Cost Growth Benchmark Performance Assessment

Nevada Patient Protection Commission

January 19, 2022

bailit health

Agenda

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

Agenda

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

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.

Governor Sisolak's Executive Order (1 of 3)

- 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:

Year	Median Wage Weight	Gross State Product Weight	Benchmark Value
2022	20%	80%	3.19%
2023	35%	65%	2.98%
2024	50%	50%	2.78%
2025	65%	35%	2.58%
2026	80%	20%	2.37%

Section 2: The Target applies across all Nevada health care markets and populations.

Governor Sisolak's Executive Order (2 of 3)

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.

Governor Sisolak's Executive Order (3 of 3)

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.

Agenda

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

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

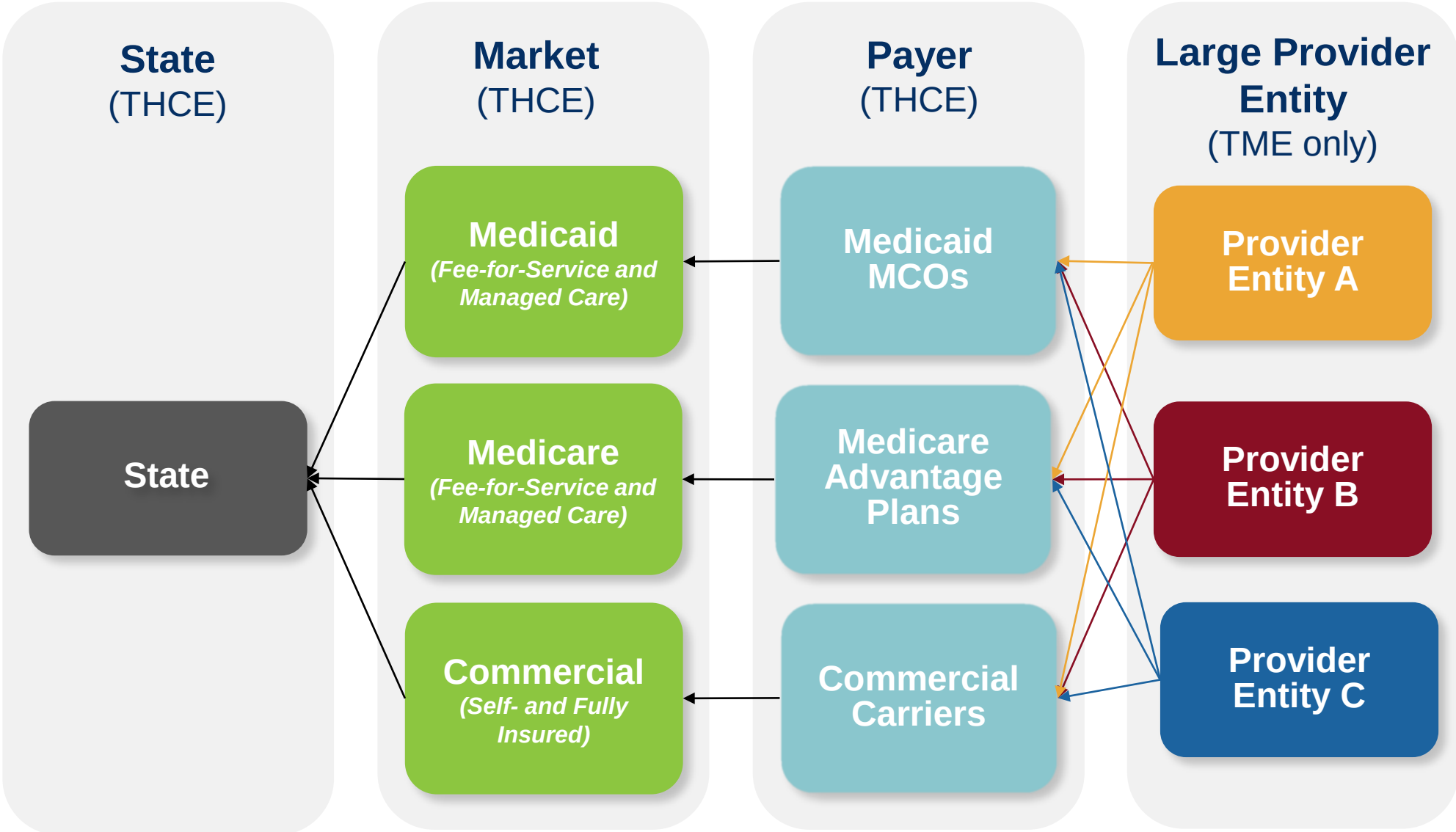
- **What is this?** A calculation of health care cost growth over a given time period using payer-collected aggregate data
- **Data Type:** Aggregate data that allow assessment at multiple levels, e.g., state region, insurer, large provider entity
- **Data Source:** Insurers and public payers
- **State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

How will we determine the drivers of overall cost and cost growth? Where are there opportunities to contain spending?

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.

