Cost Growth Benchmark Stakeholder Advisory Board

Meeting Date	Meeting Time	Location
September 16, 2020	1:00pm – 3:00pm	Webinar/Zoom

Cost Growth Benchmark Technical Team Members Present		
Reginald Eadie	Karen Gee	Hector Glynn
Kathleen Silard	Marie Smith	Rick Melita
Robert Kosior	Tekisha Everette	Ted Doolittle
Richard Searles	Pareesa Charmchi Goodwin	Susan Millerick
Ken Lalime	Howard Forman	Kristin Whitney-Daniels
Janice Henry	Fiona Mohring	Jonathan Gonzalez-Cruz
Margaret Flinter	Lori Pasqualini	Jill Zorn
Members Absent		
Sal Luciano	Nancy Yedlin	Vicki Veltri
Others Present		
Michael Bailit, Bailit Health	Margaret Trinity, Bailit Health	

Meeting Information is located at: https://portal.ct.gov/OHS/Content/Cost-Growth-Benchmark

	Agenda	Responsible Person(s)
1.	**Welcome and Introductions**	**Olga Armah**
	Olga Armah called the meeting to order at 1:05pm.	
2.	**Approval of Previous Meeting Minutes**	**Olga Armah**
	Howard Forman moved to approve the minutes of the Board's August 26th meeting. Pareesa Charmchi Goodwin seconded the motion. The minutes were approved by a roll call vote with the following Board members voting in support: Reginald Eadie, Kathleen Silard, Janice Henry, Robert Kosior, Richard Searles, Ken Lalime, Margaret Flinter, Karen Gee, Marie Smith, Tekisha Everette, Pareesa Charmchi Goodwin, Howard Forman, Hector Glynn, Ted Doolittle, Kristin Whitney-Daniels, Susan Millerick, Jonathan Gonzalez-Cruz, Lori Pasqualini, and Jill Zorn. Fiona Mohring abstained.	
3.	**Public Comment**	**Olga Armah**
	Olga Armah invited public comment and none was voiced.	
4.	**Letter from Board members**	**Michael Bailit**
	Michael Bailit stated that Vicki Veltri received a letter from several members of the Board. The letter shared four recommendations for OHS as it moves forward with implementation of the healthcare cost growth benchmark: 1) carrier performance against the benchmark should be included in the process; 2) the data use strategy should include reporting on out-of-pocket spending changes; 3) OHS should undertake separate reporting of private vs public spending; and 4) performance reports at the provider level should be made public. Michael confirmed that the Technical Team had previously decided affirmatively on all four points, and so these recommendations will be included in the Technical Team's report.	
5.	**Follow up from the Technical Team's September 10th Meeting**	**Michael Bailit**
	Michael Bailit shared the Technical Team's September 10th discussion, which included the following cost growth benchmark topics: from which insurers will data be requested; how risk-adjustment will be applied; and minimum attribution size for providers. Michael also shared the Technical Team's most recent deliberations related to the primary care target. **Insurer Data Request** Michael Bailit reviewed the first issue: from which insurers would data be requested for the cost growth benchmark. As a reminder, Michael explained that data to support the cost growth benchmark need to be supplied by payers. OHS consulted with the Insurance Department and had recommended that in addition to traditional Medicare and Medicaid, the insurers listed on the Consumer Report Card on Health Insurance Carriers be requested to submit data to support the cost growth benchmark. Michael shared with the Board the list of recommended payers from which healthcare spending data would be requested for commercial payers, Medicare payers, and Department of Social Services for Medicaid. He said that OHS will also obtain summary-level data from the VA and the CT Department of Corrections. The Board voiced no concerns regarding this Technical Team recommendation. In response to a question from Kathy Silard, Michael confirmed that insurers will report on both their fully-insured and self-insured business. Kathy stated that she would like to have OHS collect data from PBMs. Michael explained that in other states in cases where pharmacy is carved out, the insurer/TPA makes an adjustment to estimate what that cost would be based on its book of business. The Stakeholder Advisory Board asked that staff explore whether it would be possible to request reporting from at least the three largest PBMs in the market. Michael stated that Bailit Health will explore if this is possible. If not,	

Michael said that insurer would be asked to estimate the pharmacy spending. Fiona Mohring asked if OHS will compel insurers to provide self-insured data. Michael clarified that the six commercial payers will be asked to report on aggregate spending and covered lives for both fully- and self-insured business. Michael clarified that as of right now this as an "ask" as opposed to compelling insurers to provide these data. Michael stated that other states have not experienced any opposition from self-funded employers because the data being collected are in aggregate. He noted that OHS intends to collect aggregate data and examine per capita spending.

