Cost Growth Benchmark Performance Assessment

Nevada Patient Protection Commission Advisory Subcommittee
January 28, 2022
1. Benchmark Methodology and Value
2. Reporting Performance Against the Cost Growth Benchmark
3. Attributing Members to Clinicians, and Clinicians to Large Provider Entities
4. Methods to Ensure the Accuracy and Reliability of Benchmark Performance Measurement
   a. Performing Statistical Testing on Benchmark Performance
   b. Mitigating the Impact of High-Cost Outliers on Per Capita Spending
   c. Applying Risk Adjustment
   d. Reporting for Sufficient Population Sizes
5. Next Steps
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Recap of Last Advisory Group (10/1) and PPC (10/20) Meetings

- There was general agreement that **Gross State Product (GSP)** and **Median Wage** should be used to calculate a benchmark value.

- There was not consensus on a recommendation, but of those members who voiced a preference, most recommended a cost growth benchmark value of **2.4% or 2.8% for a duration of four or five years**.

- Most preferred that the value **remain constant** over the time period.

- PPC staff conveyed these recommendations to the Governor’s Office.
On December 29, 2021, Governor Sisolak issued an Executive Order establishing cost growth benchmarks for 2022-2026.

Section 1: The Nevada Health Care Cost Growth Target ("Target") is hereby established for 2022 through 2026 as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Median Weight</th>
<th>Wage Weight</th>
<th>Gross Product Weight</th>
<th>Benchmark Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2022</td>
<td>20%</td>
<td>80%</td>
<td>3.19%</td>
<td></td>
</tr>
<tr>
<td>2023</td>
<td>35%</td>
<td>65%</td>
<td>2.98%</td>
<td></td>
</tr>
<tr>
<td>2024</td>
<td>50%</td>
<td>50%</td>
<td>2.78%</td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>65%</td>
<td>35%</td>
<td>2.58%</td>
<td></td>
</tr>
<tr>
<td>2026</td>
<td>80%</td>
<td>20%</td>
<td>2.37%</td>
<td></td>
</tr>
</tbody>
</table>

Section 2: The Target applies across all Nevada health care markets and populations.
Section 3: The Agencies shall, within the scope of their legal authority:

a. Monitor health care spending growth across all public and private payers and populations in Nevada and report at least annually to the Governor on such growth;

b. Engage relevant parties, including insurers, providers, and community partners, to develop strategies to help meet the Target that are data-based and practicable;

c. Ensure that consumers and businesses purchasing health insurance share in the positive impact of the Target and related work.

d. Report annually during the fourth quarter on performance relative to the Target during the prior calendar year at:

   i. State, health insurance market (e.g., commercial, Medicaid, Medicare, Medicare Advantage) and individual payer levels; and,

   ii. Accountable care organization (ACO) level for entities of a sufficient size, using clinical risk adjustment methodologies;

e. No later than October 1, 2026 the PPC shall make a recommendation to the Governor regarding the appropriate cost growth benchmarks for the year 2027 and beyond.
Section 4: The Division of Insurance, the Department of Health and Human Services, and any other relevant state agencies shall cooperate and coordinate with one another and with the PPC and its Executive Director to implement this Order.

Section 5: Should the PPC find that there have been significant changes to the economy after the effective date of this Order, it may recommend to the Governor changes to the cost growth benchmarks set forth in Section 1, or recommend changes to the manner in which benchmark performance is assessed.

Section 6: This Order is effective upon signature and shall remain in force, unless amended, modified, terminated, or rescinded by the Governor.
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Reminder: Cost Growth Benchmark Analysis vs. Data Use Strategy

How will we determine the level of cost growth from one year to the next?

Benchmark Analysis

- **What is this?** A calculation of health care cost growth over a given time period using payer-collected aggregate data
- **Data Type:** Aggregate data that allow assessment at multiple levels, e.g., state region, insurer, large provider entity
- **Data Source:** Insurers and public payers
- **State Resources to be Used:** Staff from the DHHS Office of Analytics have been assigned to this work.

