Cost Growth Benchmark Technical Team Meeting

Meeting Date	Meeting Time	Location
Thursday, August 27, 2020	1:00pm – 3:00pm	Webinar/Zoom

Participant Name and Attendance

Cost Growth Benchmark Technical Team Members Present					
Pat Baker		Paul Lombardo		Kate McEvoy	
Zack Cooper		Luis Perez			
Paul Grady		Rae-Ellen Roy			
Angela Harris		Vicki Veltri			
Members Absent					
Rebecca Andrews		Judy Dowd			
Others Present					
Olga Armah, OHS		Megan Burns, Bailit Health			
Michael Bailit, Bailit Health					

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

	Agenda	Responsible Person(s)
1.	**Call to Order**	**Victoria Veltri**
	Victoria (Vicki) Veltri called the meeting to order at 1:02pm.	
2.	**Review and Approval of Prior Meeting Minutes**	**Victoria Veltri**
	Luis Perez made a motion to approve the meeting minutes and Pat Baker provided a second to the motion. The motion was approved unanimously.	
2.	**Public Comment**	**Victoria Veltri**
	Vicki Veltri invited public comment; none was voiced.	
3.	**Stakeholder Advisory Board Feedback**	**Michael Bailit**

Michael Bailit noted that on August 26th he met with the Stakeholder Advisory Board and shared with them the Technical team's initial recommended primary care spend target strategy and an overview of policy questions related to the data use strategy. The Stakeholder Advisory Board provided the following feedback on the definitions of primary care and primary care services.

- The Stakeholder Advisory Board wished the Technical Team to be explicit that Doctors of Osteopathy (DOs) are included in the definition of who "primary care provider." Michael Bailit asked if anyone thought it was not reasonable and no one voiced a concern.
- The Stakeholder Advisory Board made a general request to include OB/GYNs and all OB/GYN services in the definitions. There was a specific suggestion for "routine" GYN services delivered by a PCP in the primary care services definition. Luis Perez agreed that GYN services performed by a PCP made sense.
- Michael Bailit noted that one member of the Stakeholder Advisory Board recommended ED services be included, but most people were opposed. Pat Baker said she could not see a rationalization for including ED services, noting that including ED services defeated the purposes of what CT was trying to accomplish. Kate McEvoy concurred. Luis Perez voiced concern that it is difficult to steer people away from using the ED for care that would otherwise be delivered by a primary care provider.

Michael Bailit noted the Stakeholder Advisory Board was a large body and when he shares feedback, it was not conveying that all of its members were expressing the sentiment. Vicki Veltri added that the strongest input was related to adding GYN services to the primary care definition. She said there were Stakeholder Advisory Board members on both sides of the ED issue and the rationale given was that currently some people use the ED or urgent care clinics for primary care services. She said some of these places could be considered primary care by some patients. Pat Baker said that if large healthcare facilities provided primary care clinics, she might be more open to it. However, she noted that these facilities no longer provide primary care services. If funding increased those types of services, large health clinics might come back. She noted that while EDs are critically important, we don't want them to be agents of primary care. Kate McEvoy said she concurred with Pat's comments. There was consensus among the Technical Team that ED services should not be included in the definition of primary care services.

Kate McEvoy said calling a GYN a primary care provider is different than saying GYNs provide primary care services. It's a departure from DSS practice.

Michael Bailit said that Luis Perez suggested the Technical Team adopt include routine GYN services performed by PCP as primary care services. He asked if others supported Luis Perez' proposal. Paul Grady said that he supported the proposal, and no one disagreed. Michael Bailit said that it will be included in the staff write-up of the Technical Team recommendations.

Michael Bailit noted that there will be a narrative summary of the recommendations so the Technical Team can look at them and confirm accuracy.

Michael Bailit also shared that Stakeholder Advisory Board wanted pediatric dental risk assessments to be included in the definition of primary care services. He said its rationale was that behavioral health behavioral health assessments were included, so why not dental assessments? These services are performed by PCPs. He said the Stakeholder Advisory Board also advocated for inclusion of fluoride varnish application, which Michael Bailit thought the Technical Team had already supported. Kate McEvoy and Rae-Ellen Roy voiced support for including pediatric dental risk assessments and fluoride varnish. Nobody disagreed.

Michael Bailit said the Stakeholder Advisory Board thought efforts to increase primary care spend should focus on rewarding performance. An additional suggestion was to increase primary care spend by delivering more primary care to people not currently receiving it.

