Policy Brief
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PAYMENT MODEL PRIMER

Cost Growth Targets

Cost-growth target models, also referred to as benchmarking models, are cost-containment strategies that seek to limit how much health care spending can grow each year.[1] Cost growth targets set an expected rate of per capita growth of health care spending, and can be applied at the provider, payer, or state level.[1]

HOW IS IT SUPPOSED TO WORK?

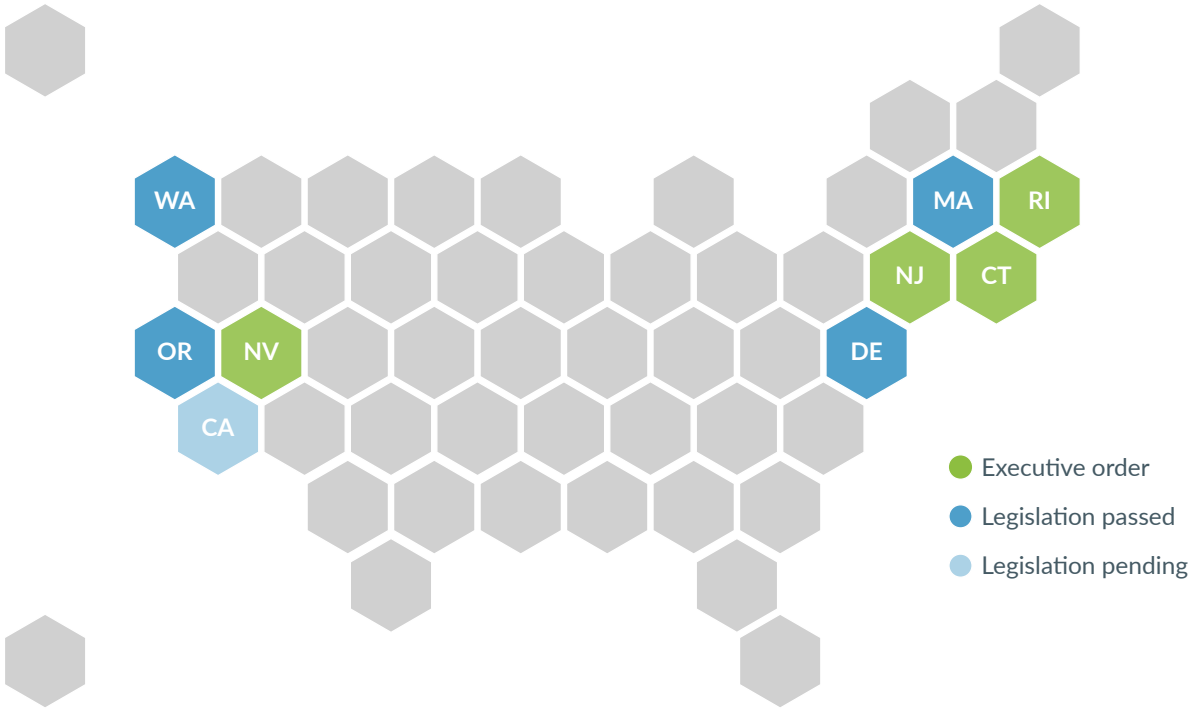
The target that is set allows comparison across years and enables accountability through analysis to uncover specific cost growth drivers.[1] Ultimately, the analyses and the underlying data can be used to inform actions that providers, payers, or states can undertake to address health care cost growth.[1]

Setting a cost growth target alone is not likely to be sufficient in slowing the rate of growth, so benchmarking initiatives tend to be launched in parallel with value-based payment (VBP) initiatives, often at the initiation of governors or state legislatures.[1] In these instances, cost target initiatives are used to help define how each model shares up and downside risk among payers and providers.[1] Benchmarking efforts can also help both payers and providers understand how they will be evaluated under a VBP and what reasonable goals should be. This can aid in not only accountability, but also increase buy-in for payer-provider risk-sharing arrangements.[1]

WHAT IS THE GOAL?