Data Use Strategy

- **What is this?** A plan to analyze cost drivers and identify promising opportunities for reducing cost growth and informing policy decisions
- **Data Type:** Granular data (claims and/or encounters)
- **Data Source:** APCD, when available. Until then, only Medicaid and Public Employees’ Benefits Program (PEBP) data will be used.
- **State Resources to be Used:** Until the APCD is available, DHHS Office of Analytics will coordinate the analysis of Medicaid data. PEBP will coordinate the analysis of PEB Program data, with the support of its contractor, Aon.

How will we determine the drivers of overall cost and cost growth? Where are there opportunities to contain spending?
States Typically Report Benchmark Performance at Four Levels

- **State (THCE)**
  - Medicaid (Fee-for-Service and Managed Care)
  - Medicare (Fee-for-Service and Managed Care)
  - Commercial (Self- and Fully Insured)

- **Market (THCE)**
  - Medicaid
  - Medicare
  - Commercial

- **Payer (THCE)**
  - Medicaid MCOs
  - Medicare Advantage Plans
  - Commercial Carriers

- **Large Provider Entity (TME only)**
  - Provider Entity A
  - Provider Entity B
  - Provider Entity C
Reporting at the State Level: DE Example

**TOTAL HEALTH CARE EXPENDITURES**

- Total health care expenditures (THCE) went from $7.6 billion in CY 2018 to $8.2 billion in CY 2019 an 8.5% increase
- CY 2019 spending by component (similar to CY 2018 spending mix):
  - Medicare (FFS and managed care): 37.3% of spending
  - Commercial (fully and self-insured): 29.8% of spending
  - Medicaid (FFS and managed care): 26.2% of spending
  - Net Cost of Private Health Insurance (NCPHI): 4.2% of spending
  - Veterans Health Administration: 2.5% of spending

**Figure 1. CY 2019 State Total Health Care Expenditures (THCE)**

- Veterans Health Administration $0.2 B
- NCPHI $0.3 B
- Medicaid $2.1 B
- Commercial $2.4 B
- Medicare $3.1 B

**Total Overall Spending $8.2 B**

**OVERVIEW OF BENCHMARK TREND REPORT: CY 2019 RESULTS**

* Medicare FFS, Medicaid FFS, and Veterans Health Administration does not have NCPHI, so expressed as a percentage of THCE, NCPHI is relatively low.

Reporting at the Market Level: RI Example (Commercial)

Commercial Market Exceeded the 3.2% Target in 2019

- **2018**: $5,823 PMPY
- **2019**: $6,009 PMPY

**TOTAL EXCESS COST GROWTH**
- $31.7 million

**PER CAPITA TME TREND**
- 4.7%

SOURCE: April 29, 2021 presentation to the Rhode Island Cost Trends Steering Committee.
Reporting at the Payer Level: MA Example (Commercial)

Change in Preliminary Commercial HSA TME by Payer, 2018-2019

Reporting at the Provider Level: MA Example

Change in Final Managing Physician Group Commercial HSA TME, 2017-2018

The largest physician groups experienced varied HSA TME growth by network in 2018.

A Note on Reporting at the Provider Level

- Benchmark performance reporting at the provider level is limited to those providers that:
  - Are sufficiently large such that performance against the benchmark can be accurately and reliably measured.
  - Have responsibility for meeting all a patient’s needs (i.e., medical groups, health systems and IPAs that can engage in total cost of care contracts).

- The Commission will discuss how to specifically define and identify provider entities whose performance will be measured against the benchmark.
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1. How should patients be attributed to a clinician?

2. How should clinicians be organized into large provider entities for the purpose of measurement and reporting?
Spending is attributed to an individual member.

Member is attributed to a primary care provider (PCP), if possible.

PCP is attributed to a large provider entity, if possible.

