OHS CONNECTICUT Office of Health Strategy

Cost Growth Benchmark Technical Team Meeting

Meeting Date	Meeting Time	Location
Wednesday, July 29, 2020	1:00pm – 3:00pm	Webinar/Zoom

Participant Name and Attendance

Cost Growth Benchmark Technical Team Members Present					
Pat Baker		Paul Lombardo		Judy Dowd	
Judy Dowd		Rae-Ellen Roy			
Paul Grady		Vicki Veltri			
Angela Harris		Kate McEvoy			
Members Absent					
Luis Perez					
Zack Cooper					

Others Present		
Michael Bailit, Bailit Health	Olga Armah, OHS	
Deepti Kanneganti, Bailit Health	Jason Prignoli, OHS	
Margaret Trinity, Bailit Health		

Meeting Information is located at: https://portal.ct.gov/OHS/Pages/Cost-Growth-Benchmark-Technical-Team

	Agenda	Responsible Person(s)
1.	**Welcome and Introductions**	**Victoria Veltri**
	Victoria (Vicki) Veltri called the meeting to order at 1:04pm.	
2.	**Public Comment**	**Victoria Veltri**
	Vicki Veltri invited public comment; none was voiced.	
3.	**Revisiting the Cost Growth Benchmark Values**	**Michael Bailit**
	Michael Bailit provided a recap of the Technical Team's prior meeting discussion during which a few members expressed their concern that the benchmark was too low in initial years. In response to those concerns, Michael shared two options for alternate cost growth target values during the early years of the program: the first option would add 0.5% to the benchmark's base value for the first two years, and the second option would add 0.5% to the benchmark value in 2021 and then 0.3% in 2022. He noted that both options continue with the PGSP /Median Income blend that was reaffirmed by most Technical Team members during the last meeting. He said that the new baseline values under each option would be in line with the initial values implemented by other benchmark states in terms of relationship to historical trend and still meet the Technical Team's goal of increased affordability. Pat Baker stated that the stakeholder feedback that caused the Technical Team to reexamine the benchmark value in its early years was appropriate and she was willing to adjust the benchmark value. Pat expressed her preference for the second option with a benchmark value of 3.4 percent in 2021 and 3.2 percent in 2022, stating that this would reflect both flexibility and a commitment to OHS' goal. Rae-Ellen Roy, Paul Grady, Angela Harris and Vicki Veltri agreed with Pat Baker's statement.	
4.	**Primary Care Spend Target**	**Michael Bailit**
	Michael Bailit shared information provided by two Stakeholder Advisory Board members about the outcome of two primary care-focused efforts in the State. The first was that a state employee union negotiated a requirement that individuals see their primary care provider (PCP) in 2011, at which time 40 percent of employees lacked a PCP. After the first year of implementation, there was no net increase in costs, despite almost 100 percent of employees having formed a relationship with a PCP. The second was that insurer data has reportedly shown high-performing medical groups that manage spending well experience primary care utilization that is typically higher than low-performing groups, and lower specialty spending. Rae-Ellen Roy clarified that the first effort described by Michael was, in fact, for the entire state-covered population (not just for one union) and applied to general physical services obtained from any provider. She commented that this first effort reduced the number of individuals who lacked a PCP or did not utilize PCP services regularly to 20 percent. Michael said that the Board considered two key questions related to the definition of primary care: who are primary care providers, and how to define total spending? He promised to share the Stakeholder Advisory Board's input, and noted that this distinction was an important one because primary care physicians and specialist sometimes deliver the same services. He said that as a result, the Technical Team will need to define both the provider type and the services that constitute primary care. Michael noted that the more services and providers grouped in the primary care definition, the fewer resources there will be available to invest in primary care relative to the primary care spend target. He stated that the Governor's goal with the primary care spending target was likely to increase investment in the State's traditional primary care delivery system.	