4. Data Use Strategy — **Michael Bailit**

Michael Bailit noted that this topic was discussed during the last meeting. For this meeting there would be continued discussion. Michael reminded the group that the "Data Use Strategy" is defined as strategic use of the APCD and other data resources to identify what influences cost growth and issues related to primary care spend, quality and equity. He said that this meeting's focus of discussion would be on analysis of factors influencing costs and cost growth.

Michael Bailit reviewed three proposed data use strategy goals:

1. Produce routine analyses that pinpoint leading opportunities to reduce healthcare spending and healthcare 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 healthcare spending analyses and link findings with recommended actions for the intended audiences (e.g., providers and provider organizations, employers, policymakers).

Technical Team members reacted to the proposed data strategy goals as follows:

- Pat Baker thanked Michael Bailit for giving the Technical Team something to react to. She said she liked the three strategy goals. and would like to see "and quality" inserted after "…health care spending growth in a manner that will not harm patients." Pat added that quality needs to be strongly inserted there.

- Kate McEvoy thought it would be useful to articulate the use of data for the examination of gaps in care, etc. because of stakeholder concern about stinting and reductions in care and include it as a way of tracking and preventing it. Michael Bailit discussed the concept of possibly identifying gaps in care through "cold spotting" where cities, towns, and neighborhoods are identified for their under-utilization of services.

- Paul Grady agreed with Pat Baker's point about quality. He suggested that outcomes need to be part of a discussion of quality. He also agreed with the three proposed goals.

- Paul Lombardo said that he agreed with the goal suggestions, and with the comments of others.

Angela Harris asked whether consumers were intentionally left out of the priority intended audiences. Michael Bailit explained that this strategy is intended to equip those entities subject to the benchmark as well as state policymakers with information to help them take action to meet the benchmark. It is not intended to exclude consumers. OHS will make the information available in hearings and on the website. Michael noted that extensive research has shown that consumer-oriented data on health care spending, including the kind that is on the HealthScore CT, tends not to get used by consumers. Nonetheless, all analyses to be public. Angela Harris suggested that consumers should not be expressly left out as it feels alienating. Michael Bailit expressed a desire to follow up with Angela after the meeting.

Michael Bailit reviewed the following proposed guidelines for consideration on all analyses, noting that they were not meant to be exclusive.

1. Analyses should be stratified by sub-populations that are of interest to stakeholders, including by:
    - insurance coverage (e.g., commercial, Medicaid, Medicare) **(*HCC[1]);**
    - 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)**, and
    - geography (e.g., zip code, town/city, county).
2. Analyses should be structured to produced statistically valid and reliable results, including through use of risk adjustment.
3. Analyses should support comparisons to peer organizations and other benchmarks, and display change over time.

Michael noted that any analyses that would be performed would be stratified.

Paul Lombardo said that he supported the guidelines.

Pat Baker said she disliked the phrase "to the extent possible." She suggested that there be a strong commitment to address these challenges. She said she has seen "to the extent possible" previously and then nothing happened. She urged that there be a commitment to good-faith effort and commitment to try to improve race, ethnicity, language and disability (RELD) data. Pat said that when you tie this to the analysis or quality, RELD becomes important to link race with quality metrics. Michael Bailit said staff would add that intention, and clarify that analysis would look at individual insurers, not just at insurance market.

Kate McEvoy asked whether commercial insurers have plans around tracking RELD data. She said she felt like we get to a point in the conversation and then it stalls. Michael Bailit noted that commercial insurers don't collect RELD data. Vicki Veltri said it might be more likely collected through the state health information exchange (HIE) than through claims. Kate McEvoy said if we're signaling this is critical than we need a companion piece that catalyzes that information. Kate said that RELD is in Medicaid data. Michael Bailit said large institutional providers may track it but not necessarily track it in the same way. Vicki Veltri said it may be very difficult to collect the data, but maybe could update the APCD specifications guide. OHS is having a lot of those conversations. Kate McEvoy asked whether we could report out in all of the strata identified in the first line of the presentation slide. She was worried about overselling what is possible. Michael Bailit noted that it depends on what we use for the provider directory. Vicki Veltri said that a conversation about the provider directory was forthcoming and that in the first year or two, it might not be as fully blown out as it will be with the HIE. Kate McEvoy said in in terms of setting reasonable expectations she thought it important to lay out the process.

