Cost Growth Benchmark Stakeholder Advisory Board Meeting #5
August 26, 2020

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Agenda

Time	Topic
1:00 p.m.	Call to Order
1:05 p.m.	Review and Approval of Prior Meeting Minutes
1:10 p.m.	Public Comment
1:20 p.m.	Technical Team's Recommendations on the Primary Care Spend Target
2:10 p.m.	Introduction to the Data Use Strategy
2:55 p.m.	Wrap-Up and Next Steps
3:00 p.m.	Adjourn

Call to Order and Roll Call

Stakeholder Advisory Board Members

- Vicki Veltri – Office of Health Strategy
- Reggie Eadie – Trinity Health of NE
- Kathy Silard – Stamford Health
- Janice Henry – Anthem BCBS of CT
- Robert Kosior - ConnectiCare
- Richard Searles – Merritt Healthcare Sol.
- Ken Lalime - CHCACT
- Margaret Flinter – Community Health Ctr
- Karen Gee – OptumCare Network of CT
- Marie Smith – UConn School of Pharmacy
- Tekisha Everette – Health Equity Solutions
- Pareesa Charmchi Goodwin – CT Oral Health Initiative
- Howard Forman – Yale University
- Nancy Yedlin – Donaghue Foundation
- Fiona Mohring – Stanley Black and Decker
- Lori Pasqualini – Ability Beyond
- Sal Luciano – CT AFL-CIO
- Hector Glynn – The Village for Fam & Children
- Rick Melita – SEIU CT State Council
- Ted Doolittle – Office of the Healthcare Adv
- Susan Millerick - patient representative
- Kristen Whitney-Daniels - patient represent.
- Jonathan Gonzalez-Cruz - patient represent.
- Jill Zorn - Universal Health Care Foundation

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Review and Approval of Prior Meeting Minutes

Public Comment

Technical Team's Recommendations on the Primary Care Spend Target

Technical Team's recommendations on the primary care spend target

- Over its last three meetings, the Technical Team considered several parameters for how to define primary care spending in Connecticut.
- Staff conveyed the Stakeholder Advisory Board's input to the Technical Team prior to its formation of recommendations. We'll now review those recommendations that are most substantive.

Technical Team's recommendations for data collection methodology

- First, the Technical Team recommended adopting two definitions of primary care providers and services:
  1. a narrower definition for measurement against the primary care spend target, and
  2. a broader definition for measurement of primary care spending more comprehensively.
- Second the Technical Team recommended collecting data through direct-payer reporting, similar to how data will be collected for the cost growth benchmark.

Technical Team's recommendations for defining "primary care providers"

	Definition 1: Narrow	Definition 2: Broad
Included Providers (in outpatient settings*)	• **MDs**: Internal Medicine when practicing primary care, Family Medicine, Pediatric and Adolescent Medicine, Geriatric Medicine when practicing primary care • **NPs and PAs**: when practicing primary care	• **MDs**: Internal Medicine when practicing primary care, Family Medicine, Pediatric and Adolescent Medicine, Geriatric Medicine when practicing primary care, OB/GYN and midwifery • **NPs and PAs**: when practicing primary care
Excluded Providers (among others)	• OB/GYN and midwifery • Behavioral health • Emergency room physicians • Naturopathic health care providers	• Behavioral health • Emergency room physician • Naturopathic health care providers

*Including but not limited to private practices, primary care clinics, FQHCs and school-based health centers

**The Technical Team expressed interest in inclusion of integrated behavioral health providers and services in the future.

