OHS CONNECTICUT Office of Health Strategy

Stakeholder Advisory Board Meeting

Meeting Date	Meeting Time	Location
March 25, 2021	3:00 pm – 5:00 pm	Webinar/Zoom

Participant Name and Attendance

Cost Growth Benchmark Technical Team					
Nancy Yedlin		Lori Pasqualini		Rob Kosior	
Theresa Riordan		Marie Smith		Richard Searles	
Jonathan Gonzales-Cruz		Kristen Whitney-Daniels		Tekisha Everette	
Jill Zorn		Hector Glynn		Susan Millerick	
Pareesa Charmchi Goodwin		Margaret Flinter		Victoria Veltri	
Ken Lalime		Karen Gee			
Others Present					
Kelly Sinko, OHS		Krista Moore, OHS		Michael Bailit, Bailit Health	
Olga Armah, OHS		Hanna Nagy, OHS		Margaret Trinity, Bailit Health	
KeriAnn Wells, Mathematica					
Members Absent:					
Reginald Eadie		Howard Forman		Sal Luciano	
Kathleen Silard		Fiona Mohring		Rick Melita	
Ted Doolittle					

Meeting Information is located at: https://portal.ct.gov/OHS/Pages/Cost-Growth-Benchmark-Stakeholder-Advisory-Board/Members

	Agenda	Responsible Person(s)
1.	**Welcome and Introductions**	**Victoria Veltri**
	Vicki Veltri welcomed members of the Stakeholder Advisory Board.	
2.	**Public Comment**	**Victoria Veltri**
	Vicki Veltri welcomed public comment. None was voiced.	
3.	**Approval of the CGB Technical Team Meeting Minutes**	**Victoria Veltri**
	Karen Gee made a motion to approve the Board's last meeting minutes, and Theresa Riordan seconded the motion. The following members voted to approve the minutes: Theresa Riordan, Jonathan Gonzales-Cruz, Jill Zorn, Pareesa Charmchi Goodwin, Richard Searles, Lori Pasqualini, Marie Smith, Kristen Whitney-Daniels, Margaret Flinter and Tekisha Everette. Nancy Yedlin abstained from the vote. Several other members joined the meeting after the vote.	
4.	**Healthcare Benchmark Initiative Updates**	**Michael Bailit**
	Vicki Veltri stated that OHS held a public forum on March 24th titled, "Using the Cost Growth Benchmark as a Tool to Improve Health Care Affordability." She noted that the forum had 85 participants. Vicki stated that the forum highlighted OHS's efforts to address affordability and included a review of select cost growth drivers in Connecticut. She added that the forum showcased consumer voices, including Angela Harris of the Technical Team and Susan Millerick of the Stakeholder Advisory Board. Michael Bailit stated that OHS planned to make an initial pre-benchmark data request on March 31st for payers to submit CY 2018-2019 data. He added that the pre-benchmark analysis would only be at state and market level, and that OHS would add reporting of individual payer and provider entity performance against the 2021 benchmark in early 2023. Michael noted that with significant help from Jonathan Gonzales-Cruz, OHS was moving forward with requesting data on health care spending for people who are uninsured.	
5.	**Minimum Population Size for Reporting of Provider Benchmark Performance**	**Michael Bailit**
	Michael Bailit stated that in January 2021, the Technical Team explored how OHS would make determinations of payer and provider entity performance against the benchmark. He stated that at that time, the Technical Team recommended that OHS perform calculations of statistical significance when reporting benchmark performance to ensure the accuracy of findings. He noted that in so doing, the Technical Team had endorsed the same methodology developed by Oregon for the same purpose. Michael stated that the Technical Team expressed support for OHS not setting a specific threshold for attributing lives at this time. Instead, OHS will collect pre-benchmark data from payers in spring 2021 and analyze the data by summer 2021. OHS will calculate confidence intervals based on the actual data submitted by payers for Advanced Networks, and then propose a recommendation for a minimum threshold for public reporting of 2021 provider performance. He added that the threshold set by OHS can be re-evaluated over time.	