States Typically Report Benchmark Performance at Four Levels

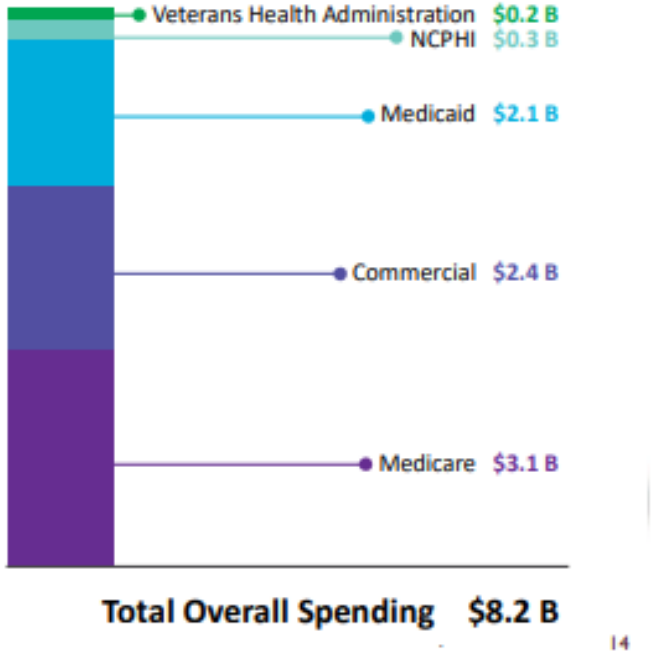


Reporting at the State Level: DE Example

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)

