HEALTHCARE COST CONTAINMENT COMMITTEE

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STATE OF CONNECTICUT
HEALTHCARE POLICY & BENEFIT SERVICES DIVISION
OFFICE OF THE STATE COMPTROLLER

HEALTHCARE COST CONTAINMENT COMMITTEE MEETING MINUTES
June 10, 2024

Meeting Called to Order by **Josh Wojcik**:

Attendance:

Labor	State Comptroller Administrative Staff
Carl Chisem – CEUI	Joshua Wojcik
Dan Livingston – SEBAC	Thomas Woodruff
	Presenters
	Bernie Slowik – OSC
	Rae-Ellen Roy – OSC
Management	Lisa Hill -OSC
Gregory Messner	Tracy Cellilie-OSC
Karen Nolen	Sandra Czunas-OSC
	Consultants
Dept. of Insurance	Terry DeMattie, Segal
Paul Lombardo	

Public Comment:

No public comment

Financials:

Our budget has been quite active this month. The general fund appropriation was reduced by $8 million to cover other budget costs. We attended a Financial Advisory Committee (FAC) meeting on Friday to make a few adjustments. We added $2.75 million to the active appropriation to cover the costs of the reinstated UConn Health fringe benefit allotment.

As a result of these adjustments, approximately $3.36 million will be deducted from our active appropriation. This brings our final outlook for the active appropriation, assuming all goes as anticipated for the next few weeks, to a balance close to zero. We're expecting to close the year at about $845,000, which is as close to zero as we can get for that account. The active health FAD accounts are still in good shape, and we aim to close the year with a reserve of about $157.2 million for both the health and pharmacy accounts. Despite a slight increase in claims this month, it's nothing to be concerned about.

There has been some activity related to retiree appropriation. $3 million was withdrawn from that account to cover other general fund expenses, including $1.6 million for the UConn Health Center fringe adjustment. As a result, we anticipate closing the year with approximately $978,000 remaining in those accounts, aiming for as close to zero as possible. This figure includes anticipated activity for the June payroll cycle, including the rate adjustment for retirees for the upcoming fiscal year. Regarding the retiree OPEB FAD accounts, we continue to utilize the reserve, which currently stands at a healthy $224 million.

Partnership:

As of June 1st, we currently have 156 groups enrolled, with just over 23,000 employees and about 50,000 members. Next month, we expect a significant increase as eleven new groups will join, adding approximately 2800 new employees and about 6300 members in total. Additionally, we plan to schedule the quarterly meetings in early July for our existing partnerships, during which we will review the HEP and other relevant statistics for existing and new groups.

Partnership 1.0 still has five enrolled groups, with approximately 2400 employees and just under 3400 members.

High-Level Utilization:

We consistently observe high utilization data levels every month. Last month, we noticed a significant increase in pharmacy costs, contributing to a 7.5% rise in overall care costs. We anticipate that pharmacy costs will remain 7% to 8% in the coming months. This increase is due to the broader market trends in pharmacy costs, as the savings from programs such as Prudent RX, the manufacturer assistance program are now factored into the baseline costs.

We expect this trend to continue for the next few months, but we anticipate a decline as we move into the new year. This should help balance out some of the other cost trends we observe in medical care, where costs are either low or negative, particularly in inpatient facilities.

Quantum Stats:

This month, we want to highlight Quantum Health's engagement activity with our members. Over 215,000 participants have engaged through calls, over 7,500 through chats, and about 12,600 through secure messages. It should be noted that these numbers represent the state population. The call volumes have been notably high, resulting in slightly increased wait times. However, after

bringing this issue to our attention, Quantum Health promptly adjusted its resources to address this.

It's important to emphasize that 46% of our population is engaged when calling in. These calls are not about rushing members off the phone but about engaging them in meaningful health conversations, providing support for family members, offering clinical support, and collaborating with providers. This collaborative approach ensures that everyone's needs are met.

The data shows an average of about 4.4 provider interactions per member. This indicates that providers are utilizing this service to get benefits quoted and expedite the approval process for authorizations for our members.

These details are about partnership-specific engagement. The total engagement overview indicates that partnership members prefer to make calls rather than chat or use secure messaging.
The engagement rate for the partnership is 44%, slightly lower than the state of Connecticut. However, it's notable that they predominantly use the phone to seek support for their healthcare journey, not just for specific questions about claims. However, they could also call for that purpose. They also receive additional support from the Care Coordinator. There are about 4.1 provider interactions per member and approximately 2.5 engagement activities per member, comparable to the state population. It's interesting to see that both of our populations tend to behave in a similar manner.

Communications Update:

We launched an awareness campaign in mid-April, starting with a benefits overview to educate employees about the available benefit resources. Subsequently, we sent out weekly emails covering various benefit topics leading up to the end of open enrollment.