- Insurers report spending by large provider entity.
- Insurers also report spending in aggregate for members who cannot be attributed to a PCP and for members whose PCP cannot be attributed to a large provider entity.
1. How Should Members Be Attributed to Clinicians?

- Members need to be attributed to a clinician for the costs incurred by that member.

- Attribution is performed routinely by insurers for value-based contracts whereby individual clinicians and provider entities are held accountable for quality and/or the cost of care.

- Insurers also attribute members to clinicians and provider entities for other purposes, including care management and internal analyses. Some states and quality improvement organizations do the same.
Being attributed to a clinician for the purpose of analyses does not mean that:
– the member was required to see that clinician, or
– the clinician delivered all of the care the patient received.

Attribution is used, however, to indicate that a clinician had a caregiving relationship with a member and the clinician helped to direct the member’s care in some manner.
## Two Approaches to Attributing Members to Clinicians

<table>
<thead>
<tr>
<th>Method</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members are attributed using a <strong>common methodology</strong>, where insurers work together to agree upon the methodology and apply it to this process.</td>
<td>Supports potential comparisons of performance across insurers</td>
<td>Adds a layer of complexity to the process</td>
</tr>
<tr>
<td>Members are attributed using each <strong>insurer’s own methodology</strong> employed with its value-based payment contracts or for other purposes</td>
<td>Makes reporting easier for insurers</td>
<td>Variation in methodology would produce inconsistent results and is not ideal for supporting provider comparisons across insurers</td>
</tr>
</tbody>
</table>
Massachusetts, Delaware, Rhode Island, Connecticut, and Oregon are all using a primary care attribution model, and have all taken a similar approach, leaving the exact methodology up to each insurer.

Massachusetts and Oregon have added some specificity, however, requiring that each carrier’s primary care attribution method follow a hierarchy:
- Member selection
- Contract arrangement
- Utilization
The PPC agreed on allowing insurers to use their own attribution methodologies and asking each insurer to disclose that methodology.

The PPC also recommended performing an analysis in the future to see whether the differences in methodologies are substantive enough to warrant a common methodology.

Does the Advisory Subcommittee wish to recommend that payers report health care cost growth data using:

- Their own attribution methodologies?
- Their own attribution methodologies, but specifying a hierarchy?
- A common, to-be-determined, member attribution methodology?
2. How Should Clinicians Be Organized Into Larger Entities?

- To report data, payers need technical instructions on how to organize clinicians into provider entities.

- There are two general approaches to organizing clinicians into large entities for which benchmark performance can be reported:
  - Attribution based on statewide provider directory (Massachusetts and Oregon)
  - Attribution based on contracting arrangements (Rhode Island and Connecticut)
Massachusetts has a provider directory that maps individual physician NPI numbers to physician groups.

- Provider directories can also use Tax ID numbers.
- Either approach to developing provider directories – using NPIs or TINs – has associated advantages and disadvantages.
- Using both is also an option.

Insurers then report spending for the identified physician groups.
Oregon did not provide a pre-defined list of provider organizations.

The state instead asked payers to report provider organizations by their tax ID numbers (TINs). Oregon will build the provider directory based on the submissions.

Oregon is currently analyzing payer submissions and determining for which provider entities it will report.
Rhode Island Identifies the Largest Accountable Care Organizations

- Total cost of care contracts require a listing of which individual primary care clinicians belong to an ACO.
- Rhode Island identified the commercial and Medicaid ACOs in the state (there aren’t many!).
- Insurers identify the individual clinicians “underneath” those ACOs, consistent with their own total cost of care contracts.