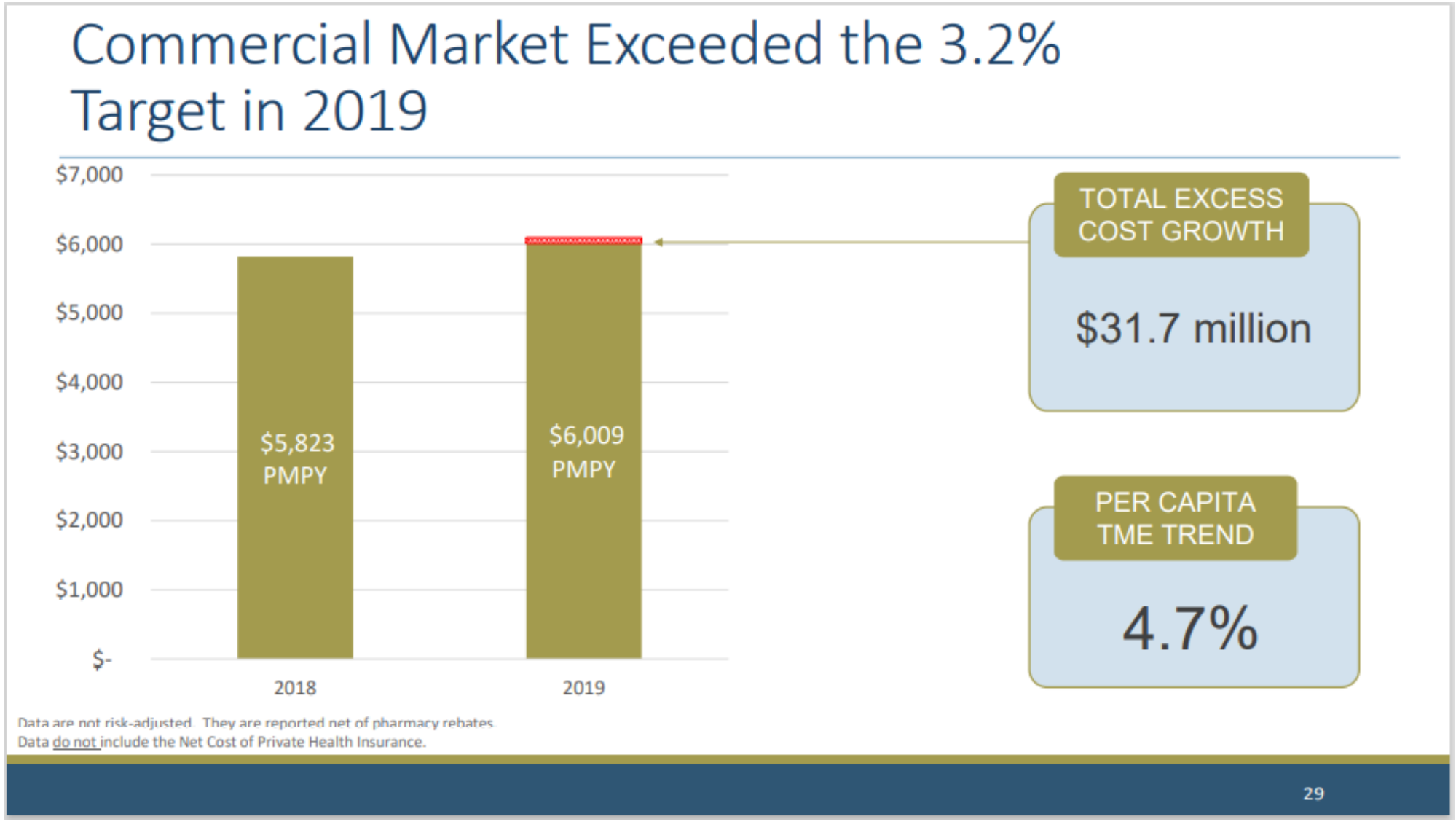


OVERVIEW OF BENCHMARK TREND REPORT: CY 2019 RESULTS 14

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

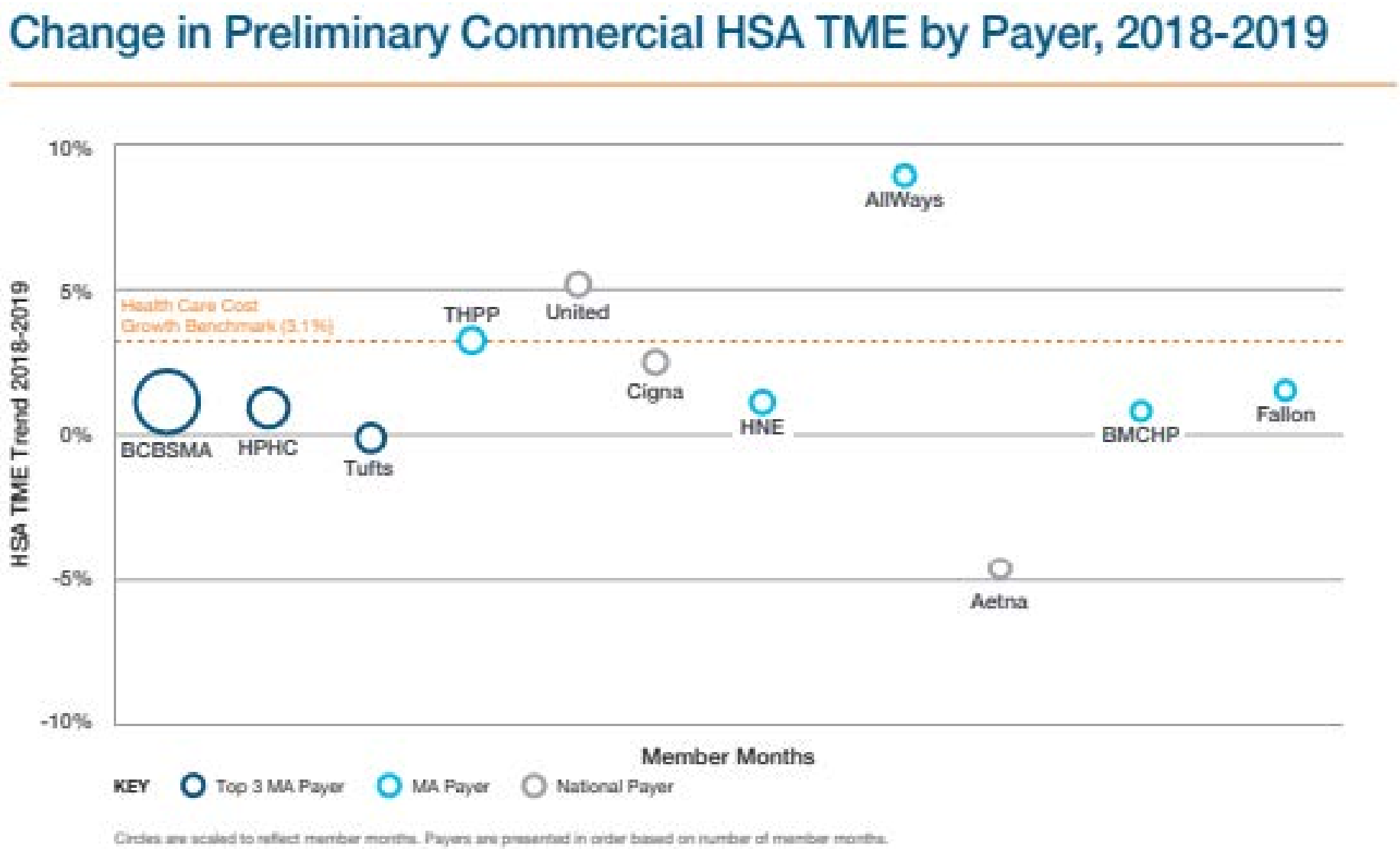
SOURCE: Overview of Benchmark Trend Report Calendar Year 2019 Results and Proposed Quality Measures, April 1, 2021, available at: https://dhss.delaware.gov/dhcc/files/benchmarkpresentation033021.pdf.

Reporting at the Market Level: RI Example (Commercial)



SOURCE: April 29, 2021 presentation to the Rhode Island Cost Trends Steering Committee.

