

Cost Growth Benchmark Technical Team Meeting

Meeting Date	Meeting Time	Location
February 22, 2021	4:00 pm – 5:30 pm	Webinar/Zoom

Participant Name and Attendance

Cost Growth Benchmark Technical Team					
Pat Baker		Angela Harris			
Zack Cooper		Judy Dowd			
Paul Lombardo		Paul Grady			
Rae-Ellen Roy					
Vicki Veltri					
Others Present					
Olga Armah		KeriAnn Wells		Kelly Sinko	
Rachel Block		Dan Kinber		Hanna Nagy	
Marian Wrobel					

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

	Agenda	Responsible Person(s)
1.	Welcome and Introductions	Victoria Veltri
	Vicki Veltri called the meeting to order at 4:05pm.	
2.	Public Comment	Victoria Veltri
	Vicki welcomed public comment. None was voiced. Vicki acknowledged receipt of comments from the Connecticut Hospital Association.	
3.	Criteria for When to Report Provider Benchmark Performance	Michael Bailit
	<p>Michael stated -- as a reminder -- that OHS will report individual payer and provider entity performance against the benchmark for 2021 in early 2023. He noted that at its January 2021 meeting, 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.</p> <p>Michael stated that the Technical Team had yet to decide on whether there should be a minimum population threshold for Advanced Networks to be assessed against the benchmark. He explained the need for sufficient population size in order to measure provider performance against the benchmark, noting that a provider needs to be sufficiently large to help dampen any “noise” in the data, and to reduce the chance that random variation played a part in its performance. He added that while payers and providers contract on a shared savings or shared risk basis for as few as 3,000 attributed lives, studies have shown that random variation for such small populations can be significant. As a result, Michael stated that OHS had asked the Technical Team to set a minimum reporting threshold for public reporting.</p> <p>Michael shared the approaches taken by four other benchmark states to set minimum attributed lives for public reporting of provider performance: Delaware, Massachusetts, Oregon, and Rhode Island.</p> <p>In response to a question from Zack Cooper, Michael stated that staff are not recommending that OHS set a specific minimum threshold for attributed lives at this time. He explained that instead staff were recommending that OHS analyze the pre-benchmark data once they become available and calculate confidence intervals based on the actual data submitted by payers. Based on this analysis, staff propose developing a recommendation for establishing minimum threshold for public reporting of 2021 provider performance in 2023. Michael added that this threshold could be re-evaluated over time. Michael noted that the threshold would offer at least some parameters for OHS to evaluate 2021 data in 2023, and for determining if the population size was insufficient to support analysis.</p> <p>Zack Cooper expressed his support for the proposed approach.</p> <p>Paul Grady asked if any of the providers would be uncomfortable with the uncertainty of the proposed approach. Michael stated that the pre-benchmark analysis will be completed by the summer, and that this will allow sufficient time to provide guidance on this topic prior to public reporting in 2023. Paul Grady expressed his support for the proposed approach.</p> <p>Michael said that the Technical Team would return to this topic in the late summer or early fall with a recommendation.</p>	

