Healthcare Benchmark Initiative Steering Committee Meeting

Meeting Date	Meeting Time	Location
December 20, 2021	3:00 pm – 5:00 pm	Webinar/Zoom

Participant Name and Attendance

Healthcare Benchmark Initiative Steering Committee		
Ben Alvarez	Paul Grady	Wendy Sherry
Ted Doolittle	Paul Lombardo	Kathy Silard
Judy Dowd	Andy Markowski	Chris Ulbrich
Lou Gianquinto	Cassandra Murphy	Victoria Veltri
Deidre Gifford	Fiona Scott Morton	Josh Wojcik
Others Present		
Kelly Sinko, OHS	Krista Moore, OHS	Erin Campbell, Bailit Health
Olga Armah, OHS		Matt Reynolds, Bailit Health
Brent Miller, OHS	Michael Bailit, Bailit Health	Deepti Kanneganti, Bailit Health
Members Absent:		
Stephanye Clarke	Tiffany Donelson	Jeff Flaks
Ken Lalime	Chris O'Connor	Michael Posner

	Agenda	Responsible Person(s)
1.	**Welcome and Roll Call**	**Victoria Veltri**
	Vicki Veltri welcomed everyone to the December Steering Committee meeting and invited Matt Reynolds to conduct a roll call. There was a quorum present.	
2.	**Public Comment**	**Victoria Veltri**
	Vicki Veltri offered the opportunity for public comment. There were no public comments.	
3.	**Approval of November 30, 2021 Meeting Minutes**	**Victoria Veltri**
	Vicki Veltri asked for a motion to approve the November 30 meeting minutes with a minor amendment. Ben Alvarez motioned to approve the minutes. Paul Lombardo seconded the motion. There were no objections or abstentions. The meeting minutes were approved.	
4.	**Approval of the 2022 Steering Committee Meeting Schedule**	**Victoria Veltri**
	Vicki Veltri asked for a motion to approve the 2022 Steering Committee meeting schedule. Kathy Silard motioned to approve the meeting schedule. Ben Alvarez seconded the motion. There were no objections or abstentions. The meeting schedule was approved.	
5.	**Primary Care Spend Target**	**Deepti Kanneganti**
	Deepti Kanneganti of Bailit Health reviewed background information related to the primary care spend target, 2018-2019 baseline data used for the targets, and the 2022-2024 primary care spend target values. Wendy Sherry asked Deepti if primary care spending included virtual primary care. Deepti said that if a provider used a place-of-service code to indicate a virtual visit and that code was included in the core list of codes used by OHS to define primary care, then it would count towards primary care spending. Deepti said there likely were some telehealth visits that did not	

	get captured. Wendy thought this would be more essential to capture going forward with the increased use of virtual visits due to COVID starting in 2020. ***Post-meeting clarification***: In addition to the place-of-service codes, there are 14 telehealth-specific codes included in OHS' claims-level primary care definition. More information can be found here: https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/Guidance-for-Payer-and-Provider-Groups/Attachment-3-Cost-Growth-Benchmark-_-Primary-Care-Taxonomy-and-Procedure-Codes.xlsx Paul Grady asked Josh Wojcik how the Office of the State Comptroller's (OSC) primary care spending compared to the payer-level spending data Deepti presented. Josh said that OSC's primary care spending based on percent of spend data fell somewhere around 5%, similar to the ranges for commercial payer-level spending data Deepti presented. Paul Grady asked if Medicaid had a higher percentage of primary care spending due to difficulty accessing specialist care. Michael Bailit said there are likely multiple factors contributing to Medicaid's trend, adding, for example, that Medicaid compensates Federally Qualified Health Centers (FQHCs) generously. Michael also highlighted that for Medicare, the comparatively low percentage of primary care spending is influenced by a large denominator attributed to the high burden of chronic illness and associated use of acute care in the Medicare population. Fiona Scott Morton asked what actions providers and insurers could take in pursuit of the primary care target and how these expected actions took into account the variation in demographics and health status of their populations. Michael said that the targets were primarily geared towards actions by insurers noting that approaches by individual insurers would likely vary depending on their populations. Wendy Sherry disagreed with the notion that only insurers needed to invest for Connecticut to reach its primary care targets. She said she thought it required a collaborative approach with providers, consumers, and others. Michael Bailit clarified that he thought that payers probably had a more significant role than providers, but that everyone had a role to play. Deidre Gifford agreed with Michael that the payment system was primarily responsible for creating the incentives and disincentives through payment. Kathy Silard asked how OHS would bring Medicare to the table. Michael Bailit replied that the Center for Medicare and Medicaid Innovation (CMMI) is targeting certain states with a lot of collaborative activity to focus on advancing primary care, but that Connecticut was likely not on the current shortlist. He said there was a possibility that Connecticut could position itself so that CMMI would see Connecticut as a partner for a future aligned initiative, but Michael added that this was likely not achievable in the short term.
6.	**Primary Care Roadmap**	**Erin Campbell**
	Erin Campbell of Bailit Health reviewed the purpose for and elements of the Roadmap for Strengthening and Sustaining Primary Care.	

