OHS CONNECTICUT Office of Health Strategy

Cost Growth Benchmark Technical Team Meeting
May 5, 2020

Meeting Date	Meeting Time	Location
May 5, 2020	3:00 pm – 5:00 pm	Webinar/Zoom

Cost Growth Benchmark Technical Team					
Paul Grady					
Rae-Ellen Roy					
Paul Lombardo					
Pat Baker					
Maureen Flaherty					
Rebecca Andrews					
Louis Perez					
Angela Harris					
Members Absent:					
Zack Cooper		Deidre Gifford			
Judy Dowd					

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

	Agenda	Responsible Person(s)
1.	**Welcome and Introductions**	**Victoria Veltri, OHS**
	OHS Executive Director Victoria Veltri called the meeting to order at 3:04 pm.	
2.	**Public Comment**	**Victoria Veltri, OHS**
	The Technical Team did not receive any public comments.	
3.	**Review of Charter**	**Victoria Veltri, OHS**
	Victoria (Vicki) Veltri reviewed revisions made to the Technical Team Charter and Bylaws based on input received from Technical Team members at their first meeting on March 17th. This feedback resulted in inclusion of a recommendation related to health equity, and to best practices in other states. Vicki Veltri reviewed the major work of the Technical Team, which is to recommend annual cost growth benchmarks across all payers and populations for CYs 2021-2025, and to recommend a primary care target across all payers and populations. Patricia Baker asked that quality be included as an objective in the Technical Team Charter. Vicki Veltri replied that the overarching objective for the entire project includes quality, and the Office of Health Strategy (OHS) could include quality in the Technical Team Charter. She noted that the Quality Council is the primary body tasked with quality benchmark development. Vicki Veltri promised to add quality as an objective in the Technical Team's Charter, and suggested perhaps this could be addressed through the third objective. Paul Grady expressed agreement with Patricia Baker's comment. He noted that other states have failed to tie cost and quality together; he asked that the OHS clarify this link in the Technical Team Charter. Paul Grady also asked if existing OHS work on quality could be incorporated into the work of the Technical Team, and expressed interest in population-based measures. Vicki Veltri noted the Executive Order guiding OHS' work requires OHS to establish cost growth benchmark and primary care targets between March and October 2020. She commented that the quality benchmarks work would take place after this timeframe. She observed that Delaware uses population-based quality measures, which are easier to implement than those measures related to clinical quality. She noted	

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	that the Executive Order does not require implementation of quality benchmarks until 2022, so the Technical Team cannot expect providers to adhere to them at an earlier date. Michael Bailit stated that if consideration of quality measures began after initial work on cost growth benchmark and primary care targets, the State could select quality benchmarks and examine baseline performance for measures, potentially publishing that information in 2021 in anticipation of an effective date for the quality benchmarks in 2022. Vicki Veltri noted that there is a lot of publicly available information on quality performance for Connecticut providers. Paul Grady stated that employers previously conducted a study of Connecticut centers of excellence and found that they were low cost but not of high quality. Luis Pérez expressed concern that the timing of development of the cost growth benchmark and quality benchmarks are not better aligned. Vicki Veltri agreed that quality is important, and noted that there is a lot of quality data available that should be shared more broadly. She commented that the timeline for development of the quality benchmarks was intended to allow sufficient time for provider buy-in, and also reflects interest in considering quality in the context of multiple patient and provider populations. Luis Pérez noted that there will be scrutiny of the quality benchmark recommendations, which may delay the process further. Angela Harris expressed concern over unintended consequences; she said the Technical Team should use not just its "rear view" mirror but also its "front view" mirror as it relates to bringing quality care to residents of the state who may not have access to quality health care. Vicki Veltri reiterated that quality will continue to be a part of the Technical Team's conversation moving forward, but that provider accountability for quality benchmarks developed by the Quality Council will not begin until 2022. Rebecca Andrews shared her physician's perspective on the development of quality metrics, noting that some quality metrics lack evidence and create administrative burden. She expressed support for the development timeline for the State's quality benchmarks, and recommended a recent *New England Journal of Medicine* paper about the lack of evidence supporting many quality metrics. Megan Burns of Bailit Health, OHS's consultant, reviewed the objectives of the Technical Team, noting that the Team must meet bimonthly or monthly between March and September in order to meet those objectives. She explained that the Technical Team will engage the Practice Transformation Task Force and the legislature's Medical Assistance Program Oversight Council (MAPOC) for primary care target development considerations. Megan noted that the Stakeholder Advisory Board will hold its first meeting on May 14th, and the Board will advise the Technical Team in development of the cost growth benchmark and primary care targets. Megan Burns stated that the Technical Team's responsibilities include defining the minimum requirements in terms of information needs for development of the benchmark, and recommending methods of analysis that ensure the credibility of the process and the recommended benchmarks. She explained that as part of this process, the Bailit Health team will review for the Technical Team other state examples; the majority of those states use claims data she noted. Vicki Veltri commented that an important consideration is aligning the data collection and analysis across payers.	
4.	**Review of Bylaws**	**Victoria Veltri, OHS**
	Vicki Veltri shared the bylaws that were reviewed at the Technical Team's first meeting in March. Michael Bailit of Bailit Health clarified that for Article II, Section I.A., the Technical Team will need to complete the benchmark	

