Cost Growth Benchmark Stakeholder Advisory Board

Meeting Date	Meeting Time	Location
July 14, 2020	3:00 pm – 5:00 pm	Webinar/Zoom

Participant Name and Attendance

Cost Growth Benchmark Stakeholder Advisory Board		
Reginald Eadie	Pareesa Charmchi Goodwin	Jonathan Gonzalez-Cruz
Janice Henry	Howard Forman	Jill Zorn
Rob Kosior	Nancy Yedlin	Lori Pasqualini
Richard Searles	Sal Luciano	Vicki Veltri
Kathy Silard	Hector Glynn	
Marie Smith	Ted Doolittle	
Ken Lalime	Kristen Whitney-Daniels	
Karen Gee	Tekisha Everette	
Members Absent		
Rick Melita	Fiona Mohring	
Margaret Flinter	Susan Millerick	
Others Present		
Michael Bailit	Margaret Trinity	
Deepti Kanneganti		

Meeting Information at: https://portal.ct.gov/OHS/Services/Cost-Growth-Benchmark/Stakeholder-Advisory-Board

	Agenda	Responsible Person(s)
1.	**Welcome and Introductions**	**Victoria Veltri**
	Victoria (Vicki) Veltri called the meeting to order at 1:02pm. Vicki announced that Kathy Flaherty had resigned from the Board, and thanked Kathy for her participation and contributions to the Stakeholder Advisory Board. Vicki welcomed Jill Zorn, Senior Policy Officer at the Universal Health Care Foundation of Connecticut, to the Stakeholder Advisory Board.	
2.	**Review and Approval of the Prior Meeting Minutes**	**Victoria Veltri**
	Sal Luciano made a motion to approve the Board's prior meeting minutes, which was seconded by Pareesa Charmchi Goodwin. The motion passed with one abstention by Jill Zorn. The following Board members voted to approve the minutes: Vicki Veltri, Janice Henry, Rob Kosior, Ken Lalime, Karen Gee, Marie Smith, Pareesa Charmchi Goodwin, Howard Forman, Nancy Yedlin, Sal Luciano, Hector Glynn, Kristen Whitney-Daniels.	
3.	**Public Comment**	**Vicki Veltri**
	Vicki welcomed public comment; none was voiced.	
4.	**Connecticut's Need for a Cost Growth Benchmark**	**Olga Armah**
	OHS' Olga Armah reviewed the need for a cost growth benchmark. She stated that over the past two decades, healthcare spending has grown at a pace more than double the growth in median household income. She noted that this trend has made it difficult for Connecticut residents, sharing the cost of coverage for a family of four for unsubsidized healthcare coverage, noting that the so-called "low cost" plan offered via Access Health Connecticut requires a family of four to pay an $18,000 annual premium for a policy with a $13,000 annual deductible. Olga reviewed the impacts of high healthcare costs on consumers (especially low-wage earners), including that employers offer less comprehensive coverage, and consumers delay or avoid necessary care. Karen Gee stated that the healthcare cost trend was not sustainable and she fully agreed with the reason for implementation of Connecticut's healthcare cost growth benchmark. She noted that the state's high cost of healthcare coverage may make it more difficult to attract employers to the state, and will impact the State's economy. She added that the healthcare cost growth benchmark offers a starting point for the state to tackle growth in healthcare costs.	
5.	**Technical Team's Response to the Stakeholder Advisory Board's Cost Growth Benchmark Feedback**	**Michael Bailit**
	Michael Bailit of Bailit Health reviewed the Technical Team's response to the Advisory Board's cost growth benchmark feedback. He stated that as a result of the Stakeholder Advisory Board's input, the Technical Team agreed that the wording in the third criterion for selecting a benchmark methodology should be more explicit, and they agreed to restate it as "lower growth in spending *for consumers, employers and taxpayers*." He also reported that the Technical Team agreed with the Board's assessment that the value of the previously recommended cost growth	

benchmark may be, at the outset, too low. He added that the Technical Team asked that staff prepare a modified proposal to address this concern for the Technical Team's consideration at its July 29th meeting.

