Healthcare Benchmark Initiative Technical Team
Meeting Minutes

Meeting Date	Meeting Time	Location
December 13, 2024	3:00 pm – 5:00 pm	Microsoft Teams Meeting: Meeting ID: 252 157 479 723 Passcode: ehmTkj

Technical Team Member Name	Attendance	Technical Team Member Name	Attendance
Loren Adler	A	Paul Grady	A
Don Berwick	A	Jason Hockenberry	A
Sabrina Corlette	A	Chris Manzi	A
Francois de Brantes	A	Roslyn Murray	A
Stefan Gildemeister	A	Joshua Wojcik	A
OHS and Contractors	**Attendance**	**OHS and Contractors**	**Attendance**
Deidre Gifford, OHS	A	Patty Blodgett, OHS	A
Alex Reger, OHS	A	Michael Bailit, Bailit Health	A
Lisa Sementilli, OHS	A	Erin Taylor, Bailit Health	A
A = Attended; NA = Did not attend			

Agenda

	Topic	Responsible Party	Time
1.	**Welcome**	**Deidre Gifford**	**3:00 pm**

Deidre Gifford welcomed everyone to the third meeting of the Healthcare Benchmark Initiative (HCBI) Technical Team and reviewed the meeting agenda. Deidre expressed appreciation for the Technical Team members' time, insight, and engagement thus far. Deidre acknowledged that the timeframe to meet the Technical Team objectives is compressed. Deidre asked Technical Team members if they would be willing to commit to an additional two meetings to ensure sufficient time to explore policy options and recommendations. Technical Team members agreed to do so.

2.	**Meeting 2 Recap**	**Michael Bailit**	**3:05 pm**

Michael Bailit provided a recap of Meeting #2. Michael summarized key takeaways and OHS action items from the discussion during Meeting #2, including discussion of the following during the second meeting:

- Criteria for selecting an economic indicator
- Benchmark construction
- Preferred indicators
- Additional discussion topics

<u>Criteria for selecting an economic indicator</u>

Michael Bailit presented new language to the criteria that would inform selection of an economic indicator and asked Technical Team members if the proposed language was responsive to their feedback during the second meeting. The suggested revision to the third criterion read: *"produce a benchmark value such that spending growth will not exceed change in resident ability to pay."*

- Don Berwick asked if the phrase "not exceed change in resident ability to pay" would be interpreted as not exceeding the cost of living. Don asked if that would be sufficient to reflect the different income levels within the population?
- Josh Wojcik suggested including "the state's" ability to pay, acknowledging the role of state funding in the Medicaid program.
- Michael Bailit explained that the prior language referenced consumers, employers, and taxpayers and asked if members thought the suggested revision should expand resident to be inclusive of taxpayers and employers. Josh and Chris Manzi supported Michael's suggestion.

Benchmark construction

Michael Bailit indicated that during the second meeting, Technical Team members identified two alternative or complementary approaches to the benchmark construction. Michael reviewed each of the approaches and considered their advantages and disadvantages.

a. Create benchmarks for separate utilization and price.

- Sabrina Corlette responded to one of the "cons" and said the approach might not represent a significant expansion of payer reporting requirements. She said that payers distinguish between unit prices and utilization now, and so requiring them to report this information might not constitute a significant "lift."
    - Francois de Brantes and Roz Murray agreed with Sabrina.
    - Francois asked if there was, in fact, additional complexity around holding changes in service mix constant, as described as a con. Michael Bailit responded with the example of newly introduced obesity medications (GLP-1) and said that changes in utilization due to a new service (drug) would impact utilization, and therefore cost – but not price.
    - Francois de Brantes said that reporting in aggregate masks and blends together nuances. Specifically, it does not distinguish the drivers of increases. Francois indicated that it is important to know if a new therapy has been introduced that contributes to increases in spending, for example. He said the challenge in setting a benchmark is that it does not allow for a deeper dive into factors driving trend. Michael Bailit indicated that OHS performs complementary analyses of cost drivers using APCD data that do look separately at price and utilization.
- Deidre Gifford said OHS would present options for the Technical Team to consider on this topic.
- Stefan Gildemeister provided a different perspective. Stefan said it is important to understand the distinction between prices and the extent to which price or utilization changes impact spending but it may not need to be a component of the benchmark. Stefan said it is essential for OHS to complement the benchmark with reporting of utilization and price. Stefan suggested a benchmark on aggregate spending, or THCE, consistent with the statute. Stefan said a higher-level benchmark communicates the expectation to stakeholders and provides flexibility for how accountable entities meet the target. Stefan said it is important for the state to take a pragmatic and collaborative approach.
- Don Berwick said that prices are driving excess costs, and not utilization. Don indicated that transparency on price would really help inform policy options, particularly when there is such variation in prices.