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4.	Mathematica Data Use Strategy	Marian Wrobel
<p>Mathematica’s Marian Wrobel shared findings from its analysis of healthcare cost and cost growth drivers. She reviewed the purpose of the data use strategy, which is to provide insight into cost growth drivers and support solutions for achieving cost growth benchmarks.</p> <p><u>Overview of All-Payer Claims Databases</u> Marian provided a brief overview of all-payer claims databases, noting that APCDs compile enrollment and claims data submitted by payers. She clarified that payers do not report non-claims costs such as shared savings or capitated payments made outside the claims system, and so these data are not captured in APCDs. She noted that one disadvantage of APCD data is there are significant time lapses between payment data occurrence and payer data submission. However, she added that the benefit of APCDs is that the claims data can be analyzed at a very granular level (e.g., by payer, by region, by provider type, by patient population segment, etc.)</p> <p><u>Overview of Analytic Population</u> Marian 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 commercial fully insured and State employees. She noted that the analysis was limited to medical claims from 2015 to 2018. She added that self-insured plans are not obligated to submit to APCDs. In response to a question from Paul Grady, Michael stated that pharmacy data were not included in the Mathematica analysis and acknowledged that this is a significant exclusion given that pharmacy can account for one quarter of all commercial healthcare spending. Michael clarified that the Mathematica analysis included medical pharmacy and only retail pharmacy was excluded.</p> <p>Marian noted that Mathematica’s analysis found that demographics in the state were stable. Marian stated that the analysis captured member months over the time period for six major commercial payers, of which Anthem was the largest. Marian added that Anthem had lost market share from 2015 to 2018. She said that UnitedHealthcare was the second largest payer and gained market share from 2015 to 2018.</p> <p>In response to a question from Angela Harris, Paul Lombardo stated that Harvard Pilgrim Health Care entered the marketplace in 2015 and stated that it is not on the health insurance exchange. Paul stated that only Anthem and ConnectiCare are offered on Connecticut’s exchange. In response to a question from Paul Grady, Marian stated that the nine million member months in the data analysis represented approximately 800,000 individuals. Marian noted that approximately half of the commercially insured population in Connecticut is fully insured and in the APCD. Paul Lombardo corrected this figure, noting that only 30 percent of the commercial population in Connecticut is fully insured and 70 percent is self-insured.</p> <p>Marian stated that medical spending per member per month (PMPM) increased 15 percent from 2015 to 2018. She stated that annual changes were as follows: 8.1 percent between 2015 and 2016, and a little over 3 percent in each of the next two years. In response to a question from Zack Cooper, Marian confirmed that the medical spending figures were not adjusted for inflation. Zack stated that since the figures were not inflation-adjusted, health spending essentially went down in real terms from 2016 onwards. Zack stated that once adjusted for inflation, in fact, there would be little-to-no growth in medical spending. He cautioned that the statement that medical spending increased 15 percent was not accurate because of the lack of an inflation adjustment. Michael explained that for the purposes of the cost growth benchmark, OHS will not be making inflation adjustments, so the annual changes in medical spending are valid as a comparator to the benchmark value.</p> <p>Marian stated that medical spending increased most quickly for children and older men. She stated that Mathematica had adjusted the three-year growth rate for changes in demographic composition. She noted that the growth persisted despite these adjustments, meaning that the growth in medical spending was not a result of demographic changes.</p> <p>Marian stated that out-of-pocket spending increased more quickly than total spending. She said that from 2015 to 2018, out-of-pocket spending increased 26 percent compared to overall spending, which increased 15.3 percent. She added that the general finding that out-of-pocket spending rose more quickly than total spending is a trend she had seen in other states.</p> <p>Angela Harris asked if Mathematica had examined health-related drivers such as chronic conditions. Marian stated that the presented spending data were simple descriptive numbers, and they were not controlled for the medical status of the population.</p> <p><u>Spending by Service Category</u> Marian noted 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.</p>		

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Marian stated that in 2018, more than half of out-of-pocket spending by consumers was for professional services (61.1 percent). She added that this did not include pharmacy, which is a major source of out-of-pocket spending. Marian stated that patients paid -- on an out-of-pocket basis -- 19 percent of the total cost of professional services and 3 percent of the total cost of inpatient services.

PMPM Spending Growth – Roles of Utilization and Spending Per Unit

Marian stated that Mathematica examined the percentage change in spending per unit within the four top service categories, and also calculated the three-year percentage change in service volume. The analysis showed that the driving factor for PMPM growth was spending per unit, not number of units (volume).

In response to a question from Zack, Marian explained that the unit for inpatient stays was a count of admissions. She noted that it was a crude unit measure, adding that change in spending per unit could result from either a change in composition or in unit prices. Michael added that price can mask changes in service mix and changes in services. He acknowledged that Mathematica was not able to determine how much of the PMPM growth was the result of a change in price to services year over year or to substitution of services. In response to a question from Paul Grady, Marian stated that Mathematica had service volume (utilization) data for 2016 and 2017, in addition to the 2018 volume data shown on the slide. Michael noted that the three-year percent change in volume showed a decrease in inpatient acute stays of 4.1 percent, and a decrease in outpatient emergency services of 1.1 percent. Marian stated that professional services experienced a three-year percentage change increase in volume of 4.4 percent. Michael noted that nationally, inpatient hospital utilization has declined, and outpatient hospital utilization has increased. Michael stated that Rhode Island experienced the similar utilization trends, however, Rhode Island's prices did not increase as much as Connecticut's.

Michael noted the importance of Mathematica's findings that the per unit increases in hospital prices was the greatest driver of health care spending, emphasizing that at the same time there had been only a modest increase in professional services volume without a substantial increase in the per unit price. Paul Grady stated that these trends are true across the country. Zack Cooper urged caution in interpreting this slide as evidence that prices increased per unit. He said that the intensity of the stay, the mix of procedures and quality of services also play a role in the per unit price. Zack stated that additional analysis was needed to determine if it was truly price driving up the per unit increase as opposed to these other factors. Michael and Marian agreed that further drill down analysis was needed.

Angela Harris asked how Mathematica categorized the services rendered by satellite facilities owned by the large healthcare systems. Marian stated it would depend on how the claims were billed. Angela noted that satellite facilities owned by healthcare systems were proliferating within Connecticut. Michael agreed that OHS would want to examine this further, and noted that in Massachusetts, large facility fees associated with satellite clinics contributed to differences in prices.