	Karen Gee asked how continuous enrollment will be handled with regard to attribution. Michael stated that the approach adopted by the Technical Team is to have each payer use whatever attribution approach they currently use. Rob Kosior asked how patients who cannot be attributed will be handled. Michael stated that the OHS Implementation Manual asks the payers to report unattributed lives and spending separately. He noted that people who are unattributed might be individuals who did not access any care, or who are only accessed care from a specialist(s).	
6.	**Mathematic Analysis Findings**	**Michael Bailit**
	Michael Bailit introduced the main agenda topic for the meeting, a review of a spending analysis performed for OHS by Mathematica using the State's All-Payer Claims Database and other data sources. He noted that Mathematica's analysis met the "Data Use Strategy" aim of Executive Order #5, which calls for a complementary strategy that leverages the state's APCD, and potentially other sources, to analyze cost and cost growth drivers. Overview of All-Payer Claims Databases Michael noted that Mathematica primarily used Connecticut's APCD for the analysis. He added that the initial purpose of Mathematica's analysis was to provide insight into cost drivers and to support solutions for achieving the cost growth benchmark. Michael provided a brief overview of all-payer claims databases, noting that APCDs compile enrollment and claims data submitted by payers. Michael reviewed both the advantages and disadvantages of APCDs. Their principal advantage is they can support very detailed analysis of spending patterns. Their disadvantages include the lack of non-claims spending such as performance incentive payments and capitation payments, they lack clinical data, and there is a significant lag time associated with APCD data. Overview of Analytic Population Michael provided an overview of the analytic population and framework for Mathematica's analysis, noting that the study population was limited to Connecticut residents under age 65, and those commercial fully insured or enrolled in the state employee health plan. He acknowledged that the analysis was for medical claims only, and that the omission of pharmacy claims was a big gap in the analysis. Michael noted that demographic data supporting analysis of disparities came from a database maintained by the U.S. Census Bureau. Jill Zorn asked if the cost sharing analysis was for cost sharing paid by the patient or billed to the patient. Michael stated that the cost sharing analysis related to the amount that the patient was obligated to pay. Ken Lalime asked if change in mix of services was included in the analysis as a contributor to spending growth. Michael said that with one exception changes in mix of services was not analyzed, adding that in the future OHS would like to better understand changes in spending patterns and the relative contributions to those patterns of changes in price, volume, service mix and acuity. Michael presented enrollment data, noting that from 2015 to 2018 Anthem and UnitedHealthcare represented the largest commercial payers in Connecticut's APCD, accounting for two-thirds of the market in 2018. He said that the remaining four payers insured just a bit more than one third of the fully insured commercial market in 2018. Michael noted that during the 2015-2018 time period the commercial population declined slightly (by 0.7 percent). Vicki Veltri noted that the small group market in Connecticut had been shrinking. She said that the privately insured commercial market is approximately 30 percent of the total commercial market. In response to a question from Marie Smith, Michael stated that the Connecticut APCD collects Medicaid data, but that Mathematica's analysis focused only on commercial spending. Michael noted that Mathematica's analysis found that from 2015 to 2018, the Connecticut population had become slightly older and had trended a bit more toward female. He also noted that there had been a reduction in the share of commercial members in the 0-25 age group. In response to a question from Margaret Flinter, Vicki Veltri stated that OHS was working on securing Medicaid data from DSS.	

<u>Changes in Spending</u>

Michael stated that commercial medical spending per member per month (PMPM) increased 15 percent from 2015 to 2018. He noted that the analysis included patient cost sharing. He added that wages during this time period grew at an annual rate of 1.47 percent. Michael stated that out-of-pocket spending increased more quickly than total spending. He said that from 2015 to 2018, out-of-pocket spending increased 26 percent compared to overall spending, which increased 15.3 percent. Michael noted that reasons for this increase included changes in employer benefit plan design and changes in employee plan selection.

Marie Smith asked why commercial pharmacy data had not been included in the analysis. Michael stated that Mathematica had been unable to incorporate commercial pharmacy data. He acknowledged that this was unfortunate given trends associated with pharmacy spending.