b. Market-specific benchmarks

Michael Bailit identified the next approach to benchmark construction that Technical Team members discussed during the second meeting: market-specific benchmarks.

- Francois de Brantes said trends in the Medicare and Medicaid markets hide the growth and contribution of high commercial spending growth and especially market prices. Francois said the current approach signals an acceptance of the trade-off between negative trend rate for public payers for much higher growth rates in commercial.
- Loren Adler agreed that market-specific benchmarks would focus attention on the commercial market trend and not to mask it due to low Medicare and Medicaid growth. Loren added that state policy priorities for Medicaid may drive increases in Medicaid rates and growth in spending, such as coverage expansion decisions.
- Roz Murray asked if OHS could just do a commercial benchmark. Michael Bailit replied that the statute requires a benchmark for total health care spending in the state and that it is silent on whether there can be market-specific benchmarks.
- Stefan Gildemeister noted that different benchmarks and levels may result in discussion of cost shifting, to which OHS may need to respond. Deidre Gifford said cost shifting has and will continue be a topic of discussion.
- Deidre Gifford observed that the discussion of market trends and market-specific benchmarks ties back to the criterion regarding taxpayer, employer, and resident ability to pay. Deidra said that affordability lends itself to reporting the benchmarks separately by market and different payers.

- Sabrina Corlette and Alex Reger identified reporting separately by market as an simpler alternative that could support the policy objective and place greater attention on the commercial market trend. (OHS currently reports trend by market and statewide. Michael Bailit noted that hospitals have advocated that provider entity level performance be reported in total, across markets. Currently, OHS reports provider entity total medical expense, or TME, trend by market.)
- Josh Wojcik agreed that reporting by market helps and asked if market-specific benchmarks could change the conversation and framing that can inform policy solutions.
- Loren Adler said part of the reason to have separate benchmarks is to focus attention on the commercial benchmark, particularly if there are future enforcement mechanisms for exceeding the benchmark.
- Deidre Gifford said that OHS has the authority to hold hearings and call entities that are "significant contributors" to cost growth. She conjectured that market-specific benchmarks could result in more focused questions in the hearings and identify cost drivers.
- Jason Hockenberry asked if Medicare Advantage and Medicare fee-for-service (FFS) are reported separately. Michael Bailit said Medicare Advantage and Medicare FFS are combined. Loren Adler and Sabrina Corlette noted that prices are at least roughly the same between Medicare Advantage and Original (i.e., FFS) Medicare.

<u>Preferred indicators</u>

Michael Bailit identified the five indicators Technical Team members had previously expressed interest in considering and asked members to think about the indicators in the context of the criteria.

1. Inflation (two options)
    a. CPI-U (all items)
    b. Personal Consumption Expenditures (PCE)
2. Average Wage
3. Median Household Income
4. Growth Rate Necessary for THCE to Equal a Target Percentage of Median Household Income
5. Growth in Medicare Spending

- Don Berwick asked how a rate would be set for the fourth indicator. Michael Bailit said it would need to be further explored and added that it would likely produce a negative benchmark. Loren Adler indicated that the option was to provide some rationale for a gradually declining benchmark. Sabrina Corlette indicated that it would be difficult for a public audience to understand option #4.
- Sabrina Corlette said she liked use of the inflation rate (option #1) because it responds to hospital concern about growth in input costs.
- Josh Wojcik asked about considering potential gross state product (PGSP). Michael Bailit said OHS has not included PGSP in the list because Technical Team members did not voice enthusiasm for it during the second meeting.

