OHS CONNECTICUT Office of Health Strategy

Cost Growth Benchmark Technical Team Meeting

Meeting Date	Meeting Time	Location
January 25, 2021	4:00 pm – 5:00 pm	Webinar/Zoom

Participant Name and Attendance

Cost Growth Benchmark Technical Team		
Paul Grady	Luis Perez	
Zack Cooper	Angela Harris	
Rae-Ellen Roy	Kate McEvoy	
Rebecca Andrews		
Judy Dowd		
Others Present		
Vicki Veltri, OHS	Hanna Nagy, OHS	January Angeles, Bailit Health
Kelly Sinko, OHS	Krista Moore, OHS	Margaret Trinity, Bailit Health
Olga Armah, OHS	Michael Bailit, Bailit Health	
Members Absent:		
Pat Baker	Paul Lombardo	

	Agenda	Responsible Person(s)
1.	**Welcome and Introductions**	**Victoria Veltri**
	Vicki Veltri called the meeting to order at 4:02pm. She introduced Kelly Sinko, OHS' new Director of Healthcare Innovation.	
2.	**Public Comment**	**Victoria Veltri**
	Vicki Veltri invited public comment. None was voiced.	
3.	**Healthcare Benchmark Initiative Updates**	**Michael Bailit**
	<u>Pre-Benchmark Measurement</u> Michael Bailit stated that OHS has launched the pre-benchmark measurement effort, which will examine cost growth for the 2018-19 period. He stated that OHS will release an Implementation Manual, which will provide the specifics of the data request of payers, and which will identify some of the steps that will be taken once the payers submit their data to OHS. Michael said he anticipated that payers would share data this spring, and that OHS will be able to share trends related to per capita cost growth between 2018 and 2019 (and spending growth by service category) during the summer. He added that because this initial data request was a test run, findings will not be published at the insurer and provider entity levels. He noted that this would constitute a test run of the process for having payers submit data and would inform future data collection. Paul Grady asked if the carriers were agreeable to the data submission request. Michael said that OHS had not yet received any objections. He noted that all the carriers except Anthem and ConnectiCare had received similar data requests in other cost growth benchmark states where they operate. Michael said that discussions were underway to collect Medicaid data from DSS, and a request had been submitted to CMS for Medicare data. <u>Finalization of Monitoring Measures to Detect Potential Adverse Consequences</u> Michael stated that OHS made a number of modifications to the monitoring measures based on comments submitted by the Technical Team. He shared the details of the modifications made by OHS to the monitoring measure set. Michael said that OHS received feedback on how to potentially leverage community health center data to better understand utilization of people who are uninsured. He said that OHS was still evaluating this potential data source and would update the Technical Team once OHS determined whether this was a viable approach. <u>Primary Care Spending Target</u> Michael reminded the Technical Team members that they had made a recommendation for the primary care spending target value for 2021, and that they had asked the Primary Care and Community Health Reforms Work Group to advise on target setting for 2022-24. This Work Group will also consider approaches for achieving increased primary care spending. After data collection for the pre-implementation period, OHS will also have 2018-2019 data on primary care spending as a percentage of total spending. The Work Group will use this information to inform its recommendations to the Technical Team on primary care spending targets for 2022-2024. <u>Quality Benchmark Development</u> Michael said that the Quality Council had been briefed on its benchmark recommendation charge in November. He added that in December, the Quality Council began a much needed update review process for the Core Measure Set after which the Quality	

