Healthcare Cost Growth Benchmark

This file combines correspondence between the Connecticut Hospital Association (CHA) and the Office of Health Strategy (OHS) dated from July 2024 to June 2025. The page preceding the correspondence provides a brief description.

July 2024: CHA Requests Data Improvements to the Cost Growth Benchmarking Process

CHA sends correspondence to OHS, urging the agency to consider data and process improvements to the current benchmark program. Suggested areas of focus include advanced network reporting, process updates, analytic changes, and the state's cost-driver assessments.

7/19/2024

CT Cost Growth Benchmarking
Data and Process Considerations

Advanced Network Reporting (Benchmark Measurement)

Require efficient access to:

- The exact OHS criteria that it provides to payers so the payers can report to OHS Advanced Network total cost of care PMPM and trend results
- Payer-specific template results that payers provided to OHS
- Each payer must summarize differences between the OHS criteria compared to the criteria the payer used in the payer's established value-based arrangements as contracted with the Advanced Networks
- OHS must provide, for each Advanced Network, detailed data, including raw cost and utilization data (claim line), by payer that OHS analyzes and summarizes to produce the completed OHS templates with cost and trend results. OHS must also provide these data to a CHA-engaged Healthcare Economist, along with applicable payment methodologies (at the claim level)
- OHS must provide Advanced Networks with the aggregated payer cost and trend details and reports it uses (currently produced by Bailit)

Process Updates:

- Payers must submit their completed OHS templates to the Advanced Networks at least 8 weeks in advance of their submission to OHS. Advanced Networks and payers must review, reconcile, and make adjustments of necessary discrepancies and appropriate qualification of discrepancies that cannot be reconciled
- Only after the review and reconciliation process with Advanced Networks is completed, may payers submit templates to OHS
- At the same time payers submit templates to OHS, they must also submit the templates to the CHA engaged Healthcare Economist as well as the underlying detailed data, including raw utilization data
- For Advanced Networks with material and substantiated discrepancies in results between Advanced Network calculations and OHS calculations, OHS must include a clear disclaimer in its reporting indicating the Advanced Network's position on the discrepancy

Analytic Changes (to be discussed through the Steering Committee Work Group):

- To ensure OHS is capturing actual physician alignment by Advanced Network, OHS must give the Advanced Networks the instructions it plans to give payers related to provider entity aggregation. Advanced Networks must confirm the physicians aligned with the entity

- Incorporate acuity-based risk adjustment
- Incorporate adjustments for service mix
- Normalize for changes in patient demographics
- Consider impacts of material benefit modifications
- Aggregate the PMPM and trend by Advanced Network across all payer populations, including Medicare FFS, Medicare Advantage, Medicaid, and Commercial, to reflect the accurate calculation of the total population cost and cost trend results
- The final assessment of the cost growth benchmark result for each Advanced Network must be measured in aggregate across all populations

All-Payer Claims Database (Cost-Drivers Assessment)

- CHA must have access to the full, raw utilization data in the All-Payer Claims database for all payers and populations, including Medicare FFS, Medicare Advantage, Medicaid, and Commercial via an engaged Healthcare Economist – third-party consultant experienced in health economics and analytics
- The CHA engaged Healthcare Economist must conduct a comprehensive analysis of reimbursement and population-based analytics to create a profile by and across populations – by health system entity and in aggregate – normalized with accounting for appropriate adjustments for risk, acuity, service mix, site of care migration, payment methodologies, and population demographics
- OHS calculations of drivers of cost increases, which are based on its unit cost trend assessment from analysis of the All-Payer Claims Database, must be shared with CHA and any identified health systems at least four weeks prior to OHS's formal reporting or OHS's use of calculations in presentations for review and attempted reconciliation
- OHS's reporting should prominently acknowledge the limitations of the APCD, including a statement that it is incomplete and only captures the fully insured Commercial, State of CT Commercial, Medicare, and Medicaid data, and not the self-insured data, and that therefore, any calculations completed from the APCD will not fully represent the cost and trend experience of a health system entity. OHS's reporting must state the percentage and dollar value of total claims data not included in the report
- Results not reconciled should either not be reported or should be reported with a clear and appropriate disclaimer regarding the results, including a statement that the data could not be reconciled by payers and health systems

September 2024: Response from OHS to CHA

OHS responds to CHA's requests for data improvements to the healthcare cost growth benchmarking process.

September 30, 2024

Mr. Paul Kidwell
Senior Vice President, Policy
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PO Box 90
Wallingford, CT 06492-0090

Dear Paul,

Thank you for your July 24th, 2024, email providing Connecticut Hospital Association (CHA) considerations for the Office of Health Strategy's (OHS) Benchmarking Initiative. Thank you for being a part of this ongoing and important conversation. I am responding on behalf of Commissioner Gifford and the Healthcare Benchmark Initiative team.

Keeping healthcare affordable and measuring that affordability with the best available data and methods is a priority for both our organizations. OHS is committed to working with all its partners to maximize the value of the benchmark data and analysis.

There are several areas of agreement between OHS and CHA. For example, while CHA has requested the exact specifications payers use to report data to OHS, we note that OHS already publishes these specifications as a part of our continuing commitment to data integrity. We have provided links to those materials in the table below. OHS will continue to work to share Advanced Network data with CHA and explain the necessary permissions. OHS also commits to finding efficiencies in the benchmark data sharing process.

In your letter, you request numerous changes, modifications and clarifications to the data sharing and transparency process for the benchmark program. To most clearly and efficiently respond to those requests, we have outlined each request and OHS's corresponding response in the Tables below.

