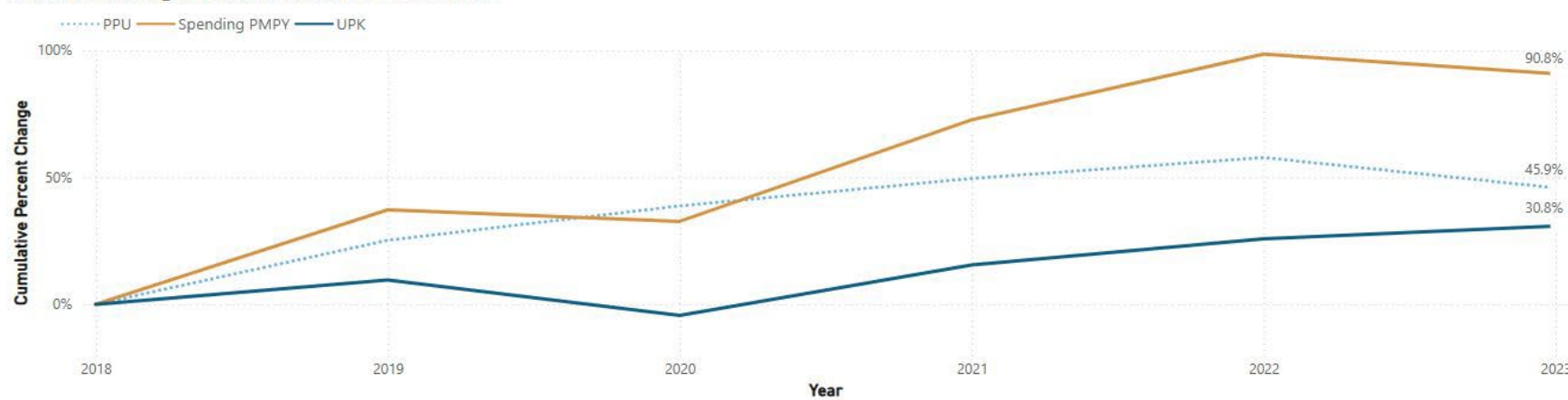
Select Services: Annual and Cumulative Trends

Service Category: Outpatient | Service Trend: Most Spending | Service: 99285: EMERGENCY DEPT VISIT HI MDM | Hospital: All Hospitals

Annual and Cumulative Change in PMPY, PPU, and UPK for EMERGENCY DEPT VISIT HI MDM since 2017

Service and Year	Spending PMPY (\$)	Cumulative Change in PMPY(%)	Annual Change in PMPY(%)	UPK	Cumulative Change in UPK(%)	Annual Change in UPK(%)	PPU (\$)	Cumulative Change in PPU(%)	Annual Change in PPU(%)
2018	\$49.13	0.0%		40.87	0.0%		\$1,202	0.0%	
2019	\$67.40	37.2%	37.2%	44.78	9.6%	9.6%	\$1,505	25.2%	25.2%
2020	\$65.18	32.7%	-3.3%	39.08	-4.4%	-12.7%	\$1,668	38.8%	10.8%
2021	\$84.83	72.7%	30.1%	47.19	15.5%	20.8%	\$1,798	49.6%	7.8%
2022	\$97.54	98.5%	15.0%	51.42	25.8%	9.0%	\$1,897	57.8%	5.5%
2023	\$93.74	90.8%	-3.9%	53.47	30.8%	4.0%	\$1,753	45.9%	-7.6%

Cumulative Change in PMPY, UPK, and PPU since 2018



The image to the left is a screenshot of the Hospital Cost Tool Dashboard to provide an example of its functionality.

In the image, the "Select Services" tab is filtered to show commercial spending trends for high severity ED visits for all hospitals.

