Cost Growth Benchmark Technical Team Meeting

Meeting Date	Meeting Time	Location
June 16, 2020	2:00 pm – 4:00 pm	Webinar/Zoom

Participant Name and Attendance

Cost Growth Benchmark Technical Team		
Members Present:		
Rebecca Andrew	Paul Grady	
Pat Baker	Paul Lombardo	
Zack Cooper	Luis Perez	
Melanie Flaherty	Rae-Ellen Roy	
Angela Harris	Vicki Veltri	

Technical Team Staff		
Michael Bailit, Bailit Health	January Angeles, Bailit Health	Olga Armah, OHS
Megan Burns, Bailit Health	Margaret Trinity, Bailit Health	Jason Prignoli, OHS

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 welcomed members of the Technical Team. Vicki said that the Technical Team's meeting dates are posted on the OHS website, but that the OHS site had crashed on June 15th and as a result OHS staff were only able to post the meeting materials the morning of June 16th.	
2.	**Public Comment**	**Victoria Veltri**
	Vicki Veltri invited comments from members of the public. There were no public comments voiced.	
3.	**Approval of the CGB Technical Team Meeting Minutes**	**Victoria Veltri**
	Pat Baker made a motion to approve the Technical Team's June 4th meeting minutes, and Paul Grady seconded approval of the minutes. The motion carried following a roll call vote during which Vicki Veltri, Pat Baker, Zack Cooper, Angela Harris, Paul Grady, and Rae-Ellen Roy voted in the affirmative.	
4.	**Recap of Preliminary Recommendations to Date**	**Michael Bailit**
	Michael Bailit stated that the Technical Team had previously made a preliminary recommendation that Total Health Care Expenditures (THCE) should be defined as the allowed amount of claims-based spending from payer to provider, all non-claims-based spending from payer to provider, and the net cost of private health insurance. He noted that the Technical Team had recommended that the THCE should be inclusive of spending on behalf of Connecticut residents who are insured by Medicare, Medicaid and commercial carriers, as well as residents who obtain coverage from self-insured employers. Further, THCE should include spending for care received by Connecticut residents from any provider in or outside of Connecticut. He said that the Technical Team had previously recommended that THCE should exclude spending for out-of-state residents receiving care from in-state providers, and that THCE should include spending for Connecticut residents who receive their coverage through the Veterans Health Administration or other military coverage. He noted that the Technical Team had previously expressed its preference to include spending for Connecticut residents incarcerated in a state correctional facility, but had understood the potential limitations of OHS being able to do so in terms of the availability and comparability of such data. Technical Team members offered no further comment regarding these previously made recommendations.	
5.	**Feedback from the Stakeholder Advisory Board**	**Michael Bailit**
	Michael Bailit reported that the Advisory Board met on June 11th, and that Bailit Health had shared with the Board a summary of the key topics and preliminary recommendations made by the Technical Team in its two previous meetings. Michael stated that the Advisory Board had focused on the definition of THCE and the methodology for defining the cost growth benchmark. He noted that Advisory Board members had many questions regarding THCE. He stated that Advisory Board members expressed their preference that out-of-pocket expenditure growth of Connecticut residents be measured. Michael indicated that this topic would be discussed further as part of the Data Use Strategy work stream. He said that the Advisory Board had also expressed its interest in identifying the cost burden to individuals without insurance, and had learned more about the challenges associated with collecting such data.	

Michael Bailit stated that the Advisory Board reviewed the methodology for the benchmark and the four economic indicators that could be used for setting the benchmark target. He noted that Advisory Board members did not reach consensus on which of the four economic indicators to use for the cost growth benchmark, although they expressed support for the presented indicators with the exception of the average wage indicator. He said that some Advisory Board members expressed support for a composite measure, although there was also support amongst several Advisory Board members for a single measure. He noted that the Advisory Board had lacked time to discuss specific benchmark values.

Pat Baker asked if OHS could provide greater detail regarding the nuances of the Advisory Board discussion; for example, more detail on the Advisory Board's evolving views regarding the indicators. Michael Bailit explained in response that the Advisory Board discussion was comprised largely of questions and answers of Megan and Michael. Vicki Veltri added that she has asked for additional meetings of the Advisory Board to allow for more discussion. Pat Baker asked OHS to be conscious in the future of how Advisory Board member positions evolve over time during the course of Advisory Board discussions and to share this information with the Technical Team; she asked that staff flag open questions or area of particular interest to the Advisory Board.

