Cost Growth Benchmark Technical Team Meeting

Meeting Date	Meeting Time	Location
September 10, 2020	2:00 pm – 4:00 pm	Webinar/Zoom

Participant Name and Attendance

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

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

	Agenda	Responsible Person(s)
1.	**Welcome and Introductions**	**Olga Armah**
	Olga Armah called the meeting to order at 2:03pm.	
2.	**Public Comment**	**Olga Armah**
	Olga welcomed public comment and none was voiced.	
3.	**Approval of Previous Technical Team Meeting Minutes**	**Olga Armah**
	Pat Baker made a motion to approve minutes of the Technical Team's August 27th meeting. Luis Perez seconded the motion, which was approved by roll call vote with the following members voting affirmatively: Paul Lombardo, Rae-Ellen Roy, Zack Cooper, Angela Harris, Luis Perez, Paul Grady, and Pat Baker.	
4.	**Cost Growth Benchmark**	**Michael Bailit**

Michael Bailit stated that the Technical Team previously discussed several items related to the Cost Growth Benchmark that required follow-up research. He said that he had updates to share on the following topics, after which the Technical Team would have completed discussion of the cost growth benchmark methodology.

- From which insurers data will be requested
- How risk-adjustment will be applied
- Minimum attribution size for providers
- Provider directory options

From which insurers data will be requested

Michael Bailit reminded the Technical Team of the type of data needed to support the cost growth benchmark, noting that OHS must request these data from payers. He provided a reminder that APCD data cannot be used because payers will be the only source for non-claims payment, self-insured data and pharmacy rebate data, adding that other states with benchmark policies have payers submitting summarized data.

Michael stated that OHS had consulted with the Insurance Department and that having done so, OHS recommended that in addition to traditional Medicare and Medicaid, the insurers listed on the Consumer Report Card as health insurance carriers in Connecticut be requested to submit data to support the cost growth benchmark. Michael identified the recommended payers from which OHS would request healthcare spending data. He said that OHS recommended that data be requested from six commercial payers, representing most of the market in Connecticut, from five payers with Medicare products, and from the Department of Social Services for Medicaid. Michael noted that, in addition, OHS will obtain summary level data from the VA and the Connecticut Department of Corrections.

In response to a question from Paul Grady, Michael confirmed that OHS will be asking for both fully insured and self-insured data from the commercial payers. Paul Grady suggested that the data request refer to both Aetna and Aetna's wholly-owned subsidiaries. Rae Ellen Roy recommended that OHS make this same request of all commercial payers. Michael stated that Bailit Health will follow up with Paul Grady and Rae-Ellen Roy to ensure we utilize the correct insurer names. The Technical Team expressed its support for OHS proceeding with outreach to these insurers for purposes of requesting healthcare spending data.

Paul Grady asked whether there should be an independent request for pharmaceutical spending of PBMs, citing CVS as an example. Michael said that part of the data request will be to ask insurers to provide an estimate of pharmaceutical spending if they are not administering it. OHS will ask the insurers to report their pharmacy rebates; Michael said this had been done in other states. Rae-Ellen Roy asked how insurers will be able to do so if they contract with PBMs. Megan Burns stated that other states

that are requesting pharmacy rebate data have not been able to secure pharmacy rebate data from PBMs, however the pharmacy spending can be estimated by the insurer. Paul Grady asked if there is a downside of requesting this information from PBMs. Zack Cooper stated that the PBMs will be unwilling to provide this data. Michael agreed that securing these data from PBMs would provide a more complete picture, but also agreed with Zack's assessment that PBMs may not agree to provide pharmacy rebate data. Michael said that he was not aware of any states who have requested this information. Megan stated that such a request would create a complex administrative burden for OHS. Michael stated that OHS could focus such a request on the three largest PBMs. Megan clarified that at an aggregate level, OHS will report total medical PMPM spending "out the door" net of rebates.

Paul Lombardo stated that as part of Public Health Act 1841, beginning in March 2021 his department will getting an aggregate rebate amount from all registered PBMs that handle formularies for fully insured commercial plans providing services to Connecticut residents. This means that the State will have an aggregate dollar amount of rebate that may be useful for the benchmark calculation. Paul Grady stated that it would be great to have better transparency with regard to PBMs, and noted that the pharmacy rebate amount for the state employee health plan, which is using CVS as its PBM, will not be available. Paul Lombardo said that the big PBMs in Connecticut are CVS Caremark, Express Scripts and Optum. Anthem recently developed a PBM. Michael committed that staff would look into this to determine if this is a viable way to capture pharmacy spend and rebate information. He said that staff will follow up with Paul Lombardo to determine if there is a way to leverage the aggregate rebate information that is being captured as a result of Act 1841.