Technical Team's recommendations for defining "primary care services" (1 of 2)

	Proposed Definition 1: Narrow	Proposed Definition 2: Broad
Included Services	• Office or home visits • General medical exams • Routine adult medical and child health exams • Preventive medicine evaluation or counseling • Telehealth visits • Administration and interpretation of health risk assessments • Behavioral health risk assessments, screening and counseling, *if performed by a PCP* • Immunizations • Hospice care	• Office or home visits • General medical exams • Routine adult medical and child health exams • Preventive medicine evaluation or counseling • Telehealth visits • Admin. and interpretation of health risk assessments • Behavioral health risk assessments, screening and counseling, *if performed by a PCP* • Immunizations • Hospice care • Routine primary care and non-specialty gyn. services delivered by OB/GYNs and midwifery

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Technical Team's recommendations for defining "primary care services" (2 of 2)

	Proposed Definition 1: Narrow	Proposed Definition 2: Broad
Excluded Services	• Routine primary care and non-specialty gyn. services delivered by OB/GYNs and midwifery • Minor outpatient procedures • Inpatient care • ED care • Nursing facility care • Practice-administered pharmacy	• Minor outpatient procedures • Inpatient care • ED care • Nursing facility care • Practice-administered pharmacy

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Does the Stakeholder Advisory Board want to provide the Technical Team with feedback on its recommended definitions of primary care providers and services?

Technical Team's recommendations for defining "total spending"

- The Technical Team recommended adopting the same definition of total spending from the cost growth benchmark, but it recommended excluding long-term care.

Technical Team's recommendations on complementary analyses to understand primary care spending (1 of 2)

- In order to better understand trends in primary care spending, OHS will need to identify which complementary analyses it should perform. These analyses will be limited by what data are available.
- Examples of feasible analyses to perform include stratifying spending by:
    - Age
    - Comorbidity (e.g., asthma, diabetes)
    - Geography (e.g., zip code)
    - Insurance category (e.g., commercial, Medicaid, Medicare)
- *OHS at this time is unable to stratify data by disability status (not captured in the APCD) or race and ethnicity (not consistently populated in the APCD), although race could be imputed using public data sources.*

Technical Team's recommendations on complementary analyses to understand primary care spending

- The Technical Team recommended including the following stratifications:
  - by provider/ACO
  - by race/ethnicity (using Medicaid race/ethnicity data)
  - by patients with no vs. multiple comorbidities
  - by treatment modality (e.g., telehealth vs. in-person visits)
  - by payment model (e.g., fee-for-service vs. alternative payment models)

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Does the Stakeholder Advisory Board want to provide the Technical Team with feedback on the recommended complementary analyses to understand primary care spending?

Technical Team’s recommendations on parameters for how spend is increased (1 of 2)

- Payers have multiple options for means to increase the percentage of spending that goes to primary care.
- Rhode Island wanted its target to encourage innovative contracting and payment as well as primary care system investment. It did not want insurers to simply change rates of reimbursement for specific codes in order to meet its target.
- Therefore, Rhode Island specified insurers could not increase premiums or engage solely in fee service manipulation to meet the primary care spend target.

Technical Team's recommendations on parameters for how spend is increased (2 of 2)

- The Technical Team deferred specifying the parameters for how spend is increased to OHS' new primary care work group. It did, however, offer the following guidelines for that work group to consider:
  - Increase spending (1) in alignment with existing statewide initiatives and policies, (2) through increased utilization of value-based incentives and (3) in a way that provides value.*
  - Continuously update policies based on incoming data on primary care spending and cost growth.
  - Measure decreased spending elsewhere that is a byproduct of increased primary care spending.
  - Leverage the increased spending to enhance how primary care is delivered, perhaps guided by the National Alliance of Health Care Purchaser Coalitions recommendations on advancing primary care.**

*Value can be defined as improved quality, increased utilization and access and improved outcomes.

**Includes: enhanced access for patients, more time with patients, realigned payment methods, organization and infrastructure backbone, behavioral health integration, disciplined focus on health improvement and referral management

Does the Stakeholder Advisory Board want to provide the Technical Team with feedback on the recommended parameters for how spend is increased?

Introduction to the Data Use Strategy

What is a "data use strategy" anyway?