Michael Bailit summarized the conversation by saying that it was clear that the Technical Team would like to make a recommendation for prioritized attention to building infrastructure to collect and report RELD data.

Michael Bailit asked the Technical Team to weigh in on which analyses to prioritize in the data use strategy. He presented some options. The options were summarized as follows:

1. Cost growth driver analyses
2. Cost driver analyses
3. Effects of the cost growth benchmark analyses

Regarding the cost growth driver analyses, Zack Cooper cautioned being careful what is attributed to price. He said when you look at difference between cars you can attribute a lot to price, but not take into account the model. If one looks at hip replacement price, different implants getting better over time is not just about price. Michael Bailit said breaking down cost growth to its component eliminates is indeed an imperfect methodology and we need to be careful about assigning false precision. He stated suggested there was still benefit to looking at the data in this way. Zack Cooper said anything that's loaded onto price is imperfect. Paul Grady said even if it's imperfect, it gives us a better sense, which is more than what we have today.

Michael Bailit then discussed the second category: cost driver analyses. He said Mathematica was doing some of this analysis and will adjust for age and gender, which is a rough risk adjustment. There are more sophisticated risk-adjustment methods, but age and gender will roughly account for some differences. Other analyses could look at low-value, overutilized or underutilized services.

[1] 2019 Health Care Cabinet report priority recommendation

Regarding episode-based analysis, which is a sub-category of the cost driver analyses, Michael Bailit said the example data analysis from RI was not intended as a transparency tool, but really to assess what the potential was if episode-based payment was implemented. Episode-based payments are in use in Medicare program, and in use in certain states for their Medicaid program, and then sporadically by commercial payers / providers. Rae-Ellen Roy noted that 12 procedural episodes are going to go live on October 1, 2020 in the state employee health benefit program.

Finally, Michael Bailit discussed analyses that would review the effects of cost growth benchmark by analyzing underutilization, affordability, and the impact on marginalized populations. Michael said there was no evidence that underutilization had incurred in the Massachusetts cost growth benchmark program, but as the Technical Team and other stakeholders had talked about regarding the cost growth benchmark, it could lead to stinting. Therefore, he said, it's responsible for the data use strategy to assess underutilization. Quality benchmarks could also be used to this end.

Michael Bailit asked the Technical Team three questions: (1) Would you like these analyses performed? (2) Are there other analyses you would wish to see? and (3) Which ones are the highest priority? The following text summarizes the discussion of the Technical Team members.

- Paul Grady wanted to know about the cost of complications or healthcare-acquired infections. He said that CT is in the middle of the pack when it comes to Leapfrog quality and that it would be helpful to understand to what extent it costs all of us money. Michael Bailit said the episode software package is one means, but there could be another means of performing such analysis. Paul Grady also expressed interest in price variation. Finally, Paul suggested that the episode software that is supporting the Comptroller's initiative may be utilized in that way.

- Paul Grady also said that he would like to understand the mix of primary care vs. specialty services by geography and by health care system. Michael said this analysis was possible.

- Angela Harris noted that a new trend is to build ambulatory surgical centers (ASCs) or other satellite locations. However, she said when they are located across the street it's not being considered an extension of the hospital and that people are splitting hairs on definitions of ASCs. If that impacts costs, and potentially utilization, she said, her concern is that folks manipulate the system to make the numbers spin the numbers the way you want. Michael Bailit said this would be a valuable ad-hoc analysis to understand ASCs impact on cost growth, utilization and access and whether that varies by ASCs away from hospitals and those next to hospitals. Michael said there could other analysis on growth of urgent care centers or facility fees on utilization / spending. If OHS is able to have the type of analytical support to allow an advisory body in the future put its finger on trends that people are seeing in the community, that type of analysis could be done.

- Luis Perez said he was struggling with prioritizing. He said the cost driver point-in-time measurement would be a good reference point to measure against, but he did want to capture the cost growth driver is to see what the change over time as. Luis added that he was very concerned about the benchmark, particularly around the underutilization in certain populations. He urged OHS not to lose track of assessing the effects of cost growth benchmark, including capturing any negative effects that may occur.

- Pat Baker said there could be staging of the analyses. She added that the effects of the cost growth benchmark were critically important to her and a high priority. She understood starting with a point-in-time analysis, but felt that change-over-time analysis was also important. She said she really liked the episode analysis a great deal. She said she thought if she had to start, she would do so with the cost driver analysis, and then look at the effects of utilization, price, cost and patient demographics in the cost driver analysis.

