# Cost Growth Benchmark Stakeholder Advisory Board

| Meeting Date | Meeting Time | Location |
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| August 26, 2020 | 1:00 pm – 3:00 pm | Webinar/Zoom |

**Participant Name and Attendance**

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

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

| | Agenda | Responsible Person(s) |
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| **1.** | **Welcome and Introductions** | **Victoria Veltri** |
| | Victoria (Vicki) Veltri called the meeting to order at 1:01pm. | |
| **2.** | **Review and Approval of the Prior Meeting Minutes** | **Victoria Veltri** |
| | Howard Forman made a motion to approve the Board's prior meeting minutes, which was seconded by Pareesa. The motion passed with four abstentions.<br><br>The following Board members voted to approve the minutes: Reggy Eadie, Kathy Silard, Ken Lalime, Karen Gee, Marie Smith, Tekisha Everette, Pareesa Charmchi Goodwin, Howie Forman, Nancy Yedlin, Lori Pasqualini, Hector Glynn, Ted Doolittle, Kristen Whitney Daniels, Rob Kozior and Jonathan Gonzales-Cruz. | |
| **3.** | **Public Comment** | **Victoria Veltri** |
| | Vicki welcomed public comment; none was voiced. | |
| **4.** | **Technical Team's Recommendations on the Primary Care Spend Target** | **Michael Bailit** |
| | Michael Bailit reviewed the provisions in the Executive Order relating to the primary care spending target, which specify that by 2025, primary care spending should equal 10 percent of total medical spending. The Technical Team is to advise on how primary care spending should be defined and what the interim target(s) should be between 2021-2025. Michael then presented the Technical Team's initial recommendations.<br><br>The Technical Team adopted two definitions of primary care providers and services:<br>1. A narrower definition for measurement against the primary care spending target<br>2. A broader definition for measurement of spending for more comprehensive reporting<br><br>The Technical Team recommended collecting data through direct-payer reports, similar to how data will be collected for the cost growth benchmark. Insurers, Medicaid and Medicare will report primary care spending separate from Total Medical Expenditures. For the purposes of measuring progress against the primary care spending target, Connecticut will not use the All-Payer Claims Database (APCD).<br><br>Michael reviewed the two definitions of "primary care providers" (PCPs), noting that for the purposes of measuring progress against the primary care spend target, OB/GYNs and midwives were excluded from the list of providers. He noted that this recommendation was reached after extensive discussion that included consideration of prior | |

Stakeholder Advisory Board input. In addition, the recommendation was for included providers to be defined as PCPs when delivering care in outpatient settings.

Howard Forman clarified that MDs and DOs are both licensed and noted that DOs should be explicitly included in the PCP definition.

Rick Melita asked about how long-term care (LTC) providers are treated. Michael Bailit indicated that LTC providers are not included in definition of PCP, although this is not meant to imply that they and other providers don't on occasion deliver primary care.

Kathy Silard underscored that for many women of child-bearing age, an OB/GYN is a substitute for a PCP, and many women get routine care, such as well-woman exams from their OB/GYN. Kathy also noted that for many low-income and underserved individuals who don't have access to a regular source of care, ER physicians serve as the PCP and can be instrumental to connecting individuals to the PCP. She recommended including them in the definition of PCPs, along with ER and behavioral health providers that provide primary care.

Tekisha Everette disagreed with the inclusion of ER providers given the ER is not an appropriate setting for providing primary care services and the overall goal is to move people into appropriate settings for care. She also noted that the decision to exclude non-integrated behavioral health providers from the PCP definition creates an artificial barrier between integrated behavioral health and behavioral health in general, and recommended that the Technical Team revisit this decision. Hector Glynn commented that the intent of the legislation was to provide holistic care, including behavioral health and integration of other practices.

Reggy Eadie expressed concern that by narrowing the definition of primary care to exclude ER physicians, we would exclude populations that don't have access to primary care and cause harm to vulnerable communities. He indicated that in some areas with a significant physician shortage, people have no choice but to go to ER for routine care.

Nancy Yedlin indicated that for women, routine medical exams and preventive medical evaluations are provided by OB/GYNs. She recommended including routine, well-woman care in the definition of primary care services.

There was additional discussion about whether or not to include primary care services delivered in ER settings. A majority opposed including such services, but some supported their inclusion noting that many low-income individuals who don't have a regular source of care receive primary care at the ER.

Pareesa Goodwin agreed with the inclusion of behavioral health risk assessments as a primary care service when provided by a PCP. She recommended inclusion of dental screenings as well as it is becoming more of the norm for PCPs to provide those services. She also recommended including fluoride varnish for high-risk cases.

Rick Melita asked about whether routine care provided in LTC facilities was included. Michael noted that the Technical Team so far has not recommended including these services.

Michael Bailit discussed the question of how to define total spending, which would be used for the denominator to determine the percentage of spending that is attributed to primary care. The Technical Team initially recommended using the same definition of total spending as used to calculate the cost growth benchmark, but recommended excluding LTC since LTC is applicable to Medicaid, but not to Medicare or the commercial markets. There were no questions or comments on this recommendation.