- We use the term "**data use strategy**" to refer to a plan to purposefully leverage state data in order to achieve state health policy objectives:
  - Restrained cost growth
  - Increased primary care investment
  - Improved quality of care
- In this instance, we are discussing how to leverage the state's All-Payer Claims Database (APCD), and perhaps other data sources, to make sure the aims of the Governor's Executive Order #5 are achieved.

Proposed rationale for Connecticut's data use strategy (1 of 2)

- Specific to making progress in reducing cost growth and meeting the cost growth benchmark, CT needs information on where **costs are high**, where **costs are growing rapidly** and where **costs are variable**.
- By analyzing data, OHS can shine light on these three areas and identify what spending categories warrant greatest attention for **moving the needle on the cost growth benchmark**.
- The Cost Containment Data Work Group, convened by the Healthcare Cabinet, presented several priority recommendations in 2019 for how to contain costs that align with the goals of Connecticut's data use strategy.
  - Their recommendations are denoted with a **(*HCC)** throughout this presentation.

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Proposed rationale for Connecticut's data use strategy (2 of 2)

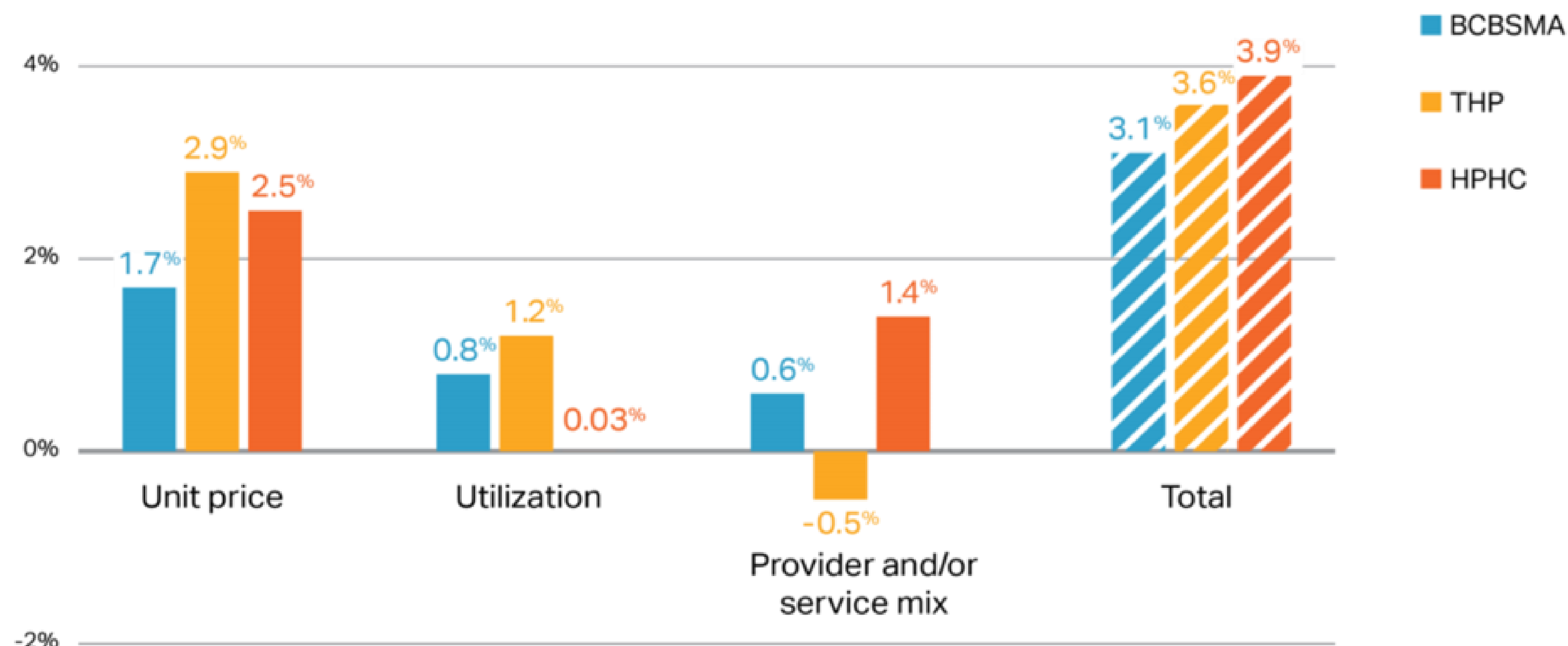
While identification of cost growth reduction opportunities should be a priority of the data use strategy, it should not be the only focus.