The overall goal of cost-growth targets is to slow the growth of healthcare spending, making healthcare more affordable. In addition, transparency and engagement are increased because payers and providers, as well as state budget expenditures, can be compared to the target, and increases, decreases, and drivers of cost can be identified and reported. Some states also use their benchmarking programs to monitor how spending is distributed among certain services, such as primary care and behavioral health, and to collect information on provider consolidation and other market trends that impact health care costs.[1] Cost growth targets can also be used to bring stakeholders together to work towards a common goal of controlling the growth of health care costs.

FIGURE 1
Statewide health care cost growth benchmarks (as of 2021)



Source: Milbank Memorial Fund.[2]

HOW AND WHERE HAS IT BEEN USED?

Key components of payment structure

As of December 2021, there were 8 states that had adopted benchmarking programs (Figure 1).[1] Massachusetts was the first to do so in 2012, followed by Delaware in 2018 and Oregon and Rhode Island in 2019.[1] Those states were followed by Connecticut and Washington in 2020, and Nevada and New Jersey in 2021.[1] These state efforts commonly include potential gross state product (PGSP), as a measurement of expected state economic growth.[1] Generally, state officials use PGSP to set a target for health care cost growth that does not exceed average growth rate of the state's economy.[1] PGSP accounts for a number of economic factors, including the expected growth in national labor force productivity, state civilian labor force, national inflation, and state population growth.[1] States with current cost growth target efforts have set a range from 2.9% to 3.5% per-capita annual growth, based on these factors.[1]

Multipayer opportunities or past applications

Due to the nature of cost drivers affecting targets, cost growth target initiatives are naturally-occurring multipayer initiatives.[1] Officials in 5 of the states in Figure 1 (Connecticut, Delaware, Massachusetts, Oregon, and Rhode Island) set benchmarks based on medical expense data from commercial insurance, Medicare, and Medicaid claims.[1] In addition, all but Rhode Island incorporate data from Veterans Affairs, while Oregon is the only state to uniquely incorporate data from the Indian Health Service. Connecticut and Oregon also utilize data from their Departments of Corrections.[1]

Provider types and provider characteristics

This model is used broadly to make comparisons year over year and across categories such as

hospital inpatient, hospital outpatient, pharmacy, physician services, long-term care, and home health. However, it can also be used to track specific areas of care, including identifying underlying cost drivers and target transformation efforts at specific sectors that may have an ability to affect the global target. Common areas of focus include primary care and behavioral health.

Primary care

Officials from several states have instituted cost growth targets as a way to incentivize the use of primary care services.[1] Investments in primary care lead to improved patient health, reduced emergency department visits, fewer hospitalizations, and long-term cost savings.[1] Benchmarking allows state officials to compare primary care spending with total system spending and use this information to improve funding allocation for preventive care.[1] Connecticut's governor issued an executive order in 2020 for the state's Office of Health Strategy to develop a primary care spending target by 2021 in order to reach a primary care spending target of 10% of the state's total healthcare budget by 2025.[1]

Behavioral health

Some state officials are also using cost growth targets to assess needed investments in behavioral health services.[1] The goal of such efforts is to bolster access to such services.[1] In 2019, Massachusetts' governor required the establishment of behavioral health expenditure targets and set a goal of increasing spending on these services by 30% between 2019 and 2022.[1]

WHAT HAVE BEEN THE RESULTS?

Financial

In 2019, total health care expenditures (THCE) in Massachusetts were $64.1 billion.[3] THCE per capita grew 4.3% to $9,294 per resident, exceeding the 2019 benchmark of 3.1% set by state officials the year prior.[3] Spending growth accelerated across all hospital inpatient, hospital outpatient, pharmacy, and physician services between 2018 and 2019.[3] In addition, gross prescription drug spending increased by 7.2% in 2019, which accounted for the greatest share of the growth in THCE in Massachusetts.[3] For Massachusetts Medicaid specifically, the THCE increase was less than the state's threshold which was 2.8% in 2019.[3] A reason for the lower growth rate was Medicaid enrollment declined during this period.[3] Despite, exceeding the benchmark, Massachusetts total health care spending has remained at or below national growth rates for 10 consecutive years.[4]