Michael said that Rhode Island and Oregon are the two states that currently have primary care spend targets. Rhode Island has had its target for 10 years, and Oregon for just a few years. He reviewed the definitions of primary care providers utilized by Rhode Island, Oregon, and the definitions developed by New England States Consortium Systems Organization (NESCSO), a non-profit organization governed by the New England State Health and Human Services agencies and the University of Massachusetts Medical School, that is currently working to calculate primary care spending in a standard way across six participating New England states. Michael reported that the NESCSO analysis of Connecticut primary care spending was taking a bit longer than expected, but that OHS would share it with the Technical Team when it became available.

Michael noted that there was consensus across Rhode Island, Oregon and NESCSO to include family practice, general practice, internal medicine, pediatrics, and geriatrics in the definition of primary care physician specialties. He said that Rhode Island includes behavioral health providers only if they are accepting the role and fees of a PCP (Michael noted that this rarely happens). He said that Oregon includes psychiatry and general psychiatry among primary care providers, as required by the legislature. NESCSO does not include behavioral health providers in its definition of primary care providers. Michael shared that many states are now advancing primary care payment reform in order to sustain practices during the COVID-19 pandemic. Colorado is one such state and he noted that Colorado has emphasized the integration of behavioral health and primary care, and as a result includes behavioral health services in the definition of primary care only when the behavioral health clinician is part of the primary care practice.

Oregon includes OB/GYNS as PCPs because the legislature requires the State to do so. In Colorado, the State includes OB/GYN physicians only when practicing general primary care. Michael noted the difficulty of implementing this definition. Oregon includes naturopathic health care providers in the definition of primary care providers, but neither Rhode Island nor NESCSO do so. Michael reviewed primary care clinics, federally qualified health centers (FQHCs), rural health centers (RHCs) and school-based clinics, noting that NESCSO includes all of these in definition of primary care providers, but Rhode Island neither explicitly includes or excludes these practice types, and Oregon includes primary care clinics, FQHCs and RHCs in the definition of primary care providers.

Michael said that Oregon includes OB/GYNs and psychiatric providers in its definition of primary care providers, but a 2017 OHA report found that only 0.4 percent of all claims-based primary care spending was allocated to these providers when defined as PCPs. Michael recalled that during its last meeting, the Technical Team discussed at length whether OB/GYNs should be considered primary care providers. He reminded the Team that one of its members had noted that the state health plan experience is that 15 percent of women use an OB/GYN as their primary care provider. He also said that Technical Team members had noted that many women enter the health care system through their OB/GYN relationship, and that OB/GYNs may be a primary source of women's care in underserved communities. Michael shared some new information with the Technical Team in order to offer guidance on OB/GYNs serving as primary care providers, noting

- guidance from the Cleveland Clinic that OB/GYNs can serve as PCPs for women who are generally healthy, but not for women with a strong family history of disease;
- findings of a recent Commonwealth Fund report, "Transforming Primary Care for Women," which were consistent with the Cleveland Clinic's guidance that younger and healthier women can be well served for primary care services by OB/GYNs, but that as women age, they require the care of a PCP;
- the Connecticut Quality Council decided not to define OB/GYNs as PCPs in 2018, but the Council recently had an extended conversation with a variety of views on this subject during its July meeting;
- New England states participating in the NESCSO study agreed that while many women view their OB/GYN as their PCP, OB/GYNs do not provide the continuum of care included in commonly accepted definitions of PCPs, and
- a 2014 study that found PCPs were nearly 2.5 times as likely as OB/GYNs to address problems such as mental health issues, circulatory, respiratory and digestive diseases among others.

Michael shared concerns expressed by several members of the Stakeholder Advisory Board that excluding OB/GYNs and behavioral health providers may dis-incentivize use of these providers; Michael added that he felt these concerns indicated a misunderstanding of the function of the primary care spend target. He noted that three Stakeholder Advisory Board members objected to defining OB/GYNs as PCP. Michael shared recommendation offered by the Board, the first of which was to examine OB/GYN services and identify which are primary care-focused and which are specialty-focused. The second recommendation was that the Technical Team consider inclusion of OB/GYN, behavioral health, emergency room and dental providers, as they all can perform primary care-focused services.