<table>
<thead>
<tr>
<th>ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blackstone Valley Community Health Care</td>
</tr>
<tr>
<td>Coastal Medical</td>
</tr>
<tr>
<td>Integra Community Care Network</td>
</tr>
<tr>
<td>Integrated Healthcare Partners</td>
</tr>
<tr>
<td>Lifespan</td>
</tr>
<tr>
<td>Providence Community Health Centers</td>
</tr>
<tr>
<td>Prospect CharterCARE</td>
</tr>
<tr>
<td>Thundermist Health Center</td>
</tr>
<tr>
<td>Members Not Attributed to an ACO</td>
</tr>
</tbody>
</table>
Connecticut developed a list of provider entities based on feedback from carriers regarding their total cost of care contracts with “Advanced Networks” – providers with value-based payment contracts – and other known large provider entities in the state.

- For purposes of its baseline analysis only, the state then narrowed the list of those large provider entities to 11 that had significant overlap in total cost of care contracts across the carriers.
- Connecticut plans to expand the number of assessed provider entities when it reports first year (2021) performance.
The PPC supported the creation and use of a statewide provider directory to attribute clinicians to large provider entities, if feasible. DHHS has agreed to evaluate the feasibility of this option. The fallback option would be to rely on payers for this information.

What does the Advisory Subcommittee wish to recommend with respect to attributing clinicians to large provider entities? Does the Advisory Subcommittee wish to consider attribution based on:

- A statewide provider directory?
- Contracting arrangements – either through ACO contracts or through the identification of large provider entities that could engage in a total cost of care contract?
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The Problem of Small Numbers

- Random fluctuations in service use and medical expenditures can impact per capita cost growth of entities with small populations.

- Payers and provider entities must have sufficient member/patient volume to:
  - accurately and reliably detect changes in annual per capita total medical expenditures, and
  - minimize the effect of the presence (or absence) of a few unusually complex and expensive patients on an entity’s benchmark performance.

- In determining benchmark performance, it is important to ensure that entities which are more likely to be impacted by such random variation are not unfairly assessed.
There are some strategies we can implement to reduce the chance that random variation plays a significant part in a carrier or provider entity’s performance and increase our confidence in DHHS’ performance assessment:

1. Perform statistical testing on benchmark performance data.
2. Mitigate the impact of high-cost outliers.
3. Apply risk adjustment.
4. Only report on entities with sufficient population sizes for which performance can be measured reliably.
Implementing strategies to minimize the impact of small population sizes on insurer and provider performance involves balancing multiple factors:

- Having a high degree of confidence in the accuracy and reliability of performance data
- Data completeness
- Payers’ data reporting burden
- Project staff workload to collect, validate, and analyze data
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Performing Statistical Testing on Benchmark Performance

- DHHS could develop “confidence intervals” around benchmark performance.

- A confidence interval shows the possible range of values in which we are fairly sure our true value lies.

- In practice, it allows us to make the following statement:
  - “We are 95% confident that the interval between A [lower bound] and B [upper bound] contains the true rate of cost growth for entity C.”
Determining Performance with Confidence Intervals

- Performance **cannot be determined** when the upper or lower bound intersects the benchmark (payer A).

- Benchmark has **not been achieved** when the lower bound is fully over the benchmark (payer B).

- Benchmark **has been achieved** when the upper bound is fully below the benchmark (provider org C).
Other States’ Use of Statistical Testing

- OR, CT, and RI are the first states to use confidence intervals when determining benchmark performance.
  - OR developed the methodology, which CT and RI then adopted.
  - All three states are now actively analyzing data for reporting in early 2022.

- WA recently adopted use of confidence intervals. It has yet to commence baseline reporting.

- MA’s methodology is defined in statute and lacks confidence interval use. The methodology cannot be changed without legislation.

- DE has thus far only reported at the state and market level, for which statistical testing is not critical.
The PPC recommended applying statistical testing and the use of confidence intervals to determine payer and provider entity benchmark performance.

