

Healthcare Benchmark Initiative Stakeholder Advisory Board

March 10, 2022 Meeting



Call to Order

Agenda

<u>Time</u>	<u>Topic</u>
2:00 p.m.	I. Call to Order
2:05 p.m.	II. Public Comment
2:10 p.m.	III. Approval of June 29th Meeting Minutes - Vote
2:15 p.m.	IV. Approval of December 8th Meeting Minutes - Vote
2:20 p.m.	V. Pre-Benchmark Analysis
3:10 p.m.	VI. Follow-Up Mathematica Analyses re: ED Utilization Disparities
3:25 p.m.	VII. Primary Care Spend Target
3:40 p.m.	VIII. Quality Benchmarks
3:55 p.m.	IX. Wrap-Up and Next Steps
4:00 p.m.	X. Adjourn

Public Comment

Approval of June 29th Meeting Minutes - Vote

Approval of December 8th Meeting Minutes - Vote

Pre-Benchmark Analysis

Connecticut's Healthcare Cost Growth Benchmark

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

Connecticut's cost growth benchmark is an **annual rate-of-growth benchmark for statewide healthcare spending.**

The benchmark values are based on a methodology that was developed through a stakeholder process that considered various economic indicators.

The trends presented today are **pre-benchmark**, meaning they are establishing a baseline and not being measured against a specific benchmark value.

Total Healthcare Expenditures

Total Medical Expense (TME)

+

Net Cost of Private Health Insurance (NCPHI)

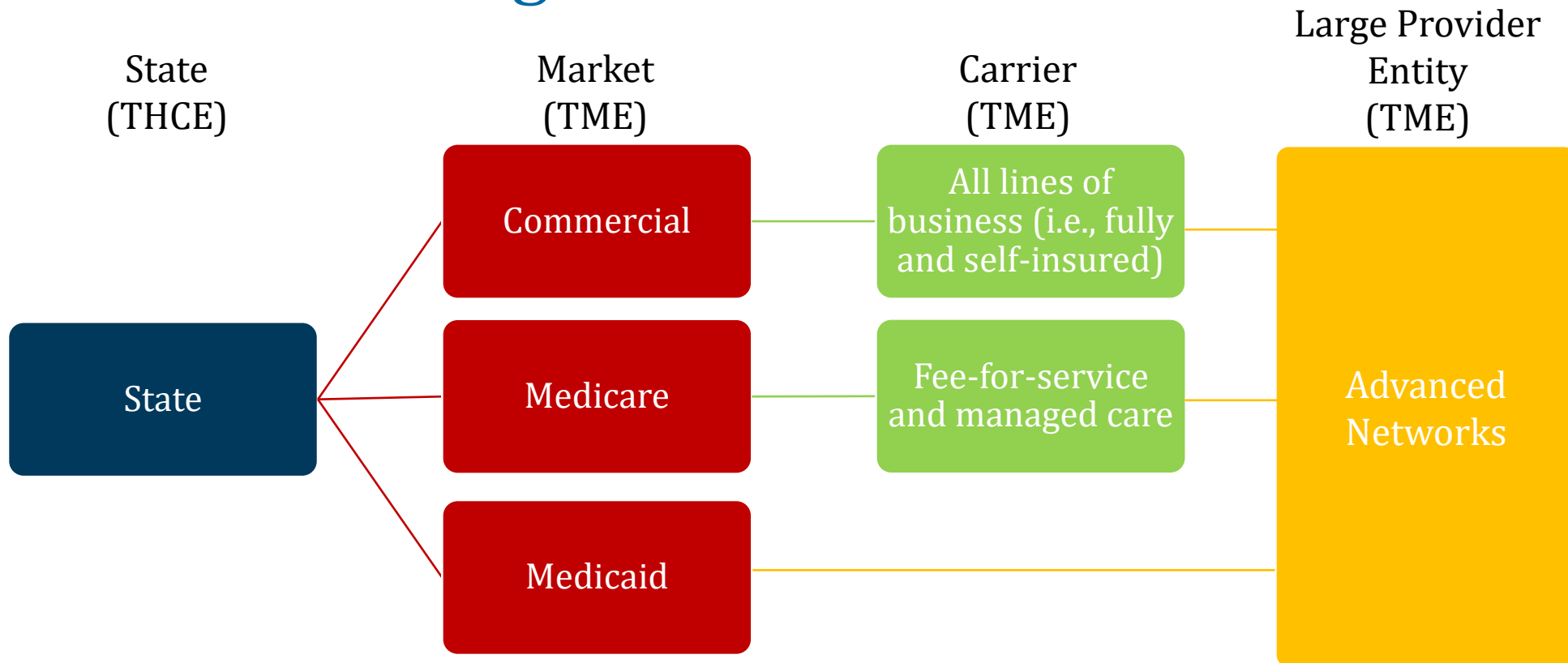
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Total Healthcare Expenditures (THCE)

All incurred expenses for CT residents for all healthcare services, regardless of where the care was delivered and regardless of the situs of the member's plan.

The costs to CT residents associated with the administration of private health insurance.

Four Levels of Performance Measurement Against the Benchmark and Target



Note: For 2018-2019 pre-benchmark measurement, cost growth is *only* being reporting at the state and market levels.

Data Sources for THCE

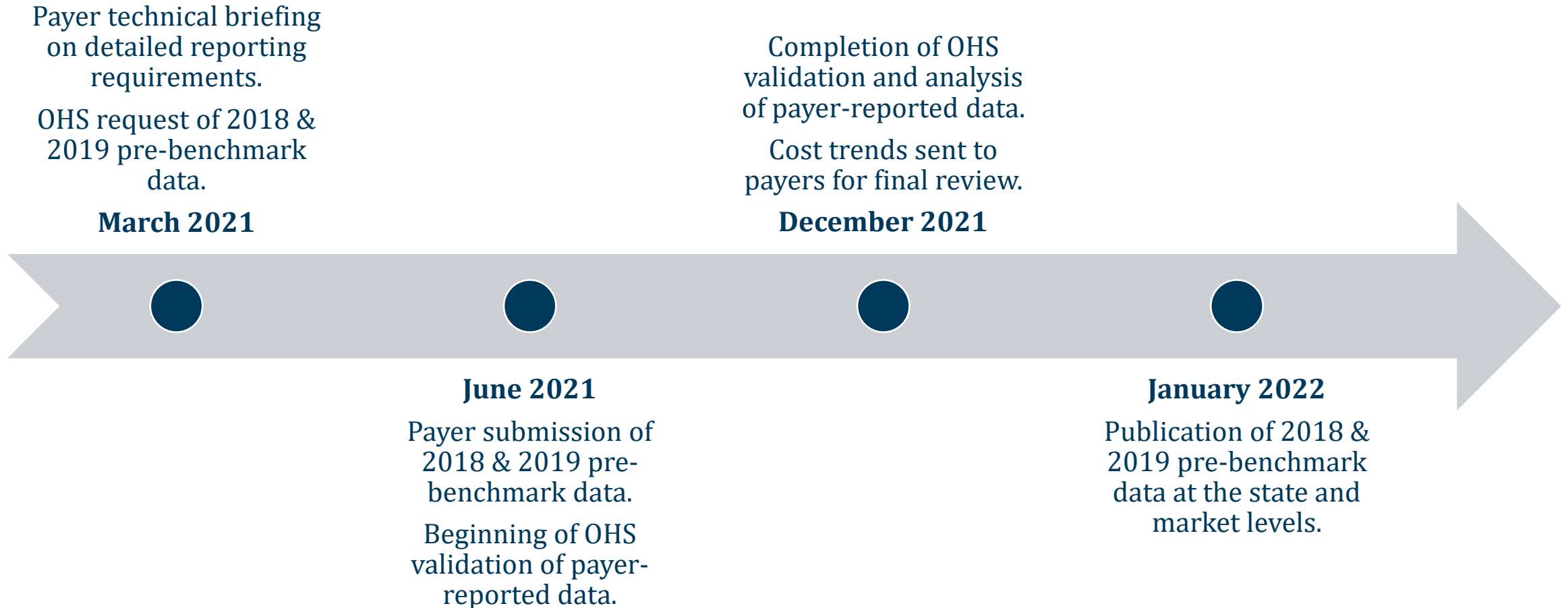
THCE Component	Data Source
Commercial spending	TME reported by carriers
Medicare Managed Care spending	TME reported by carriers
Medicare FFS spending	Centers for Medicare & Medicaid Services
Medicaid spending	TME reported by Department of Social Services
NCPHI	Calculated from regulatory reports submitted by insurers or obtained through public sources
Veterans Health Administration spending	Veterans Health Administration
Department of Correction spending	Department of Correction

