Cost Growth Benchmark Technical Team Meeting

Meeting Date	Meeting Time	Location
July 2, 2020	1:00 pm – 3:00 pm	Webinar/Zoom

Cost Growth Benchmark Technical Team Members Present					
Rae-Ellen Roy		Zack Cooper			
Luis Perez		Angela Harris			
Paul Grady		Judy Dowd			
Paul Lombardo		Kate McEvoy			
Vicki Veltri					
Members Absent					
Pat Baker		Rebecca Andrews			
Others Present					
Lisa Honigfeld		Michael Bailit, Bailit Health			
Olga Armah, OHS		Margaret Trinity, Bailit Health			

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

	Agenda	Responsible Person(s)
1.	**Welcome and Introductions**	**Victoria Veltri**
	Vicki called the meeting to order at 1:02pm.	
2.	**Public Comment – switch order**	**Victoria Veltri**
	Lisa Honigfeld, Vice President for Health Initiatives at the Child Health and Development Institute, offered public comment to the Technical Team. She stated her appreciation for the opportunity to speak on behalf of the Child Health and Development Institute, a Connecticut-based non-profit organization dedicated to improving systems of health care for children. Lisa noted that the pediatric primary care experience can have a positive impact on many aspects of a child's life and asked that the Technical Team consider greater flexibility in payments to pediatric providers. She noted that the Institute, working with the Connecticut Healthcare Foundation, recently convened a study group that outlines payment reforms in pediatric care, and invited Technical Team members to review the recommendations of the study group. Vicki Veltri stated that the Office of Health Strategy (OHS) plans to reactivate a primary care work group to discuss how best to achieve the primary care spending target, work which will begin in the fall. Vicki stated that OHS will publish a solicitation for membership on this group on its website, and noted that currently there is a solicitation on the OHS website for consumer representatives to the Quality Council. Lisa Honigfeld noted that there is an important opportunity to address mental health needs within pediatric care as 98 percent of children in the state receive pediatric care. Luis Perez thanked Lisa Honigfeld for reminding the Team of the intersection of primary care and mental health across the life span.	
3.	**Approval of the Technical Team Meeting Minutes**	**Victoria Veltri**
	Paul Lombardo made a motion to approve the Technical Team's July 16th meeting minutes, which was seconded by Luis Perez, and then approved by a roll call vote with the following Team members voting affirmatively: Angela Harris, Paul Grady, Zack Cooper, Judi Dowd, Paul Lombardo, Kate McEvoy, Rae-Ellen Roy, and Vicki Veltri.	
4.	**Stakeholder Advisory Board Feedback**	**Michael Bailit**
	Michael noted that the July 2nd meeting discussion would focus on the primary care spending target. First, however, Michael shared feedback from the Stakeholder Advisory Board regarding the Team's preliminary recommendations related to the healthcare cost growth benchmark. During the Stakeholder Advisory Board's June 30th meeting, Michael asked for Board feedback on the Technical Team's cost growth benchmark recommendation and rationale. He stated that his goal in sharing the Board's feedback was to have Technical Team members process the feedback and determine if they wished to revise their previous recommendation.	

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Michael shared general Stakeholder Advisory Board feedback regarding benchmark implementation. He noted that there was general concern voiced by some Stakeholder Advisory Board members that a cost growth benchmark would be harmful by causing providers to limit patient access to services. Michael reported that he had shared with the Stakeholder Advisory Board that there was potential for a strategy to monitor potential unintended consequences, particularly for vulnerable populations. He stated that there seemed to be receptivity amongst Stakeholder Advisory Board members for such a strategy.

Michael noted that a member of the Stakeholder Advisory Board had emphasized the importance of tracking spending by the uninsured, and suggested that the State ask the provider community to collect these data so that the State can report on it.

Michael noted that there was also a Stakeholder Advisory Board member suggestion that data be captured to track changes in plan benefit design as part of the data use strategy, for example changes in copays and deductibles.

Michael stated that a different Stakeholder Advisory Board member had suggested that the State, as an alternative to setting a benchmark, measure annual change in health care spending, but not relative to setting any benchmark.

Luis Perez stated concurrence with the Stakeholder Advisory Board on the topic of out-of-pocket expenses, and he agreed that this information would be important. Michael noted that the Technical Team had previously recognized the importance of this topic and flagged it for inclusion in data use strategy.