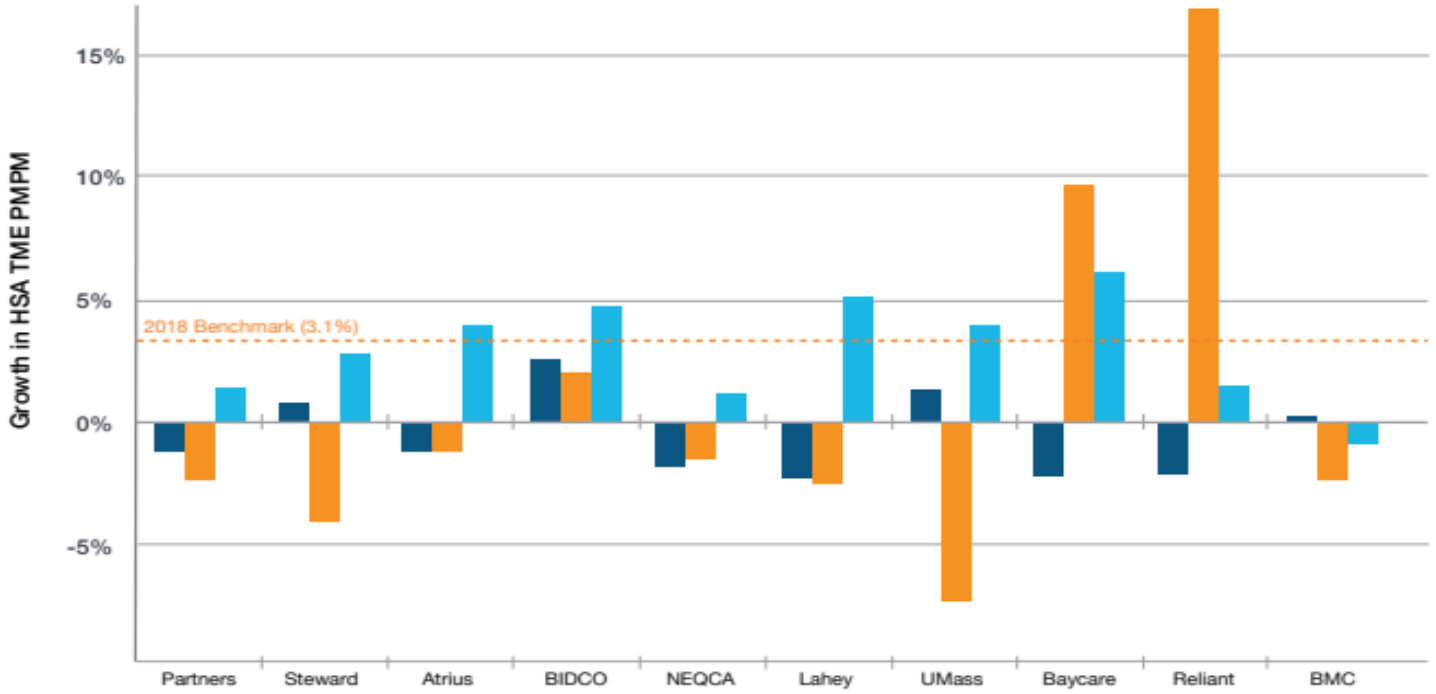
Reporting at the Payer Level: MA Example (Commercial)



SOURCE: Massachusetts Center for Health Information and Analysis, “Annual Report on the Performance of the Massachusetts Health Care System,” March 2021.

Reporting at the Provider Level: MA Example

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



	Partners	Steward	Atrius	BIDCO	NEQCA	Lahey	UMass	Baycare	Reliant	BMC
BCBSMA, HPHC, and Tufts Share of Group's Managed Member Months	94.7%	81.0%	89.8%	72.9%	96.9%	89.7%	79.9%	47.3%	61.6%	66.3%
Total Managed Member Months in 2018	3.1M	2.3M	2.2M	1.6M	1.3M	1.2M	1.0M	0.8M	0.7M	0.5M

Key ■ BCBSMA ■ HPHC ■ Tufts

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

SOURCE: Massachusetts Center for Health Information and Analysis, "Annual Report on the Performance of the Massachusetts Health Care System," March 2021.

A Note on Reporting at the Provider Level

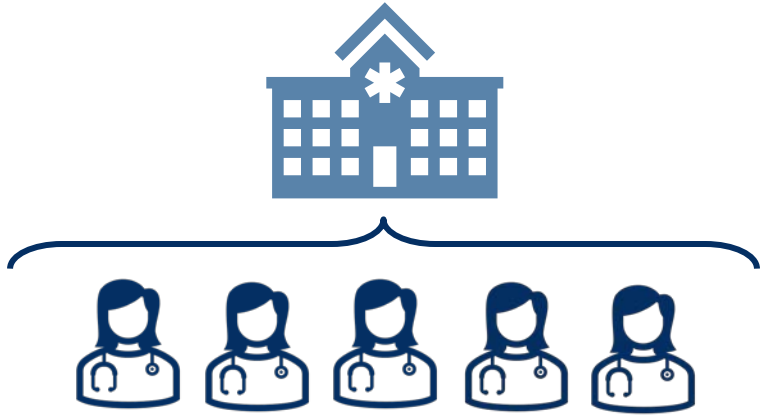
- Benchmark performance reporting at the provider level is limited to those providers that:
  - Are sufficiently large such that performance against the benchmark can be accurately and reliably measured.
  - Have responsibility for meeting all a patient's needs (i.e., medical groups, health systems and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