- Additional analyses should examine **cost growth benchmark impact**. The Technical Team and Stakeholder Advisory Board have already identified the following:
  - identification of any **unintended adverse consequences** of the cost growth benchmark, and
  - assessment of the benchmark's impact on consumer **out-of-pocket spending**.
- Finally, the data use strategy should look at **health disparities** (utilization, cost and quality) and at **quality** more generally.

Example analyses from Massachusetts' data use strategy (1 of 4)

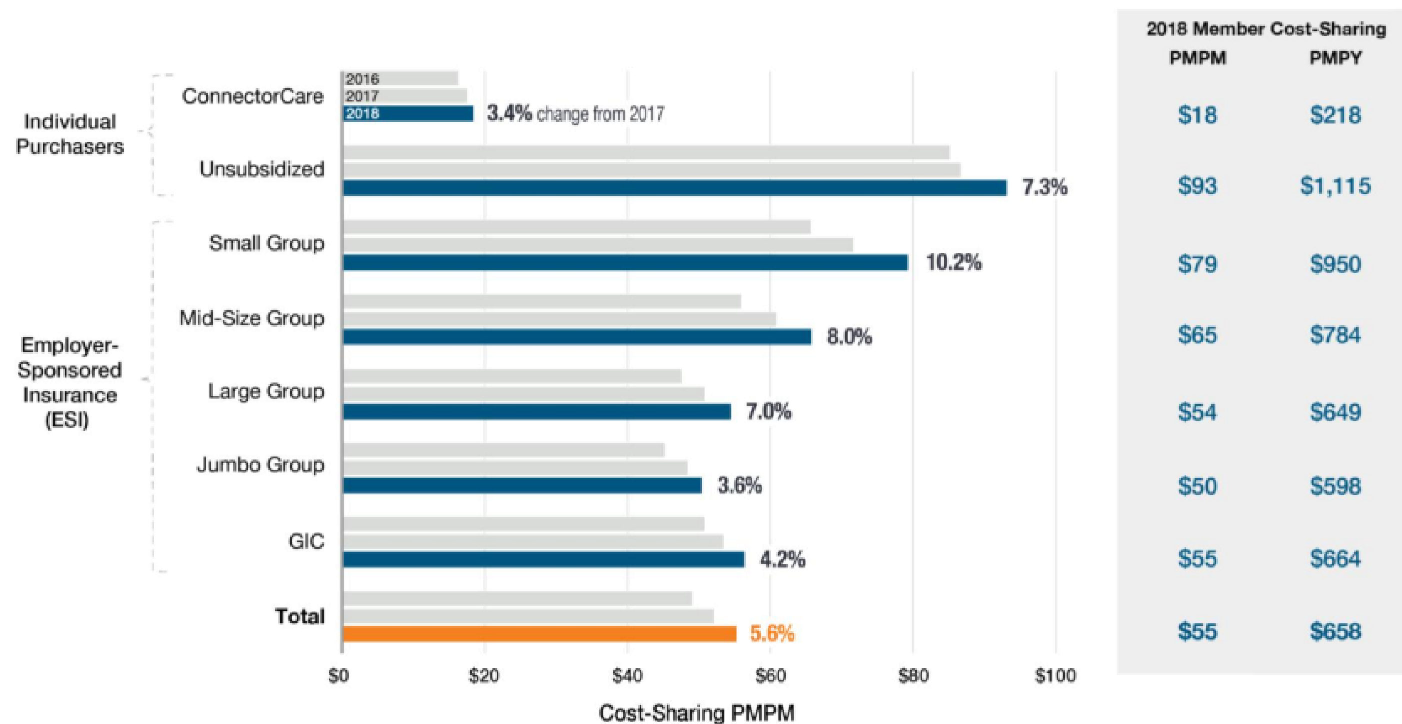
- Massachusetts has been analyzing APCD cost-related data for many years from a number of sources (e.g., APCD, payer-reported total medical expenditures, hospital discharge databases, national health expenditure accounts).
- One of three agencies tasked with monitoring the cost growth benchmark now publishes analyses relative to the benchmark. The agency produces recommendations based on these analyses and convenes a hearing on these analyses annually.