In response to a question from Pat Baker, Michael Bailit clarified that THCE includes all patient cost-sharing amounts, including deductibles and copayments.

Michael Bailit provided a recap of key learnings from the recent Advisory Board meeting: 1) the Advisory Board is interested in tracking out-of-pocket expenditure growth; 2) Advisory Board members are interested in tracking health care costs of the uninsured; and 3) there was interest amongst at least some Advisory Board members in using a composite measure for the benchmark value.

Paul Grady noted that employers have managed health care costs by shifting them to employees. Michael Bailit said that to the extent that cost growth is tempered by the benchmark, employers should feel less pressure to shift costs.

6. Cost Growth Benchmark Value — **Michael Bailit**

Michael Bailit provided an overview of historical per capita cost growth in Connecticut's commercial, Medicare and Medicaid markets. Michael noted that in other states, as in Connecticut, the commercial growth rate is highest. Paul Grady remarked that the measure of average annual growth in the commercial market may not be measuring the total cost, it may just be a paid amount if it is claims-based. Michael clarified that the historical per capita commercial average growth rate reflects allowed amounts.

In response to a request from Zack Cooper at the Team's June 4th meeting, Michael Bailit shared a slide showing that Connecticut has higher household income distribution inequality than almost all other states. Angela Harris noted that consumers may change benefits packages as their needs change particularly given the pandemic, and asked if Bailit Health's work had addressed this. Michael Bailit acknowledged that people move in and out of type of coverage and benefit design on a regular basis. He said that in general the more cost sharing there is, the less people access care. In response to an observation from Rae-Ellen Roy, Michael stated that providers will negotiate for higher rates from commercial payers, and that they cannot do so for Medicare and Medicaid.

Michael Bailit stated that during the Technical Team's June 4th meeting, there was some interest in creating a composite of the economic indicators. As a result, staff developed three models based on a weighted composite of the following indicators: 1) PGSP/Median Income; 2) CPI/Median Income; and 3) PGSP/Average Wage. He presented values for each these three models based on the following weightings: 80%/20%, 50%/50%, and 20%/80%.

Michael Bailit provided an additional piece of contextual information in response to a previous request made by Zack Cooper that the Team examine historical growth in health care expenditures in other states with cost growth benchmarks. Michael shared this information and noted that in three of the four states, the state selected benchmarks that declined over time. He said that states started with benchmark values that were 59-70% of their historical 20-year GSP growth, and dropped those benchmark values over time to 52-60% of that historical growth rate, except for RI which kept a steady benchmark at 60% of the state's 20-year growth rate.

Michael solicited the Team's input on the three models and the options for weighted values of those models. Megan clarified that forecast median wage data were not available, and the modeling used forecast average wage as a result. Zack Cooper stated that given Connecticut's income inequality, he felt it was important to use the median value of whatever variable is representing income. Michael Bailit replied that median income was a viable option. Paul Grady said that he liked the idea of

using a composite that considered both growth in the economy and income; he said that he did not feel strongly as to what the weighting should be.

Pat Baker expressed her strong support for a composite measure, and said that her inclination was for the PGSP/Median Income model. She said that she would like to understand further the implications of the various weightings. Michael responded that ultimately the Technical Team's goal is to select a value that represents a target that will result in lower health care spending. Michael Bailit encouraged the Technical Team to select a thoughtful basis for calculating benchmark value and one that OHS can communicate to stakeholders. He added that there is no objective basis for setting the weighting other than what seems right.

Zack Cooper noted that the median income value was depressing the value of the PGSP/Median Income and CPI/Median Income composite measures compared to the PGSP/Average Wage measure. Zack suggested that the Technical Team consider a value that captures what consumers are feeling in their pocketbook, and indicated that he favored the CPI/median income model with an 80%/20% weighting.

Pat Baker stated that she preferred a blend of growth and income, and expressed support for the PGSP/Median Income model with a 50%/50% weighting, noting that she would prefer equal values of growth and income. Pat said that the reason she recommended the PGSP/Median Income Model was because there is a relationship between growth in state economy and an individual's economic outlook.

Rae-Ellen Roy also expressed support for the PGSP/median income model.