Insurance Carriers

Insurance Carriers

1. Aetna Health & Life
 2. Anthem
 3. Cigna
 4. ConnectiCare
 5. Harvard Pilgrim Health Care
 6. UnitedHealthcare
-

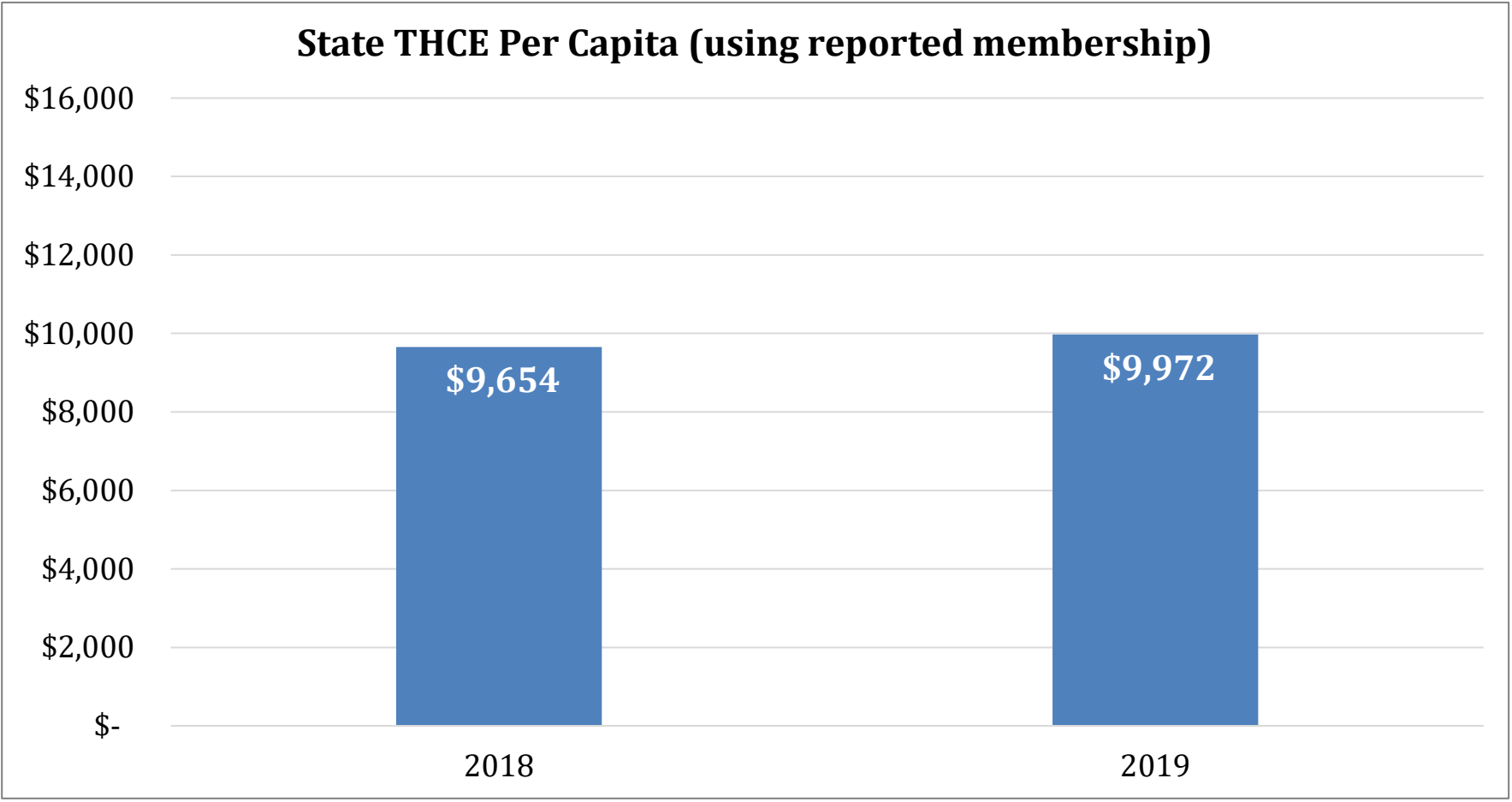
Data Collection, Validation and Analysis Timeline



Data Validation Process

- **Completeness checks** to ensure there were no obvious errors or omissions in the submitted data
- **Reasonableness checks** to ensure that data seemed appropriate when compared to external sources and at face value
- **Meetings with payers** to discuss potential data omissions and aberrant trends
- **Resubmissions** from payers to align data specifications in the Implementation Manual

Connecticut's Total Health Care Expenditures Grew 3.3% in 2019

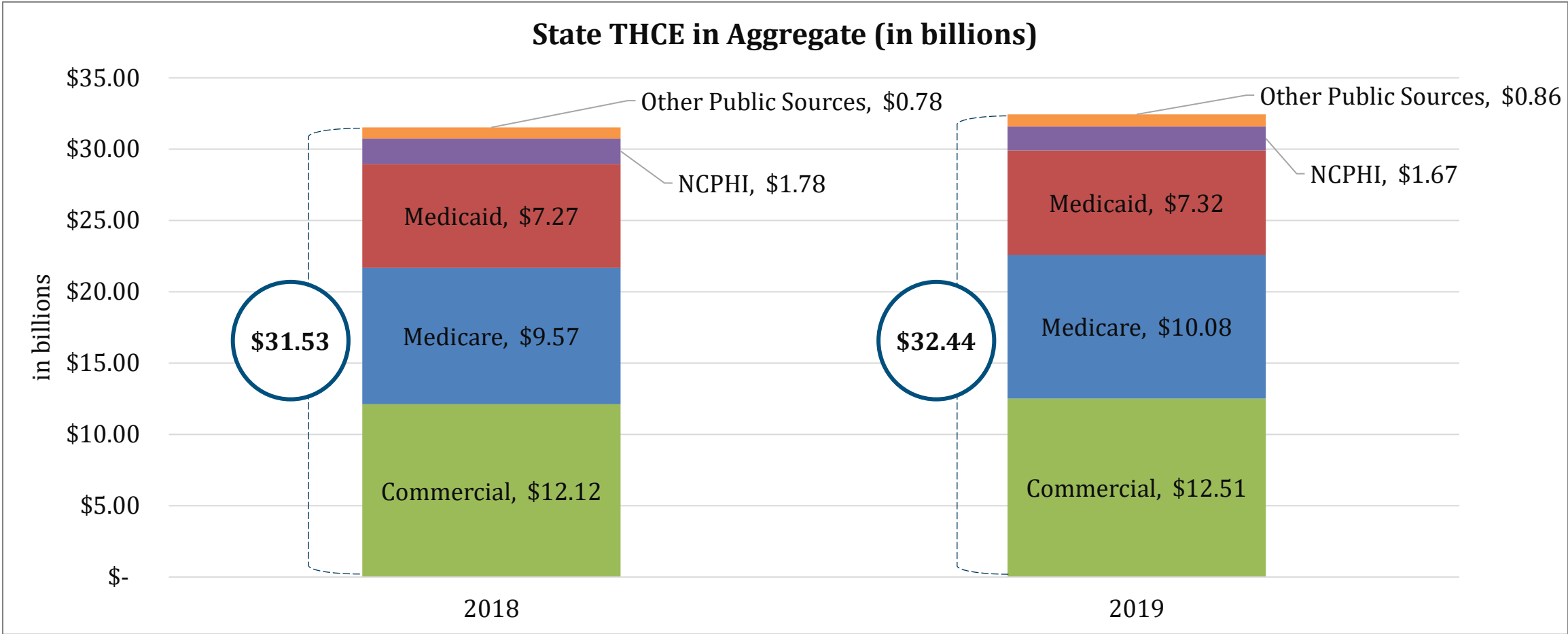


THCE Trend Per Capita

3.3%

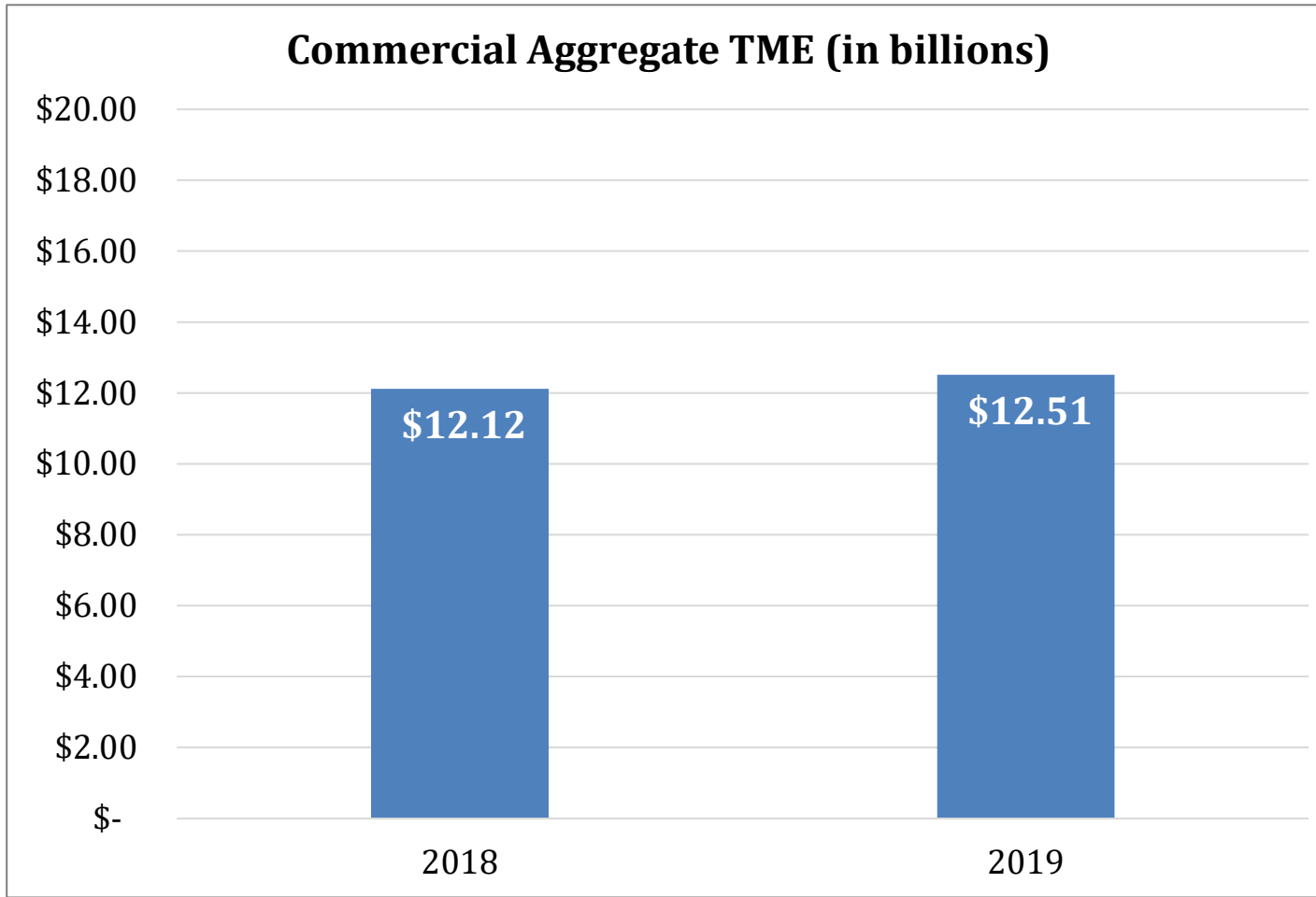
Data are not risk-adjusted. They are reported net of pharmacy rebates.
Data include the Net Cost of Private Health Insurance (NCPHI).
Total reported membership was 3,252,773 in 2019. The CT Census reported 3,565,287 individuals in 2019.

Connecticut's THCE was \$32 Billion in 2019



“Other Public Sources” includes CT Department of Correction and Veterans Health Administration spending.