Table 1: CHA Requests Regarding Advanced Networks	
CHA Requests:	**OHS Response**
1a. The exact OHS criteria that it provides to payers so the payers can report to OHS Advanced Network total cost of care PMPM and trend results	The criteria (specifications) that OHS provides to payers for calculating and reporting Advanced Network total medical expense data are publicly available on OHS' webpage in Appendix A of the Cost Growth Benchmark Implementation Manual. The cost growth benchmark implementation manual is updated on an annual basis. The cost growth benchmark data submission template is also available on OHS' webpage.
1b. Payer-specific template results that payers provided to OHS	OHS does not release the original cost growth benchmark data that payers submit annually because they include (1) spending data for all Advanced Networks, which contains confidential and proprietary information (e.g., information that can be used to infer Advanced Network payment rates, which may be considered competitively sensitive information), and (2) raw, unadjusted data. See below for additional information about the process and specifications for the age/sex adjustments that OHS performs on these data. However, OHS sends each Advanced Network its own payer-level cost growth benchmark data consolidated into an Excel workbook (titled *Advanced Network First-Look at Reporting for the Cost Growth Benchmark Initiative*) prior to any public reporting. Advanced Networks which wish to share their data with CHA, with proper confidentiality and data protections, are free to do so.
1c. Each payer must summarize differences between the OHS criteria compared to the criteria the payer used in the payers' established value-based arrangements as contracted with the Advanced Networks	OHS does not have access to provider-level agreements between Advanced Networks and payors. However, since Advanced Network-level reporting began in 2022, OHS has instructed payers to respond to Advanced Networks' questions about their cost growth benchmark data. Some payers have not been sufficiently responsive. OHS will continue to communicate to each payer the importance of promptly and thoroughly responding to each Advanced Network's questions about differences between the payers' cost growth benchmark data and the contracted value-based arrangements. We encourage payers and advanced networks to communicate with each other regarding discrepancies.
1d. OHS must provide, for each Advanced Network,	OHS does not collect raw cost and utilization data from payers through the cost growth benchmark data request.

Table 1: CHA Requests Regarding Advanced Networks	
detailed data, including raw cost and utilization data (claim line), by payer that OHS analyzes and summarizes to produce the completed OHS templates with cost and trend results. OHS must also provide these data to a CHA engaged Healthcare Economist along with applicable payment methodologies (at the claim level)	OHS requires payers to submit cost growth benchmark data aggregated at the service level (e.g., aggregate hospital inpatient claims spending, aggregate hospital outpatient claims spending). OHS provides service categories and definitions in the cost growth benchmark data submission template and the cost growth benchmark implementation manual.
1e. OHS must provide Advanced Networks with the aggregated payer cost and trend details and reports it uses (currently produced by Bailit).	OHS already sends each Advanced Network its payer-level cost growth benchmark data in an annual *Advanced Network First-Look at Reporting for the Cost Growth Benchmark Initiative* (Excel workbook).

Table 2: CHA Requests Regarding Updates to the Benchmark Process	
CHA Requests:	**OHS Response**
2a. Payers must submit their completed OHS templates to the Advanced Networks at least 8 weeks in advance of their submission to OHS. Advanced Networks and payers must review, reconcile, and make adjustments of necessary discrepancies and appropriate qualification of discrepancies that cannot be reconciled.	Payers utilize 180 days of claims runout, which means they do not begin conducting analyses until June 30. They submit to OHS by mid-August, which is only 6 weeks later. Therefore, there is not ample time for 8 weeks of review. As a result, payers are unable to submit their completed OHS templates 8 weeks in advance of OHS' submission deadline. As the data submission process improves, OHS will look to provide payers more time to review the information. In addition, payers may resubmit their data to OHS multiple times after their initial submission to correct for errors identified during OHS data validation checks. If payers sent their completed templates to Advanced Networks before OHS review and validation, it would be difficult, and likely time consuming, for Advanced Networks to discern whether data discrepancies are due to contractual differences, data validity or methodology issues. OHS can send Advanced Networks their annual *Advanced Network First-Look at Reporting for the Cost Growth Benchmark Initiative* in Excel with more time for Advanced Networks to review and discuss discrepancies with payers. This is contingent on OHS receiving payer submissions and resolving data validation issues in a timely fashion. OHS can then send the First Look Excel workbooks to Advanced Networks at least eight weeks before OHS reports the results.
2b. Only after the review and reconciliation process with Advanced Networks is completed, may payers submit templates to OHS.	OHS often finds errors and/or inconsistencies in the original data submissions. It would not be efficient or helpful to have the unvalidated data shared with ANs before corrections are made. Therefore, OHS *first* validates data and *then* sends Advanced Networks their respective data. Having payers reconcile data directly with Advanced Networks would likely delay completion of OHS' analytic process. It would also compromise OHS' ability to meet its legislatively required March reporting deadline. As noted above, OHS will send the First Look Excel workbooks to Advanced Networks containing validated and adjusted data at least

Table 2: CHA Requests Regarding Updates to the Benchmark Process	
	eight weeks before OHS reports the results, contingent upon receiving submissions and resolving data validation issues in a timely fashion.
2c. At the same time payers submit templates to OHS, they must also submit the templates to the CHA engaged Healthcare Economist as well as the underlying detailed data, including raw utilization data	If CHA obtains written permission from the relevant Advanced Networks, OHS can send CHA the *Advanced Network First-Look at Reporting for the Cost Growth Benchmark Initiative* Excel workbooks for any Advanced Networks that CHA is interested in reviewing. OHS can send these reports on the same timeline as OHS sends the reports to the individual Advanced Networks. As noted above, OHS does not collect raw cost and utilization data from payers through the cost growth benchmark data request. Payers submit cost growth benchmark data to OHS aggregated at the service category level (e.g., aggregate hospital inpatient claims spending, aggregate hospital outpatient claims spending). OHS provides service categories and definitions in the cost growth benchmark data submission template and cost growth implementation manual.
2d. For Advanced Networks with material and substantiated discrepancies in results between Advanced Network calculations and OHS calculations, OHS must include a clear disclaimer in its reporting indicating the Advanced Network's position on the discrepancy.	We encourage Advanced Networks to engage in direct communication with insurers and OHS if there are significant concerns or discrepancies. Our team is always open to discussions and willing to work collaboratively to resolve any issues and ensure that the data we present is as accurate and reflective of the actual performance as possible. OHS is committed to transparency regarding valid limitations in data quality, availability or analysis and will continue to work with stakeholders to clarify those limitations. However, Introducing potentially subjective disclaimers could lead to confusion and undermine the standardization and objectivity of our reports.