Michael then asked the Technical Team based on the guidance he shared and Stakeholder Advisory Board input, how did the Team recommend primary care providers be defined? Pat Baker said that she was inclined to include GYN services in the definition of primary care providers; otherwise the definition would exclude women who receive care from clinics such as Planned Parenthood, and who view these clinics as their primary care provider. Michael observed that if the Team included non-

OB and non-specialty GYN services, the target would then encourage payers to increase their investment not only to primary care providers, but also to OB/GYNs. Vicki noted that OB/GYNs are highly compensated. Pat Baker agreed that deliveries should not be included as primary care services, but that young women accessing clinics are receiving primary care services from OB/GYNs. Michael noted that insurers might have difficulty in identifying the subset of OB/GYN services that are primary care services for investment purposes. Rae-Ellen Roy encouraged the Technical Team to discuss what services are considered primary care services first.

Michael reviewed the categories of codes that are included in various definitions of primary care by Rhode Island, Oregon and NESCSO. He noted that Oregon and NESCSO both define behavioral health risk assessments, screening and counseling as primary care services, but only when they are delivered by a classified PCP. He shared feedback from the Stakeholder Advisory Board, noting that some members felt that GYN services are primary care services, regardless of who provided them. He said that one Board member encouraged including routine oral health care in the definition of primary care services. This Board member noted that if the State did not wish to crowd the definition of primary care spending, it could create a separate oral health-focused definition.

Rae-Ellen Roy stated that she was comfortable with including the services included in various definitions of primary care as presented on slide 24. She asked why hospice care would be included as primary care; Michael said that an individual in hospice does not receive physician care from the hospice.

Paul Grady commented on a recent multi-stakeholder call where there was strong support for integration of behavioral health in primary care; he stated that he supported inclusion of behavioral health in the definition of primary care services. He asked if it would be feasible to measure or encourage such integration by means of the primary care spend target. Michael discussed the data challenges associated with measuring behavioral health delivered in a primary care setting. He said that for right now the Technical Team could exclude behavioral health services in the definition of primary care services, which is the approach that Oregon and NESCSO have taken, but could also broaden its approach such that behavioral health services do not have to be delivered by the PCP but could be delivered by the practice. Paul Grady expressed his support for this approach. Paul said he is was okay with naturopaths not being included in the definition of primary care providers.

Rae-Ellen Roy said she felt that routine gynecological services should be included if they are provided in a primary care setting, but she would also prefer inclusion of primary care services delivered by an OB/GYN. Michael said that we would need to determine if we can identify which OB/GYN office visits could be classified as primary care services. Rae Ellen Roy asked what percent of services provided by OB/GYNs are preventive and primary care services. Michael said he was not sure how OB/GYN service are billed, and would need to explore this further. He said that for these purposes, he does not have confidence in the findings of the 2017 Oregon Health Authority report, which found that approximately 0.4 percent of all claims-based primary care spending was allocated to OB/GYNs and psychiatric providers defined as PCPs.

Paul Grady suggested including FQHCs as PCPs, because FQHCs seem like they are providing a lot of primary care services. Vicki noted that not all services provided by FQHCs are primary care services, so counting the primary care services that they do provide makes sense, but not counting FQHCs as primary care providers. Vicki noted that including behavioral health as part of a primary care practice in order to encourage primary care teams, and to not include LCSWs, would dis-incentivize that team approach to delivering primary care services.

Vicki said that one of the purposes of the target was to resource primary care and the more providers and services included in the primary care definitions, the fewer resources will be devoted to primary care providers/services more broadly. Michael said that the Team could establish two definitions; the first for tracking primary care spending that is inclusive of primary care delivered by OB/GYNs, and the second for focusing increased investment in primary care services that is delivered by traditional primary care specialties. Rae-Ellen Roy expressed support for this approach, as did Judy Dowd. Pat Baker said she was not sure.

Michael recapped the Technical Team's tentative recommendations thus far.