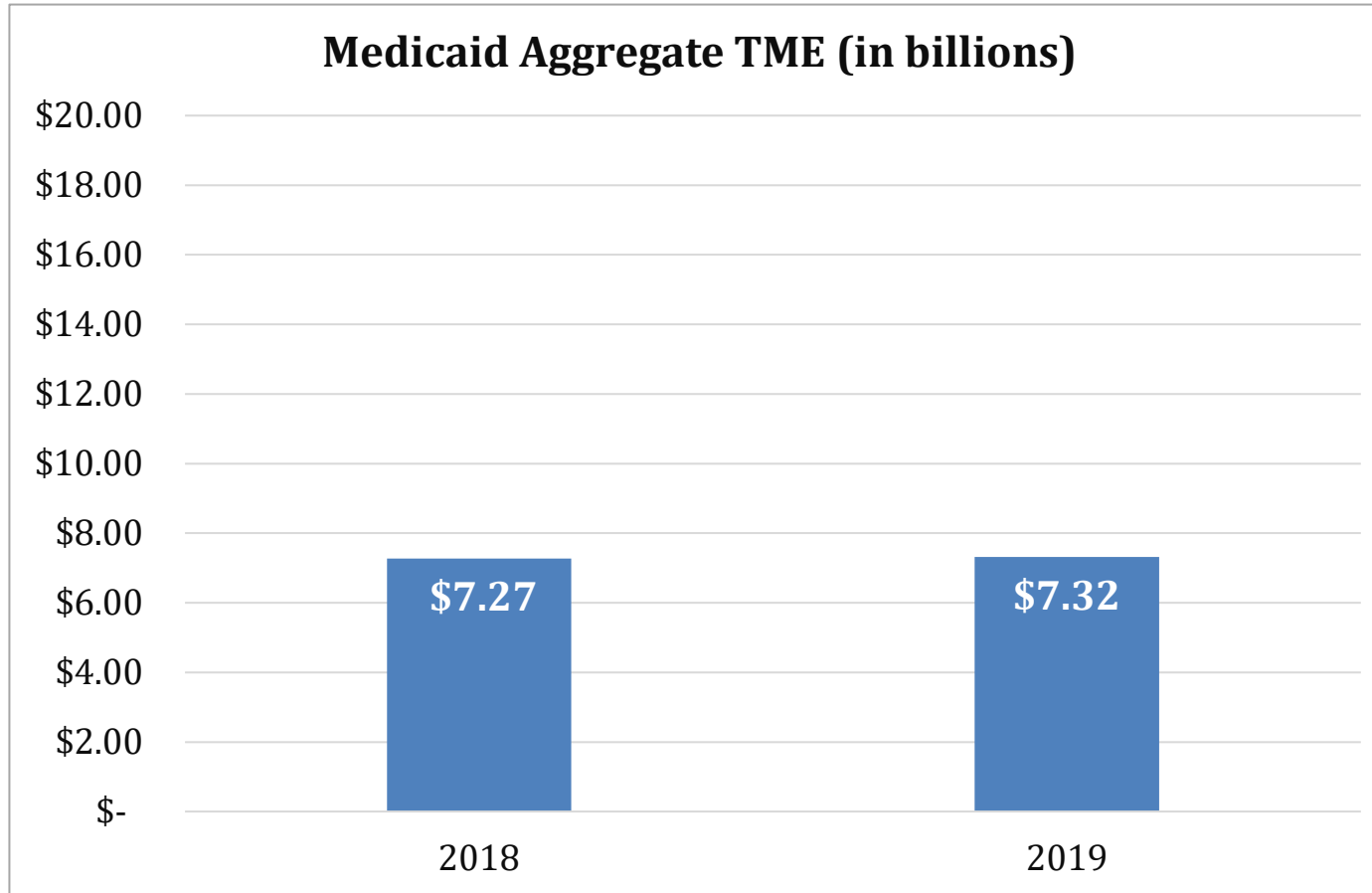
Commercial Per Capita Spending Growth in 2019 was 6.1%



Year	TME Per Capita	TME Trend Per Capita
2018	\$6,843	6.1%
2019	\$7,257	

Data are not risk-adjusted. They are reported net of pharmacy rebates.
Data do not include the Net Cost of Private Health Insurance (NCPHI).

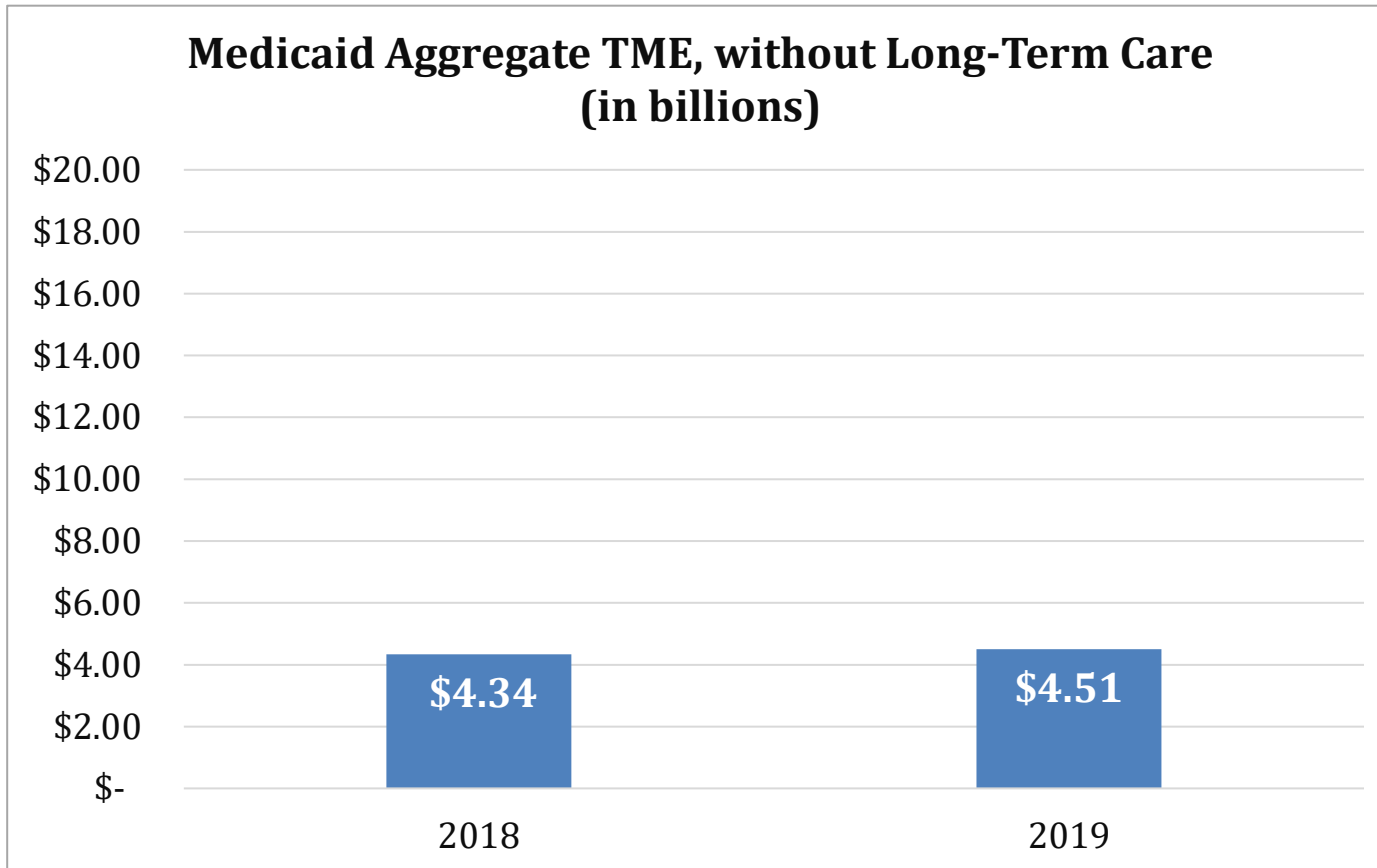
Medicaid Per Capita Spending Growth in 2019 was -0.9%



Year	TME Per Capita	TME Trend Per Capita
2018	\$8,498	
2019	\$8,419	-0.9%

Data are not risk-adjusted. They are reported net of pharmacy rebates.
Data include Medicaid spending on the dually eligible population.
Data do not include payments to CT Administrative Services Organizations.

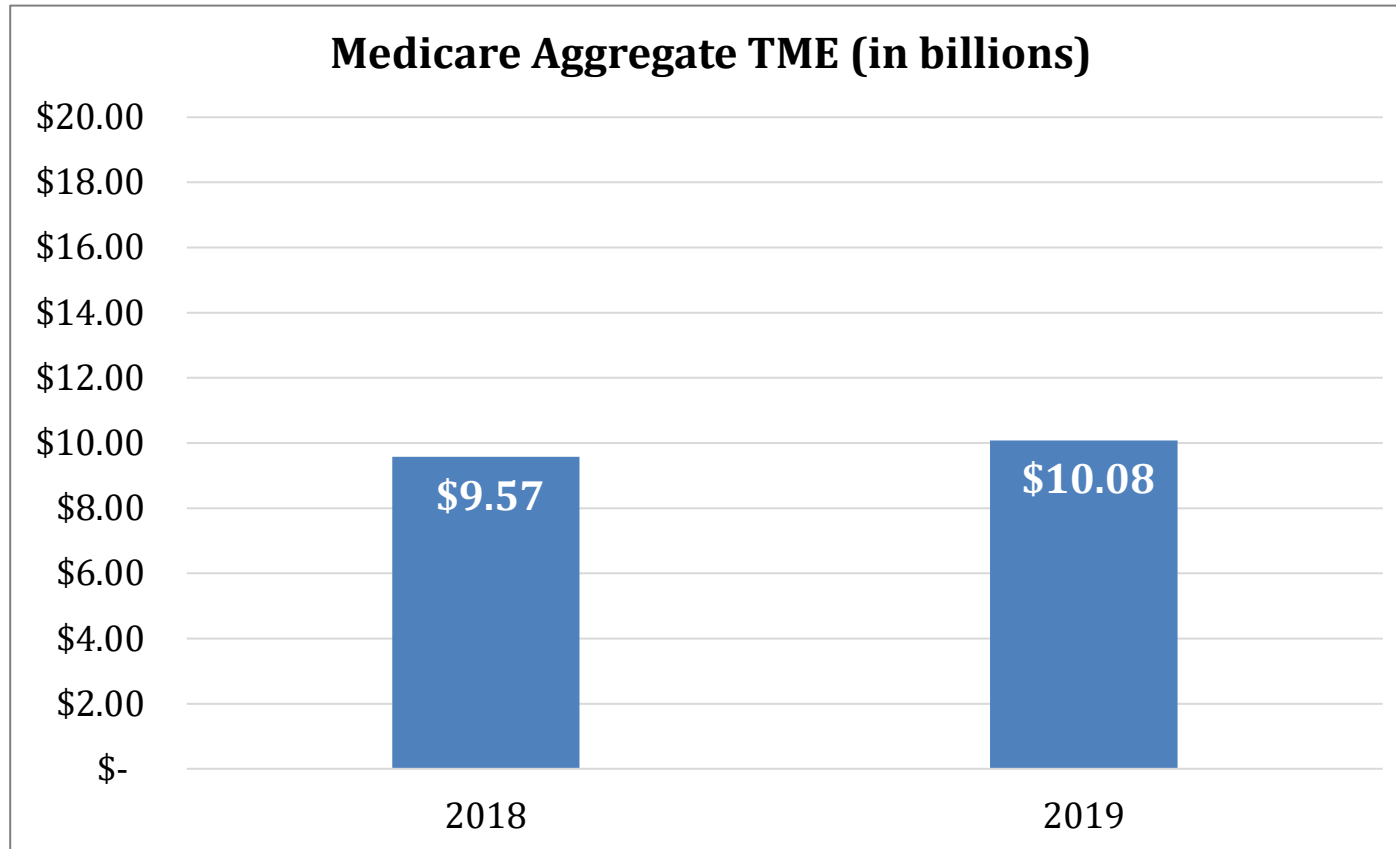
Medicaid Per Capita Spending Growth without Long-Term Care in 2019 was 2.1%



Year	TME Per Capita	TME Trend Per Capita
2018	\$5,073	2.1%
2019	\$5,181	

Data are not risk-adjusted. They are reported net of pharmacy rebates.
 Data include Medicaid spending on the dually eligible population.
 Data do not include payments to CT Administrative Service Organizations.