Overview of OHS' New Analytic Dashboards (7 of 7)

- The "**Retail Pharmacy Tool Dashboard**" allows users to view pharmacy spending trends in Connecticut between 2018–2023 by drug category and by drug.
 - The dashboard also shows the contributions of utilization and payment per unit to observed spending trends.
- Data can also be sorted by:
 - Market
 - Generic vs Brand

Addressing Consolidation in Healthcare

Addressing Consolidation in Health Care

- During our last Steering Committee meeting in December, a member asked that the Steering Committee discuss how to address consolidation in health care and the resulting lack of competition.

Disclaimer

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Report on Health Care Consolidation



CONNECTICUT Health Strategy

Impacts of Connecticut Hospital and Health Care
System Consolidation (2016-2021)

A report prepared by Altarum
on behalf of the
Office of Health Strategy
pursuant to C.G.S § 19a-613 and §19a - 634
Deidre S. Gifford, MD, MPH
Executive Director
March 26, 2024

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- The 2024 report compared prices and utilization at entities that were and were not part of a consolidation transaction
- The report found faster price growth at hospitals that were part of consolidation
- The report found greater use of some high-profit services and less use of some low-profit services at hospitals that were part of consolidation

Certificate of Need (CON)

Overview

What is it?

Statutorily defined regulatory process for certain healthcare transactions

- C.G.S. § 19a-612d
- C.G.S. § 19a-638
- C.G.S. § 19a-639



What does it do?

- Prevents duplication of services
- Protects access to /continuity of health care services
- Protects affordability
- Protects quality of healthcare
- Gives CT residents a voice
- Ensures health system changes adhere to a long-term planning process

Certificate of Need (CON)

When is a CON required?

Per C.G.S. § 19a-638

- New healthcare facility (in most cases)
- **Transfer of ownership of a health care facility**
- Transfer of ownership of a large group practice (in some cases)
- Establishment of a free-standing emergency department (ED) or termination of an ED by a hospital
- Termination of inpatient (IP) or outpatient (OP) services by a hospital
- Establishment of an OP surgical facility or termination of OP surgical services
- Establishment of certain cardiac services
- Acquisition of CT, MRI, PET, PET-CT scanners
- Acquisition of nonhospital based linear accelerators
- Increase in licensed bed capacity of a healthcare facility
- Acquisition of equipment using technology new to Connecticut
- Increase of two or more operating rooms within any three-year period
- Termination of IP/OP services by facility operated by the state



Certificate of Need (CON)

What guides the process for OHS?

12 Statutory criteria for CON review and approval enumerated in C.G.S. § 19a-639

- Cost
- Quality
- Access
- Duplication/need for service
- Medicaid access

Certificate of Need (CON)

What guides the process for OHS?

Additional criteria specifically for hospital mergers/acquisitions/affiliations (19a-639(d))

- In any deliberations involving a certificate of need application ... that involves the transfer of ownership of a hospital, the unit shall ... make written findings concerning each of the following guidelines and principles:
 - (A) Whether the applicant fairly considered alternative proposals or offers in light of the purpose of maintaining health care provider diversity and consumer choice in the health care market and access to affordable quality health care for the affected community; and
 - (B) ...how health care services will be provided by the new hospital for the first three years following the transfer of ownership of the hospital, including any consolidation, reduction, elimination or expansion of existing services or introduction of new services.
 - (3) *The unit shall deny any certificate of need application involving a transfer of ownership of a hospital unless the executive director finds that the affected community will be assured of continued access to high quality and affordable health care* after accounting for any proposed change impacting hospital staffing.

Certificate of Need (CON)

What guides the process for OHS?