- Include the following provider types in the definition of primary care providers: primary care MD specialties (family practice, internal medicine, pediatrics, geriatrics), and NPs and PAs in primary care settings.
- Include behavioral health services when they are delivered by a primary care practice.
- Utilize two definitions: 1) the first, for purposes of the target which does not include OB/GYNs, and 2) a second for purposes of tracking of primary care spending, which includes non-specialty services provided by OB/GYNS (primary and preventive care, and non-specialty GYN services).
- Include primary care services delivered by FQHCs, but not specialty services delivered by FQHCs.

	Michael noted that FQHCs have mental health services that are part of the FQHC, and asked if the Team recommended including behavioral health when it is part of an FQHC even though it may be a specialty practice. Pat Baker said that HRSA has pushed for a long time to integrate primary and behavioral health care in FQHCs. Vicki asked for Kate McEvoy's perspective on FQHC services being counted as primary care. Kate said that DSS distinguishes claims as medical, behavioral, dental, and noted that the premise of PCMH is co-located and integrated behavioral health care services in a primary care setting. She noted, however, the encounter is not paid on an integrated basis so it would be premature to include behavioral health services provided by FQHCs at the moment. Michael said he felt that except for behavioral health services delivered by a PCP, we will not be able to include such services delivered at the same site as a primary care practice. Michael said he would document the Technical Team's preliminary recommendations for their review at next Technical Team meeting. Michael welcomed additional input via email.	
5.	**Defining Primary Care Payments**	**Michael Bailit**
	Michael explained that Rhode Island defines services payments as paid medical claims, as does Oregon. He noted that Rhode Island did so because health plans have the ability to only control paid amounts, and Oregon did so because legislators focused on plan investments in primary care. He said that paid amounts do not include the patient portion. Michael reviewed the pros and cons of these approaches, noting that utilizing paid medical claims captures the spending amount that health plans can control. He said the advantage of using allowed medical claims is that it captures total health care spending because it includes the patient portion (although patient cost sharing is smaller for primary care than for other services). He asked the Technical Team if it preferred utilizing paid or allowed medical claims. Paul Lombardo stated that he sympathized with Rhode Island's rationale, but total medical expenditure is actually allowed medical claims, so utilizing allowed medical claims was his preference. Pat Baker and Rae-Ellen Roy agreed, as did Kate McEvoy, Paul Grady and Angela Harris. Kate McEvoy noted that there is no out-of-pocket spending in Medicaid. Michael asked the group to consider how it wishes to define non-service-based payments, which can include payments for care management, PCMH infrastructure, pay-for-performance, shared savings distributions, capitation, episode-based payment, and EHR/HIT infrastructure, and a fairly large category of other types of non-service-based payments (e.g., behavioral health screen in primary care settings, patient navigators, etc.). Michael shared information on the approach taken by Rhode Island, Oregon and NESCSO to non-service-based payments, noting that by and large they are similar and inclusive. Michael noted a fairly new category of such payments, federal COVID-19 support payments, which Rhode Island, Oregon and NESCSO have not yet determined how to handle. Michael said that NESCSO has taken the most inclusive approach, which is what he recommended – to include all these payment types as non-service-based payments. Rae-Ellen Roy and Paul Lombardo agreed that it made sense to include as many of these non-service-based payments as feasible. Kate McEvoy expressed her agreement, but noted that the Team should be cautious about including COVID-19 payments as they address extraordinary costs. Michael said he was not sure in any case as to feasibility of including the COVID-19 payments. Vicki Veltri noted that COVID-19 payments are likely to be one-time payments. Michael said that it was possible that there will not be need for additional COVID-19 payments in 2021. Michael transitioned the Technical Team to discussion of three topics related to calculation of primary care spending target: defining total payments, defining the population, and defining the payers. He noted that the Technical Team had the option of aligning its recommendations on these topics with those it had made for the cost growth benchmark. He shared several advantages to aligning the definitions. For example, doing so would reduce the reporting burden on payers. He noted, however, that if the Technical Team aligned its recommendations with those for the cost growth benchmark, this may create non-alignment with other states in terms of their approach to measuring primary care spending. Michael explained that the calculation of total payments is the denominator for the primary care spending target calculation, and that said there were a few key spending categories that differed in terms of inclusion among states. He said that the Technical Team could either choose to recommend the same definition of total payments as that utilized for the cost growth benchmark, or a separate definition. Michael noted that the Connecticut cost growth benchmark included in its definition total spending for prescription drugs (including pharmacy rebates), lab and imaging services, and long-term care. He noted that including long-term care in the definition of total spending could be problematic for making comparisons across commercial, Medicaid and Medicare markets, and said that Rhode Island, Oregon and NESCSO had all excluded it. He stated that the Stakeholder Advisory Board was supportive of excluding long-term care from the definition. Michael said that the benefit of including more categories in total spending was that it made the calculation of total medical expenses more comprehensive. Michael asked if the Technical Team wished to make recommendations that aligned with those for the cost growth benchmark; as an alternate he suggested that the Technical Team could use the same definition as cost growth benchmark but exclude long-term care. Paul Lombardo expressed support for removing long-term care from the total spending calculation. Pat Baker, Rae-Ellen Roy, and Angela Harris agreed. Paul Lombardo and Paul Grady expressed support for using the same definitions as for benchmark, with the exception of long-term care.	

