Healthcare Benchmark Initiative Steering Committee Meeting

Meeting Date	Meeting Time	Location
March 28, 2022	3:00 pm – 5:00 pm	Webinar/Zoom

Participant Name and Attendance

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

	Agenda	Responsible Person(s)
1.	**Welcome and Roll Call**	**Victoria Veltri**
	Vicki Veltri welcomed everyone to the March 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 January 24, 2022 Meeting Minutes**	**Victoria Veltri**
	Ben Alvarez motioned to approve the January 24 meeting minutes. Karen Moran seconded the motion. There was no opposition, nor were there any abstentions. The minutes were approved.	
4.	**Proposed Benchmark Methodology Changes**	**Michael Bailit**
	Michael Bailit asked the Steering Committee if it wished to recommend truncation of high-cost outliers' spending when measuring and reporting payer and Advanced Network benchmark performance. Paul Lombardo asked about how truncation weighs the severity of a claim vs the cost of service. Michael Bailit noted that the approach used in other states and proposed for Steering Committee consideration only looked at total spend, and not what contributed to it. Paul Grady asked if it would be possible to exclude from truncation high-cost outliers whose costs were the result of hospital-acquired infections. Michael Bailit replied that the aggregate payer data used for the benchmark assessment do not include details on the services associated with a given patient's costs. For this reason, Michael explained that Paul's suggested approach would not be feasible.	

Ben Alvarez, Wendy Sherry, Kathy Silard, and Paul Grady voiced support for truncation. No members disagreed with the proposal.

Michael Bailit noted that the next steps would be to meet with payers to determine the level(s) at which truncation should be applied for the commercial, Medicaid and Medicare markets.

Michael Bailit then asked if, and if yes, how the Steering Committee wanted to modify its approach to risk adjustment at the payer and provider entity levels when evaluating year-over-year benchmark performance. Michael presented the following options for the Steering Committee to consider:
1. Adjustment using normalized clinical risk scores
2. Adjustment using age/sex factors only
3. Making no adjustment for changing population risk.

Fiona Scott Morton asked if making no adjustment for changing population risk could incentivize a payer or provider entity to only capture healthy members. Michael Bailit explained that benchmark performance does not impact compensation and added that risk adjustment is only for the purposes of comparing a population to itself from one year to the next. Therefore, Michael noted that the concern would not be that a payer or provider entity would only try to capture healthy members, but that an entity may try to drop sicker patients from its roster from one year to the next. Michael shared that OHS' contractor Mathematica was preparing to apply measurement methodologies to detect unintended consequences of the benchmark program such as this.

Kathy Silard voiced a strong preference for using normalized clinical risk scores. Kathy stated her view that clinical profiles do change year-over-year and need to be accounted for. Kathy added that increases in coding completeness more accurately reflected a patient's clinical picture.

Tiffany Donelson asked about the challenges of using APCD data if using normalized clinical risk scores. Michael Bailit explained that using APCD data for normalization would be feasible but would require greater time and state resources than the other approaches. Michael added that the biggest concern of taking this approach would be timeliness because APCD data would have to be updated, cleaned, and ready for analysis. Michael noted that if the Steering Committee elected to recommend adjustment using normalized clinical risk scores, OHS would have to perform additional research to confirm that it could carry out this approach in a sufficiently timely and cost-effective manner.

Josh Wojcik asked how using normalized clinical risk scores would work since the APCD does not include self-insured commercial claims. Michael Bailit confirmed that normalization of payer-level risk scores would only include fully insured and state employee health plan commercial claims, although all claims could be included for insurer calculation of normalized Advanced Network performance. He added that clinical risk grouper software could be run for