Kate McEvoy noted that DSS has examined closely the underutilization of services. She said that it would be helpful if the Technical Team would consider endorsing the underservice strategies that DSS has recommended, noting that the agency has undertaken a significant effort to address this. She asked that the Technical Team incorporate this effort by reference and acknowledge that use of a benchmark and value-based reimbursement could potentially incentivize providers wrongly but DSS will continue to commit to examination of underservice in context of this benchmark work. Vicki Veltri committed to doing so.

Paul Grady asked if there were specific measures that could be included for the entire population to assess cost and utilization, not just for Medicaid. Michael said that we could identify measures of inappropriate underutilization, resulting either from the benchmark of other influences in the marketplace. Vicki noted the value of a baseline measurement of access as part of the data use strategy.

Michael then shared Stakeholder Advisory Board member comments on the benchmark methodology, noting that a Stakeholder Advisory Board member had requested that the third criterion for selecting the methodology not just address lower growth in spending but "lower growth in spending *for households, employers and taxpayers*." Technical Team members did not express any concerns with this change. Vicki noted that a consideration that has come up in other OHS work is that the word "households" may not be as helpful as "residents." In response to a question from Paul Grady, Michael said that this would not create a requirement that spending be measured at the household, employer and taxpayer level. Paul expressed support for the rewording. Luis did not like the word "households" or "residents" and suggested "consumers" as an alternative. The Team approved the rewording of "consumers, employers and taxpayers."

Michael shared a Stakeholder Advisory Board suggestion to use a 90/10 weighting of potential gross state product and median income, because of concern that the current method yields a value that is too low, and could lead to access and quality issues. Michael noted that the current recommendation is a 20/80 weighting of potential gross state product and median income which yields on average 2.9 percent over five years, and the Stakeholder Advisory Board member recommendation of a 90/10 weighting of potential gross state product and median income would result in an average benchmark value over five years of 3.4 percent. Paul Lombardo stated that he still supported the 20/80 weighting, and noted that the Technical Team developed this value as a group based on careful consideration of the underlying indicators.

Paul Grady expressed support for Paul Lombardo's comment, but noted that the quality benchmark won't be implemented until after the first year of benchmark implementation. He expressed caution in creating a benchmark

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value that is too low without a means to measure unintended consequences. Michael Bailit suggested the option of establishing a higher value for the benchmark during the first year, because many payer contracts with providers for CY 2021 may already have been negotiated by the time the benchmark is finalized in the fall, making it difficult to address the price component of health care spending growth during such a short timeframe. He noted that it is very difficult to revisit the terms of these contracts once they have been negotiated.

Vicki Veltri commented on the Stakeholder Advisory Board's benchmark recommendation, stating that the Team's weighting and methodology was well thought out, however this would not preclude adjusting the number, particularly during Year One. She expressed concern over setting an unrealistic benchmark value in Year One; she stated that she would like to make sure the benchmark value is achievable and that it incentivizes provider and payer behavior. She said that she also wants to ensure provider buy-in to the benchmark initiative, and expressed interest in a realistic benchmark value particularly during Years One and Two.

Michael noted that one Stakeholder Advisory Board member shared the Technical Team's concerns over income inequality, and suggested using the 25th percentile for wages rather than median wage.

Paul Lombardo expressed support for the Team's previous recommendation of a benchmark value using a 20/80 weighting of potential gross state product and median income, with an add-on factor that grades down over time. Luis Perez expressed his support for this recommendation, as did Rae-Ellen Roy. Michael Bailit promised to bring add-on factor options and step down over next few years to the next meeting of the Technical Team, and to share rationales for options that the Technical Team could consider.

Michael reminded the Technical Team that it had previously selected a downward slope and suggested keeping the value at 2.9 percent for 2023 – 2025.

Zack Cooper expressed confidence with the Technical Team's previous recommendation.

Michael shared that some Stakeholder Advisory Board members felt that using only a significant increase in inflation as a trigger for re-visiting the benchmark value was too narrow, and that additional triggers should be identified. Rae-Ellen Roy expressed concern over adding too many triggers, and Luis Perez agreed. The Technical Team decided to leave a spike in inflation as the only trigger that would result in a reassessment of the benchmark value.

Zack Cooper asked that the names of Board members who make comments be shared with the Technical Team.