Example analyses from Massachusetts' data use strategy (2 of 4)



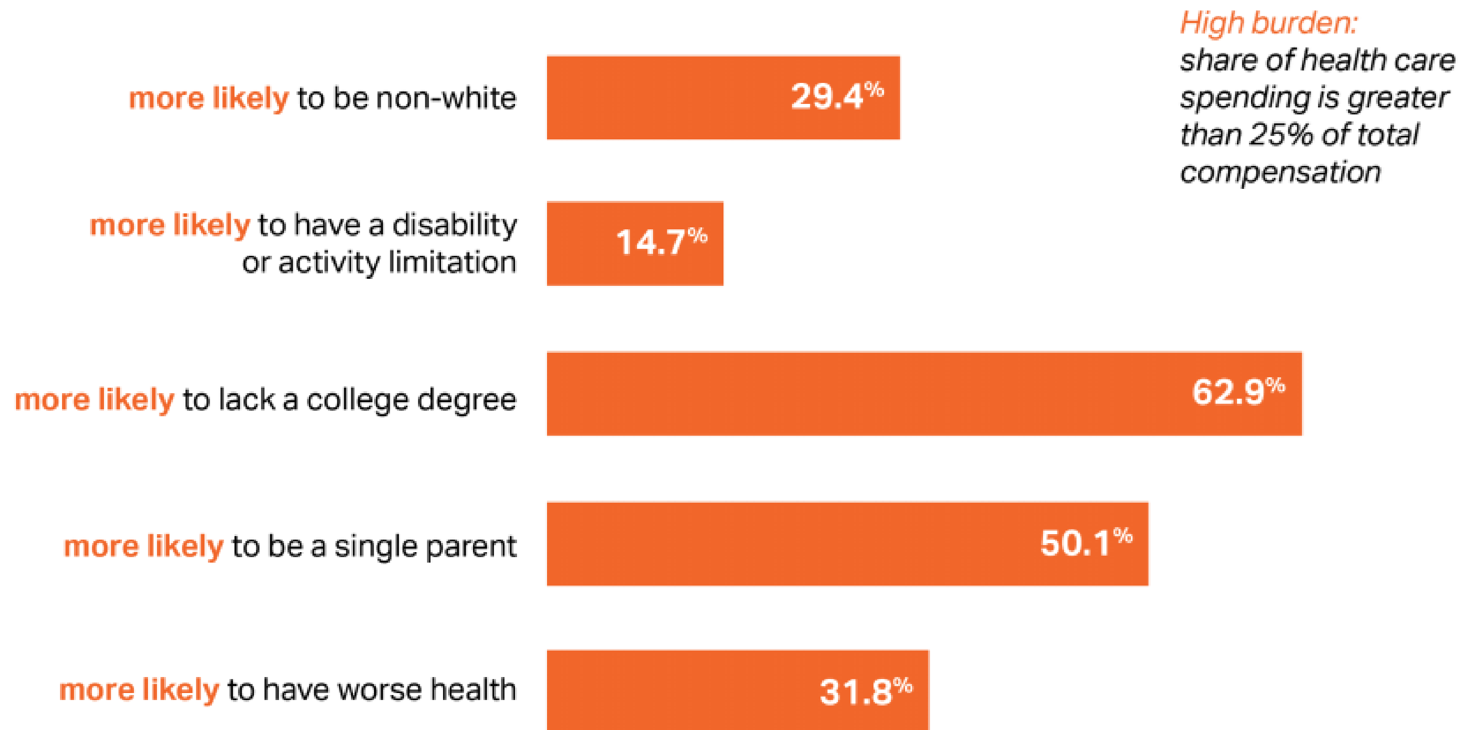
Source: MA HPC Cost Trends Hearing. 2019. https://www.mass.gov/doc/presentation-2019-cost-trends-hearing-day-one/download.