<u>Additional discussion topics</u>

Michael Bailit summarized two additional discussion topics from the second meeting: Technical Team members emphasized the importance of enforcement to meet the benchmark objectives and suggested OHS report change in out-of-pocket spending, consistent with the state's affordability goals.

3.	**Setting the 2026-2030 Healthcare Cost Growth Benchmark**	**Michael Bailit**	**3:35 pm**

Michael Bailit reviewed the specific topics that would be discussed in the context of setting the 2026-2030 benchmark:

- Value of preferred indicator and / or combination of indicators
- Setting a multi-year benchmark, including possibly adjusting the benchmark base value
- Reporting performance against the healthcare cost growth benchmark, including risk adjustment and improving statistical confidence (truncation, confidence intervals). *Note: The Technical Team did not get to discussion of truncation and confidence intervals due to time. Those topics will be included for discussion during the fourth meeting.*

Current spending trends in Connecticut

Michael Bailit reviewed the current benchmark values and spending trends in Connecticut observing that commercial market TME growth in 2021 (18.8% growth from 2020) was the highest growth reported in any of the cost growth benchmark states that reported performance.

Historical or forecasted values

Michael Bailit reviewed considerations for using historical or forecasted values to inform the benchmark and asked Technical Team members if there was a preference.

- Loren Adler and Don Berwick favored using forecasted values as the projections smooth out volatility.

Economic indicators: average annual change

Michael Bailit reviewed the 10- and 20-year historical trends and 10-year forecasts for the indicators under consideration. Michael also reviewed the average annual change charts for each indicator, observing the following:

- The two indicators of inflation are closely aligned.
- Differences in average annual wage and median household income trends.
- The slowdown of Medicare's trend since 2010.

Michael also discussed a basic calculation that could inform discussions of setting a benchmark that is a percentage of Median Household Income.

Discussion of advantages and disadvantages of options

Michael Bailit reviewed the advantages and disadvantages of the indicator options. Members discussed the options.

- Deidre Gifford reminded the group that OHS could combine indicators and attach weights to them to set a benchmark. The 2021-2025 benchmark uses 80% forecasted median household income and 20% PGSP. Michael Bailit said some states use a single indicator, citing California as an example.
- Francois de Brantes noted that data over the last two decades show premium or premium-equivalent in the commercial market has substantially increased relative to CPI and wage growth. Francois said tying Medicare to growth to CPI would provide a different view than Medicaid to CPI and a different picture than commercial to CPI. Francois emphasized that health care for privately insured has increased so much more than any of the indicators. Michael Bailit agreed, and said the trend for commercial should be negative because coverage is already unaffordable but acknowledged that it might not be feasible to implement a negative benchmark.
- Loren Adler agreed about feasibility and suggested median household income or average annual wage, less a percentage point, could acknowledge the already high growth and signal that health care should be growing much more slowly than measures of consumer income.
    - Stefan Gildemeister conveyed his support for a pragmatic approach and agreed that using average annual wages less a to-be-decided percentage that changes over time seemed feasible.
    - Sabrina Corlette agreed with using average wage and / or median household income minus 1%.
    - Don Berwick agreed with the approach of adjusting downward by a percentage value.
- Don Berwick asked about the possibility of indexing the benchmark to the 25th percentile of household income rather than median, which would show a sensitivity to households at the lower end of the curve. Michael Bailit said there might not be projections for wage growth at different deciles.
- Josh Wojcik said Connecticut's minimum wage is now benchmarked to inflation, so historic trend will be different than projections. Michael Bailit noted that OHS would need to use the forecast if using annual wage. Alex Reger said the 90th percentile of wage income in Connecticut is about $135K.
- Paul Grady suggested adopting a price index minus "x." Paul added that the "x" could be modified if there was an increase in primary care spending. Michael Bailit observed that moderating assessment of benchmark performance for investment in primary care could be applied to any of the indicators. Michael also said there would be a lag because of when the data on primary care investment would be available. This would mean that a reduction in the "x" would not happen for a few years after the investment.