Clinical Risk Adjustment

Michael Bailit shared the Technical Team's deliberations related to a second issue: risk adjustment of cost growth benchmark data. Michael noted that in order to report on payer and provider performance against the cost growth benchmark, cost data will need to be risk adjusted. He stated that for the Technical Team's purpose, "risk adjustment" is defined as the modification of spending data to reflect changes in underlying insurer or provider population over the course of the year. He added that the adjustment ensures that assessment of cost growth benchmark attainment considers changes in the underlying health status of the insurer's or provider's served population. Michael explained that there are two types of risk adjustment: clinical risk adjustment and social risk adjustment. He noted that social risk adjustment is a newer concept. Michael said that other states have applied risk adjustment at insurer and provider levels, but not at the statewide and market level because the populations are sufficiently large to make annual changes in population risk less likely. He added that for insurer-level and provider-level risk adjustment, the year-over-year trend is risk adjusted.

Michael explained that there are two options for performing clinical risk adjustment of cost data: the first is for each insurer to use its own risk adjuster, which is administratively less complex, but previously had been thought to negate combining risk-adjusted data across payers. The second option is for the insurers to adopt a common risk adjuster, which would be administratively burdensome for insurers. Michael stated that recently Bailit Health consulted with a nationally recognized risk adjustment expert. Her opinion is that the differences across risk adjuster products are not so significant and risk-adjusted data could be combined across payers. For these reasons, the Technical Team recommended the first option – to allow insurers to utilize their own individual risk adjusters because it is much more likely to secure payer buy in than it would be to ask them to use a common risk adjuster. Michael stated that the Technical Team also recommended requiring payers to report which risk adjustment tool they used and which version of the tool with their data submission.

In response to a question from Karen Gee, Michael clarified that the risk adjustment approach pertains only to commercial payers. Kathy Silard commented that there should be a robust conversation about the risk adjustment methods used by payers so that OHS can understand the differences. She would like the payers to report not only which risk tools they use, but also in general terms what methods they use so that stakeholders can understand at outset if there are large differences in methods across the payers. With regard to a social risk adjuster, Kathy Silard urged OHS to determine how it will incorporate social factors into the risk-adjustment process.

Ted Doolittle asked if the risk adjusters are in-house products or purchased from vendors. Michael stated that UnitedHealthcare's business unit Optum has its own product, but otherwise they are all purchased from vendors. Michael clarified that the products get upgraded regularly. Ted Doolittle stated that he prefers a common risk adjuster because the risk adjustment process is fraught with game playing, and without a common risk adjuster, insurers will game how they are presenting their data in comparison to one another. Rob Kosior asked if there was an option for the State to aggregate data and apply risk adjusters to the entire body of data. Michael replied that this was unfortunately not an option. He said that the State could only do this if the payers provided individual-level claims data, which it cannot compel for self-insured businesses. Rob said it will be important to identify changes in risk scores of fully-insured versus self-insured population. Michael agreed that this was an important point.

In response to a question from Ken Lalime, Michael clarified that risk adjustment is at two levels: the insurer market level and the large provider entity level; there will not be risk adjustment at the individual provider level. He noted that a large provider entity level will have many affiliated providers to whom a large number of patients are attributed.

Michael recapped the Board's discussion, noting: 1) Ted Doolittle expressed his preference for the second option, using a common risk adjuster across insurers; 2) Rob Kosior expressed caution when combining data across payers because a similar risk score may not mean the same thing depending on the adjuster used; and 3) Kathy Silard cautioned that we make sure we understand how the different tools work.

Rob Kosior said that he would not support the second option.

Margaret Flinter asked if there was a legislative requirement to require common risk adjuster. Michael said that the program was initiated by the Governor's Executive Order #5 and there is no legislative authority for the program. Rob Kosior said he was

previously under the understanding that the data request would be supported by the APCD. He said that he now realized this will require all the payers to provide a lot more data in addition to data they are submitting to the APCD. Michael stated that the APCD is missing half the self-insured data, the non-claims-based payments data, and pharmacy rebate data. As a result, these data are being requested directly from insurers. Michael acknowledged that this has caused some frustration on the part of insurers.

Karen Gee commented that she did not support option 2, i.e. moving to a common risk adjuster due to the administrative complexity and cost of doing so. Fiona Mohring agreed with Karen's comment.