Michael reported on several additional decisions made by the Team, including agreement that a sharp rise in inflation should continue to serve as the economic basis for any revisiting of the benchmark values over the initial five years. He said that the Technical Team agreed with the Stakeholder Advisory Board upon the importance of tracking trends in consumer out-of-pocket spending. He also stated that there was as suggestion to respond to concerns about potential future underutilization by adopting Department of Social Services (DSS) underservice monitoring strategies for its PCMH+ program. Michael said the Technical Team gave serious consideration to the Board's feedback, and while it agreed with the Stakeholder Advisory Board in some cases, it did not agree in all. Michael promised to share DSS' underservice strategies with the Stakeholder Advisory Board.

Vicki Veltri reported on a July 13th stakeholder engagement meeting with the Ministerial Health Fellowship. She noted that Fellowship members engaged positively in a discussion of the cost growth benchmark, and that she had expressed her agreement for the need to focus on structural racism.

Sal Luciano reported that Windham Hospital had recently closed its high-risk labor and delivery unit, and had filed a Certificate of Need (CON) to eliminate all labor and delivery services. He noted the potential impact of this closure on underserved populations. Vicki Veltri declined to comment due to the ongoing Certificate of Need (CON) review process being conducted by OHS, but noted that the review process allowed for submission of public comment.

In response to a question from Ted Doolittle, Michael Bailit stated that OHS had presented both Ted Doolittle's and Kathy Silard's proposals for reweighting the benchmark, and that the Technical Team had offered little comment in response to Ted's proposal to use the 25th percentile for wages rather than median wage. Michael noted that Ted's proposal would have lowered the benchmark, and the Team was reluctant to do so. Ted expressed support for having the benchmark higher in the near term, but also expressed concern with the long-term impact of using median income as a component of the benchmark indicator. Michael noted that there will be an opportunity to reexamine the benchmark after five years. Ted Doolittle expressed appreciation for the Technical Team's work.

6.	**Primary Care Spend Target: Key Concepts and Context for CT**	**Michael Bailit**

Michael stated that the Governor's Executive Order directive is to increase primary care spending as a percentage of total healthcare spending to 10 percent by 2025. He then shared the rationale for pursuing such a target. Research shows that greater relative investment in primary care leads to better patient outcomes, lower costs, and improved patient experience of care, he said. Michael noted that many states have been working incrementally to use primary care as a means of strengthening their overall healthcare systems, for example, by supporting improved primary care delivery, and also by increasing the percentage of total spending that is allocated towards primary care – as Connecticut is now doing under Executive Order #5. Michael noted that Rhode Island implemented a primary care spending target through commercial health insurance regulation, and emphasized that the State's effort focused on the commercial market. He noted that from 2008 to 2018, Rhode Island's commercial primary care spending as a percentage of total medical spending increased from 5.7 percent to 12.3 percent.

Michael shared information about Oregon's 2015 legislative mandate to report the percentage of medical spending allocated to primary care for select health insurers in the State. He said that subsequent legislation required health insurance carriers and Medicaid managed care plans to allocate at least 12 percent of health expenditures to primary care by 2023. Michael added that while Oregon produces a lot of detailed public reporting on primary care spending, Rhode Island does not. Michael stated that Delaware is starting to pursue a similar initiative to measure primary care spending.

Sal Luciano stated that in 2011, the state employees negotiated a requirement that individuals see their primary care physician, at intervals that vary based on age. He said that this change revealed that 40 percent of state employees lacked a primary care physician, and that with implementation of this requirement the figure jumped to over 90 percent. He noted that after the first year of implementation of the requirement, there was no net increase in costs, and the second year of implementation resulted in a 6 percent savings.

Jill Zorn asked if other states are changing fee schedules to support implementation of the primary care spend target. Michael acknowledged that increasing fees for primary care practices at a higher rate than for other providers would be one way of achieving the primary care spend target.

Michael promised to share with Board members information on how Oregon reports on primary care spending, in addition to DSS' strategy for measuring potential underservice.

Janice Henry shared her perspective as an insurer representative, stating that Anthem enhances primary care provider rates with payments from its value-based program, based on achievement of quality measures; she noted that this is a means of ensuring reasonable compensation to primary care providers. She said that she would like to know how Rhode Island collects information on value-based payments that primary care providers receive from insurers. Michael promised to share this information.

Rob Kosior stated that in his work, high-performing medical groups that manage spending well typically experience higher primary care utilization and lower specialty spending. He said the primary care spending target needs to be tied to a goal of decreasing utilization for specialty services.