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	development process by October 1st (not November). Vicki Veltri reminded the Technical Team that its recommendations are for five years, but can be changed. Luis Pérez urged the Technical Team to consider social risk, and said that if it does not do so then it will not be able to address disparities within the state. He noted that those disparities are especially evident during the current pandemic. Michael Bailit stated that the science on how to adjust cost and quality measures for social risk is, unfortunately, not very advanced yet. He promised to discuss the concept of risk adjustment at a future meeting. Technical Team members discussed several wording changes to the bylaws. Vicki Veltri noted that meetings will take place bimonthly, between March and September, and the bylaws would need to be updated to reflect this schedule. The Team discussed the charge to "recommend risk adjustment that includes social risk" and alternatives to the word "recommend." Michael Bailit said that he was comfortable with the term "recommend" as long as there is a shared understanding of what is possible currently with regard to a risk adjustment for social risk. Paul Grady suggested that as soon as a credible measure of social risk is available it should be incorporated into the benchmark. The Technical Team agreed to the following changes to the bylaws: • Retain the word "recommend" for Article II, Section I, H. • Change Article II, Section I, A., to read "convene bimonthly or monthly between March and September." Paul Grady made a motion to approve the bylaws as amended. Paul Lombardo seconded the motion. By roll call vote the motion to amend the bylaws was carried.	
5.	**Connecticut Cost Growth Benchmark and Primary Care Target**	**Michael Bailit and Megan Burns, Bailit Health**
	Michael Bailit reviewed the four work streams for the Technical Team, noting that the cost growth benchmark will be the focus of the Technical Team's first few meetings. The Technical Team will then shift its focus to the primary care targets in June, as well as to the data use strategy. Finally, the Technical Team will turn its attention to the fourth work stream, which is quality benchmarks. He noted that the Technical Team has primary responsibility for advising the State on the cost growth benchmark program. He explained that the Stakeholder Advisory Board (SAB) is a larger group that will provide input to the Technical Team. The Bailit Health team will summarize the input of the SAB and convey that input to the Technical Team on an ongoing basis. Michael Bailit reviewed the role of the Quality Council, which will have responsibility for developing the quality benchmarks; Michael noted that the Quality Council will do so in coordination with the Technical Team and with support from OHS and the Connecticut Department of Social Services (DSS). He added that a number of other bodies will have a voice in the process, including the OHS Consumer Advisory Council, Health Care Cabinet, Practice Transformation Task Force, MAPOC, in addition to other stakeholders who will be consulted and whose input will be shared with the Stakeholder Advisory Board. Michael Bailit explained that the cost growth benchmarks work stream will address two primary questions, for which the Bailit Health team will share options as well as associated pros and cons: ○ What health care spending is to be measured? ○ How will the cost growth benchmark be set? Michael Bailit said that with regard to the primary care targets, there are two primary questions the Technical Team will need to weigh: ○ How is primary care defined and how will spending on primary care be measured? ○ What incremental primary care spend targets should lead up to 10 percent by 2025, and how should they be determined?	

