Cost Growth Benchmark Technical Team Meeting

Meeting Date	Meeting Time	Location
Thursday, August 13, 2020	1:00pm – 3:00pm	Webinar/Zoom

Participant Name and Attendance

Cost Growth Benchmark Technical Team Members Present		
Rebecca Andrews	Kate McEvoy	
Patricia Baker	Luis B. Perez	
Zack Cooper	Rae-Ellen Roy	
Judy Dowd	Vicki Veltri	
Paul Grady		
Angela Harris		
Paul Lombardo		
Members Absent		
Others Present		
Michael Bailit, Bailit Health		
Deepti Kanneganti, Bailit Health		

Meeting Information is located at:

	Agenda	Responsible Person(s)
1.	**Welcome and Introductions**	**Victoria Veltri**
	Victoria (Vicki) Veltri called the meeting to order at 1:01pm.	
2.	**Approval of July 29, 2020 Meeting Minutes**	**Victoria Veltri**
	Paul Lombardo made a motion to approve the Technical Team's July 29, 2020 meeting minutes. Pat Baker seconded the motion to approve the minutes. The minutes were approved by a roll call vote with Vicki Veltri, Pat Baker, Paul Grady, Luiz Perez, Angela Harris, Zack Cooper, Rae-Ellen Roy, Paul Lombardo, Kate McEvoy and Judy Dowd voting affirmatively. Rebecca Andrews was not present at the time of the vote.	
3.	**Public Comment**	**Victoria Veltri**
	Vicki Veltri invited public comment; none was voiced.	
4.	**Primary Care Spending Target Methodology**	**Michael Bailit**
	<u>Continued Discussion of Topics from the July 29, 2020 Meeting</u> Michael Bailit shared that the Technical Team previously agreed to recommend two definitions of primary care spending – a narrower definition for measurement against the primary care spend target and a broader definition for measurement of primary care spending more comprehensively. The narrow and broad definition of primary care providers are identical, except the narrow definition excludes OB/GYNs and midwifery. The Technical Team previously expressed interest in including integrated behavioral health providers and services in the future. Pat Baker and Paul Grady shared that this definition was consistent with what they recalled from the prior meeting. Michael Bailit then summarized that the narrow and broad definition of primary care services are identical, except the narrow definition does not include routine primary care and non-specialty gynecological services delivered by OB/GYNS and midwifery. Rae-Ellen Roy, Paul Grady and Pat Baker shared that this definition was consistent with what they recalled from the prior meeting. Michael noted that following the last meeting, a member raised a question around the inclusion of children's preventive dental care services. Michael Bailit noted that such services are not explicitly included in the Technical Team's definition, but the Technical Team can choose to include fluoride varnish, since it is a standard pediatric primary care service. Kate McEvoy strongly recommended including the service from a Medicaid standpoint. No Technical Team member expressed concern with its inclusion. Michael also noted that a member also asked after the last meeting if home visits for newborns, as supported in the Primary Care Modernization project, was included in the definition of primary care services. Vicki Veltri clarified that such home visitations were included as part of a flexible payment structure in a primary care bundle. Michael Bailit shared that its inclusion likely would not have a significant impact on spending. Pat Baker expressed a preference for including the service, as it is important. Judy Dowd agreed with Pat Baker and asked if it was billed to the child or the mom. Michael said he was unsure. No Technical	

Team member expressed concern with its inclusion. Luis Perez stated that he wanted to also highlight behavioral health risk assessments as performed by a PCP. Michael Bailit said this service was already explicitly included, and Luis expressed support.

The Technical Team confirmed that it approved the previously shared definition of primary care providers and services, with the addition of children's preventive dental care services (fluoride varnish) and home visits for newborns.