Social Risk Adjustment

Michael Bailit stated that there are no established methods for adjusting spending data for social risk, and there do not appear to be any commercial payers doing so nationally. He said that the only examples we have of social risk adjustment are from Massachusetts and Minnesota Medicaid programs. The social risk adjustment factors being used by these two states do not explain much of the underlying variation in expenditures, however. Michael said that for these reasons, the Technical Team recommended not applying social risk adjustment to cost growth benchmark performance. The Technical Team did, however, strongly urge the State to adjust for social risk as part of the data use strategy.

Kathy Silard said she would urge that since the Executive Order calls for it, that OHS examine and undertake social risk adjustment in the future. Michael stated that Kathy's sentiment was consistent with the recommendation of the Technical Team.

Tekisha Everette asked for clarification of state efforts to undertake social risk adjustment. Michael described Minnesota's social risk adjusters, which look at extent of poverty and other variables that together indicate a level of elevated social risk. Minnesota found that the neighborhood risk score it utilized was associated with decreased health care spending. Michael noted that ultimately social risk adjustment is about adjusting expenditures for social risk. He posited that the inability of the Minnesota social risk adjusters to do so likely had to do with measuring the wrong things. He stated that Massachusetts found an opposite relationship between social risk and spending.

Fiona Mohring said she understood the recommendation, but noted that the experiences of Massachusetts and Minnesota contradicted what she was seeing. She emphasized that social risk adjustment needed to happen in future, and maybe Connecticut can do a social risk adjuster better and become the gold standard. Michael said that to accomplish this, Connecticut would need to do a lot more data analysis and look at more variables to capture relationship between social risk and spending. He said that social risk adjustment is a greatly understudied area. Hector Glynn said we don't want to penalize a provider that serves a higher proportion of a patient population that is vulnerable. Hector expressed concern about putting a cap on the entire system will lead to underservice, and noted that other states have found a way to at least measure social risk. He asked, if we don't adjust for social risk, what can we do to make sure that underservice does not happen? Hector said that it seemed like a "punt" to not try social risk adjustment. Michael noted that the Technical Team strongly urged OHS to pursue social risk adjustment.

Ken Lalime said that vulnerable patients are often not the highest consumers for the conditions that they are experiencing. Patients in highest need may not receive sufficient resources. Michael Bailit stated that it sounded like the Stakeholder Advisory Board was advocating for allocation of resources to development of a social risk adjuster. Fiona Mohring asked if the Technical Team's recommendation was enough, noting that it appeared that many Board members would like the Technical Team to do more than "urge" the State to adjust for social risk.

The Board agreed to the following recommendation: "The Stakeholder Advisory Board recommends that the State gather social risk data, and analyze the relationship between social risk variables and health care spending using APCD data."

Pareesa Charmchi Goodwin stated that there is a difference between a community having higher needs and a community getting more health care dollars spent on them. She said that pursuing social risk factors by means of the data use strategy was an interesting idea. She said that having two different steps or definitions for rurality would make better sense for Connecticut as the current definition of rural in Connecticut captured both suburban areas and deeply rural areas.

Margaret Flinter stated that there are other available data sources in Connecticut related to medical underservices, for example CHIME. She asked the Board to urge the State to use all available existing resources to measure social risk. She agreed with other Board members that the risk of underservice was huge.

Minimum Attribution Size

Michael Bailit explained that to report on healthcare spending at the provider level, a provider needed to be sufficiently large to help dampen any "noise" in the data and reduce the chance that random variation played a part in its performance. He said that statistical analysis has revealed that random variation will impact cost performance assessments unless populations are quite large. Michael explained that Delaware, Massachusetts and Rhode Island have chosen 3,000 to 10,000 lives as their minimum population size. Massachusetts is the only state to have reported performance publicly. Michael noted that while Massachusetts chose 3,000 as the minimum for *collecting* data, it is reporting on provider entities that are much larger, and has not publicly stated a minimum for *reporting* data. Michael stated that Delaware and Rhode Island are just now collecting data on their first performance period, and intend to report at 5,000 lives for Medicare and 10,000 lives for commercial and Medicaid.

In response to a comment from Pareesa Charmchi Goodwin, Michael stated that Massachusetts has published reports on provider entities but they are difficult to locate.

Michael stated that Delaware, Rhode Island and Oregon are planning to make all their reporting public. Michael stated that Oregon is developing an empirical model to use as the basis for setting a minimum population size for publicly reporting data, and Bailit Health hoped that this model would be completed in October. He said that project staff and the Technical Team suggested that Connecticut wait for the results of this analysis before making a decision on this policy parameter.