Agenda

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

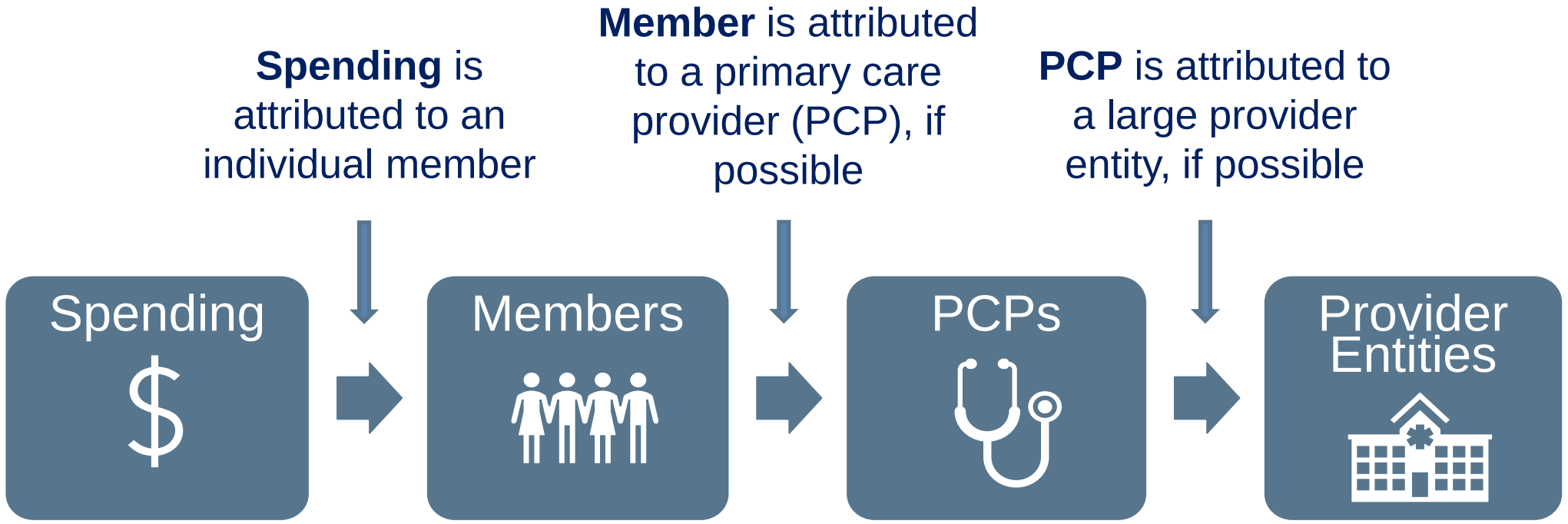
Key Attribution Questions to Address for Provider-Level Reporting

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?

Resident and Provider Attribution for Benchmark Performance Reporting



- 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 to be attributed to a clinician.
- 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.

Attribution in the Context of Reporting on the Cost Growth Benchmark

- 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

Method	Pros	Cons
Members are attributed using a **common methodology,** where insurers work together to agree upon the methodology and apply it to this process.	Supports potential comparisons of performance across insurers	Adds a layer of complexity to the process
Members are attributed using each **insurer's own methodology** employed with its value-based payment contracts or for other purposes	Makes reporting easier for insurers	Variation in methodology would produce inconsistent results and is not ideal for supporting provider comparisons across insurers

Member Attribution Approach in Other Cost Growth Benchmark States

- 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

Design Recommendation: Member Attribution to Clinicians

Does the PPC 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 Matches NPIs to Physician Groups

	A	B	C
1	NPI Number	OrgID	TME Physician Group
2	1033171749	10910	Acton Medical Associates
3	1043292360	10910	Acton Medical Associates
4	1053302158	10910	Acton Medical Associates
5	1184690505	10910	Acton Medical Associates
6	1447365408	10910	Acton Medical Associates
7	1538170774	10910	Acton Medical Associates
8	1588861660	10910	Acton Medical Associates
9	1922205020	10910	Acton Medical Associates
10	1124019765	10995	Affiliated Pediatric Practices (APP)
11	1164412839	10995	Affiliated Pediatric Practices (APP)
12	1245221019	10995	Affiliated Pediatric Practices (APP)
13	1356332985	10995	Affiliated Pediatric Practices (APP)
14	1396736161	10995	Affiliated Pediatric Practices (APP)
15	1497748834	10995	Affiliated Pediatric Practices (APP)
16	1528059128	10995	Affiliated Pediatric Practices (APP)
17	1568664795	10995	Affiliated Pediatric Practices (APP)
18	1578554713	10995	Affiliated Pediatric Practices (APP)
19	1679835011	10995	Affiliated Pediatric Practices (APP)
20	1881685485	10995	Affiliated Pediatric Practices (APP)
21	1891909305	10995	Affiliated Pediatric Practices (APP)
22	1922061878	10995	Affiliated Pediatric Practices (APP)
23	1215305040	11764	Allied Pediatrics of Greater Brockton, Inc.
24	1780849943	11764	Allied Pediatrics of Greater Brockton, Inc.
25	1942301239	11764	Allied Pediatrics of Greater Brockton, Inc.
26	1003044272	9995	Atrius Health
27	1003939703	9995	Atrius Health
28	1013975457	9995	Atrius Health
29	1023074366	9995	Atrius Health

- 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 directors – 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 Asks Payers to Report by TINs

- 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.

PRV01	PRV02
free text	text, 9 digits including leading zero
Provider Organization Name	**Provider Organization TIN**

Rhode Island Identifies the Largest Accountable Care Organizations

ACO
Blackstone Valley Community Health Care
Coastal Medical
Integra Community Care Network
Integrated Healthcare Partners
Lifespan
Providence Community Health Centers
Prospect CharterCARE
Thundermist Health Center
Members Not Attributed to an ACO

- 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.

Connecticut Developed a List Based on Carrier Identification of TCOC Contracts

- 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.

Design Recommendation:
How to Organize Clinicians Into Large Provider Entities

What does the PPC wish to recommend with respect to attributing clinicians to large provider entities? Does the PPC 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?