Karen Gee expressed support for both Janice Henry's and Rob Kosior's remarks, noting that increases in primary care payments should be in the form of value-based incentives. She expressed interest in learning about Rhode Island's effort to achieve innovative contracting and payment, not just fee schedule manipulation.

Vicki noted that OHS will be convening a primary care work group that will conduct a deeper dive into how to reach the primary care target once it has been set, as well as the Population Health Council. She noted that there will be a solicitation for joining these groups forthcoming on the OHS website.

Michael noted that in order to implement the primary care spending target, OHS will first need to understand the level of Connecticut's recent spending on primary care. Without this, he noted that it would be difficult to figure out how to increase primary care spending as a percentage of total healthcare spending to 10 percent by 2025. He stated that three separate analyses have been performed recently to calculate what percentage of total healthcare spending in Connecticut has gone to primary care. He said that the data sources, and results, for these three results varied. Michael stated that there was a fourth analysis underway, which was being performed with the other five New England states through an organization known as "NESCSO." Preliminary results should be available later in July.

Michael reviewed the three different studies of primary care spending, noting differences in the studies in terms of their methodologies, data sources, payer markets examined, and study years. He then reviewed the results of these three studies, noting that they varied significantly based on the definition of primary care (the numerator), the definition of total medical expense (the denominator) and the data source. Michael observed that claims data would likely serve as a more reliable data source than survey data. He noted that the calculations by studies utilizing claims yielded higher percentages for primary care spending than did the study that used MEPS survey data. He noted that using claims as the primary data source, UConn found that primary care spending represented 5.8 percent of the commercial payer market, and 2.7 percent of the Medicare market. Freedman Healthcare's analysis found that primary care spending represented 9.0 percent of the Medicaid market. He stated that the primary care spending share for the Medicare market is typically lower than for commercial and Medicaid markets, because the Medicare population is comparatively sicker and therefore utilizes more acute and specialty services. In response to a question from Karen Gee, Michael said that findings from these three studies related to traditional Medicare FFS spending, and not Medicare Advantage.

Karen Gee noted the relatively high share of primary care spending for the Medicaid population in the Freedman analysis. Michael agreed, noting that many Medicaid recipients receive care from community health centers which tend to have higher fee schedules. Ken Lalime noted that community health centers also provide free and low-cost care as part of their mission.

Nancy Yedlin noted that high-deductible plans on the commercial side may be impacting the findings that Michael shared, when compared to the other payer categories where there is more first dollar coverage. Michael noted that

research has found that when people have high cost sharing they access services less, but he did not know to what extent high deductible commercial plans are impacting primary care spending in the commercial payer market.

Michael said that how primary care spending is weighted when calculating state-level spending has a significant impact, noting that if primary care spending is weighted by population size, that will yield a different result than if we weight spending by total healthcare expenditures, because of the effect of Medicare. He said that determining the methodology has major implications and was a question that the Technical Team will need to consider. Michael observed that when using currently available baseline data, calculating a weighted average of total primary care spending using population size would yield 6.0 percent using claims data, thereby necessitating an increase of 4 percentage points in primary care spending to reach the Governor's target. Calculating the weighted average of total primary care spending using total healthcare expenditures yields a significantly lower baseline of 4.8 percent and necessitating an increase in 6.2 percentage points to reach the target. Michael said he expects the increase in percentage points needed to reach the primary care spend target to be 5 to 6 percentage points, and looked forward to completion of the NESCSO analysis to provide additional data points.

Michael shared implications for the work of the Technical Team and Stakeholder Advisory Board, noting that primary care spending varies significantly across public and private sectors, regardless of whether the data source is claims or survey data. First, he noted the importance of developing precise definitions of primary care and total medical spending in order to achieve target. Second, he said that having developed these definitions, OHS will need to examine historical spending using those definitions in order to set specific annual targets to reach the Executive Order target of 10 percent by 2025. Third, he said aggregating data across payers creates a challenge because of the inclusion of Medicare. He noted that Rhode Island created a primary care expenditure target just for commercial payers, and Oregon did so for commercial payers and Medicaid, but Connecticut's primary care expenditure target is aimed inclusively at commercial payers, Medicaid and Medicare.