Similar results were noted in Delaware which launched its benchmarking program at the start of 2019.[5] For that year, the benchmark was set at 3.8%.[5] Cost per individual grew from $7,814 in 2018 to $8,424 in 2019, which equaled 7.8%, more than twice as much as the target.[5] Overall health care spending in Delaware totaled $8.2 billion versus $7.6 billion for 2018.[5] Hospital costs were the primary driver for the increase.[5]

Low- and high-value services

Massachusetts's Cost Growth Target Initiative has not had an impact on dissuading low-value care in the state.[6] In 2018, state officials reviewed claims from between 2013 and 2015, and 20.5% of sample commercial claims showed patients received at least one of 19 screenings the state has defined as low value.[6] These include imaging for lower back pain or for uncomplicated headaches, carotid artery disease screening for those at low-risk, and pap smears for women under 21.[6] Spending on these low value procedures totaled $80 million, with more than $12 million being paid out-of-pocket.[6] This study intentionally excluded Medicaid and Medicare patients as they typically have greater health needs and more encounters with the medical system than commercial enrollees.[6]

Health outcomes

Most of the states with benchmark efforts were established too recently to be evaluated for impact on patient outcomes.[1] The annual reports on Massachusetts' model only evaluate the effort for its impact on healthcare spending, not on patient outcomes.[3]

Model sustainability

An area of concern in terms of sustainability is the potential impact that cost growth targets may have on hospital and clinician practice workforces.[1] Hospital and clinician stakeholders may need to cut staff to reduce costs, which potentially impedes access to care.[1] To avoid this scenario, Oregon state officials have announced plans to monitor changes in healthcare workforces as a result of its benchmarking initiative.[1] California officials have also announced a proposal to collect and analyze data related to health care workforce stability.[1]

Rhode Island officials have questioned their ability to continue to implement and monitor cost growth targets due to lack of funding.[7] They were able to begin their work as the result of a grant from the Peterson Center on Healthcare.[7] The funding was used to provide a start-up investment to develop cost growth targets and data analysis capacity related to those goals.[7] The state's fiscal year 2022 budget proposes a tax on commercial insurers, Medicaid, and self-funded businesses to sustain funding to support the program and to codify the work in statute. In addition, Rhode Island officials are also seeking local foundation funding to support benchmarking efforts.[7]

Health equity and social determinants of health

States with cost growth target programs have been looking for ways to use the efforts to advance health equity across their populations.[1] In one example, Nevada's governor explicitly stated

What works and what doesn't?

Strengths and impacts

A cost growth target offers[1]:

- Increased transparency to clinicians, payers, policy makers, and the public on healthcare cost drivers within a state, making it easier to develop solutions to address those issues.
- The opportunity to engage stakeholders, and ensure common goals across the range of variables and parties that affect cost.
- The chance for shared accountability among parties through a common approach to measuring progress.
- The opportunity to leverage the strengths of various organizations and parties that can impact cost.

Concerns and downsides

- Current cost growth targets do not factor in social risk factors of patient populations or regional differences (i.e., rural vs. urban) in populations.[1]
- Most models also do not have a way to factor in issues outside the control of organizations included in the model (such as drug prices for hospitals and clinicians).[10]
- Cost growth models assume organizations are capable of acting to address cost drivers uncovered by the model.

in his cost benchmarking executive order that a goal of the effort was to identify and address disparities in health care outcomes among people of color and LGBTQ+ individuals.[8]

One idea is to use data analysis under cost growth targets to assess how health care spending may be inequitably distributed by population type or region, and whether consumer cost and cost liability present a disproportionate barrier for some populations more than others.[1] Oregon is exploring focusing cost analyses on variations in utilization and cost across populations and publishing that information as part of its strategy to reduce inequities related to health care costs.[1]

The Massachusetts Hospital Association has been urging the state to factor in spending by its members to address social determinants of health in its cost growth targets.[9] While numerous efforts are in place in the state to help address these issues, it is still too early to factor in cost-savings of these efforts when determining ideal cost growth targets.[9]

WHAT ARE THE OPERATIONAL CONSIDERATIONS?