Zack Cooper stated that the more concerned the Technical Team was about income inequality, the more he would lean toward a model that blends CPI with median income.

Angela Harris stated that Connecticut not only has some of the richest counties in the country, but also the poorest. She said that as a result, she would lean toward using a measure that addresses inequalities, and so would prefer the model that blended CPI with median income.

Luis Perez stated that he agreed with previous comments and that the CPI/Median Income model offered an opportunity to address the consumer perspective, and the income inequalities in the State.

Paul Grady said he was initially a supporter of the PGSP/Median Income model. He said the CPI/median income model would produce a target that was significantly lower than that used by other states and so he wondered how realistic and achievable such a low target would be. He expressed preference for aligning Connecticut's benchmark with that of other states. Paul suggested a 50/50 weighting of the PGSP/median income model.

Zack Cooper suggested using the PGSP/Median Income model with a 20/80 weighting in recognition of fact that income is expected to grow slowest for those who have the least. Pat Baker said this was a good compromise.

Luis Perez said the discussion was not about fixing income inequality, it was about addressing the impact of income inequality. He said the Team's goal was to make health care feel less weighty to the average resident.

Paul Grady asked again about the achievability of the goal. Michael Bailit said that a 20/80 weighting of the PGSP/median income model would yield a lower value than that used by other states, but would not be inconsistent with the values used by other states. Megan Burns noted that OHS would have opportunity to adjust the benchmark moving forward. She noted that Delaware had a transitional market adjustment, starting at 3.8% and then lowering that value on an annual basis.

Michael Bailit queried the Technical Team members' comfort level with a benchmark value that would represent a 20%/80% weighted composite of the PGSP/Median Income model. Pat Baker expressed her support for such a model and weighting, as did Zack Cooper, Vicki Veltri, Luis Perez, and Angela Harris. Paul Grady said that he would prefer the PGSP/Median Income model with a 50%/50% weighting, and noted that he would also prefer flexibility to adjust the benchmark value up or down in future years.

Zack Cooper suggested that the target average out to 2.9% over five years. Michael Bailit noted that this would mean the following benchmark values over five years: 2021: 3.1%; 2022: 3.0%; 2023: 2.9%; 2024: 2.8%; and 2025: 2.7%. Paul Grady and

Rae-Ellen Roy expressed support for this suggestion, as did Rebecca Andrews. Michael Bailit said he would share this preliminary recommendation with the Stakeholder Advisory Board and that the Technical Team would have opportunity to finalize this recommendation at its next meeting.

Megan Burns asked if the Technical Team would prefer flexibility during the first five years of implementation to stop and review and perhaps change the methodology underlying the benchmark value. She noted that in any case the Technical Team would need to review the benchmark methodology during its fourth year of implementation, and the question before the Technical Team was whether it wished flexibility to review the methodology earlier. Rae-Ellen Roy said she would not support reexamining the benchmark methodology earlier, but would support re-examining the value. Some states have created an opt-out provision allowing for earlier examination of the benchmark value without changing the methodology, Michael Bailit noted.

Zack Cooper said he would be most comfortable with a force majeure clause in the case of a recession or other event that would spark a re-examination of the methodology, or if income equality were greatly reduced, he might wish to reconsider the weighting of the measure.

Michael Bailit noted that even in the event of a sudden economic loss such as we are currently experiencing, there would not be a big change in the benchmark value, although if inflation spikes, that would have a dramatic impact on the benchmark. He noted the difficulty of setting parameters for what would constitute an "off ramp" or "escape hatch" that would trigger the Technical Team's reassessment of the benchmark.

Luis Perez asked if the Technical Team could identify a set percentage of increase in inflation rate that would require a re-calculation of the benchmark value. Zack Cooper expressed support for providing an off-ramp if interest rates spike, although specifying the amount of interest rate increase that would trigger this would be tricky. Michael Bailit suggested that there be a clause that specifies what would trigger reconvening of Technical Team to examine benchmark. The Technical Team expressed its support for this suggestion.

6. Reporting on Performance Against Benchmark — **Megan Burns**

Megan Burns stated that there are four levels for reporting on performance against the benchmark: state, insurance market, insurer, and provider/health system. She shared examples of reporting prepared by Massachusetts at each of these levels. She noted that Massachusetts reports on total medical expense growth by insurer, and Massachusetts is still relatively new at reporting total medical expense at the provider level.

