



FY 2022 & FY 2023 Appropriations Budget Hearing

February 23, 2021

Questions:

1. Out of the total number of currently vacant positions in the agency, how many of these positions has the agency been authorized to refill, to date?

OHS currently has 3 authorized positions to refill. Two positions in the Health Systems Planning Unit will complete the 23-position count under the general fund. We anticipate that the new staff will start within the next month. The HITO position is a statutory position that has been authorized to refill.

The seven positions under the general fund on HIT are being added to the position count but have existed under OHS' work to support coordination of HIT initiatives under our statutory charge and HIE. Four are filled. One is the HITO—see above—one is a lead planning analyst that has been submitted for refill and the other for an administrative assistant will be submitted for approval shortly.

2. How many more vacant positions are anticipated to be authorized to be refilled before the end of the current fiscal year?"

OHS has one insurance fund vacancy. OHS expects to fill that position with a data expert.

3. What company, or companies, might OHS contract with for Healthcare Cost Growth Benchmarks, and, separately, HIE, in FY 22 and FY 23?

OHS currently has a contract with Bailit Health for the work with the cost growth benchmark. The contract expires in April of 2022

Governor Lamont signed EO 5 in January 22. Secretary McCaw highlighted this work as part of the Gov's budget as a priority in containing costs and improving outcomes for everyone. The budget for benchmark would support experts in developing CGBs, primary care target, quality benchmarks and the kinds of expertise to develop models and programs to sustain the benchmark including expertise in health care claims analysis, risk adjustment methodology and deep analytical expertise to assist in the data use strategy, which includes detailed analyses from the All-Payer Claims Database to identify cost drivers and to assist in developing targeted strategies for cost containment efforts. The analytical needs are substantial. The funds also support consumer and stakeholder engagement on the benchmark, including stakeholder work groups and facilitation for primary care, quality, technical team and stakeholder advisory board. This budget is comparable to other states that do this work. We were cognizant of other states' budgets when we develop our budget.

OHS has an existing contract with Bailit Health that was funded through the carry forward and continued with the support from the Governor's budget.

4. How will benchmarks help the State address areas of health inequity across the State?

OHS' mission has always included the elimination of health disparities, particularly for BIPOC populations. In the benchmark work, we have prioritized our work by our data collection by race and ethnicity. OHS directed its technical team to do the benchmark work through an equity lens. For that reason, the following are included:

- the Technical Team, strongly recommended that OHS gather social risk factor data (e.g., income, education, race and ethnicity, language, housing stability and quality, etc.) and analyze the relationship between social risk variables and health care spending using APCD data to inform future social risk adjustment of cost growth relative to the cost growth benchmark
- The Technical Team also encouraged use of the State's Health Information Exchange as a potential future source for social risk factor data. ON that score OHS has a bill in front of the Ins. Comm to ensure the collection of that data.
- The Technical Team highlighted the importance of stratifying primary care spending data to understand current spending trends and identify opportunities for improvement. Future analyses will include stratifying by provider/accountable care organization (ACO), race/ethnicity, gender, multiple comorbidities, modality (e.g., telehealth, in-person visits) and payment model (e.g., fee-for-service or alternative payment model). These analyses can also help measure any unintended consequences that arise from the primary care spending target.
- Data use strategy:
 - a. race, ethnicity, language, and disability status, to the extent possible
 - b. Effects of the cost growth benchmark in terms of impact on marginalized populations, was important to the Technical Team and Stakeholder Advisory Board. This can be assessed by stratifying the previously discussed analyses by income, race/ethnicity, geography, disability status and select social determinants of health (SDOH) factors.
 - c. Patient demographics analyses can focus on the prevalence of and spending by chronic conditions and various SDOH. These require integrating APCD data with other public data sets (e.g., American Community Survey) that capture patient demographics (e.g., race, ethnicity, language) and SDOH information (e.g., housing status, income). They can highlight communities of highest social risk and help providers better understand how to serve their populations more holistically and proactively.
- Also developed a benchmark unintended adverse consequences measurement plan.
 - a. The Technical Team and Stakeholder Advisory Board expressed interest in assessing the effects of the cost growth benchmark on marginalized populations. Based on stakeholder input, this can include stratifying utilization and spending data based on income, insurance status, race/ethnicity, social risk factors and zip code. OHS will combine several of these variables to focus on specific vulnerable

populations, such as combining geography, income and race/ethnicity to assess communities of color in the lowest income zip codes.

- This will allow analysis to ensure cold spotting and hot spotting.
5. What revenue streams offset OHS' General Fund expenditures (i.e., the Hospital Assessment, the Medicaid administrative claim prepared by DSS)?
 6. What revenue stream offsets OHS' Insurance Fund expenditures (e.g., the **Insurance Fund General Assessment** is assessed based on a company's proportion of the total premium taxes and charges paid by domestic insurers and entities to the Department of Revenue Services (DRS) the preceding year. It pays for the entirety of the expenditures of the Connecticut Insurance Department (CID) and the Office of the Healthcare Advocate, **a portion of the expenditures of the Office of Health Strategy**, as well as supporting certain other programs as identified in State statute.)?