Michael Bailit summarized the Technical Team's additional recommendations from the July 29th meeting, including use of allowed claims to calculate service-based payments; adoption of NESCSO's definition for non-service-based payments; adoption of the definition of total spending from the cost growth benchmark, excluding long-term care; adoption of the population measured for the cost growth benchmark and NESCSO (i.e., in-state residents and all providers); inclusion of commercial and Medicaid payers, Medicare (noting that OHS will likely need use APCD data and not payer-reported summary data for Medicare); inclusion of Veterans Health Administration, if feasible; and collection of data only from insurers and TPAs that meet a minimum size requirement.

Setting the Target (Part 1 of 2)

Michael Bailit summarized some remaining questions the Technical will need to consider to set the target, including "What is baseline spending and how does it differ by market?", "Should the statewide spending calculation be weighted by total market spending or by total market population?" and "At what level should performance be reported?" He added that baseline spending helps inform how much Connecticut will need to increase primary care spending annually to reach the 10 percent target by 2025. Michael shared that the Connecticut has pulled together initial data for the NESCSO calculations, but the data are not complete.

Michael Bailit introduced the first question on baseline spending. He reminded the group that it previously recommended that payers report data for the primary care spend target, similar to reporting for the cost growth benchmark. Given this information, Technical Team staff recommended that Connecticut establish baseline spending using payer-reported summary data. Michael Bailit added that other states, like Rhode Island, collected historical data for establishing baseline spending when collecting the initial set of primary care spend data. He suggested that the Technical Team recommend the same approach (i.e., collect 2018 and 2019 data in the first year of reporting). Technical Team staff recommended that to set the annual targets, OHS would subtract baseline spending from 10% and divide by five.

Pat Baker shared that she thought such a process to set annual targets was too arbitrary and did not capture start-up spending that may be related to implementing value-based payments. She did not have a specific counter proposal in mind. Angela Harris said one avenue to increase primary care spending could be through increasing utilization, e.g., tracking the number of people using the system. This would build upon previous efforts to increase enrollment and allow Connecticut to track engagement with the health care system. Michael Bailit said this was a good idea and that the Technical Team was scheduled to discuss the topic of *how* to increase primary care spending.

Michael Bailit recommended revisiting the topic of target setting later in the meeting following the discussion of how to increase primary care spending.

Kate McEvoy shared that she supported NESCSO's approach for calculating spending, as she is often asked about Connecticut's performance relative to other states. She asked if NESCSO will have better and more complete data in the future. Michael Bailit said the challenge with NESCSO is that its data are missing over half of the commercial market. He said NESCSO's information will still have value, but it will not work well for the purpose of setting spending targets.

Michael Bailit introduced the second question on calculating a statewide primary care spend value. He said calculating statewide spending varies if calculating the weighted average using the population size or the total health care expenditures. If weighting by population size, overall primary care spending will be higher as a percentage of total health care expenditures. If weighting by total health care expenditures, however, it is lower. This is primarily because of Medicare, which has a sicker population that spends more on specialty care relative to primary care.

Paul Lombardo confirmed that the objective of this effort was to increase primary care spend to 10% of total health care expenditures. He therefore expressed a preference for weighting using total health care expenditures. Paul Grady agreed with Paul Lombardo.

Michael Bailit introduced the third question on which levels of spending to report. He noted that while the State is obligated to report statewide spending, it can choose to report additional levels. He shared that Oregon publishes an annual primary care spending report by insurance market and by insurer. Michael Bailit asked for the Technical Team's feedback on which levels to report, if any.

Pat Baker noted that big hospital systems can impact spending and wondered if it would be valuable to report spending at the health system level. Michael Bailit said the objective for setting the primary care spend target is to increase payer investment in primary care. For this reason, he said that it was most relevant for Connecticut to report at the payer level and state level. He added that one could, however, look at spending by hospital system, even though it is not entirely relevant for the target's policy objectives. Rae-Ellen Roy and Luis Perez said for the sake of transparency, Connecticut should report by state, market and provider. Kate McEvoy, Angela Harris and Paul Grady agreed with Rae-Ellen Roy, Luis Perez and Pat Baker.