- Zack Cooper said he would pick a basket of 10 services and benchmark those services across providers. He said he would do non-differentiated services, e.g., colonoscopy, MRI, joint replacement, OB care (c-section, vaginal delivery), do it across providers and do it bi-annually. Zack referred to a paper in which he conducted a similar analysis. Michael asked Zack to send the paper he referenced.

- Paul Grady said the Choosing Wisely group has looked at Washington's analysis and duplicating that would help citizens understand the opportunities, including by looking at geographic variation.

Michael Bailit said he understood prioritizing these analyses is hard since they have all value, but noted that the work can be staged so that they can all be addressed in time.

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5.	**Cost Growth Benchmark**	**Michael Bailit**

Michael Bailit noted there were some "loose threads" to resolve relating to the cost growth benchmark. He specifically noted that the Technical Team recommended that all major markets (Medicare, Medicaid, commercial) be included in the benchmark. Previously, the Technical Team had discussed including healthcare spending by the Department of Corrections and that research by project staff had been conducted to assess feasibility. Michael Bailit said Corrections healthcare spending can be collected from on a fiscal year basis. This is not the same time period as the cost growth benchmark, but it's something, and OHS could collect it every year. The Technical Team agreed to include Corrections spending data.

The second open cost growth benchmark issue was related to dental spending. Michael Bailit noted that the Technical Team discussed including medical claims and non-claims data in the definition of healthcare spending. He noted that Technical Team and Stakeholder Advisory Board members previously wanted to explore the idea of including dental carriers. Michael noted that some spending on dental services was already including in the cost growth benchmark. He cited as examples coverage of dental services through HuskyHealth and limited Medicare coverage. Michael said collecting data from dental carriers may be feasible. He reviewed the advantages as being a way to capture spending related to health care more holistically. Disadvantages included that large portions of the population coverage don't have dental coverage and so we would be missing a lot of spending for those paying out-of-pocket. Technical Team members reacted with the following comments:

- Paul Lombardo noted that dental carriers have very limited benefit scope of coverage. He said that more broad-based dental coverage tends to be included in medical coverage. Paul said that he would be very surprised if dental spending from dental insurance companies and from strictly dental-only plans amounted to much spending.

- Pat Baker said the Foundation had been very committed to oral health and her heart wanted to say "include", but her head said "exclude." She was concerned that OHS would not get the data needed. Pat felt that the disadvantages of inclusion would outweigh what would be achieved through inclusion. She said this spoke to the lack of good coverage for oral health. If Medicare covered oral health, she might be more inclined to include it.

- Vicki Veltri said that for kids, Husky has robust coverage that will come into the spending data. Paul Lombardo noted that one of the carriers on the exchange includes dental as part of medical coverage. There are dental-only carriers registered with the exchange that will be missed.

- Vicki Veltri said the APCD advisory group was discussing the collection and feasibility of collecting dental data. She said that the topic of dental spending inclusion could be revisited over time. Angela Harris said CT should worry more about increasing access to dental care and coverage as opposed to worrying about making it part of the cost growth benchmark.

- Luis Perez said there are so many other areas that are not included and that we risk not being able to look at the entire health care system, but dental is not pertinent to this particular initiative.

- Kate McEvoy said plans on the exchange should report their dental spending. She said DSS could report dental coverage by provider on HuskyHealth and was publicly available information.

Michael Bailit summarized the discussion as follows: when dental services are included as a medical benefit, it should be included in the cost growth benchmark calculation, but OHS should not separately collected data from commercial dental carriers. Final, this decision should be revisited in the future.

6.	**Wrap-up & Next Steps**	**Vicki Veltri**

Michael noted the next meeting was scheduled for September 10, 2020 and during that meeting, additional outstanding cost growth benchmark and primary care target work will be reviewed. He said the Technical Team will talk about other issues, including minimum population size for insurers and providers to be measured against the cost growth benchmark and what to publicly report. Prior to the last scheduled meeting, a written draft of recommendations made to date will be shared.

Vicki announced that this was Pat's last official week as the President and CEO of the Connecticut Health Foundation, but she will continue on with this Technical Team. She acknowledged Pat's contribution to healthcare in the state of Connecticut, and complimented her on her leadership, collaboration and participation, particularly in the area of disparities and inequities.

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7.	**Adjourn**	**Vicki Veltri**
	Pat Baker made a motion to adjourn the meeting and Paul Grady seconded the motion. The meeting adjourned at 2:50pm.	