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	To advance this primary care targets work, Bailit Health will share information on studies done on Connecticut's primary care spending by payer types, including work done by NESCSO. Michael Bailit stated that the data use strategy is a complementary area of focus that will advance in parallel to establishment of cost growth benchmark and primary care targets. Michael noted that Bailit Health's partner, Mathematica, will be developing recommendations and will work with UConn AIMS and OHS on how to utilize the All Payer Claims Database (APCD) to analyze cost and cost growth drivers so that performance against the cost growth benchmark, primary care targets and eventual quality benchmarks can be understood. The Technical Team will discuss what types of analyses will be routinely developed and with whom they will be shared. Michael Bailit said that for the quality benchmarks area of focus Bailit Health will coordinate with the Quality Council to make sure the Technical Team has input into the development of the benchmarks, and how they should be set. Michael then reviewed the timeline and sequence of future meetings. He explained that the Technical Team will have more frequent meetings of shorter duration due to the need to host them virtually instead of in person. Michael noted that the Technical Team will spend more time on the health care cost growth benchmark because it is a more technically complex topic than the primary care spending target. Paul Grady commented that the plan of meetings and timing looked good. He asked about the cost of collecting the data, and observed that other states have lacked the budget for this set of activities. Michael Bailit said that Massachusetts has devoted the greatest effort and spending on its data use strategy and not to the cost growth benchmark. The latter work can be performed with a relatively modest allocation of state resources. Angela Harris commented that the agenda looked reasonable if the technical Team was able to keep on track. Michael Bailit said keeping work on track would be Bailit Health's responsibility, and that OHS will proceed with scheduling of future meetings.	
6.	**Review of Other States' Health Care Cost Growth Benchmark Programs**	**Megan Burns, Bailit Health**
	Megan Burns reviewed the definition of a cost growth benchmark. When it is implemented, Connecticut will be the fifth state with such a benchmark, she said. Megan noted that some states use the term "target" and "benchmark", and these are interchangeable. In addition, the terms, "cost" and "spending" have the same meaning for the purposes of the Technical Teams. Megan Burns commented that, generally, states have pursued targets for the same reasons as Connecticut is doing so. She reviewed the enabling legislative, regulatory and administrative requirements utilized by Delaware, Massachusetts, Oregon, and Rhode Island. Thus far, Massachusetts is the only state with published experience. Megan Burns provided an overview of Massachusetts' work to establish a cost growth benchmark, noting that the State's 2012 enabling legislation established both the benchmark value and the oversight entities, the Health Policy Commission (HPC) and the Center for Healthcare Information Analysist (CHIA). She stated that the Massachusetts benchmarks are set in statute and pegged to potential gross state product, which is a forecasted average growth rate of the state's economy. Angela Harris noted the impact of COVID-19 on health care spending, and Michael Bailit promised to include discussion of this topic during the Technical Team's next meeting. Megan Burns explained that, in Massachusetts, the State measures performance against the benchmark using Total Health Care Expenditures (THCE), which is a measure of health care spending from public and private sources. She stated that THCE includes patient cost-sharing, and net cost of private health insurance (NCPHI). THCE does not	

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include non-medical spending by payers, nor does it include vision or dental care, nor expenditures that are recorded by providers but not by insurers.

Paul Lombardo asked how Massachusetts gets access to self-insured data. Megan Burns replied that the insurers submit summary level self-insured data.

Megan Burns explained that CHIA makes actuarial adjustments for carved-out services (behavioral health, pharmacy), and also collects medical expenses for other payers that don't report TME. She said that in Massachusetts, HPC has authority to enforce the benchmark and to implement a performance improvement plan (PIP) and penalties. She explained that the PIPs are for large provider organizations with a significant number of attributed members, such that their data can be organized and summarized.

In terms of Massachusetts' cost growth benchmark experience, Megan Burns stated that from 2012 to 2018, annual health care spending growth averaged 3.38 percent below the state benchmark, but Massachusetts has not achieved its benchmark every single year. She said that since 2013, the State reports having saved $7.2 billion, and commercial spending growth in Massachusetts has been below the national rate every year since 2013.

In describing Delaware's cost benchmark program, Megan Burns explained that it launched with a 2017 House Resolution to establish and plan for monitoring and implementation of annual health care benchmark. Delaware subsequently developed a public and private all-payer cost-benchmarking program and advisory group. Megan explained that Delaware calculated its potential gross state product (PGSP) at 3 percent, but decided to implement its benchmark with transitional adjustments whereby the PGSP declines from a high of 3.8 percent in 2019, to 3.00 percent in 2022 and 2023. Megan stated that Delaware established eight quality targets for its annual benchmarking program, and the targets vary for each measure by population (e.g., commercial, Medicaid, total state population).

Megan Burns provided an overview of Rhode Island's cost growth benchmark effort, stating that in 2016, Governor Raimondo asked a group of health care provider and insurer leaders to recommend a method for setting a cost growth benchmark. She said that the Rhode Island Steering Committee in December 2018 signed a voluntary compact which remains in effect until December 2022. The compact was subsequently reinforced by the Governor's executive order in February 2019. Megan noted that this compact stipulates that only highly significant changes in the economy will trigger re-visiting the target methodology. She added that Rhode Island has not yet revisited the definition as a result of the pandemic.