Table 3: Analytic Changes	
CHA Requests:	**OHS Response**
3a. To ensure OHS is capturing actual physician alignment by Advanced Network, OHS must give the Advanced Networks the instructions it plans to give payers related to provider entity aggregation. Advanced Networks must confirm the physicians aligned with the entity.	The instructions that OHS gives to payers related to provider entity aggregation are publicly available on OHS' webpage in the cost growth benchmark implementation manual (see page A-41 of the implementation manual for details on attribution). OHS is committed to continually improving the benchmark data quality. For the first time this year, OHS requested Tax Identification Numbers (TINs) from Advanced Networks to provide to the payers for the purposes of attribution in cost growth benchmark data. Most, but not all, Advanced Networks submitted TINs in response to this request. Furthermore, OHS will also be newly collecting member months and spending in attribution hierarchy tiers so that OHS and Advanced Networks are aware of how many members were attributed by payers based on member selection, contractual arrangement, and utilization, respectively.
3b. Incorporate acuity-based risk adjustment	CHA's request is unclear which analytic process to which this refers. Specific to the benchmark program reporting on Total Healthcare Expenditures and Total Medical Expenditures, OHS uses age/sex risk adjustment rather than clinical risk adjustment because the health status of a population is typically stable between consecutive years. In contrast, clinical risk scores can change annually without changes in the population's underlying risk due to improved documentation of patient condition on claims.[1] Rhode Island, Washington, Oregon, New Jersey, and California are also using age/sex risk adjustment in their cost growth benchmark programs rather than clinical risk adjustment.
3c. Incorporate adjustments for service mix	CHA's request is unclear which analytic process to which this refers. With respect to the year-over-year trends in Total Healthcare Expenditure and Total Medical Expenditures, the data received by OHS to calculate these trends does not include sufficient claim-level detail to study changes in service mix.

[1] See Appendix 1.

Table 3: Analytic Changes	
	As described above, OHS currently accounts for annual changes in *population health status* through age/sex adjustment at the payer and AN levels. Adjusting for changes in service mix in the THCE and TME reports has the potential to obscure trends in utilization that are significant drivers of cost and may or may not be associated with improved outcomes. It is more appropriate to examine changes in service mix as a part of the secondary, APCD-derived analyses OHS conducts to better understand the drivers of healthcare spending. In addition, we note that none of the seven other cost growth benchmark states make an adjustment for service mix in their Cost Growth trend analyses, and there is no generally accepted methodology for service mix adjustment.
3d. Normalize for changes in patient demographics	In the THCE and TME reports, OHS normalizes for changes in patient demographics through its age/sex risk adjustment methodology. OHS's age/sex adjustment methodology is available in Appendix L of the Implementation Manual. OHS makes adjustments to TME at the payer and AN level. OHS reports unadjusted TME at the market and state level.
3e. Consider impacts of material benefit modifications	Most benefit design changes involve increases to member cost sharing obligation to counter rising costs. OHS currently measures changes in allowed spending, which includes both the paid amount and the member obligation. None of the seven other cost growth benchmark states make such an adjustment. We encourage stakeholders to look at underlying cost drivers. The benchmark initiative goal is to measure and, to the extent possible, identify some of these drivers. It may not be feasible to define and measure a material benefit modification that substantially increases TME, but OHS is always willing to work with stakeholders to examine potential underlying cost-drivers.
3f. Aggregate the pmpm and trend by Advanced Network across all payer populations including Medicare FFS,	OHS measures performance separately for the commercial, Medicare Advantage and Medicaid markets to understand and ensure that health care spending is growing at a sustainable rate

Table 3: Analytic Changes	
Medicare Advantage, Medicaid, and Commercial to reflect the accurate calculation of the total population cost and cost trend results	in each market. This is consistent with the approach taken in all seven of the other states with cost growth benchmark programs.
3g. The final assessment of the cost growth benchmark result for each Advanced Network must be measured in aggregate across all populations.	See above

Table 4: All Payer Claims Database (Cost-Drivers Assessment)	
CHA Requests:	**OHS Response**
4a. CHA must have access to the full, raw utilization data in the All Payer Claims database for all payers and populations including Medicare FFS, Medicare Advantage, Medicaid, and Commercial via an engaged Healthcare Economist - third party consultant experienced in health economics and analytics.	Through a standardized, privacy-compliant request process, CHA has access to commercial APCD data. CHA's health economist may perform analyses on this data in any ways that are compliant with the data use agreement, and we encourage CHA's engagement in the process. To further enhance data access, OHS proposed an expedited process in the 2024 legislative session which did not receive legislative approval. Access to Medicare and Medicaid data should be requested separately from CMS and DSS respectively due to the terms of the data use agreements that OHS holds with DSS and CMS, both of which authorize data use by state agencies only.
4b. The CHA engaged Healthcare Economist must conduct a comprehensive analysis of reimbursement and population-based analytics to create a profile by and across populations – by health system entity and in aggregate – normalized with accounting for appropriate adjustments for risk, acuity, service mix, site of care migration, payment methodologies and population demographics.	CHA may engage a healthcare economist to undertake any analysis of its choosing.
4c. OHS calculations of drivers of cost increases, which are based on its unit cost trend assessment from analysis of the All Payer Claims Database must be shared with CHA and any identified health systems at least four weeks prior to OHS's formal reporting or OHS's use of is calculations in presentations for review and attempted reconciliation.	OHS has not publicly identified any health system or hospital in its reports on cost-drivers. OHS' analytic methodologies are generally described at the Healthcare Benchmark Initiative Steering Committee meeting and are available to health systems in the post-meeting materials. OHS is on schedule to make APCD cost driver analysis dashboards and associated technical notes, available on the OHS website. OHS's hosts a Data Analytics workgroup and receives input and feedback from stakeholders as to analytic methods. We will continue to engage in these conversations to

Table 4: All Payer Claims Database (Cost-Drivers Assessment)	
	ensure that our analyses and methods are appropriate and valid to the questions under consideration.
4d. OHS's reporting should prominently acknowledge the limitations of the APCD including a statement that it is incomplete and only captures the fully insured Commercial, State of CT Commercial, Medicare and Medicaid data, and not the self-insured data and that therefore, any calculations completed from the APCD will not fully represent the cost and trend experience of a health system entity. OHS's reporting must state the percentage and dollar value of total claims data not included in the report.	OHS agrees that disclosures of analytic limitation are important to the validity of the benchmarking program. OHS routinely discloses that the APCD does not contain the entirety of the commercial market when it presents APCD-based findings. While data on the self-insured is incomplete, the data that the APCD contains are representative of the commercial market population (see slides 19-26 of the February 7th 2024 Data Analytic Workgroup presentation). Per the 2015 Supreme Court *Gobeille* decision, self-insured employers are not required to submit claims data to state APCDs. Therefore, we are unable to include the full self-insured claims data in the APCD. However, research shows no evidence that self-insured plans differ systematically from fully insured plans in terms of benefit design or price[2] and may even pay higher prices for services.[3,4] In addition, OHS analysis has documented similar patterns of hospital service use between the commercial population in the APCD and the full commercial market population.

The Healthcare Benchmark Initiative team, and Office of Health Strategy leadership appreciate your continued partnership and collaboration. Thank you for your time and attention to the Benchmark data and analysis. Please contact me if I may provide additional information or respond to any questions.