Kate McEvoy said it was essential that pharmacy rebates be taken into account, and that the Technical Team needed to annotate its recommendations to describe this. She said that DSS has been constrained from releasing information regarding its rebates, and anticipates this will be a difficulty.

Vicki Veltri noted that pharmacy rebates help Medicaid and other programs reduce overall spending, but obscure prices for pharmaceuticals.

Michael next asked the Technical Team which patient population to include in the primary care spending calculation. He reminded the Technical Team that the cost growth benchmark did not include out-of-state residents, but included in-state residents and both in-state and out-of-state providers. He noted that Rhode Island included out-of-state residents, and Oregon did so as well, but only for public employees and educators.

Michael asked the Technical Team if in defining the population for primary care target it would prefer an approach other than that which it had undertaken for defining the population for the cost growth benchmark. Pat Baker and Paul Lombardo said no.

Paul Lombardo raised the question of whether to include out-of-state primary care providers. Michael said that OHS was including out-of-state providers for the benchmark, but the objective for the primary care spend target was different because it is trying to increase investment within the cost growth benchmark for primary care.

Pat Baker noted that we are ultimately doing this in order to help improve outcomes for CT residents, and she thought the technical team should stick with the same population definitions as it recommended for the benchmark. No one expressed disagreement.

Michael next discussed the topic of defining which payers to include in the calculation of the primary care spending. He noted that the Governor's Executive Order calls for measuring primary care spending across public and private payers in the State, but said that it was likely only feasible to collect data for Medicaid, Medicare and commercial payers. He noted that it would be difficult to collect primary care data for VHA and state correctional facilities, and that primary care spending for these categories was likely a very small fraction of overall primary care spending. Vicki noted that there had been some beginning discussions with OPM and VHA about extracting primary care spending data for incarcerated individuals and Veterans respectively, but that securing these data would likely be challenging, especially for incarcerated populations. Kate McEvoy said that corrections would likely not be able to support this effort, but the VHA might. Michael expressed skepticism that the VHA would be willing to break out primary care spending. Pat Baker said she would prefer to try to secure primary care spend data from VHA. Angela Harris agreed and said she would also like to secure corrections data, if feasible. Michael committed to do research on breaking out primary care spend data for VHA services.

Michael said that the Executive Order calls for including Medicare in the primary care spend target, but Bailit Health contacted CMS and CMS indicated that it was unlikely that it would be able to provide Connecticut-specific aggregate Medicare primary care spending. Kate McEvoy said she was not surprised, and suggested Dawn Lambert at DSS may be a good contact for Bailit Health as CMS is providing refreshes of data for dual eligibles.

Michael clarified that we are looking for CMS, the insurers to give report aggregate spending for just primary care. Kate McEvoy said that she would ask her staff if they could provide an aggregate primary care spend file for Medicaid, augmenting it with Medicare data for dual eligibles. Kate noted that if we do not have the Medicare data, we will not have an accurate picture of spending for duals. Michael promised to follow up with Kate.

