

**STATE OF CONNECTICUT**  
**State Innovation Model**  
**Equity and Access Council**  
**Design Group 1 – Cost Benchmark Calculation**  
**Design Workshop #3**  
**Meeting Summary**  
**Friday, March 6, 2015**  
**12:00 – 1:00p.m.**

**Location:** By Conference Call and WebEx

**Members Present:** Ellen Andrews; Arnold DoRosario; Keith vom Eigen; Robert Willig; Katherine Yacavone

**Other Participants:** Lisa Douglas; Mark Schaefer; Katie Sklarsky; Adam Stolz

**Agenda Items:**

1. **Introductions**
2. **Public Comment**
3. **Overview of Design Group Process**
4. **Discussion of Cost Benchmark Calculation**
5. **Synthesis of Cost Benchmark Initial Hypotheses**

**Meeting Summary:**

The meeting was called to order at 12:05p.m.

There was no public comment.

Katie Sklarsky facilitated a group discussion. Participants articulated a number of perspectives including:

**Sources for Establishing Cost Benchmarks**

- The group discussed the differences between historical benchmarks and concurrent control group benchmarks, and the advantages of each.
- Advantages of using a control group include:
  - It accounts for unpredicted changes in the population's disease prevalence (e.g. bad flu season) and in the availability of treatments (e.g. a new drug is brought to market)
  - It is aligned with the broader objective of encouraging standardization of clinical approach and associated cost profiles
- Disadvantages of using a control group include:
  - Will there be a sufficient control group in the future if shared savings contracts cover 80%+ of the state's population in a few years?
- Another concern raised was the ability to compare cost profiles for providers that have very different populations i.e. as expressed by payer mix. It was noted that each payer will write its own shared savings contracts and presumably create cost benchmarks based on its own population – so providers will have cost benchmarks specific to payer populations, which may obviate this concern.
- Aetna described a method it uses that rewards ACOs both for cost performance against a fixed benchmark and also for performance against the ACOs own historical performance (trend over time).
  - The group generally viewed a “trend” method favorably, because it rewards incremental improvement in managing a given population rather than rewarding an

ACO for differences in performance that might partially result from the nature of its population. The hypothesis is that this deters patient selection.

- The group was particularly favorably disposed toward a method that uses hybrid of performance against a fixed benchmark and trend against one's own prior performance.
- A concern about rewarding ACOs for their trend is that it may inadvertently reward those who did poorly in the past and therefore have the most opportunity to improve.
- [Note: conceptually a "trend" method could be used with either a historical benchmark or a control group benchmark. The distinguishing feature of the "trend" method appears to be that instead of rewarding ACOs for performance relative to the benchmark, it takes compares the ACO's relative performance in a given year to its relative performance in a prior year].

#### Development of Region-Specific Benchmarks

- The group discussed the idea of defining cost benchmarks specific to geographic areas in the context of using control groups to establish cost benchmarks.
- Counties provide one possible unit of organization for geography-specific benchmarks. This is what the CT State Medical Society used for an IPA that it developed.
- Is it acceptable for there to be substantial variance in average total cost of care across regions, or might that indicate a lack of health equity? One reason why total cost of care per capita might be relatively low in a given area could be lack of access to providers or to particular types of treatments. The group discussed reasons why regional variation in cost might reflect this type of equity or access issue and why it might reflect regional differences in actually providing services (e.g. cost of office space). This issue was acknowledged as highly pertinent to the EAC's charge and was tabled for consideration during the broader "Phase 2" of the EAC's work.

#### Risk Adjustment

- The group agreed that accounting for social determinants of health is an important element of risk adjustment with respect to deterring patient selection.
- There was discussion about the extent to which socioeconomic factors are inherently built into risk adjustment methodologies and to the extent that they manifest themselves in clinical conditions and cost profiles that "standard" risk adjustment methodologies rely upon.
- The group asked that we follow up with the State of Oregon to learn more about the socioeconomic factors that it is working to incorporate in risk adjustment methods.
- The issue of providers stinting on care for people who are under-adjusted (i.e. healthy patients who receive an adverse diagnosis during the course of the year, the cost of treating which is not built into that patient's cost benchmark). One solution is to risk adjust more frequently than annually, or to utilize a year-end reconciliation. The group felt this was not a substantial risk because the patients whose care is more resource-intensive than their benchmark would predict will be offset by patients whose care is less resource-intensive than predicted.

#### Supplemental Contract Features

- Supplemental payments (e.g. PMPM care management fee or payments earmarked for a given resource) are a useful way to ensure that complex patients, especially patients with socioeconomic attributes that create barriers or perceived barriers to care, are not selected against, and that their providers have resources adequate to meet their needs.
- Truncation of claims at a certain level (e.g. 99<sup>th</sup> percentile) is a way to deter under-service that might result from providers' hesitance to order a very expensive intervention. On the other hand, it was noted that truncating claims may disincentive management of inappropriate use (e.g. ED over-utilization) that we actually want to reward.

## General

- As an overall approach to this topic, the group favored issuing a set of high-level recommendations rather than detailed, prescriptive methods.
- The group's general view was that use of supplemental payments for complex patients, combined with retrospective monitoring for adverse trends related to cost benchmarking, would be more effective than trying to tailor risk adjustment methodologies to prospectively account for every social determinant of health that might characterize a population at risk of being selected against.
- Some of this design group's work overlaps with that of Design Group 4, which is exploring monitoring. Monitoring outcomes of the transition to value-based payment will yield information that bears on cost benchmarking and risk adjustment. Payers or other entities should be able to look back and observe, for example, whether certain subgroups are being under-served by ACOs, experiencing atypically frequent changes in PCP, etc. It was noted that it remains to be defined exactly what data someone might look back at for clues along these lines.

The meeting adjourned at 1:04pm.