Megan Burns stated that Massachusetts, Delaware and Rhode Island all intend to publish performance data for the purposes of transparency. She noted that Oregon's legislature passed SB 889 in June 2019 in order to establish the State's cost growth benchmark program. Recently, the Governor paused all public meetings in response to the pandemic, and a timeline for final recommendations is undetermined. Megan noted that in Oregon, formal recommendations have not yet been made, but in order to determine the benchmark, the implementation committee reviewed historical and forecasted economic data. Michael Bailit clarified that Oregon already had a 3.4 percent spending growth cap legislated for its public employee benefits program, and there was also a Medicaid 1115 waiver growth cap for Oregon's Medicaid program.

Megan Burns said that the intention in Oregon is similar to that in Massachusetts, Delaware and Rhode Island, which is to assess performance against the benchmark using THCE. There are some differences in Oregon from other states, including that Oregon's THCE calculation includes spending by the Indian Health Services.

Rae-Ellen Roy asked about frequency of reporting from providers. Megan Burns responded that insurers provide data annually, and providers do not report data for purposes of a benchmark. Megan noted that in Massachusetts there are two different reporting time periods. She added that in Massachusetts, the State is measuring

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	performance for the larger provider groups. Delaware is using submitted data based on each insurer's top ten provider groups in terms of size, while Rhode Island has insurers report for each contracted accountable care organization (ACO). Michael Bailit noted that Oregon is interested in looking at underlying expenditures, and not just at TCHE. Oregon is interested in assessing other cost contributors at the individual provider level. Oregon is going beyond TCHE, and is planning on making a big investment in data analytics. Michael said that Oregon is also interested in an accountability and transparency structure. Rae-Ellen Roy said the Oregon approach sounds like a good model to follow. Vicki Veltri stated that her office has undertaken work on the topic of current primary care spending, and that this relates to work undertaken by NESCSO. She said that she would like to incorporate the Connecticut OHS' information on this topic in future discussion of primary care spending. Rebecca Andrews asked which of the state examples most resemble Connecticut in terms of practice type. She noted that Connecticut is different from other states in that it has the highest number of providers at retirement age and the greatest number of small provider practices of any state. Megan Burns replied that Delaware is likely the closest example to Connecticut. Michael Bailit said that one analysis Mathematica could perform is to analyze provider contracting arrangements with insurers. Michael said that Massachusetts appears to have had some success through its initiative particularly in terms of moderating health care spending among the commercially insured. However, he said that specific contextual factors exist in Massachusetts that are not present in other states. Michael noted that the Technical Team will need to discuss specific steps in Connecticut for making the cost growth benchmark and primary care spending target strategies successful. He promised that this would be a future discussion topic for the Technical Team. Paul Grady asked the Bailit Health team if there were questions or challenges that were experienced on a consistent basis by the comparator states. Megan Burns replied that a common and challenging discussion topic for the comparator states was the value of the benchmark. She noted that values and priorities differ from state to state, so the amount of time spent on a given topic depends on culture of a given state, and also who is in room at the time of the discussion. Vicki Veltri noted that the Stakeholder Advisory Board will help to provide a sense to the Technical Team of which issues may prove challenging (or not). Michael Bailit observed that the depth of interest in establishing quality benchmarks is greater in Connecticut than it has been in some other states.	
7.	**Wrap Up & Next Steps**	**Victoria Veltri, OHS**
	Megan Burns suggested that the Technical Team discuss the impact of COVID-19 on its work at the start of its next meeting. She also suggested a refresher on the primary care target at a later meeting. In wrapping up, Vicki Veltri stated that OHS will need to update the charter and bylaws based on the Technical Teams input at the May 5th meeting. She promised to communicate with the Technical Team soon regarding scheduling of future meetings. Vicki said she assumed that a regular meeting time would be preferred by the Team. Vicki said that the schedule of Technical Team meetings will need to be shared with the Secretary of State moving forward. She stated that OHS' Mayda Capozzi would send a Doodle poll to Team members requesting their preferred meeting time.	

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	Paul Grady requested that Technical Team members be unmuted at the beginning of the Team's next meeting. Paul motioned for adjournment, and Rebecca Andrews seconded the motion to adjourn.

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