Rob Kosior asked if OHS had the ability to suggest that the Executive Order be revised so the target did not include all three payers. Michael replied that there are no limitations on recommendations made by the Stakeholder Advisory Board, but he did not know whether such a recommendation would be considered by the Governor. Rob recommended using claims data as the data source for determining primary care spending, noting that it would be the most accurate source.

Marie Smith asked if OHS was trying to mend the current primary care system or if it wished to examine new models of primary care delivery. She noted that claims data is an easy source of data.

Michael responded to Marie's second comment, saying that Rhode Island and Oregon use claims data and supplement with non-claims-based payments, because there is a fair amount of primary care spending that takes place outside of claims. Michael responded to Marie's first comment by explaining that the Executive Order addressed spending, but not how primary care is organized or delivered. He noted that Vicki would be creating a new primary care group to discuss how to achieve the 10 percent target, and expected that this group would address reform to the primary care delivery system. Vicki Veltri added that the Executive Order also directed OHS to monitor the development of alternative payer models. She anticipated that the primary care group would examine new models of primary care delivery and payment.

Nancy Yedlin commented on the pros and cons of including Medicare in the calculation, noting that there are innovative models of Medicare service delivery across the country.

Pareesa Charmchi Goodwin stated that preventive dental services should be considered as oral health primary care, and noted that such services are likely not factored into the data shared by Michael. She recommended preventive and routine oral healthcare should be included in the definition of primary care services.

7.	**Questions for Stakeholder Advisor Board Consideration**	**Michael Bailit**

Michael reviewed several policy questions for the Stakeholder Advisory Board's consideration, noting that the Technical Team had not yet advanced far in its discussion of the primary care spending target methodology. He noted that in general, states and other organizations universally agree on certain components of the definition of primary care spending, however, there are still many differences in definitions of primary care and total spending across the studies discussed earlier and in the states that have implemented such targets.

Michael said that two key questions for the Stakeholder Advisory Board's consideration and in order to provide input to the Technical Team were "Who are primary care providers (PCPs)?" and "How to define total spending?" With regard to the question of who are primary care providers, Michael noted that in the calculation of primary care spending, there is typically consensus for including primary care physician specialties, primary care nurse practitioners and physician assistants who are delivering care in a primary care practice, and geriatricians/gerontologists. He noted that there is much less consensus on whether OB/GYN providers who sometimes provide primary care services should be included as primary care providers. He shared that one member of the Technical Team said that state health plan experience is that 15 percent of women use an OB/GYN as their primary care provider. He noted that the Cleveland Clinic suggests that OB/GYNs can serve as primary care providers for women who are generally healthy, but not for women with a strong family history of disease. He noted that other states, for example Rhode Island, and also health plans, typically OB/GYNs and other specialists are classified as PCPs only if the specialist accepts the full role and fees of a PCP. He shared several other points of reference, including that the Quality Council decided not to define OB/GYNs as PCPs in 2018.

Michael asked if the Stakeholder Advisory Board recommended including behavioral health providers and/or OB/GYNs as PCPs. Tekisha Everette said that yes, she supported inclusion of OB/GYNs as primary care providers, noting that this is typically the point of entry to the healthcare delivery system for women. She asked if dividing obstetrics versus gynecological services might offer a means of categorizing OB/GYN primary care and specialty services. Michael noted that including OB/GYN services in the definition would make it easier to achieve the target.

Howard Forman noted that the majority of OB/GYN and mental health providers offer primary care services, and that excluding these providers would create divergent standards for primary care and specialty care services.

Sal Luciano expressed support for inclusion of OB/GYNs in definition of primary care providers, noting that the state employee health plan defines OB/GYNs as primary care physicians.

Reggie Eadie expressed agreement that OB/GYNs and mental health providers should be included in the definition of primary care providers. He said that OHS should also include emergency room providers in the definition.

Hector Glynn expressed concern that excluding OB/GYNs would disincentivize the use of these providers. He noted the push for integration of behavioral health services into primary care delivery, and encouraged including behavioral health services and providers in the definition of primary care. He acknowledged that not all behavioral health is primary care, but this was an opportunity to push for greater integrated care.

Pareesa encouraged the Board to consider routine and preventative oral health services as primary care services. She cautioned that the definition not get overcrowded so as to ensure a meaningful definition.