Additional criteria specifically for hospital mergers/acquisitions/affiliations (19a-639(d))

- (4) The unit may deny any certificate of need application involving a transfer of ownership of a hospital subject to a cost and market impact review pursuant to section 19a-639f if the executive director finds that (A) the affected community will not be assured of continued access to high quality and affordable health care after accounting for any consolidation in the hospital and health care market that may lessen health care provider diversity, consumer choice and access to care, and (B) any likely increases in the prices for health care services or total health care spending in the state may negatively impact the affordability of care.
- (5) The unit may place any conditions on the approval of a certificate of need application involving a transfer of ownership of a hospital consistent with the provisions of this chapter.
- C.G.S. § 19a-639f: (a) The Health Systems Planning Unit of the Office of Health Strategy shall conduct a cost and market impact review in each case where (1) an application for a certificate of need ... involves the transfer of ownership of a hospital ... and (2) the purchaser is a hospital, ... that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars

Cost and Market Impact Reviews (CMIRs)

- A CMIR is required when a transfer of ownership of a hospital involves a hospital or system with net patient revenues in 2013 over \$1.5B
 - The CMIR is an analysis of the effects of the transaction including those on the cost of healthcare, the market consolidation, market competition, and access to health services
 - CMIR results in past dockets have led to incorporation of price constraints in the agreed settlements to mitigate the effect consolidation may have on healthcare cost increases
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Governor's Proposal for Enhanced Oversight

- Governor Lamont announced a forthcoming bill to enhance oversight of healthcare transactions by engaging both OHS and the Attorney General in the notice of material change
- This bill would expand the types of transactions reviewed and the types of entities that require review
- OAG and OHS will work together to review for antitrust issues and potential issues related to cost, access, and quality of healthcare in the affected community
- If there is unacceptable risk, OAG may impose conditions on the transaction or refer to OHS for a certificate of need

OHS Legislative Proposals

2.1 Cost Growth Benchmark

Employer Opt-In

Background:

- Each year OHS collects data from CT Health Insurers to measure the state's performance against the Cost Growth and Primary Care benchmarks.
- Insurers are required to submit this data, known as "Benchmark Data" to OHS. To date, all insurers have included ALL of their covered lives, both self-funded and fully insured without issues or concerns.

Issue:

- Anthem has recently decided to withhold data on the self-insured lives from its Benchmark Data:
- Self-insured plans make up 30% of all Anthem members—approximately 210,000 individuals
- Anthem concluded that **self-insured data is precluded** from automatic submission to state cost growth benchmark programs and concludes that they only need to report on fully-insured lives.
- Unnecessary partial data submissions to the Benchmark program could become a threat to the integrity of the program

Solution:

- Require a **payer to ask an employer** of a self-funded employee health plan **to opt-in to providing data** required for the benchmark.
- Allow OHS to impose a **civil penalty for failure of an insurer to seek approval from an employer** to submit to OHS.

Participation in the Cost Growth Benchmark Hearing

Background:

- Statute requires OHS to hold an Annual Public Hearing on the Benchmark results.
- OHS identifies "significant contributors" to the benchmark results and calls them to appear at the hearing. Statute states that significant contributors **shall participate** in the hearing if called by OHS.

Issue:

- For two consecutive years, Pharmaceutical manufacturers **refused to both attend and participate** in the cost growth benchmark hearing as required by statute.

Solution:

- Clarify the meaning of "participate" in the benchmark hearing
- Allow OHS to subpoena testimony and/or documents from those who refuse to participate

Performance Improvement Plan Study

Issue:

Many stakeholders have encouraged OHS to strengthen the benchmark program.

Solution:

- Require OHS to conduct a one-time study to assess performance improvement plans as a tool to slow cost growth.
- Demonstrates that the state is committed to curbing health care cost growth evaluating the effectiveness of means to achieve such goal.

Policies and Procedures

Issue:

Some statutory provisions necessitate implementing regulations.

Regulations can take up to 2 years or more to promulgate. Some parts of OHS statute have ability to use policies and procedures, while others do not.

Solution:

Allow OHS to establish policies and procedures throughout the CGB statute while regulations are being promulgated.

2.2 Certificate of Need

CON Proposed Changes

- Authorize an Expedited Review Pathway
- Definition Updates
 - “Termination of Service” and add Proton Beam Therapy
- CMIR Fixes
 - Clarify agency review and increase funding limit
- Allow for Policies and Procedures while promulgating regulations

Update Definition of “Termination of Services”

Background:

- CON statute requires OHS to approve certain “terminations” of services, such as Labor and Delivery or ICU.
- Many terminations of service lines are occurring in CT and around the country.

