Cost Growth Benchmark Stakeholder Advisory Board

Meeting Date	Meeting Time	Location
February 10, 2021	2:00 pm – 3:00 pm	Webinar/Zoom

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

Attendees		
Victoria Veltri	Nancy Yedlin	Theresa Riordan
Ted Doolittle	Pareesa Charmchi Goodwin	Kathleen Silard
Ken Lalime	Reginald Eadie	Marie Smith
Tekisha Everette	Richard Searles	Jill Zorn
Margaret Flinter	Rob Kosior	
Jonathan Gonzalez-Cruz	Lori Pasqualini	
Others Present		
Vicki Veltri	Krista Moore	Michael Bailit
Kelly Sinko	Hanna Nagy	Margaret Trinity
Members Absent:		
Karen Gee	Fiona Mohring	Sal Luciano
Howard Forman	Hector Glynn	Rick Melita
Susan Millerick	Kristen Whitney-Daniels	

	Agenda	Responsible Person(s)
1.	**Welcome and Introductions**	**Victoria Veltri**
	Vicki Veltri welcomed new member Theresa Riordan of Anthem to her first Stakeholder Advisory Board meeting. Vicki expressed appreciation for the work of the Board.	
2.	**Public Comment**	**Victoria Veltri**
	Vicki Veltri invited public comment. None was voiced.	
3.	**Healthcare Benchmark Initiative Updates**	**Michael Bailit**

Cost Growth Benchmark Measurement

Michael Bailit reported that OHS had started the process for collecting data and performing a pre-benchmark measurement, which entails looking at the cost growth between CY2018 and CY2019. He stated that OHS had met with the carriers in November 2020 to kick off the process and provide education on future data reporting requirements. He said that OHS will publish the results this summer for the 2018-19 analysis. He said these results will include per capita spending growth at the state and health insurance market level, as well as spending growth by major service categories – for Medicaid, Medicare and commercial markets. He added that the pre-benchmark results will not be published at the insurer and provider entity levels, but added that future reporting will include benchmark performance at the insurer and provider entity levels. Michael stated that OHS will be distributing a cost growth benchmark implementation manual to carriers, and that the manual will inform both payer and internal OHS activity. He said that sharing of the implementation manual will initiate the data request of carriers that will lead to the publication of pre-benchmark results during the summer of 2021.

Detecting Unintended Adverse Consequences to the Cost Growth Benchmark

Michael reminded the Board that OHS previously had shared a draft measurement methodology to detect potential adverse consequences from the cost growth benchmark. Michael stated that OHS had received four sets of comments on the monitoring plan, and he shared a summary of those comments. Michael noted that OHS recently followed up with DSS to confirm that the agency would be able to provide some of the data necessary for this plan. He stated that the monitoring measures will serve as an "early warning system" by flagging negative trends that are correlated with the benchmark. He added that the monitoring measures will not be able to indicate whether there is a causal relationship between negative trends detected by the measures and implementation of the benchmark. He added that Oregon is initiating a similar monitoring plan using the work of the OHS advisory bodies as a starting point for developing Oregon's methodology for monitoring its cost growth benchmark.

In response to a question from Ken Lalime, Michael reviewed the timeline for implementation of the cost growth benchmark. He noted that the Technical Team had set benchmark values for 5 years starting with 2021. He added that calculation of the 2020 to 2021 trend will likely not provide a meaningful assessment of performance against the benchmark given the impact of COVID-19. He noted that healthcare spending in 2020 will likely be lower than expected due to depressed demand for care, and that this will lead to a high rate of growth in 2021.

Measuring Costs Associated with Services Delivered to Uninsured Persons

Jonathan Gonzalez-Cruz stated that the data sources being used by OHS do not provide spending information for uninsured populations. He said that Connecticut's 17 community health centers serve 400,000 patients annually of whom 66,000 are uninsured. Jonathan noted that the centers' Uniform Data System collects geography, income, insurance status, race and ethnicity, and social risk factors. He suggested that the best source of data on spending for the uninsured would be the community health centers. Olga Armah added that some data on spending for the uninsured is available on the HRSA website. Ken Lalime noted there is significant variability in data on the uninsured. Michael Bailit stated that OHS will provide future updates on efforts related to assessing costs associated with service delivery to uninsured persons.