Tekisha Everette asked if deferring this decision meant that this became the work of OHS with the Technical Team. Michael replied that Executive Order does not specifically require that the Technical Team make this decision, but that OHS knows that this is a policy decision that must be made at some point. Michael added that initially meetings of the Technical Team and Stakeholder Advisory Board were anticipated only through September. He stated that Vicki Veltri had indicated her interest in continuing to consult with both advisory groups.

Jill Zorn asked about the minimum attribution size and expressed concern that some providers such as small rural hospitals will be left out given this reporting threshold, noting that it appears reporting will only capture larger provider organizations. Michael agreed that this will be the case as many providers will not make threshold for reporting purposes and it would also be unfair to report on them if they do not have sufficient covered lives for doing so. Michael noted that we will know more following a test-run analysis.

In response to a question from Susan Millerick, Michael stated that provider data will be reported at the state level and market level calculation, and in most cases at insurer level calculation but as the units of measurement get smaller, that's when the minimum attribution thresholds become more important.

In response to a question from Lori Pacqualini, Michael stated that the decision on minimum attribution size can wait until it is informed by Oregon's analysis. Michael said that OHS was not in a rush because the data will not be analyzed for over a year. Michael stated that he anticipated Oregon would publish its white paper on this topic in about three weeks.

In response to a comment from Pareesa Charmchi Goodwin, Michael noted that per capita spending will be very different across the commercial, Medicare, and Medicaid markets, and also very different by service within each of those three markets.

Primary Care Target – Setting the Target

Michael stated that the Technical Team previously recommended calculating a statewide weighted average of total primary care spending using total healthcare expenditures. He noted that OHS' current estimate of total primary care spending was 4.8 percent, and as such an additional 5.2 percentage points are needed to reach the Executive Order target of 10 percent. He stated that the Technical Team had struggled with how to set interim targets as OHS does not yet have the data needed to inform such targets. Michael stated that as a result, the Technical Team recommended setting a conservative 2021 primary care spend target at 5.0 percent. The Team made this recommendation for three reasons. First, OHS lacks baseline data from payers to identify current primary care spending. He noted that the 4.8 percent figure is a best estimate for current spending. Second, COVID-19 has significantly impacted primary care utilization in 2020, which is likely to continue into early 2021, at the very least. Third, Michael noted that the 2021 measurement period was to begin in just a few months, which did not give payers and providers sufficient advance notice of the target, nor time to take action to increase primary care spending. Michael noted that the Technical Team also recommended deferring setting of targets for 2022-2024 until after the baseline payer data were collected, and OHS had opportunity to consult with the OHS Work Group that will be focused on primary care. Several Stakeholder Advisory Board members commented in response:

- Marie Smith stated that she agreed with these recommendations in principle. She asked if the primary care work group had been named. Olga Armah responded that the primary care work group had been formed and would convene the week of September 22.

- Kathy Silard stated that a target should not be set for upcoming year for three reasons. First, she noted that the target for upcoming year was negligible and visits to primary care physicians are way down due to COVID-19. Second, she stated that until the work group gets started, there was not a completely agreed upon definition of what is primary care. Third, she said that it will take some time to invest in recruiting primary care physicians in order to reach target of 10 percent primary care spending as a percentage of total spending. Kathy said that setting a meaningless target for 2021 was useless.
- Margaret Flinter expressed agreement with Kathy.
- Susan Millerick said if you don't have a target and lack an improvement plan that you are marching towards, then there is a missing piece.
- Rob Kosior stated that he was unsure what the State was trying to achieve with the primary care spend target. He noted that as a payer representative, his organization had done a lot to try to increase primary care payments especially for value-based payments. He noted that those increases in primary care payments are combined with a clear expectations in terms of expected outcomes for patients. Michael replied that OHS did have a discussion with the Technical Team related to steps being taken to meeting the primary care spend target. The Technical Team had several specific recommendations on steps towards achieving target. He noted that the Technical Team report will convey recommendations as to what path should be taken to achieve target.
- Tekisha Everette expressed her support with the Technical Team recommendation for establishing 5 percent target for year one.
- Karen Gee said that increasing primary care spending should be performance-based, and not consist of just increasing rates. Michael stated that this was consistent with what the Technical Team recommended.