There was no additional comment on the list of insurers that Michael shared on slide 8.

How risk adjustment will be applied

Michael Bailit noted that in order to report on payer and provider performance against the cost growth benchmark, OHS will need to risk adjust the cost data. Such an adjustment makes sure that assessment of payer and provider benchmark attainment considers changes in the underlying health status of populations served by payer and provider. He stated that there are two types of risk adjustment – clinical and social. He noted that risk adjustment is applied to measurement only at the insurer and provider levels.

Michael shared several options for performing clinical risk adjustment. Under the first option, each insurer uses its own risk adjuster; the second option is to apply a common risk adjuster across insurers. Michael noted that the first option is administratively less complex. He added that it was previously thought that combining risk-adjusted data across payers could not be done. Michael stated that the advantage of the second approach (using a common risk adjuster) is that provider experience could be more confidently compared across insurers. The key drawback to the second approach is that insurers use many different risk adjustment products, and would be reluctant to switch risk adjusters. Michael stated that Bailit Health recently undertook research to determine if it is truly improper to combine risk-adjusted data across insurers within a market, stating that a prominent researcher concluded it would be reasonable to combine data because risk adjustment products share many attributes. Michael shared his conclusion that combining risk-adjusted data across insurers (even if the insurers use different adjusters) would be the better approach. He invited reactions from Technical Team members.

Kate McEvoy said that it is illuminating that there are options for combining data across payers. She said that the Medicaid uses the Hopkins ACG tool for risk adjustment purposes. Michael noted that this is one of the most common risk adjustment products.

Rebecca Andrews expressed caution and asked if two different organizations used very different adjustment methods, how much would that impact data comparisons across providers? Michael stated that the Society of Actuaries has conducted multiple analyses comparing the most commonly used risk-adjustment software programs, which look at conditions within a population based on claims data to determine underlying risk of population and expected spend data. He said that these analyses did not find major differences in the ability of these risk adjusters in terms of explaining variations in population spending.

Paul Lombardo asked if there was usefulness in the annual federal report on ACA risk adjustment process. Michael replied probably not because we are asking insurers to report changes for all lines of business

Angela Harris asked if entities are being required to report which adjustment tool they are using for each time period. Michael said that yes, this is being requested in other states, and probably would be requested in CT. He said that in other states payers are asked to report which risk adjusters they are using, and if they change products over time periods, the payers need to restate old data.

Luis Perez said that we would be more likely to secure payer buy-in if we allow them to use their current risk adjuster for data submission; he noted that the only downside would be potential issues in combining data where payers are using different risk adjustment software.

Michael clarified that the suggested approach is to have the payers use their own risk adjuster as it will be quite difficult to get them to do otherwise.

No objections were raised by the Technical Team regarding this approach.

Rebecca Andrews noted that a number of non-clinical factors impact the complexity of a patient visit, for example literacy level. Michael noted that the duties of the Technical Team per its bylaws include recommending risk adjustment that includes social risk, noting that literacy was one such social risk. He acknowledged growing interest nationally in applying social risk factor adjustment to healthcare payments, but cautioned there is very limited experience in doing so and the methods for doing so are nascent. Michael stated that in the commercial market, Bailit Health has not identified any payers who are undertaking social risk adjustment. It does not appear that there is a means for applying social risk factor adjustment to cost data supplied by payers for Connecticut's cost growth benchmark, although there is potential to do so in the future. He said that for this reason, OHS recommended against social risk adjustment to cost growth benchmark performance calculations, and that this topic be revisited in the future. Pat Baker said she was not surprised but disappointed. Pat said she would like to push OHS to consider other types of analyses to address social factors; she added that she recommends this strongly.

Luis Perez asked about social determinants of health and noted that many payers are examining these more closely. Michael agreed and stated that this is for analytic purposes, but not for risk adjustment purposes.

Kate McEvoy stated that ICD-10 z codes might offer a pathway for securing the descriptors that Pat Baker would like. She encouraged OHS to pursue this as a possible way forward. Michael suggested the American Community Survey, which can be used to analyze statistical relationships between communities and outcomes. He also affirmed Kate's suggestion, recommending provider reporting of ICD-10 a codes, which flag where there are social risks. Michael noted that if these codes were routinely reported it would provide a rich trove of individual-level data for statistical analysis. Michael said that research indicates that there is sometimes a negative correlation between social risk factors and spending, because some individuals are underserved. The first step is to collect more data and do more analysis, he said. Pat Baker stated that our aspiration should be more than claims data, especially once the HIE is up and running; we should be explicit about this.