Medicare Per Capita Spending Growth in 2019 was 2.2%



Year	TME Per Capita	TME Trend Per Capita
2018	\$14,763	2.2%
2019	\$15,087	

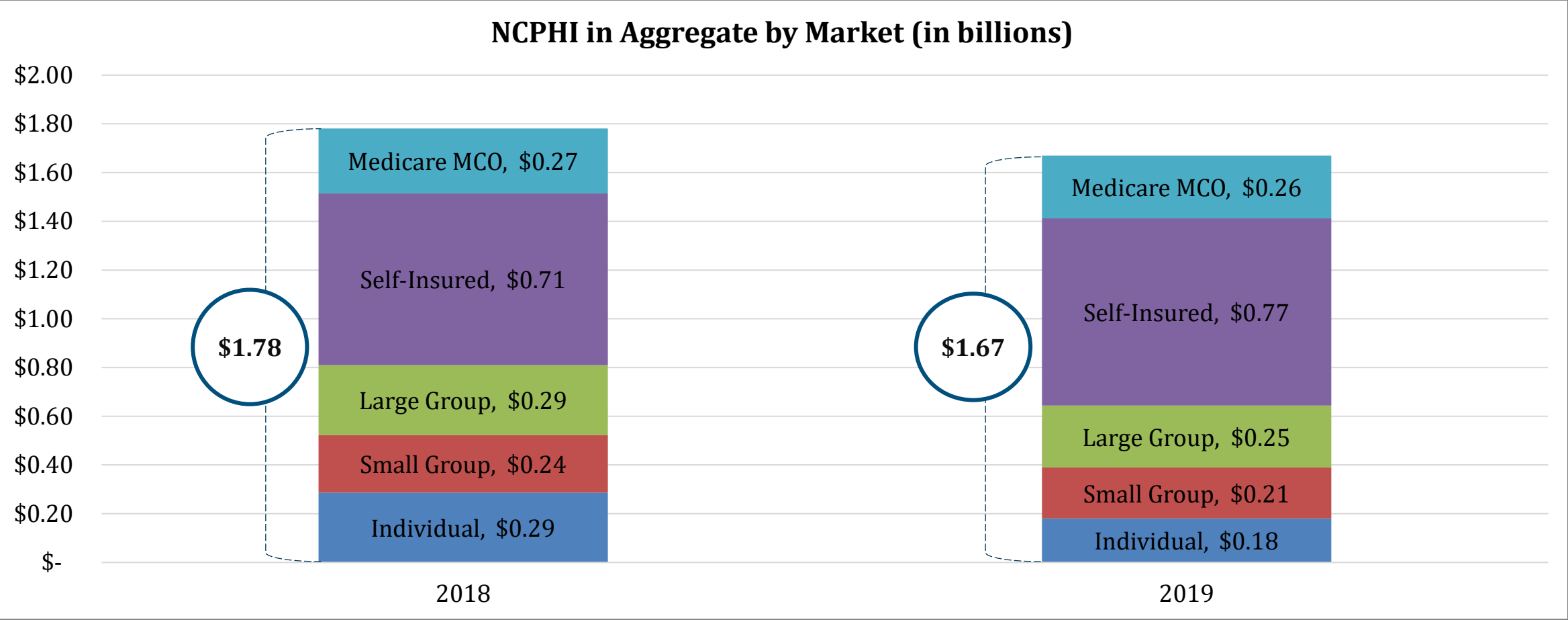
Medicare spending includes traditional Medicare, Medicare Advantage, and Part D pharmacy. Data are not risk-adjusted. They are reported net of pharmacy rebates (OHS did not receive pharmacy rebate information from CMS).

Data include Medicare spending on the dually eligible population.

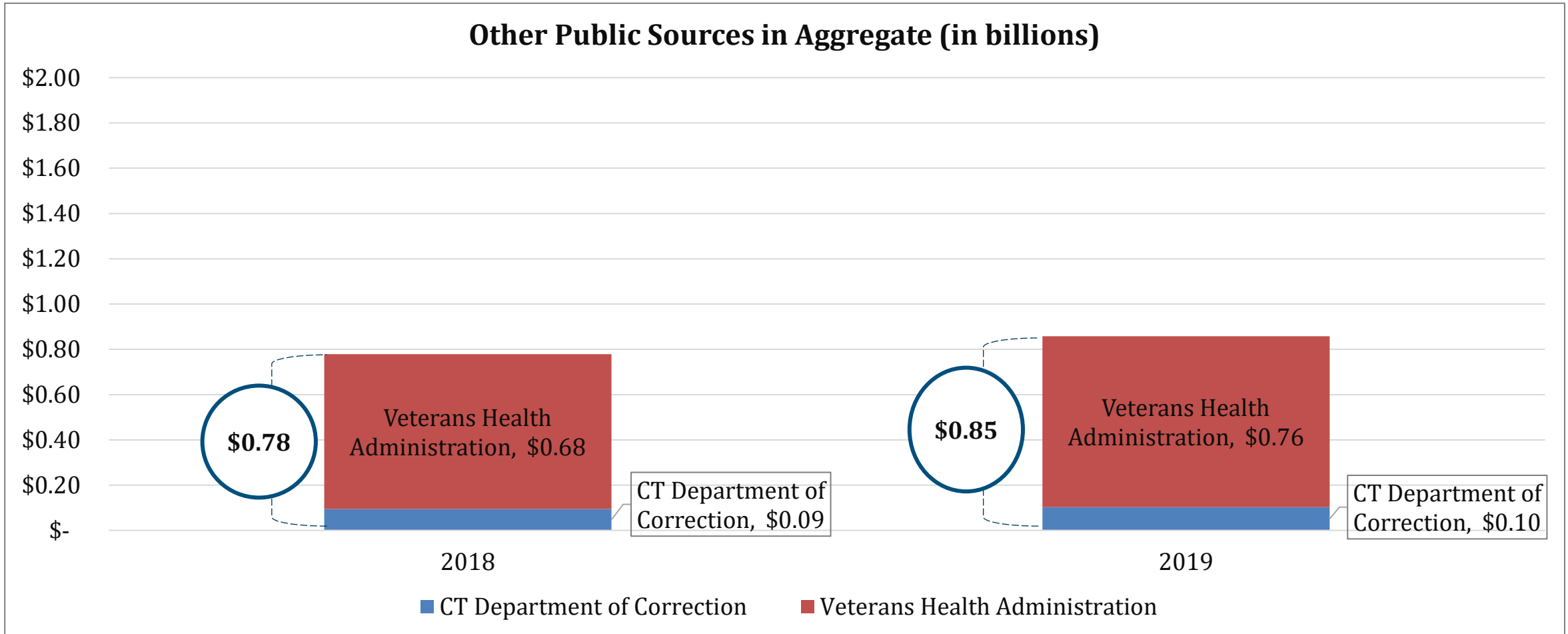
Data do not include NCPHI.

Net Cost of Private Health Insurance Contributed \$1.67 Billion to State THCE in 2019

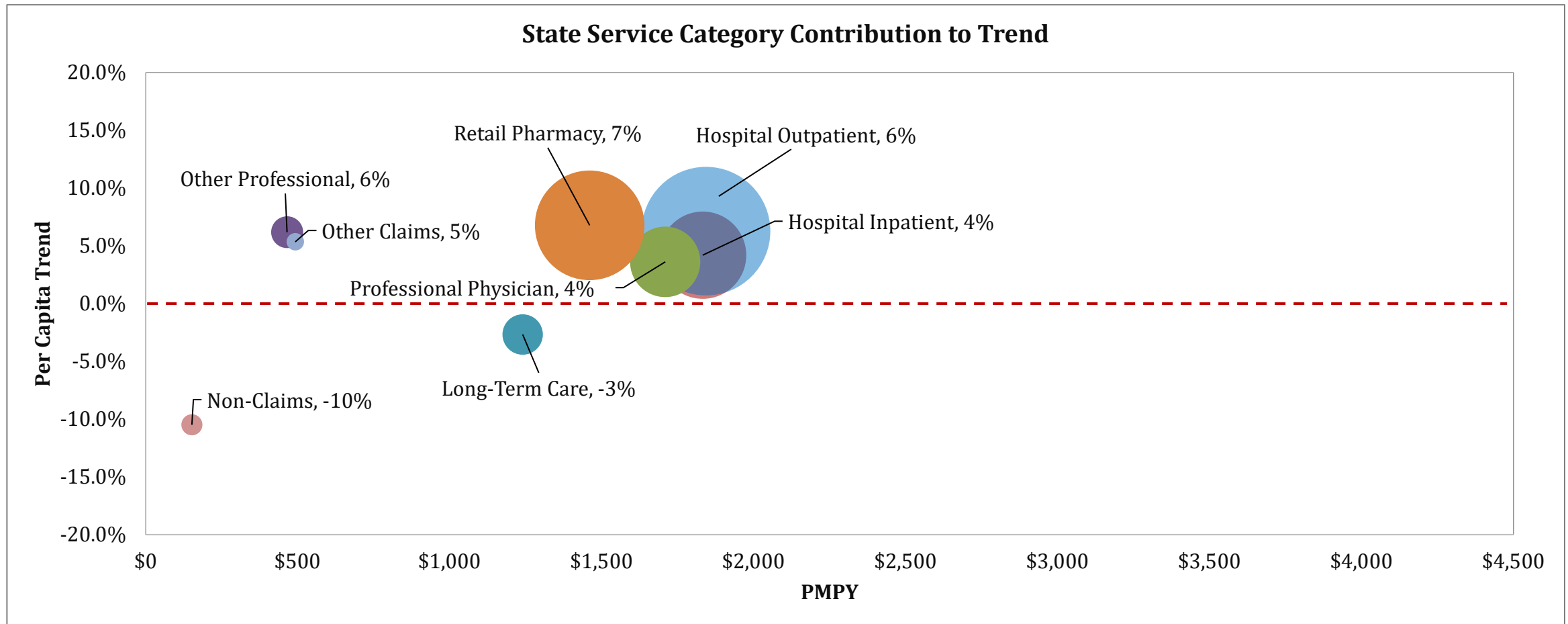
NCPHI in Aggregate by Market (in billions)