Does the Advisory Subcommittee wish to recommend the application of statistical testing and the use of confidence intervals to determine payer and provider entity benchmark performance?
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Mitigating the Impact of High-Cost Outlier on Per Capita Spending

- High-cost outliers are member/patients with extremely high levels of annual health care spending
  - The members/patients represent real spending that we need to represent in trend calculations. They mostly present randomly in a population, and there are limits to how much of their spending can be influenced due to their complex medical condition and high intensity care needs.
  - It is not fair to judge insurer and provider performance against the benchmark when it is significantly influenced by spending on high-cost outliers.
How to Address High-Cost Outliers

- It is common practice in total cost of care contracts to *truncate* expenditures to prevent a small number of extremely costly members from significantly affecting providers’ per capita expenditures.

- Truncation involves capping individual patient annual spending at a high level. For example, that level is often between $100K and $150K for commercial population contracts.

- Truncation can be applied to benchmark performance assessment.
  - Spending above the cap can be *excluded* from benchmark performance assessment at the insurer and provider entity levels.
  - Spending above the cap can be *included* in benchmark performance assessment at the state and market levels.
RI’s Experience With High-Cost Outliers

- In RI, analyses showed that high-cost outliers significantly affected performance of provider entities.
  - For one RI ACO, including high-cost outlier spending raised the trend rate by several percentage points.

- The differential treatment of high-cost outliers in the cost growth benchmark program and in TCOC contracts led to confusion and tension around reporting of performance.

- As a result, RI is truncating high-cost outliers starting with 2020 performance data.
The PPC leaned toward supporting truncation of high-cost outliers’ spending and recommending an analysis of outliers’ spending to identify its causes and opportunities to slow spending growth, but did not come to closure.

Does the Advisory Subcommittee wish to recommend truncation of high-cost outliers’ spending when measuring insurer and provider entity benchmark performance?
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Cost growth benchmark states typically risk adjust data to account for population changes over time.

- The composition of a payer’s or provider’s population may change over the course of a year.
- Such changes will impact spending growth, e.g., a population that is sicker than a year prior is expected to have higher spending than it would have otherwise.
Risk Adjustment Models

- *Clinical risk adjustment* is used to assess conditions diagnosed and treated during the performance year to predict spending in the same year.

- Available models use claim and encounter data, such as diagnoses, procedures, and prescription drugs.
  - They do not include medical record information (e.g., clinical indicators of severity, measures of prior use, lifestyle or supplemental demographic information).

- The best risk adjustment models can explain about half of the variation on health care spending, and a little more if spending for the highest cost outliers is truncated.*

*Accuracy of Claims-Based Risk Scoring Models, Society of Actuaries, October 2016.*
Risk Adjustment Is Only Performed at the Carrier and Provider Levels

- Year-over-year trend is not risk adjusted
- Year-over-year trend is risk adjusted
Coding Completeness and Rising Risk Scores

- The health status of a full population is typically fairly stable between consecutive years because changes in the demographic and health characteristics that might affect an entire population’s risk score occur slowly.

- However, clinical risk scores can change annually without changes in the population’s underlying risk due to improved documentation of patient condition on claims.
MA’s Experience with Rising Risk Scores

- MA has observed steadily rising risk scores year after year, amounting to an 11.7% increase between 2013 and 2018.
  - Only a small portion of the increase could be explained by demographic trends or changes in disease prevalence.
  - The MA Health Policy Commission now recommends evaluating payer and provider performance based on growth in unadjusted spending.
RI’s Experience with Rising Risk Scores

- In RI, excluding the duals plans, payer risk scores grew 4.6% from 2018 to 2019.
  - Rising risk scores had the effect of essentially raising the cost growth target value by 3.2%, doubling to 6.4% the trend that would meet the cost growth target with an average rising risk score.
  - Consequently, RI decided to only risk-adjust data by age and sex starting with the 2020 performance year.
    - WA has since decided to do the same.
“During 2013–16 HCC-based risk scores grew faster than CAHPS-based risk scores (2.1 percent versus 0.3 percent annually)…The average gap in risk score growth appears to be the result primarily of HCC coding practices..., suggesting that coding...may account for most of the observed risk score growth for ACO beneficiaries.”