Luis Perez noted that the Technical Team is encountering barriers and also noted the compressed timeline stipulated by the Governor's Executive Order. He asked that the Technical Team's report capture Kate and Pat's recommendation so as to influence state leadership.

Minimum attribution size for providers

Michael Bailit reviewed the third question, which is what is a sufficient population size to measure provider performance against the benchmark? Michael explained that to report on healthcare spending at the provider level, the provider needs to be sufficiently large to reduce the chance that random variation impacted its performance. He said that other states have chosen between 3,000 and 10,000 lives as their minimum population size. Massachusetts is the only state to have reported performance publicly, he noted, and while Massachusetts chose 3,000 as the minimum for *collecting* data, it is reporting on provider entities that are larger, but has not publicly stated a minimum for *reporting* data. He said that Delaware and Rhode Island are just now collecting data on their first performance period (CY19), and intend to report on insurer and provider performance for those with 5,000 lives (Medicare) and 10,000 lives (commercial and Medicaid). Zack Cooper stated there is robust literature on this topic that we should utilize for purposes of establishing minimum population size. Zack said he would share this research with the Bailit Health team.

Oregon has been working on an empirical model to use as basis for setting a minimum population size for publicly reporting data. Michael stated that OHS recommends waiting for Oregon to complete its analysis - and to also review the literature to be shared by Zack Cooper – especially since this decision is not yet time sensitive. The Technical Team supported this recommendation.

Provider directory options

At its June 16th meeting, the Technical Team discussed the concept of organizing individual providers into larger provider entities for reporting purposes. Michael recapped the four options that staff described at that meeting. The first is to utilize work that UConn has done in support of the HealthScore CT and Quality Scorecard. The second is to leverage Medicaid's provider files. The third is to wait for development of OHS's provider directory, and the fourth is to use existing payer total cost of care contracts.

Pat Baker asked about the consequences of using the UConn work. Michael Bailit said that this approach can work if UConn updates it once a year (at least), He said that there are providers who regularly have relationships with more than one provider, and UConn's method isn't designed to account for this. Michael noted that the UConn approach is the best of four challenging approaches. He said that the few states with a provider directory have an electronic process to allow regular updating of information. Michael said that until OHS's HIE provider directory is developed, project staff recommend utilizing the work