Michael said that the Technical Team could consider a hybrid approach. He explained potential challenges with this approach, noting that a hybrid data collection method would diverge from the Technical Team's initial recommendation to collect data through payer reporting. Further, he said that Medicare data may not be aligned with payer-reported commercial data and Medicaid data due to limitations on non-claims-based data available via the APCD. Finally, he noted that there could be quite a delay in terms of when Medicare data would be available via the APCD.

Michael observed that not including Medicare primary care spend data in the target may make it more feasible for Connecticut to reach the Executive Order's 10 percent target, because the Medicare population experiences much more spending on acute and specialty services. This issue aside, Michael stated that he did not think it would be operationally feasible to include Medicare in the primary care spend target because CMS has stated that it cannot provide these data, and if OHS were to use APCD Medicare data, there would be a considerable time lag. Milbank Memorial Fund's Rachel Block commented in the chat that the Commonwealth Fund will have FFS Medicare primary care spend data available in its state scorecard by September. Kate said that she understood the technical complexities, but if there was some way to do it, she would like to. Michael said he

	would like to include Medicare, but did not see how to do so in a timely fashion. He noted that OHS could include Medicare at a later date, but that it might be significantly later (e.g. two years). Pat Baker said she agreed that theoretically Medicare should be included in the primary care spending target calculation, but she appreciated the challenges that Michael described. She said that including Medicare would be her preference, although it may not be feasible, and that perhaps two reporting periods would be a feasible approach. Michael noted that neither OR nor RI include Medicare. The sentiment of the Technical Team was to include Medicare if at all possible, and continue to explore methods for inclusion. If it is necessary to report two separate times, so be it. Michael next asked the Technical Team for its input on the topic of from which payers OHS should collect primary care spend data. He shared with the Technical Team an analysis performed by Bailit Health with data provided by Paul Lombardo that indicated a handful of Connecticut insurers and TPAs cover or administer coverage for 96 percent of commercially covered lives in the State. Michael stated his recommendation that OHS should only collect primary care spend data from insurers meeting a threshold size in terms of covered lives. Paul Grady and Rae-Ellen Roy expressed support for this proposal. Michael promised to share Oregon's work on the topic of setting a covered lives threshold for insurer submission spend data. Michael commented that the Executive Order aims for increased primary care spending as a percentage of total health care spending of 10 percent by 2025. At its next meeting, the Technical Team will consider a step-wise approach for achieving this goal by 2025. Michael stated that he hoped that NESCSO's analysis would be complete in time for the Technical Team's next meeting, as he believed that the NESCSO data would serve as the basis of future calculations for setting the target. The Technical Team concluded its discussions at slide 55 of the July 29 slide deck. Michael told the Technical Team that at its next meeting he would present a summary of the Team's preliminary recommendations related to the definition of primary care, particularly for primary care services and primary care providers. He said he would send out a summary of the Team's preliminary recommendations in the slides for the next meeting. Michael stated that the Bailit Health team would conduct further research and exploration on securing primary care spend data from the VHA, and that it would explore avenues for possibly securing primary care spend data for Medicare. Michael stated that at the Technical Team's next meeting, the Team will spend complete its work on the primary care spending target, and then shift to discussion of the data use strategy.	
6.	**Approval of Previous Meeting Minutes**	**Vicki Veltri**
	Paul Grady made a motion to approve the Technical Team's July 2nd meeting minutes. Pat Baker seconded the motion to approve the minutes. The minutes were approved by a roll call vote with Judy Dowd, Kate McEvoy, Paul Lombardo, Rae-Ellen Roy, Angela Harris, Paul Grady and Pat Baker voting affirmatively.	
7.	**Adjourn**	**Vicki Veltri**
	Vicki noted that the Technical Team's recommendations will be shared through a public hearing process. Michael Bailit thanked the Team for its active and thoughtful engagement. Angela Harris made a motion to adjourn the meeting and Pat Baker seconded the motion. The meeting adjourned at 2:50pm.	