We observed that the dental benefits topic had the highest open rate, indicating strong interest among the audience, mainly consisting of state work email addresses. We also tailored some content specifically for non-Medicare retirees. The open rates for each group are listed in the same column order.

In May, we hosted three highly interactive live events for active employees and one for retirees. These events, which saw approximately 1000 total participants, were a testament to the high level of engagement, with participants actively involved in the Q&A chats. For those unable to attend the live events, a prerecorded slideshow was made available on Care Compass. Additionally, the live event could be re-watched using the same webinar link.

This year, we created a payroll stuffer that was distributed to 8,000 state employees' homes. A digital PDF version of the stuffer was also available on Care Compass.

We directed individuals to the Care Compass website for more information throughout our communications. The user influx on the website steadily increased during May, with the highest increase occurring at the start and end of open enrollment. We also noticed higher engagement times and increased time spent on each page during this period. The impact on Care Compass stats

before the open enrollment communications began, especially when compared to mid-April or earlier, was significant.

During the open enrollment period, the most visited page on Care Compass was the benefits enrollment page, followed by the dental and medical pages and then the retiree versions. Various communications, such as emails, postcards, routine updates, and the provider of distinction, also contributed to spikes in page views. An open enrollment meeting with the agency benefits staff was held to remind them about the resources available on the agency pages, which likely encouraged more exploration of the site.

Our communication message, which focused on ensuring that members' current plans meet their needs, was well-received. This led to a commendable level of engagement with the medical decision tools and the dental decision tool. Cigna's insights into what members selected as their top needs in the plan further validated the success of our strategy.

The Care Compass Facebook page played a role in reinforcing all user emails and providing extra reminders throughout the year and during open enrollment. We have 835 followers as of May, and our posts reached over 57,000 users during open enrollment. Posts and ads were also boosted to reach a broader audience, resulting in significantly higher reach and impressions than the follower count. There were also about 4,500 unique clicks, representing the total number of times users clicked on a link within a post, directing them back to the Care Compass site.

Now that open enrollment is over, we are focusing on making improvements. Earlier this year, we conducted a focus group with health plan members who gave us feedback on communications and other topics. We are planning another focus group, with agency benefits staff and HR managers as participants. The goal is to understand what kind of assistance they need from us and how we can better collaborate. Their insights will help us improve the Care Compass website. We have updated and reformatted several key web pages this year, including those for active and retiree medical, dental, pharmacy, and supplemental pages. Now, we are developing new pages focused on medical weight management, behavioral health, and partnerships, including dedicated sections for members and administrative perspective groups.

PCI Presentation:

This is an update on our primary care initiative for the State Employee Health Plan and partnership.

As most of us know, in 2020, the governor issued an executive order outlining specific objectives for improving healthcare in Connecticut. The primary goals were to enhance health outcomes and simultaneously reduce the growth rate of healthcare costs.

This was to be achieved through two main strategies: first, setting a healthcare cost growth benchmark for the state to slow the growth of healthcare costs, and second, increasing investments in primary care by 10% by 2025. The increase was planned to be gradual, starting at around 5% in 2021, aiming for 6.9% in 2023, and reaching the 10% target in 2025.

We have previously provided some high-level overviews of the primary care initiative we have been working on, and today, we have more results to share.

For some time now, we have been working on this primary care initiative to provide additional support to the primary care groups. To achieve this, we hired dedicated staff from Anthem, including nurse consultants. These individuals have been instrumental in meeting with provider groups to guide them through reporting and data, helping them focus on areas that need improvement.

One of our goals is to create a reimbursement structure that aligns with providers' incentives. Previously referred to as the triple aim, we are now focusing on the quadruple aim. This entails improving quality outcomes, affordability, and the work that primary care clinicians do. We are aware of the burnout issues in primary care and aim to address this.

Additionally, we are improving the quality of reporting by enhancing our data. We are using the State Quality Council's quality council measures to assess our data quality. The primary care initiative focuses on 11 core areas established by the Office of Health Strategy, which were detailed in the primary care investment roadmap published by the Office of Health Strategy and can be found in the appendix.

The focus of these 11 core areas revolves around building practice teams within primary care. To put it in perspective, one of our care coordinators at Anthem likened the primary care clinicians to quarterbacks who manage a lot and cannot do it alone. Therefore, our objective is to encourage primary care groups to expand their practice teams, enabling them to enhance their outreach and care coordination capabilities.

We have introduced a system for scoring quality, allowing primary care groups to earn a quality bonus for scoring well. We are also providing additional staffing support at Anthem.

Let's review the list of quality measures used for scoring in the initiative. These measures, vetted by the Quality Council and the Statewide Quality Council, are primarily claims-based. Some require additional data, such as lab data for the diabetes HBA1C control measure, which serves as a benchmark. Meeting or exceeding this benchmark earns providers a bonus points in quality.