Health Affairs, December 2021
Three Options for Addressing Changing Population Risk

1. Adjust using normalized clinical risk scores.
   - Normalization supports recognition of population changes while mitigating overall risk score increases due to coding.
   - Requires APCD analysis when performed at the health plan level.
   - Normalization does not remove the provider and plan incentive to increase coding completeness, however.

2. Adjust performance data using age/sex factors only.
   - Using clinical risk scores overcompensates for yearly changes in population health status and creates distortion due to claim coding practices.
   - Age/sex adjustment will capture the impact of an incrementally aging population, which may be the most significant change affecting population health status over the course of a year.
   - Age/sex adjustment will not capture more substantive changes in health status of a population.
3. Make no adjustment for changing population risk.

- Using clinical risk scores overcompensates for yearly changes in population health status and creates distortion due to claim coding practices, and the impact of changes in age/sex composition on an annual basis may not be substantive.
- Making no adjustment could disadvantage a plan or provider entity with a large population change over the course of a year.
The PPC has not yet had an opportunity to discuss this topic.

Which of the three options does the Advisory Subcommittee wish to recommend for risk-adjustment of benchmark performance data?

1. Adjust using normalized clinical risk scores.
2. Adjust performance data using age/sex factors only.
3. Make no adjustment for changing population risk.
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In determining “sufficient” population sizes, there are three separate but related questions to address:

1. How many enrolled lives must a payer have to report THCE?
2. How many attributed lives must a provider entity have with a payer for its TME to be reported?
3. How many lives must a payer/provider entity have in a line of business for its performance to be publicly reported?
## Population Size Thresholds Established by Other States

<table>
<thead>
<tr>
<th>State</th>
<th>Payers Required to Report</th>
<th>Thresholds for Public Reporting Provider Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>DE and RI</td>
<td>The largest insurers in the state, as determined by the state</td>
<td>By line of business, provider entities with: • At least 10,000 attributed commercial or Medicaid lives • At least 5,000 attributed Medicare lives</td>
</tr>
<tr>
<td>CT</td>
<td>The commercial and Medicare insurers representing ~85% of commercial covered lives in the state</td>
<td>TBD</td>
</tr>
<tr>
<td>MA</td>
<td>Payers with at least 3,600 attributed lives</td>
<td>No published standard for public reporting</td>
</tr>
<tr>
<td>OR</td>
<td>At least 1,000 covered lives across all lines of business</td>
<td>Across all markets, provider entities with at least 10,000 attributed lives</td>
</tr>
</tbody>
</table>
Determining What Is a “Sufficient” Population Size

- Determining “sufficient” population sizes becomes less pressing with the adoption of confidence intervals.
- OR and CT are collecting “pre-benchmark” data, which should shed light on the population sizes at which confidence intervals become so large as to make it difficult to determine benchmark performance.

For now, we recommend:

- Requiring reporting by all Medicaid MCOs and by carriers with commercial or Medicare Advantage market share at 5% or higher.
- Deferring on provider entity thresholds until OR and CT have completed their pre-benchmark analyses.
The PPC has not yet had an opportunity to discuss this topic.

Does the Advisory Subcommittee support the following draft recommendations?

- Require reporting by all Medicaid managed care organizations and by commercial and Medicare Advantage carriers with market share of 5% or higher.
- Defer a recommendation on provider entity population thresholds until OR and CT have completed their pre-benchmark analyses.
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Reminder: The Logic Model For a Cost Growth Benchmark

- **Implement**: Implement strategies to slow cost growth
- **Measure**: Measure performance relative to the cost growth benchmark
- **Analyze**: Analyze spending to understand cost trends and cost growth drivers
- **Report**: Publish performance against the benchmark and analysis of cost growth drivers

**Cost Growth Benchmark**

- **Identify**: Identify opportunities and strategies to slow cost growth
### Timeline for Benchmark Analysis