Agenda

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

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:
  - for detected changes in annual per capita total medical expenditures to be accurate and reliable
  - to 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.

Strategies for Ensuring That Benchmark Performance Data Are Reliable

- 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.

Considerations for Mitigating the Impact of Small Population Sizes

- 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.

Agenda

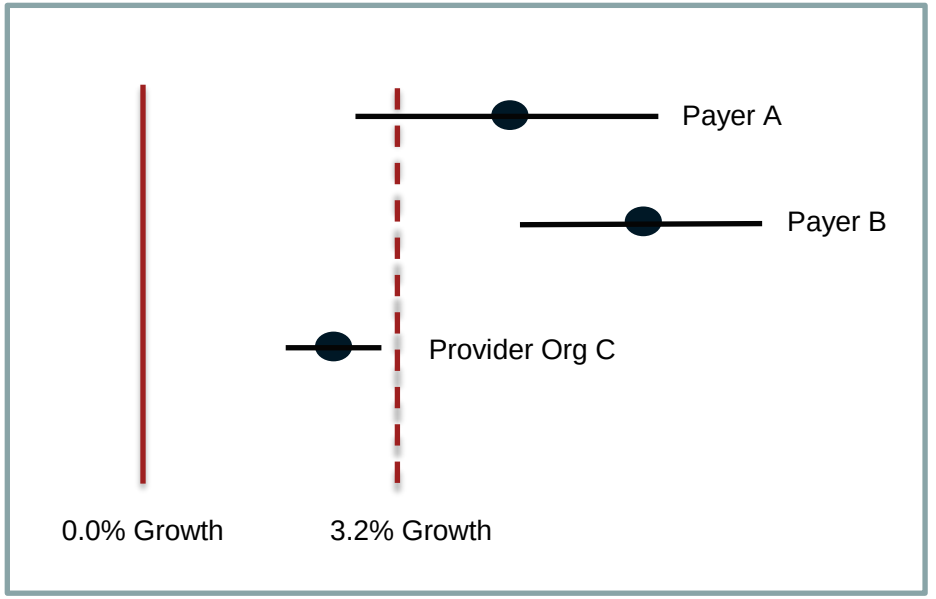
1. Benchmark Methodology and Value
2. Reporting Performance Against the Cost Growth Benchmark
3. Attributing Members to Clinicians, and Clinicians to Large Provider Entities
4. Methods to Ensure the Accuracy and Reliability of Benchmark Performance Measurement
    a. Performing Statistical Testing on 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

Performing Statistical Testing on Benchmark Performance

- Nevada 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).



Note: Figure is not to scale

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.

Design Recommendation: Use of Confidence Intervals

Does the PPC wish to recommend to application of statistical testing and the use of confidence intervals to determine payer and provider entity benchmark performance?

Agenda

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

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.

Design Recommendation: Truncation of High-Cost Outliers

Does the PPC wish to recommend truncation of high-cost outliers' spending when measuring insurer and provider entity benchmark performance?

Agenda

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

Applying Risk Adjustment

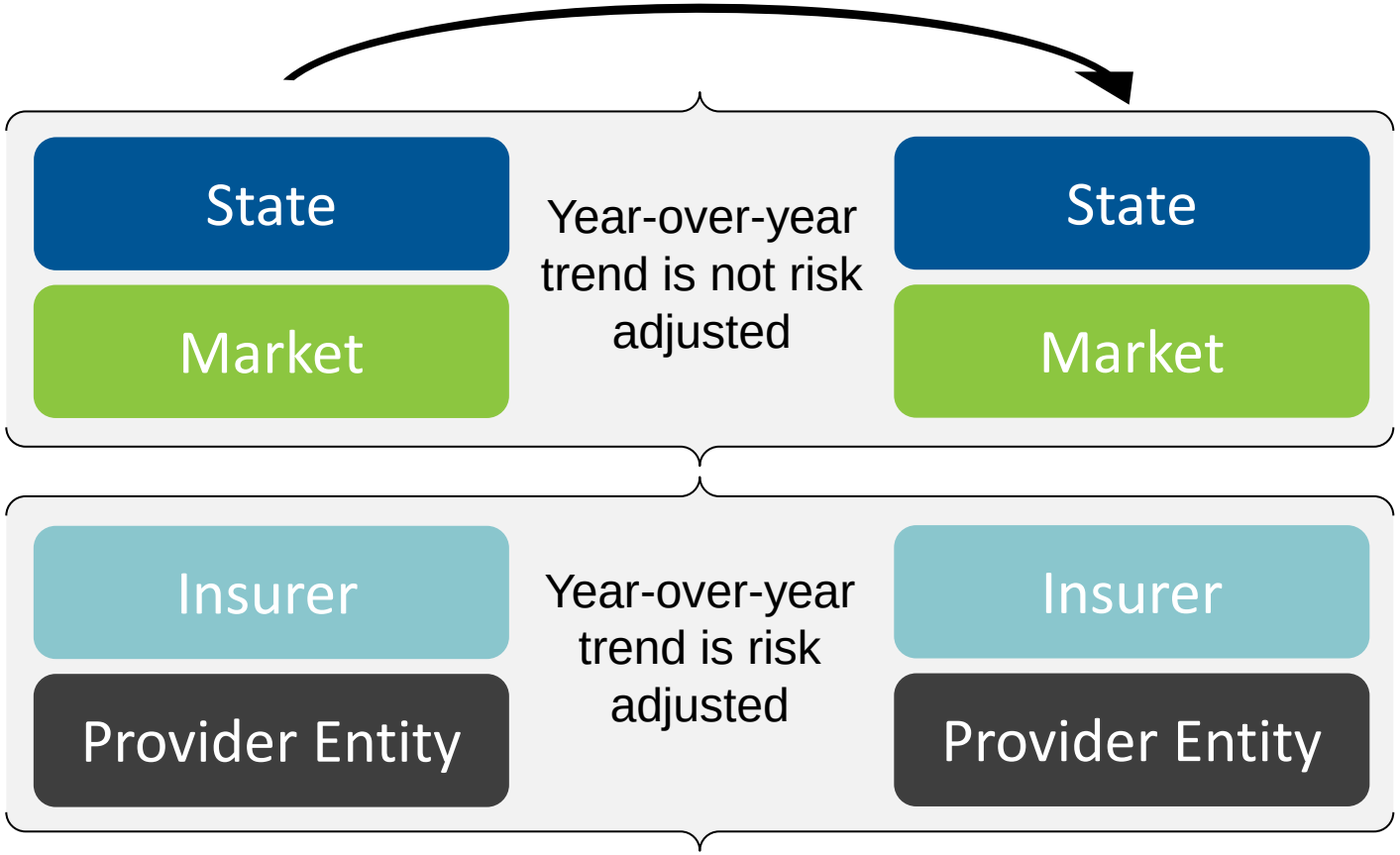
- Cost growth benchmark states typically risk adjust data to account for population changes over time.
  - The composition of a payer's or provider's population may change over the course of a year.
  - Such changes will impact spending growth, e.g., a population that is sicker than a year prior is expected 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