5. Primary Care Spending Target — **Michael Bailit**

Michael Bailit reviewed the Executive Order charge related to the primary care spending target, which is that by 2025, primary care spending as a percentage of total health care expenditures will reach a target of 10 percent.

Michael reviewed the reasons for setting a primary care spending target, noting that the U.S. healthcare system is largely specialist-oriented, more so than the majority of developed countries. He noted that states have been working on strengthening their primary care delivery systems by expanding primary care teams, and more recently by increasing the percentage of total dollars invested in primary care. He said that a few other states have pursued a primary care spending target. He shared the example of Rhode Island, which set a primary care spending target through its regulation of commercial health insurance, with implementation of "affordability standards" in 2009 under the guidance of its Health Insurance Advisory Council. Rhode Island's goal was to increase primary care spending by 5 percentage points over five years. Michael noted that Rhode Island exceeded this target, by increasing commercial primary care spending as a percentage of total medical spending from 5.7 percent in 2008 to 12.3 percent in 2018. Michael stated that Oregon in 2015 and 2016 required reporting the percentage of medical spending allocated to primary care for select health insurers in the state, and then in 2017 Oregon required that health insurance carriers and Medicaid coordinated care organizations (CCOs) to allocate at least 12 percent of health care expenditures to primary care by 2023. Michael observed that Rhode Island achieved its primary care spending target by means of regulation, and Oregon by means of statute. He noted that these two states defined primary care differently.

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Michael stated that the Technical Team's work on a primary care target will benefit from prior and concurrent work in the state. He explained that Connecticut is participating in a collaborative with the other New England states to measure primary care spending using a consistent methodology, noting that this work is sponsored by the New England States Consortium Systems Organization ("NESCSO"). He said that other Connecticut work related to primary care that may inform this effort include and analysis of Connecticut primary care spending previously undertaken for OHS by Freedman Healthcare and work of the Practice Transformation Task Force.

Michael stated that three separate analyses have been performed recently to calculate what percentage of total health care spending has gone to primary care. He noted that NESCSO's work will offer a fourth analysis, and the results of that analysis will be available by end of the month. Michael stated the results of the three analyses vary. The first analysis was conducted by Freedman Healthcare examined commercial spending using state employee claims data and Medicaid claims. The second analysis was undertaken by PCPCC utilizing MEPS survey data for four payer markets – commercial, Medicaid, Medicare, and dually eligible, using 2011-16 data. Third, the UConn SIM evaluation used APCD claims data for commercial and Medicare payer markets.

Michael noted that the three analyses used varied data sources, resulting in an "apples-to-oranges" comparison. He shared that using claims as the primary data source, the UConn SIM analysis found that the primary care spending for the commercial payer market was 5.8%, Medicaid was at 9.0% and the UConn SIM analysis of the Medicare payer market found that the primary care spending percent was 2.7 percent. He noted that Medicare will always have a smaller percent primary care spend data level because of greater use of acute and specialist services by Medicare beneficiaries than by other populations.

Michael noted that the analysis that used the MEPS survey data as its primary data source resulted in lower values for the primary care spending percent across all the payer markets.

Michael said that NESCSO is using claims data from the state's APCD for its primary care spending analysis. Michael clarified that the analysis is being conducted by a contractor to OHS that is mining the APCD for these calculations.

Michael noted that not all primary care spending is captured by claims, and as a result not all primary care spending is captured in the APCD.

Paul Lombardo asked if we are including data for both fully insured and self-funded employers. The only self-insured group in the APCD is the state employees, Michael said. The APCD is missing almost the entire self-insured market, which is a significant drawback of using the APCD.

Judy Dowd noted that many primary care providers participate in the Connecticut Medicaid program. Because there are a lot of institutional costs built into Medicaid as well as long-term care services, the 9 percent Medicaid figure is a testament to the Medicaid program. Angela Harris said that maybe this figure was worth highlighting in communications related to the primary care spending target.

Zack Cooper shared his hesitancy regarding the primary care spending target, noting the difficulty of measuring primary care spending. He remarked that the relationship between primary care and health care spending is not rigorous and lacks an adequate evidence base. He also noted his concern over regulating what an industry should spend on a particular part of that industry. He stated his concern that the target could lead to provider gamesmanship. Michael noted that any gamesmanship would be by payers, not providers.