Primary Care Spending Target

Michael Bailit stated that the Technical Team had made a recommendation for the primary care spending target for 2021, and had asked the Primary Care and Community Health Reforms Work Group to advise on target setting for 2022-24 as well as for how payers and providers should increase primary care spending. He added that during the first half of 2021, the Work Group will consider approaches to achieving increased primary care spending. He said that during the second half of 2021 -- after the results of the pre-benchmark analysis become available -- the Work Group is charged with developing the primary care spending targets for 2022-2024.

Cost Growth Benchmark and Primary Care Spending Target Reporting Timeline

Michael Bailit reviewed the timeline for cost growth benchmark and primary care spending target reporting. He noted that OHS would conduct a payer briefing later in February on the detailed data reporting requirements associated with the benchmark, and would make a formal data request of the payers. He added that OHS had already made a formal request of CMS for Medicare spending data, and had had multiple conversations with DSS regarding Medicaid data. In response to a question from Ken Lalime, Michael stated that payers will submit aggregate spending data for CY 2018-19 and OHS will validate the data. He added that the payers will provide per member per month spending by several major service categories and lines of business; payers will also be providing data at the Advanced Network level although these will not be reported this year. Michael stated that OHS will publish the pre-benchmark data analysis this summer, and then meet with the Technical Team and Stakeholder Advisory Board to identify where there are opportunities to slow cost growth so that the benchmark can be achieved in the future. He stated that OHS will request CY 2020 data from payers in the fall of 2021.

Ken Lalime asked that the pre-benchmark data analysis be detailed enough so as to be actionable. Michael responded that the data use strategy will allow for the types of detailed analyses that will guide the advisory bodies in identifying opportunities to slow cost growth.

Quality Benchmark Development

Michael Bailit stated that in November 2020, OHS briefed the Quality Council on its charge to recommend quality benchmarks. He added that in December 2020 and January 2021, the Council began updating its Core Measure Set, which had not been updated for several years. After the Council has completed updating of the Core Measure Set, the Council will focus on developing quality benchmarks with the goal of making recommendations to OHS this fall for 2022-25 quality benchmarks. He added that the Quality Benchmarks may include, but not be limited to, measures in the Core Measure Set.

Data Use Strategy

Michael Bailit stated that OHS' contractor, Mathematica, recently completed its initial analysis of the APCD. Mathematica examined commercial insurance cost drivers and cost growth drivers. He said that Mathematica examined trends in spending during the 2015 -2018 time period, and presented findings to OHS in January. He indicated that Mathematica will share its findings with the Technical Team later in February. Michael stated that OHS is scheduling an additional meeting of the Stakeholder Advisory Board in March to review the findings from this analysis. He noted that OHS is enthused about sharing these data with the Board, and discussing what actions the Board might recommend in response to the data analysis.

Michael stated that in response to a question from a member of the Technical Team, staff researched the reliability of race, ethnicity and language (REL) data obtained from the Census Bureau's Current Population Survey (CPS). Michael said that Mathematica had confirmed the integrity of using the CPS REL data for purposes of conducting analyses at a broad population level.

4.	**Criteria for When to Report Provider and Payer Benchmark Performance**	**Michael Bailit**

Michael Bailit reviewed the Technical Team's consideration of the policy question "what criteria should OHS apply for deciding when to report provider and payer performance relative to the benchmark?" Michael stated that OHS will report at the payer and provider entity level against the benchmark for 2021 cost growth in early 2023. He said that at its January meeting, the Technical Team considered how OHS should decide whether or not a payer or provider entity met (or did not meet) the benchmark. He said that the Technical Team recommended that OHS perform calculations of statistical significance when reporting benchmark performance so that there is a high level of confidence in the accuracy of the findings. Michael noted that