Paul Grady asked if health systems could be obstacles to more spending on primary care. Michael Bailit said they could be, based on who they decide to hire and which services they decide to offer. Pat Baker noted that Yale is divesting its primary care centers because they are not profitable. Michael Bailit highlighted that this is not entirely Yale's fault, as the payment system is set up in a way that encourages specialty care. Paul Grady said insurers may be willing to pay more for primary care, but health systems need to execute strategies that will enforce this. Therefore, it may be worthwhile to make bigger health systems accountable for increasing primary care spending. Michael Bailit agreed, noting that if there is more spending on primary care, primary care becomes more financially viable. He encouraged Paul Grady to raise the issue of holding health systems accountable when discussing the data use strategy.

Complementary Analyses to Understand Primary Care Spending

Michael Bailit asked the Technical Team which analysis would be of use to better understand primary care spending. He said some feasible analysis could include analyzing spending by age, comorbidity, geography and/or insurance category. He added that the APCD does not capture disability status or race/ethnicity information effectively. However, linking APCD data with Census data allows for stratification by geography (e.g., zip code) and thereby by imputed race/ethnicity.

Michael Bailit shared that the Technical Team previously expressed interest in analyzing spending at the provider level. He said additional analyses can look at total spend for certain populations (e.g., patients seen by a specific IPA). These analyses would require risk-adjustment, as sicker populations have less spending on primary care relative to acute and specialty care. Pat Baker confirmed her interest in these analyses.

Angela Harris encouraged the Technical Team to consider how to better get race/ethnicity data, highlighting that lack of data is often used as a rationale for not focusing on the issue. Michael Bailit and Vicki Veltri agreed with Angela Harris. Pat Baker asked if Connecticut could use a robust HIE to collect these data, noting that 90 percent of providers collect race/ethnicity data in the HIE. Michael Bailit said it was possible with a robust HIE. He added that race/ethnicity data may not be collected in a uniform format in the HIE and that the HIE likely does not include disability data.

Luis Perez cautioned the group to not be expedient and use Census data because of lack of race/ethnicity data because certain race/ethnicity groups have lower response rates to the Census. He recommended using a number of different data points to mitigate any limitations of individual data sources.

Rebecca Andrews said stratifying spending based on multiple comorbidities is really important, as each comorbidity is associated with an increase in spending on medications and other costs. These high costs then lead to a decrease in patient adherence.

Kate McEvoy said where it is feasible, OHS should push to collect race/ethnicity data. She added that the Husky Health does collect race/ethnicity data, which OHS could use to augment APCD data. She supported Luis' comment to not immediately use proxy data because of lack of other data. She said Husky Coverage Group C would be a helpful standpoint when it comes to age and disability status. Medicaid race/ethnicity data is a self-reported field and is constrained by the fields dictated by the federal government, but it is available if needed. Michael Bailit asked Kate what percentage of data includes race/ethnicity data. Kate said historically the percentage had been high, but she would ask her team for more information.

Paul Grady said it would be helpful to have complementary analysis to assess how a) ACOs are performing, b) trends associated with virtual care, and c) information on what percentage of primary care spending is through FFS or an alternative payment model.

Parameters for How Spend is Increased

Michael Bailit noted that with any policy, there is a possibility for unintended consequences. He shared that Rhode Island wanted its target to encourage innovative contracting and payment as well as primary care system investment. It did not want insurers to simply change rates of reimbursement for specific codes in order to meet its target. Therefore, it specified that insurers could not increase premiums or engage solely in fee service manipulation to meet the primary care spend target. He added that the Stakeholder Advisory Board expressed interest in Rhode Island's approach and wanted to encourage insurers to utilize value-based incentives in order to increase primary care spending.

Michael Bailit asked if the Technical Team had any recommendations on how payers should increase spending to meet the target. Vicki Veltri noted that there will be a separate primary care-focused work group that will discuss this strategy in detail and therefore the Technical Team does not need to be too prescriptive.