Paul Grady discussed the public comment from the hospital association and recalled that the hospitals encouraged OHS to examine both the Medicaid and Medicare spending. Michael stated that the hospital association also pointed to other factors that may be driving up per unit inpatient costs, including the shift of lower acuity cases to outpatient settings. Michael said that regardless, the analysis shows that it was the percentage change in spending per unit across these categories that drove up spending, and further analysis was warranted to understand the underlying reasons.

Marian shared several slides that were graphical representations of the findings she had described. She shared data indicating that age and gender-adjusted inpatient spending per unit was highest for residents of Fairfield and New Haven, and lowest for residents in Windham county. Zack suggested extending this analysis by dividing the data on slide 21 by the Medicare wage index. Marian stated that the way that units were classified was by where individuals reside as opposed to where they received services.

Marian shared data indicating that when examined by Diagnostic Related Group (DRG), the changes in spending per inpatient stay were typically between 11 percent and 25 percent, with a median of 15 percent. Marian explained that a DRG is a diagnostic grouping or classification used when hospital stays are billed. Marian stated that while the average spending growth per inpatient stay was 15 percent, even for a specific type of stay, there was still significant increase in spending per stay over the three years.

Prevalence and Costs of Chronic Conditions

Marian stated the analysis included findings on the prevalence and cost of chronic conditions. She noted that the analysis sample was 455,780, and was limited to those over 18 and those who had been enrolled in their health insurance for over two years. She added that the two-year period of enrollment was needed in order to reliably identify chronic conditions. She stated, for example, that in 2018, 28,608 members had diabetes with an average annual cost of \$14,197.

Marian shared an analysis of co-existing conditions, noting that people with one chronic condition often had one or more additional conditions. In response to a question from Zack Cooper, Marian stated that member IDs were in the APCD. Zack

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recommended an additional analysis to examine the concentration of healthcare spending among individuals. This analysis would address the question “what percentage of the population is accountable for what percentage of the healthcare spending?” Marian agreed this would be a great analysis.

Marian shared a slide showing conditions that were less common but that were associated with very high spending. For example, in 2018 there were 475 cases of lung cancer, with an annual cost of \$96,691 PMPY. Pat Baker asked to see the information on less common but expensive conditions for 2016 and 2017 in order to determine what the trends have been in these conditions and the associated costs over time. Marian agreed the trends would be interesting to examine and stated that Mathematica had delivered a two-year trend that included the 2017 sample in addition to the 2018 sample.

Marian displayed data that indicated 6.0 percent of the population had more than \$20,000 in medical spending in 2018. She also noted that about 8 percent of the continuously enrolled population spent more than \$2,500 in out-of-pocket medical spending for an individual (excluding spending on drugs). Marian noted that these findings provided a picture of the financial burden of health care costs on individuals and families, especially lower income families. As an example, there were 90 members with a hip or pelvic fracture, and 92.2 percent of those involved healthcare costs of over \$20,000 in 2018 with 44 percent having experienced out-of-pocket costs greater than \$2,500.

Variation by County

Marian stated that Mathematica had examined geographic spending, noting significant variations by county. She stated the highest spending PMPM was associated with residents of New Haven and New London counties.

Marian noted findings of interest when applying an equity lens. She stated that Mathematica sorted individuals by income in their zip code. Marian shared several slides that depicted the income decile and decile range, and then the emergency visits and inpatient stays per 1,000 for members falling within those deciles. She stated the analysis found that emergency department (ED) use was higher among residents of lower income communities. In response to a question from Zack Cooper, Marian clarified that the ED visits are for people residing in the zip code. She stated that in low-income communities, residents experienced 804.7 ED visits per 1,000 members compared to less than half that in the highest-income communities. Marian noted that while a similar trend was evidenced for inpatient stays, it was not as dramatic.

Pat Baker said that CT Healthcare Foundation recently reviewed data that showed only 46 percent of people of color had a primary care physician compared to 77 percent of the majority population. She hypothesized that racial and ethnic data would share further light on the Mathematica findings.

Judy Dowd said that she would like Medicaid to replicate Mathematica’s analysis of variations by county noting that the Medicaid program had invested significantly in primary care; she said she would anticipate better trends in Medicaid. Michael stated that the primary care physician relationship is not a predictor of the rate of ED visits. Rae Ellen Roy stated that it is likely that visit coinsurance rates may be a better predictor of rate of ED visits.

Marian showed a data slide illustrating that chronic conditions are more common among residents of lower income communities.

5.	Adjourn	Vicki Veltri
Vicki Veltri adjourned the meeting at 5:23 pm.		