The scoring system works on a points system. Points are earned for each quality measure for which a sufficient number of cases can be scored. The averaged scores are then multiplied by the maximum base bonus of $3 to determine the bonus amount.

For the past measurement period in 2023, we have some standout results. Several groups, including CMC, Connecticut Children's Care Network, earned additional funds in the excess quality pool. These groups were highly engaged and receptive to feedback on data improvement. Anthem also received supplemental data from these groups, allowing them to understand their data better and focus their efforts where needed.

Another component of this initiative is medical cost performance. The groups were required to manage a fixed panel of attributed members with a total cost of care target.

The contracts included a shared savings opportunity and a downside risk, which is new to our contracting. The targets were based on the prior year and did not include the care coordination fee payments from the baseline, as they were absent. These enhanced care coordination payments started in 2023. The results provided below are preliminary and only go through Q3. The final quarter has not been shared, so these results are preliminary.

It is evident that some groups performed very well and were highly engaged, while others were not. As a result, the groups will change.
The combined gain is 4.3, of which the state has realized a savings of 3.6.
We have come under the target spend, and I have included this in the appendix, which explains all the calculations in the various columns.

Finally, the next piece is an annual report. It's important to understand the challenges faced by provider groups and have them report directly to OSC. Some of the challenges provider groups face include initiatives and ongoing efforts to invest in primary care, such as allocating funds to hire staff, improve access, and provide post-discharge resources.

One of the main challenges identified in our meetings is the transition of care in primary care. Provider groups sometimes receive feedback when patients are in the hospital or the emergency department. By offering provider groups insight into the care their patients receive outside of their practices, we've been able to address this challenge.

Some groups have hired dedicated staff to improve follow-up and medication reconciliation during care transitions. They have also established links with providers outside their organizations and made technological enhancements to facilitate scheduling, follow-ups, and referrals.

Furthermore, the investments also aim to support and enhance existing programs and foster collaboration with community-based organizations.

Here's a detailed overview of the various categories in which we asked the teams to provide more information about how they allocated the funds earned through the care coordination fee prospective payments.

Some top-performing groups, such as CCMC and NEMG, were highly engaged and strongly interested in their data. They were willing to share supplemental data to address data gaps and improve their quality scores. Where there were no data gaps but the need for improvement was recognized, plans were in place to target and enhance their focus and efforts.

One of the challenges faced by some groups was managing attributed patient lists, but they overcame this challenge by working closely with the anthem team to identify patients in need of enhanced care coordination and additional follow-up.

NEMG focused on targeting transitions of care, recognizing it as a critical area where improvements could prevent hospital readmissions and emergency room visits. UCONN also stood out by hiring dedicated staff to improve medication reconciliation and follow-up with

transitions of care. Additionally, they embedded behavioral health clinicians in all their practices, aligning with the primary care roadmap from the Office of Health Strategy.

There is a growing need for behavioral health, and practices are striving to meet this demand by embedding committed behavioral health clinicians and expanding collaboration with community-based resources for counseling and therapy sessions.

Challenges persist in data management, reconciliation, and understanding patient attribution and physician rosters. Efforts have been made to address these challenges, including frequent meetings with provider groups to review reporting, care opportunities, and patient complexities. This has provided valuable insight to understand the challenges faced by provider groups and how best to support them.

Overall, the successful initiatives have included improved data collection, highly engaged groups focusing on opportunities, and improved collaboration with the provider groups.

We are working on a major initiative to utilize Connie, a statewide Health Information Exchange (HIE) with which our office has been involved for years. Most providers are now required to connect to Connie, and we plan to use the data from it to enhance our quality reporting. We've had meetings with Anthem and the Connie team to discuss leveraging this data and reducing the administrative burden on provider groups by eliminating the need to submit additional data to close information gaps.

In the upcoming year, we will be adding new quality measures, including prenatal and postpartum care transitions and pharmacy experience. We will also consider the total cost of care and pharmacy data supported by our pharmacy benefit manager (PBM), CVS.

Due to the retirement of one of our care consultants, we are looking to hire two additional consultants to support the provider groups.

With the extra funds being sent to primary care, once we achieve the ultimate goal from the governor's plan, we will be spending approximately 10% of our total cost of care. This means we are asking these groups to manage the remaining 90% of the total cost of care.

As we continue through this year and into next year, we will carefully assess whether the money we are investing in primary care is being more than offset by the total cost of care. There are indications that this may be starting to happen.

Josh Wojcik – Invited other questions or comments from committee members and the public. There were no additional questions or comments, call for motion to adjourn.

Motion to Adjourn was made by Dan Livingston, seconded by Karen Nolan.

Meeting was adjourned.