- Don Berwick asked about the volatility in the primary care spend numbers. Michael Bailit said OHS would need to look into this question. Michael said primary care spending in the commercial market in Connecticut is low.
- Alex Reger asked if primary care investment could be considered in determining if an entity's excess growth is reasonable.
- Josh Wojcik said using average annual wage or median household income and excluding growth in primary care spend from calculation of trend could be an option to acknowledge the investment.

- Deidre Gifford asked the Technical Team whether legislative action on added enforcement mechanisms would be more difficult if OHS set a benchmark that did not consider inflation since industry would argue that it does not reflect the current economic circumstances. Deidre said OHS had advocated for legislation to impose performance improvement plans on entities for excess cost growth but had not been successful.
  - Chris Manzi said it would be more difficult. He said there was a need to consider the reaction of industry as OHS seeks additional enforcement authority.
  - Loren Adler said that the measures under consider all reflected consideration of inflation to in the forecasts.
  - Sabrina Corlette said that it might make a difference to blend inflation and wage or household income so there is a link to the price of goods. She added that hospitals would fight accountability no matter which indicator the State selected.

Michael Bailit asked the group to reflect on the historical and forecasted average annual change values for each of the indicators.

- Loren Adler expressed a preference for median household income to acknowledge affordability for the average person.
- Josh Wojcik also favored median household income vs. average wage and asked about median wages. Michael Bailit said forecasted median wage for Connecticut was not available.
- Roz Murray asked what value would trigger legislative review and approval. *(A value that is below 2.8 and above 3.8 would require legislative review.)*
- Jason Hockenberry said forecasted median household income was 2.7% and the current benchmark 2.9%. Jason added that 2.7% was aspirational, especially for the commercial market. Jason said there may not need to be a minus "x" if the Technical Team recommended median household income.
- Paul Grady said there was a need to show how much insurers were paying for services in the commercial market to apply pressure to systems.
- Michael Bailit pointed out the average annual change in forecasted median household income was 2.7% and for average annual wages it is 3.7% and asked the Technical Team to reflect on Jason's comment about "minus x" for a value that might be aspirational.
  - Francois de Brantes expressed a preference for median household with a minus, saying that it would give households a change to catch up to the high healthcare cost burden.
  - Stefan Gildemeister said a "minus x" signals that the current level of growth is a problem of affordability for people in Connecticut. Stefan favored a pragmatic approach and asked OHS what might be feasible in the political climate.
  - Deidre Gifford said a "minus x" might be feasible if there was an end date or goal, for example, until primary care spending investment was met. Deidre said there might be more acceptance if there was a known goal for entities to work toward.
  - Sabrina Corlette suggested there would be value in setting a benchmark that triggers legislative review so that the legislature can weigh in on whether the benchmark should be higher or lower. Sabrina said a benchmark value that triggers legislative review might present opportunity for engagement.

<u>Reporting Performance Against the Healthcare Cost Growth Benchmark</u>

Michael Bailit reviewed how risk adjustment has been incorporated in states' cost growth benchmark programs. Michael said that OHS currently reported spending adjusted by age and sex factors using data

	collected from payers. Michael asked if OHS should continue to report this way or consider other adjustments or no adjustment. • Francois de Brantes said if looking at price versus utilization, then the trend should be risk adjusted by age and sex factors. • Technical Team members voiced no objections to OHS continuing to report age and sex-adjusted spending performance.		
4.	**Public Comment**	**Members of the Public**	**4:50 pm**
	There was no public comment.		
5.	**Wrap-up and Next Steps**	**Deidre Gifford**	**4:55 pm**
	Deidre Gifford thanked the members of the Technical Team for their insights. During the next meeting, the Technical Team will finish the benchmark conversation and then begin discussing the primary care spending target. Deidre said the next meeting was scheduled for Friday, January 10, 2025, from 2-4pm.		
6.	**Adjourn**	**All**	**5:00 pm**

All meeting information and materials are published on the OHS website located at:
https://portal.ct.gov/ohs/programs-and-initiatives/healthcare-benchmark-initiative/hcbi-technical-team?language=en_US