Pat Baker said payers should be doing this in alignment with existing statewide initiatives and policies. She added that spending should provide value, which to her is improving quality, increasing utilization and access and improving outcomes. She shared that her ultimate goal is to improve health in Connecticut. Pat added that she wanted to ensure that raising fees increased value.

Luis Perez said that as the process evolves, there were will more data available to consider. He supported Pat Baker's recommendations. He added that the information gathered through focus groups and the quality team should be molded into the decision-making process moving forward.

Paul Lombardo agreed with Pat Baker's comments. He said that increasing primary care spending may result in decreased spending elsewhere. He expressed interest in understanding what spending is decreased, which will be insightful but perhaps difficult to capture. Michael Bailit noted that in Massachusetts, insurers slowed commercial price growth to meet the cost growth benchmark. Luis Perez said this trend was problematic and highlighted why the Technical Team should provide guidance on how it should increase spending to meet the target. He said he did not want to hinder access to care.

Paul Grady agreed with the comments expressed previously. He shared that the National Alliance of Health Care Purchaser Coalitions have done around advanced primary care. He said the Technical Team could include some of the high-level elements in their recommendations (e.g., enhanced access for patients, behavioral health integration).[1] Michael Bailit said these elements could be captured in a statement similar such as, "increased investment in primary care should be used to enhance how primary care is delivered."

Setting the Target (Part 2 of 2)

Michael Bailit returned to the conversation of how to set annual targets from now until 2025 to reach the 10% target. He summarized that he previously proposed set increments each year.

Paul Lombardo said the annual targets should consider what the primary care work group recommends for policies to increase primary care spending. This would account for any up-front costs that may be associated with increasing primary care spending in the future. Michael Bailit agreed with Paul, but noted that the challenge is that the primary work group has not met yet and the technical team is charged with completing its recommendations by September.

Pat Baker said that the Technical Team could set parameters for how to meet the target, but should not necessarily dictate by how spending should increase each year. This could provide flexibility for payers to align their investments with the recommendations from the primary care work group.

Michael Bailit confirmed with Vicki Veltri that the annual targets for increasing primary care spending could be set after the primary care work group has developed its recommendations, even if this occurs after September. Luis Perez, Rae-Ellen Roy, Angela Harris and Rebecca Andrews supported this direction.

Angela Harris noted that the order in which the Technical Team discussed the components of the Executive Order could perhaps have been restructured, as quality benchmarks will impact how to increase primary care spending. Vicki Veltri shared that there were concerns around including quality discussions in 2020 because historically it has been challenging for stakeholders to agree on which quality measures to include without extensive discussion taking many months. The Executive Order implements quality benchmarks for 2022 to allow for sufficient time to discuss the topic. In addition, she added that from the Governor's perspective, cost and affordability have become big issues, particularly for those with commercial insurance. Further, the intent is that initial data from the cost growth benchmark, primary care target and data use strategy can help inform the quality benchmarks.

Kate McEvoy highlighted that there is a companion Executive Order that requires Commissioner Gifford to establish an advisory body on cost transparency and quality in Medicaid. Medicaid already reports each year on these topics and publishes individual profiles on systems. The advisory body was deferred due to COVID-19, but it will be on the radar soon. She agreed with Vicki's comment on the challenges associated with gaining consensus on quality benchmarks.

[1] The complete list of National Alliance of Health Care Purchaser Coalitions' recommendations includes: enhanced access for patients, more time with patients, realigned payment methods, organization and infrastructure backbone, behavioral health integration, disciplied focus on health improvement and referral management. For more information, see: https://connect.nationalalliancehealth.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=6ca6ceb5-a85b-0f2d-0a10-21eb7ce3bf69&forceDialog=0.