Sincerely,

[2] Rand Health Quarterly. June 2011. Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA). Accessed on August 8, 2024 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4945181/#:~:text=Overall%2C%20we%20find%20little%20evidence,exemptions%20for%20self%2Dinsured%20plans

[3] Aditi P. Sen, Jessica Y. Chang, and John Hargraves. September 2023. Health Care Service Price Comparison Suggests That Employers Lack Leverage To Negotiate Lower Prices. Health Affairs Vol. 42, No. 9. Accessed on August 5, 2024 at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2023.00257

[4] Health Care Cost Institute. April 2024. *2022 Health Care Cost and Utilization Report. Accessed on August 14, 2024 from https://healthcostinstitute.org/images/pdfs/HCCI_2022_Health_Care_Cost_and_Utilization_Report.pdf*

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Healthcare Benchmark Initiative Program Director

Appendix 1: Risk Assessment Research

In general, OHS finds evidence that clinical risk scores are not well aligned with changes in risk as assessed by other sources and methodologies. In Massachusetts, the state with the most advanced benchmarking program, the Health Policy Commission's (HPC) 2019 Annual Health Care Cost Trends Report notes "a steady rise in patient risk scores over time, amounting to an 11.7 percent increase between 2013 and 2018…The HPC has found that only a small portion of this increase can be explained by demographic trends such as the age/sex mix of the population or changes in disease prevalence" (p. 18). The HPC concludes that "It is implausible that the health of the Massachusetts population has truly worsened to this extent," equivalent to 20% of the commercially insured population developing cerebral palsy. In 2022, the Massachusetts Attorney General's Office reviewed the impact of clinical risk scores on the allocation of resources. It found that payers with lower CMS risk scores (i.e., better health based on clinical coding) have worse self-reported health, lower rates of preventive care, and more barriers to accessing health. Notably, it found that there were large differences between the CMS risk scores as compared to their self-reported health burden score, showing almost an inverse correlation between the two (see slide 9).

Additionally, a relatively recent study (Chernew et al. 2021) published in *Health Affairs* found that measured risk in Medicare's Accountable Care Organization (ACO) programs varied dramatically between self-reported, survey-based health data (0.3% annual increase) and diagnosis-based clinical risk assessment (2.1% annual increase). Other research indicating similar misalignments between clinical risk scores and changes in risk include:

- Carter GM, Newhouse JP and Relles DA. "How much change in the Case Mix Index is DRG creep?" *Journal of Health Economics* 1990.
- Coustasse A. "Upcoding Medicare: Is Healthcare Fraud and Abuse Increasing?" *Perspectives in Health Information Management* Fall 2021.
- Chernew M et al. "Coding-Driven Changes in Measuring Risk in Accountable Care Organizations" *Health Affairs* December 2021.
- Geruso M and Layton T. "Upcoding: Evidence from Medicare on Squishy Risk Adjustment" *Journal of Political Economy* March 2020.
- Kronick R. "Projected Coding Intensity In Medicare Advantage Could Increase Medicare Spending By $200 Billion Over Ten Years" *Health Affairs* February 2017.
- Massachusetts Health Policy Commission. "2019 Cost Annual Health Care Cost Trends Report" February 2020.
- Post B et al. "Hospital-physician integration and risk-coding intensity" *Health Economics* April 2022.
- Preyra C. "Coding Response to a Case-Mix Measurement System Based on Multiple Diagnoses" *Health Services Research* June 2004.
- U.S. Department of Health and Human Services Office of Inspector General "Trend Toward More Expensive Inpatient Hospital Stays in Medicare Emerged Before COVID-19 and Warrants Further Scrutiny" February 2021

December 2024: CHA Response to OHS

CHA provides a follow-up response to OHS.

Table 1: CHA Requests Regarding Advanced Networks		
CHA Requests	OHS Response	CHA Response
1a. The exact OHS criteria that it provides to payers so the payers can report to OHS Advanced Network total cost of care PMPM and trend results	The criteria (specifications) that OHS provides to payers for calculating and reporting Advanced Network total medical expense data are publicly available on OHS' webpage in Appendix A of the Cost Growth Benchmark Implementation Manual. The cost growth benchmark implementation manual is updated on an annual basis. The cost growth benchmark data submission template is also available on OHS' webpage.	It was clear during the attribution workgroup meetings, that payers were following their own interpretations of the criteria and specifications and that those interpretations varied (sometimes significantly) from payer to payer. We would be interested in a solution that supports the standardization of criteria specifications and their application.
1b. Payer-specific template results that payers provided to OHS	OHS does not release the original cost growth benchmark data that payers submit annually because they include (1) spending data for all Advanced Networks, which contains confidential and proprietary information (e.g., information that can be used to infer Advanced Network payment rates, which may be considered competitively sensitive information), and (2) raw, unadjusted data However, OHS sends each Advanced Network its own payer-level cost growth benchmark data consolidated into an Excel workbook (titled *Advanced Network First-Look at Reporting for the Cost Growth Benchmark Initiative*) prior to any public reporting. Advanced Networks which wish to share their data with CHA, with proper confidentiality and data protections, are free to do so.	While the decision to withhold the totality of original cost growth benchmark data due to confidentiality concerns is understandable, we are interested in each Advanced Network receiving exactly what OHS receives from the payers on that individual Advanced Network's performance. Providing Advanced Networks with access to the original data would allow Advanced Networks to better understand factors contributing to their measured performance and identify best practices and areas for improvement. The consolidated benchmark data does not provide enough granular detail to truly determine what may be driving aberrant results. And as previously stated, the consolidated benchmark data has shown significant differences from payer Joint Operating Committee materials which still has not been sufficiently explained. Is it possible that the data be blinded somehow?
1c. Each payer must summarize differences between the OHS	OHS does not have access to provider-level agreements between	Though OHS does not have access to provider level agreements, this