	the approach recommended by the Technical Team utilized the same methodology developed by Oregon for the same purpose. Michael added that the Technical Team still needs to decide whether there should be a minimum population threshold for Advanced Networks to be assessed against the benchmark. Michael reviewed the methodology recommended by the Technical Team for performing calculations of statistical significance when reporting benchmark performance. He explained that performance against the benchmark would be determined by developing an upper and lower bound around payer and provider entity performance. Using this methodology, a provider entity or payer will have achieved the benchmark when the upper bound is fully below the benchmark. If a payer or provider entity's performance intersects the benchmark, then OHS will be unable to determine performance against the benchmark. For payers or provider entities with a lower bound that is fully over the benchmark, OHS will make a determination that the benchmark has not been achieved. Michael explained that the upper and lower bound represent a confidence interval or estimate that shows a range of values within which we can be confident that the true value lies. Michael stated that the Technical Team preferred the greater statistical confidence gained from this approach, even though it would require some additional resources in order to calculate the confidence intervals. Michael added that the Technical Team had asked OHS to communicate the methodology in a manner that will be understandable to the general public. Michael reviewed the approach taken by other states to determine minimum attributed lives for public reporting of payer performance. He stated that Delaware, Massachusetts and Rhode Island have generally required those insurers with the largest market share to report. He noted that OHS had adopted a similar approach by requesting that the six largest payers in Connecticut report. Michael stated that Oregon had taken a slightly different approach by including payers and TPAs with at least 5,000 lives in a given market in its public reporting, and that Oregon planned to report all others in aggregate. Jill Zorn asked if there would be any opportunity to get information for self-insured populations. Michael stated that OHS will acquire self-insured information. He explained that OHS' data request of payers will be to report for both their fully insured and self-insured populations. In response to a question from Marie Smith, Michael noted that Connecticut's top six commercial payers are Aetna Health & Life, Anthem, Cigna, ConnectiCare, Harvard Pilgrim Health Care, and UnitedHealthcare. Michael stated that OHS had decided that, like DE, MA and RI, it would require the largest insurers in the state to report, without setting an enrolled lives threshold. Michael stated that the Technical Team had not yet had opportunity to make a recommendation related to minimum attributed lives for public reporting of provider performance. He shared the standards established by DE, MA, OR and RI for minimum attributed lives needed for public reporting of provider performance. He said that OHS will report back to the Board regarding the Technical Team's deliberations on this topic at the Board's April meeting. Jill Zorn stated that health systems participating in a recent meeting of the Health Care Cabinet had reported that they are not doing well. She expressed interest in reporting for the many smaller units that comprise the state's health systems. Michael stated that OHS will treat complex entities, for example, Hartford Healthcare, as a single entity for reporting purposes. He added that this is necessitated by the lack of a definitive Connecticut provider directory. He noted that the State is in the process of developing a provider directory through its HIE but that this will not be available for use in 2021. Kathleen Silard noted that every health care system allocates costs differently, and that this will make benchmark comparisons difficult. She added that OHS will need to examine the continuing impact of COVID-19 on hospitals. She stated that vaccine distribution had resulted in significant unexpected costs for hospitals. She asked OHS to consider in the future how these costs might be accounted for. Reginald Eadie expressed his agreement. Michael noted that the benchmark measures spending by payers to providers, and not costs incurred by providers. He added that OHS may wish to note in its pre-benchmark analysis that the report does not provide a complete picture of costs incurred by providers during these unique times.	
5.	**Stakeholder Engagement**	**Michael Bailit**
	Michael stated that in 2021, OHS planned to continue with stakeholder engagement with a focus on seeking the input of consumers, especially Black, Indigenous, and People of Color Communities (BIPOC). Michael noted that OHS will continue to provide briefings to legislators, MAPOC, hospitals, payers, providers, employers, and other stakeholders.	
6.	**Adjourn**	**Vicki Veltri**
	Ken Lalime made a motion to approve the minutes from the Board's November 17, 2020 meeting. Reginald Eadie seconded the motion. No objections or abstention to approval of meeting minutes were voiced. The meeting adjourned at 3pm.	