Michael acknowledged the need to expand the scope of the analysis to include Medicare, Medicaid and pharmacy in the future. He stated that the Mathematica analysis was an initial effort.

Michael pointed out that the out-of-pocket spending growth did not account for premium growth, which consumers are having withdrawn from their paychecks.

In response to a question from Lori Pasqualini, Michael clarified that it is OHS' intent that the next analysis incorporate 2019 and 2020 data. Lori stated that she anticipated that such an analysis would demonstrate that employee costs grew even more in 2019 and 2020.

Michael stated that healthcare spending growth was much faster than wage growth, and the out-of-pocket spending growth rate for consumers was even worse.

<u>Spending by Category of Services</u>

Michael stated that Mathematica analyzed spending growth for five service categories: professional, inpatient acute, hospital outpatient (not ER), hospital outpatient ER and other. Michael stated that in 2018, 99 percent of spending was in four service categories (professional at 42.3 percent, inpatient acute at 21.7 percent, hospital outpatient (not ER) at 20.8 percent, hospital outpatient ER at 14.2 percent). "Other" spending accounted for the remaining 1.1 percent.

Michael noted that PMPM spending for inpatient and outpatient hospital services grew faster than for professional services. He stated that the average annual change in spending for professional services was only 2.7 percent from 2015 to 2018. In comparison, the average annual change in spending for inpatient acute services was 6.8 percent; the average annual change in spending for outpatient services -- both ER and non-ER -- was 7.0 percent. He noted that hospital spending drove the overall increases in commercial healthcare spending between 2015 and 2018.

Susan Millerick asked if the hospital spending included hospital-owned urgent care centers. She noted the proliferation of urgent care centers in the past few years. KeriAnn Wells of Mathematica responded by stating that the hospital outpatient (not ER) category included freestanding sites, FQHCs and rural clinics. Michael stated that additional analysis was needed, particularly to understand hospital spending at a level of detail that the initial Mathematica analysis did not provide.

Karen Gee suggested that future analysis drill down further on the hospital outpatient (not ER) category of spending in order to distinguish spending associated with freestanding sites owned by hospitals.

Michael clarified that the analysis showed how much spending grew from 2015 to 2018, but not by how much it varied across the state during this same time period. Michael stated that a drilldown analysis to quantify variation in spending across the state would be valuable.

Michael noted that the Connecticut Hospital Association provided comments to OHS on what the association and its members believe was contributing to the increases in spending for hospital services identified by the Mathematica analysis.

Susan Millerick stated that the Mathematica analysis findings related to hospital spending were disappointing given the hospital consolidation that has taken place across Connecticut. She noted that the analysis did not suggest that any efficiencies were gained from such consolidation, as she would have expected.

Vicki stated that OHS is in the early phases of compliance efforts related to two recent hospital consolidations that had requirements related to caps on prices.

Margaret Flinter noted that while household budgets have been squeezed, the analysis indicates that hospitals have not felt a similar pressure.

Michael stated that the data use strategy is predicated on the idea that you cannot solve a problem until you know more about it.

Michael noted that in 2018, more than half of out-of-pocket spending was for professional services. He added that this reflects the design of employer health care benefits.

Role of Utilization and Spending Per Unit

Michael noted that the volume changes for two of three service categories actually decreased during the analysis time period of 2015 to 2018. He observed that utilization of professional services had the most growth across the four service categories during the study period. Michael stated that the percentage change in spending per unit (defined as a discharge) over the study period grew at far greater rates for the three categories of hospital services (inpatient, outpatient ER, outpatient not ER) compared to professional services.

Michael added that he had delved a bit deeper into this portion of the analysis with Mathematica, and together they had determined that about three quarters of the change in spending per unit for inpatient services resulted from a change in price and one quarter resulted from a change in service mix.

In response to a question from Karen Gee, Michael noted that the volume figures were population-adjusted.

Nancy Yedlin stated that the findings made her wonder about what state residents are getting in terms of the outcomes and quality of services they are receiving in relation to the expenses associated with those services.