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.

Recent Research on Rising Risk Scores

"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*****."**

ACCOUNTABLE CARE

By Michael E. Chernew, Jessica Carichner, Jeron Impreso, J. Michael McWilliams, Thomas G. McGuire, Sartaj Alam, Bruce E. Landon, and Mary Beth Landrum

DOI: 10.1377/hlthaff.2021.00361
HEALTH AFFAIRS 40,
NO. 12 (2021): 1909–1917

Coding-Driven Changes In Measured Risk In Accountable Care Organizations

ABSTRACT **Claims data, which form the foundation of risk adjustment in payment for health care services, may reflect efforts to capture more—or more severe—clinical conditions rather than true changes in health status. This can distort payments. We quantify this in the context of Medicare's accountable care organization (ACO) program by comparing risk scores derived from two different measurement approaches. One approach uses diagnoses coded on claims based on Centers for Medicare and Medicaid Services Hierarchical Condition Categories (HCC), and the other uses self-reported, survey-based health data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). During 2013–16 HCC-based risk scores grew faster than CAHPS-based risk scores (2.1 percent versus 0.3 percent annually), and the gap in HCC- and CAHPS-based risk score growth varied widely across ACOs. The average gap in risk score growth appears to be the result primarily of HCC coding practices rather than poor performance of the CAHPS model, suggesting that coding practices (not necessarily driven by ACO contracts) may account for most of the observed risk score growth for ACO beneficiaries.**

Michael E. Chernew (Chernew @hcp.med.harvard.edu) is the Leonard D. Schaeffer Professor of Health Care Policy in the Department of Health Care Policy, Harvard Medical School, in Boston, Massachusetts.

Jessica Carichner is a research assistant in the Department of Health Care Policy, Harvard Medical School, and a master of public health student in the Department of Health Policy and Management, Harvard T. H. Chan School of Public Health, in Boston, Massachusetts.

Jeron Impreso is an advisory analyst for Medicaid at Mathematica in Washington, D.C. He was a research associate for health policy, Committee for a Responsible Federal Budget, in Washington, D.C., when this

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.

Three Options for Addressing Changing Population Risk

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.

Design Recommendation: How to Risk Adjust Data

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

Agenda

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

Reporting for “Sufficient” Population Sizes

- 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

State	Payers Required to Report	Thresholds for Public Reporting Provider Performance
DE and RI	The largest insurers in the state, as determined by the state	By line of business, provider entities with: • At least 10,000 attributed commercial or Medicaid lives • At least 5,000 attributed Medicare lives
CT	The commercial and Medicare insurers representing ~85% of commercial covered lives in the state	TBD
MA	Payers with at least 3,600 attributed lives	No published standard for public reporting
OR	At least 1,000 covered lives across all lines of business	Across all markets, provider entities with at least 10,000 attributed lives

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.

Design Recommendation: Minimum Population Sizes

Does the PPC support with the following draft recommendations?