5.	Data Use Strategy	Michael Bailit

Overview

Michael Bailit explained that the data use strategy is a plan that leverages state data in order to achieve health policy objectives. This is based on first, APCD data, but perhaps other data sources too (e.g., hospital discharge database). Michael said the data use strategy can help shed light on where costs are high, where costs are growing rapidly and where costs are variable, all to help shed light on areas of opportunity to aid payers and providers in meeting the cost growth benchmark.

Paul Grady asked where reducing low-value care fits into the data use strategy. Michael Bailit said it is not one of the three priority lenses he suggested, but added that reducing provision of low-value care definitely can help in meeting the benchmark and can be part of the data use strategy.

Pat Baker noted that there is a lot of duplication of care, including low-value services as well as needed care. She asked if this will be considered. Michael Bailit said there is no defined data use strategy yet and that the Technical Team can inform which analysis should be included in the final strategy. He added that what Pat described is often described as "waste."

Michael Bailit summarized some data use strategy component recommendations the Technical Team and Stakeholder Advisory Board have already identified, including identification of any unintended adverse consequences of the cost growth benchmark and assessment of the benchmark's impact on consumer out-of-pocket spending.

Michael Bailit shared historical perspective on data use work in Connecticut. In 2018, the Healthcare Cabinet convened a Cost Containment Data Work Group. They highlighted some priority recommendations, which have been integrated into the meeting presentation.

Michael Bailit provided information on other states' data use strategies, including for Massachusetts, Rhode Island and Oregon. Massachusetts has been analyzing APCD data for several years and supplementing data from other sources. It has two agencies dedicated to performing health care analytics and assessing performance against cost growth benchmark. The latter produces analyses annually on steps that should be taken to achieve the State's cost growth benchmark. Further, it schedules a hearing to review these analyses and explain any associated recommendations or actions. Michael Bailit shared example analyses from their reports, one of which focused on breaking down what factors influence spending growth (e.g., unit price, utilization, provider and/or service mix).

Paul Grady and Luis Perez shared that an analysis of factors influence spending growth would be helpful for Connecticut. Luis Perez confirmed with Michael that the Massachusetts agencies are funded through state budget appropriation. He expressed concerned that Connecticut may not have the same investment available for this work. Michael Bailit said there are two steps associated with having meaningful analyses: (1) ensure there is clean and complete data and (2) use the APCD to inform analyses. He noted that as states use the APCD more, the greater likelihood that there will be clean and complete data. He highlighted that states often invest more to maintain the APCD than to use the data within it.

Vicki Veltri added that Massachusetts' appropriations are funded using assessments of the health care industry, and not through general fund expenditures. The same is true of OHS. She confirmed that Connecticut will not have the same resources as Massachusetts, but highlighted that OHS is looking at which options it can pursue with its resources. Michael Bailit added that this is not an all-or-nothing approach – even with fewer resources, Connecticut can still make a big impact.

Pat Baker asked if Massachusetts was interested in selling its analytic services for use with other states so that Connecticut does not need to re-build some of the same analyses. Michael said Rhode Island was interested in the same question, but that the approach has not been pursued seriously. Kate McEvoy shared that she would be happy to raise this question with NESCSO. Vicki Veltri said these discussions happen routinely with other states around the NESCSO work and added that OHS already has a data use agreement with MA for other cross-state initiatives.

Angela Harris asked if there was a ballpark estimate for much it would take to maintain data in the APCD. Vicki Veltri said it is roughly $700,000 per year to maintain the APCD, which does not include funding needed to perform analytic work using APCD data.

Michael Bailit shared two additional analyses from Massachusetts focused on cost-sharing by market sector and the demographics of families that face high health care cost burden.

Michael Bailit shared that Rhode Island's data use strategy is much more nascent. The State hosted a one-day conference, bringing together states with multi-payer claims databases and providers to learn about which analyses will be helpful. It

worked with stakeholders to design reports for 2019 and 2020. After the reports are designed, the State will run them using its APCD and post the reports on its website.