6. **Ensuring Success** — **Michael Bailit**

Michael Bailit asked the Board to consider what strategies would be needed to ensure the success of the underlying goals of Connecticut's cost growth benchmark and primary care spend target initiatives. Michael shared details of Massachusetts's cost growth benchmark experience, noting that the State's commercial spending growth has been below the national average growth rate since 2013. Michael shared three factors that had contributed to the success of the cost growth target program in Massachusetts. First, extensive negative press regarding provider market power and high prices, followed by legislative attention on healthcare costs, contributed to provider readiness to respond to accountability measures. Second, Massachusetts experienced wide adoption of total cost of care contracts in response to rising healthcare costs, and those contracts easily translated to a cost growth benchmark. Third, Massachusetts instituted annual hearings and reports, both of which have shone a spotlight on the main drivers of healthcare cost growth and provided strong incentive to keep cost increases down. Michael noted that Massachusetts had not experienced lowered consumer out-of-pocket cost growth as a result of cost growth benchmark implementation.

Michael shared the Technical Team's perspective, which is to highlight the importance of data transparency and a strong communications strategy when ensuring success of the cost growth benchmark. The Technical Team further recommended that OHS hold annual hearings, seek buy-in from stakeholder groups, especially providers, and articulate clearly the benefit and purpose of the benchmark, for example, conveying that the benchmark is not attempting to cut cost at the expense of quality.

Jill Zorn stated that Massachusetts is also unique in terms of the presence of strong HMOs that have implemented innovative payment plans, noting that Connecticut is behind Massachusetts in this regard and this may slow things down. She remarked that in Massachusetts, powerful entities have evaded the cost growth benchmark. Michael stated this was not the case and that larger entities have not avoided compliance with the Massachusetts benchmark. Rob Kosior noted that for many years in Massachusetts there was an all-payer rate setting system, and perhaps fear of returning to this contributed to provider compliance. Michael said that Massachusetts has had a very activist legislature when it comes to healthcare, and provider concern about what the legislature might do further was certainly a motivator.

Jill Zorn noted that providers in Connecticut are competing to attract patients away from urban centers such as NYC and Boston. Michael noted a similar dynamic in Rhode Island. Kathy Silard noted several factors that have contributed to Massachusetts success with the cost growth benchmark, including transparency. She said that she was pleased that transparency was also an underpinning of OHS' efforts. Kathy stated that Massachusetts valued the contributions of healthcare systems to the overall state economy, and as a result the formula was more weighted to the GDP. She further noted that when the benchmark was implemented in Massachusetts, there was no punitive consequence during first several years for providers. She said that in Massachusetts, the State tried make sure that the cost benchmark did not have unintended consequence of limiting access. Kathy spoke to need to make sure this happens in Connecticut as well.

Rick Melita asked if a cost growth benchmark would be successful if it simply shifted costs to workers, and noted that Massachusetts was not successful in lowering out-of-pocket expenses for consumers. He cautioned that OHS needs to be thoughtful as to definition of success. If costs are shifted to consumers, is that really a successful benchmark program? Michael

	said that if healthcare spending does not grow as fast, there will be less reason for employers to shift healthcare costs to employees. Fiona Mohring noted that there was nothing in these initiatives that would incent employers to shift costs to employees. Ted Doolittle supported several of Kathy Silard's points. He stated that he was not interested in any punitive measures towards providers. Karen Gee commented that providers also need to address access issues by embracing technology and embracing various access points of care. Ken Lalime agreed and said that we could measure telehealth visits and use of various technologies that have the ability to stabilize costs. Michael noted that in Oregon, a member of the State's advisory board recommended that independent of any benefit design features, it become a standard feature when individuals sign up for coverage, they select a PCP. Lori Pasqualini expressed her support, noting that such a measure can encourage primary care use instead of emergency care and urgent care use. Rob Kosior said that as a payer representative, his organization spends a lot of time attributing members to primary care providers, and so he would very much support this. Fiona Mohring expressed her support as well, as did Ted Doolittle. Michael encouraged Board members to reach out after the meeting via email if they had additional ideas for how to ensure the cost growth benchmark's success in Connecticut.	
6.	**Next Steps**	**Michael Bailit**
	Michael Bailit stated that OHS will share the Board's feedback and recommendations with the Technical Team. In addition, OHS will work to continue its stakeholder engagement activities moving forward. Michael noted that staff are drafting a report that OHS will be sharing with the Technical Team next week. Once the report is finished, OHS will share it with the Stakeholder Advisory Board. Michael stated that Vicki Veltri had indicated there may be a hearing to review recommendations in the report. Michael encouraged members to share their feedback on their Board experience over the past six months, and to do so via email to Olga Armah. He noted that this feedback will be particularly helpful as we plan for future steps. Olga expressed her thanks to the Board. She said OHS hoped to continue to engage the Board in coming months.	
7.	**Adjourn**	**Olga Armah**
	Susan Millerick moved to adjourn. The motion was seconded by Howard Forman. No votes were made in opposition to the motion.	