	performed by UConn to support HealthScore CT and the Quality Scorecard. Michael said the OHS provider directory will not be ready for a few more years. Luis Perez said there would be implications for quality work group of this recommendation, i.e. would a recommendation to use the UConn provider directory limit the quality work group. Michael said that he did not think this would limit the quality work group, and added that we do not know yet the direction that the work group will take. He said that, for example, Delaware developed population-based measures, for which a provider directory was not needed.	
5.	**Primary Care Spend Target**	**Michael Bailit**
	Michael Bailit reviewed several outstanding primary care spend target issues. He reminded the Technical Team that in August, the Team initially recommended deferring setting of the primary care spend target to the primary care-focused work group. He updated the Technical Team that OHS believes there will not be enough time for this work group to perform the necessary work to inform target selection. Michael shared OHS's proposed strategy, which was to set a conservative target for 2021 based on currently available data, and defer setting targets for 2022-24 to a future work group once payer-submitted data are available. Michael reminded the Technical Team that it had previously recommended calculating a statewide weighted average of total primary care spending using total healthcare expenditures. He noted that using this calculation, the best estimate is that Connecticut's primary care spending is at 4.8 percent and would have to add 5.2 percentage points to achieve the 10 percent target by 2025. Michael explained that OHS recommended setting the 2021 primary care spend target at 5.0 percent for three reasons. The first was that OHS did not yet have baseline data from payers to identify current primary care spending; 4.8 percent is only a best estimate for current level of primary care spending. Second, COVID-19 has significantly impacted primary care utilization in 2020, and this impact will continue to be felt into early 2021 and likely beyond. Third, the 2021 measurement period was to begin in a few months, which did not allow payers and providers much advanced notice of the target, nor time to undertake efforts to increase primary care spending. Pat Baker said she thought it is wise to defer as recommended. She also stated that the 5.0 percent recommendation felt somewhat arbitrary and stating that the baseline should not be eroded may be a more viable approach. Paul Lombardo said that even a slight movement in year one would move CT towards the 10 percent target; he liked the idea of at least some movement in 2021 since it is a five-year project. Rebecca Andrews stated that it will be interesting to see if telemedicine services continue to be paid for at current level before setting year 1 target. Kate McEvoy stated that she viewed telemedicine as an enabling service at this time, and there are signals of intent to maintain coverage and make it permanent. Kate expressed agreement with Paul Lombardo in preferring a 5.0 percent target for year one. She noted that Medicaid was in a good position relative to target. Luis Perez expressed his support for OHS's recommendation with regard to the primary care spend target in year one.	
6.	**Data Use Strategy**	**Michael Bailit**
	Michael Bailit shared with the Technical Team feedback that the Stakeholder Advisory Board provided specific to the data use strategy. Michael asked if the Technical Team would like this feedback incorporated into the report of the Team's recommendations. Pat Baker expressed support for including the Board's feedback in the report. Luis Perez expressed his support as well, as did Kate McEvoy. Michael noted that the Board's recommendation to capture and analyze data on uninsured and undocumented immigrants was not feasible; Kate McEvoy stated that this was not a reason to not memorialize this feedback into the report. Paul Lombardo suggested alternate wording of the Board feedback as follows: "continue to work towards capturing and analyzing data on the uninsured." Pat supported Paul Lombardo's suggestion. The Technical Team expressed its support for incorporating the Board's feedback in the report.	
7.	**Ensuring Program Success**	**Michael Bailit**
	Michael Bailit asked the Technical Team to consider what steps OHS should take to make sure that all the activities required by Executive Order 5 attain their aim. Michael shared with the Technical Team several assessments of the Massachusetts benchmark program's impact. Michael noted three reasons why Massachusetts had experienced success with its cost growth benchmark program: • After extensive negative press regarding provider market power and high prices, and with legislative attention on health care costs, providers were ready to be responsive to accountability measures. • To help control rising healthcare costs, there was wide adoption of total cost of care contracts across the state, which translated easily to a cost growth benchmark. • Annual hearings and reports put a spotlight on the main drivers of health care cost growth, which provided strong incentives to keep cost increases down. Michael noted several additional accountability measures in Massachusetts including that the Office of Attorney General can compel healthcare entities to testify publicly at an annual hearing; in addition, the Health Policy Commission Board can require	

	a health care entity to submit a performance improvement plan (although it has not done so). Michael stated that these measures help restrain market behavior, because entities want to avoid the "public shaming" that could result from either of these measures. Michael noted that Connecticut is different from Massachusetts, and asked the Technical Team what steps need to be taken in Connecticut that could help facilitate the cost growth benchmark program's success? Pat Baker expressed support for the idea of annual hearings and reports that shine a spotlight on the main drivers of healthcare cost growth in Connecticut; she added that such measures will be important to include as part of OHS's overall transparency effort. She said that it might be challenging given the COVID-19 pandemic to achieve sustained public focus or press attention on provider performance under the cost growth benchmark. Pat said that some stakeholders may either resist change or may wish that the initiative does not succeed. Pat emphasized the importance of ongoing stakeholder education. Rebecca Andrews expressed support for Pat's suggestion, and noted the importance of garnering public support and trust. She said that public opinion may be negative initially based on the State's past experience with reform. She noted that Connecticut's response to the COVID-19 pandemic has helped foster public support for the State. Luis Perez said that OHS needs to engage not only the public at large, but also other stakeholder groups, most especially providers. He said that a good barometer of buy-in from the payer perspective will be the first report due on physical and mental health parity in March 2021. Paul Lombardo stressed the importance of clear communication, and the need for executive summaries that explain the objective of the benchmark program. He shared a general concern he has heard, which is that the initiative is attempting to cut expenses at the cost of quality. Rebecca Andrews suggested including a statement about the risk of overtreatment when discussing concerns about underutilization; this is about providing the right amount of care at the right time to the right person, she said. Zack Cooper said that what Massachusetts did exceptionally well is to publish transparency reports and then let the data speak for itself; the data told a fairly cohesive story. He recommended that OHS focus on good public reporting and objective communication of the facts. Pat Baker said that in the communications strategy, articulating the "why" of doing this will be important, as well as the benefit of the initiative. She said that identifying trustworthy messengers will be important as well, and added that this is not marketing but an in depth process to help everyone understand the initiative. We do not need a mile deep of detail, Paul Lombardo remarked. Rae Ellen Roy agreed and said we need to be mindful of our audience.	
8.	**Adjourn**	**Olga Armah**
	Luis Perez moved to adjourn, and Pat Baker seconded Luis' motion. The meeting adjourned at 2:55pm.	