Michael Bailit added that Oregon is in the process of developing its data use strategy. The State's timeline is similar to Connecticut's. There is legislation to create its cost growth target, as well to establish cost accountability for all providers, and not just those that are subject to the cost growth benchmark. He shared that Oregon has a sophisticated analytics department.

Connecticut's Data Use Strategy

Michael Bailit shared that Oregon and Rhode Island identified provider organizations as a priority audience for their data use strategy reports, followed by policymakers and the public. Priority was not given to payers, as they already have substantial data on costs, and consumers, as repeated research shows that consumers do not use cost information even when made available. Pat Baker asked what the distinction was between the public and consumers. Michael said consumers use was defined as informing care-seeking decisions, whereas public use was defined as broadly sharing information with the public.

Pat Baker noted that employers were not on the priority list. Paul Grady shared that he wanted to include employers as a priority audience, given their influence on changing the system. Pat Baker supported Paul Grady's suggestion and added that she wanted to prioritize the same three audiences highlighted by Rhode Island and Oregon. Luis Perez agreed with Paul Grady and Pat Baker. Vicki confirmed that policymakers included the Executive Branch.

Angela Harris cautioned against underestimating the ability for the public to use and synthesize this information to make personal health decisions as well as to hold health institutions and elected officials accountable for the policy decisions made that impact their lives.

Kate McEvoy said consumer engagement has not been successful to date and asked if the State should think about how to solve for this moving forward. She added that it seemed like a missed opportunity. Vicki Veltri said OHS intends to do substantial consumer engagement and has just brought on a vendor to assist in doing so.

Rebecca Andrews noted that capturing data is expensive. She added that incorrect data demoralizes primary care providers as it does not give them credit for what they do well. She expressed interest in investing money and effort into capturing high-quality data, as low-quality data has multiple down-stream effects. Michael Bailit noted that the broader the list of priority audiences, the more resources OHS will need.

Vicki Veltri noted that there is a statutory requirement to have a website that includes information from the APCD. This is why OHS has a Cost Estimator. She noted that it may not be the best resource and added that there is a focus group focused on improving that tool.

Angela Harris asked if it was possible to loop in state educational institutions into analytic work. Vicki Veltri said UConn Health and UConn AIMS is looped into the work. They still need to be paid for their services, however.

Michael Bailit noted that the APCD has information gaps. If OHS has the resources and desire, it can consider additional data sources to supplement APCD data. Which data sources it chooses to leverage will be based on which analyses it chooses to perform.

Finally, Michael Bailit described who will be performing the analyses specified in the data use strategy. In the short-term, contractor Mathematica will be performing calculations on areas of high costs and high cost growth. It will begin with commercial medical claims and move on to Medicaid and Medicare. Its narrower scope of work provides room for stakeholders to provide input on how to revise the data use strategy moving forward. In the future, other actors at the direction of the State will continue to perform these analyses.

6.	**Adjourn**	**Vicki Veltri**

Michael said the next discussion will be focused on the goals of the data use strategy.

Paul Grady said he would like to better understand the frequency and prevalence of value-oriented payments. He asked if other states have been able to capture information related to alternative payment models, such as capitation. Michael Bailit confirmed with Vicki Veltri that this information will be captured under the Executive Order. Vicki Veltri said over the last few years, she has surveyed carriers and therefore has a general sense of how many people are in ACOs or specific payment models. Paul Grady asked why this information is captured separately from the data use strategy. Vicki Veltri said it is because these data are hard to capture in the APCD, which utilizes NPI identifiers to collect information. Michael Bailit shared that in Oregon, there is broad stakeholder consensus that prospective payments could improve provider sustainability during the pandemic, and affordability to meet its cost growth benchmark.

	Michael Bailit thanked the group for its productive contribution. He reminded the group that the next meeting will be on August 27, 2020 from 1:00pm – 3:30pm. Luis Perez made a motion to adjourn the meeting and Angela Harris seconded the motion. The meeting adjourned at 2:56pm.