criteria compared to the criteria the payer used in the payers' established value-based arrangements as contracted with the Advanced Networks	Advanced Networks and payers. However, since Advanced Network-level reporting began in 2022, OHS has instructed payers to respond to Advanced Networks' questions about their cost growth benchmark data. Some payers have not been sufficiently responsive.	should not preclude a more proactive approach to ensuring OHS has an understanding of the difference in their data collection and the agreements reached between providers and payers. A more proactive approach would help better align the measurement of the cost growth benchmark with the reality of provider-payer agreements. We agree that the payers' responsiveness to questions about cost growth benchmark data has not improved. We believe OHS should leverage its position to advocate for increased transparency and cooperation from payers. As the CBG requires partnership from all involved parties, we would be interested in pursuing a remedy to ensure all payers are appropriately responsive.
1d. OHS must provide, for each Advanced Network, detailed data, including raw cost and utilization data (claim line), by payer that OHS analyzes and summarizes to produce the completed OHS templates with cost and trend results. OHS must also provide these data to a CHA engaged Healthcare Economist along with applicable payment methodologies (at the claim level)	OHS does not collect raw cost and utilization data from payers through the cost growth benchmark data request. OHS requires payers to submit cost growth benchmark data aggregated at the service level (e.g., aggregate hospital inpatient claims spending, aggregate hospital outpatient claims spending). OHS provides service categories and definitions in the cost growth benchmark data submission template and the cost growth benchmark implementation manual.	Aggregated data collection can limit the utility of information for Advanced Networks. Without the level of granularity that comes with raw utilization data collection, stakeholders lack a comprehensive understanding of cost drivers and utilization trends. More specifically, stakeholders cannot fully identify how to remediate aberrant trends or determine what might be actionable (i.e. trends driven by utilization changes) versus what is not actionable (trends driven by cost). If the cost growth benchmark was created as a tool to examine healthcare costs, payers and the public must have a more contextualized understanding of why or why not the benchmark was met for that year.
1e. OHS must provide Advanced Networks with the aggregated payer cost and trend details and	OHS already sends each Advanced Network its payer-level cost growth benchmark data in an annual	We acknowledge that Advanced Networks receive the aggregated excel workbook but as previously

reports it uses (currently produced by Bailit).	*Advanced Network First-Look at Reporting for the Cost Growth Benchmark Initiative* (Excel workbook).	stated, aggregated service level data is insufficient to accurately calculate trends and to analyze drivers of those trends.

Table 2: CHA Requests Regarding Updates to the Benchmark Process		
CHA Request	OHS Response	CHA Response
2a. Payers must submit their completed OHS templates to the Advanced Networks at least 8 weeks in advance of their submission to OHS. Advanced Networks and payers must review, reconcile, and make adjustments of necessary discrepancies and appropriate qualification of discrepancies that cannot be reconciled.	Payers utilize 180 days of claims runout, which means they do not begin conducting analyses until June 30. They submit to OHS by mid-August, which is only 6 weeks later. Therefore, there is not ample time for 8 weeks of review. As a result, payers are unable to submit their completed OHS templates 8 weeks in advance of OHS' submission deadline. As the data submission process improves, OHS will look to provide payers more time to review the information. In addition, payers may resubmit their data to OHS multiple times after their initial submission to correct for errors identified during OHS data validation checks. If payers sent their completed templates to Advanced Networks before OHS review and validation, it would be difficult, and likely time consuming, for Advanced Networks to discern whether data discrepancies are due to contractual differences, data validity or methodology issues. OHS can send Advanced Networks their annual *Advanced Network First-Look at Reporting for the Cost Growth Benchmark Initiative* in Excel with more time for Advanced Networks to review and discuss discrepancies with payers. This is contingent on OHS receiving payer submissions and resolving data validation issues in a timely fashion. OHS can then send the	We appreciate that there is a tight turnaround between when the payers start conducting their analysis and when they have to produce their templates to OHS. We also understand that OHS needs enough time to meet their legislative obligation. Nevertheless, we urge OHS to consider some creative alternatives that would allow Advanced Networks to receive the completed OHS templates. For example, is it necessary for payers to use 180 days of claims runout? Or will 90 days suffice? Along with receiving the First Look Excel workbooks before OHS reports the results, we would be interested in learning what information OHS requests from the payers as a part of the validation process. This way the Advanced Networks could have a better understanding whether data discrepancies are related to contractual differences, data validity issues, or otherwise. The lack of ample time for Advanced Networks to address their concerns about the accuracy of the cost growth benchmark data, layered with the potential request to participate in a hearing on the results, continue to wed Advanced Networks to a broken data process.

	First Look Excel workbooks to Advanced Networks at least eight weeks before OHS reports the results.	
2b. Only after the review and reconciliation process with Advanced Networks is completed, may payers submit templates to OHS.	OHS often finds errors and/or inconsistencies in the original data submissions. It would not be efficient or helpful to have the unvalidated data shared with ANs before corrections are made. Therefore, OHS *first* validates data and *then* sends Advanced Networks their respective data. Having payers reconcile data directly with Advanced Networks would likely delay completion of OHS' analytic process. It would also compromise OHS' ability to meet its legislatively required March reporting deadline. As noted above, OHS will send the First Look Excel workbooks to Advanced Networks containing validated and adjusted data at least eight weeks before OHS reports the results, contingent upon receiving submissions and resolving data validation issues in a timely fashion.	Again, we acknowledge the challenges around the timing of the data, but the current process has not alleviated our concerns about the accuracy and validity of the cost growth benchmark data.
2c. At the same time payers submit templates to OHS, they must also submit the templates to the CHA engaged Healthcare Economist as well as the underlying detailed data, including raw utilization data	If CHA obtains written permission from the relevant Advanced Networks, OHS can send CHA the *Advanced Network First-Look at Reporting for the Cost Growth Benchmark Initiative* Excel workbooks for any Advanced Networks that CHA is interested in reviewing. OHS can send these reports on the same timeline as OHS sends the reports to the individual Advanced Networks.	CHA is interested in reviewing *Advanced Network First-Look at Reporting for the Cost Growth Benchmark Initiative* Excel workbook. However as previously stated, aggregated service level data is insufficient to accurately calculate trends and to analyze drivers of those trends.

	As noted above, OHS does not collect raw cost and utilization data from payers through the cost growth benchmark data request. Payers submit cost growth benchmark data to OHS aggregated at the service category level	
2d. For Advanced Networks with material and substantiated discrepancies in results between Advanced Network calculations and OHS calculations, OHS must include a clear disclaimer in its reporting indicating the Advanced Network's position on the discrepancy.	We encourage Advanced Networks to engage in direct communication with insurers and OHS if there are significant concerns or discrepancies. Our team is always open to discussions and willing to work collaboratively to resolve any issues and ensure that the data we present is as accurate and reflective of the actual performance as possible. OHS is committed to transparency regarding valid limitations in data quality, availability or analysis and will continue to work with stakeholders to clarify those limitations. However, Introducing potentially subjective disclaimers could lead to confusion and undermine the standardization and objectivity of our reports.	The purpose of the discrepancy disclaimer is to ensure that any unresolved issues related to data clarity or responsiveness from payers to OHS or Advanced Networks are properly addressed. If OHS were to publish data without confirming that all discrepancies have been resolved, it would undermine the standardization and objectivity of the reports, potentially affecting their accuracy, reliability, and credibility. Added to that concern is the challenge of Advanced Networks potentially being called on to participate in a hearing on data that they cannot be certain is accurate.