Marie Smith encouraged the Board to examine the definition of services as a spectrum of services ranging from primary care, preventative care, specialty care, and integrated care.

Nancy Yedlin remarked that many of the recommendations of the U.S. Preventative Task Force require service delivery by OB/GYNs, and encouraged the Board to consider OB/GYNs' role in providing well care to women.

Kathy Silard said that OB/GYN and behavioral health services as well as urgent and emergency care that is primary care in nature should be included in the definition of primary care. Kathy noted that if the goal is to increase primary care spending to 10 percent, it will be difficult to accomplish this with Medicare spending included in the calculation of expenditures.

Ken Lalime stated that primary care providers are those providers who are coordinating the entire care of a patient.

In response to a comment from Tekisha Everette, Michael Bailit stated that OHS could try to separate the care delivered by OB/GYNs that are primary care in nature, although it would be difficult to do so.

Jill Zorn noted that OB/GYNs are trained as surgeons, and said that everyone should be able to have a primary care physician. She stated that she does not view OB/GYNs as primary care providers. She expressed caution about including OB/GYNs in the definition of primary care providers, and invited the Board to envision a system where there is greater access to primary care providers.

Rob Kosior noted the target's goal of shifting resources to primary care, and OB/GYNs and behavioral health providers are not as well positioned to provide comprehensive care as are primary care providers.

Howard Forman commented that OB/GYNs can serve as a primary care home for patients, and some OB/GYNs are doing exclusively tertiary care and others are focused on primary care.

Michael promised to share with the Technical Team the range of perspectives shared by the Board regarding the definition of primary care services and primary care providers.

Michael reviewed the question of how to define total spending, noting that total spending is the denominator value used to calculate primary care spending as a percentage of total healthcare expenditures. He stated that there are several spending categories that differ among states in terms of their inclusion, for example prescription drugs, lab and imaging services, and dental services. He noted that Connecticut could align its definition of total spending with the cost growth benchmark definition, which would reduce the reporting burden and offer other benefits. He noted that doing so would create non-alignment with other states, however. He further remarked that including more categories in total spending makes the calculation of total medical expenses more comprehensive, but that a narrower definition of total medical expenses might be more equitable across payers because it is limited to service categories that are applicable across multiple markets. Michael shared a table that provided information on what components of spending are included in total spending for the Connecticut cost growth benchmark, and for Rhode Island, Oregon and NESCSO primary care spending definitions. He noted that lab and imaging services are included in definition of total spending across all four sources, but vision services are not.

Rob Kosior asked if long-term care spending included custodial care, and Michael said it did, including both facility-based care and home and community-based services.

Jill Zorn asked why Oregon excluded prescription drugs from its definition of total spending. Deepti Kanneganti of Bailit Health said the reason was that the Oregon statute that defined the primary care spend target did not include prescription drugs.

Michael invited input from the Board on whether to include or exclude any of these services (prescription drugs, lab and imaging services, dental services, vision services, and long-term care) from the denominator. Pareesa Charmchi Goodwin said that for dental services, there needs to be a way to separate routine oral health and include that in numerator, and then include oral surgery and restorative dental care in the denominator. Michael wondered if there might be a separate spend target for oral health, and oral health primary spend calculation.

Hector Glynn asked whether the three studies that Michael reviewed previously included prescription drugs, lab and imaging services, dental services, vision services, and long-term care services. Michael said he thought prescription drugs, and lab and imaging were included, but he thought dental and vision were likely excluded, and he was not sure if the Medicaid calculation that resulted in 9% primary care spending included long-term care.

Sal Luciano said that he was inclined to include long-term care in the primary care spending calculations, but acknowledged that its inclusion would make a big impact. Michael said that it is hard to make a comparison across payers if long -term care services are included, because these services are only covered by Medicaid. Nancy Yedlin, Rob Kosior and Marie Smith all expressed support for excluding long-term care.

Kathy Silard stated that she supported increased primary care spending, but asked if efforts to boost primary care spending might result in suppression of spending in other areas.

Cost Growth Benchmark Stakeholder Advisory Board

8.	**Adjourn**	**Vicki Veltri**
	Sal Luciano made a motion to adjourn the meeting, which was seconded by Howard Forman. There was no opposition to motion to adjourn and the meeting adjourned at 2:57pm.	