Cost Growth Benchmark Stakeholder Advisory Board Meeting #4 July 14, 2020

OHS
CONNECTICUT
Office *of* Health Strategy

Agenda

Time	Topic
1:00 p.m.	Call to Order
1:05 p.m.	Review and Approval of Prior Meeting Minutes
1:10 p.m.	Public Comment
1:20 p.m.	Connecticut's Need for a Cost Growth Benchmark
1:30 p.m.	Technical Team's Response to Cost Growth Benchmark Feedback
1:50 p.m.	Primary Care Spend Target: Key Concepts and Context for Connecticut
2:10 p.m.	Questions for Stakeholder Advisory Board Consideration
2:55 p.m.	Wrap-Up and Next Steps
3:00 p.m.	Adjourn

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Call to Order and Roll Call

Stakeholder Advisory Board Members

- Vicki Veltri – Office of Health Strategy
- Reggie Eadie – Trinity Health of NE
- Kathy Silard – Stamford Health
- Janice Henry – Anthem BCBS of CT
- Robert Kosior - ConnectiCare
- Richard Searles – Merritt Healthcare Sol.
- Ken Lalime - CHCACT
- Margaret Flinter – Community Health Ctr
- Karen Gee – OptumCare Network of CT
- Marie Smith – UConn School of Pharmacy
- Tekisha Everette – Health Equity Solutions
- Pareesa Charmchi Goodwin – CT Oral Health Initiative
- Howard Forman – Yale University
- Nancy Yedlin – Donaghue Foundation
- Fiona Mohring – Stanley Black and Decker
- Lori Pasqualini – Ability Beyond
- Sal Luciano – CT AFL-CIO
- Hector Glynn – The Village for Fam & Children
- Rick Melita – SEIU CT State Council
- Ted Doolittle – Office of the Healthcare Adv
- Susan Millerick - patient representative
- Kristen Whitney-Daniels - patient represent.
- Jonathan Gonzalez-Cruz - patient represent.
- Jill Zorn - Universal Health Care Foundation

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Review and Approval of Prior Meeting Minutes

Public Comment

Connecticut's Need for a Cost Growth Benchmark

Connecticut's Need for a Cost Growth Benchmark

- During the Stakeholder Advisory Board's June 30th meeting a few members questioned the rationale for Governor Lamont's executive order calling for the creation of a cost growth benchmark.
- OHS will explain why the Governor - and many others - find the case for a cost growth benchmark compelling.

Connecticut's Need for a Cost Growth Benchmark

1. For the last two decades health care spending has annually grown at a pace *more than double* growth in median household income (4.8% vs. 2.0%).*

2. Connecticut residents can't afford health care - not insurance premiums, and not the cost sharing.

   AccessHealth CT unsubsidized coverage for a family of four as of July 2020

   - "low cost" plan: $18,000 premium plus $13,000 annual deductible
   - high cost plan: $28,000 premium plus $9,000 annual deductible

*Office of Health Strategy. Cost Growth Benchmark Technical Team Meeting #5, June 16, 2020.

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Connecticut's Need for a Cost Growth Benchmark

3. High growth in health care costs have a terrible effect on consumers – especially on those with low and modest wages.
   - Employers offer less comprehensive coverage
   - Employers reduce workers' wage growth due to health coverage cost growth
   - Consumers have less money to spend on non-health care needs
   - Consumers delay or avoid necessary care – and suffer as a result
   - State government cuts spending everywhere else - human services, public health, housing, public works, public safety, etc.

- Continued high growth in health care spending is a terrible problem for Connecticut residents.

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Technical Team's Response to the Stakeholder Advisory Board's Cost Growth Benchmark Feedback

Technical Team's Response to the Advisory Board's Cost Growth Benchmark Feedback

- The Technical Team discussed the Advisory Board's June 30th feedback on the cost growth benchmark methodology during its July 2nd meeting. As a result of discussion, it agreed upon the following:
  - The wording in the third criterion for selecting a benchmark methodology should be more explicit. It agreed to restate it as "lower growth in spending *for consumers, employers and taxpayers*."
  - The value of the previously recommended cost growth benchmark may be, at the outset, too low. Staff should bring a modified proposal to the next meeting (7/29) for Technical Team consideration.

Technical Team's Response to the Advisory Board's Cost Growth Benchmark Feedback

- The Technical Team further agreed upon the following:
  - 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.
  - OHS should track trends in consumer out-of-pocket spending.
- Finally, there was a suggestion to respond to concerns about potential future underutilization by adopting DSS's recommended underservice strategies.