Table 3: CHA Requests Regarding Analytic Changes		
CHA Request	OHS Response	CHA Response
3a. To ensure OHS is capturing actual physician alignment by Advanced Network, OHS must give the Advanced Networks the instructions it plans to give payers related to provider entity aggregation. Advanced Networks must confirm the physicians aligned with the entity.	The instructions that OHS gives to payers related to provider entity aggregation are publicly available on OHS' webpage in the cost growth benchmark implementation manual (see page A-41 of the implementation manual for details on attribution). OHS is committed to continually improving the benchmark data quality. For the first time this year, OHS requested Tax Identification Numbers (TINs) from Advanced Networks to provide to the payers for the purposes of attribution in cost growth benchmark data. Most, but not all, Advanced Networks submitted TINs in response to this request.	We appreciate the extra step on physician alignment from the payer perspective, and continue to urge confirmation from Advanced Networks. Advanced Networks continue to be concerned about primary care attribution methodologies that payers are using, and it would be helpful to ensure data accuracy by implementing another crosscheck.
3b. Incorporate acuity-based risk adjustment	CHA's request is unclear which analytic process to which this refers. Specific to the benchmark program reporting on Total Healthcare Expenditures and Total Medical Expenditures, OHS uses age/sex risk adjustment rather than clinical risk adjustment because the health status of a population is typically stable between consecutive years. In contrast, clinical risk scores can change annually without changes in the population's underlying risk due to improved documentation of patient condition on claims.[1] Rhode Island, Washington, Oregon, New Jersey, and California are also using age/sex risk adjustment in their cost growth benchmark programs rather than clinical risk adjustment.	It is our understanding that a clinical risk adjustment score is a mandatory data element in the TME file, but it is not currently used to adjust spending. We view integration of the clinical risk adjustment as a critical piece of the analytic process that could lend to a more comprehensive understanding of the benchmark findings, and urge that it is incorporated as an analytic change. Age/sex risk adjustment alone is insufficient to account for the severity of care delivered during the course of a year. There is a significant clinical difference between a healthy 35-year-old female and a 35-year-old female with diabetes and high blood pressure that cannot be captured through age/sex risk adjustment alone. Moreover, the health status of a population is not always stable

		from year to year, particularly when self-insured plan sponsors switch carriers. Finally, if CMS and every national payer risk adjusts, it raises the question of whether OHS disagrees with the approach taken by these national entities.
3c. Incorporate adjustments for service mix	CHA's request is unclear which analytic process to which this refers. With respect to the year-over-year trends in Total Healthcare Expenditure and Total Medical Expenditures, the data received by OHS to calculate these trends does not include sufficient claim-level detail to study changes in service mix. As described above, OHS currently accounts for annual changes in *population health status* through age/sex adjustment at the payer and AN levels. Adjusting for changes in service mix in the THCE and TME reports has the potential to obscure trends in utilization that are significant drivers of cost and may or may not be associated with improved outcomes. It is more appropriate to examine changes in service mix as a part of the secondary, APCD-derived analyses OHS conducts to better understand the drivers of healthcare spending. In addition, we note that none of the seven other cost growth benchmark states make an adjustment for service mix in their Cost Growth trend analyses, and there is no generally accepted methodology for service mix adjustment.	Understanding the year-to-year change in service mix and that trend over time is essential, at a minimum, to providing context to spending trends. Given OHS makes determinations about significant contributors to healthcare spending in its presentations and annual reports, it is important that OHS has a view of the services being provided and any changes in that services mix which may contribute to spending changes. Many hospitals are actively working to appropriately move care to lower cost settings, leaving the higher acuity, more complex and higher cost cases behind. Without some sort of service-mix/severity adjustment, the trends at those higher cost settings may be artificially inflated. The payers standardly adjust for mix and this should be an easy calculation for an actuary to make.
3d. Normalize for changes in patient demographics	In the THCE and TME reports, OHS normalizes for changes in patient demographics through its age/sex risk adjustment methodology. OHS's age/sex adjustment methodology is available in Appendix L of the Implementation Manual. OHS makes adjustments	While age adjustments can account for some demographic differences, they fail to capture more granular or emergent trends that can have significant impacts on cost and utilization. For example, shifts in racial and ethnic demographics, or increasing prevalence of chronic

	to TME at the payer and AN level. OHS reports unadjusted TME at the market and state level.	conditions may not be adequately normalized if only traditional measures like age or clinical diagnoses are considered. This could potentially skew the trend analysis, especially in communities where health disparities are more pronounced.
3e. Consider impacts of material benefit modifications	Most benefit design changes involve increases to member cost sharing obligation to counter rising costs. OHS currently measures changes in allowed spending, which includes both the paid amount and the member obligation. None of the seven other cost growth benchmark states make such an adjustment. We encourage stakeholders to look at underlying cost drivers. The benchmark initiative goal is to measure and, to the extent possible, identify some of these drivers. It may not be feasible to define and measure a material benefit modification that substantially increases TME, but OHS is always willing to work with stakeholders to examine potential underlying cost-drivers.	As you are aware, a material benefit change can include items such as year-to-year inclusion or removal of benefits; changes to cost-sharing, such as increases in premiums, deductibles, coinsurance or copayments; and new conditions, like prior authorization, that impact the type or duration of care provided. These changes have an impact on the spending being measured by the cost growth benchmark and the analysis supported by the APCD. Our request is that the analytic framework used in our deliberations include a review of these types of changes and their impact on spending. We appreciate that other states with a cost growth benchmark use similar adjustments to Connecticut, however we reiterate the need to consider the unique dynamic of Connecticut's healthcare system. We also caution against the assumption that what other states have in place is the correct path forward.
3f. Aggregate the pmpm and trend by Advanced Network across all payer populations including Medicare FFS, Medicare Advantage, Medicaid, and Commercial to reflect the accurate calculation of the total population cost and cost trend results	OHS measures performance separately for the commercial, Medicare Advantage and Medicaid markets to understand and ensure that health care spending is growing at a sustainable rate in each market. This is consistent with the approach taken in all seven of the other states with cost growth benchmark programs.	As defined by OHS, the benchmark is the targeted annual per person growth rate for Connecticut's total healthcare spending, expressed as the percentage growth from the prior year's per person spending. As defined, the benchmark should be measured on a statewide basis and attainment or non-attainment of the benchmark should not be further delineated arbitrarily.