Rob Kosior stated that there needs to be a specific focus on hospital quality, as opposed to HEDIS-like measures. Michael stated that the OHS core measure set does not include hospital measures and that he anticipates the Quality Council will discuss this topic at an upcoming meeting.

Vicki Veltri noted that she did not anticipate that similar analyses for the self-insured would dramatically differ in terms of inpatient and ED utilization. Michael stated that research shows a general national trend toward lower hospital utilization and higher inpatient spending. Susan Millerick stated that she is curious how much of the increase in spending was due to end-of-life care.

Rob Kosior suggested that OHS examine how service settings have changed. Michael agreed that site of care is another significant variable to examine.

Michael noted that there are interesting patterns in terms of where spending growth is the highest in terms of inpatient spending per unit.

Michael reviewed data showing changes in spending per inpatient stay by DRG, noting that changes in spending ranged from 11 percent to 25 percent, with a median of 15 percent. Michael restated that 75 percent of the change in inpatient spending was due to changes in payments as opposed to changes in the mix of services.

Prevalence and Costs of Chronic Conditions

Michael noted that almost half of the adult Connecticut population had one or more of 27 chronic conditions, and a quarter had two or more. Michael noted that PMPY spending for all members with one of 27 chronic condition for those continuously enrolled during 2017 and 2018 was $6,151, and that this figure jumped to $10,336 for those with one or more of the 27 chronic conditions, and to $14,379 for those with two or more of the 27 chronic conditions.

Marie Smith commented that specialty pharmacy and biologics for some diseases are a major cost driver. Michael clarified that medical pharmacy (i.e., drugs administered by a clinician) was included in the Mathematica analysis, and that this category included biologics.

Variation by County, Income and Community Racial Composition

Michael noted that based on Mathematica's analysis there did not appear to be a direct relationship between family income and PMPM spending, which indicates that family income is not driving health care spending.

	Michael shared data on ED use, noting that it was much higher among residents of lower income communities. He noted that there was also similar variation on inpatient stays, but it was not as great a variation as it was for ED visits. Jill Zorn noted that Medicaid data were missing from the charts. Rob Kosior stated that it would be helpful to examine utilization comparisons between commercial and Medicaid population. Michael noted that chronic conditions were more common among residents of lower income communities. He added that the burden of illness appeared to be significantly higher among lower income decile populations amongst the commercially insured population. Michael shared a final slide that showed that ED use was also more common among residents of communities with a lower percentage of white residents. Next Steps Michael shared a list of areas of OHS and Technical Team interest for future analyses. These include interest in a deeper dive into hospital spending growth so that OHS may better understand what drove hospital unit price growth from 2015 to 2018. He said that OHS would also like to analyze variation in hospital pricing and price growth by hospital and DRG. He stated that OHS intends to expand upon Mathematica's analysis by adding the following data elements: 2019 data, pharmacy data, Medicaid data, and clinical risk adjustment, and variation in ED utilization by race and income stratum. In response to a question from Jill Zorn, Michael stated that Rhode Island had observed that the presence of a PCP relationship did not seem to have an impact on individual's ED utilization. Pareesa Charmchi Goodwin stated that she would like to know what portion of ED visits are due to urgent dental care, noting that it is among the top three reasons reported by patients for a visit to the ED. Michael stated that future analysis should include why people go to the ED, and whether there is a higher prevalence of dental pain amongst those with lower incomes. Ken Lalime stated that he would like to dive deeper into the analysis of professional services spending, and expressed interest in distinguishing between primary care versus specialty care spending. Michael stated that OHS would like to develop a standard set of reports moving forward. Margaret Flinter expressed interest in whether psychiatric, behavioral health and substance use disorder data was included as a separate line or included in a general category. KeriAnn Wells stated that the inpatient category did not indicate these as separate line items. She added that "mental health clinic" is listed under both inpatient and professional services. Vicki Veltri noted Rob Kosior's recommendation that OHS conduct a site of care analysis. Karen Gee suggested understanding better avoidable ED visits.	
6.	**Adjourn**	**Vicki Veltri**
	Margaret Flinter made a motion to adjourn, which was seconded by Jill Zorn.	