Vicki noted that the target has to be set appropriately in order to ensure that primary care is being delivered in the right way and as a complementary strategy to the target.

Paul Lombardo noted that there are two ways to impact primary care spending: 1) overall compensation to primary care providers; and 2) utilization of primary care services. Michael noted that if you decrease spending on non-primary care services, then primary care service spending will also increase; he noted that the Governor's intent was to increase overall primary care service spending and utilization. He said that a possible outcome is that non-

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	primary care spending might be held level. Michael pointed out that the primary care spending target will be implemented in the context of the cost growth benchmark, and payers have lowered price increases over time in states that have pursued a benchmark. Angela Harris expressed concern that providers may try to reclassify procedures as a result of the primary care spending target, as a way to try to beat the system. Michael noted that any time you set parameters such as the target, you need to ensure their integrity. He noted that in Rhode Island, the State did identify one insurer that erroneously categorized some of its expenses. He said that ideally the State would establish a mechanism to ensure that insurers are behaving appropriately. Paul Grady stated that it is time for primary care providers be paid more appropriately. Michael noted that primary care providers earn far less than specialist providers. Vicki noted that the National Quality Forum published a paper on achieving quality, which focused on primary care as a means of achieving improved quality; she promised to share the paper with the Technical Team. Michael stated that OHS was awaiting the analysis being prepared by OHS' contractor, Onpoint, as part of the NESCSO scope of work. He noted that if we calculate a weighted average of total primary care spending in Connecticut by a) population size and b) total health care expenditures, it has an impact on the total primary care percentage. Michael said that this has major implications for what action is needed to reach the 10 percent target. Michael shared Connecticut primary care spending values utilizing claims versus survey data, and weighted by population size versus total health care expenditures. He said that using the claim data weighted by population size indicates that primary care spending is approximately 6.0 percent and as such would require 4.00 percentage points to reach the 10 percent target, and using survey data would require an increase of 6.2 percentage points to reach the target. Weighting using total health care expenditures data yields lower values due to Medicare's weight of expenditures. He observed that claims data represents the most viable means of determining primary care spending (rather than survey data). Michael shared his assessment of the implications of the preceding discussion for the Technical Team's work, noting that primary care spending varies across public and private sectors regardless of the data source. He shared three major implications for the Technical Team's work. First, he noted that the Technical Team must develop a precise definition of primary care and of total medical spending. Michael said that a second implication is that the Technical Team should rely on calculating historical spending using this precise definition in order to set specific annual targets to reach the Executive Order's target of 10 percent by 2025. Michael noted a third implication, which is the Executive Order sets the target in aggregate across all payers, and so it will be challenging to achieve a 10 percent target given the need to include Medicare spending in the calculation. Angela Harris asked if the Technical Team's work to define primary care spending means reinventing the wheel. Michael replied by stating that currently there is no national standard for calculating primary care spending to guide the work of the Team. He clarified that the Team will be creating a standard for Connecticut. Angela Harris asked to what extent payers will need to respond to requests for data from multiple states that are developing a primary care spending target. Michael responded that this would not be the case, at least yet, since only Rhode Island is asking insurers for such data, and different insurers operate in the Rhode Island and Connecticut markets.	
6.	**Roadmap for Primary Care Spending Target Work**	**Michael Bailit**
	Michael stated that two key decisions for the Technical Team are: 1) What is the definition of primary care? and 2) What constitutes primary care payments? Michael stated that the Technical Team would be referencing NESCSO's work and the experience of other states to help inform the Technical Team's deliberations on the definition of primary care. NESCSO has multiple definitions of primary care and the "core" definition is narrower in scope. NESCO's core definition does not include obstetric/gynecological services as primary care, but NESCSO's broader definition does. Michael asked if the Team is comfortable excluding Ob/gyn providers from the definition of primary care. Rae-Ellen Roy noted that the state health plan experience is that 15 percent of women use their Ob/gyn as their primary care physician, and that she is not comfortable with this exclusion because it would leave out a substantial portion of the primary care services	

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women are receiving. Angela Harris concurred, noting that many women rely on their Ob/gyn for primary care. Paul Lombardo said he could call the carriers to identify how many members have an Ob/gyn as a specified PCP. Vicki said that there was significant discussion in the Quality Council on this topic. Angela Harris expressed interest in having the State provide administrative support to Ob/gyns to help them code appropriately.