IT infrastructure and analytics

Launching a cost growth target initiative will require robust IT infrastructure that tracks data specific to the target and its definition, and is able to track and aggregate spending across cost centers such as clinicians, hospitals, and payers.[10] If enforcement or penalties are part of the authorizing statute or regulation for cost growth targets, the IT infrastructure system will need to provide reliable data to state officials who are tasked with such enforcement.[10] Several of the states with benchmark programs have all payer claims databases that can help enable aggregation and allow state officials to have access to patient-level claims data.[10] State officials will need to gain buy-in from payers for such databases as federal law prohibits states from compelling insurance plans to supply self-insured data.[10]

State officials must have the capacity to collect, assess the quality of, and analyze the health care spending data they receive to inform the state's specific data use goals.[1] Data scientists, or other staff are needed who are capable of performing data specification, developing data collection and quality assurance, and reporting strategies.[1] Massachusetts has 2 agencies with designated staff responsible for supporting the state's benchmarking program.[1] Rhode Island has been able to perform similar work with a handful of staff members.[7]

Analytic reports used to track benchmarks have common components, including:

- the amount a payer reimburses a provider for a service
- quantity of service units or treatment episodes
- scope and types of services utilized for treatment
- population characteristics such as age, gender, clinical conditions (e.g., diabetics)
- the number of clinicians, including rate of specialists available in a state.[11]

Stakeholder perspective

Setting cost growth targets requires intensive outreach and engagement.[1] To achieve systematic changes within healthcare systems, state officials must gain buy in from relevant stakeholders at the level of target setting.[1] To be successful these models require engagement in the operational details, such as data exchange agreements and other areas that will require behavior change among hospitals and clinicians to respond to findings presented in the data about what is driving cost.[1] As health care cost estimates are released, benchmarking programs can continue to bring relevant stakeholders together and allow them play a part in the development of policies to address rising spending.[1] The Massachusetts' state legislature has an annual hearing, where relevant

stakeholders can testify on what factors should be considered when developing cost growth targets.[12] For 2022, stakeholders have raised worries around whether or not the targets will factor in the impact of COVID-19 on patient utilization trends.[12]

The Massachusetts Medical Society has noted that its state benchmark goal of around 3% growth is aggressive and falls below rates of health care inflation.[13] They voiced hope that going forward cost setting goals would factor in the reduction of care sought out by patients since the start of the COVID-19 pandemic, and that there is likely to be a large increase in spending as patients return to hospitals and doctor offices to seek care for non-emergent conditions or elective procedures.[13] If not, they expressed worry that the cost growth targets could harm access to care.[13] The Massachusetts Health and Hospital Association voiced similar concerns noting that from fiscal year (FY) 2019 to FY 2020, emergency department utilization fell by 16.8% as patients feared even entering a hospital.[9] During that same period, discharges fell by 7.4%, operating room visits dropped by 17.9%, and inpatient days fell 3.8%.[9] These changes do not reflect a steady-state environment suitable for measuring against a benchmark, according to the association.[9] Rising prescription drug prices and salary and wage growth pressures are also not fully accounted for in Massachusetts's cost growth targets.[9]

Authorities (state and federal)

States with current benchmark programs had them initiated by executive orders (EO) or legislation (see Figure 1).[1] Between the 2 strategies, EOs have allowed state officials to move more quickly to implement cost-containment goals and address specific policy priorities.[1] Use of EOs also allow states to hasten engagement of stakeholders to address practical program design questions.[1] However, cost growth initiatives established by EOs tend to have a more limited scope of focus and potentially limited sustainability depending on next gubernatorial administrations in those states.[1] For example, EOs on their own do not provide the authority needed to perform necessary data collection efforts to measure health care system spending against cost growth goals.[1] Benchmark efforts established by legislation tend to have broader authority to collect and use health care data, greater stakeholder and political buy-in, and tend to be established as longer term initiatives.[1]

Other briefs in this series

- Capitated Payments
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