Other Public Sources Contributed \$0.86 Billion to State THCE in 2019

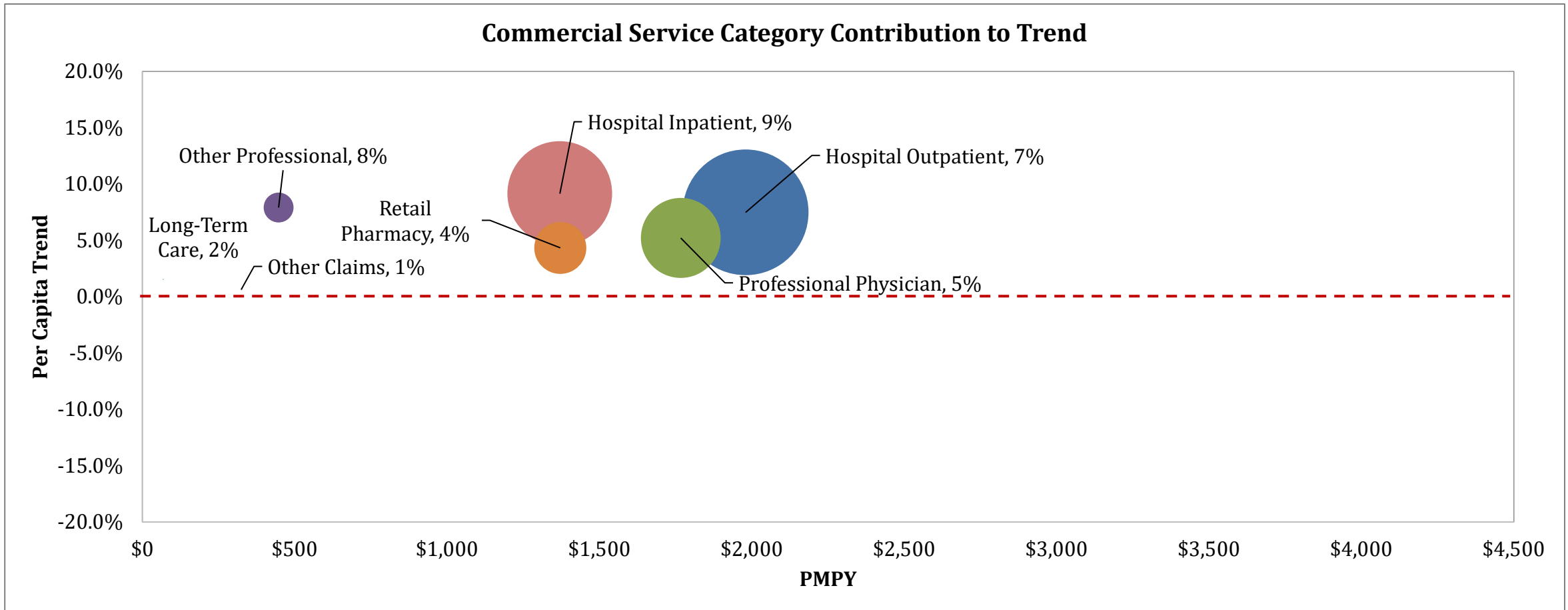


Retail Pharmacy and Hospital Outpatient Drove Connecticut's State Level Spending Growth in 2019



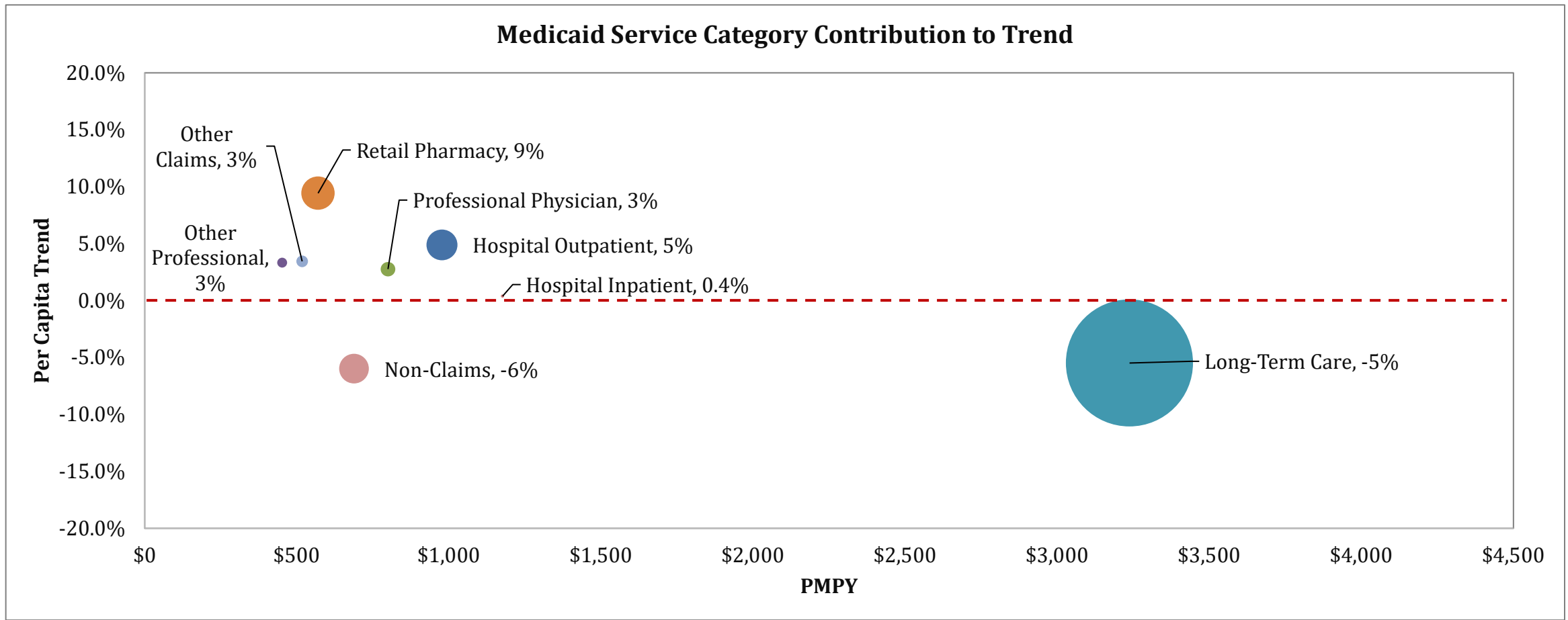
Data are not risk-adjusted. They are reported net of pharmacy rebates.
The width of the bubbles represents contribution to trend.

Hospital Outpatient and Hospital Inpatient Drove Connecticut's Commercial Market Spending Growth in 2019



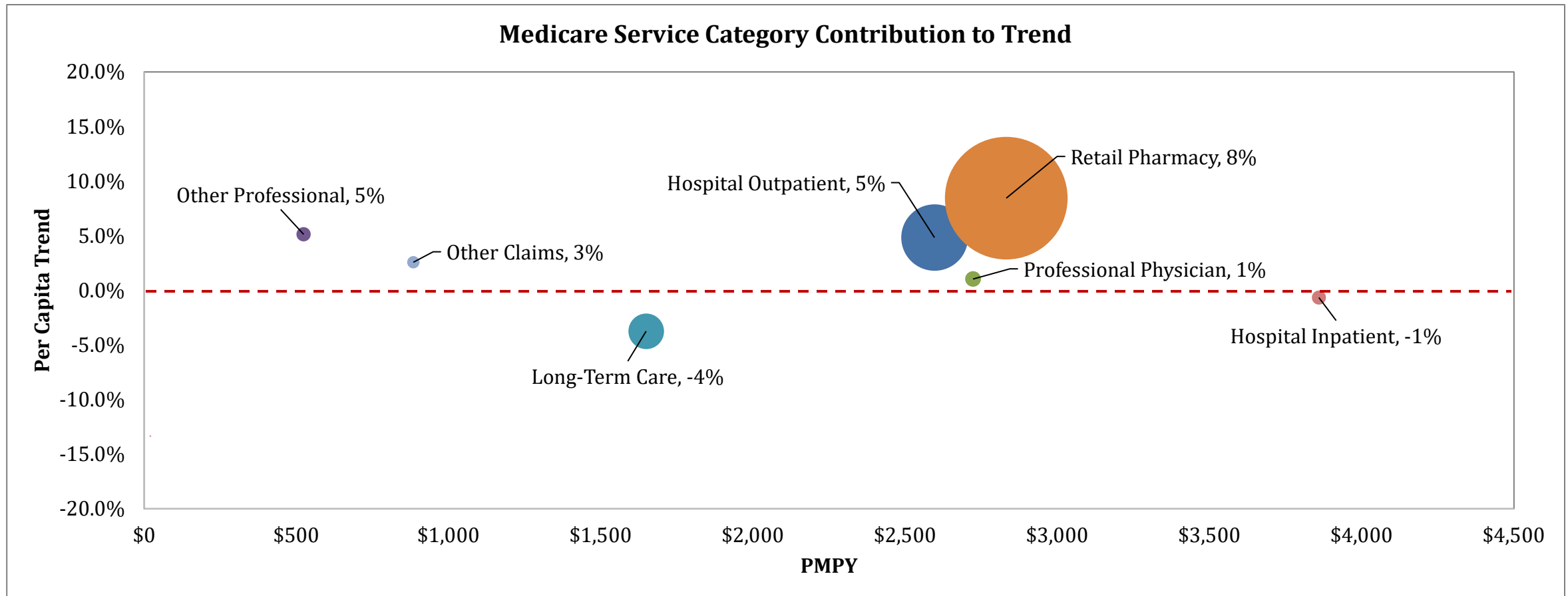
Data are not risk-adjusted. They are reported net of pharmacy rebates.
The width of the bubbles represents contribution to trend.