Michael Bailit discussed the types of analyses that could be performed to understand primary care spending, including stratifying primary care spending by age group, prevalence of chronic conditions, geography and insurance category. He talked about how OHS could use the APCD for such analysis, but noted the APCD doesn't capture disability status or race and ethnicity data at present. There are means of capturing race and ethnicity using other public data sources, however, and integrating them with the APCD to allow for stratification. However, this cannot be done for disability status.

Kathy Silard supported using data analytics to understand health care cost growth. She indicated that all stakeholders should have access to analytics to be able to replicate and validate information, and monitor spending over time.

Jonathan Gonzalez-Cruz asked how spending on undocumented immigrants who are uninsured will be factored in, noting that it is a large population and accounts for a large amount of spending. Vicki Veltri indicated that the only places spending on this population would be captured would be in emergency medical coverage, which is not primary care, or in COVID vaccinations. The only way to measure this would be to separately obtain data from FQHCs, which would be hard to do.

Michael Bailit asked if there are any parameters that the Stakeholder Advisory Board wanted to recommend for how to increase investments in primary care for those providers and services that are being included.

Kathy Silard indicated that if we increase primary care spending and it's measured as successful by reducing specialty care spending, we need to be conscious that this may reduce access to vulnerable populations' access to specialty care because of low payment rates for those specialty care. Access to specialty care is still a problem, she stated, and there is a need to ensure that the primary care spend target doesn't lead to decreased access to it as an unintended consequence.

Marie Smith indicated that one strategy is to look at expanded care teams. She also suggested making more services billable, noting that there are services provided today that are not included/billed in a fee-for-service environment but are included in value-based payment programs.

Karen Gee emphasized looking beyond just fee increases. Increases in primary care spending should be based on rewarding performance on aspects of care such as access and quality.

Nancy Yedlin commented that a presentation slide footnote that said an increase in primary care spending could be achieved through increased access. She felt this strategy should be elevated from the footnote and should be one of the main considerations for increasing primary care spending.

**5. Introduction to the Data Use Strategy** — **Michael Bailit**

Michael Bailit introduced the concept of a data use strategy, which is a state's strategic use of its data resources to support broader policy objectives. For the data use strategy, the data source is first and foremost the APCD, but can include other databases as well. Data can shed light on where costs are high, growing rapidly, and are variable. Other potential uses of data use strategy are to identify any unintended adverse consequences of a cost growth benchmark, as well as the impact of the cost growth benchmark on consumer out-of-pocket spending. The data use strategy can also be used to look at health disparities and quality more generally. Michael Bailit then presented examples of data analyses that Massachusetts has conducted using its APCD.

Michael Bailit asked the Stakeholder Advisory Board what the priorities should be when defining the data use strategy. He presented the following proposed goals:

1. Produce routine analysis that pinpoint leading opportunities to reduce healthcare spending and healthcare spending growth in a manner that will not harm patients, and to improve quality.
2. Produce ad-hoc analyses in areas of perceived opportunity and that are of specific interest to stakeholders.
3. Interpret analyses and link findings with recommended actions for the intended audiences.

Rob Kozior indicated that one of the key reasons to have a healthcare cost growth target is to bring more transparency on what's going on with healthcare. It allows the State to identify the drivers of cost increases, and to better understand those drivers. He suggested not looking at goals with the level of specificity outlined by the Technical Team. Rather, to use the broader context of transparency on an ongoing basis.

Nancy Yedlin asked whether the project has started to think about issues such as how will ad hoc analyses be prioritized, and how to provide access to data. She suggested developing a framework for how to deal with these issues in an equitable way.

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| | Margaret Flinter suggested rethinking the proposed goal of producing reports that reduce healthcare spending and spending growth as it may trigger unnecessary opposition. The overall goal is really to improve healthcare, and invest in higher value healthcare.<br><br>Michael presented proposed guidelines for the data use strategy which included:<br>1. stratifying by subpopulations of interest to stakeholders;<br>2. designing for statistically valid and reliable results, and<br>3. supporting comparisons to peer organizations and other benchmarks, and display change over time.<br><br>Ken Lalime asked whether risk adjustment would be part of this moving forward, and suggested adding to the guidelines risk adjustment, where appropriate.<br><br>There was discussion about how the messaging to consumers is complicated because the link between the cost growth benchmark to the consumer is not direct. Kathy Gee recognized the complexities and commented that the goal is to level growth. She indicated that the greater the transparency, validation, and reliability in numbers, the more people would react to them positively.<br><br>In terms of additional analyses to consider, Nancy Yedlin suggested looking at episodes of care around the treatment of particular chronic conditions as this allows for performance comparisons. Karen Gee suggested adding site of service (e.g., urgent care vs ED visit) to the types of analyses to consider. | |
| **6.** | **Wrap-up & Next Steps** | **Michael Bailit** |
| | The next meeting is scheduled for September 16, at which time the Stakeholder Advisory Board will engage in a conversation around steps that should be taken to ensure all the strategies the Stakeholder Advisory Board has been discussing will be successful and don't have adverse unintended consequences. | |
| **7.** | **Adjourn** | **Vicki Veltri** |
| | Susan Millerick made a motion to adjourn the meeting, which was seconded by Rob Kosior. There was no opposition to motion to adjourn and the meeting adjourned at 2:55pm. | |