	each Advanced Network to determine what the risk score would be by market and that information could be used for normalization. Josh Wojcik brought up that there is inconsistency across risk adjusters. Michael Bailit agreed with Josh and noted that this was an imperfection of the normalized clinical risk score approach. Josh Wojcik asked how much room there still was for coding to continue to improve before patient records were as complete as they could possibly be, in which case increases in coding completeness would no longer pose a concern to the clinical risk score approach. Michael Bailit responded that Massachusetts had far more risk-based provider contracting than Connecticut, and yet Massachusetts continues to report increases in coding completeness year after year. Josh Wojcik expressed support for using age/sex factors. Deidre Gifford agreed, noting that the approach would maintain a nod to adjusting for population changes but for factors that are more immutable in the coding process. Deidre added that Connecticut has the good fortune of learning from other states and cited information Michael Bailit shared during his presentation that no other benchmark states were currently using normalized clinical risk scores as an argument against taking that approach. Fiona Scott Morton voiced support for making no adjustment for changing population risk since it would be the simplest and most practical approach. Fiona also expressed concern with the need to use APCD data for normalized clinical risk scores since the APCD does not include self-insured commercial claims. Paul Grady voiced support for making no adjustment for changing population risk, but added that age/sex adjustment was a reasonable alternative. Karen Moran tentatively expressed support for age/sex adjustment but asked what the timeline was for the Steering Committee to decide, as she stated she would like to consult her colleagues before committing to a stance. Wendy Sherry and Christine Cappiello (who attended the meeting in Lou Gianquinto's stead prior to his arrival) shared that they too would like to consult their colleagues before sharing their preferred approaches. Michael Bailit noted a decision was likely needed by the April Steering Committee meeting in order to allow sufficient time for OHS to update the benchmark implementation parameters before distribution to payers. Michael Bailit stated that the Steering Committee would return to this question at the April meeting.	
5.	**APCD Commercial Trend Analysis with Retail Pharmacy Added**	**Michael Bailit**
	Michael Bailit reported on updated commercial spending patterns between 2015 and 2019, with retail pharmacy spending added. Michael shared that annual per capita retail pharmacy spending growth was 7.6%, higher than any other service category. The impact of the addition of the addition of retail pharmacy spend was to increase total 2015-19 trend from a 4.9% average annual increase to a 5.3% average annual increase. Michael shared that OHS' contractor	

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	Mathematica would be carrying out more detailed pharmacy spend analyses to share with the Steering Committee in the future.	
6.	**Reasons for Commercial Hospital Price Growth**	**Michael Bailit**
	Michael Bailit reminded the Steering Committee a member asked two questions in response to the November presentation the described how hospital price growth was a leading driver of commercial market spending between 2015 and 2019: 1. What has been behind hospital price growth? 2. Is cost shifting occurring? <u>What has been behind hospital price growth?</u> Michael Bailit shared research that has shown that market power has been the leading factor in commercial hospital price growth. Vicki Veltri informed the Steering Committee of the actions OHS had been taking to address market consolidation. Fiona Scott Morton noted that while OHS' actions were good, they were not strong enough to address the problem. Karen Moran asked what reactions had been to OHS' requirements for negotiations to be held with individual hospitals and not health systems. Vicki Veltri stated that she was not able to comment on how discussions had gone in the settlement process since she was not personally involved in those discussions. Jeff Flaks asked Vicki Veltri for OHS' vision for the future of the Connecticut health system. Vicki stated that a shared vision needed to be developed that considered the perspectives of all the various stakeholders, but added that she thought financial incentives needed to be realigned to encourage greater focus on prevention. Paul Grady said that he hoped the vision included slowing healthcare spending growth. Kathy Silard stated that it would be necessary for the collective vision to focus on improving the health status of the community, improving access, and keeping the health system itself healthy. <u>Is cost shifting occurring?</u> Michael Bailit shared that national research indicated that hospitals do not cost shift, but rather price discriminate. Vicki Veltri noted it would be useful to have a visual representation of cost shifting vs price discrimination. Chris O'Connor shared his view that the dynamics involved in the topic of cost shifting are very complex. Jeff Flaks stated that he thought healthcare in the United States is broken and that hospitals need to disrupt themselves in order to bring about positive change. He stated that what worries him most are the access issues and the fragmentation of the current healthcare system. Jeff added that he believed that various healthcare facilities in Connecticut needed updating. Jeff pointed to increased use of urgent care as an example of change that had started to work.	

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	Chris Ulbrich stated that he thought quality needed to be a bigger focus of improvement for healthcare in Connecticut. Vicki Veltri noted that quality was a big focus of the Quality Council, adding that perhaps the Steering Committee needed an update on Quality Council activities. Jeff Flaks stated that Connecticut has a lot of room for improvement on quality but also has a lot to be proud of based on how Connecticut's healthcare quality compares to other states in the country.	
7.	**Impact of Urgent Care Utilization on ED Utilization Disparities**	**Michael Bailit**
	Topic not discussed due to lack of time.	
8.	**Wrap-Up and Next Steps**	**Victoria Veltri**
	Vicki Veltri thanked everyone for their contributions to the rich meeting discussion and invited members to submit via email any suggestions for Steering Committee agenda topics.	
9.	**Adjourn**	**Victoria Veltri**
	Paul Grady motioned to adjourn. Andy Markowski seconded the motion. The meeting adjourned at 5:00 pm.	