Primary Care Spend Target:
Key Concepts and Context for Connecticut

Directive to develop a primary care spending target

- Executive Order #5 directs the Executive Director OHS to:
  - "…monitor health care spending growth across all public and private payers and populations in Connecticut…",
  - "..convene a Connecticut Cost Benchmark Technical Advisory Board to assist her in developing such benchmarks…" and
  - ensure "**such health care cost growth benchmarks shall account for current primary care spending and set targets within each annual benchmark for increased primary care spending as a percentage of total health care expenditures to reach a target of *10% by calendar year 2025*.**"

Why Set a Primary Care Spending Target?

Why set a primary care spending target?

- The U.S. healthcare system is largely specialist-oriented. Research has demonstrated that greater relative investment in primary care leads to better patient outcomes, lower costs, and improved patient experience of care.
- States have elected to utilize primary care to strengthen their healthcare systems by:
  - ***supporting improved primary care delivery*** (e.g., expanding the primary care team, supporting advanced primary care model adoption)
  - ***increasing the percentage of total spending that is allocated towards primary care***.

State example: Rhode Island

- Background: Primary care spending target established through commercial health insurance regulation.
  - Rhode Island Office of the Health Insurance Commissioner (OHIC) implemented "affordability standards" in 2009, with the guidance of its Health Insurance Advisory Council.
  - One of the initial four standards required commercial insurers to ***increase the portion of medical expense allocated to primary care by one percentage point every year for five years*** without increasing premiums or fee schedule manipulation.
    - Re: "fee schedule manipulation", RI wanted innovative contracting and payment, as well as primary care system investment, and not simply changing rates of reimbursement for specific codes.

State example: Rhode Island – Results

- From 2008 to 2018:
  - Commercial primary care spending as a percentage of total medical spending increased from **5.7%** to **12.3%**.
    - Total fully insured primary care spending increased 66% from $47 million to $78 million.
    - Total fully insured medical spending decreased 22% from $823 million to $638 million.*

*RI believes the decline was due to growing use of self-insurance, leakage to Medicaid from ACA expansion, and an aging population.

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State example: Oregon

- Background: Primary care spend reporting and target required by statute.
  - Senate Bill 231 (2015) and House Bill 4017 (2016) required the Oregon Health Authority and Department of Consumer and Business Services to ***report the percentage of medical spending allocated to primary care*** for select health insurers in the state.
  - Senate Bill 934 (2017) required health insurance carriers and Medicaid coordinated care organization (CCOs) to allocate at least ***12 percent of health care expenditures to primary care by 2023***.

How much does Connecticut spend on primary care?

How much does Connecticut spend on primary care?

- It is important to know the level of Connecticut's recent spending on primary care. Otherwise, it will be hard to chart a course to reach the Executive Order #5 directive to increase primary care spending as a percentage of total healthcare spending to 10% by 2025.
- Answering this question is not a simple task.

It's unclear what Connecticut spends on primary care!

- Three separate analyses have been performed recently to calculate what percentage of total healthcare spending has gone to primary care.
  - The measured populations, time periods and methodologies have varied across the three efforts.
  - As a result, it is not surprising that their results have varied too.
- A *fourth* analysis is currently underway, this one being performed as part of the NESCSO project. Preliminary results should be available by the end of the month, and final results by the end of August.

Calculations of CT Primary Care Spend %

Source	Data Source	Payer Markets	Years
Freedman Healthcare*	OSC claims DSS claims	Commercial (state employees) Medicaid	2017 (Commercial) 2018 (Medicaid)
Patient-Centered Primary Care Collaborative (PCPCC)	MEPS (survey)	Commercial Medicaid Medicare Dually Eligible	2011-2016
UConn SIM evaluation	APCD claims	Commercial Medicare	FFY2013-2017 (Commercial) FFY2013-2017 (Medicare)**

*Freedman also reported the MEPS figure for Medicare.
**Medicare pharmacy data is from FFY2013 – FFY2015.

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What did these three efforts find?

- Primary care spending in Connecticut varies drastically based on the definition of primary care (the numerator), the definition of total medical expense (the denominator) and the data source!