Retail Pharmacy and Hospital Outpatient Experienced the Largest Growth in the Medicaid Market in 2019



Data are not risk-adjusted. They are reported net of pharmacy rebates. The width of the bubbles represents contribution to trend.

Retail Pharmacy and Hospital Outpatient Drove Connecticut's Medicare Market Spending Growth in 2019



Data are not risk-adjusted. They are reported net of pharmacy rebates.
The width of the bubbles represents contribution to trend.

Three Service Categories Drove TME Cost Growth Across All Markets in 2019

	Hospital Inpatient	Hospital Outpatient	Retail Pharmacy (Net of Rebates)
State		✓	✓
Commercial	✓	✓	
Medicaid		✓	✓
Medicare		✓	✓

Follow-Up Mathematica Analyses to Understand ED Utilization Disparities

Follow-Up Mathematica Analyses

- During the Steering Committee's November review of ED utilization disparities by race and income, members asked if the disparities persisted if an analysis controlled for:
 - chronic illness prevalence
 - age and sex
 - utilization of urgent care facilities
- Mathematica has completed an analysis of the impact of chronic illness prevalence, age and sex. Its analysis of utilization of urgent care facilities is nearly done but is not ready for this meeting.

Purpose of the Analysis

- To assess disparities in Emergency Department (ED) use after controlling for chronic condition prevalence and population demographics (age and gender)
- Research question: *Once we control for differences among deciles in population demographics and chronic conditions (i.e., set them to the state average), what are the disparities in ED use?*

Study Population

- CT residents under age 65, as indicated in 2019
- Commercial (fully insured, and State employees and retirees)
- Enrolled for entirety of 2018 – 2019
- Exclusions (about 7% of members and claim lines per year):
 - Non-CT residents
 - Secondary payers, vision-only, and some student plans
 - Denied, reversed, and non-primary claim lines
 - Claim lines with negative payment or cost-sharing
 - Paid date within 6 months of service year

Methods

- **Chronic conditions**

Chronic conditions defined by Chronic Condition Warehouse (CCW) algorithm
Logic reviews of two years of historical claims to identify members with certain chronic conditions

Study population restricted to those with two full years of enrollment (2018-2019) to reduce portion of false negatives, i.e., those with chronic conditions but insufficient claims history to observe diagnoses

- **Race and Income Deciles**

Using U.S. Census data, assign CT zip codes to race and income deciles based on the percentage of white residents and the median income, respectively.

Decile 1: Highest proportion of people of color; lowest incomes

Decile 10: Lowest proportion of people of color; highest incomes

Methods – Adjusted ED rates

- Adjustment controls for differences among communities in population demographics (age and gender) and in rates of chronic conditions
- First model just includes demographic adjustment; second model adds chronic conditions
- Based on a linear regression
 - Unit of observation is the zip code
 - All variables are calculated from the study data
 - Adjusted ED rate removes differences among zip codes that can be explained by age, gender, and chronic conditions but retains other, unexplained differences

Lower income deciles tend to have a higher proportion of older persons and females

Group/ CT	Income Decile										
	1	2	3	4	5	6	7	8	9	10	
	52.1%	53.1%	53.0%	52.8%	52.1%	52.6%	52.7%	52.4%	51.8%	51.5%	51.3%
M All	47.9%	46.9%	47.0%	47.2%	47.9%	47.4%	47.3%	47.6%	48.2%	48.5%	48.7%
	3.4%	2.3%	2.0%	2.6%	2.8%	3.0%	3.2%	3.4%	3.8%	3.9%	4.1%
5-11	8.1%	6.3%	5.7%	6.0%	6.5%	6.9%	7.2%	7.7%	8.6%	9.1%	10.7%
	9.0%	6.7%	6.8%	6.9%	7.1%	7.7%	8.3%	8.7%	9.2%	10.2%	11.8%
18-25	11.9%	11.7%	12.0%	11.0%	10.7%	11.2%	11.4%	11.3%	11.3%	13.1%	13.4%
	9.5%	12.9%	11.9%	11.6%	11.7%	11.4%	10.1%	10.1%	9.3%	7.8%	5.8%
35-44	14.4%	16.5%	15.4%	15.9%	15.6%	15.0%	14.3%	14.5%	14.7%	13.9%	12.5%
	20.2%	20.5%	21.9%	20.8%	20.7%	20.1%	20.1%	20.4%	20.1%	19.8%	20.0%
55-64	23.4%	22.9%	24.4%	25.3%	24.8%	24.6%	25.4%	23.8%	23.0%	22.3%	21.6%

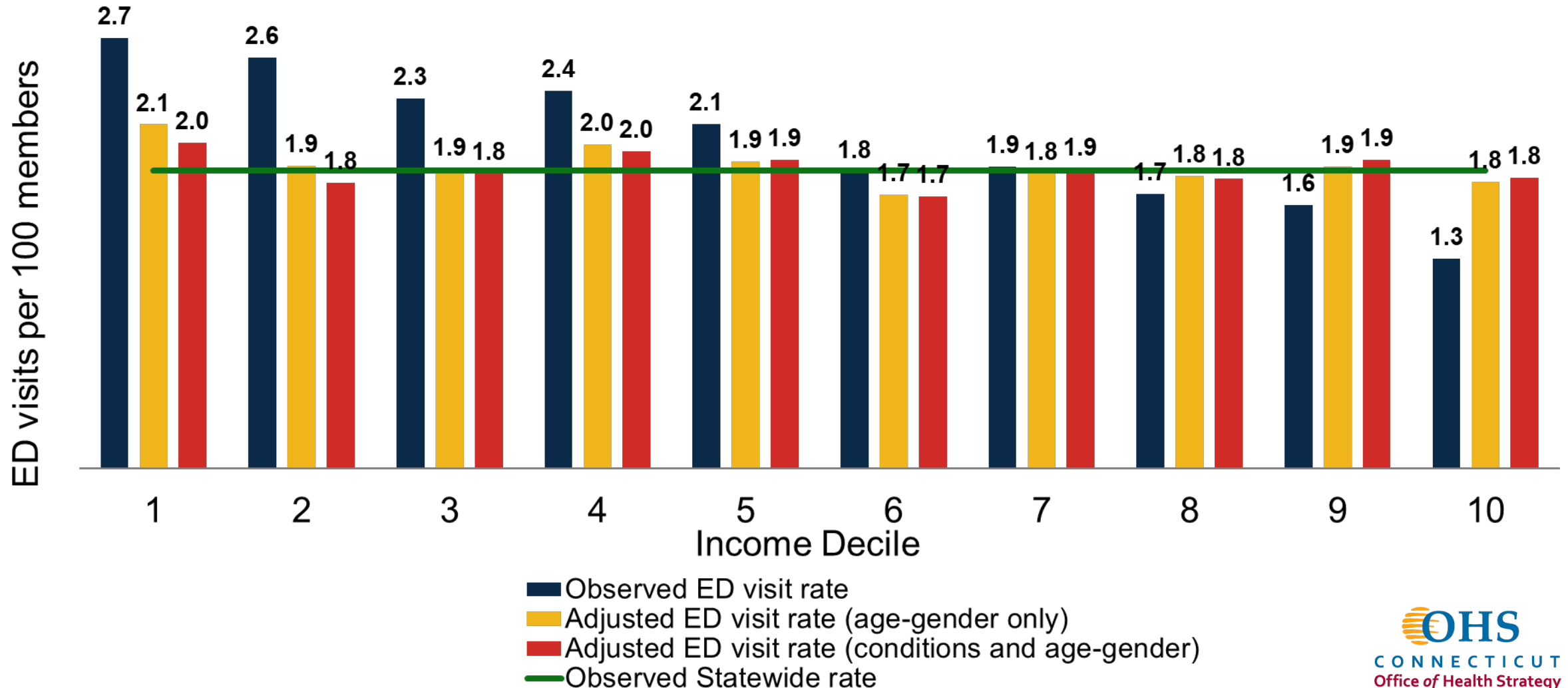
Limited to CT residents up to age 64 who were fully enrolled in commercial plans in 2018 and 2019.
Non-excluded members only.

Communities with more people of color tend to have a higher proportion of older persons and females

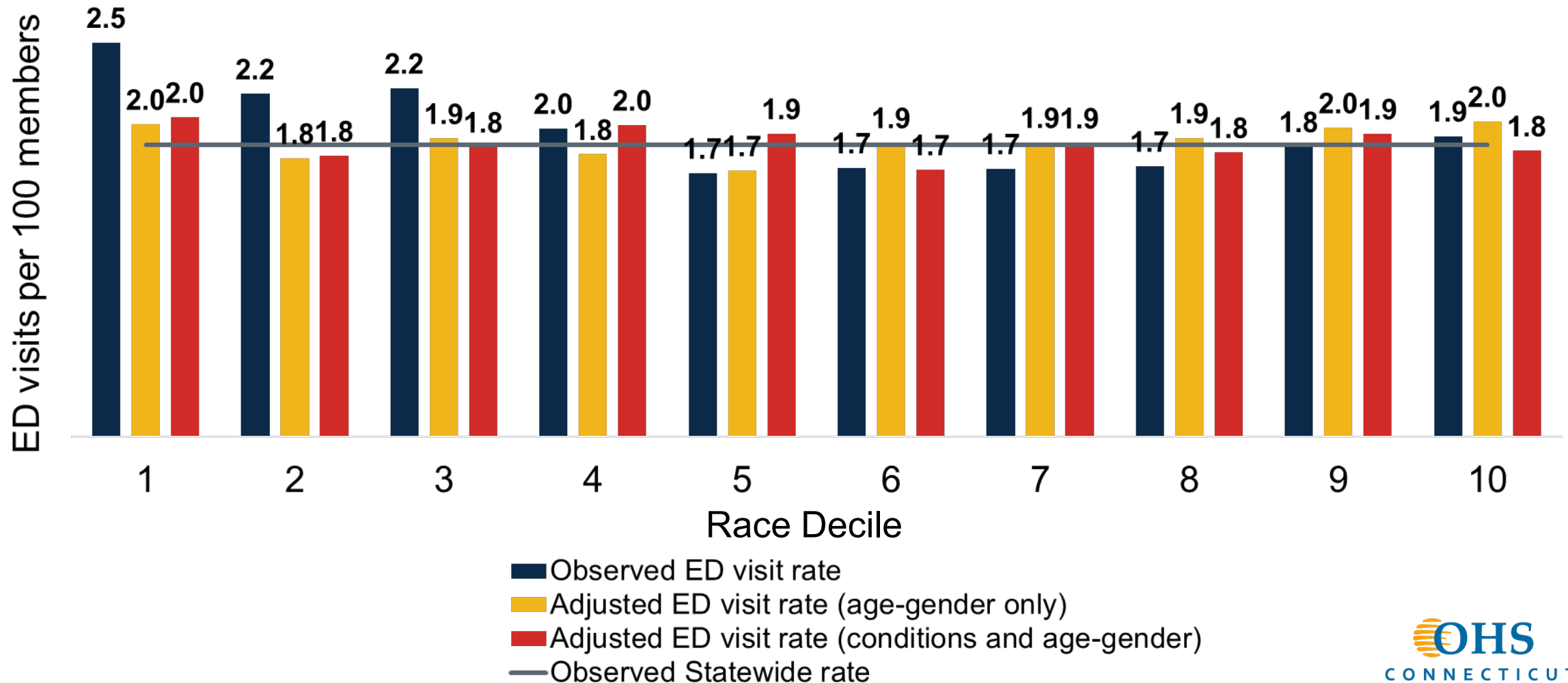
Group	CT	Race Decile									
		1	2	3	4	5	6	7	8	9	10
	52.1%	52.8%	53.4%	52.5%	52.6%	52.5%	51.9%	51.5%	51.7%	51.4%	51.8%
M All	47.9%	47.2%	46.6%	47.5%	47.4%	47.5%	48.1%	48.5%	48.3%	48.6%	48.2%
	3.4%	2.4%	2.7%	3.2%	3.3%	3.6%	3.9%	3.6%	3.8%	3.4%	3.4%
5-11	8.1%	6.2%	6.5%	6.6%	7.1%	8.2%	9.1%	8.8%	9.1%	7.9%	8.1%
	9.0%	7.0%	7.1%	6.8%	7.8%	9.0%	9.5%	10.0%	10.1%	9.6%	9.4%
18-25	11.9%	11.8%	11.5%	10.6%	10.9%	11.6%	11.6%	12.5%	12.1%	12.5%	12.2%
	9.5%	11.7%	12.4%	13.1%	11.1%	10.0%	8.8%	8.4%	7.8%	8.0%	8.1%
35-44	14.4%	16.2%	15.7%	16.4%	15.5%	14.8%	14.8%	13.6%	13.6%	12.8%	12.9%
	20.2%	21.2%	20.3%	19.9%	20.2%	20.0%	19.8%	20.0%	20.4%	20.4%	20.6%
55-64	23.4%	23.5%	23.8%	23.4%	24.1%	22.7%	22.6%	23.0%	23.2%	25.4%	25.2%