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<thead>
<tr>
<th>Deadline</th>
<th>Key Deliverable</th>
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<tbody>
<tr>
<td>6/30/2022</td>
<td>Issue formal baseline data request to insurers</td>
</tr>
<tr>
<td>6/30/2022</td>
<td>Distribute benchmark implementation manual and hold trainings with payers</td>
</tr>
<tr>
<td>8/31/2022</td>
<td>Receive aggregate baseline benchmark data from payers</td>
</tr>
<tr>
<td>10/1/2022</td>
<td>Validate, analyze, and review baseline benchmark findings with PPC and stakeholders</td>
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<tr>
<td></td>
<td>Complete Medicaid and PEBP updated analyses for 2021 data</td>
</tr>
</tbody>
</table>

**Measure**

Measure performance relative to the cost growth benchmark

**Report**

Publish performance against the benchmark and analysis of cost growth drivers
Timeline for Cost Driver Analysis

**Analyze**
Analyze spending to understand cost trends and cost growth drivers

**Report**
Publish performance against the benchmark and analysis of cost growth drivers

<table>
<thead>
<tr>
<th>Deadline</th>
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<tbody>
<tr>
<td>3/31/2022</td>
<td>Medicaid and PEBP to complete Phase 1 of cost driver analysis</td>
</tr>
<tr>
<td>4/30/2022</td>
<td>Review findings of Phase 1 cost driver analyses with the PPC</td>
</tr>
<tr>
<td>5/31/2022</td>
<td>Share findings of Phase 1 cost driver analyses with Advisory Subcommittee and other public stakeholders</td>
</tr>
<tr>
<td>7/1/2022</td>
<td>Begin Phase 2 cost driver analysis and update Phase 1 analysis with 2021 data</td>
</tr>
</tbody>
</table>
## Timeline for Policy Initiatives

<table>
<thead>
<tr>
<th>Deadline</th>
<th>Key Deliverable</th>
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</thead>
<tbody>
<tr>
<td>1/1/2022</td>
<td>Effective date of cost growth benchmark implementation</td>
</tr>
<tr>
<td>5/31/2022</td>
<td>PPC to make a decision on what three bills to draft for the 2023 legislative session</td>
</tr>
<tr>
<td>7/31/2022</td>
<td>Vote on and submit three bill drafts for 2023 legislative session</td>
</tr>
<tr>
<td>10/31/2022</td>
<td>Discuss pre-filing requirements for three bill drafts</td>
</tr>
</tbody>
</table>

**Identify**
Identify opportunities and strategies to slow cost growth

**Implement**
Implement strategies to slow cost growth
The Patient Protection Commission will next meet on **February 16th** at 9:00am.

<table>
<thead>
<tr>
<th>PPC Meeting Date</th>
<th>Primary Topics of Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 16th</td>
<td>Authority for and governance of benchmarks; transparency and accountability; data use strategy</td>
</tr>
<tr>
<td>March 16th</td>
<td>Three bill drafts to prioritize and request for 2023 legislative session; process for identification and prioritization of cost growth mitigation strategies</td>
</tr>
<tr>
<td>April 20th</td>
<td>Review findings of Medicaid &amp; PEBP Phase 1 cost driver analyses</td>
</tr>
<tr>
<td>May 18th</td>
<td>Cost growth mitigation strategies to ensure the benchmark strategy is successful; review three bill drafts to request for 2023 legislative session</td>
</tr>
<tr>
<td>June 15th</td>
<td>Discuss vote of bill draft</td>
</tr>
<tr>
<td>October 19th</td>
<td>Discuss pre-filing requirements</td>
</tr>
</tbody>
</table>
The Advisory Subcommittee’s next meeting date is not yet determined.

Moving forward, the Advisory Subcommittee will be asked to provide feedback and recommendations on topics prior to PPC consideration so that feedback can be shared with the PPC as the topic is introduced.