Issue:

- Current definition of “termination of services” is not precise
- Providers can cycle services on and off indefinitely while arguing that the service was not terminated, leading to confusion and loss of staff

Solution:

Clarify that a termination of services is “a combined total of greater than 180 days within any two-year period” or “at least 30 consecutive days”

Add Proton Beam Therapy to CON Review

Background:

Current statute requires a CON for technologies not in use in the state

Issue:

In 2025, OHS anticipates the opening of CT's first Proton Beam Therapy facility, meaning that this will no longer be a "technology not in use in the state."

Solution:

Add proton beam therapy to list of services that require a CON

Expedited Review Process

Issue:

There are instances when an expedited review process is warranted but currently no process exists.

Solution:

- Authorize an expedited review process for applicants that address a **significant unmet need** in the service area
- An expedited review application would be resolved as follows: 1) approved with or without conditions; 2) with an agreed settlement; or 3) requiring the applicant to submit a full CON application.
- There would be no public hearing for an expedited application

Cost and Market Review (CMIR) Allotment

Background:

Certain hospital transfers of ownership require a detailed study (CMIR) of the impact of transfer on healthcare markets and prices

Issue:

The cost of conducting a Cost and Market Impact Review has not kept up with changing vendor requirements and has limited OHS's ability to find appropriate resources for the CMIR.

Solution:

Increase amount that a vendor can receive for a CMIR to \$300K from \$200K. (This is paid by the applicant)

Clarify Cost and Market Impact Review (CMIR) use in CON Determination

Issue:

- OHS is required to conduct a CMIR for certain hospital transfers of ownership, which then goes to the Attorney General for consideration of anti-trust violations.
- The statute is unclear on whether OHS can use the CMIR in its CON application deliberations.

Solution:

- Clarify that OHS shall be permitted to use the CMIR preliminary report, applicant responses to such report, and the final report in the CON determination.

Policies and Procedures

Issue:

Some statutory provisions necessitate implementing regulations.

Some parts of OHS statute have ability to use policies and procedures, while others do not.

Solution:

Allow OHS to establish policies and procedures throughout the CON statute while regulations are being promulgated.

2.3 Health Care Cabinet

Update Health Care Cabinet Membership

Issue:

Current Health Care Cabinet membership is outdated

Solution:

Update membership by 1) removing the “Nonprofit Liaison to the Governor” position which no longer exists;

2) Adding the Behavioral Health Advocate;

3) Adding a representative of the nonprofit community;

4) Cleaning up the Sustinet language; and,

5) Removing references to the ACA

Public Comment

Wrap-Up and Next Steps

Wrap-Up and Next Steps

- The next meeting is February 24, 2025, 3-5pm.

Appendix

Healthcare Benchmark Technical Team

Loren Adler, MS, Fellow and Associate Director, Center on Health Policy, Brookings Institution

Don Berwick, MD, MPP, Senior Fellow at the Institute for Healthcare Improvement

Sabrina Corlette, JD, Co-Director, Center of Health Insurance Reforms, Georgetown University's McCourt School of Public Policy

Francois de Brantes, MS, MBA, Senior Partner, High Value Care Incentives Advisory Group

Stefan Gildemeister, MA, State Health Economist and Director, Minnesota Department of Health

Paul Grady, Connecticut Business Group on Health

Jason Hockenberry, PhD, Associate Dean for Faculty Affairs, Department Chair and Professor of Public Health (Health Policy), Yale School of Public Health

Chris Manzi, MBA, President, Pequot Health Care

Roslyn Murray, PhD, MPP, Assistant Professor of Health Services, Policy and Practice, Brown University Affiliated Faculty, Center for Advancing Health Policy through Research

Josh Wojcik, Director, Health Policy and Benefits Services Division, Office of the State Comptroller