Limited to CT residents up to age 64 who were fully enrolled in commercial plans in 2018 and 2019. Non-excluded members only.

Controlling for age-gender rates greatly reduces disparities in observed ED use across income deciles



Controlling for age-gender rates also eliminated disparities in observed ED use across race deciles



Key Takeaways

- **ED use is higher in lower income communities**
 - Much of this difference can be explained by differences in population demographics (age/gender) and chronic condition prevalence
 - Once we control for age/gender, chronic conditions have little additional explanatory power.
- **ED use is also higher in communities with more people of color, especially in the first three deciles.**
 - Again, controlling for age and gender greatly reduces observed disparities

What's going on here?

- A national study published in January 2021 found age-standardized per-person spending was significantly greater for Black individuals for emergency department care than the all-population mean, but lower for Hispanic individuals.

This study was at a person level, as compared to our analysis which looks at the community-level where it's a bit harder to detect differences.

- Still, we may be missing important differences between Black and Hispanic populations by combining them.
- OHS will consider a follow-up analysis that separates Black and Hispanic populations.

Not having granular race, ethnicity, and language data in the APCD makes this a challenge and this remains an area of focus for OHS.

Primary Care Spend Target

Overview of the Primary Care Spend Target

- Executive Order #5 (January 2020) established a target to increase primary care spending as a percentage of total healthcare expenditures to 10 percent by calendar year 2025.
 - The target is intended to rebalance and strengthen Connecticut's healthcare system by supporting improved primary care delivery.
- OHS and the predecessor advisory body to the Steering Committee established a definition of primary care spending in 2020 that built upon a methodology established in collaboration with other New England states.

Why Invest In Primary Care?

- Research has demonstrated that greater relative investment in primary care correlated with better patient outcomes, lower costs, and improved patient experience of care.
- CMS, states and private payers have elected to leverage primary care to strengthen healthcare system performance by:
 - supporting improved primary care delivery
 - increasing the percentage of total spending allocated to primary care
- In CT, an analysis by ConnectiCare found that **primary care utilization is typically higher in high-performing medical groups.** These groups manage spending well compared to low-performing groups and have lower specialty spending.

Definition of Primary Care Spending

- **Primary care spending:**
 - **Claims-based spending:** spending for care management; care planning; consultation services; health risk assessments, screenings and counseling; home visits; hospice/home health services; immunization administrations; office visits and preventive medicine and dental care visits.
 - There is a specific code list to calculate claims-based primary care spending.
 - **Non-claims-based spending:** capitation or salaried expenditures, PCMH infrastructure, performance-based payments, risk-based reconciliation, HIT infrastructure, workforce expenditures, COVID-19 support payments.

Definition of Primary Care Spending (Cont'd)

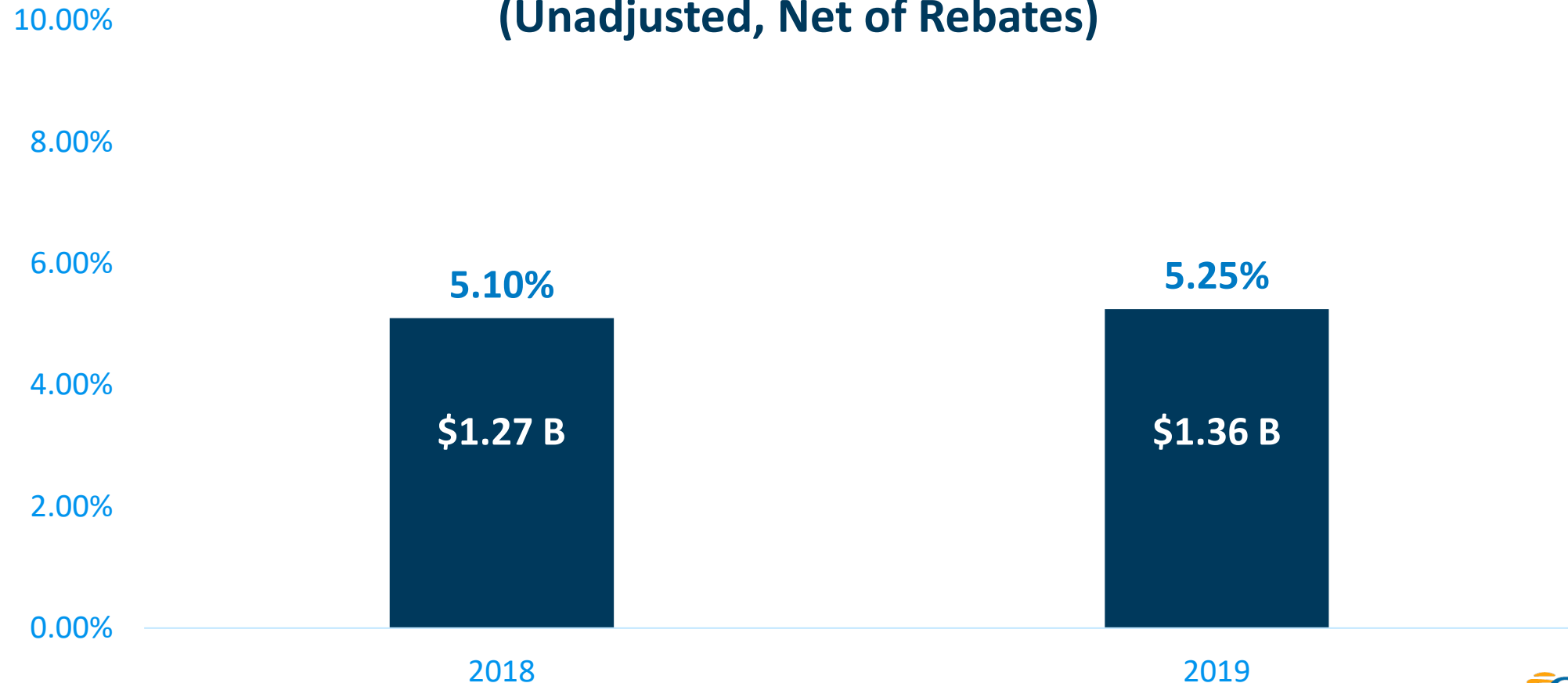
- **Primary care providers:**
 - **MDs and DOs:** geriatric medicine (when practicing primary care), family medicine, internal medicine (when practicing primary care) and pediatric and adolescent medicine.
 - **NPs and PAs:** when practicing primary care.
 - Of note, OHS is also assessing primary care spending associated with OB/GYNs and midwifery for monitoring purposes.

2018-19 Baseline Data Analysis

- OHS collected data on 2018-19 healthcare spending, including primary care spending on the following:
 - six commercial and Medicare Advantage insurers:
 - Aetna Health & Life
 - Anthem
 - Cigna
 - ConnectiCare
 - Harvard Pilgrim
 - UnitedHealthcare
 - Connecticut Department of Social Services (for Medicaid)
 - Centers for Medicare & Medicaid Services (for Medicare)