		There is only one cost growth benchmark target, and as such, it does not make sense to examine the lines of business PMPMs and trends separately.
3g. The final assessment of the cost growth benchmark result for each Advanced Network must be measured in aggregate across all populations.	See above	See above

Table 4: CHA Requests Regarding All Payer Claims Database (Cost-Drivers Assessment)		
CHA Request	OHS Response	CHA Response
4a. CHA must have access to the full, raw utilization data in the All Payer Claims database for all payers and populations including Medicare FFS, Medicare Advantage, Medicaid, and Commercial via an engaged Healthcare Economist - third party consultant experienced in health economics and analytics	Through a standardized, privacy-compliant request process, CHA has access to commercial APCD data. CHA's health economist may perform analyses on this data in any ways that are compliant with the data use agreement, and we encourage CHA's engagement in the process. To further enhance data access, OHS proposed an expedited process in the 2024 legislative session which did not receive legislative approval. Access to Medicare and Medicaid data should be requested separately from CMS and DSS respectively due to the terms of the data use agreements that OHS holds with DSS and CMS, both of which authorize data use by state agencies only.	Commercial access is insufficient for a comprehensive understanding of health trends across all payer types. The limitation to only commercial data significantly restricts CHA's ability to conduct robust analyses that include Medicare FFS, Medicare Advantage, and Medicaid populations, which are essential for a holistic view of healthcare utilization and cost. The requirement to request Medicare and Medicaid data separately from CMS and DSS places an unnecessary barrier to comprehensive analysis. Instead of fragmenting the data request process, OHS should work towards a more coordinated approach that facilitates easier access to all relevant datasets.
4b. The CHA engaged Healthcare Economist must conduct a comprehensive analysis of reimbursement and population-based analytics to create a profile by and across populations – by health system entity and in aggregate – normalized with accounting for appropriate adjustments for risk, acuity, service mix, site of care migration, payment methodologies and population demographics.	CHA may engage a healthcare economist to undertake any analysis of its choosing.	We are interested in pursuing this option, and propose that OHS be willing to engage with the CHA-engaged healthcare economist in conversation, and reconcile or respond to any significant findings conducted through the economist's analysis. We acknowledge that in order to do this, the CHA economist would need access to the same datasets given to OHS.
4c. OHS calculations of drivers of cost increases, which are based on its unit cost trend assessment from analysis of the All Payer Claims Database must be shared with CHA and any identified health systems at least four weeks prior to OHS's formal reporting or OHS's use of is calculations in presentations for	OHS has not publicly identified any health system or hospital in its reports on cost-drivers. OHS' analytic methodologies are generally described at the Healthcare Benchmark Initiative Steering Committee meeting and are available to health systems in the post-meeting materials. OHS is	OHS regularly uses data from the APCD to identify hospitals and health systems in the state as drivers of spending growth. While OHS provides a cursory overview of the methods used to use those data to make its presentations, it does not make the data used to underpin the presentation

review and attempted reconciliation.	on schedule to make APCD cost driver analysis dashboards and associated technical notes, available on the OHS website. OHS's hosts a Data Analytics workgroup and receives input and feedback from stakeholders as to analytic methods. We will continue to ensure that our analyses and methods are appropriate and valid to the questions under consideration.	available to CHA or other stakeholders for corroboration. Without access to the data and specific methodology used by OHS, stakeholders cannot be certain of OHS's results.
4d. OHS's reporting should prominently acknowledge the limitations of the APCD including a statement that it is incomplete and only captures the fully insured Commercial, State of CT Commercial, Medicare and Medicaid data, and not the self-insured data and that therefore, any calculations completed from the APCD will not fully represent the cost and trend experience of a health system entity. OHS's reporting must state the percentage and dollar value of total claims data not included in the report.	OHS agrees that disclosures of analytic limitation are important to the validity of the benchmarking program. OHS routinely discloses that the APCD does not contain the entirety of the commercial market when it presents APCD-based findings. While data on the self-insured is incomplete, the data that the APCD contains are representative of the commercial market population (see slides 19-26 of the February 7th 2024 Data Analytic Workgroup presentation). Per the 2015 Supreme Court *Gobeille* decision, self-insured employers are not required to submit claims data to state APCDs. Therefore, we are unable to include the full self-insured claims data in the APCD. However, research shows no evidence that self-insured plans differ systematically from fully insured plans in terms of benefit design or price and may even pay higher prices for services. In addition, OHS analysis has documented similar patterns of hospital service use between the commercial population in the APCD and the full commercial market population.	While OHS notes that the data in the APCD are representative of the commercial market population, this representation is not complete and should be clearly acknowledged as such. The absence of self-insured claims data—which comprises a significant and growing portion of the overall market—could result in a significant bias in the reported cost and trend analysis. We appreciate that current research may not show any systematic difference from self-insured and fully insured plans, however, the context of Connecticut's specific health system and market dynamics remains an important factor that could impact the robustness and accuracy of cost trend analysis. Including the percentage of the total market represented by self-insured plans and the dollar value of claims data in the report is an important limitation that should be acknowledged.

June 2025: CHA Comment Letter

In response to OHS's "Proposed 2026-2030 Benchmarks and Recommendations of the Technical Team" report, released in June 2025, CHA submits a comment letter to the agency, expressing concerns with the benchmark's underlying data process and the recommendations for the next five years.

CONNECTICUT HOSPITAL ASSOCIATION

June 27, 2025

Amy Porter
Acting Commissioner
Office of Health Strategy
PO Box 340308, 450 Capitol Ave MS510OHS
Hartford, CT 06106

RE: CHA Comments – Healthcare Benchmark Initiative, Proposed Benchmarks for Years 2026 - 2030

Dear Acting Commissioner Porter:

The Connecticut Hospital Association (CHA) appreciates the opportunity to comment on the proposed 2026–2030 Cost Growth Benchmark recommendations.

Since the launch of the Healthcare Benchmark Initiative in early 2020, Connecticut hospitals and health systems have served as committed partners in advancing its goals. Hospital representatives have actively participated in the Stakeholder Advisory Board, the Healthcare Benchmark Initiative Steering Committee, the Data Analytics Work Group, and various public forums and hearings. Throughout, we have advocated consistently for a more cohesive and transparent data process and a benchmark methodology that better accounts for the real operational costs of healthcare providers and supports the ongoing development of the state's healthcare delivery system.