Example analyses from Massachusetts' data use strategy (3 of 4)



Source: MA HPC Cost Trends Hearing. 2019. https://www.mass.gov/doc/presentation-2019-cost-trends-hearing-day-one/download.

Example analyses from Massachusetts' data use strategy (4 of 4)



Source: MA HPC Cost Trends Hearing. 2019. https://www.mass.gov/doc/presentation-2019-cost-trends-hearing-day-one/download.

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Connecticut's data use strategy (1 of 3)

- **Priority audiences**: provider organizations, policymakers (executive and legislative), employers, and the public
- **Data source**: primarily the state APCD, supplemented by additional data sources as needed (e.g., hospital discharge data)
- **Primary analytics staff**: Mathematica (a contractor to Bailit Health) in the short-term and OHS in the long-term

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Connecticut's data use strategy (2 of 3)

- **Proposed Goals**:

1. Produce **routine analyses that pinpoint leading opportunities to reduce health care spending and health care spending growth** in a manner that will not harm patients, and to **improve quality**.
2. Produce **ad-hoc, one-time analyses in areas of perceived opportunity and that are of specific interest to stakeholders** committed to reducing spending while improving and/or maintaining access and quality.
3. Interpret health care spending analyses and **link findings with recommended actions for the intended audiences** (e.g., providers and provider organizations, employers, policymakers).

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Connecticut's data use strategy (3 of 3)

- **Proposed Guidelines**:

1. Analyses should be stratified by sub-populations that are of interest to stakeholders, including by:
   - insurance coverage (e.g., commercial, Medicaid, Medicare) **(*HCC)**
   - age (e.g., pediatric, adult)
   - provider (e.g., care site, practice, facility, network, system) **(*HCC)**
   - provider specialty
   - presence of chronic conditions
   - race, ethnicity, language and disability status, to the extent possible **(*HCC)**
   - geography (e.g., zip code, town/city, county)
2. Analyses should be designed for statistically valid and reliable results
3. Analyses should support comparisons to peer organizations and other benchmarks, and display change over time.

Does the Stakeholder Advisory Board want to provide the Technical Team with feedback on the proposed overall parameters of Connecticut's data use strategy?

Potential types of analyses to consider

- There are multiple categories of analyses the Technical Team can recommend for the data use strategy, including:
  1. cost growth drivers (what contributed to cost growth?)
  2. cost drivers (what is causing costs to be so high?)
  3. wasteful spending, including low-value care and duplicative services
  4. effects of the cost growth benchmark
- In addition, we can look at:
  - What are the respective roles of price, use, service mix/intensity and demographics in cost growth?
  - How does performance vary across providers and regions?
  - How does experience vary by patient population?

Potential types of analyses to consider

- We exclude quality as a topic for analysis because the Quality Council will consider this topic in the fall. The conversation will include consideration of quality from an equity perspective. **(*HCC)**
- As we consider each category of analysis, we will indicate which will be performed by Mathematica in 2020.

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Does the Stakeholder Advisory Board want to provide the Technical Team with feedback on the types of analyses included in Connecticut's data use strategy?

Wrap-Up & Next Steps

Plan of Meetings

Meeting #	Date	Meeting Goals
5	September 16, 1p.m.-3p.m.	• Discuss Technical Team data use strategy recommendations. • Discuss what steps should be taken to ensure the cost growth benchmark and primary care spending target are successful, and how to avoid any unintended consequences. • Discuss upcoming quality benchmark development