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	Council will focus on developing quality benchmark recommendations. He added that the Core Measure Set may serve as a source for some of the quality benchmarks. Data Use Strategy Michael stated that Mathematica delivered its initial data use strategy analysis of cost drivers and cost growth drivers in Connecticut's commercial market. He said that the Technical Team would devote its February meeting to delving into the findings of the Mathematica analysis. He added that prior to that meeting, OHS would meet with a small group of provider stakeholders to review findings and solicit reactions to Mathematica's findings. In response to a question from Paul Grady, Michael stated that the small provider stakeholder group was an ad hoc group, and not a standing body. Michael reviewed a concern raised by Angela Harris at the Technical Team's November meeting related to the reliability of REL data obtained from the Census Bureau's Current Population Survey (CPS). Michael stated that he had spoken to researchers at Mathematica, who shared information that significantly supported use of the CPS data for imputing race, ethnicity and language, and as an accurate and well-tested methodology particularly at the large population level. Michael promised to share the background information on the use of CPS data for imputing REL with Angela Harris.	
4.	**Criteria for When to Report Payer and Provider Benchmark Performance**	**January Angeles**
	January Angeles from Bailit Health stated that OHS will report individual payer and provider entity performance against the benchmark for 2021 cost growth, and that this reporting will occur in early 2023. She explained that OHS would like to explore how best to make determinations of payer and provider entity performance against the benchmark. She added that OHS will need to answer the question of "how do we determine when a payer or provider entity has met the benchmark or not?" January explained that from year to year, spending and service utilization are subject to random fluctuations particularly in smaller populations. She noted that this could impact statistical confidence in assessments of payer/provider entity performance against the benchmark. In particular, OHS will need to make sure that smaller organizations are not being unfairly assessed. To ensure this, she said that OHS could consider adopting requirements similar to those used by other cost growth benchmark states. One option would be to set a minimum population size for performance to be reported, and then perform a simple comparison of rates. Another approach would be to set a minimum population size and then apply statistical analysis parameters. January reviewed the approaches taken by other states with regard to setting minimum attributed lives for **public reporting of <u>payer</u> performance** in other states, noting that DE, MA and RI do not set a requirement for minimum enrolled lives for public reporting of payer performance, but only request data from their largest payers. January stated that OHS is taking a similar approach by only requesting data from the largest payers. In response to a question from Luis Perez, Michael noted that Connecticut's top six payers (Aetna Health & Life, Anthem, Cigna, ConnectiCare, Harvard Pilgrim Health Care, UnitedHealthcare) account for the majority of commercial covered lives. Luis requested data on the number of lives that these six payers cover and Michael promised to share that with the Technical Team with the meeting notes. [In response to Luis' request, these top six payers together account for 84 percent of the market (commercial *and* Medicare Advantage market)]. January asked the Technical Team to consider what should be the minimum attributed lives for **public reporting of <u>provider</u> performance**. She noted that while Massachusetts has no published standard for public reporting, the state set a minimum threshold for payer reporting to the state of 3,600 attributed lives. January stated there is little research to support a particular threshold. January reviewed three options for determining payer and provider performance against the cost growth benchmark. <u>Option 1</u>: Compare payer and provider performance to the cost growth benchmark. In this case, OHS would determine that the benchmark has been achieved if a payer's or provider's measured performance is at or below the benchmark value. The benchmark would be judged to have not been achieved when measured performance is above the benchmark value. <u>Option 2</u>: Develop an upper and lower bound around payer and provider performance, and compare that range to the cost growth benchmark. With this approach, OHS would determine the benchmark has been achieved when the upper bound is fully below the benchmark. The benchmark would be determined to not have been achieved when the lower bound is fully over (above) the benchmark. She said that the benefit of this option is that it would apply a level of rigor to the assessment that Option 1 lacks. Michael noted that Option 2 is more resource intensive but would offer greater statistical confidence. Angela Harris asked if Option 1 or 2 allow for any acknowledgement of whether a payer had started "out of bounds" and improved, even though it did not hit the benchmark. Michael said that no, every year the calculation would start over given that it is designed only to measure year-to-year changes in per capita spending relative to the benchmark.	

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	Option 3: Develop an upper and lower bound *around* the cost growth benchmark. With this approach, benchmark performance would be considered achieved when measured performance is below the benchmark value's lower bound, and the benchmark would be considered not achieved when measured performance is above the benchmark value's upper bound. January reviewed advantages and disadvantages of each option, noting that the first option is the simplest because it does not require additional data collection or analysis, and the method is easily understandable to a layperson. However, she said that the first option is not statistically rigorous and could produce inaccurate findings. January stated that the second option is rigorous and provides a strong level of confidence around whether an entity has or has not met the benchmark. However, this approach would require additional data collection from payers and the methodology would be harder for a layperson to understand. For context, January added that Oregon plans to use Option 2, developing an upper and lower bound (confidence interval) around payer and provider performance. January stated that Delaware and Rhode Island use Option 1, which is to make simple comparisons against the benchmark value. Zack Cooper said that the true choice is between Option 1 and Option 2, as there is not a strong argument for adopting Option 3. Zack expressed support for Option 2 because applying a confidence interval would increase the rigor of the assessment. Paul Grady expressed support for Option 2. He asked if the additional data and resources required for Option 2 would add significant time. January said that it should not be a big "lift" for payers because it will not be that much more work to provide standard deviation and confidence interval data. Rae-Ellen Roy and Luis Perez both expressed support for Option 2. In response to a question from Angela Harris, Michael stated that OHS would provide technical notes to accompany the results of the statistical analysis so as to make it accessible to the public. Angela Harris expressed support for Option 2 as long as the analysis was presented by OHS in a manner that could be understood by the public. No member of the Technical Team expressed disagreement with Option 2. Angela Harris asked if Connecticut's payers were predominantly statewide or if some were regional in their coverage patterns. Michael replied that they were predominantly statewide. In response to a question from Rebecca Andrews, Michael stated that OHS had clinical risk adjustment built into the methodology, so there would be an adjustment if a provider panel's population "got sicker." Michael said that due to lack of time, the Technical Team would defer discussion of minimum population size for public reporting of provider performance to its February meeting.	
5.	**Additional Updates**	**Michael Bailit**
	Michael provided an update on stakeholder engagement activities, noting that OHS plans to focus in 2021 on the input of consumers, especially Black, Indigenous and People of Color (BIPOC) communities. Kate McEvoy stated that there is a small cadre of advocates who have expressed concern that the benchmarks inherently present risk for Medicaid beneficiaries. She stated that Vicki joined her in a formal response to the advocates, and she wanted to reinforce that she would like to see this message continue to be emphasized in stakeholder engagement. Michael stated that OHS had begun receiving technical assistance as a new participant in the Peterson-Milbank Program for Sustainable Costs.	
6.	**Adjourn**	**Kelly Sinko**
	Luis Perez made a motion to approve the November 2020 minutes of the Technical Team and Angela Harris seconded approval of the minutes. The Technical Team voted unanimously to accept the motion. Rebecca Andrews made a motion to adjourn, which was seconded by Paul Grady. The Technical Team voted unanimously to accept the motion.	

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