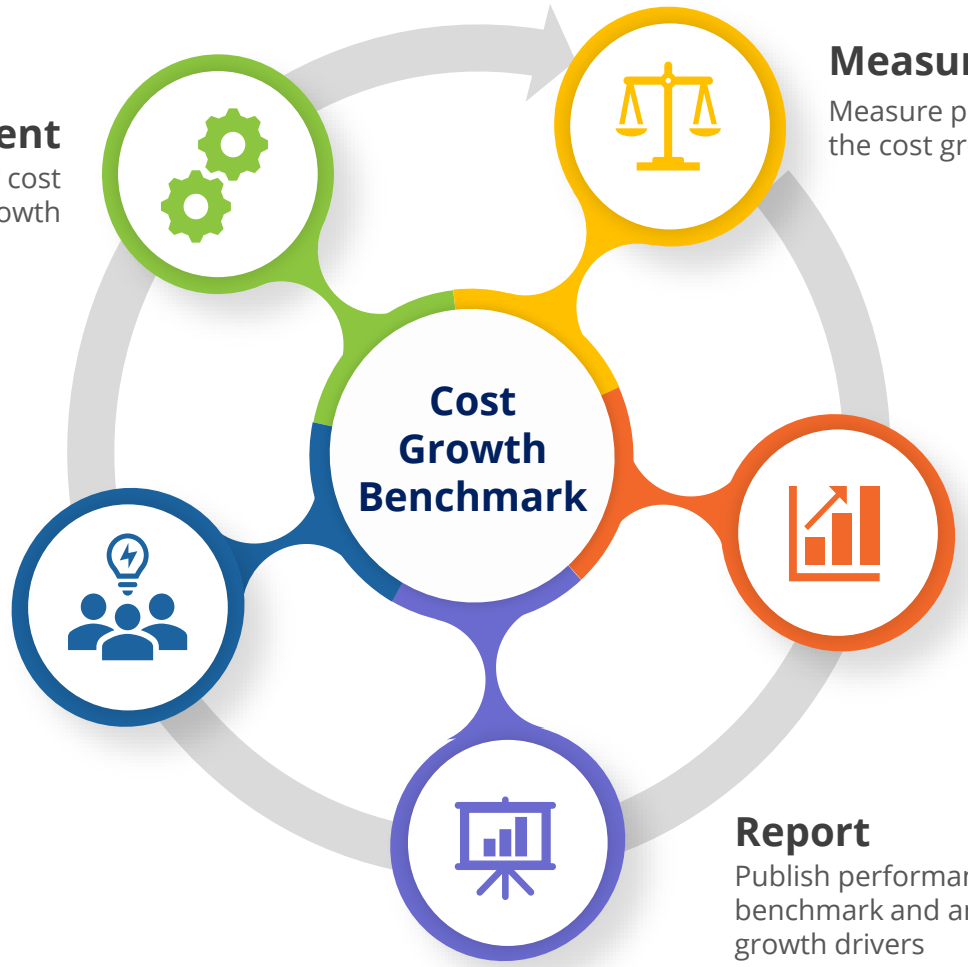
- Require reporting by all Medicaid managed care organizations and by commercial and Medicare Advantage carriers with market share of 5% or higher.
- Defer a recommendation on provider entity population thresholds until OR and CT have completed their pre-benchmark analyses.

Agenda

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

Reminder: The Logic Model For a Cost Growth Benchmark

The Logic Model for a Cost Growth Benchmark



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

Identify
Identify opportunities and strategies to slow cost growth

Implement
Implement strategies to slow cost growth

Timeline for Benchmark Analysis

Measure

Measure performance relative to the cost growth benchmark

Report

Publish performance against the benchmark and analysis of cost growth drivers

Deadline	Key Deliverable
3/24/2022	Issue formal baseline data request to insurers
3/31/2022	Distribute benchmark implementation manual and hold trainings with payers
6/1/2022	Receive aggregate baseline benchmark data from payers
10/1/2022	Validate, analyze, and review baseline benchmark findings with PPC and stakeholders Complete Medicaid and PEBP updated analyses for 2021 data

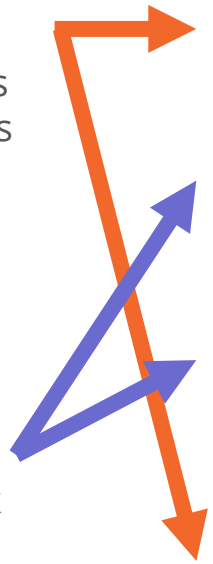
Timeline for Cost Driver Analysis

Analyze

Analyze spending to understand cost trends and cost growth drivers

Report

Publish performance against the benchmark and analysis of cost growth drivers



Deadline	Key Deliverable
3/31/2022	Medicaid and PEBP to complete Phase 1 of cost driver analysis
4/30/2022	Review findings of Phase 1 cost driver analyses with the PPC
5/31/2022	Share findings of Phase 1 cost driver analyses with Advisory Subcommittee and other public stakeholders
7/1/2022	Begin Phase 2 cost driver analysis and update Phase 1 analysis with 2021 data

Timeline for Policy Initiatives

Identify

Identify opportunities and strategies to slow cost growth

Implement

Implement strategies to slow cost growth

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

Future Meetings

- The Patient Protection Commission will next meet on **February 16th** at 9:00am.

PPC Meeting Date	Primary Topics of Discussion
February 16th	Authority for and governance of benchmarks; transparency and accountability; data use strategy
March 16th	Three bill drafts to prioritize and request for 2023 legislative session; process for identification and prioritization of cost growth mitigation strategies
April 20th	Review findings of Medicaid & PEBP Phase 1 cost driver analyses
May 18th	Cost growth mitigation strategies to ensure the benchmark strategy is successful; review three bill drafts to request for 2023 legislative session
June 15th	Discuss vote of bill draft
October 19th	Discuss pre-filing requirements