Using claims as the primary data source

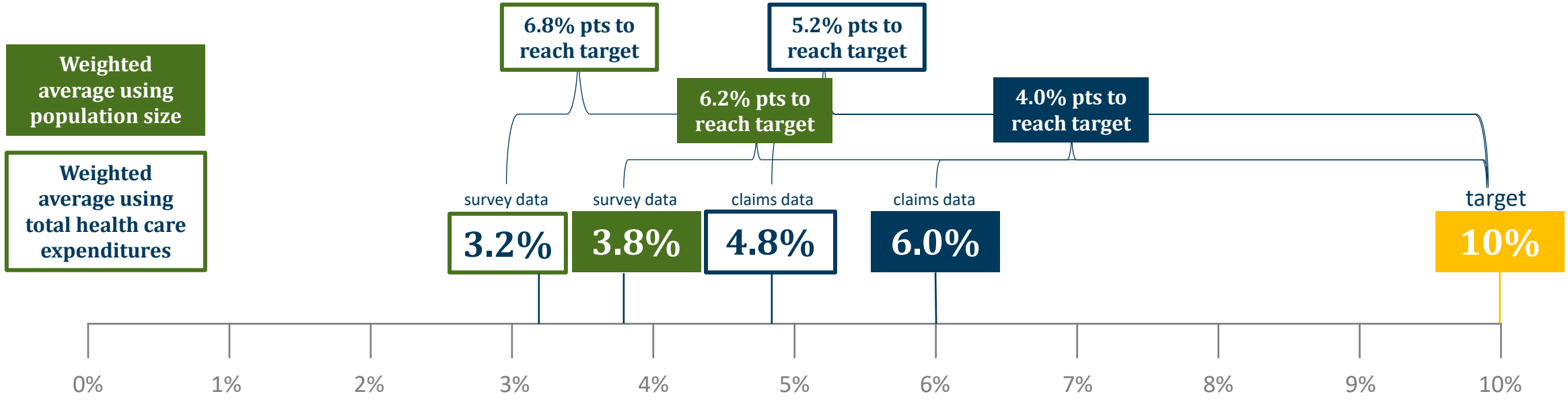
Payer Markets	Years	Primary Care Spending %	Source
Commercial	FFY 2017	5.8%	UConn SIM
Medicaid	2018	9.0%	Freedman
Medicare	FFY 2017	2.7%	UConn SIM

Using MEPS survey data as the primary data source (traditionally less reliable)

Payer Markets	Years	Primary Care Spending %	Source
Commercial	2011-2016	3.6%	PCPCC (Narrow)
Medicaid	2011-2016	5.4%	PCPCC (Narrow)
Medicare	2011-2016	2.1%	PCPCC (Narrow)
Dually Eligible	2011-2016	2.5%	PCPCC (Narrow)

Where does this leave us? (cont'd)

- If we calculate a weighted average of total primary care spending in Connecticut by (a) population size and (b) total health care expenditure, spending varies dramatically by data source. This has major implications for what action is needed to reach the 10% target.



Source: Bailit Health analysis using data from the Freedman Healthcare analysis, the UConn SIM evaluation report, the PCPCC primary care report, the Kaiser Family Foundation Health Insurance coverage estimates for 2018 and CT DSS Medicaid spending estimates.

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Implications for our work

- As seen in the previous slides, primary care spending varies across public and private sectors, regardless of the data source.
- These findings have three major implications:
  1. The State must develop a precise definition of primary care and total medical spending.
  2. The State should rely on calculating historical spending using this precise definition in order to set specific annual targets to reach the Executive Order's target of 10% by 2025.
  3. The Executive Order sets the target in aggregate across payers. It will be challenging to get to 10% given Medicare's inclusion in the calculation.

Questions for Stakeholder Advisor Board Consideration

Primary care spending target methodology (1 of 3)

- Measuring primary care spending has four key components:

$$\frac{\text{Claims-based primary care payments} + \text{Non-claims-based primary care payments}}{\text{Total claims-based payments} + \text{Total non-claims-based payments}} = \textbf{Primary care spending as a percentage of total healthcare expenditures}$$

Primary care spending target methodology (2 of 3)

- Many states and organizations universally agree on certain components of the definition of primary care spending (e.g., include preventive medicine services provided by an MD specializing in family medicine).

- There are, however, key differences in the definitions of primary care and total spending that impact primary care spending as a percentage of total health care expenditures.

Primary care spending target methodology (3 of 3)

- Today, OHS seeks the Advisory Board's on the following questions:
  1. Who are "primary care providers"?
  2. How to define "total spending"?
- The following slides refer to the definitions in use by Rhode Island, Oregon and NESCSO to help guide our discussion.