As the Office of Health Strategy (OHS) and the technical team consider updates to the Healthcare Cost Growth Benchmark, Quality Benchmarks, and Primary Care Spending Targets for the next five-year period, we urge thoughtful revisions that more accurately reflect the dynamic nature of the healthcare market. Specifically, we strongly encourage OHS to set targets that realistically reflect the cost for hospitals and other providers to deliver care to patients, address the persistent data inconsistencies that compromise stakeholder trust in the process and undermine the program's stated goal of accountability and improvement, and advance the benchmark program in a way that takes into consideration the suggestions and views of stakeholders that actually provide care to patients and are responsible for the healthcare infrastructure on which the state's residents depend.

Flawed Benchmark Methodology

We believe OHS's newly proposed 2.8% benchmark for 2026–2030 continues to overlook several critical factors that directly impact hospitals' ability to deliver affordable high-quality care in Connecticut. Though a clear goal of the benchmark, as outlined in OHS's June 9 Healthcare Benchmark Initiative report, is to provide a stable, predictable target grounded in transparent calculations, the benchmark and its proposed associated

recommendations fall short of reflecting the operational and financial realities hospitals and health systems face. The continued exclusion of key cost drivers from the methodology — specifically, the impact of inflation, tariffs, workforce shortages, supply chain disruptions, and chronic government underpayment — present a fundamental obstacle to setting a realistic and achievable benchmark over the next five years and highlight a growing disconnect between the stated goals of the cost growth benchmark and the current approach OHS is taking to calculate and report on benchmark performance.

We are concerned that the lack of attention to underlying structural issues hinders progress toward the program's intended outcomes and risks undermining broader efforts to address healthcare affordability and access across the state. As OHS finalizes its recommendations, we urge consideration of a more comprehensive and pragmatic recalibration of the benchmark methodology to better reflect the true cost of care delivery.

OHS's proposed recommendations do not adequately address the impact of increased economic pressures and government underpayment for hospitals. Like any other industry, hospitals are significantly affected by external economic pressures beyond their control. In just one year in Connecticut, from FY 2022 to FY 2023, hospitals faced operating expenses that grew by $1 billion, including workforce expenses that grew by $169 million, drug expenses that grew by $249 million, and the cost of medical supplies that grew by $92 million. Rising expenses, combined with other factors, have resulted in Connecticut hospitals losing more than $76 million in FY 2023 (Kaufman Hall). Moreover, the chronic underpayment of Medicaid and Medicare continues to strain access to essential health services. After accounting for the taxes that hospitals pay to fund the state share of Medicaid services, reimbursement for care provided to beneficiaries sits at less than 60 cents on the dollar. Low reimbursement rates not only result in a cost shift to the private market but also force hospitals and health systems to consider scaling back on essential services, jeopardizing patient access. OHS notes that both healthcare access and cost shift to the commercial market are priorities of interest in its report, yet the recommendations do not address their connection with government underpayment.

OHS's proposed recommendations lack the flexibility needed to account for the wide range of factors that routinely impact the cost of care. In addition to economic pressures, hospitals must remain nimble and responsive to any number of situational, clinical, demographic changes. This includes adapting to pandemic-related pressures, increased complexity of care for patients, environmental disasters, or changes to state and federal legislation that impact how care is delivered. Neglecting to appropriately apply risk - adjustment for patient acuity and other demographic factors is a fundamental flaw in the benchmark methodology that further endangers the validity of reported results. This error should not be perpetuated for another 5 years.

CHA objects to the sole reliance on the forecasted median household income as the basis for the benchmark. This proposed approach oversimplifies the complexities of healthcare costs and creates a disconnect between benchmark projections and the realities of hospitals' financial status. We note that the current benchmark methodology applies an 80/20 weighting of Connecticut Median Income (MI) and Connecticut Potential Gross State Product (PGSP). Though this methodology is not without its limitations, we believe applying a heavier weight on PGSP would at least be helpful in capturing some of the costs associated with care delivery. The recommendation to scale back from the use of PGSP presents an even more constrained approach—one that makes it harder to align the benchmark with the real-world financial and operational challenges hospitals are forced to grapple with daily.

Deficiencies in the Data Reporting Process

We are concerned that the proposed recommendations do not include steps to improve the data collection and reporting process, despite longstanding issues of data discrepancies.

Since the outset of the benchmark program, there have been persistent concerns about misalignment between the data submitted by insurers about the Advanced Networks and the data validated by the Advanced Networks themselves. Often, the submitted data has not been thoroughly validated, and even when discrepancies are identified, they frequently go unresolved before publication.

While we acknowledge that OHS has routinely referred Advanced Networks to the Cost Growth Benchmark Implementation Manual for reporting requirements, it is clear that payers may interpret instructions differently, leading to variation in payer reported data.

We strongly urge OHS to make a concerted effort to ensure there is mutual agreement between payers and Advanced Networks on both the content and application of submitted data. Without full access to standardized payer data submissions, Advanced Networks are left with limited insight into the trends and performance metrics that they are later expected to explain during public hearings, or more importantly act on to help slow the rate of healthcare cost growth. If one of the core goals of the benchmark is indeed increased transparency, we believe OHS should use its full authority to facilitate better communication and data sharing among all stakeholders.

Premature Implementation of Enforcement Mechanisms

We find the recommendation for increased enforcement measures for non-attainment of the benchmark to be premature and unnecessary. Hospitals and health systems have been active and engaged participants from the beginning of the process. Despite ongoing challenges—including flaws in the current implementation process and accounting for the broader economic pressures facing healthcare—the proposed recommendations continue to emphasize penalties for non-attainment of the annual benchmark. With so many areas of misalignment still unresolved, pursuing enforcement at this stage is counterproductive and unlikely to lead to meaningful progress.

Improving affordability, sustaining exceptional patient care and improving access to healthcare services are at the center of our collective goals, yet we believe strongly there is a better way to achieve them. We urge OHS to consider more meaningful revisions to the program and avoid setting the same rigid conditions for the next 5 years. CHA remains optimistic that with appropriate and significant changes, the benchmark program could be a meaningful tool for the state.

Thank you for your attention and consideration of our comments.

Paul Kidwell
Senior Vice President, Policy

cc: Alex Reger, Director, Healthcare Benchmark Initiatives, Office of Health Strategy