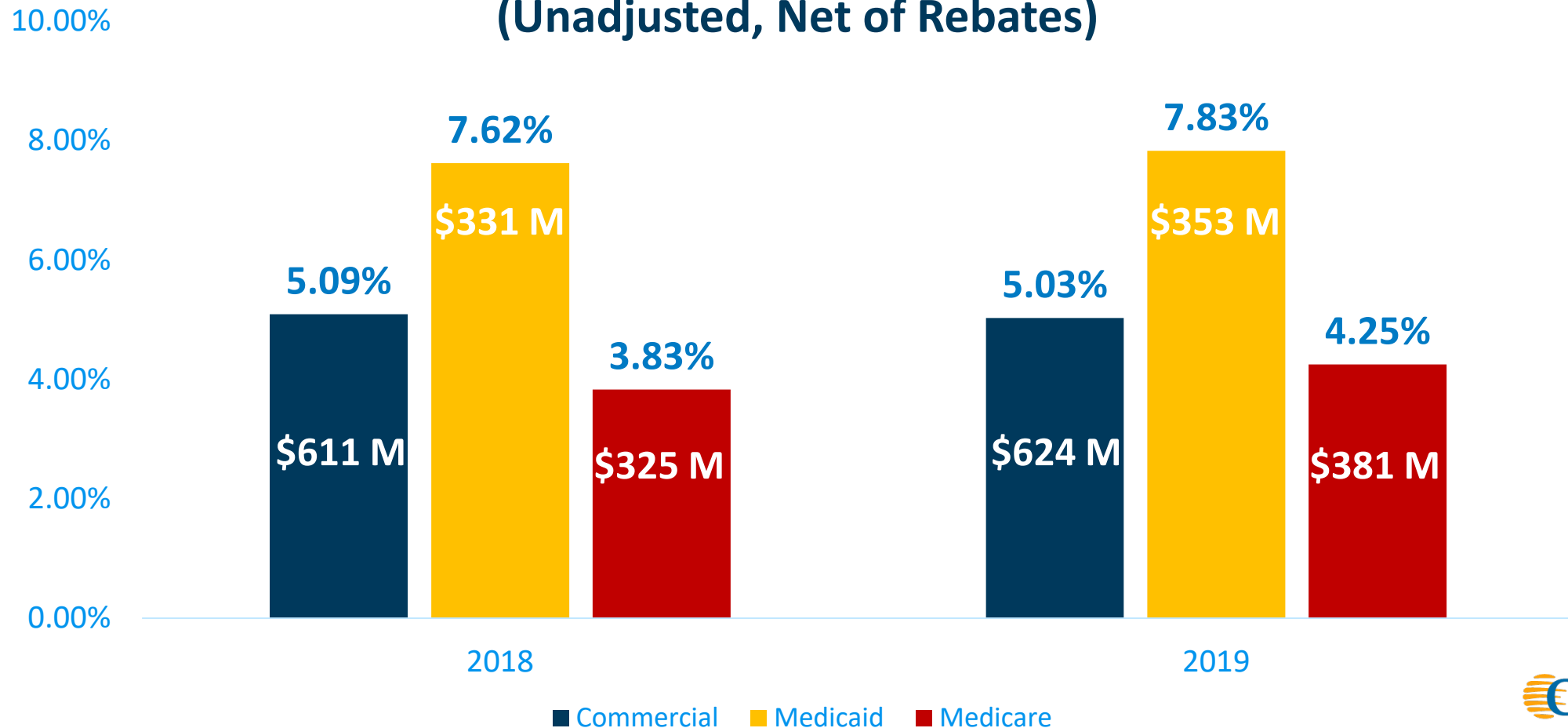
State-Level Primary Care Spending

Primary Care Spending as a Percentage of Total Spending (Unadjusted, Net of Rebates)



Market-Level Primary Care Spending

Primary Care Spending as a Percentage of Total Spending (Unadjusted, Net of Rebates)



Payer-Level Spending

- Commercial carriers

	2018	2019
Primary Care Spending as a Percentage of Total Spending	3.6% - 6.8%	3.5% - 6.7%
PMPM Primary Care Spending	\$21 - \$35	\$21 - \$38

- Medicare Advantage carriers

	2018	2019
Primary Care Spending as a Percentage of Total Spending	5.1% - 7.7%	4.5% - 7.6%
PMPM Primary Care Spending	\$34 - \$89	\$33 - \$84

2022-25 Primary Care Spend Targets

- The 2022 target was set at 5.3%, the baseline level calculated for 2019.
- Targets for years 2023-2025 include near-equal annual increases.

Year	Target
2022	5.3%
2023	6.9%
2024	8.5%
2025	10%

Primary Care Subgroup and OHS Rationale for the targets:

1. Targets must be realistic. December notification of 2022 targets provided short notice to insurers who had already negotiated contracts with primary care organizations for 2022.
2. The methodology establishing the 2022-24 targets should be simple to explain.

Quality Benchmarks

Overview of the Quality Benchmarks

- Executive Order #5 charged the Quality Council with developing healthcare quality benchmarks to become effective on January 1, 2022. The benchmarks:
 - shall ensure the **maintenance and improvement of healthcare quality**;
 - shall be applied across all **public and private payers**, and
 - *may* include **clinical quality, over- and under-utilization** and **patient safety measures**.
- Connecticut is the second state to have quality benchmarks.
 - Delaware was the first state – it established quality benchmarks in 2019.

Overview of the Quality Benchmarks (Cont'd)

- The Quality Council recommended two types of measures for the Quality Benchmarks:
 - **health status measures**, which quantify certain population-level characteristics of CT residents (e.g., statewide obesity rate) and are assessed at the state level
 - **healthcare measures**, which quantify performance on healthcare processes or outcomes and are assessed at the state, market, insurer and provider levels (e.g., OHS' Core Measure Set measures)

Overview of the Quality Council

- OHS looked to its Quality Council to provide feedback on the Quality Benchmarks, including:

Consumer Advocates

- CT Center for Patient Safety
- CT Health Foundation
- Three consumer representatives

Payers

- Anthem
- Cigna
- ConnectiCare
- UnitedHealthcare

State Agencies

- Dept. of Mental Health and Addiction Services
- Dept. of Public Health

Providers

- Cardiology Associates of New Haven
- Community Health Center of CT
- Community Medical Group
- CT Hospital Association
- Eastern CT Health Network / Quinnipiac
- First Choice Health Centers
- Stamford Health
- Trinity Health of New England
- Yale, Yale New Haven Health, Yale New Haven Hospital

- Dept. of Social Services
- Office of the State Comptroller

Quality Benchmark Measures

Phase 1: Beginning for 2022

- Asthma Medication Ratio
- Controlling High Blood Pressure
- Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control

Phase 2: Beginning for 2024

- Child and Adolescent Well-Care Visits
- Follow-up After ED Visit for Mental Illness (7-day)
- Follow-up After Hospitalization for Mental Illness (7-day)
- Obesity Equity Measure*

*Performance for this measure will only be assessed at the state level (and not by market).

Quality Benchmarks Values

- OHS will set **separate Quality Benchmark values** for each measure for the **commercial** market, **Medicaid** market, and **Medicare Advantage** market for 2025.
 - *Obesity Equity Measure* will only have one statewide value.
- Phase 1 measures will also have **interim annual targets** (for 2022, 2023, and 2024).
 - OHS and the Quality Council recommended keeping the 2022 Benchmark value for Phase 1 measures the same value as the baseline rate. They recognized that it is unlikely that there will be notable improvement towards the Benchmark values for Phase 1 Quality Benchmarks in 2022 because the Benchmarks were finalized just before the start of the measurement year.

Commercial Market Benchmark Values: Phase 1 Measures

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source	Percentage Point Improvement
Asthma Medication Ratio (Ages 5-18)	79%	81%	83%	86% <i>Between the national commercial 50th and 75th percentiles</i>	Overall: 7% Annual: 2%
Asthma Medication Ratio (Ages 19-64)	78%	80%	82%	85% <i>National commercial 90th percentile</i>	Overall: 7% Annual: 2%
Controlling High Blood Pressure	61%	63%	65%	68% <i>Between the New England commercial 50th and 75th percentiles</i>	Overall: 7% Annual: 2%
HbA1c Control for Patients with Diabetes: HbA1c >9%*	27%	26%	25%	23% <i>Between the national commercial 75th and 90th percentiles</i>	Overall: 4% Annual: 1%

The annual change in Benchmark values may not be even due to rounding.

*A lower rate indicates higher performance.

Commercial Market Benchmark Values: Phase 2 Measures

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source	Percentage Point Improvement
Child and Adolescent Well-Care Visits	TBD	TBD	TBD	TBD	TBD
Follow-up After ED Visit for Mental Illness (7-Day)	60%	N/A	N/A	75% <i>Between the New England commercial 75th and 90th percentiles</i>	Overall: 15%
Follow-up After Hospitalization for Mental Illness (7-Day)	56%	N/A	N/A	63% <i>Between the New England commercial 75th and 90th percentiles</i>	Overall: 7%

The annual change in Benchmark values may not be even due to rounding.

Medicaid Market Benchmark Values: Phase 1 Measures

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source	Percentage Point Improvement
Asthma Medication Ratio (Ages 5-18)	66%	68%	70%	73% <i>Between the national Medicaid 50th and 75th percentiles</i>	Overall: 7% Annual: 2%
Asthma Medication Ratio (Ages 19-64)	63%	65%	67%	70% <i>Between the national Medicaid 75th and 90th percentiles</i>	Overall: 7% Annual: 2%
Controlling High Blood Pressure	61%	63%	65%	68% <i>National Medicaid 75th percentile</i>	Overall: 7% Annual: 2%
HbA1c Control for Patients with Diabetes: HbA1c >9%*	37%	36%	35%	33% <i>National Medicaid 75th percentile</i>	Overall: 4% Annual: 1%

The annual change in Benchmark values may not be even due to rounding.

*A lower rate indicates higher performance.

Medicaid Market Benchmark Values: Phase 2 Measures

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source	Percentage Point Improvement
Child and Adolescent Well-Care Visits	TBD	TBD	TBD	TBD	TBD
Follow-up After ED Visit for Mental Illness (7-Day)	50%	N/A	N/A	65% <i>National Medicaid 90th percentile</i>	Overall: 15%
Follow-up After Hospitalization for Mental Illness (7-Day)	48%	N/A	N/A	55% <i>New England Medicaid 90th percentile</i>	Overall: 7%

Medicare Advantage Market Benchmark Values

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source	Percentage Point Improvement
Controlling High Blood Pressure	73%	75%	77%	80% <i>National Medicare Advantage 75th percentile</i>	Overall: 7% Annual: 2%
HbA1c Control for Patients with Diabetes: HbA1c >9%*	20%	18%	16%	15% <i>National Medicare Advantage 75th percentile</i>	Overall: 5% Annual: 2%

The annual change in Benchmark values may not be even due to rounding.

*A lower rate indicates higher performance.

Statewide Benchmark Values

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source	Percentage Point Improvement
Obesity Equity Measure <i>the ratio of the White, non-Hispanic obesity rate and Black, non-Hispanic obesity rate</i>	1.65	N/A	N/A	1.33 <i>National ratio</i>	Overall: 0.32

Strategies to Generate Action on the Quality Benchmarks

- Does the Stakeholder Advisory Board have recommendations on how to generate focused attention and improvement activity on the Quality Benchmarks?

- As a reminder...

Phase 1 Measures

- Asthma Medication Ratio
- Controlling High Blood Pressure
- Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control

Phase 2 Measures

- Child and Adolescent Well-Care Visits
- Follow-up After ED Visit for Mental Illness (7-day)
- Follow-up After Hospitalization for Mental Illness (7-day)
- Obesity Equity Measure

Wrap-up & Next Steps

Next Steps

- The next Stakeholder Advisory Board meeting will be held on Thursday June 9th from 2:00-4:00 p.m.

Adjourn