Fiona Scott Morton expressed concern that payers would not be incentivized to carry out activities aimed at preventing long-term expenses because they would be unlikely to reap the benefits for a given member due to churn. She thought there needed to be a prescriptive process for what activities insurers and providers had to carry out, including clinical protocols for primary care practices. Michael Bailit said that the draft Roadmap did not currently discuss clinical protocols, but that tying the primary care spend target and the Roadmap together would both set the expectation for and empower practices to deliver better care. Michael said that OHS would bring forth Fiona's recommendation once the Roadmap is final and future planning work focuses on operational detail.

Deidre Gifford added that from her perspective, the best long-term investment the State could make would be to focus on children and young families. To be successful in the long-term though, Deidre said that she thought it was essential to think about interim process and outcome measures that would help move the needle on longer term goals.

Ben Alvarez wanted to know how OHS planned to measure roadmap success. Michael Bailit replied that while the Roadmap currently outlined process expectations primarily; measurement and evaluation strategies had not yet been worked out.

Paul Grady said that he thought insurers recognized that primary care physicians needed to be paid more. He shared that OHS should be prepared for employers to ask why they were going to be paying more for primary care. Michael Bailit replied that he thought the best way to message this was to tie the primary care spend target to the cost growth benchmark and explain that increased primary care spending would reduce overall spending.

Wendy Sherry wondered if enhanced payments were intended to be in addition to what insurers were already offering or if what insurers were already doing could satisfy the requirements. Michael Bailit replied that payers had the flexibility to determine how to achieve the primary care spend target, and that they could decide not to offer additional incentives to provider organizations in which they are already making increased investment.

Kathy Silard thought it was essential to make upfront payments to providers in order to for them to reasonably be able to carry out activities that would produce savings and be impactful in terms of hospitalization rates and use of services.

Paul Grady wondered how common upfront payments were currently. Vicki Veltri said that OHS did not have that information but was preparing to gather that data via survey.

Paul Grady shared that he did not think a provider would change how they practice if say only one payer representing something like 20% of their patient panel offered a different form of payment. Therefore, Paul said that he thought all payers would have to act together. Fiona Scott Morton agreed and added that she thought there was no incentive for insurers to move first. She thought it was important to have insurers move together at the direction of the State. Michael Bailit agreed that this effort would not work if it was not a coordinated, multi-payer effort.

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	Paul Lombardo noted that in Connecticut, 70% of insurance coverage was self-funded and 30% was via employer. Fiona Scott Morton did not think this mattered. Wendy Sherry said that the design of the payment model did not depend on self vs. fully insured, but stated that employers had to agree with how insurers used their funds. Erin Campbell encouraged Steering Committee members and their colleagues to submit feedback on the Roadmap during the 30-day comment period.	
7.	**Quality Benchmarks**	**Deepti Kanneganti**
	Deepti Kanneganti reviewed the quality benchmark measures beginning in 2022 (phase 1) and 2024 (phase 2) and their associated benchmark values. Kathy Silard shared her view that the measures were thoughtfully selected and would improve outcomes and quality of care. She added that she thought the interim benchmark goals were reasonable and achievable. Deepti Kanneganti reviewed the *Obesity Equity* measure and associated benchmark value. Deidre Gifford asked if *Obesity Equity* was a homegrown measure. Deepti stated it was not a measure used in contracts between payers and providers but rather was based on a survey administered by the CDC. Michael Bailit clarified that the underlying obesity rate measure was an existing measure, but the *Obesity Equity* measure was homegrown. Deepti Kanneganti asked if the Steering Committee had recommendations on how to generate focused attention and improvement activity on the quality benchmarks. Kathy Silard thought that the Quality Council likely had access to what the drivers of success were on each measure and how providers could work to achieve better outcomes. Josh Wojcik voiced concern that the *Asthma Medication Ratio* measure incentivized waste for individuals with seasonal asthma. He wondered if that was taken into consideration by the Quality Council. Deepti noted that the Quality Council discussed the measure extensively, though they did not specifically discuss the sometimes seasonal nature of asthma. She noted that the Quality Council did discuss limitations such as that the measure may penalize providers for prescribing inhalers for multiple locations. Deepti added that the Quality Council still recommended the measure, despite its limitations, for several reasons: (1) the rate of asthma is very high in Connecticut, (2) there are known inequities in performance on the measure, and (3) the Quality Council determined *Asthma Medication Ratio* to simply be the best available asthma measure.	
8.	**Wrap-Up and Next Steps**	**Victoria Veltri**
	Vicki Veltri stated that the minutes from the meeting would be distributed, and noted the next meeting was scheduled for January 24th from 3-5 pm. Vicki shared that OHS planned to present pre-benchmark cost growth trend data for 2018-2019 at the January meeting.	
9.	**Adjourn**	**Victoria Veltri**

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	Vicki Veltri asked for a motion to adjourn. Ben Alvarez made a motion to adjourn. Andy Markowski seconded the motion. The meeting was adjourned at 4:57 PM.