Michael said that when the NESCSO analysis is complete, we will know what the primary care spending level is with Ob/gyn included. Olga Armah added that the NESCSO analysis does provide code-level data for Ob/gyn services.

Michael asked if the group should classify mental health as primary care services. Zack Cooper said he would like to make the definition as broad as possible to include Ob/gyn services and mental health services. Paul Grady noted that the more services included, the easier it will be to achieve the target and said that he would prefer a narrower definition that might result in more spending for primary care. Judy Dowd stated that she would like to exclude mental health; she noted that there are many efforts to link primary care and mental health but that mental health services is not generally viewed as primary care. Vicki Veltri wondered how the Freedman analysis coded mental health. Paul Lombardo stated that he was not aware of any carrier that has categorized behavioral health providers as primary care providers. Michael asked Paul Lombardo to conduct his promised research on Ob/gyn.

Vicki Veltri said that she would like Michael to include in the next meeting's slides behavioral health services that may be considered primary care services, and not just a listing of the providers.

Michael reviewed the key decision points for the Technical Team, noting that there are many decisions ahead. The first decision that Michael reviewed is which data source(s) should be used for the primary care spending target calculation. He noted that the choices are to utilize the APCD, direct payer reporting, or a combination of the two. Michael shared data sources used by Rhode Island, Oregon and NESCSO. He then reviewed the advantages and disadvantages with using the state's APCD versus direct payer reporting as data sources. Olga noted that there is a one year lag before APCD data are available, which is one of the disadvantages of this data source. Michael noted that an advantage of using direct payer reporting as the data source for calculating the primary care spending target is that it can be piggybacked onto the cost growth benchmark payer reporting, but that it does create additional burden on payers.

Paul Grady asked if we could ask for self-insured data in the payer reporting. Michael said that it would be possible but potentially messy if it had to be "married" to data generated from the APCD and he would have concerns about the integrity of the combined data.

Zack Cooper expressed concern that additional administrative burdens placed on insurers would result in incremental cost increases for consumers.

Michael expressed his view that if the Team wanted to get self-insured data, he would suggest direct payer reporting to accomplish this so that the State could request both self-insured data and non-claims based data.

Paul Grady said he liked the idea of using a method that will make it easier to compare to other states. Michael said that assuming the NESCSO methodology has" legs", that would mean using the combination of APCD supplemented with direct payers reporting for non-claims-based payments. Michael asked if they would also like to supplement via direct payer reporting for self-insured populations. Rae Ellen noted that there is a large proportion of self-insured in the state. Michael stated that asking the insurers to direct payer report for the self- insured would create a more comprehensive picture, although the insurers will not like the burden of this reporting.
Paul Lombardo asked if the payers would be willing to report self-funded data. Michael noted that this is a similar question as arose for the cost growth benchmark. Michael stated that the ERISA *Gobeille* Supreme Court decision does not tend to be a barrier because this request would be for aggregate data-level reporting. He noted that in Delaware and Rhode Island, the carriers have been willing to provide this information (with one exception). He added that this does not mean the Connecticut carriers would necessarily agree to report self-insured data, and that the State would need to use the Executive Order to accomplish this.

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	The Team appeared to agree on a hybrid approach of using the APCD and direct payer reporting for non-claims data. Michael said that the question for the Team was whether direct payer reporting should also include self-insured data that is not in the APCD. Paul Grady asked for more information on how difficult such a data reporting request would be for them. Michael said that he viewed this request as feasible, but it raised the question of whether it would be simpler to just have the payers report fully insured and self-insured combined, rather than securing this from two different sources and combining them. Michael asked the Team for their preference for hybrid or just direct payer reporting. Zack said he would prefer the simplest version, which would be reporting just from the APCD. Michael noted that this would mean excluding non-claims-based payment. Paul Grady said he would prefer to get everything from the insurers via direct payer reporting, and Rae-Ellen Roy supported this approach as well noting that it is in alignment with cost growth benchmark approach. Paul Lombardo expressed agreement, as did Angela Harris.	
7.	**Adjournment**	**Vicki Veltri**
	Vicki expressed her thanks and wished a good holiday weekend to everyone. Paul Grady made a motion to adjourn the meeting which was seconded by Rae-Ellen Roy. No one expressed opposition and the meeting adjourned at 3:00pm.	

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