Angela Harris asked that Bailit Health include Medicaid performance reports in future shared examples, noting that Connecticut will be reporting on performance against the cost benchmark for all insurers, including Medicaid.

Megan noted that reporting at the state and insurer level is fairly straightforward, but that reporting at the provider level is more challenging. She noted several questions for the Technical Team's consideration:

- How should providers be organized into larger entities for the purposes of reporting?
- How should Connecticut residents be attributed to reporting providers?
- What is a sufficient population size to measure provider performance against the benchmark?

Megan noted that Bailit Health was conducting research with another state that will help inform the Technical Team's deliberations on sufficient population size to measure provider performance against the benchmark. She promised to return to this topic at a future meeting. Megan noted that the topic of applying risk adjustment would need to be deferred to the July 2nd meeting.

With regard to how best to organize providers into larger entities for the purpose of reporting, Megan stated that one approach was to have a provider directory that would allow the State to map individual providers to their affiliated organizations, as Massachusetts does with its provider directory program. She noted that some states are using Tax Identification Numbers (TINs) to create a physician directory and to link affiliated physicians with their affiliated organization; she said that National Provider Identification numbers (NPIs) alone are not always reliable.

Megan noted that a different approach would be to organize physicians by total cost of care contracts, as does Rhode Island. She said this is a good option if there are a large number of entities participating in ACO or other value-based payment arrangements.

	Kate McEvoy stated that there is already work that has been done by DSS that may be used for this purpose. She noted that Medicaid does not enroll providers with respect to their affiliated practices. As a result, she recommended a hybrid approach even though it is more work at outset. She noted the work of the Office of the Comptroller on this topic. Vicki Veltri said that UConn Analytics and Information Management Solutions (AIMS) was building a directory for the health information exchange, but that it was not an easy an undertaking. She said there may be time to get this directory up and running for this purpose. Rebecca Andrews said that each doctor operates differently, and urged caution in organizing providers into larger entities. Megan Burns replied that the purpose of grouping physicians together for purposes of reporting is simply to identify the cost trend. She said that of the four work streams that the Technical Team had discussed, the data use strategy can dive further into the data to understand why one physician group or entity might vary. Paul Grady noted that historically Connecticut has had a lot of small practices. Vicki Veltri said that the substantially all primary care providers were in some type of accountable care entity, based on the work of Tom Woodruff in the Office of the Comptroller. Vicki promised that staff would examine the work of the Office of the Comptroller this topic, especially with regard to Rebecca Andrews' observation that many primary care physicians are independent. Kate McEvoy noted that DSS' work does not capture all primary care providers. Kate said DSS had recently had a large increase in the number of primary care providers recorded by the Medicaid program, but not all primary care doctors in Connecticut. Kate noted that almost 3,000 primary care providers are enrolled in Medicaid. Megan said that another option is leveraging the work of UConn on HealthscoreCT. She said that the scorecard uses a two-step process that attributes patients to providers and providers to medical groups, and then identifies advanced networks, which are any provider that has a value-based payment contract, including pay-for-performance contracts. Megan Burns recapped the options available to the Technical Team for organizing providers into larger entities for the purpose of reporting: based on existing payer total cost of care contracts, using the HealthscoreCT methodology for identifying advanced networks, or using Medicaid's work in this area although it may not capture all providers. Paul Grady expressed support for organizing providers into larger entities based on their existing payer total cost of care contracts because these data are available from the Comptroller's Office. Pat Baker said that there does not seem to be a good method for capturing this information. She wondered about the unintended consequences of one approach versus another. Michael Bailit suggested that the Bailit Health team follow up with Kate McEvoy in order to identify what data are available and identify short and long-term options. Luis Perez supported this suggestion. Megan Burns noted that in other states where individual physicians cannot be identified, spending is still reported at state, market and insurer level but not at the provider level. Megan stated that at the next Stakeholder Advisory Board meeting, the Board would review the Technical Team's preliminary recommendation on the benchmark value.	
6.	**Adjourn**	**Vicki Veltri**
	Michael Bailit asked the Technical Team members if they would be willing to extend their future meetings by 30 minutes because the group is falling behind. Members of the Technical Team expressed their willingness to do so. Pat Baker made a motion to adjourn the meeting, which was seconded by Luis Perez.	