1. Who are “primary care providers”? (1 of 3)

- It is common to define primary care physician specialties, NPs and PAs and geriatrics/gerontology providers as “primary care providers”.
- There is much less consensus around whether to include select specialty providers who sometimes provide some primary care services, particularly OB/GYN providers.

1. Who are “primary care providers”? (2 of 3)

- One member of the Technical Team noted that the state health plan experience is that 15 percent of women use an OB/GYN as their primary care provider.
  - The Cleveland Clinic suggests that OB/GYNs can serve as PCPs for women who are generally healthy, but not for women with a strong family history of disease.*
- Other states (e.g., Rhode Island) and health plans typically classify OB/GYNs and other specialists as PCPs only if the specialist accepts the full role and fees of a PCP.

*Source: https://health.clevelandclinic.org/is-it-ok-to-see-your-obgyn-for-primary-care/

1. Who are "primary care providers"?

- Other perspectives on defining OB/GYNs as primary care providers:
  - **Connecticut precedent:**
    - The Quality Council decided not to define OB/GYNs as PCPs in 2018 .
    - Medicaid does not recognize OB/GYNs as PCPs (similar to NCQA and CMS).
    - Trinity Health of New England lists OB/GYNs as primary care clinicians on its web site. Stamford Health does not.
  - **NESCSO primary care project:**
    - The New England states participating in the NESCSO study agreed that while many women consider their OB/GYNs to be their PCP, OB/GYNs do not provide the continuum of care, especially for chronic care services, that are included in the commonly accepted definitions of PCPs.
  - **In the literature:**
    - One 2014 analysis found that PCPs were nearly 2.5 times as likely as OB/GYNs to address problems such as mental health issues, metabolic conditions and circulatory, respiratory, digestive and skin diseases during a preventive gynecological visit.*

*Source: https://www.jabfm.org/content/27/1/13.long

What input does the Stakeholder Advisory Board want to provide on the definition of primary care providers and services?

1. Does the Board recommend including behavioral health providers and/or OB/GYNs as PCPs?

2. How to define “total spending”? (1 of 4)

- Total spending is the denominator value used to calculate primary care spending as a percentage of total health care expenditures.
- There are a few key spending categories (i.e., prescription drugs, lab and imaging services and dental services) that differ in terms of inclusion among states.

2. How to define “total spending”? (2 of 4)

- Connecticut can align its definition of total spending with the cost growth benchmark, which is beneficial because it:
  - greatly reduces reporting burden,
  - allows for select comparisons to be made between the target and benchmark, and
  - can be viewed as consistent with the EO language: “set targets within each annual benchmark for increased primary care spending.”
- It may, however, create non-alignment with other states.

2. How to define “total spending”? (3 of 4)

- The benefit of including more categories in total spending makes the calculation of total medical expenses more comprehensive.
- However, a narrower definition of total medical expense may be more equitable across payers, as it is limited to service categories that are applicable across multiple markets (e.g., excludes skilled long-term care spending that is concentrated in Medicaid).

2. How to define "total spending"? (4 of 4)

- For reference, the table below provides information on what is included in total spending for various sources.

Spending Category	CT Cost Growth Benchmark	Rhode Island	Oregon	NESCSO
Prescription drugs	**Yes (incl. pharmacy rebates)**	**Yes (pharmacy rebates TBD)***	No	**Yes (pharmacy rebates TBD)****
Lab and imaging services	Yes	Yes	Yes	Yes
Dental services	TBD	No	No	No
Vision services	No	No	No	No
Long-term care	**Yes**	**No**	**No**	**No (except Skilled Nursing Facility)**

*Rhode Island is refining its primary care spending target definition this summer. It will finalize whether to include pharmacy rebates at that time.
**NESCSO aims to include pharmacy rebates in its definition of total spending, but will finalize its definition after states submit their initial data in July 2020.

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What input does the Stakeholder Advisory Board want to provide on the definition of total spending?

1. Does the Board recommend aligning the definition of total spending with the cost growth benchmark?

Wrap-Up & Next Steps

Plan of Meetings

Meeting #	Date	Meeting Goals
4	August 11, 2p.m.-4p.m.	• Discuss Technical Team primary care spending target recommendations. • Share information regarding the Mathematica analysis and its relationship to the data use strategy
5	September 16, 1p.m.-3p.m.	• Discuss Technical Team data use strategy recommendations. • Discuss what steps should be taken to ensure the cost growth benchmark and primary care spending target are successful, and how to avoid any unintended consequences. • Discuss upcoming quality benchmark development